Gold Coast Health Plan℠
A Public Entity

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

Regular Meeting
Monday, October 25, 2021, 2:00 p.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room
Camarillo, CA 93010
Meeting held pursuant to AB 361
Conference Call Number: 805-324-7279
Conference ID Number: 902 304 710#
Para interpretación al español, por favor llame al 805-322-1542 clave 1234

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

AGENDA

CALL TO ORDER

ROLL CALL

PUBLIC COMMENT

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

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

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

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Regular Meeting Minutes of September 27, 2021.

Staff: Maddie Gutierrez, MMC, Clerk to the Commission

RECOMMENDATION: Approve the minutes of September 27, 2021.

2. Adopt a Resolution to Renew Resolution No. 2021-012, to Extend the Duration of Authority Empowered in the CEO to issue Emergency Regulations and Take Action Related to the Outbreak of Coronavirus ("COVID-19")

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Adopt Resolution No. 2021-013 to extend the duration of authority empowered in the CEO through December 16, 2021.

3. Approval of Quality Improvement Committee Member

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

RECOMMENDATION: Approve Rachel Stern, M.D., as an active member of the Quality Improvement Committee.

UPDATES

4. HSP MediTrac Update

Staff: Anna Sproule, Sr. Director of Operations

RECOMMENDATION: Receive and file the update.

FORMAL ACTION

5. AB 361, Brown Act Virtual Meetings

Staff: Scott Campbell, General Counsel

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

6. Quality Improvement Committee 2021 Third Quarter Report

Staff: Nancy Wharfield, M.D., Chief Medical Officer
Kim Timmerman, Director of Quality Improvement

RECOMMENDATION: Approve the 2020 QI Program Evaluation. Receive and file the complete report as presented.

7. Moss Adams FY 20-21 Audited Financial Statements

Staff: Kashina Bishop, Chief Financial Officer
Moss Adams Representatives: Stelian Damu & Kimberly Sokoloff

RECOMMENDATION: Staff requests that the Commission approve the FY 20-21 audited financial statements.

8. September 2021 Financials

Staff: Kashina Bishop, Chief Financial Officer

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

REPORTS

9. Chief Executive Officer (CEO) Report

Staff: Margaret Tatar, Chief Executive Officer

RECOMMENDATION: Receive and file the report.

10. Chief Medical Officer (CMO) Report

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

RECOMMENDATION: Receive and file the report.

11. Chief Diversity Officer (CDO) Report

Staff: Ted Bagley, Chief Diversity Officer

RECOMMENDATION: Receive and file the report.

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

Staff: Michael Murguia, Executive Director of Human Resources

RECOMMENDATION: Receive and file the report.

CLOSED SESSION

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

ADJOURNMENT

Date and location of the next meeting to be determined at the October 25, 2021 meeting.

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

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5512. Notification for accommodation must be made by the Monday prior to the meeting by 3 p.m. to enable the Clerk of the Commission to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO. 1

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Maddie Gutierrez, MMC, Clerk of the Board

DATE: October 25, 2021

SUBJECT: Meeting Minutes of September 27, 2021 Regular Commission Meeting

RECOMMENDATION:

Approve the minutes.

ATTACHMENT:

Copy of Minutes for the September 27, 2021 Regular Commission Meeting.

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) September 27, 2021 Regular Meeting Minutes

CALL TO ORDER

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

ROLL CALL

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

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

Commissioner Shawn Atin was not present at roll call.

Attending the meeting for GCHP were Nancy Wharfield, MD., Chief Medical Officer, Kashina Bishop, Chief Financial Officer, Michael Murguia Executive Director of Human Resources, Scott Campbell, General Counsel, Cathy Salenko, Health Care General Counsel, Marlen Torres, Executive Director of Strategy and External Affairs, Robert Franco, Ted Bagley, Chief Diversity Officer, and Nick Liguori, Chief Operations Officer

Additional staff participating on the call: Anna Sproule, Vicki Wrighster, Dr. Anne Freese, Kim Timmerman, Nicole Kanter, Stacy Luney, Jamie Louwrens, Carolyn Harris, Leslie Cole, Kris Schmidt, Lucy Marrero, Susana Enriquez, Paula Cabral, and Sandi Walker.

PUBLIC COMMENT

None.

CONSENT

1. **Approval of Ventura County Medi-Cal Managed Care Regular Meeting Minutes of July 26, 2021.**

   Staff: Maddie Gutierrez, MMC, Clerk to the Commission.

   RECOMMENDATION: Approve the regular meeting minutes of August 23, 2021.

2. **Adopt a Resolution to Renew Resolution No. 2021-011, to Extend the Duration of Authority Empowered in the CEO to issue Emergency Regulations and Take Action Related to the Outbreak of Coronavirus ("COVID-19")**

   Staff: Scott Campbell General Counsel

   RECOMMENDATION: Adopt Resolution No. 2021-012 to extend the duration of authority empowered in the CEO through October 25, 2021.

Commission Chair, Dee Pupa asked for a motion on Consent items 1 and 2.

Commissioner Laura Espinosa motioned to approve Consent Items 1, and 2. Commissioner Swenson seconded.

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

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Shawn Atin, Gagan Pawar, M.D, and Andrew Lane.

Commissioner Pupa declared the motion carried.

General Counsel, Scott Campbell, stated the Governor has signed a bill to allow remote meetings without posting at each location. We will be able to continue for an indefinite period.

Supervisor Ramirez asked if the Commission would need vote to meet remotely every thirty (30) days. Mr. Campbell stated that is correct.

UPDATES

3. Return to Office Planning Update

Staff: Michael Murguia, Executive Director of Human Resources

RECOMMENDATION: Receive and file the update.

Executive Director of Human Resources, Michael Murguia presented an update in the return-to-work plan. He stated GCHP is currently working at an optimal level and there are no impediments to members. Productivity and performance are monitored. The original return to the office date was January 2022, but it has now been pushed back to April due to the Delta variant. There are still many unknowns and GCHP feels better leaving employees remote until April1, 2022.

Commissioner Espinosa asked if a member shows up in person, is there someone there to meet them. She asked if it was an employee or a security guard. Mr. Murguia stated we do not have security on the premises. We have Facilities staff who is present everyday of the week during business hours. If the members need someone from Member Services, that department is contacted, and they take over to assist.

Commissioner Cho asked for more detail on production and performance. Mr. Murguia stated member calls are answered and deadlines are met. Mr. Murguia requests reports of who is online and so far, there have been no issues. Dr. Wharfield, Chief Medical Officer, stated GCHP has been doing this for a long time. Her department is a production department and information must be submitted in a timely manner.

Mr. Murguia stated Marlen Torres, Executive Director of Strategy & External Affairs is part of the Executive Staff and is on the Return to Office Committee. Ms. Torres did an evaluation and noted more flexibility on remote work. Employees want more flexibility per the survey taken by staff. Out of State employees work remotely 100%. He noted that some employees are now asking to keep their job but want to move out of state.

Mr. Murguia noted that with these changes, there might be changes in the building leases – if more employees work remotely, we won't need as much office space.

4. HSP MediTrac Go-Live Update

Staff: Anna Sproule, Sr. Director of Operations

RECOMMENDATION: Receive and file the update.

Anna Sproule, Sr. Director of Operations gave a verbal update on the HSP/Conduent project. She noted we have contracted with an agency to provide temporary resources in claims inventory.

Provider network/Health Services/ Operations is testing. Defects in the testing process were found. There has been a date change due to these defects and correction is needed. The call center also now has additional resources and the call waiting period is down to 1-2 minutes.

Commissioner Pupa asked if more staff has been brought on. Ms. Sproule responded currently there are 40 additional staff and 15 more will start the next week (Monday).

Supervisor Ramirez asked of this staff is paid by Conduent. Ms. Sproule responded that GCHP pays staff, and the dollar amounts are deducted from the Conduent invoice. The salary is at a competitive rate.

Commission Chair, Dee Pupa asked for a motion on Update items 3 and 4.

Commissioner Theresa Cho, M.D. motioned to approve Update Items 3 and 4. Supervisor Carmen Ramirez seconded.

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

NOES: None.

ABSENT: Commissioners Shawn Atin, Antonio Alatorre, Gagan Pawar, M.D, and Andrew Lane.

Commissioner Pupa declared the motion carried.

Commissioner Shawn Atin joined the meeting at 2:31 p.m.

FORMAL ACTION

5. August 2021 Financials

Staff: Kashina Bishop, Chief Financial Officer

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

Chief Financial Officer, Kashina Bishop stated the August net gain is $3.8 million. Fiscal year to date net gain is now $10.1 million and TNE is at 302%. Medical Loss Ration is 88.5% and Administrative Rationis 5.4%. CFO Bishop stated she expects to reach 400% of the TNE by end of 2022. The Solvency Action Plan (SAP) will continue until this goal is reached. She noted net premium revenue is $165.8 million and over budget by $214,980.

CFO Bishop stated membership rates have leveled off. Medical Expense is under budget by 4%. She noted there are still outstanding issues that Conduent is working on. Monthly claims payment shave increased and payments to providers are improving.

CFO Bishop noted long term care expenses have decreased, outpatient expenses are holding steady as is ER expenses. Mental & Behavioral health has increased with the pandemic.

Commissioner Cho stated she noted the drop in outpatient expense in April was significant. CFO Bishop stated there was a billing dispute with a provider and now the contract has been re-negotiated, so it is now holding steady. Commissioner Cho asked how it relates to April. CFO Bishop stated we are seeing increases in some categories and there was a contractual change.

Chief Medical Officer, Nance Wharfield, M.D. stated there was a 42% decrease in Emergency Department use. Supervisor Ramirez stated people didn't want to go to the ER because they were afraid of catching COVID, but needed services were put off – she asked if we would see an increase at some point. CMO Wharfield responded yes.

Commission Pupa asked if the situation with Conduent has delayed the Moss Adams audit. CFO Bishop stated we still anticipate audit financials next month.

Commission Chair, Dee Pupa asked for a motion on Formal Action item 5 – August Financials.

Commissioner Jennifer Swenson. motioned to approve Formal Action item 5 – August Financials. Supervisor Carmen Ramirez seconded.

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

NOES: None.
ABSENT: Commissioners Antonio Alatorre, Gagan Pawar, M.D, and Andrew Lane.

Commissioner Pupa declared the motion carried.

REPORTS

6. Chief Executive Officer (CEO) Report

Staff: Margaret Tatar, Chief Executive Officer

RECOMMENDATION: Receive and file the report.

Chief Executive Officer Margaret Tatar is not present. Chief Financial Officer Kashina Bishop presented highlights from the CEO Report. DHCS issued a letter to improve vaccine numbers. GCHP submitted a plan to give vaccines – we will be working with the County, and do radio public service announcements, she noted members will receive incentives for vaccines. GCHP will be getting $4.7 million in incentives. CFO Bishop stated the Commission could review legislative updates and sponsorships. She noted there were six (6) community events and GCHP participated.

Commissioner Pupa asked if there was a way to capture how many people participated. Marlen Torres, Executive Director of Strategy & External Affairs stated her staff track who they talk to – both GCHP members and just community. She stated she will add a level of more detailed information and include who receives gift cards.

Commissioner Cho asked if incentives are available to clinics who vaccinate GCHP members. Ms. Torres stated we are working with clinics and strategizing with them.

7. Chief Medical Officer (CMO) Report

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

RECOMMENDATION: Receive and file the report.

Nancy Wharfield, M.D., Chief Medical Officer reviewed her report. She stated COVID level has dropped, today hospital admits are down by 36%. She noted average length of stay in hospital has been affected by COVID, but admissions have dropped. ER utilization has dropped by 50%. She also reviewed the top 10 diagnosis.

Dr. Anne Freese, Director of Pharmacy, stated Medi-Cal Rx is back on with an implementation date of January 1, 2022 and we have received State information. There will be no 90-day notice to members. DHCS will send a 60-day letter in November/December of 2021 and GCHP will start an outreach campaign on radio and in print. In December a 30-day letter will be sent to GCHP members and new ID cards will be issued in January 2022.

Dr. Freese reviewed pharmacy trends and noted opioid graphs will be updated at the next commission meeting.

Commissioner Pupa as if implementation of Medi-Cal Rx will affect CAP rate. CFO Bishop responded yes. The carve-out will help improve TNE.

8. Chief Diversity Officer (CDO) Report

Staff: Ted Bagley, Chief Diversity Officer

RECOMMENDATION: Receive and file the report.

Chief Diversity Officer, Ted Bagley, stated he is continuing his community relations involvement with the County and Ms. Marlen Torres. He noted the Diversity, Equity & Inclusion Team has been asked to review values within the Plan. CDO Bagley stated there is a down trend on staff complaints but we should consider re-developing the Personnel Committee to avoid burn out. Employees are doing a great job, but we do not want to lose staff due to burnout.

Commissioner Espinosa stated she appreciated CDO Bagley's work and efforts. GCHP serves a low-income community, and we need to be sensitive to all.

CDO Bagley stated he hopes COVID will ease in 2022, as we need to train employees more. Commissioner Espinosa stated the Commission needs to be included in the trainings. CDO Bagley stated the trainings stopped due to COVDI but he has continued with Lunch & Learns.

Supervisor Ramirez noted we all need to be conscious of how we face the public. People don't think about what some symbols mean. She noted that Oxnard School District has some schools named after racist people, but the schools are now renaming their sites, which is a great and positive trend.

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

Staff: Michael Murguia, Executive Director of Human Resources

RECOMMENDATION: Receive and file the report.

Michael Murguia, Executive Director of Human Resources stated there have been three (3) resignations in the last 30 days. Helen Miller, Sr. Director of IT has resigned. A new vacancy in Human Resources has been filled and we are on-boarding the new Chief Operating Officer.

HR is continuing to evaluate benefits packages and looking for enhancements. Open enrollment will be in November and it will be virtual.

Commissioner Espinosa asked how the onboarding for the COO is going. Mr. Murguia stated he is onboard and on site. Mr. Nick Liguori, Chief Operating Officer, stated he has been emersed in work and his calendar is filling up.

Commission Chair, Dee Pupa asked for a motion on Report items 6 through 9.

Commissioner Shawn Atin motioned to approve Report Items 6 through 9. Commissioner Sevet Johnson seconded.

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

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Gagan Pawar, M.D, and Andrew Lane.

Commissioner Pupa declared the motion carried.

Closed Session began at 3:23 p.m.

CLOSED SESSION

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

11. PUBLIC EMPLOYEE APPOINTMENT
Title: Chief Executive Officer

ADJOURNMENT

General Counsel, Scott Campbell stated there was no reportable action in Closed Session. The meeting was adjourned at 5:13 p.m.

Approved:

_____
Maddie Gutierrez, MMC
Clerk to the Commission

AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: October 25, 2021

SUBJECT: Adopt a Resolution to Renew Resolution No. 2021-012, to Extend the Duration of Authority Empowered in the CEO to issue Emergency Regulations and Take Action Related to the Outbreak of Coronavirus ("COVID-19")

SUMMARY:

Adopt Resolution No. 2021-013-to:

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

BACKGROUND/DISCUSSION:

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

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

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

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

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

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

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

Since the adoption of Resolution No. 2020-003, the Commission has renewed and reiterated the emergency powers granted to the CEO on July 27th, August 24th, September 28th, October 26th, January 25th, February 22nd, March 22nd, April 26th, June 28th, July 26th, and more recently by adopting Resolution No. 2021-011 on August 23, 2021. Resolution No. 2021-011 expires today, September 27, 2021.

COVID-19 continues to present an imminent threat to the health and safety of Plan personnel. Although vaccines are now widely available, many people in the State and County are still not fully vaccinated and remain susceptible to infection. As of October 11, 2021, 71.5% of the state's *eligible* population are *fully vaccinated*. This is a 1.9% increase from last month. Although, vaccination rates are increasing, the disease can still spread rapidly through person-to-person contact and those in close proximity. Further, more contagious variants of the disease are now present in the State and County, the most predominant of which is the Delta variant.

While the State's economy has reopened and an increasing amount of events that gather large groups of people have resumed, the COVID-19 pandemic continues to loom. State and local officials, including the public health community are continuing to enforce rules and regulations and explore ways to stymie the spread of the disease. An example of this is the FDA's authorization of booster shots and the growing number of public agencies from all levels of government and private businesses that are implementing COVID-19 vaccination mandates.

VCPH is strongly urging all County residents that are eligible but have not yet been fully vaccinated to get vaccinated as soon as possible. The County is aligned with the California Department of Public Health and the Center for Disease Control and Prevention guidance on mask wearing, which recommends that everyone regardless of vaccination status wear masks indoors, and that requires those that are not fully vaccinated to mask indoors. The County Public Health Officer recently issued a health officer order, extending its mask regulations through at least October 19, 2021.

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

This resolution will continue to empower the CEO with the authority to issue orders and regulations necessary to prevent the further spread of the disease and protect the health and safety of Plan members and staff through December 16, 2021 the date of its Strategic Planning meeting as the November regularly scheduled meeting may be cancelled. The intent of this resolution is to balance the ability to continue the safe and efficient operations of the Plan during the global health pandemic. As State and County health orders evolve, the Plan's response should also evolve. Measures adopted to reduce the spread of COVID-19 amongst Commission staff may be rescinded when they are no longer needed in response to the pandemic. Pursuant to Resolution No. 2020-002, the Plan's Local Emergency proclamation shall remain effective through the duration of the Governor's State of Emergency proclamation or when the Commission terminates its declaration of Local Emergency, whichever occurs last.

FISCAL IMPACT:

None.

RECOMMENDATION:

1. Adopt Resolution No. 2021-013 to extend the duration of authority empowered in the CEO through December 16, 2021.

ATTACHMENT:

1. Resolution No. 2021-013.

RESOLUTION NO.2021-013

A RESOLUTION OF THE VENTURA COUNTY MEDICAL MANAGED CARE COMMISSION, DOING BUSINESS AS THE GOLD COAST HEALTH PLAN (“PLAN”), TO RENEW AND RESTATE RESOLUTION NO. 2021-012 TO EXTEND THE DURATION OF AUTHORITY EMPOWERED IN THE CHIEF EXECUTIVE OFFICER ("CEO") RELATED TO THE OUTBREAK OF CORONAVIRUS ("COVID-19")

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

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

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

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

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

WHEREAS, since the adoption of Resolution No. 2020-003, the Commission has renewed and reiterated the emergency powers granted to the CEO on July 27th, August 24th, September 28th, October 26th, January 25th, February 22nd March 22nd, April 26th, May 24th June 28th, July 26th, August 23rd, and more recently on September 27, 2021, by adopting Resolution No. 2021-012. Resolution No. 2021-012 expires today, October 25, 2021; and

WHEREAS, unless renewed by the Commission, the delegation of authority empowered in the CEO, pursuant to Resolution No. 2021-012 shall expire today, October 25, 2021; and

WHEREAS, this resolution will continue to empower the CEO with the authority to issue orders and regulations necessary to prevent the further spread of the disease and protect the health and safety of Plan members and staff through December 16, 2021, its Strategic Planning meeting as the November meeting may be cancelled.; and

WHEREAS, although vaccines are now widely available, many people in the State and County are still not fully vaccinated and remain susceptible to infection. Further, more contagious

variants of the disease are now present in the State and County, the most predominant of which is the Delta variant; and

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

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

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

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

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

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

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

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

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

B. Help alleviate hardship suffered by Plan staff related to emergency conditions associated with the continued spread of the disease such as acting on near-term policies relating to sick leave for Plan staff most vulnerable to a severe case of COVID-19.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 6. Since the adoption of Resolution No. 2020-003, the Commission has renewed and reiterated the emergency powers granted to the CEO on July 27th, August 24th, September 28th, October 26th, January 25th, February 22nd, March 22nd, April 26th, May 24th June 28th, July 26th, August 23rd and more recently on September 27, 2021, by adopting Resolution No. 2021-012. Resolution No. 2021-012 expires today, October 25, 2021.

Section 7. The Commission now seeks to renew and reiterate the authority granted to the CEO approved in Resolution No. 2021-012 through December 16, 2021.

Section 8. Unless renewed by the Commission, the delegation of authority empowered in the CEO, pursuant to this Resolution shall expire on December 16, 2021.

PASSED, APPROVED AND ADOPTED by the Ventura County Medi-Cal Managed Care Commission at a regular meeting on the 25th day of October 2021, by the following vote:

AYE:

NAY:

ABSTAIN:

ABSENT:

_____

Chair:

Attest:

_____

Clerk of the Commission

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: October 25, 2021

SUBJECT: Approval of Quality Improvement Committee Member

SUMMARY:

The Quality Improvement Committee Charter specifies that membership will include at least one practicing physician in the community.

Rachel Stern, M.D. has been nominated to replace Theresa Cho, M.D., as an active member of the Quality Improvement Committee ("QIC"). Dr. Stern is the Chief Medical Quality Officer of Ambulatory Care at Ventura County Healthcare Agency.

RECOMMENDATION:

Approve Rachel Stern, M.D., as an active member of the Quality Improvement Committee.

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Anna Sproule, Sr. Director of Operations

DATE: October 25, 2021

SUBJECT: HSP / MediTrac Go-Live Update

VERBAL PRESENTATION

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

CC: Margaret Tatar. Chief Executive Officer

FROM: Scott Campbell, General Counsel

DATE: October 25, 2021

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

SUMMARY/RECOMMENDATION:

That if the Ventura County Medi-Cal Managed Care Commission ("Commission") dba as Gold Coast Health Plan ("Plan") desires to continue to meet virtually, without posting the agenda at each location from where Commissioner attends, that the Commission make findings authorizing remote teleconference/virtual meetings of the Commission and its legislative bodies pursuant to Assembly Bill 361 based on the ongoing COVID-19 pandemic. Specifically, that the Commission determine that the COVID-19 state of emergency proclaimed by the Governor still exists and has been considered by the Commission in deciding to have teleconference meetings not noticed and held at each teleconference location and one of the two following secondary findings be made: that state or local officials have imposed or recommended measures to promote social distancing in connection with COVID-19, or, that as result of the COVID-19 emergency, meeting in person would present imminent risks to the health or safety of attendees. It is recommended that both secondary findings be made. Because these findings must be made every thirty (30) days, the Commission would have to schedule additional meetings for the purpose of making the findings going forward if it desires to meet without the requirement of posting the agenda at each location and allowing members of the public to attend from any of the posted locations.

Additionally, under AB 361, the Commission is required to provide members of the public the option of calling in or attending via the internet, even if all Commission members attend the meeting in person or telecommute.

BACKGROUND/DISCUSSION:

The Brown Act generally allows for teleconference or virtual meetings, provided that the physical locations of the legislative body's members joining by teleconference are posted on the agenda, that those locations are open to the public and that a quorum of the members is located within its jurisdiction. Newly enacted AB 361 provides an exception to these procedures in order to allow for fully virtual meetings during proclaimed emergencies, including the COVID-19 pandemic without posting the agenda at each

teleconference location and allowing the public access to each location, even if the public is unvaccinated.

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

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

Specific Findings Required under AB 361

Under AB 361, the Commission and all other Plan Brown Act bodies, can hold meetings without providing notice of the each of body's teleconference locations if the Commission (or its legislative bodies) make the determination that there is a Governor-proclaimed state of emergency which the Commission (and its legislative bodies) consider in their determination, and one of two secondary criteria listed below exists:

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

2. The Commission (or its legislative bodies) determine that requiring a meeting in person would present an imminent risk to the health and safety of attendees.
3.

If adopted, the Commission may continue to meet as it has been meeting as long as the findings are made every thirty (30) days. The public will still be able to attend the meetings in person in the Community Room or via phone or the internet.

COVID-19 continues to present an imminent threat to the health and safety of Commission members, and its personnel, and the Governor's declaration of a COVID-19 emergency still exists. Although vaccines are now widely available, many people in the State and County are still not fully vaccinated and remain susceptible to infection. The disease can still spread rapidly through person-to-person contact and those in close proximity. Further, more contagious variants of the disease are now present in the State and County, the most predominant of which is the Delta variant. Additionally, many Commission and committee members hold meetings in medical facilities or offices, and

allowing members of the public to attend meetings at these posted locations when they may not be vaccinated may pose a threat to the health and safety of attendees.

Because AB 361 is unclear if the Plan's committees must make these findings as well, the Commission committees that are required to comply with the Brown Act will also be asked to make these findings. In case the law is clarified to state that only the governing body (the Commission) needs to make these findings, the Commission is being asked to make the findings for each of its Brown Act committees.

Re-Authorization is Required Every 30 Days

Consistent with the provisions of Government Code Section 54953(e)(3), the findings listed above must be made every 30 days "after teleconferencing for the first time" under AB 361. Thus, if the Commission desires to continue to meet remotely without having to post the location of each teleconference location, and require the same for its committees and other Plan Brown Act bodies, the Commission must find that the COVID-19 emergency still exists and that one of the two following findings can be made: that state or local officials have imposed or recommended measures to promote social distancing in connection with COVID-19, or, that a result of the COVID-19 emergency, meeting in person would present imminent risks to the health or safety of attendees.

The Commission may extend the authorization for an additional thirty (30) days via another staff report on a consent calendar that makes the above specific findings in support of continuing virtual meetings. Doing this would require the scheduling of monthly meetings for the purpose of extending this authorization.

Lastly, it is important to note that AB 361 is optional. If the Commission wishes, it may choose to meet fully in person or meet remotely with notices of the agenda posted at each location and access to the public at each noticed location. The authorization under AB 361 is intended to provide the option to utilize the AB 361 procedures in lieu of the Brown Act's standard teleconferencing requirements. A consent calendar item will be placed on each agenda to reauthorize remote meetings if that is the Commission's direction. In the event that a regularly scheduled Commission meeting is more than thirty (30) days after an authorization under AB 361 has been made by the Commission, and the Commission desires to continue to hold virtual meetings under AB 361, the Commission may hold a special meeting for the purpose of making the reauthorization.

CONSEQUENCES OF NOT FOLLOWING RECOMMENDED ACTION:

As noted above, AB 361 is optional. If the Commission wishes, it may choose to meet fully in person, or meet remotely with notices of the agenda posted at each location and access to the public at each noticed location. However, to continue to hold remote teleconference/virtual meetings, the Commission must make the specific findings required by AB 361 as they are enumerated in this staff report to allow meetings to continue without the requirement of posting the agenda at each location and allowing members of the public to attend from any of the posted locations. Additionally, under AB

361, the Commission is required to provide members of the public the option of calling in or attending via the internet, even if all Commission member attend the meeting in person.

FOLLOW UP ACTION:

Potentially scheduling special meetings every thirty (30) days to extend this authorization.

ATTACHMENT:

None.

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, M.D., Chief Medical Officer
Kim Timmerman, Director of Quality Improvement

DATE: October 25, 2021

SUBJECT: Quality Improvement Committee – 2021 Third Quarter Report

SUMMARY:

The Department of Health Care Services ("DHCS") requires Gold Coast Health Plan ("GCHP") to implement an effective quality improvement system and to ensure that the governing body routinely receives written progress reports from the Quality Improvement Committee ("QIC").

The attached PPT report contains a summary of activities of the QIC and its subcommittees.

APPROVAL ITEMS:

- 2020 Quality Improvement Evaluation

FISCAL IMPACT:

None

RECOMMENDATION:

Staff recommends that the Ventura County Medi-Cal Managed Care Commission approve the 2020 QI Evaluation as presented and receive and file the complete report as presented.

ATTACHMENTS:

1) Timmerman, K., (2021). Quality Improvement, Ventura County Medi-Cal Managed Care Commission, Quality Improvement Committee Report – Q3 2021, Presentation Slides.

Gold Coast Health Plan℠
A Public Entity

Quality Improvement Committee Report Q3 2021

October 25, 2021

Kimberly Timmerman, MHA, CPHQ
Director, Quality Improvement

Integrity
Accountability
Collaboration
Trust
Respect

Return to Agenda

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

Quality Improvement Activities

2020 Quality Improvement Evaluation

Approval Requested

Q3 2021 Quality Improvement Update

Return to Agenda

QI Activities

Return to Agenda

Member Engagement

- Following refined TCPA ruling/legal guidance - Relaunch gaps in care campaign utilizing text outreach in Q4 2021
- Return to Primary Care – GCHP website revamp https://www.goldcoasthealthplan.org/for-members/health-and-wellness-services/return-to-care/
- COVID-19 Vaccine outreach and incentive program

Provider Engagement

- 10/20 QI Collaboration Meeting
- Strengthened Clinic System Collaborations – VCMC, CMH, CDCR, Dignity, Kaiser

Performance Improvement Projects

- COVID-19 QIP
- Women's Health SWOT
- Comprehensive Diabetes Care - HbA1c
- Health Equity – Cervical Cancer Screening
- Adolescent Well Care
- CAHPS Member Satisfaction Improvement

Annual Quality Improvement Evaluation

- Comprehensive assessment of quality improvement activities undertaken during the year
- Evaluation of barriers, achievements and continued focus areas for improvement within the scope of the QI program
- Interdepartmental collaboration to achieve goals:
  - Quality Improvement
  - Health Services/Health Education
  - Network Operations
  - Compliance
  - Member Services
  - Grievances and Appeals
  - Pharmacy
  - Information Technology
- Analyze performance to help drive development of the subsequent QI Work Plan to ensure ongoing performance improvement

Return to Agenda

Objective 1: Improve Quality and Safety of Clinical Care Services

Objective 2: Improve Quality and Safety of Non-Clinical Care Services

Objective 3: Improve Member Safety

Objective 4: Assess and Improve Member Experience

Objective 5: Ensure Organizational Oversight of Delegated Activities

Return to Agenda

Practice Guidelines

Metric(s)	Outcome
• Guidelines (Asthma, Diabetes, Preventive Health) approved by Medical Advisory Committee	Met
• Distribute guidelines to appropriate practitioners	Met
• Align Preventive Health Guidelines with Provider Manual and policies	Met

Key Points:
- The guidelines were approved in 2020 and made available to practitioners through the GCHP website and the Provider Manual.
- The guidelines were incorporated into GCHP's policies.

Advanced Prevention: Tobacco Cessation

Metric(s)	Outcome
• 100% of identified smokers receive counseling and 32% receive cessation medication.	Audits on hold due to COVID-19

Key Points:
- Q1 2020 Data: 100% of identified smokers were counseled but only 12.5% offered smoking cessation medication.
- Q2 2020 to present: Per DHCS APL 20-004 IHA requirements suspended until the end of the public health emergency. No medical record audits conducted.

Return to Agenda

Advanced Prevention: Initial Health Assessment (IHA)

Metric(s)	Outcome
Increase rate of IHA completion by 5% compared to CY19	IHA on hold due to COVID-19

Key Points:
Per APL 20-004, DHCS temporarily suspended the 120-day IHA requirement for newly enrolled members between 12/01/19 until the end of the public health emergency. IHA medical record audits were placed on hold.

Advanced Prevention: Adverse Childhood Experiences (ACEs)

Metric(s)	Outcome
• Establish baseline and monitoring process for members (pediatrics and adults) who are screened for ACEs using a standardized screening tool.	Partially met

Key Points:
- Report development to establish baseline will be completed in 2021.
- Multiple outreach campaigns, community collaborations, and ACE trainings completed.

Return to Agenda

Advanced Prevention: Lead Screening in Children (LSC)

Metric(s)	Outcome
• Increase by 2% the percentage of children who had one or more blood tests for lead poisoning by their 2nd birthday.	Not Met

Key Points:

- LSC rate decreased 1.83% points from 71.25% to 69.42%.
- Preventive care outreach letter (Age 0-6) promoted lead screenings.
- Lead Poisoning Prevention Week ~ Distribution of Provider Education Materials.
- QI & HE/CL developed well-child (age 0-3) health education material for parents/guardians.
- COVID-19 caused decline in preventive care screenings.

MCAS Measure: Asthma Medication Ratio (AMR)

Metric(s)	Outcome
• Increase rates by 3% over previous measurement year.	Not met

Key Points:

- AMR rate decreased 1.57% from 50.09% (2019 MY) to 48.52% (2020 MY).
- Launched INDICES® Provider Insights Dashboard to improve provider access to performance rate and gap reports.
- QI & HE/CL departments collaborated on an asthma education member outreach campaign.

Return to Agenda

MCAS Measure: Cervical Cancer Screening (CCS)

Metric(s)	Outcome
• Increase by 3% the percentage of women, 21-64 years of age, who completed a cervical cancer screening	Not met

Key Points:

- CCS rate decreased 7.54% points from 64.23% (MY 2019) to 56.69% (MY 2020).
- Launched INDICES® Provider Insights Dashboard to improve provider access to performance rate and gap reports.
- Member Incentive Program ($25 gift card)
- Provider Incentive program with VCMC: clinic system met their target goal
- Member-centric reporting established with Quest Diagnostics and in process with Lab Corp.

MCAS Measure: Chlamydia Screening in Women

Metric(s)	Outcome
• Meet or exceed DHCS MPL (50th percentile) for percentage of women, age 16-24, identified as sexually active and had at least one chlamydia screening.	Not met

Key Points:

- CHL rate decreased 3.30% points from 56.02% (MY 2019) to 52.72% (MY 2020)
- Launched INDICES® Provider Insights Dashboard to improve provider access to performance and gap reports.
- Provider Incentive program with VCMC: clinic system met their target goal
- Member-centric reporting established with Quest Diagnostics and in process with Lab Corp

Return to Agenda

MCAS Measure: Childhood Immunization Status Combo 10 (CIS-10)

Metric(s)	Outcome
• Meet or exceed the DHCS MPL (50th percentile) for percentage of two-year old children who complete all required vaccines on or before their 2nd birthday.	Met

Key Points:

- The CIS-10 rate decreased 2.43% points from 42.09% (MY 2019) to 39.66% (MY 2020), but MY 2020 met the DHCS MPL.
- Preventive care outreach letter (Age 0-6) promoted childhood immunizations.
- QI & HE/CL developed well-child (age 0-3) health education material for parents/guardians.

MCAS Measure: Developmental Screening in Children (DEV)

Metric(s)	Outcome
• Establish baseline for children screened for risk of developmental, behavioral, and social delays using a standardized screening tool.	Met

Key Points:

- The DEV rate increased 3.72% points from 32.31% (MY 2019) to 36.03% (MY 2020).
- QI & HE/CL developed well-child (age 0-3) health education material for parents/guardians.
- GCHP collaborated with HMG Ventura/First 5 on promoting developmental screenings.
- DHCS provider incentive payment through Prop 56.

Return to Agenda

MCAS Measure: Well-Child Visits in the First 30 Months of Life (W30)

Metric(s)	Outcome
• Establish baseline for new well-child measure (six or more well-child visits with a PCP during first 15 months of life, and two visits between 15-30 months).	Met

Key Points:

- Measure transitioned from W15 → W30 and from hybrid (medical record) → administrative data only.
- DHCS Preventive Care Outreach to 0-6 years old via multi-modal approach including letters to parents/guardian, collaboration with providers and community partners.
- QI & HE/CL developed well-child (age 0-3) health education material for parents/guardians.

MCAS Measure: Child & Adolescent Well-Care (WCV)

Metric(s)	Outcome
• Establish baseline for new well-child measure (age 3-21, at least one well-care visit).	Met

Key Points:

- Measure transitioned from W34 & AWC → WCV and from hybrid → administrative data only.
- Well-care member incentive program $15 gift card promoted via provider and member outreach campaigns.
- DHCS Preventive Care Outreach to 0-6 years old.

Return to Agenda

QI Project: DHCS Asthma Medication Ratio (AMR) IP 2020-2021

Metric(s)	Outcome
• Meet or exceed the DHCS MPL	AMR IP In progress until 08/02/21

Key Points

- Cause-Effect Barrier Analysis/Disparity Analysis/Plan-Do-Study Act (PDSA) submissions to DHCS
- QI and HE/CL departments collaborated on a telephonic outreach to (1) promote the importance of routine asthma exams with a PCP; (2) maintain a current asthma action plan; (3) take asthma medication as prescribed; (4) assess barriers to asthma management; and (5) assess the need for asthma education.

QI Project: DHCS COVID-19 QIP 2020-2021

Metric(s)	Outcome
• Implement interventions to increase provision of preventive services, behavioral health services, and/or chronic disease care to members during the COVID-19 pandemic.	Met

Key Points

- 11 COVID-19 interventions: 5 preventive care; 3 chronic disease care; 3 behavioral health.
- Vulnerable Population Outreach, Childhood Preventive Care Services Outreach Campaign, Beacon Health's My Strength Program, High Risk Chronic Disease Self-Management Program
- DHCS commended GCHP's level of community collaboration.

