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

Special Meeting
Thursday, May 16, 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: 952 997 635#

Clinicas del Camino Real Inc.
1040 Flynn Rd.
Camarillo, CA 93012

233 Corte Linda
Santa Paula, CA 93060

2220 E. Gonzales Road, Suite 210B
Oxnard CA 93036

Community Memorial Health System
147 N. Brent Street
Ventura, CA 9300

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 April 18, 2024

Staff: Maddie Gutierrez, MMC, Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

FORMAL ACTION

2. March Year to Date Financial Results

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests the Executive Finance Committee approval of the March year-to-date financial results.

3. FY 2024/25 Budget and Three-Year Planning

Staff: Nick Liguori, Chief Executive Officer
Sara Dersch, Chief Financial Officer
Eve Gelb, Chief Innovation Officer
Paul Aguilar, Chief Human Resources & Organizational Performance Officer
Felix Nunez,M.D. Chief Medical Officer
Erik Cho, Chief Policy & Program Officer
Marlen Torres, Executive Director of Strategy & External Affairs

RECOMMENDATION: Staff requests the Commission review information and provide feedback to staff for budgeting and planning purposes.

CLOSED SESSION

4. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

5. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Executive Finance Committee
Unrepresented employee: 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 - Clerk of the Board

DATE: May 16, 2024

SUBJECT: Meeting Minutes for regular meeting minutes of April 18, 2024

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copies of the Executive Finance Committee regular Executive Finance Committee meeting minutes of April 18, 2024.

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

April 18, 2024

CALL TO ORDER

Committee Chair Dee Pupa called the meeting to order at 3:03 p.m. The meeting was held virtually. The Clerk was in the Community Room, 711 E. Daily Drive, Suite 110 Camarillo, California.

ROLL CALL

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

Absent: Commissioner James Corwin

GCHP Executive Team in attendance: CEO Nick Liguori, CHR Paul Aguilar, CPPO Erik Cho, CIO Eve Gelb, CCO Robert Franco, CFO Sara Dersch, CMO Felix Nunez, M.D., CDO Ted Bagley, Exec. Director of Strategy & External Affairs, Marlen Torres, General Counsel, Scott Campbell, and Leeann Habte of BBK.

GCHP Staff In attendance: Susana Enriquez-Euyoque, Kim Timmerman, Vicki Wrighster, Michelle Espinosa, Carolyn Harris, Mayra Hernandez, Stacy Luney, Victoria Warner, Pauline Preciado, Lupe Harrion, and Consultant Amit Jain.

PUBLIC COMMENT

None.

CONSENT

1. Approval of Executive Finance Committee special meeting minutes of February 22, 2024.

Staff: Maddie Gutierrez, MMC, Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

Commissioner Espinosa motioned to approve the minutes as presented. Commissioner Abbas seconded the motion.

AYES: Commissioners Anwar Abbas, Laura Espinosa, and Dee Pupa

NOES: None.

ABSENT: Commissioner James Corwin.

The clerk declared the motion carried.

FORMAL ACTION

Commissioner Pupa stated that Formal Action items 2 and 3 are intertwined, and one vote will be taken once both items are presented.

2. Quality Based Funding and Financial Impact

Staff: Erik Cho, Chief Policy & Programs Officer
Felix Nunez, M.D., Chief Medical Officer
Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests the Committee review information and provide feedback to staff for budgeting and planning purposes.

3. Fiscal Year 2024/2025 Budget Framework and Principles

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests the Executive Finance Committee review information and provide feedback to staff for budgeting and planning purposes.

CEO Nick Liguori stated that our budget must ensure funding for our quality care mission and for providers. He explained the approach of a broader budget planning process. He noted that the medical program is becoming more complex. We are approaching deadlines for DSNP, and operational readiness. The approach this year and going forward is to begin budget engagement sooner and April. Management will be reporting on the baseline information that is being used to draw up plans and our budgets for the next three years. CEO Liguori stated staff will review the PowerPoint presentation with the committee.

CIO Eve Gelb stated we need to focus on quality. We have to improve and lift the quality. We are being held accountable for outcomes. We have a continually changing MCAS as new measures come on. We also have a new population that needs different resources and approaches in order to achieve the outcomes. She noted that the state

and our funders are putting those funds at risk for achieving quality outcomes. The state is getting serious about how they fund, move and drive quality forward.

Chief Financial Officer, Sara Dersch stated that we are trying to find a way to adequately fund our mission. We need to ensure that we have appropriate investment in our capabilities. We ensure that we have investment in our providers to make sure that care is delivered in a timely manner and of the highest quality. We measure that through our member experience, and through quality results.

CFO Dersch stated that we want to make sure the Commission understands the information being presented and that they are in agreement. She stated that she is committed to a budget process that optimizes quality and also transparency. Some of the information is gathered from the industry, and some from our actuarial service provider, Edrington. Some of the information is regulatory information that is coming to use, some is our own data, our own utilization, feedback from our members and feedback from out providers. These are some of the variables that are going to influence the budget build. We are also committed to continued improvement in our budgeting process. Last year the budget process began in May, this year we are starting in April.

Leeann Habte, of BBK stated GCHP is committed to the fullest funding possible to the health care delivery system and the funding program. This commitment is rooted in fundamental principles related to GCHP's responsibility for administration of taxpayer dollars and Medicaid funds. GCHP technologies funding must be adequate for safety net providers to deal with inflationary cost trends. It must provide value in access quality, outcomes to the health plan, the members, as well as to the state and federal regulators who review our programs. Funding must always be compliant with state and federal laws, regulations that define permissible use of funds, but also our corporate integrity agreement (CIA). The CIA is under the oversight of the Office of the Inspector General, which is a high priority. Ms. Habte stated that funding plans have been subject to a comprehensive legal review by BBK. As far as legal, BBK commits to provide the best analysis possible to ensure the maximum amount of funding to the healthcare delivery system.

CFO Dersch reviewed the timeline with the Committee. She noted that mid-May through mid-June there will be one on one meetings scheduled with each of the committee members, while working through feedback. We want to ensure that everyone is comfortable and understands the budget. At the end of June, a complete budget will be presented to the Commission for approval.

CFO Dersch reviewed TNE rankings of other plans in the stated and noted that we are in the middle of the rankings. The rankings are from highest to lowest. Kaiser is at the top with 2300% of required TNE, which is very high. She stated that the TNE use

is a lever that we have to pull and that we are being very strategic about. We are in a good place within the rankings. We are reverting to pre-pandemic and redetermination is back. She noted that there are pressures that existed before the PHE there were put on pause and are now coming back. This is our opportunity to make the most of what we have.

When looking at our budget we need to think about medical costs. The Medical Benefit Ratio (MBR) is the same as the MLR (Medical Loss Ratio). MBR more appropriately describes what we are doing with funding, and what the state expects us to do with this funding. The current MBR trended forward, we are at 85% which does not include the initial phase of the QIPP Program. We are going to add components to our MBR that are going to influence out total budget. We are going to have an expansion of the QIPP program, we have seen good results for this, and we need to continue to invest in it. We have transitional rates, which are the incremental expense of rate increases that we are working in with some of our providers as we move closer to a value-based construct. These rates compensate for providing extended care – such as extended hours, additional services such as going into the community, and we are continuing to invest in our provider and community grants programs. That is going to add on to our medical benefit ratio.

CFO Dersh stated that the targeted rate increase is state mandated, and it is a phased approach. They are supposed to be neutral. We receive an increase in premium for expected utilization. The other item that is going to influence our MBR is our member incentives. We have seen a good response to our member incentives through our unprecedented increase in quality scores, and we will continue that program. Our MBR is probably going to be 92 to 93% for next year.

CPPO Erik Cho stated that some of the elements CFO Dersch mentioned are elements that we are add into in order to create a greater system performance. There is an 85% bucket sitting there as the cost that goes out. We must keep in mind how we are able to control our costs. A major impact to the 85% is an actuarial unit cost comparison that was provided for us. That is an analysis of our unit cost, and it provides valuable insight for forecasting the future premium rates. CPPO Cho noted that the number one take away is that regional rate setting is coming and that is going to have an impact. It is moving towards a model where it is done at a regional level. If we have outlier costs that we are reimbursing relative to the regio, we are at risk for not getting full reimbursement from the state for those in future premium rate development. If we are out of line and it does not come back to GCHP directly, that will get into a formula where we could be brought down to a level that looks closer to the others. We are aware and know we have to manage. Past performance is what details what the future premium is. An outlier fee for service spending is at risk if not being fully reimbursed as DHCS looks to create greater regional cost parity. The way we get this to work correctly is continued focus on value and quality to ensure long

term success is to raise up what the system and we are able to do within these bounds. The analysis strongly supports what has already been our plan to focus and where the dollar should be focused to in order to make sustainable and lasting improvements. We need to make performance gains that matter to our patients and that will bend over the cost curve for us.

Commissioner Pupa asked how a regional rate will impact us. CPPO Cho stated that he did not have a direct answer. He stated that the hope is that it would be higher than the median, CEO Liguori stated that we do not have any more insights at this time. We do know from the stated, from LHPC, and the industry at large that the outlier reimbursement is going to be at risk. CFO Dersch stated this is going to put pressure on us when we go to the regional rate setting. We cannot quantify right now, but it is something that we need to be thoughtful about as we develop future rating models and provider reimbursement models. If we get a higher quality score, then we will be eligible for higher rates, which means we can pay higher rates. We do not want to get into a situation where we are on the high end, those odds are not in our favor. We are all waiting to see when this will be rolled out by the state. We have to be in a position where we can respond to it, and fortunately with our current fiscal position, we will be okay. Proactive strategic thinking is going to help keep us in a position where GCHP remains sustainable.

Commissioner Abbas asked how a region is defined. CFO Dersch stated we could be considered as part of Central Coast. If we are part of the five-county model, our rates will be compared to a Molina or Centene rate. It will be harder for us, but it can be overcome. If we are compared to a Central coast region, you are looking at lower populations, more agriculture, lower cost all around. As soon as we get more information, we will share with you.

CEO Liguori noted that there is a direct relationship between TNE reserves and income. Income is either adding or subtracting to our TNE reserves. In order for us to spend down our reserves, which has been our commitment and plan, we cannot have a positive bottom line. In order to spend down we must except a negative net income position.

CFO Dersch stated that our TNE is running at approximately 1025%. Our total TNE is at 380,000,000. The Commission set a rate of 700% that we do not touch, it is part of our restricted reserves, which we keep ensuring the financial viability of the organization should there be any adverse effects. It is imperative that we continue to maintain the 700%. That leaves us with an additional 325% of out TNE that is unrestricted, and we can make recommendation on how to best use. What we are proposing is that since we are launching a new program with D-SNP and the first few years of operation of this program will incur deficits, which is standard. Generally, it takes three to four years before seeing a profit. We will have a profitable Medicare line

of business, but it takes a few years to get that membership up to where you have sufficient revenue to cover your fixed cost. The next item of focus is the $60 million that we are proposing we invest in community providers. We are able to maximize the amount that we can share with the providers. The $60 million represents a number that we will get out over the next three budget cycles. If we spend this, we will not put our Medicare program at risk, no will we put our current Medi-Cal population at risk. It is in our best interest to spend that money down over the next three years. CFO Dersh noted that the $60 million will be rooted in quality-based initiatives. If we have any rating issues that come up or unprecedented cost increases, we have an opportunity to do some course correction with rates as well. We will review this on an annual basis as to how we are spending the money and how we can continue to invest in the providers.

CEO Liguori noted that we think of the 700% restricted revenue as our Medi-Cal reserves. We want GCHP to be able to thrive for the long term and we feel that those reserves are adequate. For the first time we are able to get a clear picture of the reserves we will need for D-SNP. We will have to maintain reserves for Medicare for D-SNP, and DMHC. We approach going live with D-SNP operations in January. We think it is time to reserve that money for Medicare. $60 million is sufficient to meet our reserve requirements that will be set by DMHC, and also to plan for the expected substantial losses that we know are coming.

Commissioner Pupa stated that losses are hard to accept, but in this case, this is what we need to do, we are financially able to do, and is a planned budgeted loss. This is intentional and what we need to do to ensure that we have the appropriate rates so that they are not cut and continue to provide quality care.

Commissioner Abbas stated that D-SNP is important because we don't have that type of service within Ventura County, and we have people, and that population will grow in the future. We do need to have D-SNP services provided and if it takes money to do so, we should find ways to do so. Commissioner Abbas stated that that it is forward thinking from the GCHP perspective to allocate funding for these types of projects, and it is appreciated.

CPPO Cho stated that we have made the commitment on where the funding is going and how it will work with the impact we are trying to make. It is a direct investment in our providers to make lasting impacts that will be best for our members. CPPO Cho stated the spend that is committed from 2023 to 2024 is currently $55 million – which is $30 million in the QIPP program now, and we have offered to expand, as well as the first portion of the provider grants by $25 million. We are planning for a projected $240.5 million spend. We are seeking a maximum amount of funding that we can put out and develop.

CPPO Cho stated there are three major areas: 1) the advancement of the quality incentives from a $25 million annual commitment all the way up to $50 million. We are also pushing forward funding for grants in order to make impact sooner and be able to fund larger projects. There is also a vision for a community component.

Scott Campbell, General Counsel, reminded the committee that these are goals/targets, and each of these programs will be reviewed to make certain that they comply with the Corporate Integrity Agreement. Our goal is to get the maximum fuds out to the providers, consistent with our obligation to operate under the CIA and make sure that it is not challenged. We do not want providers to spend money and then have it pulled back.

CPPO Cho stated this is a huge investment. The increases that are coming will bring quality up across the board. Currently there is a $10 million expansion for QIPP that is going out to the core providers. We have been able to release funding in advance because we have seen success. It seems everyone is meeting and exceeding standards. The 2024 standards are even higher, and people are working towards those. There are some metrics that are still difficult to achieve, but there is new funding on the table for that. We are also moving forward with getting a hospital program launched.

By the end of fiscal year 2024 the projection is to have $31 million committed. We will also be launching an access-oriented grant program, which expands to community organizations, community investments, and will connect people to us and to our providers. CPPO Cho stated we have gotten thirty-seven approvals out for providers through the grant program and there will be more. We have been able to broaden access to primary care, and to impacted specialties. This has created a work together environment with the overall QIPP. We will be sharing equipment grants information soon. This will make a nice impact on FQHC and rural health clinics. There will be new grants in the future for other provider types, not just doctors, because that are community needs too.

