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

Provider Advisory Committee (PAC) Special Meeting

Tuesday, June 11, 2024, 7:30 a.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010
Members of the public can participate using the Conference Call Number below.
Conference Call Number: 1-805-324-7279
Conference ID: 684 563 989 #

7466 Beverly Boulevard Suite #205
Los Angeles CA 90036

AGENDA

CALL TO ORDER

ROLL CALL

OATH OF OFFICE

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 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.

OPENING REMARKS / WELCOME

Marlen Torres, Executive Director of Strategy & External Affairs
Erik Cho, Chief Policy & Program Officer

CONSENT

1. Approval of regular meeting minutes of March 5, 2024

Staff: Maddie Gutierrez, MMC, Clerk of the Commission

RECOMMENDATION: Approve the minutes as presented.

PRESENTATIONS

2. Operations Of The Future (OOTF) for Provider Partners – Background and Readiness

Staff: Anna Sproule, Executive Director of Operations
Vicki Wrighster, Sr. Director of Network Operations

RECOMMENDATION: Receive and file the presentation

3. Wellth Presentation

Staff: Rob Davenport, Manager, Wellness and Prevention Program

RECOMMENDATION: Receive and file the presentation

4. 2024/25 Budget Presentation

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Receive and file the presentation

FORMAL ACTION

5. Creation of an Ad Hoc Subcommittee for the Nomination of a Chairperson and Vice-Chairperson to Serve on the Ventura County Medi-Cal Managed Care Commission's Provider Advisory Committee (PAC)

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Staff recommends the PAC establish a nomination ad hoc subcommittee to commence the selection process of the Chairperson and Vice-Chairperson of the PAC.

ADJOURNMENT

Unless otherwise determined by the PAC, the next meeting is scheduled for September 10, 2024 and will be held at Gold Coast Health Plan located at 711 E. Daily Drive, Suite 110, 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 Committee after distribution of the agenda packet are available for public review during normal business hours at the office of the Secretary of the Committee.

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5562. Notification for accommodation must be made by the Monday prior to the meeting by 1:00 p.m. to enable GCHP to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO. 1

TO: Provider Advisory Committee (PAC)

FROM: Maddie Gutierrez, MMC, Clerk of the Board

DATE: June 11, 2024

SUBJECT: Approval of the Provider Advisory Committee Meeting minutes of March 5, 2024

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the March 5, 2024 Provider Advisory Committee meeting minutes.

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)
Provider Advisory Committee (PAC)
March 5, 2024

CALL TO ORDER

The Clerk to the Commission called the meeting to order at 7:33 a.m., in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

ROLL CALL

Present: Committee members: Masood Babaeian, Amelia Breckenridge, M.D., Claudia Gallard, Katy Krul, Amanda Larson, Sim Mandelbaum, Kristine Supple, and Dr. Pablo Velez.

Absent: None.

Gold Coast Health Plan Staff in attendance: Nick Liguori, Chief Executive Officer, Marlen Torres, Executive Director of Strategy & External Affairs, Ted Bagley, Chief Diversity Officer, Felix Nunez, MD, Chief Medical Officer, Robert Franco, Chief Compliance Officer, Erik Cho, Chief Policy & Program Officer, Paul Aguilar, Chief of Human Resources, Alan Torres, Chief Information Officer, Eve Gelb, Chief Innovation Officer, Susana Enriquez-Euyoque, Adriana Sandoval-Jimenez, Erin Slack, Carolyn Harris, Vicki Wrighster, Kim Timmerman, Lupe Harrion, and Lorraine Carrillo.

Guests: Vince Pillard, Josie Roemhild, Molly Corbett, and Milad Pezeshki

PUBLIC COMMENT

None.

OPENING REMARKS

CPPO Erik Cho welcomed all to the PAC meeting. He also greeted guests/potential committee members.

CPPO Cho stated the committee will also have an opportunity to present feedback, opinions, and ideas on programs that we are launching. We are putting together a group that is diverse across our provider community. He noted that GCHP is in a phase where we are advancing and making changes at a rapid pace. We are core to our mission of improving health outcomes, improving quality, improving access for our members. It is our first and foremost responsibility and concern. We want to work together to make sure that we are meeting the

needs not only of our members but also our providers. This includes funding, and an opportunity for grants.

We want to encourage dialogue in these meetings, please feel free to ask questions at any time.

CONSENT

1. Approval of special meeting minutes of December 5, 2023

Staff: Maddie Gutierrez, MMC, Clerk of the Commission

RECOMMENDATION: Approve the minutes as presented.

Committee member Masood Babaeian motioned to approve Agenda item 1 as presented. Committee member Dr. Pablo Velez seconded.

AYES: Committee members: Masood Babaeian, Amelia Breckenridge, M.D., Claudia Gallard, Katy Krul, Amanda Larsen, Sim Mandelbaum, Kristine Supple, and Dr. Pablo Velez.

NOES: None.

The motion carried.

FORMAL ACTION

2. Revised Provider Advisory Committee Charter

Staff: Marlen Torres, Executive Director of Strategy & External Affairs
Erik Cho, Chief Policy & Program Officer

RECOMMENDATION: GCHP's management team recommends that the PAC Committee approve the revised PAC Charter. The revised PAC Charter will be shared at the next Commission meeting on Monday, April 22, 2024.

Marlen Torres, Executive Director of Strategy & External Affairs stated that PAC members in 2022 began to look at the Charter. An AdHoc committee was created. Members of the AdHoc committee were Katy Krul, Dr. Pablo Velez, and David Fein (former PAC Chair). The committee mad a number of recommendations for a revised Charter. Unfortunately, the PAC lost quorum, and we had to put the Provider Advisory Committee on pause until we were able to recruit multiple members.

There were proposed changes recommended by the PAC AdHoc along with additional change added by management.

Ms. Torres stated that originally the committee agreed to eleven members. Management believed it was important to extend to thirteen in order to ensure that we had good representation. We needed a diverse group of our provider network to make sure they were represented.

Ms. Torres stated that at the next PAC meeting there will be the selection of a Chair and Vice Chair. Once those individuals are selected, we will ask for support in creating the agendas to make sure that we continue to collaborate with one another. Ms. Torres reminded members that this committee reports up to the Commission.

Ms. Torres reviewed the revisions:
1. Increase the numbers of PAC members from 11 to 13.
2. Updated the purpose of the charter to include providing feedback on GCHP's Model of Care, improving access to quality care, and feedback on GCHP membership.
3. Provide greater clarity on PAC responsibilities.
4. Provisions regarding the selection of a Committee Chair and Vice Chair.
5. PAC membership term limits including Ventura County members.
6. PAC membership enhancement to include non-traditional providers.

Ms. Torres stated there will be a two-year term limit. There is a maximum number of terms and members will have the opportunity to reapply and go through the process.

CPPO Cho stated that GCHP appreciates the AdHoc Committee and their work on the revisions of the Charter. He stated that GCHP wants to make sure these revisions make sense to all, and that there are no concerns, questions, or something that might need to be clarified. CPPO Cho and Ms. Torres gave the opportunity for questions and/or feedback.

Committee member Claudia Gallard stated that the revisions to the Charter made sense. Committee member Amanda Larson noted an error in the number of members for the committee. That will be corrected on the Charter. Ms. Larson asked if voting needed to be done in person. Ms. Torres asked the Clerk to explain attendance to meetings and voting. The Clerk explained AB361 which was in effect during the pandemic. The Public Health Emergency is now over, and all meetings will be held in person. If a committee member cannot attend in person, they must have the address from where they are going to participate in the meeting listed on the agenda in order to count toward a quorum and be able to vote.

Committee member Dr. Pablo Velez stated the initial Charter and procedures worked

well in the beginning, but as the committee evolved, it was important to make the revisions.

Committee member Amanda Larson motioned to approve Formal Action agenda item 2 as presented. Committee member Claudia Gallard seconded.

AYES: Committee members: Masood Babaeian, Amelia Breckenridge, M.D., Claudia Gallard, Katy Krul, Amanda Larsen, Sim Mandelbaum, Kristine Supple, and Dr. Pablo Velez.

NOES: None.

The motion carried.

PRESENTATIONS

3. Health Risk Assessment

Staff: Erin Slack, Sr. Manager, Population Health

RECOMMENDATION: Receive and file the presentation.

Erin Slack, Sr. Manager of Population Health stated she was going to present our new health risk assessment implementation approach. She stated that she is looking for feedback from the committee on the process and how to partner without and make sure our members are not overburdened in terms of collecting information on their health status.

Ms. Slack explained the population health management framework. In June of 2022, DHCS established a population health management strategy and framework in order to give use a guiding principle to implement a population health management program. As a managed care plan, we have several components of the population, health management framework, this puts it all together under one umbrella and at the core of the framework is being able to understand the needs of our members.

Upon gathering multiple data sets, aggregating, and correlating the members' information on a specific level in order to identify risks to our member population and place members into risk tiers. We then develop programs and interventions based on the risk within the population. If we do not have the data to support the effort, we are hindered. Ms. Slack noted that we are required to become NCQA as part of the population health management framework.

Through the NCQA accreditation process there are several different standards in the population health management section. She noted that in the fourth section there is a standard regarding health risk assessment which requires us to have the capabilities, on an annual basis, to perform a health risk assessment for our adult member population.

Ms. Slack stated that DHCS previously focused just on member population, but in the new framework and policy guide they have expanded the population needs assessment, and we are required to collaborate with partner agencies to develop a collaborative needs assessment. This include nonprofit hospitals, public health department, and community benefit organizations to look at what are social drivers of health within our community. We need to determine what are the social needs within our community and what are the priority health issues. As a community we should be working together to address those priority health needs. The health risk assessment process will help identify what are the needs for our member population. This will help our entire community identify needs and social determinants of health that are affecting our member population.

Ms. Slack noted that we are also implementing a Model of Care, which is similar to the population health management framework. Understanding membership is the first part of the Model of Care. She noted that this is similar to Model of Care, it is a rebranding that DHCS has done in terms of Model of Care. The health risk assessment is integral to both Model of Care and population health management implementation.

Committee member Amanda Larson asked if it was only nonprofit hospitals. Ms. Slack responded that nonprofit hospitals are required by the IRS for their nonprofit stats, to do a health needs assessment. That is why they are required to be part of the process. We have the Ventura County Community Health Improvement Collaborative which has been in existence since 2016. We have had some participation from Los Robles, but not in terms of investment and engagement in that process.

CIO Eve Gelb stated what we want to get to the intent of the requirement which is the need to understand the community needs. We want to have programs and services that will need the needs and to measure the outcomes so that we can ensure that we are continuously improving.

Ms. Slack stated that in working with the health improvement collaborative and the cross-sector partnership, we have been able to work together and have gone from assessing the community to developing intervention strategies. If we did not have multiple partners that have different views and experiences in the community, we would not be where we are. These partnerships are going to make our process more valuable, and the member experience will improve.

Committee member Dr. Pablo Velez stated there are nonprofit hospitals throughout the county except Thousand Oaks. He asked if that meant that Thousand Oaks is an area that is under-represented, and the information is not well captured for the area. He noted that the area has grown tremendously and so have the needs. There are up to six families living in one house in the Thousand Oaks area. He asked if we are capturing the profile of that population. Ms. Slack stated the data sources that are used as part of the process are include of the entire community. We get the data from the state, and it covers the entire community. But it is important to engage partners because there are not a lot of resources for the more vulnerable population in that area. Ms. Slack stated there is a census track in Thousand Oaks that has the highest percentage of children living under poverty in a small community there. There is a high need in that area. We could do a better job of trying to engage our healthcare partners in that area.

Committee member Katy Krul asked if when collecting data based on claims, are adults who have Medicare also captured. Ms. Slack stated we can only capture the claims that were billed for that account. CIO Gelb stated we are sometimes responsible for a portion of the Medicare claim. In that case we do collect information because Medicare covers up to a certain amount and Medi-Cal is the payer of last resort. We cover 27,000 people who have both Medicare and Medi-Cal. Their Medi-Cal is enrolled with us, but their Medicare is not. We are working to launch a dual special needs plan in 2026 where people can enroll their Medicare with us too. We currently pay for the portion that we are responsible for. We look at data in terms of encounters to understand who is getting the right kind of care.

Ms. Krul asked about those who are in nursing facilities. CIO Gelb stated that those who qualify for long-term care in an institution custodial level of care as well as skilled need, we have that data, and we pay for the portion we are responsible for.

At risk assessment process is one of the foundational steps to developing an integrated care team approach. Once we identify the member needs an individual care plan is developed and the team can focus on that care plan. With the health risk assessment, we learn what are the needs for our members and what we have in terms of resources to address those needs. Ms. Slack noted that there are a couple of ways to collect the information. If a new member comes on to the plan, they are required to have an initial health appointment with their provider which must occur within 120 days of becoming a new member and it is a way to capture some information. We can also capture information through codes and claims that would identify social determinants of health. We also send out a new member form that is approved by DHCS and has ten questions which ask about chronic conditions, pregnancy status, etc. The ultimate goal is to figure out the best way to ensure that the assessment process is smooth. We want to be able share data with the integrated care team, and it is also the goal of DHCS because they are moving toward identifying a population health management

service where all the assessments done at the provider or health plan level are within one database so that everyone that is part of the team would be able to access the information. This concept is still in the future. In the meantime, we need to work together to identify the best process for our members in terms of collecting information.

We are currently in a pilot phase for our health risk implementation in determining what is the best way to reach the member. It could be a phone call, or text with a link. It is part of a learning process for us and what works best to collect data and share information so that providers who are part of the integrated care team have access to the data.

Ms. Slack reviewed the process for Health Risk Assessment development, she reviewed the topics in the twenty-question assessment and the question selection process. Completing the survey takes time and we want to be respectful of the member's time. We want to be able to establish a baseline for program planning which will help us learn over time. We can look at trends of our member population and also help us meet NCQA requirements. Responses to the questions would help to determine if a referral is necessary and our care management team will do a further assessment. Members need to support the development of the individualized care plan.

Committee member Claudia Gallard asked if the assessment is done only over the phone. Ms. Slack stated that is the way we are launching the survey. We are currently doing outbound calls to members. Eventually our call center will be making the calls for the assessment. Committee member Amanda Larson asked what the capture rate is. Ms. Slack stated we do not know because we have not done this before. We are doing a phased approach because we do not want to ask people what their needs are and then not follow up with them. We are trying to determine what the threshold is, what care management can oversee in terms of a weekly load of referrals. Initially we are doing one thousand calls, and we are launching on Monday. We are doing one thousand calls every two weeks until we get to the point where we know how much data we are getting back. Ms. Slack stated she would like to share an update with the committee, which would include statistics and outcomes.

CIO Gelb stated most of the special needs plan that conduct health risk assessments do it telephonically, but it takes time for the member to realize that this is core to the health plan being able to sere and meet their needs. We need to figure out the right balance. Committee member Amanda Larson asked how it is decided who is called first.

