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

Provider Advisory Committee (PAC)

Special Meeting
Tuesday, July 13, 2021, 7:30 a.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010
Executive Order N-25-20
Conference Call Number: 1-805-324-7279
Conference ID Number: 607 768 791#

AGENDA

CALL TO ORDER

ROLL CALL

PUBLIC COMMENT

The public has the opportunity to address Ventura County Medi-Cal Managed Care Commission (VCMMCC) doing business as Gold Coast Health Plan (GCHP) on the agenda. Persons wishing to address VCMMCC should complete and submit a Speaker Card.

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 Provider Advisory Committee (PAC) March 9, 2021 Minutes

Staff: Maddie Gutierrez, MMC - Clerk of the Board

RECOMMENDATION: Approve the minutes as presented.

UPDATES

2. Fiscal Year 2021-2022 State Budget Update

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

RECOMMENDATION: Receive and file the update.

3. Enhanced Care Management (ECM) / In Lieu of Services (ILOS) Update

Staff: Marlen Torres, Executive Director of Strategy & External Affairs
Pauline Preciado, Sr. Director of Population Health & Health Equity

RECOMMENDATION: Receive and file the update.

4. HSP MediTrac Update

Staff: Eileen Moscaritolo, HMA Consultant

RECOMMENDATION: Receive and file the update.

5. Provider Contracting and Credentialing Management (PCCM) Update

Staff: Vicki Wrighster, Director of Network Operations
Kim Timmerman, Director of Quality Improvement

RECOMMENDATION: Receive and file the update.

PRESENTATIONS

6. 2021-2022 Operating and Capital Budget

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Receive and file the presentation.

7. Health Equity & Inclusion Presentation

Staff: Ted Bagley, Chief Diversity Officer

RECOMMENDATION: Receive and file the presentation.

COMMENTS FROM COMMITTEE MEMBERS

ADJOURNMENT

Unless otherwise determined by the PAC, the next regular PAC meeting will be held on September 7, 2021 at Gold Coast Health Plan at 711 E. Daily Drive, Suite 106, Community Room, Camarillo, CA 93010.

Administrative Reports relating to this agenda are available at 711 East Daily Drive, Suite #106, Camarillo, California, during normal business hours and on http://goldcoasthealthplan.org. Materials related to an agenda item submitted to the Committee after distribution of the agenda packet are available for public review during normal business hours at the office of the Secretary of the Committee.

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

AGENDA ITEM NO. 1

TO: Provider Advisory Committee

FROM: Maddie Gutierrez, MMC, Clerk of the Board

DATE: July 13, 2021

SUBJECT: Approval of the Provider Advisory Committee Meeting Regular Minutes of March 9, 2021.

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the March 9, 2021 Provider Advisory Committee regular meeting minutes.

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)
Provider Advisory Committee
March 9, 2021

CALL TO ORDER

Committee Chair David Fein, called the virtual meeting to order at 7:34 a.m., in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

ROLL CALL

Present: Committee members: Masood Babeian, Linda Baker, David A. Fein, Will Garand. Katy Krul, and Pablo Velez.

Absent: Sim Mandelbaum and Joan Buck-Plassmeyer.

PUBLIC COMMENT

None.

CONSENT

1. Approval of Provider Advisory Committee (PAC) Minutes for December 8, 2020 and review of April 7, 2020 Informal Notes.

Staff: Maddie Gutierrez, MMC, Clerk to the Commission

RECOMMENDATION: Approve the minutes.

Committee member Linda Baker motioned to approve the minutes as presented.
Committee member Will garand seconded.

AYES: Committee members Masood Babeian, Linda Baker, David A. Fein, Will Garand. Katy Krul, and Pablo Velez.

NOES: None.

ABSENT: Sim Mandelbaum and Joan Buck-Plassmeyer.

Committee Chair David Fein declared the motion carried.

UPDATES

2. New Commission Officers and Members.

Staff: Steve Peiser, Senior Director of Network Management.

RECOMMENDATION: Receive and file the update.

Steve Peiser, Senior Director of Network Management, informed the committee that GCHP had new Commissioners, Dr. Sevet Johnson, with Ventura County Health Care Agency. She is the director for the Ventura County Behavioral Health Department. Scott Underwood, M.D., who is the independent designate for the Commission. Dee Pupa was voted in as the new chair to the Commission and Jennifer Swenson got a second term as vice-chair for the Commission.

3. Provider Dispute Resolution (PDR) Update

Staff: Anna Sproule, Senior Director of Finance and Claims

RECOMMENDATION: Receive and file the update.

Anna Sproule, Senior Director of Finance and Claims reviewed regulatory requirements for PDR's. There is a new form as well as training materials on the GCHP website. Ms. Sproule's PowerPoint explained how providers can locate the necessary forms as well as how to fill them out correctly.

4. Health Interoperability

Staff: Helen Miller, Senior Director of IT
Eileen Moscaritolo, HMA Consultant

RECOMMENDATION: Receive and file the update.

Helen Miller, Senior Director of IT reviewed her PowerPoint. Ms. Miller stated there are two (2) new CMS rules which become effective January 2021. The two (2) new rules are the ONC's CURES Act Final Rule and the Interoperability & Patient Access Final Rule. Due to COVID-19 the effective date was deferred to July 2021. Ms. Miller explained how the rules work together to assist in patient and provider access. Mandated technical standards were reviewed. The U.S. Core Data chart was reviewed with the committee. Patient benefits and how the requirements will make an impact. The policies in the rules will help members make informed decisions about their health care. The provider benefits and payer benefits were also reviewed. The

data and analytics graph demonstrated that five (5) years of data is required to be provided. GCHP will have the framework to share data and maintain compliance.

Committee member, Katy Krul, asked if this was only for providers under CMS. Ms. Miller stated it applies to CMS regulated entities. GCHP would meet interoperability requirements. Eileen Moscaritolo HMS Consultant, stated this is a way to try to get Medicaid and Medicare plans up to speed. Committee member Pablo Velez asked if the data is kept for five (5) years and does it keep data for pediatric patients five (5) years after they turn 18 years of age. Ms. Miller responded if it is a regulated entity, and they have five (5) years of data, they are required to share the five (5) years of data.

Committee Chair, David Fein, stated this is a working timeline and he asked that information continue to be shared as it is developed.

Ms. Miller stated she will be presenting to the Commission at the end of June for approval.

5. Legislative Update: Governor's May Revisions to the Budget

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

RECOMMENDATION: Receive and file the update.

Ms. Torres gave a high-level overview of the Governor's May Revise for the 2020/2021 proposed state budget with the committee. There is an estimated $54 billion deficit. Several programs were cut, such as CalAIM, as well as some reserves were proposed to be used; rainy day fund, the safety net reserve and Proposition 98, which is mostly school funding.

The Senate budget proposal expects federal money, if not, trigger cuts will take effect October 1, 2020. Senate and Assembly need to negotiate and present a legislative bill by June 15, 2020. The Medi-Cal proposal table was reviewed. The table showed the Governor's proposal and the Senate proposal.

More information will be provided at the next PAC meeting, once the final state budget has been adopted.

Committee member Katy Krul asked if there has been an increase in members. Ms. Torres stated we must see how rates will be calculated, but we do expect a membership increase. Committee member Pablo Velez stated in the budget proposal, there has been a lack of outpatient services and procedures, he asked if this has t been a savings to the state. Ms. Torres stated she is not aware of any savings.

Once we return to the new normal, we expect to see an increase in claims and there is a prediction that there will be a ramp up. Chief Financial Officer, Kashina Bishop, stated we have seen a savings on the plan side, but it is not much financial benefit due to cuts in rates. The State is increasing long-term care rates. Committee Chair, David Fein, asked if federal funding was going to happen. Ms. Torres stated there has not been a discussion to guarantee it, we are waiting to see what happens in the months to come.

Committee member Katy Krul stated the amount of money GCHP spends affects rates in the future. She askedhow rates will be affected in the future. CFO Bishops stated she did not know. 2020 rates set rates for 2023, we must wait and see.

Committee Chair David Fein asked about the 1.5% reduction. CFO Bishop stated the reduction is significant to GCHP. The reduction is retro to July of 2019. GCHP was looking to January 2021 revenue increase, but we don't know, we may break even at the end of 2021.

6. Solvency Update

Staff: Steve Peiser, Senior Director of Network Management

RECOMMENDATION: Receive and file the update.

Steve Peiser, Senior Director of Network Management, stated COVID-19 has had a significant impact to GCHP. The TNE reflects the Plan's solvency. GCHP has the lowest TNE in the state. Mr. Peiser reviewed the PowerPoint charts. He stated that we hope to keep TNE above 200%. We have had a loss of revenue in the amount of $16 million. Although there have been rate cuts, GCHP has not passed those rate cuts to providers.

CFO Bishop stated GCHP is not a for-profit organization, we have absorbed the difference. Unfortunately, we are at a place where we cannot continue to absorb the difference. We need to save on medical expenses.

Mr. Peiser stated our TNE is at 212% of the required amount by the state. In order to remain solvent, GCHP needs to pass on the rate cuts. Nobody is immune. An update on the Solvency Action Plan will be presented on a monthly basis to the Commission and committees. GCHP is committed to providing quality care to members.

Mr. Peiser reviewed the phases of the Solvency Action Plan. The first wave/phase will take place immediately after the Commission meeting, the second phase will take place in a couple of months and the third phase will be done later in the year. CFO

Bishops stated we are focused on areas where we are paying outlier rates to providers. The first step is to look at capitation and outlier rates. We have been told the State does not plan to increase our rates.

CFO Bishop stated we applied for a FEMA grant, but we did not get it. Committee member Katy Krul asked if there was any way of financial help for providers for PPE. CFO Bishop responded no.

Committee Chair David Fein stated that from a provider perspective, it would be helpful to have transparency from GCHP. Mr. Peiser stated that after the June Commission meeting, he will be able to share more information with PAC. Mr. Peiser stated he agreed with Mr. Fein; there will be a lot of direct work with providers in order to be transparent. CFO Bishop stated that if there are opportunities to save without impacting providers, please let GCHP know. We want the least amount of impact to providers as possible.