Return to Agenda

QI Project: Cervical Cancer Screening Health Disparity PIP 2020-2022

Metric(s)	Outcome
By December 31, 2022, increase the percentage of cervical cancer screening among 24 to 29-year-old GCHP female members assigned to Magnolia Family Medical Clinic, from 36.41% to 50.00%.	PIP in progress until 12/31/22

QI Project: Child and Adolescent Well-Care (WCV) PIP 2020-2022

Metric(s)	Outcome
By December 31, 2022, increase the percentage of well-care exams among 12 to 17-year-old GCHP members assigned to CMH Centers for Family Health Airport Marina Clinic, from 37.78% to 50.00%.	PIP in progress until 12/31/22

Return to Agenda

Cultural & Linguistics Needs & Preferences

Metric(s)	Outcome
• Develop and implement action plan to provide members with available resources to meet cultural, ethnic and linguistic needs.	Met

Key Points

- Network Operations continued to acquire languages spoken by practitioners and professionals including ethnicity.
- Health Education/Cultural Linguistics collaborated with Provider Network Operations to ensure providers had resources to address the cultural, ethnic and linguistic needs of our members through updates in the POB, GCHP website, provider training modules, member and community newsletters, member and provider handbooks.

Primary and Specialty Care Access

Metric(s)	Outcome
• Standards met for minimum of 90% of providers for appointment availability	Met

Key Points

- The Provider Appointment Availability Survey (PAAS) was conducted by SPH Analytics between 12/20 – 03/21.
- CAPs & training issued to providers who did not meet office wait times, average call back time and urgent care appointments.

Return to Agenda

After Hours Availability

Metric(s)	Outcome
• Standards met for minimum of 90% of providers for ability to reach provider after hours	Met

Key Points

- The After-Hours Survey was conducted by SPH Analytics between 12/20-03/21.
- Network Operations implemented interventions to monitor and address performance.
- No after-hours grievances reported in 2020.

Network Adequacy

Metric(s)	Outcome
• Ratios of providers (PCP, NP, PA, etc.) to members • PCP located within 30 minutes or 10 miles → *30 minutes AND 10 miles* • Core specialists located within 60 minutes or 30 miles → *60 min AND 30 miles* • Hospitals located within 30 minutes or *15 miles* → *30 min AND 15 miles*	Partially Met

Key Points

- In Q2 2020 the DHCS Timely Access Standards changed: "Time OR Distance " to "Time AND Distance."
- 4 of 7 metrics met in 2020.
  - PCP: 98.90% (goal 100%)
  - Core specialists: 99.90% (goal 100%)
  - Hospitals: 99.90% (goal 100%)

Return to Agenda

Provider Satisfaction

Metric(s)	Outcome
• Development and implementation of action plan as needed to improve rates.	Not Met

Key Points

- GCHP created a list of key needs and expectations for a more tailored approach to the Provider Satisfaction Survey.
- Due to competing strategic (i.e., two system implementations) and State regulatory reporting priorities, the provider satisfaction survey was placed on hold and is scheduled for Q4 2021.

Facility Site Monitoring

Metric(s)	Outcome
• Complete FSRs and PARs 100% on time	FSRs on hold due to COVID-19

Key Points

- Per DHCS APL 20-004 and APL 20-011, the onsite FSR audits were placed on hold due to the COVID-19 public health emergency.
- Virtual site reviews were advised for initial site reviews, relocation, focused review and follow-up on CAPs
  - 2 Periodic virtual site reviews with PARS completed
  - 5 initial virtual site reviews completed

Return to Agenda

Credentialing/Recredentialing

Metric(s)	Outcome
• 100% on time for primary source verification, ongoing monitoring, recredentialing	Partially met

Key Points
- Credentialing files were processed according to NCQA, DHCS and GCHP policy standards.
- Q2-Q4 credentialing delays (timeliness of verification, timeliness of processing initial applications, timeliness of processing recredentialing applications, timeliness of organization reassessment) were due to staffing shortage, transition to new software system and vendor delays.

Pharmacy

Metric(s)	Outcome
• Achieve reduction in potential unsafe opioid prescriptions by 2% compared to prior year metrics.	Met

Key Points
- 25.9% decrease in opioid users >90 mg MEDD from 2019 to 2020
- 4.33% decrease in total opioid users from 2019 to 2020
- Total number of concurrent opioids and antipsychotics users was undetermined due to inconsistent data from DHCS, but further analysis will be conducted on available data.

Return to Agenda

Member Access & Satisfaction

Metric(s)	Outcome
Development and implementation of action plan to improve.	Met

Key Points

- Call Center: No issues identified
- Member Grievances:
  - Delay in Care: G&A and Provider relations collaborated on a provider awareness campaign.
  - Transportation: Issues addressed with vendor during Joint Operations Meetings.

Call Center Monitoring

Metric(s)	Outcome
• ASA: 30 seconds or less • Abandonment Rate: 5% or less • Phone quality results: ≥ 95%	Met

Key Points

- Call Center member survey satisfaction rate: 96.58%
- ASA and abandonment rates met every month in 2020
  - Average ASA: 11 seconds
  - Average abandonment rate: 0.47%

Return to Agenda

Delegation Oversight

Metric(s)	Outcome
Complete 100% oversight of all delegated activities.	Met

Key Points

- Quarterly delegation oversight completed for all delegated activities.
- CAPs issued were monitored for completion.

Return to Agenda

2020 QI Work Plan Evaluation Summary

Return to Agenda

2020 QI Work Plan Evaluation Summary

Objectives That Met Goals (12)

- Practice Guidelines
- Child Immunization Status – Combo 10 (CIS-10)
- Developmental Screening in Children (DEV)
- Well-Child Visits in the First 30 Months of Life (W30)
- Child and Adolescent Well-Care Visits (WCV)
- Cultural and Linguistics Needs & Preferences: Practitioner Availability
- Primary and Specialty Care Access
- After Hours Availability
- Pharmacy
- Member Access and Satisfaction
- Call Center Monitoring
- Delegation Oversight

Objectives That Partially Met Goals (3)

- Adverse Childhood Experiences (ACE)
- Network Adequacy: Availability of Practitioners
- Credentialing and Recredentialing

Return to Agenda

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2020 QI Work Plan Evaluation Summary Cont.

Objectives That Did Not Met Goals (5)

- Lead Screening in Children (LSC)
- Asthma Medication Ratio (AMR)
- Cervical Cancer Screening (CCS)
- Chlamydia Screening in Women (CHL)
- Provider Satisfaction Survey

Objectives Still In-Process (4)

- 2020-2021 Asthma Medication Ratio IP
- 2020-2021 COVID-19 QIP
- 2020-2022 Cervical Cancer Screening (Ages 21-29) Health Equity PIP
- 2020-2022 Child and Adolescent Well-Care (Ages 12-17) PIP

Objectives On Hold Due to COVID-19 (3)

- Tobacco Cessation
- Initial Health Assessment
- Facility Site Monitoring

Return to Agenda

Gold Coast Health Plan℠
A Public Entity

Questions?

Recommendation:

Approve the 2020 QI Program Evaluation

Return to Agenda

AGENDA ITEM 7

To: Ventura County Medi-Cal Managed Care Commission

From: Kashina Bishop, Chief Financial Officer

Date: October 25, 2021

Re: FY 2020-21 Audit Results (Presented by Moss Adams)

SUMMARY:

Moss Adams LLP (Moss Adams) is presenting the annual financial statements of Gold Coast Health Plan (GCHP) as of and for the year ended June 30, 2021.

The auditor's report reflects an "unmodified opinion" which means the determination is that the financial statements for the audit period present fairly, in all material respects, the financial position of GCHP as of June 30, 2021 in accordance with accounting principles generally accepted in the United States of America.

BACKGROUND / DISCUSSION:

The primary purpose of the audit is for the Commission and stakeholders to gain assurance that GCHP's financial statements are properly presented, are free of material misstatements and have been prepared in conformity with accounting principles generally accepted in the U.S.

We are pleased to report that there were no audit adjustments. From the preliminary June close, GCHP staff identified necessary adjustments and immediately communicated those to Moss Adams. Below is a comparison of the June 30, 2021 financial statements approved by the Commission in July to the final audit report.

	Preliminary FY 20-21	Adjustments	Audited FY 20-21
Net Capitation Revenue	$ 917,972,897	$ (1,315,268)	$ 916,657,629
Health Care Costs	845,119,016	(6,030,151)	839,088,866
Administrative Expenses	49,637,603	-	49,637,603
Non-Operating Revenue/(Expense)	460,444	-	460,444
Total Increase/(Decrease) in Net Assets	$ 23,676,724	$ 4,714,882	$ 28,391,605
GCHP TNE	$ 100,999,994		$ 105,714,877
Required TNE	$ 36,313,908		$ 36,072,702
% of Required	**278%**		**293%**

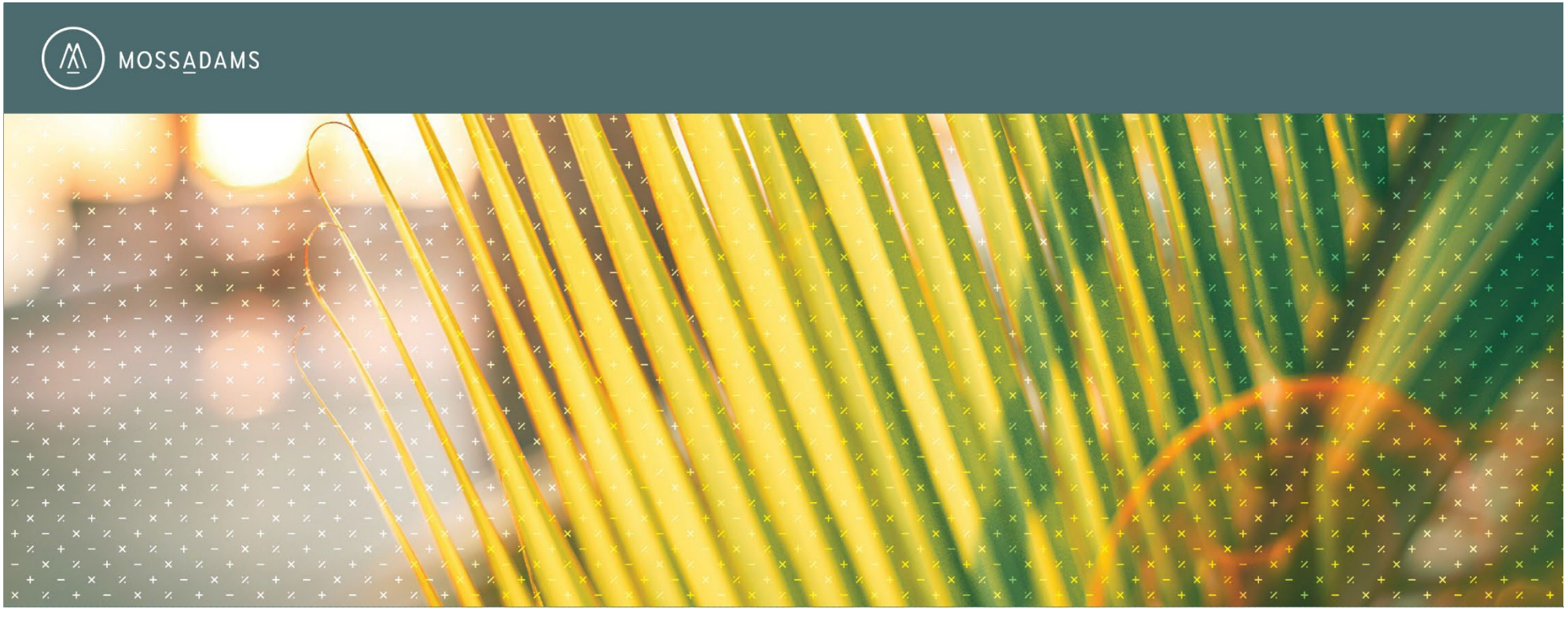
The net adjustment which improved the year end results is related to the receipt of revised capitation rates from the DHCS that were retroactive to January 2021. There were some reclassifications from medical expense to a contra revenue account that did not impact the net results.

A secondary and important purpose of the audit is to test and comment on the GCHP's design and operation of internal controls that have a relationship with financial reporting. Moss Adams has identified a deficiency in internal controls related to Conduent claims processing and the impact that has in the medical expense estimation process. Staff has increased internal review over claims and actively addressed issues as they arise. In addition, GCHP retained over 60 temporary claims processors with strong claims processing experience to ensure complete adjudication of backlogged claims.

RECOMMENDATION:
Staff recommends that the Commission approve the audited financial statements as of and for the year ended June 30, 2021.

CONCURRENCE
N/A

ATTACHMENT:
Draft Report of Independent Auditors and Financial Statements for GCHP as of June 30, 2021 and 2020



Audit Results – Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan

Prepared by the Moss Adams Health Care Group

October 25, 2021

Return to Agenda

Ventura County Medi-Cal Managed Care Commission

Gold Coast Health Plan

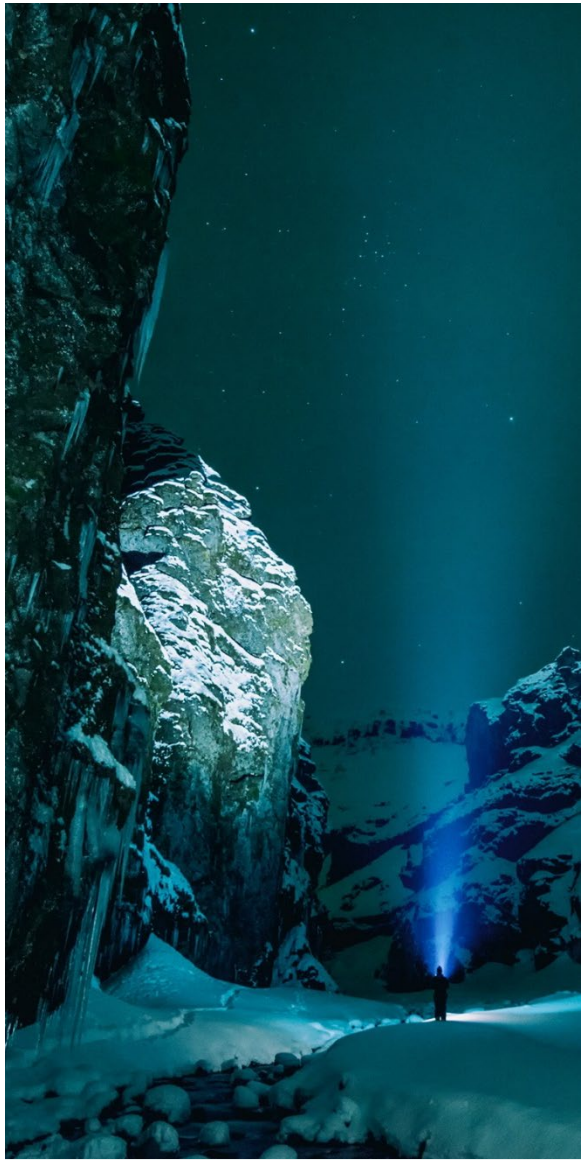
Dear Commissioners:

Thank you for your continued engagement of Moss Adams LLP. We are pleased to have the opportunity to meet with you to discuss the results of our audit of the financial statements of Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan (the "Plan") for the year ended June 30, 2021.

The accompanying report, which is intended solely for the use of the Commission and management, presents important information regarding the financial statements of the Plan and our audit that we believe will be of interest to you. It is not intended for, and should not be used by, anyone other than these specified parties.

We conducted our audit with the objectivity and independence that you expect. We receive the full support and assistance of the Plan personnel. We are pleased to serve and be associated with the Plan as its independent public accountants and look forward to our continued relationship.

We look forward to discussing our report or any other matters of interest with you during this meeting.



Agenda

1. Auditor Opinion & Report
2. Communications with Those Charged with Governance
3. Exhibit: Management Representation Letter
4. Exhibit: Communication of Internal Control Related Matters
5. Other Information

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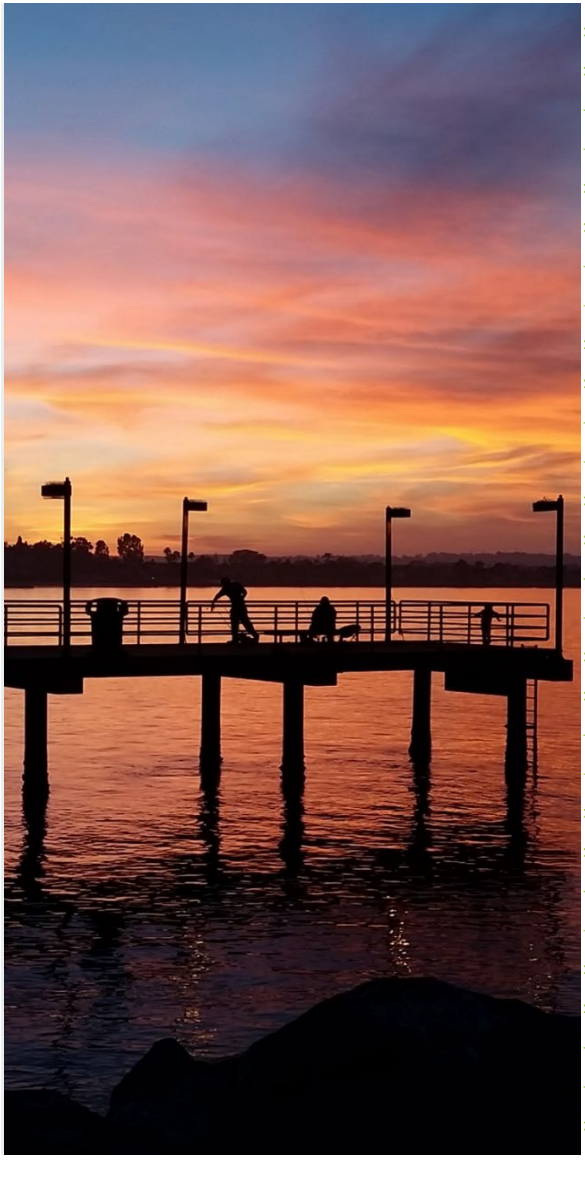
Auditor Opinion & Report



Return to Agenda

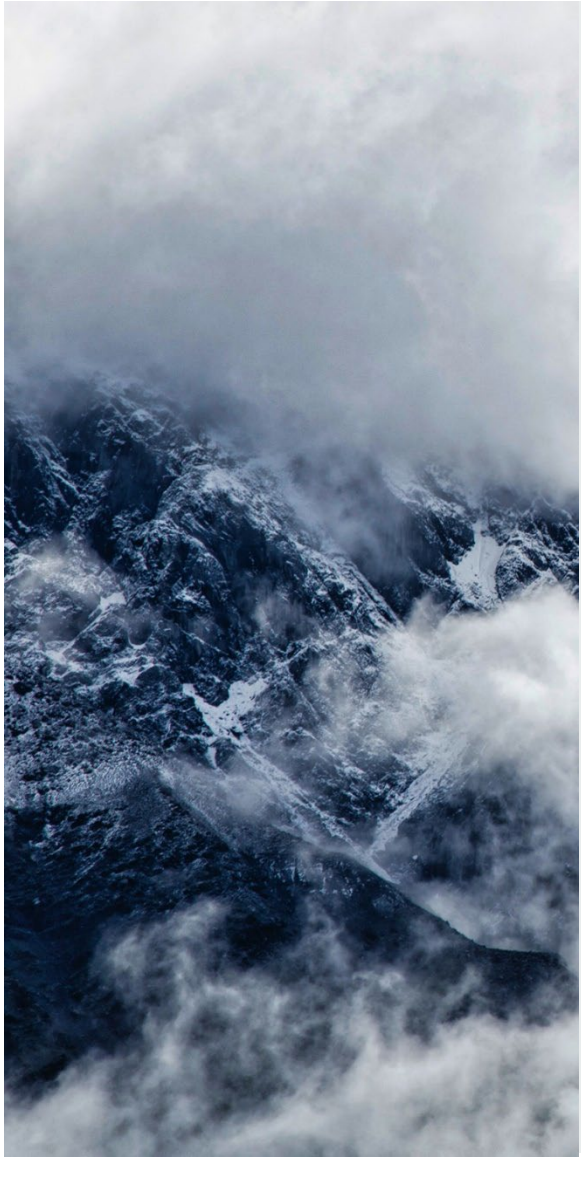
Scope of Services

We have performed the following services for Gold Coast Health Plan:

- Annual financial statement audit as of and for the year ended June 30, 2021.

We have also performed the following nonattest services:

- Assisted in the drafting the financial statements of the Plan



Auditor Report on the Financial Statements

Unmodified Opinion

- Financial statements are presented fairly and in accordance with US GAAP

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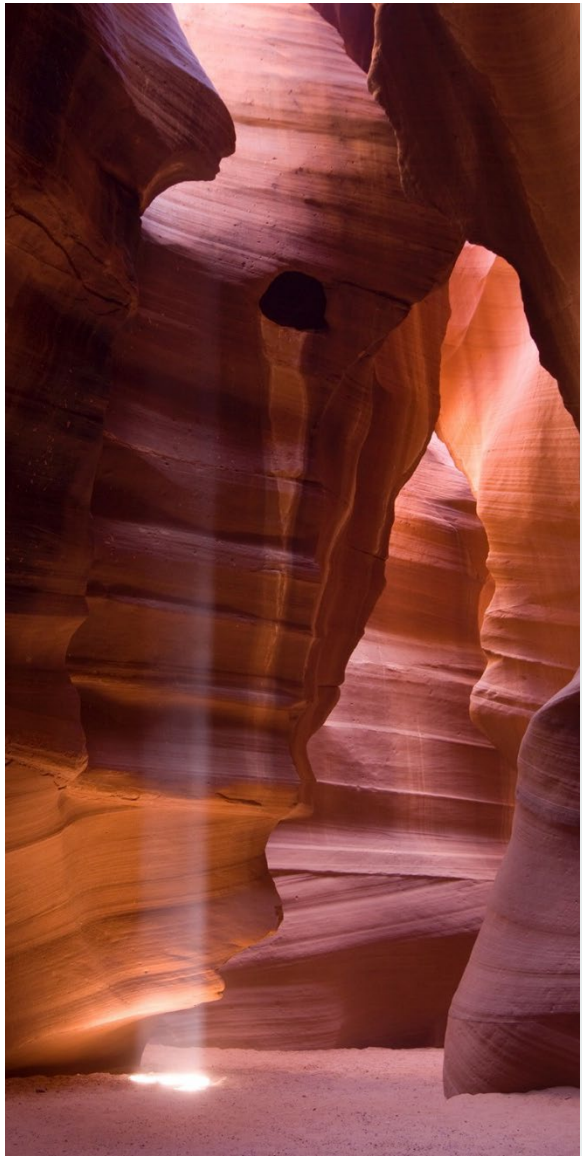
Communications with Those Charged with Governance



Return to Agenda

Our Responsibility

			
To express our opinion on whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, and in accordance with U.S. GAAP. However, our audit does not relieve you or management of your responsibilities.	To perform an audit in accordance with generally accepted auditing standards issued by the AICPA, and design the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement.	To consider internal control over financial reporting as a basis for designing audit procedures but not for the purpose of expressing an opinion on its effectiveness or to provide assurance concerning such internal control.	To communicate findings that, in our judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Planned Scope & Timing of the Audit

It is the auditor's responsibility to determine the overall audit strategy and the audit plan, including the nature, timing, and extent of procedures necessary to obtain sufficient appropriate audit evidence and to communicate with those charged with governance an overview of the planned scope and timing of the audit.

Our Comments

The planned scope and timing of the audit was communicated to the Plan's Executive/Finance Committee at the audit entrance meeting and was included in the engagement letter for the year ended June 30, 2021.

Significant Accounting Policies & Unusual Transactions

The auditor should determine that the Commission is informed about the initial selection of and changes in significant accounting policies or their application. The auditor should also determine that the Commission is informed about the methods used to account for significant unusual transactions and the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.

Our Comments

Management has the responsibility for selection and use of appropriate accounting policies. The significant accounting policies used by the Plan are described in the footnotes to the financial statements. Throughout the course of an audit, we review changes, if any, to significant accounting policies or their application, and the initial selection and implementation of new policies. There were no changes to significant accounting policies for the year ended June 30, 2021.

We believe management has selected and applied significant accounting policies appropriately and consistent with those of the prior year.

Management Judgments & Accounting Estimates

The Commission should be informed about the process used by management in formulating particularly sensitive accounting estimates and about the basis for the auditor's conclusions regarding the reasonableness of those estimates.

Our Comments

Management's judgments and accounting estimates are based on knowledge and experience about past and current events and assumptions about future events. We apply audit procedures to management's estimates to ascertain whether the estimates are reasonable under the circumstances and do not materially misstate the financial statements.

Significant management estimates impacted the financial statements including the following: medical claims liabilities, payable to the State of California (which includes the estimate related to the medical loss ratio requirements), and capitation payable.

We deem them to be reasonable.

Areas of Audit Emphasis

	Capitation revenue and receivables
	Cash and cash equivalents
	Investments
	Medical claim liability, capitation payable, and payable to the State of California
	Non-routine transactions, including the implementation of a new claims processing system (in process)

Significant Accounting Policies, Accounting Estimates, and Financial Statement Disclosures

Our views about the quantitative aspects of the entity's significant accounting policies, accounting estimates, and financial statement disclosures.

Our Comments

The disclosures in the financial statements are clear and consistent. Certain financial statement disclosures may be particularly sensitive because of their significance to financial statements users. We call your attention to the following notes:

- Note 7 – Medical Claims Liability
- Note 8 – Commitments and Contingencies

Significant Audit Adjustments & Unadjusted Differences Considered by Management to Be Immaterial

The Commission should be informed of all significant audit adjustments arising from the audit. Consideration should be given to whether an adjustment is indicative of a significant deficiency or a material weakness in the Plan's internal control over financial reporting, or in its process for reporting interim financial information, that could cause future financial statements to be materially misstated.

The Commission should also be informed of uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented that were determined by management to be immaterial, both individually and in the aggregate, to the financial statements as a whole.

Our Comments

CORRECTED ADJUSTMENTS:

No significant adjustments noted

UNCORRECTED ADJUSTMENTS:

None noted

Deficiencies in Internal Control

Any material weaknesses and significant deficiencies in the design or operation of internal control that came to the auditor's attention during the audit must be reported to the Commission.

Our Comments

MATERIAL WEAKNESS

- None noted

SIGNIFICANT DEFICIENCIES

- Conduent, Inc. claims processing controls around the new system implementation

Potential Effect on the Financial Statements of Any Significant Risks, Exposures & Uncertainties

The Commission should be adequately informed of the potential effect on financial statements of significant risks, exposures, and uncertainties that are disclosed in the financial statements.

Our Comments

The Plan is subject to potential legal proceedings and claims that arise in the ordinary course of business, which are disclosed in the notes to the financial statements.

Difficulties Encountered in Performing the Audit

The Commission should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the Plan's financial statements or the auditor's report.

Our Comments

No significant difficulties were encountered during our audit, other than incremental audit procedures performed in response to the claims system implementation challenges.

We are pleased to report that there were no disagreements with management.

Material Uncertainties Related to Events & Conditions/ Fraud & Noncompliance with Laws & Regulations

Any doubt regarding the entity's ability to continue, as a going concern, should be communicated to the Commission.

Fraud involving senior management and fraud (whether caused by senior management or other employees) that causes a material misstatement of the financial statements should be communicated. We are also required to communicate any noncompliance with laws and regulations involving senior management that come to our attention, unless clearly inconsequential.

Our Comments

No such matters came to our attention.

We have not become aware of any instances of fraud or noncompliance with laws and regulations, other than recent communication from DHCS regarding claims processing delays.

Other Material Written Communications

Report to those charged with governance significant written communications between the auditor and management.

Our Comments

See Exhibit 1 for management representation letter.

See Exhibit 2 for communication of internal control related maters.

Other than the engagement letter, management representation letter, and communications to those charged with governance, there have been no other significant communications.

Management's Consultation with Other Accountants

In some cases, management may decide to consult about auditing and accounting matters. If management has consulted with other accountants about an auditing and accounting matter that involves application of an accounting principle to the Plan's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts.

Our Comments

We are not aware of any significant accounting or auditing matters for which management consulted other accountants.

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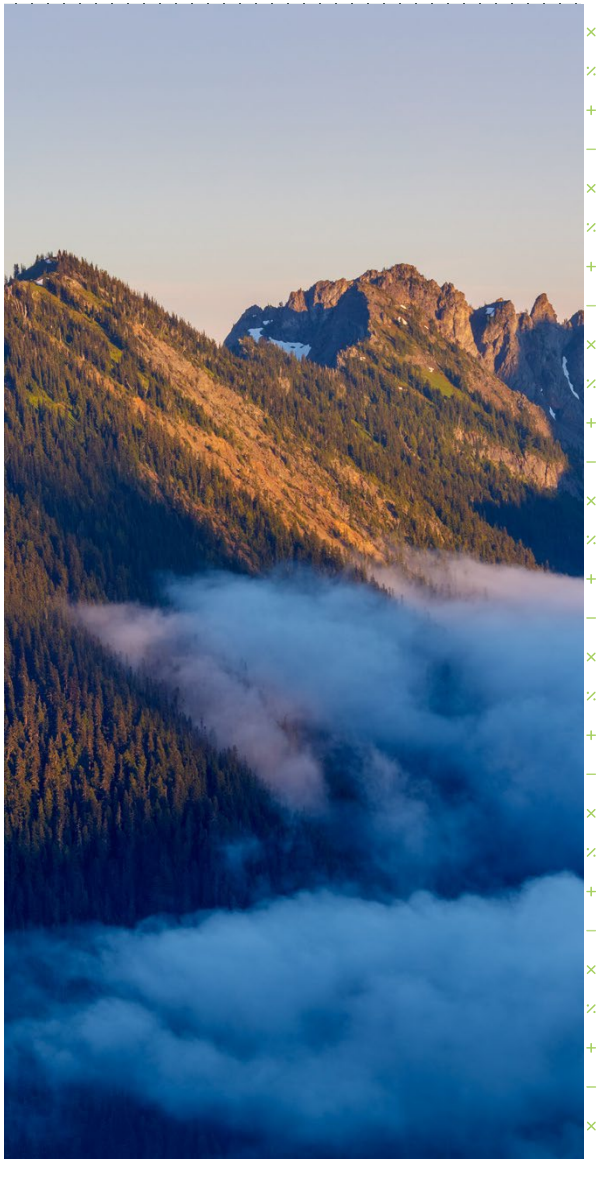
Management Representation Letter

Exhibit



Return to Agenda

Management Representation Letter

October 26, 2021

Moss Adams LLP
101 Second Street, Suite 900
San Francisco, CA 94105

We are providing this letter in connection with your audit of the financial statements of Ventura County Medi-Cal Managed Care Commission, dba Gold Coast Health Plan ("GCHP") which comprise the statements of net position and the related statements of revenues, expenses, and changes in net position, and cash flows as of June 30, 2021 and 2020 and for the years then ended and the related notes to the financial statements for the purpose of expressing an opinion as to whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States (U.S. GAAP). Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Except where otherwise stated below, immaterial matters less than $900,000 collectively are not considered to be exceptions that require disclosure for the purpose of the following representations. This amount is not necessarily indicative of amounts that would require adjustment to or disclosure in the financial statements.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of the date of this letter.

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the Financial Audit Services Service Order No. 09 dated October 9, 2020, for the preparation and fair presentation of the financial statements in accordance with U.S. GAAP.
2. We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material

Note: a copy of the full management representation letter is available, upon request.

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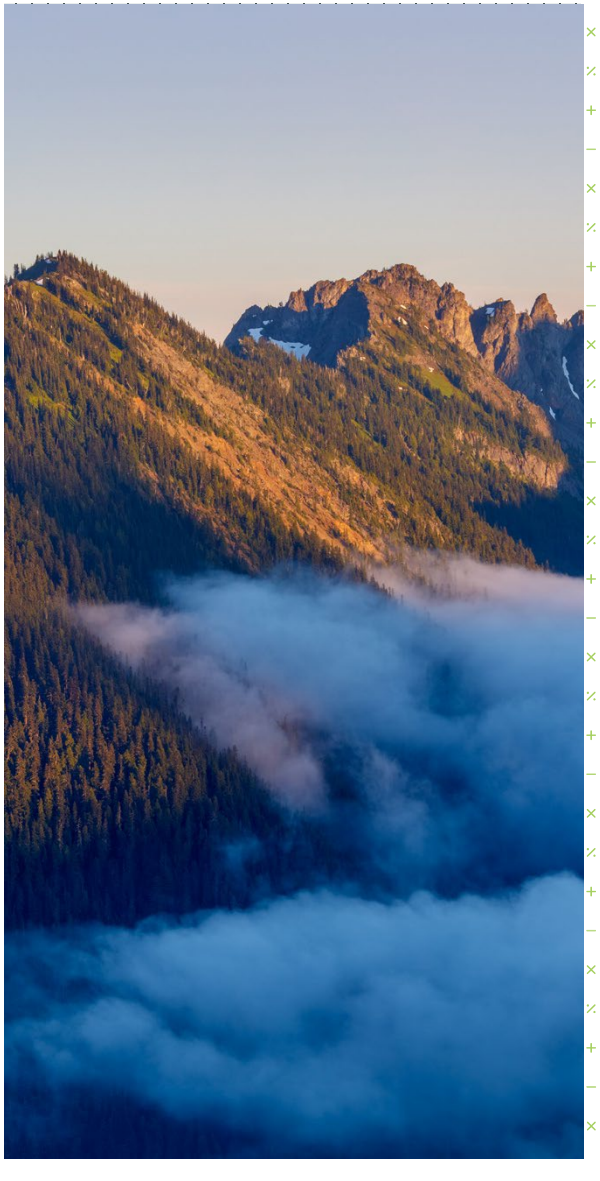
Communication of Internal Control Related Matters

Exhibit



Return to Agenda

Communication of Internal Control Related Matters

Ventura County Medi-Cal Managed Care Commission Dba Gold Coast Health Plan

June 30, 2021

Communication of Internal Control Related Matters

To the Management and Commissioners of
Ventura County Medi-Cal Managed Care Commission DBA Gold Coast Health Plan

In planning and performing our audit of the financial statements of Ventura County Medi-Cal Managed Care Commission DBA Gold Coast Health Plan (the "Plan") as of and for the year ended June 30, 2021, in accordance with auditing standards generally accepted in the United States of America, we considered the Plan's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, we do not express an opinion on the effectiveness of the Plan's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Our audit was also not designed to identify deficiencies in internal control that might be significant deficiencies. A significant deficiency is a deficiency, or combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the following deficiencies in the Plan's internal control to be a significant deficiency:

Conduent, Inc. Claims Processing

During our control test procedures over the Health Solutions Plus Meditrac claims processing cycle, we noted that Conduent, Inc., the Plan's third-party claims processing organization, has not consistently processed claims within the required 30 working days since the system was implemented in May 2021 and certain errors were noted in initial claims processing, both of which have caused payment errors and significant delays in processing claim payments. Additionally, the claims processing data utilized for the estimation of the medical claims liability contained reporting errors and was not categorized at a precise level, causing challenges in the estimation process.

Management's Response:

GCHP has aggressively monitored Conduent's performance since the system conversion and consistently issued Notices of Deficiency and followed up to ensure Corrective Action Plans were defined. GCHP staff has increased manual review of claims payments to minimize errors. In addition, GCHP retained over 60 temporary claims processors with strong claims processing experience to ensure complete adjudication of backlogged claims. GCHP has experienced some challenges in the data files utilized for the medical claims liability. GCHP has root caused the issues and works daily to remediate and update the data mapping.

The Plan's written response to the significant deficiency identified in our audit was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

This communication is intended solely for the information and use of management, Commissioners and others within the organization, and is not intended to be and should not be used by anyone other than these specified parties.

San Francisco, California
October __, 2021

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Accounting Update

Exhibit

Return to Agenda

New Standards

GASB 84

Fiduciary Activities

Clarifies fiduciary activities as having the following characteristics:

1. Government controls the assets of the activity.
2. Those assets are not derived solely from the government's own source revenue.
3. One of the following:
   - The assets result from a pass-through grant or trust agreement.
   - Assets are used to benefit individuals not typical recipients of the government's goods and services (i.e. employees receive the benefit instead of patients.)
   - Assets are to be used to benefit other organizations or governments.

- Would require stand alone business-type entities (i.e. hospitals) with pension and OPEB trusts or patient custodial accounts to report separate fiduciary fund financial statements within the financial statements.
- Effective for reporting periods beginning after December 15, 2019. Earlier application is encouraged.

New Standards

GASB 87

Leases

- Would treat all leases as financings (no classification of capital v. operating) similar to FASB ASU 2016-02.
- Includes non-cancellable period + periods covered by options to renew if reasonably certain to be exercised.
- Lessee would record an intangible asset (amortized over the shorter of its useful life or lease term) and present value of future lease payments as a liability.
- Lessor would record a lease receivable and deferred inflow of resources for cash received up front + future payments (revenue recognized over lease term in a systematic and rational basis).
- Effective for reporting periods beginning after June 15, 2021. Earlier application is encouraged.

