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

Regular Meeting
Monday, September 27, 2021, 2:00 p.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room
Camarillo, CA 93010
Governor's Executive Order
Conference Call Number: 805-324-7279
Conference ID Number: 137 221 839#

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 Meeting Minutes of August 23, 2021

Staff: Maddie Gutierrez, MMC, Clerk to the Commission

RECOMMENDATION: Approve the regular meeting minutes of August 23, 2021.

2. Adopt a Resolution to Renew Resolution No. 2021-011, 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 No. 2021-012 to extend the duration of authority empowered in the CEO through October 25, 2021.

UPDATES

3. Return to Office Planning Update

Staff: Michael Murguia, Executive Director of Human Resources

RECOMMENDATION: Receive and file the update.

4. HSP MediTrac Go-Live Update

Staff: Anna Sproule, Sr. Director of Operations

RECOMMENDATION: Receive and file the update.

FORMAL ACTION

5. August Financials

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Staff requests that the Commission approve the August 2021 financial package.

REPORTS

6. Chief Executive Officer (CEO) Report

Staff: Margaret Tatar, Chief Executive Officer

RECOMMENDATION: Receive and file the report.

7. Chief Medical Officer (CMO) Report

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

RECOMMENDATION: Receive and file the report.

8. Chief Diversity Officer (CDO) Report

Staff: Ted Bagley, Chief Diversity Officer

RECOMMENDATION: Receive and file the report.

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

Staff: Michael Murguia, Executive Director of Human Resources

RECOMMENDATION: Receive and file the report.

CLOSED SESSION

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

11. PUBLIC EMPLOYEE APPOINTMENT
Title: Chief Executive Officer

ADJOURNMENT

Unless otherwise determined by the Commission, the next meeting will be held at 2:00 P.M. on October 25, 2021 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 of the Board

DATE: September 27, 2021

SUBJECT: Meeting Minutes of August 23, 2021 Regular Commission Meeting

RECOMMENDATION:

Approve the minutes.

ATTACHMENT:

Copy of Minutes for the August 23, 2021 Regular Commission Meeting.

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) August 23, 2021 Regular Meeting Minutes

CALL TO ORDER

Commission Chair Dee Pupa called the meeting to order via teleconference at 6:03 pm. The Clerks were in the Community Room located at Gold Coast Health Plan, 711 East Daily Drive, Camarillo, California.

ROLL CALL

Present: Commissioners Shawn Atin, Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Dee Pupa, Supervisor Carmen Ramirez and Scott Underwood, M.D.

Absent: Commissioners Antonio Alatorre, Gagan Pawar, M.D., and Jennifer Swenson.

Attending the meeting for GCHP were Margaret Tatar, Chief Executive Officer, Nancy Wharfield, MD., Chief Medical Officer, Kashina Bishop, Chief Financial Officer, Michael Murguia Executive Director of Human Resources, Scott Campbell, General Counsel, Cathy Salenko, Health Care General Counsel, Marlen Torres, Executive Director of Strategy and External Affairs, Robert Franco, Ted Bagley, Chief Diversity Officer, Nick Ligouri, Chief Operations Officer, and Eileen Moscaritolo, HMA Consultant.

Additional staff participating on the call: Anna Sproule, Vicki Wrighster, Dr. Anne Freese, Helen Miller, Dr. Lupe Gonzalez, Pauline Preciado, Kim Timmerman, Nicole Kanter, Stacy Luney, Luis Aguilar, Adriana Sandoval, Jamie Louwrens, Susana Enriquez, and Lucy Marrero.

Also, in attendance were Conduent representatives: Sheila Curr, Lisa Hopper, Susan Shirley, Susan Meikle, Rajandra Kadam, and Michael Calabrese, legal counsel.

PUBLIC COMMENT

Dr. Sandra Aldana with the State Council of Disabilities, and member of the Community Advisory Committee for the University Center of Excellence of Developmental Disabilities at USC, East Los Angeles, stated her comment related to the information on what qualifies individuals for boosters under the immuno-compromised definition and the impacts on these individuals

INTRODUCTION

Introduction of new Chief Operations Officer, Mr. Nick Ligouri

Chief Executive Officer, Margaret Tatar introduced GCHP's new Chief Operations Officer, Mr. Nick Ligouri. CEO Tatar gave a brief professional background on Mr. Ligouri. COO Ligouri thanked the Commission for allowing him to join the organization and stated he looked forward to working with GCHP and the community.

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Regular Meeting Minutes of July 26, 2021.

Staff: Maddie Gutierrez, MMC, Clerk to the Commission.

RECOMMENDATION: Approve the regular meeting minutes of July 26, 2021.

2. Adopt a Resolution to Renew Resolution No. 2021-010, 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 No. 2021-011 to extend the duration of authority empowered in the CEO through September 27, 2021.

3. Introduction of New CAC Members

Staff: Marlen Torres, Executive Director of Strategy & External Affairs
Luis Aguilar, Member Services Manager
Ruben Juarez, Community Advisory Committee (CAC) Chair

RECOMMENDATION: The CAC Member Application Ad-Hoc Committee recommends that the three (3) individuals be approved by the Commission as new CAC members. They were approved at the Special CAC meeting on August 16, 2021 by the current Community Advisory Committee. Once approved by the Commission, they will be contacted of their official appointment.

Commissioner Laura Espinosa requested Consent Item 3; Introduction of New CAC members be discussed before the vote.

Commission Chair, Dee Pupa asked for a vote on Consent items 1 and 2.

Supervisor Ramirez motioned to approve Consent Items 1, and 2. Commissioner Atin seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Dee Pupa, Supervisor Carmen Ramirez, and Scott Underwood, M.D.

NOES: None.

ABSENT: Commissioners Gagan Pawar, M.D, and Jennifer Swenson.

Commissioner Pupa declared the motion carried.

3. Introduction of new CAC Members

Staff: Marlen Torres, Executive Director of Strategy & External Affairs
Luis Aguilar, Member Services Manager
Ruben Juarez, Community Advisory Committee (CAC) Chair

RECOMMENDATION: The CAC Member Application Ad-Hoc Committee recommends that the three (3) individuals be approved by the Commission as new CAC members. They were approved at the Special CAC meeting on August 16, 2021 by the current Community Advisory Committee. Once approved by the Commission, they will be contacted of their official appointment.

Commissioner Espinosa stated she recognized the great effort to recruit. She asked how many applications were received. Marlen Torres, Executive Director of Strategy & External Affairs, stated 7 applications were received. All applications were reviewed by the CAC Ad-Hoc committee and the top three (3) candidates were selected and approved by the Community Advisory Committee at the August 16, 2021 meeting. She noted there is still one (1) seat open. There are currently two (2) applications still pending review. The CAC Ad-Hoc will meet again to review once more applications have been received. Commissioner Espinosa asked once the vacancies are filled what will be the total of the Committee seats that will be filled. Ms. Torres responded 11 seats for CAC. The seats have designated categories. Commissioner Espinosa asked if it could be more than eleven (11) seats. Ms. Torres stated the seat count is what is in the charter and policy. Commissioner Espinosa asked what seat is still unfilled. Ms. Torres stated it is a member seat. Supervisor Carmen Ramirez asked if there are bilingual members on the committee. Ms. Torres

stated the language is not designated. Supervisor Ramirez stated she encouraged non-English speakers to apply.

Commissioner Laura Espinosa motioned to approve Consent Item3. Supervisor Carmen Ramirez seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Dee Pupa, Supervisor Carmen Ramirez, and Scott Underwood, M.D.

NOES: None.

ABSENT: Commissioners Gagan Pawar, M.D, and Jennifer Swenson.

Commissioner Pupa declared the motion carried.

UPDATES

4. GCHP Strategic Plan 2021 Quarter II Update

Staff: Marlen Torres, Executive Director of Strategy & External Affairs

RECOMMENDATION: Receive and file the update.

Commissioner Jennifer Swenson joined the meeting.

Marlen Torres, Executive Director of Strategy & External Affairs reviewed the second quarter Strategic Plan 2021 update. She noted there are a total of 34 goals with 109 measures that go into timeframes. Ms. Torres stated there was nothing overdue, although there have been pauses in some of the priorities. Major initiatives in progress were reviewed. The next quarterly review will be presented in October 2021.

5. Conduent Update

Staff: Anna Sproule, Sr. Director of Operations
Guest Speakers: Sheila Curr, President, Commercial Healthcare/Conduent
Mark Forsberg, VP, Portfolio Leader/Conduent

RECOMMENDATION: Receive and file the update.

The following verbatim minutes are edited for clarity. The verbatim minutes have been transcribed by First Legal Depositions per the direction of General Counsel, Scott Campbell.

Ms. Sproule introduced members of the Conduent team; Sheila Curr, President, Commercial Healthcare/Conduent, Lisa Hopper, the Vice President of Payer Healthcare; Susan Shirley, the Director of Business Operations; and Raj Kadam, the Vice President and Chief Information Officer.

MS. SHEILA CURR: Good evening to the Commissioners and to the Gold Coast staff. I am Sheila Curr. I'm President of Commercial Healthcare. Unfortunately, tonight, Mark Forsberg could not join us. Mark is the Vice President who is overseeing the enterprise transformation for Gold Coast. He had a family member that was taken ill in the hospital, so Lisa will be providing those updates. We will walk through the project updates and the roadmap to move forward. We'll talk about how we've strengthened our team to both tackle existing challenges and how we will use that team to meet any new ones. We're going to look at some metrics that will tell us what kind of progress we're making towards compliant steady state and the detail of resources we're deploying to keep that progress going. We'll be giving you as much detail as the time and today's format allows. When we last appeared at the commission meeting, we told this board that Conduent was ready to go live, and we fully believed that we were. All go live testing, preparations, and delivery were completed with positive results that were validated and confirmed in a formal go/no go review. Therefore, the testing results made Conduent comfortable that the system was ready to go live. However, unforeseen scenarios related to claim types, historical data mappings and re-mappings, and developing capabilities surrounding change control process created our current issues. In the face of ongoing difficulties, Conduent made Gold Coast its highest priority project. The senior leadership team, including myself, is engaged in daily oversight to assist and provide continuous oversight and inspection. Including myself—with addition to myself, excuse me—I have the following senior leadership team members that are part of that oversight, Adam Applebee, global head of operations; Mark Prout, Chief Information Officer. We also have twice a week leadership oversight calls that are internal, and daily Gold Coast and Conduent calls. While the project has realized challenges, the Conduent team is actively working and resolving post-conversion issues daily and targeting complete resolution of high-priority issues in the coming weeks. Committed to achieving compliance, steady state for all operational components, inventory reduced from 180,157 to 85,000, since July 1st, 2021. We also conducted an on-site meeting to review expectations and outlying challenges with the leadership of Gold Coast and the leadership of Conduent, and have been adding to our expense many, many folks within the organization to join in on the remediation plan. With that, I'm going to turn it over to Lisa Hopper. Lisa will walk through the implementation updates.

MS. LISA HOPPER: Today I'll be talking about the implementation itself. We'll go into deep dive on each of the three areas that we're focused on. From the highest level, the implementation plan itself, we're continuing to track all the post-conversion issues and enhancements and make progress daily towards that completion. We had 400. We're at 410 post-conversion issues today. We have closed out 322, and we have 88 in progress. So, we have closed out—we're standing at about 78.5%. We have dedicated teams, inclusive of project management, information technology, and operations that are engaged to provide that guidance across all our working teams. Leads are actively engaged in the work streams to track progress, to escalate issues and provide daily executive updates. We have checkpoint meetings and conference calls on a daily/weekly cadence to monitor the progress and to address issues as they arise. Let's dive into the inventory reduction. Despite the ongoing labor market challenges, Conduent continues to recruit in the market and has added team members from across the company, skilled in automation, agile project management, and overall product IT expertise to focus on inventory reduction and issue resolution. We've had multiple accelerators that we've executed to address this inventory reduction effort. From a people perspective, we have added additional internal staff which we've shifted from other areas to reduce the efforts from all—and again, shifting from all the verticals within the organization, along with active external recruiting and hiring. We have shifted approximately 43 people from other areas inside Conduent, to help in the inventory reduction. We continue to increase our focus on the California landscape, to hire individuals with Medi-Cal/Medicaid experience. We have actively recruiting of 25 FTEs in the California market, and we've had significant response to date. We have 30 contract resources that were required by Gold Coast that we are actively onboarding as part of our inventory reduction plan. We are also in partnership with one of our clients, who is undergoing a reduction to acquire up to 40 FTEs.

COMMISSIONER PUPA: This is Commissioner Pupa. Thank you for the update on the inventory. I know that we talked a little bit about this at Executive Finance as well; but with the inventory being reduced to about 9,600, looking at it from a timeline perspective, it looks like the inventory won't be at a pre-implementation level until October, so can you speak to the specific plan to reduce the claims inventory back down to the 20,000 or 30,000 that was pre-migration?

MS. HOPPER: We delivered a plan on Friday to Gold Coast, which demonstrated our efforts and all the resources to get us back to normal inventory levels by around September 15th.

COMMISSION CHAIR PUPA: September 15th? That's good news.

MS. HOPPER: The plan is ongoing, right, and is dynamic. The plan that was presented Friday gets us back down to the level that we anticipate being more of the steady state level by mid-September.

COMMISSIONER ATIN: I just wanted to ask did you anticipate this level of inventory buildup because I heard that you'd gone live. Is this a normal development that would occur on a go-live date?

MS. CURR: Raj, would you answer that question, please?

MR. RAJ KADAM: Normally, when we go live, this is not the level of claims backlog that we get. To some extent, we do have a freeze period when we go live. We had to put the prior system on freeze for a week or more. We do get some backlog. But yes, we did get more than anticipated backlog for sure.

COMMISSIONER ATIN: It just seems to me that at some point it was more than four or five times the level of normal. And I just question whether go-live is the right term, I don't mean to be hypercritical on this, but it does seem that it's caused a lot of disruption and there was a lot of unplanned hiring, which we're all very glad that it's occurred. So now the next question is how confident are you that September 15th we'll be able to be back to a normal level inventory? Do you have a high confidence in that? Or what are the impediments that you might see?

MS. CURR: Again, Mark is running our program, but we put a very conservative plan in place, with the additional staffing. So again, we've been very transparent with that plan, and we will work that plan daily and mitigate, as we have, any issues that arise. But we have looked at all the different categories of claims. We've looked at all the different variables that we need to manage going forward. And this plan, we believe, is a very solid plan. We continue to work this plan. And again, with our partnership with Gold Coast, and we have deep appreciation for the continuous scrub of that plan.

COMMISSIONER ATIN: So, you have a high confidence level that by September 15th, we'll have a 25,000-inventory level. That's what I'm hearing you say. Is that correct?

MS. CURR: We'll have a normal inventory level. Again, because of the increase in membership, we're working with Anna and team to come up with is the number—the number prior to go live might have been 20,000 to 30,000. We are estimating that a normal level will be around 35,000. We continue to look at that number. We continue to do everything we can to add resources, to scrub the plan, and really adjust as we see things coming up.

COMMISSIONER ATIN: Okay. Thank you very much.

CHAIR PUPA: Commissioner Espinosa has her hand up.

COMMISSIONER ESPINOSA: Yes. Ms. Curr, in your opening remarks, you said that there were unforeseen claim types. What did you mean by that, and how did that impact your belief that you could go-live, that we were ready to go-live?

MS. CURR: Raj or Susan Shirley, in combination, would you please answer that question?

MS. SUSAN SHIRLEY: Madam Commissioner and Commissioners of the Board. So, we did encounter a lot of different gyrations with the claim types that we did implement. There were some system configuration changes that had to be done, in and around go-live that affected volumes and that affected our ability to adjudicate those claims immediately, post go-live.

COMMISSIONER ESPINOSA: I'm just curious. Could you explain to a lay person, again, what do you mean by claim types?
MS. SHIRLEY: A long-term care claim or a specific claim type on a hospital claim form, or a specific claim type that's related to professional services. I don't have the specific examples in front of me, but I can get those for you all.

COMMISSIONER ESPINOSA: No, you explained it. I was trying to understand. This is the typical managed care health system claim. I was thinking, what was so unforeseen about those claims?

MS. SHIRLEY: I think there were some Gold Coast specific rules that perhaps had not been fully vetted and contemplated, prior to the go-live. We had to make some changes in configuration that were up and close to the go-live date, and then some obviously post go-live as well. So those factors really attributed to increase in inventory because we couldn't process through all the related claims that were associated with those issues that we had.

COMMISSIONER ESPINOSA: But once you assessed those claims, then it still had to have impacted, I would think, your decision that we were ready to go live—I mean, I'm really trying to make sense of it, and I apologize for the inquiry. But I'm not following the rationale. If we are being told that we're ready to go-live but there were unforeseen claim types, then that would mean you weren't ready to go-live, I guess.

MS. SPROULE: Commissioner Espinosa, this is Anna Sproule, the Senior Director of Operations for Gold Coast. I would completely agree with you. None of these claim types that are being mentioned are anything new for Gold Coast Health Plan. They are claims that we've been processing for years. I am also struggling to understand the response.

MS. CURR: I would ask my colleague, Susan Meikle, she was our Implementation Director and is a little bit closer to some of the issues that were encountered close to go-live. Susan, do you have any additional information that you could provide, surrounding this situation?

MS. SUSAN MIEKLE: I think as we went through our testing of all the different claims, and our financial analysis, I think you try to test every single type of claim. Again, what sometimes happens is you're loading the claims. While they might look okay for this population of providers, maybe a different population of providers, something is not working as expected. I think the universe of our testing population, we may not have loaded enough of it to test. We were focused on high-visibility providers. We were focused on high-visibility types of benefits. I think that when we went live and started loading all the real claims to the system, or we started loading daily claims to the system, we started to see things that we hadn't encountered during testing, which resulted in us having to pin the claims, fix some configuration. There were new requirements that we had to vet out and write certain business logic for, to inject into the system updates and benefit plans, or benefit types, or benefit fee schedules. We believed we had done our due diligence in the testing. Unfortunately, when you're loading the daily claim files, if you're not really getting a true sampling of everything, it's hard, you're looking at certain providers and certain types, and limited claims. Again, going live, now you're really getting the true picture of everything that's coming through the door. We started to see things come up that we weren't seeing with the universe of providers that we were working with. We started to see issues with those specific claim types that we hadn't seen before in the testing.

COMMISSIONER ATIN: This is Commissioner Atin. One quick question. How long have we been a client with Conduent, because I think a lot of us have gone through system conversions. I understand that a new client conversion would be difficult, and you'd have to test, and you don't know what you don't know. But I understood that we were clients of Conduent for some time. Is that not correct?

SHEILA CURR: That is correct.

MR. KADAM: That is certainly correct.

MS. SPROULE: That is correct.

COMMISSIONER ATIN: You've had a number of years, and I think we're focusing on we were ready to go-live on a certain date. I think you can agree, it didn't go as planned. I just question the responsibility or the due diligence that may have gone through or not gone through because you should have seen all our claim types for many, many years.

MS. SPROULE: Commissioner Atin This is Anna Sproule. We have been contracted with Conduent for over 10 years now, so they are very aware of our claim types, as you mentioned. The financial accuracy that was pointed out by Ms. Meikle was something that Gold Coast Health Plan requested specifically because of the errors that we were seeing in testing, as well as moving forward. I'd like to point out that this analysis and the items that are being brought up are items that were brought up by Gold Coast, due to the errors. In addition to that, there were no specific new requirements that were laid out prior to go-live that couldn't be tested prior to go-live. I am concerned about the assessment that is being made at this point.

MS. MIEKLE: Anna, let me clarify. I didn't mean prior to the live. I meant after it went live, as we went through it, while it may not have been a new requirement, in some cases it was a new requirement to fix the issue and obtain the new requirements to make sure we weren't missing anything as we fixed a benefit or updated a transform with a code that hadn't been included initially, things like that. I wasn't speaking before go-live. I was speaking more after go-live as we started to see some of the issues that we were seeing on claims that weren't hitting a particular transform that we had created. Again, there may have been a code or two missing. Or maybe it was what we call a UB place to service rule that we needed to tweak, or change, or add. That's when I talk about new requirements. It was nothing before go-live. It was things that we were seeing afterwards.

MS. SPROULE: Thank you for that clarification. I believe there are other commissioners with their hands up.

COMMISSION CHAIR PUPA: Yes, Commissioner Johnson has a question.

COMMISSIONER JOHNSON: I appreciate you all being here today and allowing us to pose some questions because as you can see, we have some concerns. I think one of the things, if I can give you some context from my comments first is that Ventura County, we're not this huge county that doesn't know our community and our population that we serve. And honestly, we're not serving clients. We are serving our neighbors. For us, this really comes down to how are our community members, our neighbors, our loved ones being served, and how does this disrupt the services that they need and that they are eligible for, and that they can't get anywhere else? For us, for me, this is very troubling because I can recall that I keep hearing the phrase that there were unforeseen circumstances that caused the situation that we're in. Ms. Hopper, you said that, and another individual said that. And the reality of that narrative is inaccurate because these challenges, these circumstances were brought to the attention of Conduent. And I still do not understand why they weren't heeded. So, what it feels like for me is that there were deficits in planning, that there were deficits in understanding or having sensitivities to the population that we serve, and that there is now this reactive push to add resources that

should have been done proactively and could have prevented what we are seeing now and was communicated to Conduent. In the months leading up to the go-live, we had commission meetings where there were questions that were put forth, and the only response we heard was, "We believe we're ready. This is good. This is good." But there were no concrete answers. So again, Ms. Hopper, when you said today, "We believed we were ready," can you tell me, exactly what does that mean, because we have seen that Conduent was not ready, even with the warnings, even with all the questions? That is clear. What do you all mean, when you say, "We believed we were ready"?

MS. HOPPER: There was a 17 different process disciplines across the implementation that we had documentation. And again, we are so glad to be here in front of the commission and our Gold Coast constituents because we have been focused a hundred percent on going forward.

MS. CURR: Lisa, let Raj and Susan Meikle, if you could answer the question.

MR. KADAM: I'll talk and Susan Meikle, you can add to it. Commissioner, when we said we were ready, there were no showstoppers that were there. We went through a whole list. As you know, the go-live was set back in last year, and it got moved further and further as and how we had those showstopper issues. But when we said we were ready, all those showstopper issues were no longer there. But obviously there were these nuances, the claim types, and everything that due to lack of testing or whatever, was not uncovered, right? But from a system perspective, there were no showstopper issues first day, for the go-live, when we said that we were ready for go-live. Susan Meikle, if you want to add anything to that.

MS. MIEKLE: I would just agree with what you said, Raj. The testing that we did, again, maybe we didn't test enough, but based on what we had tested and what we went over with Gold Coast, and again, our financial analysis that we did, and anything that was different, we researched it. We looked at it. We fixed those issues when we saw the discrepancies. We really felt, based on the testing that we had done, anything that we couldn't resolve before we went live, we had an appropriate workaround in place for that, again, that was put in place, based on conversations with Gold Coast. We really felt, based on where we stood with resolution of our defects, and the testing that had been done, all the test cases being passed. Anything that hadn't passed, we had workarounds for. We felt that we were ready for go-live.

MS. SPROULE: If I may, Ms. Meikle, I'd like to just respectfully disagree, Conduent, having been with us for so many years, was ready to go-live. We did not agree with Conduent, regarding the showstoppers. And we did not agree with the assessment that you mentioned, that Conduent conducted, and that was all voiced to the Conduent leadership

team, prior to go-live. I just would like to point that out, and potentially move to the next question.

COMMISSIONER JOHNSON: Ms. Meikle, what I can appreciate about what you said is that you did acknowledge that Conduent did not do all the testing they should have done. I do absolutely agree with that. I do have another question. And that is: Is this how you're ready with all your other clients? Is this what it looks like when Conduent says, "I'm ready," or, "We're ready to go-live," because I posed that question at the commission meeting, just prior to going live, when we heard of all the concerns that were brought up. And one of the questions I posed is that do you really believe you're ready to go-live, and is this what go-live looks like with other clients? Seeing everything that has unfolded, I'm very curious if this is what go-live looks like with other clients.

MS. CURR: Raj can answer that question, but we will not talk about other clients. Raj can talk in general terms about how we handle it.

MR. KADAM: Generally speaking, Madam Commissioner, we do implement such systems, even at the state level, with Medicaid, MMI systems, as well as other customers. We have, in the past, have had successful implementations. This nuance between moving from iCloud to HSP, there were certain aspects that as we talked about some testing was not covered. But generally, we have had successful implementation in other customer locations.

COMMISSIONER JOHNSON: Thank you. I see fellow commissioners have other questions, so I will yield my time for now. I will have further questions later. Thank you.

MS. CURR: Ready to move on?

CHAIR PUPA: This is Commissioner Pupa. I do have a concern. Because of the claims backlog and the claims inventory, I understand that we're somewhat on a watch list right now with DHCS, where there's constant communication between Gold Coast and DHCS, regarding these claims backlog and the impact to our providers. How are you going to ensure that our Gold Coast Health plan is held harmless, regarding the compliance that goes along with this backlog of claims inventory?

MR. CALABRESE: Sheila, do you want me to step in here.

MS. CURR: Yes please.

MR. CALABRESE: Commissioner Pupa, Michael Calabrese from Foley and Mardiner. We, outside counsel to Conduent, obviously there is an ongoing conversation about responsibility. I don't think we're at a point we're going to be able to fully vet that

conversation, till we get to the end of this. So that's not an appropriate topic, in our view, for today's meeting. We fully intend to address that topic, but here and now is not the right time.

COMMISSIONER ALATORRE: I have a comment. This is Commissioner Alatorre, and we're talking about going live and whether we were ready to go-live on May 3rd. And covered some claim types or—that we weren't ready for. We weren't ready for any claim type. There were providers that were not getting paid on time. This was a primary care provider. This was a PT provider. This was a different type of provider. We've had duplicate claims, a large amount of duplicate claims. I don't know if this is causing some of the backlog. But we have large amounts of duplicate claims for all of our providers. When is that going to get cleaned up? Rerouted claims—I don't know if this is something that Conduent is doing, or what the system is doing to delay payment for providers. The entire claims system was not ready to go-live. There's provider abrasion. I don't know if Gold Coast has shared letters and the calls that they received through the customer service portal. Last week I just heard that the authorizations are being faxed in - - manual system. We're back to a manual system for referrals and authorizations. The provider portal was supposed to be done July 1 or end of July. We still don't have a provider portal. When we went live, we didn't even have logins for the providers. We weren't ready to provide the providers with logins. They had to go through two or three different systems to get a login. Customer service is, was poorly handled for members and for our providers. I just don't get it. I don't get why we keep saying that we were ready on May 3rd to go-live. All of those are showstoppers. Everything that I've mentioned are showstoppers. We shouldn't have gone live on May 3rd.

CHAIR PUPA: And it put us out of compliance with DHCS on many levels.

COMMISSIONER ATIN: This is Commissioner Atin. I think Commissioner Johnson asked, is this normal live? And the answer was yes, we've successfully converted other clients. But I think Commissioner Alatorre's comments also indicate just the order of magnitude of problems here just really indicate that this is way out of bounds, as far as an implementation. I know I would be shocked if this is your normal or anywhere close to your normal way of converting any client, any existing client, never mind new client. So that's our point. I know we're beating the point. But the point is, it's just shocking, given the community we serve, given the relationship we've had with you, that the order of magnitude is 25,000 inventory, goes up to 125,000. After a May go-live date, you're giving us assurance. And I did not hear that you said high confidence. I tried to insert that in your answer, but you failed to answer. Do we have a high confidence in September, that you're going to get to a normal level? That's the point I think you're hearing the commissioners make; is that this has just been an incredibly unfortunate experience.

CHAIR PUPA: And Commissioner Ramirez has some questions as well.

SUPERVISOR RAMIREZ: Actually, the other Commissioners have asked the questions I would have asked. I just want to say this. I think first of all, I'm a lawyer, so I understand why your lawyer is here. And I understand that you need to be careful in what you say. But I don't need to be careful. I think I might be the only elected official here. So really, the buck stops with me. This organization has gone through quite a few difficult times of getting our act together, to serve our clients, our community, which let's just face it, who they are. They are people in need. People don't always have the finances or the access. They depend on us to provide the best service. And of course, it does mean getting their doctors, their providers paid. I know that if we hope that everything goes well, from the next hour on. But it may not. People will be looking at all of us commissioners, but for me, as a member of the Board of Supervisors, what did you do? When did you know there was trouble, and what did you do? And why did it take so long? I'm really feeling the responsibility to get this fixed. And I want to convey that to you and tell you that I wouldn't like to be in your position and having to deal with this. I feel for you, as one human to another, to several humans. It is our responsibility to try to get this right. It hasn't gone right. I know people are tremendously frustrated, the patients, the providers, our staff, and frankly our commissioners. I just have to say that. Right now, I have a headache from it, frankly. I'll just leave it there.

