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

Executive Finance Committee
AMENDED AGENDA

Regular Meeting
Thursday, June 20, 2024 – 3:00 p.m.
711 E. Daily Drive Suite 110 Community Room

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

Conference Call Number: 805-324-7279
Conference ID Number: 408 865 718#

Clinicas del Camino Real Inc.
1040 Flynn Rd.
Camarillo, CA 93012

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 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 attend the meeting in person, 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 Executive Finance Committee regular meeting minutes of May 16, 2024

Staff: Maddie Gutierrez, MMC, Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

FORMAL ACTION

2. Budget for Fiscal Year 2024/2025 and 3-Year Planning

A. CEO Report on Budget Objectives and Strategic Vision

Staff: Nick Liguori, Chief Executive Officer

B. Development of a Quality Investment Focused Budget: MCAS Return on Investment

Staff: Eve Gelb, Chief Innovation Officer
Felix Nunez, M.D., Chief Medical Officer
Kim Timmerman, Sr. Director of Quality Improvement

C. Development of a Quality Investment Focused Budget: Health Engagement Program Return on Investment (GCHP – Wellth Partnership)

Staff: Eve Gelb, Chief Innovation Officer
Erik Cho, Chief Policy & Program Officer
Erin Slack, Sr. Manager, Population Health

D. Development of a Quality Investment Focused Budget: Review of April 2023/2024 Year-to-Date as Solid Financial Foundation

Staff: Sara Dersch, Chief Financial Officer

E. Proposed Budget Fiscal Year 2024/2025 and 3-Year Quality Investment Program

Staff: Sara Dersch, Chief Financial Officer
Executive Team

RECOMMENDATION: Staff requests that the Executive Finance Committee recommend that the Commission approve the 2024/2025 Budget.

CLOSED SESSION

4. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

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

ADJOURNMENT

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

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 Tuesday prior to the meeting by 3 p.m. will enable the Clerk of the Board to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO. 1

TO: Executive Finance Committee

FROM: Maddie Gutierrez, MMC - Clerk of the Board

DATE: June 20, 2024

SUBJECT: Meeting Minutes for special Exec. Finance meeting of May 16, 2024

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copies of the Executive Finance Committee special meeting minutes of May 16, 2024.

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
Executive/Finance Committee
Regular Meeting via Teleconference

May 16, 2024

CALL TO ORDER

Committee Chair Laura Espinosa called the meeting to order at 3:02 p.m. The meeting was held virtually. The Clerk was in the Community Room, 711 E. Daily Drive, Suite 110 Camarillo, California.

ROLL CALL

Present: Commissioners Laura Espinosa, Anna Monroy, and Dee Pupa

Absent: Commissioners Anwar Abbas, and James Corwin

GCHP Executive Team in attendance: CEO Nick Liguori, CHR Paul Aguilar, CPPO Erik Cho, CIO Eve Gelb, CCO Robert Franco, CFO Sara Dersch, CMO Felix Nunez, M.D., CDO Ted Bagley, Exec. Director of Strategy & External Affairs, Marlen Torres, and General Counsel, Scott Campbell.

GCHP Staff In attendance: Susana Enriquez-Euyoque, Kim Timmerman, Vicki Wrighster, Michelle Espinosa, Mayra Hernandez, Stacy Luney, Victoria Warner, Pauline Preciado, Rachel Lambert, Bob Bushey, Chris Dulan, Kimberly Marquez-Johnson, David Kirkpatrick, Josephine Gallella, Lupe Gonzalez, Lupe Harrion, and Consultant Amit Jain.

Guest: Kyle Edrington

PUBLIC COMMENT

None.

CONSENT

1. Approval of Executive Finance Committee special meeting minutes of April 18, 2024.

Staff: Maddie Gutierrez, MMC, Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

Commissioner Pupa motioned to approve the minutes as presented. Commissioner Monroy seconded the motion.

AYES: Commissioners Laura Espinosa, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: Commissioners Anwar Abbas, and James Corwin.

The clerk declared the motion carried.

Commissioner Corwin joined the meeting at 3:09 p.m.

FORMAL ACTION

2. March Year to Date Financial Results

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests the Executive Finance Committee approval of the March year-to-date financial results.

Chief Financial Officer, Sara Dersch, reviewed how the organization has done over the past nine months of the year. She stated that our underlying financial performance is strong. It reflects a Medi-Cal managed care plan under effective management control and operating in accordance with parameters of our medical premiums. We continue to have favorability in our net income, and we continue to add to our reserves. We continue to effectively manage items that are within our control, and we continue to be judicious about the remainder of the year. We are careful on administrative cost spending. We mitigate action items where possible. She noted there have been cost adjustments resulting in a $33.4 million impact to our operating gain. There was a 2023 acuity adjustment that the state invoked in January without a pre-warning. The stated noted that in 2023 the population was healthier than the rates they had provided, and they overpaid us. They took back some of the monies we had received. Another was a $17.3million acceleration in our quality incentive pool and program – payment to our providers. This program has done well, and the success is better than we anticipated. The spend is now $17.3million greater than forecast year to date. The third items that influences our financial results is our member mix.

CFO Dersch reviewed our profit and loss statement. She stated that from a member month perspective we are favorable on a year-to-date perspective. We are 36,435 member months favorable, and our total revenue is favorable. We came in at $791.8

million versus a forecast of $782.7 million but when looking at PMPM we are unfavorable by $1.58. She noted that the rates are set on a calendar year basis.
CFO Dersch stated there are retroactive revenue adjustments year to date. We had a $16.1 million take back. There have been a few items that mitigated the impact. There will always be some retroactivity. Enrollment is always being reinstated retroactively. In our month to date results we had $100,000, which is reasonable and expected. The $16.1 million that was offset, is now $13.5 million unfavorable – that was not expected, but that is what is driving those retro revenue adjustments. This is not combined with our current operating premiums.

Our medical benefit ratio of 88.2% approximates where we need to be. It was noted that it is greater than our forecasted rate of 85.4%. This reflects the acceleration of the QIPP program and also reflects some rate increases. We have paid $29.4 million in the QIPP program. This is money that we are getting out to the healthcare delivery system. If we exclude the $29.4 million from our current spend on medical benefits, our medical benefits rate would be 86%, and exactly where we should be. We are effectively managing the results of this organization. From a fee for service perspective, we are experiencing some increases in almost every category. The increases are due to unit cost increases, not utilization. We have some minor favorability in claims recoveries, and we have some capitations offset.

CFO Dersch reviewed the total spend by category of service. She noted the highest two categories of spend are in-patient and long-term-care/skilled nursing. Both of these combined are 50% of our total medical spend. Long-term-care/skilled nursing is favorable in our forecast. The other items are unfavorable, which is driven by the increase in membership. Although unfavorable these items are very close to forecast. The spend approximates where the membership is.

CFO Dersch stated that controlling administrative costs continues to be a management focus. There is a monthly meeting to review line by line on the spend. She noted that our admin expense is $1,000,000 greater that the forecast – this is driven by our membership We had 17,000 additional members in January. Each member gets a Welcome kit, those kits drive the majority of the administrative cost. She also noted that the OOTF project had some accelerated spends to ensure we are ready for the July 1 live date. This acceleration put some pressure on earlier months in the year. As we prepare to go live it is noted that the project portfolio line item is actually $1.5 million favorable, which is what was expected, and we expect to see favorability for the remainder of the year in this category.

We did end the month at a $9.1 million decrease in our unrestricted net assets versus a forecast of $2.3 million unfavorable from a year-to-date perspective, we are adding $8.4 million back into reserves. The $8.4 million is the result of accelerating the QIPP combined with the impact of the unknown rate take back at the time of the forecast.

She noted that we were able to improve the provider experience without impacting our members.
CFO Dersch stated that we have a potential for reduction in our incurred but not paid expenses in the last quarter of the year. The incurred but not paid reflects expected reimbursements for those services which have been provided but we have not been billed for yet.

We are continuing to monitor benefit utilization of the newly eligible adult population. She noted this is a new population for us and Medi-Cal. CFO Dersch stated there could be additional state actions which will influence results over the next few months. She noted that members got adequate and appropriate Covid testing, and we were advanced dollars, the state and federal government are now looking at all the Covid testing that we did with that money and now want dollars back for unused testing. This should not be a large impact, but we know that it is coming. The state is struggling to balance their fiscal budget and there could be additional take backs. Governor Newsom has stated there will be future cuts in healthcare spending. CFO Dersch stated that if there are additional take back from the state, we have the fund to cover that without impact to our member or impacting our providers.

CFO Dersch reviewed the balance sheet. She stated we have $871 million in assets. She also noted that the balance sheet changes on a daily basis as we pay claims and receive money. She reviewed liabilities. CFO Dersch stated our accounts payable is down because we are able to pay our invoices faster. She stated that we have $667 million in cash on hand or in investment. She also stated that we are where we thought we would be on a PMPM basis and continue to approximate what we had reforecast. Our TNE is currently at 1029%, we had reforecast at 971%. As our assets and liabilities go up and down, so will our TNE.

CFO Dersch noted that everything is in alignment with where we thought it would be.

Commissioner Monroy motioned to approve the March Year-to-Date financials as presented. Commissioner Corwin seconded the motion.

AYES: Commissioners James Corwin, Laura Espinosa, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: Commissioner James Corwin.

The clerk declared the motion carried.

3. FY 2024/25 Budget and Three-Year Planning

Staff: Nick Liguori, Chief Executive Officer
Sara Dersch, Chief Financial Officer
Eve Gelb, Chief Innovation Officer
Paul Aguilar, Chief Human Resources & Organizational Performance Officer
Felix Nunez, Chief Medical Officer
Erik Cho, Chief Policy & Program Officer
Marlen Torres, Executive Director of Strategy & External Affairs

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

Chief Executive Officer, Nick Liguori thanks the management team for the work on the development of our plans and our proposed budget for the next fiscal year and our budgetary thinking for the next three fiscal years. CEO Liguori noted that the entire leadership team is very engaged and dedicated to GCHP, our commission, our members, and our providers. In this current fiscal year and years to come we are proposing in partnership with the Committee to budget for a spend down of our reserves where our bottom line will show a reduction in assets. A $22.5 million planned spend down, a $16 million revenue take back, and the accumulation of other slight adverse adjustments by DHCS. The plans and budgets being reviewed have been developed based on an understanding of our members and their healthcare needs.

CFO Dersch stated she will review the budget design, what is going on in the industry, and what is going on in the provider environment and in the quality environment. She noted that we are still a maturing organization building capacities and capabilities to ensure long term success. She reviewed budget objectives. She noted that we have looked at our current trends, evaluated improvements that are being implemented and continue to develop innovative programming. This budget will have spend downs in our reserves to help achieve our mission of high quality, accessible care for our members and for the communities we serve. She noted that we request committee feedback.

At the end of June, we will present our final proposed budget which will include our personnel/staffing budget, which will include consultants and vendor projected spend. The first requirement is strong financial management over this year. The second requirement for good budget design is guiding principles which align to support our mission. We have added a third guiding principle, which is to maximize the level of quality investment. Investment in our community-based services, investment in our providers, investment in grants through rate increases which are tied to quality improvements.

Marlen Torres, Executive Director of Strategy & External Affairs noted that in the May Revise Governor Newsom shows his commitment to the CalAIM program. Over the last two years CalAIM initiatives have asked health plans to step outside of a traditional environment and address social drivers of health. As an example, we are a part of the student behavioral incentive program – and we are working more closely with schools. We recognize the importance of being able to reach across various sectors of support for our members. We are providing/coordinating care for children and families while our fellow peers provide educational services.

Commission Chair Espinosa noted that schools in the County now have Wellness Centers, however there are no standards. She asked how we would work with the County Superintendent of Schools so that standards will be implemented. She noted there is a major problem getting healthcare to students. She asked if there was something GCHP can help facilitate with the Superintendent of Schools. Ms. Torres stated that Lucy Marrero, Director of Behavioral Health has been working closely with leadership and VCOE. She will get more information and will present the information gathered.

Ms. Torres stated that we have been working together as a community, and efforts can be seen through the work done with redetermination and maintaining membership enrollment. We have maintained a higher percentage of retention and enrollment higher than state average and much higher than nationwide averages. We are also addressing social drivers of health through Community Supports and Enhanced Care Management. We are making sure that we service our members and working with nontraditional providers.

We have new populations of focus: we have our 26- to 49-year-old expansion population, the justice involved system transition, and benefits through Street Medicine, community health workers and doulas. As we develop our upcoming budget there are Health Equity requirements through DHCS. We are being asked to do more, think differently, and be prudent financially. We are advancing our quality scores and working together as a community, not just with our providers, but through community care, and health fairs that we have held. We also have NCQA health plan and Health Equity accreditation, which is due to CalAIM.

Ms. Torres noted that the state is experiencing a budget deficit, and due to the deficit, there has been some stepping back of the commitments mad in the MCO Tax from a provider rate or reimbursement. We will continue to monitor now that the governor has included Medicare to be added into the MCO tax proposal.

CFO Dersch introduced Kyle Edrington from Edrington Healthcare Consulting. Mr. Edrington is our Chief Actuary. He is an expert on California Medi-Cal and participates closely with Sacramento in developing programs and being a sounding board. He is also an expert in our data. CFO Dersch stated there will be a Q&A forum with Mr. Edrington.

CFO Dersch asked Mr. Edrington what are driving some of the changes that Ms. Torres spoke about. Mr. Edrington stated there are two main themes. The first is that DHCS has continued to focus on ensuring that payments to Medi-Cal health plans are appropriate and reinforce the goals of the program. There is additional oversight to the context of care delivered to Medi-Cal beneficiaries, as well as financial performance of the health plan and its providers. The other key point is that profitability is cyclical. Generally, health plan financials have been healthy in recent years. The experience you are profitable today drives your future rates. CFO Dersch asked how the premium environment is changing now and over the next few years. She also asked about regional rate setting. She asked what it is, why is it coming and when it does what will it mean for us. Mr. Edrington stated the main concept is that regional rates is a shift from the status quo. Rates have been developed off of a single plan experience with adjustment and oversight. It is a shift to utilizing a broader multi-county aggregation. Instead of having a single plan experience drive, single plan rates you are broadening the pool so that enables benchmarking. It is the ability for DHC and consultant, Mercer, to understand the tone and reasonableness of any plan's experience, and a way to mitigate outliers. There are multiple plans in the aggregation and one is an outlier on the higher end that then has the potential for financial pressure at the same time, if you are an outlier on the lower end while promoting the goals of Medi-Cal and meeting all requirements, there is an opportunity for efficiency and positive financial results. CFO Dersh asked if we are on the higher end for some services, we will experience unfavourability as we move into the regional rate setting. Mr. Edrington responded yes. He noted that every member has their own unique needs. Every county and Medi-Cal plan has its own demographics and mix. Although you appear to be an outlier, you have a higher needs population that one of your peers. There is a risk score and acuity factor much like in Medicare. As we make this shirt is it important to ensure that we are capturing data accurately. CFO Dersch asked about premium development. When our rates are determined by the state, the state is not looking at last Fall's rates, they are looking at our costs from a couple of years ago. She asked how this will be impacted by the regional rate setting. Mr. Edrington replied that the concept of a lag between experience and revenue will persist. Last year there were significant efforts among most Medi-Cal plans, public hospitals and DHCS to work toward incorporating hospital rate increases earlier that the norma two-year data process. CFO Dersch stated health plans capitate cost of care to

some providers, and they get upfront PMPM. She asked how the state is looking at margin in those sub-capitation arrangements differently and what might that mean for us. Mr. Edrington stated there are two things to focus on; the first is the MLR reporting that will be reinforced within the states. The state receiving kind of provider level or capitation level transparency and understanding margin levels, understanding if there is any remittance. The process of awareness around the general tone and performance of those rate increases through the MLR. Now the conversation about physician services needs to include the targeted rate increase as well, which are the MCO tax-based state efforts to increase reimbursement closer to Medicare for certain services. CFO Dersch asked about cost management capabilities and Model of Care pertaining to those high-cost members. Mr. Edrington stated infrastructure for this scenario improves the live of individuals, which is the goal. Second to that we have oversight from DHCS. They drive a large percentage of spend. If a plan cannot manage that group as well as their peers, then there is significant financial potential, financial strain. In order to manage that population, there are appropriate care management protocols that have the data to demonstrate that the needs impact the revenue. You must ensure that your data is your greatest asset for informing appropriate engagement and clinical decisions for members and also enabling DHCS and Mercer. If the data is not there, the system does not work.

Commissioner Monroy asked about the criteria for the regional rate setting; besides geographic, she asked if it is performance based. Mr. Edrington stated the concept of regional rates has been in development for some time, but the state has never done a public release. The presumption is that regional rates will be geographically focused. Commissioner Corwin asked about the acuity scores – he asked if they are going to use the standard HTC models or are new models being built. He also asked if there is an opportunity for partnering on additional data submissions. Mr. Edrington stated the acuity model used in Medi-Cal is called CDPS Plus Rx. It is developed by UC San Diego and utilized in Medicare /Medicaid programs nationally for the last 15 years. GCHP was not risk adjusted because it is a coast. There is no competitor, but in other counties there are competitors, and this risk adjustment model has been used. It was recently expanded to include diagnosis codes in addition to just pharmacy claims, it is a robust, well-known model. The state is calibrating it already. There are also opportunities to refine that process, especially for populations of high need. Commissioner Espinosa asked how Covid fits into the industry trends. She asked if there is any influence that two years ago those levels would influence our rates for today. Mr. Edrington stated the 2024 rates that Gold Coast is being paid today are loosely based on experience from July 2021 through June 2022 with appropriate prospective adjustments. For the years leading into 2024, DHCS and its actuaries had to make significant adjustment,

and in 2024 they decided that that experience we got to use might have smaller modifications to it.

Chief of Policy & Programs, Erik Cho, stated that we sought feedback from some of our core providers to get qualitative insight. Providers are a key to the advancement of strategic imperatives that we have and want for the system across the county. We seek high levels of coordination, collaboration, and transparency.

Chief Medical Officer, Felix Nunez, M.D. stated that providers face significant barriers in expanding delivery and addressing care gaps. The pandemic caused limitations and shortcomings in the workforce, along with financial and technical pressures. In the workforce it was noted that the aftereffects of the pandemic presented great challenges in recruitment and retention of staff. The increasing cost of living and provider dissatisfaction with administrative burden within a clinical setting. Operational expenses continue to grow year after year. We have to find a way to ensure that our providers have the resources needed to sustain their operations and meet the challenges ahead.

CMO Nunez noted that data sharing elements remain a key barrier to true integration of our systems. We need to continue investments in our provider network and within Gold Coast. It is critical and vital to meet those challenges. We have implemented quality incentives and grants. Our providers have told us that they struggle to address common chronic conditions. Our quality incentive programs support innovation and the organizational operational development that is needed to close the care gaps. We have designed recruitment and retention grants to attract, recruit, and retain primary and specialty care providers as well as other licensed healthcare professionals that are needed.

CPPO Cho stated that our core vision is to lift the health of the community by connecting members with care.

Chief Innovation Officer, Eve Gelb, stated that members who have access to high quality care and who have a positive experience with care have improved health outcomes – this is the focus of Medi-Cal and the focus of Gold Coast Health Plan. It is also the focus of the Centers for Medicare and Medicaid Services. Federal and state agencies are holding plans accountable through payment. There are three main payment mechanisms. The first is quality. There was a withhold of approximately half of a percent, and we have an opportunity to earn that revenue back based on our performance on a subset of the MCAS scores and our performance on two specific caps; access to needed care and timeliness of care for both adult and children. There is also an opportunity to

achieve an improvement factor, which is a new way that the state is holding us accountable for this year. It is half of a percent of our margin in the upcoming year, it approximates our entire margin and going forward could be more if the state follows suit with other states that have done this. It could be up to 5 – 7% of our margin that would be withheld for quality outcomes. This brand new to us, but not to the state. The state did this through the financial alignment demonstration known as Cal Medi-Connect, where there was the quality withhold, they have a process and methodology for doing this. We are doing well on our MCAS scores. Our CAP scores could use work and we are focusing on that through the provider environment.

The second action is quality sanctions. These sanctions have been increasing. They are primarily driven by MCAS scores and by the scale the impact of the failure to meet minimum performance level. The third is risk adjustment rates. The rate adjustment is intended to pay plans for population acuity. Acuity can only be accurately assessed if members are connected with care. If the only engagement a member with multiple complex chronic conditions has with our system is a hospitalization, then the payment will not reflect the acuity of that member who does not get regular primary care.

There is an opportunity to invest in the accuracy and the completeness of this data and how that data is transmitted to the health plan and the state. We might have expert care delivered, but if the data is not captured, then the acuity is not reflected in the payment.

CMO Nunez stated we are in an environment of transformation of Medi-Cal or mandates to expand the scope of services beyond the established models of healthcare delivery. There are demands for a demonstration of greater transparency, accountability, and value to the stated and other stakeholders. We must have a deliberate and strategic process of strategic thinking, and planning or it will not add up.

CFO Dersch stated we need to understand the challenges and opportunities in order to manage the business. One year ago, we started at 255,000 members. In January we had a jump in our enrollment driven by the new population now eligible for Medi-Cal. However, we lost 7,000 members to Kaiser. Over the last few months, we have seen a return to a steady state. We can identify our current members and analyze the utilization. We can develop appropriate programs and develop appropriate partnerships with providers.

CIO Gelb stated we have focused on understanding the needs of our members. The Model of Care begins with understanding our members, with a focus on the needs of our newest members. We have launched our first health risk

assessment with over 1,300 members. (1,300 out of 1,700 new members) The first foundational step in our Model of care is health risk assessments – they are a vital part of our strategy to implement a Model of Care informed by specific insights that will impact the design of programs and services to meet the needs. We must develop an informed budget strategy that reflects the needs of our members. We need to budget as accurately as possible for additional expenditures such as behavioral health and mental health care services. We are looking at the needs of our members in a very direct and specific way.

Commissioner Espinosa asked about the percentage of the number of members assessed, and how many were there out of the 255,000 members in total. CMO Nunez stated the survey reflects 1,300 members. CIO Gelb stated the data is used in the aggregate, but also used at the individual member level. We want to make sure we could stage/ support each member for follow-up. These numbers represent 20% of the 1,300 members who have completed the assessment. Out of the 1,300 members assess, 36% of those have resulted in a referral to our care management department. CMO Nunez stated that staging was the right approach.

Commissioner Pupa stated it would be interesting to see how these numbers adjust as we fold in more surveys. Our members are taking the time to answer questions. We hear about access, but to have it quantified in categories is appreciated.

CIO Gelb stated that because they are new to our health system, we wanted to make sure that their onboarding process was good, and that we understood their needs.

Commissioner Pupa stated that the clinic system has a requirement for a health assessment questionnaire in the first, sixth and twelve months – it will be interesting to see how the data outcome compares to the health assessments the clinics do.

CMO Nunez stated that we are cognizant of the potential burden of questionnaires on members, and there are thoughts on how to streamline the process and coordinate with our clinic partners, who are also collecting this information. Everything is by design.

Commissioner Monroy stated the collection of data is very insightful. She asked if this is essentially the population that falls under the expansion of 26- to 49-year-olds. CIO Gelb replied yes, we are surveying all of our new members. Our goal is to have this in place for all new members and to create a cadence through which we renew the insight for our membership on an ongoing basis.

We want to support through community care, mobile care and find other ways to engage with the population.

Commissioner Espinosa ask if the data could be broken down geographically. CIO Gelb stated it could be done and the information will be distributed to the committee.

CFO Dersch stated we are going back to pre-pandemic margins. This industry is very cyclical, profit is cyclical. We have lost healthier members through redetermination, and that is impacting us. We have a population of members that account for 85-90% of our cost, though it is 10% of the total membership. These are the members with multiple, chronic conditions. They are the members who need our service, and we need to give attention to. We have to do more with less dollars.

CFO Dersch reviewed some of the driver that are impacting our actual cost. Going forward it I critical that we align our unit cost increases with premium developments. We cannot overspend, we need to spend within our means. If we overspend, we are not meeting our mission and we will have to continue to draw into our reserves, and that is not what the reserves are for. The reserves are meant to be the opportunity to add investment in the community, as we are proposing with this proposed budget. Our unit costs are not decreasing. Any increase in spend is fully tied to unit cost increases and not utilization on a normalized basis.

CIO Gelb stated that members that remained with us after redetermination have a higher need, and their needs are specific. They have difficulty accessing primary care. The expectation from DHS and Mercer is that after initial demand, those utilization might decrease - we hope that is we are able to engage them in primary care upfront we will see improvement in our MCAS measures, and will increase utilization in primary care, specialty are and behavioral health care, but we must expand efforts to ensure that they are effective. We must make sure we are engaging the right populations in these programs so that we can see the results of the cost curve.

CFO Dersch moved on to review budgetary perspective. She reviewed key numbers from our forecast, which was approved in January. We then align it with our proposed budget. Our premium revenue is slightly up, $31 million in total. We have to do more with less from a revenue perspective. We will have our base Medi-Cal benefit rate of 88%, we are then adding on the additional investment in our quality programming of $22.5 million, which gets us to 92% of our premium, and we are maintaining our administrative spend at 19%. We are suggesting/proposing that we draw down our reserves to fund that

investment in the provider delivery system and in the community supports and services. This proposed draw down is projected to occur over the next three years and will give us the ability to create an infrastructure within the county that can serve our members now and in the future. We must take this opportunity now or we might not have the option in the future. Our industry is going in the direction where we must have documentation on the acuity of our member base. We must have proactive intervention with our members.

CFO Dersh noted that we could have other state take backs that we cannot anticipate, there could be retroactive equity adjustments. Our membership health could be more acute than what we are currently projecting. We will have proactive monitoring of our member health to ensure acuity needs are met in a timely manner. We must have a high discipline on what we can control, we will continue to review monthly and will engage in conversations on how we are performing. We will effectively manage the $22.5 million spend down of reserves and it will not go above that. We will continue to invest in our member incentives to help improve our MCAS scores. There is a projected spend of $250 million from 2025 through 2027. Proposing a spend down of reserves is not something that is done lightly, it is the right thing to do. This is a great opportunity for the county, and to ensure we have a strong healthcare delivery system.

Commissioner Corwin stated that we are investing in all the right elements from the quality perspective. The return on some of this investment - getting 100% will be a challenge but we should get back at lest 50-67% at some point. CFO Dersch stated this is an uncharted journey for us, but we will perform longitudinal analysis over the next few years to see the impact of all the spend.

Commissioner Monroy motioned to receive and file Fiscal Year 2024/25 Budget and Three-Year Planning as presented. Commissioner Corwin seconded the motion.

AYES: Commissioners James Corwin, Laura Espinosa, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: Commissioner James Corwin.

The clerk declared the motion carried.

The Committee went into Closed session at 5:19 p.m.

CLOSED SESSION

5. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

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

ADJOURNMENT

There was no reportable action. The meeting adjourned at 5:29 p.m.

Approved:

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Maddie Gutierrez, MMC
Clerk to the Commission

AGENDA ITEM NO. 2

TO: Executive Finance Committee

DATE: June 20, 2024

SUBJECT: Budget for Fiscal Year 2024/2025 and 3-Year Planning

RECOMMENDATION:

Staff requests that the Executive Finance Committee recommend that the Commission approve the 2024/2025 Budget.

ATTACHMENTS:

A CEO Report on Budget Objectives and Strategic Vision

B Development of a Quality Investment Focused Budget: MCAS Return on Investment

C Development of a Quality Investment Focused Budget: Health Engagement Program Return on Investment (GCHP – Wellth Partnership)

D Development of a Quality Investment Focused Budget: Review of April 2023-2024 Year-To-Date as Solid Financial Foundation

E Proposed Budget Fiscal 2024 / 2025 and 3-Year Quality Investment Program

Budget FY 2024-25 Financial Statements (including vendor contract listing)

AGENDA ITEM NO. A

TO: Executive Finance Committee

FROM: Nick Liguori, Chief Executive Officer

DATE: June 20, 2024

SUBJECT: CEO Report on Budget Objectives and Strategic Vision

VERBAL PRESENTATION

AGENDA ITEM NO. B

TO: Executive Finance Committee

FROM: Eve Gelb, Chief Innovation Officer
Felix Nunez, M.D., Chief Medical Officer
Kim Timmerman, Sr. Director of Quality Improvement

DATE: June 20, 2024

SUBJECT: Development of a Quality Investment Focused Budget: MCAS Return on Investment

PowerPoint with Verbal Presentation

ATTACHMENTS:

Investments in the Model of Care – Managed Care Accountability Set (MCAS) Investment Impact

Gold Coast Health Plan℠
A Public Entity

Investments in the Model of Care—Managed Care Accountability Set (MCAS) Investment Impact

Felix Nunez, MD, Chief Medical Officer
Kim Timmerman, Sr. Director Quality Improvement

Integrity
Accountability
Collaboration
Trust
Respect

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

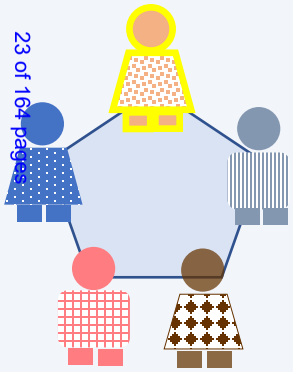
GCHP Model of Care—Co-Designing for Quality Health Outcomes

Advanced data capabilities to identify populations for focused health and quality interventions

Advanced capabilities to improve quality and satisfaction while controlling costs (VALUE)

An Integrated Care Team Model that applies individualized member management/support on a population scale

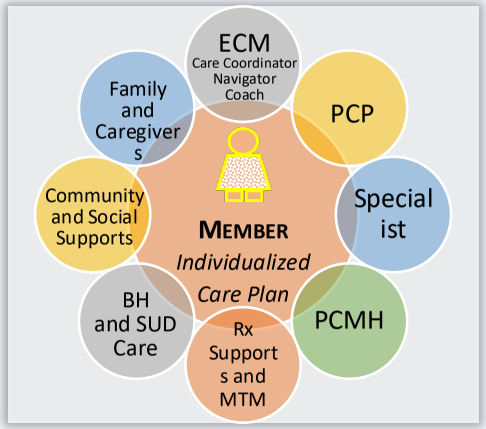
Member-centered health plan operations to improve member experience and engagement



Programs for chronic conditions

Member Incentives

Value Based Payment and Performance and Provider Incentives



Member Services – call center and field-based

Member Engagement

Operational capabilities to track costs and quality

The impact of investment in Model of Care results in high quality care and superior member experience and shifts care from acute facilities to primary, specialty and behavioral health care and care and services where and when our members want and need that care and services.

1 Member engagement in accessing care

2 Reducing total cost of care

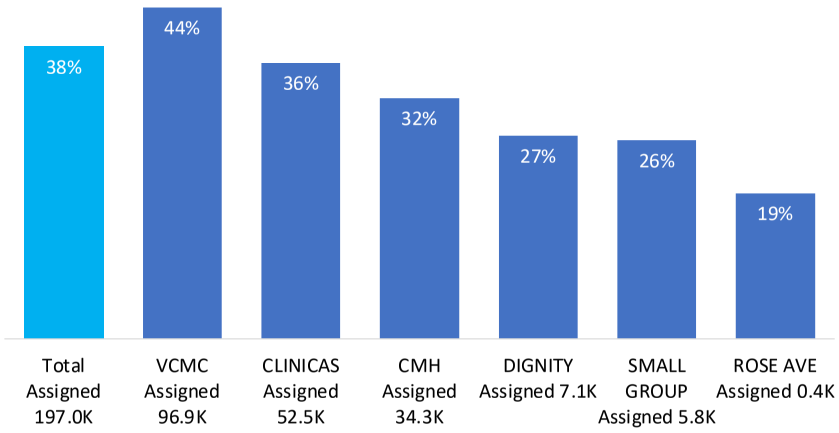
23 of 164 pages

Return to Agenda

Analysis Drives Model of Care Effectiveness

Our Model of Care is being built to get/keep people in regular engagement with their PCP (and specialists and behavioral healthcare providers). As of April 2024, 38% of members with PCP assigned did not have a PCP visit in the last 12 months. A Model of Care that is effective at care/cost/quality management aims for <10%.

% with PCP Assigned but no PCP Visit Last 12 Months, as of Apr24



PCP visits within 12 months are based on HEDIS metrics and HEDIS reporting period for the latest file. For example, 3/1/2024 members' PCP visits are determined using the 2/15/2024 file based on claims between 11/15/2022 and 11/14/2023.

Source: Membership Metrics Report accessed 4/30/2024

Our Model of Care is designed to Connect Members with Care that helps them manage the complex chronic physical and mental health conditions that impact their lives.

Top 25 EDC's Based On Filters

EDC	# Of Subscriber IDs Active	% Of Total
Hypertension	28,913	11.59%
Disorders of lipid metabolism	28,193	11.30%
Anxiety, neuroses	20,061	8.04%
Type 2 diabetes	17,181	6.88%
Obesity	16,132	6.46%
Asthma, w/o status asthmaticus	9,966	3.99%
Major depression	9,440	3.78%
Degenerative joint disease	9,316	3.73%
Depression	8,730	3.50%
Refractive errors	8,391	3.36%
Developmental disorder	7,145	2.86%
Hypothyroidism	5,952	2.38%
Chronic liver disease	5,705	2.29%
Musculoskeletal disorders, other	5,495	2.20%
Other endocrine disorders	4,770	1.91%
Chronic renal failure	4,619	1.85%
Ischemic heart disease (excluding acute myocardial infarction)	4,578	1.83%
Deafness, hearing loss	4,529	1.81%
Cardiac arrhythmia	4,482	1.80%
Migraines	4,242	1.70%
Autism Spectrum Disorder	3,882	1.56%
Neurologic disorders, other	3,680	1.47%
Substance use	3,546	1.42%
Disorders of the immune system	3,524	1.41%
Benign and unspecified neoplasm	3,514	1.41%
Total	**88,357**	**35.40%**

When looking at the top 25 diagnoses (ECD), Hypertension, Metabolic Disorders, Anxiety and Diabetes rank at the top in almost all population cohorts.

Return to Agenda

MCAS 2023
Why These Measures Matter

25 of 164 pages

Return to Agenda

Children's Health

WCV	Child and Adolescent Well – Care Visits
W30-6+	Well-Child Visits in the First 0 to 15 Months of Life – 6+ Well-Child Visits
W30-2+	Well-Child Visits in the First 15 to 30 Months of Life – 2+ Well-Child Visits
CIS-10	Childhood Immunization Status – Combo 10
IMA-2	Immunizations for Adolescents – Combo 2
DEV	Developmental Screening in the First Three Years of Life
LSC	Lead Screening in Children
TFL	Topical Fluoride for Children

Cancer Prevention

BCS	Breast Cancer Screening
CCS	Cervical Cancer Screening

Behavioral Health

FUA	Follow Up After an Emergency Department (ED) Visit Substance Use Disorder - 30 Days
FUM	Follow Up After an ED Visit Mental Health - 30 days

Chronic Disease Management

AMR	Asthma Medication Ratio
CBP	Controlling High Blood Pressure
HBD	Hemoglobin A1c Control for Patients With Diabetes – > 9%*

Reproductive Health

CHL	Chlamydia Screening in Women
PPC - Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care
PPC - Post	Prenatal and Postpartum Care: Postpartum Care

MCAS Measurement Year 2023 Performance Highlights*

83% at Minimum Performance Level **(MPL)** or above

15 of 18 Measures **improved** compared to MY 2022

7 Measures **at 75th% or above** (39% compared to 17% in MY 2022)

7 measures **increased** in percentile level performance

3 measures achieved **MPL** for the **first time** in GCHP history

3 "High Five" measures **met** High Performance Level (HPL)

* All rates noted within this presentation are considered preliminary until auditor approval and finalization on 6/14/24

Return to Agenda

MCAS/HEDIS MY 2023
High Five Measures

- PPC-Prenatal: Met 90th percentile
- PPC-Postpartum: Met 90th percentile
- HBD: Met 90th percentile
- BCS: 75th percentile
- CCS: 50th percentile – 2 hits away from 75th percentile

"Even when it is not fully attained, we become better by striving for a higher goal." – Viktor Frankl

Return to Agenda

MCAS 2023 Interventions
A Team Effort

- $55M Quality Funding
  - ✓ Incentivized Provider focus on quality of care through QIPP
  - ✓ Provider grants to improve access and quality
- Data Improvements
  - ✓ EMR Data feeds from 3 largest health systems
  - ✓ Conversion to Inovalon file format
  - ✓ Data validation and documentation process improvement
  - ✓ Data deep dives in Partnership with health systems
  - ✓ Mom to baby linkage refinement
  - ✓ Non-standard supplemental data collection through medical record abstraction

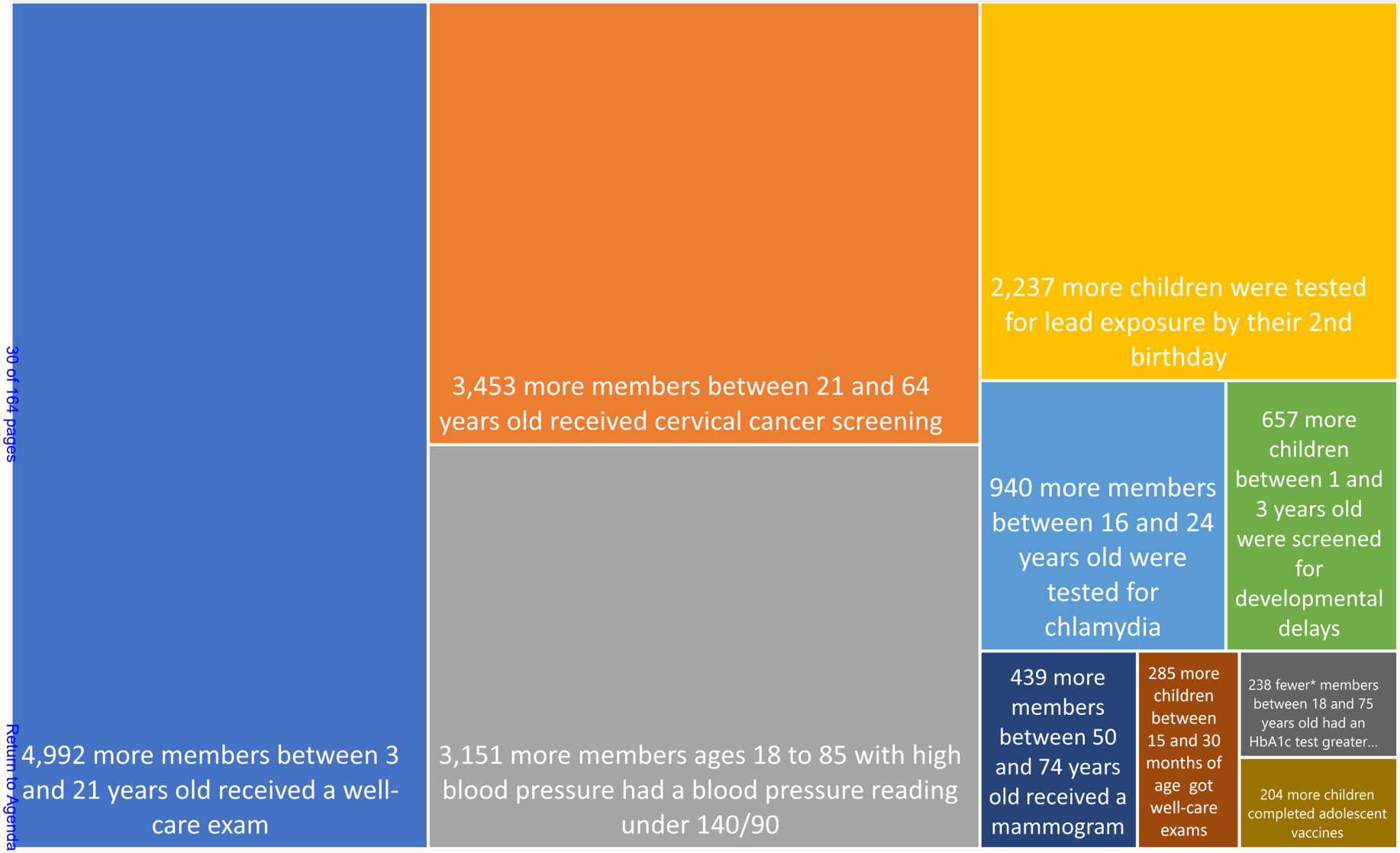
- Member Outreach Campaigns
  - ✓ CareNet gap closure appointment scheduling
  - ✓ Internal call campaign
  - ✓ Health Education outreach
- Meeting members where they are
  - ✓ Health Fairs
  - ✓ Home health visits
  - ✓ Wellth Behavioral Economics Program
- Member Incentive Expansion
  - ✓ Point of Care Member Incentive locations increase ~400%
  - ✓ 20,000 members using member incentives in 2023

Return to Agenda

MY 2023 MCAS Member Impact

Return to Agenda

15,657 More Connections *with* Care in 2023

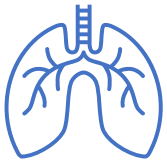


30 of 164 pages

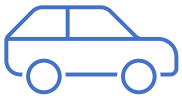
Return to Agenda

Data improvements reflected 24,180 more children between 1 and 21 years old received at least two topical fluoride varnish applications.

