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

Regular Meeting
Monday, April 22, 2024 2:00 p.m.
Members of the public can participate using the Conference Call Number below.

Conference Call Number: 1-805-324-7279
Conference ID Number: 315 352 474 #

Para interpretación al español, por favor llame al: 1-805-322-1542 clave: 1234

Clinicas del Camino Real
1040 Flynn Road,
Camarillo, CA 93012

Las Islas Clinic
2400 South C St
Oxnard, CA 93033

Human Services Agency
855 Partridge Drive
Ventura, CA 93003

AGENDA

CLERK ANNOUNCEMENT

All public is welcome to call into the conference call number listed on this agenda and follow along for all items listed in Open Session by opening the GCHP website and going to ***About Us > Ventura County Medi-Cal Managed Care Commission > Scroll down to Commission Meeting Agenda Packets and Minutes***

CALL TO ORDER

INTERPRETER ANNOUNCEMENT

OATH OF OFFICE New Commissioner: J. Tabin Cosio

ROLL CALL

PUBLIC COMMENT

The public has the opportunity to address Ventura County Medi-Cal Managed Care Commission (VCMMCC) and Committee doing business as Gold Coast Health Plan (GCHP) on the agenda.

Persons wishing to address VCMMCC and Committee 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 and Committee.

Members of the public may call in, using the numbers above, or can submit public comments to the Commission and Committee via email by sending an email to ask@goldchp.org. If members of the public want to speak on a particular agenda item, please identify the agenda item number. Public comments submitted by email should be under 300 words.

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Regular Commission meeting minutes of February 26, 2024

Staff: Maddie Gutierrez, MMC Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

2. Approval of Funds deposit into the Restricted Account for Knox Keene License

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Approve a deposit of $300,000 into a Restricted Deposit Account, in accordance with the licensure requirements under the Knox-Keene Act.

FORMAL ACTION

3. Election of Chairperson and Vice-Chairperson to serve two-year terms and appointments to the Executive/Finance Committee

Staff: Scott Campbell, General Counsel

RECOMMENDATION:

1. Elect a Commissioner to serve as Chairperson for a two-year term.
2. Elect a Commissioner to serve as Vice-Chairperson for a two-year term.
3. Make any necessary appointments to the Executive/Finance Committee as follows:
   a. Chairperson (same as Commission Chairperson).
   b. Vice-Chairperson (same as Commission Vice-Chairperson)
   c. Private Hospital Healthcare Representative (if required).
   d. Ventura County Medical Health System Representative (if required).
   e. Clinicas Del Camino Real Representative (if required).

4. Consideration of appointments to the Compliance Advisory Committee

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Staff requests that the Commission determine whether it wants to fill the vacancy in the Compliance Oversight Committee, caused by the termination of former Commissioner Jennifer Swenson's service on the Commission.

5. Revised Provider Advisor Committee Charter

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

RECOMMENDATION: GCHP's management team recommends that the Commission approve the revised PAC Charter.

6. Addition of New Provider Advisory Committee (PAC) Members

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

RECOMMENDATION: GCHP's management team recommends that the four (4) individuals recommended be approved by the Commission as new PAC members. Once approved by the Commission, they will be contacted of their official appointment.

7. Operations of the Future (OOTF) Readiness Report

Staff: Jan Schmitt, Principal Project Manager
Anna Sproule, Exec. Director of Operations
Marlen Torres, Exec. Director of Strategy & External Affairs
Alan Torres, Chief Information & system Modernization Officer
Paul Aguilar, Chief of Human Resources & Organization Performance Officer

RECOMMENDATION: Receive and file the report.

8. Strategy and Budget Principles and Framework

Staff: Sara Dersch, Chief Financial Officer
Erik Cho, Chief Policy & Programs Officer
Felix L. Nuñez, MD, MPH, Chief Medical Officer

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

9. February Year- to-Date Financial Results

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests the Commission approve the February Year-to-Date financial results.

REPORTS

10. Chief Executive Officer (CEO) Report

Staff: Nick Liguori, Chief Executive Officer

RECOMMENDATION: Receive and file the report

11. Chief Medical Officer (CMO) Report

Staff: Felix L. Nuñez, MD, MPH, Chief Medical Officer

RECOMMENDATION: Receive and file the report

12. Human Resources (H.R.) Report

Staff: Paul Aguilar, Chief of Human Resources & Organization Performance Officer

RECOMMENDATION: Receive and file the report

CLOSED SESSION

13. PUBLIC EMPLOYEE PERFORMANCE EVALUATION

Title: Chief Executive Officer

14. CONFERENCE WITH LABOR NEGOTIATORS

Agency designated representatives: Commission
Unrepresented employee: Chief Executive Officer

ADJOURNMENT

The next meeting will be on held on May 20, 2024, at 2:00 p.m., in the Community Room located at GCHP 711 E. Daily Dr. Suite 110, Camarillo, CA 93010

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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 Commission.

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5512. Notification for accommodation must be made by the Monday prior to the meeting by 1:00 p.m. to enable the Clerk of the Commission to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO. 1

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Maddie Gutierrez, MMC, Clerk for the Commission

DATE: April 22, 2024

SUBJECT: Regular Meeting Minutes of February 26, 2024

RECOMMENDATION:

Approve the minutes.

ATTACHMENT:

Copy of Commission regular meeting minutes of February 26, 2024

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
Commission Meeting
Regular Meeting via Teleconference & In Person

February 26, 2024

CALL TO ORDER

Committee Chair Dee Pupa called the meeting to order at 2:14 pm. in the Community Room located at Gold Coast Health Plan, 711 East Daily Drive, Suite 110, Camarillo, California.

INTERPRETER ANNOUNCEMENT

The interpreter made her announcement.

ROLL CALL

Present: Commissioners Anwar Abbas, Shawn Atin, Allison Blaze, M.D., Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, and Dee Pupa.

Absent: Commissioners James Corwin, Melissa Livingston, Sara Sanchez, Jennifer Swenson, and Scott Underwood, D.O.

Attending the meeting for GCHP were Nick Liguori, Chief Executive Officer, Alan Torres, Chief Information Officer, CPPO Erik Cho, CFO Sara Dersch, Marlen Torres, Executive Director, Strategy and External Affairs, Paul Aguilar, Chief of Human Resources, Felix Nunez, M.D., Chief Medical Officer, Robert Franco, Chief Compliance Officer, Ted Bagley, Chief Diversity Officer, Eve Gelb, Chief Innovation Officer, Susana Enriquez-Euyoque, and Scott Campbell, General Counsel.

Also in attendance were the following GCHP Staff: Kim Timmerman, Rachel Lambert, Nicole Kanter, David Tovar, Mayra Hernandez, Lucy Marrero, Adriana Sandoval, Michelle Espinosa, Carolyn Harris, Lupe Gonzalez, Lily Yip, Joanna Hioureas, James Cruz, M.D., Kris Schmidt, Benjamin Lacey, Kim Marquez-Johnson, Anna Sproule, Carmen Moran, Victoria Warner, Zed Haydar. Erin Slack, Jeff Yarges, Jan Schmitt, Michael Mitchell, Paula Cabral, Lupe Harrion and consultants Don Harbart and Amit Jain.

PUBLIC COMMENT

None.

CONSENT

1. Resolutions 2024-001 and 2024-002 Honoring Commissioners Jennifer Swenson and Shawn Atin

Staff: Nick Liguori, Chief Executive Officer

RECOMMENDATION: Staff requests that the Commission approve Resolutions 2024-001 and 2024-002.

Chief Executive Officer, Nick Liguori thanked both Commissioners Jennifer Swenson, and Shawn Atin for their years of service on the Commission. He noted that their work has been instrumental in creating future vision.

CEO Liguori requested the Commission approve a resolution recognizing both Commissioner Swenson and Commissioner Atin for their dedication, support, and service on the Commission.

A plaque was presented to Commissioner Atin. Commissioner Swenson's plaque will be mailed to her.

Commissioner Pupa motioned to approve Consent Agenda Item 1. Commissioner Monroy seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Laura Espinosa, Supervisor Lopez, Anna Monroy, and Dee Pupa

ABSTAIN: Commissioner Shawn Atin

NOES: None.

ABSENT: Commissioners James Corwin, Melissa Livingston, Sara Sanchez, Jennifer Swenson, and Scott Underwood, D.O.

The clerk declared the motion carried.

Commissioner Atin stated that it has been a pleasure to serve on the commission and it has been a learning experience. He stated that he believed the future of Gold Coast is very bright, and the service provided by GCHP is exceptional. He thanked all for allowing him to serve on this commission.

2. Approval of Ventura County Medi-Cal Managed Care Regular Commission meeting minutes of January 22, 2024

Staff: Maddie Gutierrez, MMC Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

3. Restricted Deposit to Meet Knox-Keene Application Requirements

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests the Commission approve the creation of a restricted bank account.

Commissioner Espinosa motioned to approve Consent agenda Items 2 and 3. Commissioner Monroy seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Shawn Atin, Allison Blaze, M.D., Laura Espinosa, Supervisor Lopez, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: Commissioners James Corwin, Melissa Livingston, Sara Sanchez, Jennifer Swenson, and Scott Underwood, D.O.

The clerk declared the motion carried.

PRESENTATIONS

4. DHCS Contracts

Staff: Robert Franco, Chief Compliance Officer

RECOMMENDATION: Receive and file the presentation.

CCO Robert Franco stated he would highlight changes. CCO Franco stated that DHCS has issued a new contract for all Medicare health plans. There are some areas that it will strengthen not only within the community but the plan as well. DHCS is requiring public posting of additional information for their own contractors and subcontractors. There are many things that they are now requiring us, as a plan, to post to our website. We are in the process, once these become available, we will be posting them to the site.
One of the new requirements is the memorandum of understanding with third parties. This has been a huge initiative that DHCS has issued.

For high quality care you see many of the initiatives that have already begun on how we are operating as a health plan. There are new requirements to exceed DHCS to establish quality improvements, and benchmarks at Medi-Cal health plans and subcontractor level. CCO Franco noted that there are sanctions and possible profit surrender for unmet quality benchmarks which have been discussed within the Executive Finance. He noted the achievement of NCQA accreditation by January 1st which we, as an organization are in the process of doing.

Access to Care & Continuum of Care aligns with CalAIM. A big focus for DHCS is the ongoing implementation of the CalAIM initiatives, including Enhanced Care Management, Community Supports, and the newly carved in benefits of major organ transplants and long-term care services. DHCS has been providing guidance since the inception. CCO Franco also noted that they have started requiring plans to attest and provide their readiness in the third quarter of 2022, and by the end of December 2023 we submitted our last deliverable. There are a total of 250 deliverables that were received as part of the readiness submitted and were approved by DHCS. CCO Franco stated that a highlight of this initiative was a cross functional initiative that all of the departments had to revise their existing policies to meet the new contractual requirements. We are now in the process of making sure that our readiness submissions are implemented correctly.

In coordinated and integrated care CCO Franco noted strengthened care coordination for all members. This includes enhanced coordination with local health departments, county behavior, health plans, schools, justice systems and community-based organizations. This has been one of the state's huge initiatives to partner all the Medi-Cal plans with the existing county infrastructures.

In regard to increasing health equity and reducing health disparities, CCO Franco stated we will be getting the second accreditation by January 2026. In addressing social drivers of health, all MCPs will implement new strategies to address unmet health-related social needs. We are required from a contractual perspective to implement the community Supports and document members' social determinants of health needs and services. One of the main drivers of the contract revision is to codify the CalAIM changes that were made.

In local presence and engagement, it is noted that stronger provisions for members and family engagement. DHCS is asking health plans to not only engage with providers but also with the community. We will also be partnering with local education agencies to provide additional support for children, by implementing interventions at school sites, as well as early interventions in behavioral health services as part of our memorandum of understanding.

CCO Franco noted that DHCS has required regular reporting to the federal government and on the DHCS website progress related monitoring and overseeing Medi-Cal health plans. There is also new delegated reporting and compliance plans that are required. He noted that this now includes performance on subset of metrics by race and ethnicity.

DHCS is paying close attention to this. He stated that DHCS wants strengthen performance requirements and there will be penalties if the MLRs are not met at the 85% minimum.

Commissioner Livingston joined the meeting at 2;21 p.m.

CCO Franco reviewed what the members can expect. There will be more information and insight to inform a choice of plan, holistic care based on social determinants of health, culture and linguistic differences and physical and behavioral health needs, and appropriate care. CCO Franco noted there are many initiatives that we have that align with DHCS requirements coming from the 2024 contract.

Commissioner Espinosa asked if on the item regarding increasing health equity and reducing disparities, will DHCS be creating the measures or identifying the measures and will it be related to our MCAS five key areas of focus. Could it be different or a combination. She asked if we know yet. Chief Innovation Officer, Eve Gelb stated it is related to our MCAS, what DHCS has done is required certain measures. Not only do we report on the measure, but we also report by various segments of our population. We gather the data, and the state will determine where inequities exist. It might not exist in our population, but they look at it from a state perspective.

Commissioner Espinosa stated that we are voting on the new updated version of the Mental Health Service Act, the first legislation was in 2004, which required race be considered. She asked if this measure passes, will it change any language, because it is a concern in Ventura County. She noted that health advocates and currently discussing with Ventura County Behavioral Health is a Latino Disparities Reduction Committee. CIO Gelb stated she did not know if there would be any change on what DHCS has proposed in the contract. She noted there are two behavioral health measures and currently for MCAS are follow-up after a mental health emergency visit and follow up after substance use disorder. She was not sure if those two were modified. She did note that the State of California is going toward improving mental health services and the MCAs measures proposed for 2025 and beyond include significant increase in the number of mental health related MCAS measures. CIO Gelb stated that we track, measure, monitor and address all of our measures by race, and by language spoken by ethnicity. Commissioner Pupa stated the health equity focus is not just on managed Medi-Cal plans it is also in the entire insurance industry, they have the same requirement as GCHP in regard to health equity.

5. Emergency Response

Staff: Felix L. Nuñez, MD, MPH, Chief Medical Officer
Anna Sproule, Executive Director of Operation

RECOMMENDATION: Receive and file the presentation

Commissioner Corwin joined the meeting at 2:30 p.m.

Ana Sproule, Executive Director of Operations stated that in February Gold Coast Health Plan activated our emergency response team to address two separate emergencies that our county was faced with on February 4th. There was a flood situation that was addressed and on February 9th, there was an earthquake and several aftershocks, fortunately there was no disruption or impact to member care and all services provided by the plan remained operational. Ms. Sproule stated a detailed overview of the protocols will be presented at the April Commission meeting.

6. Member Services Everywhere/ Experience

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

RECOMMENDATION: Receive and file the presentation.

Marlen Torres, Executive Director of Strategy & External Affairs stated she will be reviewing strategic initiatives and provide an update on where we are. Ms. Torres stated that through the Operations of the Future, one of the major components was to focus on the member experience as a whole and bring the call center in house so we could hire locally and have full control and design of the training and the overall service that the agents are providing to our members. Another major strategic component was to move forward with having a community deployed service team out at provider offices and key community locations. We have seen tremendous success with our Community Relations Specialist team members embedded at a number of our county clinic partners offices and supporting members there through our redetermination efforts. We have partnered with the Operations team, member services, grievance and appeals and also other member facing teams to be able to support our members. We are looking to expand and develop our strategy.

Another component is our interest in expansion of satellite offices at key locations where our members are. We want to honor our local model and support our members in person, as there is no better way to interact with many of our members other than through the in-person approach. Ms. Torres stated another component is centered around training, not only for the call center agents, but all member facing departments in the organization. She noted that this is all to improve our member experience, which is measured through CAHPS. We will be able to support our members and increase our MCAS scores by closing care gaps.

Ms. Torres stated that we have been looking at our strategic components and designing a holistic campaign to elevate the quality of service provided to GCHP members through improved communication, which has been key. We want to have clear communication with our members, being a trusted partner from a member perspective, and connecting the member with care.

Anna Sproule, Executive Director of Operations, stated that significant headway has been achieved in developing several program elements, and we have reached many milestones in the past couple of months. We have hired 23 Call center coordinators and they have begun their service with GCHP. We have also identified areas within the community in which the majority of our members are, and we can try to focus our resources in that area. We will continue to collaborate with the different departments as well as on-boarding new staff over the next several weeks.

Ms. Sproule stated that Ms. Torres has focused on training and the program in its entirety. Ms. Sproule wants to focus on technology. GCHP has made great investments in technology in regard to the Operations of the Future program. Within that program we have invested in Salesforce and Genesys. Salesforce is our customer resource manager and Genesys partners closely with Salesforce for the telephone system and bridges gaps between the phone call and how we are going to manage that call. Salesforce is a leader in the industry and their Customer Resource Manager (CRM) allows for organizations to streamline their operations, improve our member relationships, and drive growth as necessary through enhanced efficiency, collaboration, and insight driven decision making. We continue to build the system and integrate the system through the Operations of the Future programs. We have built out the integration between the CRM, Salesforce, and the phone system which will allow us to help a member by serving all their needs and connecting them with care.

Ms. Sproule sated that we plan to have our first outbound calls take place by April 1 and our full take over from our prior vendor by July 1. We will be testing and working the system with agents getting familiar with how it works, and how to serve our members in the best, most streamlined manner possible to provide care and compassionate resources.

Supervisor Lopez asked if there is a different contact line for partner agencies or providers. Ms. Sproule responded that the call center serves both. Commissioner Monroy asked about operational hours for the call center now and in the future. Ms. Sproule stated that this first group operate between the hours of 8:00 a.m. and 6:00 p.m., however we will open up the ability to serve members later into the evening as well as over the weekends.

7. Gold Coast Health Plan MCAS 2023 Update and 2024 Strategy

Staff: Felix L. Nuñez, MD, MPH, Chief Medical Officer
Eve Gelb, Chief Innovation Officer
Erik Cho, Chief Policy & Program Officer
Marlen Torres, Executive Director Strategy & External Affairs
Kimberly Timmerman, Sr. Director Quality Improvement

RECOMMENDATION: Receive and file the presentation

Kim Timmerman, Sr. Director of Quality Improvement, stated she will review our results year to date and our projections. She noted that there are two different types of MCAS measures; those that are held to the minimum performance level and administrative measures – which are based on claims encounter and supplemental data. She reviewed the information on her chart. A hybrid measure is all of the data sets plus medical records. These measures used administrative data, health information exchange and electronic health records as a data source. Ms. Timmerman reviewed the year-to-date percentile results, which is preliminary data. For MCAS and year 23 the year-to-date percentile is based on administrative data only. For projection, once everything is submitted and a rate lift that we anticipate getting from that medical records search is what we are projecting, which is to be at the 50% MPL for Child and Adolescent WellCare visits. We also project to be at the 50% for Well-Child visits for ages 0 to 15 months, last year we were at 10%. The third measure is Chlamydia – we project to be at 75%, and last year we were at 25%. We have strong projections for measurement year 2023. Ms. Timmerman pointed out that we still have opportunities for improvement that will be the focus of measurement year 2024. For topical fluoride varnish we are currently projecting to be below the MPL, but we are still looking into that data. We are also projecting to be below MPL for follow-up after and ER visit for substance abuse. She did note that for that particular measure the MPL for year 2023 increased by 15% this year and therefore there are some challenges that are unknown. Asthma medication ratio is also below MPL. Ms. Timmerman stated one thing to note about higher rates compared to last year was the increased number of services that our members are receiving. For WCV (Well Child Visit) it was almost 5,000 more visits that our members received.

Felix Nunez, M.D., Chief Medical Officer, stated that ours. are getting better which is directly connected with more members seeing their providers for care. Moving the needle by just 1% on some of these metrics is an enormous effort and is due to collaboration and coordination of care.

We need to focus on children ages 10 and older, it is a particularly difficult group to work with and trying to connect them with care. We need to work on developing collaborative strategies that will give this population greater access and motivation to seek out preventative care services.

CIO Eve Gelb stated that we were provided with our sanction amount for 2022. DHCS looks at everything they calculate, engage with us on the calculation, we agree, then they issue the sanction. Although we got sanctioned, the good news is that our sanction is lower than our prior year, and a second point is that we are aligned with the state. We need to go for the high-performance level for our members. She also noted that our sanction was among the lowest. We do not know what our sanction will be for 2023 data, but it will be calculated based on measures that we missed that are below the MPL.
The other thing that is factored into how the sanctions work is repeat measures where the mark has been missed multiple years, as well as if there are multiple measures in a domain. If there are multiple measures in a domain, it is an indication that we are not meeting the needs of our members. She is hopeful that will have good news next year and she noted that we are pushing for excellence.

Supervisor Lopez acknowledge the article in the VC Star and stated that it was unfortunate that some people only read the title, which makes it seem like there is a big problem. She noted that there has been great progress, and she is hopeful that we will be in a better place with the 2023 report. Commissioner Espinosa stated the GCHP comments were explained well.

CIO Gelb stated that we are focused on the highest quality possible, not just meeting minimum performance level. Our projections for 2023 show that our measures are moving above the MPL which means our aggregate quality score is moving up. What we are going for is consistency. We are performing well on all of our metrics, but there is always something that is hard, and as the state brings on new measures, we have to learn about those measures, and continuously improve. The more we improve, the more we lift the health of the community that we serve. We could not have done this without our providers and community partners or member engagement.

CEO Nick Liguori wanted to discuss risks and realities. Quality performance is the significant factor in our ability to thrive long-term. In a financial context about .8% of our premium depends on high performance that is based on a withhold of .5%, which is expected to be 1% this year. He noted that .5% of our premium is being held back by the stat and will be available to us only after we exceed performance levels when this year is complete, which is the end of next calendar year. Those are funds we can use, but they are also at risk. Next year will be 2% or more. We are already hearing that the state does intend to ramp up that withhold, meaning those revenues are at risk, but also to increase the extent of sanctions, not only the number of sanctionable measures, but the amount that they levy now will also increase and more of our premiums will be at risk. We are exposed to losing 5% or more of our premium due to quality performance that may not reach high levels. CIO Gelb noted that other states have already gone through this, and it has resulted in a significant reduction in the number of health plans. It is a long-term risk. She also noted that when discussing MPL and high-performance levels, the state expects to see performance increase across the board, and that translates into that 75% of this year will be the minimum performance level in the future. The 75% or 90% of today is not long-term sustainable. Those numbers may become the average, so we must continue to invest for long-term. Adding to that risk assessment to how the 50% is set, it is not the California 50%, it is the United States 50%. When other plans or other states are further ahead than us and lifting benchmarks, then we get behind. We need to get ahead of the pack. We need to think about how we move forward, consistency, and the continuous quality improvement is what we need to follow. Where we can really lead is the engagement of our providers and our community.

Commissioner Atin asked if GCHP is passing the incentive system at the same pace to providers because it will be going at the same pace as the state is going. CEO Liguori stated we are outpacing that in two ways. One, the introduction of the $50million two-year quality incentive pool and program, which is now fully contracted. Three of the largest providers are covering more than 90% of our membership, and we are working on our smaller providers, and we will have that done. The $50million exceeds what the

state is putting us at risk for and our intention is to grow that program further accelerating beyond the states own pace in the future. Commissioner Atin stated it would be good to see how much GCHP is sanctioned by the state, and then how much GCHP sanctions the providers. He stated that everyone will see that there are leaders. CMO Nunez stated it is not to sanction providers or for us to be sanctioned. The idea is that these investments are going to build and grown and support our network to achieve high performance in the future. CEO Liguori noted that our providers have been amazing, they have been waiting for this kind of partnership and they deserve the investments that we have made available.

CEO Liguori noted that in the April Commission meeting we will present a comprehensive approach to tying financial partnership to quality that takes us beyond the quality incentive, and also looking at reimbursement rates being tied to quality. If quality is not there, rates may not increase.

CMO Nunez stated that quality improvement and achievement on our scorecard has advanced our work across our network. He noted that there is collaboration among providers. They look at the numbers and ask who they can collaborate with to innovate more, get better scores on the metrics. It is important to understand what the drivers are and that is also an opportunity to collaborate.

CEO Liguori stated that if the Commission would like, in a future meeting, there could be a presentation with detail on each measure, and the factors that we see hold back performance.

Ms. Timmerman reviewed the timeline and what is next. We are now in measurement year 2023, the results are primarily based on care given in 2023. There are some measures with a longer look back period.

Administrative data are the measures determined by data on claims and encounter supplemental data. The collection of administrative data goes through the end of the project, administrative data will be refreshed monthly. The hybrid measures are determined by a combination of administrative data and data from medical records. The collection of those hybrid measures is happening February to May. We then go into the data validation phase, once the data collection is complete, the results are calculated and audited, then submitted to the stand and NCQA. June 14 is our deadline for submission. In October we will see the state dashboard, and then releases the performance that compares our results across other plans, and we can see where we landed.

Marlen Torres, Executive Director of Strategy & External Affairs stated that there were a number of member initiatives that were implemented last year to help increase our measures. Member incentives proved to reduce the No Show rate. Gift cards were available on the spot for members, and that has been very successful. There was also a number of member outreach campaigns that proved effective. There were also a number of lessons learned that we are looking into in order to improve for this year. We also

launched Community-Care activities, including health fairs, which all proved to be effective. We are also exploring home-health pilots, and mobile mammograms.

CIO Gelb stated that for 2024 we are setting our targets earlier than usual, which can be dangerous since we do not know what the benchmarks are going to be. We wanted to get everyone aligned, working earlier in the year in order to increase improvement, and also the fourth quarter pushes a burden on many.

Commissioner Pupa noted that is nice to see improvement because it was not always the case in the past.

CMO Nunez stated that there is no metric that is less important on our quality score card than any other metric. We have to move forward and progress on all the metrics. There are four metrics that are notably challenging. We have been developing targeted interventions to begin to address the root cause of the barriers. There are other challenges that will require additional innovation and collaboration.

Commissioner Pupa asked if there was a shortage of the actual fluoride kits. CMO Nunez stated it is access to the actual varnish that has been a problem. We are strategizing on ways that we can improve access of the fluoride for our network providers, then how to actualize the application of the varnish to the population. Another issue is how it will be coded because it is not a usual thing that a PCP does or codes in their system.

Commissioner Abbas motioned to approve agenda Items 4 through 7. Commissioner Atin seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Laura Espinosa, Melissa Livingston, Supervisor Lopez, Anna Monroy, Dee Pupa, Sara Sanchez, and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Shawn Atin, and Scott Underwood, D.O.

The clerk declared the motion carried.

FORMAL ACTION

8. Notice of Non-Award, Lot 2 Request for Proposal Number GCHP05012023, Lot 2, Mailroom Services

Staff: Alan Torres, Chief Information & System Modernization Officer
Paul Aguilar, Chief of Human Resources & Organization Performance Officer

RECOMMENDATION: It is the Plan's recommendation that the Ventura County Medi-Cal Managed Care Commission approve continuing these services with Conduent for six, (6) months for an amount not to exceed $650,000 and reject all bids and notify the bidders of a non-award of this contract.

Alan Torres, Chief Information & System Modernization Officer, stated that staff is recommending that the Commission reject all bids and approve continued mailroom services with Conduent for a six-month period. GCHP intends to internalize our mailroom services to enhance efficiency and streamline operations by January 1, 2025. Cost of the six-month extensions is $650,000. This entails transitioning our current outsource mailroom functions to an in-house set-up. This is a strategic move that will enable us to gain greater control over mailroom processing, improve turn around times and optimize our resource allocations. GCHP will conduct an RFP to procure equipment and software associated with imaging and scanning services by July 2024 and present all costs transition.

CISMO Torres reviewed a high-level timeline of the steps that will be taken to meet our objectives and be ready on or before December 31, 2024.

General Counsel, Scott Campbell stated the Executive Finance Committee heard this matter and concurred with the recommendation of staff to approve both items. CEO Liguori stated the intention with the six-month extension is to gain the time needed to transition our current outsourced mailroom function to an in-house set-up.

Commissioner Abbas motioned to approve agenda Item 8. Supervisor Lopez seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Laura Espinosa, Melissa Livingston, Supervisor Lopez, Anna Monroy, Dee Pupa, Sara Sanchez, and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Shawn Atin, and Scott Underwood, D.O.

The clerk declared the motion carried.

9. Contract Approval for Edifecs Change Order- Encounter Management & Smart Trading Cloud Software

Staff: Alan Torres, Chief Information & System Modernization Officer

RECOMMENDATION: It is the Plan's recommendation that the Ventura County Medi-Cal Managed Care Commission authorize the CEO to execute a contract with Edifecs Inc., to include the additional work associated with the licensing and implementation of Edifecs Encounter Management and Smart Trading Cloud software. The term of the change order/contract will be 4-6 months of implementation and 5 years of production commencing March 1, 2024, and expiring on February 28, 2029, for an amount not to exceed $4.7M.

Alan Torres, Chief Information & System Modernization Officer stated staff is recommending the Commission approve the execution of additional contract authorizations with Edifecs. The initial contracted work totaled $8.3 million over six years. This covered all electronic transactions with the exception of encounters. GCHP was aware of the need to request additional work to support encounter processing and provided advanced notice to the Commission of the need for additional services after the completion of the implementation discovery phase of Edifecs work. This is the last step in preparing the technology support encounter data processing and with the technology secured, will be able to define a full operational picture. A core function of EDI is the ability to manage data files and their storage during implementation discovery sessions of our initial work with Edifecs it was identified that Edifecs had changed file management capability into a separate product, and it was not part of the original contract. CIO Torres noted that Edifecs has a strong relationship with DHCS to support the regulatory changes that come with encounter processing. We expect high performance and quality in our encounter data processing. We want to make sure that we are getting the best-in-class capability.

CIO Torres stated for a four to six-month implementation and a period of five years of licensed use adding these two components will not exceed $4.7 million for a total of $13 million for these two RFPs: one RFP, one change order.

We are asking for approval to execute a contract with Edifecs to include the additional work associated with licensing and implementation of Edifecs encounter management and smart trading cloud software. The terms of the change order will be four to six months for implementation and five years of production beginning March 1, 2024, and ending February 28, 2029, for an amount not to exceed $4.7 million.

Commissioner Pupa reminded the Commission that in June 2023 when the initial amount was approved, we knew that this other element or module was not quite there yet. She stated that it seems odd to refer to it as a Change Order because it is not really a Change Order it is basically going through the process of adding the last bolt to this process.

Commissioner Atin motioned to approve agenda Item 9. Commissioner Abbas seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Laura Espinosa, Melissa Livingston, Supervisor Lopez, Anna Monroy, Dee Pupa, Sara Sanchez, and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Shawn Atin, and Scott Underwood, D.O.

The clerk declared the motion carried.

10. FY 2023-24 Financial Update – December 2023 YTD

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests the Commission approve the Fiscal Year to Date financial update.

Sara Dersch, Chief Financial Officer stated she will present the December year to date results and also the economic impact which is affecting us in January. December results approximate very closely our reforecast amount. She noted that the Commission approved the reforecast in January. It is the new baseline of where we compare ourselves. Our December net income was $4.3million versus the reforecast amount of $3.9 million. This brings our year-to-date income to $45.4 million. Our premium income is in line with the reforecast from a PM perspective. CFO Dersh noted that we are experiencing higher membership in the categories that have a lower reimbursement amount. We have a high membership in children than projected, our adult expansion is also a higher membership than projected, both are lower premium categories. The higher premium categories such as senior and people with disabilities and long-term care, are actually less than we had forecasted.

Our medical costs are also in line with expectations. Our general administrative expenses are close to our forecast. We are mindful of how we are spending our general and administrative expenses and continue to ensure that we are deploying all of the dollars that we can for our quality efforts for our medical cost efforts. The project portfolio is funning slightly unfavorable, which is related to timing. We are doing more work now so we can free up some additional dollars later in the year.

CFO Dersh stated that we were told by the state a few months back that our acuity adjustment, which everyone receives, would be a reduction of .15%, some things have happened since that time. The state and Mercer have been able to investigate and unpack the impacts of the redetermination, looking at those people that are redetermined

off and do not come back, combined with the timing of redetermination. The redetermination was supposed to begin in April and in reality, did not start until July. The impact of this is we have “leavers” who were not as healthy as originally thought. They are taking with them some of those higher premium dollars, combined with the fact that we received two additional months of premium now resulting in a reduction of 1.95%. The new amount is now $16.1 million. It is a 13fold increase over what the state had originally told us. We are not alone in this, just about every county, every organization was negatively impacted. The state average was -1.8%, we came in at -1.95%, we were close to average.

The increase in net income that we had reforecast going from $23million to approximately $45 million, we can absorb the $16.1 million take back without any negative impact to our members, without negative impact to the quality work that we are doing, to the grant work we are doing, and without negative impact to our providers.

CFO Dersch stated the Commission decided to raise the TNE amount up to 700% last summer for this type of reason, we know that the state does have the prerogative to come in and execute on some of these initiatives. We were not expecting this, it happened, and we can accept this and continue to do the work we need to do, and there should not be any concerns around the increased take back.

Reviewing categories, CFO Dersch stated that we are exactly in line with where we expected to be during the reforecast process. This tells us our trends are normalized. We have a strong reforecasting partnership with Edrington Health Management, and we are happy with the work they are doing, and we do not see anything that would tell us that we should expect any change in utilization over the near term.

Commissioner Espinosa stated our TNE is well over 1100%, which is good because we can absorb the $16 million, and with all of our initiatives that have been presented, we will still be in a good position in the future. CFO Dersch stated she was correct. Our TNE position allows us to be positively disruptive in how we are developing new programs, on thinking outside of the box, on helping develop new P for P, coming up with new ways to get care to the members, to develop and reinvest in technology so we can have a strong contact center. We can get out in the community where the members are. This is exactly what we need to be doing. By supporting this great work, it will improve our quality scores, which will put us in a better position and help us to get more money through rate advocacy. It is a positive feedback loop that we are going to be able to engage in.

Commissioner Pupa stated that it is good that we are fiscally strong because this is indicative of the state constantly changing the healthcare landscape. We do have that balance with retained earnings, TNE, getting the dollars in the hands of the providers. CFO Dersch stated we are smart and thoughtful and apply a disciplined rigor around how we are determining how to spend out TNE an ensuring that we are maximizing the return on those dollars and ensuring that our members are getting what they need.

