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

Regular Meeting
Monday, September 23, 2024 2:00 p.m.
Meeting Location: Community Room
711 E. Daily Drive #110
Camarillo, CA 93010

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

Conference Call Number: 1-805-324-7279
Conference ID Number: 241 703 834#

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

Community Memorial Hosp
147 N. Brent St
Ventura, CA 93003

Los Robles Hospital
215 W. Janss Rd
Thousand Oaks, CA 91360

AGENDA

CLERK ANNOUNCEMENT

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

CALL TO ORDER

INTERPRETER ANNOUNCEMENT

ROLL CALL

PUBLIC COMMENT

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

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

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

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Regular Commission meeting minutes of August 26, 2024 and special meeting minutes of August 28, 2024.

Staff: Maddie Gutierrez, MMC Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

2. Tangible Net Equity (TNE) and Working Capital Reserve Funds Policy Revision

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff recommends the Commission adopt (accept and file) the increase in targeted TNE to 700% of required TNE.

UPDATES

3. Operations Dashboard

Staff: Anna Sproule, Executive Director of Operations
Alan Torres, Chief Information & System Modernization Officer

RECOMMENDATION: Receive and file the update.

4. Operations Of The Future (OOTF) Update

Staff: Alan Torres, Chief Information & System Modernization Officer
Anna Sproule, Executive Director of Operations

RECOMMENDATION: Receive and file the update.

5. Dual Eligible Special Needs Plan (D-SNP) Update

Staff: Kimberly Marquez-Johnson, Director of Dual Special Needs Plan
James Cruz, M.D., Senior Medical Director
Michelle Espinoza, Executive Director of Delivery Systems Operations
Eve Gelb, Chief Innovation Officer

RECOMMENDATION: Receive and file the update.

6. Compliance Update

a. Department of Health Care Services (DHCS) Audit

Staff: Robert Franco, Chief Compliance Officer

RECOMMENDATION: Receive and file the update

FORMAL ACTION

7. Reinstituting Commission Strategic Planning Retreat Ad Hoc Committee

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

RECOMMENDATION: Staff recommends that the Commission reconstitute the Strategic Planning Ad Hoc Committee and select up to five Commissioners who will serve in the ad hoc committee. Additionally, staff recommends that the Strategic Planning Retreat be held in person this year.

REPORTS

8. Chief Executive Officer (CEO) Report

Staff: Felix L. Nunez, M.D., MPH, Acting Chief Executive Officer

RECOMMENDATION: Receive and file the report

9. Chief Medical Officer (CMO) Report

Staff: James Cruz, M.D., Acting Chief Medical Officer

RECOMMENDATION: Receive and file the report

10. Human Resources (H.R.) Report

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

RECOMMENDATION: Receive and file the report

CLOSED SESSION

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

12. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: One Case.
GCHP has received a letter from the IRS regarding an examination of GCHP withholdings. A copy of the letter is available upon request.

13. PUBLIC EMPLOYEE PERFORMANCE EVALUTION
Title: Acting Chief Executive Officer

14. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Commission &
Chief of Human Resources & Organization Performance Officer
Unrepresented employee: Acting Chief Executive Officer

15. PUBLIC EMPLOYEE APPOINTMENT
Title: Chief Executive Officer

ADJOURNMENT

The next meeting will be on held on October 28, 2024, at 2:00 p.m. Community Room located at 711 E. Daily Dr. #110 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 Clerk of the Commission.

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

AGENDA ITEM NO. 1

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Maddie Gutierrez, MMC, Clerk for the Commission

DATE: September 23, 2024

SUBJECT: Regular Meeting Minutes of August 26, 2024, and Special Meeting Minutes of August 28, 2024

RECOMMENDATION:

Approve the minutes.

ATTACHMENT:

Copy of Commission regular meeting minutes of August 26, 2024 and special meeting minutes of August 28, 2024

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

August 26, 2024

CALL TO ORDER

Committee Chair Laura Espinosa called the meeting to order at 6:00 pm The meeting was held in the Multi-Purpose Room at Glen City School located at 141 S. Steckel Road in Santa Paula, California, 93060

INTERPRETER ANNOUNCEMENT

The interpreter made her announcement.

ROLL CALL

Present: Commissioners Anwar Abbas, James Corwin, Laura Espinosa, Melissa Livingston, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, Sara Sanchez, and Scott Underwood D.O.

Absent: Commissioners Allison Blaze, M.D., Phil Buttell, and Tabin Cosio,

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

Also in attendance were the following GCHP Staff: Kriscilla Walker, Kim Timmerman, David Tovar, Mayra Hernandez, Michelle Espinosa, Lupe Gonzalez, James Cruz, M.D., Kris Schmidt, Kim Marquez-Johnson, Anna Sproule, Josephine Gallella. TJ Piwowarski, Rachel Lambert, Lucy Marrero, Victoria Warner, Susana Enriquez-Euyoque, Lupe Harrion, Deb Sulzbach, Jeff Register, Jan Schmitt, Luis Aguilar, Vicki Wrighster, Shannon Robledo, Stacy Luney, Jerry Wang, Alex Fernandez, Veronica Estrada, Adriana Sandoval, Pauline Preciado, Valerie Paz, Erin Slack, Thalia Ocampo, Holly Krull, Allison Jewel, Sergio Cendejas, Greg Antonino, Leeann Habte of BBK Law, consultants Don Harbart, and Amit Jain.

Guests: Nancy Wharfield M.D., Brent Baker, and Jeff Baltas.

Commission Chair, Laura Espinosa welcomed members of the public and thanked everyone for attending the meeting. She requested that all staff introduce themselves.

Commissioner Tabin Cosio arrived at 6:07 p.m.

PUBLIC COMMENT

- Dr. Sandra Aldana stated she is with the University Center of Excellence and developmental disabilities where she represents Ventura County at the Children's Hospital in Los Angeles. Dr. Aldana stated that she noticed that changes had been made to the commission by the Board of Supervisors, and she wanted to ensure that the Commission formally address the Medicaid access rule (Amendment Section 1915C) which will have an impact on individuals with intellectual disabilities and development disabilities in terms of consumer impact, reporting requirements, and the grievance process. The rule calls for changes to advisory committees by July 2025, payment rate transparency rate by July 2025. Dr. Aldana stated that she wanted to ensure that the commission would carefully look to ensure that there is understandable information put out to clients that are on that waiver.
- Carmen Hernandez stated that she represents the Santa Clara Valley Wellness Foundation. She noted that she lives in Fillmore. Ms. Hernandez collaborates with the communities in Santa Paula, Fillmore, and Piru. She asked how GCHP will help residents improve their healthcare. She also addressed the proposed closing of the OB and ICU at the Santa Paula hospital. She stated that residents in the community be represented and have access to healthcare in a safe and meaningful way.

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Regular Commission meeting minutes of June 24, 2024

Staff: Maddie Gutierrez, MMC Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

2. Approval of Amendments to the Ventura County Medi-Cal Managed Care Commission's Bylaws to bring the Bylaws into Conformance with the Governing Ordinance Adopted by the Ventura County Board of Supervisors.

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Staff recommends the Commission amend its bylaws to conform with recent changes made to the Governing Ordinance with respect to the composition of the Commission's Board of Directors.

Commissioner Monroy motioned to approve Consent items 1 and 2. Commissioner Corwin seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, James Corwin, Tabin Cosio, Laura Espinosa, Melissa Livingston, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, Sara Sanchez, and Scott Underwood D.O.

NOES: None.

ABSENT: Commissioners Allison Blaze, M.D., and Phill Buttell.

Motion carried.

PRESENTATIONS

3. GCHP Community-Level Membership Health Report

Staff: Eve Gelb, Chief Innovation Officer
Felix Nunez, M.D., Chief Medical Officer
Erik Cho, Chief Policy & Program Officer
Erin Slack, Senior Manager of Population Health
Lupe Gonzalez, PhD, Sr. Director of Health Education & Linguistics

RECOMMENDATION: Receive and file the presentation.

Commissioner Allison Blaze M.D. joined the meeting at 6:17 p.m.

Chief Innovation Officer, Eve Gelb stated that this presentation is a demonstration of how GCHP achieves its mission, how they do their job on ensuring the best healthcare possible, access to quality healthcare, and a superior member experience equitable for all members through a community approach to health.

CIO Gelb noted that our role is to promote quality. The state directs us to improve health, and we must contract with providers so that the members we serve get the care they need. Not only are we to provide access to care, but we must ensure that the care is high quality and that it focuses on prevention, education, early intervention, and care management. CIO Gelb reviewed GCHP's Model of Care. She noted that her report today focuses on the combination of Santa Paula, Fillmore and Piru communities; also known as the Santa Clara Valley. This area represents 11% of the total GCHP membership.

Chief Medical Officer, Felix L. Nunez, M.D., MPH reviewed how the state measures health and quality and what GCHP strives for in this community. CMO Nunez reviewed MCAS measures, and the performance scorecard. He noted that there are twenty-three measures that align with a population across the spectrum of ages and genders, and align with DHCS quality strategy and Ten-Year vision for Medi-Cal. The vision states that people served by Medi-Cal should have longer, healthier, and happier lives. These

measures help us to assess any disparities which exist, and by improving these quality measures we can affect our Model of care and improve the health of members and communities that we serve.

CMO Nunez noted that Gold Coast has a unique commitment to the Santa Clara Valley. He noted that this area has a greater reliance on Medi-Cal than in most communities. The Santa Clara valley relies on Medi-Cal and GCHP for their health outcomes Our Model of Care must be built for these communities.

Dr. Lupe Gonzalez, Sr. Director of health Education & Linguistics reviewed detailed data. She noted that collecting data from various sources enables us to prepare health outcome reports of our membership and helps identify the barriers to receiving quality care. She also shared demographic information about the Santa Clara Valley and how it compares to the general population. Dr. Gonzalez also highlighted quality improvement measures that are important to the Department of Health Care Services (DHCS). Data analytics is used to understand risk factors of the population we serve and help identify which diseases are most prevalent in the communities we serve. A second method used to understand members is the health risk assessment. The HRA is an individualized tool used to understand how members perceive their own health and allows us to ensure that members receive appropriate levels of care and resources needed.

Two things stood out when reviewing the Santa Clara Valley membership. One was that this area had a relatively young population when compared to the general population and second, the demographic insight should that 77% of the Santa Clara Valley membership is Latino. By collecting data on race and ethnicity, we can design programs and interventions that are culturally and linguistically appropriate for the members we serve. We have found that there is a slightly higher utilization of Emergency Room by these members. We have found through the Health Risk Assessment that approximately 53% of our members reported that they worry that they may run out of food. Fifty-two percent depend on seasonal/migrant farm worker income as their main source of income. We also found that there are barriers to seeking care, including transportation needs, childcare needs, school, and time off from work. Cultural linguistic challenges were also noted. Dr. Gonzalez noted that GCHP is working to understand why families are not going to medical appoints. We are collaborating with providers and members to design intervention programs that are culturally and linguistically appropriate for our members.

Erik Cho, Chief Policy & Programs Officer stated that GCHP's highest priority is to promote quality to improve the health of our members. He noted that we are contracted with a robust provider network, and we are constantly working to improve access, quality, access to primary care to specialty care and ancillary services. There are 319 contracted providers who provide services to our members. We are working to connect members with care and support them in their daily lives, as well as supporting them in activities that improve their health. We also support long-term care, and services such as physical therapy and speech therapy. CPPO Cho noted that Urgent care is not as plentiful in the

Santa Clara Valley area which may be a contributor to increased Emergency Department utilization.
CMO Nunez stated there is one hospital in the community; Santa Paula Hospital, which is a 49-bed acute care facility which offers emergency, medical, surgical, imaging, laboratory, and up until recently, obstetrics, and ICU care. The announcement of the closure of obstetrics and ICU services is going to be a burden to the community. Due to the closure, the intent is to support all members with high quality maternal health care.

In order to monitor progress on improving quality material and infant health, the federal government has identified a core set of maternal and perinatal health measures for Medicaid, and California has incorporated three of the metrics into our MCAS; those are prenatal care, postpartum care and well-baby visits focusing on prenatal and postpartum care. These three metrics are a testament to the collaboration and commitment of our GCHP team working with network partners, community partners and our members. We must strengthen our efforts to listen to the community and to our providers to address barriers that remain. Commissioner Espinosa noted that the obstetrics care management program is building capacity for additional community resources by the launch of new benefits such as doulas. We have developed a recent partnership between MICOP and Gold Coast Health Plan, which is focusing on promoting doulas in the Mixteco population. CMO Nunez stated birth outcomes has improved and we are taking advantage of the opportunity to roll out this new benefit with a focus on that population. The Promotoras program focuses on perinatal, prenatal care, birthing support and postpartum. This is an opportunity that the state has provided to our members, and it is unique for the County of Ventura in how the way all the community pulls together all the different entities, all the stakeholders are working to provide quality healthcare to our members with the Doula program. Commissioner Espinosa noted that there quite a few home births in the valley. CMO Nunez stated that we also need to make sure that we are designing our programs and initiatives around what the community wants and needs.
Commissioner Cosio noted that 22% of our members delivered at Santa Paula Hospital, compared to 27.9 at VCMC, and 37.7 at Community Memorial Hospital. He asked why members are choosing to go outside of Santa Paula. CIO Gelb noted that often where the doctor wants to deliver often drives the decision about where the patient will go. We need to do more research in terms of birthing services. Commissioner Cosio stated the question would be how many providers OB/Gyn are in the Santa Clara Valley, and if that is one of the factors that influences the location of delivery. CMO Nunez stated we need to do a deeper dive and understanding what is moving in this community regarding where choices are being made for delivery. We want to provider better coordination of care.

CPPO Cho stated that we are providing services that help address members social health related needs as well through Community Supports to help our member live healthier lives. We are going beyond the hospitals and the healthcare settings. Some of these include medically tailored meals, and to secure and maintain housing. We are working with CBOs in a partnership, as well as with the County. We also have ECM providers who collaborate with members to stay connected with their providers.

Erin Slack, Sr. Manager of Population Health will review some of the quality program investments and the impact they are making. Ms. Slack stated the goal of this presentation is to demonstrate the needs and assets available to our membership in the Santa Clara Valley. The initial phase of the quality program and funding GCHP directed funding and interventions to members and providers. The quality activities have been wide reaching, closing over 8100 quality care gaps in 2023 for our membership. We have had many interventions, but the focus will be on three of them. The first is Wellth, which is a behavioral intervention to improve the lives or our members with chronic conditions such as diabetes and hypertension. Wellth has helped connect these members with primary care and supports them in engaging in health behaviors. The Wellth program has empowered member to take control and action in terms of their health. In the Wellth program members receive rewards for engaging in healthy behaviors or accessing preventative care and closing care gaps. In the Santa Clara Valley there has been $107,000 in funding that has been reinvested into the community in the form or rewards that have been delivered to members. The second member intervention is our targeted outreach. GCHP has outreach campaigns that support members by educating them about preventative care and facilitating access to appointments. The campaign focuses on specific MCAS measures. Lastly, we have our incentive program. GCHP offers member incentives ranging from $25.00 to $50.00 to members who close care gaps that are related to our MCAS measures. Care gap closure incentives are also offered through Wellth. These incentives are offered at both the clinic site and through incentive forms mailed to their homes. The member completes the form after receiving care and then mails it back to GCHP to get their member incentive.

The provider focused quality funding has been instrumental in improving MCASA outcomes and improving integration among providers and between providers and GCHP. The success was seen in our significant improvements in MCAS scores in 2023 when compared to 2022. Ms. Slack noted that $1.2million in quality funding was paid out to providers who serve members in the Santa Clara Valley. This equals to over 10% of the quality incentive pool and program funding dollars. Thirty-three percent of all provider recruitment grants and 44% of our equipment grants. The grant funding increased provider capacity by bringing twenty-eight additional providers to the community and providing vital funding for equipment needed for Satna Clara residents in 2024. This funding will grow by 40% and more grants will be available within the community. GCHP is also adding value -based rates to improve access to care.

Commissioner Pupa stated that when looking at the measurements, our system is doing a good job. We do have some opportunities with the well child visits, those are always hard to meet. She noted that CMO Nunez has a plan to get the Doulas more engaged. She also noted that both pre- and post-natal are getting outstanding care.

CIO Gelb stated that upon looking at our data, it tells us that members are younger in the Santa Clara Valley, and it tells us that we have an opportunity to improve care for these younger members. We must continue to expand the activities that work, including Wellth. We must expand access to care through creative ways of using funding. We must bring care to the community. We must create capacity for new benefits leveraging existing community assets. We need to listen to the expertise that exists in the

community. Our members are the experts in their own lives and their own health. We need to work with the community to create health and well-being, we must partner with our members, families, and our communities.

Commissioner Abbas stated that we have a short-term solution like doulas, but also asked if there were long term strategies to fix gaps. CMO Nunez stated there are several approaches. We need to understand why members are making the decisions they are making, why they receive care in certain facilities and not others. We must also look at transportation services, to ensure that care is accessible to our members. Long-term we need to strategize and be informed by what we learn from the population and understand the needs of the population in terms of what services we can bring, creating more spaces for more opportunities for prenatal care, engagement, or other supports in the community.

Supervisor Lopez stated that what stood out to her was the emergency room visits. The number is high. She asked if members are not seeking care or visiting their primary care physicians. CMO Nunez stated that often the Emergency Room is convenient as far as availability and the timing of care.

Data can only take us so far and we will be doing focus groups in the community led by Marlen Torres, Executive Director of Strategy & External Affairs. Ms. Torres leads the "Voice of the Member" efforts. The focus groups, surveys, and interviews are important. We will also need to determine if the number of urgent cares (currently 7) are proportional to the needs of the members in this community. Our hope is to move more care into the primary care offices, recruitment grants will help support the needs. We will also offer incentives to drive greater access in hours and visits.

Carmen Hernandez, member of the public stated that she wanted more information on why this community is going to other hospitals. She stated there are not enough resources. If a member contacts a primary care office and tries to schedule an appointment, the office often does not have an opening until one to three months later, therefore that member is going to look outside of the area to get service quicker. This is one of the reasons that many members of the community go out of the immediate area. Another reason is the language barrier. Everyone is looking on how to get the best quality healthcare they can, so they go out of their immediate area.

Dr.Sandra Aldana, member of the public, stated there is a log of folk medicine beliefs within our communities, these beliefs should be addressed so that there is trust. We need to bring in more specialists into the county instead of sending members out of the area for special services. Commission Chair Espinosa stated that GCHP is working on incentives to attract special services and primary providers into the area.

Commissioner Pupa motioned to receive and file agenda item 3. Supervisor Lopez seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Tabin Cosio, Laura Espinosa, Melissa Livingston, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, Sara Sanchez, and Scott Underwood D.O.

NOES: None.

ABSENT: Commissioner Phill Buttell.

Motion carried.

4. Proposed Improvements to Consultant / Vendor Contract Reporting

Staff: Sara Dersch, Chief Financial Officer
Eve Gelb, Chief Innovation Officer
Scott Campbell, General Counsel

RECOMMENDATION: Receive and file the presentation.

General Counsel, Scott Campbell, stated this item will be presented in October to the Executive Finance Committee and the Commission. He stated that at the June Commission meeting the Commission stated that there should be more vigorous and more transparent reporting.

Mr. Campbell reviewed the three types of contracts:

- Contracts under $100,000 – those contracts are for Staples and supplies etc. Those are not presented to the Commission.
- Contracts over $100,000 which are presented to the Commission and are voted on. For example: there were eight contracts presented to the Commission with respect to Operations of the Future. Legal contracts are also in this group.
- The third type of contracts are the contracts that come up that the Commission approve in the budget. Those consist of contracts affiliated with projects. There are also renewals of contracts.

The budge requires that the Commission see the contracts that are affiliated with projects and contracts that are being renewed.

Staff will be working with the Executive Finance Committee and will bring back their recommendations in October.

Supervisor Lopez motioned to receive and file agenda item 4. Commissioner Sanchez seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Tabin Cosio, Laura Espinosa, Melissa Livingston, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, Sara Sanchez, and Scott Underwood D.O.

NOES: None.

ABSENT: Commissioner Phill Buttell.

Motion carried.

UPDATES

5. Operations Of the Future (OOTF) Update

Staff: Nick Liguori, Chief Executive Officer

RECOMMENDATION: Receive and file the update.

CEO Liguori thanked the Commission for the support over the past two years for a complete rebuilding of our operating platform. We went live on July 1st with eight new systems and services, a large and complex assemblage of new vendor partners, new electronic data interchange circuitry and modern data warehouse. He stated that our members and our providers, our staff and our vendors depend on the components of our system working around the clock producing accurate complete and timely services. He noted that the report today is to inform the Commission how the systems are operating today, eight weeks after going live. CEO Liguori noted that there have been some operational performance issues, and a metrics type dashboard will be presented going forward.

Anna Sproule, Executive Director of Operations gave a brief overview of our current state. She noted that we have quickly identified system and configuration issues and have begun making progress to address all delays that are being experienced. DHCS received a concern about our timeliness in paying our claims for Skilled Nursing Facilities (SNF) and long-term-care. We have worked with Netmark (our partner) and were able to find the cause for payment delays and adjudicate 100% of the clean claims over the past several weeks for these providers that were nearing or over 30 days of age. This remediation resolved in 9,000 claims in that time with approximately 2,500 of those claims that have interest that is due. Two hundred fifty-four providers will be receiving payments in this week. In summary, we are making strides that are necessary to ensure timely payments, processing claims, and addressing any issues that may arise or are identified.

Commissioner Blaze asked what the root cause for this issue was. Ms. Sproule stated in system conversion as with any system implementation there are challenges that are experienced.

Ms. Sproule stated that SNF claims are disproportionately for dual eligible members, which is a predominant issue. This requires coordination of benefits between Medi-Cal and Medicare, and there is complexity of processing for these claims. These claims are processed in a highly specialized manner. With these type of claims issues do come up. The claims are extremely challenging to process, and they provide a specialized set of service. At times, the service is contracted, and other times there is a letter of agreement. Instead of one service at a time we usually get a moth of services that could be multifaceted services, which adds to the complexity. It is difficult to determine how quickly we will be able to pay it. Often there is secondary information needed by a provider.

Commissioner Abbas asked if the claims examiners are in the US or are they somewhere outside of the US for claims that are not adjudicated automatically. He also asked if they are outside of the US what type of security measures have been taken. Ms. Sproule referred to Mr. Alan Torres, Chief Information & System Modernization Officer, who in turn referred to Paul Aguilar, Chief of Human Resources & Organization Performance Officer to speak about the process for the vetting of the offshore staff. Mr. Aguilar stated that we have a number of regulatory requirements that we must keep. One is the exclusion list that we manage, and we make sure working with our partner, Netmark, that they attest to the information they collect locally from their staff in India. Background checks in India are done regarding criminal background checks. It is a standard process that Netmark manages. As part of our CIA agreement, we attest that we ensure the safety of these individuals are upheld from a security standpoint.

Jeff Baltas, Chief Revenue Officer, and Chief Administrator for Netmark stated that Netmark is high trust certified, which is the top certification of the data integrity security systems. He stated that Netmark also has server farms in West Chester Ohio, so data never leaves the United States from that standpoint. He noted that there are all sorts of measures that are in place to maintain high trust security.

Commissioner Pupa stated the commission requested some additional industry standard dashboard that might not be ready yet, but she looks forward to seeing typical dashboards that go along with the implementation with regard to the claims dollars pay dates, any potential interest, and dashboard items that go along with claims processing and system conversion.

Ms. Sproule stated she would like to review the member call center. She stated that she partnered with Ms. Marlen Torres to implement the member services call center. The center started receiving inbound calls on July 1 and in July the managed over 6,500 calls. Ms. Torres and her team are going to be partnering throughout the organization to ensure that not only are the audits taking place by the member call center or member

services teams, but also by others within the organization to evaluate our ability to provide strong member service.

