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

Regular Meeting

Monday, March 22, 2021, 2:00 p.m.

Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010

Executive Order N-25-20

Conference Call Number: 805-324-7279
Conference ID Number: 316 991 973#

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

AGENDA

CALL TO ORDER

ROLL CALL

PUBLIC COMMENT

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

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

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

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Regular Minutes of February 22, 2021.

Staff: Deborah Munday – Associate Clerk to the Commission

RECOMMENDATION: Approve the minutes of February 22, 2021.

2. Resolution Extension through April 26, 2021

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Adopt Resolution No. 2021-003 to extend the duration of authority empowered in the CEO through April 26, 2021.

FORMAL ACTION

3. Approval of Revised 2021 Meeting Dates for Executive Finance, and December Strategic Planning.
Request Direction from Commission for 2021 After Hours/Evening Meetings for the Community.

Staff: Scott Campbell, General Counsel
Maddie Gutierrez, Clerk to the Commission

RECOMMENDATION: Approve the revised 2021 meeting dates for the Executive Finance Committee in order to review financials prior to regular Commission meetings, and approve moving the Strategic Planning meeting to December 16, in order not to conflict with the Board of Supervisors meeting.

Staff also requests direction from the Commission on scheduling meeting dates for the after-hours/evening Commission meetings for calendar year 2021.

4. Member Auto-Assignment to a Primary Care Physician Policy

Staff: Scott Campbell, General Counsel
Cathy Deubel Salenko, Health Care Counsel

RECOMMENDATION: Staff recommends the Commission ratify the current Policy and the Policy amended in 2021 that is pending DHCS approval. The current Policy is effective until DHCS approves the 2021 Policy, which will be effective on DHCS approval.

5. Provider Contracting and Credentialing Management ("PCCM") System Implementation

Staff: Eileen Moscaritolo, HMA Consultant
Nancy Wharfield, M.D., Chief Medical Officer

RECOMMENDATION:

GCHP staff recommend the Commission approve and delegate to the CEO the authority to execute agreement amendments and/or change orders with Symplr with a new NTE amount of $1,924,005 for the duration of the five-year agreement.

6. February 2021 Financials

Staff: Kashina Bishop, Chief Financial Officer

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

7. Pharmacy Benefits Manager (PBM) Contract Amendment

Staff: Nancy Wharfield, M.D., Chief Medical Officer
Anne Freese, PharmD., Director of Pharmacy

RECOMMENDATION: Authorize CEO to sign an amendment to the Pharmacy Benefits Manager contract to accommodate the delay of the implementation of Medi-Cal Rx.

UPDATES

8. Compliance Overview

Staff: Robert Franco, Chief Compliance Officer

RECOMMENDATION: Receive and file the update.

REPORTS

9. Chief Executive Officer (CEO) Report

Staff: Margaret Tatar, Chief Executive Officer

RECOMMENDATION: Receive and file the report.

10. Chief Medical Officer (CMO) Report

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

RECOMMENDATION: Receive and file the report.

11. Chief Diversity Officer (CDO) Report

Staff: Ted Bagley, Chief Diversity Officer

RECOMMENDATION: Receive and file the report.

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

Staff: Michael Murguia, Executive Director of Human Resources

RECOMMENDATION: Receive and file the report.

CLOSED SESSION

13. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) Section 54956.9: One case.

ADJOURNMENT

Unless otherwise determined by the Commission, the next meeting will be held at 2:00 P.M. on April 26, 2021, at Gold Coast Health Plan at 711 E. Daily Drive, Suite 106, Community Room, Camarillo, CA 93010.

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

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

AGENDA ITEM NO. 1

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Deborah Munday, Sr. Executive Assistant / Associate Clerk of the Board

DATE: March 22, 2021

SUBJECT: Meeting Minutes of February 22, 2021 Regular Commission Meeting

RECOMMENDATION:

Approve the minutes.

ATTACHMENT:

Copy of Minutes for the February 22, 2021 Regular Commission Meeting.