Commissioner Espinosa motioned to approve agenda Item 10. Commissioner Monroy seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Laura Espinosa, Melissa Livingston, Supervisor Lopez, Anna Monroy, Dee Pupa, Sara Sanchez, and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Shawn Atin, and Scott Underwood, D.O.

The clerk declared the motion carried.

Commissioner Pupa stated that in the interest of time, if there were no objections from Commissioners she would like to receive and file reports 11 and 12.

REPORTS

11. Chief Executive Officer (CEO) Report

Staff: Nick Liguori, Chief Executive Officer

RECOMMENDATION: Receive and file the report

12. Human Resources (H.R.) Report

Staff: Paul Aguilar, Chief of Human Resources & Organization Performance Officer

RECOMMENDATION: Receive and file the report

Commissioner Abbas motioned to approve agenda Items 11 and 12. Commissioner seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Laura Espinosa, Melissa Livingston, Supervisor Lopez, Anna Monroy, Dee Pupa, Sara Sanchez, and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Shawn Atin, and Scott Underwood, D.O.

The clerk declared the motion carried.

Open session ended at 4:12 p.m. The Commission went into closed session at 4;14 p.m.

CLOSED SESSION

13. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

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

ADJOURNMENT

The meeting was adjourned at 5;46 p.m. There was no reportable action.

Approved:

_____
Maddie Gutierrez, MMC
Clerk to the Commission

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Sara Dersch, Chief Financial Officer

DATE: April 22, 2024

SUBJECT: Approval of Funds deposit into the Restricted Deposit Account for Knox-Keene License

SUMMARY:

Gold Coast Health Plan ("GCHP") is required by the Department of Managed Health Care ("DMHC") to launch a Dual Eligible Special Needs Plan ("D-SNP") by January 1, 2025. To do so, GCHP must obtain licensure from the Department of Managed Health Care ("DMHC") for its D-SNP line of business in accordance with the Knox-Keene Act. On February 26, 2024, the Commission approved the creation of a restricted deposit account as required by the Knox-Keene licensure application.

In addition, the Knox-Keene application requires the applicant *(i.e.*, GCHP) to obtain and maintain a tangible net equity deposit at the time of application, pursuant to 28 CCR Section 1300.76.1. The amount of the required deposit is $300,000. The applicant is required to file a completed assignment form, a copy of the bank statement evidencing the deposit, and a copy of the Commission resolution approving the deposit with DMHC.

RECOMMENDATION:

Approve a deposit of $300,000 into a Restricted Deposit Account, in accordance with the licensure requirements under the Knox-Keene Act.

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: April 22, 2024

SUBJECT: Election of Chairperson and Vice-Chairperson to serve two-year terms and appointments to the Executive/Finance Committee

SUMMARY:

Pursuant to the bylaws of the Ventura County Medi-Cal Managed Care Commission (Commission), the Commission must elect from its membership a Chairperson and a Vice-Chairperson to serve two-year terms at its first meeting after the County of Ventura makes appointments and reappointments to the Commission. This is the meeting to have the election. The Chairperson and Vice-Chairperson of the Commission also both serve on the five person Executive/Finance Committee. The bylaws also provide that once these officers are elected, the Commission will need to make appointments to fill the balance of the Executive/Finance Committee.

BACKGROUND/DISCUSSION:

The Commission's bylaws require that the Chairperson and Vice-Chairperson be elected to a two-year term by a majority vote of its members, and that no individual may serve more than two consecutive two year terms in either position. (See Bylaws, Art. III). The bylaws also provide that the Vice Chairperson will become the Chairperson if the position of the Chairperson is vacant. The current Chairperson Dee Pupa is not eligible to serve another term as she has served two full two year terms. Vice-Chairperson Laura Espinosa was recently reappointed to the Commission and, pursuant to the bylaws, should be elected Chairperson. The position of Vice Chairperson may be filled by any Commissioner, including former Chairperson Dee Pupa.

The Chairperson is responsible for presiding at all Commission meetings, executing all documents approved by the Commission, seeing that all actions of the Commission are implemented, and maintaining consultation with the Chief Executive Officer. The Vice-Chairperson is responsible for performing the duties of the Chairperson in the Chairperson's absence and performing such other responsibilities as agreed upon with the Chairperson. The bylaws do not contain any specific nominating process; Staff recommends that the Commission nominate Vice Chairperson Laura Espinosa for Chairperson and then vote to approve her appointment as set forth in the bylaws. The Commission should then nominate Commissioners for the Vice Chairperson and, once

all nominations are submitted, a vote should be taken. No second is necessary for a nomination.

The bylaws also establish the five-person Executive/Finance Committee. The Executive/Finance Committee consists of the Commission Chairperson, Vice-Chairperson, and three other Commission members. The bylaws also provide that the Executive/Finance Committee must have at least one member from the following represented groups: a private hospital/healthcare representative, a Ventura County Medical Health System representative, and a Clinicas Del Camino Real representative. (See Bylaws, Art. IV, section (b)(ii).) If the Chairperson and/or Vice-Chairperson is a representative from one of these agencies, then the Commission "may appoint any one of its members to fill" the remaining open Committee positions. (See Bylaws, Art. IV, section (b)(ii).) Appointments to the Executive/Finance Committee must be made at either the regular meeting in which the Chairperson and Vice-Chairperson are elected, or at the next regular meeting thereafter. Elections for the Executive/Finance Committees should be held after the election of the Chairperson or Vice-Chairperson.

The Executive/Finance Committee is an advisory committee of the Commission and reviews key contracts and initiatives, serves as the interview committee for certain executive positons and make recommendations to the Commission on various matters, including the budget. The Executive/Finance Committee meets every other month, except during the budget season, when it meets every month.

FISCAL IMPACT:

None.

RECOMMENDATION:

1. Elect a Commissioner to serve as Chairperson for a two-year term.
2. Elect a Commissioner to serve as Vice-Chairperson for a two-year term.
3. Make any necessary appointments to the Executive/Finance Committee as follows:
   a. Chairperson (same as Commission Chairperson).
   b. Vice-Chairperson (same as Commission Vice-Chairperson)
   c. Private Hospital Healthcare Representative (if required).
   d. Ventura County Medical Health System Representative (if required).
   e. Clinicas Del Camino Real Representative (if required).

ATTACHMENT:

Gold Coast Health Plan Bylaws

AMENDED AND RESTATED BYLAWS FOR THE OPERATION OF THE VENTURA COUNTY ORGANIZED HEALTH SYSTEM

VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION (dba Gold Coast Health Plan)

Approved: October 24, 2011
Amended: April 25, 2022

Table of Contents

AMENDED AND RESTATED BYLAWS FOR THE OPERATION OF THE VENTURA COUNTY ORGANIZED HEALTH SYSTEM (dba Gold Coast Health Plan)

ARTICLE I

Name and Mission

The name of this Commission shall be the Ventura County Medi-Cal Managed Care Commission, hereafter referred to in these Bylaws as the VCMMCC. VCMMCC shall operate under the fictitious name, Gold Coast Health Plan.

The VCMMCC shall design and operate a program or programs, whose mission is to improve the health of its members through the provision of the best possible quality care and services. This will be accomplished by:

(a) Delivering medical care via a contracted provider network that will improve access to primary, specialty and ancillary services;

(b) Establishment of mechanisms to assure that medical care services meet appropriate quality of care standards;

(c) Incorporating a plan of service delivery and implementing reimbursement mechanisms which promote the long-term viability of a locally operated Medi-Cal managed care system and the existing participating provider networks inclusive of "Safety Net" providers herein defined as Medi-Cal disproportionate share hospitals, county clinics, federally qualified health centers, and licensed rural health clinics;

(d) Implementing a financial plan which includes the creation of a prudent reserve and which provides that if additional surplus funds accrue, they shall be used to expand access, improve benefits and augment provider reimbursement in Ventura County;

(e) Placing a high priority on prevention, education, early intervention services and case management for enrolled recipients;

(f) Ensuring that all obligations, statutory, contractual or otherwise, shall be the obligations of the VCMMCC and shall not be the obligations of the County of Ventura or the State of California; and

(g) Implementing programs and procedures to ensure a high level of member satisfaction.

ARTICLE II

Commissioners

The governing board of the VCMMCC shall consist of eleven (12) voting members. It is desirable that members of the VCMMCC possess skills and knowledge necessary in the design and operation of a publicly managed health care delivery system.

Members of the VCMMCC shall be appointed by a majority vote of the Board of Supervisors and shall consist of the following:

(a) Physician Representatives. Two members shall be practicing physicians who serve a significant number of Medi-Cal beneficiaries in Ventura County. One shall be nominated by the Ventura County Medical Association, and one shall be nominated by the Ventura County Medical Center Executive Committee.

(b) Private Hospital/Healthcare System Representatives. Two members shall be representatives of private hospitals and healthcare systems operating within Ventura County and shall be nominated by the Hospital Association of Southern California. Nominees shall be from different hospitals and healthcare systems. The two appointed members shall not be affiliated with the same hospital or healthcare system.

(c) Ventura County Medical Center Health System Representative. One member shall be a representative of the Ventura County Medical Center Health System and shall be nominated by the Ventura County Medical Center System Administration.

(d) Public Representative. One member shall be a member of the Board of Supervisors, nominated and selected by the Board of Supervisors.

(e) Clinicas Del Camino Real Representatives. Two members shall be representatives of Clinicas del Camino Real nominated by the Clinicas del Camino Real Chief Executive Officer.

(f) Ventura County Health Care Agency Representative. One member shall be the Ventura County Health Care Agency Director or designee nominated by the Health Care Agency Director.

(g) Consumer Representative. One member shall be a Medi-Cal beneficiary and/or a representative of an advocacy organization that serves the Medi-Cal population and is not otherwise represented on the Ventura County Medi Cal Managed Care Commission. This member shall be appointed from applications submitted to the Ventura County Executive Office after a posting of public notice for the open position.

(h) County of Ventura Representative. One member shall be a representative of the County of Ventura nominated by the Ventura County Executive Officer and approved by the Board of Supervisors.

Selection and Terms of Commissioners

In order to stagger terms with the intent of maintaining experienced members, in the initial cycle of appointments, the following appointees shall serve two-year terms: one of the Ventura County Medical Center Health System Representatives, the Physician Representative nominated by the Ventura County Medical Association, the Public Representative, and one Private Hospital/Healthcare System Representative. All other initial appointments and all subsequent appointments to the VCMMCC shall be for four-year terms. No member may serve more than two consecutive four year terms. Any vacancy will be filled by the Board of Supervisors for the remainder of the unexpired term and shall maintain the balance of representation on the VCMMCC. The term of each subsequent appointment shall be deemed to commence on March 15 of the year of the appointment.

A member may resign effective on giving written notice to the Clerk of the VCMMCC, unless the notice specifies a later date for his/her resignation to become effective. Upon receipt of such notice, the Clerk shall notify the Chairperson and the Board of Supervisors. The Clerk of the VCMMC shall enter the notice in the proceedings of the Commission. The acceptance of a resignation shall not be necessary to make it effective.

A member may be removed from the VCMMCC by a 4/5 vote of the Board of Supervisors.

Nominations to the VCMMCC shall be submitted to the Ventura County Executive Office, which shall be responsible for screening nominees and presenting candidates to the Board of Supervisors.

ARTICLE III

Officers

(a) Officers of the VCMMCC shall be a Chairperson and Vice-Chairperson.

(b) The Chairperson and the Vice-Chairperson shall be elected by majority vote of the members in attendance at the first meeting of the VCMMCC to serve for the remainder of the calendar year in which the first meeting occurs. Officers subsequently elected to these offices, pursuant to the procedures outlined under “Election” below, shall serve a term of two years or until their successor(s) has/have been duly elected.

(c) No individual shall serve more than two consecutive terms in any of the elected officer positions.

Election

(a) The VCMMCC shall elect officers by majority vote of the members present.

(b) The election of officers shall be held at the first regular meeting of the VCMMCC after March 15 (or after the date upon which the Board of Supervisors appoints Commissioners for the present term if later than March 15) in every even-numbered year. The two-year terms of office shall be deemed to commence on March 15 of the year of the election, regardless of when the election actually occurs. The officers of the prior term shall continue to preside over any meetings and perform all other functions of their offices until new officers are elected.

(c) The Vice-Chair shall automatically become Chair when the position of Chair becomes available, if the Vice Chair is still one of the Commissioners.

(d) Notwithstanding the normal election process detailed in paragraphs (a),(b) and (c) above, when circumstances warrant it, an election may be held at any time during the year. Circumstances that would warrant a special election include: one or more of the officers wishes to resign as an officer, or one or more of the officers is terminated.

Duties

(a) The Chairperson shall:

1. Preside at all meetings;

2. Execute all documents approved by the VCMMCC;

3. Be responsible to see that all actions of the VCMMCC are implemented; and

4. Maintain consultation with the Chief Executive Officer (CEO).

(b) The Vice-Chairperson shall:

1. Exercise all the responsibilities of the Chairperson in the absence of the Chairperson; and
2. In agreement with the Chairperson, perform all responsibilities mutually agreed upon.
3. Amended Bylaws - GCHP

ARTICLE IV

Standing Committees

(a) At a minimum, the VCMMCC shall establish two (2) committees/advisory boards, one member/consumer based and one provider based. VCMMCC staff will be responsible to gather a list of potential appointments and make recommendations to the VCMMCC for membership on these boards. Each of the boards shall submit a charter to the VCMMCC for approval. All meetings of standing committees shall be subject to the provisions of the Brown Act.

(b) Executive/Finance Committee.

i. Purpose. The role of the Executive/Finance Committee shall be to assist the CEO and VCMMCC accomplish its work in the most efficient and timely way. Meetings of this committee shall be at the request of the Chairperson or CEO to evaluate time sensitive matters. The Committee shall report on all of its activities to the governing board at the next regular meeting of the governing board.

ii. Membership. The Executive/Finance Committee shall be comprised of the following five (5) Commissioners:

1. Chairperson.

2. Vice-Chairperson.

3. Private hospital/healthcare system representative (to rotate between the two representatives following the representative's resignation from the committee). If the Chairperson and/or Vice-Chairperson is a private hospital/healthcare system representative, then the Commission may appoint any one of its members to fill this position.

4. Ventura County Medical Center Health System representative. If the Chairperson and/or Vice-Chairperson is a Ventura County Medical Center Health System representative, then the Commission may appoint any one of its members to fill this position.

5. Clinicas Del Camino Real representative. If the Chairperson and/or Vice-Chairperson is a Clinicas Del Camino Real representative, then the Commission may appoint any one of its members to fill this position.

The CEO and Finance Director will serve as Ex-Officio members to Co-Chair the committee.

Appointments to the Committee shall be made at either the regular meeting in which the Chairperson and Vice-Chairperson are elected or at the next regular meeting immediately thereafter. Appointments may also be made at any regular meeting where the appointment is necessitated by a resignation, termination, vacancy, special election of officers, or other event which results in the Committee lacking full membership.

iii. Duties of the Executive/Finance Committee.

1. Advise the governing board Chairperson on requested matters.

2. Assist the CEO in the planning or presentation of items for governing board consideration.

3. Assist the CEO or VCMMCC staff in the initial review of draft policy statements requiring governing board approval.

4. Assist the CEO in the ongoing monitoring of economic performance by focusing on budgets for pre-operational and operational periods.

5. Review proposed State contracts and rates, once actuary has reviewed and made recommendations.

6. Review proposed contracts for services over the assigned dollar value/limit of the CEO.

7. Establish basic tenets for payment-provider class and levels as related to Medi-Cal rates:

   - PCP
   - Specialists
   - Hospitals o LTC
   - Ancillary Providers

8. Recommend auto-assignment policies for beneficiaries who do not select a Primary Care Provider.

9. Review and recommend provider incentive program structure.

10. Review investment strategy and make recommendations.

11. On an annual basis, develop the CEO review process and criteria.

12. Serve as Interview Committee for CEO/CMO/CFO.

13. Assist the governing board and/or the CEO in determining the appropriate committee, if any, to best deal with questions or issues that may arise from time-to-time.

14. Develop long-term and short-term business plans for review and approval by the governing board.

15. Undertake such other activities as may be delegated from time-to-time by the governing board.

iv. Limitations on Authority. The Executive/Finance Committee shall not have the power or authority in reference to any of the following matters:

1. Adopting, amending or repealing any bylaw.

2. Making final determinations of policy.

3. Approving changes to the budget or making major structural or contractual decisions (such as adding or eliminating programs).

4. Filling vacancies or removing any Commissioner.

5. Changing the membership of, or filling vacancies in, the Executive/Finance Committee.

6. Hiring or firing of senior executives, but may make recommendations to the governing board as to their appointment, dismissal or ongoing performance.

7. Taking any action on behalf of the governing board unless expressly authorized by the governing board.

ARTICLE V

Special Committees

Members may be asked to participate on a subcommittee, task force or special project as part of their responsibilities. The VCMMCC may establish a committee(s) or advisory board(s) for any purpose that will be beneficial in accomplishing the work of the VCMMCC.

ARTICLE VI

Meetings

(a) All meetings shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code relating to meetings of local agencies (“Brown Act”).

(b) A regular meeting shall be held monthly. The VCMMCC shall by resolution establish the date, time and location for the monthly meeting. A regular meeting may, for cause, be rescheduled by the Chairperson with 72 hour advance notice.

(c) Closed session items shall be noticed in compliance with Government Code section 54954.5.

(d) Special meetings may be called, consistent with the Brown Act, by the Chairperson or by a quorum of the VCMMCC. Notice of such special meeting shall conform to the Brown Act.

(e) Any meeting at which at least a quorum cannot attend, or for which there is no agenda item requiring action may be cancelled by the Chairperson with 72 hour advance notice.

(f) A quorum shall be defined as one person more than half of the appointed members of the VCMMCC. For these purposes, “appointed members” excludes unfilled positions and those vacated by resignation or removal. Unless otherwise expressly stated in these bylaws, a majority vote of members present and constituting a quorum shall be required for any VCMMCC action.

(g) After three (3) absences of any member during a fiscal year, the reasons for the absences will be reviewed by the VCMMCC and it may notify the Board of Supervisors of the absences, if it deems this action appropriate. Three or more absences from regular meetings may be cause for the VCMMCC to recommend dismissal of that member to the Board of Supervisors.

Conduct of Meetings

(a) The Chairperson shall adhere to the order of items as posted on the agenda. Modifications to the order of the agenda may be made to the extent that (on the advice of counsel) the rearrangement of the agenda items does not violate the spirit or intent of the Brown Act.

(b) All motions or amendments to motions require a second in order to be considered for action. Upon a motion and a second the item shall be open for discussion before the call for the vote.

(c) Voice votes will be made on all items as read. An abstention will not be recognized except for a legal conflict of interest. In furtherance of the foregoing, an abstention or refusal to vote (not arising from a legal conflict of interest) shall be deemed a vote with the majority of those Commissioners who do vote, except when there is a tie vote and the motion or action fails. For example, if there are 7 Commissioners present at a meeting (none of whom are subject to a legal conflict of interest), (i) a motion passes with 3 votes in favor and 4 Commissioners abstaining, (ii) a motion passes with 3 votes in favor, 2 votes against and 2 Commissioners abstaining; and (iii) a motion fails with 3 votes in favor, 3 votes against and 1 Commissioner abstaining.

(d) A call for a point of order shall have precedence over all other motions on the floor.

(e) Without objection, the Chairperson may continue or withdraw any item. In the event of an objection, a motion to continue or reset an item must be passed by a majority of the members present. A motion to continue or reset an item shall take precedence over all other motions except for a point of order.

(f) An amendment to a motion must be germane to the subject of the motion, but it may not intend an action contrary to the motion. There may be an amendment to the motion and an amendment to an amendment, but no further amendments. In the event the maker of the original motion accepts the amendment(s), the original motion shall be deemed modified. In the event the maker of the original motion does not accept the amendment(s), the amendment(s) shall be voted separately and in reverse order of proposal.

(g) Where these Bylaws do not afford an adequate procedure in the conduct of a meeting, the Chairperson may defer to the most current edition of *Rosenberg's Rules of Order*, to resolve parliamentary questions.

(h) The Chairperson shall be permitted to make motions and vote on all matters to the same extent and subject to the same limitations as other Commissioners.

ARTICLE VII

Powers and Duties

The VCMMCC is responsible for all of the activities described in Article I of these Bylaws and in its enabling ordinance. In furtherance of such responsibility, the VCMMCC shall have the following powers and duties and shall:

(a) Advise the Chief Executive Officer (CEO) and request from the CEO information it deems necessary;

(b) Conduct meetings and keep the minutes of the VCMMCC;

(c) Provide for financial oversight through various actions and methodologies such as the preparation and submission of an annual statement of financial affairs and an estimate of the amount of funding required for expenditures, approval of an annual

budget, receipt of monthly financial briefings and other appropriate action in support of its financial oversight role;
(d) Evaluate business performance and opportunity, and review and recommend strategic plans and business strategies;

(e) Establish, support and oversee the quality, service utilization, risk management and fraud and abuse programs;

(f) Encourage VCMMCC members to actively participate in VCMMCC committees as well as subcommittees;

(g) Comply with and implement all applicable federal, state and local laws, rules and regulations as they become effective;

(h) Provide for the resolution of or resolve conflict among its leaders and those under its leadership;

(i) Respect confidentiality, privacy and avoid any real or potential conflict of interest; and

(j) Receive and take appropriate action, if warranted, based upon reports presented by the CEO (or designated individual). Such reports shall be prepared and submitted to the VCMMCC at least annually.

ARTICLE VIII

STAFF

The VCMMCC shall employ personnel and contract for services as necessary to perform its functions. The permanent staff employed by the VCMMCC shall include, but not be limited to, a Chief Executive Officer (CEO), Clerk and Assistant Clerk.

Chief Executive Officer

The CEO shall have the responsibility for day to day operations, consistent with the authority conferred by the VCMMCC. The CEO is responsible for coordinating all activities of the County Organized Health System.

The CEO shall:

(a) Direct the planning, organization, and operation of all services and facilities;

(b) Direct studies of organizations, operations, functions and activities relating to economy, efficiency and improvement of services;

(c) Direct activities which fulfill all duties mandated by federal or state law, regulatory or accreditation authority, or VCMMCC board resolution, and shall bring any conflict between these laws, regulations, resolutions or policy to the attention of the VCMMCC;

(c) Appoint and supervise an executive management staff, and such other individuals as are necessary for operations. The CEO may delegate certain duties and responsibilities to these and other individuals where such delegated duties are in furtherance of the goals and objectives of the VCMMCC;

(d) Retain and appoint necessary personnel, consistent with all policies and procedures, in furtherance of the VCMMCC's powers and duties; and

(f) Implement and enforce all policies and procedures, and assure compliance with all applicable federal and state laws, rules and regulations.

Clerk

The Clerk shall:

(a) Perform the usual duties pertaining to secretaries;

(b) Cause to be kept, a full and true record of all VCMMCC meetings and of such special meetings as may be scheduled;

(c) Cause to be issued notices of regular and special meetings;

(d) Maintain a record of attendance of members and promptly report to the VCMMCC any member whose position has been vacated; and

(e) Attest to the Chair or Vice-Chair's signature on documents approved by the VCMMCC.

Assistant Clerk

The Assistant Clerk shall perform the duties of the Clerk in the Clerk's absence.

ARTICLE IX

Rules of Order

The Chairperson shall be responsible for maintaining decorum during VCMMCC meetings. All motions, comments, and questions shall be made through the Chairperson. Any decision by the Chairperson shall be considered final unless an appeal of the decision is requested and passed by a majority of the VCMMCC members present.

ARTICLE X

Amendments

(a) These Bylaws may be amended by an affirmative vote of a majority of the voting members of the VCMMCC. A full statement of a proposed amendment shall be submitted to the VCMMCC at least two weeks prior to the meeting at which the proposed amendment is scheduled to be voted upon.

(b) The Bylaws shall be reviewed annually and amendments to the Bylaws may be proposed by any VCMMCC member.

(c) Bylaws may be suspended on an ad hoc basis upon the affirmative vote of a majority of the VCMMCC members present.

ARTICLE XI

Nondiscrimination Clause

The VCMMCC or any person subject to its authority shall not discriminate against or in favor of any person because of race, gender, religion, color, national origin, age, sexual orientation or disability with regard to job application procedures, hiring, advancement, discharge, compensation, training or other terms or condition of employment of any person employed by or doing business with the VCMMCC or any person subject to its direction pursuant to federal, state or local law.

ARTICLE XII

Conflict of Interest and Ethics

VCMMCC members are subject to conflict of interest laws, including Government Code section 1090 and the 1974 Political Reform Act (Government Code section 8100 et seq.), as modified by Welfare and Institutions Code section 14087.57, and must identify and disclose any conflicts and refrain from participating in any manner in such matters in accordance with the applicable statutes**.** Members of the VCMMCC agree to adhere to all relevant standards established by state or federal law regarding ethical behavior.

ARTICLE XIII

Dissolution

Pursuant to California Welfare & Institutions Code, section 14087.54:

(a) In the event the Commissioners determine that VCMMCC may no longer function for the purposes for which it was established, at the time that VCMMCC's then existing obligations have been satisfied or VCMMCC's assets have been exhausted, the Board of Supervisors may by ordinance terminate the VCMMCC.

(b) Prior to the termination of the VCMMCC, the Board of Supervisors shall notify the State Department of Health Care Services (“DHCS”) of its intent to terminate VCMMCC. The DHCS shall conduct an audit of VCMMCC’s records within 30 days of the notification to determine the liabilities and assets of VCMMCC. The DHCS shall report its findings to the Board of Supervisors within 10 days of completion of the audit. The Board of Supervisors shall prepare a plan to liquidate or otherwise dispose of the assets of VCMMCC and to pay the liabilities of VCMMCC to the extent of VCMMCC’s assets, and present the plan to the DHCS within 30 days upon receipt of these findings.

(c) Upon termination of the VCMMCC by the Board of Supervisors, the County of Ventura shall manage any remaining assets of VCMMCC until superseded by a DHCS-approved plan. Any liabilities of VCMMCC shall not become obligations of the County of Ventura upon either the termination of the VCMMCC or the liquidation or disposition of VCMMCC’s remaining assets.

(d) Any assets of VCMMCC shall be disposed of pursuant to provisions contained in the contract entered into between the state and VCMMCC.

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: April 22, 2024

SUBJECT: Consideration of Compliance Oversight Committee Appointments

SUMMARY:

As part of the Corporate Integrity Agreement, the Ventura County Medi-Cal Managed Care Commission (Commission), dba Gold Coast Health Plan (GCHP) has established a Compliance Oversight Committee (Committee) with four members of the Commission. As former Commissioner Jennifer Swenson, served on the Committee, the Commission may appoint another member to replace Commissioner Swenson.

RECOMMENDATION:

Staff requests that the Commission determine whether it wants to fill the vacancy in the Compliance Oversight Committee, caused by the termination of former Commissioner Jennifer Swenson's service on the Commission. The Committee meets quarterly, usually an hour before a Commission meeting, and provides general oversight of GCHP compliance functions and the Corporate Compliance Agreement in particular. A copy of the Corporate Compliance Agreement is attached.

The current members of the Committee are Commissioners Corwin, Espinosa and Pupa. The Commission may decide, but is not required to, fill the currently vacancy. Filling the vacancy will allow more flexibility in scheduling meetings if a Commissioner cannot make a meeting.

Staff requests that the Commission determine if it wants to add another member to the Compliance Oversight Committee and if so, appoint such a member.

ATTACHMENT:

OFFICE OF INSPECTOR GENERAL CORPORATE COMPLIANCE AGREEMENT

CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION

I. PREAMBLE

Ventura County Medi-Cal Managed Care Commission d/b/a Gold Coast Health Plan ("Gold Coast") hereby enters into this Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) to promote compliance with the statutes, regulations, and written directives of Medicaid and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) (Federal health care program requirements). Contemporaneously with this CIA, Gold Coast is entering into a Settlement Agreement with the United States.

II. EFFECTIVE DATE, TERM, AND DEFINITIONS

A. Effective Date. The "Effective Date" of this CIA shall be the signature date of the final signatory to this CIA.

B. Term. The term of this CIA shall be five years from the Effective Date, except that Sections VII and X shall continue for 120 days after OIG's receipt of: (1) Gold Coast's final Annual Report or (2) any additional documentation relating to the final Annual Report requested by OIG, whichever is later. In addition, if OIG issues a Stipulated Penalties Demand Letter pursuant to Section X.C.1 or a Notice of Material Breach and Intent to Exclude pursuant to Section X.E.2 prior to the expiration of the 120 day period, then Section X shall remain in effect until the Stipulated Penalties Review described in Section X.E.2 or the Exclusion Review described in Section X.E.3 is completed, and Gold Coast complies with the decision.

C. Definitions.

1. "Arrangements" means:

a. every arrangement or transaction that involves, directly or indirectly, the offer, payment, solicitation, or receipt of anything of value and is between Gold Coast and (i) any actual or potential source of health care business or referrals to Gold Coast or (ii) any actual or potential recipient of health care business or referrals from Gold Coast.

i. "Source of health care business or referrals" means any individual or entity that refers, recommends, arranges for,

orders, leases, or purchases any good, facility, item, or service for which payment may be made in whole or in part by a Federal health care program.

ii. "Recipient of health care business or referrals" means any individual or entity (a) to whom Gold Coast refers an individual for the furnishing or arranging for the furnishing of any item or service, or (b) from whom Gold Coast purchases, leases or orders or arranges for or recommends the purchasing, leasing, or ordering of any good, facility, item, or service, for which payment may be made in whole or in part by a Federal health care program.

2. "Certifying Employees" means the following: Chief Executive Officer, Chief Financial Officer, Chief Compliance Officer, and Chief Medical Officer, and Chief Operating Officer.[1]

3. "Covered Persons" means: (a) all owners who are natural persons, officers, board members, and employees of Gold Coast; and (b) all contractors who furnish patient care items or services or perform billing, coding, and state Medicaid rate development or reporting functions on behalf of Gold Coast, but excluding healthcare providers or suppliers contracted by Gold Coast for the delivery of Medicaid services as part of Gold Coast's network subject to the standards at 42 C.F.R. § 438.68.

4. "Disclosure Program" means a program that enables individuals to disclose to the Compliance Officer or some other person who is not in the disclosing individual's chain of command any potential violations of criminal, civil, or administrative law related to the Federal health care programs or any issues or questions associated with Gold Coast's policies, conduct, practices, or procedures.

5. "Exclusion Lists" means the HHS/OIG List of Excluded Individuals/Entities (LEIE) (available at http://www.oig.hhs.gov) and state Medicaid program exclusion lists that are publicly available.

6. "Ineligible Person" means an individual or entity who: (a) is currently excluded from participation in any Federal health care program or (b) has been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a) (mandatory exclusion) but has not yet been excluded from participation in any Federal health care program.

7. "Overpayment" means any funds that Gold Coast receives or retains under any Federal health care program to which Gold Coast, after applicable reconciliation, is not entitled under such Federal health care program.

8. "Reportable Event" means: (a) a substantial Overpayment; (b) a matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which criminal penalties or civil monetary penalties under Section 1128A or 1128B of the Social Security Act (the "Act") or exclusion under Section 1128 of the Act may be authorized; (c) the employment of or contracting with a Covered Person who is an Ineligible Person; or (d) the filing of a bankruptcy petition by Gold Coast.

9. "Reporting Period" means each one-year period during the term of this CIA, beginning with the one-year period following the Effective Date.

10. "Training Plan" means a written plan that outlines the steps Gold Coast will take to ensure that Covered Persons receive training on a periodic basis during the term of the CIA regarding Gold Coast's CIA requirements and compliance program and the applicable Federal health care program requirements, including the requirements of 42 U.S.C. § 1320a-7b(b) (the Anti-Kickback Statute).

11. "Transition Plan" means a plan to address whether and how Gold Coast's compliance program will continue to include the compliance program requirements set forth in Section III of the CIA, following the end of the CIA's term.

III. COMPLIANCE PROGRAM REQUIREMENTS

Gold Coast shall establish and maintain a compliance program that includes the following elements:

A. Compliance Officer, Compliance Committee, Board Oversight, and Management Certifications.

1. *Compliance Officer*. Within 90 days after the Effective Date, Gold Coast shall appoint a Compliance Officer who is an employee and a member of senior management of Gold Coast. The Compliance Officer shall report directly to the Chief Executive Officer of Gold Coast and shall not be or be subordinate to the General Counsel or Chief Financial Officer or have any responsibilities that involve acting in any capacity as legal counsel or supervising legal counsel functions for Gold Coast. The Compliance Officer shall be authorized to report to the Governing Board of Gold Coast (Board) regarding compliance matters at any time. The Compliance Officer shall be responsible for, without limitation:

a. developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and with Federal health care program requirements;

b. making at least quarterly reports regarding compliance matters to the Board;

c. monitoring the day-to-day compliance activities engaged in by Gold Coast; and

d. all reporting requirements of this CIA.

The Compliance Officer shall not have any noncompliance job responsibilities that, in OIG's discretion, may interfere or conflict with the Compliance Officer's ability to perform the duties outlined in this CIA.

Gold Coast shall report to OIG, in writing, any changes in the identity, duties, or job responsibilities of the Compliance Officer within five business days after such a change.

2. *Compliance Committee*. Within 90 days after the Effective Date, Gold Coast shall appoint a Compliance Committee that is chaired by the Compliance Officer. The Compliance Committee shall include, at a minimum, the members of senior management necessary to meet the requirements of this CIA. The Compliance Committee shall be responsible for, among other things, reviewing the policies and procedures required by Section III.B below at least annually, reviewing the training required by Section III.C below at least annually, implementation and oversight of the risk assessment and internal review process required by Section III.E below, and the development and implementation of the Transition Plan required by Section III.J below. The Compliance Committee shall meet at least quarterly.

Gold Coast shall report to OIG, in writing, any changes to the membership of the Compliance Committee within 15 business days after such a change.

3. *Board Oversight.* The Board (or the Reimbursement Compliance Committee of the Board ("Board Committee") shall be responsible for the review and oversight of Gold Coast's compliance with Federal health care program requirements and the requirements of this CIA. The Board must include independent (i.e., non-employee and non-executive) members.

