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**
**AGENDA**

**Regular Meeting**
**Thursday, August 15, 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: 837 712 539#**

Additional Telephonic Location:
Community Memorial Hospital
147 N. Brent Street
Ventura, CA 93003

## 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 June 20, 2024**

Staff: Maddie Gutierrez, MMC, Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

## UPDATES

**2. Operations of the Future – Focus on Claims/Provider Functions**

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

RECOMMENDATION: Receive and file the update.

## PRESENTATIONS

**3. Proposed Improvements to Consultant / Vendor Contract Reporting**

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Receive and file the presentation.

## FORMAL ACTION

**4. May 2024 Year-To-Date and June Preliminary Fiscal Year End Results**

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests the Executive Finance Committee approval of the May 2024 financial results and preliminary fiscal year end results.

## CLOSED SESSION

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

**6. PUBLIC EMPLOYEE PERFORMANCE EVALUATION**
Title: Chief Executive Officer

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

## ADJOURNMENT

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**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: August 15, 2024

SUBJECT: Meeting Minutes for regular Exec. Finance meeting of June 20, 2024

## RECOMMENDATION:

Approve the minutes.

## ATTACHMENTS:

Copies of the Executive Finance Committee regular meeting minutes of June 20, 2024.

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

**June 20, 2024**

## CALL TO ORDER

Committee Chair Laura Espinosa called the meeting to order at 3:03 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: Kim Timmerman, Kimberly Marquez-Johnson, Josephine Gallella, Lupe Gonzalez, Lupe Harrion, Erin Slack, Rachel Lambert, and Consultants Amit Jain, and Don Harbart.

## PUBLIC COMMENT

None.

## 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.

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

Roll Call Vote:

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

NOES: None.

ABSENT: Commissioners Anwar Abbas, and James Corwin.

The clerk declared the motion carried.

**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

CEO Nick Liguori made opening remarks. He thanked the commissioners for their time, effort, and guidance in the support of the development of the GCHP plans and budget. He noted that over the past three months there has been review of proposed next stage quality funding program, and the 2024 fiscal year budget of investing a portion for financial reserves for sustained improvements to member quality care. There was also an assessment of the changing medical environment for its impacts on our current and future financial performance. CEO Liguori state that final details will be reviewed today. This will include a breakout of the administrative budget, principal strategic initiatives for the next fiscal year, the vendor contract list that will be renewed, extended, or newly contracted in the coming fiscal year.

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

Staff: Eve Gelb, Chief Innovation Officer
Erik Cho, Chief Policy & Program Officer
Kim Timmerman, Sr. Director of Quality Improvement

Eve Gelb, Chief Innovation Officer, stated the budget is an investment, and for us (GCHP) it is an investment in our community and an investment in our Model of Care which will improve the outcomes for our community.

Chief Medical Officer, Felix Nunez, M.D. reviewed the GCHP Model of Care. He stated that this is the road map that has been built for achieving and measuring

success, not only by financial returns but returns for the community in terms of health and wellbeing.

CMO Nunez reviewed the infrastructure that we need to build as a health plan. He reviewed the concepts for the MOC as well as the foundation upon which we are building. We need to understand our members. We need to understand the social drivers that impact care. It is the foundation for understanding how we build the health plan, and how to advance the work. We look at how to develop programs and how we can engage the member as well.

CMO Nunez stated that the member is at the center of the MOC because we design programs, we provider interventions, and collaborate with community partners in our network to get the right care for the member in a structured way. We also want to engage our members by developing resources. We must have a member centered focus on the work the plan is doing. We want to provide our members with the right care at the right place and right time. Resources are valuable, and it is important for us to be good stewards of those resources and design our MOC around that.

Our Model of Care is data driven. We use the data to be targeted in our use of resources and innovations that will address critical gaps in care as measured by MCAS and our scorecard. The data guides us.

Commissioner Pupa asked for clarification; she noted that the total assigned was 197,000 and if the 38%, which is approximately 74,000, had not seen their primary care physician in the last twelve months. CIO Gelb stated that was correct. CIO Gelb did note that some of these members might be relatively new to an assigned provider. CIO Gelb stated that we are not even at the 25% for that particular rate of adults accessing primary care services. We have many who are not accessing primary care services. This has a lot to do with people who are of working age and might not have schedules that allow for them to access dare during regular business hours. This is one of the reasons for provider grants. We will support the recruitment of additional providers, and additional hours of availability. She noted that in the budget to come, we have invested in outreach to members in order to close gaps in care. Gold Coast is taking on the challenge, and we are working on outreach, and providers have an obligation to provide services as well. Doctor offices, clinics, need to reach out to their patients. We need to design our Model of Care so that we, the plan, and our providers come together to provide engagement and solutions for our members.

The next point is the member experience. If a provider does not have the capacity to hire outreach staff, GCHP will be supportive of that provider. We want to reinforce the provider/member relationship and support that relationship. We have

done a great amount of working to bring in providers, we must also provide additional resources to help our providers achieve their objectives. We are trying to design programs that expand access everywhere, increase access hours, including mobile care, and connecting members with care.

CPPO Erik Cho, noted great provider participation through the provider incentives program. Progress is being made. There will be an expansion of access times and availability for both primary and specialty care. We are collaborating with our providers in order to meet member needs.

CMO Nunez stated that we are working to design systems and work collaboratively with our providers to have a system that is most impactful for our members and achieve a better state of health.

Moving forward, Kim Timmerman, Sr. Director of Quality Improvement, reviewed highlights from MCAS measures for 2023. She noted that she will share more information at the Commission meeting. She did point out that eighty-three%of the measures scored at the minimum performance level or above the MPL. Fifteen of the eighteen measures held to MPL improved, compared to last year. Seven of the measures scored at the 75%. Three measures achieved the MPL for the first time in goals history, and we also had three measures that achieved a high-performance level of 90%. CMO Nunez noted that the level of coordination and collaboration with our providers has been outstanding. It is about promoting health and wellbeing for an entire community, and it speaks volumes on our work. He thanked the commission for their support in the efforts to advance the work needed to provide our members with the much-needed access to care.

**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

Erin Slack, Sr. Manager, Population Health, introduced the Wellth Program. Wellth aligns and enhances our Model of Care by leveraging our existing members to understand targeted interventions. It engages and incentivizes our members with chronic condition management, and it also provides an additional tool for our providers in delivering care. Wellth will benefit our organization by focusing on care gaps and high-cost utilization.

CEO Liguori requested that we table this item and have the presentation given at the Monday Commission meeting – where all commissioners will be present.

Commission Chair Espinosa stated the Wellth program will be tabled until Monday.

**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

Chief Financial Officer Sara Dersch stated that we ended the month with a $2.4 million total increase to our net assets. We have a positive result which was influenced by our volume, and our management costs. She also noted that our revenue was higher than forecasted. We had revenue of $118.8 million versus a forecast of $85.1 million. $26.5 million of that revenue is a pass-through, which means the funding gets channeled from the state to provider level participants goes right through us.

Commissioner Espinosa noted that $13.2 million was for the Housing and Homeless Incentive Program and included was $10 million for transitional housing that occurs when someone is released from the hospital and needs a clean sanitary place to stay. She asked how the $3.2 million remaining was used. CPPO Cho stated that there were more investments coming soon. $10 million was for two recuperative care sites. There are other components which includes connection to the HMIS system, which is the homelessness information system that tracks individuals experiencing homelessness and information is shared. There will also be investments in street medicine, which is the next component for this funding.

CEO Liguori clarified “pass-through”. There is funding that passes through us/the organization, and there are pass-throughs that we do have some say in what the money is programmed for, and we work together, we are very involved in identifying where the greater needs are. We negotiate, contract, and are very involved in developing the funding. It is shaping the future of the healthcare system across many programs, and CalAIM Incentive Payment Program (IPP). Marlen Torres, Executive Director of Strategy & External Affairs stated that our last 1115 waiver and the prime program were strict “pass-throughs” through hospitals waivers. The reference to the QIPP Program is all tied through the waivers which incorporates CalAIM and the 1114/1915 fee waivers.
CFO Dersch stated there is detail on this information in her report.

CFO Dersch stated there is a large variance that can be seen in the medical benefits. She noted that it is not an unexpected increase in utilization. We reflected the revenue as a pass-through. It is an in and out in our income statement. Inpatient and long-term care continue to account for approximately half of our

medical spend. We are performing analytics on this and will be presenting trends of what we are seeing in programs that we are developing to help manage this cost.

We had some unfavourability in administrative core expense which was related to the Operations of the Future readiness. She noted that we are still favorable on a month to date perspective and from a year-to-date perspective we are slightly off the reforecast. She also noted that we got more members than expected from the newly eligible group ages 26 to 49, but we are favorable in our month to date, and by $5.3 million from a year-to-date perspective.

CFO Dersch stated that we are managing our resources effectively to ensure that we get as much of the spend that we can get out to the community and to the members and providers.

There are some potential items that will influence our May and June results – there is a Covid testing risk corridor adjustment. We have Prop 56, the tax on tobacco. There is also a deceased member take-back which will go back to 2014.The state will go back to 2014 to see if we might have received payment on members after they passed away and they will ask for that money back. Goin back ten years might have to do with the budget deficit. She also noted that our IBNR is an estimate for services which we know out members received but we have not yet received payment for that claim. There will be variations month to month.

Our TNE changes as our total assets go up and down, that percentage of TNE will move with that. Our TNE continues to be high, we vacillate between 1000% and 1050% and the consistency on a monthly basis shows our business is sold.