Areas for Continued Focus




Mental Health and Asthma measures did not meet MPL



Full implementation of Transportation improvements

Continued investment in Quality Funding Plan

Continued data analytics to recognize the care that is being delivered

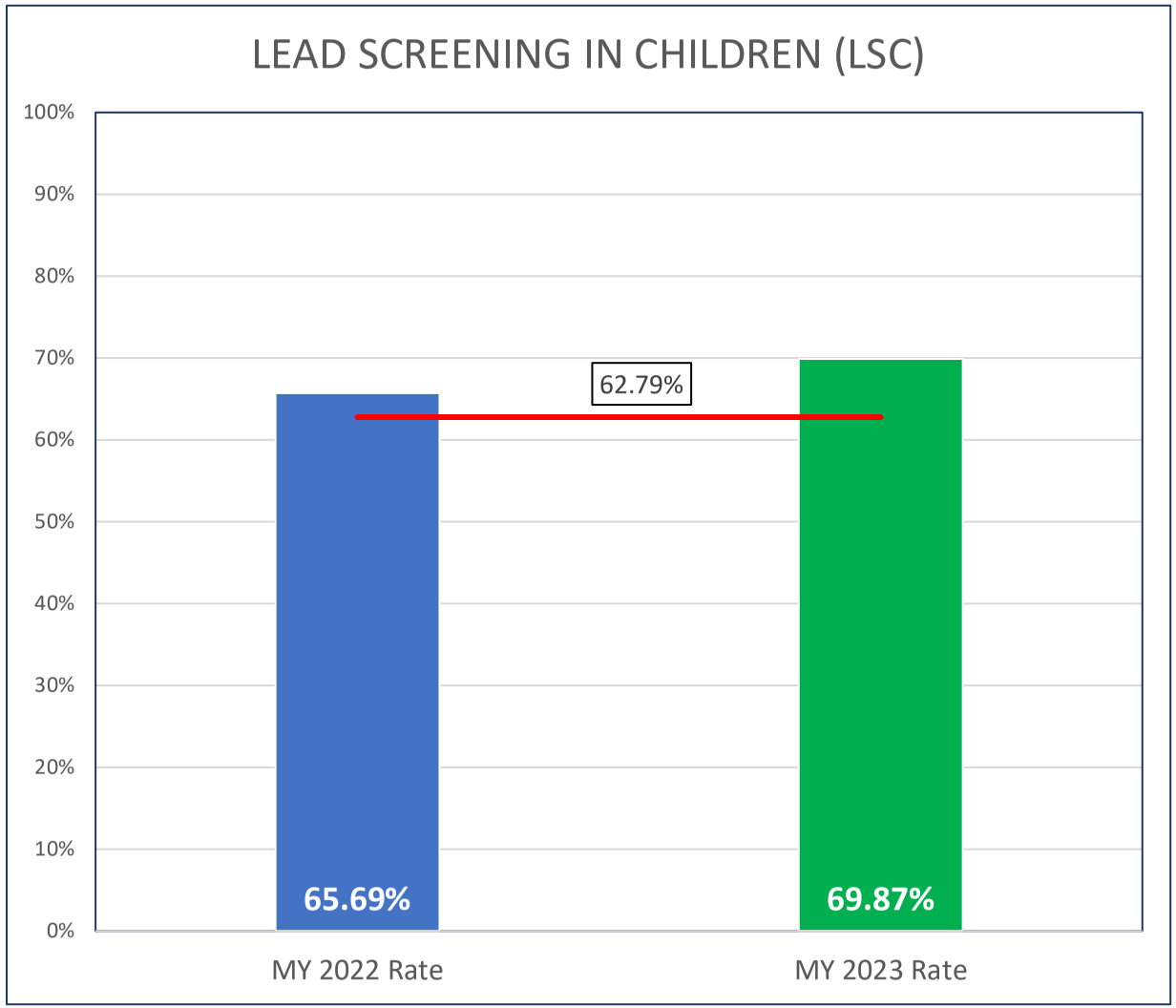
Continued innovation and collaboration including chronic condition management and community care

Voice of the Member

Return to Agenda

Appendix—Details of Measures Meeting MPL

Return to Agenda



2,237 more children were tested for lead exposure by their 2nd birthday in 2023 compared to 2022.

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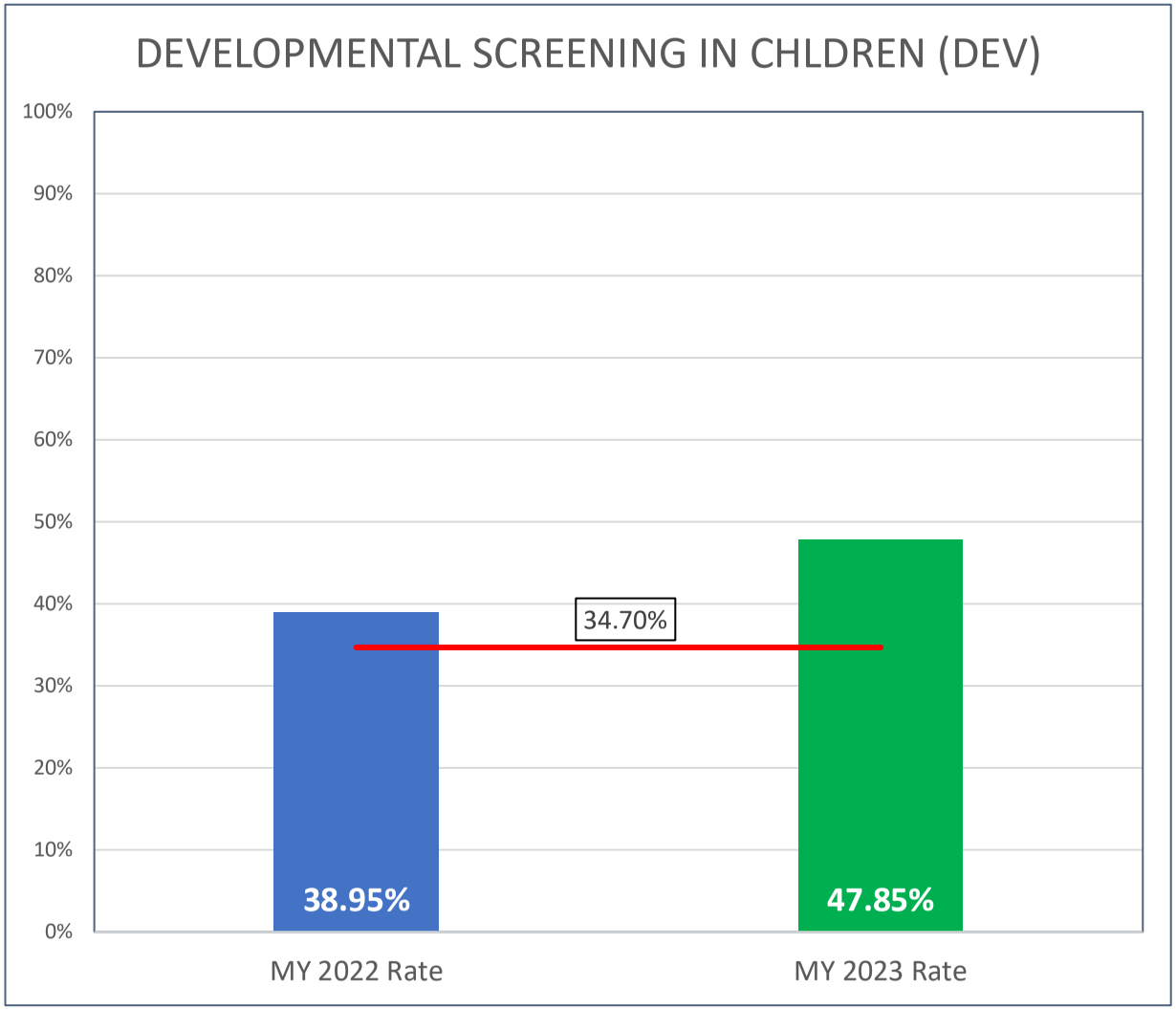

657 more children between 1 and 3 years old were screened for developmental delays in 2023 compared to 2022.

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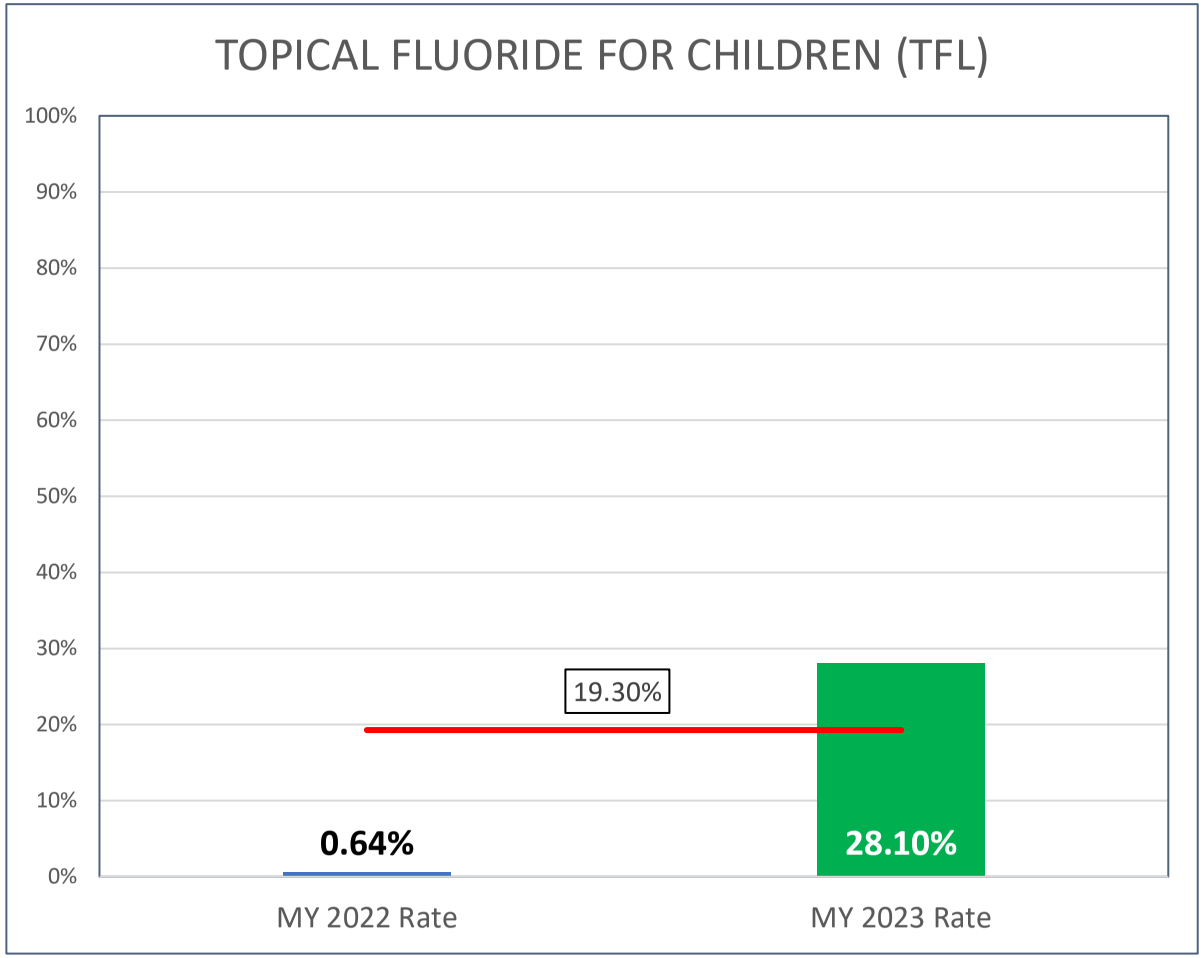

24,180[1] more children between 1 and 21 years old received at least two topical fluoride varnish applications in 2023 compared to 2022.

[1] Note: Data mapping improvement conducted for MY 2023

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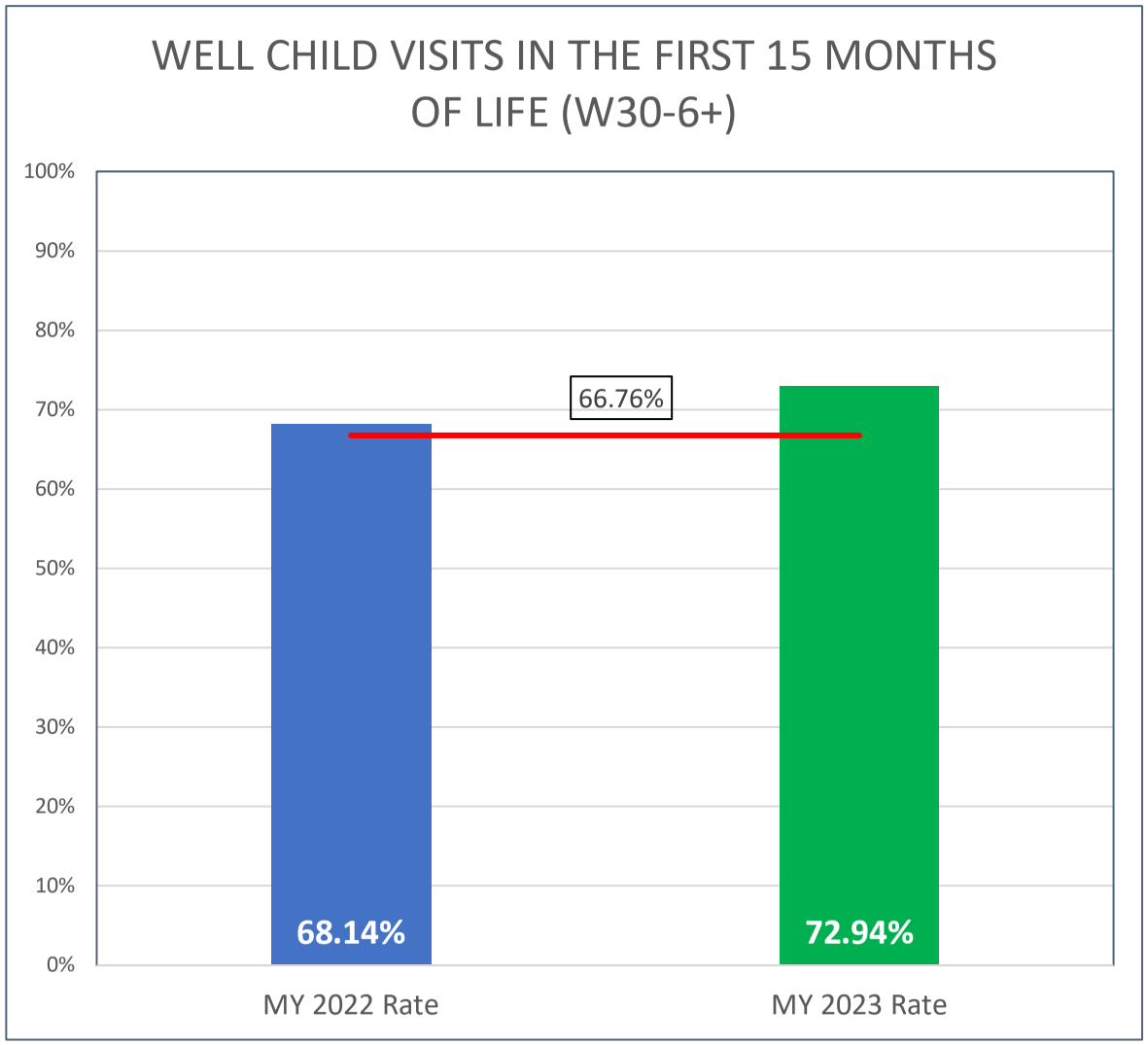

12 fewer* children between 0 and 15 months of age received at least six well-care exams in 2023 compared to 2022.

*While 12 fewer children received well-care exams, 264 fewer children were due for a well-care exam, resulting in an overall improvement in the percent of children who received a well-care exam.

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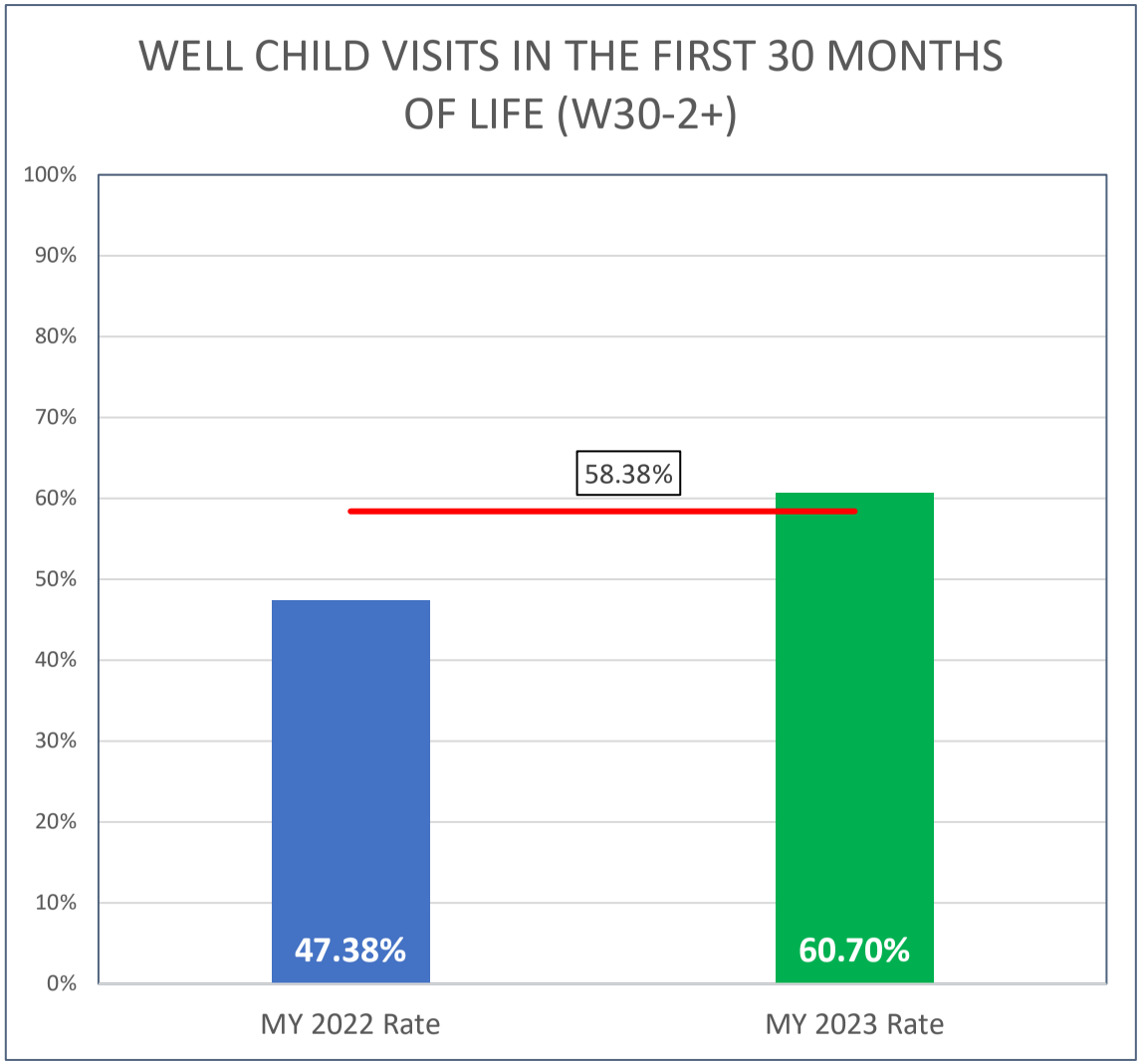

285 more children between 15 and 30 months of age received at least two well-care exams in 2023 compared to 2022.

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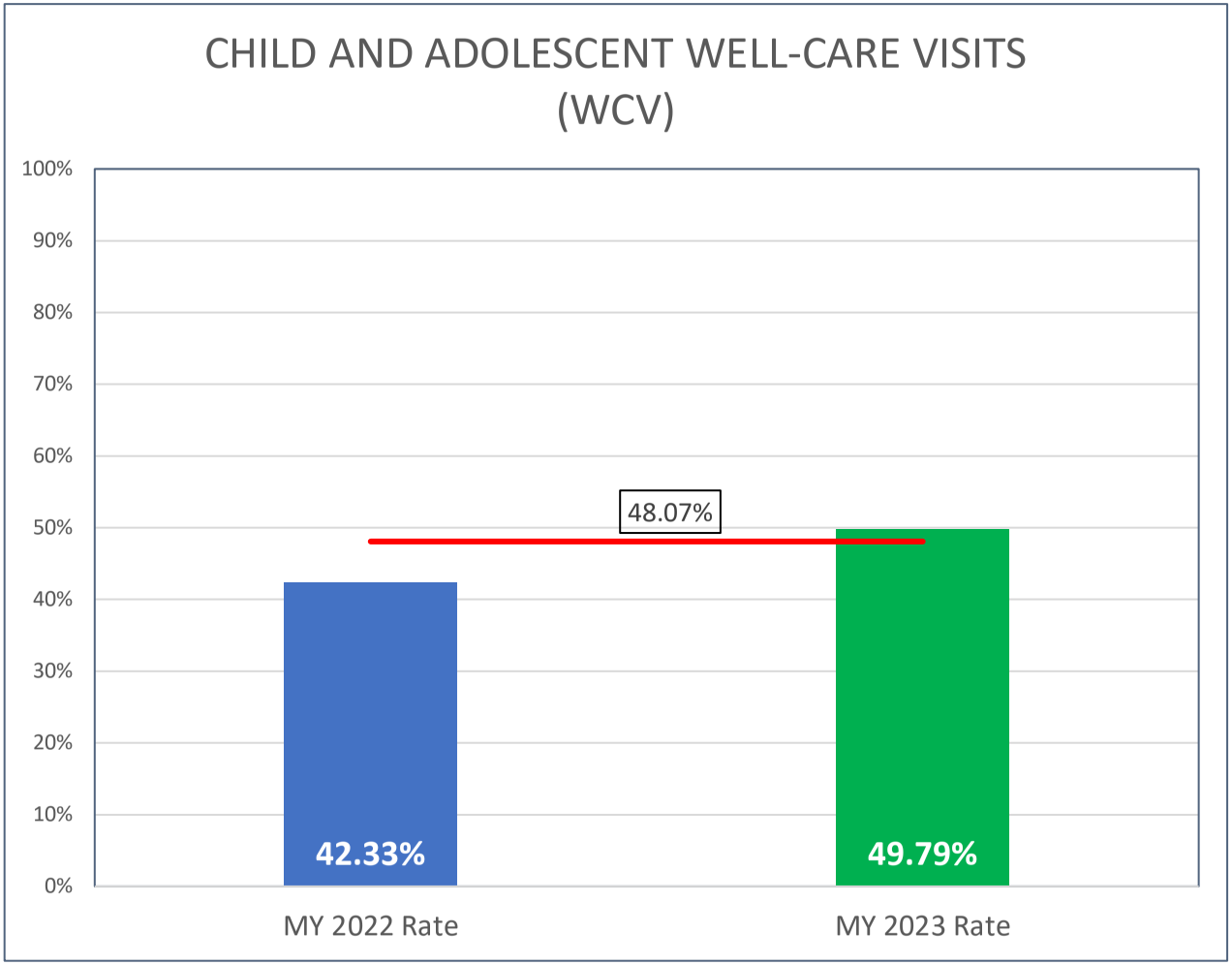

4,992 more members between 3 and 21 years old received a well-care exam in 2023 compared to 2022.

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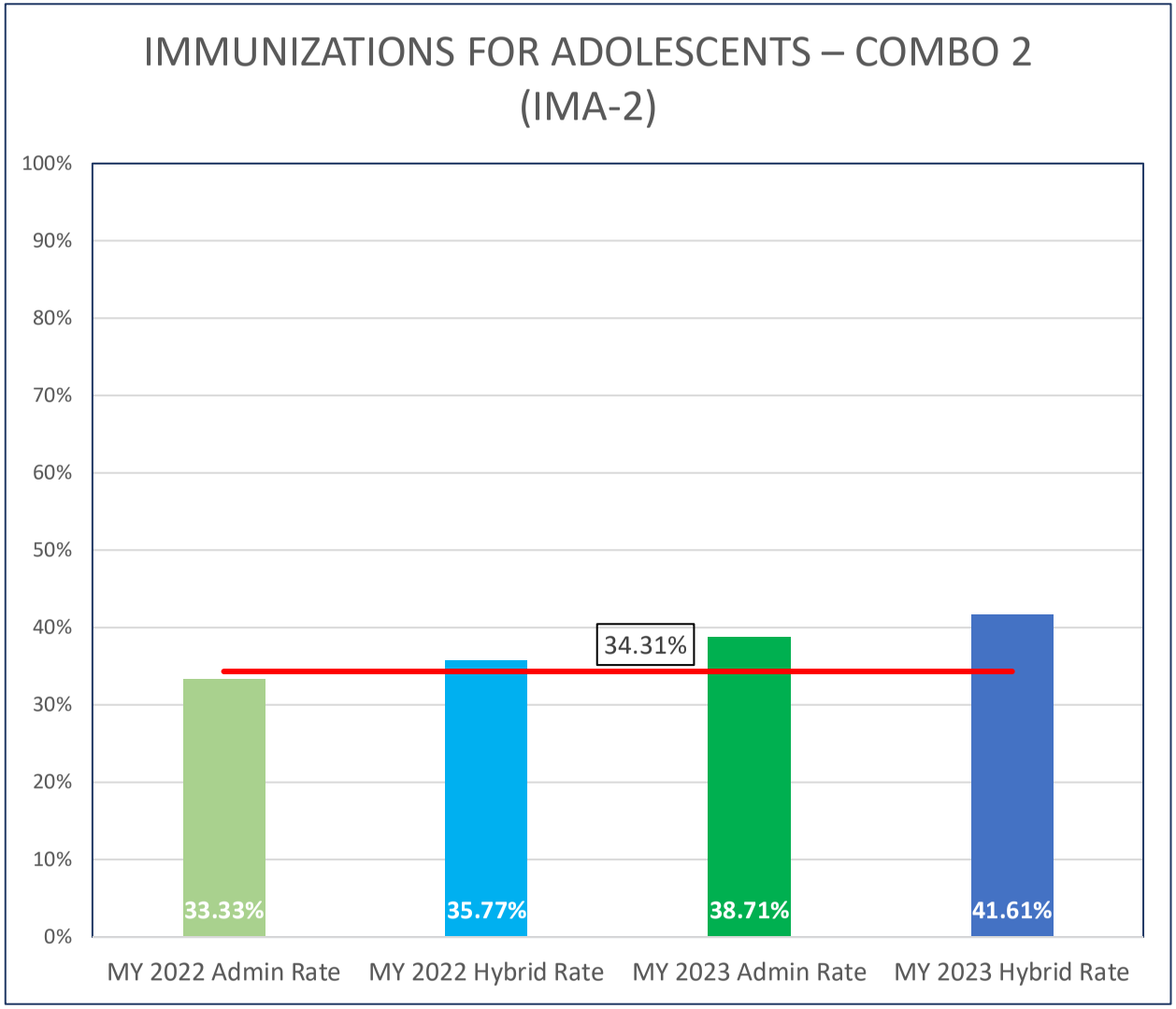

204 more children completed all recommended adolescent vaccines by their 13th birthday in 2023 compared to 2022.

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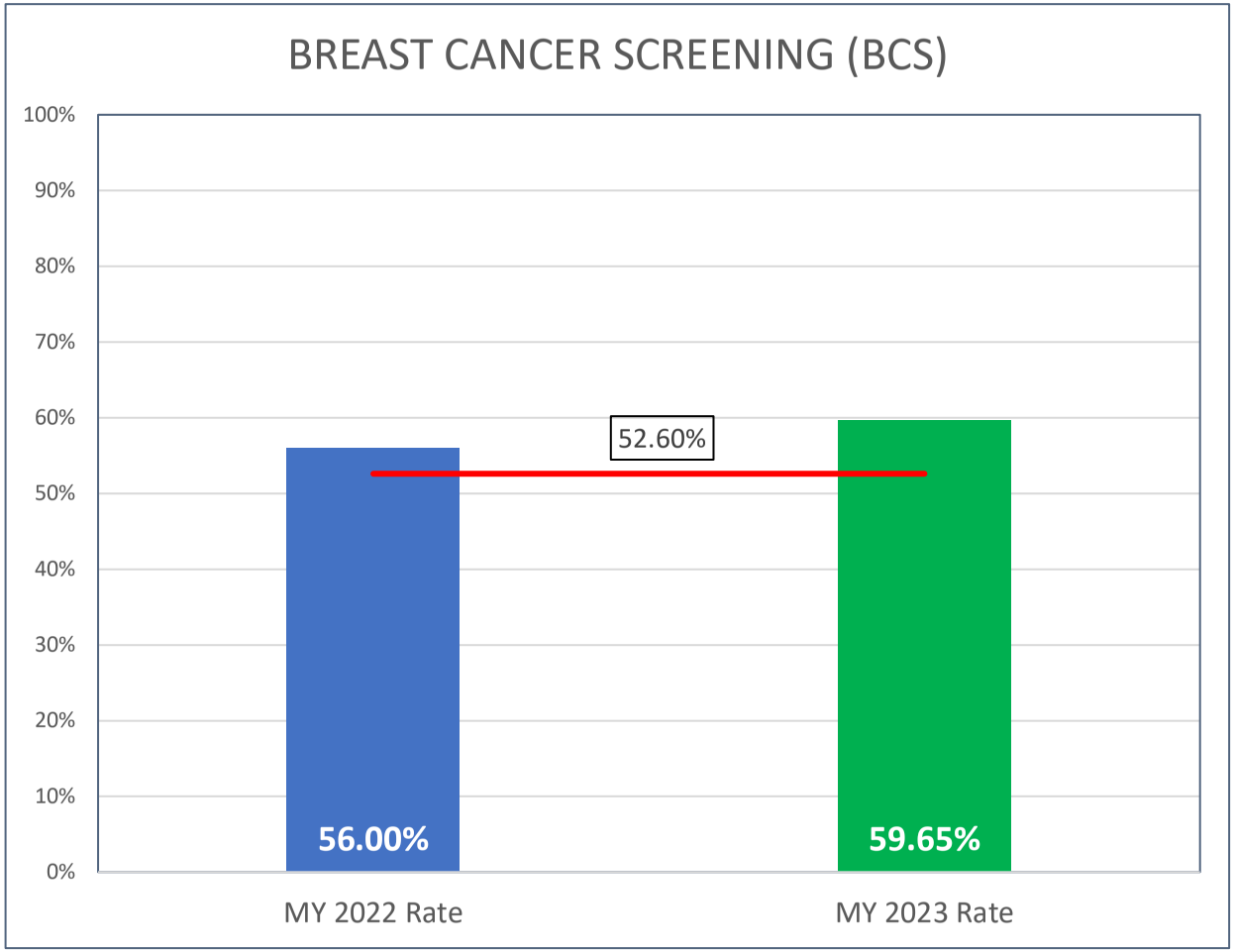
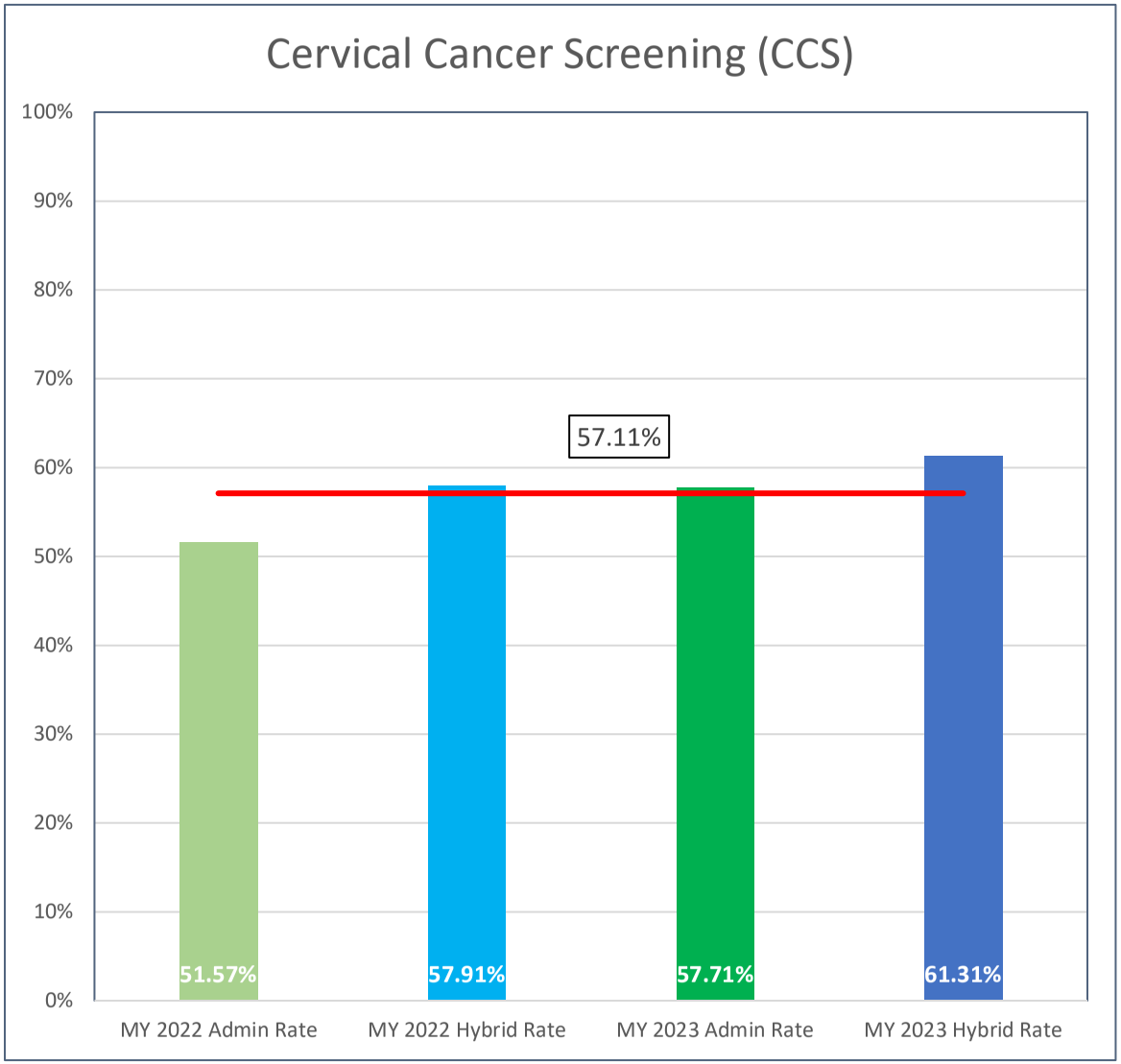


439 more members between 50 and 74 years old received a mammogram in 2023 compared to 2022.

Return to Agenda



3,453 more members between 21 and 64 years old received cervical cancer screening in 2023 compared to 2022.

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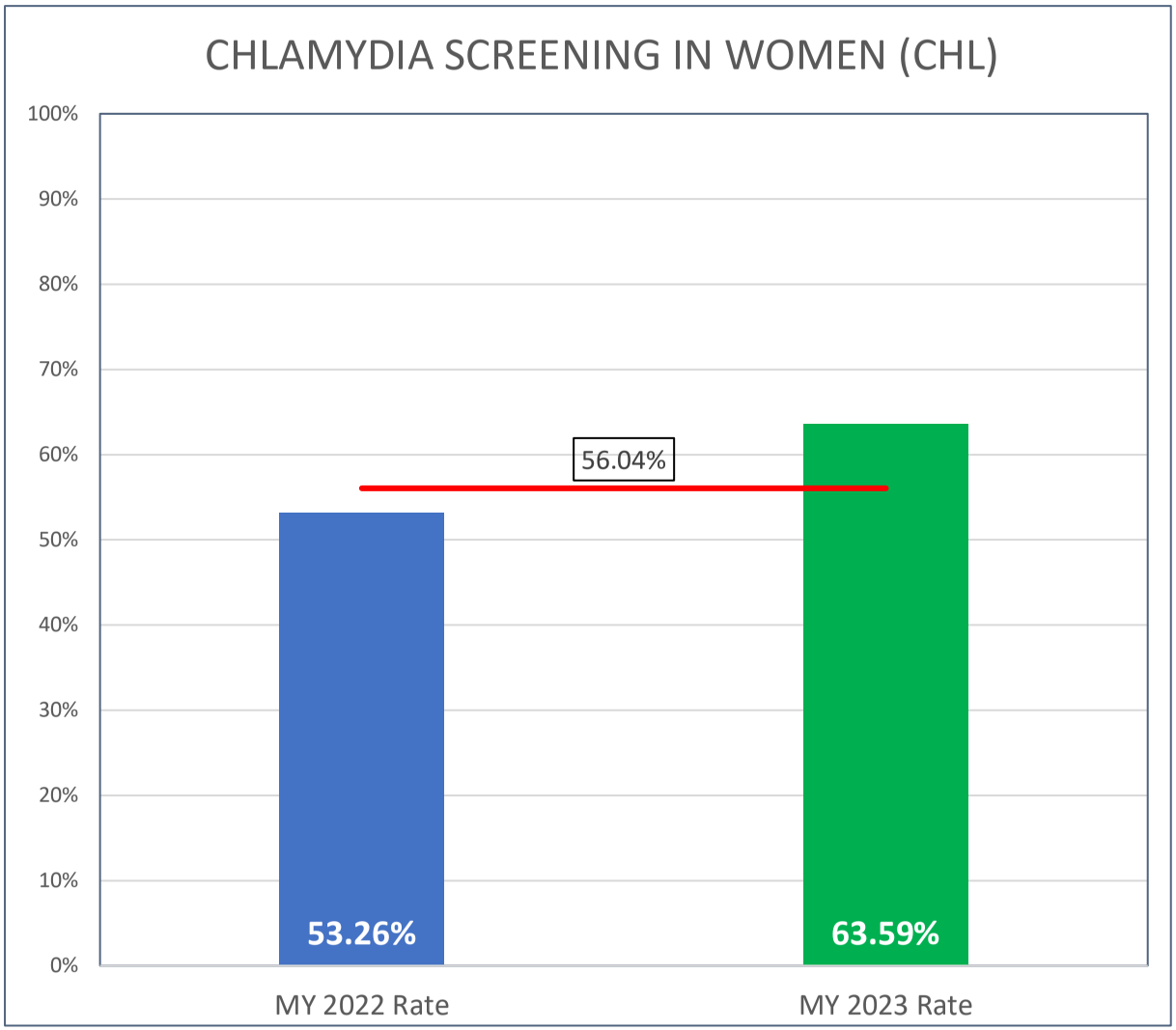
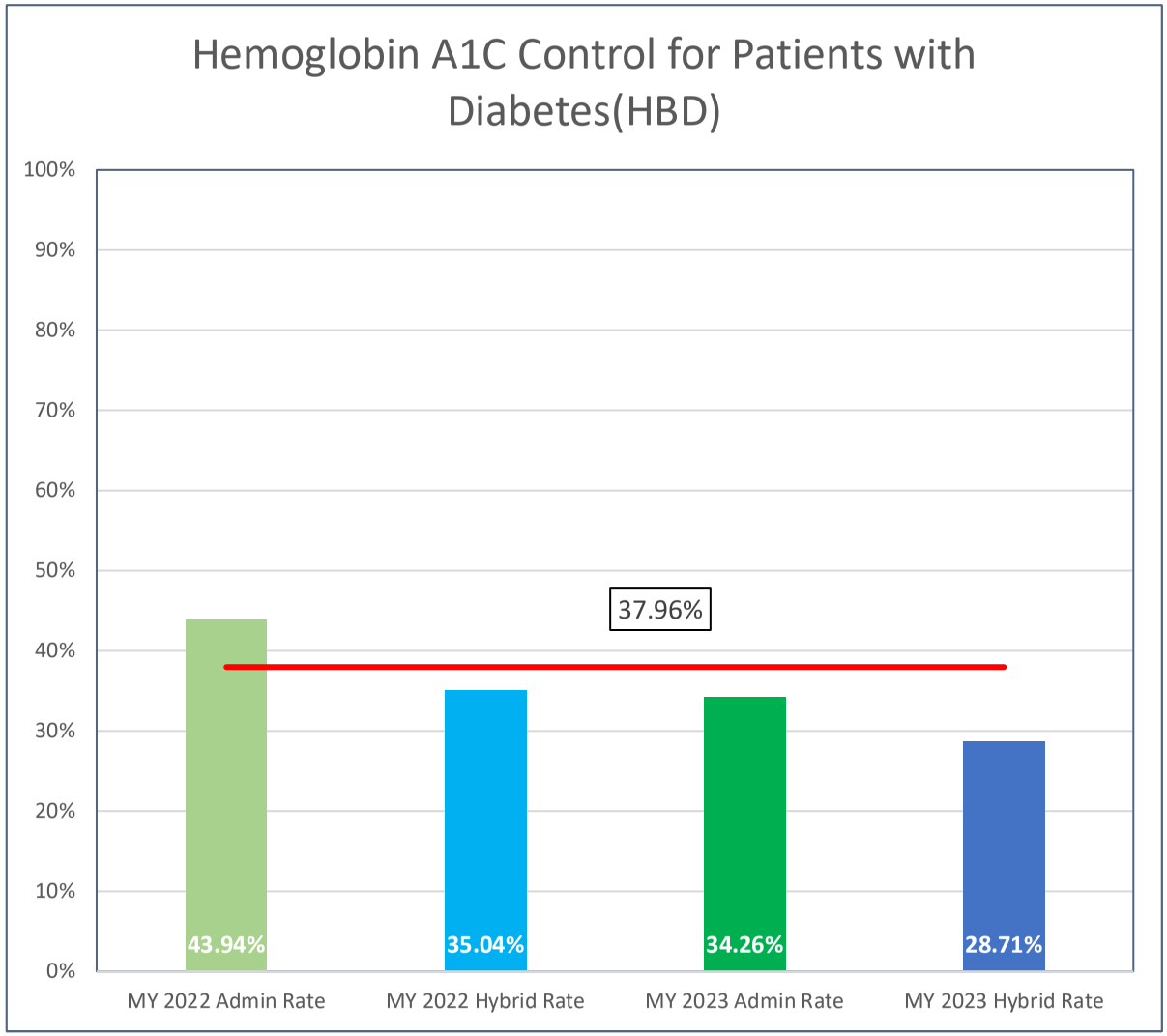


940 more members between 16 and 24 years old were tested for chlamydia in 2023 compared to 2022.