The Board shall, at a minimum, be responsible for the following:

a. meeting at least quarterly to review and oversee Gold Coast's compliance program, including but not limited to the performance of the Compliance Officer and Compliance Committee;

b. submitting to OIG a description of the materials it reviewed and any additional steps taken, such as the engagement of an independent advisor or other third-party resources, in its oversight of the compliance program and in support of making the resolution below during each Reporting Period; and

c. for each Reporting Period of the CIA, adopting a resolution approved by each member of the Board regarding its review and

oversight of Gold Coast's compliance with Federal health care program requirements and the requirements of this CIA.

At minimum, the resolution shall include the following language:

> "The Board has made a reasonable inquiry into the operations of Gold Coast's compliance program, including the performance of the Compliance Officer and the Compliance Committee. Based on its inquiry and review, the Board has concluded that, to the best of its knowledge, Gold Coast has implemented an effective compliance program to meet Federal health care program requirements and the requirements of Gold Coast's Corporate Integrity Agreement with the Office of Inspector General of the Department of Health and Human Services."

If the Board is unable to adopt such a resolution, the Board shall provide a written explanation of the reasons why it is unable to adopt the resolution and the steps the Board is taking to implement an effective compliance program at Gold Coast.

Gold Coast shall report to OIG, in writing, any changes in the membership of the Board, within 15 business days after such a change.

4. *Management Certifications.* The Certifying Employees shall monitor compliance within the divisions or departments for which they are responsible and annually certify that the applicable Gold Coast division or department is in compliance with applicable Federal health care program requirements and the requirements of this CIA. For each Reporting Period, each Certifying Employee shall certify as follows:

> "I have been trained on and understand the compliance requirements and responsibilities as they relate to [insert name of division or department], an area under my supervision. My job responsibilities include ensuring [insert name of division or department]'s compliance with all applicable Federal health care program requirements, requirements of the Corporate Integrity Agreement, and Gold Coast's policies and procedures. To the best of my knowledge, the [insert name of division or department] is in compliance with all applicable Federal health care program requirements and the requirements of the Corporate Integrity Agreement. I understand that this certification is being provided to and relied upon by the United States."

If any Certifying Employee is unable to provide this certification, the Certifying Employee shall provide a written explanation of the reasons why he or she is unable to provide the certification.

Within 90 days after the Effective Date, Gold Coast shall develop and implement a written process for Certifying Employees to follow for the purpose of completing the certification required by this section (e.g., reports that must be reviewed, assessments that must be completed, sub-certifications that must be obtained, etc. prior to the Certifying Employee making the required certification).

B. Written Standards. Within 90 days after the Effective Date, Gold Coast shall develop and implement written policies and procedures (Policies and Procedures) that address the following: (1) the operation of Gold Coast's compliance program, including the compliance program requirements outlined in this CIA; (2) Gold Coast's compliance with Federal health care program requirements, including but not limited to compliance with the Anti-Kickback Statute, and the regulations and other guidance documents related to these statutes; (3) a written review and approval process for Arrangements, the purpose of which is to ensure that all Arrangements do not violate the Anti-Kickback Statute; and (4) the identification, quantification, and repayment of Overpayments. Gold Coast shall enforce its Policies and Procedures and make compliance with its Policies and Procedures an element of evaluating the performance of all Covered Persons. The Policies and Procedures shall be made available to all Covered Persons.

The Compliance Committee shall review the Policies and Procedures at least annually and update the Policies and Procedures as necessary. Any new or revised Policies and Procedures shall be made available to all Covered Persons. All Policies and Procedures shall be made available to OIG upon request.

C. Training and Education.

1. *Covered Persons Training.* Within 90 days after the Effective Date, Gold Coast shall develop a Training Plan that includes the following information: (a) training topics: (b) categories of Covered Persons required to attend each training session; (c) length of the training session(s); (d) schedule for training; and (e) format of the training. The Compliance Committee shall review the Training Plan at least annually and update the Training Plan as necessary.

2. *Board Training*. Within 90days after the Effective Date, members of the Board shall receive training regarding their responsibilities for corporate governance and review and oversight of the compliance program. The training shall address the specific responsibilities of health care board members, including the risks, oversight areas, and approaches to conducting effective oversight of a health care entity and shall include a discussion of the OIG's guidance on board member responsibilities. Each member of the Board also shall receive the training described in Section III.C.1.

New members of the Board shall receive the training described in this Section III.C.2 within 30 days after becoming a member or within 90 days after the Effective Date, whichever is later. The Compliance Committee shall review the Board training at least annually and update the Board training as necessary.

3. *Training Records*. Gold Coast shall make available to OIG, upon request, training materials and records verifying that the training described in Sections III.C.1 and III.C.2 has been provided.

D. Review Procedures.

1. *General Description.*

a. *Engagement of Independent Review Organization*. Within 90 days after the Effective Date, Gold Coast shall engage an entity (the "Independent Review Organization" or "IRO") that meets the qualifications and requirements outlined in Appendix A to this CIA, which is incorporated by reference, to perform the reviews described in this Section III.D.

b. *Retention of Records*. The IRO and Gold Coast shall retain and make available to OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports exchanged between the IRO and Gold Coast related to the reviews described in this Section III.D.

c. *Access to Records and Personnel.* Gold Coast shall ensure that the IRO has access to all records and personnel necessary to complete the reviews listed in this Section III.D and that all records furnished to the IRO are accurate and complete.

2. *Medical Loss Ratio (MLR) Element Review.* The IRO shall review a MLR Numerator Element to determine whether Gold Coast's calculation and reporting of the selected element was accurate, supported by underlying documentation, consistent with generally accepted accounting principles, and otherwise complied with the terms of its contract with the California Department of Health Care Services (DHCS) and the applicable Medicaid laws, regulations, and guidance and shall prepare a Review Report, as outlined in Appendix B to this CIA, which is incorporated by reference.

3. *Independence and Objectivity Certification*. The IRO shall include in its report(s) to Gold Coast a certification that the IRO has (a) evaluated its professional independence and objectivity with respect to the reviews required under this Section III.D and (b) concluded that it is, in fact, independent and objective, in accordance with the requirements specified in Appendix A to this CIA. The IRO's certification shall include a summary of all current and prior engagements between Gold Coast and the IRO.

E. Risk Assessment and Internal Review Process. Within 90 days after the Effective Date, Gold Coast shall develop and implement a centralized annual risk assessment and internal review process to identify and address risks associated with Gold Coast's participation in the Federal health care programs, including but not limited to the risks associated with the submission of claims for items and services furnished to Medicaid program beneficiaries and the Anti-Kickback Statute risks associated with Arrangements. The Compliance Committee shall be responsible for implementation and oversight of the risk assessment and internal review process. The risk assessment and internal review process shall be conducted at least annually and shall require Gold Coast to: (1) identify and prioritize risks, (2) develop work plans or audit plans (as

appropriate) related to the identified risk areas, (3) implement the work plans and audit plans, (4) develop corrective action plans in response to the results of any internal audits performed, and (5) track the implementation of the work plans and any corrective action plans and assess the effectiveness of such plans.

F. Disclosure Program. Within 90 days after the Effective Date, Gold Coast shall establish a Disclosure Program. Gold Coast shall appropriately publicize the existence of the Disclosure Program (e.g., via periodic e-mails to employees or by posting the information in prominent common areas). The Disclosure Program shall include a reporting mechanism for anonymous communications for which appropriate confidentiality shall be maintained. The Disclosure Program shall prohibit retaliation against Covered Persons relating to use of the Disclosure Program and Gold Coast shall not retaliate against Covered Persons for use of the Disclosure Program. The Compliance Officer (or designee) shall conduct a review of each disclosure received through the Disclosure Program, including gathering all relevant information from the disclosing individual, and ensure that appropriate follow-up is conducted.

The Compliance Officer (or designee) shall record all disclosures (whether or not related to a potential violation of criminal, civil, or administrative law related to the Federal health care programs) in a written disclosure log within two business days of receipt of the disclosure. The disclosure log shall include the following information: (1) a summary of each disclosure received (whether anonymous or not), (2) the date the disclosure was received, (3) the individual or department responsible for reviewing the disclosure, (4) the status of the review, (5) any corrective action taken in response to the review, and (6) the date the disclosure was resolved.

G. Ineligible Persons.

1. *Screening Requirements.* Gold Coast shall:

a. screen all prospective Covered Persons against the Exclusion Lists prior to engaging their services and, as part of the hiring or contracting process shall require such Covered Persons to disclose whether they are Ineligible Persons;

b. screen all current Covered Persons against the Exclusion Lists within 90 days after the Effective Date and on a monthly basis thereafter; and

c. require all Covered Persons to disclose immediately to the Compliance Officer (or designee) if they become an Ineligible Person.

2. *Removal Requirement*. If Gold Coast has actual notice that a Covered Person has become an Ineligible Person, Gold Coast shall remove such Covered Person from any position for which the Covered Person's compensation or the items or services furnished, ordered, or prescribed by the Covered Person are paid for in whole or part, directly or indirectly, by any Federal health care program(s) from which the Covered Person has been excluded, at

least until such time as the Covered Person is reinstated into participation in such Federal health care program(s). Items or services furnished, ordered, or prescribed by excluded persons are not payable by Federal health care programs and Gold Coast may be liable for overpayments and/or criminal, civil, and administrative sanctions for employing or contracting with an excluded person regardless of whether Gold Coast meets the requirements of Section III.G.

H. Notification of Government Investigation or Legal Proceeding. Gold Coast shall notify OIG, in writing, of any ongoing investigation or legal proceeding by a governmental entity or its agents involving an allegation that Gold Coast has committed a crime or has engaged in fraudulent activities, within 30 days of Gold Coast receiving notice of such investigation or legal proceeding. This notification shall include a description of the allegation(s), the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. Within 30 days after resolution of the matter, Gold Coast shall notify OIG, in writing, of the resolution of the investigation or legal proceeding.

I. Reportable Events. Gold Coast shall notify OIG, in writing, within 30 days after determining that a Reportable Event exists, as follows:

1. *Substantial Overpayment.* The report to OIG shall include:

   a. a complete description of all details relevant to the Reportable Event, including, at a minimum, the types of claims, transactions, or other conduct giving rise to the Reportable Event; the period during which the conduct occurred; and the names of individuals and entities believed to be implicated, including an explanation of their roles in the Reportable Event;

   b. the Federal health care programs affected by the Reportable Event;

   c. a description of the steps taken by Gold Coast to identify and quantify the Overpayment; and

   d. a description of Gold Coast's actions taken to correct the Reportable Event and prevent it from recurring.

Within 60 days of identification of the substantial Overpayment, Gold Coast shall repay the Overpayment, in accordance with the requirements of 42 U.S.C. § 1320a-7k(d) and any applicable regulations and Centers for Medicare and Medicaid Services (CMS) guidance, and provide OIG with documentation of the repayment.

2. *Probable Violation of Law.* The report to OIG shall include:

   a. a complete description of all details relevant to the Reportable Event, including, at a minimum, the types of claims, transactions or other conduct giving rise to the Reportable Event; the period during which the conduct occurred; and the names of individuals

and entities believed to be implicated, including an explanation of their roles in the Reportable Event;

b. a statement of the Federal criminal, civil or administrative laws that are probably violated by the Reportable Event;

c. the Federal health care programs affected by the Reportable Event;

d. a description of the steps taken by Gold Coast to identify and quantify any Overpayments; and

e. a description of Gold Coast's actions taken to correct the Reportable Event and prevent it from recurring.

If the Reportable Event involves an Overpayment, within 60 days of identification of the Overpayment, Gold Coast shall repay the Overpayment, in accordance with the requirements of 42 U.S.C. § 1320a-7k(d) and any applicable regulations and CMS guidance, and provide OIG with documentation of the repayment.

3. *Ineligible Person.* The report to OIG shall include:

a. the identity of the Ineligible Person and the job duties performed by that individual;

b. the dates of the Ineligible Person's employment or contractual relationship;

c. a description of the Exclusion Lists screening that Gold Coast completed before and/or during the Ineligible Person's employment or contract and any flaw or breakdown in the screening process that led to the hiring or contracting with the Ineligible Person;

d. a description of how the Ineligible Person was identified; and

e. a description of any corrective action implemented to prevent future employment or contracting with an Ineligible Person.

4. *Bankruptcy.* The report to OIG shall include documentation of the bankruptcy filing and a description of any Federal health care program requirements implicated.

J. Transition Plan. Prior to the end of the fourth Reporting Period, Gold Coast shall develop a Transition Plan that is reviewed and approved by the Board. The Transition Plan shall be implemented following the end of the CIA's term. A copy of Gold Coast's approved Transition Plan shall be included in Gold Coast's fourth Annual Report.

IV. SUCCESSOR LIABILITY

If, after the Effective Date, Gold Coast proposes to (a) sell any or all of its business, business units, or locations (whether through a sale of assets, sale of stock, or other type of transaction) relating to the furnishing of items or services that may be reimbursed by a Federal health care program; or (b) purchase or establish a new business, business unit, or location relating to the furnishing of items or services that may be reimbursed by a Federal health care program, the CIA shall be binding on the purchaser of any business, business unit, or location and any new business, business unit, or location (and all Covered Persons at each new business, business unit, or location) shall be subject to the requirements of this CIA, unless otherwise determined and agreed to in writing by OIG. Gold Coast shall notify OIG, in writing, of such sale or purchase within 30 days following the closing of the transaction and shall notify OIG, in writing, within 30 days of establishing such new business, business unit, or location.

If Gold Coast wishes to obtain a determination by OIG that a proposed purchaser or proposed acquisition will not be subject to the CIA requirements, Gold Coast must notify OIG in writing at least 30 days in advance of the proposed sale or purchase. This notification shall include a description of the business, business unit, or location to be sold or purchased, a brief description of the terms of the transaction and, in the case of a proposed sale, the name and contact information of the prospective purchaser.

V. IMPLEMENTATION REPORT AND ANNUAL REPORTS

A. Implementation Report. Within 120 days after the Effective Date, Gold Coast shall submit a written report (Implementation Report) to OIG that includes, at a minimum, the following information:

1. the name, business address, business phone number, and position description of the Compliance Officer required by Section III.A.1, and a detailed description of any noncompliance job responsibilities;

2. the names and positions of the members of the Compliance Committee required by Section III.A.2;

3. the names of the Board members who are responsible for satisfying the Board compliance requirements described in Section III.A.3;

4. the names and positions of the Certifying Employees required by Section III.A.4 and a copy of the written process for Certifying Employees to follow in order to complete the certification required by Section III.A.4;

5. a list of the Policies and Procedures required by Section III.B;

6. the Training Plan required by Section III.C.1 and a description of the Board training required by Section III.C.2 (including a summary of the topics covered, the length of the training, and when the training was provided);

7. the following information regarding the IRO(s): (a) identity, address, and phone number; (b) a copy of the engagement letter; (c) information to demonstrate that the IRO has the qualifications outlined in Appendix A to this CIA; and (d) a certification from the IRO regarding its professional independence and objectivity with respect to Gold Coast that includes a summary of all current and prior engagements between Gold Coast and the IRO;

8. a description of the risk assessment and internal review process required by Section III.E;

9. a description of the Disclosure Program required by Section III.F;

10. a description of the Ineligible Persons screening and removal process required by Section III.G;

11. a description of Gold Coast's corporate structure, including identification of any parent and sister companies, subsidiaries, and their respective lines of business;

12. a list of all of Gold Coast's locations (including mailing addresses), the corresponding name under which each location is doing business; and

13. a certification by the Compliance Officer and Chief Executive Officer that:

a. to the best of his or her knowledge, except as otherwise described in the report, Gold Coast has implemented and is in compliance with all of the requirements of this CIA;

b. he or she has reviewed the report and has made reasonable inquiry regarding its content and believes that the information in the report is accurate and truthful; and

c. he or she understands that the certification is being provided to and relied upon by the United States.

B. Annual Reports. Gold Coast shall submit to OIG a written report (Annual Report) for each of the five Reporting Periods that includes, at a minimum, the following information:

1. any change in the identity, position description, or noncompliance job responsibilities of the Compliance Officer; a current list of the Compliance Committee members, a current list of the Board members who are responsible for satisfying the Board compliance requirements, and a current list of the Certifying Employees, along with the identification of any

changes made during the Reporting Period to the Compliance Committee, Board, or Certifying Employees;

2. the dates of each meeting of the Compliance Committee (copies of the meeting minutes shall be made available to OIG upon request);

3. the dates of each report made by the Compliance Officer to the Board (written documentation of such reports shall be made available to OIG upon request);

4. the Board resolution required by Section III.A.3 and a description of the materials reviewed by the Board and any additional steps taken in its oversight of the compliance program and in support of making the resolution;

5. a description of any changes to the written process for Certifying Employees to follow in order to complete the certification required by Section III.A.4;

6. the certifications of Certifying Employees required by Section III.A.4;

7. a list of any new or revised Policies and Procedures required by Section III.B. developed during the Reporting Period;

8. a description of any changes to the Training Plan required by Section III.C, and a summary of all training furnished to Covered Persons and Board members during the Reporting Period;

9. a complete copy of all reports prepared pursuant to Section III.D and Gold Coast's response to the reports, along with corrective action plan(s) related to any issues raised by the report, and documentation of Gold Coast's refund of the Estimated Overpayment (as defined in Appendix B to this CIA);

10. a certification from the IRO regarding its professional independence and objectivity with respect to Gold Coast, including a summary of all current and prior engagements between Gold Coast and the IRO;

11. a description of any changes to the risk assessment and internal review process required by Section III.E, including the reason(s) for such changes;

12. a summary of the following components of the risk assessment and internal review process during the Reporting Period: (a) risk areas identified, (b) work plans and internal audit plans developed, (c) internal audits performed, (d) corrective action plans developed in response to internal audits, and (e) steps taken to track the implementation of the work plans and corrective action plans. Copies of any work plans, internal audit reports, and corrective action plans shall be made available to OIG upon request;

13. a summary of the disclosures in the disclosure log required by Section III.F that relate to Federal health care programs, including at least the following information: (a)

a description of the disclosure, (b) the date the disclosure was received, (c) the resolution of the disclosure, and (d) the date the disclosure was resolved. The complete disclosure log shall be made available to OIG upon request;

14. a description of any changes to the Ineligible Persons screening and removal process required by Section III.G, including the reason(s) for such changes;

15. a summary of any ongoing investigation or legal proceeding required to have been reported pursuant to Section III.H that includes a description of the allegation(s), the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding;

16. a summary of all Reportable Events required to have been reported pursuant to Section III.I during the Reporting Period;

17. (in the fourth Annual Report), a copy of the Transition Plan required by Section III.J;

18. a summary of any audits conducted during the applicable Reporting Period by any state Medicaid program contractor or any government entity or contractor, involving a review of Federal health care program claims, and Gold Coast's response and corrective action plan (including information regarding any Federal health care program refunds) relating to the audit findings;

19. a description of all changes to the most recently provided list of Gold Coast's locations (including addresses) as required by Section V.A.12;

20. a description of any changes to Gold Coast's corporate structure, including any parent and sister companies, subsidiaries, and their respective lines of business; and

21. a certification by the Compliance Officer and Chief Executive Officer that:

a. to the best of his or her knowledge, except as otherwise described in the report, Gold Coast has implemented and is in compliance with all of the requirements of this CIA;

b. he or she has reviewed the report and has made reasonable inquiry regarding its content and believes that the information in the report is accurate and truthful; and

c. he or she understands that the certification is being provided to and relied upon by the United States.

The first Annual Report shall be received by OIG no later than 60 days after the end of the first Reporting Period. Subsequent Annual Reports shall be received by OIG no later than the anniversary date of the due date of the first Annual Report.

C. Designation of Information. Gold Coast shall clearly identify any portions of its submissions that it believes are trade secrets, or information that is commercial or financial and privileged or confidential, and therefore potentially exempt from disclosure under the Freedom of Information Act (FOIA), 5 U.S.C. § 552. Gold Coast shall refrain from identifying any information as exempt from disclosure if that information does not meet the criteria for exemption from disclosure under FOIA.

VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

All notifications and reports required under this CIA shall be submitted using the following contact information:

OIG:

Administrative and Civil Remedies Branch
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, S.W.
Washington, DC 20201
Telephone: 202.619.2078
Email Address: officeofcounsel@oig.hhs.gov

Gold Coast:

Richard Egger
Best Best & Krieger, LLP
2855 E. Guasti Rd.,
Suite 400
Ontario, CA 91761
(909) 466-4915
Richard.egger@bbklaw.com

Unless otherwise requested by OIG, all notifications and reports required by this CIA shall be submitted electronically. OIG shall notify Gold Coast in writing of any changes to the OIG contact information listed above. Gold Coast shall notify OIG in writing within two business days of any changes to the Gold Coast contact information listed above.

VII. OIG INSPECTION, AUDIT, AND REVIEW RIGHTS

In addition to any other rights OIG may have by statute, regulation, or contract, OIG or its duly authorized representative(s) may conduct interviews, examine and/or request copies of or copy Gold Coast's books, records, and other documents and supporting materials, and conduct on-site reviews of any of Gold Coast's locations, for the purpose of evaluating: (a) Gold Coast's compliance with the requirements of this CIA and (b) Gold Coast's compliance with the requirements of the Federal health care programs. The documentation described above shall be made available by Gold Coast to OIG or its duly authorized representative(s) at all reasonable times for inspection, audit, and/or reproduction. For purposes of this provision, OIG or its duly authorized representative(s) may interview any of Gold Coast's owners, employees, contractors, and Board members who consent to be interviewed at the individual's place of business during normal business hours or at such other place and time as may be mutually agreed upon between the individual and OIG. Gold Coast shall assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. Gold Coast's owners, employees, contractors, and Board members may elect to be interviewed with or without a representative of Gold Coast present.

VIII. DOCUMENT AND RECORD RETENTION

Gold Coast shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs and to compliance with this CIA for six years (or longer if otherwise required by law) from the Effective Date.

IX. DISCLOSURES

Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, OIG shall make a reasonable effort to notify Gold Coast prior to any release by OIG of information submitted by Gold Coast pursuant to this CIA and identified upon submission by Gold Coast as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, Gold Coast shall have the rights set forth at 45 C.F.R. § 5.42(a).

X. BREACH AND DEFAULT PROVISIONS

A. Stipulated Penalties. OIG may assess:

1. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.A;

2. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.B;

3. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.C;

4. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.D;

5. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.E.;

6. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.F;

7. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.G;

8. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.H;

9. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.I;

10. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.J;

11. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section IV;

12. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section V;

13. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section VII;

14. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section VIII; or

15. A Stipulated Penalty of up to $50,000 for each false certification or false statement made to OIG by or on behalf of Gold Coast under this CIA.

B. Timely Written Requests for Extensions. Gold Coast may, in advance of the due date, submit a timely written request for an extension of time to perform any act or file any notification or report required by this CIA. If OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one day after Gold Coast fails to meet the revised deadline set by OIG. If OIG denies such a timely written request, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until three business days after Gold Coast receives OIG's written denial of such request or the original due date, whichever is later. A "timely written request" is defined as a request in writing received by

OIG at least five business days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

C. Payment of Stipulated Penalties.

1. *Demand Letter*. If OIG determines that a basis for Stipulated Penalties under Section X.A exists, OIG shall notify Gold Coast of: (a) Gold Coast's failure to comply and (b) OIG's demand for payment of Stipulated Penalties. (This notification shall be referred to as the "Demand Letter.")

2. *Response to Demand Letter.* Within 15 business days after the date of of the Demand Letter, Gold Coast shall either: (a) pay the applicable Stipulated Penalties or (b) request a hearing before an HHS administrative law judge (ALJ) to dispute OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.E.

3. *Form of Payment*. Payment of the Stipulated Penalties shall be made by electronic funds transfer to an account specified by OIG in the Demand Letter.

D. Exclusion for Material Breach.

1. *Definition of Material Breach*. A material breach of this CIA means:

a. failure to comply with any of the requirements of this CIA for which OIG has previously issued a demand for Stipulated Penalties under Section X.C, unless such Stipulated Penalty was overturned by an ALJ on appeal pursuant to the procedures described in Section X.E below;

b. failure to comply with Section III.A.1;

c. failure to comply with Section III.D;

d. failure to comply with Section III.I;

e. failure to comply with Section V;

f. failure to respond to a Demand Letter in accordance with Section X.C;

g. a false statement or false certification made to OIG by or on behalf of Gold Coast under this CIA;

h. failure to pay Stipulated Penalties within 20 days after an ALJ issues a decision ordering Gold Coast to pay the Stipulated Penalties or within 20 days after the HHS Departmental Appeals

Board (DAB) issues a decision upholding the determination of OIG; or

i. failure to come into compliance with a requirement of this CIA for which OIG has demanded Stipulated Penalties, pursuant to the deadlines listed in Section X.E.2.

2. *Notice of Material Breach and Intent to Exclude*. The parties agree that a material breach of this CIA by Gold Coast constitutes an independent basis for Gold Coast's exclusion from participation in the Federal health care programs. The length of the exclusion shall be in the OIG's discretion, but not more than five years for each material breach. Upon a preliminary determination by OIG that Gold Coast has materially breached this CIA, OIG shall notify Gold Coast of: (a) Gold Coast's material breach and (b) OIG's intent to exclude Gold Coast. (This notification shall be referred to as the "Notice of Material Breach and Intent to Exclude.")

3. *Response to Notice*. Gold Coast shall have 30 days from the date of the Notice of Material Breach and Intent to Exclude to submit any information and documentation for OIG to consider before it makes a final determination regarding exclusion.

4. Exclusion Letter. If OIG determines that exclusion is warranted, OIG shall notify Gold Coast in writing of its determination to exclude Gold Coast. (This letter shall be referred to as the "Exclusion Letter.") Subject to the Dispute Resolution provisions in Section X.E, below, the exclusion shall go into effect 30 days after the date of the Exclusion Letter. The effect of the exclusion shall be that no Federal health care program payment may be made for any items or services furnished, ordered, or prescribed by Gold Coast, including administrative and management services, except as stated in regulations found at 42 C.F.R. §1001.1901(c). The exclusion shall have national effect. Reinstatement to program participation is not automatic. At the end of the period of exclusion, Gold Coast may apply for reinstatement by submitting a written request for reinstatement in accordance with the provisions at 42 C.F.R. §§ 1001.3001-.3004.

E. Dispute Resolution.

1. *Review Rights*. Upon OIG's issuing a Demand Letter or Exclusion Letter to Gold Coast, and as an agreed-upon remedy for the resolution of disputes arising under this CIA, Gold Coast shall be afforded certain review rights comparable to the ones that are provided in 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005. Specifically, OIG's determination to demand payment of Stipulated Penalties or to seek exclusion shall be subject to review by an HHS ALJ and, in the event of an appeal, the DAB, in a manner consistent with the provisions in 42 C.F.R. § 1005.2-1005.21, but only to the extent this CIA does not provide otherwise. Notwithstanding the language in 42 C.F.R. § 1005: (a) the request for a hearing involving Stipulated Penalties shall be made within 15 business days after the date of the Demand Letter and the request for a hearing involving exclusion shall be made within 25 days after the date of the Exclusion Letter and (b) no discovery shall be available to the parties. The procedures relating to the filing of a

request for a hearing can be found at
http://www.hhs.gov/dab/divisions/civil/procedures/divisionprocedures.html

2. *Stipulated Penalties Review*. Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CIA shall be: (a) whether Gold Coast was in full and timely compliance with the requirements of this CIA for which OIG demands payment and (b) the period of noncompliance. Gold Coast shall have the burden of proving its full and timely compliance. If the ALJ upholds the OIG's determination that Gold Coast has breached this CIA and orders Gold Coast to pay Stipulated Penalties, Gold Coast must (a) come into compliance with the requirement(s) that resulted in the OIG imposing Stipulated Penalties and (b) pay the Stipulated Penalties within 20 days after the ALJ issues a decision, unless Gold Coast properly and timely requests review of the ALJ decision by the DAB. If the ALJ decision is properly and timely appealed to the DAB and the DAB upholds the determination of OIG, Gold Coast must (a) come into compliance with the requirement(s) that resulted in the OIG imposing Stipulated Penalties and (b) pay the Stipulated Penalties within 20 days after the DAB issues its decision.

3. *Exclusion Review*. Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a material breach of this CIA shall be whether Gold Coast was in material breach of this CIA. If the ALJ sustains the OIG's determination of material breach, the exclusion shall take effect 20 days after the ALJ issues the decision. If the DAB finds in favor of OIG after an ALJ decision adverse to OIG, the exclusion shall take effect 20 days after the DAB decision. Gold Coast shall waive its right to any notice of such an exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB. If the DAB finds in favor of Gold Coast, Gold Coast shall be reinstated effective on the date of the original exclusion.

4. *Finality of Decision.* The review by an ALJ or DAB provided for above shall not be considered to be an appeal right arising under any statutes or regulations. The parties to this CIA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this CIA and Gold Coast agrees not to seek additional review of the DAB's decision (or the ALJ's decision if not appealed) in any judicial forum.

XI. EFFECTIVE AND BINDING AGREEMENT

Gold Coast and OIG agree as follows:

A. This CIA constitutes the complete agreement between the parties and may not be amended except by written consent of the parties to this CIA.

B. All requirements and remedies set forth in this CIA are in addition to and do not affect (1) Gold Coast's responsibility to follow all applicable Federal health care program requirements or (2) the government's right to impose appropriate remedies for failure to follow applicable Federal health care program requirements.

C. The undersigned Gold Coast signatories represent and warrant that they are authorized to execute this CIA. The undersigned OIG signatories represent that they are signing this CIA in their official capacities and that they are authorized to execute this CIA.

D. This CIA may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same CIA. Electronically transmitted copies of signatures shall constitute acceptable, binding signatures for purposes of this CIA.

ON BEHALF OF VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION D/B/A GOLD COAST HEALTH PLAN

Nicholas Liguori

NICHOLAS LIGUORI
Chief Executive Officer
Gold Coast Health Plan

July 29, 20222
DATE

Charles J. Stevens

CHARLES J. STEVENS
Gibson, Dunn & Crutcher
Counsel for Gold Coast Health Plan

August 1, 2022
DATE

ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Lisa M. Re /RMP

LISA M. RE
Assistant Inspector General for Legal Affairs
Office of Inspector General
U.S. Department of Health and Human Services

8/10/2022
DATE

Sarah Kessler

SARAH KESSLER
Senior Counsel
Office of Inspector General
U.S. Department of Health and Human Services

8/11/2022
DATE

APPENDIX A

INDEPENDENT REVIEW ORGANIZATION

This Appendix contains the requirements relating to the Independent Review Organization (IRO) required by Section III.D of the CIA.

A. IRO Engagement

1. Gold Coast shall engage an IRO that possesses the qualifications set forth in Paragraph B, below, to perform the responsibilities in Paragraph C, below. The IRO shall conduct the review in a professionally independent and objective fashion, as set forth in Paragraph E. Within 30 days after OIG receives the information identified in Section V.A.7 of the CIA or any additional information submitted by Gold Coast in response to a request by OIG, whichever is later, OIG will notify Gold Coast if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, Gold Coast may continue to engage the IRO.

2. If Gold Coast engages a new IRO during the term of the CIA, that IRO must also meet the requirements of this Appendix. If a new IRO is engaged, Gold Coast shall submit the information identified in Section V.A.7 of the CIA to OIG within 30 days of engagement of the IRO. Within 30 days after OIG receives this information or any additional information submitted by Gold Coast at the request of OIG, whichever is later, OIG will notify Gold Coast if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, Gold Coast may continue to engage the IRO.

B. IRO Qualifications

The IRO shall:

1. assign individuals to conduct the Medical Loss Ratio (MLR) Element Review who have expertise in the medical loss ratio standards and calculations required by 42 C.F.R. § 438.8 and the applicable medical loss ratio calculation and reporting requirements of the California Department of Health Care Services; and

2. have sufficient staff and resources to conduct the reviews required by the CIA on a timely basis.

C. IRO Responsibilities

The IRO shall:

1. perform each MLR Element Review in accordance with the specific requirements of the CIA;

2. follow all applicable Medicaid program requirements as well as the terms of Gold Coast's contract with the California Department of Health Care Services (DHCS) in making assessments in the MLR Element Review;

3. request clarification from the Medicaid program or DHCS if in doubt of the application of a particular program policy or regulation or contractual provision;

4. respond to all OIG inquires in a prompt, objective, and factual manner; and

5. prepare timely, clear, well-written reports that include all the information required by Appendix B to the CIA.

D. Gold Coast Responsibilities

Gold Coast shall ensure that the IRO has access to all records and personnel necessary to complete the reviews listed in III.D of this CIA and that all records furnished to the IRO are accurate and complete.

E. IRO Independence and Objectivity

The IRO must perform the MLR Element Review in a professionally independent and objective fashion, as defined in the most recent Government Auditing Standards issued by the U.S. Government Accountability Office.

F. IRO Removal/Termination

1. *Gold Coast and IRO*. If Gold Coast terminates its IRO or if the IRO withdraws from the engagement during the term of the CIA, Gold Coast must submit a notice explaining (a) its reasons for termination of the IRO or (b) the IRO's reasons for its withdrawal to OIG, no later than 30 days after termination or withdrawal. Gold Coast must engage a new IRO in accordance with Paragraph A of this Appendix and within 60 days of termination or withdrawal of the IRO.

2. *OIG Removal of IRO*. In the event OIG has reason to believe the IRO does not possess the qualifications described in Paragraph B, is not independent and objective as set forth in Paragraph E, or has failed to carry out its responsibilities as described in Paragraph C, OIG shall notify Gold Coast in writing regarding OIG's basis for determining that the IRO has not met the requirements of this Appendix. Gold Coast shall have 30 days from the date of OIG's written notice to provide information regarding the IRO's qualifications, independence or performance of its responsibilities in order to resolve the concerns identified by OIG. If, following OIG's review of any information provided by Gold Coast regarding the IRO, OIG determines that the IRO has not met the requirements of this Appendix, OIG shall notify Gold Coast in writing that Gold Coast shall be required to engage a new IRO in accordance with Paragraph A of this Appendix. Gold Coast must engage a new IRO within 60 days of its receipt of OIG's written notice. The final determination as to whether or not to require Gold Coast to engage a new IRO shall be made at the sole discretion of OIG.

