

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

Executive Finance Committee

Special Meeting

Monday, June 12, 2023 – 3:00 p.m.

711 E Daily Drive, Camarillo

Community Room

Members of the public can participate using the Conference Call Number below.

Conference Call Number: 805-324-7279

Conference ID Number: 531 578 694#

Adventist Health Simi Valley
2975 N. Sycamore Dr.
Simi Valley, CA. 93065

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

Community Memorial Health System
147 N. Brent St.
Ventura, CA 93003

233 Corte Linda
Santa Paula, CA 93060

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.

FORMAL ACTION

1. Contract Approval – Electronic Data Interchange Software

Staff: Alan Torres, Chief Information Officer

RECOMMENDATION: It is the Plan's recommendation that the Executive Finance Committee recommend the Ventura County Medi-Cal Managed Care Commission waive any irregularities in Edifec's proposal and authorize the CEO to execute a contract with Edifecs Inc., to include the additional work in SOW 2 above subject to non-material terms to be agreed upon and acceptable to the CEO and General Counsel. The term of the contract will be 12 months of implementation and 5 years of production commencing July 1, 2023, and expiring on June 30, 2029, for an amount not to exceed \$8.3M.

2. Discussion of 2023/2024 Budget

Staff: Nick Liguori, Chief Executive Officer

RECOMMENDATION: Staff requests the Executive Finance Committee provide direction.

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: Alan Torres, Chief Information Officer

DATE: June 12, 2023

SUBJECT: Contract Approval – Electronic Data Interchange Software

BACKGROUND/DISCUSSION:

Project Background

By this request, GCHP staff is asking that the Executive Finance Committee recommend that the Commission award a competitively bid contract for Electronic Data Interchange Software (EDI) that will support claims processing efficiencies with an enhanced provider and member experience. Following the health plan industry's standard practice of regularly evaluating capabilities and performance against the nationwide market of system and service providers, GCHP began a comprehensive procurement of technologies and services, (reference the initiative list below in table 1). GCHP intends to implement these solutions by July 1, 2024. The Commission has authorized GCHP staff to undertake improvements throughout the Plan to improve medical care and outcomes and become a leader in the delivery of health care services to members.

The specific initiative relative to this request was to survey the marketplace through a competitive bidding process (RFP 1) for a new EDI infrastructure which will help transform GCHP. The solution will be expected to support and enhance the modernized capabilities of the new Health Edge Health Rules Core Administration system. EDI is the automated transfer of data in a specific format following specific data content rules between a health care provider and health care plan, or between DHCS and another health care plan. Some examples of types of EDI Documents exchanged in the healthcare industry are enrollments, claims, claim status and claim processing, benefit eligibility inquiries.

GCHP staff is recommending that Edifecs be awarded the contract. GCHP staff has meet with the current EDI software vendor, Conduent, and has explained the reasons why GCHP is migrating to a new EDI platform.

Table 1

RFP 1	EDI Services
RFP 2	Core Claims Processing Software
RFP 3	Medical Management Software
RFP 4	Provider and Member Portal Software
RFP 5	BPO (Claims Processing Services)
RFP 6	Mailroom and Claims Editing Services
RFP 7	Print and Fulfillment Services
RFP 8	Call Center Software/Technology

Procurement Background

Lead by GCHP's Executive team on November 1, 2022, staff issued a Request For Proposal, (RFP) for Electronic Data Interchange Software directly to the twelve, (12) vendors listed:

Edifecs	Gainwell
TransUnion	OptumInsight
Conduent	UST
Oracle	First Source
Accenture	Broad Path
Deloitte	Catalyst Solutions

Set forth below is the schedule utilized for the RFP.

Event	Date	Time (If applicable)
RFP Released	11/01/2022	
Intent to Propose Notification Due By	11/04/2022	5:00pm. PT
Questions Due	11/09/2022	5:00pm. PT
Questions Answered	11/16/2022	
Proposal Due Date	12/05/2022	5:00pm. PT
Short List Established and Contractual Discussions Begin	12/19/2022	
Short List –Solution Review	01/09/2023	Scheduled for the week of the 1/09/2023

GCHP received three (3) responsive proposals. A cross functional evaluation team was formed with representation from IT, (2 team members), Operations, (1 team member), Provider Contracting, (1 team member) and Procurement, (1 team member) to evaluate the proposals. Using predetermined evaluation criteria and weights, the team scored each proposal from the RFP's qualitative and quantitative requirements.

The scoring results from the evaluation team are as follows:

Overall Scores (High to Low):

Vendor	Qualitative Score	Quantitative Score	Overall Score
Edifecs	40.59	18.80	59.39
Conduent	38.15	9.62	47.76
Deloitte	39.72	2.00	41.72

Contracting Discussions

The GCHP team determined that Edifecs was the clear leader and commenced contract discussions.

Key takeaways during the contracting discussions:

- Leveraged existing agreements and added in revised regulatory clauses in the Master License and Services Agreement
 - Specific additional language includes:
 - The right to perform services offshore
 - The DHCS Availability of Funds clause
 - DHCS Records and Audit language
 - DHCS Suspended, Excluded or Ineligible Employees language
 - Government Claims Act (Government Code Section 900)
 - California Public Records Act language
- Updated the Business Associate Agreement

Edifecs's Qualitative Value

Edifec's provides industry leading capabilities in the area of electronic data exchange. Health plans can more efficiently partner with providers and DHCS in real time to create a more connected, efficient experience across Medical and D-SNP lines of business. Edifec's makes it easier for payers to exchange and connect data, satisfy regulatory and member demands.

- Ensures EDI best practices that are also utilized by our sister plans
 - Edifec's has DHCS regulatory edits included as part of the product
 - Robust data tracking and visibility layer allowing easy on demand dashboarding
 - Edifec's is already NCQA accredited and will provide best practices for us to achieve our NCQA accreditation goals
- The capability is highly configurable and requires less human intervention which drives efficiencies and lowers the operating costs

Contract Negotiations

As noted above, GCHP prioritized contract negotiations with Edifecs. Contractually, Edifecs agreed to the revised regulatory clauses and updated the BAA. The work contemplated by the RFP and upon which the scoring was performed is set forth in Statement of Work 1, described in the chart below. The total cost for this work is an amount not to exceed \$6.8 million dollars. Conduent's bid for such services was \$8.1 million dollars.

SOW 1 (Requirements of the RFP)
TMAAS – Base SaaS Platform
834 – Enrollment Transactions
837 – Claims & Encounter transactions

During discussions with Edifecs, after GCHP staff determined that it would recommend that the contract be awarded to Edifecs, GCHP and Edifecs discussed other enhanced services that GCHP will most likely require prior to the June 30, 2024, Operations of the Future "Go-Live Date". These additional services have been added to the contract and total an additional not to exceed amount of \$1.5 million. They are set forth in the chart below.

SOW 2 Additional Implementation Services
270/271 – Eligibility Benefit Inquiry and Response
276/277 – Claim Status Inquiry and Response
278/278R – Authorization Request for Review and Response
820 – Capitation/Premium payment information
274 – Provider Directory
835 – Claim Payment/Remittance Advice
Business Operations Services

GCHP concluded negotiations on a contract that is acceptable to GCHP, and the Proposers will be notified of the recommendation to award the contract to Edifecs. GCHP is still working on the overall implementation plan and will determine if other services with Edifecs should be contracted

FISCAL IMPACT:

The total cost over the projected useful life of the 12-month implementation period and 5-year agreement (7/1/2023- 6/30/2029) is projected to not exceed \$6.8M. The additional implementation labor cost to support SOW 2 listed above is projected to not exceed \$1.5M, over the same period. The total cost of this contract is a not to exceed amount of \$8.3 million, which is just \$200,000 above the amount of Conduent's bid for the services covered by SOW 1 alone. The annual license fee includes a fixed annual increase of 5% per year.

RECOMMENDATION:

It is the Plan's recommendation that the Executive Finance Committee recommend the Ventura County Medi-Cal Managed Care Commission waive any irregularities in Edifec's proposal and authorize the CEO to execute a contract with Edifecs Inc., to include the additional work in SOW 2 above subject to non-material terms to be agreed upon and acceptable to the CEO and General Counsel. The term of the contract will be 12 months of implementation and 5 years of production commencing July 1, 2023, and expiring on June 30, 2029, for an amount not to exceed \$8.3M.

If the Executive Finance Committee desires to review this contract, it is available at Gold Coast Health Plan's Finance Department.

AGENDA ITEM NO. 2

TO: Executive Finance Committee

FROM: Nick Liguori, Chief Executive Officer

DATE: June 12, 2023

SUBJECT: 2023/2024 GCHP Budget Discussion

PowerPoint with Verbal Presentation

FOR EXECUTIVE FINANCE COMMITTEE

June 12, 2023

Gold Coast Health Plan FY 2023-24 Budget - Income Statement

TOTAL	1H FY2024	2H FY2024	FY2024
Revenue			
Base Cap	\$ 484,183,425	\$ 419,784,008	\$ 903,967,433
Quality Withhold/Earnback	\$ -	\$ (4,197,840)	\$ (4,197,840)
Plan Arrangement	\$ 2,613,169	\$ 1,946,329	\$ 4,559,498
Premium Tax Revenue	\$ 51,040,737	\$ 45,733,724	\$ 96,774,462
ECM Revenue	\$ 6,052,231	\$ 5,711,005	\$ 11,763,236
Provider Incentives	\$ 4,520,403	\$ 7,032,833	\$ 11,553,236
Prop 56	\$ 12,314,205	\$ 11,004,371	\$ 23,318,576
BHT 0-6	\$ -	\$ -	\$ -
BHT 7-20	\$ -	\$ -	\$ -
Hyde (including Prop 56)	\$ 395,523	\$ 337,613	\$ 733,137
Maternity	\$ 11,602,500	\$ 11,932,624	\$ 23,535,124
Hep-C	\$ -	\$ -	\$ -
TOTAL REVENUE	\$ 572,722,193	\$ 499,284,667	\$ 1,072,006,861
820 MMs	1,483,742	1,329,469	2,813,211
FFS Expense			
Inpatient	\$ 110,963,821	\$ 106,566,361	\$ 217,530,182
Long Term Care	\$ 81,512,607	\$ 82,714,088	\$ 164,226,695
Outpatient Facility	\$ 37,782,366	\$ 36,548,912	\$ 74,331,278
Specialty Physician	\$ 35,355,244	\$ 33,842,643	\$ 69,197,887
Emergency Room	\$ 18,873,267	\$ 18,311,857	\$ 37,185,123
Home and Community Based Services - CBAS	\$ 9,329,794	\$ 9,627,081	\$ 18,956,875
Mental Health	\$ 17,740,388	\$ 17,759,666	\$ 35,500,054
Other Medical	\$ 5,983,971	\$ 6,009,027	\$ 11,992,998
FQHC - Primary Care Physician	\$ 5,055,743	\$ 4,875,941	\$ 9,931,684
Primary Care Physician	\$ 9,221,654	\$ 8,903,287	\$ 18,124,941
Home and Community Based Services - Hospice Services	\$ 3,197,465	\$ 3,254,204	\$ 6,451,670
Lab and Radiology	\$ 5,716,032	\$ 5,506,508	\$ 11,222,540
Other Medical Professionals	\$ 2,088,394	\$ 2,039,481	\$ 4,127,875
FQHC - Specialty Physician	\$ 2,093,774	\$ 1,979,533	\$ 4,073,307
Home and Community Based Services - Other	\$ 1,165,322	\$ 1,140,438	\$ 2,305,761
Transportation	\$ 1,149,016	\$ 1,123,477	\$ 2,272,493
Prop 56 Payment	\$ 11,698,495	\$ 10,454,152	\$ 22,152,647
Pharmacy: PBM	\$ -	\$ -	\$ -

FOR EXECUTIVE FINANCE COMMITTEE

June 12, 2023

Capitation Expense				
Clinicas	\$ 15,577,286	\$ 13,830,830	\$ 29,408,116	
VCMC	\$ 7,861,216	\$ 7,082,443	\$ 14,943,659	
Dignity	\$ 512,402	\$ 461,534	\$ 973,936	
CMH	\$ 2,523,788	\$ 2,306,645	\$ 4,830,433	
VSP	\$ 1,101,641	\$ 1,017,492	\$ 2,119,134	
VTS	\$ 5,229,310	\$ 4,829,868	\$ 10,059,178	
Americas	\$ -	\$ -	\$ -	
Kaiser	\$ 10,899,979	\$ -	\$ 10,899,979	
Other Providers	\$ 241,708	\$ 219,991	\$ 461,699	
Other Expenditures				
Pharmacy Rebates	\$ -	\$ -	\$ -	
Provider Grant Program	\$ 10,000,000	\$ 5,000,000	\$ 15,000,000	
Settlements	\$ -	\$ -	\$ -	
Claims Recoveries (non-system adjusted)	\$ (600,000)	\$ (600,000)	\$ (1,200,000)	
Reinsurance (net of recoveries)	\$ 950,000	\$ 950,000	\$ 1,900,000	
Provider Incentives	\$ 18,138,363	\$ 13,133,928	\$ 31,272,290	
ILOS/Community Supports	\$ 3,000,000	\$ 3,000,000	\$ 6,000,000	
GEMT	\$ 1,415,686	\$ 1,293,403	\$ 2,709,089	
Premium Tax	\$ 51,040,737	\$ 45,733,724	\$ 96,774,462	
ECM	\$ 5,749,619	\$ 5,425,455	\$ 11,175,074	
TOTAL EXPENSE	\$ 492,569,086	\$ 454,341,971	\$ 946,911,058	
Member Months	1,470,315	1,320,207	2,790,522	
MLR	85%	90%	88%	

Care Management Credit		\$ 23,347,392
MLR - with care management		90.5%
Net Income (Loss) Before Administrative		\$ 101,748,411
Administrative Cost		\$ 89,206,608
Interest Income		\$ 10,080,000
Net Income (Loss)		\$ 22,621,803
Margin (Net Income as % of Revenue)		2.1%
Administrative Cost as a % of Revenue		8.3%

FY 2023-24 Budget Review Executive Finance Committee

June 12, 2023

Presented by the Gold Coast Health Plan Executive Team

PRESENTATION SECTIONS

- Slide 3: FY 2022-23 Budget Performance Review
- Slides 4-9: FY 2023-24 Budget Summary
- Slides 10-14: TNE and "Free Surplus" Policy Proposal
- Slides 15-23: Staffing and Administrative Budget

The remaining slides (24-70) are from the May 15th Executive Finance Committee Meeting and provided here for your convenient reference.