Return to Agenda

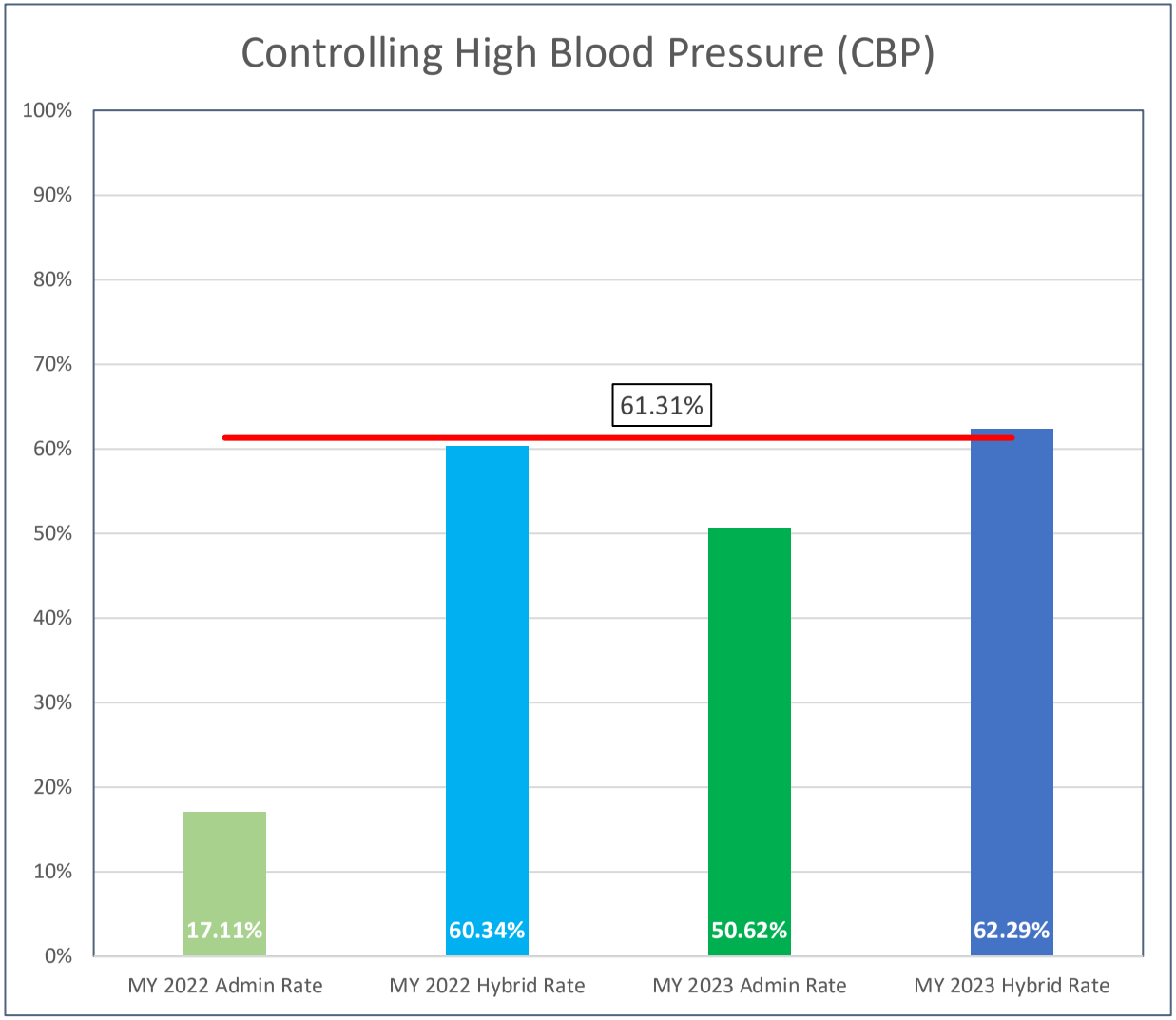


A lower rate is better and indicates fewer members with poor HbA1c control.

238 fewer* members between 18 and 75 years old with diabetes had an HbA1c test greater than 9.0% in 2023 compared to 2022.

*A reduction in members with a high HbA1c test shows in improvement in diabetes management.

Return to Agenda



3,151 more members ages 18 to 85 with high blood pressure had a blood pressure reading under 140/90 in 2023 compared to 2022.

Return to Agenda

AGENDA ITEM NO. C

TO: Executive Finance Committee

FROM: Eve Gelb, Chief Innovation Officer
Erik Cho, Chief Policy & Program Officer
Erin Slack, Sr. Manager, Population Health

DATE: June 20, 2024

SUBJECT: Development of a Quality Investment Focused Budget: Health Engagement Program Return on Investment (GCHP – Wellth Partnership)

PowerPoint with Verbal Presentation

ATTACHMENTS:

Investments in the Model of Care – Wellth & GCHP Partnership and Outcomes

Gold Coast Health Plan℠
A Public Entity

Investments in Model of Care—Wellth & Gold Coast Health Plan Partnership and Outcomes

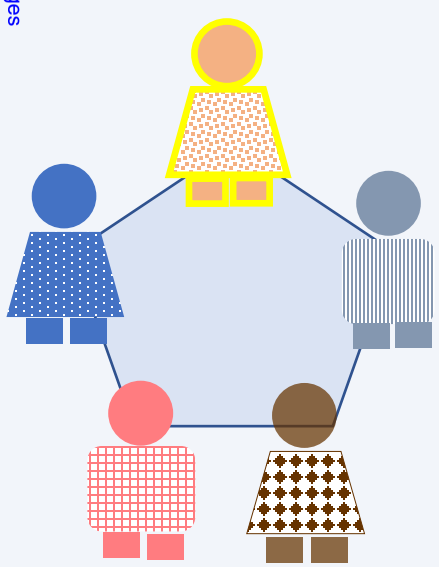
Erik Cho, Chief Policy and Program Officer
Erin Slack, Senior Manager Population Health Management
Matt Loper, Chief Executive Officer and Co-Founder Wellth
Dinesh Apte, Senior Vice President of Growth & Strategy Wellth
Russ Gagnon, Chief Product Officer Wellth
Haley Kesler, Customer Success Manager Wellth

Integrity
Accountability
Collaboration
Trust
Respect

Return to Agenda

GCHP Model of Care
Quality Health Outcomes by Design—Wellth

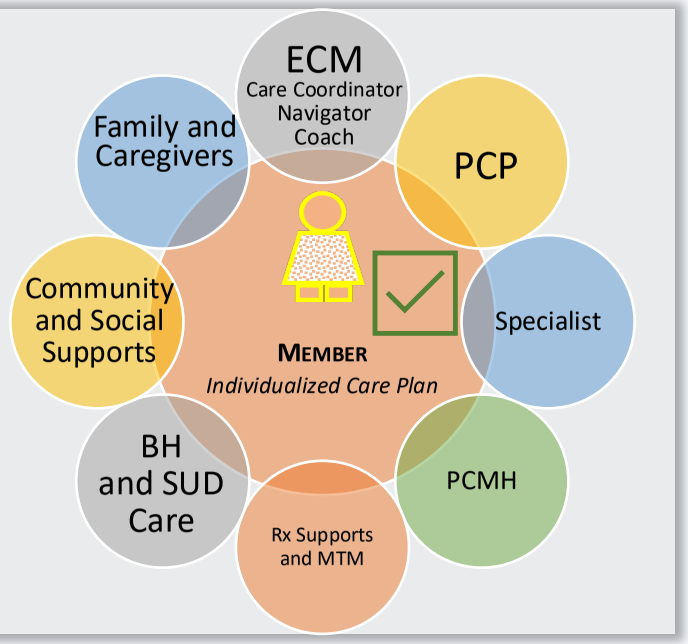
Advanced data capabilities to identify populations for focused health and quality interventions



Advanced capabilities to improve quality and satisfaction while controlling costs (VALUE)

- Programs for chronic conditions
- Member Incentives
- Value Based Payment and Performance and Provider Incentives

An Integrated Care Team Model that applies individualized member management/support on a population scale



Member-centered health plan operations to improve member experience and engagement

- Member Services – call center and field-based
- Member Engagement
- Operational capabilities to track costs and quality

47 of 164 pages

Return to Agenda

wellth

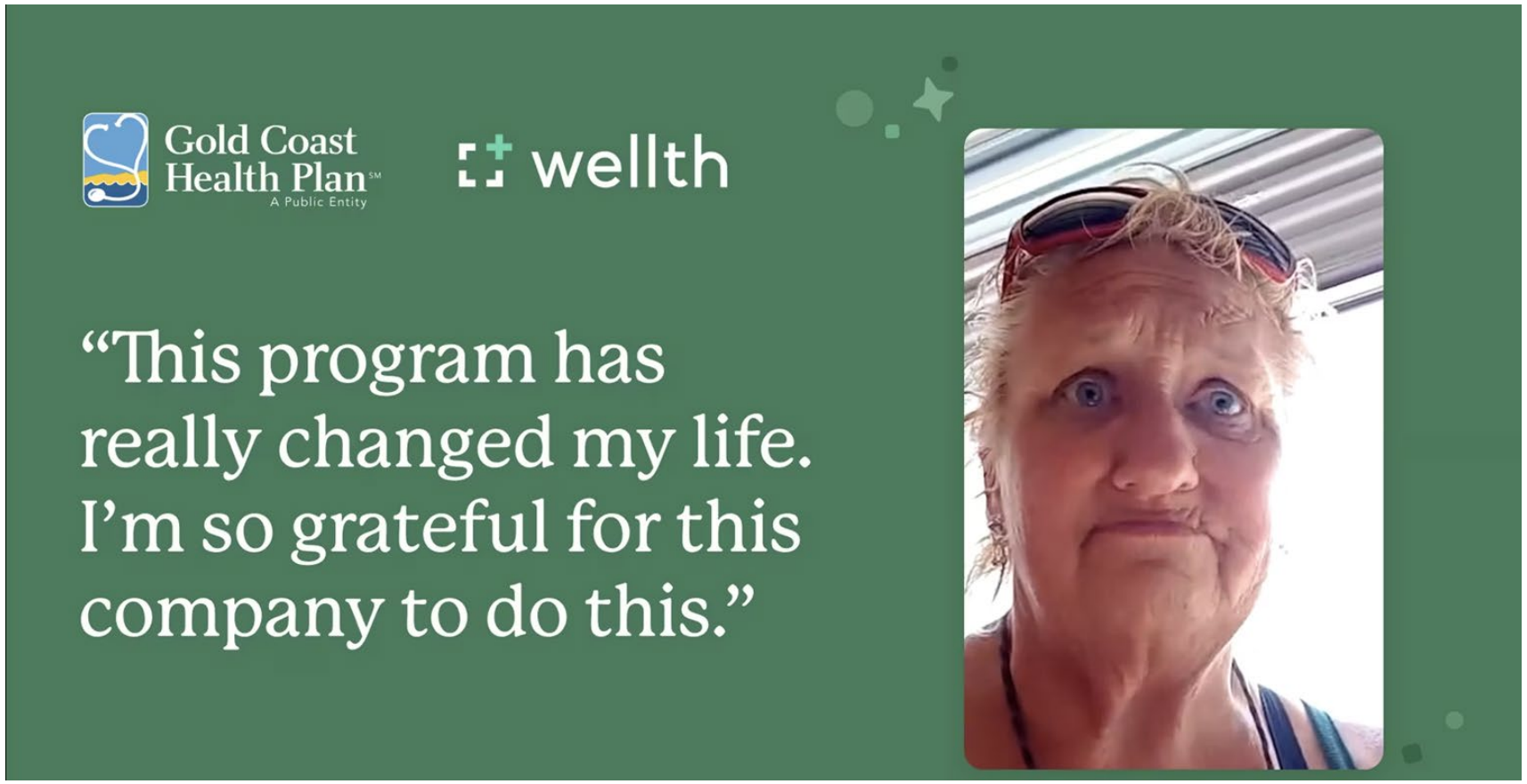
Wellth & Gold Coast Health Plan

Program Review

June 24, 2024

Return to Agenda

Gold Coast Health Plan Is Changing Its Members Lives For The Better



Click to watch

wellth

Agenda

- Wellth Overview
- Program Overview
- Outcomes Review
- Upcoming Activities

50 of 164 pages

Return to Agenda

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Wellth Overview

Return to Agenda

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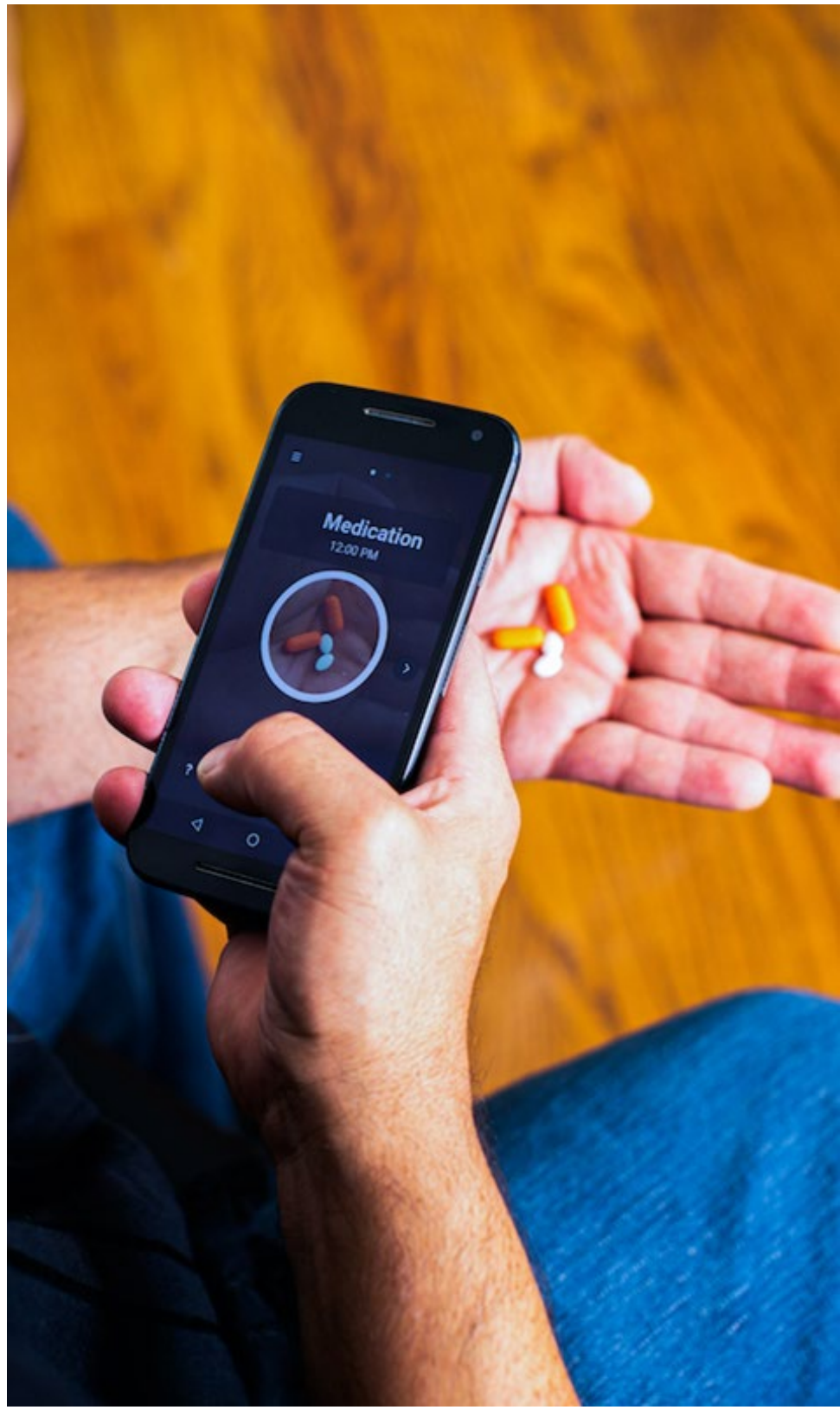
Wellth uses the **power of behavioral science** to help people change their daily behavior.

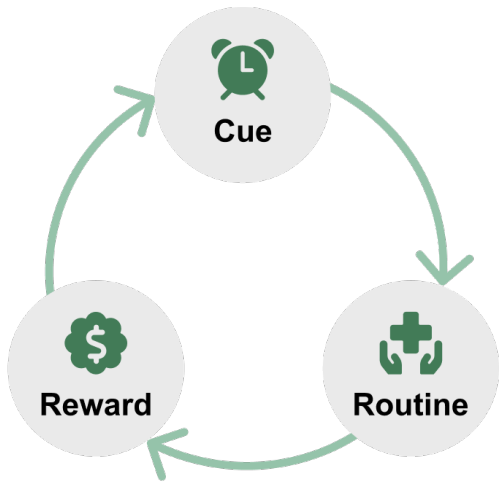


Return to Agenda

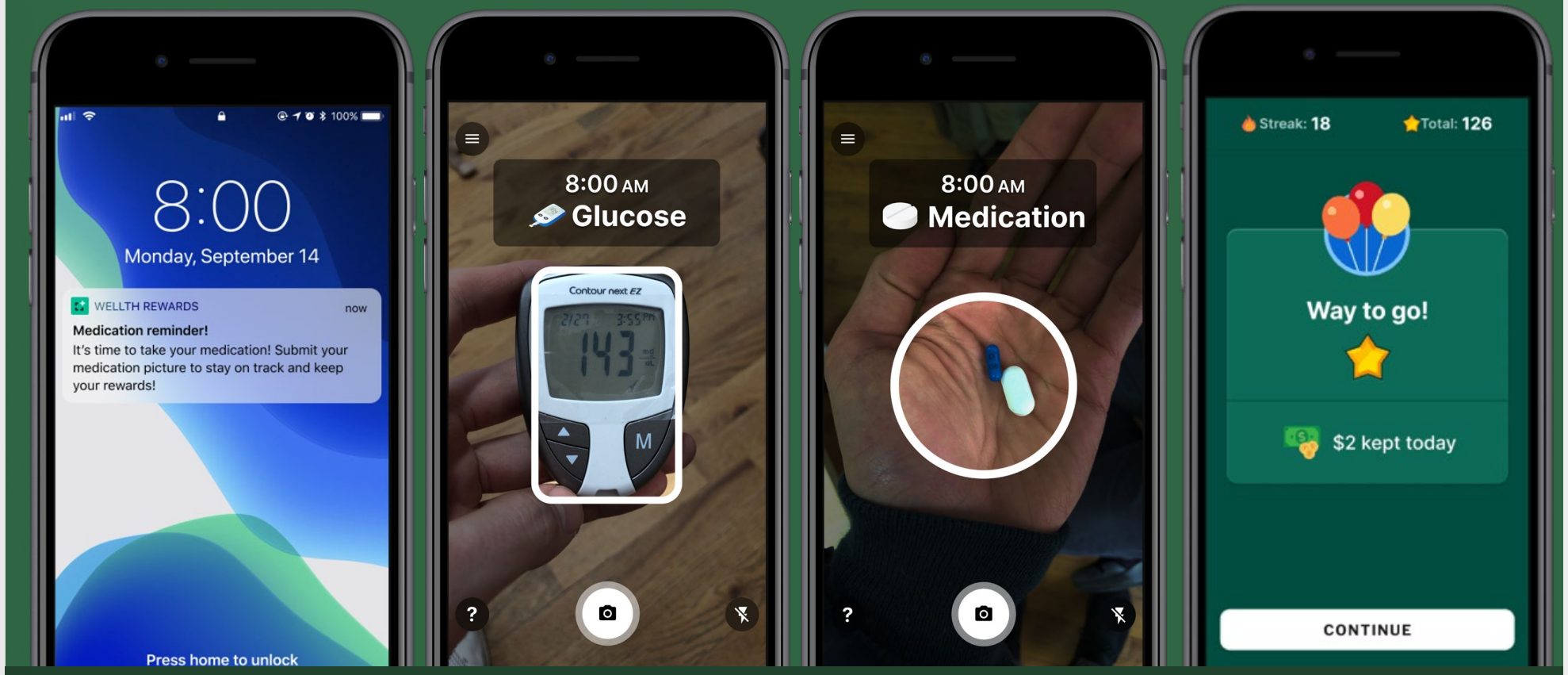
Maria, 58

Female
Speaks Spanish
Fillmore, CA
Verified Phone Number
Verified Email Address

- Type 2 Diabetes
- Hypertension
- Baseline A1c: 9.4
- Glucose check and takes 2 pills at 8:00 AM



Daily Care Plan Habit Loops



Cue **Routine** **Reward**

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John, 56

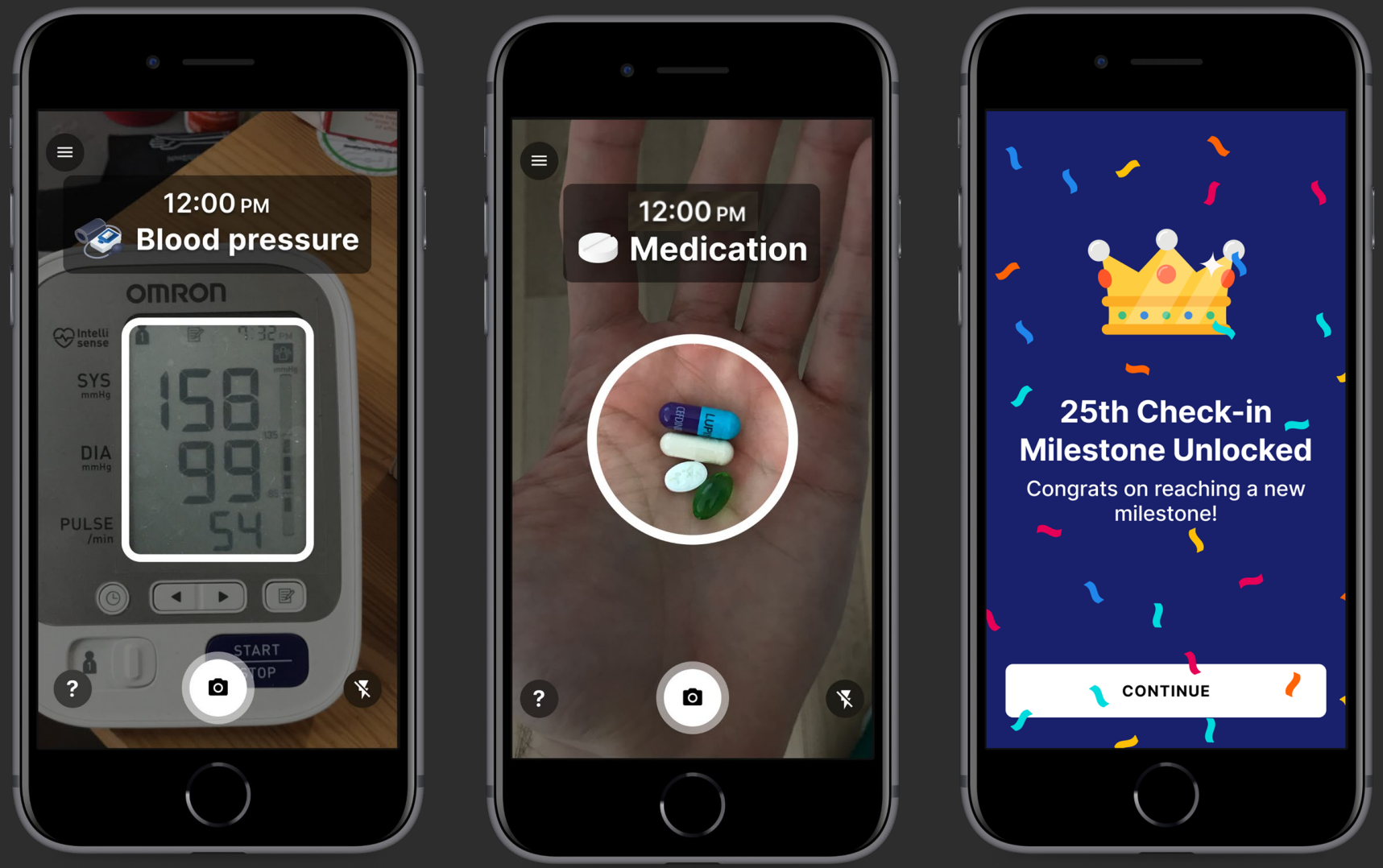
Male

Speaks English

Ojai, CA

Verified Phone Number

- CVD
- Type 2 Diabetes
- Hypertension
- Very low prior historical adherence
- Needs A1c test; needs colon cancer screening
- Last HbA1c: 9.2



Wellth's journey helps John stay focused on what's most important, establish strong habits and routines, and feel connected to support each step of the way

wellth

SDOH Category Gift Rewards Card

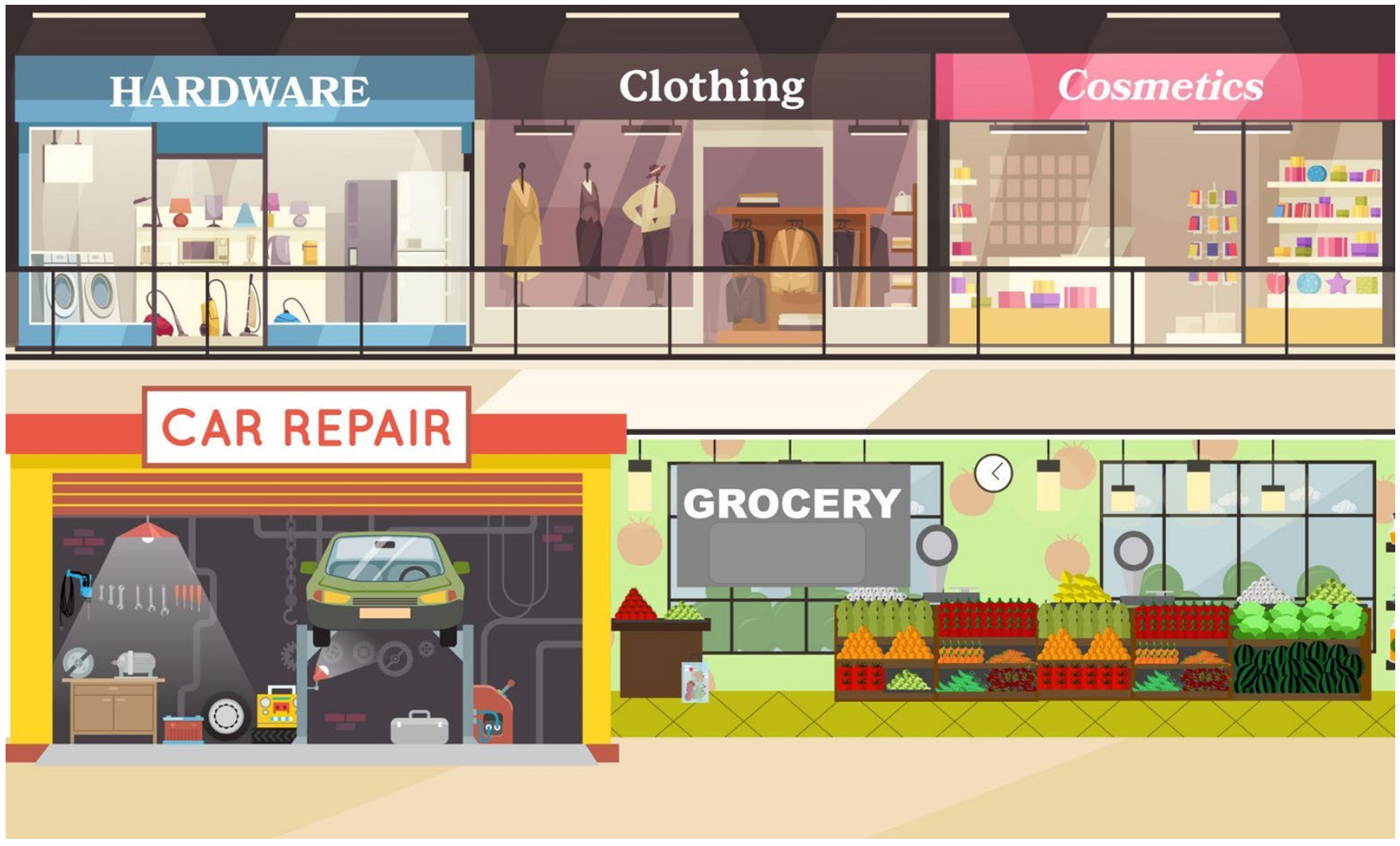
Food & Groceries

Clothing

Transportation & Communication

Home & Lodging

Personal Care, Education & Entertainment



We offer a gift reward card solution that is limited to specific SDOH Categories including:

- Food & Groceries
- Clothing
- Transportation & Communication
- Home & Lodging
- Personal Care, Education & Entertainment

55 of 164 pages

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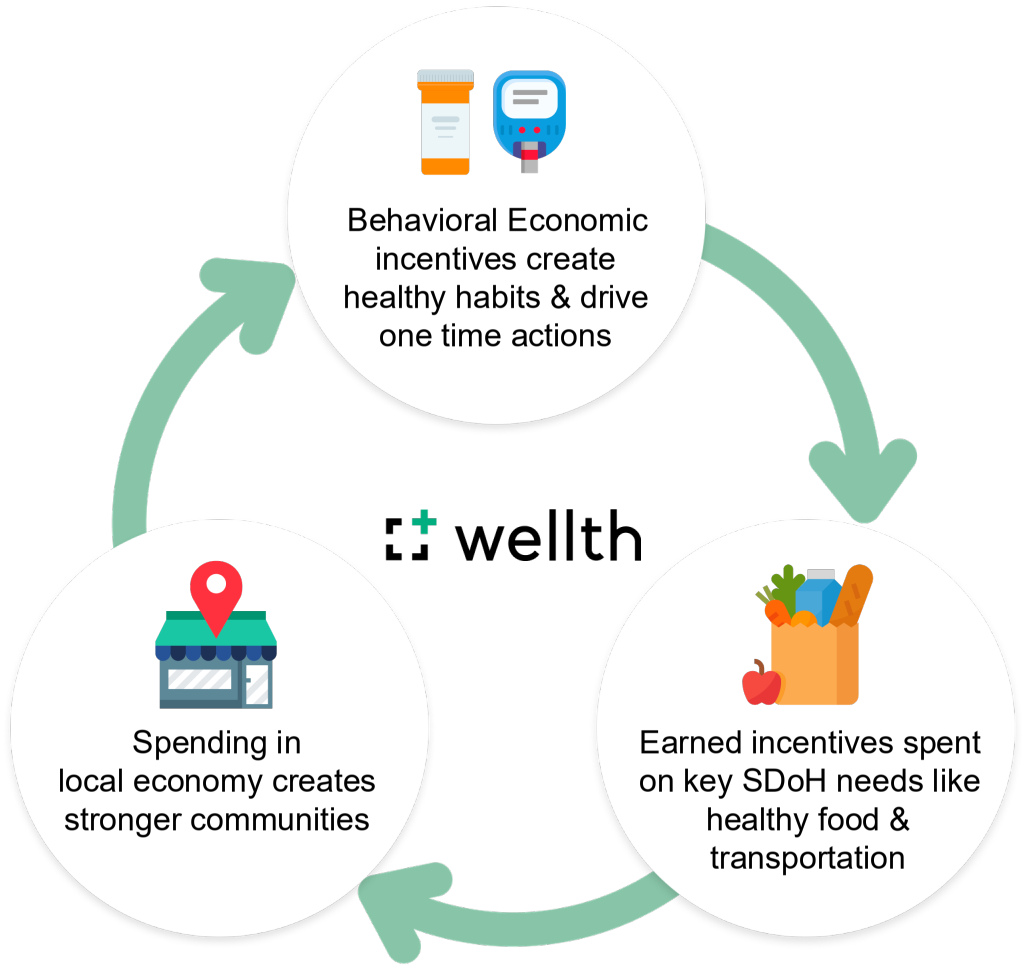
wellth

Solution

Wellth creates a virtuous cycle. Incentives not only create healthy habits and outcomes but put money in members pockets for key SDoH needs and, ultimately, healthier communities



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Program Overview

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Gold Coast Health Plan and Wellth Program Overview

Phase 1

Utilization Reduction Program

Enrollment Period

Sept ’23 – Nov ‘23

Activated Members

1,504

Initial activation goal: 1,500

Eligibility Criteria

Medicaid members with physical and behavioral health conditions at risk for high-cost utilization

Program Goals

Primary Objective:

- Reductions in Avoidable High-Cost Utilization & Cost
- Care Gap Closures*

Secondary Objectives:

- Improvements to Medication Adherence (PDC)
- Member Satisfaction (NPS > +50)

*Moved from secondary to primary objective based on updated GCHP goals

Phases 2 & 3

Quality Improvement Program

Enrollment Period

Dec ’23 – June ‘24

Activated Members

5,066

Initial activation goal: 5,000

Eligibility Criteria

Medicaid members with at least one open MCAS care gap

Program Goals

Primary Objectives:

- Cervical Cancer Screening compliance
- Breast Cancer Screening compliance
- A1c Control compliance
- BP Control compliance

Secondary Objective:

- Member Satisfaction (NPS > +50)

wellth

Most members engage every single day

The Wellth & Gold Coast Health Plan program continues to see outstanding daily engagement and program retention, translating to significant reductions in high-cost utilization, strong improvements to medication adherence across key drug classes and increased MCAS care gap closures.

PARTICIPATION

Activated Members (Utilization: 1,504 | QI: 5,066)	6,570	Daily Engagement/Action Rate	85%
Program Retention	91%	Members with 3+ Chronic Conditions	76%

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wellth

Daily habit support drives strong impact

The Wellth & Gold Coast Health Plan program continues to see outstanding daily engagement and program retention, translating to significant reductions in high-cost utilization, strong improvements to medication adherence across key drug classes and increased MCAS care gap closures.

PARTICIPATION

Activated Members (Utilization: 1,504 | QI: 5,066)	6,570
Daily Engagement/Action Rate	85%
Program Retention	91%
Members with 3+ Chronic Conditions	76%

OUTCOMES (6 MONTHS POST-ENROLLMENT)

Reduction in Inpatient Days Utilization PMPM	**57%**
Reduction in Readmission Days Utilization PMPM	**47%**
Improvement to Adherence (PDC) for Diabetes Medications	**18%**
BCS Care Gap Closure vs Not Enrolled “Control” Group	**19%**

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Member Experience

wellth

Wellth's **daily care motivation platform** guides individuals to **follow through on their care plan every single day**

Members start their program focused on their daily check-ins: typically taking medication, measuring blood pressure or blood glucose, or eating a healthy meal

TRAIN

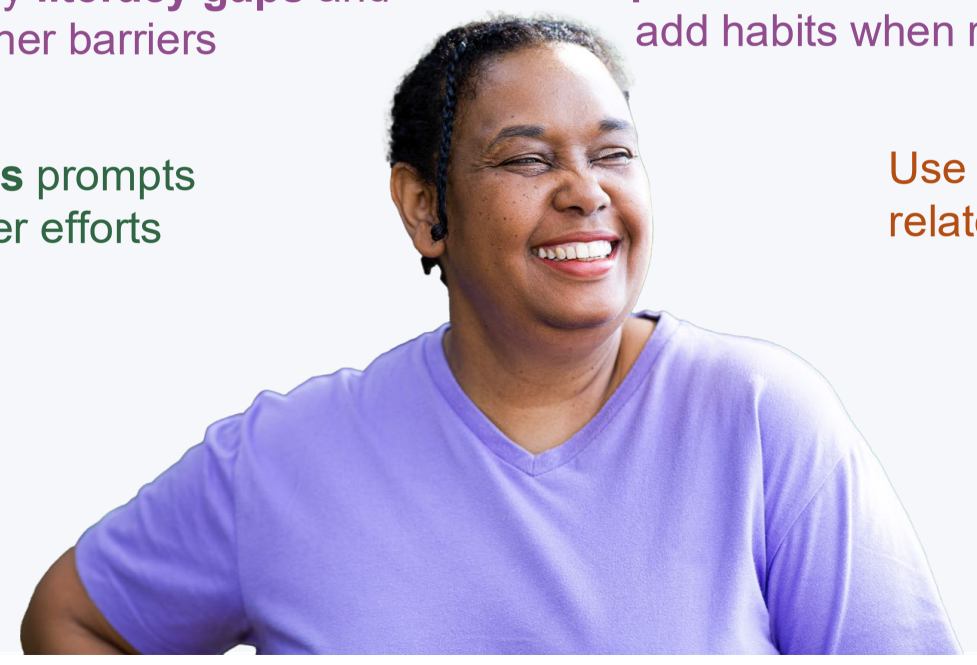
Identify and address key **literacy gaps** and other barriers

Prompt needed **preventative care** and add habits when ready

Once Members have shown mastery of their daily check-ins, they broaden and build their healthy behavior repertoire and self-management skills as they progress in their program

INITIATE

Endowed progress prompts Maria to build on her efforts



MAINTAIN

Use **social proof** to boost relatedness & empathy

Build consistency with **Cue - Routine - Reward** behavioral loop

Leverage **habit coupling** to strengthen habit formation

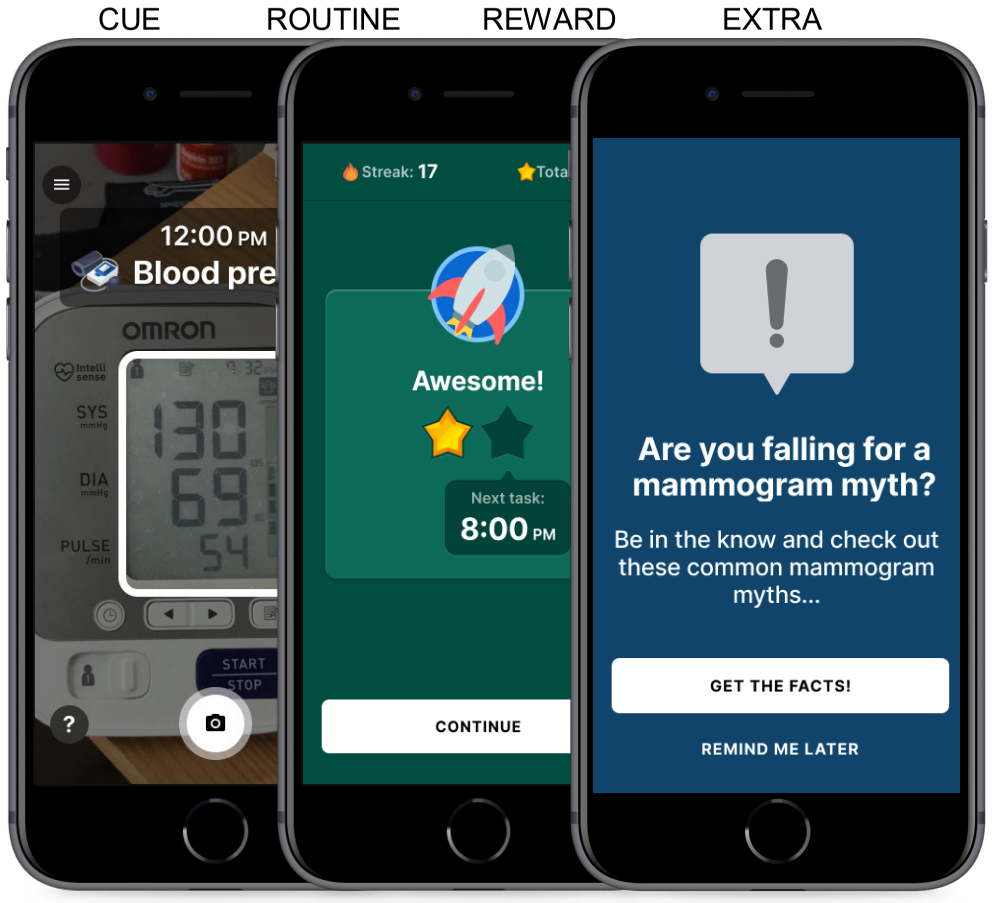
Sporadic attention to health
Extrinsic motivation
Anxious, Effortful
Low engagement

Persistent, daily habits
Intrinsic motivation
Easy, fulfilling
High engagement

Return to Agenda

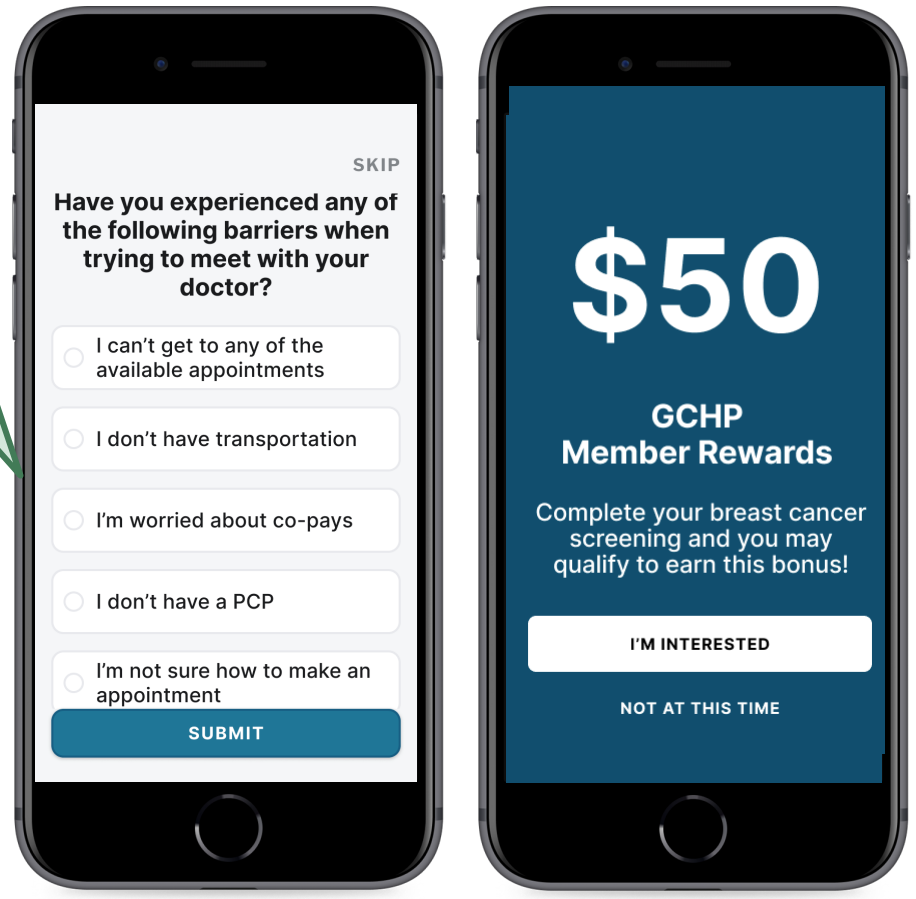
Leveraging daily engagement to address member needs and drive care gap closure activities

Members are engaging with personalized in-app experiences to earn rewards for key preventive services and care gap closure activities.