Commissioner Pupa noted a job well done.

CEO Liguori noted that the staff on site are all from Ventura County and nearly 100% bilingual and their fluency has been tested. He also wanted to review authorizations. He stated authorizations and authorizing care is a critical function of the health plan. He noted that our performance during a challenging Go-Live period remains above our standards. GHP wants to provide care when needed to support our providers and our performance continues to be strong and stable.

Commissioner Monroy motioned to receive and file agenda item 5. Commissioner Abbas seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Tabin Cosio, Laura Espinosa, Melissa Livingston, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, Sara Sanchez, and Scott Underwood D.O.

NOES: None.

ABSENT: Commissioner Phill Buttell.

Motion carried.

FORMAL ACTION

6. Student Behavioral Health Incentive Program (SBHIP) & Scholarship Proposal

Staff: Lucy E. Marrero, Director, Behavioral Health
Erik Cho, Chief Policy & Programs Officer
Eve Gelb, Chief Innovation Officer

RECOMMENDATION: Receive and file the presentation and approve the program.

Lucy Marrero, Director of Behavioral Health will review the SBHIP Program, and the impact made so far. Ms. Marrero stated that currently we are entering into the last phase of our implementation years. In 2022 we had a needs assessment that was done countywide and partnered with the County Office of Education as well as MICOP to hear the voice of our students and families, administrators, teachers, and staff. As a result, a project plan was created that focused on four key areas. Two are the interventions that Fillmore and Santa Paula Unified School District chose. These two school districts invested money we had funded into Wellness centers. They were the first elementary

school Wellness centers in the county. Blanchard and Babara Webster Schools for Santa Paula and Piru and Mountain View Elementaries for Fillmore. They have peer mentors who are students who welcome a give a tour of the centers. There centers are now entering into a period of sustainability. Thie year we are looking at what is needed to support our school districts in sustaining the infrastructure that they have build in the wellness centers. We are also partnering with the Wellness Collaborative that HAS leads and many of our partners participate in. We are focused on how we can support them financially so moving from the Medi-Cal funding through GCHP to partnering directly as contractors through the school district.

Ms. Marrero stated that out of the seven Wellness centers that were funded by GCHP, four of those centers are in the Santa Clara Valley. We have had over 8,000 visits and over 1,000 students have been served. Students have signed up for expanding the behavioral health workforce as an intervention. This has created an opportunity for students to learn about behavioral health careers, focusing on the Wellness peers and might be interested in becoming a behavioral health professional.

The scholarship program is part of the SBHIP program, we can take funds and use them as needed according to the needs of the community. The goal with the scholarship program is to promote behavioral health equity in Ventura County by increasing the number and diversity of behavioral health providers in our county. We are investing $1.5 million into scholarships for students who will provide direct behavioral health services after graduation. We are partnering with MICOP as well as the Ventura County Community Foundation and half of the money will be going to MICOP to administer and half to VCCF to administer. All the scholarship and the fees are covered by those incentive funds that are earmarked for student behavioral health.

CPPO Erik Cho stated that he wanted to provide maximum clarity that is funding provided through the state and we are proud that these are not operating funds or reserves. We are proud and thankful for our role to connect this funding which is available for behavioral health now and for years to come.

Ms. Marrero stated eligible students are residents of Ventura County and the pathway could be at any level, so they could be a community health worker certificate program, peer support specialist, substance abuse counselor, nurse practitioner, etc. The funds can be used by the recipients for anything needed. We are removing educational barriers, so if that is transportation, childcare, whatever the student needs. On the MICOP side it is a five-year program. We will start with the Spring of 2025 with a half year cycle and have four full years and then another half year cycle at the end of the period for VCCF Scholarship. It is an endowment, what that means is we can continue to offer those scholarships in perpetuity and the exact number of the awards will de dependent on those top applicants.

Kristy Thompson, director of the scholarship program with VCCF thanked the Commission for their support. She noted that this a groundbreaking project for this county.

Ms. Marrero thanked the Commission for their consideration, and the GCHP team for their support. She also thanks Dr. Nancy Wharfield, former Chief Medical Officer at GCHP for her support and guidance. Ms. Marrero then reviewed the eligibility requirements for recipient funding.

Commissioner Sanchez asked about the residency requirements; for example, students who attend Cal State Channel Islands from out of the area. Ms. Marrero stated the student must have a Ventura County address. Commissioner Espinosa asked if MICOP students are the only eligible for this scholarship. Ms. Marrero stated no it is not limited to MICOP students.

Ms. Marrero stated that she will be working with a marketing consultant to be able to communicate information on the scholarship. Commissioner Abbas asked if the scholarship is multi-year or just one time. Ms. Marrero stated it would be an application for every year. Commissioner Cosio stated this was a great program.

Commissioner Abbas motioned to receive and file agenda item 6. Commissioner Livingston seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Tabin Cosio, Laura Espinosa, Melissa Livingston, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, Sara Sanchez, and Scott Underwood D.O.

NOES: None.

ABSENT: Commissioner Phill Buttell.

Motion carried.

7. Financial Briefing May YTD and Preliminary 2023-24 Fiscal Year-End Results

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests the Commission approve the May 2024 financial results and preliminary fiscal year-end results.

REPORTS

8. Chief Executive Officer (CEO) Report

Staff: Nick Liguori, Chief Executive Officer

RECOMMENDATION: Receive and file the report

In the interest of time, General Counsel, Scott Campbell requested that both Agenda items 7 and 8 will be noted as receive and file.

Commissioner Abbas motioned to receive and file agenda items 7 and 8. Commissioner Monroy seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Tabin Cosio, Laura Espinosa, Melissa Livingston, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, Sara Sanchez, and Scott Underwood D.O.

NOES: None.

ABSENT: Commissioner Phill Buttell.

Motion carried.

General Counsel Scott Campbell stated Closed Session agenda item 9 will be tabled. Discussion will be only on Agenda items 10 and 11.

The commission went into Closed Session at 8:15 p.m.

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.

10. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

11. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Commission &
Chief of Human Resources & Organization Performance Officer
Unrepresented employee: Chief Executive Officer

General Counsel, Scott Campbell stated there was no reportable action.

ADJOURNMENT

With no other business to conduct, the meeting was adjourned at 9:21 p.m.

Approved:

_____
Maddie Gutierrez, MMC
Clerk to the Commission

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
Commission Meeting
Special Meeting via Teleconference

August 28, 2024

CALL TO ORDER

Committee Chair Laura Espinosa called the meeting to order at 5:34 pm. Via remote Teams meeting. The Clerk was in the Community Room located at Gold Coast Health Plan, 711 East Daily Drive, Suite 110, Camarillo, California.

INTERPRETER ANNOUNCEMENT

The interpreter made her announcement.

ROLL CALL

Present: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Tabin Cosio, Laura Espinosa, Melissa Livingston, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, Sara Sanchez, and Scott Underwood D.O.

Absent: Commissioner Phil Buttell

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

Also in attendance were the following GCHP Staff: Kim Timmerman, Nicole Kanter, David Tovar, Mayra Hernandez, Michelle Espinosa, Lupe Gonzalez, Yoonhee Kim, Joanna Hioureas, James Cruz, M.D., Kris Schmidt, Kim Marquez-Johnson, Anna Sproule, Josephine Gallella. TJ Piwowarski, Rachel Lambert, Lucy Marrero, Victoria Warner, Bianca Naron, Susana Enriquez-Euyoque, Paula Cabral, Lupe Harrion, Deb Sulzbach, Sandi Walker, Jeff Register, Tonya Diggs, Lorraine Carrillo, Celley Griffith, Alex Fernandez, Jeff Yarges, Sergio Cendejas, Rachel Ponce, Shannon Robledo, consultant, and Amit Jain.

PUBLIC COMMENT

None.

REPORT

1. Report of Closed Session Action on August 26, 2024

Staff: Scott Campbell, General Counsel

General Counsel, Scott Campbell stated this is a report, pursuant to government code 54957.1a5, otherwise known as the Brown Act. The reportable action is that on August 26, 2024, regular evening commission meeting during the Closed Session the commission unanimously voted not to extend the contract of the current Chief Executive Officer (CEO). This concluded the report of action on August 26, 2024.

The Commission moved into Closed Session at 5:19 p.m.

CLOSED SESSION

2. PUBLIC EMPLOYEE APPOINTMENT

Title: Acting Chief Executive Officer

The Commission returned to Open Session at 6:16 p.m.

General Counsel Scott Campbel stated there was reportable action from Closed Session. Mr. Campbell stated the Commission unanimously appointed Dr. Felix Nunez, M.D. as acting Chief Executive Officer.

FORMAL ACTION

3. Adoption of Resolution(s) and Approval of Documents on Signing Authority

Staff: Scott Campbell, General Counsel
Sara Dersch, Chief Financial Officer

General Counsel Scott Campbell stated there is one resolution. The title is broader in order to ensure that all necessary documents are covered. Resolution 2024-003 is for the Commission to approve Felix Nunez, M.D. to sign documents that the CEO usually signs. This resolution will give Felix Nunez, M.D. signature authority.

Commissioner Abbas motioned to approve resolution 2024-003 giving Felix Nunez, M.D., acting Chief Executive Officer signature authority. Commissioner Pupa seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Tabin Cosio, Laura Espinosa, Melissa Livingston, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, Sara Sanchez, and Scott Underwood D.O.

NOES: None.

ABSENT: Commissioner Phill Buttell.

Motion carried.

ADJOURNMENT

With no other business to conduct, the meeting was adjourned at 6:20 p.m.

Approved:

_____
Maddie Gutierrez, MMC
Clerk to the Commission

AGENDA ITEM 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Sara Dersch, Chief Financial Officer

DATE: September 23, 2024

SUBJECT: Tangible Net Equity and Working Capital Reserve Funds Policy Revision

SUMMARY

This policy revision increases the amount of Tangible Net Equity (TNE) the Plan must retain in order to ensure future obligations to meet financial liabilities. There is no change to Capital Reserve Funds.

BACKGROUND / DISCUSSION

Current policy mandates that the Plan maintain a TNE amount equal to 500% of the required TNE (a formula-driven amount based on current trends in claims payments and capitation rates). Management is recommending increasing the minimum-required TNE to 700% of the required amount due to State actions over the last couple of years which have resulted in significant and material fiscal impacts to the Plan. Maintaining 700% of TNE will ensure the Plan will carry sufficient reserves such any unexpected State rate action can be met by the Plan without having any impact to Members or Providers.

FISCAL IMPACT

None. The Plan currently maintains a TNE that on average is between 900% and 100% of required TNE. Any excess of TNE between 700% and actual TNE will be used to fund Commission-approved Quality Improvement and Strategic Planning as well as fund the establishment of the Medicare Dual-Special Needs Plan effective January 1, 2026.

RECOMMENDATION

Staff recommends the Commission adopt (accept and file) the increase in targeted TNE to 700% of required TNE.

ATTACHMENTS

Policy document FI-004 “Tangible Net Equity and Working Capital Reserve Funds”

Gold Coast Health Plan
A Public Entity

Title: Tangible Net Equity and Working Capital Reserve Funds	**Policy Number:** FI-004
Department: Accounting and, Financial Planning and Analysis **CEO Approved:**	**Effective Date:** 01/07/2016 **Revised:**

1. **Policy:**

Gold Coast Health Plan's ("GCHP" or "Plan") policy is to establish, maintain, and utilize Tangible Net Equity ("TNE") and Working Capital Reserve funds for the benefit of GCHP's long-term financial solvency.

a. It is the Plan's policy to comply with all provisions of its contract with the California Department of Health Care Services ("DHCS") as a County Organized Health System ("COHS"), including maintenance of statutorily required levels of TNE as defined in Title 28, California Code of Regulations §1300.76 ("28 CCR Section 1300.76"). The required regulatory TNE amount is a stated legal "capitalization" amount and is not reflective of the amount of actual working capital required by the Plan to ensure continuance of operations and/or long-term financial sustainability.

b. It is the Plan's policy to comply with the Knox-Keene Act and maintain all legally required requirements related to reservations of TNE as outlined in Title 28, California Code of Regulations §1300.84.3 ("28 CCR Section 1300.84.3") and any guidelines established by the Department of Managed Health Care ("DMHC").

c. In addition to setting aside funds to meet TNE requirements, GCHP shall establish, and maintain appropriate levels of working capital reserves (more commonly referred to as "liquid reserve funds") to ensure that current and future financial obligations of the Plan are met.

2. **Required Tangible Net Equity**

28 CCR Section 1300.76 requires the TNE amount to be calculated based on either revenue or medical cost. Because of its current business structure, GCHP calculates its required TNE amount based on medical cost.

a. Except for that provided for COHS or as detailed in subsection 2c of this Policy, 28 CCR Section 1300.76(a) states that the required TNE be at least equal to the greater of:

1) $1 million; or

2) The sum of two percent (2%) of the first $150 million of annualized premium revenues plus one percent (1%) of annualized premium revenues in excess of $150 million; or

3) An amount equal to the sum of:

a) Eight percent (8%) of the first $150 million of annualized health care expenditures except those paid on a capitated basis or managed hospital payment basis; plus

b) Four percent (4%) of the annualized health care expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of $150 million; plus

c) Four percent (4%) of annualized hospital expenditures paid on a managed hospital payment basis.

b. Pursuant to 28 CCR Section 1300.76(b), each plan licensed pursuant to the provisions of the Knox-Keene Act and which offers only specialized health care service contracts shall, at all times, have and maintain a tangible net equity at least equal to the greater of:

1) $50,000; or

2) the sum of two percent (2%) of the first $7,500,000 of annualized premium revenues plus one percent (1%) of annualized premium revenues in excess of $7,500,000; or

3) an amount equal to the sum of:

a) eight percent (8%) of the first $7,500,000 of annualized health care expenditures, except those paid on a capitated or managed hospital payment basis; plus

b) four percent (4%) of the annualized health care expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of $7,500,000; plus

4) four percent (4%) of annualized hospital expenditures paid on a managed hospital payment basis.

c. 28 CCR Section 1300.84.3 defines certain specific situations that require reservations of TNE.

3. <u>Actual Tangible Net Equity</u>

For the purpose of this section *"net equity"* means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the DHCS or DMHC. *TNE* means *net equity* reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates and which are not more than sixty (60) days past due; long term prepayments of deferred charges, and nonreturnable deposits. An obligation is fully secured for the purposes of this subsection if it is secured by tangible collateral, other than by securities of the Plan or an affiliate, with equity with an equity of at least one hundred and ten percent (110%) of the amount owing (reference 28 CCR Section 1300.76 (c).

a. To ensure financial longevity, it is the Plan's goal to maintain a minimum TNE amount of 700% of the required TNE amount.

4. Accounting For Tangible Net Equity

a. Tangible Net Equity is reported in account 900-3000 in the general ledger. Increases to TNE result from net income for the fiscal period. Decreases to TNE result from net loss for the fiscal period.

b. TNE is comprised of three components:

1) *Net invested in capital assets.* This amount is the aggregate net book value ("NBV") of the Plan's capital assets. NBV is the original cost of an asset, less any accumulated depreciation, accumulated depletion, or accumulated amortization, and less any accumulated impairment. The Plan's Capital Assets Policy should be referenced for additional information on asset cost, depreciation, depletion, amortization and impairment.

2) *Restricted - Required Tangible Net Equity.* 28 CCR Section 1300.76 states that this is the statutorily required TNE amount for the Plan. Reference to above Section 2 of this policy for discussion on the methodology used to compute the required TNE amount.

3) *Unrestricted net position.* The unrestricted net position amount is total TNE (reference to above Section 3) less *net invested in capital assets* (from paragraph 4.b.1) above) and less *restricted - required tangible net equity* (from paragraph 4.b.2) above).

c. *Net invested in capital assets* and *restricted-required tangible net equity* are considered statutory required reserve funds of the Plan's TNE.

5. Financial Reporting of TNE

a. The Controller is responsible for ensuring the propriety of the Plan's TNE and required TNE amounts.

b. The CFO or designee shall update the Commission on the Plan's TNE and required TNE amounts. The TNE amount, including any accumulated reserve for allocation, shall be shown on GCHP's balance sheet.

6. Working Capital or Liquid Reserve Funds

The Plan shall establish and maintain liquid reserve funds to ensure that it is able to meet its current and future financial obligations. Liquid reserve funds are accounts or securities that can be easily converted to cash at little or no loss of value. Examples of liquid reserve funds include: cash, money in bank accounts, money markets mutual funds, U.S. treasury bills, etc.

a. It shall be the goal of the Plan to maintain liquid reserve funds whose amount is no less than the greater of the combined budgeted medical and administrative expenses for the

ensuing three months period; or, the combined actual medical and administrative expenses for the most recent three months period.

b. The Plan shall also maintain liquid reserve funds to ensure that financial obligations arising from unfinished or in-process Commission approved capital projects carried-over from prior fiscal years, Commission approved capital projects for the current fiscal year and other long term liabilities whose payments are projected for the current operating cycle are met.

c. If Capitation Revenue from the State is Delayed:

1) In the event of a delay in the Plan's receipt of capitation revenue from the State and the Plan's unrestricted cash falls to a level requiring the use of liquid reserve funds for continuous payments to health care providers and vendors for medical and administrative expenses incurred in the operations of the Plan, management is authorized to use liquid reserve funds for two months or until the liquid reserve funds amount reaches a level equaled to one-month's projected working capital requirement.

a) Examples of medical and administrative expenses eligible for payment by liquid reserve funds include wages payable and other payroll related expenses, liabilities owed to health care providers and vendors, MCO tax liability, and other expenses incurred in the operations of the Plan

2) When the level of liquid reserve funds falls to one-month's projected working capital requirement, management may cease payments to health care providers and vendors until such time as the State restores capitation revenue to the Plan.

3) Once capitation from the State is resumed, restoration of liquid reserve funds to its appropriate amount shall be a priority.

d. Management may create additional reserve funds as necessary to ensure the long-term wellness of the Plan.

Attachments:
None

References:

Title 28, California Code of Regulations, Sections 1300.76 and 1300.84.3.

Gold Coast Health Plan
A Public Entity

Title: Tangible Net Equity and Working Capital Reserve Funds	**Policy Number:** FI-004
Department: Accounting and, Financial Planning and Analysis	**Effective Date:** 01/07/2016
CEO Approved:	**Revised:**

Revision History:

Review Date	Revised Date	Approved By
01/07/2016		Ventura County Medi-Cal Managed Care Commission
02/26/2016		Dale Villani (CEO)

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Anna Sproule, Executive Director of Operations

DATE: September 23, 2024

SUBJECT: Operations Dashboard Update

PowerPoint with Verbal Presentation

ATTACHMENTS:

Operations Dashboard

Gold Coast Health Plan℠
A Public Entity

Integrity

Accountability

Collaboration

Trust

Respect

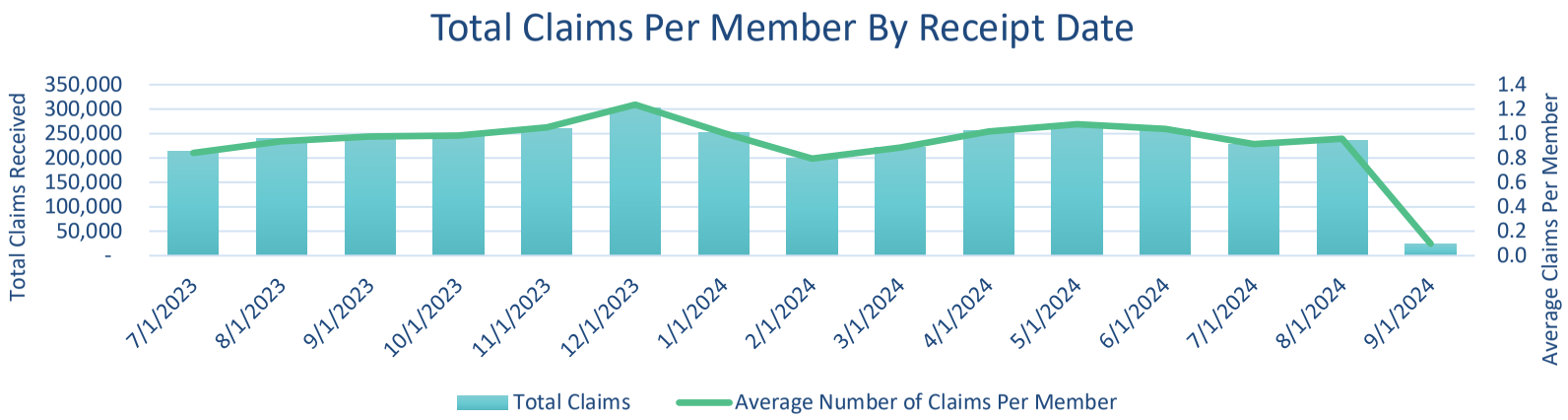
Operations Dashboard
September Commission Meeting

Alan Torres, Chief Information and System Modernization Officer
Anna Sproule, Executive Director, Operations

Claims Volume

- Total claims volume and average claims per member remained fairly constant post-conversion when compared with pre-conversion.

Receipt Month	Jul-23	Aug-24	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Total Members	254,988	255,302	251,446	249,168	247,031	244,727	251,846	251,356	251,319	250,981	250,466	249,318	247,938	246,685
Total Claims	214,565	239,133	245,005	245,278	259,565	302,592	252,660	199,990	222,512	255,366	269,769	258,398	226,754	236,388
Avg Claims Per Member	0.8	0.9	1.0	1.0	1.1	1.2	1.0	0.8	0.9	1.0	1.1	1.0	0.9	1.0



*Pre-Conversion are Claims Received 7/1/2023-6/30/2024 and Post-Conversion are Claims Received 7/1/2024 to Present

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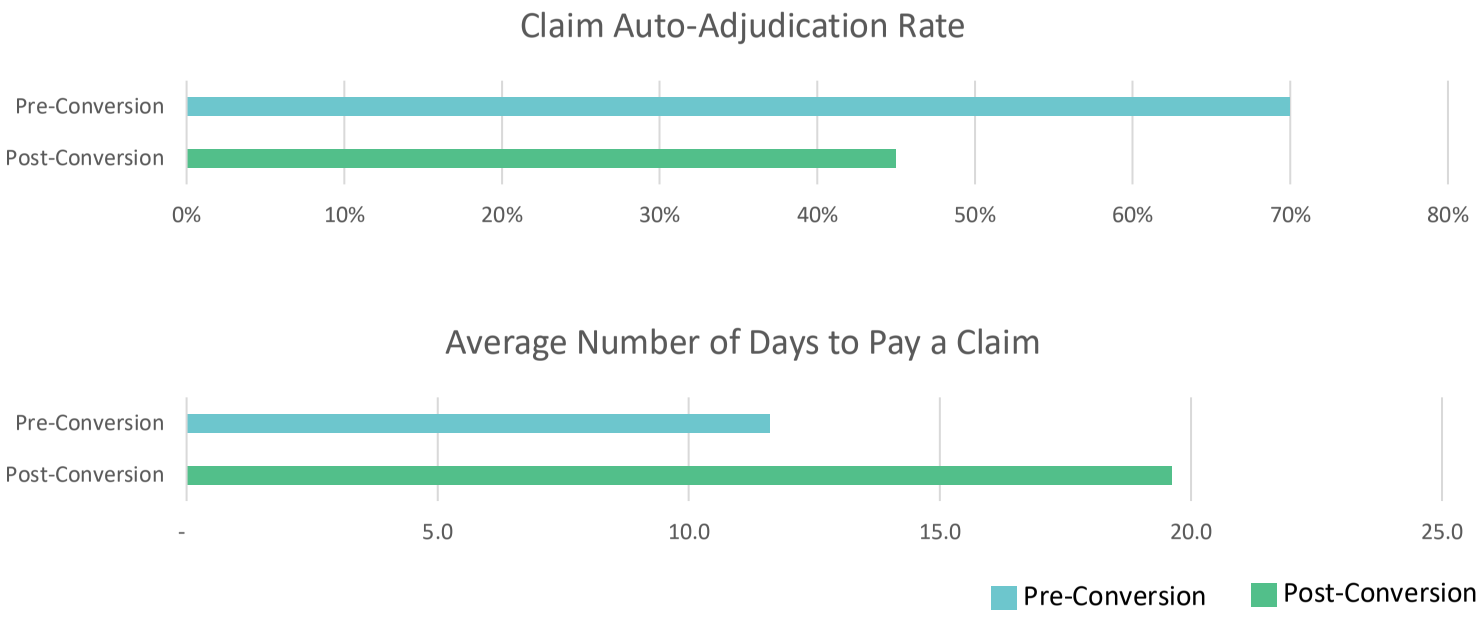
Auto Adjudication and Claims Payments

Claims Auto-Adjudication Rate declined from about **70%** Pre-Conversion to **45%** Post-Conversion.