CIO Eve Gelb stated D-SNP is a quality focused TNE investment because it is building a quality plan for a population that we currently do not serve but will in the future. She noted that it takes resources to improve out MCAS outcomes and access to care. CIO Gelb stated that we filed out Knox-Keene application in April, which was a major milestone. If we get a star rating lower than four, we do not get the quality bonus that comes with a high-quality plan. The financial picture is then negative. What it will take to operate this plan is to pay our providers a percentage of the Medicare fee for service, as well as what we can do to manage the costs of those high-risk incidences/higher dollar claims, and whether we can get a savings of the fee for service Medicare rate. All of this impacts our ability to create a high quality financially

sustainable compliant plan. Therefore, we are being focused. We are using data to do our analysis, as well as scenario planning so we understand the impact.

She noted that the $60 million in our TNE goes to our providers as we work toward building a high-quality plan that will get us to four stars or higher. This is a quality investment in our community and the provider community but recognize that the cost varies on assumptions and activities that we do not have control over. We do not know how the County will behave; this is something new for the state. There are other counties that have D-SNPs, but they do not have in the environment/context in which we will. We cannot predict human behavior.

CFO Dersch stated this is our budget strategy and the approach we will take over the next two months. This is a preview and will again be presented at Commission.

Commissioner Pupa acknowledged a great job on the presentation.

Commissioner Abbas motioned to approve combined agenda items 2 and 3. Commissioner Pupa seconded the motion.

AYES: Commissioners Anwar Abbas, Laura Espinosa, and Dee Pupa

NOES: None.

ABSENT: Commissioner James Corwin.

The clerk declared the motion carried.

4. February Year to Date Financial Results

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests the Executive Finance Committee approval of the February year-to-date financial results.

CFO Sara Dersch reviewed the results of how we did in February. We continue to reflect a fiscally healthy organization. And that trend will continue for the remainder of the year. We know there is uncertainty. She noted that last month she informed the committee of a significant take back of $16.5 million by the state in January. That rate might increase a bit. We are expecting the final acuity adjustment for calendar year 2023 before the end of this month. CFO Dersch stated that she did not expect it to be a significant increase. But there is uncertainty, and DHCS and the state, with the current state budget gaps, they look for ways to bring in more funding.

CFO Dersh stated that our redetermination efforts have been highly successful. We continue to see members re-enroll, and this is keeping our membership up. There is a new demographic that is now eligible for Medi-Cal benefits, it is the Unsatisfactory Immigration Status (UIS) for adults ages 26 to 49. We were given 17,000 of these members. She noted that there are varying rates between the satisfactory immigration status and the unsatisfactory - same age group, different immigration status. They receive different reimbursement revenues from the state. Unfortunately, the revenues we earn for care of the UIS population is less than the cure of the reimbursement we receive for the Satisfactory.

CFO Dersh stated that quality results tend to be remarkably high, there is great work being done through the QIPP program which is influencing our financial results for the month and for the year. She noted that we continue to monitor a couple of different areas in our medical utilization – primarily inpatient. We are starting to see an increase in utilization for three months in a row. We are watching our long-term care costs, and this will go into influencing how we account for estimates in our new year budget. We are also expanding the readiness, which is adding onto our total expense, but we are taking action to bring those costs back in line with the budget.

CFO Dersch noted that she has changed how financials are presented in order to be more transparent.

CFO Dersch reviewed P&Ls and focused on different components of the P&L. The first focus is on revenue. While membership is favorable to our forecast month to date and year to date. She will review the demographics we expected versus what we actually have. Even though we are favorable in membership, the amount we are getting on a per member per month basis is slightly beneath what was forecasted. She noted that we have retro adjustments every month. Under the Medical benefit CFO Dersch noted that we were able to release more of the upfront QIPP funds. This is resulting in a $15.1 million unfavorable variance for the month. This brings our year-to-date variance up to 18.7, this is planned, and is a good thing.

CFO Dersch noted that we have been working with Edrington, our actuarial partner, on further refining our incurred but not paid claims reserves. We know that with a membership increase the utilization will increase.

We are working to ensure our reserving process is not too conservative and not too liberal, it is exactly where it needs to be. CFO Dersch stated that we are starting to get back to a pre-pandemic utilization pattern, and high variance swings are over.

Our administrative expense and our project portfolio are primarily our Operations of the Future shows fiscal discipline in managing costs. The disciplined resource

optimization program which was implemented in December which ensures that staffing is correct according to the reforecast, and it is working well.

In the Operations of the Future there is acceleration of work so we can be ready July1. There are additional readiness costs that is unfavorable for the month by $1.2 million and is $2.7 million year-to-date. Initial results for March indicate that the unfavourability is reversing.

This all adds up for a net income perspective at a $9.1 million deficit versus a projected deficit of $400,000, $8.7 million unfavorable, but this is driven primarily by the QIPP acceleration from a year-to-date perspective that we are still trending favorable. We are adding $17.6 million year to date to our reserves. Although this does not come close to the reforecast of $44.8 million (done prior to our revenue take back) our assessment of the QIPP is much more successful than what we initially expected. The results underscore a fiscally health organization. The deficit for the month is a one-time event that we knew about. It is not something that is uncontrollable,

CFO Dersch reviewed membership and medical benefit. She noted that the child population approximates the forecast, but in the adult, and adult expansion, the actuals are higher than the reforecast. She also reviewed in-patient and long-term care which are the highest categories for medical benefits and those are tracked and monitored.

CFO Dersch reviewed membership breakdown. She reviewed the relative ranking of our membership by category of aid. Children are high – we have more children than any other category of aid. Adult expansion is close behind. Looking ahead, we expect to show an additional $4.9 million expense in the month of March. We continue to monitor the reserves that sit on our balance sheet are appropriate for the year end and that our expenses are not understated or overstated from a medical benefit perspective.

We are working together to produce a more robust analytics function that will be able to report on not just historically, but what is current. We will be able to better predict what we think our costs are going to be over the next few months.

Commissioner Pupa stated she liked the new format. She stated that she was having trouble understanding the difference between satisfactory and unsatisfactory documented. Chief Medical Officer, Felix Nunez, M.D. stated it is legal residency established or citizenship here in the US for benefits. It makes a difference in Medi-Cal because of the use of federal funds is prohibited in populations who have unsatisfactory legal status or satisfactory immigration status. CFO Dersch stated there are two categories. Effective January of 2023 the adults there were age 50 and older became eligible for Medi-Cal, and effective January 1 of this year adults aged

26 to 49 became eligible for full Medi-Cal benefits, but they do not qualify for the federal portion of the funding.

Commissioner Pupa asked if the benefits were the same. CFO Dersch stated yes, they are exactly the same. Commissioner Pupa stated everybody should have access to healthcare, and she is glad the state is doing the right thing.

CEO Liguori stated we have a 17,000-member increase in this population and the state reduced those rates by approximately 20%. There is uncertainty because this program and its funding is being driven by the state. We welcome these members, but the state has reduced our ability to fully fund their healthcare needs. We might have costs that are in excess of the funding the state has given us.

CFO Dersh stated that underscores that our 700% TNE is prudent and appropriate because it will allow us to continue to serve this population without any type of rate cutting to our providers. The right care at the right place at the right time will continue.

Commissioner Pupa stated that the enrollment of the 17,000 shows a comfort level and trust with GCHP.

Commissioner Espinosa asked if there is data or trending that speaks on this issue. CMO Nunez stated we have started doing health risk assessments on this population and there is data coming in. This is a population that is unknown to use and to the healthcare system in general. The assessments give us some information, but it is not telling us the full picture because these members are unknown to our network and our systems. It is a variable that is difficult to predict. Utilization is going to be difficult until we get a better handle as we start to have this population be seen, get primary care and start to get diagnosis done. We need to continue to invest in our data and analytic capabilities.

Commissioner Abbas stated that crosschecking needs to be done, and could be done by providers, they are capable of doing this.

CEO Liguori stated we need to connect these individuals with regular primary care, specialty care and the behavioral care that they need.

CEO Liguori noted that the population that has left GCHP through redetermination is on the average 40% less expensive than the population that remains, and we anticipated this, almost to the dollar. We will do our best work.

Commissioner Pupa asked if Type 2 diabetes is being diagnosed at an earlier age. CMO Nunez stated it is an epidemic.

Commissioner Espinosa motioned to approve agenda item 4 as presented. Commissioner Abbas seconded the motion.

AYES: Commissioners Anwar Abbas, Laura Espinosa, and Dee Pupa

NOES: None.

ABSENT: Commissioner James Corwin.

The clerk declared the motion carried.

CLOSED SESSION

5. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

6. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Executive Finance Committee
Unrepresented employee: Chief Executive Officer

The Committee went into Closed session at 3:58 p.m.

ADJOURNMENT

The meeting adjourned at 4:02 p.m. due to lack of quorum.

Approved:

_____
Maddie Gutierrez, MMC
Clerk to the Commission

AGENDA ITEM NO. 2

TO: Executive Finance Committee

FROM: Sara Dersch, Chief Financial Officer

DATE: May 16, 2024

SUBJECT: March Year-to-Date Financial Results

PowerPoint with Verbal Presentation

ATTACHMENTS:

March 2024 Financial Results

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

March 2024 Year-to-Date Financial Results

Ventura County Medi-Cal Managed Care Commission
Executive Finance Committee
May 16, 2024
Sara Dersch, Chief Financial Officer

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

March Year-To-Date (YTD) Financial Results Summary

- GHCP's underlying financial performance today is strong, reflecting a Medi-Cal Managed Care Plan under effective management control and operating in accordance with parameters of our Medi-Cal premiums.

- There have been a couple of material revenue and cost adjustments that have resulted in a cumulative $(33.4M) impact to the Operating Gain:

  - $16.1M revenue "take-back" by the State associated with the State's assessment that our members in 2023 had lower acuity (were healthier in general than originally forecasted).

  - $17.3M in earlier-than-forecasted provisioning of Quality Incentive Pool and Program (QIPP) payments; these investments help our community partners have resources to ensure access to and delivery of high-quality care for our members; these expenses have been contemplated in the complete year forecast.

- Medi-Cal populations have grown the most in those premium categories of aid experiencing the greatest rate reductions.

- While there are, and always will be, economic events that we cannot foresee (ex: retroactive rate adjustments), GCHP management continues to diligently monitor and take action on those Income Statement and Balance Sheet line items that are controllable and weather those items that not controllable.

Return to Agenda

March YTD P&L: Revenue

($Ms except pmpms & mm)	MTD Actual	MTD Reforecast	MTD Var Fav / (Unfav)	YTD Actual	YTD Reforecast	YTD Var Fav / (Unfav)
Member Months	250,139	237,795	12,344	2,270,106	2,233,671	36,435
Revenue	$ 89.3	$ 86.1	$ 3.2	$ 791.8	$ 782.7	$ 9.2
pmpm	*$ 357.16*	*$ 362.14*	*$ (4.99)*	*$ 348.81*	*$ 350.40*	*$ (1.58)*
Non-Operating Revenue / (Expense)	$ 1.6	$ 0.9	$ 0.7	$ 12.9	$ 10.4	$ 2.5
pmpm	*$ 6.24*	*$ 3.79*	*$ 2.45*	*$ 5.68*	*$ 4.66*	*$ 1.02*
Medical Benefits	$ 90.1	$ 78.8	$ (11.3)	$ 698.4	$ 668.4	$ (30.0)
pmpm	*$ 360.11*	*$ 331.30*	*$ (28.8)*	*$ 307.66*	*$ 299.24*	*$ (8.4)*
% of Revenue	*100.8%*	*91.5%*		*88.2%*	*85.4%*	
Admin Exp	$ 8.7	$ 7.7	$ (1.0)	$ 66.4	$ 65.4	$ (1.1)
pmpm	*$ 34.87*	*$ 32.51*	*$ (2.36)*	*$ 29.26*	*$ 29.27*	*$ 0.01*
% of Revenue	*9.8%*	*9.0%*		*8.4%*	*8.4%*	
Project Portfolio	$ 1.3	$ 2.8	$ 1.5	$ 18.0	$ 16.8	$ (1.2)
pmpm	*$ 5.19*	*$ 11.86*	*$ 6.67*	*$ 7.93*	*$ 7.54*	*$ (0.39)*
% of Revenue	*1.5%*	*3.3%*		*2.3%*	*2.2%*	
Operating Gain/(Loss)	$ (10.8)	$ (3.2)	$ (7.5)	$ 9.0	$ 32.0	$ (23.0)
	$ (43.01)	*$ (13.53)*	*$ (29.48)*	*$ 3.96*	*$ 14.35*	*$ (10.38)*
Retro Revenue Adjustments	$ 0.1	$ -	$ 0.1	$ (13.5)	$ -	$ (13.5)
pmpm	*$ 0.31*	*$ -*	*$ 0.31*	*$ (5.93)*	*$ -*	*$ (5.93)*
Total Increase / (Decrease) in Unrestricted Net Assets	$ (9.1)	$ (2.3)	$ (6.8)	$ 8.4	$ 42.5	$ (34.0)
pmpm	*$ (36.45)*	*$ (9.74)*	*$ (26.71)*	*$ 3.72*	*$ 19.01*	*$ (15.29)*
% of Revenue	*-10.2%*	*-2.7%*		*1.1%*	*5.4%*	

- Membership favorability comes from the new members aged 26-49 years covered regardless of immigration documentation; GCHP forecasted 5K members but realized 17K additional members, a variance of 12K.
- While membership is greater than forecasted, the membership "mix" (breakout of members by age and acuity categories) skews towards more members in lower premium cohorts.
- $16.1M Revenue "Take Back" in January as a result of a retroactive reduction in 2023 rates is partially offset by $2.7M pick-up membership-related retroactivity, resulting in a cumulative adjustment of $(13.5M).