MS. HOPPER: Thank you for the feedback, Madam Chair, and members of the Commission. We understand this time period. So, we are a hundred percent focused on the plan forward, getting us back to where we need to be. I'll continue kind of going through that, and then, and again, we'll address issues, your concerns. We talked about the people that we've added. Let's talk a little bit about the process that we've gone through. We've added recommendations for process reviews and upgraded or depth level procedures. We've also worked with Gold Coast to determine opportunities for continued streamlining of procedures. From a technology perspective, again, focused on our automation, and our IT, and product experts that we've brought in to help with other levers on reducing the overall inventory levels. We're tracking daily inventory metrics and process, and progress towards completion. We believe the plan that we presented, and the plan that we're all working through is a conservative plan. We have benchmarked it. We have put in all the constraints, for it to be successful. We continue to be agile, and we continue to adapt as different areas arise. I know we've talked a lot about inventory reduction. Let's move to contact center. From a contact center, these are our call centers. We continue to add staff to manage the call center volumes and wait times. We have added somewhere around 15 additional resources to our call center staff. We have temps. We have 23 temps that are also engaged, putting us up to around 38 customer service resources that we've added. We also are recruiting for an additional 15. We continue to staff and to adjust that staffing toward the overall improvement of the area. Cross scaling of resources for all cues. Our call center has the begun to achieve

the SLAs for ASA in August, due to this additional staffing. We are seeing progress. We have added fax lines, which have added to allow providers the fax authorization status requests in. We've also made changes in our operating procedures that are incorporating into those processing manuals. We continue to do the quality reviews and adding resources to that QA team. We are actively recruiting and interviewing candidates, to continue to add to the QA resources.

COMMISSIONER JOHNSON: I have a question. This is related to the call center, I'm assuming, correct?

MS. HOPPER: Yes.

COMMISSIONER JOHNSON: When people call in, the wait times and everything. I do appreciate the fact that wait items have gone down from 12 to 17 minutes, to about a minute and a half. I still do believe that a minute and a half is a long time to wait, when someone is already frustrated or feel like they need help in trying to engage a service. I do have a concern. There are reports that members, even after holding for the minute and a half, two minutes, and getting to someone, the call being disconnected, for whatever reason, without them having their needs served. My understanding is that, in digging into that, there's a significant lag time of about three weeks for QA. My question is why is that cadence so far out? It seems impossible to catch issues as they come up, if they're waiting three weeks to review the quality of the calls coming into the call center.

MS. HOPPER: Susan Shirley?

MS. SHIRLEY: I would like to take the opportunity to answer that question. We did in fact have a backlog in our QA process for the call center agents. It has since been caught up to be within about four days. We are hiring folks in the QA area as well and are in the process of training right now to have more auditors available to do that more intensive QA that you've talked about and discussed. We certainly are not happy with the impact that the community has felt regarding the long wait times within the call center for both providers and members, and specifically on the member side because we know that they really should not have been affected at all by this transition. To Ms. Hopper's point, we are continuously adding people within the call center, both within the QA area and within the customer service agent area, to make sure that we've always got a training class going on, and that we essentially have a bench, so that we can get back below that 30 second average speed of answer time, and make sure that people don't get annoyed having to wait for a minute and a half or even longer before their call is answered.

COMMISSIONER JOHNSON: Thank you. I don't want to go too far into details, but I am curious as to what is the goal for the QA review? What frequency is the goal? Is it four

days, three days, two days? What is the goal, to be able to follow up with these calls and make sure that the members are being provided with high quality customer service?

MS. SHIRLEY: We typically like to be no later than 24 hours behind, in reviewing calls, so that we can not only address issues, if they've come up, if someone has been provided an incorrect response, say, so we can go back in and call that provider or call that number. And as we add resources, that's the guideline that we managed to.

COMMISSIONER JOHNSON: Is there a date that you anticipate being able to be at the place where you have staff that are trained, and will be able to attain within 24 hours, you're able to play back these calls, and then reach out to the members as needed. Is there a date?

MS. SHIRLEY: Let me go back and verify that with the quality team, and get a specific date for the commission, if that is acceptable.

COMMISSIONER JOHNSON: Thank you very much.

MS. HOPPER: We are currently finalizing our provider portal. The vendor authorization enhancements. The priority CCDs are being addressed. We have 28 CCDs, and 14 of those have been closed. We have additional functionality that's being prioritized for development and delivery. These collaborative and integrated planning include all our stakeholders and a schedule that the parties are committed to meet. Good news from our LAS, our finance committee; we are looking at an October date for the release of the portal. We have moved that up from our last discussion. We remain committed to urgency and getting all these enhancements implemented. The current scope of the delivery focuses on immediate needs for the vendor capabilities. We continue to work with Gold Coast on alternative portal to meet future needs.

MS. SPROULE: Do you have a specific date, Lisa, in October because the last date was November.

MS. HOPPER: I heard October 3rd is the date.

MS. SPROULE: And that's all inclusive, specific to the authorization?

MS. HOPPER: Yes. Raj, do you want to answer that?

MR. KADAM: Anna, there are those specific CCD's, right? September 24th will be the date that we deliver. And then that will open till October, right? That is the date that we have put. We had thought was October 29th, we have pushed up by a month to September

24th for those two CCDs, mainly that were the biggest problem that we discussed on our Monday, Wednesday, Friday call.

MS. SPROULE: That will include all the contact information and the eligibility detail? Is that correct?

MR. KADAM: Yes, the eligibility detail contact information, I think so. That was the third CCD, if I'm not mistaken. And we've been working with your team to get more requirements around it. That will be delivered as well.

MS. SPROULE: That is a huge issue for us. If that is not going to be delivered by the October date, if you could please provide the commissioners with the updated date because that would not be an accurate go-live date. Thank you.

MR. KADAM: Yes.

MS. HOPPER: Okay. That's the end of the presentation.

COMMISSIONER JOHNSON: Just to be clear if we could back up a little bit. I know our staff are extremely well versed in all the language and lingo. For myself, I am not. I just want to make sure I understood that last interaction. I believe the question on the table was if the September 24th date would include eligibility and contact information for authorizations, the necessary information. Is it correct that it will include that or not?

MR. KADAM: It will, yes. The teams are working together to get more clarification, Madam Commissioner. But yes, we have pushed up the dates by one month to expedite on those particular things.

MS. HOPPER: To be clear, Raj, you're waiting on requirements from Gold Coast, correct?

MR. KADAM: Yes, because that was one specific thing in which they mentioned it is nice to have and not a must have. We just need a little clarification on that.

MS. SPROULE: I'd like to further elaborate on what I'm hearing. Raj, I've heard two different messages in this discussion. One I heard that the authorizations contact information, which is necessary for when we receive authorizations from providers, that we have the ability to reach out to the provider in case we need additional information. Initially, I heard you say that will not be ready. Now I'm hearing you say that it will be ready for the October go-live date. If you can answer that first, and then I'll go to my next question, please.

MR. KADAM: Let me circle back … the submit authorization contact information, which is CCD number, and I could find my email. I was looking for that, 3.93 as the MediTrac customization 3690, yes, they will be done by the October date.

MS. SPROULE: All requirements have been provided by the Gold Coast team as quickly as they are requested. Please help me to understand what specific requirements you are waiting for and when those were submitted for request to Gold Coast Health Plan?

MR. KADAM: I can get those details certainly, Anna. And we can talk about it.

MS. SPROULE: Can you give me that specific date again in October?

MS. HOPPER: October 3rd.

COMMISSIONER JOHNSON: Just a follow up because I want to have clarity here because I feel there's been so much confusion. I hear a team member saying that you're waiting on information from Gold Coast Health Plan. When staff asks for clarification as to what information you're waiting for and when the request was sent, I hear a response of we'll have to circle back. I'm really troubled to understand what information are you waiting for? If you're able to say that you're waiting for information, I would think in some case, you'd be able to give us an idea of what that information is you're waiting for from Gold Coast.

MR. KADAM: I'd have to check with my team if we have all the information. The last I heard was there was something pending. But I have to check with my team again, and I will circle back with this.

COMMISSIONER JOHNSON: So maybe an accurate statement would have been, I need to check with my team, instead of saying we're waiting for information from Gold Coast. It's been established that that's not clear. Is that accurate?

MR. KADAM: Yes.

COMMISSIONER JOHNSON: Thank you.

CHAIR PUPA: Are there any other questions from Commissioners? If there are none, we will move on to agenda item number 6.

6. HSP MediTrac Go-Live Update

Staff: Anna Sproule, Sr. Director of Operations

RECOMMENDATION: Receive and file the update.

The following verbatim minutes are edited for clarity. The verbatim minutes have been transcribed by First Legal Depositions per the direction of General Counsel, Scott Campbell.

MS. SPROULE: Good evening, Madam Chair, and members of the Commission. I will be updating you on the ETP project. There are actually four topics I'd like to discuss with the team today. The current claims inventory reduction plans, provider portal testing update, Conduent oversight, and data warehouse data integrity.

MS. SPROULE: As mentioned by the Conduent team, the current outstanding claims inventory has continued to trend downward. On July 16th, we had 164,000 claims in inventory, and we were down to 96,000 on August 19th. The state has continued to monitor Gold Coast Health Plan progress towards the claims inventory compliance daily. Conduent has indicated that they are unable to meet the 8/31 deadline for claims compliance, as the state is expecting. As a result, Gold Coast Health Plan has procured additional temporary claims staff to assist with the claims processing. In addition, Gold Coast Health Plan team members are working overtime to assist with the inventory reduction and do quality review and training. We are also experiencing an increase in claims, claim provider disputes, which is causing a lot of rework, of claims processed on our new system since go live. Due to the claims incorrectly getting included into the pay run as mentioned, with duplicate claims, on Thursday, August 19th, we did have to cancel that payment run. We'll reschedule it again for tomorrow. The inventory reduction plans provided to Gold Coast to date do not account for errors in the system in incorrect denials or overpayments and duplicates that may exist.

I'd like to discuss the provider portal. The Gold Coast Provider Network, health services and operations teams have continued testing the authorization related changes to the portal. The updates made to the portal are to allow providers to submit and check status of authorizations on the portal directly. A functioning provider portal was projected to be released to Gold Coast Health Plan providers by September 1st. This has, however, changed as you heard, to October, due to the defects identified in the testing. This continues to impact our providers who have to fax authorizations to Gold Coast health plans utilization management team and are unable to review the authorization status on the provider portal. In addition, this has had significant impacts on the Gold Coast Health Plan utilization management team and their workload, and the progress that they have made to date, with streamlining the processes.

Next, I'd like to talk about the oversight that is being completed with Conduent. The Gold Coast Leadership Team is meeting with Conduent daily to review inventory, call center statistics, adherence to plans to reduce inventory, as well as the quality assurance that should be taking place. These meetings will continue until such time as the contractual obligations of Conduent are being met and sustainability has been proven. The claims inventory has continued to reduce, and the call center has improved the average speed of answer, from over 10 minutes on average, to less than 2 minutes, so far for the month of August. This is attributed to additional resources having been added to the Conduent call center over the last several weeks. As previously mentioned, we were concerned about the delays in the quality assurance being three weeks plus behind. I look forward to seeing the evidence that it has been conducted up to date—has been completed up to date. Finally, the data warehouse data integrity issues have created the need for Gold Coast Health Plan resources to validate the data that's in the data warehouse. This has caused significant downstream reporting impacts, with several of our reports. That includes regulatory reports, as well as separate and independent financial reporting requirements. Do any of the commissioners have any questions?

COMMISSIONER JOHNSON: I have a question. I'm curious about a couple of things in your report. I don't know if the question is honestly for you, more than Conduent staff. You mentioned in your report that Gold Coast staff are working overtime to fix errors that have been discovered. Gold Coast had to acquire 30 additional resources, to work on the inventory reduction. My question is it does seem like that is the role of Conduent. I am wondering why Gold Coast is taking that on. I don't know if the question is for you, but more for Conduent staff to address. Is that regular practice, or am I missing something here?

MS. CURR: We will answer that in respect to the additional people were brought to us by the Gold Coast staff. In the respect that every company out there, including Conduent, is having trouble recruiting, post COVID, we took Gold Coast up on that offer of the additional staff. We are trying to remediate very quickly and are trying to staff very quickly, we have every organization within our organization, looking for staff. We answered that question with yes, we would take that staff, and yes, Gold Coast could, with transparency, charge us for that staff.

MS. SPROULE: Sheila, thank you for providing that insight. We did offer to source 30 staff that we have sourced within Gold Coast, so we have provided them the supplies, the materials, the computers, the interviews, etc. We were able to procure that staff within two days of the outreach beginning. I understand there may be concerns about finding staff, but we were able to identify staff very quickly. Commissioner Johnson, I believe that that was your question. Is that correct?

COMMISSIONER JOHNSON: Yes, that is correct. Again, I feel I'm left with confusion after more context is provided. Thank you for the information. It's very helpful.

COMMISSIONER ALATORRE: Anna, I think on Thursday I asked about the late payments and any interest that needs to be paid when a claim is paid late. Also, with authorizations, I asked about timeliness. Is that affecting us? I know these are huge compliance issues for DHCS, the Department of Healthcare Services.

MS. SPROULE: Yes, regarding the authorizations, I would like to ask if Dr. Wharfield for assistance in a response.

MS. NICOLE KANTER: I can respond.

Ms. NICOLE KANTER: This is Nicole Kanter. I'm the Director for Utilization Management. Yes, we are in compliance with our authorizations. We are still meeting our turnaround times. We have a lot of overtime for our non-clinical staff, to make sure we're creating these cases timely and getting them over to our nurses for review, and we are within the five business days for standard request and 72 hours for urgent. We are monitoring that closely and we are meeting our regulatory requirements at this time.

MS. SPROULE: With regard to the interest, we are looking at upwards of $160,000 in interest since May, since the go-live. Did that answer both of your questions, Commissioner?

COMMISSIONER ALATORRE: Yes, is Conduent helping with the interest payments and with the overtime, paying for the overtime, to make sure that the authorizations and the referrals of our members get processed timely?

MS. SPROULE: We did send a request to Conduent to respond to both areas, and I'd like to defer to Ms. Curr.

MS. CURR: We have said that once we have inspected, we will discuss. And Michael Calabrese, I don't know if you would like to step in.

MR. CALABRESE: I was about to. Again, it's just a separate conversation. As I said, we're not here to discuss liability. It doesn't mean deny liability or anything like that. It's just a separate conversation that has to be had. And this just is not the appropriate forum. I do understand the request, and we do intend to address it, just not here and now.

CHAIR PUPA: Anna, you had mentioned the $180,000 in interest and penalties. That, in my mind, translates to many, many, many late payments to our providers. Do you have any ballpark number of claims that were impacted by the interest and late fees?

MS. SPROULE: I do not, offhand, Madam Chair, but I can provide that to you in an offline commission memo if that's okay.

CHAIR PUPA: Thank you. I would like to see that because I'm sure it's many, many claims to add up to $180,000 in interest.

MS. SPROULE: It is.

CHAIR PUPA: Thank you.

MS. SPROULE: Are there any other questions from the Commission? Thank you again for your time today.

Commissioner Laura Espinosa motioned to approve Updates 4, 5 and 6. Commissioner Atin seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Supervisor Carmen Ramirez, Jennifer Swenson and Scott Underwood, M.D.

NOES: None.

ABSENT: Commissioner Gagan Pawar, M.D.

Commissioner Pupa declared the motion carried.

FORMAL ACTION

7. Strategic Planning Ad-Hoc Committee

Staff: Marlen Torres, Executive Director of Strategy & External Affairs

RECOMMENDATION: Staff recommends that the Commission reconstitute the Strategic Planning Ad Hoc Committee and select up to five Commissioners who will serve in the ad hoc committee.

Marlen Torres, Executive Director of Strategy & External Affairs stated she would like meetings for the Ad-Hoc committee to begin to meet in September. This committee will give guidance on the strategic plan. Ms. Torres is requesting reconstitution of the Ad-Hoc committee and asked commission of there were volunteers to join the committee.

General Counsel, Scott Campbell stated a maximum of five (5) members is needed for this committee.

Commissioner Dee Pupa stated she would like to continue the committee. Commissioner Jennifer Swenson stated she would also like to continue. Commissioner Sevet Johnson stated she would like to join, and Commissioner Alatorre stated he would like to continue this committee.

Commissioner Laura Espinosa motioned to approve the 2021 Strategic Planning Ad-Hoc Committee. Commissioner Theresa Cho, M.D. seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Supervisor Carmen Ramirez, Jennifer Swenson and Scott Underwood, M.D.

NOES: None.

ABSENT: Commissioner Gagan Pawar, M.D.

Commissioner Pupa declared the motion carried.

8. Amendment of Chief Diversity Officer Contract with Theodore Bagley dba TBJ Consulting

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Staff recommends that the Commission approve the proposed Fourth Amendment to the Consulting Services Agreement.

General Counsel, Scott Campbell stated the amendment includes a 10% rate increase, noting there has been no raise since the start of his work at GCHP. Authorization for 100 additional hours is also requested, if needed.

Commissioner Atin stated he was a proponent of Mr. Bagley's. He stated health equity is a prominent issue and he supports the additional hours requested. Commissioner Atin asked if there had been an analysis of rates. General Counsel, Scott Campbell replied yes. Chief Financial Officer, Kashina Bishop stated the amount requested did not exceed the budget.

Commissioner Pupa thanked Mr. Bagley for attending additional meetings. Commissioner Johnson stated she appreciated his work in the community and noted that he has gone above and beyond in working with the Community. Commissioner Espinosa stated she has had many conversations with Mr. Bagley and noted that he has bone beyond the scope of work. She did add the need for a permanent CDO position. Commission Underwood stated he agreed with the proposal and stated Mr. Bagley has done great work.

Ted Bagley stated that in four plus years that he has been at GCHP he has not overcharged. He does not include travel expenses, seminars attended or after hour calls. He is very dedicated to the GCHP employees. CEO Tatar stated Ted Bagley has done great work and they have a good relationship. She noted Mr. Bagley had served as Interim HR Director, serving duo roles for almost one year.

Commissioner Andrew Lane left the meeting at 7:44 p.m.

Supervisor Carmen Ramirez motioned to approve the amendment of the Chief Diversity Officer contract. Commissioner Jennifer Swenson seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Gagan Pawar, M.D., Dee Pupa, Supervisor Carmen Ramirez, Jennifer Swenson and Scott Underwood, M.D.

NOES: None.

ABSENT: Commissioners Andrew Lane and Gagan Pawar, M.D.

Commissioner Pupa declared the motion carried.

9. July 2021 Financials

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Staff requests that the Commission approve the June 2021 financial package.

Chief Financial Officer, Kashina Bishop, gave a financial overview for the month of July. The July net gain was $6.3 million. Fiscal Year to Date net gain is also $6.3 million. TNE is now 293% of the minimum required. Medical loss ratio is 87.6% and administrative ratio is 4.8%.

We have hit a milestone for the Solvency Action Plan (SAP) in the month of July. In August of 2020 TNE was 192% and now, one year later we are at 293%. CFO Bishop has reviewed next steps for the SAP. She also noted our net premium revenue is $83.3 million, over budget by $881,496.

Membership trends were reviewed. Membership has leveled out at 222,000 pending unemployment rates.

Medical Expenses FYTD health care costs are $73.0 million and $2.7 million, which is 4% under budget. IBNR is difficult to calculate due to the system conversion, we do not have an accurate data file which is impacting category of service on financials.

CFO Bishop reviewed inpatient medical expenses, long-term care expenses, outpatient expenses, ER expenses, and mental and behavioral health.

Commission Chair Dee Pupa stated it was a refreshing comparison from 12 – 18 months ago. She thanked CFO Bishop and her team for all her hard work, especially during the claims migration.

Commissioner Antonio Alatorre motioned to approve the July 2021 Financials. Supervisor Carmen Ramirez seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Dee Pupa, Supervisor Carmen Ramirez, Jennifer Swenson and Scott Underwood, M.D.

NOES: None.

ABSENT: Commissioners Andrew Lane and Gagan Pawar, M.D.

Commissioner Pupa declared the motion carried.

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.

Commissioner Atin motioned to approve all reports presented. Supervisor Carmen Ramirez seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Dee Pupa, Supervisor Carmen Ramirez, Jennifer Swenson and Scott Underwood, M.D.
NOES: None.

ABSENT: Commissioners Andrew Lane and Gagan Pawar, M.D.

Commissioner Pupa declared the motion carried.

The Commission moved to Closed Session at 8:04 p.m.

CLOSED SESSION

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

ADJOURNMENT

General Counsel, Scott Campbell stated there was no reportable action in Closed Session. The meeting was adjourned at 8:33 p.m.

Approved:

_____
Maddie Gutierrez, MMC
Clerk to the Commission

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AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: September 27, 2021

SUBJECT: Adopt a Resolution to Renew Resolution No. 2021-011, 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. 2021-012-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. 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 spread rapidly 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 Chief Executive Officer ("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 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.

Since the adoption of Resolution No. 2020-003, the Commission has renewed and reiterated the emergency powers granted to the CEO on July 27th, August 24th, September 28th, October 26th, January 25th, February 22nd, March 22nd, April 26th, June 28th, July 26th, and more recently by adopting Resolution No. 2021-011 on August 23, 2021. Resolution No. 2021-011 expires today, September 27, 2021.

COVID-19 continues to present an imminent threat to the health and safety of Plan personnel. Although vaccines are now widely available, many people in the State and County are still not fully vaccinated and remain susceptible to infection. As of September 9, 2021, 69.6% of the *eligible* population are *fully vaccinated*. This is a 3.4% increase from last month. Although, vaccination rates are increasing, the disease can still spread rapidly through person-to-person contact and those in close proximity. Further, more contagious variants of the disease are now present in the State and County, the most predominant of which is the Delta variant. Additionally, a variant of concern, the Mu variant is now present in the State and nearby counties. According to the World Health Organization, the Mu variant is found to have key mutations linked to greater transmissibility and the potential to evade antibodies.

VCPH is strongly urging all County residents that are eligible but have not yet been fully vaccinated to get vaccinated as soon as possible. The County is aligned with the California Department of Public Health and the Center for Disease Control and Prevention guidance on mask wearing, which recommends that everyone regardless of vaccination status wear masks indoors, and that requires those that are not fully vaccinated to mask indoors.

Additionally, Cal/OSHA released revised rules for workplaces, which became effective immediately pursuant to Executive Order N-09-21 issued by Governor Newsom on June 17, 2021. Among other updates, Cal/OSHA's revisions align with the latest guidance from CDPH based on guidelines issued by the CDC. The Plan's CEO and Human Resources Director are evaluating how this will impact the Plan's back to work plans and will provide an update to the Commission.

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 October 25, 2021, the next regularly scheduled Commission meeting. The intent of this resolution is to balance the ability to continue the safe and efficient operations of the Plan during the global health pandemic. As State and County health orders evolve, the Plan's response should also evolve. Measures adopted to reduce the spread of COVID-19 amongst Commission staff may be rescinded when they are no longer needed in response to the pandemic. 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. 2021-012 to extend the duration of authority empowered in the CEO through October 25, 2021.

ATTACHMENT:

1. Resolution No. 2021-012.

RESOLUTION NO.2021-012

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. 2021-011 TO EXTEND THE DURATION OF AUTHORITY EMPOWERED IN THE 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, 2020-006, 2020-007, 2021-001, 2021-002, 2021-003, 2021-004, 2021-005, 2021-009, 2021-010, and 2021-011 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 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 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, since the adoption of Resolution No. 2020-003, the Commission has renewed and reiterated the emergency powers granted to the CEO on July 27th, August 24th, September 28th, October 26th, January 25th, February 22nd March 22nd, April 26th, May 24th June 28th, July 26th and more recently on August 23rd 2021, by adopting Resolution No. 2021-011. Resolution No. 2021-011 expires today, September 27, 2021; and

WHEREAS, on June 11, 2021, the Governor of the State of California issued Executive Order No. N-07-21 that rescinded the statewide safer at home order issued on March 19, 2020 and the state's Blueprint for a Safer Economy that set forth the tier based framework for reopening the economy. Also on June 11, 2021, the Governor issued Executive Order No. N-08-21 that identifies specified provisions adopted in pervious State executive orders that notwithstanding the rescission of the State's Stay at Home order and the Blueprint, will continue to remain in place for a specific period of time set forth in Order No. N-08-21; and Cal/OSHA released revised rules for workplaces which became effective immediately pursuant to Executive Order N-09-21 issued by Governor Newsom on June 17, 2021; and

WHEREAS, unless renewed by the Commission, the delegation of authority empowered in the CEO, pursuant to Resolution No. 2021-011 shall expire today, September 27, 2021; 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 October 25, 2021, the next regularly scheduled Commission meeting; and

WHEREAS, unfortunately, the State and County and currently experiencing a surge in confirmed COVID-19 cases and hospitalizations. Although vaccines are now widely available, many people in the State and County are still not fully vaccinated and remain susceptible to infection. Further, more contagious variants of the disease are now present in the State and County, the most predominant of which is the Delta variant; 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 in to 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.

B. Resolution No. 2020-001 expired on April 27, 2020.

Section 4. 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 5. 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 6. Since the adoption of Resolution No. 2020-003, the Commission has renewed and reiterated the emergency powers granted to the CEO on July 27th, August 24th, September 28th, October 26th, January 25th, February 22nd, March 22nd, April 26th, May 24th June 28th, July 26th and more recently on August 23, 2021, by adopting Resolution No. 2021-011. Resolution No. 2021-011 expires today, September 27, 2021.

Section 7. The Commission now seeks to renew and reiterate the authority granted to the CEO approved in Resolution No. 2021-011 through October 25, 2021.

Section 8. Unless renewed by the Commission, the delegation of authority empowered in the CEO, pursuant to this Resolution shall expire on October 25, 2021.

PASSED, APPROVED AND ADOPTED by the Ventura County Medi-Cal Managed Care Commission at a regular meeting on the 27th day of September 2021, by the following vote:

AYE:

NAY:

ABSTAIN:

ABSENT:

_____

Chair:

Attest:

_____

Clerk of the Commission

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Michael Murguia, Executive Director of Human Resources

DATE: September 27, 2021

SUBJECT: Return to Office Planning Update

PowerPoint with Verbal Presentation

ATTACHMENTS:

Return to Office Planning Update

Gold Coast Health Plan℠
A Public Entity

Gold Coast Health Plan

Return to Office Planning Update

Integrity

Accountability

Collaboration

Trust

Respect

Return to Agenda

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

Our Return to Office Update

- Our current situation is working
- We are meeting all service levels for our members
- All indicators and metrics are positive
- We have not experienced any issues with Non-Exempt staff
- We have not experienced any worker compensation issues
- We monitor production and performance
- We are ensuring that any in person member situations are resolved quickly

Due to Delta Variant and the safety of our employees we have extended our return to office to April 1st 2022

Return to Agenda

Our Return to Office Update

- Competition is moving towards more flexibility
- The “New Reality” will require this type of flexibility
- Out of area and out of State work must be addressed
- We currently have employees requesting moves out of State
- Policy changes
- Cultural changes
- Longer term implications would include a plan for Office Configurations and Real Estate

Return to Agenda

Our recommended strategy is a remote flexible workforce that works for our Plan and members

EMPLOYEE SURVEY RESULTS

Return to Agenda

Department	Executive Leader	I prefer to work both from home and the office.	I prefer to work in the office 100% of the time.	I prefer to work remotely 100% of the time.	Grand Total
Finance	Bishop	5		5	10
Compliance	Franco	2		8	10
Claims	Liguori			7	7
Grievance & Appeals	Liguori	2		4	6
Member Services	Liguori	1		4	5
Network Operations/Contracting	Liguori	2		8	10
DSS	Moscaritolo			5	5
Information Technology	Moscaritolo	2		13	15
Operations Support Services/EDI	Moscaritolo	1		4	5
Project Management Office	Moscaritolo			1	1
Solution Services	Moscaritolo	1			1
Facilities	Murguia		1		1
Human Resources	Murguia	1		3	4
Communications	Tatar	2			2
Executive	Tatar	1		3	4
Government Relations	Torres	1		2	3
Care Management	Wharfield	2	2	18	22
Health Education	Wharfield	2	1	4	7
Health Services	Wharfield	5	1	28	34
Pharmacy	Wharfield	2			2
Population Health	Wharfield	1			1
Quality	Wharfield	2		8	10
Utilization Management	Wharfield	1	1	12	14
Grand Total		**36**	**6**	**137**	**179**

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Anna Sproule, Sr. Director of Operations

DATE: September 27, 2021

SUBJECT: HSP / MediTrac Go-Live Update

VERBAL PRESENTATION

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kashina Bishop, Chief Financial Officer

DATE: September 27, 2021

SUBJECT: August 2021 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached August 2021 fiscal year-to-date ("FYTD") financial statements of Gold Coast Health Plan ("GCHP") for review and approval.

BACKGROUND/DISCUSSION:

The staff has prepared the unaudited 2022 FYTD financial packages, including statements of financial position, statement of revenues and expenses, changes in net assets, statement of cash flows and schedule of investments and cash balances.

Financial Overview:

GCHP experienced a gain of $3.8 million for the month of August 2021 and is favorable to the budget for August 2021 by $3.0M. The favorability is due to timing of administrative and project expenses, and medical expense estimates that are currently less than budget.

Solvency Action Plan (SAP):

GCHP is on the right trajectory to ensure its long-term viability. That said, GCHP remains in a vulnerable position and must continue to build reserves to levels that are, at minimum, consistent with the Commission policy. To that end, your management team remains focused on the next phases of the SAP and that solvency-related actions are implemented in a manner that respects the provider community and mitigates any adverse impact on our providers or members.

The SAP is comprised of three main categories: cost of healthcare, internal control improvements and contract strategies. The primary objectives within each of these categories is as follows:

1. Cost of healthcare – to ensure care is being provided at the optimal place of service which both reduces costs and improves member experience.

2. Internal control improvements – to ensure GCHP is operating effectively and efficiently which will result in administrative savings and safeguard against improper claim payments.
3. Contracting strategies – to ensure that GCHP is reimbursing providers within industry standard for a Medi-Cal managed care plan and moving toward value-based methodologies.