FY 2022-23 REVIEW (APRIL YTD)

Budget Item	Budget 2022-23	Actual 2022-23	Explanation
Enrollment	229,251	246,304	Enrollment is 7.4% higher than expected due to the continuation of the PHE (and continuous enrollment requirement) through July 2023 in Medi-Cal. Based on best available information at the time, Budget assumed the PHE would end in October 2022 with redetermination beginning at that time (vs the now known July 2023 date).
Revenue (Total Net Premium)	\$814,012,556	\$825,402,616	Revenue 1.4% higher due to enrollment exceeding expectations (see above) and MCO Premium Taxes being 30% lower than expected due to the timing of DHCS policy changes.
Total Cost of Health Care	\$708,064,963	\$622,403,489	Medical costs are 12% lower than expected due almost entirely to the continuation of the PHE and suspension of redetermination (see member analysis on pages 8/9).
General & Administrative Expenses	\$60,784,742	\$60,795,158	GCHP has managed almost exactly to the G&A budget (0.00017% difference). Personnel costs were slightly higher and project and implementation expenses were lower.

BUDGET OVERVIEW:

In FY 2023-24, GCHP is expected to experience a post-Public Health Emergency reset of business fundamentals that will significantly impact membership, revenue, medical costs (and risk profile), and margin and will require modern managed care capabilities and infrastructure to manage care/cost/quality going forward.

Net Income \$ 23M (2.1%) | YE Membership 212k



TNE 1,000% of the minimum required | Spend down plan will aim to reduce this to ~700% over the 2023-2026 timeframe

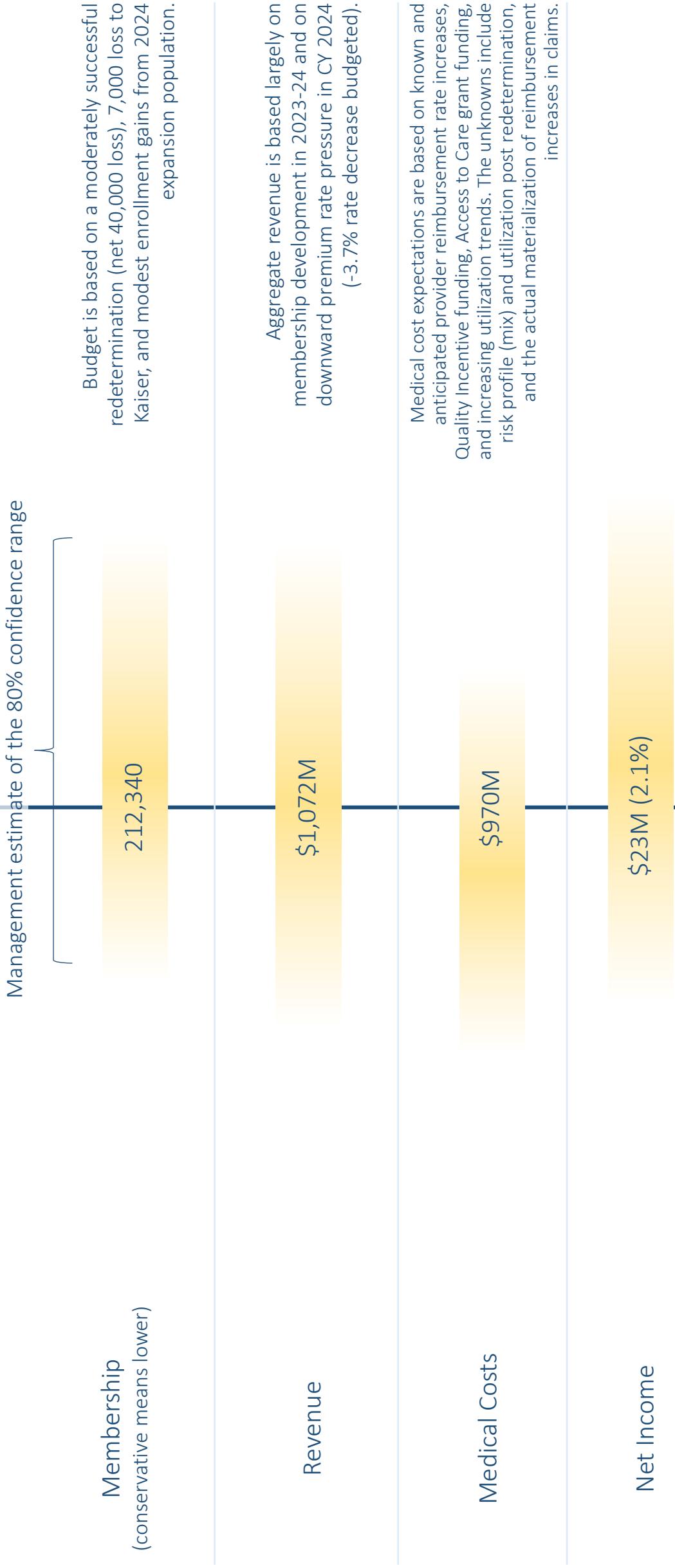
YTD MEDICAL EXPENSE RATIO 88% (90.5% with care management costs)

YTD ADMIN EXPENSE RATIO 8.3%

Financial Scenarios

More Conservative

More Aggressive



Financial Scenarios

More Conservative

More Aggressive

Management estimate of the 80% confidence range

Membership
(conservative means lower)

212,340

-3% ↓
Lower than expected

Budget is based on a moderately successful redetermination (net 40,000 loss), 7,000 loss to Kaiser, and modest enrollment gains from 2024 expansion population.

Revenue

\$1,072M

-4% ↓
Lower than expected

Aggregate revenue is based largely on membership development in 2023-24 and on downward premium rate pressure in CY 2024 (-3.7% rate decrease budgeted).

Medical Costs

\$970M

-5% ↓
Lower than expected

Medical cost expectations are based on known and anticipated provider reimbursement rate increases, Quality Incentive funding, Access to Care grant funding, and increasing utilization trends. The unknowns include risk profile (mix) and utilization post redetermination, and the actual materialization of reimbursement increases in claims.

Net Income

\$23M (2.1%)

\$125M (11.1%)

Worst Case Expectation
Relatively Low Chances

Best Case Expectation
Relatively Low Chances

MER Drivers – Accounting for every % of the increase in the Medical Expense Ratio

	FY 2022-23 YTD Through April	Projected FY 2023-24 Budget MLR
	75.1%	90.5%
Provider	Medical Loss Ratio Difference: FY 2022-23 YTD (Actual) to FY 2023-24 (Budget)	
Provider Quality Incentive Program		2.2%
Provider Grant Program		1.5%
Unit Cost (Contracted Reimbursement Rate Increases)		2.0%
Sub-Capitation Contract Increases		0.5%
Additional Provider Reimbursement Adjustments		1.0%
PHE Redetermination Acuity Impact (25K Top 10%)		2.1%
Utilization Trend (Return to Population Normal)		0.6%
Premium	CY24 GCHP Premium Decrease (-3.7 CY2024)	1.8%
Health Plan	CY24 GCHP Premium Withhold (1% of premium)	0.4%
All Other	All Other (e.g., differences in reserve treatment in budget)	0.4%
		2.0%

88% just Medi-Cal benefits without MLR qualifying care management costs

~\$80M

TNE Comparison

Tangible Net Equity by Medi-Cal Managed Care Plan

March 2023 should be available some time in June 2023

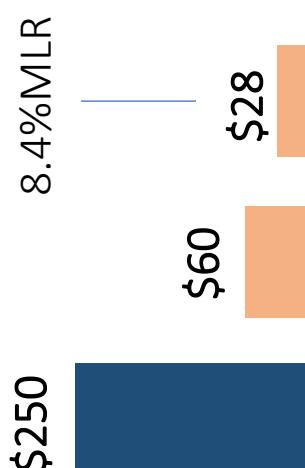
Non-Governmental Medi-Cal Plans not included - reserves are generally kept at parent

	December 2021	December 2022
CalOptima	1279%	1482%
San Francisco Health Plan	664%	1413%
Health Plan of San Mateo	839%	1268%
Health Plan of San Joaquin	789%	1220%
Central California Alliance for Health	1007%	1156%
CalViva Health	745%	838%
Partnership HealthPlan	677%	829%
Gold Coast Health Plan	351%	750%
IEHP	600%	712%
L.A. Care Health Plan	701%	690%
Alameda Alliance	532%	677%
CenCal Health	465%	666%
Santa Clara Family Health Plan	782%	640%
Kern Health Systems	491%	623%
Contra Costa Health Plan	665%	573%

- As of April 2023 YTD performance, GCHP had reserves of \$325,893,791 (983% of required TNE).
- We forecast “free surplus” to grow by year end FY 2022-23 to ~\$170M+.
- The proposed FY 2023-24 Budget includes a \$23M net income addition to reserves.



- >25k GCHP members are reported to have “other health insurance” by DHCS in the monthly enrollment roster.
- In addition to this being a COB concern now, we expect these individuals to likely disenroll through the redetermination process as we reasonably assess this group as being largely composed of those with employer coverage.
 - Cost profile of these 25k: ~\$60 PMPM over past 18 months, \$28 over past 6 months
 - 84.2% margin off 8.4% MLR and admin
 - Cost profile of GCHP overall: ~\$240-260 PMPM range (\$270PMPM without this group)