Committee member Dr. Pablo Velez asked how the kids questions are being organized that are culturally appropriate. He also stated that with the amount of phone spam people are reluctant. He stated there are barriers and trust issues. Dr. Velez

stated that the relationship built with the provider might be a better place to answer the questions. Committee member Amanda Larson suggested questioning the people who are in hospitals or walking into clinics and give them a written survey in a place where they have already begun to have trust and are already reaching out for help.

CIO Gelb asked how to do this survey with children, because the caregiver/guardian/parent needs to be engaged. We need to find the right way to ask the questions, are they even the right questions. We are dealing with a family and there will be other questions as well. We have not developed that tool. We do not want to have the same questions asked over and over. We need to figure that out. The initial approach is for those who we have no information because they are not accessing the system, or they are new to us.

Ms. Slack noted that we have a birth equity stakeholder group that include partners that work with the zero to five population, First Five child development resources, and we are starting to collect standard assessments that they have to do for their program eligibility and enrollment. We are in the beginning stages, and there is not an actual timeline because we are still building.

In January we had an increase in our enrollment, it included the expanded eligibility for undocumented. The focus of our initial health risk assessment is selection from that pool and also non utilizers of healthcare services. We are randomly selecting five hundred Spanish speakers and five hundred English speakers; it is an automated process.

Committee member Claudia Gallard asked if the questionnaire could be part of the information when they are enrolling with GCHP. Ms. Slack stated it is not currently part of the application process. We do leverage data that is part of the application process in every way that we can, race, city, language, gender. There will be some modifications made to better collapse for sexual orientation, gender identity, which is currently not being captured, but we do have access to that information. Currently, DHCS does not require that risk assessment portion to be part of the enrollment process.

Committee member Kristine Supple stated that it will have to be a multi-model approach. Calling is good but you will only get a certain subsection. Texting may be a good strategy. People like to text because they are used to interacting in that manner. Having the provider take on the assessment takes time away from the provider. If the provider is reimbursed, he might be more willing to do a reimbursed targeted exam. There are ways to do this, but people will be asked the same questions multiple times because most likely you will not be able to get it all in one setting. Partnering with providers is one way to have a dedicated exam and do it through claims and reimburse the provider. Ms. Slack asked if a provider incentive associated with doing the risk

assessment on an annual basis would be good. Ms. Larson stated aligning it with what Medicare is doing. CMH has multiple wat that the patient accesses the number; one is on the website. The other way is one week prior to their appointment they receive a secure link where they can answer the questions and the secure link gets upload and it is there in context – when the patient goes for their visit you can see if they completed their questions, or they can complete it while sitting in the waiting room. It is then uploaded to the doctor, the doctor reviews, it creates a preventative health plan that is printed out for the patient. The codes are dropped on the backside so that there is a claim. UCLA is doing the something similar for their patients.

If the member is assigned to a clinic, nobody at the clinic knows anything about them, engaging in this process you get the information you need, the patient gets the resources they need, and a communication link have been made with the provider. It improves the communication between levels of care. Dr. Velez stated it is trust. The doctor or entity where they are receiving services – they are the one that the member will open up and expose their life to.

Dr. Velez stated he would not call it an incentive for the provider, it is really reimbursing them for the time they take to gather the information. You will not tell your health care system but at the same time you are giving the information to the healthcare system. Who you are talking to is critical. CIO Gelb stated that the doctor might not have the time or the training to listen. Committee member Kristine Supple stated you only want to ask those questions if you have good resources. You need to make sure you have strong care management services. Committee member Claudia Gallard stated her system has health educators. It has been noted that they open up to them. The health educators have all the resources to know how to guide the patient. The patient trusts their health educators. Committee member Dr. Amelia Breckenridge stated that she agrees. She stated she is already doing the Stay Health assessment for all GCHP patients which has some overlap with the health risk assessment, and if you add more questions it is going to add more time to each one of the visits. If you can get the information up front, it will be more streamlined. Ms. Supple stated that you are going to require a muti-prong approach to get all the right information. Some like to text, some like the link, or answer the questionnaire while sitting in the waiting room.

Ms. Slack stated there is a lot of work to do in terms of learning what is best for each population. Once our member portal is online, they can complete that through the member portal. CIO Gelb stated that for new members it can be asking their preferred method of communication. We want new members to start off recognizing that we can be more than just a card, we can be a source for transportation, food, or housing support. CIO Gelb stated that we have 17,000 new members. We normally get approximately 3,000 per month. Some of the 17,000 have already engaged with our health system. Part of the support is to understand a population up front so that we can design with their preferences and needs in mind.

CPPO Cho stated it is important to understand our members. We need to engage early. We also need to talk with providers about partnership. There needs to be coordination and outreach.

Dr. Velez stated that the 17,000 new members are of nonlegal status, there are many that are hoping to actually make their status legal. They know that if they are using social services in this country, they will be banned from pursuing their long-term legal status. This is going in the opposite direction that GCHP is trying to accomplish versus their long-term view for their life here that requires how to bypass these questions because if they complete the information will it ban them from getting their residency or green card. They are concerned if they use too much American dollars it will affect their potential goal to become legal. The concern is that IRS or INS will use that information and they will be prohibited to acquire their new status. GCHP will need to go to legal counsel and find out if this is going to lead in an opposite direction for these people. Ms. Slack stated research could be done and provide the information in the new member packet. We need to make sure that what we are saying is communicated clearly to everyone.

Ms. Slack thanked everyone for the valuable feedback.

4. Asthma Medication Ratio and Well Child Visit Quality Measure Discussion

Staff: Felix Nunez, M.D., Chief Medical Officer
Eve Gelb, Chief Innovation Officer

RECOMMENDATION: Receive and file the presentation.

CIO Gelb stated this presentation is focusing on two specific quality metrics. She noted that we have come a long way with our quality metrics. She reviewed where we stand today and what our projected results are. She noted one huge improvement which is the Well Child visit. This is the first time that we are projecting to hit the minimum performance level and it is a big achievement. The other measure is the Asthma medication ratio - this is a measure that we are not going to hit our minimum performance level and there are many barriers and issues associated with it.

Chief Medical Office, Felix Nunez, M.D. reviewed the five metrics that we are struggling with on our MCAS scorecard. He did note that no measure is below minimum performance levels. This means we will not be sanctioned, but more important is that we are meeting a metric of care for our members. We are striving for high performance; the performance was the bar we set for 2024 with the addition of high-performance measures being added on. The five that are really difficult, and we are facing challenges.

The Well Child visit metric is one that we have been challenged on and we have been collaborating with our provider network to make strides in that measure, such as opening up additional care gap clinics, extending hours of operation, and adding clinic days. We are still running into challenges, and it is a metric that we want to achieve. The challenge has been in connecting with kids greater than age 10 and older, and we are hoping for feedback on how we can impact the population. One of the thoughts we have had is how can we impact at the school level.

The asthma medication ratio is the other metric we want to present to the committee and get some insight.

CMO Nunez reviewed the dashboard which shows how we are doing on the metrics. It is refreshed on a monthly basis as we get new data, and the data is validated.

We have run into some barrier and there is going to be provider interventions, which includes outreach and education to our members, outreach and education to our pharmacists who dispense the medication, and also providers.

CMO Nunez asked about barriers that members and providers fac regarding ensuring appropriate ratio of rescue and maintenance medications. We want to know what GCHP can do.

CIO Gelb stated the asthma medication is impacted by the prescribing pattern. It is impacted by where they pick up their meds, what the fill process is for the pharmacy and how they engage. It is also impacted by whether or not they are seeking regular care. We are interested in any insight you may have on this particular measure. CIO Gelb asked how difficult or easy it is to engage with people who have asthma to ensure that they are getting the right treatments.

Committee member Kristine Supple stated she has done a lot of care management over the last ten years at CMH and have promoted some disease management programs. One way to do this is if you have open gaps, who has the highest volume. For example, if CMH has the highest volume, you have two hundred patients at CMH, there is collaboration with an asthma nurse practitioner that might be able to do a home intervention, assessing the patient and getting information back to the PCP.

CMO Nunez stated that there has been discussion on this, and the approach would be from the pharmacy department and using a pharmacist to do some of that work. It would be very receptive at a provider level. CIO Gelb stated GCHP cannot hire someone that delivers direct care, but we can hire someone that engages with our members to do education and support.

Committee member D. Pablo Vellez stated that looking at cultural background of this situation, you are dealing with the majority of Hispanic families, and you need to understand the level of education. The majority of parents do not have a high school degree. These parents often see long term medication as being harmful to the children. When you have two or more medications, that is great for the pharmacist to dispense, but they begin to have a problem because the people are not getting the meds and the concern of the parent is the amount of medication for the child. The parent is not seeing that the episodes of attacks are caused by the asthma, they think it is cause by the medications. The same thing happens with mental disorders, hypertension, and diabetes. There is a cultural barrier that needs to be managed. In order to break these barriers, it requires a community understanding and education their language, through media. Currently First Five is advertising and trying to make a change. They are working to make parents aware of all the chronic stressors and how they affect their child's brain. This needs to be managed in a broader method. You still need to change the mind of the grandma; this might be the person who makes all the decisions in the house. You cannot bypass her.

CMO Nunez asked Dr. Velez about Promotoras in this role. Dr. Velez stated that is an assistant that is linked back to where they were coming from, and they are familiar with and trust. This has been done with the World Health Organization in countries where they come from. We need to learn from what they have been doing and bypass this.

Dr. Breckenridge stated she agrees with Promotoras, community health workers, someone who specializes in asthma, can educate on asthma, and educate on the inhalers. There has also been discussion on auto refills and if you take a medication off of auto refill then all their medications are off of auto refill. It is either all or nothing, and they are not getting other medications that they do need monthly. Another issue is having multiple inhalers scattered all around; one at school, one at mom's house, one at grandma's house, and they are not using any of them. There are so many different levels on this specific metric. Another thing is that the guidelines changed in 2021, in the middle of a pandemic. Pharmacists were overwhelmed with Covid, and although we have tried to make sure everyone is updated on the guidelines, it might be good to provide education to providers on the guidelines because there are people who have fallen through the cracks.

Dr. Velez stated there is a problem for the parents, they are losing workdays because they have to stay home with their child. The child being chronically sick affects their financial situation. They need to embrace the idea that the medicine can help the child stay healthy and they can then go to work. We also need to look at environmental things and take into consideration the cost of getting four medications every single month. They might need a heater so that the airways are not affected during the night. The need to stop heating the house with the stove. There is also agricultural industry,

they need to water consistently so they do not create dust. We might want to look at this issue in a more holistic way, not just the amount of medication that is given to the child.

Marlen Torres, Executive Director of Strategy & External Affairs stated that we had a policy for this topic, and we cannot just add community but also the air controller, along with a number of other key stakeholders. The takeaway that the Plan did was piloting the Asthma Remediation which is now Community Support under CalAIM. Maybe combining larger groups on some of these types of measures in order to be able to advance the work.

Committee member Amanda Larson stated taking a more simplistic approach, she was a child with childhood asthma and her mom took the holistic approach. At that time there were not preventative medicines. When the group discussed family assessments, this should be part of that assessment. She noted that certain seasons kick off asthma. Ms. Larson also noted the side effects of long-term use of preventative medicine are scary.

CIO Gelb thanked everyone for the great discussion. There was one more measure that will be tabled and presented at the next meeting. CMO Nunez thanked everyone for the feedback.

Committee member Dr. Pablo Velez motioned to approve agenda items 3 and 4 as presented. Committee member Kristine Supple seconded.

AYES: Committee members: Masood Babaeian, Amelia Breckenridge, M.D., Claudia Gallard, Katy Krul, Amanda Larsen, Sim Mandelbaum, Kristine Supple, and Dr. Pablo Velez.

NOES: None.

The motion carried.

COMMENTS FROM COMMITTEE MEMBERS

None.

ADJOURNMENT

With no further items to be addressed, the Clerk adjourned the meeting at 9:02 a.m.

Approved:

_____
Maddie Gutierrez, MMC
Clerk to the Commission

AGENDA ITEM NO. 2

TO: Provider Advisory Committee (PAC)

FROM: Anna Sproule, Executive Director of Operations
Vicki Wrighster, Sr. Director of Network Operations

DATE: June 11, 2024

SUBJECT: Operations Of The Future (OOTF) Provider Portal Presentation

PowerPoint with Verbal Presentation

ATTACHMENTS:
PROVIDER PORTAL PRESENTATION

Gold Coast Health Plan℠
A Public Entity

Gold Coast Health Plan

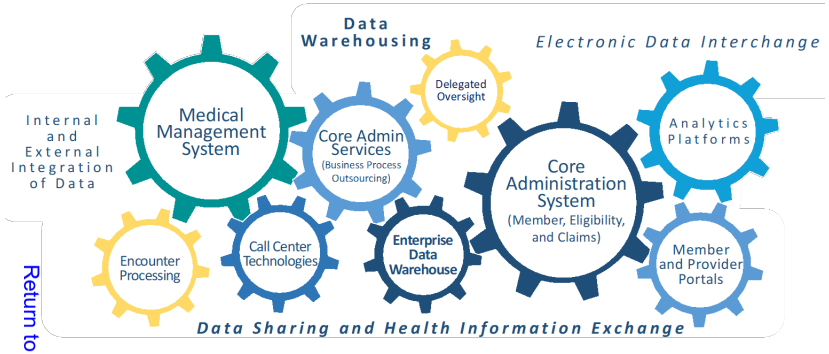
Operations of the Future Readiness Report

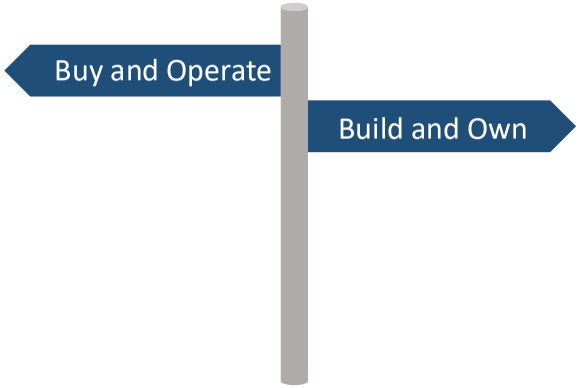
June 11th , 2024

Anna Sproule, Executive Director Operations
Vicki Wrighster, Sr. Director, Network Operations

Integrity
Accountability
Collaboration
Trust
Respect

Operations of the Future – Readiness Report





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GCHP Operational Readiness Update

OOTF Phase Completion:

- GCHP is now completing the Operations of the Future (OOTF) phase of configuration, testing, and training that will yield "Operational Readiness" for Day 1 Operations on July 1st.

Regular Commission Reports:

- At every Commission meeting in 2024, GCHP Management will provide a report on OOTF readiness and performance.

Current Focus:

- This month, we provide a deeper understanding of readiness of the Provider Portal and Core Administration System and Services.