Return to Agenda

March YTD P&L: Medical Benefit

($Ms except pmpms & mm)	MTD Actual	MTD Reforecast	MTD Var Fav / (Unfav)	YTD Actual	YTD Reforecast	YTD Var Fav / (Unfav)
Member Months	250,139	237,795	12,344	2,270,106	2,233,671	36,435
Revenue	$ 89.3	$ 86.1	$ 3.2	$ 791.8	$ 782.7	$ 9.2
pmpm	*$ 357.16*	*$ 362.14*	*$ (4.99)*	*$ 348.81*	*$ 350.40*	*$ (1.58)*
Non-Operating Revenue / (Expense)	$ 1.6	$ 0.9	$ 0.7	$ 12.9	$ 10.4	$ 2.5
pmpm	*$ 6.24*	*$ 3.79*	*$ 2.45*	*$ 5.68*	*$ 4.66*	*$ 1.02*
Medical Benefits	$ 90.1	$ 78.8	$ (11.3)	$ 698.4	$ 668.4	$ (30.0)
pmpm	*$ 360.11*	*$ 331.30*	*$ (28.8)*	*$ 307.66*	*$ 299.24*	*$ (8.4)*
% of Revenue	*100.8%*	*91.5%*		*88.2%*	*85.4%*	
Admin Exp	$ 8.7	$ 7.7	$ (1.0)	$ 66.4	$ 65.4	$ (1.1)
pmpm	*$ 34.87*	*$ 32.51*	*$ (2.36)*	*$ 29.26*	*$ 29.27*	*$ 0.01*
% of Revenue	*9.8%*	*9.0%*		*8.4%*	*8.4%*	
Project Portfolio	$ 1.3	$ 2.8	$ 1.5	$ 18.0	$ 16.8	$ (1.2)
pmpm	*$ 5.19*	*$ 11.86*	*$ 6.67*	*$ 7.93*	*$ 7.54*	*$ (0.39)*
% of Revenue	*1.5%*	*3.3%*		*2.3%*	*2.2%*	
Operating Gain/(Loss)	$ (10.8)	$ (3.2)	$ (7.5)	$ 9.0	$ 32.0	$ (23.0)
	$ (43.01)	*$ (13.53)*	*$ (29.48)*	*$ 3.96*	*$ 14.35*	*$ (10.38)*
Retro Revenue Adjustments	$ 0.1	$ -	$ 0.1	$ (13.5)	$ -	$ (13.5)
pmpm	*$ 0.31*	*$ -*	*$ 0.31*	*$ (5.93)*	*$ -*	*$ (5.93)*
Total Increase / (Decrease) in Unrestricted Net Assets	$ (9.1)	$ (2.3)	$ (6.8)	$ 8.4	$ 42.5	$ (34.0)
pmpm	*$ (36.45)*	*$ (9.74)*	*$ (26.71)*	*$ 3.72*	*$ 19.01*	*$ (15.29)*
% of Revenue	*-10.2%*	*-2.7%*		*1.1%*	*5.4%*	

YTD MBR approximates our target of 88%, influenced largely by QIPP and fee-for-service (FFS) rate increases.

- Acceleration of QIPP funding has resulted in $7.0M of MTD expense, a $(5.8M) variance.
  - QIPP expenses total $29.4M vs a forecast of $12.1M.
  - Excluding QIPP, YTD MBR is 86.0%.
- FFS medical benefit spend is increasing in most care categories (please see the next slide for detail) due in large part to unit cost increases , not utilization.
- Total FFS spend was $606.7M versus a forecast of $573.3M, including QIPP.
- Minor favorability in claims recoveries and capitation offset some of the FFS variance.
- While some of the increase in spend is associated with a higher level of membership, increases in provider rates also contribute to the variance.

Return to Agenda

March YTD P&L: Medical Benefit Categories

	Mar 2024	March 2024 Year-To-Date		Variance	Variance
	Actual	Actual	Reforecast	Fav / (Unfav)	%
Medical Benefits:					
Capitation:					
PCP, Specialty, Kaiser, NEMT & Vision	8,154,224	71,151,877	69,422,596	(1,729,280)	-2.5%
ECM	583,495	3,668,128	6,890,668	3,222,540	46.8%
Total Capitation	8,737,719	74,820,005	76,313,264	1,493,259	2.0%
FFS Claims:					
Inpatient	24,094,950	152,324,633	151,156,524	(1,168,109)	-0.8%
LTC / SNF	12,205,720	140,319,254	147,595,946	7,276,692	4.9%
Outpatient	7,349,522	63,808,910	59,766,696	(4,042,214)	-6.8%
Laboratory and Radiology	1,720,416	9,786,625	7,124,531	(2,662,094)	-37.4%
Directed Payments - Provider	1,258,092	23,940,118	21,182,675	(2,757,443)	-13.0%
Emergency Room	4,000,078	29,896,354	27,761,286	(2,135,068)	-7.7%
Physician Specialty	7,686,803	59,232,385	57,700,584	(1,531,801)	-2.7%
Primary Care Physician	3,531,323	25,735,890	24,084,688	(1,651,202)	-6.9%
Home & Community Based Services	3,632,815	24,635,415	19,708,963	(4,926,452)	-25.0%
Applied Behavioral Analysis/Mental Health Services	2,756,674	27,254,950	27,734,268	479,318	1.7%
Quality Incentives/Provider Reserves	*(22,307,610)*	*2,276,053*	-	(2,276,053)	0.0%
Quality Incentive Provider Program (QIPP)	*29,494,938*	*29,494,938*	*12,157,644*	(17,337,293)	-142.6%
Other Medical Professional	494,436	3,675,869	3,513,563	(162,306)	-4.6%
Other Medical Care		-	3,640	3,640	100.0%
Other Fee For Service	2,082,711	13,342,972	11,408,153	(1,934,819)	-17.0%
Transportation	(21,995)	1,097,769	2,380,592	1,282,823	53.9%
Total Claims	77,978,873	606,737,940	573,279,753	(33,542,381)	-5.9%
Provider Grant Program	-	-	3,333,333	3,333,333	100.0%
Medical & Care Management	3,255,142	17,929,956	16,140,000	(1,789,956)	-11.1%
Reinsurance	396,846	1,164,015	810,723	(353,292)	-43.6%
Claims Recoveries	(292,083)	(2,325,115)	(1,478,586)	846,529	-57.3%
Sub-total	3,359,906	16,853,049	18,805,470	2,036,615	10.8%
Total Medical Benefits	**90,076,498**	**698,410,994**	**668,398,487**	**(30,012,507)**	**-4.5%**

Return to Agenda

March YTD P&L: Administrative Costs

($Ms except pmpms & mm)	MTD Actual	MTD Reforecast	MTD Var Fav / (Unfav)	YTD Actual	YTD Reforecast	YTD Var Fav / (Unfav)
Member Months	250,139	237,795	12,344	2,270,106	2,233,671	36,435
Revenue	$ 89.3	$ 86.1	$ 3.2	$ 791.8	$ 782.7	$ 9.2
pmpm	*$ 357.16*	*$ 362.14*	*$ (4.99)*	*$ 348.81*	*$ 350.40*	*$ (1.58)*
Non-Operating Revenue / (Expense)	$ 1.6	$ 0.9	$ 0.7	$ 12.9	$ 10.4	$ 2.5
pmpm	*$ 6.24*	*$ 3.79*	*$ 2.45*	*$ 5.68*	*$ 4.66*	*$ 1.02*
Medical Benefits	$ 90.1	$ 78.8	$ (11.3)	$ 698.4	$ 668.4	$ (30.0)
pmpm	*$ 360.11*	*$ 331.30*	*$ (28.8)*	*$ 307.66*	*$ 299.24*	*$ (8.4)*
% of Revenue	*100.8%*	*91.5%*		*88.2%*	*85.4%*	
Admin Exp	$ 8.7	$ 7.7	$ (1.0)	$ 66.4	$ 65.4	$ (1.1)
pmpm	*$ 34.87*	*$ 32.51*	*$ (2.36)*	*$ 29.26*	*$ 29.27*	*$ 0.01*
% of Revenue	*9.8%*	*9.0%*		*8.4%*	*8.4%*	
Project Portfolio	$ 1.3	$ 2.8	$ 1.5	$ 18.0	$ 16.8	$ (1.2)
pmpm	*$ 5.19*	*$ 11.86*	*$ 6.67*	*$ 7.93*	*$ 7.54*	*$ (0.39)*
% of Revenue	*1.5%*	*3.3%*		*2.3%*	*2.2%*	
Operating Gain/(Loss)	$ (10.8)	$ (3.2)	$ (7.5)	$ 9.0	$ 32.0	$ (23.0)
	$ (43.01)	*$ (13.53)*	*$ (29.48)*	*$ 3.96*	*$ 14.35*	*$ (10.38)*
Retro Revenue Adjustments	$ 0.1	$ -	$ 0.1	$ (13.5)	$ -	$ (13.5)
pmpm	*$ 0.31*	*$ -*	*$ 0.31*	*$ (5.93)*	*$ -*	*$ (5.93)*
Total Increase / (Decrease) in Unrestricted Net Assets	$ (9.1)	$ (2.3)	$ (6.8)	$ 8.4	$ 42.5	$ (34.0)
pmpm	*$ (36.45)*	*$ (9.74)*	*$ (26.71)*	*$ 3.72*	*$ 19.01*	*$ (15.29)*
% of Revenue	*-10.2%*	*-2.7%*		*1.1%*	*5.4%*	

- Controlling administrative costs continues to be a Management focus.
- The YTD variance of $(1.1M) is attributed to the increase in membership; more membership results in additional "day-to-day" costs.
  - $460K of vendor fees associated with new member welcome letters.
  - All core health plan operations delegated to Conduent costs, which are calculated on a "per member per month" basis.
- We expect Project Portfolio (primarily "Operations of the Future") costs will continue to realign with the Reforecast as the year progresses.

Return to Agenda

March YTD P&L: Net Assets

($Ms except pmpms & mm)	MTD Actual	MTD Reforecast	MTD Var Fav / (Unfav)	YTD Actual	YTD Reforecast	YTD Var Fav / (Unfav)
Member Months	250,139	237,795	12,344	2,270,106	2,233,671	36,435
Revenue	$ 89.3	$ 86.1	$ 3.2	$ 791.8	$ 782.7	$ 9.2
pmpm	*$ 357.16*	*$ 362.14*	*$ (4.99)*	*$ 348.81*	*$ 350.40*	*$ (1.58)*
Non-Operating Revenue / (Expense)	$ 1.6	$ 0.9	$ 0.7	$ 12.9	$ 10.4	$ 2.5
pmpm	*$ 6.24*	*$ 3.79*	*$ 2.45*	*$ 5.68*	*$ 4.66*	*$ 1.02*
Medical Benefits	$ 90.1	$ 78.8	$ (11.3)	$ 698.4	$ 668.4	$ (30.0)
pmpm	*$ 360.11*	*$ 331.30*	*$ (28.8)*	*$ 307.66*	*$ 299.24*	*$ (8.4)*
% of Revenue	*100.8%*	*91.5%*		*88.2%*	*85.4%*	
Admin Exp	$ 8.7	$ 7.7	$ (1.0)	$ 66.4	$ 65.4	$ (1.1)
pmpm	*$ 34.87*	*$ 32.51*	*$ (2.36)*	*$ 29.26*	*$ 29.27*	*$ 0.01*
% of Revenue	*9.8%*	*9.0%*		*8.4%*	*8.4%*	
Project Portfolio	$ 1.3	$ 2.8	$ 1.5	$ 18.0	$ 16.8	$ (1.2)
pmpm	*$ 5.19*	*$ 11.86*	*$ 6.67*	*$ 7.93*	*$ 7.54*	*$ (0.39)*
% of Revenue	*1.5%*	*3.3%*		*2.3%*	*2.2%*	
Operating Gain/(Loss)	$ (10.8)	$ (3.2)	$ (7.5)	$ 9.0	$ 32.0	$ (23.0)
	$ (43.01)	*$ (13.53)*	*$ (29.48)*	*$ 3.96*	*$ 14.35*	*$ (10.38)*
Retro Revenue Adjustments	$ 0.1	$ -	$ 0.1	$ (13.5)	$ -	$ (13.5)
pmpm	*$ 0.31*	*$ -*	*$ 0.31*	*$ (5.93)*	*$ -*	*$ (5.93)*
Total Increase / (Decrease) in Unrestricted Net Assets	$ (9.1)	$ (2.3)	$ (6.8)	$ 8.4	$ 42.5	$ (34.0)
pmpm	*$ (36.45)*	*$ (9.74)*	*$ (26.71)*	*$ 3.72*	*$ 19.01*	*$ (15.29)*
% of Revenue	*-10.2%*	*-2.7%*		*1.1%*	*5.4%*	

In summary, the YTD Net Asset balance variance of $(34.0M) is primarily the result of:

- $9.2M premium revenue favorability (membership volume-related).
- $(30.0M) unfavorability in medical spend (driven by the $(17.3M) in acceleration of QIPP payments and $(16.1M) increase in FFS medical costs, offset by favorability in non-FFS spend.
- $(16.1M) 2023 acuity adjustment State "take-back" in premium rates (not known at time of reforecast) offset by other minor retroactivity.

Return to Agenda

Looking Ahead….

- Potential for reduction in Incurred But Not Paid (IBNP: Expected expenses for services provided but not yet submitted for provider reimbursement) in the last quarter of the year.
- Benefit utilization for membership in new eligibility category could add pressure to MBR.
- State actions could result in additional prior period revenue take-backs:
  - Covid Testing Risk Corridor reconciliation/adjustment.
  - Targeted Rate Increase Reconciliation.

Return to Agenda

Exhibits

This section contains the following exhibits

- March Balance Sheet
- March Cash and Short-Term Investment Portfolio
- Revenue and Medical Benefit Per Member Month Values
- Membership Breakdown

Return to Agenda

March YTD Balance Sheet: Assets

	03/31/24	06/30/23
ASSETS		
Current Assets:		
Total Cash and Cash Equivalents	**568,700,715**	**344,166,987**
Total Short-Term Investments	**98,537,175**	**95,269,796**
Medi-Cal Receivable	176,593,108	96,222,357
Interest Receivable	(482,596)	462,872
Provider Receivable	6,316,034	422,995
Other Receivables	79,547	59,542
Allowance for Doubtful Accounts	(639,602)	
Total Accounts Receivable	**181,866,492**	**97,167,766**
Total Prepaid Accounts	12,804,175	5,545,603
Total Other Current Assets	135,560	135,560
Total Current Assets	**862,044,117**	**542,285,711**
Total Fixed Assets	**8,527,164**	**9,224,593**
Total Assets	**$ 870,571,281**	**$ 551,510,304**

- Medi-Cal Receivable: 2024 Managed Care Organization tax for January through March plus expected State premiums.
- Provider Receivable: includes payment advances related to Change Healthcare data breach.
- Total Prepaid Accounts: primarily member incentives we have purchased but not yet disbursed.

