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

Special Meeting
Monday, October 26, 2020, 2:00 p.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010
Executive Order N-25-20
Conference Call Number: 805-324-7279
Conference ID Number: 391 999 832#
Para interpretación al español, por favor llame al 805-322-1542 clave 1234

AGENDA

CALL TO ORDER

ROLL CALL

PUBLIC COMMENT

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

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

Members of the public may call in, using the numbers above, or can submit public comments to the Committee via email by sending an email to ask@goldchp.org. If members of the public want to speak on a particular agenda item, please identify the agenda item number. Public comments submitted by email should be under 300 words.

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Regular Minutes of September 28, 2020.

Staff: Maddie Gutierrez, MMC – Clerk of the Commission

RECOMMENDATION: Approve the minutes of September 28, 2020.

2. Resolution Extension through January 25, 2021

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Adopt Resolution No. 2020-008 to extend the duration of authority empowered in the CEO through January 25, 2021.

3. Chief Diversity Officer Contract Extension

Staff: Joseph T. Ortiz, BBK Diversity Counsel

RECOMMENDATION: Staff recommends that the Commission approve the proposed Third Amendment to the Consulting Services Agreement and Statement of Work.

4. Pharmacy Benefits Manager (PBM) Contract Amendment

Staff: Nancy Wharfield, M.D., Chief Medical Officer
Anne Freese, PharmD., Director of Pharmacy

RECOMMENDATION: Staff recommends the Commission authorize the signing of the amendment.

UPDATES

5. Medi-Cal Rx Update

Staff: Nancy Wharfield, M.D., Chief Medical Officer
Anne Freese, PharmD., Director of Pharmacy

RECOMMENDATION: Accept and file the update.

FORMAL ACTION

6. June 2020 Audited Financial Statements

Staff: Kashina Bishop, Chief Financial Officer
Moss Adams Representatives

RECOMMENDATION: Staff recommends that the Commission approve the audited financial statements as of, and for the year ending June 30, 2020.

7. September 2020 Financials Report

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Staff recommends the Commission approve the September 2020 financial package.

8. Provider Contracting Credentialing, and Data Management (PCCM) System Implementation – Approval of Additional Funds

Staff: Nancy Wharfield, Chief Medical Officer
Eileen Moscaritolo, HMA Consultant

RECOMMENDATION: Staff recommend the Commission approve and delegate to the CEO the authority to execute agreement amendments and/or change orders with Symplr with a new NTE amount of $1,592,700 for the duration of the five year agreement.

9. Quality Improvement Committee 2020 Third Quarter Report

Staff: Nancy Wharfield, M.D., Chief Medical Officer
Kim Timmerman, Director of Quality Improvement

RECOMMENDATION: Approve the 2019 QI Program Evaluation. Receive and file the complete report as presented.

REPORTS

10. Chief Executive Officer (CEO) Report

Staff: Margaret Tatar, Chief Executive Officer

RECOMMENDATION: Receive and file the report.

11. Chief Medical Officer (CMO) Report

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

RECOMMENDATION: Receive and file the report.

12. Chief Diversity Officer (CDO) Report

Staff: Ted Bagley, Chief Diversity Officer

RECOMMENDATION: Receive and file the report.

13. Executive Director of Human Resources (H.R.) Report

Staff: Michael Murguia, Executive Director of Human Resources

RECOMMENDATION: Receive and file the report.

CLOSED SESSION

14. LIABILITY CLAIMS
CLAIMANT: Lifeline Medical Transport (Ojai Ambulance Inc.)
AGENCY CLAIMED AGAINST: Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan

ADJOURNMENT

Unless otherwise determined by the Commission, the next meeting will be held at 2:00 P.M. on December 15, 2020, as part of the Strategic Planning Retreat 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 Commission.

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 Commission to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO. 1

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Maddie Gutierrez, MMC - Clerk to the Commission

DATE: October 26, 2020

SUBJECT: Meeting Minutes of September 28, 2020 Regular Commission Meeting.

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of Minutes for the September 28, 2020 Regular Commission Meeting.

Ventura County Medi-Cal Managed Care Commission
(VCMMCC)
dba Gold Coast Health Plan (GCHP)
September 28, 2020 Regular Meeting Minutes

CALL TO ORDER

Commission Chair Dee Pupa called the meeting to order via teleconference at 2:03 p.m. Clerks were in the Community Room located at Gold Coast Health Plan, 711 East Daily Drive, Camarillo, California.

ROLL CALL

Present: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Dr. Sevet Johnson, Gagan Pawar, M.D., Dee Pupa, and Supervisor John Zaragoza.

Absent: Commissioners Fred Ashworth, Laura Espinosa, Jennifer Swenson, and Scott Underwood, M.D.

Attending the meeting for GCHP were: Margaret Tatar, Chief Executive Officer, Nancy Wharfield, M.D., Chief Medical Officer, Ted Bagley, Interim Chief Diversity Officer, Kashina Bishop, Chief Financial Officer, Michael Murguia, Exec. Director of Human Resources, Robert Franco, Interim Chief Compliance Officer, Scott Campbell, General Counsel, Cathy Salenko, Health Care General Counsel, Marlen Torres, Executive Director of Strategies and External Affairs, and Eileen Moscaritolo, HMA Consultant.

Additional Staff participating on the call: Vicki Wrighster, Dr. Anne Freese, Rachel Lambert, Bob Bushey, Helen Miller, Dr. Lupe Gonzalez, Pauline Preciado, Kim Timmerman, Nicole Kanter, Debbie Rieger, Steve Peiser, Sandi Walker, Paula Cabral, and Susana Enriquez-Euyoque.

Rohan Reid from AmericasHealth Plan (AHP), Barry Zimmerman from the County of Ventura, and Anna Rangel, interpreter.

PUBLIC COMMENT

None.

CONSENT

1. **Approval of Ventura County Medi-Cal Managed Care Commission Regular Minutes of August 24, 2020.**

   Staff: Maddie Gutierrez, MMC – Clerk of the Commission

   RECOMMENDATION: Approve the minutes of August 24, 2020.

2. **Adopt a Resolution to Renew Resolution No. 2020-005 to Extend the Duration of Authority Empowered in the CEO to Issue Emergency Regulations and Take Action related to the Outbreak of Coronavirus ("COVID-19")**

   Staff: Scott Campbell, General Counsel

   RECOMMENDATION: Adopt resolution 2020-006 to:
   1. Extend the duration of authority granted to the CEO to issue emergency regulations and take action related to the outbreak of COVID-19.

3. **Adopt a Resolution Canceling the Upcoming November 16, 2020 Ventura County Medi-Cal Managed Care Commission ("Commission") Regular Meeting.**

   Staff: Scott Campbell, General Counsel

   RECOMMENDATION: Staff recommends the following:

   1. To adopt Resolution No. 2020-007 to cancel the upcoming November 16, 2020 regular Commission meeting.

4. **Approve Amendment No. 4 to Agreement ("Agreement") with Health Management Associates ("HMA") to authorize additional HMA resources to assist in management of Gold Coast Health Plan (GCHP).**

   Staff: Scott Campbell, General Counsel

   RECOMMENDATION: Staff recommends the following:

   1. To approve Amendment No. 4 authorizing additional HMA resources to assist CEO, Margaret Tatar, in management of Gold Coast Health Plan (GCHP).

Supervisor Zaragoza motioned to approve Consent agenda items 1 through 4. Commissioner Pupa seconded.

Roll Call Vote:

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Dr. Sevet Johnson, Gagan Pawar, M.D., Dee Pupa, and Supervisor John Zaragoza.

NOES: None.

ABSENT: Commissioners Fred Ashworth, Laura Espinosa, Jennifer Swenson, and Scott Underwood, M.D.

Commissioner Pupa declared the motion carried.

Commissioners Laura Espinosa and Scott Underwood, M.D. joined the meeting at 2:05 p.m.

FORMAL ACTION

5. GCHP's PACE Organization Letter of Support Criteria Policy

Staff: Margaret Tatar, Chief Executive Officer

RECOMMENDATION: Staff recommends the Commission approve to delegate the Chief Executive Officer (CEO) to manage any requests in accordance with this Commission policy.

Chief Executive Officer, Margaret Tatar, reviewed the PACE program. CEO Tatar noted that GCHP has taken a proactive approach and has written an internal policy. The policy is to set criteria that must be met in order to operate a PACE center in Ventura County. The CEO will manage all requests in accordance with Commission policy.

Commissioner Atin asked for clarification. Commissioner Atin stated there might be other parties interested in participating in PACE. CEO Tatar stated interested parties can be reviewed and discussed. Commissioner Atin asked if the contracts have a significant value, and scope. CEO Tatar stated PACE delivers both Medicare and Medicaid – two (2) checks would be received. Commissioner Alatorre asked what other plans are doing. He asked if Commission could also approve issuance of the letter or only the CEO. CEO Tatar stated requests can be on an Ad-Hoc basis and presented to the Commission.

Commissioner Atin stated he would support the policy with an amendment stated the Commission must be notified prior to approval of the letter. CEO Tatar stated criteria can be approved to analyze and present to the Commission. Commissioner Atin

asked if an RFP process would be used for letter approval or will it be sole source. CEO Tatar stated we (GCHP) are not the procurer of the services. COHS duals are mandatorily enrolled in our plan. There is no ability to dis-enroll. Commissioner Atin asked how many PACE providers there will be. CEO Tatar stated it is not unlimited but that CMS and DHCS decide. CEO Tatar believes that Ventura County could support 1 to 4 PACE organizations. Commissioner Atin asked how it is determined approval of one organization over another. CEO Tatar stated there is no way to predict on how the State will decide. . Commissioner Atin stated he thought it would be reasonable to notify the Commission of letters of interest. The CEO would then present recommendations to the Commission for action.

Commissioner Atin motioned to approve the amended motion stating the Commission would approve criteria and that approval of letters would be decide by the Commission. Commissioner Pupa seconded.

Commissioner Espinosa noted point of discussion: approve the criteria and give authority to the CEO to make recommendations and the Commission would give final approval. CEO Tatar stated the Commission would have final say. The Commission could vote on the criteria only, and CEO will present recommendations for approval by Commission.

Roll Call Vote:

AYES: Commissioners Antonio Alatorre, Laura Espinosa, Dr. Sevet Johnson, Gagan Pawar, M.D., Dee Pupa, Scott Underwood, M.D. and Supervisor John Zaragoza.

NOES: None.

ABSENT: Commissioners Fred Ashworth, and Jennifer Swenson.

Commissioner Pupa declared the motion carried.

6. August 2020 Financial Report

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Staff recommends that the Commission approve the August 2020 financial package.

Chief Financial Officer Kashina Bishop presented the unaudited August 2020 Financials PowerPoint. She gave a financial overview noting August net loss of $266,000. Fiscal Year to Date Net Loss of $1.0 million. TNE is $68.0 million and 192%

of the minimum required. The Medical Loss Ratio is 95.3# and administrative ratio is 5.6%.

CFO Bishops anticipated a significant decrease to the IBNR liability. She will present final audited statements at the October Commission meeting. Financial impacts due to COVID-19 were reviewed. CFO Bishop noted an increase in membership as well as a 10% increase to long-term care facility rates. Authorizations and claims volume continue to increase but is still lower on a PMPM basis.

CFO Bishop reviewed updates on the Solvency Action Plan noting total annual savings of $10.1 – 11.1 million. She reviewed the current focus and annualized impact in savings.

Net premium revenue is $144.5 million, over budget by $6.6 million and 5%. CFO Bishop also reviewed the Membership graphs. She noted current health care costs are $137.6 million and $4.9 million over budget.

Graphs for Total Fee for Service, Inpatient medical expenses, and long-term care expenses were reviewed. CFO Bishop noted directed payments are over budget by $3.6 million and pharmacy is over by $1.2 million. We are currently at 192% of the TNE required.

Commission Chair Pupa asked if once adjustments are made, we will adjust June financials and roll forward. CFO Bishop stated that was correct. Commissioner Alatorre asked how this can be avoided going forward. CFO Bishop stated we are improving internal controls. HMA Consultant, Eileen Moscaritolo, stated with the new platform there will be new controls. Commissioner Alatorre asked if overpayments were recovered. CFO Bishops stated $6 million of $9 million were recovered. Commissioner Alatorre asked if these were claw backs or letters. CFO Bishop stated there were claw backs from future payments.

Commissioner Atin motioned to approve the August 2020 financial package. Commissioner Alatorre seconded.

Roll Call Vote:

AYES: Commissioners Antonio Alatorre, Laura Espinosa, Dr. Sevet Johnson, Gagan Pawar, M.D., Dee Pupa, Scott Underwood, M.D. and Supervisor John Zaragoza.

NOES: None.

ABSENT: Commissioners Fred Ashworth, and Jennifer Swenson.

Commissioner Pupa declared the motion carried.

REPORTS

7. Chief Executive Officer (CEO) Report

Staff: Margaret Tatar, Interim Chief Executive Officer

RECOMMENDATION: Receive and file the report.

Chief Executive Officer, Margaret Tatar announced that last Thursday DHCS approved the GCHP/AHP proposal. She stated the organization is very happy to secure the proposal approval and will continue to work with AHP.

Commissioner Pupa requested the Commission be updated on the readiness review. CEO Tatar stated she will make this a standing item in her report.

CEO Tatar stated DHCS has an RFI for commercial plans – this does not affect GCHP, but we are watching. The Stated indicates terms will be reflected in all managed care plans in 2023/24. At the local level we continue to be committed to the community.

Commissioner Jennifer Swenson joined the meeting at 2:55 p.m.

8. Chief Medical Officer (CMO) Report

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

RECOMMENDATION: Receive and file the report.

Chief Medical Officer, Nancy Wharfield, M.D., reviewed her report including charts and graphs. Dr. Anne Freese gave an update on the Medi-Cal Rx transition. She noted there is pending information on details of the appeals process. She will keep the Commission informed and more details released. Dr. Freese also noted the State now has a dedicated Rx website available.

9. Chief Diversity Officer (CDO) Report

Staff: Ted Bagley, Interim Chief Diversity Officer/ Interim Human Resources Director

RECOMMENDATION: Receive and file the report.

Chief Diversity Officer, Ted Bagley noted he has attended various Zoom meetings, He has created "Ted Talks" on the website and touches upon various topics of interest. He noted there are no new cases.

CDO Bagley did ask the Commission to begin to consider what they want to do with the CDO position. His contract ends in December, and he is asking the Commission to consider options on contract renewal and length of time. This item can be discussed in more detail at the next Commission meeting.

10. Executive Director of Human Resources (H.R.) Report

Staff: Michael Murguia, Executive Director of Human Resources

RECOMMENDATION: Receive and file the report.

Executive Director of Human Resources, Michael Murguia, noted he has completed his transition period with Mr. Bagley. Training sessions on home education has been completed. The trainings were done in collaboration with Mr. Joe Ortiz of BBK.

He is currently working through the performance review process. Mr. Murguia is also initiated the action plan on the employee survey. He will begin to create an Employee Action Team to assist with the survey. Mr. Murguia is also reviewing organization policies, beginning with an assessment of recruiting processes and policies. There is currently a lot of activity in recruitment in the organization.

Commissioner Alatorre motioned to approve Agenda items 7 - CEO Report, 8 – CMO Report, 9 – CDO Report and 10 – Executive Director of H.R. Report. Commissioner Atin seconded.

Roll Call Vote:

AYES: Commissioners Antonio Alatorre, Laura Espinosa, Dr. Sevet Johnson, Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson, Scott Underwood, M.D. and Supervisor John Zaragoza.

NOES: None.

ABSENT: Commissioners Fred Ashworth.

Commissioner Pupa declared the motion carried.

ADJOURNMENT

Commissioner Pupa adjourned the meeting at 3:27 p.m.

Approved:

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Maddie Gutierrez, MMC
Clerk to the Commission

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: October 26, 2020

SUBJECT: Adopt a Resolution to Renew Resolution No. 2020-006, to Extend the Duration of Authority Empowered in the CEO to issue Emergency Regulations and Take Action Related to the Outbreak of Coronavirus ("COVID-19")

SUMMARY:

Adopt Resolution No. 2020-008 to:

1. Extend the duration of authority granted to the CEO to issue emergency regulations and take action related to the outbreak of COVID-19.

BACKGROUND/DISCUSSION:

COVID-19, which originated in Wuhan City, Hubei Provence, China in December, 2019, has resulted in an outbreak of respiratory illness causing symptoms of fever, coughing, and shortness of breath. Reported cases of COVID-19 have ranged from very mild to severe, including illness resulting in death. Since that time, confirmed COVID-19 infections have continued to increase in California, the United States, and internationally. To combat the spread of the disease Governor Newsom declared a State of Emergency on March 4, 2020. The State of Emergency adopted pursuant to the California Emergency Services Act, put into place additional resources and made directives meant to supplement local action in dealing with the crisis.

In the short period of time following the Governor's proclamation, COVID-19 has rapidly spread through California necessitating more stringent action. On March 19, 2020, Governor Newsom issued Executive Order N-33-20 (commonly known as "Safer at Home") ordering all residents to stay at home to slow the spread of COVID-19, except as needed to maintain continuity of operation of the federal critical infrastructure sectors.

The following day, the Ventura County Health Officer issued a County-wide "Stay Well at Home", order, requiring all County residents to stay in their places of residence subject to certain exemptions set forth in the order.

Prompted by the increase of reported cases and deaths associated with COVID-19, the Commission adopted Resolution No. 2020-001 declaring a local emergency and empowering the interim CEO with the authority to issue emergency rules and regulations to protect the health of Plan's members, staff and providers. Specifically, section (2) of Resolution No. 2020-001 describes the emergency powers delegated to the CEO which include, but are not limited to: entering into agreements on behalf of the Plan, making and implementing personnel or other decisions, to take all actions necessary to obtain Federal and State emergency assistance, and

implement preventive measures to preserve Plan activities and protect the health of Plan's members, staff and providers.

Normally under Government Code Section 8630, the Commission must review the need for continuing the local emergency once every sixty (60) days until the local governing body terminates the local emergency. However, under Governor Newsom's March 4, 2020, State of Emergency proclamation, that 60-day time period in section 8630 is waived for the duration of the statewide emergency. Pursuant to Resolution No. 2020-001, the Plan's Local Emergency proclamation and emergency authority vested in the CEO expired on April 27, 2020.

On April 27, 2020, the Commission adopted Resolution No. 2020-002 to renew Resolution No. 2020-001 to: (1) reiterate and renew the Plan's declaration of a Local Emergency through the duration of the Governor's State of Emergency proclamation or when the Commission terminates its declaration of Local Emergency, whichever occurs last; and (2) to extend the duration of authority empowered in the CEO to issue emergency regulations and take action. Resolution No. 2020-002 expired on May 18, 2020.

On April 28, 2020, Governor Gavin Newsom alongside State Public Health Officer Dr. Sonia Angell, announced California's Roadmap to Pandemic Resilience, which discussed how the state is planning to modify its state-wide Safer at Home order to "reopen California".

On May 4, 2020, Governor Newsom issued Executive Order N-60-20, declaring that California is prepared to move into the early phase of "Stage 2" to permit the gradual reopening of lower risk businesses and open spaces commencing on Friday, May 8, 2020, with modifications. As the state moves forward with reopening of certain businesses and spaces, Executive Order N-60-20 directs the State Public Health Officer to establish criteria and procedures, as set forth in the order, to determine whether and how local jurisdictions may implement local measures that depart from statewide directives.

Following the Governor's order, the Ventura County Health Officer modified its County-wide Stay Well at Home order on May 7, 2020, to align itself with the State's reopening process announced on May 4, 2020. Under the County Health Officer's May 7th order, certain low risk businesses such as florists, clothing stores, bookstores, and sporting goods stores are permitted to re-open with modifications.

On May 18, 2020, the Commission adopted Resolution No. 2020-003 to renew and reiterate the enumerated powers granted to the CEO in Resolution No. 2020-002 above, and to: (1) authorize the CEO, with the advice counsel, to implement a staggered return to work program for Plan personnel; and (2) extend the duration of authority empowered in the CEO to issue emergency regulations and take action. Resolution No. 2020-003 expired on June 22, 2020.

Following the Commission's adoption of Resolution No. 2020-003, the State has permitted new specified businesses and recreation areas to reopen subject to modifications designed to implement social distancing and prevent the further spread of the disease. To help guide businesses and outdoor recreation areas as they reopen, the State Public Health Officer issues individual reopening protocols for each industry that is permitted to reopen. The individual protocols require these spaces to implement industry-specific safety measures to help combat COVID-19.

In line with the State's directives, the County Health Officer updated its May 7, 2020 order again on May 20th, May 22nd, May 29th, and June 11, 2020. As with the previous County Health Officer orders, the June 11th order permits specified new industries to re-open in line with the State's directives.

In the following weeks however, the State and County Health Department reported a sharp increase in new confirmed COVID-19 cases and hospitalizations. Evidence demonstrates that the timing of these increases is in line with the reopening of “high risk” businesses where individuals may congregate with members who are not part of the same household and remove their face coverings to eat and drink. The uptick in cases prompted the County Health Officer to issue an order on July 2, 2020, (“July 2nd Order”) to require the closure of bars, and the temporary closure of County beaches in anticipation of large crowds that were expected and did gather during the Fourth of July weekend.

On July 13, 2020, the State Public Health Officer issued a state-wide order to require the immediate closure of: (1) indoor and outdoor operations of bars, pubs, brewpubs and breweries; and (2) indoor operation of restaurant dining, movie theaters, zoos, museums, cardrooms, wineries and tasting rooms. The order also imposes more stringent requirements on specified counties, including Ventura County that have appeared on the State’s monitoring list for three consecutive days to prohibit the indoor operations of: gyms and fitness centers, places of worship, protests, offices for non-critical infrastructure sectors, personal care services, hair salons, barbershops, and malls. Also on July 13, 2020, the County Health Officer issued an order, requiring the closure of indoor operations of the following establishments: gyms and fitness centers, worship services, protests, offices for non-essential sectors, personal care services (e.g., nail salons, body waxing, and tattoo parlors), hair salons and barbershops, and malls.

On July 16, 2020, the County Health Officer amended its July 2nd Order to permit bars that serve food, wineries, and wine tasting rooms to reopen provided that they operate outdoors and abide by applicable State orders and guidance, and additional local requirements set forth in the County order.

On July 27, 2020, the Commission adopted Resolution No. 2020-004 to renew and reiterate the enumerated powers granted to the CEO in Resolution No. 2020-003 through August 24, 2020. On August 24, 2020, the Commission again renewed and reiterated the enumerated powers granted to the CEO in Resolution No. 2020-004 through September 28, 2020.

On August 28, 2020, the State Health Officer issued a new order that sets forth an updated framework that is intended to guide the gradual reopening of businesses and activities in the state while reducing the increased community spread of the disease. The new framework is entitled, “California’s Plan for Reducing COVID-19 and Adjusting Permitted Sector Activities to Keep Californians Healthy and Safe”. Under this updated framework, every county in California is assigned to a tier based on how prevalent COVID-19 is in each county and the extent of community spread—Purple (Widespread), Red (Substantial), Orange (Moderate) and Yellow (Minimal). The color of each respective tier indicates what sectors may reopen. As of the date of this report, Ventura County is the Red Tier. Since the State’s transition from the “County Monitoring List” to a tiered framework tied to public health data, the County Health Officer updated its public health order on August 31st, September 18th, September 22nd and October 6, 2020 to conform to the State’s directives, and among other things, gradually permit additional sectors to operate indoors and to extend the hours of operation of specified businesses.

More recently, on September 28, 2020, the Commission adopted Resolution No. 2020-006 to renew and reiterate the enumerated powers granted to the CEO through October 26, 2020. Unless renewed by the Commission, the delegation of authority empowered in the CEO, pursuant to Resolution No. 2020-006 shall expire today, October 26, 2020.

Although, recent public health data demonstrates the infection and hospitalization rates are down, COVID-19 continues to pose a significant threat to the public health and safety of

Commission personnel. There is still no vaccine proven to combat the disease and the disease can spread rapidly through person-to-person contact and by those in close proximity.

This resolution will continue to empower the CEO with the authority to issue orders and regulations necessary to prevent the further spread of the disease and protect the health and safety of Plan members and staff through January 25, 2021, the next regularly scheduled Commission meeting. The Commission cancelled the November meeting and the meeting in December will concentrate on the Strategic Plan. As mentioned above, pursuant to Resolution No. 2020-002, the Plan's Local Emergency proclamation shall remain effective through the duration of the Governor's State of Emergency proclamation or when the Commission terminates its declaration of Local Emergency, whichever occurs last.

FISCAL IMPACT:

None.

RECOMMENDATION:

1. Adopt Resolution No. 2020-008 to extend the duration of authority empowered in the CEO through January 25, 2021.

ATTACHMENT:

1. Resolution No. 2020-008.

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RESOLUTION NO.2020-008

A RESOLUTION OF THE VENTURA COUNTY MEDICAL MANAGED CARE COMMISSION, DOING BUSINESS AS THE GOLD COAST HEALTH PLAN ("PLAN"), TO RENEW AND RESTATE RESOLUTION NO. 2020-006 TO EXTEND THE DURATION OF AUTHORITY EMPOWERED IN THE INTERIM CHIEF EXECUTIVE OFFICER OR CHIEF EXECUTIVE OFFICER ("CEO") RELATED TO THE OUTBREAK OF CORONAVIRUS ("COVID-19")

WHEREAS, all recitals in the Commission's Resolution Nos. 2020-001, 2020-002 2020-03, 2020-004, 2020-005, and 2020-006 remain in effect and are incorporated herein by reference; and

WHEREAS, a severe acute respiratory illness caused by a novel (new) coronavirus, known as COVID-19, has spread globally and rapidly, resulting in severe illness and death around the world. The World Health Organization has described COVID-19 as a global pandemic; and

WHEREAS, on March 19, 2020, the Commission adopted Resolution No. 2020-001, proclaiming a local emergency pursuant to Government Code Sections 8630 and 8634, and empowered the CEO with the authority to issue rules and regulations to preserve Plan activities, protect the health and safety of its members staff and providers and prevent the further spread of COVID-19; and

WHEREAS, on April 27, 2020, the Commission adopted Resolution No. 2020-002 to: (1) renew and reiterate the declaration of a local emergency related to the outbreak of COVID-19 declared in Resolution No. 2020-001 to remain effective through the duration of the Governors' State of Emergency proclamation or when the Commission terminates its declaration of Local Emergency, whichever occurs last; and (2) to extend the duration of authority empowered in the CEO through Resolution No. 2020-001 to May 18, 2020; and

WHEREAS, on May 18, 2020, the Commission adopted Resolution No. 2020-003 to renew the authority first granted to the CEO in Resolution No. 2020-001 to June 22, 2020 and to authorize the CEO, with the advice counsel, to implement a staggered return to work program for Plan personnel; and

WHEREAS, following the reopening of "high risk businesses" where individuals may congregate with members who are not part of the same household and remove their face coverings to eat and drink, the State and County Health Department reported a sharp increase in new confirmed COVID-19 cases and hospitalizations ; and

WHEREAS, the uptick in cases prompted the County Health Officer to issue an order on July 2, 2020, ("July 2nd. Order") to require the closure of bars, and the temporary closure of County beaches in anticipation of large crowds that were expected and did gather during the Fourth of July weekend; and

WHEREAS, on July 13 2020, the State Public Health Officer issued a state-wide order to require the immediate closure of: (1) indoor and outdoor operations of bars, pubs, brewpubs and breweries; and (2) indoor operation of restaurant dining, movie theaters, zoos, museums, cardrooms, wineries and tasting rooms. The order also imposes more stringent requirements on specified counties, including Ventura County that have appeared on the State's monitoring list for three consecutive days to prohibit the *indoor* operations of: gyms and fitness centers, places of worship, protests, offices for non-critical infrastructure sectors, personal care services, hair salons, barbershops, and malls; and

WHEREAS, also on July 13, 2020, the County Health Officer issued an order, requiring the closure of indoor operations of the following establishments: gyms and fitness centers, worship services, protests, offices for non-essential sectors, personal care services (e.g., nail salons, body waxing, and tattoo parlors), hair salons and barbershops, and malls; and

WHEREAS, on July 16, 2020, the County Health Officer amended its July 2nd Order to permit bars that serve food, wineries, and wine tasting rooms to reopen provided that they operate outdoors and abide by applicable State orders and guidance, and additional local requirements set forth in the County order; and

WHEREAS, on July 27, 2020, the Commission adopted Resolution No. 2020-004 to renew and reiterate the enumerated powers granted to the CEO in Resolution No. 2020-003 through August 24, 2020; and

WHEREAS, on August 24, 2020, the Commission adopted Resolution No. 2020-005 to renew and reiterate the enumerated powers granted to the CEO in Resolution No. 2020-004 through September 28, 2020; and

WHEREAS, on August 28, 2020, the State Health Officer issued a new order that sets forth an updated framework that is intended to guide the gradual reopening of businesses and activities in the state while reducing the increased community spread of the disease, entitled "California's Plan for Reducing COVID-19 and Adjusting Permitted Sector Activities to Keep Californians Healthy and Safe"; and

WHEREAS, under this updated framework, every county in California is assigned to a tier based on how prevalent COVID-19 is in each county and the extent of community spread—Purple (Widespread), Red (Substantial), Orange (Moderate) and Yellow (Minimal) and the color of each respective tier indicates what sectors may reopen. As of the date of this Resolution, Ventura County is in the Red tier; and

WHEREAS, since the State's transition from the "County Monitoring List" to a tiered framework tied to public health data, the County Health Officer updated its public health order on August 31st, September 18th, September 22nd and October 6, 2020 to conform to the State's directives, and among other things, gradually permit additional sectors to operate indoors and to extend the hours of operation of specified businesses; and

WHEREAS, the Commission more recently renewed and reiterated the enumerated powers granted to the CEO through October 26, 2020 by adopting Resolution No. 2020-006 on September 28, 2020. Unless renewed by the Commission, the delegation of authority empowered in the CEO, pursuant to Resolution No. 2020-006 shall expire today, October 26, 2020; and

WHEREAS, this resolution will continue to empower the CEO with the authority to issue orders and regulations necessary to prevent the further spread of the disease and protect the health and safety of Plan members and staff through January 25, 2021, the next regularly scheduled Commission meeting. The Commission cancelled the November meeting and the meeting in December will concentrate on the Strategic Plan; and

WHEREAS, there is still no vaccine proven to combat the disease, and the disease can spread rapidly through person-to-person contact and those in close proximity; and

WHEREAS, the imminent and proximate threat of introduction of COVID-19 in Commission staff workplaces continues to threaten the safety and health of Commission personnel; and

WHEREAS, under Article VIII of the Ventura County Medi-Cal Managed Care Commission aka Gold Coast Health Plan's (the “Plan's”) bylaws, the CEO is responsible for coordinating day to day activities of the Ventura County Organized Health System, including implementing and enforcing all policies and procedures and assure compliance with all applicable federal and state laws, rules and regulations; and

WHEREAS, California Welfare and Institutions Code section 14087.53(b) provides that all rights, powers, duties, privileges, and immunities of the County of Ventura are vested in the Plan's Commission; and

WHEREAS, California Government Code section 8630 permits the Plan's Commissioners, acting with the County of Ventura's powers, to declare the existence of a local emergency to protect and preserve the public welfare of Plan's members, staff and providers when they are affected or likely to be affected by a public calamity; and

WHEREAS, the Plan is a public entity pursuant to Welfare and Institutions Code section 14087.54 and as such, the Plan may empower the CEO with the authority under sections 8630 and 8634 to issue rules and regulations to prevent the spread of COVID-19 and preserve Plan activities and protect the health and safety of its members, staff and providers; and

NOW, THEREFORE, BE IT RESOLVED, by the Ventura County Medi-Cal Managed Care Commission as follows:

Section 1. Pursuant to California Government Code sections 8630 and 8634, the Commission adopted Resolution No. 2020-001 finding a local emergency exists

caused by conditions or threatened conditions of COVID-19, which constitutes extreme peril to the health and safety of Plan's members, staff and providers.

Section 2. Resolution No. 2020-001 also empowered the CEO with the authority to furnish information, to promulgate orders and regulations necessary to provide for the protection of life and property pursuant to California Government Code sections 8630 and 8634, to enter into agreements, make and implement personnel or other decisions and to take all actions necessary to obtain Federal and State emergency assistance and to implement preventive measures and other actions necessary to preserve Plan activities and protect the health of Plan's members, staff and providers, including but not limited to the following:

A. Arrange alternate "telework" accommodations to allow Plan staff to work from home or remotely, as deemed necessary by the CEO, to limit the transfer of the disease.

B. Help alleviate hardship suffered by Plan staff related to emergency conditions associated with the continued spread of the disease such as acting on near-term policies relating to sick leave for Plan staff most vulnerable to a severe case of COVID-19.

C. Address and implement expectations issued by the California Department of Health Care Services ("DHCS") and the Centers for Medicare & Medicaid Services ("CMS") regarding new obligations to combat the pandemic.

D. Coordinate with Plan staff to realign job duties, priorities, and new or revised obligations issued by DHCS and CMS.

E. Take such action as reasonable and necessary under the circumstances to ensure the continued provision of services to members while prioritizing the Plan's obligations pursuant to the agreement between DHCS and the Plan ("Medi-Cal Agreement").

F. Enter into such agreements on behalf of the Plan as necessary or desirable, with advice of legal counsel, to carry out all actions authorized by the Commission in the Resolution.

G. Authorize the CEO to implement and take such action on behalf of the Plan as the CEO may determine to be necessary or desirable, with advice of legal counsel, to carry out all actions authorized by the Commission in this Resolution.

Section 3. In Resolution 2020-001, the Commission further ordered that:

A. The Commission approves and ratifies the actions of the CEO and the Plan’s staff heretofore taken which are in conformity with the intent and purposes of these resolutions.

Section 4. Resolution No. 2020-001 expired on April 27, 2020.

Section 5. On April 27, 2020, the Commission adopted Resolution No. 2020-002 to:

A. Renew and reiterate the declaration of a local emergency related to the outbreak of COVID-19 to remain effective through the duration of the Governors' State of Emergency proclamation or when the Commission terminates its declaration of Local Emergency, whichever occurs last; and

B. To extend the duration of authority empowered in the CEO to issue emergency regulations related to the COVID-19 outbreak to May 18, 2020.

Section 6 The Commission adopted Resolution No. 2020-003 on May 18, 2020, to renew and reiterate the authority granted to the CEO approved in Resolution No. 2020-002 and to adopt the following additional emergency measures:

A. In addition to the authority granted to the CEO in Section 2, to authorize the CEO, with the advice counsel, to implement a staggered return to work program for Plan personnel; and

B. Extend the authority granted to the CEO through June 22, 2020.

Section 7. On May 4, 2020, California Governor, Gavin Newsom issued Executive order N-60-20, to modify its state-wide Safer at Home order and allow the state to move into Stage 2 of the reopening process to permit certain low risk businesses and open spaces to open with modifications. Executive Order N-60-20, also directs the State Public Health Officer to establish and criteria and procedures, as set forth in the order to determine how local jurisdictions may implement public health measures that depart from state-wide directives of the State Public Health Officer.

Section 8. The Commission adopted Resolution No. 2020-004 on July 27, 2020 to renew and reiterate the authority granted to the CEO approved in Resolution No. 2020-003 through August 24, 2020. Resolution No. 2020-004 expired on August 24, 2020.

Section 9. The Commission adopted Resolution No. 2020-005 on August 24, 2020 to renew and reiterate the authority granted to the CEO approved in Resolution No. 2020-004 through September 28, 2020. Resolution No. 2020-005 expired on September 28, 2020.

Section 10. The Commission adopted Resolution No. 2020-006 on September 28, 2020 to renew and reiterate the authority granted to the CEO approved in Resolution No. 2020-005 through October 26, 2020.

Section 11. The Commission now seeks to renew and reiterate the authority granted to the CEO approved in Resolution No. 2020-008 through January 25, 2021.

Section 12. Unless renewed by the Commission, the delegation of authority empowered in the CEO, pursuant to this Resolution shall expire on January 25, 2021.

PASSED, APPROVED AND ADOPTED by the Ventura County Medi-Cal Managed Care Commission at a regular meeting on the 26th day of October 2020, by the following vote:

AYE:

NAY:

ABSTAIN:

ABSENT:

_____
Chair:

Attest:

_____
Clerk of the Commission

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Manager Care Commission

FROM: Joseph T. Ortiz, Best Best & Krieger LLP- Diversity Counsel

DATE: October 26, 2020

SUBJECT: Interim Chief Diversity Officer Contract

SUMMARY:

Theodore Bagley dba TBJ Consulting ("TBJ Consulting") has agreed to continue work on an interim capacity as Gold Coast Health Plan's Chief Diversity Officer ("CDO"). TBJ Consulting has previously provided interim CDO services to Gold Coast Health Plan ("Plan") since 2017.

The Commission will recall that in 2017, following negotiations, TBJ Consulting agreed to provide CDO services at an hourly rate of $250.00 per hour of work. TBJ Consulting is offering to extend these same terms through December 31, 2021. Approval is sought to continue the prior contract expense cap of $225,000. Of course, the work is expected to ultimately cost much less that that proposed cap. The original 2017 Consulting Services Agreement, which indicates that the Plan may terminate services at any time with fourteen (14) days of notice, is attached hereto as Exhibit 1. The proposed Third Amendment to the Agreement to the Consulting Services Agreement is attached hereto as Exhibit 2. Mr. Bagley will be prepared to discuss the Agreement, the proposed Amendment, and his services at the meeting.

Pursuant to Statement of Work, TBJ Consulting will perform all duties as outlined in the CDO job description, including but not limited to the investigation, investigation oversight and reporting on all diversity-related issues.

Per the requirements of the CDO position, TBJ Consulting will report directly to the Commission and will issue quarterly reports to the Commission and the Ventura County Board of Supervisors. Should this contract be accepted, TBJ Consulting will continue work through 2021 or until a permanent CDO is hired or until otherwise terminated pursuant to the Services Agreement. If the contract extension is not approved, the Commission should begin a search for another CDO and TBJ Consulting will work under an interim contract until a new CDO is retained.

BACKGROUND/DISCUSSION:

On October 6, 2015, the Ventura County Board of Supervisors adopted Ordinance 4481, which required that the Plan to establish a Cultural Diversity Program. Section 1382 of Ordinance

4481 also called for the creation of the CDO position to oversee the program. A copy of Ordinance 4481 is attached. After creating the job description, the Plan used consultants, including TBJ Consulting, to provide CDO services while recruitment efforts for a permanent CDO were underway. The prior CDO left the position as of September 8, 2017, and the Commission contracted with TBJ Consulting for CDO services. TBJ Consulting has provided CDO consultant services since that date.

FISCAL IMPACT:

No more than $225,000 in annual fees.

RECOMMENDATION:

Staff recommends that the Commission approve the proposed Third Amendment to the Consulting Services Agreement and Statement of Work.

CONCURRENCE:

N/A

ATTACHMENT:

Exhibit 1: The Original 2017 Consulting Services Agreement.
Exhibit 2: The proposed Third Amendment to the Consulting Services Agreement.
Exhibit 3: Ordinance 4481.

EXHIBIT 1

CONSULTING SERVICES AGREEMENT

THIS CONSULTING SERVICES AGREEMENT ("Agreement"), entered into on the 9th day of November, 2017, between Ventura County Medi-Cal Managed Care Commission d.b.a. Gold Coast Health Plan, a public entity (hereinafter "PLAN"), and TBJ Consulting, an independent contractor (herelnafter "Consultant") to provide consulting services to the PLAN on matters related to the Chief Diversity Officer's position at GCHP.

WHEREAS, PLAN is a County Organized Health System (COHS) model of managed care organization under contract to the State of California, Department of Health Care Services, (DHCS) pursuant to which it has enrolled Medi-Cal beneficiaries into its Health Plan (hereinafter "Members"); and

WHEREAS, PLAN desires to engage consultant to provide PLAN with professional consulting services on matters related to audio

WHEREAS, Consultant has experience and expertise necessary to provide such services;

NOW, therefore, be it resolved that in consideration of the mutual promises set forth below, the Parties hereby agree as follows:

I. Services

1.1 During the term of this Agreement, Consultant shall furnish the services set forth in Attachment A (Statement of Work) of this Agreement, which is attached and incorporated herein (the "Services"). The Services shall be performed by Consultant as an independent contractor and not as an agent or employee of PLAN. Consultant and PLAN may enter into one or more Statements of Work, and each Statement of Work shall be governed by and made a part of this Agreement and shall be deemed attached to and incorporated into this Agreement upon execution.

1.2 Consultant shall perform all Services provided pursuant to this Agreement in compliance with: (i) all applicable standards set forth by law or ordinance or established by the rules and regulations of any federal, state or local agency, commission, association or other pertinent governing, or accrediting body, having authority to set standards for health plans and county organized health systems; and (ii) all PLAN rules, regulations, policies and procedures.

1.3 Consultant shall at all times maintain such licenses or certifications as may be necessary to perform the Services in the State of California (the "State").

1.4 Consultant represents and warrants to PLAN as follows: (i) Consultant's licenses or certifications required under this Agreement have never been denied, suspended, revoked, terminated, relinquished under threat of disciplinary action, or restricted in any way; (ii) Consultant's professional privileges granted by any other organization, if any, have never been denied, suspended, revoked, terminated, relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction; (iii) Consultant has not in the past conducted, and is not presently conducting business or professional practice in such a manner as to cause Consultant to be suspended, excluded, debarred or sanctioned under the Medicare or Medicaid Programs, or any government licensing agency, nor has Consultant ever been charged with or convicted of a criminal offense related to health care, or listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation; and (iv) each of the representations and warranties set forth herein shall be continuing and in the event any such representation or warranty fails to remain true and accurate during the term of this Agreement,

Consultant shall immediately notify PLAN.

II. Compensation

2.1 PLAN will pay Consultant according to the fees and payment schedule for the Services outlined in each Statement of Work.

Consultant shall be responsible for payment of all expenses and costs related to the execution of these Services, such as consultation time with PLAN, mileage, and miscellaneous out-of-pocket expenses, unless otherwise approved by PLAN. Consultant shall keep PLAN reasonably apprised on the progress of his activities related to performance of the Services.

2.2 Payment for the Services rendered and reimbursement for expenses (to the extent approved by PLAN) shall be made by PLAN to Consultant upon timely submission of invoices. Invoices shall be submitted to the attention of the Chief Executive Officer at the address provided in Section IX, Notices. The invoices will include the dates in which the Services were performed and hours performing the Services. Payment shall be made within thirty (30) days of receipt of a properly submitted invoice.

2.3 Consultant is responsible for paying all income taxes, including estimated taxes, incurred as a result of the compensation paid by PLAN for Services rendered under this Agreement. Consultant shall indemnify PLAN for any claims, costs, losses, fees, penalties, interest, or damages suffered by PLAN resulting from Consultant's failure to comply with this tax payment provision.

III. Independent Contractor

Consultant shall perform the services set forth above as an independent contractor of PLAN. Consultant is not and will not become an employee, agent or principal of PLAN as a result of the performance of the Services. Consultant is not entitled to the rights or benefits afforded to PLAN employees, including disability or unemployment insurance, workers' compensation medical insurance, sick leave, or any other employment benefit. Consultant is responsible for providing, at his own expense, and to the extent required, workers' compensation insurance, training, permits and licenses in addition to the insurance indicated below.

IV. Indemnification and Insurance

4.1 Indemnification by PLAN. PLAN shall hold harmless, indemnify and defend Consultant for any and all claims resulting from any injury, disability or death arising out of or related to Consultant's performance of the Services or operating of PLAN, except to the extent such injury, disability or death arises out of or is related to Consultant's willful, reckless, fraudulent or criminal conduct.

4.2 Indemnification by Consultant. Consultant shall hold harmless, indemnify and defend PLAN for any and all claims resulting from any injury, disability or death arising out of or related to Consultant's performance of the Services or operating of PLAN, to the extent such injury, disability or death arises out of or is related to Consultant's willful, reckless, fraudulent or criminal conduct.

4.3 Consultant Insurance. Consultant shall procure and maintain for the duration of the Agreement, at Consultant's own expense, the following insurance against claims for injuries to persons or damage to property which may arise from or in connection with the performance of the Services: (a) automobile liability insurance with a minimum combined single limit for bodily injury

and property damage of $1,000,000 per accident, and (b) workers compensation insurance as may be required by the laws of the State. Consultant's insurance coverage shall be primary insurance as respect to PLAN. Any insurance or self-insurance maintained by PLAN shall be excess of Consultant's insurance and shall not contribute with it. Upon request by PLAN, Consultant shall provide the PLAN with evidence of the insurance required herein.

4.4 PLAN Insurance. PLAN shall maintain, at PLAN's expense, comprehensive general liability, directors and officers, and professional liability insurance, or an equivalent program of self-insurance, against claims for injuries to persons or damage to property which may arise from or in connection with the performance of the Services. Upon request by PLAN, Consultant shall provide the PLAN with evidence of the insurance required herein.

V. Term and Termination

5.1 Term. The term of this Agreement shall begin on the date set forth on the first page of the Agreement and continue until the Agreement is terminated by PLAN or Consultant as set forth below.

5.2 Termination for Convenience. Consultant may terminate this Agreement at any time for any reason or for no reason with at least fourteen (14) days prior written notice to PLAN. PLAN may terminate this Agreement at any time for any reason or for no reason with at least fourteen (14) days prior written notice to Consultant.

5.3 Termination for Cause. PLAN may terminate this Agreement immediately by written notice to Consultant upon Consultant's failure to satisfy the representations and warranties in Section 1.4, upon Consultant's material breach of the HIPAA Business Associate Agreement executed by the parties, or upon Consultant's material breach of the provisions of Articles VI or VII of this Agreement.

VI. Confidentiality of Member Information

6.1 Consultant shall preserve as confidential and shall use only in connection with Consultant's performance of the Services, all privileged information acquired from PLAN in the performance of this Agreement. The term "privileged information" shall include without limitation unpublished information and data related to operations of PLAN, any and all beneficiary information and plans, methods, processes, internal specifications and reports.

6.2 Notwithstanding any other provision of the Agreement, the names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with 42, CFR, §431.300 et. seq. and §14100.2, Welfare and Institutions Code (W&I Code) and regulations adopted thereunder. For the purpose of this Agreement, Consultant and his staff will protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Agreement and pertaining to Members.

6.3 With respect to any identifiable information concerning a Member under this Agreement that is obtained by the Consultant, the Consultant:

(a) will not use any such information for any purpose other than carrying out the express terms of the Agreement,

(b) will promptly transmit to PLAN all requests for disclosure of such information,

(c) will not disclose except as otherwise specifically permitted by the Agreement, any such information to any party other than PLAN, the U S Department of Health and Human Services, or the Department of Health Care Services (DHCS) without prior written authorization specifying that the information is releasable under 42 C.F.R. § 431.300 et. seq., W&I Code §14100.2, and regulations adopted thereunder, and

(d) will, at the expiration or termination of the Agreement, return all such information to PLAN or maintain such information according to written procedures sent to PLAN by DHCS for this purpose.

