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

Regular Meeting

Monday, January 31, 2022, 2:00 p.m.

Due to the public health emergency, the Community Room at Gold Coast Health Plan is currently closed to the public.

The meeting is being held virtually pursuant to AB 361.

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

Conference Call Number: 805-324-7279
Conference ID Number: 721 570 419#

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

Due to the declared state of emergency wherein social distancing measures have been imposed or recommended, this meeting is being held pursuant to AB 361.

AGENDA

CALL TO ORDER

OATH OF OFFICE

ROLL CALL

PUBLIC COMMENT

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

Persons wishing to address VCMMCC are limited to three (3) minutes unless the Chair of the Commission extends time for good cause shown. Comments regarding items not on the agenda must be within the subject matter jurisdiction of the Commission.

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

CONSENT

1. **Approval of Ventura County Medi-Cal Managed Care Regular Meeting Minutes of November 22, 2021 and December 16, 2021, and Special Meeting Minutes of January 10, 2022.**

   Staff: Deborah Munday, CMC, Assistant Clerk to the Commission

   RECOMMENDATION: Approve the Regular Meeting Minutes of November 22, 2021 and December 16, 2021, and Special Meeting Minutes of January 10, 2022.

2. **Adopt a Resolution to Renew Resolution No. 2022-01, to Extend the Duration of Authority Empowered in the CEO to issue Emergency Regulations and Take Action Related to the Outbreak of Coronavirus ("COVID-19")**

   Staff: Scott Campbell, General Counsel

   RECOMMENDATION: Adopt Resolution No. 2022-01 to extend the duration of authority empowered in the CEO through February 28, 2022.

3. **Findings to Continue to Hold Remote Teleconference/Virtual Commission Meetings Pursuant to Assembly Bill 361.**

   Staff: Scott Campbell, General Counsel

   RECOMMENDATION: It is recommended that the Commission adopt the findings to continue to meet remotely.

4. **Approval of Credentials / Peer Review Committee Members**

   Staff: Nancy Wharfield, M.D., Chief Medical Officer

   RECOMMENDATION: Approve Agustin "Jaime" Lara, M.D. and Allison Blaze, M.D. as active members of the Credentials / Peer Review Committee.

5. **Student Behavioral Health Incentive Program ("SBHIP")**

   Staff: Nancy Wharfield, M.D., Chief Medical Officer
   Lucy E. Marrero, MA LMFT CPHQ, Director, Behavioral Health and Social Programs

   RECOMMENDATION: Authorize GCHP participation in the Department of Health Care Services Student Behavioral Health Incentive Program.

FORMAL ACTION

6. Resolution 2022-002 in Recognition of Margaret Tatar

Staff: Nick Liguori, Chief Operating Officer

RECOMMENDATION: Staff requests the Commission approve Resolution 2022-002.

7. November / December 2021 Financials

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Staff requests that the Commission approve the November 2021 and December 2021 financial package.

STRATEGIC PLANNING SESSION

8. Review of Five-Year Proposed Strategic Plan

Staff: Marlen Torres, Executive Director of Strategy & External Affairs and GCHP Executive Team

RECOMMENDATION: Receive and file the proposed five-year strategic plan as presented.

CLOSED SESSION

9. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
Initiation of litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: One case.

ADJOURNMENT

Date and location of the next meeting to be determined at the January 31, 2022 meeting.

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 Commission 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 3 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: Deborah Munday, CMC, Assistant Clerk to the Commission

DATE: January 31, 2022

SUBJECT: Regular Meeting Minutes of November 22, 2021 and December 16, 2021, and Special Meeting Minutes of January 10, 2022

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of Regular Meeting Minutes of November 22, 2021, December 16, 2021, and Special Meeting Minutes of January 10, 2022.

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)
November 22, 2021
Regular Meeting Minutes

CALL TO ORDER

Commission Chair Dee Pupa called the meeting to order via teleconference at 2:05 p.m. The Clerks were in the Community Room located at Gold Coast Health Plan, 711 East Daily Drive, Camarillo, California.

ROLL CALL

Present: Commissioners Shawn Atin, Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Dee Pupa, Supervisor Carmen Ramirez, Jennifer Swenson and Scott Underwood, M.D.

Absent: Commissioners Antonio Alatorre and Gagan Pawar, M.D.

Attending the meeting for GCHP were Margaret Tatar, Chief Executive Officer, Nancy Wharfield, Chief Medical Officer, Kashina Bishop, Chief Financial Officer, Nick Liguori, Chief Operating Officer, Alan Torres, Chief Information Officer, Ted Bagley, Chief Diversity Officer, Robert Franco, Chief Compliance Officer, Michael Murguia, Executive Director, Human Resources, Scott Campbell, General Counsel, and Marlen Torres, Executive Director of Strategy and External Affairs.

Additional staff participating on the call: Susana Enriquez, Lupe Gonzalez, Nicole Kanter, Rachel Lambert, Jamie Louwerens, Olga Negrete, Adriana Sandoval-Jimenez, Anna Sproule, Kim Timmerman, David Tovar, Sandi Walker, Victoria Warner, Vicki Wrighster

PUBLIC COMMENT

No public comment

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Regular Meeting Minutes of October 25, 2021.

Staff: Deborah Munday, CMC, Assistant Clerk to the Commission

RECOMMENDATION: Approve the minutes of October 25, 2021.

2. AB 361, Brown Act Virtual Meetings

Staff: Scott Campbell, General Counsel

RECOMMENDATION: It is recommended that the following findings be made: The Commission has reconsidered the circumstances of the state of the emergency and finds the state of emergency continues to directly impact the ability of Commission members to meet safely in person and State and local officials continue to impose or recommend measures to promote social distancing.

3. Adoption of Schedule for 2022

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Approve calendar for 2022 to allow the Commission to continue virtual meetings pursuant to AB 361.

Supervisor Carmen Ramirez motioned to approve Items 1, 2 and 3. Commissioner Atin seconded.

Vote on Agenda Item 1.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Dr. Sevet Johnson, Dee Pupa, Supervisor Carmen Ramirez, Jennifer Swenson, and Scott Underwood, M.D.

NOES: None.

ABSTAIN: Commissioners Laura Espinosa and Andrew Lane

ABSENT: Commissioner Antonio Alatorre and Gagan Pawar, M.D.

Vote on Agenda Items 2 and 3.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Dee Pupa, Supervisor Carmen Ramirez, Jennifer Swenson, and Scott Underwood, M.D.

NOES: None.

ABSENT: Commissioner Antonio Alatorre and Gagan Pawar, M.D.

Commissioner Chair Pupa declared the motion carried.

Commissioner Gagan Pawar, M.D. joined the meeting at 2:55 p.m.

UPDATES

4. HSP MediTrac Update

Staff: Anna Sproule, Senior Director of Operations

RECOMMENDATION: Receive and file the update.

Anna Sproule, Senior Director of Operations stated in July 2021 there were 164,000 claims in inventory. As of November 22, 2021, there are approximately 10,000 claims in inventory. This inventory is expected to remain normalized. We were successful coming into compliance with Department of Health Care Services (DHCS) requests on the inventory on November 8, 2021.

The provider portal authorization updates were successfully put into production on November 15, 2021.

GCHP leadership is continuing to meet with Conduent daily to review inventory, call center statistics, and adherence to plans for improvement in both of those categories.

Commissioner Laura Espinosa motioned to approve Item 4. Commissioner Scott Underwood, M.D. seconded.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Supervisor Carmen Ramirez, Jennifer Swenson, and Scott Underwood, M.D.

NOES: None.

ABSENT: Commissioner Antonio Alatorre

Commissioner Chair Pupa declared the motion carried.

FORMAL ACTION

5. Contracting and Funding for Vaccine Outreach Initiative

Staff: Nancy Wharfield, M.D., Chief Medical Officer

RECOMMENDATION: GCHP recommends that the Commission give GCHP the authority to negotiate contracts with vendors in order to execute its plan to increase vaccination rates.

Chief Medical Officer, Nancy Wharfield, M.D., stated that DHCS reviewed the COVID-19 vaccination rates in the Medi-Cal population, and they were lower than the general population. There was approximately a 24% difference between the Medi-Cal population and the general population. The request is to increase vaccinations efforts for the Medi-Cal population. DHCS has put some funding behind the demand. GCHP complied with the request to submit a vaccination promotion plan. DHCS will support a $50 gift card member incentive, which amounts to $1.9M.

We are in the process of selecting a procurement vendor. About half of the $945K from the plan which was submitted would go to the vendors that will be doing letters, radio, and gift card fulfillment. The other half would go to the providers for incentives on a per shot basis per assigned member. We are requesting authority to execute contracts to support this effort and to ensure our Medi-Cal members receive at least one shot. There will be no fiscal impact to GCHP. The funds will come directly from DHCS to support this effort.

Commissioner Espinosa asked if the gift card incentive for a first vaccination is going forward from a certain date. CMO Wharfield stated that some gift cards are being given out now. The Community Outreach team has been working at the public health events. Commissioner Laura Espinosa asked how the names of people who received the vaccine in October 2021 will be known if they didn't attend one of the events. CMO Wharfield stated this has been a collaboration of data between DHCS, Public Health and the plans where there is a registry of members who have received their first COVID shot. It is called the Cares Registry and DHCS has organized with Public Health and the information is sorted and sent to the Plans.

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Supervisor Ramirez asked if we know how many members are vaccinated. CMO Wharfield stated we receive a file of vaccinated members. At the beginning of November 2021, just under 60% of members were vaccinated. Supervisor Ramirez asked if we were in communication with Public Health about this kind of gap and how to address it. CMO Wharfield stated we work very closely with the Public Health Department.

Commissioner Cho asked if the gift cards can be a way to incentivize our patients throughout the county to go to their primary care clinics to get the vaccine. CMO Wharfield stated that we want our members to go wherever is most convenient to receive the vaccine. Commissioner Cho asked if it is similar to other incentives where they fill something out to indicate they received their vaccine. CMO Wharfield stated a feed is received from the state through Public Health of members who have been vaccinated through the Care's Registry.

Commissioner Laura Espinosa motioned to approve Item 5. Commissioner Jennifer Swenson seconded.

AYES: Commissioners Shawn Atin, Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Supervisor Carmen Ramirez, Jennifer Swenson and Scott Underwood, M.D.

NOES: None.

ABSTAIN/
NO RESPONSE: Commissioner Theresa Cho, M.D.

ABSENT: Commissioner Antonio Alatorre

Commissioner Chair Pupa declared the motion carried.

6. October 2021 Financials

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Staff requests that the Commission approve the October 2021 financial package.

CFO Bishop presented the October financial statements. There was a gain of $6.7M which brings us to a fiscal year to date net gain of $23.1M. The Tangible Net Equity (TNE) is $128.9M and 346% of the required. Our Medical Loss Ratio is at 87.8% and Administrative Ratio is 5.3%.

The Solvency Action Plan (SAP) was reviewed. There has been a gain on meeting our target for TNE to be between 400 and 500%. We are currently at 346We received our rates for calendar year 2022, based on our medical expenses in calendar year 2019.

Net premium revenue is $333.9M, which is in line with budget. Revenue has been impacted by membership. We are currently at about 225,000 members and we budgeted that we would be about 236,000. Although membership continues to increase it hasn't increased to the extent that we had anticipated.

Our fiscal year to date health care costs is running at $293.1M. Medical Loss Ratio (MLR) is 87.8% a 4.4% budget variance.

We received good news this month since our system conversion, we relied upon a file that we used to make an estimate called the Incurred but Not Paid Expenses (IBNP). The next couple of months will still be challenging due to the historical lag between when a service is performed and when the claim is actually paid. There is still some uncertainty, and it impacts our reserves, but we have been able to use the file.

Overall medical expenses on a per member per month have remained stable. Our medical expenses in 2021 are still below what we experienced in 2019. As membership is rising, we are not seeing an increase in utilization up to the 2019 levels.

Long-Term Care was reviewed. There was a slight spike at the beginning of the fiscal year which was expected. Every year the State changes facility rates and we anticipate that the long-term care costs will go up each year.

Costs for outpatient expenses were very close to what we had estimated in the prior months. There was a bit of a spike in September and October.

There was a significant decrease in Emergency Room costs but over the last several months it is increasing.

Administrative Expenses are running at $17.7M fiscal year to date and that is about $4.5M and 20% under budget. The biggest driver is the Enterprise Project Portfolio (EPP) and that's about $1.9M of the budget variance. Salaries, Wages and Employee Benefits are close to $700,000 of the budget variance. Outside Services is mostly Conduent and it is paid on a per month per member basis. Because our membership is lower than projected, that constitutes a $1M difference in what we estimated for Conduent.

Commissioner Espinosa asked if it was possible to show the total number of GCHP members on the Mental and Behavioral Health slide who have access to services. CMO Wharfield stated this is generally a high-level view of that and we would look at our penetration rate for the mild to moderate services. We have Beacon as our service provider. We are slightly ahead of other plans, but our numbers are single digits, and we are in between 4% and 5%. Additional detail can be provided with breakdowns. Commissioner Johnson stated for County health plans we are looking at a comparison to other counties and believe their penetration rates would be compared to the other managed care plans in this state based on acuity

Commission Chair Pupa asked since there has been significant improvement in the TNE how would you weigh the impact of the reduced medical costs and our Solvency Action Plan. How much is attributable to the decrease in medical costs associated with COVID? CFO Bishop stated COVID has been significant and assigning a dollar amount to the increase in membership would be difficult.

Supervisor Ramirez motioned to approve Item 6. Commissioner Swenson seconded.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Supervisor Carmen Ramirez, Jennifer Swenson, and Scott Underwood, M.D.

NOES: None.

ABSENT: Commissioner Antonio Alatorre

Commissioner Chair Pupa declared the motion carried.

REPORTS

7. Chief Medical Officer (CMO) Report

Staff: Nancy Wharfield, M.D., Chief Medical Officer

RECOMMENDATION: Receive and file the report.

CMO Wharfield reviewed the Community Information Exchange (CIE) which is a platform for information exchange and where entities that work on social determinants of health care can share their information about the support they are providing to our members. This is real time, and it is a critical tool that provides services to our members going forward, especially in the California Advancing and Innovating Medi-Cal (CalAIM) mandates, as they are always mentioning wanting the

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development of infrastructure that includes health information exchange (HIE) and community information exchange (CIE) tools. This is being led by the Ventura County Health Improvement (VC CHIC). GCHP is now a founding member of that collaborative, and we serve on the CIE Board. Hopefully by the end of 2022 we should be able to launch the CIE.

The Student Behavioral Health Incentive Program (SBHIP) program will launch at the beginning of 2022. There is a strong collaboration between Ventura County Behavioral Health and the school systems. DHCS will now involve the plans as a payer source to facilitate this work and grow the existing infrastructure.

Utilization Management Network has secured a contract with Primary Medical Group in Oxnard for the administration of the drug Regen-COV. This is a monoclonal antibody treatment used for members who are at high risk for progression of severe COVID. Supervisor Ramirez stated that a few weeks ago she was contacted by Dr. Yu who is working to get the County a clinic for the monoclonal antibody treatment and there was a real issue with supply. CMO Wharfield stated the supply issue comes and goes; currently there is not a problem. Supervisor Ramirez stated this therapy is needed for people who are at high risk for progression, so there is a need to recognize and act quickly in the early stages of COVID. CMO Wharfield noted this is not a treatment for someone already in the hospital.

COVID related admissions were up to 649 members, which was reported to DHCS.

Pharmacy Hot Topics were reviewed by CMO Wharfield. Medi-Cal Rx will go live on January 1, 2022. GCHP has hit all intended marks for member and provider communications.

GCHP wants to minimize any disruption to members after the 180-day proactive time. The goal is to have providers do proactive submissions of any prior authorization requirements so care will not be disrupted. October 2021 was the last look we were able to do, and we believe anywhere between 10% to 15% of the medications that we cover may not be covered via Medi-Cal Rx. We reported this to DHCS and there is an ongoing analysis. DHCS will take this information and they are changing their formulary to ensure that they reduce any disruption.

A Quick Guide will be published with common medications that we think won’t be covered with suggestions of medication alternatives that will be covered by Medi-Cal Rx. If there isn’t an alternative, we will assist our providers to get insight into guidelines for prior authorization. We are trying to anticipate everything we can do to support our members and doctors.

8. Chief Operating Officer (COO) Report

Staff: Nick Liguori, Chief Operating Officer

<u>RECOMMENDATION:</u> Receive and file the report.

COO Liguori stated he is committed to providing the Commission with transparency on the operations of GCHP. A critical focus has been on Conduent operations and performance as well as operational activities across the health plan. COO Liguori added that his approach will be to build collaboration between the operational areas and all the functions of the organization.

We are working on creating the development of operational components of the five-year strategic plan with a critical focus on CalAIM.

The Call Center Dashboard was reviewed for October. The chart shows the volume of calls that were handled in October, the abandonment rate, which is the percent of calls dropped before a member spoke with a live representative, an industry standard is less than 5%. The average speed to answer a call to receive live help is less than 30 seconds. The volume of calls exceeded the call center's capacity to answer 85% of calls within 30 seconds and it was reported at 77.6%.

We are working with Conduent to ensure adequate staffing. There is an anticipated increase in calls for January 2022 due to the carve out of pharmacy benefits to Medi-Cal Rx and the rollout of the ECM and CS services.

Member Grievances and Member Clinical Appeals were reviewed. They are reported as part of Operations because of the intaking, handling and supporting of the grievances.

Performance is within industry norms for County Organized Health Systems (COHS) plans. The average rate of grievances is measured at a rate of 1,000 members and here at 0.19% is below the historical COHS average.

Member Satisfaction Initiatives were reviewed. When members contact us, place grievances, and when we survey them for their satisfaction and their experience, the insight we gain can assist us target what we call true satisfaction drivers. We will also expand our quality assurance and continuous call calibration, not just with Conduent, but wherever our members experienced service through the call center.

The AHP Plan-to-Plan Enrollment was reviewed. There has been a long collaboration between AHP and GCHP to develop this plan-to-plan pilot and with approvals from our regulators and the Commission. We went live with active

enrollment in November 2021. On September 24, 2021 notices were sent to approximately 71,000 GCHP member households, excluding administrative members, to inform them of the pilot and provide voluntary enrollment consent forms. Enrollment started on October 5, 2021. We are tracking disenrollment from AHP which means a member will return back to GCHP. Disenrollment through this period remains fairly small at 50.

The provider portal has been a priority for GCHP and our providers during the HSP implementation and our internal cross functional efforts have been extraordinary. The UM prior authorization team and the efforts of handling a labor intensive and manual authorization fax process, as well as being available to listen to and support providers as needed during the transition was great. User guides have been created for the portal training and webinars were held and all of these materials are available on the portal page of the GCHP website. The portal went live on November 15, 2021.

The provider network initiatives are very strict across strategic contracting and operational activities. The strategic activity is primarily aligned with CalAIM. Contracting has focused on ECM and CS services with our partners at the County and we are talking about the expansion in the community service and support realm. One of our other key community support partners, National Healthcare Foundation, will be supporting us and our members with recuperative care.

COO Liguori reviewed highlights for future reports, including trending and fulfillment, which is the delegated activity handled by Conduent to provide members and providers with notices and other physical printed materials. Encounters will look at accuracy, completeness, and timeliness. We will also report on the quality of the service provided to our members and provider call centers.

Commissioner Atin thanked COO Liguori for his report, which was clear, concise, and informative. Supervisor Ramirez thanked COO Liguori for his report, which was impressive. Commissioner Espinosa stated it was a great report, and the graphics were very understandable. Commissioner Espinosa added she has been on the Commission long enough to know what previous service levels were and she is attributing all of this to Conduent. Commission Chair Pupa stated she really appreciated the report as it has been many months since we have had a COO report. It is a critical report that we have been missing due to not having a COO.

9. Chief Information Officer (CIO) Report

Staff: Alan Torres, Chief Information Officer

RECOMMENDATION: Receive and file the report.

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CIO Torres stated he has completed all of his onboarding. A new associate, Kathleen Phillips, was hired and will be supporting the Health Services organization from a process perspective. CIO Torres said he is getting familiar with and digging into a lot of the key activities, from CalAIM to HIE.

From a technology perspective, we have a lot of good insights and how we see what type of investments we want to make within the organization over the next several years in conjunction with the five-year strategic plan. From a data perspective, we will be developing an understanding all of the data needs that we have within the organization, and what is driving the changes in the need for data. CalAIM is important, but there are other areas of focus within the data domain that we want to pay close attention to. Whether it's CalAIM or Dual Special Needs Plan (D-SNP), those activities are going to continue to make our landscape more diverse and intricate over time. We lack some balancing controls within the organization and how data flows across the organization.

CIO Torres discussed a 90-day plan. There are opportunities to get to the point where we begin to advance and modernize our capabilities. Regarding people, it is making sure that our organization is aligned correctly to deliver the work that is ahead of us, right staff, right roles, and succession training.

We do have an opportunity to look at a different way of how we choose to do work at GCHP. We look at agile adoption, which might be one mechanism on how we change the way work is being delivered at GCHP. This is something we are working closely with Nick Liguori and the rest of the executives to understand the needs. There is also a CIO scorecard, and this will be presented to this group in the future.

Technology capabilities were reviewed. First and foremost is really to understand the current footprint of the current landscape. There are some opportunities for road maps, a lot of areas we don't have road maps clearly defined and documented.

10. Executive Director of Human Resources (H.R.) Report

Staff: Michael Murguia, Executive Director of Human Resources

RECOMMENDATION: Receive and file the report.

We held our second virtual benefits fair on November 3 and 4, 2021. Last year was the first time we ever attempted an open enrollment process. The meetings went very well, and the break-out sessions were well attended.

We have a strategic plan in Human Resources with the overall goal of making GCHP

the best place to work and within that strategy there was a compensation and benefits focus. About six or seven months ago we started evaluating our benefits portfolio and did an evaluation of our benefit brokers. We looked at costs, and our objective was to drive more services and save costs.

We have been able to keep premiums at the same cost and lower deductibles for our employees for the fourth year in a row. We were also able to retain the majority of employees' physician networks.

We were able to add additional services like Clever Rx for prescription savings, enhanced Employee Assistance Programs available 24/7, a travel assistance program, a telemedicine mobile app with 24/7 service, increased disability benefits and increased dental coverage.

We completed open enrollment within two weeks. We were able to get 100% of everyone enrolled. Commissioner Atin stated he would like to review the plan design and costing, either in a different session or one on one, because with self-insured plans it is not year 1, it is years 2, 3 and 4 that are important; year 1 is based on actuarial assumptions. Mr. Murguia stated that is correct the first year is based on actual assumptions and it is what type of activity levels you have at the various benefit levels that push you in the second and third years. Commission Chair Pupa stated she would like to be included in the discussion.

There was one voluntary resignation within the last thirty (30) days. Our Facilities group does a great job in keeping our buildings in spectacular condition and making sure our employees are totally safe when they are in the office.

11. Chief Diversity Officer (CDO) Report

Staff: Ted Bagley, Chief Diversity Officer

RECOMMENDATION: Receive and file the report.

CDO Bagley reviewed Community Relations. This is an important part of the report and you will be hearing a lot about HEAC (County Health Equity Advisory Committee); Commissioner Espinosa and I both serve on this committee. It is important that the right people are selected for this committee and Commissioner Espinosa made it very clear to the group that it is vital that we have qualified people on this committee. It is important to have multicultural knowledge of the people on the committee.

Several requests have come to me about writing job descriptions for a diversity person. The latest was the Ventura Community College District.

There have been no new case investigations. The importance of this is managers and supervisors are doing the right thing to ensure we respond in a timely manner to cases. CDO Bagley stated he is proud of how those issues are being handled, both from a HR standpoint as well as from a senior team standpoint.

The Diversity, Equity and Inclusion team has been challenged to look at our plan's values, mission, and vision. This is an important area to periodically review to ensure we are on point.

CDO Bagley reviewed the calls and contacts from employees, including Lunch-n-Learn, Health Equity, Career Counseling, Diversity Discussions and Opportunities.

Along with Human Resources, we are continuing to work on a strategy to return people to work in the office. The Diversity Committee is celebrating and recognizing cultures every month that make up the GCHP.

Commissioner Atin thanked Mr. Bagley and expressed his appreciation.

12. Chief Executive Officer (CEO) Report

Staff: Margaret Tatar, Chief Executive Officer

RECOMMENDATION: Receive and file the report.

CEO Tatar stated she was proud to bring to the Commission two new exemplary members of our executive team, Nick Liguori, Chief Operating Officer and Alan Torres, Chief Information Officer.

The Legislative Analyst's Office is predicting a budget surplus in 2022 of $31B. The governor's budget will be published January 10, 2022.

CalAIM reflects the governor's proposal to Centers for Medicare and Medicaid Services (CMS) for the five-year waiver pursuant to which Medicaid will be operating for the years 2022 through 2026. We are fairly confident that the CalAIM proposal has been promulgated and will likely be approved by CMS. CalAIM seeks to transform Medi-Cal managed care and to ensure that all the plans be ready by a date certain in the future to offer Medicare D-SNP benefits. It also seeks to have the plans all be Knox Keene licensed and to ensure all of the plans meet accreditation standards. It also seeks to ensure all of the plans meet accreditation standards by the National Committee on Quality Assurance (NCQA).

CEO Tatar reviewed the latest in connection with state, federal and local guidance that would impact our program. There is a significant amount of guidance coming from DHCS related to CalAIM. We anticipate approval of the CalAIM waiver proposal by the end of December 2021.

January 2022 marks the effective date of the Medi-Cal pharmacy transition, moving the pharmacy benefit from the plans to the State.

Commission Chair Pupa thanked CEO Tatar for adding a column for AHP enrollment and asked to have total enrollment column added. CEO Tatar said it would be added. Commission Chair Pupa asked about the change in numbers for Admin members from July 2021 to August 2021. COO Ligouri stated he would have to look into that and speak with Anna Sproule, who may be able to get some technical details.

Commission Chair Pupa thanked everyone for their reports and the time spent in preparation.

Commissioner Espinosa motioned to approve Items 7-12. Commissioner Swenson seconded.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Dee Pupa, Supervisor Carmen Ramirez, and Jennifer Swenson

NOES: None.

ABSTAIN/
NO RESPONSE: Commissioners Gagan Pawar, M.D. and Scott Underwood, M.D.

ABSENT: Commissioner Antonio Alatorre

Commissioner Chair Pupa declared the motion carried.

The meeting adjourned to Closed Session at 3:57 pm.

CLOSED SESSION

13. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
Initiation of litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: One case.

14. PUBLIC EMPLOYEE APPOINTMENT
Title: Chief Executive Officer

15. CONFERENCE WITH LABOR NEGOTIATORS
Agency Designated Representative: Michael Murguia
Unrepresented Employee: Chief Executive Officer

ADJOURNMENT

General Counsel, Scott Campbell stated there was no reportable action in Closed Session. The meeting was adjourned at 5:29 p.m.

Approved:

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Deborah Munday, CMC
Assistant Clerk to the Commission

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)
December 16, 2021
Strategic Planning Retreat Minutes

CALL TO ORDER

Commission Chair Dee Pupa called the meeting to order via teleconference at 2:06 p.m. The Assistant Clerk was in the Community Room located at Gold Coast Health Plan, 711 East Daily Drive, Camarillo, CA 93010.

ROLL CALL

Present: Commissioners Shawn Atin, Theresa Cho, M.D., Andrew Lane, Gagan Pawar, M.D., Dee Pupa and Scott Underwood, M.D.

Absent: Commissioners Antonio Alatorre, Laura Espinosa, Supervisor Carmen Ramirez, and Jennifer Swenson.

Commissioners Antonio Alatorre, Laura Espinosa, Supervisor Carmen Ramirez, and Jennifer Swenson were not present at roll call.

Attending the meeting for GCHP were Margaret Tater, Chief Executive Officer, Nancy Wharfield, M.D., Chief Medical Officer, Nick Liguori, Chief Operating Officer, Alan Torres, Chief Information Officer, Kashina Bishop, Chief Financial Officer, Ted Bagley, Chief Diversity Officer, Robert Franco, Chief Compliance Officer, Marlen Torres, Executive Director of Strategy & External Affairs, Michel Murguia, Executive Director of Human Resources, Scott Campbell, General Counsel, and Cathy Salenko, Health Care General Counsel.

Additional staff participating on the call: Anna Sproule, Michael Maestaz, Veronica Estrada, Adriana Sandoval-Jimenez, David Tovar, Victoria Warner, Vicki Wrighster, Pauline Preciado, Rachel Lambert, Nicole Kanter, Lupe Gonzalez, Lucy Marrero, Kim Timmerman, Anne Freese, Eileen Moscaritolo, and Susana Enriquez.

PUBLIC COMMENT

None.

Commissioner Jennifer Swenson joined the meeting.

CONSENT

1. **Adopt a Resolution to Renew Resolution No. 2021-013, to Extend the Duration of Authority Empowered in the CEO to issue Emergency Regulations and Take Action Related to the Outbreak of Coronavirus (“COVID-19”).**

   Staff: Scott Campbell, General Counsel

   RECOMMENDATION: Adopt Resolution No. 2021-014 to extend the duration of authority empowered in the CEO through January 31, 2022.

2. **Findings to Continue to Hold Remote Teleconference/Virtual Commission Meetings Pursuant to Assembly Bill 361.**

   Staff: Scott Campbell, General Counsel

   RECOMMENDATION: It is recommended that the Commission adopt the findings to continue to meet remotely.

Commissioner Shawn Atin moved to approve consent items 1 and 2. Commissioner Theresa Cho, M.D. seconded.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson.

NOES: None.

NO RESPOSE: Commissioner Scott Underwood, M.D.

ABSENT: Commissioners Antonio Alatorre, Laura Espinosa, and Supervisor Carmen Ramirez.

Commissioner Pupa declared the motion carried.

3. **Approval of an Employment Agreement for Nick Liguori to Serve as Chief Executive Officer and Approval of Expenditures for Additional Services for Health Management Associates.**

   Staff: Scott Campbell, General Counsel

   RECOMMENDATION: It is recommended that the Commission authorize:

   1. The approval of the employment agreement between Gold Coast Health Plan and Nick Liguori so that Mr. Liguori can begin his term as Chief Executive Officer of the Gold Coast Health Plan effective February 1, 2022.

2. Authorize the CEO to spend up to $100,000 in services from Health Management Associates during the time GCHP is without a COO and during the period of implementation of the CalAIM initiative and resolution of Conduent performance issues.

Michael Murguia, Executive Director of Human Resources, summarized the employment agreement and expenditures for Nick Liguori as new Chief Executive Officer effective February 1, 2022. Mr. Liguori has been serving as the Chief Operating Officer and has been promoted as the Chief Executive Officer as the HMA contract will expire in January 2022. The employment proposal includes a competitive annual base salary of $450,000 with a 20% performance bonus measured by the commission over three years. Mr. Liguori is requesting a budget of $100,000 to use at his discretion. Chair Pupa asked if there was a cost-of-living adjustment (COLA) agreement. General Counsel, Scott Campbell said there is no COLA increase and Mr. Liguori is fine with that.

Commissioner Shawn Atin moved to approve agenda item 3. Commissioner Chair Dee Pupa seconded.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson and Scott Underwood, M.D.

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Laura Espinosa, and Supervisor Carmen Ramirez.

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Commissioner Antonio Alatorre and Supervisor Carmen Ramirez joined the meeting.

Mr. Liguori expressed his gratitude for the responsibility entrusted in him and looks forward to working in partnership with the Commissioners. Supervisor Ramirez stated that she congratulates everyone and looks forward to working with Mr. Liguori.

Motion carried.

STRATEGIC PLANNING SESSION

4. Strategic Planning Themes

Marlen Torres, Executive Director, Strategy and External Affairs, voiced her excitement to present the first part of the strategic plan. Ms. Torres thanked the Commission on behalf of the executive team and the Strategic Planning Ad Hoc Committee members, Commissioners Antonio Alatorre, Dee Pupa and Jennifer Swenson for meeting over the last several months, providing feedback and being open to the new approach. Ms. Torres thanked CEO Margaret Tarter for her guidance.

Ms. Torres reviewed the agenda for the presentation:

- Landscape for 2022-2026.
- Major Medi-Cal Care Program Changes that include timeliness, GCHP impacts, and policy and programmatic themes.
- Strategic planning process.
- Budget forecasting led by the Chief Financial Officer, Kashina Bishop.
- Quarterly reporting to the commission.
- Overall strategic plan theme and objectives presented by the executive team.

Ms. Torres stated the presentation will share major policy themes around the California Advancing and Innovating Medi-Cal (CalAIM) initiatives and priorities, and the impact on the organization by each department's viewpoint.

Ms. Torres highlighted the landscape drivers which include the importance of the waiver tied to CalAIM. Major initiatives like enhanced care management and community supports will begin in 2022. The work throughout the next five years will be tied to CalAIM. There will be an increase to federal stimulus funding due to the pandemic, although a deficit in the State's budget was anticipated. Several programs received federal funding that are very similar to enhanced care management and community supports.

Ms. Torres emphasized that there will be a two-part program for the strategic plan. There will be a setting the stage discussion over the next two hours. The next part of the strategic plan will include details of the 5-year plan and specifically looking at the 1-year plan tied to FY 2022-2023 budget. On January 31, 2022, commissioners will hear from directors who have been leading this work.

Commissioner Laura Espinosa joined the meeting.

Ms. Torres reviewed the timeline of the Medi-Cal program changes which include Enhanced Care Management / Community Supports (ECM/CS), National Committee for Quality Assurance (NCQA), Dual Special Needs Plan (D-SNP), and Medi-Cal Rx. Medi-Cal Rx is scheduled to go live January 1, 2022. Preparation of becoming Knox Keene licensed will be led by Robert Franco, Chief Compliance Officer. Alan Torres, Chief Information Officer will be going through the importance of information technology, interoperability, and data warehouse and their themes.

Ms. Torres reviewed major policy and programmatic issues and themes focused on the implications to GCHP. The implementation of D-SNP will bring multiple regulators to the plan, Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and Children's Medical Services (CMS). Ted Bagley, Chief Diversity Officer, will continue his work in diversity, equity, and inclusion coupling with health equity. Financial analysis will take place around the Knox Keene licensure and forecasting for CalAIM and D-SNP. Data modernization will include health and community information. There will be a contracting

model that includes provider strategy. A needs assessment will be conducted for Medi-Cal beneficiaries to understand how to serve this population. Member and community strategy will be implemented.