**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.

CFO Dersch stated that lots of the information for the upcoming budget has been presented at prior Exec. Finance and Commission meetings. She wanted to review components of our budget objectives and our budget risks, as well as focus on strategic initiatives. The strategic initiatives are the next phase of work that we have started this current year. It is a continuation of our improvement in our investments from a budget perspective. We are back to normal margins / pre-pandemic levels Our MBR will run between 85 and 87 percent. Our admin rate will stay in 105 which leave

us approximately a 2% margin. We are focused on quality; it is essential element of a financial plan to achieve long term viability. She noted that the commission has approved a substantial investment in our quality spend over the next three years. This quality spend of approximately one quarter of a billion dollars will help our members and help the Medi-Cal care delivery system in this county. There will be an incentive for PCPs to have evening hours, early morning hours, and weekend hours. Money will be used to bring in additional PCP and specialists. We will continue to invest in the build out of our infrastructure to better manage cost and quality care and to provide a superior level of support for providers and deliver excellent member services. There are no new projections, we are continuing the work that was approved.

CFO Dersch reviewed budget risks. She stated that in the next few years in a planned use of our reserves we are asking to invest $28 million of the reserves to advance sustainable quality performance in the system and to engage members in their health journey from a broader perspective. We are going to use some of our reserves to help fund this spend. She noted that we are committed to maintaining 700% of our required TNE and remaining reserves will be used to continue the support for the providers in the community and will also be used to support our D-SNP program launch. We will also meet DMHC regulatory requirements for reserves of that program.

CFO Dersch reviewed the summary of our budget. The only item that changes was the addition to the medical cost which includes the latest date through May. She noted that we are now standing at the use of reserves in the amount of $28.2 million. She also noted that we were not going to reduce the amount of spend for the quality incentive program.

CEO Liguori stated there is one change that he would like to highlight. He stated that the Management Team has always designed the quality program which is composed of three programs. One is the quality incentive pool which includes a hospital incentive. Currently the quality incentive is just for primary care groups. We will also expand beyond to bring in incentive to other providers and community-based organizations. The next program is called Value Based rates. There is flexibility in this program that allows us to incentivize our providers who are willing to expand access sustainably, expand access through various ways by enhancing their rates so that they are able to provide access after-hours, overhead costs for Saturday hours and possibly adding physicians. We have the grants program; grants estimated at $18.75 million. He stated that if one of our providers brings an idea to us about expanding access, we ask for some fungibility because we need to act fast and when ideas come up we may not have time to come to the commission so we ask for some terms to think with freedom. Commission Chair Espinosa asked if this was outside of the CEO's discretionary power that he currently has. CEO Liguori stated he is not asking for freedom to make significant changes, but just want to be clear on fungibility. He clarified that there is currently nothing in mind, we just want to be able to move

quickly if necessary. He just wants to ensure transparency. He noted that we cannot find a way to grant fund the acquisition of mobile care. We are finding barriers to fully implementing in the way we had envisioned.

CFO Dersch stated there is a listing of all the vendors by contract and projected spend. This list is formed by our strategic initiatives. Included in the list is information on what these vendors will be used for. General Counsel, Scott Campbell stated the policy that the Commission adopted in 2016 notes that if there is a contract that GCHP currently has with a vendor, it can be renewed if it is on the list provided and approved in the budget for that amount, and if there is a project that is approved by the Commission and there may be contracts affiliated with those projects, and we do not have them contracted yet, but we know we have to do something for an approved project -if the project is approved through approval of the budget the contract will be approved.

Chief of Human Resources & Organization Performance Officer reviewed the strategic initiatives. In this ask of investment you will see that we are going to be more externally focused. He stated these are part of our overall organization transformation and some of the key projects that are planned for the fiscal year and categories. Mr. Aguilar reviewed each category, under the key initiatives, staffing and budget.

Commissioner Espinosa asked if he was reviewing all the positions. She asked if this is current staff of something new that is being onboarded. Mr. Aguilar stated that we are looking at adding forty-two positions and that will get us to 399 staff, showing a 12% growth. The forty-two positions are lining up to these initiatives. Thirty-four of the positions are tied directly to do the build out of our Model of Care and really focused on external activities. Commissioner Espinosa asked what the forty-two broke down to. She asked if they were new positions. Mr. Aguilar stated yes, they are all new positions. Some would be full time positions, and some would be a continuous improvement consultant or temporary labor what would assist with a specific initiative. CEO Liguori stated the forty-two would be detailed out to exact work that they will be doing. CIO Gelb stated the continuous improvement consultant is listed on the vendor table and is listed as TBD. General Counsel, Scott Campbell stated that for those vendors who have not been identified yet, the purchasing policy is followed in terms of going out to bid, getting multiple bids, selection of the company that offers the best value for GCHP.

CHR Aguilar reviewed the positions under each category. An Auditor is being added to Compliance. He also noted that the fourth category listed with a culture celebration. Recognition that aligns with the growth and evolution of the organization. We are going to work to define out culture and enhance how to recognize our staff. We are looking into a recognition program that is geared toward compliments, milestones, and anniversaries. Commissioner Espinosa asked if this would include training. CHR Aguilar replied yes, that would be the third-party group and conversations have

already started with them, Co-Creations. He noted that we are building up relationships with nine new partners that we are going to be working with in Operations of the Future. We will focus on how we provide oversight, ensure that they are meeting expected endpoints, and performance expectations.

CFO Dersch stated her category is Finance of the Future, which will be replacement of some of our core finance technology that is old, we are using a system that is primarily meant for hospital management. We are looking at a technology that we can use and expand our current budgeting software and bring in additional modules that will speak to each other instead of having to migrate data. This will include HR management software as well which will allow for better communication between finance and HR.

CFO Dersch noted that there is a data engineer position that is a repurpose of a current open position. As we change platforms, and our business, we need to determine how to better align our current resources.

CIO Gelb stated the D-SNP project has three phases. We are completing the first phase now [ which is our initial Knox Keene filing as well as procurement of pharmacy benefit management software. There are things that need to be in place in order to move into the next phase, which is preparing us with the compliance and operational readiness in order to get to the point where we file a bid with Medicare. There are three positions that are focused on compliance and making all the filings happen. We also need to set up the operational processes in a way that is going to make ongoing compliance easier. The first is overall expertise in our compliance team. The compliance team has a lot of history with D-SNP, but nobody that will specifically be dedicated to do D-SNP. While leveraging existing resources, this is a specific focus on the vast number of regulations that come associated with Medicare. She stated that Medicare has a Medicare Managed Care Manual which requires processes be operated in a certain way to meet a set of requirements. It will however require legal oversight too.

We had to submit a specific budget for D-SNP to the state as part of our application. CIO Gelb noted that although working with legal, there is not an overlap of duties. This is about supporting our operations to be compliant. Over the next year we have to amend existing contracts, but we also have to partner with new providers who have never been a part of our network because they will not work in Medi-Cal. New contract writing and amended contract writing is an example of the work that will need to be done. There are also member materials – our plan will not market across organizations because people already enrolled as our members will be able to enroll in Medicare, but there are stringent protocols for member materials that change frequently. We are investing up front to set up processes as well so we can be efficient.

There are also functions that will need to be delegated to pharmacy benefit manager – it is by regulation, because we have not been a Medicare Advantage plan yet. After a few years, we will be able to take some of those functions back.

There is stringent oversight, and we must make sure that we are implementing well, but that we are learning from how we can take that in-house once allowed.

CIO Gelb stated we have made huge improvements in MCAS, but there is still more to do. MCAS is constantly changing, and it becomes harder to move results. We are asking for investments in data, people who are HEDIS experts so that we can be the owners of the results. She also noted that the QIPP work requires many meetings and interactions coordination. We need to use a project management approach to track action items and ensure that we are delivering on our commitments. There are various vendors that will do support.

The Operations of the Future is designed with D-SNP in mind. We will also need to do specific submission and materials. Filings that will need outside support for phase two. Phase Three will be a full operations build in the 25/26 budget year. We are looking to leverage skills and existing resources. We do not want this product to drive our overall administrative costs up. We want to build it into our existing processes as best we can. CEO Liguori explained that previously we were responsible for managing pharmacy benefit and maintaining a network of pharmacies that our members could use to access prescriptions. MediCal Rx was carved out of the managed care benefits effective 2022 We do not agree with that policy, and it may come back to us in time. For Medicare, we are responsible for pharmacy. For D-SNP we are going to be responsible for maintaining pharmacy network and responsible for managing the costs associated with that pharmacy utilization. PM will bring us the network and they provide important services, pharmacy related operations in conjunction with our team and policy.

We are also partnering well with our providers. We are investing in our contracting processes and our provider support processes and we have new types of providers that we did not have before. We have Enhanced Care Management providers, Community Support providers, which is significant. We are making sure those processes are working.

CHR Aguilar will continue with Ops of the Future. He stated there is continuous improvement. He stated that we will go live and have transition support. We will have a hyper-care room that will be set up over the next month that will be catching and escalating any issues that come up. The implementation will be on July 1, 2024. We will be reinitiating our member portal activities. Members will have access to their health information and will be able to utilize and support of their care.

CEO Liguori stated that we see in the next year is taking major leaps in digital supports for our members. Members will be able to download an app that has their ID card instead of the required plastic card. They will also be able to view information about their care or let us know how we can help them. It is a great way to receive member feedback. CEO Liguori noted that we will be transitioning from Conduent to managing mailroom activities internally beginning January. There is also work around the Contact center and our member services reps.

Commissioner Espinosa stated that she liked options for communication with members. Commissioner Monroy asked if the reps at the contact center will have the ability to connect members directly to providers. CIO Gelb responded yes; they can do a warm handoff. Part of the vision is that they stay with the member on the line and make the connection with our provider network. Commissioner Monroy stated this was ideal.

We also want to leverage the infrastructure to drive the Model of Care in a way that supports our most vulnerable members and how they access care. We will leverage the data analytic to drive the right Model of Care and then our performance strategy. We are also putting a quarter of a billion dollars into our provider system. CPPO Cho stated that in future months funding will be for an internal grant administrator. They will develop grants, an application process, reporting and data collection that will support grantees to assist in keeping up with the program. There is a lot of grant funding, and we need to seek it, pursue it and win it. Grant funds will be for the betterment of our communities.

CFO Dersch stated there was a lot of information presented and the committee now has time to consider questions for the Monday Commission meeting.

Commissioner Pupa asked if Edrington is through HMA. CEO Liguori stated that it is through HMA.