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Readiness – Executive Summary

Core Admin *HRP*	Medical Management *TruCare*	BPO *Netmark*	Print/Fulfilment	Mail Room/ Imaging	EDI *Edifecs TMaaS*
On Track	On Track	On Track	On Track	On Track	On Track

Provider Portal *NTT vendor*	Data Conversion ***EDP/MDW***	Call Center	Member Experience	Org Readiness	Member Portal *NTT vendor*
On Track	On Track	On Track	On Track	On Track	Procurement Done

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Provider Portal

Vicki Wrighster, Sr. Director Network Operations

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Benefits of NTT Data Portal

- Providers gain improved visibility into the comprehensive care of GCHP members, positively affecting patient care by facilitating better access to member information
- The system's simplicity contributes to heightened provider satisfaction, consequently leading to increased member satisfaction
- The NTT portal is extremely user-friendly
- Advanced functionalities provide clearer insights into the status of authorization and claims processing
- The enhanced user-friendly features result in expedited, timely, and precise access to member information
- A streamlined registration process for provider portal users ensures smoother operations

PROVIDER PORTAL – Current State

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- Dependence on GCHP for registration procedures
- Separate sign-on requirements for each provider location
- Few self-service functionalities
- Limited to professional claims submission
- Utilization of electronic claim and authorization submission methods
- Only Network wide provider messaging available
- Providers must contact GCHP to assist if user loses passwords and/or usernames

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PROVIDER PORTAL – FUTURE STATE (NTT DATA)

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- Enhanced provider autonomy in portal registration processes
- Improved intuitiveness and user-friendliness
- Capability for both professional and facility claims submission
- Integration of global and targeted provider messaging functionalities
- Facilitation of access to multiple contracted locations via a unified sign-on mechanism
- Strengthened security through the implementation of Two Factor Authentication
- Self-service functionality available for resolving issues related to lost passwords and usernames
- Introduction of a new widget feature providing comprehensive insights into the status of claims and authorization submissions
- Eligibility data presented clearly and thoroughly, including Other Health Insurance information

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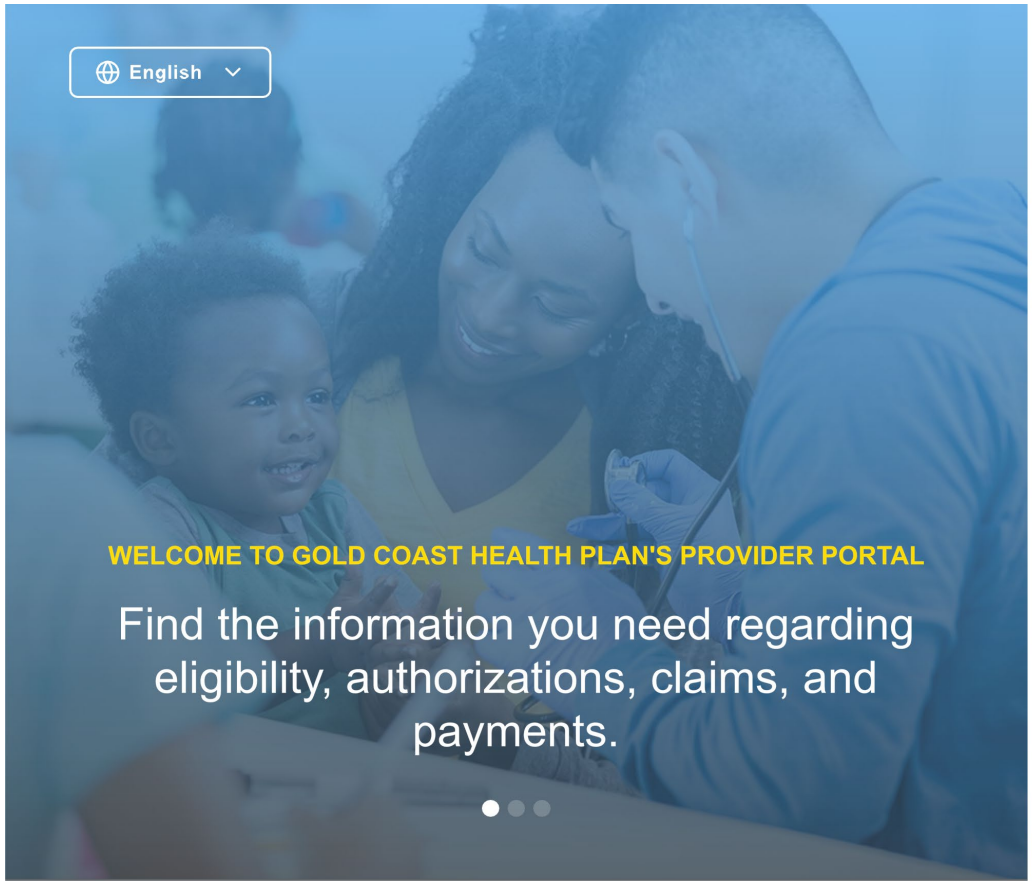
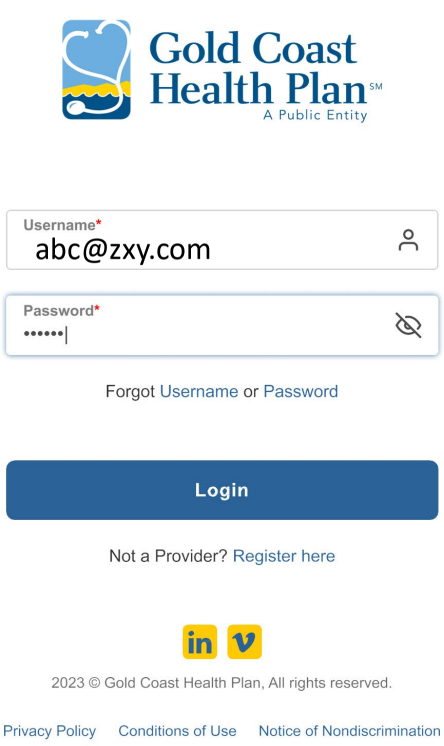
PROVIDER PORTAL DEMO





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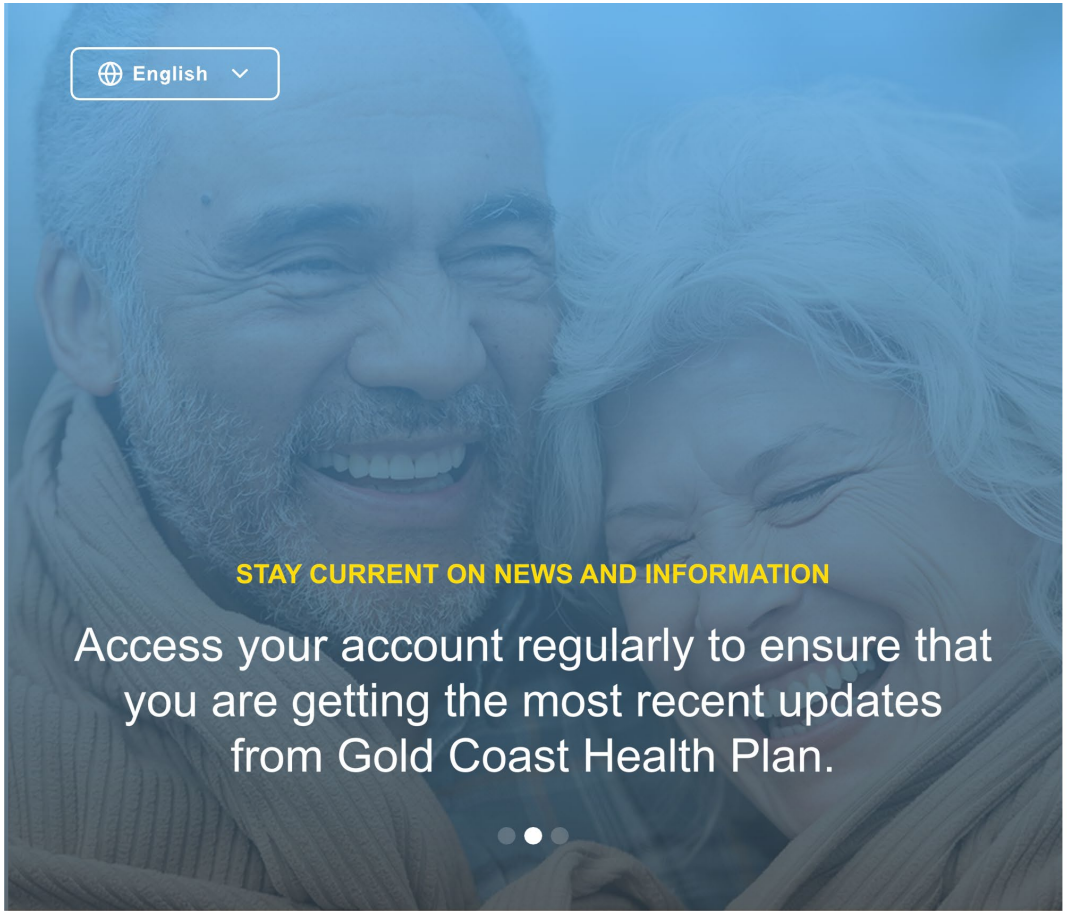

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Username*
abc@zxy.com

Password*
••••••

Forgot Username or Password

Login

Not a Provider? Register here

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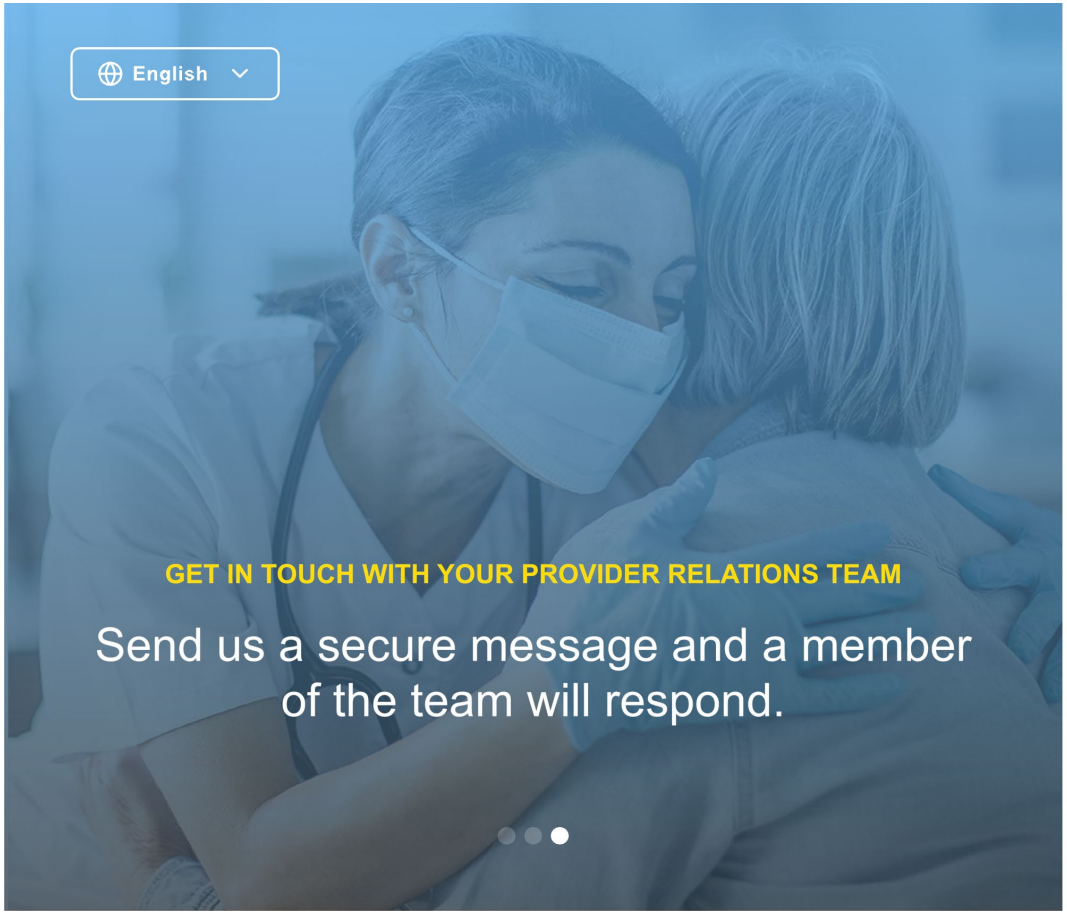
PROVIDER PORTAL DEMO



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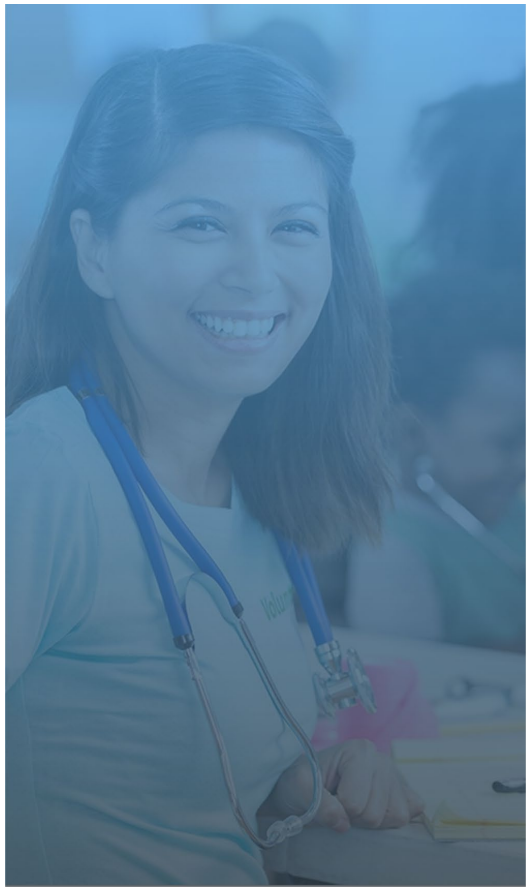

REGISTRATION

Step 1 of 3

Choose the type of user

(•) Vendor ( ) Office Location

Billing Tax ID*

Note : Third party vendors should not register as provider admin without approval from contracted provider.