The management team concluded several months ago that it is imperative that GCHP have a keen focus on fundamental activities that are essential to its providers and members, most notably the system conversion and implementation of CalAIM. This has and will continue to cause some delay in implementing some of the below initiatives, but the focus and hard work remains particularly on the efforts to tighten internal controls. During the system conversion, staff was able to complete two significant internal control improvements:

1. Appropriate diversion of ED claims to California Children's Services; these services are carved out of GCHP.
2. Implementation of additional claims edit system checks which will minimize payment errors.

Category	Current Focus	Annualized impact in savings
Cost of Healthcare	LANE – avoidable ER analysis	TBD
	Pro-active transplant management approach	TBD
	Analysis of leakage to out of area providers	TBD
Internal Control Improvements*	Review of provider contracts for language interpretation and validation	N/A
	Develop revised provider contract templates and a standard codified DOFR template	N/A
	Improve quality and completeness of encounter data	Revenue implications
	Capitation reconciliation at member level	Revenue
	RDT data improvement	Revenue
Contracting Strategies	Expansion of capitation arrangements	Required TNE and risk reductions
	LANE/HCPCS analysis	TBD
	Outlier rate analysis	TBD

* this is a sub-set of the internal control improvements with direct impacts to the SAP and providers. Staff will periodically update the Commission on the comprehensive list.

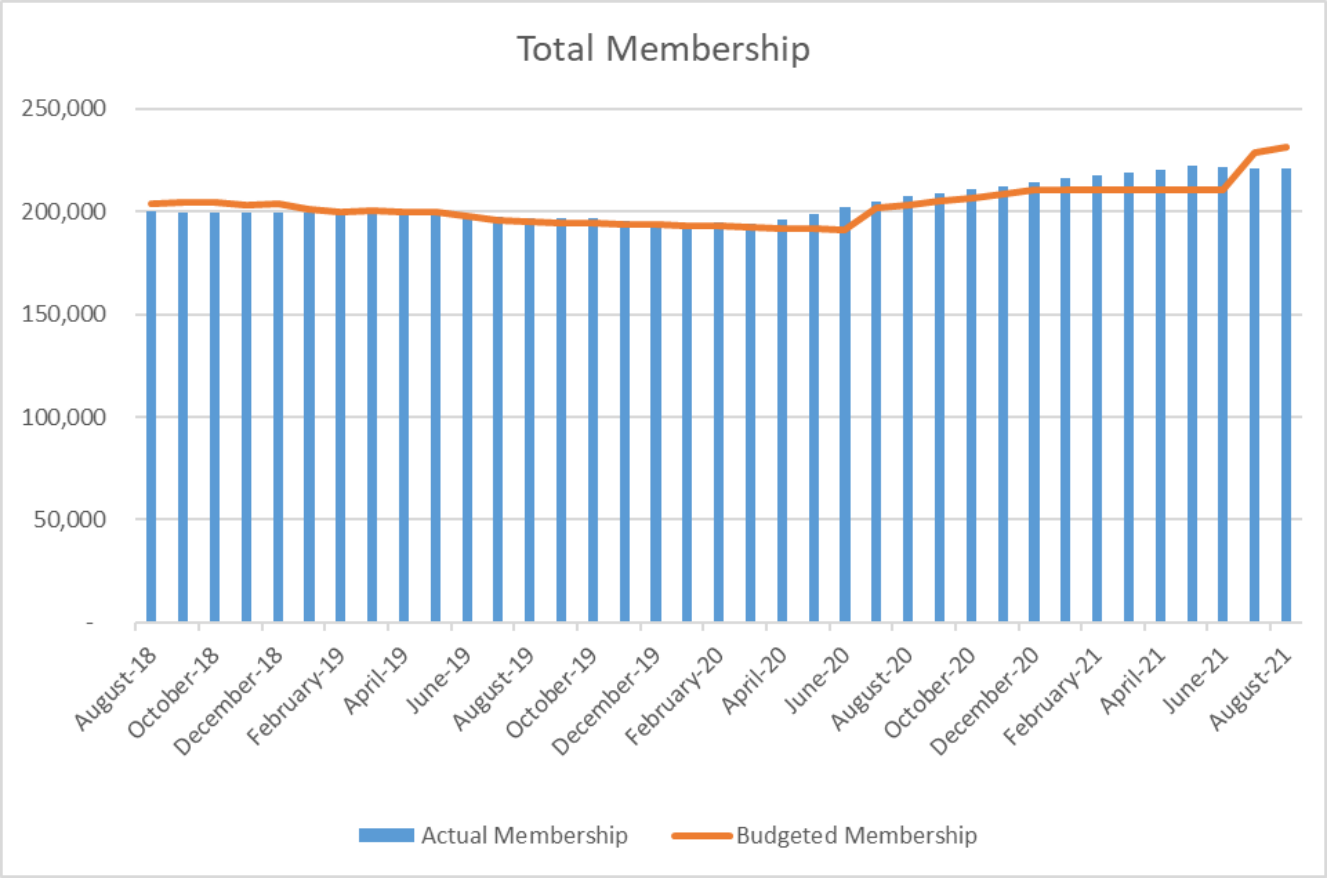
Financial Report:

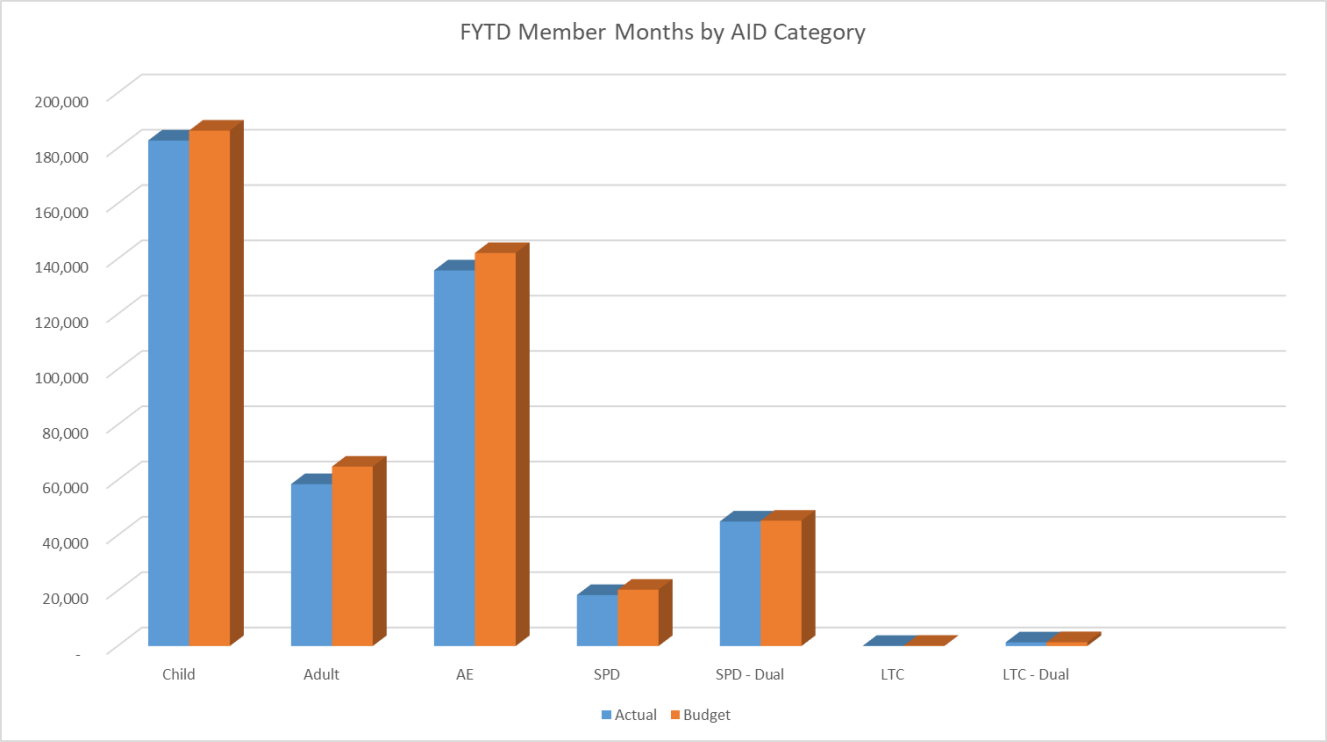
GCHP is reporting net gains of $3.8 million for the month of August 2021.

August 2021 FYTD Highlights:

1. Net gain of $10.1 million, a $8.0 million favorable budget variance.
2. FYTD net revenue is $165.8 million, $214,980 over budget.
3. FYTD Cost of health care is $146.8 million, $5.5 million under budget.
4. The medical loss ratio is 88.5% of revenue, 3.4% less than the budget.
5. FYTD administrative expenses are $8.9 million, $2.4 million under budget.
6. The administrative cost ratio is 5.4%, 1.4% under budget.
7. Current membership for August is 222,382.
8. Tangible Net Equity is $111.1 million which represents approximately 44 days of operating expenses in reserve and 302% of the required amount by the State.

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


Total Membership
250,000
200,000
150,000
100,000
50,000
-
August-18
October-18
December-18
February-19
April-19
June-19
August-19
October-19
December-19
February-20
April-20
June-20
August-20
October-20
December-20
February-21
April-21
June-21
August-21
Actual Membership
Budgeted Membership


FYTD Member Months by AID Category
200,000
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
-
Child
Adult
AE
SPD
SPD - Dual
LTC
LTC - Dual
Actual
Budget

Revenue
Net Premium revenue is $165.8 million; a $214,980 and .1% favorable budget variance.

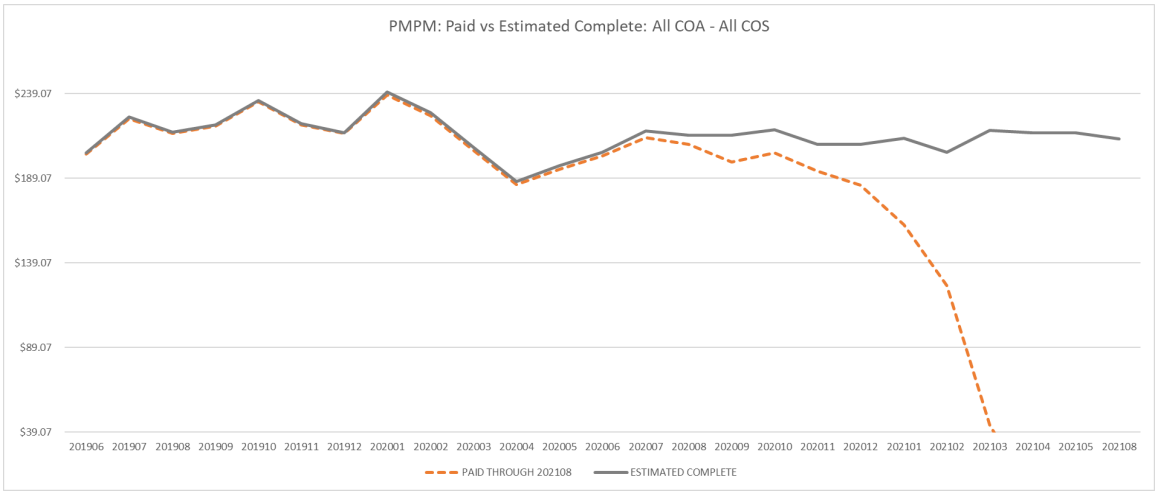
Health Care Costs
FYTD Health care costs are $146.8 million; a $5.5 million and 4% favorable budget variance.

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.

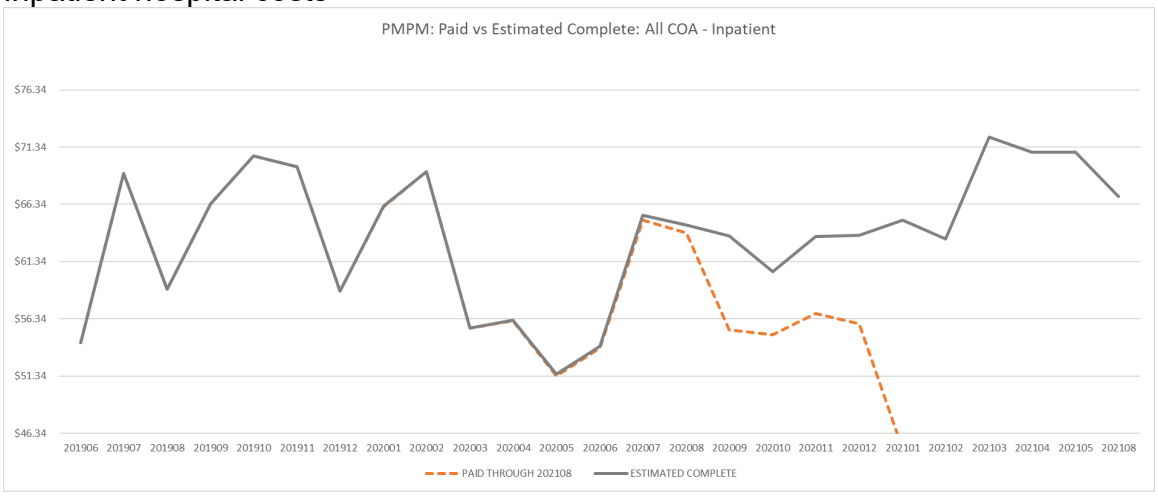
Due to the system conversion, staff does not yet have an accurate data file to complete the estimate with the same level of detail as has been the historical process. One of the issues being addressed is discrepancies in the mapping of data to the correct category of service. This impacts staff's ability to research actual and budget variances at the category of service level. At a high level, medical expenses have remained consistent with prior months and are running below budget expectations which were conservative.

High level trends on a per member per month (PMPM) basis for the major categories of service are as follows:

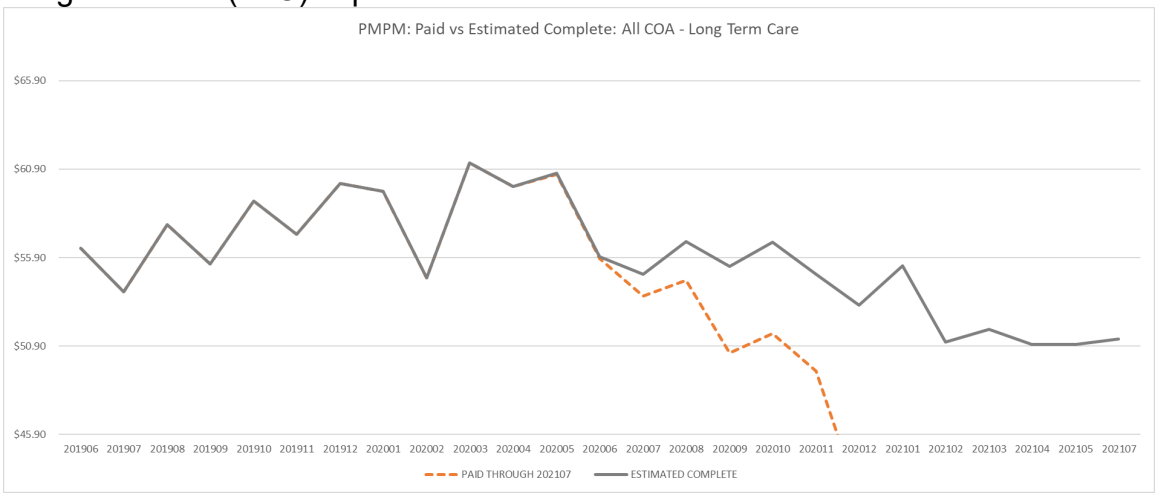
1. All categories of service



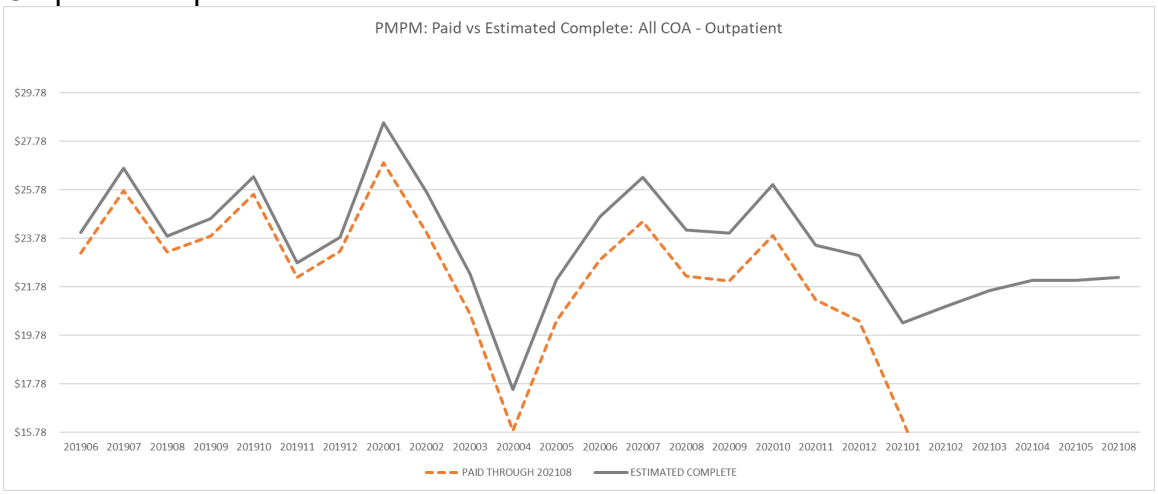
2. Inpatient hospital costs



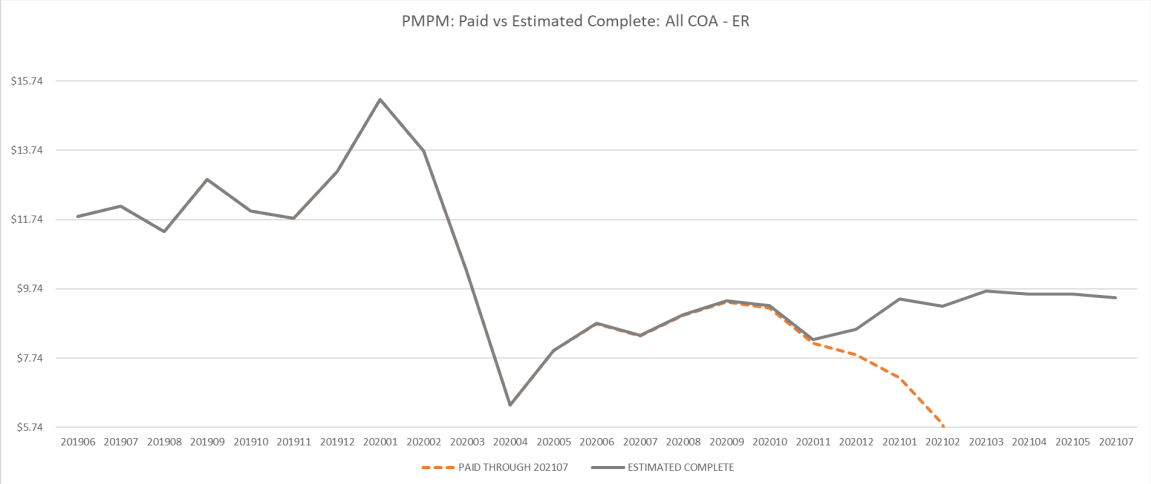
3. Long term care (LTC) expenses



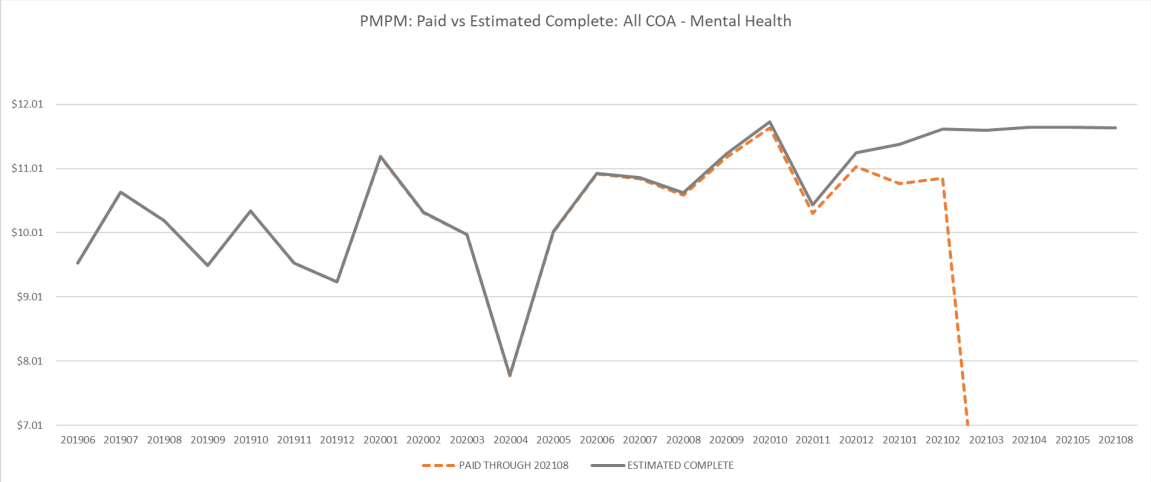
4. Outpatient expenses



5. Emergency Room expenses



6. Mental and behavioral health services



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 public health plans in California.

For the fiscal year to date through August 2021, administrative costs were $8.9 million and $2.4 million below budget. As a percentage of revenue, the administrative cost ratio (or ACR) was 5.4% versus 6.8% for budget.

The following are drivers of administrative expense favorability:

- *Enterprise Project Portfolio*: timing of consulting services related to multiple projects (~$700K)
- *Salaries, Wages & Employee Benefits*: primarily related to timing of filling open IT positions (~$350K)

- *Outside Services*: favorability of Conduent expenses due to membership lower than projected and lower fulfillment related charges (~$350K)
- *Professional Services*: timing of employee recruitment in budget (~$270K), favorable consulting expenses related to timing ($240K)
- *Occupancy, Supplies, Insurance and Other*: timing of software and non-capital equipment purchases and implementation (~$300K)

Cash and Short-Term Investment Portfolio

At August 31 the Plan had $233.2 million in cash and short-term investments. The investment portfolio included Ventura County Investment Pool $18.3 million; LAIF CA State $25.2 million; the portfolio yielded a rate of 2.5%.

SCHEDULE OF INVESTMENTS AND CASH BALANCES

	Market Value* August 31, 2021	Account Type
Local Agency Investment Fund (LAIF)[1]	$ 25,207,145	investment
Ventura County Investment Pool[2]	$ 18,338,883	investment
CalTrust	$ 3,772	short-term investment
Bank of West	$ 179,055,159	money market account
Pacific Premier	$ 9,068,459	operating accounts
Mechanics Bank[3]	$ 1,541,181	operating accounts
Petty Cash	$ 500	cash
Investments and monies held by GCHP	***$ 233,215,100***	

	Aug-21	FYTD 21-22
Local Agency Investment Fund (LAIF)		
Beginning Balance	$ 25,207,145	$ 206,976
Transfer of Funds from Ventura County Investment Pool	-	25,000,000
Quarterly Interest Received	-	414
Quarterly Interest Adjustment	-	(245)
Current Market Value	**$ 25,207,145**	**$ 25,207,145**
	-	-
Ventura County Investment Pool		
Beginning Balance	$ 18,321,618	$ 43,304,353
Transfer of funds to LAIF	-	(25,000,000)
Interest Received	17,265	34,530
Current Market Value	**$ 18,338,883**	**$ 18,338,883**

Medi-Cal Receivable

At August 31 the Plan had $103.8 million in Medi-Cal Receivables due from the DHCS.

RECOMMENDATION:

Staff requests that the Commission approve the August 2021 financial package.

CONCURRENCE:

N/A

ATTACHMENT:

August 2021 Financial Package

Gold Coast Health Plan℠
A Public Entity

FINANCIAL PACKAGE
For the month ended August 31, 2021

TABLE OF CONTENTS

- Executive Dashboard
- Statement of Financial Position
- Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Cash Flows
- Schedule of Investments & Cash Balances

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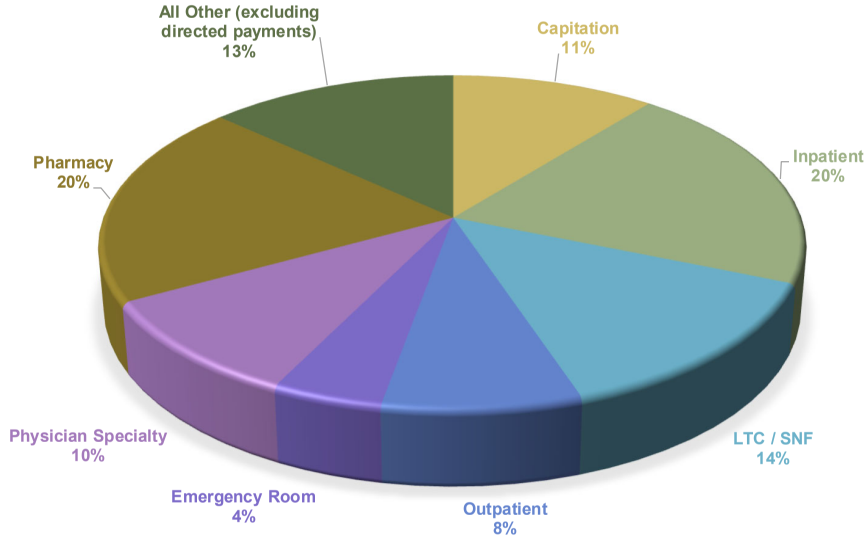
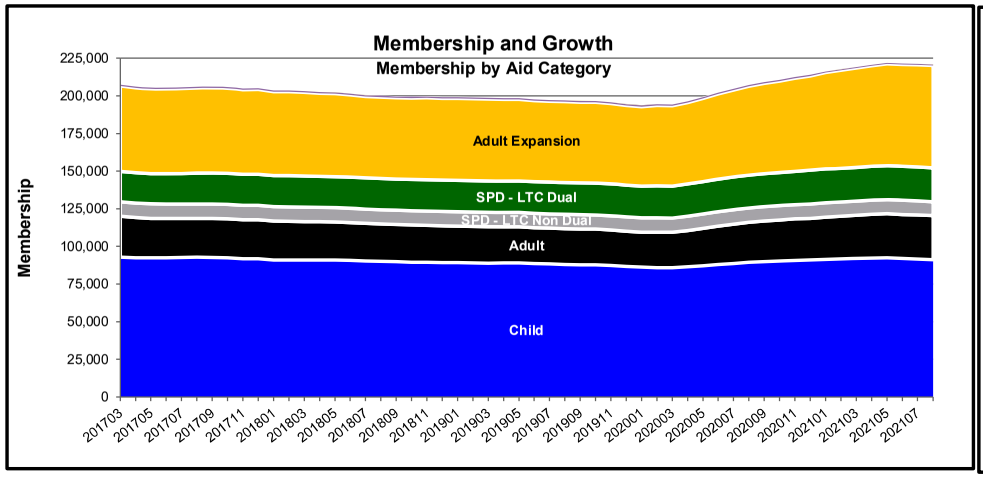
Gold Coast Health Plan

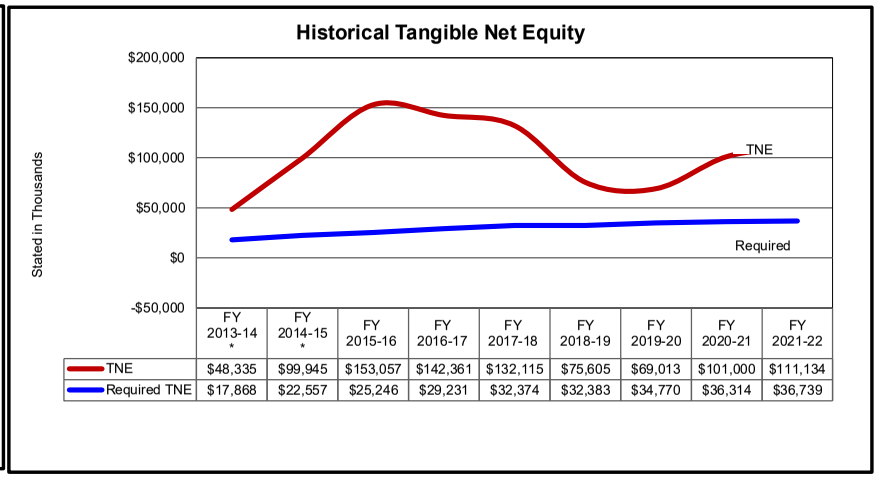
Executive Dashboard as of August 31, 2021

	FYTD 21/22 Budget*	FYTD 21/22 Actual	FY 20/21 Actual	FY 19/20 Actual
Average Enrollment	230,288	222,855	213,547	196,012
PMPM Revenue	$ 371.04	$ 372.07	$ 358.22	$ 348.73
Medical Expenses				
Capitation	$ 36.07	$ 34.34	$ 34.03	$ 24.93
Inpatient	$ 65.24	$ 65.32	$ 66.52	$ 65.19
LTC / SNF	$ 56.83	$ 43.44	$ 55.42	$ 59.20
Outpatient	$ 25.86	$ 25.50	$ 23.16	$ 25.81
Emergency Room	$ 12.73	$ 14.26	$ 9.25	$ 11.97
Physician Specialty	$ 26.76	$ 30.83	$ 25.71	$ 27.63
Pharmacy	$ 64.16	$ 63.34	$ 62.07	$ 61.05
All Other *(excluding directed payments)*	$ 38.17	$ 42.00	$ 43.20	$ 41.07
Total Per Member Per Month	$ 325.82	$ 319.02	$ 319.36	$ 316.86
Medical Loss Ratio	92.0%	88.5%	92.1%	94.6%
Total Administrative Expenses	$ 11,253,361	$ 8,889,546	$ 49,637,603	$ 50,821,685
% of Revenue	6.8%	5.4%	5.4%	6.2%
TNE	$ 100,654,230	$ 111,133,635	$ 100,999,994	$ 71,272,142
Required TNE	$ 37,464,756	$ 36,738,989	$ 36,313,908	$ 34,685,521
% of Required	269%	302%	278%	205%