Commissioner Espinosa asked if there was a comparison of expenses in 2023 to the expected expenses for 2024. She requested it be made available. CFO will present the information at the Commission meeting.

Commissioner Espinosa asked about the vendor Crossroads staffing services. CEO Liguori stated it is one of the agencies that we work with to provide temporary services and support. We have paid $2.9million and propose to renew for one year. CFO Dersch stated it is for the current fiscal year. She noted that a schedule for the current fiscal year only can be created and presented.

CEO Liguori noted that Co-Creation is for the culture and recognition at GCHP. This will be a new vendor. We want to work on our culture and embrace our mission.

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

Roll Call Vote:

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

NOES: None.

ABSENT: Commissioners Anwar Abbas, and James Corwin.

The clerk declared the motion carried.

The Committee went into Closed session at 5:55 p.m.

## CLOSED SESSION

**3. PUBLIC EMPLOYEE PERFORMANCE EVALUATION**
Title: Chief Executive Officer

**4. 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 6:53 p.m.

Approved:

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Maddie Gutierrez, MMC
Clerk to the Commission

**AGENDA ITEM NO. 2**

TO: Executive Finance Committee

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

DATE: August 15, 2024

SUBJECT: Operations of the Future – Focus on Claims/Provider Functions

# VERBAL PRESENTATION

## Documents will be presented at the meeting

**AGENDA ITEM NO. 3**

TO: Executive Finance Committee

FROM: Sara Dersch, Chief Financial Officer

DATE: August 15, 2024

SUBJECT: Proposed Improvements to Consultant / Vendor Contract Reporting

# VERBAL PRESENTATION

## Documents will be presented at the meeting

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect



# Gold Coast Health Plan Continuous Performance Improvement FY2024-25 Vendor/Contract Reporting

Executive Finance Committee
August 15, 2024
Eve Gelb, Chief Innovation Officer
Sara Dersch, Chief Financial Officer

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# Unwavering Commitment to Commission Oversight

**Principles of Commission-Level Contracting Oversight**

- Commission oversight of GCHP procurement and contracting for consultant/vendor systems and services is a necessary and required part of good governance and fiscal stewardship.
- Contracting oversight is an essential function of the Commission's larger financial responsibility to ensure Medi-Cal public funds are used ethically, efficiently, and responsibly in the service of members and pursuit of the Mission.
- The Commission must receive any/all information it deems necessary for fiscal oversight of the health plan.
- GCHP Management commitment to supporting the Commission fulfill their oversight role is unwavering.



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# Unwavering Commitment to Commission Oversight (continued)

## Need for Third Party Contracting

- It is neither financially nor operationally efficient, nor even feasible in nearly all cases, that health plans – *nationwide, large and small, for-profit and non-profit alike* – develop and maintain the specialized technical systems and hire and employ the full scale of specialized personnel and expertise needed to perform all health plan work.
- Consistent with industry-wide practice, GCHP must leverage the expertise and capacity of industry consultants and the state-of-the-art systems and services of leading industry vendors to perform day-to-day work and to achieve the strategic objectives of our Mission.

## GCHP Commitment to Highest Ethical Standards and Efficiency in Procurement and Contracting

- Third party contractors must be procured and contracted by GCHP in accordance with established procurement policies and principles. Key aspects of this policy should always include the requirements that:
    - The best capabilities are procured and contracted at competitive and within budget.
    - Systems, services, and capabilities are available and ready when we need them.
    - Management has at-the-ready, post-contracting plans to implement new capabilities and optimize consultant/vendor value.
    - We maintain a high level of executive oversight (CEO, CFO, CDO, General Counsel) of outside contracting, with a focus on these key aspects: (i) appropriate use of CEO discretionary authority; (ii) budget achievement and financial strength of the health plan; (iii) diversity in contracting (with minority owned partners); (iv) inclusion of industry best practices to ensure procurement of highest quality systems and services; (v) industry standards in service level agreements and performance incentives/penalties; (vi) local purchasing whenever possible and economical; and (vii) regulatory compliance.



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# Contract Reporting to Commission: **GCHP Historical Practice**

Annual report on contracting accompanies the budget.

Detailed report one time per year

Incomplete set of data elements and no meaningful organization of the data

Lack of insightful summary report

| 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 |



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# Contract Reporting to Commission: **GCHP Practice Improvements**

Quarterly report (start of quarter) summarizing all contracting that occurred during the prior quarter period will include:

- Summary of contracting by type of system/service procured and budget/financial amounts and considerations.
- Breakdown of contracting by business unit, business/program need, and classification of procured/contracted system or service (e.g., consultant, information technology, and temporary staffing).
- Women/Minority Owned Business (W/MOB) reporting by the Chief Diversity Officer.
- Information about any application of Sole Source policy.



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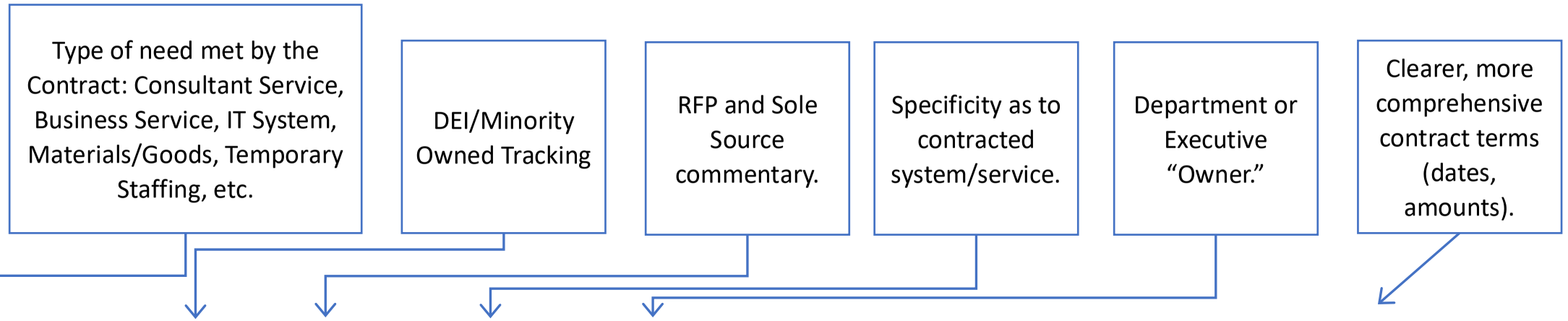
# Contract Reporting to Commission: **GCHP Practice Improvements (continued)**

Enhanced reporting details with new contract information and insightful grouping/ organization of the data.




| Classification by System or Service Need | Vendor | DEI/Minority-Owned Co | Comments on RFP or Sole Source | Specific Services Provided | GCHP "Business Owner" | Contract # | Contract Start Date | Contract End Date | Contract Amount | Contract-to-Date Spend | Amount left on Contract | Current Approved FY Budget | Current Approved FY Reforecast | Current FY Spend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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# Next Steps

- GCHP Management submits this proposal to the Executive Finance Committee today for your later review.
- We will follow this submission with a copy of the Procurement Policy, also for your review.
- We will include review/discussion of these materials in 1:1's between now and the next Committee meeting on Thursday October 17, 2024. We kindly request the extension of 1:1's to one (1) hour to accommodate this in those agendas.
- We will incorporate Committee member changes and feedback into next versions of these materials and will distribute the next versions ahead of the October Committee meeting.
- At the October Committee meeting, Management requests that the Committee decide on the recommendation of adopting changes, with input from GCHP Auditors who will be presenting the financial Audit at that meeting. Recommendations would then go the full Commission meeting on October 28, 2024.



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**AGENDA ITEM NO. 4**

TO: Executive Finance Committee

FROM: Sara Dersch, Chief Financial Officer

DATE: August 15, 2024

SUBJECT: May 2024 Year-to-Date Financial Results and Preliminary June Year-End Results

# PowerPoint with Verbal Presentation

**ATTACHMENTS:**

*May 2024 Year to Date Financials & Preliminary June Year-End Results*

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

# May 2024 Year-to-Date Financial Results and Preliminary June Year-End Results
# Executive Finance Committee

August 15, 2024

Sara Dersch, Chief Financial Officer



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

# Financial Results Summary: Year-End

- Preliminary* year-end results demonstrate effective fiscal management of Gold Coast Health Plan (GCHP).
- GCHP ended the year with a Net Asset position of $4.8M. This represents a $(28.8M) variance to the Reforecast.
- GCHP was impacted by several financial events relating to prior years and mandated by the State:
  - 2023 acuity adjustment resulting in $17.3M revenue ceded back to the State,
  - 2019-2021 Prop 56 final reconciliation resulting in $9.1M increased expense, and
  - 2019-2020 Covid Risk Corridor final reconciliation resulting in $5.7M increased expense.
- Evaluation of the "in the year, for the year" results (in other words, analyzing how GCHP used current year premium revenue to manage current year medical and administrative expenses) demonstrates a final Net Asset position of $34.2M, which is a $0.6M variance to the January-approved Reforecast.
- Financial results reflect a disciplined management of administrative expenses further contributing to a positive Net Asset position despite the financial events listed above.



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**Note: Final year-end results are subject to fiscal audit completion.*

# Financial Results Summary: May

- May's month-to-date (MTD) ($6.0M) Net Asset position represents a ($4.2M) variance to Reforecast and is the result of:
  - Co-occurrence of 5 claims averaging over $1M each; GCHP typically experiences an average of 0-1 of these claims each month; the 5 claims paid out in May have varying dates of services over the last 2 years and do not present a trend or pattern and should be considered a random event. GCHP has reinsurance against claims exceeding $1.1M; the recovery for these claims is reflected in the financial statements.
  - Management now has a complete picture of the earnings in the Quality Incentive Program & Pool (QIPP); financials reflect an expected 95% achievement rate.
  - Prior Period Adjustments relating to 2023 revenue, 2019-2020 Covid Risk Pool reconciliation, application of appropriate accounting treatment for amortizable expenses. These items are detailed further in the deck.