Return to Agenda

March YTD Balance Sheet: Liabilities

	03/31/24	06/30/23
LIABILITIES & NET ASSETS		
Current Liabilities:		
Incurred But Not Reported	$ 111,346,872	$ 84,436,777
Claims Payable	18,803,088	12,923,764
Capitation Payable	8,019,870	8,998,514
Physician Payable	34,025,397	31,865,385
AB 85 Payable	-	-
DHCS - Reserve for Capitation Recoup	44,932,112	10,411,049
Lease Payable- ROU	3,386,589	3,300,319
Accounts Payable	296,221	1,455,088
Accrued ACS	4,707,627	3,902,303
Accrued Provider Incentives/Reserve	25,223,140	17,427,573
Accrued Pharmacy	-	-
Accrued Expenses	94,821,928	7,559,682
Accrued Premium Tax	147,573,159	-
Accrued Interest Payable	-	-
Current Portion of Deferred Revenue	-	-
Accrued Payroll Expense	4,011,590	3,189,633
Current Portion Of Long Term Debt	-	-
Other Current Liabilities	-	-
Total Current Liabilities	**497,147,593**	**185,470,089**
Long-Term Liabilities:		
Lease Payable - NonCurrent - ROU	5,036,269	6,088,559
Deferred Revenue - Long Term Portion	-	-
Notes Payable	-	-
Total Long-Term Liabilities	**5,036,269**	**6,088,559**
Total Liabilities	**502,183,862**	**191,558,647**
Net Assets:		
Beginning Net Assets	359,951,657	176,617,059
Total Increase / (Decrease in Unrestricted Net Assets)	8,435,762	183,334,598
Total Net Assets	**368,387,419**	**359,951,657**
Total Liabilities & Net Assets	**$ 870,571,281**	**$ 551,510,304**

- Incurred But Not Reported: Expected expenses for services provided but not yet submitted for provider reimbursement: increasing due to claims payments timing, membership levels, and unit cost rates.
- Accounts Payable is down due to faster invoice processing.
- Accrued Premium Tax reflects our expected Managed Care Organization Tax (this appears only our Balance Sheet and does not impact our financial results).

Return to Agenda

Cash and Short-Term Investment Portfolio

SCHEDULE OF INVESTMENTS AND CASH BALANCES

		Market Value* March 31, 2024	Account Type
Local Agency Investment Fund (LAIF)[1]	$	42,080,748	investment
Ventura County Investment Pool[2]	$	19,054,764	investment
CalTrust	$	37,401,663	short-term investment
Bank of West	$	412,201,156	money market account
Pacific Premier	$	156,499,058	operating accounts
Mechanics Bank[3]	$	-	operating accounts
Petty Cash	$	500	cash
Investments and monies held by GCHP	***$***	***667,237,888***	

Cash and short-term investments: $667.2M.

- The investment portfolio includes Ventura County Investment Pool $19.1M; LAIF CA State $42.1M; Cal Trust $37.4.

Return to Agenda

PMPM and TNE Values

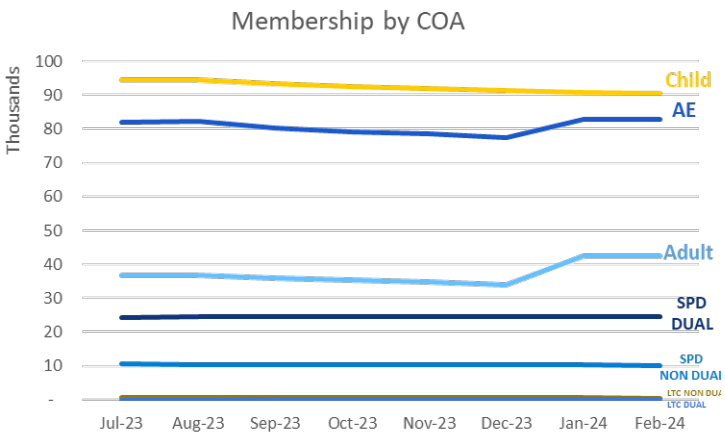
	FYTD 23/24 Reforecast	FYTD 23/24 Actual	FYTD 22/23 Actual	FYTD 21/22 Actual
Average Enrollment	248,186	252,234	247,854	229,367
PMPM Revenue	$ 350.40	$ 348.81	$ 340.86	$ 347.72
Medical Benefits				
Capitation	$ 34.16	$ 32.96	$ 34.18	$ 32.44
Inpatient	$ 67.67	$ 67.10	$ 54.64	$ 68.62
LTC / SNF	$ 66.08	$ 61.81	$ 54.86	$ 59.92
Outpatient	$ 26.76	$ 28.11	$ 23.88	$ 22.59
Emergency Room	$ 12.43	$ 13.17	$ 11.32	$ 10.80
Physician Specialty	$ 25.83	$ 26.09	$ 23.44	$ 22.49
Quality Incentives	$ 5.44	$ 1.00	$ 0.69	$ -
Provider Grant Program *	$ 1.49	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ (0.15)	$ 29.71
All Other	$ 59.37	$ 64.42	$ 53.03	$ 45.41
Total Per Member Per Month	$ 299.24	$ 294.66	$ 255.89	$ 291.97
Medical Benefit Ratio	85.4%	88.2%	75.1%	86.9%
Total Administrative Expenses	$ 82,227,487	$ 84,434,267	$ 78,852,534	$ 53,680,738
% of Revenue	10.5%	10.7%	7.8%	5.6%
TNE	$ 402,411,706	$ 368,387,419	$ 359,814,027	$ 176,562,922
Required TNE	$ 41,438,176	$ 35,817,173	$ 32,913,795	$ 36,609,789
% of Required	971%	1029%	1093%	482%

Return to Agenda

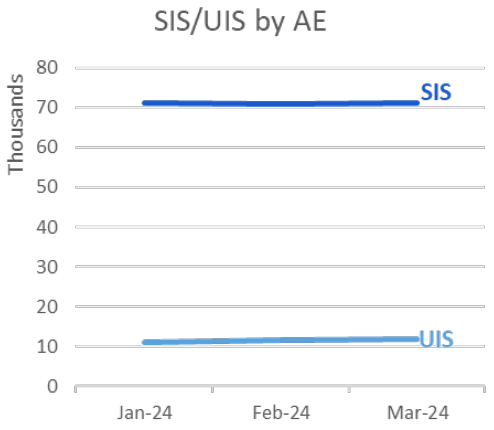
Membership Breakdown

- Child and Adult Expansion cohorts account for about three-quarters of GCHP's membership.

- The State of California provides Medi-Cal coverage to people who meet Medi-Cal requirements regardless of immigration status. For purposes of rate and specific benefit eligibility, the State uses the term "Unsatisfactory Immigration Status" (UIS) to refer to people without immigration documentation.



Data source: IBNP MM – Feb 2024



Data source: [DIM_GCHP_MEMBERS], [ACS_MEMBER_OTHER_PARAMETERS]

Return to Agenda

AGENDA ITEM NO. 3

TO: Executive Finance Committee

FROM: Nick Liguori, Chief Executive Officer
Sara Dersch, Chief Financial Officer
Eve Gelb, Chief Innovation Officer
Paul Aguilar, Chief Human Resources & Organizational Performance Officer
Felix Nunez,M.D., Chief Medical Officer
Erik Cho, Chief Policy & Program Officer
Marlen Torres, Executive Director of Strategy & External Affairs

DATE: May 16, 2024

SUBJECT: Fiscal Year 2024/25 Budget and Three-Year Planning

PowerPoint with Verbal Presentation

ATTACHMENTS:

Fiscal Year 2024/25 Budget and Three-Year Planning

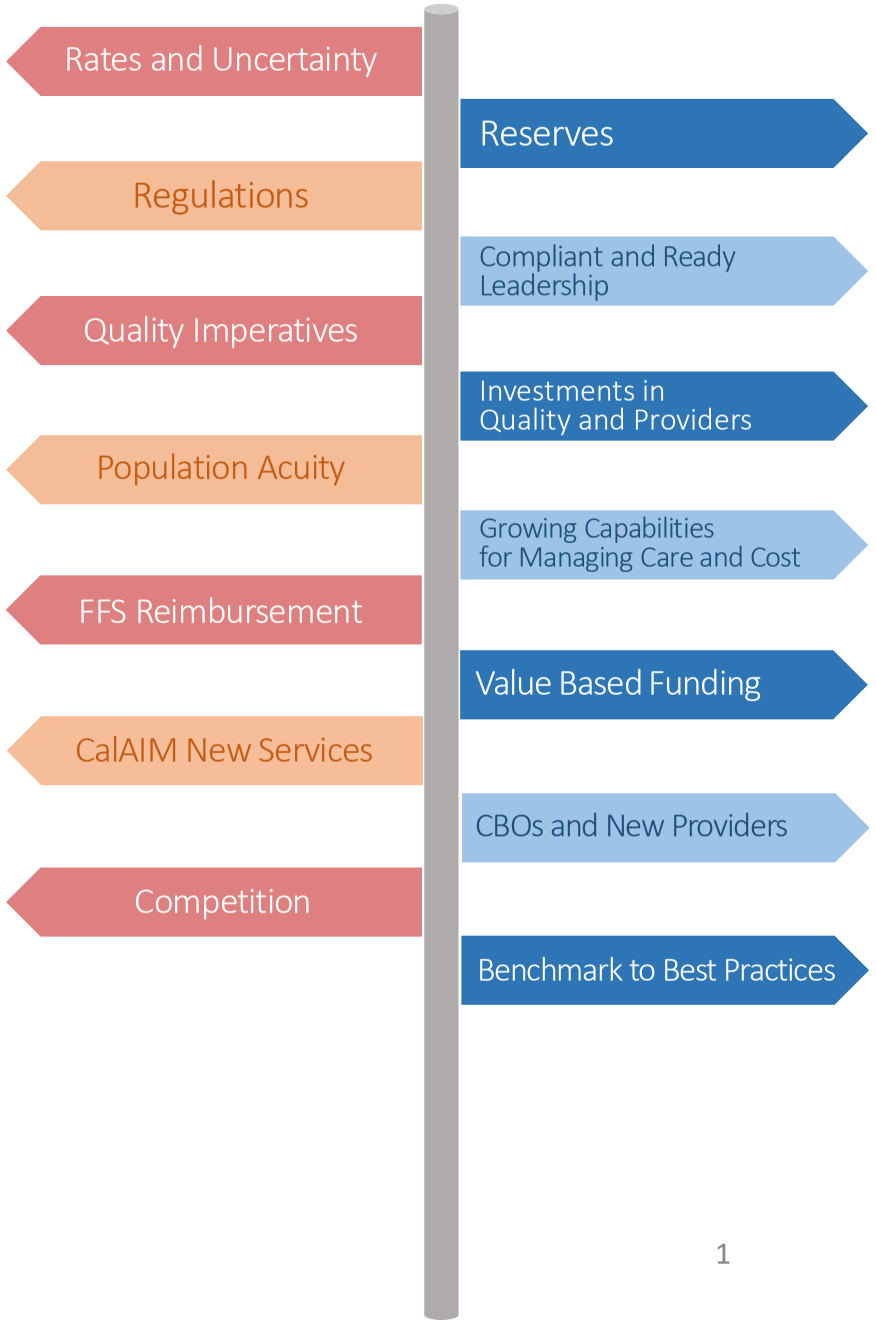
All Pages DRAFT

33 of 71 pages

FY2024/25 Budget and 3 Year Planning

Gold Coast Health Plan Executive Finance Committee
May 16, 2024

Nick Liguori, Chief Executive Officer
Sara Dersch, Chief Financial Officer
Eve Gelb, Chief Innovation Officer
Paul Aguilar, Chief Human Resources and Organizational Performance Officer
Dr. Felix Nuñez, M.D., Chief Medical Officer
Erik Cho, Chief Policy and Program Officer
Marlen Torres, Executive Director, Strategy and External Affairs



Return to Agenda

Topics We Will Review

1. Today's Objectives
2. Budget Design
3. Medi-Cal Industry Environment
   - Opportunities and Challenges
   - Question and Answer Session with Kyle Edrington, Founder of Edrington Health Consulting
   - Provider Environment
   - Quality Environment
4. Gold Coast Health Plan Environment
   - Membership and Associated Premium Rates
   - Medical Benefit Cost Trends
   - Unique Needs of New Members
5. FY2024/25 Proposed Budget

Return to Agenda

OBJECTIVES

(1) Understand where we are in the budget process.

(2) Understand Medi-Cal program and industry trends.

(3) Understand the need to plan for to use a portion of our reserves to expand the investment in Quality and Providers begun 2 years ago.

(4) Gain feedback from the Commission.

In April, Management provided the FY2024-25 budget framework outlining planned use of reserves.

Today, we will review the budget as well as important considerations for how management has developed the budget and will successfully implement that budget.

In June, we will bring the final budget packet which will include more-detailed administrative budget content. This administrative content will include the following: the personnel budget, a comprehensive review of existing and new vendor/consultant contracts and related budgets, operations of the future budget, and more.

Return to Agenda

Gold Coast Health Plan
Fiscal Year (FY) 2024-25 Budget Design

- GHCP's underlying financial performance today is strong, reflecting a Medi-Cal Managed Care Plan under effective management control, and operating in accordance with parameters of our Medi-Cal premiums.

  Excluding GCHP's Quality Funding Program:

  - 88% of premiums go to Medi-Cal member benefit spend.
  - 10% goes to efficient operations of the health plan and ongoing investments in Operations of the Future.
  - 2% would be available for addition to reserves.

- In order to meet the imperative of our Mission to improve Quality Care and Access for our members and to support the Ventura County Medi-Cal healthcare delivery system, management has developed a pioneering Quality Funding Programs that increases funds available for quality care and services by $90M in FY 2024-25 and by $250M over the next 3 years. These unprecedented new programs build off the funding programs and plan-provider partnerships that produced incredible successes in MCAS improvements in the current fiscal year.

- Bottom line change in reserves: The new Quality Funding Programs will involve a $22.5M spend down of reserves by the end of FY 2024-25. This will appear as a planned $22.5M reduction of reserves in the health plan's income statements.

Environment – Medi-Cal Program and Industry

Return to Agenda

Medi-Cal Environment Presents Opportunities and Challenges

New Programs and Populations provide great opportunities to serve our members and our community in new and important ways. These opportunities require significant strategic foresight, coordination and partnering with others to connect members with care, along with sophisticated budgeting with a strong grasp on administrative costs, medical cost management, and other health plan investments for underfunded efforts. Therefore, progressive quality focused plans must balance the opportunities with the risks to remain sustainable.