** 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	FY 2021-22
TNE	$48,335	$99,945	$153,057	$142,361	$132,115	$75,605	$69,013	$101,000	$111,134
Required TNE	$17,868	$22,557	$25,246	$29,231	$32,374	$32,383	$34,770	$36,314	$36,739

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STATEMENT OF FINANCIAL POSITION

	08/31/21	07/31/21	06/30/21
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**189,665,301**	**181,564,813**	**193,947,005**
Total Short-Term Investments	**43,549,800**	**43,532,535**	**43,515,100**
Medi-Cal Receivable	103,816,730	101,312,336	97,642,752
Interest Receivable	86,401	99,015	119,520
Provider Receivable	1,025,836	2,161,503	1,754,312
Other Receivables	6,551,713	6,320,713	6,320,713
Total Accounts Receivable	**111,480,679**	**109,893,566**	**105,837,297**
Total Prepaid Accounts	3,160,044	3,033,715	1,951,162
Total Other Current Assets	153,789	153,789	153,789
Total Current Assets	**348,009,614**	**338,178,418**	**345,404,352**
Total Fixed Assets	**1,389,413**	**1,173,684**	**1,198,472**
Total Assets	**$ 349,399,027**	**$ 339,352,102**	**$ 346,602,824**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 125,246,814	$ 133,395,431	$ 62,443,653
Claims Payable	7,380,747	9,818,017	72,815,453
Capitation Payable	25,377,384	25,368,834	25,281,330
Physician Payable	26,499,767	25,713,235	24,975,873
DHCS - Reserve for Capitation Recoup	6,027,119	6,027,119	6,027,119
Accounts Payable	759,926	190,618	1,683,582
Accrued ACS	3,498,567	3,355,584	4,874,494
Accrued Provider Reserve	1,560,330	1,489,014	1,418,117
Accrued Pharmacy	21,839,389	14,017,265	21,625,295
Accrued Expenses	2,180,746	2,166,098	1,860,807
Accrued Premium Tax	14,377,200	7,188,600	19,409,220
Accrued Payroll Expense	2,544,532	2,341,053	2,195,823
Total Current Liabilities	**237,292,519**	**231,070,868**	**244,610,768**
Long-Term Liabilities:			
Other Long-term Liability-Deferred Rent	972,873	982,468	992,062
Deferred Revenue - Long Term Portion	-	-	-
Notes Payable	-	-	-
Total Long-Term Liabilities	**972,873**	**982,468**	**992,062**
Total Liabilities	**238,265,393**	**232,053,336**	**245,602,830**
Net Assets:			
Beginning Net Assets	100,999,994	100,999,994	77,323,271
Total Increase / (Decrease in Unrestricted Net Assets)	10,133,640	6,298,772	23,676,724
Total Net Assets	**111,133,635**	**107,298,766**	**100,999,994**
Total Liabilities & Net Assets	**$ 349,399,027**	**$ 339,352,102**	**$ 346,602,824**

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR MONTH ENDED August 31, 2021

	August 2021	August 2021 Year-To-Date		Variance	Variance	August 2021 Year-To-Date		Variance
	Actual	Actual	Budget	Fav / (Unfav)	%	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	223,382	445,710	460,576	(14,866)	-3%	PMPM - FYTD		
Revenue								
Premium	$ 89,676,630	$ 180,211,726	$ 165,619,546	$ 14,592,180	9%	$ 404.33	$ 359.59	$ 44.73
Reserve for Cap Requirements	-	-	-	-	0%	-	-	-
MCO Premium Tax	(7,188,600)	(14,377,200)	-	(14,377,200)	0%	(32.26)	-	(32.26)
Total Net Premium	**82,488,030**	**165,834,526**	**165,619,546**	**214,980**	**0%**	**372.07**	**359.59**	**12.48**
Other Revenue:								
Miscellaneous Income	195	285	-	285	0%	0.00	-	0.00
Total Other Revenue	195	285	-	285	0%	0.00	-	0.00
Total Revenue	**82,488,225**	**165,834,811**	**165,619,546**	**215,265**	**0%**	**372.07**	**359.59**	**12.48**
Medical Expenses:								
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	7,636,110	15,305,990	16,101,301	795,311	5%	34.34	34.96	0.62
FFS Claims Expenses:								
Inpatient	18,525,663	29,113,174	29,120,273	7,099	0%	65.32	63.23	(2.09)
LTC / SNF	5,699,209	19,359,461	25,367,793	6,008,332	24%	43.44	55.08	11.64
Outpatient	5,232,182	11,363,864	11,541,517	177,652	2%	25.50	25.06	(0.44)
Laboratory and Radiology	287,893	1,074,915	1,127,534	52,620	5%	2.41	2.45	0.04
Directed Payments - Provider	2,329,430	4,642,675	4,398,784	(243,890)	-6%	10.42	9.55	(0.87)
Emergency Room	4,031,123	6,355,980	5,682,569	(673,412)	-12%	14.26	12.34	(1.92)
Physician Specialty	6,914,584	13,741,811	11,945,119	(1,796,692)	-15%	30.83	25.94	(4.90)
Primary Care Physician	687,548	1,796,485	3,345,125	1,548,640	46%	4.03	7.26	3.23
Home & Community Based Services	2,030,257	4,077,227	4,512,060	434,833	10%	9.15	9.80	0.65
Applied Behavioral Analysis/Mental Health Service	2,608,771	5,192,397	5,117,041	(75,356)	-1%	11.65	11.11	(0.54)
Pharmacy	14,390,797	28,229,547	28,636,681	407,134	1%	63.34	62.18	(1.16)
Provider Reserve	(159,684)	(88,787)	-	88,787	0%	(0.20)	-	0.20
Other Medical Professional	167,158	432,943	775,837	342,894	44%	0.97	1.68	0.71
Other Medical Care	1,040	260	-	(260)	0%	0.00	-	(0.00)
Other Fee For Service	943,468	1,943,753	1,803,211	(140,542)	-8%	4.36	3.92	(0.45)
Transportation	815,015	1,844,320	355,970	(1,488,350)	-418%	4.14	0.77	(3.37)
Total Claims	64,504,453	129,080,025	133,729,514	4,649,490	3%	289.61	290.35	0.75
Medical & Care Management Expense	1,243,398	2,498,643	2,598,325	99,682	4%	5.61	5.64	0.04
Reinsurance	(554,595)	(261,849)	621,778	883,627	142%	(0.59)	1.35	1.94
Claims Recoveries	987,785	210,695	(713,124)	(923,819)	130%	0.47	(1.55)	(2.02)
Sub-total	1,676,587	2,447,489	2,506,979	59,490	2%	5.49	5.44	(0.05)
Total Cost of Health Care	**73,817,150**	**146,833,503**	**152,337,794**	**5,504,291**	**4%**	**329.44**	**330.75**	**1.32**
Contribution Margin	**8,671,074**	**19,001,308**	**13,281,752**	**5,719,556**	**43%**	**42.63**	**28.84**	**13.79**
General & Administrative Expenses:								
Salaries, Wages & Employee Benefits	2,101,052	4,270,312	4,659,436	389,124	8%	9.58	10.12	0.54
Training, Conference & Travel	2,993	3,620	26,600	22,980	86%	0.01	0.06	0.05
Outside Services	2,287,758	4,462,910	4,872,942	410,032	8%	10.01	10.58	0.57
Professional Services	393,526	559,988	1,120,708	560,720	50%	1.26	2.43	1.18
Occupancy, Supplies, Insurance & Others	966,887	1,578,212	1,871,918	293,707	16%	3.54	4.06	0.52
Care Management Reclass to Medical	(1,243,398)	(2,498,643)	(2,598,325)	(99,682)	4%	(5.61)	(5.64)	(0.04)
G&A Expenses	4,508,818	8,376,399	9,953,279	1,576,880	16%	18.79	21.61	2.82
Project Portfolio	342,910	513,147	1,300,082	786,935	61%	1.15	2.82	1.67
Total G&A Expenses	**4,851,728**	**8,889,546**	**11,253,361**	**2,363,816**	**21%**	**19.94**	**24.43**	**4.49**
Total Operating Gain / (Loss)	**3,819,347**	**10,111,762**	**2,028,391**	**8,083,372**	**399%**	**22.69**	**4.40**	**18.28**
Non Operating								
Revenues - Interest	15,522	21,878	60,000	(38,122)	-64%	0.05	0.13	(0.08)
Gain/(Loss) on Sale of Asset	-	-	-	-	0%	-	-	-
Total Non-Operating	**15,522**	**21,878**	**60,000**	**(38,122)**	**-64%**	**0.05**	**0.13**	**(0.08)**
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 3,834,868**	**$ 10,133,640**	**$ 2,088,391**	**$ 8,045,250**	**385%**	**$ 22.74**	**$ 4.53**	**$ 18.20**

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STATEMENT OF CASH FLOWS	August 2021	FYTD 20-21
Cash Flows Provided By Operating Activities		
Net Income (Loss)	$ 3,834,868	$ 10,133,640
Adjustments to reconciled net income to net cash provided by operating activities		
Depreciation on fixed assets	41,978	66,766
Disposal of fixed assets	-	-
Amortization of discounts and premium	-	-
Changes in Operating Assets and Liabilites		
Accounts Receivable	(1,587,113)	(5,643,383)
Prepaid Expenses	(126,329)	(1,208,883)
Accrued Expense and Accounts Payable	8,814,262	(1,293,819)
Claims Payable	(1,642,189)	702,231
MCO Tax liablity	7,188,600	(5,032,020)
IBNR	(8,148,617)	(1,713,829)
Net Cash Provided by (Used in) Operating Activities	8,375,461	(3,989,297)
Cash Flow Provided By Investing Activities		
Proceeds from Restricted Cash & Other Assets		
Proceeds from Investments	(17,266)	(34,701)
Purchase of Property and Equipment	(257,707)	(257,707)
Net Cash (Used In) Provided by Investing Activities	(274,973)	(292,408)
Increase/(Decrease) in Cash and Cash Equivalents	8,100,488	(4,281,704)
Cash and Cash Equivalents, Beginning of Period	181,564,813	193,947,005
Cash and Cash Equivalents, End of Period	189,665,301	189,665,301

Gold Coast Health Plan℠
A Public Entity

August 2021 Financial Statements

September 27, 2021

Kashina Bishop
Chief Financial Officer

Integrity
Accountability
Collaboration
Trust
Respect

Return to Agenda

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

Financial Overview:

AUGUST NET GAIN	$ 3.8 M
FYTD NET GAIN	$10.1 M
TNE is $111.1 M and 302% of the minimum required	
MEDICAL LOSS RATIO	88.5%
ADMINISTRATIVE RATIO	5.4%

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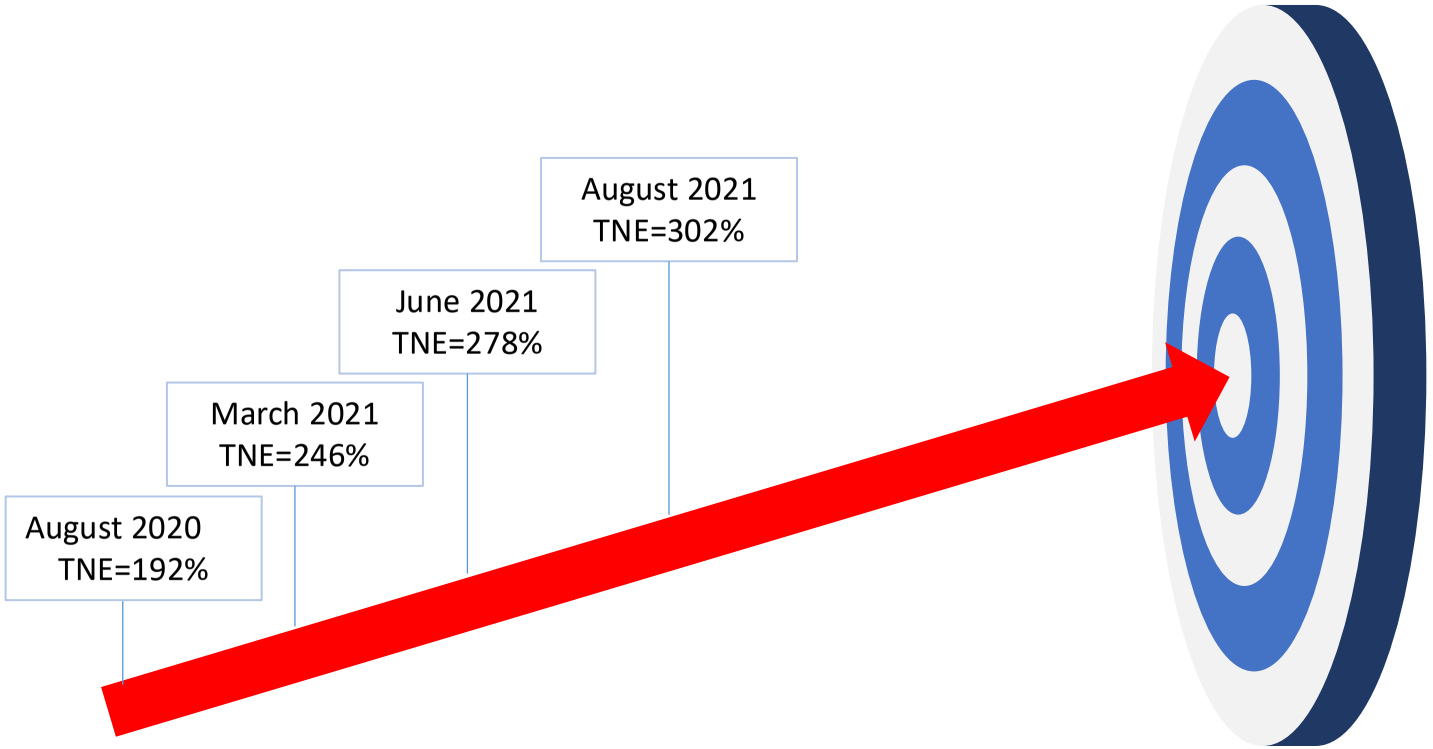
Solvency Action Plan

Target: TNE % = 400-500% of Required



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Solvency Action Plan – next steps

Category	Current Focus	Annualized impact in savings
Cost of Healthcare	LANE – avoidable ER analysis	TBD
	Pro-active transplant management approach	TBD
	Analysis of leakage to out of area providers	TBD
Internal Control Improvements*	Review of provider contracts for language interpretation and validation	N/A
	Develop revised provider contract templates and a standard codified DOFR template	N/A
	Improve quality and completeness of encounter data	Revenue implications
	Capitation reconciliation at member level	Revenue
	RDT data improvement	Revenue
Contracting Strategies	Expansion of capitation arrangements	Required TNE and risk reductions
	LANE/HCPCS analysis	TBD
	Outlier rate analysis	TBD

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Revenue

Net Premium revenue is $165.8 million, over budget by $214,980.

- Favorable CY 2021 rates.

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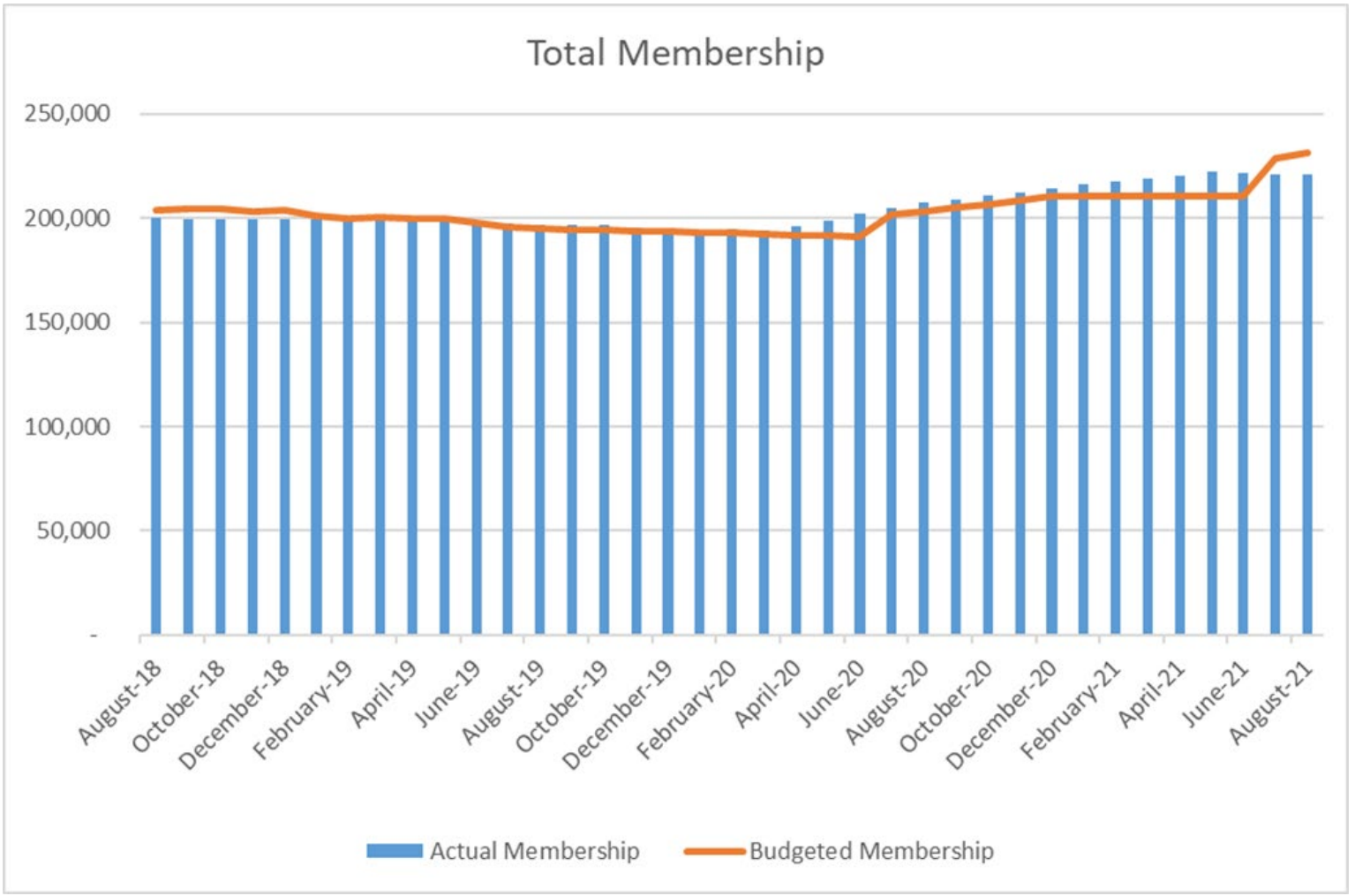
Membership trends



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Medical Expense

FYTD Health care costs are $146.8 million and $5.5 million and 4% under budget. Medical loss ratio is 88.5%, a 3.4% budget variance.

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Incurred But Not Paid (IBNP) Medical Expense Reserve

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.

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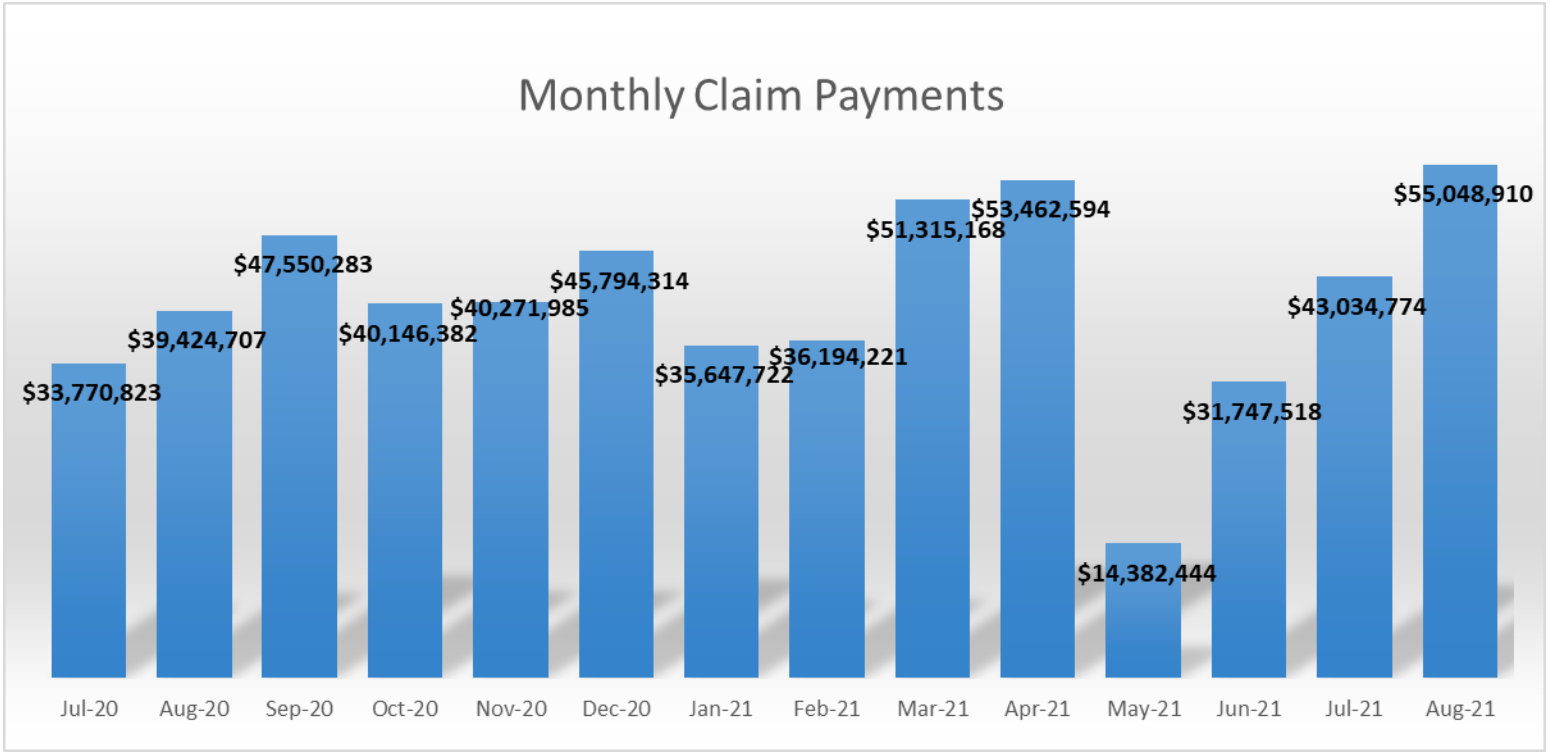
Incurred But Not Paid (IBNP) Medical Expense Reserve – post system conversion

Accurately calculating the reserve becomes more challenging:

1. Historical lag between when a service is performed and when the claims is paid is disrupted
2. Do not have an accurate data file – impacting category of service on financials



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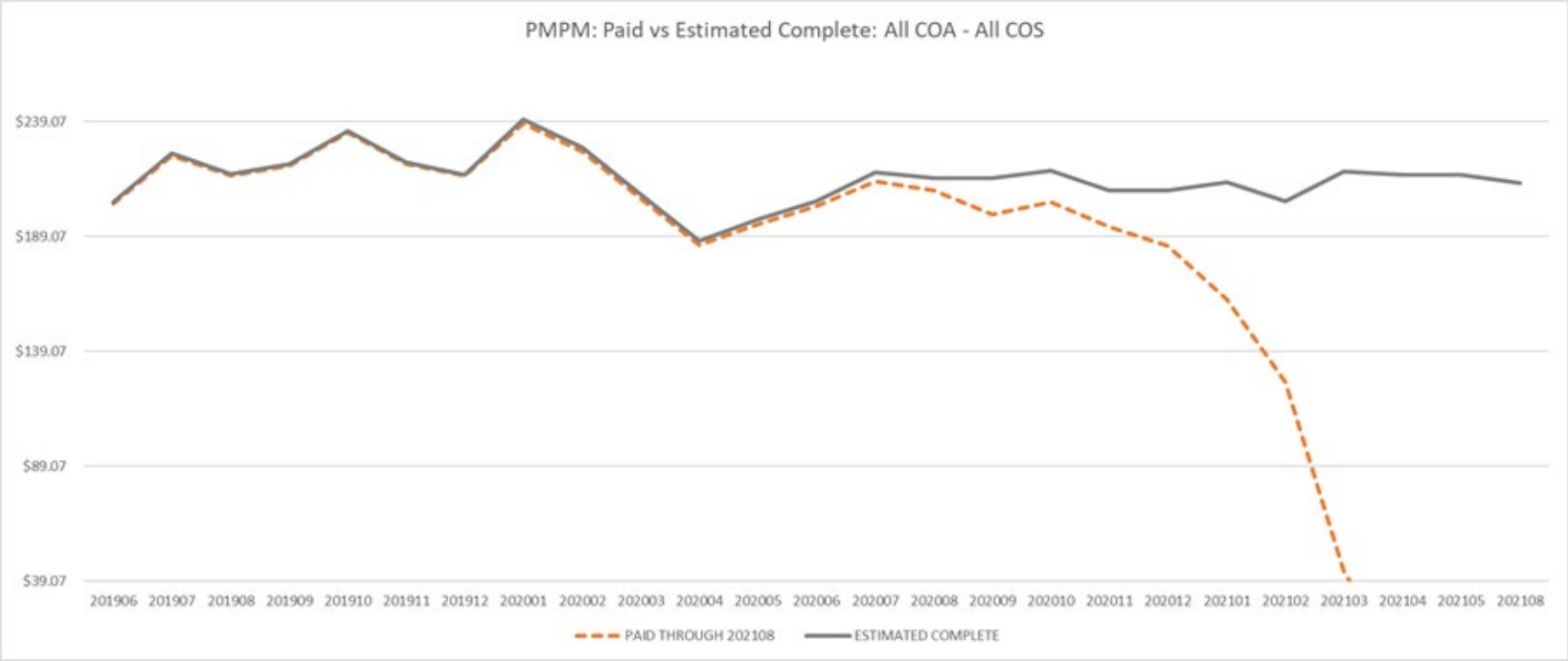
Incurred But Not Paid (IBNP) Medical Expense Reserve



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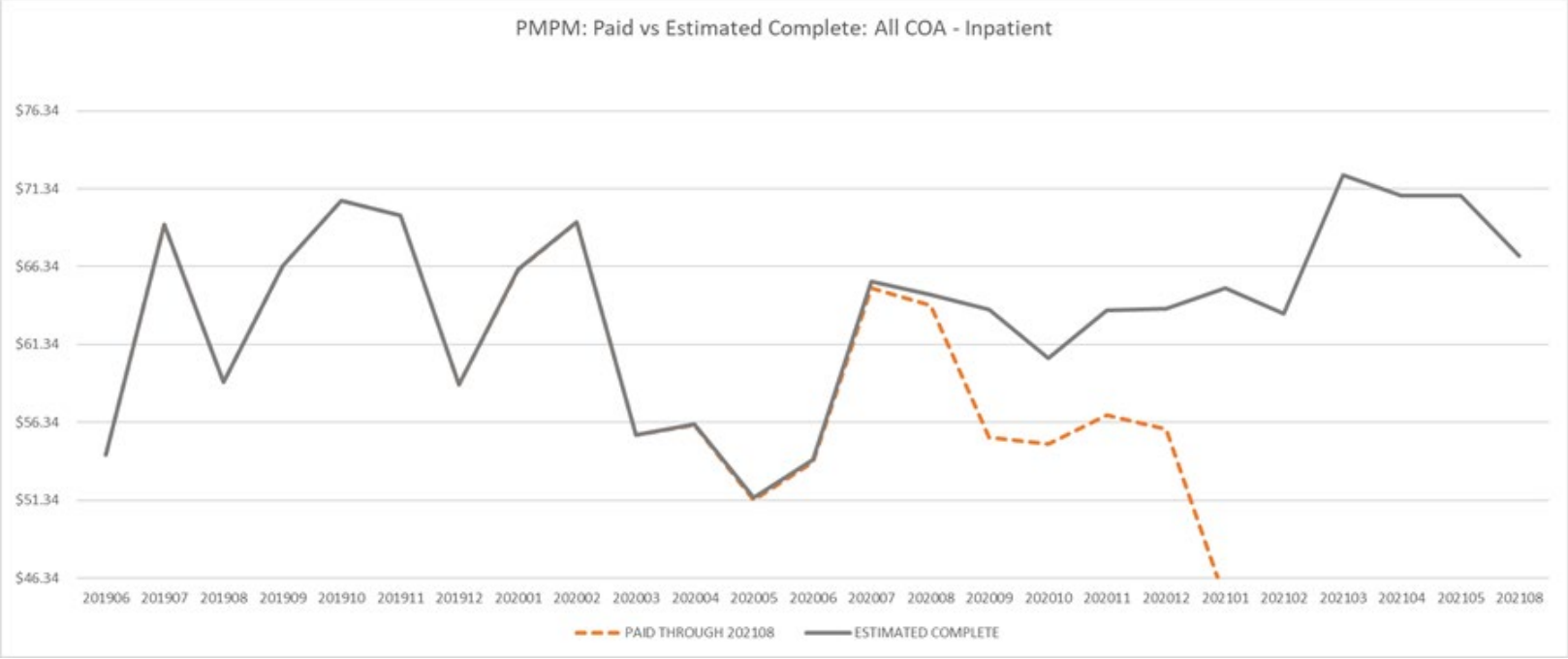
Inpatient Medical Expenses



