Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

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

Executive Finance Committee
AGENDA

Regular Meeting
Thursday, November 14, 2024 – 3:00 p.m.
Members of the public can participate using the Conference Call Number below.
Conference Call Number: 805-324-7279
Conference ID Number: 874 456 017 #

Additional Telephonic Location:

Community Memorial Hospital
147 N. Brent Street
Ventura, CA 93003

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 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 attend the meeting in person, 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 Executive Finance Committee regular meeting minutes of October 24, 2024

Staff: Maddie Gutierrez, MMC, Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

FORMAL ACTION

2. September Year to Date Financial Results

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Receive and file the report.

3. Conversion of Fiscal Year

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Approve the plan to convert the fiscal year to follow the calendar year.

4. FY 2024-25 Duals Special Needs Plan (D-SNP) Revised Operational Readiness Costs

Staff: Eve Gelb, Chief Innovation Officer
Sara Dersch, Chief Financial Officer
Robert Franco, Chief Compliance Officer

RECOMMENDATION: It is GCHP's recommendation that the Executive Finance Committee recommend the Ventura County Medi-Cal Managed Care Commission to approve up to $5.3M additional budget for D-SNP operational readiness for the remainder of the 2024/2025 Fiscal Year.

CLOSED SESSION

5. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Commission &
Chief of Human Resources & Organization Performance Officer
Unrepresented employee: Chief Executive Officer

6. PUBLIC EMPLOYEE APPOINTMENT
Title: Chief Executive Officer

ADJOURNMENT

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 Committee after distribution of the agenda packet are available for public review during normal business hours at the office of the Clerk of the Board.
In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5512. Notification for accommodation must be made by the Tuesday prior to the meeting by 3 p.m. will enable the Clerk of the Board to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO. 1

TO: Executive Finance Committee

FROM: Maddie Gutierrez, MMC – Sr. Clerk of the Board

DATE: November 14, 2024

SUBJECT: Meeting Minutes for regular Exec. Finance meeting of October 24, 2024

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copies of the Executive Finance Committee regular meeting minutes of October 24, 2024.

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
Executive/Finance Committee
Regular Meeting via Teleconference

October 24, 2024

CALL TO ORDER

Committee Vice Chair Dee Pupa called the meeting to order at 3:02 p.m. The meeting was in the Community Room, 711 E. Daily Drive, Suite 110 Camarillo, California.

ROLL CALL

Present: Commissioners Anwar Abbas, Laura Espinosa, Anna Monroy, and Dee Pupa

Absent: Commissioner James Corwin

GCHP Executive Team in attendance: Acting CEO Felix L. Nunez, M.D., CHR Paul Aguilar, CIO Eve Gelb, CCO Robert Franco, CFO Sara Dersch, Acting CMO James Cruz, M.D., CDO Ted Bagley, Chief of Member Experience & External Affairs, Marlen Torres, Alan Torres, CIO, CPPO Erik Cho, Anna Sproule, Exec. Director of Operations, Scott Campbell, General Counsel, and Leeann Habte of BBK Law.

GCHP Staff In attendance: Kim Timmerman, Kimberly Marquez-Johnson, Josephine Gallella, Lupe Gonzalez, Lupe Harrion, Chris Dulan, Lucy Marrero, Yoonhee Kim, David Kirkpatrick, Vicki Wrighster, Michelle Espinosa, Susana Enriquez-Euyoque, David Tovar, Kevin Ortloff, Victoria Warner, Bob Bushey, Jeff Register, Jerry Wang, Pauline Preciado, Carolyn Harris, Paula Cabral, and Consultant Don Harbart.

Guests: Stelian Damu, Kimberly Sokoloff, and Ashley Merda from Moss Adams

PUBLIC COMMENT

None.

CONSENT

1. Approval of Executive Finance Committee regular meeting minutes of August 15, 2024

Staff: Maddie Gutierrez, MMC, Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

2. Approval of the 2025 Executive Finance Meeting Calendar

Staff: Maddie Gutierrez, MMC, Clerk to the Commission

RECOMMENDATION: Approve the 2025 meeting calendar as presented.

Commissioner Abbas motioned to approve Consent agenda items 1 and 2. Commissioner Monroy seconded the motion.

Roll Call Vote:

AYES: Commissioners Anwar Abbas, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: Commissioners James Corwin and Laura Espinosa

The clerk declared the motion carried.

PRESENTATIONS

3. Proposed Improvements to Consultant / Vendor Contract Reporting

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Receive and file the presentation.

Chief Financial Officer, Sara Dersch, stated there is a document with continued revisions to our vendor and consultant report list. She noted this is a work in progress, and it will be presented quarterly. Suggested changes have been added to the document. CFO Dersch noted that some columns have been added to the report. There is a column for diversity, ownership, and approved contract amount, and balance remaining on the contract. There is also a column for fiscal year to date sum. This report will continue to be modified.

CFO Dersch noted that if the Committee had questions on a particular vendor or service provided to please reach out to her. She stated that this report will become part of the standard financial packet. It will be presented on a quarterly basis. Commissioner Pupa asked if there was a way to identify the number of FTEs, some of the contracts include contracted individuals and she cannot tell from looking at the report how many are contracted support staff or consultants. CFO Dersch stated she is still working on that – it is a manual process, and we are working it under our Chief of HR's team and the finance team. She stated she can prepare a report for staffing that is brought in through vendors and consulting. Commission Pupa stated she would like to tie it to the vendors and would like a clear picture of all the resources needed. It will give a full perspective of all the resources that are required to get us to where we need to be either contracted or employees. Commissioner Abbas asked if there is any significant difference in some of the vendors in how much we are spending. CFO Dersch stated that right now we are spending per contract much as planned. She noted that over the last six weeks there have been a couple of vendors/consultants that we have parted company with, and there will be a noticeable difference going forward. Commissioner Monroy as if there was a reason some vendors are listed twice. She noted that the service type was different, and the contract ID was different, but the contract spend amount was about the same. CFO Dersch stated that we do have separate contract numbers – that was the origination of our contract. The dollars are the same because we cannot pull them differently by contract – this is one of the shortcomings of our systems. The systems do not talk to each other. Once we mitigate to our new general ledger and contract management system it will be seamless and we can tell you specifically by contract, even when it is the same vendor.

Commissioner Abbas motioned to approve agenda item 3. Commissioner Monroy seconded the motion.

Roll Call Vote:

AYES: Commissioners Anwar Abbas, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: Commissioners James Corwin and Laura Espinosa

The clerk declared the motion carried.

FORMAL ACTION

4. Moss Adams Audit Results

Staff: Sara Dersch, Chief Financial Officer
Moss Adams Representatives – Stelian Damu & Kimberly Sokoloff

RECOMMENDATION: Receive and file the Moss Adams audit results as presented.

CFO Dersch introduced Moss Adams representatives: Stelian Damu, Kimberly Sokoloff, and Ashley Merda, who will present the audit findings.

Kimberly Sokoloff stated that they will present the results of the financial statement audit for the year ending June 30, 2024. Moss Adams performs non-attest services – these services do not have an audit opinion attached to them. Moss Adams is required to identify areas of the financial statements that contain a higher audit risk, and once identified they are required to perform an incremental audit response.

Ms. Sokoloff stated that there are three areas of risk that historically have been identified: Capitation Revenue Recognition, Medical Claims Liability, and Management Override of controls. Internal controls were tested, and inquiries were performed No significant unusual transactions were identified, and no difficulties were encountered. She also noted that all financial statements are appropriate and reasonable.

Moss Adams assessed internal controls around revenue recognition, they vouch revenue amounts to supporting payments and membership and the rates from the state, then reconcile them. They also include obtaining an understanding of new programs that the health plan was subject to, as well as any revised communication from the state about criteria associated with those programs that are required to be met to earn the revenue.

In evaluating the claims payable liability estimate, Moss Adams has concluded that the 2024 balance appears reasonable.

Ms. Sokoloff noted there is a significant new system implementation. Due to the implementation occurring on July 1, additional testing will happen at next year's audit. However, Moss Adams did perform some additional audit procedures in response to the claim system implementation and the records that were output from the claim system.

Ashley Merda noted that there were no changes in the plans' approach to applying the critical accounting policies. There were no unusual transactions identified and no

significant difficulties encountered during the audit. There were no issues or other findings arising from the audit to report.

Upon issuance of the financial statements, Moss Adams has requested certain representations from management that will be included in the management representation letter. The letter will be dated October 29, 2024, and a full copy of the letter will be available once signed.

Commissioner Abbas asked about the three risks identified in the audit findings. He asked what the plan of action is, and will another audit be performed and what is the procedure. Ms. Sokoloff stated auditing standards require Moss Adams to identify significant risks to respond to during the audit. It does not mean that they believe there is something flawed with the health plan's financial records of the controls in these areas – it is merely due to the nature of these areas revenue recognition. In next year's 2024 annual audit Moss Adams will do a risk assessment again and similar risk areas will be seen. Ms. Sokoloff noted that organizations such as Gold Coast will always have high areas of risk.

CFO Dersch stated that she was happy to say that Moss Adams had not found anything in our accounting for all our revenue or medical liability, or cash that would indicate that there are any issues with our current practices. She was please that they did not find any reason for us to make any changes to our year end financials.

Commissioner Abbas motioned to approve agenda item 4. Commissioner Monroy seconded the motion.

Roll Call Vote:

AYES: Commissioners Anwar Abbas, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: Commissioners James Corwin and Laura Espinosa

The clerk declared the motion carried.

5. Fiscal Year 2024-2025 Year-To-Date Financial Results

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests the Executive Finance Committee approval of the August 2024 Year-To-Date results as presented.

CFO Sara Dersch stated that our current position is $5.9million deficit. We had planned to be in a deficit for this time based on general business cycles and the ongoing work with our Operations of the Future. It is an estimated $1.5 million unfavorable variance to budget. The primary drivers include our membership mix.