5. Process for Strategic Planning, Budget, and Quarterly Reporting

Ms. Torres reviewed the strategic planning process including, planning, budget, and commission reporting. Community input on the strategic plan will be obtained through Provider Advisory Committee (PAC) and Community Advisory Committee (CAC). The strategic plan will inform the FY 2022-2023 budget. Reporting will be conducted on a quarterly basis to the commission.

Ms. Torres reviewed the strategic plan timeline. The strategic planning began in December 2021 with the strategic planning ad hoc committee. In January 2022, there will be a 1-year breakdown of the strategic plan. GCHP will seek approval of the strategic plan in February 2022. Quarterly reporting to the commission will begin in March 2022.

6. Strategic Plan Overview

Kashina Bishop, Chief Financial Officer reviewed the financial strategy for the 5-year strategic plan. CFO Bishop voiced her excitement around the changes to Medi-Cal managed care programs. She noted that the changes bring significant financial risk. The plan enters these changes at a financial deficit. There is catching up to do financially and within the infrastructure. Tangible Net Equity (TNE) will be met in the near term and the focus will be on protecting it in the midst of increased risk. Major risks include investing in people, processes, and technology. These investments need to be made to protect the plan from even greater financial risk. At the same time, there is provider rate increase demand, new program regulators, and revenue uncertainty. In 2023, uncertainty on Medi-Cal rates and membership may affect the plan financially. CFO Bishop noted that change to regional rates can significantly impact the plan.

CFO Bishop discussed strategies to mitigate financial risk. These include, maximizing available incentives, comprehensive financial analysis and forecasting, continued development of internal controls, strategic investments, and oversight and monitoring of programs.

CFO Bishop reviewed financial milestones for 2022. There will be maintenance and adherence of the solvency action plan, primary care provider (PCP) rate analysis, financial analysis around Knox-Keene licensure, and monitoring of the AmericasHealth Plan (AHP)-GCHP's plan-to-plan model.

Robert Franco, Chief Compliance Officer reviewed the compliance strategy. Focus will be on building a culture of compliance. Internal controls will be placed to mitigate risks associated to regulation changes. Oversight and monitoring will be put in place to control operational

activities and remain in compliance with regulators. There will be monitoring of control processes related to auditing.

CCO Franco provided and overview of compliance milestones for 2022. Submission of the Knox-Keene application will be the focus in 2022. Followed by developing the staffing model for D-SNP. D-SNP brings new regulators and new ways of reporting. A compliance program and team will be developed for the current and upcoming lines of business.

Nick Liguori, Chief Operations Officer expressed his gratitude to commissioners for their participation in the strategic planning.

Nancy Wharfield, Chief Medical Officer reviewed the clinical strategy. There will be increased expectations and demands from new regulators. This includes new turnaround times for utilization review and a new technology platform. There will be new programs and new ways to satisfy requirements. This means working with providers to make sure they are well positioned to deliver the new opportunities. Focus is on meeting the program goals while staying innovative. These activities are seeded on population health, the measuring of population outcomes. This looks at health disparities, language, and geographic area to measure health outcomes. Technology is required to conduct risk analysis on members and predictive analytics.

All these analytic tools are required to exchange data with providers and health information exchange with members. Community Health Exchange has begun in the community.
All these technologies will help health care outcomes move forward.

CMO Wharfield provided an overview of the health services strategy timeline. Whole Person Care Program is transitioning to Enhanced Care Management. New populations of focus are introduced now. These include high utilizers, homeless, serious mental illness, substance use disorder, and justice involved populations. Next will come long-term care, those at risk of institutionalization, and those who want to transition from a skilled nursing facility to the community. In 2024, all other children and youth populations will transition. There is a suite of community supports available to members. Every 6 months a new community support will be added. D-SNP will bring new requirements like a new a pharmacy benefits manager (PMB). Behavior Health efforts will begin next year. AHP performance data will be evaluated to report health outcomes.

Alan Torres, Chief Information Officer reviewed information technology (IT) and data strategies. The primary focus is data and will continue to push the plan forward to the future. Data will be evaluated by looking at the timeliness, accuracy, and how easy is to understand. Analysis of internal infrastructure will be conducted to make investments and be ready for the future. CIO Torres stated that there will be leveraging of technologies that don't exist currently. These include artificial intelligence, real-time architecture, and cloud computing. Staffing and training will be required for the technologies coming. Population health management is a key capability that must be supported with technology.

CIO Torres discussed the strategic plan for IT. There is a necessity to modernize data capabilities. This will allow for a population health platform and a foundation to support regulatory capabilities. Building a Health Information Exchange platform will allow the sharing of information with providers and constituents. Analysis will be conducted on Conduent (core admin platform) to bring operational efficiencies.
CIO Torres reviewed the digital transportation of technology for the plan. This begins with IT processes and oversight while upgrading the infrastructure. Followed by supporting regulatory changes and increase in operational excellence. Lastly, moving from a reactive state to a proactive state with predictive analytics and enabling real-time capabilities.

Nick Liguori, Chief Operating Officer thanked CEO Margaret Tatar for her vision in operations.

Nick Liguori, Chief Operating Officer reviewed operations and community engagement strategies. COO Liguori stated that it is imperative that GCHP improves in claims processing and provider responsiveness. New programs will bring new provider types and new lines of business that brings new risks. New Provider types include community-based organization that will contract with GCHP to implement CalAIM. GCHP will find new ways to engage with stakeholders to collaborate across the community. Community engagement will bring new population in to managed care like justice involve and foster care individuals.

COO Liguori reviewed key areas of the operations and community engagement strategic plan. New benefits are coming on July 2022. Medi-Cal contracting is coming that will identify the structure for new managed care. Entering the Medicare business line will require new policies and strategies that must be operationalized. Priorities today include Enhanced Care Management and Community Supports. In three years, other new benefits will come, and preparedness now is key.

COO Liguori discussed CalAIM legal issues. These include integration of justice-involved, foster-care, students, and other new population groups into managed care. There will be contracting challenges with new providers. New quality standards pose a challenge as they require new accreditations. Payment mechanisms will include an increased use of value-based purchasing models. COO Liguori stated that to face these challenges and be successful, financial issues and compliance issues need to be address. COO Liguori reviewed licensure and accreditation and noted that they will be different and significant. COO Liguori stated that new applications will need to be learned and policies and procedures will need to be updated to satisfy new standards. Communication with regulatory authorities will be required.

Supervisor Carmen Ramirez asked if there is an assessment of staff capabilities. COO Liguori stated that the creation of the budget will include this recommendation. CDO Bagley stated that there has been a discussion with Mr. Murguia around the need of upsize in staffing and eliminating stagnation in jobs.

Ted Bagley, Chief Diversity Officer reviewed workforce and diversity, equity, and inclusion strategy. There is critical need to invest in people, processes, and technology. Promoting diversity, equity, and inclusion (DEI) and accountability is required. Fulfillment of CalAIM goals to reduce disparities and bias will be a big part of the organization strategy. CDO Bagley noted that it is not enough to identify disparities. The next step will need to include solutions for the identified disparities. Staffing needs to be in accordance with the work for the members. There needs to be a robust discussion around proper staffing. CDO Bagley noted that the platforms of staffing and the platform of treating people equally needs to be looked at. He emphasized accountability throughout the organization.

CDO Bagley thanked Ms. Torres for the help she has given him and putting a lot of these charts together.

CDO Bagley provided an overview of DEI. The primary focus is completing the core values to make sure the values are strong. The DEI conference will include County representation and other plans to get ideas. Community representation will be present at the conference. More training will occur on bias and generation impact on organizations and microaggression. Health Equity and DEI will be combined. Assessments will be conducted with stakeholders for health equity and for social determinants of health. A health equity subcommittee will be established to review health equity initiatives.

Michel Murguia, Executive Director of Human Resources reviewed the strategic plan for workforce. The overall strategy is to attract, develop, and retain GCHP employees. There has been work around benchmarking compensation impacting about 50 employees and adjusting their job descriptions. Compensation and Benefits analysis will continue in the next several years. The return to office strategy will be ongoing. There is an out of state policy that has been drafted and he would like it to be adopted. Another area of focus will be around performance reviews and manager development. There will be a new employee survey committee and a new survey in 2022. Recruitment strategy includes working with a partner recruitment firm to re-engineer the recruitment process. Managers will be taught how to recruit and how to onboard new employees.

Commissioner Shawn Atin stated that he is following with great interest the work of Mr. Murguia and CDO Bagley and congratulated their great work.

7. Conclusion and Next Steps

COO Liguori expressed his appreciation of the partnership between the Commission and Gold Coast Health Plan team.

CEO Tater thanked the Commission.

Commission Chair Dee Pupa expressed her appreciation to the entire executive team.

CDO Bagley thanked Commission Chair Pupa for being part of the GCHP holiday celebration.

COMMENTS FROM COMMISSIONERS

None.

The Commission moved to Closed Session at 3:32 p.m.

CLOSED SESSION

8. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION:
Initiation of litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: One case.

9. REPORT INVOLVING TRADE SECRET:
Discussion will concern: Proposed new service and program
Estimated date of public disclosure: Second half of 2024

10. PUBLIC EMPLOYEE APPOINTMENT:
Title: Chief Operating Officer

ADJOURNMENT

Scott Campbell, General Counsel, BBK, stated there was no reportable action in Closed Session.

The meeting adjourned at 4:48 p.m.

Approved:

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Deborah Munday, CMC
Assistant Clerk to the Commission

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)
January 10, 2022
Special Meeting via Teleconference

CALL TO ORDER

Commission Chair Dee Pupa called the meeting to order via teleconference at 2:01 p.m.

ROLL CALL

Present: Commissioners Shawn Atin, Theresa Cho, M.D., Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Supervisor Carmen Ramirez, and Jennifer Swenson

Absent: Commissioners Antonio Alatorre, Laura Espinosa, and Scott Underwood, M.D.

Attending the meeting for GCHP were Margaret Tatar, Chief Executive Officer, Nick Ligouri, Chief Operating Officer, Alan Torres, Chief Information Officer, Robert Franco, Chief Compliance Officer, Michael Murguia, Executive Director of Human Resources, and Scott Campbell, General Counsel.

Additional staff participating on the call: Paula Cabral, Susana Enriquez, Veronica Estrada, Monica Gonzales and Anna Sproule.

PUBLIC COMMENT

None.

CONSENT

1. Findings to Continue to Hold Remote Teleconference/Virtual Commission Meetings Pursuant to Assembly Bill 361.

Staff: Scott Campbell, General Counsel

RECOMMENDATION: It is recommended that the Commission adopt the findings to continue to meet remotely.

Commissioner Pupa motioned to approve Consent item 1. Commissioner Swenson seconded.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Supervisor Carmen Ramirez, and Jennifer Swenson

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Laura Espinosa, and Scott Underwood, M.D.

Committee Chair Pupa declared the motion carried.

ADJOURNMENT

Commission Chair Dee Pupa adjourned the meeting at 2:04 pm

Approved:

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Deborah Munday, CMC
Assistant Clerk to the Commission

Gold Coast Health Plan[SM]
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: January 31, 2022

SUBJECT: Adopt a Resolution to Renew Resolution No. 2021-014, to Extend the Duration of Authority Empowered in the CEO to issue Emergency Regulations and Take Action Related to the Outbreak of Coronavirus ("COVID-19")

SUMMARY:

Adopt Resolution No. 2022-001-to:

1. Extend the duration of authority granted to the CEO to issue emergency regulations and take action related to the outbreak of COVID-19.

BACKGROUND/DISCUSSION:

COVID-19, which originated in Wuhan City, Hubei Provence, China in December, 2019, has resulted in an outbreak of respiratory illness causing symptoms of fever, coughing, and shortness of breath. Reported cases of COVID-19 have ranged from very mild to severe, including illness resulting in death. To combat the spread of the disease Governor Newsom declared a State of Emergency on March 4, 2020. The State of Emergency adopted pursuant to the California Emergency Services Act, put into place additional resources and made directives meant to supplement local action in dealing with the crisis.

In the short period of time following the Governor's proclamation, COVID-19 spread rapidly through California necessitating more stringent action. On March 19, 2020, Governor Newsom issued Executive Order N-33-20 (commonly known as "Safer at Home") ordering all residents to stay at home to slow the spread of COVID-19, except as needed to maintain continuity of operation of the federal critical infrastructure sectors. The following day, the Ventura County Health Officer issued a County-wide "Stay Well at Home", order, requiring all County residents to stay in their places of residence subject to certain exemptions set forth in the order.

Prompted by the increase of reported cases and deaths associated with COVID-19, the Commission adopted Resolution No. 2020-001 declaring a local emergency and empowering the Chief Executive Officer ("CEO") with the authority to issue emergency rules and regulations to protect the health of Plan's members, staff and providers. Specifically, section (2) of Resolution No. 2020-001 describes the emergency powers delegated to the CEO which

include, but are not limited to: entering into agreements on behalf of the Plan, making and implementing personnel or other decisions, to take all actions necessary to obtain Federal and State emergency assistance, and implement preventive measures to preserve Plan activities and protect the health of Plan's members, staff and providers.

Normally under Government Code Section 8630, the Commission must review the need for continuing the local emergency once every sixty (60) days until the local governing body terminates the local emergency. However, under Governor Newsom's March 4, 2020, State of Emergency proclamation, that 60 day time period in section 8630 is waived for the duration of the statewide emergency. Pursuant to Resolution No. 2020-001, the Plan's Local Emergency proclamation and emergency authority vested in the CEO expired on April 27, 2020.

On April 27, 2020, the Commission adopted Resolution No. 2020-002 to renew Resolution No. 2020-001 to: (1) reiterate and renew the Plan's declaration of a Local Emergency through the duration of the Governor's State of Emergency proclamation or when the Commission terminates its declaration of Local Emergency, whichever occurs last; and (2) to extend the duration of authority empowered in the CEO to issue emergency regulations and take action. Resolution No. 2020-002 expired on May 18, 2020.

On May 18, 2020, the Commission adopted Resolution No. 2020-003 to renew and reiterate the enumerated powers granted to the CEO in Resolution No. 2020-002 above, and to: (1) authorize the CEO, with the advice counsel, to implement a staggered return to work program for Plan personnel; and (2) extend the duration of authority empowered in the CEO to issue emergency regulations and take action. Resolution No. 2020-003 expired on June 22, 2020.

Since the adoption of Resolution No. 2020-003, the Commission has renewed and reiterated the emergency powers granted to the CEO on July 27, 2020, August 24, 2020, September 28, 2020, October 26, 2020, January 25, 2021, February 22, 2021, March 22, 2021, April 26, 2021, June 28, 2021, July 26, 2021, August 23, 2021, September 27, 2021, October 25, 2021 and more recently by adopting Resolution No. 2021-014 on December 16, 2021. Resolution No. 2021-014 expires today, January 31, 2022.

COVID-19 continues to present an imminent threat to the health and safety of Plan personnel. Although vaccines are now widely available, many people in the State and County are still not fully vaccinated and remain susceptible to infection. As of January 4, 2022, 71.3% of the state's *eligible* population (persons age 5 and older) are *fully vaccinated.* Also, as of January 5, 2022, 72.1% of the County's *eligible* population (persons age 5 and older) are *fully vaccinated*. Although, vaccination rates are increasing, and the vaccine is now available to persons as young as five, the disease can still spread rapidly through person-to-person contact and those in close proximity. Further, more contagious variants of the disease are now present in the State and County, the most predominant of which is the Omicron variant. However, other variants such as the Delta variant, continues to exist in the State and County.

While the State's economy has reopened the COVID-19 pandemic continues to loom. State and local officials, including the public health community are continuing to enforce rules and regulations and explore ways to stymie the spread of the disease. An example of this is the FDA's authorization of booster shots, emergency use authorization of the Pfizer vaccine for persons as young as five, and the growing number of public agencies from all levels of government and private businesses that are implementing COVID-19 vaccination mandates.

VCPH is strongly urging all County residents that are eligible but have not yet been fully vaccinated to get vaccinated as soon as possible. The County is aligned with the California Department of Public Health and the Center for Disease Control and Prevention guidance on mask wearing, which recommends that everyone regardless of vaccination status wear masks indoors. The County Public Health Officer recently issued a health officer order, extending its mask regulations until: (1) the County reached the moderate yellow tier, (2) COVID-19 hospitalizations in the County are low and stable in the judgment of the County Health Officer; and (3) 8 weeks shave passed since a COVID-19 vaccine has been authorized for emergency use by federal and state authorities for 5 to 11 year olds or 80% of the County's total eligible population is fully vaccinated with two doses of Pfizer or Moderna or one dose of Johnson & Johnson; OR until the order is extend, rescinded or superseded by the County Health Officer. Additionally, the State and County are currently experiencing a surge of COVID-19 confirmed cases, which according to public health officials is fueled by the rising cases of the Omicron variant. As a precautionary measure, the County has announced that commencing January 5, 2022, it will temporarily close County buildings to members of the public for a period of three weeks.

Additionally, Cal/OSHA released revised rules for workplaces, which became effective immediately pursuant to Executive Order N-09-21 issued by Governor Newsom on June 17, 2021. Among other updates, Cal/OSHA's revisions align with the latest guidance from CDPH based on guidelines issued by the CDC. The Plan's CEO and Human Resources Director are evaluating how this will impact the Plan's back to work plans and will provide an update to the Commission.

This resolution will continue to empower the CEO with the authority to issue orders and regulations necessary to prevent the further spread of the disease and protect the health and safety of Plan members and staff through February 28, 2022, the next regularly scheduled Commission meeting. The intent of this resolution is to balance the ability to continue the safe and efficient operations of the Plan during the global health pandemic. As State and County health orders evolve, the Plan's response should also evolve. Measures adopted to reduce the spread of COVID-19 amongst Commission staff may be rescinded when they are no longer needed in response to the pandemic. Pursuant to Resolution No. 2020-002, the Plan's Local Emergency proclamation shall remain effective through the duration of the Governor's State of Emergency proclamation or when the Commission terminates its declaration of Local Emergency, whichever occurs last.

FISCAL IMPACT:

None.

RECOMMENDATION:

1. Adopt Resolution No. 2022-001 to extend the duration of authority empowered in the CEO through February 28, 2022.

ATTACHMENT:

1. Resolution No. 2022-001.

RESOLUTION NO.2022-001

A RESOLUTION OF THE VENTURA COUNTY MEDICAL MANAGED CARE COMMISSION, DOING BUSINESS AS THE GOLD COAST HEALTH PLAN ("PLAN"), TO RENEW AND RESTATE RESOLUTION NO. 2021-014 TO EXTEND THE DURATION OF AUTHORITY EMPOWERED IN THE CHIEF EXECUTIVE OFFICER ("CEO") RELATED TO THE OUTBREAK OF CORONAVIRUS ("COVID-19")

WHEREAS, all recitals in the Commission's Resolution Nos. 2020-001, 2020-002 2020-03, 2020-004, 2020-005, 2020-006, 2020-007, 2021-001, 2021-002, 2021-003, 2021-004, 2021-005, 2021-009, 2021-010, 2021-011, 2021-12, 2021-13 and 2021-14 remain in effect and are incorporated herein by reference; and

WHEREAS, a severe acute respiratory illness caused by a novel (new) coronavirus, known as COVID-19, has spread globally and rapidly, resulting in severe illness and death around the world. The World Health Organization has described COVID-19 as a global pandemic; and

WHEREAS, on March 19, 2020, the Commission adopted Resolution No. 2020-001, proclaiming a local emergency pursuant to Government Code Sections 8630 and 8634, and empowered the CEO with the authority to issue rules and regulations to preserve Plan activities, protect the health and safety of its members staff and providers and prevent the further spread of COVID-19; and

WHEREAS, on April 27, 2020, the Commission adopted Resolution No. 2020-002 to: (1) renew and reiterate the declaration of a local emergency related to the outbreak of COVID-19 declared in Resolution No. 2020-001 to remain effective through the duration of the Governor's State of Emergency proclamation or when the Commission terminates its declaration of Local Emergency, whichever occurs last; and (2) to extend the duration of authority empowered in the CEO through Resolution No. 2020-001 to May 18, 2020; and

WHEREAS, on May 18, 2020, the Commission adopted Resolution No. 2020-003 to renew the authority first granted to the CEO in Resolution No. 2020-001 to June 22, 2020 and to authorize the CEO, with the advice counsel, to implement a staggered return to work program for Plan personnel; and

WHEREAS, since the adoption of Resolution No. 2020-003, the Commission has renewed and reiterated the emergency powers granted to the CEO on July 27, 2020, August 24, 2020, September 28, 2020, October 26, 2020, January 25, 2021, February 22, 2021, March 22, 2021, April 26, 2021, May 24, 2021, June 28, 2021, July 26, 2021, August 23, 2021, September 27, 2021, October 25, 2021 and more recently on December 16, 2021 by adopting Resolution No. 2021-014. Resolution No. 2021-014 expires today, January 31, 2022; and

WHEREAS, unless renewed by the Commission, the delegation of authority empowered in the CEO, pursuant to Resolution No. 2021-014 shall expire today, January 31, 2022; and

WHEREAS, this resolution will continue to empower the CEO with the authority to issue orders and regulations necessary to prevent the further spread of the disease and protect the health and safety of Plan members and staff through February 28, 2022, the next regularly scheduled Commission meeting; and

WHEREAS, although vaccines are now widely available, many people in the State and County are still not fully vaccinated and remain susceptible to infection. Further, more contagious variants of the disease are now present in the State and County, the most predominant of which is the Omicron variant. However, other variants such as the Delta variant, continues to exist in the State and County; and

WHEREAS, the imminent and proximate threat of introduction of COVID-19 in Commission staff workplaces continues to threaten the safety and health of Commission personnel; and

WHEREAS, under Article VIII of the Ventura County Medi-Cal Managed Care Commission aka Gold Coast Health Plan's (the "Plan's") bylaws, the CEO is responsible for coordinating day to day activities of the Ventura County Organized Health System, including implementing and enforcing all policies and procedures and assure compliance with all applicable federal and state laws, rules and regulations; and

WHEREAS, California Welfare and Institutions Code section 14087.53(b) provides that all rights, powers, duties, privileges, and immunities of the County of Ventura are vested in the Plan's Commission; and

WHEREAS, California Government Code section 8630 permits the Plan's Commissioners, acting with the County of Ventura's powers, to declare the existence of a local emergency to protect and preserve the public welfare of Plan's members, staff and providers when they are affected or likely to be affected by a public calamity; and

WHEREAS, the Plan is a public entity pursuant to Welfare and Institutions Code section 14087.54 and as such, the Plan may empower the CEO with the authority under sections 8630 and 8634 to issue rules and regulations to prevent the spread of COVID-19 and preserve Plan activities and protect the health and safety of its members, staff and providers; and

NOW, THEREFORE, BE IT RESOLVED, by the Ventura County Medi-Cal Managed Care Commission as follows:

Section 1. Pursuant to California Government Code sections 8630 and 8634, the Commission adopted Resolution No. 2020-001 finding a local emergency exists caused by conditions or threatened conditions of COVID-19, which constitutes extreme peril to the health and safety of Plan's members, staff and providers.

Section 2. Resolution No. 2020-001 also empowered the CEO with the authority to furnish information, to promulgate orders and regulations necessary to provide for the protection of life and property pursuant to California Government Code sections 8630 and 8634, to enter into agreements, make and implement personnel or other decisions and to take all actions necessary to obtain Federal and State emergency assistance and to implement preventive measures and other actions necessary to preserve Plan activities and protect the health of Plan's members, staff and providers, including but not limited to the following:

A. Arrange alternate "telework" accommodations to allow Plan staff to work from home or remotely, as deemed necessary by the CEO, to limit the transfer of the disease.

B. Help alleviate hardship suffered by Plan staff related to emergency conditions associated with the continued spread of the disease such as acting on near-term

policies relating to sick leave for Plan staff most vulnerable to a severe case of COVID-19.

C. Address and implement expectations issued by the California Department of Health Care Services ("DHCS") and the Centers for Medicare & Medicaid Services ("CMS") regarding new obligations to combat the pandemic.

D. Coordinate with Plan staff to realign job duties, priorities, and new or revised obligations issued by DHCS and CMS.

E. Take such action as reasonable and necessary under the circumstances to ensure the continued provision of services to members while prioritizing the Plan's obligations pursuant to the agreement between DHCS and the Plan ("Medi-Cal Agreement").

F. Enter in to such agreements on behalf of the Plan as necessary or desirable, with advice of legal counsel, to carry out all actions authorized by the Commission in the Resolution.

G. Authorize the CEO to implement and take such action on behalf of the Plan as the CEO may determine to be necessary or desirable, with advice of legal counsel, to carry out all actions authorized by the Commission in this Resolution.

Section 3. In Resolution 2020-001, the Commission further ordered that:

A. The Commission approves and ratifies the actions of the CEO and the Plan's staff heretofore taken which are in conformity with the intent and purposes of these resolutions.

B. Resolution No. 2020-001 expired on April 27, 2020.

Section 4. On April 27, 2020, the Commission adopted Resolution No. 2020-002 to:

A. Renew and reiterate the declaration of a local emergency related to the outbreak of COVID-19 to remain effective through the duration of the Governors' State of Emergency proclamation or when the Commission terminates its declaration of Local Emergency, whichever occurs last; and

B. To extend the duration of authority empowered in the CEO to issue emergency regulations related to the COVID-19 outbreak to May 18, 2020.

Section 5. The Commission adopted Resolution No. 2020-003 on May 18, 2020, to renew and reiterate the authority granted to the CEO approved in Resolution No. 2020-002 and to adopt the following additional emergency measures:

A. In addition to the authority granted to the CEO in Section 2, to authorize the CEO, with the advice counsel, to implement a staggered return to work program for Plan personnel; and

B. Extend the authority granted to the CEO through June 22, 2020.

Section 6. Since the adoption of Resolution No. 2020-003, the Commission has renewed and reiterated the emergency powers granted to the CEO on July 27, 2020, August 24, 2020, September 28, 2020, October 26, 2020, January 25, 2021, February 22, 2021 March 22 2021, April 26, 2021, May 24, 2021 June 28, 2021, July 26, 2021, August 23, 2021, September 27, 2021, October 25, 2021 and more recently on December 16, 2021, by adopting Resolution No. 2021-014. Resolution No. 2021-014 expires today, January 31, 2022.

Section 7. The Commission now seeks to renew and reiterate the authority granted to the CEO approved in Resolution No. 2021-014 through February 28, 2022.

Section 8. Unless renewed by the Commission, the delegation of authority empowered in the CEO, pursuant to this Resolution shall expire on February 28, 2022.

PASSED, APPROVED AND ADOPTED by the Ventura County Medi-Cal Managed Care Commission at a regular meeting on the 31st day of January 2022, by the following vote:

AYE:

NAY:

ABSTAIN:

ABSENT:

____

Chair:

Attest:

____

Clerk of the Commission

Gold Coast Health Plan[SM]
A Public Entity

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: January 31, 2022

SUBJECT: Findings to Continue to Hold Remote Teleconference/Virtual Commission Meetings Pursuant to Assembly Bill 361

SUMMARY/RECOMMENDATION:

At its January 10, 2022, meeting, the Ventura County Medi-Cal Managed Care Commission ("Commission") dba as Gold Coast Health Plan ("Plan") made findings pursuant to Assembly Bill 361 to continue to meet remotely. To continue this practice, it is required, that the Commission determine that the COVID-19 state of emergency proclaimed by the Governor still exists and has been considered by the Commission in deciding to continue to have teleconference meetings and that state or local officials have imposed or recommended measures to promote social distancing in connection with COVID-19, and that as result of the COVID-19 emergency, meeting in person would present imminent risks to the health or safety of attendees. Because these findings must be made every thirty (30) days, it is time to remake the findings.

BACKGROUND/DISCUSSION:

Traditionally, the Brown Act allows for teleconference or virtual meetings, provided that the physical locations of the legislative body's members joining by teleconference are posted on the agenda, that those locations are open to the public and that a quorum of the members is located within its jurisdiction. Newly enacted AB 361 provides an exception to these procedures in order to allow for fully virtual meetings during proclaimed emergencies, including the COVID-19 pandemic.

Since March of 2020 and the issuance of Governor Newsom's Executive Order N-29-20, which suspended portions of the Brown Act relating to teleconferencing, the Commission and the Plan's Committees have had virtual meetings without having to post the location of the legislative body members attending virtually. Most public agencies have been holding public meetings using virtual platforms since this time. In June of 2021, Governor Newsom issued Executive Order N-08-21, which provided that the exceptions contained in EO N-29-20 would sunset on September 30, 2021.

On September 10, 2021, the Legislature adopted AB 361, which allows public agencies to hold fully virtual meetings under certain circumstances without the posting of the agenda from each location a legislative body member is attending. Governor Newsom signed the bill into law on September 16, 2021. Because it contained an urgency provision, it took immediate effect.

Specific Findings Required under AB 361

Under AB 361, the Commission, can hold virtual meetings without providing notice of the Commissioner's teleconference location if the Commission makes the determination that there is a Governor-proclaimed state of emergency which the Commission will consider in their determination, and one of two secondary criteria listed below exists:

1. State or local officials have imposed or recommended measures to promote social distancing in connection with COVID-19; or

2. The Commission determines that requiring a meeting in person would present an imminent risk to the health or safety of attendees.

COVID-19 continues to present an imminent threat to the health and safety of Commission members, and its personnel, and the Governor's declaration of a COVID-19 emergency still exists. Although vaccines are now widely available, many people in the State and County are still not fully vaccinated and remain susceptible to infection. The disease can still spread rapidly through person-to-person contact and those in close proximity. Further, more contagious variants of the disease are now present in the State and County, the most predominant of which continues to be the Delta variant. However, another "variant of concern"—the Omicron variant, which has spread rapidly through South Africa and which spurred President Biden's travel ban to several countries in that continent, has also been detected in California. Additionally, several Commissioners attend meetings in medical facilities or offices, and allowing members of the public to attend meetings at these posted locations when they may not be vaccinated would pose a threat to the health or safety of attendees.

Re-Authorization is Required Within 30 Days

The Commission made the findings listed above at its October 25, 2021, November 22, 2021, December 16, 2021 Commission meetings and again during its January 10, 2022 special Commission meeting. Consistent with the provisions of Government Code Section 54953(e), the findings must be made every 30 days "after teleconferencing for the first time" under AB 361. Thus, if the Commission desires to continue to meet remotely without having to post the location of each teleconference location, the Commission must again find that the COVID-19 emergency still exists and that one of the two following findings can be made: that state or

local officials have imposed or recommended measures to promote social distancing in connection with COVID-19, or, that a result of the COVID-19 emergency, meeting in person would present imminent risks to the health or safety of attendees.

It is recommended that the Commission make these findings.

CONSEQUENCES OF NOT FOLLOWING RECOMMENDED ACTION:

The Commission will have to follow the Brown Act provisions that existed prior to the COVID-19 pandemic.

FOLLOW UP ACTION:

That the Commission make the findings under AB 361 at its February 28, 2022 special Commission meeting.

ATTACHMENT:

None.

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, M.D., Chief Medical Officer

DATE: January 31, 2022

SUBJECT: Approval of Credentials / Peer Review Committee Members

SUMMARY:

As directed by the Gold Coast Health Plan (GCHP) Practitioner Credentialing Policy (QI-025), the Ventura County Medi-Cal Managed Care Commission is required to approve changes to the Credentials / Peer Review Committee (C/PRC) membership.

Agustin "Jaime" Lara, M.D. has been nominated as an active member of the C/PRC to replace Richard Reisman, M.D. Dr. Lara is the Co – Medical Director and GCHP's main contact for CFH issues related to Medicaid compliance and GCHP provider and contract issues. Dr. Lara is a practicing Family Medicine at Main Street clinic in Ventura.

Allison Blaze, M.D. has been nominated as an active member of the C/PRC. Dr. Blaze is a board-certified Family Medicine physician and currently serves as the Chief Medical Officer, Ambulatory Care for Ventura County Health Care Agency.

RECOMMENDATION:

Approve Agustin "Jaime" Lara, M.D. and Allison Blaze, M.D., as active members of the Credentials / Peer Review Committee.

Gold Coast Health Plan[SM]
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, M.D., Chief Medical Officer
Lucy Marrero, Director, Behavioral Health and Social Programs

DATE: January 31, 2022

SUBJECT: Student Behavioral Health Incentive Program ("SBHIP") Participation

BACKGROUND/DISCUSSION:

The World Health Organization notes that 10% of children and adolescents experience a mental disorder, but the majority do not seek help or receive care. Suicide is the fourth leading cause of death in 15-19 year-old teens worldwide. COVID-19 impacts on school closures have added additional stress and anxiety to school age children. The consequences of not addressing mental health conditions for children and adolescents extend to adulthood.

Behavioral Health provisions in California Assembly Bill 133 established the Children and Youth Behavioral Health Initiative to transform California's behavioral health system into an innovative and prevention-focused system providing routine screening, support, and services for children and youth 25 years of age and younger. School-linked partnerships, capacity, and infrastructure grants to support behavioral health services occurring in school settings are one of the components of this initiative.

The Department of Health Care Services Student Behavioral Health Incentive Program ("SBHIP") recognizes schools can be a critical point of access for preventive and early-intervention behavioral health services. Early identification and treatment through school-affiliated behavioral health services can reduce emergency room visits, crisis situations, inpatient stays, and placement in high-cost special education settings and/or out of home placement. The program also identifies opportunities to reduce behavioral health disparities. African American, Native American, and Pacific Islander students are more likely to be chronically absent, suspended, or expelled. LGBTQ students are twice as likely to report depression and three times more likely to report suicidal ideation than non-LGBTQ peers. Development of a cross-system partnership focused on increasing access to behavioral health services in school and school-affiliated settings is critical for improving these outcomes.

The SBHIP is a voluntary program running from January 1, 2022, through December 31, 2024, and requires submission of a 12-month needs assessment, project plan, and implementation of a minimum of four interventions and engagement with two Local Educational Entities ("LEAs"). GCHP has begun collaborative discussions with the Ventura County Behavioral Health Department ("VCBH") and the Ventura County Office of Education ("VCOE"), who both have stated intentions to partner with GCHP in this program effort. GCHP

and these core partners view this program as an opportunity to expand on and enhance existing behavioral health programs such as the Wellness Centers funded through Mental Health Student Services ("MHSS") under the Mental Health Services Act ("MHSA"). Additionally, discussions so far focus on addressing gaps in behavioral health services that are equitable and culturally and linguistically appropriate; an aim promoted by the SBHIP program design.

Funding totals $7.8M, with $335,000 in upfront funding contingent upon two deliverables in Q1 2022:

- Letter of Intent due January 31, 2022
- Partner List identifying the LEAs due by March 15, 2022.