Average days to pay a claim increased from **11.6** to **19.6** after conversion.



*Pre-Conversion are Claims Received 7/1/2023-6/30/2024 and Post-Conversion are Claims Received 7/1/2024 to Present

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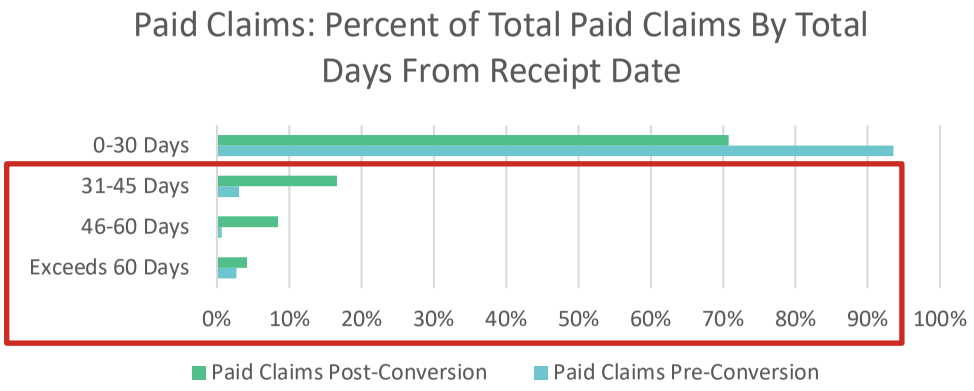
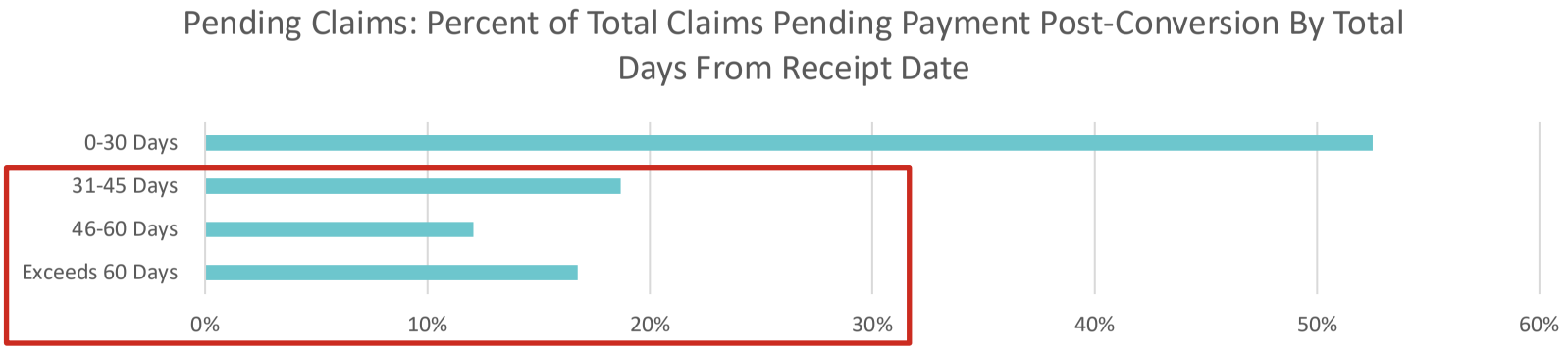
Claims Turnaround Time

A total of 151,999 claims are pending payment:

- 28,404 are 31-45 days from receipt. These claims are out of compliance, but do not have and interest penalty
- 43,802 are more than 45 days from the receipt date. There is an interest penalty for these claims.





*Pre-Conversion are Claims Received 7/1/2023-6/30/2024 and Post-Conversion are Claims Received 7/1/2024 to Present

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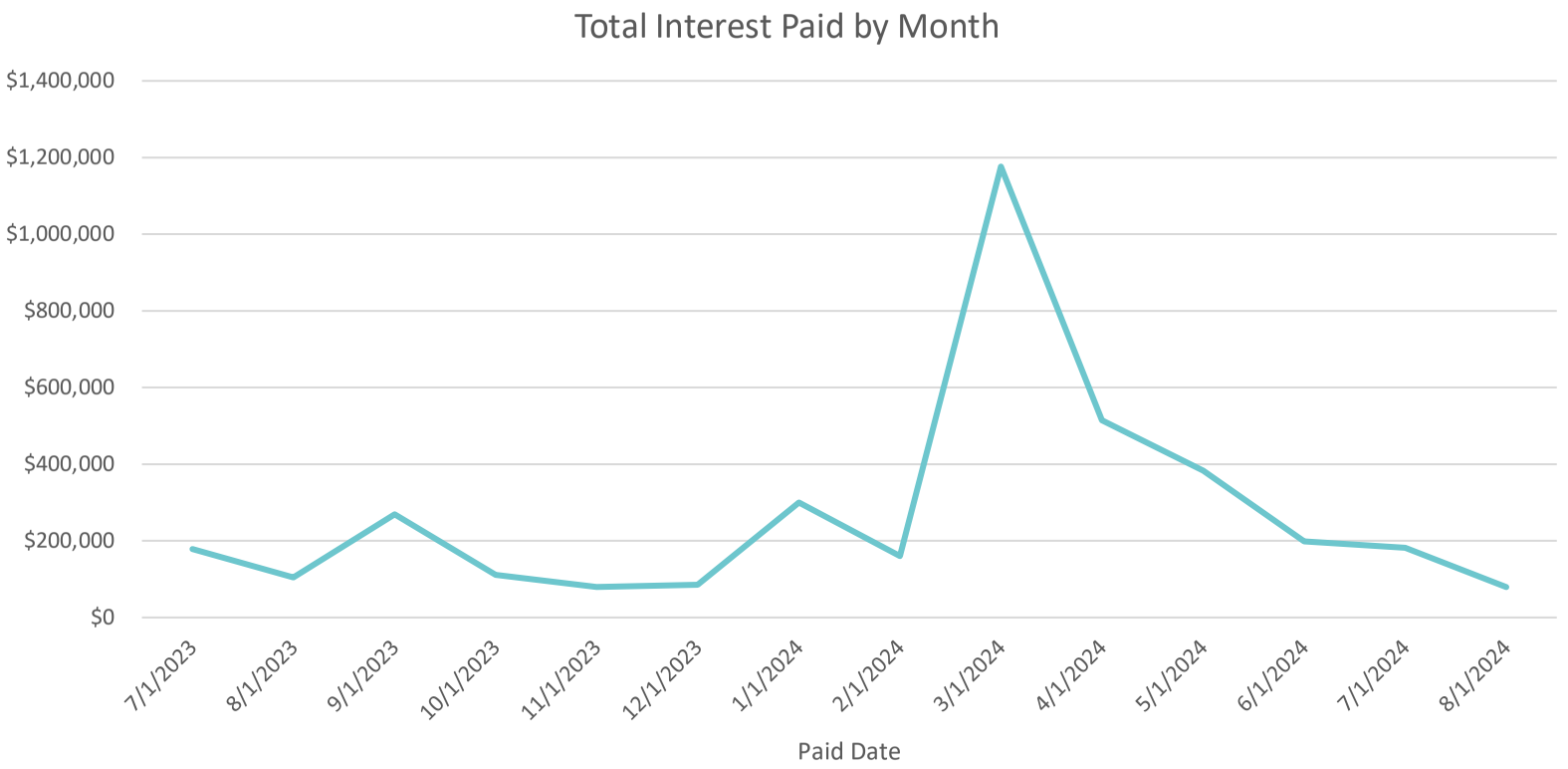
Total Interest Payable by Month



*Pre-Conversion are Claims Received 7/1/2023-6/30/2024 and Post-Conversion are Claims Received 7/1/2024 to Present

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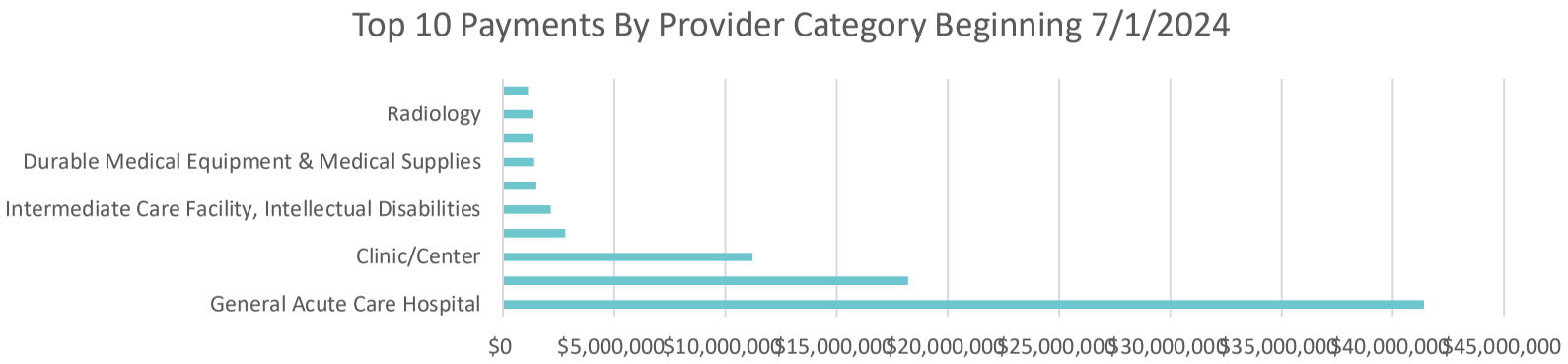
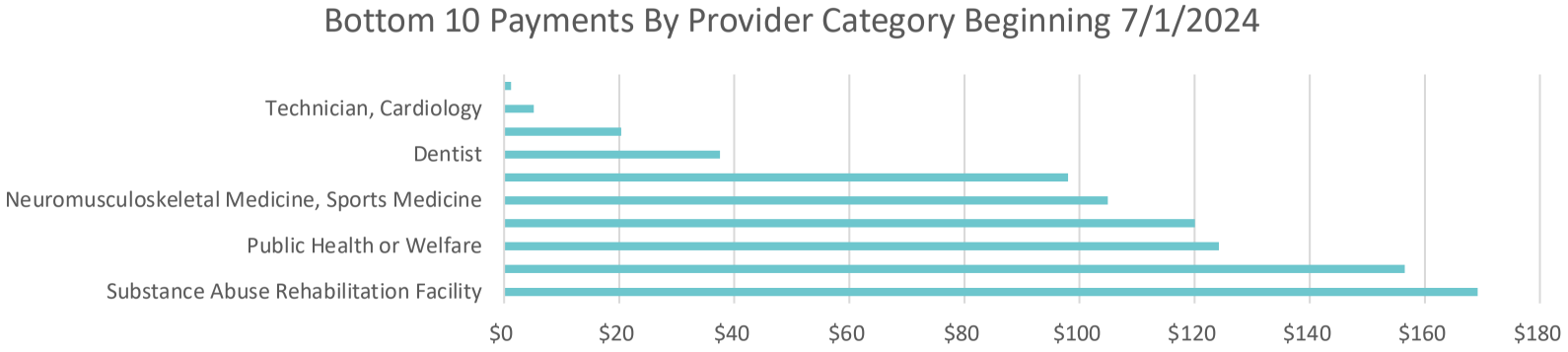
Claims Payments by Provider Category





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Go to Dashboard

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AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Anna Sproule, Executive Director of Operations
Alan Torres, Chief Information & System Modernization Officer

DATE: September 23, 2024

SUBJECT: Operations of the Future (OOTF) Update

PowerPoint with Verbal Presentation

ATTACHMENTS:

Operations Stabilization Strategy

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

Operations Stabilization Strategy

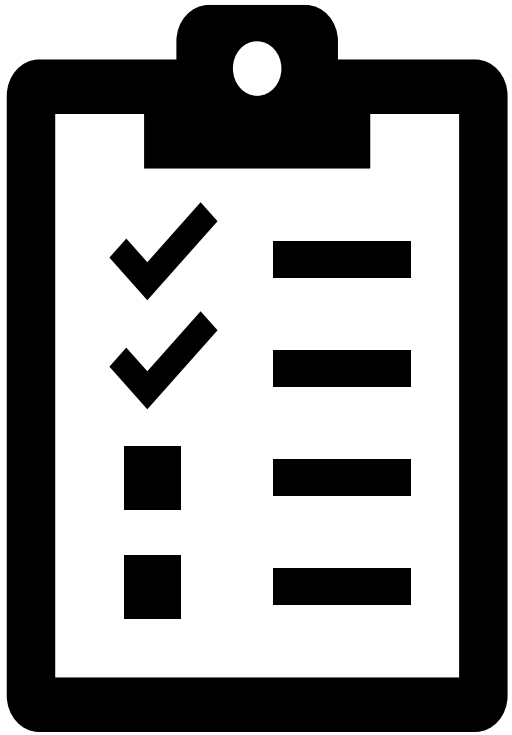
September Commission Meeting

Alan Torres, Chief Information and System Modernization Officer
Anna Sproule, Executive Director, Operations

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

Claims Inventory Update

- Aged inventory has reduced by 27% since last update to commission on 8/26/2024.
- Plan includes projected claims inventory stabilization by 10/31/2024.



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Highlights

Provider

The GCHP team has identified system errors which require enhancements to process claims. The enhancements will happen by November 1.

Electronic Data Interchange (EDI)

Plan includes complete remediation of Electronic Remittance Advice (835) by November 29.

Membership

Enrollment and eligibility will be reconciled by September 30.

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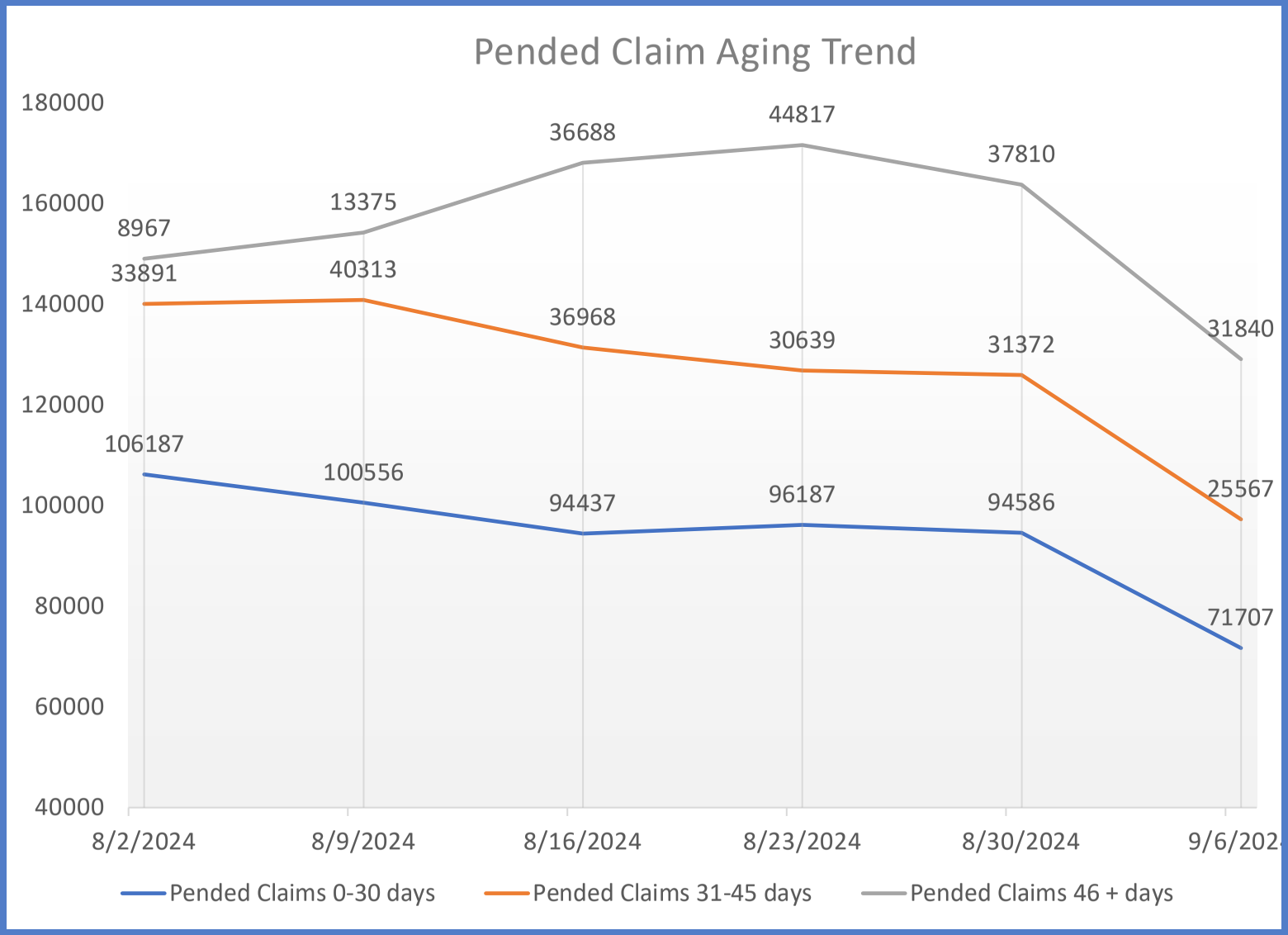
Inventory Trending



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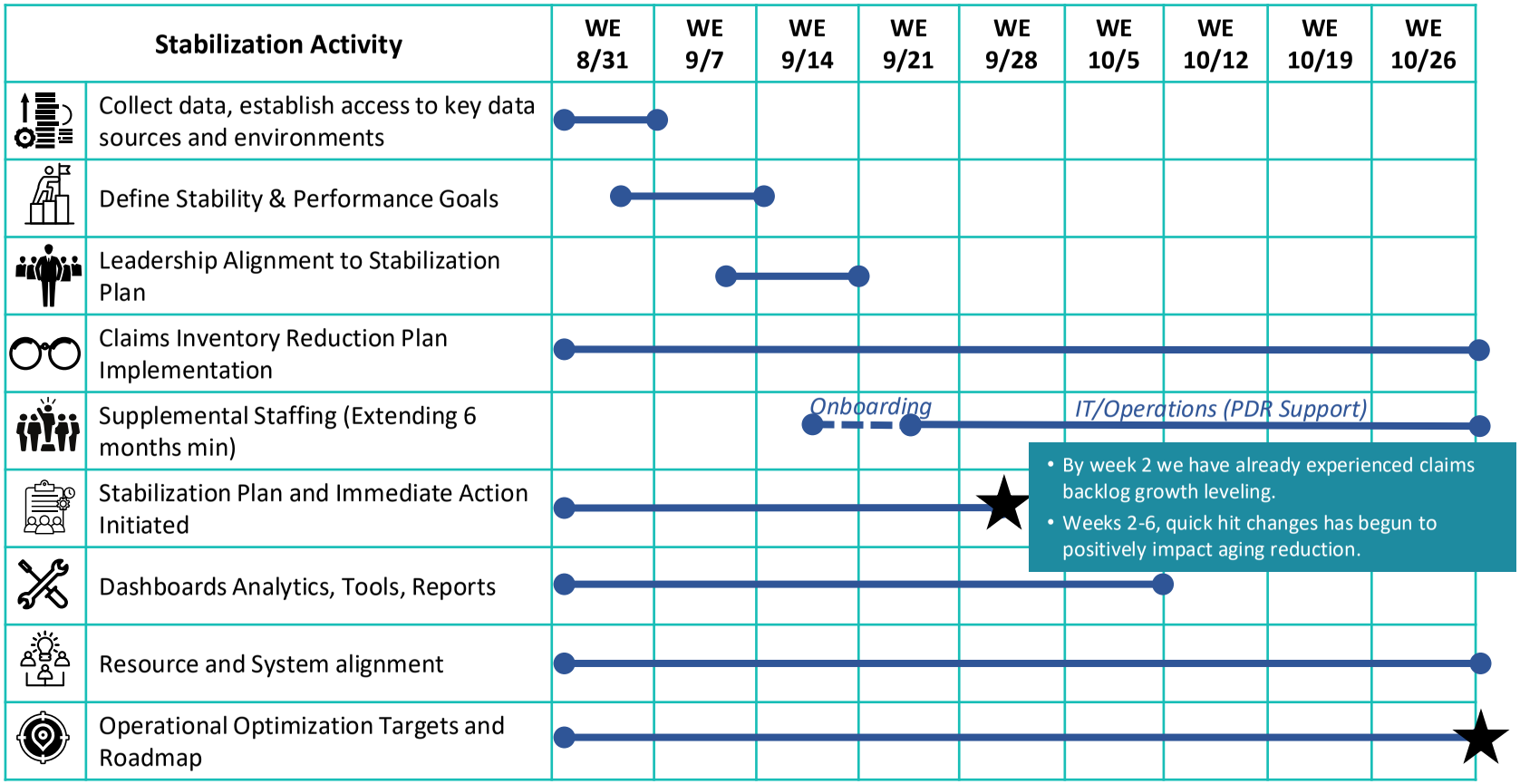
Claims Stabilization Roadmap



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Prepayments

- To reduce the impact of delayed claims payments to the Provider Community, payments will be advanced for potential delayed claims in inventory.

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AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kimberly Marquez-Johnson, Director of Dual Special Needs Plan
Eve Gelb, Chief Innovation Officer
James Cruz, MD, Senior Medical Director
Michelle Espinoza, Executive Director Delivery Systems Operations

DATE: September 23, 2024

SUBJECT: D-SNP (Dual Special Needs Plan) Update

PowerPoint with Verbal Presentation

ATTACHMENTS:

D-SNP Update

Gold Coast Health Plan℠
A Public Entity

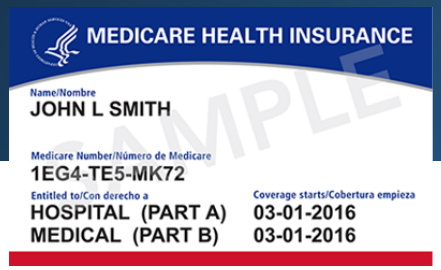
Gold Coast Health Plan Dual Eligible Special Needs Plan (DSNP) Update

September 23, 2024

Eve Gelb, Chief Innovation Officer
Kimberley Marquez-Johnson, Director DSNP
James Cruz, MD, Senior Medical Director
Michelle Espinoza, Executive Director Delivery Systems Operations

Integrity
Accountability
Collaboration
Trust
Respect

Coverage for People with Medicare and Medi-Cal (Duals)



Federal health insurance program for people aged 65 or older and younger people with certain disabilities. Services covered include:

- **Medicare Part A:** Inpatient care in hospitals and skilled nursing facilities (not custodial or long-term care), some home health care.
- **Medicare Part B:** Medically necessary doctors' services, outpatient care, home health services, durable medical equipment, mental health services, and other medical services.
- **Medicare Part D:** Prescription drugs.