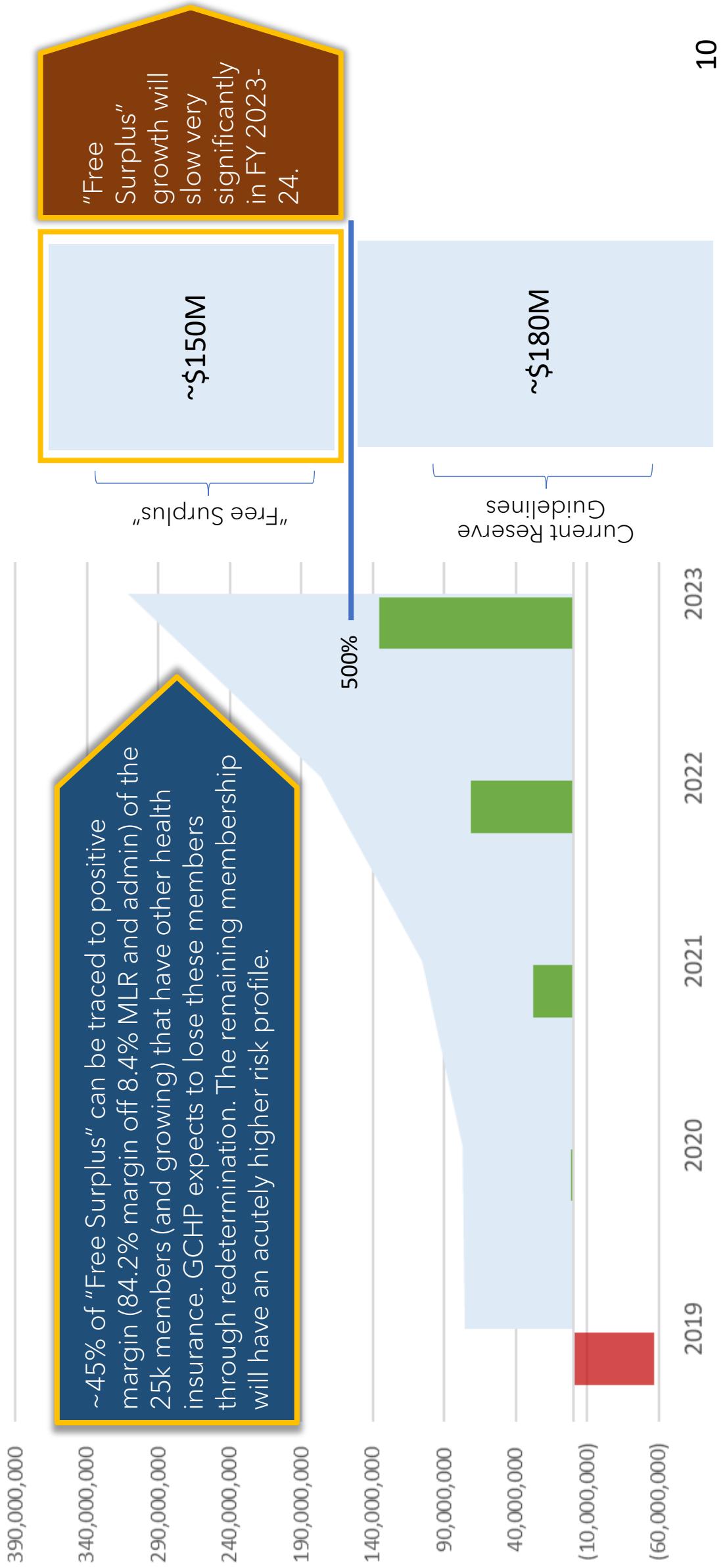
MORE LIKELY TO DISENROLL

MORE LIKELY TO BE RETAINED

- ~25k GCHP members account for nearly all controllable medical expenses (referred to as the “Top 10%”).
 - ~60% have 5+ chronic conditions.
 - >60% have co-occurring behavioral health conditions. When accounting for under-diagnosis, this is likely significantly higher.
 - ~2/3 have been with GCHP since 2015, or earlier.



Current Reserve Guidelines and "Free" Surplus (as of April 2023)



TNE and "Free Surplus" Policy

- GCHP management greatly values and respectfully requests Executive Finance Committee review and input to this policy as part of the budget process.
- GCHP management considers these main principles and core strategic objectives to be the basis for long-term reserve planning:
 - 1) GCHP must maintain financial strength adequate to ensure long-term viability of the health plan and Mission success.
 - 2) GCHP must compliantly meet the imperative to fund improvements in member health outcomes and member access to quality healthcare and equitable healthcare across the Ventura County Medi-Cal delivery system via quality incentives, grants, and other care/service program funding.
 - 3) GCHP must compliantly do its part to ensure adequate and equitable funding of the Ventura County Medi-Cal deliver system of care (providers) and services (providers and community-based organizations).
 - 4) All our efforts must align with our Mission to improve member health outcomes, member access to quality healthcare and equitable healthcare, and member experience with health, healthcare, and GCHP.

TNE and "Free Surplus" Policy (continued)

- With these principles in mind, GCHP management recommends the following policy for reserve setting and excess surplus ("Free Surplus") deployment:
 - 1) A target reserve range between 500% (est. \$180M) - 700% (est. \$230M) of TNE.
 - Management recommends this to prepare for a period of some uncertainty ahead (rates and risks). We recommend to revisit the policy, including loosening, on a twice-annual basis (at budget and reforecast) based on emerging information. The next review would be January 2024 for FY 2023-24 reforecast and budget review.
 - Management recommends establishing now the reserves needed for Dual SNP (January 2026) - \$30-35M.
 - Management recommends to account now in reserves for non-recurring one-time costs (development and investments) that may be needed over the 2024-2026 period for D-SNP operational build out and operational readiness and for continuous improvement in modernizing operations and technologies - \$20M.
 - 2) Surplus exceeding 700% (presently this excess is ~\$100M and growing) should be deployed in the following ways that prioritize adequate funding of providers (and community-based organizations) and improved access to and availability of quality healthcare and services for our members:
 - Priority 1: Adequate provider reimbursement rates (via permanent rate structures and short-term performance-focused increases/dividends).
 - Priority 2: Adequate funding of incentives, grants, and other program funding that support providers in their efforts to improve health outcomes and improve access to quality healthcare.
 - Priority 3: Adequate funding (including grants and incentives) of services and supports provided by providers and community-based organizations (e.g., care management services, community supports, data sharing).
 - Priority 4: Other long-term investments that the Commission approves as necessary to ensure enduring impact of GCHP in the areas of member health outcomes, member access to quality healthcare and equitable healthcare, and member experience with health, healthcare, and GCHP.

TNE and “Free Surplus” Policy (continued)

PROPOSED REFORECAST FOR BUDGET FISCAL YEAR 2023-24:

- ❖ In the FY 2023-24 Budget, GCHP is deploying \$80M in increased funding to the provider delivery system in the form of known and anticipated reimbursement rate increases, the launch of a major quality incentive program, and the launch of a major access/availability grant program.
- ❖ In addition (and based on emerging information in the year), GCHP will begin to deploy additional funds in the 2nd half of FY 2023-24 via a Budget Reforecast to be presented for recommendation by the Executive Finance Committee and for approval by the Commission. This will be in addition to the reimbursement increases and other funding already accounted for in the Budget (\$80M). This can be tied to the goal of producing a Break-even Net Income result for FY 2023-24 (the expected net income in the initial budget is \$23M).
- ❖ GCHP Management proposes to continue to deploy substantial funding compliantly to providers (along with other member-focused, quality-focused investments) in the 2024-25-26 timeframe with the concurrent aims of reducing “free surplus” and improving member health outcomes, member access to quality healthcare and equitable healthcare, and member experience with health, healthcare, and GCHP.

Policy for Deployment of Surplus - 3+ Year Planning

Modernizing the Health Plan

Additional implementation costs of Commission approved "Operations of the Future" Plan and Portfolio

**FREE SURPLUS
DEFINITION: ABOVE
700% TNE
REQUIREMENT**

> 700% TNE: ~\$100M

As of April 2023 (reports to be presented at the Commission May 22, 2023 meeting).

GCHP has not prepared a projection for YE results. However, at the current surplus trend GCHP could reasonably and roughly project \$120M+ for YE "free surplus."

Plus the FY 2023-24 Budget assumes a contribution of an additional \$23M margin.

D-SNP Financial and Operational Readiness

DHCS requirement to operate Medicare/Medi-Cal plan for low-income seniors

Initial "start up" losses + operational readiness + reserves

~\$35M

Updating Provider Reimbursement Rates

Provider Quality Incentive Pool & Program

Quality Improvement Investment Funding to Providers → Quality is our Mission and GCHP should compliantly maximize the deployment of funds to incentive provider - and member - performance in access to quality healthcare

GCHP proposes to continuously review and update all provider reimbursement rates

Financial impact and sustainability modelling will continue to be part of the analysis.

~\$45M

Proposed policy: Provider funding is the priority for additional "Free Surplus" deployment going forward. The principles of the "Free Surplus" deployment plan are to be reviewed by Executive Finance Committee on a quarterly basis.

FY 2023-24 Budgeted Administrative Expense

- Comparative Staffing Data
- Service Program of Future
- Clinical Staffing - Qualifies as Medical Expense
- Operational Staffing

Staffing Comparison

Comparison of Staffing Levels: Medi-Cal Managed Care Plans and National Benchmarks

FTEs per 10,000 Medi-Cal Members



BETTER RESOURCED

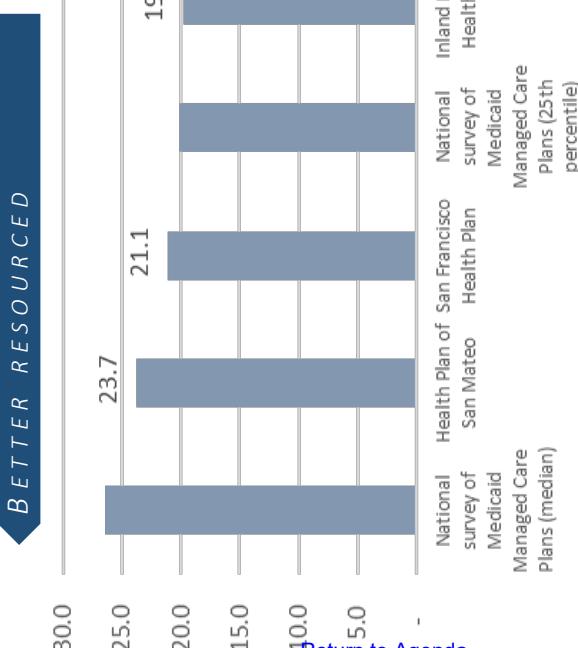
UNDER RESOURCED

- Adequate resourcing of people/skills is an essential factor in meeting member and provider needs.
- Quality is a company-wide enterprise, requiring dedicated staffing everywhere – our Quality improvement efforts will under achieve without additional staff.
- We are currently under resourced relative to our Mission, our Improvement Plan, and the industry.
- GCHP management is doing its part to keep staff (95.5% retention); we need to bring more staff in to do the work.

27 of 81 pages

Comparison of Staffing Levels: Medi-Cal Managed Care Plans and National Benchmarks

FTEs per 10,000 Medi-Cal Members



BETTER RESOURCED

UNDER RESOURCED

Hiring Trends: Medi-Cal and Managed Care Industry run on resources, talent continues.

- 2022/23: ~15%+ increases (available MCP data);
- Quality Improvement (data, operations, joint plan-provider operations);
- Operational Oversight;
- Model of care; and
- Dual SNP.

Staffing Budget

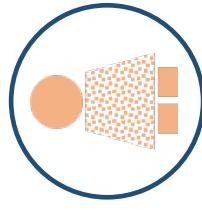
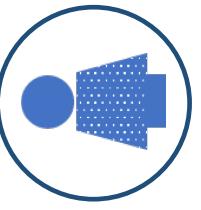
- In the current fiscal year, GCHP proved to be highly effective in employee retention (95%).
- Recruitment of specialized industry talent is increasingly challenging due to competition in local and national industry.

- Headcount investments in FY 2023-24 Budget focus on Quality Improvement Operations, Health Services, Behavioral Health, and Provider Network Operations.**

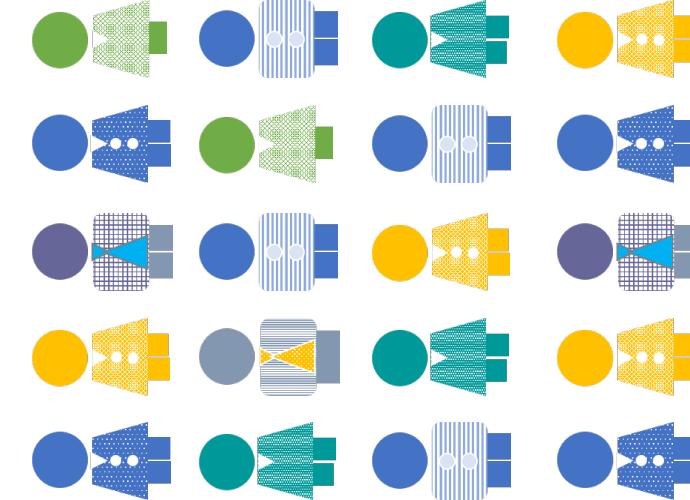
Gold Coast Health Plan - Budgeted Headcount Fiscal Year 2023-24

Function	FY 2022-23						FY 2023-24 BUDGET					
	Active Headcount	Open Requisitions	Forecasted Headcount YE 2022/23	% of Total Headcount	Added Headcount	Forecasted HC YE 2023/24	% of Total Headcount	Headcount Growth	As of May 30, 2023			
Health Services and Quality	108	4	112	38.2%	16	128	35.9%	14.3%				
Information Technology and Project Management Office	51	1	52	17.7%	2	54	15.1%	3.8%				
Policy & Programs (incl. Network Operations)	31	4	35	11.9%	11	46	12.9%	31.4%				
Operations	25	4	29	9.9%	5	34	9.5%	17.2%				
<i>In-house Member and Provider Services</i>	N/A	N/A	N/A	N/A	25	25	7.0%	N/A				
Compliance and Oversight	15	2	17	5.8%	2	19	5.3%	11.8%				
Finance (incl. Procurement)	12	3	15	5.1%	0	15	4.2%	0.0%				
Human Resources and Facilities	12	0	12	4.1%	0	12	3.4%	0.0%				
Executive Office	10	1	11	3.8%	2	13	3.6%	18.2%				
Government Relations and Community Affairs	5	1	6	2.0%	1	7	2.0%	16.7%				
Communications	4	0	4	1.4%	0	4	1.1%	0.0%				
Grand Total (without In-house Services)					39	332	13.3%					
Grand Total	273	20	293	100.0%	64	357	21.8%					

Gold Coast Health Plan will:

-  Build an in-house and community-based service program in FY 2023-24 to replace Conduent (contracted service ends June 2024). GCHP's service program will go live in the 2nd half of the FY 2023-24 fiscal year to optimize service capability ahead of switch-over.
-  Develop and successfully operate (1) a call center; (2) a community-employed service team that will be embedded in provider offices and community events; and (3) satellite office(s).
-  Deliver high quality service and member satisfaction at a lower cost than today. The primary measures of member satisfaction will be the Consumer Assessment of Healthcare Providers and Systems (CAHPS)* survey administered biennially by DHCS and interim GCHP-administered Voice of the Member surveys.