Members receive targeted experiences to learn more about chronic disease management boost health literacy.

Spanish-speaking members are showing a ~40% Click Rate to key in-app messages



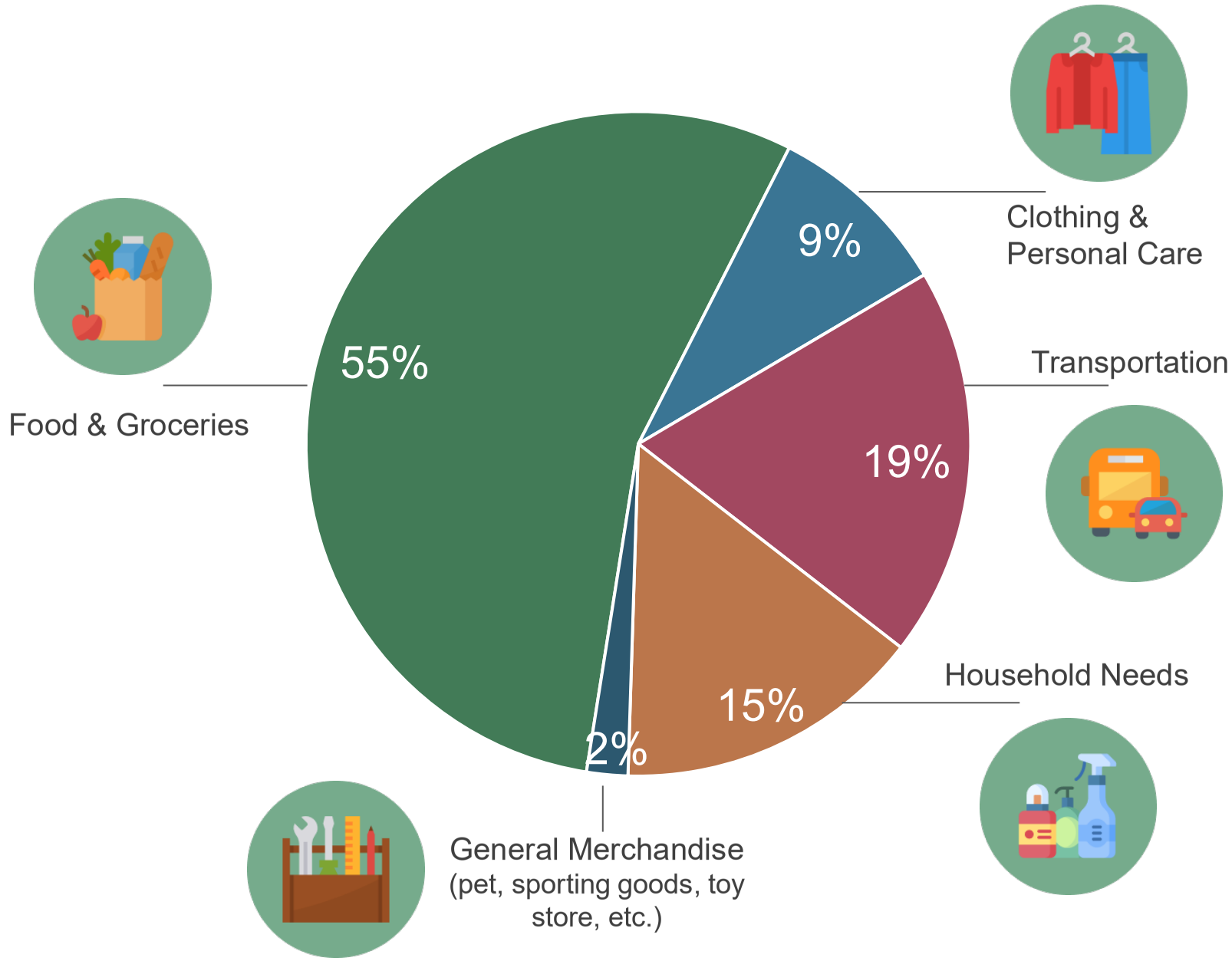
Wellth uncovers daily obstacles and barriers to care to guide members towards resources, supports and targeted calls to action.

Return to Agenda

Over $356k in rewards has been reinvested in Gold Coast members and local communities at stores such as Vallarta Supermarket and Superior Grocers.

Members use their rewards to address a variety of SDOH needs.

How Gold Coast Members Spend Their Wellth Rewards



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Utilization Program Demographic & Outcomes

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Utilization Program Demographics (GCHP Analysis)

Age Group	Gender	Race and Ethnicity	Primary Language	Top Cities
32% 55-64 years	69% Female	73% Hispanic or Latino	57% English	42% Oxnard
23% 45-54 years	31% Male	75% Some Other Race	42% Spanish	13% Ventura

PCP Assignment: 49% VCMC, 20% Clinicas, 18% CMH, 4% Dignity

Return to Agenda

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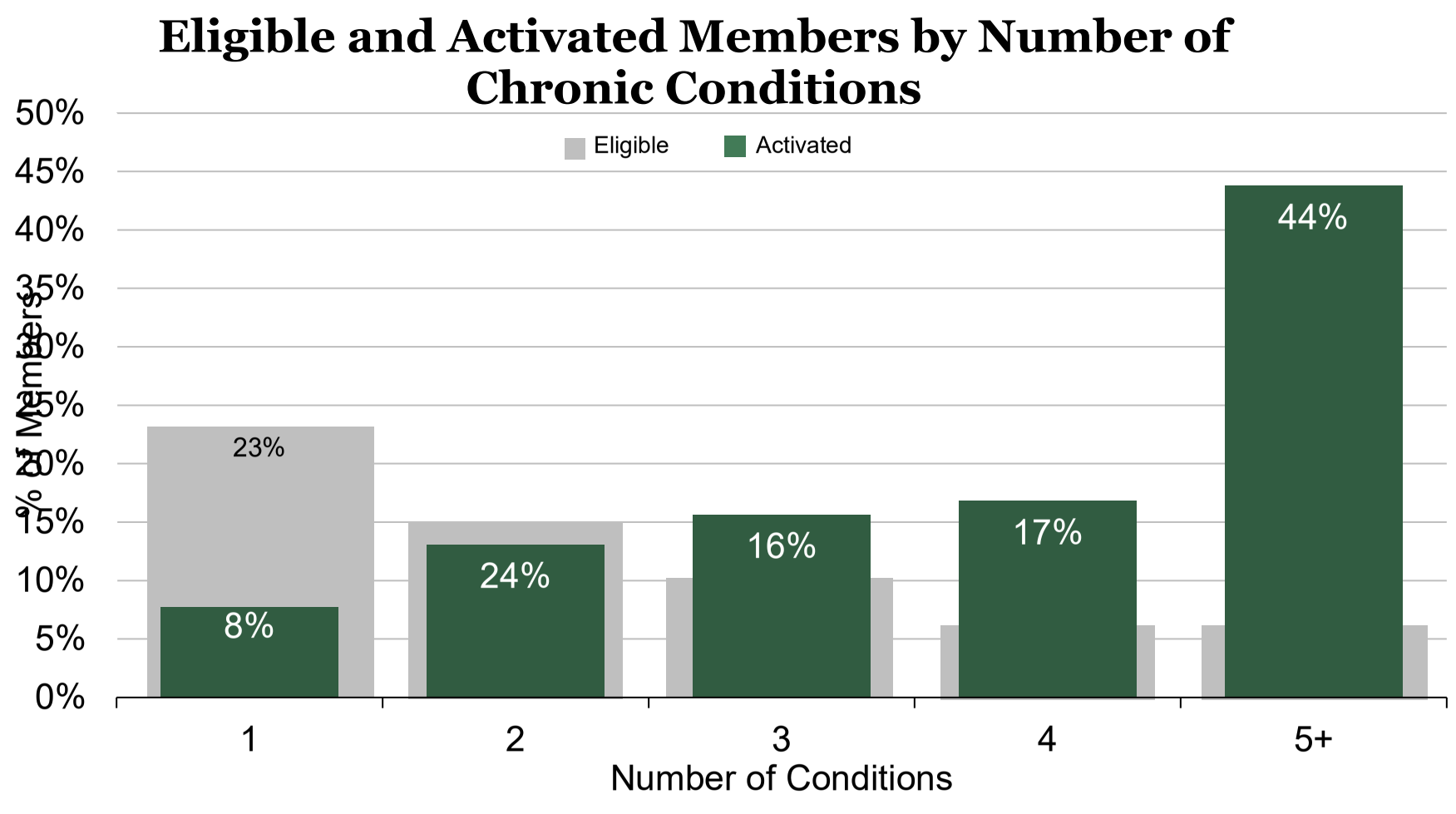
Wellth has targeted the highest-risk, most complex members for enrollment with **76% of all enrolled members managing 3+ chronic conditions.**



Note - Data through May 28, 2024.

67 of 164 pages
Return to Agenda

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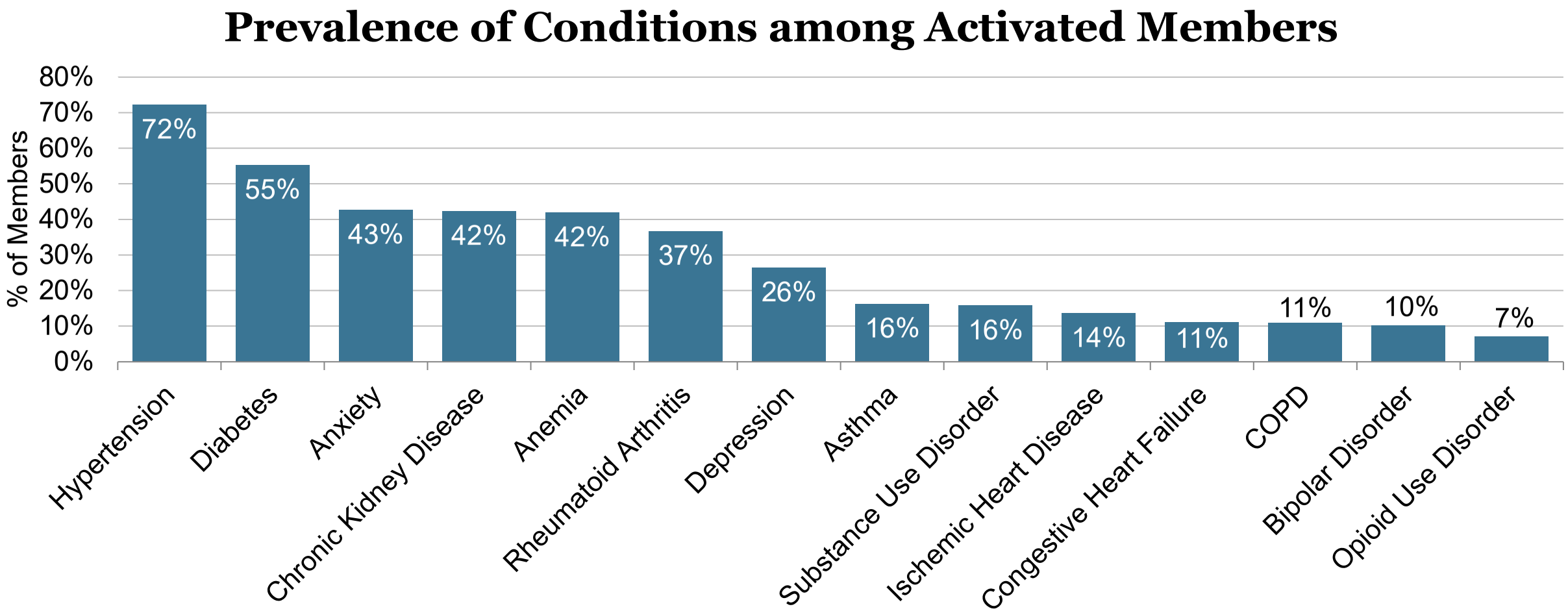
Members are managing a range of physical and behavioral health conditions. Nearly all members have a diagnosis of hypertension and half of the enrolled population have diabetes.

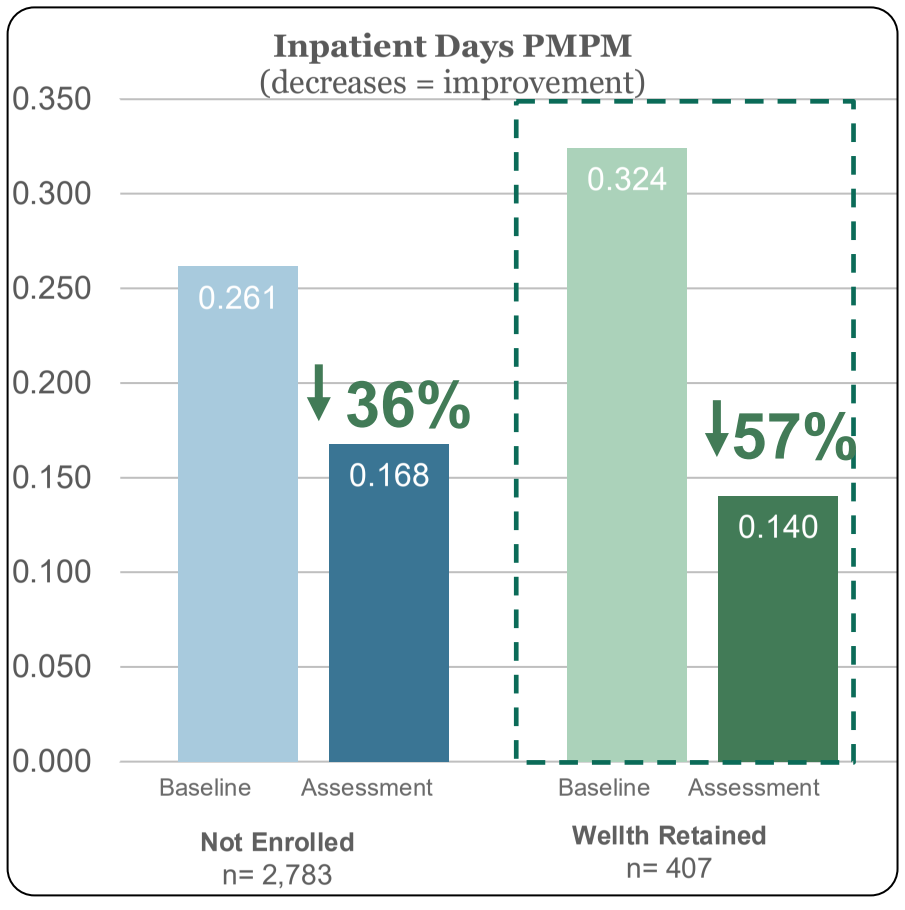


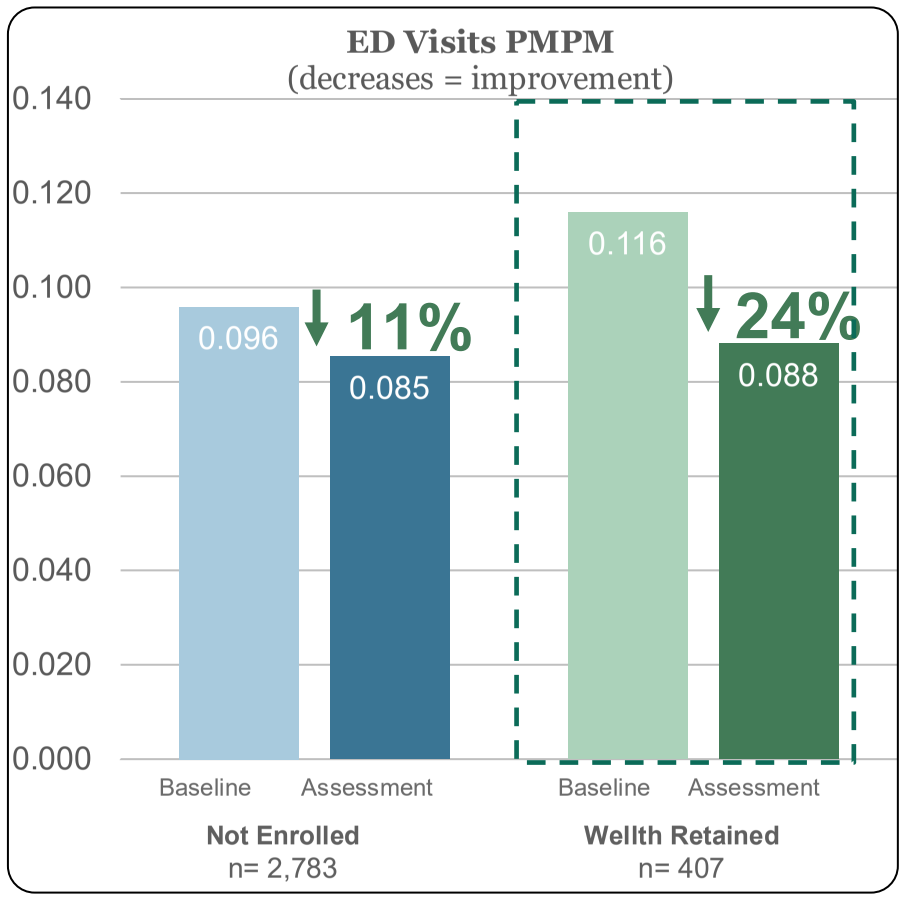
Data through May 28, 2024.

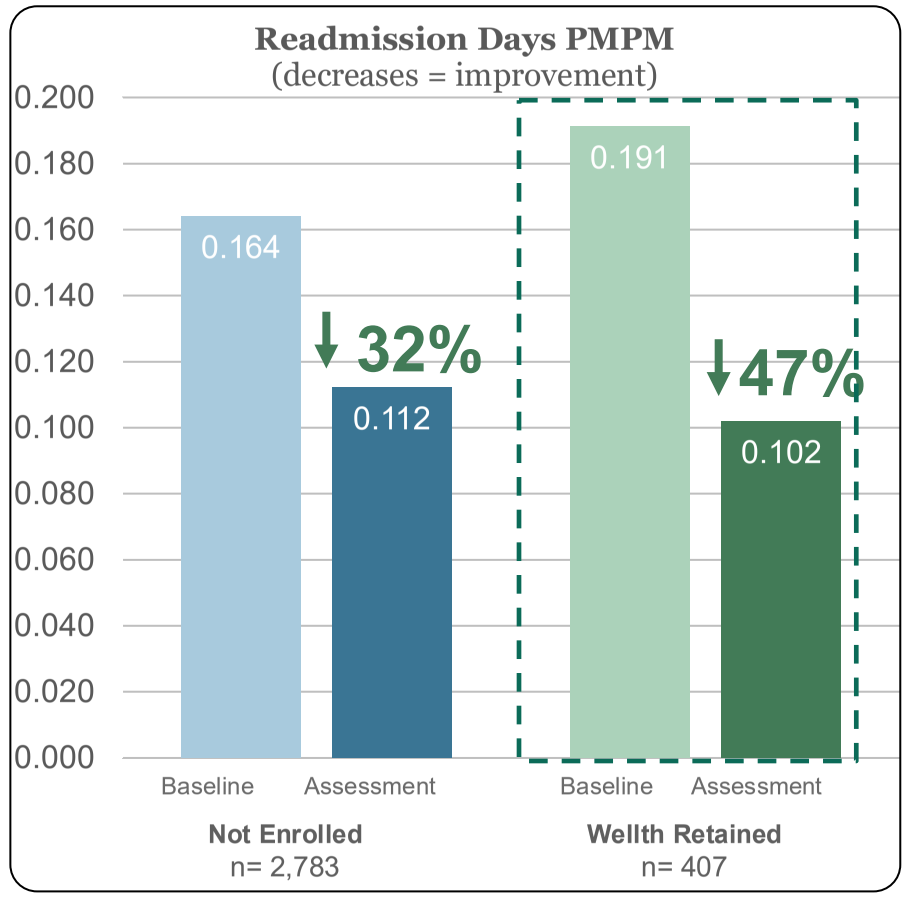
68 of 164 pages

Return to Agenda

Wellth members are demonstrating strong improvements to high-cost utilization with a **57% reduction in inpatient stays, 24% reduction in emergency department visits and a 47% reduction in readmissions.**







Claims data through 5/9/2024. Analysis limited to members with continuous coverage 12 months before and 6 months after index. Index date for non-members = mid-program outreach date. Not enrolled population limited to members targeted for the program and whose data continues to be shared with Wellth.

Baseline= 12 months prior to enrollment
Assessment= 6 months post-enrollment

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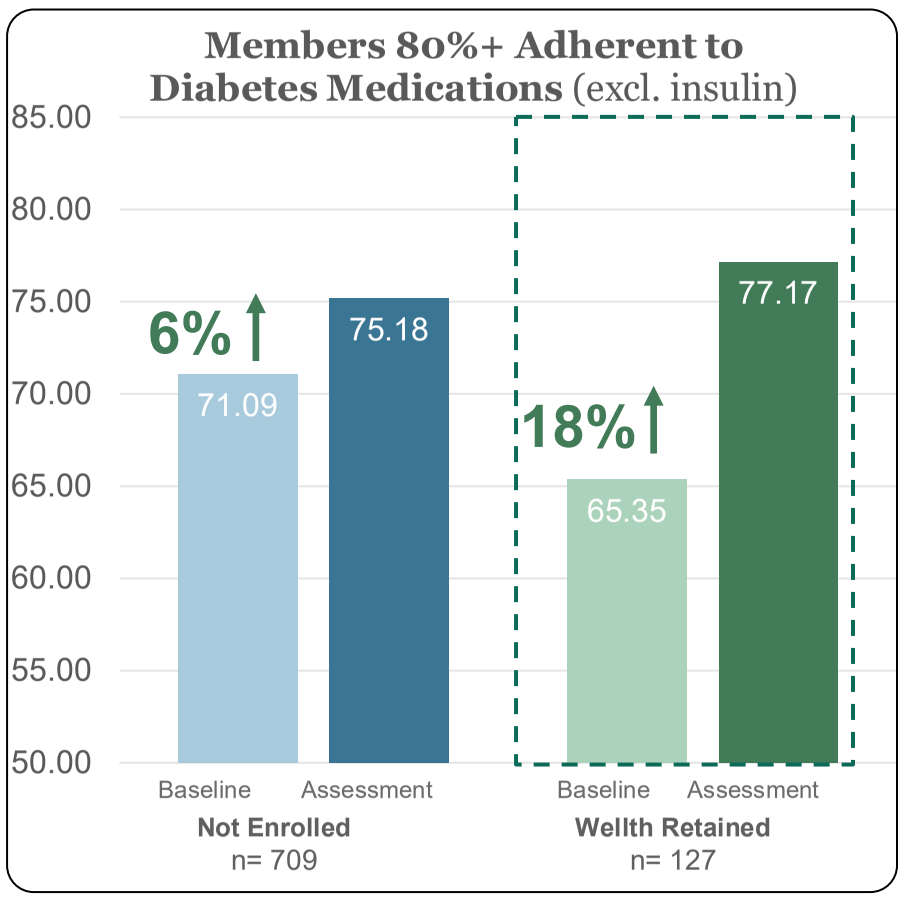
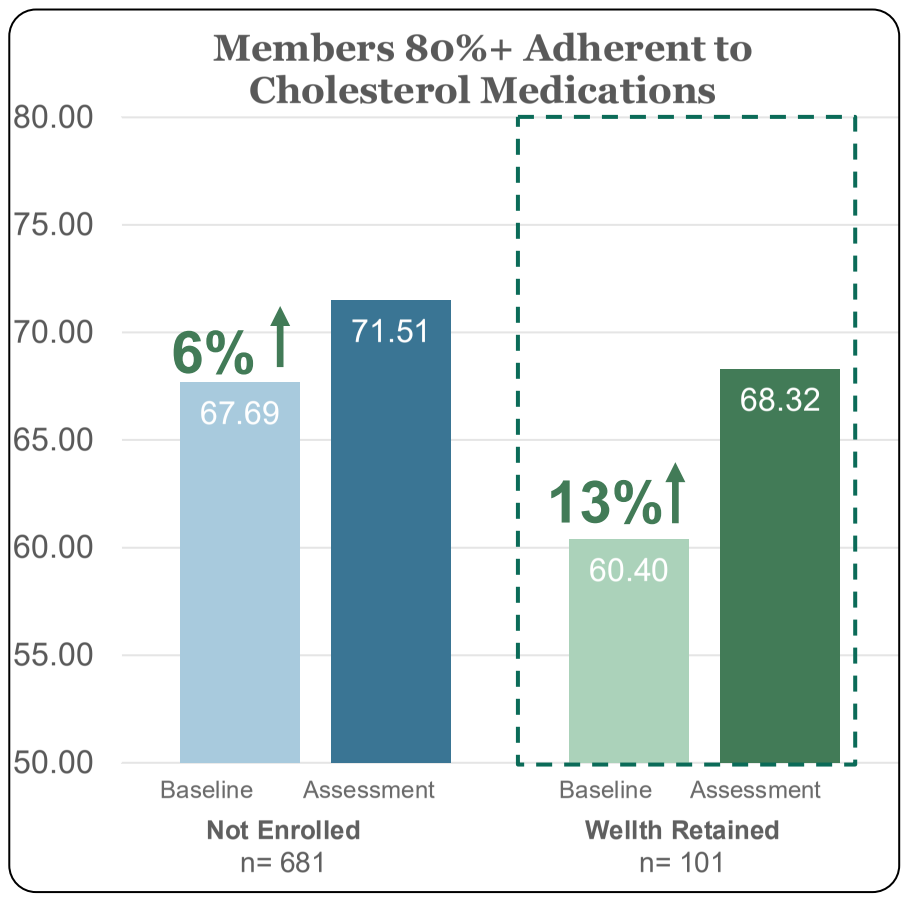
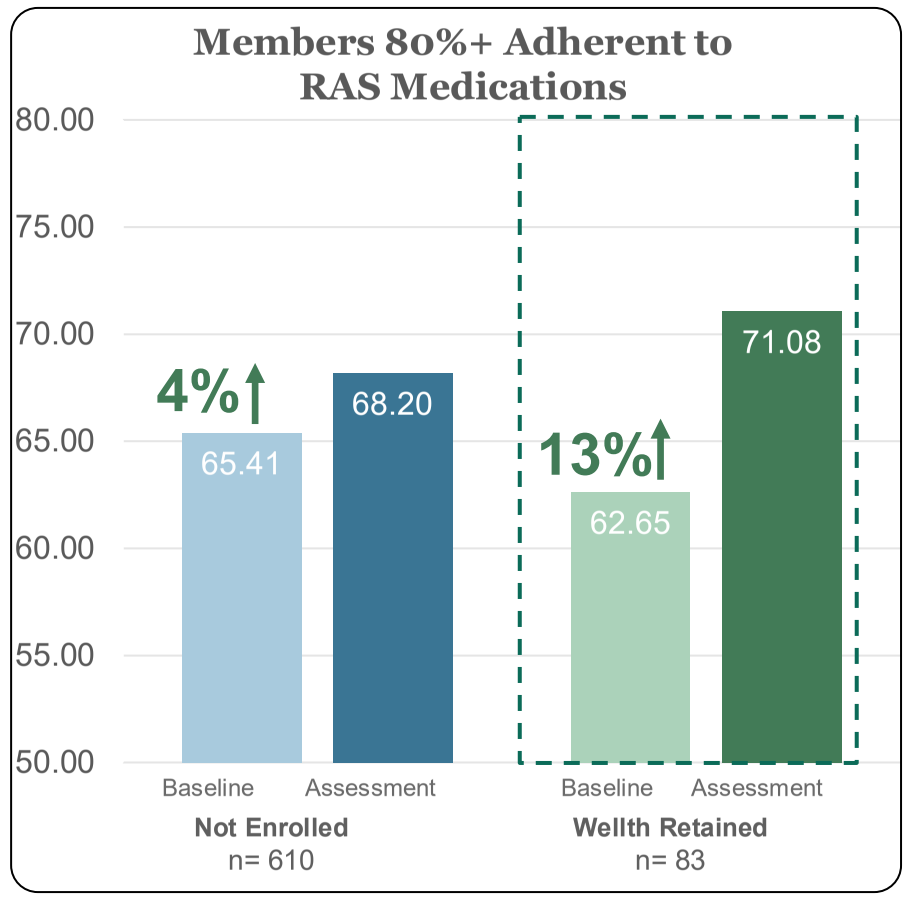
Six months post-enrollment, **Wellth members have seen a 14% improvement in medication adherence across drug classes.**







Data through 4/21/2024. Comparison groups= Not Enrolled and Wellth Retained. Analysis limited to members with full coverage and available claims data 9 months pre- and 6 months post-enrollment. Index date for non-enrolled members = mid-program outreach date. Not enrolled population limited to members targeted for the program and whose data continues to be shared with Wellth.

Baseline= 9 months prior to enrollment
Assessment= 6 months post-enrollment

Return to Agenda

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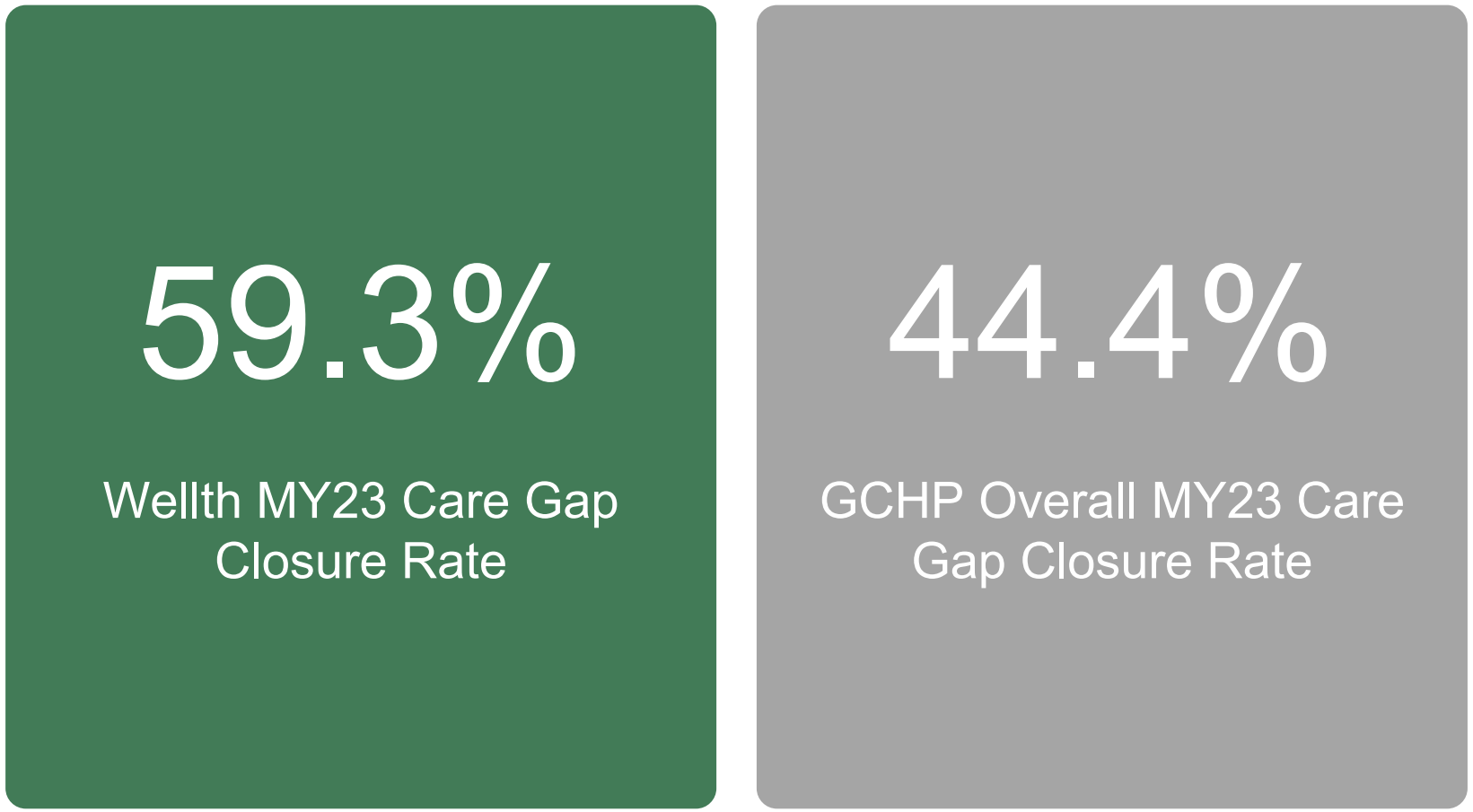
Despite launching the utilization program in September 2023, Wellth members outperformed the non-Wellth group across key MCAS quality metrics such as BCS, CCS, and CBP.

GCHP MY2023 MCAS Performance Review
Comparing Wellth Members vs. Not Enrolled "Control"

Measure	Not Enrolled	Wellth	Absolute Difference (Wellth vs Not Enrolled)
Breast Cancer Screening (BCS)	59%	67%	8%
Cervical Cancer Screening (CCS)	43%	53%	10%
Controlling Blood Pressure (CBP)	29%	31%	2%
Hemoglobin A1c Control for Patients with Diabetes (HBD)	44%	44%	-

Data through 5/28/2024. Comparison groups= Not Enrolled and Wellth Retained. Analysis limited to members with full coverage and available data. Index date for non-enrolled members = mid-program outreach date.

Wellth members closed 59.3% of their care gaps in MY23 compared to 44.4% of care gaps closed by GCHP membership.



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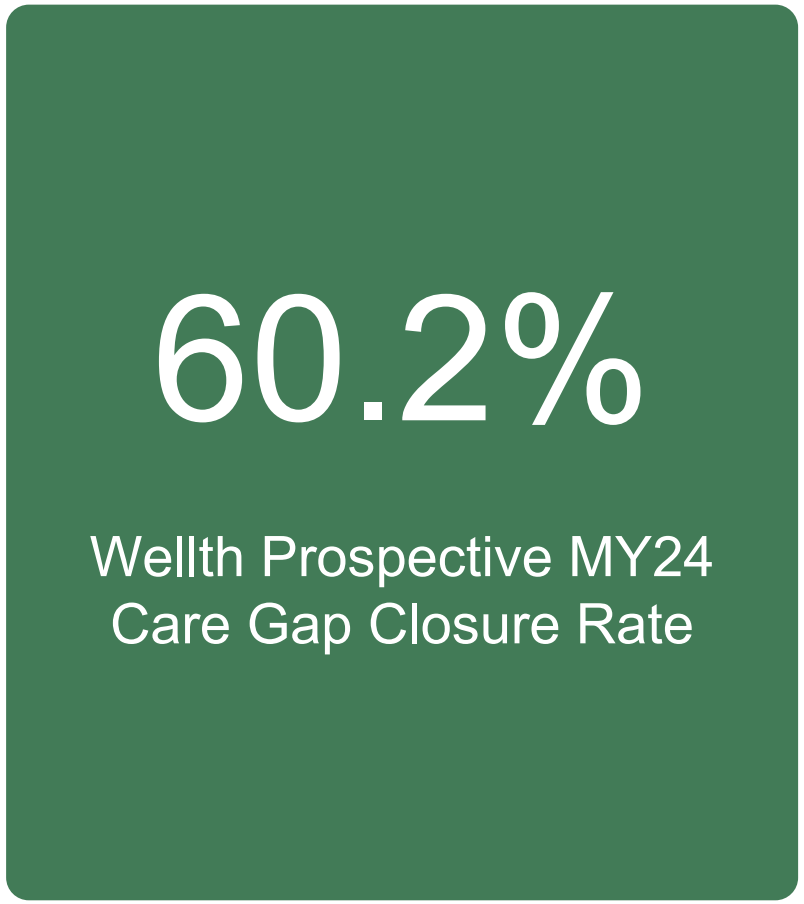
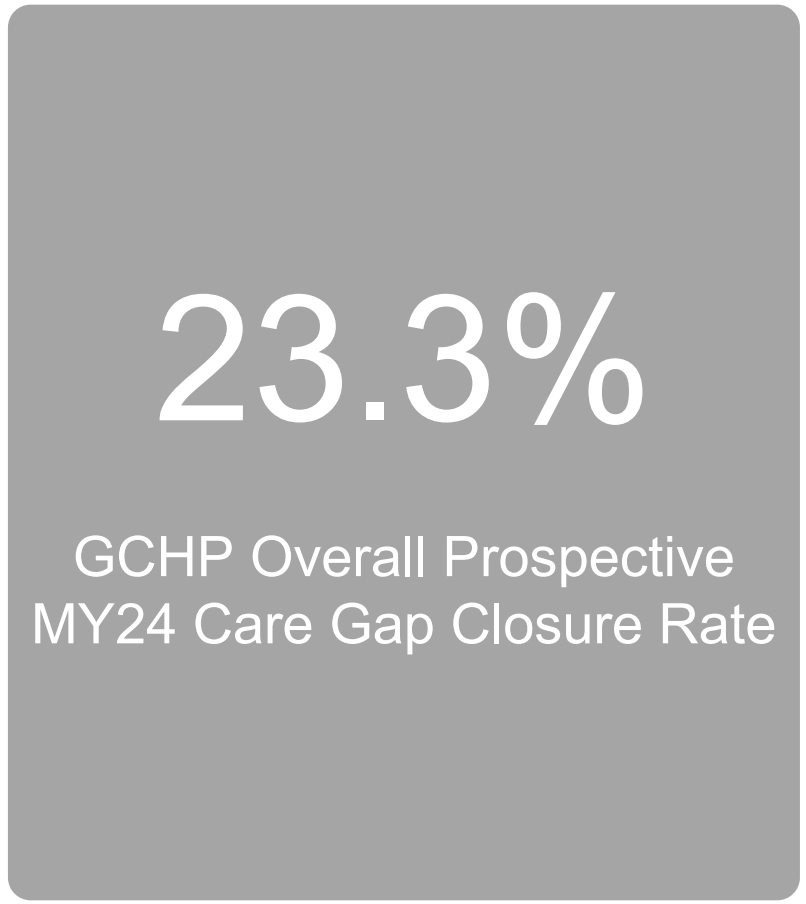
Prospective MY24 Care Gap Closure Analysis (Utilization Program - GCHP Analysis)

Wellth members closed 60.2% of their care gaps in MY24 compared to 23.3% of care gaps closed by GCHP membership.