Medicare Advantage (MA) Plans include Part A and Part B, and additional benefits such as vision, hearing, and dental, bundled together in one plan. MA plans usually cover prescription drugs (Medicare Part D) as well in an Medicare Advantage Part D (MAPD) Plan.

California's version of the Federal Medicaid program that offers no-cost and low-cost health coverage to people based on low income or other needs.

Benefits include:

- Doctor visits
- Emergency services and hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Laboratory services, such as blood tests
- Programs such as physical therapy
- Medical supplies and devices
- Children's services, including oral and vision care
- In-home care and other long-term services and supports

Options for California's Duals: Medi-Medi Plans

Medicare Medi-Cal Plans (Medi-Medi Plans) are a type of Medicare Advantage plan in California that are only available to dual eligible beneficiaries.

Beneficiaries enrolled in a Medi-Medi Plan receive their Medicare benefits through a Dual Eligible Special Needs Plan (D-SNP) and their Medi-Cal benefits through a Medi-Cal Managed Care Plan (MCP).

The Federal goverment calls this type of plan and Exclusively Aligned Enrollment (EAE) D-SNP.

D-SNP + MCP
Medi-Medi Plan

D-SNPs provide Medicare services, such as:

- Hospitals
- Providers
- Prescription drugs

MCPs provide wrap-around services, such as:

- Medicare cost-sharing
- Long-Term Services and Supports (LTSS)
- Transportation

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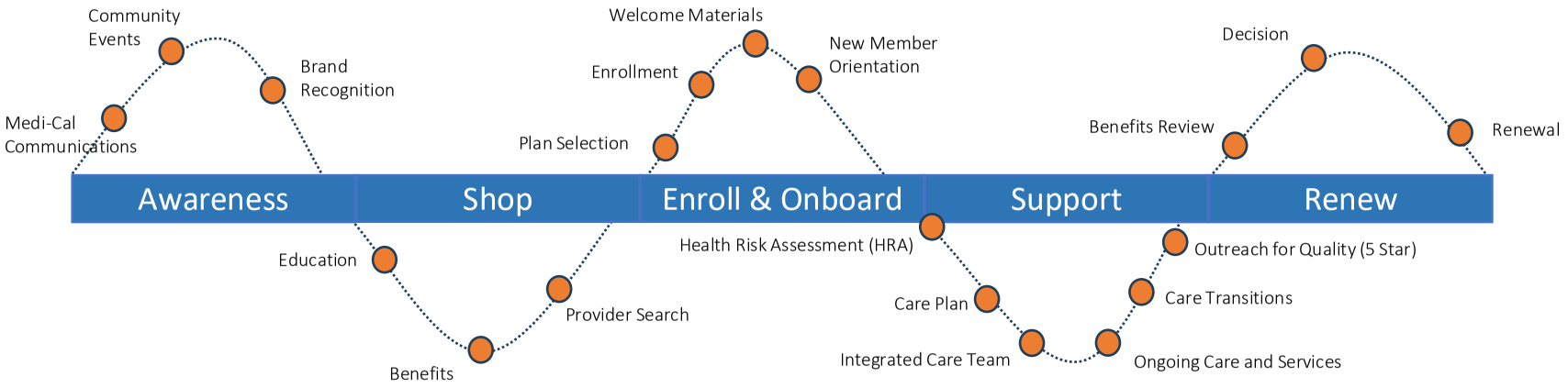
Member Journey Through the Future Gold Coast Health Plan D-SNP



Benefit design, provider network contracts, vendor contracts for pharmacy benefit management and supplemental benefits, and other costs combine to form a bid that is submitted to Medicare.

The Model of Care supports the member from the moment they enroll in the plan through their renewal or disenrollment improving health outcomes and supports medical cost management.

Plans that connect members with ongoing high quality care and receive higher reimbursement from Medicare through risk adjustment and quality bonuses.

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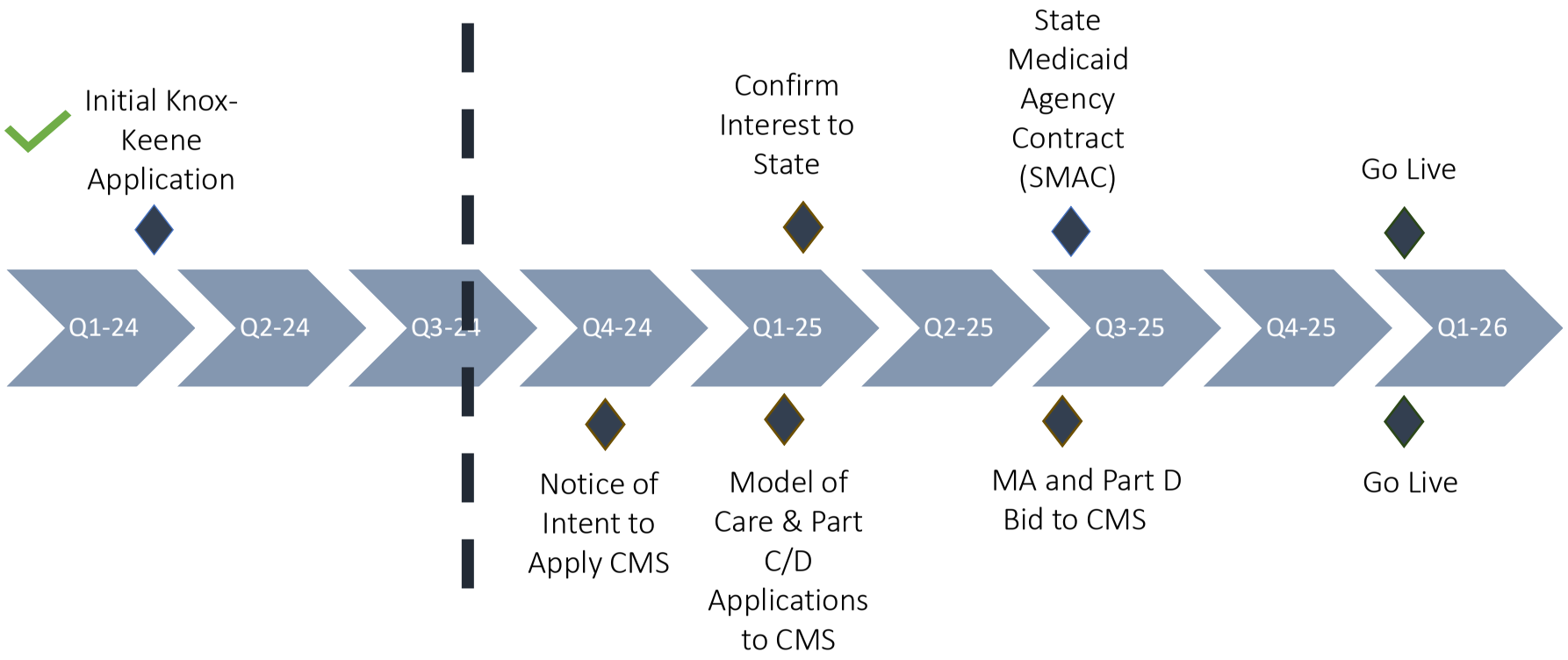
Regulatory Schedule Timeline

There are several regulatory requirements steps that must be completed and obtain with DMHC, CMS, and DHCS for GCHP to operate as an Exclusively Aligned Enrollment(EAE) D-SNP, Medi-Medi Plan starting on January 1, 2026.



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Pharmacy Benefit Manager Contracting Status

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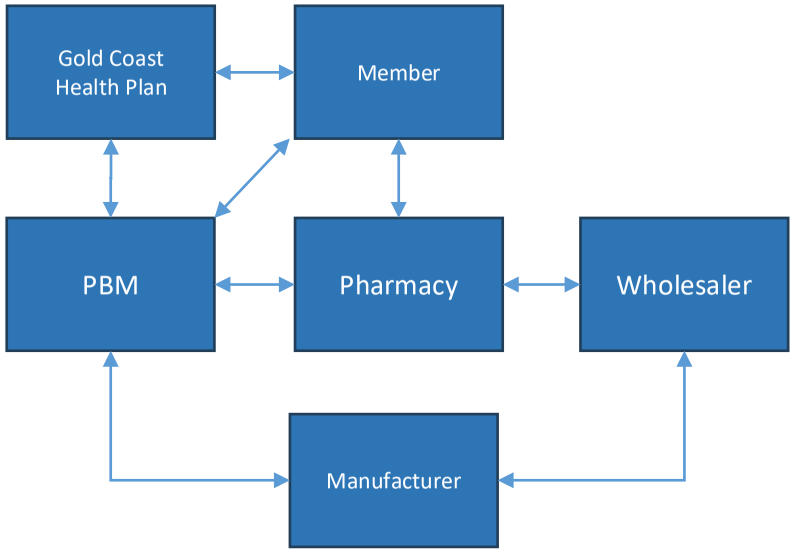
Pharmacy Benefit Managers (PBM) Support the Member and the Plan through the Complexities of the Pharmaceutical Industry

GCHP Medi-Cal members get their drugs through Medi-Cal RX. GCHP D-SNP Members will get their drugs through Medicare Part D. GCHP must contract with a PBM to administer the Medicare Part D benefit.



Complexities of the Pharmaceutical Industry:

- Manufacturers produce drugs and negotiate the price of those drugs with PBM that use large purchasing power to get favorable rates.
- Manufacturers issue rebates to promote the use of certain drugs and get them on plans' formularies.
- PBMs design formularies for clinical efficacy and cost effectiveness
- Wholesalers get drugs from manufacturers and get them to retail and mail-order pharmacies.
- Members get their drugs from pharmacies
- Pharmacies bill PBMs.
- PBMs also ensure that members are getting the right drugs through utilization management and quality management activities.
- Health Plans contract with PBMs to deliver the pharmacy benefit and ensure regulatory requirements are met.

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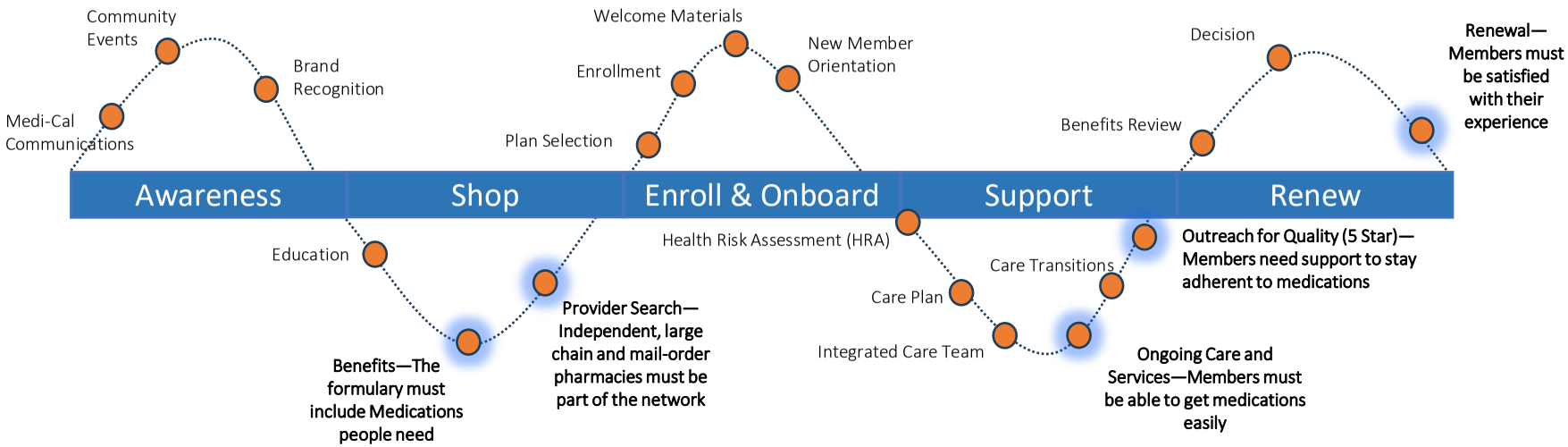
Member Journey Supported by PBM

GCHP Medi-Cal members get their drugs through Medi-Cal RX. GCHP D-SNP Members will get their drugs through Medicare Part D. GCHP must contract with a PBM to administer the Medicare Part D benefit.



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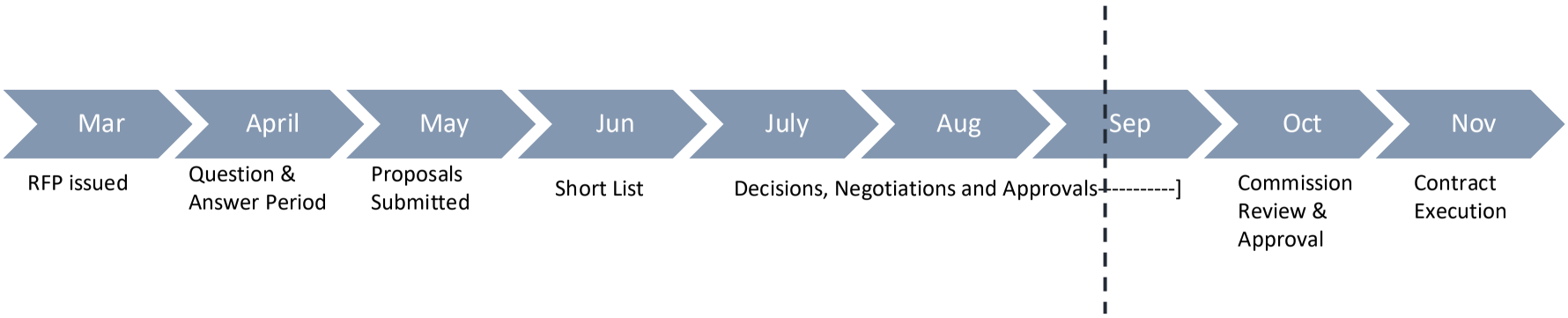
PBM Procurement Process for Part D Medicare

- A cross-functional team approach with Procurement leading the team: Pharmacy, Legal, Compliance, Finance, Operations, IT, D-SNP, Pharmacy Consultant group (PSG)
- Team developed Request for Proposal (RFP) questions and Legal developed the contract which comprised the official Request for Proposal packet



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Network Development Status

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D-SNP Network Requirements

Adequacy

- Medicare network adequacy requirements for D-SNPs are monitored by CMS
- Combined Medicare and Medi-Cal networks are assessed to ensure the network is sufficient to meet the network adequacy requirement

Alignment

- Ensure continuity of access to providers across Medi-Cal and Medicare for Members
- EAE D-SNPs must report to DHCS the percent and number of contracted Medi-Cal providers for DSNPs that are also contracted Medicare providers
- 2025 DHCS recommendation is 90% overlap of Primary and Specialty Care providers

Language Capability

- Analyze linguistic services for languages offered by the plan and/or interpreters
- Analysis should evaluate differences between Medicare network providers and the specified Medi-Cal network providers
- Identify and address gaps

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Medicare Network Development

Knox Keene Milestone—On track

- Obtained LOIs with key providers as part of initial Knox-Keene filing
- LOIs with providers that are materially financial in terms of overall network structure
  - Hospitals
  - PCPs/SCPs
  - Post Acute Care (SNF, LTC, HH)
  - Dialysis
  - Ancillary (DME, Lab)

CMS/DHCS Milestone—Launching now

- Contract with network of providers to meet CMS and DHCS adequacy, alignment and language capability standards

Model of Care Milestone—Launching now

- Contract with providers and supplemental benefit vendors to deliver the Model of Care
- Train all providers on the Model of Care
- Support providers in launch and operations

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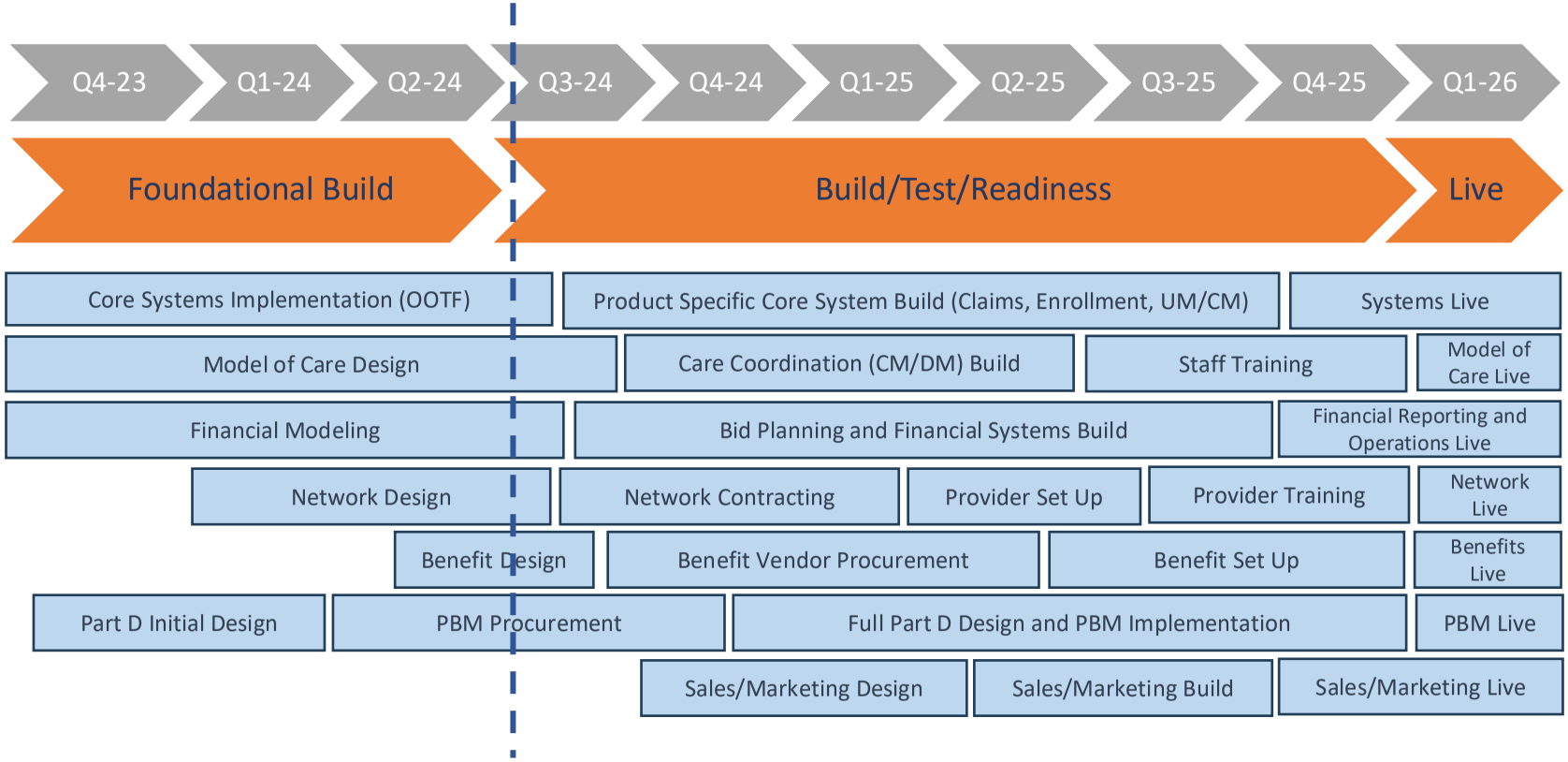
D-SNP Operations and Systems Implementation

We have completed most of the foundational work and will soon embark on operations and systems build.



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Appendix

The following items are provided for background and definition:

1. What is Medicare Advantage (MA)?
2. How are MA Plans Paid?
3. What is 5 Star?
4. What is a Pharmacy Benefit Manager (PBM)?
5. What is a D-SNP?
6. What is a Model of Care?
7. What is a Knox Keene License?

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1. What is a Medicare Advantage Plan?

Citation: Christina Ramsay, Gretchen Jacobson, Steven Findlay, and Aimee Cicciello, "Medicare Advantage: A Policy Primer, 2024 Update" (explainer), Commonwealth Fund, Jan. 31, 2024. https://doi.org/10.26099/69fq-dy8

Medicare Advantage plans are private health insurance plans paid by the federal government to provide Medicare-covered benefits as an alternative to "traditional" or "original" Medicare.

Most Medicare Advantage plans are either **HMOs,** which generally cover only care provided by in-network doctors, hospitals, and other health providers, or by **PPOs,** which also offer access to out-of-network providers but at a higher cost than in-network providers.

Covered benefits. Medicare Advantage plans must cover all services covered by traditional Medicare under Part A (hospital services, some home health, hospice care, skilled nursing care) and Part B (physician services, durable medical equipment, outpatient drugs, mental health, ambulance services). The vast majority of plans (89% in 2024) also cover Part D prescription drug benefits. Most plans offer additional benefits such as eyeglasses, hearing aids, and some coverage of dental care, such as cleanings.

In 2020, the government began allowing Medicare Advantage plans to include a wide range of telehealth benefits as part of their basic benefit package. Some plans also cover fitness club memberships, caregiver support, meal delivery, or acupuncture.

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2. How are MA Plans Paid?

Citation: Christina Ramsay, Gretchen Jacobson, Steven Findlay, and Aimee Cicciello, "Medicare Advantage: A Policy Primer, 2024 Update" (explainer), Commonwealth Fund, Jan. 31, 2024. https://doi.org/10.26099/69fq-dy8

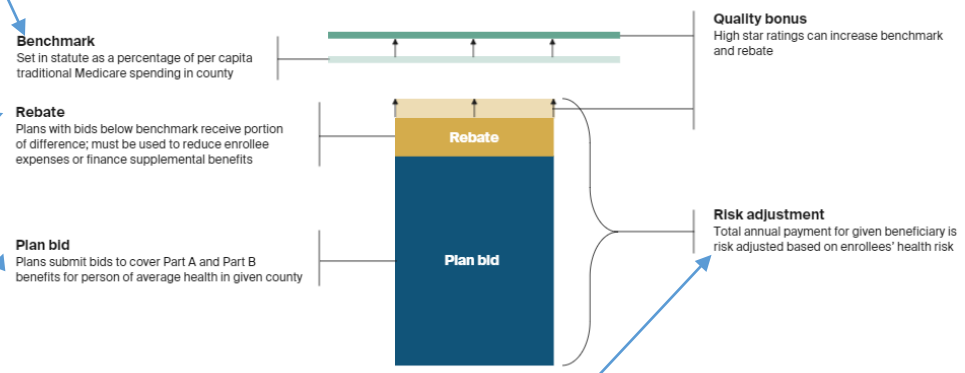
Benchmarks. Plan benchmarks are the maximum amount the federal government will pay a Medicare Advantage plan. Benchmarks are set in statute as a percentage of traditional Medicare spending in a given county, ranging from 115 percent to 95 percent. Special Needs Plans and other Medicare Advantage plans are paid in the same manner, with the same benchmarks.

Rebates. If a plan's bid is *below* the local benchmark — as is the case for the majority of plans — then the plan keeps part of the difference between the bid and benchmark. This amount, called the rebate, is equivalent to a shared savings between the federal government and plans. Plans are required to use the rebate to lower patient cost sharing, lower premiums, or provide some coverage for benefits not included in traditional Medicare. Rebate dollars also can be used to pay for administrative expenses and profits associated with providing additional benefits.

Bids. Health insurance companies bid every year to enroll Medicare beneficiaries in their Medicare Advantage plans. That bid is based on companies' assessment of their costs to provide Part A and Part B services to the average beneficiary.