Committee member Velez stated the goal is to have 400-500 percentTNE, he asked by when that goal will be achieved. CFO Bishop stated that in short term, we are looking at staying above 150-200%. In order to achieve a 400%to 500% it could be 2023 or beyond.

Committee member Krul asked if telehealth is working for GCHP. CFO Bishop stated we are seeing a significant increase in telehealth utilization but there is no projection for long-term savings.

7. Provider Advisory Committee (PAC) Monitoring and Reporting

Staff: Steve Peiser, Senior Director of Network Management

RECOMMENDATION: Receive and file the update.

Steve Peiser, Senior Director of Network Management, stated we need to create a formalized reporting structure to the Commission. A monitoring and reporting process need to be developed.

Mr. Peiser asked if a sub-committee should be created, led by the Committee Chair, to meet and develop the process. Mr. Peiser asked if there were volunteers for this sub-committee. Committee members who volunteered are Pablo Velez, Katy Krul, Sim Mandelbaum and Committee Chair, David Fein. Mr. Peiser stated he will set up a meeting date and time.

Committee member Katy Krul motioned to approve agenda items 2 through 7 as presented. Committee member Pablo Velez seconded.

AYES: Committee members Masood Babeian, David A. Fein, Will Garand. Katy Krul, Sim Mandelbaum and Pablo Velez.

NOES: None.

ABSENT: Linda Baker and Joan Buck-Plassmeyer.

Committee Chair David Fein declared the motion carried.

ROUNDTABLE/DISCUSSION

Marlen Torres, Executive Director of Strategy & External Affairs stated that the Plan developed a Telehealth Tip Sheet located at in the back of the PAC packet. She reviewed the TIP sheet and asked that committee members make copies and share with their members.

Committee member Velez stated information such as the TIP sheet is well received by families. Mr. Peiser stated telehealth will be a staple going forward. From GCHP's perspective, we support telehealth, it has proved to be effective and efficient.

Committee Chair, David Fein, asked how GCHP is operating, he asked if it was closed to the public. Mr. Peiser stated all are working remotely. A timeframe has not been determined when employees will return to the buildings. Surveys are being done and there are internal discussions but there is not a solid date to return to work. CFO Bishop noted services to members continue to be provided

ADJOURNMENT

With no further items to be addressed, Committee member Pablo Velez motioned to adjourn the meeting. Committee member Katy Krul seconded. The meeting was adjourned at 9:01 A.M.

Approved:

_____
Maddie Gutierrez, MMC
Clerk to the Commission

AGENDA ITEM NO. 2

TO: Provider Advisory Committee

FROM: Marlen Torres, Executive Director, Strategy & External Affairs

DATE: July 13, 2021

SUBJECT: State Budget Overview

PowerPoint with Verbal Presentation

ATTACHMENTS:

STATE BUDGET OVERVIEW PRESENTATION

Gold Coast Health Plan℠
A Public Entity

The California Budget Fiscal Year 2021-2022

July 13, 2021

Marlen Torres
Executive Director, Strategy & External Affairs

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

Budget Overview

- As of June 27, 2021, a budget deal between the Legislature and the Governor has not been announced.
- Negotiations between the Governor, Senate President pro Tempore, and Speaker of the Assembly have reached a general understanding regarding expenditures in the FY 2021-22 budget.
- The June 28th Budget's total spending of **$262.6 billion**
  - $196.4 is from the General Fund
  - $25.2 billion General Fund reserves

Return to Agenda

Medi-Cal Related Budget Proposals

Proposal	Description
Medi-Cal at 50+, Regardless of Immigration Status	Provides ongoing funding growing to $1.3 billion to expand Medi-Cal eligibility to all income eligible Californians 50-plus years of age, regardless of immigration status.
Medi-Cal Asset Test removal	Eliminates the Medi-Cal asset test for seniors to remove the “senior savings” penalty, to expand access to more income eligible seniors.
Youth Behavioral Health	Invests $4.4 billion dollars over five years to create a new, modern, and innovative behavioral health system for youth ages 0 to 25, including $205 million for the Mental Health Student Services Act to fund school and county mental health partnerships to support the mental health and emotional needs of children and youth as they return to schools and everyday life.

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Medi-Cal Health Benefits

Proposal	Description
Dyadic Services Benefit	New statewide benefit that provides integrated physical and behavioral health screening and services to the whole family. This model of care has been proven to improve access to preventive care for children, rates of immunization completion, coordination of care, child social-emotional health and safety, developmentally appropriate parenting, and maternal mental health.
Doula Benefit	Doula services include personal support to pregnant individuals and families throughout pregnancy, labor, and the postpartum period.
Expansion Medi-Cal Post Pregnancy	Extends how long women can stay on Medi-Cal post pregnancy from 60 days to a year. This expansion will be in place for five years.

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Other Health Related Proposals

Proposal	Description
Behavioral Health Continuum Infrastructure	Invests $2.2 billion for competitive grants to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources. These funds include an allocation of $150 million, combined with $55 million of federal funding, to support mobile crisis support teams to assist youth and adults experiencing a behavioral health crisis.
Public Health and Health Equity Infrastructure	Builds the foundation for a 21st century public health system to address preventable death and disease, reduce health disparities, and support an agile public health workforce, with $300 million annually beginning in 2022-23.

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Homelessness Related Proposals

Proposal	Description
Record-level Investment to Address Homelessness	Provides nearly $12 billion in new funding for homelessness programs over the next two years.
Local Multi-Year Support for Local Governments	Includes $1 billion in support for local governments to address homelessness for both 2021-22 and 2022-23, with additional years upon appropriation.
Sending More Resources to Front-Line Anti-Poverty Programs	Includes more than $4 billion over two year for various programs operated out of the Department of Social Services.

Questions

Return to Agenda

AGENDA ITEM NO. 3

TO: Provider Advisory Committee

FROM: Marlen Torres, Executive Director, Strategy & External Affairs
Pauline Preciado, Senior Director, Population Health & Equity

DATE: July 13, 2021

SUBJECT: ECM/ILOS Overview

PowerPoint with Verbal Presentation

ATTACHMENTS:

ECM/ILOS OVERVIEW PRESENTATION

Gold Coast Health Plan℠
A Public Entity

ECM/ILOS Overview

July 13, 2021

Marlen Torres
Executive Director, Strategy and External Affairs

Pauline Preciado
Senior Director, Population Health and Equity

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Agenda

1. Enhanced Care Management/In Lieu of Services (ILOS) Background
   a. ECM/ILOS: What is It?
   b. ECM/ILOS: How do We Get There?
   c. ECM Model of Care
   d. ECM/ILOS Populations of Focus
   e. ECM Go Live Dates by Populations of Focus

2. GCHP ILOS Options

3. ECM/ILOS Timeline and Work Plan

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Background

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ECM/ILOS: What is it?

1. The ECM benefit is designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs or high-cost and/or high-need Medi-Cal beneficiaries
    a. Systemic coordination of services
    b. Primarily community based, interdisciplinary
    c. High-touch and comprehensive
    d. ILOS, as identified by DHCS, are flexible wrap-around services that managed care plans can integrate into their population health strategy and are provided as a substitute to, or to avoid, other covered services
    e. Complementary services with ECM benefits
    f. Addresses social needs and/or social determinants of health (SDOH)

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ECM/ILOS: How do we get there?

How:

1. DHCS urges plans to contract with Whole Person Care entities to deliver ECM and ILOS.
2. DHCS also urges plans to select *all* ILOS services that will be offered to them to offer to enrollees.
3. DHCS has already provided plans with final template contract terms for contracts with the entities that will deliver ECM and ILOS.
4. GCHP submitted the Model of Care #1 on July 1, 2021

When:

1. DHCS has submitted its 1915/1115 waivers to CMS. The CMS comment period will be open in July 2021.
2. DHCS provided the plans with ECM and ILOS draft rates in May 2021
3. DHCS anticipates a phased in approach to ECM and ILOS implementation:
    a. Phase I: Jan. 1, 2022
    b. Phase II: July 1, 2022
    c. Phase III: Jan. 1, 2023

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ECM Model of Care Person Centered Approach

Intensive, multi-disciplinary care coordination

- (Medical, mental health, alcohol and drug, social services)

Skilled Community Health Workers

- Address SDOH barriers
- Health Navigation Assistance
- Building capacity for self-management

Field-based services (at home or in the community)

- Immediate and Accessible care to Medical, Behavioral and community services
- Comprehensive assessments to identify needs

Return to Agenda

ECM/ILOS: Populations of Focus

Homeless*	Children and Youth	High Utilizers*	Risk for Initialization-Long Term Care	Nursing Facility Transition to Community	SMI, SED, SUD Individuals at Risk for Initialization	Individuals Transitioning from Incarceration
• Individuals experiencing homelessness or chronic homelessness or who are at risk of experiencing homelessness with complex health and behavioral health needs.	• Children (Up to age 21, or foster youth to age 26) with complex behavioral, and/or developmental health needs, with significant functional limitations and social factors influencing their health outcomes (California Children Services and Foster Youth).	•Members with multiple hospital admissions, OR multiple short-term skilled nursing stays, OR multiple emergency room visits that could be avoided with appropriate outpatient care or improved treatment adherence.	•Members who, in the absence of services and supports would otherwise require care for 90 consecutive days or more in an inpatient nursing facility (NF) would qualify. •Must meet NF level of care criteria AND be able to continue to live safely in the community with warp around supports.	•Members residing in a NF but desire to return to living in the community. •Voluntary	•Members at risk for initialization who have co-occurring chronic health conditions.	•Including justice-involved juveniles who have significant complex physical or behavioral health needs requiring immediate transition of services to the community. •Individuals must have been released from incarceration within the last 12 months.

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*Current populations being served by the Whole Person Care Program in Ventura County.

CM Go Live Dates: By Target Populations

1/1/2022

Phase 1

Homeless Population

Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless

High utilizers

Individuals with frequent hospital admissions, short-term skilled nursing facility stays or emergency room visits

At Risk SMI/ SUD

Serious mental illness (SMI)or substance use disorder (SUD) with co-occurring chronic health conditions.