New Standards

GASB 96

Subscription-Based Information Technology Arrangements

- Provides guidance on the accounting and financial reporting for subscription-based information technology arrangements (SBITAs) for government end users
  - Defines a SBITA as a contract that conveys control of the right to use another party's information technology software, alone or in combination with tangible capital assets, as specified in the contract for a period of time in an exchange or exchange-like transaction
  - Establishes that a SBITA results in a right-to-use subscription asset (intangible asset) and a corresponding subscription liability
  - Provides the capitalization criteria for outlays other than subscription payments, including implementation costs of a SBITA
  - Requires note disclosures regarding a SBITA
- Based on the standards established in Statement No. 87, *Leases*
- Effective for fiscal years beginning after June 15, 2022.

New Standards

GASB 97

Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans

- Provides updated guidance and clarification on Statement No. 84, *Fiduciary Activities*
- Requires that a Section 457 plan be classified as either a pension plan or other employee benefit plan and clarifies that Statement No. 84 should be applied to all arrangements organized under IRC Section 457 to determine whether those arrangements should be reported as fiduciary activities.
- Certain requirements in this standard are effective immediately.
- The requirements related to the accounting and financial reporting for Section 457 plans are effective for fiscal years beginning after June 15, 2021.

On the Horizon – Exposure Drafts and Preliminary Views

- **Financial Reporting Model Improvements** – Proposes defining "operating" vs. "non-operating" activities; proposes requiring combining financial statements as supplementary information for blended component units; proposes classification of government-wide expenses by function or program.
- **Revenue and Expense Recognition** – Better differentiates exchange from non-exchange transactions; proposes a uniform revenue recognition standard with 3 models to be evaluated.
- **Disclosure Framework** – Proposes a framework for the development and evaluation of notes to financial statements for the purpose of improving the effectiveness of note disclosures.
- **Compensated Absences** – Addresses certain types of accrued leave benefits not covered in Statement No. 16, measurement options for sick leave, and usefulness of required notes to financial statements for decision-making and assessing accountability.
- **Prior-Period Adjustments, Accounting Changes, and Error Corrections** – Examines existing standards to address issues related to inconsistency in practice, confusion about and difficulty in applying requirements, and usefulness of related disclosures.
- **Risks and Uncertainties Disclosures** – Identifies potential risks and uncertainties in the state and local government environment and develops disclosure requirements for these.
- **Renaming the Comprehensive Annual Financial Report** – Considers whether a new name for the comprehensive annual financial report should be established.

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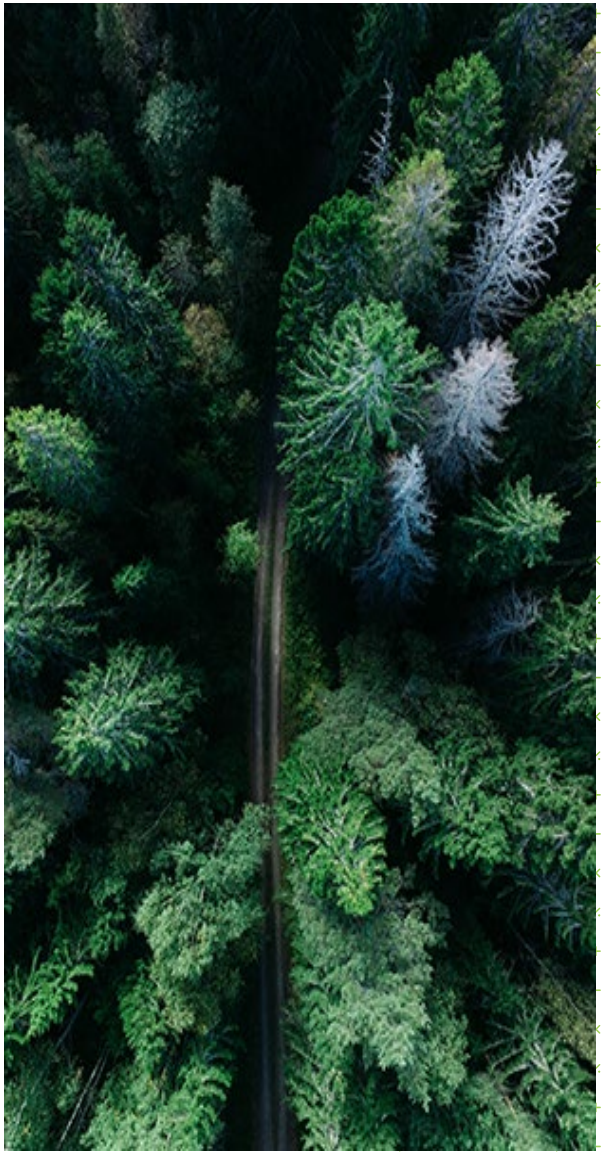
About Moss Adams



Return to Agenda

2021 Health Care Executive Webcast Series

KEYNOTE SPEAKERS

Liz Fowler
Deputy Director
CMMI

Patrick J. Kennedy
Former US
Representative

Mark McClennan
Former Administrator
CMS

Susan Dentzer
Senior Policy Fellow
Duke-Margolis Center

Shawn Coughlin
President and CEO
NABH

David Lloyd
Sr. Policy Advisor
The Kennedy Forum

John Arch
State Senator
Nebraska

Ford Koles
Vice President
The Advisory Board

SESSIONS

REGISTER & LEARN MORE

2021 State of the Union: Health Care
November 2, 2021
11:00 AM-12:30 PM PT

Presenter Ford Koles of The Advisory Board provides insight into the aftermath of the COVID-19 pandemic. He'll address key opportunities and challenges for the health care industry and steps you can take to prepare your organization for 2022.

CMMI's Vision of Future Payment Models and Value-Based Care
November 9, 2021
12:30 PM-2:00 PM PT

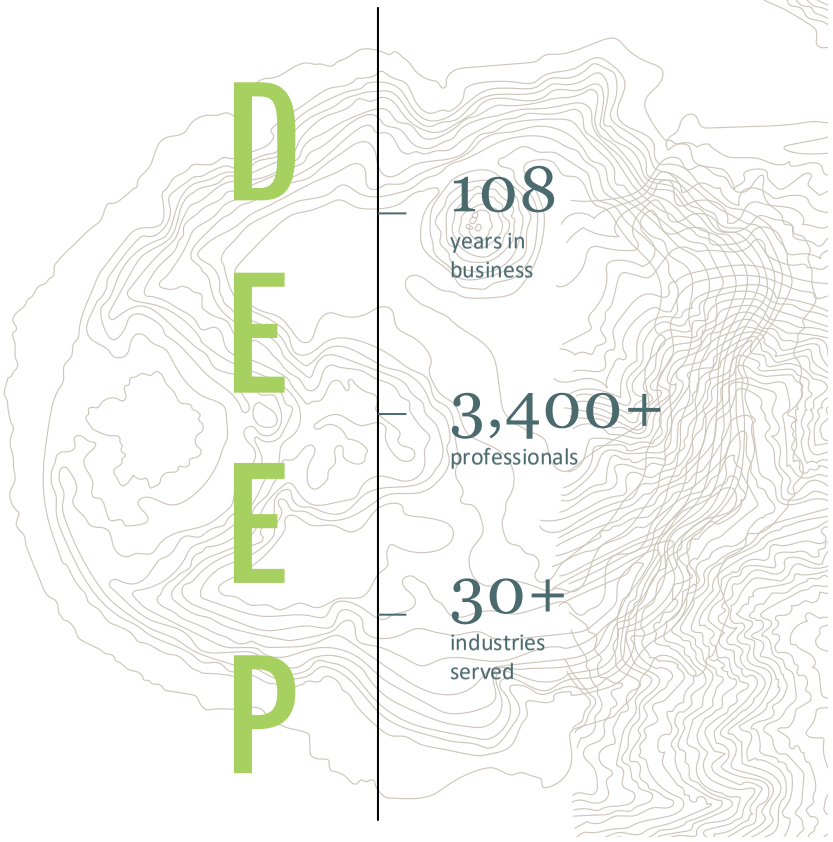
Presenters Dr. Liz Fowler, Dr. Mark McClennan and Susan Dentzer discuss the Center for Medicare and Medicaid Innovation's (CMMI's) vision of the future of payment models and value-based care.

Behavioral Health Transformation and Payment Reform
November 11, 2021
11:00 AM-12:30 PM PT

This panel discussion features former US Representative Patrick J. Kennedy and other industry professionals on transformation and payment reform in behavioral health. We'll address payment parity at the federal and state levels, and how it's impacting the continuum of care.

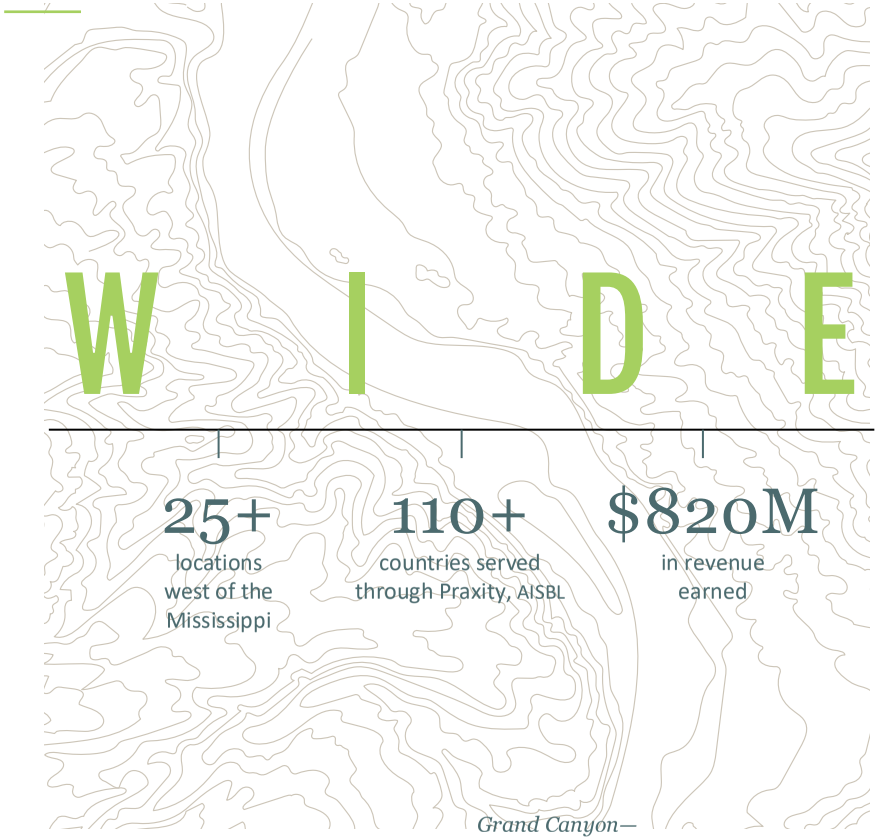
Return to Agenda

Our Expertise



Crater Lake—
A monument to perseverance, North America's deepest lake filled to 1,949 feet over 720 years.

Our Reach



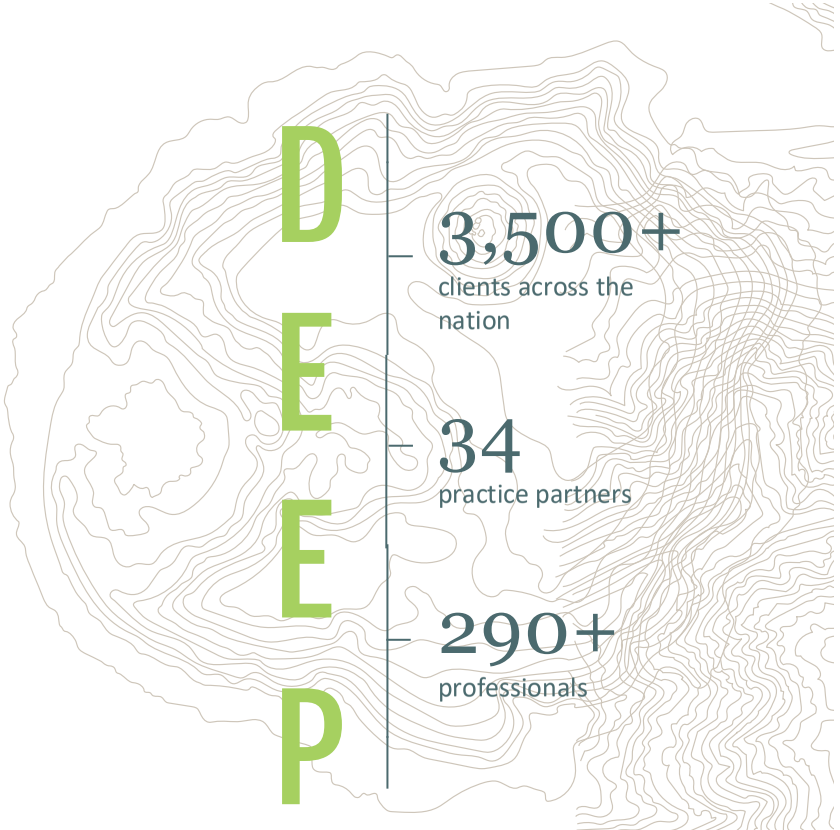
Grand Canyon—
At 277 miles long and up to 18 miles wide, this icon serves as a testament to determination and time.

Health Care Industry Experience

Our health care professionals dedicate their careers to serving the industry.

We cover the full spectrum of health care including:

- Hospitals and health systems
- Independent practice associations
- Medical groups
- Community health centers
- Behavioral health organizations
- Long-term care
- Surgery centers
- Knox Keene licensed health plans
- Health care ancillary services



Crater Lake—
A monument to perseverance, North America's deepest lake filled to 1,949 feet over 720 years.

Our Response to COVID-19

The COVID-19 pandemic has touched all aspects of our lives. We're here to guide you to the information and resources you need now and provide strategies for the changes to come. We'll support you as you rebuild and help you take advantage of rising opportunities.

NAVIGATE

- Stay up to date with guidance and support to help combat uncertainty
- Reach out to your Moss Adams professional with any questions on the most current updates and advisements

ARTICLE

- Weather COVID-19 Market Volatility: Investments, Finances, and Tax Planning

REBUILD

- Strategize needs and be aware of what's to come
  - We'll connect you with the right resource, either within the greater Moss Adams team or through our various industry contacts
- Review Moss Adams announcements that provide tax and regulatory relief

ALERTS

- CARES Act Overview: Implications for Business Taxpayers
- CARES Act: Implications for Individual Taxpayers

THRIVE

- Take steps to bolster your workforce and organization
- Evaluate additional service needs, such as the following:
  - Capital sourcing
  - Cloud tools
  - Cost segregation
  - Enterprise resource planning
  - Estate and succession planning
  - Financial planning
  - Forecasting
  - IT security and cybersecurity
  - Process improvement
  - Outsourced finance accounting
  - R&D tax credits
  - Risk assessment
  - State and local tax
  - Transactions services

HELPING YOU ADAPT TO UNCERTAIN TIMES

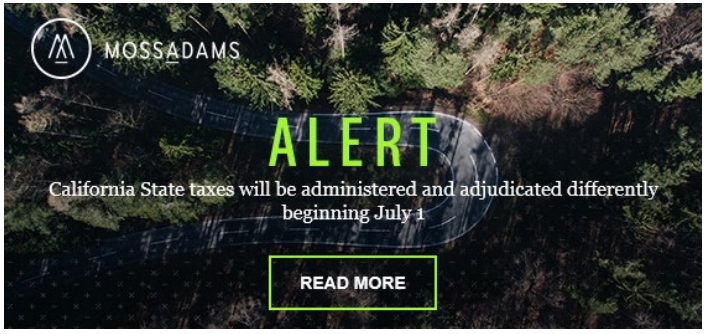
Find more information and resources here: https://mossadams.com/covid-19-implications

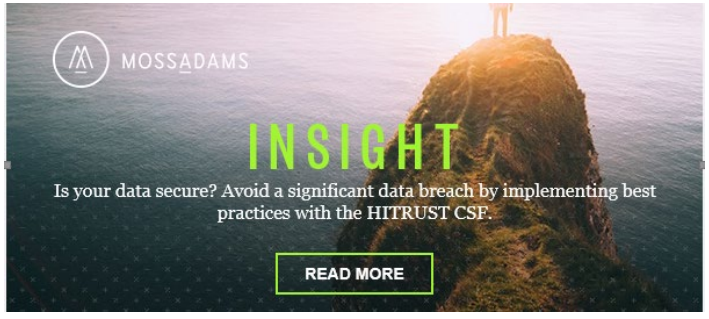
Insights and Resources

We'll keep you informed to help you stay abreast of critical industry issues.

Moss Adams closely monitors regulatory agencies, participates in industry and technical forums, and writes about a wide range of relevant accounting, tax, and business issues to keep you informed.

We also offer CPE webinars and events that are archived and available on demand, allowing you to watch them on your schedule.





Connect With Us

In today's fast-paced world, we know how precious your time is. We also know that knowledge is key. These resources offer what you need to know, when you need to know it, and are presented in the format that fits your life.

LinkedIn: www.linkedin.com/company/moss-adams-llp

Twitter: @Moss_Adams

Subscribe to our emails: www.mossadams.com/subscribe

RSS feeds: www.mossadams.com/RSS

YouTube: http://www.youtube.com/mossadamsllp

Stelian Damu, Assurance Partner
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Kimberly Sokoloff, Assurance Senior Manager
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(925) 952-2506

THANK YOU

Return to Agenda

Report of Independent Auditors
and Financial Statements

Ventura County Medi-Cal Managed Care Commission Dba Gold Coast Health Plan

June 30, 2021 and 2020

Return to Agenda

Table of Contents

The intent of the Management's Discussion and Analysis is to provide readers with an overview of the Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan's ("GCHP" or the "Plan") financial activities for the fiscal years ended June 30, 2021 and 2020. This overview is provided in conjunction with the Plan's fiscal year ended June 30, 2021 financial statements. Readers should review this overview in conjunction with GCHP's financial statements and accompanying notes to the financial statements to enhance their understanding of the financial performance.

GOLD COAST HEALTH PLAN OVERVIEW

On June 2, 2009, the Ventura County Board of Supervisors approved the implementation of a county-organized health system ("COHS") model to transition Ventura County Medi-Cal members from a fee-for-service model to a managed care model. Ordinance No. 4409 (April 2010) established the Ventura County Medi-Cal Managed Care Commission as an oversight entity. The Commission's 11 members oversee a single plan—Gold Coast Health Plan—to serve Ventura County Medi-Cal beneficiaries.

As a COHS, the Plan has an exclusive contract (the "Contract") with the State of California (the "State") Department of Health Care Services ("DHCS") to arrange for the provision of health care services to Ventura County's approximately 222,000 Medi-Cal beneficiaries at June 30, 2021. The Plan receives virtually 100 percent of its revenue in the form of capitation from the State of California.

OVERVIEW OF THE FINANCIAL STATEMENTS

This annual report consists of financial statements and notes to those statements, which reflect GCHP's financial position and results of operations for the fiscal years ended June 30, 2021 and 2020. The financial statements of GCHP include the statements of net position, statements of revenues, expenses, and changes in net position, statements of cash flows, and notes to the financial statements.

- The statements of net position includes all of GCHP's assets and liabilities, using the accrual basis of accounting.
- The statements of revenues, expenses, and changes in net position presents the results of operating activities during the fiscal year and the resulting change in net position.
- The statements of cash flows reports the net cash provided by operating activities, as well as other sources, and uses of cash from investing, capital, and related financing activities.

The following discussion and analysis addresses GCHP's overall program activities.

FINANCIAL HIGHLIGHTS

The table below presents condensed statements of net position of the Plan as of June 30, 2021, 2020, and 2019:

Table 1 – Condensed Statements of Net Position as of June 30

(Dollars in Thousands)

	2021	2020	2019	2021 - 2020 Change		2020 - 2019 Change	
				Amount	Percentage	Amount	Percentage
ASSETS							
Current assets and other assets	$ 350,936	$ 244,402	$ 237,883	$ 106,534	43.6 %	$ 6,519	2.7 %
Capital assets, net	1,199	1,610	1,668	(411)	(25.5)%	(58)	(3.5)%
Total assets	352,135	246,012	239,551	106,123	43.1 %	6,461	2.7 %
LIABILITIES							
Current liabilities	246,420	168,689	163,946	77,731	46.1 %	4,743	2.9 %
Total liabilities	246,420	168,689	163,946	77,731	46.1 %	4,743	2.9 %
NET POSITION							
Invested in capital assets	1,198	1,610	1,668	(412)	(25.6)%	(58)	(3.5)%
Unrestricted net position	104,517	75,713	73,937	28,804	38.0 %	1,776	2.4 %
Total net position	105,715	77,323	75,605	28,392	36.7 %	1,718	2.3 %
Total liabilities and net position	$ 352,135	$ 246,012	$ 239,551	$ 106,123	43.1 %	$ 6,461	2.7 %

FISCAL YEAR 2021

- As of June 30, 2021 and 2020, total assets were approximately $352,135,000 and $246,012,000, respectively, an increase of $106,123,000 or 43.1 percent due to an increase in cash and cash equivalents driven by the increase in accrued medical expenses.

- Current liabilities as of June 30, 2021, were $246,420,000 compared with $168,689,000 as of June 30, 2020, a 46.1 percent increase. The increase was primarily driven by an increase in accrued medical expenses resulting from claims inventory build-up that occurred due to the claims systems migration to Health Solutions Plus MediTrac.

- The Plan's total net position increased by approximately $28,392,000, or 36.7 percent, during fiscal 2021. This increase in net position was attributable to favorability in capitation rates from the State and overall reduced utilization as a result of the COVID-19 pandemic, which resulted in a net position at June 30, 2021 of $105,715,000 compared to a net position of $77,323,000 at June 30, 2020.

- Tangible Net Equity ("TNE") at June 30, 2021, was 293 percent of the DHCS required minimum of $36,073,000.

FISCAL YEAR 2020

As of June 30, 2020 and 2019, total assets were approximately $246,012,000 and $239,551,000 respectively, an increase of $6,461,000 or 2.7 percent.

- Current liabilities at June 30, 2020, were $168,689,000, compared with $163,946,000 at June 30, 2019, a 2.9 percent increase. The increase was primarily related to increases in accrued pharmacy.

- The Plan's total net position increased by approximately $1,718,000, or 2.3 percent, during fiscal 2020. This increase in net position was attributable to favorability in capitation rates from the State, which resulted in a net position at June 30, 2020 of $77,323,000 from a net position of $75,605,000 at June 30, 2019.

- TNE at June 30, 2020, was 225 percent of the DHCS required minimum of $34,440,000.

RESULTS OF OPERATIONS

As mentioned above, GCHP's fiscal 2021 operations and nonoperating revenues and expenses, net resulted in a $28,392,000 increase in net position. GCHP's fiscal 2020 operations and nonoperating revenues and expenses, net resulted in a $1,718,000 increase in net position. The following table shows the changes in revenues and expenses for 2021 compared to 2020 and 2020 compared to 2019.

Table 2 – Revenues, Expenses, and Changes in Net Position for Fiscal Years Ended June 30

(Dollars in Thousands)

				2021 to 2020 Change		2020 to 2019 Change	
	2021	2020	2019	Amount	Percentage	Amount	Percentage
Capitation revenues	$ 985,385	$ 854,969	$ 808,723	$ 130,416	15.3 %	$ 46,246	5.7 %
Total operating revenues	985,385	854,969	808,723	130,416	15.3 %	46,246	5.7 %
Provider capitation	87,192	58,648	56,824	28,544	48.7 %	1,824	3.2 %
Claim payments to providers and facilities	570,844	552,877	521,847	17,967	3.2 %	31,030	5.9 %
Prescription drugs	159,068	143,601	134,567	15,467	10.8 %	9,034	6.7 %
Other medical	16,624	15,493	16,212	1,131	7.3 %	(719)	(4.4)%
Reinsurance, net of recoveries	(3,549)	(895)	(3,496)	(2,654)	296.5 %	2,601	(74.4)%
Total health care expenses	830,179	769,724	725,954	60,455	7.9 %	43,770	6.0 %
Salaries, benefits, and compensation	14,635	15,560	14,897	(925)	(5.9)%	663	4.5 %
Professional fees	29,220	28,449	25,639	771	2.7 %	2,810	11.0 %
General administrative fees	3,118	3,258	2,766	(140)	(4.3)%	492	17.8 %
Supplies, occupancy, insurance, and other	2,020	2,265	2,221	(245)	(10.8)%	44	2.0 %
Premium tax	77,637	34,505	96,569	43,132	125.0 %	(62,064)	(64.3)%
Depreciation	514	467	534	47	10.1 %	(67)	(12.5)%
Total administrative expenses	127,144	84,504	142,626	42,640	50.5 %	(58,122)	(40.8)%
Total operating expenses	957,323	854,228	868,580	103,095	12.1 %	(14,352)	(1.7)%
Operating income (loss)	28,062	741	(59,857)	27,321	3687.0 %	60,598	(101.2)%
Interest income	458	1,800	3,993	(1,342)	(74.6)%	(2,193)	(54.9)%
Interest expense	(128)	(823)	(646)	695	(84.4)%	(177)	27.4 %
Total nonoperating revenues and expenses, net	330	977	3,347	(647)	(66.2)%	(2,370)	(70.8)%
Increase (decrease) in net position	28,392	1,718	(56,510)	26,674	1552.6 %	58,228	(103.0)%
Total net position, beginning of year	77,323	75,605	132,115	1,718	2.3 %	(56,510)	(42.8)%
Total net position, end of year	$ 105,715	$ 77,323	$ 75,605	$ 28,392	36.7 %	$ 1,718	2.3 %

ENROLLMENT, CAPITATION REVENUE AND HEALTH CARE EXPENSES

ENROLLMENT

Enrollment is divided into aid categories, which correspond to specific rates of capitation to be received by the Plan from the State. During fiscal 2021, the Plan served an average of 213,585 members per month, compared to an average of 194,879 members per month in fiscal 2020 and an average of 199,109 members per month in fiscal 2019. The increase in enrollment is attributed to the moratorium on redeterminations as a result of the COVID-19 pandemic.

Table 3 – Medi-Cal Enrollment by Aid Category
(Shown as Average Member Months)

Enrollment Category	2021	2020	2019
Child	89,885	86,238	89,325
Adult	28,535	24,009	24,407
Adult Expansion	63,226	53,798	54,220
Seniors and Persons with Disabilities ("SPD")	10,310	10,169	9,344
SPD - Dual	20,748	19,628	20,747
Breast and Cervical Cancer Treatment Program ("BCCTP")	76	154	171
Long Term Care ("LTC")	49	53	27
LTC - Dual	757	830	868
Total average monthly enrollment	213,586	194,879	199,109

Significant aid categories are defined as follows:

1. Child: Qualifying members under age 19.

2. Adult: Qualifying members between the ages of 19 and 64.

3. Adult Expansion ("AE"): Refers to members who became eligible for the Medi-Cal program effective January 1, 2014, as a result of the implementation of the Affordable Care Act ("ACA") and the expanded eligibility criteria for Medicaid.

4. Senior and Persons with Disabilities ("SPD")*: Includes individuals who are 65 years of age and older who receive supplemental security income (SSI) checks, or are medically needy if their income and resources are within the Medi-Cal limits, and individuals who met the criteria for disability set by the Social Security Administration and the State Program-Disability and Audit Program Division.

5. Long-Term Care* ("LTC"): Includes frail, elderly, nonelderly adults with disabilities and children with developmental disabilities, and other disabling conditions requiring long-term care services.

6. Breast and Cervical Cancer Treatment Program ("BCCTP"): Provides cancer treatment for eligible low-income California residents who are screened by the Cancer Detection Program: Every Woman Counts ("CDP:EWC") or Family Planning, Access, Care and Treatment ("Family PACT") programs and found to be in the need of treatment for breast and/or cervical cancer. For the CY2021 rate year this category of aid was rolled into the SPD category of aid.

*"Dual" coverage refers to enrollees who are eligible for both Medi-Cal and Medicare Parts A, B, and D.

FISCAL YEAR 2021

CAPITATION REVENUE

Premium revenue (capitation received by the Plan from the State) is determined by rates set by the State at the beginning of the plan year and generally are effective for the entire year. The State may, on occasion, provide updated rates during the fiscal year. Total revenue for fiscal year 2021 was $985,385,000, a 15.3 percent increase from the prior year. The increase was primarily attributable to favorability in capitation rates from the State.

HEALTH CARE EXPENSES

Aggregate health care expenses were $830,179,000 in fiscal 2021, compared to $769,724,000 in fiscal 2020, which is an increase of 7.9 percent. The Plan's medical loss ratio, or health care expenses as a percent of operating revenues (net of Managed Care Organization ("MCO") taxes), was 91.5 percent in fiscal 2021, compared to 93.8 percent in fiscal 2020.

Note the following regarding the components of health care expenses:

1. Provider capitation represents monthly payments for members assigned to primary care providers who have agreed to accept risk to provide specific services (when needed) to their members. Rates are fixed by contract and are generally known at the beginning of the fiscal year. Capitation expense for fiscal 2021 was $87,192,000, or $28,544,000 higher than in fiscal 2020. The increase was primarily due to a contract change with a provider in which they took on additional services as well as higher capitated membership from prior year.

2. Pharmacy expenses were $159,068,000, or $15,467,000 higher in fiscal 2021 than in the prior year. The 10.8 percent increase in costs were impacted by an overall increase in utilization and an overall increase in unit costs consistent with a national trend and allowing for 90-day supplies starting in the latter half of fiscal 2020 due to COVID-19 and continuing through the entire fiscal 2021.

3. Other medical, including care management, expense was $16,624,000 in fiscal 2021, or $1,131,000 and 7.3 percent higher than in fiscal 2020. The increase was primarily due to an increase in care management expenses from the prior year due to additional staffing and software costs.

4. Total reinsurance, net of recoveries and provider refunds resulted in a $3,549,000 reduction to health care expenses in fiscal 2021, versus $895,000 in fiscal 2020.

Administrative Expenses

Total administrative expenses were approximately $127,144,000 in fiscal 2021, compared to $84,504,000 in fiscal 2020, for an increase of $42,640,000. The increase was predominantly due to premium tax expense, which was $77,637,000 in fiscal year 2021 compared to $34,505,000 in fiscal year 2020. The increase in premium tax was due to a 6-month gap in required premium tax in fiscal 2020. Senate Bill X2-2 established the managed care organization tax between July 1, 2016 through June 30, 2019. The tax was renewed with the Centers for Medicare and Medicaid Services CMS approval of Assembly Bill 115 with an effective date of January 1, 2020.

Senate Bill ("SB") X2-2, which passed in March 2016, redefined the premium tax payment and calculation. Per SB X2-2, the tax rate was a pre-determined liability based on DHCS projected Medi-Cal membership, and specified rates and was effective through June 30, 2019. Assembly Bill 115 re-established a managed care enrollment tax, using a modified tiered taxing model. On April 3, 2020, the federal government approved the State's revised proposal to implement a tax on MCOs to help fund the Medi-Cal program. The new AB115 MCO tax is effective from January 2020 through December 2022.

FISCAL YEAR 2020

CAPITATION REVENUE

Premium revenue (capitation received by the Plan from the State) is determined by rates set by the State at the beginning of the plan year and generally are effective for the entire year. The State may, on occasion, provide updated rates during the fiscal year. Total revenue for fiscal year 2020 was $854,969,000, a 5.7 percent increase from the prior year. The increase was primarily attributable to favorability in capitation rates from the State.

HEALTH CARE EXPENSES

Aggregate health care expenses were $769,724,000 in fiscal 2020, compared to $725,954,000 in fiscal 2019, which is an increase of 6.0 percent. The Plan's medical loss ratio, or health care expenses as a percent of operating revenues (net of MCO taxes), was 93.8 percent in fiscal 2020, compared to 101.9 percent in fiscal 2019.

Note the following regarding the components of health care expenses:

1. Provider capitation represents monthly payments for members assigned to primary care providers who have agreed to accept risk to provide specific services (when needed) to their members. Rates are fixed by contract and are generally known at the beginning of the fiscal year. Capitation expense for fiscal 2020 was $58,648,000, or $1,824,000 higher than in fiscal 2019. The increase was primarily due to a contract change with a provider in which they took on additional services.

2. Pharmacy expenses were $143,601,000, or $9,034,000 higher in fiscal 2020 than in the prior year. The 6.7 percent increase in costs were impacted by an overall increase in utilization, primarily for dermatology and diabetes, and an overall increase in unit costs consistent with a national trend and allowing for 90-day supplies in the latter half of fiscal 2020 due to COVID-19.

3. Other medical, including care management, expense was $15,493,000 in fiscal 2020, or $719,000 and 4.4 percent lower than in fiscal 2019. The decrease was primarily due to a decrease in provider reserves in fiscal 2020, which was partially offset by an increase in care management expenses from the prior year due to additional staffing and software costs.

4. Total reinsurance, net of recoveries and provider refunds resulted in a $895,000 reduction to health care expenses in fiscal 2020, versus $3,496,000 in fiscal 2019.

ADMINISTRATIVE EXPENSES

Total administrative expenses were approximately $84,504,000 in fiscal 2020, compared to $142,626,000 in fiscal 2019, for a decrease of $58,122,000. The decrease was predominantly due to premium tax expense, which was $34,505,000 in fiscal year 2020 compared to $96,569,000 in fiscal year 2019. The decrease in premium tax was due to a 6-month gap in required premium tax. Senate Bill X2-2 established the managed care organization tax between July 1, 2016 through June 30, 2019. The tax was renewed with the CMS approval of Assembly Bill 115 with an effective date of January 1, 2020.

Senate Bill X2-2, which passed in March 2016, redefined the premium tax payment and calculation. Per SB X2-2, the tax rate was a pre-determined liability based on DHCS projected Medi-Cal membership, and specified rates and was effective through June 30, 2019. Assembly Bill 115 re-established a managed care enrollment tax, using a modified tiered taxing model. On April 3, 2020, the federal government approved the State's revised proposal to implement a tax on MCOs to help fund the Medi-Cal program. The new AB115 MCO tax is effective from January 2020 through December 2022.

Other administrative expenses increased from the prior year due to increased expenses related to Enterprise Projects as compared to prior years and increases in staffing.

Tangible Net Equity

GCHP is required by DHCS to maintain certain levels of TNE. Regulatory TNE levels are determined by formula and are based on specified percentages of revenue and medical expenses. Driven by its operating performance, the Plan's TNE at June 30, 2021 was $105,715,000, which exceeded the required TNE amount of $36,073,000. The Plan's TNE at June 30, 2020, was $77,323,000, which exceeded the required TNE amount of $34,440,000.

Table 4 – Tangible Net Equity (TNE)
(Dollars in Thousands)

	June 30, 2021	June 30, 2020	June 30, 2019
		(in thousands)	
Actual TNE, beginning balance	$ 77,323	$ 75,605	$ 132,115
Change in net position	28,392	1,718	(56,510)
Actual TNE, ending balance	$ 105,715	$ 77,323	$ 75,605
Required TNE	$ 36,073	$ 34,440	$ 32,907

REQUESTS FOR INFORMATION

This financial report has been prepared in the spirit of full disclosure to provide the reader with an overview of GCHP's operations. If the reader has questions or would like additional information about GCHP, please direct the request to GCHP, 711 East Daily Drive, Suite 106, Camarillo, CA 93010 or call 805-437-5500.