Do More

- Medi-Cal Managed Care Plans (MCPs) need to broaden their footprint and infrastructure to support social drivers of health and behavioral health initiatives.
- Community Supports are expected to be converted into regular member benefits.
- Adult Expansion, elimination of asset limits, new Medi-Cal benefits, and D-SNP.
- Added requirements such as expanded Transitional Care Services and Health Equity.

Do Better

- Withholding a percentage of payments with an opportunity for MCPs to earn it back by achieving quality and health equity benchmarks.
- New requirement to invest 5% to 7.5% of margin back into the community. MCPs that don't meet quality expectations will have to reinvest an additional 7.5% of their profits into the community.
- Compete with Kaiser.
- New standardized contracts that will strengthen and clarify requirements and expectations regarding oversight and compliance. Greater penalties for poor performance.
- NCQA Health Plan and Health Equity Accreditation.

Get Paid Differently

- Rate transparency to support cost containment and downstream provider margins.
- Regional Rate Setting to create price leverage.
- 2024 Targeted Rate Increases (TRI) and expanded TRI in 2025+.
- Payment based on acuity.
- Managed Care Organization (MCO) Tax if successful would inject funding into the funding pool.

Edrington Q&A – Guest Speaker on Industry Trends

1) What is driving the changes in the Medi-Cal Program that we learned about on the previous slide?

2) How is the Medi-Cal industry-wide "premium environment" changing now and over the next few years? How do you expect GCHP's premiums to change based on actual cost data?

3) Can you provide more detail on regional rate setting? Why is it coming, when is it coming, and what will it mean for GCHP?

4) The historical Medi-Cal premium development paradigm essentially provided managed care plans with near full "reimbursement" of costs, albeit on a 2-year lag. How will regional rate setting change this?

5) How important is GCHP's development of care and cost management capabilities and Model of Care around the following:

    1) Care management of those high-cost members with multiple chronic conditions?

    2) Continued high-Quality performance across all MCAS measures?

6) Open questions from the Commission

Return to Agenda

Kyle Edrington founded Edrington Health Consulting (EHC) in 2014 and has provided actuarial, financial, and strategic support to Local Medi-Cal health plans for over 15 years, including support for Gold Coast Health Plan since 2018. Kyle and the EHC team currently work with 14 of the 17 Local Medi-Cal health plans as trusted advisors supporting each health plan's operations and strategy. In addition, Kyle contributes to DHCS workgroups and other technical discussions to support its capitation rate development process and strategic direction of Medi-Cal. EHC is a subsidiary of HMA.

Provider Environment

Understanding the provider delivery system – needs, challenges, and goals – is key to GCHP's strategies, essential to the strength of plan-provider partnership, and GCHP's budget success.

40 of 71 pages

Workforce Shortages Impact Access to Care

The healthcare industry is still feeling the impact of "the great resignation" and has pressing need for primary care providers, certain specialists, and nursing staff. The pressures in finding, hiring, and retaining talent are exacerbated by burdensome administrative issues (such as prior authorization), and the increased cost of living and other drivers that create wage inflation. Additionally, space limitations prevent full execution of staffing plans.

Rate Pressure

Rate Stability and sufficiency is an ongoing issue. Providers are facing lower reimbursement compared to increasing delivery costs with a greater dependency on supplemental funding and funding based on quality performance. It is difficult for providers to get internal commitment and build new capabilities needed for sustained quality when payment is not guaranteed.

Return to Agenda

Technology is Both an Opportunity and a Challenge

Both the promise of new tools and systems as well as the challenges of data/cyber security. Many are somewhere in the process of new system implementation and felt the immediate impact of and are dealing with the vulnerabilities identified in the Change Healthcare Cybersecurity Issue.

Quality and Community Focus

We have alignment with goals and approaches to lift the health of the community by connecting members with care. Innovation and targeted interventions are needed to address individual needs in areas of:

Chronic conditions

- Hypertension
- Diabetes
- Asthma

Targeted populations:

- School aged children with developmental needs
- Teens with mental health needs
- Frailty driven by age, disability, and/or medical complexity
- Social complexity, especially housing insecurity

Quality Environment

Quality is the basis of evaluation and funding for GCHP today and in the future. Adequate funding for GCHP and the Ventura County delivery system are now and will be increasingly tied to better scores on the Managed Care Accountability Set (MCAS), Consumer Assessment of Health Plans and Systems (CAHPS) and other standardized quality measures aligning with the National Quality Strategy.

Quality Withhold 0.5% of Revenue in 2024, increasing in 2025 and beyond to approximate our margin.	=	8 Managed Care Accountability Set (MCAS) Measures, with 9th measure added in 2025	+	4 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Measures (2 adult and 2 children)	x	Improvement Factor
Quality Sanctions	=	MCAS Measures below Minimum Performance Level (MPL)	x	Volume of Members in the measures that are not at MPL	x	Corrective Actions Factor
Risk Adjusted Rates using Chronic Illness and Disability Payment System(CDPS) + Medicaid Pharmacy (Rx)	=	CDPS: Presence of Certain disease Categories and the severity of the disease based on diagnosis codes	+	Rx: Use of certain medications indicating disease or risk	-	Certain carved out populations

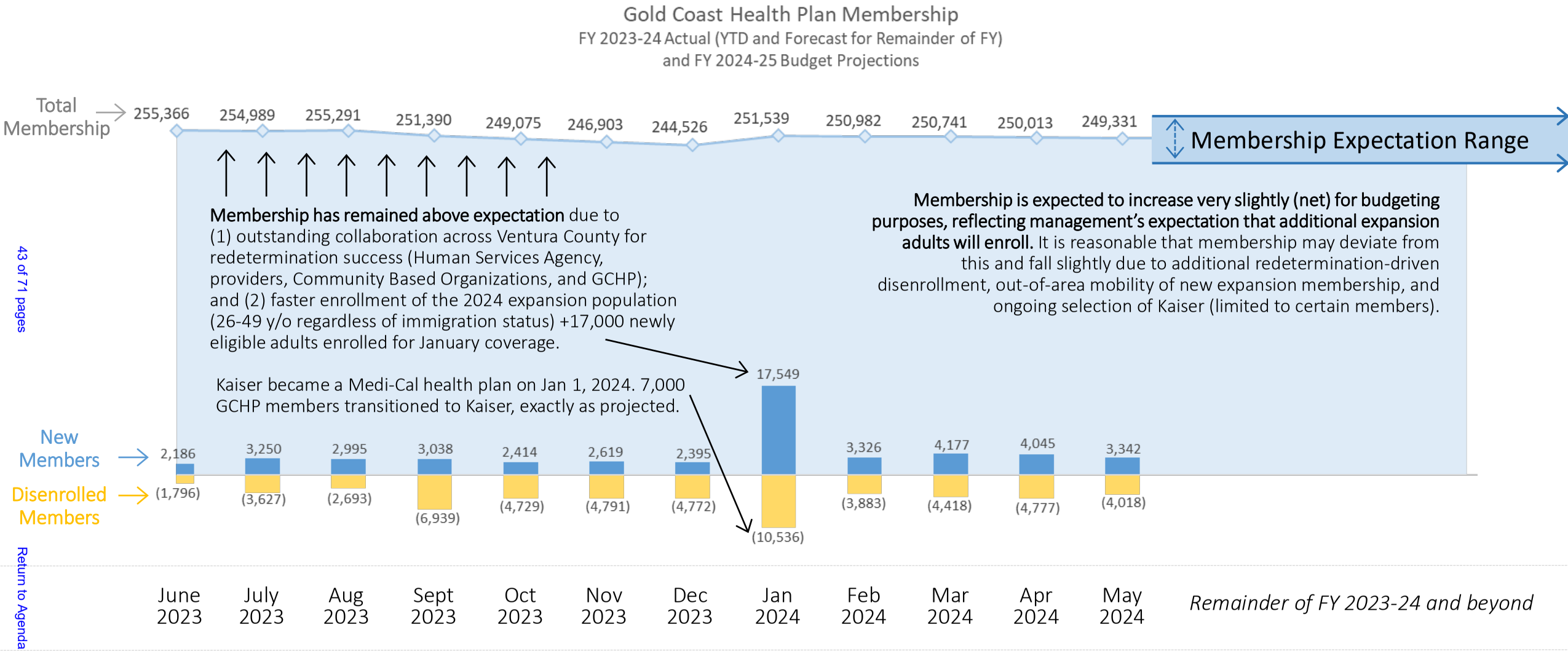
Connecting *with* Care: Members who have access to high quality care and a positive experience with care will have improved health outcomes. Medi-Cal requires it. Our members deserve it. GCHP is leading he way.

This is the Quality Imperative.

Understanding Challenges and Opportunities in Order to Manage the Business of Gold Coast Health Plan

Return to Agenda

Data Based Foundation for Budgeting: Membership Trends



43 of 71 pages

Return to Agenda

Unique Needs of New Members

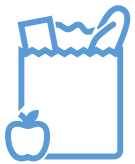
Health Risk Assessments (HRAs) launched in Q1 for our newest members have helped us better understand their needs.

22% of the members rate their health as fair or poor. This is a predicter of health decline and increased utilization.

53% of the members had problems getting care from a doctor in the past 6 months.

17% of members either have used the Emergency Department or Hospital in the past 6 months or had a family member use those resources.

32% of the members felt down, depressed or hopeless in the last 2 weeks.



57% of the members are worried about food running out before they get more money.

48% of the members have seasonal or migrant farmwork as their family's main source of income.

Gold Coast Health Plan
Key insights for our management of costs and sustainability

- Medi-Cal populations have grown the most in premium categories of aid that have decreased the fastest.
- While outsiders view Medi-Cal as increasing premiums, the reality for Medi-Cal Managed Care Plans is that premiums are remaining flat due to the interplay of membership mix and rate setting.
- “Fee for Service” reimbursement rate increase demands in the provider delivery system remain high and in fact are significantly greater than funding available in premiums.
- Healthier members left the health plan through redetermination and the Kaiser transition, as expected. The population that remains has a higher acuity (higher need for care and services).
- GCHP’s “Top 10%”population has an extraordinary occurrence of multiple chronic conditions and a great need for programmatic solutions and integrated care team interventions to improve health and “bend the future cost curve.”
- GCHP is developing a full profile of Inpatient and Long-Term Care costs and utilization drivers as well as a responsive solution to keeping these costs in line with available premium funding.

Data Based Foundation for Budgeting: Membership Mix and Premium Development

- DHCS develops premiums at a population cohort level ("Categories of Aid"), based on age (child or adult), level of need (age and disability), and immigration status (UIS, SIS).
- CY 2024 premiums developed favorably for some categories and unfavorably for others – yielding a flat plan-wide composite premium between CY 2023 and CY 2024. Essentially this means there was no more money per-capita to cover cost increases that were being created by contracted provider reimbursement rate increases.

Membership				DHCS Major "Categories of Aid" Premium Rate Categories	Base Premium Rates			
Actual CY 2023	Actual CY 2024	CY 2024 vs CY 2023 Change	CY 2024 vs CY 2023 % Change		Actual CY 2023	Actual CY 2024	CY 2024 vs CY 2023 $ Change	CY 2024 vs CY 2023 % Change
91,687	87,350	(4,337)	-4.7%	Child - SIS	95.84	$ 103.73	7.89	8.2%
3,720	3,788	68	1.8%	Child - UIS	78.69	$ 100.40	21.71	27.6%
27,601	25,946	(1,655)	-6.0%	Adult - SIS	296.66	$ 326.48	29.82	10.1%
5,992	15,990	9,998	166.9%	Adult - UIS	508.72	$ 470.51	(38.21)	-7.5%
71,180	67,563	(3,617)	-5.1%	Adult Expansion - SIS	357.8	$ 331.05	(26.75)	-7.5%
6,385	12,023	5,638	88.3%	Adult Expansion - UIS	761.52	$ 544.21	(217.31)	-28.5%
10,086	9,928	(158)	-1.6%	SPD - SIS	1177.93	$ 1,252.52	74.59	6.3%
1,178	1,221	43	3.7%	SPD - UIS	1824.05	$ 1,333.13	(490.92)	-26.9%
24,583	24,501	(82)	-0.3%	SPD Dual - SIS	579.44	$ 638.58	59.14	10.2%
638	677	39	6.2%	LTC Dual - SIS	579.44	$ 638.58	59.14	10.2%

GCHP experienced some of the largest declines in rates for our fastest growing population cohorts (expansion groups).

Data Based Foundation for Budgeting: Drivers of Benefit Cost Growth

47 of 71 pages

Return to Agenda

Unit Cost

(excluding the Quality Funding Program)

- Reimbursement rate increases contracted in FY 2023-24 grew annual benefit costs by ~4%; LTC and inpatient costs trends are even steeper.
- Reimbursement rate increases are budgeted to further grow annual benefit costs >1% in FY 2024-25.
- DHCS' Targeted Rate Increase (TRI), a resetting of the baseline Medi-Cal payment schedule, added ~1.5% to benefit costs (MHSA, LTC, and other medical costs) in FY 2023-24 and the TRI program will expand in CY 2025 in yet to be defined ways.
- **Going forward, GCHP must prudently align unit cost increases with premium developments → long-term sustainability requires we spend only what we have in premiums.**

- Unit Costs are <u>not</u> decreasing in any way.