1/1/2023

Phase 2

Individuals transitioning from incarceration *(Adults/ youth)*

who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

Individuals at risk for institutionalization

Individuals who *are eligible for long-term care services*

High Risk Nursing facility residents

Residents who want to transition to the community

1/1/2023

Phase 3

All other children and youth populations

Physical, behavioral, developmental and oral health needs e.g., California Children Services, foster care, youth with clinical high-risk syndrome or first episode of psychosis

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GCHP ILOS Options

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ILOS

Benefit	Description
Housing deposits[a]	Funding for one-time services necessary to establish a household, including security deposits to obtain a lease, first month's coverage of utilities, or first and last month's rent required prior to occupancy.
Housing transition navigationservices[a]	Assistance with obtaining housing. This may include assistance with searching for housing and completing housing applications, as well as developing an individual housing support plan.
Housing tenancy andsustaining services[a]	Assistance with maintaining stable tenancy once housing is secured. This may include interventions for behaviors that may jeopardize housing, such as late rental payment and services, to develop financial literacy.
Asthma remediation[b]	Physical modifications to a beneficiary's home to mitigate environmental asthma triggers.
Day habilitation programs	Programs provided to assist beneficiaries with developing skills necessary to reside in home-like settings, often provided by peer mentor-type caregivers. These programs can include training on use of public transportation or preparing meals.
Environmental accessibilityadaptions	Physical adaptations to a home to ensure the health and safety of the beneficiary. These may include adaptations ramps and grab bars
Meals/medically tailored meals	Meals delivered to the home that are tailored to meet beneficiaries' unique dietary needs, including following discharge from a hospital.
Nursing facility transition/diversion to assisted living facilities[c]	Services provided to assist beneficiaries transitioning from nursing facility care to community settings or prevent beneficiaries from being admitted to nursing facilities.
Nursing facility transition to ahome	Services provided to assist beneficiaries transitioning from nursing facility care tohome settings in which they are responsible for living expenses.
Personal care and homemaker services[d]	Services provided to assist beneficiaries with daily living activities, such as bathing, dressing, housecleaning, and grocery shopping.
Recuperative care (medicalrespite)	Short-term residential care for beneficiaries who no longer require hospitalization, but still need to recover from injury or illness.
Respite	Short-term relief provided to caregivers of beneficiaries who require intermittent temporary supervision.
Short-term post-hospitalization housing[a]	Settings in which beneficiaries can continue receiving care for medical, psychiatric, or substance use disorder needs immediately after exiting a hospital.
Sobering centers	Alternative destinations for beneficiaries who are found to be intoxicated and would otherwise be transported to an emergency department or jail.

[a] Restricted to use once in a lifetime, unless managed care plan can demonstrate cost-effectiveness of providing a second time.
[b] New benefit introduced this year. Restricted to lifetime maximum amount of $5000, unless beneficiary's condition changes dramatically.
[c] Includes residential facilities for the elderly and adult residential facilities.
[d] Does not include services already provided in the In-Home Supportive Services program.
*Existed Previously between GCHP and VCPH

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GCHP ILOS Options

GCHP's Proposed Strategic Approach: Conservative, staggered roll out of preliminary ILOS

Population	ILOS	Start Data	Anticipated Vendor
Phase I Eligibility Criteria	1. Housing Suite 2. Respite Care 3. Recuperative Care	Jan. 1, 2022	County
Phase I Eligibility Criteria	1. Medically Tailored Meals	July 1, 2022	TBD
All Eligible Plan Members	1. Housing Suite 2. Respite Care 3. Recuperative Care	July 1, 2022	County
All Eligible Plan Members	1. Medically Tailored Meals	Jan. 1, 2023	TBD

ECM/ILOS Implementation Plan and Timeline

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GCHP Implementation Plan

Current State

- Working on WPC transition with HCA Pilot Program
- MOC Part 1 Submission completed; MOC Part 2 in progress
- Finalized Payment Rates & Incentive Guidance: pending August 2021
- Preliminary ILOS options selected

GCHP Timeline

- Contract with the County of Ventura- Phase I
- Phase I Populations (Go Live 1/1/22):
  - ✓Eligible WPC Members
  - ✓High Utilizers
  - ✓Individuals & Families Experiencing Homelessness
  - ✓SMI/SUD Populations
- Phase 2 Populations (Go Live 1/1/23)
  - ✓Individuals transitioning from Incarceration *(adults and children/youth)*
  - ✓Members Eligible for LTC and at risk of Institutionalization
  - ✓Nursing Home Residents transitioning to community
- Phase 3 Populations (Go Live 7/1/23)
  - ✓ ECM goes live for all other Children and Youth

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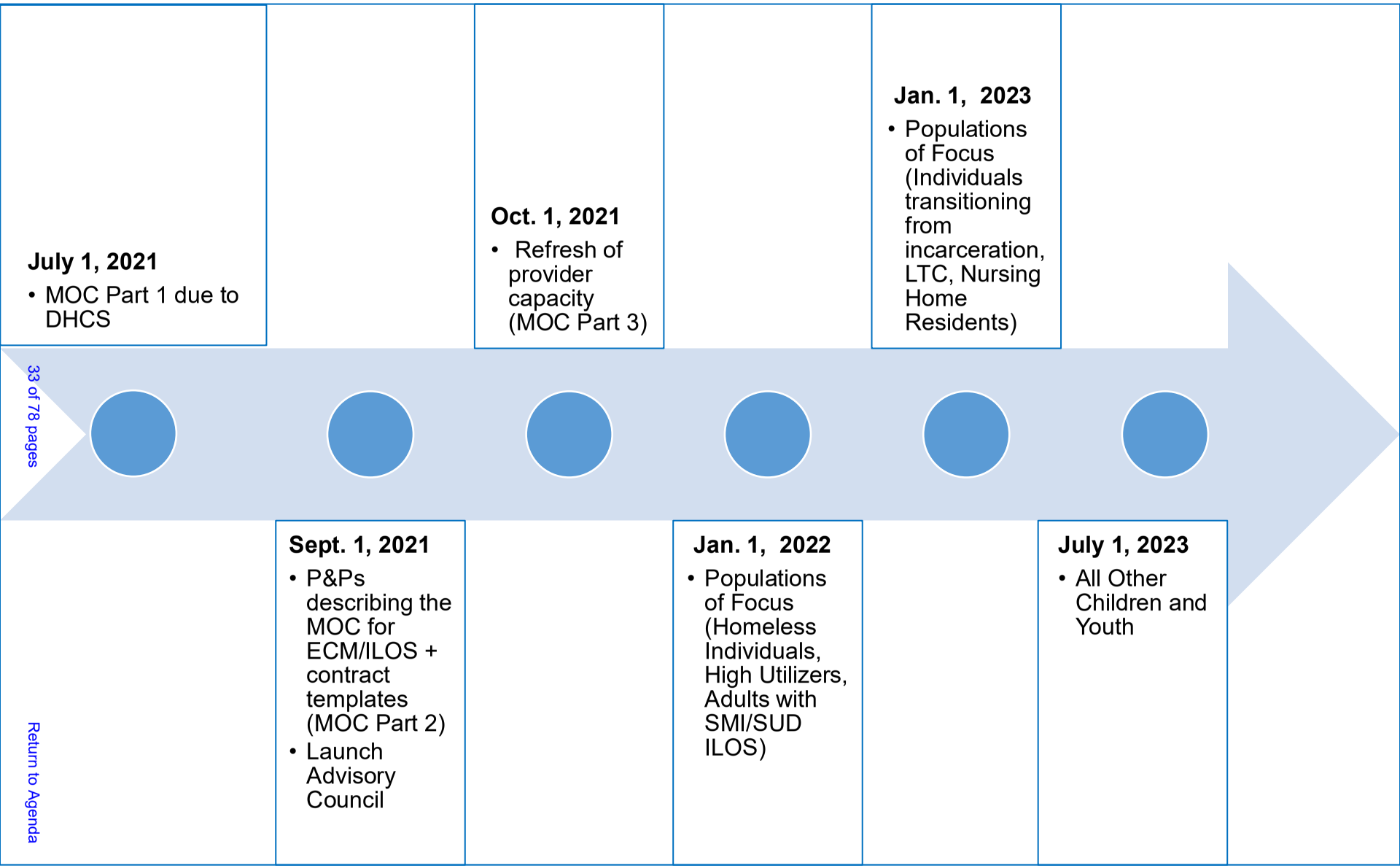
ECM/ILOS Timeline



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Questions?

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AGENDA ITEM NO. 4

TO: Provider Advisory Committee

FROM: Eileen Moscaritolo, HMA Consultant

DATE: July 13, 2021

SUBJECT: HSP MediTrac Update

SUMMARY:

HSP MediTrac Update.

RECOMMENDATION:

Accept and file the update.

AGENDA ITEM NO. 5

TO: Provider Advisory Committee

FROM: Vicki Wrighster, Director of Network Operations
Kim Timmerman, Director of Quality Improvement

DATE: July 13, 2021

SUBJECT: Provider Contracting and Credentialing Management (PCCM) Update

PowerPoint with Verbal Presentation

ATTACHMENTS:

Provider Advisory Committee Meeting_07132021_PCCM

Gold Coast Health Plan℠
A Public Entity

Provider Contracting and Credentialing Management (PCCM) Update

July 13, 2021

Kimberly Timmerman, Director, Quality Improvement
Vicki Wrighster, Director, Network Operations

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Software Components

- eApply: This is an online application for data entry that feeds directly into eVIPs solution. Once providers have entered their data, changes, or documents via eApply, the data can be reviewed by internal GCHP staff and merged into the production database.
- eStatus: This application offers the ability for providers to log on to a secure webpage to research the status of files being processed. Full practitioner information including images, confirmation dates, and enrollment statuses can be viewed.
- Contract Management: eVIPS will allow a configurable, end-to-end contract management solution to manage all pre-contracted and renewal contract negotiations. Demographic information maintenance.