Report of Independent Auditors

The Commission
Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan
Camarillo, California

Report on Financial Statements

We have audited the accompanying financial statements of Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan ("GCHP" or the "Plan") (a discrete component unit of the County of Ventura, California), which comprise the statements of net position as of June 30, 2021 and 2020, and the related statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of GCHP as of June 30, 2021 and 2020, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 1 through 8 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, which considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

San Francisco, California
[DATE]

Financial Statements

Ventura County Medi-Cal Managed Care Commission
dba Gold Coast Health Plan
Statements of Net Position
June 30, 2021 and 2020

ASSETS

	June 30, 2021	June 30, 2020
CURRENT ASSETS		
Cash and cash equivalents	$ 193,947,004	$ 89,586,429
Short-term investments	43,515,100	43,040,224
Capitation receivable	103,174,578	102,000,828
Provider receivables	1,754,312	727,334
Reinsurance and other receivables	6,440,232	7,141,958
Prepaid expenses and other assets	2,104,933	1,905,555
Total current assets	350,936,159	244,402,328
CAPITAL ASSETS	1,198,472	1,610,328
Total assets	$ 352,134,631	$ 246,012,656

LIABILITIES AND NET POSITION

LIABILITIES		
Medical claims liability	$ 173,767,418	$ 102,596,475
Capitation payable	26,699,447	18,217,262
Payable to the State of California	14,936,921	5,257,358
Accounts payable	1,683,582	2,363,635
Accrued payroll and employee benefits	2,195,823	2,187,982
Accrued premium tax	19,409,220	34,505,280
Accrued expenses and other	7,727,364	3,561,402
Total current liabilities	246,419,775	168,689,394
Total liabilities	246,419,775	168,689,394
NET POSITION		
Net invested in capital assets	1,198,472	1,610,328
Unrestricted net position	104,516,384	75,712,934
Total net position	105,714,856	77,323,262
Total liabilities and net position	$ 352,134,631	$ 246,012,656

Ventura County Medi-Cal Managed Care Commission
dba Gold Coast Health Plan
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2021 and 2020

	2021	2020
OPERATING REVENUES		
Capitation revenues	$ 985,384,706	$ 854,968,887
Total operating revenues	985,384,706	854,968,887
OPERATING EXPENSES		
Health care expenses		
Provider capitation	87,191,841	58,647,943
Claim payments to providers and facilities	570,844,057	552,877,249
Prescription drugs	159,068,436	143,601,339
Other medical	16,623,754	15,492,871
Reinsurance, net of recoveries	(3,549,024)	(895,291)
Total health care expenses	830,179,064	769,724,111
ADMINISTRATIVE EXPENSES		
Salaries, benefits, and compensation	14,635,320	15,560,002
Professional fees	29,219,779	28,448,531
General administrative fees	3,118,060	3,258,036
Supplies, occupancy, insurance, and other	2,020,162	2,264,505
Premium tax	77,636,880	34,505,280
Depreciation	514,342	467,455
Total administrative expenses	127,144,543	84,503,809
Total operating expenses	957,323,607	854,227,920
Operating income	28,061,099	740,967
NONOPERATING REVENUES AND EXPENSES, NET		
Interest income	459,359	1,800,513
Interest expense	(128,864)	(823,164)
Total nonoperating revenues and expenses, net	330,495	977,349
Increase in net position	28,391,594	1,718,316
NET POSITION, beginning of year	77,323,262	75,604,946
NET POSITION, end of year	$ 105,714,856	$ 77,323,262

Ventura County Medi-Cal Managed Care Commission
dba Gold Coast Health Plan
Statements of Cash Flows
Years Ended June 30, 2021 and 2020

	2021	2020
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation revenues received	$ 993,890,519	$ 812,509,761
Reinsurance premiums paid	(4,233,183)	(3,387,261)
Payments to providers and facilities	(746,807,828)	(761,098,988)
Payments of premium tax	(92,732,940)	(23,626,246)
Payments of administrative expenses	(45,698,961)	(48,367,314)
Net cash provided by (used in) operating activities	104,417,607	(23,970,048)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchases of capital assets	(104,101)	(410,013)
Interest payments	(128,864)	(823,166)
Net cash used in capital and related financing activities	(232,965)	(1,233,179)
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from sale of investments	-	5,000,000
Interest income	175,933	825,344
Net cash provided by investing activities	175,933	5,825,344
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	104,360,575	(19,377,883)
Cash and cash equivalents, beginning of year	89,586,429	108,964,312
Cash and cash equivalents, end of year	$ 193,947,004	$ 89,586,429
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating income	$ 28,061,099	$ 740,967
Adjustments to reconcile operating income to net cash provided by (used in) operating activities		
Depreciation	514,342	467,455
Changes in assets and liabilities		
Receivables	(1,688,825)	(30,214,369)
Prepaid expenses and other assets	(199,378)	292,304
Medical claims liability	71,170,943	13,127,479
Capitation payable	8,482,185	(9,780,522)
Payable to the State of California	9,679,563	(10,353,850)
Accounts payable	(680,053)	(1,894,150)
Accrued premium tax and other liabilities	(10,922,269)	13,644,638
Net cash provided by (used in) operating activities	$ 104,417,607	$ (23,970,048)

NOTE 1 – ORGANIZATION AND OPERATIONS

Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan ("GCHP" or the "Plan") is a county-organized health system ("COHS") organized to serve Medi-Cal beneficiaries living in Ventura County, California. The formation of GCHP was approved by the Board of Supervisors of the County of Ventura in December 2009 through the adoption of Ordinance No. 4409.

As a COHS, GCHP maintains an exclusive contract (the "Contract") with the State of California Department of Health Care Services ("DHCS") to arrange for the provision of health care services to Ventura County's approximately 200,000 Medi-Cal beneficiaries. All of GCHP's revenues are earned from the State of California (the "State") in the form of capitation payments. Revenue is primarily based on enrollment and capitation rates as provided for in the Contract. The Plan began providing services to Medi-Cal beneficiaries in July 2011. In August 2013, the State of California transferred the Healthy Families Program members in Ventura County into the Medi-Cal program, Targeted Low Income Program ("TLIC"). In January 2014, the federal Affordable Care Act ("ACA") expanded health coverage to certain adults age 19 or older and under 65 and resulted in new enrollment through Adult Expansion ("AE") and other population groups.

NOTE 2 – COMPLIANCE WITH THE DHCS, CONCENTRATION RISK, AND RESTRICTED NET POSITION

GCHP's contract with the DHCS includes several financial and nonfinancial requirements. As established by the contract, GCHP is required to meet and maintain a minimum level of tangible net equity ("TNE"). TNE is defined as the excess of total assets over total liabilities, excluding subordinated liabilities and intangible assets.

Required and actual TNE are as follows:

	June 30, 2021	June 30, 2020
	(in thousands)	
Actual TNE, beginning balance	$ 77,323	$ 75,605
Change in net position	28,392	1,718
Reportable TNE	$ 105,715	$ 77,323
Required TNE	$ 36,073	$ 34,440

The ability of GCHP to continue as a going concern is dependent on its continued compliance with the DHCS requirements. The loss of this contract would have an adverse effect on GCHP's future operations.

In March 2020, the World Health Organization declared the COVID-19 virus spread a pandemic and public health emergency. The duration and intensity of the disruption from the pandemic is uncertain. Therefore, there may be adverse financial pressures on GCHP that could impact GCHP's future operations.

NOTE 3 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of presentation – GCHP is a county-organized health system governed by an 11-member Ventura County Medi-Cal Managed Care Commission appointed by the Ventura County Board of Supervisors. Effective for the fiscal year ended June 30, 2011, GCHP began reporting as a discrete component unit of the County of Ventura, California. The County made this determination based on the County Board of Supervisors having the right to elect 100 percent of the GCHP Commissioners.

Basis of accounting – GCHP uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis, using the economic resources measurement focus. The accompanying financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board ("GASB").

Use of estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America ("U.S. GAAP") requires management to make estimates and assumptions that affect the amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Fair value of financial instruments – The carrying amounts of cash and cash equivalents approximate fair value because of the short maturity of these financial instruments. The carrying amounts reported in the statement of net position for capitation receivable, provider receivables, reinsurance and other receivables, prepaid expenses and other assets, medical claims liability and capitation payable, accounts payable, premium reserve, accrued payroll, and accrued premium tax and other liabilities approximate their fair values, as they are expected to be realized within the next fiscal year.

Cash and cash equivalents – Cash and cash equivalents include highly liquid instruments purchased with an original maturity of three months or less when purchased.

Custodial credit risk-deposits – Custodial credit risk is the risk that in the event of a bank failure, GCHP may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the state law. As of June 30, 2021 and 2020, all accounts were covered by posted collateral.

Investments – Investments are stated at fair value in accordance with GASB Codification Section 150. The fair value of investments is estimated based on quoted market prices, when available. For debt securities not actively traded, fair values are estimated using values obtained from external pricing services or are estimated by discounting the expected future cash flows, using current market rates applicable to the coupon rate, credit and maturity of the investments.

All investments with an original maturity of one year or less when purchased are recorded as current investments, unless designated or restricted for long-term purposes.

Capitation receivable – Capitation receivable represents capitation revenue for the years ended June 30, 2021 and 2020, received subsequent to June 30, 2021 and 2020, respectively. Capitation receivable also includes final revenue rate adjustments based on communications from the DHCS. Management determines the allowance for doubtful accounts by regularly evaluating individual receivables and considering payment history, financial condition, and current economic conditions. Subsequent adjustments to the contracted rates or enrollments are recognized in the period the adjustment is determined.

Provider receivables – Provider receivables are recorded for all claim refunds due from providers. Management determines the allowance for doubtful accounts by regularly evaluating individual receivables and considering payment history, financial condition, and current economic conditions.

Reinsurance – In the normal course of business, the Plan seeks to reduce the loss that may arise from events that cause unfavorable medical claim results by reinsuring certain levels of risk in various areas of exposure with a reinsurer. Amounts recoverable from reinsurance are estimated in a manner consistent with the development of the medical claim liability.

Amounts recoverable from reinsurers that relate to paid claims are classified as assets and as a reduction to medical expenses incurred. Reinsurance premiums paid are included in medical expenses.

Capital assets – Capital assets are stated at cost at the date of acquisition. The costs of normal maintenance, repairs, and minor replacements are expensed when incurred. Capital assets acquired but not yet placed into service are reported as construction in progress. Construction-in-progress assets are not depreciated until they are placed into service.

Depreciation is calculated using the straight-line method over the estimated useful lives of the assets. Long-lived assets are periodically reviewed for impairment. The estimated useful lives of three to seven years are used for furniture, fixtures, computer equipment, and software. Leasehold improvements are depreciated over the life of the lease or estimated useful life, whichever is shorter. Depreciation expense for the years ended June 30, 2021 and 2020, was approximately $514,000 and $467,000, respectively.

Medical claims liability, capitation payable, and medical expenses – GCHP establishes a claims liability based on estimates of the ultimate cost of claims in process and a provision for claims incurred but not yet reported, which is actuarially determined based on historical claims payment experience and other operational changes. In cases where adequate historical claims payment experience does not yet exist for a new population, a book-to-budget methodology is used in which GCHP relies on state-developed medical rates or medical loss ratios to estimate claims liabilities.

Such reserves are continually monitored and reviewed, with any adjustments made as necessary in the period the adjustment is determined. Management believes that the claims liability is adequate and fairly stated; however, this liability is based on estimates, and the ultimate liability may differ from the amount provided.

GCHP has provider services agreements with several health networks in Ventura County, whereby the health networks provide care directly to covered members or through subcontracts with other health care providers. Payment for the services provided by the health networks is on a fully capitated basis. The capitation amount is based on contractually agreed-upon terms with each health network. GCHP may withhold amounts from providers at an agreed-upon percentage of capitation payments made to ensure the financial solvency of each contract. The capitation expense is included in provider capitation in the statements of revenues, expenses, and changes in net position.

Payable to the State of California – The liability at June 30, 2021 and 2020 was approximately $14,937,000 and $5,257,000, respectively, due to state of California funding programs that have minimum Medical Loss Ratio ("MLR") requirements and potential amounts due back to the State. The balance as of June 30, 2021 represents an estimate due back to the State of California for the Proposition 56 programs in effect for state fiscal years 2018 and 2019. The balance as of June 30, 2020 represents an estimate due back to the State of California for the Proposition 56 programs in effect for state fiscal year 2019. The liability may vary depending on actual claims experience and final reconciliation and audit results. This liability is presented in the payable to the State of California in the accompanying statements of net position.

Accounts payable and accrued expenses – GCHP is required to estimate certain expenses, including accrued payroll, payroll taxes, and professional services fees, as of each statement of net position date and make appropriate accruals based on these estimates. Estimates are affected by the status and timing of services provided relative to the actual level of services performed by the service providers. The date on which certain services commence, the level of services performed on or before a given date, and the cost of services are often subject to judgment. These judgments are based upon the facts and circumstances known at the date of the financial statements. For the periods presented in the financial statements, there were no material adjustments to the estimates for accrued payroll, payroll taxes, and professional services fees.

Premium deficiency reserves – GCHP performed an analysis of its expected future health care and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve would be accrued. A premium deficiency reserve was not required at June 30, 2021 or 2020.

Accrued compensated absences – GCHP's policy permits eligible employees to accrue vacation based on their individual employment agreements. Unused vacation may be carried over into subsequent years, up to limits indicated in their employment agreements. Accumulated vacation will be paid to the employee upon separation from service with GCHP. All compensated absences are accrued and recorded in accordance with GASB Statement No. 16, *Accounting for Compensated Absences*, and are included in accrued payroll and employee benefits in the accompanying statements of net position.

Premium taxes – Senate Bill X2-2, which passed in March 2016, redefined the premium tax payment and calculation. Per SB X2-2, the tax rate was a pre-determined liability based on DHCS projected Medi-Cal membership, and specified rates and was effective through June 30, 2019. Assembly Bill 115, *Committee on Budget, Chapter 348, Statutes of 2019,* re-established a managed care enrollment tax, using a modified tiered taxing model and the implementation of the tax is projected to generate a net state benefit of approximately $7 billion over the three-year duration of the tax. On April 3, 2020, the federal government approved the state's revised proposal to implement a tax on Managed Care Organizations ("MCO") to help fund the Medi-Cal program. The new MCO tax is effective from January 2020 through December 2022. The DHCS calculated GCHP's total MCO tax liabilities for the years ended June 30, 2021 and 2020, to be approximately $77,637,000 and $34,505,000, respectively. A premium tax refund receivable of approximately $6,321,000 and $6,833,000 was recognized at June 30, 2021 and 2020, respectively, and is included in the reinsurance and other receivables balance on the accompanying statements of net position.

Net position – Net position is broken down into three categories, defined as follows:

Net invested in capital assets – This component of net position consists of capital assets, including restricted capital assets, net of accumulated depreciation, and is reduced by the outstanding balances of any bonds, notes, or other borrowings that are attributable (if any) to the acquisition, construction, or improvement of those assets.

Restricted – This component of net position consists of external constraints placed on net asset used by creditors (such as through debt covenants), grantors, contributors, or law or regulations of other governments. It also pertains to constraints imposed by law or constitutional provisions or enabling legislation. There were no amounts classified as restricted net position as of June 30, 2021 or 2020.

Unrestricted – This component of net position consists of net position that does not meet the definition of "restricted" or "net invested in capital assets."

Revenue recognition – Capitation revenue received under the Contract is recognized during the period in which GCHP is obligated to provide medical service to the beneficiaries. This revenue is based on estimated enrollment provided monthly by the DHCS and capitation rates as provided for in the DHCS Contract. Enrollment and the capitation rates are subject to retrospective changes by the DHCS. As such, capitation revenue includes an estimate for amounts receivable from or refundable to the DHCS for these retrospective changes in estimates. These estimates are continually monitored and reviewed, with any changes in estimates recognized in the period when determined.

During the years ended June 30, 2021 and 2020, GCHP received approximately $47,791,000 and $27,828,000, respectively, of supplemental fee revenue from the DHCS as a hospital quality assurance fee ("HQAF") as a result of SB 229 and SB 335, respectively.

DHCS implemented a managed care Designated Public Hospital ("DPH") Quality Incentive Pool ("QIP") that was expanded effective July 1, 2020 under which managed care plans were directed to make QIP payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The QIP payments are linked to delivery of services under the managed care plan contracts and increase the amount of funding tied to quality outcomes. During the years ended June 30, 2021 and 2020, GCHP received approximately $97,215,000 and $51,212,000, respectively, in QIP payments.

DHCS also established a Directed Payments DPH Enhanced Payment Program ("EPP") under which managed care providers were directed to reimburse California's 21 DPHs for network contracted services delivered by DPH systems, enhanced by either a uniform percentage or dollar increment based on actual utilization of network contracted services. The State will evaluate the extent to which enhanced payments are achieving the goals identified. During the years ended June 30, 2021 and 2020, GCHP received approximately $31,101,000 and $30,685,000, respectively, through the EPP.

DHCS also established a Private Hospital Directed Payment Program ("PHDPP") under which managed care providers were directed to reimburse private hospitals as defined in WIC 14169.51, based on actual utilization of contracted services. The enhanced payment is contingent upon hospitals providing adequate access to service, including primary, specialty, and inpatient (both tertiary and quaternary) care. During the years ended June 30, 2021 and 2020, GCHP received approximately $45,441,000 and $29,931,000, respectively, through the PHDPP.

GCHP passed these HQAF, QIP, EPP and PHDPP funds through to providers. These amounts were not reflected in the accompanying financial statements for the years ended June 30, 2021 and 2020, as the amounts passed through to the providers do not meet requirements for revenue recognition under Government Accounting Standards ("GAS").

GCHP has an agreement with the DHCS to receive an intergovernmental transfer ("IGT") through a capitation rate increase of $39,931,000 and $34,987,000 recorded in years ended June 30, 2021 and 2020, respectively. Under the agreement, these funds that are distributed to providers are not reported on the statements of revenues, expenses and changes in net position, or the statements of net position, as these amounts do not meet requirements for revenue recognition under GAS. GCHP did not retain any of this IGT during the years ended June 30, 2021 and 2020 for administrative costs.

Operating revenues and expenses – GCHP's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with arranging for the provision of health care services. Operating expenses are all expenses incurred to arrange for the provision of health care services, as well as the costs of administration. Claims adjustment expenses are an estimate of the cost to process the claims and are included in operating expenses. Nonexchange revenues and expenses are reported as nonoperating revenues and expenses.

Administrative expenses – Administrative expenses are recognized as incurred and consist of administrative expenses that directly relate to the implementation and operation costs of the Plan. Capitation contract acquisition costs are expensed in the period incurred.

Defined contribution plan – GCHP has adopted, and its employees are participants in, the California Public Agencies Self-Directed Tax-Advantaged Retirement System ("CPA STARS"). CPA STARS is a California public trust organized under the laws of the State of California and includes the STARS 401(a) Retirement Plan (the "401 Plan"), which is a retirement plan under Section 401(a) of the Internal Revenue Code. GCHP participation in the 401 Plan is defined by the 401(a) Trust Agreement and the 401 Plan Agreement between GCHP and CPA STARS.

All regular employees participate in the CPA STARS 401 Plan. Employee contributions to the 401 Plan are not allowed. GCHP makes employer contributions to the 401 Plan in an amount annually determined under the 401 Plan Agreement. For the years ended June 30, 2021 and 2020, GCHP contributions to the 401 Plan were $1,855,000 and $1,863,000, respectively.

Deferred compensation plan – GCHP has adopted, and its employees are participants in, the CPA STARS 457(b) deferred compensation plan (the "457 Plan"). The 457 Plan was created in accordance with Internal Revenue Code Section 457 and permits employees to defer a portion of their annual salary until future years. GCHP participation in the 457 Plan is defined by the 457 Trust Agreement between GCHP and CPA STARS. Employee participation in the 457 Plan is voluntary, and GCHP has not made any contributions. As such, there were no GCHP employer contributions for years ended June 30, 2021 and 2020.

Income taxes – GCHP operates under the purview of the Internal Revenue Code, Section 501(a) and corresponding California Revenue and Taxation Code provisions. As such, GCHP is not subject to federal or state taxes. Accordingly, no provision for income tax has been recorded in the accompanying financial statements.

Risk management – GCHP is exposed to various risks of loss from torts, business interruption, errors and omissions, and natural disasters. Commercial insurance coverage is purchased by GCHP for claims arising from such matters. No claims have exceeded commercial coverage.

Recent accounting pronouncements – In January 2017, the GASB issued Statement No. 84, *Fiduciary Activities* ("GASB 84"). The principal objective of GASB 84 is to enhance the consistency and comparability of fiduciary activity reporting by state and local governments. GASB 84 is also intended to improve the usefulness of fiduciary activity information primarily for assessing the accountability of governments in their roles as fiduciaries. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance*, which deferred the effective date of GASB 84 to reporting periods beginning after December 15, 2019. GCHP adopted GASB 84 for the fiscal year ended June 30, 2021, which did not have a significant impact on the financial statements.

In June 2017, the GASB issued Statement No. 87, *Leases* ("GASB 87"). GASB 87 increases the usefulness of financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. GASB 87 also establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance*, which deferred the effective date of GASB 87 to reporting periods beginning after June 15, 2021. GCHP is reviewing the impact of the adoption of GASB 87 for the fiscal year ending June 30, 2022.

In May 2020, the GASB issued Statement No. 96, *Subscription-Based Information Technology Arrangements* ("GASB 96"). GASB 96 provides guidance on the accounting and financial reporting for subscription-based information technology arrangements ("SBITA") for government end users (governments). GASB 96 (1) defines a SBITA; (2) establishes that a SBITA results in a right-to-use subscription asset—an intangible asset—and a corresponding subscription liability; (3) provides the capitalization criteria for outlays other than subscription payments, including implementation costs of a SBITA; and (4) requires note disclosures regarding a SBITA. To the extent relevant, the standards for SBITAs are based on the standards established in Statement No. 87, *Leases*, as amended. The requirements of GASB 96 are effective for fiscal years beginning after June 15, 2022, and all reporting periods thereafter. GCHP is reviewing the impact of the adoption of GASB 96 for the fiscal year ending June 30, 2023.

NOTE 4 – CASH AND INVESTMENTS

Investments – The Plan invests in obligations of the U.S. Treasury, other U.S. government agencies and instrumentalities, state obligations, corporate securities, and money market funds.

Interest rate risk – In accordance with its Annual Investment Policy ("investment policy"), GCHP manages its exposure to decline in fair value from increasing interest rates by matching maturity dates to the extent possible with the Plan's expected cash flow draws. Its investment policy limits maturities to five years, while also staggering maturities. The Plan maintains a low-weighted average maturity strategy, targeting a portfolio with maturities of three years or less, with the intent of reducing interest rate risk. Portfolios with low weighted average maturities are less volatile because they are less sensitive to interest rate changes. As of June 30, 2021, the weighted average maturity of GCHP's investments, including cash equivalents was approximately 1 day.

The Plan's investments at June 30, 2021, are summarized as follows:

Investment Type	Fair Value	Maximum Maturity*	Weighted Average Maturity (Years)	Weighted Average Maturity (Days)
Cal Trust Investment Fund	$ 3,771	N/A	-	1
Local Agency Investment Fund	206,976	N/A	-	1
Ventura County Investment Pool	43,304,353	N/A	-	1
	$ 43,515,100		-	1

*Per investment policy (Gov't code section 53601)

Credit risk – GCHP's investment policy conforms to the California Government Code as well as to customary standards of prudent investment management. Credit risk is mitigated by investing in only permitted investments. The investment policy sets minimum acceptable credit ratings for investments from two nationally recognized rating services: Standard and Poor's Corporation ("S&P"), and Moody's Investor Service ("Moody's"). For an issuer of short-term debt, the rating must be no less than A-1 (S&P) or P-1 (Moody's), while an issuer of long-term debt shall be rated no less than an "A."

Credit ratings of investments and cash equivalents as of June 30, 2021, are summarized below:

			Ratings as of Year-End (SP / MDY)				
Investment Type	Fair Value	Minimum Legal Rating*	Exempt from rating	A-1 / P-1	A1 / AA+	A1 / A+	A2 / A
Cal Trust Investment Fund	$ 3,771	None	$ 3,771	$ -	$ -	$ -	$ -
Local Agency Investment Fund	206,976	None	206,976	-	-	-	-
Ventura County Investment Pool	43,304,353	None	43,304,353	-	-	-	-
	$ 43,515,100		$ 43,515,100	$ -	$ -	$ -	$ -

*Per investment policy (Gov't code section 53601)

Credit ratings of investment and cash equivalents as of June 30, 2020, are summarized below:

Investment Type	Fair Value	Minimum Legal Rating*	Ratings as of Year-End (SP / MDY)				
			Exempt from rating	A-1 / P-1	A1 / AA+	A1 / A+	A2 / A
Cal Trust Investment Fund	$ 3,760	None	$ 3,760	$ -	$ -	$ -	$ -
Local Agency Investment Fund	205,239	None	205,239	-	-	-	-
Ventura County Investment Pool	42,831,225	None	42,831,225	-	-	-	-
	$ 43,040,224		$ 43,040,224	$ -	$ -	$ -	$ -

*Per investment policy (Gov't code section 53601)

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of The Plan's investment in a single issuer. GCHP's Policy does not contain any specific provisions to limit exposure to concentration of credit risk, but conforms to the California Government Code sections 53601 to meet the percentage limits of investment holdings.

The Plan's percentage of portfolio as of June 30, 2021, is summarized below:

Investment Type	Issuer	Fair Value	Percentage of Portfolio
Cal Trust Investment Fund	Wells Fargo	$ 3,771	0.0%
Local Agency Investment Fund	State of California Treasurer	206,976	0.5%
Ventura County Investment Pool	County of Ventura Treasurer	43,304,353	99.5%
Total Funds Available for Investments		$ 43,515,100	100.0%

The Plan's percentage of portfolio as of June 30, 2020, is summarized below:

Investment Type	Issuer	Fair Value	Percentage of Portfolio
Cal Trust Investment Fund	Wells Fargo	$ 3,760	0.0%
Local Agency Investment Fund	State of California Treasurer	205,239	0.5%
Ventura County Investment Pool	County of Ventura Treasurer	42,831,225	99.5%
Total Funds Available for Investments		$ 43,040,224	100.0%

Investments – GCHP categorizes its fair value investments within the fair value hierarchy established by U.S. GAAP. The hierarchy for fair value measurements is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date.

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for an asset or liability, either directly or indirectly.

Level 3 – Significant unobservable inputs.

The following is a description of the valuation methodologies used for instruments at fair value on a recurring basis and recognized in the accompanying statements of net position, as well as the general classification of such instruments pursuant to the valuation hierarchy.

External investment pools – CalTrust is organized as a Joint Powers Authority established by public agencies in California for the purpose of pooling and investing local agency funds. A Board of Trustees supervises and administers the investment program of the Trust. CalTrust has four pools: money market account, short-term, medium-term, and long-term. The Plan has deposits in the Short-Term Fund. Investments in CalTrust Short-Term Fund are highly liquid, as deposits can be converted to cash within 24 hours without loss of interest.

The Plan is a voluntary participant in CalTrust. The Plan's investment in this pool is reported in the accompanying financial statements at fair value based on the Plan's pro rata share of the respective pool as reported by CalTrust. As of both June 30, 2021 and 2020, the Plan held approximately $4,000 in CalTrust.

The California State Treasurer's Office makes available the Local Agency Investment Fund ("LAIF") through which local governments may pool investments. Each governmental entity may invest up to $65 million in the fund. Investments in the LAIF are highly liquid, as deposits can be converted to cash within 24 hours without loss of interest. The Plan is a voluntary participant in the LAIF. The fair value of the GCHP's investments in the LAIF is reported in the accompanying financial statements based on the GCHP's pro rata share of the fair value provided by the LAIF for the entire LAIF portfolio. As of June 30, 2021 and 2020, the Plan held approximately $207,000 and $205,000 in LAIF, respectively.

The Ventura County Investment Pool ("VCIP") is available to local public governments, agencies, and school districts within Ventura County (the "County"). Wells Fargo Bank NA serves as custodian for the pool's investments. The portfolio is typically comprised of U.S. agency securities and high-quality short-term instruments, resulting in a relatively short-weighted average maturity. Fair value calculations are based on market values provided by the County's investment custodian. Investments in the VCIP are highly liquid, as deposits can be converted to cash within 24 hours without loss of interest. The Plan is a voluntary participant in the VCIP. The fair value of the GCHP's investments in the VCIP is reported in the accompanying financial statements based on the GCHP's pro rata share of the fair value provided by the VCIP for the entire VCIP portfolio. As of June 30, 2021 and 2020, the Plan held approximately $43,304,000 and $42,831,000 in VCIP, respectively.

The following table presents the fair value measurements of assets recognized in the accompanying statements of net position measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall:

The Plan had the following recurring fair value measurements as of June 30, 2021:

	Total	Fair Value Measurements Using: Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments not subject to fair value hierarchy				
Cal Trust Investment Fund	$ 3,771			
Local Agency Investment Fund	206,976			
Ventura County Investment Pool	43,304,353			
	$ 43,515,100			

The Plan had the following recurring fair value measurements as of June 30, 2020:

	Total	Fair Value Measurements Using: Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments not subject to fair value hierarchy				
Cal Trust Investment Fund	$ 3,760			
Local Agency Investment Fund	205,239			
Ventura County Investment Pool	42,831,225			
	$ 43,040,224			

NOTE 5 – ADMINISTRATIVE SERVICES AGREEMENTS

Conduent, Inc. ("Conduent"), formerly Affiliated Computer Services – GCHP entered into an agreement with Conduent on June 28, 2017, to provide certain operational services, for a two-year term with 4 to 6 month extensions beginning July 1, 2017. On May 1, 2019, GCHP and Conduent entered into a new agreement extending service through June 30, 2024. Included in the extension is a project to replace the existing technology platform with a new system and realign business processes. Compensation for these services is based on a per-member, per-month cost at varying membership levels. These costs are recorded as expenses in the period incurred. Total expenses for services provided for the years ended June 30, 2021 and 2020, were approximately $19,370,000 and $19,994,000, respectively, and are reported in professional fees on the accompanying statements of revenues, expenses, and changes in net position.

OptumRx, Inc. ("Optum Rx") – GCHP entered into a three-year agreement with Optum Rx, effective June 1, 2017, replacing Script Care as the provider of pharmacy administration and management services. The agreement was renewed effective July 1, 2020, and will expire on June 30, 2024. Optum Rx services are specific to the prescription benefit drug program for GCHP Medi-Cal beneficiaries. Total expenses for Optum Rx services were approximately $2,028,000 and $1,826,000 for the years ended June 30, 2021 and 2020, respectively, and are included in other medical expenses on the accompanying statements of revenues, expenses, and changes in net position.

Beacon Health Strategies, LLC ("Beacon Health Strategies") – On April 14, 2014, GCHP entered into a two-year agreement with Beacon Health Strategies to provide administrative services to arrange for and support the administration of behavioral health services for GCHP. The agreement with Beacon Health Strategies has been extended until February 28, 2022. Total expenses for Beacon Health Strategies were approximately $2,171,000 and $1,948,000 for the years ended June 30, 2021 and 2020, respectively, and are included in professional fees on the accompanying statements of revenues, expenses, and changes in net position.

NOTE 6 – CAPITAL ASSETS

Capital asset activity during the years ended June 30, 2021 and 2020, consisted of the following:

	Balance June 30, 2020	Increases	Transfers	Decreases	Balance June 30, 2021
Capital assets					
Leasehold improvements	$ 1,800,989	$ 3,987	$ -	$ -	$ 1,804,976
Software and equipment	1,789,959	100,114	-	-	1,890,073
Furniture and fixtures	1,207,135	-	-	9,685	1,197,450
Total capital assets	4,798,083	104,101	-	9,685	4,892,499
Less accumulated depreciation and amortization for					
Leasehold improvements	815,421	199,547	-	-	1,014,968
Software and equipment	1,405,124	149,840	-	-	1,554,964
Furniture and fixtures	967,210	164,955	-	8,070	1,124,095
Total accumulated depreciation	3,187,755	514,342	-	8,070	3,694,027
Total capital assets, net	$ 1,610,328	$ (410,241)	$ -	$ (1,615)	$ 1,198,472

	Balance June 30, 2019	Increases	Transfers	Decreases	Balance June 30, 2020
Capital assets					
Leasehold improvements	$ 1,780,212	$ 20,777	$ -	$ -	$ 1,800,989
Software and equipment	1,450,920	339,039	-	-	1,789,959
Furniture and fixtures	1,156,938	50,197	-	-	1,207,135
Total capital assets	4,388,070	410,013	-	-	4,798,083
Less accumulated depreciation and amortization for					
Leasehold improvements	583,928	231,493	-	-	815,421
Software and equipment	1,328,325	76,799	-	-	1,405,124
Furniture and fixtures	808,047	159,163	-	-	967,210
Total accumulated depreciation	2,720,300	467,455	-	-	3,187,755
Total capital assets, net	$ 1,667,770	$ (57,442)	$ -	$ -	$ 1,610,328

NOTE 7 – MEDICAL CLAIMS LIABILITY

Medical claims liability and capitation payable consists of the following:

	June 30, 2021	June 30, 2020
Claims payable or pending approval	$ 29,923,759	$ 34,897,614
Capitation payable	26,699,447	18,217,262
Provisions for claims incurred but not yet reported and other	126,960,643	51,769,339
Directed payments to providers payable	16,883,016	15,929,522
	$ 200,466,865	$ 120,813,737

The cost of health care services is recognized in the period in which care is provided and includes an estimate of the cost of services that has been incurred but not yet reported. GCHP estimates accrued claims payable based on historical claims payments and other relevant information. Estimates are continually monitored and reviewed, and as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate amount of claims paid is dependent on future developments, management is of the opinion that the accrued medical claims payable is adequate.

The following is reconciliation of the medical claims liability and capitation payable activity for the years ended June 30:

	2021	2020
Medical claims liability and capitation payable at beginning of year	$ 120,813,737	$ 117,466,780
Incurred		
Current	827,996,130	780,676,321
Prior	4,856,499	(10,164,318)
Total incurred	832,852,629	770,512,003
Paid		
Current	669,483,942	670,892,743
Prior	79,851,476	96,596,307
Total paid	749,335,418	767,489,050
Net balance at end of year	204,330,948	120,489,733
Provider and reinsurance receivable of paid claims, beginning	(948,446)	(624,442)
Provider and reinsurance receivable of paid claims, ending	(2,915,637)	948,446
Medical claims liability and capitation payable at end of year	$ 200,466,865	$ 120,813,737

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities at any year end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established prior reporting period liability. Negative amounts reported for incurred, related to prior years, result from claims being adjudicated and paid for amounts less than originally estimated. Results for the years ended June 30, 2021 and 2020, included an increase of prior year incurred of approximately $4,856,000 and a decrease of prior year incurred of approximately $10,164,000, respectively. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Additional estimation uncertainty exists as of June 30, 2021, resulting from the impact of a new claims system implemented in May 2021.

NOTE 8 – COMMITMENTS AND CONTINGENCIES

Lease commitments – GCHP leases office space and equipment under long-term operating leases ending on various dates through March 2026. The total amount of rental payments due over the lease terms is being recognized as rent expense using the straight-line method over the term of the lease. Rent and lease expenses were approximately $1,371,000 and $1,423,000 for the years ended June 30, 2021 and 2020, respectively. Minimum annual rent and lease payments are as follows:

	Minimum Lease Payments
Years Ending June 30,	
2022	$ 1,524,800
2023	1,556,410
2024	1,588,917
2025	1,633,606
2026	1,250,872
Thereafter	-
	$ 7,554,605

Litigation – Through the course of ordinary business, the Plan became party to various administrative proceedings, mediations, and was party to various legal actions and subject to various claims arising as a result. During the year ended June 30, 2021, the Plan has successfully resolved some matters, and other administrative and legal matters are still proceeding. As a result of pending administrative and legal matters, the Plan has recorded a liability for these contingencies. It is the opinion of management that the ultimate resolution of such claims will not have a material adverse effect on the financial statements.

Regulatory matters – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties. Management believes that GCHP is in compliance with fraud and abuse, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review a interpretation as well as regulatory actions unknown or unasserted at this time.

In September 2021, GCHP received a request from DHCS to submit a corrective action plan related to claims processing backlogs due to a new claims processing system implementation during the year ended June 30, 2021. While the ultimate outcome of this matter is not known, it is the opinion of management that the ultimate resolution of this matter will not have a material adverse effect on the financial statements.

Patient protection and Affordable Care Act – The ACA allowed for the expansion of Medicaid members in the State of California. Any future federal or state changes in eligibility requirements or federal and state funding could have an impact on the Plan. With the changes in the executive branch, the future of PPACA and impact of future changes in Medicaid to the Plan is uncertain at this time.

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kashina Bishop, Chief Financial Officer

DATE: October 25, 2021

SUBJECT: September 2021 Fiscal Year to Date Financials

SUMMARY:

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

BACKGROUND/DISCUSSION:

The staff has prepared the unaudited 2022 FYTD financial packages, including statements of financial position, statement of revenues and expenses, changes in net assets, statement of cash flows and schedule of investments and cash balances.

Financial Overview:

GCHP experienced a gain of $6.3 million for the month of September 2021 and is favorable to the budget for September 2021 by $5.4M. The favorability is due to timing of administrative and project expenses, and medical expense estimates that are currently less than budget.

Solvency Action Plan (SAP):

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

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

1. Cost of healthcare – to ensure care is being provided at the optimal place of service which both reduces costs and improves member experience.

2. Internal control improvements – to ensure GCHP is operating effectively and efficiently which will result in administrative savings and safeguard against improper claim payments.
3. Contracting strategies – to ensure that GCHP is reimbursing providers within industry standard for a Medi-Cal managed care plan and moving toward value-based methodologies.

The management team concluded several months ago that it is imperative that GCHP have a keen focus on fundamental activities that are essential to its providers and members, most notably the system conversion and implementation of CalAim. This has and will continue to cause some delay in implementing some of the below initiatives, but the focus and hard work remains particularly on the efforts to tighten internal controls. During the system conversion, staff was able to complete two significant internal control improvements:

1. Appropriate diversion of ED claims to California Children's Services; these services are carved out of GCHP.
2. Implementation of additional claims edit system checks which will minimize payment errors.