Population/Utilization

- After redetermination and the Kaiser transition, we are seeing a higher acuity (higher need) membership remain and a lower acuity group exit. This is as expected. The group that has left has costs that are ~40% lower than those who remain. **GCHP and provider partners must be increasingly effective at managing care and cost of high acuity, multiple chronic condition populations.**
- The 2024 expansion group of 26-49 regardless of immigration status comes to managed care with a history of high ER use for care. Also, there is potentially a pent-up demand for care and services. GCHP must understand membership needs and tailor solutions that deliver high engagement in regular outpatient primary healthcare, specialty healthcare, and behavioral healthcare.
- CY 2024 premiums include DHCS/Mercer's assumption that utilization in the 2024 expansion population will decrease over the near term after some early pent-up demand. This is expected by DHCS to result in ~1.3% lower costs in FY 2024-25. **Will this show up?**
- GCHP program interventions aimed at "bending the curve of costs= growth" for higher need members, including those with multipole chronic conditions, is having unprecedented, yet expected, favorable impact in the form of prevented readmissions and greater quality care. **We must expand the use of these pioneering and highly effective programs.**

Proposed Budget
Gold Coast Health Plan

Return to Agenda

Summary of Management's Proposed FY2024/25 Budget

	FY2023/24 Forecast	FY2024/25 Budget	Comments
Membership	228,289	**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	$1.042B	**$1.073B**	As presented, this reflects essentially flat revenue even though membership is favorable; the changing member "mix" accounts for the minimal revenue increase; an additional $10M in investment income brings total revenue to $1.084B. MCO tax (which is a pass-through from the Federal government to the State) of $303.7M brings total receipts to $1.376B.
Medical Benefit Cost *(Ratio)*	$885.7M *85.0%*	**$987.2M** ***92.0%***	Prior to the $82.5M Quality Funding Programs, the underlying MBR is 88%.
Administrative Expense *(Ratio)*	$135.5M *13.0%*	**$107.3M** ***10.0%***	The $28M reduction in administrative expenses is due to significantly less funding needed for the Operations of the Future build-out in FY 2024-25 and continuous efficiency improvement in the operations of the health plan. The year-over-year administrative expense reduction is also after accounting for proposed new investments in staffing and additional consulting services."
Reserve Increase/(Decrease)	$33.8M	**$(22.5M)**	Net income prior to the Quality Funding Programs is $60M, or 2% of total revenue (premium revenue plus investment income). The Quality Funding Program produces a planned $(22.5M) decrease to reserves.
Net Increase to Reserves	$33.8M	**$0**	We will be using our $60M operating margin plus $22.5M in reserves for the Quality Funding Programs.

49 of 71 pages

Return to Agenda

A Planned Spend Down of Reserves Has Significant Risks

Going into a planned spend-down position requires us to be even more sensitive to variabilities in our environment that can adversely impact our financial position. Unfavorable changes in any of a multitude of factors could create a far larger spend down than planned. *For instance, think of another $16.3M premium acuity adjustment on top of a planned $22.5M reduction in reserves.*

- Membership Health
  Factors such as redetermination and the introduction of newly-eligible populations could result in a higher-utilizing membership.

- State Rate Actions
  The State has the ability and precedent to invoke revenue reductions retroactively using the historical utilization as rationale.

- Provider Reimbursement Expectations
  The narrowing gap between premium revenues and medical benefits puts pressure on our ability to fund continued fee-for-service increases.

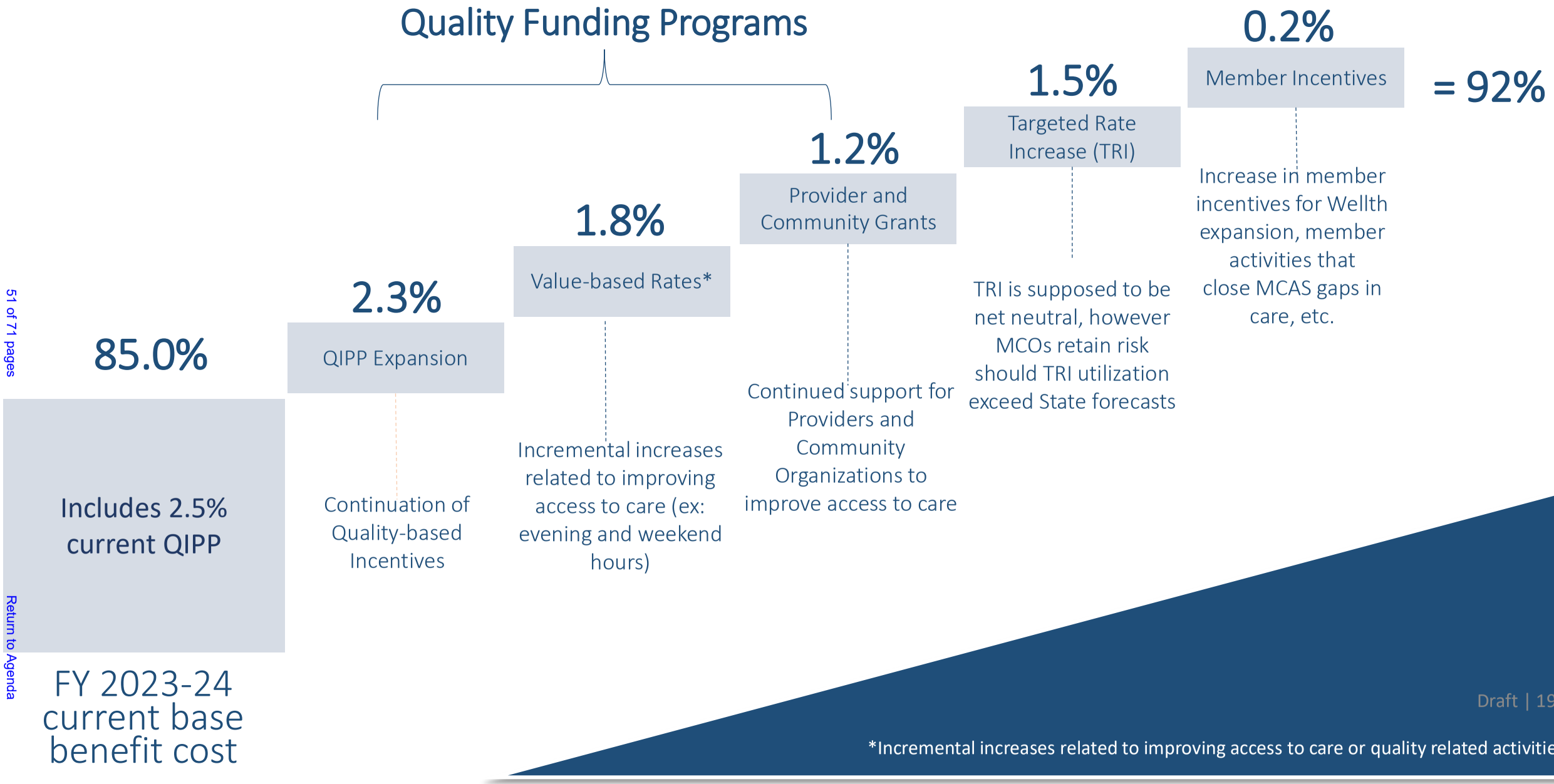
Management Actions
Including but not limited to

- ✓ Proactive monitoring of member health to ensure acuity needs are met timely, preventing unnecessary care in expensive settings.
- ✓ Rate advocacy with State for premium adequacy.
- ✓ Recalibrate reserve recommendations should unfavorable developments require.
- ✓ Advance sophisticated capabilities for managing care and cost, especially of high acuity, chronic condition populations.
- ✓ High discipline on what we can control.

50 of 71 pages

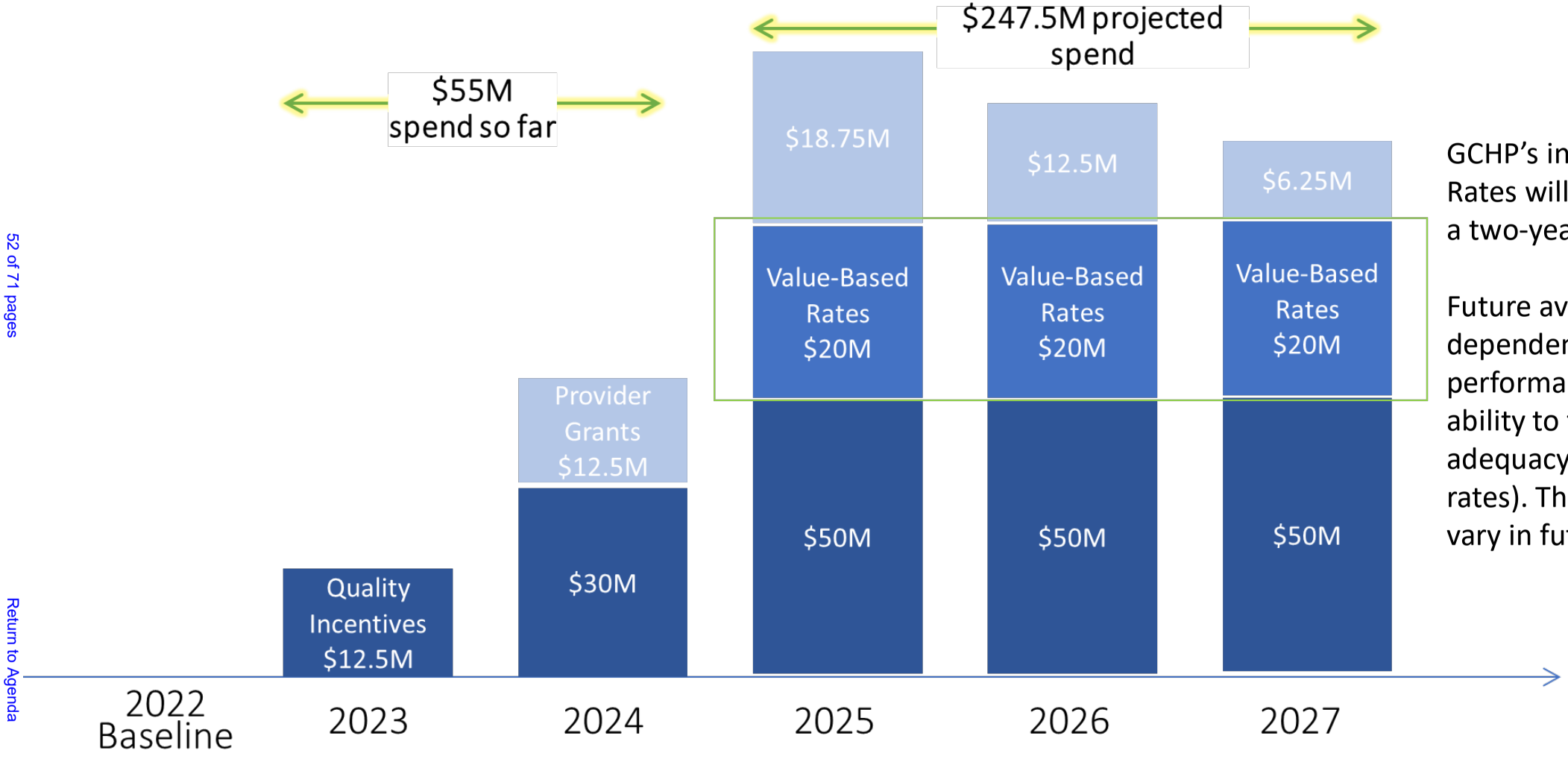
Return to Agenda

Budget FY2024/25 MBR Components → Getting to 92%



Budget FY 2024-25 | Quality Funding Programs and Value-Based Rates

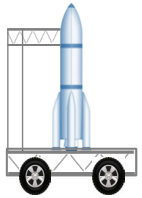
Valued Based Rates reward providers based on increased access, efficiency, and/ or quality.



GCHP's initial Value-Based Rates will be available for a two-year period.

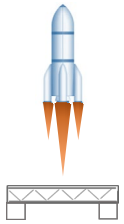
Future availability is dependent on provider performance and GCHP's ability to fund (i.e., adequacy of premium rates). The standards may vary in future years.

Effective Execution of an Unprecedented Budget



Getting Ready for Takeoff 2024/25

- Integrated Care Team full implementation
- Voice of the Member (surveys, feedback); deep understanding of member and community need
- Service Everywhere community resource centers
- Performance Management and Leadership Development
- Strengthening project management capability organization-wide
- Financial strength and continued investment in modernizing health plan capabilities to improve health, quality healthcare, and member experience



Launched 2023/24

- State of art operating systems and services and operational performance excellence
  - Core Admin and BPO
  - Care Management System
  - Provider Portal
  - Modern Data Warehouse
  - CRM
- Community Care model bringing healthcare to members where they want it including school, work, home and neighborhood
- Delegation and vendor oversight to drive performance and value
- DSNP Readiness/Knox Keene
- NCQA Accreditation
- Optimized Data, Analytics & Metrics
- Corporate Integrity Agreement implementation

Landing Well 2023/24

- Highly effective system-wide quality improvement program achieving unprecedented MCAS improvement
- Procurement of best-in-class systems to implement the model of care
- Stellar performance on DHCS, MLR and Claims Audits.
- In-house local contact center
- Healthcare Programs and Services connect members with healthcare/services including Wellth, Community Supports, Member Incentive Programs

- All members get care "Whenever/ wherever" they need it (access and equity for all); High MCAS scores reflect this
- High member engagement in health and healthcare (members know, want, get, and stay active in health and regular primary and specialty care and Rx adherence) yields lasting impacts to individual, family, and community health and wellbeing
- The healthcare system and providers of community-based services are higher performing and continuously improving to meet GCHP/DHCS goals for quality, satisfaction, and equity

53 of 71 pages
Return to Agenda

Gold Coast Health Plan
Fiscal Year (FY) 2024-25 Budget Design conclusion

- GHCP's underlying financial performance today is strong.
- We are planning a judicious use of reserves to further the Quality Funding Programs.
- We seek your feedback on our proposed FY 2024/25 budget today and in 1:1's scheduled for the next few weeks.

Appendices

(1) “Strategy and Budget Principles and Framework” presented to the Executive Finance Committee on April 18,2024 and to the Ventura County Medi-Cal Managed Care Commission on April 22, 2024

Appendix 1—Strategy and Budget Principles and Framework

Return to Agenda

Strategy and Budget Principles and Framework

Executive Finance Committee
April 18, 2024
Nick Liguori, Chief Executive Officer
Sara Dersch, Chief Financial Officer
Erik Cho, Chief Program and Policy Officer
Dr. Felix Nuñez, Chief Medical Officer

Framework for Budget Fiscal Year 2024-25 and 3-Year Planning

Budgets bring our Mission, Vision, and Strategies to life. GCHP Management is developing a budget for the Fiscal Year (FY) 2024-25 and the 3-year period July 2024 – June 2027 that will accomplish the following in alignment with our **MISSION**:

1. **GCHP** | Ensure GCHP has the health plan capabilities necessary to meet our Mission of the best health possible, best access possible to quality healthcare, and superior experience for the members and communities we serve – for both Medi-Cal (low income vulnerable) and D-SNP (low income and/or disabled dually eligible) programs.

    - GCHP is now in the second annual budget of a multi-year transformation of health plan capabilities to meet its Mission, having historically performed low relative to other Medi-Cal local/community health plans in Mission-related measures (MCAS, CAHPS, health outcomes).