*The survey is designed by the federal Agency for Healthcare Research and Quality to "advance our scientific understanding of experience with healthcare." States are required to administer the survey on a biennial basis. Results are used by NCQA as a factor in overall health plan Quality performance (along with preventative care and treatment of conditions).



Call Center Staffing Model – Integrated Member and Provider

- Initially, GCHP will bring in **20 locally sourced call center personnel**, including call center representatives, team leads, and a manager. These will report to current GCHP leadership with some re-organization planned to provide intensive management supports to the development and readiness of the call center.
- Hiring, onboarding, training, and deployment is slated for the 2nd half of FY 2023-24 (January-June), with “go-live” of outbound calls in Apr-May 2024 timeframe. A job fair will be slated for November 2023 in support of local hiring and an in-person co-located operating model.
- Staffing is based on capacity vs demand analysis, using Conduent call activity reports.
- Consulting support may be needed to develop training materials, job aides, metrics.
- “Operations of the Future” RFP schedule includes CRM/telephony in Summer-Fall 2023

Community-Based Service Team

- GCHP’s service model will include service representatives deployed at provider offices and other community settings to provider service where our members need it.
- This Team will merge with existing GCHP community resources. **5 locally sourced community-based service personnel will be added.**
- GCHP is re-evaluating a satellite “walk-in” location model (with focus on the Oxnard and Santa Paula areas).

Clinical and Health Services Staffing - MLR

- GCHP plans to enhance capabilities that directly impact member health and wellness.
 - Total of 26 positions to meet member health and service needs:
 - Care management
 - Quality Improvement
 - Integrated Care Teams
 - Pharmacy Services
 - Behavioral Health
 - Population Health Management
 - Utilization Management
- Nearly all the costs of these roles are accounted for by DHCS as medical expense and therefore part of our Medical Loss Ratio (MLR) rather than our administrative costs due to their impact on clinical services and quality.
- We have asked our auditors to provide a thorough review on what jobs will qualify as MLR. We will finalize our staffing plan based on this and will provide updates.

Operational Staffing

➤ Total of 12 positions added to improve core operational capabilities:

- Analytical and project management capabilities (1)
- Compliance and the Corporate Integrity Agreement (2)
- Operations and delegation oversight (5)
- Provider network operations (4)

		Non-Salary Performance Based Compensation		Work Model & Workplace Highlights	
Salary	Health and Employee Benefits	Retirement Benefits	Health and Employee Benefits	Work Model & Workplace Highlights	
 Cold Coast Health Plan A Public entity.  CenCalHEALTH Local Quality. Healthcare.	↓ 5-10% below median *At market Competitive in IT ↔ At or below median	No current practice 6% of salary to 45.7% vesting after 10 years ↔ At median	Median or below Up to 10% of salary based on performance Up to 10% of salary based on performance	Comparable and Competitive Hiring even executive level positions as permanently WFH	Flex work model is aligned with industry
 SAN FRANCISCO HEALTH PLAN	↑ At median or above	 CalOptima Better. Together.  L.A. Care HEALTH PLAN N°  Santa Clara Family Health Plan 33 of 81 pages	Staff 4%; Supervisor 4.5%; Manager 5%; Leadership 5.5-10%; Chiefs 20% based on goals ↓ 5-10% below median ↔ At median	The Medi-Cal industry has not yet majorly used health and benefits as a competitive distinction in the pursuit of talent - GCHP is competitive The Medi-Cal industry has a wide range of retirement benefit offerings, including CalPERS, that are similar to or better than GCHP	Hiring all positions as permanently Flexible or WFH
 PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency	↑ Above market ↔ At median	 HealthPlan of SAN MATEO  IEHP Inland Empire Health Plan	Chief/Senior Directors - 8%; Directors/Assoc Directors - 5%; Managers - 3%; (all "up to") based on company wide goals ↑ Above market ↑ Above market	Chief/Senior Directors - 8%; Directors/Assoc Directors - 5%; Managers - 3%; (all "up to") based on company wide goals Up to 5% based on company wide goals No current practice Alameda, Central California are considering	Hiring all positions as permanently Flexible or WFH
Health Plan Industry	Varies by market		Standard practice = 5-20% Publicly traded plans also offer stock options	Flexible work models are increasingly the norm	

Administrative Expense in the FY 2023-24 Budget

\$15,685,168 Administrative Expense Difference (Increase): Between FY 2023-24 Budget vs FY 2022-23

\$7,100,710 System and service implementation costs: Operations of the Future (e.g., Core Admin System, Medical Management System)

3,600,000 Compensation: annual merit increase, equity adjustments, and pilot of a bonus program

3,500,000 Personnel additions

200,000 Management Development

1,284,458 Includes scheduled increases in vendor costs, travel and strategy meetings and other implementation costs incorporated in admin

The following slides are from the May 15th 2023
Executive Finance Committee Meeting

The Way Forward

Today we launch a meaningful engagement with the Executive Finance Committee on the 2023-24 Budget and Long-Term Financial Planning

Executive Finance Committee Role

*GCHP support needed from Committee in
the FY 2023-23 Budget process:*

- | | |
|--|---|
|  | Review and monitor “economic performance” with focus on FY 2022-23 and FY 2023-24 Budget development. |
|  | Review and establish “basic tenants” of and plan to update provider payments and spend down surplus. |
|  | Review and recommend “provider incentive program structure.” |
|  | Review and recommend “investment strategy.” |
|  | Develop long-term and short-term business plans for review and approval by the Commission. |

- THE GOLD COAST HEALTH PLAN EXECUTIVE TEAM APPRECIATES AND RESPECTS THE VITALLY IMPORTANT GOVERNANCE ROLE OF THE EXECUTIVE FINANCE COMMITTEE (“COMMITTEE”) IN THE DEVELOPMENT AND MONITORING OF OUR BUDGETS AND PLANS.
 - THE CEO AND EXECUTIVE TEAM PROPOSES TO ENGAGE THE COMMITTEE ✓ EARLIER IN THE BUDGET PROCESS, ✓ MORE OFTEN, AND ✓ WITH GREATER BREADTH AND DEPTH OF INFORMATION TO PROVIDE THE BEST SUPPORT TO THE COMMITTEE AS IT DISCHARGES ITS FIDUCIARY DUTY. THIS IS A BEST PRACTICE FOR A COMPANY WITH THE SIZE AND COMPLEXITY OF OUR BUSINESS, PROGRAMS, CHALLENGES, OPPORTUNITIES, AND RISKS.

FY 2023-24 Budget Timeline

May 2023

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
		7	8	9	10	11
	14	15	16	17	18	19
	21	22	23	24	25	26
		28	29	30	31	

Today – initial engagement with the Executive Finance Committee on FY 2023-24 Budget and Financial Planning

May 22nd – Commission Meeting

June 2023

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3		
	4	5	6	7	8	9
	11	12	13	14	15	16
	18	19	20	21	22	23
	25	26	27	28	29	30

May-June – 1:1's with Committee Members

TBD June – 2nd Budget meeting with Committee

June 26 – Commission Meeting with vote on FY 2023-24 Budget

FY 2023-24 Budget Timeline (continued)

January 2024

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
				4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

◆ **TBD January 2024 Executive Finance Committee Meeting**

◆ **TBD January 2024 Commission Meeting**

GCHP MANAGEMENT PROPOSES TO ADD A MID-YEAR BUDGET RE-FORECAST AND REVIEW TO THE ANNUAL BUDGETARY ENGAGEMENT WITH THE COMMITTEE AND COMMISSION. THIS WOULD INVOLVE THE FOLLOWING, AT LEAST:

1. AN IN-DEPTH REPORT ON THE ACTUAL VS BUDGET PERFORMANCE OF THE PLAN.
2. MANAGEMENT ANALYSIS OF THE DRIVERS OF PERFORMANCE AND DEVELOPING TRENDS.
3. MANAGEMENT ANALYSIS OF DEVELOPING INDUSTRY, MARKET, AND REGULATORY CONDITIONS.

Decision
Today

PURPOSE OF TODAY'S MEETING: GCHP MANAGEMENT PRESENTATIONS ARE DESIGNED TO PROVIDE DECISION SUPPORT CONTEXT AND INFORMATION FOR YOUR REVIEW OF THE FY 2023-24 BUDGET

OUTLINE OF TOPICS FOR TODAY

- ✓ Review and decide on process and timetable for FY 2023-24 Budget
- ✓ Performance of FY 2022-23 Budget investments
- ✓ Proposed financial bases for FY 2023-24 Budget
- ✓ Proposed plan for managing current “Free Surplus”
- ✓ Proposed Provider Quality Incentive Pool and Program and Member Engagement Plan
- ✓ Proposed high level plan for staffing investments in FY 2023-24 Budget

FORMAT FOR TODAY

GOAL FOR TODAY

FOR 1:1'S AND JUNE TBD COMMITTEE MEETING

- ✓ Management proposes that today be dedicated to presentations designed to provide information to support deeper engagement in 1:1's and Committee meeting in June.

✓ Today and in 1:1's, GCHP respectfully asks for your requests for additional information – what can Management provide to support your review and recommendation on the FY 2023-24 Budget?

- ✓ Comprehensive packet for proposed FY 2023-24 Budget will be distributed ahead of 1:1's and June TBD Committee meeting.
- ✓ Packet will include "scenario" modeling.
- ✓ Packet will include detailed staffing budget.
- ✓ Proposed "Free Surplus" policy.
- ✓ Proposed "Free Surplus" policy.
- ✓ Proposed update to investment policy.
- ✓ Management will provide additional information as requested by Committee Members.

Review of FY 2022-23 Budget Investments

FY 2022-23 was a year of foundation building for GCHP → new and expanded capabilities, the launch of the “Operations of the Future,” new modernized skills and systems for data and analysis, development of people/skills and much-needed positions, investments in members and providers and staff, and beyond.

This vital work has begun to drive GCHP toward a future of sustained high quality and growing impact on the health and healthcare of members and communities we serve (VISION AND MISSION).

Building a High-Quality Health Plan

COMPREHENSIVE PLAN TO ACHIEVE SUSTAINED HIGH QUALITY

FOCUS OF FY 2022-23

VISION – ANALYSIS – PLANNING – FOUNDATION
WORK – LAUNCH PIONEERING PROGRAMS

Developed Quality Improvement organization, added key resources, and added leading-edge consulting support

- Added QM nursing staff and resources for program/population analytics.
- Cutting edge Inovalon member health and healthcare data system will help advance care management and program design and integrate these capabilities with Quality improvement initiatives.
- Through the selection of The Mihalik Group, a boutique consultancy with market-leading know how in NCQA/HEDIS/Quality performance, GCHP has advanced NCQA readiness efforts and greatly accelerated the development of a comprehensive and detailed Quality Improvement Work Plan.