Category	Current Focus	Annualized impact in savings
Cost of Healthcare	LANE – avoidable ER analysis	TBD
	Pro-active transplant management approach	TBD
	Analysis of leakage to out of area providers	TBD
Internal Control Improvements*	Review of provider contracts for language interpretation and validation	N/A
	Develop revised provider contract templates and a standard codified DOFR template	N/A
	Improve quality and completeness of encounter data	Revenue implications
	Capitation reconciliation at member level	Revenue
	RDT data improvement	Revenue
Contracting Strategies	Expansion of capitation arrangements	Required TNE and risk reductions
	LANE/HCPCS analysis	TBD
	Outlier rate analysis	TBD

* this is a sub-set of the internal control improvements with direct impacts to the SAP and providers. Staff will periodically update the Commission on the comprehensive list.

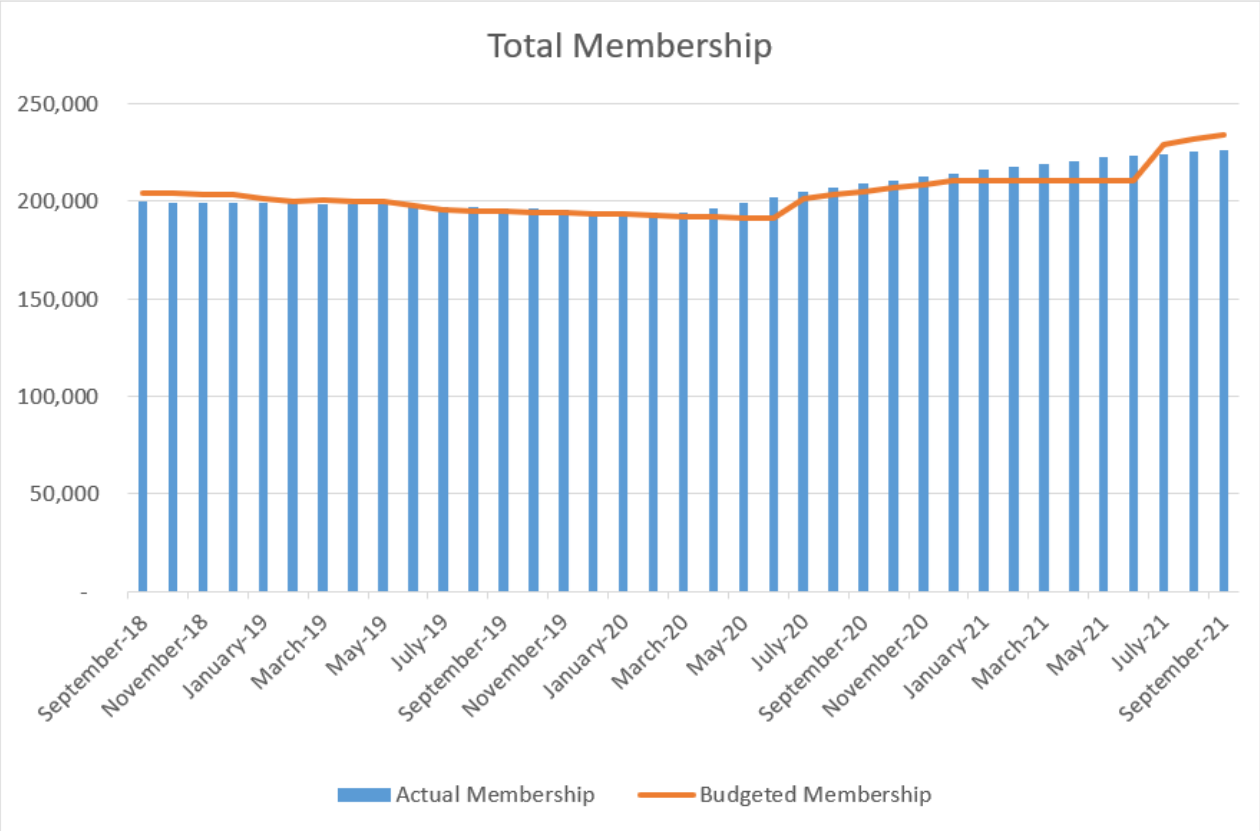
Financial Report:

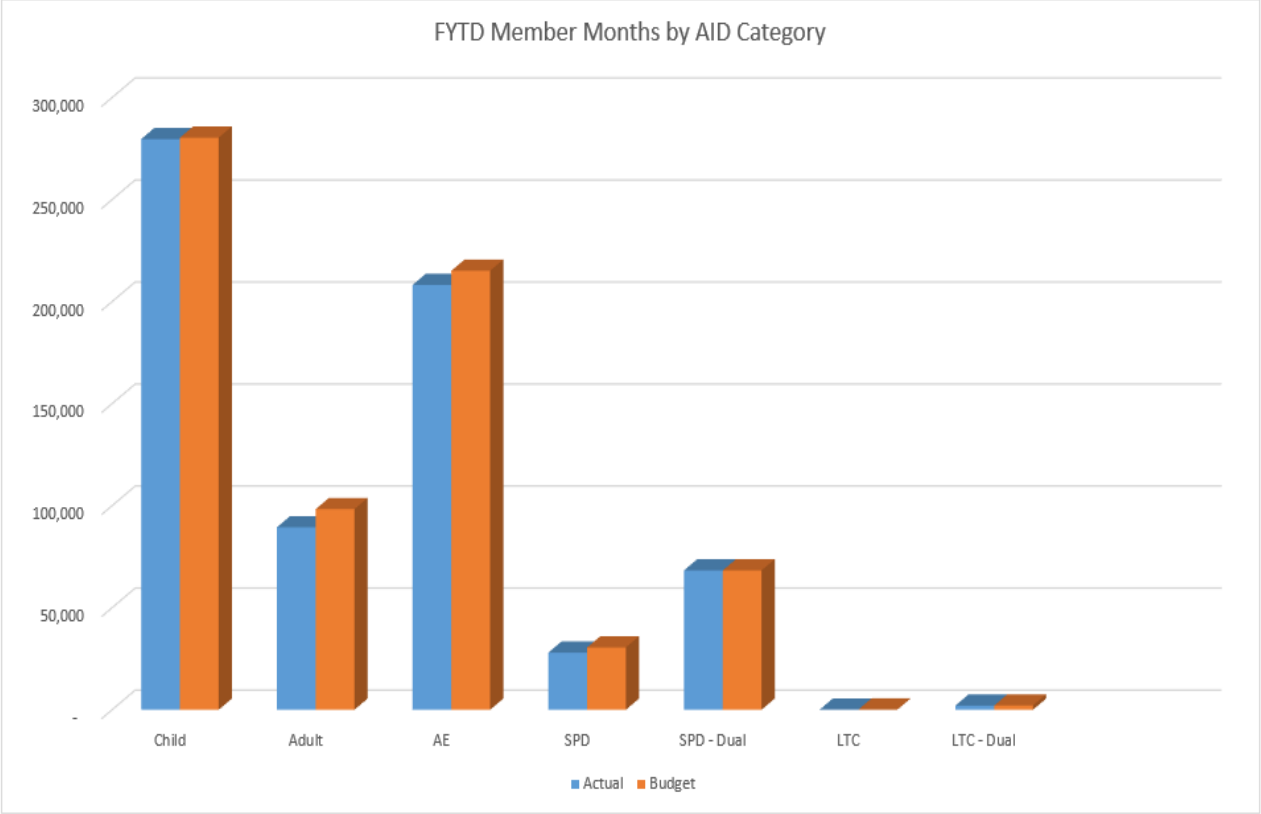
GCHP is reporting net gains of $6.3 million for the month of September 2021.

September 2021 FYTD Highlights:

1. Net gain of $16.4 million, a $13.2 million favorable budget variance.
2. FYTD net revenue is $249.9 million, $233,600 over budget.
3. FYTD Cost of health care is $220.0 million, $9.8 million under budget.
4. The medical loss ratio is 88.0% of revenue, 4.0% less than the budget.
5. FYTD administrative expenses are $13.5 million, $3.2 million under budget.
6. The administrative cost ratio is 5.4%, 1.3% under budget.
7. Current membership for September is 224,580.
8. Tangible Net Equity is $122.2 million which represents approximately 48 days of operating expenses in reserve and 333% of the required amount by the State.

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





Revenue

Net Premium revenue is $249.9 million; a $233,600 and .1% favorable budget variance.

Health Care Costs

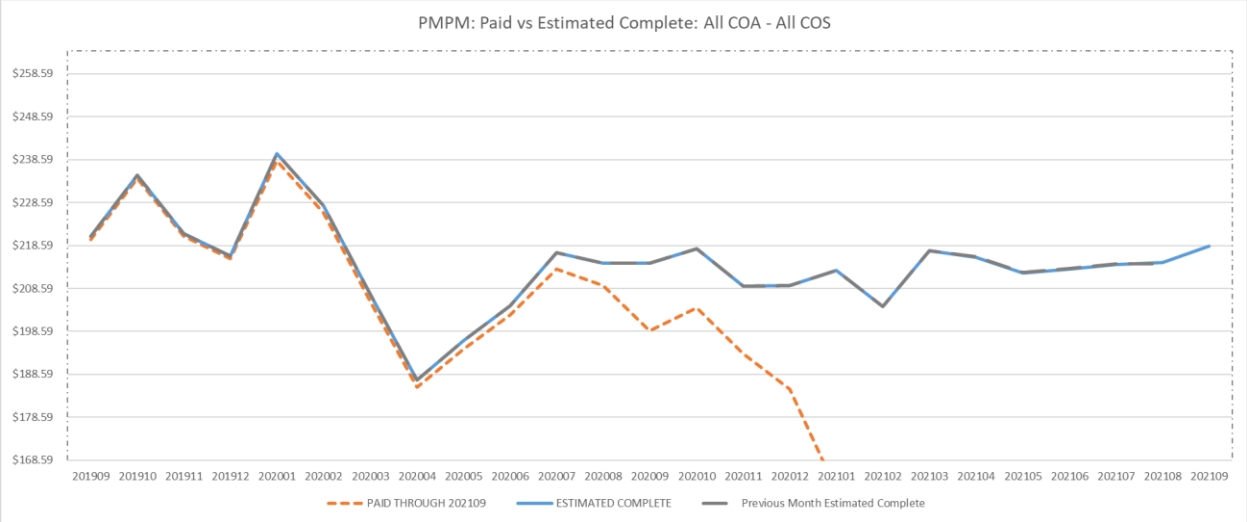
FYTD Health care costs are $220.0 million; a $9.8 million and 4% favorable budget variance.

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

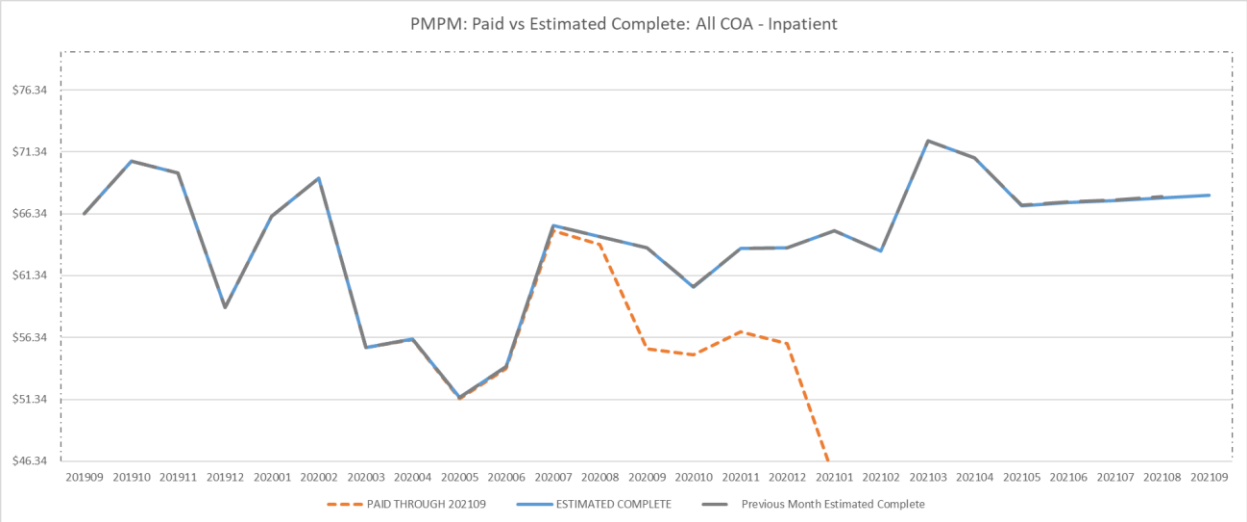
Due to the system conversion, staff does not yet have an accurate data file to complete the estimate with the same level of detail as has been the historical process. One of the issues being addressed is discrepancies in the mapping of data to the correct category of service. This impacts staff’s ability to research actual and budget variances at the category of service level. At a high level, medical expenses have remained consistent with prior months and are running below budget expectations which were conservative.

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

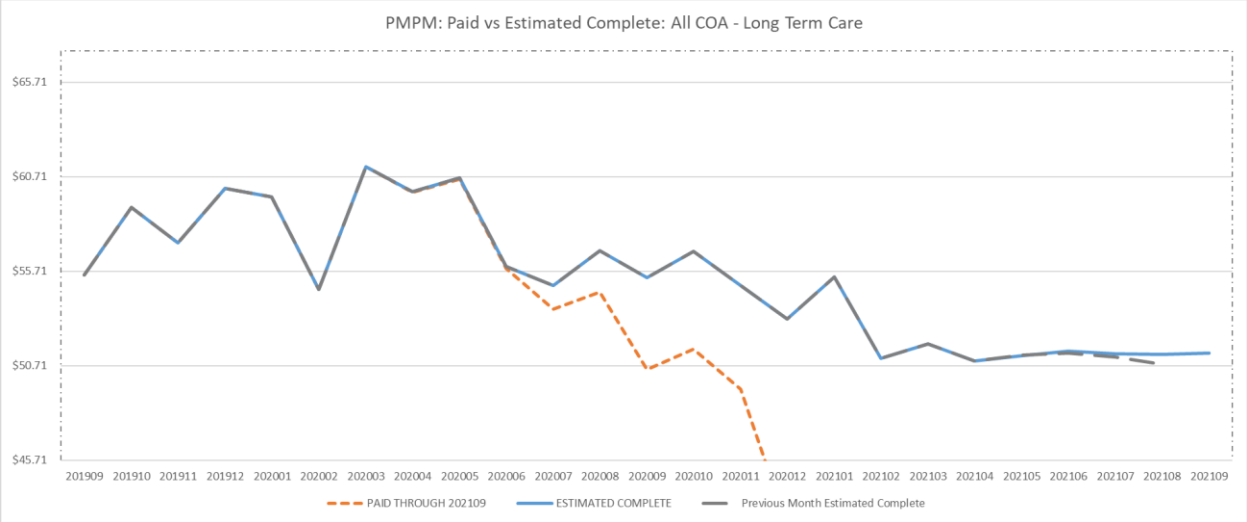
1. All categories of service



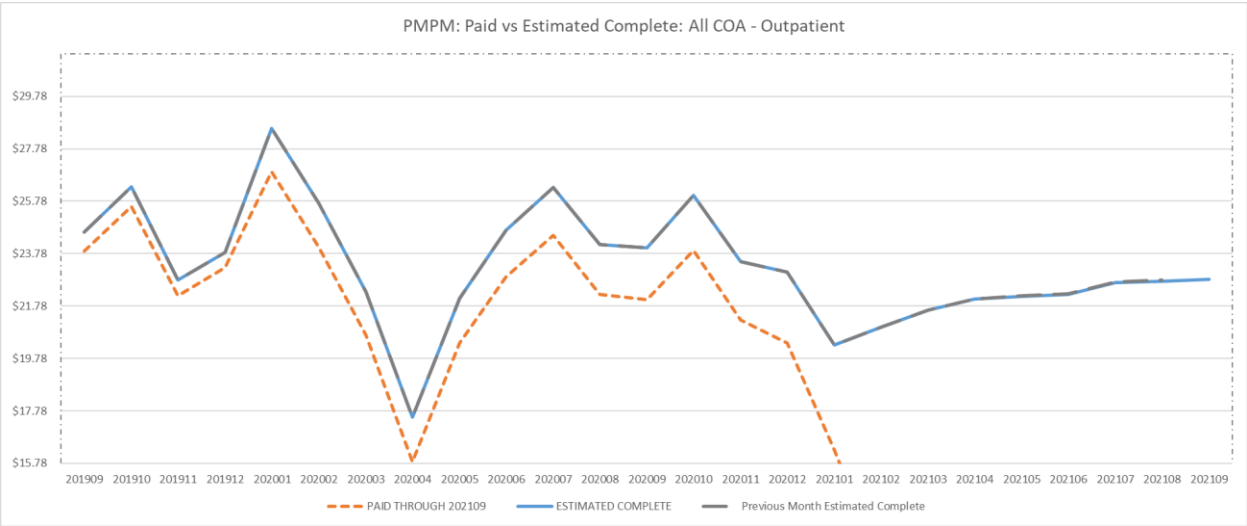
2. Inpatient hospital costs



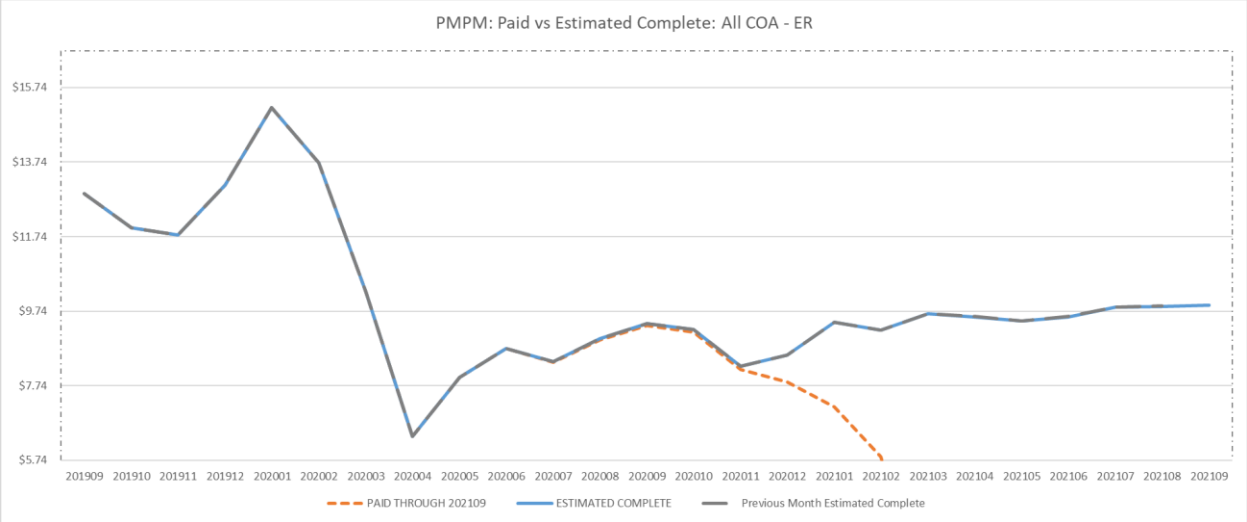
3. Long term care (LTC) expenses



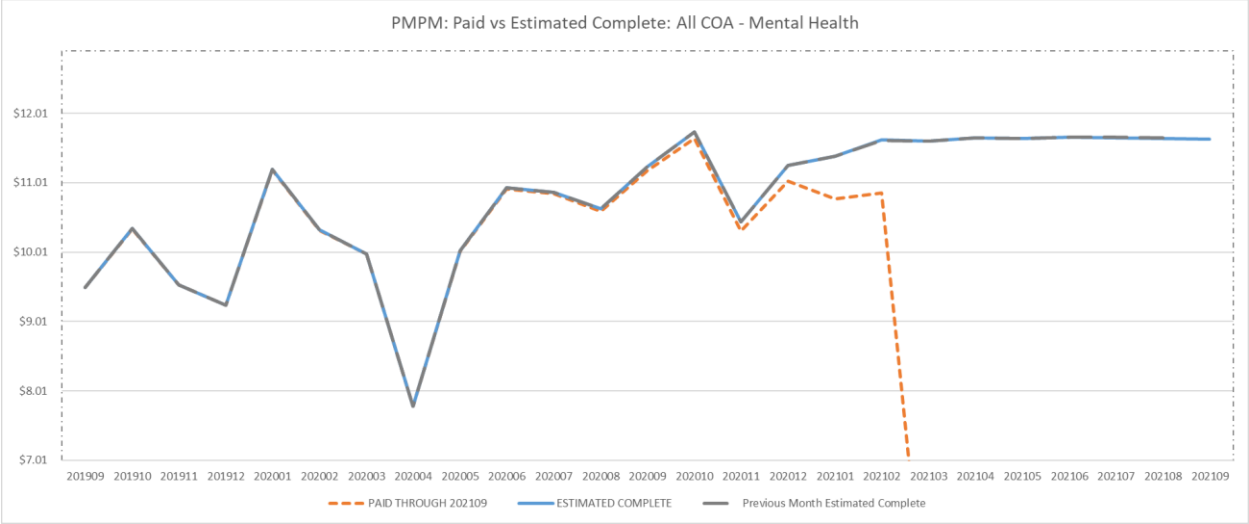
4. Outpatient expenses



5. Emergency Room expenses



6. Mental and behavioral health services



Administrative Expenses

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

For the fiscal year to date through September 2021, administrative costs were $13.5 million and $3.2 million under budget. As a percentage of revenue, the administrative cost ratio (or ACR) was 5.4% versus 6.7% for budget.

The following are drivers of administrative expense favorability:

- *Enterprise Project Portfolio*: timing of consulting services related to multiple projects (~$1.2M)
- *Salaries, Wages & Employee Benefits*: primarily related to timing of filling open IT positions (~$559K)
- *Outside Services*: favorability of Conduent expenses due to membership lower than projected and lower fulfillment related charges (~$648K)
- *Professional Services*: timing of employee recruitment in budget (~$219K), favorable consulting expenses related to timing ($435K)
- *Occupancy, Supplies, Insurance and Other*: timing of software and non-capital equipment purchases and implementation (~$353K)

Cash and Short-Term Investment Portfolio

At September 30 the Plan had $244.5 million in cash and short-term investments. The investment portfolio included Ventura County Investment Pool $18.3 million; LAIF CA State $25.2 million; the portfolio yielded a rate of 2.5%.

SCHEDULE OF INVESTMENTS AND CASH BALANCES

	Market Value* September 30, 2021	Account Type
Local Agency Investment Fund (LAIF)[1]	$ 25,207,145	investment
Ventura County Investment Pool[2]	$ 18,338,883	investment
CalTrust	$ 3,773	short-term investment
Bank of West	$ 172,981,649	money market account
Pacific Premier	$ 26,412,436	operating accounts
Mechanics Bank[3]	$ 1,540,672	operating accounts
Petty Cash	$ 500	cash
Investments and monies held by GCHP	***$ 244,485,057***	

	Sep-21	FYTD 21-22
Local Agency Investment Fund (LAIF)		
Beginning Balance	$ 25,207,145	$ 206,976
Transfer of Funds from Ventura County Investment Pool	-	25,000,000
Quarterly Interest Received	-	414
Quarterly Interest Adjustment	-	(245)
Current Market Value	**$ 25,207,145**	**$ 25,207,145**
	-	-
Ventura County Investment Pool		
Beginning Balance	$ 18,338,883	$ 43,304,353
Transfer of funds to LAIF	-	(25,000,000)
Interest Received	-	34,530
Current Market Value	**$ 18,338,883**	**$ 18,338,883**

Medi-Cal Receivable

At September 30 the Plan had $103.8 million in Medi-Cal Receivables due from the DHCS.

RECOMMENDATION:

Staff requests that the Commission approve the September 2021 financial package.

CONCURRENCE:

N/A

ATTACHMENT:

September 2021 Financial Package

Gold Coast Health Plan℠
A Public Entity

FINANCIAL PACKAGE
For the month ended September 30, 2021

TABLE OF CONTENTS

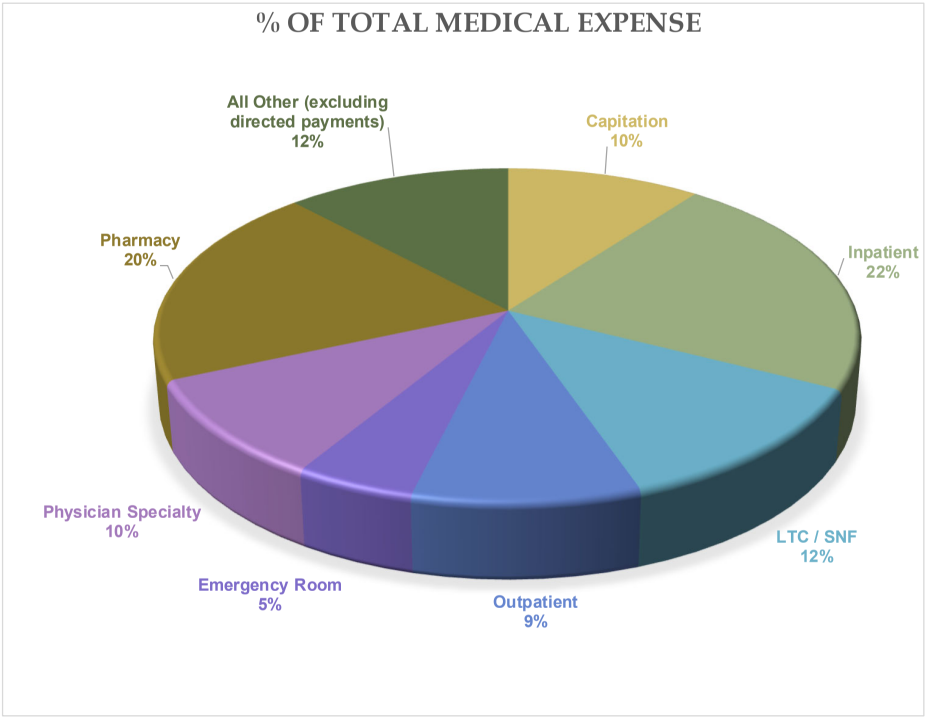
Return to Agenda

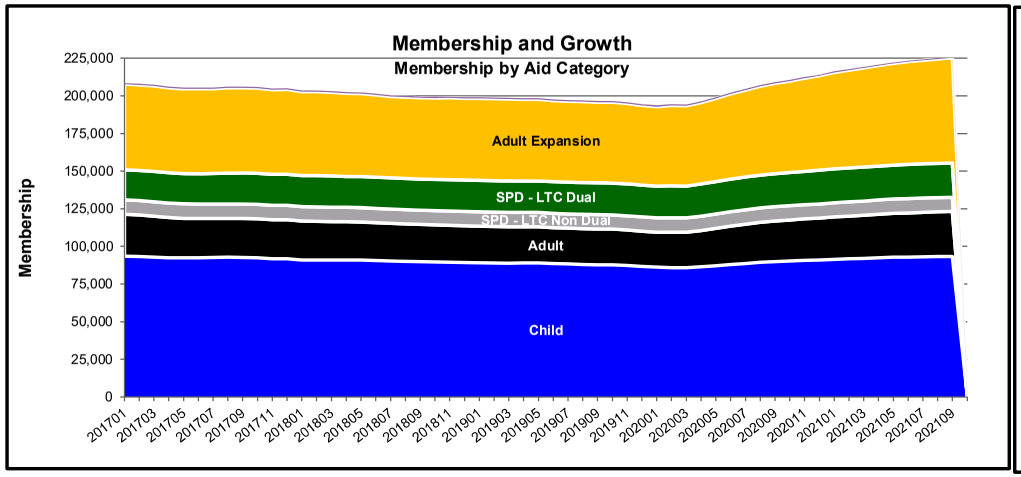
Gold Coast Health Plan

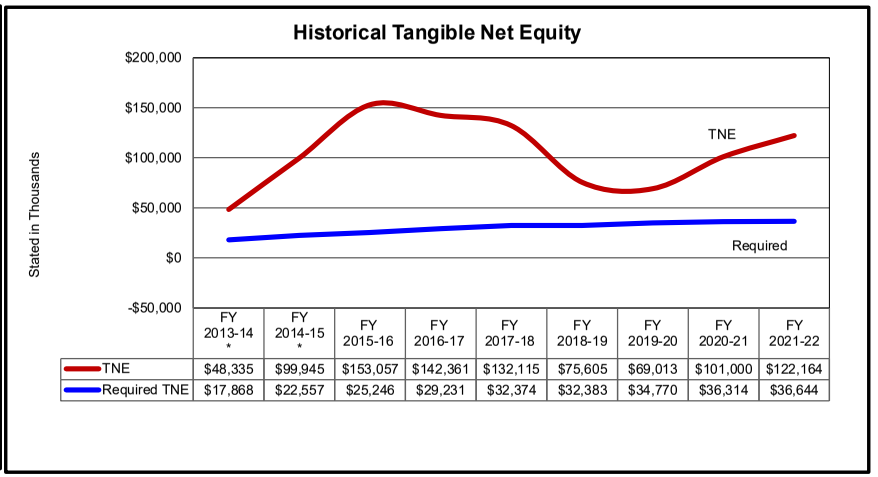
Executive Dashboard as of September 30, 2021

	FYTD 21/22 Budget*	FYTD 21/22 Actual	FY 20/21 Actual	FY 19/20 Actual
Average Enrollment	77,202	223,430	213,547	196,012
PMPM Revenue	$ 371.47	$ 372.80	$ 358.22	$ 348.73
Medical Expenses				
Capitation	$ 36.12	$ 32.55	$ 34.03	$ 24.93
Inpatient	$ 65.44	$ 70.71	$ 66.52	$ 65.19
LTC / SNF	$ 56.72	$ 38.75	$ 55.42	$ 59.20
Outpatient	$ 25.93	$ 29.10	$ 23.16	$ 25.81
Emergency Room	$ 12.90	$ 15.43	$ 9.25	$ 11.97
Physician Specialty	$ 26.82	$ 30.82	$ 25.71	$ 27.63
Pharmacy	$ 64.39	$ 62.59	$ 62.07	$ 61.05
All Other *(excluding directed payments)*	$ 38.09	$ 37.82	$ 43.20	$ 41.07
Total Per Member Per Month	$ 326.41	$ 317.78	$ 319.36	$ 316.86
Medical Loss Ratio	92.0%	88.0%	92.1%	94.6%
Total Administrative Expenses	$ 16,646,520	$ 13,470,675	$ 49,637,603	$ 50,821,685
% of Revenue	6.7%	5.4%	5.4%	6.2%
TNE	$ 100,654,230	$ 122,164,057	$ 100,999,994	$ 71,272,142
Required TNE	$ 37,464,756	$ 36,644,265	$ 36,313,908	$ 34,685,521
% of Required	269%	333%	278%	205%

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







	FY 2013-14 *	FY 2014-15 *	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
TNE	$48,335	$99,945	$153,057	$142,361	$132,115	$75,605	$69,013	$101,000	$122,164
Required TNE	$17,868	$22,557	$25,246	$29,231	$32,374	$32,383	$34,770	$36,314	$36,644

Return to Agenda

STATEMENT OF FINANCIAL POSITION

	09/30/21	08/31/21	07/31/21
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**200,935,258**	**189,665,301**	**181,564,813**
Total Short-Term Investments	**43,549,801**	**43,549,800**	**43,532,535**
Medi-Cal Receivable	103,846,657	109,348,556	106,844,162
Interest Receivable	91,238	86,401	99,015
Provider Receivable	1,456,069	1,025,836	2,161,503
Other Receivables	6,551,713	6,551,713	6,320,713
Total Accounts Receivable	**111,945,677**	**117,012,506**	**115,425,393**
Total Prepaid Accounts	3,112,850	3,160,044	3,033,715
Total Other Current Assets	156,289	153,789	153,789
Total Current Assets	**359,699,874**	**353,541,441**	**343,710,244**
Total Fixed Assets	**1,346,277**	**1,389,413**	**1,173,684**
Total Assets	**$ 361,046,151**	**$ 354,930,854**	**$ 344,883,929**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 113,127,383	$ 125,246,814	$ 133,395,431
Claims Payable	10,081,989	7,380,747	9,818,017
Capitation Payable	24,190,667	25,377,384	25,368,834
Physician Payable	19,916,310	18,406,909	26,530,179
DHCS - Reserve for Capitation Recoup	14,922,016	14,936,921	6,027,119
Accounts Payable	2,255,970	759,926	190,618
Accrued ACS	3,478,638	3,498,567	3,355,584
Accrued Provider Reserve	1,631,919	1,560,330	1,489,014
Accrued Pharmacy	22,669,416	21,839,389	14,017,265
Accrued Expenses	2,103,839	2,180,746	2,166,098
Accrued Premium Tax	21,565,800	14,377,200	7,188,600
Accrued Payroll Expense	1,974,868	2,544,532	2,341,053
Total Current Liabilities	**237,918,815**	**238,109,464**	**231,887,813**
Long-Term Liabilities:			
Other Long-term Liability-Deferred Rent	963,279	972,873	982,468
Deferred Revenue - Long Term Portion	-	-	-
Notes Payable	-	-	-
Total Long-Term Liabilities	**963,279**	**972,873**	**982,468**
Total Liabilities	**238,882,094**	**239,082,337**	**232,870,280**
Net Assets:			
Beginning Net Assets	105,714,877	105,714,877	105,714,877
Total Increase / (Decrease in Unrestricted Net Assets)	16,449,181	10,133,640	6,298,772
Total Net Assets	**122,164,057**	**115,848,517**	**112,013,649**
Total Liabilities & Net Assets	**$ 361,046,151**	**$ 354,930,854**	**$ 344,883,929**

Return to Agenda

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR MONTH ENDED September 30, 2021

	September 2021	September 2021 Year-To-Date		Variance	Variance	September 2021 Year-To-Date		Variance
	Actual	Actual	Budget	Fav / (Unfav)	%	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	224,580	670,290	694,822	(24,532)	-4%	PMPM - FYTD		
Revenue								
Premium	$ 91,237,806	$ 271,449,532	$ 249,650,132	$ 21,799,400	9%	$ 404.97	$ 359.30	$ 45.67
Reserve for Cap Requirements	-	-	-	-	0%	-	-	-
MCO Premium Tax	(7,188,600)	(21,565,800)	-	(21,565,800)	0%	(32.17)	-	(32.17)
Total Net Premium	**84,049,206**	**249,883,732**	**249,650,132**	**233,600**	**0%**	**372.80**	**359.30**	**13.50**
Other Revenue:								
Miscellaneous Income	165	450	-	450	0%	0.00	-	0.00
Total Other Revenue	165	450	-	450	0%	0.00	-	0.00
Total Revenue	**84,049,371**	**249,884,182**	**249,650,132**	**234,050**	**0%**	**372.80**	**359.30**	**13.50**
Medical Expenses:								
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	6,508,941	21,814,930	24,275,066	2,460,136	10%	32.55	34.94	2.39
FFS Claims Expenses:								
Inpatient	18,281,051	47,394,226	43,980,114	(3,414,111)	-8%	70.71	63.30	(7.41)
LTC / SNF	6,616,811	25,976,271	38,122,280	12,146,009	32%	38.75	54.87	16.11
Outpatient	8,142,395	19,506,260	17,427,146	(2,079,113)	-12%	29.10	25.08	(4.02)
Laboratory and Radiology	476,445	1,551,360	1,664,467	113,107	7%	2.31	2.40	0.08
Directed Payments - Provider	2,355,145	6,997,820	6,628,146	(369,674)	-6%	10.44	9.54	(0.90)
Emergency Room	3,984,146	10,340,126	8,670,470	(1,669,656)	-19%	15.43	12.48	(2.95)
Physician Specialty	6,919,456	20,661,266	18,024,233	(2,637,033)	-15%	30.82	25.94	(4.88)
Primary Care Physician	1,015,918	2,812,404	5,033,273	2,220,870	44%	4.20	7.24	3.05
Home & Community Based Services	1,064,250	5,141,477	6,793,225	1,651,748	24%	7.67	9.78	2.11
Applied Behavioral Analysis/Mental Health Service	2,727,547	7,919,944	7,663,564	(256,379)	-3%	11.82	11.03	(0.79)
Pharmacy	13,726,482	41,956,028	43,270,796	1,314,767	3%	62.59	62.28	(0.32)
Provider Reserve	71,589	(17,198)	-	17,198	0%	(0.03)	-	0.03
Other Medical Professional	222,441	655,384	1,177,093	521,709	44%	0.98	1.69	0.72
Other Medical Care	-	260	-	(260)	0%	0.00	-	(0.00)
Other Fee For Service	696,158	2,639,911	2,727,083	87,172	3%	3.94	3.92	(0.01)
Transportation	130,601	1,974,921	539,061	(1,435,860)	-266%	2.95	0.78	(2.17)
Total Claims	66,430,434	195,510,459	201,720,952	6,210,493	3%	291.68	290.32	(1.36)
Medical & Care Management Expense	1,250,197	3,748,840	3,935,813	186,973	5%	5.59	5.66	0.07
Reinsurance	295,615	33,766	938,010	904,244	96%	0.05	1.35	1.30
Claims Recoveries	(1,318,681)	(1,107,986)	(1,067,716)	40,270	-4%	(1.65)	(1.54)	0.12
Sub-total	227,130	2,674,620	3,806,107	1,131,488	30%	3.99	5.48	1.49
Total Cost of Health Care	**73,166,505**	**220,000,009**	**229,802,126**	**9,802,117**	**4%**	**328.22**	**330.74**	**2.52**
Contribution Margin	**10,882,866**	**29,884,173**	**19,848,006**	**10,036,167**	**51%**	**44.58**	**28.57**	**16.02**
General & Administrative Expenses:								
Salaries, Wages & Employee Benefits	2,208,172	6,478,484	7,013,415	534,931	8%	9.67	10.09	0.43
Training, Conference & Travel	8,214	11,833	38,915	27,082	70%	0.02	0.06	0.04
Outside Services	2,187,101	6,650,012	7,377,081	727,069	10%	9.92	10.62	0.70
Professional Services	428,079	988,067	1,457,166	469,099	32%	1.47	2.10	0.62
Occupancy, Supplies, Insurance & Others	776,069	2,354,281	2,616,786	262,505	10%	3.51	3.77	0.25
Care Management Reclass to Medical	(1,250,197)	(3,748,840)	(3,935,813)	(186,973)	5%	(5.59)	(5.66)	(0.07)
G&A Expenses	4,357,438	12,733,836	14,567,549	1,833,713	13%	19.00	20.97	1.97
Project Portfolio	223,692	736,839	2,078,971	1,342,131	65%	1.10	2.99	1.89
Total G&A Expenses	**4,581,130**	**13,470,675**	**16,646,520**	**3,175,845**	**19%**	**20.10**	**23.96**	**3.86**
Total Operating Gain / (Loss)	**6,301,736**	**16,413,498**	**3,201,486**	**13,212,012**	**413%**	**24.49**	**4.61**	**19.88**
Non Operating								
Revenues - Interest	15,051	36,929	90,000	(53,071)	-59%	0.06	0.13	(0.07)
Gain/(Loss) on Sale of Asset	(1,247)	(1,247)	-	(1,247)	0%	(0.00)	-	(0.00)
Total Non-Operating	**13,804**	**35,683**	**90,000**	**(54,317)**	**-60%**	**0.06**	**0.13**	**(0.07)**
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 6,315,540**	**$ 16,449,181**	**$ 3,291,486**	**$ 13,157,694**	**400%**	**$ 24.54**	**$ 4.74**	**$ 19.80**