Funds are considered unearned until submission of the needs assessment and project plan in Q4 2022. The remaining $7.5M in incentive funding is contingent upon submission of quarterly progress reports and achievement of the milestones and metrics associated with interventions selected in the project plan.

GCHP staff anticipate allocating available upfront funding in the following manner to promote a thorough and effective needs assessment and development of a strong project plan in the following manner:

- $225,000 to outsource assessment project management; data collection, strategy, and analysis; facilitation of stakeholder engagement meetings and surveys; and development of recommendations for targeted interventions
- $100,000 to core VCOE and VCBH partners for participation in the assessment process and facilitating engagement with stakeholder groups as required by DHCS
- $10,000 to support costs associated with hosting and facilitating the surveys and stakeholder meetings such as food/snacks and participation incentives to stakeholders

FISCAL IMPACT:

There is no fiscal impact. Assessment will be funded by the upfront SBHIP assessment allocation in Q1 2022.

RECOMMENDATION:

GCHP staff recommend the Commission approve participation in the SBHIP.

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nick Liguori, Chief Operating Officer

DATE: January 31, 2022

SUBJECT: Resolution 2022-002 in Recognition of Margaret Tatar

SUMMARY:

On Margaret Tatar's last day as Chief Executive Officer of Gold Coast Health Plan, the Ventura County Medi-Cal Managed Care Commission recognizes her exemplary service from 2019-2022.

RECOMMENDATION:

Staff requests the Commission approve Resolution 2022-002.

ATTACHMENTS:

Resolution 2022-002

Resolution No. 2022-002

The following resolution is being issued by the Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan in recognition of Margaret Tatar's exemplary service as Chief Executive Officer from 2019-2022.

Whereas, Gold Coast Health Plan was founded in 2011 with a mission "To improve the health of our members through the provision of high-quality care and services," and

Whereas, Gold Coast Health Plan proudly serves more than 245,000 Medi-Cal beneficiaries in Ventura County through its network of primary care physicians, specialists, behavioral health providers, and hospitals, and

Whereas, In November 2019, the Ventura County Medi-Cal Managed Care Commission appointed Margaret Tatar as Chief Executive Officer of Gold Coast Health Plan in her capacity as managing principal of Health Management Associates, and

Whereas, Margaret Tatar quickly assessed the state of the health plan and began assembling multi-functional teams to tackle Gold Coast Health Plan's most pressing issues, and

Whereas, In March 2020, a public health emergency was declared in response to the fast spread of a novel coronavirus, prompting Margaret Tatar and the Executive Team to take unprecedented measures to create a remote workforce in order to comply with quickly evolving state and local public health orders, and

Whereas, Throughout the pandemic, Margaret Tatar stressed the importance of considering impacts to staff, members, and providers in all decision making, and

Whereas, Margaret Tatar created and cultivated a culture of transparency, and

Whereas, On July 1, 2021, Gold Coast Health Plan began its second decade of service to Ventura County with a focus on meeting the needs of its members, providers, and community in new ways, and

Whereas, Through her unwavering commitment to continuous process improvement, Margaret Tatar set Gold Coast Health Plan on the path to becoming a best-in-class managed care plan, and

Whereas, Margaret Tatar's extraordinary leadership during such extraordinary times has left an indelible impression on Gold Coast Health Plan, and,

Now, Therefore, Be It Resolved, that the Ventura County Medi-Cal Managed Care Commission honors Margaret Tatar for her exemplary service to Gold Coast Health Plan.

Passed, Approved, and Adopted by the Ventura County Medi-Cal Managed Care Commission at a regular meeting on the 31st day of January, 2022, by the following vote:

AYE:

NAY:

ABSTAIN:

ABSENT:

____
Commission Chair

____
Clerk of the Commission

AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kashina Bishop, Chief Financial Officer

DATE: January 31, 2022

SUBJECT: November 2021 and December 2021 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached November 2021 and December 2021 fiscal year-to-date (“FYTD”) financial statements of Gold Coast Health Plan (“GCHP”) for review and approval.

BACKGROUND/DISCUSSION:

The staff has prepared the unaudited November 2021 and December 2021 FYTD financial packages, including statements of financial position, statement of revenues and expenses, changes in net assets, statement of cash flows and schedule of investments and cash balances.

Financial Overview:

GCHP experienced gains of $1.1 million and $2.1 million November and December 2021 respectively. As of December 31st, GCHP is favorable to the budget estimates by $21.1 million. The favorability is due to administrative and project expenses that are under budget by $6.6 million, and medical expense estimates that are currently less than budget by $14 million.

Solvency Action Plan (SAP):

GCHP is on the right trajectory to ensure its long-term viability. That said, GCHP remains in a vulnerable position and must continue to build reserves to levels that are, at minimum, consistent with the Commission policy. To that end, your management team remains focused the SAP and that solvency-related actions are implemented in a manner that respects the provider community and mitigates any adverse impact on our providers or members.

The SAP is comprised of three main categories: cost of healthcare, internal control improvements and contract strategies. The primary objectives within each of these categories is as follows:

1. Cost of healthcare – to ensure care is being provided at the optimal place of service which both reduces costs and improves member experience.
2. Internal control improvements – to ensure GCHP is operating effectively and efficiently which will result in administrative savings and safeguard against improper claim payments.
3. Contracting strategies – to ensure that GCHP is reimbursing providers within industry standard for a Medi-Cal managed care plan and moving toward value-based methodologies.

The management team concluded several months ago that it is imperative that GCHP have a keen focus on fundamental activities that are essential to its providers and members, most notably the system conversion and implementation of CalAIM. This has and will continue to cause some delay in implementing some of the initiatives previously intended, but the focus and hard work remains particularly on the efforts to tighten internal controls.

Financial Report:

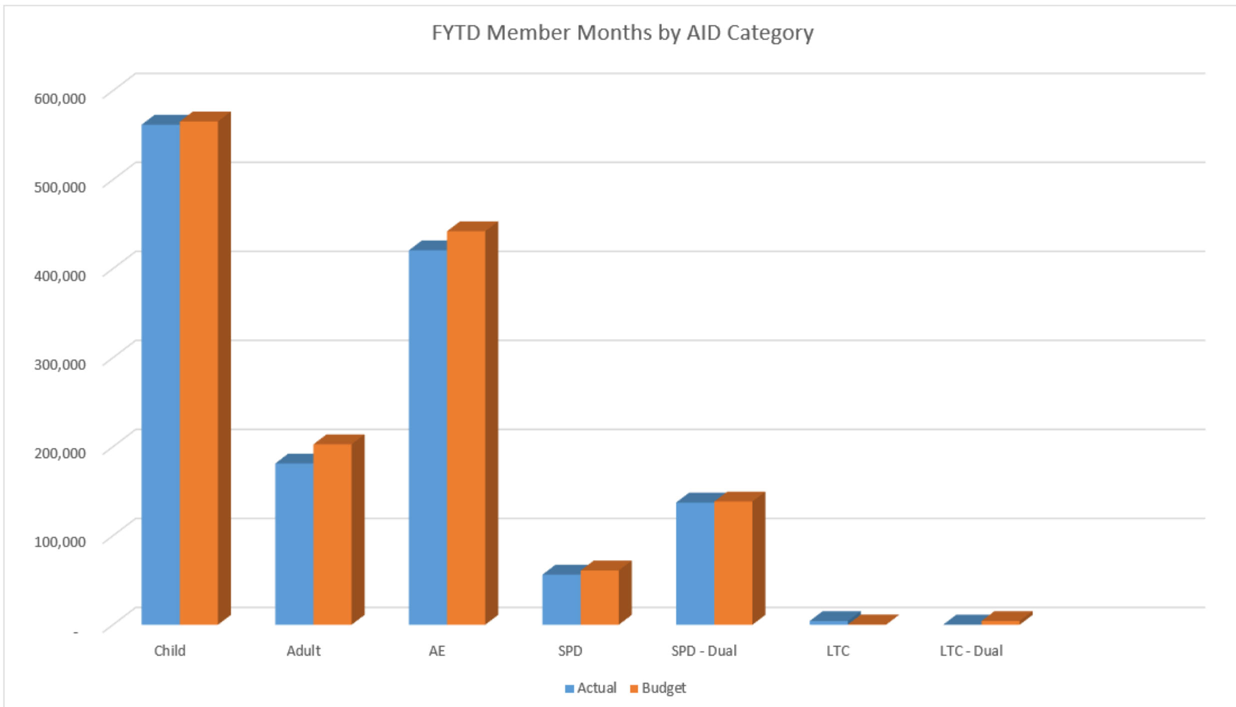
GCHP is reporting net gains of $1.1 million and $2.1 million for the months of November 2021 and December 2021 respectively.

December 2021 FYTD Highlights:

1. Net gain of $26.3 million, a $21.1 million favorable budget variance.
2. FYTD net revenue is $503.4 million, $178,106 under budget.
3. FYTD Cost of health care is $450.3 million, $14.8 million under budget.
4. The medical loss ratio is 89.5% of revenue, 2.9% less than the budget.
5. FYTD administrative expenses are $26.9 million, $6.6 million under budget.
6. The administrative cost ratio is 5.3%, 1.3% under budget.
7. Current membership for December is 227,759.
8. Tangible Net Equity is $132.1 million which represents approximately 51 days of operating expenses in reserve and 351% of the required amount by the State.

Note: To improve comparative analysis, GCHP is reporting the budget on a flexible basis which allows for updated revenue and medical expense budget figures consistent with membership trends.

Total Membership
300,000
250,000
200,000
150,000
100,000
50,000
-
December-18
February-19
April-19
June-19
August-19
October-19
December-19
February-20
April-20
June-20
August-20
October-20
December-20
February-21
April-21
June-21
August-21
October-21
December-21
Actual Membership
Budgeted Membership


FYTD Member Months by AID Category
600,000
500,000
400,000
300,000
200,000
100,000
-
Child
Adult
AE
SPD
SPD - Dual
LTC
LTC - Dual
Actual
Budget

<u>Revenue</u>
Net Premium revenue is $503.3 million; a $285,685 and -0.1% unfavorable budget variance.

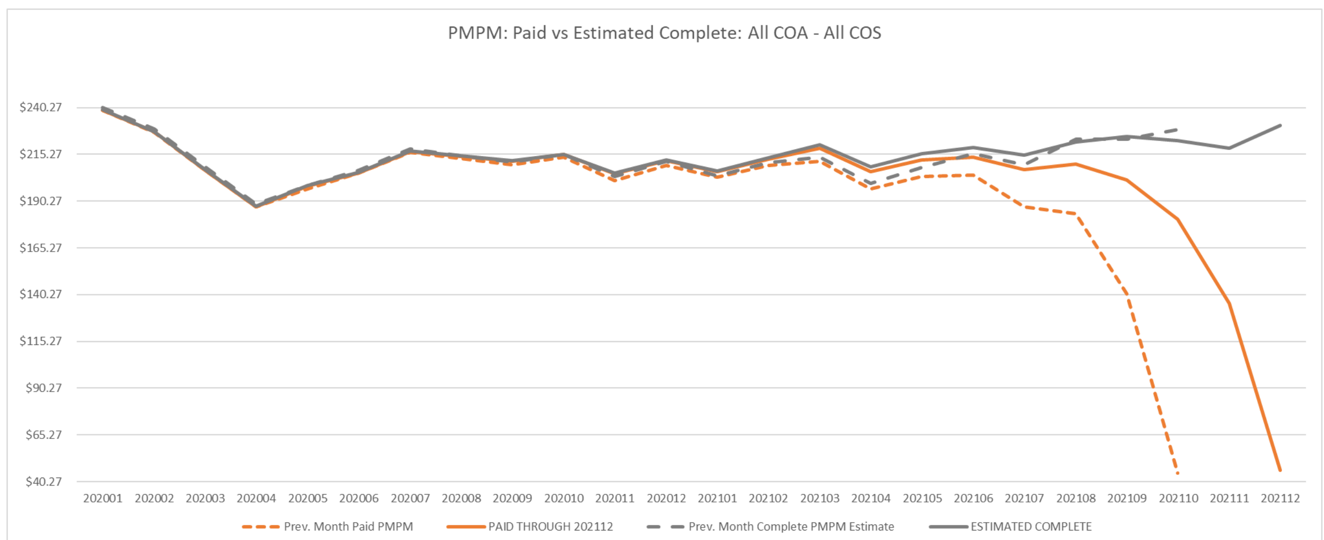
<u>Health Care Costs</u>
FYTD Health care costs are $450.3 million; a $14.8 million and 3.2% favorable budget variance. Due to the unknown impacts of the pandemic, the budget was established by trending forward CY 2019 medical expenses.

Medical expenses are calculated through a predictive model which examines the timing of claims receipt and claims payments. It is referred to as “Incurred but Not Paid” (IBNP) and is a liability on the balance sheet. On the balance sheet, this calculation is a combination of the Incurred but Not Reported and Claims Payable.

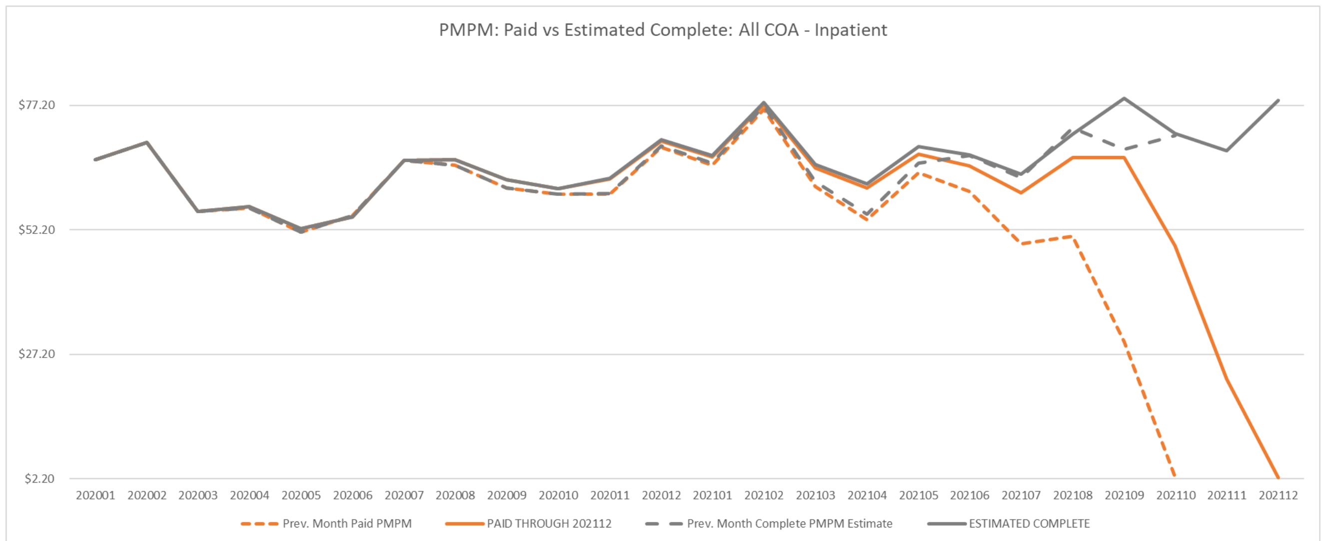
One of the issues being addressed from the system conversion is discrepancies in the mapping of data to the correct category of service. This impacts staff’s ability to research actual and budget variances at the category of service level. At a high level, medical expenses have remained consistent with prior months and are running below budget expectations which were conservative.

High level trends on a per member per month (PMPM) basis for the major categories of service are as follows:

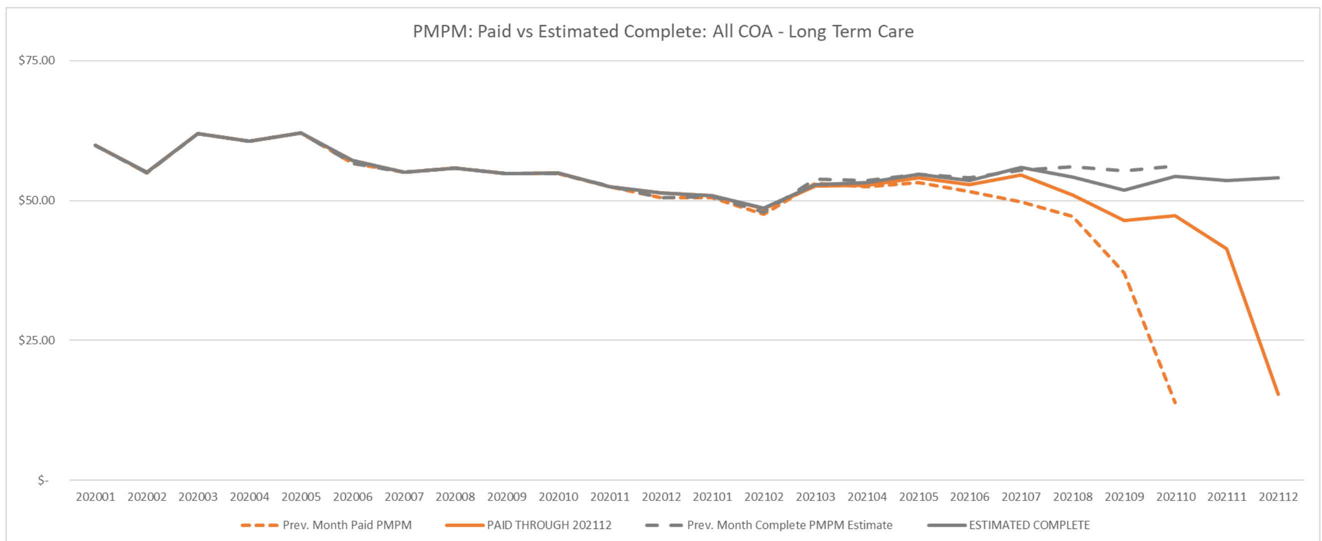
1. All categories of service



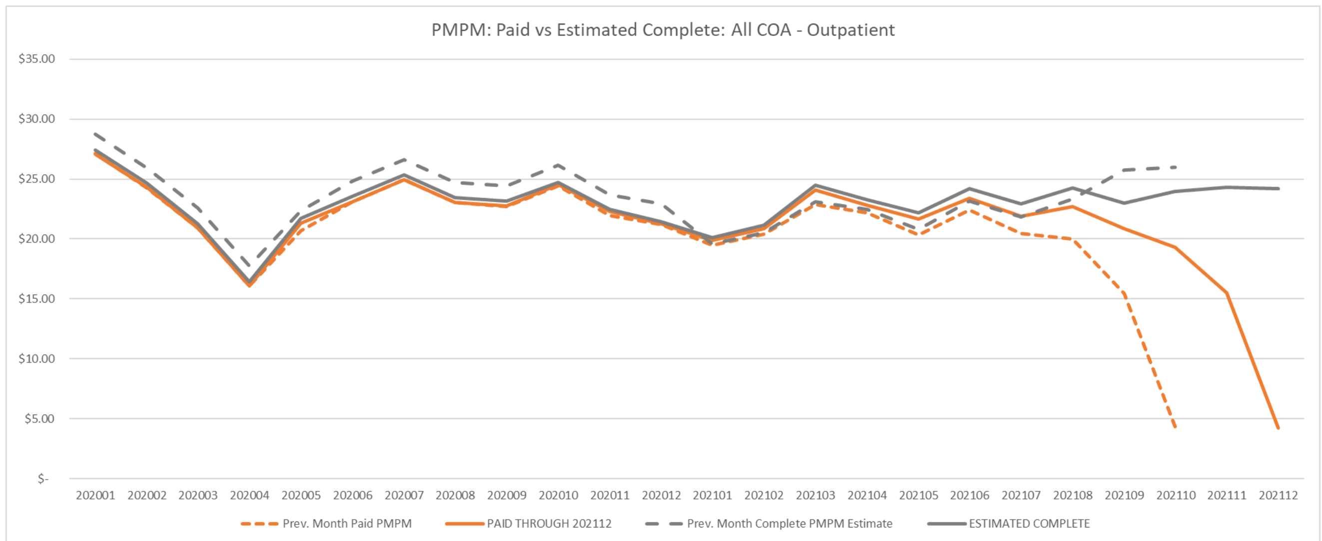
2. Inpatient hospital costs



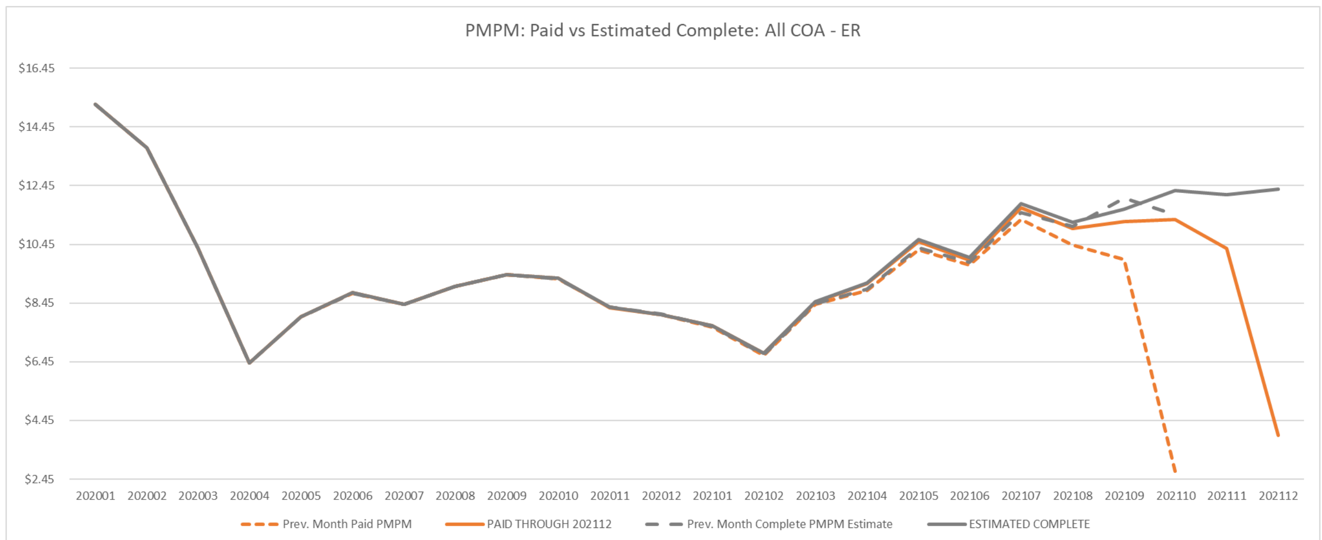
3. Long term care (LTC) expenses



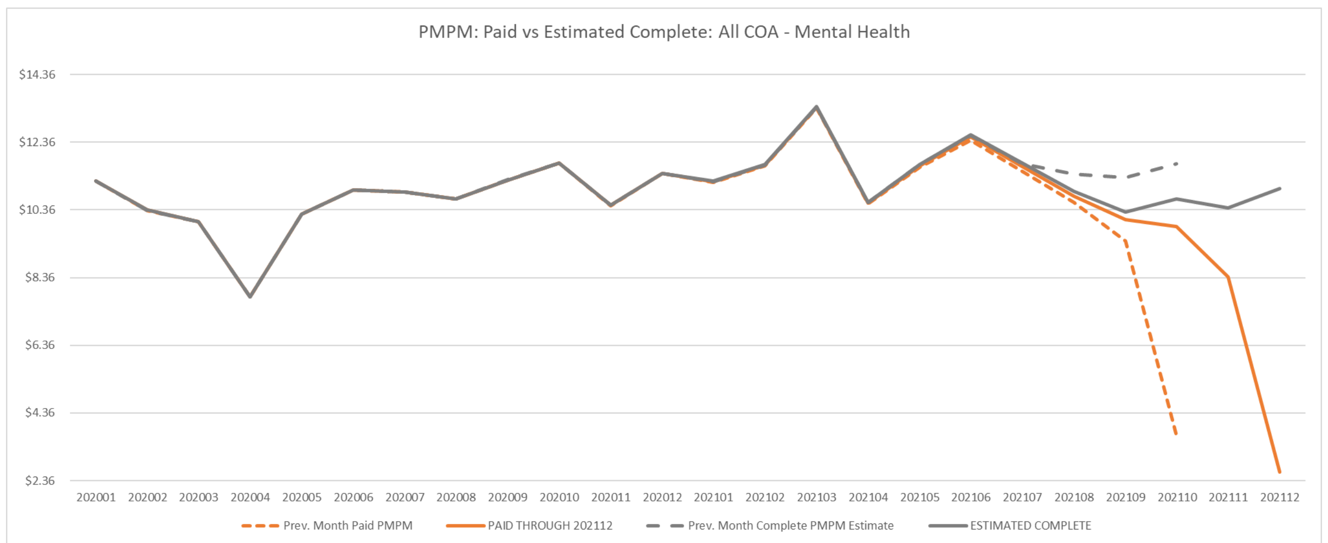
4. Outpatient expenses



5. Emergency Room expenses



6. Mental and behavioral health services



Administrative Expenses

The administrative expenses are currently running within amounts allocated to administration in the capitation revenue from the State. In addition, the ratio is comparable to other public health plans in California.

For the fiscal year to date through December 2021, administrative costs were $26.9 million and $6.6 million under budget. As a percentage of revenue, the administrative cost ratio (or ACR) was 5.3% versus 6.6% for budget.

The following are drivers of administrative expense favorability:

- *Enterprise Project Portfolio*: timing of consulting services related to multiple projects (~$2.9M)
- *Salaries, Wages & Employee Benefits*: primarily related to timing of filling open positions in IT/Health Services (~$.6M)
- *Outside Services*: favorability of Conduent and PBM admin fee expenses due to membership lower than projected and lower fulfillment related charges and Conduent invoice chargebacks (~$1.7M)
- *Professional Services*: timing of employee recruitment in budget (~$.2M), favorable translations expenses ($.1M) favorable consulting expenses related to timing ($.6M) offset by unfavorable legal expenses of $.5M
- *Occupancy, Supplies, Insurance and Other*: timing of software and non-capital equipment purchases and implementation, lower printing expenses and lower than budgeted interest expense (~$1.1M)

Cash and Short-Term Investment Portfolio

At December 31 the Plan had $221.7 million in cash and short-term investments. The investment portfolio included Ventura County Investment Pool $18.4 million; LAIF CA State $40.2 million; Cal Trust $35.0M; the portfolio yielded a rate of 2.5%.

SCHEDULE OF INVESTMENTS AND CASH BALANCES

		Market Value* December 31, 2021	Account Type
Local Agency Investment Fund (LAIF)[1]	$	40,220,179	investment
Ventura County Investment Pool[2]	$	18,351,494	investment
CalTrust	$	34,976,409	short-term investment
Bank of West	$	122,807,726	money market account
Pacific Premier	$	3,797,925	operating accounts
Mechanics Bank[3]	$	1,539,128	operating accounts
Petty Cash	$	500	cash
Investments and monies held by GCHP	***$***	***221,693,361***	

		Dec-21		FYTD 21-22
Local Agency Investment Fund (LAIF)				
Beginning Balance	$	40,220,179	$	206,976
Transfer of Funds from Ventura County Investment Pool		-		40,000,000
Quarterly Interest Received				13,448
Quarterly Interest Adjustment		-		(245)
Current Market Value	**$**	**40,220,179**	**$**	**40,220,179**
		-		-
Ventura County Investment Pool				
Beginning Balance	$	18,351,494	$	43,304,353
Transfer of funds to LAIF		-		(25,000,000)
Interest Received				47,141
Current Market Value	**$**	**18,351,494**	**$**	**18,351,494**

Medi-Cal Receivable

At December 31 the Plan had $102.6 million in Medi-Cal Receivables due from the DHCS.

RECOMMENDATION:

Staff requests that the Commission approve the November 2021 and December 2021 financial packages.

ATTACHMENT:

November 2021 Financial Package
December 2021 Financial Package

FINANCIAL PACKAGE
For the month ended December 31, 2021

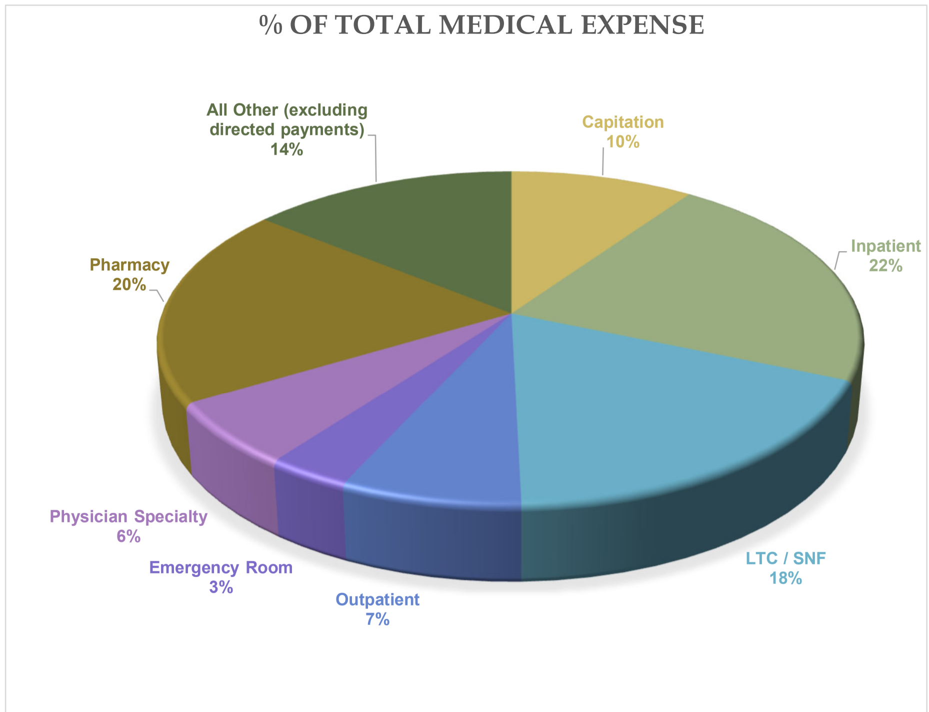
TABLE OF CONTENTS

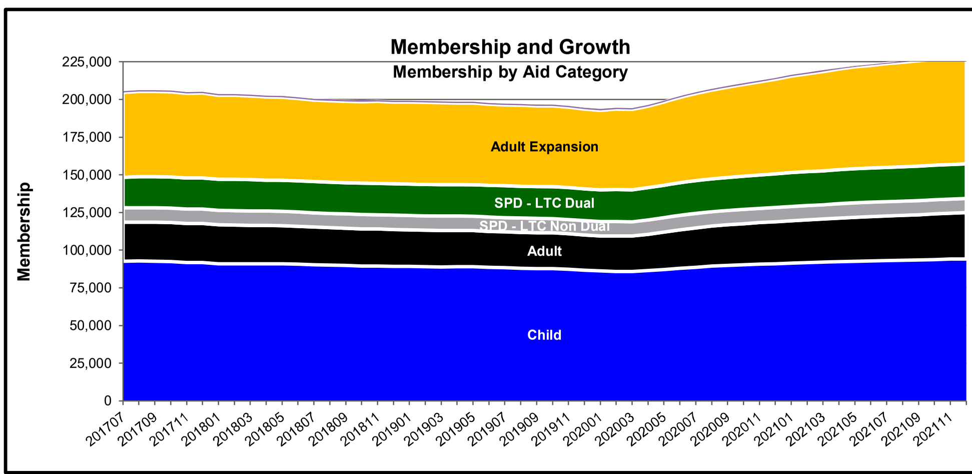
- Executive Dashboard
- Statement of Financial Position
- Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Cash Flows
- Schedule of Investments & Cash Balances

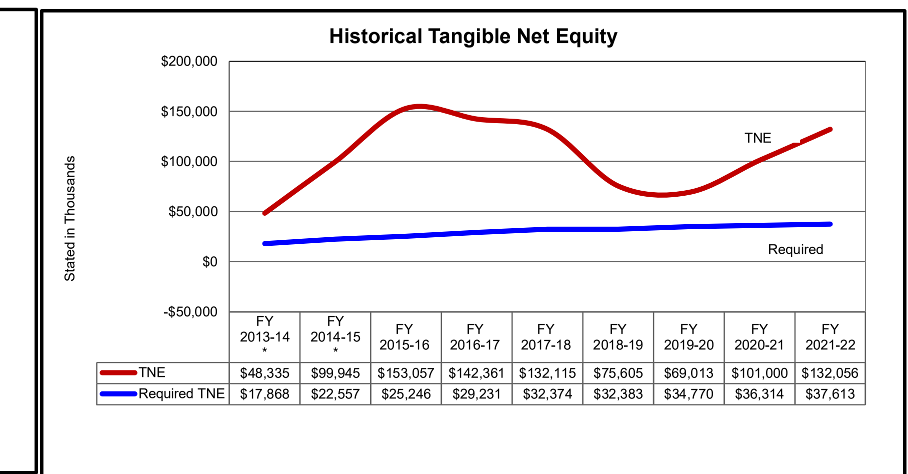
Gold Coast Health Plan
Executive Dashboard as of December 31, 2021

	FYTD 21/22 Budget*	FYTD 21/22 Actual	FY 20/21 Actual	FY 19/20 Actual
Average Enrollment	235,648	225,689	213,547	196,012
PMPM Revenue	$ 371.90	$ 371.69	$ 358.22	$ 348.73
Medical Expenses				
Capitation	$ 36.18	$ 31.22	$ 34.03	$ 24.93
Inpatient	$ 65.81	$ 69.87	$ 66.52	$ 65.19
LTC / SNF	$ 56.74	$ 58.71	$ 55.42	$ 59.20
Outpatient	$ 26.09	$ 23.37	$ 23.16	$ 25.81
Emergency Room	$ 13.40	$ 10.84	$ 9.25	$ 11.97
Physician Specialty	$ 26.92	$ 19.98	$ 25.71	$ 27.63
Pharmacy	$ 64.92	$ 62.54	$ 62.07	$ 61.05
All Other *(excluding directed payments)*	$ 37.91	$ 45.57	$ 43.20	$ 41.07
Total Per Member Per Month	$ 327.98	$ 322.10	$ 319.36	$ 316.86
Medical Loss Ratio	92.3%	89.5%	92.1%	94.6%
Total Administrative Expenses	$ 33,448,322	$ 26,869,972	$ 49,637,603	$ 50,821,685
% of Revenue	6.6%	5.3%	5.4%	6.2%
TNE	$ 102,670,560	$ 132,055,682	$ 100,999,994	$ 71,272,142
Required TNE	$ 38,676,020	$ 37,613,177	$ 36,313,908	$ 34,685,521
% of Required	265%	351%	278%	205%