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Quality Improvement Program Demographics & Outcomes

Return to Agenda

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QI Program Demographics (GCHP Analysis)

Age Group	Gender	Race and Ethnicity	Primary Language	Top Cities
28% 55-64 years	79% Female	65% Hispanic or Latino	58% English	41% Oxnard
27% 18-34 years	21% Male	68% Some Other Race	41% Spanish	14% Ventura

PCP Assignment: 44% VCMC, 20% Clinicas, 18% CMH, 4% Dignity

Return to Agenda

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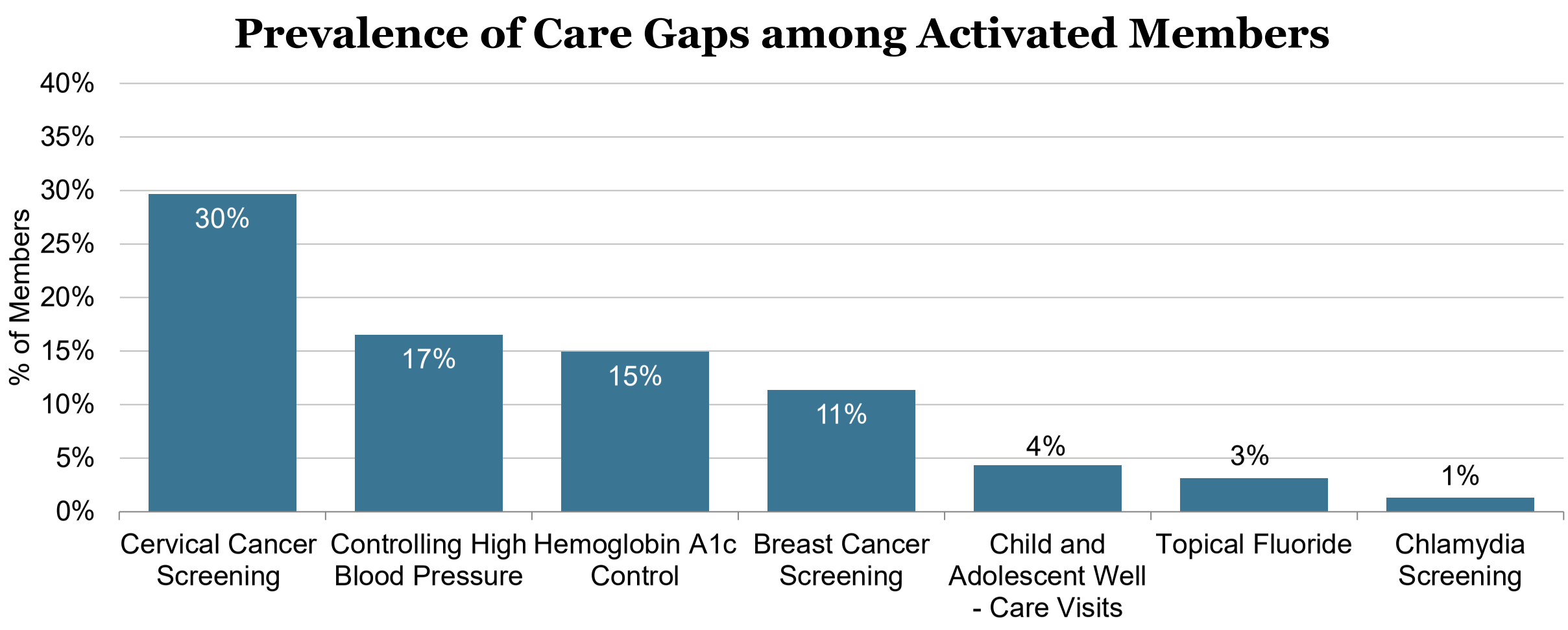
Aligned with program design, Wellth has targeted enrollments for members with cervical cancer screening, breast cancer screening, blood pressure, and A1c control care gaps.



Data through May 28, 2024.

76 of 164 pages
Return to Agenda

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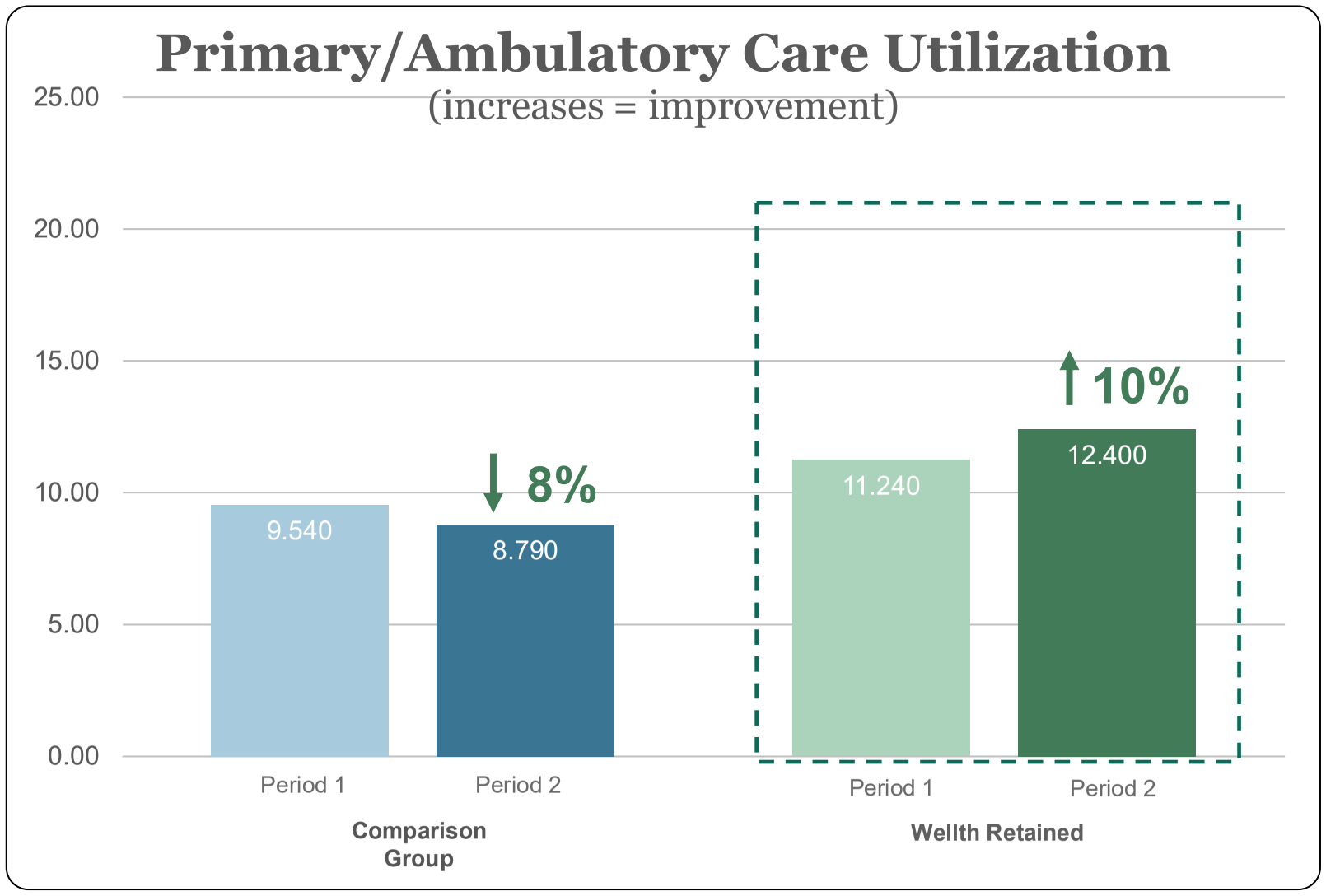
Wellth members have seen increased Primary Care engagement since enrollment.



Period 1= 5/31/2022 – 5/30/2023
Period 2= 5/31/2023 – 5/30/2024

*Note: Reviewing the **Wellth Eligible** population across two consecutive 12-month periods indicates that 3,626 members have PCP claims within both periods.

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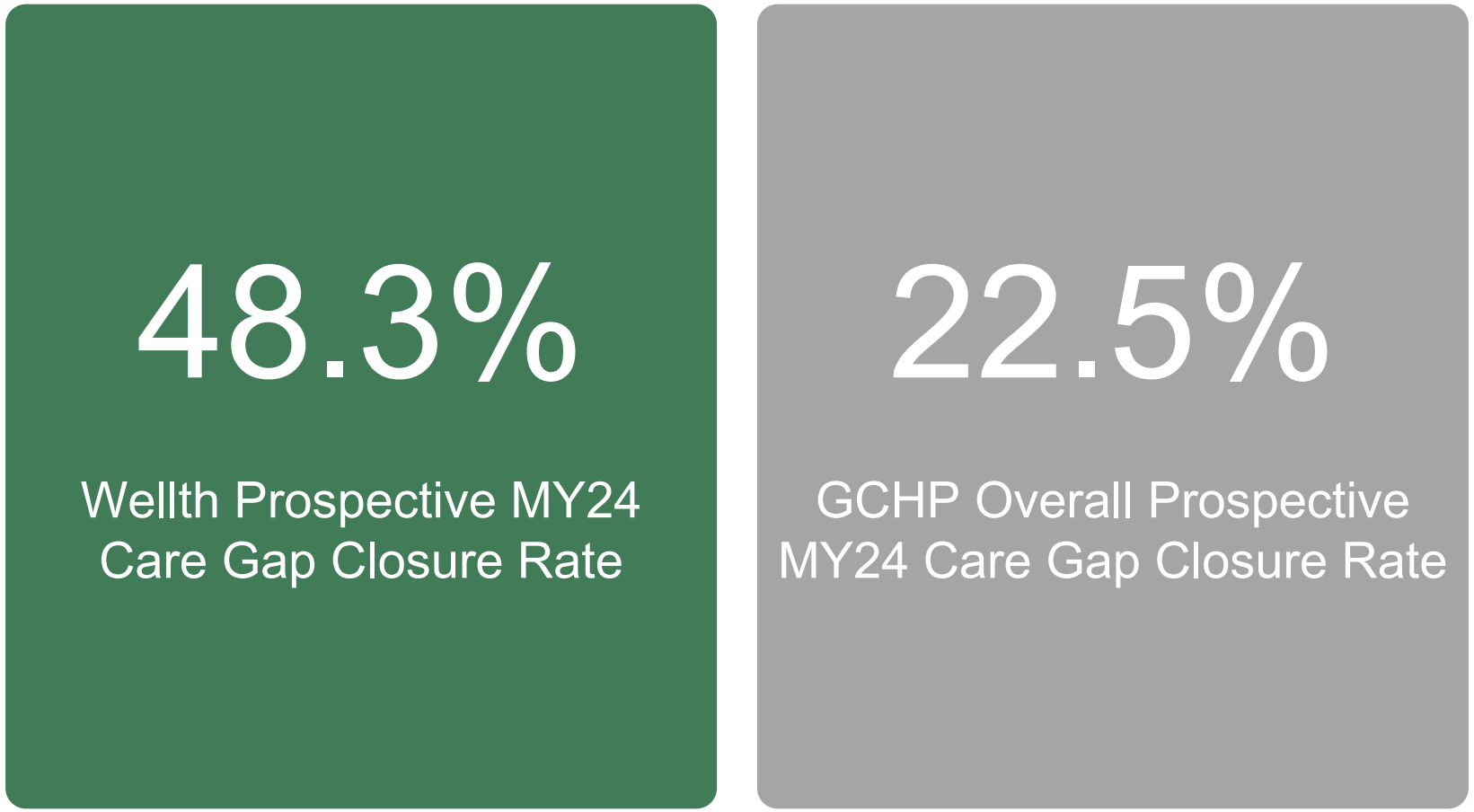
In 2024, Wellth members are consistently outperforming the non-Wellth group across key MCAS quality metrics, **with a 4%+ stronger performance across BCS, CCS, BCP, and HBD measures.**

GCHP MY2024 MCAS Performance Review Through March 2024
Comparing Wellth Members vs. Not Enrolled "Control"

Measure	Not Enrolled	Wellth	Absolute Difference (Wellth vs Not Enrolled)
Breast Cancer Screening (BCS)	13%	32%	19%
Cervical Cancer Screening (CCS)	7%	15%	8%
Controlling Blood Pressure (CBP)	37%	41%	4%
Hemoglobin A1c Control for Patients with Diabetes (HBD)	11%	17%	6%

Data through 5/28/2024. Comparison groups= Not Enrolled and Wellth Retained. Analysis limited to members with full coverage and available data. Index date for non-enrolled members = mid-program outreach date.

Wellth members closed 48.3% of their care gaps in MY24 compared to 22.5% of care gaps close by GCHP membership.



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Upcoming Activities

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GCHP Model of Care—Quality Health Outcomes by Design—Wellth

Following the success of the initial Utilization & QI program phases, GCHP and Wellth teams to align on priorities and focuses for Phase 4.

GCHP and Wellth teams to align on enrollment focus for Phase 4

Return to Agenda

1. Optimize outreach and enrollment strategies to achieve 5,500 activations in Phase 4

GCHP members were particularly receptive to outreach materials shared during Phases 1-3. To maximize high-value enrollments, Wellth and GCHP will partner on review and approval of additional outreach materials to align with Wellth's best in class enrollment strategy. Additionally, teams to explore pathways for provider referrals for program participation.

2. Leverage daily member engagement to support GCHP's 2024 goals and encourage member retention

As demonstrated by extremely strong in-app engagement, especially with the Spanish-speaking population, Wellth will continue to support and reinforce GCHP's 2024 initiatives and priorities by encouraging members to close MCAS care gaps with the use of health literacy and action rewards, driving members to get timely Rx fills, and promoting available health plan resources. As the program continues to expand, GCHP will realize greater impact on overall measure performance.

Return to Agenda

Thank you, Gold Coast Health Plan!

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AGENDA ITEM NO. D

TO: Executive Finance Committee

FROM: Sara Dersch, Chief Financial Officer

DATE: June 20, 2024

SUBJECT: Development of a Quality Investment Focused Budget: Review of April 2023-2024 Year-To-Date as Solid Financial Foundation

PowerPoint with Verbal Presentation

ATTACHMENTS:

April 2024 Year-To-Date Financial Results

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

April 2024 Year-to-Date Financial Results

Executive Finance Committee
June 20, 2024
Sara Dersch, Chief Financial Officer

Return to Agenda

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

April Year-To-Date (YTD) Financial Results Summary

- April's $2.4M increase in net assets is $5.3M favorable to Reforecast, bringing YTD net assets to $10.8M. The YTD variance of $(28.7M) versus Reforecast is primarily the result of investment in the Ventura County care delivery system as well as prior year premium revenue adjustments from the State. Major contributors:
  - YTD Results reflect an additional $18.3M in medical benefit costs associated with the earlier-than-forecasted provisioning of Quality Incentive Pool and Program (QIPP) payments; these investments help our community partners have resources to ensure access to and delivery of high-quality care for our members.
  - Decrease of $12.9M in revenue is a result of a $16.1M "take-back" by the State associated with the State's assessment that our members in 2023 had lower acuity (were healthier in general than originally forecasted) offset by other retroactive favorability.
  - Consolidated (core administration plus Project Portfolio) administrative expenses are $(0.9M) versus Reforecast primarily Operations of the Future readiness.
- While there are, and always will be, economic events that we cannot foresee (ex: retroactive rate adjustments), GCHP management continues to diligently monitor and take action on those Income Statement and Balance Sheet line items that are controllable and monitor those items that are not controllable.

Return to Agenda

April YTD P&L: Revenue

($Ms except pmpms & mm)	MTD Actual	MTD Reforecast	MTD Var Fav / (Unfav)	YTD Actual	YTD Reforecast	YTD Var Fav / (Unfav)
Member Months	249,931	234,573	15,358	2,520,037	2,468,244	51,793
Revenue	$ 118.8	$ 85.1	$ 33.7	$ 910.7	$ 867.8	$ 42.9
pmpm	*$ 475.50*	*$ 362.95*	*$ 112.55*	*$ 361.38*	*$ 351.59*	*$ 9.79*
Non-Operating Revenue / (Expense)	$ 2.7	$ 0.9	$ 1.8	$ 15.6	$ 11.3	$ 4.3
pmpm	*$ 10.85*	*$ 3.84*	*$ 7.01*	*$ 6.19*	*$ 4.58*	*$ 1.61*
Medical Benefits	$ 110.5	$ 78.4	$ (32.1)	$ 808.9	$ 746.8	$ (62.1)
pmpm	*$ 442.20*	*$ 334.35*	*$ (107.9)*	*$ 321.00*	*$ 302.57*	*$ (18.4)*
% of Revenue	*93.0%*	*92.1%*		*88.8%*	*86.1%*	
Admin Exp	$ 6.1	$ 7.7	$ 1.7	$ 72.5	$ 73.1	$ 0.6
pmpm	*$ 24.33*	*$ 32.98*	*$ 8.65*	*$ 28.77*	*$ 29.62*	*$ 0.85*
% of Revenue	*5.1%*	*9.1%*		*8.0%*	*8.4%*	
Project Portfolio	$ 3.1	$ 2.8	$ (0.3)	$ 21.1	$ 19.7	$ (1.5)
pmpm	*$ 12.46*	*$ 11.98*	*$ (0.48)*	*$ 8.38*	*$ 7.96*	*$ (0.41)*
% of Revenue	*2.6%*	*3.3%*		*2.3%*	*2.3%*	
Operating Gain/(Loss)	$ (0.9)	$ (3.8)	$ 3.0	$ 8.1	$ 28.2	$ (20.1)
	$ (3.50)	*$ (16.36)*	*$ 12.87*	*$ 3.22*	*$ 11.43*	*$ (8.20)*
Retro Revenue Adjustments	$ 0.5	$ -	$ 0.5	$ (12.9)	$ -	$ (12.9)
pmpm	*$ 2.14*	*$ -*	*$ 2.14*	*$ (5.13)*	*$ -*	*$ (5.13)*
Total Increase / (Decrease) in Unrestricted Net Assets	$ 2.4	$ (2.9)	$ 5.3	$ 10.8	$ 39.5	$ (28.7)
pmpm	*$ 9.50*	*$ (12.52)*	*$ 22.02*	*$ 4.29*	*$ 16.01*	*$ (11.72)*
% of Revenue	*2.0%*	*-3.4%*		*1.2%*	*4.6%*	

- April revenue is greater than Reforecast primarily due to $26.5M in pass-through incentive payments* received from the state for:
  - $13.2M for the Housing and Homeless Incentive Program (community-based investments in addressing homelessness and keeping people housed).
  - $11.9M for other California Advancing and Innovating Medi-Cal (CalAIM)-related incentives.
  - $1.4M for the Behavioral Health Incentive Program (providing patient-centered care using a systematic approach).
- $16.1M Revenue "Take Back" in January is a result of a retroactive reduction in 2023 rates and is partially offset by $3.2M pick-up membership-related retroactivity, resulting in a cumulative adjustment of $(12.9M).

**Note: See "Description of State Incentive Programs" exhibit in the Appendix for additional detail of programs.*

Return to Agenda

April YTD P&L: Medical Benefits

($Ms except pmpms & mm)	MTD Actual	MTD Reforecast	MTD Var Fav / (Unfav)	YTD Actual	YTD Reforecast	YTD Var Fav / (Unfav)
Member Months	249,931	234,573	15,358	2,520,037	2,468,244	51,793
Revenue	$ 118.8	$ 85.1	$ 33.7	$ 910.7	$ 867.8	$ 42.9
pmpm	*$ 475.50*	*$ 362.95*	*$ 112.55*	*$ 361.38*	*$ 351.59*	*$ 9.79*
Non-Operating Revenue / (Expense)	$ 2.7	$ 0.9	$ 1.8	$ 15.6	$ 11.3	$ 4.3
pmpm	*$ 10.85*	*$ 3.84*	*$ 7.01*	*$ 6.19*	*$ 4.58*	*$ 1.61*
Medical Benefits	$ 110.5	$ 78.4	$ (32.1)	$ 808.9	$ 746.8	$ (62.1)
pmpm	*$ 442.20*	*$ 334.35*	*$ (107.9)*	*$ 321.00*	*$ 302.57*	*$ (18.4)*
% of Revenue	*93.0%*	*92.1%*		*88.8%*	*86.1%*	
Admin Exp	$ 6.1	$ 7.7	$ 1.7	$ 72.5	$ 73.1	$ 0.6
pmpm	*$ 24.33*	*$ 32.98*	*$ 8.65*	*$ 28.77*	*$ 29.62*	*$ 0.85*
% of Revenue	*5.1%*	*9.1%*		*8.0%*	*8.4%*	
Project Portfolio	$ 3.1	$ 2.8	$ (0.3)	$ 21.1	$ 19.7	$ (1.5)
pmpm	*$ 12.46*	*$ 11.98*	*$ (0.48)*	*$ 8.38*	*$ 7.96*	*$ (0.41)*
% of Revenue	*2.6%*	*3.3%*		*2.3%*	*2.3%*	
Operating Gain/(Loss)	$ (0.9)	$ (3.8)	$ 3.0	$ 8.1	$ 28.2	$ (20.1)
	$ (3.50)	*$ (16.36)*	*$ 12.87*	*$ 3.22*	*$ 11.43*	*$ (8.20)*
Retro Revenue Adjustments	$ 0.5	$ -	$ 0.5	$ (12.9)	$ -	$ (12.9)
pmpm	*$ 2.14*	*$ -*	*$ 2.14*	*$ (5.13)*	*$ -*	*$ (5.13)*
Total Increase / (Decrease) in Unrestricted Net Assets	$ 2.4	$ (2.9)	$ 5.3	$ 10.8	$ 39.5	$ (28.7)
pmpm	*$ 9.50*	*$ (12.52)*	*$ 22.02*	*$ 4.29*	*$ 16.01*	*$ (11.72)*
% of Revenue	*2.0%*	*-3.4%*		*1.2%*	*4.6%*	

- YTD MBR of 88.8%, while exceeding forecast by 2.7%, reflects reinvestment in our care delivery system. The primary driver of the MBR is the increase in QFP payments of $18.3M vs forecast (YTD spend is $31.6M; forecast is $13.7M).
- YTD Medical Benefit spend reflects unforecasted State incentive "pass-through" (meaning Gold Coast is simply the administrator) program expenses totaling $26.5M (note: the expenses are offset by a commensurate payment from the State).
- Remaining Medical Benefits variance of $17.3M is attributed to:
  - Fee for Service (FFS) utilization volume associated with the higher than expected membership and a unit cost increase.
  - Increase in member incentives vs Reforecast.

Return to Agenda

April YTD P&L: Medical Benefit Categories

	Apr 2024	April 2024 Year-To-Date		Variance	Variance
	Actual	Actual	Reforecast	Fav / (Unfav)	%
Medical Benefits:					
Capitation:					
PCP, Specialty, Kaiser, NEMT & Vision	$ 8,281,865	$ 79,433,741	$ 76,447,178	$ (2,986,563)	-3.9%
ECM	570,953	4,239,081	8,228,473	3,989,391	48.5%
Total Capitation	8,852,818	83,672,823	84,675,651	1,002,829	1.2%
FFS Claims:					
Inpatient	22,871,301	175,195,933	169,867,541	(5,328,393)	-3.1%
LTC / SNF	10,888,347	151,207,601	164,102,184	12,894,582	7.9%
Outpatient	7,597,207	71,406,117	67,080,672	(4,325,444)	-6.4%
Laboratory and Radiology	899,588	10,686,213	8,058,216	(2,627,997)	-32.6%
Directed Payments - Provider	1,091,103	25,031,221	21,902,323	(3,128,897)	-14.3%
Emergency Room	2,645,653	32,542,007	31,098,836	(1,443,170)	-4.6%
Physician Specialty	8,160,588	67,392,972	65,183,061	(2,209,911)	-3.4%
Primary Care Physician	4,546,525	30,282,415	27,462,598	(2,819,817)	-10.3%
Home & Community Based Services	4,087,490	28,722,905	21,926,404	(6,796,500)	-31.0%
Applied Behavioral Analysis/Mental Health Services	3,241,476	30,496,426	31,038,938	542,512	1.7%
Quality Incentives/Provider Reserves	*26,585,020*	*28,861,073*	-	(28,861,073)	0.0%
Quality Incentive Provider Program (QIPP)	*2,129,146*	*31,624,083*	*13,277,644*	(18,346,439)	-138.2%
Other Medical Professional	474,105	4,149,974	3,907,963	(242,011)	-6.2%
Other Fee For Service	2,656,492	15,999,464	12,502,714	(3,496,750)	-28.0%
Transportation	909,450	2,007,220	2,816,137	808,917	28.7%
Total Claims	98,783,490	705,521,431	640,228,872	(65,376,752)	-10.2%
Provider Grant Program	-	-	4,166,667	4,166,667	100.0%
Medical & Care Management	2,805,115	20,735,070	18,360,448	(2,374,622)	-12.9%
Reinsurance	396,068	1,560,083	985,566	(574,516)	-58.3%
Claims Recoveries	(317,481)	(2,642,596)	(1,589,193)	1,053,403	-66.3%
Sub-total	2,883,702	19,736,751	21,923,488	2,270,931	10.4%
Total Medical Benefits	**110,520,010**	**808,931,004**	**746,828,012**	**(62,102,993)**	**-8.3%**

Return to Agenda

April YTD P&L: Administrative Costs

($Ms except pmpms & mm)	MTD Actual	MTD Reforecast	MTD Var Fav / (Unfav)	YTD Actual	YTD Reforecast	YTD Var Fav / (Unfav)
Member Months	249,931	234,573	15,358	2,520,037	2,468,244	51,793
Revenue	$ 118.8	$ 85.1	$ 33.7	$ 910.7	$ 867.8	$ 42.9
pmpm	*$ 475.50*	*$ 362.95*	*$ 112.55*	*$ 361.38*	*$ 351.59*	*$ 9.79*
Non-Operating Revenue / (Expense)	$ 2.7	$ 0.9	$ 1.8	$ 15.6	$ 11.3	$ 4.3
pmpm	*$ 10.85*	*$ 3.84*	*$ 7.01*	*$ 6.19*	*$ 4.58*	*$ 1.61*
Medical Benefits	$ 110.5	$ 78.4	$ (32.1)	$ 808.9	$ 746.8	$ (62.1)
pmpm	*$ 442.20*	*$ 334.35*	*$ (107.9)*	*$ 321.00*	*$ 302.57*	*$ (18.4)*
% of Revenue	*93.0%*	*92.1%*		*88.8%*	*86.1%*	
Admin Exp	$ 6.1	$ 7.7	$ 1.7	$ 72.5	$ 73.1	$ 0.6
pmpm	*$ 24.33*	*$ 32.98*	*$ 8.65*	*$ 28.77*	*$ 29.62*	*$ 0.85*
% of Revenue	*5.1%*	*9.1%*		*8.0%*	*8.4%*	
Project Portfolio	$ 3.1	$ 2.8	$ (0.3)	$ 21.1	$ 19.7	$ (1.5)
pmpm	*$ 12.46*	*$ 11.98*	*$ (0.48)*	*$ 8.38*	*$ 7.96*	*$ (0.41)*
% of Revenue	*2.6%*	*3.3%*		*2.3%*	*2.3%*	
Operating Gain/(Loss)	$ (0.9)	$ (3.8)	$ 3.0	$ 8.1	$ 28.2	$ (20.1)
	$ (3.50)	*$ (16.36)*	*$ 12.87*	*$ 3.22*	*$ 11.43*	*$ (8.20)*
Retro Revenue Adjustments	$ 0.5	$ -	$ 0.5	$ (12.9)	$ -	$ (12.9)
pmpm	*$ 2.14*	*$ -*	*$ 2.14*	*$ (5.13)*	*$ -*	*$ (5.13)*
Total Increase / (Decrease) in Unrestricted Net Assets	$ 2.4	$ (2.9)	$ 5.3	$ 10.8	$ 39.5	$ (28.7)
pmpm	*$ 9.50*	*$ (12.52)*	*$ 22.02*	*$ 4.29*	*$ 16.01*	*$ (11.72)*
% of Revenue	*2.0%*	*-3.4%*		*1.2%*	*4.6%*	

- Controlling administrative costs continues to be a Management focus.
- The YTD combined variance of $(900K) between Administrative Expense and Project Portfolio is attributed to Project Portfolio spend, including Operations of the Future preparedness for July "go-live."
- Administrative costs favorability is a result of an increase in the amount of quality-related spend recategorized to Medical Benefits. GCHP has spent more than reforecast on member incentives, thus the increase in the recategorization.
- GCHP Management expects cost discipline will result in administrative costs being equal or less than Reforecast by the end of the year.

Return to Agenda

April YTD P&L: Net Assets

($Ms except pmpms & mm)	MTD Actual	MTD Reforecast	MTD Var Fav / (Unfav)	YTD Actual	YTD Reforecast	YTD Var Fav / (Unfav)
Member Months	249,931	234,573	15,358	2,520,037	2,468,244	51,793
Revenue	$ 118.8	$ 85.1	$ 33.7	$ 910.7	$ 867.8	$ 42.9
pmpm	*$ 475.50*	*$ 362.95*	*$ 112.55*	*$ 361.38*	*$ 351.59*	*$ 9.79*
Non-Operating Revenue / (Expense)	$ 2.7	$ 0.9	$ 1.8	$ 15.6	$ 11.3	$ 4.3
pmpm	*$ 10.85*	*$ 3.84*	*$ 7.01*	*$ 6.19*	*$ 4.58*	*$ 1.61*
Medical Benefits	$ 110.5	$ 78.4	$ (32.1)	$ 808.9	$ 746.8	$ (62.1)
pmpm	*$ 442.20*	*$ 334.35*	*$ (107.9)*	*$ 321.00*	*$ 302.57*	*$ (18.4)*
% of Revenue	*93.0%*	*92.1%*		*88.8%*	*86.1%*	
Admin Exp	$ 6.1	$ 7.7	$ 1.7	$ 72.5	$ 73.1	$ 0.6
pmpm	*$ 24.33*	*$ 32.98*	*$ 8.65*	*$ 28.77*	*$ 29.62*	*$ 0.85*
% of Revenue	*5.1%*	*9.1%*		*8.0%*	*8.4%*	
Project Portfolio	$ 3.1	$ 2.8	$ (0.3)	$ 21.1	$ 19.7	$ (1.5)
pmpm	*$ 12.46*	*$ 11.98*	*$ (0.48)*	*$ 8.38*	*$ 7.96*	*$ (0.41)*
% of Revenue	*2.6%*	*3.3%*		*2.3%*	*2.3%*	
Operating Gain/(Loss)	$ (0.9)	$ (3.8)	$ 3.0	$ 8.1	$ 28.2	$ (20.1)
	$ (3.50)	*$ (16.36)*	*$ 12.87*	*$ 3.22*	*$ 11.43*	*$ (8.20)*
Retro Revenue Adjustments	$ 0.5	$ -	$ 0.5	$ (12.9)	$ -	$ (12.9)
pmpm	*$ 2.14*	*$ -*	*$ 2.14*	*$ (5.13)*	*$ -*	*$ (5.13)*
Total Increase / (Decrease) in Unrestricted Net Assets	$ 2.4	$ (2.9)	$ 5.3	$ 10.8	$ 39.5	$ (28.7)
pmpm	*$ 9.50*	*$ (12.52)*	*$ 22.02*	*$ 4.29*	*$ 16.01*	*$ (11.72)*
% of Revenue	*2.0%*	*-3.4%*		*1.2%*	*4.6%*	

In summary, the YTD Net Asset variance of $(28.7M) is primarily the result of:

- Current year premium favorability associated with an increase in membership.
- Quality Funding Program increase in provider participation.
- Operations of the Future expense in excess of Reforecast.
- Retroactive 2023 premium rate adjustment not known at time of Reforecast.

Return to Agenda

Looking Ahead….

- State actions could result in additional prior period revenue take-backs:
  - Covid Testing Risk Corridor adjustment.
  - Prop 56 payments.
  - Targeted Rate Increase Reconciliation.
  - Deceased Member Takebacks for FY 2014 to April 2024.
  - Final 2023 acuity rate adjustment.
  - 2024 Acuity rate adjustment.
- Potential for reduction in Incurred But Not Paid (IBNP): Expected expenses for services provided but not yet submitted for provider reimbursement) in the last quarter of the year.

Return to Agenda

Exhibits

This section contains the following exhibits:

- Description of State Incentive Programs
- Balance Sheet
- Cash and Short-Term Investment Portfolio
- Revenue and Medical Benefit Per Member Month Values
- Membership Breakdown

Return to Agenda

Description of State Incentive Programs

Housing and homelessness Incentive Program (HHIP)

- An incentive program launched by DHCS in 2021 to address social determinants of health and health disparities related to engaging unhoused members and housing issues. GCHP was able to earn incentive funds for making investments and progress in addressing homelessness and keeping members housed in the community.
- To date GCHP has made over $10,000,000 in investment to address issues that impact our homeless and at-risk members.
  - Expand Recuperative Care in Ventura County by 125 beds (construction to be complete by 2026)
  - Connect to the Homeless Management Information System (HMIS)
  - Support the Ventura County Continuum of Care and the local Point in Time Count (PIT)

CalAIM Incentive Payment Program (IPP)

- Launched in 2021 IPP supports the implementation and expansion of Enhanced Care Management (ECM), Community Supports, and other CalAIM initiatives. IPP incentives are support four priority areas:
  - Member engagement and service delivery, including reaching new members
  - Building sustainable infrastructure and capacity, including health information technology, workforce, and provider networks
  - Promoting program quality, with measurable impacts on utilization
  - Creating equitable access for ECM Populations of Focus
- To date GCHP has dedicated approximately $13,000,000 in funding to support our network, with additional funding opportunities planned in in 2024 and 2025. Examples of funding include:
  - Six ECM Providers
  - Four Community Supports Providers
  - Two Community Based Organizations to launch Community Health Worker and Doula Services
  - The Ventura County Community Information Exchange (VCCIE)

Student Behavioral Health Incentive Program (SBHIP)

- Implemented in 2022, SBHIP targets interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for TK-12 children in public schools.
- GCHP works with five school districts, Oxnard Unified High School District, Fillmore Unified School District, Santa Paula Unified School District, Hueneme Elementary School District and Rio School District.
- SBHIP has supported over 27,000 visits to campus Wellness Centers by over 7,500 students.

Return to Agenda

April YTD Balance Sheet: Assets

ASSETS	04/30/24	06/30/23
Current Assets:		
Total Cash and Cash Equivalents	**$ 454,500,102**	**$ 344,166,987**
Total Short-Term Investments	98,599,499	95,269,796
Medi-Cal Receivable	201,106,224	96,222,357
Interest Receivable	919,439	462,872
Provider Receivable	12,503,782	422,995
Other Receivables	-	59,542
Total Accounts Receivable	**214,529,445**	**97,167,766**
Total Prepaid Accounts	10,362,476	5,545,603
Total Other Current Assets	133,545	135,560
Total Current Assets	**778,125,066**	**542,285,711**
Total Fixed Assets	**8,380,209**	**9,224,593**
Total Assets	**$ 786,505,276**	**$ 551,510,304**

- The $235M increase in total Assets/Liabilities is attributed to the following:
  - Medi-Cal Receivable: 2024 Managed Care Organization (MCO) tax for January through April and expected State premiums.
  - Provider Receivable: includes payment advances related to Change Healthcare data breach.
  - Total Prepaid Accounts: primarily QIPP advances to providers that they have not yet earned and prepaid software licenses.

Return to Agenda

April YTD Balance Sheet: Liabilities

LIABILITIES & NET ASSETS		
Current Liabilities:		
Incurred But Not Reported	$ 108,910,692	$ 84,436,777
Claims Payable	28,021,111	12,923,764
Capitation Payable	8,041,305	8,998,514
Physician Payable	35,104,367	31,865,385
AB 85 Payable	-	-
DHCS - Reserve for Capitation Recoup	34,507,928	10,411,049
Lease Payable- ROU	3,396,342	3,300,319
Accounts Payable	14,265,354	1,455,088
Accrued ACS	3,724,560	3,902,303
Accrued Provider Incentives/Reserve	27,014,998	17,427,573
Accrued Pharmacy	-	-
Accrued Expenses	42,300,929	7,559,682
Accrued Premium Tax	101,110,000	-
Accrued Interest Payable	-	-
Current Portion of Deferred Revenue	-	-
Accrued Payroll Expense	3,577,157	3,189,633
Current Portion Of Long Term Debt	-	-
Quality Withhold	856,147	
Other Current Liabilities	-	-
Total Current Liabilities	**410,830,890**	**185,470,089**
Long-Term Liabilities:		
Lease Payable - NonCurrent - ROU	4,913,120	6,088,559
Deferred Revenue - Long Term Portion	-	-
Notes Payable	-	-
Total Long-Term Liabilities	**4,913,120**	**6,088,559**
Total Liabilities	**415,744,009**	**191,558,647**
Net Assets:		
Beginning Net Assets	359,951,657	176,617,059
Total Increase / (Decrease in Unrestricted Net Assets)	10,809,609	183,334,598
Total Net Assets	**370,761,266**	**359,951,657**
Total Liabilities & Net Assets	**$ 786,505,276**	**$ 551,510,304**

- Incurred But Not Reported: Expected expenses for services provided but not yet submitted for provider reimbursement are increasing due to claims payments timing, membership levels, and unit cost rates.
- Accounts Payable balance reflects Prop 56 payments of $10.4M.
  - CY19-20: $1.5M
  - CY21: $8.9M
- Accrued Premium Tax reflects our expected Managed Care Organization Tax (this appears only on our Balance Sheet and does not impact our financial results).

Return to Agenda

Cash and Short-Term Investment Portfolio

SCHEDULE OF INVESTMENTS AND CASH BALANCES		
	Market Value* April 30, 2024	Account Type
Local Agency Investment Fund (LAIF)[1]	$ 42,080,748	Investment
Ventura County Investment Pool[2]	19,054,764	Investment
CalTrust	37,463,987	Short-term investment
Bank of West	455,154,991	Money market account
Pacific Premier	(655,391)	Operating accounts
Petty Cash	500	Cash
Investments and monies held by GCHP	***$ 553,099,599***	

Cash and short-term investments: $553.1M.

- The investment portfolio includes Ventura County Investment Pool $19.1M; LAIF CA State $42.1M; Cal Trust $37.4.