    - While always seeking to improve Quality and Satisfaction, we must also build (invest in) our capabilities to better manage medical costs to ensure long term financial viability.

2. **PROVIDERS** | Ensure we can make substantial, sustained, and transformational investments in Ventura County's delivery system of healthcare and healthcare-supportive services with the objective of increasing access to - *and provision of* - quality healthcare for the vulnerable members and communities enrolled in Medi-Cal, where and when they need the care and services.

3. **MEMBERS** | The primary purpose of our work and the fundamental principle that guides us in how we do that work is better health for our members and communities. Our members will be the main beneficiaries of all our many and major efforts to crate a more capable health plan and greater access to needed care across the healthcare system.

Return to Agenda

Budget FY 2024-25 | Commitments

- Management's objective with the budget is to optimize quality care for our members and to ensure the long-term viability and success of GCHP. We do this by ensuring the Ventura County Medi-Cal delivery system has funding to achieve high standards of access and quality care.
- Transparency is a paramount commitment by Management to Commission.
- Management's aim is to provide all information that supports the Commission in making budget decisions compliant with their fiduciary duty, legal requirements and accountability for the health plan's viability and success.
- GCHP continuous improvement: Per best practice, Management is engaging the Commission earlier (April) and more meaningfully in the budget process than ever before.

Return to Agenda

Management values feedback from Commissioners and we are available to answer questions and take in your feedback at any time.

Budget FY 2024-25 | Compliance and Legal Review

- ✓ GCHP Management desires to ensure the fullest funding possible to the Ventura County's Medi-Cal healthcare delivery system, and our funding programs since 2022 demonstrate this commitment.
- ✓ GCHP Management's funding programs are rooted in fundamental principles:
  - We are entrusted with the best use of taxpayer funds.
  - Funding for healthcare services must be adequate for safety net providers dealing with inflationary cost trends.
  - Funding must provide value (access, quality, outcomes) to the health plan and our membership as well as to our State and federal regulators who determine funding and its purpose.
  - Funding must always be compliant with state and federal laws/regulations that define permissible use of funds.
  - Funding must always be reasonable relative to value, services, market standards, industry practices, etc.
- ✓ Compliance is paramount under all circumstances. Compliance under the Corporate Integrity Agreement requires the highest standards of compliance.
- ✓ These slides describe GCHP's plans. BBK (Leeann Habte) on behalf of GCHP is performing a comprehensive legal review of all provider funding, including Quality Incentives, Reimbursement Arrangements, and Grants for compliance with federal and State laws and GCHP's Corporate Integrity Agreement with the Office of the Inspector General. This expert-based review includes consultation with an outside consultant with specialized expertise in value-based funding programs.

Return to Agenda

Budget FY 2024-25 | Process and Timeline

April 2024 Key Dates and Deliverables

- April 18th – Executive Finance Committee presentation on background, context, concepts, and process for Budget FY 2024-25 and 3-Year Plan. Staff request: questions and feedback.
- April 22nd – Commission presentation on the same. Staff request: questions and feedback.

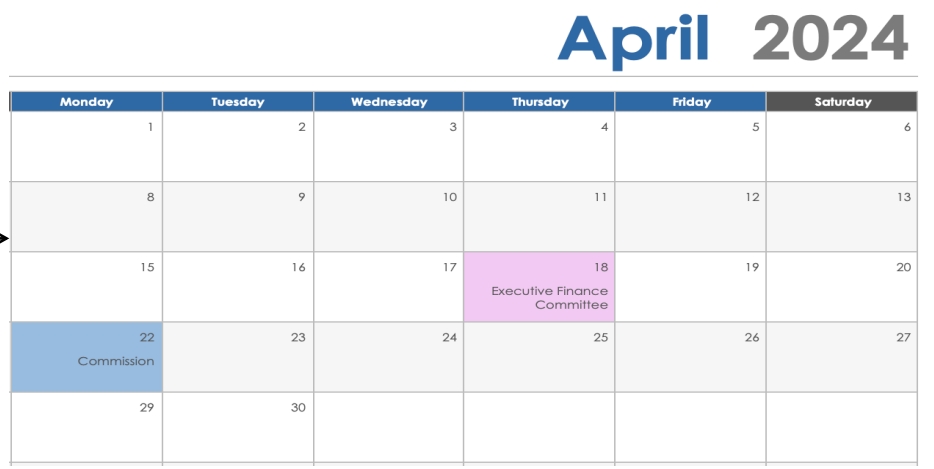
May 2024 Key Dates and Deliverables

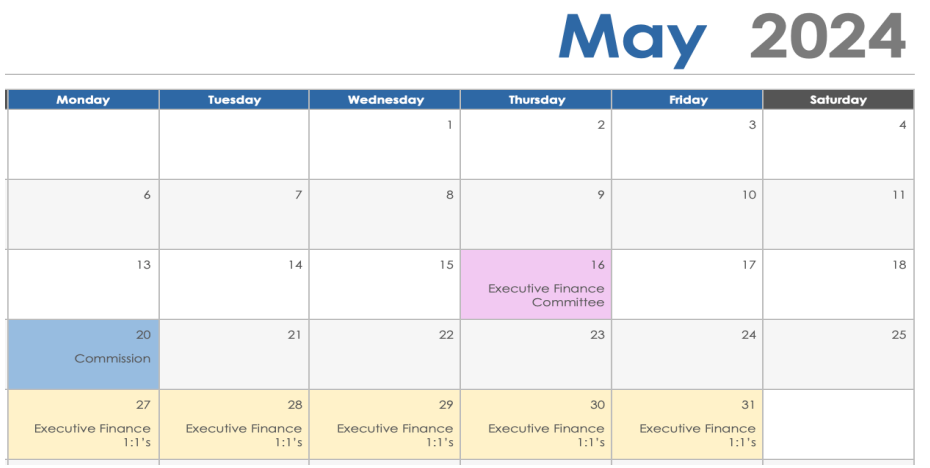
- May 16th – Executive Finance Committee presentation on preliminary Budget FY 2024-25 and 3-Year Plan. Staff request: questions and feedback.
- May 20th – Commission presentation on the same. Staff request: questions and feedback.

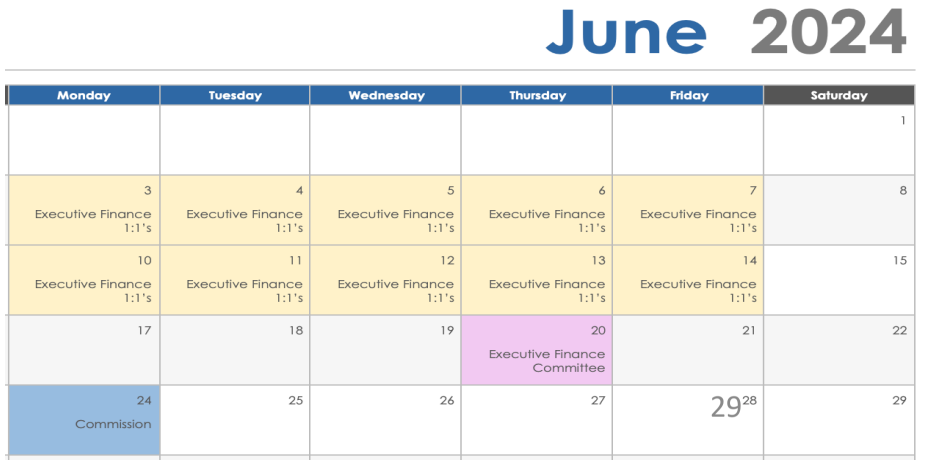
May 17th to June 14th – 1:1s with Executive Finance Committee

June 2024 Key Dates and Deliverables

- June 20th—Executive Finance Committee presentation on proposed final Budget FY 2024-25. Staff request: recommendation.
- June 24th—Commission presentation on the same. Staff request: approval.
- June 25th—Management begins new budget implementation.







Return to Agenda

Budget FY 2024-25 | TNE Industry Perspective

GCHP Management desires to invest some reserves in value-based financing of the Ventura County healthcare delivery system. The Plan is outlined in the following slides. Here is an updated view of TNE across the Medi-Cal industry.

Industry Perspective | Tangible Net Equity by Medi-Cal Managed Care Plan (as % of required TNE)

Source: "Financial Summary of Medi-Cal Managed Care Plans (Quarters Ending June 30, 2023 and September 30, 2023); GCHP source is internal financial reporting.
Non-Governmental Medi-Cal Plans not included - reserves are generally kept at parent

	June 2022	December 2022	June 2023	September 2023
Kaiser Foundation Health Plan		2154%	2209%	2252%
CalOptima	1340%	1482%	1556%	1577%
Health Plan of San Joaquin	988%	1220%	1447%	1381%
Scan Health Plan	1352%	1332%	1306%	1318%
Health Plan of San Mateo	977%	1268%	1275%	1241%
Central California Alliance for Health	1092%	1156%	1180%	1211%
Gold Coast Health Plan	482%	750%	1094%	1025%
L.A. Care Health Plan	716%	690%	789%	954%
CalViva Health	789%	838%	853%	866%
CenCal Health	563%	666%	811%	820%
Inland Empire Health Plan	725%	712%	794%	796%
Kern Health Systems	545%	623%	729%	741%
Alameda Alliance	605%	677%	758%	737%
Partnership HealthPlan	784%	829%	771%	729%
San Francisco Health Plan	1024%	1413%	784%	710%
Santa Clara Family Health Plan	585%	640%	716%	654%
Contra Costa Health Plan	554%	585%	617%	604%

Kaiser and SCAN are shown for additional perspective. Kaiser is included as it is now a fully licensed Medi-Cal Managed Care Plan. SCAN is a standard bearer for managing D-SNP. GCHP will be responsible for fiscally managing D-SNP and its reserves in the next budget year (FY '25-'26).

GCHP ranks near the middle as compared to other Medi-Cal Plans. GCHP TNE declined slightly due to changes in total assets and liabilities.

Preliminary 2024 financial reports are that LA Care will exceed GCHP's position in Year End rankings due to its pace of reserve growth.

Budget FY 2024-25 | MBR Components

85.0%

Includes 2.5% current QIPP

FY 2023-24 base benefit cost trended

2.5%

QIPP Expansion

Continuation of Quality-based Incentives

2.0%

Transitional Rates*

Incremental increases related to improving access to care (ex: evening and weekend hours)

1.3%

Provider and Community Grants

Continued support for Providers and Community Organizations to improve access to care

TBD

Targeted Rate Increase (TRI)

TRI is supposed to be net neutral, however MCOs retain risk should TRI utilization exceed State forecasts

TBD

Member Incentives

Increase in member incentives for Wellth expansion, member activities that close MCAS gaps in care, etc.

> 92%

*Incremental increases related to improving access to care or quality related activities

Return to Agenda

Budget FY 2024-25 | Actuarial Unit Cost Comparison

- This analysis of GCHP Unit Cost vs. those of other Southern California Medi-Cal regions (7 counties, 7 Medi-Cal Managed Care Plans) provides valuable insight for forecasting future premium rates. This analysis of unit cost closely approximates a comparison of reimbursement rates.
- Key to future rate development will be the maintenance of traditional FFS spending that is "in line" with spending across Medi-Cal plans. **Outlier FFS spending is at risk of not being fully reimbursed as DHCS looks to create greater regional cost parity.**
- Regional rate setting will replace individual plan rate setting in the near future. GCHP Management is actively preparing our reimbursement program to succeed in this new premium paradigm – **a focus on value/quality is one way to ensure long term success** (both financial success and Mission success).
- Key findings of the analysis strongly support Management's plan to focus spending increases for the greatest Quality (MCAS) impact:
    1. **MCAS improvements are principally achieved by greater use of outpatient primary healthcare, specialty healthcare, behavioral healthcare, and transportation to care.**
    2. **Physician Primary Care, Behavioral Healthcare, and Transportation unit costs are low relative to the industry.**

Category of Healthcare Service	GCHP Percentile (100% = Highest Rate in Region)
Inpatient Hospital	100.0%
Hospice	93.2%
Laboratory and Radiology	91.9%
CBAS	83.7%
BHT Services	76.6%
FQHC	76.6%
Physician Specialty	76.5%
Long-Term Care	75.4%
Emergency Room	61.5%
Other Medical Professional	56.6%
Outpatient Facility	55.2%
Mental Health - Outpatient	46.1%
All Other (small category $-wise)	37.6%
Physician Primary Care	37.2%
Home and Community Based Services	34.9%
Transportation	33.7%
Overall	71.6%

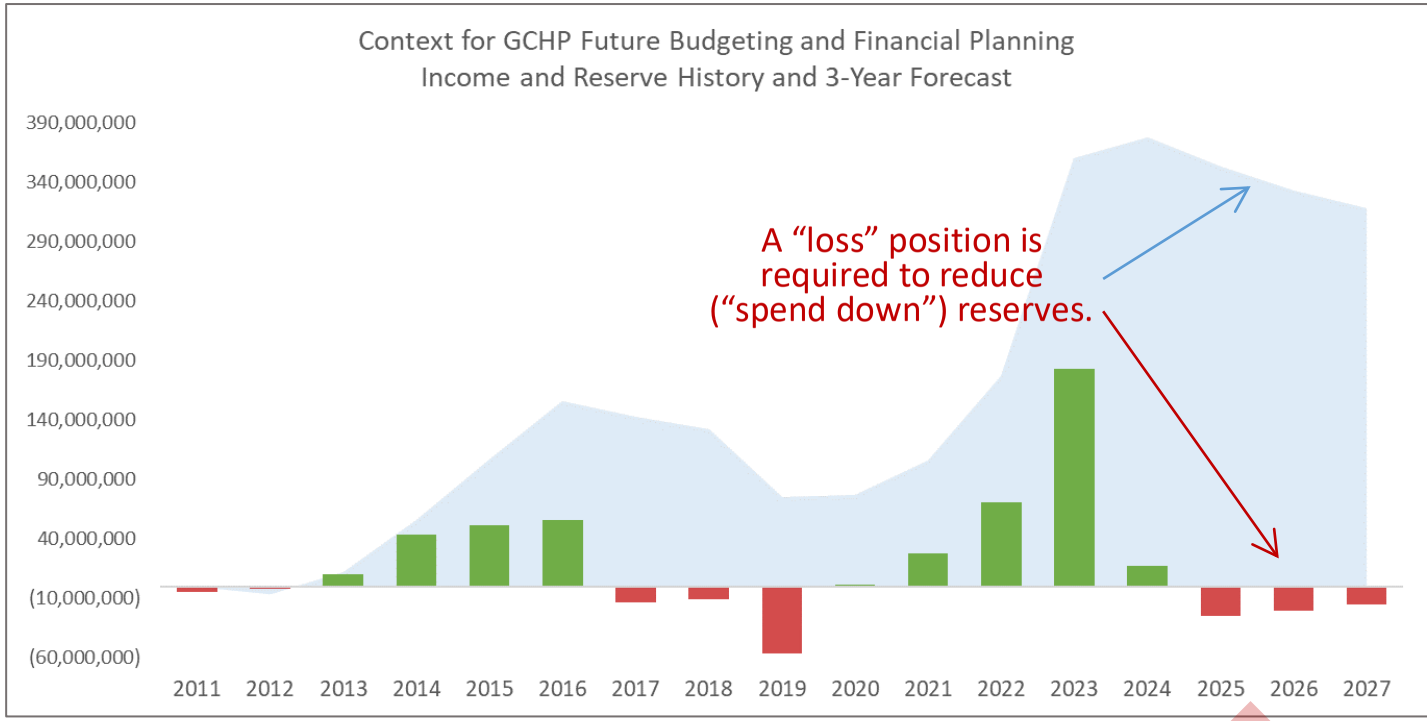
Costs are for the adult population and excludes the impact of population acuity and utilization. Counties include Kern, Los Angeles, Riverside, Santa Barbara, San Bernardino, San Luis Obispo, and Ventura.