** Flexible Budget (uses actual membership & member mix against budgeted rates)*







	FY 2013-14 *	FY 2014-15 *	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
TNE	$48,335	$99,945	$153,057	$142,361	$132,115	$75,605	$69,013	$101,000	$132,056
Required TNE	$17,868	$22,557	$25,246	$29,231	$32,374	$32,383	$34,770	$36,314	$37,613

STATEMENT OF FINANCIAL POSITION

	12/31/21	11/30/21	10/31/21
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**128,145,280**	**29,799,837**	**158,793,981**
Total Short-Term Investments	**93,548,083**	**93,578,243**	**43,575,443**
Medi-Cal Receivable	102,639,830	198,581,833	106,511,000
Interest Receivable	101,704	92,807	83,910
Provider Receivable	1,231,908	1,278,799	1,298,494
Other Receivables	6,857,663	7,023,478	6,551,713
Total Accounts Receivable	**110,831,105**	**206,976,917**	**114,445,117**
Total Prepaid Accounts	2,039,519	2,284,620	2,827,817
Total Other Current Assets	156,289	156,289	156,289
Total Current Assets	**334,720,276**	**332,795,907**	**319,798,647**
Total Fixed Assets	**1,373,067**	**1,387,654**	**1,322,364**
Total Assets	**$ 336,093,343**	**$ 334,183,560**	**$ 321,121,011**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 85,887,896	$ 81,565,595	$ 90,725,590
Claims Payable	9,372,894	15,385,048	8,541,595
Capitation Payable	24,717,445	24,534,814	24,261,004
Physician Payable	20,856,194	20,214,872	22,170,448
DHCS - Reserve for Capitation Recoup	14,899,225	14,901,090	14,916,507
Accounts Payable	306,382	1,172,058	63,027
Accrued ACS	3,308,488	3,229,490	3,405,002
Accrued Provider Reserve	1,848,804	1,776,217	1,703,890
Accrued Pharmacy	14,434,060	21,414,228	14,365,100
Accrued Expenses	3,447,845	2,363,248	1,971,952
Accrued Premium Tax	21,565,800	14,377,200	7,188,600
Accrued Payroll Expense	2,458,133	2,315,490	1,989,940
Total Current Liabilities	**203,103,166**	**203,249,349**	**191,302,654**
Long-Term Liabilities:			
Other Long-term Liability-Deferred Rent	934,496	944,090	953,684
Deferred Revenue - Long Term Portion	-	-	-
Notes Payable	-	-	-
Total Long-Term Liabilities	**934,496**	**944,090**	**953,684**
Total Liabilities	**204,037,662**	**204,193,439**	**192,256,338**
Net Assets:			
Beginning Net Assets	105,714,877	105,714,877	105,714,877
Total Increase / (Decrease in Unrestricted Net Assets)	26,340,805	24,275,245	23,149,796
Total Net Assets	**132,055,682**	**129,990,122**	**128,864,673**
Total Liabilities & Net Assets	**$ 336,093,343**	**$ 334,183,560**	**$ 321,121,011**

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR MONTH ENDED December 31, 2021

	November 2021	December 2021	December 2021 Year-To-Date		Variance	Variance	December 2021 Year-To-Date		Variance
	Actual	Actual	Actual	Budget	Fav / (Unfav)	%	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	227,379	227,759	1,354,135	1,413,888	(59,753)	-4%	PMPM - FYTD		
Revenue									
Premium	$ 92,070,833	$ 91,746,868	$ 546,447,312	$ 503,601,397	$ 42,845,915	9%	$ 403.54	$ 356.18	$ 47.36
Reserve for Cap Requirements	-	-	-	-	-	0%	-	-	-
MCO Premium Tax	(7,188,600)	(7,188,600)	(43,131,600)	-	(43,131,600)	0%	(31.85)	-	(31.85)
Total Net Premium	**84,882,233**	**84,558,268**	**503,315,712**	**503,601,397**	**(285,685)**	**-0.1%**	**371.69**	**356.18**	**15.51**
Other Revenue:									
Miscellaneous Income	125	106,929	107,579	-	107,579	0%	0.08	-	0.08
Total Other Revenue	125	106,929	107,579	-	107,579	0%	0.08	-	0.08
Total Revenue	**84,882,358**	**84,665,197**	**503,423,291**	**503,601,397**	**(178,106)**	**0%**	**371.69**	**356.18**	**15.59**
Medical Expenses:									
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	6,901,100	6,999,946	42,281,120	48,989,998	6,708,878	14%	31.22	34.65	3.43
FFS Claims Expenses:									
Inpatient	25,108,002	18,047,112	94,610,931	89,120,608	(5,490,323)	-6%	69.87	63.03	(6.84)
LTC / SNF	6,465,765	12,336,841	79,496,057	76,837,826	(2,658,231)	-3%	58.71	54.35	(4.36)
Outpatient	4,193,608	5,587,569	31,647,629	35,332,882	3,685,253	10%	23.37	24.99	1.62
Laboratory and Radiology	577,327	556,135	3,642,632	3,139,838	(502,795)	-16%	2.69	2.22	(0.47)
Directed Payments - Provider	2,379,461	2,384,738	14,108,004	13,369,874	(738,129)	-6%	10.42	9.46	(0.96)
Emergency Room	4,501,451	2,869,282	14,675,165	18,143,222	3,468,057	19%	10.84	12.83	1.99
Physician Specialty	2,174,340	5,336,734	27,058,169	36,457,002	9,398,832	26%	19.98	25.78	5.80
Primary Care Physician	6,418,599	2,252,616	14,957,860	10,123,872	(4,833,989)	-48%	11.05	7.16	(3.89)
Home & Community Based Services	2,699,798	1,931,831	12,294,567	13,719,085	1,424,518	10%	9.08	9.70	0.62
Applied Behavioral Analysis/Mental Health Service	1,729,038	2,535,820	14,887,605	15,249,730	362,125	2%	10.99	10.79	(0.21)
Pharmacy	14,573,400	14,153,777	84,685,193	87,908,908	3,223,715	4%	62.54	62.18	(0.36)
Provider Reserve	72,327	72,587	199,687	-	(199,687)	0%	0.15	-	(0.15)
Other Medical Professional	242,478	391,058	1,733,221	2,421,464	688,242	28%	1.28	1.71	0.43
Other Medical Care	-	5,070	5,330	-	(5,330)	0%	0.00	-	(0.00)
Other Fee For Service	1,520,259	968,339	6,164,363	5,578,720	(585,643)	-10%	4.55	3.95	(0.61)
Transportation	286,276	476,801	3,311,743	1,101,826	(2,209,916)	-201%	2.45	0.78	(1.67)
Total Claims	72,942,128	69,906,310	403,478,157	408,504,856	5,026,699	1%	297.96	288.92	(9.04)
Medical & Care Management Expense	1,281,138	1,428,090	7,696,833	7,770,480	73,647	1%	5.68	5.50	(0.19)
Reinsurance	(322,522)	299,723	308,070	1,908,749	1,600,679	84%	0.23	1.35	1.12
Claims Recoveries	(1,529,548)	(752,068)	(3,489,179)	(2,116,513)	1,372,666	-65%	(2.58)	(1.50)	1.08
Sub-total	(570,932)	975,746	4,515,725	7,562,716	3,046,991	40%	3.33	5.35	2.01
Total Cost of Health Care	**79,272,297**	**77,882,002**	**450,275,001**	**465,057,570**	**14,782,568**	**3%**	**332.52**	**328.92**	**(3.60)**
Contribution Margin	**5,610,061**	**6,783,195**	**53,148,290**	**38,543,827**	**14,604,462**	**38%**	**39.17**	**27.26**	**11.91**
General & Administrative Expenses:									
Salaries, Wages & Employee Benefits	2,274,868	2,469,553	13,412,015	13,987,489	575,474	4%	9.90	9.89	(0.01)
Training, Conference & Travel	3,770	5,714	25,055	99,985	74,930	75%	0.02	0.07	0.05
Outside Services	2,012,154	2,244,520	13,074,349	14,727,041	1,652,692	11%	9.66	10.42	0.76
Professional Services	564,074	371,069	2,062,250	2,461,499	399,249	16%	1.52	1.74	0.22
Occupancy, Supplies, Insurance & Others	716,195	801,161	4,621,693	5,688,641	1,066,948	19%	3.41	4.02	0.61
Care Management Reclass to Medical	(1,281,138)	(1,428,090)	(7,696,833)	(7,770,480)	(73,647)	1%	(5.68)	(5.50)	0.19
G&A Expenses	4,289,923	4,463,927	25,498,529	29,194,175	3,695,646	13%	18.83	20.65	1.82
Project Portfolio	209,063	238,956	1,371,444	4,254,146	2,882,703	68%	1.01	3.01	2.00
Total G&A Expenses	**4,498,986**	**4,702,883**	**26,869,972**	**33,448,322**	**6,578,349**	**20%**	**19.84**	**23.66**	**3.81**
Total Operating Gain / (Loss)	**1,111,075**	**2,080,312**	**26,278,317**	**5,095,506**	**21,182,812**	**416%**	**19.33**	**3.60**	**15.72**
Non Operating									
Revenues - Interest	14,374	(14,752)	63,734	180,000	(116,266)	-65%	0.05	0.13	(0.08)
Gain/(Loss) on Sale of Asset	-	-	(1,247)	-	(1,247)	0%	(0.00)	-	(0.00)
Total Non-Operating	**14,374**	**(14,752)**	**62,488**	**180,000**	**(117,512)**	**-65%**	**0.05**	**0.13**	**(0.08)**
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 1,125,449**	**$ 2,065,560**	**$ 26,340,805**	**$ 5,275,506**	**$ 21,065,299**	**399%**	**$ 19.37**	**$ 3.73**	**$ 15.64**

STATEMENT OF CASH FLOWS	December 2021	FYTD 20-21
Cash Flows Provided By Operating Activities		
Net Income (Loss)	$ 2,065,560	$ 26,340,805
Adjustments to reconciled net income to net cash provided by operating activities		
Depreciation on fixed assets	44,344	237,672
Disposal of fixed assets	-	-
Amortization of discounts and premium	-	-
Changes in Operating Assets and Liabilites		
Accounts Receivable	96,145,812	538,018
Prepaid Expenses	245,101	(90,857)
Accrued Expense and Accounts Payable	(6,478,478)	(7,949,669)
Claims Payable	(5,188,200)	4,483,724
MCO Tax liablity	7,188,600	2,156,580
IBNR	4,322,301	(41,072,747)
Net Cash Provided by (Used in) Operating Activities	98,345,040	(15,356,475)
Cash Flow Provided By Investing Activities		
Proceeds from Restricted Cash & Other Assets		
Proceeds from Investments	30,161	(50,032,983)
Purchase of Property and Equipment	(29,757)	(412,267)
Net Cash (Used In) Provided by Investing Activities	403	(50,445,250)
Increase/(Decrease) in Cash and Cash Equivalents	98,345,443	(65,801,725)
Cash and Cash Equivalents, Beginning of Period	29,799,837	193,947,005
Cash and Cash Equivalents, End of Period	128,145,280	128,145,280

Gold Coast Health Plan℠
A Public Entity

November and December 2021 Financial Statements

January 31, 2022

Kashina Bishop
Chief Financial Officer

Integrity

Accountability

Collaboration

Trust

Respect

Return to Agenda

Financial Overview:

NOVEMBER NET GAIN $ 1.1 M

DECEMBER NET GAIN $2.1

FYTD NET GAIN $26.3 M

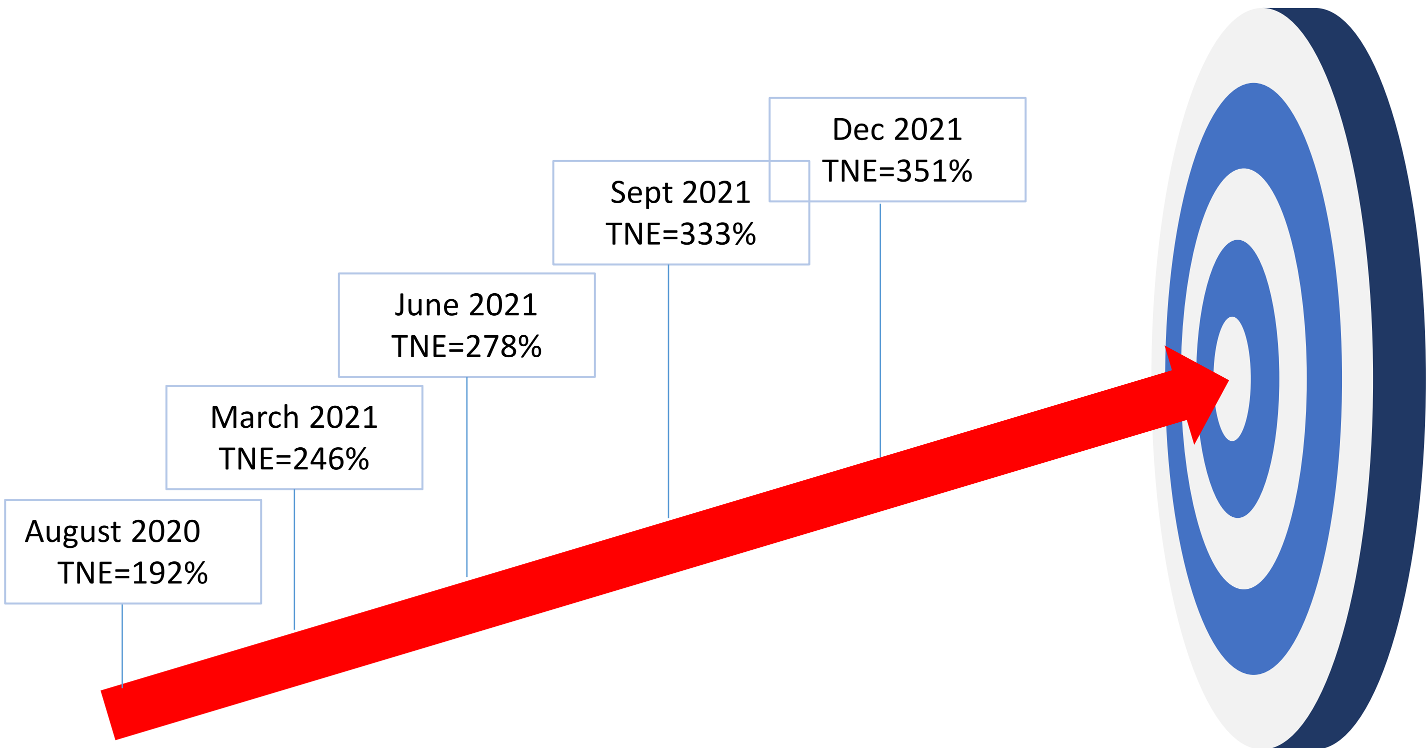
TNE is $132.1 M and 351% of the minimum required

MEDICAL LOSS RATIO 89.5%

ADMINISTRATIVE RATIO 5.3%

Solvency Action Plan

Target: TNE % = 400-500% of Required



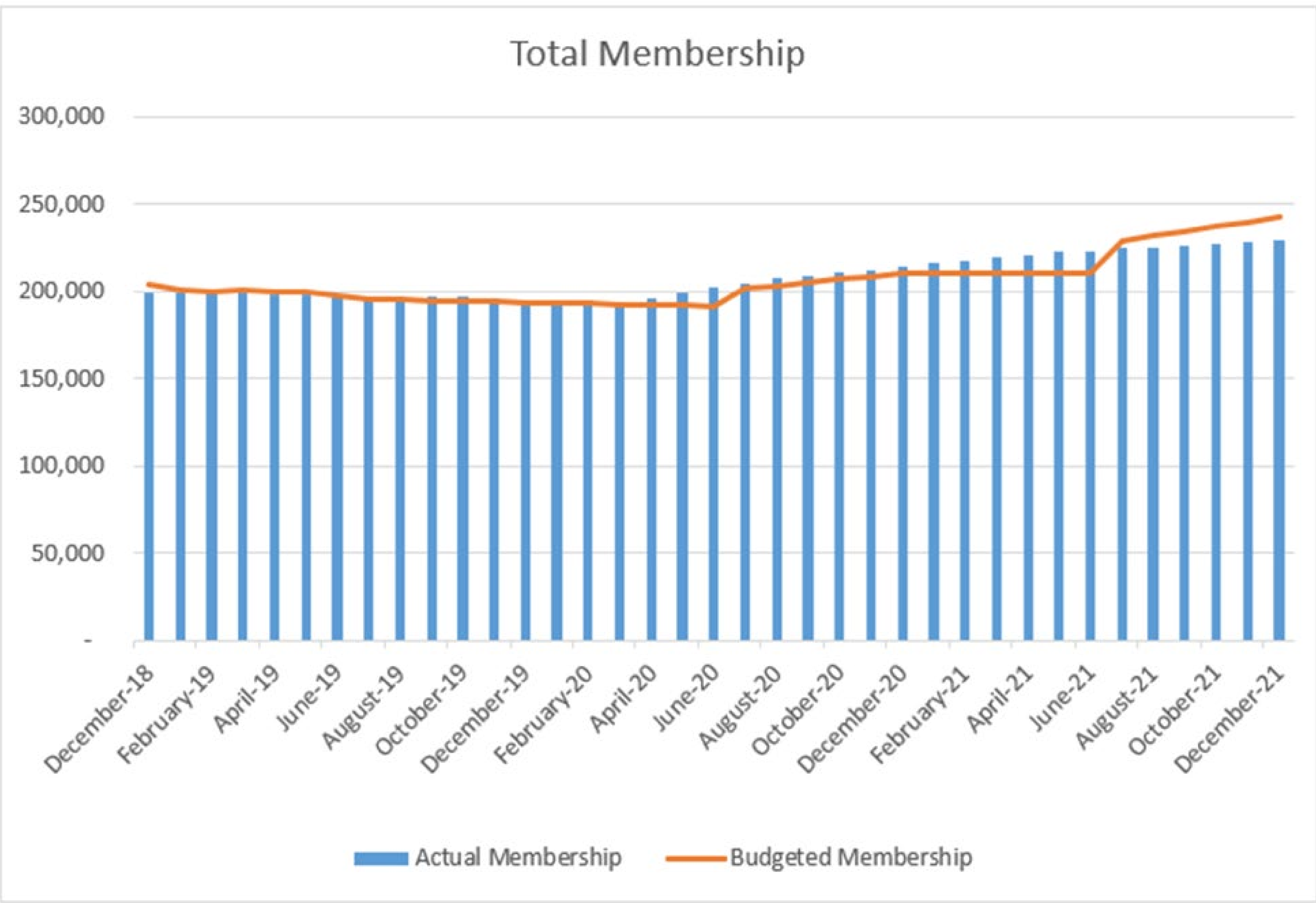
Revenue

Net Premium revenue is $503.3 million, under budget by $285,685.

Next Month:

1. Revised Capitation rates in effect
2. Anticipate at least two updates to CY 22 rates

Membership trends



Medical Expense

FYTD Health care costs are $450.3 million and $14.8 million and 3% under budget. Medical loss ratio is 89.5%, a 2.9% budget variance.

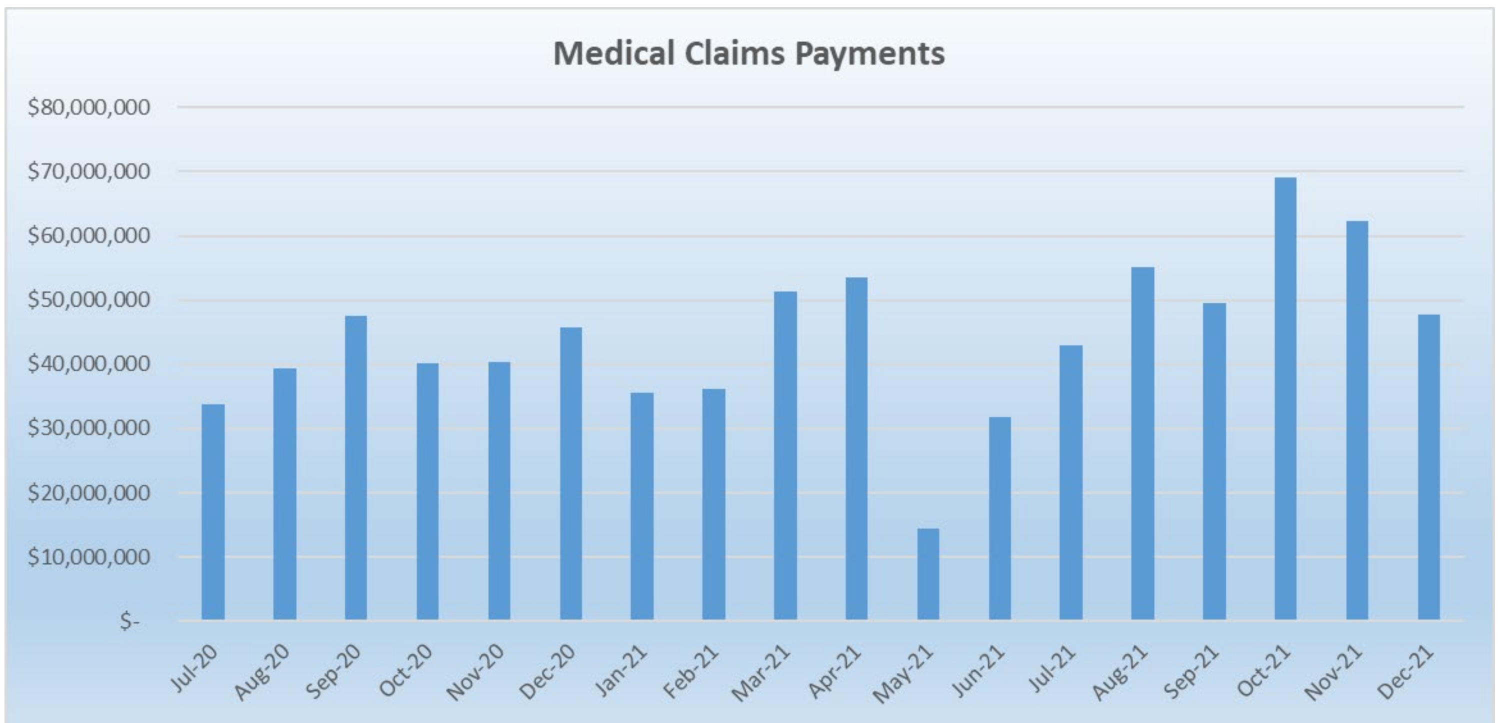
The budget for medical expenses was based on CY 2019 pmpm costs and trended forward. FYTD, actual pmpm costs are have not escalated to that level.

Return to Agenda

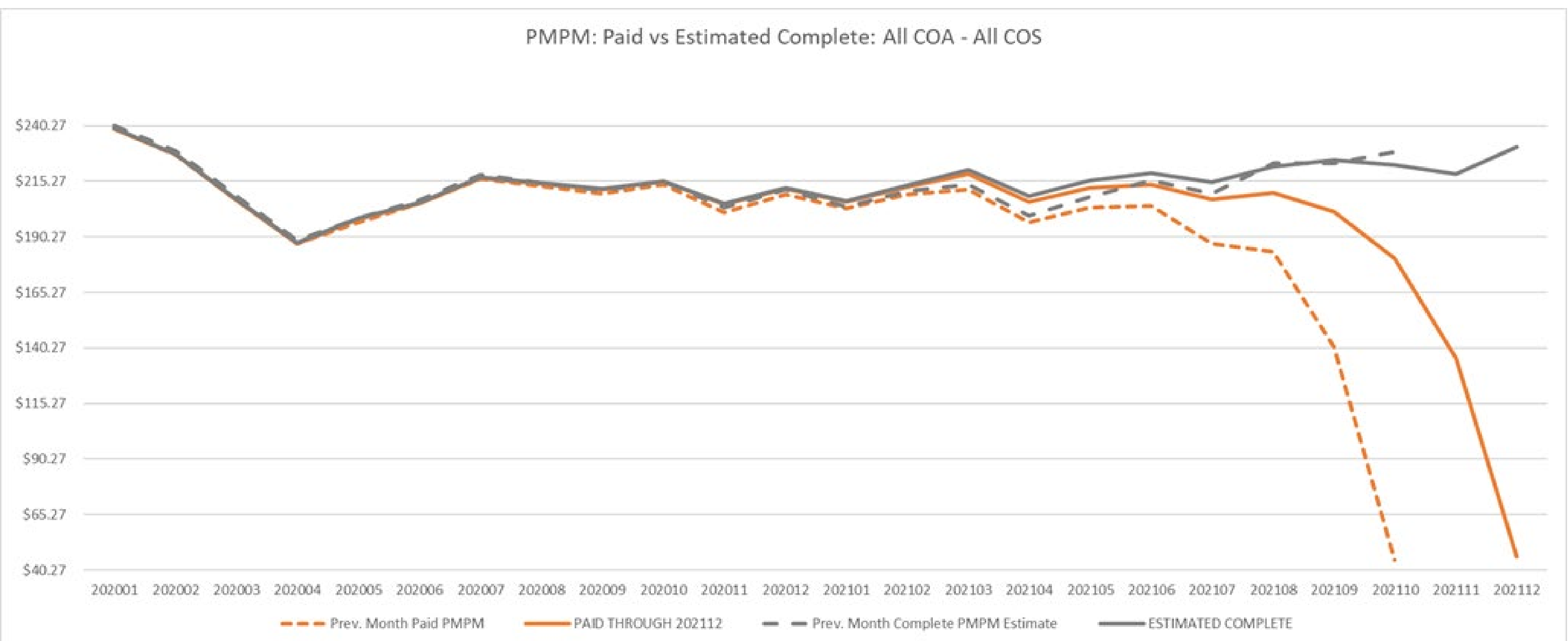
Incurred But Not Paid (IBNP) Medical Expense Reserve – post system conversion

Accurately calculating the reserve becomes more challenging:

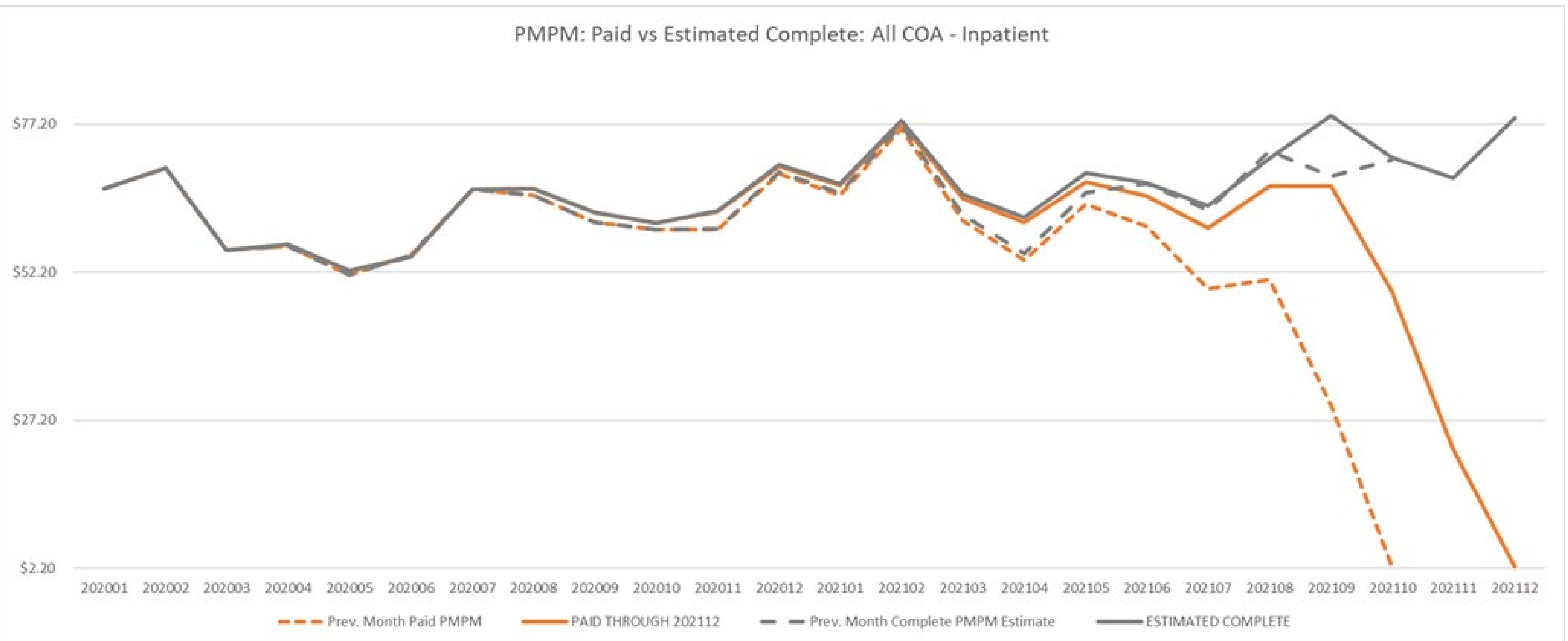
1. Historical lag between when a service is performed and when the claims is paid is disrupted
2. Still need to correct category of service on the financial statements.



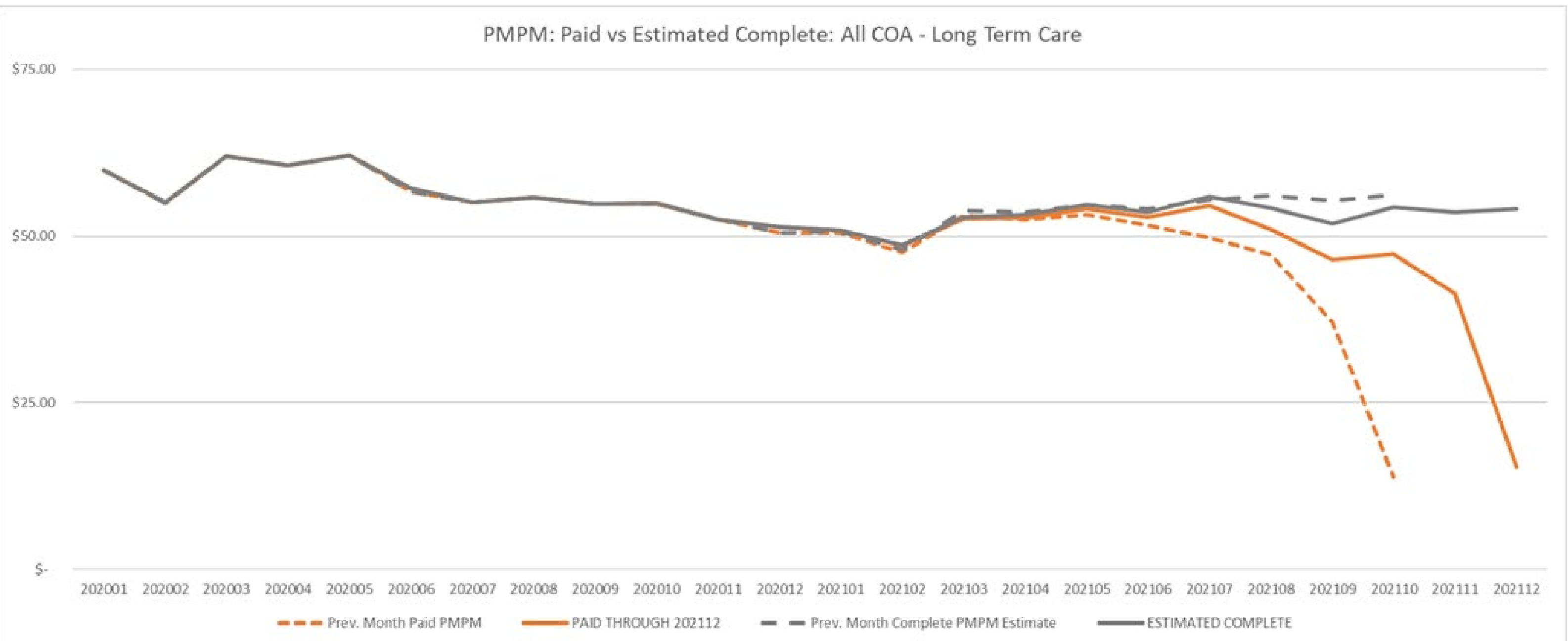
Incurred But Not Paid (IBNP) Medical Expense Reserve