Develop contracts and payment/program structures of a pioneering Provider Quality Incentive Pool and Program

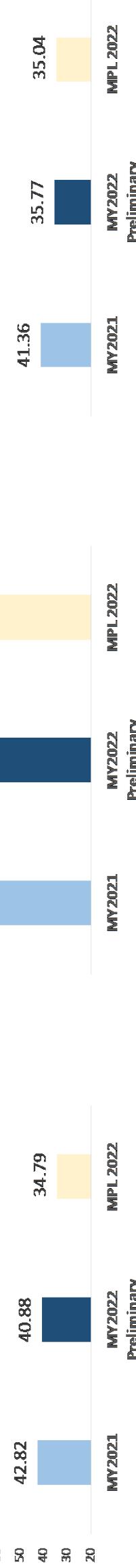
- GCHP now has a standard-setting Provider Quality Incentive Pool and Program that will provide substantial performance-based funding and program support to enable the healthcare delivery system to continuously improves Access and Quality for Medi-Cal members.
 - Quality contracting efforts have begun and will advance rapidly with our largest primary care providers.
- We must maintain the momentum and the level of investments, and we should strive to innovate (not just being good at the basics, but new and improved capabilities.**

- ✓ THE FOLLOWING SLIDES ILLUSTRATE OUR IMPACT ON QUALITY PERFORMANCE IN THE FIRST YEAR OF A MULTIYEAR PLAN TO ACHIEVE SUSTAINED BEST-IN-CLASS QUALITY RESULTS.
- ✓ THESE CHARTS SPAN THE MEASURES OF THE MANAGED CARE ACCOUNTABILITY SET, WHICH IS THE DEPARTMENT OF HEALTH CARE SERVICES' (DHCS) PRINCIPAL BASIS FOR MEASURING MEDI-CAL MANAGED CARE PLAN PERFORMANCE.
- ✓ MCAS PERFORMANCE IS THE BASIS FOR QUALITY SANCTIONS (TODAY AND GOING FORWARD), PREMIUM WITHHOLDS (1% IN 2024), AND QUALITY-ADJUSTED REGIONAL PREMIUMS (IN THE COMING YEARS).

BUILDING A QUALITY FOUNDATION – MY 2022

- HYBRID MEASURES COMBINE CLAIMS/ENCOUNTERS WITH DATA ABSTRACTED FROM MEMBER RECORDS
 - EHR/RECORDS ARE MATERIAL TO FULL CAPTURE OF CARE
 - ALL BETTER THAN MPL (50TH PERCENTILE); 3 IN 75-90TH; SCORES ARE FINALIZED NEXT MONTH AND CAN INCREASE
 - AIM FOR MY 2023 IS TO ACHIEVE 75-90TH PERCENTILE FOR ALL HYBRID MEASURES; EHR FEEDS ARE KEY
- HYBRID MEASURES –

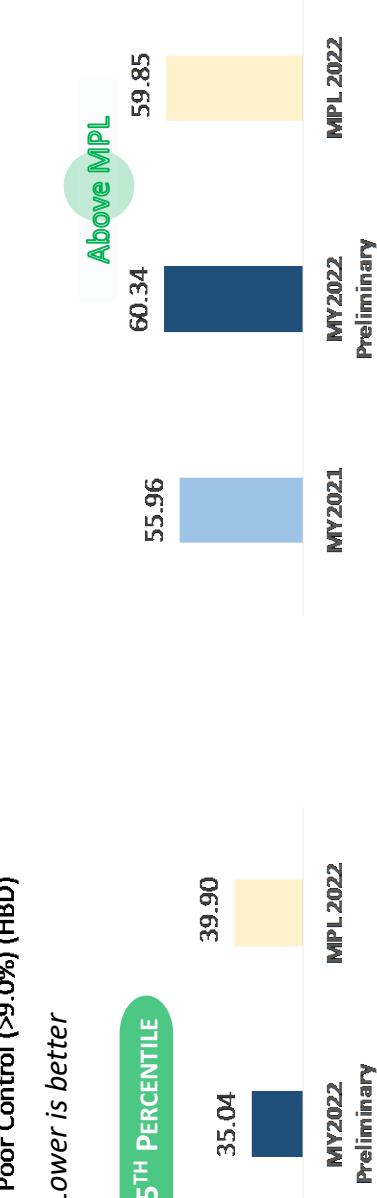
Childhood Immunization Status (CS-10)



Cervical Cancer Screening (CCS)



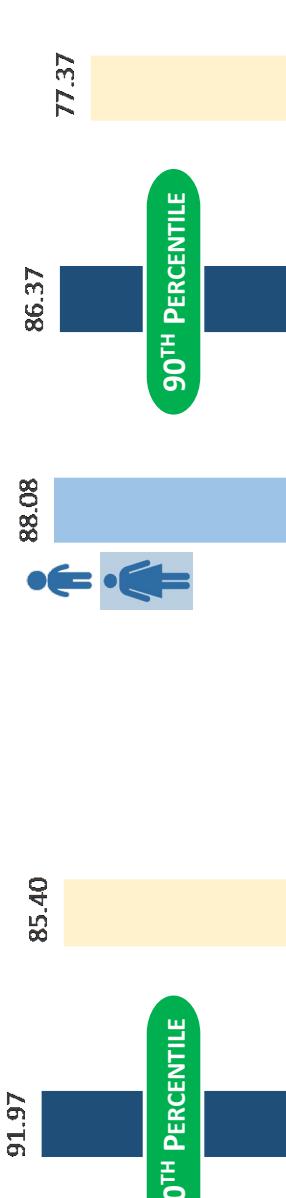
Hemoglobin A1c Control for Patients with Diabetes HbA1c Poor Control (>9.0%) (HBD)



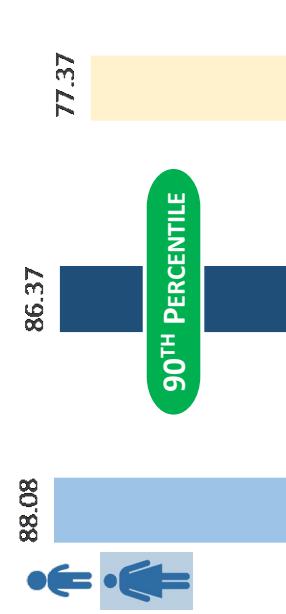
Lead Screening in Children (LSC)



Timely Prenatal Care (PPC-Pre)



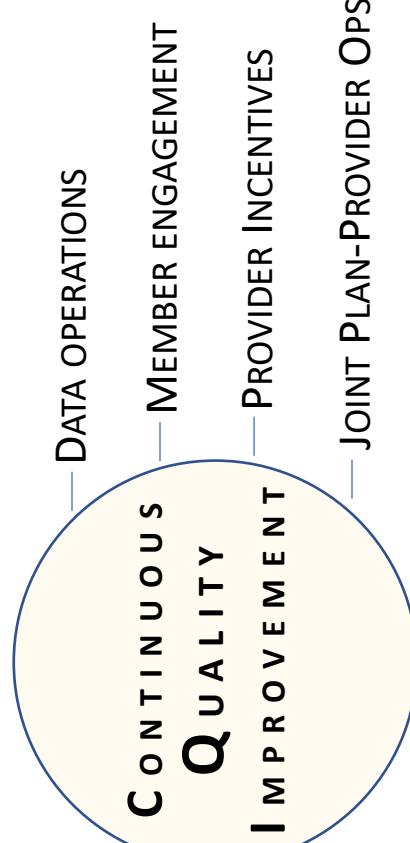
Timely Postpartum Care (PPC-Post)



BUILDING A QUALITY FOUNDATION – MY 2022

- ADMINISTRATIVE MEASURES DEPEND ON CLAIMS/ENCOUNTERS SUBMITTED BY PROVIDERS
- COMPLETE AND TIMELY ENCOUNTERS ARE ESSENTIAL
- 5 OF 7 IMPROVED; 3 OF 7 ABOVE MPL
- AIM FOR MY 2023 IS TO ACHIEVE 50TH PERCENTILE FOR ALL ADMINISTRATIVE MEASURES; CARE ACCESS/AVAILABILITY IS KEY

— ADMINISTRATIVE MEASURES —



47 of 81 pages

Breast Cancer Screening (BCS)



Follow Up After ED Visit for Mental Illness (FUMI)



Follow Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA)



Follow Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA)



Chlamydia Screening in Women (CHL)



Return to Agenda

Operations of the Future

Operations of the Future – Current Progress

This is how our investment added value to our organization



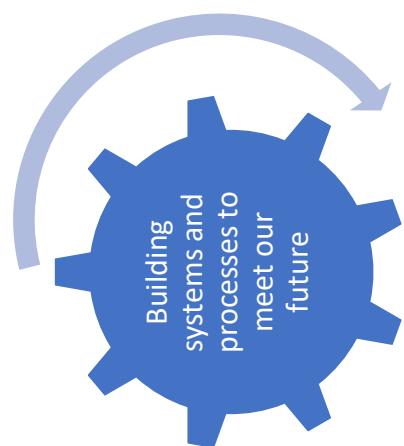
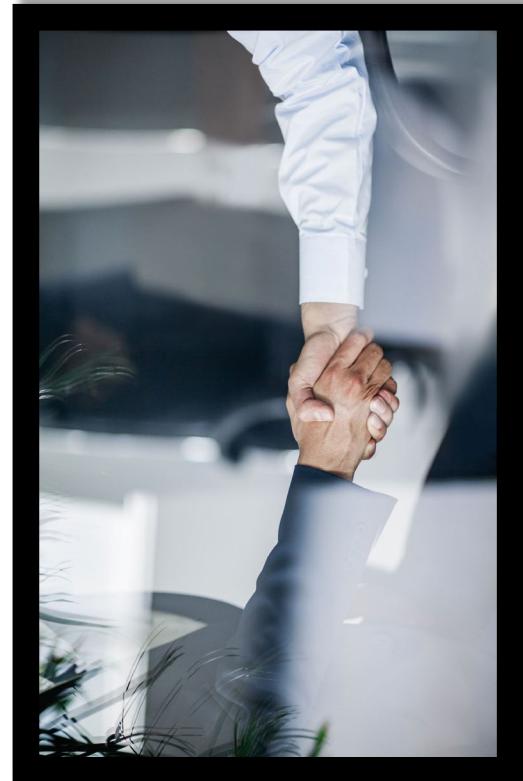
Building a high performing IT organization via People, Process, and Technology which will allow us to modernize and transform operations....

- A New Testing Organization
- A New Application Architecture Organization
- Our Development Teams Supporting Our New Data Warehouse Capability
- Providing Stability With Our Current Processes

Operations of the Future

We Developed A Strategy And Are Now Executing And Delivering Value

- Project management staff to support the project portfolio demand
- Business Systems Analysts to support the Operations of the Future program
- Critical experienced leadership added



Operations of the Future

“...think of the difference between tactical and strategic oversight as the difference between doing things right and doing the right things. Both are required.” - Bruce Schneier

- Operational Oversight staff to support continuous monitoring of plan delegates' performance which allows for:
 - Identification of potential performance risk.
 - Ensure regulatory and contractual compliance through expedited feedback processes.
 - Streamlined reporting processes to track findings, recommendations and corrective action plans.



Operations of the Future

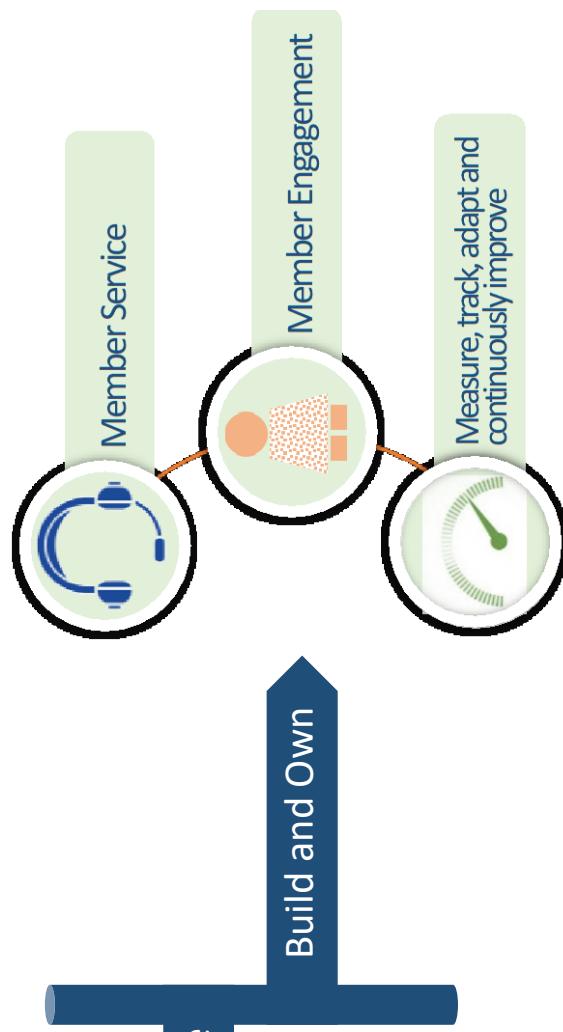


GCHP MANAGEMENT HAS COMPLETED MAJOR STEPS IN PROCUREMENT PLAN – CORE ADMIN SYSTEM, MED MANAGEMENT SYSTEM, ELECTRONIC DATA INTERCHANGE, AND PORTALS. ALL RFPS WILL BE COMPLETED BY SUMMER 2024. IMPLEMENTATIONS ARE NOW UNDERWAY. INTERNAL MEMBER/PROVIDER SERVICE BUILD OUT IS A PRIORITY IN THE SECOND HALF OF FY 2023-23.