6.4 Consultant and PLAN shall make any and all efforts and take any and all actions necessary to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, and the regulations promulgated thereunder (collectively, "HIPAA Requirements"). Consultant shall take such actions and develop such capabilities as are required to support PLAN compliance with HIPAA Requirements, including, if applicable, acceptance and generation of appropriate electronic files in HIPAA compliant standards formats.

6.5 Consultant shall execute and comply with the PLAN Business Associate Agreement in addition to this Agreement and any other instruments as may be required by HIPAA Requirements.

VII. Non-Discrimination

During the performance of the Services under this Agreement, Consultant and his staff shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, sexual orientation, gender identity or expression, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40), marital status, veteran status, and use of family care leave. Consultant and his staff shall ensure that the evaluation and treatment of Consultant's employees and applicants for employment are free of such discrimination and harassment.

VIII. Disputes

8.1 Judicial Reference. At the election of either party to this Agreement (which election shall be binding upon the other party), a dispute between Consultant and PLAN arising out of this Agreement shall be heard and decided by a referee appointed pursuant to California Code of Civil Procedure Section 638 (or any successor provision thereto, if applicable), who shall hear and determine any and all of the issues in any such action or proceeding, whether of fact or law, and to report a statement of decision, subject to judicial review and enforcement as provided by California law, and in accordance with Chapter 6 (References and Trials by Referees), of Title 8 of Part 2 of the California Code of Civil Procedure, or any successor chapter. The referee shall be a retired judge of the California superior or appellate courts determined by agreement between the parties, provided that in the absence of such agreement either party may bring a motion pursuant to the said Section 638 for appointment of a referee before the appropriate judge of the Ventura Superior Court. The parties acknowledge that they forego any right to trial by jury in any judicial reference proceeding. Any counterpart or copy of this Agreement, filed with such Court upon such motion, shall conclusively establish the agreement of the parties to such appointment. The parties agree that the only proper venue for the submission of claims to judicial reference shall be the courts of general jurisdiction of the State of California located in Ventura County. The parties reserve the right to contest the referee's decision and to appeal from any award or order of any court. The designated non- prevailing party in any dispute shall be required to fully compensate the referee

for his or his services hereunder at the referee's then respective prevailing rates of compensation.

8.2 Limitations. Consultant must comply with the claim procedures set forth in the Government Claims Act (Government Code Section 900, et. seq.) prior to filing any legal proceeding, including judicial reference, against PLAN. If no such Government Code claim is submitted, no action against PLAN may be filed. Notwithstanding anything to the contrary contained in this Agreement, any suit, judicial reference or other legal proceeding must be initiated within one (1) year after the date the facts giving rise to a dispute occurred or such dispute shall be deemed waived and forever barred; provided that, if a shorter time period is prescribed under the Government Claims Act, then, the shorter time period (if any) prescribed under the Government Claims Act shall apply.

8.3 Venue. Unless otherwise specified in this Section, all actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state courts located in the County of Ventura, State of California.

IX. Notices

Any notice or other communication required or permitted in this Agreement shall be in writing and shall be deemed to have been duly given on the day of service if served personally or by facsimile transmission with confirmation, or three (3) days after mailing if mailed by registered or certified mail, or two (2) days after delivery to a nationally recognized overnight courier, to the person and address noted below or to such other person or address as a party may designate in writing from time to time. The addresses for notice shall be changed in the manner provided for in this Section IX.

If served on PLAN, it should be addressed to:

Chief Executive Officer
Gold Coast Health Plan
711 E. Daily Drive, Suite 106
Camarillo, CA 93010

With copy to: Scott Campbell, Esq.
Best Best & Krieger LLP
300 South Grand Avenue
25th Floor
Los Angeles, CA 90071

If served on Consultant, it should be addressed to:

TBJ Consulting
71 Golden Glen Drive
Simi Valley, CA 93065

X. General Provisions

10.1 Amendment. All amendments must be agreed to in writing by PLAN and Consultant.

10.2 No Third-Party Beneficiaries. The obligations created by this Agreement shall be enforceable only by the parties hereto, and no provision of this Agreement is intended to, nor shall it be construed to, create any rights for the benefit of or be enforceable by any third party, including but not limited to any Member.

10.3 Waiver. To be effective, the waiver of any provision or the waiver of the breach of any provision of this Agreement must be set forth specifically in writing and signed by the giving party. Any such waiver shall not operate or be deemed to be a waiver of any prior or future breach of such provision or of any other provision. It is understood and agreed that no failure or delay by PLAN in exercising any right, power or privilege hereunder shall operate as a waiver thereof, nor shall any single or partial exercise thereof preclude any other or further exercise thereof or the exercise of any right, power or privilege hereunder.

10.4 Severability. Should any provisions of this Agreement be declared or found to be illegal, unenforceable, ineffective, or void (by any federal or state courts in a final order or judgment that has not been appealed, or in a final determination by an appellate court), then each party shall be relieved of any obligation arising in that provision; the balance of this Agreement, if capable of performance, shall remain in full force and effect.

10.5 Entire Agreement. This Agreement and its attachments, and any Business Associate Agreement, constitutes the entire agreement between the parties with respect to its subject matter and constitutes and supersedes all prior agreements, representations and understandings of the parties, written or oral.

10.6 Governing Law. This Agreement shall be construed in accordance with and governed by the laws of the State of California.

XI. Special Terms and Conditions

Consultant agrees to comply with the special terms and conditions set for in Attachment B (Special Terms and Conditions).

IN WITNESS WHEREOF the parties hereto have signed this Agreement as of the date set forth below by their authorized representative.

Ventura County Medi-Cal Managed Care Commission d.b.a. Gold Coast Health Plan

Signature: _____
Dale Villani, CEO

Date: _____

TBJ Consulting

Signature: _____

Date: _____

ATTACHMENT A

STATEMENT OF WORK

THIS STATEMENT OF WORK NO. is made as of this 9th day of November, 2017 ("Statement of Work Effective Date") by and between Theodore Bagley ("Consultant") and Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan, a California public entity established under the laws of the State of California, (hereinafter "PLAN") The parties entered into Consulting Services Agreement dated as of 9 November, 2017 ("Agreement"). The terms and conditions of the Agreement are incorporated into this Statement of Work No. __ by this reference thereto and this Statement of Work No. __ is subject to such terms and conditions. If there is a conflict between a specific term in this Statement of Work No.__ and the terms of the Agreement, the specific term of the Agreement shall control.

1. BACKGROUND

A short summary of the project's history and proposed approach, including:

Short statement of the problem to be resolved;
Time line or review of major dates in the project development process;
Client organizational units and key individuals involved in advancing the project;
Alternative solutions or implementation strategies evaluated proposed approach.

1.1. Objectives

The key end results that the project will achieve when successfully executed. Measurable performance indicators for anticipated benefits may also be listed here.

1.2. Reference Materials

Insert a list of all documents or portions of documents referenced in the Statement of Work

2. SCOPE OF WORK

The Detailed Scope includes a list of the specific requirements that the project must satisfy. It also includes a listing of the deliverables that will be generated by the Project Team, as well as those deliverables that are specifically excluded from the scope.

2.1. Consultant Responsibilities

Identify and list the Consultant's responsibilities

2.2. PLAN Responsibilities

Identify and list the PLAN's responsibilities

2.3. Deliverables

List all deliverables referenced in the Project Schedule and provide a brief description of the related acceptance criteria for each. Provide a copy of the completed Log as an Appendix to this document.

3. PROJECT SCHEDULE

PROJECT SCHEDULE	
Milestone or Major Project Deliverable	**Completion Date**
Perform all duties of the Chief Diversity Officer as required	TBD
Investigate all Diversity related issues in a timely manner	TBD

3.1. Assumptions

Insert certain assumptions upon which the Statement of Work is based

4. TERM

4.1. The Initial Term of this Statement of Work shall be from November 9th, 2017 until contract end. The current term shall be month-to-month until termination by either party.

Or

4.2. Start Date: November 9th, 2017 End Date: TBD

5. COMPENSATION

5.1. **Compensation.** For Services rendered as outlined herein, Consultant shall be compensated as follows:

5.1.1. Fixed Fee: The fixed hourly fee to PLAN for the delivery of the Services is, $250.00 an hour as planned. Additional hours are at the discretion of the plan and as needed for effective performance of the duties of this position.

5.1.2. Payment Terms: PLAN shall pay Consultant for the Services in accordance with the following fixed fee payment schedule.

Project Task/Milestone	Payment to Consultant
Establish a successful diversity environment within the Plan.	As stated above
Development internal and external relationships for efficiency and effectiveness.	As stated above
Conduct fair and equitable investigations.	As stated above
Operate in conjunction with the officers of the Plan.	As stated above

or

5.1.3. Time and Materials Fees. Except as otherwise agreed by the Parties, Consultant agrees to invoice PLAN the labor hour fee's listed below.

Skill-Set	Estimated Number of Hours	Hourly Fee
Business and diversity experience	20 hrs monthly[1]	$250.00

[1] Consultant requests authorization of up to 40 hours per month for the first two months of this Agreement's term. The additional time is intended for program ramp up and outreach. Such additional time shall be agreed to upon written authorization from the PLAN Commission or CEO.

-Investigation	Incl.	
-Training	Incl.	
Build a diversity culture with assistance from GCHP	Incl.	

5.1.4. ☐ Travel & Expenses: (check if applicable) $ N/A

5.1.5. **Total Compensation.** The total compensation for the project under this Statement of Work No. ___ shall not exceed $_____.

6. ACCEPTANCE

Consultant shall provide regular invoices for review and payment by the PLAN.

In witness whereof, the parties have caused this Statement of Work to be executed by their respective duly authorized representatives.

Ventura County Medi-Cal Managed Care Commission d.b.a. Gold Coast Health Plan

BY: _____

NAME: Dale Villani

TITLE: Chief Executive Officer

DATE: _____

TBJ Consulting
71 Golden Glen Drive
Simi Valley, CA 93065

BY: TBJ Consulting

NAME: Ted Bagley

TITLE: CEO/President

DATE: November 9th, 2017

ATTACHMENT B
SPECIAL TERMS AND CONDITIONS

1. EQUAL OPPORTUNITY REQUIREMENTS

(a) The Consultant will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national orlgin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Consultant will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, gender identity and expression, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following; employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Consultant agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government California Department of Health Care Services setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212). Such notices shall state the Consultant's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

(b) The Consultant will, in all solicitations or advancements for employees placed by or on behalf of the Consultant, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

(c) The Consultant will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State of California, advising the labor union or workers' representative of the Consultant's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

(d) The Consultant will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment

Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

(e) The Consultant will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

(f) In the event of the Consultant's noncompliance with the requirements of the provisions herein or with any Federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Consultant may be declared ineligible for further Federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

(g) Consultant shall comply with all applicable Federal requirements in Section 504 of the Rehabilitation Act of 1973 (29 USC §794) Nondiscrimination under Federal grants and programs; Title 45 CFR Part 84 Nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance; Title 28 CFR Part 36 Nondiscrimination on the basis of disability by public accommodations and in commercial facilities; Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 the Age Discrimination Act of 1975; and all other laws regarding privacy and confidentiality.

2. HUMAN SUBJECTS USE REQUIREMENTS

By signing this Agreement, Consultant agrees that if any performance under this Agreement or any subcontract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 41 USC 263a (CLIA) and the regulations thereto.

3.

DEBARMENT AND SUSPENSION CERTIFICATION

(a) By signing this Agreement, the Consultant agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

(b) By signing this Agreement, the Consultant certified to the best of its knowledge and belief, that it and its principals:

i. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

ii. Have not within a three-year period preceding this Agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

iii. Are not presently indicted for or otherwise criminally or civilly charged by a governmental Entity (Federal, State or local) with commission of any of the offenses enumerated in Sub-provision B.(2) herein;

iv. Have not within a three-year period preceding this Agreement had one or more public transactions (Federal, State or local) terminated for cause or default;

v. Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

vi. Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions, and in all solicitations for lower tier covered transactions.

(c) If the Consultant is unable to certify to any of the statements in this certification, the Consultant shall submit an explanation to PLAN.

(d) The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

(e) If the Consultant knowingly violates this certification, in addition to other remedies available to the Federal Government, PLAN may immediately terminate this Agreement for cause.

4. SMOKE-FREE WORKPLACE CERTIFICATION

(a) Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 19, if the services are funded by Federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.

(b) Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

(c) By signing this Agreement, Consultant certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

(d) Consultant further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

5. COVENANT AGAINST CONTINGENT FEES

The Consultant warrants that no person or selling agency has been employed or retained to solicit/secure this Agreement upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by the Consultant for the purpose of securing business. For breach or violation of this warranty, PLAN shall have the right to annul this Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover, the full amount of, such commission, percentage, and brokerage or contingent fee.

6. OFFICIALS NOT TO BENEFIT

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this Agreement, or to any benefit that may arise therefrom. This Provision shall not be construed to extend to this Agreement if made with a corporation for its general benefits.

7. PROHIBITED USE OF STATE FUNDS FOR SOFTWARE

Consultant certifies that is has appropriate systems and controls in place to ensure that PLAN funds will not be used in the performance of this Agreement for the acquisition,

operation or maintenance of computer software in violation of copyright laws.

8. ALIEN INELIGIBILITY CERTIFICATION

By signing this Agreement, the Consultant certifies that he/she is not an alien that is ineligible for State and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 USC 1601, et seq.)

9. AUDITS AND INSPECTIONS

(a) Consultant will maintain such books and records necessary to disclose how Consultant discharged its obligations under this Agreement. These books and records will disclose the quantity of Services provided under this Agreement, the quality of those Services, the manner and amount of payment made for those Services, the entities or individuals receiving the Services, the manner in which Consultant administered in daily business, and the cost thereof. These books and records shall be maintained for a minimum of five (5) years from the end of the year in which the applicable book or record was created or used, unless a longer period is required by law, or in the event Consultant has been notified that PLAN, the State, the federal government, or their authorized agencies or representatives have commenced an audit or investigation of the Agreement, until such time as the matter under audit or investigation has been resolved, whichever is later.

(b) Consultant shall, through the end of the records retention period specified in subsection 9(a), at any time during normal business hours, allow PLAN, the State, the federal government, or their authorized agencies or representatives, to inspect Consultant's facilities, books and records with respect to the matters covered by this Agreement.

(c) For the purpose of this Section 9, books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance of the Services under this Agreement, including working papers, reports, financial records, books of account, medical records, prescription files, subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members.

EXHIBIT 2

GOLD COAST HEALTH PLAN
THIRD AMENDMENT TO CONSULTING SERVICES AGREEMENT

This Third Amendment to CONSULTING SERVICES AGREEMENT (this "Third Amendment") between the Ventura County Medi-Cal Managed Care Commission dba. Gold Coast Health Plan, a public entity (hereinafter "PLAN") and TBJ Consulting, an independent contractor (hereinafter "Consultant") is entered into this 1st day of November 2020.

Except as modified in this Third Amendment, which supersedes the prior First and Second Amendments, and the Consulting Services Agreement originally dated November 9, 2017 ("Agreement") between the Plan and Consultant shall remain in full force and effect.

The parties to this Third Amendment agree to the following changes:

1. Section I entitled "Services" references a Statement of Work, attached to Subsection 1.1 as "Attachment A." This Amendment shall replace the original "Attachment A" with the version of "Attachment A" enclosed with this Third Amendment.

2. Section V entitled "Term and Termination" is hereby amended to revise Subsection 5.1 to reflect a single year term:

> "5.1 Term. The term of this Agreement shall begin on the date set forth on the first page of the Agreement and continue through December 31, 2021 or until a permanent Chief Diversity Officer is hired or until the Agreement is terminated by PLAN or Consultant as set forth below."

The Plan and the Employee have duly executed this Third Amendment as of the date first written above.

Ventura County Medi-Cal Managed Care Commission d.b.a. Gold Coast Health Plan

Signature: _____
Margaret Tartar, CEO

Date: _____

TBJ Consulting

Signature: _____
Ted Bagley, CEO/ Pres.

Date: _____

ATTACHMENT A

STATEMENT OF WORK NO. 3

THIS STATEMENT OF WORK NO. 3 is made as of this 1st day of November 2020 Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan, a California public entity established under the laws of the State of California, (hereinafter "PLAN") The parties entered into Consulting Services Agreement dated as of November 9, 2017 ("Agreement"). The terms and conditions of the Agreement are incorporated into this Statement of Work No. 3 by this reference thereto and this Statement of Work No. 3 is subject to such terms and conditions. If there is a conflict between a specific term in this Statement of Work No. 3 and the terms of the Agreement, the specific term of the Agreement shall control.

1. SCOPE OF WORK

The Detailed Scope includes a list of the specific requirements that the project must satisfy. It also includes a listing of the deliverables that will be generated by the Project Team, as well as those deliverables that are specifically excluded from the scope.

1.1. Consultant Responsibilities

See CDO Job Description.

1.2. PLAN Responsibilities

See *Consulting Services Agreement dated as of November 9, 2017.*

1.3. Deliverables

List all deliverables referenced in the Project Schedule and provide a brief description of the related acceptance criteria for each. Provide a copy of the completed Log as an Appendix to this document.

2. PROJECT SCHEDULE

PROJECT SCHEDULE	
Milestone or Major Project Deliverable	**Completion Date**
Perform all duties of the Chief Diversity Officer	TBD
Investigate all Diversity related issues in a timely manner	TBD

The PLAN acknowledges that Consultant is not required to engage in day-to-day human resources planning, process, and implementation, except so far as Diversity-related issues are relevant. Where no such Diversity-related issues are relevant, Consultant will defer to PLAN human resources staff.

2.1. Assumptions

If applicable, insert certain assumptions upon which the Statement of Work is based.

3. TERM

3.1. The Initial Term of this Statement of Work shall be from November 1st, 2020 until December 31, 2021 or until a permanent Chief Diversity Officer is hired by the PLAN or until otherwise terminated pursuant to the terms of the Services Agreement.

or

3.2. Start Date: November 1st 2020 End Date: December 31st 2021

4. COMPENSATION

4.1. **Compensation.** For Services rendered as outlined herein, Consultant shall be compensated as follows:

4.1.1. Fixed Fee: The fixed fee to PLAN for the delivery of the Services is, $250.00 an hour as planned. Additional hours are at the discretion of the plan and as needed for effective performance of the duties of this position.

4.1.2. Payment Terms. PLAN shall pay Consultant for the Services in accordance with the following fixed fee payment schedule.

Project Task/Milestone	Payment to Consultant
Establish a successful diversity environment within the Plan.	As stated above
Development internal and external relationships for efficiency and effectiveness	As stated above
Conduct fair and equitable investigations	As stated above
Operate in conjunction with the officers of the Plan	As stated above

or

4.1.3. Time and Materials Fees. Except as otherwise agreed by the Parties, Consultant agrees to invoice PLAN the labor hour fee's listed below.

Skill-Set	Estimated Number of Hours	Hourly Fee
Business and diversity experience	75 hrs monthly	$250.00
-Investigation		
-Training		
Build a diversity culture with assistance from GCHP		

4.1.4. **Travel & Expenses:** (check if applicable) **as needed**

4.1.5. **Total Compensation.** The total compensation for the project under this Statement of Work No. 2 shall not exceed $225,000.00.

5. ACCEPTANCE

Invoicing will trigger reasonable responsibility to provide payment.

In witness whereof, the parties have caused this Statement of Work to be executed by their respective duly authorized representatives.

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

BY: _____

NAME: Margaret Tartar

TITLE: Chief Executive Officer

DATE: _____

TBJ Consulting
71 Golden Glen Drive
Simi Valley, CA 93065

BY: _____

NAME: Ted Bagley

TITLE: Chief Executive Officer

DATE: _____

EXHIBIT 3

ORDINANCE NO. 4481

AN ORDINANCE OF THE VENTURA COUNTY BOARD OF SUPERVISORS, REPEALING AND REENACTING, AS AMENDED, ARTICLE 6, CHAPTER 3, DIVISION 1 OF THE VENTURA COUNTY ORDINANCE CODE (COUNTY ORGANIZED HEALTH SYSTEM)

The Board of Supervisors of the County of Ventura ordains as follows:

SECTION 1: Repeal of Existing Ventura County Organized Health System Ordinance

Ordinance No. 4409 of the County of Ventura, which enacted Article 6 of Chapter 3 of Division 1 of the Ventura County Ordinance Code, is hereby repealed.

SECTION 2: Enactment of Ventura County Organized Health System Ordinance

Article 6 of Chapter 3 of Division 1 of the Ventura County Ordinance Code is hereby amended and reenacted as follows:

Chapter 3.

Article 6. County Organized Health System

1380 General Provisions.

1380-1.

Pursuant to Welfare and Institutions Code section 14087.54, there is hereby formed a commission, referred to in this Article as the Ventura County Medi-Cal Managed Care Commission.

1380-2.

The Ventura County Medi-Cal Managed Care Commission is empowered to negotiate and enter into exclusive contracts with the State of California Department of Health Care Services pursuant to Welfare and Institutions Code section 14087.5, and to arrange for the provision of health care services under Division 9, Part 3, Chapter 7 of the Welfare and Institutions Code. The Ventura County Medi-Cal Managed Care Commission is also authorized to:

(a) Enter into contracts for the provision of health care services to persons who are eligible to receive medical benefits, subject to the limitations of Welfare and Institutions

Code section 14087.54, subdivision (b)(2);

(b) Provide health care delivery systems for:

(1) persons who are eligible to receive medical benefits under both the Medicare program as defined in title 18 of the Federal Social Security Act (42 U.S.C. §1395 et seq.) and under the Medicaid program as defined in title 19 of the Federal Social Security Act (42 U.S.C.§ 1396 et seq.), and or

(2) persons who are eligible to receive medical benefits under the Medicaid program as defined in title 19 of the Federal Social Security Act (42 U.S.C.§1396 et seq.);

(c) File the statement required by Government Code section 53051;

(d) Acquire, possess, and dispose of real or personal property, as may be necessary for the performance of its functions;

(e) Employ personnel and contract for services required to meet its obligations;

(f) Sue and be sued;

(g) Enter into agreements under Chapter 5 (commencing with section 6500) of Division 7 of Title 1 of the Government Code.

1380-3.

The Ventura County Medi-Cal Managed Care Commission shall for all purposes be an entity separate from the County of Ventura, and shall be deemed a public entity for purposes of Division 3.6 (commencing with section 810) of Title 1 of the Government Code. Any obligations of the Ventura County Medi-Cal Managed Care Commission (statutory, contractual, or otherwise) shall be the obligations solely of the Ventura County Medi-Cal Managed Care Commission and shall not be obligations of the County of Ventura or the State of California.

1380-4.

The Ventura County Medi-Cal Managed Care Commission 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 Ventura County Medi-Cal Managed Care Commission and shall not be the obligations of the County of Ventura or the State of California;

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

1381 Board of Directors (Commission)

1381-1.

The governing board of the Ventura County Medi-Cal Managed Care Commission shall consist of eleven (11) voting members who shall be legal residents of the County of Ventura. Members of the

Ventura County Medi-Cal Managed Care Commission shall possess the requisite skills and knowledge necessary to design and operate a publicly managed health care delivery system.

1381-2.

Members of the Ventura County Medi-Cal Managed Care Commission shall be appointed by a majority vote of the Board of Supervisors and shall consist of the following:

a. 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. (Physician Representatives)

b. 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. (Private Hospital/Healthcare System Representatives)

c. 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. (Ventura County Medical Center Health System Representative)

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

e. 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. (Clinicas Del Camino Real Representative)

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

g. 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. (Consumer Representative)

h. One member shall be a representative of the County of Ventura nominated by the Ventura County Executive Officer and approved by the Board of Supervisors. (Ventura County Representative)

1381-3.

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 Ventura County Medi-Cal Managed Care Commission 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 Ventura County Medi-Cal Managed Care Commission.

A member may be removed from the Ventura County Medi-Cal Managed Care Commission by a 4/5 vote of the Board of Supervisors.

Nominations to the Ventura County Medi-Cal Managed Care Commission shall be submitted to the Ventura County Executive Office, which shall be responsible for screening nominees and presenting candidates to the Ventura County Board of Supervisors. Appointments will be based on the individuals' knowledge of the

healthcare needs of women, children, seniors, and/or the disabled, and business, finance and/or political experience.

1381-4.

Procedures for the conduct of business not otherwise specified in this Article shall be contained in bylaws adopted by the Ventura County Medi-Cal Managed Care Commission.

1381-5.

The Ventura County Medi-Cal Managed Care Commission may establish a committee(s) or advisory board(s) for any purpose that will be beneficial in accomplishing the work of the Ventura County Medi-Cal Managed Care Commission. At a minimum, two (2) committees/advisory boards shall be established, one member/consumer based and one provider based.

1382 Cultural Diversity Program

The Ventura County Medi-Cal Managed Care Commission shall establish a Cultural Diversity Program to insure that employees, contractors and recipients of health care services are treated with respect and without discrimination. The governing board of the Ventura County Medi-Cal Managed Care Commission shall appoint a Chief Diversity Officer, who shall be responsible for implementation of the Cultural Diversity Program, and shall provide staff and resources for the Chief Diversity Officer as necessary and appropriate. The Chief Diversity Officer shall report directly to the governing board of the Ventura County Medi-Cal Managed Care Commission, and shall have the authority, independent of any other executive officer, to take disciplinary action against any employee, except the chief executive officer, for failure to comply with the Cultural Diversity Program. The Chief Diversity Officer shall also provide reports to the Ventura County Board of Supervisors, through the County's Chief Executive Officer, on a quarterly or more frequent basis.

SECTION 3: This ordinance shall take effect and be in full force and effect thirty (30) days after its passage. Before the expiration of fifteen (15) days after passage of this ordinance it shall be published once with the names of the members of the Board of Supervisors voting for and against the ordinance in the Ventura County Star, a newspaper of general circulation published in the State of California.

PASSED AND ADOPTED this 6th day of October, 2015, by the following vote:

AYES: Bennett, Parks, Foy, Zaragoza, and Long

NOES:

ABSENT:

Kathy Long
CHAIR, BOARD OF SUPERVISORS

ATTEST: MICHAEL POWERS,
Clerk of the Board of Supervisors,
County of Ventura, State of California.

By: KPelicano
Deputy Clerk of the Board

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, M.D., Chief Medical Officer
Anne Freese, PharmD, Director of Pharmacy

Date: October 26, 2020

RE: Pharmacy Benefits Manager (PBM) Contract Amendment

SUMMARY:

Gold Coast Health Plan ("GCHP") contracts with a Pharmacy Benefits Manager ("PBM") in order to provide pharmacy benefit services to its members. In November 2016, GCHP signed a contract with OptumRx, Inc. GCHP will no longer require PBM services with the onset of Medi-Cal Rx on January 1, 2021. However, GCHP will require 6 months of run-out services which are detailed in the contract. This contract amendment decreases the fees associated with the processing of pharmacy encounters during the run-out period from January 1, 2021 to June 30, 2021.

DISCUSSION:

This amendment changes the costs associated with the processing and submission of encounters for GCHP from a per member per month charge to a reasonable monthly flat rate resulting in cost savings to GCHP of approximately $150,000.

FISCAL IMPACT:

This amendment is estimated to save GCHP approximately $150,000.

RECOMMENDATION:

Staff recommends the Commission authorize the signing of the amendment.

Fourth Amendment to
Agreement for Professional Services
between
Ventura County Medi-Cal Managed Care Commission
Doing Business as Gold Coast Health Plan
and
OptumRx, Inc.

This Fourth Amendment (the "**Amendment**") is by and between Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan ("**GCHP**") and OptumRx, Inc., ("**CONTRACTOR**"), and is effective as of November 1, 2020 (the "**Amendment Effective Date**"), unless otherwise set forth herein. All capitalized terms used, but not otherwise defined herein, shall have their meanings set forth in the Agreement for Professional Services between Contractor and GCHP entered into as of November 15, 2016, together with any and all Exhibits attached thereto (the "**Agreement**").

WHEREAS, Contractor and GCHP desire to amend the terms of the Agreement as hereinafter set forth.

NOW, **THEREFORE**, in consideration of the premises and covenants and agreements contained herein, the parties agree as follows:

1. Effective January 1, 2021, Section 4 (exclusive of Section 4.1, which shall remain unchanged by this Amendment) of Schedule A-2-(a) to Schedule A-2 Service Fees and Charges is deleted and replaced with the following:

4. OTHER SPECIFIED FEES. GCHP will pay Contractor for the services and amounts set forth on to the following table during the term of this Service Order ("**Other Fees**"):

Service	**Runout Services Period** **January 1, 2021 to June 30, 2021**
Clinical Prior Authorization (per written authorization)	$30.00
Direct Member Reimbursement (per processed paper claim)	$2.50
Encounter Processing	$2,500 per month
Manual Eligibility Maintenance (per record)	$0.50

2. This Amendment is hereby added to and incorporated into the Agreement by this reference. The terms and conditions set forth in this Amendment will control in the event of any

conflict with the terms and conditions set forth in the Agreement. Except as expressly amended hereby, the terms and conditions of the Agreement remain the same. This Amendment may be

executed in counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed as of the day and year first above written.

Ventura County Medi-Cal Managed Care Commission d/b/a Gold Coast Health Plan	**OptumRx, Inc.**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, M.D., Chief Medical Officer
Anne Freese, PharmD, Director of Pharmacy

DATE: October 26, 2020

SUBJECT: Medi-Cal Rx Update

SUMMARY:

Presentation by staff providing an update on the implementation of the pharmacy benefit carve-out, Medi-Cal Rx.

RECOMMENDATION:

Staff recommends that the Ventura County Medi-Cal Managed Care Commission receive and file the presentation.

ATTACHMENT:

1) Freese, A., (2020). Director of Pharmacy, Ventura County Medi-Cal Managed Care Commission, GCHP: Medi-Cal Rx, Presentation Slides.

Gold Coast Health Plan℠
A Public Entity

Medi-Cal Rx Update

Integrity

Accountability

Collaboration

Trust

Respect

Annie Freese, Pharm.D.
Director of Pharmacy

711 East Daily Drive, Suite 106, Camarillo, CA 93010 www.goldcoasthealthplan.org

Agenda

- What is Medi-Cal Rx?
- Claim Responsibilities
- Post Transition Responsibilities
- PA and Appeals
- Transition Benefit
- Provider Communication and Training
- Member Communication
- Medi-Cal Rx Website

Return to Agenda

Medi-Cal Rx

- What is Medi-Cal Rx?
  - On January 1, 2021, all retail pharmacy claims will be billed to the state and not to GCHP.
- What do we know so far?
  - Member Communication
  - Transition Benefit
  - Provider Education
- What challenges to we expect?
  - Real time claim access
  - Data sharing
  - Coordination of care
- How will GCHP communicate with the state/assist beneficiaries with prescription issues after the transition?
  - PBM Liaison

Return to Agenda

Claim Responsibilities

Delivery System	Claim Type	Pre-Transition	Post Transition
GCHP	Medical/Institutional claim	GCHP	GCHP
	Pharmacy Claims	GCHP (via PBM)	Medi-Cal Rx
FFS	Medical/Institutional claim	FFS Fiscal Intermediary (FI)	FFS FI
	Pharmacy Claims	FFS FI	Medi-Cal Rx

Return to Agenda

Post Transition Responsibilities

Responsibility	State	GCHP	Medi-Cal Rx
Maintain Medi-Cal Pharmacy Policy	X		
Make Final Determinations on PAs Denials and SFH	X		
Negotiation of Rebates	X		
Pharmacy Reimbursement Methodology	X		
Pharmacy Network	X		
Care Coordination		X	
Oversee pharmacy adherence and disease/medication management programs		X	
Pharmacy Services billed on medical/institutional claims		X	
Participate in the DUR Board		X	
Pharmacy claim administration, processing and payment			X
Coordination of Benefits with OHI			X
Utilization Management (including all PAs with 24 hours)			X
Prospective and Retrospective DUR			X
Drug Rebate Administration			X

Return to Agenda

How Will This Affect PAs and Appeals?

Prior Authorizations

- Submitted by providers OR pharmacies via the Magellan Provider Portal.
- Initial review by Magellan pharmacist.
- If denied, secondary review by DHCS pharmacist prior to decision being issued.
- Final decision to be issued within 24 hours day of submission.
- Decision may be deferred.

Appeals

- There will be a provider appeal process.
- If an authorization request is denied, the member may request a State Fair Hearing (SFH)
- A provider may request a SFH upon written authorization from the member.
- The SFH process may take up to 135 days to be resolved, with an average resolution turn around time of 52 days.

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What about a Transition Benefit?

DHCS Transition Policy Principals:

- 180 day transition period
- Claim and PA history provided to Medi-Cal Rx PBM
- For existing prescriptions that did not require a PA under the MCP (GCHP), but will under Medi-Cal RX, grandfathering will be offered:
  - Match based upon prescription number, **not** the drug and limited to 1 year from the date the prescription was written
- For existing prescriptions that did require a PA under the MCP (GCHP), and will also need a PA under Medi-Cal RX, grandfathering will be offered:
  - Match based upon PA authorization dates and date prescription was written, **not** the drug and limited to 1 year from the date the prescription was written
- For new prescriptions regardless of need for a prior authorization, grandfathering will not apply.

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Communication Schedule: Providers

Date	Audience	Topic
August 2020	Providers (pharmacies and prescribers)	Training announcements and instructions
September 2020	Providers (pharmacies and prescribers)	120-day pharmacy transition
October 2020	Pharmacies	90-day notice letter
November 2020	Pharmacies	60-day notice letter
December 2020	Pharmacies	30-day notice letter

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Medi-Cal Rx: Training Schedule

Date	Audience	Topic
August 2020	Providers (pharmacies and prescribers)	Registration instructions for the secured portal and associated applications
September 2020	Providers (pharmacies and prescribers)	General training begins
October 2020	Providers (pharmacies and prescribers)	General training continues
November 2020	Pharmacies	Web claims submission trainings
November 2020	Providers (pharmacies and prescribers)	General training continues

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Other GCHP Provider Outreach

Item	Targeted Date	Description
Provider Operations Bulletins (POB)	Mid-October	An article in the POB will be placed regarding Medi-Cal Rx
Provider Emails Blasts	Ongoing	Email blasts containing important information and notification of website updates
Resource Guide	October	Guide with description of all major changes occurring January 1.
JOMs or Targeted Medi-Cal Rx Meetings	October/November	Presentations at upcoming JOM to discuss impact of Medi-Cal Rx
GCHP Website Banner and Landing Page	Now live	Website containing important links and information regarding Medi-Cal Rx

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Communication Schedule: Members

Date	Topic	Responsibility
October 2020	90-Day Notice Letter	DHCS
November 2020	60-Day Notice Letter	DHCS
November-December 2020	~~Outbound Call Campaign~~ Outreach Campaign	GCHP
December 2020	30-Day Notice Letter	GCHP
January 2021	New ID Cards	GCHP

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Medi-Cal Rx Web Portal: NOW LIVE!

https://medi-calrx.dhcs.ca.gov/home/

Information Available:

- Program Overview and FAQs
- Training and Communication Schedules
- Details regarding Transition Policy
- Email subscription service alert sign up – SIGN UP NOW!

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Other Important Links

Medi-Cal Rx Dedicated Transition Website:

Medi-Cal Rx Transition

Contract Drug List (CDL):

Medi-Cal Pharmacy Manual

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In Summary:

What is Medi-Cal Rx?

- On January 1, 2021, all pharmacy claims will be billed to Medi-Cal Rx, the new FFS pharmacy program
- GCHP can assist members and providers, but the benefit will be administered by the state
- The formulary will change under Medi-Cal Rx and members may need new authorizations or to change medications
- There will be a transition 180 day transition period for grandfathering of medications

What Do I Need to Do?

- **Register** for and **access** the Medi-Cal Rx **secure provider portal**
- **Complete** any necessary **training** and education modules to know how to help members access their pharmacy benefits including how to submit a prior authorization or appeal
- **Educate office staff** on new phones numbers, web portal, etc.

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Medi-Cal Rx: Questions

- For questions and/or comments regarding Medi-Cal Rx, DHCS invites stakeholders to submit those via email to rxcarveout@dhcs.ca.gov

- For questions and/or comments for GCHP regarding pharmacy benefits, please reach out to Annie Freese at afreese@goldchp.org

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AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kashina Bishop, Chief Financial Officer

DATE: October 26, 2020

SUBJECT: FY 2019-20 Audit Results (Presented by Moss Adams)

SUMMARY:

Moss Adams LLP (Moss Adams) is presenting the annual financial statements of Gold Coast Health Plan (GCHP) as of, and for the year ending June 30, 2020.

The auditor's report reflects an "unmodified opinion" which means the determination is that the financial statements for the audit period present fairly, in all material respects, the financial position of GCHP as of June 30, 2020 in accordance with accounting principles generally accepted in the United States of America.

BACKGROUND / DISCUSSION:

The primary purpose of the audit is for the Commission and stakeholders to gain assurance that GCHP's financial statements are properly presented, are free of material mis-statements and have been prepared in conformity with accounting principles generally accepted in the U.S.

We are pleased to report that there were no audit adjustments. From the preliminary June close, GCHP staff identified necessary adjustments and immediately communicated those to Moss Adams. Below is a comparison of the June 30, 2020 financial statements approved by the Commission in August to the final audit report.

	Approved by Commission on 8/24/20	Unaudited with Proposed Adjustments
Revenue	$ 820,463,607	$ 820,463,607
Medical expenses	778,034,088	769,724,112
Administrative Expenses	50,821,685	50,821,685
Other income	1,800,513	1,800,513
Net Income (Loss)	$ (6,591,653)	$ 1,718,323
Tangible Net Equity	$ 69,013,294	$ 77,323,271
% of Required	198%	225%

The adjustment is due to the implementation of a new process for corrected claims which caused variances between the claims check register and the claims data file utilized to estimate medical expenses. The issue was identified, remediated, and the appropriate adjustment has been made to the financial statements.

A secondary and important purpose of the audit is to test and comment on the GCHP's design, implementation and maintenance of a system of internal controls that have a relationship with financial reporting. Moss Adams has recommended continued rigor be placed over Conduent claims processing. Staff is taking this recommendation seriously and continually seeking to improve internal controls.

RECOMMENDATION:

Staff recommends that the Commission approve the audited financial statements as of, and for the year ended June 30, 2020.

CONCURRENCE
N/A

ATTACHMENT:

Draft Report of Independent Auditors and Financial Statements for GCHP as of June 30, 2020 and 2019.

Gold Coast Health Plan℠
A Public Entity

Gold Coast Health Plan

Integrity

Accountability

Collaboration

Trust

Respect

FYTD Audited Financial Statements
As of June 30, 2020

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711 East Daily Drive, Suite 106, Camarillo, CA 93010 www.goldcoasthealthplan.org

June 2020 Financial Statement Adjustment:

	FYTD June 30, 2020 As Presented 8/24/20	Adjustments	Final FYTD June 30, 2020
Revenue	$ 820,463,607	$ -	$ 820,463,607
Health Care Costs	778,034,088	(8,309,976)	769,724,112
Administrative Expenses	50,821,685	-	50,821,685
Non-Operating Revenue/(Expense)	1,800,513	-	1,800,513
Total Increase/(Decrease) in Net Assets	$ (6,591,653)	$ 8,309,976 *	$ 1,718,323
GCHP TNE	$ 69,013,294	$ 8,309,976	$ 77,323,271
Required TNE	$ 34,770,196	$ (330,055)	$ 34,440,141
% of Required	**198%**		**225%**

*** Net adjustment due to the financial implications of a change to the corrected claims process.**

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Internal Control Recommendation:

- "Continued rigor be placed over Conduent claims processing oversight."

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Conduent – Internal Control Focus:

1. Internal workgroup to assess and review the Change Control Document (CCD) Process with Conduent
2. In progress – issues tracking log and weekly status meetings
3. Daily meetings for the system implementation

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REPORT OF INDEPENDENT AUDITORS
AND FINANCIAL STATEMENTS

VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION dba GOLD COAST HEALTH PLAN

June 30, 2020 and 2019

MOSSADAMS

Table of Contents

The intent of the Management's Discussion and Analysis is to provide readers with an overview of the Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan's ("GCHP" or the "Plan") financial activities for the fiscal years ended June 30, 2020 and 2019. This overview is provided in conjunction with the Plan's fiscal year ended June 30, 2020 audit. Readers should review this overview in conjunction with GCHP's financial statements and accompanying notes to the financial statements to enhance their understanding of the financial performance.

Gold Coast Health Plan Overview

On June 2, 2009, the Ventura County Board of Supervisors approved the implementation of a county-organized health system (COHS) model to transition Ventura County Medi-Cal members from a fee-for-service model to a managed care model. Ordinance No. 4409 (April 2010) established the Ventura County Medi-Cal Managed Care Commission as an oversight entity. The Commission's 11 members oversee a single plan—Gold Coast Health Plan—to serve Ventura County Medi-Cal beneficiaries.

As a COHS, the Plan has an exclusive contract (the "Contract") with the State of California (the "State") Department of Health Care Services ("DHCS") to arrange for the provision of health care services to Ventura County's approximately 200,000 Medi-Cal beneficiaries at June 30, 2020. The Plan receives virtually 100 percent of its revenue in the form of capitation from the State of California.

Overview of the Financial Statements

This annual report consists of financial statements and notes to those statements, which reflect GCHP's financial position and results of operations for the fiscal years ended June 30, 2020 and 2019. The financial statements of GCHP include the statement of net position, statement of revenues, expenses, and changes in net position, statement of cash flows, and notes to the financial statements.

- The statement of net position includes all of GCHP's assets and liabilities, using the accrual basis of accounting.

- The statement of revenues, expenses, and changes in net position presents the results of operating activities during the fiscal year and the resulting change in net position.

- The statement of cash flows reports the net cash provided by operating activities, as well as other sources, and uses of cash from investing, capital, and related financing activities.

The following discussion and analysis addresses GCHP's overall program activities.

Financial Highlights

The table below presents condensed statements of net position of the Plan as of June 30, 2020, 2019, and 2018:

Table 1 – Condensed Statements of Net Position as of June 30

(Dollars in Thousands)

	2020	2019	2018	2020 - 2019 Change		2019 - 2018 Change	
				Amount	Percentage	Amount	Percentage
ASSETS							
Current assets and other assets	$ 244,402	$ 237,883	$ 431,759	$ 6,519	2.7 %	$ (193,876)	(44.9)%
Capital assets, net	1,610	1,668	1,973	(58)	(3.5)%	(305)	(15.5)%
Total assets	246,012	239,551	433,732	6,461	2.7 %	(194,181)	(44.8)%
LIABILITIES							
Current liabilites	168,689	163,946	301,617	4,743	2.9 %	(137,671)	(45.6)%
Total liabilities	168,689	163,946	301,617	4,743	2.9 %	(137,671)	(45.6)%
NET POSITION							
Invested in capital assets	1,610	1,668	1,973	(58)	(3.5)%	(305)	(15.5)%
Unrestricted net position	75,713	73,937	130,142	1,776	2.4 %	(56,205)	(43.2)%
Total net position	77,323	75,605	132,115	1,718	2.3 %	(56,510)	(42.8)%
Total liabilities and net position	$ 246,012	$ 239,551	$ 433,732	$ 6,461	2.7 %	$ (194,181)	(44.8)%

Fiscal Year 2020

- As of June 30, 2020 and 2019, total assets were approximately $246,012,000 and $239,551,000 respectively, an increase of $6,461,000 or 2.7 percent.
- Current liabilities as of June 30, 2020, were $168,689,000 compared with $163,946,000 as of June 30, 2020, a 2.9 percent increase. The increase was primarily related to increases in accrued pharmacy.
- The Plan's total net position increased by approximately $1,718,000, or 2.3 percent, during fiscal 2020. This increase in net position was attributable to favorability in capitation rates from the State, which resulted in a net position at June 30, 2020 of $77,323,000 from a net position of $75,605,000 at June 30, 2019.
- Tangible Net Equity (TNE) at June 30, 2020 was 225 percent of the DHCS required minimum of $34,440,000.

Fiscal Year 2019

- As of June 30, 2019 and 2018, total assets were approximately $239,551,000 and $433,732,000, respectively. The decrease is related to a reduction in cash and cash equivalents due to amounts paid back to the State for the Adult Expansion Medical Loss Ratio requirement. Approximately $160,500,000 million was paid back to the State of California in November of 2018 for incurred periods between January 1, 2014 and June 30, 2016.

- Current liabilities at June 30, 2019, were $163,946,000, compared with $301,617,000 at June 30, 2018, a 45.6 percent decrease. The decrease is related to a reduction in the amount payable to the State of California for the Adult Expansion Medical Loss Ratio requirement.

- The Plan's total net position decreased by approximately $56,510,000, or 42.8 percent, during fiscal 2019. This decrease in net position was attributable to increasing health care costs, which resulted in a net position at June 30, 2019, of $75,605,000 from a net position of $132,115,000 at June 30, 2018.

- Tangible Net Equity (TNE) at June 30, 2019, was 230 percent of the DHCS required minimum of $32,907,000. The reduction in TNE was caused by increasing health care costs due to both contracting and utilization changes.

Results of Operations

As mentioned above, GCHP's fiscal 2020 operations and nonoperating revenues and expenses, net resulted in a $1,718,000 increase in net position. GCHP's fiscal 2019 operations and nonoperating revenues and expenses, net resulted in a $56,510,000 decrease in net position. The following table shows the changes in revenues and expenses for 2020 compared to 2019 and 2019 compared to 2018.