Return to Agenda

STATEMENT OF CASH FLOWS	September 2021	FYTD 20-21
Cash Flows Provided By Operating Activities		
Net Income (Loss)	$ 6,315,540	$ 16,449,181
Adjustments to reconciled net income to net cash provided by operating activities		
Depreciation on fixed assets	39,930	106,696
Disposal of fixed assets	-	-
Amortization of discounts and premium	-	-
Changes in Operating Assets and Liabilites		
Accounts Receivable	5,066,829	(576,554)
Prepaid Expenses	44,695	(1,164,188)
Accrued Expense and Accounts Payable	1,706,662	412,842
Claims Payable	3,023,926	3,726,157
MCO Tax liablity	7,188,600	2,156,580
IBNR	(12,119,431)	(13,833,260)
Net Cash Provided by (Used in) Operating Activities	11,266,751	7,277,455
Cash Flow Provided By Investing Activities		
Proceeds from Restricted Cash & Other Assets		
Proceeds from Investments	(0)	(34,701)
Purchase of Property and Equipment	3,206	(254,501)
Net Cash (Used In) Provided by Investing Activities	3,205	(289,202)
Increase/(Decrease) in Cash and Cash Equivalents	11,269,957	6,988,253
Cash and Cash Equivalents, Beginning of Period	189,665,301	193,947,005
Cash and Cash Equivalents, End of Period	200,935,258	200,935,258

Gold Coast Health Plan℠
A Public Entity

September 2021 Financial Statements

October 25, 2021

Kashina Bishop
Chief Financial Officer

Integrity
Accountability
Collaboration
Trust
Respect

Return to Agenda

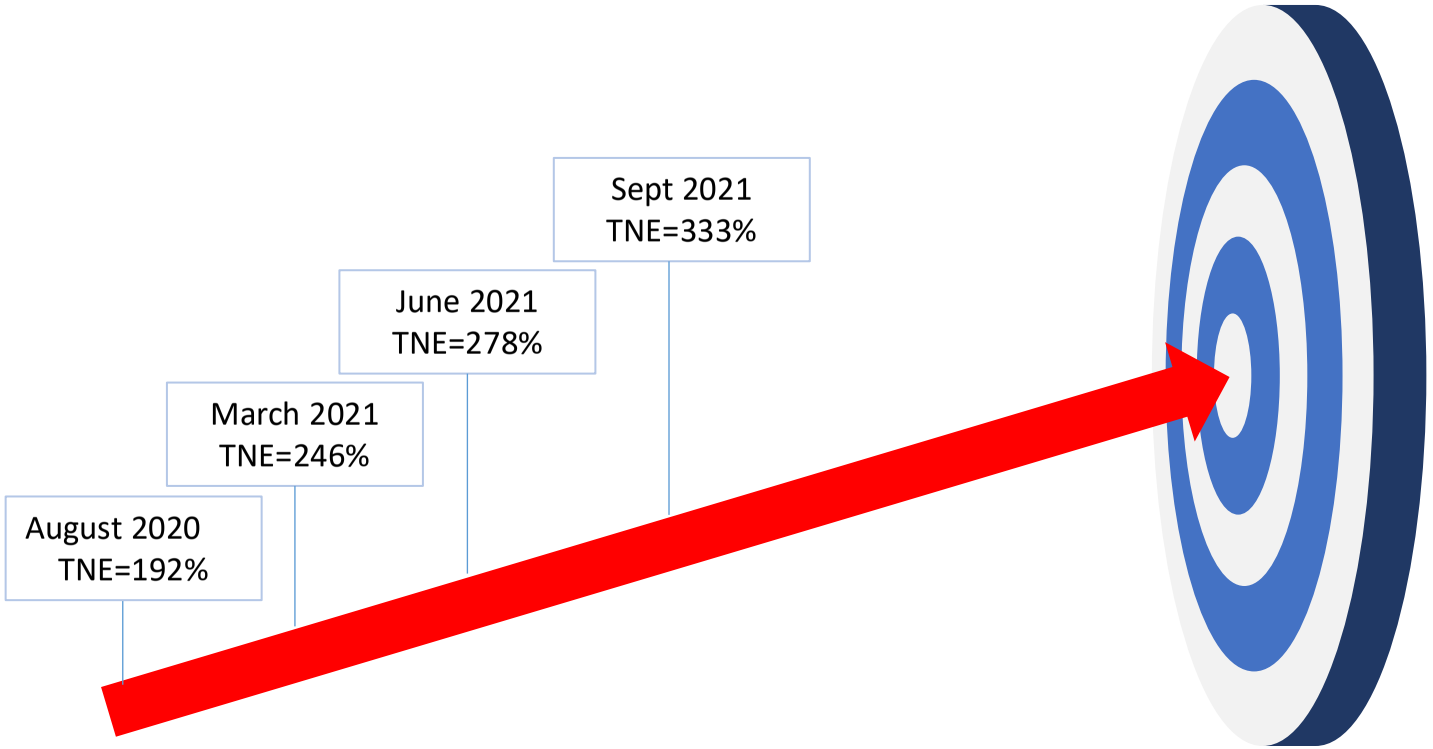
711 East Daily Drive, Suite 106, Camarillo, CA 93010 www.goldcoasthealthplan.org

Financial Overview:

SEPTEMBER NET GAIN	$ 6.3 M
FYTD NET GAIN	$16.4 M
TNE is $122.2 M and 333% of the minimum required	
MEDICAL LOSS RATIO	88%
ADMINISTRATIVE RATIO	5.4%

Solvency Action Plan

Target: TNE % = 400-500% of Required



Return to Agenda

FY 2020-21 Audited Financial Statements

	Preliminary FY 20-21	Adjustments	Audited FY 20-21
Net Capitation Revenue	$ 917,972,897	$ (1,315,268)	$ 916,657,629
Health Care Costs	845,119,016	(6,030,151)	839,088,866
Administrative Expenses	49,637,603	-	49,637,603
Non-Operating Revenue/(Expense)	460,444	-	460,444
Total Increase/(Decrease) in Net Assets	$ 23,676,724	$ 4,714,882	$ 28,391,605
GCHP TNE	$ 100,999,994		$ 105,714,877
Required TNE	$ 36,313,908		$ 36,072,702
% of Required	**278%**		**293%**

Return to Agenda

Revenue

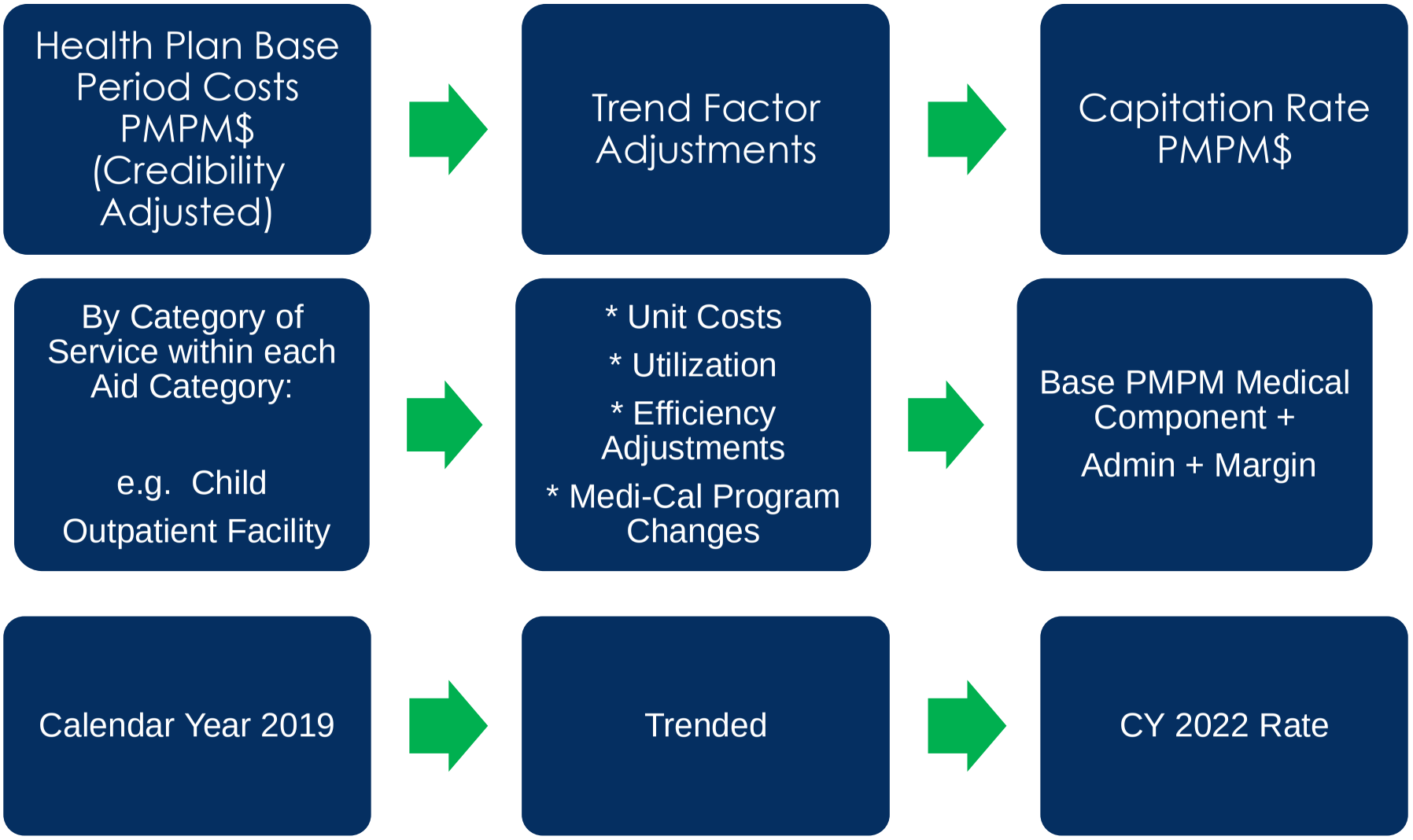
Net Premium revenue is $249.9 million, over budget by $233,600.

- Favorable CY 2021 rates.

Good news! Received draft CY 2022 rates which represented a 5.7% increase effective January 1, 2022 (1.3% higher than budget).

Return to Agenda

CY 2022 Rates



Return to Agenda

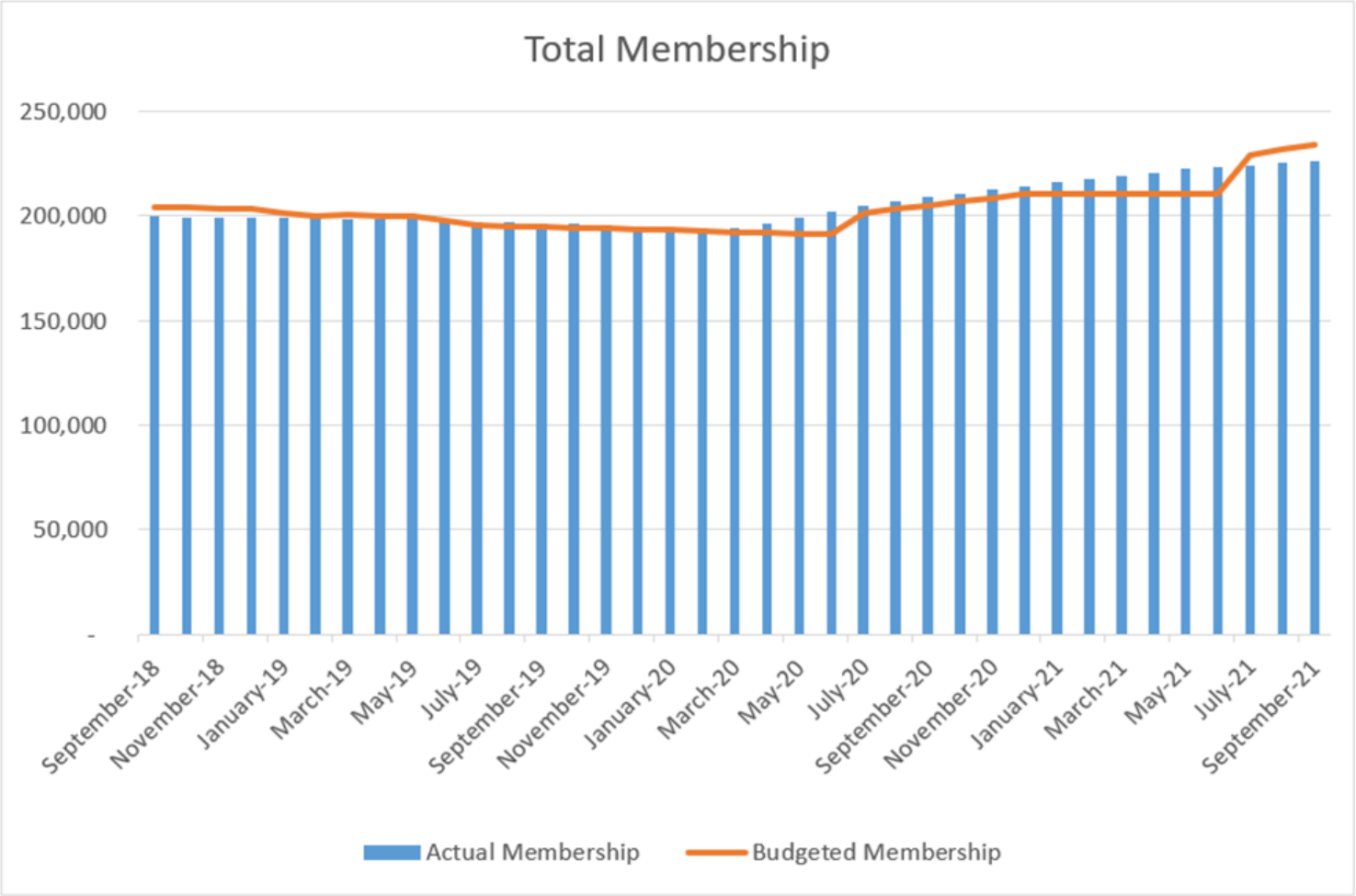
CY 2022 Rates

CY 2019 Base Medical Expenses	$	634,708,075
Trend Adjustments	$	72,638,219
Program Changes/COVID/GEMT	$	9,725,352
Efficiency Adjustments	$	(5,335,036)
Population Acuity Adjustment	$	(4,730,512)
Maternity Carve-Out	$	(23,478,197)
Administrative Component	$	66,081,486
Risk Margin	$	15,298,151
Total Base Funding*	$	764,907,537

* Excludes supplemental and directed payments.

Return to Agenda

Membership trends



Return to Agenda

Medical Expense

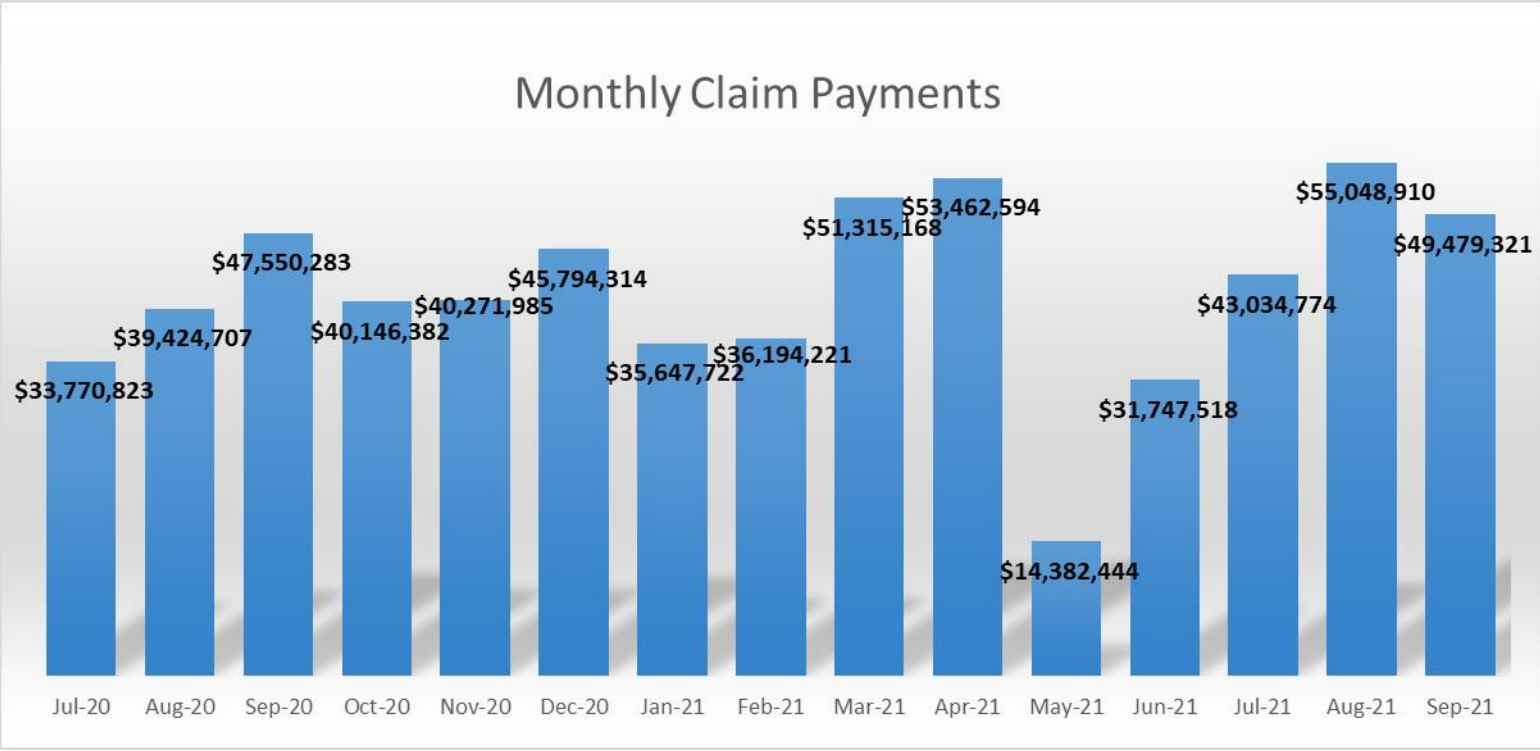
FYTD Health care costs are $220.0 million and $9.8 million and 4% under budget. Medical loss ratio is 88.0%, a 4.0% budget variance.

Return to Agenda

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

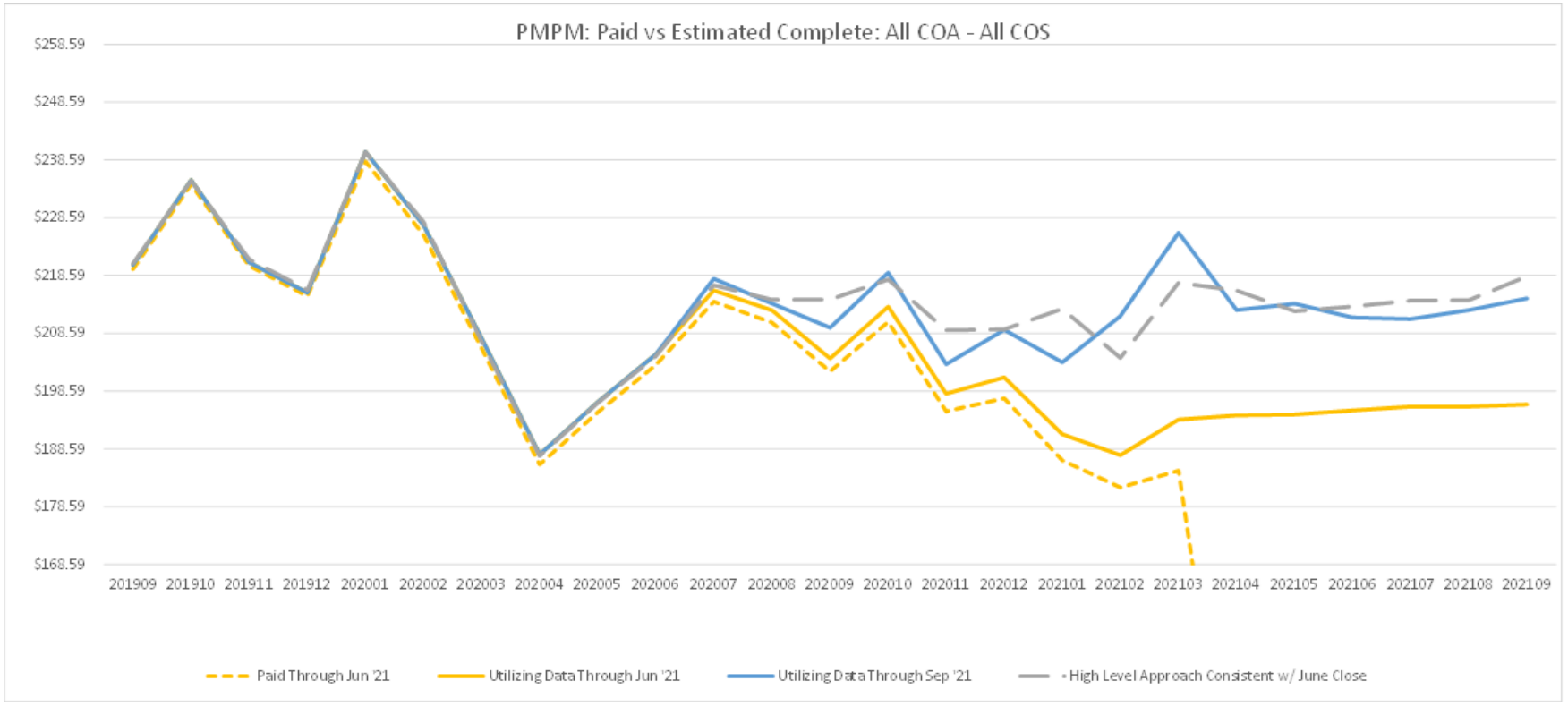
Accurately calculating the reserve becomes more challenging:

1. Historical lag between when a service is performed and when the claims is paid is disrupted
2. Do not have an accurate data file – impacting category of service on financials



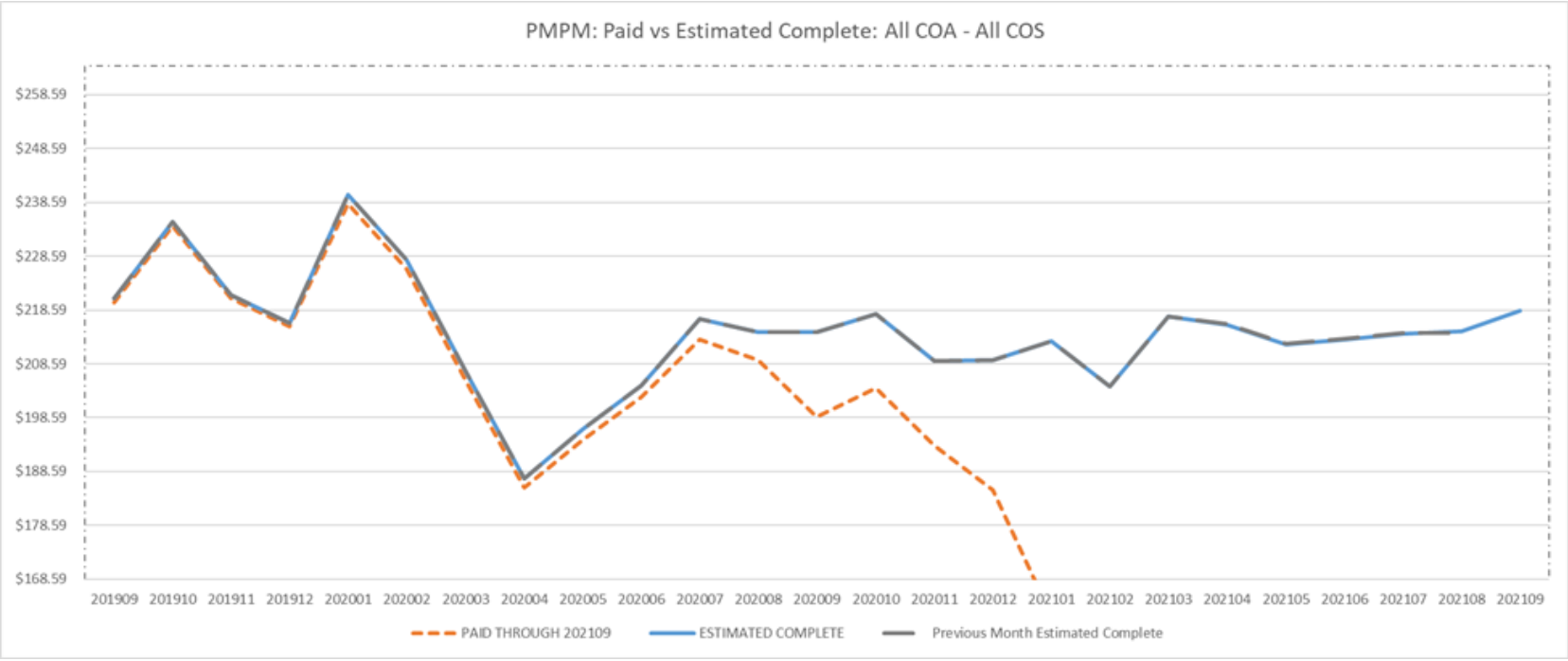
Return to Agenda

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



Return to Agenda

Incurred But Not Paid (IBNP) Medical Expense Reserve



Return to Agenda

Financial Statement Summary

	September 2021	FYTD Actual	FYTD Budget	Budget Variance
Net Capitation Revenue	$ 84,049,206	$ 249,883,732	$ 249,650,132	$ 233,600
Health Care Costs	73,166,505	220,000,009	229,802,126	(9,802,117)
Medical Loss Ratio		**88.0%**	**92.0%**	
Administrative Expenses	4,581,130	13,470,675	16,646,520	(3,175,845)
Administrative Ratio		**5.4%**	**7.3%**	
Non-Operating Revenue/(Expense)	13,804	35,683	90,000	(54,316)
Total Increase/(Decrease) in Net Assets	$ 6,315,376	$ 16,448,731	$ 3,291,486	$ 13,157,245
Cash and Investments	$ 244,485,059			
GCHP TNE	$ 122,164,057			
Required TNE	$ 36,644,265			
% of Required	**333%**			

Return to Agenda

Questions?

Staff requests the Commission approve the unaudited financial statements for September 2021.

Return to Agenda

Gold Coast Health Plan℠
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AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Margaret Tatar, Chief Executive Officer

DATE: October 25, 2021

SUBJECT: Chief Executive Officer (CEO) Report

I. EXTERNAL AFFAIRS:

A. Federal

Congressional Action (as of October 11, 2021)

H.R.5376 - Build Back Better Act (Link)

Congress is weighing in on President Biden's agenda. While much of his plan rests in the hands of a few senators, the cornerstone of the President's plan, known as the "Build Back Better Act," makes historic investments in families, workers, and health.

Key Health Provisions:
The Build Back Better Act works to expand access to health care for Americans, with an end goal of making health care more affordable. The key areas of the act's health initiatives are:

- Prescription Drug Pricing
- Medicare Dental, Vision, and Hearing Coverage
- Medicaid Coverage Gap
- Affordable Care Act Reinsurance Program
- Home- and Community-Based Services
- Children's Health Insurance Program (CHIP) and Medicaid
- Maternal Health
- Justice-Involved Populations
- Public Health Infrastructure, Workforce, and Preparedness

B. State

Executive and DHCS Action (as of Oct. 11, 2021)

APL 21-012 Enhanced Care Management (ECM) Requirements (Sept. 15, 2021)

In preparation for California Advancing and Innovating Medi-Cal (CalAIM) and the launch of ECM and Community Supports (formerly known as In Lieu of Services, or ILOS), on Jan. 1, 2022, DHCS released an ECM all-plan letter (APL) regarding provisions of the ECM benefit.

GCHP recently submitted its Model of Care (MOC). DHCS will use GCHP's MOC to determine its readiness to meet the ECM and CS requirements laid out in this APL and other guidance documents. After DHCS reviews and approves GCHP's submissions, the ECM benefit and CS program will be implemented starting Jan. 1, 2022. GCHP will continue to review guidance from DHCS in the Mandates Implementation Committee starting on Tuesday, Oct. 26, 2021.

Executive and DHCS Action (as of Oct. 11, 2021)

APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans (Oct. 4, 2021)

This APL provides guidance to managed care plans on how to submit a service delivery dispute to DHCS when the dispute cannot be resolved at the local level with mental health plans. The APL updates the dispute resolution process, expedited process, and clarifies fiscal responsibilities.

This APL supersedes APL 15-007 and will require revisions of internal policies and procedures. The Mandates Implementation Committee will review the APL and discuss required changes. New and revised polices will be brought to GCHP's Policy Review Committee prior to the January implementation date.

State Legislature Bills (as of Oct. 11, 2021)

October 10, 2021, was the last day for bills to be signed, approved without signing, or vetoed by the governor. The legislature can now override a veto with a two-thirds vote in each house.

Behavioral Health	Implications
SB 221 Health Care Coverage: Timely Access to Care Status: Chaptered (approved by the Legislature and signed by the governor) Summary: Would codify current timely access standards requiring the Department of Managed Health Care (DMHC) and the Department of Insurance to ensure that contracted providers and health networks schedule initial appointments within specified time frames of a beneficiary's request. Would expand current standards to also require follow-up appointments with a non-physician mental health or substance use disorder provider to be scheduled within 10 business days of a previous appointment related to an ongoing course of treatment.	Possible additional oversight of behavioral health appointments and payments for out-of-network care when timely access standards are not met. The 10-day follow-up appointment provision in the bill would close a loophole in state law and regulations and establish a timely access standard for follow-up appointments for mental health and substance use disorder treatment.
SB 48 Medi-Cal: Annual Cognitive Health Assessment. Status: Chaptered (approved by the Legislature and signed by the governor) This bill would expand the schedule of benefits to include an annual cognitive health assessment for Medi-Cal beneficiaries who are 65 years of age or older if they are otherwise ineligible for a similar assessment as part of an annual wellness visit under the Medicare Program. The bill would make a Medi-Cal provider eligible to receive the payment for this benefit only if they comply with certain requirements, including completing cognitive health assessment training. The bill would require the department to determine specified training and validated tools in consultation with prescribed entities, including the state Department of Public Health's Alzheimer's Disease Program. By Jan. 1, 2024, and every two years thereafter, the bill would require the department to consolidate and analyze data related to the benefit, and to post information on the utilization of, and payment for, the benefit on its website. The bill would authorize the department to implement these provisions by various means, including all-plan letters, without taking regulatory action, and would condition the implementation of these provisions to the extent federal approvals are obtained and federal financial participation is available.	Adds a Medi-Cal benefit for an annual cognitive health assessment for Medi-Cal beneficiaries who are 65 years of age or older if they are otherwise ineligible for a similar assessment as part of an annual wellness visit under the Medicare Program.

Behavioral Health (cont'd)	Implications
AB 451 Health Care Facilities: Treatment of Psychiatric Emergency Medical Conditions. Status: Chaptered (approved by the Legislature and signed by the governor) This bill would require a psychiatric unit within a general acute care hospital, a psychiatric health facility, or an acute psychiatric hospital to accept the transfer of a person with a psychiatric emergency medical condition from a health facility that operates an emergency department and to provide emergency services and care to treat that person, regardless of whether the facility operates an emergency department, if specified criteria are met.	No direct implications for GCHP.
Health Equity	**Implications**
AB 941 Farmworker Assistance: Resource Centers. Status: Chaptered (approved by the Legislature and signed by the governor) This bill would require the department to establish a grant program for counties to establish farmworker resource centers that provide farmworkers and their families information and access to services related to, among other things, labor and employment rights, education, housing, immigration, and health and human services. The bill would make a county's eligibility for funding under the grant program contingent upon the county working with local or statewide community-based organizations to develop the center, providing 25% of the center's funding under the program, and requiring the center to provide services in at least English and Spanish, to provide an assessment of the population the center would serve, and to maintain a cost-effective database to track the number and type of calls received, referrals made, and claims filed, and to monitor local trends. The bill would require the department to convene and facilitate a workgroup to help inform the establishment and administration of the grant program, as specified.	No direct implications for GCHP.

Health Information Exchange	Implications
SB 371 Health Information Technology Introduced: Feb. 10, 2021 Status: Did not pass Assembly Health; moved to two-year bill; aspects incorporated into the budget. Summary: Requires DHCS to apply for federal funding from the American Rescue Plan Act of 2021 or the Medicaid Information Technology Architecture program to create a unified data exchange between the state government, health records systems, other data exchange networks and health care providers, including for the Medi-Cal program. Funds would also be used to provide grants and technical support to small provider practices, community health centers and safety net hospitals to expand the use of health information technology and connect to exchanges.	This bill could facilitate the creation of a statewide health information exchange (HIE) to enable data exchanges related to all health plan members. An HIE would support the electronic exchange of health information among, and aggregate and integrate data from, multiple sources within our service area. Language in this bill is supported by the Health Trailer Bill AB 133.
School Based Services	**Implications**
AB 563 School-based Health Programs Introduced: Feb. 11, 2020 Status: Did not pass Senate Education and Health Committees; moved to two-year bill. Summary: Creates the Office of School-Based Health Programs within the California Department of Education (CDE), no later than July 1, 2022, to administer health programs, including the Local Education Agencies Medi-Cal Billing Option Program, and Early and Periodic Screening, Diagnostic, and Treatment (ESPDT) services. Would also require the CDE to coordinate with DHCS and Local Education Agencies to increase access to and expand the scope of school-based Medi-Cal programs.	Potential increases to utilization for school-based early and preventative treatment programs, especially utilization of dental, health, and mental health programs, and school-based health centers.