Commission Approved Plan for Procurement



Commission Approved Plan for Internal Capabilities



Organization of the Future

Organization of the Future

Upgraded Our Recruiting Strategy And We Delivered Excellent Results!

- All Budgeted HC opened in 30 days

- 90% Headcount of filled in six months

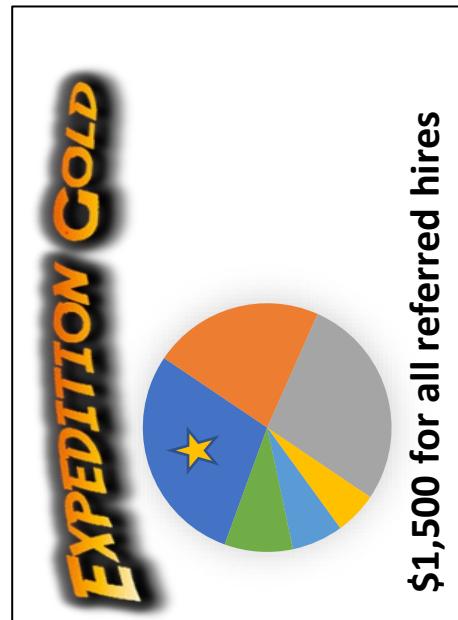
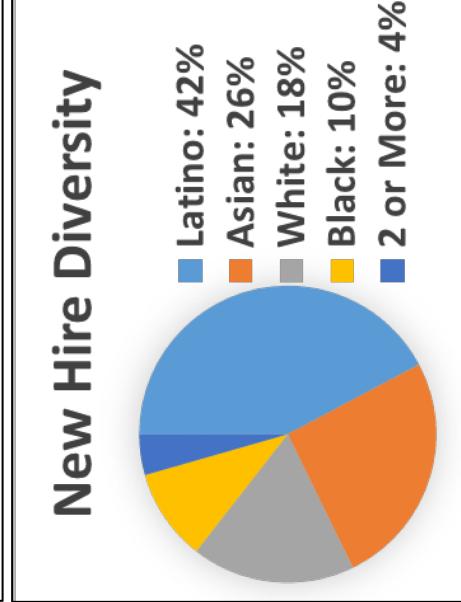
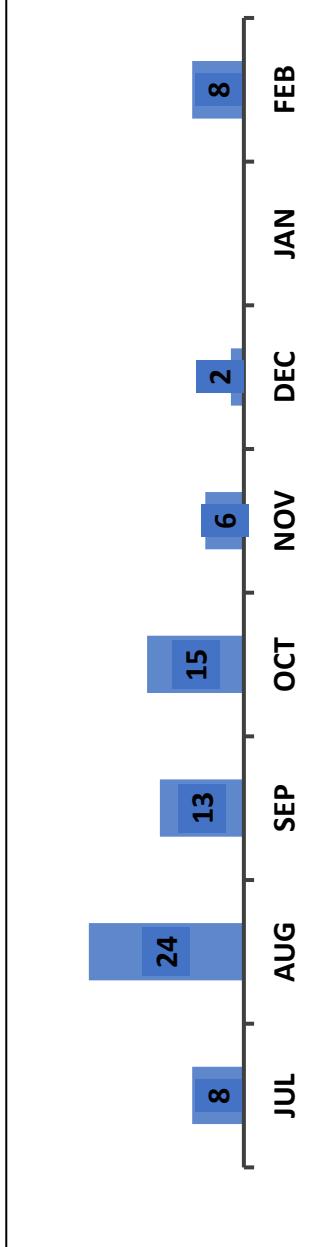
- Average days to fill 74 days

- Strengthen Industry Experience

- 29% of hires Employee Referral Program

- Lowered Search Firm Reliance (6 hires)

Employees engaged – remained **95%** staffed
(Current attrition rate is 5.5%)



Positions Added –Skills/Capacity Gained

Model of Care and Operations of the Future Investments

- Enhance Health Services Capabilities
 - Member engagement and experience
 - Quality – improving health, healthcare, and the member experience
 - Quality Data and Analytics
- Build Policy & Programs Capabilities
 - Product development and Program management
 - Provider experience, perspective and insights
- Major IT Investments
 - A New Testing Organization
 - A New Application Architecture Organization
 - New Data Warehouse Capability
 - Providing Stability With Our Current Processes
 - Processes Report – analysis, metrics, operations

2022/3 Priority

Expansion of Critical Skills at Gold Coast

Our current and future challenges require investment in **capabilities/capacities/skillsets.**
In FY 2022-23 we began to advance GCHP in the following areas.

- 1) Advocacy
- 2) Analysis (business, performance, population, etc.) → data driven decisions and priorities
- 3) Chronic conditions and SDOH program expertise
- 4) Communications
- 5) Delegation and internal oversight
- 6) Diversity and equity
- 7) Financial analysis and management
- 8) Innovation and creative problem solving
- 9) Integrated data, technology and core health plan operations
- 10) Member engagement and experience
- 11) Modern data warehouse and data systems
- 12) Modern operational technologies and systems
- 13) Product development and management
- 14) Program development and management
- 15) Project management and performance improvement
- 16) Provider experience, perspective and insights
- 17) Strategic planning – capabilities, mindset and practices
- 18) Quality – improving health, healthcare, and the member experience
- 19) Report – analysis, metrics, operations
- 20) Value based payment and performance

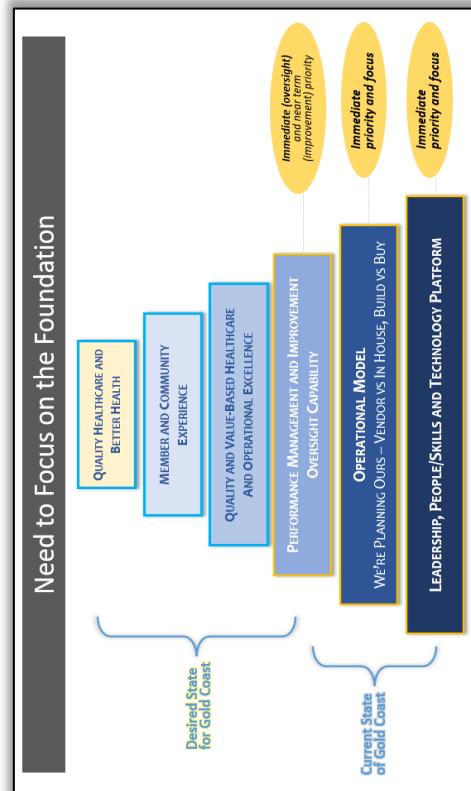
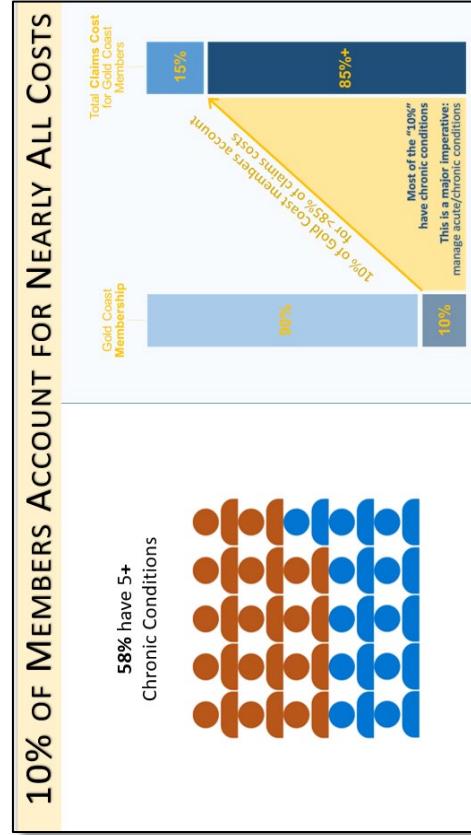
“ORGANIZATION OF THE FUTURE:” DEVELOPING HIGH PERFORMING LEADERSHIP

1ST HALF OF 2022

A VISION FOR GOLD COAST HEALTH PLAN OF THE FUTURE AND SUSTAINED MISSION ACHIEVEMENT

Gold Coast Health Plan Leadership performed a thorough strategic analysis: what we were vs what we need to be.

- Analyzed current and future regulatory and market forces. How is our business different tomorrow and how do we best position and prepare for success?
- Analyzed current-state health plan performance (financial, operational, organizational, technological) and ability to achieve our Mission → developed a robust plan for achieving long term sustained Mission success.
- Built a state-of-the-art member data system (Inovalon) → empowering us to develop data-based and member-centered plans.
- Created a “Vision for the Future” and secured full approval and support from our Commission.



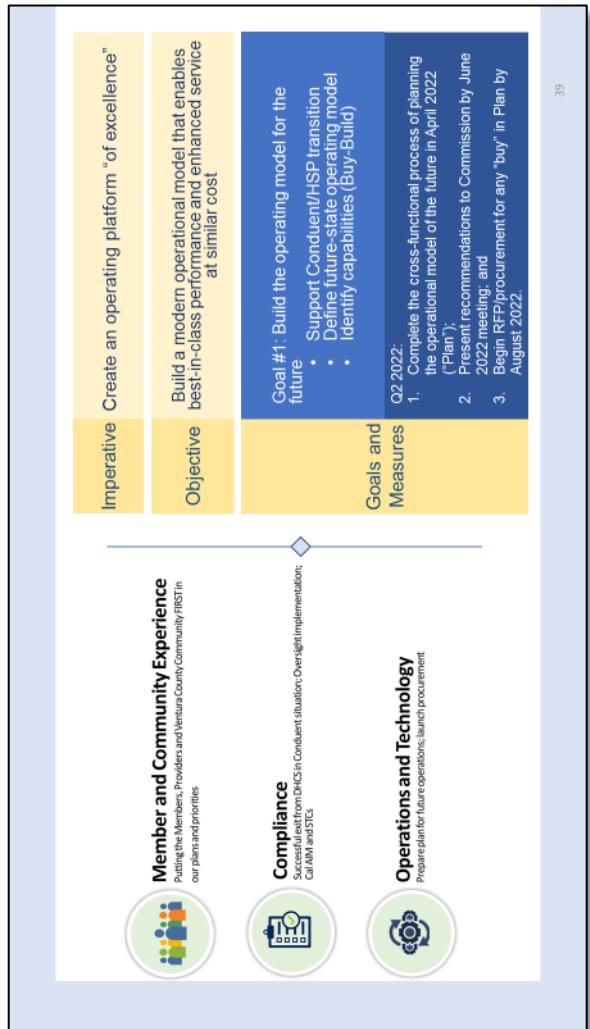
Healthcare Performance Indicators for 2020 (Source: NCQA and CAHPS)									
Overall, the HMO and PPO plans are performing well across all measures. The average of the three composite Consumer Satisfaction, Prevention, Treatment, and Prevention of Chronic Conditions scores is 8.3%.									
Indicates a plan's performance in its treatment of chronic conditions.									
Rating	Plan Name	State	Type	NCQA Accreditation	Customer Satisfaction	Prevention	Treatment	Prevention of Chronic Conditions	Overall
4.0	Community Health Group	CA	HMO	Yes	3.6	4.9	3.6	3.6	3.6
4.0	Local Health Authority - City LA Care Health Plan	CA	HMO	Yes	3.6	4.9	3.6	3.6	3.6
4.0	Orange County Health Authority - CalOptima	CA	HMO	Yes	2.6	4.9	3.6	3.6	3.6
4.0	San Francisco Community Health Authority	CA	HMO	Yes	2.6	4.9	3.6	3.6	3.6
3.5	Central Health Plan	CA	HMO	Yes	2.6	3.6	3.6	3.6	3.6
3.5	Health Empower Health Plan	CA	HMO	Yes	3.6	3.6	3.6	3.6	3.6
3.5	Nationwide Care of California Partnership Inc.	CA	HMO	Yes	3.6	3.6	3.6	3.6	3.6
3.5	Blue Cross of California Partnership Health Plan	CA	HMO	Yes	3.6	3.6	3.6	3.6	3.6
3.5	Blue Shield of California Promise Health Plan	CA	HMO	Yes	2.6	4.9	3.6	3.6	3.6
3.5	California Health & Wellness	CA	HMO	Yes	2.6	4.9	3.6	3.6	3.6
3.5	Health Net of California Inc.	CA	HMO	Yes	3.6	3.6	3.6	3.6	3.6
3.5	Santa Barbara County Health Commission Blue Santa Clara Family Health Plan	CA	HMO	No	3.6	3.6	3.6	3.6	3.6
3.5	Santa Barbara County Water Authority Santa Clara River Basin Project Area of California San Luis Obispo	CA	HMO	No	3.6	3.6	3.6	3.6	3.6
3.5	Pacific Edge Health Plan	CA	HMO	No (in process)	—	—	—	—	—
3.5	Point Health California Health Plan	CA	HMO	No (in process)	—	—	—	—	—
3.5	Partnership Health Plan of California	CA	HMO	No (in process)	—	—	—	—	—
3.5	Partnership Health Plan of California	CA	HMO	No (in process)	—	—	—	—	—
3.5	Partnership Health Plan of California	CA	HMO	No (in process)	—	—	—	—	—
3.5	Partnership Health Plan of California	CA	HMO	No (in process)	—	—	—	—	—
3.5	Partnership Health Plan of California	CA	HMO	No (in process)	—	—	—	—	—
3.5	Partnership Health Plan of California	CA	HMO	No (in process)	—	—	—	—	—
3.5	Partnership Health Plan of California	CA	HMO	No (in process)	—	—	—	—	—

“ORGANIZATION OF THE FUTURE:” DEVELOPING HIGH PERFORMING LEADERSHIP

1ST HALF OF 2022 GOALS AND YEAR 1 BUDGET FOR HEALTH PLAN TRANSFORMATION

Gold Coast Health Plan leadership developed a broad-based “Plan” (goals, strategies, and workplans) to compliantly achieve better health, better healthcare, and a superior experience for the members we serve. This Multi-Year Plan served as the basis for the FY 2022-23 Budget and is that for the FY 2023-24 Budget.