Table 2 – Revenues, Expenses, and Changes in Net Position for Fiscal Years Ended June 30

(Dollars in Thousands)

				2020 to 2019 Change		2019 to 2018 Change	
	2020	2019	2018	Amount	Percentage	Amount	Percentage
Capitation revenues	$ 854,969	$ 808,723	$ 811,504	$ 46,246	5.7 %	$ (2,781)	(0.3)%
Total operating revenues	854,969	808,723	811,504	46,246	5.7 %	(2,781)	(0.3)%
Provider capitation	58,648	56,824	33,829	1,824	3.2 %	22,995	68.0 %
Claim payments to providers and facilities	552,877	521,847	527,161	31,030	5.9 %	(5,314)	(1.0)%
Prescription drugs	143,601	134,567	121,066	9,034	6.7 %	13,501	11.2 %
Other medical	15,493	16,212	11,685	(719)	(4.4)%	4,527	38.7 %
Reinsurance, net of recoveries	(895)	(3,496)	(574)	2,601	(74.4)%	(2,922)	509.1 %
Total health care expenses	769,724	725,954	693,167	43,770	6.0 %	32,787	4.7 %
Salaries, benefits, and compensation	15,560	14,897	15,268	663	4.5 %	(371)	(2.4)%
Professional fees	28,449	25,639	27,425	2,810	11.0 %	(1,786)	(6.5)%
General administrative fees	3,258	2,766	3,078	492	17.8 %	(312)	(10.1)%
Supplies, occupancy, insurance, and other	2,265	2,221	2,183	44	2.0 %	38	1.7 %
Premium tax	34,505	96,569	84,200	(62,064)	(64.3)%	12,369	14.7 %
Depreciation	467	534	532	(67)	(12.5)%	2	0.4 %
Total administrative expenses	84,504	142,626	132,686	(58,122)	(40.8)%	9,940	7.5 %
Total operating expenses	854,228	868,580	825,853	(14,352)	(1.7)%	42,727	5.2 %
Operating income (loss)	741	(59,857)	(14,349)	60,598	(101.2)%	(45,508)	317.2 %
Interest income	1,800	3,993	4,632	(2,193)	(54.9)%	(639)	(13.8)%
Interest expense	(823)	(646)	(529)	(177)	27.4 %	(117)	22.1 %
Total nonoperating revenues and expenses, net	977	3,347	4,103	(2,370)	(70.8)%	(756)	(18.4)%
Increase (decrease) in net position	1,718	(56,510)	(10,246)	58,228	(103.0)%	(46,264)	451.5 %
Total net position, beginning of year	75,605	132,115	142,361	(56,510)	(42.8)%	(10,246)	(7.2)%
Total net position, end of year	$ 77,323	$ 75,605	$ 132,115	$ 1,718	2.3 %	$ (56,510)	(42.8)%

Enrollment, Capitation Revenue and Health Care Expenses

Enrollment

Enrollment is divided into aid categories, which correspond to specific rates of capitation to be received by the Plan from the State. During fiscal 2020, the Plan served an average of 194,879 members per month, compared to an average of 199,109 members per month in fiscal 2019 and an average of 204,207 members per month in fiscal 2018. The decline in enrollment in both years was attributed to improving economic conditions in Ventura County.

Table 3 – Medi-Cal Enrollment by Aid Category
(Shown as Average Member Months)

Enrollment Category	2020	2019	2018
Child	86,238	89,325	91,628
Adult	24,009	24,407	25,694
Adult Expansion	53,798	54,220	55,859
Seniors and Persons with Disabilities (SPD)	10,169	9,344	9,376
SPD - Dual	19,628	20,747	20,625
Breast and Cervical Cancer Treatment Program (BCCTP)	154	171	166
Long Term Care (LTC)	53	27	25
LTC - Dual	830	868	834
Total average monthly enrollment	194,879	199,109	204,207

Significant aid categories are defined as follows:

1. Child: Qualifying members under age 19.

2. Adult: Qualifying members between the ages of 19 and 64.

3. Adult Expansion (AE): Refers to members who became eligible for the Medi-Cal program effective January 1, 2014, as a result of the implementation of the Affordable Care Act (ACA) and the expanded eligibility criteria for Medicaid.

4. Senior and Persons with Disabilities (SPD)*: Includes individuals who are 65 years of age and older who receive supplemental security income (SSI) checks, or are medically needy if their income and resources are within the Medi-Cal limits, and individuals who met the criteria for disability set by the Social Security Administration and the State Program-Disability and Audit Program Division.

5. Long-Term Care*: Includes frail, elderly, non-elderly adults with disabilities and children with developmental disabilities, and other disabling conditions requiring long-term care services.

6. Breast and Cervical Cancer Treatment Program (BCCTP): Provides cancer treatment for eligible low-income California residents who are screened by the Cancer Detection Program: Every Woman Counts (CDP:EWC) or Family Planning, Access, Care and Treatment (Family PACT) programs and found to be in the need of treatment for breast and/or cervical cancer.

*"Dual" coverage refers to enrollees who are eligible for both Medi-Cal and Medicare Parts A, B, and D.

Fiscal Year 2020

Capitation Revenue

Premium revenue (capitation received by the Plan from the State) is determined by rates set by the State at the beginning of the plan year and generally are effective for the entire year. The State may, on occasion, provide updated rates during the fiscal year. Total revenue for fiscal year 2020 was $854,969,000, a 5.7 percent increase from the prior year. The increase was primarily attributable to favorability in capitation rates from the State.

Health Care Expenses

Aggregate health care expenses were $769,724,000 in fiscal 2020, compared to $725,954,000 in fiscal 2019, which is an increase of 6.0 percent. The Plan's medical loss ratio, or health care expenses as a percent of operating revenues (net of MCO taxes), was 93.8 percent in fiscal 2020, compared to 101.9 percent in fiscal 2019.

Note the following regarding the components of health care expenses:

1. Provider capitation represents monthly payments for members assigned to primary care providers who have agreed to accept risk to provide specific services (when needed) to their members. Rates are fixed by contract and are generally known at the beginning of the fiscal year. Capitation expense for fiscal 2020 was $58,648,000, or $1,824,000 higher than in fiscal 2019. The increase was primarily due to a contract change with a provider in which they took on additional services.

2. Pharmacy expenses were $143,601,000, or $9,034,000 higher in fiscal 2020 than in the prior year. The 6.7 percent increase in costs were impacted by an overall increase in utilization, primarily for dermatology and diabetes, and an overall increase in unit costs consistent with a national trend and allowing for 90-day supplies in the latter half of fiscal 2020 due to COVID-19.

3. Other medical, including care management, expense was $15,493,000 in fiscal 2020, or $719,000 and 4.4 percent lower than in fiscal 2019. The decrease was primarily due to a decrease in provider reserves in fiscal 2020, which was partially offset by an increase in care management expenses from the prior year due to additional staffing and software costs.

4. Total reinsurance, net of recoveries and provider refunds resulted in a $895,000 reduction to health care expenses in fiscal 2020, versus $3,496,000 in fiscal 2019.

Administrative Expenses

Total administrative expenses were approximately $84,504,000 in fiscal 2020, compared to $142,626,000 in fiscal 2019, for a decrease of $58,122,000. The decrease was predominantly due to premium tax expense, which was $34,505,000 in fiscal year 2020 compared to $96,569,000 in fiscal year 2019. The decrease in premium tax was due to a 6-month gap in required premium tax. Senate Bill X2-2 established the managed care organization tax between July 1, 2016 through June 30, 2019. The tax was renewed with the CMS approval of Assembly Bill 115 with an effective date of January 1, 2020.

Senate Bill X2-2, which passed in March 2016, redefined the premium tax payment and calculation. Per SB X2-2, the tax rate was a pre-determined liability based on DHCS projected Medi-Cal membership, and specified rates and was effective through June 30, 2019. Assembly Bill 115 re-established a managed care enrollment tax, using a modified tiered taxing model. On April 3, 2020, the federal government approved the State's revised proposal to implement a tax on MCOs to help fund the Medi-Cal program. The new AB115 MCO tax is effective from January 2020 through December 2022.

Other administrative expenses increased from the prior year due to increased expenses related to Enterprise Projects as compared to prior years and increases in staffing.

Fiscal Year 2019

Capitation Revenue

Premium revenue (capitation received by the Plan from the State) is determined by rates set by the State at the beginning of the plan year and generally are effective for the entire year. The State may, on occasion, provide updated rates during the fiscal year. Total revenue for fiscal year 2019 was $808,723,000, a slight decline of .3 percent from the prior year.

Declining enrollment was one driver of the decrease in revenue. Membership decreased by approximately 2.5 percent which equates to approximately $20 million in revenue. In addition, the Plan received additional funding in fiscal year 2018 from DHCS related to AB 85 Cost Balance Payments. Assembly Bill 85 (AB 85) contained a mechanism to reimburse public hospitals to a level where costs were covered for the AE population. The funding for this "Cost Balance Payment" was calculated by DHCS and distributed in fiscal 2018 and added approximately $35,000,000 to Plan revenue. In 2016, the Centers for Medicare & Medicaid Services (CMS) instituted the Medicaid Managed Care Final Rule. The Final Rule called for changes in the usage of managed care delivery systems and pass-through payments. However, CFR section 438.6(c) provided states flexibility to implement delivery systems and provider payment initiatives under Medicaid managed care plan contracts based on allowable directed payments that focus on delivery system reform. Thus, pass through payment systems like AB 85 ended and programs such as the Quality Improvement Program and the Enhanced Payment Program were adopted. Under these programs, hospitals must meet specified metrics in order to earn payment incentives.

The overall impact on revenue of the declining membership and decreased funding related to AB 85 was mitigated by an increase in base capitation rates on a per member basis received from the State, and increases to supplemental payments for behavioral health treatment.

Health Care Expenses

Aggregate health care expenses were $725,954,000 in fiscal 2019, compared to $693,167,000 in fiscal 2018, which is an increase of 4.7 percent. The Plan's medical loss ratio, or health care expenses as a percent of operating revenues (net of MCO taxes), was 101.9 percent in fiscal 2019, compared to 95.3 percent in fiscal 2018.

Note the following regarding the components of health care expenses:

1. Provider capitation represents monthly payments for members assigned to primary care providers who have agreed to accept risk to provide specific services (when needed) to their members. Rates are fixed by contract and are generally known at the beginning of the fiscal year. Capitation expense for the year was approximately $56,824,000 compared to $33,829,000 in fiscal year 2018. At the end of fiscal year 2018, approximately $22.7 million of accrued capitation payments related to a prior year were written off, which reduced the overall expense.

2. Pharmacy expenses were $134,567,000, or $13,501,000 higher in fiscal 2019 than in the prior year. The 11.2 percent increase in costs was impacted by an overall increase in utilization, primarily for dermatology and diabetes, and an overall increase in unit costs consistent with a national trend.

3. Other medical, including care management, expense was $16,212,000 in fiscal 2019, or $4,527,000 and 38.7 percent higher than in fiscal 2018. The increase was primarily due to the accrual of a withholding from provider capitation payments which can be earned back based on the attainment of reaching agreed upon quality metrics. In addition, the care management expense increased from the prior year due to additional staffing and software costs.

4. Total reinsurance, net of recoveries and provider refunds resulted in a $3,496,000 reduction to health care expenses in fiscal 2019, versus $574,000 in fiscal 2018.

Administrative Expenses

Total administrative expenses were approximately $142,626,000 in fiscal 2019, compared to $132,686,000 in fiscal 2018, an increase of $9,940,000. The increase was predominantly due to a premium tax expense, which was $96,569,000 in fiscal year 2019 compared to $84,200,000 in fiscal year 2018, an increase of $12,369,000. The total amount of premium tax due to the State for fiscal years 2019 and 2018 was $94,500,000 and $90,500,000, respectively. The difference in the premium tax expenses and amount paid to the State is related to adjustments for amounts due prior to FY 2017.

Senate Bill X2-2, which passed in March 2016, redefined the premium tax payment and calculation. Per SB X2-2, the tax rate was a pre-determined liability based on DHCS projected Medi-Cal membership, and specified rates.

Other administrative expenses decreased from the prior year due to decreased enrollment, credits to the PBM administrative fees, and a reduction in legal expenses.

Tangible Net Equity

GCHP is required by DHCS to maintain certain levels of TNE. Regulatory TNE levels are determined by formula and are based on specified percentages of revenue and medical expenses. Driven by its operating performance, the Plan's TNE at June 30, 2020, was $77,323,000, which exceeded the required TNE amount of $34,440,000. The Plan's TNE at June 30, 2019, was $75,605,000, which exceeded the required TNE amount of $32,907,000.

Table 4 – Tangible Net Equity (TNE)
(Dollars in Thousands)

	June 30, 2020	June 30, 2019	June 30, 2018
		(in thousands)	
Actual TNE, beginning balance	$ 75,605	$ 132,115	$ 142,361
Change in net position	1,718	(56,510)	(10,246)
Actual TNE, ending balance	$ 77,323	$ 75,605	$ 132,115
Required TNE	$ 34,440	$ 32,907	$ 32,374

Requests for Information

This financial report has been prepared in the spirit of full disclosure to provide the reader with an overview of GCHP's operations. If the reader has questions or would like additional information about GCHP, please direct the request to GCHP, 711 East Daily Drive, Suite 106, Camarillo, CA 93010 or call 805-437-5500.

MOSSADAMS

Report of Independent Auditors

The Commission
Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan
Camarillo, California

Report on Financial Statements

We have audited the accompanying financial statements of Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan ("GCHP" or the "Plan") (a discrete component unit of the County of Ventura, California), which comprise the statements of net position as of June 30, 2020 and 2019, and the related statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of GCHP as of June 30, 2020 and 2019, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 1 through 8 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, which considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

San Francisco, California
DATE

Ventura County Medi-Cal Managed Care Commission
dba Gold Coast Health Plan
Statements of Net Position

ASSETS

	June 30, 2020	June 30, 2019
CURRENT ASSETS		
Cash and cash equivalents	$ 89,586,429	$ 108,964,312
Short-term investments	43,040,224	46,961,600
Capitation receivable	102,000,828	69,895,552
Provider receivables	727,334	1,624,443
Reinsurance and other receivables	7,141,958	8,239,209
Prepaid expenses and other assets	1,905,555	2,197,859
Total current assets	244,402,328	237,882,975
CAPITAL ASSETS	1,610,328	1,667,770
Total assets	$ 246,012,656	$ 239,550,745

LIABILITIES AND NET POSITION

LIABILITIES		
Medical claims liability	$ 102,596,475	$ 89,468,996
Capitation payable	18,217,262	27,997,784
Payable to the State of California	5,257,358	15,611,208
Accounts payable	2,363,635	4,257,785
Accrued payroll and employee benefits	2,187,982	1,291,500
Accrued premium tax	34,505,280	23,626,246
Accrued expenses and other	3,561,402	1,692,280
Total current liabilities	168,689,394	163,945,799
Total liabilities	168,689,394	163,945,799
NET POSITION		
Net invested in capital assets	1,610,328	1,667,770
Unrestricted net position	75,712,934	73,937,176
Total net position	77,323,262	75,604,946
Total liabilities and net position	$ 246,012,656	$ 239,550,745

See accompanying notes.

Ventura County Medi-Cal Managed Care Commission
dba Gold Coast Health Plan
Statements of Revenues, Expenses, and Changes in Net Position

	Years Ended June 30,	
	2020	2019
OPERATING REVENUES		
Capitation revenues	$ 854,968,887	$ 808,723,007
Total operating revenues	854,968,887	808,723,007
OPERATING EXPENSES		
Health care expenses:		
Provider capitation	58,647,943	56,824,389
Claim payments to providers and facilities	552,877,249	521,846,851
Prescription drugs	143,601,339	134,566,717
Other medical	15,492,871	16,212,181
Reinsurance, net of recoveries	(895,291)	(3,496,023)
Total health care expenses	769,724,111	725,954,115
ADMINISTRATIVE EXPENSES		
Salaries, benefits, and compensation	15,560,002	14,897,090
Professional fees	28,448,531	25,638,724
General administrative fees	3,258,036	2,766,295
Supplies, occupancy, insurance, and other	2,264,505	2,221,025
Premium tax	34,505,280	96,568,748
Depreciation	467,455	534,470
Total administrative expenses	84,503,809	142,626,352
Total operating expenses	854,227,920	868,580,467
Operating income (loss)	740,967	(59,857,460)
NONOPERATING REVENUES AND EXPENSES, NET		
Interest income	1,800,513	3,992,912
Interest expense	(823,164)	(645,885)
Total nonoperating revenues and expenses, net	977,349	3,347,027
Increase (decrease) in net position	1,718,316	(56,510,433)
NET POSITION, beginning of year	75,604,946	132,115,379
NET POSITION, end of year	$ 77,323,262	$ 75,604,946

See accompanying notes.

Ventura County Medi-Cal Managed Care Commissions
dba Gold Coast Health Plan
Statements of Cash Flows

	Years Ended June 30, 2020	2019
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation revenues received	$ 812,509,761	$ 665,311,710
Reinsurance premiums paid	(3,387,261)	(2,956,755)
Payments to providers and facilities	(761,098,988)	(713,924,643)
Payments of premium tax	(23,626,246)	(93,214,760)
Payments of administrative expenses	(48,367,314)	(50,671,507)
Net cash used in operating activities	(23,970,048)	(195,455,955)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchases of capital assets	(410,013)	(229,124)
Interest payments	(823,166)	(645,885)
Net cash used in capital and related financing activities	(1,233,179)	(875,009)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of investments	-	(19,926,500)
Proceeds from sale of investments	5,000,000	172,054,644
Interest income	825,344	1,864,601
Net cash provided by investing activities	5,825,344	153,992,745
NET DECREASE IN CASH AND CASH EQUIVALENTS	(19,377,883)	(42,338,219)
Cash and cash equivalents, beginning of year	108,964,312	151,302,531
Cash and cash equivalents, end of year	$ 89,586,429	$ 108,964,312
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating income (loss)	$ 740,967	$ (59,857,460)
Adjustments to reconcile operating income (loss) to net cash used in operating activities:		
Depreciation	467,455	534,470
Changes in assets and liabilities:		
Receivables	(30,214,369)	1,869,138
Prepaid expenses and other assets	292,304	(331,110)
Medical claims liability	13,127,479	14,010,521
Capitation payable	(9,780,522)	(2,530,403)
Payable to the State of California	(10,353,850)	(147,687,835)
Accounts payable	(1,894,150)	1,347,403
Accrued premium tax and other liabilities	13,644,638	(2,810,679)
Net cash used in operating activities	$ (23,970,048)	$ (195,455,955)

See accompanying notes.

Note 1 – Organization and Operations

Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan ("GCHP" or the "Plan") is a county-organized health system (COHS) organized to serve Medi-Cal beneficiaries living in Ventura County, California. The formation of GCHP was approved by the Board of Supervisors of the County of Ventura in December 2009 through the adoption of Ordinance No. 4409.

As a COHS, GCHP maintains an exclusive contract (the "Contract") with the State of California Department of Health Care Services ("DHCS") to arrange for the provision of health care services to Ventura County's approximately 200,000 Medi-Cal beneficiaries. All of GCHP's revenues are earned from the State of California (the "State") in the form of capitation payments. Revenue is primarily based on enrollment and capitation rates as provided for in the Contract. The Plan began providing services to Medi-Cal beneficiaries in July 2011. In August 2013, the State of California transferred the Healthy Families Program members in Ventura County into the Medi-Cal program, Targeted Low Income Program (TLIC). In January 2014, the federal Affordable Care Act (ACA) expanded health coverage to certain adults age 19 or older and under 65 and resulted in new enrollment through Adult Expansion (AE) and other population groups.

Note 2 – Compliance with the DHCS, Concentration Risk, and Restricted Net Position

GCHP's contract with the DHCS includes several financial and nonfinancial requirements. As established by the contract, GCHP is required to meet and maintain a minimum level of tangible net equity (TNE). TNE is defined as the excess of total assets over total liabilities, excluding subordinated liabilities and intangible assets.

Required and actual TNE are as follows:

	June 30,	
	2020	2019
	(in thousands)	
Actual TNE, beginning balance	$ 75,605	$ 132,115
Change in net position	1,718	(56,510)
Reportable TNE	$ 77,323	$ 75,605
Required TNE	$ 34,440	$ 32,907

The ability of GCHP to continue as a going concern is dependent on its continued compliance with the DHCS requirements. The loss of this contract would have an adverse effect on GCHP's future operations.

In March 2020, the World Health Organization declared the COVID-19 virus spread a pandemic and public health emergency. The duration and intensity of the disruption from the pandemic is uncertain. Therefore, there may be adverse financial pressures on GCHP that could impact GCHP's future operations.

Note 3 – Summary of Significant Accounting Policies

Basis of presentation – GCHP is a county-organized health system governed by an 11-member Board of Directors appointed by the Ventura County Board of Supervisors. Effective for the fiscal year ended June 30, 2011, GCHP began reporting as a discrete component unit of the County of Ventura, California. The County made this determination based on the County Board of Supervisors having the right to elect 100 percent of the GCHP Board of Directors.

Basis of accounting – GCHP uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis, using the economic resources measurement focus. The accompanying financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB).

Use of estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Fair value of financial instruments – The carrying amounts of cash and cash equivalents approximate fair value because of the short maturity of these financial instruments. The carrying amounts reported in the statement of net position for capitation receivable, provider receivables, reinsurance and other receivables, prepaid expenses and other assets, medical claims liability and capitation payable, accounts payable, premium reserve, accrued payroll, and accrued premium tax and other liabilities approximate their fair values, as they are expected to be realized within the next fiscal year.

Cash and cash equivalents – Cash and cash equivalents include highly liquid instruments purchased with an original maturity of three months or less when purchased.

Custodial credit risk-deposits – Custodial credit risk is the risk that in the event of a bank failure, GCHP may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the state law. As of June 30, 2020 and 2019, all accounts were covered by posted collateral.

Investments – Investments are stated at fair value in accordance with GASB Codification Section 150. The fair value of investments is estimated based on quoted market prices, when available. For debt securities not actively traded, fair values are estimated using values obtained from external pricing services or are estimated by discounting the expected future cash flows, using current market rates applicable to the coupon rate, credit and maturity of the investments.

All investments with an original maturity of one year or less when purchased are recorded as current investments, unless designated or restricted for long-term purposes.

Note 3 – Summary of Significant Accounting Policies (continued)

Capitation receivable – Capitation receivable represents capitation revenue for the years ended June 30, 2020 and 2019, received subsequent to June 30, 2020 and 2019, respectively. Capitation receivable also includes final revenue rate adjustments based on communications from the DHCS. Management determines the allowance for doubtful accounts by regularly evaluating individual receivables and considering payment history, financial condition, and current economic conditions. Subsequent adjustments to the contracted rates or enrollments are recognized in the period the adjustment is determined.

Provider receivables – Provider receivables are recorded for all claim refunds due from providers. Management determines the allowance for doubtful accounts by regularly evaluating individual receivables and considering payment history, financial condition, and current economic conditions.

Reinsurance – In the normal course of business, the Plan seeks to reduce the loss that may arise from events that cause unfavorable medical claim results by reinsuring certain levels of risk in various areas of exposure with a reinsurer. Amounts recoverable from reinsurance are estimated in a manner consistent with the development of the medical claim liability.

Amounts recoverable from reinsurers that relate to paid claims are classified as assets and as a reduction to medical expenses incurred. Reinsurance premiums paid are included in medical expenses.

Capital assets – Capital assets are stated at cost at the date of acquisition. The costs of normal maintenance, repairs, and minor replacements are expensed when incurred. Capital assets acquired but not yet placed into service are reported as construction in progress. Construction-in-progress assets are not depreciated until they are placed into service.

Depreciation and amortization are calculated using the straight-line method over the estimated useful lives of the assets. Long-lived assets are periodically reviewed for impairment. The estimated useful lives of three to seven years are used for furniture, fixtures, computer equipment, and software. Leasehold improvements are depreciated over the life of the lease or estimated useful life, whichever is shorter. Depreciation and amortization expense for the years ended June 30, 2020 and 2019, was approximately $467,000 and $534,000, respectively.

Medical claims liability, capitation payable, and medical expenses – GCHP establishes a claims liability based on estimates of the ultimate cost of claims in process and a provision for claims incurred but not yet reported, which is actuarially determined based on historical claims payment experience and other operational changes. In cases where adequate historical claims payment experience does not yet exist for a new population, a book-to-budget methodology is used in which GCHP relies on state-developed medical rates or medical loss ratios to estimate claims liabilities.

Such reserves are continually monitored and reviewed, with any adjustments made as necessary in the period the adjustment is determined. Management believes that the claims liability is adequate and fairly stated; however, this liability is based on estimates, and the ultimate liability may differ from the amount provided.

Note 3 – Summary of Significant Accounting Policies (continued)

GCHP has provider services agreements with several health networks in Ventura County, whereby the health networks provide care directly to covered members or through subcontracts with other health care providers. Payment for the services provided by the health networks is on a fully capitated basis. The capitation amount is based on contractually agreed-upon terms with each health network. GCHP may withhold amounts from providers at an agreed-upon percentage of capitation payments made to ensure the financial solvency of each contract. The capitation expense is included in provider capitation in the statements of revenues, expenses, and changes in net position.

Payable to the State of California – The liability at June 30, 2020 and 2019, was approximately $5,257,000 and $15,611,000, respectively, due to state of California funding programs that have minimum MLR requirements and potential amounts due back to the State. The balance as of June 30, 2020 represents an estimate due back to the State of California for the Proposition 56 programs in effect for state fiscal year 2019. The liability may vary depending on actual claims experience and final reconciliation and audit results. This liability is presented in the payable to the State of California in the accompanying statements of net position. As of June 30, 2019, amounts have been repaid relating to the medical loss ratio requirement through fiscal year June 30, 2016. As of June 30, 2020, amounts have been repaid relating to the medical loss ratio requirement through fiscal year June 30, 2017.

Accounts payable and accrued expenses – GCHP is required to estimate certain expenses, including payroll, payroll taxes, and professional services fees, as of each statement of net position date and make appropriate accruals based on these estimates. Estimates are affected by the status and timing of services provided relative to the actual level of services performed by the service providers. The date on which certain services commence, the level of services performed on or before a given date, and the cost of services are often subject to judgment. These judgments are based upon the facts and circumstances known at the date of the financial statements. For the periods presented in the financial statements, there were no material adjustments to the estimates for payroll, payroll taxes, and professional services fees.

Premium deficiency reserves – GCHP performed an analysis of its expected future health care and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve would be accrued. A premium deficiency reserve was not required at June 30, 2020 or 2019.

Accrued compensated absences – GCHP's policy permits eligible employees to accrue vacation based on their individual employment agreements. Unused vacation may be carried over into subsequent years, up to limits indicated in their employment agreements. Accumulated vacation will be paid to the employee upon separation from service with GCHP. All compensated absences are accrued and recorded in accordance with GASB Statement No. 16, *Accounting for Compensated Absences*, and are included in accrued payroll and employee benefits in the accompanying statements of net position.

Note 3 – Summary of Significant Accounting Policies (continued)

Premium taxes – Senate Bill X2-2, which passed in March 2016, redefined the premium tax payment and calculation. Per SB X2-2, the tax rate was a pre-determined liability based on DHCS projected Medi-Cal membership, and specified rates and was effective through June 30, 2019. Assembly Bill 115 (Committee on Budget, Chapter 348, Statutes of 2019) re-established a managed care enrollment tax, using a modified tiered taxing model and the implementation of the tax is projected to generate a net state benefit of approximately $7 billion over the three-year duration of the tax. On April 3, 2020, the federal government approved the state's revised proposal to implement a tax on MCOs to help fund the Medi-Cal program. The new MCO tax is effective from January 2020 through December 2022. The DHCS calculated GCHP's total MCO tax liabilities for the years ended June 30, 2020 and 2019, to be approximately $34,505,000 and $96,569,000, respectively. A premium tax refund receivable of approximately $6,321,000 was recognized at both June 30, 2020 and 2019, and is included in the reinsurance and other receivables balance on the accompanying statements of net position.

Net position – Net position is broken down into three categories, defined as follows:

Net invested in capital assets – This component of net position consists of capital assets, including restricted capital assets, net of accumulated depreciation and amortization, and is reduced by the outstanding balances of any bonds, notes, or other borrowings that are attributable (if any) to the acquisition, construction, or improvement of those assets.

Restricted – This component of net position consists of external constraints placed on net asset used by creditors (such as through debt covenants), grantors, contributors, or law or regulations of other governments. It also pertains to constraints imposed by law or constitutional provisions or enabling legislation. There were no amounts classified as restricted net position as of June 30, 2020 or 2019.

Unrestricted – This component of net position consists of net position that does not meet the definition of "restricted" or "net invested in capital assets."

Revenue recognition – Capitation revenue received under the Contract is recognized during the period in which GCHP is obligated to provide medical service to the beneficiaries. This revenue is based on estimated enrollment provided monthly by the DHCS and capitation rates as provided for in the DHCS Contract. Enrollment and the capitation rates are subject to retrospective changes by the DHCS. As such, capitation revenue includes an estimate for amounts receivable from or refundable to the DHCS for these retrospective changes in estimates. These estimates are continually monitored and reviewed, with any changes in estimates recognized in the period when determined.

During the years ended June 30, 2020 and 2019, the Plan received approximately $27,828,000 and $60,800,000, respectively, of supplemental fee revenue from the DHCS as a hospital quality assurance fee as a result of SB 229 and SB 335, respectively.

GCHP passed these funds through to providers. These amounts were not reflected in the accompanying financial statements for the years ended June 30, 2020 and 2019, as the amounts passed through to the providers do not meet requirements for revenue recognition under Government Accounting Standards.

Note 3 – Summary of Significant Accounting Policies (continued)

GCHP has an agreement with the DHCS to receive an intergovernmental transfer (IGT) through a capitation rate increase of $34,987,000 and $33,645,000 recorded in years ended June 30, 2020 and 2019, respectively. Under the agreement, these funds that are distributed to providers are not reported on the statements of revenues, expenses and changes in net position, or the statements of net position, as these amounts do not meet requirements for revenue recognition under Government Accounting Standards. GCHP did not retain any of this IGT during the years ended June 30, 2020 and 2019 for administrative costs.

Operating revenues and expenses – GCHP's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with arranging for the provision of health care services. Operating expenses are all expenses incurred to arrange for the provision of health care services, as well as the costs of administration. Claims adjustment expenses are an estimate of the cost to process the claims and are included in operating expenses. Non-exchange revenues and expenses are reported as nonoperating revenues and expenses.

Administrative expenses – Administrative expenses are recognized as incurred and consist of administrative expenses that directly relate to the implementation and operation costs of the Plan. Capitation contract acquisition costs are expensed in the period incurred.

Defined contribution plan – GCHP has adopted, and its employees are participants in, the California Public Agencies Self-Directed Tax-Advantaged Retirement System (CPA STARS). CPA STARS is a California public trust organized under the laws of the State of California and includes the STARS 401(a) Retirement Plan (the "401 Plan"), which is a retirement plan under Section 401(a) of the Internal Revenue Code. GCHP participation in the 401 Plan is defined by the 401(a) Trust Agreement and the 401 Plan Agreement between GCHP and CPA STARS.

All regular employees participate in the CPA STARS 401 Plan. Employee contributions to the 401 Plan are not allowed. GCHP makes employer contributions to the 401 Plan in an amount annually determined under the 401 Plan Agreement. For the years ended June 30, 2020 and 2019, GCHP contributions to the 401 Plan were $1,863,000 and $1,792,000, respectively.

Deferred compensation plan – GCHP has adopted, and its employees are participants in, the CPA STARS 457(b) deferred compensation plan (the "457 Plan"). The 457 Plan was created in accordance with Internal Revenue Code Section 457 and permits employees to defer a portion of their annual salary until future years. GCHP participation in the 457 Plan is defined by the 457 Trust Agreement between GCHP and CPA STARS. Employee participation in the 457 Plan is voluntary, and GCHP has not made any contributions. As such, there were no GCHP employer contributions for years ended June 30, 2020 and 2019.

Income taxes – GCHP operates under the purview of the Internal Revenue Code, Section 501(a) and corresponding California Revenue and Taxation Code provisions. As such, GCHP is not subject to federal or state taxes. Accordingly, no provision for income tax has been recorded in the accompanying financial statements.

Note 3 – Summary of Significant Accounting Policies (continued)

Risk management – GCHP is exposed to various risks of loss from torts, business interruption, errors and omissions, and natural disasters. Commercial insurance coverage is purchased by GCHP for claims arising from such matters. No claims have exceeded commercial coverage.

Recent accounting pronouncements – In January 2017, the GASB issued Statement No. 84, *Fiduciary Activities* (GASB 84). The principal objective of GASB 84 is to enhance the consistency and comparability of fiduciary activity reporting by state and local governments. GASB 84 is also intended to improve the usefulness of fiduciary activity information primarily for assessing the accountability of governments in their roles as fiduciaries. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance*, which deferred the effective date of GASB 84 to reporting periods beginning after December 15, 2019. GCHP is reviewing the impact of the adoption of GASB 84 for the fiscal year ending June 30, 2021.

In June 2017, the GASB issued Statement No. 87, *Leases* (GASB 87). GASB 87 increases the usefulness of financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. GASB 87 also establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance*, which deferred the effective date of GASB 87 to reporting periods beginning after June 15, 2021. GCHP is reviewing the impact of the adoption of GASB 87 for the fiscal year ending June 30, 2022.

Note 4 – Cash and Investments

Investments – The Plan invests in obligations of the U.S. Treasury, other U.S. government agencies and instrumentalities, state obligations, corporate securities, and money market funds.

Interest rate risk – In accordance with its Annual Investment Policy (“investment policy”), GCHP manages its exposure to decline in fair value from increasing interest rates by matching maturity dates to the extent possible with the Plan’s expected cash flow draws. Its investment policy limits maturities to five years, while also staggering maturities. The Plan maintains a low-weighted average maturity strategy, targeting a portfolio with maturities of three years or less, with the intent of reducing interest rate risk. Portfolios with low weighted average maturities are less volatile because they are less sensitive to interest rate changes. As of June 30, 2020, the weighted average maturity of GCHP’s investments, including cash equivalents was approximately 1 day.

Note 4 – Cash and Investments (continued)

The Plan's investments at June 30, 2020 are summarized as follows:

Investment Type	Fair Value	Maxiumim Maturity*	Weighted Average Maturity (Years)	Weighted Average Maturity (Days)
Cal Trust Investment Fund	$ 3,760	N/A	-	1
Local Agency Investment Fund	205,239	N/A	-	1
Ventura County Investment Pool	42,831,225	N/A	-	1
	$ 43,040,224		-	1

*Per investment policy (Gov't code section 53601)

Credit risk – GCHP's investment policy conforms to the California Government Code as well as to customary standards of prudent investment management. Credit risk is mitigated by investing in only permitted investments. The investment policy sets minimum acceptable credit ratings for investments from two nationally recognized rating services: Standard and Poor's Corporation (S&P), and Moody's Investor Service (Moody's). For an issuer of short-term debt, the rating must be no less than A-1 (S&P) or P-1 (Moody's), while an issuer of long-term debt shall be rated no less than an "A."

Credit ratings of investments and cash equivalents as of June 30, 2020, are summarized below:

			Ratings as of Year-End (SP / MDY)				
Investment Type	Fair Value	Minimum Legal Rating*	Exempt from rating	A-1 / P-1	A1 / AA+	A1 / A+	A2 / A
Cal Trust Investment Fund	$ 3,760	None	$ 3,760	$ -	$ -	$ -	$ -
Local Agency Investment Fund	205,239	None	205,239	-	-	-	-
Ventura County Investment Pool	42,831,225	None	42,831,225	-	-	-	-
	$ 43,040,224		$ 43,040,224	$ -	$ -	$ -	$ -

*Per investment policy (Gov't code section 53601)

Credit ratings of investment and cash equivalents as of June 30, 2019, are summarized below:

			Ratings as of Year-End (SP / MDY)				
Investment Type	Fair Value	Minimum Legal Rating*	Exempt from rating	A-1 / P-1	A1 / AA+	A1 / A+	A2 / A
Cal Trust Investment Fund	$ 3,666	None	$ 3,666	$ -	$ -	$ -	$ -
Local Agency Investment Fund	5,108,010	None	5,108,010	-	-	-	-
Ventura County Investment Pool	41,849,924	None	41,849,924	-	-	-	-
	$ 46,961,600		$ 46,961,600	$ -	$ -	$ -	$ -

*Per investment policy (Gov't code section 53601)

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of The Plan's investment in a single issuer. GCHP's Policy does not contain any specific provisions to limit exposure to concentration of credit risk, but conforms to the California Government Code sections 53601 to meet the percentage limits of investment holdings.

Note 4 – Cash and Investments (continued)

The Plan's percentage of portfolio as of June 30, 2020, is summarized below:

Investment Type	Issuer	Fair Value	Percentage of Portfolio
Cal Trust Investment Fund	Wells Fargo	$ 3,760	0.0%
Local Agency Investment Fund	State of California Treasurer	205,239	0.5%
Ventura County Investment Pool	County of Ventura Treasurer	42,831,225	99.5%
Total Funds Available for Investments		$ 43,040,224	100.0%

The Plan's percentage of portfolio as of June 30, 2019, is summarized below:

Investment Type	Issuer	Fair Value	Percentage of Portfolio
Cal Trust Investment Fund	Wells Fargo	$ 3,666	0.0%
Local Agency Investment Fund	State of California Treasurer	5,108,010	10.9%
Ventura County Investment Pool	County of Ventura Treasurer	41,849,924	89.1%
Total Funds Available for Investments		$ 46,961,600	100.0%

Investments – GCHP categorizes its fair value investments within the fair value hierarchy established by accounting principles generally accepted in the United States of Americal. The hierarchy for fair value measurements is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date.

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for an asset or liability, either directly or indirectly.

Level 3 – Significant unobservable inputs.

The following is a description of the valuation methodologies used for instruments at fair value on a recurring basis and recognized in the accompanying statements of net position, as well as the general classification of such instruments pursuant to the valuation hierarchy.

External investment pools – CalTrust is organized as a Joint Powers Authority established by public agencies in California for the purpose of pooling and investing local agency funds. A Board of Trustees supervises and administers the investment program of the Trust. CalTrust has four pools: money market account, short-term, medium-term, and long-term. The Plan has deposits in the Short-Term Fund. Investments in CalTrust Short-Term Fund are highly liquid, as deposits can be converted to cash within 24 hours without loss of interest.

Note 4 – Cash and Investments (continued)

The Plan is a voluntary participant in CalTrust. The Plan's investment in this pool is reported in the accompanying financial statements at fair value based on the Plan's pro rata share of the respective pool as reported by CalTrust. As of both June 30, 2020 and 2019, the Plan held approximately $4,000 in CalTrust.

The California State Treasurer's Office makes available the Local Agency Investment Fund (LAIF) through which local governments may pool investments. Each governmental entity may invest up to $65 million in the fund. Investments in the LAIF are highly liquid, as deposits can be converted to cash within 24 hours without loss of interest. The Plan is a voluntary participant in the LAIF. The fair value of the GCHP's investments in the LAIF is reported in the accompanying financial statements based on the GCHP's pro rata share of the fair value provided by the LAIF for the entire LAIF portfolio. As of June 30, 2020 and 2019, the Plan held approximately $205,000 and $5,108,000 in LAIF, respectively.

The Ventura County Investment Pool (VCIP) is available to local public governments, agencies, and school districts within Ventura County (the "County"). Wells Fargo Bank NA serves as custodian for the pool's investments. The portfolio is typically comprised of U.S. agency securities and high-quality short-term instruments, resulting in a relatively short-weighted average maturity. Fair value calculations are based on market values provided by the County's investment custodian. Investments in the VCIP are highly liquid, as deposits can be converted to cash within 24 hours without loss of interest. The Plan is a voluntary participant in the VCIP. The fair value of the GCHP's investments in the VCIP is reported in the accompanying financial statements based on the GCHP's pro rata share of the fair value provided by the VCIP for the entire VCIP portfolio. As of June 30, 2020 and 2019, the Plan held approximately $42,831,000 and $41,850,000 in VCIP, respectively.

The following table presents the fair value measurements of assets recognized in the accompanying statements of net position measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall:

The Plan had the following recurring fair value measurements as of June 30, 2020:

		Fair Value Measurements Using		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments not subject to fair value hierarchy:				
Cal Trust Investment Fund	$ 3,760			
Local Agency Investment Fund	205,239			
Ventura County Investment Pool	42,831,225			
	$ 43,040,224			

Note 4 – Cash and Investments (continued)

The Plan had the following recurring fair value measurements as of June 30, 2019:

		Fair Value Measurements Using		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments not subject to fair value hierarchy:				
Cal Trust Investment Fund	$ 3,666			
Local Agency Investment Fund	5,108,010			
Ventura County Investment Pool	41,849,924			
	$ 46,961,600			

Note 5 – Administrative Services Agreements

Conduent, Inc. (Conduent, formerly Affiliated Computer Services) – GCHP entered into an agreement with Conduent on June 28, 2017 to provide certain operational services, for a two-year term with 4–6 month extensions beginning July 1, 2017. On May 1, 2019, GCHP and Conduent entered into a new agreement extending service through June 30, 2024. Included in the extension is a project to replace the existing technology platform with a new system and realign business processes. Compensation for these services is based on a per-member, per-month cost at varying membership levels. These costs are recorded as expenses in the period incurred. Total expenses for services provided for the years ended June 30, 2020 and 2019, were approximately $19,994,000 and $19,856,000, respectively, and are reported in professional fees on the accompanying statements of revenues, expenses, and changes in net position.

OptumRx, Inc. (Optum Rx) – GCHP entered into a three-year agreement with Optum Rx, effective June 1, 2017, replacing Script Care as the provider of pharmacy administration and management services. The agreement was renewed effective June 1, 2020 and will expire on May 31, 2021. Optum Rx services are specific to the prescription benefit drug program for GCHP Medi-Cal beneficiaries. Total expense for Optum Rx services was approximately $1,826,000 and $1,573,000 for the years ended June 30, 2020 and 2019, respectively, and is included in other medical expenses on the accompanying statements of revenues, expenses, and changes in net position.

Beacon Health Strategies, LLC (Beacon Health Strategies) – On April 14, 2014, GCHP entered into a two-year agreement with Beacon Health Strategies to provide administrative services to arrange for and support the administration of behavioral health services for GCHP. The agreement with Beacon Health Strategies has been extended until December 31, 2020. Total expense for Beacon Health Strategies was approximately $1,948,000 and $1,779,000 for the years ended June 30, 2020 and 2019, respectively, and is included in professional fees on the accompanying statements of revenues, expenses, and changes in net position.

Note 6 – Capital Assets

Capital asset activity during the years ended June 30, 2020 and 2019, consisted of the following:

	Balance June 30, 2019	Increases	Transfers	Decreases	Balance June 30, 2020
Capital assets					
Leasehold improvements	$ 1,780,212	$ 20,777	$ -	$ -	$ 1,800,989
Software and equipment	1,450,920	339,039	-	-	1,789,959
Furniture and fixtures	1,156,938	50,197	-	-	1,207,135
Total capital assets	4,388,070	410,013	-	-	4,798,083
Less accumulated depreciation and amortization for:					
Leasehold improvements	583,928	231,493	-	-	815,421
Software and equipment	1,328,325	76,799	-	-	1,405,124
Furniture and fixtures	808,047	159,163	-	-	967,210
Total accumulated depreciation	2,720,300	467,455	-	-	3,187,755
Total capital assets, net	$ 1,667,770	$ (57,442)	$ -	$ -	$ 1,610,328

	Balance June 30, 2018	Increases	Transfers	Decreases	Balance June 30, 2019
Capital assets					
Leasehold improvements	$ 1,741,780	$ 38,432	$ -	$ -	$ 1,780,212
Software and equipment	1,330,981	119,939	-	-	1,450,920
Furniture and fixtures	1,086,185	70,753	-	-	1,156,938
Total capital assets	4,158,946	229,124	-	-	4,388,070
Less accumulated depreciation and amortization for:					
Leasehold improvements	395,751	188,177	-	-	583,928
Software and equipment	1,208,067	120,258	-	-	1,328,325
Furniture and fixtures	582,012	226,035	-	-	808,047
Total accumulated depreciation	2,185,830	534,470	-	-	2,720,300
Total capital assets, net	$ 1,973,116	$ (305,346)	$ -	$ -	$ 1,667,770

Note 7 – Medical Claims Liability

Medical claims liability and capitation payable consists of the following:

	June 30, 2020	June 30, 2019
Claims payable or pending approval	$ 34,897,614	$ 37,711,083
Capitation payable	18,217,262	27,997,784
Provisions for claims incurred but not yet reported and other	51,769,339	51,757,913
Directed payments to providers payable	15,929,522	-
	$ 120,813,737	$ 117,466,780

The cost of health care services is recognized in the period in which care is provided and includes an estimate of the cost of services that has been incurred but not yet reported. GCHP estimates accrued claims payable based on historical claims payments and other relevant information. Estimates are continually monitored and reviewed, and as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate amount of claims paid is dependent on future developments, management is of the opinion that the accrued medical claims payable is adequate.

Note 7 – Medical Claims Liability (continued)

The following is reconciliation of the medical claims liability and capitation payable activity for the years ended June 30:

	2020	2019
Medical claims liability and capitation payable at beginning of year	$ 117,466,780	$ 105,986,661
Incurred:		
Current	780,676,321	729,213,377
Prior	(10,164,318)	(3,802,360)
Total incurred	770,512,003	725,411,017
Paid:		
Current	670,892,743	632,690,004
Prior	96,596,307	81,148,294
Total paid	767,489,050	713,838,298
Net balance at end of year	120,489,733	117,559,380
Provider and reinsurance receivable of paid claims, beginning	(624,442)	(717,042)
Provider and reinsurance receivable of paid claims, ending	948,446	624,442
Medical claims liability and capitation payable at end of year	$ 120,813,737	$ 117,466,780

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities at any year end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established prior reporting period liability. Negative amounts reported for incurred, related to prior years, result from claims being adjudicated and paid for amounts less than originally estimated. Results for the years ended June 30, 2020 and 2019, included a decrease of prior year incurred of approximately $10,164,000 and $3,802,000, respectively. Original estimates are increased or decreased as additional information becomes known regarding individual claims.

Note 8 – Commitments and Contingencies

Lease commitments – GCHP leases office space and equipment under long-term operating leases ending on various dates through March 2026. The total amount of rental payments due over the lease terms is being recognized as rent expense using the straight-line method over the term of the lease. Rent and lease expenses were approximately $1,423,000 and $1,470,000 for the years ended June 30, 2020 and 2019, respectively. Minimum annual rent and lease payments are as follows:

	Minimum Lease Payments
Years Ending June 30,	
2021	$ 1,462,103
2022	1,503,200
2023	1,545,460
2024	1,588,917
2025	1,633,606
Thereafter	1,250,872
	$ 8,984,158

Litigation – Through the course of ordinary business, the Plan became party to various administrative proceedings, mediations, and was party to various legal actions and subject to various claims arising as a result. During the year ended June 30, 2020, the Plan has successfully resolved some matters, and other administrative and legal matters are still proceeding. As a result of pending administrative and legal matters, the Plan has recorded a liability for these contingencies. It is the opinion of management that the ultimate resolution of such claims will not have a material adverse effect on the financial statements.

Regulatory matters – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties. Management believes that GCHP is in compliance with fraud and abuse, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

Patient protection and Affordable Care Act – The ACA allowed for the expansion of Medicaid members in the State of California. Any future federal or state changes in eligibility requirements or federal and state funding could have an impact on the Health Plan. With the changes in the executive branch, the future of PPACA and impact of future changes in Medicaid to the Plan is uncertain at this time.