Commission Chair Laura Espinosa arrived 3:31 p.m.

CFO Dersch noted that we are paid different rates by category of aid. She noted that we have more members in categories of aid that have a lower premium rate. We have fewer members in those categories that have a higher premium rate. This will drive some unfavourability in revenue. We also have some unfavourability in our medical benefits. We are seeing our primary care physician costs start to go up, this tells us that a lot of outreaches that we are doing for MCAS, the health fair that we are doing is getting our members in regular care more often. We will then see some of our outpatient and specialist costs go down in the future. This is a trend that we will be monitoring and reporting. Primary care expense will go up. We do have some favorability in our administrative expense which is related to some of the timing of our spend for the year and related to some timing of invoices that we had not approved. We will have a catch-up next month.

CFO Dersch stated our revenue from a year-to-date perspective is $1.2 million unfavorable. Our medical benefits are running at $4 million unfavorable. We do have favorability in administrative expense which is primarily our Ops of the Future. She did note that we will have a catch-up for our Quarter One close, which is our September close.

CFO Dersch reviewed the breakout of medical cost by categories of service. Our inpatient is running slightly unfavorable to budget due to the UIS category which was the January of this year newly eligible members where there was no utilization. We tried to predict where that utilization might be but the reality with that population is that have not had regular care. New members have greater needs and have not had an opportunity in the past to get care.

Our budget is based partially on the rates that Mercer had determined in developing our 2024 rates. We should expect to see revised 2024 rates go up slightly. We should expect to see an increase in our 2024 inpatient rates, and we will know more by February.

For Operations of the Future, we will be re-prioritizing strategic initiatives in response to our focus on ensuring our core functionality or core claims and enrollment functionality. We will be processing accurately and timely. We have had our initial 2025 rates come out a couple of days ago and we will be making recommendations soon for specific advocacy.

One of the challenges that we are seeing with the rate advocacy is that when our rates are developed, they go back up to two years. We look at an 18-month window for rates that began for 2025 from 2022 to March of 2023 to determine our 2025 rates. In 2022 we were just coming out of the pandemic, so the 2022 actual utilization does not represent a normal year. Once we start to get back to a pre-Covid normal trend of utilization, we will have the ability to actively advocate. We will go to Mercer and the state and ask that they look at our current utilization through March of 2023. If we look at claims utilization through March 2024, you will see that our actual spend is much more that what we are being paid in premium revenue. Commissioner Pupa stated that through that advocacy you are also advocating for providers. CFO Dersch stated we will continue to watch utilization changes.

CFO Dersch noted that effective January 1, we had the new 26- to 49-year-old UIS group, DHCS also moved the 20- and 21-year-olds from the adult category, which paid higher, to the lower paying child category rate.

Commissioner James Corwin joined the meeting at 3:42 p.m.

CFO Dersch stated that we will continue to advocate for us and for our community. We will also be looking at D-SNP and ensuring that we plan appropriately and in January we will present our revised budget, such as was done last year.

Commissioner Abbas motioned to approve agenda item 5. Commissioner Monroy seconded the motion.

Roll Call Vote:

AYES: Commissioners Anwar Abbas, James Corwin, Laura Espinosa, Anna Monroy, and Dee Pupa

NOES: None.

The clerk declared the motion carried.

6. D-SNP Pharmacy Benefit Manager (PBM) Contract Approval

Staff: James Cruz. M.D., Acting Chief Medical Officer

Sara Dersch, Chief Financial Officer
Eve Gelb, Chief Innovation Officer

RECOMMENDATION: It is the Plan's recommendation that the Executive Finance Committee recommend the Ventura County Medi-Cal Managed Care Commission authorize the CEO to execute a 50-month agreement with Prime Therapeutics

CIO Eve Gelb stated that the Plan is seeking contract approval for D-SNP and the Pharmacy Benefits Manager (PBM). She thanks staff and various departments for their work on the contract.

James Cruz, M.D., Acting Chief Medical Officer gave an overview of the PBM and the process. He noted that members can experience challenges in understanding how they can best access their medications as well as their pharmacy benefits. – this is why the PBM is so important to both the member and the plan.

CMO Cruz stated that Medicare members receive their drugs through Medicare Part D – it is a requirement. Our Medi-Cal members currently receive their meds through Medi-Cal RX. The PBM is necessary to help navigate the complexities of the pharmaceutical industry, as it can get very confusing.

There is an outline of the role and functions that the PBM will perform at GCHP. Some of the key things is that they will negotiate the pharmacy and contract with the pharmacy network, which will include both national large chains and local independent pharmacies in Ventura County. There will be a diversity of pharmacy options for our members. The PBM will be instrumental in developing the formulary design which is the structure of the drugs that will be part of the benefit that will be provided to our members. They will be instruments in drug cost negotiation as well as securing any rebates from the pharmacy industry. They will be actively involved in claims payment and ensuring that our claims are paid on time and correctly. They will be forming a variety of utilization management functions as well as elements of member service and executing on quality programs and ensuring that the plan remains compliant with CMS.

Procurement took the lead on organizing the process to identify a pharmacy benefit manager. CMO Cruz noted that a cross functional team composed of various departments (pharmacy, legal, compliance and finance) worked on this process. This team developed an RFP (request for Proposal). Two proposals were received. The team also engaged in an evaluation with the help from our D-SNP colleagues. He noted that procurement objectively and fairly evaluated the proposals received and based on predetermined evaluation criteria and weights, the team scored each proposal for both qualitative and quantitative requirements. One of the key features

was pricing. We used two models to estimate price, one was using data based on our current GCHP members and another approach was using a proxy data that helped approximate utilization.

CIO Gelb stated that the two vendors that submitted bids were Prime Therapeutics and Med Impact. She noted that it was difficult to price a contract when you do not know what your utilization is going to be or what your members are going to be, so we were supported by our pharmacy consultant PSG. There were two data sets, and we ran the same data sets for both bidders to see the pricing, the expected utilization, the expected mix of generic to brand drugs, and a variety of things. The same model was used to for both vendors. Prime was less costly/more cost effective that Med Impact. Therefore, we are recommending the selection of Prime Therapeutics – they scored well. Both vendors were collaborative, engaged and supported us in our process. The Prime pricing model is an easier model for us to manage and was clearer in how it would work. They were very responsive to our terms and conditions, as well as how we want to manage quality and stars. They demonstrated a high level of Medicare expertise, and they have a lot of Medi-Cal expertise. They own the entity that manages Medi-Cal Rx. We also did a vendor reference check and spoke with a plan that is about our size and we got clear confirmation that they were very responsive, and their account management was excellent.

CFO Dersch stated that one of the key factors was we needed to consider was our ability to come in with a Five Star score. Stars for pharmacy are critical. Prime demonstrated that we have a much better likelihood to have a high 4.5 star to a 5-star rating with them. This is key for us as a plan. Plans live and die on a star rating in the revenue rates. Prime was more transparent that many other PBMs and will help us from a member benefit perspective. CFO Dersch stated that she believes they will be much more amenable to the specific needs of our members. We do not want disruption for our members when it comes to their medications.

CFO Dersch stated that we have done a Not-To-Exceed contract because we do not know that the utilization would be, but we have provided an estimate of year one. year two, and year three. These dollars only come after we start getting revenue from the federal government for these members, and these dollars are built into our financial projections.

Commissioner Abbas asked about implementation. CIO Gelb stated the contract if for 50 months – it is starting now for implementation until January 1, 2026 – there is no cost for implementation. It is a three-year service agreement, and we will renegotiate as we come to the end of that term and better understand our member experience.

Commissioner Monroy asked what the estimated membership for year is one and year three. CIO Gelb stated our estimated membership for year one to start is nine hundred members, and at the end of year five our estimate is 21,000 members.

Commissioner Pupa asked about rebates – are they pass-through rebates. Jared Tate, PSG Consultant, stated that in the traditional sense the answer is yes. There is a discrete rebate feel but all other rebates are passed through at GCHP. He also stated that market checks are built into the contract as well as incremental improvements in the pricing guarantees.

Commissioner Abbas motioned to approve agenda item 6. Commissioner Monroy seconded the motion.

Roll Call Vote:

AYES: Commissioners Anwar Abbas, James Corwin, Laura Espinosa, Anna Monroy, and Dee Pupa

NOES: None.

The clerk declared the motion carried.

7. Grant Administrator – Contract Approval

Staff: Erik Cho, Chief Policy & Programs Officer
David Tovar, Incentive Strategy Manager

RECOMMENDATION: The Plan recommends that the Executive Finance Committee recommend the Ventura County Medi-Cal Managed Care Commission authorize the CEO to execute a 44-month agreement with Institute for Healthcare Improvement, a non-profit organization for an amount not to exceed $1.2M.

CPPO Erik Cho stated that Dvid Tovar, Incentive Strategy Manager, would be presenting this agenda item with him. CPPO Cho thanked several staff members, legal, and the procurement process for their assistance.

CPPO Cho stated that the past cycle of grants was very successful. He noted that approximately ninety recruitment grants for providers were issued and equipment grants that allowed for 393 pieces of equipment for our FQHC were purchased. These are lasting pieces of investment for our provider community, and we are now pivoting into the next phase of the grant program. We want to bring on a grant administrator to collaborate with us to do a program with a broader scope and broader impact. The

administrator would provide support for us, the applicants, and the grantees as they work through the process. We want to develop our program fully. We need to administer the program, have ongoing reporting and understanding of impact and work with us to develop those programs. This would be an entity that disperses the funds directly. They would help in moving forward with the assessment of the program. We want to make the best use of the funding with the best outcomes for our members.