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) February 22, 2021 Regular Meeting Minutes

CALL TO ORDER

Commission Chair Dee Pupa called the meeting to order via teleconference at 2:04 pm. The Clerk was in the Community Room located at Gold Coast Health Plan, 711 East Daily Drive, Camarillo, California.

OATH OF OFFICE

Andrew Lane took his Oath of Office.

ROLL CALL

Present: Commissioners Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Supervisor Carmen Ramirez, and Jennifer Swenson.

Absent: Commissioners Antonio Alatorre, Shawn Atin and Scott Underwood, M.D.

Attending the meeting for GCHP were Margaret Tatar, Chief Executive Officer, Nancy Wharfield, MD., Chief Medical Officer, Ted Bagley, Interim Chief Diversity Officer, Kashina Bishop, Chief Financial Officer, Michael Murguia Executive Director of Human Resources, Scott Campbell, General Counsel, Cathy Salenko, Health Care General Counsel, Marlen Torres, Executive Director of Strategy and External Affairs, and Eileen Moscaritolo, HMA Consultant.

Additional staff participating on the call: Vicki Wrighster, Dr. Anne Freese, Rachel Lambert, Helen Miller, Jamie Louwerens, Dr. Lupe Gonzalez, Pauline Preciado, Anna Sproule, Luis Aguilar, Paula Cabral, Sandi Walker, Nicole Kanter, Susana Enriquez, Carolyn Harris, and David Tovar.

Ana Rangel, Interpreter.

Additional participants were Ruben Juarez, Community Advisory Committee (CAC) Acting Committee Chair and David Fein, Provider Advisory (PAC) Committee Chair.

PUBLIC COMMENT

Dr. Sandra Aldana, California State Council on Developmental Disabilities, commented regarding the vaccination protocols in the County. Dr. Aldana recently attended a meeting with the California Vaccine Community Advisory Committee and was excited that 140,000 more doses were received. There have been fast-paced changes to vaccination prioritization groups and would like to see if GCHP can work with our public health officer, Dr. Levin, to be as responsive to these changes.

On February 12, 2021, Governor Newsom stated he was moving individuals with disabilities from Phase 1C to Phase 1B and expanding the original vaccine priority of certain groups. Acquiring COVID-19 will limit an individual's ability to receive ongoing care or services vital to their well-being and survival. Providing adequate and timely COVID-19 care will be challenging due to the individual's disability.

It is hoped that we can work closely with new distribution points for the vaccine to ensure that we follow the prioritization groups once we move to an age based distribution model and priority groups will not have to compete with other groups. She thanked the Commission for their willingness to always listen.

Commission Chair Pupa thanked Dr. Aldana for her comments and partnership.

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Regular Minutes of January 25, 2021.

Staff: Deborah Munday, Sr. Executive Assistant / Associate Clerk of the Board

RECOMMENDATION: Approve the minutes of January 25, 2021

2. Resolution Extension through March 23, 2021

Staff: Scott Campbell General Counsel

RECOMMENDATION: Adopt Resolution 2021-002 to extend the duration of authority empowered in the CEO through March 23, 2021.

Supervisor Ramirez motioned to approve agenda items 1 and 2. Commissioner Johnson seconded.

AYES: Commissioners Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Supervisor Carmen Ramirez, and Jennifer Swenson.
NOES: None.

ABSENT: Commissioners Antonio Alatorre, Shawn Atin and Scott Underwood, M.D.

Commissioner Pupa declared the motion carried.

At Commissioner Espinosa's request, agenda item 3, Edrington Health Consulting, was moved to Formal Action.

UPDATE

4. HSP MediTrac Update

Staff: Eileen Moscaritolo, HMA Consultant

RECOMMENDATION: Accept and file the update.

Eileen Moscaritolo, HMA Consultant, stated we are focused on migrating from our existing managed care system with our vendor partner Conduent. Our current system is IKA and we are migrating to HSP. Gold Coast Health Plan (GCHP) has been working with Conduent for the past two years to work on the transition.