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

Prepared by the Moss Adams Health Care Group

10/26/2020

Return to Agenda

Ventura County Medi-Cal Managed Care Commission

Gold Coast Health Plan

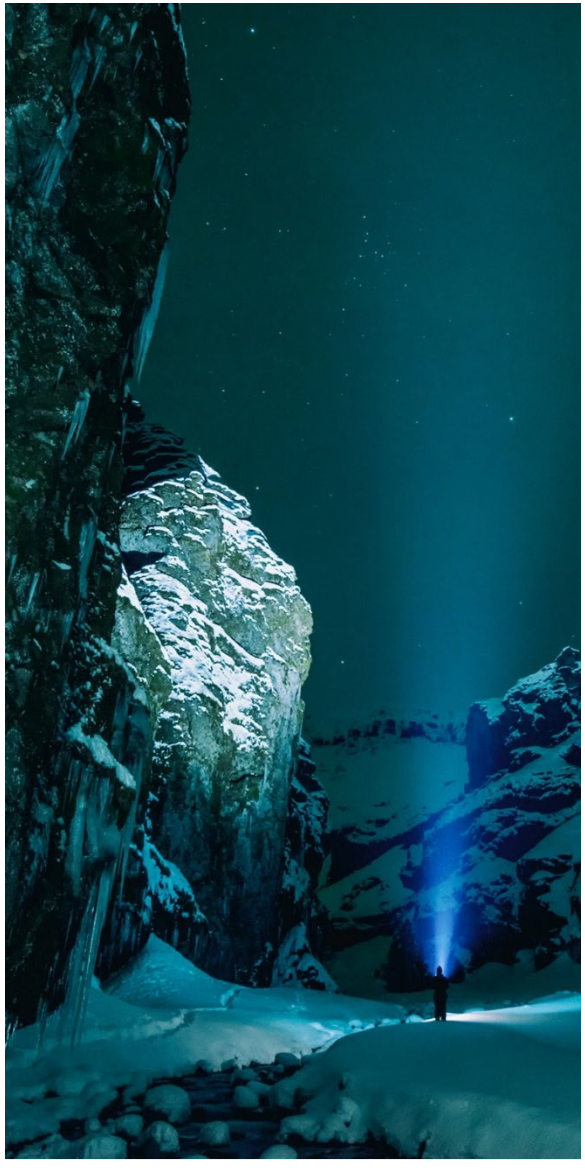
Dear Commissioners:

Thank you for your continued engagement of Moss Adams LLP. We are pleased to have the opportunity to meet with you to discuss the results of our audit of the financial statements of Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan (the "Plan") for the year ended June 30, 2020.

The accompanying report, which is intended solely for the use of the Commission and management, presents important information regarding the financial statements of the Plan and our audit that we believe will be of interest to you. It is not intended for and should not be used by anyone other than these specified parties.

We conducted our audit with the objectivity and independence that you expect. We receive the full support and assistance of the Plan's personnel. We are pleased to serve and be associated with the Plan as its independent public accountants and look forward to our continued relationship.

We look forward to discussing our report or any other matters of interest with you during this meeting.



Agenda

1. Auditor Opinion & Report
2. Communications with Those Charged with Governance
3. Exhibit 1: Management Representation Letter
4. Other Information

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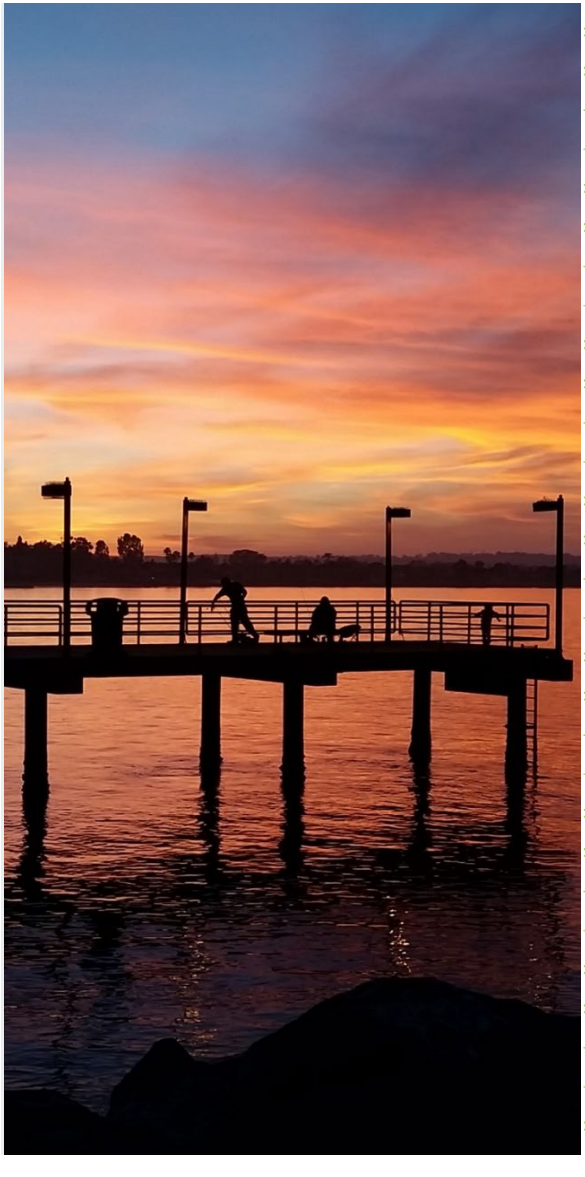
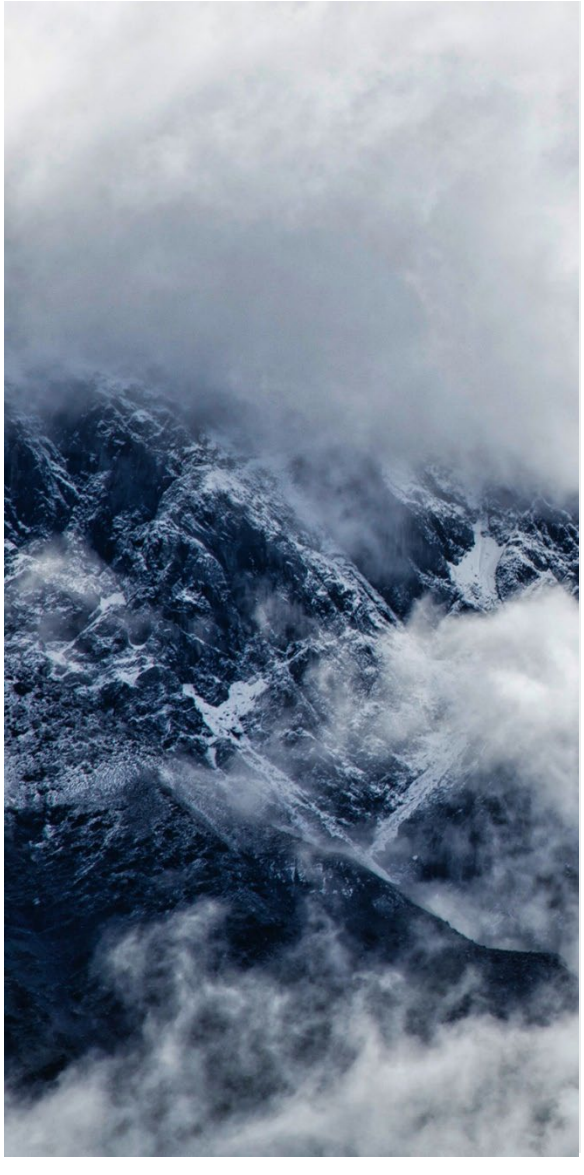
Auditor Opinion & Report



Scope of Services



Auditor Report on the Financial Statements

- Financial statements are presented fairly and in accordance with Generally Accepted Accounting Principles (U.S. GAAP)

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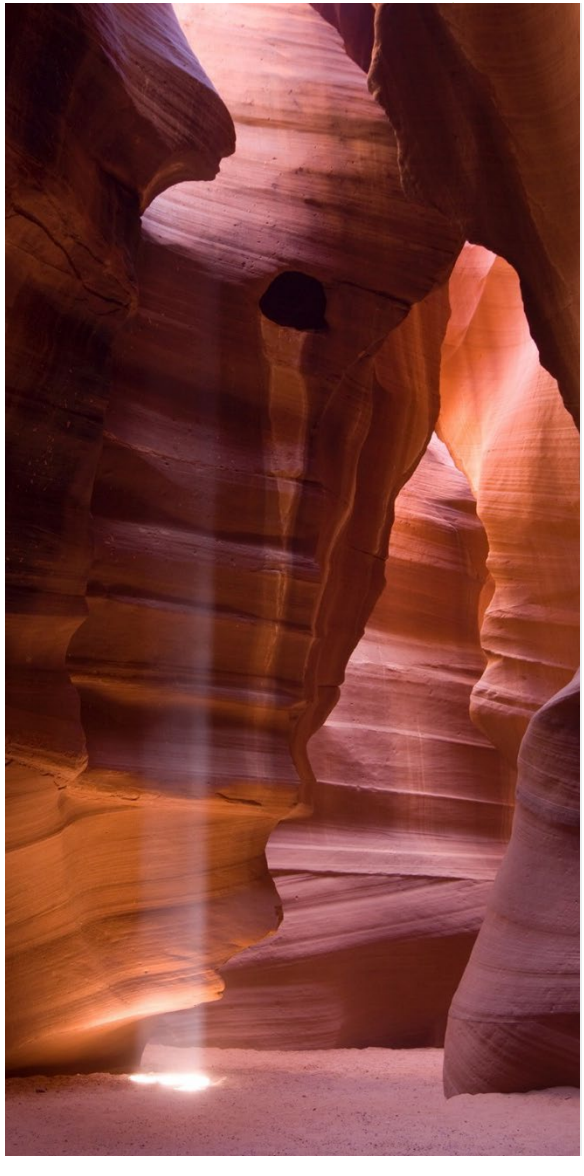
Communications with Those Charged with Governance



To express our opinion on whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, and in accordance with U.S. GAAP. However, our audit does not relieve you or management of your responsibilities.	To perform an audit in accordance with generally accepted auditing standards issued by the AICPA, and design the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement.	To consider internal control over financial reporting as a basis for designing audit procedures but not for the purpose of expressing an opinion on its effectiveness or to provide assurance concerning such internal control.	To communicate findings that, in our judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Planned Scope & Timing of the Audit

Our Comments

The planned scope and timing of the audit was communicated to the Plan's Executive/Finance Committee at the audit entrance meeting and was included in the engagement letter for the year ended June 30, 2020.

Significant Accounting Policies & Unusual Transactions

Our Comments

Management has the responsibility for selection and use of appropriate accounting policies. The significant accounting policies used by the Plan are described in the footnotes to the financial statements. Throughout the course of an audit, we review changes, if any, to significant accounting policies or their application, and the initial selection and implementation of new policies. There were no changes to significant accounting policies for the year ended June 30, 2020.

We believe management has selected and applied significant accounting policies appropriately and consistent with those of the prior year.

Management Judgements & Accounting Estimates

Our Comments

Management's judgements and accounting estimates are based on knowledge and experience about past and current events and assumptions about future events. We apply audit procedures to management's estimates to ascertain whether the estimates are reasonable under the circumstances and do not materially misstate the financial statements.

Significant management estimates impacted the financial statements including the following: medical claims liabilities, payable to the state of California (which includes the estimate related to the medical loss ratio requirements), premium deficiency reserve, and capitation payable.

We deem them to be reasonable.

Areas of Audit Emphasis

	Capitation revenue and receivables
	Cash and cash equivalents
	Investments
	Medical claims liability, capitation payable, and payable to state of California
	Non-routine transactions, including the impact of COVID-19

Management Judgements & Accounting Estimates

Our Comments

The disclosures in the financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statements users; however, we do not believe any of the footnotes are particularly sensitive.

Significant Audit Adjustments & Unadjusted Differences Considered by Management to Be Immaterial

Our Comments

CORRECTED ADJUSTMENTS:

No significant adjustments noted.

UNCORRECTED ADJUSTMENTS:

None noted.

Deficiencies in Internal Control

Our Comments

MATERIAL WEAKNESS

- None noted.

SIGNIFICANT DEFICIENCIES

- Nothing to communicate.

OTHER CONTROL RECOMMENDATIONS

- Recommend continued rigor be placed over Conduent claims processing oversight.

Potential Effect on the Financial Statements of Any Significant Risks & Exposures

Our Comments

The Plan is subject to potential legal proceedings and claims that arise in the ordinary course of business, which are disclosed in the notes to the financial statements.

Difficulties Encountered in Performing the Audit

Our Comments

No significant difficulties were encountered during our audit.

We are pleased to report that there were no disagreements with management.

Material Uncertainties Related to Events & Conditions/ Fraud & Noncompliance with Laws and Regulations

Our Comments

No such matters came to our attention.

We have not become aware of any instances of fraud or noncompliance with laws and regulations.

Other Material Written Communications

Our Comments

See Exhibit 1 for management representation letter.

Other than the engagement letter, management representation letter, and communication to those charged with governance, there have been no other significant communications.

Management's Consultation with Other Accountants

Our Comments

We are not aware of any significant accounting or auditing matters for which management consulted other accountants.

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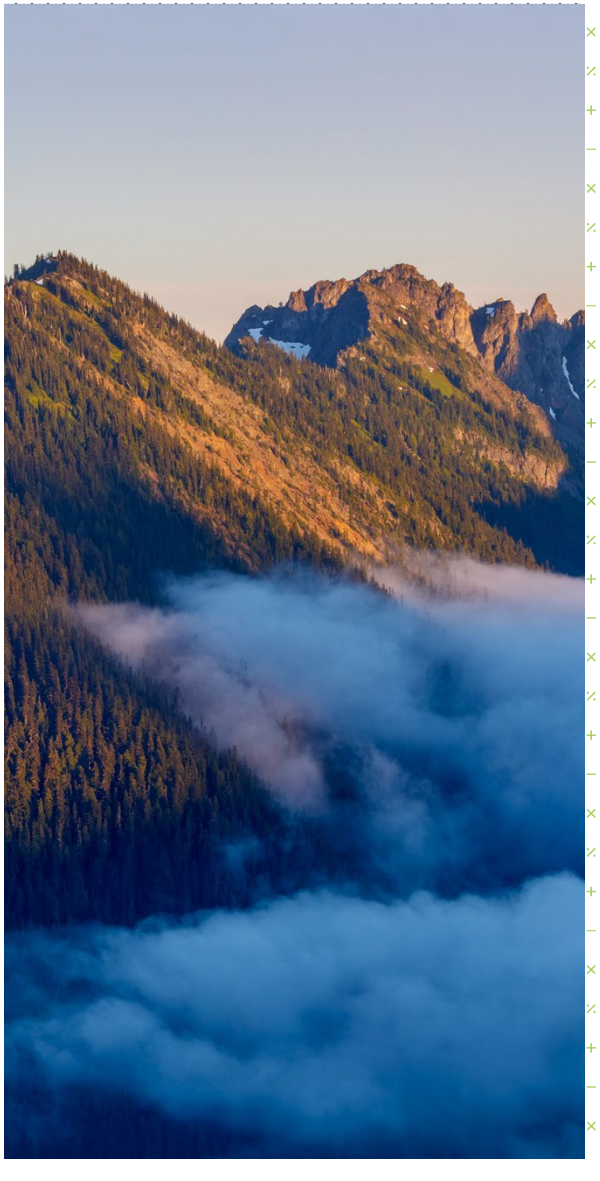
Exhibit 1



Return to Agenda

Management Representation Letter

October 27, 2020

Moss Adams LLP
101 Second Street, Suite 900
San Francisco, CA 94105

We are providing this letter in connection with your audit of the financial statements of Ventura County Medi-Cal Managed Care Commission, dba Gold Coast Health Plan ("GCHP") which comprise the statements of net position and the related statements of revenues, expenses, and changes in net position, and cash flows as of June 30, 2020 and 2019 and for the years then ended and the related notes to the financial statements for the purpose of expressing an opinion as to whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States (U.S. GAAP). Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Except where otherwise stated below, immaterial matters less than $825,000 collectively are not considered to be exceptions that require disclosure for the purpose of the following representations. This amount is not necessarily indicative of amounts that would require adjustment to or disclosure in the financial statements.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of the date of this letter.

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated May 6, 2020, for the preparation and fair presentation of the financial statements in accordance with U.S. GAAP.

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Accounting Update

New Standards

Clarifies fiduciary activities as having the following characteristics:

1. Government controls the assets of the activity.
2. Those assets are not derived solely from the government's own source revenue.
3. One of the following:
   - The assets result from a pass-through grant or trust agreement.
   - Assets are used to benefit individuals not typical recipients of the government's goods and services (i.e. employees receive the benefit instead of patients).
   - Assets are to be used to benefit other organizations or governments.

- Would require stand alone business-type entities (i.e. hospitals) with pension and OPEB trusts or patient custodial accounts to report separate fiduciary fund financial statements within the financial statements.
- Effective for fiscal year ending June 30, 2021.

New Standards

- Would treat all leases as financings (no classification of capital v. operating) similar to FASB ASU 2016-02.
- Includes non-cancellable period + periods covered by options to renew if reasonably certain to be exercised.
- Lessee would record an intangible asset (amortized over the shorter of its useful life or lease term) and present value of future lease payments as a liability.
- Lessor would record a lease receivable and deferred inflow of resources for cash received up front + future payments (revenue recognized over lease term in a systematic and rational basis).
- Effective for fiscal year ending June 30, 2022.

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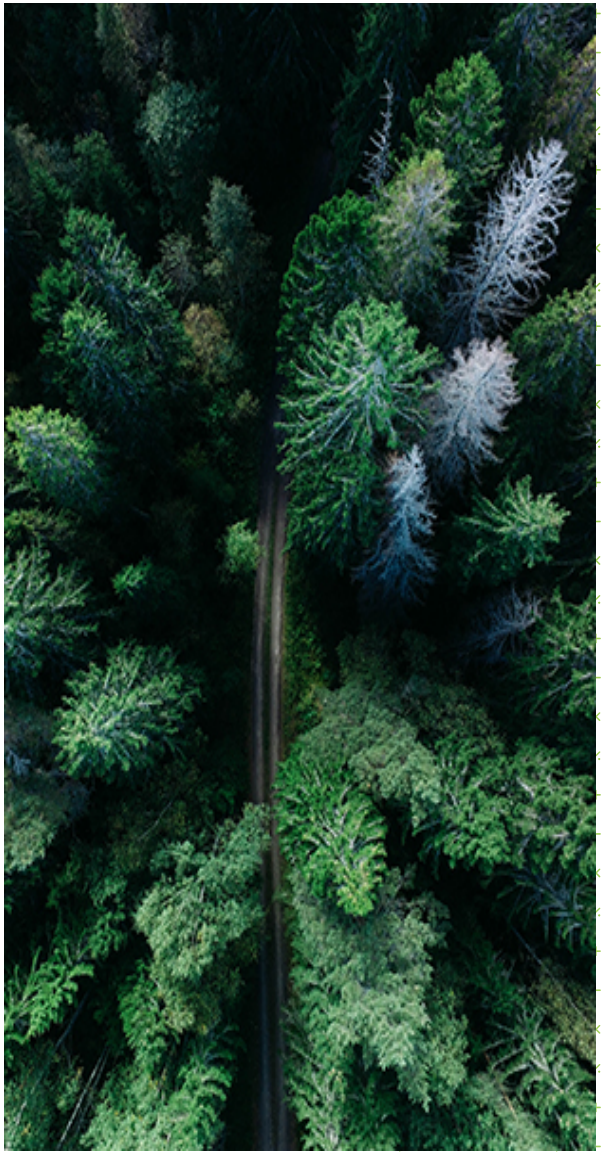
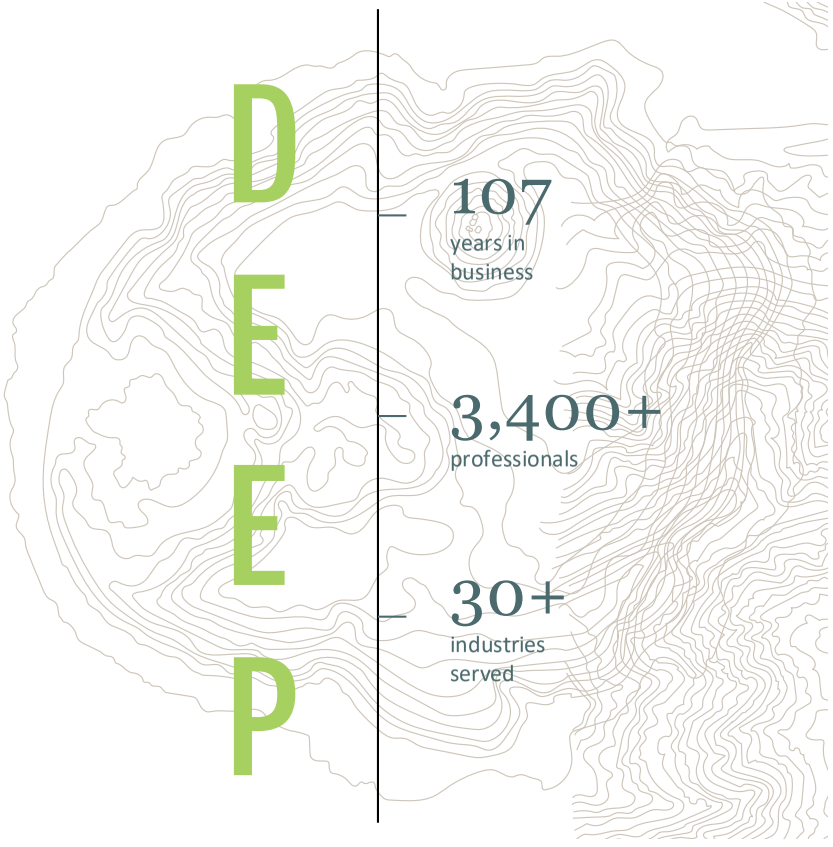
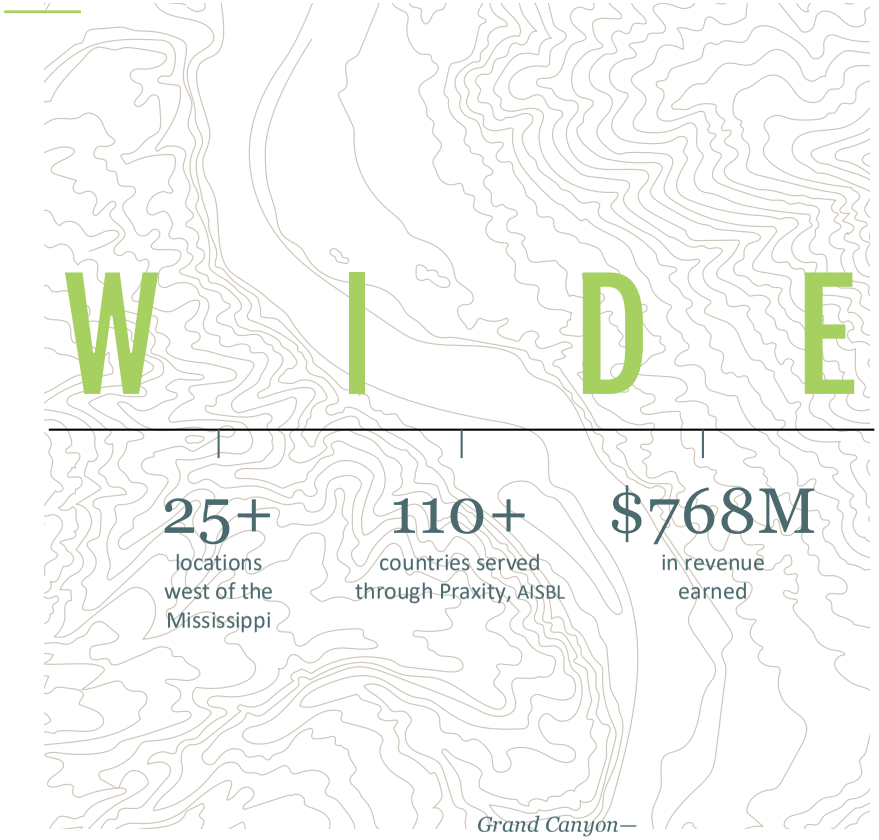
About Moss Adams



Our Expertise



Our Reach

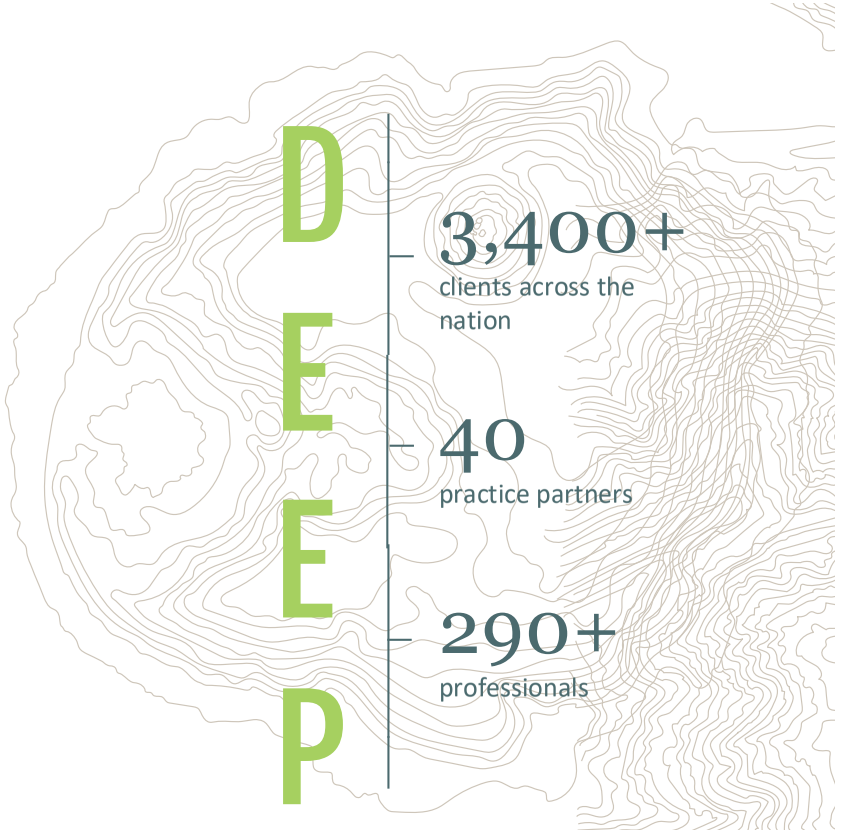


Grand Canyon—
At 277 miles long and up to 18 miles wide, this icon serves as a testament to determination and time.

Our health care professionals dedicate their careers to serving the industry.

We cover the full spectrum of health care including:

- Hospitals and health systems
- Independent practice associations
- Medical groups
- Community health centers
- Behavioral health organizations
- Long-term care
- Surgery centers
- Knox Keene licensed health plans
- Health care ancillary services



Crater Lake—
A monument to perseverance, North America's deepest lake filled to 1,949 feet over 720 years.

Our Response to COVID-19

The COVID-19 pandemic has touched all aspects of our lives. We're here to guide you to the information and resources you need now and provide strategies for the changes to come. We'll support you as you rebuild and help you take advantage of rising opportunities.

NAVIGATE

- Stay up to date with guidance and support to help combat uncertainty
- Reach out to your Moss Adams professional with any questions on the most current updates and advisements

ARTICLE

- Weather COVID-19 Market Volatility: Investments, Finances, and Tax Planning

REBUILD

- Strategize needs and be aware of what's to come
  - We'll connect you with the right resource, either within the greater Moss Adams team or through our various industry contacts
- Review Moss Adams announcements that provide tax and regulatory relief

ALERTS

- CARES Act Overview: Implications for Business Taxpayers
- CARES Act: Implications for Individual Taxpayers

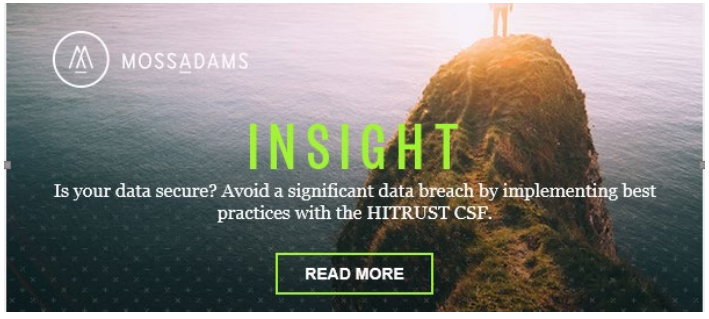
THRIVE

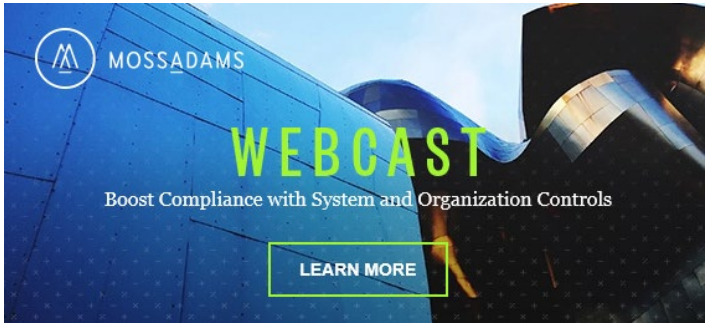
- Take steps to bolster your workforce and organization
- Evaluate additional service needs, such as the following:
  - Capital sourcing
  - Cloud tools
  - Cost segregation
  - Enterprise resource planning
  - Estate and succession planning
  - Financial planning
  - Forecasting
  - IT security and cybersecurity
  - Process improvement
  - Outsourced finance accounting
  - R&D tax credits
  - Risk assessment
  - State and local tax
  - Transactions services

HELPING YOU ADAPT TO UNCERTAIN TIMES

Find more information and resources here: https://mossadams.com/covid-19-implications

Insights and Resources





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(925) 952-2506

THANK YOU

AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kashina Bishop, Chief Financial Officer

DATE: October 26, 2020

SUBJECT: September 2020 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached September 2020 fiscal year-to-date ("FYTD") financial statements of Gold Coast Health Plan ("GCHP") for the Commission to review and approve.

BACKGROUND/DISCUSSION:

The staff has prepared the unaudited September 2020 FYTD financial package, including statements of financial position, statement of revenues and expenses, changes in net assets, and statement of cash flows.

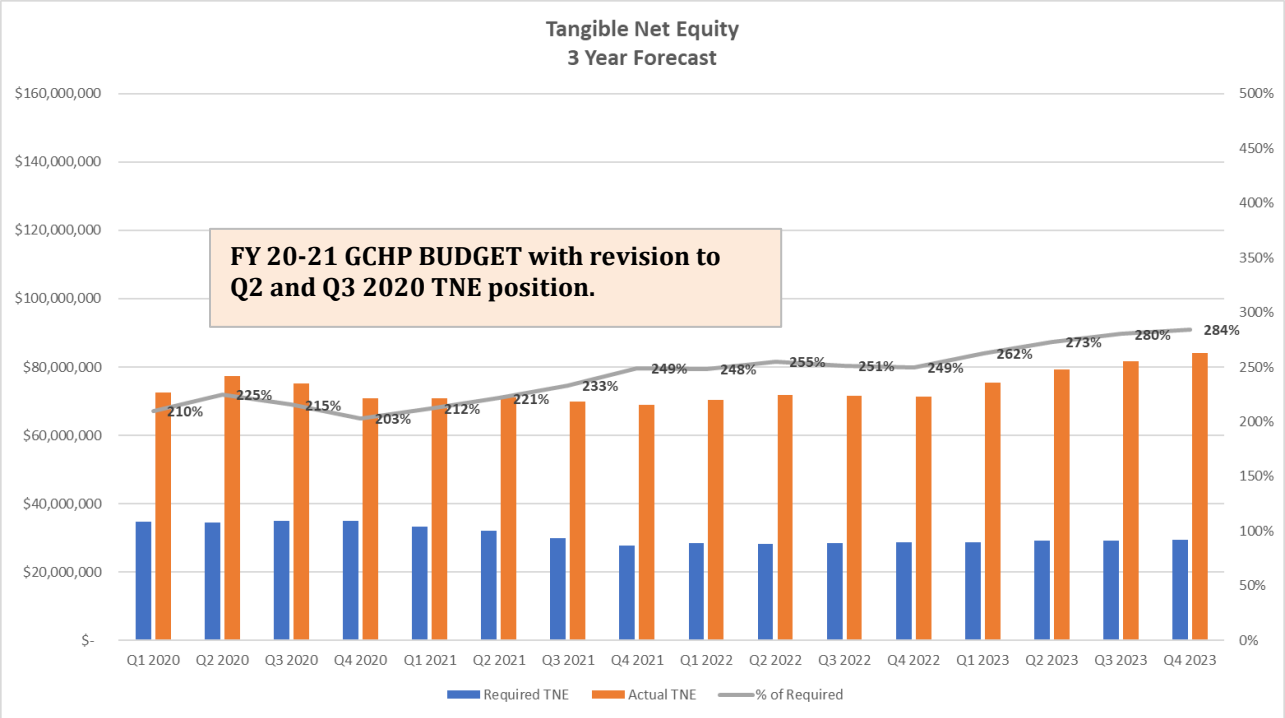
Financial Overview:

GCHP experienced a net loss of $1,191,839 in the month of September, much better than budgeted. The improvement from budget projections is attributed to the timing of administrative expenses and increased revenue due to changes in prior year membership estimates.

Staff will revise the financial forecasts as new information is obtained, which may have a material effect on the projections. Key factors which will impact GCHP's financial position are as follows:

1. Receipt of calendar year 2021 capitation rates from the State.
2. The length of time Long Term Care facilities obtain a 10% increase (currently indefinite through the emergency).
3. Potential changes to utilization and the unknown impact of the pandemic.

Due to the June 30, 2020 financial statement adjustments, GCHP's current forecasts have improved upon budget projects. While there remains uncertainty, both in future rates and the impact of the pandemic, the revised forecast indicates GCHP may stay above the 200% of TNE required.



The State will distribute draft capitation rates for calendar year 2021 in a few iterations between September and December 2020, each with potentially significant financial impacts dependent on the severity of the reductions to GCHP's base rates. Your management team will keep the Commission apprised of all these phases of rate changes and their implications to GHCP and the Solvency Action Plan (SAP):

A. September 2020 draft rates were received and incorporated the following adjustments to the base data submitted in the Rate Development Template (RDT):
   1. The pharmacy carve-out reflective of the transition to the Medi-Cal Rx program;
   2. A 0.5% reduction to the underwriting gain;
   3. Potentially Preventable Admissions efficiency adjustment; and
   4. The pharmacy Healthcare Common Procedure Coding System (HCPCS) efficiency adjustment. This will identify the top 50 HCPCS in total statewide spend and compare to Medicare Part B unit price.
   5. A reduction to allowable medical expenses associated with global sub-capitated payments.

Adjustment	Annualized Dollar Impact
Global Sub-capitated Admin	($900,000)
PPA	($850,000)
HCPCS	($1,750,000)
Underwriting Gain Reduction	($3,500,000)
Other	N/A – Base Data Accepted
Total Adjustment	**($7,000,000)**

Except for the reduction to allowable medical expenses for globally sub-capitated payments, the adjustments were anticipated and consistent with the budget process.

B. October 2020 draft rates will also reflect the Low Acuity Non-Emergent (LANE) efficiency adjustment. This identifies potentially preventable ER visits and quantifies savings that would have been achieved if the services were delivered in a more appropriate level of care.

C. December 2020 draft rates will include a potential population acuity adjustment or other base data adjustments.

Solvency Action Plan Update:

While the staff at GCHP remains committed to process improvement, strong internal controls, and fair and transparent contract negotiations with providers, we now also maintain a keen focus on the SAP driven by our highly limited reserves and the adverse impact of the economic downturn on the Medi-Cal program. Since the beginning of the fiscal year, GCHP management has made the following progress in connection with the Commission-approved Solvency Action Plan:

Actions	Annualized impact in savings
Continued focus on interest expense reduction	$500,000
Reduction of LTC facility rates to 100% of Medi-Cal rate	$1.8 million
Sent notification to providers regarding reduction of Adult Expansion PCP rates	$4.5 million
Revision to Non-Pharmacy Dispensing Site policy	$2-3 million
Contract signed – rate reduction to tertiary hospital	$1.3 million
Optum contract rate reduction	$150,000
TOTAL ANNUAL SAVINGS	**$10.3 – 11.3 million**

The focus going forward will be on phase 2 of the Solvency Action Plan which involves the below initiatives. We are pleased to report that the Provider Advisory Committee has created a subcommittee to propose changes for Phase 2 of the SAP. In order to reduce potential provider associated with the system conversion, provider rate and contractual changes associated with the SAP will be on hold through the system conversion. Staff is committed to the planning and preparation for phase 2 with a target implementation of the first quarter in 2021.

Current Focus	Annualized impact in savings
Outlier contract rates	TBD
Implementation of HMS – scheduled for late October	$1-3 million
Improved contract language	TBD
Expansion of capitation arrangements	Required TNE and risk reductions
LANE/HCPCS analysis	TBD
Consideration of across the board reductions	TBD
California Children's Services – ED Diversion	$500,000

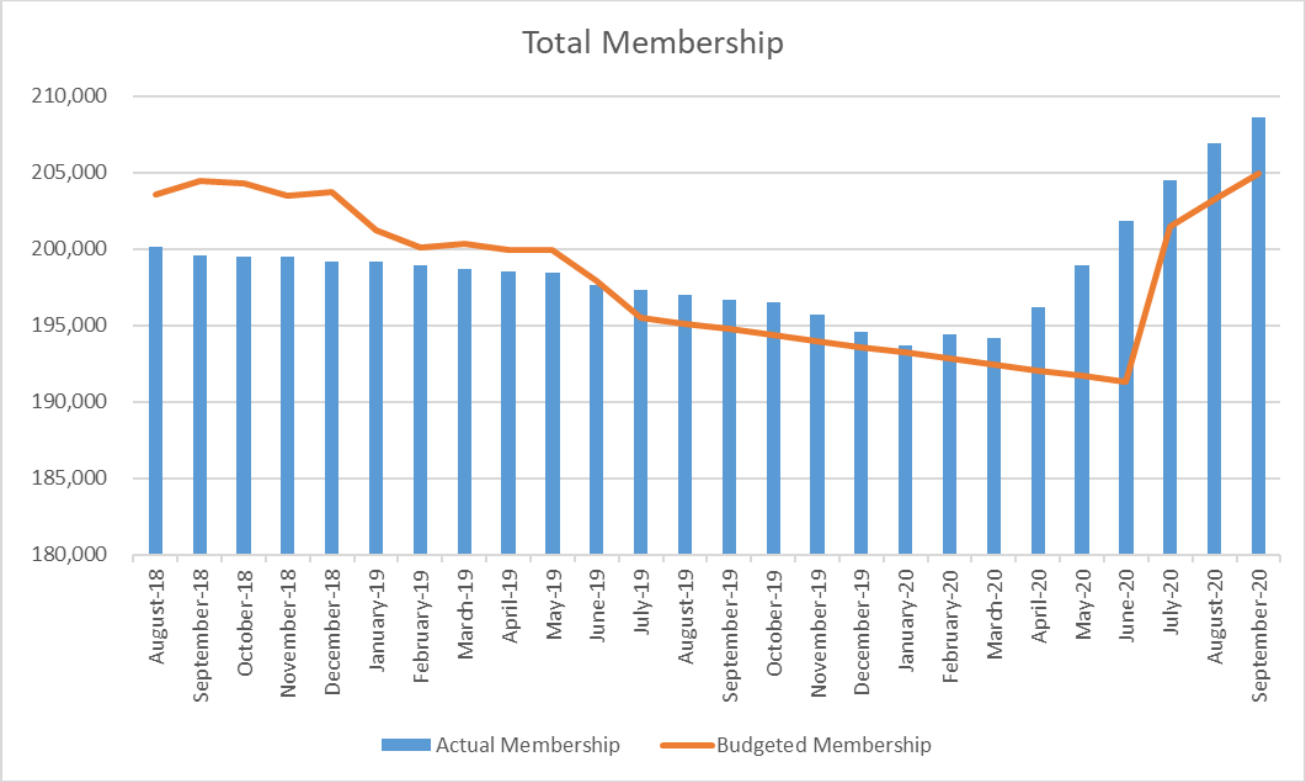
Financial Report:

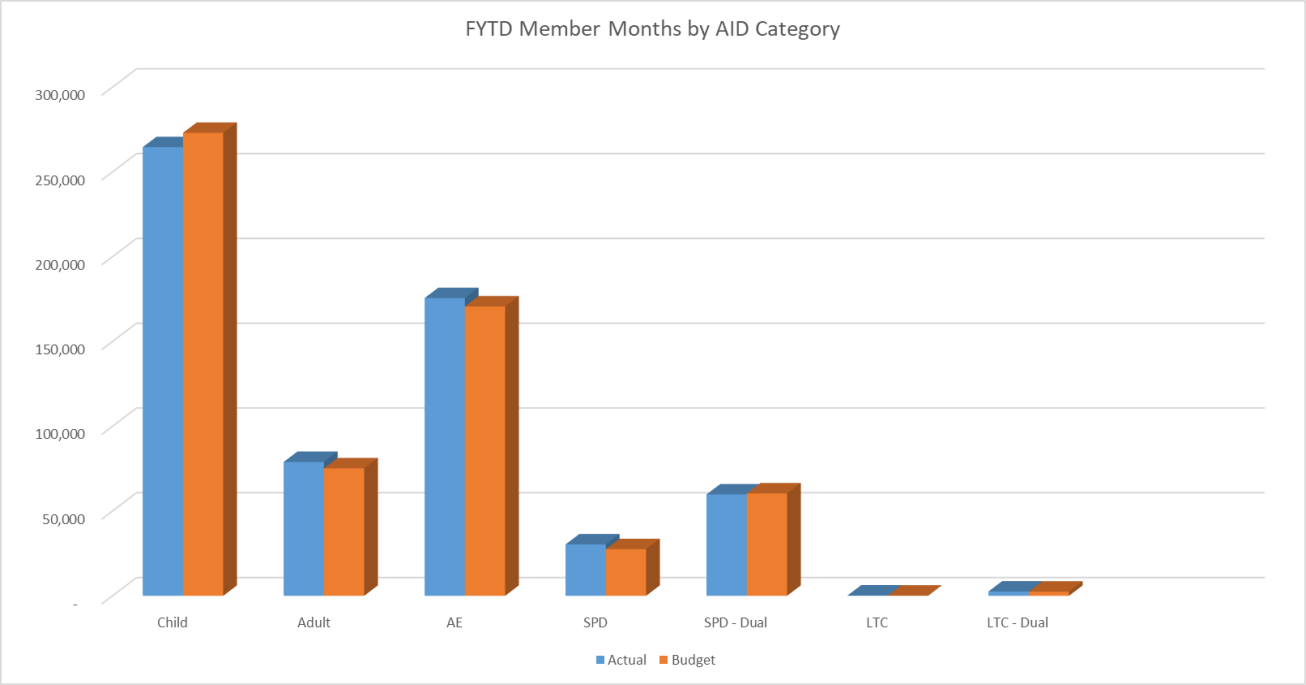
For the month of September 2020, GCHP is reporting a net loss of $1,191,839.

September 2020 FYTD Highlights:

1. Net loss of $2.2 million, a $4.8 million favorable budget variance.
2. FYTD net revenue is $218.1 million, $8.7 million over budget.
3. FYTD Cost of health care is $208.4million, $6.8 million over budget.
4. The medical loss ratio is 95.5% of revenue, .7% less than the budget.
5. FYTD administrative expenses are $12.3 million, $2.7 million under budget.
6. The administrative cost ratio is 5.6%, 1.7% under budget.
7. Current membership for September is 207,555.
8. Tangible Net Equity is $75.1 million which represents approximately 30 days of operating expenses in reserve and 215% of the required amount by the State.

Note: To improve comparative analysis, the Plan is reporting the budget on a flexible basis which allows for updated revenue and medical expense budget figures consistent with membership trends.





Revenue

Net Premium revenue is $218.1 million; a $8.7 million and 4% favorable budget variance. The primary drivers of the budget variance are revenue associated with directed payments and changes in estimate for prior year revenue.

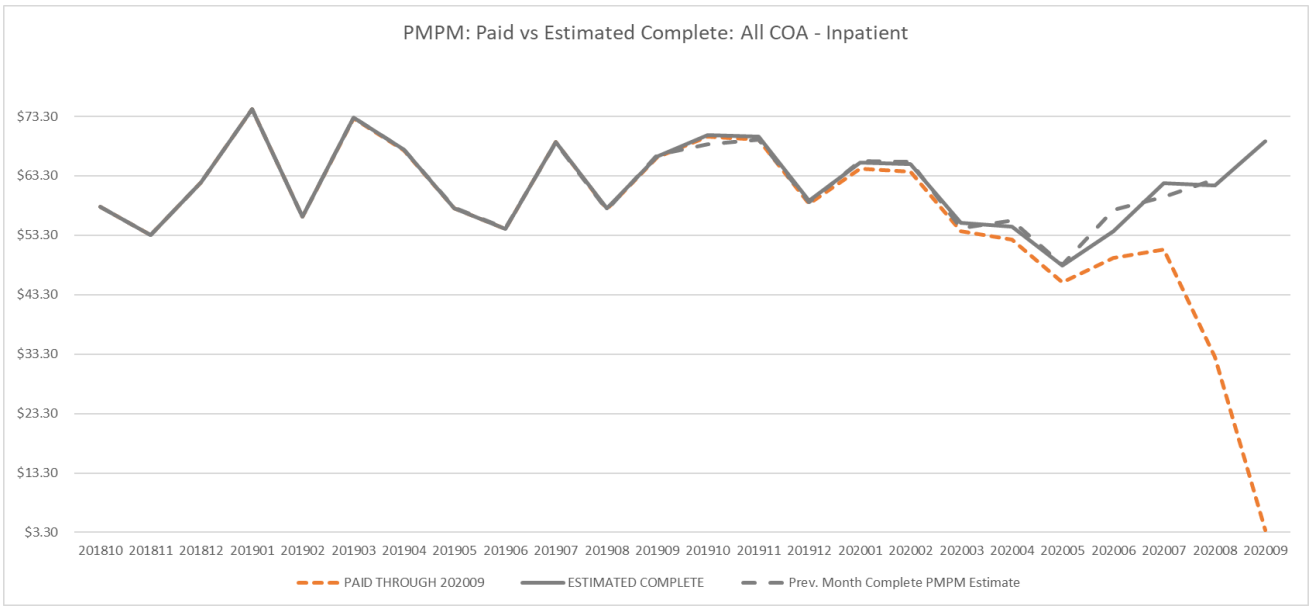
Health Care Costs

FYTD Health care costs are $208.4 million; a $6.8 million and 3% unfavorable budget variance.