APPENDIX B

MEDICAL LOSS RATIO ELEMENT REVIEW

A. Medical Loss Ratio (MLR) Element Review. The IRO shall perform the MLR Element Review for each Reporting Period.

1. *Definitions*.

a. "Annual MLR Report" means the report described in section 42 C.F.R. § 438.8(k).

b. "MLR Numerator Element" means any of the following: Incurred Claims, Non-Claims Costs, expenditures for Activities that Improve Health Care Quality, or Fraud Prevention Activities.[1]

c. "Activities that Improve Health Care Quality" mean the categories of activities identified in 42 C.F.R. § 438.8(e)(3), which include, among others, those primarily designed to:

i. improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations;

ii. prevent hospital readmissions through a comprehensive program for hospital discharge;

iii. improve patient safety, reduce medical errors, and lower infection and mortality rates; or

iv. implement, promote, and increase wellness and health activities.

d. "Non-Claims Costs" means those expenses for administrative services that are not: Incurred Claims; expenditures on Activities that Improve Health Care Quality; or licensing and regulatory fees, or Federal and State taxes, defined in 42 C.F.R. § 438.8(b).

e. "Incurred Claims" means any of the following, as defined in 42 C.F.R. § 438.8(e):

i. Direct claims that Gold Coast paid to providers (including under capitated contracts with network providers) for services supplies

[1] Fraud Prevention Activities are a MLR Numerator Element subject to review under this Appendix B to the extent that CMS requires that Fraud Prevention Activities be incorporated into the MLR calculation for the applicable Reporting Period. See 42 C.F.R. § 438.8(e)(4) and 85 Fed. Reg. 72754 at 72792 (Nov. 30, 2020).

covered under the contract and services meeting the requirements of 42 C.F.R. § 438.3(e) provided to enrollees.

ii. Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported.

iii. Withholds from payments made to network providers.

iv. Claims that are recoverable for anticipated coordination of benefits.

v. Claims payments recoveries received as a result of subrogation.

vi. Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.

vii. Changes in other claims-related reserves.

viii. Reserves for contingent benefits and the medical claim portion of lawsuits.

2. *MLR Element Review.* At least 90 days prior to the end of each Reporting Period, the OIG shall select the MLR Numerator Element to be reviewed by the IRO and notify Gold Coast of its selection (Selected Element). Within 60 days of OIG's notification to Gold Coast, the IRO shall develop and submit to OIG a workplan that outlines the IRO's detailed methodology (including any sampling proposals) for determining whether Gold Coast's calculation and reporting of the Selected Element was accurate, supported by underlying documentation, consistent with generally accepted accounting principles, and otherwise complied with the terms of its contract with the California Department of Health Care Services (DHCS) and the applicable Medicaid laws, regulations, and guidance. The OIG shall have 30 days from its receipt of the IRO's workplan to provide any comments or to raise any objections to the workplan. The IRO shall implement the workplan once all of OIG's comments and objections have been addressed to the OIG's satisfaction.

3. *Supplemental Materials.* The IRO shall request all documentation required for its review of the Selected Element and Gold Coast shall furnish such documentation to the IRO prior to the IRO initiating its review of the Selected Element. If the IRO accepts any supplemental documentation from Gold Coast after the IRO has completed its initial review of the Selected Element (Supplemental Materials), the IRO shall include the following in the MLR Element Review Report: (i) a description of the Supplemental Materials, (ii) the date the Supplemental Materials were accepted, (iii) the IRO's reason(s) for accepting the Supplemental Materials, and (iv) the relative weight the IRO gave to the Supplemental Materials in its review.

B. MLR Element Review Report. The IRO shall prepare a MLR Element Review Report for each MLR Element Review that includes the following information:

1. *Review Methodology.*

   a. Review Objective. A statement of the objective intended to be achieved by the MLR Element Review.

   b. Selected Element. A description of the Selected Element subject to the MLR Element Review.

   c. Source of Data. A description of the documentation reviewed, any personnel interviewed, and other information sources relied on by the IRO when performing the MLR Element Review (e.g., Annual MLR Report, Rate Development Templates, Gold Coast's historical paid claims or encounter data, Gold Coast's contract with DHCS, financial statements or Annual MLR Reports for prior years, Gold Coast's contracts with providers or third party vendors, CMS Informational Bulletins, and other policies, regulations, or directives, etc.).

   d. Review Protocol. A narrative description of how the MLR Element Review was conducted, the standards used, and what was evaluated.

   e. Supplemental Materials. The information regarding any Supplemental Materials required by A.3., above.

2. *Review Findings.*

   a. Narrative Results.

      i. A description of Gold Coast's process for calculating and reporting each Selected Element in its Annual MLR Report, including the identification, by position description, of the personnel involved in calculating and reporting the MLR.

      ii. A description of controls in place at Gold Coast to ensure that each Selected Element is accurately calculated and reported consistent with the terms of Gold Coast's contract with the DHCS and the applicable Medicaid laws, regulations, and guidance.

      iii. A narrative explanation of the results of the IRO's review of the Selected Element, including an explanation of the IRO's findings and recommendations regarding Gold Coast's calculation and reporting of the Selected Element in the Annual MLR Report.

   b. Quantitative Results.

      i. A spreadsheet that includes the following information for the Selected Element:

1. Name of Medi-Cal MCO
2. MLR Reporting Year
3. Incurred Period
4. Expenses actually paid for the Selected Element
5. Expenses reported on the Annual MLR Report for the Selected Element
6. The dollar difference between the expenses actually paid for the Selected Element and the expenses reported for the Selected Element.

c. Recommendations. The IRO's MLR Element Review Report shall include any recommendations for improvements to Gold Coast's MLR classification, calculation and reporting or to Gold Coast's controls for ensuring that all Annual MLR Reports by Gold Coast contain revenues, expenditures, and amounts that are appropriately identified, classified, calculated, and reported based on the findings of the MLR Element Review.

3. *Credentials*. The names and credentials of the individuals who: (1) developed the review methodology utilized for the MLR Element Review and (2) performed the MLR Element Review.

C. Reporting of Findings. Within 60 days of receipt, Gold Coast shall provide a copy of the MLR Element Review Report to DHCS. The MLR Element Review Report shall also be included in Gold Coast's Annual Report for that Reporting Period, along with documentation to demonstrate that Gold Coast provided a copy of the MLR Element Review Report to DHCS. OIG, in its sole discretion, may refer the findings of the MLR Element Review Report to CMS for appropriate follow up.

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: April 22, 2024

SUBJECT: Revised Provider Advisor Committee (PAC) Charter

SUMMARY:

On March 5, 2024, the GCHP management team reviewed the Draft PAC charter with the committee members. The PAC unanimously approved the changes made to the charter and expressed excitement regarding to the scope of work they will be providing feedback on. Thus, modernizing the PAC's span, via the charter, to include the rapidly advancing programmatic and quality imperatives GCHP has calibrated the priority of the PAC-GCHP partnership to today's dynamic regulatory environment (e.g., CalAIM) and our main strategic principle of Quality Improvement and Alignment with Providers.

The revisions consist of the following:

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

Attached you will find the redline charter with the Ad Hoc Committee's recommendation / GCHP management changes, and the proposed changes discussed at the November 20 Commission meeting, where at the recommendation of the Commission all PAC members are to have term limits. You will also find the clean version of the revised charter.

RECOMMENDATION:

GCHP's management team recommends that the Commission approve the revised PAC Charter.

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Committee Charter:
Provider Advisory Committee

Committee Purpose

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

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

Responsibilities

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

1. ~~1)~~1. Address clinical and administrative topics that affect interactions between P~~P~~roviders and GCHP.
2. ~~2)~~2. Discuss local, state, and national issues related to enhancing member care.
3. Provide input on health care services of GCHP.
4. Provide input on the program design and structures of the provider Quality incentives, Grant programs, and value based payments to improve access to care for members and quality measures.

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5. Provide input on GCHP's Model of Care design and structures of member incentives and healthcare programs aimed at increasing member engagement in health/wellness, healthcare, and adherence to treatment.

~~3)~~6. Provide input on GCHP membership to better understand their needs, barriers, and priorities.

~~4)~~7. Provide input on the coordination of services between networks of GCHP.

~~5)~~8. Improve communications, relations, and cooperation between P~~p~~roviders and GCHP.

9. Provide expertise to GCHP relative to a PAC member~~"~~s area of practice.

~~6)~~10. Provide feedback on Quality Improvement Health Equity Workplan

~~7)~~11. GCHP budget review updates. ~~GCHP budget review.~~

~~8)~~12. Changes to programs that impact Providers, such as Health Education, contracting, DHCS guidance, etc. ~~Changes to programs that impact Providers, such as Health Education, contracting, etc.~~

13. Benefit changes and interpretation. ~~Benefit changes and interpretation.~~

~~9)~~14. The Chair and Vice Chair will present to the Commission at least on an annual basis.

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Meetings

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

Members

The VCMMC determined the PAC would consist of thirteen~~eleven~~ (13) GCHP Providers or Practitioners ~~(11) GCHP Providers or Practitioners~~ members with one dedicated seat representing the Ventura County Health Care Agency (VCHCA). Each of the appointed members~~, with the exception of the designated VCHCA seat position,~~ would serve a two-year term, serve up to three termsterms~~have no term limits~~ and individuals could apply for re-appointment if they haven't met their term limits. The thirteen~~eleven~~ voting members would represent various professional disciplines and/or constituencies, which include: allied health services, durable medical equipment, pharmacies, community clinics, hospitals, long-term care, non-physician medical practitioners, nurses, physician, and traditional / safety net, transportation, behavioral health, and community based organizations.

~~PAC Membership~~

~~1) One (1) VCHCA~~

~~2) One (1) Physician participating in Primary Care Providers (PCP)~~

~~3) Two (2) hospital representatives~~

~~4) One (1) allied health service provider~~

~~5) One (1) community clinic provider or practitioner~~

~~6) One (1) long-term care provider~~

~~7) One (1) non-physician medical practitioner~~

~~8) One (1) nurse~~

~~9) One (1) traditional or safety net provider~~

~~10)One (1) practicing member from the Behavioral Health discipline~~

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

~~1)~~1. Chief Executive Officer (CEO)~~, or designee~~

~~2)~~2. Chief Diversity Officer~~, or designee~~

~~3)~~3. Chief Medical Officer (CMO)~~, or designee~~

~~4) Chief Operating Officer (COO), or designee~~

~~5)~~4. Chief Financial Officer (CFO)~~, or designee~~

5. Chief Compliance Officer~~, or designee~~

6. Chief Program and Policy Officer

7. Chief Information and System Modernization Officer

8. Chief Innovation Officer

~~6)~~9. Chief Human Resources and Organizational Performance Officer

~~7)~~10. Senior Director of Network Operations/Provider Relations~~, or designee~~

11. Executive Director, Strategy and External Affairs,~~ or designee~~

~~8)~~

~~9) Director, Behavioral Health and Social Programs~~

Membership Chair and Vice Chair Selection Process

1. Nomination Process

   a. To establish a nomination ad hoc subcommittee, the PC~~C~~AC chairperson or vice-chair shall ask three to four members to serve on the ad hoc

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subcommittee. PAC members who are being considered for reappointment, cannot participate in the nomination ad hoc subcommittee.

2. Prior to the PAC nomination ad hoc subcommittee meeting: At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The PAC nomination ad hoc subcommittee shall:

   i. Review, evaluate and select a prospective chairperson, vice-chair, and a candidate for each of the open seats.

   ii. The ad hoc subcommittee shall convene to discuss and select a chairperson, vice-chair, and a candidate for each of the expiring seats using the attendance record if relevant, and the prospective candidate's references.

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

a. On a biannual basis, PAC shall select a Chairperson and Vice-Chair from its membership to coincide with the biannual recruitment and nomination process.

   i. The PAC Chairperson and Vice-Chair may serve one-year terms with two term extensions with a vote taken by the PAC members annually.

   ii. The PAC Chairperson or Vice-Chair may be removed by a majority vote from GCHP's Commission.

b. Upon selection of a recommendation for a Chairperson, Vice-Chair and a slate of Candidates, the ad hoc subcommittee shall forward its recommendation to the PAC for consideration.

c. Following consideration, the PACs recommended slate of new Candidates shall be submitted to GCHP Commission for review and final approval.

d. Following GCHP's Commission approval of PAC's recommendation, the new PAC members' terms shall be effective at the next regular meeting.

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

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

Membership Responsibilities

The Chair shall:

1. Preside at all PAC meetings

2. Work with GCHP staff to develop the PAC regular meeting agendas

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3. Report at least on annual basis to the Commission
4. Attend PAC meetings on a regular basis and can only have up to three (3) unexcused absences.

The Vice Chair shall:

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

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Membership

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

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~~**Membership requirements/limits – ex: cannot be in ligation with GCHP, must be in good standing, etc.~~

~~**How are members removed? Does the CEO have the power to remove someone from PAC?~~

~~** How do we handle vacant seats?~~

~~** How are the Chair and Vice Chair selected?~~

Meeting Procedures

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

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

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

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

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Committee Charter:
Provider Advisory Committee

Committee Purpose

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

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

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

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

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

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

Membership Chair and Vice Chair Selection Process

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

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

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

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

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

Membership Responsibilities

The Chair shall:

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

The Vice Chair shall:

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

Membership

1. Attend PAC meetings on a regular basis
2. Give feedback on topics presented by GCHP staff at PAC meetings
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**

Meeting Procedures

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

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AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Marlen Torres, Executive Director, Strategy and External Affairs
Erik Cho, Chief Policy and Program Officer

DATE: April 22, 2024

SUBJECT: Addition of New Provider Advisory Committee (PAC) Members

SUMMARY:

Gold Coast Health Plan (GCHP) has been actively recruiting new members to join the PAC as it currently is comprised of nine out of thirteen required members. Ms. Torres and Mr. Cho have served as the reviewing committee which consisted of reviewing all applications and interviewing the interested applicants. Thus, the reviewing committee is recommending the following individuals to join the PAC:

1. **Molly Corbett, President & CEO, Livingston Memorial Visiting Nurse Association & Hospice**: In her current role, Ms. Corbett has been with Livingston Memorial VNA for over five years and has experience in health insurance contracting, program development, advocacy and public policy. Ms. Corbett is an active member of her community has been serving in the City of Santa Paula Public Housing Commission since July 2022. She also serves as a volunteer in the following Organizations: Justice for All, Camarillo Farmers Market, and the Museum of Ventura Conty. Finally, Ms. Corbett brings with her 25 years of experience working with vulnerable populations.

2. **Vincent Pillard, Owner, Slate Bistro**: As the owner of Slate Bistro Mr. Pillard, has led Slate Bistro in providing meals for various programs throughout Ventura County including CAlAIM, Great Plates Seniors, Plan B Seniors, Project Quarantine, Project Room Key (over a million meals), Project Home Key, Mercy House Shelters, and HOUSING FOR HARVEST QUARANTINE MEALS PROGRAM. Providing over 2 million meals to Ventura County residents in the past three years. Mr. Pillard currently serves as a board member for Camarillo Old Town Association and Mercy House Ventura County. He was named Entrepreneur of the Year from the Camarillo Chamber of Commerce in 2019 and Business of the Year in 2022.

3. **Josie Roemhild, LCSW, Carelon:** Ms. Roemhild is a licensed clinical social worker and experienced administrator with expertise in community mental health from direct care, clinical supervision, wraparound, crisis response, and navigating complex systems of

care. Ms. Roemhild's business expertise includes strategy, product development, and project management focusing on improving whole-person healthcare. Identifying best practices and critical thinking through to implementation are her key strengths, enhanced with her ability to build high performing teams, a collaborative culture, and authentic partnerships along the way. Ms. Roemhild lives by "one has no right to hope without endeavor" and is committed to advocating for and advancing the behavioral health system of care.

4. **Milad Pezeshki, M.D., Director of Outpatient Operations, Adventist Health Simi Valley:** As Director of Outpatient Operations, Dr. Pezeshki is overseeing the consolidation of 3 primary care clinics into one. He initiated the launch of surgical specialty service lines in urology and bariatrics. He has also provided oversight for the Child Development Center, and Cardiology. With over 12 years of experience in healthcare, he has a strong focus on implementing the six-sigma lean model of healthcare to drive quality and efficiency in his operations. Dr. Pezeshki became interested in the administrative side of medicine after completing medical school, recognizing the potential to improve healthcare on a larger scale.

RECOMMENDATION:

GCHP's management team recommends that the four (4) individuals recommended be approved by the Commission as new PAC members. Once approved by the Commission, they will be contacted of their official appointment. The next meeting will take place on Tuesday, June 4, 2024.

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AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Jan Schmitt, Principal Project Manager
Anna Sproule, Exec. Director of Operations
Marlen Torres, Exec. Director of Strategy & External Affairs
Alan Torres, Chief Information & system Modernization Officer
Paul Aguilar, Chief of Human Resources & Organization Performance Officer

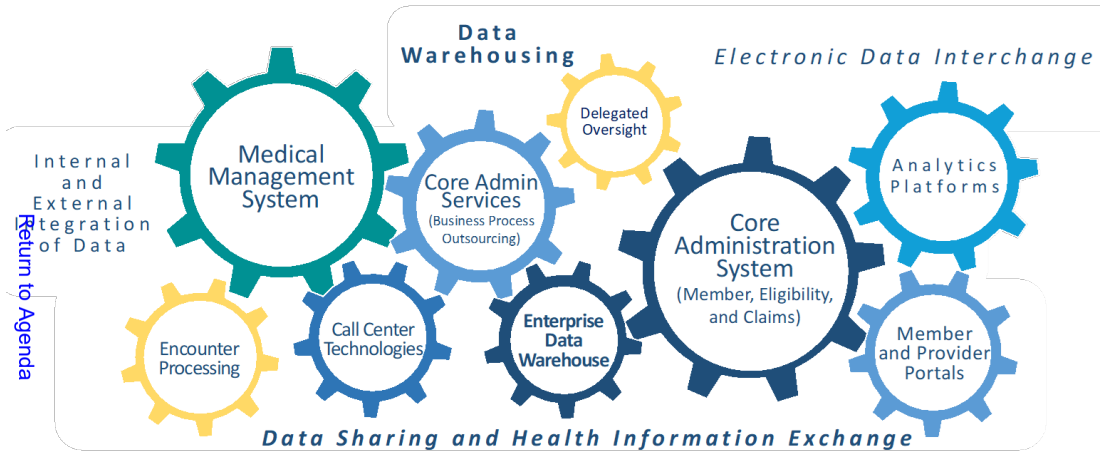
DATE: April 22, 2024

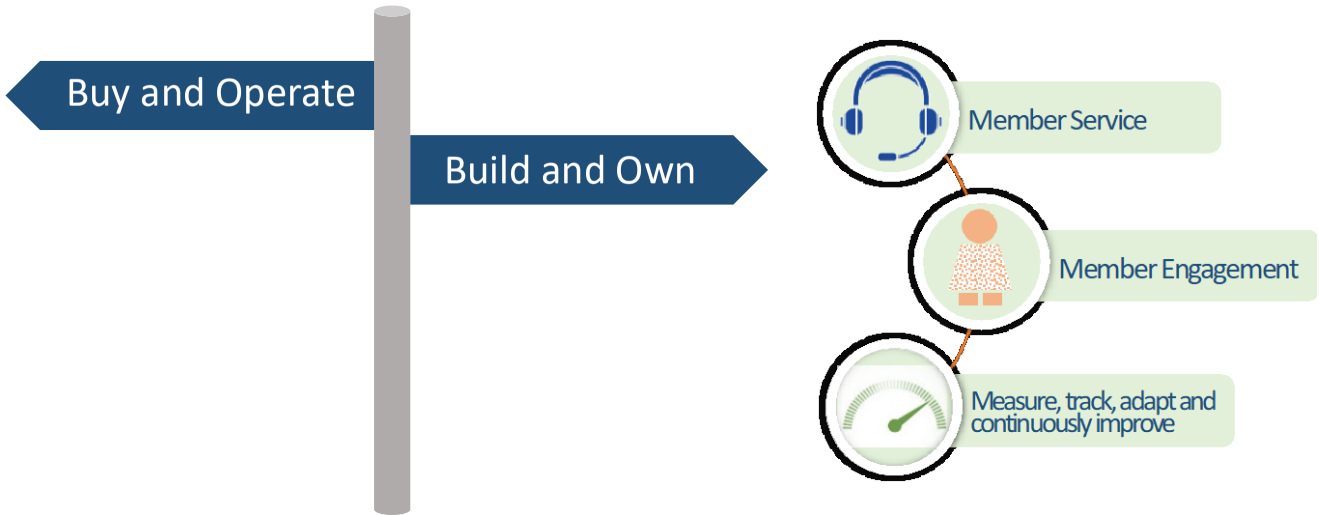
SUBJECT: Operations of the Future (OOTF) Readiness Report

PowerPoint with Verbal Presentation

ATTACHMENTS:
Operations of the Future (OOTF) Readiness Report

Operations of the Future – Readiness Report





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Readiness – Executive Summary

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On Track	On Track	On Track	On Track	On Track	On Track
Core Admin *HRP*	**Medical Management** *TruCare*	**BPO** *Netmark*	**Print/Fulfillment**	**Mail Room/ Imaging**	**EDI** *Edifecs TMaaS*
On Track	On Track	On Track	On Track	On Track	Procurement Done
Provider Portal *NTT vendor*	**Data Conversion** ***EDP/MDW***	**Call Center**	**Member Experience**	**Org Readiness**	**Member Portal** *NTT vendor*

Challenges and Opportunities

- The "Operational Transformation Initiative" marks the most significant shift in our organization since its inception, aiming to modernize and integrate new operational systems amidst substantial change management challenges.

- The program is entering a critical transition from its technical construction phase to focusing on operational readiness and the adoption of best practices. This shift presents a challenge in aligning the newly built technical infrastructure with efficient operational workflows and ensuring seamless team preparedness.

- Expanding our integration from a single vendor to nine will test our capacity for oversight and management, necessitating enhanced coordination and the allocation of more resources. This growth introduces a strategic challenge in maintaining operational harmony and effectiveness across a significantly broader partner network.

- Conducting thorough testing activities that are critical to confirming the technical applications and features of the new system, ensuring they meet our operational standards and requirements are crucial in validating the system's reliability and performance before it becomes integral to our daily operations. This test effort will yield new information in regards to readiness to go life readiness.

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- Instituting a continuous improvement process after the Go-Live will be pivotal in progressively enhancing our system capabilities and staying competitive.

GCHP's "Member Services Everywhere" Program

A principal component of the GCHP's **Operations of the Future** is the ownership of Member Services. This involves the intaking of the member services call center function (which has been vendor delegated since GCHP's founding) as well as the development of a comprehensive community-based service program. The fundamental role of providing health plan services and supports to members will now fully be with the health plan and we intend to enhance and expand both the level and location of service available to our members.

Member Services at Provider Sites

Call Center

Community Based "Storefront"

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GCHP Member Services – We Will Be Service Ready

Member Services at Provider Sites

Critical Implementation Focus Now

GCHP must have call center services in operation on July 1 to handle __ calls per day, __ per month

Call Center

Community Based "Storefront"

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GCHP Member Services – We Will Be Service Ready

Important Current Phase
GCHP is finalizing plans to prototype "embedded" health plan Member Care Ambassadors with early adopter provider partners

Member Services at Provider Sites

Call Center

Community Based "Storefront"

GCHP Member Services – Planning Ahead

Member Services at Provider Sites

Call Center

Important for FY 2024-25

GCHP is evaluating sites in the Oxnard and Santa Paula areas for community located service representatives. This includes the evaluation of "storefront" rentals and site sharing with CBOs.

Community Based "Storefront"

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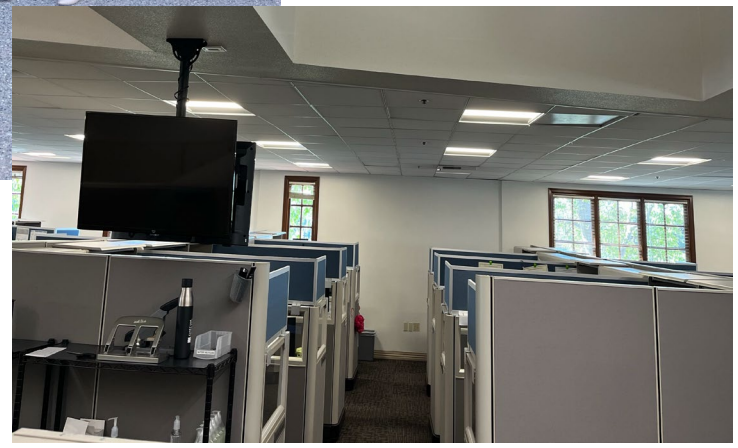
Member Services – Call Center



- On July 7, 2024, GCHP will own call center services for the first time in our history. **We will be ready!**
- Local, community-based service team: 22 call center representatives hired from Ventura County, Director; 95% are fluently bilingual.
- Intensive training underway: GCHP Model of Care, Medi-Cal Benefits and Services, GCHP Delivery System (Providers and CBOs).
- Outbound calling initiatives pre-July and beyond will support MCAS gaps in care initiatives – the goal is to get members into needed care.
- Fiscal Year 2024-25 Budget will include some additional call center staff (representatives, management, and support resources).

Member Services – Customer Service Technology

- CRM innovation
- Gaps in Care
- Call center and anywhere access
- Integration with medical management and MCAS systems
- Centralized member interaction data

- Improved productivity
- Increased efficiency
- Scalability
- Improved customer interaction
- Real time insights

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Member Services – Provider Site Services

- GCHP members can benefit from having a wide range of health plan services and supports available at points of care.
- It is common to have health plan “enrollment” support (tabling, brochures) in the waiting area.
- GCHP model is to adopt a best practice seen in high quality health plans that have track records of sustained high levels of member engagement in care.
- By putting specially trained service representatives in the provider office, we can provide:
  - Support with specialist follow up visits scheduling.
  - Point-of-care integration with member care plans.
  - Provider “heads up” about gaps in care that can be resolved in the day’s appointments.
  - Member service issues (PCP selection, coverage and benefits questions, ID cards, complaints)
  - A channel for member feedback

Return to Agenda

GCHP Member Services – What's Next

Thank You, Commissioners, for your continued support of the Operations of the Future Program through investments and championing. We are on our way to realizing the vision of a high performing health plan.

- Launch call center outbound activities in April.
- Prototype of provider site member services starts before July – update at May Commission Meeting.
- Fiscal Year 2024-2025 Budget will include costs associated with the full build out of the member call center (staff, management, and support resources).
- Fiscal Year 2024-2025 Budget will include costs associated with community-based services. The evaluation of service sites will include "storefront" rental properties and co-located site sharing with CBOs.
- GCHP Management will provide regular reports on member services readiness and performance to the Commission going forward.

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AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: April 22, 2024

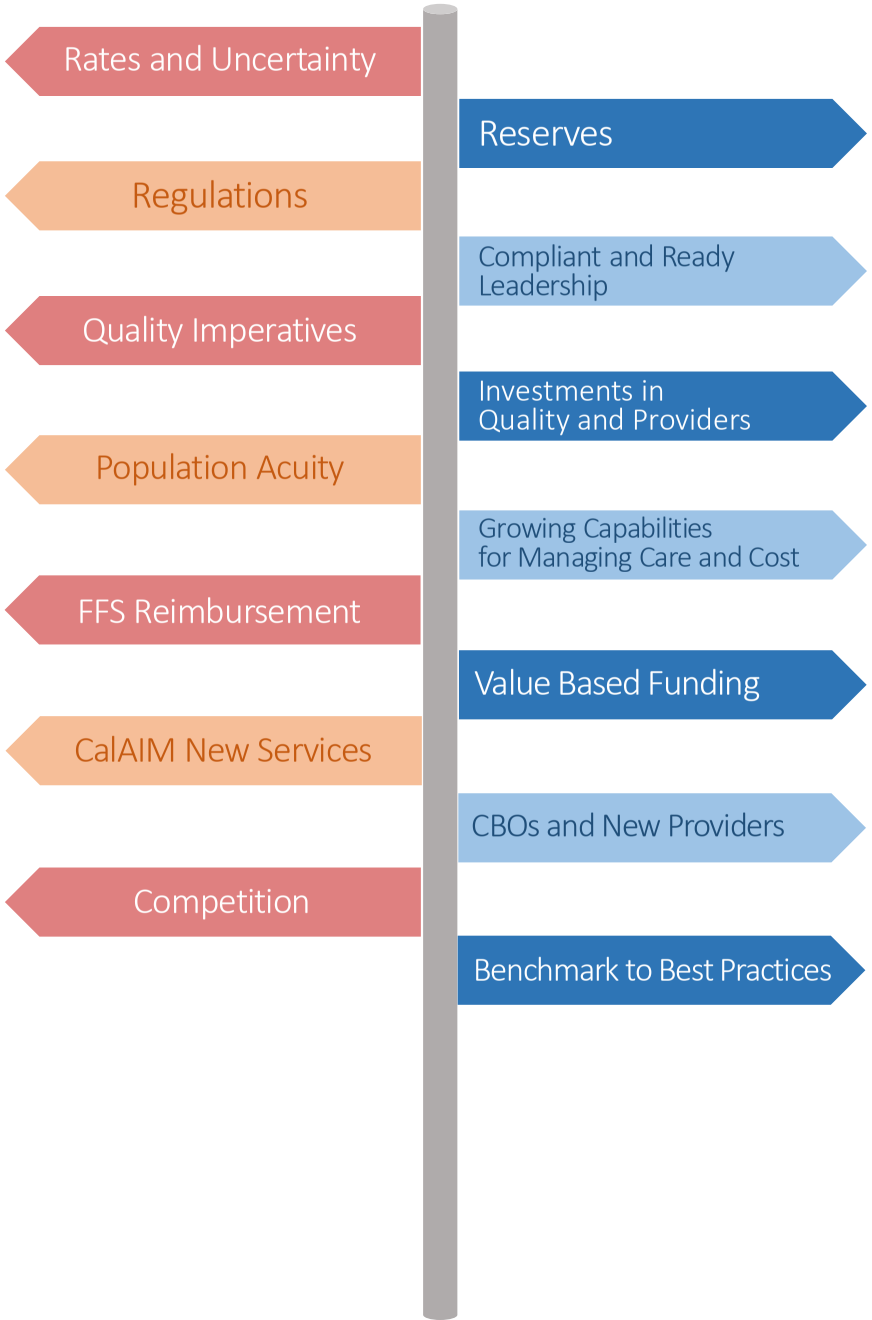
SUBJECT: Strategy & Budget Framework Principles

PowerPoint with Verbal Presentation

ATTACHMENTS:

Strategy & Budget Framework Principles

Strategy and Budget Principles and Framework



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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.

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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.

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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.

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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.

April 2024

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5	6
8	9	10	11	12	13
15	16	17	18 Executive Finance Committee	19	20
22 Commission	23	24	25	26	27
29	30				

May 2024

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3	4
6	7	8	9	10	11
13	14	15	16 Executive Finance Committee	17	18
20 Commission	21	22	23	24	25
27 Executive Finance 1:1's	28 Executive Finance 1:1's	29 Executive Finance 1:1's	30 Executive Finance 1:1's	31 Executive Finance 1:1's	

June 2024

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1
3 Executive Finance 1:1's	4 Executive Finance 1:1's	5 Executive Finance 1:1's	6 Executive Finance 1:1's	7 Executive Finance 1:1's	8
10 Executive Finance 1:1's	11 Executive Finance 1:1's	12 Executive Finance 1:1's	13 Executive Finance 1:1's	14 Executive Finance 1:1's	15
17	18	19	20 Executive Finance Committee	21	22
24 Commission	25	26	27	28	29

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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

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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 care, specialty care, behavioral health care, 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.

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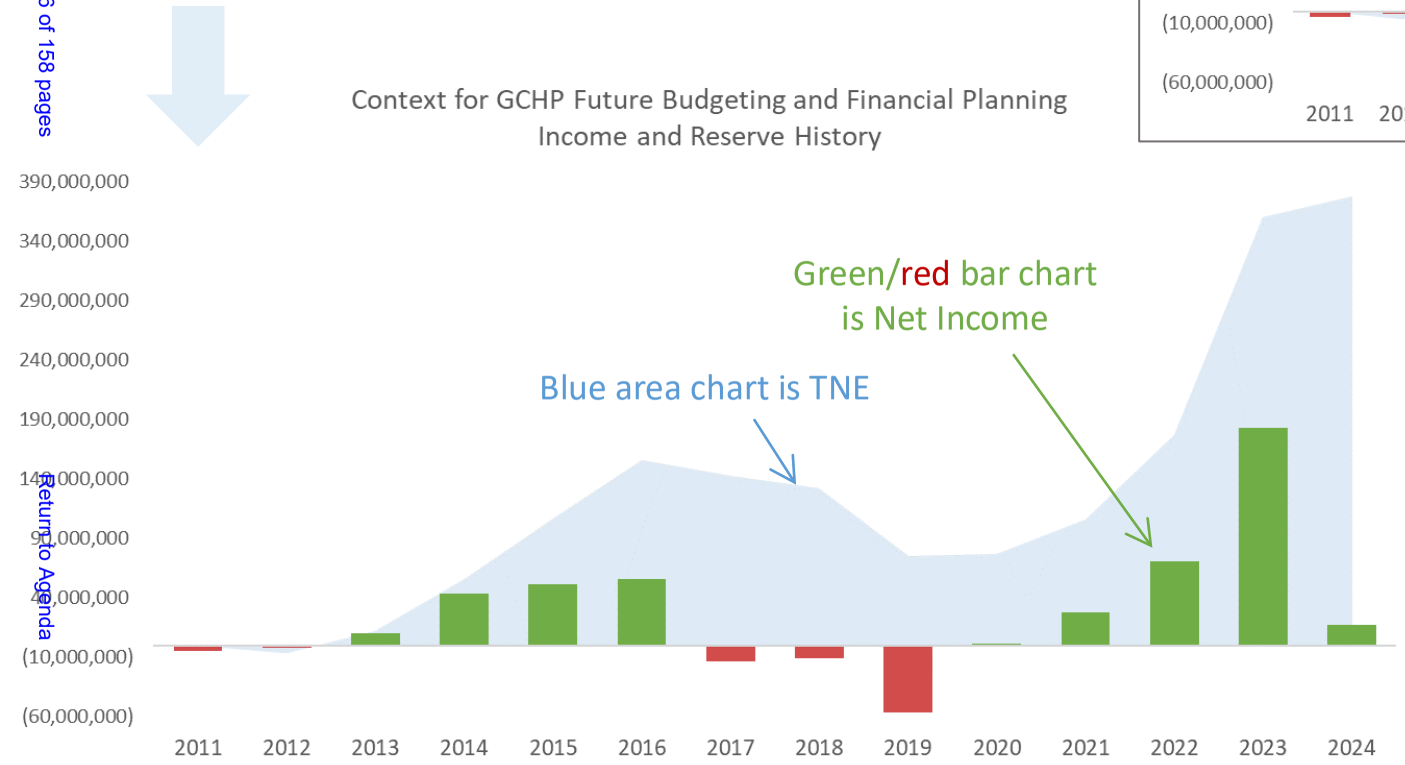
Income and TNE Position

- 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.