Back | Validate

PROVIDER PORTAL DEMO

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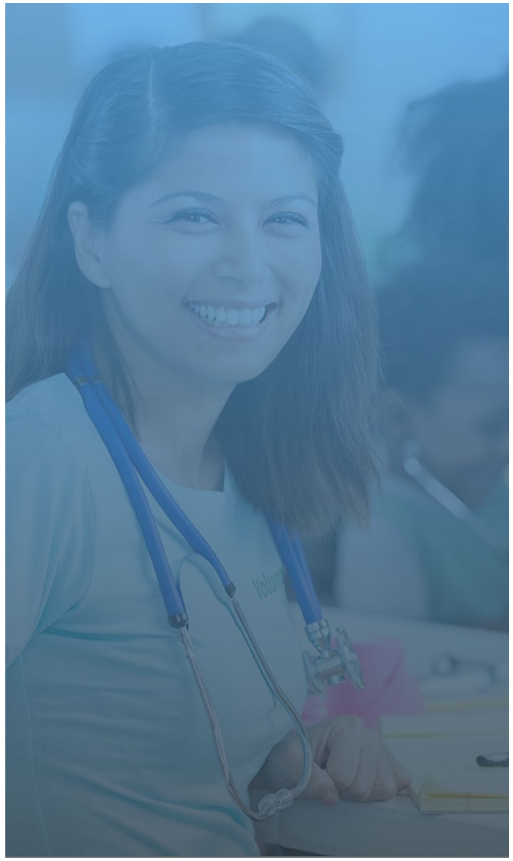

REGISTRATION

Step 1 of 3

Choose the type of user

○ Vendor ◉ Office Location

Billing Tax ID*

Location ID*

Back | Validate

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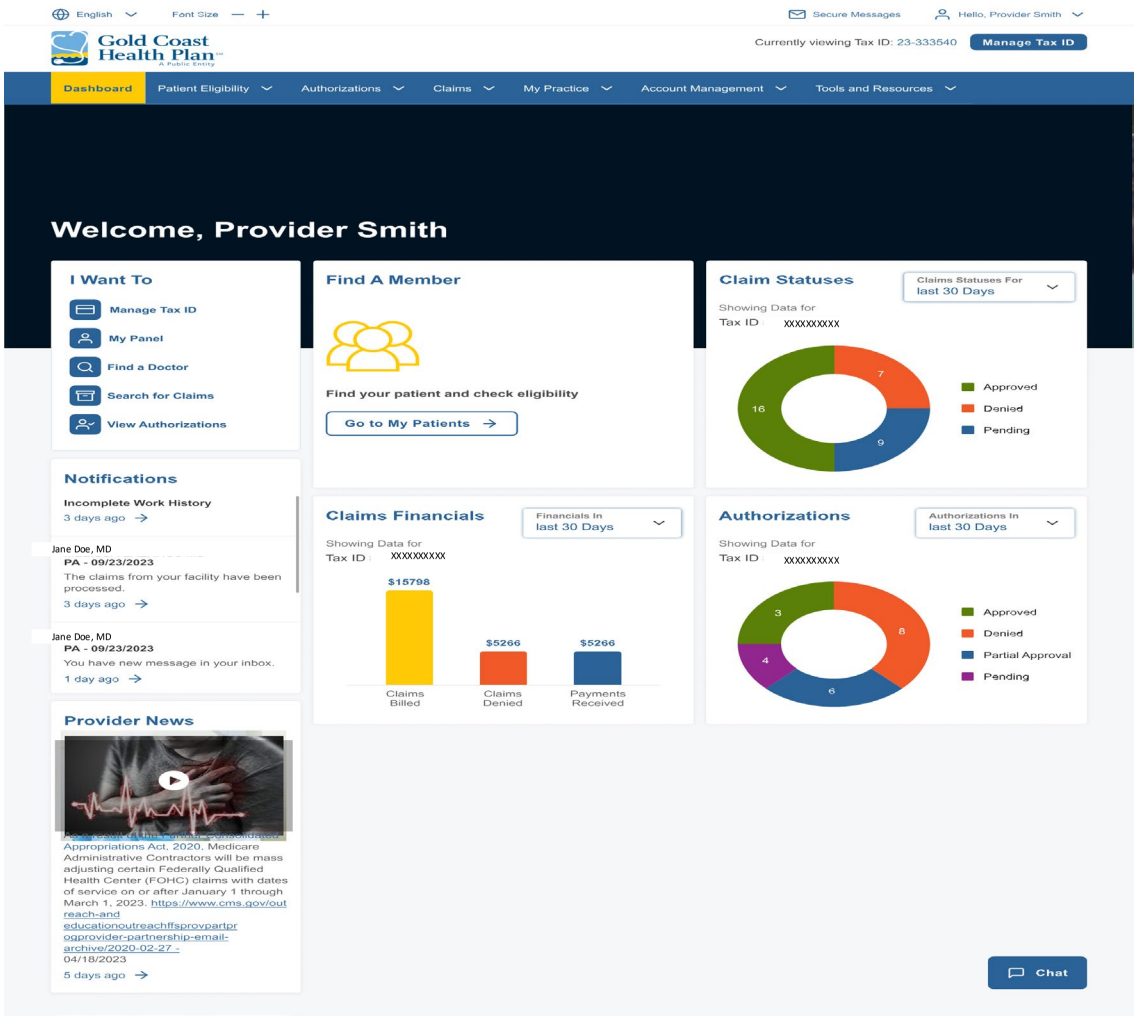

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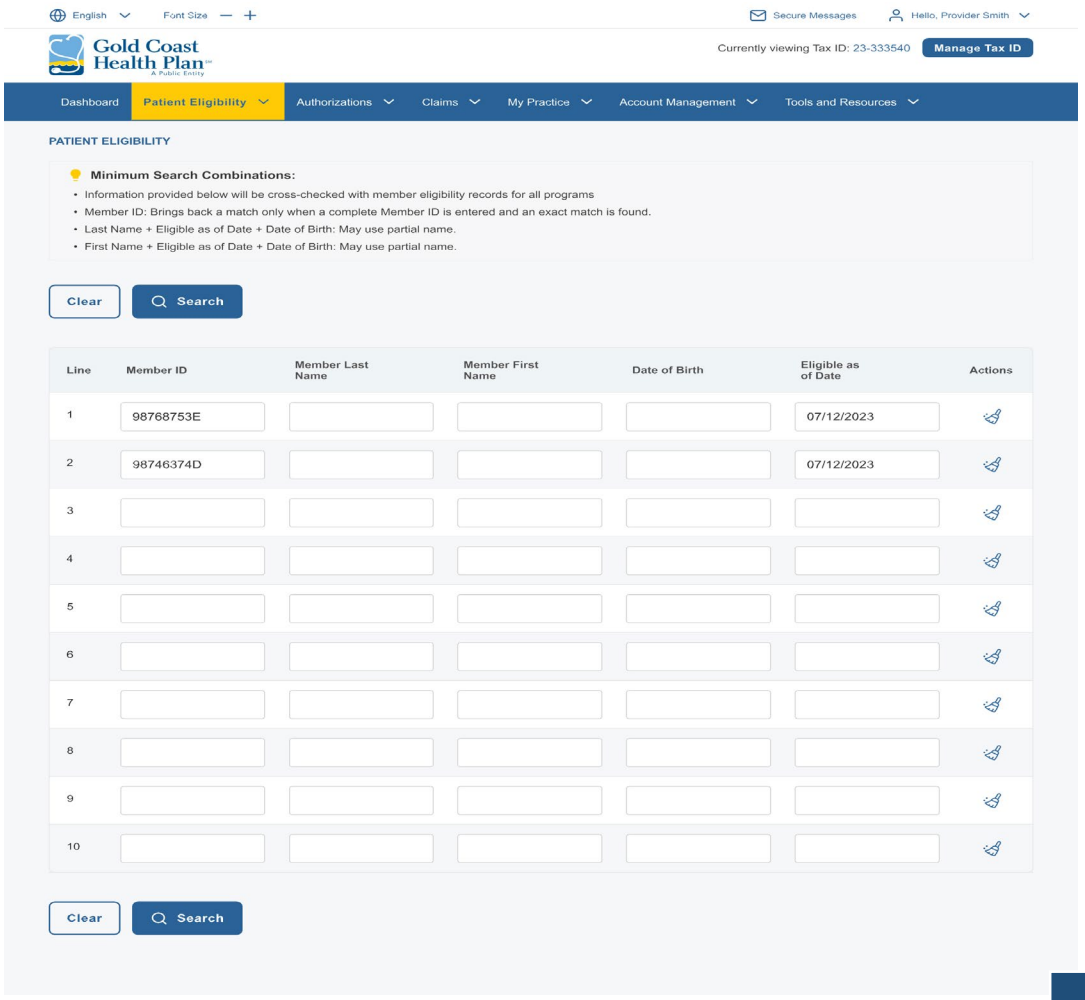

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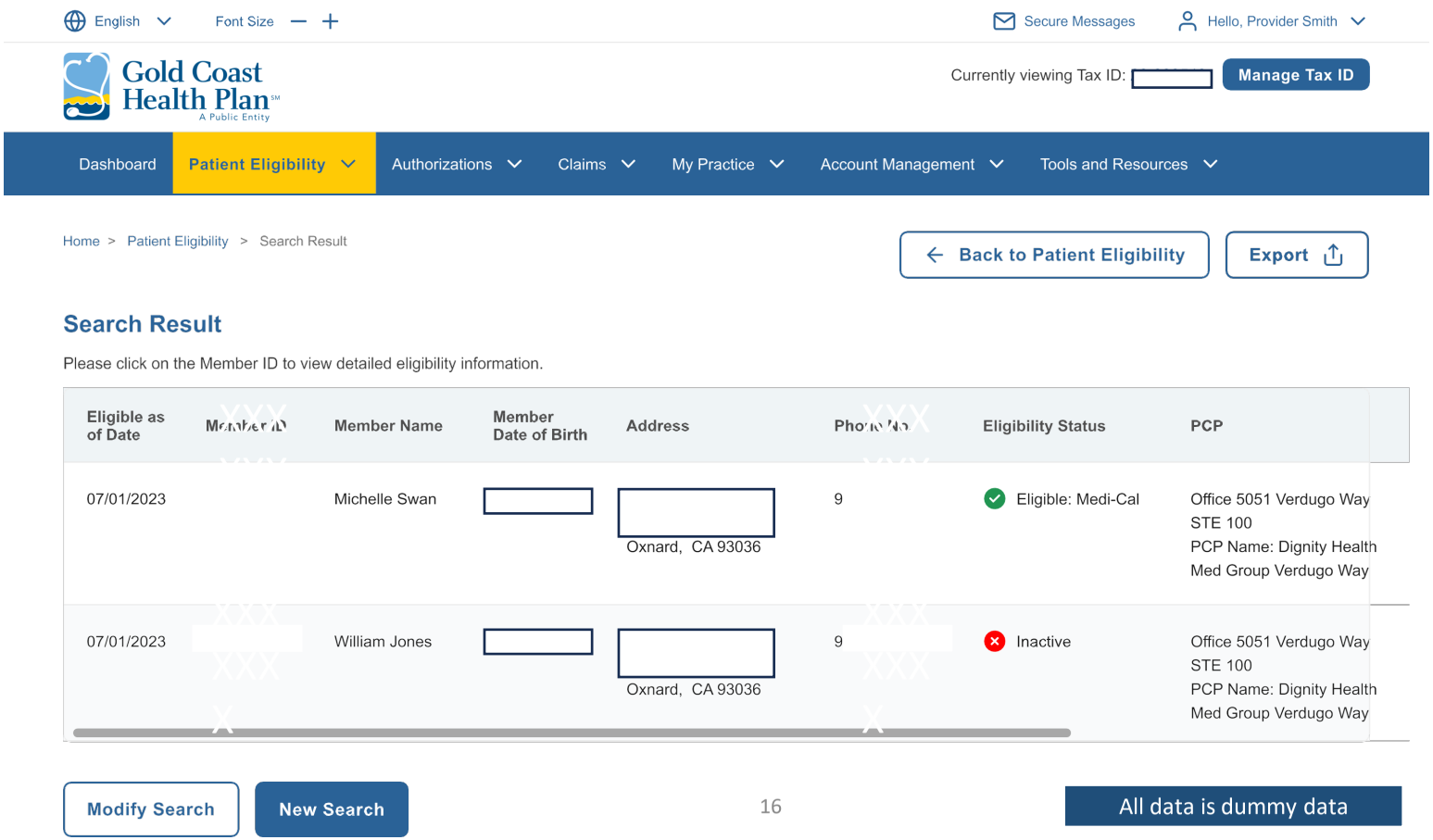

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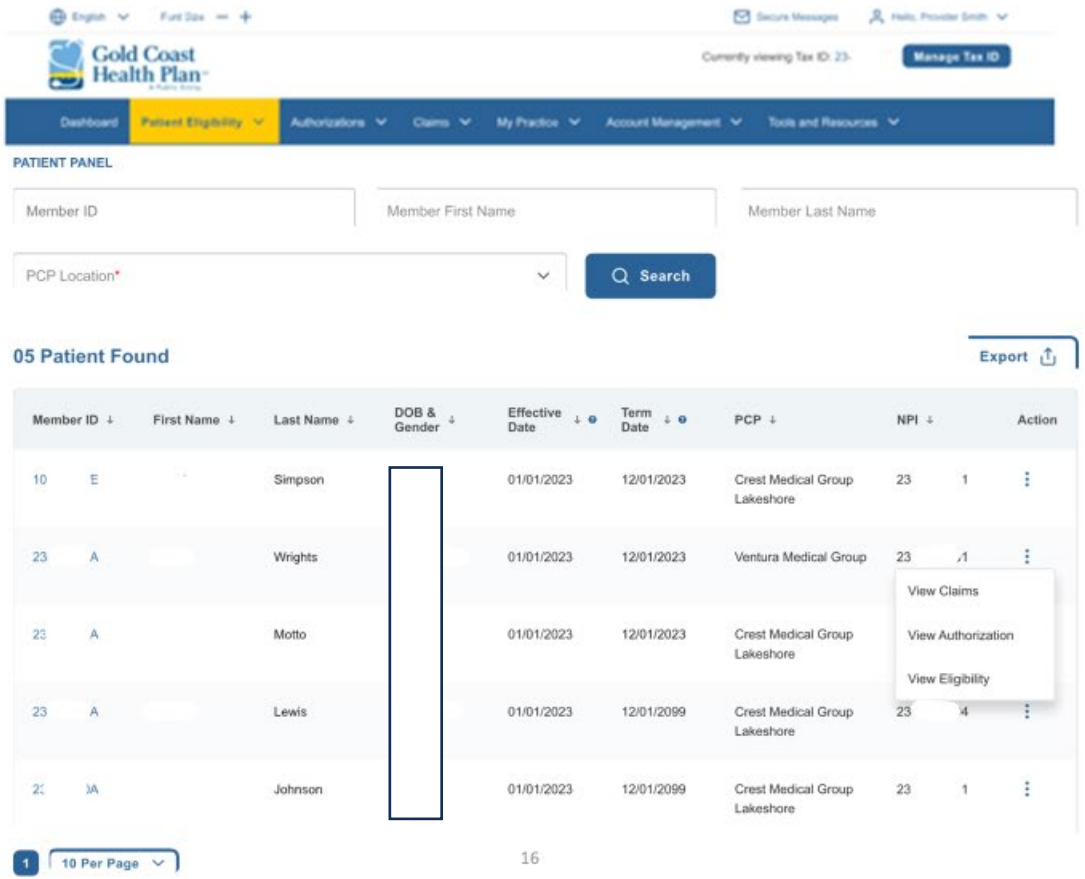

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Core Administration System

Anna Sproule, Executive Director Operations

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CORE ADMINISTRATION SYSTEM OVERVIEW

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- **WHAT IS THE CORE ADMIN SYSTEM?**
  - Central point technology for claims processing, provider payments, and member eligibility. Also, the data stem of claims, payments, and eligibility data interfacing that occurs withing large complex array of other systems that GCHP uses for care, quality, service, and other major functions of health plan administration.
- **THE PRIMARY GOAL OF PROCUREMENT PROCESS FOR CORE ADMIN SYSTEM:**
  - Evaluate GCHP current and future needs for core admin system/technology (Medi-Cal and D-SNP Medicare) against the rapidly advancing and value-driven market that provides systems and services to the nationwide health plan industry.
- **SYSTEM SELECTED:** HEALTHEDGE
  - On the bases of capabilities, performance, industry reputation, and cost/value, among other factors, Health Edge was selected as the core admin system vendor of the future. This will propel GCHP to best-in-class capabilities. GCHP negotiated a high-value, performance-based contract that will provide state of the art capabilities at a cost that is both lower than current and lower than the next-best bidder.
  - The Core Admin System, supported by our BPO partner Netmark using HealthEdge, is integral to processing claims and eligibility, underscoring the inseparability of the system and the service. Netmark will be formally introduced at an upcoming Commission meeting.