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# Preliminary* June YTD P&L

| ($Ms except pmpms & mm) | MTD Actual | MTD Reforecast | MTD Var Fav / (Unfav) | YTD Actual | YTD Reforecast | YTD Var Fav / (Unfav) |
|---|---|---|---|---|---|---|
| Member Months | 248,514 | 228,289 | 20,225 | 3,018,213 | 2,927,937 | 90,276 |
| Revenue | $ 88.9 | $ 85.7 | $ 3.2 | $ 1,086.7 | $ 1,042.3 | $ 44.5 |
| *pmpm* | *$ 357.78* | *$ 375.59* | *$ (17.81)* | *$ 360.06* | *$ 355.97* | *$ 4.09* |
| Non-Operating Revenue / (Expense) | $ 1.9 | $ 0.9 | $ 1.0 | $ 19.1 | $ 13.1 | $ 6.0 |
| *pmpm* | *$ 7.50* | *$ 3.96* | *$ 3.54* | *$ 6.33* | *$ 4.48* | *$ 1.85* |
| Medical Benefits | $ 83.8 | $ 79.6 | $ (4.1) | $ 990.9 | $ 908.6 | $ (82.3) |
| *pmpm* | *$ 337.05* | *$ 348.83* | *$ 11.8* | *$ 328.31* | *$ 310.32* | *$ (18.0)* |
| *% of Revenue* | *94.2%* | *92.9%* | | *91.2%* | *87.2%* | |
| Administrative Expense | $ 6.3 | $ 8.2 | $ 1.9 | $ 86.4 | $ 88.8 | $ 2.4 |
| *pmpm* | *$ 25.22* | *$ 35.81* | *$ 10.59* | *$ 28.63* | *$ 30.33* | *$ 1.70* |
| *% of Revenue* | *7.0%* | *9.5%* | | *8.0%* | *8.5%* | |
| Project Portfolio | $ 0.7 | $ 2.9 | $ 2.1 | $ 9.2 | $ 24.3 | $ 15.1 |
| *pmpm* | *$ 2.92* | *$ 12.58* | *$ 9.66* | *$ 3.04* | *$ 8.30* | *$ 5.26* |
| *% of Revenue* | *0.8%* | *3.3%* | | *0.8%* | *2.3%* | |
| Operating Gain/(Loss) | $ (1.8) | $ (4.9) | $ 3.1 | $ 0.2 | $ 20.5 | $ (20.3) |
| | *$ (7.41)* | *$ (21.62)* | *$ 14.22* | *$ 0.07* | *$ 7.01* | *$ (6.94)* |
| Retro Revenue Adjustments | $ - | $ - | $ - | $ (14.5) | $ - | $ (14.5) |
| *pmpm* | *$ -* | *$ -* | *$ -* | *$ (4.82)* | *$ -* | *$ (4.82)* |
| Total Increase / (Decrease) in Unrestricted Net Assets | $ 0.0 | $ (4.0) | $ 4.1 | $ 4.8 | $ 33.6 | $ (28.8) |
| *pmpm* | *$ 0.09* | *$ (17.67)* | *$ 17.76* | *$ 1.59* | *$ 11.49* | *$ (9.90)* |
| *% of Revenue* | *0.0%* | *-4.7%* | | *0.4%* | *3.2%* | |



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Membership

While membership is favorable overall, we are experiencing higher-than-projected volumes in the membership categories which receive lower premium rates.

Revenue

Favorability of $44.5M reflects $26.5M unforecasted Program Incentive Revenue (described in April) and $18.0M due to member volume.

Medical Cost

Variance to Reforecast is driven by multiple factors including volume-related utilization, overall increase in Inpatient utilization on a "per member" basis, Targeted Rate Increase and Proposition 56 payback (these are "directed payments" from the State which must be returned if not earned by Providers), Quality Incentive Program and Pool, and payments for the State-funded Program Incentives (described in April).

Administrative Cost

Favorability associated with effective management and application of appropriate amortization accounting.

**Note: Results are preliminary and are subject to change pending completion of annual audit results and potential late-coming General Ledger entries*

# Preliminary* June YTD P&L, Current Year Items Only

| ($Ms except pmpms & mm) | YTD Actual | Out of Period Adjustments | Adjusted Actual | Reforecast | Var Fav / (Unfav) |
|---|---|---|---|---|---|
| Member Months | 3,018,213 | - | 3,018,213 | 2,927,937 | 90,276 |
| Revenue | $ 1,086.7 | $ - | $ 1,086.7 | $ 1,042.3 | $ 44.5 |
| *pmpm* | *$ 360.06* | *$ -* | *$ 360.06* | *$ 355.97* | *$ 4.09* |
| Non-Operating Revenue / (Expense) | $ 19.1 | $ - | $ 19.1 | $ 13.1 | $ 6.0 |
| *pmpm* | *$ 6.33* | *$ -* | *$ 6.33* | *$ 4.48* | *$ 1.85* |
| Medical Benefits | $ 990.9 | $ (14.9) [1][2] | $ 976.1 | $ 908.6 | $ (67.4) |
| *pmpm* | *$ 328.31* | *$ (4.92)* | *$ 323.39* | *$ 310.32* | *$ (13.1)* |
| *% of Revenue* | *91.2%* | *-1.4%* | *89.8%* | *87.2%* | |
| Administrative Expense | $ 86.4 | $ - | $ 86.4 | $ 88.8 | $ 2.4 |
| *pmpm* | *$ 28.63* | *$ -* | *$ 28.63* | *$ 30.33* | *$ 1.70* |
| *% of Revenue* | *8.0%* | *0.0%* | *8.0%* | *8.5%* | |
| Project Portfolio | $ 9.2 | $ - | $ 9.2 | $ 24.3 | $ 15.1 |
| *pmpm* | *$ 3.04* | *$ -* | *$ 3.04* | *$ 8.30* | *$ 5.26* |
| *% of Revenue* | *0.8%* | *0.0%* | *0.8%* | *2.3%* | |
| Operating Gain/(Loss) | $ 0.2 | $ 14.9 | $ 15.1 | $ 20.5 | $ (5.5) |
| *pmpm* | *$ 0.07* | *$ 4.92* | *$ 4.99* | *$ 7.01* | *$ (2.02)* |
| Retro Revenue Adjustments | $ (14.5) | $ 14.5 [3] | $ - | $ - | $ - |
| *pmpm* | *$ (4.82)* | *$ 4.82* | *$ -* | *$ -* | *$ -* |
| Total Increase / (Decrease) in Unrestricted Net Assets | $ 4.8 | $ 29.4 | $ 34.2 | $ 33.6 | $ 0.5 |
| *pmpm* | *$ 1.59* | *$ 9.74* | *$ 11.33* | *$ 11.49* | *$ (0.16)* |
| *% of Revenue* | *0.4%* | *2.7%* | *3.1%* | *3.2%* | |

Eliminating the revenue and medical expenses related to prior fiscal year actions show that the true "in the year, for the year" operations yields a positive Net Assets margin of $34.2M, which is a $0.5M variance to the Reforecast.

[1] July 2019 - December 2021 $9.2M Proposition 56 reconciliation and settlement
[2] July 2019 - December 2020 $5.7M Covid-19 Risk Corridor Settlement
[3] 2022 - 2023 $14.5M net Premium Adjustments

**Note: Results are preliminary and are subject to change pending completion of annual audit results and potential late-coming General Ledger entries*


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# May 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 | 249,662 | 231,404 | 18,258 | 2,769,699 | 2,699,648 | 70,051 |
| Revenue | $ 87.1 | $ 88.7 | $ (1.6) | $ 997.8 | $ 956.5 | $ 41.3 |
| *pmpm* | *$ 349.04* | *$ 383.30* | *$ (34.26)* | *$ 360.27* | *$ 354.31* | *$ 5.96* |
| Non-Operating Revenue / (Expense) | $ 1.7 | $ 0.9 | $ 0.8 | $ 17.3 | $ 12.2 | $ 5.0 |
| *pmpm* | *$ 6.62* | *$ 3.90* | *$ 2.72* | *$ 6.23* | *$ 4.52* | *$ 1.71* |
| Medical Benefits | $ 98.2 | $ 82.1 | $ (16.1) | $ 907.2 | $ 829.0 | $ (78.2) |
| *pmpm* | *$ 393.41* | *$ 354.99* | *$ (38.4)* | *$ 327.53* | *$ 307.07* | *$ (20.5)* |
| *% of Revenue* | *112.7%* | *92.6%* | | *90.9%* | *86.7%* | |
| Administrative Expense | $ 7.6 | $ 7.5 | $ (0.1) | $ 80.2 | $ 80.6 | $ 0.5 |
| *pmpm* | *$ 30.61* | *$ 32.47* | *$ 1.86* | *$ 28.94* | *$ 29.87* | *$ 0.93* |
| *% of Revenue* | *8.8%* | *8.5%* | | *8.0%* | *8.4%* | |
| Project Portfolio | $ (12.7) | $ 1.8 | $ 14.4 | $ 8.5 | $ 21.4 | $ 13.0 |
| *pmpm* | *$ (50.68)* | *$ 7.71* | *$ 58.39* | *$ 3.06* | *$ 7.94* | *$ 4.89* |
| *% of Revenue* | *-14.5%* | *2.0%* | | *0.8%* | *2.2%* | |
| Operating Gain/(Loss) | $ (6.1) | $ (2.7) | $ (3.3) | $ 2.1 | $ 25.5 | $ (23.4) |
| | *$ (24.30)* | *$ (11.88)* | *$ (12.43)* | *$ 0.74* | *$ 9.43* | *$ (8.69)* |
| Retro Revenue Adjustments | $ (1.6) | $ - | $ (1.6) | $ (14.5) | $ - | $ (14.5) |
| *pmpm* | *$ (6.48)* | *$ -* | *$ (6.48)* | *$ (5.25)* | *$ -* | *$ (5.25)* |
| Total Increase / (Decrease) in Unrestricted Net Assets | $ (6.0) | $ (1.8) | $ (4.2) | $ 4.8 | $ 37.7 | $ (32.9) |
| *pmpm* | *$ (24.17)* | *$ (7.98)* | *$ (16.19)* | *$ 1.72* | *$ 13.96* | *$ (12.23)* |
| *% of Revenue* | *-6.9%* | *-2.1%* | | *0.5%* | *3.9%* | |

MTD

DHCS has recategorized members aged 19 and 20 from the Adult Category of Aid to the lower premium Child Category of Aid resulting in lower overall member revenue.