Quality adjustments. Quality ratings affect benchmarks as well as rebate size.. Benchmarks are raised by 5 percent for plans with four or more stars and, in certain counties, are increased by 10 percent for plans with high ratings. For the rebate, plans with three stars or fewer receive 50 percent of the difference between the bid and the benchmark; plans with three-and-a-half or four stars receive 65 percent of the difference; and plans with four-and-a-half or five stars receive 70 percent of the difference

Medicare Advantage payments are based on a system of benchmarks, bids, and quality incentives.



Source: Christina Ramsay, Gretchen Jacobson, Steven Findlay, and Aimee Cicciello, *Medicare Advantage: A Policy Primer, 2024 Update* (Commonwealth Fund, Jan. 2024). https://doi.org/10.26099/69fq-dy83

Risk adjustment. Both the rebate and the bid amount are "risk adjusted" to account for enrollees' health status. Payment is affected by each beneficiary's risk score, which represents the expected cost of each enrollee relative to the cost of the average Medicare beneficiary. Thus, the average enrollee has a risk score of 1.0. An older person with multiple chronic conditions would have a risk score above 1.0, whereas a younger person with no health issues would have a risk score below 1.0.

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3. What is 5 Star and What Are the 2026 Measures?

The Centers for Medicare & Medicaid Services (CMS) establishes a set of 45 quality measures for Medicare Advantage (Medicare Part C) and Medicare Part D plans. Measures have different weights and measure health outcomes as well as processes. The Star Ratings system helps Medicare consumers compare the quality of Medicare health and drug plans being offered so they are empowered to make the best health care decisions for them. An important component of this effort is to provide Medicare consumers and their caregivers with meaningful information about quality alongside information about benefits and costs to assist them in being informed and active health care consumers. Highly quality plans (4 Star or higher) receive quality bonus payments.

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Table 2. 2026 Star Ratings Part D Measures and Measure Weights

Measure Name	Weighting Category	Part D Summary and MA-PD Overall Weight
Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2
Complaints about the Drug Plan	Patients' Experience and Complaints Measure	2
Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2
Drug Plan Quality Improvement	Improvement Measure	5
Rating of Drug Plan	Patients' Experience and Complaints Measure	2
Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	2
MPF Price Accuracy	Process Measure	1
Medication Adherence for Diabetes Medications	Intermediate Outcome Measure	3
Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measure	3
Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measure	3
MTM Program Completion Rate for CMR	Process Measure	1
Statin Use in Persons with Diabetes (SUPD)	Process Measure	1

Source: https://www.cms.gov/files/document/2026-star-ratings-measures.pdf

Table 1. 2026 Star Ratings Part C Measures and Measure Weights

Measure Name	Weighting Category	Part C Summary and MA-PD Overall Weight
Breast Cancer Screening	Process Measure	1
Colorectal Cancer Screening	Process Measure	1
Annual Flu Vaccine	Process Measure	1
Improving or Maintaining Physical Health	Outcome Measure	1*
Improving or Maintaining Mental Health	Outcome Measure	1*
Monitoring Physical Activity	Process Measure	1
Special Needs Plan (SNP) Care Management	Process Measure	1
Care for Older Adults – Medication Review	Process Measure	1
Care for Older Adults – Pain Assessment	Process Measure	1
Osteoporosis Management in Women who had a Fracture	Process Measure	1
Diabetes Care – Eye Exam	Process Measure	1
Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3
Kidney Health Evaluation for Patients with Diabetes	Process Measure	1
Controlling Blood Pressure	Intermediate Outcome Measure	3
Reducing the Risk of Falling	Process Measure	1
Improving Bladder Control	Process Measure	1
Medication Reconciliation Post-Discharge	Process Measure	1
Plan All-Cause Readmissions	Outcome Measure	3
Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1
Transitions of Care	Process Measure	1
Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Process Measure	1
Getting Needed Care	Patients' Experience and Complaints Measure	2
Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	2
Customer Service	Patients' Experience and Complaints Measure	2
Rating of Health Care Quality	Patients' Experience and Complaints Measure	2
Rating of Health Plan	Patients' Experience and Complaints Measure	2
Care Coordination	Patients' Experience and Complaints Measure	2
Complaints about the Health Plan	Patients' Experience and Complaints Measure	2
Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2
Health Plan Quality Improvement	Improvement Measure	5
Plan Makes Timely Decisions about Appeals	Measures Capturing Access	2
Reviewing Appeals Decisions	Measures Capturing Access	2
Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2

*Measure has a weight of 1 for the 2026 Star Ratings because it is considered a new measure.

4. What is a Pharmacy Benefit Manager (PBM)?

sources:
JAMA Health Forum. 2023;4(11):e233804. doi:10.1001/jamahealthforum.2023.3804
https://www.medicare.gov/drug-coverage-part-d/what-medicare-part-d-drug-plans-cover

PBMs are companies that manage prescription drug benefits for health insurers, Medicare Part D drug plans, self-insured employers, and other payers, such as state Medicaid programs. They provide useful services in a very complex environment.

Formulary Development/Management
The formulary specifies which drugs the PBM will cover and the associated patient-level costs when the drug is dispensed. Formularies are typically developed by a committee of pharmacists and physicians, often called a pharmacy and therapeutics committee.

All MA plans must cover a wide range of prescription drugs that people with Medicare take, including most drugs in certain protected classes," like drugs to treat cancer or HIV/AIDS. Each plan has its own formulary with drugs placed into different levels, called "tiers," on their formularies. Drugs in each tier have a different cost. For example, a drug in a lower tier will generally cost less than a drug in a higher tier.

Utilization Management (UM)
UM encompasses several common practices, including prior authorization, step therapy requirements, supply limits (on dosage or number of days), and various financial incentives (eg, deductibles, co-payments, coinsurance).

Negotiated Rates
PBMs negotiate with pharmacies, wholesalers, and drug manufacturers on behalf of plans. Drug manufacturers offer rebates and discounts to ensure that their branded (high-cost) pharmaceuticals are included in a formulary and/or placed on a preferred tier.

Pharmacy Network
PBMs create and manage a network of pharmacies (including specialty pharmacies) at which members can access prescriptions. The PBM generally ensures that beneficiaries have access to a mix of local retail pharmacies, and specialty pharmacies.

Mail Order
Mail order services enable members to receive medications delivered to their homes. This is usually for routine medications and is a convenient way for people with transportation barriers to easily obtain medications.

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5. What are SNPS and What is a D-SNP?

Special Needs Plans (SNPs) are a type of Medicare Advantage (MA) coordinated care plan designed for individuals with special needs. Initially authorized with the passage of The Medicare Modernization Act of 2003 , SNPs established a type of MA coordinated care plan specifically designed to provide targeted care to individuals with special needs. These individuals' conditions were defined as: 1) institutionalized individuals; 2) 'dual eligibles' (for Medicare and Medicaid); and/or 3) individuals with severe or disabling chronic conditions, as specified by the Centers for Medicare and Medicaid Services.

Congress intended SNPs to exclusively or disproportionately enroll persons with serious chronic conditions to more effectively serve high-risk populations through specialization and a comprehensive benefit offering (SNPs must offer Medicare Parts A, B, and D benefits). These plans function under most of the same Medicare Advantage regulations, with some exceptions, and use the same payment methodology as other MA plans.

- SNPs can limit enrollment to targeted special needs individuals.
- Dually eligible and institutionalized beneficiaries may enroll and disenroll throughout the year rather than only during open enrollment period,
- Plans must submit and adhere to an approved Model of Care (MOC) for all beneficiaries enrolled in any SNP type.
- SNPs integrating Medicare and Medicaid benefits may target enrollment to certain subsets of dual beneficiaries.

Dual Eligible Special Needs Plans (D-SNPs) are MA plans that enroll individuals dually eligible for Medicare and Medicaid.

There are four types of D-SNPs each with varying levels of coordination and integration (types of D-SNPs are Coordination Only, Exclusively Aligned Enrollment, Highly Integrated, and Fully Integrated).

D-SNPs must have existing, executed contract(s) with state Medicaid agencies (SMAs), and must coordinate and integrate all services and benefits covered by Medicare and Medicaid.

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Source: https://snpalliance.org/what-we-do/about-snps/

6. What is a Model of Care (MOC)?

Every SNP must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). The MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices. The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes.

There are four SNP MOC elements (specific requirements and scoring guidelines are available at https://snpmoc.ncqa.org/scoring-guidelines-latest):

MOC 1: Description of the Population—Demonstrates understanding of their experience and needs	MOC 3: Network—Relevant facilities and providers to address unique and specialized needs
MOC 2: Care Coordination—Ensures that needs and preferences are met	MOC 4: Quality and Performance Improvement—Continuously improve ability to deliver services and care

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7. What is a Knox Keene License?

What is a Knox-Keene License?

A Knox-Keene license is a license obtained through the Department of Managed Health Care ("DMHC") pursuant to California's Knox-Keene Health Care Service Plan Act and its implementing regulations (collectively, the "Knox-Keene Act"). The Knox-Keene Act requires California managed care plans to obtain a license from the DMHC to operate in the State of California.

What is the Scope of DMHC's Regulation of GCHP for its D-SNP under the Knox-Keene Act?

Because GCHP is exempt from licensure for its Medi-Cal line of business, DMHC's primary focus is on the GCHP's financial viability and contracts with vendors and providers. It does not enforce network access or quality; those activities fall under the purview of DHCS and CMS.

Why doesn't Gold Coast Health Plan ("GCHP") have a license, and why does GCHP need one now?

The Ventura County Medi-Cal Managed Care Commission d.b.a. Gold Coast Health Plan was created as a County Organized Health Care System ("COHS") to deliver managed care services to Medi-Cal beneficiaries. In COHS counties, a single plan serves all Medi-Cal beneficiaries who are enrolled in managed care. Under California law, COHS are exempt from Knox-Keene licensure for their Medi-Cal line of business.

However, in order to offer a Dual-Special Needs Plan ("D-SNP"), GCHP must obtain approval from the federal Centers for Medicare and Medicaid Services ("CMS"). CMS requires that health plans obtain state licensure before they receive approval from CMS to offer D-SNP plans, and similarly, the Knox-Keene Act requires a license for Medicare lines of business. Therefore, applying for an obtaining a Knox-Keene license is one of the first steps in implementation of the D-SNP.

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Footnote: While there are other Knox-Keene license types, such as restricted Knox-Keene licenses, those restricted Knox-Keene licenses are for provider organizations that bear global risk (i.e., Risk Bearing Organizations) and not health care service plans.

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Robert Franco, Chief Compliance Officer

DATE: September 23, 2024

SUBJECT: Compliance Update

PowerPoint with Verbal Presentation

ATTACHMENTS:

2024 DHCS Medical Audit

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

2024 DHCS Medical Audit
September 23, 2024

Compliance Department
Robert Franco, Chief Compliance Officer

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

What is a DHCS Medical Audit

The DHCS Medical Audit will consist of an evaluation of Gold Coast Health Plan's compliance with its contract and regulations in the areas of

1. Utilization management,
2. Case management and coordination of care,
3. Availability and accessibility,
4. Member's rights,
5. Quality management, and
6. Administrative and organizational capacity.

2024 Highlights

- New Audit Team – Los Angeles Field Office
- Focused Audit – fewer areas of review
- Review Period July 1, 2023 – June 30, 2024
- Virtual Audit Interviews begins September 23, 2024 – October 4, 2024

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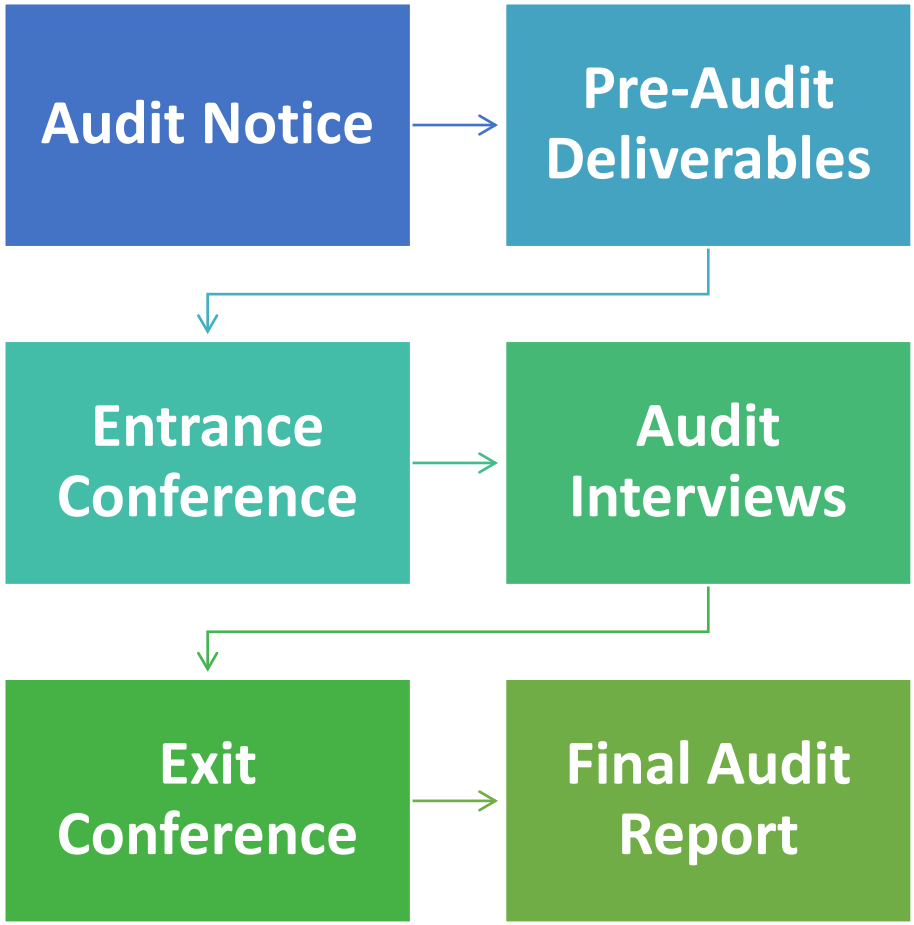
AUDIT PROCESS



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AUDIT PROCESS continued…

Entrance Conference → Monday, September 23, 2024

Audit Interviews →

Interviews will be conducted with the following:
- Medical Director,
- Director of Quality Management,
- Director of Utilization Management,
- and other staff as necessary.

The audit will also involve medical record review and will include a separate interview with Carelon regarding delegated UM.

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2024 DHCS Areas of Focus

Utilization Management
- 1.1.A UM Program Requirements
- 1.1.B Referral Tracking System
- 1.2 Prior, Concurrent, and Retro Auth Reviews
- 1.3 Appeal Procedures
- 1.4 Medical Director and Medical Decisions
- 1.5 Delegated UM Activities – Carelon Behavioral Health

Case Management and Coordination of Care
- 2.1.B Basic Case Management
- 2.1.D Initial Health Assessments
- 2.2 Complex Case Management
- 2.4 Coordination of Care
- 2.5 Mental Health and Substance Use Disorder

Access and Availability
- 3.1 Appointment Procedures and Monitoring Waiting Times
-3.6 State Supported Services (Claims)
-3.8 Non-Emergency Medical Transportation and Non-Medical Transportation

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2024 DHCS Areas of Focus

Areas of Focus

Member's Rights
-4.1 Member Grievance System and Oversight
Quality Improvements
-5.1 Quality Improvement System
-5.2 Delegation of QI Activities
-5.3 Provider Qualifications (New Provider Training)
Administrative and Organizational Capacity
-6.3 Encounter Data
- Addendum A General Information
- Addendum B Policies and Procedures
- Addendum C Resume/Curriculum Vitae
- Addendum D Organization Charts
- Addendum E Plan Committees
- Addendum F Member Evidence of Coverage/Member Handbook, Provider Manual, and Provider Directory
- Addendum G Provider Newsletters and Member Newsletters issued during audit period
- Addendum H Provide a brief summary of corrective actions and interventions for the prior year audit finding(s).

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AUDIT PROCESS continued…

Exit Conference → Friday, October 4, 2024

Preliminary findings

Final Report → Usually issued in 90-days from the Exit Conference

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2024 Medical Audit Highlights

New Audit Team

Potentially longer interviews to provide additional context

New areas of Focus

Behavioral Health – Carelon

Encounter Data

Access and Availability wait times

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Prior Year Findings

2022 Medical Audit

Initial Health Assessments (2 Findings)

New Provider Training (1 Finding)

Transportation (2 findings)

2023 Medical Audit

SPD Health Risk Assessments (2 findings)

Corrective Action Issuance & Timeliness (2 findings)

2023 Focus Audit

Behavioral Health (4 Findings)

Transportation (1 Finding)

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Next Steps

Review prior audit finding for sustained compliance.

Review submitted audit documentation for any known issues.

Conducted audit Prep Meetings with GCHP and Delegated Staff ahead of the DHCS Interviews

Hold Compliance Post Audit Interviews to capture action items, areas of concern and feedback for the next interviews.

Hold Daily Compliance Office Hours to answer questions and provide audit updates.

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Questions

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Appendix

DHCS Technical Assistance Guides (TAG):

DHCS TAGS

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AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: September 23, 2024

SUBJECT: Reconstitute the Strategic Planning Ad Hoc Committee

SUMMARY:

In preparation of last year's Strategic Planning Retreat the Commission convened a Strategic Planning Ad Hoc Committee to provide GCHP staff guidance on the strategic plan.

Prior members consisted of the following Commissioners:

1. Dee Pupa
2. Laura Espinosa
3. Ana Monroy

Staff is presently preparing for the Strategic Planning Retreat, which will be on December 12, 2024. Staff believes the input from Commissioners would be very beneficial for a successful retreat and would like to reconvene the Ad Hoc Committee.

Staff recommends meeting in person once again this year, as the Public Health Emergency has been lifted.

NEXT STEPS:

Once reconvened, the Strategic Planning Ad Hoc Committee will begin meeting monthly starting in September 2023.

RECOMMENDATION:

Staff recommends that the Commission reconstitute the Strategic Planning Ad Hoc Committee and select up to five Commissioners who will serve in the ad hoc committee. Additionally, staff recommends that the Strategic Planning Retreat be held in person this year.

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Felix Nunez, MD, Acting Chief Executive Officer

DATE: September 23, 2024

SUBJECT: Chief Executive Officer (CEO) Report

Acting Chief Executive Officer (CEO) Message

It is a pleasure to share my first update as Acting Chief Executive Officer (CEO) and report on the status of GCHP's leadership transition. Since assuming the role of Acting CEO, I have worked closely with our Executive and Leadership teams to maintain focus on organizational goals to advance access to high quality health care for our members. As an Executive Team, we are united in our desire to work collaboratively across the entire organization to assess how we can best approach this strategic work, mindful of the need to support our teams during a period of organizational change.

I have made myself available, along with Paul Aguilar, GCHP's Chief Human Resource and Organizational Performance Officer, to join departmental meetings to discuss any concerns and provide regular updates regarding the change in leadership. To date, I can report that our staff has remained steadfast in their commitment to our mission and members, without any noted disruption to operations or morale. I, along with the entire Executive Team, will remain attentive to the needs of the staff and continue to provide support and encouragement.

In keeping with the need to have clear delineation of the work of the CEO from that of the Chief Medical Officer (CMO), I have appointed Dr. James Cruz as GCHP's Acting CMO. Dr. Cruz has served GCHP with dedication and distinction as Senior Medical Director and has graciously accepted this position in support of our work. I will continue to be aligned with Dr. Cruz and our Health Services Team as we onboard our new Medical Director, Dr. Teri Brown. Dr. Brown joins us from Promise Blue Shield Health Plan, where she served as a Senior Medical Director leading appeals and grievances. She has had a distinguished career as a physician and physician leader in the Medi-Cal managed care industry and has a lifelong commitment to serving low-income populations.

On Sept. 11, 2024, I attended a CEO meeting in Sacramento that is led by the state Department of Health Care Services (DHCS). The meeting brought together Medi-Cal managed care plan (MCP) executive leadership to receive updates and discuss issues with senior leadership from DHCS, including Director Michelle Baass. Among the topics discussed were Medi-Cal rate-setting strategies for the coming years, programmatic reports, and benefit

updates on behavioral health transformation, efforts to enhance cybersecurity, the quality withhold program, and transitional rent post hospitalization (which you can read about in the External Affairs update below).

There was a great deal of discussion with many MCP leaders sharing concerns regarding the rate-setting methodology, specifically concerning the need to ensure that rates truly reflect rising health care costs across the state. In addition, there was robust discussion of the limitations of current data sharing to advance quality goals across governmental and non-governmental agencies, with several suggestions to DHCS leadership as to how they can promote and improve our capabilities.

DHCS committed to taking our concerns and suggestions into consideration as they move forward on rate setting and the rollout of new benefits and programs. We will continue to provide updates as we receive them.

I. External Affairs

A. Federal Affairs

Association for Community Affiliated Plans (ACAP) Submits Comments Supporting 12-month Continuing Eligibility (CE) for Individuals Under 19 and Other Provisions in the Centers for Medicare and Medicaid Services (CMS) Proposed Rule

Gold Coast Health Plan's (GCHP) trade association, the Association for Community Affiliated Plans (ACAP), submitted comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule on the Calendar Year (CY) 2025 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. ACAP's comments reflect support and recommendations for key Medicaid proposals in the OPPS proposed rule including:

- **Continuing Eligibility (CE):** ACAP supports codifying the requirement for states to provide 12-months of continuous eligibility (CE) for children under age 19 in Medicaid and the Children's Health Insurance Program (CHIP). ACAP recommends that CMS reduce the financial burden for CHIP plans and allow enough time for states and CHIP plans to update payment and enrollment systems relating to premium collections.
- **"Four Walls" Exceptions:** ACAP supports the three proposed additional exceptions to the Medicaid clinic services benefit four walls requirement for services provided outside of Indian Health Services (IHS) / Tribal clinics, behavioral health clinics, and clinics in rural areas. ACAP recommends that CMS consider expanding the proposal beyond rural geographic areas and working with Congress to clarify that the statute does not limit the use of telehealth for clinic services. Additionally, ACAP urges CMS to finalize the definition of 'rural' used by the Census Bureau to ensure that all clinics in rural areas could be included in this exception and that all individuals living in rural or remote areas can benefit from this policy.
- **Formerly Incarcerated Individuals:** ACAP supports changes to improve Medicare enrollment and care for formerly incarcerated individuals and urges CMS to work with stakeholders such as state Medicaid agencies, providers, and health plans to assess

if additional actions are needed to support continuity of coverage and care for justice-involved individuals.

Managed care plans (MCP), including GCHP, participated in ACAP's proposed rule review and comment development process. The ACAP letter underscores the industry's longstanding support and advocacy for the expansion of the CE for children under age 19. GCHP's Government Relations Team will provide updates upon release of the final rule.

B. State Updates

State Department of Health Care Services (DHCS) Releases Transitional Rent Concept Paper for Public Comment

The state Department of Health Care Services (DHCS) released for comment a Transitional Rent Concept Paper that outlines the process for MCPs to provide Transitional Rent to eligible members for a period of up to six months beginning with voluntary implementation on Jan. 1, 2025, and mandating implementation by Jan. 1, 2026.

Eligible members must meet three specific requirements:

1. Meet one or more Clinical Risk Factors – Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS) ***or*** one or more serious chronic conditions (including pregnant and postpartum up to 12 months), or physical intellectual or developmental disabilities,
2. Experiencing or at risk of homelessness (using federal Housing and Urban Development (HUD) definitions, but expanding at risk period from 14 to 21 days), and
3. Be within a specified transitioning population or Unsheltered or Full Service Partnership (FSP) eligible.