We want to support connections to care and access for our members. To meet objective unmet healthcare needs or access issues. We know that there are areas that need to be addressed, and we can help with that. This includes bringing care to our members where they live, work and/or go to school. We want to improve outcomes as well as the experience. We want to increase member education – and do this in a culturally responsive way with a focus on health equity. We are also willing to support non-traditional health care solutions and remove structural barriers to care.

Mr. Tovar reviewed a timeline, noting that we want to have meaningful grants out by the end of this fiscal year. Mr. Tovar stated that we are excited to get these funds out to the community and to our network partners to assist them and facilitate creating innovative and fresh solutions to our healthcare issues.

Mr. Tovar stated that the RFP was released to the community in June of 2024. We received three responses. Moss Adams was one of the responses, and after a discussion we realized we could not move forward with them because part of the grant administrator role was holding and distributing funds, and it would be a conflict. Second was Community Partners and third was IHI. Community Partners proposed costs that were significantly higher than IHI and we met and discussed if cost could be reduced, however it was still out of range. We want to make sure that the grant dollars are invested in the community rather than with an administrator. We moved forward with IHI. He noted that IHI is an organization that has worked within this space for over 30 years, and reviewing the responses we felt comfortable in their abilities. The grant program is now being called the RISE Program (Resilience, Innovation, Sustainability, and Equity) We want to make sure that we are successful in what we put into our applications as well as what we are receiving back in terms of measurable differences.

Commissioner Espinosa asked if these grants go to the providers or to the community. CPPO Cho stated these grants go to the providers primarily, but we are also looking for innovative solutions, such as providing services to neighborhood schools and communities.
Mr. Tovar stated that we will be working closely with IHI to ensure that our vision is built into all of this. Throughout the next three months, if this contract is approved, we will be collaborating weekly with them to develop a grant charter and develop a rubric.

CIO Gelb stated that although they are based in Boston, IHI is currently engaged with DHCS in California on many quality improvements and health Equity programs. They have knowledge of Medi-Cal and our community. They are also leading in behavioral health.

Commissioner Abbas asked if we know how IHI plans to evaluate the grant application. He asked if they tell us, and we accept it. Mr. Tovar stated that this is something that is built into our statement of work – we develop these applications together, building in measures and evaluation metrics that will be monitored continuously. We are trying not to be too restrictive as to what the measures may be, but we want to have a standardized framework for reporting to ensure that we are measuring what matters. After the applications close and the providers do the work, then we will be looking at it from the back end on the specific areas that they decided to work with. IHI will take the framework and then work on the application materials and there will be a selection committee that will review and evaluate the awards, and GCHP will have input.

IHI are experts in healthcare and quality improvement, and we felt that they would add value to the grantees as they move through to support and evaluate outcomes. They will be the administrator of the dollars, but they will also be supporting in the design and quality aspects.

Commissioner Pupa stated that we are at a point where we need someone to take over, not only for transparency, but it is also something that the OIG would look upon very favorably, and it goes along with our Corporate Integrity Agreement too.

Leeann Habte, BBK Law, stated that from the perspective of the CIA, it provides independence in regard that it cannot be seen as GCHP is deciding to give dollars to certain providers it can come under increased scrutiny. CCO Robert Franco stated that as part of delegating this responsibility to them, they would be subject to some of the delegation oversight.

Mr. Tovar stated that if this contract is approved the contract will be launched November 1 and immediately start our project activation period, which will go through January. Applicants will submit application February through May, decisions would be made, and the distribution of funds would be done, then the process starts over again in the next cycle.

Commissioner Abbas motioned to approve agenda item 7. Commissioner Pupa seconded the motion.

Roll Call Vote:

AYES: Commissioners Anwar Abbas, James Corwin, Laura Espinosa, Anna Monroy, and Dee Pupa

NOES: None.

The clerk declared the motion carried.

8. Operations of the Future Remediation Timeline and Cost Projections

- OOTF Remediation Timeline
- OOTF Change Orders and Cost Projections

Staff: Alan Torres, Chief Information & Systems Modernization Officer
Anna Sproule, Executive Director of Operations
Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests that the Executive Finance Committee recommend the Ventura County Medi-Cal Managed Care Commission to approve the execution of additional contract authorizations with the vendors listed above and approve the revised amount of $21.6M (adding $11.7M which includes contingency of 10%) to the Operations of the Future budget.

Alan Torres, Chief Information Officer & System Modernization Officer introduced Anna Sproule, Executive Director of Operations. Ms. Sproule stated that she will discuss how we are going to get Operations of the Future back on track, which will include stabilization activities, the road map for success and discuss all the cost projections. This revised plan was put together and agreed upon by the entire Executive Team, as well as other staff. She noted that we have made great progress in the past thirty days. She demonstrated a comparison of where we were at the beginning of August compared to where we were at the end of last week. She noted that we now have great momentum in the total inventory. She reviewed claims that are between 0 to 30 days of age. She also stated that we will always have an inventory prior to our transition, and it was an inventory of approximately 30,000 claims average, and we expect to have one to two weeks of inventory on hand at any given time. Ms. Sproule noted that we are to where we were pre-deployment of the new system. She went on to review aged inventory over 45 days and noted that we are making progress. She stated that 12,000 claims are getting ready to get processed by the weekend. It was all one type of error, and a decision has been made on it. Those will all go through quickly. The 31 to 45 days is the smallest amount of inventory. Ms. Sproule stated she was going to review the road map of how we will move forward. Staff evaluated how to make progress and still maintain a level of continuity in our incoming claims inventory. We have gotten support from the Executive Team on the 835 remediation, and we have begun to make substantial progress and inventory is reducing. We

anticipate being on track by the end of October, stabilizing inventory to where it should be. There are several steps that need to be taken to ensure that we have a fix.

CIO Alan Torres. stated that with regards to the 835, our plan is to address the backlog by the end of November and get to an operational SLA performance level of 24 hours of the generation of 835s post payment claims pay cycle. The required is 48 hours. He noted that we are now able to provide additional information that is required to providers so they can close out books while we address the backlog.

Ms. Sproule shared her current dashboard screen so the committee could see where we are today, and there would be full transparency.

Commissioner Pupa stated that she has talked with providers and let them know that staff is doing everything possible to remediate the problem. She noted that providers are grateful that this happened at the start of a fiscal year. CEO Nunez stated that staff has been providing communications back to the network. Commissioner Corwin stated that providers need to receive communication to show that GCHP is still a good partner. We need to get the word out because many have been impacted. CPPO Cho stated we owe responsiveness to our providers.

Ms. Sproule shared her screen and showed the totality of the inventory, and what has been processed. As of last night, we have 26,000 claims and we have remained consistent in the 31 days - which is approximately 6,000. Within 30 days we are at 40,000. We have almost 70% paid within the 30 days. She noted that we are making great strides.

Commissioner Abbas stated the inventory of claims is always based on provider. He asked what the status is of contracted versus non-contracted providers. Ms. Sproule stated that is not in the dashboard, but she will get the information and shar it at the next meeting. We are still working to remediate some of the contracts. Commissioner Pupa stated she appreciated the transparency of the dashboard. Commissioner Espinosa asked how many people encompass this team specifically working on this issue. Ms. Sproule replied that on the claims issue there are approximately 120 resources within Netmark working on the claims. Then there are additionally within the operations team approximately twelve people that are not fully dedicated but are spending a good percentage of time working directly on this – five of them are fully dedicated. IT also supports us, and we also have a claim coder to validate that things are operating as expected.
CEO Nunez stated staff comes to you in full transparency and honesty in terms of the work being done to mitigate. We are currently working through technical issues of integration; makings systems all fit together and work together seamlessly to accomplish our goals. There is humility as we approach this work. He stated that he encouraged questions and discussion on this issue. He also noted that the price tag

for this work is not cheap. We are confident that the plans that have been put together to mitigate the current issues and remediation work that is being done are going to get us back on to our timeline. We encourage discussion on the process that we are putting together, and we will be asking for consent and approval of the work moving forward.

CIO Torres stated that now he will present future change orders and revised cost projections, as well as the change orders needed to get back on track and expand our operational capabilities. He stated he will go through each one of the drivers behind the budget changes. The first is operational continuity and vendor extensions – we are extending Conduent for read access to have information that goes beyond what we have converted into the new systems, as well as support our business processes until the end of March of next year. The next is the MedHok extension, they are our old medical management system, which we are keeping available and will have access to information that we did not convert. We plan to bring over the remaining data elements as part of our conversion in the coming months. Next is investment in labor, both IT and operational labor. IT costs are increasing due to IT production support group that has been extended for the next several months to complete tasks such as data conversion, and some of our key extracts and reports are part of that. Operational labor and provider call center Ops. This is operational support for the implementation of those capabilities and start up a provider call center internally.

We have some new vendors that we are going to engage with EMIDS, who will support the completion of our 835-development work. Deloitte will provide additional support with provider contracts, provider data and print data.

We have looked at all of o. vendor contacts, they are all PMPM based. They are tiered, and they will be increased as a result of our increased membership. The revised budget contains a 10% contingency as part of standard practice, project management, risk mitigation, and financial stability. This will give us any additional funds we may need for anything that may come up in the coming months. He then reviewed the breakdown of line items of all the cost contributing to the new budget, CIO Torres stated that our original budget came in at just under $10 million, with the revised difference of approximately $11.5 million, the new proposed revised budget is $21.5 million.

Commissioner Abbas asked if there was a consideration for the provider portal. CIO Torres stated we do have a change request that is embedded in the breakout. There is a minor change order regarding the provider portal, but no additional costs have been identified.

Ms. Sproule stated that we utilized a similar demand capacity model to determine how many staff it will take to answer incoming call volume. On average we receive between

7 to 900 calls per day. Those calls a longer period of time depending on the number of questions asked in each call. To meet the demand of the incoming calls is a total of twenty-seven resources, which includes two managers and 25 staff answering the phone.