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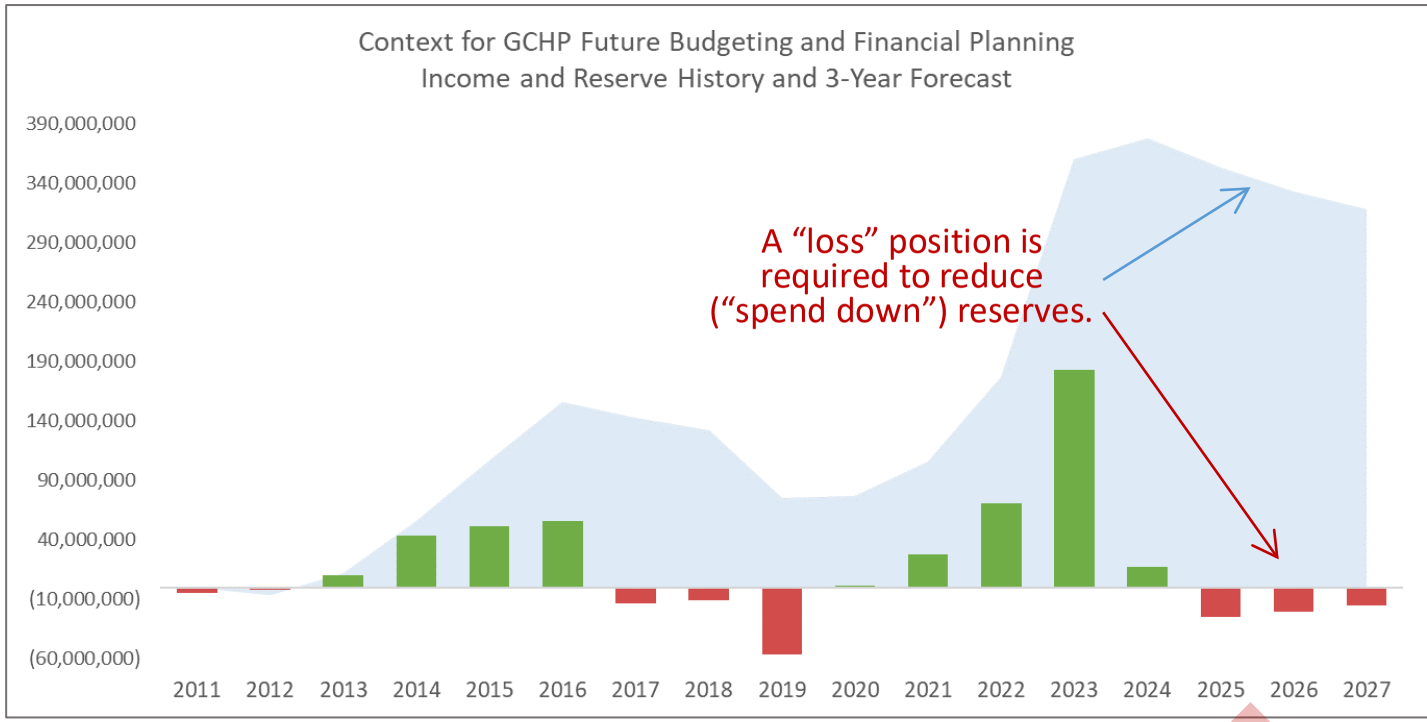

- To achieve a spend down of some Unrestricted Reserves (i.e., not in the 700% of TNE Policy), GCHP must go into a negative Net Income ("loss") position.

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.

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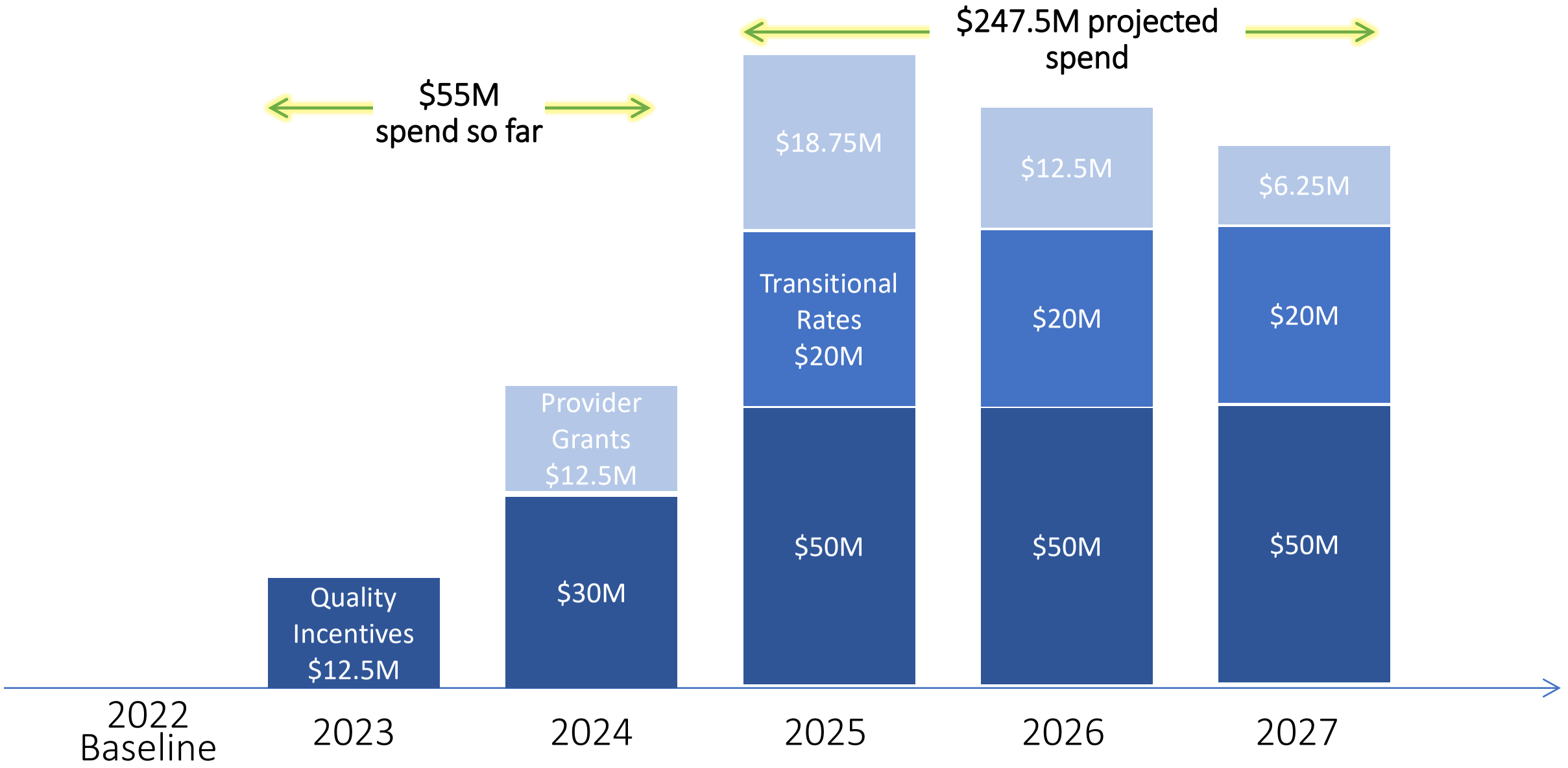
Budget FY 2024-25 | Quality-Focused Funding Increase 23-27



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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.

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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

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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.

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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.

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AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Sara Dersch, Chief Financial Officer

DATE: April 22, 2024

SUBJECT: February Year-to-Date Financial Results Presentation

PowerPoint with Verbal Presentation

ATTACHMENTS:

February 2024 Financial Results

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

February 2024 and Year to Date Financial Results

Ventura County Medi-Cal Managed Care Commission
April 22, 2024
Sara Dersch, Chief Financial Officer

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

February Year to Date (YTD) Financial Results Summary

- GCHP's YTD results continue to reflect strength of the health plan's financial performance, though margin is significantly diminished relative to the PHE era, as forecasted by Management and the Industry.
- Management continues to see – and forecast – significant uncertainty in Medi-Cal. This will manifest in many ways, including an impossible-to-predict revenue environment (driven by State budget shortfalls) which can frustrate our ability to accurately project financial performance.
- Indeed, uncertainty is being felt now through unplanned retroactive revenue "take backs."
- Membership remains stronger than expected as Ventura County's redetermination collaboration (Human Services Agency, GCHP, CBOs, and more) is producing better results than the state overall and nearly all other counties.
- The 2024 expansion of Medi-Cal eligibility provides full-scope benefits to adults ages 26 through 49 regardless of immigration status. GCHP has already seen 17,000 of these expansion individuals enroll (of the approximately 23,000 eligible), which is better than expected and a welcomed development in our service to the communities. That said, Medi-Cal pays lower premium rates for this newly eligible population than it does for other adults, which creates near-term and long-term rate adequacy questions – GCHP and the industry are advocating for better rates.

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February Year to Date (YTD) Financial Results Summary
(continued)

- Quality improvement efforts are on track. Year-end Quality results (MCAS) are expected to be above high targets overall and the Quality Incentive Pool and Program (QIPP) is producing system-wide plan-provider collaboration that should have lasting impact.
- In fact, Management projects that all potential QIPP funds will be earned by providers – an outstanding outcome. Reflecting this, Management released more "upfront" funds to participating providers, thereby enhancing their wherewithal to reinvest in access and quality initiatives and to otherwise support their operational/financial needs.
- Management is tracking and analyzing the continued growth inpatient and long term care costs. Along with Quality investments, these are the key drivers of benefit spend. We do know that planned reimbursement rate increases ("unit cost") are contributing to this cost growth.
- There will always be economic events that we cannot fully foresee (ex: DHCS retroactive revenue "take backs") and Management will continue to diligently monitor all facets of our business, industry, and market. One focus at this time is on managing project portfolio expenses (Operations of the Future) back in line with budget/reforecast, which we expect to do.

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February 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	250,314	241,072	9,242	2,019,967	1,995,876	24,090
Revenue	$ 94.0	$ 87.1	$ 6.9	$ 702.5	$ 696.6	$ 5.9
pmpm	*$ 375.49*	*$ 361.35*	*$ 14.14*	*$ 347.78*	*$ 349.00*	*$ (1.22)*
Non-Operating Revenue / (Expense)	$ 1.0	$ 0.9	$ 0.1	$ 11.3	$ 9.5	$ 1.8
pmpm	*$ 4.15*	*$ 3.74*	*$ 0.41*	*$ 5.61*	*$ 4.76*	*$ 0.84*
Medical Benefits	$ 94.2	$ 79.1	$ (15.1)	$ 608.3	$ 589.6	$ (18.7)
pmpm	*$ 376.23*	*$ 328.06*	*$ (48.2)*	*$ 301.16*	*$ 295.42*	*$ (5.7)*
% of Revenue	*100.2%*	*90.8%*		*86.6%*	*84.6%*	
Admin Exp	$ 7.0	$ 7.3	$ 0.3	$ 57.7	$ 57.6	$ (0.1)
pmpm	*$ 27.78*	*$ 30.22*	*$ 2.44*	*$ 28.57*	*$ 28.88*	*$ 0.31*
% of Revenue	*7.4%*	*8.4%*		*8.2%*	*8.3%*	
Project Portfolio	$ 3.2	$ 2.0	$ (1.2)	$ 16.7	$ 14.0	$ (2.7)
pmpm	*$ 12.96*	*$ 8.29*	*$ (4.67)*	*$ 8.27*	*$ 7.03*	*$ (1.24)*
% of Revenue	*3.5%*	*2.3%*		*2.4%*	*2.0%*	
Operating Gain/(Loss)	$ (10.4)	$ (1.3)	$ (9.1)	$ 19.8	$ 35.3	$ (15.5)
	$ (41.48)	*$ (5.22)*	*$ (36.26)*	*$ 9.78*	*$ 17.67*	*$ (7.89)*
Retro Revenue Adjustments	$ 0.3	$ -	$ 0.3	$ (13.5)	$ -	$ (13.5)
pmpm	*$ 1.14*	*$ -*	*$ 1.14*	*$ (6.70)*	*$ -*	*$ (6.70)*
Total Increase / (Decrease) in Unrestricted Net Assets	$ (9.1)	$ (0.4)	$ (8.7)	$ 17.6	$ 44.8	$ (27.2)
pmpm	*$ (36.19)*	*$ (1.48)*	*$ (34.70)*	*$ 8.69*	*$ 22.43*	*$ (13.74)*
% of Revenue	*-9.6%*	*-0.4%*		*2.5%*	*6.4%*	

- **Changing revenue** | While membership is greater than forecast, the membership "mix" (breakout of members by age and frailty categories) skews towards lower premium cohorts (healthier from an actuarial perspective).
- **Uncertainty** | DHCS' $16.1M Revenue "Take Back" in January was a result of a retroactive "acuity adjustment" to 2023 rates. This was partially offset by a favorable $2.6M membership-related retroactive premium development.

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February 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	250,314	241,072	9,242	2,019,967	1,995,876	24,090
Revenue	$ 94.0	$ 87.1	$ 6.9	$ 702.5	$ 696.6	$ 5.9
pmpm	*$ 375.49*	*$ 361.35*	*$ 14.14*	*$ 347.78*	*$ 349.00*	*$ (1.22)*
Non-Operating Revenue / (Expense)	$ 1.0	$ 0.9	$ 0.1	$ 11.3	$ 9.5	$ 1.8
pmpm	*$ 4.15*	*$ 3.74*	*$ 0.41*	*$ 5.61*	*$ 4.76*	*$ 0.84*
Medical Benefits	$ 94.2	$ 79.1	$ (15.1)	$ 608.3	$ 589.6	$ (18.7)
pmpm	*$ 376.23*	*$ 328.06*	*$ (48.2)*	*$ 301.16*	*$ 295.42*	*$ (5.7)*
% of Revenue	*100.2%*	*90.8%*		*86.6%*	*84.6%*	
Admin Exp	$ 7.0	$ 7.3	$ 0.3	$ 57.7	$ 57.6	$ (0.1)
pmpm	*$ 27.78*	*$ 30.22*	*$ 2.44*	*$ 28.57*	*$ 28.88*	*$ 0.31*
% of Revenue	*7.4%*	*8.4%*		*8.2%*	*8.3%*	
Project Portfolio	$ 3.2	$ 2.0	$ (1.2)	$ 16.7	$ 14.0	$ (2.7)
pmpm	*$ 12.96*	*$ 8.29*	*$ (4.67)*	*$ 8.27*	*$ 7.03*	*$ (1.24)*
% of Revenue	*3.5%*	*2.3%*		*2.4%*	*2.0%*	
Operating Gain/(Loss)	$ (10.4)	$ (1.3)	$ (9.1)	$ 19.8	$ 35.3	$ (15.5)
	$ (41.48)	*$ (5.22)*	*$ (36.26)*	*$ 9.78*	*$ 17.67*	*$ (7.89)*
Retro Revenue Adjustments	$ 0.3	$ -	$ 0.3	$ (13.5)	$ -	$ (13.5)
pmpm	*$ 1.14*	*$ -*	*$ 1.14*	*$ (6.70)*	*$ -*	*$ (6.70)*
Total Increase / (Decrease) in Unrestricted Net Assets	$ (9.1)	$ (0.4)	$ (8.7)	$ 17.6	$ 44.8	$ (27.2)
pmpm	*$ (36.19)*	*$ (1.48)*	*$ (34.70)*	*$ 8.69*	*$ 22.43*	*$ (13.74)*
% of Revenue	*-9.6%*	*-0.4%*		*2.5%*	*6.4%*	

- The release of more "upfront" QIPP funds to providers resulted in $12.5M of MTD expense and a $(11.4M) variance to budget.
- Incurred but not Paid (IBNP) claims reserves involve the estimation of services that have been received but not yet paid for in adjudicated claims.
- IBNP increased by $6.7M due to trends seen in claims payments.
  - Inpatient reserves increased by $3.2M (primarily with the Adult Expansion population; $2.5M); and
  - $1.4M related to redetermination resumption.
- Management is working with our actuaries to ensure that IBNP is set at the right targets – not too low to expose the health plan to financial risks and not too conservative.

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February 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	250,314	241,072	9,242	2,019,967	1,995,876	24,090
Revenue	$ 94.0	$ 87.1	$ 6.9	$ 702.5	$ 696.6	$ 5.9
pmpm	*$ 375.49*	*$ 361.35*	*$ 14.14*	*$ 347.78*	*$ 349.00*	*$ (1.22)*
Non-Operating Revenue / (Expense)	$ 1.0	$ 0.9	$ 0.1	$ 11.3	$ 9.5	$ 1.8
pmpm	*$ 4.15*	*$ 3.74*	*$ 0.41*	*$ 5.61*	*$ 4.76*	*$ 0.84*
Medical Benefits	$ 94.2	$ 79.1	$ (15.1)	$ 608.3	$ 589.6	$ (18.7)
pmpm	*$ 376.23*	*$ 328.06*	*$ (48.2)*	*$ 301.16*	*$ 295.42*	*$ (5.7)*
% of Revenue	*100.2%*	*90.8%*		*86.6%*	*84.6%*	
Admin Exp	$ 7.0	$ 7.3	$ 0.3	$ 57.7	$ 57.6	$ (0.1)
pmpm	*$ 27.78*	*$ 30.22*	*$ 2.44*	*$ 28.57*	*$ 28.88*	*$ 0.31*
% of Revenue	*7.4%*	*8.4%*		*8.2%*	*8.3%*	
Project Portfolio	$ 3.2	$ 2.0	$ (1.2)	$ 16.7	$ 14.0	$ (2.7)
pmpm	*$ 12.96*	*$ 8.29*	*$ (4.67)*	*$ 8.27*	*$ 7.03*	*$ (1.24)*
% of Revenue	*3.5%*	*2.3%*		*2.4%*	*2.0%*	
Operating Gain/(Loss)	$ (10.4)	$ (1.3)	$ (9.1)	$ 19.8	$ 35.3	$ (15.5)
	$ (41.48)	*$ (5.22)*	*$ (36.26)*	*$ 9.78*	*$ 17.67*	*$ (7.89)*
Retro Revenue Adjustments	$ 0.3	$ -	$ 0.3	$ (13.5)	$ -	$ (13.5)
pmpm	*$ 1.14*	*$ -*	*$ 1.14*	*$ (6.70)*	*$ -*	*$ (6.70)*
Total Increase / (Decrease) in Unrestricted Net Assets	$ (9.1)	$ (0.4)	$ (8.7)	$ 17.6	$ 44.8	$ (27.2)
pmpm	*$ (36.19)*	*$ (1.48)*	*$ (34.70)*	*$ 8.69*	*$ 22.43*	*$ (13.74)*
% of Revenue	*-9.6%*	*-0.4%*		*2.5%*	*6.4%*	

- "Day-to-day" administrative costs approximate forecast due to:
  - Disciplined monitoring of resource optimization (right people in the right places at the right time) implemented in December; and
  - In-depth monthly reviews of current and projected non-personnel spend.
- Project Portfolio costs (primarily Operations of the Future) continue to run higher than expected due to the acceleration of implementation and readiness efforts. Management actions have been taken to align actual results with the reforecast over the coming months.

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February 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	250,314	241,072	9,242	2,019,967	1,995,876	24,090
Revenue	$ 94.0	$ 87.1	$ 6.9	$ 702.5	$ 696.6	$ 5.9
pmpm	*$ 375.49*	*$ 361.35*	*$ 14.14*	*$ 347.78*	*$ 349.00*	*$ (1.22)*
Non-Operating Revenue / (Expense)	$ 1.0	$ 0.9	$ 0.1	$ 11.3	$ 9.5	$ 1.8
pmpm	*$ 4.15*	*$ 3.74*	*$ 0.41*	*$ 5.61*	*$ 4.76*	*$ 0.84*
Medical Benefits	$ 94.2	$ 79.1	$ (15.1)	$ 608.3	$ 589.6	$ (18.7)
pmpm	*$ 376.23*	*$ 328.06*	*$ (48.2)*	*$ 301.16*	*$ 295.42*	*$ (5.7)*
% of Revenue	*100.2%*	*90.8%*		*86.6%*	*84.6%*	
Admin Exp	$ 7.0	$ 7.3	$ 0.3	$ 57.7	$ 57.6	$ (0.1)
pmpm	*$ 27.78*	*$ 30.22*	*$ 2.44*	*$ 28.57*	*$ 28.88*	*$ 0.31*
% of Revenue	*7.4%*	*8.4%*		*8.2%*	*8.3%*	
Project Portfolio	$ 3.2	$ 2.0	$ (1.2)	$ 16.7	$ 14.0	$ (2.7)
pmpm	*$ 12.96*	*$ 8.29*	*$ (4.67)*	*$ 8.27*	*$ 7.03*	*$ (1.24)*
% of Revenue	*3.5%*	*2.3%*		*2.4%*	*2.0%*	
Operating Gain/(Loss)	$ (10.4)	$ (1.3)	$ (9.1)	$ 19.8	$ 35.3	$ (15.5)
	$ (41.48)	*$ (5.22)*	*$ (36.26)*	*$ 9.78*	*$ 17.67*	*$ (7.89)*
Retro Revenue Adjustments	$ 0.3	$ -	$ 0.3	$ (13.5)	$ -	$ (13.5)
pmpm	*$ 1.14*	*$ -*	*$ 1.14*	*$ (6.70)*	*$ -*	*$ (6.70)*
Total Increase / (Decrease) in Unrestricted Net Assets	$ (9.1)	$ (0.4)	$ (8.7)	$ 17.6	$ 44.8	$ (27.2)
pmpm	*$ (36.19)*	*$ (1.48)*	*$ (34.70)*	*$ 8.69*	*$ 22.43*	*$ (13.74)*
% of Revenue	*-9.6%*	*-0.4%*		*2.5%*	*6.4%*	

- The main drivers of YTD variance between actual and forecasted increase in net assets:
  - DHCS's unexpected retroactive adjustment of 2023 premiums; and
  - Increase in the "upfront" QIPP payments to providers.
- GCHP continues to track to a positive net income.

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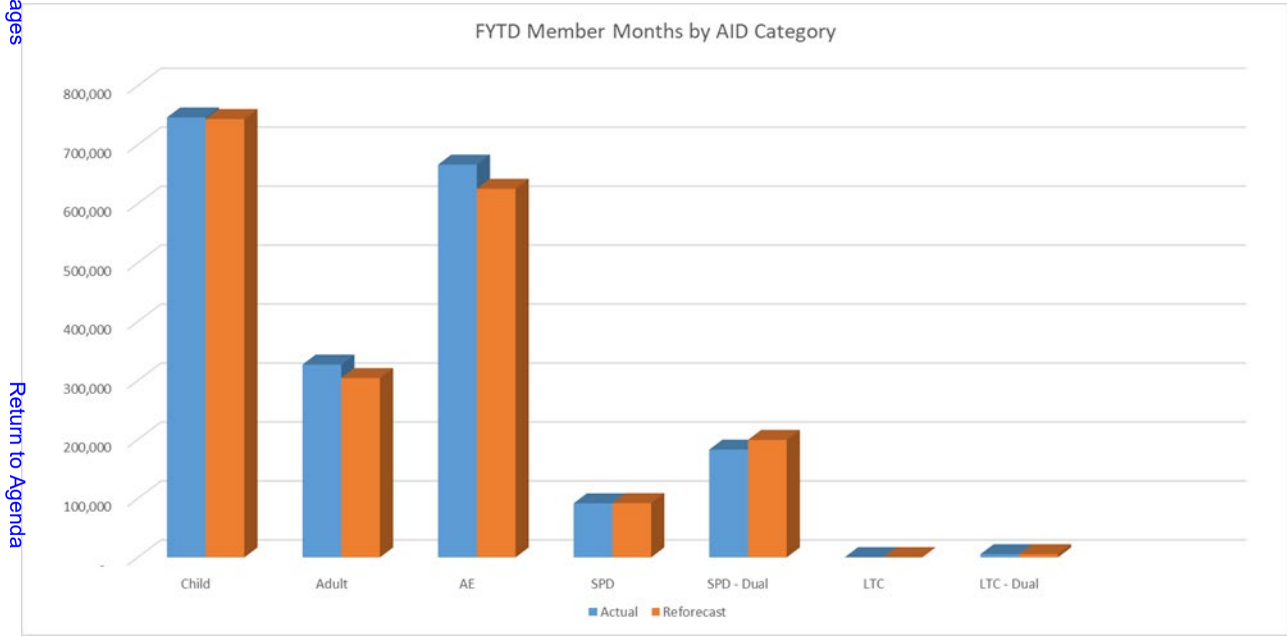
Membership and Medical Benefit

Inpatient and Long Term Care categories of service remain the largest components of medical benefits and the fastest growing. Management is performing deep analysis of the drivers of these trends and opportunities to get costs in greater control. This will be in focus in future financial reports to the Executive Finance Committee and Commission.



	FYTD 23/24 Reforecast	FYTD 23/24 Actual	FYTD 22/23 Actual	FYTD 21/22 Actual
Average Enrollment	249,485	252,496	247,854	229,367
PMPM Revenue	$ 349.00	$ 347.78	$ 340.86	$ 347.72
Medical Benefits				
Capitation	$ 33.99	$ 32.71	$ 34.18	$ 32.44
Inpatient	$ 66.32	$ 63.48	$ 54.64	$ 68.62
LTC / SNF	$ 65.65	$ 63.42	$ 54.86	$ 59.92
Outpatient	$ 26.27	$ 27.95	$ 23.88	$ 22.59
Emergency Room	$ 12.23	$ 12.82	$ 11.32	$ 10.80
Physician Specialty	$ 25.15	$ 25.52	$ 23.44	$ 22.49
Quality Incentives	$ 5.50	$ 12.17	$ 0.69	$ -
Provider Grant Program	$ 1.25	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ (0.15)	$ 29.71
All Other	$ 59.06	$ 63.08	$ 53.03	$ 45.41
Total Per Member Per Month	$ 295.42	$ 301.16	$ 255.89	$ 291.97
Medical Benefit Ratio	84.6%	86.6%	75.1%	86.9%
Total Administrative Expenses	$ 71,675,679	$ 74,413,110	$ 78,852,534	$ 53,680,738
% of Revenue	10.3%	10.6%	7.8%	5.6%
TNE	$ 404,728,173	$ 377,505,859	$ 359,814,027	$ 176,562,922
Required TNE	$ 41,438,176	$ 36,842,063	$ 32,913,795	$ 36,609,789
% of Required	977%	1025%	1093%	482%

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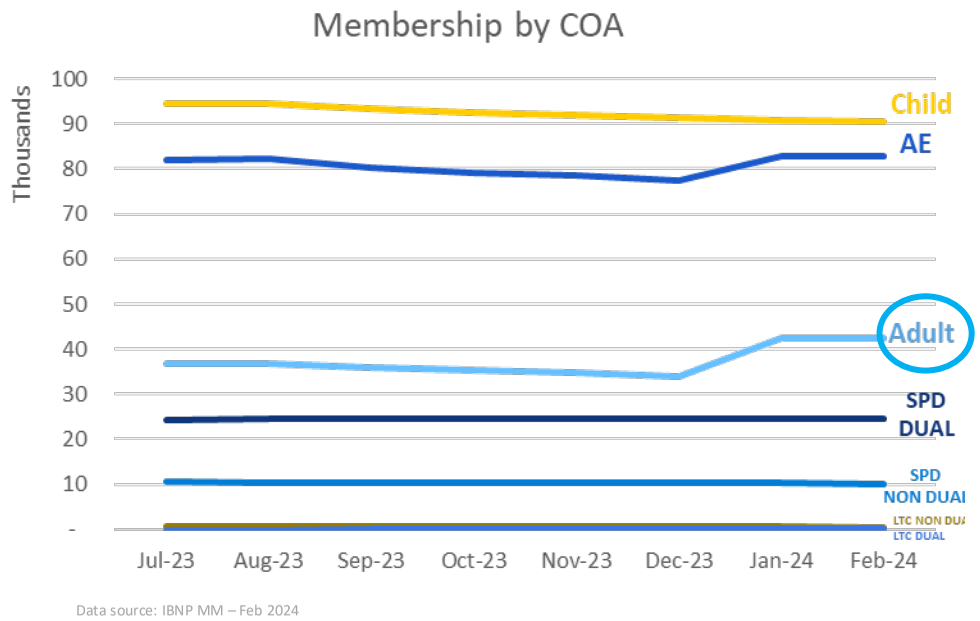
Membership Breakdown

- Child and Adult Expansion cohorts account for about 3/4 of GCHP's membership
- In the Adult Expansion cohort, roughly 13% are enrolled as part of Medi-Cal expansion to cover all regardless of immigration status. DHCS' premium rate category for this group is called "unsatisfactory immigration status or UIS."



Data source: IBNP MM – Feb 2024

UIS membership growth: 17,000 in January 2024

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Looking Ahead….

- A QIPP accounting “true-up” will show $4.9M in additional expenses.
- There is potential for a reduction in IBNP in the last quarter of the fiscal year that will result in some reduction in medical benefit reserves (which would be favorable to net income).
- DHCS’ Final 2023 Acuity Change will be announced in April – the impact of any further retroactive rate impacts are unknown.
- Management will provide further analysis of the inpatient and long term care cost trends.

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AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nick Liguori, Chief Executive Officer

DATE: April 22, 2024

SUBJECT: Chief Executive Officer (CEO) Report

I. EXTERNAL AFFAIRS

A. Federal Affairs

The Centers for Medicare and Medicaid Services (CMS) Releases Streamlining Eligibility and Enrollment Final Rule

The Centers for Medicare and Medicaid Services (CMS) released the final rule, "Streamlining the Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Application, Eligibility Determination, Enrollment, and Renewal Processes." The final rule, effective June 3, 2024, is the second of a two-part final rule that aligns enrollment and renewal requirements for most individuals in Medicaid; establishes beneficiary protections related to returned mail; creates timeliness requirements for redeterminations of eligibility; makes transitions between programs easier; and eliminates access barriers for children enrolled in CHIP.

Specifically, the rule:

- Eliminates annual and lifetime limits on children's coverage in CHIP.
- Ends the practice of locking children out of CHIP coverage if a family is unable to pay premiums.
- Eliminates waiting periods for CHIP coverage so children can access health care immediately.
- Improves the transfer of children seamlessly from Medicaid to CHIP when a family's income rises.
- Requires states to provide all individuals with at least 15 days to provide any additional information when applying for the first time and 30 days to return documentation when renewing coverage.
- Prohibits states from conducting renewals more frequently than every 12 months and requiring in-person interviews for older adults and those with disabilities.

CMS received more than 7,000 comments on the proposed rule including comments from GCHP's trade association, the Association for Community Affiliated Plans (ACAP). CMS finalized several provisions supported by ACAP, including making permanent and strengthening flexibilities granted to states during the unwinding period, requiring states to accept updated enrollee contact information supplied by Medicaid health plans, and requiring states to partner with the National Change of Address Database and USPS forwarding address service. Additionally, ACAP supports the final rule's requirement that state retain applicant and enrollee information for three years, reducing errors caused by missing paperwork.

The GCHP Government Relations Team is attending an upcoming overview webinar of the final rule and will continue to share updates and information related to the rule with the business.

CMS Releases Interoperability and Prior Authorization Final Rule

CMS released the final rule, "Advancing Interoperability and Improving Prior Authorization (PA) Processes for Medicare Advantage (MA) Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Federally-facilitated Exchange (FFE), Merit-based Incentive Payment System (MIPS) Eligible Clinicians, Eligible Hospitals and Critical Access Hospitals (CAHs) in the Medicare Promoting Interoperability Program." The rule requires stakeholders to update prior authorization processes and use technology to update the way requests and responses can be accessed and transmitted among stakeholders through the use of application programming interfaces (APIs). Notably, the final rule does not require payers to include PAs for prescription drugs; however, it does not restrict them from including drug PAs in their policies.

The rule's requirements for payers to use APIs are technical in nature and build off of the 2020 Interoperability and Patient Right of Access final rule. That rule requires impacted payers to, in part, implement and maintain a Patient Access API, Provider Access API, and Payer-to-Payer API that allow patients, providers, and payers to obtain access to the claims, patient encounters, and clinical information in an enrollee's record. The new rule requires the addition of information about PA requests, responses, and decisions into the existing APIs. Provisions in the final rule are phased in, requiring by Jan. 1, 2026 that decisions to standard PA requests be made within seven calendar days, and expedited PA decisions must be sent within 72 hours. These requirements build on the sustained movement to make information more accessible and improve efficiency and transparency in the PA process.

During a recent webinar overview of the final rule attended by GCHP's Government Relations Team, the consensus of managed care plans in attendance was while there is great promise for these APIs, the Patient Access API has not been used by members and the opt-in structure for providers to connect to Provider Access API leaves little incentive and low utilization. GCHP's Government Relations Team continues to share information relating to the final rule with the business.

Stakeholders are also awaiting the Ensuring Access to Medicaid Services (CMS-2442) and Medicaid and CHIP Managed Care Access, Finance, and Quality (CMS-2439) final rules, expected in Spring 2024. The Government Relations Team continues to monitor federal legislative and regulatory activity and will provide updates as they become available.