The Transitional Rent will be offered as a Community Support under the current 1115 Demonstration Waiver; DHCS intends the Transitional Rent to complement the Housing Trio services already available under California Advancing and Innovating Medi-Cal (CalAIM) Community Supports (housing navigation, deposits, and sustaining services). Beginning Jan. 1, 2026, MCPs will be required to provide Transitional Rent to eligible members for a period of up to six months; the rent does not have to be used consecutively but must be used within a year of authorization in most cases.

MCPs are expected to work in partnership with Continuums of Care (CoCs) to identify potentially eligible members for transitional rent – including data sharing and ensuring non-duplication of services using the Coordinated Entry System and data sharing agreements. Additionally, the concept paper states that Public Housing Agencies (PHAs) should work with MCPs to maximize uptake of federally funded housing supports administered by the PHA.

The concept paper outlines the requirements for the development of an Individualized Housing Support Plan (IHSP) by either the transitional rent provider or the member's provider of housing navigation services or Housing and Tenancy Sustaining services as appropriate and places requirements on MCPs to ensure that settings meet minimum quality standards. The development of the IHSP will require significant time and resources and must include the permanent housing strategy for the member and be informed by member preferences / needs and reviewed / updated based on the members circumstances. DHCS states that MCPs will

be responsible for ensuring the covered settings meet minimum quality standards but have not yet detailed how MCPs will perform this function.

DHCS intends to pay Transitional Rent outside of the capitation rate for first 2 to 3 years after the program launch and states that Transitional Rent should be provided in conjunction with other Medi-Cal services including the Housing Trio, Enhanced Care Management (ECM), and physical and behavioral health services, as well as non-Medi-Cal social supports. The Transitional Rent must be "medically appropriate" as determined by a provider – finding that Transitional Rent is likely to reduce or prevent the need for acute care or other Medicaid services including, but not limited to, inpatient hospitalizations, Skilled Nursing Facility (SNF) stays, or emergency department (ED) visits. This aligns with existing Community Supports policy.

The concept paper lacks the details needed to operationalize such a program and would significantly expand the role of MCPs in coordinating and covering housing services for eligible members. GCHP is working closely with its trade association, Local Health Plans of California (LHPC), to identify the policy gaps, detail areas where additional information is needed, and highlight aspects of the proposal that are not feasible to implement in the timeframe allotted. The GCHP Government Relations Team will provide updates upon release of the final all-plan letter (APL).

DHCS Continues Development of Children and Youth Behavioral Health Initiative (CYBHI) Fee Schedule

DHCS continues to hold weekly stakeholder implementation calls on the Children and Youth Behavioral Health Initiative (CYBHI) to develop the process for the fee schedule and payment processing between MCPs and the third-party administrator (TPA), Carelon Behavioral Health. The CYBHI is a statewide multi-payer school-linked fee schedule to reimburse school-linked providers for the provision of specified outpatient mental health and substance use disorder services furnished to students 25 years of age or younger at a school site.

Cohorts 1 and 2 were eligible to begin billing for the CYBHI fee schedule in 2024; Cohort 3 begins onboarding the CYBHI fee schedule in Jan. 2025 and Cohort 4 in July 2025. In Ventura County, two Local Education Agencies (LEAs), Ventura Unified and Santa Paula school districts, met DHCS' Cohort 2 readiness requirements. Other LEAs interested in participating in Cohort 3 must complete the program readiness application by Sept. 27, 2024.

Under the CYBHI, LEAs are permitted to bill plans directly when a direct relationship exists between the two entities. GCHP is working directly with LEAs to implement the CYBHI as well as working to establish the third-party fee schedule process. Additionally, GCHP is participating in the DHCS stakeholder process and providing feedback to LHPC to inform the policy development of the fee schedule and seek clarity where needed. The GCHP Government Relations Team will continue to provide updates as the CYBHI continues to be rolled out across the state and county.

DHCS Releases Closed-Loop Referral Implementation Guidance in Addendum to the Population Health Management (PHM) Policy Guide

DHCS released for comment an addendum to the PHM Policy Guide that provides Closed-Loop Referral Implementation Guidance to plans. The guidance specifies that MCPs must be able to close the loop on all ECM referrals by Jan. 1, 2025. GCHP met with the Ventura County

Community Information Exchange (VCCIE) team and verified that we are able to the meet the requirements through the Community Information Exchange (CIE). However, additional implementation time is needed for the needed IT resources and development.

The GCHP Government Relations Team provided feedback to LHPC and will provide updates as they become available.

DHCS Releases Several Draft APLs for Public Comment

DHCS released several draft APLs for public comment covering a broad range of topics, including Transgender, Gender Diverse or Intersex (TGI) Cultural Competency Training Program and Provider Directory Requirements, Medical Loss Ratio (MLR) Requirements for Subcontractors and Downstream Subcontractors, and Community Reinvestment Requirements.

Transgender, Gender Diverse or Intersex (TGI) Cultural Competency Training Program and Provider Directory Requirements: The TGI and Provider Directory Requirements draft APL requires MCPs to develop a TGI evidence-based cultural competency training program in collaboration with a TGI-serving organization and to train all subcontractors, downstream subcontractors, and MCP staff in direct contact, including staff that have oral and/or written contact, with members, by March 1, 2025, and at least annually thereafter. GCHP has established relationships with the local TGI-serving organization and is on track with the development of the training.

Additionally, the draft APL requires MCPs to ensure their provider directories meet minimum criteria, including noting in the directory in-network providers who have attested that they offer gender-affirming services and a mechanism to receive and update information from in-network providers attesting that they provide gender affirming services within 30 calendars of receipt of information. GCHP is reviewing the updated timelines to ensure our systems are compliant by the March 1, 2025 deadline.

Further, MCPs must update their Grievance and Appeals processes to ensure that members are made aware of their rights to submit grievances surrounding TGI services and providers and must report grievances for failure to provide trans-inclusive health care through their monthly Managed Care Program Data (MCPD) file under the benefit type “Gender Affirming Care.” The GCHP Government Relations Team will provide updates upon release of the final APL.

Medical Loss Ratio Requirements (MLR) for Subcontractors and Downstream Subcontractors: DHCS also released a draft APL establishing MLR requirements for MCP Subcontractors and Downstream Subcontractors. The draft proposes that beginning Jan. 1, 2025, MCPs being imposing MLR remittance requirements equivalent to the requirements in 42 CFR section 438.8(j) on their applicable Subcontractors and Downstream Subcontractors. The draft includes details for MCP oversight, reporting, and state directed payment programs and recalculation guidance. The Government Relations Team will provide updates upon release of the final APL expected later this year.

Community Reinvestment: DHCS released the Community Reinvestment draft APL that requires MCPs to contribute a minimum percentage of annual net income to the communities in which they operate as well as an additional investment for MCPs that do not meet quality outcome metrics. The draft APL proposes that the Community Reinvestment is effective

beginning in CY 2024; for this year, contributions are based on both an MCP's CY 2024 annual net income and CY 2024 Managed Care Accountability Set (MCAS) measure performance.

MCPs are required to initiate Community Reinvestment planning starting in CY 2024, with Community Reinvestment activities starting in CY 2026. Initial concerns with the proposal include the lack of recognition of current plan investments or plans' multi-year investments, DHCS's exploration of the legal permissibility and operational feasibility of share governance structures for oversight of Community Reinvestment and "potentially other governance and decision-making structures," and the extensive reporting requirements at the county level.

GCHP is reviewing the draft APL requirements and working with LHPC to submit comments on the proposed APL that detail plan concerns and the lack of inclusion of previous plan feedback on community investments. The Government Relations Team will provide updates upon release of the final APL.

C. State Legislative Updates

California's 2023-24 regular legislative session concluded on Aug. 31, 2024. Gov. Gavin Newsom has until Sept. 30, 2024, to sign or veto bills passed by the legislature. Below is a list of the bills we have been tracking throughout the session and their status. The GCHP Government Relations Team will provide a final report on all Medi-Cal-related bills signed into law after the Sept. 30, deadline.

Bill Title	Summary	GCHP Potential Impact(s)
AB 236: Provider Directories	AB 236 mandates health care plans to ensure provider directories are up-to-date and accurate on an annual basis. Plans will be mandated to delete erroneous information and ensure the directory is 60% accurate by July 1, 2025, and 95% accurate by July 1, 2028. Beginning July 1, 2025, plans are required to remove providers from the directory if plans have not financially compensated that provider in the prior year, with some limited exceptions. This bill will also require the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) to establish set processes for monitoring provider directory accuracy. Failure to meet deadlines and inaccurate provider listings will result in monetary penalties for the plan.	GCHP is compliant with existing provider directory requirements including providing a current and continuously updated directory of network providers. Upon becoming Knox-Keene licensed, GCHP would need to build additional processes to routinely pull data on providers who have not been financially compensated in the prior year and remove those providers from the provider directory. On July 29, 2024, LHPC submitted a comment letter opposing AB 236. LHPC highlighted how plans are committed to accurate provider information but placing a disproportionate responsibility on plans with the threat of financial penalty is unfair as plans and providers are equally accountable for accurate provider directories. *Status:* AB 236 is held under submission in the Senate Committee on Appropriations.
AB 2466: Medi-Cal Managed Care: Network Adequacy Standards	Under federal and state network adequacy requirements, there are time and distance standards for certain Medi-Cal covered services, and this includes appointment time thresholds. This bill notes that a Medi-Cal managed care plan would be considered not compliant with regulatory requirements if less than 85% of network providers had an appointment available within the appointment time standards and if the state is provided information that the plan did not deliver timely or accessible health care to members. If a plan is found noncompliant, plans can face contract termination or the consequences of sanctions.	This bill increases the penalties for network inadequacy and highlights how accountability continues to be a priority for the Legislature as failure to comply with appointment time standards may lead to contract termination or the imposition of sanctions on managed care plans. GCHP will have to ensure that contract requirements surrounding network adequacy are consistently met and continue to provide timely, efficient, and accessible care to members. LHPC has taken an “oppose-unless-amended” position and noted how the 85% threshold conflicts with DMHC appointment time standards, as outlined in APL 23-018, and also limits the ability of DHCS to implement recommendations from the audit report, “*Children Enrolled in Medi-Cal Face Challenges in Accessing Behavioral Health Care*.” *Status*: AB 2466 is held under submission in the Assembly Committee on Appropriations.

Bill Title	Summary	GCHP Potential Impact(s)
AB 3260: Health Care Coverage: Reviews and Grievances	AB 3260 mandates health plans to process prior authorization (PA) requests and communicate the outcome to the member and provider within a 72-hour timeframe if the member's condition is considered urgent. If additional information is needed for a PA decision, the health plan must notify the provider and member within 24 hours after receipt of the PA request. If health plans are unable to comply with the timeline requirements, the health plan must resolve the grievance in favor of the member, with limited exceptions.	PA is a contentious topic and there have been multiple legislative attempts in California and the country to restrict the use of PA for utilization review and plan oversight. LHPC has taken an opposed position on AB 3260 and argues how this bill mandates challenging time constraints for PA decisions and will significantly increase the administrative burden and costs of MCPs. LHPC is concerned that implementation of this bill will have unintended consequences such as the preemptive denial of many PA requests for plans to reach the defined timelines and avoid penalties. *Status*: AB 3260 is held under submission in the Senate Committee on Appropriations.
AB 1943: Medi-Cal: Telehealth	AB 1943 would require DHCS to track telehealth outcomes associated with patient and population health, access, quality of care, morbidity rates, and other clinical outcomes. DHCS would have to use the Medi-Cal data and other data sources to develop and publicize a report on telehealth.	Although AB 1943 will not directly impact MCPs as the majority of the administrative and research burden falls on DHCS, implementation of this bill will help foster a greater understanding surrounding telehealth, determine policy recommendations to mitigate telehealth disparities, and increase access to necessary services and care for Californians. *Status*: AB 1943 is currently held under submission in the Senate Committee on Appropriations.

Bill Title	Summary	GCHP Potential Impact(s)
AB 3275: Health Care Coverage: Claim Reimbursement	AB 3275 would require a health plan to reimburse a clean claim no later than 30 workdays after receipt of the claim and to notify the claimant within thirty days if the claim is contested or denied. This bill authorizes DMHC and CDI to determine guidance and regulation for timely implementation. There were significant amendments to this bill. Originally, AB 3275 required health plans to reimburse providers within a 15-day period. LHPC submitted a letter in April 2024, opposing the timeline and the bill's intended creation of a separate claims process for certain provider types.	There were significant amendments to this bill. Originally, AB 3275 required health plans to reimburse providers within a 15-day period and the development of a list of claim codes that must be paid within five days. LHPC submitted a letter in April 2024, opposing the timeline and the bill's intended creation of a separate claims process for certain provider types. Last minute amendments were accepted, removing the most concerning provisions (i.e., deeming a claim complete for a plan's failure to communicate to the provider a denial or contesting a claim). Several of LHPC's amendments were accepted and the bill ended in a more favorable position from where it began. *Status*: On Aug. 29, 2024, Senate amendments were accepted, and AB 3275 was passed by the Legislature.
AB 815: Health Care Coverage: Provider Credentials	Beginning Jan. 1, 2026, AB 815 directs health plans and insurers to verify health care provider qualifications within 90 days of a completed application submission. Plans must notify providers within 10 days to verify receipt of a completed application. This bill requires the California Health and Human Services Agency (CHHS) to develop and maintain a provider credentialing board and establish provider credentialing policies and procedures.	The rationale of this bill is to streamline the health care credentialing process for providers and plans. LHPC has taken an oppose position and argues that the credentialing process should remain as a responsibility of health plans. LHPC asserts that if plans rely on information provided by credentialing entities, there must be bill language that protects the plans from legal or financial penalty for non-compliance. *Status*: AB 815 is held under submission in the Senate Committee on Appropriations.

Bill Title	Summary	GCHP Potential Impact(s)
AB 1895: Public Health: Maternity Ward Closures	AB 1895 would require a hospital with an operating perinatal unit that is facing financial duress and concerns of future perinatal service reduction or closure to report on the number of deliveries, patient services, prior performance, and medical staff in the perinatal unit. Hospitals must submit this information to the Department of Health Care Access and Information (HCAI). HCAI, alongside DHCS and CDPH, will determine impacts to the community within 90 days of information receipt.	MCPs, including GCHP, recognize how maternity ward closures can worsen maternal and infant health outcomes for the most vulnerable Californians. On July 29, 2024, LHPC submitted a comment letter in support of AB 1895 and noted how there continues to be a statewide lack of access to obstetric care and services. Further, LHPC recognized how passage of this bill will allow for potential state intervention before a hospital fully closes its perinatal unit. *Status*: AB 1895 passed in the Senate and was passed by the Legislature on Aug. 30, 2024.
AB 2250: Social Determinants of Health: Screening and Outreach	AB 2250 would mandate social determinant of health (SDOH) screenings as a Medi-Cal covered benefit, instruct DHCS to reimburse for SDOH screenings, and ensure primary care physicians (PCPs) access to necessary Community Health Workers (CHW), social workers, and other SDOH care providers. Implementation of this bill is dependent upon legislative appropriation.	This bill aligns with other California Advancing and Innovating Medi-Cal (CalAIM) measures, including Population Health Management, Community Supports (CS), and Enhanced Care Management (ECM). MCPs have been highly supportive of these programs to address SDOH outcomes and most plans, including GCHP, offer the majority of CS benefits. LHPC submitted a letter in support and emphasized how making SDOH a covered benefit will better connect vulnerable members to the right care providers. *Status*: Senate amendments were accepted, and the bill was passed by the Legislature on Aug. 31, 2024.

Bill Title	Summary	GCHP Potential Impact(s)
AB 1975: Medi-Cal: Medically Supportive Food and Nutrition Interventions	Subject to federal approval and final guidance from DHCS, AB 1975 would make medically supportive food and nutrition interventions a covered Medi-Cal benefit through both the fee-for-service and managed care delivery systems beginning July 1, 2026. DHCS must determine the definitions of medically supportive food and nutrition interventions and ensure they are aligned with federal dietary guidelines.	GCHP currently offers medically supportive food for individuals that have recently been hospitalized for diabetes or congestive heart failure-related reasons within the past 30 days. This bill would require GCHP to provide medically supportive food and nutrition interventions for up to 12 weeks if found medically necessary for a member. On July 29, 2024, LHPC submitted a letter in support and highlighted how nutrition interventions will improve health outcomes, especially for those with chronic illnesses, reduce long-term health care spending, and decrease health disparities for members. *Status*: Senate amendments were accepted, and AB 1975 was passed by the Legislature on Aug. 29, 2024.
AB 2703: Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs): Psychological Associates	Existing law limits the ability of FQHCs and RHCs to receive reimbursement for services that are provided by psychological associates. AB 2703 would add encounters with licensed professional clinical counselors as a billable visit and also requires DHCS to attain any necessary federal approval.	Health plans are ardent supporters of expanding the behavioral health continuum of care and protecting the most vulnerable members. Currently, MCPs, including GCHP, provide free mental health assessments for members and cover outpatient mental health services for mild to moderate mental health conditions. As outlined in LHPC's letter of support, allowing FQHCs and RHCs to bill for psychological associates will improve timely access for members to mental and behavioral health providers and services. *Status*: AB 2703 was ordered to a Senate special consent calendar on Aug. 26, 2024, and subsequently passed by the legislature.

Bill Title	Summary	GCHP Potential Impact(s)
AB 2860: Licensed Physicians and Dentists from Mexico Programs	AB 2860 expands the Licensed Physicians and Dentists from Mexico pilot program. This bill updates the required curriculum for the physician program, ensures fees charged to the participants are in accordance with fees charged to other licensed California physicians, requires individuals to verify a certain pass rate on the Occupational English Test or a similar evaluation, amends the fee schedule for participants, and increases the number of eligible physicians every four years.	Throughout the country as well as in California, there is a current provider shortage. MCPs are acutely aware of this concern as providers are central for member access to equitable and timely care. LHPC submitted a letter in support and noted how expansion of this pilot program will increase the number of culturally and linguistically competent providers in the state and help mitigate the physician shortage especially in underserved communities. *Status*: On Aug. 27, 2024, Senate amendments were accepted, and AB 2860 passed by the Legislature and sent to the governor on Sept. 5, 2024.
SB 516: Health Care Coverage: Prior Authorization (PA)	SB 516 mandates DMHC and CDI to instruct and create a standard reporting template for health plans and insurers to report specific information surrounding covered services, supplies, and other health care items that are subject to PA by July 1, 2025. Health plans are required to report this information to CDI and/or DMHC by Dec. 31, 2025, and the state must publicize covered health care services, items, and supplies that require PA, the approval percentage rate, and all other relevant data surrounding PA determinations and processes.	There have been extensive changes to this bill. Originally, SB 516 instituted an iteration of “gold carding” and removed the authority of a health care plan or insurer from requiring a contracted provider to acquire PA for covered services if the plan or insurer approved or would have approved a minimum of 90% of all PA requests in the last one-year contract period. If enacted, the bill aims to improve the PA process and timely access to care by increasing transparency. The California Association of Health Plans (CAHP) has an “oppose-unless-amended” position and asserts how SB 516 should be limited to in-network providers and delineate the plan process to appeal the decision to remove certain services, items, and/or supplies. *Status*: SB 516 is currently in the Assembly Committee on Health.

Bill Title	Summary	GCHP Potential Impact(s)
SB 1120: Health Care Coverage: Utilization Review	SB 1120 would require that health plans follow certain requirements when utilizing artificial intelligence (AI) and other types of software tools for utilization management. The bill would mandate that all AI and software tools be equitably applied, openly inspected, based upon individual clinical circumstances and enrollee medical history, not engage in discriminatory practices, and be governed by accountability and reliability policies.	AI is a growing concern in the health care industry. Discussions have been ongoing at the state and federal levels for how to utilize AI and reduce administrative workloads for providers, enrollees, and plans. LHPC did express initial concerns surrounding claims that are denied for medical necessity. The bill language was later amended and now requires the denial, delay, or modification of health care services as related to medical necessity be conducted by a health care provider or physician. *Status*: SB 1120 was passed by the Legislature and sent to the Governor.
SB 953: Medi-Cal: Menstrual Products	SB 953 would add the coverage of menstrual products as a Medi-Cal benefit and requires DHCS to seek and garner federal approvals and use federal funds to implement this new benefit.	There are a variety of Medi-Cal services that are covered for Medi-Cal enrollees and GCHP members, including violence prevention services, diabetic testing supplies, certain nutrition products, and in-home medical care services. This bill will expand the list of Medi-Cal covered services and help low-income, vulnerable populations have access to necessary medical supplies. *Status*: SB 953 is held under submission in the Senate Committee on Appropriations.

E. Community Relations: Sponsorships

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

Organization	Description	Amount
Santa Paula Latino Town Hall	The Santa Paula Latino Town Hall is a nonprofit organization dedicated to working to enhance, promote, mobilize, cultivate, and raise the level of social awareness in Ventura County. The sponsorship supported the "27th Annual Awards Dinner" fundraising event, which provides youth scholarships, career educational seminars, and youth leadership conferences.	$5,000
Oxnard Police Activities League, Inc. (PAL)	The mission of PAL is to build positive relationships between youth, police officers, and the community. The sponsorship will help fund programs and resources for low-income children in the City of Oxnard.	$3,000
Port of Hueneme Banana Festival	The Port of Hueneme's Banana Festival provides educational programs and resources for the community. The funding will go toward providing free services to Ventura County residents.	$1,500
Food Share of Ventura County	Food Share is dedicated to leading the fight against hunger in Ventura County. The sponsorship will go toward the "3rd Annual Fed Up Shindig" event. Proceeds from the event will help fed more than 190,000 people.	$1,500
Help of Ojai	The mission of Help of Ojai is to combine community and individual resources to respond to the unmet needs of individuals in the Ojai Valley. Help of Ojai will be celebrating more than five decades dedicated to making a difference in the Ojai Valley. The sponsorship will support their three main areas of focus: health care, nutritious food, and sustainable housing support.	$1,000
TOTAL		**$12,000**

F. Community Relations: Community Meetings and Events

From Aug. 10 to Sept. 8, the Community Relations Team provided information about GCHP's benefits and services at 13 community events. The purpose of these events is to connect with members and community partners, raise awareness about benefits and services, and connect members with care.

Food Distributions	
GCHP's Community Relations Team attended the following food distributions to answer questions, provide resources, and promote health care initiatives.	
Organization	**Date**
Westminster backpack and food distribution	Aug. 13,2024
Sacred Hearts	Aug. 14, 2024
Samaritan Center	Aug. 16, 2024
New Creations Church	Aug. 21, 2024
School Screenings & Kindergarten Oral Health Assessment	Aug. 21, 2024
Salvation Army	Aug. 27, 2024
Help of Ojai	Aug. 28, 2024
Collaborative Meetings	
Collaborative meetings allow community-based organizations to share resources, announcements, and upcoming community events.	
Oxnard PD Outreach Coordinators	Sept. 4, 2024
Circle of Care Community Collaborative	Sept. 4, 2024
Strengthening Families Collaborative	Sept. 4, 2024

Community Events	
Community events offer an opportunity to engage with GCHP members and the community at large. Participants learned about community resources and GCHP benefits and services.	
Swap Meet Justice	Aug. 25, 2024
Blackstock Junior High: Back-to-School Resource Fair	Sept. 5, 2024
Promotoras y Promotores: Ventura Market Resource Fair	Sept. 7, 2024

G. Community Relations: Speakers Bureau

Location	Description	Date
Camarillo Public Library	GCHP's Health Education Department provided two workshops, in English and Spanish, to GCHP members and the community at large on men's health. The presentation included information about the importance of routine health exams, screenings, vaccines, and healthy habits.	Aug. 22, 2024

II. PLAN OPERATIONS

A. Membership

	VCMC	CLINICAS	CMH	DIGNITY	PCP-OTHER	ADMIN MEMBERS	NOT ASSIGNED
Aug-24	95,846	53,150	33,816	6,894	4,890	47,863	3,241
Jul-24	95,090	52,679	33,841	6,999	5,991	47,682	4,710
Jun-24	96,738	53,128	34,234	7,075	4,940	48,058	3,004

NOTE:

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

Administrative Member Details

Category	Aug. 2024
Total Administrative Members	47,863
Share of Cost (SOC)	618
Long-Term Care (LTC)	717
Breast and Cervical Cancer Treatment Program (BCCTP)	21
Hospice (REST-SVS)	30
Out of Area (Not in Ventura County)	432
DUALS (A, AB, ABD, AD, B, BD)	26,903
Commercial Other Health Insurance (OHI) (Removing Medicare, Medicare Retro Billing, and Null)	22,149

NOTE:

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

METHODOLOGY

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

1. Share of Cost (SOC-AMT) > zeros
    a. AID Code is not 6G, 0P, 0R, 0E, 0U, H5, T1, T3, R1 or 5L
2. LTC members identified by AID codes 13, 23, and 63.
3. BCCTP members identified by AID codes 0M, 0N,0P, and 0W.
4. Hospice members identified by the flag (REST-SVS) with values of 900, 901, 910, 911, 920, 921, 930, or 931.
5. Out of Area members were identified by the following zip codes:
    a. Ventura Zip Codes include: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93000-12, 93015-16, 93020-24, 93030-36, 93040-44, 93060-66, 93094, 93099, 93225, 93252
    b. If no residential address, the mailing address is used for this determination.
6. Other commercial insurance was identified by a current record of commercial insurance for the member.