Approximately one year ago we presented the thought of bringing the mailroom in-house and hire locally for a total of thirteen resources. This will increase GCHP staff by forty staff members.

CIO Torres stated that we are committed to maintaining transparency throughout this process and will provide consistent detailed updates each month. We are asking the approval of the revised budget amount of $21.6 million to enable these initiatives.

CFO Dersch noted that a group of staff began at ground zero to rebuild the budget, then presented it to the Executive Team, who then vetted over every single number. She noted that all were aligned on this budget, and all are accountable for this. This will get us back on our timeline.

Commissioner Abbas motioned to approve agenda item 8. Commissioner Monroy seconded the motion.

Roll Call Vote:

AYES: Commissioners Anwar Abbas, James Corwin, Laura Espinosa, Anna Monroy, and Dee Pupa

NOES: None.

The clerk declared the motion carried.

Open session ended at 5:07 p.m.

Closed Session started at 5;10 p.m.

CLOSED SESSION

9. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Commission &

Chief of Human Resources & Organization Performance Officer
Unrepresented employee: Chief Executive Officer

10. PUBLIC EMPLOYEE APPOINTMENT
Title: Chief Executive Officer

ADJOURNMENT

There was no reportable action. The meeting adjourned at 5:33 p.m.

Approved:

_____
Maddie Gutierrez, MMC
Clerk to the Commission

AGENDA ITEM NO. 2

TO: Executive Finance Committee

FROM: Sara Dersch, Chief Financial Officer

DATE: November 14, 2024

SUBJECT: November 2024 Year to Date Financials

SUMMARY:
Staff is presenting the attached September 2024 fiscal year-to-date ("FYTD") unaudited financial statements of Gold Coast Health Plan ("GCHP") for review and approval.

ATTACHMENT:
September 2024 Financial Package

APPENDIX:

- Income Statement FYTD
- Balance Sheet
- Statement of Cash Flow
- Statement of Investments and Cash Balances

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR MONTH ENDED September 30, 2024

	Sept2024	September 2024 Year-To-Date		Variance	Variance
	Actual	Actual	Budget	Fav / (Unfav)	%
Membership (includes retro members)	245,569	739,652	749,120	(9,468)	-1.3%
Revenue					
Premium	$ 123,380,285	$ 370,487,362	$ 269,232,108	$ 101,255,255	37.6%
Reserve for Cap Requirements	(212,873)	(624,284)	(641,531)	17,247	-2.7%
MCO Premium Tax	(34,472,500)	(103,417,500)	-	(103,417,500)	0.0%
Total Net Premium	**88,694,911**	**266,445,578**	**268,590,577**	**(2,144,999)**	**-0.8%**
Other Revenue:					
Miscellaneous Income	90	315	-	315	0.0%
Total Other Revenue	90	315	-	315	0.0%
Total Revenue	**88,695,001**	**266,445,893**	**268,590,577**	**(2,144,684)**	**-0.8%**
Medical Benefits:					
Capitation:					
PCP, Specialty, Kaiser, NEMT & Vision	$ 5,376,589	$ 20,516,996	$ 19,195,621	$ (1,321,375)	-6.9%
ECM	737,908	2,196,797	$ 4,181,967	1,985,169	47.5%
Total Capitation	6,114,498	22,713,794	23,377,587	663,794	2.8%
FFS Claims:					
Inpatient	15,754,308	57,640,671	55,332,940	(2,307,731)	-4.2%
LTC / SNF	13,330,754	43,766,031	45,597,580	1,831,549	4.0%
Outpatient	7,357,954	22,056,210	23,684,525	1,628,316	6.9%
Laboratory and Radiology	1,972,192	3,262,482	2,428,166	(834,316)	-34.4%
Directed Payments - Provider	1,059,432	4,817,301	2,391,676	(2,425,625)	-101.4%
Emergency Room	1,596,285	8,688,593	10,156,956	1,468,363	14.5%
Physician Specialty	6,891,348	22,994,109	22,392,312	(601,797)	-2.7%
Primary Care Physician	2,710,023	10,527,533	10,713,870	186,338	1.7%
Home & Community Based Services	1,186,138	6,630,126	5,793,100	(837,026)	-14.4%
Applied Behavioral Analysis/Mental Health Services	3,746,664	11,778,837	10,960,073	(818,764)	-7.5%
Pharmacy	-	-	-	-	0.0%
Adult Expansion Reserve	-	-	-	-	0.0%
Quality Incentives/Provider Reserves	*772,472*	*917,854*	5,000,000	4,082,146	0.0%
Quality Incentive Provider Program (QIPP)	*3,607,161*	*10,097,732*	12,500,000	2,402,268	48.0%
Other Medical Professional	468,058	915,827	1,211,127	295,300	2.4%
Other Medical Care	-	-	-	-	0.0%
Professional Fee For Service	-	6,650	-	(6,650)	0.0%
Other Fee For Service	4,536,348	9,777,109	5,743,920	(4,033,189)	-70.2%
Transportation	291,201	667,603	1,398,618	731,015	52.3%
Total Claims	65,280,337	214,544,668	215,304,864	760,196	0.4%
Provider Grant Program	4,626,543	5,026,543	3,125,000	(1,901,543)	-60.8%
Medical & Care Management	3,316,621	8,169,270	8,663,897	494,627	5.7%
Reinsurance	145,324	807,186	475,000	(332,186)	-69.9%
Claims Recoveries	(195,687)	(917,033)	(300,000)	617,033	-205.7%
Sub-total	7,892,800	13,085,965	11,963,897	(1,122,068)	-9.4%
Total Medical Benefits	**79,287,635**	**250,344,426**	**250,646,348**	**301,922**	**0.1%**
Contribution Margin	**9,407,367**	**16,101,467**	**17,944,229**	**(1,842,761)**	**-10.3%**
General & Administrative Expenses:					
Salaries, Wages & Employee Benefits	4,493,335	15,229,528	14,502,235	(727,293)	-5.0%
Training, Conference & Travel	46,048	147,685	440,774	293,089	66.5%
Outside Services	4,670,968	7,302,816	9,138,630	1,835,814	20.1%
Professional Services	1,766,435	3,579,829	1,612,147	(1,967,682)	-122.1%
Occupancy, Supplies, Insurance & Others	1,697,816	5,127,069	7,324,751	2,197,683	30.0%
Sponsorships	5,000	25,498		(25,498)	0.0%
Care Management Reclass to Medical	(3,316,621)	(8,169,270)	(8,663,897)	(494,627)	5.7%
G&A Expenses	9,709,047	23,589,221	24,354,640	765,420	3.1%
Project Portfolio (OOTF)	(2,284,118)	-	4,000,000	4,000,000	100.0%
Strategic Initiatives (SI)	4,917,420	4,917,420	722,304	(4,195,115)	
				-	
Total G&A Expenses	**12,342,349**	**28,506,640**	**29,076,945**	**570,304**	**2.0%**
Total Operating Gain / (Loss)	**(2,934,983)**	**(12,405,173)**	**(11,132,716)**	**(1,272,457)**	**11.4%**
Retro Premium Adj	**76,334**	**51,996**	**-**	**51,996**	**0.0%**
Non Operating					
Revenues - Interest	1,845,979	5,466,366	4,000,000	1,466,366	36.7%
Expenses - Interest		-	-	-	-
Gain/(Loss) on Sale of Asset	-	-	-	-	-
Total Non-Operating	**1,845,979**	**5,466,366**	**4,000,000**	**1,466,366**	**36.7%**
Total Increase / (Decrease) in Unrestricted Net Assets	**$ (1,012,670)**	**$ (6,886,811)**	**$ (7,132,716)**	**$ 245,905**	**-3.4%**

STATEMENT OF FINANCIAL POSITION

ASSETS	9/30/2024	06/30/24
Current Assets:		
Total Cash and Cash Equivalents	**$ 505,535,828**	**$ 430,974,305**
Total Short-Term Investments	**100,671,075**	**99,718,245**
Medi-Cal Receivable	199,730,240	173,911,167
Interest Receivable	1,189,713	772,425
Provider Receivable	11,253,281	12,484,788
Other Receivables	7,481,904	5,579,474
Total Accounts Receivable	**219,655,138**	**192,747,856**
Total Prepaid Accounts	6,236,710	10,875,162
Total Other Current Assets	133,545	133,545
Total Current Assets	**832,232,297**	**734,449,113**
Total Fixed Assets	**48,044,277**	**23,343,857**
Total Assets	**$ 880,276,574**	**$ 757,792,970**

LIABILITIES & NET ASSETS	9/30/2024	06/30/24
Current Liabilities:		
Incurred But Not Reported	$ 146,367,695	$ 103,483,161
Claims Payable	18,370,448	18,370,448
Capitation Payable	8,392,018	8,201,415
Physician Payable	32,651,218	30,314,835
DHCS - Reserve for Capitation Recoup	52,145,186	55,107,254
Lease Payable- ROU	4,674,563	2,411,196
Accounts Payable	1,682,958	4,671,951
Accrued ACS	463,689	4,068,323
Accrued Provider Incentives/Reserve	7,643,142	8,389,182
Accrued Expenses	46,045,080	9,112,142
Accrued Premium Tax	174,080,831	138,769,137
Accrued Payroll Expense	3,274,438	4,240,566
Quality Withhold	1,911,317	1,287,033
Total Current Liabilities	**497,702,584**	**388,426,645**
Long-Term Liabilities:		
Lease Payable - NonCurrent - ROU	23,771,837	3,677,360
Total Long-Term Liabilities	**23,771,837**	**3,677,360**
Total Liabilities	**521,474,421**	**392,104,005**
Net Assets:		
Beginning Net Assets	359,814,824	359,951,657
Total Increase / (Decrease in Unrestricted Net Assets)	(1,012,670)	5,737,309
Total Net Assets	**358,802,155**	**365,688,966**
Total Liabilities & Net Assets	**$ 880,276,574**	**$ 757,792,970**