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OOTF OPERATIONS LEGACY STATE

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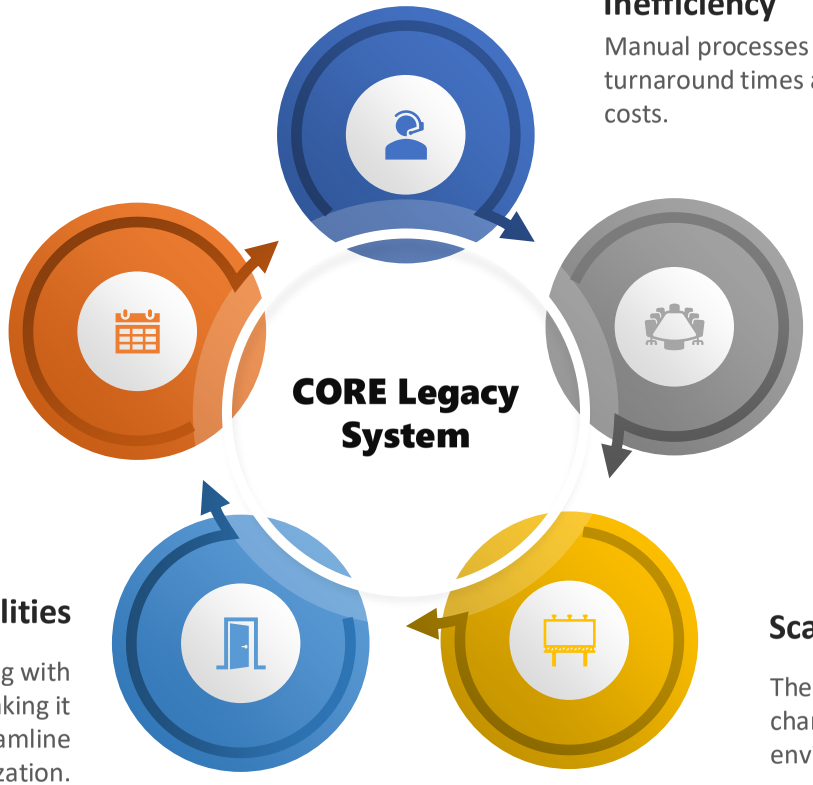

Inefficiency

Manual processes lead to slow turnaround times and high labor costs.

Lack of Insights

Limited data analytics delay process optimization.

Inaccuracy

Errors in data entry and processing result in claim rejections and disputes.

Limited Capabilities

Limited capabilities for integrating with other systems and technologies, making it difficult to share data and streamline processes across the organization.

Scalability

The system struggles accommodate changes to the CA regulatory environment (i.e. CALAIM).

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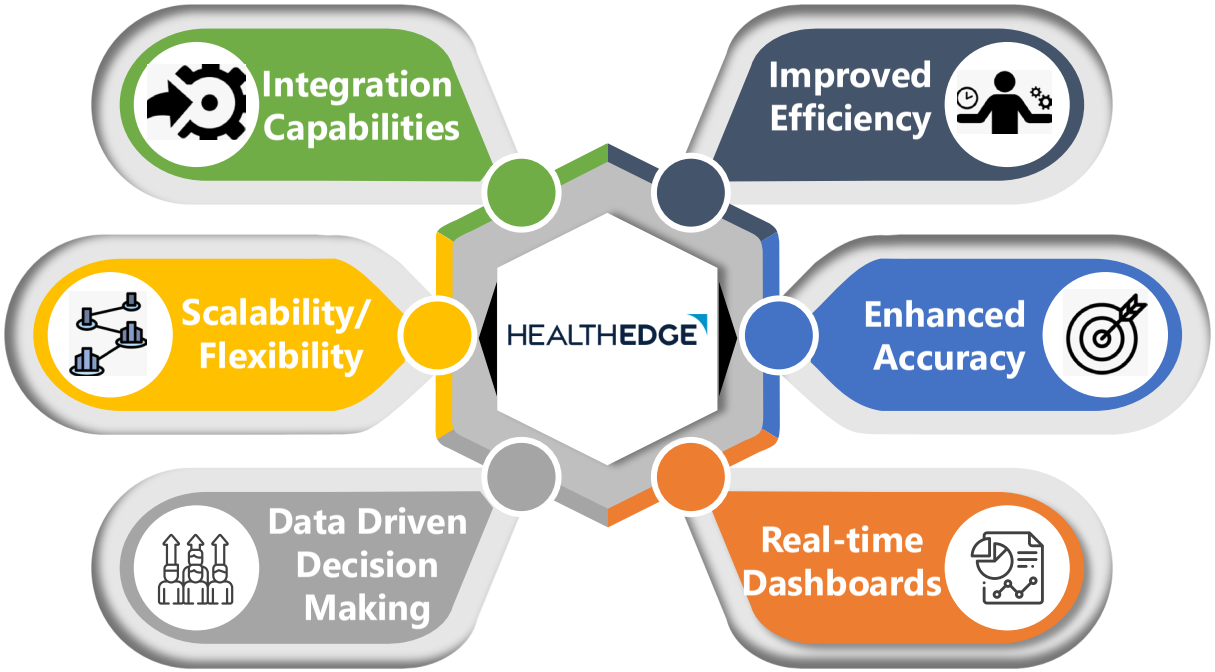
OOTF OPERATIONS FUTURE STATE



- HealthEdge will support the claims turnaround that our providers are accustomed to.
- Over time, HealthEdge will support a much higher auto-adjudication rate than the 60-70% that has been typical with the current core administration system. Our aim is to achieve 90% over time, which will mean accurate and timely claims, at a lower per-claim cost than ever before.

What is next?

- In June, GCHP Management will present an in-depth review of the new Care/Medical Management System and provide a final pre-Go-Live Operational Readiness assessment.
- We extend our gratitude to our incredible vendor partners:
  - HealthEdge (Core Admin System)
  - Edifics (Electronic Data Interchange)
  - KP (Print Fulfillment)
  - Netmark (Claims and Eligibility Processing)
  - NTT (Provider Portal)
  - Salesforce/Silverline (Customer Relationship Management)
  - Zyter/TruCare (Care/Medical Management System)—

…and to the outstanding GCHP Team whose dedicated efforts are bringing the Operations of the Future to life.

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AGENDA ITEM NO. 3

TO: Provider Advisory Committee

FROM: Rob Davenport, PHM Manager of Wellness and Prevention

DATE: June 11, 2024

SUBJECT: Wellth Presentation

PowerPoint with Verbal Presentation

ATTACHMENTS:

Wellth Program

wellth

Wellth & Gold Coast Health Plan

Provider Advisory Committee

June 11, 2024

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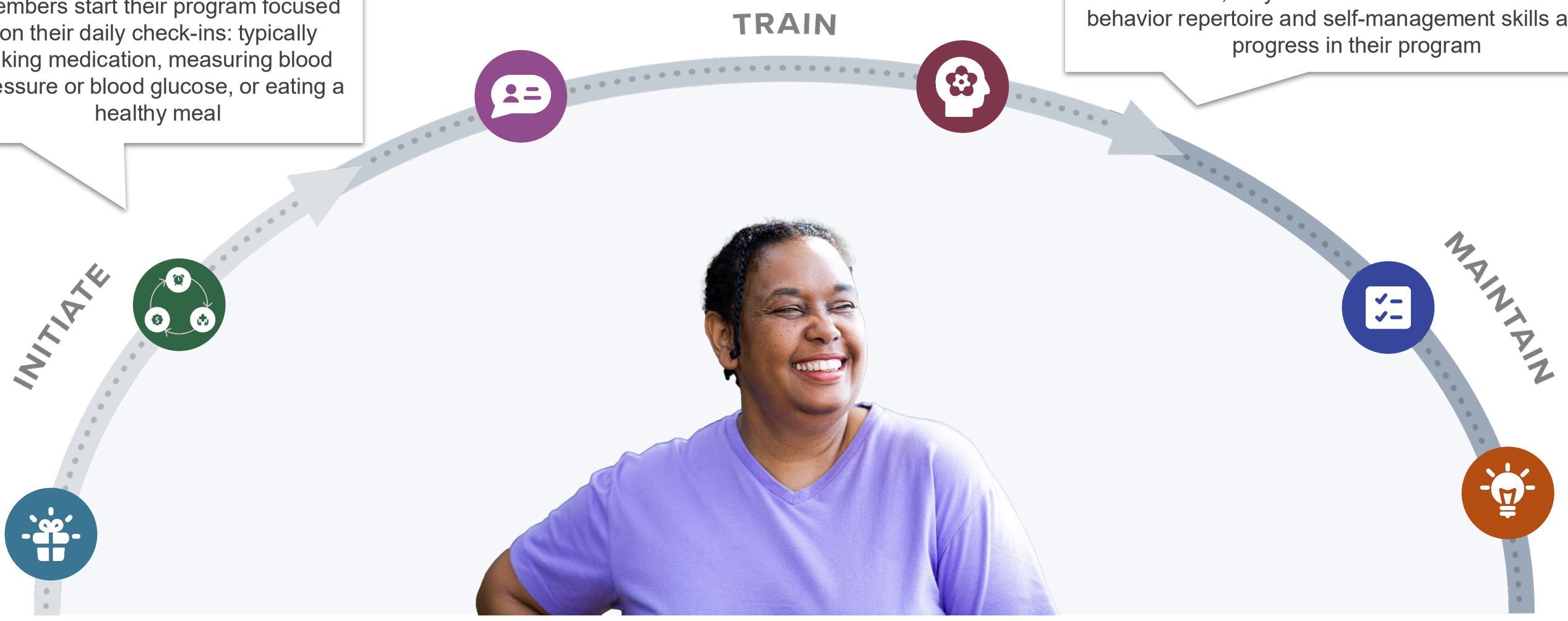
Program Overview: Member

Members start their program focused on their daily check-ins: typically taking medication, measuring blood pressure or blood glucose, or eating a healthy meal

Once Members have shown mastery of their daily check-ins, they broaden and build their healthy behavior repertoire and self-management skills as they progress in their program



Extrinsically motivated
High degree of effort
Elevated anxiety
Low Engagement
Start / Month 1

Intrinsically motivated
Increased automaticity
Confident actions
High Engagement
Months 12-24+

Wellth's behavioral training platform leverages a **3-phase approach** to help increasingly engage Members in their care plan **every single day**.

wellth

Gold Coast Health Plan and Wellth Program Overview

86% Daily Engagement

Phase 1

Utilization Reduction Program

Enrollment Period

Sept ’23 – Nov ‘23

Activated Members

1,504

Initial activation goal: 1,500

Eligibility Criteria

Medicaid members with physical and behavioral health conditions at risk for high-cost utilization

Program Goals

Primary Objective:

- Reductions in Avoidable High-Cost Utilization & Cost
- Care Gap Closures*

Secondary Objectives:

- Improvements to Medication Adherence (PDC)
- Member Satisfaction (NPS > +50)

*Moved from secondary to primary objective based on updated GCHP goals

87% Daily Engagement

Phases 2 & 3

Quality Improvement Program

Enrollment Period

Dec ’23 – present

Activated Members

4,959

Initial activation goal: 5,000

Eligibility Criteria

Medicaid members with at least one open MCAS care gap

Program Goals

Primary Objectives:

- Cervical Cancer Screening compliance
- Breast Cancer Screening compliance
- A1c Control compliance
- BP Control compliance

Secondary Objective:

- Member Satisfaction (NPS > +50)

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Executive Summary

The Wellth & Gold Coast Health Plan program continues to see outstanding daily engagement and program retention, translating to significant reductions in high-cost utilization, strong improvements to medication adherence across key drug classes and increased MCAS care gap closures.