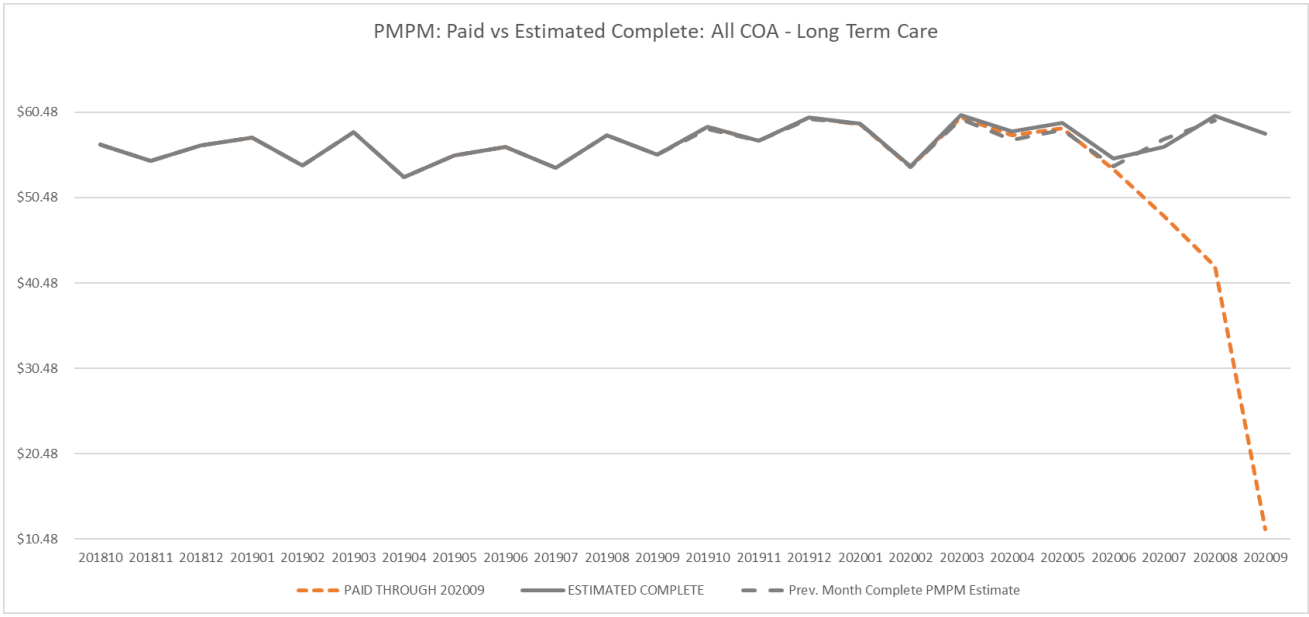
Notable variances from the budget are as follows:

1. Directed payments for Proposition 56 are over budget by $5.9 million. GCHP did not budget for Proposition 56 expenses as the May revise of the State budget had removed funding for Proposition 56. The State budget in June ultimately included Proposition 56 funding. GCHP receives funding to offset the expense.

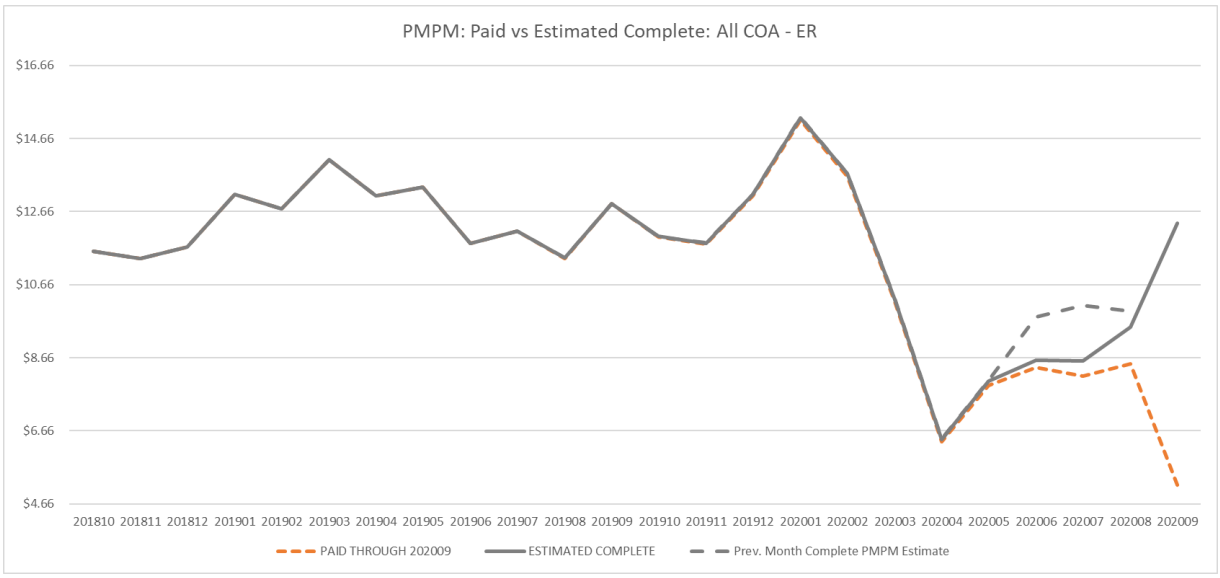
2. Inpatient hospital costs are under budget by $2.7 million due to decreased utilization from COVID-19 and the increase in membership.



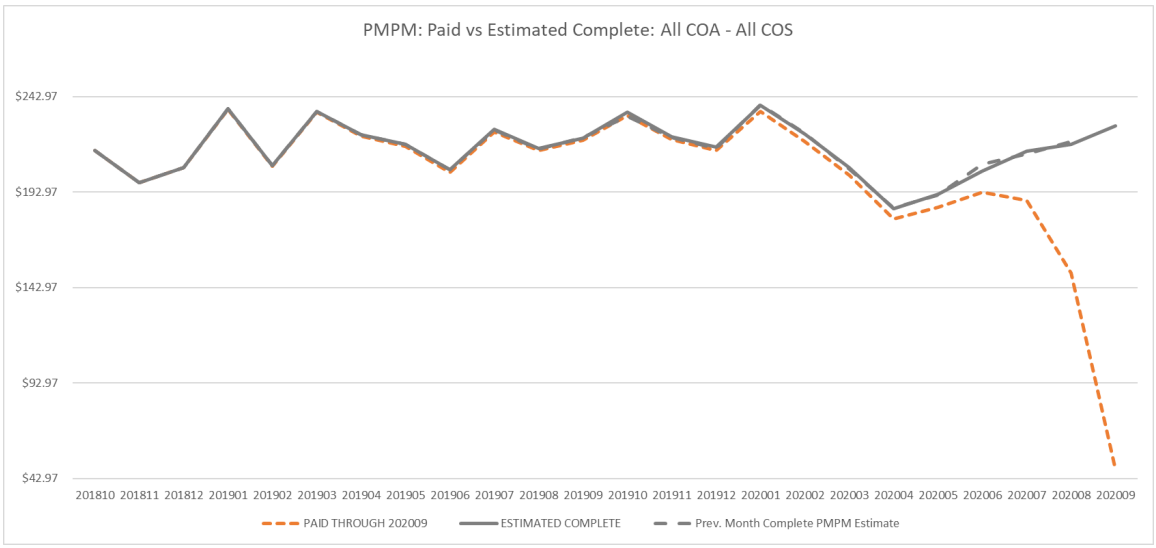
3. Long term care (LTC) expenses are over budget by $2.1 million. The State increased facility rates by 10% effective March 1, 2020 through the emergency. The full impact was mitigated through the Solvency Action Plan and the reduction of LTC contractual rates to 100% of the Medi-Cal fee schedule.



4. Emergency Room expenses are under budget by $1.9 million (24%) due to decreased utilization associated with COVID-19.



5. Total fee for service health care pmpm costs excluding capitation and pharmacy, and considering date of service, are under budget by $4.90 PMPM (2.2%).



Note: Medical expenses are calculated through a predictive model which examines the timing of claims receipt and claims payments. It is referred to as “Incurred But Not Paid” (IBNP) and is a liability on the balance sheet. On the balance sheet, this calculation is a combination of the Incurred But Not Reported and Claims Payable. The total liability is the difference between the estimated costs (the orange line above) and the paid amounts (in grey above).

Administrative Expenses

The administrative expenses are currently running within amounts allocated to administration in the capitation revenue from the State. In addition, the ratio is comparable to other local initiative health plans.

For the fiscal year to date through September, administrative costs were $12.3 million and $2.3 million below budget. As a percentage of revenue, the administrative cost ratio (or ACR) was 5.6% versus 7.3% for budget.

Cash and Short-Term Investment Portfolio

At September 30, the Plan had $156.8 million in cash and short-term investments. The investment portfolio included Ventura County Investment Pool $43.1 million; LAIF CA State $206,000; the portfolio yielded a rate of 2.5%.

Medi-Cal Receivable

At September 30, the Plan had $84 million in Medi-Cal Receivables due from the DHCS.

RECOMMENDATION:

Staff recommends that the Commission approve the September 2020 financial package.

CONCURRENCE:

N/A

ATTACHMENT:

September 2020 Financial Package

Gold Coast Health Plan℠
A Public Entity

FINANCIAL PACKAGE
For the month ended September 30, 2020

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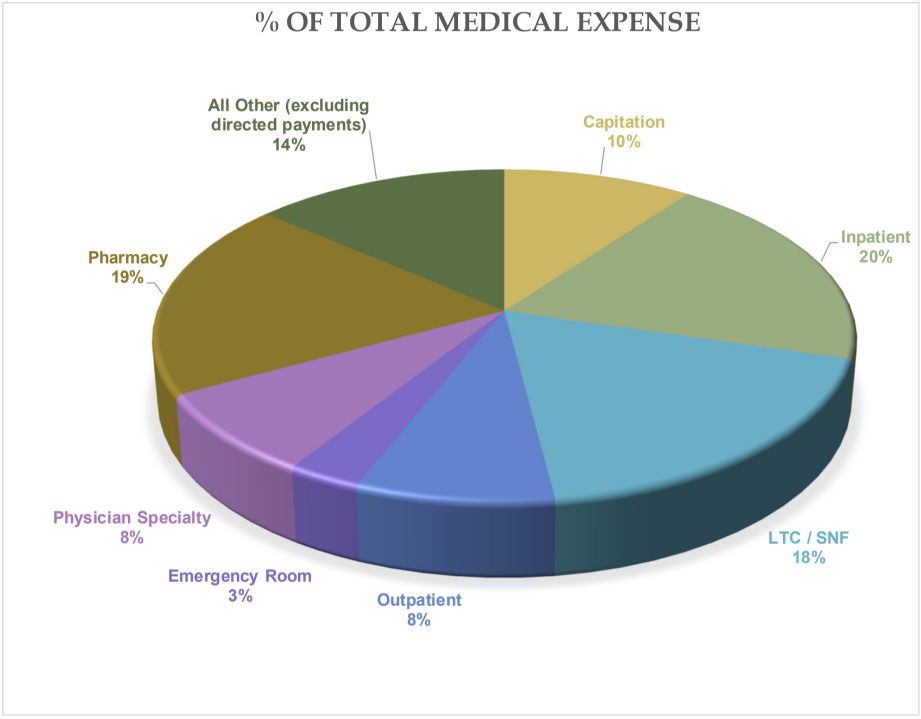
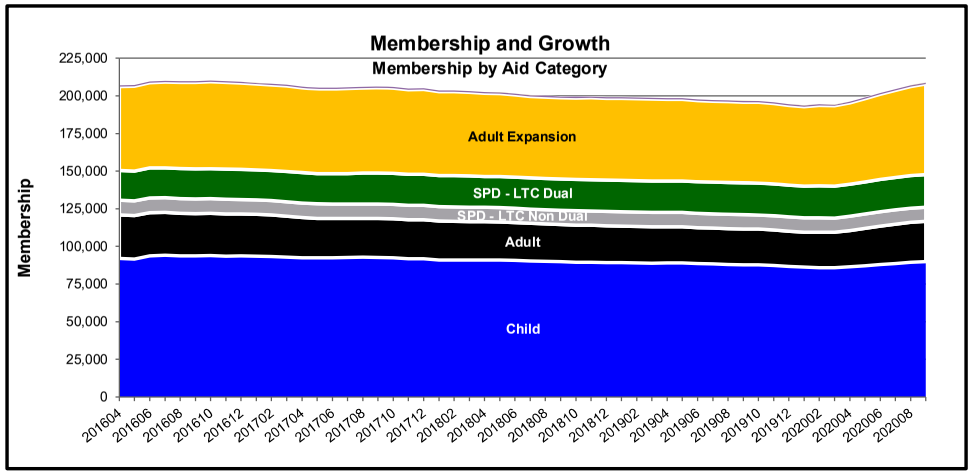
Gold Coast Health Plan

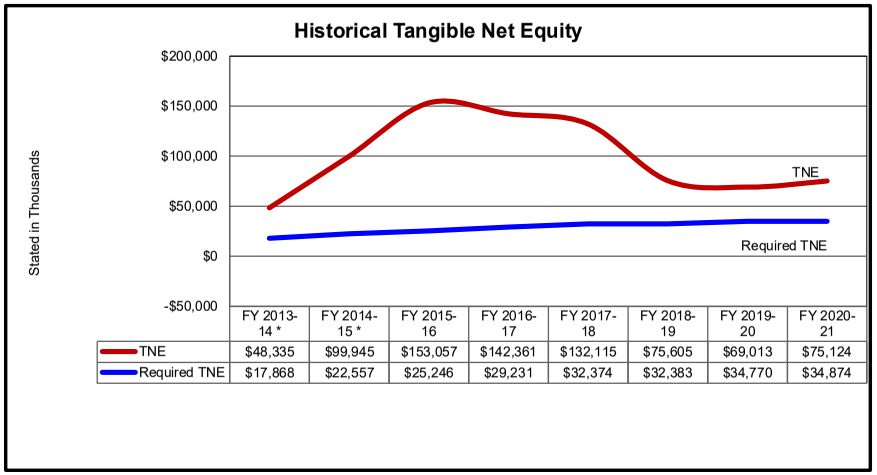
Executive Dashboard as of September 30, 2020

	FYTD 20/21 Budget*	FYTD 20/21 Actual	FY 19/20 Actual	FY 18/19 Actual
Average Enrollment	203,236	204,969	196,012	198,140
PMPM Revenue	$ 340.55	$ 354.70 [1]	$ 348.73	$ 299.23
Medical Expenses				
Capitation	$ 33.18	$ 33.28	$ 24.93	$ 23.90
Inpatient	$ 68.47	$ 64.15	$ 65.19	$ 62.09
LTC / SNF	$ 57.17	$ 60.54	$ 59.20	$ 56.06
Outpatient	$ 25.98	$ 26.43	$ 25.81	$ 25.88
Emergency Room	$ 12.95	$ 9.89	$ 11.97	$ 12.14
Physician Specialty	$ 25.84	$ 26.31	$ 27.63	$ 26.71
Pharmacy	$ 64.47	$ 63.86	$ 61.05	$ 56.60
All Other *(excluding directed payments)*	$ 32.12	$ 44.77	$ 41.07	$ 38.20
Total Per Member Per Month	$ 320.18	$ 329.24	$ 316.86	$ 301.58
Medical Loss Ratio	96.2%	95.5%	94.6%	102.0%
Total Administrative Expenses	$ 15,048,465	$ 12,314,836	$ 50,821,685	$ 46,655,880
% of Revenue	7.3%	5.6%	6.2%	6.6%
TNE	$ 50,232,476	$ 75,123,681	$ 71,272,142	$ 75,604,948
Required TNE	$ 27,745,713	$ 34,873,635	$ 34,685,521	$ 32,382,791
% of Required	181%	215%	205%	233%

** Flexible Budget (uses actual membership & member mix against budgeted rates)*







	FY 2013-14 *	FY 2014-15 *	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
TNE	$48,335	$99,945	$153,057	$142,361	$132,115	$75,605	$69,013	$75,124
Required TNE	$17,868	$22,557	$25,246	$29,231	$32,374	$32,383	$34,770	$34,874

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STATEMENT OF FINANCIAL POSITION

	09/30/20	08/31/20	07/31/20
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**113,473,100**	**105,540,807**	**92,825,177**
Total Short-Term Investments	**43,299,622**	**43,220,038**	**43,299,622**
Medi-Cal Receivable	84,040,471	112,054,954	103,385,754
Interest Receivable	366,344	359,362	232,554
Provider Receivable	1,059,076	887,733	618,291
Other Receivables	6,320,713	5,471,781	5,471,781
Total Accounts Receivable	**91,786,604**	**118,773,830**	**109,708,380**
Total Prepaid Accounts	3,404,652	3,403,018	3,157,127
Total Other Current Assets	153,789	153,789	153,789
Total Current Assets	**252,117,768**	**271,091,481**	**249,144,095**
Total Fixed Assets	**1,494,745**	**1,525,090**	**1,568,069**
Total Assets	**$ 253,612,513**	**$ 272,616,571**	**$ 250,712,164**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 62,746,645	$ 59,014,404	$ 55,094,076
Claims Payable	17,576,572	23,486,358	20,101,380
Capitation Payable	16,269,702	16,180,122	16,051,298
Physician Payable	16,480,804	15,113,136	14,584,624
DHCS - Reserve for Capitation Recoup	5,257,358	5,257,358	5,257,358
Accounts Payable	2,354,697	666,022	1,821,454
Accrued ACS	1,696,926	3,331,133	1,720,204
Accrued Provider Reserve	800,239	734,000	668,922
Accrued Pharmacy	13,955,698	20,918,642	13,764,427
Accrued Expenses	2,235,591	1,180,743	874,611
Accrued Premium Tax	35,508,624	46,524,861	40,491,437
Accrued Payroll Expense	2,547,969	2,830,074	2,630,403
Total Current Liabilities	**177,430,824**	**195,236,850**	**173,060,194**
Long-Term Liabilities:			
Other Long-term Liability-Deferred Rent	1,058,008	1,064,202	1,070,396
Total Long-Term Liabilities	**1,058,008**	**1,064,202**	**1,070,396**
Total Liabilities	**178,488,832**	**196,301,052**	**174,130,590**
Net Assets:			
Beginning Net Assets	77,323,271	77,323,271	77,323,271
Total Increase / (Decrease in Unrestricted Net Assets)	(2,199,590)	(1,007,752)	(741,696)
Total Net Assets	**75,123,681**	**76,315,519**	**76,581,575**
Total Liabilities & Net Assets	**$ 253,612,513**	**$ 272,616,571**	**$ 250,712,164**

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR MONTH ENDED September 30, 2020

	September 2020	September 2020 Year-To-Date		Variance	Variance	September 2020 Year-To-Date		Variance
	Actual	Actual	Budget	Fav / (Unfav)	%	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	207,599	614,906	609,708	5,198	1%	PMPM - FYTD		
Revenue								
Premium	$ 79,846,394	$ 236,363,547	$ 209,403,957	$ 26,959,590	13%	$ 384.39	$ 343.45	$ 40.94
Reserve for Cap Requirements	-	-	-	-	0%	-	-	-
MCO Premium Tax	(6,236,403)	(18,255,984)	-	(18,255,984)	0%	(29.69)	-	(29.69)
Total Net Premium	**73,609,991**	**218,107,563**	**209,403,957**	**8,703,606**	**4%**	**354.70**	**343.45**	**11.25**
Other Revenue:								
Miscellaneous Income	-	468	-	468	0%	0.00	-	0.00
Total Other Revenue	-	468	-	468	0%	0.00	-	0.00
Total Revenue	**73,609,991**	**218,108,031**	**209,403,957**	**8,704,074**	**4%**	**354.70**	**343.45**	**11.25**
Medical Expenses:								
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	7,021,749	20,466,409	20,402,021	(64,388)	0%	33.28	33.46	0.18
FFS Claims Expenses:								
Inpatient	14,313,686	39,444,107	42,101,767	2,657,660	6%	64.15	69.05	4.91
LTC / SNF	12,668,969	37,227,899	35,154,462	(2,073,437)	-6%	60.54	57.66	(2.88)
Outpatient	6,058,730	16,251,245	15,975,060	(276,185)	-2%	26.43	26.20	(0.23)
Laboratory and Radiology	621,002	1,972,730	1,153,698	(819,031)	-71%	3.21	1.89	(1.32)
Directed Payments - Provider	2,328,305	5,933,412	-	(5,933,412)	0%	9.65	-	(9.65)
Emergency Room	1,895,505	6,082,879	7,960,742	1,877,863	24%	9.89	13.06	3.16
Physician Specialty	5,262,817	16,176,495	15,888,396	(288,100)	-2%	26.31	26.06	(0.25)
Primary Care Physician	1,627,812	4,494,471	3,812,499	(681,972)	-18%	7.31	6.25	(1.06)
Home & Community Based Services	1,387,940	5,285,664	4,870,323	(415,340)	-9%	8.60	7.99	(0.61)
Applied Behavioral Analysis/Mental Health Service	2,876,750	7,274,303	6,188,550	(1,085,753)	-18%	11.83	10.15	(1.68)
Pharmacy	11,987,037	39,268,347	39,643,346	374,999	1%	63.86	65.02	1.16
Provider Reserve	162,489	484,433	288,750	(195,683)	-68%	0.79	0.47	(0.31)
Other Medical Professional	261,011	1,002,475	1,099,809	97,334	9%	1.63	1.80	0.17
Other Medical Care	2,730	13,000	-	(13,000)	0%	0.02	-	(0.02)
Other Fee For Service	687,538	2,306,098	2,142,963	(163,134)	-8%	3.75	3.51	(0.24)
Transportation	148,446	1,074,584	484,406	(590,177)	-122%	1.75	0.79	(0.95)
Total Claims	62,290,767	184,292,140	176,764,771	(7,527,369)	-4%	299.71	289.92	(9.79)
Medical & Care Management Expense	1,510,173	3,799,517	3,669,138	(130,379)	-4%	6.18	6.02	(0.16)
Reinsurance	330,955	640,054	704,213	64,159	9%	1.04	1.16	0.11
Claims Recoveries/Budget Reduction	(409,128)	(815,602)	-	815,602	0%	(1.33)	-	1.33
Sub-total	1,432,000	3,623,969	4,373,351	749,382	17%	5.89	7.17	1.28
Total Cost of Health Care	**70,744,517**	**208,382,518**	**201,540,143**	**(6,842,375)**	**-3%**	**338.89**	**330.55**	**(8.33)**
Contribution Margin	**2,865,475**	**9,725,513**	**7,863,814**	**1,861,699**	**24%**	**15.82**	**12.90**	**2.92**
General & Administrative Expenses:								
Salaries, Wages & Employee Benefits	2,006,445	5,927,177	6,526,288	599,111	9%	9.64	10.70	1.06
Training, Conference & Travel	2,000	3,323	23,259	19,936	86%	0.01	0.04	0.03
Outside Services	2,418,707	6,666,269	6,559,071	(107,198)	-2%	10.84	10.76	(0.08)
Professional Services	246,800	1,056,958	1,072,379	15,422	1%	1.72	1.76	0.04
Occupancy, Supplies, Insurance & Others	837,748	1,803,921	2,250,003	446,082	20%	2.93	3.69	0.76
Care Management Reclass to Medical	(1,510,173)	(3,799,518)	(3,669,138)	130,380	-4%	(6.18)	(6.02)	0.16
G&A Expenses	4,001,528	11,658,130	12,761,863	1,103,733	9%	18.96	20.93	1.97
Project Portfolio	174,154	656,706	2,286,602	1,629,896	71%	1.07	3.75	2.68
Total G&A Expenses	**4,175,681**	**12,314,836**	**15,048,465**	**2,733,628**	**18%**	**20.03**	**24.68**	**4.65**
Total Operating Gain / (Loss)	**(1,310,206)**	**(2,589,323)**	**(7,184,651)**	**4,595,328**	**-64%**	**(4.21)**	**(11.78)**	**7.57**
Non Operating								
Revenues - Interest	118,367	388,647	225,000	163,647	73%	0.63	0.37	0.26
Gain/(Loss) on Sale of Asset	-	1,086	-	1,086	0%	0.00	-	0.00
Total Non-Operating	**118,367**	**389,733**	**225,000**	**164,733**	**73%**	**0.63**	**0.37**	**0.26**
Total Increase / (Decrease) in Unrestricted Net Assets	**$ (1,191,839)**	**$ (2,199,590)**	**$ (6,959,651)**	**$ 4,760,061**	**-68%**	**$ (3.58)**	**$ (11.41)**	**$ 7.84**

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FYTD PMPM BUDGET TO ACTUAL ANALYSIS - FEE FOR SERVICE BY AID CATEGORY

	Adult				Child				Adult Expansion			
	Budget	Actual	Variance	%	Budget	Actual	Variance	%	Budget	Actual	Variance	%
Inpatient	$ 127.55	$ 123.37	$ (4.18)	-3%	$ 5.88	$ 5.60	$ (0.28)	-5%	$ 115.70	$ 104.81	$ (10.89)	-9%
Outpatient	45.30	49.38	4.08	9%	$ 4.32	2.85	(1.47)	-34%	$ 38.32	37.77	(0.55)	-1%
ER	17.34	15.20	(2.14)	-12%	$ 10.03	6.13	(3.90)	-39%	$ 16.70	14.62	(2.08)	-12%
LTC	8.04	16.98	8.94	111%	$ 0.31	0.34	0.03	11%	$ 22.53	23.79	1.26	6%
PCP	6.55	8.60	2.05	31%	$ 5.83	5.38	(0.45)	-8%	$ 5.75	7.22	1.47	26%
Specialty	45.22	47.01	1.79	4%	$ 4.15	4.15	0.00	0%	$ 41.38	39.42	(1.96)	-5%
Pharmacy	91.13	100.75	9.62	11%	$ 11.59	11.86	0.27	2%	$ 110.06	114.20	4.14	4%
Mental Health/ABA	5.57	6.89	1.32	24%	$ 8.91	9.94	1.03	12%	$ 5.60	6.66	1.06	19%
All Other	10.64	13.81	3.17	30%	1.28	2.13	0.85	67%	12.61	14.16	1.55	12%
Total	$ 357.34	$ 381.99	$ 24.65	7%	$ 52.30	$ 48.38	$ (3.92)	-7%	$ 368.65	$ 362.65	$ (6.00)	-2%
FYTD Member Months	75,168	78,933	3,765	5%	273,012	264,557	(8,455)	-3%	170,670	175,598	4,928	3%

	Seniors and Persons with Disabilities (SPD)				SPD - Dual				Long Term Care (LTC)			
	Budget	Actual	Variance	%	Budget	Actual	Variance	%	Budget	Actual	Variance	%
Inpatient	$ 277.82	$ 307.31	$ 29.49	11%	$ 20.38	$ 17.58	$ (2.80)	-14%	$ 717.20	$ 798.92	$ 81.72	11%
Outpatient	99.41	106.93	7.52	8%	20.37	22.48	2.11	10%	240.62	114.71	(125.91)	-52%
ER	28.18	25.38	(2.80)	-10%	1.93	1.62	(0.31)	-16%	16.66	-	(16.66)	-100%
LTC	151.74	148.49	(3.25)	-2%	96.90	90.22	(6.68)	-7%	7,854.68	8,995.48	1,140.80	15%
PCP	14.89	24.41	9.52	64%	4.51	5.01	0.50	11%	11.21	6.76	(4.45)	-40%
Specialty	79.40	103.37	23.97	30%	21.13	20.72	(0.41)	-2%	236.35	359.33	122.98	52%
Pharmacy	308.07	347.29	39.22	13%	5.26	5.60	0.34	6%	341.77	217.48	(124.29)	-36%
Mental Health/ABA	76.70	75.95	(0.75)	-1%	1.19	1.55	0.36	31%	3.60	-	(3.60)	-100%
All Other	77.33	86.53	9.20	12%	56.77	69.14	12.37	22%	586.12	478.88	(107.24)	-18%
Total	$ 1,113.56	$ 1,225.66	$ 112.10	10%	$ 228.43	$ 233.92	$ 5.49	2%	$ 10,008.20	$ 10,971.56	$ 963.36	10%
FYTD Member Months	27,501	30,287	2,786	10%	60,375	59,772	(603)	-1%	102	164	62	61%

	LTC - Dual			
	Budget	Actual	Variance	%
Inpatient	$ 61.49	$ 18.03	$ (43.46)	-71%
Outpatient	13.59	5.83	(7.76)	-57%
ER	0.72	0.54	(0.18)	-25%
LTC	7,382.67	7,439.13	56.46	1%
PCP	0.55	0.10	(0.45)	-82%
Specialty	11.59	24.78	13.19	114%
Pharmacy	0.08	0.21	0.13	177%
Mental Health/ABA	0.64	0.37	(0.27)	-42%
All Other	169.81	106.68	(63.13)	-37%
Total	$ 7,641.13	$ 7,595.67	$ (45.46)	-1%
FYTD Member Months	2,454	2,529	75	3%

FFS expenses budgeted based on CY 2019 PMPM data, with the following trend assumptions:

Inpatient - 1% annual trend and known contractual changes.
ER - 1% annual trend and known contractual changes.
LTC - 2.5% estimated fee schedule change
Specialty Physician - 1% estimated fee schedule change
Mental Health/ABA - 2% annual increase due to utilization.
Pharmacy - 5% overall annual increase.
Home and Community Based Services - 2% annualized increase due to utilization.

Return to Agenda

STATEMENT OF CASH FLOWS	September 2020	FYTD 20-21
Cash Flows Provided By Operating Activities		
Net Income (Loss)	$ (1,191,838)	$ (2,199,590)
Adjustments to reconciled net income to net cash provided by operating activities		
Depreciation on fixed assets	41,680	117,233
Disposal of fixed assets	-	9,684
Amortization of discounts and premium	-	-
Changes in Operating Assets and Liabilites		
Accounts Receivable	26,987,226	18,083,516
Prepaid Expenses	(1,634)	(1,652,878)
Accrued Expense and Accounts Payable	(6,075,686)	(4,687,379)
Claims Payable	(4,452,538)	2,506,167
MCO Tax liablity	(11,016,237)	1,003,344
IBNR	3,732,241	10,977,308
Net Cash Provided by (Used in) Operating Activities	8,023,213	24,157,405
Cash Flow Provided By Investing Activities		
Proceeds from Restricted Cash & Other Assets		
Proceeds from Investments	(79,585)	(179,814)
Purchase of Investments plus Interest reinvested	-	-
Purchase of Property and Equipment	(11,335)	(11,335)
Net Cash (Used In) Provided by Investing Activities	(90,919)	(191,149)
Increase/(Decrease) in Cash and Cash Equivalents	7,932,294	23,886,671
Cash and Cash Equivalents, Beginning of Period	105,540,807	89,586,429
Cash and Cash Equivalents, End of Period	113,473,100	113,473,100

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Gold Coast Health Plan

Integrity

Accountability

Collaboration

Trust

Respect

FYTD Unaudited Financial Statements
September 2020

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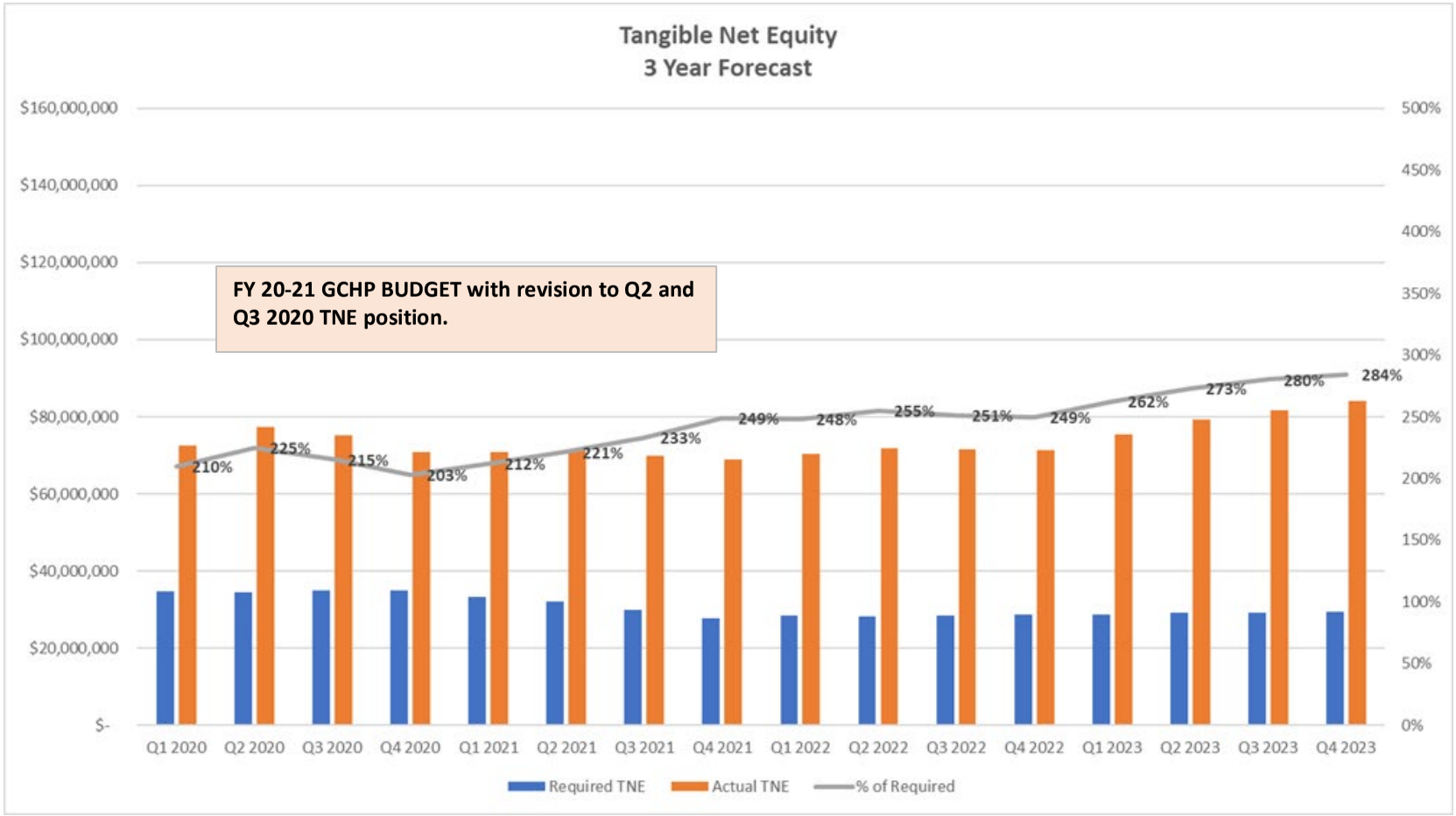
Financial Overview:

SEPTEMBER NET LOSS	$ 1.2 M
FYTD NET LOSS	$2.2 M
TNE is $75.1 M and 215% of the minimum required	
MEDICAL LOSS RATIO	95.5%
ADMINISTRATIVE RATIO	5.6%

150 of 215 pages
Return to Agenda

Revised Forecast:



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CY 2021 Draft Rates – Version 1 Analysis:

- Includes the following adjustments:
  1. Reduction to allowable medical expense for globally sub-capitated members.
  2. Potentially Preventable Admissions Efficiency Adjustment (PPA).
  3. Healthcare Common Procedure Coding System Efficiency Adjustment (HCPCS).
  4. Reduction to the underwriting gain (2% to 1.5%).
  5. Other program changes and base data adjustments.

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CY 2021 Draft Rates – Version 2:

GCHP anticipates a version 2 in October which will include the Low Acuity Non-Emergent (LANE) efficiency adjustment.

Estimated dollar impact is .25% and $1,500,000

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CY 2021 Draft Rates – Version 3:

GCHP anticipates a version 3 in December which will include a potential adjustment for population acuity.

Estimated dollar impact – ?????

If .5% = $3 million
If 2% = $12 million

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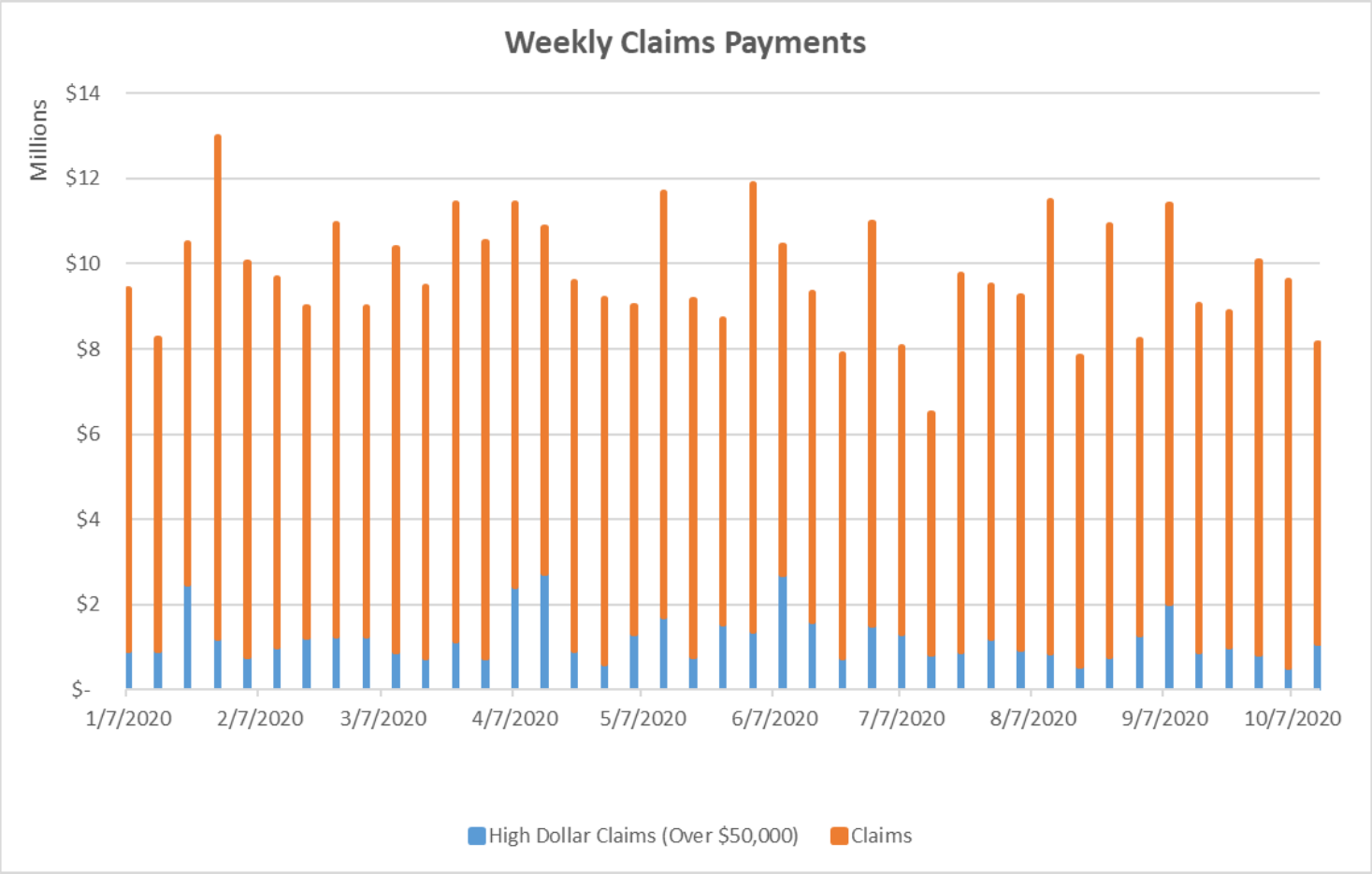
Financial Impacts of Covid-19:

- Increase in membership – redeterminations pended "through the emergency".
- Unfunded 10% increase to LTC facility rates.
- Decrease in inpatient and ER costs being offset by increase to mental health, LTC and laboratory costs.

Return to Agenda

Weekly claims payment review:



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Update on the Solvency Action Plan:

Actions	Annualized impact in savings
Continued focus on interest expense reduction	$500,000
Reduction of LTC facility rates to 100% of Medi-Cal rate	$1.8 million
Sent notification to providers regarding reduction of Adult Expansion PCP rates	$4.5 million
Revision to Non-Pharmacy Dispensing Site policy	$2-3 million
Contract signed – rate reduction to tertiary hospital	$1.3 million
Optum contract rate reduction	$150,000
TOTAL ANNUAL SAVINGS	**$10.3 – 11.3 million**

Return to Agenda

Next steps -
Phase 2: Solvency Action Plan

- WORK/ANALYSIS ON SOLVENCY ACTION CONTINUES
- HOWEVER, IMPLEMENTATION OF ANY PROVIDER RATE/CONTRACT CHANGES WILL ON HOLD THROUGH THE SYSTEM CONVERSION
- GCHP remains committed to preparation and planning for CY 2021

Return to Agenda

Next steps -
Phase 2: Solvency Action Plan

Current Focus	Annualized impact in savings
Outlier contract rates	TBD
Implementation of HMS – scheduled for late October	$1-3 million
Improved contract language	TBD
Expansion of capitation arrangements	Required TNE and risk reductions
LANE/HCPCS analysis	TBD
Consideration of across the board reductions	TBD
California Children's Services – ED Diversion	$500,000

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Revenue

Net Premium revenue is $218.1 million, over budget by $8.7 million and 4%.

- **Revenue for Proposition 56 is $6.9 million.**
- **Increase in revenue related to FY 19-20.**

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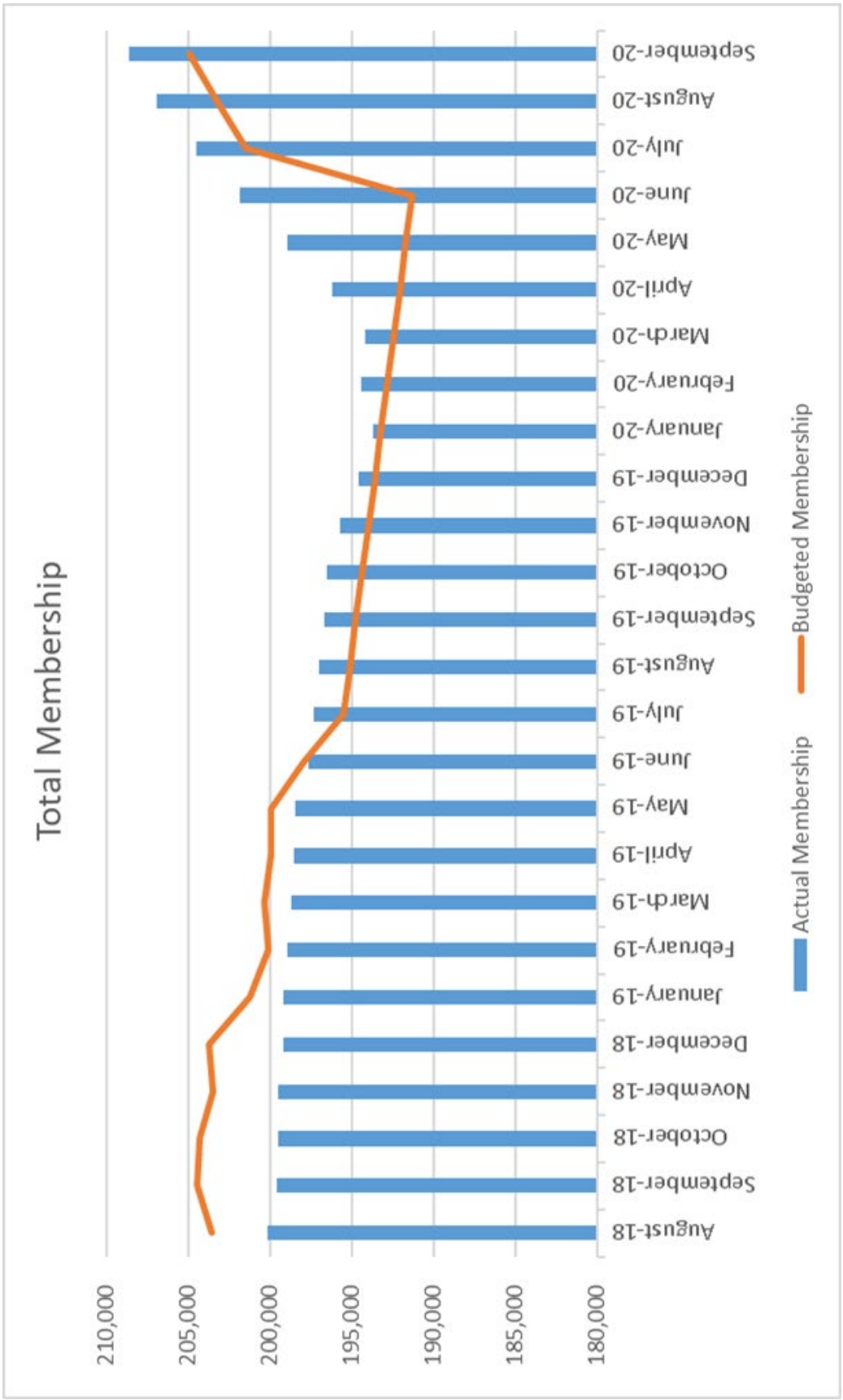
Total Membership
210,000
205,000
200,000
195,000
190,000
185,000
180,000
August-18
September-18
October-18
November-18
December-18
January-19
February-19
March-19
April-19
May-19
June-19
July-19
August-19
September-19
October-19
November-19
December-19
January-20
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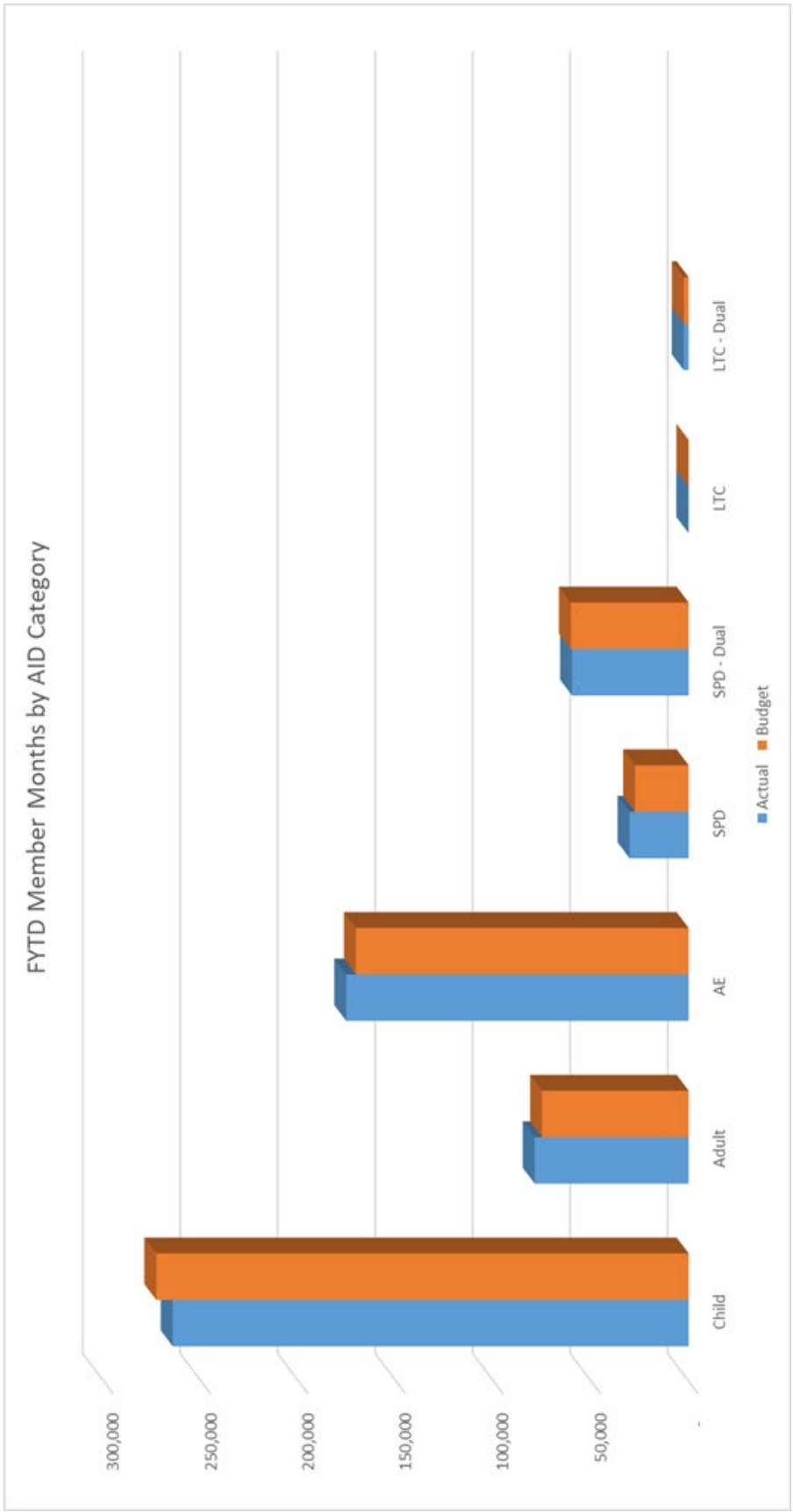
May-20
June-20
July-20
August-20
September-20
Actual Membership
Budgeted Membership


FYTD Member Months by AID Category
300,000
250,000
200,000
150,000
100,000
50,000
-
Child
Adult
AE
SPD
SPD - Dual
LTC
LTC - Dual
Actual
Budget

Medical Expense

FYTD Health care costs are $208.4 million and $6.8 million over budget. Medical loss ratio is 95.5%, a .7% budget variance.