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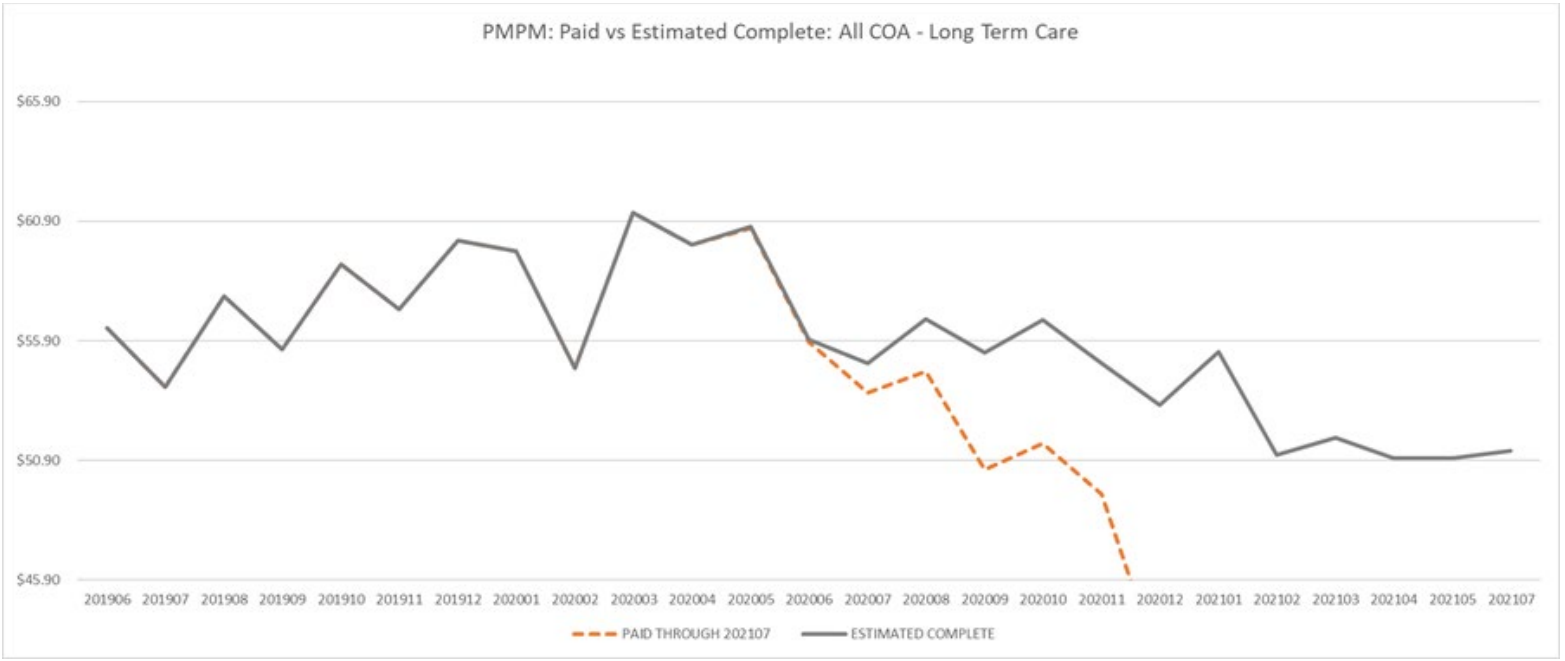
Long Term Care Expenses



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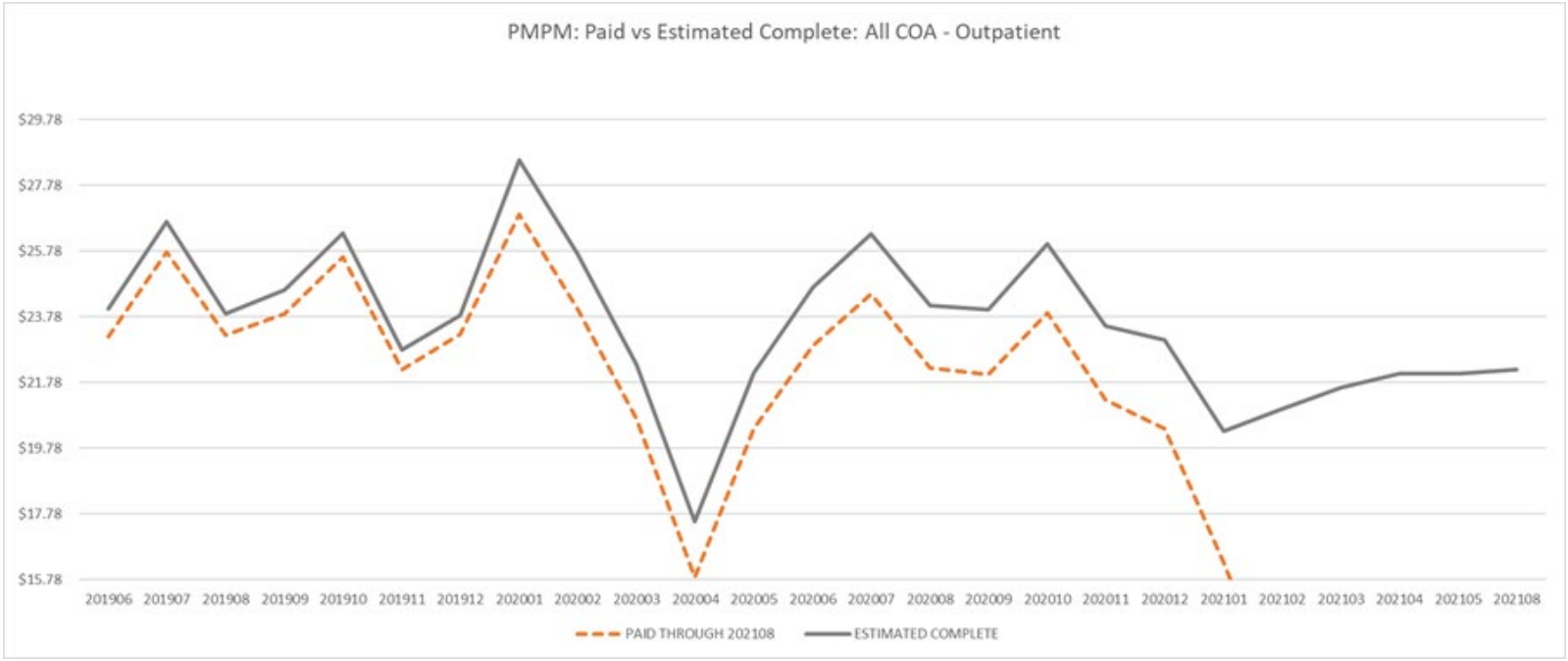
Outpatient Expenses



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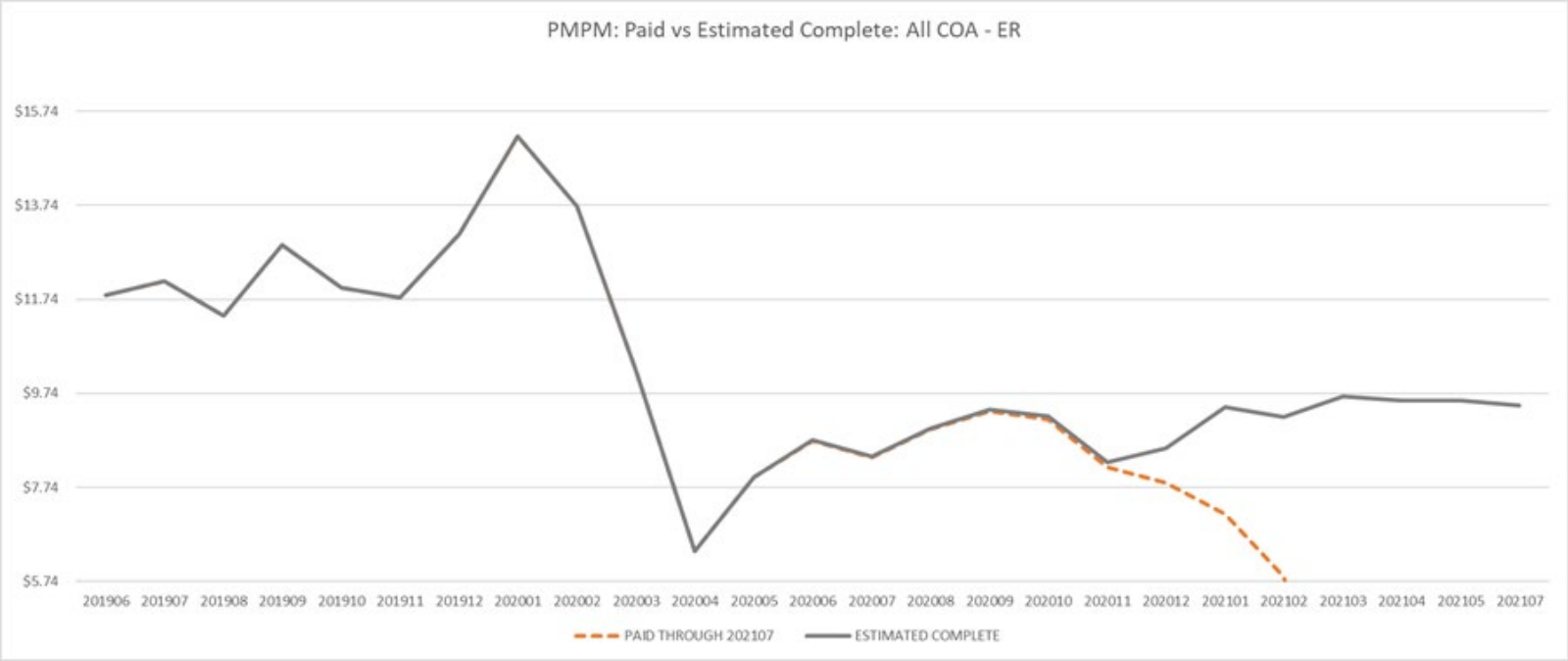
Emergency Room Expenses



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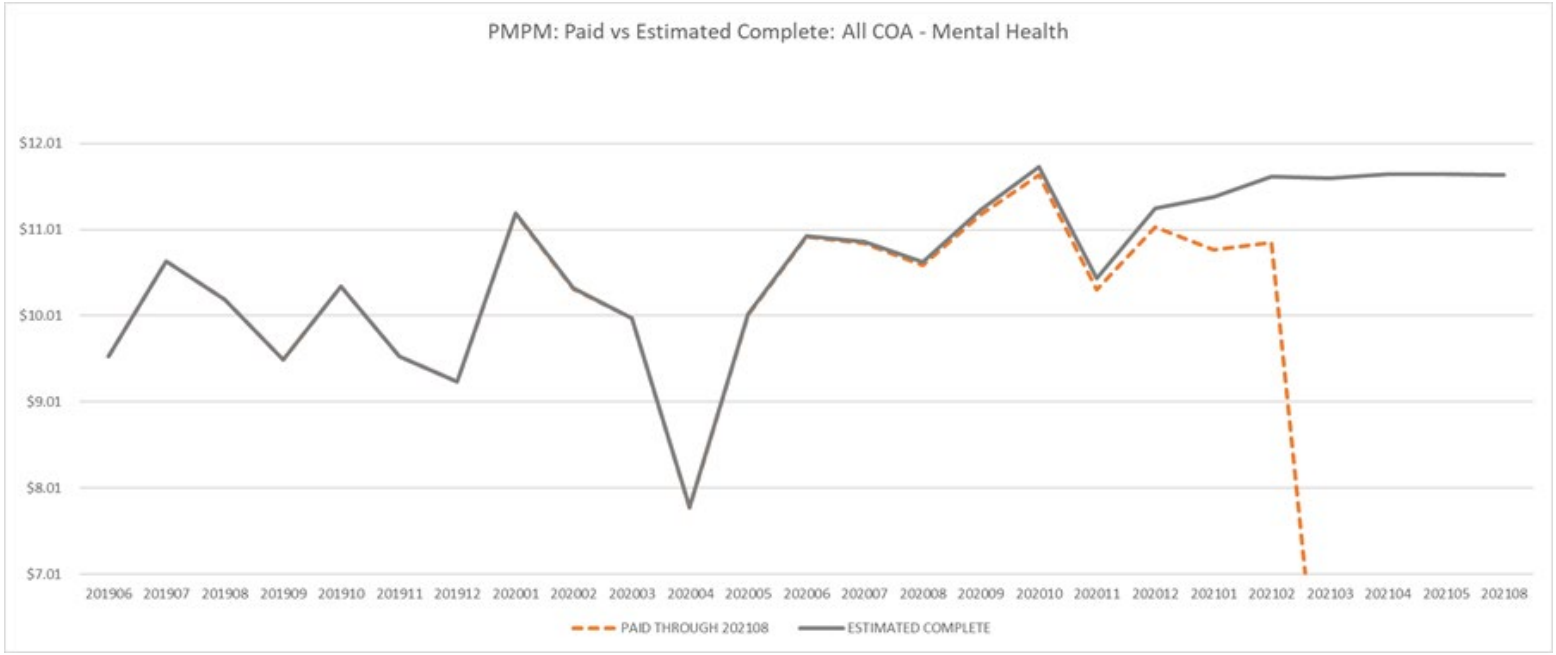
Mental and Behavioral Health



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Financial Statement Summary

	August 2021	FYTD Actual	FYTD Budget	Budget Variance
Net Capitation Revenue	$ 82,488,030	$ 165,834,526	$ 165,619,546	$ 214,980
Health Care Costs	73,817,150	146,833,503	152,337,794	(5,504,291)
Medical Loss Ratio		**88.5%**	**92.0%**	
Administrative Expenses	4,851,728	8,889,546	11,253,361	(2,363,816)
Administrative Ratio		**5.4%**	**7.3%**	
Non-Operating Revenue/(Expense)	15,522	21,878	60,000	(38,121)
Total Increase/(Decrease) in Net Assets	$ 3,834,674	$ 10,133,356	$ 2,088,391	$ 8,044,966
Cash and Investments	$ 233,215,101			
GCHP TNE	$ 111,133,635			
Required TNE	$ 36,738,989			
% of Required	**302%**			

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Questions?

Staff requests the Commission recommend approve the unaudited financial statements for August 2021.

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AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Margaret Tatar, Chief Executive Officer

DATE: September 27, 2021

SUBJECT: Chief Executive Officer (CEO) Report

I. EXTERNAL AFFAIRS:

On Aug. 13, 2021, the state Department of Health Care Services (DHCS) issued All-Plan Letter 21-010 requiring managed care plans (MCPs) to develop a vaccination response plan to improve vaccine access. MCPs are eligible to earn incentive payments for activities that are designed to close vaccination gaps with their enrolled members. This comes after Gov. Gavin Newsom's announcement last month on the allocation of $350 million to incentivize COVID-19 vaccination efforts in the Medi-Cal managed care delivery system from Sept. 1, 2021 through Feb. 28, 2022.

The focus populations:

1. Are homebound and unable to travel to vaccination sites.
2. Are 50-64 years of age with multiple chronic diseases.
3. Self-identify as persons of color.
4. Are 12-25 years of age.

Gold Coast Health Plan's (GCHP) Vaccine Response Plan was approved by DHCS on Sept. 15, 2021.

In anticipation of this mandate, the Community Relations team partnered with Westminster Clinic and Ventura County Public Health to host a vaccine mobile clinic during the two Back-to-School Backpack Drives held by Westminster Clinic in Oxnard and Thousand Oaks. About 90 people were vaccinated. In addition, GCHP's chief medical officer, Dr. Nancy Wharfield, participated in three Facebook Live events on Sept. 13-15, 2021, hosted by Amigo Baby to promote COVID-19 vaccinations.

The Community Relations team has started partnering with key community partners to schedule outreach events in targeted neighborhoods where there are low vaccination rates. For more information, please review the Community Relations section of this report. A monthly update regarding this effort will be shared there.

A. Federal

Executive Action (as of Sept. 9, 2021)

President Biden Releases the COVID-19 ACTION PLAN, Sept. 9, 2021 (Link)
The President announced the implementation of a six-pronged, national strategy that utilizes a science-based approach to combating COVID-19. The plan aims to use every viable instrument to fight COVID-19 and save lives, keep schools open and safe, and protect the economy from lockdowns and economic damage.

The six approaches are:

1. Vaccinating the Unvaccinated
2. Further Protecting the Vaccinated
3. Keeping Schools Safely Open
4. Increasing Testing and Requiring Masking
5. Protecting Our Economic Recovery
6. Improving Care for those with COVID-19

Executive Orders on Ensuring Adequate COVID Safety Protocols for Federal Contractors & Requiring Coronavirus Disease 2019 Vaccination for Federal Employees, Sept. 9, 2021(Link)
The President announced the sweeping COVID-19 vaccine requirements, which could affect approximately 100 million Americans. The Executive orders include a vaccine mandate for all federal workers and contractors, and a requirement that large companies with 100 or more employees must mandate vaccines or regular testing for employees.

Congressional Action (as of Sept. 10, 2021)

Committee Markup of Build Back Better Act, Sept. 13, 2021
Energy and Commerce Committee Chairman Frank Pallone, Jr. (D-NJ) announced the Energy and Commerce Committee will hold a full Committee markup on legislative recommendations for its budget reconciliation instructions, which were passed in August by the House and Senate.
Subtitle I: Budget Reconciliation Legislative Recommendations Relating to Medicaid
Subtitle J: Budget Reconciliation Legislative Recommendations Relating to Public Health

B. State

Executive and Department Action (as of Sept. 9, 2021)

Governor's $2.75 Billion Expansion of Homekey, Sept. 9, 2021
The Governor announced the next phase of the state's homeless housing initiative, Homekey, with the release of funds from his $2.75 billion investment to expand the program to purchase and rehabilitate buildings – including hotels, motels, vacant apartment buildings, tiny homes, and other properties – and converting them into up to 14,000 more permanent, long-term housing units for people experiencing or at risk of homelessness. Homekey prioritizes speed and cost-efficiency by making competitive grants available to local governments across the state.

Executive and Department Action (as of Sept. 10, 2021)
William Lightbourne Steps Down and Michelle Baass is appointed Director of the California Health and Human Services Agency, Sept. 10, 2021 Governor Gavin Newsom announced the appointment of California Health and Human Services Agency (CHHS) Undersecretary Michelle Baass as Director of the California Department of Health Care Services, filling the role held by outgoing Director William Lightbourne. CHHS Deputy Secretary of Program and Fiscal Affairs Marko Mijic has been appointed to serve as Undersecretary of the Agency. Michelle Baass, 47, of Sacramento, has been Undersecretary of CHHS since 2018. She was Deputy Secretary of the Office of Program and Fiscal Affairs at CHHS from 2017 to 2018 and Deputy Director and Principal Consultant at the California State Senate Committee on Budget and Fiscal Review from 2012 to 2017. She was Deputy Director and Principal Consultant at the California State Senate Office of Research from 2008 to 2012. Baass earned a Master of Public Policy and Administration from California State University, Sacramento. The position requires Senate confirmation.
APL 21-009 Collecting Social Determinants of Health Data, Aug. 10, 2021 The APL provides plans with priority Social Determinants of Health (SDOH) codes to collect reliable SDOH data for the California Advancing and Innovating Medi-Cal (CalAIM) initiative. A key part of CalAIM is the Population Health Management (PHM) that will work to identify and manage member health risks and needs through whole person care approaches while focusing on and addressing SDOH.
APL 21-010 Medi-Cal COVID-19 Vaccination Incentive Program, Aug. 13, 2021 The state Department of Health Care Services (DHCS) has allocated $350 million to incentivize COVID-19 vaccination efforts in the Medi-Cal managed care delivery system from Sept. 1, 2021 through Feb. 28, 2022. Managed care plans are eligible to earn incentive payments for activities that are designed to close vaccination gaps with their enrolled members. Participating plans will develop Vaccination Response Plans to improve vaccine access and to develop the infrastructure to support this work in the long term. Impacted and Focus Populations: 1. Are homebound and unable to travel to vaccination sites; 2. Are 50-64 years of age with multiple chronic diseases; 3. Self-identify as persons of color; and 4. Are 12-25 years of age. GCHP's Vaccine Response Plan was approved by DHCS on Sept. 15, 2021.

Executive and Department Action (as of Sept. 10, 2021) cont'd
APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates, Aug. 31, 2021 The APL supersedes APL 17-006 (Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments) and includes member notification templates developed by DHCS, as well as updated DHCS templates for the attachments that must accompany member notifications.
Executive and Department Action (as of Sept. 10, 2021)
Draft APL 21-XXX Benefit Standardization and Mandatory Managed Care Enrollment Provisions of The California Advancing and Innovating Medi-Cal (CalAIM) Initiative The Draft APL aims to provide guidance on the Benefit Standardization and Mandatory Managed Care Enrollment (MMCE) provisions of the CalAIM initiative. Benefit Standardization looks at Specialty Mental Health Services, Institutional Long-Term Care Services, and Major Organ Transplants.
Draft APL 21-XXX CalAIM Incentive Payment Program The Draft APL provides managed care plans with guidance on the incentive payments linked to the Enhanced Care Management (ECM) and In Lieu of Services (ILOS) programs in CalAIM.
State Legislature Bills (as of Sept. 10, 2021)
Sept. 10 was the last day for any bill to be passed within both houses of the legislature. The clock now starts for the Governor to sign, approve without signing, or veto bills by October 10. If the Governor chooses to veto any bill, the legislature can override a veto with a two-thirds vote in each house.

Behavioral Health	Implications
SB 221 Health Care Coverage: Timely Access to Care Introduced: Jan. 13, 2021 Status: Passed Assembly & Senate Floor, Ayes 9/9 Enrolled for the Governor. Summary: Would codify current timely access standards requirements by the Department of Managed Health Care (DMHC) and the Department of Insurance to ensure that contracted providers and health networks schedule initial appointments within specified time frames of a beneficiary's request. Would expand current standards to also require follow-up appointments with a non-physician mental health (MH) or substance use disorder (SUD) providers to be scheduled within 10 business days of a previous appointment related to an ongoing course of treatment.	Possible additional oversight of MH appointments and payments for out-of-network care when timely access standards are not met. The 10-day follow-up appointment provision in the bill would close a loophole in state law and regulations and establish timely access standard for follow-up appointments for MH and SUD treatment.

Behavioral Health	Implications
SB 293 Medi-Cal Specialty Mental Health Services Introduced: Feb. 1, 2021 Status: Did not pass Assembly Appropriations; moved to two-year bill. Summary: Would require DHCS to develop standardized forms for specialty mental health services provided under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) after Jan. 1, 2022. Consistent with the CalAIM proposal, the forms would address medical necessity criteria, screening tools, and transition of care tools, which would impact coordination and referrals with Medi-Cal managed care plans.	Would require GCHP to implement new forms and processes yet-to-be developed by DHCS for executing portions of the Youth Behavioral Health Initiative.
Health Equity	**Implications**
SB 17 Office of Racial Equity Introduced: Dec. 7, 2020 Status: Did not pass Assembly Appropriations; moved to two-year bill; aspects incorporated into the budget. Summary: This bill establishes the Office of Racial Equity, which would develop statewide guidelines for inclusive policies and practices that reduce racial inequities, promote racial equity, address individual, institutional, and structural racism, and establish goals and strategies to advance racial equity and address structural racism and racial inequities.	No direct implications for GCHP.
Health Information Exchange (HIE)	**Implications**
SB 371 Health Information Technology Introduced: Feb. 10, 2021 Status: Did not pass Assembly Health, moved to two-year bill; aspects incorporated into the budget. Summary: Requires DHCS to apply for federal funding from the American Rescue Plan Act of 2021 or the Medicaid Information Technology Architecture program to create a unified data exchange between the state government, health records systems, other data exchange networks and health care providers, including for the Medi-Cal program. Funds would also be used to provide grants and technical support to small provider practices, community health centers, and safety net hospitals to expand the use of health information technology and connect to exchanges.	This bill could facilitate the creation of a statewide HIE to enable data exchanges related to all health plan members. An HIE would support the electronic exchange of health information among, and aggregate and integrate data from, multiple sources within our service area. Language in this bill is supported in the Health Trailer Bill AB 133.

Medi-Cal	Implications
AB 470 Medi-Cal: Eligibility Introduced: Feb. 8, 2021 Status: Did not pass Assembly Health; held under submission. Summary: Would prohibit the consideration of any assets or property in determining Medi-Cal eligibility under any aid category, subject to federal approval.	Potential increase in GCHP membership. Language was adopted into the Health Trailer Bill AB 133 and mirrors AB 470 to eliminate the asset test for Medi-Cal eligibility.

Medi-Cal	Implications
SB 56 Medi-Cal: Eligibility Introduced: Dec. 7, 2020 Status: Language was adopted into the trailer bill for undocumented persons 50 years of age and older. Summary: Effective July 1, 2022, this bill would extend eligibility for full-scope Medi-Cal benefits to individuals who are 65 years of age or older and who are otherwise eligible for those benefits if not for their immigration status.	Potential increase in GCHP membership. Language was adopted into the trailer bill that closely follows SB 56 to expand Medi-Cal for individuals age 50 and older who would be eligible for Medi-Cal except for the immigration status.

School Based Services	Implications
AB 563 School-Based Health Programs Introduced: Feb. 11, 2020 Status: Did not pass Senate Education and Health Committees, moved to two-year bill. Summary: Creates the Office of School-Based Health Programs within the California Department of Education (CDE), no later than July 1, 2022, to administer health programs, including the Local Education Agencies (LEA) Medi-Cal Billing Option Program, and Early and Periodic Screening, Diagnostic, and Treatment (ESPDT) services. Would also require the CDE to coordinate with DHCS and LEAs to increase access to and expand the scope of school-based Medi-Cal programs.	Potential increases to utilization for school-based early and preventative treatment programs especially utilization of dental, health, and mental health programs, and school-based health centers.

School Based Services	Implications
AB 586 Pupil Health: Health and Mental Health Services: School Health Demonstration Project. Introduced: Feb. 11, 2020 Status: Did not pass Senate Education and Health committees; moved to two-year bill. Summary: Establishes the School Health Demonstration Project as a two-year program to expand comprehensive physical and mental health access to students. The California Department of Education would provide support, technical assistance, and $500,000 in annual grants to Local Education Agencies to join in additional Medi-Cal funding opportunities and build partnerships with Medi-Cal managed care plans, county mental health plans, and private health plans.	No direct implications for GCHP.
Telehealth	**Implications**
AB 32 Telehealth Introduced: Dec. 7, 2020 Status: Incorporated into the Budget. This bill expands the definition of synchronous interaction for purposes of telehealth to include audio-video, audio-only, and other virtual communication. Requires health plans and insurers to reimburse for audio-video, audio-only, and other virtual communication on the same basis and to the same extent that the plan/insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.	Potential to increase access for members to all services that can be provided via telehealth. The bill could influence costs due to reimbursements being fixed at the same rate as in-person visits. Language was adopted into the trailer bill that mirrors AB 32 to provide parity for audio-only telehealth.

A. Community Relations – Sponsorships

Gold Coast Health Plan (GCHP) continues its support of organizations in Ventura County through its sponsorship program. Sponsorships are awarded to community-based organizations in support of their efforts to help Medi-Cal members and other vulnerable populations. The following organizations were awarded sponsorships in August 2021:

Name of Organization	Description	Amount
Secure Beginnings	The mission of Secure Beginnings is to nurture healthy relationships for Ventura County families with children ages 0-5. The sponsorship will fund diapers and wipes for 200 children.	$1,000
American Cancer Society	The American Cancer Society's mission is to save lives, celebrate lives, and lead the fight for a world without cancer. The sponsorship is for the "Making Strides Against Breast Cancer of the Greater Ventura County" 5k walk.	$1,000
Interface Children & Family Services	The mission of Interface Children & Family Services is to strengthen children, families, individuals, and communities to be safe, healthy, and thriving through comprehensive social services. The sponsorship is in support of the "Hope & Light" fundraising gala.	$1,000
Food Share of Ventura County	Food Share is dedicated to leading the fight against hunger in Ventura County. The sponsorship is for the "10th Annual CAN-tree Drive" fundraiser.	$1,500
Big Brothers Big Sisters of Ventura County (BBSVC)	BBSVC's mission is to build and professionally support one-to-one relationships to ignite the biggest possible future for youth. The sponsorship is in support of the "Bags, Bling & Bubbly" fundraising event.	$1,000
Oxnard Police Activities League (PAL)	The mission of PAL is to build positive relationships between youth, police officers, and the community. The sponsorship will provide low-income children with school supplies and backpacks for the new school year.	$1,000
TOTAL		**$6,500**

In August, GCHP supported the Oxnard PAL with an in-kind donation. A total of 150 pull string backpacks, pencil pouches, crayons, pencils, and coloring books were distributed to low-income families in the City of Oxnard. Families also received information about care management, transportation, member services, and member rewards.