PARTICIPATION

Activated Members (Utilization: 1,504 | QI: 4,959) **6,463**	Daily Engagement/Action Rate **86%**
Program Retention **91%**	Members with 3+ Chronic Conditions **76%**

OUTCOMES (6 MONTHS POST-ENROLLMENT)

Reduction in Inpatient Days Utilization PMPM **57%**	Reduction in Readmission Days Utilization PMPM **47%**
Improvement to Adherence (PDC) for Diabetes Medications **18%**	BCS Care Gap Closure vs Not Enrolled “Control” Group **19%**

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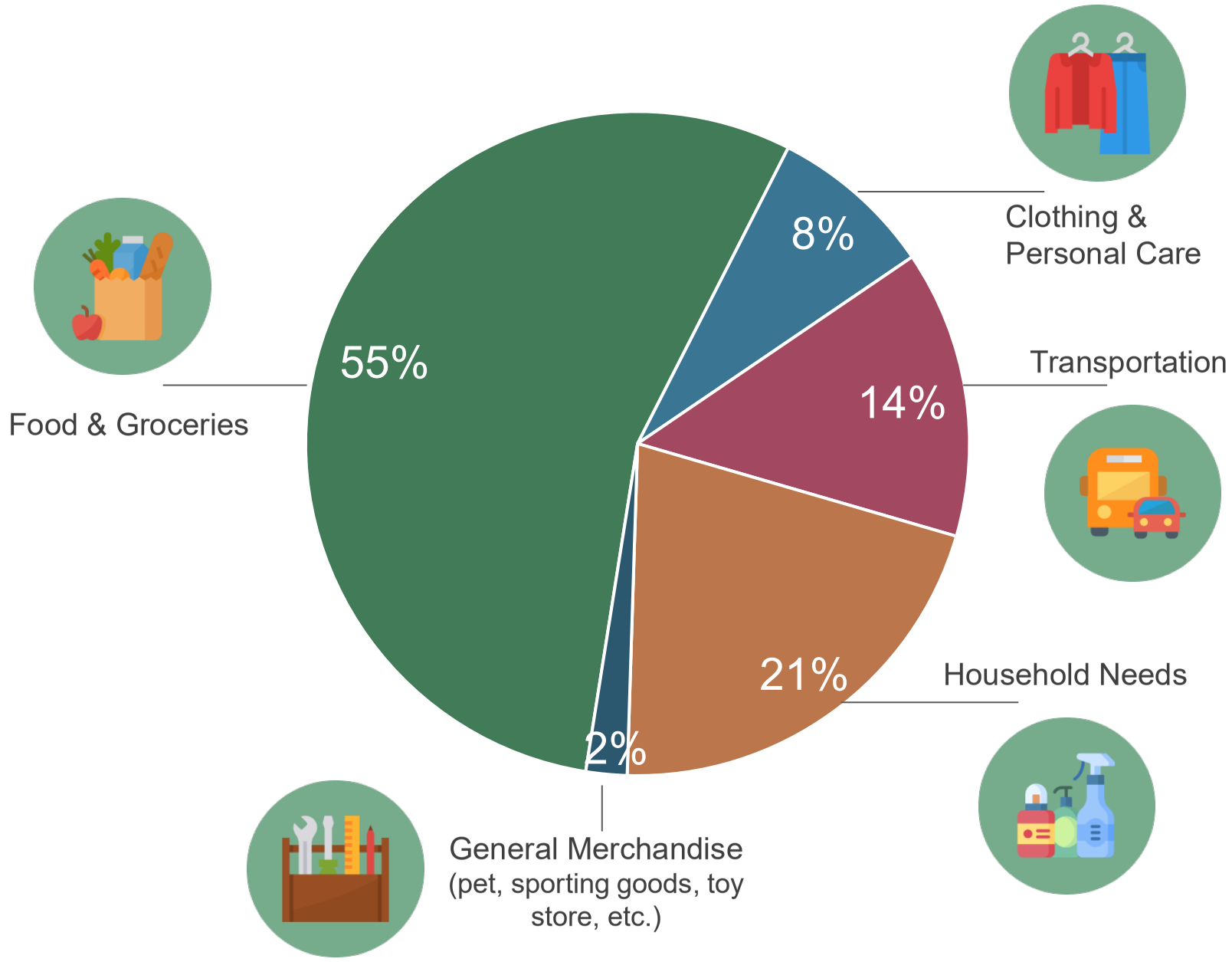
Spending Rewards

Over $499k in rewards has been reinvested in Gold Coast members and local communities.

Members use their rewards to address SDOH needs.

How Gold Coast Members Spend Their Wellth Rewards



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wellth

https://vimeo.com/914920250/35526191df

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> “
>
> **Thank you for Wellth, Gold Coast! Wellth has been great at reminding me to take my medications, and the rewards have helped buy toiletries and other necessities that food vouchers don’t buy.**
>
> **- Diane**

> “
>
> **I want to thank Wellth for the support. The rewards given help me with things I need like food and gas to travel to doctors’ appointments. Thank you, it is very much needed.**
>
> **- Deanna**

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Phase 4 Wellth Program Implementation

- If GCHP were to open up referrals to providers, what target population would you include?

- What would be the easiest way for you to make a referral to the program?

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For more information about the Wellth Program

wellth

Wellth Talking Points and FAQs for Gold Coast Health Plan

Talking Points

- Gold Coast Health Plan has partnered with Wellth to offer a new health and wellness program in which members can earn up to $500 for participating in daily healthy check-ins.
- The Wellth Rewards App is an easy and rewarding way to help you stay healthy. The program provides you with daily reminders to follow your care plan and all you have to do is check in every day through the Wellth Rewards App.
- The Wellth Rewards program also gives you access to the Wellth support team to help keep you motivated and stay on track with your care plan.
- There's no cost to participate. It only takes a few seconds, it's fun, and you earn rewards!

FAQs

What is Wellth?

- Wellth is a benefit available to members with non-compliance in at least one MCAS quality measure or are a high utilizer of inpatient and/or emergency services or have a history of non-adherence to prescribed medications. Wellth uses the science of behavioral economics to help members develop and maintain healthy habits. Members can earn up to $500 annually by completing daily healthy check-ins based on their care plan.
- Members will check in on the app daily to keep their rewards by taking a photo of their healthy tasks. These tasks include glucometer readings, blood pressure readings, healthy meals, and medication check-ins. If a member misses a required check-in, they will lose $2 of their rewards that day.
- Each member will have a personalized routine configured during onboarding with a live Wellth agent over the phone. Members will receive daily reminders to complete their check-ins to help with program adherence. Throughout the member journey, the program will include in-app messages to provide encouragement and celebrate successes, improve health literacy, support closure of care gaps and promote autonomy around managing health conditions.
- Members will have access to a live Wellth support team member who can navigate them through self-management support, care coordination, and provide health education as needed.

How are members made aware of Wellth?

Eligible members will receive informational materials about the program through mail, email, phone calls, and SMS. Wellth will be calling eligible members to invite them to sign up. These members qualify for the program based on a variety of factors including but not limited to frequent utilization of high cost services (i.e. inpatient/emergency department), non-adherence to prescribed medications, and non-compliance with recommended preventative services and/or screenings.

wellth

Wellth Program Overview

WHAT IS WELLTH?

Wellth is a digital health behavior change company that motivates adherence to prescribed treatment plans by using incentives through the science of behavioral economics. Members access the Wellth program through an enjoyable and intuitive mobile app experience where they receive daily check-ins and rewards for care plan adherence.

HOW DOES WELLTH WORK?

Wellth develops lasting habits through a reminder, behavior, reward mechanism. Members begin their Wellth program with a rewards balance. To keep their rewards, members complete a daily "check-in" by taking a photo of their care plan behaviors via the Wellth app. If a member forgets to check in, they lose $2 in rewards. Members collect their balance payouts through a Wellth limited incentive rewards card.

WHAT ARE THE BENEFITS OF THIS PROGRAM?

- Improve care plan adherence
- Improve health outcomes
- Build lasting, long-term habits
- Reduce risk and lower cost of care
- Improve member engagement and experience
- Provide insights to care teams

WHAT IS THE SCOPE OF THIS PROGRAM?

Gold Coast Health Plan is partnering with Wellth to offer a 12-month medication adherence program. Eligible members can earn up to $400 by checking in with the Wellth app every day and taking a photo of their medication, with the option of including tasks for remote monitoring devices or healthy meals. The program will launch September 12, 2023.

Wellth Program Eligibility Criteria:

- Medicaid coverage
- 18 years or older
- Have a history of non-adherence to prescribed medications
- Have a smartphone
- Speak English or Spanish

QUESTIONS?

For more info about Wellth: www.wellthapp.com

Listen in to the 6/24 GCHP Commission Meeting and/or
Contact eslack@goldchp.org for more information!

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wellth

AGENDA ITEM NO. 4

TO: Provider Advisory Committee (PAC)

FROM: Sara Dersch, Chief Financial Officer

DATE: June 11, 2024

SUBJECT: Fiscal Year 2024-2025 Draft Budget Presentation

PowerPoint with Verbal Presentation

ATTACHMENTS:

Fiscal Year 2024-2025 Draft Budget Presentation

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Integrity
Accountability
Collaboration
Trust
Respect

Fiscal Year 2024-25 Draft Budget

June 11, 2024

Nick Liguori, Chief Executive Officer
Sara Dersch, Chief Financial Officer
Eve Gelb, Chief Innovation Officer

Budget Objectives and Risks

- Medi-Cal is now in the **Post-Public Health Emergency** era where the focus must be on managing care and costs to ensure viability in a "slim" Medicaid margin/premium paradigm. "Normal course" financial planning for community-based health plans operating in Medi-Cal assumes ~2% "margin." Medi-Cal premiums have historically been developed with a ~2% margin component.

- GCHP is committed to substantially funding/investing in quality improvement within the Ventura County Medi-Cal Delivery System (healthcare and social services/supports) through both the use of health plan premium revenue and a portion of reserves.

- The GCHP FY 2024-25 Budget is founded on the principal that we must plan medical/member benefit funding at levels adequate to meet the imperative to get and keep our members in Quality Care with a high Satisfaction rate. This is our *Mission*.

- The financial health and viability of GCHP over the long term depends on sustained high performance in Quality (through the Managed Care Accountability Set - MCAS) and Member Satisfaction (through the Consumer Assessment of Healthcare Providers and Systems - CAHPS). This is our *Imperative* – to change and continuously improve GCHP and the Delivery System in order to deliver sustained high Quality and high Satisfaction.

- As FY 2024-25 Budget funds – *medical benefits and the Quality Funding Program* – are projected to exceed revenue, the planned financial outcome is a "spend down" of reserves.

- The new margin paradigm requires effective management of the underlying business to ensure the sustainability of our system investments. Risks of not effectively managing costs become magnified in a planned reserve "spend down" budget.

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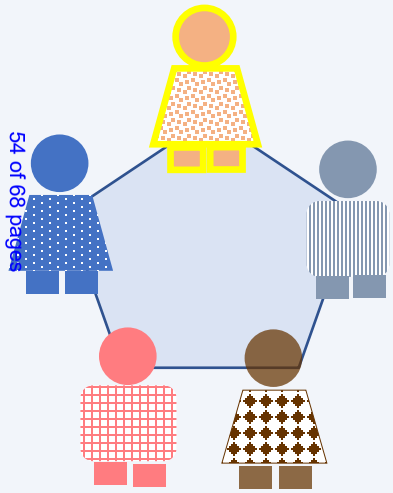
GCHP Model of Care

Advanced data capabilities to identify populations for focused health and quality interventions

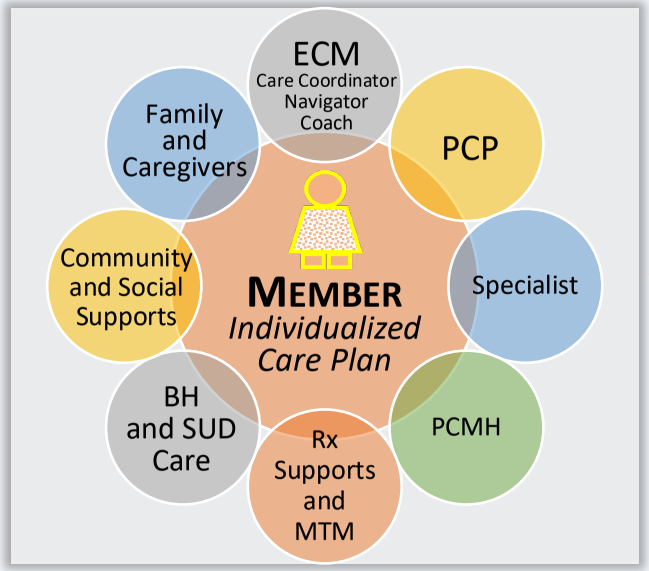
An Integrated Care Team Model that applies individualized member management/support on a population scale



Programs for chronic conditions

Member Incentives

Value Based Payment and Performance and Provider Incentives



Member Services – call center and field-based

Member Engagement

Operational capabilities to track costs and quality

Advanced capabilities to improve quality and satisfaction while controlling costs (VALUE)

GCHP Platform

People, Process and Technologies

Provider Partnerships

Oversight

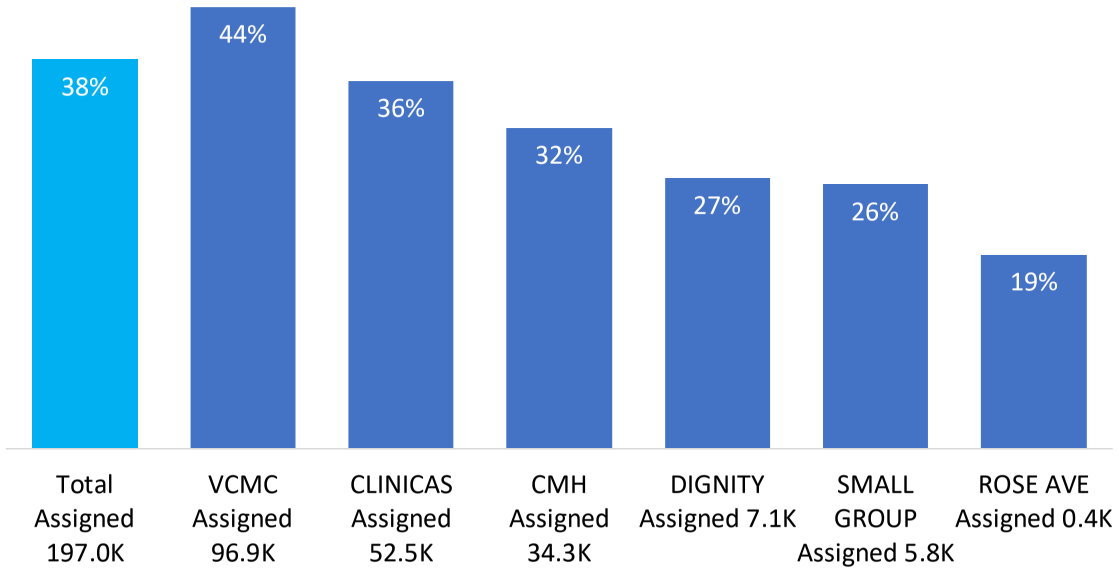
Member-centered health plan operations to improve member experience and engagement

Return to Agenda

Analysis Drives Model of Care Effectiveness

Our Model of Care is being built to get/keep people in regular engagement with their PCP (and specialists and behavioral healthcare providers). As of April 2024, 38% of members with PCP assigned did not have a PCP visit in the last 12 months. A Model of Care that is effective at care/cost/quality management aims for <10%.

% with PCP Assigned but no PCP Visit Last 12 Months, as of Apr24



PCP visits within 12 months are based on HEDIS metrics and HEDIS reporting period for the latest file. For example, 3/1/2024 members' PCP visits are determined using the 2/15/2024 file based on claims between 11/15/2022 and 11/14/2023.

Source: Membership Metrics Report accessed 4/30/2024

Our Model of Care is designed to Connect Members with Care that helps them manage the complex chronic physical and mental health conditions that impact their lives.