B. Provider Contracting Update

Provider Network Contracting Initiatives

Provider Network Operations (PNO)

Regulatory / Audit Updates

The state Department of Health Care Services (DHCS) implemented provider network readiness assessments which are used to monitor a Managed Care Plan's (MCP's) network for newly launched covered services, initiatives, or programs. PNO submitted deliverables for the Memorandum of Understanding (MOU) Report Template and contributed to the Community Health Worker (CHW) Report Template.

Additionally, PNO submitted responses to DHCS for the DHCS and Mercer Value-Based Payment (VBP) Supplemental Data Request (SDR) report. The VBP SDR collects data from MCPs for Calendar Year (CY) 2023. Along with other internal stakeholders, such as the Quality Improvement and Finance departments, PNO submitted responses based on our current VBP arrangements that include capitation and quality, as well as our intentions for evaluating provider partners on development of future state VBP arrangements with a focus on quality and risk.

Operations of the Future

PNO continues to outreach to and train providers on the new Provider Portal and to address any escalated issues. The portal currently has more than 3,390 registered users.

PNO is upgrading and enhancing its Provider Contracting and Credentialing Management (PCCM) system, sPayer. These improvements will enable GCHP to capture additional provider demographic information for inclusion in both printed and web-based provider directories, ensuring compliance with NCQA accreditation requirements. The updates are scheduled to take place Sept. – Oct. 2024.

Provider Network Developments: Aug. 1-31, 2024

Network Developments for New Contracts	
Provider Additions Fulfilling Network Gaps	**Count**
Home Health	2
Durable Medical Equipment (DME)	1
Orthotic and Prosthetic	1

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

GCHP Provider Changes	
Provider Additions and Terminations	**Count**
Additions	143
Terminations	55
Midwife	0

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

GCHP Provider Network Additions and Total Counts by Provider Type			
Provider Type	**Network Additions**		**Total Counts**
	June-24	**July-24**	
Hospitals	**0**	**0**	**25**
Acute Care	0	0	19
Long-Term Acute Care (LTAC)	0	0	1
Tertiary	0	0	5
Providers	**78**	**49**	**7,898**
Primary Care Providers (PCPs) & Mid-levels	7	5	522
Specialists	36	43	6,587
Hospitalists	35	1	789
Ancillary	**2**	**7**	**620**
Ambulatory Surgery Center (ASC)	0	0	8
Community-Based Adult Services (CBAS)	0	0	14
Durable Medical Equipment (DME)	0	1	99
Home Health	0	0	28
Hospice	0	0	22
Laboratory	0	0	40
Optometry	0	2	102
Occupational Therapy (OT) / Physical Therapy (PT) / Speech Therapy (ST)	2	4	160
Radiology / Imaging	0	0	64
Skilled Nursing Facility (SNF) / Long-Term Care (LTC) / Congregate Living Facility (CLF) / Intermediate Care Facility (ICF)	0	0	83
Behavioral Health	**62**	**0**	**539**
CalAIM and Non-Traditional Providers	**18**	**5**	**34**
Enhanced Care Management (ECM)	1	0	6
Community Supports (CS)	15	4	25
Community Health Worker (CHW)	2	1	3

C. Delegation Oversight

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

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

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

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

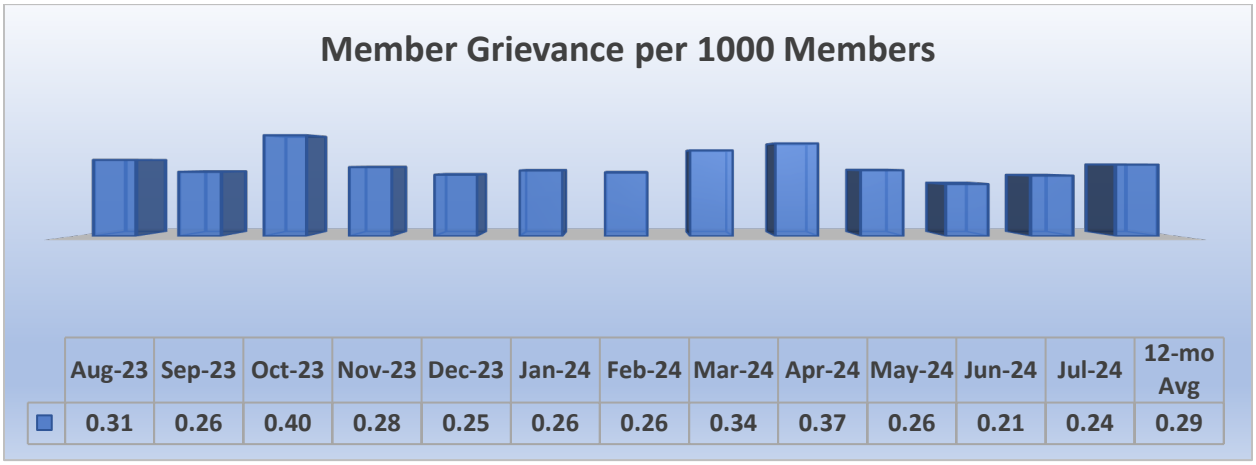
The following table includes audits and CAPs that are open and closed. Closed audits are removed after they are reported to the Commission. The table reflects changes in activity through Aug. 31, 2024.

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Clinicas del Camino Real (CDCR)	2024 Q3 Utilization Management (UM) Audit	Closed	7/22/2024	8/30/2024	N/A
CDCR	2023 Q4 Focused Claim Audit	Open	3/8/2024	Under CAP	N/A
CDCR	2023 Annual Claims Audit	Open	2/8/2024	Under CAP	N/A

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
CDCR	2023 Quarterly Focused Claim Audit (July)	Open	9/7/2023	Under CAP	N/A
CDCR	2024 Q1 Focused Claim Audit	Closed	4/5/2024	8/5/2024	N/A
Ventura County Medical Center (VCMC)	2024 Annual Credentialing & Recredentialing	Open	8/27/2024	Under CAP	N/A
VSP	2024 Annual Quality Improvement (QI) & Cultural & Linguistic (C&L) Audit	Closed	7/1/2024	8/21/2024	N/A
Ventura Transit System (VTS)	2024 Annual Call Center Audit	Open	4/19/2024	Under CAP	N/A
VTS	2024 Driver Credentialing Audit	Closed	5/23/2024	8/16/2024	N/A
VTS	2024 Downstream Subcontractor Audit	Open	8/30/2024	Under CAP	N/A

Privacy & Security CAPs					
Delegate	**CAP Type**	**Status**	**Date CAP Issued**	**Date CAP Closed**	**Notes**
N/A	N/A	N/A	N/A	N/A	N/A
Operational CAPs					
Delegate	**CAP Type**	**Status**	**Date CAP Issued**	**Date CAP Closed**	**Notes**
N/A	N/A	N/A	N/A	N/A	N/A

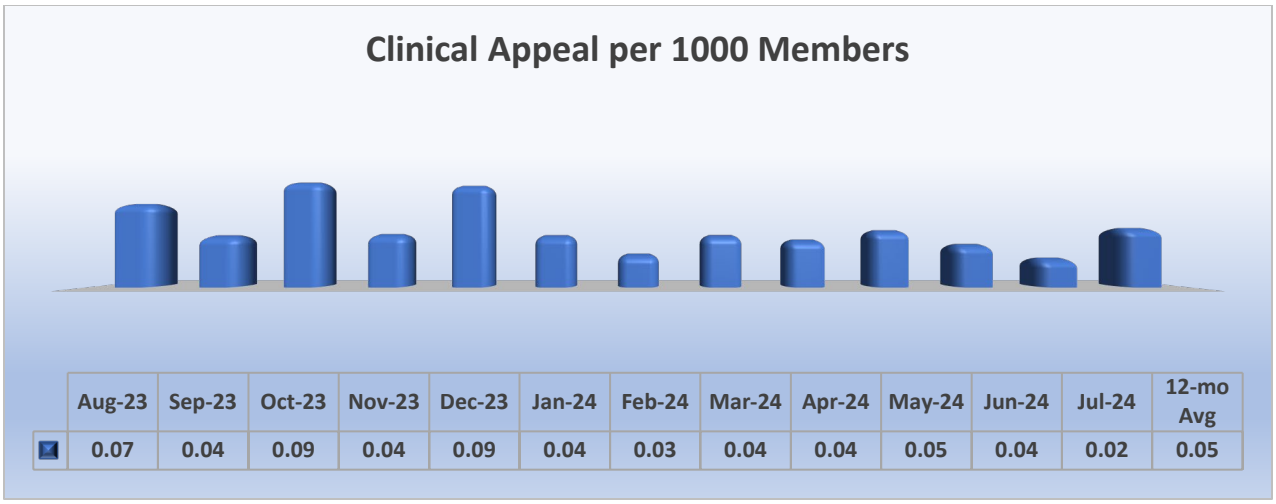
D. Grievance and Appeals



Member Grievances per 1,000 Members

The data show GCHP's volume of grievances increased in July. In July, GCHP received 60 member grievances. Overall, the volume is still relatively low, compared to the number of enrolled members. The 12-month average of enrolled members is 249,027, with an average annual grievance rate of .29 grievances per 1,000 members.

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



	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	12-mo Avg
	0.07	0.04	0.09	0.04	0.09	0.04	0.03	0.04	0.04	0.05	0.04	0.02	0.05

Clinical Appeals per 1,000 Members

The data comparison volume is based on the 12-month average of .05 appeals per 1,000 members.

In July 2024, GCHP received six clinical appeals.

RECOMMENDATION:

Receive and file.

AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: James Cruz, MD, Acting Chief Medical Officer

DATE: September 23, 2024

SUBJECT: Chief Medical Officer (CMO) Report

CMO COMMISSION REPORT - September 2024

Measurement Year (MY) 2024 Managed Care Accountability Set (MCAS) Update
Throughout Gold Coast Health Plan (GCHP), quality improvement activities are in progress to sustain the gains achieved in Measurement Year 2023 and to continue to improve quality outcomes performance in 2024. To continue building on GCHP's goal of making an even greater impact on ensuring members receive recommended screenings and preventive services, GCHP has established the following Measurement Year 2024 (MY 2024) measure targets:

- Meet the High Performance Level (HPL) or 90th percentile for 6 measures
  - Timely Prenatal Care (PPC-Pre)
  - Postpartum Care (PPC-Post)
  - Cervical Cancer Screening (CCS)
  - Breast Cancer Screening (BCS)
  - Glycemic Status Assessment for Patients with Diabetes (GSD) - formerly HBD
  - Lead Screening in Children (LSC)
- Achieve the 75th percentile for 4 measures
  - Childhood Immunization Status – Combination 10 (CIS-10)
  - Immunizations for Adolescents – Combination 2 (IMA -2)
  - Well Child Visits in the First 30 Months of Life – 2 or more visits (W30 - 2+)
  - Chlamydia Screening (CHL)
- Exceed the Minimum Performance Level (MPL) or 50th percentile for the remaining 8 measures held to MPL

As of the July rate reporting, reflecting care rendered through June, three measures are currently at the 75th percentile: Postpartum Care (PPC-Post), Lead Screening in Children (LSC), and Well Child Visits in the First 30 Months of Life W30 - 2+). Breast Cancer Screening (BCS), Prenatal Care (PPC-Pre), Immunizations for Adolescents (IMA -2), and Developmental Screenings in the First Three Years of Life (DEV) are currently at the MPL. While most measures are on track to meet or exceed targets, three measures are at risk for falling below MPL:

- Follow-up after an ED visit for Substance Use Disorder within 30 days (FUA)
- Follow-up after an ED visit for Mental Illness within 30 days (FUM)
- Asthma Medication Ratio (AMR)

Several workgroups are focused on improving these metrics through collaborative efforts with our provider network. FUA and AMR have been added as new core measures to the Quality Incentive Pool and Program (QIPP).

Due to Operations of the Future initiatives and focus, the August rate refresh has been delayed. Both Information Technology (IT) and Quality Improvement (QI) teams have been completing robust data validation activities to ensure the data included for August reporting is complete and accurate. August rates reflecting care rendered through the end of July are expected in mid-September.

Data improvement activities focused on updated data mapping, refinement of provider data submissions, and enhancement of data capture from outside sources such as the California

Immunization Registry (CAIR) continue to progress. While data improvement activities are a year-round activity, currently identified data improvements are on track for completion prior to MY 2024 MCAS reporting in 2025.

National Committee for Quality Assurance Accreditation (NCQA) Project Update
Gold Coast Health Plan (GCHP) continues to prepare to achieve NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA) by January 2026, as mandated under CalAIM. The HEA survey start date is scheduled for June 10, 2025. A survey start date for HPA is pending. The HPA application will be submitted in Q4 2024 with a requested start date in September 2025.

In preparation for the 2025 surveys, the NCQA project team is organizing mock surveys with our contracted NCQA consultants, The Mihalik Group (TMG), and business owners across the organization. The HEA mock survey is scheduled from mid-September through mid-October. The HPA mock survey will be scheduled from early-October through mid-November. The mock surveys serve as a midway readiness assessment to evaluate our current compliance with NCQA standards, identify remaining gaps, and develop plans to remediate those gaps.

GCHP will undergo Health Equity Accreditation under the 2024 NCQA standards, and Health Plan Accreditation under the 2025 NCQA standards. The 2025 HPA Standards & Guidelines were released in late-August by NCQA. TMG will conduct a training for GCHP in early-October to review the changes and recommendations for incorporating the new 2025 requirements into our current HPA workplan. NCQA does not plan to release 2025 HEA Standards, as there are no changes from the 2024 version.

High-level risks currently within focus include Health Equity Accreditation outstanding policies and reports, updates to the Provider Directory, and completion of delegation agreement revisions.

Additional team members are being assigned to complete Heath Equity outstanding work items that were delayed as teams supported the new system implementations in July and August. The Provider Directory is on track for completion in October and expected to be in production in November. The NCQA team is working with Best Best & Krieger (BBK), Provider Network Operations, and Procurement on addressing delegation agreement gaps. Teams are also working with Compliance and Operations Oversight to establish a standardized mechanism for conducting oversight of NCQA delegates' reporting, per NCQA requirements. The team continues to closely monitor all risks and issues and escalate barriers to leadership, as appropriate.

Below is the current performance by Standard Category, as of 8/23/24.

Accreditation	Standard Category	Total Points Possible	Current Points	Percent
Health Plan Accreditation	Credentialing and Re-credentialing (CR)	20	16	80.00%
	Member Experience (ME)	28	12	42.86%
	Network Management (NET)	29	8.5	29.31%
	Population Health Management (PHM)	23	9	39.13%
	Utilization Management (UM)	47	9	19.15%
	Quality Improvement (QI)	15	8	53.33%
Health Equity Accreditation	Health Equity (HE)	27	3	11.11%

To earn Accreditation, GCHP must meet **at least 80%** of applicable points in each standards category.

Below is a high-level timeline for the NCQA accreditation journey.

Aug – Dec 2022	Jan – Jun 2023	Jul – Dec 2023	Jan – Jun 2024	Jul – Dec 2024	Jan – Jun 2025	Jun – Sept 2025	Jan 2026
☑ Aug – Engaged TMG & kicked off NCQA Accreditation project ☑ Nov – Completed 1st HPA readiness assessment	☑ Jan – Received HPA Readiness Report & began gap remediation ☑ Jan – Completed 1st HEA readiness assessment	☑ July – Dec Continued HPA and HEA gap remediation with bi-weekly workgroup sessions	☑ Continue HPA and HEA gap remediation with bi-weekly workgroup sessions and TMG working sessions	☑ 7/1/24 Systems Go-Live ❑ Conduct HEA mock survey from Sept - Oct ❑ Conduct HPA mock survey from Oct - Nov	❑ All systems in production by 1/1/25 ❑Compile reports and finalize evidence	❑ Submit HEA Survey Tool in June 2025 ❑ Submit HPA Survey Tool in Sept 2025 ❑ NCQA to review GCHP submissions	❑ NCQA HPA & HEA achieved, as required under CalAIM

Milestone

Quality Incentive Pool and Program (QIPP) Update

Gold Coast Health Plan (GCHP) has completed the first measurement year (MY) in the Quality Incentive Pool and Program (QIPP).

The QIPP is a multi-year initiative for improvement in quality performance measures included in the Managed Care Accountability Set (MCAS) for measures held to the minimum performance level (MPL) by the Department of Health Care Services (DHCS).

GCHP designed the QIPP in alignment with provider partners to improve quality scores through pioneering quality incentive funding and supporting innovative member engagement programs and interventions focused on providing comprehensive high quality health care to members.

QIPP is a collaborative partnership between the plan and network providers, requiring operational integration activities such as leadership and operational meetings, quarterly and annual provider work plan submissions including quality improvement activities to GCHP, and data sharing activities.

For participating Health Systems (large integrated medical groups) in MY 2023, the QIPP included five core measures and five optional measures to be chosen by the Health System. The optional measures were chosen from any measure within the MCAS held to the DHCS-established MPL, not already included in the core measures.

Quality performance in the QIPP was measured using final audited MCAS performance rates for MY 2023, with MY 2022 serving as the baseline.

QIPP MY 2023 participating Health Systems included the following:

- Ventura County Health Care Agency
- Clinicas del Camino Real
- Community Memorial Health

With the partnership and collaboration of participating Health Systems through QIPP, the below MCAS measures had significant MY 2023 performance improvements for GCHP:

Measure Acronym	MCAS Measures Held to Minimum Performance Level (MPL)	MY2022 GCHP %ile Rank	MY2023 GCHP %ile Rank
WCV*	Child and Adolescent Well-Care Visits	10th	50th
W30-6+*	Well-Child Visits in the First 30 Months of Life: 6 Well-Child Visits in the First 15 Months of Life	10th	50th
W30-2+*	Well-Child Visits in the First 30 Month of Life: 2 Well-Child Visits Between 15 to 30 Months of Life	50th	75th
CHL*	Chlamydia Screening in Women	25th	75th
HBD	Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (> 9%)	75th	90th
IMA-2	Immunizations of Adolescents: Combination 2	50th	75th

*QIPP Core measure

For participating Health Systems in MY 2024, the QIPP includes seven core measures and seven optional measures to be chosen by the Health System. The optional measures can be chosen from any measure within the MCAS held to the DHCS-established MPL, not already included in the core measures.

QIPP MY 2024 Core Measures include the following:

- Well-Child Visits for Children 0-15 months – 6+ (W30-6+)
- Well-Child Visits for Children 15-30 months – 2+ (W30-2+)
- Child and Adolescent Well Care Visits (WCV)
- Chlamydia Screening in Women (CHL)
- Cervical Cancer Screening (CCS)
- Asthma Medication Ratio (AMR) - *New Core Measure for MY 2024*
- Follow-up after an Emergency Department Visit for Substance Use Disorder – 30 days (FUA -30) - *New Core Measure for MY 2024*

For participating independent providers, the QIPP includes two to four core measures. There are two required core measures for all independent providers within the program:

- Child and Adolescent Well Care Visits (WCV)
- Topical Fluoride for Children (TFL)

There are additional core measures in each independent provider's core measure set determined by both GCHP and the individual provider practice.

SR. MEDICAL DIRECTOR UPDATE

a. Considerable progress continues to identify a Pharmacy Benefit Manager (PMB) for GCHP to contract with for the Dual Eligible Special Needs Plan (D-SNP) line of business. A more complete summary of these activities will be presented as part of Ms. Eve Gelb's D-SNP overview presentation to the Commission.

b. Health Services preparation for the Department of Health Services (DHCS) routine audit scheduled 9/23/24-10/4/24 continues. Utilization Management (UM) preparation work includes review of member files pulled for DHCS review. The Sr. Medical Director is working closely with the UM Sr. Director to prepare GCHP's narrative to DHCS, and address risks identified.

c. From a compliance standpoint, GCHP has maintained Member Grievance Turn Around Time compliance standards. GCHP's Sr. Medical Director is working closely with the grievance review nurses to ensure timely resolution of member grievances.

d. Oversight of pharmacy services is a key activity. The GCHP Sr. Medical Director is working closely with Health Services' interim Pharmacy Director, Ms. Yoonhee Kim, PharmD, APh, to prepare the quarterly Pharmacy and Therapeutics Committee agenda. Additionally, GCHP's Sr. Medical Director closely supports the interim Pharmacy Director's role in evaluating the PBM Request for Proposal (RFP) applicants, and the PBM applicant's proposed contract terms and implementation plan.

UTILIZATION MANAGEMENT

Utilization Management continues to work in a highly aligned and focused way to maintain regulatory compliance. Our new medical management software (MMS), TruCare, went live 7/1/2024. Staff are fully trained and processing authorization requests within regulatory timeframes.

We are continuing preparation for the California Department of Health Services (DHCS) annual medical Audit. Preparation work includes review of all member files submitted to DHCS for review and addressing any risks identified.
Overall, Utilization Management remains dedicated to enhancing our daily operations to improve member access to essential medical care and reduce administrative burdens for our network providers.