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Project Timeline

- Project began in Q1 2019
- Expected Completion Date
  - Mid-August 2021
- Internal Departments
  - Project Management Office
  - Credentialing/QI
  - Provider Network Operations
  - IT

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Benefits of PCCM

- Integrate the provider credentialing, contracting and maintenance processes
- Replace the Provider Network Database (PNDB) system
- Eliminate the manual provider credentialing process
- Self-service provider tools to streamline the data collection process including online submissions of Credentialing applications and required documents.
- Automate the provider credentialing and contracting processes, e.g. real-time license verification
- Eliminate provider data maintenance inefficiencies
  - Reduction of provider data errors and eliminates the redundancy of provider data input
  - Improved provider demographic tracking
  - Improved provider data quality
- Provide enhanced reporting and tracking
- Timely compliance with DHCS regulatory changes

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Provider Communications

- Provider Updates
  - Introduction of PCCM
  - Additional Updates – Rollout of Credentialing Products
    - ✓eApply
    - ✓eStatus – post GoLive
- Provider Operation Bulletins
- Credentialing Committee
- GCHP Website – Credentialing Site
  - Provider Training
    - ✓Including a step-by-step visual guideline document and a short video

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Questions

Return to Agenda

AGENDA ITEM NO. 6

TO: Provider Advisory Committee

FROM: Kashina Bishop, Chief Financial Officer

DATE: July 13, 2021

SUBJECT: 2021-2022 Operating and Capital Budget

PowerPoint with Verbal Presentation

Gold Coast Health Plan℠
A Public Entity

Integrity

Accountability

Collaboration

Trust

Respect

Gold Coast Health Plan

FY 2021-2022
Operating and Capital Budgets

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Budget Highlights

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FYTD NET GAIN

$ 16.6 M

TNE is $114.5M & 314% of min. required at 6/30/22

MEDICAL LOSS RATIO

91.7%

ADMINISTRATIVE RATIO

6.5%

FY 2021-22 Operating Budget

GOLD COAST HEALTH PLAN FY 2021-22 OPERATING BUDGET	Jul 1- Dec 31 2021	Jan 1- Jun 30 2022*	TOTAL
Program Revenue	$ 567,622,662	$ 472,074,012	$ 1,039,696,673
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Net Revenue	$ 524,491,062	$ 428,942,412	$ 953,433,473
Medical Expenses	$ 486,370,870	$ 388,367,621	$ 874,738,491
MLR	92.7%	90.5%	91.7%
Gross Margin	$ 38,120,191	$ 40,574,791	$ 78,694,982
General & Administrative Expenses	$ 29,194,175	$ 26,895,911	$ 56,090,086
Project Portfolio	$ 4,254,146	$ 2,077,496	$ 6,331,642
Admin %	6.4%	6.8%	6.5%
Interest Income	$ 180,000	$ 180,000	$ 360,000
Net Gain	$ 4,851,870	$ 11,781,385	$ 16,633,255

* Assumes pharmacy carve-out effective 1/1/22.

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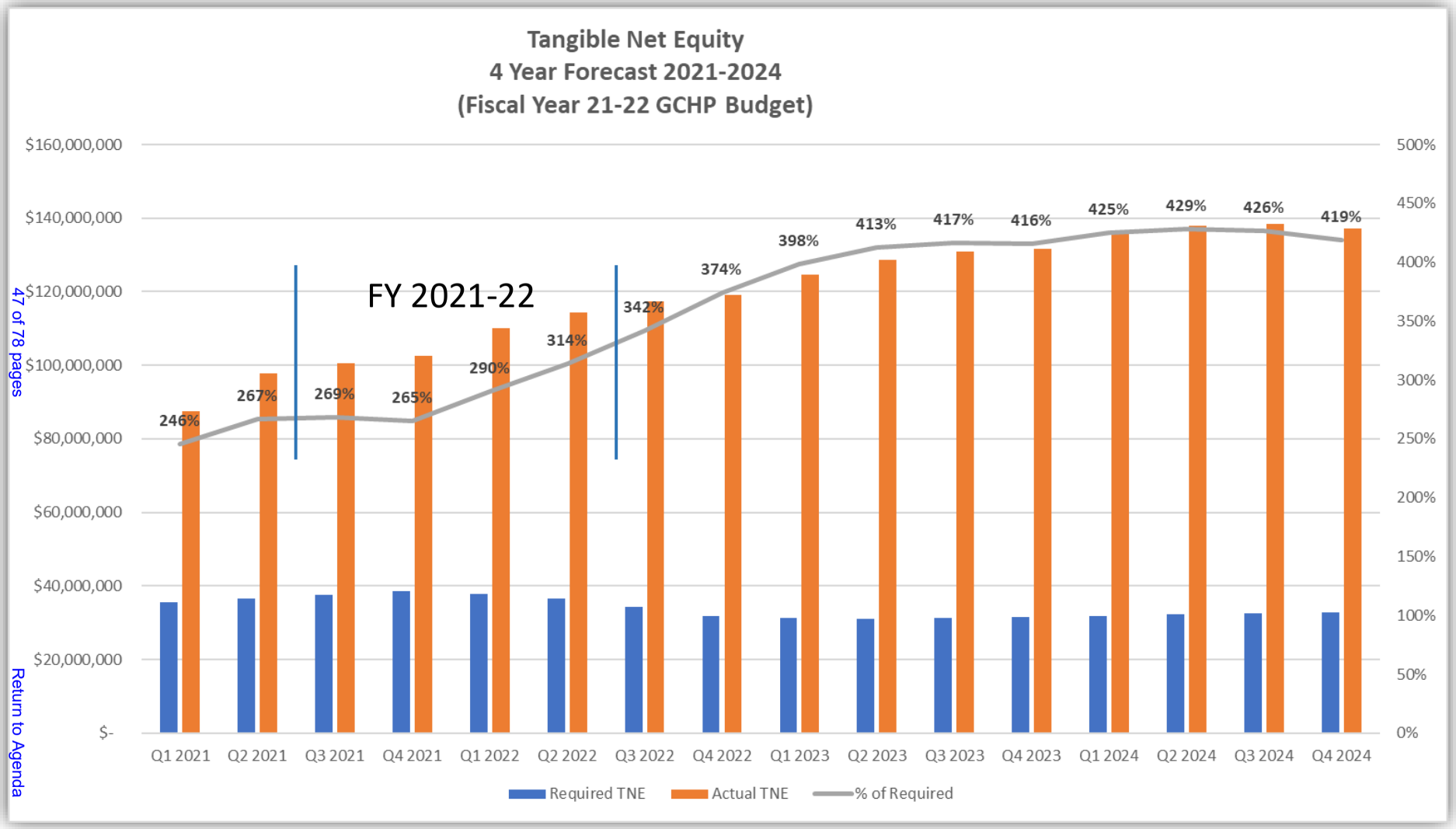
Tangible Net Equity (TNE) Forecast



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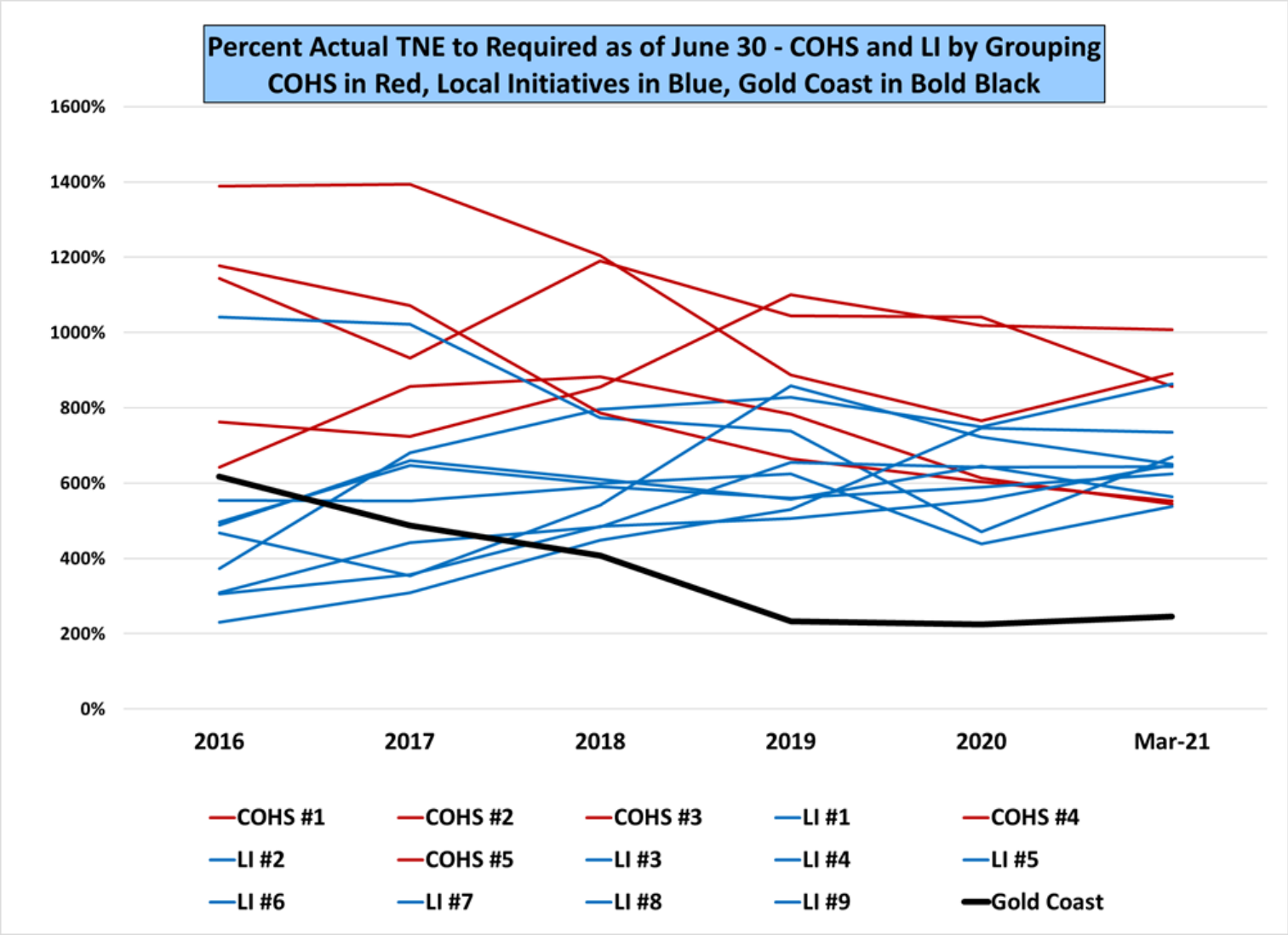
Tangible Net Equity (TNE) Comparison