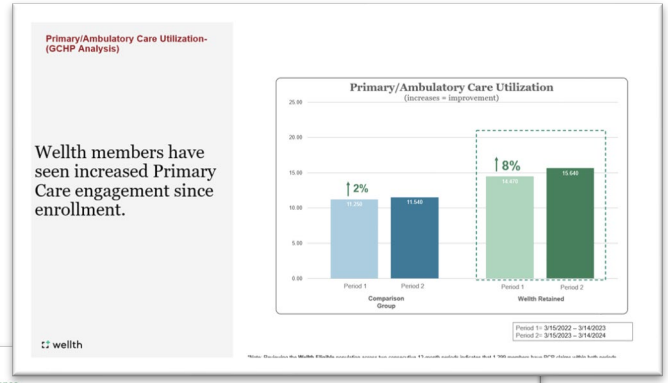
Top 25 EDC's Based On Filters

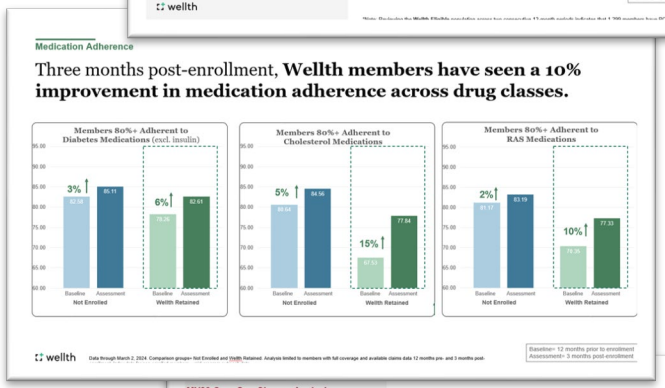
EDC	# Of Subscriber IDs Active	% Of Total
Hypertension	28,913	11.59%
Disorders of lipid metabolism	28,193	11.30%
Anxiety, neuroses	20,061	8.04%
Type 2 diabetes	17,181	6.88%
Obesity	16,132	6.46%
Asthma, w/o status asthmaticus	9,966	3.99%
Major depression	9,440	3.78%
Degenerative joint disease	9,316	3.73%
Depression	8,730	3.50%
Refractive errors	8,391	3.36%
Developmental disorder	7,145	2.86%
Hypothyroidism	5,952	2.38%
Chronic liver disease	5,705	2.29%
Musculoskeletal disorders, other	5,495	2.20%
Other endocrine disorders	4,770	1.91%
Chronic renal failure	4,619	1.85%
Ischemic heart disease (excluding acute myocardial infarction)	4,578	1.83%
Deafness, hearing loss	4,529	1.81%
Cardiac arrhythmia	4,482	1.80%
Migraines	4,242	1.70%
Autism Spectrum Disorder	3,882	1.56%
Neurologic disorders, other	3,680	1.47%
Substance use	3,546	1.42%
Disorders of the immune system	3,524	1.41%
Benign and unspecified neoplasm	3,514	1.41%
Total	**88,357**	**35.40%**

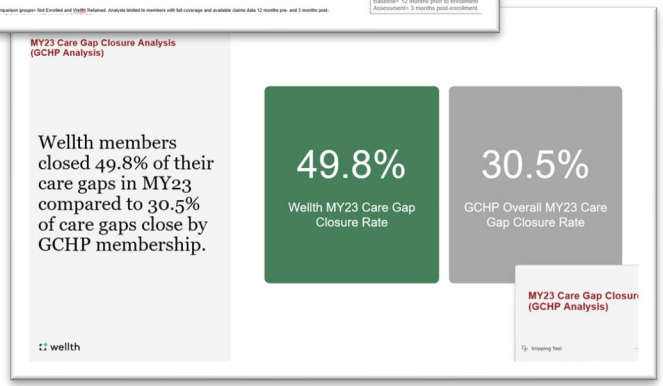
When looking at the top 25 diagnoses (ECD), Hypertension, Metabolic Disorders, Anxiety and Diabetes rank at the top in almost all population cohorts.

Return on Model of Care Investment

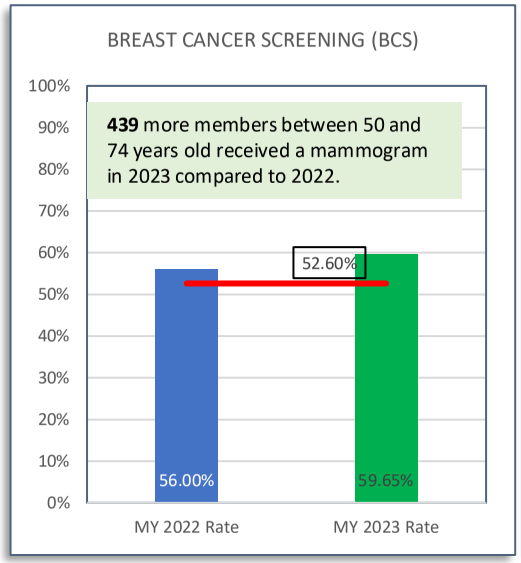
90% engagement with members on the Wellth program and early outcomes including 8% increase in use of primary care, 50% of members closing gaps in care, 10% increase in medication improvement, and early positive results in reduced inpatient utilization

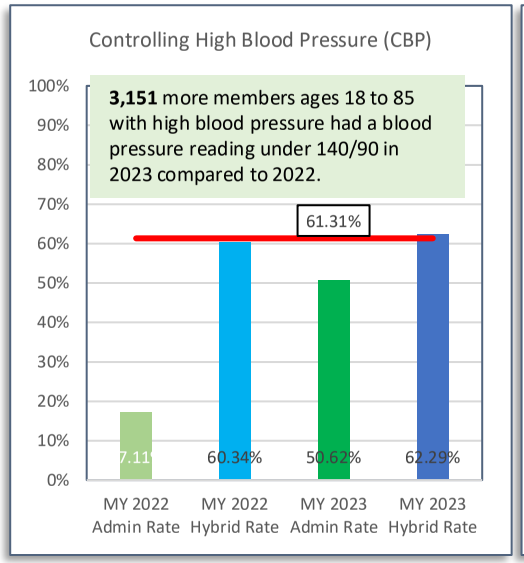


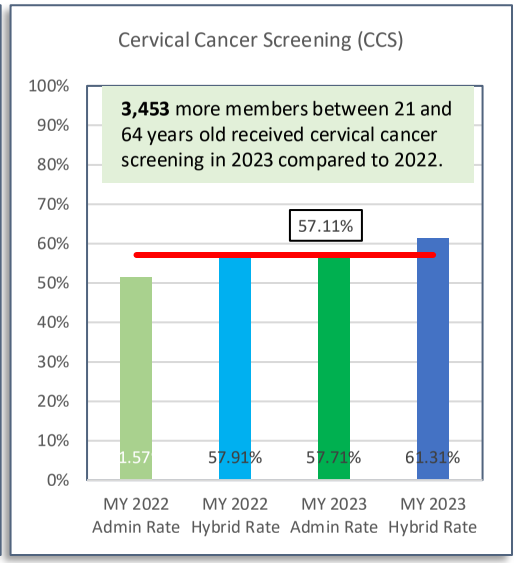


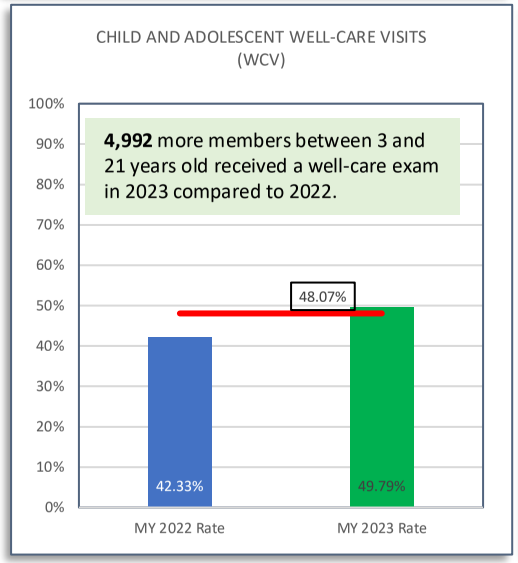


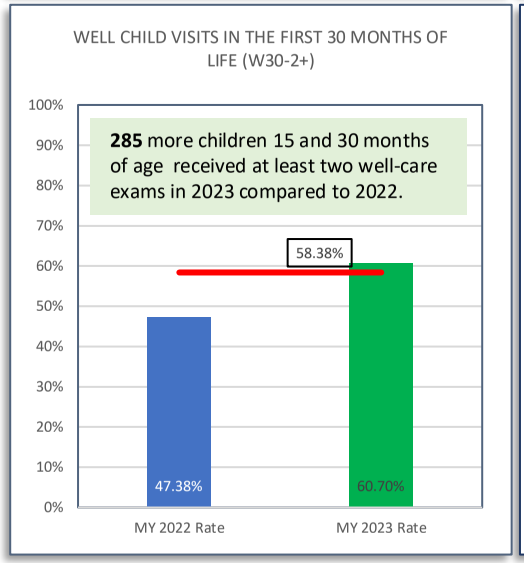
20,000 members participated in the GCHP Member Incentive Program which resulted in 30% reduction in no-show rates, improved MCAS scores and improved provider joy in work and unprecedented improvements in MCAS rates resulting in payout to provider partners of $55M.

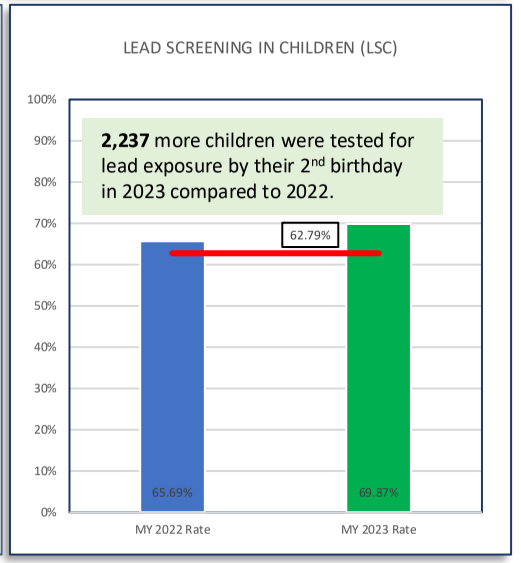






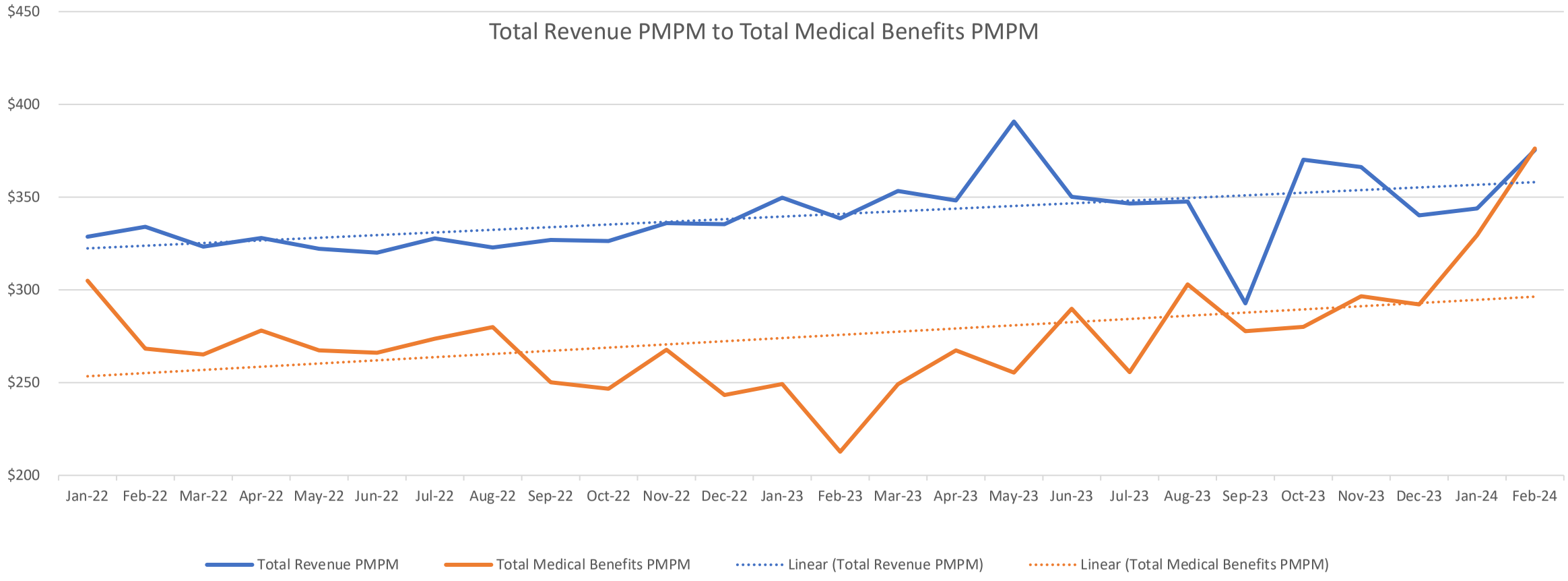






Total Revenue PMPM to Total Medical Benefits PMPM

- Medi-Cal is now in the **Post-PHE Era** where the focus must be on managing care and costs to ensure viability in a "slim" Medicaid margin paradigm. GCHP is committed to substantially funding/investing in the Ventura County Medi-Cal delivery system but must effectively manage the underlying business to ensure the sustainability of this funding. Risks of not effectively managing costs become magnified in a planned reserve "spend down" budget.