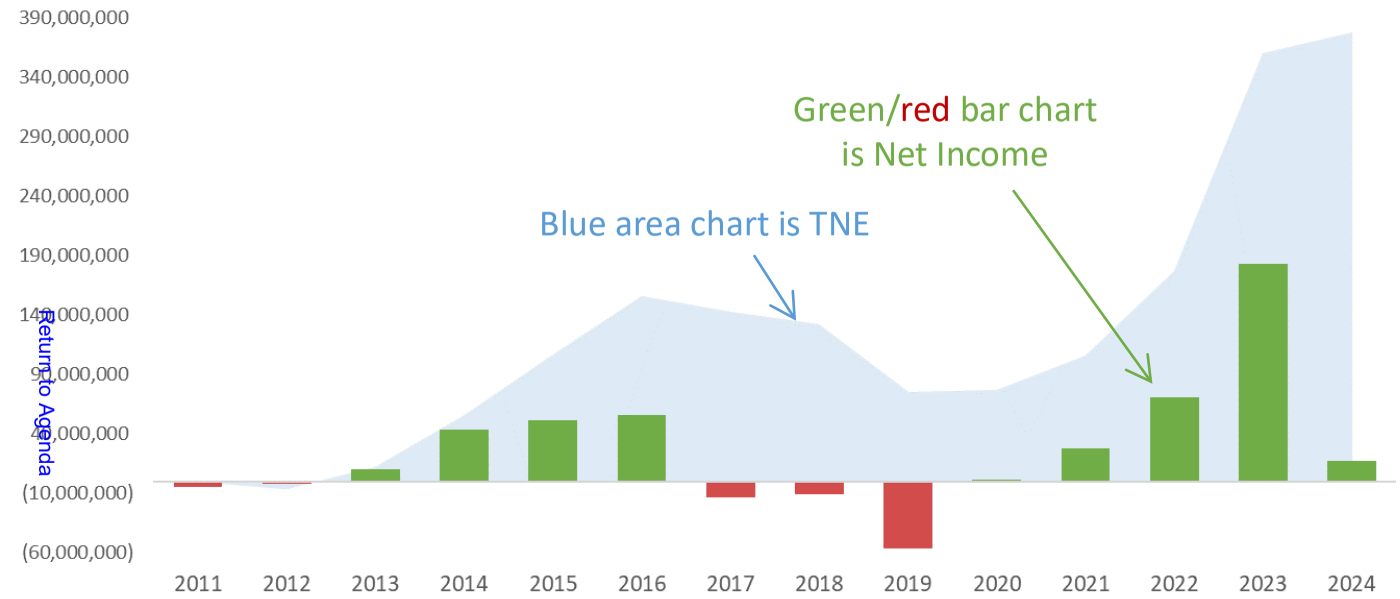
64 of 71 pages

Return to Agenda

Income and TNE Position

- Net Income adds to or reduces health plan reserves – adds to if Net Income is positive, reduces if negative. You can see the historical relationship in the chart below – when Net Income is positive, reserves grow by that amount; conversely, "losses" reduce reserves.





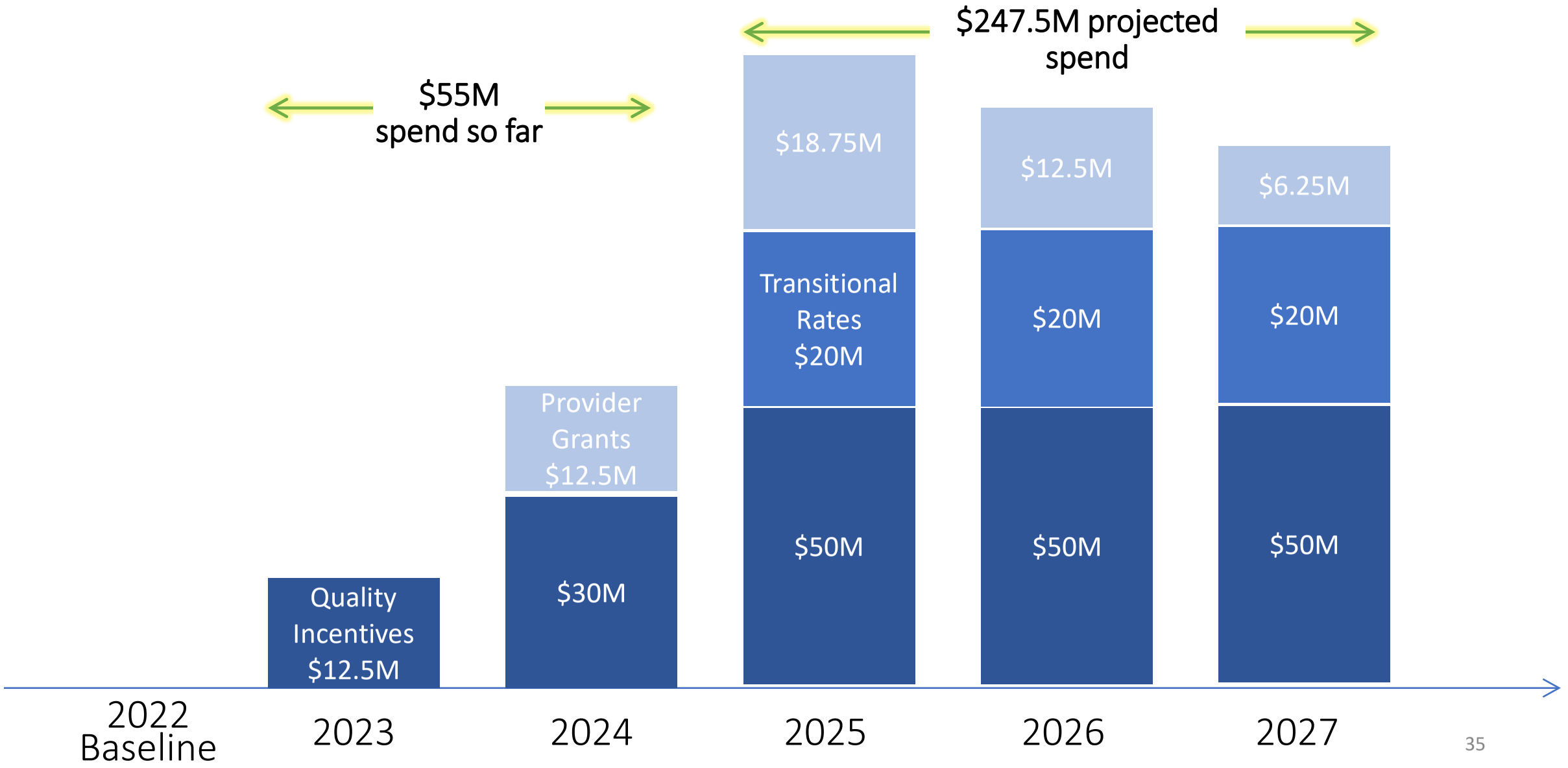
- To achieve a spend down of some Unrestricted Reserves (i.e., not in the 700% of TNE Policy), GCHP must go into a negative Net Income ("loss") position.

Budget FY 2024-25 | TNE Composition and Planning

Today		Management Analysis	GCHP Management Recommended Actions
1025%	Unrestricted Reserves 325%	$60M	GCHP Management proposes to plan for a $60M reduction in reserves over the next 3 budgets (spanning July 2024 – June 2027) in the form of compliant and value-based funding for providers.
		$60M	D-SNP expenses (provider and administrative) are highly sensitive to minor changes in our modeling assumptions. Slightly adverse developments increase magnitude of losses. These are expected losses for D-SNP (actuarially developed) which has been filed with DMHC in its Knox Keene license application.
	Restricted Reserves 700%	$258M	These funds are restricted for maintenance of adequate reserves for long term viability of GCHP. These funds were established as GCHP TNE Reserve by Commission approval of the FY 2023-24 Budget (current year). For Medi-Cal alone, this provides for adequate long-term thinking and planning and investments to GCHP and providers. For Medi-Cal AND D-SNP combined, these reserve levels are inadequate. Management recommends adding to these reserves to meet satisfactory TNE for both programs.

- ✓ We seek to invest in providers through enhanced Quality-based funding. To do this, we must plan for 3 years of losses. We will course correct if rates and/or medical cost pressures trend adversely to forecast.
- ✓ GCHP Management and Actuaries recommend combining D-SNP TNE and Medi-Cal TNE to account for combined reserve needs.
- ✓ GCHP's actuarial model for D-SNP financial performance filed with the Knox Keene application expects $30M cumulative losses Years 1-3.
- ✓ An additional $30M reserves (on top of $30M expected losses) is prudent due to significant uncertainty in D-SNP performance/losses in 2026-2029.
- ✓ GCHP is entering a period of industry-wide anticipated premium pressures.

Budget FY 2024-25 | Quality-Focused Funding Increase 23-27



Budget FY 2024-25 | Quality-Focused TNE Investment

Program	FY 2024	FY 2025	FY 2026	FY 2027
PCP Quality Improvement Programs Up To:	$30M	$35M	$35M	$35M
Hospital and other incentives which may include Specialty, Long Term Care and Behavioral Health Integration Up To:		$15M	$15M	$15M
Transitional Rates Up To:		$20M	$20M	$20 M
Provider and Community Grants Up To:	$12.5M	$18.75M	$12.5M	$6.25 M

GCHP's financial targets will drive Quality and Access through provider investments aligned with Commission- Approved spend.

- **Quality Incentives:** $10 MQIPP Expansion to roll out this FY with incentive programs across other provider areas in development.
- **Transitional Rates:** These rates will be impacted, as much as possible, by quality, access to care, and transitions of care activities and improvements.
- **Provider and Community Grants:** We aim to deliver early on the $25M, 2–3-year commitment made starting in FY 23-24 and provide an additional $25M in funding through FY 2027.

D-SNP/Medicare Forecast Impact on TNE

Model Assumptions	Knox Keene Filed Scenario	Lower Stars Higher Reimbursement	Higher Membership, Lower Stars, Lower Savings Higher Reimbursement
Membership by Year 3	5,190	5,190	13,080
CMS Quality Star Rating	4	3.5	3.5
Managed Care Savings (from "unmanaged FFS")	20%	20%	15%
Provider Reimbursement (% of Medicare Fee Schedule)	102.5%	105%	105%
3- Year Cumulative Losses	-$17M	-$39M	-$60M or more*

* Management is working with actuaries on additional scenario planning

Budget FY 2024-25 | Key Terms (1 of 2)

CMS Quality Star Rating: The Medicare equivalent of the DHCS Managed Care Accountability Set (MCAS). Ratings focus on health plan quality based on measurements of customer satisfaction and the quality of care a plan delivers. Plans are rated on a scale of one to five, with one star representing poor performance and five stars representing excellent performance.

D-SNP: A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan specifically designed to provide targeted care and limit enrollment to special needs individuals. A Dual Eligible Special Needs Plans (D-SNPs) is a type of SNP that enrolls individuals who are entitled to both Medicare and Medicaid (Medi-Cal in California).

Medical Benefit Expense: Costs for medical, dental, vision, transportation, meals, and other covered supplemental benefits.

Medical Benefit Ratio (MBR): Ratio of Medical Benefits to Premium Revenue; the percentage of state revenue that is spent on medical care.

Medicare Fee Schedule: A complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fees used to reimburse a physician and/or other providers on a fee-for-service basis.

Medical Management Savings: Savings generated from health plan activities related to the medical management of health services as compared to the Medicare Fee-For-Service costs.

Return to Agenda

Net Income: The remaining profit or loss after all expenses have been subtracted from all revenues. The Net Income increases reserves if positive or reduces reserves if negative.

Budget FY 2024-25 | Key Terms (2 of 2)

Premium Revenue: Amount received from the State to provide medical care and other covered services to GCHP members.

Quality Incentive Pool and Program (QIPP): A focused effort to direct funding to Providers for the achievement of Quality measures.

Restricted Reserves: The portion of Tangible Net Equity (TNE) that GCHP is required by policy to maintain (i.e. not be used). For GCHP's existing line of business (Medi-Cal), this amount is currently set at 700% of the Department of Health Care Services (DHCS) required minimum TNE.

Tangible Net Equity (TNE): GCHP total assets (cash, physical property, amounts we are owed) less total liabilities (both realized and incurred, such as amounts GCHP owes to pay current claims, vendors, personnel, etc). GCHP is required to maintain the DHCS formula-derived minimum TNE to ensure continuity of payments and services.

Targeted Rate Increase: To improve access to care, quality and equity, the California Department of Health Care Services (DHCS) is increasing rates to 87.5% of Medicare for certain Medi-Cal services.

Unrestricted Reserves: The portion of GHCP's TNE above and beyond the Commission-specified minimum. The unrestricted reserves will be used to cover expected losses in the first years of D-SNP as well as the quality-related funding for providers and other Commission-approved uses.

Value-Based Care: Care that ties the amount providers earn to the results they deliver for their patients, such as the quality, access and equity.