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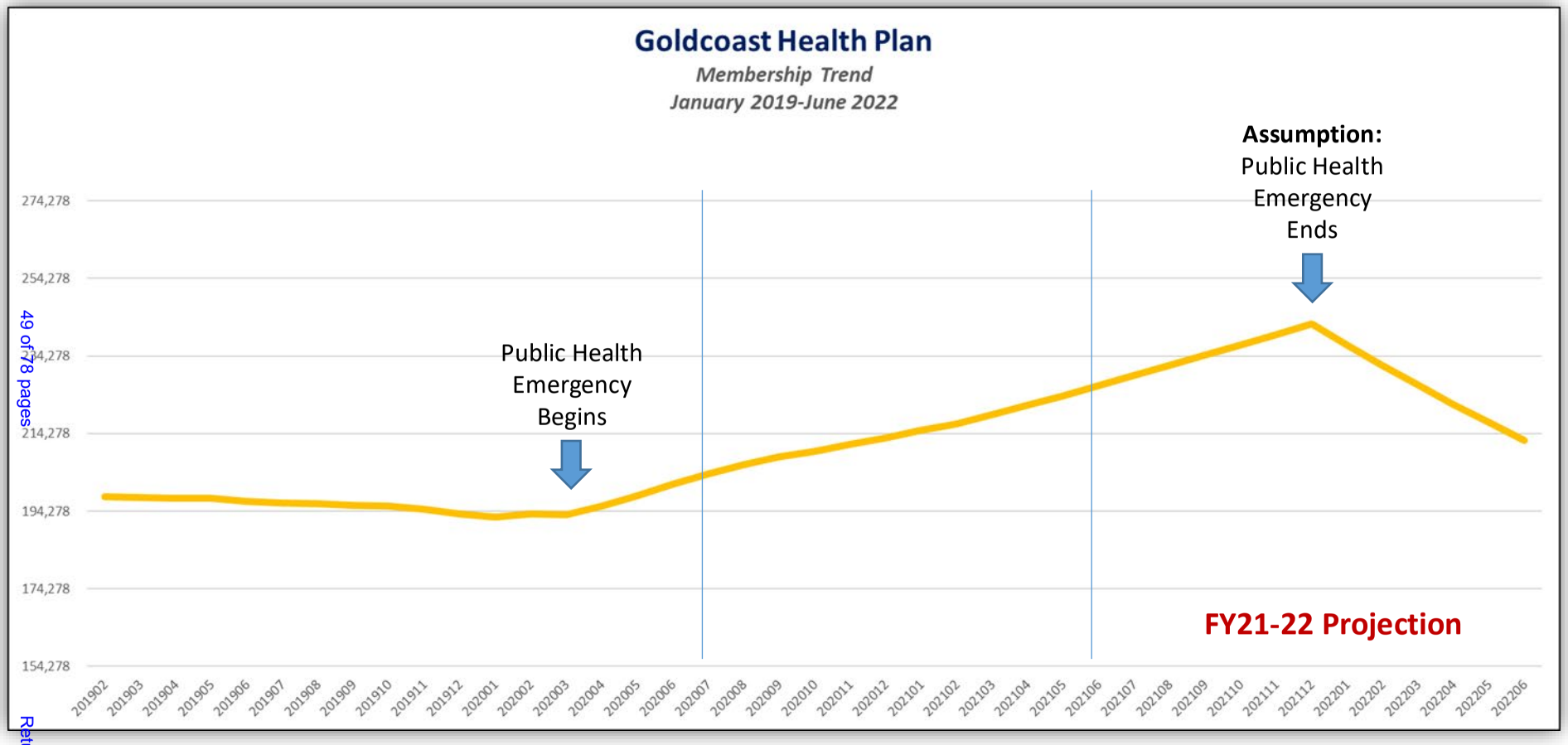
Membership



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Enrollment: Assumes a membership increase of 7.6% through the end of assumed PHE (12/31/21) and thereafter membership drops down to pre-COVID levels over a 6-month time period (~-16% per month). 6-month ramp down once redeterminations begin again (assumed 1/1/22) to ~212K by fiscal year end.

Revenue Assumptions

- Flexible budget
- Enhanced Care Management under CalAIM – draft rates received 5/28/21
- Includes Proposition 56 directed payments, GEMT and MCO Tax Premium
- Pharmacy carve out effective January 1, 2022
- CY 2022 revenue based on CY 2019 RDT

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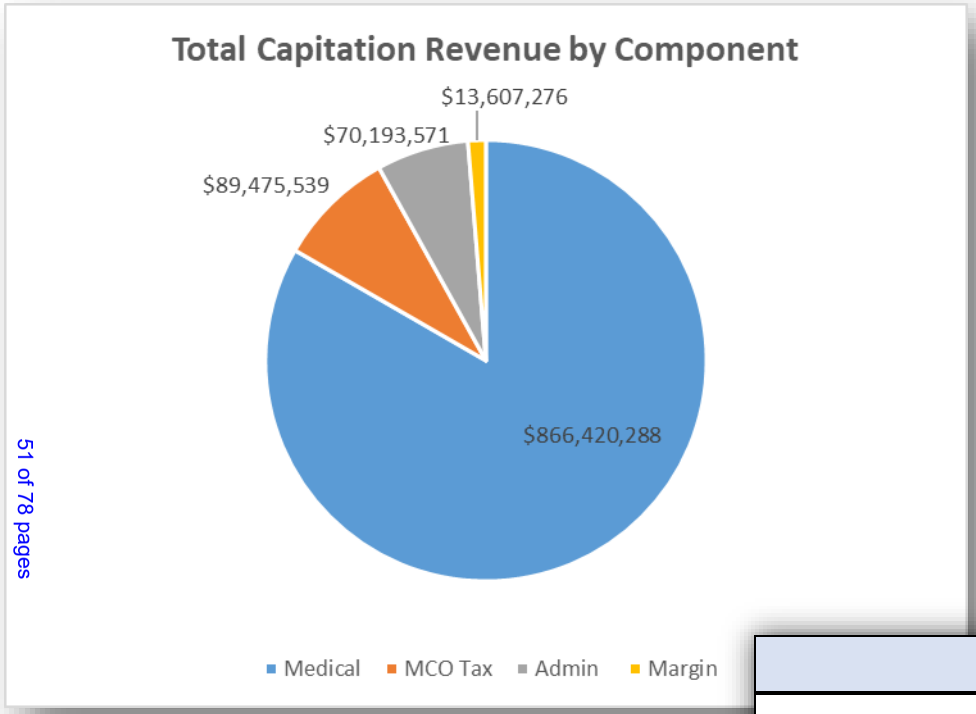
Revenue



FY21-22 Projections			
Base Capitation	$	879,670,559	**84.6%**
ECM Revenue (CalAIM)	$	1,741,851	**0.2%**
Hep C Supplemental	$	2,341,784	**0.2%**
BHT Supplemental	$	16,858,080	**1.6%**
Maternity Supplemental	$	20,818,197	**2.0%**
Prop 56 Directed Payments	$	28,790,663	**2.8%**
MCO Premium Tax	$	89,475,539	**8.6%**
	$	**1,039,696,673**	

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Medical Expense Assumptions

- Flexible budget
- Based on CY 2019 PMPM expenses and trended forward
- Trend factors consistent with RDT (2-4%)
- Assumed some decrease to utilization through PHE
- 3.9% increase to LTC costs
- Removal of 10% increase to LTC at end of PHE
- 5.8% increase to Pharmacy costs
- Included Directed Payments under Proposition 56 and GEMT
- Pharmacy carve out effective January 1, 2022

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Medical Expense Budget

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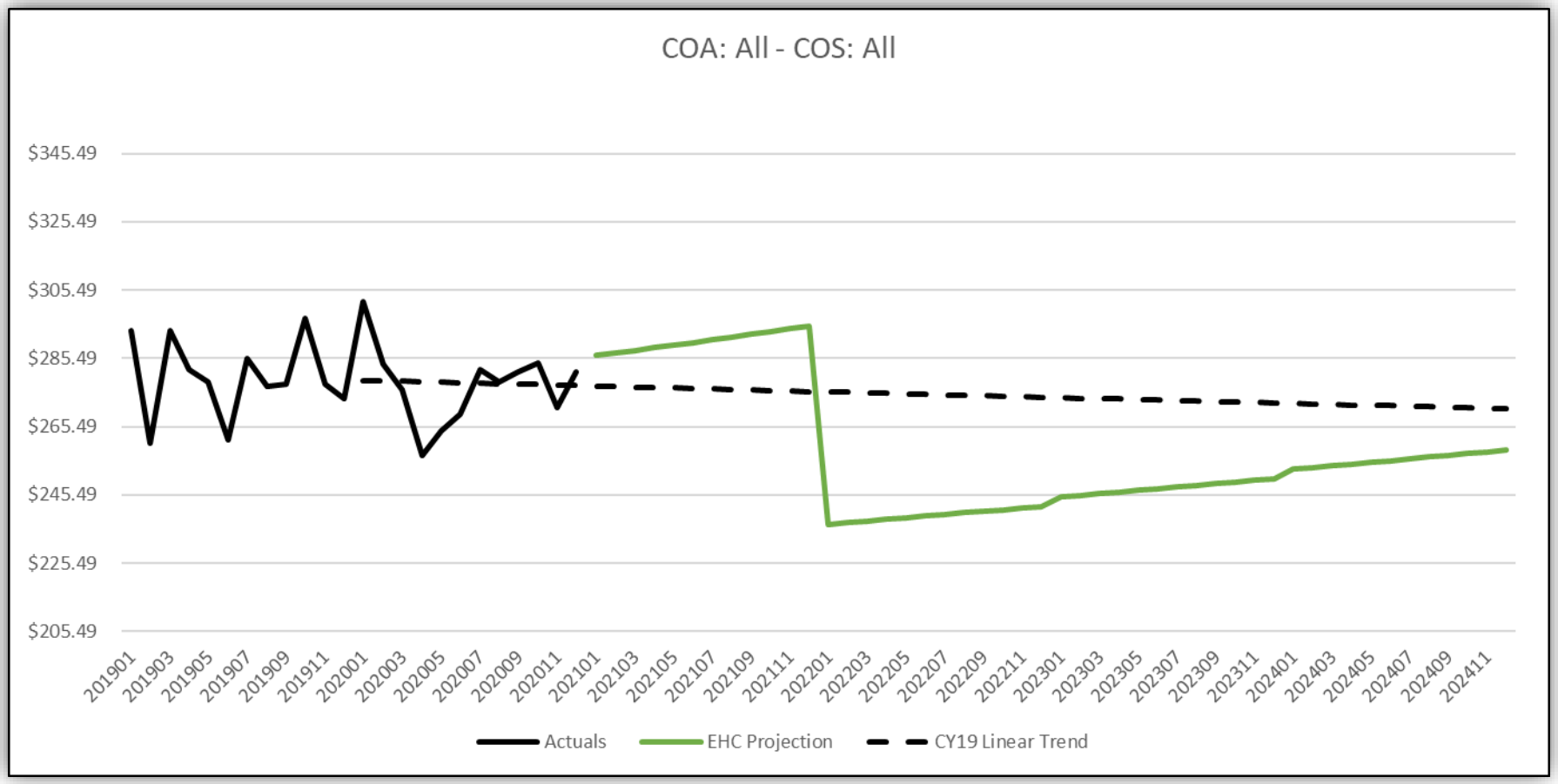
FY 2021-22 MEDICAL EXPENSE BUDGET