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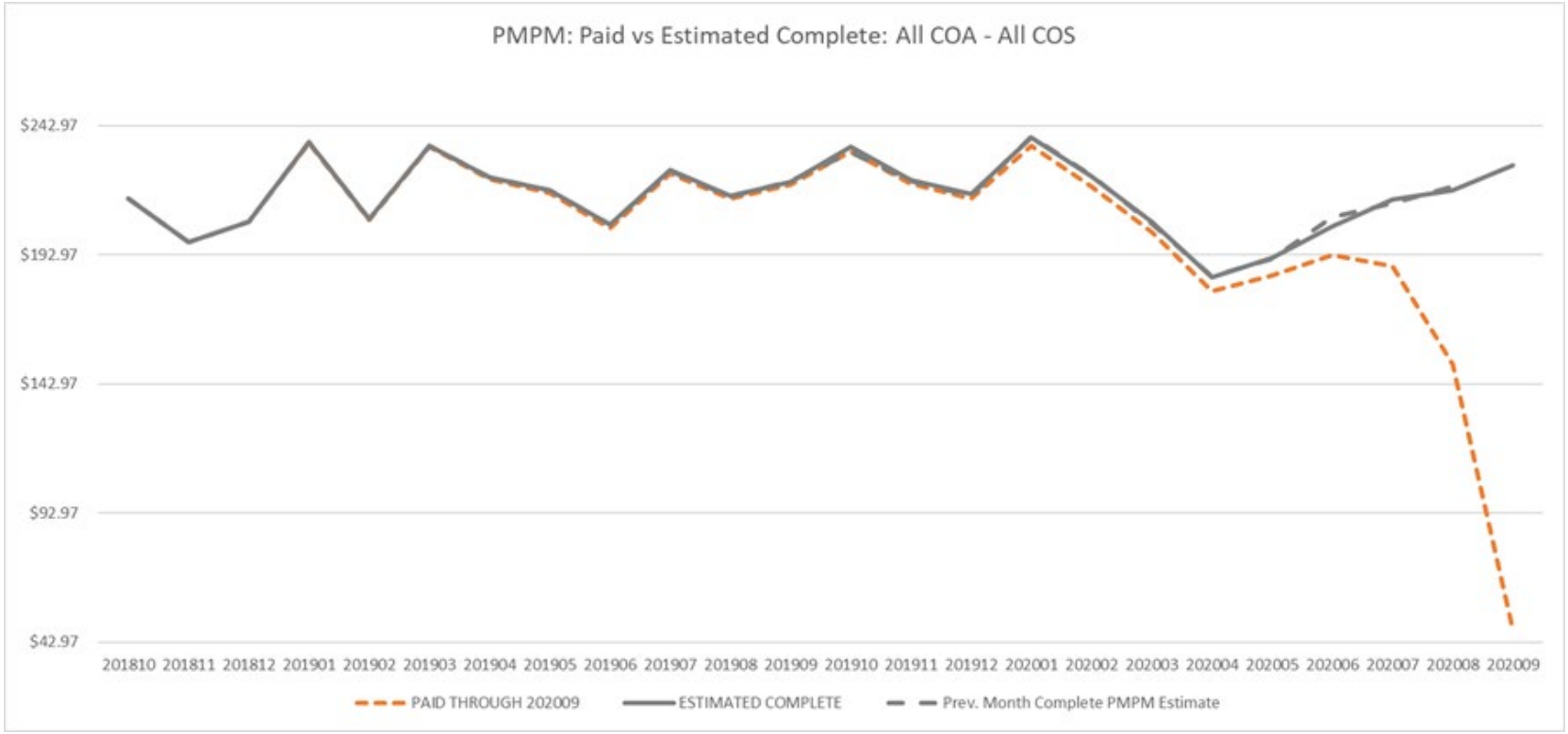
Total Fee For Service Medical Expenses



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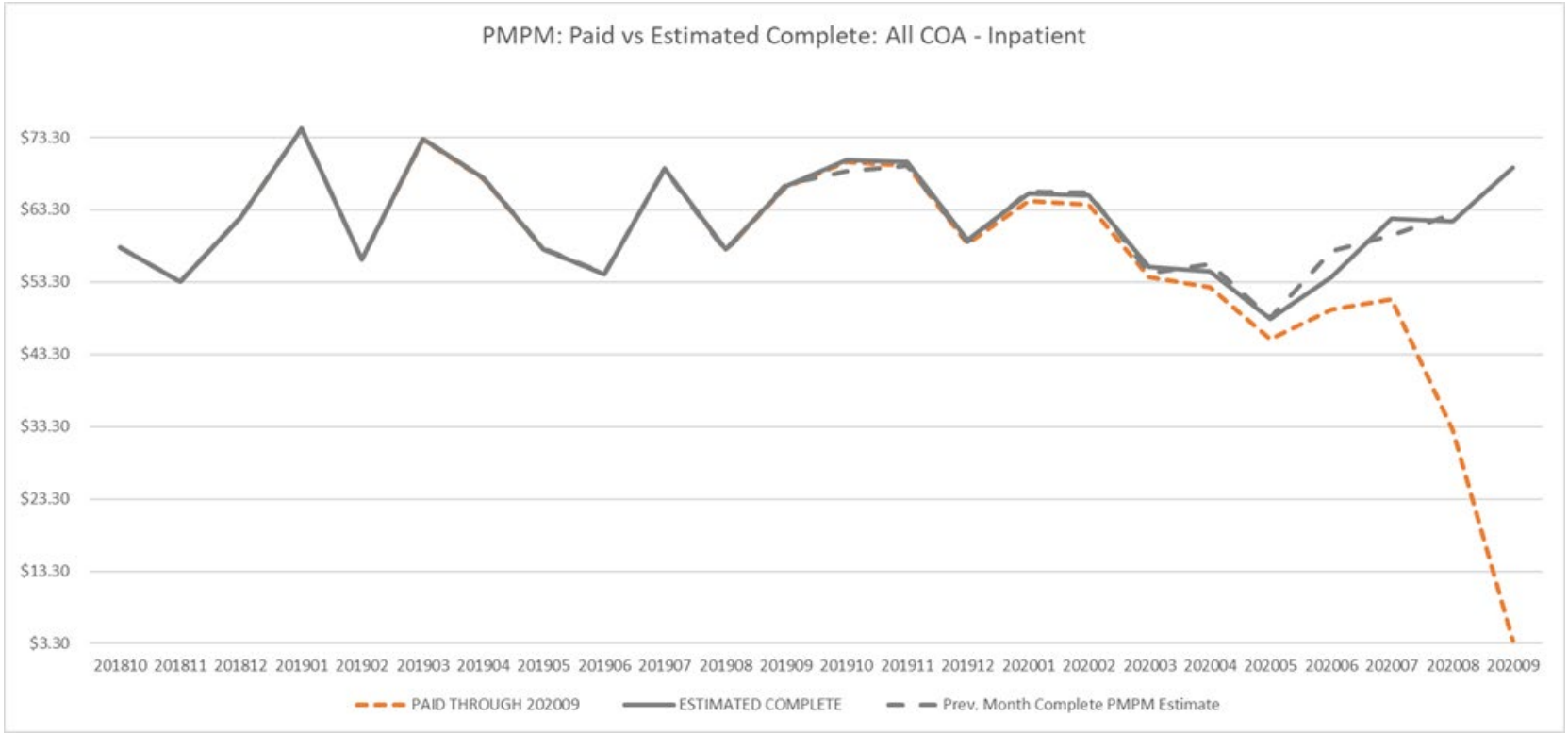
Inpatient Medical Expenses: Under Budget by $2.7 Million (6%)



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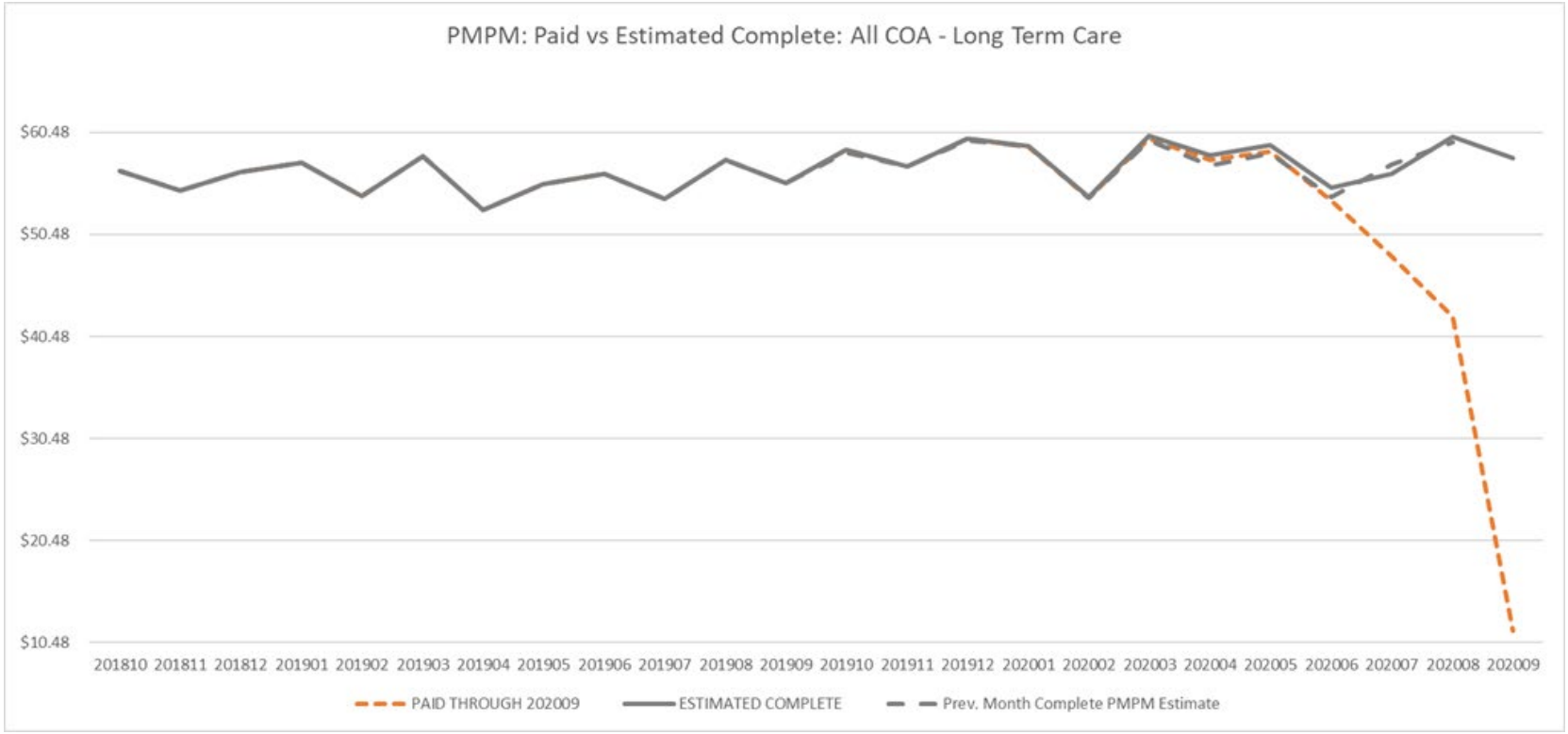
Long Term Care Expenses: Over budget by $2.1 million (6%)



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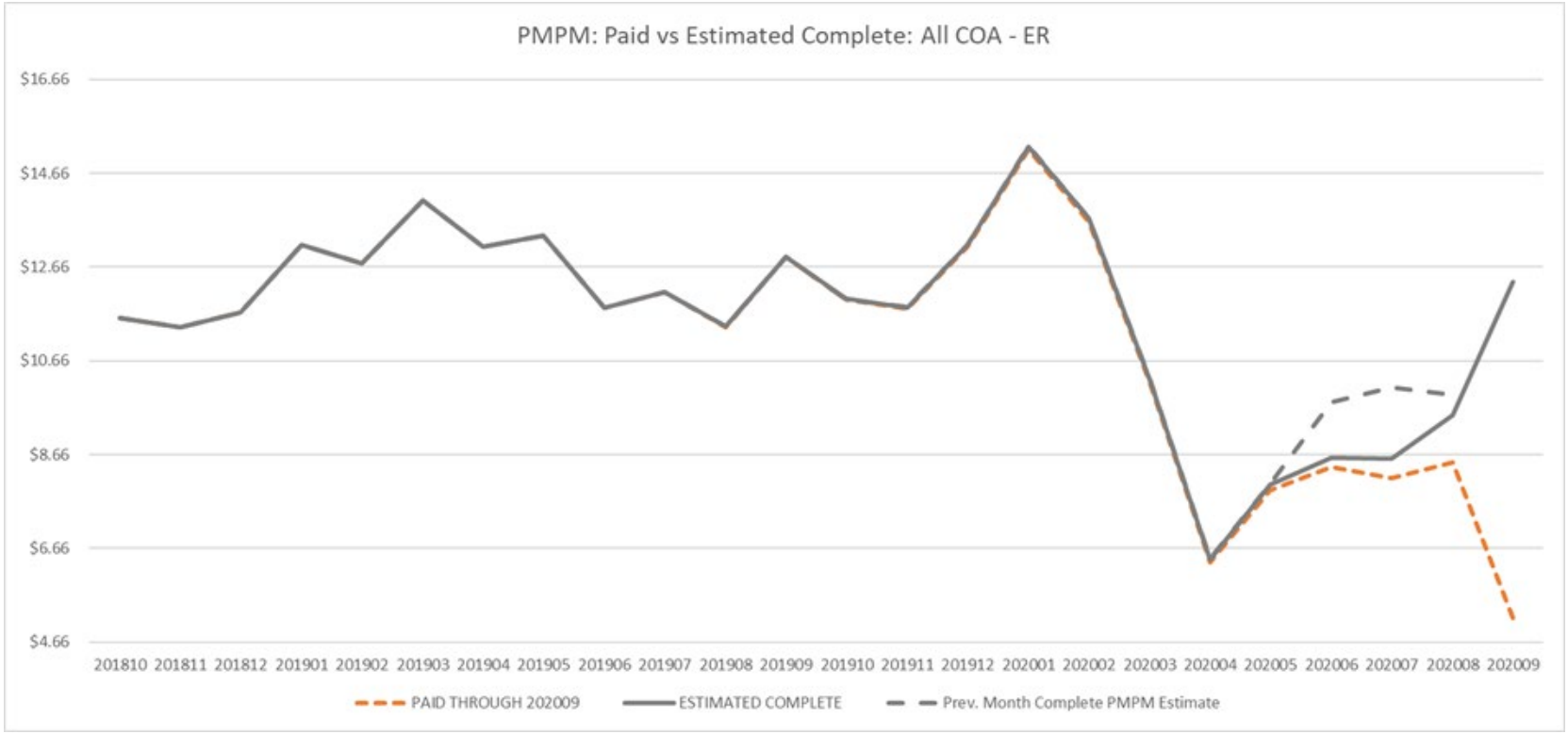
Emergency Room Expenses: Under budget by $1.9 million (24%)



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Other Impacts to Medical Expenses:

Directed Payments – over budget by $5.9 million

Laboratory – over budget by $819,000

Mental and Behavioral Health – over budget by $1.1 million

Return to Agenda

Financial Statement Summary

	September	FYTD	FYTD Budget	Budget Variance
Net Capitation Revenue	$ 73,609,991	$ 218,108,031	$ 209,403,957	$ 8,704,074
Health Care Costs	70,744,517	208,382,518	201,540,143	6,842,375
Medical Loss Ratio		**95.3%**	**96.3%**	
Administrative Expenses	4,175,681	12,314,836	15,048,465	(2,733,629)
Administrative Ratio		**5.6%**	**7.3%**	
Non-Operating Revenue/(Expense)	118,367	389,733	225,000	164,733
Total Increase/(Decrease) in Net Assets	$ (1,191,839)	$ (2,199,589)	$ (6,959,651)	$ 4,760,061
Cash and Investments	$ 156,772,722			
GCHP TNE	$ 75,123,681			
Required TNE	$ 34,873,635			
% of Required	**215%**			

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Questions?

Staff recommends the Commission approve the unaudited financial statements for September 2020

Return to Agenda

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, MD, Chief Medical Officer

DATE: October 26, 2020

SUBJECT: Provider Contracting and Credentialing Management ("PCCM") System Implementation

SUMMARY:

Gold Coast Health Plan ("GCHP") leadership is requesting a revised not-to-exceed-amount approval to complete an in-progress, critical Provider Contracting, Credentialing, and provider data Management ("PCCM") system implementation.

Medi-Cal Managed Care Health Plans ("MCPs") have responsibility for managing and reporting on a vast amount of information about provider identification and practice locations, provider contracts, and provider credentialing status. GCHP developed a customized, in-house data base to support production of provider directories and provider network data reporting to the Department of Health Care Services ("DHCS"). Today, credentialing efforts are 100% manual and rely upon the use of Excel spreadsheets. These custom and highly manual approaches are not scalable or configurable to keep pace with increasingly frequent changes to regulatory requirements. To address this, GCHP released a Request for Proposals ("RFP") for a Provider Credentialing, Contracting, and Provider Data Management business-technology platform in 2017.

In October of 2018, the GCHP Commission approved the Plan entering into a contract with a yet to be identified qualified vendor for a 5-year contract estimated to be $1.25 million. The RFP considered separate platforms for credentialing, contracting, and provider data as well as an all-in-one solution. GCHP selected Symplr as an all-in-one, integrated solution which provided equivalent software capabilities with improved process efficiencies, decreased implementation time, and lower total costs. Symplr offers features such as eApply, eSearch, and eStatus which support primary source verification, tracking and verifying the education, work history, licensing, renewals, affiliations and references, continuing education, expirations (licenses, insurance, boards, sanctions) and much more with the original source of a specific qualification. All of these functions have previously been supported manually. GCHP staff anticipate completing implementation of this new platform in February 2021.

After contract negotiations with Symplr were completed, a more accurate picture of annual maintenance, hosting, and implementation costs and variance from the original estimate has been obtained. The revised amount needed for the project is $343k for a new not-to-exceed

("NTE") total of $1,592,700 over 5 years. Of note, GCHP staff negotiated 200 hours of annual professional services at a significantly reduced rate resulting in a savings of approximately $88,000.

FISCAL IMPACT:

The revised projects costs will impact the FY2020-2021 budget with an additional $343,000.

The revised 5 year costs are as follows:

Contract Year	Revised Projected Amount
Year 1 - Licensing, Hosting, Implementation Fees	$ 1,078,600
Year 2 Hosting, Maint Fees, Addr Verif Svc	$ 104,000
Year 3 Hosting, Maint Fees, Addr Verif Svc	$ 110,600
Year 4 Hosting, Maint Fees, Addr Verif Svc	$ 114,000
Year 5 Hosting, Maint Fees, Addr Verif Svc	$ 117,500
Contingency 20% of new approval request amount (340k)	$ 68,000
	$ 1,592,700

RECOMMENDATION:

GCHP staff recommend the Commission approve and delegate to the CEO the authority to execute agreement amendments and/or change orders with Symplr with a new NTE amount of $1,592,700 for the duration of the five year agreement.

AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, M.D., Chief Medical Officer
Kim Timmerman, Director of Quality Improvement

DATE: October 26, 2020

SUBJECT: Quality Improvement Committee – 2020 Third Quarter Report

SUMMARY:

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 PowerPoint report contains a summary of activities of the QIC and its subcommittees.

APPROVAL ITEMS:

- 2019 QI Evaluation

FISCAL IMPACT:

None

RECOMMENDATION:

Staff recommends that the Ventura County Medi-Cal Managed Care Commission approve the 2019 QI Evaluation as presented and receive and file the complete report as presented.

ATTACHMENTS:

1) Timmerman, K., (2020). Quality Improvement, Ventura County Medi-Cal Managed Care Commission, Quality Improvement Committee Report – Q3 2020, Presentation Slides.

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Quality Improvement Committee Report – Q3 2020

October 26, 2020

Kimberly Timmerman, MHA, CPHQ
Director, Quality Improvement

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Quality Improvement Update

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QUALITY IMPROVEMENT ACTIVITIES

2019 QUALITY IMPROVEMENT EVALUATION

Approval Requested

HMS Eliza Member Outreach

Status Updates/Next Steps:

- HMS Eliza Member Outreach for gaps in care is on hold due to legal/TCPA concerns related to member consent.
- Affects IVR/robocalls and text messaging.
- Future gap outreach efforts and Education Campaigns (IVR + text) are pending organizational solution for obtaining member consent

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DHCS Preventive Care Outreach

Status Updates/Next Steps:

- The DHCS Preventive Care Outreach mandate will be addressed via a multi-modality approach including:
  - Member letter via direct mail
  - Collaboration with local health departments, school districts and community partners
  - Partnership with provider systems
  - Member/Provider newsletter communications
  - Website content
  - Well Care Member Incentive Program
- Focus on immunizations + lead screening in 0-6 years of age
- Target outreach completion by December 31, 2020

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Annual Quality Improvement Evaluation

- Comprehensive assessment of quality improvement activities undertaken
- Evaluation of areas of success and needed improvements in services rendered within the QI program
- Interdepartmental collaboration to achieve quality improvement goals
  - Quality Improvement
  - Health Services/Health Education
  - Network Operations
  - Compliance
  - Member Services
  - Grievances and Appeals
  - Pharmacy
  - Information Technology
- Analysis includes an assessment of performance to help drive the development of the subsequent QI Work Plan to ensure ongoing performance improvement

Return to Agenda

Objective 1: Improve Quality and Safety of Clinical Care Services

Objective 2: Improve Quality and Safety of Non-Clinical Care Services

Objective 3: Improve Member Safety

Objective 4: Assess and Improve Member Experience

Objective 5: Ensure Organizational Oversight of Delegated Activities

Return to Agenda

Practice Guidelines

Metric(s)	Outcome
• Guidelines approved by Medical Advisory Committee	Met
• Distribute guidelines to appropriate practitioners	Met
• Align PHG with Provider Manual and applicable policies	Met

Key Points:
- The guidelines were approved in 2019 and made available to practitioners through the GCHP website and the Provider Manual.
- The guidelines were incorporated into GCHP's updated policies.

Advanced Prevention: Tobacco Cessation

Metric(s)	Outcome
• 50% of identified smokers receive intervention	Partially met

Key Points:
- 100% of identified smokers were counseled but only 30% offered smoking cessation medication.

Return to Agenda

Advanced Prevention: Initial Health Assessment

Metric(s)	Outcome
• Increase rate of IHA completion by 5% compared to CY18	Met

Key Points:
- Increased rate of IHA completion by 7% from 40% (CY18) to 47% (CY19).
- The average provider compliance for IHA appointments is 91%.

HEDIS®/MCAS Measures: Postpartum Care

Metric(s)	Outcome
• Maintain 90th percentile performance	Met

Key Points:
- Postpartum care rate increased 9.29% points from 77.39% (2018 MY) to 86.86% (2019 MY) and the rate remained in the 90th national Medicaid percentile ranking.

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HEDIS®/MCAS Measures: Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)

Metric(s)	Outcome
• Increase rate by 3% over 2018 MY rate	Met
Key Points: • W34 rate increased 3.86% points from 74.73% (2018 MY) to 78.59% (2019 MY).	

HEDIS®/MCAS Measures: Childhood Immunization Status - Combo 10 (CIS-10)

Metric(s)	Outcome
• Meet or exceed the DHCS MPL (50th percentile)	Met
Key Points • The 2019 MY CIS-10 rate was 42.09% and met the 75th percentile.	

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HEDIS®/MCAS Measures: Children & Adolescents' Access to PCP (CAP)

Metric(s)	Outcome
• Increase rates by 3% in each age stratification over the previous MY	Not met

Key Points: Rates improved in all age groups

- CAP 12-24 months: increased 1.06% points from 94.43 2018 MY to 95.49% 2019 MY (25th percentile)
- CAP 2 - 6 years: increased 0.81% points from 86.82 2018 MY to 87.63 2019 MY (25th percentile)
- CAP 7 - 11 years: increased 2.02% points from 87.74 2018 MY to 89.76 2019 MY (25th percentile)
- CAP 12-19 years: increased 1.66% points from 85.17 2018 MY to 86.83 2019MY (25th percentile)

HEDIS®/MCAS Measures: Cervical Cancer Screening (CCS)

Metric(s)	Outcome
• Increase rates by 4% over previous measurement year	Met

Key Points:

- CCS rate increased 8.15% points from 56.08% (2018 MY) to 64.23% (2019 MY).

Return to Agenda

HEDIS®/MCAS Measure: Asthma Medication Ratio (AMR)

Metric(s)	Outcome
• Increase rates by 3% over previous MY	Not met

Key Points:
- AMR rate decreased 7.64% from 57.73% (2018 MY) to 50.09% (2019 MY).

HEDIS®/MCAS Measure: Well-Child Visits in the First 15 Months of Life (W15)

Metric(s)	Outcome
• Meet or exceed DHCS MPL (50th percentile)	Not met

Key Points:
- The 2019 MY W15 rate was 54.99% and met the 25th percentile.
- Barrier analysis revealed vendor did not retrieve/abstract all compliant medical records which caused W15 rate to be underreported.

Return to Agenda

HEDIS®/MCAS Measure: Adolescent Well Care (AWC)

Metric(s)	Outcome
• Meet or exceed DHCS MPL (50th percentile)	Met

Key Points:

- 2019 MY AWC rate was 58.15 and met the 50th percentile.

Quality Improvement Projects: Comprehensive Diabetes Care HbA1c > 9.0 (CDC-H9) 2017-2019 Health Disparity PIP

Metric(s)	Outcome
By June 30, 2019, decrease the clinic's CDC-H9 rate in the target population from 70.39% to 59.20%.	Not Met

Key Points

- Telephonic outreach & triage intervention was successful with increasing HbA1c testing.
- Barriers to decreasing overall HbA1c > 9.0 rates was making contact with members during outreach causing low percentage of members to be triaged.

Return to Agenda

Quality Improvement Projects: Child Immunization Status Combo 3 (CIS-3) 2017-2019 PIP

Metric(s)	Outcome
By June 30, 2019, increase the clinic's CIS Combo 3 rate by 10% points from 73.64% to 83.64%.	Not Met

Key Points

- Evaluating immunization at each clinic encounter helped increase immunizations administered and reduce the risk of missing immunizations before the child's 2nd birthday and improve coordination of care
- Barriers to improving immunization rates was lack of outreach staff to schedule well-care and immunization appointments.

Return to Agenda

Quality Improvement Projects: Asthma Medication Ratio (AMR) 2018-2019 DHCS IP

Metric(s)	Outcome
• Meet or exceed the DHCS MPL	Not Met

Key Points

- The 2019 MY AMR rate decreased 7.64% from 57.73% (2018 MY) to 50.09% (2019 MY).
- The Optum Rx intervention did help increase the AMR rate for the study population by 6.2% from 59.55% (240/403) to 65.75% (265/403).
- Feedback from CMH CFH on the Optum Rx provider outreach campaign is the faxes were being sent to the prescribing providers, who may not have been the patient's primary care provider.

Return to Agenda

Cultural & Linguistics Needs & Preferences

Metric(s)	Outcome
• Develop and implement of action plan to provide members with available resources to meet cultural, ethnic and linguistic needs.	Met

Key Points

- Network Operations continued to acquire languages spoken by practitioner and professionals including ethnicity.
- Health Education/Cultural Linguistics collaborate to ensure providers have resources to address the cultural, ethnic and linguistic needs of our members.

After Hours Availability

Metric(s)	Outcome
• Standards met for minimum of 90% of providers	Partially Met

Key Points

- Provider After Hours Availability:
  - PCPs: 2 of the 3 measure indicators met the 90% goal
  - Specialists: 2 of the 3 measure indicators met the 90% Goal
- Network Operations implemented interventions to monitor and address performance.
- No after-hours grievances reported in 2019.

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Primary and Specialty Care Access

- **Goal(s):**
  - **Primary Care**
    - Non-urgent primary care within 10 business days of request
    - Urgent care within 24 hours
  - **Specialty Care**
    - Non-urgent specialty care appointment within 15 business days
    - Non-urgent ancillary services within 15 business days

Metric(s)	Outcome
• Standards met for minimum of 90% of providers	Partially Met

Key Points

- 2 of the 8 primary/specialty survey indicators met the 90% goal and PNO continued to monitor and educate providers on access regulations.
- G&A monitored increase in grievances related to transportation issues and met regularly with the transportation vendor to address issues.

Return to Agenda

Network Adequacy

Metric(s)	Outcome
• Ratios of providers (PCP, NP, PA, etc.) to members • PCP located within 30 minutes or 10 miles • Core specialists located within 60 minutes or 30 miles • Hospitals located within 30 minutes or 15 miles	Met

Key Points
- All metrics met in 2019

Provider Satisfaction

Metric(s)	Outcome
• Development and implementation of action plan to improve.	Met

Key Points
- Provider satisfaction survey completed and 6 of the 7 survey indicators met the 80% benchmark goal.
- Developed and implemented interventions as needed to improve rates
  - PNO: JOMs, provider site visits, provider publications, new credentialing system
  - Call Center: Improved new-hire training process and ongoing training
  - Finance: JOMs, new claims system

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Facility Site Monitoring

Metric(s)	Outcome
• Completed FSRs and PARs 100% on time	Met

Key Points
- All FSRs and PARs were completed on time and reported to DHCS.
- G & A monitored grievances and reports PQIs to the QI Department.

Credentialing/Recredentialing

Metric(s)	Outcome
• 100% on Time	Met

Key Points
- Credentialing files are process according to NCQA/DHCS and GCHP policy standards and no issues were found during the 2019 DHCS and internal Compliance audit.
- All credentialing, re-credentialing and sanctioning reviews were completed 100% on time.

Return to Agenda

Pharmacy

Metric(s)	Outcome
• Reduce rate by 5% from prior year metrics	Met

Key Points:
- 9.8% decrease in total opioid utilizers from 2018Q4 to 2019Q4
- 12.9% decrease in number of users who use benzodiazepines concurrently
- 7.3% increase in number of users who use prenatal vitamins concurrently

Call Center Monitoring

Metric(s)	Outcome
• ASA: 30 seconds or less • Abandonment Rate: 5% or less	Met

Key Points
- Call Center member survey satisfaction rate: 97.01%
- ASA and abandonment rates met every month in 2019
  - Average ASA: 13 seconds
  - Average abandonment rate: 0.62%

Return to Agenda

Delegation Oversight

Metric(s)	Outcome
Complete 100% oversight of all delegated activities.	Met

Key Points

- Delegation oversight completed quarterly for all delegated activities
- CAPs issued were monitored for completion.

Return to Agenda

2019 QI Work Plan Evaluation Summary

Objective 1: Improve Quality and Safety of Clinical Care Services

7/14 (50%) Objectives Met Goals

- **Key Successes:** IHA, Postpartum Care, W34, Childhood Immunization, Cervical Cancer Screening, Adolescent Well Care
- **Areas for continued improvement:** Tobacco Cessation, Asthma, W15

Objective 2: Improve Quality and Safety of Non-Clinical Care Services

5/5 (100%) Objectives Met/Partially Met Goals

- **Key Successes:** Cultural/Linguistics services, Network Adequacy, Provider Satisfaction
- **Areas for continued improvement:** Primary Care and Specialty Care access (after hours, appt availability, wait times, average call back time)

Return to Agenda

2019 QI Work Plan Evaluation Summary

Objective 3: Improve Member Safety

3/3 (100%) Objectives Met Goals

- **Key Successes:** Facility Site Monitoring, Credentialing timeliness and ongoing monitoring, Reduction in Unsafe Opioid Use

Objective 4: Assess and Improve Member Experience

1/1 (100%) Objectives Met Goals

- **Key Successes:** Call Center Member Satisfaction, ASA, abandonment rates

Objective 5: Ensure Organizational Oversight of Delegated Activities

1/1 (100%) Objectives Met Goals

- **Key Successes:** Timely audits and CAP monitoring

Return to Agenda

Questions?

Recommendation:

Approve the 2019 QI Program Evaluation

Return to Agenda

AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Margaret Tatar, Chief Executive Officer

DATE: October 26, 2020

SUBJECT: Chief Executive Officer Report

SUMMARY: Verbal Update.

Government and Community Relations Update:

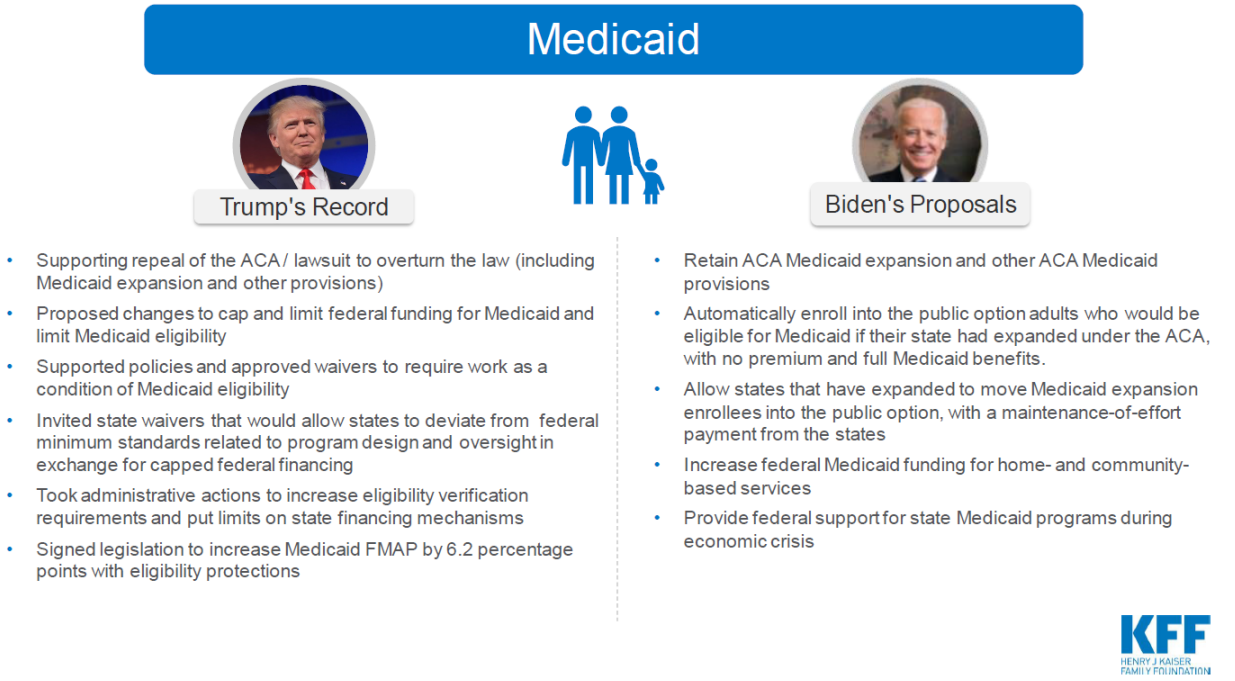
Federal Update:

Presidential Election and What it Could Mean for the Medicaid Program

As the presidential election nears, there are several issues we are all tracking for various reasons, such as: the appointment of a new Supreme Court Justice, immigration, education, workforce, COVID-19 response, criminal justice reform, gun violence, healthcare and many others. As experts have said, this is one of the most critical elections of our time.

Of interest at Gold Coast Health Plan (GCHP), is the presidential candidates' stance on health care issues, specifically, the Medicaid program. The Affordable Care Act (ACA) allowed approximately 60,000 Ventura County residents (childless adults between the ages of 19-64 years) to qualify for the Medi-Cal program because of the Adult Expansion provision. Over 200,000 Ventura County residents have Medi-Cal coverage. Therefore, the Medicaid program is vital as it provides health care coverage to our most vulnerable populations.

Per the Kaiser Health Foundation, President Trump supported the repeal of the Affordable Care Act (ACA), proposed changes to Medicaid funding by instituting Block Grants and limit Medicaid eligibility, made changes to immigration policy to restrict entry of individuals who are likely to use Medicaid and certain other public programs. Joe Biden, former Vice President, supports retaining and strengthening the ACA and creating a new public option, proposes maintaining the ACA Medicaid expansion, and provides the option to enroll in Medicare at age 60. Below you'll find a side by side comparison on the presidential candidates' positions regarding the Medicaid program.



For a complete health comparison analysis from the Kaiser Family Foundation click here.

At the December 15, 2020 strategic meeting we will have an in-depth discussion on the potential impact the outcome of the election will or could have on the Medicaid program, Gold Coast Health Plan, and Ventura County.

California Legislative Update:

As indicated last month, Governor Newsom had until September 30, 2020 to sign or veto the legislative bills put forth by the California Legislature at the end of the Legislative Session. Below is the status of the legislative bills discussed at the September Commission meeting.

The next step is for GCHP to work with the Department of Health Care Services (DHCS) on implementing the approved legislative bills, that will impact GCHP, in 2021.

Number	Author	Name	Description	Analysis	Governor's Action
AB 2360	Maienschein	Telehealth: Mental Health	This bill requires health care service plans and health insurers to establish a telehealth mental health consultation program by July 1, 2021, that provides contracted providers who treat children and persons who are pregnant or up to one year postpartum with	The Department of Finance is opposed to this bill as it results in costs not included in the 2020 Budget Act.	Vetoed

Number	Author	Name	Description	Analysis	Governor's Action
			access to mental health consultation services.		
AB 890	Wood	Nurse Practitioners : Scope of Practice	Effective January 1, 2023, authorizes Nurse Practitioners to provide specified services and in specified settings, if certain educational and training requirements are met. It also establishes the Nurse Practitioner Advisory Committee within the Board of Registered Nursing; requires the Board to develop a test for independent practice competency; and establishes physician consultation and other oversight requirements.	AB 890 addresses California's workforce challenges by creating a new category of licensed nurse practitioners and expands their scope of practice under certain conditions. Specifically, the bill permits a nurse practitioner with a certification from a national certifying body to perform specific functions, without supervision by a physician and surgeon in settings such as clinics, medical group practices, and health care agencies.	Approved
SB 803	Beall	Mental Health Services: Peer Support Services Certification	The bill requires the Department establish standards for peer support specialists that counties may use in developing local peer certification programs. Counties that opt to participate in the program must fund the non-federal share of peer support services. The bill requires the Department seek federal approval for the pilot program.	The California Department of Finance opposes this bill as it results in significant General Fund costs not included in the 2020 Budget Act and General Fund costs annually thereafter for DHCS to develop and implement a peer support specialist certification program, seek the necessary federal approvals to amend the Medicaid state plan, and reimburse counties pursuant to Proposition 30.	Approved

Number	Author	Name	Description	Analysis	Governor's Action
				Supporters argue peer providers use their lived experience with mental illness, addiction, and recovery, coupled with skills learned through formal training to provide invaluable behavioral health services. The sponsors also point out that research demonstrates that peer support specialists reduce hospitalizations and hospital days, improve client functioning, increase client satisfaction, reduce family concerns, alleviate clinical symptoms, and increase client self-advocacy.	
AB 2276	Reyes	Medi-Cal: Blood Lead Screening tests	Specifically, it requires providers seek a signed statement of voluntary refusal to be included in the medical record when the recommended screening is refused by the parent/guardian. It also requires that plans identify all children who have missed a recommended blood lead screening on a quarterly basis and notify the responsible provider (rather than identification of children under 6 years of age, which is consistent with Title 17 guidelines testing).	DHCS and CDPH are developing a statewide blood lead screening monitoring and identification system for children enrolled in Medi-Cal. DHCS is in the process of securing enhanced federal funding for this effort. A statewide system would likely be less costly than having each of Medi-Cal's 29 managed care plans develop a separate system. Additionally, a statewide system would be more effective as beneficiaries frequently move	Approved

Number	Author	Name	Description	Analysis	Governor's Action
				between managed care plans.	

Community Relations:

Sponsorships

From the beginning of the COVID-19 pandemic GCHP's sponsorship program has been focused on supporting our community and members with their social needs. This past month, GCHP awarded sponsorships to organizations assisting families with school supplies, food, clothing, and free flu vaccinations, to name a few. Below are tables summarizing GCHP efforts. In the first quarter of the fiscal year, GCHP has awarded $18,200 to community-based organizations providing essential services to our members and the community at large.

The table below is a summary of the sponsorships awarded in August and September:

Name of Organization	Description	Amount
Promotoras y Promotores Foundation	Promotoras y Promotores Foundation "Conexion", provide ongoing emotional support to the Latinx population in the Santa Clara Valley. This sponsorship will provide computers to participants for virtual support group sessions.	$2,500
Future Leaders of America (FLA)	Future Leaders of America provides leadership training, educational experiences, and promotes the personal development of youth and families. Through this sponsorship FLA will continue funding programs in addition, they're hosting their 7th Annual "El Reencuentro" to raise funds.	$1,000
Oxnard Union High School District	Oxnard Union High School District (OUHSD) Career Education Department is currently preparing to apply for the California Technical Education Incentive Grant (CTEIG) and K12 Strong Workforce Program (K12 SWP) for the 2020/2021 school year. The primary goal of these grants is to prepare students for the workforce and to improve the local economy.	Letter of Support
Santa Paula Latino Town Hall	Santa Paula Latino Town Hall is dedicated to working to enhance, promote, mobilize, cultivate, and raise the level of social awareness in the Latino community of Santa Paula. The sponsorship will go towards funding the 24th Annual "Community Awards Celebration" and support local food pantries and food shelters.	$1,000

In-Kind Donations

The Covid-19 crisis continues to challenge vulnerable populations in our community. GCHP has received multiple requests from community partners asking for in-kind donations. In response, GCHP has donated over 3,000 items to community-based organizations. Below you can find more information.

Name of the Organization	Description	Promotional Item total 3,550
Oxnard Police Activities League	The Oxnard Police Activities League hosted their annual Backpack Giveaway K -12 for low income families. Students received school supplies and resources. GCHP provided an in-kind donation to further allow for more students to have the necessary supplies for school.	150 Pens
		150 Pencils
		150 Pencil Pouches
		300 Coloring Books
		300 Crayons
Police Activities League Southwinds Neighborhood Council Backpack Giveaway	The Oxnard Police Activities League in collaboration with the Southwinds Neighborhood Council hosted their annual backpack giveaway to support the Southwinds community in the city of Oxnard.	150 Pens
		150 Pencils
		150 Pencil Pouches
		300 Coloring Books
		300 Crayons
Cesar Chavez Elementary School	The community relations team in collaboration with the Employee Activities Committee (EAC) provided in-kind donations to underserved children. Children received school materials like pencils, pens, crayons, and coloring books. Additionally, GCHP staff donated personal undergarments for children and school supplies.	150 Pens
		150 Pencils
		150 Pencil Pouches
		300 Coloring Books
		300 Crayons
Good Farms	As farmworkers continue to work under extreme conditions with limited resources, GCHP collaborated with Good Farms to provide farmworkers with cooling towels and water bottles to keep farmworkers hydrated and cool during the heatwave.	200 Water Bottles
		200 Cooling Towels

Community Meetings

The Community Relations team continues to participate in collaborative meetings, community town hall meetings, and trainings via virtual platforms. Through these avenues the team can gage the community/ member needs, learn about community organizations that assist low-income families, and engage with community partners. Below you can find more information about the meetings attended:

Name of Meeting	Date	Description
Oxnard Police Department Outreach Coordinators meeting (recurring monthly meeting)	August 5,2020 September 2,2020 October 7,2020	The Oxnard Police Department hosts this collaborative meeting. Community partners share resources, promote outreach events, and bring presenters to educate participants. The goal is to bring community awareness and resources to Ventura County residents.
Circle of Care (recurring monthly meeting)	August 5,2020 September 2, 2020	One Step A La Vez hosts this meeting on a monthly basis to engage community leaders, share resources, network, and promote community events. The goal of this collaborative meeting is to better serve the Santa Clara Valley.
Tele Town Hall: Conversation with Secretary of State Alex Padilla, Senator Hannah-Beth Jackson, Assembly member Monique Limon, and Congressman Salud Carbajal	August 12, 2020	California representatives discussed the importance of participating in the 2020 Census and the impact the Census has on public services. Additionally, the group answered questions from the public regarding voting. As a note, GCHP included census information in the recent Member Newsletter.
Building Community Safety Training (three-week training one day a week for 2 hours)	September 16,2020 September 23,2020 September 30,2020	The Urban Peace Institute in collaboration with City Impact and the Oxnard Police Department hosted a three-week training for community workers. The training educated participants on how to conduct outreach and communicate with individuals that live in communities with a heavy gang presence.
Multi-Unit Smoke -Free Task Force	September 17, 2020	The task force is responsible of engaging the community to create a smoke free environment in multi-unit housing in the City of Oxnard.
Ventura County Action on Smoking Collation	September 24,2020	A coalition formed by community partners to share resources, ideas on ways to help prevent and reduce smoking in Ventura County.