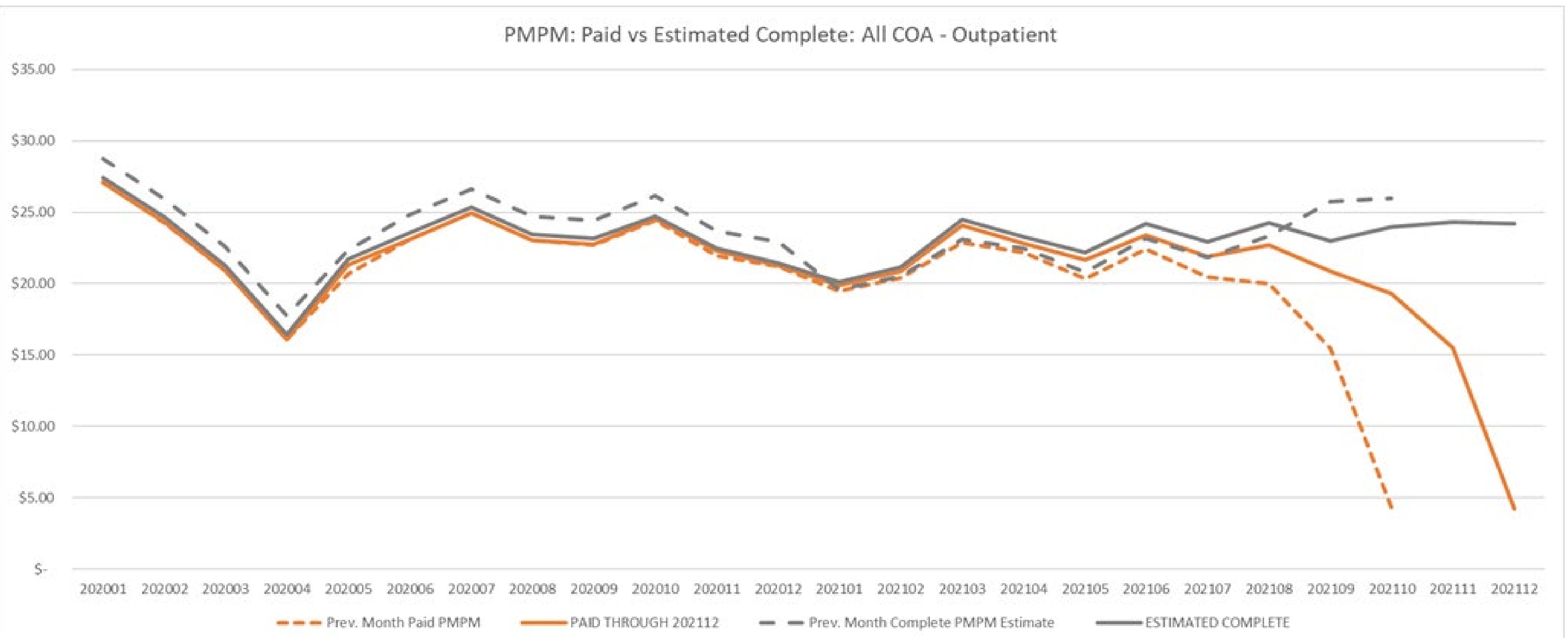
Inpatient



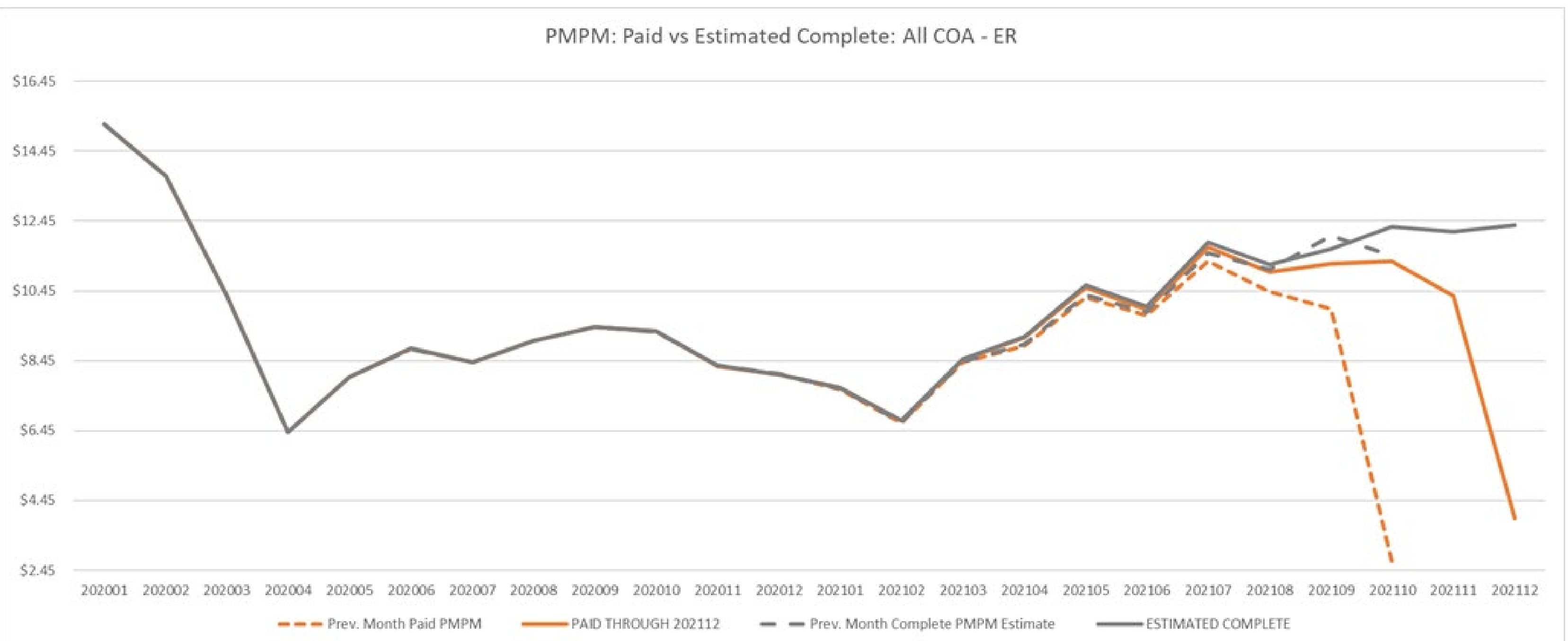
Long Term Care



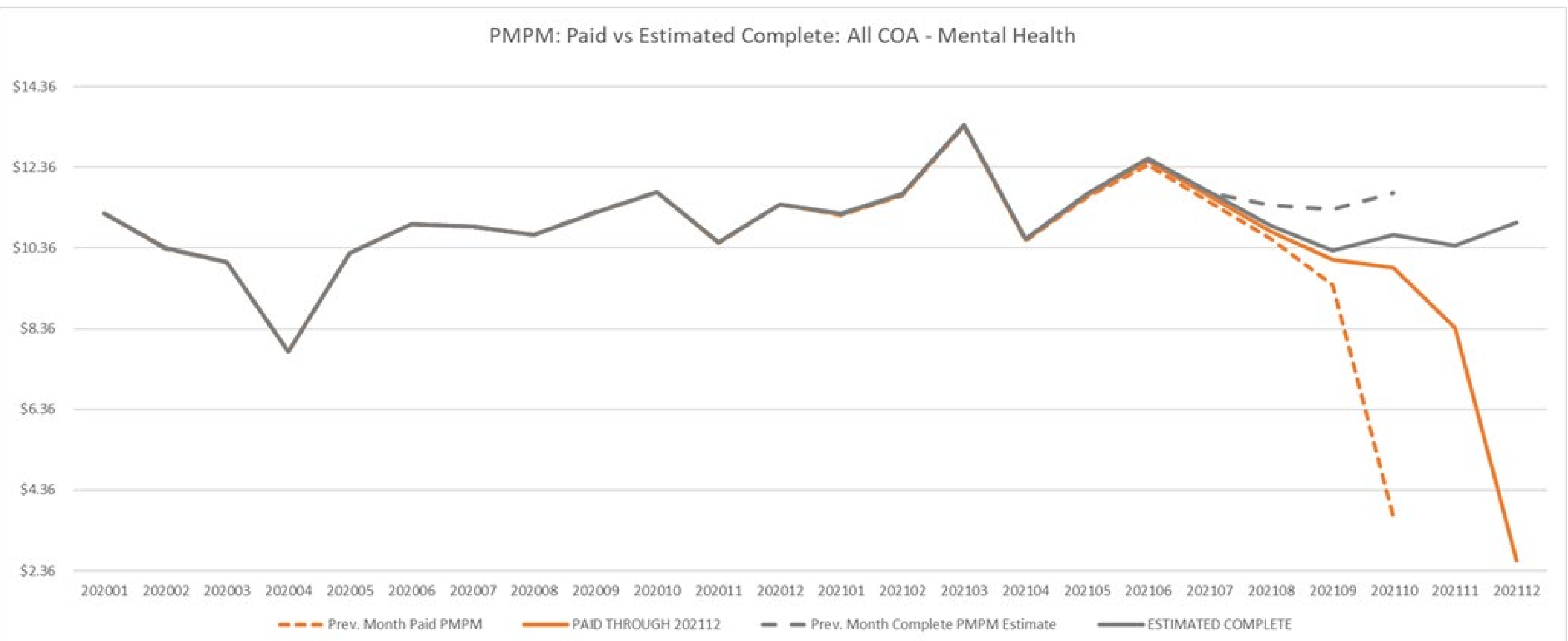
Outpatient



Emergency Room



Mental and Behavioral Health



Administrative Expenses

FYTD administrative costs are $26.9 million and $6.6 million and 20% under budget. Administrative cost ratio is 5.3%, a 1.3% budget variance.

The following are the most significant drivers of administrative expense favorability:

- *Enterprise Project Portfolio*: timing of consulting services related to multiple projects (~$2.9M)
- *Salaries, Wages & Employee Benefits*: primarily related to timing of filling open positions (~$575K)
- *Outside Services*: favorability of Conduent and PBM admin expenses due to membership lower than projected and lower fulfillment related charges (~$1.7 M)
- *Occupancy, Supplies, Insurance and Other:* timing of software and non-capital equipment purchases and implementation, lower printing expenses and lower than budgeted interest expense (~$1.1M)

Financial Statement Summary

	November 2021	December 2021	FYTD Actual	FYTD Budget	Budget Variance
Net Capitation Revenue	$ 84,882,233	$ 84,558,268	$ 503,315,712	$ 503,601,397	$ (285,685)
Health Care Costs	79,272,297	77,882,002	450,275,001	465,057,570	(14,782,568)
Medical Loss Ratio			**89.5%**	**92.3%**	
Administrative Expenses	4,498,986	4,702,883	26,869,972	33,448,322	(6,578,349)
Administrative Ratio			**5.3%**	**7.3%**	
Non-Operating Revenue/(Expense)	14,499	92,177	170,066	180,000	(9,933)
Total Increase/(Decrease) in Net Assets	$ 1,125,449	$ 2,065,560	$ 26,340,805	$ 5,275,506	$ 21,065,300
Cash and Investments	$ 123,378,080	$ 221,693,363			
GCHP TNE	$ 129,990,122	$ 132,055,682			
Required TNE		$ 37,613,177			
% of Required		**351%**			

Questions?

Staff requests the Commission approve the unaudited financial statements for November and December 2021.

Return to Agenda

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Marlen Torres, Executive Director, Strategy & External Affairs and GCHP Executive Team

DATE: January 31, 2022

SUBJECT: Review of Five-Year Proposed Strategic Plan

PowerPoint with Verbal Presentation

ATTACHMENTS:

REVIEW OF FIVE-YEAR PROPOSED STRATEGIC PLAN

Gold Coast Health Plan℠
A Public Entity

GCHP FIVE YEAR STRATEGIC PLAN: 2022 – 2026

January 31, 2022

Integrity

Accountability

Collaboration

Trust

Respect

Agenda

1. **General Overview**
2. **CalAIM**
   a. Enhanced Care Management/Community Supports (ILOS)
   b. Population Health Management
   c. NCQA Health Plan Accreditation
   d. D-SNP/PBM Timeline and Overview
   e. Behavioral Health
3. **Diversity, Equity, and Inclusion**
   a. Health Equity
   b. DEI Employee Efforts
4. **Workforce**
5. **Technology**
6. **Request for Input from Commission**
7. **Conclusion and Next Steps**
8. **Appendix**

1. General Overview

What to expect from today's session

...in the context of the larger Strategic Planning process

Continue the presentations started on December 16th with the aim of providing background/context for the imperatives of the 5 Year Strategic Plan ("Plan").

OBJECTIVE FOR TODAY

To further develop the foundation of background/context we all need to evaluate the goals of the 5 Year Strategic Plan and to support near-term actions and priorities.

KEY NEXT STEPS

February/March meetings involve deeper engagement with the Commission on 2022 actions and priorities for success now and throughout the Plan. This will include a review of current and planned staffing and other investments as a build-up to the Budget.

DECISIONS AND ACTION

Engagement on Budget begins in the 2nd Quarter (Commission and Executive Finance Committee) with the goal of approval in the June Commission meeting.

Return to Agenda

2. California Advancing and Innovating Medi-Cal (CalAIM)

Return to Agenda

CalAIM Overview

1. CalAIM's vision is to meet people where they are in life, address social drivers of health, and break down the walls of health care.
2. CalAIM will offer Medi-Cal enrollees coordinated and equitable access to services that address their **physical, behavioral, developmental, dental, and long-term care needs,** throughout their lives.
3. A better Medi-Cal is a key building block of California's broader commitment to building a **healthier** and more **equitable** state.

California Advancing and Innovating Medi-Cal (CalAIM)
Our Journey to a Healthier California for All

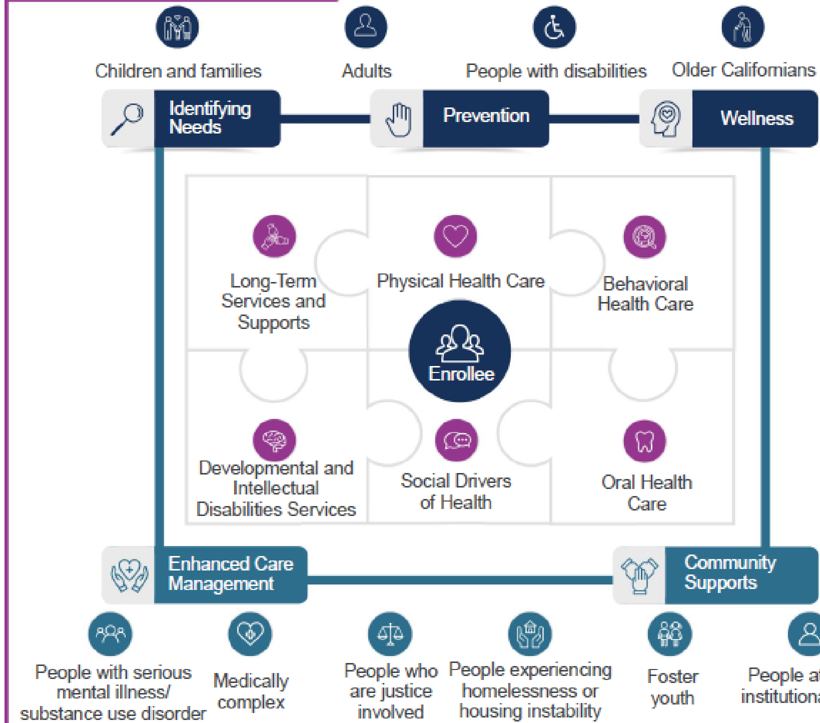
CalAIM is a long-term commitment to transform and strengthen Medi-Cal, making the program more equitable, coordinated, and person-centered to help people maximize their health and life trajectory.

CalAIM Goals

Implement a whole-person care approach and address social drivers of health.

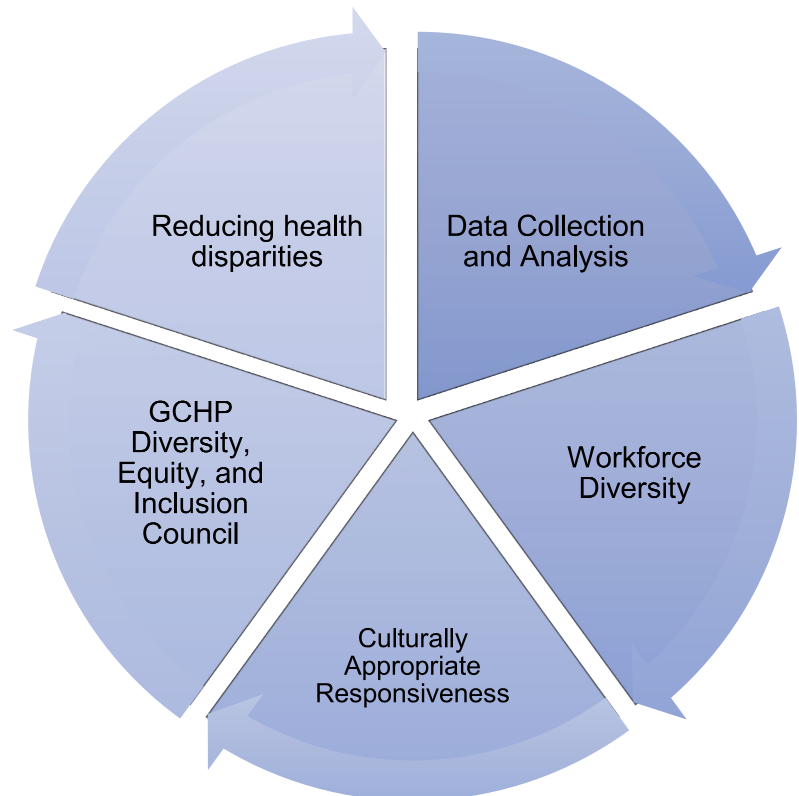
Improve quality outcomes, reduce health disparities, and drive delivery system transformation.

Create a consistent, efficient, and seamless Medi-Cal system.

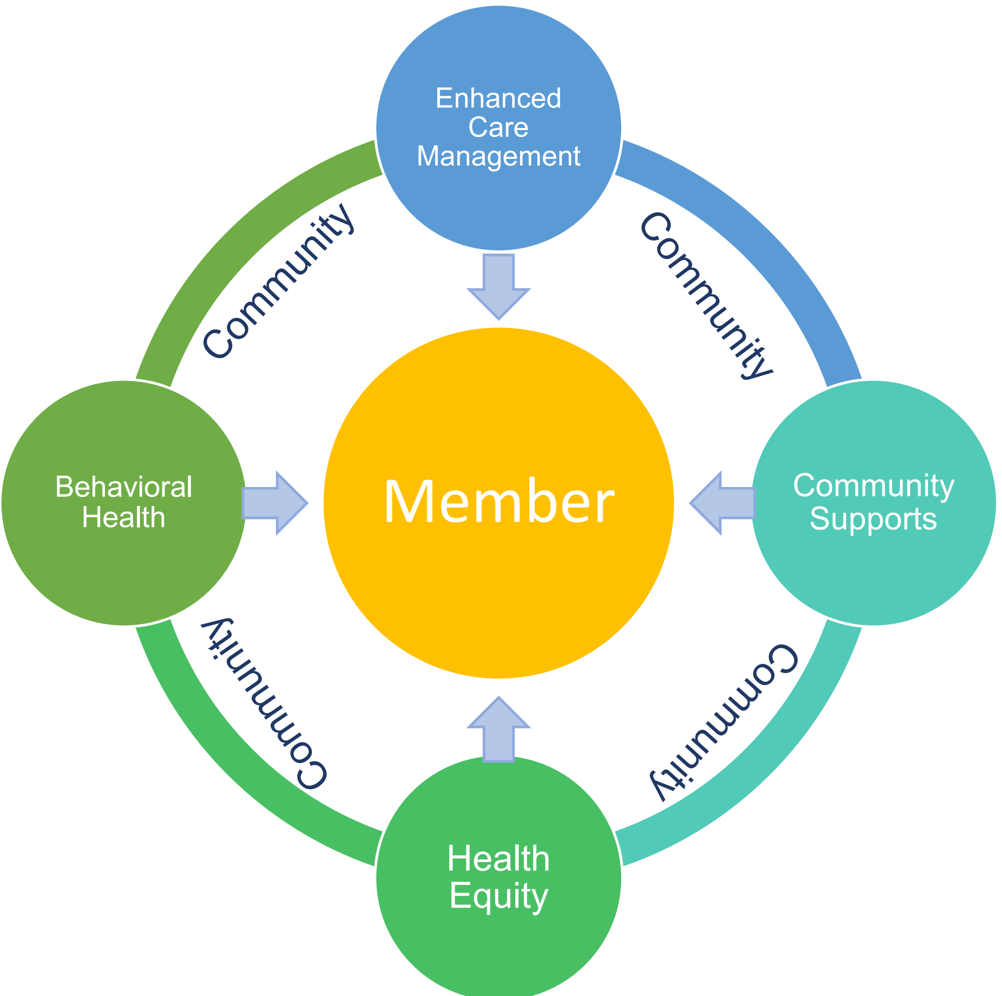


CalAIM and Health Equity

- CalAIM objective is to address health inequities by doing the following:
  - Data collection: Complete and accurate data collection to identify and address health inequities.
  - Workforce diversity: Workforce, at all levels, will reflect the diversity of the Medi-Cal beneficiary population.
  - Culturally appropriate responsiveness: Always provide culturally and linguistically appropriate care.
  - GCHP's Diversity, Equity, and Inclusion Council: The council is a diverse, multi-functional group whose mission it is to develop and maintain a climate that welcomes and promotes respect for a wide variety of human experiences.
  - Reducing health care disparities: Eliminate racial, ethnic, and other disparities within the Medi-Cal population.



Member Centered Approach



CalAIM Incentive Payment Program

Delivery System Infrastructure

- Purchase or upgrade of ECM and ILOS IT systems.
- Closed-loop on referrals.
- Billing systems/services.
- Enhancements to health information exchange capabilities.

ECM & ILOS Provider Capacity

- Expand ECM Provider networks.
- Hire and train ECM care managers, care coordinators, and community health workers.

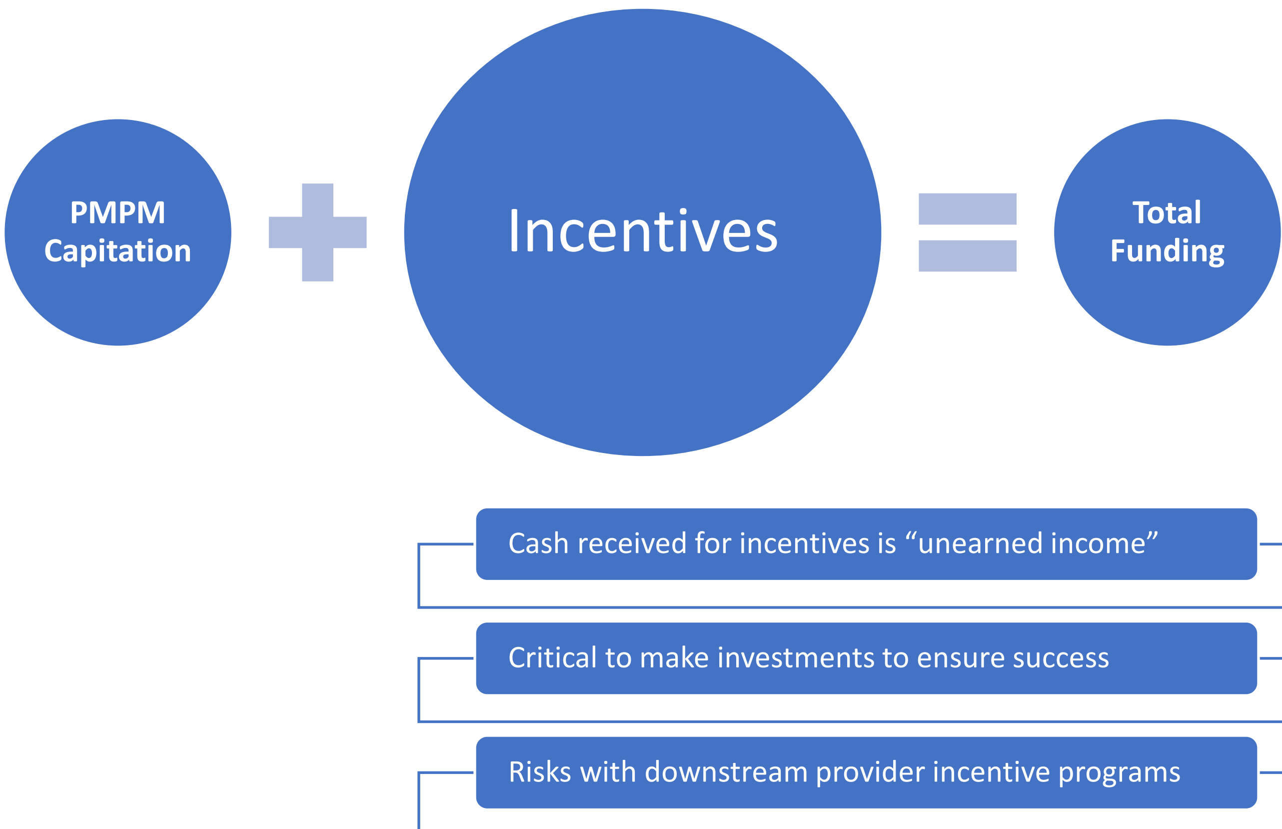
ILOS Provider Capacity

- Build/expand ILOS Provider networks.
- Expand reach of ILOS offered.

Quality Performance

- Reduce Health Disparities and Promote Health Equity.
- Baseline Reporting.

Financial Considerations



A. Enhanced Care Management / Community Supports (ILOS)

Agenda

1. Current State
2. Implementation Progress
3. Expansion Strategy

Return to Agenda

Enhanced Care Management (ECM)

ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries.

January 1, 2022 *(Phase 1)*	**January 1, 2023** *(Phase 2)*	**July 1, 2023** *(Phase 3)*
1. WPC Transition 2. High Utilizers 3. Homeless Individuals 4. Severe mental Illness (SMI) / Substance Use Disorder (SUD) 5. Justice Involved Populations	1. Members at risk for Long-Term Care / Institutionalization 2. Skilled Nursing Facility transition / diversion to Assisted Living Facilities 3. Skilled Nursing Facility transition / diversion to a home	1. All other children and youth populations of focus

Community Supports

**Housing Transition Navigation Services

**Housing Deposits

**Housing tenancy and Sustaining Services

** Medically Tailored Meals/Medically Supportive Food

**Recuperative Care (Medical Respite)

Short-Term Post Hospitalization Housing

Respite Services

Day Habilitation Programs

Skilled Nursing Facility transition/diversion on to Assisted Living Facilities

Skilled Nursing Facility transition/diversion to a home

Personal Care & Homemaker Services

Environmental Accessibility Adaptations (Home Modifications)

Sobering Centers

Asthma Remediation

*** Available to Eligible GCHP members Jan. 1, 2022 ***

Return to Agenda

Implementation Progress

Community/Provider Engagement

- Communication Plan
- Community ECM/CS Advisory Committee

Operations

- Transition Planning (Phase I)
- Network Operations for ECM/CS Providers

Provider Engagement

- Technical Assistance & Education
- Network Development

Data/IT

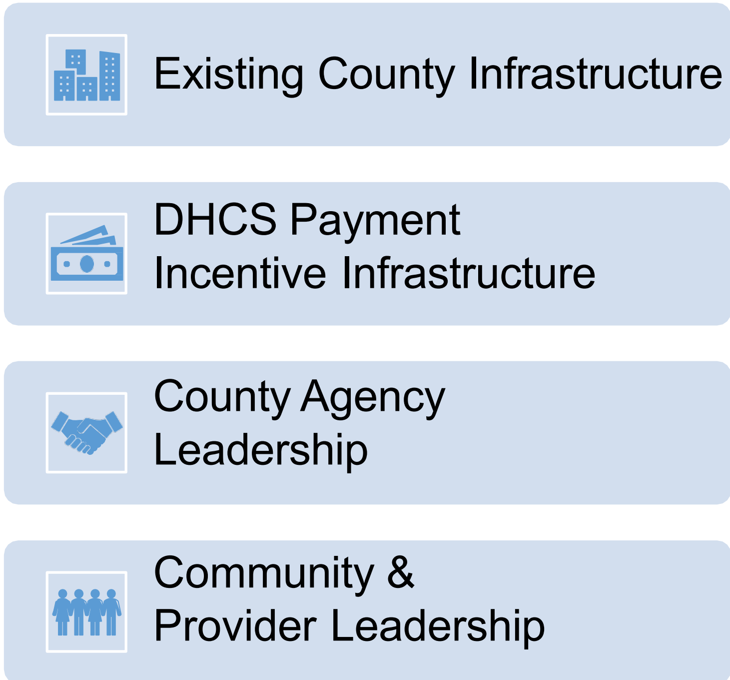
- Business Process Design
- Data Sharing Agreement
- DHCS Reporting & Incentive Payment Program (IPP)

Compliance

- Readiness Assessment Review

Return to Agenda

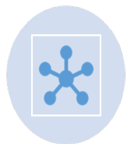
Key Considerations



Key Drivers for Expansion

Utilization Oversight & Analysis

County Infrastructure Development


Network Development

Stakeholder Input:

ECM/CS Advisory Committee

ECM/CS Implementation Timeline

Plan Area:	Milestones		
	2022	2023	2024
Enhanced Care Management (ECM) Populations of Focus	1. WPC Transition 2. High Utilizers 3. SMI/SUD 4. Homeless individuals 5. Justice Involved Populations	6. At risk for LTC/ institutionalization 7. Nursing Home Residents transitioning to the community	8. All other children and youth populations of focus
Community Supports *(** CS services can be revised every 6 months**)*	1. Housing Navigation 2. Housing Deposits 3. Housing Tenancy 4. Medically Tailored Meals 5. Recuperative Care **<u>July 2022</u>** 6. Asthma Remediation 7. Short Term Post Hospitalization	8. Respite 9. SNF transition/ diversion to assisted living facilities 9. SNF transition/ diversion to a home 11. Personal Care / Homemaker services 12. Environmental Accessibility Adaptions	13. Day Habilitation 14. Sobering Center

All Community Support (CS) Services will be implemented by Dec. 2024

Return to Agenda

B. Population Health Management

Return to Agenda

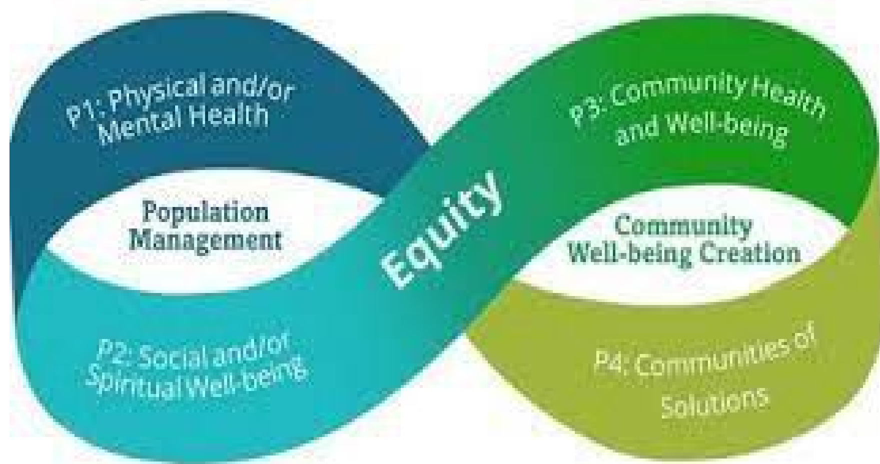
Agenda

1. CalAIM Population Health Management Overview
2. National Committee Quality Accreditation (NCQA) Standards
3. GCHP Implementation Plan

What is CalAIM Population Health Management (PHM)?