	FY 2020-21 as of March 2021 PMPM	Projected Jul - Dec 2021 PMPM	Projected Jan - Jun 2022 PMPM	FY 2021-22 PMPM	% Change	Projected Dollars
Capitation - PCP Expense	$ 34.17	$ 36.57	$ 34.03	$ 35.33	3%	$ 99,203,619
Fee For Service						
Inpatient FFS Expense	$ 66.45	$ 66.35	$ 73.87	$ 70.02	5%	$193,309,969
Outpatient FFS Expense	23.44	26.24	29.46	27.81	19%	76,779,169
LTC/SNF Expense	56.72	55.41	54.08	54.76	-3%	151,185,196
ER Facility Services FFS	9.06	13.45	14.29	13.86	53%	38,273,865
Physician Specialty Services FFS	25.58	27.11	27.14	27.12	6%	74,878,141
Transportation FFS	1.47	0.81	0.83	0.82	-44%	2,268,988
Primary Care Physician FFS	7.04	7.47	7.48	7.47	6%	20,631,465
Mental and Behaviorial Health	11.98	11.03	11.12	11.07	-8%	30,569,722
Pharmacy Expense FFS	62.67	65.14	-	33.36	-47%	92,104,164
Other Medical Professional	1.47	1.79	1.85	1.82	24%	5,021,692
Home & Community Based Svcs	9.35	9.91	10.44	10.17	9%	28,076,269
Laboratory and Radiology Expense	3.28	2.35	2.06	2.21	-33%	6,094,824
Other Medical Care Expenses	3.77	4.06	4.27	4.16	10%	11,483,512
Directed Payments	10.47	11.01	9.85	10.45	0%	28,844,065
Provider Reserve	0.50	-	-	-	-100%	-
Sub-total	$ 293.25	$ 302.13	$ 246.75	$ 275.12	-6%	$759,521,041
Reinsurance-Net	$ 1.30	$ 1.35	$ 1.35	$ 1.35	4%	$ 3,726,997
Refunds & Recoveries	$ (1.81)	$ (1.56)	$ (0.77)	$ (1.17)	-35%	$ (3,242,210)
Care Management	$ 6.03	$ 5.50	$ 5.76	$ 5.62	-7%	$ 15,529,043
Total Medical Expenses	$ 332.94	$ 344.00	$ 287.12	$ 316.25	-5%	$874,738,491
MLR	**93.1%**	**92.7%**	**90.5%**	**91.7%**	**-1.4%**	

Total FFS Medical Expenses



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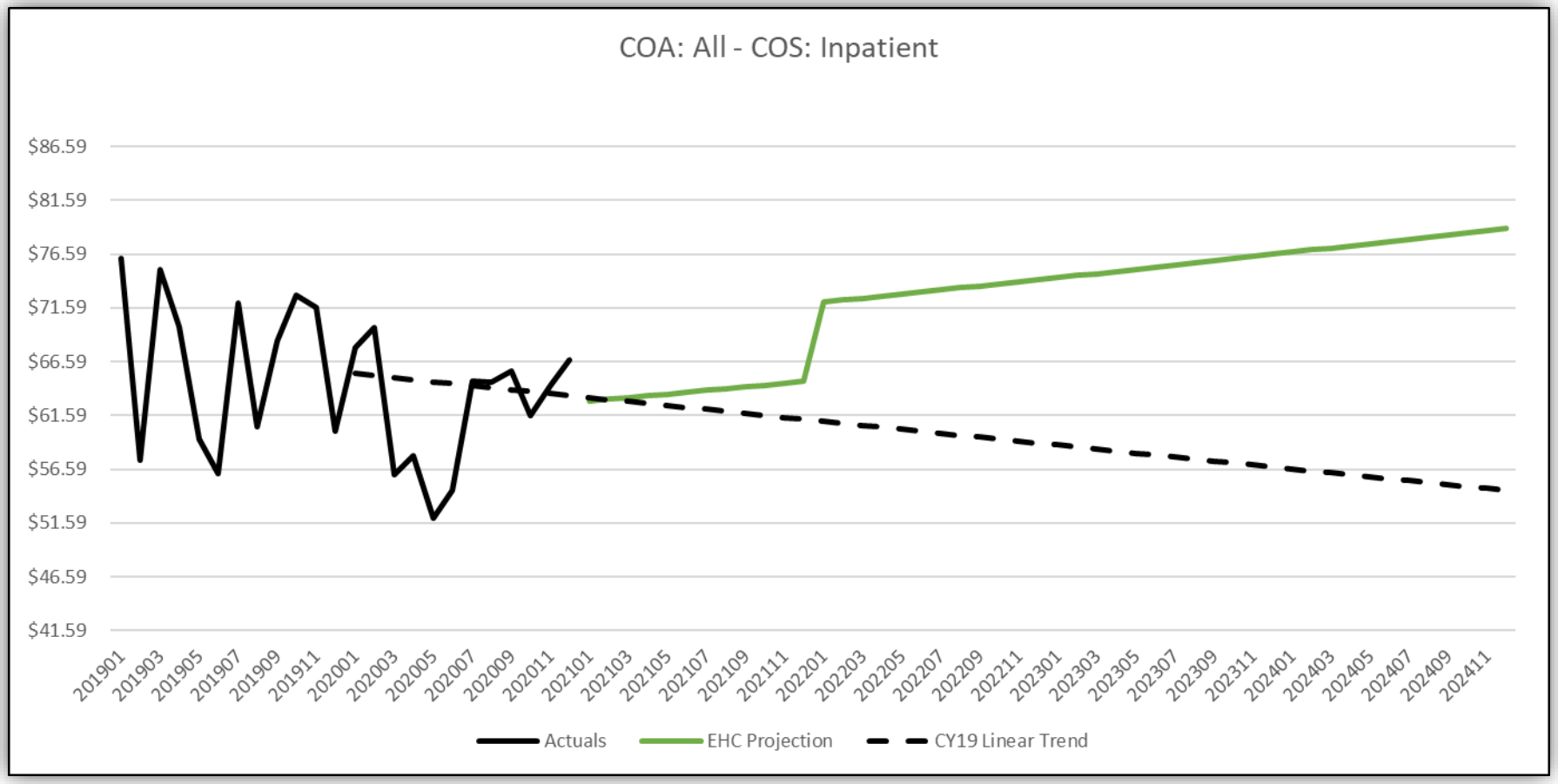
Inpatient FFS Medical Expenses