YTD

Revenue favorability of $41.3M reflects $26.5M in Program Incentive Revenue (described last month) and $14.8M due to member volume and mix.

- ($17.3M) Revenue "Take Back" in January is a result of a retroactive reduction in 2023 rates and is partially offset by a pick-up in membership-related retroactivity, resulting in a cumulative adjustment of ($14.5M).



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# May 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 | 249,662 | 231,404 | 18,258 | 2,769,699 | 2,699,648 | 70,051 |
| Revenue | $ 87.1 | $ 88.7 | $ (1.6) | $ 997.8 | $ 956.5 | $ 41.3 |
| *pmpm* | *$ 349.04* | *$ 383.30* | *$ (34.26)* | *$ 360.27* | *$ 354.31* | *$ 5.96* |
| Non-Operating Revenue / (Expense) | $ 1.7 | $ 0.9 | $ 0.8 | $ 17.3 | $ 12.2 | $ 5.0 |
| *pmpm* | *$ 6.62* | *$ 3.90* | *$ 2.72* | *$ 6.23* | *$ 4.52* | *$ 1.71* |
| Medical Benefits | $ 98.2 | $ 82.1 | $ (16.1) | $ 907.2 | $ 829.0 | $ (78.2) |
| *pmpm* | *$ 393.41* | *$ 354.99* | *$ (38.4)* | *$ 327.53* | *$ 307.07* | *$ (20.5)* |
| *% of Revenue* | *112.7%* | *92.6%* | | *90.9%* | *86.7%* | |
| Administrative Expense | $ 7.6 | $ 7.5 | $ (0.1) | $ 80.2 | $ 80.6 | $ 0.5 |
| *pmpm* | *$ 30.61* | *$ 32.47* | *$ 1.86* | *$ 28.94* | *$ 29.87* | *$ 0.93* |
| *% of Revenue* | *8.8%* | *8.5%* | | *8.0%* | *8.4%* | |
| Project Portfolio | $ (12.7) | $ 1.8 | $ 14.4 | $ 8.5 | $ 21.4 | $ 13.0 |
| *pmpm* | *$ (50.68)* | *$ 7.71* | *$ 58.39* | *$ 3.06* | *$ 7.94* | *$ 4.89* |
| *% of Revenue* | *-14.5%* | *2.0%* | | *0.8%* | *2.2%* | |
| Operating Gain/(Loss) | $ (6.1) | $ (2.7) | $ (3.3) | $ 2.1 | $ 25.5 | $ (23.4) |
| | *$ (24.30)* | *$ (11.88)* | *$ (12.43)* | *$ 0.74* | *$ 9.43* | *$ (8.69)* |
| Retro Revenue Adjustments | $ (1.6) | $ - | $ (1.6) | $ (14.5) | $ - | $ (14.5) |
| *pmpm* | *$ (6.48)* | *$ -* | *$ (6.48)* | *$ (5.25)* | *$ -* | *$ (5.25)* |
| Total Increase / (Decrease) in Unrestricted Net Assets | $ (6.0) | $ (1.8) | $ (4.2) | $ 4.8 | $ 37.7 | $ (32.9) |
| *pmpm* | *$ (24.17)* | *$ (7.98)* | *$ (16.19)* | *$ 1.72* | *$ 13.96* | *$ (12.23)* |
| *% of Revenue* | *-6.9%* | *-2.1%* | | *0.5%* | *3.9%* | |

MTD Medical Benefits variance is the result of an upward trend in Inpatient high-dollar claims (those claims exceeding $50K each) along with volume-based utilization. In addition, prior period true-ups relating to Covid-19 and directed payments, in adherence to Proposition 56, also drove May's results. The variance to Reforecast was partially offset by reinsurance recoveries.

YTD MBR of 90.9% reflects Fee for Service(FFS) volume associated with higher-than-expected membership, ongoing Quality Funding Program and increases in inpatient utilization. This increase is expected to continue and reflected in 2024/25 budget.



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# May P&L: Medical Benefit Categories

| (In Millions) | May 2024 Month-To-Date Actual | May 2024 Month-To-Date Reforecast | Variance Fav / (Unfav) | May 2024 Year-To-Date Actual | May 2024 Year-To-Date Reforecast | Variance Fav / (Unfav) |
|---|---|---|---|---|---|---|
| **Medical Benefits:** | | | | | | |
| Capitation: | | | | | | |
| PCP, Specialty, Kaiser, NEMT & Vision | $7.9 | $6.9 | ($1.0) | $87.3 | $83.4 | ($3.9) |
| ECM | $.6 | $1.3 | $.8 | $4.8 | $9.6 | $4.8 |
| Total Capitation | $8.5 | $8.3 | ($.2) | $92.1 | $92.9 | $.8 |
| FFS Claims: | | | | | | |
| Inpatient | $26.8 | $18.6 | ($8.1) | $202.0 | $188.5 | ($13.5) |
| LTC / SNF | $14.0 | $16.5 | $2.4 | $165.2 | $180.6 | $15.3 |
| Outpatient | $6.7 | $7.3 | $.6 | $78.1 | $74.4 | ($3.8) |
| Laboratory and Radiology | $.9 | $.9 | $.1 | $11.6 | $9.0 | ($2.6) |
| Directed Payments - Provider | $10.9 | $.7 | ($10.2) | $35.9 | $22.6 | ($13.3) |
| Emergency Room | $3.0 | $3.3 | $.3 | $35.6 | $34.4 | ($1.2) |
| Physician Specialty | $7.7 | $7.5 | ($.2) | $75.1 | $72.6 | ($2.4) |
| Primary Care Physician | $3.6 | $3.4 | ($.3) | $33.9 | $30.8 | ($3.1) |
| Home & Community Based Services | $4.3 | $2.2 | ($2.1) | $33.0 | $24.1 | ($8.9) |
| Applied Behavioral Analysis/Mental Health Services | $4.5 | $3.3 | ($1.2) | $34.9 | $34.3 | ($.6) |
| Quality Incentives/Provider Reserves | $.1 | $.0 | ($.1) | $28.9 | $.0 | ($28.9) |
| Quality Incentive Provider Program (QIPP) | $2.3 | $5.2 | $2.9 | $33.9 | $18.5 | ($15.4) |
| Other Medical Professional | $.3 | $.4 | $.1 | $4.5 | $4.3 | ($.2) |
| Other Fee For Service | $6.8 | $1.1 | ($5.7) | $22.8 | $13.6 | ($9.2) |
| Transportation | $.3 | $.4 | $.2 | $2.3 | $3.2 | $1.0 |
| Total Claims | $92.2 | $70.8 | ($21.4) | $797.7 | $711.0 | ($86.8) |
| Provider Grant Program | $.0 | $.8 | $.8 | $.0 | $5.0 | $5.0 |
| Medical & Care Management | $3.1 | $2.2 | ($.9) | $23.8 | $20.6 | ($3.2) |
| Reinsurance | ($5.3) | $.2 | $5.5 | ($3.8) | $1.2 | $4.9 |
| Claims Recoveries | ($.2) | ($.1) | $.1 | ($2.8) | ($1.7) | $1.1 |
| Sub-total | ($2.4) | $3.1 | $5.5 | $17.3 | $25.0 | $7.8 |
| **Total Medical Benefits** | **$98.2** | **$82.1** | **($16.1)** | **$907.2** | **$829.0** | **($78.2)** |
| **Contribution Margin** | **($11.1)** | **$6.6** | **($17.6)** | **$90.7** | **$127.5** | **($36.9)** |



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# May 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 | 249,662 | 231,404 | 18,258 | 2,769,699 | 2,699,648 | 70,051 |
| Revenue | $ 87.1 | $ 88.7 | $ (1.6) | $ 997.8 | $ 956.5 | $ 41.3 |
| *pmpm* | *$ 349.04* | *$ 383.30* | *$ (34.26)* | *$ 360.27* | *$ 354.31* | *$ 5.96* |
| Non-Operating Revenue / (Expense) | $ 1.7 | $ 0.9 | $ 0.8 | $ 17.3 | $ 12.2 | $ 5.0 |
| *pmpm* | *$ 6.62* | *$ 3.90* | *$ 2.72* | *$ 6.23* | *$ 4.52* | *$ 1.71* |
| Medical Benefits | $ 98.2 | $ 82.1 | $ (16.1) | $ 907.2 | $ 829.0 | $ (78.2) |
| *pmpm* | *$ 393.41* | *$ 354.99* | *$ (38.4)* | *$ 327.53* | *$ 307.07* | *$ (20.5)* |
| *% of Revenue* | *112.7%* | *92.6%* | | *90.9%* | *86.7%* | |
| Administrative Expense | $ 7.6 | $ 7.5 | $ (0.1) | $ 80.2 | $ 80.6 | $ 0.5 |
| *pmpm* | *$ 30.61* | *$ 32.47* | *$ 1.86* | *$ 28.94* | *$ 29.87* | *$ 0.93* |
| *% of Revenue* | *8.8%* | *8.5%* | | *8.0%* | *8.4%* | |
| Project Portfolio | $ (12.7) | $ 1.8 | $ 14.4 | $ 8.5 | $ 21.4 | $ 13.0 |
| *pmpm* | *$ (50.68)* | *$ 7.71* | *$ 58.39* | *$ 3.06* | *$ 7.94* | *$ 4.89* |
| *% of Revenue* | *-14.5%* | *2.0%* | | *0.8%* | *2.2%* | |
| Operating Gain/(Loss) | $ (6.1) | $ (2.7) | $ (3.3) | $ 2.1 | $ 25.5 | $ (23.4) |
| | *$ (24.30)* | *$ (11.88)* | *$ (12.43)* | *$ 0.74* | *$ 9.43* | *$ (8.69)* |
| Retro Revenue Adjustments | $ (1.6) | $ - | $ (1.6) | $ (14.5) | $ - | $ (14.5) |
| *pmpm* | *$ (6.48)* | *$ -* | *$ (6.48)* | *$ (5.25)* | *$ -* | *$ (5.25)* |
| Total Increase / (Decrease) in Unrestricted Net Assets | $ (6.0) | $ (1.8) | $ (4.2) | $ 4.8 | $ 37.7 | $ (32.9) |
| *pmpm* | *$ (24.17)* | *$ (7.98)* | *$ (16.19)* | *$ 1.72* | *$ 13.96* | *$ (12.23)* |
| *% of Revenue* | *-6.9%* | *-2.1%* | | *0.5%* | *3.9%* | |

Non-Project Portfolio expenses reflect the application of a Governmental Accounting Standards Board (GASB) accounting adjustment for Operations of the Future initiative labor amortization; these adjustments are detailed on a following slide.