C. Community Relations – Sponsorships

GCHP continues to support Ventura County organizations through sponsorships. Sponsorships are awarded to community-based organizations in support of their efforts to serve Medi-Cal members and other vulnerable populations. The following organizations were awarded sponsorships in August:

Organization	Description	Amount
Brain Injury Center	The Brain Injury Center's mission is to raise awareness, provide support/resources to survivors and caregivers, and improve their quality of life. The sponsorship supports the "Annual Evening of Magical Memories" fundraising event.	$1,000
TOTAL		**$1,000**

D. Community Relations – Community Meetings and Events

In September, the Community Relations team participated in various collaborative meetings, community events, vaccine outreach, and council meetings. The purpose of these events is to connect with our community partners and members to engage in dialogue to bring awareness and services to the most vulnerable Medi-Cal beneficiaries.

Organization	Description	Date
Ventura County Public Health	Oxnard's Southwinds Neighborhood and Ventura County Public Health partnered to host a COVID-19 Vaccine mobile clinic in Oxnard.	Sept. 20, 2021
Ventura County Public Health	Westminster Free Clinic and Ventura County Public Health partnered to host a COVID-19 Vaccine mobile clinic in Oxnard.	Sept. 28, 2021
Many Mansions	The Big Idea Series: Homelessness Needs and Solutions is a quarterly collaborative meeting that discusses the needs of the homeless population and how to connect them to housing resources.	Sept. 29, 2021
Amigo Baby	The Moving Forward in COVID-19: Working Together Conference addressed telehealth, the latest research on poverty and how it affects brain development, adult mental health and how it affects the development of a child, and what parents have experienced during the pandemic.	Sept. 30, 2021
Ventura County Public Health	Vallarta Supermarkets and Ventura County Public Health partnered to host a COVID-19 Vaccine mobile clinic in Oxnard.	Oct. 1, 2021
Ventura County Public Health	Our Lady of Guadalupe Church and Ventura County Public Health partnered to host a COVID-19 Vaccine mobile clinic in Santa Paula.	Oct. 3, 2021

Organization	Description	Date
Simi Valley Neighborhood Council #2	The Neighborhood Council offers residents an opportunity to voice their concerns, provide input to Simi Valley city officials, and develop ideas and recommendations on various topics.	Oct. 12, 2021
Ventura County Public Health	Mary Star of the Sea Church and Ventura County Public Health partnered to host a COVID-19 Vaccine mobile clinic in Oxnard.	Oct. 13, 2021
Simi Valley Neighborhood Council #3	The Neighborhood Council offers residents an opportunity to voice their concerns, provide input to Simi Valley city officials, and develop ideas and recommendations on various topics.	Oct. 14, 2021
Vista Real Charter High School	Vista Real Charter High School hosted a COVID-19 Vaccine mobile clinic in Santa Paula.	Oct. 16, 2021
Ventura County Public Health	Oxnard's Lemonwood neighborhood and Ventura County Public Health hosted a COVID-19 Vaccine mobile clinic in Santa Paula.	Oct. 22, 2021
Total community meetings and events		**11**

On Sept. 28, 2021, we piloted our member vaccine incentive. We partnered with Ventura County Public Health to join the COVID-19 mobile vaccine clinics to incentivize our members to get vaccinated. Full-scope members who receive either their first or second vaccine received a $25 gift card. Below you will find our outreach data from Sept. 28, 2021 through Oct. 3, 2021.

Outreach Efforts			
	Spanish	English	Total
Adult Member	4	2	6
Child Member	5	6	11
Senior Member	0	1	1
Non-Member Adult	39	24	63
Non-Member Child	0	5	5
Non-Member Senior	0	2	2
Total			88

Member Gift Card Distribution			
	Spanish	English	Total
Adult Member	3	2	5
Child Member	4	6	10
Senior Member	0	0	0
Total			15

E. Community Insight Coalition

The Community Insight Coalition is an alliance group focused on health initiatives, community needs, and outreach efforts to ensure GCHP members receive high-quality care. The coalition will work to strengthen member accessibility to care and community resources and identify any barriers members may have.

In November, the coalition will have its first meeting. We will provide an overview of GCHP's services and the upcoming changes prompted by California Advancing and Innovating Medi-Cal (CalAIM). We also will discuss our member vaccine initiative and the different ways in which we can engage our members in that effort.

F. Building Community Newsletter

The Building Community Newsletter highlights GCHP's contributions to the community, along with services and resources available to members. We are working on the next issue, which will include information about Medi-Cal Rx, Enhanced Care Management (ECM) / Community Supports (CS), vaccine outreach efforts, and much more. Click here to read the latest issue.

II. PLAN OPERATIONS

A. Membership

	VCMC	CLINICAS	CMH	PCP-OTHER	DIGNITY	ADMIN MEMBERS	NOT ASSIGNED	KAISER	AHP
Aug-21	86,143	43,141	32,430	5,138	6,324	42,535	2,369	6,676	No Data
Jul-21	85,488	42,747	32,130	5,114	6,298	16,880	3,714	6,584	No Data
Jun-21	85,284	42,466	32,057	5,092	6,229	16,828	3,808	6,559	No Data

Notes:

1. The 2021 Admin Member numbers will differ from the member numbers below as both reports represent different snapshots of eligibility.
2. Unassigned members are those who have not been assigned to a PCP and have 30 days to choose one. If a member does not choose a PCP, GCHP will assign one to them.
3. As of Oct. 18, 2021, GCHP has received enrollment forms for 1,078 members for AHP. Going forward membership data will be included in the chart above, which will be included in the upcoming COO report.

AmericasHealth Plan (AHP):

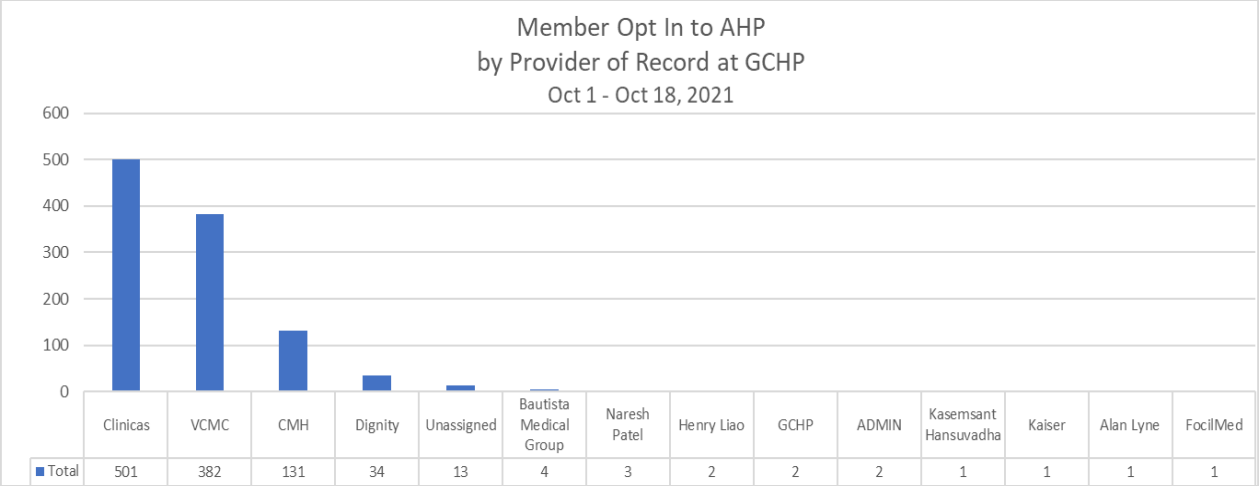
In Sept. 2021, notices were sent to 70,892 GCHP member households, excluding Administrative members, informing them of the pilot program between AmericasHealth Plan (AHP) and GCHP and how to enroll (with affirmative opt-in). As of Oct. 18, 2021, GCHP has received enrollment forms for 1,078 members. The GCHP Member Services team is working on assigning those members to AHP as of the start of the pilot on Nov. 1, 2021. After the significant efforts to build and launch this partnership and pilot, the GCHP team is excited to see and support the member interest and enrollment.

There are three key oversight metrics that the GCHP team is monitoring as the AHP pilot enrollment develops: the provider of record, the method of transmission of the enrollment form, and the timeliness of AHP member materials sent to enrollees.

1. Through Oct. 18, 2021, more than half (54%) of enrollments into the pilot were requested by members currently associated in GCHP's system with a provider outside of Clinicas del Camino Real (CDCR). The chart below details the trend. The GCHP team is working to understand non-CDCR interest in the pilot (which can be due to multiple factors) and will provide follow-up reporting to the commission.
2. Through Oct. 18, 2021, 75% of enrollment forms were received by mail and 25% were received by fax. We are confirming whether the higher-than-expected rate of faxed forms indicates that members are looking for support with the enrollment process at the CDCR clinic sites.

3. GCHP will include tracking of member notices in upcoming commission reports.

The pilot program was designed by AHP and GCHP – and approved by the Department of Health Care Services and the Department of Managed Health Care – as a provider-plan partnership for advancing coordination and integration of care for enrollees. Though there are no additional benefits available to enrollees in this program, AHP and GCHP expected member interest due, in part, to the desire in the community and marketplace for the promise of greater access and coordination of patient-centered care. The GCHP team is working in full support of this goal and we will continue to carefully monitor and report on the progress.



Administrative Member Details

Category	August 2021
Total Administrative Members	41,465
Share of Cost	1,710
Long Term Care	783
BCCTP	77
Hospice (REST-SVS)	xx
Out of Area (Not in Ventura)	304
Other Health Care	
DUALS (A, AB, ABD, AD, B, BD)	27,002
Commercial OHI (Removing Medicare, Medicare Retro Billing and Null)	10,133

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

METHODOLOGY

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

GCHP works with providers through:

1. **Agreements:** Newly negotiated contracts between GCHP and a provider.
2. **Amendments:** Updates to existing Agreements.
3. **Interim Letters of Agreement (LOA):** Agreements created for providers who have applied for Medi-Cal enrollment but have not been approved. Once Medi-Cal enrollment has been approved and the provider has been credentialed by GCHP, the provider will enter into an Agreement with GCHP. Also used for out-of-area providers who are Medi-Cal enrolled to meet DHCS out-of-network contracting requirements.
4. **Letters of Agreement (LOA):** Member-specific negotiated agreements with non-contracted GCHP providers.

From September 1-30, 2021, the following contracting actions were taken:

Agreements - Total: 2		
Provider	**Specialty**	**Action Taken**
Ruihai Liu dba Abundant Blessing Acupuncture	Acupuncturist	New contract to fill network gap for acupuncturists in East County. Provider is in Simi Valley.

Provider	Specialty	Action Taken
Ardalan Alen Nourian MD APC	Orthopedic Surgeon	New contract to fill network gap for orthopedic surgeon in East County. Provider is in Thousand Oaks.

Interim Letters of Agreement – Total: 2		
Provider	**Specialty**	**Action Taken**
Simi Valley Surgery Center Inc.	ASC	The Contract Steering Committee approved the facility specializing in endoscopy services in East County for a contract. Interim LOA approved so facility can start seeing members effective Sept. 1, 2021.
CSI Medical Group	Specialist Group	Interim LOA needed to provide member access for dermatology. Office was pending 35 member visits due to lack of staffing; Dr Taft is currently pending credentialing so Interim LOA was put in place.

Contract Amendments – Total: 4		
Provider	**Specialty**	**Action Taken**
Community Memorial Health Systems	Hospital Contract	Contract update to include rev code 210
Dignity Medical Foundation Amendment Four	PCP Contract	Update to the effective date of the PCP CAP rates
County of Ventura Interim LOA Amendment 17	Specialist Contract	Addition of three physicians to the Interim LOA
Ventura Orthopedic Medical Group Interim LOA Amendment 23	Physical Therapy	Addition of two therapists, termination of one therapist, one demographic update, and one name change for a therapist

Letters of Agreement – Total: 10		
Provider	**Specialty**	**Action Taken**
Jason Gotlib/Stanford Medical Center	Hospital	LOA for member with Systemic Mastocytosis participating in 2203 pioneer study for symptomatic patients. This is the only location for a clinical trial in California.
Glendale Surgical Assoc/Pacific Coast OMS	Specialty Group	LOA for member diagnosed with Inflammatory Condition of Jaw in need of jaw surgery and tooth extraction – Physician's Charges.
Bente Kaiser M.D., Inc. dba All Womens Care	Specialty Group	LOA for high-risk baby that must be delivered at HPMC – Physician Charges.
Hollywood Presbyterian Medical Center	Hospital	LOA for high-risk baby that must be delivered at HPMC – Facility Charges.
William Brown, MD	Surgeon	LOA for member diagnosed with Unilateral Inguinal Hernia in need of hernia repair without mesh.
Accredo Health	Infusion Therapy	Home infusion therapy for member
Daniel Allison, MD	Surgeon	LOA for member in need of total knee arthroplasty revision. Member had private insurance when surgery was performed. Member became effective with GCHP on June 1, 2020.
Acorn Stairlifts	DME	LOA for member diagnosed with unspecified abnormalities of gait and mobility in need of stairlift.
Daniel Allison, MD	Surgeon	LOA for member in need of total knee arthroplasty revision. This LOA is for the Continuity of Care office visits with surgeon.
Physicians Adventist Surgery Center	Ambulatory Surgery Center	LOA for member diagnosed with Inflammatory Condition of Jaw in need of jaw surgery and tooth extraction – Facility Charges.

Network Operations Department Projects

Project	Status
BetterDoctor: BetterDoctor is a product that performs outreach to providers to gather and update provider demographic information. This is an ongoing initiative.	Network Operations continues to meet weekly with Quest Analytics. In Sept. 2021, the team verified demographic information from BetterDoctor: 1. 1,362 provider records were audited.
Provider Contracting and Credentialing Management System (PCCM): Working on upgrade to Symplr Payer (HTML5 version). Microsoft will no longer support the Silverlight platform on which the current PCCM operates. The upgrade is intended to go live in early November.	The Network Operations team is working on the following processes: 1. Desk-level Procedures 2. Data Corrections / Maintenance 3. Reporting requirements review and revisions completed 4. Reviewing conversion from current Silverlight browser to new eVIPs HTML5 version 5. Provider Directory online user acceptance testing (UAT) ongoing 6. 274 extract testing ongoing 7. Supervising physician reporting completed 8. BetterDoctor extract requirements reviewed and coordination with Quest for completion of the extract completion

Provider Additions: September 2021 – Total 49

Provider Type	In-Area Providers	Out-of-Area Providers
Midlevel	4	4
PCP	1	0
Specialist	18	21
Specialist-Hospitalist	1	0
Total	24	25

Provider Terminations: September 2021 – Total 27

Provider Type	In-Area Providers	Out-of-Area Providers
Midlevel	4	1
PCP	0	0
Specialist	14	7
Specialist-Hospitalist	1	0
Total	19	8

The provider terminations have no impact on member access and availability. Of note, the specialist terminations are primarily associated with tertiary adult and pediatric academic medical centers where interns, residents, and fellows have finished with their clinical rotations.

C. Compliance

Delegation Oversight

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 subcontractor
- 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 and GCHP is required to monitor the delegate closely as it is a risk to GCHP when delegates are unable to comply.*

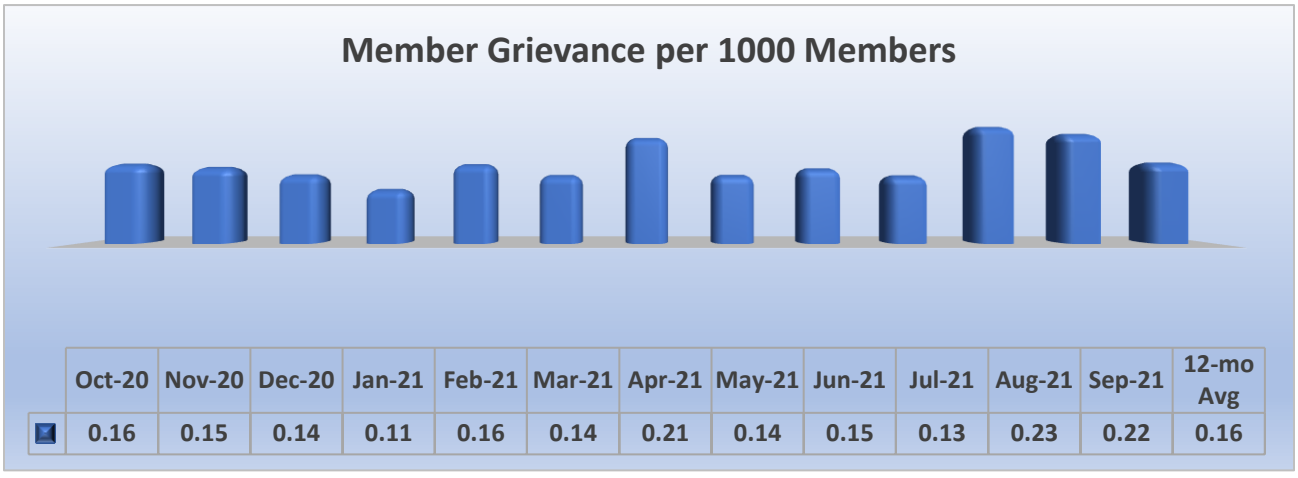
Compliance will continue to monitor all CAPs. GCHP's goal is to ensure compliance is achieved and sustained by its delegates. It is a DHCS requirement for GCHP to hold all delegates accountable. The oversight activities conducted by GCHP are evaluated during the annual DHCS medical audit. DHCS auditors 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 oversight of 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 from Sept. 23 – Oct. 4, 2021.

Delegate	Audit Year/Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Conduent	2017 Annual Claims Audit	Open	12/28/2017	Under CAP	Issue will not be resolved until new claims platform conversion
Conduent	2021 Annual Claims Audit	Open	07/21/2021	Under CAP	
Beacon	2020 Annual Claims Audit	Open	4/21/2020	Under CAP	
Beacon	2021 Annual Claims Audit	Open	5/06/2021	Under CAP	
VSP	2021 Annual Claims Audit	In Progress			
Conduent	2020 Call Center Audit	Open	1/20/2021	Under CAP	
VTS	2021 Call Center Audit	Open	5/21/2021	Under CAP	
Beacon	2021 Call Center Audit	Open	10/04/2021	Under CAP	
Privacy & Security CAPs					
Delegate	**CAP Type**	**Status**	**Date CAP Issued**	**Date CAP Closed**	**Notes**
Conduent	Annual Vendor Security Risk Assessment 2020	Closed	9/22/2020	7/09/2021	
Conduent	Call Center Recordings Website	Open	1/06/2021	N/A	
Operational CAPs					
Delegate	**CAP Type**	**Status**	**Date CAP Issued**	**Date CAP Closed**	**Notes**
Conduent	February 2021 Service Level Agreements	Open	4/15/2021	N/A	

Delegate	CAP Type	Status	Date CAP Issued	Date CAP Closed	Notes
Conduent	IKA Inventory, KWIK Queue, APL 21-002	Open	4/28/2021	N/A	IKA Inventory and KWIK Queue findings closed
Conduent	HSP Provider Portal	Open	4/29/2021	N/A	
Conduent	Call Center Stats and System Edits	Open	5/25/2021	N/A	
Conduent	IVR System Dropped Calls	Open	5/27/2021	N/A	
Conduent	May 2021 Service Level Agreements	Open	7/07/2021	N/A	
Conduent	August 2021 Service Level Agreements 1. Authorization Files 2. Check Issuance Errors 3. Member Handbook 4. Dropped Calls by Call Center	Open	9/10/2021	N/A	

D. GRIEVANCE AND APPEALS



Member Grievances per 1,000 Members

The data show GCHP's volume of grievances is low in comparison to the number of enrolled members. The 12-month average of enrollees is 219,719, with an average annual grievance rate of .16 grievances per 1,000 members.

In September 2021, there were 52 member grievances. The top reason was "Inappropriate Care" due to outpatient physical health. As previously reported, this is a new category created by DHCS in order to streamline the reporting categories for all the health plans. The previous category reported was "Quality of Care" due to inappropriate provider care.

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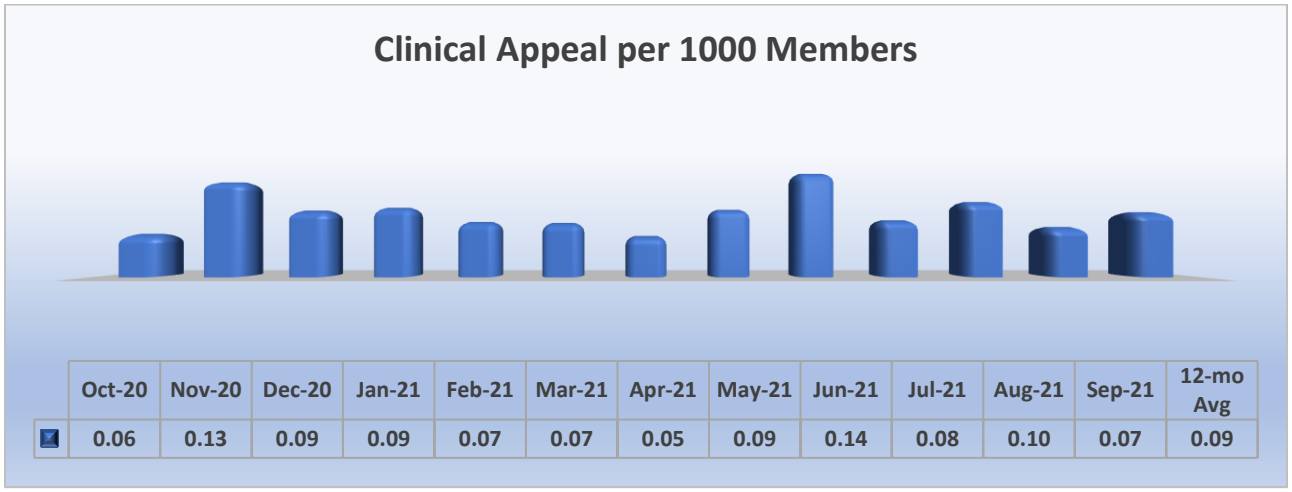


	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	12-mo Avg
☑	0.06	0.13	0.09	0.09	0.07	0.07	0.05	0.09	0.14	0.08	0.10	0.07	0.09

Clinical Appeals per 1,000 Members

The data comparison volume is based on the 12-month average of .09 appeals per 1,000 members.

In September 2021, GCHP received 16 clinical appeals:

1. Six were overturned.
2. Four were upheld.
3. Five are still in review.
4. One was withdrawn.

RECOMMENDATION:

Accept and File

AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: October 25, 2021

SUBJECT: Chief Medical Officer (CMO) Report

Participation in B-Core Opportunity

Gold Coast Health Plan ("GCHP") staff are pleased to announce participation in the Birth-Centered Outcomes Research Engagement in Medi-Cal ("B-Core") Collaborative spearheaded by Priya Batra, M.D., Senior Medical Director for Inland Empire Health Plan ("IEHP"). This project, launching in October 2021 for a year-long duration, will focus on maternal mortality and severe maternal morbidity in the Medi-Cal population**.**

The United States has the highest rate of maternal mortality among all industrialized nations and severe maternal morbidity often leads to maternal mortality. Even though maternal mortality rates in California have declined by more than half over the past two decades, Medi-Cal recipients represent a disproportionate burden of maternal morbidity and deaths. Medi-Cal members account for less than half of the births in the state but represent almost two-thirds of pregnancy-related deaths. The B-Core Collaborative seeks to engage Medi-Cal enrollees who have experienced pregnancy/birth with Medi-Cal perinatal providers, health plan administrators, and researchers in order to respond to priorities identified by Medi-Cal stakeholders.

Kathy Touake, RN Case Manager, will represent GCHP in this collaborative effort across health plans, providers, and members. Additional B-Core collaborators include the National Committee for Quality Assurance ("NCQA"), the Department of Health Care Services ("DHCS"), California Healthcare Foundation ("CHCF"), Institute for Medicaid Innovation, and the California Maternal Quality Care Collaborative ("CMQCC").

DHCS Innovation Award Submission

GCHP Quality Improvement ("QI") staff submitted a DHCS Innovation Award proposal titled *"Using a cascade-of-care model to integrate member and provider interventions focused on improving asthma management across a continuum of care*" as part of DHCS' Call for 2021 Innovation and Health Equity Award Nominations.

The program focused on members 19-51 years of age identified with inappropriate utilization of asthma medications. Understanding the challenges with improving the Asthma Medication Ratio ("AMR") rate, the demographics and characteristics of the target population, and the need to develop an innovative approach that integrated both provider and member

engagement, a cascade-of-care approach was applied that utilized successive health plan and clinic-led interventions to promote the same message across a continuum of care. The interventions included (1) health plan led telephonic outreach; (2) health plan/clinic outreach partnerships with contracted providers; and (3) development of the asthma member incentive program. The health plan's program included telephonic outreach by Health Navigators to (1) promote the importance of routine asthma exams with a PCP; (2) maintain a current asthma action plan; (3) take asthma medication as prescribed by the PCP; (4) assess barriers to asthma management; and (5) assess the need for asthma education. A post-intervention analysis showed the AMR rates for the two outreach groups increased 3.65% and 4.85%, respectively. Follow-up calls indicated that 72% of the members contacted confirmed they had scheduled an asthma exam with their PCP. Four Ventura County Medical Center ("VCMC") clinics participated in a pilot project, with each clinic receiving GCHP-developed outreach tools and the asthma incentive forms to contact members, promote the incentive program, and schedule office or telehealth appointments. Based on completed outreach, asthma exams were scheduled for 70% of the members contacted. The clinics also reported that the member incentive program requirements alerted providers to complete all three components during the clinic visit and engaged members to complete the appointment.

DHCS will announce award recipients during the DHCS Quality Conference on Wednesday, October 27, 2021.

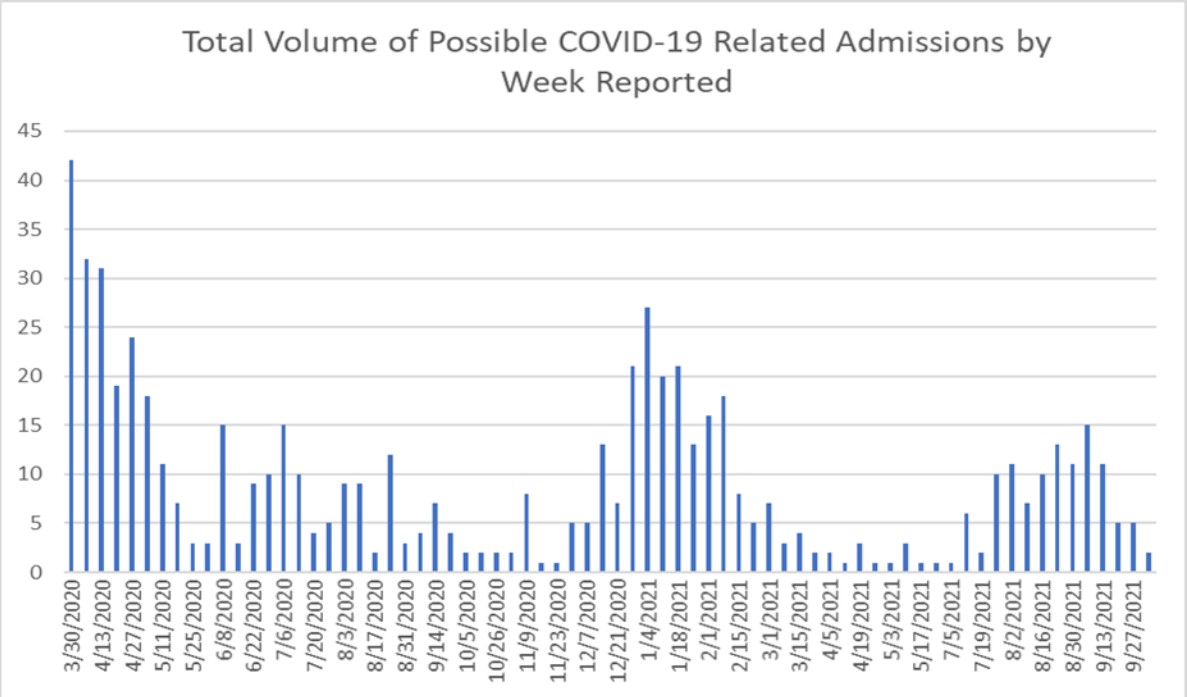
Behavioral Health Update

The Behavioral Health and Social Programs department has supported several key behavioral health initiatives in the past quarter, including the Proposition 56 Behavioral Health Integration Incentive Program ("BHIIP"), the Children and Youth Behavioral Health Initiative's Student Behavioral Health Incentive Program ("SBHIP") and the California Advancing and Innovating Medi-Cal ("CalAIM") Behavioral Health Initiative. Efforts and accomplishments include participation in DHCS workgroups to shape implementation of the various programs, hosting a second BHIIP provider convening and strengthening provider monitoring and oversight mechanisms, strengthening partnerships with Ventura County Behavioral Health and participating on the clinical advisory council for Adverse Childhood Experiences ("ACEs") Aware Ventura County to promote ACEs screening among provider systems. The Behavioral Health department also supports CalAIM Enhanced Care Management planning to ensure the needs of Ventura County's members living with Serious Mental Illness and Substance Use Disorders are adequately and appropriately addressed.

Utilization Update

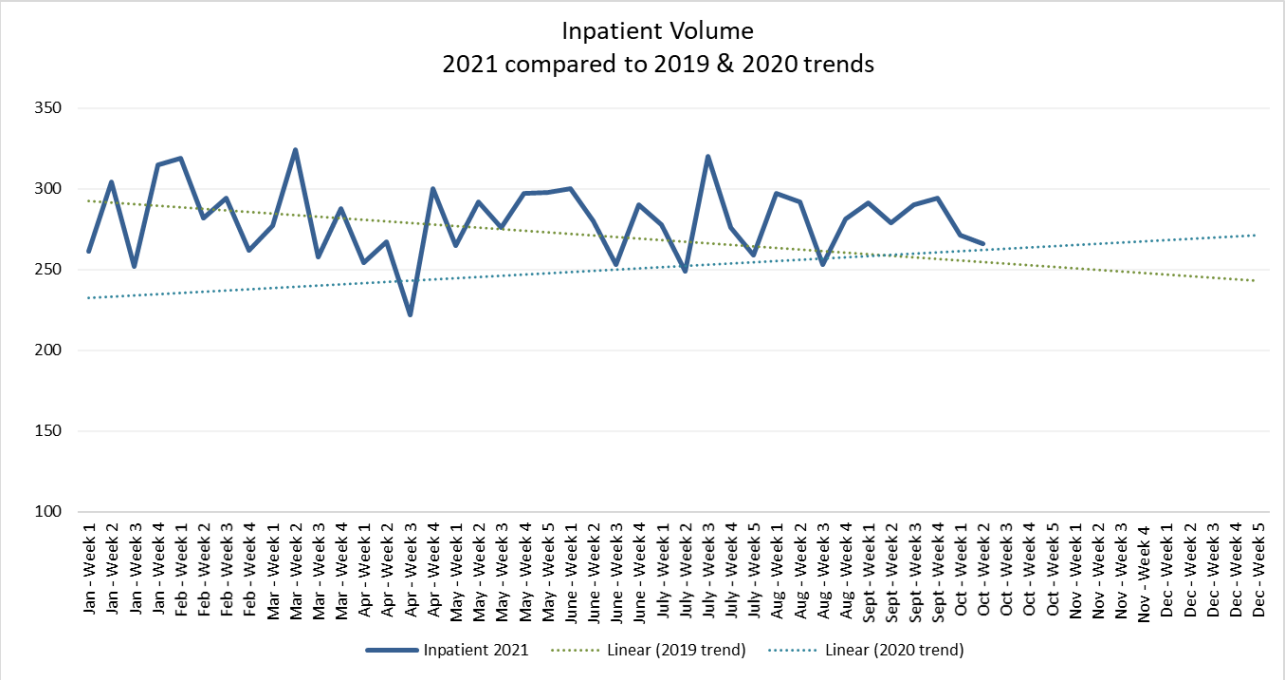
COVID-19 Update

GCHP staff are detecting decreased COVID-19 admissions through the last week of September 2021. As of October 11, 2022, the Centers for Disease Control and Prevention ("CDC") downgraded the level of transmission in Ventura County from High to Substantial. Compared with the prior week, COVID-19 hospital admissions have decreased by about 31% and there has been no change in the number of ICU beds days being used in the county.

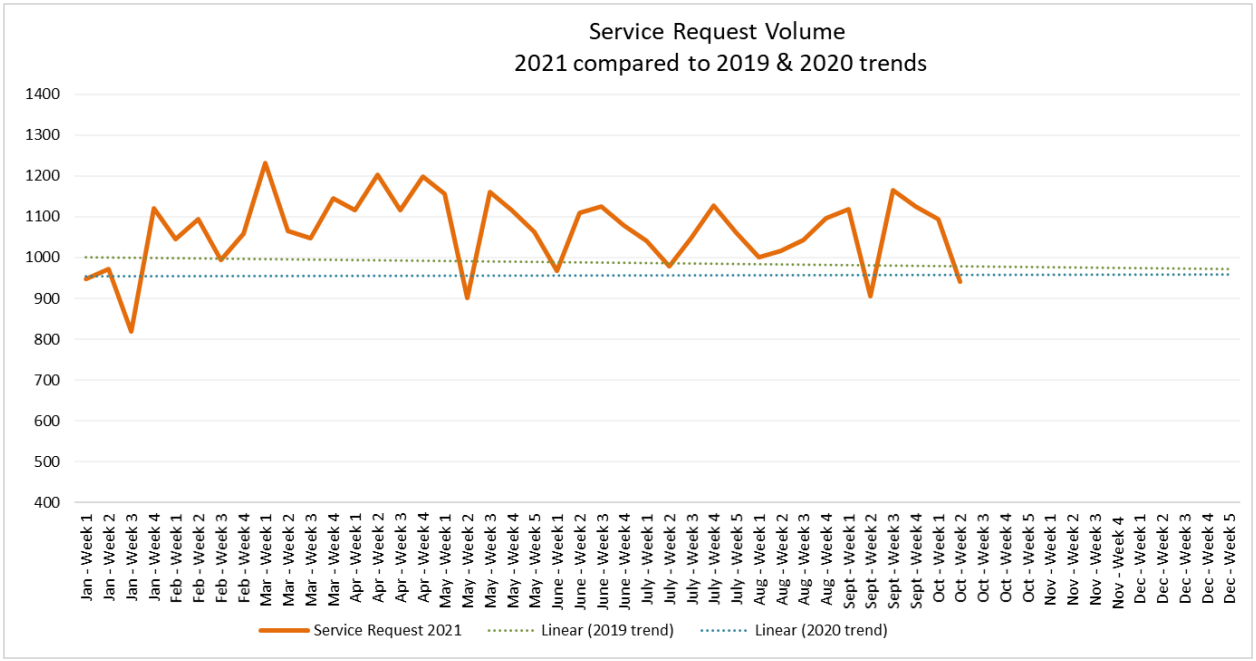


Inpatient and Outpatient Service Requests

Inpatient service requests for Q3 CY2021 are only slightly increased compared to Q3 CY 2020 (1.87% increase).

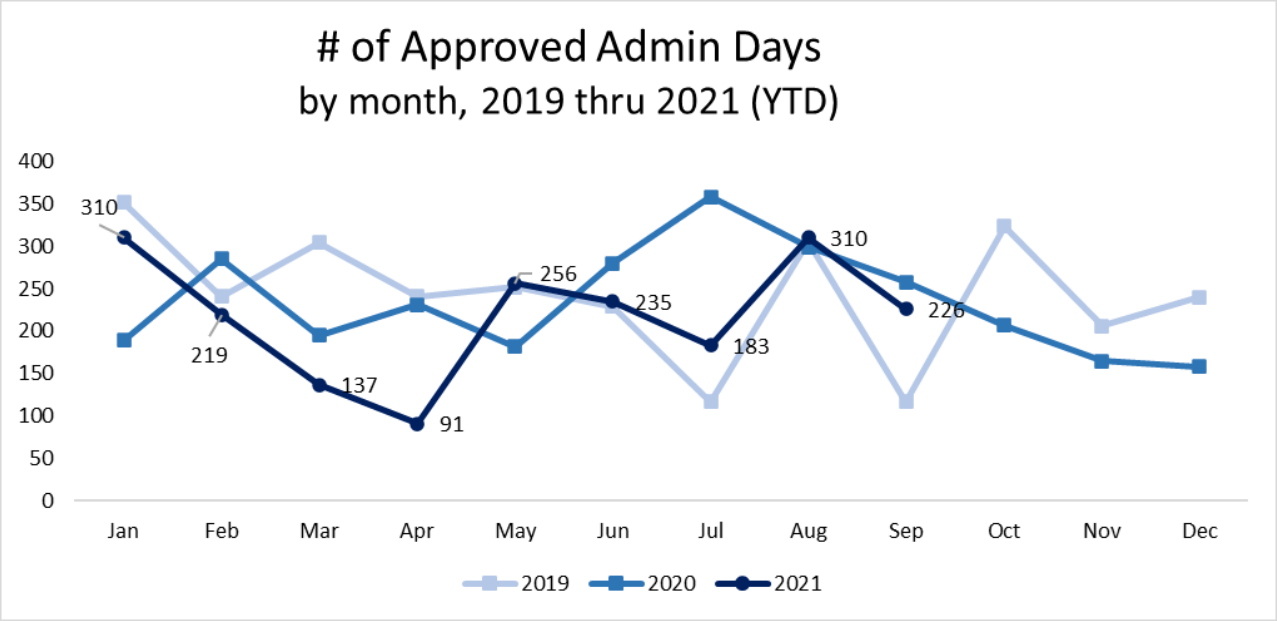


Outpatient service requests for Q3 CY2021 are also mirroring Q3 CY 2020 volumes.