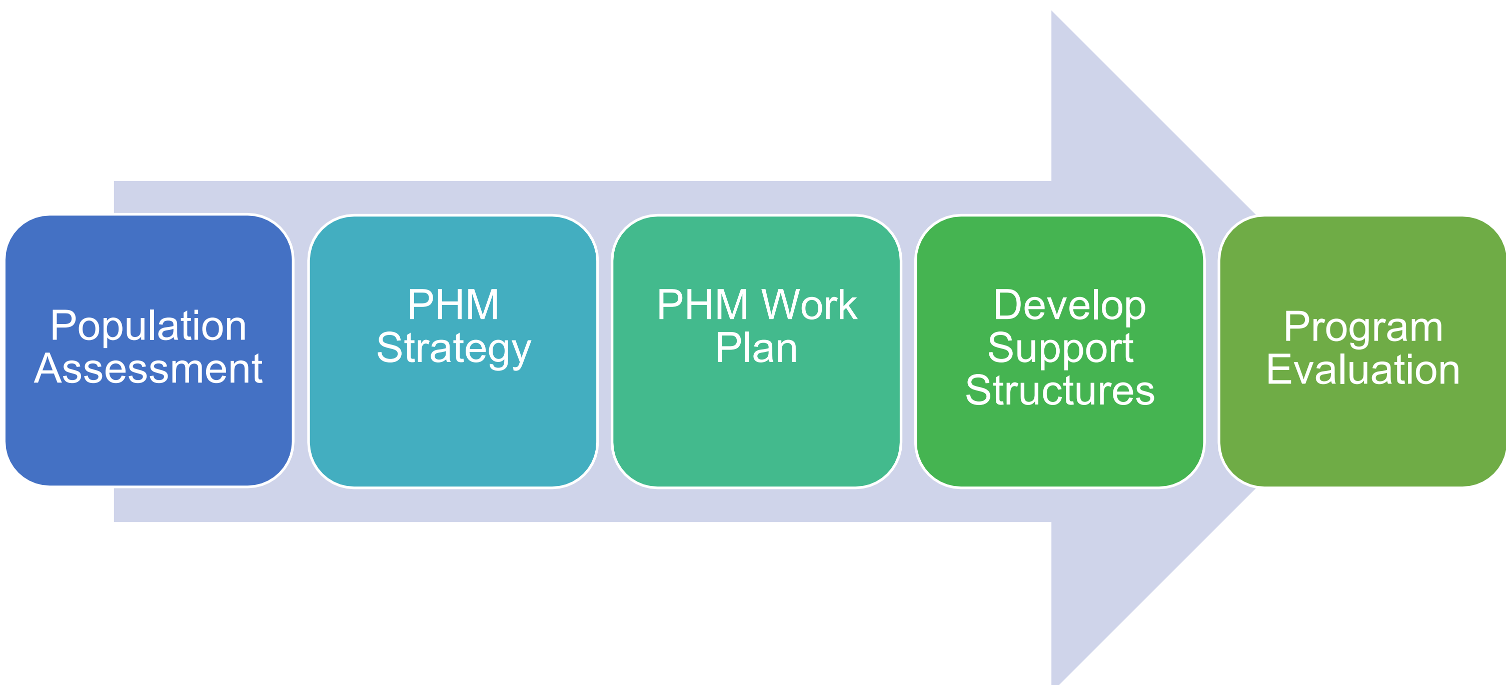
How we promote the health and wellbeing of the communities we serve, including:

- Assessing the population
- Segmenting the population
- Developing/targeting activities to meet needs of the population
- Analyzing the results and continuously improving interventions

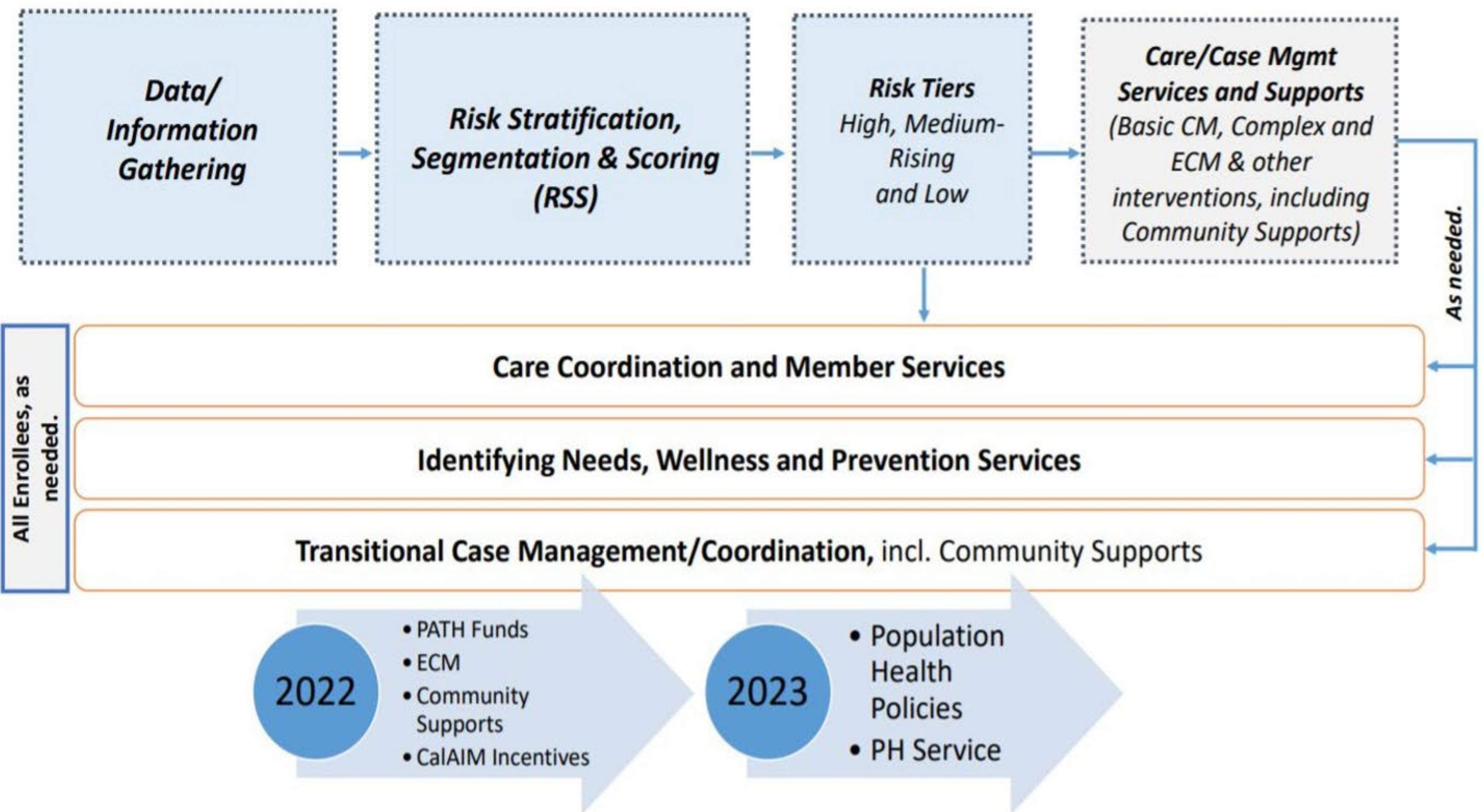


Return to Agenda

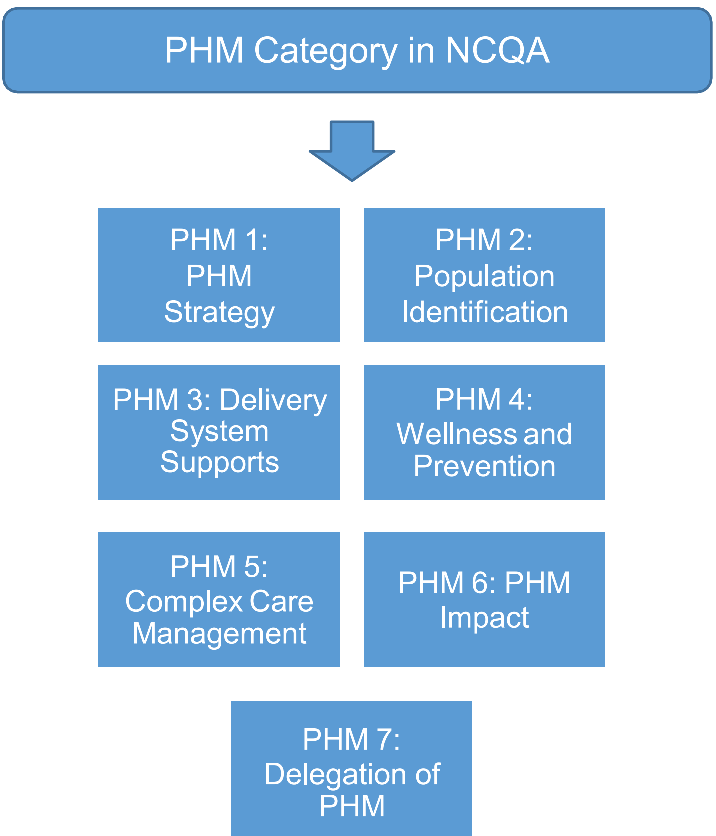
GCHP’s PHM Framework



Population Health Management



CalAIM Proposed Requirements for PHM: Aligning with NCQA PHM Standards

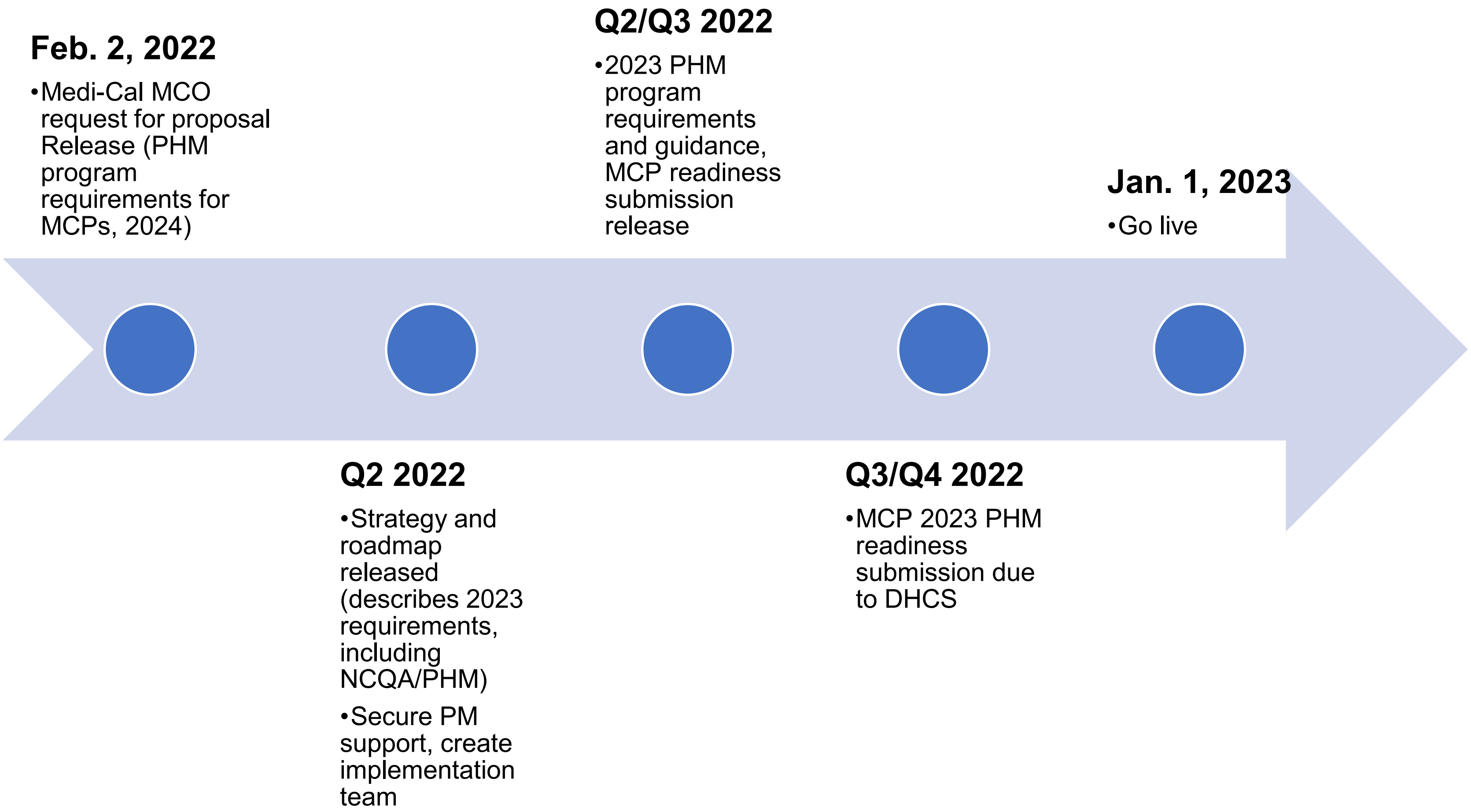


Return to Agenda

Where DHCS Adds to NCQA

- Additional focus on health disparities and SDOH
- Required assessment elements and member-contact assessment
- More specific risk stratification and segmentation requirements
- Enhanced contract wellness and other services
- More specific transition coordination requirements
- More comprehensive information sharing goals

PHM Timeline



C. NCQA Health Plan Accreditation

Agenda

1. NCQA Accreditation Background
2. Provider Quality Incentive Program
3. Timeline

NCQA Background

NCQA Health Plan Accreditation is an organization-wide effort requiring cross-departmental resources and adherence to detailed standards.

Standards evaluate plans on:

- Quality Management and Improvement
- Population Health Management
- Network Management
- Utilization Management
- Credentialing and Recredentialing
- Members’ Rights and Responsibilities
- Member Experience

NCQA Scoring

To earn Accreditation:

- Meet at least 80% of applicable points in each standards category
- Submit HEDIS/CAHPS reporting after first full year of accreditation
- Submit HEDIS/CAHPS annually thereafter

Organizations are evaluated on how many factors are satisfied in each applicable element (worth 1 or 2 points)

- Met = Meets all eligible points
- Partially Met = Meets half of the eligible points
- Not Met = Meets no eligible points

Reaccreditation surveys occur every three years.

Health Plan Ratings:

- Overall rating is the weighted average of an organization’s HEDIS and CAHPS measure ratings, plus Accreditation points.

Provider Quality Incentive Program

Background

For FY 21-22, QI allocated $40,000 for consulting services to establish a Provider Quality Incentive Program.

Quality performance would be based on MCAS/HEDIS measures and utilize data available through Inovalon.

Project goal is improved quality performance, reduced risk for DHCS sanctions based on quality indicators, and improved health plan ratings for GCHP.

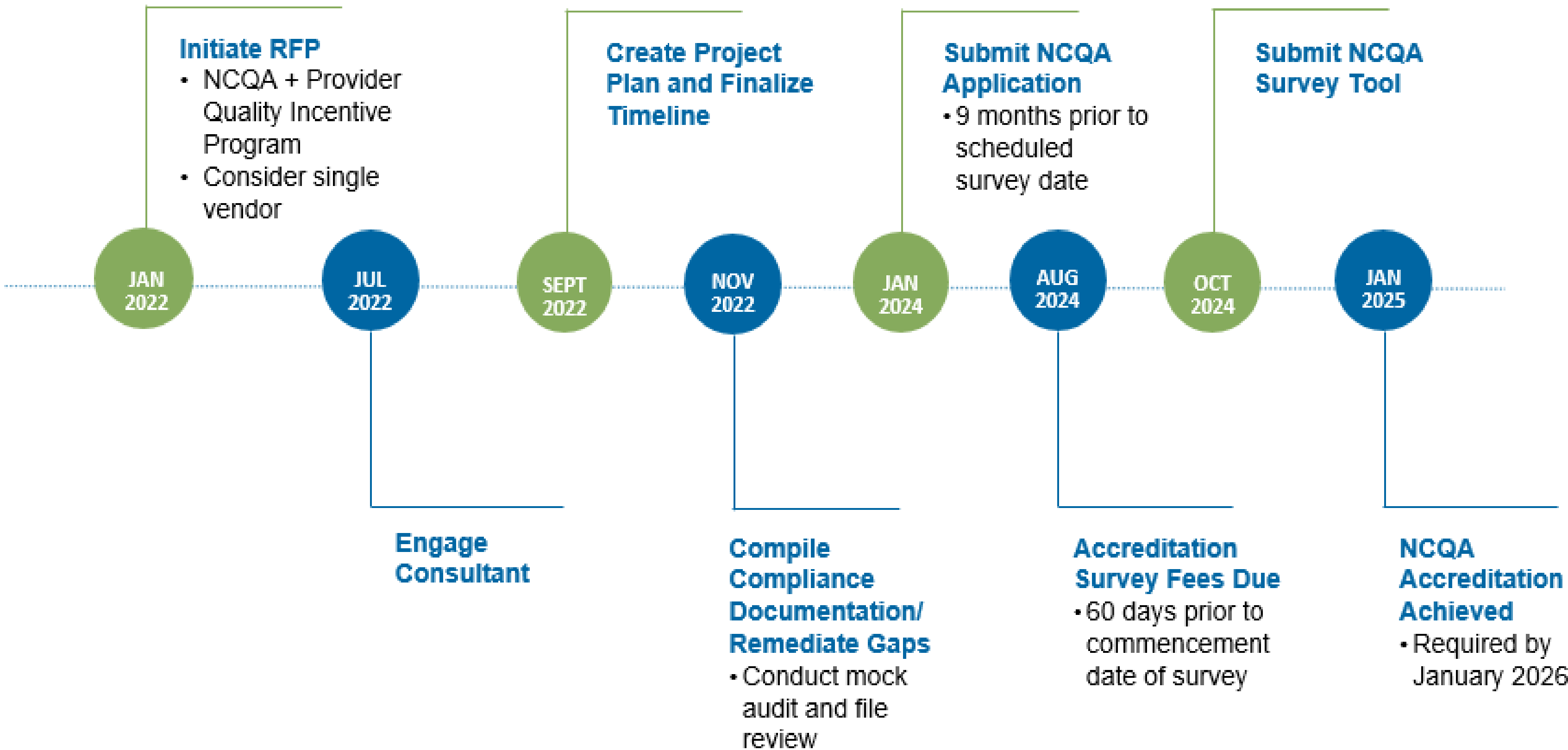
Project Details

- Enlist consultant/SME
- Measure selection
- Funding – Seed money/provider withhold
- Provider Contracts
- Provider Rollout/communications

Considerations

- Timeline (align with NCQA RFP or seek to engage consultant earlier to be ready to implement Q1 2022)
- Single vendor vs. separate entities

NCQA Accreditation Timeline

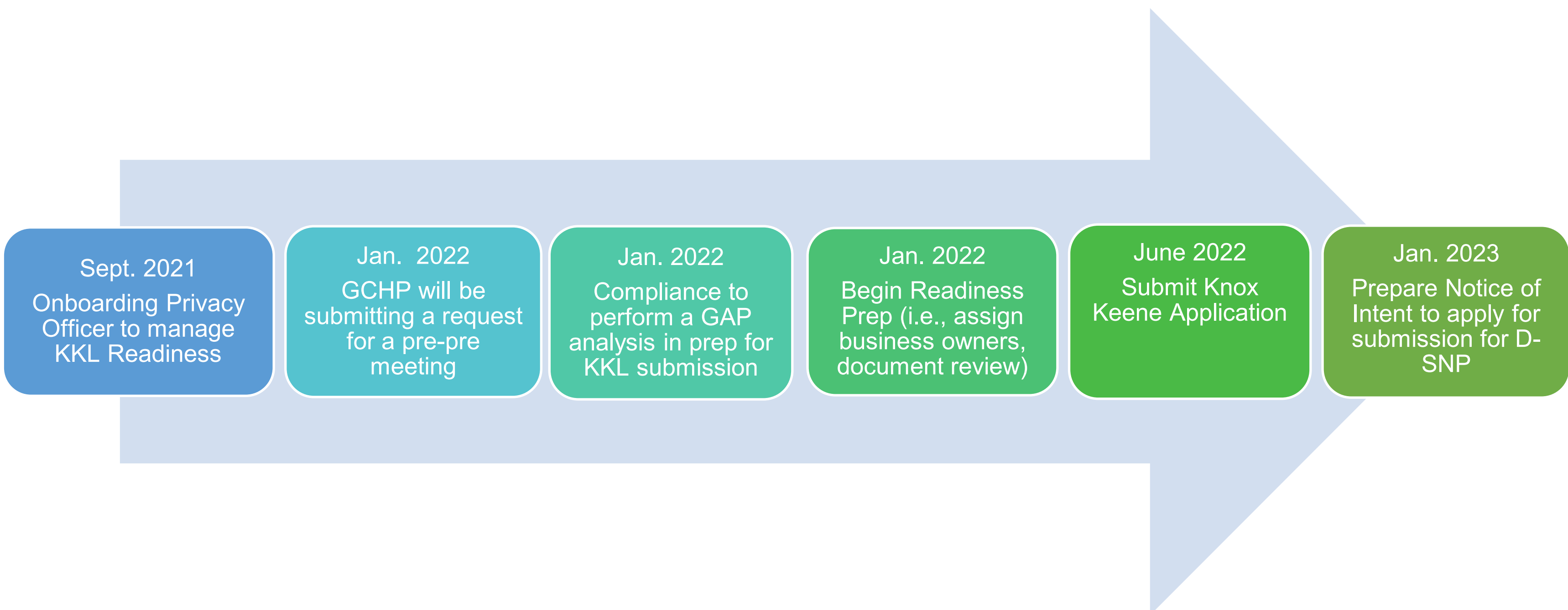


D. D-SNP/PBM Timeline and Overview

Agenda

1. Current and future state of preparing for D-SNP
2. Timelines
3. Operational Considerations
4. Strategic Implications

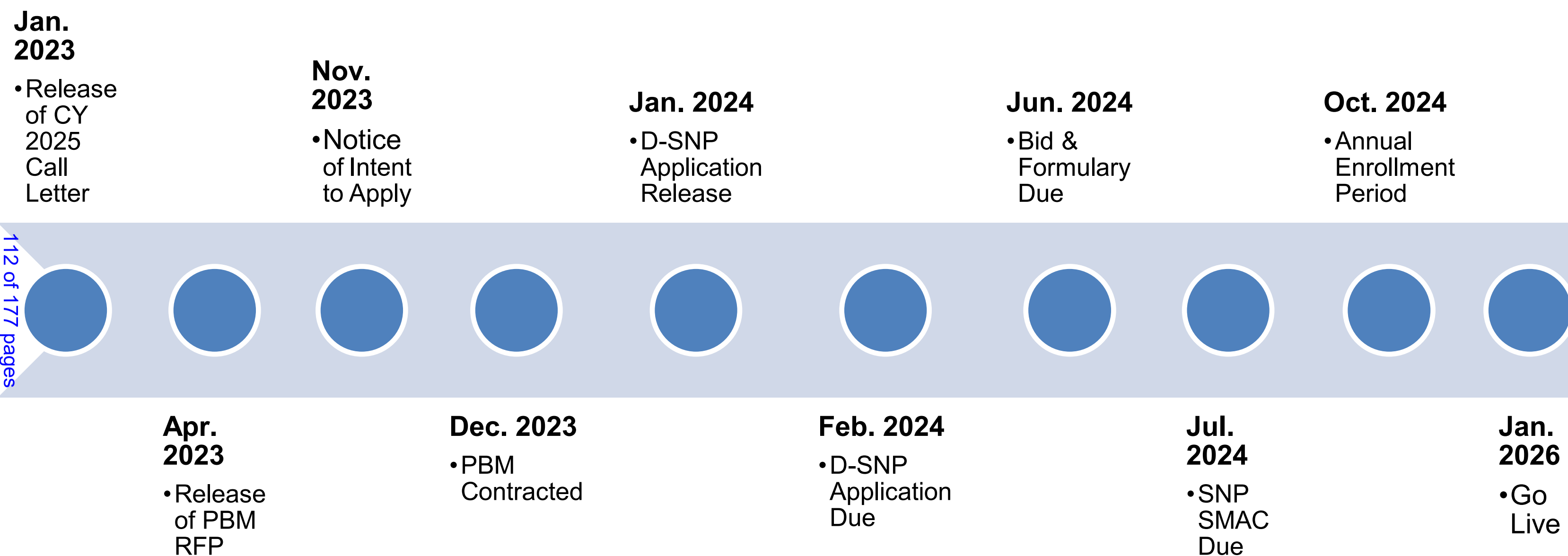
Knox Keene License Timeline



Strategic Implications

1. Support financial analysis and modeling related to KKL and application
2. Manage new risk(s) related to KKL and DMHC reporting
3. Conduct financial analysis/forecasting related to MA D-SNP; work with GCHP leadership to evaluate the D-SNP delivery system model and the D-SNP staffing model
4. Determine contractor and staffing models defined for D-SNP

D-SNP Timeline



Return to Agenda

Operational Considerations

PBM Delegation Decisions

- ✓ Claim Adjudication and Formulary Administration
- ✓ Encounters (PDE) and Pricing Files
- ✗ Pharmacy and Therapeutics Committee
- ❑ Coverage Determinations
- ❑ Grievances and Appeals
- ❑ Medication Therapy Mgmt (MTM)

Internal Operations and Vendors Decisions

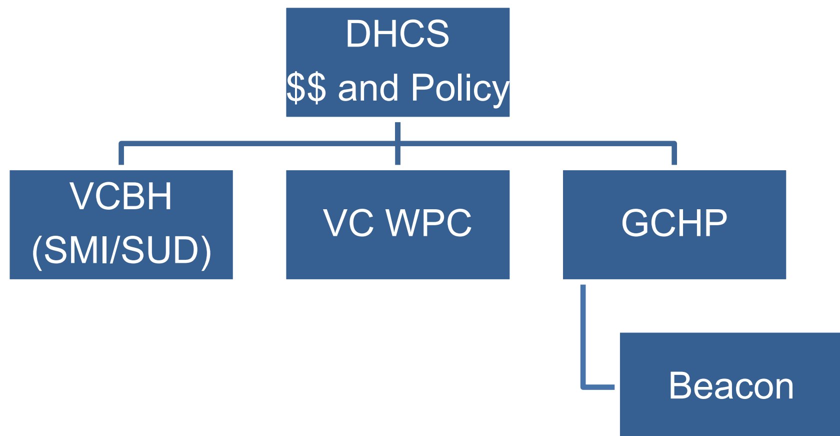
- ❑ Medicare vs. Medicaid operational unit segregation
- ❑ Actuary
- ❑ Data validation vendor (needed in 2026 for CY2025 validation)
- ❑ PBM consultant
- ❑ Marketing/Sales Support Team
- ❑ Star Rating Booster Programs

E. Behavioral Health

Agenda

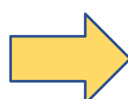
1. Current and future state of integrated behavioral health
2. Moving Towards Integration
3. Timeline
4. Student Behavioral Health Incentive Program

Behavioral Health Integration: Current and Future State



Current

- Members struggle to navigate this system
- Care is disjointed
- Providers struggle to meet member's whole-person health needs



Future

- Care is coordinated and integrated
- Members can access care multiple ways
- Providers have the information they need to make good treatment decisions

Moving Toward Integration

1. Member-centric, multi-disciplinary care for the whole person and family
2. Proposition 56 Behavioral Health Integration Incentive Program (BHIIP) Pilots
3. Children and Youth Behavioral Health Initiative Proposal-Student Behavioral Health Incentive Program (SBHIP)

BH Transformation Timeline

Jan. 2021
- BHIIP Begins

Jan. 2022
- Student Behavioral Health Incentive Program (SBHIP) begins

Jan. 2022
- SMHS eligibility criteria rework; Non-specialty MH services defined

July 2022
- SUD/SMH CalAIM Initiatives and new BH benefits begin

Dec. 2023
- BHIIP ends

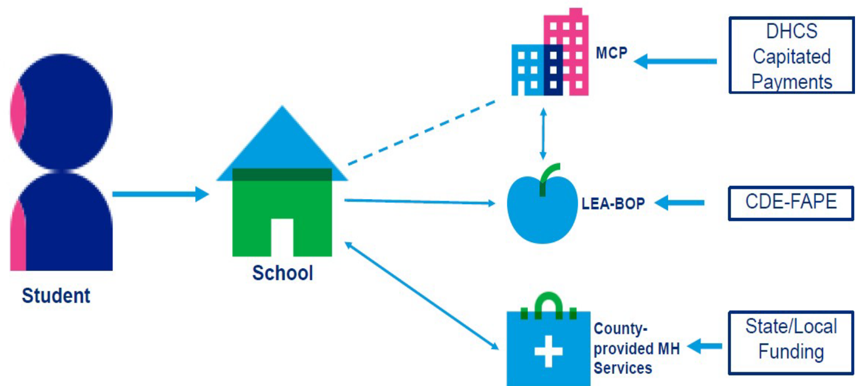
Jan. 2023
- Standardize Screening & transition tools (MCP-MHP)

Feb. 2024
- Beacon contract ends

Jan. 2027
- Go-live CalAIM Full Integration Pilot

Student Behavioral Health Incentive Program (SBHIP)

- 3 years (2022-2024)
- 2022: Assessment and project plan
- 2023-2024: implement interventions and then report outcomes
- Establish and strengthen partnerships, supplement existing programs
- Goal: increase non-specialty BH services for Medi-Cal students
- Partner with Ventura County Behavioral Health and Ventura County Office of Education
- ~7.8M to Ventura County



Budget implications: Consultant engagement for 12-month assessment funded by DHCS upfront payment Q1 2022

3. Diversity, Equity, and Inclusion

a. Health Equity

Agenda

- GCHP Health Equity Framework
- Health Equity Domains
- Reducing Health Care Disparities
- Data Collection & Stratification
- Work Diversity & Cultural Awareness

What is Health Equity?

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

Robert Wood Johnson Foundation

Return to Agenda

Framework for Health Care Organizations to Achieve Health Equity

Identifying GCHP Disparity Populations: DHCS Health Equity Report

DHCS generates annual health equity reports for each Medi-Cal Managed Care Plan with sub-rates for four demographic categories to compare the health outcomes of each demographic and to identify disparities.

The four demographic categories include:

1. age group
2. gender
3. language
4. race/ethnicity

AMM-Acute	Numerator	Denominator	Rate
Gold Coast Health Plan			
MCP Aggregate			
Age			
18–64 Years	732	1,165	62.83%
65+ Years	23	30	76.67%
Gender			
F	514	812	63.30%
M	241	383	62.92%
Language			
English	612	970	63.09%
Arabic	1	1	100.00%
Chinese	1	2	50.00%
Farsi	2	3	66.67%
Russian	1	1	100.00%
Spanish	134	212	63.21%
Tagalog	1	2	50.00%
Other	1	2	50.00%
Unknown/Missing	2	2	100.00%
Total			
All	755	1,195	63.18%
Race/Ethnicity			
White	259	381	67.98%
American Indian or Alaska Native	4	9	44.44%
Asian	16	21	76.19%
Black or African American	13	21	61.90%
Hispanic or Latino	303	529	57.28%
Native Hawaiian or Other Pacific Islander	1	1	100.00%
Other	138	207	66.67%
Unknown/Missing	21	26	80.77%

Indicator: AMM-A... | AMM-C... | AMR-Tot | BCS | CCP-M... | CCW-M... | CCW-M... | CDF-1217 | CDF-1864 | CDF-65 | CHL-Tot | DEV-Tot | PCR-OR...

Demographic Variable: Age | Gender | Language | Race/Ethnicity | Total

MCP: Gold Coast Health Plan

Reporting Unit: MCP Aggregate | Ventura

1. Asterisk(*) indicates a lower rate means better performance

Return to Agenda

Current Health Equity Efforts

- Quality-related requirements & activities
- Population Needs Assessment (PNA) annual reporting
- Health Initiatives: CalAIM ECM Community Supports (ILOS), NCQA
- Expanding state level health equity infrastructure
- Incentive program initiatives

Upcoming Health Equity Requirements & Activities

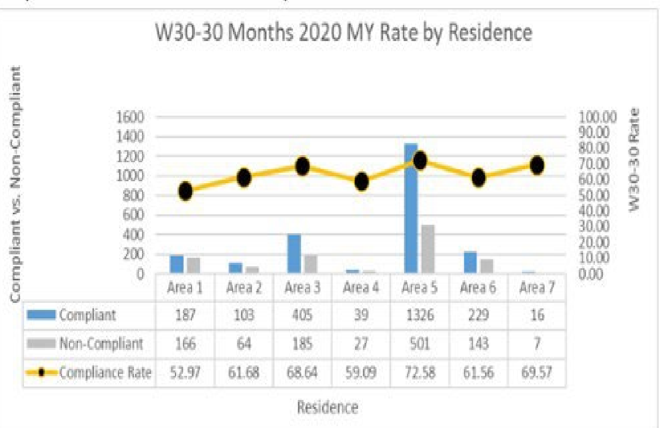
Proposed Equity Metrics for 2022		
Colorectal cancer*	Prenatal and postpartum care*	Child and adolescent WCV
Controlling high blood pressure*	Childhood immunizations *	Perinatal and postpartum depression screening
HgbA1c for persons with DM*	Adolescent immunizations	Follow up after emergency department visit for mental illness and substance use disorder (SUD)

**Metrics recommended by National Committee for Quality Assurance for stratification by race/ethnicity*

Identifying GCHP Disparity Populations:

Calculating Rates by Sub-Group

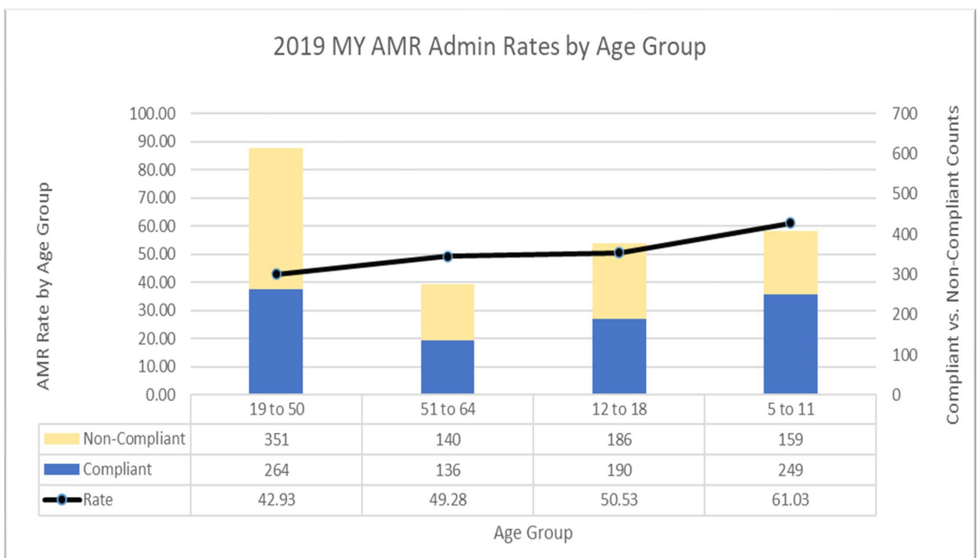
Graph 6B: W30-30 2020 MY Rate by Residence



	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7
Compliant	187	103	405	39	1326	229	16
Non-Compliant	166	64	185	27	501	143	7
Compliance Rate	52.97	61.68	68.64	59.09	72.58	61.56	69.57

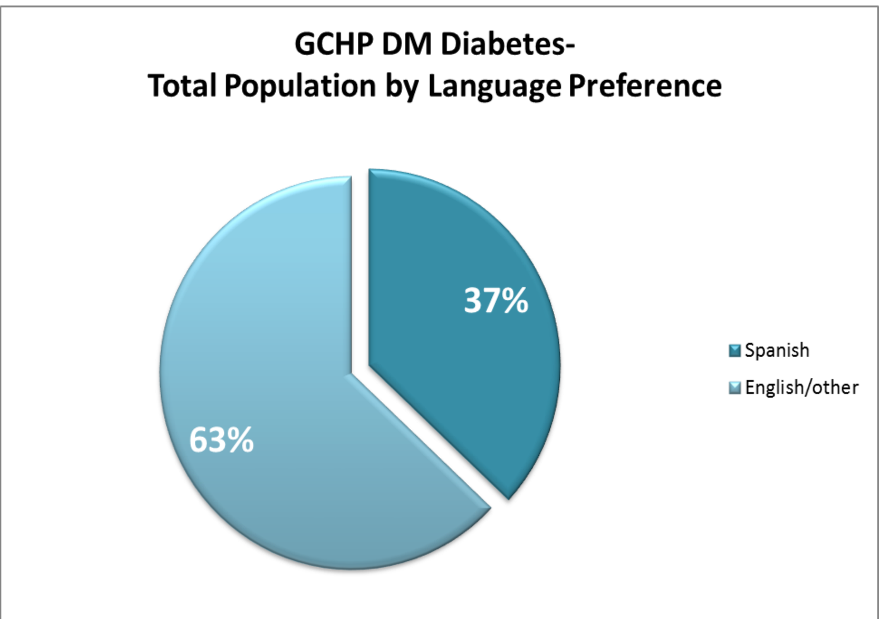
Graph 3B: W30-30 2020 MY Rate by Race

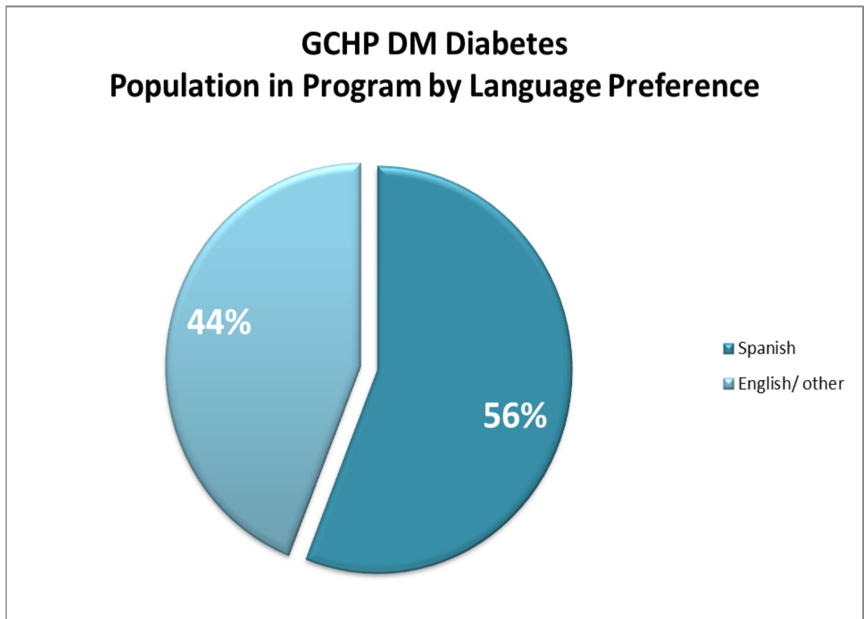
	1-White	2-African American	3-American Indian/Alaska Native	4-Asian	6-Other Rate	7-2+ Races	8-Declined
Compliant	280	12	381	28	3	1525	76
Non-Compliant	222	15	223	11	590	32	
Compliance Rate	55.78	44.44	63.08	71.79	0.51	97.94	100.00



	19 to 50	51 to 64	12 to 18	5 to 11
Non-Compliant	351	140	186	159
Compliant	264	136	190	249
Rate	42.93	49.28	50.53	61.03

Measured Impact of Health Equity Interventions for GCHP Members





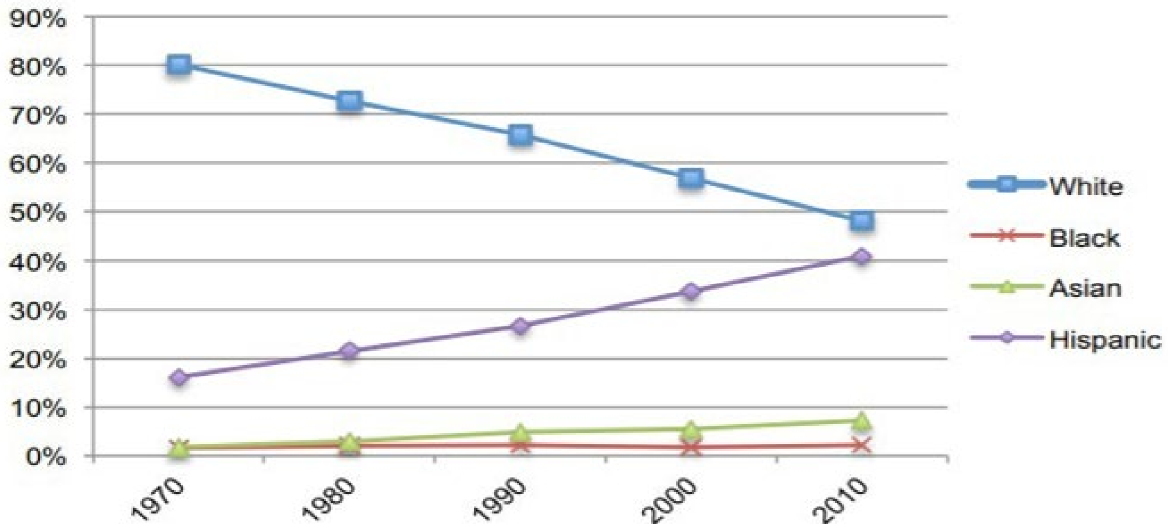
b. DEI Employee Efforts

GCHP Diversity, Equity, and Inclusion

Population Demographics in Ventura County

Race	Population Ventura County	% of Total	GCHP	% of Total
Total Population	854,223	100%	195	100%
White	551,888	65.2%	76	39%
Latino / Hispanic	377,765	44.64%	75	38%
Asian	64,331	7.6%	20	10%
African American	17,286	2.4%	10	5%
American Indian	8,872	1.1%	2	1%
Native Hawaiian / Pacific Islander	1,859	0.2%	3	2
Other / Mixed Race	42,474	4%	8	4%

Ventura County Population



Source: U.S. Census Bureau

The County's population over the last two decades,1990-2010, has become increasingly Hispanic. Therefore, Ventura County's Latino population has increased by more than 30% between 2000 and 2010. This trend is seen across California, where Latinos increased from 32% of the total population to 38% from 2000 to 2010.