Non-Project Portfolio administrative expenses remain commensurate to Reforecast.



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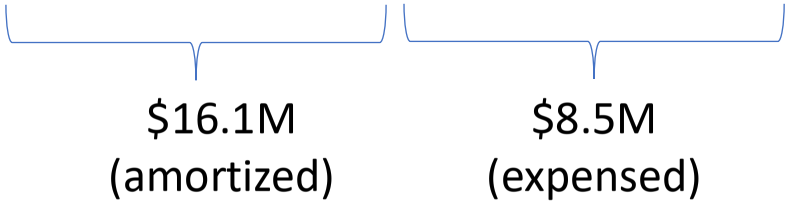
# May YTD P&L: GASB-96 Adjustment

- Government Accounting Standards Board (GASB-96) is the accounting policy for reporting the amortization of subscription-based software applications.

- Prior to May, applicable Vendor and Contractor expense of $16.1M had not been amortized. This adjustment was made as part of May month-end close. The true YTD expense as of the end of May is $8.5M.

| Application | May YTD Implementation Costs | | | | Total |
|---|---|---|---|---|---|
| | App Vendor | Contractors | Temp Labor | Internal Labor | Imp. Costs |
| Casenet | $ 468,444 | $ - | $ 590,757 | $ 173,594 | $ 1,232,795 |
| HealthEdge | $ 9,539,000 | $ - | $ 2,729,999 | $ 1,080,761 | $ 13,349,760 |
| KP Print | $ 831,250 | $ - | $ - | $ - | $ 831,250 |
| Salesforce | $ - | $ 1,668,410 | $ - | $ - | $ 1,668,410 |
| Transaction Applications Group | $ 2,099,502 | $ - | $ 119,144 | $ - | $ 2,218,646 |
| TTEC Government Solutions, LLC | $ 274,485 | $ - | $ - | $ - | $ 274,485 |
| Edifects | $ 1,165,207 | $ - | $ 182,376 | $ - | $ 1,347,583 |
| Modern Data Warehouse | $ - | $ - | $ 3,678,648 | $ - | $ 3,678,648 |
| **Totals** | **$ 14,377,888** | **$ 1,668,410** | **$ 7,300,924** | **$ 1,254,355** | **$ 24,601,577** |



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# May 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 | 249,662 | 231,404 | 18,258 | 2,769,699 | 2,699,648 | 70,051 |
| Revenue | $ 87.1 | $ 88.7 | $ (1.6) | $ 997.8 | $ 956.5 | $ 41.3 |
| *pmpm* | *$ 349.04* | *$ 383.30* | *$ (34.26)* | *$ 360.27* | *$ 354.31* | *$ 5.96* |
| Non-Operating Revenue / (Expense) | $ 1.7 | $ 0.9 | $ 0.8 | $ 17.3 | $ 12.2 | $ 5.0 |
| *pmpm* | *$ 6.62* | *$ 3.90* | *$ 2.72* | *$ 6.23* | *$ 4.52* | *$ 1.71* |
| Medical Benefits | $ 98.2 | $ 82.1 | $ (16.1) | $ 907.2 | $ 829.0 | $ (78.2) |
| *pmpm* | *$ 393.41* | *$ 354.99* | *$ (38.4)* | *$ 327.53* | *$ 307.07* | *$ (20.5)* |
| *% of Revenue* | *112.7%* | *92.6%* | | *90.9%* | *86.7%* | |
| Administrative Expense | $ 7.6 | $ 7.5 | $ (0.1) | $ 80.2 | $ 80.6 | $ 0.5 |
| *pmpm* | *$ 30.61* | *$ 32.47* | *$ 1.86* | *$ 28.94* | *$ 29.87* | *$ 0.93* |
| *% of Revenue* | *8.8%* | *8.5%* | | *8.0%* | *8.4%* | |
| Project Portfolio | $ (12.7) | $ 1.8 | $ 14.4 | $ 8.5 | $ 21.4 | $ 13.0 |
| *pmpm* | *$ (50.68)* | *$ 7.71* | *$ 58.39* | *$ 3.06* | *$ 7.94* | *$ 4.89* |
| *% of Revenue* | *-14.5%* | *2.0%* | | *0.8%* | *2.2%* | |
| Operating Gain/(Loss) | $ (6.1) | $ (2.7) | $ (3.3) | $ 2.1 | $ 25.5 | $ (23.4) |
| | *$ (24.30)* | *$ (11.88)* | *$ (12.43)* | *$ 0.74* | *$ 9.43* | *$ (8.69)* |
| Retro Revenue Adjustments | $ (1.6) | $ - | $ (1.6) | $ (14.5) | $ - | $ (14.5) |
| *pmpm* | *$ (6.48)* | *$ -* | *$ (6.48)* | *$ (5.25)* | *$ -* | *$ (5.25)* |
| Total Increase / (Decrease) in Unrestricted Net Assets | $ (6.0) | $ (1.8) | $ (4.2) | $ 4.8 | $ 37.7 | $ (32.9) |
| *pmpm* | *$ (24.17)* | *$ (7.98)* | *$ (16.19)* | *$ 1.72* | *$ 13.96* | *$ (12.23)* |
| *% of Revenue* | *-6.9%* | *-2.1%* | | *0.5%* | *3.9%* | |

In summary, the YTD Net Asset variance of $(32.9M) is primarily the result of:

- Current year premium favorability associated with an increase in membership,
- Quality Funding Program increase in provider participation,
- Project Portfolio GASB 96 reclassification of expense to the Statement of Financial Position,
- Retroactive 2023 premium rate adjustments not known at time of Reforecast, and
- Prior year adjustments for Covid-19 risk corridor and Proposition 56 true-up.



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# Looking Ahead….

- Items which could still impact FY2023-24
  - 2024 Acuity rate adjustment (note: this would apply for January through June only).
  - Final accounting recommendations suggested by external fiscal Auditors.

- Items impacting FY2024-25 (thus informing the mid-year reforecast)
  - 2024 Acuity rate adjustment; this could function as either a headwind or a tailwind; discussions between the State and its Actuarial Services partner are occurring now.
  - Utilization analysis. As we continue to invest in quality outcomes, we will assess impact on utilization and develop programs focused on proactive care to reduce hospitalization.
  - Revised Provider rate changes coming out of current and future contract negotiations.
  - Medical Cost initiatives (specifically around Long Term Care (LTC) and preauthorization process improvements). These initiatives will help bend the short-term and long-term cost curves down.



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# Exhibits

This section contains the following exhibits:

- Summary of Major Adjustments
- Membership Breakdown
- Balance Sheet
- Cash and Short-Term Investment Portfolio
- Revenue and Medical Benefit Per Member Month Values
- High Dollar Claims and Utilization
- Inpatient SIS – UIS Days
- State Incentive Programs



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# May Summary of Major Prior Period Adjustments

| Summary of Prior Period Major Adjustments Impacting May | | | | |
|---|---|---|---|---|
| Gold Coast Health Plans | | | | |
| To be recorded in May, 2024 | | | | |
| | | | | |
| **Month** | **Description** | **Related to** | **Amount *** | **Impact** |
| May | COA Change Adult -> Child | Jan 2024 - Apr 2024 | 3.5 | Decrease to Revenue |
| May | Acuity Rate Reduction - Final | Jan 2023 - Dec 2023 | 1.2 | Decrease to Revenue |
| May | Deceased Member Takeback | 2014 - 2024 | 0.4 | Decrease in Revenue |
| May | Prop 56 | Jul 2019 - Dec 2020 | 1.5 | Increase to Expense |
| May | Prop 56 | Jan 2021 - Dec 2021 | 7.6 | Increase to Expense |
| May | Covid Risk Corridor | Jul 2019 - Dec 2020 | 5.7 | Increase to Expense |
| May | 2022 Maternity True-Up - Estimated | Sep 2022 - Jun 2023 | 0.4 | Increase in Revenue |
| May | 2023 Maternity True-Up - Estimated | Jul 2023 - Jun 2024 | 0.1 | Increase in Revenue |
| May | GASB 96 Reclass - Estimated | Jul 2023 - Jun 2024 | 16.1 | Decrease to Admin Expense related to Ops of the Future fixed assets |
| May | Amortization Expense True-Up | Jul 2023 - Jun 2024 | 1.1 | Increase to Admin Expense related to existing fixed assets |
| May | Reinsurance Recoveries | Jul 2023 - Jun 2024 | 5.5 | Decrease to Med Exp |
| | | | | |
| **Summary** | | | | |
| | Total positive impacts | | $ 22.1 | |
| | Total negative impacts | | 21.0 | |
| | Net Positive impact | | $ 1.1 | |
| | | | | |
| * Some of the amounts are estimated, either because we only recently received the information and are still evaluating it (for instance, the Maternity True-Up), or | | | | |
| because there are still transactions happening throughout the organization that will likely impact the final adjustment (for instance, the GASB 96 Reclass). | | | | |