The Plan will transform our capabilities across the board – Clinical, Compliance, Operational, Organizational, and Technological capabilities – to industry standards, and beyond. The Plan will also ensure we maintain financial strength for the long term, while we invest in the transformation of our capabilities and ready for the future.



“ORGANIZATION OF THE FUTURE:” DEVELOPING HIGH PERFORMING LEADERSHIP

BY YEAR END 2022

GOALS TRANSLATED TO DETAILED WORK PLANS;

LEADERSHIP OPERATING REVIEWS

We are advancing Goals-Focused Leadership by instituting new practices and tools. Operating Reviews are in-depth, multi-hour monthly engagements between cross-functional goal teams and the executives who are accountable for supporting the success of each goal. Status reports are shorter meetings focused on what's next, what's needed for success. Operating Review Reports are posted to Compass (GCHP Intranet). Some Operating Reviews are recorded and available to all staff.

Don Harbert, an expert consultant, has managed our rapid development and supports our continuous improvement of this work.

Operating Review: Operations of the Future – Core Admin						
Goal	Prioritized Milestones (Oct-Dec.)	Barrier(s)/Ask	Deliverables	Start Date	End Date	Accountable Person
Build the operating model for the future – Core Admin	Complete RFP procurement for <ul style="list-style-type: none"> RFP 2 – Core Admin RFP 3 – Medical Management RFP 4 – Digital 	Barrier: None Mitigation: None Risk: None	<ul style="list-style-type: none"> Identify RFPs for Technology Evaluate intent to bid by 11/27/22 Complete Requests by 11/28/22 Present to Commission Final Contracts 11/15 Review contracts for internal GCP approvals and finalization by 11/30/23 Support RFP Preparation activities for remaining RFPs by TBD date identified in RFP schedule 	8/1/22	1/30/23	Bob Bushney
Build the operating model for the future – Core Admin	Create HR Requirements for: <ul style="list-style-type: none"> RFP 3 – BPO, Workforce / Imaging Print/Fulfillment RFP 8 – Call Center 	Barrier: Need additional resources Ask: Internal vendor to support request Risk: Risk of resourcing RFP's and project overall implementation schedule		TBD	1/31/23	Alan Torres Bob Bushney Anna Sproule
Build the operating model for the future – Core Admin	Complete Program Charter	Barrier: None Ask: None Risk: None	<ul style="list-style-type: none"> Create project charter - Scope, Goals, Success Metrics Define roles and responsibilities - RACI Define new organizational structure Create a communication plan Identify project team Create a staffing plan including FTE's & Contractors 	10/17/22	11/14/22	Josephine Gallotta
Build the operating model for the future – Core Admin	Complete Current State – Technical Assessment <ul style="list-style-type: none"> (RFP/Medtrac/Epic/Porta/ED/DSO +etc) 	Barrier: Will need SME support in the RFP process Risk: None	<ul style="list-style-type: none"> Document current state architecture Create business process flowchart What's changing? Create system/Application impact Document data flow + lineage Document data gaps - where are we not getting today Document data quality issues 	9/1/22	12/31/22	Chris Dullen

59 of 81 pages

[Return to Agenda](#)

Financial Basis of the 2023-24 Budget

Near-term expectation: downward industry pressure on premium rates. GCHP: a rate decrease is anticipated for CY 2024, with uncertainty beyond.

- Introduction to Kyle Edrington and Edrington Health Consulting – role in Medi-Cal Industry and history with GCHP.
- Insight to DHCS/Mercer thinking for Medi-Cal industry rates for 2024-2025 period.
- High-level review of GCHP PMPM rate modeling for 2024 – what is driving premium PMPM decrease – utilization vs unit cost.
- High-level review of GCHP aggregate revenue for 2024 – impact of redetermination and Kaiser transition.
- How wide-ranging are the scenarios – *what can account for significant budget variance on rates.*
- IP reserving and conservatism release – *what can be said about FY 2023-24.*
- Launching independent advocacy by GCHP – one need for advocacy is around provider rate increases being applied today and the need to account for this sooner than the 30-month lag.

Context for GCHP Future Budgeting and Financial Planning

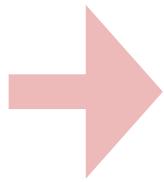
Premium Rates



2023-24 Budget Major Factors

Membership

Membership declines due to redetermination and Kaiser Direct Medi-Cal, grows due 2024 expansion of full scope Medi-Cal coverage to adults ages 26 - 49 who do not have a satisfactory immigration status.

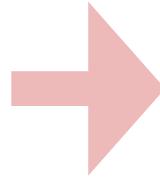


Membership as of May 2023 = ~255,000
Preliminary thinking for FY 2023-24 Budget is that year end enrollment will be in range of 205,000 to 215,000 (~15-20% decline).

There is now and will continue to be uncertainty about enrollment in the market. One thing that is clearer, 25,000 GCHP members with other health insurance and 7,000 Kaiser electees seem highly likely to exit. We are working now to model the timing and size of increase from the newly eligible.

2023-24 Budget Major Factors

Revenue



Premium revenue will decline due to net enrollment decreases, expected rate decrease impact (~3.7% in CY 2024) in the second half of the fiscal year, and an anticipated 1% Quality Withhold.

Estimated premium revenue for FY 2022-23 = ~\$1.07B
Preliminary calculations for FY 2023-24 Budget = ~\$900M.

GCHP Management will lead independent advocacy for premium rates that account for underlying medical risk (that remains after redetermination) and increasing provider spend (long-delayed reimbursement rate updates and quality incentives).

2023-24 Budget Major Factors

Medical costs



Medical expenses are expected to grow, despite a considerable decrease in membership and anticipated premium rate decrease.

Projected medical cost for FY 2022-23 = ~\$760M
Preliminary estimates for FY 2023-24 Budget = ~\$885M.

This is driven by increasing reimbursement rates, anticipated Quality incentive spend, expected retention of the high cost/utilizing members who need the most services, and the expected disenrollment (via redetermination) of a large group of low/non-utilizers.

MORE LIKELY TO DISENROLL

25k

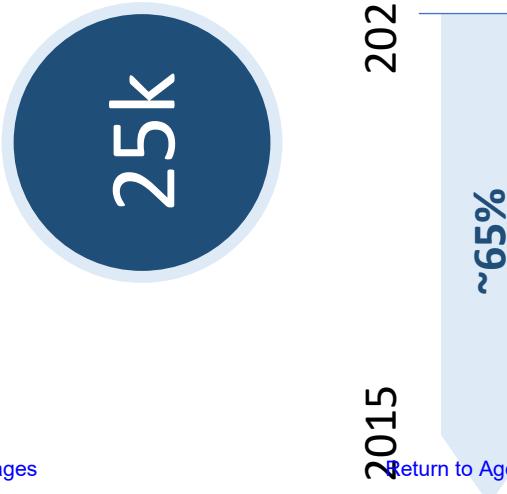
- >25k GCHP members are reported to have “other health insurance” by DHCS in the monthly enrollment roster.
- In addition to this being a COB concern now, we expect these individuals to likely disenroll through the redetermination process as we reasonably assess this group as being largely composed of those with employer coverage.
 - Cost profile of these 25k: ~\$60 PMPM (over past 18 months)
 - Cost profile of GCHP overall: ~\$240-260 PMPM range

\$250

\$60



25k



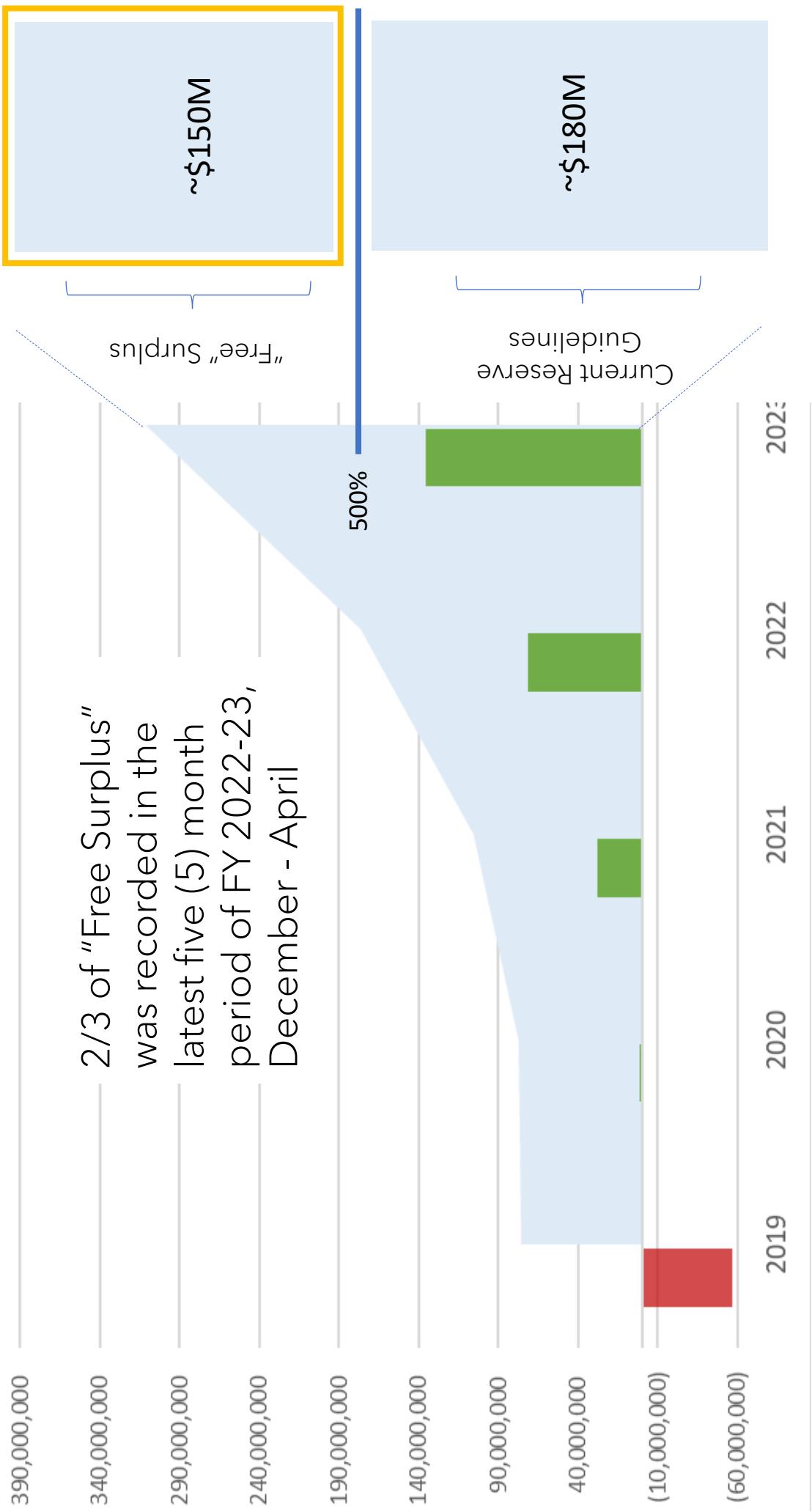
MORE LIKELY TO BE RETAINED

- ~25k GCHP members account for nearly all controllable medical expenses (referred to as the “Top 10%”).
 - ~60% have 5+ chronic conditions.
 - >60% have co-occurring behavioral health conditions. When accounting for under-diagnosis, this is likely significantly higher.
 - ~2/3 have been with GCHP since 2015, or earlier.