Return to Agenda

PMPM and TNE Values

	FYTD 23/24 Reforecast	FYTD 23/24 Actual	FYTD 22/23 Actual	FYTD 21/22 Actual
Average Enrollment	246,824	252,004	247,854	229,367
PMPM Revenue	$ 351.59	$ 361.38	$ 340.86	$ 347.72
Medical Benefits				
Capitation	$ 34.31	$ 33.20	$ 34.18	$ 32.44
Inpatient	$ 68.82	$ 69.52	$ 54.64	$ 68.62
LTC / SNF	$ 66.49	$ 60.00	$ 54.86	$ 59.92
Outpatient	$ 27.18	$ 28.34	$ 23.88	$ 22.59
Emergency Room	$ 12.60	$ 12.91	$ 11.32	$ 10.80
Physician Specialty	$ 26.41	$ 26.74	$ 23.44	$ 22.49
Quality Incentives	$ 5.38	$ 6.22	$ 0.69	$ -
Provider Grant Program *	$ 1.69	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ (0.15)	$ 29.71
All Other	$ 59.71	$ 66.28	$ 53.03	$ 45.41
Total Per Member Per Month	$ 302.57	$ 303.22	$ 255.89	$ 291.97
Medical Benefit Ratio	86.1%	83.9%	75.1%	86.9%
Total Administrative Expenses	$ 92,773,947	$ 93,629,005	$ 78,852,534	$ 53,680,738
% of Revenue	10.7%	10.3%	7.8%	5.6%
TNE	$ 399,475,312	$ 370,761,266	$ 359,814,027	$ 176,562,922
Required TNE	$ 41,438,176	$ 36,934,714	$ 32,913,795	$ 36,609,789
% of Required	964%	1004%	1093%	482%

TNE is a function of net assets and as such will change each month. Asset fluctuation month over month is a normal business function. Reasons for fluctuations can include (but are not limited to):

- Changes in the amounts owed to GCHP by the State ("Accounts Receivable")
- Amounts GCHP owes Providers ("Claims Payable")
- Number of claims cycles paid in that current month (cash reduction)
- Amounts owed to vendors ("Accounts Payable")

Return to Agenda

AGENDA ITEM NO. E

TO: Executive Finance Committee

FROM: Sara Dersch, Chief Financial Officer
GCHP Executive Team

DATE: June 20, 2024

SUBJECT: Proposed Budget Fiscal 2024 / 2025 and 3-Year Quality Investment Program

PowerPoint with Verbal Presentation

ATTACHMENTS:

al Results

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

FY2024-25 Budget and 3-Year Quality Funding Strategy

Executive Finance Committee

June 20, 2024

Sara Dersch, Chief Financial Officer
Nick Liguori, Chief Executive Officer
Eve Gelb, Chief Innovation Officer
Paul Aguilar, Chief Human Resources & Organizational Performance Officer

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

Budget Objectives

- In the **Post-Public Health Emergency** era, we now operate in a "normal" financial/premium paradigm in which community-based health plans are funded for 88-90% Member Benefit Ratio (MBR) / 8-10% Administrative Expense Ratio (AER) / 2% margin.
- Having now returned to this constrained funding paradigm, our focus must be on managing the cost and quality of care to ensure GCHP viability for the long term.
- Quality is the essential element of a financial plan to achieve long-term viability. The State strategy to use Quality as the basis for premium rate-setting demands sustained high performance in Quality (Managed Care Accountability Set-MCAS and Consumer Assessment of Health Plans and Systems-CAHPS). Quality is the way we (GCHP and Providers) ensure the maximum funding for the Ventura County Medi-Cal Delivery System ("System") and member health/healthcare.
- GCHP has developed the **FY 2024-25 Budget** and our **3-Year Quality Funding Program (QFP) Strategy** to substantially invest in quality improvement within the System through both the use of health plan premium revenue and a portion of reserves.
- GCHP has also developed the Budget and Strategy around continued build-out of health plan capabilities for managing the cost and quality of care, to provide a superior level of support for providers, and to deliver a superior experience for the members and communities we serve.

The Budget and Strategy are founded on the principal that we must plan (and adequately fund our plan) to get and keep our members connected with Quality care (measured through MCAS) and to ensure high Satisfaction (measured through CAHPS).

This is our ***Mission***.

The financial health and viability of GCHP over the long term depends on our ability to change and continuously improve GCHP and the System to deliver sustained high Quality and Satisfaction.

This is our ***Imperative***.

Return to Agenda

Budget Risks

- The FY 2024-25 Budget funds Member Benefits and Quality at a level that exceeds revenue. This involves GCHP investing a portion (~$28M) of reserves to advance sustainable Quality performance in the System and to engage members in their health/healthcare.
- Our broader Quality Funding Program (2025-2027) deploys nearly a quarter of a Billion dollars to improve Quality (member experience and health outcomes). This level of funding involves an investment of reserves that occurs over a 3-year period.
- As GCHP remains in this investment mode (i.e., using a portion of reserves to fund Quality improvement), the risks of prevailing financial uncertainty in Medi-Cal and the risks of significant unexpected increases in the unit costs or utilization of member benefits are amplified.
- While the Medi-Cal industry concurs that further budgetarily-driven, unfavorable revenue adjustments are possible, the industry is also aligned on how to respond to future actions which might exacerbate the lack of Medi-Cal funding soundness. As such, the Management Team does not endorse reserving for significant unknown adjustments (which will take funds away from member and Quality planning) and instead will make financial course-corrections should such State adjustments come to pass. GCHP, alongside other Medi-Cal Health Plans and Providers, continues to actively advocate against further erosion of Medi-Cal funding.
- **Overall, success in this next fiscal year and the 3-year period of sustained Quality investment requires a high level of expert management of the health plan and dedication to fiscal prudence by the Commission and Management.**

Return to Agenda

Budget FY 2024-25 | TNE Composition and Planning

Current Reserves		Analysis	Plan
1025%	Unrestricted Reserves 325%	$60M	GCHP Management proposes to plan for a $60M reduction in reserves over the next 3 budgets (spanning July 2024 – June 2027) in the form of compliant and value-based funding for providers.	Investment in providers through enhanced Quality Funding Program. Quality Funding Program funding levels are based on expectations and targets may be adjusted based on priorities and member needs.
		$60M	D-SNP will have 2 financial requirements: – D-SNP expenses (provider and administrative) are expected to produce losses for the first 3+ years of operations, ranging from $17M to $30M+. – D-SNP will require its own reserves on top of the expected initial losses.	Reserve for anticipated losses and retain additional reserves to account for new line of business TNE requirements.
	Restricted Reserves 700%	$258M	These funds are restricted for maintenance of adequate reserves for long term viability of GCHP. These funds were established as GCHP TNE Reserve by Commission approval of the FY 2023-24 Budget (current year). For Medi-Cal alone, this provides for adequate long-term thinking and planning and investments to GCHP and providers.	GCHP is entering a period of industry-wide anticipated premium pressures. Maintain 700% of required TNE.

Summary of Management's Proposed FY2024/25 Budget

Category	FY2024/25 Budget	Comments
Membership	251,125	Higher-than-expected membership levels are driven by successful redetermination efforts and a newly-eligible population cohort. Membership is now relatively stable and is not expected to change majorly. But membership can change if redetermination disenrollment picks up or Kaiser is expanded as a Medicaid Managed Care Plan by the State.
Premium Revenue	$1.089B	As presented, this reflects essentially flat revenue even though membership is favorable; the changing member "mix" accounts for the minimal revenue increase; premium revenue is $1.073B; an additional $16M in investment income brings total revenue to $1.089B. MCO tax (which is a pass-through from the Federal government to the State) of $303.7M brings total receipts to $1.419B.
Consolidated Medical Benefit Cost *(Ratio)*	$1.008B *92.6%*	Prior to the $82.5M Quality Funding Programs, the underlying MBR is 85.0%.
Administrative Expense *(Ratio)*	$109.3M *10.0%*	We are staying consistent with current administrative expense run-rate year over year; while the FY2023/24 focus was on infrastructure needed to transform the organization, the focus of FY2024/25 will be on Quality Programs and Care Delivery innovation. Continuing Operations of the Future budget of $4.0M included in Administrative Expense.
Reserve Increase/(Decrease)	$(28.2M) *(2.6%)*	Net income prior to the Quality Funding Programs is $43.9M, or 4.0% of total revenue (premium revenue plus investment income).

Return to Agenda

Medical Benefit Expense Highlights: Categories of Service (COS)

Capitated, fee for service (FFS), and other medical expenditures for current year to date and FY 2024-25 budget are reflected on a per member per month basis.

Capitation

The bulk of capitation is primary care and transportation. It also includes some specialty care, vision and other services.

The rate increase reflects investment in primary care and investment to add capacity to the transportation system.

Fee For Service

Utilization trends for inpatient, outpatient, and mental and behavioral health services have been increasing.

The GCHP Model of Care aims to increase utilization and unit cost for primary care, specialty care and mental health.

FFS primary care costs also include increases driven by the State Targeted Rate Increases.

FFS transportation is mostly emergency transportation.

Other Expenditures

Quality Funding Program represents the expectations and targets for spending in 2024/25 with some value-based rates already dispersed in targeted FFS categories.

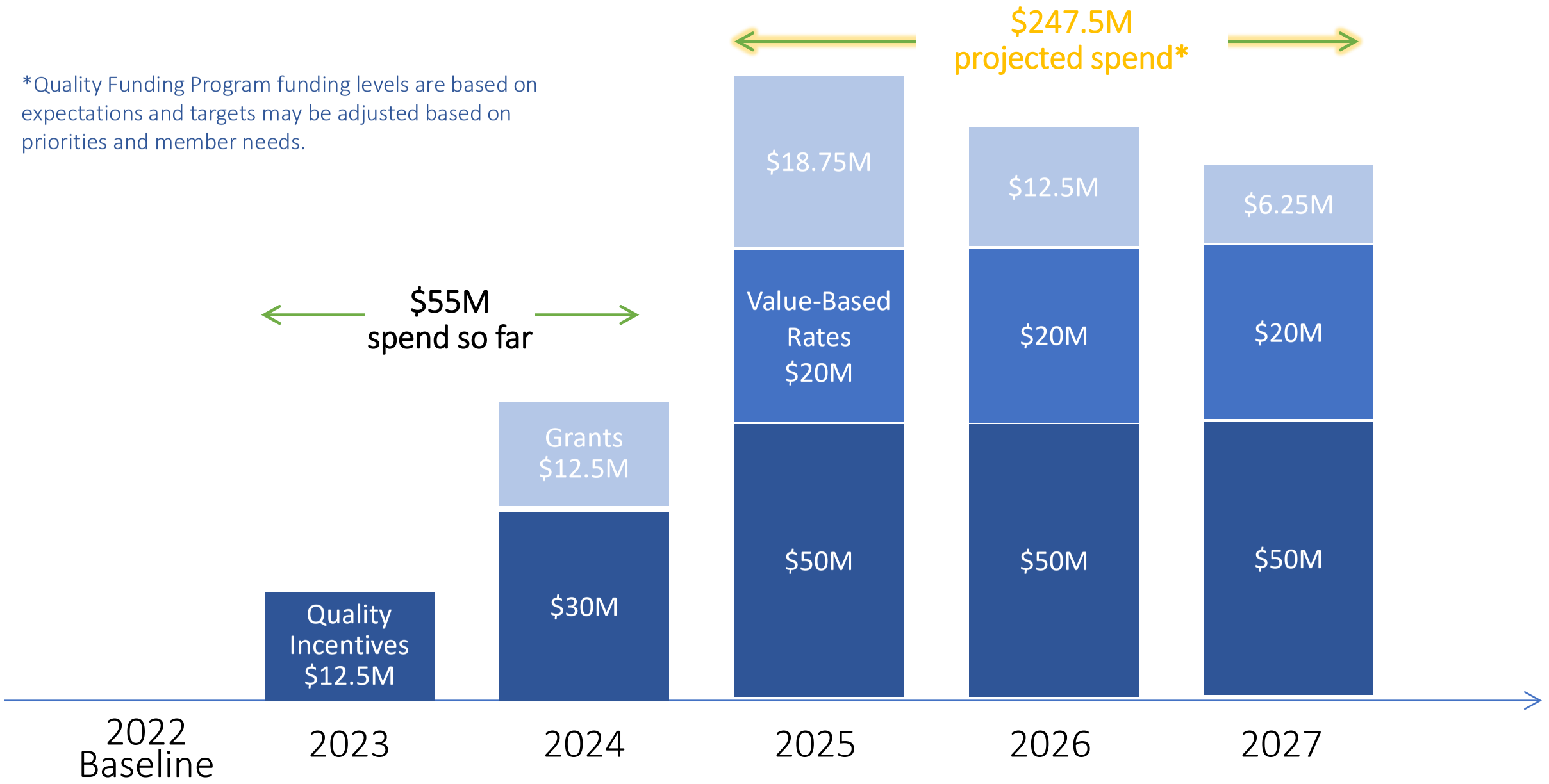
Medical Care Management is significantly increased due to increase in member incentives and inclusion of other allowable Quality Improvement health plan costs.

Carelon Care Management is now reflected as a separate line item in Medical Expense.

Return to Agenda

Budget FY2024-25 | Quality Funding Program

*Quality Funding Program funding levels are based on expectations and targets may be adjusted based on priorities and member needs.



Return to Agenda

Budget FY2024/25 MBR Components → Getting to 92.6%

Return to Agenda

Quality Funding Program*

85.0%

Includes 2.5% current QIPP

FY 2023-24 current base benefit cost

2.3%

QIPP Expansion

Continuation of Quality-based Incentives

1.8%

Value-based Rates**

Incremental increases related to improving access to care (ex: evening and weekend hours)

1.2%

Provider and Community Grants

Continued support for Providers and Community Organizations to improve access to care

1.5%

Targeted Rate Increase (TRI)

TRI is supposed to be net neutral, however MCOs retain risk should TRI utilization exceed State forecasts

0.8%

Member Incentives

Increase in member incentives for Wellth expansion, member activities that close MCAS gaps in care, etc.

= 92.6%

*Quality Funding Program funding levels are based on expectations and targets may be adjusted based on priorities and member needs.

**Provider funding increases – capitation and/or reimbursement rates – that are short term, i.e., earned and maintained by achieving improvements to access to care, Quality, and member satisfaction.

Financial Schedules

Financial schedules accompany this report. GCHP Management will reference the schedules during the discussion of these budget financial details.

Schedule	Description
Schedule 1	Medical Margin Budget: Category of Service *Line-item detail of medical costs on a per member/per month basis sorted by type and categorized by dates (July through December 2024, January through June 2025) coinciding with premium rates.*
Schedule 2	Medical Margin Budget: PMPM Cost by Aid Category *Line-item detail of medical costs sorted by on a per member/per month basis and categorized by demographic grouping ("cohort").*
Schedule 3	Medical Margin Budget *Line-item detail of premium revenue and medical cost components reported in whole dollars.*
Schedule 4	General and Administrative Expenses *Line-item detail of total administrative expenses.*
Schedule 5	Vendor Contract Listing *Listing of all contracted vendors and projected spend.*

Return to Agenda

Strategic Initiatives: Overview

Continuous improvement in day-to-day operations including:

- Furthering our commitment to compliance
- Advancing our people-first culture
- Elevating the practice of project management and process improvement
- Improving data, analytics, and managing by metrics

Next phase transformation including:

- Continued implementation of Operations of the Future
- Finance of the future enabling multiple lines of business with D-SNP
- Completion of the Modern Data Warehouse with integration of data from new systems and new lines of business
- Improvements in data exchange
- D-SNP filings and product offering build
- Building optimal provider support functions

Full launch of high-quality model of care leveraging work of the last 2 years including:

- Implementation of expanded Quality Funding Program (now expanded to include rates)
- Building care management programs to ensure high quality care and appropriate utilization of care
- Building ongoing MCAS and new Medicare 5 Star Quality infrastructure
- Wellth and Health Risk Assessments expansion
- Integrating care with our providers and community-based organizations
- Launching Diabetes Management and other chronic condition management programs

Return to Agenda

Strategic Initiatives: Dedicated to Care

Initiative	Value Description	Resources	Total $
Continuous Improvement and Project Management	Create a project-capable and continuous improvement organization by elevating the practice of these disciplines.	• 2 Project Managers • Continuous Improvement Consultant • Enterprise-wide project management tool	$550K
Office of the CEO/Communications	Improve internal and external communications including Commission and Provider Relations.	• 1 Commission Support Leader • 1 Commission/Communications Admin • 1 Member and Provider Communications Role • 1 Administration Leader Role • Marketing and Branding Outside Services	$1.1M
Compliance	Advance Compliance with State and Federal regulations.	• 1 Auditor • Auditing Software	$190K
Culture, Celebration, Recognition	Supports the culture of transformation and improves the employee experience through enhanced recognition programs.	• Culture Consultant • Employee Recognition platform and rewards	$500K
Vendor Oversight	Enhance vendor oversight.	• 1 Operations Analyst	$85K
		Total	**$2.4M**

Return to Agenda

Strategic Initiatives: Transforming for Care

Initiative	Value Description	Resources	Total $
Finance of the Future	Replacement of core Finance technology with the expansion of current technology integrating Procurement, Accounting, and Human Resources with Budget resulting in real-time access to financial data and improved vendor payment management.	• Consultant to lead implementation • Business Analyst Consultant • Platform (WorkDay)	$720K
Comprehensive Data and Analysis Capabilities	With the implementation of the Data Warehouse, we will develop an enterprise-wide consolidation of data and analytics, eliminating many of the departmental silos.	• 1 Data and Analytics Leadership Role • Consolidation of current analysts	$400K
Modern Data Warehouse	Completion of MDW implementation.	• 1 Data Engineer • Developers consultants	$209K
Data Interchange Capabilities	Improve infrastructure for data exchange within Gold Coast and with outside partner organizations.	• Repurpose existing resource • Consulting services	$320K
D-SNP (Knox-Keene Readiness)	Complete all regulatory required filings and meet requirements to launch D-SNP by 1/1/26.	• 1 DSNP Compliance Manager • 1 Member Materials/Communication Manager • 1 PBM Operations Manager • PBM Implementation Consultant • PBM Vendor • Consulting for bid filings and system configuration	$2.4M
Provider Network Operations	Establish high-functioning provider operations team for optimal network management.	• 1 Contract/Network Operations Director • 1 Network Operations Representatives	$290K
		Total	**$4.3M**

Return to Agenda

Strategic Initiatives: Transforming for Care

Operations of the Future: Continuous Improvement Phase

Initiative	Value Description	Technology and Resources	Total $
Post Go-Live Support and Transition	Post go-live support and hyper-care. Support for Core Admin, Medical Management System, Provider Portal, CRM, Mail Room and Print and Fulfillment business processes and technology changes	• IT Temp labor for three-month support • Operations Consultants • Vendor labor support	$1.2M
Member Portal	**Convenient Access and Management**: Members can view health records, ensuring they stay informed and in control of their healthcare. **Cost Transparency and Support**: Provides cost estimates for medical services, digital ID cards, and easy access to customer support, helping members understand their expenses and get assistance quickly. **Health and Wellness Resources**: Offers personalized health tips, wellness programs, secure communication with GC, and educational materials.	• NTT Vendor Development • IT Temp Labor • Conversion & integration requirements	$1.1M
Mailroom Transition	Transition Mailroom activities from Conduent to GCHP managed services	• Document Mgmt System and conversion • IT Contingent Labor • Hire GCHP FTE Staff • Technology procurement	$1.3M
CRM and Voice of Member	Claims and Provider data integration into Salesforce and Member ID Card integration between Salesforce and HealthEdge	• Silverline (Vendor) labor and technical development • IT Temp labor – data integration	$200K
Data Conversion and continued improvement / support	Prior system (Medhok and Conduent) data conversion and support, along with continued development to enhance Core Adm & MMS conversion and analytics	• Medhok Data access and support • Conduent Data access and support • GCHP IT Temp labor	$5.9M
		Total	**$9.7M**

Return to Agenda

Strategic Initiatives: Connecting *with Care*

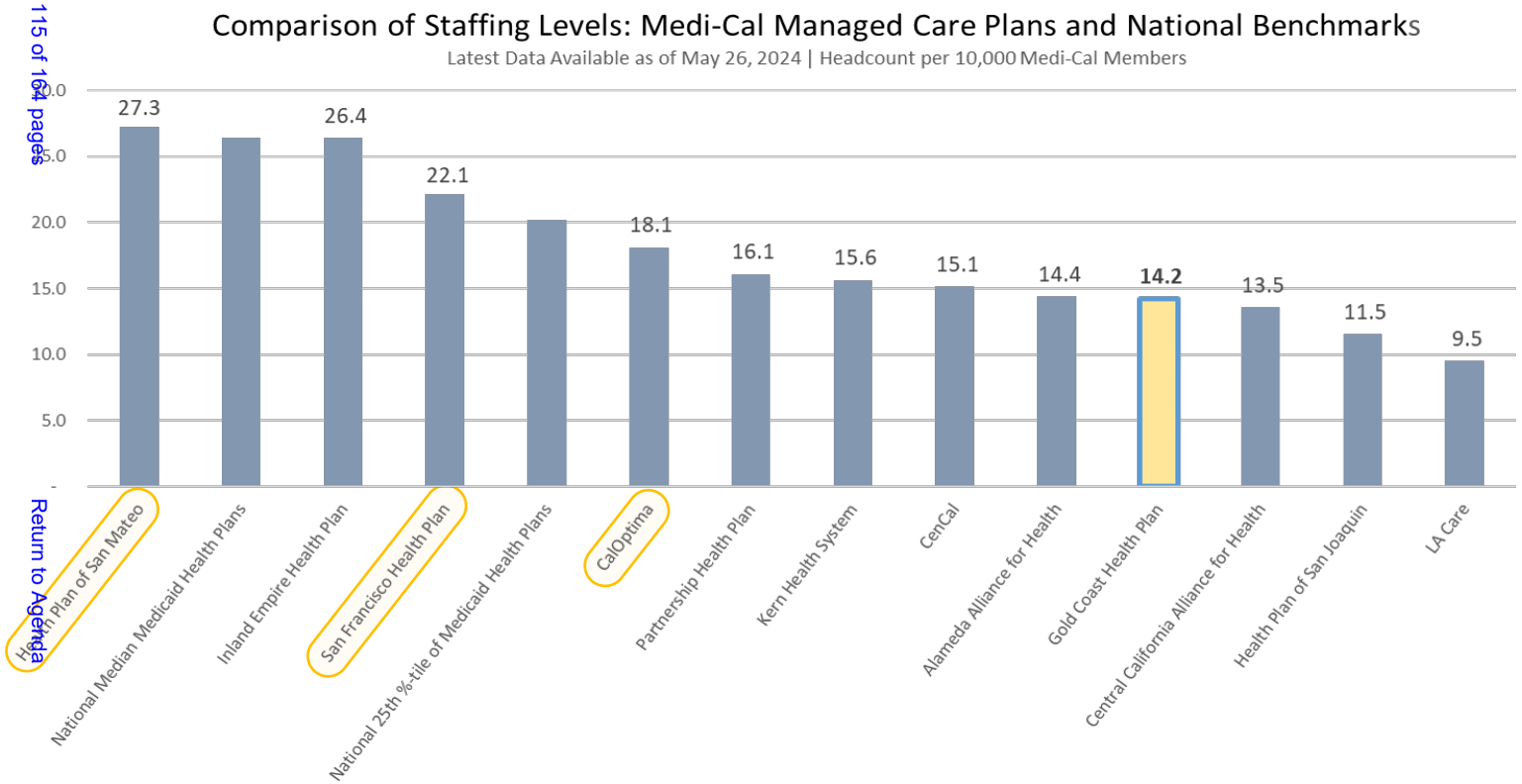
Initiative	Value Description	Resources	Total $
MCAS Operations and Improvement	Achieve 5 measures at HPL, 4 at 75th, 7 at MPL, 1 at 25th and 1 at 10th. Establish structure for ongoing MCAS and 5 Star functions.	• 1 HEDIS/5 Star Data Leader • 1 PNO Quality Specialist • Vendor for external validation of data processes • Expanded MCAS interventions to close gaps • Participation in Quality and Health Equity Collaboratives	$1.5M
Model of Care Implementation	Integrated Care Team, Connecting with Care, Transportation Improvement, HRA full execution, Healthcare Programs.	• 1 Model of Care Leader • 2 Behavioral Health Specialists • System configuration support for TruCare	$700K
Member Experience and Community Care	Member Services Everywhere launched with 5 provider sites and 2 school sites. Voice of the member program implementation including ongoing infrastructure for data gathering, analytics and continuous improvement.	• 7 Contact Center Representatives • 2 Contact Center Managers • 5 Provider-Based Member Ambassadors • 3 Quality Outreach Representatives • 1 Community Health Worker • 1 Voice of the Member Manager • GHCP Van • Journey-mapping, member digital engagement, surveys and focus groups	$2.1M
Benefit Cost Management/ Optimization	Build mature processes with identification of medical cost initiatives within 3 months of staff engagement; execution of initiatives will take anywhere from 6-18 months before medical cost savings are realized.	• Edrington Health consulting (already budgeted)	NA
Provider Strategy and Performance	Full implementation of Quality Finding Program and Community Reinvestment Grants.	• 1 Grant Leader Role • Third Party Grant Administrator • Grant management software	$400K
		Total	**$4.7M**

Return to Agenda

Industry Context: Staffing Levels

- GCHP remains in the bottom 1/3rd of headcount-per-10k Medi-Cal members and below national standards. This ratio is a measure of people capacity relative to other managed care plans in a way that normalizes comparison across widely varying membership sizes.
- Local, statewide, and national hiring activity continues to create intense competition for high-value managed care skillsets. After two years of substantial staffing investment by GCHP, we remain in essentially the same relative position - people investments in the Medi-Cal industry, and beyond, is at or greater than our levels.
- The historical pattern holds → health plans that invest the most in health plan staffing produce the highest results in quality and member satisfaction. In 2022, Health Plan of San Mateo, San Francisco Health Plan and Cal Optima achieved the highest rankings nationally, when accounting for both Quality (MCAS/HEDIS) and Member Satisfaction (CAHPS).

115 of 164 pages



Same Data

Comparison of Staffing Levels Medi-Cal Managed Care Plans and National Benchmarks Latest Data Available as of May 26, 2024 | Headcount per 10,000 Medi-Cal Members	
Health Plan of San Mateo	27.3
National Median Medicaid Health Plans	26.4
Inland Empire Health Plan	26.4
San Francisco Health Plan	22.1
National 25th %-tile of Medicaid Health Plans	20.2
CalOptima	18.1
Partnership Health Plan	16.1
Kern Health System	15.6
CenCal	15.1
Alameda Alliance for Health	14.4
Gold Coast Health Plan	14.2
Central California Alliance for Health	13.5
Health Plan of San Joaquin	11.5
LA Care	9.5

- These data are based on latest facts from LHPC and data publicly posted by the health plans.
- Data are not readily available for some local Medi-Cal health plans - namely Community Health Group and Contra Costa).
- National Median and 25th %-tile figures are from an industry standard health plan industry survey (2022 data).
- Medicaid Managed Care funding is substantially higher, per capita, in most other states (vs California), which is illustrated in the rankings of the National Median and 25th %-tile figures. (California ranked 32 on per-capita Medicaid spending.)

Return to Agenda

Staffing Budget

Function	FY 2023-24 (as of May 28, 2024) Active Headcount	Open Requisitions	Forecasted Headcount YE 2023/24	Percentage of Total Headcount	FY 2024-25 BUDGET Added Headcount	Forecasted HC YE 2024/25	Percentage of Total Headcount	Headcount Growth
Health Services	132	0	132	37%	2	134	34%	2%
Operations	55	0	55	15%	10	65	16%	18%
Information Tech	54	0	54	15%	1	55	14%	2%
Policy & Programs	44	0	44	12%	10	54	14%	23%
Compliance	18	0	18	5%	3	21	5%	17%
Finance & Accounting	18	0	18	5%	0	18	5%	0%
Office of CEO & Administration	12	0	12	3%	4	16	4%	33%
Community & Member Relations	9	0	9	3%	5	14	4%	56%
HR & Facilities	10	1	11	3%	0	11	3%	0%
Innovation / DSNP	0	0	0	0%	6	6	2%	N/A
Communications	3	1	4	1%	1	5	1%	25%
Grand Total	**355**	**2**	**357**	**100%**	**42**	**399**	**100%**	**12%**

- In the current fiscal year, GCHP proved to be highly effective in employee retention (95%).
- GCHP Management effectively managed resource investments at budget with 355 active roles vs 357 budgeted roles.
- Headcount investments in FY 2024-25 proposed to be 12% increase in roles, with 42 new positions.
- Increased capabilities added in Member Experience, Contact Center, D-SNP, Quality Improvement Operations, Health Services, and Provider Network Operations.

Return to Agenda

Resourcing our Community-based High Quality Health Plan

- **81%** of the new roles are bringing our Model of Care to life by investing in local talent that will engage directly with our members and providers to improve the health of our community.
- Total of 34 positions added to enhance member experience and quality of care:
  - Enhance and expand community-deployed service team with added investments in Provider based Member Ambassador, Community Health Worker and Quality Outreach Roles (10).
  - Expand Member service support and member health outcomes with added Contact Center Representative roles and support roles (9).
  - Increase Quality improvement with investments in Quality operations roles, Behavior Health, Quality reporting roles, and Data, Analytics and Strategy roles (8).
  - Elevate Provider relations and end-to-end service with investments in Provider Network Operations Roles (3).
  - Enhance Member and provider communications and engagement with added Communications and digital content specialist role (1).
  - Build D-SNP capability and readiness by leveraging existing resources, while adding new PBM Operations role, Member Materials role & Communications and Compliance roles (3).
- **19%** of the new roles will support building our infrastructure, compliance, and continuous improvement.

Return to Agenda

Appendices

1: Materials from the May 20, 2024 Budget Presentation to Commission

2: Materials from the April 18, 2024 Budget Presentation to Commission

Return to Agenda

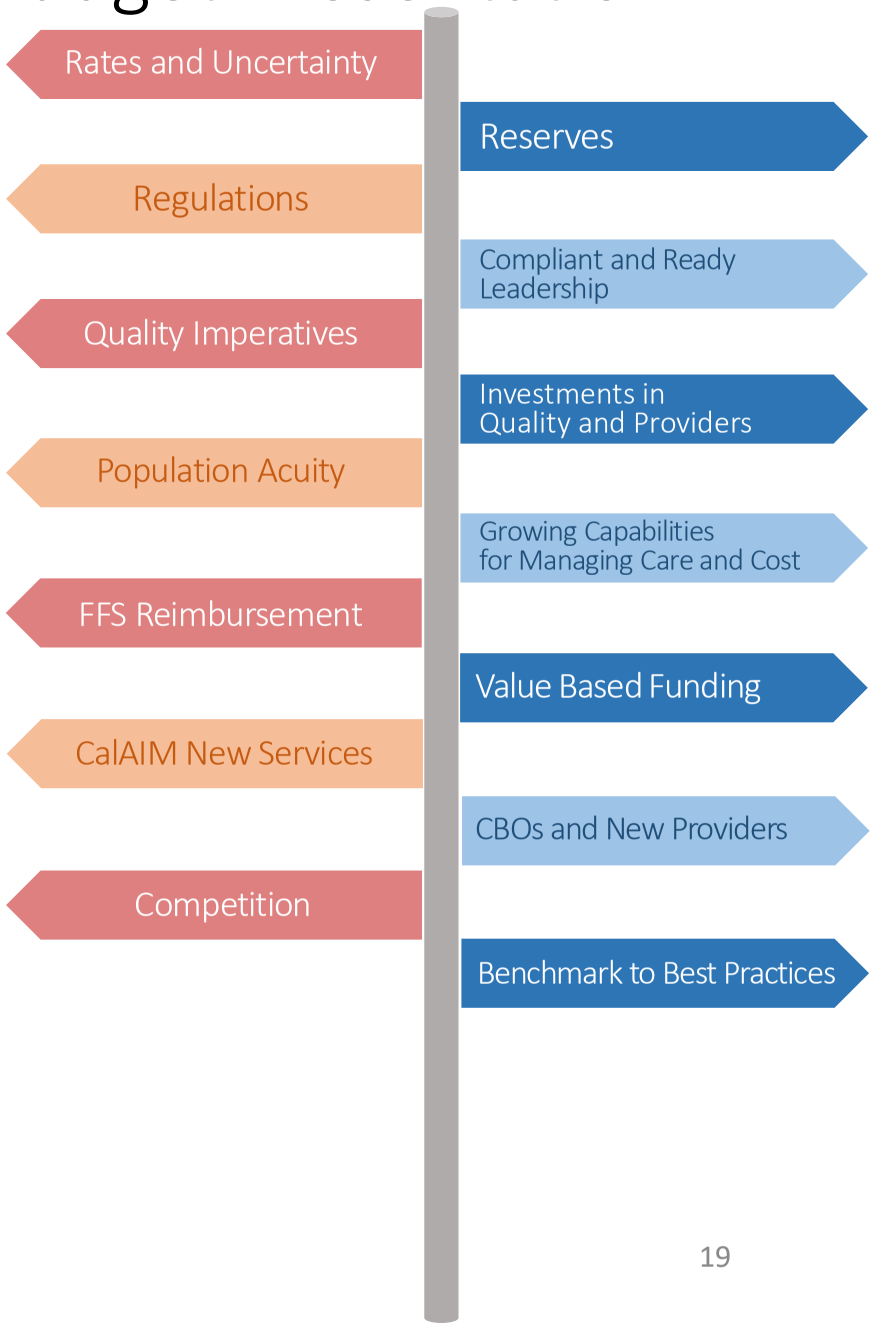
Appendix 1: Materials from the May 20, 2024 Budget Presentation

119 of 164 pages

FY2024/25 Budget and 3 Year Planning

Gold Coast Health Plan Executive Finance Committee
May 16, 2024

Nick Liguori, Chief Executive Officer
Sara Dersch, Chief Financial Officer
Eve Gelb, Chief Innovation Officer
Paul Aguilar, Chief Human Resources and Organizational Performance Officer
Dr. Felix Nuñez, Chief Medical Officer
Erik Cho, Chief Policy and Program Officer
Marlen Torres, Executive Director, Strategy and External Affairs



Return to Agenda

Topics We Will Review

1. Today's Objectives
2. Budget Design
3. Medi-Cal Industry Environment
   - Opportunities and Challenges
   - Question and Answer Session with Kyle Edrington, Founder of Edrington Health Consulting
   - Provider Environment
   - Quality Environment
4. Gold Coast Health Plan Environment
   - Membership and Associated Premium Rates
   - Medical Benefit Cost Trends
   - Unique Needs of New Members
5. FY2024/25 Proposed Budget

120 of 164 pages

Return to Agenda

(1) Understand where we are in the budget process.

(2) Understand Medi-Cal program and industry trends.

(3) Understand the need to plan for to use a portion of our reserves to expand the investment in Quality and Providers begun 2 years ago.

(4) Gain feedback from the Commission.

In April, Management provided the FY2024-25 budget framework outlining planned use of reserves.

Today, we will review the budget as well as important considerations for how management has developed the budget and will successfully implement that budget.

In June, we will bring the final budget packet which will include more-detailed administrative budget content. This administrative content will include the following: the personnel budget, a comprehensive review of existing and new vendor/consultant contracts and related budgets, operations of the future budget, and more.

121 of 164 pages

Return to Agenda

- GHCP's underlying financial performance today is strong, reflecting a Medi-Cal Managed Care Plan under effective management control, and operating in accordance with parameters of our Medi-Cal premiums.

  Excluding GCHP's Quality Funding Program:

  - 88% of premiums go to Medi-Cal member benefit spend.
  - 10% goes to efficient operations of the health plan and ongoing investments in Operations of the Future.
  - 2% would be available for addition to reserves.

- In order to meet the imperative of our Mission to improve Quality Care and Access for our members and to support the Ventura County Medi-Cal healthcare delivery system, management has developed a pioneering Quality Funding Programs that increases funds available for quality care and services by $90M in FY 2024-25 and by $250M over the next 3 years. These unprecedented new programs build off the funding programs and plan-provider partnerships that produced incredible successes in MCAS improvements in the current fiscal year.

- Bottom line change in reserves: The new Quality Funding Programs will involve a $22.5M spend down of reserves by the end of FY 2024-25. This will appear as a planned $22.5M reduction of reserves in the health plan's income statements.

Environment – Medi-Cal Program and Industry

Return to Agenda

Medi-Cal Environment Presents Opportunities and Challenges

New Programs and Populations provide great opportunities to serve our members and our community in new and important ways. These opportunities require significant strategic foresight, coordination and partnering with others to connect members with care, along with sophisticated budgeting with a strong grasp on administrative costs, medical cost management, and other health plan investments for underfunded efforts. Therefore, progressive quality focused plans must balance the opportunities with the risks to remain sustainable.

Do More

- Medi-Cal Managed Care Plans (MCPs) need to broaden their footprint and infrastructure to support social drivers of health and behavioral health initiatives.
- Community Supports are expected to be converted into regular member benefits.
- Adult Expansion, elimination of asset limits, new Medi-Cal benefits, and D-SNP.
- Added requirements such as expanded Transitional Care Services and Health Equity.

Do Better

- Withholding a percentage of payments with an opportunity for MCPs to earn it back by achieving quality and health equity benchmarks.
- New requirement to invest 5% to 7.5% of margin back into the community. MCPs that don't meet quality expectations will have to reinvest an additional 7.5% of their profits into the community.
- Compete with Kaiser.
- New standardized contracts that will strengthen and clarify requirements and expectations regarding oversight and compliance. Greater penalties for poor performance.
- NCQA Health Plan and Health Equity Accreditation.

Get Paid Differently

- Rate transparency to support cost containment and downstream provider margins.
- Regional Rate Setting to create price leverage.
- 2024 Targeted Rate Increases (TRI) and expanded TRI in 2025+.
- Payment based on acuity.
- Managed Care Organization (MCO) Tax if successful would inject funding into the funding pool.

Edrington Q&A – Guest Speaker on Industry Trends

1) What is driving the changes in the Medi-Cal Program that we learned about on the previous slide?

2) How is the Medi-Cal industry-wide "premium environment" changing now and over the next few years? How do you expect GCHP's premiums to change based on actual cost data?

3) Can you provide more detail on regional rate setting? Why is it coming, when is it coming, and what will it mean for GCHP?

4) The historical Medi-Cal premium development paradigm essentially provided managed care plans with near full "reimbursement" of costs, albeit on a 2-year lag. How will regional rate setting change this?

5) How important is GCHP's development of care and cost management capabilities and Model of Care around the following:

    1) Care management of those high-cost members with multiple chronic conditions?

    2) Continued high-Quality performance across all MCAS measures?

6) Open questions from the Commission

Return to Agenda

Kyle Edrington founded Edrington Health Consulting (EHC) in 2014 and has provided actuarial, financial, and strategic support to Local Medi-Cal health plans for over 15 years, including support for Gold Coast Health Plan since 2018. Kyle and the EHC team currently work with 14 of the 17 Local Medi-Cal health plans as trusted advisors supporting each health plan's operations and strategy. In addition, Kyle contributes to DHCS workgroups and other technical discussions to support its capitation rate development process and strategic direction of Medi-Cal. EHC is a subsidiary of HMA.

Provider Environment

Understanding the provider delivery system – needs, challenges, and goals – is key to GCHP's strategies, essential to the strength of plan-provider partnership, and GCHP's budget success.

Workforce Shortages Impact Access to Care

The healthcare industry is still feeling the impact of "the great resignation" and has pressing need for primary care providers, certain specialists, and nursing staff. The pressures in finding, hiring, and retaining talent are exacerbated by burdensome administrative issues (such as prior authorization), and the increased cost of living and other drivers that create wage inflation. Additionally, space limitations prevent full execution of staffing plans.

Rate Pressure

Rate Stability and sufficiency is an ongoing issue. Providers are facing lower reimbursement compared to increasing delivery costs with a greater dependency on supplemental funding and funding based on quality performance. It is difficult for providers to get internal commitment and build new capabilities needed for sustained quality when payment is not guaranteed.

Technology is Both an Opportunity and a Challenge

Both the promise of new tools and systems as well as the challenges of data/cyber security. Many are somewhere in the process of new system implementation and felt the immediate impact of and are dealing with the vulnerabilities identified in the Change Healthcare Cybersecurity Issue.

Quality and Community Focus

We have alignment with goals and approaches to lift the health of the community by connecting members with care. Innovation and targeted interventions are needed to address individual needs in areas of:

Chronic conditions

- Hypertension
- Diabetes
- Asthma

Targeted populations:

- School aged children with developmental needs
- Teens with mental health needs
- Frailty driven by age, disability, and/or medical complexity
- Social complexity, especially housing insecurity

Quality Environment

Quality is the basis of evaluation and funding for GCHP today and in the future. Adequate funding for GCHP and the Ventura County delivery system are now and will be increasingly tied to better scores on the Managed Care Accountability Set (MCAS), Consumer Assessment of Health Plans and Systems (CAHPS) and other standardized quality measures aligning with the National Quality Strategy.