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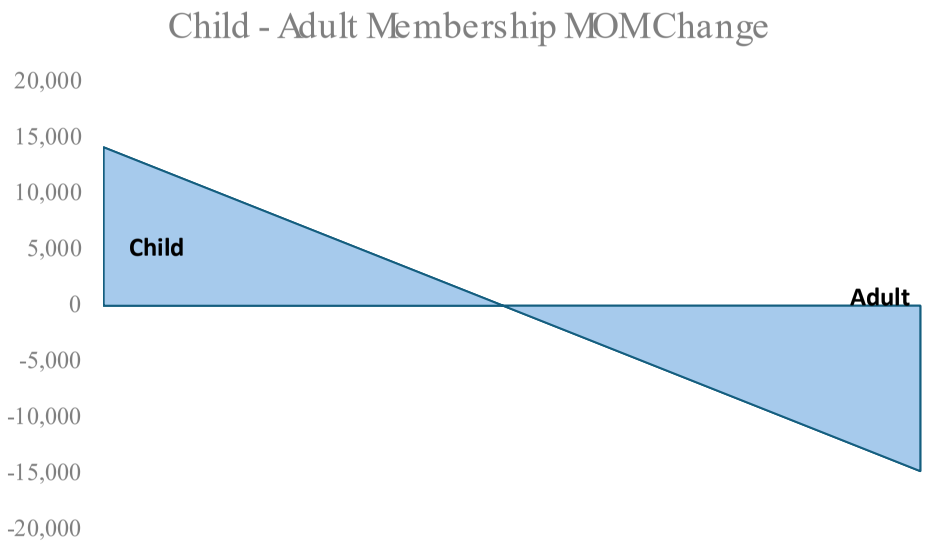
# Membership Breakdown

## Membership by Category of Aid – May 2024

The State has redesignated 19- to 20-year-olds from Adult to Child retroactively back to January

The redesignation reduced premium revenue by $3.2M

| Category of Aid | April | May | Variance |
|---|---|---|---|
| **Child** | 87,476 | 101,640 | **14,164** |
| **Adult** | 44,545 | 29,776 | **-14,769** |
| **Adult Expansion** | 82,840 | 83,169 | 329 |
| **SPD** | 11,267 | 11,186 | -81 |
| **SPD Dual** | 23,100 | 23,201 | 101 |
| **LTC** | 62 | 52 | -10 |
| **LTC Dual** | 641 | 638 | -3 |
| **Total** | **249,931** | **249,662** | **-269** |



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# May YTD Balance Sheet: Assets

| | 05/31/24 | 06/30/23 |
|---|---|---|
| **ASSETS** | | |
| **Current Assets:** | | |
| **Total Cash and Cash Equivalents** | **$ 431,802,229** | **$ 344,166,987** |
| **Total Short-Term Investments** | **98,984,970** | **95,269,796** |
| Medi-Cal Receivable | 125,456,220 | 96,222,357 |
| Interest Receivable | 937,087 | 462,872 |
| Provider Receivable | 12,461,571 | 422,995 |
| Other Receivables | 5,579,474 | 59,542 |
| **Total Accounts Receivable** | **144,434,352** | **97,167,766** |
| Total Prepaid Accounts | 6,427,121 | 5,545,603 |
| Total Other Current Assets | 133,545 | 135,560 |
| **Total Current Assets** | **681,782,216** | **542,285,711** |
| **Total Fixed Assets** | **22,524,641** | **9,224,593** |
| **Total Assets** | **$ 704,306,858** | **$ 551,510,304** |

- The $152.8M increase in total Assets/Liabilities is attributed to the following:
  - Medi-Cal Receivable: expected State premiums, MCO tax and supplemental-maternity.
  - Provider Receivable: includes payment advances related to Change Healthcare data breach.
  - Fixed Assets: includes GASB 96 reclassification of expense.



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# May YTD Balance Sheet: Liabilities

| LIABILITIES & NET ASSETS | 05/31/24 | 06/30/23 |
|---|---|---|
| **Current Liabilities:** | | |
| Incurred But Not Reported | $ 111,032,966 | $ 84,436,777 |
| Claims Payable | 20,763,288 | 12,923,764 |
| Capitation Payable | 8,158,220 | 8,998,514 |
| Physician Payable | 37,125,236 | 31,865,385 |
| AB 85 Payable | - | - |
| DHCS - Reserve for Capitation Recoup | 50,376,851 | 10,411,049 |
| Lease Payable- ROU | 2,401,208 | 3,300,319 |
| Accounts Payable | 757,498 | 1,455,088 |
| Accrued ACS | 4,058,861 | 3,902,303 |
| Accrued Provider Incentives/Reserve | 27,047,700 | 17,427,573 |
| Accrued Pharmacy | - | - |
| Accrued Expenses | 10,578,301 | 7,559,682 |
| Accrued Premium Tax | 58,281,694 | - |
| Accrued Interest Payable | - | - |
| Current Portion of Deferred Revenue | - | - |
| Accrued Payroll Expense | 4,131,122 | 3,189,633 |
| Current Portion Of Long Term Debt | - | - |
| Quality Withhold | 1,065,083 | |
| Other Current Liabilities | - | - |
| **Total Current Liabilities** | **335,778,027** | **185,470,089** |
| **Long-Term Liabilities:** | | |
| Lease Payable - NonCurrent - ROU | 3,801,738 | 6,088,559 |
| **Total Long-Term Liabilities** | **3,801,738** | **6,088,559** |
| **Total Liabilities** | **339,579,765** | **191,558,647** |
| **Net Assets:** | | |
| Beginning Net Assets | 359,951,657 | 176,617,059 |
| Total Increase / (Decrease in Unrestricted Net Assets) | 4,775,437 | 183,334,598 |
| **Total Net Assets** | **364,727,094** | **359,951,657** |
| **Total Liabilities & Net Assets** | **$ 704,306,859** | **$ 551,510,304** |

- Incurred But Not Reported Expected expenses for medical services provided but not yet submitted or paid are increasing due to claims payments timing and unit cost rates.
- Accrued Provider Incentive/Reserves are related to the Cal-AIM and HHIP Incentives. The increase over last year illustrates additional investments in State-sponsored programs.
- Accrued Premium Tax reflects our expected Managed Care Organization Tax (this appears only on our Balance Sheet and does not impact our financial results).



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# Cash and Short-Term Investment Portfolio

**SCHEDULE OF INVESTMENTS AND CASH BALANCES**

| | Market Value* May 31, 2024 | Account Type |
|---|---|---|
| Local Agency Investment Fund (LAIF)[1] | $ 42,080,748 | Investment |
| Ventura County Investment Pool[2] | 19,245,950 | Investment |
| CalTrust | 37,658,272 | Short-term investment |
| Bank of West | 429,954,658 | Money market account |
| Pacific Premier | 1,847,070 | Operating accounts |
| Petty Cash | 500 | Cash |
| ***Investments and monies held by GCHP*** | ***$ 530,787,198*** | |

Cash and short-term investments balance sits at $530.7M.

- The investment portfolio includes Ventura County Investment Pool $19.2M; LAIF CA State $42.1M; Cal Trust $37.7.



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# PMPM and TNE Values

| | FYTD 23/24 Reforecast | FYTD 23/24 Actual | FYTD 22/23 Actual | FYTD 21/22 Actual |
|---|---|---|---|---|
| Average Enrollment | 245,423 | 251,791 | 247,854 | 229,367 |
| PMPM Revenue | $ 354.31 | $ 360.27 | $ 340.86 | $ 347.72 |
| **Medical Benefits** | | | | |
| Capitation | $ 34.42 | $ 33.26 | $ 34.18 | $ 32.44 |
| Inpatient | $ 69.82 | $ 72.92 | $ 54.64 | $ 68.62 |
| LTC / SNF | $ 66.88 | $ 59.65 | $ 54.86 | $ 59.92 |
| Outpatient | $ 27.55 | $ 28.21 | $ 23.88 | $ 22.59 |
| Emergency Room | $ 12.75 | $ 12.85 | $ 11.32 | $ 10.80 |
| Physician Specialty | $ 26.91 | $ 27.10 | $ 23.44 | $ 22.49 |
| Quality Incentives | $ 6.84 | $ 22.68 | $ 0.69 | $ - |
| Provider Grant Program * | $ 1.85 | $ - | $ - | $ - |
| Pharmacy | $ - | $ - | $ (0.15) | $ 29.71 |
| All Other | $ 60.04 | $ 70.85 | $ 53.03 | $ 45.41 |
| Total Per Member Per Month | $ 307.07 | $ 327.53 | $ 255.89 | $ 291.97 |
| Medical Benefit Ratio | 86.7% | 90.9% | 75.1% | 86.9% |
| Total Administrative Expenses | $ 102,072,654 | $ 88,617,778 | $ 78,852,534 | $ 53,680,738 |
| % of Revenue | 10.7% | 8.9% | 7.8% | 5.6% |
| TNE | $ 397,629,685 | $ 364,727,094 | $ 359,814,027 | $ 176,562,922 |
| Required TNE | $ 41,438,176 | $ 37,163,028 | $ 32,913,795 | $ 36,609,789 |
| % of Required | 960% | 981% | 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").