B. Redetermination Update

California began the eligibility renewal process for Medi-Cal members with a renewal date of June 2023 one year ago on Apr. 1, 2023. Since the unwinding began, California implemented 17 flexibilities authorized by the CMMS that include income-based and administrative waivers and flexibilities that help to streamline the redetermination process. The state Department of Health Care Services (DHCS), in conjunction with the U.S. Digital Service (USDS) published an Issue Brief summarizing the flexibilities California leveraged from the federal government to improve the auto-renewal process. Citing the success of the partnership between California, USDS, and CMS (CMS), CMS notes that "California increased auto-renewal rates from an average of about 34% from June 2023 to Nov. 2023 to 66% in Dec. 2023 after adopting CMS strategies and engaging with CMS and USDS." With these improvements to ex parte processing, California's disenrollments dropped from an average of 20% to 9% over the same period.

The Kaiser Family Foundation (KFF) reports that as of March 26, 2024, states have reported renewal outcomes for approximately two-thirds of people who were enrolled in Medicaid / CHIP prior to the start of the unwinding, with at least 19.1 million Medicaid enrollees having been disenrolled from coverage nationwide - 1.5 million of which occurred in California.

According to the DHCS Jan. 2024 Unwinding Dashboard, Ventura County's disenrollment rate dropped significantly from previous months when disenrollments averaged around 25% to 11% in January with 77% of disenrollments due to procedural reasons; 89% of completed redeterminations in Ventura County resulted in continued coverage in Jan. 2024. As noted in the issue brief, the implementation of waiver flexibilities and increase in auto-renewal rates contributed to the lower disenrollment rates.

The Government Relations Team will continue to advocate for administratively efficient policies that improve the annual renewal and verification process and reduce the potential for delays in coverage due to procedural reasons.

C. State Regulatory Update

DHCS Releases Quarterly Update on Enhanced Care Management (ECM) and Community Supports (CS) Data

DHCS released updated data on the availability and utilization of Enhanced Care Management (ECM) and Community Supports (CS). The ECM benefit and CS services are part of the Population Health Management (PHM) strategy under the California Advancing and Innovating Medi-Cal (CalAIM) initiative. The latest report, updated in April 2024, reflects data from Jan. 1, 2022 to Sep. 30, 2023, and includes data at the state, county, and plan level

for various metrics concerning ECM and CS services. The report shows a continued uptick in the availability and utilization of ECM and CS services across the state.

During that period, GCHP provided CS services to members including:

- 410 members with Housing Transition Navigation Services
- 593 members with Medically Supportive Food
- 15 members with Personal Care and Homemaker Services
- 75 members with Recuperative Care Services
- 42 members with Respite Services

GCHP also provided ECM services to:

- 499 Adults Experiencing Homelessness
- 163 Adults at-risk for Avoidable Hospital or Emergency Department Utilization
- 89 Adults with Serious Mental Health or Substance Use Disorders

The Government Relations Team is conducting a full analysis of the data and will share additional details in future reporting.

On April 4, 2024, the same day the ECM and CS report was released, the Senate Budget and Fiscal Review subcommittee invited stakeholders, including GCHP's trade association, Local Health Plans of California (LHPC), to testify and share information about health plan's experiences with the benefits. The subcommittee was particularly interested in how eligibility is determined and how DHCS and MCPs conduct outreach to providers and consumers to ensure both are aware of the ECM benefit and CS services available. LHPC testified that MCPs are relying on available data on utilization management, claims, social determinants of health, etc. to proactively identify members who are at-risk and connect them to the appropriate supports, as well as providing technical support to providers. LHPC noted how there are some CS services that are harder for MCPs to provide than others. For example, sobering centers can be a challenge to provide as access is dependent on capacity and this barrier may be exacerbated in some counties or regions. Another challenge for plans is the lack of housing in rural areas. GCHP's Government Relations Team attended the hearing and shared relevant information with the organization.

Comprehensive Perinatal Services Program (CPSP) Audit Cites Lack of Data and Oversight

The State Auditor's office released an audit of the Comprehensive Perinatal Services Program (CPSP). The CPSP, established by the Legislature in 1984, provides pregnant Medi-Cal members with a comprehensive set of perinatal services. The perinatal program includes enhanced services intended to reduce maternal and infant illness and death, such as health education, nutrition counseling, and psychological services. State regulations require that CPSP providers assess Medi-Cal members for perinatal services, create individualized care plans, and then provide members with or refer members to appropriate services.

The audit findings were limited in scope due to the significant lack of utilization data available. Specifically, the report notes that "Health Care Services and Public Health did not collect the data necessary for assessing whether Medi-Cal members were using the perinatal program and that neither department conducted adequate oversite of the program or of the program's providers." In response to the audit findings, DHCS stated that it is looking to include CPSP within the birthing care model and intend to include all OB/GYNs when doing Facility Site Reviews and Medical Record Reviews, but acknowledge this will increase the workload of DHCS and MCPs and that more resources are needed. As a result of these findings, we anticipate the potential for an All-Plan Letter detailing the benefit requirements and the likely addition of new reporting requirements around the utilization of this benefit. GCHP's Government Relations Team communicated the findings to the organization and will provide updates as they become available.

D. State Legislative Update

State Legislative Activity

California Voters Pass Mental Health Ballot Initiative Proposition 1 by a Narrow Margin

California voters passed Proposition 1 (Prop. 1) by an extremely narrow margin with just 50.2% of the vote. The mental health ballot initiative will rework state law and take out a $6.4 billion bond to fund new facilities to house and treat the most severe cases of mental illness through the addition of 11,000 new behavioral health treatment beds and increasing supportive housing and outpatient capacity. Prop. 1 changes the 2004 voter-approved Mental Health Services Act (MHSA), a tax on incomes over $1 million that currently generates around $4 billion annually, imposing new requirements on how counties report and spend the funds in mental health programs.

Prop. 1 is the culmination of recent legislative efforts to address the constraints of the MHSA. Senate Bill 326 (SB 326) renames the MHSA to the "Behavioral Health Services Act" (BHSA) and contains several changes to the MHSA, including funding and reserve changes, new reporting parameters, oversight advancements, and the creation of housing intervention and early intervention programs. Assembly Bill 531 (AB 531) creates the "Behavioral Health Infrastructure Bond Act (BHIBA) of 2024" which authorizes $6.38 billion in general obligation (GO) bonds to support permanent housing and behavioral health treatment for at-risk populations, which include veterans and homeless individuals.

Investment into behavioral health supports and sustainable housing continue to be a priority for the Legislature, Administration, and stakeholders across the state. The changes to the MHSA will support Ventura County residents in need and the BHIBA will make significant funding available to important behavioral health programs and supports. GCHP's Government Relations Team will continue to report on efforts to implement the programs and policies detailed in Prop. 1.

State Budget Activity

California continues to suffer from an increasing budget shortfall. The budget deficit is the difference between projected state revenue and the estimated current baseline of spending on services. Based on state projections from the January proposed budget and recent reports from the Legislative Analyst's Office (LAO), the current budget deficit is estimated to be between $38 billion and $53 billion. Recognizing that the budget deficit will likely continue into the future years, the State Senate released its proposed 2024-25 budget on March 14, 2024.

To protect core state initiatives and decrease the budget shortfall, the Senate proposal proactively implements $17.1 billion in budget solutions and approves the Governor's proposed use of the Rainy Day Fund or state reserves ($12.2 billion). To mitigate the budget gap for FY 2023-24 and FY 2024-25, the Senate opts for a variety of budget solutions, such as program reductions ($3.3 billion), revenue and borrowing ($4.7 billion), fund shifts ($3.9 billion), delays ($3.2 billion), and deferrals ($2.1 billion). The vast majority of the proposed Senate solutions were included in the January budget proposal. With the implementation of the Senate solutions, the remaining budget shortfall range is estimated to be between $8.6 billion to $23.6 billion.

Since the Legislature reconvened on Jan. 3, 2024, each Senate budget subcommittee held hearings with state departments, advocacy groups, and other key stakeholders to determine program progress, funding needs, and options to reduce the General Fund (GF) budget shortfall and reach the $17.1 billion in budget solutions. All the Senate subcommittees proposed GF solutions under their specific purview. For Budget Subcommittee 3 on Health and Human Services, this committee put forward $4.884 million in GF solutions for FY 2023-24 and FY 2024-25 including program reductions ($360 million), revenue and borrowing ($3.888 million), fund shifts ($176 million), and delays ($459 million).

Similar to the January proposed budget, the Senate proposed budget safeguards for funding the Medi-Cal program and approves the Governor's health care proposals to:

- Delay funding for the Behavioral Health Continuum Infrastructure Program and Behavioral Health Bridge Housing until 2025-26 ($375.4 million Budget Year (BY)).
- Move $162.7 million reserve balance from the Medi-Cal Drug Rebate Special Fund to the GF ($135.1 million Calendar Year (CY) and $27.6 million BY).
- Increase the managed care organization (MCO) tax, seek federal approval, and prevent cuts to the Medi-Cal program ($1.020 million in CY and $2.779 million in BY). The early action MCO tax proposal, encompassed in SB 136, increases the tax by $1.5 billion to $20.9 billion. From that, $12.9 billion would support the Medi-Cal program and $8 billion would be used for the targeted rate increases in the areas of primary care, obstetrics, doula services, and non-specialty mental health. SB 136 passed in the Legislature, received Governor approval on March 25, 2024, and is currently awaiting federal approval.
- Revert unexpended funds from the 2022-23 CalWORKs Single Allocation ($336 million in CY).

- Withdraw removal of the two-week fee-for-service payment delay for certain Medi-Cal providers ($532.5 million in BY).

The budget is a working document, and the release of the Legislature's budget proposal is the next step in the budget process. After extensive discussion between the Administration and the Legislature over the next few months, the Administration will release its updated budget in May (termed the "May Revise"). Through state constitutional mandate, the Legislature must pass a balanced budget by June 15. You can access the full Senate budget proposal here.

GCHP's Government Relations Team will continue to provide updates about California's 2024-25 budget to ensure the organization and the Commission are aware of all significant budgetary or legislative changes that may impact the Medi-Cal delivery system and/or Medi-Cal managed care plans.

State Legislative Activity

Below is a list of priority bills that GCHP's Government Relations Team is currently tracking. This list will continue to be updated as bills move through the legislative process.

Bill Title	Summary	GCHP Potential Impact(s)
AB 236: Provider Directories	AB 236 mandates health care plans to ensure provider directories are up-to-date and accurate on an annual basis. Plans will be mandated to delete erroneous information and ensure directory is 60% accurate by July 1, 2025, and 95% accurate by July 1, 2028. Beginning July 1, 2025, plans are required to remove providers from the directory if plans have not financially compensated that provider in the prior year, with some limited exceptions. Failure to meet deadlines and inaccurate provider listings will result in monetary penalties for the plan.	GCHP is compliant with existing provider directory requirements, including providing a current and continuously updated directory of Network Providers. Upon becoming Knox-Keene licensed, GCHP would need to build additional processes to routinely pull data on providers who have not been financially compensated in the prior year and remove those providers from the provider directory. *Status:* AB 236 has passed in the Assembly and is currently awaiting assignment in the Senate Committee on Rules.
AB 1943: Health Information	AB 1943 would request the DHCS to track telehealth outcomes associated with patient and population health. Some key measurable data points include information surrounding morbidity rates, public health interventions, and environmental factors.	AB 1943 would provide insights for California state and managed care plans to understand the reach and effectiveness of telehealth. Information from this data tracking may assist Medi-Cal managed care plans to address gaps in care or access to care and promote the betterment of health outcomes for members.

Bill Title	Summary	GCHP Potential Impact(s)
AB 2466: Medi-Cal Managed Care: Network Adequacy Standards	Under federal and state network adequacy requirements, there are time and distance standards for certain Medi-Cal covered services, and this includes appointment time thresholds. This bill notes that a Medi-Cal managed care plan would be considered not compliant with regulatory requirements if less than 85% of network providers had an appointment available within the appointment time standards and if the state is provided information that the plan did not deliver timely or accessible health care to members. If a plan is found noncompliant, plans can face contract termination or the consequences of sanctions.	Given the harsh penalties, including the potential for contract termination as a penalty for noncompliance, stakeholders are working with the author to address concerns with network adequacy compliance while providing education on the complexities of coordination between provider offices and managed care plans. GCHP continuously monitors network adequacy to ensure that contract requirements are consistently met, and that members have timely, efficient, and accessible care. If enacted, GCHP will implement processes to comply with the requirements of AB 2466.
SB 516: Health Care Coverage: Prior Authorization (PA)	SB 516 restricts a health care plan or insurer from requiring a contracted provider to acquire PA for covered services if the plan or insurer approved or would have approved a minimum of 90% of all PA requests in the last one-year contract period. The bill also creates standards for the PA exemption and outlines details for process, rescission, and appeal. SB 516 allows the plan or insurer to examine the continuation of exemption once every 12 months and rescind an exemption at the end of the 12-month period if certain conditions are met.	If enacted, SB 516 will require GCHP to align PA protocols with the revised state and federal requirements. GCHP will continue to monitor federal and state PA requirements as there continues to be an increased focus on streamlining the process for enrollees.
SB 953: Medi-Cal: Menstrual Products	SB 953 would add the coverage of menstrual products as a Medi-Cal benefit and requires DHCS to seek and garner federal approvals and utilize federal funds to implement this new benefit.	There are a variety of services that are covered for Medi-Cal enrollees and GCHP members, including violence prevention services, diabetes testing supplies, certain nutrition products, and in-home medical care services. This bill will expand the list of Medi-Cal covered services and help low-income, vulnerable populations have access to necessary medical supplies.

Bill Title	Summary	GCHP Potential Impact(s)
AB 2428: Community-Based Adult Services (CBAS)	This bill would require providers to be reimbursed at an amount equal to or greater than the amount paid for the service in the Medi-Cal fee-for-service delivery system. Under the bill, no later than Jan. 1, 2025, for payments commencing on July 1, 2019, a Medi-Cal managed care plan that has not reimbursed a network provider furnishing CBAS according to the provisions would be required to reimburse the network provider the difference between the amount required and the amount that has been paid.	This bill is related to the 10% rate restoration for CBAS in 2019-20 through Prop. 56. Although most plans have restored the 10% rate cut that resulted from AB 97 a handful have not. GCHP is reviewing the bill for potential impacts.

E. Community Relations: Sponsorships

Through its sponsorship program, GCHP continues to support the efforts of community-based organizations in Ventura County to help Medi-Cal members and other vulnerable populations. The following organizations were awarded in March 2024:

Organization	Description	Amount
Habitat for Humanity of Ventura County	Habitat for Humanity of Ventura County offers support to low-income homeowners in need of home repairs and builds affordable housing. The sponsorship will support the homeownership, home repair, and advocacy programs.	$1,000
Breastfeeding Coalition of Ventura County	The mission of the Breastfeeding Coalition is to promote breastfeeding in the community by providing resources and education to families, health care professionals, employers, and policy makers. The sponsorship will go toward funding coalition services to moms and families.	$750
Mixteco / Indigena Community Organization Project (MICOP)	MICOP supports, organizes, and empowers the indigenous migrant communities in California's Central Coast. The sponsorship will support their annual "2024 Tequio Rising" event, which provides scholarships to college students from Ventura County who are of indigenous-Mexican roots.	$2,500

Organization	Description	Amount
Caregivers: Volunteers Assisting the Elderly	The mission of Caregivers is to promote the health, well-being, dignity, and independence of frail, homebound elders through one-on-one relationships with trusted volunteers. The sponsorship will go toward their annual "Wearing o' the Green" event to raise funds for non-medical, in-home support services, and transportation for homebound elders.	$600
TOTAL	**$4,850**	

F. Community Relations: Community Meetings and Events

In March, the Community Relations team participated in various collaborative meetings and community events and partnered with community-based organizations on health fairs. The purpose of these events is to connect with community partners and members to raise awareness about services for the most vulnerable Medi-Cal members.

Organization	Description	Date
Cabrillo Economic Development (CEDC) Rodney Fernandez Apartments **Food Distribution**	The Rodney Fernandez Apartments is an affordable community serving farmworkers and low-income families. GCHP's Community Relations Team provided information about GCHP's benefits and services, helped with Medi-Cal renewals, and connected people with other resources.	March 1, 2024
El Rio School District Food Giveaway **Food Distribution**	The El Rio School District hosts its bi-monthly food distribution events where community organizations share information and resources. GCHP's Community Relations Team was onsite to provide resources and answer questions about Medi-Cal renewals.	March 5, 2024 March 19, 2024
Strengthening Families **Collaborative Meeting**	The Partnership for Safe Families & Communities of Ventura County is a collaborative non-profit organization providing inter-agency coordination, networking, advocacy, and public awareness. The collaborative meeting engages parents and community representatives in sharing resources, announcements, and community events.	March 6, 2024

Organization	Description	Date
Charles Blackstock Junior High **Café con Leche ELAC Meeting**	Café con leche is a parent meeting that provides an opportunity to meet with the school's administrative staff and the counseling teams. Guest speakers and community partners are invited to share resources. GCHP's Community Relations Team hosted a table at the meeting and connected with families to provide information about GCHP's benefits and services and remind them about their Medi-Cal renewals.	March 7, 2024
MICOP Acceso & Amigo Baby **Child Development Conference**	The Child Development Conference is an event to provide education to families with children ages 0-21. The conference covered information on child development, child activities, and resources for families. GCHP staff provided information on GCHP services and benefits, transportation, and health screenings.	March 9, 2024
Manna Conejo Valley **Food Bank**	Manna Conejo Valley's food bank supports families in the Conejo Valley struggling with food insecurity. More than 180 families are served each month. GCHP's Community Relations Team was onsite to provide resources and answer questions about Medi-Cal renewals.	March 12, 2024
Fillmore Police Store Front **Food Distribution**	The store front is a food distribution event and venue for community-based organizations to provide resources and services for the most vulnerable in the Santa Clara Valley. GCHP team members were onsite to provide resources and answer questions about Medi-Cal renewals.	March 12, 2024
Sacred Health Food Pantry	The Scared Heart hosts a weekly food distribution event. Organizations share information and resources with participants. GCHP's Community Relations Team was onsite to provide resources and answer questions about Medi-Cal renewals.	March 13, 2024
St. John's Health Ministries Cristo Rey Church **Food Distribution**	Health Ministries Basic Needs program offers food boxes for families experiencing income loss and a tightened budget. In addition, providers are onsite monthly to help families with their medical needs. The GCHP Community Relations Team was onsite to provide information about GCHPs services and benefits and help members with their Medi-Cal renewals.	March 14, 2024

Organization	Description	Date
Promotoras y Promotores **Colonia Market**	Promotoras y Promotores is a wellness organization connecting community members with behavioral health resources and services. GCHP team members were onsite to provide resources and answer questions about Medi-Cal renewals.	March 17, 2024
Mexican Consulate **Resource Event**	The Mexican Consulate provides consular protection and assistance with immigration, human rights, education opportunities, and health guidance. GCHP's Community Relations is onsite to provide resources and answer questions about Medi-Cal benefits and services.	March 19, 2024
Piru Neighborhood Council (PNC) **Food Distribution**	The PNC promotes better living conditions, education, and improved housing. The monthly food pantry distribution provides Ventura County residents with food boxes and community resources.	March 20, 2024
Westpark Community Center **Food Distribution**	The Westpark Community Center hosts a weekly food distribution for seniors over the age of 60. Additionally, organizations share information and resources with participants. GCHP's Community Relations Team was onsite to provide resources, referrals to GCHP programs, and answer questions about Medi-Cal renewals.	March 20, 2024
New Creations Community Church **Food Pantry**	New Creations Community Church hosts a food pantry for families in need of a food box. The Community Relations Team was onsite providing resources and benefit information, help with referrals to GCHP programs, and answer questions about Medi-Cal renewals.	March 20, 2024
The Samaritan Center Simi Valley **Food Distribution**	The Samaritan Center offers residents experiencing housing and food insecurities supportive services. GCHP representatives attend their food distribution and connect members with GCHP services.	March 21, 2024
Vista Real Charter High School **Career and Wellness Fair**	Vista Real Charter High School hosted their annual career and wellness fair. Community-based organizations were onsite offering students' resources and connecting them to services. GCHP's community relations team provided students with information about annual health screenings, and on Medi-Cal services and benefits.	March 22, 2024

Organization	Description	Date
BRITE **Lemonwood Spring Fest Event**	The BRITE agency hosted its community resource fair and invited agencies to participate to provide community resources to participants. GCHP's Community Relations Team provided information on member health screenings, services, and benefits, and how to access GCHP transportation services.	March 23, 2024
City of Oxnard **Egg-cessible Event**	The City of Oxnard hosted its annual egg hunt event for kids. Community agencies provided information about community resources. GCHP's Community Relations team provided information on member health screenings, services, and benefits, and referred members to GCHP programs.	March 23, 2024
Indivisible Ventura Swap Meet Justice **Health Fair**	Swap Meet Justice is a citizen and family resource fair. Various community organizations shared resources and information with attendees at Oxnard College. GCHP staff conducted blood pressure screenings for members, their families, and other attendees. In addition, GCHP staff helped members with their Medi-Cal renewals and answered their questions.	March 24, 2024
Salvation Army Oxnard **Food Distribution**	The Salvation Army offers youth programs, utility bill assistance, food pantries, and rapid rehousing services. GCHP representatives attended their food distribution and connect members to GCHP services.	March 26, 2024
Help of Ojai **Food Distribution**	The mission of Help of Ojai is to combine community and individual resources to respond to the unmet basic needs of Ojai Valley residents. GCHP's staff shared information about GCHP's benefits and services and helped families with their Medi-Cal renewals.	March 27, 2024
One Step A La Vez **Food Distribution**	One Step A La Vez focuses on serving communities in the Santa Clara Valley by providing a safe environment for 13- to 19-year-olds and bridging the gaps of inequality while cultivating healthy individuals in the community. GCHP's staff shared information about its services and benefits to families.	March 27, 2024
Housing Authority of the City of Oxnard **Cesar Chavez March**	The Cesar Chavez March honored the activist who improved working conditions for laborers. The march began at the Cesar Chavez Elementary School and ended at a food distribution and a resource fair where community organizations shared information and resources.	March 30, 2024

Organization	Description	Date
Open Houses	The Open House is an event for parents / guardians to connect with the school and engage with community organizations. Participants learned about community resources available to them.	• March 19, 2024: Harrington, Rose Park, and Norma Brekke elementary schools • March 21, 2024: Lemonwood Elementary School, Del Sol High School, Blackstock Junior High School • March 26, 2024: Sunkist and Haycox elementary schools • March 28, 2024: Hueneme High School
Total		**33**

G. Community Relations: Speakers Bureau

The purpose of the Speakers Bureau is to educate and inform the public, partners, and external groups about GCHP and its mission in the community. In March, GCHP participated in two presentations.

Name of organization	Description	Date
Cabrillo Economic Development Corporation GCHP Overview Presentation	The Community Relations Team presented information on GCHP's benefits and services. The presenter talked about how to access transportation, medical screenings, and connect with our Care Management Team. In addition, we provided an overview of the GCHP website and showed where to find additional GCHP information.	March 4, 2024
Charles Blackstock Junior High Café con Leche ELAC Meeting GCHP Overview Presentation		March 7, 2024

H. Community Relations: Community Insight Coalition

The Community Insight Coalition identifies and addresses barriers members may have when accessing care and community resources. The goal of the coalition is to work with community partners and address shared challenges to strengthen our community.

In March, GCHP's registered dietitian provided a presentation to the group about Medically Supportive Food. She provided an overview of the program, and information on how members can access the benefits and how community partners can refer members. Additionally, the coalition participants shared resources and updates from their organizations.

The next coalition meeting is scheduled for May 14, 2024.

II. PLAN OPERATIONS

A. Membership

	VCMC	CLINICAS	CMH	DIGNITY	PCP-OTHER	ADMIN MEMBERS	NOT ASSIGNED
Mar-24	95,346	53,767	34,660	7,106	5,169	49,599	3,359
Feb-24	90,017	49,754	34,059	7,060	4,944	49,628	13,622
Jan-24	89,244	48,529	34,072	7,039	4,935	49,405	16,124

NOTE:
Unassigned members are those who have not been assigned to a Primary Care Provider (PCP) and have 30 days to choose one. If a member does not choose a PCP, GCHP will assign one to them.

Administrative Member Details

Category	March 2024
Total Administrative Members	49,599
Share of Cost (SOC)	607
Long-Term Care (LTC)	699
Breast and Cervical Cancer Treatment Program (BCCTP)	67
Hospice (REST-SVS)	28
Out of Area (Not in Ventura County)	262
DUALS (A, AB, ABD, AD, B, BD)	27,093
Commercial Other Health Insurance (OHI) (Removing Medicare, Medicare Retro Billing, and Null)	22,099

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

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

1. Share of Cost (SOC-AMT) > zeros
    a. AID Code is not 6G, 0P, 0R, 0E, 0U, H5, T1, T3, R1 or 5L
2. LTC members identified by AID codes 13, 23, and 63.
3. BCCTP members identified by AID codes 0M, 0N,0P, and 0W.
4. Hospice members identified by the flag (REST-SVS) with values of 900, 901, 910, 911, 920, 921, 930, or 931.
5. Out of Area members were identified by the following zip codes:

   a. Ventura Zip Codes include: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93000-12, 93015-16, 93020-24, 93030-36, 93040-44, 93060-66, 93094, 93099, 93225, 93252
   b. If no residential address, the mailing address is used for this determination.
6. Other commercial insurance was identified by a current record of commercial insurance for the member.

B. Provider Contracting Update

Provider Network Contracting Initiatives

Provider Network Operations (PNO)

The Annual Network Certification (ANC) administered by the state Department of Health Care Services (DHCS) is complete. DHCS divided the ANC into two deliverables, one of which was completed in Jan. 2024. The second one was submitted in March 2024.

DHCS implemented provider network readiness assessments used to monitor a Managed Care Plan's (MCP's) network for newly launched covered services. PNO submitted several deliverables for the Long-Term Care (LTC) Carve-In, which included a Network Readiness template for Intermediate Care Facilities (ICFs) and Subacute Care facilities (adult and pediatric), an ICF provider agreement template, and ICF claims, billing, and invoice guidance content for provider education.

Other notable deliverables and collaborations include:

- Regulatory: Bi-Annual Provider Directory
- Regulatory: Doula Services Survey and Readiness
- Regulatory: DHCS Post Transitional Monitoring (PTM) Adult Expansion & LTC-DD / Subacute Report
- GCHP: HealthPayer Core System Implementation
- GCHP: Provider Portal

As part of GCHP's continuing education of the provider network, Provider Relations held a Primary Care Physician and a Specialist Care Physician Joint Operation Meetings (JOM) in March 2023. Also, with DCHS ongoing focus on Long Term Care ICF/DD education and in accordance with APL23-023, an updated Long Term Care Billing Update was added on the GCHP website.

To support our Knox-Keene filing to the Department of Managed Health Care (DMHC) for the Exclusively Aligned Enrollment (EAE) D-SNP, PNO was able to secure Letters of Intent with key provider partners that represent a broad range of hospitals, primary and specialty care physicians, as well as skilled nursing facilities:

- Ventura County Medical Center (Facility and Professional)
- Community Memorial Health (Facility and Professional)

- Adventist Simi Valley (Facility and Professional)
- Carelon Behavioral Health
- Vision Service Plan
- Greenfield Care Center
- Vista Cove Nursing
- Coastal View Health Care Center
- Victoria Care Center
- Simi Valley Care Center

In addition, to support GCHP's organizational goals, PNO is leading the Quality Provider Incentive and Network Access Goal and is a key collaborator / stakeholder in other goal teams. For Network Access, PNO analyzed the Network Access and Availability process using the expanded scope to include appointment access availability survey results, network adequacy (time / distance standards), member grievances, cultural and linguistic services, and PCP-to-member ratios. The analysis will be presented to the goal workgroup for review and approval. PNO will incorporate this expanded scope into how the overall member experience of access to care (both traditional and non-traditional services) will be evaluated, monitored, and enforced with an emphasis on increasing quality outcomes. The analysis will occur monthly with a quarterly report-out to the Quality Improvement and Health Equity Committee.

Provider Network Developments: Feb. 1-29, 2024

Network Developments for New Contracts	
Provider Additions Fulfilling Network Gaps	**Count**
Pathology Group	1
Dermatology	1
Midwife	1

Note: The numbers above represent contract completion in targeted specialties to close GCHP provider network gaps. PNO continues its outreach to targeted specialties and areas, such as eastern Ventura County, where provider network gaps exist.

GCHP Provider Changes from Jan-24 to Feb-24	
Provider Additions and Terminations	**Count**
Additions	74
Terminations	22
Midwife	1

Note: The additions and terminations above are for GCHP tertiary providers and do not have a significant impact on member access for services.

C. Delegation Oversight

Gold Coast Health Plan (GCHP) is contractually required to perform oversight of all functions delegated through subcontracting arrangements. Oversight includes, but is not limited to:

- Monitoring / reviewing routine submissions from subcontractors
- Conducting onsite audits
- Issuing a Corrective Action Plan (CAP) when deficiencies are identified

**Ongoing monitoring denotes the delegate is not making progress on a CAP issued and/or audit results were unsatisfactory. GCHP is required to monitor the delegate closely, as it is a risk to GCHP when delegates are unable to comply.*

Compliance will continue to monitor all CAPs. GCHP's goal is to ensure compliance is achieved and sustained by its delegates. It is a state Department of Health Care Services (DHCS) requirement for GCHP to hold all delegates accountable. The oversight activities conducted by GCHP are evaluated during the annual DHCS medical audit. DHCS auditors review GCHP's policies and procedures, audit tools, audit methodology, and audits conducted and corrective action plans issued by GCHP during the audit period. DHCS continues to emphasize the high level of responsibility plans have in the oversight of their delegates.

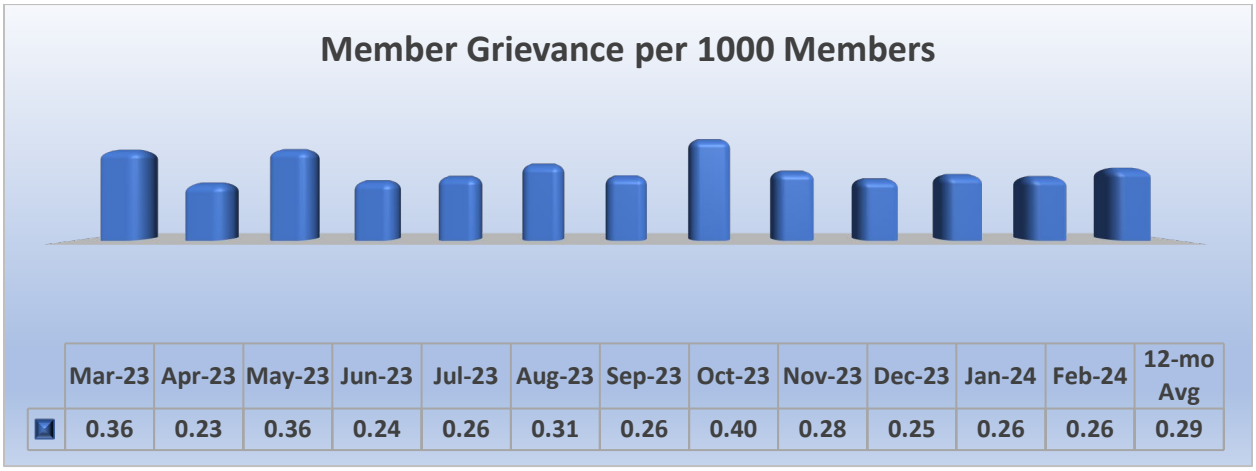
The following table includes audits and CAPs that are open and closed. Closed audits are removed after they are reported to the Commission. The table reflects changes in activity through March 31, 2024.

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Carelon	2023 Annual Claims Audit	Open	5/11/2023	Under CAP	Has been escalated to GCHP leadership and Carelon
Clinicas del Camino Real (CDCR)	2023 Q4 Focused Claim Audit	Open	3/8/2024	Under CAP	N/A
CDCR	Quarterly UM Audit – Q1 2024	Closed	2/12/2024	3/14/2024	N/A
CDCR	2023 Annual Claims audit	Open	2/8/2024	Under CAP	N/A
CDCR	2023 Quarterly Focused Claim Audit (July)	Open	9/7/2023	Under CAP	N/A
Conduent	2022 Annual Claims Audit	Open	8/31/2022	Under CAP	N/A

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Conduent	2023 Annual Claims Audit	Open	8/1/2023	Under CAP	N/A
Conduent	2023 Annual Call Center Audit	Open	3/8/2024	N/A	N/A
Ventura Transit System (VTS)	2023 Focused Call Center Audit	Open	12/21/2023	Under CAP	N/A
VTS	2023 Annual Non-Medical Transportation (NMT) / Non-Emergency Medical Transportation (NEMT) Audit	Closed	11/20/2023	3/18/2024	N/A
VTS	2022 Annual NMT / NEMT Audit	Closed	11/17/2022	2/1/2024	N/A
Privacy & Security CAPs					
Delegate	**CAP Type**	**Status**	**Date CAP Issued**	**Date CAP Closed**	**Notes**
N/A	N/A	N/A	N/A	N/A	N/A
Operational CAPs					
Delegate	**CAP Type**	**Status**	**Date CAP Issued**	**Date CAP Closed**	**Notes**
Conduent	IKA Inventory, KWIK Queue, APL 21-002	Open	4/28/2021	N/A	IKA Inventory and KWIK Queue Findings Closed
Conduent	Sept. 23, 2021 CAP	Open	9/23/2021	N/A	N/A
Conduent	Oct. 2021 CAPs	Open	11/22/2021	N/A	N/A
Conduent	Nov. 2021 Service Level Agreements (SLA)	Open	1/28/2022	N/A	N/A
Conduent	Jan. 2021 Contract Deficiencies	Open	2/4/2022	N/A	N/A

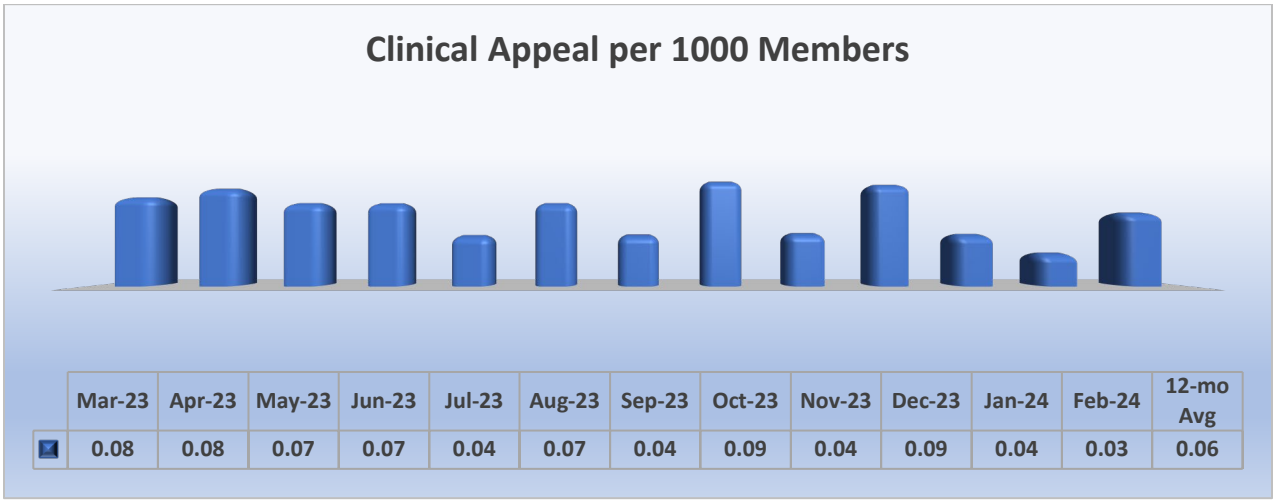
Delegate	CAP Type	Status	Date CAP Issued	Date CAP Closed	Notes
Conduent	Dec. 2021 Contract Deficiencies	Open	2/11/2022	N/A	N/A
Conduent	March 2022 SLA Deficiencies & Findings	Open	3/11/2022	N/A	N/A
Conduent	Jan. 2022 SLA CAP	Open	3/25/2022	N/A	N/A
Conduent	Feb. 2022 SLA CAP	Open	4/15/2022	N/A	N/A
Conduent	March 2022 SLA CAP	Open	6/17/2022	N/A	N/A

D. Grievance and Appeals



Member Grievances per 1,000 Members
The data show GCHP's volume of grievances decreased slightly in February. In February, GCHP received 64 member grievances. Overall, the volume is still relatively low, compared to the number of enrolled members. The 12-month average of enrolled members is 251,121, with an average annual grievance rate of .29 grievances per 1,000 members.