Delegation Oversight

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 subcontractor
- Conducting onsite audits
- Issuing a Corrective Action Plan (CAP) when deficiencies are identified

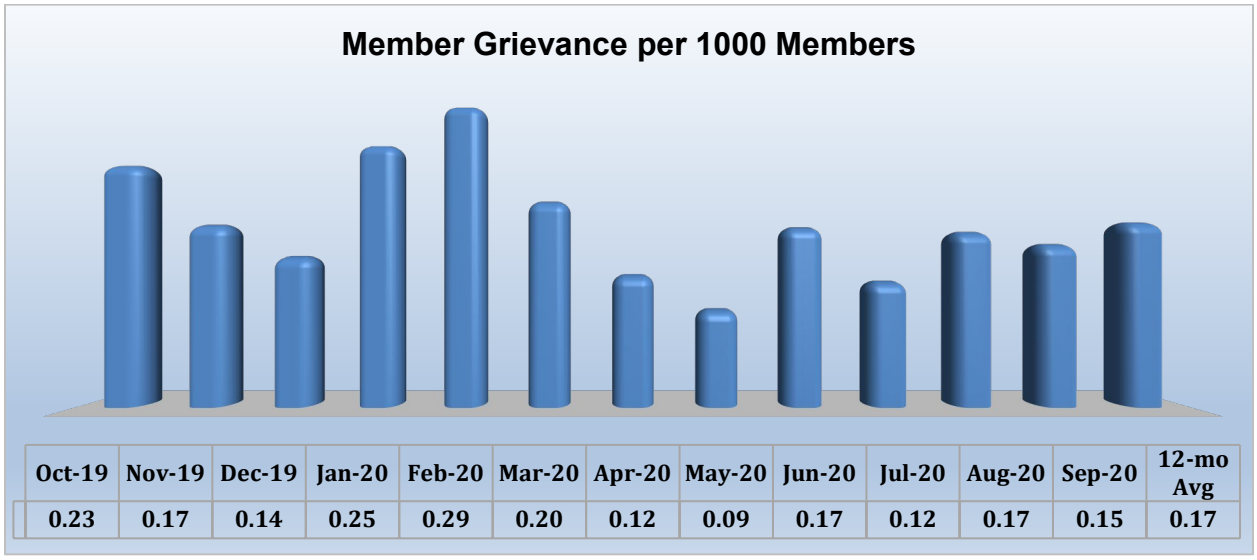
**Ongoing monitoring denotes delegate is not making progress on a CAP issued and/or audit results were unsatisfactory and GCHP is required to monitor the delegate closely as it is a risk to GCHP when delegates are unable to comply.*

Compliance will continue to monitor all CAPs. GCHP's goal is to ensure compliance is achieved and sustained by its delegates. It is a DHCS requirement for GCHP to hold all delegates accountable. The oversight activities conducted by GCHP are evaluated during the annual DHCS medical audit. DHCS auditors review GCHP's policies and procedures, audit tools, audit methodology, and audits conducted, and corrective action plans issued by GCHP during the audit period. DHCS continues to emphasize the high level of responsibility Plans have in oversight of delegates.

Delegate	Audit Year/Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Conduent	2017 Annual Claims Audit	Open	12/28/2017		Issue will not be resolved until new claims platform conversion
Kaiser	2019 Annual Claims Audit	Closed	9/23/2019	06/23/2020	CAP items resolved and audit closed 06/23/2020
VTS	2019 Annual Call Center Audit	Open	4/26/2019	10/7/20	
VSP	2019 Annual Claims Audit	Open	10/29/2019	Under CAP	Pending discussion with Claims Department
Conduent	2019 Call Center Audit	Closed	1/14/2020	05/15/2020	CAP Item resolved and audit closed 05/15/2020
Beacon	2020 Annual Claims Audit	Open	04/21/2020	Under Cap	

Delegate	Audit Year/Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Beacon	2020 Annual QI, UM, Member Rights and C&L	Closed	8/25/2020	9/16/2020	
Conduent	2020 Annual Claims Audit	Open	04/21/2020	10/7/20	
Kaiser	2020 Annual Claims Audit	Pending	10/9/20		Awaiting documents from Kaiser regarding payment error disclosures
VTS	2019 Annual Transportation Audit	Closed	1/17/2020	06/15/2020	CAP items resolved and audit closed 06/15/2020
USC	2020 Annual Credentialing Recredentialing Audit	Closed	04/09/2020	06/22/2020	CAP items resolved and audit closed 06/22/2020
VTS	2019 Annual NEMT Audit	Closed	4/21/2020	06/15/2020	CAP items resolved and audit closed 06/15/2020.
VTS	2020 Call Center Audit	Open	05/14/2020	Pending	Audit was conducted on March 30, 2020.
City of Hope	2020 Annual Credentialing Recredentialing Audit	Closed	07/08/2020	07/28/2020	CAP items resolved and audit closed on 07/28/2020
CHLAMG	2020 Annual Credentialing Recredentialing Audit	Closed	N/A	N/A	Completed on 7/21/2020. No findings.
CSMCF	2020 Annual Credentialing Recredentialing Audit	Closed	NA	NA	Audit conducted on July 31 and Aug 3 with no findings.

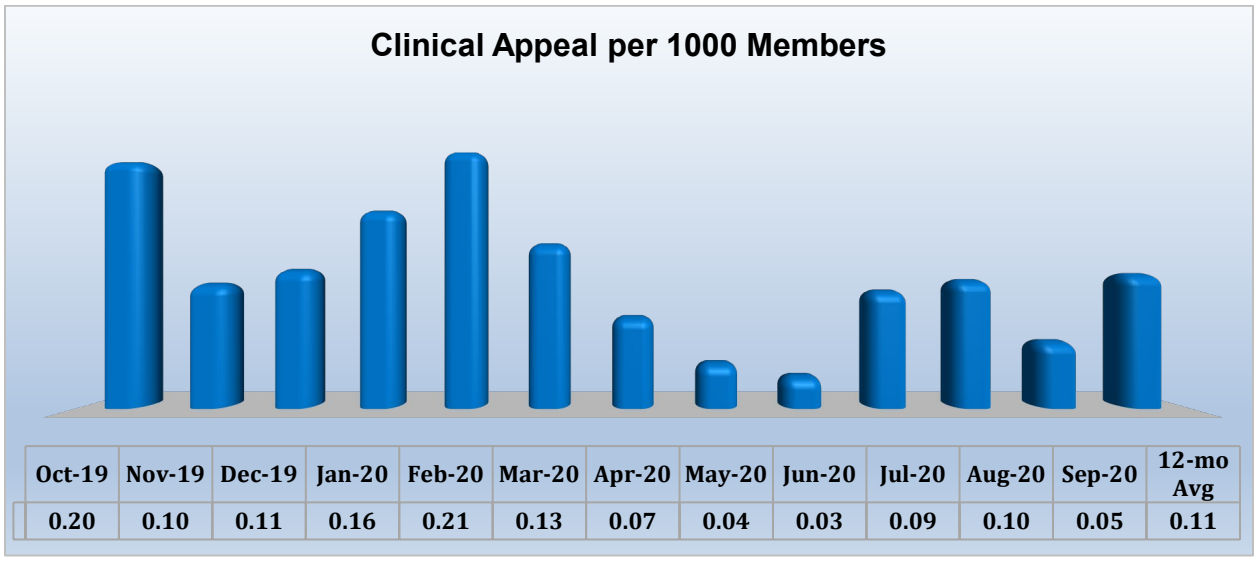
Grievance and Appeals



Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	12-mo Avg
0.23	0.17	0.14	0.25	0.29	0.20	0.12	0.09	0.17	0.12	0.17	0.15	0.17

Graph displays an ongoing review of the volume of member grievances based on the monthly population by 1000 members enrolled. The data showed that GCHP volume is low in comparison to the number of members enrolled with the plan. The 12-month average of enrollees is 195,252, with an average annual grievance rate of 0.17 grievances per 1000 members.

In September, there were total of 32 member grievances. The top reason is quality of care which resulted from a delay in care.



Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	12-mo Avg
0.20	0.10	0.11	0.16	0.21	0.13	0.07	0.04	0.03	0.09	0.10	0.05	0.11

Graph displays an ongoing review of the volume of clinical appeals based on the monthly enrollment population calculated per 1000 members. The data comparison volume is based on the 12-month average of 0.11 appeals per 1000 members.

There was a total of 11 Clinical appeals received in the month of September. Two (2) were overturned, 2 upheld, 6 still in review and 1 withdrawn.

System Conversion / HSP MediTrac Update

Enterprise Transformation Project (ETP) is a full replacement of the IKA core claims system with HSP MediTrac with a scheduled go-live date of December 14, 2020.

The 2 ETP project risks are:

1. Making sure that we migrate the new HSP MediTrac data to the current data structure. We are currently working to make sure that the data coming in from the new system will allow us to be able to produce the existing internal and external data exchange and reports.
2. Thorough testing is a critical component for the claims system migration. Conduent and Gold Coast teams are currently conducting User Acceptance Testing. Testing has been trending behind in some critical functional areas, but we have a plan to resolve this risk.

We are actively mitigating these risks by:

1. Having daily management calls with Conduent so that we can closely monitor progress, continue to make progress daily and to be able to remove any barriers that may exist.
2. Conduent has staffed an open a daily conference call line so that the Gold Coast team can ask questions on testing and functionality so there is no delay in getting these questions answered.

The providers will see some changes as we implement the new HSP MediTrac system. We have created a Provider Resource Guide which outlines these changes. This Guide was reviewed with PAC during the September 8 meeting. We received feedback at that time and have incorporated that feedback into the revised guide. The Guide was reviewed again at the October 13 PAC meeting. The Provider Resource Guide will be posted to the Gold Coast provider section of the website. We have also started to review the Provider Resource guide through educational and training webinars will start in October and continue into November.

We have started testing our encounter data with DHCS and this testing will be completed by the end of October.

Network Operations

- **PCP- Member Mix- Refer to Attachment A**

- **AmericasHealth Plan (AHP) Pilot**
  - Gold Coast Health Plan (GCHP) received approval from DHCS on the Plan-to-Plan Contract on 9/23/2020.
  - DHCS approval letter reflected GCHP's and AHP's regulatory obligations to oversee and ensure contractual, sub-contractual and payment compliance. These items cited in the approval letter will be included in an amendment to the Plan-to-Plan agreement, which has been drafted and is currently under review.

- The Readiness Review is in process.

➢ **Regulatory:**

Completed:

- File and Use Provider Directory submitted timely-09/03/2020
- New enhancement to GCHP website availability of Online PDF Provider Directory on a monthly update as of 09/03/2020.
- Bi-Annual Provider Directory approved by DHCS on 09/03/2020 and sent to Print and Fulfillment
- Business check out Per Monthly Data Check Report 9/23/2020 received for September submission indicated "Pass" for all data performance measures:
    - Minimal data corrections for Provider Network Database (PNDB)
    - Metric for "Submission of Timeliness" did not pass. This due to inaccurate file submission from one of our vendor providers. Issue is in process of remediation and resolution.

In Process:

274 Provider Data:

- New Site Telehealth Indicator deployed on PNDB as well as changes to data selections according to DHCS requirements for 274:
    - Revising requirements per DHCS notifications
    - Strategic planning on obtaining current telehealth information using new data values
- Joint Operation Meetings
- Provider Operations Bulletin
- Review requirements of expansion of Provider Foreign Languages Spoken at the Site and by individual providers
- Additional validation report review
- Meeting with Beacon to address 274 file submission issues and to establish a remediation plan
- Monthly Data Corrections

➢ **COVID-19 Provider Outreach and Communication**

The Network Operations team continues to reach-out to providers regarding any COVID-19 related impacts on provider operations and member access. Given the change in tier status of the County, the Network team has modified its outreach efforts to the three provider segments listed below. The Provider Communications Workgroup continues to meet on a regular basis and provides timely and helpful updates to our network providers.

Provider Outreach is conducted twice a week by email and phone to determine closures or impact due to the Coronavirus:

- Skilled Nursing Facility (SNF) & Long-Term Care (LTC)
    - Reporting occasional outbreaks of COVID-19 among patients and staff at some facilities

- Some facilities continue to report they have no SNF/LTC bed availability, or they are not taking new admissions
- Due to the above, GCHP expects to see delays in hospital discharges, which will result in increases in admin/placement days

- Home Health- no issues
- Hospice- no issues

➢ **Provider Contracting Update:**

New Contracts

- BioMotion Physical Therapy – Physical Therapy contract for an office in Moorpark. East County needs additional resources, so this contract filled a network gap
- Raymond Lopez, MD – a new PCP contract for Family Practice physician in Oxnard

Amendments

Provider Contracting sent out a total of 7 Amendments for this time period. Amendments returned and completed are:

- County of Ventura Interim LOA (2)
  - Addition of 6 providers onto Interim LOA as they have recently applied for Medi-Cal enrollment
  - Termination of 5 providers from Interim LOA as they have recently been approved for Medi-Cal enrollment and can be added to the monthly VCMC roster for loading
- Palms Imaging Medical Group
  - Addition of new location in Moorpark
- Two Trees Physical Therapy & Wellness
  - Addition of 11 therapist onto Interim LOA while they are pending credentialing
- Amigo Baby Therapy Services
  - Addition of 10 therapist onto Interim LOA while they are pending credentialing
- Ventura Care Partners, APC
  - Addition of new practicing location at SNF facility
- Advantage Physical Therapy
  - Termination of Amendment Two where Interim LOA was added to the contract. The 2 physicians that were on the Interim LOA have since been Medi-Cal enrolled and added to the network through the contract in place with Advantage Physical Therapy.

Interim LOA

- Renaissance Imaging Medical Associates
  - Interim LOA in place for 25 radiologist that are currently pending credentialing. Credentialing is being delayed due to COVID-19.
- California Managed Imaging Medical Group
  - Interim LOA in place for 3 radiologist that are currently pending credentialing. Credentialing is being delayed due to COVID-19.
- Cassandra Woods-Pierce dba Children's Therapy Network Inc

- Interim LOA in place for 4 radiologist that are currently pending credentialing. Credentialing is being delayed due to COVID-19.

LOA

Provider Contracting sent a total of 25-member specific LOAs during this time period. LOAs returned and completed are:

- 9 Amigo Baby LOAs
- 1 Aspen Surgery Center LOA
  - Leg Tendon Surgery
- 2 Accredo Health LOAs
  - LOA for infusion supplies
- 2 Valley Grace Home LOAs
  - 1 LOA for SNF Level II – homeless member with no discharge plan denied by in-network SNF and Congregates due to no beds available
  - 1 LOA for SNF Level III – homeless member requiring 24/7 sitter at bedside, unsteady and wandering denied by in-network SNF and Congregates due to no beds available
- 1 Caremark, Inc. LOA
  - Infusion supplies/maintenance
- 2 Conejo Valley Healthcare LOAs
  - Long Term Care – both members are Medi/Medi admitted without request for authorization
- 1 Country Villa East LOA
  - 1 LOA for SNF Level IV – member tested positive for COVID-19 and required isolation
- 1 Neighbor Care Congregate Home LOA
  - 1 LOA for SNF Level II – new GCHP member effective 9/1/2020 was already at facility with previous insurance through LOA
- 1 Rancho Los Amigos LOA
  - 1 LOA for rehabilitation visit CPT Code 99214
- 1 Sherman Oaks Congregate LOA
  - 1 LOA for Long Term Care Level 1 – noncompliant member requiring 24/7 sitter
- 2 Shobana Gandhi, MD LOA
  - 2 LOAs for outpatient physician services for high-risk pregnancy
- 1 UCSF Medical Center LOA
  - 1 LOA for outpatient diagnostic procedures
- 1 Valley Grace Home Congregate LOA
  - 1 LOA for SNF Level II – homeless member denied by in-network facilities due to leaving AMA

Projects:

- LTC/SNF Amendments – Draft and save cover letters associated with amendments

- **Better Doctors:**
  Network Operations continues to meet weekly with Quest Analytics as a touch base to ensure that the process continues to move smoothly. We also continue to verify the demographic information obtained from Better Doctors. The following reviews were performed:

  - 363 Audited

- **Provider Contracting and Credentialing Management System (PCCM)**
  - Implementation moved to February 2021
  - HSP MediTrac Provider Activities
    - Provider Communications and Webinars
    - Provider Data Validation
      - Contract and rates
      - Demographic information

- **Provider Database Clean-up Project:**
  Plan leadership has postponed the implementation of this project until CY 1st Quarter. The reasoning behind this pertains to the need to focus on the implementation of the HSP system (ETP) and communication efforts to providers.

  The Network team will continue to participate in bi-weekly meetings with GCHP and Symplr staff to discuss and make decisions required to support the eVIPs conversion and process configuration as we move to implementation. This project includes the review and updating of the Provider Relations Shared Drive. It also includes the testing of the eVIPs system to ensure that information transfer from GCHP systems is accurate in the eVIPs system setup.
  - Team began Iteration 9 testing. Estimated 52 Test Cases, 7,291 Test Scripts
  - Review of reference documents to eVIPs and current provider database. Also, reviewing and analyzing multiple reports to ensure required data elements identified for conversion into the new PCCM database.
  - Taxonomy provider data updated-1,695 records completed

- **Enterprise Transformation Project (ETP)**
  To assist providers in identifying changes to the system, GCHP created a tool, the Provider Resource Guide, to assist providers in identifying and navigating changes. The Provider Advisory Committee reviewed and provided feedback on the Provider Resource Guide. Webinar based provider training begins October 1, 2020.

  - Benefits of the Provider Resource Guide
    - The Provider Resource Guide provides a single document to identify changes. Publishing of the guide is expected to occur by the end of October 2020
    - The Provider Advisory Committee has reviewed a draft of the document. Some of the changes will be incorporated into the Provider Manual.

- Example of Changes:
  - Some GCHP assigned provider numbers will change.
  - Provider Portal will require new provider accounts and logons
  - Claim Adjudication and Claims Submission

➢ **Provider Additions and Terminations**

- **Provider Additions: September 2020 Provider Additions – 53 Total**

10 In-Area Providers

Provider Type	Additions
Midlevel	1
Specialist	7
Specialist- Hospitalist	2

43 Out-of-Area Providers

Provider Type	Additions
Midlevel	6
Specialist	36
Specialist- Hospitalist	1

- **Provider Terminations: September 2020 Provider Terminations – 3 Total**

3 In-Area Providers

Provider Type	Additions
PCP	1
Specialist	1
Midlevel	1

0 Out-of-Area Providers

Provider Type	Additions
PCP	0
Specialist	0
Midlevel	0

These provider terminations have no impact on member access and availability. Of note the specialist terminations are primarily associated with tertiary adult and pediatric academic medical centers, where interns, residents, and fellows have finished with their clinical rotations.

ATTACHMENT A- MEMBER MIX

	VCMC	CLINICAS	CMH	PCP-OTHER	DIGNITY	ADMIN MEMBERS	UNASSIGNED	KAISER
Sept-20	81,887	40,180	30,639	5,711	5,584	37,033	4,005	5,886
Aug-20	81,108	39,776	30,326	5,680	5,454	35,297	4,141	5,814
Jul-20	79,862	39,146	29,849	5,632	5,299	36,039	4,160	5,693

Notes:

- The July 2020 Admin Member numbers will differ from the below member numbers as both reports represent a snapshot of eligibility.
- Unassigned members, assigned to COHS, are ones who have not been assigned a PCP and have 30 days to choose one. If the member does not choose a PCP, GCHP will assign member to a PCP.

ADMIN MEMBERS DETAILS

	JULY 2020	AUG 2020	SEPT 2020	OCT 2020
Total Administrative Members	35,955	36,334	36,717	37,220
Share of Cost	2,656	2,634	2,608	2,564
Long Term Care	884	887	875	866
BCCTP	88	88	89	88
Hospice (REST-SVS)	30	29	25	27
Out of Area (Not in Ventura)	502	529	559	517
Other Health Care				
DUALS (A, AB, ABD, AD, B, BD)	24,309	24,457	24,678	24,830
Commercial OHI (Removing Medicare, Medicare Retro Billing and Null)	11,124	18,672	11,393	19,253

Notes:

- Total in boxes will not add up to distinct count that corresponds to the total admin members as members can be represented in multiple boxes. For example, a member can be both Share of Cost and live Out of Area. They are counted in both of those boxes**. However, though a member may be represented in multiple boxes, the member is only counted as one Administrative member.**
- Share of Cost (SOC): Membership numbers will change dependent on a member's use services. SOC members are only counted in months services are rendered.
- Hospice: Membership will vary as members pass away.
- Other Health Care (OHC): OHC is validated on a monthly basis and numbers will vary.

- Medi-Medi: Participation is validated on a monthly basis and numbers will vary.

RECOMMENDATION:

Receive and file the report.

AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: October 26, 2020

SUBJECT: Chief Medical Officer Report

California Health Care Foundation: Listening to Californians with Low Incomes

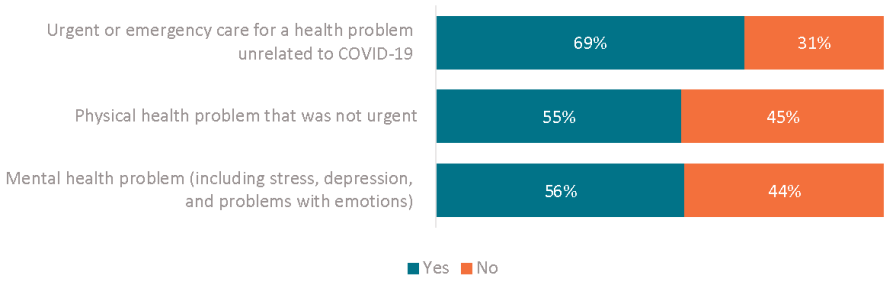
On October 8, 2020, California Health Care Foundation ("CHCF") published preliminary findings from a report on health care experiences of residents with low income during the pandemic. CHCF worked with NORC at the University of Chicago, a national research organization, to interview approximately 2,000 low-income Californians aged 18 to 64 about their health care concerns, experiences and access to care before and during the pandemic, experiences with racial discrimination, and the impact of the public emergency on employment and insurance coverage.

The full report is expected to be published early in 2021. The preliminary report is available at: https://www.chcf.org/wp-content/uploads/2020/10/ListeningCaliforniansLowIncomes.pdf

Key findings from the report include:

- Many respondents did not receive wanted care.

Figure 3. Many Respondents Did Not Receive Care for Their Health Problems Since the Start of the Pandemic
Q: SINCE THE START OF THE COVID-19 PANDEMIC, DID YOU RECEIVE CARE FOR YOUR . . .



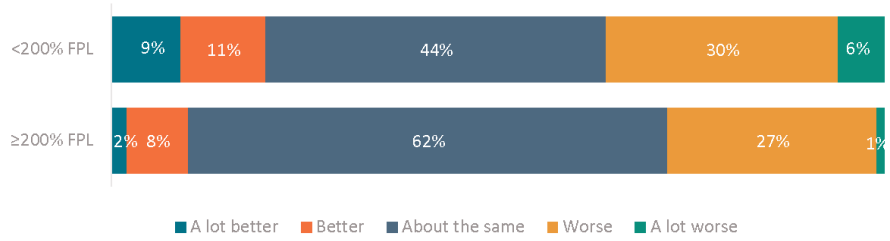
Notes: Survey conducted by NORC at the University of Chicago between June 24 and August 21, 2020. Respondents limited to California residents age 18 to 64 who saw a doctor or other health care professional since March 2019.

Listening to Californians with Low Incomes: Health Care Access, Experiences, and Concerns Since the COVID-19 Pandemic
CALIFORNIA HEALTH CARE FOUNDATION, OCTOBER 2020

- Mental Health has deteriorated since the pandemic.

Figure 6. Respondents with Low Incomes More Likely to Report Mental Health Got Worse Since Pandemic
Q: SINCE THE START OF THE COVID-19 PANDEMIC, HOW, IF AT ALL, HAS YOUR MENTAL OR EMOTIONAL HEALTH CHANGED? IS IT . . .

BY INCOME



Notes: Survey limited to California residents age 18 to 64 who saw a doctor or other health care professional since March 2019. $p < .01$ for differences between income groups.

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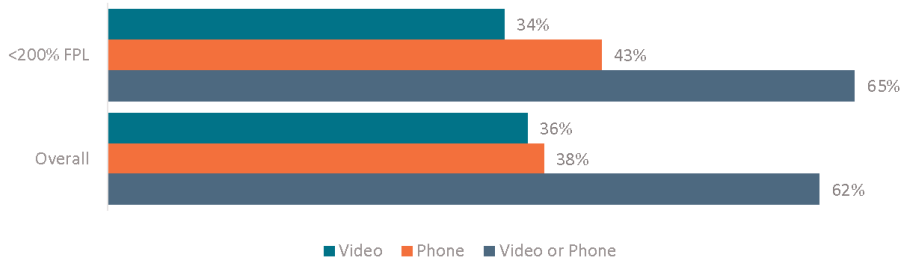
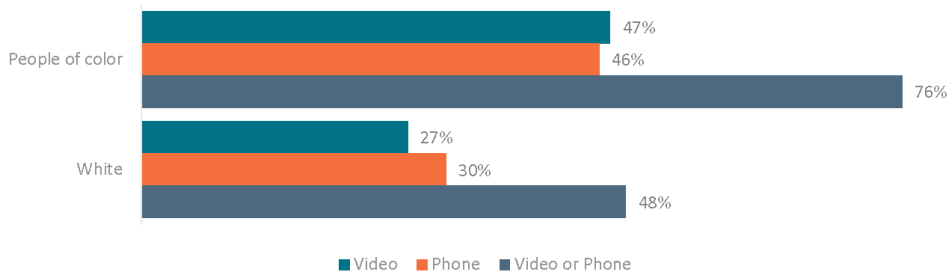
- Telehealth was an important source of care for all respondents.

Figure 12. Telehealth an Important Source of Care for All Respondents
PERCENTAGE WHO REPORTED RECEIVING CARE. . .

BY INCOME



BY RACE/ETHNICITY



Notes: Survey conducted by NORC at the University of Chicago between June 24 and August 21, 2020. Respondents limited to California residents age 18 to 64 who saw a doctor or other health care professional since March 2019. People of color include Asian, Black, Latinx, multiracial, and "other" race respondents. $p < .01$ for differences between people of color and White for video or phone.

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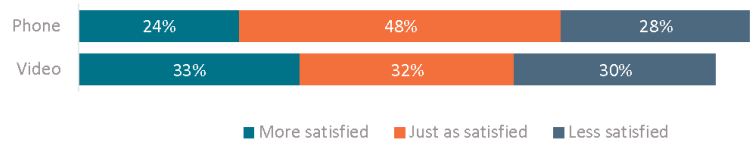
- There were high levels of satisfaction with the telehealth experience.

Figure 15. High Levels of Satisfaction with Phone and Video Visits Compared to In-Person Visits
Q: HOW SATISFIED WERE YOU WITH YOUR PHONE OR VIDEO VISIT COMPARED TO YOUR LAST IN-PERSON VISIT?



Notes: Survey conducted by NORC at the University of Chicago between June 24 and August 21, 2020. Respondents limited to California residents age 18 to 64 who saw a doctor or other health care professional since March 2019. Figures may not sum due to rounding or skipped responses.

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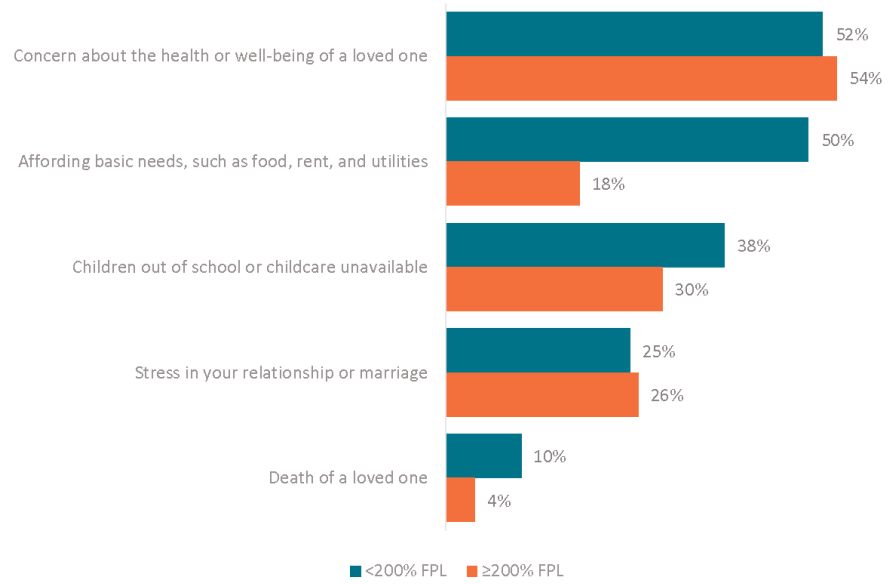
- Low income respondents reported higher levels of stress.

Figure 18. Half of Respondents Report Stress Related to Concern About the Health or Well-Being of a Loved One
Q: WHICH OF THE FOLLOWING STRESSES, IF ANY, HAVE YOU EXPERIENCED AS A RESULT OF THE COVID-19 PANDEMIC?



Notes: Survey conducted by NORC at the University of Chicago between June 24 and August 21, 2020. Respondents limited to California residents age 18 to 64 who saw a doctor or other health care professional since March 2019. $p < .01$ for differences between income groups.

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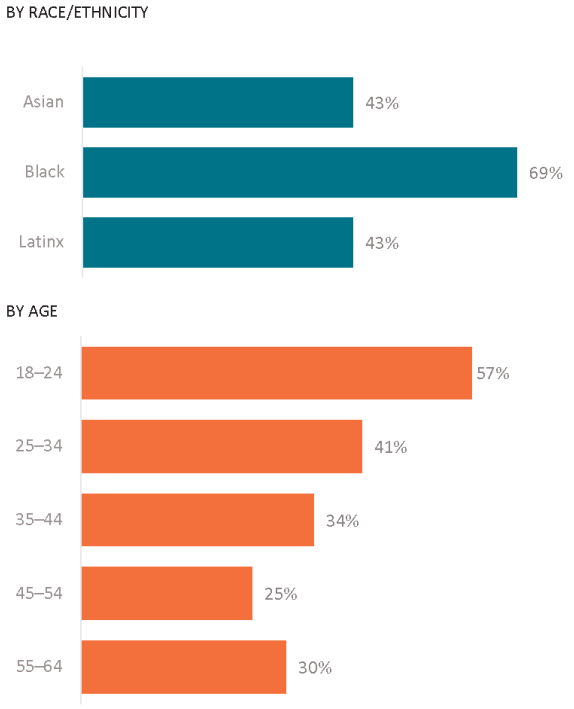
- Black and younger respondents were more likely to report experiencing racial or ethnic discrimination.

Figure 22. Black and Younger Repondents More Likely to Have Ever Experienced Racial or Ethnic Discrimination
Q: THINKING ABOUT YOUR OWN EXPERIENCE, HAVE YOU EVER PERSONALLY EXPERIENCED DISCRIMINATION OR BEEN TREATED UNFAIRLY BECAUSE OF YOUR RACE OR ETHNICITY?



Notes: Survey conducted by NORC at the University of Chicago between June 24 and August 21, 2020. Respondents limited to California residents age 18 to 64 who saw a doctor or other health care professional since March 2019. Survey used the terms *Hispanic* or *Latino*. $p < .01$ for differences by racial group and for age group 18–24 compared to all others.

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Proposition 56 Behavioral Health Integration Update

To positively impact mental health care delivery, the Department of Health Care Services ("DHCS") is using Proposition 56 funds to create the Behavioral Health Integration ("BHI") Incentive Program. The program aims to incentivize improvement in physical and behavioral health outcomes, care delivery efficiency and patient experience by expanding fully integrated care within Medi-Cal Managed care plan ("MCP") provider networks. The goal of the program is to increase MCP network integration for providers at all levels, focus on new target populations or health disparities, and improve the overall level of integration or impact.

In March 2020, DHCS postponed the program due to the pandemic. However, DHCS has recently announced the program will relaunch with a start date of January 1, 2021. All final details and program revisions will be forthcoming and communicated to the BHI providers once they are received from the state.

GCHP is proud to share DHCS has announced the tentative approval of 6 pilot programs for Ventura County. These programs will have the opportunity to demonstrate how they will meet various behavioral health integration goals, objectives, and milestones. Each BHI project contains a target population, practice redesign components, and corresponding performance measures defined by DHCS.

GCHP will continue to work with DHCS and support the implementation of our BHI programs. We look forward to partnering with our provider community as they bring innovation and best practices to Ventura County and positively impact mental health care delivery for our members and community.

DHCS Quality Award for GCHP

Every year, Department of Health Care Services ("DHCS") recognizes Medi-Cal Managed Care Plans ("MCPs") that have excelled in improving health care quality for managed care beneficiaries. The DHCS Innovation Award highlights pioneering interventions developed by health plans. On October 8, 2020, Gold Coast Health Plan ("GCHP") was recognized for its work surveying the health care needs of new members through the Health Information Form ("HIF") and connecting them with care management services. Our approach to the HIF is unique. While other health plans also send surveys to their members, many of them focus on following up with members who answered 'yes' to one or two specific questions. GCHP members who answer 'yes' to any of the questions receive a phone call from a care management coordinator. Members engaged in Care Management services have on average 26% fewer ED visits and 7% fewer inpatient days than new members not engaged in care management,18% fewer ED visits as compared to our overall population, and 71% of members engaged in Care Management had no ED utilization. This shows that proactive Care Management focused on internal and community resource connection, education on condition, and tailored support and empowerment for these members to become self-advocates significantly impacted their engagement, health literacy, and confidence in their ability to communicate their needs to their providers.

This is the third consecutive year that GCHP has been acknowledged with DHCS Quality awards. Last year, GCHP received awards for Greatest Overall Improvement in One Year and Focus Areas Most Improved Award for our work on comprehensive diabetes care, controlling high blood pressure, childhood immunizations, and prenatal and postpartum care. In 2018, GCHP received the Overall Most Improved Award based on our performance across all measures.

Inaugural Provider Recognition Awards

Gold Coast Health Plan is excited to announce the inaugural Provider Recognition Awards event. While this was intended to be an in-person celebration to honor the collaboration and outstanding performance of our network providers, 2020 has altered these well-intended plans. At the 10/21/20 Virtual Quality Improvement Collaboration Meeting with medical directors, QI managers, and clinical administrators, the following provider recognition awards were proudly issued:

- **Outstanding Performance in Child/Adolescent Preventive Health: Clinicas del Camino Real**

  For MCAS Reporting Year 2020, CDCR was the highest performer among clinic systems and scored in the 75th or 90th percentile on the following measures:
  - ✓ Well-Child Visits in the First 15 Months of Life (W15) – 75th percentile
  - ✓ Well-Child Visits in the Third, Fourth, Fifth and Six Years of Life (W34) - 90th percentile
  - ✓ Adolescent Well-Care Visits (AWC) - 90th percentile
  - ✓ Immunizations for Adolescents (IMA) - 90th percentile

- **Outstanding Performance in Early Childhood Preventive Health: Ventura County Medical Center**

  VCMC demonstrated strong performance as follows:
  - ✓ Childhood Immunization Status (CIS-10) - For MCAS Reporting Year 2020, achieved the 75th percentile
  - ✓ Developmental Screening in the First Three Years of Life – Demonstrated the highest rate among the clinic systems

- **Outstanding Performance in Chronic Condition and Medication Management: Dignity Health**

  For MCAS Reporting Year 2020, Dignity Health was the highest performer among clinic systems and scored in the 90th percentile on the following measures:
  - ✓ Controlling High Blood Pressure (CBP)
  - ✓ Antidepressant Medication Management (AMM) – Acute Phase
  - ✓ Antidepressant Medication Management (AMM) – Continuation Phase

- **Outstanding Performance in Prenatal and Postpartum Care: Community Memorial Health System**

  For MCAS Reporting Year 2020, CMH demonstrated strong performance in the 90th percentile as follows:
  - ✓ Prenatal Care (PPC-Pre)
  - ✓ Postpartum Care (PPC-Post) – Demonstrated the highest improvement compared to Reporting Year 2019, improving their rate by 17.7%

- **Member incentive Program: Highest clinic participation based on Jan 2020-Sept 2020**

  - **Well-Care Incentive Program Award Recipients**:

    - VCMC Las Islas Family Medical Group
    - VCMC Moorpark Family Medical Clinic
    - VCMC Mandalay Bay Women and Children's Medical Group
    - CMH Centers for Family Health – Saviers

  - **Cervical Cancer Incentive Program Award Recipients**:

    - VCMC Moorpark Family Medical Clinic
    - VCMC Conejo Valley Family Medical Group
    - Clinicas del Camino Real – Simi Valley
    - Clinicas del Camino Real – Oxnard

Gold Coast Health Plan congratulates these award recipients. We highly value the partnership with our providers and recognize how your efforts translate into tangible outcomes for our members. Thank you for your vital role in the pursuit of quality care to those you serve. GCHP could not achieve these exemplary outcomes without your ongoing commitment to care for the members of our community.

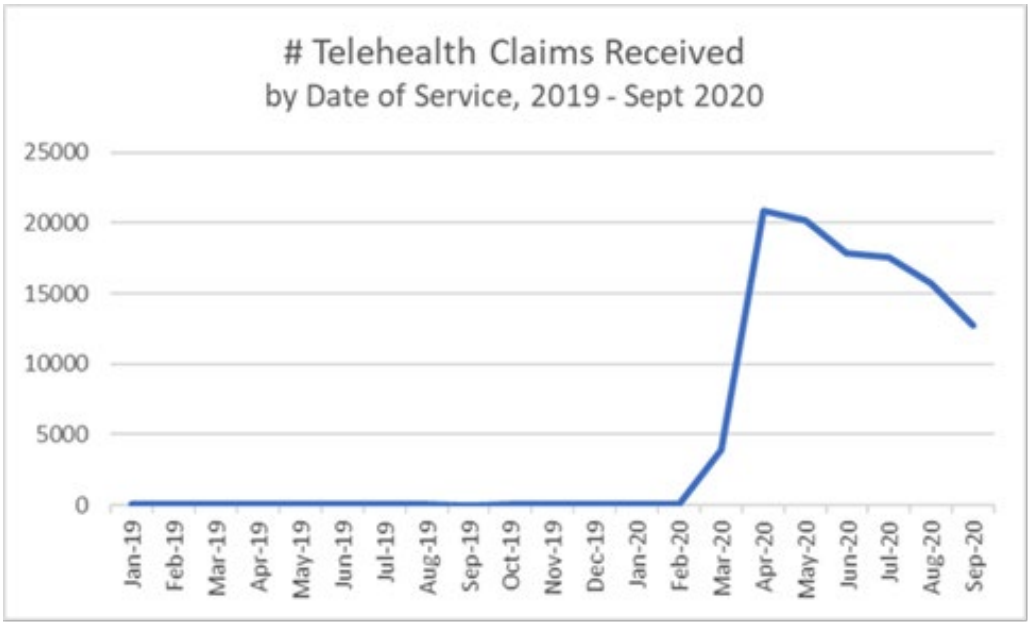
Utilization Update

Telemedicine

Telemedicine utilization has fallen from peaks of approximately 20,000 claims/month seen in April and May 2020 to just under 12,000 claims in September 2020.

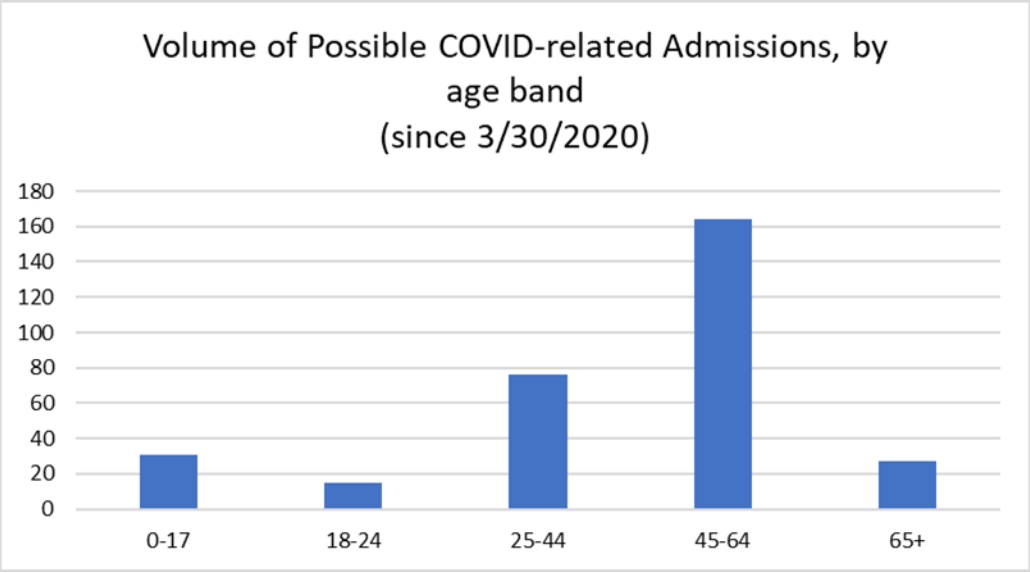
In July 2019, Gold Coast Health Plan ("GCHP") responded to a California Health Care Foundation ("CHCF") survey about telehealth in Managed Care Plans ("MCPs"). Key findings of the survey, published in April 2020, include:

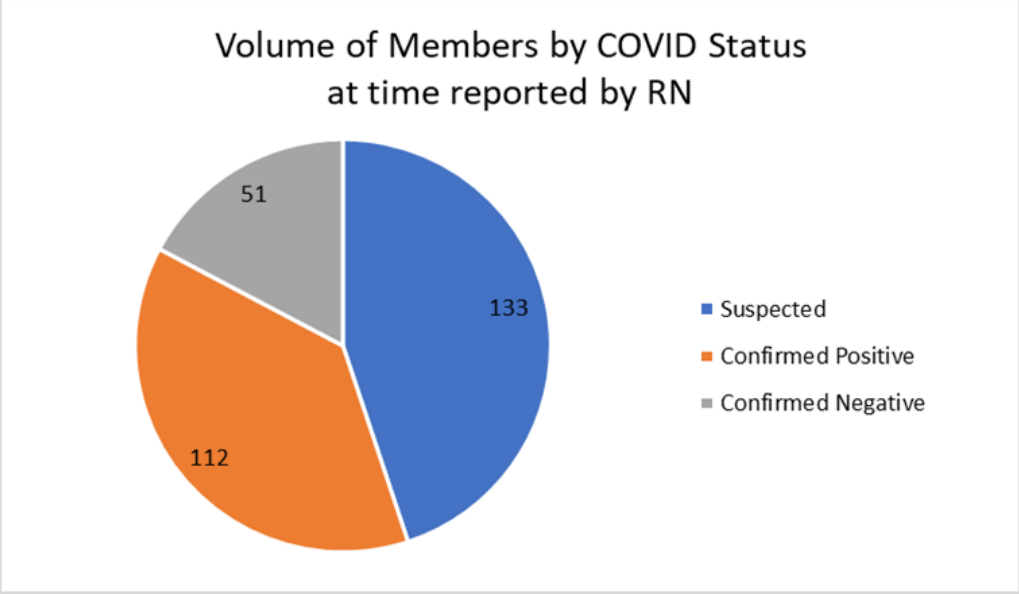
- Telehealth reporting is not yet routine or standardized across plans or required by state regulators. Plans varied on whether they included telehealth in reporting on member and provider satisfaction surveys or telehealth provider inclusion in network filings. CHCF suggests that standardized and consistent reporting across all MCPs would support regulators' and policymakers' abilities to monitor access, track utilization, and measure program outcomes for enrollees and providers.
- MCPs are confident that telehealth will improve access to specialty care, as well as improve member satisfaction and care coordination. Fewer MCPs are confident it will lower total cost of care or improve access to primary care.
- Dermatology, psychiatry, endocrinology, psychiatry, and substance use were cited as specialties where telehealth can have substantial impact on access and quality over the next two years. Certain specialties may rank higher due to relative ease of use of technology, such as capturing and sending dermatologic images. Psychiatry, mental health, and substance use treatment may rank high because of the efficacy of virtual protocols or decreased stigma attached to accessing care that does not require in-person office visit.