STATEMENT OF CASH FLOWS	Sept 2024	Sept 2024 YTD
Cash Flows Provided By Operating Activities		
Net Income (Loss)	$ (1,012,670)	$ (6,886,811)
provided by operating activities		
Depreciation on fixed assets	976,480	2,930,858
Changes in Operating Assets and Liabilites		
Accounts Receivable	(7,957,689)	(26,907,284)
Prepaid Expenses	(559,657)	4,638,452
Accrued Expense and Accounts Payable	29,019,025	48,993,382
Claims Payable	(5,663,775)	2,526,986
MCO Tax liablity	34,472,500	35,311,694
IBNR	(10,803,220)	42,884,533
Net Cash Provided by (Used in) Operating Activities	**38,470,993**	**103,491,811**
Cash Flow Provided By Investing Activities		
Proceeds from Investments	(339,796)	(952,831)
Purchase of Property and Equipment	(430,000)	(27,631,279)
Net Cash (Used In) Provided by Investing Activities	**(769,796)**	**(28,584,109)**
Cash Flow Provided By Financing Activities		
Lease Payable - ROU	(115,897)	(346,180)
Net Cash Used In Financing Activities	**(115,897)**	**(346,180)**
Increase/(Decrease) in Cash and Cash Equivalents	37,585,300	**74,561,522**
Cash and Cash Equivalents, Beginning of Period	467,950,527	**430,974,305**
Cash and Cash Equivalents, End of Period	**505,535,827**	**$ 505,535,827**

SCHEDULE OF INVESTMENTS AND CASH BALANCES	Market Value September 30, 2024	Account Type
Local Agency Investment Fund (LAIF)	$ 42,530,370	Investment
Ventura County Investment Pool	$ 19,563,321	Investment
CalTrust	$ 38,577,384	Short-term investment
Bank of West	$ 492,576,599	Money market account
Pacific Premier Bank	$ 12,959,229	Operating accounts
Investments and monies held by GCHP	**$ 606,206,903**	

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

September 2024 Fiscal Year-to-Date Financial Results

Executive Finance Committee

November 14, 2024

Sara Dersch, Chief Financial Officer

Return to Agenda

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

Financial Results Summary: September

- September 2024 fiscal year-to-date (FYTD) ($6.9M) Net Asset Decrease represents a $0.2M variance to Budget and is the result of the following:
  - FYTD Member months are 9,468 lower than budget primarily in the Child, Adult and Seniors and People with Disabilities (SPD) Duals Categories of Aid. The variance is partially offset by Adult Expansion (AE).
  - The ($2.1M) Revenue variance is primarily volume driven resulting from lower-than budgeted membership. The volume related variance is partially offset by member mix.
  - The Medical Benefits variance of $0.3M aligns with budget. September results include a reserve release of $10.8M as a result of YTD catch-up with claims data now available.
  - The Core Administrative favorability of $0.8M was primarily driven by a shift of expenses to Operations of the Future (OOTF).

Return to Agenda

September Financial Results

($Ms except pmpms & mm)	MTD Actual	MTD Budget	MTD Var Fav / (Unfav)	YTD Actual	YTD Budget	YTD Var Fav / (Unfav)
Member Months	245,569	249,848	(4,279)	739,652	749,120	(9,468)
Revenue	$ 88.7	$ 89.6	$ (0.9)	$ 266.4	$ 268.6	$ (2.1)
pmpm	*$ 361.18*	*$ 358.64*	*$ 2.54*	*$ 360.23*	*$ 358.54*	*$ 1.69*
Non-Operating Revenue / (Expense)	$ 1.8	$ 1.3	$ 0.5	$ 5.5	$ 4.0	$ 1.5
pmpm	*$ 7.52*	*$ 5.34*	*$ 2.18*	*$ 7.39*	*$ 5.34*	*$ 2.05*
Medical Benefits	$ 79.3	$ 83.6	$ 4.3	$ 250.3	$ 250.6	$ 0.3
pmpm	*$ 322.87*	*$ 334.58*	*$ 11.7*	*$ 338.46*	*$ 334.59*	*$ (3.9)*
% of Revenue	*89.4%*	*93.3%*		*94.0%*	*93.3%*	
Administrative Expense	$ 9.7	$ 8.1	$ (1.6)	$ 23.6	$ 24.4	$ 0.8
pmpm	*$ 39.54*	*$ 32.26*	*$ (7.28)*	*$ 31.89*	*$ 32.51*	*$ 0.62*
% of Revenue	*10.9%*	*9.0%*		*8.9%*	*9.1%*	
Project Portfolio	$ 2.6	$ 2.0	$ (0.6)	$ 4.9	$ 4.7	$ (0.2)
pmpm	*$ 10.72*	*$ 8.15*	*$ (2.57)*	*$ 6.65*	*$ 6.30*	*$ (0.34)*
% of Revenue	*3.0%*	*2.3%*		*1.8%*	*1.8%*	
Operating Gain/(Loss)	$ (2.9)	$ (4.1)	$ 1.1	$ (12.4)	$ (11.1)	$ (1.3)
	$ (11.95)	*$ (16.35)*	*$ 4.40*	*$ (16.77)*	*$ (14.86)*	*$ (1.91)*
Retro Revenue Adjustments	$ 0.1	$ -	$ 0.1	$ 0.1	$ -	$ 0.1
pmpm	*$ 0.31*	*$ -*	*$ 0.31*	*$ 0.07*	*$ -*	*$ 0.07*
Total Increase / (Decrease) in Unrestricted Net Assets	$ (1.0)	$ (2.8)	$ 1.7	$ (6.9)	$ (7.1)	$ 0.2
pmpm	*$ (4.12)*	*$ (11.01)*	*$ 6.89*	*$ (9.31)*	*$ (9.52)*	*$ 0.21*
% of Revenue	*-1.1%*	*-3.1%*		*-2.6%*	*-2.7%*	

Return to Agenda

Membership

Child, Adult, and SPD Duals membership is driving the unfavorable variance, which is partially offset by Adult Expansion.

Revenue

Lower membership is driving ($2.1M) variance, which is partially offset be member mix.

Medical Benefits

A YTD true-up in reserves results in alignment with budget. We are not currently seeing any unanticipated utilization across the Categories of Service.

Administrative Expense

$0.8M favorability due primarily to Software expenses shifted from Core Admin OOTF development offset by provider settlements ($0.7M) and Temp expenses ($0.7M). Note that the temp spend is likely OOTF and will be reclassed as such next month.

Project Portfolio

OOTF ($0.2M) unfavorable to budget YTD. Note that the OOTF budget was front-loaded in Q1 with no budget for Q2-4.

September Financial Results: Categories of Service

(In Millions except membership)	September 2024 Month-To-Date Actual	Budget	Variance Fav / (Unfav)	September 2024 Year-To-Date Actual	Budget	Variance Fav / (Unfav)
Membership (includes retro members)	245,569	249,848	(4,279)	739,652	749,120	(9,468)
Medical Benefits:						
Capitation						
PCP, Specialty, Kaiser, NEMT & Vision	$5.4	$6.4	$1.0	$20.5	$19.2	($1.3)
ECM	$0.7	$1.4	$0.7	$2.2	$4.2	$2.0
Total Capitation	$6.1	$7.8	$1.7	$22.7	$23.4	$0.7
FFS Claims						
Inpatient	$15.8	$18.5	$2.7	$57.6	$55.3	($2.3)
LTC / SNF	$13.3	$15.2	$1.9	$43.8	$45.6	$1.8
Outpatient	$7.4	$7.9	$0.5	$22.1	$23.7	$1.6
Laboratory and Radiology	$2.0	$0.8	($1.2)	$3.3	$2.4	($0.8)
Directed Payments - Provider	$1.1	$0.8	($0.3)	$4.8	$2.4	($2.4)
Emergency Room	$1.6	$3.4	$1.8	$8.7	$10.2	$1.5
Physician Specialty	$6.9	$7.5	$0.6	$23.0	$22.4	($0.6)
Primary Care Physician	$2.7	$3.6	$0.9	$10.5	$10.7	$0.2
Home & Community Based Services	$1.2	$1.9	$0.7	$6.6	$5.8	($0.8)
Applied Behavioral Analysis/Mental Health Services	$3.7	$3.7	($0.1)	$11.8	$11.0	($0.8)
Quality Incentives/Provider Reserves	$0.8	$1.7	$0.9	$0.9	$5.0	$4.1
Quality Incentive Provider Program (QIPP)	$3.6	$4.2	$0.6	$10.1	$12.5	$2.4
Other Medical Professional	$0.5	$0.4	($0.1)	$0.9	$1.2	$0.3
Other Fee For Service	$4.5	$1.9	($2.6)	$9.8	$5.7	($4.0)
Transportation	$0.3	$0.5	$0.2	$0.7	$1.4	$0.7
Total Claims	$65.3	$71.8	$6.5	$214.5	$215.3	$0.8
Other						
Provider Grant Program	$4.6	$1.0	($3.6)	$5.0	$3.1	($1.9)
Medical & Care Management	$3.3	$2.9	($0.4)	$8.2	$8.7	$0.5
Reinsurance	$0.1	$0.2	$0.0	$0.8	$0.5	($0.3)
Claims Recoveries	($0.2)	($0.1)	$0.1	($0.9)	($0.3)	$0.6
Total Other	$7.9	$4.0	($3.9)	$13.1	$12.0	($1.1)
Total Medical Benefits	$79.3	$83.6	$4.3	$250.3	$250.6	$0.3
Contribution Margin	$9.4	$6.0	$3.4	$16.1	$17.9	($1.8)

Return to Agenda

Looking Ahead….