In September, GCHP partnered with Reiter Affiliated Companies to provide farmworkers with hand sanitizers, first aid kits, and cooling towels. A total of 1,200 items were distributed to protect our farmworkers. Additionally, farmworkers were provided with information about the COVID-19 vaccine.

B. Community Relations – Community Meetings and Events

In September, the Community Relations team participated in various collaborative meetings, community events, and council meetings. The purpose of these events is to connect with our community partners and engage in dialogue to bring awareness and services to the most vulnerable Medi-Cal beneficiaries.

Organization	Description	Date
Oxnard Police Department Outreach Coordinators meeting	Community partners share resources, promote outreach events, and invite presenters to educate participants. The goal is to provide community awareness and resources to Ventura County residents.	Sept. 1, 2021
Circle of Care One Step A La Vez	One Step A La Vez focuses on serving communities in the Santa Clara Valley by providing a safe environment for 13-19-year-olds and bridging the gaps of inequality while cultivating healthy individuals and community. Circle of Care is a monthly meeting with community leaders to share resources, network, and promote community events.	Sept. 1, 2021
Inter-Neighborhood Council Organization (INCO) meeting	The INCO serves as an advocacy group for each neighborhood in the City of Oxnard. INCO helps neighborhood councils communicate with the city council and helps address their concerns.	Sept. 1, 2021
Santa Paula Advisory Committee	Santa Paula residents serve as advocates for people 60 years of age and older with a mission to bring awareness to issues that impact senior living and family caregivers.	Sept. 2, 2021
Simi Valley Neighborhood Council #2	The Neighborhood Council offers residents an opportunity to voice their concerns, provide input to Simi Valley city officials, and develop ideas and recommendations on various topics.	Sept. 14, 2021
Vista Real Charter High School	Vista Real Charter High School hosted a COVID-19 vaccine mobile clinic in the City of Santa Paula.	Sept. 25, 2021
Total community meetings and events		**6**

C. Speakers Bureau

GCHP participated in three speaking engagements this month via the Speakers Bureau. The Community Relations and Health Services teams provided COVID-19 vaccine information, care management, health education, transportation benefit, and member rewards. The purpose of the Speakers Bureau is to educate and inform the public, partners, and external groups about GCHP and our mission in the community.

Organization	Description	Date
Santa Paula Senior Committee	Provided an overview of GCHP's benefits and services. The presentation included an in-depth review of GCHP's website to demonstrate how to locate resources and find information about our health initiatives.	Sept. 2, 2021
Amigo Baby Facebook Live	GCHP speakers provided information about the COVID-19 vaccine, and GCHP services and benefits.	Sept. 13-15, 2021
Mixteco Indigena Community Organizing Project's (MICOP) Radio Indigena	Provided an overview of GCHP's benefits and services, COVID-19 vaccine information, and answered common listener questions.	Sept. 21, 2021

To request a speaker, complete the application located on our website on the "Community" page (click here to access the application directly). For more information, email CommunityRelations@goldchp.org.

D. Building Community Newsletter

The Building Community Newsletter highlights GCHP's contributions to the community, along with services and resources available to members. In the September newsletter, we are sharing information about the Medi-Cal expansion and other changes to the program, Medi-Cal Rx, vaccination efforts, and sponsorships awarded this month. Click here to read the latest issue.

II. PLAN OPERATIONS

A. Membership

	VCMC	CLINICAS	CMH	PCP-OTHER	DIGNITY	ADMIN MEMBERS	NOT ASSIGNED	KAISER
Jul-21	85,488	42,747	32,130	5,114	6,298	16,880	3,714	6,584
Jun-21	85,284	42,466	32,057	5,092	6,229	16,828	3,808	6,559
May-21	84,962	31,875	31,855	5,139	6,215	16,459	3,175	6,508

Notes:

1. The 2021 Admin Member numbers will differ from the member numbers below as both reports represent different snapshots of eligibility.
2. Unassigned members are those who have not been assigned to a PCP and have 30 days to choose one. If a member does not choose a PCP, GCHP will assign one to them.

Administrative Member Details

Category	July 2021
Total Administrative Members	32,866
Share of Cost	1,601
Long Term Care	728
BCCTP	78
Hospice (REST-SVS)	93
Out of Area (Not in Ventura)	212
Other Health Care	
DUALS (A, AB, ABD, AD, B, BD)	25,544
Commercial OHI (Removing Medicare, Medicare Retro Billing and Null)	XX

NOTE:
The total number of members will not add up to the total admin members, as members can be represented in multiple boxes. For example, a member can be both Share of Cost and Out of Area. They are counted in both boxes.

METHODOLOGY
Administrative members for this report were identified as anyone with active coverage with the benefit code ADM01. Additional criteria is as follows:

1. Share of Cost (SOC-AMT) > zeros
    a. AID Code is not 6G, 0P, 0R, 0E, 0U, H5, T1, T3, R1 or 5L
2. LTC members identified by AID codes 13, 23, and 63.
3. BCCTP members identified by AID codes 0M, 0N,0P, and 0W.

4. Hospice members identified by the flag (REST-SVS) with values of 900, 901, 910, 911, 920, 921, 930, or 931.
5. Out of Area members were identified by the following zip codes:
    a. Ventura Zip Codes include: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93000-12, 93015-16, 93020-24, 93030-36, 93040-44, 93060-66, 93094, 93099, 93225, 93252
    b. If no residential address, the mailing address is used for this determination.
6. Other commercial insurance was identified by a current record of commercial insurance for the member.

B. Provider Contracting Update:

GCHP works with providers through:

1. **Agreements:** Newly negotiated contracts between GCHP and a provider.
2. **Amendments:** Updates to existing Agreements.
3. **Interim Letters of Agreement (LOA):** Agreements created for providers who have applied for Medi-Cal enrollment but have not been approved. Once Medi-Cal enrollment has been approved and the provider has been credentialed by GCHP, the provider will enter into an Agreement with GCHP. Also used for out-of-area providers who are Medi-Cal enrolled to meet DHCS out-of-network contracting requirements.
4. **Letters of Agreement (LOA):** Member-specific negotiated agreements with non-contracted GCHP providers.

From August 1 - 31, 2021, the following contracting actions were taken:

Agreements – Total: 1		
Provider	**Specialty**	**Action Taken**
Amigo Baby Therapy Services Inc.	Physical Therapy	Four therapists were credential approved and transferred from Interim LOA to fully executed agreement.

Contract Amendments – Total: 4		
Provider	**Specialty**	**Action Taken**
LA Laser Center of Bakersfield	Specialty Group	Addition of one specialist
Providence Health Systems	Hospital	Tax ID and legal name change

Provider	Specialty	Action Taken
CMH Midtown Medical Brent Street	Specialty Location	Termination of Interim LOA
Planned Parenthood California Central Coast Interim LOA	Specialty Group	Termination of 10 specialists
Letters of Agreement – Total: 5		
Provider	**Specialty**	**Action Taken**
Cottage Children's Medical Group	Specialty Group	LOA for pediatric member diagnosed with interstitial pulmonary disease and multiple CCS conditions. LOA is for three office visits with pediatric pulmonologist.
Thomas Armstrong Hope, MD/UCSF Medical Center	Hospital	LOA for member with malignant neoplasm of adrenal gland. Member is being referred for administration of Azedra.
Foundation Medicine	Pharmacy	LOA for member in need of genetic testing for cancer. This is a new test and only available at this lab.
Stanford Medical Center	Hospital	LOA for member with multiple fractures to pelvis in need of pelvis and spine stabilization.
Stanford Medical Center	Hospital	LOA for member with acute myeloblastic leukemia for office consultation and office follow up visit.

Network Operations Department Projects

Project	Status
BetterDoctor: BetterDoctor is a product that performs outreach to providers to gather and update provider demographic information. This is an ongoing initiative.	Network Operations continues to meet weekly with Quest Analytics. In August 2021, the team verified demographic information from BetterDoctor: 1. 1,716 provider records were audited.
Provider Contracting and Credentialing Management System (PCCM): Referred to as eVIPs, this software will allow consolidation of contracting, credentialing, and provider information management activities.	The project went live on Sept. 14, 2021.Network Operations team is working on the following processes: 1. Desk-level Procedures 2. Data Corrections / Maintenance 3. Reporting requirements review and revisions completed 4. Completing Reference Tables 5. Reviewing conversion from current Silverlight browser to new eVIPs HTML5 version 6. MediTrac Regression and TPR Testing completed 7. Practitioner Specialty Types Testing completed 8. Provider Directory Online UAT Testing Ongoing 9. 274 Extract Testing ongoing 10. Supervising Physician reporting completed 11. BetterDoctor Extract requirements reviewed

Provider Additions: August 2021 – Total 46

Provider Type	In-Area Providers	Out-of-Area Providers
Midlevel	3	1
PCP	0	0
Specialist	28	6
Specialist-Hospitalist	5	3
Total	36	10

Provider Terminations: August 2021 – Total 46

Provider Type	In-Area Providers	Out-of-Area Providers
Midlevel	6	0
PCP	3	0
Specialist	8	28
Specialist-Hospitalist	1	0
Total	18	28

The 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.

C. Compliance

Delegation Oversight

GCHP is contractually required to perform oversight of all functions delegated through subcontracting arrangements. Oversight includes, but is not limited to:

1. Monitoring / reviewing routine submissions from subcontractor
2. Conducting onsite audits
3. Issuing a Corrective Action Plan (CAP) when deficiencies are identified

**Ongoing monitoring denotes the 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.

The following table includes audits and CAPs that are open and closed. Closed audits are removed after they are reported to the Commission. The table reflects changes in activity from Aug. 7 – Sept. 22, 2021.

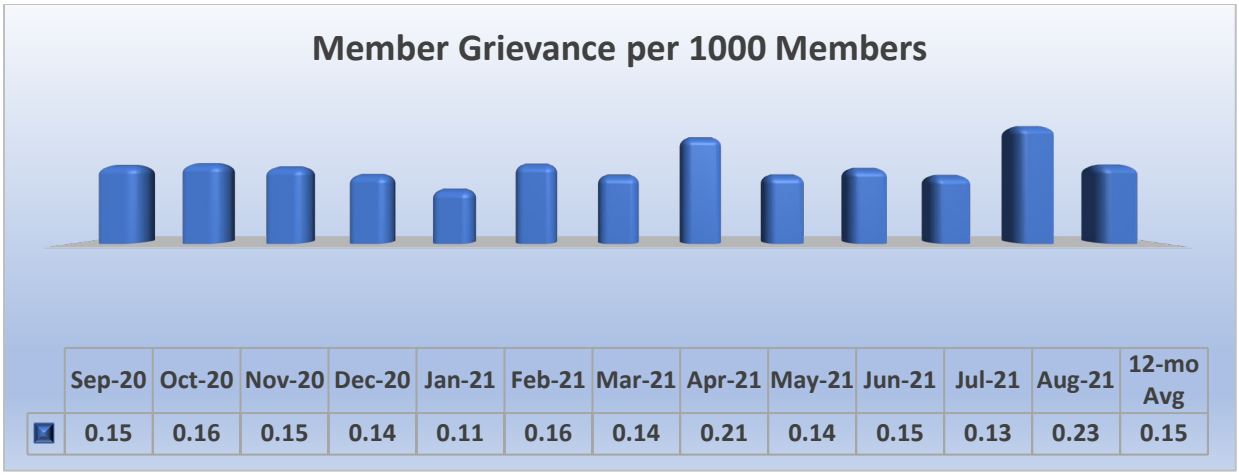
Delegate	Audit Year/Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Conduent	2017 Annual Claims Audit	Open	12/28/2017	Under CAP	Issue will not be resolved until new claims platform conversion.
Conduent	2021 Annual Claims Audit	Open	07/21/2021	Under CAP	
Beacon	2020 Annual Claims Audit	Open	4/21/2020	Under CAP	
Beacon	2021 Annual Claims Audit	Open	5/06/2021	Under CAP	
Conduent	2020 Call Center Audit	Open	1/20/2021	Under CAP	
VTS	2021 Call Center Audit	Open	5/21/2021	Under CAP	
Beacon	2021 Call Center Audit	In Progress			
Cedars Sinai	2021 Annual Credentialing Recredentialing Audit	Closed	N/A	N/A	No findings. Audit closed on 9/1/2021.

Privacy & Security CAPs					
Delegate	**CAP Type**	**Status**	**Date CAP Issued**	**Date CAP Closed**	**Notes**
Conduent	2020 Annual Vendor Security Risk Assessment	Closed	9/22/2020	7/09/2021	

Privacy & Security CAPs (cont'd)					
Conduent	Call Center Recordings Website	Open	1/06/2021	N/A	

Operational CAPs					
Delegate	**CAP Type**	**Status**	**Date CAP Issued**	**Date CAP Closed**	**Notes**
Conduent	February 2021 Service Level Agreements	Open	4/15/2021	N/A	
Conduent	IKA Inventory, KWIK Queue, APL 21-002	Open	4/28/2021	N/A	IKA Inventory and KWIK Queue findings closed on 5/21/2021
Conduent	HSP Provider Portal	Open	4/29/2021	N/A	
Conduent	Call Center Stats and System Edits	Open	5/25/2021	N/A	
Conduent	IVR System Dropped Calls	Open	5/27/2021	N/A	
Conduent	May 2021 Service Level Agreements	Open	7/07/2021	N/A	
Conduent	August 2021 SLA 1. Authorization Files 2. Check Issuance Errors 3. Member Handbook 4. Dropped Calls by Call Center	Open	9/10/2021	N/A	

D. GRIEVANCE AND APPEALS

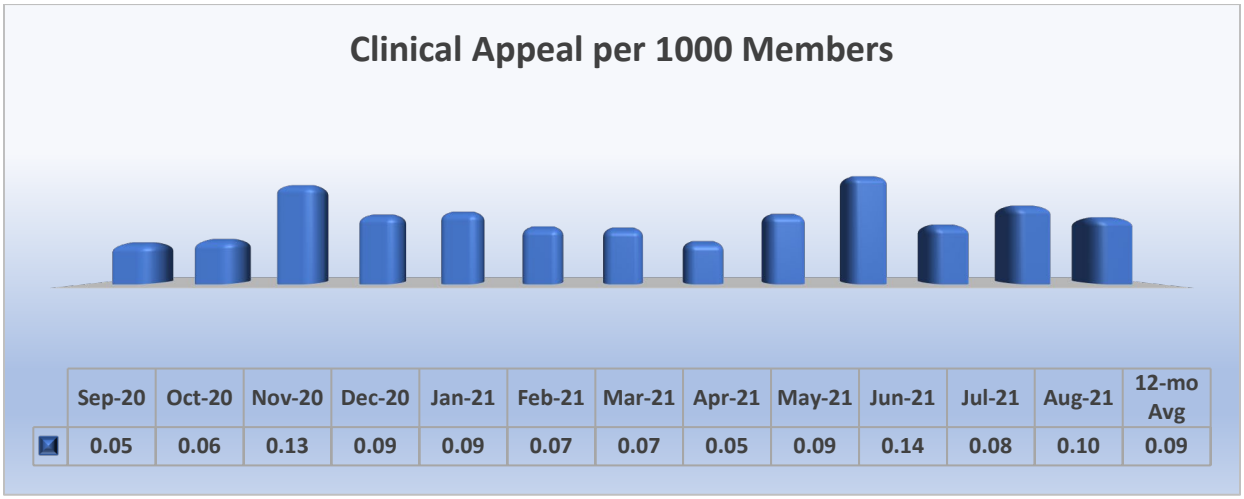


	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	12-mo Avg
☑	0.15	0.16	0.15	0.14	0.11	0.16	0.14	0.21	0.14	0.15	0.13	0.23	0.15

Member Grievances per 1,000 Members

The data show GCHP's volume of grievances is low in comparison to the number of enrolled members. The 12-month average of enrollees is 217,086, with an average annual grievance rate of .15 grievances per 1,000 members.

In August 2021, there were 55 member grievances. The top reason was "Inappropriate Care" due to outpatient physical health. As previously reported, this is a new category created by DHCS in order to streamline the reporting categories for all the health plans. The previous category reported was "Quality of Care" due to inappropriate provider care.



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	12-mo Avg
☑	0.05	0.06	0.13	0.09	0.09	0.07	0.07	0.05	0.09	0.14	0.08	0.10	0.09

Clinical Appeals per 1,000 Members

The data comparison volume is based on the 12-month average of .09 appeals per 1,000 members.

In August 2021, GCHP received 23 clinical appeals:

1. Eight were overturned
2. Eight were upheld
3. Five are still in review
4. Two were withdrawn

RECOMMENDATION:

Receive and file

AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: September 27, 2021

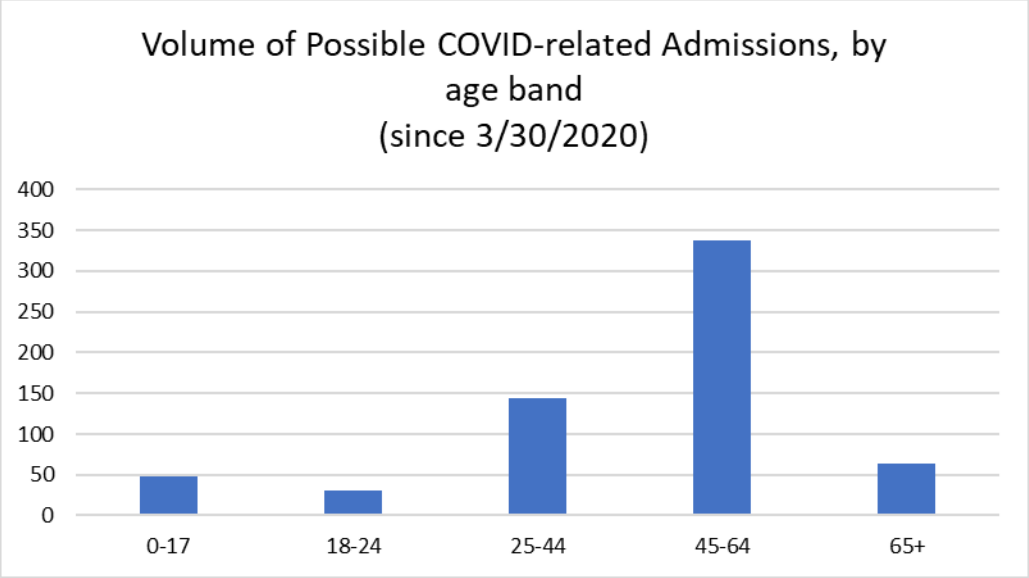
SUBJECT: Chief Medical Officer (CMO) Report

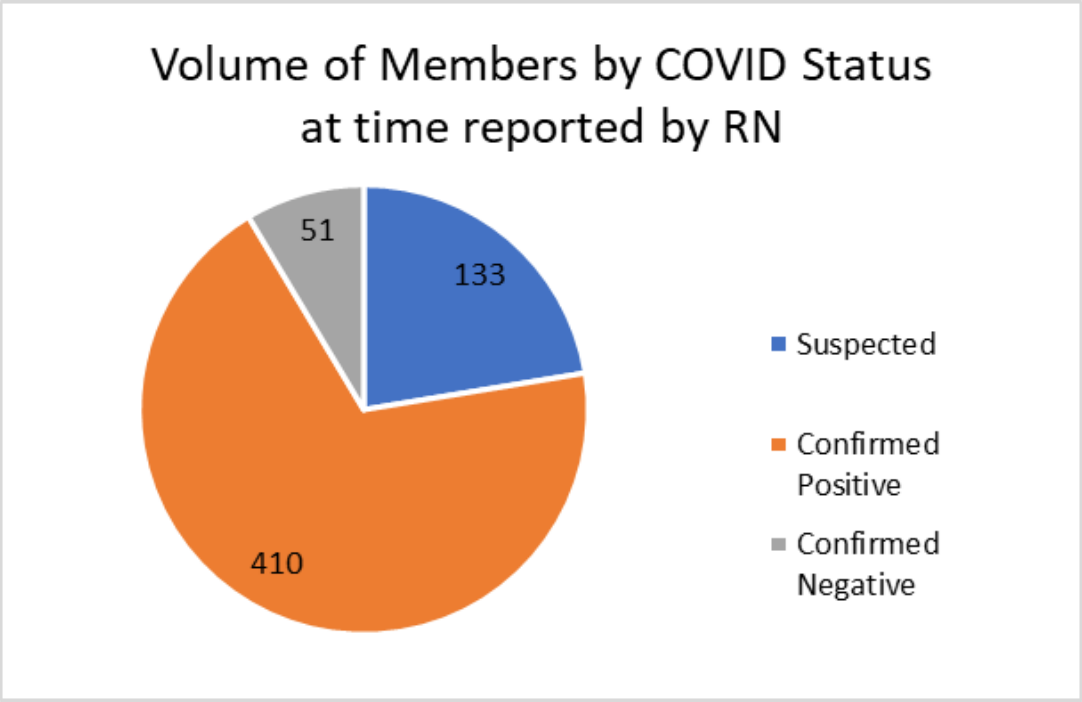
Utilization Update

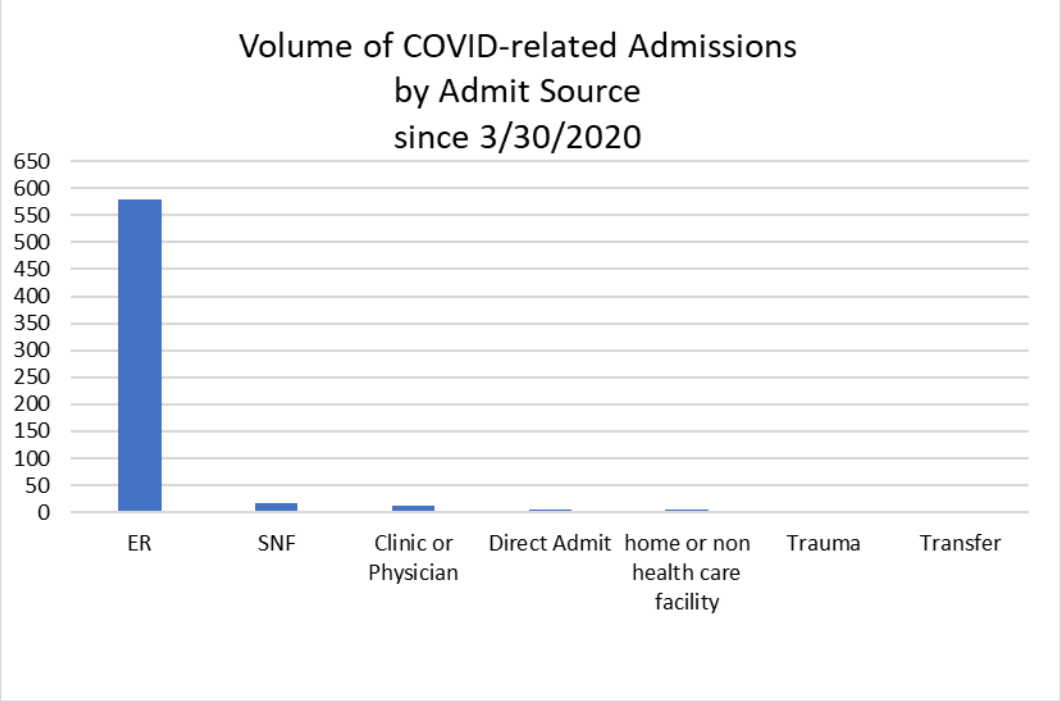
COVID-19

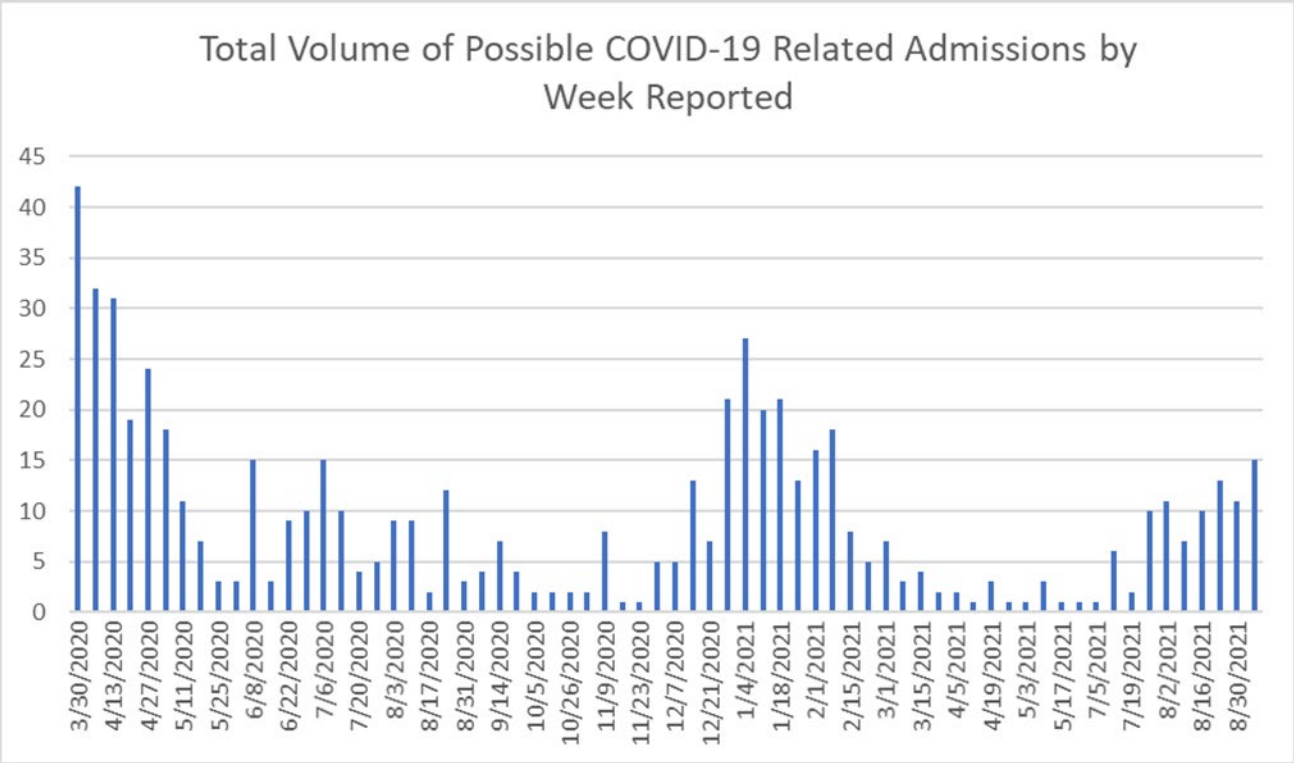
The Centers for Disease Control ("CDC") describes the level of transmission in Ventura County as high as of September 12, 2021. New COVID-19 hospital admissions are up about 2% compared to prior week and ICU bed use is up by 6%.

As of September 15, 2021 Gold Coast Health Plan ("GCHP") staff have reported 623 COVID-19 related hospital admissions to the Department of Health Care Services ("DHCS"). 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 about a quarter of admissions is pending, about 70% of all admissions were confirmed positive for COVID-19 and about 10% were confirmed negative. Most admissions continue to come through the Emergency Department and the volume of admissions has generally been increasing since mid-July 2021.