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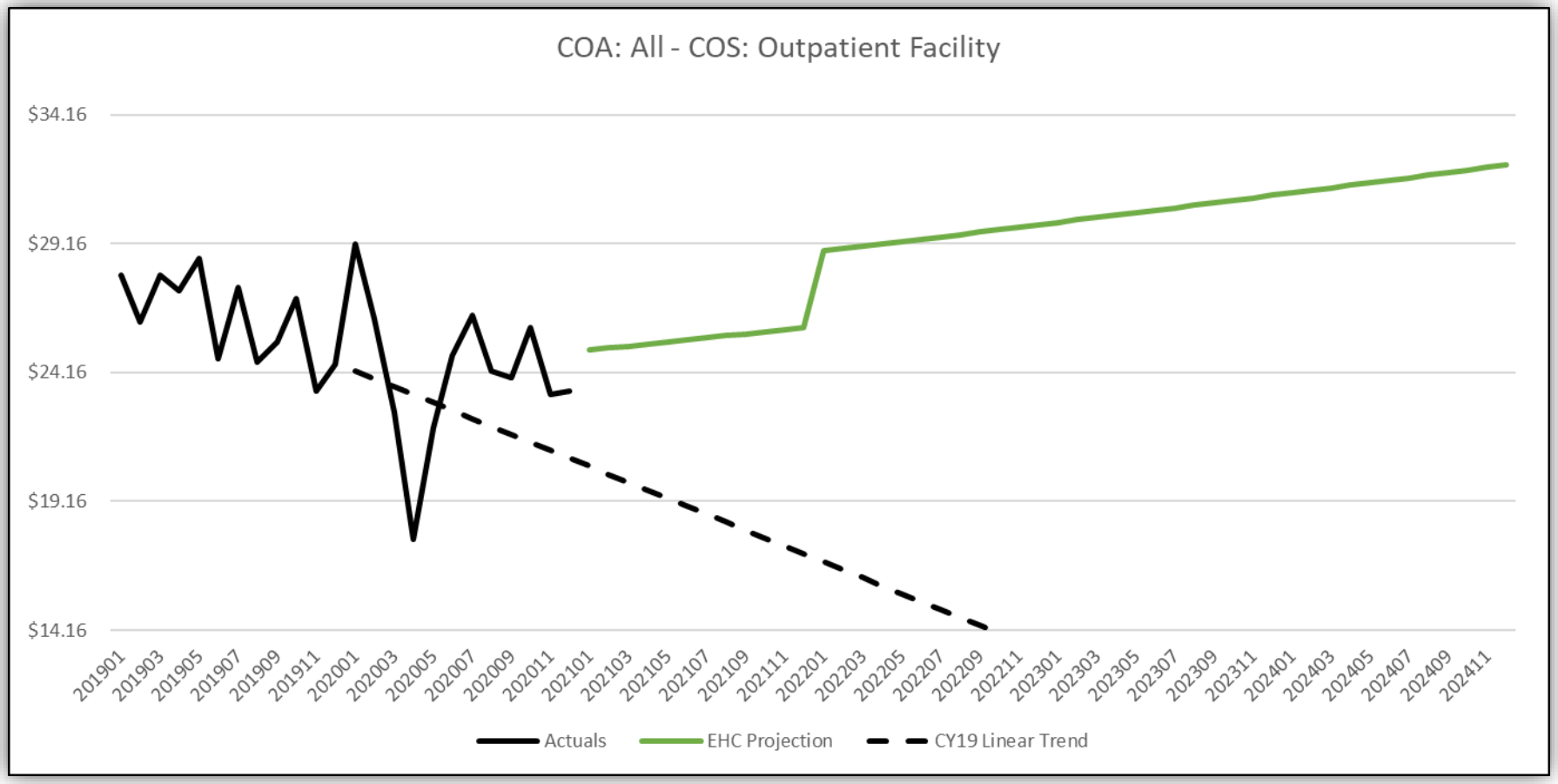
Outpatient FFS Medical Expenses



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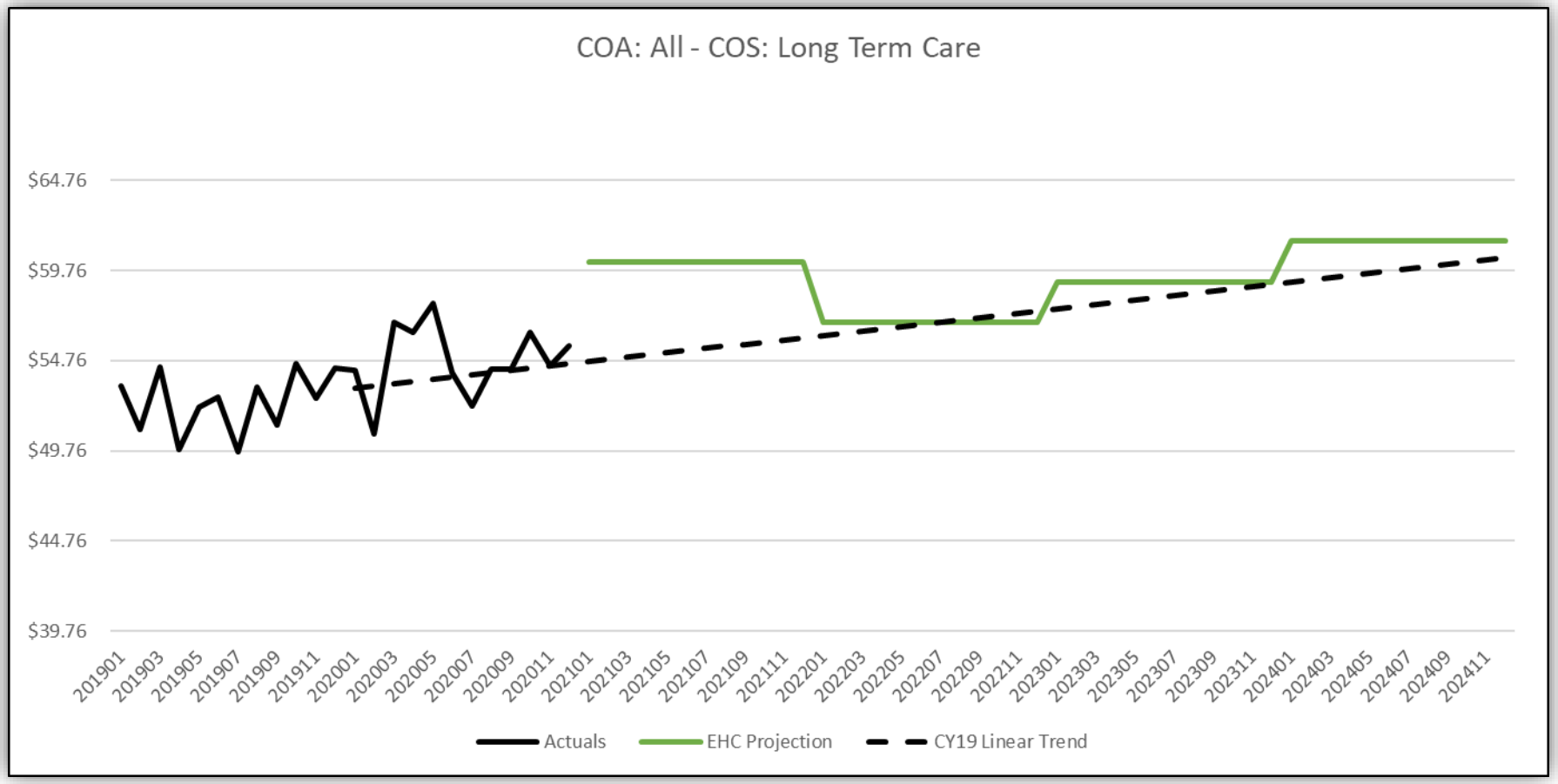
Long Term Care FFS Medical Expenses



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FY 2021-22 Strategic Plan

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Administrative Expense Assumptions

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- Fixed Budget
- 6.5% Administrative Cost Ratio (ACR)
- Within amounts allotted for administrative expense in capitation rates
- Assumes 3% merit increase re-instated (effective 8/1/2021) & 6% attrition rate
- Equity Adjustments, as a result of Compensation Analysis, are in the HR business unit as a placeholder
- Assumes Employee Benefit Expense increases (effective 1/1/2022)
- Assumes Insurance rate increases between 20-40% due to “hard market” of ~$250K; assumed mid-range for budget
- Medi-Cal Rx implementation assumed as of 1/1/2022
- In-person travel assumed to start 1/1/2022 (all training prior to this date is virtual)
- PMPM driven expenses are assumed at ~230K members for fiscal year

Administrative Expense Budget

Total Administrative Expenses (*in millions*)

	FY20-21 Actuals*	FY20-21 Budget	FY21-22 Budget		FY21-22 vs Actual Δ		FYE 22 vs FYE 21 Budget Δ	
Salaries, Wages & Benefits	$24.8M	$26.4M	$29.1M		$4.3M	17%	$2.7M	10%
Training, Conference & Travel	$0.0M	$0.2M	$0.4M		$.4M	190%	$0.2M	100%
Outside Services	$24.9M	$24.6M	$27.4M		$2.5M	10%	$2.8M	11%
Professional Services	$4.8M	$3.4M	$4.0M		($0.8M)	-17%	$0.6M	19%
Occupancy, Supplies, Insurance & Other	$7.0M	$9.4M	$10.9M		$3.9M	55%	$1.5M	15%
CM Reclass to Medical Exp	($15.2M)	($14.5M)	($15.5M)		($.3M)	2%	($1.0M)	7%
Project Portfolio	$2.7M	$5.5M	$6.3M		$3.6M	133%	$0.8M	15%
TOTAL	**$49.0M**	**$55.0M**	**$62.4M**		**$13.4M**	**27%**	**$7.4M**	**13%**

Major Drivers:

1. Increases to membership ~$ 2.5 M
2. 22 new positions (details on next slide) ~$1.5M
3. Equity Adj, Merit, Promotions, EE Recruit ~$1.2M
4. Project Portfolio ~$.8M
5. Travel Reinstatement ~$.2M
6. Benefits / Business Insurance Increases ~$.5M

** Projected*

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Project Portfolio

Gold Coast Health Plan FY 2021-22 Project Portfolio

FY 2020-21 Carry-over Initiatives

Project	Description	Strategic Plan Objective	FY 2021-22 Expense	FY 2021-22 Capital
CMS Interoperability	CMS Interoperability and Patient Access Final Rule is a mandate for payers effective January 1, 2021. The goal is to provide member's access to health data and support member choice.	Healthcare Leader Responsible Fiscal Steward	$ 1,236,078	$ -
Enterprise Data Warehouse	Strategic technology investment in data warehouse architecture, tools and resources to effectively support the provision, management, proliferation, and use of data for improved decision making, business process improvement, and faster response to regulatory conditions.	Healthcare Leader	643,900	$ -
Provider Credentialing, Contracting & Data Management (PCCM)	Implementation of an integrated system for the management of provider credentialing, contracting and data. Mission critical initiative to ensure that GCHP continues to meet ongoing and increasing regulatory requirements around provider data accuracy, support contracting efforts, and optimize business processes.	Strategic Business Partner	528,080	$ -
Manifest MedEx	Effort to support the Ventura County Health Improvement Exchange (HIE) and improve population health management. HEDIS/MCAS EMR integration project to establish EMR integration with 4 major clinical systems to support Quality Improvement initiatives	Healthcare Leader Quality Health Outcomes	382,500	
Enterprise Transformation Projects (ETP)	Initiative to convert to a new core administrative platform - Health Solutions Plus (HSP) for claims processing, eligibility, membership and benefit maintenance, along with implementation of a new customer service system solution to optimize call center efficiencies.	Future Demands of Providing Quality Care	200,500	
IT Infrastructure- Maintenance & Business Continuity Projects	Additional infrastructure hardware investments and installations to add business continuity capabilities.	Future Demands of Providing Quality Care	258,538	$ 927,100
Staff Augmentation (All Projects)			700,000	
		FY 2020-21 Carry-over Initiatives	**$ 3,949,596**	**$ 927,100**