In Feb. 2024, the top reason reported was “Quality of Care,” which is related to member concerns about the care they received from their providers.



	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	12-mo Avg
	0.08	0.08	0.07	0.07	0.04	0.07	0.04	0.09	0.04	0.09	0.04	0.03	0.06

Clinical Appeals per 1,000 Members
The data comparison volume is based on the 12-month average of .06 appeals per 1,000 members.

In Feb. 2024, GCHP received seven clinical appeals:

1. Four were overturned
2. Two were upheld
3. One was withdrawn

RECOMMENDATION:

Receive and file.

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Felix L. Nuñez, MD, MPH, Chief Medical Officer

DATE: April 22, 2024

SUBJECT: Chief Medical Officer (CMO) Report

Health Services Update

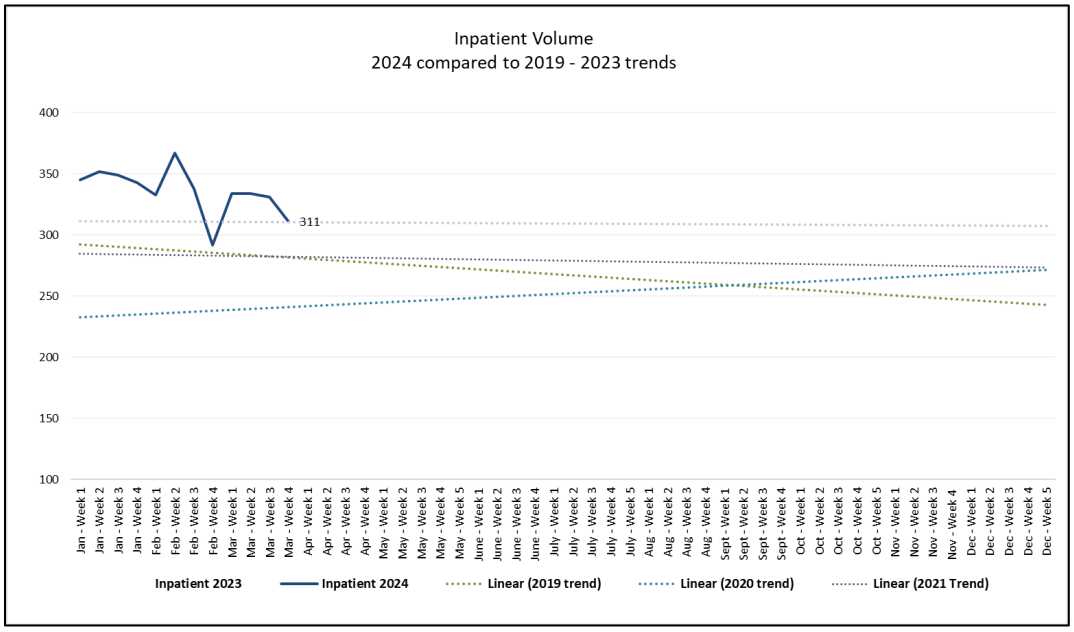
The Health Services teams have continued critical work related to our organizational development and transformation, all the while supporting and serving our members through day-to-day operational excellence. This transformational work includes the implementation of key elements of operations of the future, moving towards contracting with a pharmacy benefits management (PBM) provider, achievement of NCQA accreditation, implementing a transitions of care program, moving towards high performance on all of our quality scorecard, and active engagement with our colleagues to plan and prioritize around organizational goals. While this work does require a high level of commitment and collaboration, our teams have risen to the challenge and remain fully engaged in striving for excellence for the benefit of our members and community.

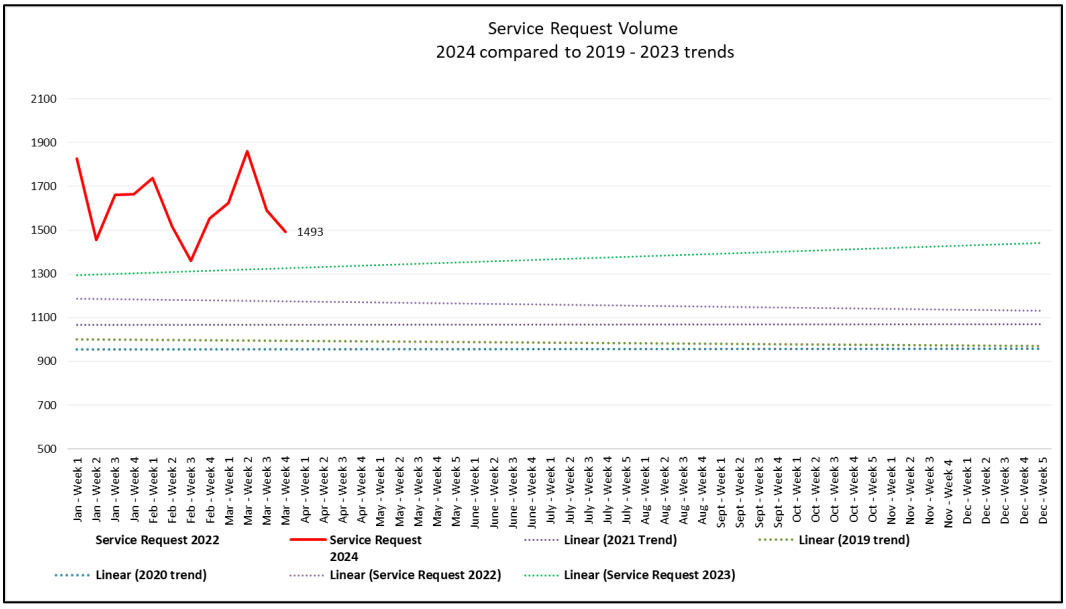
Utilization Update

Service Requests

For Q1 2024, overall authorization requests for services were up by 24% compared with the same quarter of CY 2023.

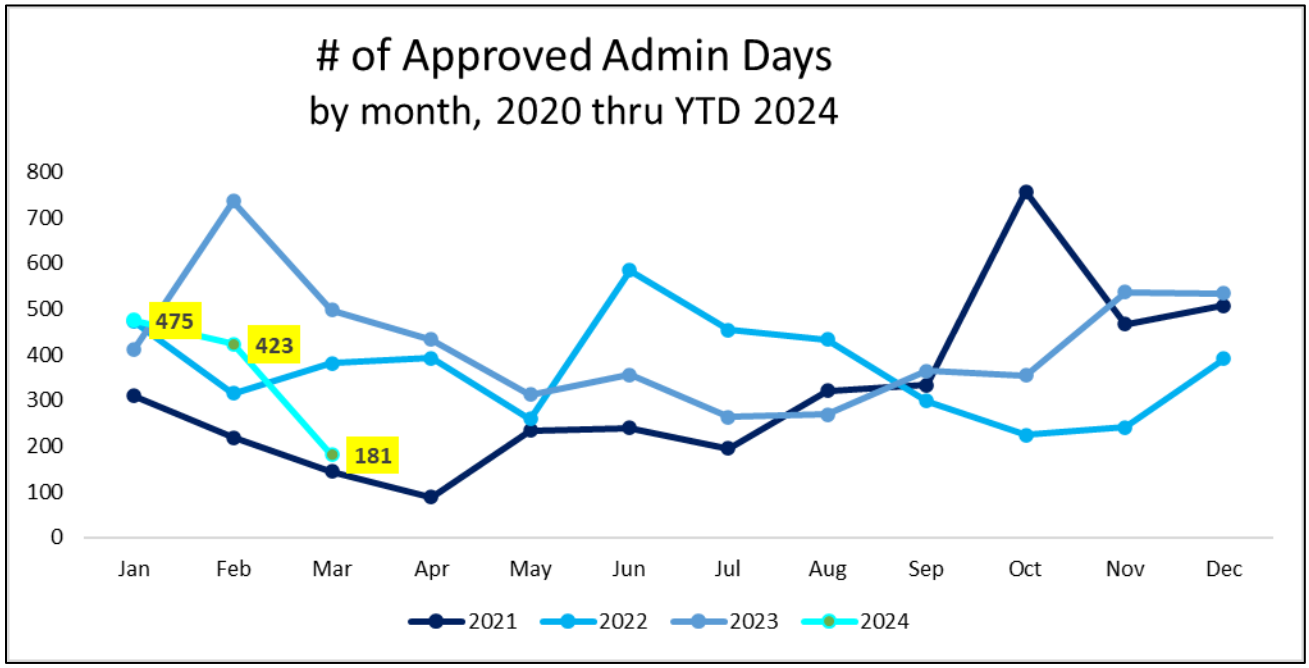
Q1 CY 2024 inpatient authorization request volume increased by 8% compared to Q1 CY 2023 and outpatient service authorization request volume increased by 28% compared to Q1 CY 2023.

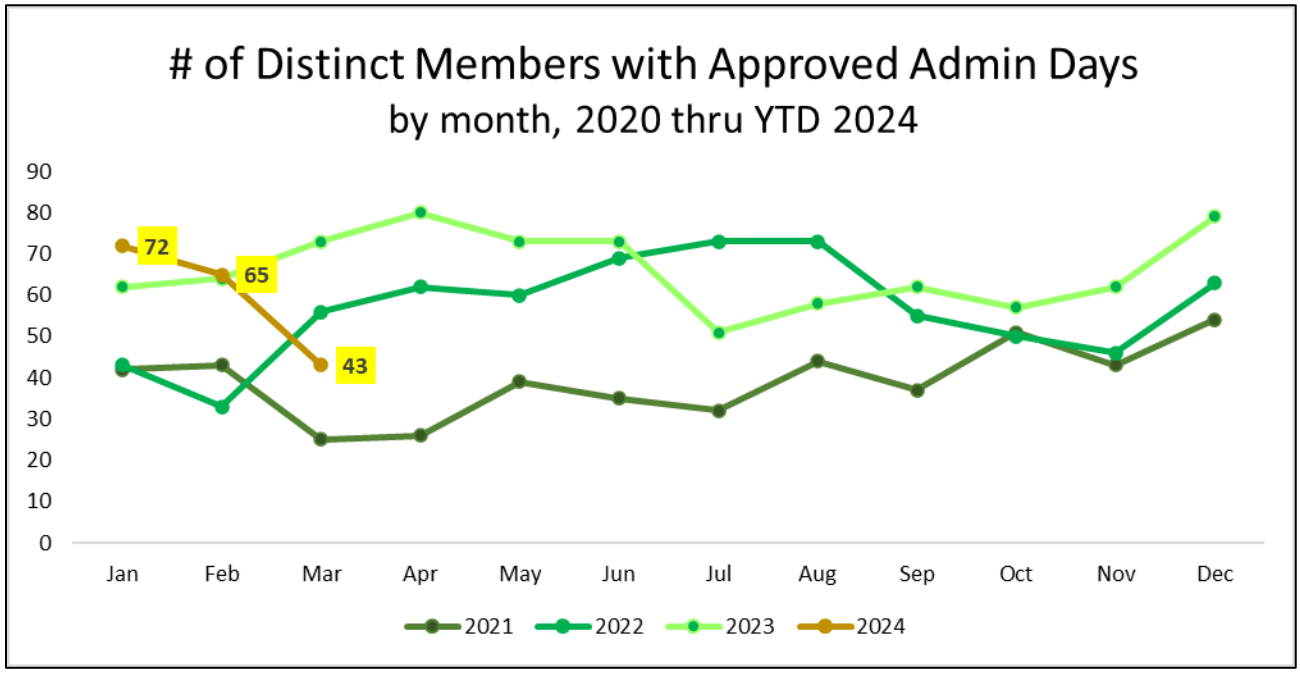




Administrative Days

For Q1 of CY 2024, the number of Administrative Days used decreased compared with the same time period in CY 2023 (34% decrease). The number of members utilizing Administrative Days also decreased by 9% for the same period (60 compared with 66).



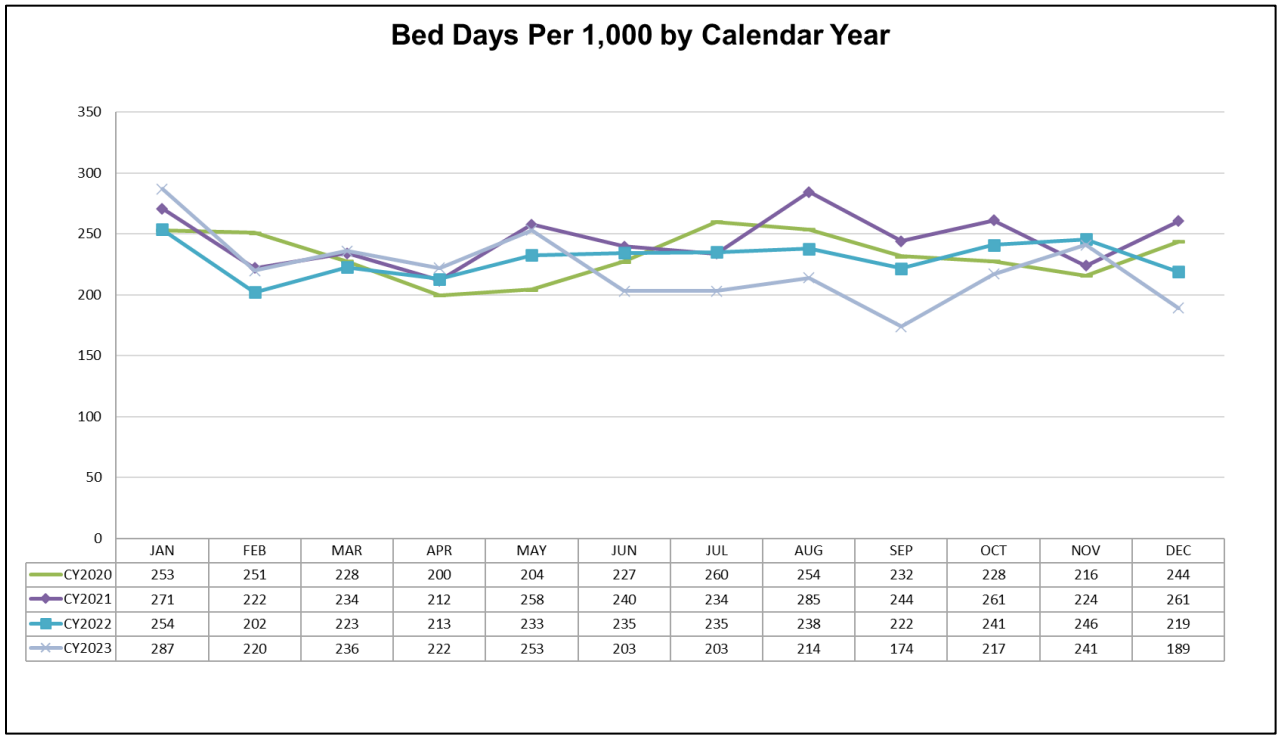


Bed Days/1000 Members

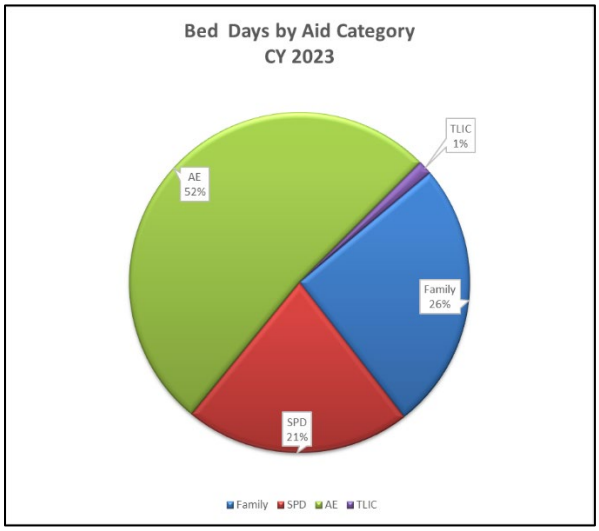
Bed days for Q4 CY 2023 are 19% lower than Q4 CY 2022 (216/1000 members compared with 235/1000 members).

For SPD population, Bed Days for Q4 CY 2023 decreased 5% compared to the same quarter of CY 2022 (877/1000 members compared with 924/1000 members).

A little more than half of all bed days are utilized by Adult Expansion (“AE”) members (51.6%), followed by Family aid code groups (25.6%) and Senior and Persons with Disabilities (“SPD”) (21.5%). Low-income children (“TLIC”) utilization is 1.3%.



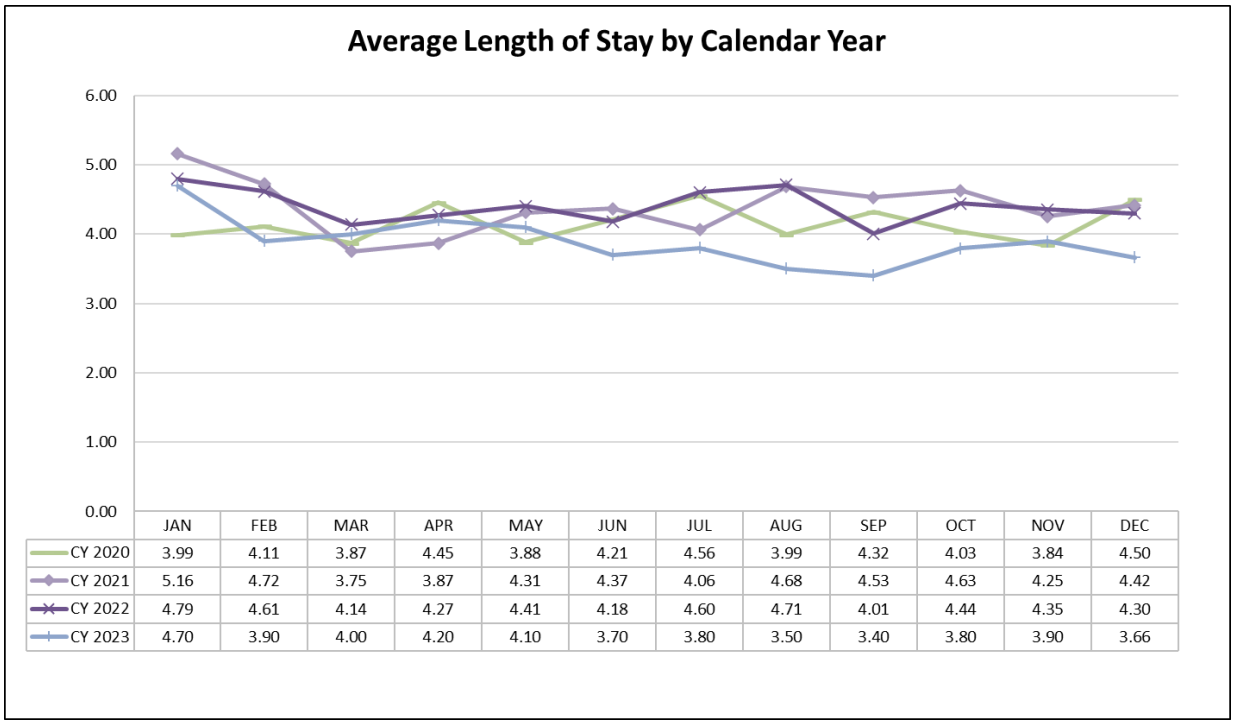
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
CY2020	253	251	228	200	204	227	260	254	232	228	216	244
CY2021	271	222	234	212	258	240	234	285	244	261	224	261
CY2022	254	202	223	213	233	235	235	238	222	241	246	219
CY2023	287	220	236	222	253	203	203	214	174	217	241	189



Average Length of Stay (“ALOS”)

Average length of stay for Q4 CY 2023 decreased to 3.8 days compared to an ALOS of 4.4 for Q4 CY 2022 (13.3% decrease).

For SPD Population, Average length of stay for Q4 CY 2023 decreased to 5.2 days compared to an ALOS of 5.5 for Q3 CY 2022 (5.5% decrease).

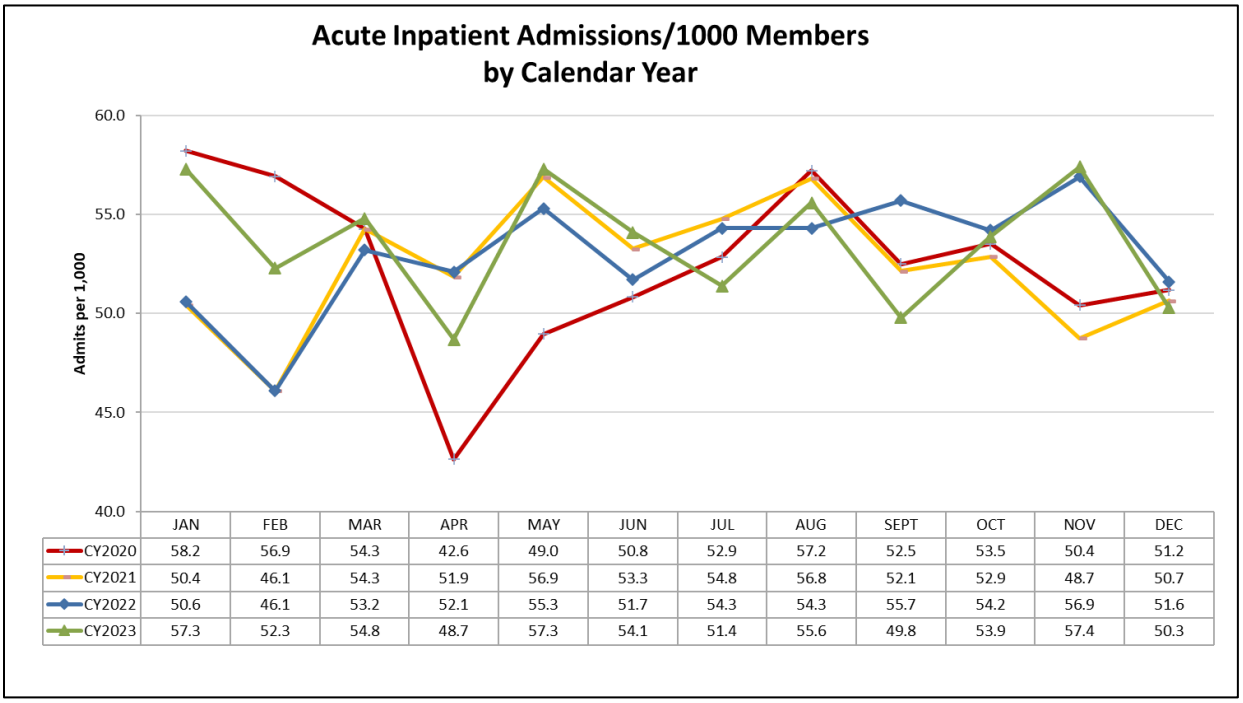


	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
CY 2020	3.99	4.11	3.87	4.45	3.88	4.21	4.56	3.99	4.32	4.03	3.84	4.50
CY 2021	5.16	4.72	3.75	3.87	4.31	4.37	4.06	4.68	4.53	4.63	4.25	4.42
CY 2022	4.79	4.61	4.14	4.27	4.41	4.18	4.60	4.71	4.01	4.44	4.35	4.30
CY 2023	4.70	3.90	4.00	4.20	4.10	3.70	3.80	3.50	3.40	3.80	3.90	3.66

Admits/1000 Members

Admits/1000 members for Q4 CY 2023 remained relatively unchanged compared with Q4 CY 2022, a decreased of only 0.6% (53.9 compared with 54.2).

For the SPD population, Admits/1000 members for Q4 CY 2023 also remained approximately the same compared with quarter Q4 CY 2022, an increase of .2% (168.4 compared with 168).



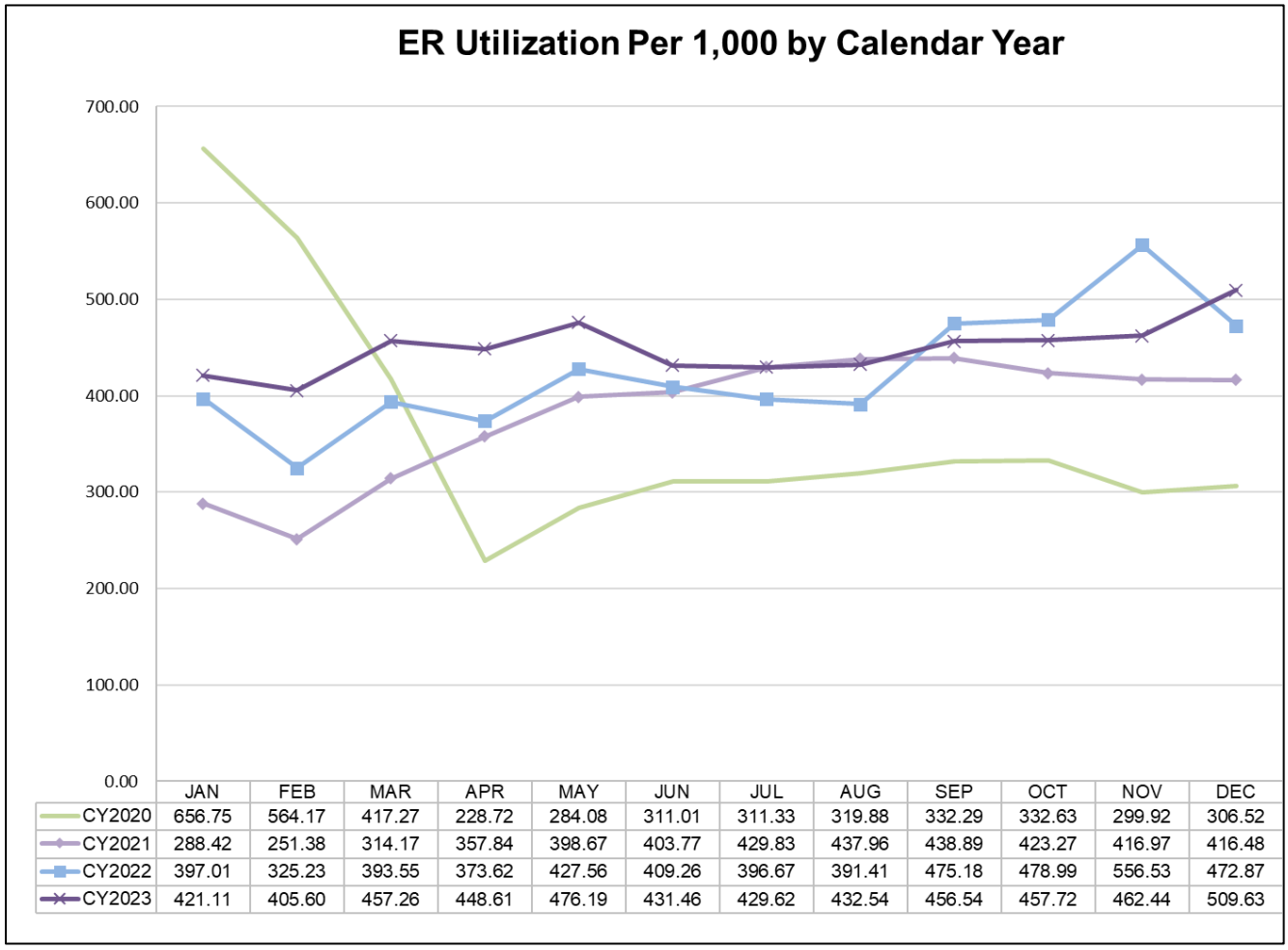
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
CY2020	58.2	56.9	54.3	42.6	49.0	50.8	52.9	57.2	52.5	53.5	50.4	51.2
CY2021	50.4	46.1	54.3	51.9	56.9	53.3	54.8	56.8	52.1	52.9	48.7	50.7
CY2022	50.6	46.1	53.2	52.1	55.3	51.7	54.3	54.3	55.7	54.2	56.9	51.6
CY2023	57.3	52.3	54.8	48.7	57.3	54.1	51.4	55.6	49.8	53.9	57.4	50.3

Emergency Department ("ED") Utilization/1000 Members

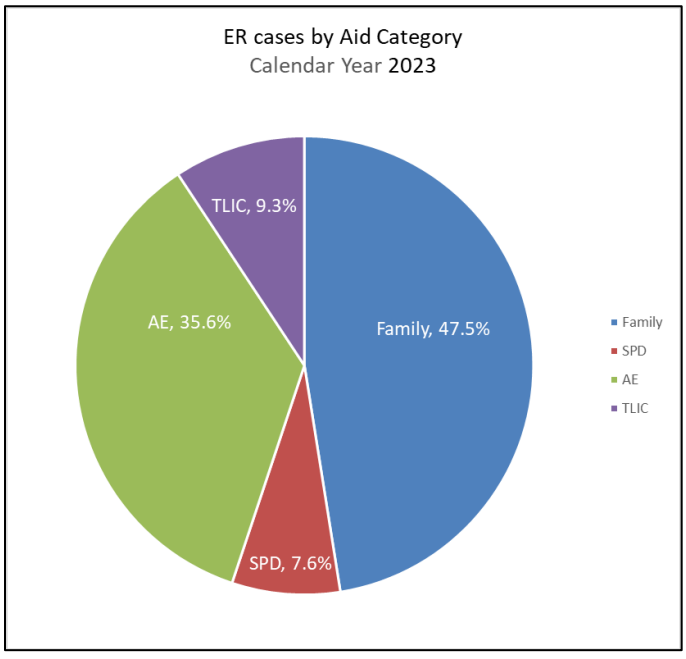
ED utilization/1000 members decreased by 5% in Q4 CY 2023 compared with Q4 CY 2022 (478 compared with 503).

For the SPD Population, ED utilization/1000 members increased 2.7% in Q4 CY 2023 compared with Q4 CY 2022 (889 compared with 866).

The Family aid code group represented 47.5% of ED utilization followed by AE (35.6%), SPD (7.6%) and TLIC (9.3%).



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
CY2020	656.75	564.17	417.27	228.72	284.08	311.01	311.33	319.88	332.29	332.63	299.92	306.52
CY2021	288.42	251.38	314.17	357.84	398.67	403.77	429.83	437.96	438.89	423.27	416.97	416.48
CY2022	397.01	325.23	393.55	373.62	427.56	409.26	396.67	391.41	475.18	478.99	556.53	472.87
CY2023	421.11	405.60	457.26	448.61	476.19	431.46	429.62	432.54	456.54	457.72	462.44	509.63



Readmission Rate

The quarterly readmission rate for Q4 CY 2023 averaged 7.6% compared with the Q4 CY 2022 average of 7.2%.

Denial Rate

The quarterly denial rate for Q4 CY 2023 averaged 4.3% compared with the Q4 CY 2022 average of 5.4%.

Medi-Cal Rx and Pharmacy Services Update

Gold Coast Health Plan (GCHP) Pharmacy Services Department has been monitoring and assisting members who need assistance with processing their prescriptions, understanding the limitations or restrictions based on the coverage criteria by Medi-Cal Rx, and facilitating communication between the members and the pharmacies/providers. We are still answering questions about the Medi-Cal Rx benefit and collaborating with Care Management and Utilization Management to assist our members with getting access to what they need.

Communication about any Medi-Cal Rx updates have been shared in the Pharmacy newsletter, Provider Operations Bulletin, GCHP website and in multiple GCHP committees to provide awareness to the GCHP team and providers to enable us to help our members. We have shared the appropriate resources to member services at the call center, the providers, as well as the internal GCHP team. GCHP will continue to work closely with the Department of Health Care Services (DHCS) and Medi-Cal Rx to assist members in accessing their medications.

The GCHP Pharmacy Services Department will continue to review and develop policies and procedures for pharmaceutical management to prepare us for National Committee for Quality Assurance (NCQA) accreditation. In the future, we will be reviewing the physician administered drug list and authorization process in our quarterly Pharmacy and Therapeutics (P&T) Committee meetings. Our next P&T meeting is scheduled for May 16, 2024.