Administrative Day Trends

Compared with the first nine months of CY2020, administrative days through September 2021 decreased by nearly 14%.



Pharmacy Hot Topics

Medi-Cal Rx

DHCS informed plans in late July that the new implementation date for Medi-Cal Rx will be January 1, 2022. Upon implementation, all retail prescription claims will be submitted directly to the state via its PBM, Magellan. GCHP will continue to work with advocacy groups, other MCPs, DHCS and its PBM in order to facilitate the implementation of the carve out and will continue to bring information as it becomes available to this group.

The DHCS dedicated website for Medi-Cal Rx is live and contains announcements, news, and secure portal training/registration. GCHP encourages all of its providers to:

1. Visit the portal
2. Sign up for the email subscription service
3. Register for the secure portal and training

The following table lists the planned member communication from both DHCS and GCHP for the upcoming transition:

Date	Topic	Responsibility
November 2021	60-Day Notice Letter	DHCS
November-December 2021	Outreach Campaign in Radio and Print Media	GCHP
December 2021	30-Day Notice Letter	GCHP
By January 1, 2022	New ID Cards	GCHP

DHCS's Dedicated Medi-Cal RX Website:
https://medi-calrx.dhcs.ca.gov/home/

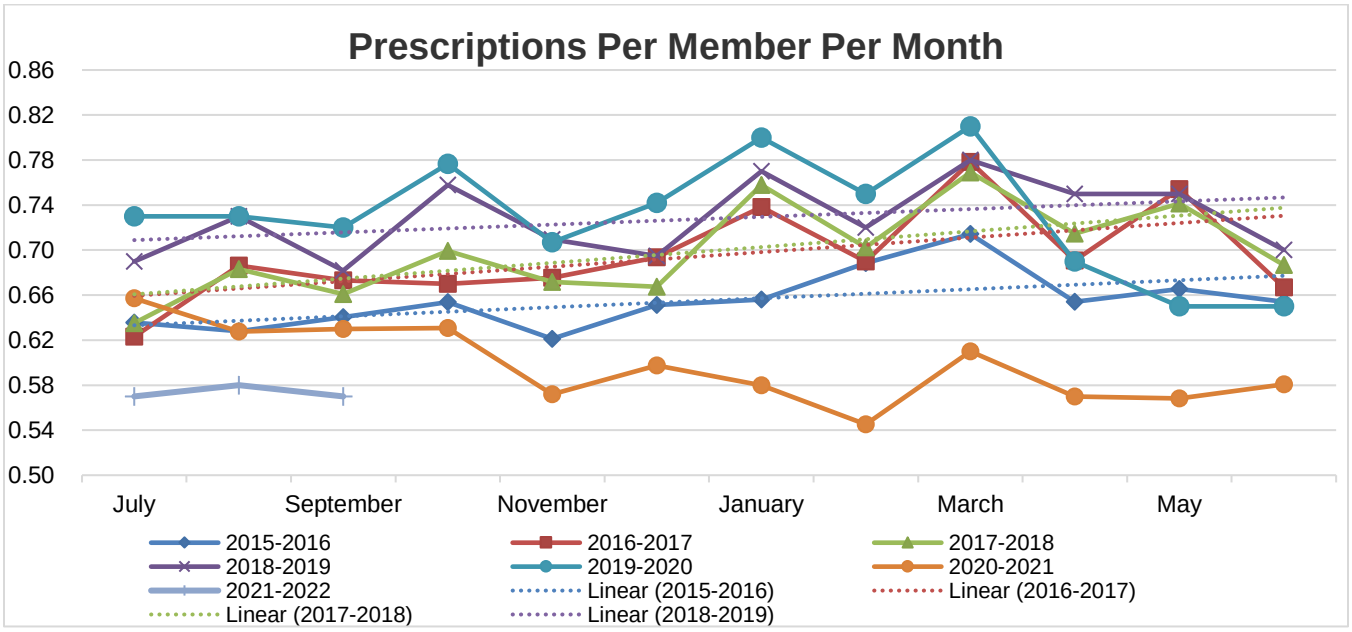
Pharmacy Benefit Cost Trends

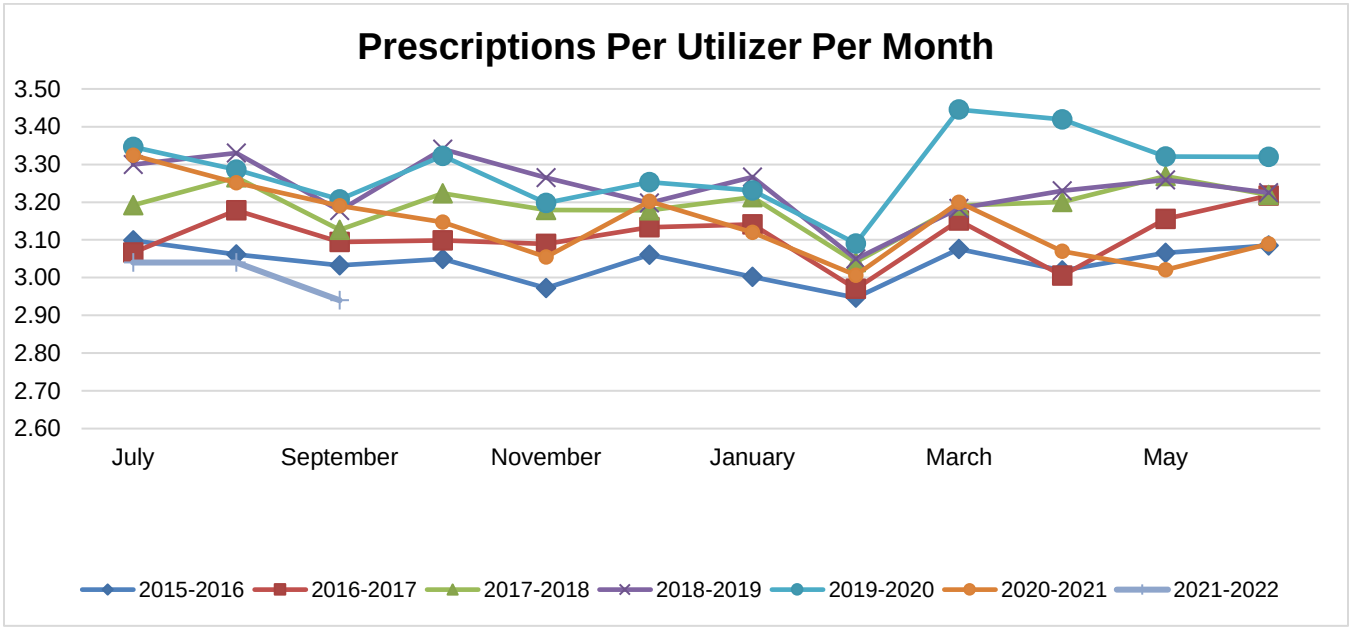
Gold Coast Health Plan's (GCHP) pharmacy trend shows an 3% increase year over year for September 2021. When looking at the per member per month costs ("PMPM"), the PMPM has decreased approximately 13.8% since its peak in March 2020. Pharmacy trend is impacted by unit cost increases, utilization, and the drug mix. Pharmacy costs were predicted to experience double digit increases (>10%) each year from now until 2025. The impact of COVID-19 and the benefit changes to allow up to a 90-day supply of maintenance medications have created a 3 month cyclic trend of higher expenditures in one month and lower in the following two months as noticed from December 2020 through July with peaks in December, March and June. This cyclic trend is expected to continue as long as there are significant fills of 90 day supply medications.

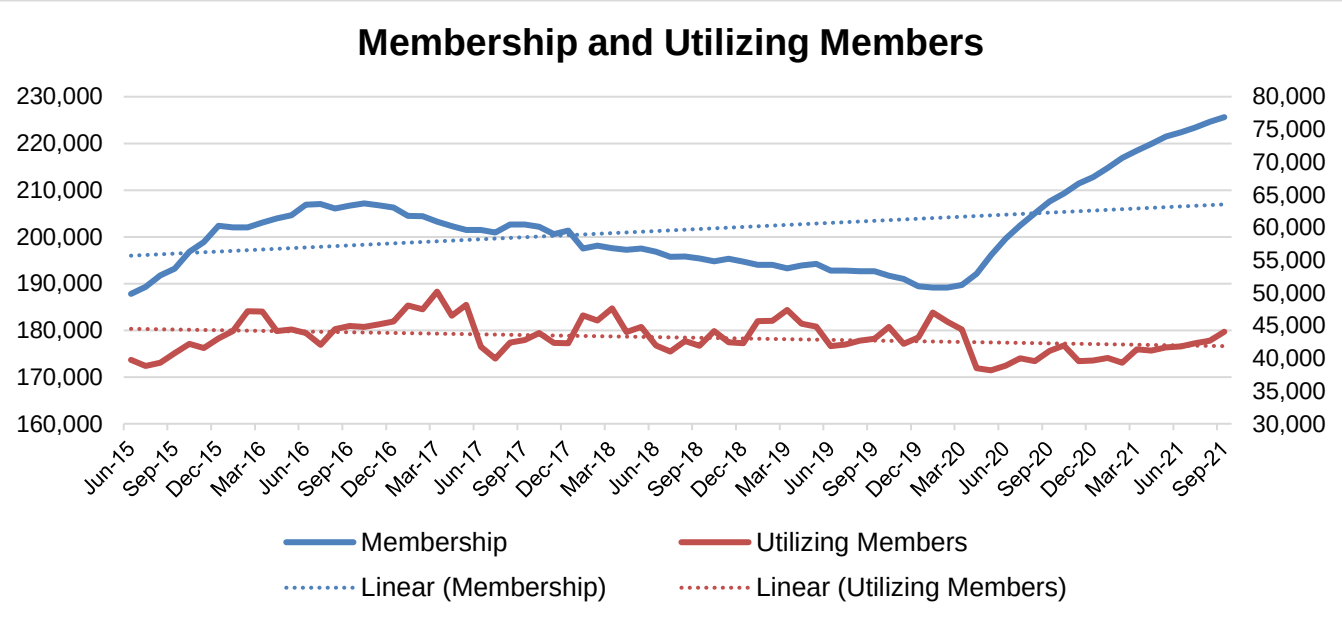
GCHP Annual Trend Data

Utilization Trends:

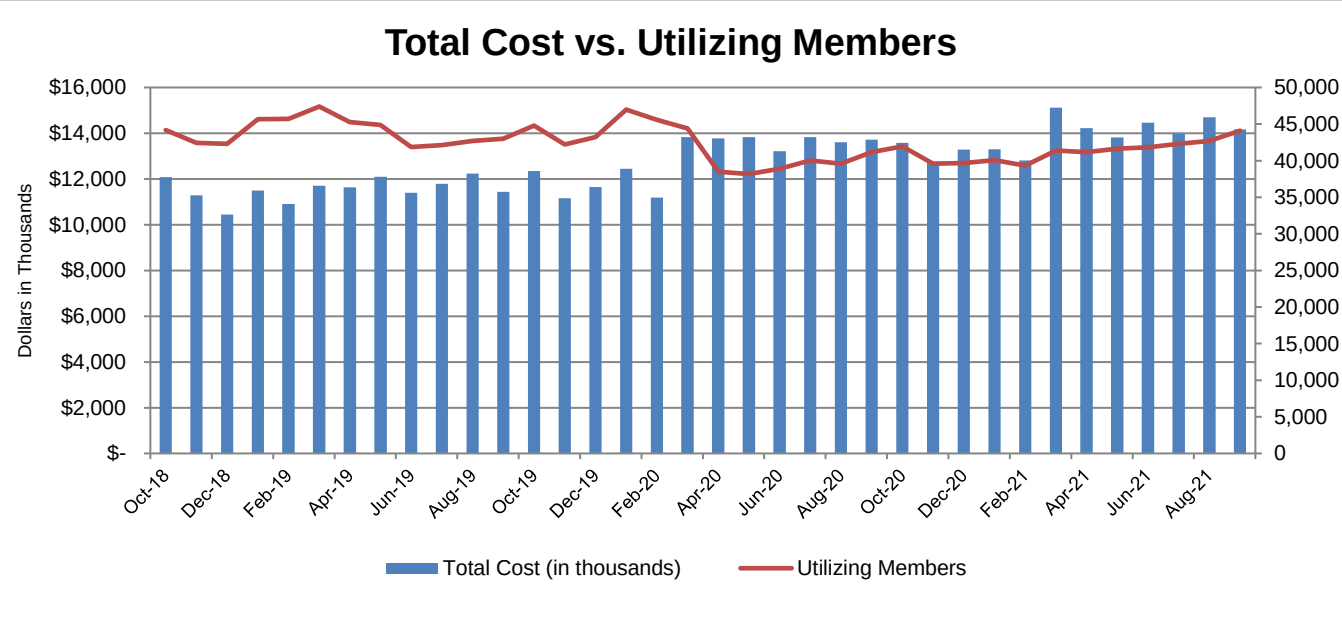
Through March 2020, GCHP's utilization was increasing as demonstrated by the number of members using prescriptions and the number of prescriptions each member is using while GCHP's total membership continued to decline. However, the impact of COVID-19 has caused an increase in membership and the utilization of extended day supplies which suppress the view of increased utilization. The graph showing prescriptions per utilizer gives a new view of the increased utilization. GCHP will be continuously monitoring the impact of COVID-19 and the increased membership.

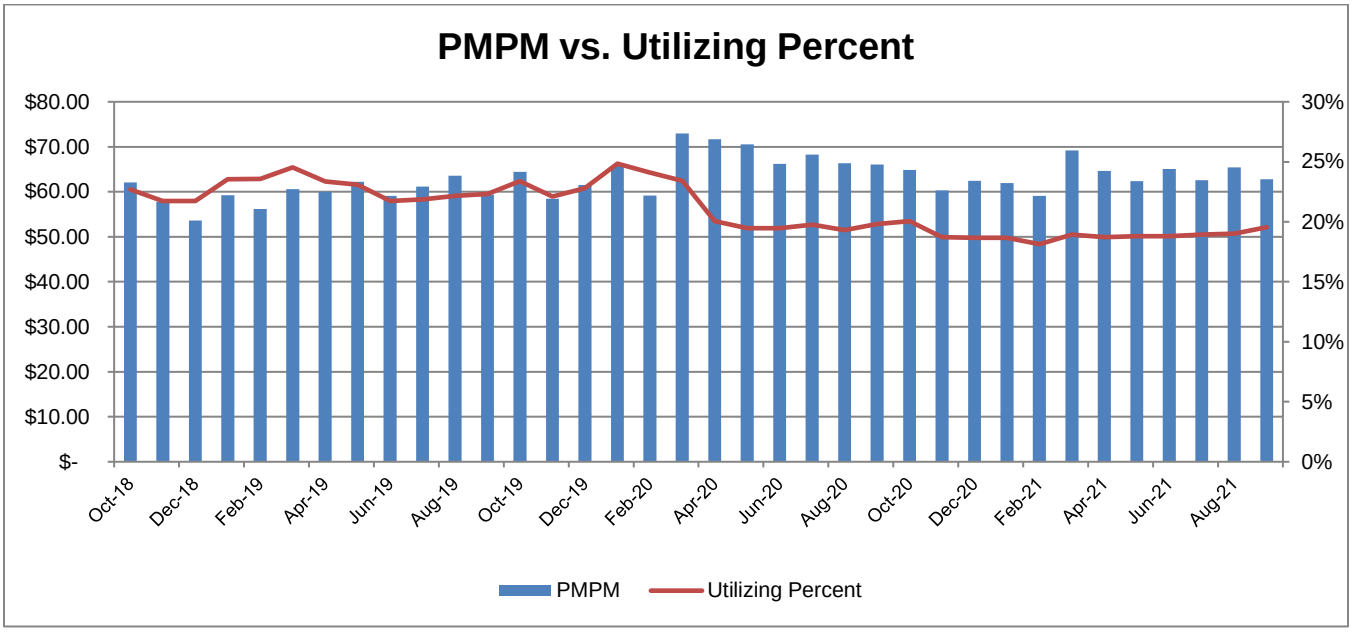

Prescriptions Per Member Per Month
0.86
0.82
0.78
0.74
0.70
0.66
0.62
0.58
0.54
0.50
July
September
November
January
March
May
2015-2016
2016-2017
2017-2018
2018-2019
2019-2020
2020-2021
2021-2022
Linear (2015-2016)
Linear (2016-2017)
Linear (2017-2018)
Linear (2018-2019)

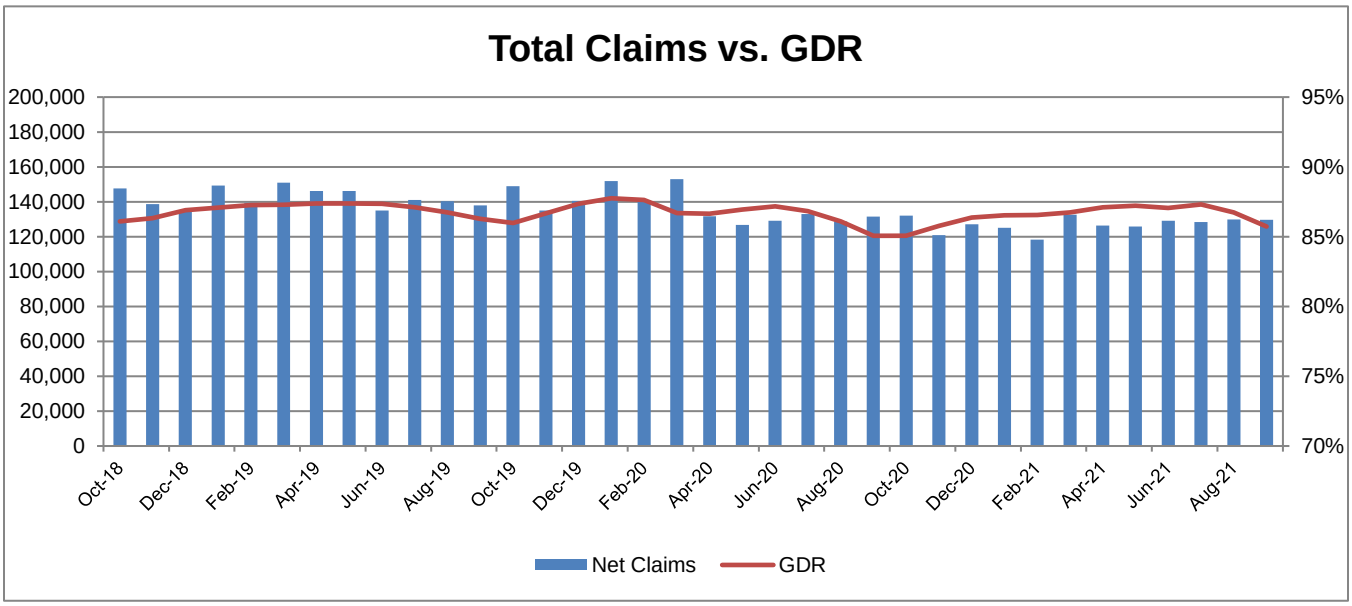

Prescriptions Per Utilizer Per Month
3.50
3.40
3.30
3.20
3.10
3.00
2.90
2.80
2.70
2.60
July
September
November
January
March
May
2015-2016
2016-2017
2017-2018
2018-2019
2019-2020
2020-2021
2021-2022



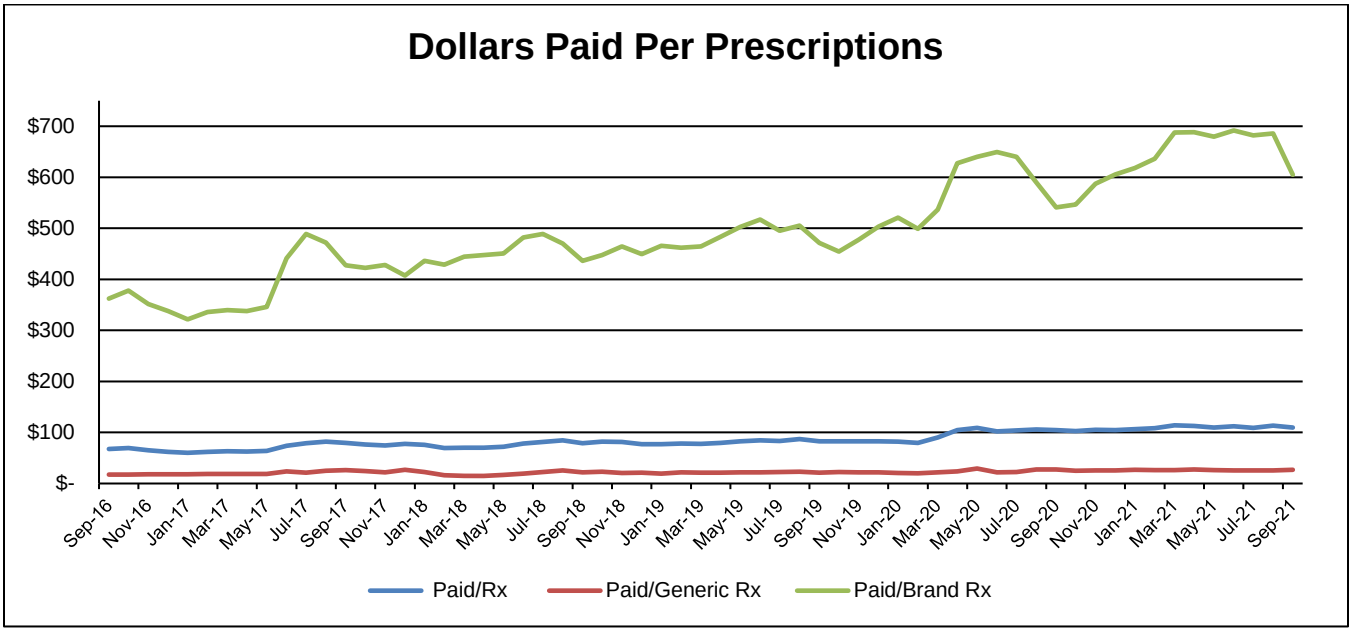
Pharmacy Monthly Cost Trends:







*Claim totals prior to June 2017 are adjusted to reflect net claims.



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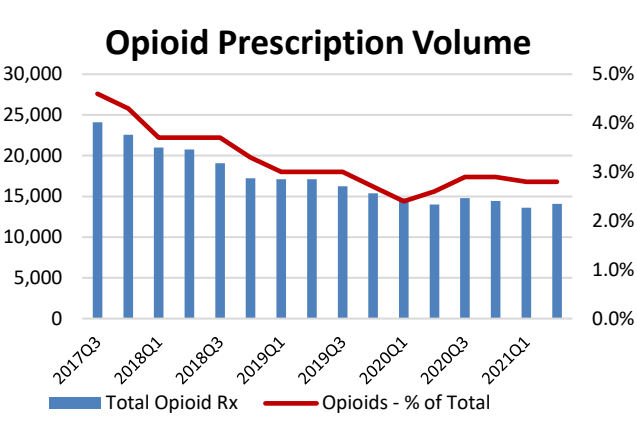
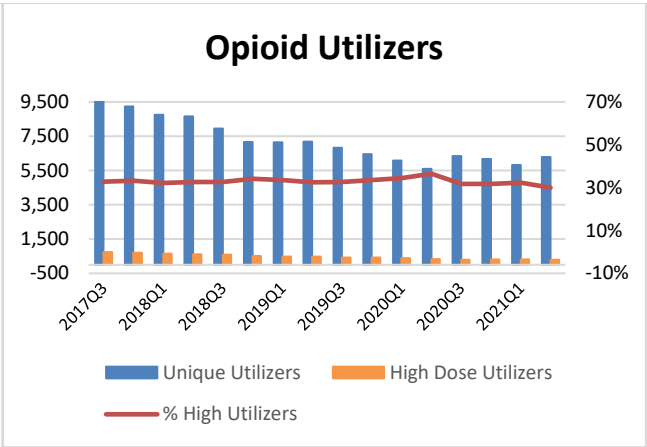
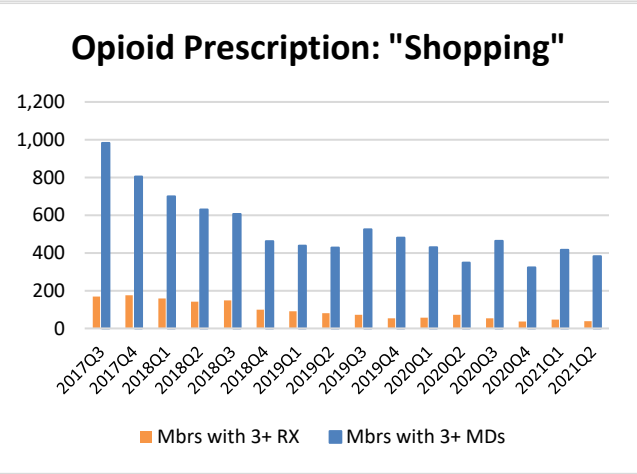
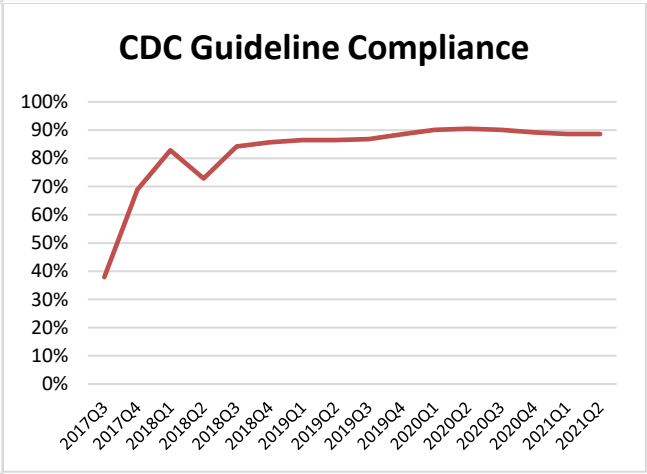
Pharmacy Opioid Utilization

GCHP continues to monitor the opioid utilization of its members and below are graphs showing some general stats that are often used to track and compare utilization. In general, GCHP continues to see a positive trend toward less prescriptions and lower doses of opioids for the membership.









Definitions and Notes:
High Dose Utilizers: utilizers using greater than 90 mg MEDD
High Utilizers: utilizers filling greater than 3 prescriptions in 120 days
Prescribers are identified by unique NPIs and not office locations.

News Regarding Opioid Use in GCHP Members

In late May 2021, twenty-nine pain management clinics throughout California closed abruptly. These included several clinics in Ventura County that were utilized by many GCHP members. In some cases, members received a final 30-day prescription of medication. However, the members were left without referrals to new pain management specialists. GCHP worked quickly to notice all providers regarding the abrupt closure and to direct members to contact

their primary care providers for treatment and referrals to new providers. Below are several additional actions taken by GCHP:

- Provider notice regarding the closure and referral options
- Member outreach for members utilizing buprenorphine to urgently connect members to new providers
- Provider system panel discussion during Quality Improvement Collaboration meeting
- Provision of California Department of Public Health ("CDPH") provider notice with additional resources and support to GCHP provider network (attached)
- Exploration of options for network expansion to address pain management provider shortage

Abbreviation Key:
PMPM: Per member per month
PUPM: Per utilizer per month
GDR: Generic dispensing rate
COHS: County Organized Health System
KPI: Key Performance indicators
RxPMPM: Prescriptions per member per month

Pharmacy utilization data is compiled from multiple sources including the pharmacy benefits manager ("PBM") monthly reports, GCHP's administrative services organization ("ASO") operational membership counts, and invoice data. The data shown is through the end of September 2021. The data has been pulled during the first two weeks of October which increases the likelihood of adjustments. Minor changes, of up to 10% of the script counts, may occur to the data going forward due to the potential of claim reversals, claim adjustments from audits, and/or member reimbursement requests.

September 7, 2021

Dear Provider,

Health care providers continue to be essential partners in addressing the opioid epidemic in California. Working together, we want to ensure that providers have access to resources and support to help improve patient pain management.

Alert: The abrupt closure of 29 California pain management centers in May 2021 resulted in over 20,000 patients without referrals, medical records, or treatment plans, and created potentially dangerous disruptions in care for patients receiving treatment with opioids therapy. This was a striking example of a common problem: many patients with long-term opioid use find themselves suddenly stranded, without a doctor, whether due to clinician retirement, state or federal action, or other cause.

Action: Given the national shortage in pain management providers, we anticipate many patients dependent on opioids may have difficulty finding a new pain management provider. Subsequently, primary care providers may inherit these patients.

On behalf of the Statewide Overdose Safety (SOS) Workgroup and partners, please consider these best practices:

- Continue opioid therapy for patients in transition.
- Develop a patient-centered, individualized care plan.
- Use caution when tapering opioid therapy.
- Document patient care decisions.
- Prescribe buprenorphine when appropriate.

Continue Opioid Therapy for Patients in Transition: Following clinical guidelines for safe opioid prescribing, providers are encouraged to consider providing opioids to patients during transitions to avoid dangerous disruptions in care. While many providers may not have chosen to start opioids for a given chronic pain condition, stopping opioid therapy is different due to the physiological changes brought on by long-term opioid therapy. Stopping opioid therapy has been

shown to increase illicit opioid use, emergency medical care utilization, mental health crises, medically-attended overdose events, and death from overdose and suicide. It may be necessary and medically appropriate to continue opioid therapy, particularly if a patient will have a prolonged wait to see a pain management specialist. Whenever possible, discuss the patient's history with their former provider, complete baseline assessments of pain, review expectations for opioid prescribing, and start discussing treatment for opioid use disorder (OUD) if appropriate. If you are unable to treat the patient, provide a warm hand-off to another provider to avoid the experience or perception of abandonment.

Develop a Patient-Centered, Individualized Care Plan: Develop an individualized plan in collaboration with the patient for continuing opioid therapy, tapering down or off of opioid therapy, or transitioning to buprenorphine. Engage the patient and include discussions around social issues and support, mental health services, alternative pain management strategies, and overdose risk. Consider the patient's perceived risks and benefits of opioid therapy.

Use Caution when Tapering Opioid Therapy: Providers should not abruptly discontinue or rapidly taper opioids in a patient who is physically dependent on opioid therapies. Safe tapers may take months to years to accomplish. Ensure patients understand the risks and benefits of dose maintenance versus dose tapering. Work with the patient to identify which medications to taper and how fast.

Document Patient Care Decisions: The majority of investigations of providers around opioid prescribing that have resulted in a complaint or disciplinary action against a license contained violations of insufficient documentation. Document the rationale for continuing or modifying a patient's opioid therapy. Include descriptions of pain conditions, previous and current therapy, assessment of risk and evidence of OUD, and opioid stewardship measures. Comprehensive documentation benefits both the patient and the provider.

Prescribe Buprenorphine when Appropriate: Buprenorphine has been shown to be a highly safe and effective treatment for pain management and OUD, and is FDA-approved for both conditions. Buprenorphine reduces craving, withdrawal, and overdose risk, has low potential for misuse and diversion, and increases

retention in care. Buprenorphine for pain has proven to be an effective and safe alternative for patients dependent on long-term opioid agonists. Buprenorphine for OUD can be prescribed by any provider with an X number (X-waiver), in-person or via telehealth, to new and existing patients with OUD. As of April 28, 2021, providers may now request an X-waiver to treat up to 30 patients with buprenorphine without having to complete training or to certify that they can provide counseling or other ancillary services. To prescribe buprenorphine to more than 30 patients, however, training and meeting certain conditions are required. Sign-up for an X-waiver. Note: Prescribing buprenorphine for pain does not require an X-waiver.

Support and Resources: The Center for Innovation in Academic Detailing on Opioids (CIAO) of the San Francisco Department of Public Health, in collaboration with the California Department of Public Health recorded a webinar in June 2021 to support providers inheriting patients on opioids. The presentation focuses on sharing information and clinical tools about inheriting patients on opioid therapy, ensuring continuity of care, and utilizing buprenorphine: A Webinar for Providers: What Do I Do With Inherited Patients on Opioids?

The National Clinician Consultation Center offers free guidance and support to providers treating patients with OUD through these telephone services:

1. California Substance Use Line: **(844) 326-2626**. Clinically-supported advice on substance use management for health care providers, staffed 24/7 in collaboration with addiction experts at the University of California, San Francisco Clinicians Consultation Center and California Poison Control.
2. Substance Use Warmline: **(855) 300-3595**. Confidential clinician-to-clinician telephone consultation from addiction medicine-certified physicians, clinical pharmacists, and nurses with special expertise in pharmacotherapy options for opioid use, available Monday through Friday, between 6 a.m. and 5 p.m. PST. Voicemail is available 24/7.

Thank you for continuing to provide quality medical care to your patients.

Sincerely,

Tomás J. Aragón, MD, DrPH
Director and State Public Health Officer
California Department of Public Health

Kimberly Kirchmeyer
Director
Department of Consumer Affairs

William Prasifka,
Executive Director
Medical Board of California

Michelle Baass
Director
California Department of Health Care Services

Return to Agenda

AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Chief Diversity Officer

DATE: October 25, 2021

SUBJECT: Chief Diversity Officer (CDO) Report

Actions:

1. **Community Relations**

- Attended the County Health Equity Advisory Committee meeting. Completed group charter. Working on position descriptions within the group.

- Met with a diverse group of citizens in Simi Valley to address pending issues within the county such as Police Reform, Anti-Racism training and selection process.

- Visited the Free Clinic in Simi Valley where they provide free Medical/Counselling, legal and dental care to those not having insurance or medical resources. Housed in the same facility are two organizations, Big Brother Big sister, and Soaring Spirits. Though most are familiar with Big Brothers Big Sisters, Soaring Spirits International provides resources and tools for the widowed community. It offers both virtual and in person programs aimed to help those coping with the loss of a spouse or partner rebuilding their lives. They have served 4,000,000 widowed individuals in the U.S. and globally.

2. **Case Investigations**

No new cases submitted during the month of September/October.

3. **Diversity Activities**

- The Diversity, Equity and Inclusion team has been challenged to look at our plan's values. It was determined by the group that because of the changing landscape, the pandemic and new cultural norms - change may be needed.

- We have some difficulty in identifying players who will be significant contributors to a proposed summit which, because of the pandemic, will be pushed to the first quarter 2022. The delay in identifying participants and the approaching holidays make the change in date necessary.

- Received five calls from employees with the following subject matter:

    1. Lunch -N- Learn feedback (2)
    2. Health Equity (1)
    3. Career counselling (2)

- Continue to work with HR in structuring a strategy on return-to-work process.

- Wrote article for our newsletter in support of Hispanic Heritage Month. The subject of the article was Henry L. Hank Lacayo, a pioneer in Hispanic emergence in Ventura County.

- Invited Commissioners Laura Espinosa and Board of Supervisor and Commissioner Carmen Ramirez to be speakers at our Lunch-n-Learn celebrating Hispanic Heritage Month scheduled for October 15, 2021.

AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Michael Murguia, Executive Director of Human Resources

DATE: October 25, 2021

SUBJECT: Executive Director of Human Resources (H.R.) Report

Human Resources Activities

Recruited our Chief Information Officer Alan Torres with a start date of October 18, 2021. Working very closely with Alan on his onboarding process with an organizational overview, assigned Executive Assistant and other activities. On his first day our COO and myself hosted a lunch after his orientation meeting. We also organized an all-IT meeting on his first day where Alan introduced himself to his organization. His direct reports joined the meeting in person to meet Alan and discuss high priorities in IT. Alan was able to tour building 770 and see his new office location. We continue to plan our virtual Benefits Fair scheduled for November 3 and 4, 2021. We did this event very successfully last year and we hope to replicate that success this year. Lastly, we are also working on a Holiday Drive thru event much like our 10-year anniversary drive thru event earlier this year. This event will be hosted by our Employee Activities Committee and Executive Staff in early December.

Attrition and Case Update

We have had one voluntary resignation over the last 30 days and no new cases.

Facilities / Office Updates

GCHP Facilities' team is dedicated to planning a return to the office when conditions allow. The team continues to meet and evaluate:

- Protocols for the flow of employees who visit the office for supplies, printing, and other business-related activities
- Protocols for our new entrance and exit process requiring temperature checks and registration in our Proxy click system is working very well
- Protocols for a return to the office, including taking temperatures
- Making any necessary modifications to improve air quality inside the buildings