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Project Portfolio

Gold Coast Health Plan FY 2021-22 Project Portfolio

New Initiatives

Project	Description	Strategic Plan Objective	FY 2021-22 Expense	FY 2021-22 Capital
Portal Capabilities	Investment to provide a consistent and more robust provider portal experience for enhanced provider engagement and GCHP improved business process effectiveness/efficiencies	Strategic Business Partner	960,500	
CalAIM	A multi-year DHCS mandated initiative to reform the Medi-Cal program to improve the quality of life and health outcomes of Medi-Cal members. The program will implement broad delivery system, program and payment reform across the Medi-Cal system, building upon the successful outcomes of various pilots. Year 1 project budget to include: -ECM/ILOS Benefit implementation -Population Health Registry -Knox-Keene Implementation (Application/License Fee) -NCQA Accreditation analysis -D-SNP / PBM RFP consultant	Collaborative Community Partner	475,630	
MHK Med Therapy Mgmt (MTM)	Implementation of a MHK module that is CMS compliant for Part D MTM's program	Quality Health Outcomes	259,167	
MHK Medical Management System Upgrade	Needed System upgrade from v3.5E to v3.9. GCHP is currently on MedHOK version 3.5.6, per contractual terms GCHP needs to be within 2 versions of the latest code.	Quality Health Outcomes	204,750	
Other- Misc. Business Process Improvement / Strategic Plan initiatives	*Misc. Business Process Improvement Projects < $100K each:* - Prospective RDT Reporting - Provider Pay for Performance Incentive Program (consulting only) -274 Business Process Improvement (automation/stabilization/decision audit log)	Responsible Fiscal Steward Strategic Business Partner Healthcare Leader	152,500	
Encounter Data Mgmt Program Assessment	Temp Labor for assistance in performing gap analysis and development of a process improvement roadmap.	Healthcare Leader	126,000	
Fix Existing Project Web PWA	Portfolio & Project Mgmt Implementation	Future Demands of Providing Quality Care	118,000	
		New Initiatives	**$ 2,296,547**	**$ -**
Depreciation & Amortization Expense			$ 85,500	
		Total Project Cost	**$ 6,331,642**	**$ 927,100**

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FY 2021-22 Operating Budget

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* Assumes pharmacy carve-out effective 1/1/22.

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Questions?

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AGENDA ITEM NO. 7

TO: Provider Advisory Committee

FROM: Ted Bagley, Chief Diversity Officer

DATE: July 13, 2021

SUBJECT: Health Equity & Inclusion Presentation

PowerPoint with Verbal Presentation

ATTACHMENTS:
HEALTH EQUITY PRESENTATION

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

Health & Health Equity (GCHP)

County of Ventura

Provider Advisory Committee

July 13, 2021

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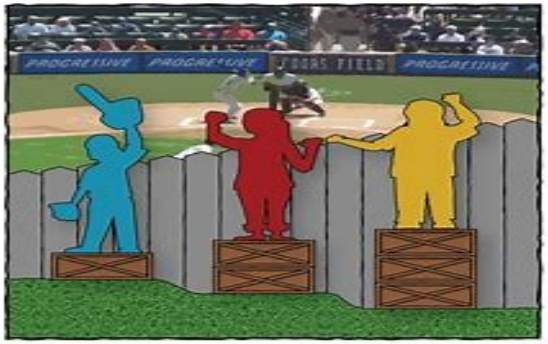
The Challenge

- Equality – We would assume that everyone would benefit from the same support. This is called equal treatment.
- Equity – Everyone gets the support they need (The concept of affirmative action), thus producing equity.
- Justice – When both Equity and Equality is accomplished. The cause of the inequity was addressed and the systematic barrier has been removed.

EQUALITY



EQUITY

"Racial equity describes the actions, policies, and practices that eliminate bias and barriers that have historically and systemically marginalized communities of color, to ensure all people can be healthy, prosperous and participate fully in civil life." SCAG

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Categories of Health Issues

- **Health Equity and Inclusion**
- **Medical Racism**
- **Systemic Health Racism**
- **Medical Deprivation**
- **Conscious Medical Bias**
- **Unconscious Medical Bias**

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What is Health Equity ?

- Equity – The absence of avoidable, unfair, or treatable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically, or by means of stratification.
- Health Equity – Implies that, ideally, everyone should have a fair opportunity to attain their full health potential, and that no one should be disadvantaged from achieving this potential.

World Health Organization (2020)

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Adult Deaths Attributed to Social Factors

Low Education	=	245,000	Individual Level poverty	=	133,000
Racial Segregation	=	176,000	Low Social Support	=	162,000
Income Inequity	=	119,000	Lung Cancer	=	155,500

CDC Sources(2018)

The United States has among the highest out of pocket and Government/Compulsory spending in the world.

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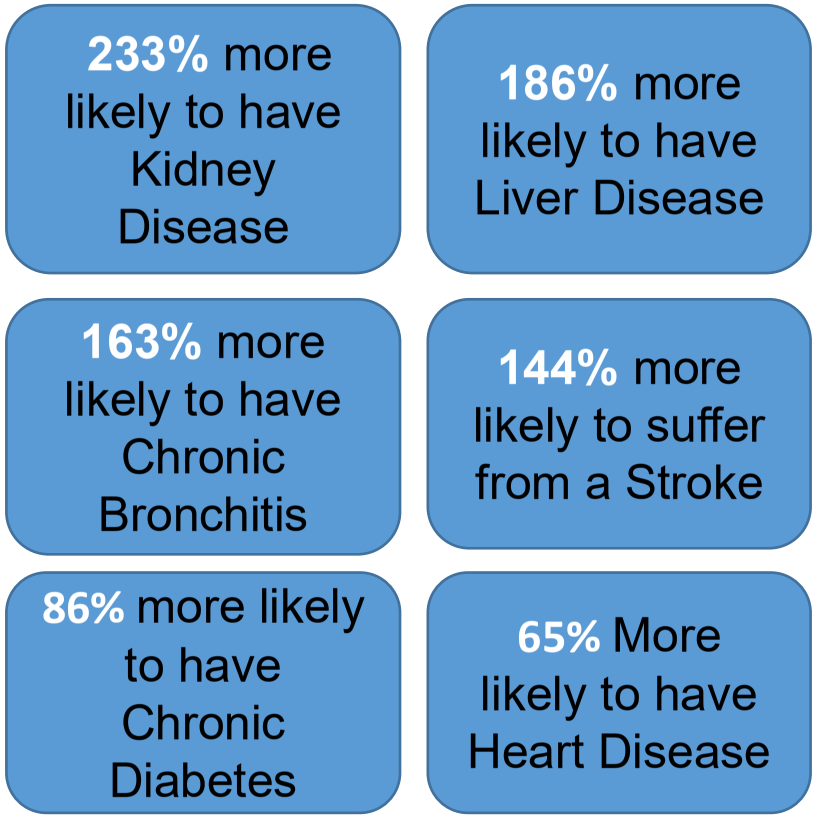
Household Income Affects Health Outcomes

Americans earning less than $35K are far more likely to develop serious chromic health conditions than those earning over $100K.



Disparities

- Breast Cancer – African American Women are nearly twice 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 rates 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.

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Participating in Clinical Trials

While death rates are decreasing across ethnicities, ethnic disparities still exist in breast cancer care and prognosis.

- African American Women are on average, 40% more likely to die of the disease than white women with breast cancer.
- Hispanic Women are more likely than non-Hispanic women to be diagnosed with tumors that are larger and are hormone receptor-negative, both of which are more difficult to treat.
- Asian/Pacific Islander Women have seen their incidents of breast cancer increase steadily. In California, which has the largest Asian population in the United States, the largest increase has been seen in Koreans (4.7%) and Southeast Asian (2.5%)

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Systematic Impact

"Systemic doesn't necessary mean intentional. It doesn't necessarily mean that many don't like people of color. It does say that some are unwilling to see how the benefits and burdens of this society are not fairly shared because of the history of racism."

Maya Wiley, JD –Sr. VP FOR Social Justice, The New school

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Recommendations

- Assess whether there are appropriate resources (Human/$$$) to make the significant impact needed.
- Ascertain if there exists a catalogue of Health Equity training modules that can be used for providers offering CME (Continuing Medical Education) credits. Develop a seamless delivery platform mechanism to disseminate the information.
- Develop a resource listing of Subject Matter Experts (SME) on Health Equity to facilitate future training. In concert with SME's, develop virtual events going forward.
- Develop Health Equity educational series regarding various topics of health equity for providers and for the community.

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Recommendations

- Work with County of Ventura to include health equity related questions in patient survey for data analysis, evaluation, and improvement measurers.
- Work with Ventura County and find evidence based practices and training regarding mitigating financial/insurance biased toward patients and their treatment via a health equity approach.
- Identify and meet with the different diverse cultures in the surrounding communities to identify real time perceptions and issues preventing effective health equity. (Mixteco, African American, Asian, American Indian, Hispanic, etc.

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Strategies

- Summit – Secure a gathering of all representatives of communities of color to assess current state. (August/ Sept)
- Integrate & Institutionalize: Focus on systems change to improve racial equity. Center racial equity in all aspects of work.
- Develop a community Awareness training process to educate the populace on identifying failures to the equity process.
- Create a centralized equity resource group as a clearinghouse of equity issues. Assign a centralized county resource to facilitate for consistency purposes. Current resources are inadequate.
- Assign appropriate budget and resources to prevent a **“check the box”** perception of the initiative.

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Resources - Consultant Dr Nancy Wharfield

- **Ted Bagley** – Chief Diversity Officer GCHP
- **Phin Xaypangna** – Ventura County Deputy Executive Officer Diversity/Inclusion
- **Pauline Preciado**- Sr. Director Population Health & Equity
- **Marlen Torres** – Executive Director Government Community Relations and Strategy
- **Susana Enriquez** – Sr. Manager Public Relation
- **Lupe Gonzalez** – Dr. Health Education Disease Management
- **Stacey Luney** – Manager Grievance and Appeals

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