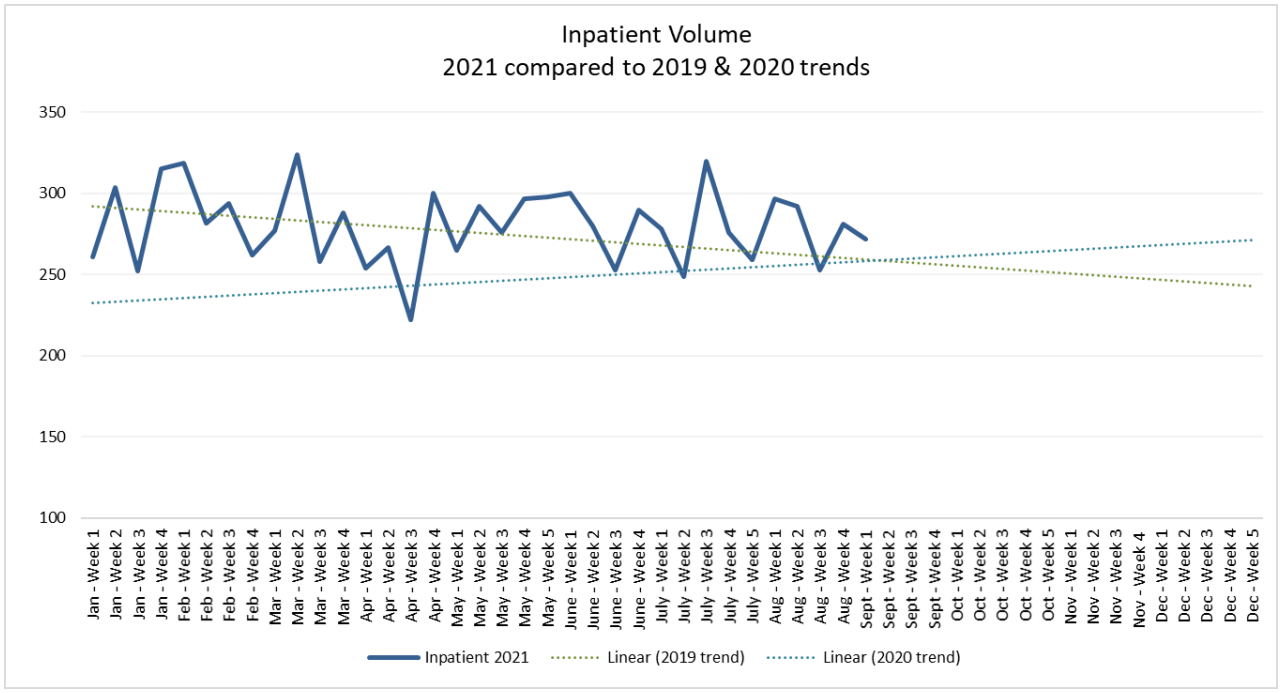

Volume of Members by COVID Status
at time reported by RN
51
133
410
Suspected
Confirmed Positive
Confirmed Negative

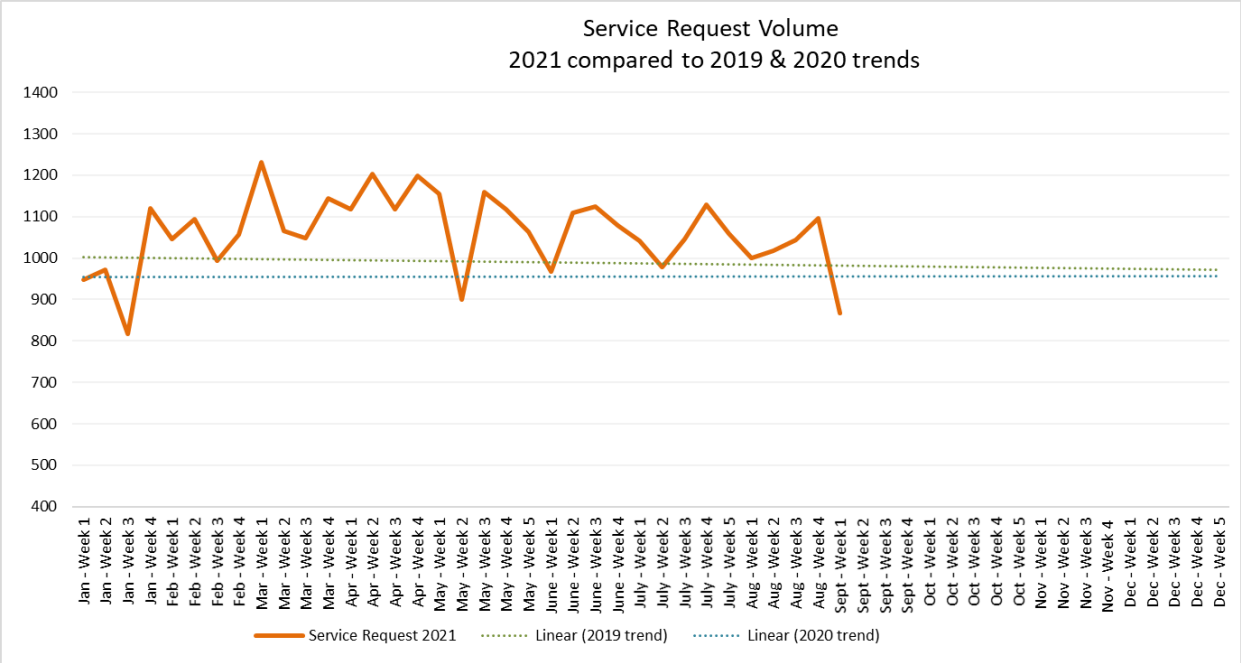

Volume of COVID-related Admissions
by Admit Source
since 3/30/2020
650
600
550
500
450
400
350
300
250
200
150
100
50
0
ER
SNF
Clinic or Physician
Direct Admit
home or non health care facility
Trauma
Transfer



Service Requests

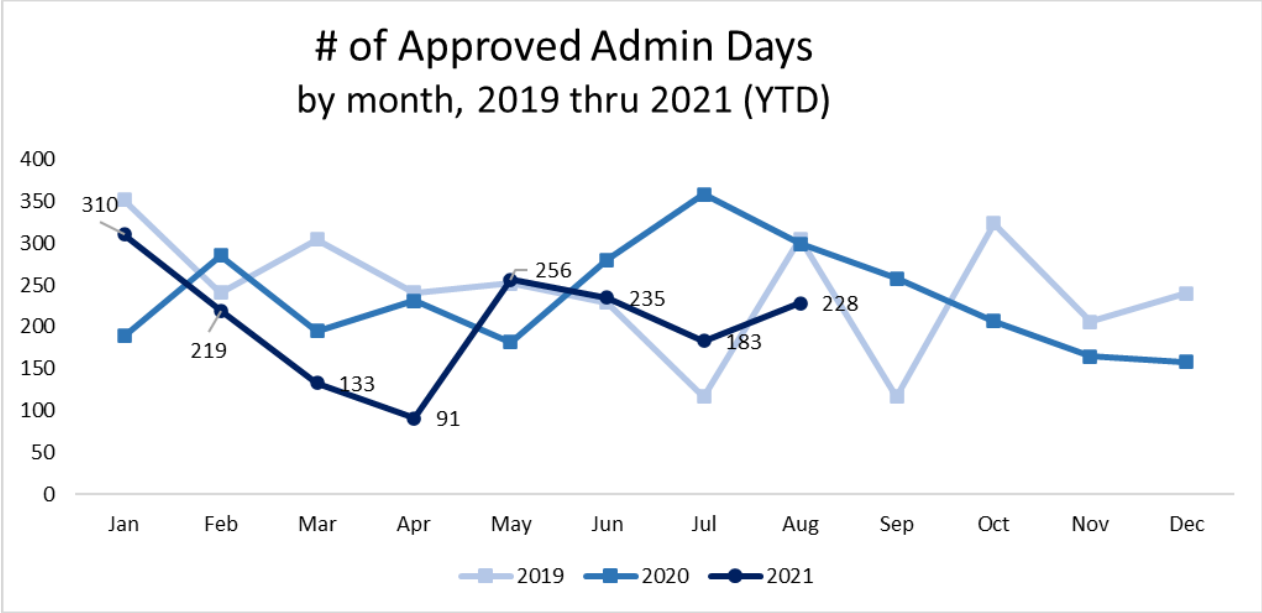
Inpatient service requests through August 2021 are similar to 2019 trends. Q2 inpatient requests are about 3% higher in CY2021 compared with Q2 CY2019. Outpatient service requests for Q2 CY 2021 are about 14% higher than Q2 CY2019.

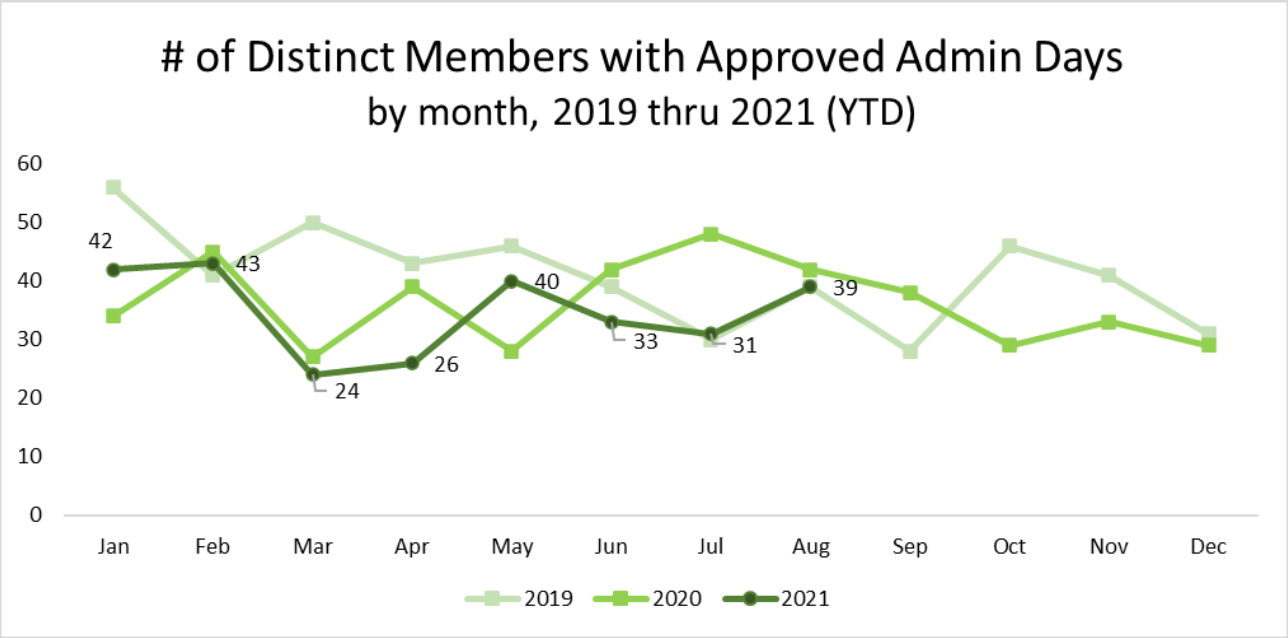




Administrative Days

The number of administrative days utilized and number of distinct members utilizing administrative days for CY 2021 through August is lower than both CY2019 and CY2020.





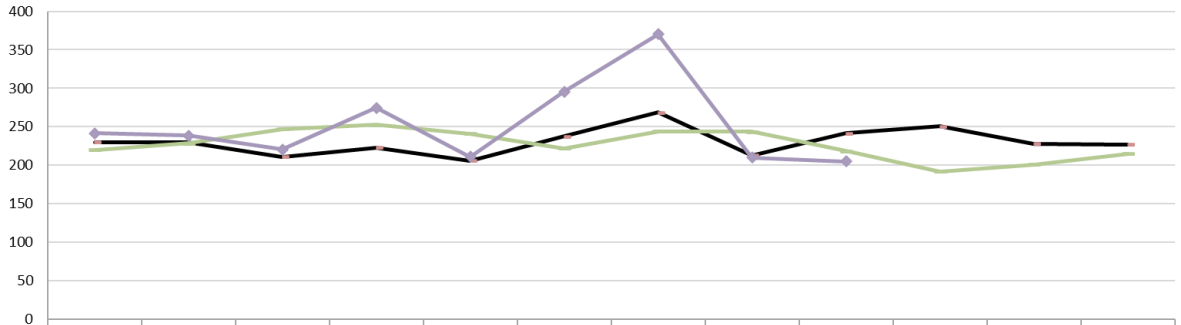
Bed Days

Bed days for Q1 CY2021 are about 8.5% higher than Q1 CY2020 (261/1000 members compared with 241/1000 members) with a prominent spike in January coinciding with a COVID-19 spike in Ventura County.

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

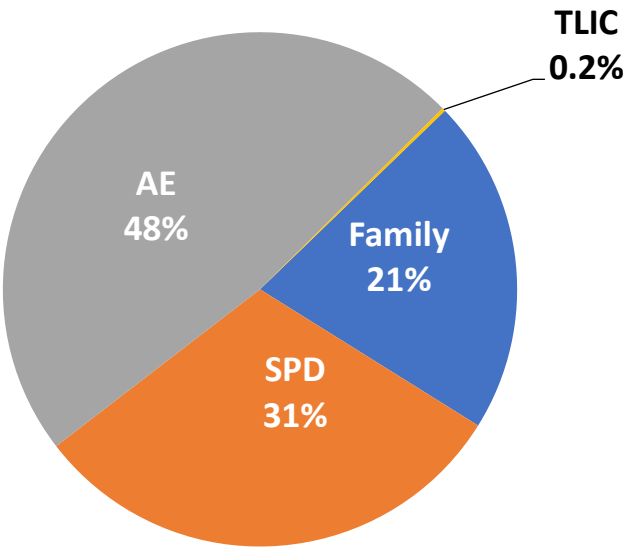
Slightly under half of bed days are utilized by Adult Expansion ("AE") members (48%), followed by Senior and Persons with Disabilities ("SPD") (31%), and Family (21%) aid code groups. Low income children ("TLIC") utilization is less than 1% (0.2%). AE members are about 34% of our population and utilize 48% of bed days. SPDs represent about 5% of membership with about 31% of bed day utilization.

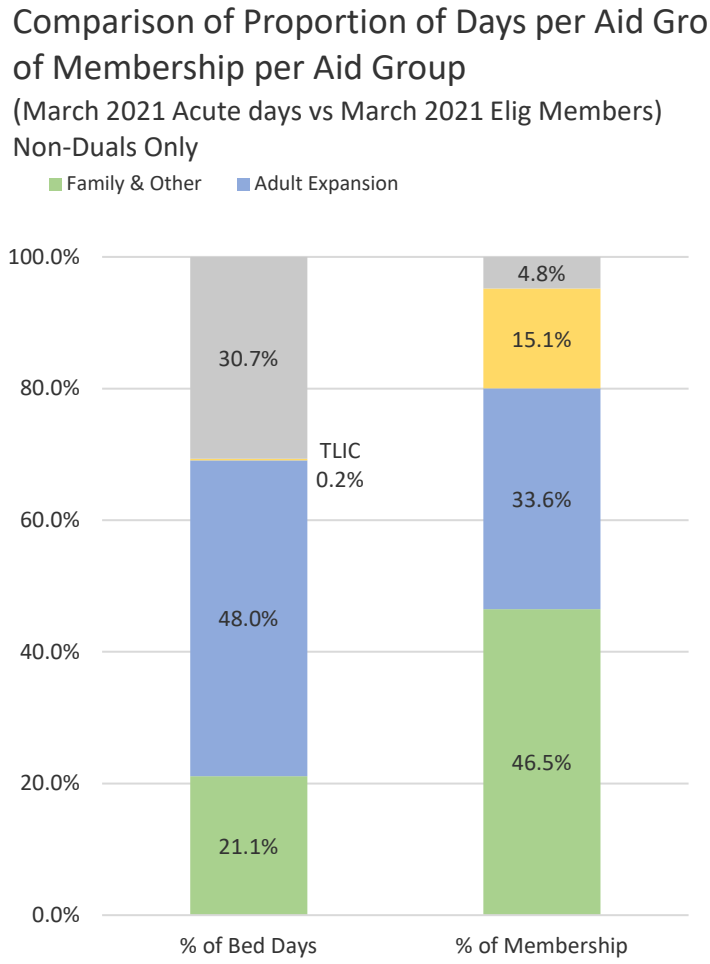
Bed Days Per 1,000



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2018-19	230	229	211	223	206	237	269	213	241	250	228	227
FY 2019-20	220	229	247	252	241	222	244	243	218	192	201	215
FY 2020-21	242	238	220	275	211	296	370	210	205			

Bed Days by Aid Category
March 2021

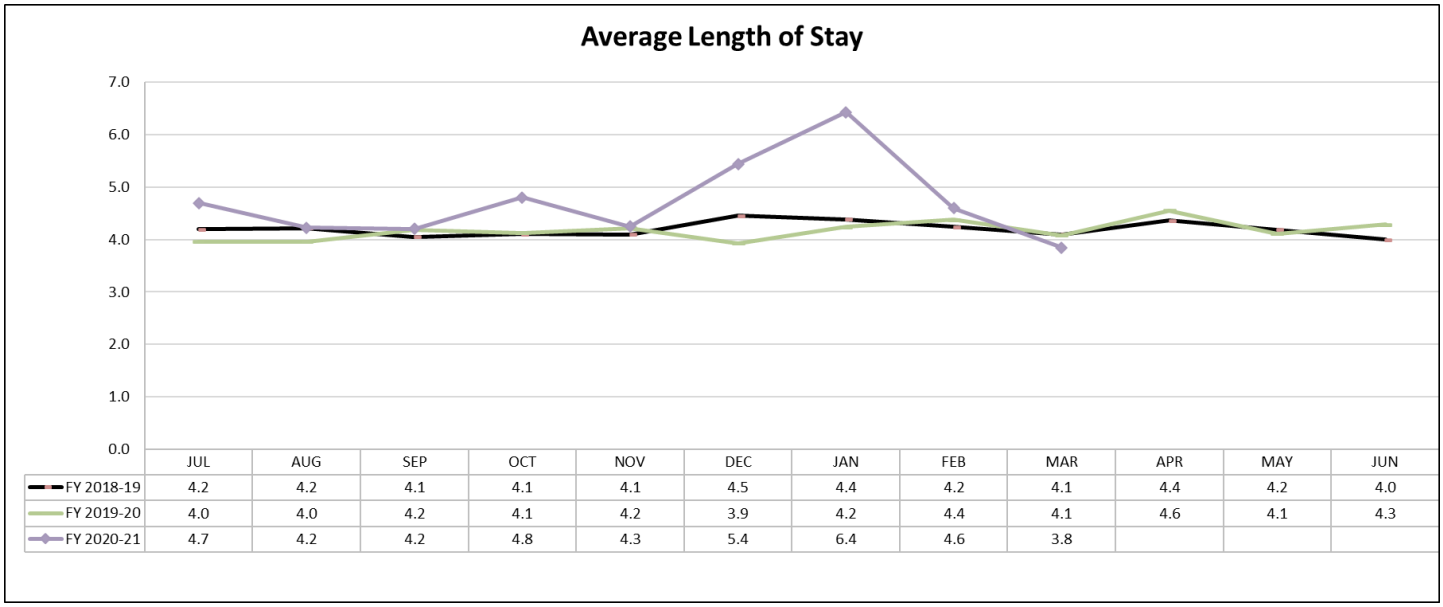




Average Length of Stay ("ALOS")

Average length of stay for Q1 CY2021 increased to 5 days compared to an ALOS of 4.3 for Q1 CY 2020. This is related to the January 2021 COVID-19 spike.

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

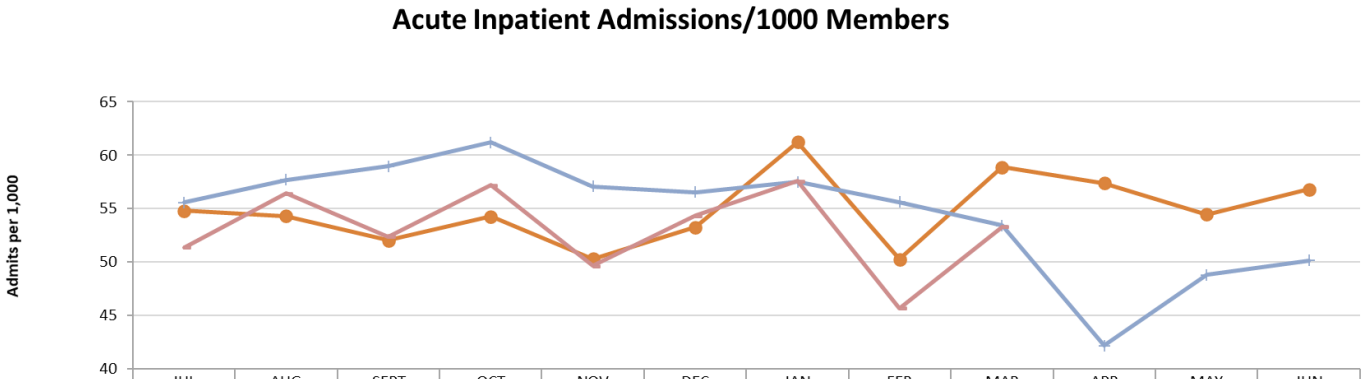


	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2018-19	4.2	4.2	4.1	4.1	4.1	4.5	4.4	4.2	4.1	4.4	4.2	4.0
FY 2019-20	4.0	4.0	4.2	4.1	4.2	3.9	4.2	4.4	4.1	4.6	4.1	4.3
FY 2020-21	4.7	4.2	4.2	4.8	4.3	5.4	6.4	4.6	3.8			

Admits/1000 Members

Admits/1000 members for Q1 CY2021 decreased by about 7% compared with Q1 CY 2021 (52.2 compared with 56.3).

Admits/1000 members benchmark: The Medi-Cal plan average is 55/1000 members.

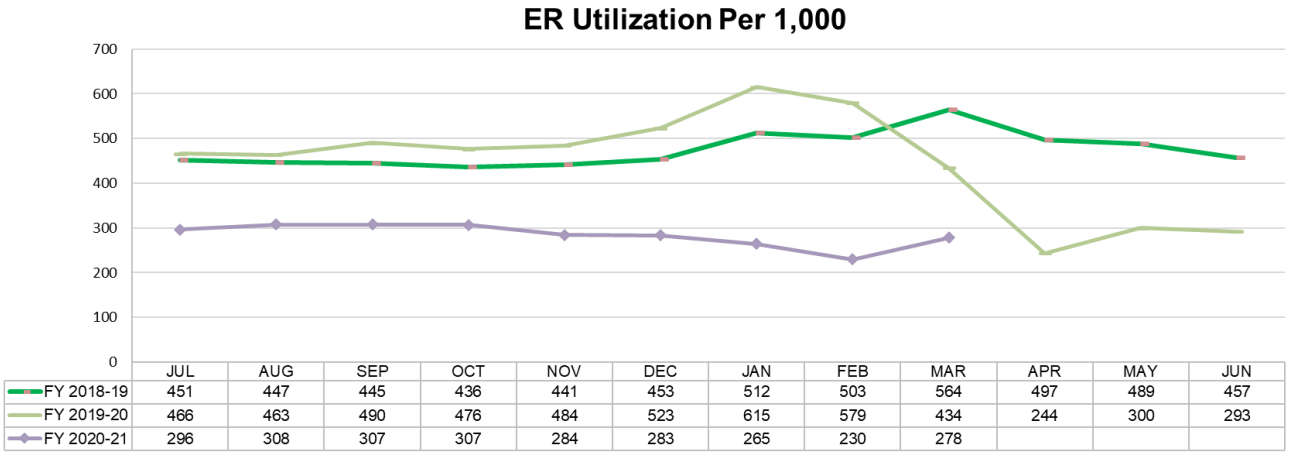


	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2018-19	55	54	52	54	50	53	61	50	59	57	54	57
FY 2019-20	56	58	59	61	57	57	58	56	53	42	49	50
FY 2020-21	51	56	52	57	50	54	58	46	53			

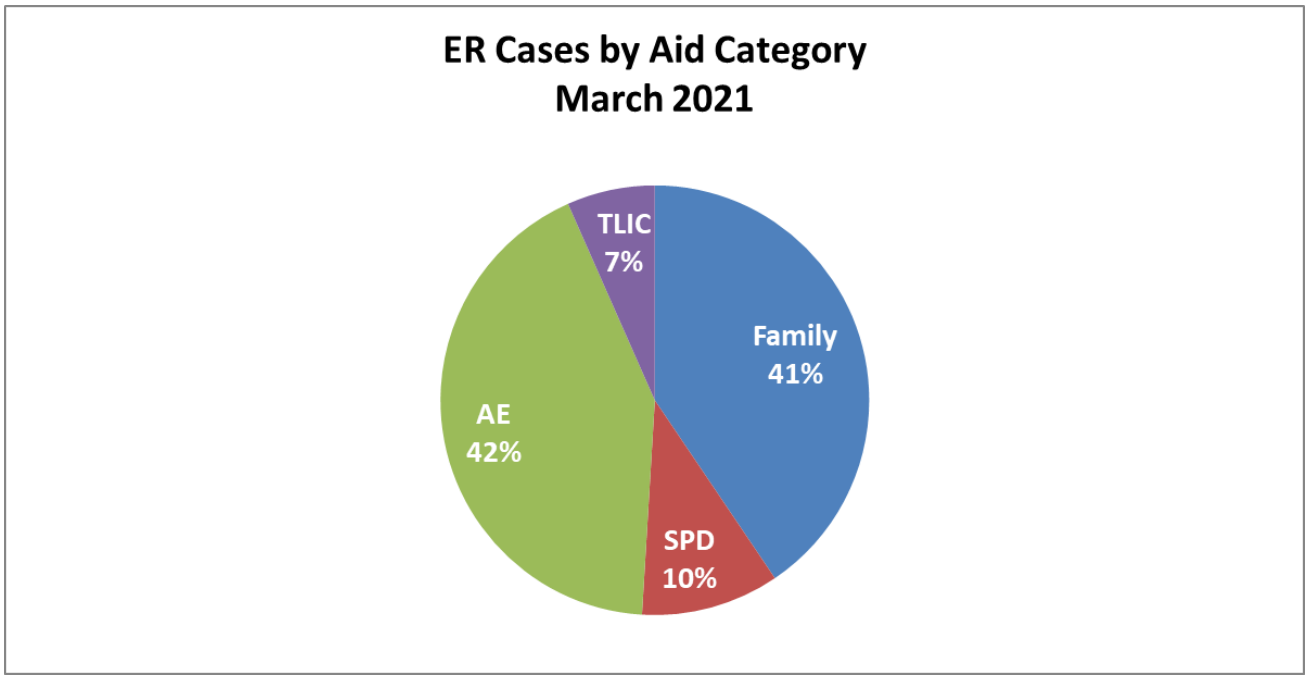
Emergency Department ("ED") Utilization/1000 Members

ED utilization/1000 members decreased by about half in Q1 CY2021 compared with Q1 CY2020 (258 v 525). The decrease in ED utilization during COVID-19 spikes was also seen in 2020. The AE and Family aid code groups each represented about 40% of ED utilization followed by SPD (10%) and TLIC (7%) aid code groups. SPD members comprise almost 5% of our membership but represent over 10% of ED visits.

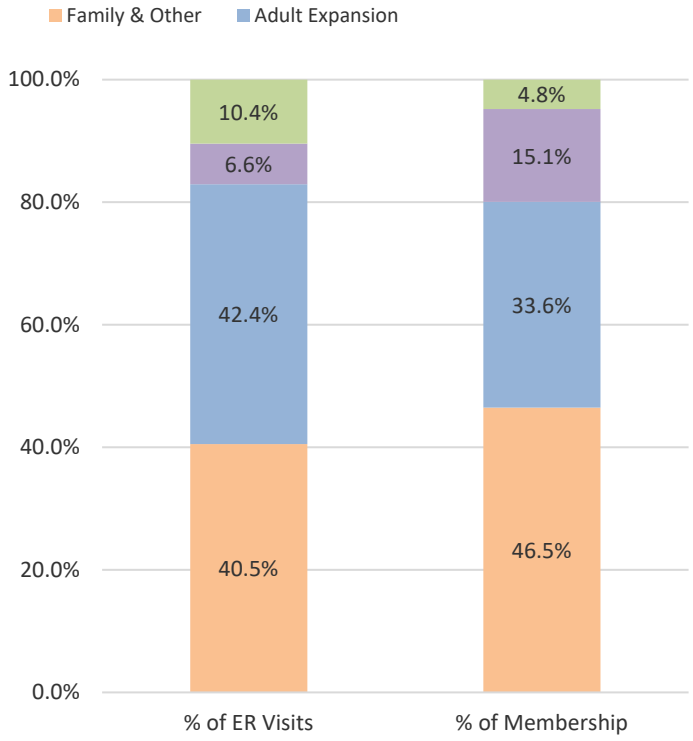
ED utilization benchmark: The Managed Care Accountability Set ("MCAS") mean for managed Medicaid plans for ED utilization/1000 members is 587.



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2018-19	451	447	445	436	441	453	512	503	564	497	489	457
FY 2019-20	466	463	490	476	484	523	615	579	434	244	300	293
FY 2020-21	296	308	307	307	284	283	265	230	278			

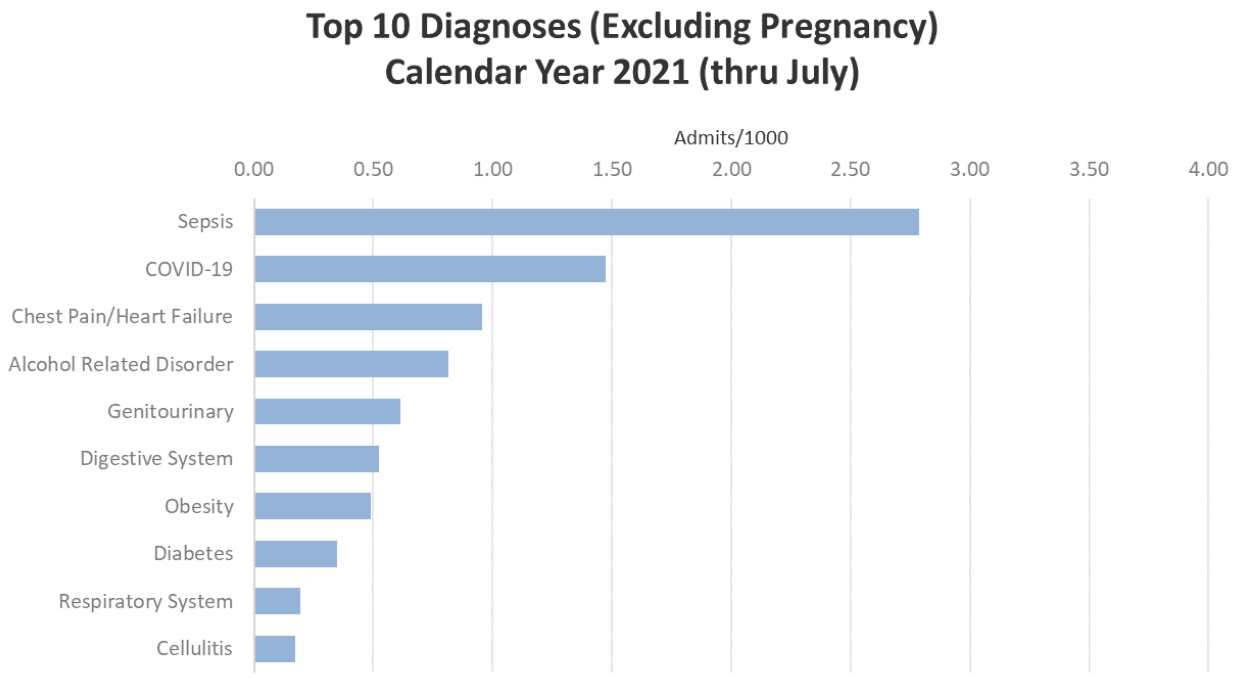


Comparison of Proportion of ER Visits per Aid Group to Proportion of Membership per Aid Group
(March 2021 ER Visits vs March 2021 Elig Members)
Non-Duals Only



Top Admitting Diagnoses

Pregnancy/childbirth continues to be our top admitting diagnosis category. When pregnancy is excluded, the top admitting diagnoses continue to be sepsis, COVID-19, and cardiac conditions. COVID-19 has moved up from position 4 for CY2020 to position 2 for Q1 of CY2021. The alcohol related disorders category has moved down from position 2 for CY2020 to position 4 for CY2021 through July.