Diversity, Equity, and Inclusion Council

Ted Bagley

Marlen Torres

Sarah Palomino

Marlin Wiley

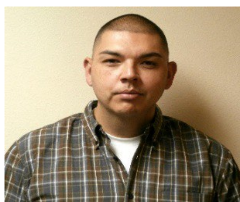
Susana Enriquez

Carolyn Harris

Rebecca Bridges

Shannon Robledo

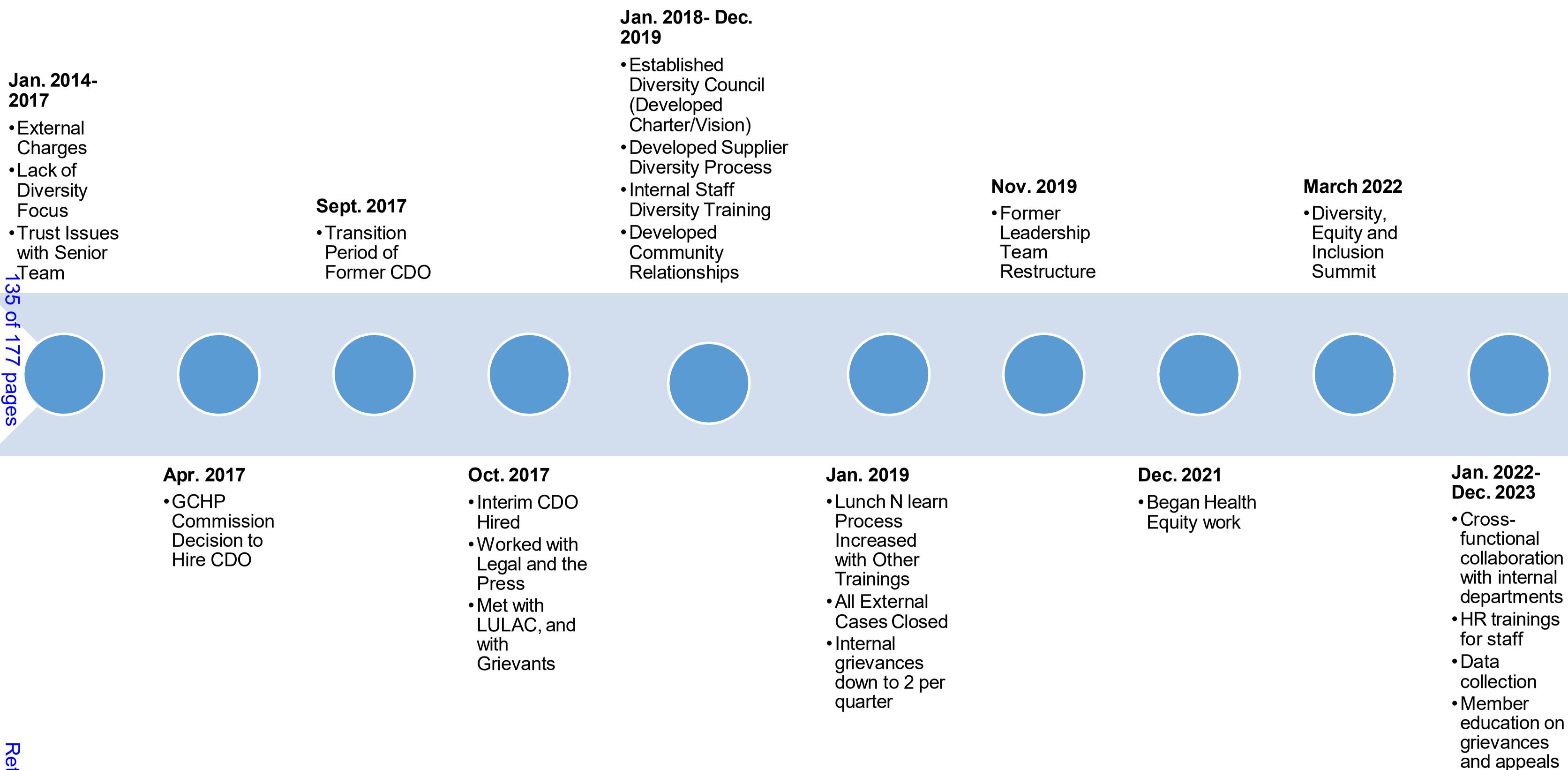
Annelie Ginn



Chris Martinez

Patricia Washington

Diversity Restructure Timeline



Return to Agenda

Diversity Wheel

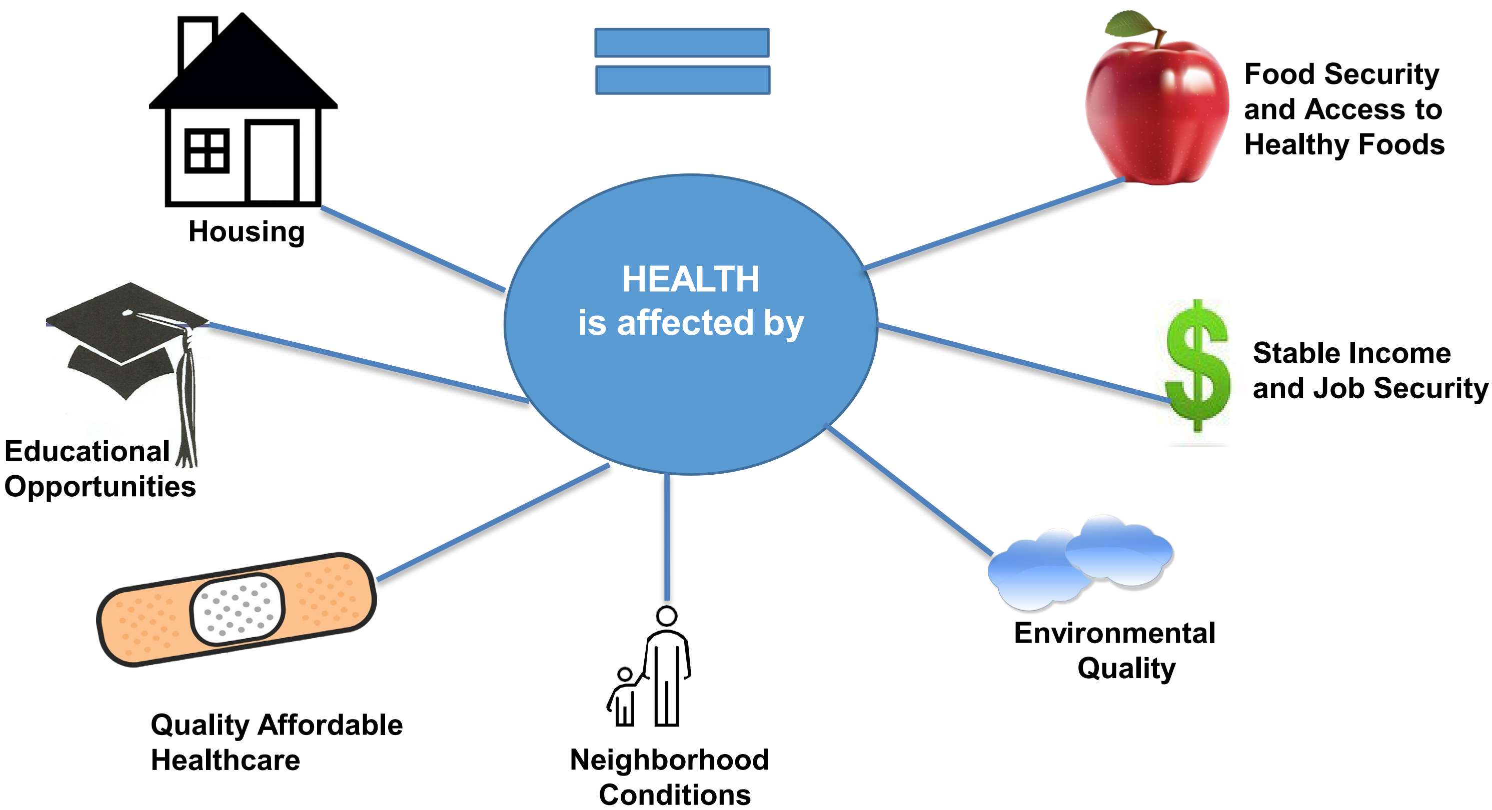
Disparities

- **Breast Cancer** – African American women are nearly twice as likely to be diagnosed with triple negative breast cancer and are more likely to die from breast cancer than white women.
- **Kidney Cancer** – Highest rates of kidney cancer and deaths occur among American Indians and Alaskan Native population.
- **Liver Cancer** – Highest rates are in American Indian, Alaskan Natives, and Asian and Pacific Islander population.
- **Prostate Cancer** – African American men are more than twice as likely to die from prostate cancer than white men.
- **Cervical Cancer** – Women in rural areas are twice as likely to die from cervical cancer than women in urban areas.
- **Multiple Myeloma** – African Americans are twice as likely to be diagnosed and die from multiple myeloma than whites.

The Path to Achieving Health Equity

What social and economic factors must be addressed on the continued path to achieving Health Equity?

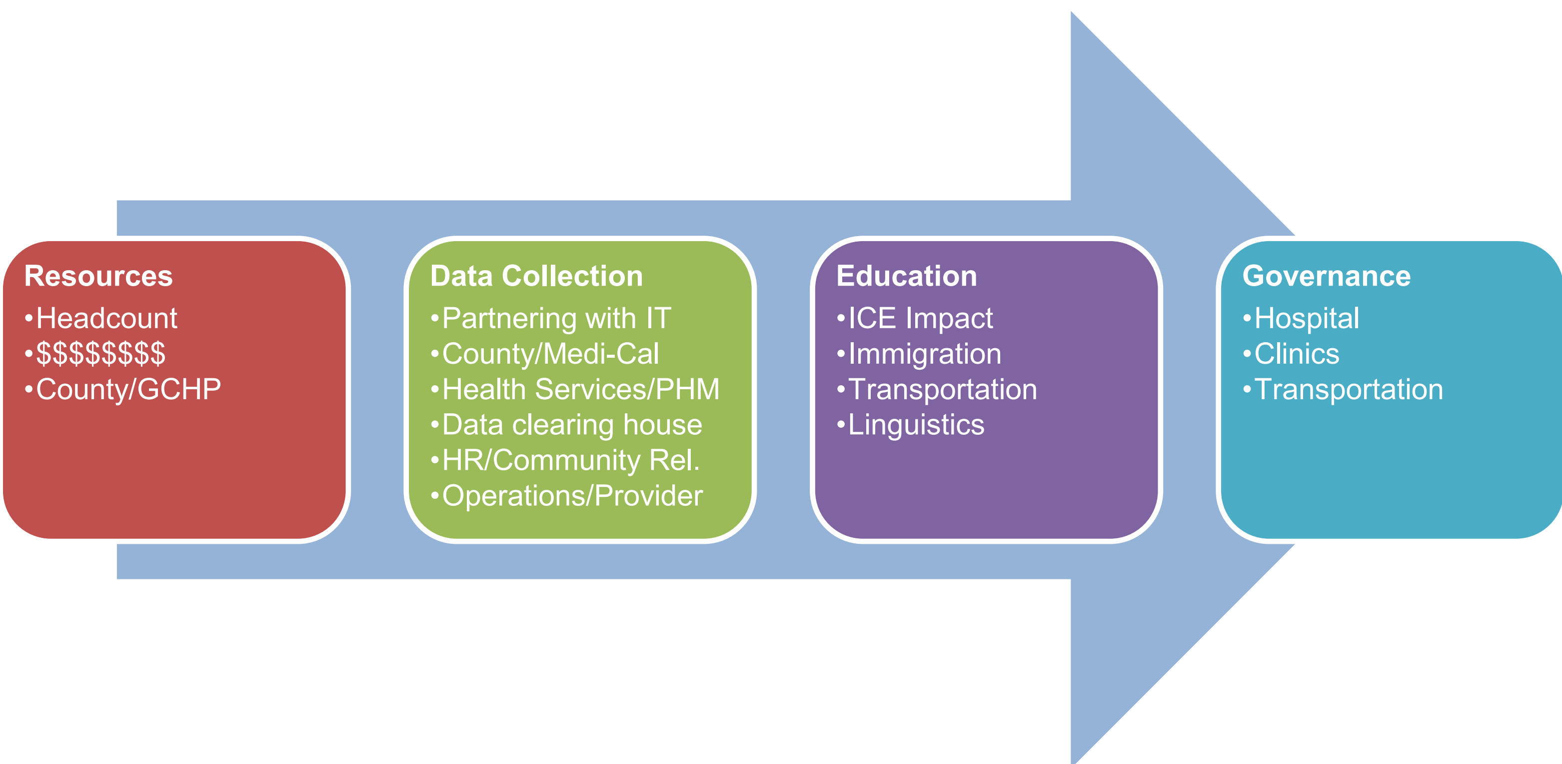
Discrimination / Minority Stressors



Health Equity aims to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

Return to Agenda

Future Focus on Health Equity, Inclusion, and Access



4. Workforce

HR Strategic Plan 2021-2022 Fiscal Year

GCHP will develop the best culture and be considered a great place to work

Develop “A Best Culture” This strategy will be accomplished through three foundational areas:		
Attract Talent: 25%	**Develop Talent: 44%**	**Retain Talent: 31%**
Recruiting Strategy	Succession Planning	Employee Survey
Compensation & Benefits	Leadership,Management Development	Compensation & Benefits
Return to Work	New Performance Review Process	Return to Work
New Performance Review Process	Updated HR Policies & Procedures	New Performance Review Process
Updated HR Policies & Procedures	Career Development	Updated HR Policies & Procedures
Career Development		Career Development

Return to Agenda

Compensation and Benefits Strategy (Attract and Retain)

We will improve our compensation and benefits strategies to provide more value to our employees and GCHP			
FY 2021 /2022	**FY 2022/2023**	**FY 2023/2024**	**FY 2024/2025**
• Conducted compensation study May 2021 • Salary ranges adjusted • 46 employees adjusted which is 24% of the population • Of the 24%, 39% of this population were hourly adjustments • Comp study cost = $285,314	• Implement wellness and total reward statements • Continue to evaluate the emerging compensation market • Explore performance bonus concepts	• Conduct compensation study	• Continue to evaluate effectiveness of benefits and compensation programs
• Conducted benefits study May 2021 • Conducted broker evaluation • Implemented Self Funding Concept • Reduced Employee Premiums & Deductibles Added more benefits for less cost	• Continue to evaluate the emerging benefits market	• Conduct benefits study	
• Evaluate total rewards and wellness programs			

Return to Agenda

Return to Office Strategy (Attract and Retain)

We will deploy a post-COVID return to office plan that meets the needs of the plan and provides a safe working environment for our employees			
FY 2021/2022	**FY 2022/2023**	**FY 2023/2024**	**FY 2024/2025**
• Surveyed employees • 77% prefer to work from home	• Implement RTO strategy	• Continue to evaluate environment of RTO	• Continue to evaluate environment of RTO
• Surveyed LPHC plans • 70% are creating a flexible working environment	• Ensure tools and guidelines are in place for leadership	• Quarterly meetings with RTO committee for adjustments	• Quarterly meetings with RTO committee for adjustments
• Established RTO committee • Completed	• Quarterly meetings with RTO committee for future adjustments		
• Update and design RTO policies (including out of state policy)	• Evaluate building and office needs based on RTO strategy		
• Designing strategic RTO plan – implementation April 2022			
• Benchmark other plans and companies			
• Implement RTO plan April 1, 2022			

Return to Agenda

Performance Review Process (Retain and Develop)

We will re-engineer and mechanize the performance review process to provide a more effective performance review and developmental plans			
FY 2021/2022	**FY 2022/2023**	**FY 2023/2024**	**FY 2024/2025**
• May 2021 - Designed expedited performance review process	• Design new performance review process	• Continue to monitor performance review process	• Continue to monitor performance review process
• Abbreviated self-assessment comments and established whole number ratings	• Implement new performance review process June 2022		
• Established recommended merit guidelines	• Incorporate goal planning • Incorporate development plans • Incorporate 360 feedback • commentary on values		
• Completed process August 2020	• Approval of executive staff		

Return to Agenda

Employee Survey (Retain)

We will have a bi-annual employee process where we will survey our employees every other year for feedback on the plan's health			
FY 2021/2022	**FY 2022/2023**	**FY 2023/2024**	**FY 2024/2025**
• Employee survey initiated in November 2019	• Establish bi-annual employee survey aligned with fiscal year • Target: July 2022	• Initiate a pulse survey to measure effectiveness of employee survey action team	• Establish bi-annual employee survey
	• Retain new employee survey partner		
• October 2020 established employee survey action team	• Establish new employee survey action team	• Continue to focus on communications and updates for the plan	• Establish new employee survey action team

• Deliverables:
  • New recognition program
  • Published org chart
  • job postings on Compass
  • All-Staff surveys
  • Leader roadshows
Hotline Communication
	• Design communications strategies and measurable results	• Establish historical trends by functional area	• Design communications strategies and measurable results

Return to Agenda

Recruiting Strategy (Attract)

We will strengthen our recruiting process and policies to improve results, strengthen efficiency and manage costs			
FY 2021/2022	**FY 2022/2023**	**FY 2023/2024**	**FY 2024/2025**
• Established recruiting data analytics	• Evaluate all search vendors	• Evaluate all search vendors	• Evaluate all search vendors
• Re-engineered recruitment process (front office – back office)	• Evaluate social media effectiveness	• Evaluate social media effectiveness	• Evaluate social media effectiveness
• Established compensation pay strategy	• Continue to re-engineer recruitment process	• Continue to re-engineer recruitment process	• Continue to re-engineer recruitment process
• Identified key recruiting search firms (Information Technology)	• Benchmarking internet strategies • Benchmarking other talent acquisition organizations		
• Re-engineer social media strategy			
• Role clarification - Front office-back office			
• Evaluating search firm efficiencies and costs and consider outsourcing full-time recruiter for 20% cost savings			

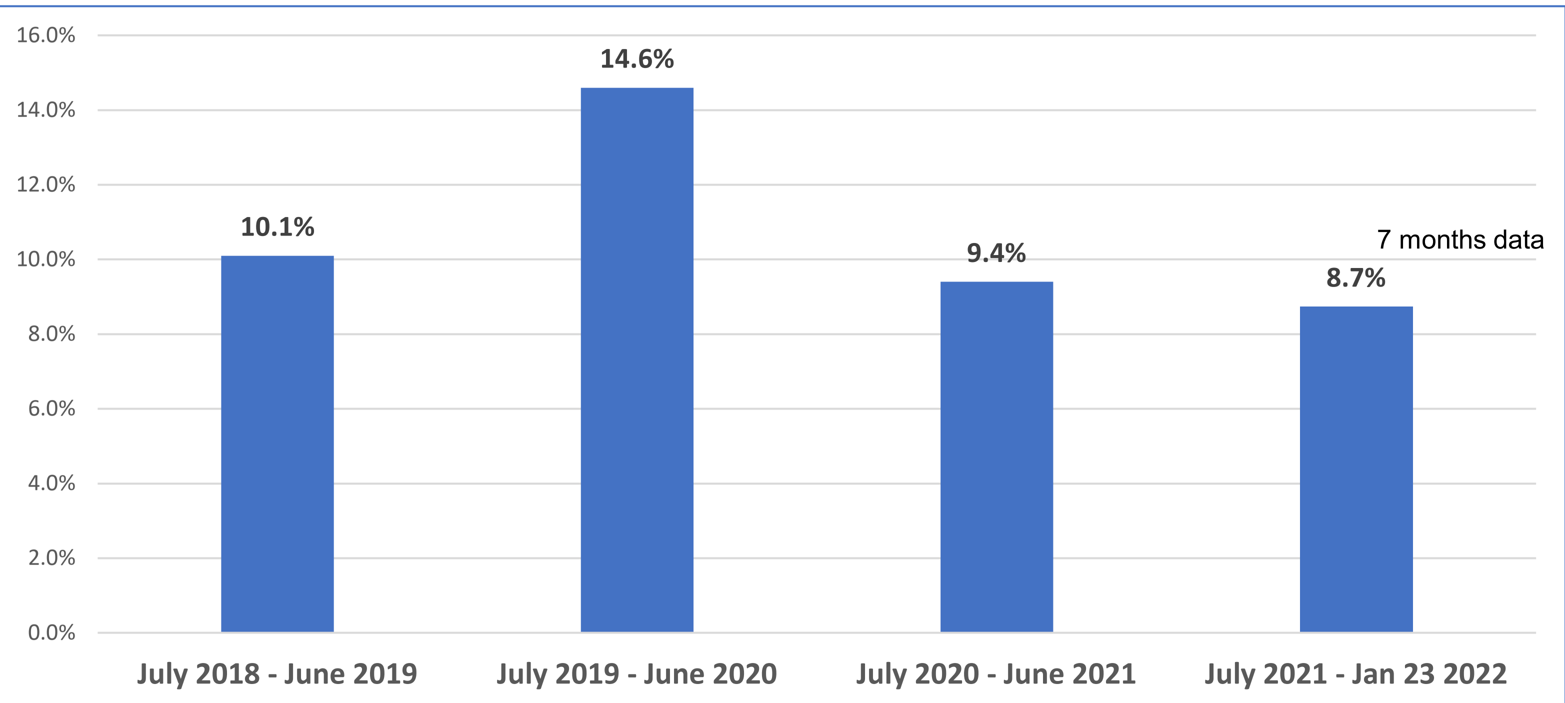
Return to Agenda

Initiatives that will begin in January 2022

Initiative	Description
New manager and leadership development - retain and develop	We will design a training plan to prepare and develop managers and leadership for their role within the plan
Career Development Process – retain and develop	We will design a career development methodology that includes management tools and training
Succession plan/top talent development - attract, retain, develop	We will assess organizational infrastructure and design succession plans for our top talent
Updating all HR policies	35% completed

Depending on 2022 new priorities (Conduent), one or more of these initiatives may have to be delayed until fiscal year 2022-2023

Turnover Trend July 2018 – January 2022



	Avg. Headcount	Total Terms	Tenure 0-1 Years	Tenure 1-4 Years	Tenure 4-7 Years	Tenure 7-10 Years
July 2018 - June 2019	187.4	19	2	9	6	2
July 2019 - June 2020	192.3	28	8	8	10	2
July 2020 - June 2021	191.9	18	4	6	6	2
July 2021 - Jan 23, 2022	194.5	17	2	6	5	4

Note: HR is now capturing detailed reasons for resignations during exit interviews

Diversity, Equity, and Inclusion

- Diversity, Equity, and Inclusion will be part of our culture and embedded in every activity associated within HR. This includes how employees are treated, promoted, developed, evaluated and paid.

- As a centralized hub of people data, we will ensure fairness, consistency and always preserve the values and ethics of GCHP.

5. Technology

GCHP has a clear vision but a complex technology landscape

With CalAIM, BH Integration, D-SNP, GCHP's technology landscape will become more diverse and intricate

Data Needs

Conduent

Regulatory Requirements

GCHP platforms are…

- Fragile
    - Data is not well understood across the enterprise
    - Data quality issues impacting our ability to meet deliverables
- Not sufficiently monitored – lack of controls
- Leverage highly manual processes

Which has driven…

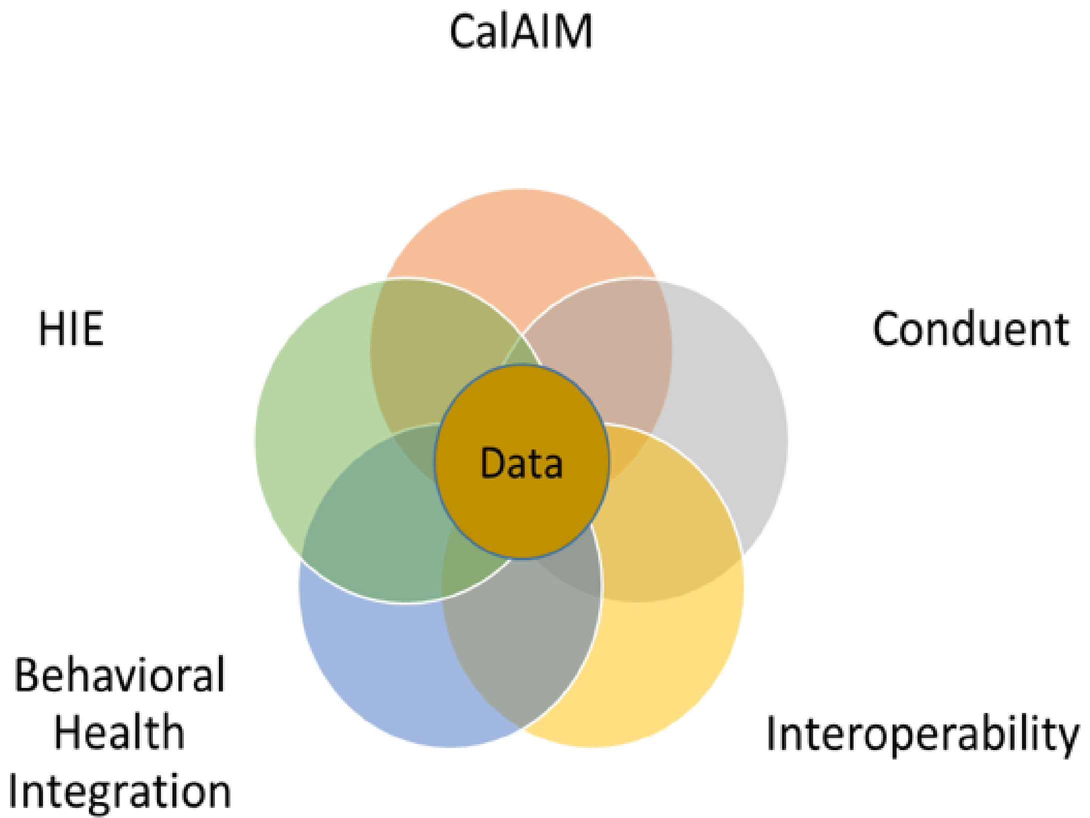
- Provider abrasions
- Inefficiencies
- Challenges meeting regulatory demands

Return to Agenda

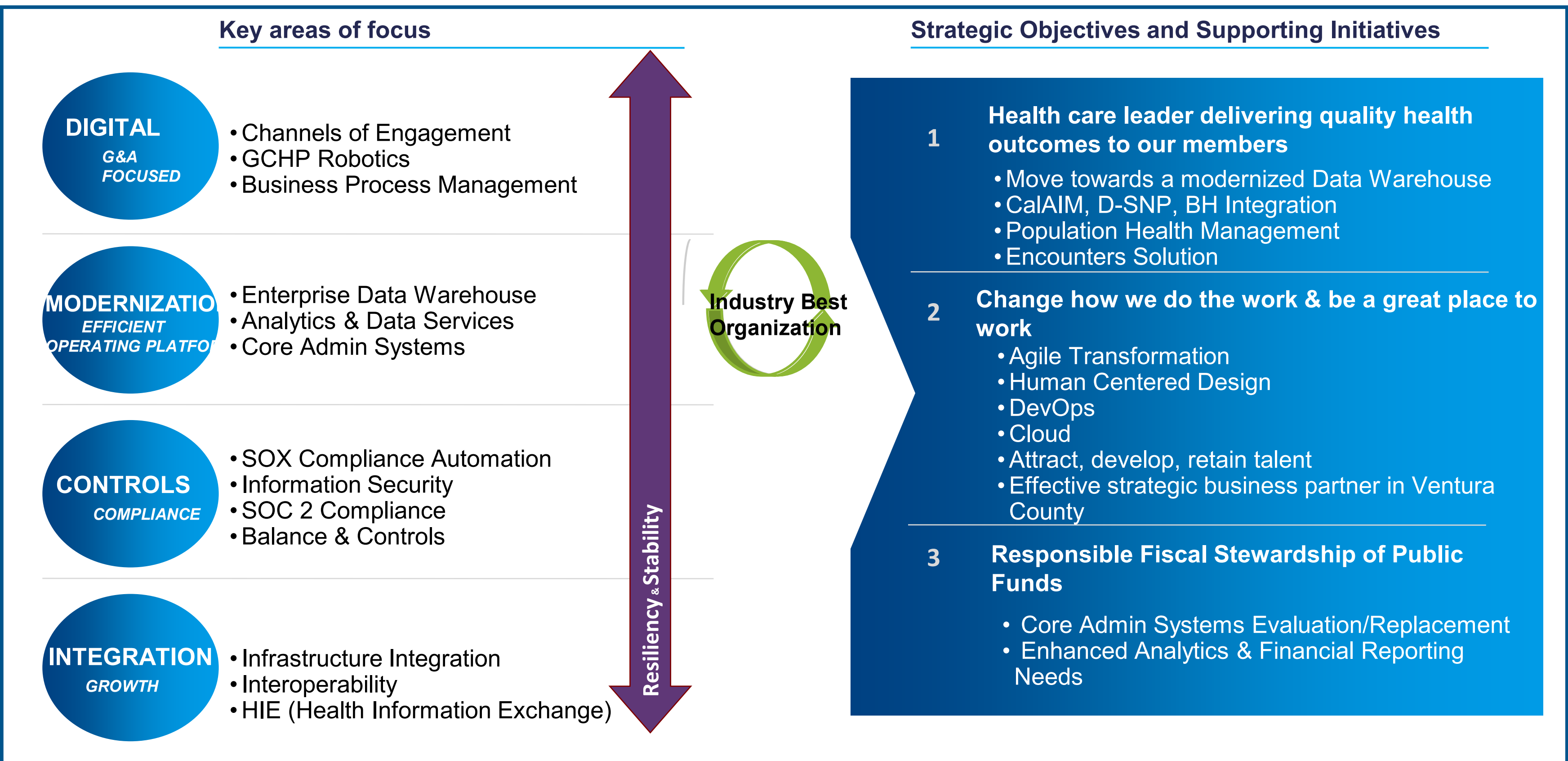
GCHP's Technology Needs to Evolve…

THE CASE FOR TRANSFORMATION…

Examples of What We Know Today



Technology Strategy



Multi-Year Technology Roadmap

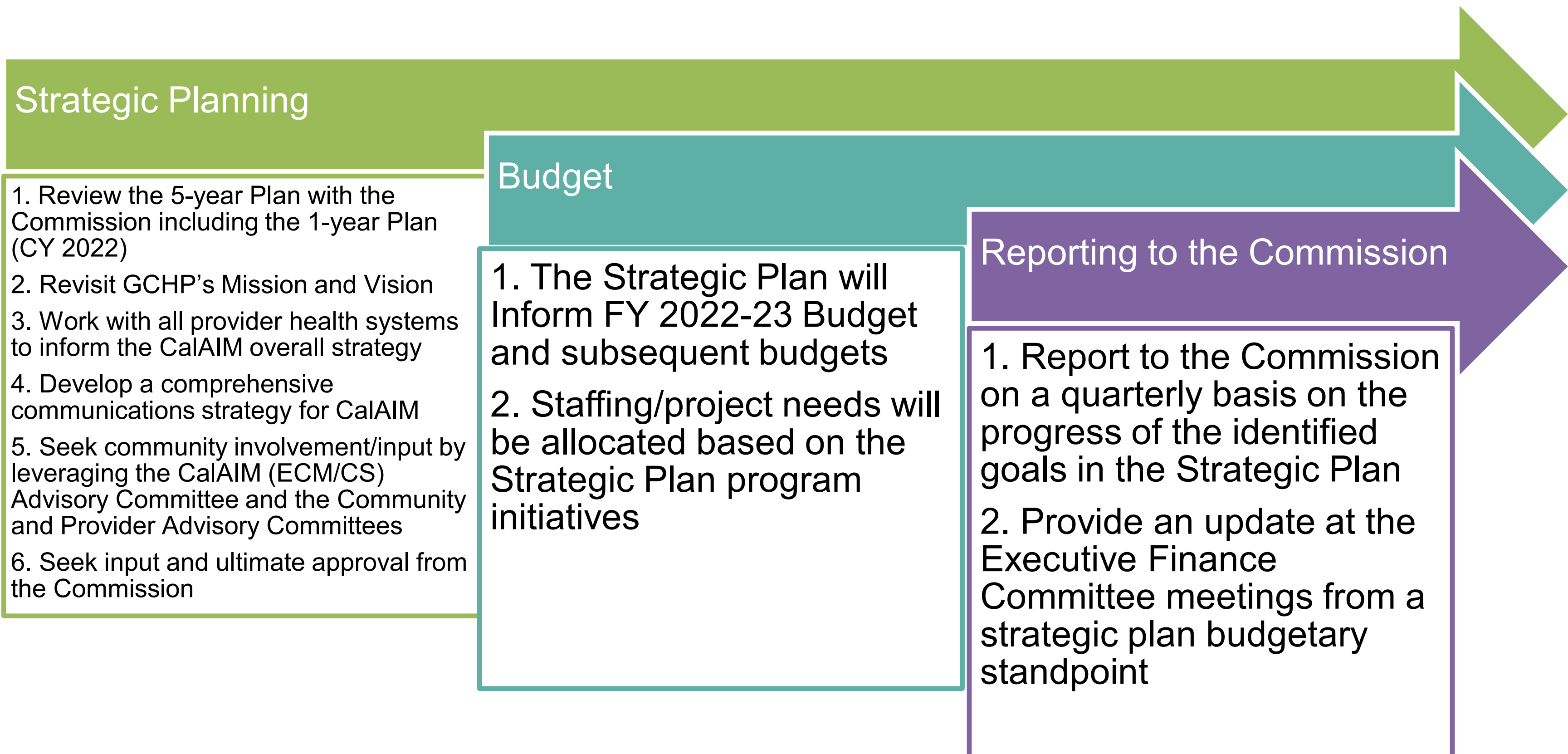
As GCHP begins its modernization, it will recognize tremendous changes and improvements across its technology landscape, business operations and processes…