At the last Commission meeting a contract amendment for March 1, 2021, was presented. Since that meeting, we have continued to work with Conduent for testing and validation of data to ensure we follow Medi-Cal claims and processing guidelines. There was a significant issue with the functionality of the system regarding authorizations of services and payment of claims associated with those services.

We are working collaboratively with Conduent and agreed to a date change of May 3, 2021. As a result, we have refocused whether our amendment to our current contract is needed and will provide information as necessary. We have completed provider training and what the changes mean for their offices/practices. We will need to relaunch some of the communication due to the time lapse and will communicate with providers as it gets close to the "go-live" date. We plan to present an amendment to the contract for the date change.

Commissioner Espinosa motioned to approve agenda item 4. Commissioner Johnson seconded.

AYES: Commissioners Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Supervisor Carmen Ramirez, and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Shawn Atin and Scott Underwood, M.D.

Commissioner Pupa declared the motion carried.

FORMAL ACTION

3. Edrington Health Consulting

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Staff recommends that the Commission approve the amended contract and increase funding for the amendment.

Kashina Bishop, Chief Financial Officer, stated we are seeking to add an additional $300,000 to a statement of work for Edrington Health Consulting. They are a strategic partner and assist with capitation development review and added actuarial services this year. They assist with our IBMP calculation and our rate development template in the supplemental data request to the State. 100% of our revenue is based on those templates that go to the State, the data that we give them is critical. Edrington provides assistance in the budgeting for medical expenses and forecasting. There was an approved statement of work through calendar year 2021.

We went over budget for a few reasons. One was the addition of actuarial services. Previously Milliman completed actuarial services. We had issues with Milliman as they made a significant mistake in their analysis which was caught through Edrington Health Consulting. We were able to complete additional analysis and found the error. If this had not been found, it would have cost the organization millions. Reporting to the State has improved and has been an area of focus. We were close to being put on a corrective action plan. Through the staff's work with Edrington Health Consulting, we have improved so much the State said we won the most improved award for submissions. Based on that and staff vacancies, we needed additional funding for this statement of work.

Commissioner Espinosa asked if the current contract runs through the end of the year and questioned the need for an additional contract or additional services, we have been working on this for a couple of years and our Chief Financial Officer has had assistance of additional staff, the guidance and mentoring of HMA, and now we are adding an additional contract. Commissioner Espinosa stated she was under the impression the Chief Financial Officer and her department were doing fine. She was assured things were improving and perhaps the improvement is because we have all of these additional services. She added she is not part of the Executive Finance Committee when this item was discussed.

Margaret Tatar, Chief Executive Officer, stated our Chief Financial Officer and the Finance Department has grown and developed. Since we have been under a hiring freeze due to the Solvency Action Plan it has put constraints on our performance. The plan's solvency was put at risk, based on the actions of 2017 and 2018, and we face

the challenge of restoring our reserve and our solvency to levels that will be acceptable to the Commission and DHCS. As CFO Bishop mentioned, we were disappointed in our vendor, but are confident that the contract with Edrington is part of the restoration process.

CFO Bishop stated another reason for the overage was staff shortages in both the Finance and Decision Support Services Departments. Both departments will be fully staffed in March. We will be training to transition some of the work done by Edrington internally. There will be some work that will be continuously needed. We currently do not have actuarial services in-house which is needed, as we look to expand our capitation agreements or plan-to-plan arrangement so we would utilize Edrington Health Consulting. Edrington knows us and they know Medi-Cal, utilizing them for services would be ongoing unless we hired an in-house actuary which is not recommended at this time. They also work on our rate development template to the State. We will not completely transition from Edrington, as they work with other local health plans and have insight that is unique. Some work will not be transitioned but there is work that we plan to move to have a cost savings. We will use them for the IBMP and the medical expense calculation. We have a new staff member, and as she is trained, she will take on more work with the support DSS. We are being strategic about developing capabilities internally, we still want to utilize Edrington Health Consulting. Commissioner Espinosa asked if the contract with Milliman is being eliminated; CFO Bishop stated yes.