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# Inpatient High Dollar Claims and Utilization

## Inpatient FFS Claims

| Paid Month | January | | | | February | | | | March | | | | April | | | | May | | | | Totals | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| COA (Groups) | Claim # | Utils | Admits | Paid | Claim # | Utils | Admits | Paid | Claim # | Utils | Admits | Paid | Claim # | Utils | Admits | Paid | Claim # | Utils | Admits | Paid | Claim # | Utils | Admits | Paid |
| Adult Expansion | 913 | 3,487 | 691 | $12,831,672 | 641 | 2,430 | 478 | $7,017,132 | 685 | 2,774 | 525 | $8,754,493 | 848 | 3,833 | 610 | $11,499,783 | 925 | 3,623 | 670 | $11,749,091 | 4,012 | 16,147 | 2,974 | $51,852,171 |
| Adult/Family | 613 | 1,404 | 387 | $4,273,292 | 498 | 1,021 | 300 | $2,932,493 | 418 | 1,008 | 252 | $3,394,291 | 687 | 1,317 | 411 | $4,082,898 | 932 | 1,751 | 487 | $7,358,653 | 3,148 | 6,501 | 1,837 | $22,041,628 |
| Disabled - Medi-Cal | 194 | 854 | 159 | $3,336,662 | 148 | 873 | 114 | $3,232,261 | 146 | 730 | 118 | $2,356,779 | 216 | 1,496 | 171 | $4,235,878 | 281 | 1,353 | 197 | $4,308,266 | 985 | 5,306 | 759 | $17,469,846 |
| Dual | 644 | 3,385 | 481 | $1,029,578 | 621 | 3,090 | 518 | $770,658 | 873 | 5,654 | 724 | $1,354,164 | 726 | 4,503 | 570 | $1,115,459 | 559 | 3,052 | 457 | $756,734 | 3,423 | 19,684 | 2,750 | $5,026,592 |
| Child/Family (under 19) | 83 | 221 | 76 | $572,660 | 82 | 193 | 74 | $736,728 | 59 | 106 | 46 | $438,972 | 73 | 158 | 59 | $557,275 | 119 | 271 | 111 | $1,050,299 | 416 | 949 | 366 | $3,355,935 |
| Aged - Medi-Cal | 58 | 215 | 57 | $941,564 | 47 | 173 | 34 | $401,762 | 47 | 185 | 38 | $559,762 | 95 | 351 | 65 | $706,456 | 78 | 239 | 58 | $531,531 | 325 | 1,163 | 252 | $3,141,076 |
| Other | 123 | 377 | 84 | $429,897 | 91 | 226 | 57 | $416,911 | 77 | 230 | 44 | $327,325 | 138 | 316 | 84 | $733,975 | 195 | 496 | 122 | $774,990 | 624 | 1,645 | 391 | $2,683,098 |
| Grand Total | 2,628 | 9,943 | 1,935 | $23,415,325 | 2,128 | 8,006 | 1,575 | $15,507,946 | 2,305 | 10,687 | 1,747 | $17,185,786 | 2,783 | 11,974 | 1,970 | $22,931,724 | 3,089 | 10,785 | 2,102 | $26,529,564 | 12,933 | 51,395 | 9,329 | $105,570,345 |

| Inpatient FFS Claims | January | February | March | April | May |
|---|---|---|---|---|---|
| Membership | 249,385 | 250,314 | 250,139 | 249,931 | 249,662 |
| Claim # | 2,628 | 2,128 | 2,305 | 2,783 | 3,089 |
| Days | 9,943 | 8,006 | 10,687 | 11,974 | 10,785 |
| Admits | 1,935 | 1,575 | 1,747 | 1,970 | 2,102 |
| Avg Days Per Admit | 5.1 | 5.1 | 6.1 | 6.1 | 5.1 |
| Paid | $23,415,325 | $15,507,946 | $17,185,786 | $22,931,724 | $26,529,564 |
| Avg Paid per Claim | $8,910 | $7,288 | $7,456 | $8,240 | $8,588 |

- Total IP Days are averaging 10.2K per month.
- Avg Paid Claims is starting to trend up, indicating both increase in rate and increase in complexity.
- Isolating High Dollar Claims provides more transparency….

## Inpatient High-Dollar Claims: Claims > $50K

| Paid Month | January | | | | February | | | | March | | | | April | | | | May | | | | Totals | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| COA (Groups) | Claim # | Utils | Admits | Paid | Claim # | Utils | Admits | Paid | Claim # | Utils | Admits | Paid | Claim # | Utils | Admits | Paid | Claim # | Utils | Admits | Paid | Claim # | Utils | Admits | Paid |
| Adult Expansion | 44 | 596 | 38 | $4,672,967 | 22 | 320 | 18 | $2,930,582 | 23 | 399 | 17 | $3,659,104 | 39 | 882 | 34 | $6,727,992 | 43 | 1,059 | 40 | $7,388,650 | 171 | 3,256 | 147 | $25,379,294 |
| Disabled - Medi-Cal | 15 | 184 | 14 | $1,310,691 | 8 | 185 | 7 | $2,155,762 | 5 | 123 | 4 | $738,776 | 20 | 323 | 17 | $3,258,479 | 10 | 251 | 10 | $2,812,590 | 58 | 1,066 | 52 | $10,276,298 |
| Adult/Family | 8 | 89 | 7 | $1,005,679 | 6 | 109 | 6 | $680,695 | 10 | 138 | 9 | $1,277,310 | 10 | 134 | 10 | $1,221,429 | 12 | 296 | 10 | $3,798,563 | 46 | 766 | 42 | $7,983,676 |
| Dual | 3 | 96 | 3 | $299,056 | 4 | 72 | 3 | $361,139 | 2 | 66 | 2 | $388,011 | 3 | 61 | 0 | $339,300 | | | | | 12 | 295 | 8 | $1,387,507 |
| Other | 2 | 58 | 2 | $221,609 | 3 | 0 | 0 | $272,588 | | | | | 2 | 25 | 2 | $177,373 | 2 | 47 | 1 | $140,682 | 9 | 130 | 5 | $812,252 |
| Aged - Medi-Cal | 4 | 42 | 4 | $332,625 | 2 | 16 | 1 | $195,906 | 1 | 3 | 0 | $66,109 | 1 | 5 | 1 | $51,270 | | | | | 8 | 66 | 6 | $645,910 |
| Child/Family (under 19) | | | | | 1 | 7 | 1 | $56,062 | | | | | 1 | 11 | 1 | $65,528 | 2 | 23 | 2 | $184,845 | 4 | 41 | 4 | $306,435 |
| Grand Total | 76 | 1,065 | 68 | $7,842,627 | 46 | 709 | 36 | $6,652,733 | 41 | 729 | 32 | $6,129,309 | 76 | 1,441 | 65 | $11,841,370 | 69 | 1,676 | 63 | $14,325,331 | 308 | 5,620 | 264 | $46,791,371 |

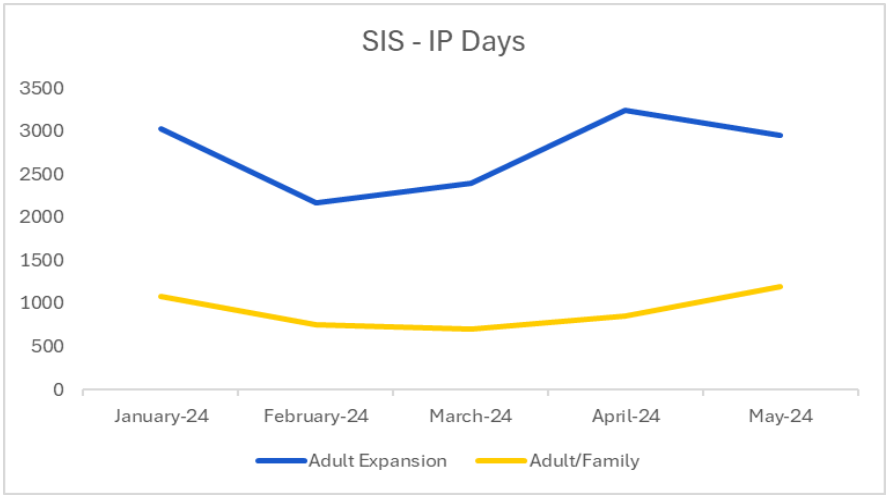
| Inpatient High Dollar | January | February | March | April | May |
|---|---|---|---|---|---|
| Membership | 249,385 | 250,314 | 250,139 | 249,931 | 249,662 |
| Claim # | 76 | 46 | 41 | 76 | 69 |
| Days | 1,065 | 709 | 729 | 1,441 | 1,676 |
| Admits | 68 | 36 | 32 | 65 | 63 |
| Avg Days Per Admit | 15.7 | 19.7 | 22.8 | 22.2 | 26.6 |
| Paid | $7,842,627 | $6,652,733 | $6,129,309 | $11,841,370 | $14,325,331 |
| Avg Paid per Claim | $103,192 | $144,625 | $149,495 | $155,808 | $207,613 |

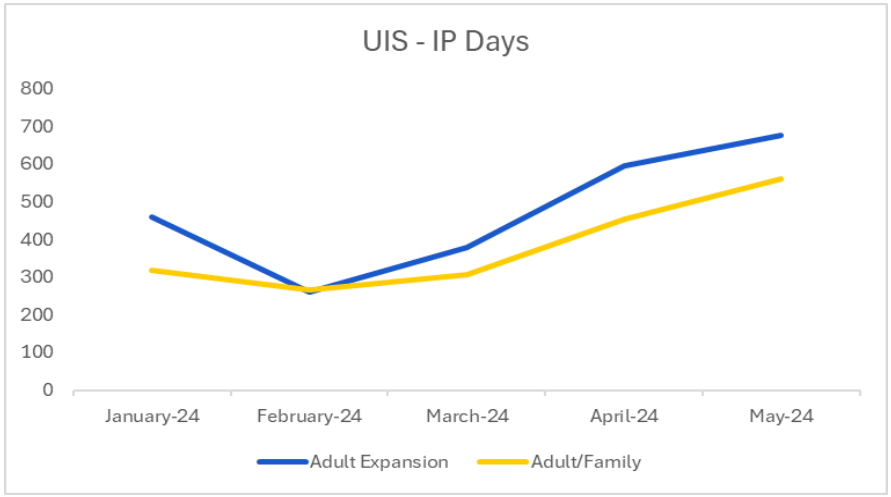
- …average days per admit has almost doubled since the beginning of the calendar year.
- May saw 5 paid claims each over $1M; while reinsurance covers 90% of costs over $1.1M, this is still a significant impact for the month.

# Inpatient SIS-UIS Days

The graphs below illustrate the trend in Inpatient Paid Days for Adult/Family and Adult Expansion Categories of Aid (COA), broken down by Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration Status (UIS).

These COAs are experiencing the largest volume of utilization.



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# 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.



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