- Items impacting FY2024-25
  - Ops of the Future Remediation / Stabilization
  - Reprioritization of Strategic Initiatives
  - 2024 & 2025 Rate Actions and Advocacy
  - Utilization Changes
  - DSNP Right-sizing
  - Revised Budget (by mid December)

Return to Agenda

Exhibits

This section contains the following exhibits:

- Operations of the Future Expenditures
- Membership Breakdown
- Balance Sheet
- Cash and Short-Term Investment Portfolio
- Medical Benefits by Category of Service

Return to Agenda

Operations of the Future Expenditures

Vendor	Sept 2024 FYTD
Conduent	$ 2,202,883
HealthEdge	1,194,342
Akkodis	1,023,520
Strategic initiatives	552,367
Ellit	480,316
Silverline	337,209
Adecco	278,609
Transaction Applications Group	241,922
OmniData	165,430
Salesforce	135,560
Divurgent	128,434
Optum Insight	69,215
Edifecs	51,004
Prophecy	50,000
symplr	37,838
TTEC Government Solutions	31,738
UpToDate, Inc	22,222
Casenet	13,288
Depreciation	10,386
Other	3,224
Insight Direct	3,028
Other Software	(12,308)
Other Temp	(12,963)
Other Consulting	(189,115)
Amortized Expenses	(1,900,728)
Total	$ 4,917,420

Category	Sept 2024 FYTD
Software Subscriptions	$ 2,509,189
Outside Services	1,400,083
Temp Help	944,364
Consulting	27,975
Software Maintenance & Support	17,415
Depreciation	10,386
Miscellaneous	8,007
Total	$ 4,917,420

Amortized Expenses to be recognized as functionality goes live	
Category	**Sept 2024 FYTD**
Outside Services	$ (1,038,407)
Consulting	(441,293)
Temp Help	(355,604)
Software Subscriptions	(65,424)
Total	$ (1,900,728)

Return to Agenda

September - Membership Breakdown

September 2024 Year to Date				
Catagories of Aid	Member Months Actual	Member Months Budget	Member Months Variance	Premium Rate Actual
Child - SIS	254,428	262,050	(7,622)	$ 108.85
Child - UIS	12,900	11,364	1,536	$ 102.93
Adult - SIS	73,807	78,098	(4,291)	$ 340.31
Adult - UIS	45,869	48,126	(2,257)	$ 481.50
SPD - SIS	29,543	29,983	(440)	$ 1,311.41
SPD - UIS	4,198	3,687	511	$ 1,352.06
SPD Dual - SIS	70,835	73,748	(2,913)	$ 656.26
SPD Dual - UIS	309	278	31	$ 517.45
LTC Non-Dual - SIS	108	103	5	$ 1,262.28
LTC Non-Dual - UIS	61	66	(5)	$ 1,273.50
LTC Dual - SIS	1,969	2,038	(69)	$ 2,021.11
LTC Dual - UIS	20	27	(7)	$ 1,483.66
Adult Expansion - SIS	206,552	203,363	3,189	$ 340.40
Adult Expansion - UIS	39,053	36,189	2,864	$ 560.69
Total	**739,652**	**749,120**	**(9,468)**	

Return to Agenda

September Balance Sheet: Assets

STATEMENT OF FINANCIAL POSITION		
	9/30/2024	06/30/24
ASSETS		
Current Assets:		
Total Cash and Cash Equivalents	**$ 505,535,828**	**$ 430,974,305**
Total Short-Term Investments	**100,671,075**	**99,718,245**
Medi-Cal Receivable	199,730,240	173,911,167
Interest Receivable	1,189,713	772,425
Provider Receivable	11,253,281	12,484,788
Other Receivables	7,481,904	5,579,474
Total Accounts Receivable	**219,655,138**	**192,747,856**
Total Prepaid Accounts	6,236,710	10,875,162
Total Other Current Assets	133,545	133,545
Total Current Assets	**832,232,297**	**734,449,113**
Total Fixed Assets	**48,044,277**	**23,343,857**
Total Assets	**$ 880,276,574**	**$ 757,792,970**

- The $122.5M increase in total Assets is attributed to the following:
  - Cash and Equivalents: Money Market Investment growth
  - Accounts Receivable: Med-Cal Receivable
  - Fixed Assets: includes GASB 96 reclassification of expense.

Return to Agenda

September Balance Sheet: Liabilities

LIABILITIES & NET ASSETS	9/30/2024	06/30/24
Current Liabilities:		
Incurred But Not Reported	$ 146,367,695	$ 103,483,161
Claims Payable	18,370,448	18,370,448
Capitation Payable	8,392,018	8,201,415
Physician Payable	32,651,218	30,314,835
DHCS - Reserve for Capitation Recoup	52,145,186	55,107,254
Lease Payable- ROU	4,674,563	2,411,196
Accounts Payable	1,682,958	4,671,951
Accrued ACS	463,689	4,068,323
Accrued Provider Incentives/Reserve	7,643,142	8,389,182
Accrued Expenses	46,045,080	9,112,142
Accrued Premium Tax	174,080,831	138,769,137
Accrued Payroll Expense	3,274,438	4,240,566
Quality Withhold	1,911,317	1,287,033
Total Current Liabilities	**497,702,584**	**388,426,645**
Long-Term Liabilities:		
Lease Payable - NonCurrent - ROU	23,771,837	3,677,360
Total Long-Term Liabilities	**23,771,837**	**3,677,360**
Total Liabilities	**521,474,421**	**392,104,005**
Net Assets:		
Beginning Net Assets	359,814,824	359,951,657
Total Increase / (Decrease in Unrestricted Net Assets)	(1,012,670)	5,737,309
Total Net Assets	**358,802,155**	**365,688,966**
Total Liabilities & Net Assets	**$ 880,276,574**	**$ 757,792,970**

- The $129M increase in Total Liabilities is primarily driven by Incurred But Not Paid (IBNP) (expenses for medical services provided but not yet submitted or paid).
- Increases in Premium Taxes and general expense accruals are also driving up total liabilities.

Return to Agenda

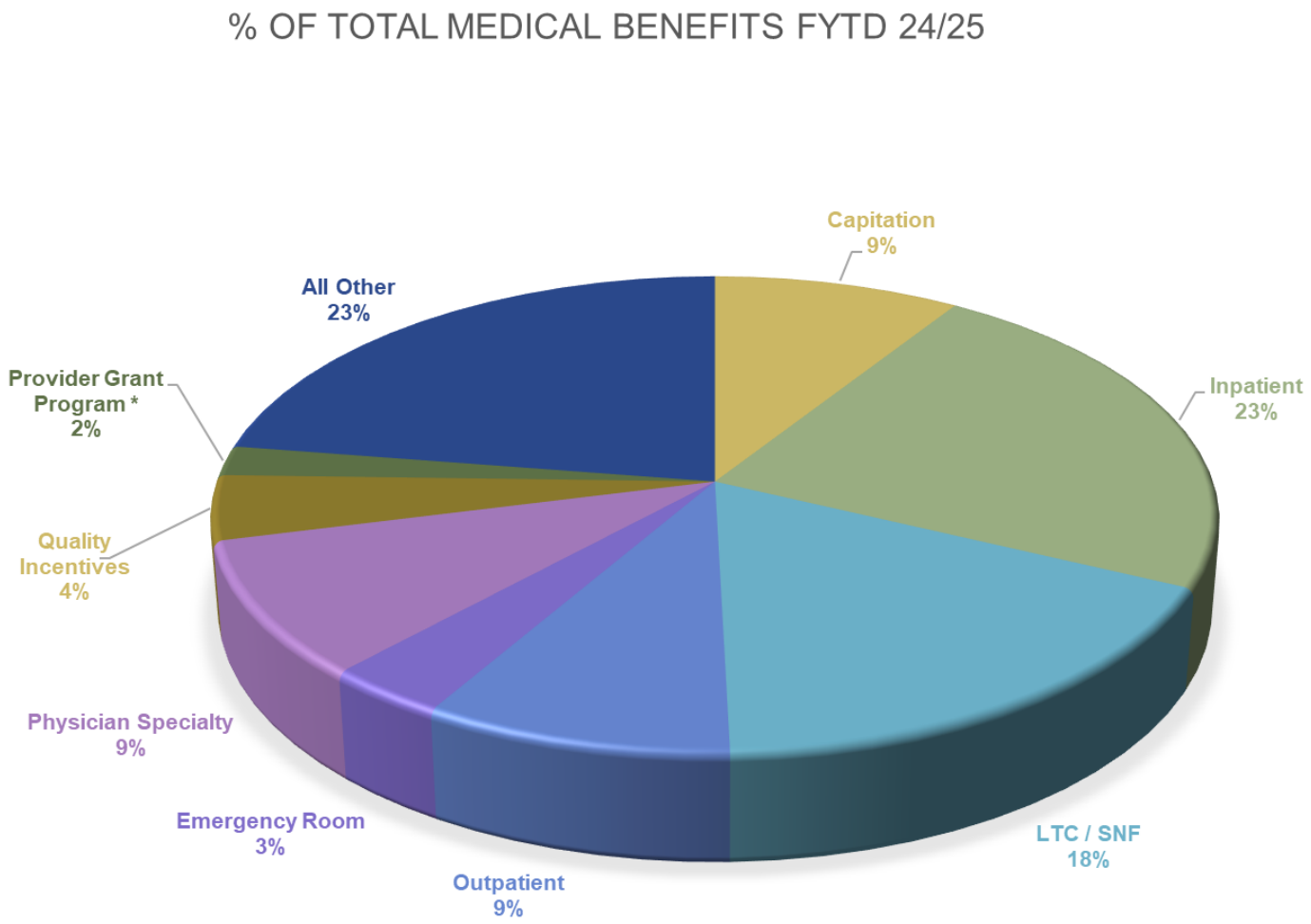
Cash and Short-Term Investment Portfolio