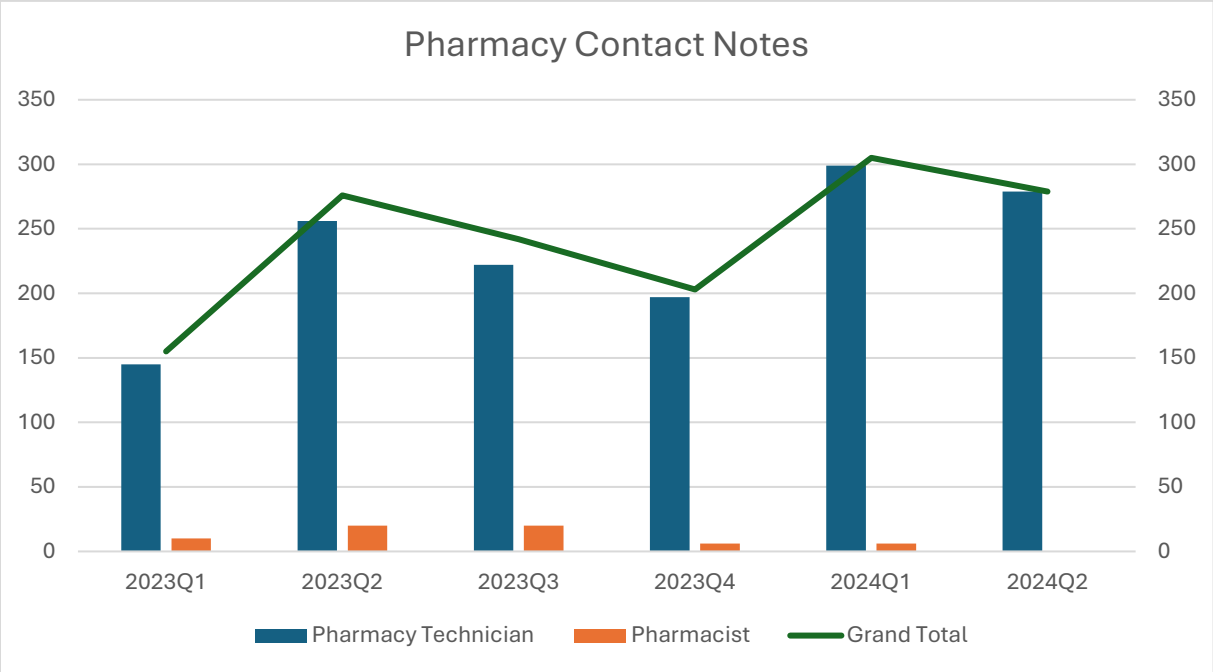
PHARMACY SERVICES

GCHP Pharmacy Services Department has been monitoring and assisting members who need assistance with processing their prescriptions, understanding the limitations or

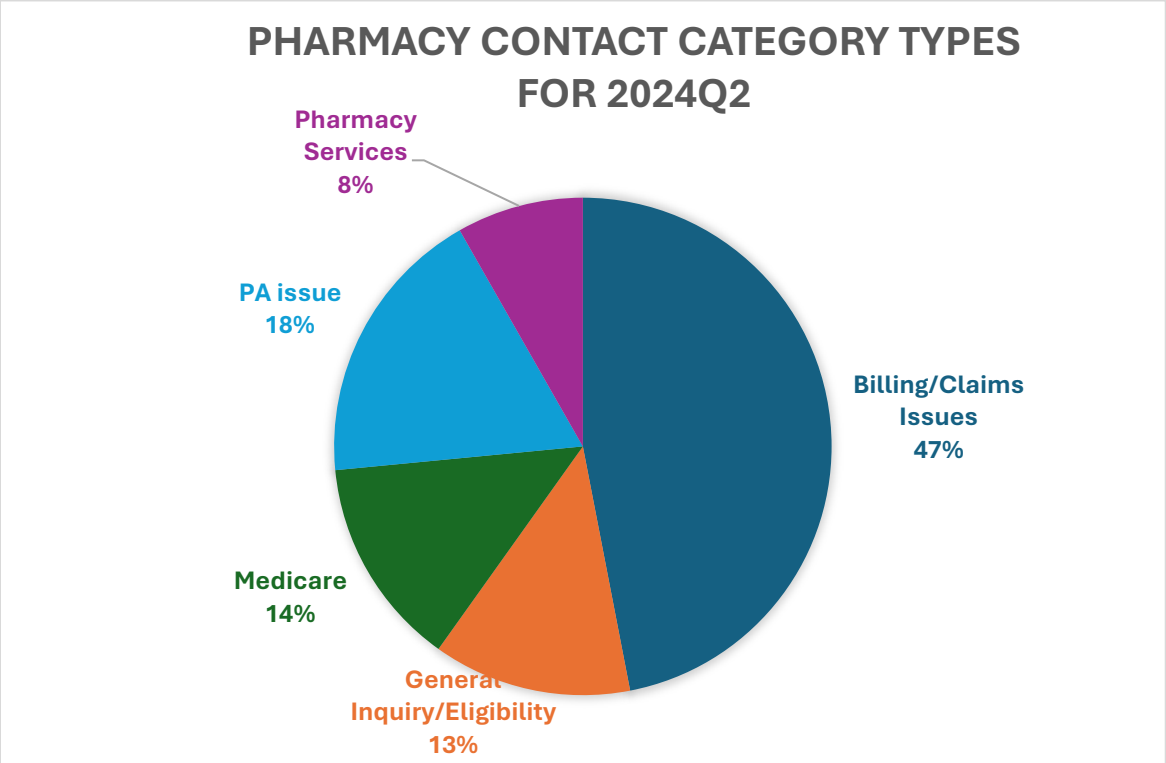
restrictions based on the coverage criteria by Medi-Cal Rx, and facilitating communication between the members and the pharmacies/providers. We are still answering questions about the Medi-Cal Rx benefit and collaborating with Care Management and Utilization Management to assist our members with getting access to what they need.

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

Starting in 2023, the Pharmacy Services Department started to capture the number of pharmacy calls, questions, issues that have been coming through from Conduent, GCHP staff, or providers/pharmacies/members. It's not an all-inclusive list. The information is being tracked in MHK (when we have the member ID information) and captured in the graph below (current as of 6/30/2024). Effective July 1, 2024, after transition to Trucare, we are now tracking and documenting in Trucare.



User ID	2023Q1	2023Q2	2023Q3	2023Q4	2024Q1	2024Q2	Grand Total
Pharmacy Technician	145	256	222	197	299	279	1398
Pharmacist	10	20	20	6	6	0	62
Grand Total	155	276	242	203	305	279	1460



Category	Total
Billing/Claims Issues	131
General Inquiry/Eligibility	36
Medicare	38
PA issue	51
Pharmacy Services	23
Grand Total	279

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA):

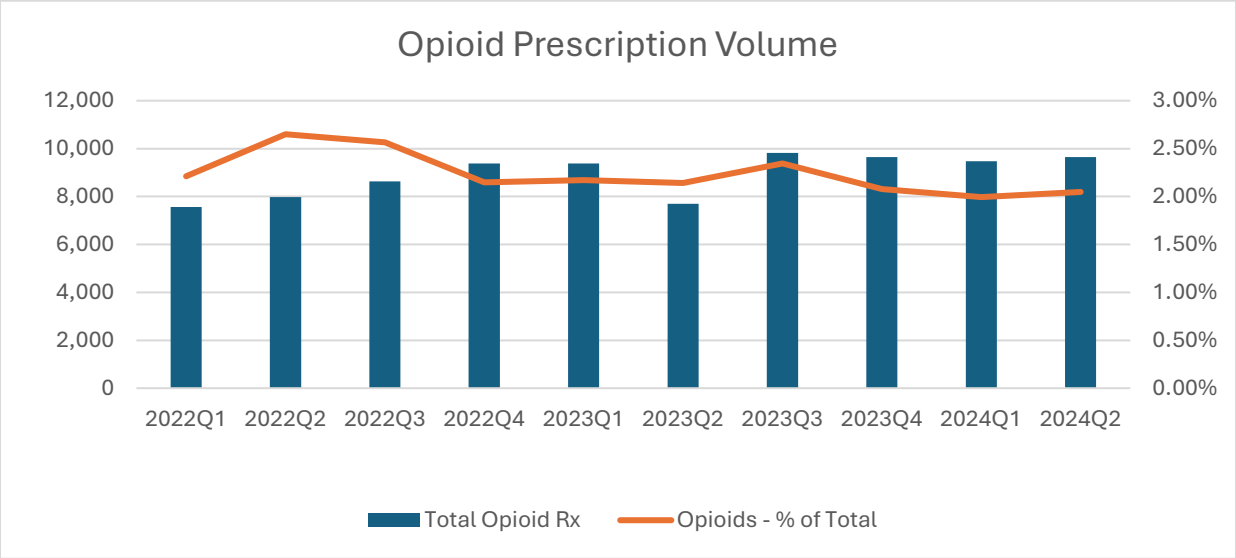
Pharmacy Services Department has developed policies and procedures for pharmaceutical management to prepare Gold Coast Health Plan for NCQA accreditation. We have been reviewing and updating the physician administered drug list and authorization process in our quarterly Pharmacy and Therapeutics (P&T) Committee meetings on May 16, 2024, August 15, 2024, and will continue to do so at our future meetings. Our next P&T meeting is scheduled for November 14, 2024.

OPIOID DASHBOARD:

As of November 2022, Medi-Cal Rx has provided access to an opioid dashboard for managed care plans. The total opioid prescription utilization remains stable at around 2%. We are seeing a downward trend in the number of members who are using more than 3 pharmacies (43 to 23, 46.5% decrease), number of concurrent opioid and benzodiazepine users (223 to

219, 1.8% decrease), and number of concurrent utilizers of opioids and antipsychotics (353 to 334, 5.4% decrease). We also see a slight upward trend in the number of members with high opioid dose (or opioid dose greater than 90 morphine equivalent dose) (117 to 127, 8.5% increase). We will continue to monitor closely to look for any unusual trends or patterns.

Summary of Opioid Utilization Based on Pharmacy Claims from CY2022-2024Q2



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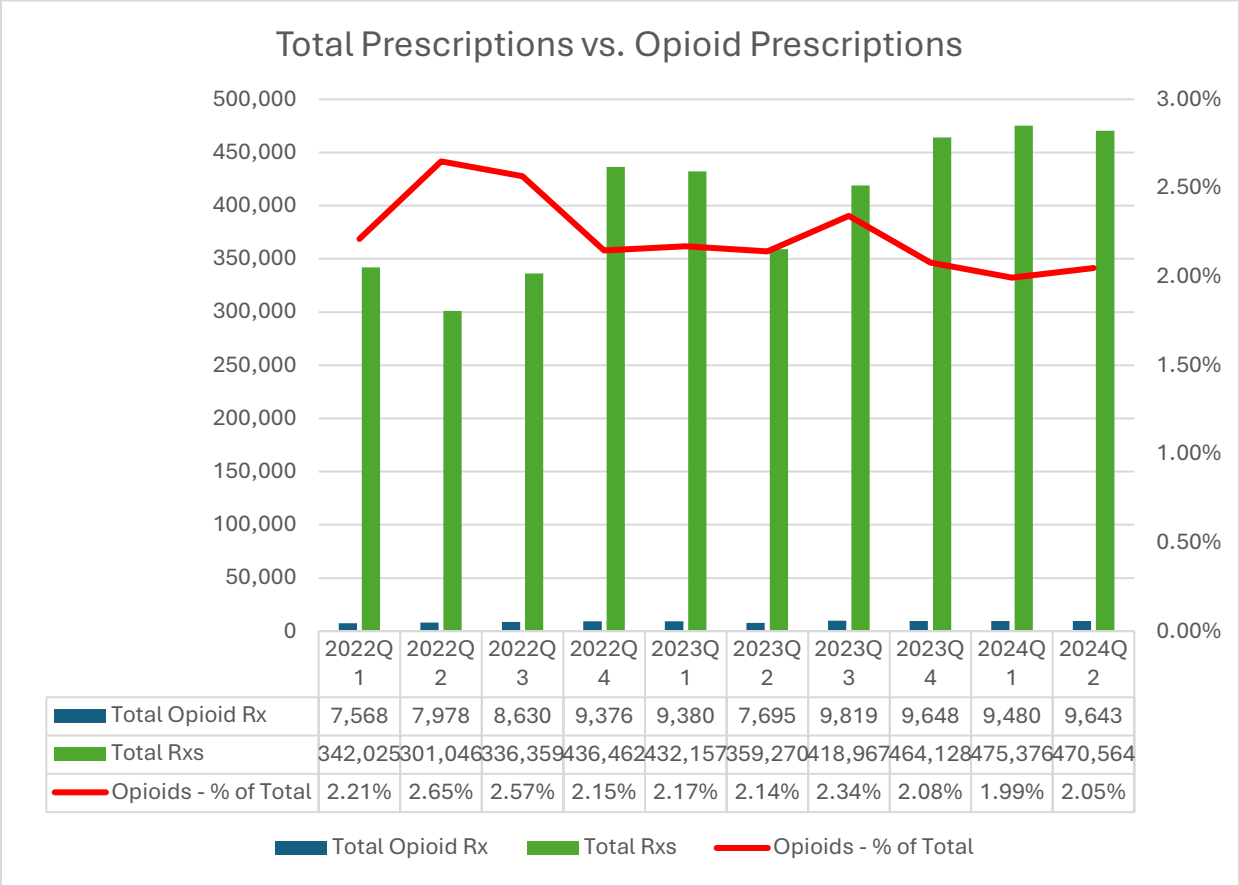
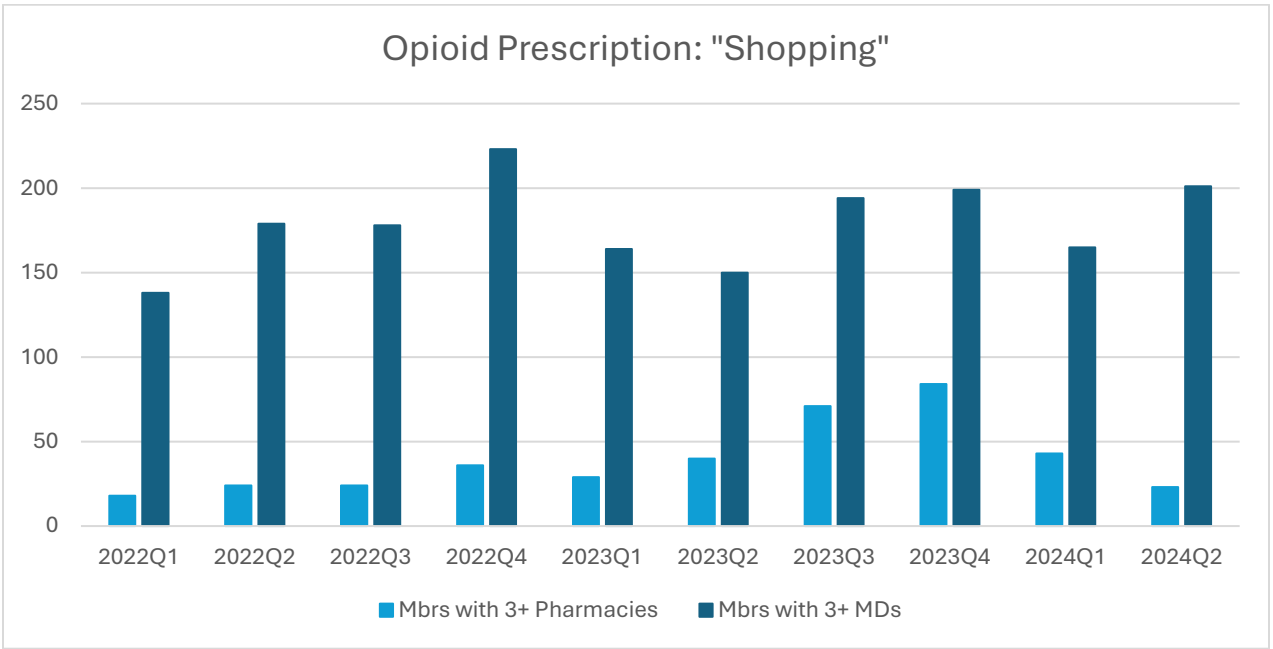
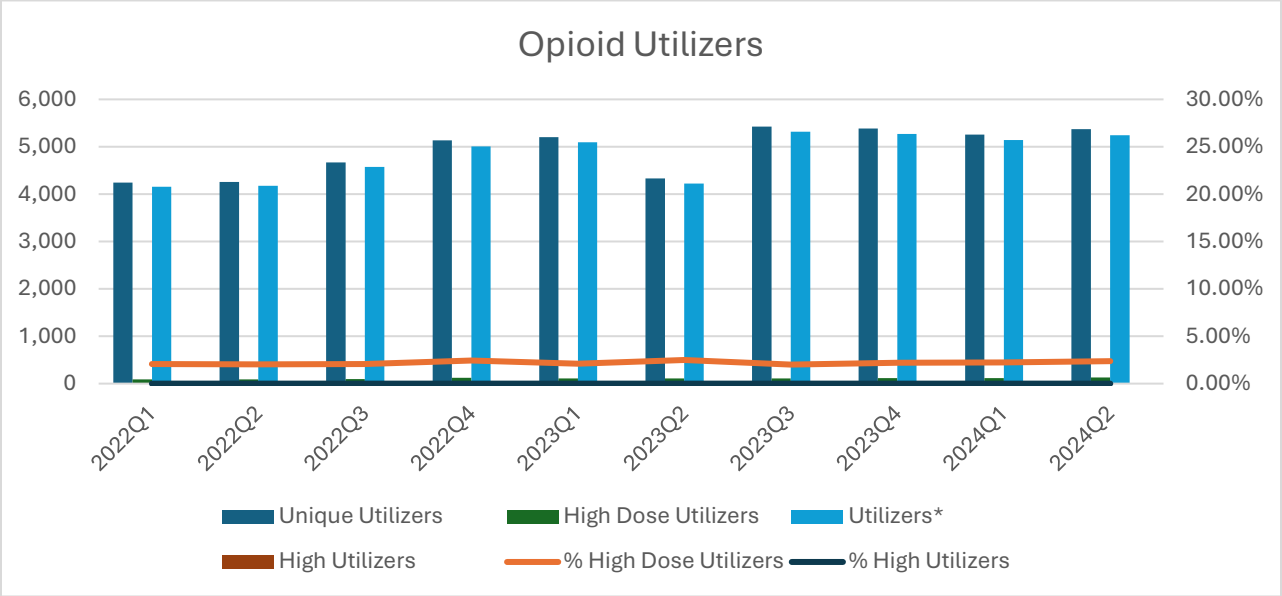
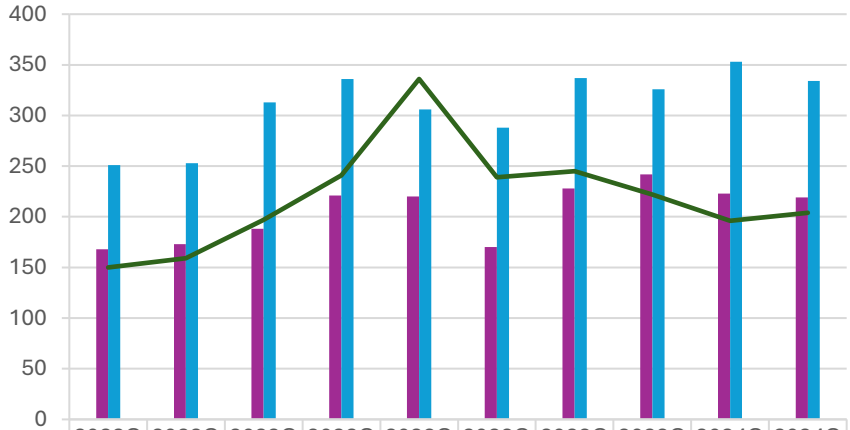


	2022Q1	2022Q2	2022Q3	2022Q4	2023Q1	2023Q2	2023Q3	2023Q4	2024Q1	2024Q2
Total Opioid Rx	7,568	7,978	8,630	9,376	9,380	7,695	9,819	9,648	9,480	9,643
Total Rxs	342,025	301,046	336,359	436,462	432,157	359,270	418,967	464,128	475,376	470,564
Opioids - % of Total	2.21%	2.65%	2.57%	2.15%	2.17%	2.14%	2.34%	2.08%	1.99%	2.05%





CONCURRENT UTILIZATION



	2022Q1	2022Q2	2022Q3	2022Q4	2023Q1	2023Q2	2023Q3	2023Q4	2024Q1	2024Q2
Concurrent utilizers of opioids and benzodiazepines	168	173	188	221	220	170	228	242	223	219
Concurrent utilizers of opioids and antipsychotics	251	253	313	336	306	288	337	326	353	334
Concurrent utilizers of opioids and naloxone	150	159	197	241	336	239	245	222	196	204

AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: September 23, 2024

SUBJECT: Human Resources (H.R.) Report

Human Resources Activities

Since the start of the new fiscal year, the Human Resource Team has focused on the following:

1. Staff engagement
2. Acquiring and retaining talent
3. Year-end Performance Management and Rewards

Staff engagement: With the recent appointment of Dr. Felix Nunez as Acting Chief Executive Officer (CEO), several staff meetings have been held to check-in with staff about the change and address any questions / concerns and provide support where needed. Overall feedback from staff is positive. The Executive and Leadership teams continue to focus on stability for the organization and keep staff on track with the important day-to-day work of connecting our members with Quality care.

Acquiring and retaining talent: Between July 1 and Sept. 9, we filled 17 positions, which increased GCHP's headcount to 359 staff. Of the 42 new budgeted roles, 13 have been filled. The table below provides a Resource Summary, which includes Employee and Contingent Worker (Temps / Contractors) by function. You will see the organization remains within current employee budget of 399 roles and effectively managing 55 contingent worker counts against the overall fiscal year budget of $6.3M (reported as a footnote).

	EMPLOYEE COUNT					CONTINGENT WORKERS			Total Resources	
Function	Active Headcount	Open Requisitions	Forecasted Headcount YE 2024/25	2024/254 Budget	Percentage of Total Headcount	Temp Roles	Contractor / Consultant Roles	Total Contingent Workers	Total Resources	Percentage of Total Resources
Health Services	132	2	134	134	34%	3	4	7	141	33%
Operations	55	7	62	65	16%	3	10	13	75	18%
Information Tech	54	2	56	55	14%	25	1	26	82	19%
Policy & Programs	44	0	44	54	11%	1	3	4	48	11%
Compliance	18	0	18	21	5%	0	0	0	18	4%
Finance & Accounting	18	1	19	18	5%	0	0	0	19	4%
Execuitve & Administration	12	0	12	16	3%	1	0	1	13	3%
Community & Member Relations	9	0	9	14	2%	0	0	0	9	2%
HR&Facilities	10	0	10	11	3%	1	3	4	14	3%
Innovation / DSNP	0	0	0	6	0%	0	0	0	0	0%
Communications	3	1	4	5	1%	0	0	0	4	1%
Grand Total	359	13	372	399	100%	34	21	55	427	100%

Note: Excluding Outsourced BPO Netmark Claims Management Roles not included

Note: Total GCHP Temporary and Consulting Budget of $6,390,266 for FY 2024-25

GCHP's attrition for the last 12 months remains low at 4.49%. This is a slight decrease from last month, as terminations have declined. Attrition trends are checked each month to assess pending organization risks or concerns.

Year-End Performance Management and Rewards: The year-end Performance Management process was completed in Aug. 2024. Managers provided employees feedback goal results and behaviors, using our values as the gauge. At the beginning of last fiscal year, the Performance Management program was revised to include individual goals for staff that were aligned with the organization's goals, in addition to evaluating behaviors based on our Values. As a result, the performance distribution across the organization resulted in a better representation of performance.

In addition, the overall budgeted 4% merit pool was better distributed based on performance, meaning those employees who performed at a higher level received a larger merit increase. The table below illustrates the performance rating distribution for all employees and the average merit increase per rating category. You see 5% of staff received an "Exceptional Performance" rating, with an average of 5.61% merit increase provided, which differentiates merit increase from employees in the other performance rating categories. In addition to merit increase, the year-end One Team Incentive of 5% base-salary was provided to eligible employees in recognition for Quality improvement and Operations of the Future goal achievements.

Rating Categories	Employees	Rating Distribution	Average Merit Increase
Exceptional Performance	18	5%	5.61%
Consistently Exceeds Expectations	108	31%	4.43%
Consistently Meets Expectations	213	62%	3.55%
Needs Improvement	5	1%	0.60%
Unsatisfactory Performance	1	0%	0%
Total	345		

The performance rating and average merit increases were also evaluated by job level and diversity to ensure all the categories are well balanced and represented properly. Moving forward, the Fiscal Year 2024-25 Performance Management process is being launched as the organization goals are being finalized and cascaded down in the organization. Individual goals will be aligned to the organization goals and managed throughout the year.

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

RECOMMENDATION:

Receive and file.