Readmission Rate

The quarterly readmission rate for Q1 – Q2 CY2021 averaged 13.65% compared with the CY2020 average of 14.6%.

Readmission rate benchmark: The Medi-Cal Plan average readmission rate is 16.1%.

Pharmacy Hot Topics

Medi-Cal Rx

DHCS informed plans in late July 2021 that the new implementation date for Medi-Cal Rx will be January 1, 2022. Upon implementation, all retail prescription claims will be submitted directly to the state via its Pharmacy Benefit Manager ("PBM"), Magellan. GCHP will continue to work with advocacy groups, other Managed Care Plans ("MCPs"), DHCS and its PBM in order to facilitate the implementation of the carve out and will continue to bring information as it becomes available to this group.

The DHCS dedicated website for Medi-Cal Rx is live and contains announcements, news, and secure portal training/registration. GCHP encourages all of its providers to:

1. Visit the portal
2. Sign up for the email subscription service
3. Register for the secure portal and training

The following table lists the planned member communication from both DHCS and GCHP for the upcoming transition:

Date	Topic	Responsibility
November 2021	60-Day Notice Letter	DHCS
November-December 2021	Outreach Campaign in Radio and Print Media	GCHP
December 2021	30-Day Notice Letter	GCHP
By January 1, 2022	New ID Cards	GCHP

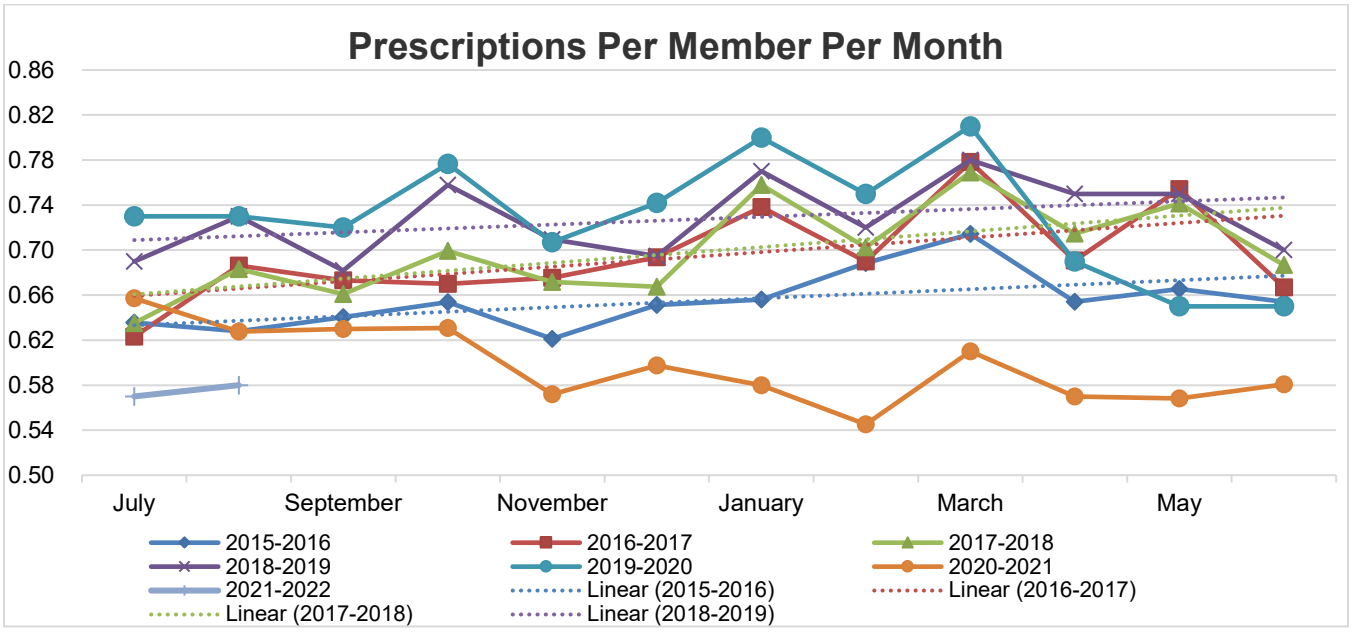
DHCS's Dedicated Medi-Cal RX Website:
https://medi-calrx.dhcs.ca.gov/home/

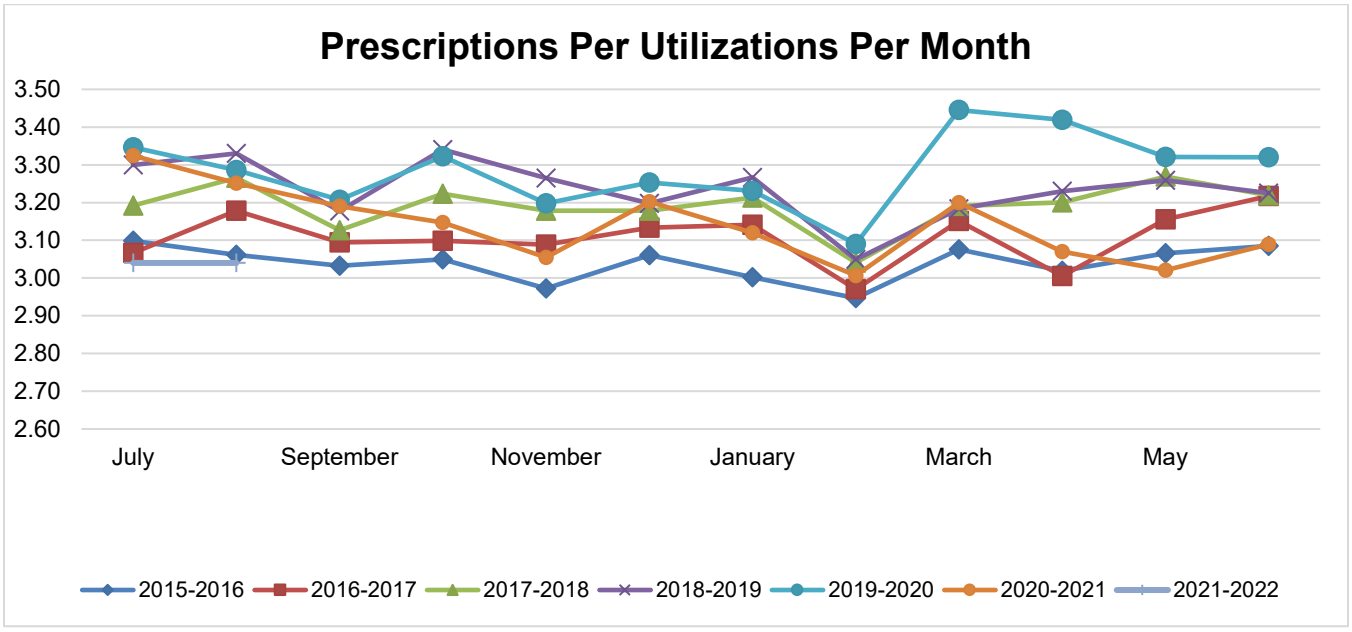
Pharmacy Benefit Cost Trends

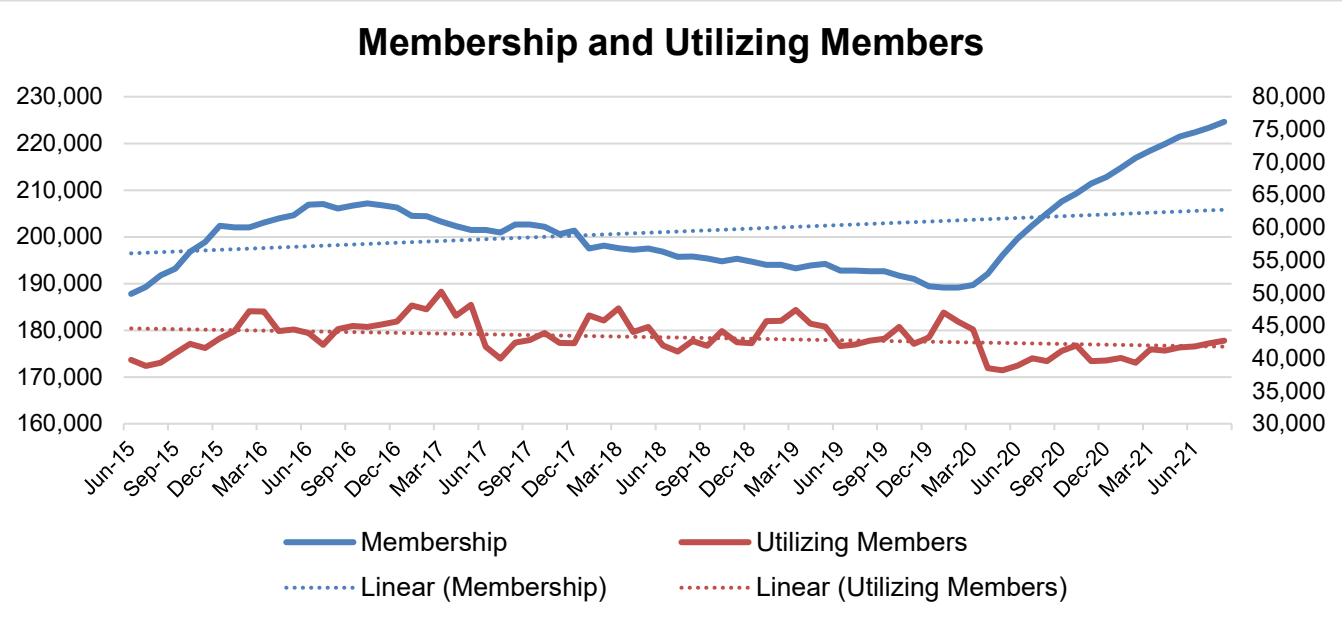
GCHP pharmacy trend shows an 8% increase year over year for August 2021. When looking at the per member per month costs ("PMPM"), the PMPM has decreased approximately 10.2% since its peak in March 2020. Pharmacy trend is impacted by unit cost increases, utilization, and the drug mix. Pharmacy costs were predicted to experience double digit increases (>10%) each year from now until 2025. The impact of COVID-19 and the benefit changes to allow up to a 90-day supply of maintenance medications have created a 3 month cyclic trend of higher expenditures in one month and lower in the following two months as noticed from December 2020 through July with peaks in December, March and June. This cyclic trend is expected to continue as long as there are significant fills of 90-day supply medications.

GCHP Annual Trend Data

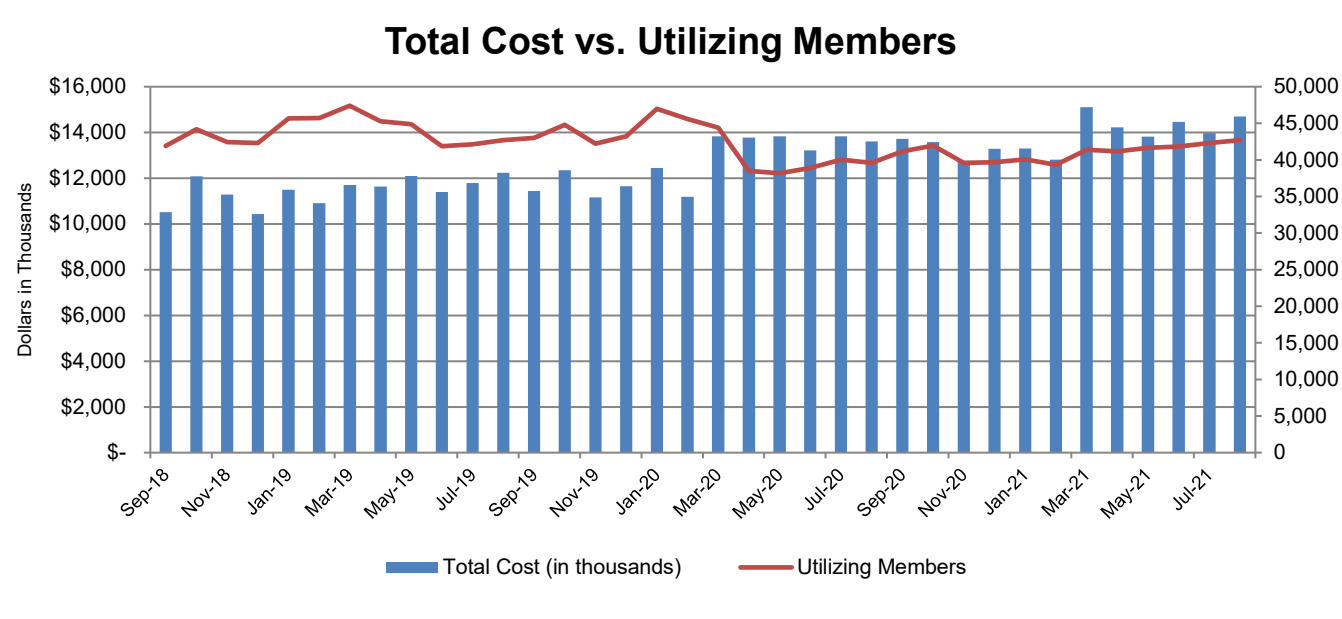
Utilization Trends:
Through March 2020, GCHP's utilization was increasing as demonstrated by the number of members using prescriptions and the number of prescriptions each member is using while GCHP's total membership continued to decline. However, the impact of COVID-19 has caused an increase in membership and the utilization of extended day supplies which suppress the view of increased utilization. The graph showing prescriptions per utilizer gives a new view of the increased utilization. GCHP will be continuously monitoring the impact of COVID-19 and the increased membership.

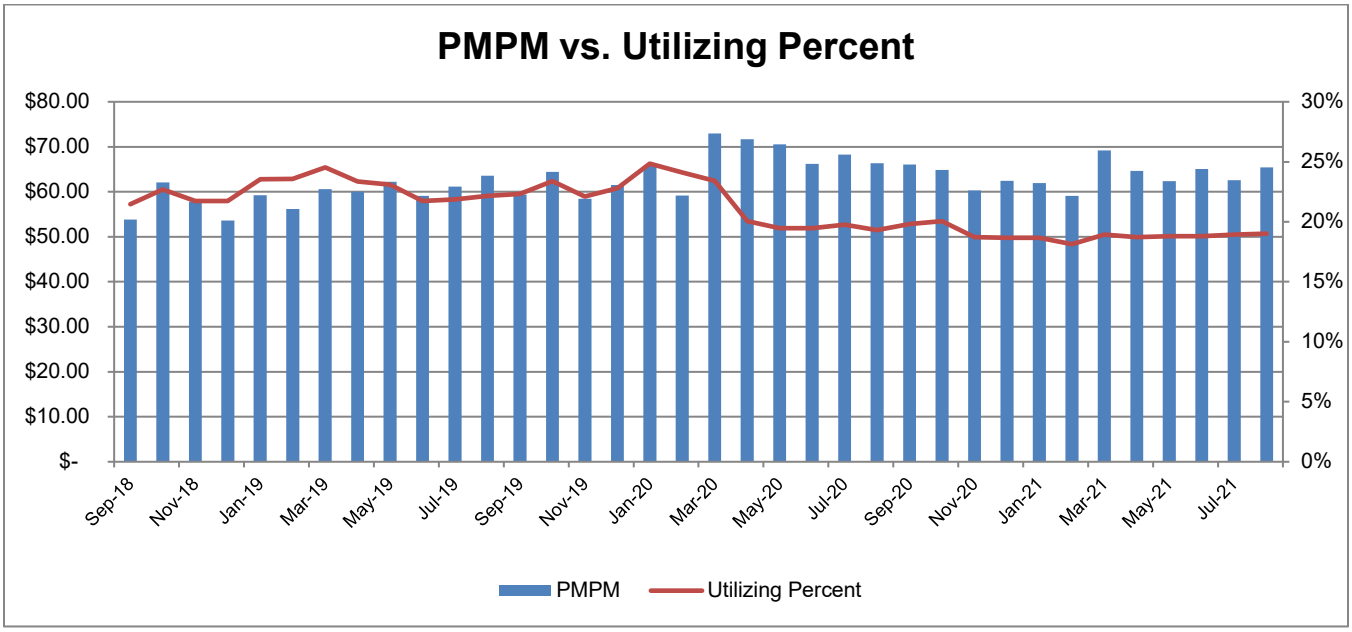

Prescriptions Per Member Per Month
0.86
0.82
0.78
0.74
0.70
0.66
0.62
0.58
0.54
0.50
July
September
November
January
March
May
2015-2016
2016-2017
2017-2018
2018-2019
2019-2020
2020-2021
2021-2022
Linear (2015-2016)
Linear (2016-2017)
Linear (2017-2018)
Linear (2018-2019)

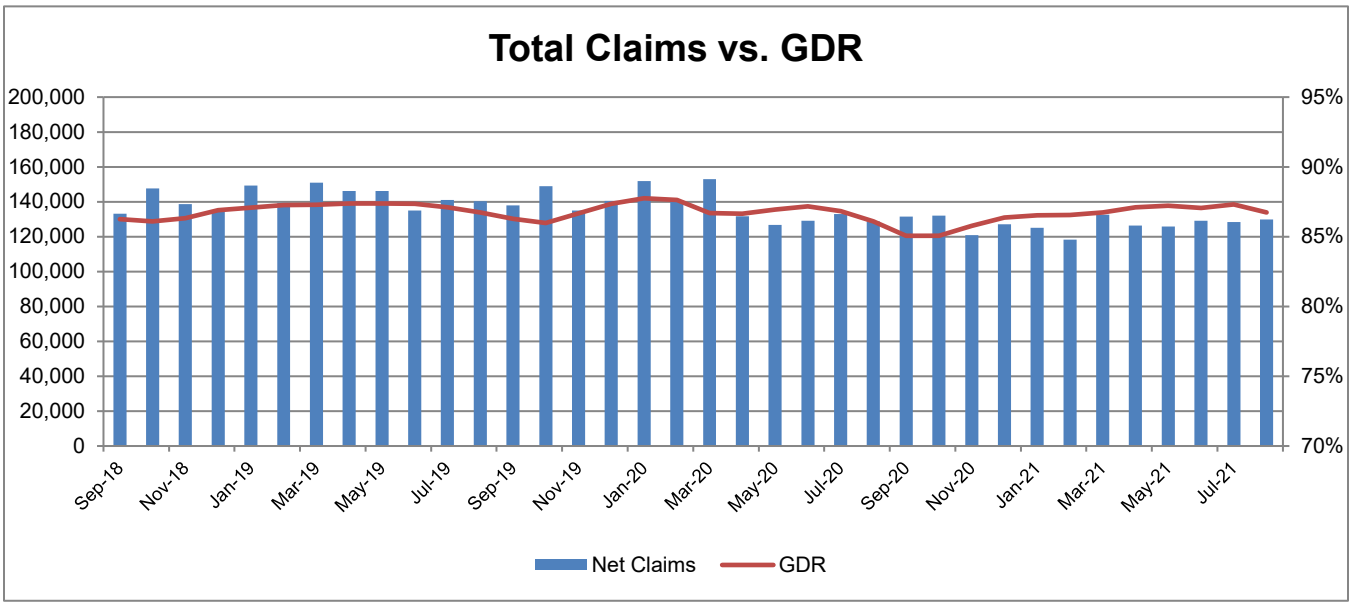

Prescriptions Per Utilizations Per Month
3.50
3.40
3.30
3.20
3.10
3.00
2.90
2.80
2.70
2.60
July
September
November
January
March
May
2015-2016
2016-2017
2017-2018
2018-2019
2019-2020
2020-2021
2021-2022



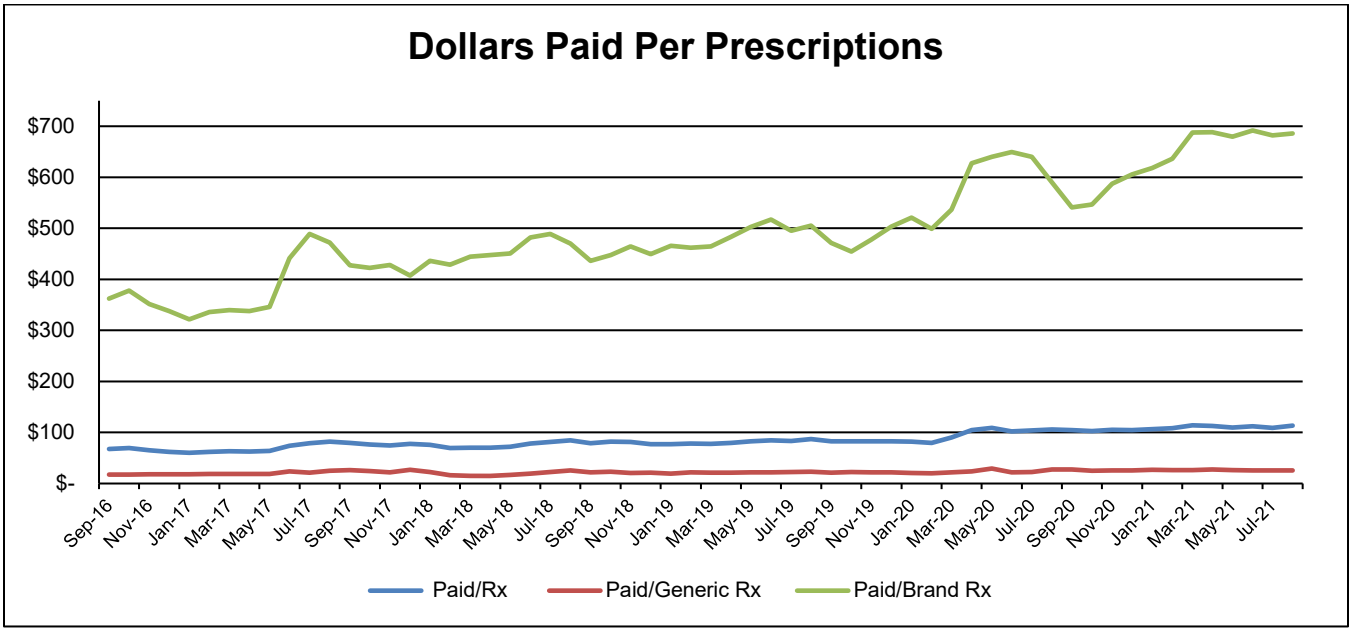
Pharmacy Monthly Cost Trends:





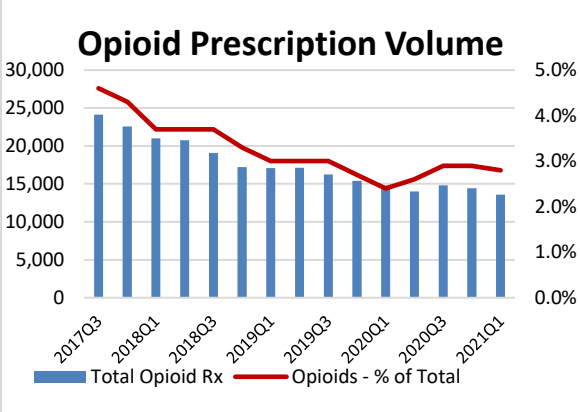


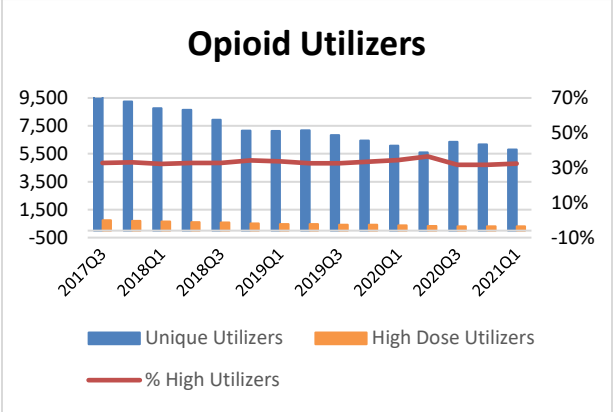
*Claim totals prior to June 2017 are adjusted to reflect net claims.

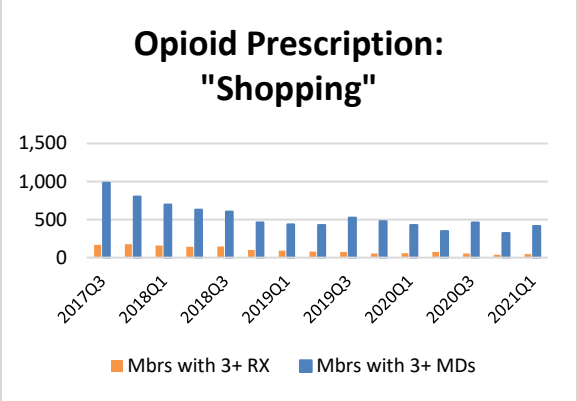


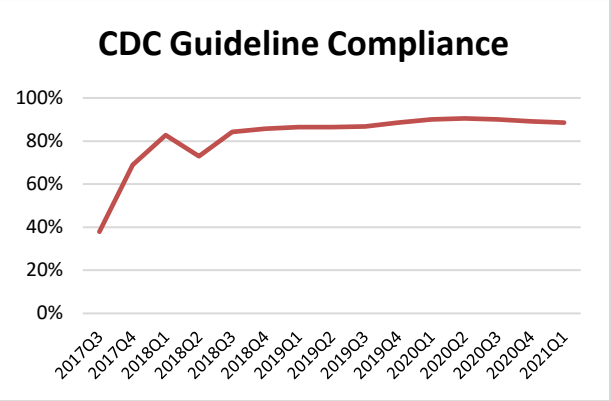
Pharmacy Opioid Utilization Statistics*

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.
*Statistics are unchanged from the last meeting and will be updated upon receipt of the next report showing data through June 2021.

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 PBM monthly reports, GCHP's administrative services organization ("ASO") operational membership counts, and invoice data. The data shown is through the end of August 2021. The data has been pulled during the first two weeks of September 2021 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.

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Chief Diversity Officer

DATE: September 27, 2021

SUBJECT: Chief Diversity Officer (CDO) Report

Actions:

I. Community Relations

- Attended a minority diversity awards ceremony at Cal Lutheran.
- Attended an EEO Zoom meeting on age and gender discrimination.
- Chosen to serve on a committee to select HEAC (Health Equity Advisory Committee members). This initiative is under the direction of the County.
- Met with the County District Attorney to address concerns of the Black and Brown communities.

II. Case Investigations

- **No new cases submitted during the month of August/September.**

III. Diversity Activities

- The Diversity, Equity and Inclusion team has been challenged to look at our plan's values and determine if, in our current reality, change is needed.
- Continuing meetings with the Health Equity and Inclusion Task team to plan for a fall summit on Health Equity, as well as participating in Strategic Planning for the health plan.
- Received eleven calls from employees regarding the following subject matter:

1. Ted Talk discussions (3)
2. Health Equity (2)
3. Career counselling (2)
4. Community events (1)
5. Compass article (1)
6. Current events (2)

- Continue to work with Human Resources in structuring a strategy on return-to-work process when appropriate.

- Lost one member of the Diversity Council (voluntary resignation)
- Wrote article for our newsletter encouraging employees to take the vaccine.
- Working with Community Relations, under the direction of Marlen Torres, to develop a Speaker's Bureau to effectively represent GCHP upon requests from our member community.

AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Michael Murguia, Executive Director of Human Resources

DATE: September 27, 2021

SUBJECT: Human Resources (H.R.) Report

Human Resources Activities

Hired a backfill for our HR Specialist role. Joanne Cowles joined us on August 30th and brings over 20 years of HR experience and was most recently working at Cal State Northridge in their Human Resources Organization. We continue to on board Nick Liguori COO. On September 15th we toured our buildings with Nick and showed him his new office. We also issued his Gold Coast badge to him. We continue to evaluate our benefits package and look for enhancements to our plan for cost savings for our employees. We are initiating our planning for our Open Enrollment in November. We will once again make this a Virtual event and hope to build upon our great success from last year.

Attrition and Case update

We have had two voluntary resignations over the last 30 days and no new cases.

Facilities / Office Updates

GCHP Facilities' team is dedicated to planning a return to the office when conditions allow. The team continues to meet and evaluate:

- Protocols for the flow of employees who visit the office for supplies, printing, and other business-related activities
- Protocols for our new entrance and exit process requiring temperature checks and registration in our Proxyclick system is working very well
- Protocols for a return to the office, including taking temperatures
- Making any necessary modifications to improve air quality inside the buildings