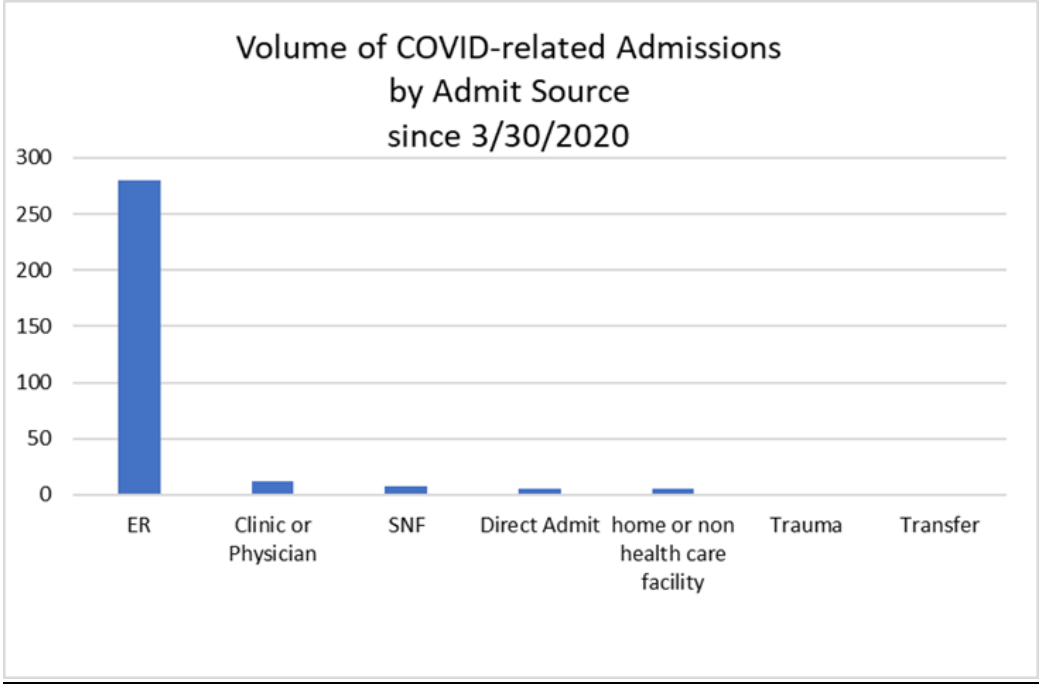


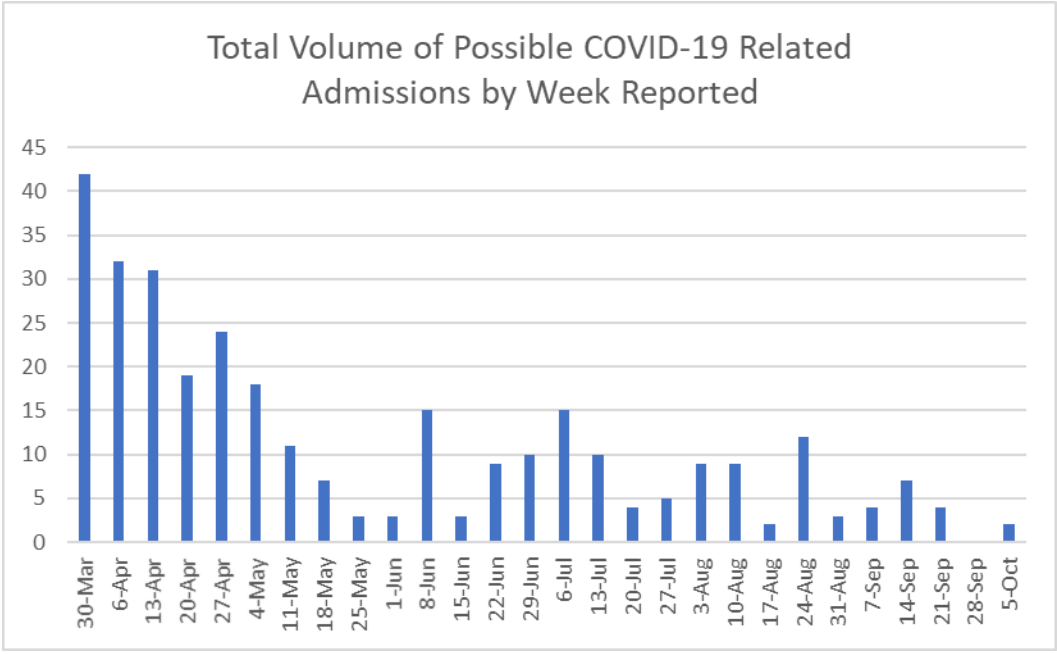
COVID-19 Related Admissions

GCHP staff have reported 313 COVID-19 related hospital admissions to the Department of Health Care Services ("DHCS") as of 10/12/2020. This total has only increased by 11 since September 16, 2020. An additional 712 positive results were identified through outpatient laboratory testing. There have been 9 readmissions for members previously reported to be positive. Most admissions continue to be for members in the 45-64 year-old age group followed by the 25-44 year-old age group. While final status of nearly half of admissions is pending, 112 (38%) of admissions were confirmed positive for COVID-19 and 51 (17%) were confirmed negative. Most admissions continue to come through the Emergency Department and volume of admissions has been variable since the peak at the end of March 2020. For the first time since the pandemic began, GCHP has reporting 0 COVID-19 related admission for the week of September 27, 2020.


Volume of Possible COVID-related Admissions, by age band
(since 3/30/2020)
180
160
140
120
100
80
60
40
20
0
0-17
18-24
25-44
45-64
65+

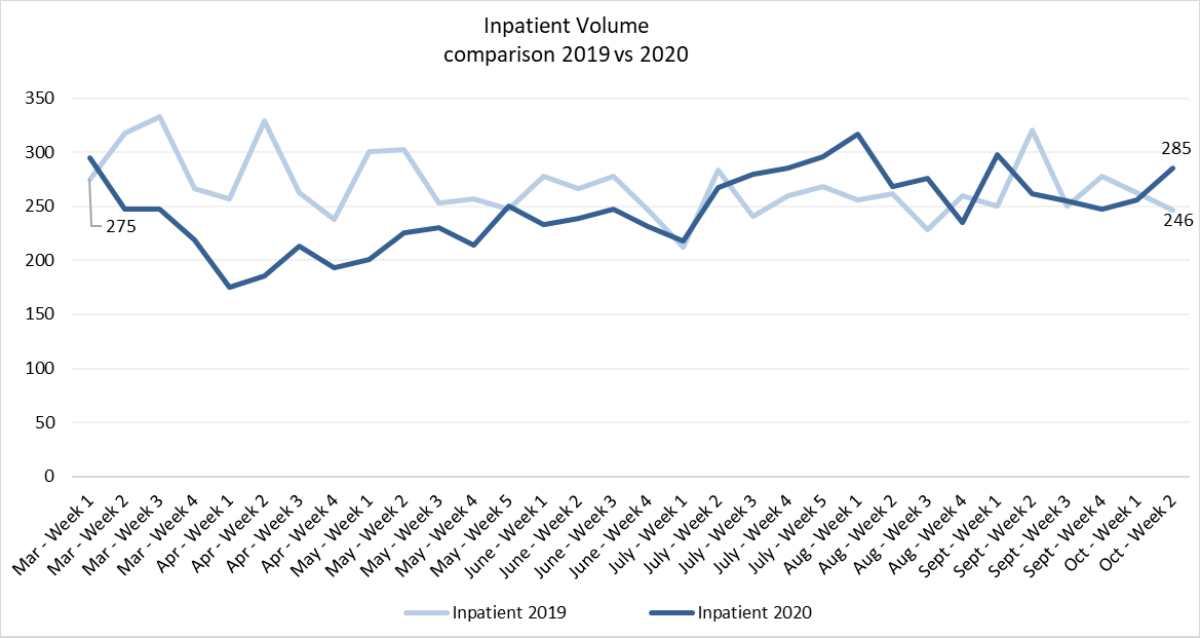

Volume of Members by COVID Status at time reported by RN
51
133
112
Suspected
Confirmed Positive
Confirmed Negative

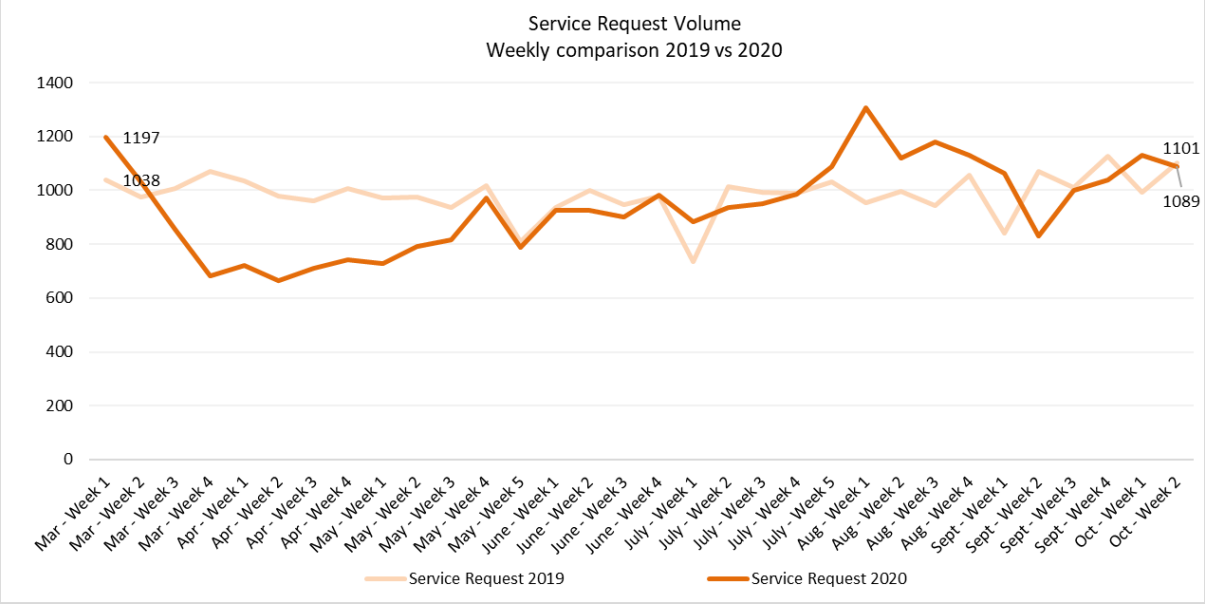

Volume of COVID-related Admissions
by Admit Source
since 3/30/2020
300
250
200
150
100
50
0
ER
Clinic or Physician
SNF
Direct Admit
home or non health care facility
Trauma
Transfer


Total Volume of Possible COVID-19 Related
Admissions by Week Reported
45
40
35
30
25
20
15
10
5
0
30-Mar
6-Apr
13-Apr
20-Apr
27-Apr
4-May
11-May
18-May
25-May
1-Jun
8-Jun
15-Jun
22-Jun
29-Jun
6-Jul
13-Jul
20-Jul
27-Jul
3-Aug
10-Aug
17-Aug
24-Aug
31-Aug
7-Sep
14-Sep
21-Sep
28-Sep
5-Oct

Service Requests

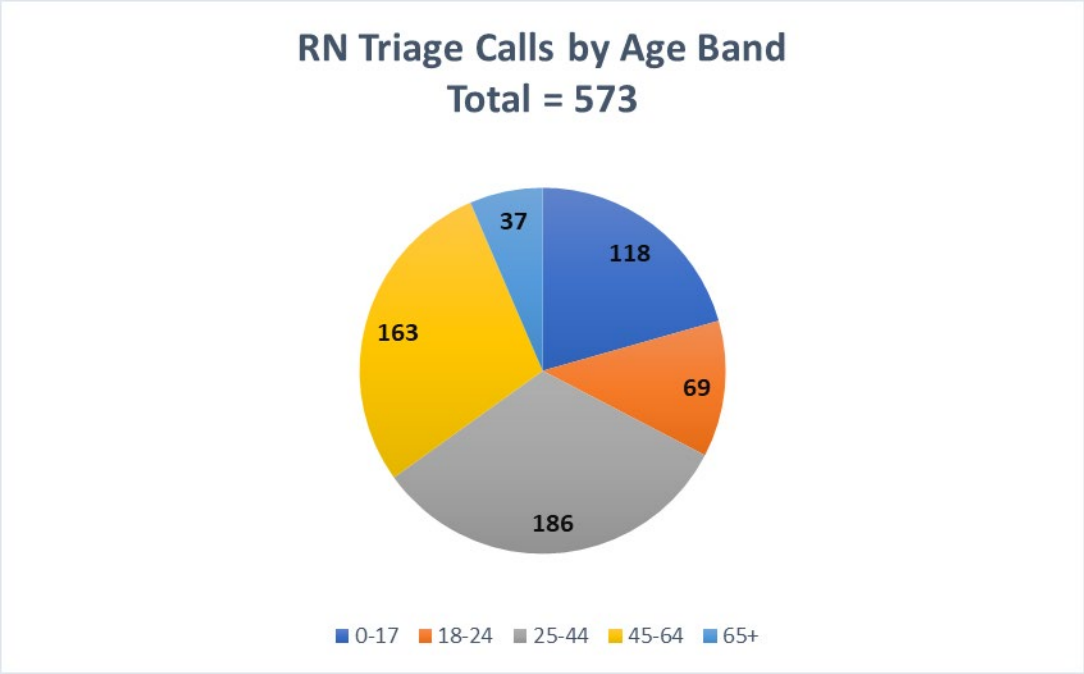
Both outpatient and inpatient service requests were increased compared to prior year in CYQ3 (6.6% and 3.7%). This is a reversal of the significant downward trends seen in 2020 CYQ1 and Q2.

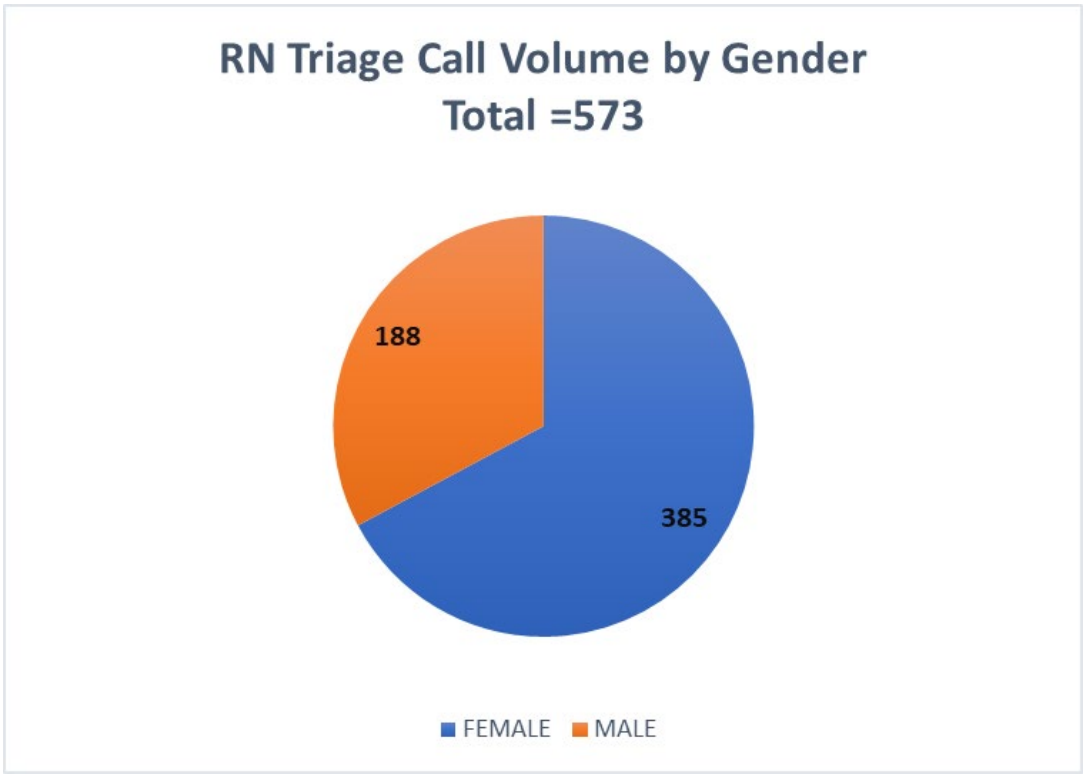


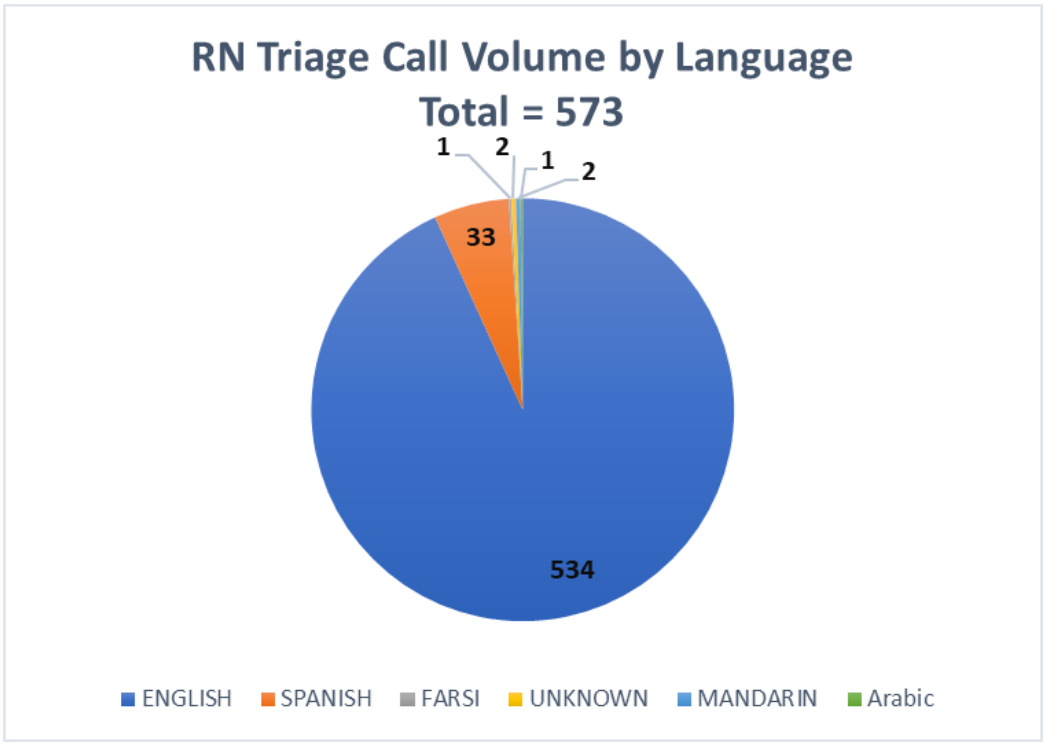


Nurse Advice Line

There have been over 2,500 calls to the GCHP Nurse Advice Line since its inception in March 2020. Call volume peaked in June and July and calls from female members outnumber calls from males 2:1. Most calls are in English and members in the 25-44, and 45-64 year-old age groups call most often. The over 65, and 18-24 year-old age groups are less likely to call than other age groups. Approximately 1% of nurse advice line calls result in a care management referral.




RN Triage Call Volume by Gender
Total =573
188
385
FEMALE
MALE

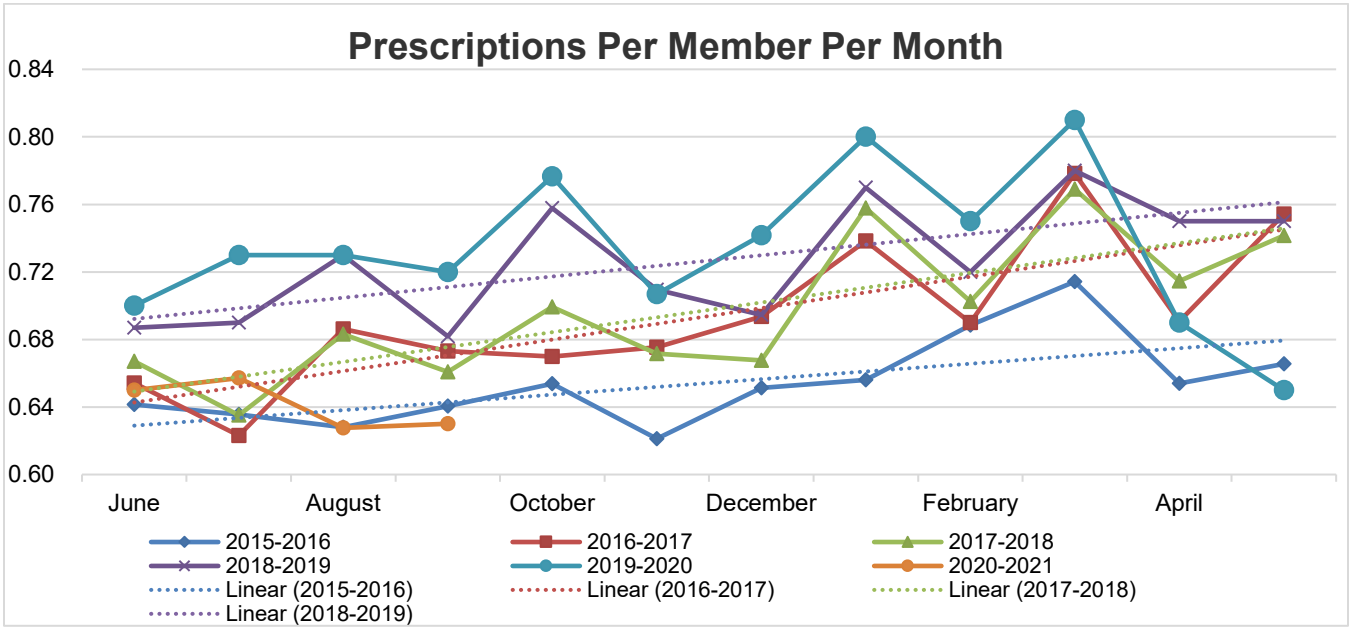

RN Triage Call Volume by Language
Total = 573
1
2
1
2
33
534
ENGLISH
SPANISH
FARSI
UNKNOWN
MANDARIN
Arabic

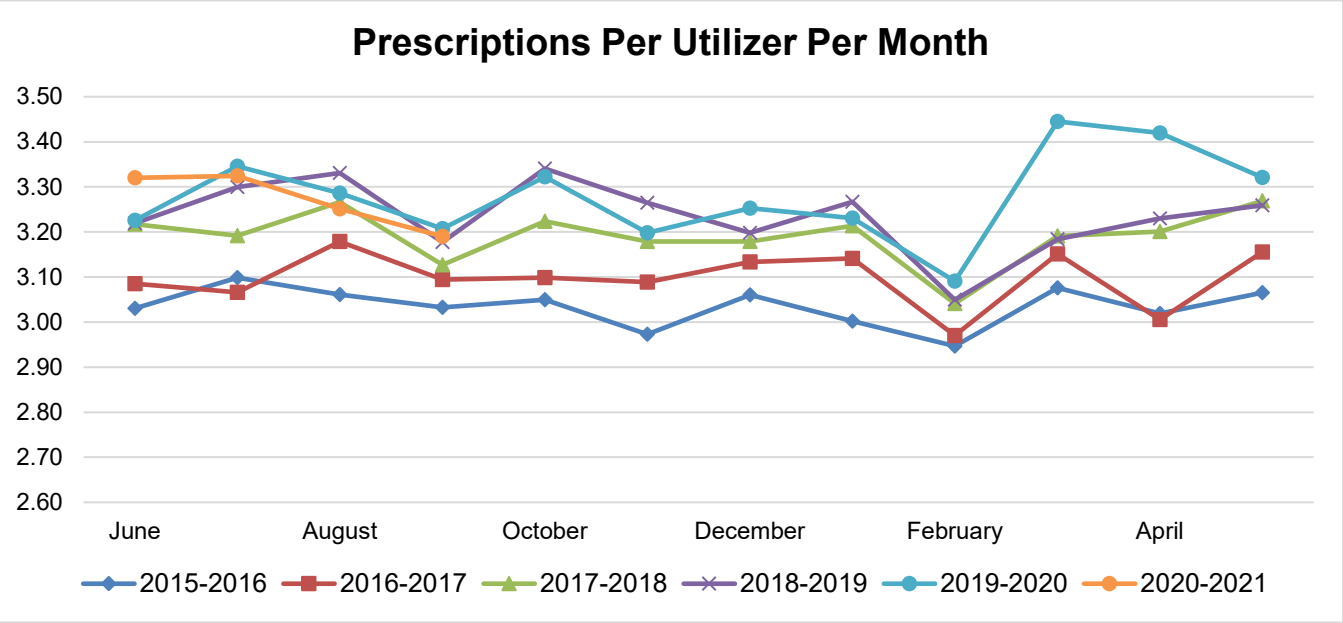
Pharmacy Benefit Cost Trends

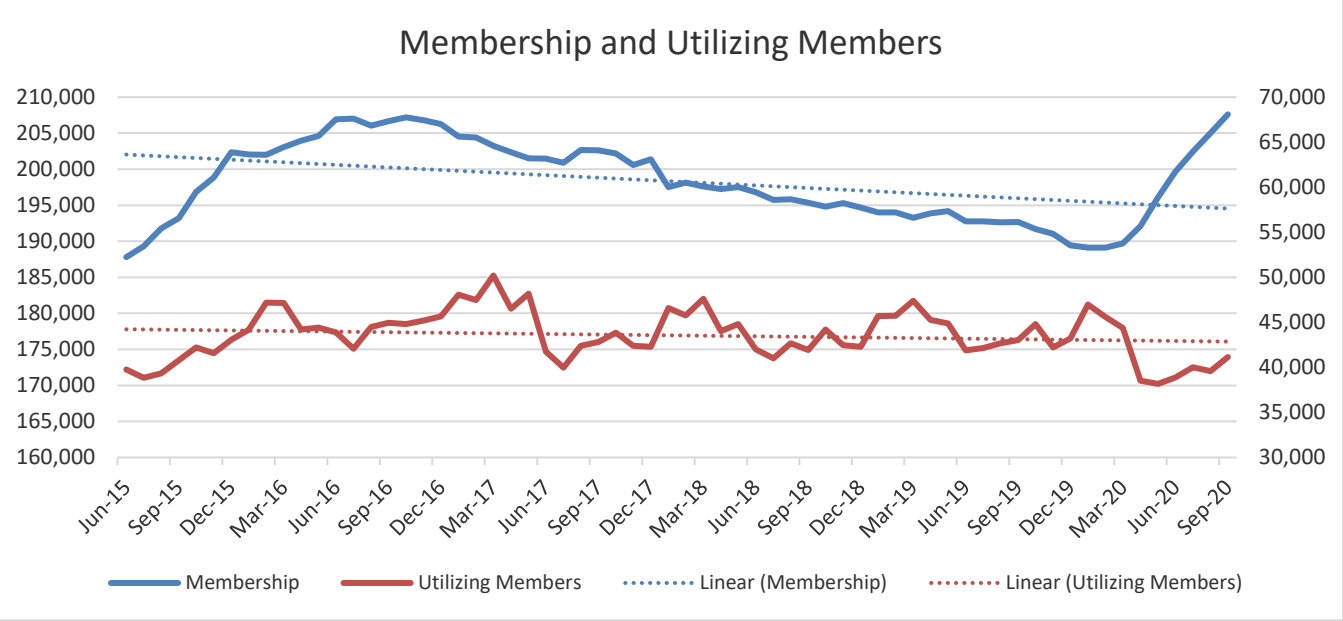
Gold Coast Health Plan's (GCHP) pharmacy trend shows in overall price increase of 19.9% from September 2019 to September 2020; this is a significant increase but is driven by increased membership and benefit changes made due to COVID-19. When looking at the per member per month costs (PMPM), the PMPM has decreased approximately 9.43% since its peak in March 2020. Pharmacy trend is impacted by unit cost increases, utilization, and the drug mix. Pharmacy costs are predicted to experience double digit increases (>10%) each year from now until 2025. GCHP's trends are in-line with state and national data that is also experiencing significant increases in pharmacy costs. Impact from COVID-19 is expect to increased costs further.

GCHP Annual Trend Data

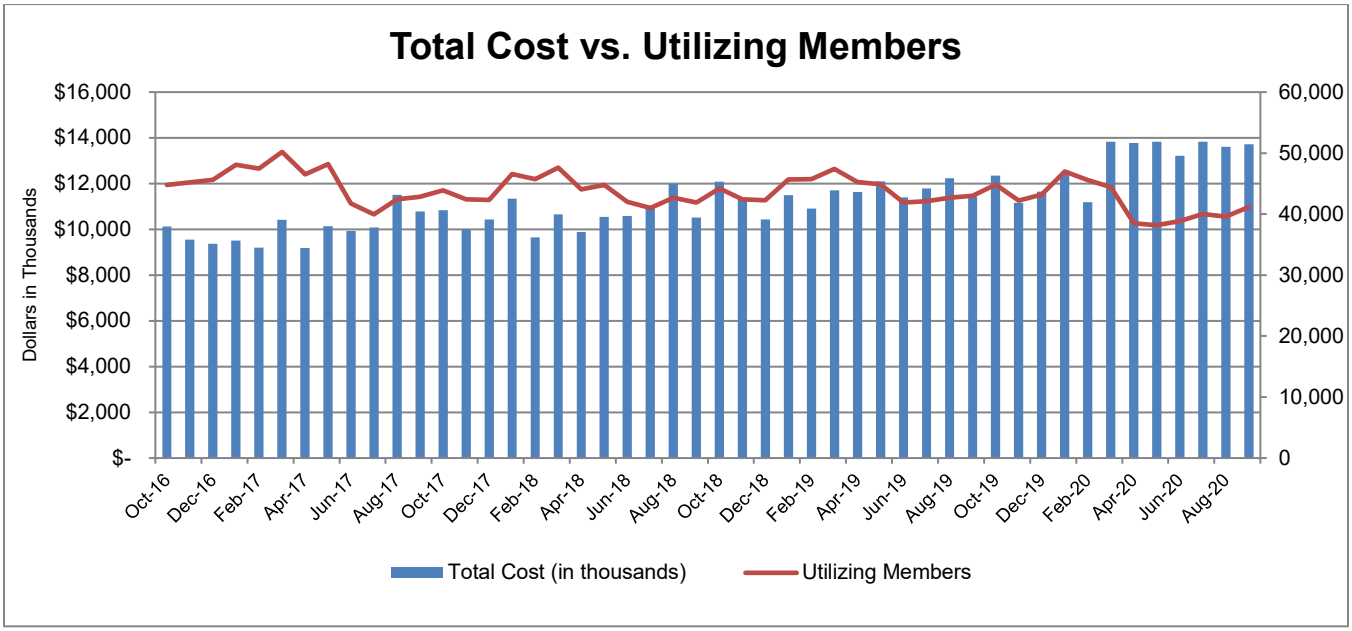
Utilization Trends:
Through March 2020, GCHP's utilization was increasing as demonstrated by the number of members using prescriptions and the number of prescriptions each member is using while GCHP's total membership continued to decline. However, the impact of COVID-19 has caused an increase in membership and the utilization of extended day supplies which suppress the view of increased utilization. The new graph showing scripts per utilizer gives a new view of the increased utilization. GCHP will be continuously monitoring the impact of COVID-19 and the increased membership.

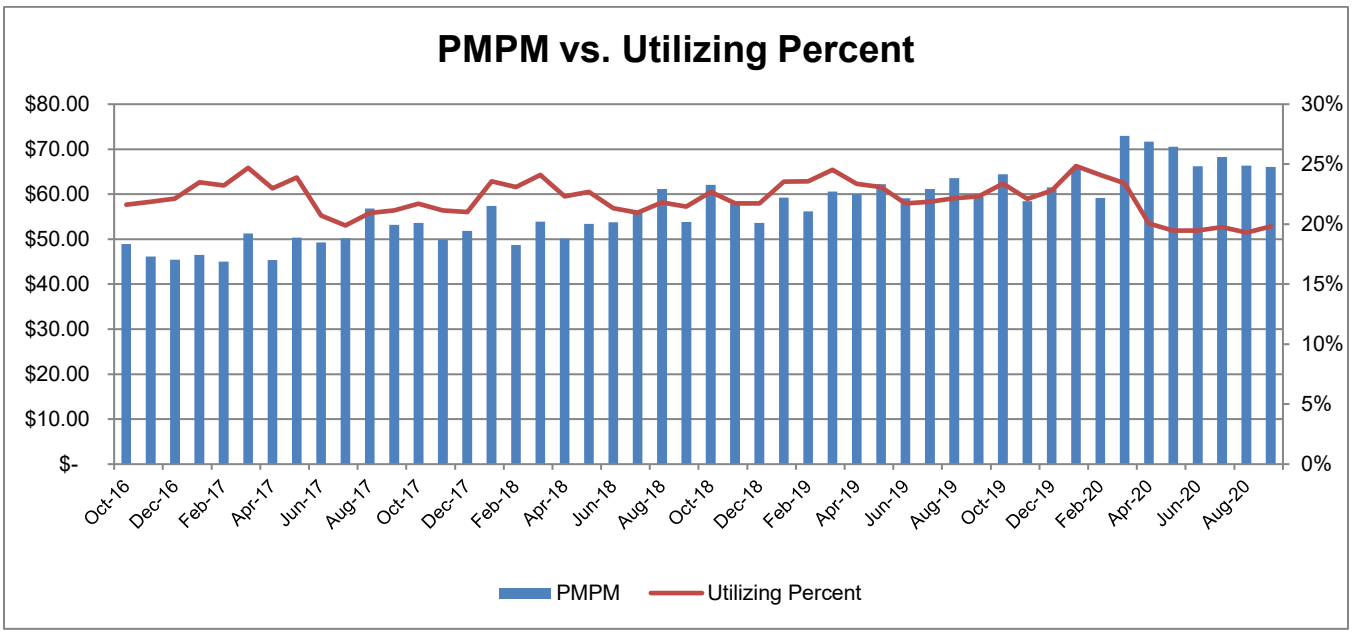


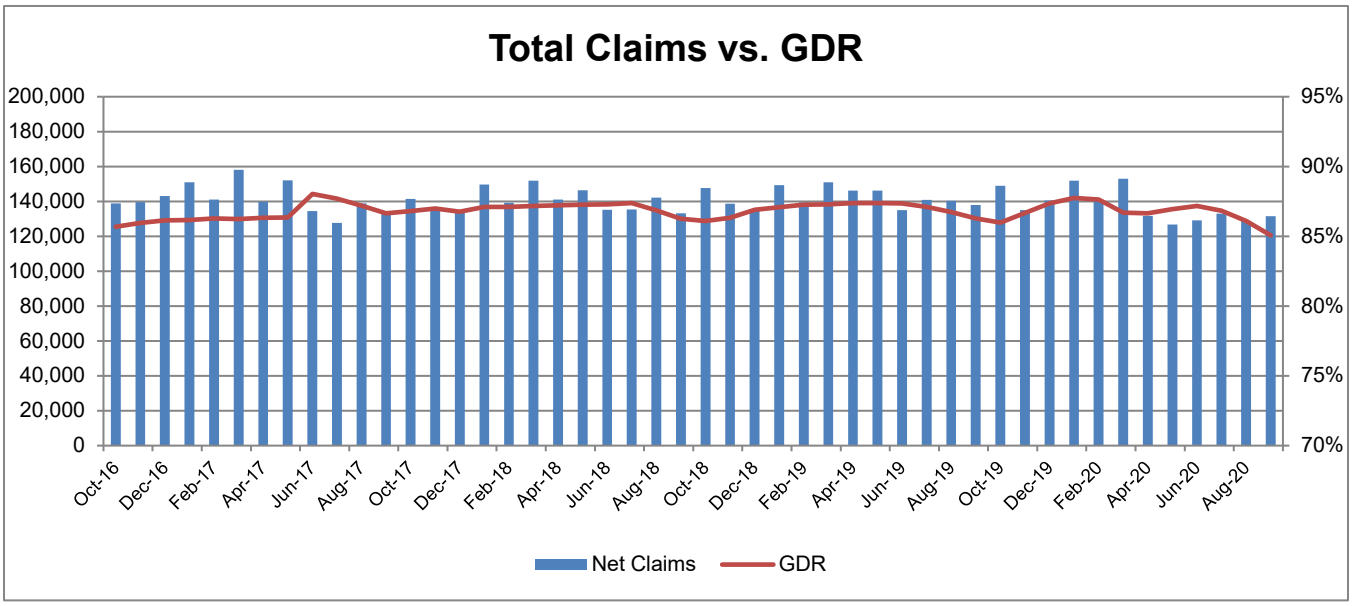

Prescriptions Per Utilizer Per Month
3.50
3.40
3.30
3.20
3.10
3.00
2.90
2.80
2.70
2.60
June
August
October
December
February
April
2015-2016
2016-2017
2017-2018
2018-2019
2019-2020
2020-2021


Membership and Utilizing Members
210,000
205,000
200,000
195,000
190,000
185,000
180,000
175,000
170,000
165,000
160,000
70,000
65,000
60,000
55,000
50,000
45,000
40,000
35,000
30,000
Jun-15
Sep-15
Dec-15
Mar-16
Jun-16
Sep-16
Dec-16
Mar-17
Jun-17
Sep-17
Dec-17
Mar-18
Jun-18
Sep-18
Dec-18
Mar-19
Jun-19
Sep-19
Dec-19
Mar-20
Jun-20
Sep-20
Membership
Utilizing Members
Linear (Membership)
Linear (Utilizing Members)

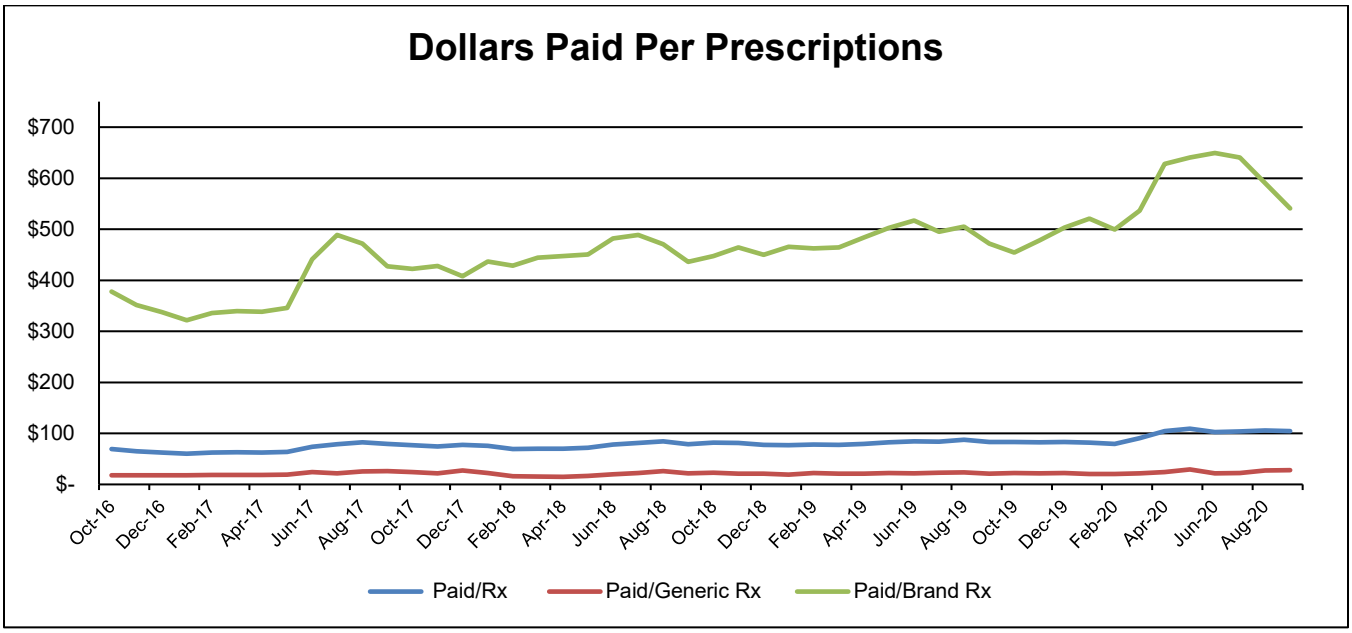
Pharmacy Monthly Cost Trends:





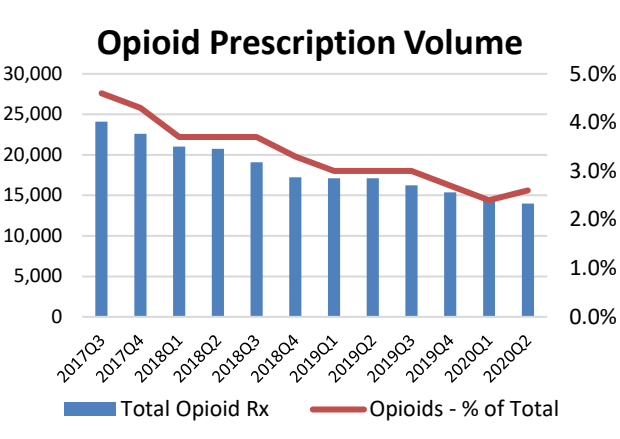


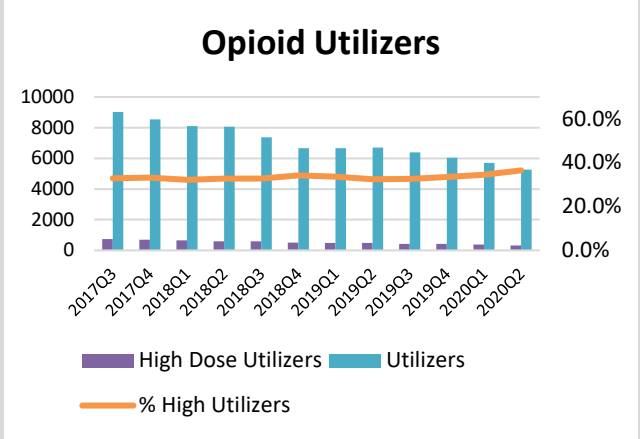
*Claim totals prior to June 2017 are adjusted to reflect net claims.

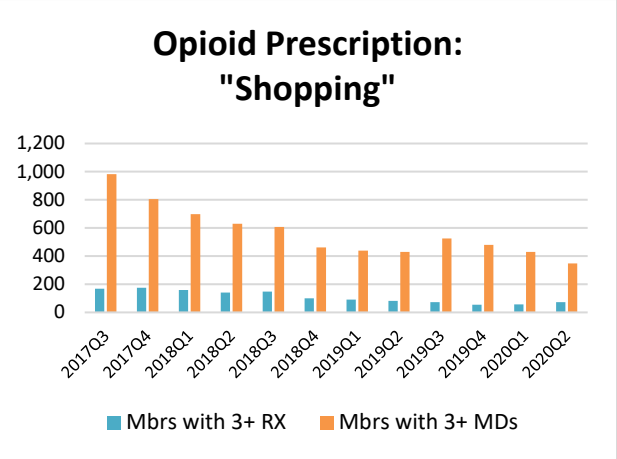


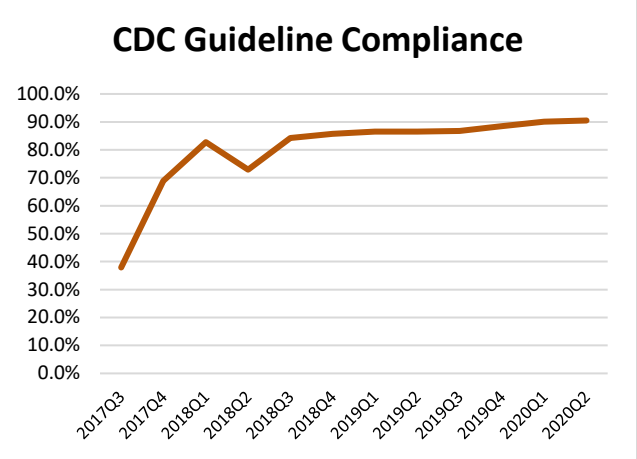
Pharmacy Opioid Utilization Statistics

GCHP continues to monitor the opioid utilization of its members and below are graphs showing some general stats that are often used to track and compare utilization. In general, GCHP continues to see a positive trend toward less prescriptions and lower doses of opioids for the membership.









Definitions and Notes:
High Dose Utilizers: utilizers using greater than 90 mg MEDD
High Utilizers: utilizers filling greater than 3 prescriptions in 120 days
Prescribers are identified by unique NPIs and not office locations.
These graphs are unchanged from the prior report and will be updated upon receipt of 2020Q3 data.

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

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 September 2020. The data has been pulled during the first two weeks of September which increases the likelihood of adjustments. Minor changes, of up to 10% of the script counts, may occur to the data going forward due to the potential of claim reversals, claim adjustments from audits, and/or member reimbursement requests.

References:

1. https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/?_sf_s=drug+spending#item-contribution-to-growth-in-drug-spending-by-growth-driver_2017
2. https://arstechnica.com/science/2019/07/big-pharma-raising-drug-prices-even-more-in-2019-3400-hikes-as-high-as-879/
3. US Food and Drug Administration. "2018 New Drug Therapy Approvals."
4. https://www.fiercepharma.com/marketing/another-record-year-for-pharma-tv-ads-spending-tops-3-7-billion-2018
5. https://www.kff.org/medicaid/issue-brief/utilization-and-spending-trends-in-medicaid-outpatient-prescription-drugs/

AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Interim Chief Diversity Officer

DATE: October 26, 2020

SUBJECT: Interim Chief Diversity Officer Report

Actions:

Community Relations

- Continued my community outreach efforts with meetings LULAC appointees, Mr. Rick Castaniero and Arnoldo Torres. Discussion centered on creating a continued working relationship to solve problems verses an adversarial relationship. I also introduced them to our new HR Executive Director, Michael Murguia.
- Held Lunch n Learn seminar in recognition of National Hispanic Month. The Lunch n Learn centered around an interview with one of Cesar Chavez's daughters.
- Reviewed Diversity Council's direction and involvement with the executive team.

Case Investigations

No new cases to-date. Worked with HR to close a few lingering insurance cases.

<u>Diversity Activities</u>

- Continue to meet regularly with the Diversity Council to address the diversity needs of Gold Coast Health Plan.
- Adding 4 new participants to the Council to balance the cultural mix.
- Attended five (5) Zoom meetings with the community involving Get -out-the-vote, diversity training, Racial injustice in our communities and Police reform.
- Bi-weekly update meetings with CEO Margaret Tatar.
- Attended 2 Zoom meetings; one originating in Westlake Village, and another with California Lutheran.

AGENDA ITEM NO. 13

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Michael Murguia, Executive Director of Human Resources

DATE: October 26, 2020

SUBJECT: Human Resources Report

Human Resources Activities

We held our first Employee Survey Action Plan team meeting October 14th. This is a cross-functional group of 15 employees that will help us validate and improve our areas of weakness identified in our Employee Survey. This team has representation that includes individual contributors, managers and Directors. Our initial areas of focus are Communications and Executive Leadership. We are validating our survey results through feedback from this team and will develop strategies once we finalize our focus areas.

During the last month, GCHP had one resignation and one retirement. We continue to evaluate any vacant positions and only backfill key positions. This process requires a review with the CEO and the executive leadership team.

I joined Mr. Ted Bagley for his community outreach efforts meeting with two LULAC representatives, Mr. Rick Castaniero and Mr. Arnoldo Torres. Discussions centered on creating a continued working relationship to solve problems verses an adversarial relationship.

During the last 30 days GCHP has no new cases to report.

Facilities / Office Updates

GCHP has a team that is dedicated to planning a return to the office when conditions allow. The team continues to meet and evaluate:

- Controlling the flow of employees who visit the office for supplies, printing, and other business-related activities.
- The possibility of employees needing additional equipment to work from home as the pandemic stretches through the end of this year and possibly into the first quarter of 2021.
- Protocols for a return to the office, including taking temperatures.
- Making any necessary modifications to improve air quality inside the buildings.