Supervisor Ramirez stated she was impressed the error was found and asked for more details. CFO Bishop stated Milliman performed an actuarial analysis for a couple of capitation agreements. It was going to be a significant financial change from the previous analysis. Edrington Health Consulting had access to our data through the work, they did an additional review of Milliman's work and pulled some data. They worked with our Decision Support Department and found an error in calculating units for particular codes. The error that Milliman made could have cost the organization millions of dollars. Supervisor Ramirez asked if they acknowledged their error; CFO Bishop stated they did.

Supervisor Ramirez motioned to approve agenda item 3. Commissioner Johnson seconded.

AYES: Commissioners Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Supervisor Carmen Ramirez, and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Shawn Atin and Scott Underwood, M.D.

Commissioner Pupa declared the motion carried.

5. Appoint replacement to the Executive Finance Committee

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Staff recommends making appointment to the Executive Finance Committee.

Scott Campbell, General Counsel, stated with the resignation of Fred Ashworth we have a vacancy on the Executive Finance Committee. Pursuant to the bylaws there are certain positions that Commissioners need to occupy. Any Commissioner is eligible to fill the vacancy on the Executive Finance Committee. The purpose of the Executive Finance Committee is outlined to review financials, new initiatives, assist the CEO when there is a CEO search, screening, and make recommendations on policies.

Commissioner Swenson asked if Commissioner Lane could provide his background. Commissioner Lane is currently CFO at Los Robles Regional Medical Center in Thousand Oaks. Los Robles is a for-profit healthcare system (HCA) where he has worked for the last ten years. Prior to this role, he was CFO at a sister facility in Fort Worth, Texas for two years and previous to that he was Vice President of Finance of another large facility in North Texas and Plano, Texas for two years. He was the controller at Riverside Community Hospital in Riverside, California, and he was at the corporate HTA headquarters doing internal audits.

Commissioner Swenson stated she would like to nominate Commissioner Lane. Commissioner Espinosa asked for the names of the individuals who currently serve on the committee. Scott Campbell, General Counsel, stated Commissioners Pupa, Alatorre, and Atin.

Commissioner Swenson motioned to approve agenda item 5. Commissioner Pupa seconded.

AYES: Commissioners Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Supervisor Carmen Ramirez, and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Shawn Atin and Scott Underwood, M.D.

Commissioner Pupa declared the motion carried.

6. January 2021 Financial Statements

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Staff recommends that the Commission approve the January 2021 financial package.

CFO Bishop presented the financial statements as of January 2021. We had a net gain of $1.5 million bringing the fiscal year to date net loss to $780,000. This is an improvement from our budget projections which indicated a loss of about $1m at this point in the fiscal year. Medical expenses are slightly lower than budget, excluding directed payments for Prop. 56 and the pharmacy carve-out delay where we see variances both on the revenue and expense side. Administrative expenses are $5.1 million under budget and in January we received favorable rates that went into effective on January 1.

Tangible Net Equity (TNE) is at $76.5 million which is 21.4% of the minimum required. Medical Loss Ratio is running at 94.7% and our administrative cost ratio is running at 5.5%. Commissioner Pupa asked CFO Bishop to remind commissioners of the typical TNE levels and the typical Medical Loss level ratios for an entity of our size. CFO Bishop stated we are running in line with other plans on the Medical Loss Ratio and the administrative cost ratio, some are higher and others lower. We are an outlier with TNE. Our goal is between 400% and 500% which would be in line with other plans.

The Solvency Action Plan remains very important. We are still in a vulnerable financial position, while Gold Coat Health Plan is currently solvent, we are able to meet our financial obligations, and building the plan to ensure we can manage operations in the foreseeable future. The Solvency Action Plan has three components. Cost of healthcare, ensuring that care is being provided at the optimal place of service, which reduces costs and improves member experience. The internal role improvement project, this ensures GCHP is operating effectively and efficiently. There will be cost savings, both administrative and medical. This safeguards us against improper claims payments. The contract strategy portion ensures that we are reimbursing providers within industry standard for Medi-Cal managed plan then moving towards value-based methodologies.