SCHEDULE OF INVESTMENTS AND CASH BALANCES			
		Market Value September 30, 2024	Account Type
Local Agency Investment Fund (LAIF)	$	42,530,370	Investment
Ventura County Investment Pool	$	19,563,321	Investment
CalTrust	$	38,577,384	Short-term investment
Bank of West	$	492,576,599	Money market account
Pacific Premier Bank	$	12,959,229	Operating accounts
Investments and monies held by GCHP	**$**	**606,206,903**	

- Cash and short-term investments balance sits at $606.2M.
- The investment portfolio includes:
  - LAIF CA State $42.5M
  - Ventura County Investment Pool $19.5M
  - Cal Trust $38.3M

Return to Agenda

September Medical Benefits by Category of Service



Return to Agenda

AGENDA ITEM NO. 3

TO: Executive Finance Committee

FROM: Sara Dersch, Chief Financial Officer

DATE: November 14, 2024

SUBJECT: Conversion of Fiscal Year

PowerPoint with Verbal Presentation

ATTACHMENTS:

Fiscal Year Change Recommendation

Gold Coast Health Plan℠
A Public Entity

Fiscal Year Change Recommendation

Executive Finance Committee
Thursday November 14, 2024

Sara Dersch, Chief Financial Officer

Integrity
Accountability
Collaboration
Trust
Respect

Return to Agenda

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

Overview

Current Practice

Gold Coast Health Plan (GCHP) has a fiscal year beginning July 1 and ending June 30.

Issue with Current Practice

This is not aligned with Medi-Cal or Medicare rate cycles (which run on a calendar-year basis), making fiscal year budgeting and regulatory reporting challenging as we have to contemplate 2 sets of rates and 2 sets of audited statements for each line of business.

Best Practice

For a health insurance entity, the plan year is a calendar year, so we should be aligned with that.

Recommendation

Align our funding and business cycles under a calendar-year basis effective January 1, 2026.

Return to Agenda

Implications

- No risks identified with this change. About half of the other Local Plans have already made this conversion, and Moss Adams has recently led another COHS through this change.

- July 1, 2025 – December 31, 2025 will be considered a “stub period,” in essence, a mini-fiscal year; we will undergo an external audit and issue audited financial statements for this stub period.

- Annual budgeting will shift to Fall; note: we will complete the annual budget for submission to the Commission each November. We will develop a 6-month budget for the stub period (will be presented to the Commission in June 2025).

- Strategic Planning with the Commission will shift to June of each year, beginning in June 2025.

- Realignment of individual goals to coincide with new fiscal year.

Return to Agenda

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 4

TO: Executive Finance Committee

FROM: Eve Gelb, Chief Innovation Officer
Sara Dersch, Chief Financial Officer
Robert Franco, Chief Compliance Officer

DATE: November 14, 2024

SUBJECT: FY 2024-25 Duals Special Needs Plan (D-SNP) Revised Operational Readiness Costs

Executive Summary

GCHP staff is seeking the recommendation of the Executive Finance Committee that the Ventura County Medi-Cal Managed Care Commission approve additional budget for the operational implementation of the Duals Special Needs Plan (D-SNP). The original D-SNP budget for 2024/25 Fiscal Year was $2.3M. Revised budget will range from $7.1M to $7.6M depending on the need for a Third Party Administrator (TPA) for core operations.

BACKGROUND/DISCUSSION:

GCHP is required to implement at D-SNP by January 1, 2026.

The team has reviewed the requirements for D-SNP in the context of current state of Operations of the Future (OOTF) system conversion, the resource constraints and capabilities amidst OOTF stabilization and other key regulatory and quality projects, and after lessons learned from OOTF. After this review and after enaging with other plans in the process of D-SNP implementation, GCHP has revised the projected costs for the remainder of the 2024/2025 Fiscal Year for D-SNP.

Current Project Status

The D-SNP implementation has two core components:

1. The regulatory filings required by the California Department of Health Care Services (DHCS), the California Department of Managed Health Care (DMHC) and the federal Centers for Medicare and Medicaid Services (CMS).
2. The operational design, build, test and go-live of systems and processes to serve Medicare members and meet regulatory requirements.

All regulatory filing work is on track. While some operational work is on track, certain elements are delayed.

Sales and Marketing, Pharmacy, Network, Pharmacy and Finance related work is currently on schedule.

Work related to the D-SNP Model of Care and benefit design is slightly delayed but will be on track by the end of 2024 with additional support requested herein. The core system design and build for processes such as eligibility and enrollment, claims and encounters and utilization and care management are significantly delayed due to the current state of OOTF.

OOTF stabilization is making significant progress, but the systems and resources are not ready for the design and build required for Medicare. The original timeline and resource plan for D-SNP was built on the assumption that resources working on OOTF would be able to turn attention to D-SNP is September and that systems would be stabilized from initial go-live and have Day 2 items in process in October 2024. To be able to be prepared for D-SNP, additional resources for D-SNP are needed, as telegraphed in October Commission meeting.

Risk Mitigation Plan

Given that the required D-SNP go-live date is January 1, 2026 and GCHP must be able to enroll members October 15, 2025, GCHP is requesting support to put in place three key risk mitigation measures:

1. Contingency plan for core systems. GCHP's goal is to go live with D-SNP on the systems implemented during OOTF. The currently in place stabilization activities for OOTF, require that GCHP consider and plan for possible outsourcing of some D-SNP systems and functions to a third-party administrator (TPA) as a contingency.
2. Bring on additional resources. GCHP lacks internal subject matter expertise on some element of D-SNP such as Sales and Marketing, Medicare Enrollment, and Risk Adjustment. Some of this expertise can be learned through the use of short-term consultant support and some will require hiring staff with the needed expertise.
3. Strong Project Governance and Implementation Support. The use of an external implementation partner for complex large cross functional projects supports project success by providing oversight, governance and transparency. GCHP is proposing the use of an implementation partner for this critical project. One of the lessons learned from the OOTF implementation is that an implementation partner would greatly help.

Proposal:

GCHP is proposing additional staffing and outside services.

The original budget requested three new D-SNP staff, one for pharmacy, one for compliance and one for marketing. Two of these staff are hired and the third is in the interview stage.

In review of key subject matter expertise gaps in areas of high risk for future success, GCHP identified 11 additional staff (listed in Table 1) that were originally planned for hire in the second half of 2025. If hired sooner, they would immediately support on-time delivery of high quality business requirements, system build and testing. Hiring resources will be more cost effective than use of consultants for these roles as the positions will transition to operational positions after go-live. Consulting costs for this expertise will be between $200 and $300 per hour, while hourly rate for hired staff, fully loaded with benefits, will range from $40 to $94 per hour.

Table 1—Proposed Additional Staffing and Timing of Hire

Proposed Additional Resources	Start Date
Utilization Management Nurse (Medical Policy)	Jan 2025
IT Staff (2)	Jan 2025
Quality Improvement Sr. Analyst (5 Star)	Jan 2025
Coding Analyst (Risk Adjustment)	Jan 2025
Grievance and Appeals Coordinator	Feb 2025
Sales Agent	Feb 2025
Enrollment Specialist/Oversight	Feb 2025
Compliance Special Investigator	Mar 2025
Claims Analyst/Oversight	Mar 2025
Medicare Reporting Analyst	Mar 2025

As presented above, GCHP has a contingency plan should existing systems not be ready for Medicare system build. The cost for additional resources (presented in Table 2) was analyzed for both the current plan (using existing systems) and the contingency plan (engaging a TPA).

Some expenses differ depending on the approach.

- Additional IT related support from our PBM implementation partner (PSG) is needed with either option, but IT Contingent labor to bolster IT resources that are strained with OOTF will be higher with the use existing systems, than the TPA scenario. In both scenarios there is significant support needed.
- Additional D-SNP staff discussed above is required for both scenarios, but the functions performed will by the staff will be focused more on oversight if GCHP engages a TPA.
- The full scope implementation partner cost is higher in the TPA scenario due to the support the partner will provide in the procurement and implementation of the TPA.

- Lastly, the cost for the TPA is only in the second scenario and reflect only implementation costs. The actual cost for operations would only begin in 2026.

GCHP will solicit the full scope implementation partner via the standard procurement process and do the same for a TPA for D-SNP implementation, should GCHP decide to pursue this option.

*Note that certain system build and implementation expenses will be amortized and realized only at the time of go-live.

Table 2—Proposed Additional Costs With and Without TPA

Item	Original Budget	Additional w/o TPA	Additional w/ TPA
Project Managers	$240,000	$0	$0
PBM Implementation Partner	$775,000	$200,000	$200,000
Business Requirements and Configuration Support	$500,000	$0	$0
Compliance/Procurement Consultant	$400,000	$0	$0
Non-Actuary Bid Consultant	$150,000	$0	$0
Actuary Consultant	$150,000	$0	$0
IT Contingent Labor*	$0	$3,000,000	$1,500,000
DSNP Staff	$353,000	$485,000	$485,000
Full scope program implementation partner	$0	$1,100,000	$1,600,000
Third Party Administrator (TPA) Implementation*	$0	$0	$1,440,000
Total	**$2,328,000**	**$4,785,000**	**$5,225,000**

FINANCIAL IMPACT:

The original D-SNP budget for 2024/25 Fiscal Year was $2.3M. Revised budget will range from $7.1M to $7.6M depending on the need for a Third Party Administrator (TPA) for core operations.

RECOMMENDATION:

It is GCHP's recommendation that the Executive Finance Committee recommend to the Ventura County Medi-Cal Managed Care Commission to approve up to $5.3M additional budget for D-SNP operational readiness for the remainder of the 2024/2025 Fiscal Year.