GCHP has completed a Request for Proposal (RFP) for a Pharmacy Benefit Manager (PBM) in March which will be required to help GCHP prepare and implement a Medicare Part D prescription drug benefit for our Dual Eligible Special Needs Plan (D-SNP) members in 2026. We will be working closely with a pharmacy consultant who has the expertise to help guide us in finding the right PBM vendor to partner with to develop a prescription drug plan that will benefit our members.

AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Paul Aguilar, Chief Human Resources & Organization Performance Officer

DATE: April 22, 2024

SUBJECT: Human Resources (H.R.) Report

Human Resources Activities

Over the last few months, the Human Resources team has been focused on:

(1) Acquiring talent.

(2) Developing the leadership team.

(3) Building a new Member Services Contact Center.

Below is a summary of the year-to-date activities through March.

Organization: We have filled 90 positions through March, which has increased GCHP's headcount to 349. The average time to fill these roles was 48 days. One of the major accomplishments over the last few months has been the Contact Center hiring. In February, we have 20 Contact Center Representatives roles filled to establish our new Contact Center.

Attrition: Our attrition for the last 12 months remains low at 6.3%. However, this is a slight increase from the 6.03% we reported in February. The increase is due to recent retirements and performance related exits. There are no specific concerning trends from the attrition data. Since July, we have had 13 voluntary terminations (three retirements, five personal life issues, four performance related, one moved out of state). The average tenure of the terminated employees is 3.56 years, with 5 employees leaving with less than one year tenure. Half of the terminations are from Health Services function, which is the largest function at GCHP. Attrition trends are monitored each month to assess pending organization risks or concerns.

Leadership Development: In January we launched "Unleash your Leadership Potential," GCHP's new leadership development program. The purpose of this program is to train our people managers with a set of standard leadership and performance management tools, aimed at increasing the overall performance and effectiveness of GCHP. These core management and leadership skills sets include coaching, providing feedback, having difficult conversations, and performance assessment and actions. All people managers will complete the program over three cohorts, which consist of two in-person sessions and related "practice" over a two-month period. We had 30 managers participate in the first and second cohorts, with the final cohort of 25 managers being held on April 24.

Salary Structure: Delineation of Authority policy requires that the salary schedule to be presented to the Commission on an annual basis. Attached is the 2023/24 Gold Coast Health Plan salary ranges for all positions.

Looking forward, we will continue to place strong emphasis on recruiting and assessing the organization to identify opportunities to develop our staff by positioning them in the right roles that advance our priorities and create the best employee experience.

RECOMMENDATION:

Receive and file.

Title	Department	FLSA Status	Pay Band Level	Minimum	Midpoint	Maximum	Minimum	Midpoint	Maximum	State
Reception Associate	Member Services	NE	102	$33,600	**$42,000**	$50,400	$ 16.15	$ 20.19	$ 24.23	
Clinical Operations Assistant I	Utilization Management	NE	106	$42,000	**$52,500**	$63,000	$ 20.19	$ 25.24	$ 30.29	
Member Services Representative I	Member Services	NE	106	$42,000	**$52,500**	$63,000	$ 20.19	$ 25.24	$ 30.29	
Pharmacy Technician	Pharmacy	NE	106	$42,000	**$52,500**	$63,000	$ 20.19	$ 25.24	$ 30.29	
Pharmacy Technician- Part Time	Pharmacy	NE	106	$39,900	**$49,875**	$59,850	$ 19.18	$ 23.98	$ 28.77	**NH**
Contact Center Care Coordinator	Operations	NE	107	$44,100	**$55,125**	$66,150	$ 21.20	$ 26.50	$ 31.80	
Grievance & Appeals Intake Coordinator I	Grievance and Appeals	NE	107	$44,100	**$55,125**	$66,150	$ 21.20	$ 26.50	$ 31.80	
PC Desktop Technician I	Infrastructure & Security	NE	107	$44,100	**$55,125**	$66,150	$ 21.20	$ 26.50	$ 31.80	
Administrative Assistant	Care Management	NE	108	$46,200	**$57,750**	$69,300	$ 22.21	$ 27.76	$ 33.32	
Administrative Assistant	Health Education	NE	108	$46,200	**$57,750**	$69,300	$ 22.21	$ 27.76	$ 33.32	
Care Management Coordinator I	Care Management	NE	108	$46,200	**$57,750**	$69,300	$ 22.21	$ 27.76	$ 33.32	
Health Navigator I	Health Education	NE	108	$46,200	**$57,750**	$69,300	$ 22.21	$ 27.76	$ 33.32	
Member Services Representative II	Member Services	NE	108	$46,200	**$57,750**	$69,300	$ 22.21	$ 27.76	$ 33.32	
Senior Pharmacy Services Technician	Pharmacy	NE	108	$46,200	**$57,750**	$69,300	$ 22.21	$ 27.76	$ 33.32	
Clinical Operations Assistant II	Utilization Management	NE	109	$48,300	**$60,375**	$72,450	$ 23.22	$ 29.03	$ 34.83	
Communications Project Coordinator	Communications	NE	109	$48,300	**$60,375**	$72,450	$ 23.22	$ 29.03	$ 34.83	
Coordinator, Operations	Operations	NE	109	$48,300	**$60,375**	$72,450	$ 23.22	$ 29.03	$ 34.83	
Facilities Administrative Technician	Facilities	NE	109	$48,300	**$60,375**	$72,450	$ 23.22	$ 29.03	$ 34.83	
Grievance & Appeals Intake Coordinator II	Grievance and Appeals	NE	110	$50,400	**$63,000**	$75,600	$ 24.23	$ 30.29	$ 36.35	
PC Desktop Technician II	Infrastructure & Security	NE	110	$50,400	**$63,000**	$75,600	$ 24.23	$ 30.29	$ 36.35	
Purchasing Coordinator	Financial Planning & Analysis	NE	110	$50,400	**$63,000**	$75,600	$ 24.23	$ 30.29	$ 36.35	
Care Management Coordinator II	Care Management	NE	111	$52,500	**$65,625**	$78,750	$ 25.24	$ 31.55	$ 37.86	
Care Management Coordinator II	Care Management	NE	111	$44,625	**$55,781**	$66,938	$ 21.45	$ 26.82	$ 32.18	**WY**
Claims Analyst I	Claims	NE	111	$52,500	**$65,625**	$78,750	$ 25.24	$ 31.55	$ 37.86	
Grievance & Appeals Specialist I	Grievance and Appeals	NE	111	$52,500	**$65,625**	$78,750				
Senior Member Services Representative	Member Services	NE	111	$52,500	**$65,625**	$78,750	$ 25.24	$ 31.55	$ 37.86	
Accounting Operations Specialist	Finance	E	112	$54,600	**$68,250**	$81,900				
Clinical Operations Assistant III	Utilization Management	NE	112	$54,600	**$68,250**	$81,900	$ 26.25	$ 32.81	$ 39.38	
Grievance & Appeals Resolution Specialist I	Grievance and Appeals	NE	112	$54,600	**$68,250**	$81,900	$ 26.25	$ 32.81	$ 39.38	
Health Navigator II	Health Education	NE	112	$54,600	**$68,250**	$81,900	$ 26.25	$ 32.81	$ 39.38	
Provider Dispute Resolution Specialist I	Grievance and Appeals	NE	112	$54,600	**$68,250**	$81,900	$ 26.25	$ 32.81	$ 39.38	
Quality Improvement Credentialing Specialist I	Quality	NE	112	$54,600	**$68,250**	$81,900	$ 26.25	$ 32.81	$ 39.38	
Senior Facilities Administrative Technician	Facilities	NE	112	$54,600	**$68,250**	$81,900	$ 26.25	$ 32.81	$ 39.38	
Behavioral Health Program Specialist	Behavioral Health	E	113	$56,700	**$70,875**	$85,050				
Health Educator	Health Education	E	113	$56,700	**$70,875**	$85,050				
Provider Services Representative I	Provider Relations	NE	113	$56,700	**$70,875**	$85,050	$ 27.26	$ 34.07	$ 40.89	
Quality Improvement Coordinator	Quality	NE	113	$56,700	**$70,875**	$85,050	$ 27.26	$ 34.07	$ 40.89	
Administrative Analyst	Operations	NE	114	$58,800	**$73,500**	$88,200	$ 28.27	$ 35.34	$ 42.40	
Care Management Coordinator III	Care Management	NE	114	$58,800	**$73,500**	$88,200	$ 28.27	$ 35.34	$ 42.40	
Communications Specialist I	Communications	NE	114	$58,800	**$73,500**	$88,200	$ 28.27	$ 35.34	$ 42.40	
Contracts Coordinator	Network Operations	E	114	$58,800	**$73,500**	$88,200				
Cultural and Linguistic Specialist	Health Education	NE	114	$58,800	**$73,500**	$88,200	$ 28.27	$ 35.34	$ 42.40	
Health Navigator III	Health Education	NE	114	$58,800	**$73,500**	$88,200	$ 28.27	$ 35.34	$ 42.40	
Provider Data Coordinator	Provider Relations	NE	114	$58,800	**$73,500**	$88,200	$ 28.27	$ 35.34	$ 42.40	
Claims Analyst II	Claims	NE	115	$60,900	**$76,125**	$91,350	$ 29.28	$ 36.60	$ 43.92	
Grievance & Appeals Resolution Specialist II	Grievance and Appeals	NE	115	$60,900	**$76,125**	$91,350	$ 29.28	$ 36.60	$ 43.92	
Grievance & Appeals Specialist II	Grievance and Appeals	NE	115	$60,900	**$76,125**	$91,350				
Provider Dispute Resolution Specialist II	Grievance and Appeals	NE	115	$60,900	**$76,125**	$91,350	$ 29.28	$ 36.60	$ 43.92	
Quality Improvement Credentialing Specialist II	Quality	E	115	$60,900	**$76,125**	$91,350				
Quality Improvement Specialist	Quality	E	115	$60,900	**$76,125**	$91,350				
Quality Improvement Specialist I	Quality	E	115	$60,900	**$76,125**	$91,350				
Senior Service Desk Technician	Infrastructure & Security	NE	115	$60,900	**$76,125**	$91,350	$ 29.28	$ 36.60	$ 43.92	
Communications Specialist II	Communications	E	116	$63,000	**$78,750**	$94,500				
Community Relations Specialist	Government Relations	E	116	$63,000	**$78,750**	$94,500				
Human Resources Project Analyst	Human Resources	E	116	$63,000	**$78,750**	$94,500				
IT Service Desk Lead	Infrastructure & Security	E	116	$63,000	**$78,750**	$94,500				
Operations Data Analyst	Operations	NE	116	$63,000	**$78,750**	$94,500	$ 30.29	$ 37.86	$ 45.43	
Provider Project Coordinator	Provider Relations	E	116	$63,000	**$78,750**	$94,500				
Senior Human Resources Associate - Strategy	Human Resources	E	116	$63,000	**$78,750**	$94,500				
Operations Oversight Analyst	Grievance and Appeals	NE	117	$65,100	**$81,375**	$97,650	$ 31.30	$ 39.12	$ 46.95	
Provider Contracts Specialist I	Network Operations	E	117	$65,100	**$81,375**	$97,650				
Provider Services Representative II	Provider Relations	NE	117	$65,100	**$81,375**	$97,650	$ 31.30	$ 39.12	$ 46.95	
Staff Accountant - AP/Payroll Specialist	Finance	E	117	$65,100	**$81,375**	$97,650				
Communications Specialist III	Communications	E	118	$69,300	**$86,625**	$103,950				
Compliance Analyst	Compliance	E	118	$69,300	**$86,625**	$103,950				
Compliance Specialist	Compliance	E	118	$69,300	**$86,625**	$103,950				
Data Analyst I	IT Data Warehouse	E	118	$69,300	**$86,625**	$103,950				
Grievance & Appeals Senior Specialist	Grievance and Appeals	NE	118	$69,300	**$86,625**	$103,950	$ 33.32	$ 41.65	$ 49.98	
Legal Compliance Specialist	Compliance	E	118	$69,300	**$86,625**	$103,950				
Policy Analyst	Government Relations	E	118	$69,300	**$86,625**	$103,950				
Program Analyst, Population Health	Population Health	E	118	$69,300	**$86,625**	$103,950				
Provider Relations Operational Lead	Provider Relations	E	118	$69,300	**$86,625**	$103,950				
Provider Relations Project Administrator	Provider Relations	E	118	$69,300	**$86,625**	$103,950				
Quality Improvement Credentialling Specialist III	Quality	E	118	$69,300	**$86,625**	$103,950				
Senior Administrative Analyst	Health Services	NE	118	$69,300	**$86,625**	$103,950	$ 33.32	$ 41.65	$ 49.98	
Senior Claims Analyst	Claims	NE	118	$69,300	**$86,625**	$103,950	$ 33.32	$ 41.65	$ 49.98	
Sr. Cultural & Linguistics Specialist	Health Education	E	118	$65,100	**$81,375**	$97,650	$ 31.30	$ 39.12	$ 46.95	
Community Relations Specialist Lead	Government Relations	NE	119	$73,500	**$91,875**	$110,250	$ 35.34	$ 44.17	$ 53.00	
Decision Support Analyst	IT Data Warehouse	E	119	$73,500	**$91,875**	$110,250				
Delegation Oversight Auditor I	Compliance	E	119	$73,500	**$91,875**	$110,250				
Executive Assistant	Compliance	NE	119	$73,500	**$91,875**	$110,250	$ 35.34	$ 44.17	$ 53.00	
Provider Contracts Specialist II	Network Operations	E	119	$73,500	**$91,875**	$110,250				
Provider Network Operations Analyst	Provider Relations	E	119	$73,500	**$91,875**	$110,250				
Quality Improvement Data Analyst I	Quality	E	119	$73,500	**$91,875**	$110,250				
Senior Claims Operations Analyst	Claims	NE	119	$73,500	**$91,875**	$110,250	$ 35.34	$ 44.17	$ 53.00	
Senior HR Project Analyst	Human Resources	E	119	$73,500	**$91,875**	$110,250				
Sr. Staff Accountant - AP/Payroll Specialist	Finance	E	119	$73,500	**$91,875**	$110,250				
System Administrator I	Infrastructure & Security	E	119	$73,500	**$91,875**	$110,250				
Associate Clerk of the Board/Sr. Executive Assistant	Executive	E	120	$77,700	**$97,125**	$116,550				
Behavioral Health Clinician I	Behavioral Health	E	120	$77,700	**$97,125**	$116,550				
Business Systems Analyst I	IT Pop Health Enablement	E	120	$77,700	**$97,125**	$116,550				
Encounter Data Analyst	IT Pop Health Enablement	E	120	$77,700	**$97,125**	$116,550				
Internal Auditor	Compliance	E	120	$77,700	**$97,125**	$116,550				
Provider Network Operations Analyst II	Provider Relations	E	120	$77,700	**$97,125**	$116,550				
Registered Dietitian	Population Health	E	120	$77,700	**$97,125**	$116,550				
Regulatory Affairs Analyst	Compliance	E	120	$77,700	**$97,125**	$116,550				
Security Analyst	Infrastructure & Security	NE	120	$77,700	**$97,125**	$116,550				
Senior Claims Analyst (Lead)	Claims	E	120	$77,700	**$97,125**	$116,550				
Senior Executive Assistant	Executive	E	120	$77,700	**$97,125**	$116,550				

Senior Policy Analyst	Government Relations	E	120	$77,700	**$97,125**	$116,550					
Senior Quaity Improvement Data Analyst	Quality	E	120	$77,700	**$97,125**	$116,550					
Senior Staff Accountant	Finance	E	120	$77,700	**$97,125**	$116,550					
Behavioral Health Clinician II	Behavioral Health	E	121	$81,900	**$102,375**	$122,850					
Clerk of the Board	Executive	E	121	$81,900	**$102,375**	$122,850					
Clerk of the Board/Senior Executive Assistant	Executive	E	121	$81,900	**$102,375**	$122,850					
Delegation Oversight Auditor II	Compliance	E	121	$81,900	**$102,375**	$122,850					
Developer I	IT Pop Health Enablement	E	121	$81,900	**$102,375**	$122,850					
Human Resources Administrator	Human Resources	E	121	$81,900	**$102,375**	$122,850					
Human Resources Business Partner I	Human Resources	E	121	$81,900	**$102,375**	$122,850					
Operations Business Relationship Manager	Operations	E	121	$81,900	**$102,375**	$122,850					
Provider Contracts Specialist III	Network Operations	E	121	$81,900	**$102,375**	$122,850					
Sr. Provider Network Operations Analyst	Provider Relations	E	121	$81,900	**$102,375**	$122,850					
Behavioral Health Clinician III	Behavioral Health	E	122	$80,719	**$107,625**	$134,531					
Clincal Care Manager, LCSW I (CM or UM)	Health Services	E	122	$80,719	**$107,625**	$134,531					
Data Analyst II	IT Data Warehouse	E	122	$80,719	**$107,625**	$134,531					
Project Manager I	Project Management Organization	E	122	$80,719	**$107,625**	$134,531					
Systems Administrator II	Infrastructure & Security	E	122	$80,719	**$107,625**	$134,531					
Business Systems Analyst II	IT Pop Health Enablement	E	123	$84,656	**$112,875**	$141,094					
Clinical Program Manager, Behavioral Health	Behavioral Health	E	123	$84,656	**$112,875**	$141,094					
Delegation Oversight Auditor III (Lead)	Compliance	E	123	$84,656	**$112,875**	$141,094					
Health Services Business Analyst	Health Services	-	123	$84,656	**$112,875**	$141,094					
Human Resources Business Partner II	Human Resources	E	123	$84,656	**$112,875**	$141,094					
RN Utilization Management, Part Time	Utilization Management	NE	123	$84,656	**$112,875**	$141,094	$ 40.70	$ 54.27	$ 67.83		
RN, Clinical Care Manager I	Care Management	E	123	$84,656	**$112,875**	$141,094					
RN, Quality Improvement I	Quality	E	123	$84,656	**$112,875**	$141,094					
RN, Utilization Management I	Utilization Management	E	123	$84,656	**$112,875**	$141,094					
RN, Utilization Management I	Utilization Management	E	123	$71,958	**$95,944**	$119,930					MO
Senior Clerk of the Board	Executive	E	123	$84,656	**$112,875**	$141,094					
Senior Financial Analyst	Finance	E	123	$84,656	**$112,875**	$141,094					
Senior Program Analyst	Policy & Program	E	123	$84,656	**$112,875**	$141,094					
Sr. Clerk of the Board	Executive	E	123	$84,656	**$112,875**	$141,094					
Wellness & Prevention Program Manager	Population Health	E	123	$84,656	**$112,875**	$141,094					
Clincal Care Manager, LCSW II (CM or UM)	Health Services	E	124	$88,594	**$118,125**	$147,656					
Human Resources Employee Experience Lead	Human Resources	E	124	$88,594	**$118,125**	$147,656					
Manager, Community Relations	Government Relations	E	124	$88,594	**$118,125**	$147,656					
Manager, Contact Center	Operations	E	124	$88,594	**$118,125**	$147,656					
Manager, Operations Support Services	IT Pop Health Enablement	E	124	$88,594	**$118,125**	$147,656					
RN, Quality Improvement II	Quality	E	124	$88,594	**$118,125**	$147,656					
Senior Decision Support Analyst	IT Data Warehouse	E	124	$88,594	**$118,125**	$147,656					
Senior IT Quality Control Analyst	Architecture & Testing	E	124	$88,594	**$118,125**	$147,656					
Senior Provider Reimbursement Analyst	Finance	E	124	$88,594	**$118,125**	$147,656					
Sr. Provider Reimbursement Analyst	Finance	E	124	$88,594	**$118,125**	$147,656					
Business Intelligence Developer	IT Pop Health Enablement	E	125	$92,531	**$123,375**	$154,219					
Developer II	IT Pop Health Enablement	E	125	$92,531	**$123,375**	$154,219					
Human Resources Business Partner III	Human Resources	E	125	$92,531	**$123,375**	$154,219					
Manager, Communications	Communications	E	125	$92,531	**$123,375**	$154,219					
Manager, Member Services	Member Services	E	125	$92,531	**$123,375**	$154,219					
Manager, Provider Network Operations - Program & Policy	Network Operations	E	125	$92,531	**$123,375**	$154,219					
Provider Network Operations - Program & Policy Manager	Policy & Program	E	125	$92,531	**$123,375**	$154,219					
Quality Improvement Program Manager I	Quality	E	125	$92,531	**$123,375**	$154,219					
RN, Clinical Care Manager II	Care Management	E	125	$92,531	**$123,375**	$154,219					
RN, Utilization Management II	Utilization Management	E	125	$87,904	**$117,206**	$146,508					WA
RN, Utilization Management II	Utilization Management	E	125	$85,708	**$111,038**	$138,797					AZ
RN, Utilization Management II	Utilization Management	E	125	$85,708	**$111,038**	$138,797					NM
RN, Utilization Management II	Utilization Management	E	125	$78,651	**$104,869**	$131,086					
RN, Utilization Management II	Utilization Management	E	125	$92,531	**$123,375**	$154,219					
Talent Acquisition Manager	Human Resources	E	125	$92,531	**$123,375**	$154,219					
Clincal Care Manager, LCSW III (CM or UM)	Health Services	E	126	$96,469	**$128,625**	$160,781					
Compliance Program Manager	Compliance	E	126	$96,469	**$128,625**	$160,781					
Implementation & Services Program Manager	Population Health	E	126	$96,469	**$128,625**	$160,781					
Project Manager II	Project Management Organization	E	126	$96,469	**$128,625**	$160,781					
RN, Delegation Oversight Auditor	Compliance	E	126	$96,469	**$128,625**	$160,781					
RN, Quality Improvement III	Quality	E	126	$96,469	**$128,625**	$160,781					
Senior Data Analyst	IT Data Warehouse	E	126	$96,469	**$128,625**	$160,781					
Senior Healthcare Data Analyst	Policy & Program	E	126	$96,469	**$128,625**	$160,781					
Senior Manager, Facilities	Facilities	E	126	$96,469	**$128,625**	$160,781					
Trainer, Health Services	Care Management	E	126	$96,469	**$128,625**	$160,781					
Business Intelligence Artchitect	IT Data Warehouse	E	127	$100,406	**$133,875**	$167,344					
Business Intelligence Lead	IT Data Warehouse	E	127	$100,406	**$133,875**	$167,344					
Clinical Compliance Program Manager	Compliance	E	127	$100,406	**$133,875**	$167,344					
Clinical Compliance Program Manager	Compliance	E	127	$90,365	**$120,488**	$150,610					MO
Community Supports Manager	Population Health	E	127	$100,406	**$133,875**	$167,344					
Delegation Oversight Program Manager	Compliance	E	127	$100,406	**$133,875**	$167,344					
Manager, Accounting and Finance	Finance	E	127	$100,406	**$133,875**	$167,344					
Manager, Behavioral Health	Behavioral Health	E	127	$100,406	**$133,875**	$167,344					
Manager, Behavioral Health	Behavioral Health	E	127	$90,365	**$120,488**	$150,610					TN
Manager, Change Control	Grievance and Appeals	E	127	$100,406	**$133,875**	$167,344					
Manager, Operations Analytics	Claims	E	127	$100,406	**$133,875**	$167,344					
Manager, Provider Contracting & Regulatory	Network Operations	E	127	$100,406	**$133,875**	$167,344					
Manager, Provider Relations	Network Operations	E	127	$100,406	**$133,875**	$167,344					
RN, Clinical Care Manager III	Care Management	E	127	$100,406	**$133,875**	$167,344					
RN, Utilization Management III	Utilization Management	E	127	$100,406	**$133,875**	$167,344					
Senior Business Systems Analyst	IT Pop Health Enablement	E	127	$100,406	**$133,875**	$167,344					
Senior Business Systems Analyst	IT Pop Health Enablement	E	127	$95,386	**$127,181**	$158,977					GA
Senior ETL DEV/Data Engineer	IT Data Warehouse	E	127	$100,406	**$133,875**	$167,344					
Test Automation Engineer	Architecture & Testing	E	127	$100,406	**$133,875**	$167,344					
Manager, Government Relations	Government Relations	E	128	$104,344	**$139,125**	$173,906					
Manager, Operations	Operations	E	128	$104,344	**$139,125**	$173,906					
Manager, Operations	Operations	E	128	$93,910	**$125,213**	$156,515					FL
Manager, Procurement Operations and Sourcing	Financial Planning & Analysis	E	128	$104,344	**$139,125**	$173,906					
Microsoft Cloud Collaboration & Systems Specialist	Infrastructure & Security	E	128	$104,344	**$139,125**	$173,906					
Quality Improvement Program Manager II	Quality	E	128	$104,344	**$139,125**	$173,906					
Senior Data Operations Engineer	IT Data Warehouse	E	128	$104,344	**$139,125**	$173,906					
Senior Data Operations Engineer	IT Data Warehouse	E	128	$93,910	**$125,213**	$156,515					FL
Senior ETL DEV/Data Engineer	IT Data Warehouse	E	128	$88,692	**$118,256**	$147,820					KY
Senior HEDIS Data Master	Quality	E	128	$104,344	**$139,125**	$173,906					
Database Administrator Architect	IT Data Warehouse	E	129	$110,250	**$147,000**	$183,750					
Internal Audit Manager	Compliance	E	129	$110,250	**$147,000**	$183,750					
Manager, Business Intelligence & Analytics	IT Data Warehouse	E	129	$110,250	**$147,000**	$183,750					
Manager, Clinical Care Management	Care Management	E	129	$110,250	**$147,000**	$183,750					

Manager, Quality Improvement	Quality	E	129	$110,250	**$147,000**	$183,750				
Manager, Utilization Management	Utilization Management	E	129	$110,250	**$147,000**	$183,750				
Senior Developer III	IT Pop Health Enablement	E	129	$110,250	**$147,000**	$183,750				
Senior Test Automation Engineer	Architecture & Testing	E	129	$110,250	**$147,000**	$183,750				
Clinical Pharmacist	Pharmacy	E	130	$118,125	**$157,500**	$196,875				
Data Information Architect	Architecture & Testing	E	130	$118,125	**$157,500**	$196,875				
EDI Manager	IT Pop Health Enablement	E	130	$118,125	**$157,500**	$196,875				
Incentive Strategy Manager	Health Services	E	130	$118,125	**$157,500**	$196,875				
Principal Data Analyst	IT Data Warehouse	E	130	$118,125	**$157,500**	$196,875				
Quality Improvement Program Manager III	Quality	E	130	$118,125	**$157,500**	$196,875				
Senior Analyst - Data Modeler	IT Data Warehouse	E	130	$118,125	**$157,500**	$196,875				
Senior Manager, Care Management & Special Programs	Health Services	E	130	$118,125	**$157,500**	$196,875				
Senior Manager, Communications and Marketing	Communications	E	130	$118,125	**$157,500**	$196,875				
Senior Manager, Financial Analysis	Finance	E	130	$118,125	**$157,500**	$196,875				
Senior Manager, Human Resources	Human Resources	E	130	$118,125	**$157,500**	$196,875				
Senior Manager, Medicare Financial Analysis	Finance	E	130	$118,125	**$157,500**	$196,875				
Senior Manager, Operations	Operations	E	130	$118,125	**$157,500**	$196,875				
Senior Manager, Operations Claims	Claims	E	130	$118,125	**$157,500**	$196,875				
Senior Manager, Operations Claims	Claims	E	130	$100,406	**$133,875**	$167,344				**KY**
Senior Manager, Population Health	Population Health	E	130	$118,125	**$157,500**	$196,875				
Senior Project Manager	Project Management Organization	E	130	$118,125	**$157,500**	$196,875				
Director, Health Education, C & L	Population Health	E	131	$126,000	**$168,000**	$210,000				
Manager, Information Security	Information Technology	E	131	$126,000	**$168,000**	$210,000				
Manager, Infrastructure and Operations	Infrastructure & Security	E	131	$126,000	**$168,000**	$210,000				
Manager, IT Business Solutions	IT Pop Health Enablement	E	131	$126,000	**$168,000**	$210,000				
Manager, PMO	Project Management Organization	E	131	$126,000	**$168,000**	$210,000				
Clinical Programs Pharmacist	Pharmacy	E	132	$133,875	**$178,500**	$223,125				
Director, Communications and Marketing	Communications	E	132	$133,875	**$178,500**	$223,125				
Director, DSNP	Executive	E	132	$133,875	**$178,500**	$223,125				
Principal Business Systems Analyst	IT Pop Health Enablement	E	132	$133,875	**$178,500**	$223,125				
Principal Project Manager	Project Management Organization	E	132	$133,875	**$178,500**	$223,125				
Senior Information Security Engineer	Infrastructure & Security	E	132	$133,875	**$178,500**	$223,125				
Senior Manager, HR Operations	Human Resources	E	132	$133,875	**$178,500**	$223,125				
Senior Manager, Strategic Planning & Talent	Human Resources	E	132	$133,875	**$178,500**	$223,125				**CA & WA**
Director Utilization Management	Health Services	E	133	$141,750	**$189,000**	$236,250				
Director, Behavioral Health & Social Services	Population Health	E	133	$141,750	**$189,000**	$236,250				
Director, Clinical Care Management	Health Services	E	133	$141,750	**$189,000**	$236,250				
Director, Contact Center	Operations	E	133	$141,750	**$189,000**	$236,250				
Director, Network Operations	Network Operations	E	133	$141,750	**$189,000**	$236,250				
Director, Quality Improvement	Health Services	E	133	$141,750	**$189,000**	$236,250				
Principal, Business Relationship Manager	Information Technology	E	133	$141,750	**$189,000**	$236,250				
Principal, Business Relationship Manager	Information Technology	E	133	$134,663	**$179,550**	$224,438				**VA**
Principal, Business Relationship Manager	Information Technology	E	133	$127,525	**$170,100**	$212,625				**MO**
Privacy Officer	Compliance	E	133	$141,750	**$189,000**	$236,250				
Procurement Officer	Financial Planning & Analysis	E	133	$141,750	**$189,000**	$236,250				
Senior Director, Health Education, C & L	Population Health	E	133	$141,750	**$189,000**	$236,250				
Senior Manager, Provider Network Operations - Program & Policy	Network Operations	E	133	$141,750	**$189,000**	$236,250				
Director, Strategy & Enterprise Analytics	IT Data Warehouse	E	134	$149,625	**$199,500**	$249,375				
Principal, Enterprise Architect	Architecture & Testing	E	134	$149,625	**$199,500**	$249,375				
Principal, Solution Architect	IT Pop Health Enablement	E	134	$149,625	**$199,500**	$249,375				
Director, Finance	Finance	E	135	$157,500	**$210,000**	$262,500				
Director, Infrastructure & Operations	IT Pop Health Enablement	E	135	$157,500	**$210,000**	$262,500				
Director, IT Business Solutions	IT Pop Health Enablement	E	135	$157,500	**$210,000**	$262,500				
Director, IT Business Solutions	IT Pop Health Enablement	E	135	$149,625	**$199,500**	$249,375				**OR**
Director, IT Data Warehouse	Information Technology	E	135	$157,500	**$210,000**	$262,500				
Director, IT Infrastructure and Security Operations	Information Technology	E	135	$157,500	**$210,000**	$262,500				
Director, Medical Informatics	Health Services	E	135	$157,500	**$210,000**	$262,500				
Director, Operations	Operations	E	135	$157,500	**$210,000**	$262,500				
Director, Portfolio and Project Management	Project Management Organization	E	135	$157,500	**$210,000**	$262,500				
Senior Director, Clinical Care Management	Health Services	E	135	$157,500	**$210,000**	$262,500				
Senior Director, Compliance	Compliance	E	135	$157,500	**$210,000**	$262,500				
Senior Director, Network Operations	Network Operations	E	135	$157,500	**$210,000**	$262,500				
Senior Director, Quality Improvement	Health Services	E	135	$157,500	**$210,000**	$262,500				
Senior Director, Utilization Management	Health Services	E	135	$157,500	**$210,000**	$262,500				
Director, Architecture	Information Technology	E	136	$173,250	**$231,000**	$288,750				
Director, Pharmacy	Pharmacy	E	136	$173,250	**$231,000**	$288,750				
Executive Director, Procurement/ Procurement Officer	Procurement	E	136	$173,250	**$231,000**	$288,750				
Senior Director, Finance	Finance	E	136	$173,250	**$231,000**	$288,750				
Senior Director, Human Resources	Human Resources	E	136	$173,250	**$231,000**	$288,750				
Senior Director, IT Data Engineering	Information Technology	E	136	$173,250	**$231,000**	$288,750				**WA**
Senior Director, Operations	Operations	E	136	$173,250	**$231,000**	$288,750				
Controller	Finance	E	137	$189,000	**$252,000**	$315,000				
Controller	Finance	E	137	$170,100	**$226,800**	$283,500				**FL**
Exec Director, Population Health and Equity	Population Health	E	137	$189,000	**$252,000**	$315,000				
Executive Director Strategy and External Affairs	Government Relations	E	137	$189,000	**$252,000**	$315,000				
Executive Director, IT	Information Technology	E	138	$204,750	**$273,000**	$341,250				
Executive Director, Operations	Operations	E	138	$204,750	**$273,000**	$341,250				
Senior Director, Human Resources & Organization Performance	Human Resources	E	138	$204,750	**$273,000**	$341,250				
Executive Director, Delivery System Operations & Strategies	Policy & Program	E	139	$220,500	**$294,000**	$367,500				
Chief Compliance Officer	Compliance	E	140	$236,250	**$315,000**	$393,750				
Chief, Human Resources & Organizational Performance Officer	Executive	E	141	$255,938	**$341,250**	$426,562				
Senior Medical Director	Health Services	E	141	$255,938	**$341,250**	$426,562				
Associate Chief Medical Officer	Executive	E	142	$275,625	**$367,500**	$459,375				
Chief Financial Officer	Executive	E	142	$275,625	**$367,500**	$459,375				
Chief Information Officer	Executive	E	142	$275,625	**$367,500**	$459,375				
Chief Innovation Officer	Executive	E	142	$275,625	**$367,500**	$459,375				
Chief Operating Officer	Executive	E	142	$275,625	**$367,500**	$459,375				
Chief Policy and Program Officer	Executive	E	143	$291,375	**$388,500**	$485,625				
Chief Medical Officer	Executive	E	144	$315,000	**$420,000**	$525,000				
Chief Executive Officer	Executive	E	145	$393,750	**$525,000**	$656,250				