Quality Withhold 0.5% of Revenue in 2024, increasing in 2025 and beyond to approximate our margin.	=	8 Managed Care Accountability Set (MCAS) Measures, with 9th measure added in 2025	+	4 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Measures (2 adult and 2 children)	x	Improvement Factor
Quality Sanctions	=	MCAS Measures below Minimum Performance Level (MPL)	x	Volume of Members in the measures that are not at MPL	x	Corrective Actions Factor
Risk Adjusted Rates using Chronic Illness and Disability Payment System(CDPS) + Medicaid Pharmacy (Rx)	=	CDPS: Presence of Certain disease Categories and the severity of the disease based on diagnosis codes	+	Rx: Use of certain medications indicating disease or risk	-	Certain carved out populations

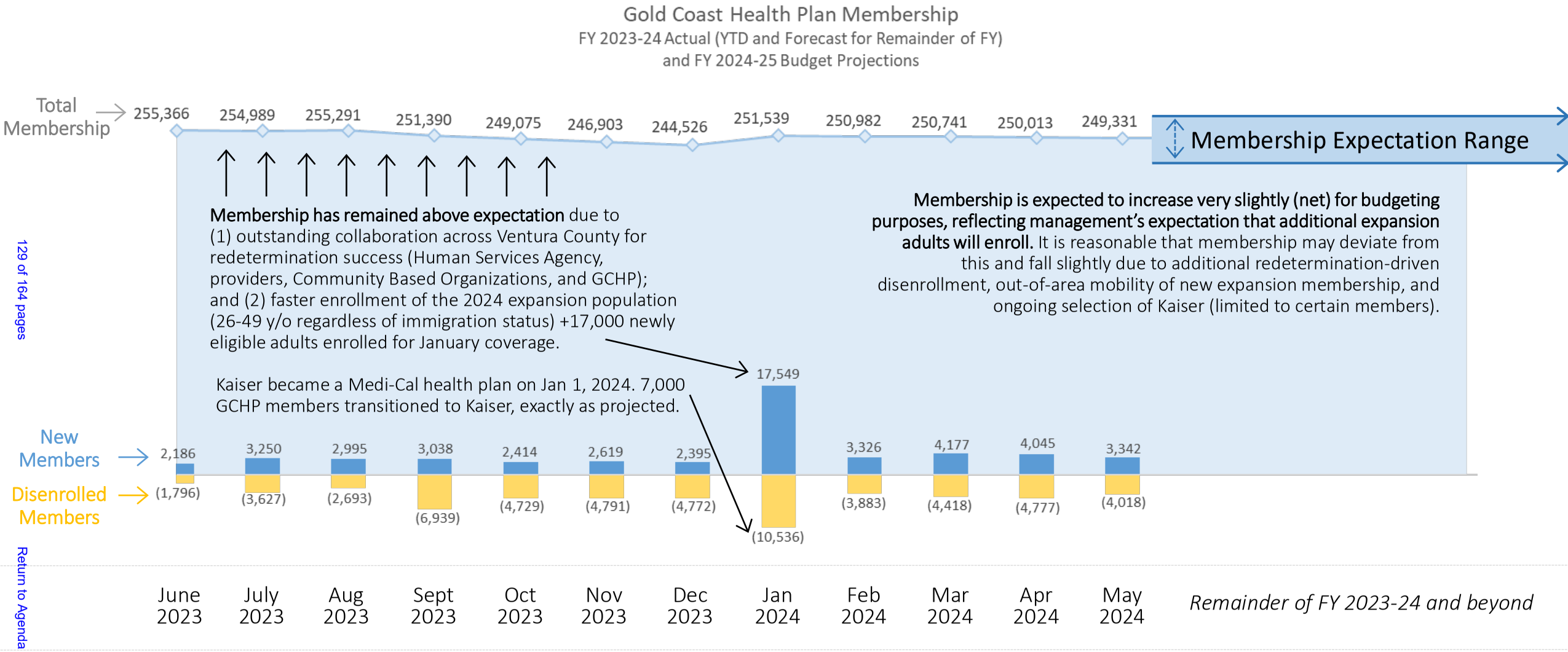
Connecting *with* Care: Members who have access to high quality care and a positive experience with care will have improved health outcomes. Medi-Cal requires it. Our members deserve it. GCHP is leading he way.

This is the Quality Imperative.

Understanding Challenges and Opportunities in Order to Manage the Business of Gold Coast Health Plan

Return to Agenda

Data Based Foundation for Budgeting: Membership Trends



129 of 164 pages

Return to Agenda

Unique Needs of New Members

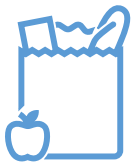
Health Risk Assessments (HRAs) launched in Q1 for our newest members have helped us better understand their needs.

22% of the members rate their health as fair or poor. This is a predicter of health decline and increased utilization.

53% of the members had problems getting care from a doctor in the past 6 months.

17% of members either have used the Emergency Department or Hospital in the past 6 months or had a family member use those resources.

32% of the members felt down, depressed or hopeless in the last 2 weeks.



57% of the members are worried about food running out before they get more money.

48% of the members have seasonal or migrant farmwork as their family's main source of income.

- Medi-Cal populations have grown the most in premium categories of aid that have decreased the fastest.
- While outsiders view Medi-Cal as increasing premiums, the reality for Medi-Cal Managed Care Plans is that premiums are remaining flat due to the interplay of membership mix and rate setting.
- “Fee for Service” reimbursement rate increase demands in the provider delivery system remain high and in fact are significantly greater than funding available in premiums.
- Healthier members left the health plan through redetermination and the Kaiser transition, as expected. The population that remains has a higher acuity (higher need for care and services).
- GCHP’s “Top 10%”population has an extraordinary occurrence of multiple chronic conditions and a great need for programmatic solutions and integrated care team interventions to improve health and “bend the future cost curve.”
- GCHP is developing a full profile of Inpatient and Long-Term Care costs and utilization drivers as well as a responsive solution to keeping these costs in line with available premium funding.

Data Based Foundation for Budgeting: Membership Mix and Premium Development

- DHCS develops premiums at a population cohort level ("Categories of Aid"), based on age (child or adult), level of need (age and disability), and immigration status (UIS, SIS).
- CY 2024 premiums developed favorably for some categories and unfavorably for others – yielding a flat plan-wide composite premium between CY 2023 and CY 2024. Essentially this means there was no more money per-capita to cover cost increases that were being created by contracted provider reimbursement rate increases.

Membership				DHCS Major "Categories of Aid" Premium Rate Categories	Base Premium Rates			
Actual CY 2023	Actual CY 2024	CY 2024 vs CY 2023 Change	CY 2024 vs CY 2023 % Change		Actual CY 2023	Actual CY 2024	CY 2024 vs CY 2023 $ Change	CY 2024 vs CY 2023 % Change
91,687	87,350	(4,337)	-4.7%	Child - SIS	95.84	$ 103.73	7.89	8.2%
3,720	3,788	68	1.8%	Child - UIS	78.69	$ 100.40	21.71	27.6%
27,601	25,946	(1,655)	-6.0%	Adult - SIS	296.66	$ 326.48	29.82	10.1%
5,992	15,990	9,998	166.9%	Adult - UIS	508.72	$ 470.51	(38.21)	-7.5%
71,180	67,563	(3,617)	-5.1%	Adult Expansion - SIS	357.8	$ 331.05	(26.75)	-7.5%
6,385	12,023	5,638	88.3%	Adult Expansion - UIS	761.52	$ 544.21	(217.31)	-28.5%
10,086	9,928	(158)	-1.6%	SPD - SIS	1177.93	$ 1,252.52	74.59	6.3%
1,178	1,221	43	3.7%	SPD - UIS	1824.05	$ 1,333.13	(490.92)	-26.9%
24,583	24,501	(82)	-0.3%	SPD Dual - SIS	579.44	$ 638.58	59.14	10.2%
638	677	39	6.2%	LTC Dual - SIS	579.44	$ 638.58	59.14	10.2%

GCHP experienced some of the largest declines in rates for our fastest growing population cohorts (expansion groups).

Data Based Foundation for Budgeting: Drivers of Benefit Cost Growth

Unit Cost

(excluding the Quality Funding Program)

- Reimbursement rate increases contracted in FY 2023-24 grew annual benefit costs by ~4%; LTC and inpatient costs trends are even steeper.
- Reimbursement rate increases are budgeted to further grow annual benefit costs >1% in FY 2024-25.
- DHCS' Targeted Rate Increase (TRI), a resetting of the baseline Medi-Cal payment schedule, added ~1.5% to benefit costs (MHSA, LTC, and other medical costs) in FY 2023-24 and the TRI program will expand in CY 2025 in yet to be defined ways.
- **Going forward, GCHP must prudently align unit cost increases with premium developments → long-term sustainability requires we spend only what we have in premiums.**

- Unit Costs are <u>not</u> decreasing in any way.

Population/Utilization

- After redetermination and the Kaiser transition, we are seeing a higher acuity (higher need) membership remain and a lower acuity group exit. This is as expected. The group that has left has costs that are ~40% lower than those who remain. **GCHP and provider partners must be increasingly effective at managing care and cost of high acuity, multiple chronic condition populations.**
- The 2024 expansion group of 26-49 regardless of immigration status comes to managed care with a history of high ER use for care. Also, there is potentially a pent-up demand for care and services. **GCHP must understand membership needs and tailor solutions that deliver high engagement in regular outpatient primary healthcare, specialty healthcare, and behavioral healthcare**.
- CY 2024 premiums include DHCS/Mercer's assumption that utilization in the 2024 expansion population will decrease over the near term after some early pent-up demand. This is expected by DHCS to result in ~1.3% lower costs in FY 2024-25. **Will this show up?**
- GCHP program interventions aimed at "bending the curve of costs= growth" for higher need members, including those with multipole chronic conditions, is having unprecedented, yet expected, favorable impact in the form of prevented readmissions and greater quality care. **We must expand the use of these pioneering and highly effective programs.**

Return to Agenda

Proposed Budget
Gold Coast Health Plan

Return to Agenda

Budget FY2024/25 MBR Components → Getting to 92%

135 of 164 pages

Return to Agenda

Quality Funding Programs*

85.0%

Includes 2.5% current QIPP

FY 2023-24 current base benefit cost

2.3%

QIPP Expansion

Continuation of Quality-based Incentives

1.8%

Value-based Rates**

Incremental increases related to improving access to care (ex: evening and weekend hours)

1.2%

Provider and Community Grants

Continued support for Providers and Community Organizations to improve access to care

1.5%

Targeted Rate Increase (TRI)

TRI is supposed to be net neutral, however MCOs retain risk should TRI utilization exceed State forecasts

0.2%

Member Incentives

Increase in member incentives for Wellth expansion, member activities that close MCAS gaps in care, etc.

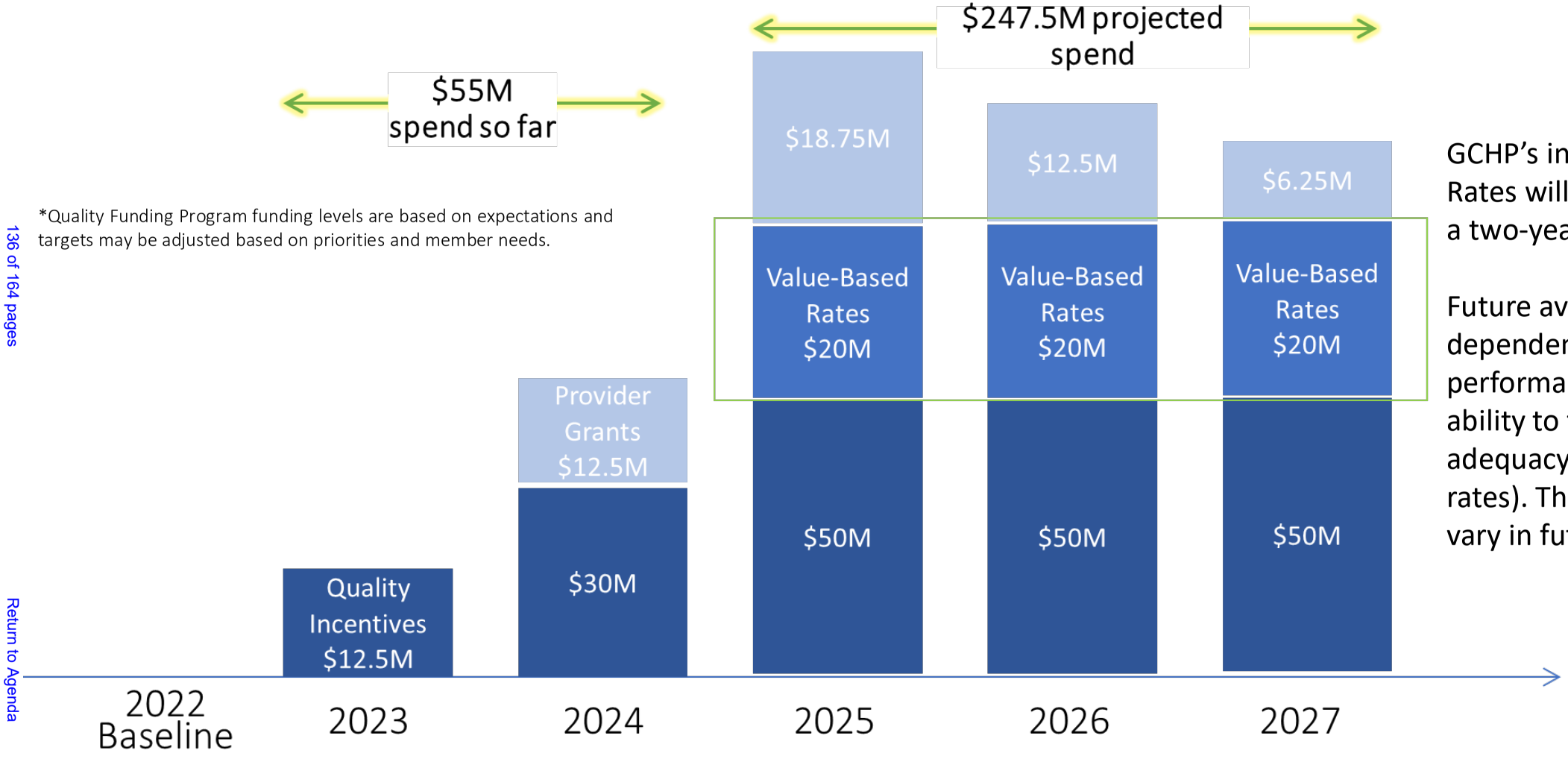
= 92%

*Quality Funding Program funding levels are based on expectations and targets may be adjusted based on priorities and member needs.

**Incremental increases related to improving access to care or quality related activities

Budget FY 2024-25 | Quality Funding Programs and Value-Based Rates*

Valued Based Rates reward providers based on increased access, efficiency, and/ or quality.



*Quality Funding Program funding levels are based on expectations and targets may be adjusted based on priorities and member needs.

GCHP's initial Value-Based Rates will be available for a two-year period.

Future availability is dependent on provider performance and GCHP's ability to fund (i.e., adequacy of premium rates). The standards may vary in future years.

136 of 164 pages

Return to Agenda

Summary of Management's Proposed FY2024/25 Budget

	FY2024/25 Budget	Comments
Membership	251,125	Higher-than-expected membership levels are driven by successful redetermination efforts and a newly-eligible population cohort. Membership is now relatively stable and is not expected to change majorly. But membership can change if redetermination disenrollment picks up or Kaiser is expanded as a Medicaid Managed Care Plan by the State.
Premium Revenue	$1.073B	As presented, this reflects essentially flat revenue even though membership is favorable; the changing member "mix" accounts for the minimal revenue increase; an additional $10M in investment income brings total revenue to $1.084B. MCO tax (which is a pass-through from the Federal government to the State) of $303.7M brings total receipts to $1.376B.
Medical Benefit Cost *(Ratio)*	$987.2M *92.0%*	Prior to the $82.5M Quality Funding Programs, the underlying MBR is 88%.
Administrative Expense *(Ratio)*	$107.3M *10.0%*	The $28M reduction in administrative expenses is due to significantly less funding needed for the Operations of the Future build-out in FY 2024-25 and continuous efficiency improvement in the operations of the health plan. The year-over-year administrative expense reduction is also after accounting for proposed new investments in staffing and additional consulting services."
Reserve Increase/(Decrease)	$(22.5M)	Net income prior to the Quality Funding Programs is $60M, or 2% of total revenue (premium revenue plus investment income). The Quality Funding Program produces a planned $(22.5M) decrease to reserves.
Net Increase to Reserves	$0	We will be using our $60M operating margin plus $22.5M in reserves for the Quality Funding Programs.

137 of 164 pages

Return to Agenda

A Planned Spend Down of Reserves Has Significant Risks

Going into a planned spend-down position requires us to be even more sensitive to variabilities in our environment that can adversely impact our financial position. Unfavorable changes in any of a multitude of factors could create a far larger spend down than planned. *For instance, think of another $16.3M premium acuity adjustment on top of a planned $22.5M reduction in reserves.*

- Membership Health
  Factors such as redetermination and the introduction of newly-eligible populations could result in a higher-utilizing membership.

- State Rate Actions
  The State has the ability and precedent to invoke revenue reductions retroactively using the historical utilization as rationale.

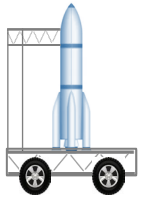
- Provider Reimbursement Expectations
  The narrowing gap between premium revenues and medical benefits puts pressure on our ability to fund continued fee-for-service increases.

Management Actions
Including but not limited to

- ✓ Proactive monitoring of member health to ensure acuity needs are met timely, preventing unnecessary care in expensive settings.
- ✓ Rate advocacy with State for premium adequacy.
- ✓ Recalibrate reserve recommendations should unfavorable developments require.
- ✓ Advance sophisticated capabilities for managing care and cost, especially of high acuity, chronic condition populations.
- ✓ High discipline on what we can control.

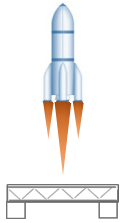
Return to Agenda

Effective Execution of an Unprecedented Budget



Getting Ready for Takeoff 2024/25

- Integrated Care Team full implementation
- Voice of the Member (surveys, feedback); deep understanding of member and community need
- Service Everywhere community resource centers
- Performance Management and Leadership Development
- Strengthening project management capability organization-wide
- Financial strength and continued investment in modernizing health plan capabilities to improve health, quality healthcare, and member experience



Launched 2023/24

- State of art operating systems and services and operational performance excellence
  - Core Admin and BPO
  - Care Management System
  - Provider Portal
  - Modern Data Warehouse
  - CRM
- Community Care model bringing healthcare to members where they want it including school, work, home and neighborhood
- Delegation and vendor oversight to drive performance and value
- DSNP Readiness/Knox Keene
- NCQA Accreditation
- Optimized Data, Analytics & Metrics
- Corporate Integrity Agreement implementation

Landing Well 2023/24

- Highly effective system-wide quality improvement program achieving unprecedented MCAS improvement
- Procurement of best-in-class systems to implement the model of care
- Stellar performance on DHCS, MLR and Claims Audits.
- In-house local contact center
- Healthcare Programs and Services connect members with healthcare/services including Wellth, Community Supports, Member Incentive Programs

- All members get care "Whenever/ wherever" they need it (access and equity for all); High MCAS scores reflect this
- High member engagement in health and healthcare (members know, want, get, and stay active in health and regular primary and specialty care and Rx adherence) yields lasting impacts to individual, family, and community health and wellbeing
- The healthcare system and providers of community-based services are higher performing and continuously improving to meet GCHP/DHCS goals for quality, satisfaction, and equity

139 of 164 pages
Return to Agenda

- GHCP’s underlying financial performance today is strong.
- We are planning a judicious use of reserves to further the Quality Funding Programs.
- We seek your feedback on our proposed FY 2024/25 budget today and in 1:1’s scheduled for the next few weeks.

Return to Agenda

Strategy and Budget Principles and Framework

Executive Finance Committee
April 18, 2024
Nick Liguori, Chief Executive Officer
Sara Dersch, Chief Financial Officer
Erik Cho, Chief Program and Policy Officer
Dr. Felix Nuñez, Chief Medical Officer

141 of 164 pages

Return to Agenda

Framework for Budget Fiscal Year 2024-25 and 3-Year Planning

Budgets bring our Mission, Vision, and Strategies to life. GCHP Management is developing a budget for the Fiscal Year (FY) 2024-25 and the 3-year period July 2024 – June 2027 that will accomplish the following in alignment with our **MISSION**:

1. **GCHP** | Ensure GCHP has the health plan capabilities necessary to meet our Mission of the best health possible, best access possible to quality healthcare, and superior experience for the members and communities we serve – for both Medi-Cal (low income vulnerable) and D-SNP (low income and/or disabled dually eligible) programs.

    - GCHP is now in the second annual budget of a multi-year transformation of health plan capabilities to meet its Mission, having historically performed low relative to other Medi-Cal local/community health plans in Mission-related measures (MCAS, CAHPS, health outcomes).

    - While always seeking to improve Quality and Satisfaction, we must also build (invest in) our capabilities to better manage medical costs to ensure long term financial viability.

2. **PROVIDERS** | Ensure we can make substantial, sustained, and transformational investments in Ventura County's delivery system of healthcare and healthcare-supportive services with the objective of increasing access to - *and provision of* - quality healthcare for the vulnerable members and communities enrolled in Medi-Cal, where and when they need the care and services.

3. **MEMBERS** | The primary purpose of our work and the fundamental principle that guides us in how we do that work is better health for our members and communities. Our members will be the main beneficiaries of all our many and major efforts to crate a more capable health plan and greater access to needed care across the healthcare system.

Return to Agenda

Budget FY 2024-25 | Commitments

- Management's objective with the budget is to optimize quality care for our members and to ensure the long-term viability and success of GCHP. We do this by ensuring the Ventura County Medi-Cal delivery system has funding to achieve high standards of access and quality care.
- Transparency is a paramount commitment by Management to Commission.
- Management's aim is to provide all information that supports the Commission in making budget decisions compliant with their fiduciary duty, legal requirements and accountability for the health plan's viability and success.
- GCHP continuous improvement: Per best practice, Management is engaging the Commission earlier (April) and more meaningfully in the budget process than ever before.

Return to Agenda

Management values feedback from Commissioners and we are available to answer questions and take in your feedback at any time.

Budget FY 2024-25 | Compliance and Legal Review

- ✓ GCHP Management desires to ensure the fullest funding possible to the Ventura County's Medi-Cal healthcare delivery system, and our funding programs since 2022 demonstrate this commitment.
- ✓ GCHP Management's funding programs are rooted in fundamental principles:
  - We are entrusted with the best use of taxpayer funds.
  - Funding for healthcare services must be adequate for safety net providers dealing with inflationary cost trends.
  - Funding must provide value (access, quality, outcomes) to the health plan and our membership as well as to our State and federal regulators who determine funding and its purpose.
  - Funding must always be compliant with state and federal laws/regulations that define permissible use of funds.
  - Funding must always be reasonable relative to value, services, market standards, industry practices, etc.
- ✓ Compliance is paramount under all circumstances. Compliance under the Corporate Integrity Agreement requires the highest standards of compliance.
- ✓ These slides describe GCHP's plans. BBK (Leeann Habte) on behalf of GCHP is performing a comprehensive legal review of all provider funding, including Quality Incentives, Reimbursement Arrangements, and Grants for compliance with federal and State laws and GCHP's Corporate Integrity Agreement with the Office of the Inspector General. This expert-based review includes consultation with an outside consultant with specialized expertise in value-based funding programs.

Return to Agenda

Budget FY 2024-25 | Process and Timeline

April 2024 Key Dates and Deliverables

- April 18th – Executive Finance Committee presentation on background, context, concepts, and process for Budget FY 2024-25 and 3-Year Plan. Staff request: questions and feedback.
- April 22nd – Commission presentation on the same. Staff request: questions and feedback.

May 2024 Key Dates and Deliverables

- May 16th – Executive Finance Committee presentation on preliminary Budget FY 2024-25 and 3-Year Plan. Staff request: questions and feedback.
- May 20th – Commission presentation on the same. Staff request: questions and feedback.

May 17th to June 14th – 1:1s with Executive Finance Committee

June 2024 Key Dates and Deliverables

- June 20th—Executive Finance Committee presentation on proposed final Budget FY 2024-25. Staff request: recommendation.
- June 24th—Commission presentation on the same. Staff request: approval.
- June 25th—Management begins new budget implementation.

April 2024

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

May 2024

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

June 2024

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

Budget FY 2024-25 | TNE Industry Perspective

GCHP Management desires to invest some reserves in value-based financing of the Ventura County healthcare delivery system. The Plan is outlined in the following slides. Here is an updated view of TNE across the Medi-Cal industry.

Industry Perspective | Tangible Net Equity by Medi-Cal Managed Care Plan (as % of required TNE)

Source: "Financial Summary of Medi-Cal Managed Care Plans (Quarters Ending June 30, 2023 and September 30, 2023); GCHP source is internal financial reporting.
Non-Governmental Medi-Cal Plans not included - reserves are generally kept at parent

	June 2022	December 2022	June 2023	September 2023
Kaiser Foundation Health Plan		2154%	2209%	2252%
CalOptima	1340%	1482%	1556%	1577%
Health Plan of San Joaquin	988%	1220%	1447%	1381%
Scan Health Plan	1352%	1332%	1306%	1318%
Health Plan of San Mateo	977%	1268%	1275%	1241%
Central California Alliance for Health	1092%	1156%	1180%	1211%
Gold Coast Health Plan	482%	750%	1094%	1025%
L.A. Care Health Plan	716%	690%	789%	954%
CalViva Health	789%	838%	853%	866%
CenCal Health	563%	666%	811%	820%
Inland Empire Health Plan	725%	712%	794%	796%
Kern Health Systems	545%	623%	729%	741%
Alameda Alliance	605%	677%	758%	737%
Partnership HealthPlan	784%	829%	771%	729%
San Francisco Health Plan	1024%	1413%	784%	710%
Santa Clara Family Health Plan	585%	640%	716%	654%
Contra Costa Health Plan	554%	585%	617%	604%

Kaiser and SCAN are shown for additional perspective. Kaiser is included as it is now a fully licensed Medi-Cal Managed Care Plan. SCAN is a standard bearer for managing D-SNP. GCHP will be responsible for fiscally managing D-SNP and its reserves in the next budget year (FY '25-'26).

GCHP ranks near the middle as compared to other Medi-Cal Plans. GCHP TNE declined slightly due to changes in total assets and liabilities.

Preliminary 2024 financial reports are that LA Care will exceed GCHP's position in Year End rankings due to its pace of reserve growth.

Budget FY 2024-25 | MBR Components

147 of 164 pages

85.0%

Includes 2.5% current QIPP

FY 2023-24 base benefit cost trended

2.5%

QIPP Expansion

Continuation of Quality-based Incentives

2.0%

Transitional Rates*

Incremental increases related to improving access to care (ex: evening and weekend hours)

1.3%

Provider and Community Grants

Continued support for Providers and Community Organizations to improve access to care

TBD

Targeted Rate Increase (TRI)

TRI is supposed to be net neutral, however MCOs retain risk should TRI utilization exceed State forecasts

TBD

Member Incentives

Increase in member incentives for Wellth expansion, member activities that close MCAS gaps in care, etc.

> 92%

*Incremental increases related to improving access to care or quality related activities

Return to Agenda

Budget FY 2024-25 | Actuarial Unit Cost Comparison

- This analysis of GCHP Unit Cost vs. those of other Southern California Medi-Cal regions (7 counties, 7 Medi-Cal Managed Care Plans) provides valuable insight for forecasting future premium rates. This analysis of unit cost closely approximates a comparison of reimbursement rates.
- Key to future rate development will be the maintenance of traditional FFS spending that is "in line" with spending across Medi-Cal plans. **Outlier FFS spending is at risk of not being fully reimbursed as DHCS looks to create greater regional cost parity.**
- Regional rate setting will replace individual plan rate setting in the near future. GCHP Management is actively preparing our reimbursement program to succeed in this new premium paradigm – **a focus on value/quality is one way to ensure long term success** (both financial success and Mission success).
- Key findings of the analysis strongly support Management's plan to focus spending increases for the greatest Quality (MCAS) impact:
  1. **MCAS improvements are principally achieved by greater use of outpatient primary healthcare, specialty healthcare, behavioral healthcare, and transportation to care.**
  2. **Physician Primary Care, Behavioral Healthcare, and Transportation unit costs are low relative to the industry.**

Category of Healthcare Service	GCHP Percentile (100% = Highest Rate in Region)
Inpatient Hospital	100.0%
Hospice	93.2%
Laboratory and Radiology	91.9%
CBAS	83.7%
BHT Services	76.6%
FQHC	76.6%
Physician Specialty	76.5%
Long-Term Care	75.4%
Emergency Room	61.5%
Other Medical Professional	56.6%
Outpatient Facility	55.2%
Mental Health - Outpatient	46.1%
All Other (small category $-wise)	37.6%
Physician Primary Care	37.2%
Home and Community Based Services	34.9%
Transportation	33.7%
Overall	71.6%

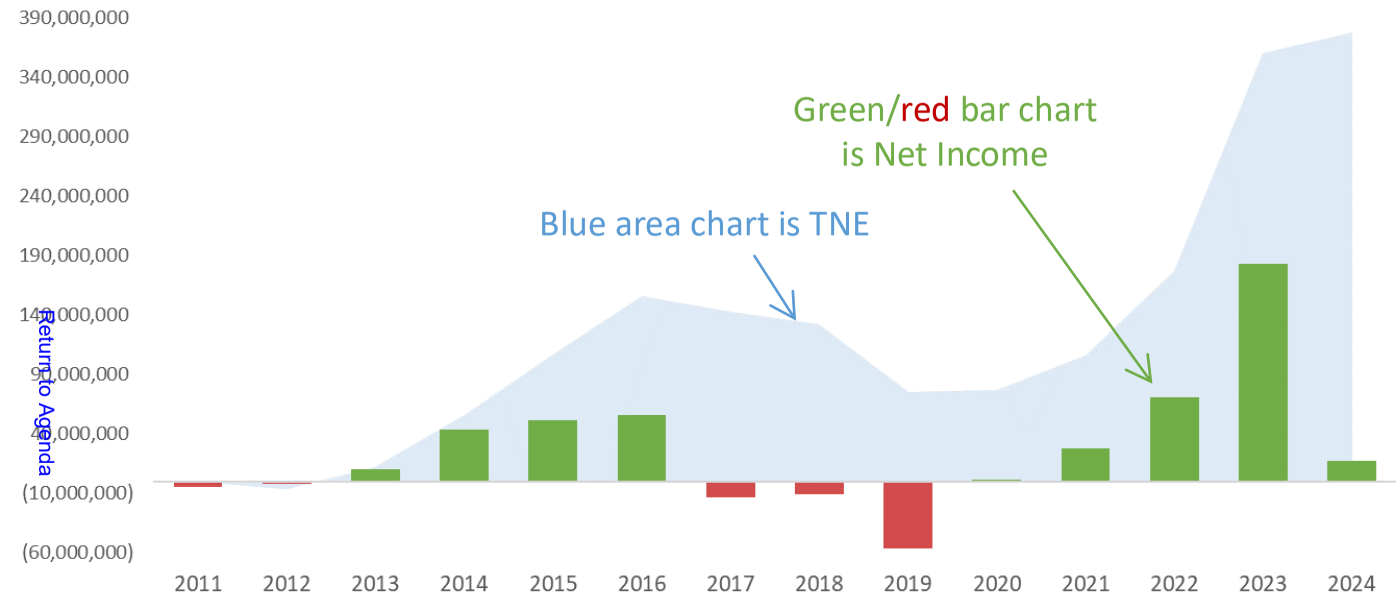
Costs are for the adult population and excludes the impact of population acuity and utilization. Counties include Kern, Los Angeles, Riverside, Santa Barbara, San Bernardino, San Luis Obispo, and Ventura.

148 of 164 pages

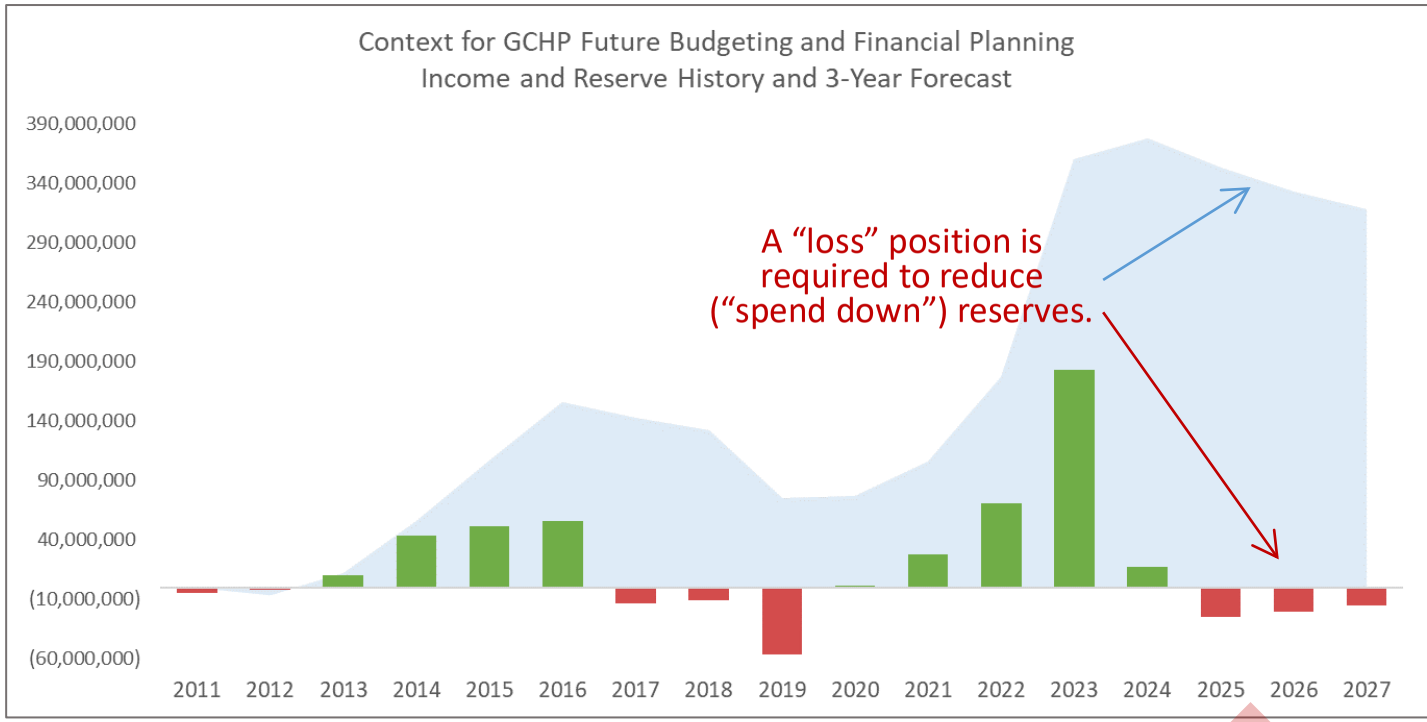
Return to Agenda

Income and TNE Position

- Net Income adds to or reduces health plan reserves – adds to if Net Income is positive, reduces if negative. You can see the historical relationship in the chart below – when Net Income is positive, reserves grow by that amount; conversely, "losses" reduce reserves.



Return to Agenda



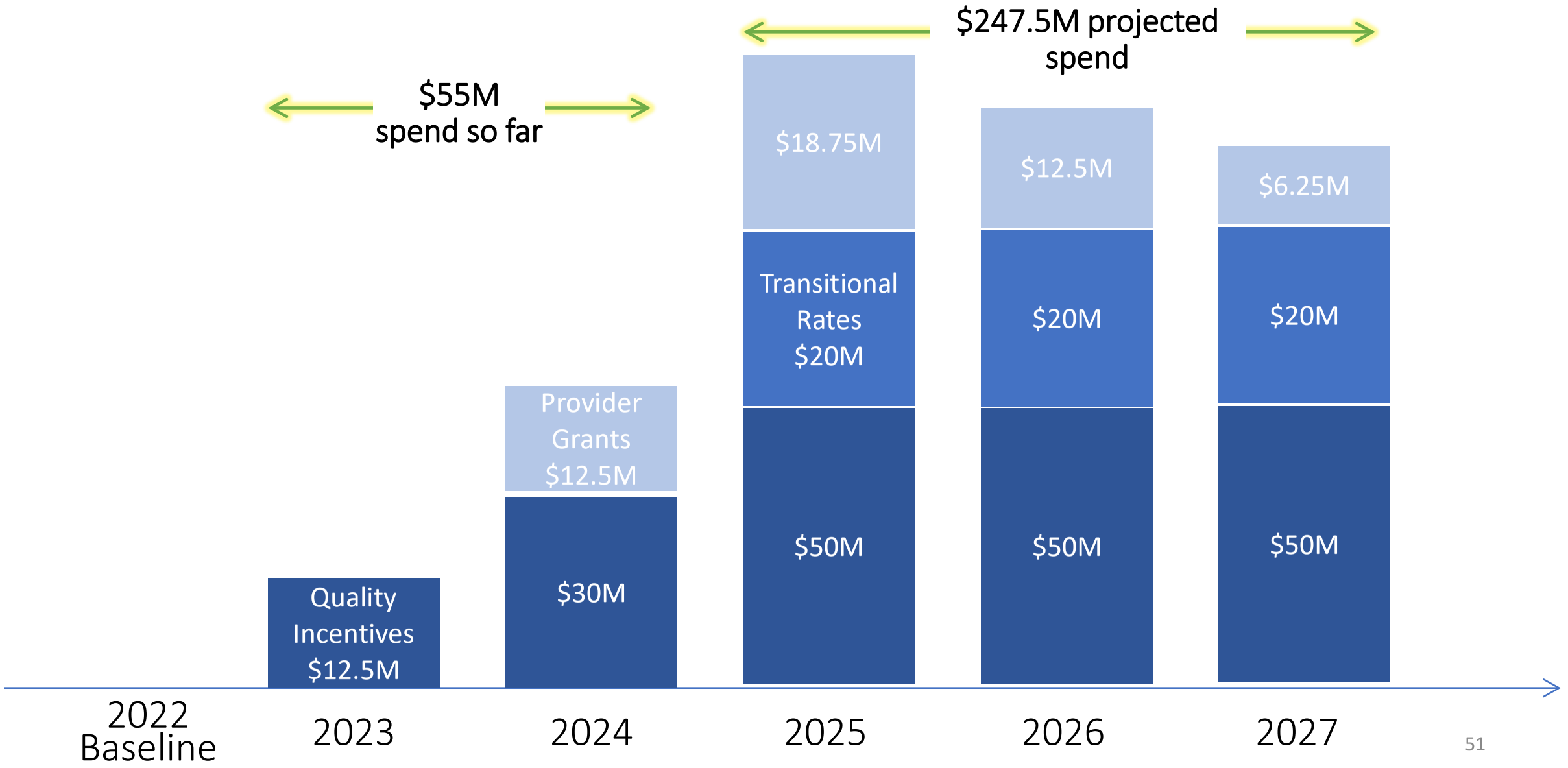
- To achieve a spend down of some Unrestricted Reserves (i.e., not in the 700% of TNE Policy), GCHP must go into a negative Net Income ("loss") position.

Budget FY 2024-25 | TNE Composition and Planning

Today		Management Analysis	GCHP Management Recommended Actions
1025%	Unrestricted Reserves 325%	$60M	GCHP Management proposes to plan for a $60M reduction in reserves over the next 3 budgets (spanning July 2024 – June 2027) in the form of compliant and value-based funding for providers.
		$60M	D-SNP expenses (provider and administrative) are highly sensitive to minor changes in our modeling assumptions. Slightly adverse developments increase magnitude of losses. These are expected losses for D-SNP (actuarially developed) which has been filed with DMHC in its Knox Keene license application.
	Restricted Reserves 700%	$258M	These funds are restricted for maintenance of adequate reserves for long term viability of GCHP. These funds were established as GCHP TNE Reserve by Commission approval of the FY 2023-24 Budget (current year). For Medi-Cal alone, this provides for adequate long-term thinking and planning and investments to GCHP and providers. For Medi-Cal AND D-SNP combined, these reserve levels are inadequate. Management recommends adding to these reserves to meet satisfactory TNE for both programs.

- ✓ We seek to invest in providers through enhanced Quality-based funding. To do this, we must plan for 3 years of losses. We will course correct if rates and/or medical cost pressures trend adversely to forecast.
- ✓ GCHP Management and Actuaries recommend combining D-SNP TNE and Medi-Cal TNE to account for combined reserve needs.
- ✓ GCHP's actuarial model for D-SNP financial performance filed with the Knox Keene application expects $30M cumulative losses Years 1-3.
- ✓ An additional $30M reserves (on top of $30M expected losses) is prudent due to significant uncertainty in D-SNP performance/losses in 2026-2029.
- ✓ GCHP is entering a period of industry-wide anticipated premium pressures.