Source: GCHP February 2024 YTD Financial Statements

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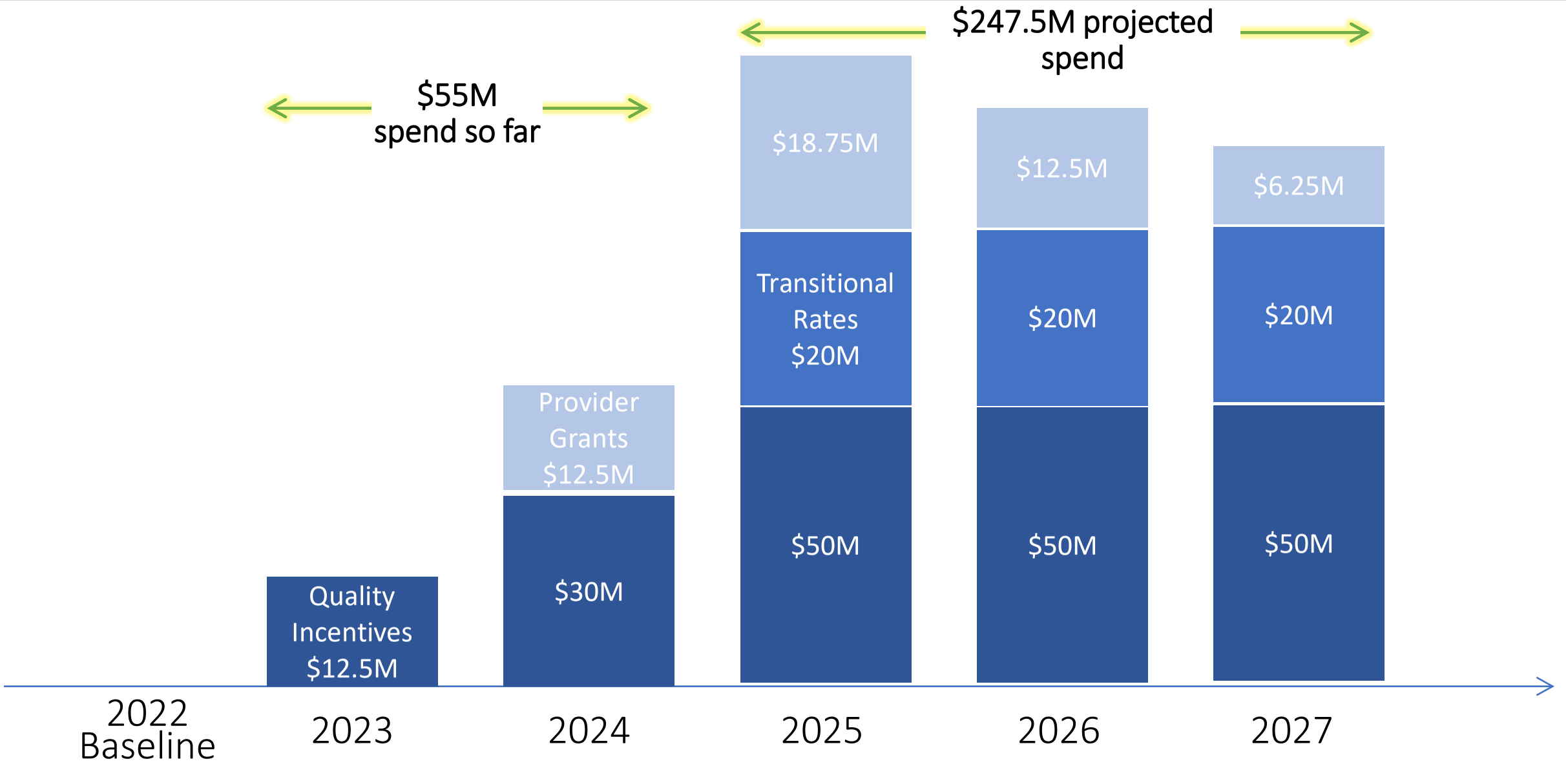
Budget FY 2024-25 | Quality Funding Program



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Budget FY 2024-25 | Quality Funding Program

	PCPs	Specialists	Hospitals	Behavioral Health
Quality	*QIPP - launched 2023. 2024 launch for smaller providers*. Expansion 2024-26, increasing funding and measures impacted.		*HQIPP - will launch 2024.* 2024 focus on data sharing and establishing workflows. 2025-26 adds P4P metrics.	*Incentives launched 2024* Impacts to Follow-Up after ED visit for Mental Health/ Substance Use.
Access	*Value-Based Rates will launch 2024.* Focused on added availability, after hours and weekend availability, telehealth, and culturally sensitive care	*Value-Based Rates will launch 2024*. Focused on added availability, after hours and weekend availability, telehealth, and culturally sensitive care		*Incentives launched 2024* Bonuses for provider expansion, improved rates of referrals leading to visits, and culturally sensitive care.

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Summary of Management's Proposed FY2024/25 Budget

Category	FY2024/25 Budget	Comments
Membership	251,125	Higher-than-expected membership levels are driven by successful redetermination efforts and a newly-eligible population cohort. Membership is now relatively stable and is not expected to change majorly. But membership can change if redetermination disenrollment picks up or Kaiser is expanded as a Medicaid Managed Care Plan by the State.
Premium Revenue	$1.089B	As presented, this reflects essentially flat revenue even though membership is favorable; the changing member "mix" accounts for the minimal revenue increase; premium revenue is $1.073B; an additional $16M in investment income brings total revenue to $1.089B. MCO tax (which is a pass-through from the Federal government to the State) of $303.7M brings total receipts to $1.419B.
Consolidated Medical Benefit Cost *(Ratio)*	$1.004B *92.2%*	Prior to the $82.5M Quality Funding Programs, the underlying MBR is 85%.
Administrative Expense *(Ratio)*	$109.3M *10.0%*	We are staying consistent with current administrative expense run-rate year over year; while the FY2023/24 focus was on infrastructure needed to transform the organization, the focus of FY2024/25 will be on quality programming and care delivery innovation. Continuing Operations of the Future budget of $4.0M included in Administrative Expense.
Reserve Increase/(Decrease)	$(23.9M)	Net income prior to the Quality Funding Programs is $58.6M, or 5.4% of total revenue (premium revenue plus investment income).

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Financial Schedules

Draft financial schedules have been made available in a pdf packet sent in conjunction with this PowerPoint presentation. Please reference those schedules during the discussion of the budget financial details.

Schedule	Description
Schedule 1	Medical Margin Budget: Category of Service *Line-item detail of medical costs on a per member/per month basis sorted by type and categorized by dates (July through December 2024, January through June 2025) coinciding with premium rates.*
Schedule 2	Medical Margin Budget: PMPM Cost by Aid Category *Line-item detail of medical costs sorted by on a per member/per month basis and categorized by demographic grouping ("cohort").*
Schedule 3	Medical Margin Budget *Line-item detail of premium revenue and medical cost components reported in whole dollars.*
Schedule 4	General and Administrative Expenses *Line-item detail of total administrative expenses.*

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AGENDA ITEM NO. 5

TO: Provider Advisory Committee (PAC)

FROM: Scott Campbell, General Counsel

DATE: June 11, 2024

SUBJECT: Creation of an Ad Hoc Subcommittee for the Nomination of a Chairperson and Vice-Chairperson to Serve on the Ventura County Medi-Cal Managed Care Commission's Provider Advisory Committee

SUMMARY:

Pursuant to the Charter of the Ventura County Medi-Cal Managed Care Commission's ("Commission") Provider Advisory Committee ("PAC"), a nomination ad hoc subcommittee must be created for the nomination of a Chairperson and Vice-Chairperson of the PAC. Accordingly, staff recommends the PAC establish a nomination ad hoc subcommittee to commence the selection process of the Chairperson and Vice-Chairperson of the PAC.

BACKGROUND/DISCUSSION:

Pursuant to its bylaws, the Commission shall establish a Provider Advisory Committee ("PAC") Pursuant to the PAC's Charter, which is attached, the PAC's purpose includes providing feedback and recommendations on the Commission's membership needs with a focus Model of Care and enhancing access to care and the relationships and interactions between providers and the Plan to enhance member care. The Commission may utilize information gained from the PAC to make recommendations or address issues brought forth by the Committee.

The PAC consists of thirteen (13) providers or practitioners. Each appointed member can serve up to three (3) two-year terms and individuals can apply for reappointment if they haven't met their term limits. Two of the PAC's thirteen members shall serve as Chairperson and Vice-Chairperson. The Chairperson and Vice-Chairperson may serve one-year terms with two term extensions, or a total of three years in each position. As the PAC membership has been selected, it is time to select a Chair and Vice-Chair.

Pursuant to the PAC's Charter, a nomination ad hoc subcommittee must be created for the nomination of a Chairperson and Vice-Chairperson of the PAC. Accordingly, staff recommends the PAC establish a nomination ad hoc subcommittee to commence the selection process of the Chairperson and Vice-Chairperson of the PAC.

To establish a nomination ad hoc subcommittee, the PAC shall select three to four PAC members to serve on the ad hoc subcommittee. PAC members who are being considered for reappointment of Chair or Vice-Chair should not participate in the nomination of the ad hoc subcommittee and should not serve on the ad hoc committee. It is suggested that Committee members interested in serving as Chair and Vice-Chair do not serve on the ad hoc committee. The ad hoc committee shall meet and make a recommendation for Chair and Vice-Chair and the PAC shall determine who to recommend to the Commission for Chair and Vice-Chair. The Commission votes on the appointments of Chair and Vice-Chair.

FISCAL IMPACT:

None.

RECOMMENDATION:

Staff recommends the PAC establish a nomination ad hoc subcommittee to commence the selection process of the Chairperson and Vice-Chairperson of the PAC.

CONCURRENCE:

N/A.

ATTACHMENT:

Committee Charter: Provider Advisory Committee (PAC)

Committee Charter:
Provider Advisory Committee

Committee Purpose

Pursuant to the Bylaws, the Ventura County Medi-Cal Managed Care Commission (VCMMC) enabling ordinance 4409 (April 2010) shall establish a Provider Advisory Committee (PAC) whose members can provide expertise relative to their respective specialties. The PAC, at a minimum, will meet quarterly and make recommendations, review policies and programs, explore issues and discuss how GCHP may best fulfill its mission. The PAC offers a forum for Providers and Practitioners to provide input and advice to Gold Coast Health Plan leadership. leadership.

The PAC's mission is to provide feedback and recommendations on GCHP's membership needs, Model of Care, understand programmatic changes (regulatory, business, current and anticipated) and the managed care industry (local, state and national), and research by the health plan focusing on enhancing access to care and the relationships and interactions between Providers and GCHP to enhance member care. These issues include improving health care, and clinical quality, and improving communications, relations, and cooperation between Providers and GCHP. GCHP leadership may utilize information gained from the PAC to make recommendations or address issues brought forth by the Commission.

Responsibilities

The following responsibilities shall serve as a guide, with the understanding that the PAC may carry out additional functions as may be appropriate considering a changing business landscape, regulatory, legal, and/or other conditions. The PAC shall also carry out any other responsibilities delegated to it by the Commission from time to time.

1. Address clinical and administrative topics that affect interactions between Providers and GCHP.
2. Discuss local, state, and national issues related to enhancing member care.
3. Provide input on health care services of GCHP.
4. Provide input on the program design and structures of the provider Quality incentives, Grant programs, and value-based payments to improve access to care for members and quality measures.
5. Provide input on GCHP's Model of Care design and structures of member incentives and healthcare programs aimed at increasing member engagement in health/wellness, healthcare, and adherence to treatment.
6. Provide input on GCHP membership to better understand their needs, barriers, and priorities.

7. Provide input on the coordination of services between networks of GCHP.
8. Improve communications, relations, and cooperation between Providers and GCHP.
9. Provide expertise to GCHP relative to a PAC member's area of practice.
10. Provide feedback on Quality Improvement Health Equity Workplan
11. GCHP budget review updates.
12. Changes to programs that impact Providers, such as Health Education, contracting, DHCS guidance, etc.
13. Benefit changes and interpretation.
14. The Chair and Vice Chair will present to the Commission at least on an annual basis.

Meetings

Regular meetings of the PAC shall be scheduled quarterly. Additional special (ad hoc) meetings, or meeting cancellations, may occur as circumstances dictate. Special meetings may be held at any time and place as may be designated by the Chair, or a majority of the members of the PAC. PAC meeting dates are scheduled one (1) year in advance.

Members

The VCMMC determined the PAC would consist of thirteen (13) GCHP Providers or Practitioners members with one dedicated seat representing the Ventura County Health Care Agency (VCHCA). Each of the appointed members would serve a two-year term, serve up to three terms and individuals could apply for re-appointment if they haven't met their term limits. The thirteen voting members would represent various professional disciplines and/or constituencies, which include: allied health services, durable medical equipment, pharmacies, community clinics, hospitals, long-term care, non-physician medical practitioners, nurses, physician, and traditional / safety net, transportation, behavioral health, and community-based organizations.

The Chief Policy and Program Office and the Executive Director, Strategy and External Affairs will serve as the Principal Executive Sponsors for the PAC. In addition, the following GCHP staff will be available at each meeting or may include a designee on a limited as-needed basis:

1. Chief Executive Officer (CEO)
2. Chief Diversity Officer
3. Chief Medical Officer (CMO)
4. Chief Financial Officer (CFO)
5. Chief Compliance Officer
6. Chief Program and Policy Officer

7. Chief Information and System Modernization Officer
8. Chief Innovation Officer
9. Chief Human Resources and Organizational Performance Officer
10. Senior Director of Network Operations/Provider Relations
11. Executive Director, Strategy and External Affairs,

Membership Chair and Vice Chair Selection Process

1. Nomination Process
    a. To establish a nomination ad hoc subcommittee, the PAC chairperson or vice-chair shall ask three to four members to serve on the ad hoc subcommittee. PAC members who are being considered for reappointment, cannot participate in the nomination ad hoc subcommittee.
2. Prior to the PAC nomination ad hoc subcommittee meeting: At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.
3. The PAC nomination ad hoc subcommittee shall:
        i. Review, evaluate and select a prospective chairperson, vice-chair, and a candidate for each of the open seats.
        ii. The ad hoc subcommittee shall convene to discuss and select a chairperson, vice-chair, and a candidate for each of the expiring seats using the attendance record if relevant, and the prospective candidate's references.

PAC Selection and Approval Process for Chairperson, Vice-Chair, and PAC Candidates

a. On a biannual basis, PAC shall select a Chairperson and Vice-Chair from its membership to coincide with the biannual recruitment and nomination process.
        i. The PAC Chairperson and Vice-Chair may serve one-year terms with two term extensions with a vote taken by the PAC members annually.
        ii. The PAC Chairperson or Vice-Chair may be removed by a majority vote from GCHP's Commission.
b. Upon selection of a recommendation for a Chairperson, Vice-Chair and a slate of Candidates, the ad hoc subcommittee shall forward its recommendation to the PAC for consideration.
c. Following consideration, the PACs recommended slate of new Candidates shall be submitted to GCHP Commission for review and final approval.
d. Following GCHP's Commission approval of PAC's recommendation, the new PAC members' terms shall be effective at the next regular meeting.

e. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following PAC meeting.

f. GCHP shall provide new PAC members with a new PAC member orientation including information on past meetings.

Membership Responsibilities

The Chair shall:

1. Preside at all PAC meetings
2. Work with GCHP staff to develop the PAC regular meeting agendas
3. Report at least on annual basis to the Commission
4. Attend PAC meetings on a regular basis and can only have up to three (3) unexcused absences.

The Vice Chair shall:

1. Exercise all the responsibilities of the Chairperson in the absence of the Chairperson
2. In agreement with the Chairperson, perform all responsibilities mutually agreed upon
3. Attend PAC meetings on a regular basis

Membership

1. Attend PAC meetings on a regular basis
2. Give feedback on topics presented by GCHP staff at PAC meetings
3. Serve in ad hoc meetings as determined by the Chair

**

Meeting Procedures

The PAC will meet on a quarterly basis. Meeting dates and times will be specified a year in advance. Meetings of the PAC shall be open and public pursuant to the Ralph M. Brown Act (Gov. Code§ 54950 et seq.)

Voting and Quorum: The thirteen voting PAC Members represent various professional disciplines. The presence of a majority of the PAC Members, shall constitute a quorum.

The PAC may invite other individuals, such as members of management, auditors, or other experts or consultants to attend meetings and provide pertinent information relating to an agenda item, as necessary.

The Clerk of the Board is responsible for notifying members of the dates and times of meetings and preparing a record of the Committee's meetings.