Provider Funding Modernizing the Health Plan Readying for Dually Eligible Special Needs Plan

Managing “Free” Surplus

Current Reserve Guidelines and "Free" Surplus



Advancing GCHP as a High-Quality Health Plan

Investments in FY 2023-24 Budget

- Provider Incentives and Funding
- Member Engagement and Incentives
- Role of the Health Plan

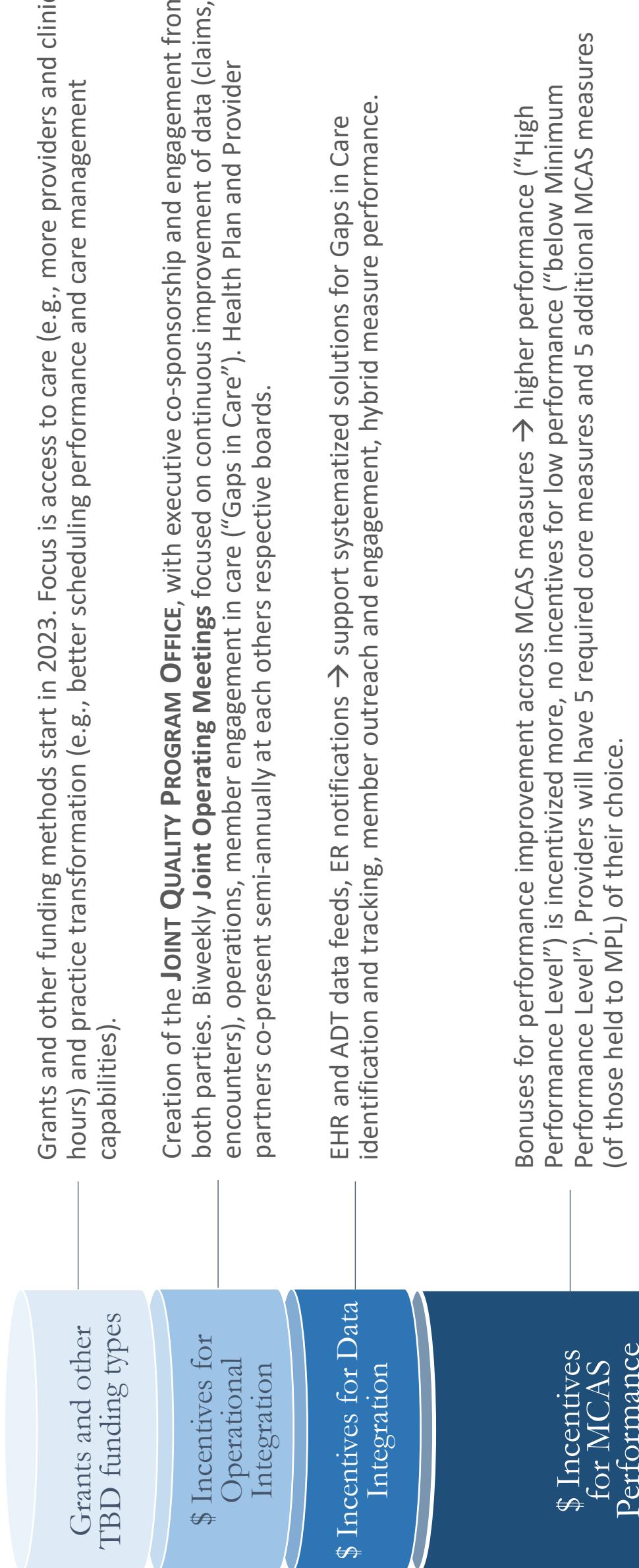
\$50,000,000

At least

QUALITY INCENTIVE POOL AND PROGRAM
GCHP Investment in Provider Quality Performance
2023-2025 Funding – All PCP Providers are eligible (>150 members)

Leading the Way to Quality – GCHP’s Quality Incentive Pool and Program

Program structures that support providers across the quality spectrum



60

Incentive Criteria: “Tranches” Year 1



DHCS “Minimum Performance Level” (MPL) – performance below is sanctioned in 2023
DHCS “High Performance Level” (HPL) – 90th percentile [comment about 2024 Contract]

PERFORMANCE TRANCHE	CRITERIA & REQUIREMENTS		
	At or Above HPL	At or Below MPL*	Improvement** From Prior Year Baseline
High	2 or more and 0	and ≥ 5	100%
High-Mid	1 or more and 0	and ≥ 5	75%
Mid	0 and 0	and ≥ 5	50%
Mid-Low	0 and 1 or 2	and ≥ 5	25%
Low	0 and 3 or more	or ≥ 6 decline	0%

*See Year 1 Gap Closure Methodology

**Measures other than those accounted for in HPL and MPL counts.

Incentive Criteria: “Tranches” Year 2



DHCS “Minimum Performance Level” (MPL) – performance below is sanctioned in 2023
DHCS “High Performance Level” (HPL) – 90th percentile [new standard in the 2024 Contract]

C R I T E R I A & R E Q U I R E M E N T S				
PERFORMANCE TRANCHE	At or Above HPL	At or Below MPL*	Improvement** From Prior Year Baseline	% of Quality Bonus
High	3 or more	and 0	and ≥ 5	100%
High-Mid	2 or more	and 0	and ≥ 5	75%
Mid	0	and 0	and ≥ 5	50%
Mid-Low	0	and 1 or 2	and ≥ 5	25%
Low	0	and 3 or more	or ≥ 6 decline	0%

*See Year 1 Gap Closure Methodology

**Measures other than those accounted for in HPL and MPL counts.

Quality Incentive “Gap Closure”



GCHP understands that certain measures for each Provider are well behind MCAS MPL and are difficult to move significantly in a short period of time. These measures still require improvement, so we are offering a flexible solution.

- In Year 1, the Provider may choose 2 core metrics for which achievement of the Gap Closure Methodology will be considered sufficient for not being considered in the “At or Below MPL” category.
- In Year 2, the Provider may choose 1 core metric for which achievement of the Gap Closure Methodology will be considered sufficient for not being considered in the “At or Below MPL” category.

Gap Closure Methodology

The “Gap” is defined as the difference between the Provider’s end of prior year performance and the HPL for the prior year. The target setting methodology is a 10.0 percent gap closure.

“Gap Closure” Example



An example of the 10 percent Gap Closure Target Setting Methodology is as follows:

- 10% gap closure between CY 2022 Performance (Baseline) and CY 2022 MCAS HPL
 - Example: MCAS Measure X
 - HPL Benchmark: 70.0%
 - Baseline: 55.0%
 - Gap: $70\% - 55\% = 15\%$
 - $10\% \text{ of } 15\% = 1.5\%$
 - $55\% + 1.5\% = 56.5\%$
 - Target: 56.5%

\$25,000,000

Up to

ACCESS AND PRACTICE TRANSPORTATION
GCHP Investment in Provider Quality Performance
2023-2025 Funding | Grants and Other Vehicles | Network-Wide Availability

Provider Recruitment
and Retention

Timely Appointments

Cultural and linguistic
needs...and more...

Advancing GCHP as a High-Quality Health Plan

- Investments in FY 2023-24 Budget
- Provider Incentive Funding and Program
- Member Engagement and Incentives
- Role of the Health Plan

Creating a Member-Centered Health Plan



Why does the Member Engagement matter?

- Decades of industry research and results show that more engaged members = more appropriate care, less skipped care and tests = better health outcomes (and higher Quality) = better experience with health and healthcare = more motivation to remain in care and adhere to Rx/Tx, and more.
- Nationwide, 60% of health plan members have sought support or guidance from their health plan and been “frustrated” by the experience (Wellframe 2020 Health Plan Member Engagement Survey).
- Multiple nationwide industry reports point to 80% of members with chronic conditions are dissatisfied with the services/supports for managing conditions from their Medicaid managed care plan.
- Nationwide, 60% of health plan members surveyed think a lot of the information and care they receive from their health plans is “too generic and not personalized to me.” (JD Powers, 2021)
- More engaged members: 5-10x less likely to have an unnecessary inpatient admission. (CareSource multi-state analysis and report on members with multiple chronic conditions, 2018)
- More engaged members: 4x more likely to adhere to Rx treatment.

Why Does Member Engagement Matter?



- ★ Engage the member in their health and healthcare → unnecessary Care and Cost goes up

- ★ Level 4 is a truly member-centered, culturally-adapted healthcare organization that has fully developed capabilities to deliver member engagement in – and improve experience with – health and health care.
- ★ High performing health plans play a vital role in member outreach and linkage/retention in care. External community-based outreach and services workers and outbound member services are essential.

EXHIBIT 2 **Predicted Per Capita Costs of Patients by Patient Activation Level**

2010 patient activation level	Predicted per capita billed costs (\$)	Ratio of predicted costs relative to level 4 PAM
Level 1 (lowest)	966**	1.21**
Level 2	840	1.05
Level 3	783	0.97
Level 4 (highest)	799	17% less unnecessary care and lower cost

SOURCE: Judith H. Hibbard, Jessica Greene, and Valerie Overton, "Patients with Lower Activation Associated with Higher Costs; Delivery Systems Should Know Their Patients' Scores," *Health Affairs* 32, no. 2 (2013): 216–22. **NOTES:** Authors' analysis of Fairview Health Services billing and electronic health record data, January–June 2011. Inpatient and pharmacy costs were not included. PAM is Patient Activation Measure. ** $p < 0.05$

- ★ Health plans must invest in providers and achieve significant changes in the culture and operations of provider systems aimed at improved patient engagement.

Bringing a Member-Centered Health Plan to Life

Our Members at the Center

IMPROVING MEMBER INCENTIVES

GCHP-WELLTH PILOT IS THE FIRST OF ITS KIND IN MEDI-CAL, RECOGNIZED AS “INNOVATIVE” BY DHCS.

INTEGRATED CARE TEAMS

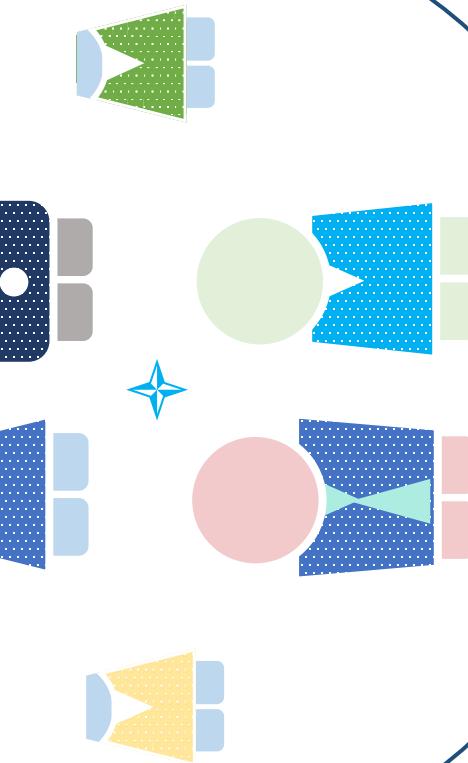
GCHP MUST SCALE UP PEOPLE, OPERATIONS, AND TECHNOLOGIES TO MEET NEEDS OF LARGE AND GROWING CHRONIC CONDITION POPULATION.

TRANSPORTATION IS KEY TO ENGAGEMENT

GCHP IS PARTNERING WITH AN EXPERT LOGISTICS/TRANSPORTATION FIRM ON THE DESIGN OF A HIGH PERFORMING MEDI-CAL TRANSPORTATION SYSTEM IN VENTURA COUNTY. WE PROVIDE >210,000 TRIPS A YEAR – FOR ~4,000 HIGH NEED MEMBERS. MORE MEMBERS SHOULD USE THIS SERVICE – EDUCATION AND IMPROVEMENTS ARE NEEDED.

MEMBER OUTREACH AND LINKAGE TO CARE

GCHP IS PARTNERING WITH EXPERT OUTREACH VENDORS TO LINK MEMBERS WITH NEEDED CARE MANAGEMENT AND COMMUNITY SUPPORTS. MEDICALLY TAILORED MEALS IS A RECENT EXAMPLE. GCHP IN-HOUSE SERVICE CAPABILITIES OF THE FUTURE WILL FOCUS ON GETTING MEMBERS INTO CARE THEY NEED AND HELPING THEM STAY IN CARE.



Member Incentives Through Behavioral Science and Economics

Target Population: 18+ years, multiple chronic conditions, history of non-adherence using care gaps, and undesirable utilization patterns.

Initial Pilot: Identify 15K eligible members with initial enrollment of 1K

Incentive: Members can earn up to \$30/month

Objectives: Wellth drives health engagement, medication management and adherence, and closure of key care gaps, which has led to greater health equity and a decrease in high-cost utilization