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



Budget FY 2024-25 | Quality-Focused TNE Investment

Program	FY 2024	FY 2025	FY 2026	FY 2027
PCP Quality Improvement Programs Up To:	$30M	$35M	$35M	$35M
Hospital and other incentives which may include Specialty, Long Term Care and Behavioral Health Integration Up To:		$15M	$15M	$15M
Transitional Rates Up To:		$20M	$20M	$20 M
Provider and Community Grants Up To:	$12.5M	$18.75M	$12.5M	$6.25 M

GCHP's financial targets will drive Quality and Access through provider investments aligned with Commission- Approved spend.

- **Quality Incentives:** $10 MQIPP Expansion to roll out this FY with incentive programs across other provider areas in development.
- **Transitional Rates:** These rates will be impacted, as much as possible, by quality, access to care, and transitions of care activities and improvements.
- **Provider and Community Grants:** We aim to deliver early on the $25M, 2–3-year commitment made starting in FY 23-24 and provide an additional $25M in funding through FY 2027.

D-SNP/Medicare Forecast Impact on TNE

Model Assumptions	Knox Keene Filed Scenario	Lower Stars Higher Reimbursement	Higher Membership, Lower Stars, Lower Savings Higher Reimbursement
Membership by Year 3	5,190	5,190	13,080
CMS Quality Star Rating	4	3.5	3.5
Managed Care Savings (from "unmanaged FFS")	20%	20%	15%
Provider Reimbursement (% of Medicare Fee Schedule)	102.5%	105%	105%
3- Year Cumulative Losses	-$17M	-$39M	-$60M or more*

* Management is working with actuaries on additional scenario planning

Budget FY 2024-25 | Key Terms (1 of 2)

CMS Quality Star Rating: The Medicare equivalent of the DHCS Managed Care Accountability Set (MCAS). Ratings focus on health plan quality based on measurements of customer satisfaction and the quality of care a plan delivers. Plans are rated on a scale of one to five, with one star representing poor performance and five stars representing excellent performance.

D-SNP: A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan specifically designed to provide targeted care and limit enrollment to special needs individuals. A Dual Eligible Special Needs Plans (D-SNPs) is a type of SNP that enrolls individuals who are entitled to both Medicare and Medicaid (Medi-Cal in California).

Medical Benefit Expense: Costs for medical, dental, vision, transportation, meals, and other covered supplemental benefits.

Medical Benefit Ratio (MBR): Ratio of Medical Benefits to Premium Revenue; the percentage of state revenue that is spent on medical care.

Medicare Fee Schedule: A complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fees used to reimburse a physician and/or other providers on a fee-for-service basis.

Medical Management Savings: Savings generated from health plan activities related to the medical management of health services as compared to the Medicare Fee-For-Service costs.

Return to Agenda

Net Income: The remaining profit or loss after all expenses have been subtracted from all revenues. The Net Income increases reserves if positive or reduces reserves if negative.

Budget FY 2024-25 | Key Terms (2 of 2)

Premium Revenue: Amount received from the State to provide medical care and other covered services to GCHP members.

Quality Incentive Pool and Program (QIPP): A focused effort to direct funding to Providers for the achievement of Quality measures.

Restricted Reserves: The portion of Tangible Net Equity (TNE) that GCHP is required by policy to maintain (i.e. not be used). For GCHP's existing line of business (Medi-Cal), this amount is currently set at 700% of the Department of Health Care Services (DHCS) required minimum TNE.

Tangible Net Equity (TNE): GCHP total assets (cash, physical property, amounts we are owed) less total liabilities (both realized and incurred, such as amounts GCHP owes to pay current claims, vendors, personnel, etc). GCHP is required to maintain the DHCS formula-derived minimum TNE to ensure continuity of payments and services.

Targeted Rate Increase: To improve access to care, quality and equity, the California Department of Health Care Services (DHCS) is increasing rates to 87.5% of Medicare for certain Medi-Cal services.

Unrestricted Reserves: The portion of GHCP's TNE above and beyond the Commission-specified minimum. The unrestricted reserves will be used to cover expected losses in the first years of D-SNP as well as the quality-related funding for providers and other Commission-approved uses.

Value-Based Care: Care that ties the amount providers earn to the results they deliver for their patients, such as the quality, access and equity.

Schedule 1 - Medical Margin Budget: PMPM Cost by Category of Service

FY 2024 -25 MEDICAL EXPENSE BUDGET
PMPM COST BY CATEGORY OF SERVICE

	FY 2023-24 as of April 2024 PMPM	Projected Jul-Dec 2024 PMPM	Projected Jan-Jun 2025 PMPM	FY 2024-25 PMPM	% Change	Projected Dollars
Capitation[1]	$ 24.61	$ 25.63	$ 25.80	$ 25.72	4%	$ 77,253,316
Fee For Service						
Inpatient	$ 69.52	$ 77.85	$ 78.61	$ 78.24	13%	$ 235,028,410
Outpatient	$ 28.34	$ 30.31	$ 30.50	$ 30.41	7%	$ 91,342,329
Long Term Care / Skilled Nursing Facility (LTC / SNF)	$ 60.00	$ 60.36	$ 62.55	$ 61.45	2%	$ 184,618,913
Emergency Room	$ 12.91	$ 12.79	$ 12.95	$ 12.87	0%	$ 38,656,501
Physician Specialty	$ 26.74	$ 28.57	$ 28.85	$ 28.71	7%	$ 86,250,542
Transportation	$ 0.80	$ 1.87	$ 1.89	$ 1.88	135%	$ 5,634,296
Primary Care Physician	$ 12.02	$ 13.31	$ 13.29	$ 13.30	11%	$ 39,957,499
Mental and Behaviorial Health Services	$ 12.10	$ 13.71	$ 13.93	$ 13.82	14%	$ 41,503,267
Other Medical Professional	$ 1.65	$ 1.61	$ 1.63	$ 1.62	-2%	$ 4,858,907
Home & Community Based Services	$ 11.40	$ 13.31	$ 13.45	$ 13.38	17%	$ 40,186,776
Laboratory and Radiology	$ 4.24	$ 3.25	$ 3.29	$ 3.27	-23%	$ 9,821,301
Directed Payments - Provider	$ 9.93	$ -	$ -	$ -	-100%	$ -
Other Fee For Service	$ 6.35	$ 7.62	$ 7.74	$ 7.68	21%	$ 23,069,406
Sub-total	**$ 256.00**	**264.54**	**268.67**	**266.61**	**4%**	**$ 800,928,147**
Other Expenditures						
Quality Funding Program	$ 24.00	$ 27.51	$ 27.42	$ 27.46	14%	$ 82,500,000
Prop 56	$ -	$ 3.19	$ 3.20	$ 3.19	0%	$ 9,595,654
Carelon Case Management	$ -	$ 0.83	$ 0.83	$ 0.83	0%	$ 2,500,000
Medical Care Management	$ 8.23	$ 11.57	$ 11.53	$ 11.55	40%	$ 34,708,829
Refunds & Recoveries	$ (1.05)	$ (0.40)	$ (0.40)	$ (0.40)	-62%	$ (1,200,000)
Reinsurance Recoveries	$ 0.62	$ 0.63	$ 0.63	$ 0.63	2%	$ 1,900,000
Sub-total	**$ 31.80**	**$ 43.34**	**$ 43.21**	**$ 43.28**	**36%**	**$ 130,004,483**
Total PMPM Medical Expense	**$ 312.41**	**$ 333.51**	**$ 337.68**	**$ 335.60**	**7%**	**$ 1,008,185,945**
MBR	**88.8%**	**91.6%**	**93.5%**	**92.6%**		**92.6%**

Note

1: Financial impact of Kaiser-aligned members have been removed from YTD results for comparative purposes

Schedule 2 - Medical Margin Budget: PMPM Cost by Category of Aid

FY 2024 -25 MEDICAL EXPENSE BUDGET
PMPM COST BY CATEGORY OF AID

	Child	Adult	Adult Expansion	SPD	SPD Dual	LTC	LTC Dual
Capitation	$ 18.47	$ 31.47	$ 35.30	$ 38.78	$ 6.17	$ 6.17	$ 6.17
Fee For Service							
Inpatient	$ 13.12	$ 132.11	$ 104.73	$ 364.82	$ 9.40	$ 369.40	$ 55.27
Outpatient	$ 4.04	$ 51.70	$ 42.15	$ 114.12	$ 15.28	$ 147.17	$ 8.12
Long Term Care / Skilled Nursing Facility (LTC / SNF)	$ 0.72	$ 13.63	$ 31.67	$ 203.51	$ 138.79	$ 7,763.64	$ 8,720.68
Emergency Room	$ 11.54	$ 16.46	$ 14.48	$ 24.60	$ 1.36	$ 15.71	$ 1.02
Physician Specialty	$ 8.24	$ 48.20	$ 39.51	$ 74.83	$ 15.02	$ 144.22	$ 11.19
Transportation	$ 0.78	$ 1.63	$ 2.72	$ 8.34	$ 0.64	$ 13.47	$ 0.95
Primary Care Physician	$ 7.88	$ 24.79	$ 13.91	$ 24.16	$ 6.98	$ 12.99	$ 4.16
Mental and Behaviorial Health Services	$ 16.72	$ 8.64	$ 9.32	$ 69.13	$ 1.63	$ -	$ 0.19
Other Medical Professional	$ 0.68	$ 1.81	$ 2.05	$ 4.99	$ 1.73	$ 3.00	$ 3.04
Home & Community Based Services	$ 2.09	$ 7.67	$ 10.84	$ 61.34	$ 46.57	$ 24.81	$ 23.63
Laboratory and Radiology	$ 0.99	$ 6.00	$ 4.59	$ 6.22	$ 0.24	$ 5.00	$ 0.08
Other Fee For Service	$ 1.22	$ 6.01	$ 5.67	$ 49.50	$ 17.00	$ 221.51	$ 158.81
Sub-total	**$ 68.01**	**$ 318.66**	**$ 281.65**	**$ 1,005.58**	**$ 254.63**	**$ 8,720.93**	**$ 8,987.14**
Other Expenditures							
Quality Funding Program	$ 20.95	$ 44.48	$ 44.53	$ 118.48	$ 66.33	$ 125.78	$ 66.55
Prop 56 Payment	$ 1.81	$ 9.47	$ 2.77	$ 1.11	$ -	$ 0.86	$ -
Carelon Case Management	$ 0.83	$ 0.83	$ 0.83	$ 0.83	$ 0.83	$ 0.83	$ 0.83
Grant Program	$ 1.30	$ 4.57	$ 4.58	$ 14.85	$ 7.61	$ 15.87	$ 7.64
Refunds & Recoveries	$ (0.40)	$ (0.40)	$ (0.40)	$ (0.40)	$ (0.40)	$ (0.40)	$ (0.40)
Reinsurance Recoveries	$ 0.63	$ 0.63	$ 0.63	$ 0.63	$ 0.63	$ 0.63	$ 0.63
Sub-total	**$ 25.13**	**$ 59.60**	**$ 52.94**	**$ 135.50**	**$ 75.00**	**$ 143.57**	**$ 75.25**
Total PMPM Medical Expense	**$ 111.61**	**$ 409.72**	**$ 369.89**	**$ 1,179.87**	**$ 335.80**	**$ 8,870.68**	**$ 9,068.56**

Schedule 3 - Medical Margin Budget

FY 2024-25 Medical Margin Budget			
	Jul - Dec 2024	Jan - Jun 2025	FY 2024-25
Revenue			
Base Cap	$ 510,105,105	$ 508,282,802	$ 1,018,387,907
Quality Withhold/Earnback	$ (1,284,750)	$ (2,541,414)	$ (3,826,164)
Maternity	$ 14,710,906	$ 15,212,438	$ 29,923,344
ECM Revenue	$ 8,816,116	$ 8,936,959	$ 17,753,075
Prop 56	$ 5,040,177	$ 5,060,511	$ 10,100,689
Hyde (including Prop 56)	$ 479,845	$ 495,922	$ 975,767
TOTAL REVENUE	**$ 537,867,399**	**$ 535,447,218**	**$ 1,073,314,618**
Fee for Service			
01-Inpatient Hospital	$ 107,373,319	$ 108,806,315	$ 216,179,634
02-Outpatient Facility	$ 45,446,200	$ 45,896,129	$ 91,342,329
03-Emergency Room	$ 19,173,228	$ 19,483,273	$ 38,656,501
04-Long-Term Care	$ 90,507,090	$ 94,111,823	$ 184,618,913
05-Physician Primary Care	$ 19,956,811	$ 20,000,687	$ 39,957,499
06-Physician Specialty	$ 42,840,481	$ 43,410,060	$ 86,250,542
07-FQHC	$ 9,371,387	$ 9,477,390	$ 18,848,776
08-Other Medical Professional	$ 2,409,165	$ 2,449,742	$ 4,858,907
09-Mental Health - Outpatient	$ 11,701,580	$ 11,917,359	$ 23,618,940
10-BHT Services	$ 8,849,459	$ 9,034,869	$ 17,884,328
12-Laboratory and Radiology	$ 4,874,507	$ 4,946,794	$ 9,821,301
13-Transportation	$ 2,797,203	$ 2,837,094	$ 5,634,296
14-CBAS	$ 6,039,705	$ 6,087,938	$ 12,127,643
15-Hospice	$ 3,015,840	$ 3,064,055	$ 6,079,895
16-HCBS Other	$ 1,522,411	$ 1,550,933	$ 3,073,344
17-All Other	$ 8,414,082	$ 8,575,430	$ 16,989,511
18-Enhanced Care Management	$ 8,375,310	$ 8,490,111	$ 16,865,421
19-Community Supports	$ 4,018,569	$ 4,101,799	$ 8,120,368
TOTAL FEE FOR SERVICE	**$ 396,686,346**	**$ 404,241,801**	**$ 800,928,147**
Capitation Expense			
TOTAL CAPITATION	**$ 38,429,766**	**$ 38,823,549**	**$ 77,253,316**
Other Expenditures			
Grant Program	$ 6,250,000	$ 6,250,000	$ 12,500,000
Claims Recoveries (non-system adjusted)	$ (600,000)	$ (600,000)	$ (1,200,000)
Reinsurance Recoveries	$ 950,000	$ 950,000	$ 1,900,000
Provider Incentives	$ 10,000,000	$ 10,000,000	$ 20,000,000
QIPP	$ 25,000,000	$ 25,000,000	$ 50,000,000
Prop 56 Payment	$ 4,788,168	$ 4,807,486	$ 9,595,654
Carelon Case Management	$ 1,250,000	$ 1,250,000	$ 2,500,000
Care Management	$ 17,354,414	$ 17,354,414	$ 34,708,829
TOTAL OTHER EXPEDITURES	**$ 64,992,583**	**$ 65,011,900**	**$ 130,004,483**
TOTAL MEDICAL BENEFITS	**$ 500,108,695**	**$ 508,077,250**	**$ 1,008,185,945**
Member Months	**1,499,517**	**1,504,617**	**3,004,133**
MBR	**91.6%**	**93.5%**	**92.6%**

Schedule 4 - General and Administrative Expenses

FY 2024-25 GENERAL AND ADMINISTRATIVE EXPENSES	FY 2023-24 Reforecast	FY 2024-25 Budget	Year / Year Change	Percent Change	*Notes*
Expense					
Salary Expense	$ 39,992,043	$ 43,352,760	$ 3,360,717	8.4%	
Taxes and Benefits	12,256,448	13,159,773	903,325	7.4%	
Overtime	0	242,916	242,916		Overtime was not broken out and therefore not budgeted for in FY2023-24
Incentive	3,077,622	2,500,000	(577,622)	-18.8%	
Temporary Labor Expense	2,839,974	647,800	(2,192,174)	-77.2%	
Tuition Reimbursement	58,854	50,400	(8,454)	-14.4%	
Training, Conference, and Travel	1,140,008	1,751,576	611,568	53.6%	Travel back to pre-pandemic levels / Healthfairs
Outside Service - Conduent	20,973,109	2,384,918	(18,588,190)	-88.6%	Temination of Conduent Relationship
Outside Services - Other	9,979,576	34,486,245	24,506,669	245.6%	Wellth $6.9M, Carelon $6.4M, Netmark $8M / Partially offset in Conduent Savings
Accounting & Actuarial Services	197,000	180,000	(17,000)	-8.6%	
Legal Expense	3,412,091	2,550,000	(862,091)	-25.3%	Reforecast icluded Jan - Dec 2023 Actuals - 2024/25 expenses projected lower
Consulting Services Expense	2,933,411	2,450,066	(483,345)	-16.5%	Planned reduction in consulting services
Translation Services	351,468	292,000	(59,468)	-16.9%	Reduction due to cessation of redetermination efforts
Committee/Advisory	12,050	0	(12,050)	-100.0%	
Employee Recruitment	1,093,555	1,000,000	(93,555)	-8.6%	Planned reduction in recruitment expense
Employee Appreciation	0	5,750	5,750		
Lease Expense -Equipment	16,193	8,800	(7,393)	-45.7%	
Lease Expense -Office	1,988,476	1,592,628	(395,848)	-19.9%	Over-budgeted in FY 2023-24
Depreciation & Amortization Expense	535,753	4,000,000	3,464,247	646.6%	Certain capitalized expenses were not anticipated in FY 2023-24 Budget
Non-Capital - Furniture & Equip.	18,031	8,400	(9,631)	-53.4%	
Non-Capital Equipment - Computer	571,748	196,800	(374,948)	-65.6%	Reduction in Temp Staff over 2023/24 resulting in lower equipment need
Office & Operating Supplies	112,739	77,674	(35,065)	-31.1%	
Shipping & Postage Expense	374,630	548,130	173,500	46.3%	Printing & Fulfillment brought in-house from Conduent
Printing Expense	747,192	1,124,700	377,508	50.5%	Printing & Fulfillment brought in-house from Conduent
Software Subscriptions	4,701,225	13,390,776	8,689,551	184.8%	Reflects new technology brought in-house; offset in Coduent Savings
Software Licenses-Non-Capital	20,794	48,756	27,962	134.5%	
Software Maintenance & Support	122,810	2,033,889	1,911,079	1556.1%	Increased cost due to bringing several systems in-house
Repairs and Maintainence	284,491	380,143	95,652	33.6%	Increased maintenance in Lease
Telephone/Internet	371,647	613,532	241,885	65.1%	Primarily Call Center related
Advertising and Promotion	646,703	1,795,000	1,148,297	177.6%	Member Incentives and Community Sponsorship
Insurance	1,488,412	1,515,000	26,588	1.8%	
Interest	507,634	225,000	(282,634)	-55.7%	Operations - Based upon a 18 month average expense
Professional Dues, Fees, and Licenses	381,907	276,751	(105,155)	-27.5%	Local Health Plans of California membewrship paid in full in Reforecast
Subscriptions and Publications	37,282	47,114	9,832	26.4%	
Bank Service Fees Expense	5,321	9,000	3,679	69.2%	
Other/ Miscellaneous Expenses	1,653	112,500	110,847	6705.8%	Provider Quality Summit, branded clothing for community events
Care Management Credit	(20,735,070)	(34,708,000)	(13,972,930)	67.4%	Includes items not previously accounted for as Quality Improvement related expenses (Member Incentives, Quality Software, and Quality related software
Total General and Administrative	**90,516,778**	**98,350,798**	**7,834,020**	**8.7%**	
% Admin to Revenue	**8.9%**	**9.0%**			
Operations of the Future (OOTF)	16,057,840	4,000,000	(12,057,840)	-75.1%	
Strategic Initiatives (SI)	0	6,968,667	6,968,667		
Total G&A (Including OOTF and SI)	**106,574,618**	**109,319,464**	**2,744,847**	**2.6%**	
% to Revenue	**10.5%**	**10.0%**			

Schedule 5
Vendor Contract Listing

Contract Number	Vendor	Minority Vendor	Actual Contract Spend as of April 10, 2024	Projected Monthly Spend	Renewal Strategy	Renewal Term (Months)	Estimated FY2024/25 Budget Amt	Renewal End Date	Contract Description
Contract_2022_00699	3M Health Information Systems	No	$134,314	$4,200	Renew for 3 years	36	$50,400	12/15/2027	IT software: All Patients Refined Diagnosis Related Groups (APR DRG) is a system that classifies patients according to their reason of admission, severity of illness and risk of mortality)
Contract_2020_00187	Adecco (Akkodis) USA, Inc.	No	$10,517,690	$41,667	Renew for 1 year	12	$500,000	1/31/2026	IT Temporary labor services
Contract_2020_00191	Advanced Medical Reviews	No	$69,197	$1,500	Renew for 3 years	36	$18,000	10/31/2027	Medical review services
Contract_2022_00751	Affiliated Monitors Inc. [AMI]	No	$177,715	$10,000	Renew for 1 year	12	$120,000	11/1/2025	Corporate integrity services
Contract_2020_00448	Allegis Grp Hold, Inc. dba Teksystems, Inc.	No	$1,408,584	$20,000	Renew for 1 year	12	$240,000	1/31/2026	IT Temporary labor services
Contract_2024_00910	Ash	No	$0	$10,000	Renew for 2 years	24		12/31/2026	Health Risk Assesment
Contract_2020_00218	CAQH	No	$69,104	$1,000	Renew for 2 years	24	$12,000	12/31/2026	Software as a Service (data sharing)
Contract_2023_00806	Carol Hsu	Asian Pacific	$421,685	$5,600	Renew for 2 years	24	$67,200	10/31/2026	Medical record review services
	Case Net LLC	No		$50,000	Renew for 5 years	60	$600,000	6/30/2029	Medical Management Capability License
Contract_2021_00584	Compuwave	Asian Pacific	$102,829	$2,333	Renewal for 1 year	12	$28,000	7/26/2025	IT Infrastructure Software
Contract_2023_00792	Consentia Health LLC	No	$733,600	$50,000	Renew for 1 year	12	$600,000	12/31/2025	CEO and Finance consulting services primarily related to provider
Contract_2023_00791	Consentia Health LLC	No	$92,000	$8,000	Renew for 1 year	12	$96,000	12/31/2025	Provider consulting services
Contract_2020_00246	Crossroads Staffing Services	Woman-owned	$2,943,888	$15,000	Renew for 1 year	12	$180,000	1/31/2026	Organziation Temporary labor services
Contract_2022_00761	Divurgent, LLC	No	$2,661,286	$150,000	Renew for 3 months	3	$450,000	10/31/2024	OOTF Operational Managemente and SME Support
Contract_2021_00593	Edelstein Gilbert Robson & Smith LLC	No	$130,900	$5,000	Renew for 2 years	24	$60,000	10/8/2026	Consulting services (government advocacy services)
Contract_2021_00596	Edifecs, Inc.	Asian Pacific	$508,231	$14,600	Renew for 2 years	24	$175,200	12/30/2026	IT software: EDI
	Edifecs, Inc.	Asian Pacific		$200,000	Renew for 5 years	24	$2,400,000	6/30/2029	New OOTF Electronic Data Interchange Platform
Contract_2023_00851	Ellit Group LLC	Woman-owned	$146,620	$28,000	Renew for 3 months only	3	$84,000	10/1/2024	OOTF Operational Managemente and SME Support
Contract_2023_00769	Emagined Security, Inc.	No	$174,167	$14,514	Renewal for 1 year	12	$174,167	12/27/2025	IT Security software
Contract_2021_00622	Enterprise Systems Solutions dba EA Networks	No	$263,056	$80,000	Renewal for 1 year	12	$960,000	8/31/2025	IT hardware maintenance
Contract_2020_00200	Ephonamation.com/Ansafone Contact Ctr	No	$55,569	$1,000	Renew for 3 years	36	$12,000	10/31/2027	Outbound calling software
Contract_2020_00580	FloQast, Inc.	No	$123,742	$2,900	Renew for 3 years	36	$34,800	12/31/2027	management.
Contract_2020_00286	Gemini Diversified Services, Inc.	No	$251,521	$5,000	Renew for 1 year	12	$60,000	9/30/2025	Credentialing services
Contract_2021_00614	Health Management Associates Inc.	No	$602,637	$28,000	Renew for 1 year	12	$336,000	7/31/2025	Temporary labor services
Contract_2024_00882	Health Management Associates Inc.	No	$75,587	$150,000	Renew for 1 year	12	$1,800,000	12/1/2025	Finance consulting services
	Healthedge	No		$191,667	Renew for 5 years	60	$2,300,000	6/30/2029	Core Admin Capability License
Contract_2023_00774	Healthwise, Incorporated	No	$51,601	$11,000	Renew for 3 years	36	$132,000	12/31/2027	IT software
Contract_2023_00873	Infomedia Group dba Carenet Healthcare Services	No	$40,707	$26,500	Renew for 6 months	6	$159,000	6/30/2025	Member / Provider Outreach services. (Texting, outbound calls etc.)
Contract_2023_00857	Infomedia Group dba Carenet Healthcare Services	No	$488,955	$50,000	Renew for 1 year	12	$600,000	12/31/2025	Member / Provider Outreach services. (Texting, outbound calls etc.)
Contract_2022_00725	Inovalon, Inc.	No	$1,608,270	$100,000	Renew for 1 year	12	$1,200,000	12/31/2025	Quality Data: IT software - Data Lake

Return to Agenda

Schedule 5
Vendor Contract Listing

Contract Number	Vendor	Minority Vendor	Actual Contract Spend as of April 10, 2024	Projected Monthly Spend	Renewal Strategy	Renewal Term (Months)	Estimated FY2024/25 Budget Amt	Renewal End Date	Contract Description
Contract_2020_00319	Inovalon, Inc.	No	$1,245,075	$27,500	Renew for 3 years	36	$330,000	12/31/2027	Quality Data: HEDIS services
Contract_2020_00318	Inovalon, Inc.	No	$1,089,940	$29,583	Renew for 3 years	36	$355,000	12/31/2027	Quality Data: HEDIS services
Contract_2020_00317	Inovalon, Inc.	No	$526,495	$14,833	Renew for 3 years	36	$178,000	12/31/2027	Quality Data: HEDIS services
Contract_2020_00322	Insight Direct USA	No	$2,452,381	$12,000	Renew for 1 year	12	$144,000	9/29/2025	Desktop Value Add Reseller (desktop software and peripherals)
Contract_2023_00807	Insight Direct USA	No	$111,200	$40,000	Renewal for 1 year	12	$480,000	4/17/2026	IT Infrastructure Software
Contract_2020_00321	Insight Direct USA	No	$129,230	$61,000	Renewal for 1 year	12	$732,000	12/15/2025	IT Infrastructure Software
Contract_2020_00337	Insight Direct USA	No	$93,428	$2,917	Renewal for 1 year	12	$35,000	6/29/2025	Network monitoring software. Critical to the business in monitoring network activity and network performance issues.
Contract_2020_00320	Insight Public Sector	No	$2,007,606	$350,000	Renewal for 1 year	12	$4,200,000	12/31/2025	IT Infrastructure Software
Contract_2020_00348	Iron Mountain	No	$111,724	$1,000	Renew for 4 months	4	$4,000	3/7/2025	Data storage
Contract_2023_00799	Jonathan Baker	No	$99,975	$5,500	Renew for 2 years	24	$66,000	2/28/2027	Medical record review services
	KP	No		$250,000	Renew for 5 years	60	$3,000,000	6/30/2029	Print and Fulfillment Capability License
Contract_2020_00361	Lazer Broadcasting Corporation	Hispanic	$96,464	$4,500	Renew for 1 year	12	$54,000	10/31/2025	Communications services
Contract_2020_00366	LinkedIn Corporation	No	$224,066	$3,000	Renew for 2 years	24	$36,000	12/3/2026	Subscription for online business training (hard skills and soft skills) modules.
Contract_2022_00743	LTC Performance Strategies Inc.	No	$75,360	$1,000	Renew for 1 year	12	$12,000	9/29/2025	HR/ Compensation & salary benchmarking services
Contract_2023_00805	Madhavi Gutta	Woman-owned	$279,865	$5,000	Renew for 2 years	24	$60,000	9/30/2026	Medical record review services
Contract_2021_00598	Manifest Medex	No	$503,461	$62,000	Renew for 2 years	24	$744,000	2/14/2027	IT software (Data sharing)
Contract_2024_00878	Milliman	No	$50,000	$8,333	Renew for 3 years	36	$100,000	12/31/2027	Actuarial services for development of the D-SNP program.
Contract_2024_00891	Moss Adams	No	$589,549	$15,000	Renew for 1 year	12	$180,000	10/31/2025	Finance auditor services
Contract_2020_00527	Multiview Corporation	No	$121,306	$3,500	Renew for 2 years	24	$42,000	8/31/2026	General Ledger, Accounts/Payable, and Procurement software.
Contract_2023_00780	Navex Global, Inc.	No	$53,017	$1,667	Renew for 1 year	12	$20,000	2/9/2026	Compliance software
Contract_2023_00779	Navex Global, Inc.	No	$72,007	$2,667	Renew for 1 year	12	$32,000	2/9/2026	Risk Mgmt Compliance software
	Netmark	No		$333,333	Renew for 5 years	60	$4,000,000	6/30/2029	New Business Process Outsource Partner supporting Core Admin functions
Contract_2022_00759	New Level Resources	Woman-owned	$39,634	$4,167	Renew for 1 year	12	$50,000	10/25/2025	Training and HR Support services
Contract_2022_00677	OptumInsight, Inc.	No	$92,714	$2,583	Renew for 5 years	36	$600,000	6/30/2029	Optum Medical Editing, Pricing Software
Contract_2022_00742	Pajaro Consulting LLC	No	$458,892	$25,000	Renew for 1 year	12	$300,000	6/30/2025	Organziation Transformation consulting services
Contract_2021_00668	Perfect Gift, LLC	No	$2,292,583	$125,000	Renew for 3 years	36	$1,500,000	12/31/2027	Gift cards used as incentives for members participation in completion of MCAS-related screenings and tests
Contract_2024_00896	Press Ganey Assoc.	No	$0	$5,000	Renew for 2 years	24	$60,000	2/28/2027	Provider survey services
Contract_2020_00542	Quest Analytics	No	$67,436	$12,750	Renew for 3 years	36	$153,000	8/11/2027	IT software - Provider geocoder software
Contract_2020_00518	Ryan, LLC dba Ryan Tax Compliance Svs LLC	No	$89,901	$8,000	Renew for 1 year	12	$2,000	2/28/2191	Abandoned and unclaimed property services
Contract_2021_00659	SAI360 Inc.	No	$111,696	$3,333	Renew for 1 year	12	$40,000	11/14/2025	Compliance 360 software licenses
	Salesforce	No		$83,333	Renew for 5 years	60	$1,000,000	6/30/2029	CRM Member Serivces platform License
Contract_2023_00862	Simpledatalabs inc dba Prophecy Inc.	Asian Pacific	$200,000	$16,667	Renewal for 1 year	12	$200,000	9/30/2025	IT Infrastructure Software
Contract_2023_00856	Stacy Miller Public Affairs	Woman-owned	$161,627	$15,862	Renew for 3 years	36	$190,344	6/30/2027	Public relations services
Contract_2021_00642	TBJ Consulting	Black	$933,166	$30,000	Renew for 1 year	12	$360,000	12/31/2025	Annual contract for Chief Diversity Officer
Contract_2020_00458	Tevora Business Solutions, Inc.	Disabled Veteran	$136,443	$2,917	Renewal for 1 year	12	$35,000	10/31/2025	IT Infrastructure Software
Contract_2021_00639	The Finish Line	Woman-owned	$93,598	$12,500	Renew for 3 years	36	$150,000	8/31/2027	Communications services
	Transaction Application Group	No		$83,333	Renew for 5 years	60	$1,000,000	6/30/2029	Provider and Member Portal Capability License

Return to Agenda

Schedule 5
Vendor Contract Listing

Contract Number	Vendor	Minority Vendor	Actual Contract Spend as of April 10, 2024	Projected Monthly Spend	Renewal Strategy	Renewal Term (Months)	Estimated FY2024/25 Budget Amt	Renewal End Date	Contract Description
	TTEC	No		$16,667	Renew for 5 years	60	$200,000	6/30/2029	Call Center Telephany Infrastructure
Contract_2023_00844	UpToDate, Inc.	No	$16,958	$9,000	Renew for 3 years	24	$108,000	6/30/2027	Pharmacy software
Contract_2022_00739	Vendor Credentialing Svs LLC dba Symplr	No	$79,616	$3,333	Renew for 2 years	24	$40,000	9/13/2026	Provider contracting and credentialing software
Contract_2020_00475	Vendor Credentialing Svs LLC dba Symplr	No	$271,654	$4,667	Renewal for 1 year	12	$56,000	1/31/2026	Hosting services, contracting and credentialing software
Contract_2023_00828	Wellth Inc.	Asian Pacific	$1,169,785	$575,290	Renew for 2 years	24	$6,903,480	7/12/2026	Behavioral economic-based member incentive vendor for managing those members with specific chronic conditions.
Contract_2022_00738	Workday Inc.	No	$103,054	$5,583	Renew for 2 years	24	$67,000	9/30/2026	Software used for budgeting administrative (non-medical) costs.
Contract_2020_00476	Xpedite Systems (Easylink) OpenText	No	$371,625	$7,500	Renewal for 2.5 years	18	$7,500	11/30/2025	Fax software. Used for centralized provider and member fax receiving and distribution.

New Vendors / Contracts for Strategic Initiative (SI) Projects

Communications	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$120,000	TBD	Rebranding Initiative with investment in media buyng, managing campaigns and upgrade in website/digital capabilities
Compliance	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$30,000	TBD	Compliance Auding software
Continuous Improvement	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$144,000	TBD	Continuous Improvement Consultant: LEAN SixSigma capability to edcuate and streamline work prcoesses.
Continuous Improvement	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$50,000	TBD	Enterprise Project Management tool that will bring visibility to all projects
Culture and Recognition	BucketList	TBD	N/A	N/A	New Contract Pending	TBD	$120,000	TBD	Implementation of Recognition, Celebration and Work Anniversary program, with platform to manage and provide rewards
Culture and Recognition	Co-Creation	Minority Owned	N/A	N/A	New Contract Pending	TBD	$350,000	TBD	Culture Transformation (Co-Creation). To enhance the work enviroment and overall performance of the organizatoin
D-SNP	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$150,000	TBD	D-SNP: System continued configuration of Core Adimn, MMS, Provider Portal, CRM, Print & fullfilment and Call Center
D-SNP	PSG	TBD	N/A	N/A	New Contract Pending	TBD	$600,000	TBD	D-SNP: PBM Consultant to establish DSNP pharma operations
D-SNP	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$70,000	TBD	DSNP: PBM Vendor system configuration
D-SNP	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$150,000	TBD	DSNP: Consultant for CMS filings and bid (non-actuary)
D-SNP	Milliman	TBD	N/A	N/A	New Contract Pending	TBD	$150,000	TBD	DSNP: Finance/Actualry Consultant
D-SNP	BBK	TBD	N/A	N/A	New Contract Pending	TBD	$180,000	TBD	DSNP: Legal and Regulatory Services and Filing

Return to Agenda

Schedule 5
Vendor Contract Listing

Contract Number	Vendor	Minority Vendor	Actual Contract Spend as of April 10, 2024	Projected Monthly Spend	Renewal Strategy	Renewal Term (Months)	Estimated FY2024/25 Budget Amt	Renewal End Date	Contract Description
D-SNP	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$40,000	TBD	DSNP: Member materials, Enrollment and Communicaitions Consutlant to set up processes and do filings
D-SNP	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$290,000	TBD	DSNP: Core Admin, MMS and Provider Portal System Configuration Support BSA / PM Consultants
Finance of the Future	Moss Adams	TBD	N/A	N/A	New Contract Pending	TBD	$50,000	TBD	Completion of Quality Improvement survey
Finance of the Future	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$112,500	TBD	Workday HRIS Consultant to configure new process and systems
Finance of the Future	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$127,500	TBD	Workday: Finance BA for gathering/documenting business requirements, UAT script development
Finance of the Future	Workday Inc.	TBD	N/A	N/A	New Contract Pending	TBD	$280,000	TBD	Finance and HRIS platform to improve efficiencies, accuracy and timeliness of reporting data.
Finance of the Future	Workday Inc.	TBD	N/A	N/A	New Contract Pending	TBD	$163,000	TBD	Finance and HRIS sustem license fees.
Management of Provider Incentives and Performance	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$150,000	TBD	Consultant for Grant Program development and oversight
Management of Provider Incentives and Performance	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$10,000	TBD	Grant program tracking software
MCAS: Quality	TMG	TBD	N/A	N/A	New Contract Pending	TBD	$200,000	TBD	MCAS intervention of data processes related to MCAS and coding accuracy for diagnoses, design and support
MCAS: Quality	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$91,667	TBD	MCAS: Targeted in home visits to close a variety of MCAS gaps in care
MCAS: Quality	ASH	TBD	N/A	N/A	New Contract Pending	TBD	$67,500	TBD	MCAS: Self-test Kit Expansion COL, CHL, HBD
MCAS: Quality	Alinea	TBD	N/A	N/A	New Contract Pending	TBD	$50,000	TBD	MCAS: Expansion of Mobile Mammogram and other Mobile Services
MCAS: Quality	CareNet	TBD	N/A	N/A	New Contract Pending	TBD	$600,000	TBD	CareNet: MCAS Quality Outreach for WCV, CCS, BCS, and COL.
MCAS: Quality	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$20,000	TBD	MCAS: Benmark and participate in Learning Colaboratives realted to Quality/Community Care
Member Experience	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$310,000	TBD	Member Experinace: CRM Configuration
Member Experience	Press Ganey Assoc	TBD	N/A	N/A	New Contract Pending	TBD	$150,000	TBD	Member Journey and VOM consultants for focus groups, surveying and journey mapping
Member Experience	Various	TBD	N/A	N/A	New Contract Pending	TBD	$120,000	TBD	Contingent Labor for Community Care Events
Model of Care	Arine	TBD	N/A	N/A	New Contract Pending	TBD	$1,000,000	TBD	Chronic Disease Care Management
Model of Care	TBD: Solera	TBD	N/A	N/A	New Contract Pending	TBD	$100,000	TBD	Diabetes Management

Return to Agenda

Schedule 5
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Contract Number	Vendor	Minority Vendor	Actual Contract Spend as of April 10, 2024	Projected Monthly Spend	Renewal Strategy	Renewal Term (Months)	Estimated FY2024/25 Budget Amt	Renewal End Date	Contract Description
Model of Care	Bamboo	TBD	N/A	N/A	New Contract Pending	TBD	$88,000	TBD	Health Information Exchange (HIE) that is used by specific major provider systems to share ADT (Admission, Departure, Transfer) data from the hospital with GCHP.
Model of Care	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$320,000	TBD	Cal-AIM requirement: Data exchange between entities (providers, vendors and other organziations)
Modern Data Warehouse	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$34,000	TBD	Completion of MDW: Short-term data developers / consultants
OOTF - Continuous Improvement	Conduent	TBD	N/A	N/A	New Contract Pending	TBD	$4,750,000	TBD	Pre-Service Transition Support and HSP & Provider Portal Data
OOTF - Continuous Improvement	Conduent	TBD	N/A	N/A	New Contract Pending	TBD	$600,000	TBD	Mailroom Operations - 6 months
OOTF - Continuous Improvement	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$900,000	TBD	Mailroom Document Mgmt System Development and IT contingent labor
OOTF - Continuous Improvement	Netmark	TBD	N/A	N/A	New Contract Pending	TBD	$2,836,000	TBD	Enrollment Data, Testing, Training and PCP Assignments and Hypercare Support
OOTF - Continuous Improvement	Medhok	TBD	N/A	N/A	New Contract Pending	TBD	$500,000	TBD	Pre-Service Transition Support and Medica Management Data
OOTF - Continuous Improvement	Adecco (Akkodis) USA, Inc.	TBD	N/A	N/A	New Contract Pending	TBD	$2,070,000	TBD	Hypercare: Post Go-Live Support with IT and Operations Contingent Labor and Member Portal Development and OOTF Continuous Improvement Widgets
OOTF - Continuous Improvement	NTT Implementation Services	TBD	N/A	N/A	New Contract Pending	TBD	$1,000,000	TBD	Implementation of Member Portal
OOTF - Continuous Improvement	Salesforce	TBD	N/A	N/A	New Contract Pending	TBD	$170,000	TBD	CRM New members services capabilties
OOTF - Continuous Improvement	Silver Implementation Services	TBD	N/A	N/A	New Contract Pending	TBD	$150,000	TBD	CRM New members services capabilties
Provider Network Operations	TBD	TBD	N/A	N/A	New Contract Pending	TBD	$210,000	TBD	Contract Management System to build efficiencies and improve quality

Return to Agenda