6. Request for Input

7. Conclusion and Next Steps

8. Appendix

Process



Strategic Plan Approval Process, Budget Correlation, and Reporting Timeline

Dec. 1, 2021
- Strategic Planning Ad Hoc Meeting

Dec. 16, 2021
- Strategic Plan Table Setting Meeting

Jan. 13, 2022
- Strategic Plan Ad Hoc Meeting

Jan. 31, 2022
- Strategic Plan Commission Meeting 5-Year Plan

Mar. 2022
- FY 2022/23 Budget Process Kick Off

Mar. 28, 2022
- Seek Approval from the Commission on the 1-Year Strategic Plan

Mar. 24, 2022
- Executive Finance Committee Meeting

June 27, 2022
- First Strategic Plan Quarterly Update

Financial Strategy: 2022-26

Critical need to invest in people, processes, and technology

Pent up demand from provider community for rate increases

New Programs; new risks

New regulators

Revenue uncertainty

Financial Risk – Mitigation Strategies:

1. Maximize available incentives
2. Comprehensive financial analysis and forecasting
3. Continued development of internal controls
4. Strategic investment
5. Oversight and monitoring of new programs

Strategic Plan Overview: Finance

<table>
<tr><th rowspan="2">Plan Area</th><th colspan="5">Milestones</th></tr>
<tr><th>2022</th><th>2023</th><th>2024</th><th>2025</th><th>2026</th></tr>
<tr><td rowspan="5">Financial</td><td>Maintain adherence to Solvency Action Plan (SAP)</td><td>Achieve Commission-approved TNE levels</td><td colspan="3">Maintain Commission-approved TNE levels</td></tr>
<tr><td>Support financial analysis and modeling relating to Knox-Keene licensure and application</td><td colspan="4">Manage new risk(s) relating to Knox-Keene licensure and DMHC reporting</td></tr>
<tr><td colspan="5">Conduct financial analysis and forecasting to maximize CalAIM incentive funding; conduct oversight</td></tr>
<tr><td colspan="2">Conduct financial analysis/forecasting relating to MA D-SNP; work with the GCHP leaders to evaluate the D-SNP delivery system model and the D-SNP staffing model</td><td>Support strategic investments and building of internal controls for D-SNP</td><td colspan="2">Oversee and monitor financial investment to launch D-SNP</td></tr>
<tr><td colspan="3">Participate in the overall evaluation of the AHP-GCHP plan-to-plan pilot</td><td colspan="2"></td></tr>
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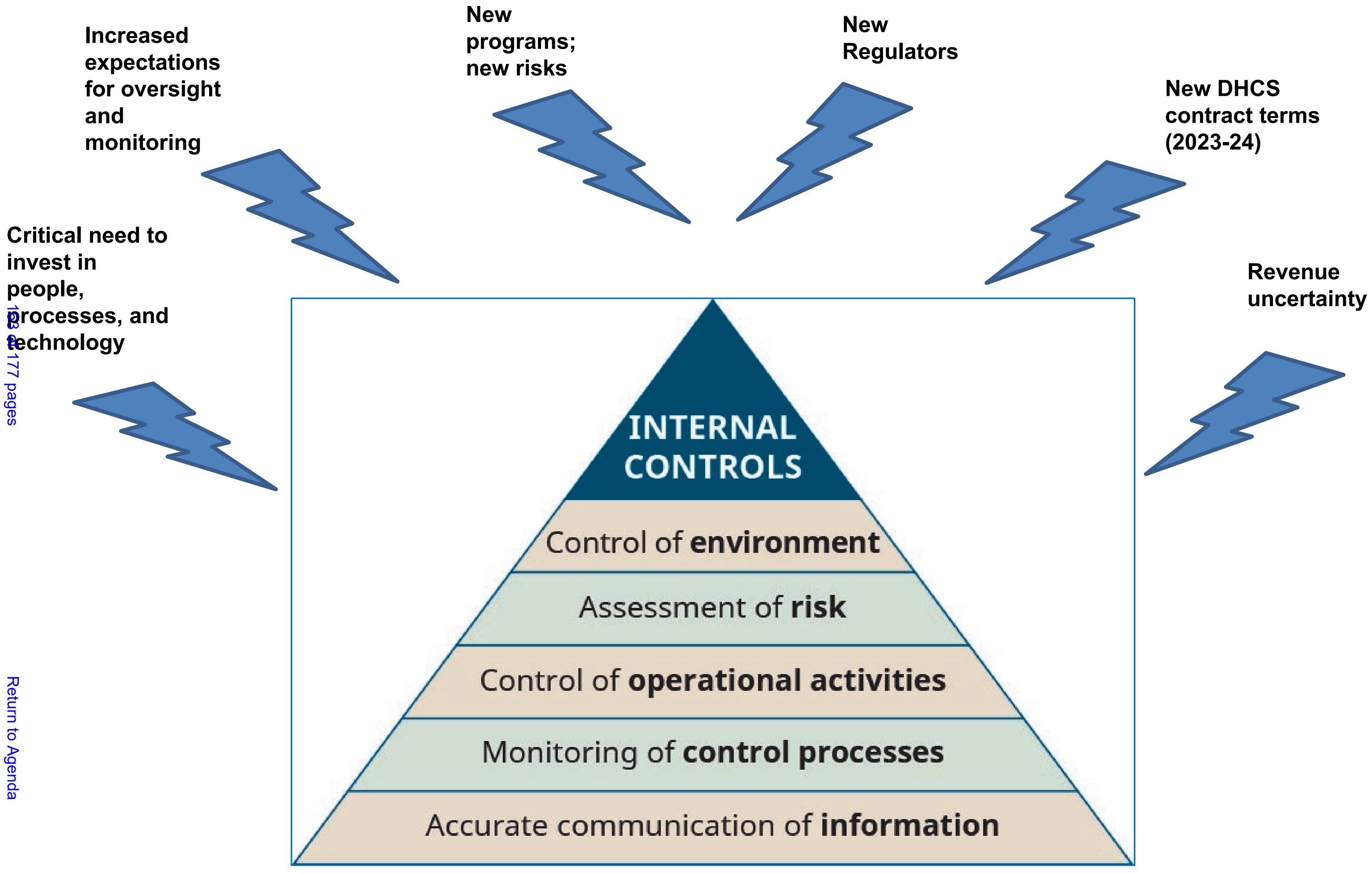
Compliance Strategy: 2022-26

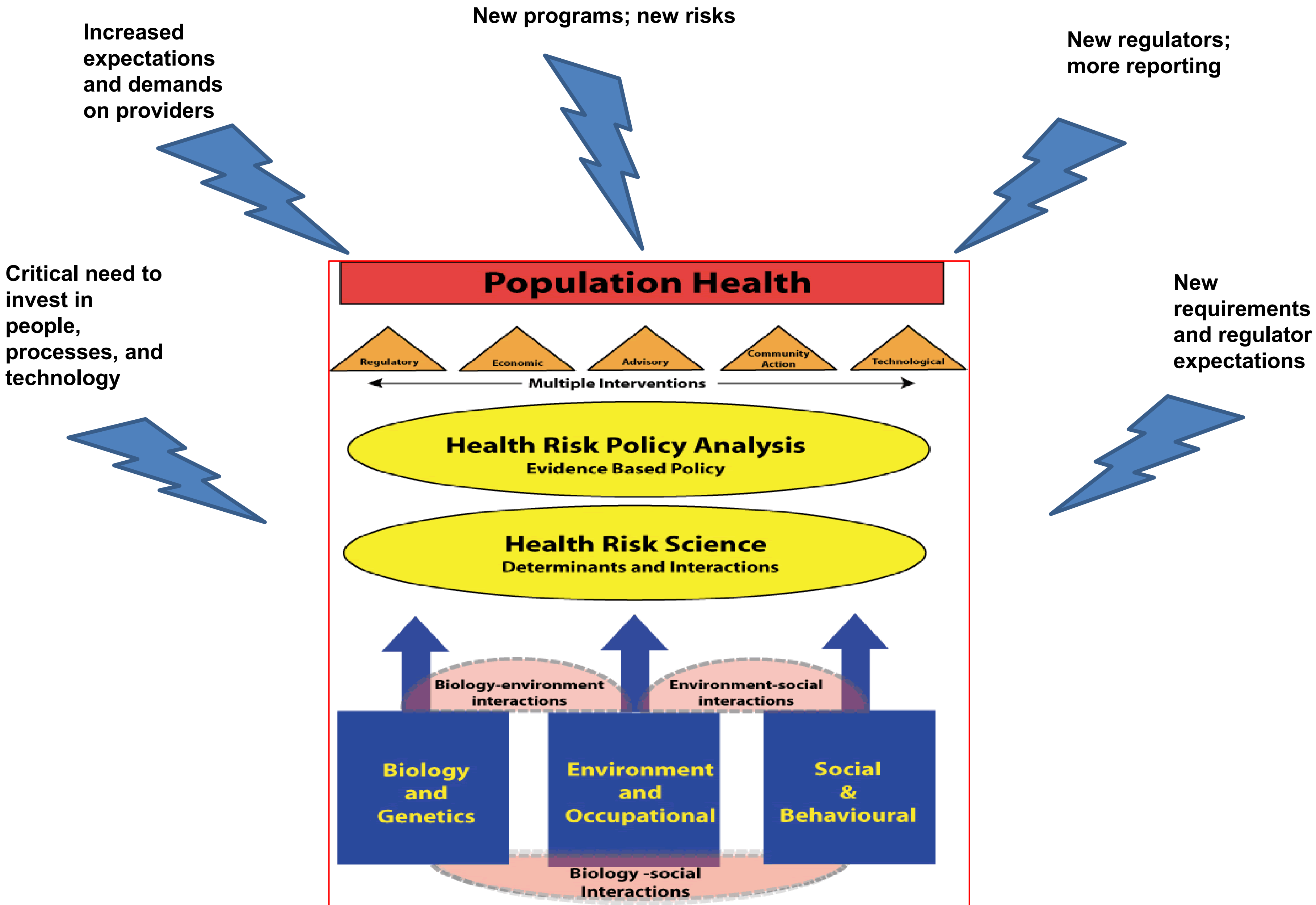


Strategic Plan Overview: Finance and Compliance

Plan Area	Milestones				
	2022	2023	2024	2025	2026
Compliance	Commence, maintain, and report on internal audits to Commission and CEO; manage all resulting CAPs and enforcement action(s)				
	Submit Knox-Keene application	Secure Knox-Keene licensure		Maintain Knox-Keene licensure	
	Establish Staffing Model D-SNP	Submit Notice of Intent to Apply D-SNP	Submit D-SNP application, bid, formulary	D-SNP Go-Live	Data validation of CY-2025 reporting
	Determination of contractor and staffing models defined for D-SNP	Release contractor(s) RFPs for D-SNP and ultimately select: i.Consultant ii.PBM iii.Actuary iv.MTM v.Claims	Conduct all necessary staff training for MA D-SNP readiness	Conduct data validation	
	Determine staffing model(s) necessary for D-SNP management		Finalize internal staffing models and requisite JDs		
	Participate in the overall evaluation of the AHP-GCHP plan-to-plan pilot				

Return to Agenda

Clinical Strategy: 2022-26



Strategic Plan Overview: Health Services

Plan Area: *Clinical*	Milestones				
	2022	**2023**	**2024**	**2025**	**2026**
Clinical management: ECM and CS	WPC/High Utilizers/Homeless/SMI/ SUD/Justice-Involved HIE	LTC & Institutionalization Risk/SNF Transitioning to Community/Children	All other high children and youth populations (CCS, Child Welfare, etc.)		
	Housing Navigation Deposits Recuperative Care MTM	1. Respite 2. SNF Diversion 3. Personal Care 4. Home Modifications 5. Asthma Remediation 6. Short-Term post Hospitalization	Sobering Center Day Habilitation		
Population Health	DHCS Proposal Registry	1. HIE Integration 2. Risk Stratification tools 3. SDOH Disparities 4. Pop Health Program Go-Live	Full Community Information Exchange (CIE) Integration		
NCQA	RFP for Consultant Compliance Documentation Mock Audit	Remediate Gaps	1. NCQA Application 2. NCQA Survey Tool	Secure NCQA Accreditation	Manage NCQA obligations
D-SNP	Establish staffing model for D-SNP	PBM RFP and Contract	Formulary	D-SNP Go-Live	Begin to prepare for first CMS audit
Knox-Keene		UM/CM/Quality staffing, regulatory and technology requirements			
Behavioral Health	Student Behavioral Health; BHIIP				
AHP Pilot	Evaluate outcomes in AHP pilot and report regularly to CEO and Commission		Lead evaluation of AHP pilot		

IT and Data Strategies: 2022-26

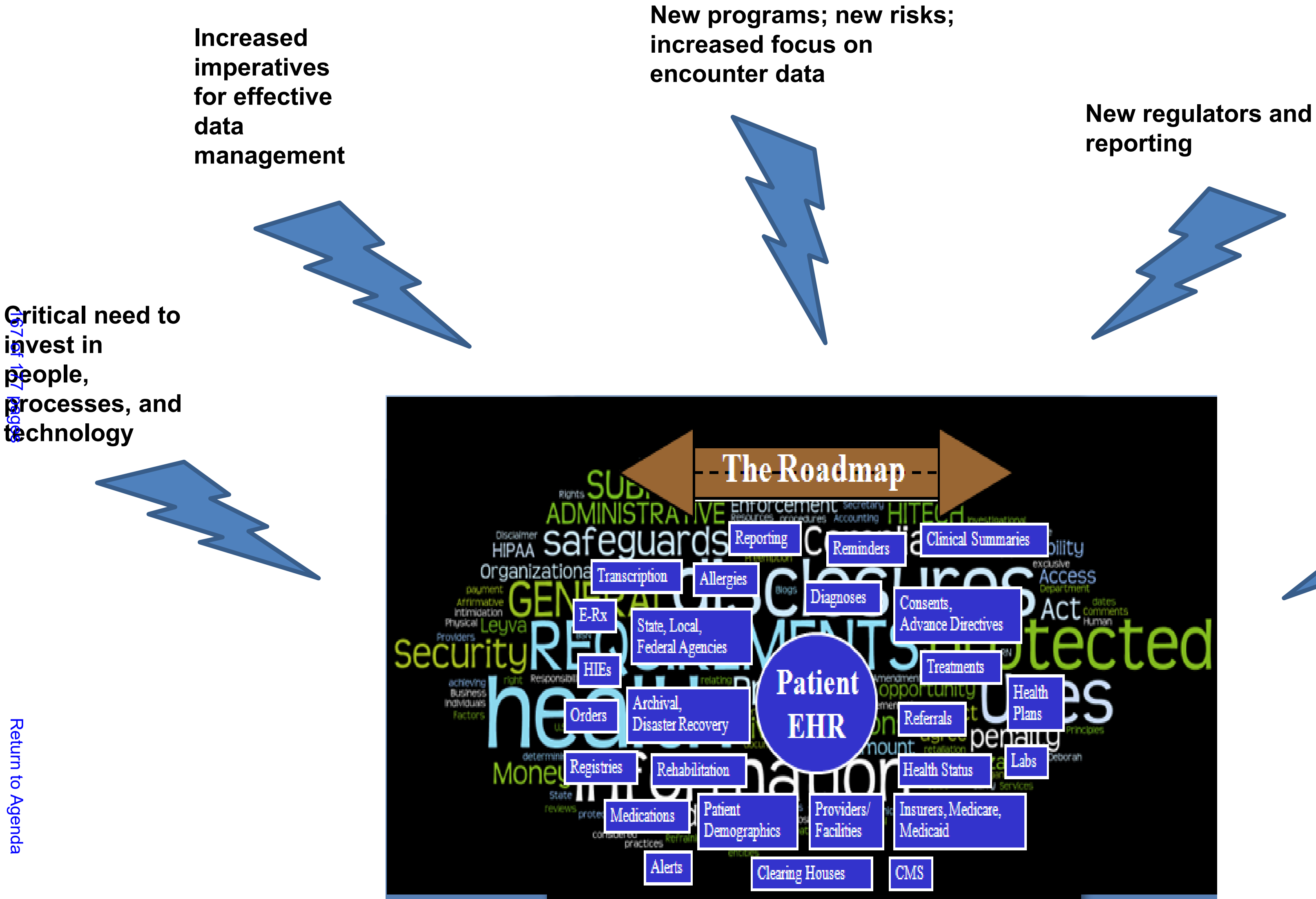
Critical need to invest in people, processes, and technology

Increased imperatives for effective data management

New programs; new risks; increased focus on encounter data

New regulators and reporting

Imperative to create technology roadmap and tools for population health management



Return to Agenda

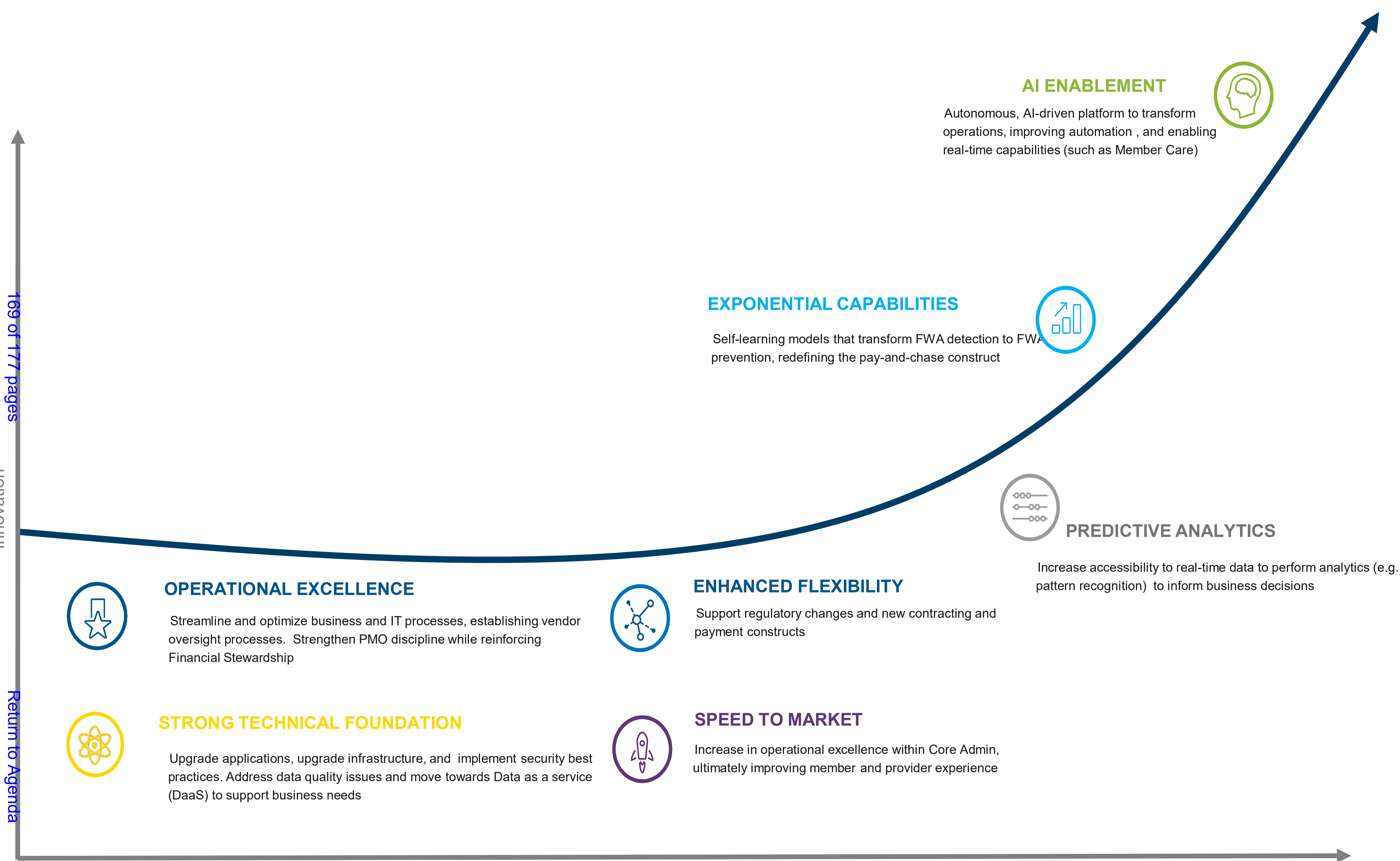
Strategic Plan Overview: IT

Plan Area: IT	Milestones				
	2022 **ECM/CS**	**2023** **Population Health**	**2024** **NCQA Application** **End of AHP Pilot** **ETA DHCS Contract**	**2025** **NCQA Accreditation** **D-SNP Go-Live**	**2026** **CalAIM waiver ends**
Modern Data Warehouse	Completion of multi-year technology roadmap Document current state inventory Document data issues Data Migration Phase 1 Ingest SDOH Creation of Health Registries Implement Visualization tools	Data Migration Phase 2 Support NCQA requirements/tools Support enhanced finance requirements Support enhanced quality requirements Ingest SDOH data set	Data Migration Phase 3 Decommission legacy DWH Integration with new Core Admin platforms/Vendor Cutover to new core platform Support NCQA requirements/tools Support Medical Device data sets	NCQA Accreditation	Support BHI
Health Information Exchange (HIE)	Complete loading of Claims Data Establish integration with Ventura County Support IPP requirements Implement Analytics Module Identify 5 use-cases (pilot)	Implement Balance & Controls Support ADT data Support EHR data Support IPP requirements	Support SDOH data sets Support Medical Device data sets	Evaluate/RFP HIE vendor	Support transition to new HIE vendor
Interoperability	Completion of multi-year technology roadmap Complete Patient Access Rule – encounters, clinical Procure and Implement Edifecs Cloud Member Access Service Procure and Implement Edifecs Plan-to-Plan Solution (Payor-to-Payor)	Support IoMT and IoHT (Medical device) integration Procure and Implement Edifecs Prior Auth Solution Implement First External APIs with 1-2 Large Providers	Support IoMT and IoHT (Medical device) integration RFP Edifecs Replacement Complete API implementations with Remaining Identified Providers	Complete Implementation of Edifecs replacement Edifecs FHIR Contract Terms (2025)	Support regulatory requirements
Conduent (Core Admin Platform)	Perform Portal evaluation Go to RFP's Create Roadmap for new portal capabilities	Implement new Portal Implement exponential technologies (Robotics and AI) to reduce operational costs	Support D-SNP requirements Implement exponential technologies (Robotics and AI) to reduce operational costs	Support steady-state operations Support D-SNP Go-Live Implement exponential technologies (Robotics and AI) to reduce operational costs	Support steady-state operations Implement exponential technologies (Robotics and AI) to reduce operational costs
Population Health Management (PHM)	Create multi-year technology roadmap Evaluate CDR	Predictive Analytic tools Risk stratification tools Support IoT data sets	Support AI Enablement Support Real-Time intelligent member care	Support Real-Time intelligent member care – leveraging new data sets	

Return to Agenda

Intelligent, flexible platform for member care

Between today and 2026, modernization will pave the path for improved patient outcomes using innovative capabilities.



Operations and Community Engagement

Imperative that GCHP improve claims processing and provider responsiveness

New programs; new provider types; new lines of business; new risks

Imperative that GCHP engage in materially new ways – and with new stakeholders – to create the transformation that CalAIM contemplates

Critical need to invest in people, processes, and technology

Strategic Plan Overview: Operations and Community Engagement

Plan Area: *Operations, Community Engagement*	Milestones				
	2022	**2023**	**2024**	**2025**	**2026**
ECM	Secure contracts and operational readiness for ECM/CS	Secure contracts and operational readiness for Phase 3 in Jan. 1, 2023	Secure contracts and operational readiness for Jan. 1, 2024		
New benefits ***D-SNP***	For July 2022,contract for new benefits, make delivery system decisions relating to such new benefits, and conduct operational readiness for: 1. Doulas 2. Community Health Workers 3. Dyadic Care	Conduct operational readiness and gap analysis for NCQA accreditation and D-SNP application	Oversee contracting and operational readiness to operate D-SNP Full operational integration of CIE	D-SNP Go-Live Contract and operational planning for migration of mild-to-moderate benefit heading towards full BHI	Prepare for first CMS MA audit
Medi-Cal Contract	DHCS RFP for commercial MCOs	Likely ETA for new DHCS contracts	Based upon likely ETA for new DHCS contract, update and revise – as necessary and appropriate – all provider contracts		
Policy and strategy		Begin to advise leadership/commission on MA policy	Ensure internal policy readiness for MA D-SNP	Engage in statewide thought leadership regarding discussions on waiver extension	
Strategic engagement	Manage strategic engagement process to maximize CalAIM incentive funding				
Input process	Launch and manage strategic process to secure comments and inputs across community to maximize CalAIM incentive funding and to ensure robust community engagement				
D-SNP engagement and marketing	Develop and socialize D-SNP model and benefits for Ventura County providers, advocates, and senior advocates		Launch marketing approach for MA D-SNP		

CalAIM Legal Issues

Transitions in health care delivery

1. Integration of justice-involved, foster-care, student, and other new population groups into managed care systems
2. Integration of physical and behavioral health services to include new benefits and social services providers to create a coordinated delivery system

Related legal issues to be addressed

1. Contract terms for new providers such as housing, short-term recovery supports, and independent living supports
2. Quality standards, oversight, credentialing processes for new types of non-licensed facilities that provide health care and related services
3. Payment mechanisms, including increased use of value-based purchasing models
4. Data sharing and information exchange among varied licensed and non-licensed persons and entities and for behavioral health, students, and other populations with more stringent restrictions, interoperability requirements

CalAIM Legal Issues (cont'd)

Standardization of managed care

1. Knox-Keene licensure requirements
2. Medicare D-SNP requirements
3. NCQA accreditation requirements

Legal issues

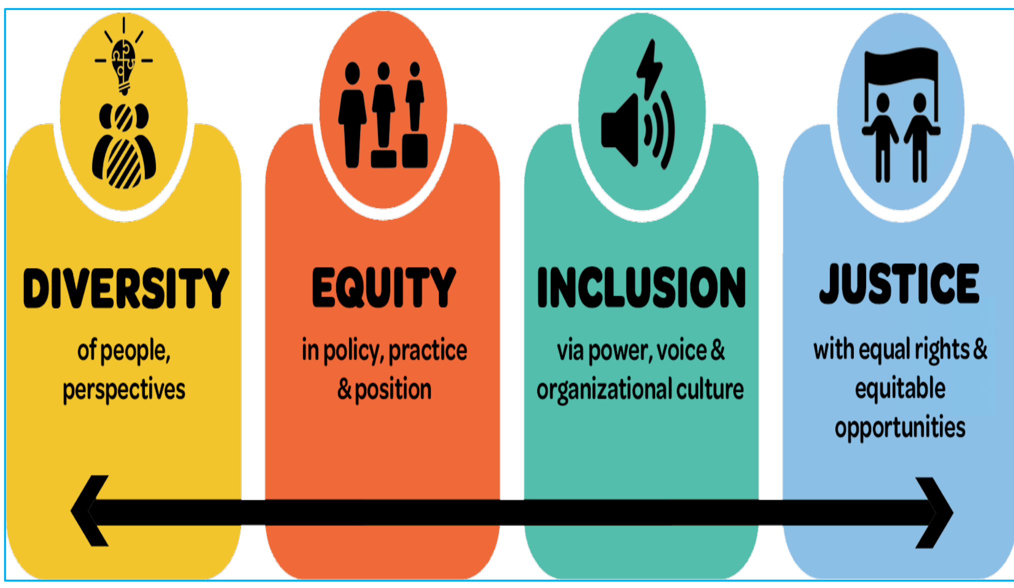
1. Review of applications and new/updated policies and procedures to satisfy these new standards
2. Assistance with communications with additional regulatory authorities, e.g., DMHC
3. Review of plan preparation for additional regulatory oversight, including DMHC oversight of financial solvency

Workforce and Diversity, Equity, and Inclusion Strategy

Critical need to invest in people, processes, and technology

Promote DEI

Fulfill CalAIM goals to reduce disparities and bias



Strategic Plan Overview: DEI

Plan Area: *DEI*	Milestones				
	2022	**2023**	**2024**	**2025**	**2026**
Complete a values review with the DEI Council	Q1Reexamine core values		Q1 Revisit values based on team dynamics		
DEI conference	Q1 Identify resources and meeting participants	Strategy Implementation and Tracking (ongoing)	Revisit summit results with data mining		
Training and staff	Q2 Biases Generations	Q2 Micro-aggression racism	Q2 Culture diversity/cultural norms		
Best practices visits	Q2/3 Verizon/Ventura County	Amgen Zoom meetings with other health plans			
Combining Health Equity and DEI work	Decisions on Health Equity Officer Hire Population Health Manager	CalAIM Go-Live			
Assessment	Conduct Health Equity Assessment with Stakeholders Implement SDOH assessment	Conduct SDOH assessment			
Establish Health Equity Subcommittee	Internal committee to review Health Equity initiatives				

Strategic Plan Overview: Workforce

Plan Area: Workforce	Milestones 2022	2023	2024	2025	2026
Compensation and Benefits	1. Consider total wellness statements 2. Explore performance bonus concepts	1. Conduct compensation study 2. Continue to evaluate the emerging benefits market	1. Continue to evaluate effectiveness of benefits and compensation programs 2. Conduct benefits study		
Return to Office	1. Implement RTO strategy 2. Ensure tools and guidelines are in place for leadership 3. Evaluate building and office needs based on RTO strategy	1. Continue to evaluate environment of RTO 2. Quarterly meetings with RTO committee for adjustments			
Performance Review	1. Design and implement new performance review process	1. Continue to monitor performance review process			
Employee Survey	1. Establish bi-annual employee survey aligned with fiscal year 2. Retain new employee survey partner 3. Design communications strategies and measurable results	1. Initiate a pulse survey to measure effectiveness of employee survey action team 2. Continue to focus on communications and updates for GCHP 3. Establish historical trends by functional area	1. Establish bi-annual employee survey 2. Establish new employee survey action team 3. Design communications strategies and measurable results		
Recruiting	1. Evaluate all search vendors 2. Evaluate social media effectiveness 3. Continue to re-engineer recruitment process organizations 4. Ensure success of recruiting for new LOB, MA D-SNP				

Glossary of Terms

AB: Assembly Bill
ACA: Affordable Care Act
ADT: Admit, Discharge, and Transfer
AI: Artificial Intelligence
API: Application Program Interface
BHI: Behavioral Health Integration
BHIIP: Prop. 56Behavioral Health Integration Incentive Program
CA: California
CalAIM: California Advancing and Innovating Medi-Cal
CAP: Corrective Action Plan
CCI: Coordinated Care Initiative
CCS: California Children's Services
CDO: Chief Diversity Officer
CDR: Clinical Data Repository
CHW: Community Health Workers
CIE: Community Information Exchange
CMS: Centers for Medicare & Medicaid Services
CS: Community Supports
CY: Calendar Year
DEI: Diversity, Equity, and Inclusion
DHCS: Department of Health Care Services
DMHC: Department of Managed Health Care
D-SNP: Dual Eligible Special Needs Plans
DWH: Data Warehouse
ECM: Enhanced Care Management
EHR: Electronic Health Record
FHIR: Fast Healthcare Interoperability Resources
FY: Fiscal Year
GCHP: Gold Coast Health Plan
HCBS: Home and Community Based Services
HIE: Health Information Exchange
IKA/HSP: Claims administration platforms
ILOS: In Lieu of Services
IoHT: Internet of Hospital Things
IoMT: Internet of Medical Things
IoT: Internet of Things
IPP: Incentive Payment Program
JD: Job Description
LOB: Line of Business
LHPC: Local Health Plans of California
LTC: Long-Term Care
LTSS: Long Term Services & Supports
MA: Medicare Advantage
MCO: Managed Care Organization
MSSP: Medicare Shared Savings Program
MTM: Medically Tailored Meals
NCQA: National Committee for Quality Assurance
PBM: Pharmacy Benefit Manager
PSO: Professional Services Organization
RFP: Request for Proposals
RTO: Return to Office
SAP: Solvency Action Plan
SCOTUS: Supreme Court of the United States
SDOH: Social Determinants of Health
SMI: Serious Mental Illness
SNF: Skilled Nursing Facility
SBHIP: Student Behavioral Health Incentive Program
SUD: Substance Use Disorder
TNE: Tangible Net Equity
WPC: Whole Person Care