Gold Coast Health Plan℠
A Public Entity

Duals Special Needs Plan (D-SNP) Operational Readiness Cost Revision for Fiscal Year 24/25

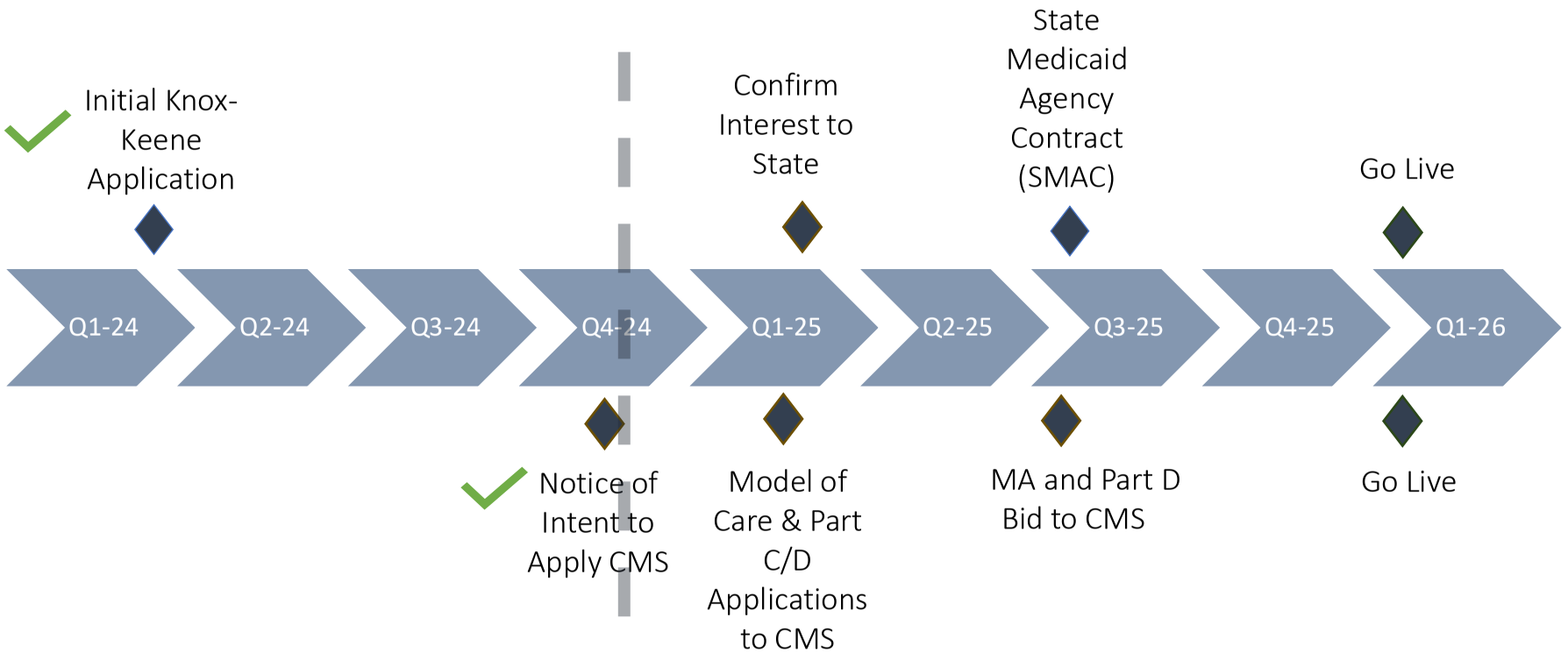
November 14, 2024

Eve Gelb, Chief Innovation Officer
Sara Dersch, Chief Financial Officer
Robert Franco, Chief Compliance Officer

Integrity
Accountability
Collaboration
Trust
Respect

Regulatory Schedule Timeline On Track

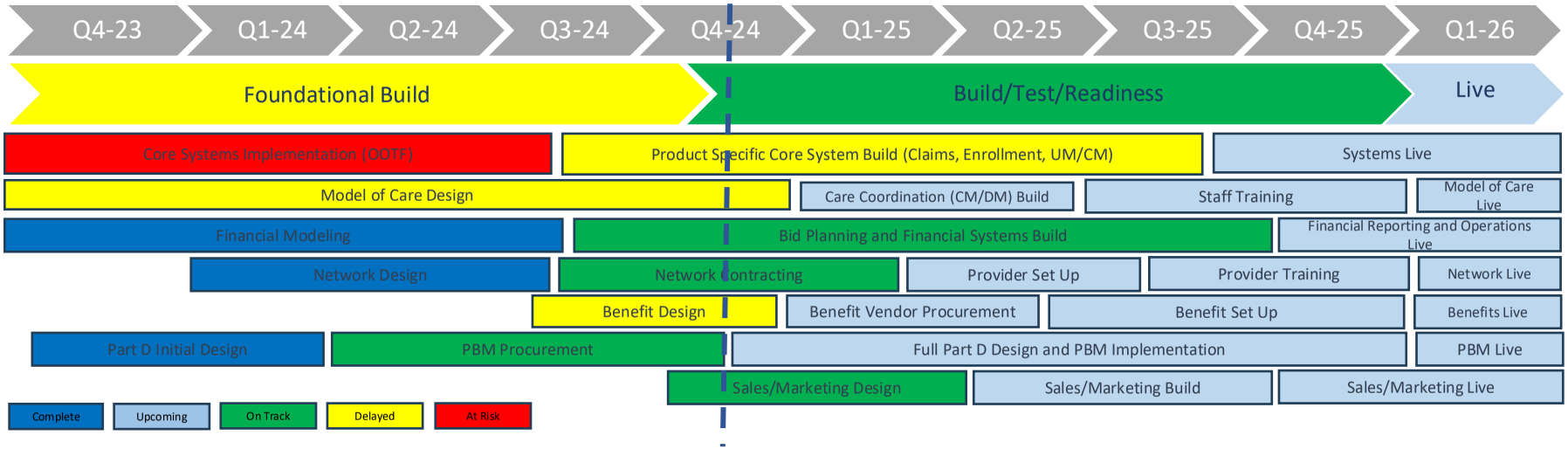
There are several regulatory requirements steps that must be completed and obtain with DMHC, CMS, and DHCS for GCHP to operate as an Exclusively Aligned Enrollment(EAE) D-SNP, Medi-Medi Plan starting on January 1, 2026.



Return to Agenda

D-SNP Operations and Systems Implementation Status

Most items are on track, but there are key risks and issue to address.

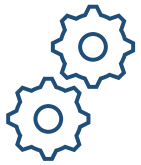


Risks/Issues/Lessons Learned:

- Risk: Building Medicare on Operations of the Future (OOTF) systems while stabilizing
- Risk: Resource and Knowledge Gaps
- Issue: Delays in benefit design and Model of Care work.
- Lessons Learned from OOTF: Strong Project Governance and Implementation Support is vital for success

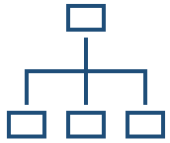
Return to Agenda

Mitigation Plan



Building Medicare on Operations of the Future (OOTF) systems while stabilizing

Develop contingency plan for core operations platforms (Third Party Administrator)



Lesson Learned: Strong Project Governance and Implementation Support

Establish Program Office and Bring on Implementation Partner

Risk: Resource & Knowledge Gaps
Issue: Delays

Bring on subject matter expertise and bandwidth by hiring D-SNP staff sooner than original plan and supplementing with consultant support

Return to Agenda

D-SNP Staffing Proposal

Original budget included 3 new D-SNP staff. Proposed budget hire 11 key D-SNP staff earlier (between January and March of 2025) for a total of 12 D-SNP hires in the 2024/2025 Fiscal Year.

Hiring staff, rather than using consultants is a more cost-effective approach to bringing on subject matter expertise and expanding bandwidth.

Budgeted Resource	Start Date
Medicare Compliance Manager	Nov 2024 (hired)
PBM Operations Manager	Nov 2024 (hired)
Medicare Marketing Manager	Dec 2024

Proposed Additional Resources	Start Date
Utilization Management Nurse (Medical Policy)	Jan 2025
IT Resources (2)	Jan 2025
Quality Improvement Sr. Analyst (5 Star)	Jan 2025
Coding Analyst (Risk Adjustment)	Jan 2025
Grievance and Appeals Coordinator	Feb 2025
Sales Agent	Feb 2025
Enrollment Specialist/Oversight	Feb 2025
Compliance Special Investigator	Mar 2025
Claims Analyst/Oversight	Mar 2025
Medicare Reporting Analyst	Mar 2025

Return to Agenda

Proposed Fiscal Year 24/25 Additional Budget Request for Operational Readiness Success

Original D-SNP budget for 2024/25 Fiscal Year was $2.3M. Revised budget will range from $7.1M to $7.6M depending on the need for a Third Party Administrator(TPA) for core operations. Implementation partner and TPA will be procured through Request for Proposal process.

Item	Original Budget	Additional w/o TPA	Additional w/ TPA
Project Managers	$240,000	$0	$0
PBM Implementation Partner	$775,000	$200,000	$200,000
Business Requirements and Configuration Support	$500,000	$0	$0
Compliance/Procurement Consultant	$400,000	$0	$0
Non-Actuary Bid Consultant	$150,000	$0	$0
Actuary Consultant	$150,000	$0	$0
IT Contingent Labor*	$0	$3,000,000	$1,500,000
DSNP Staff	$353,000	$485,000	$485,000
Full scope program implementation partner	$0	$1,100,000	$1,600,000
Third Party Administrator (TPA) Implementation*	$0	$0	$1,440,000
Total	**$2,328,000**	**$4,785,000**	**$5,225,000**

*These cost will likely be amortized and hit financials once systems go live.

Return to Agenda