Reviewing the Solvency Action Plan; our actions remain consistent with what we reported in prior months with the HMS implementation. We have hit the $2 million mark which was on the high side of our conservative estimate. We hope to update that figure in the following months. We have continued the work around internal controls. Robert Franco, Chief Compliance Officer, gave a detailed update to the Executive Finance Committee on the internal control improvement project.

Review of next steps for the SAP are consistent with what we reported in prior months. Many of these strategies are still in process. We are looking at our provider contracts

and revising templates and implemented additional claims. We are looking at avoidable emergency room (ER), our transplant approach, and leakage. We are looking at expanding capitation agreements, avoidable ER utilization and the LANE/HCPCS analysis and potential consideration of across the board reductions.

Supervisor Ramirez asked if transplant management could be explained. CFO Bishop responded that transplant management involved looking at which providers are being utilized, if there is a more cost-effective provider or contracting strategy that would reduce transplant costs while not impacting members.

Supervisor Ramirez stated about 20 years ago in her previous practice it was somewhat arbitrary to get a transplant or get on a transplant list. She added a relative of hers has been waiting for a kidney transplant, but everything is delayed due to COVID-19. I want to ensure that we are also looking at the patient's survival. CMO Wharfield stated liver and kidney transplants are very common for us, as well as heart and lung. There may be ways for us to find efficiencies that help our members receive the best care at qualified centers. We want our members to be cared for at a reasonable price point because up to the time of transplant, generally people are very ill. The transplant is an expensive operation and then members are generally immunocompromised after the transplant, which can be costly. There are transplant networks and contracting strategies that may be able to do all of those things.

CFO Bishop stated the Solvency Action Plan and the management team concluded it's imperative that Gold Coat Health Plan have a keen focus on fundamental activities that are essential to our success and will impact our ability to manage operations in the future. The HSP system conversion is at the top of the list. We have the implementation of America'sHealth Plan, behavioral health integration, CalAIM, major provider contract renewal and continuation of these internal control activities so the intensive work continue. Other strategies are on hold to both mitigate risk and also potential provider abrasion.

The timeline of fundamental activities for 2021 was reviewed. There will be increased bandwidth for some of the initiatives in the SAP in the third quarter of 2021. On the timeline for HSP and America'sHealth Plan it extends beyond the go-live dates. The go-live dates established for HSP, is May 3, 2021 and AHP is March 1, 2021, there will be work after go-live for those projects, testing and other operational activities that will be in process. Internally these are referred to as day two items that are necessary improvements but not critical to go-live.

CFO Bishop reviewed the revenue. Net premium revenue is $517.6 million, over budget by $33.1 million and 7%. The two largest components of the budget variance are the revenue associated with Prop. 56, $16.2 million, which we had not budgeted because it was taken out of the state budget. At that point we completed our internal budget and then with our capitation rates from the State again. Beginning in January they were favorable, but there was the inclusion of the pharmacy component. When

the budget for this fiscal year had been completed, pharmacy was to be carved out effective January 1, 2021, it was extended to April 1, 2021 and now carve-outs are pushed out indefinitely. This will create an impact both on revenue and expense sides. Commission Chair Pupa asked if the revenue side with increased enrollment would have an impact. CFO Bishop stated we are budgeting for revenue and medical expenses on a flexible basis, we change our budget if enrollment changes, it wouldn't necessarily impact the budget to actual. We know that the pharmacy carve-outs are extended indefinitely, we will receive revised rates. When the draft rates for 2021 were received, they added a pharmacy component in the first few months. Based on estimates of expense and revenue we would break even. We had a slight gain in January on pharmacy. With change to pharmacy carve-out we will receive revised capitation rates, if we receive the same add-on, we would have losses on pharmacy. As membership grows, we receive more revenue.

Total Membership is 215,000 members which is up 20,000 from a low in January 2020 which was under 195,000. In review of changes by category of aid, it is a similar pattern seen in the past months. While the child aid category has increased, it didn't increase as we had budgeted, but the adult aid category, adult expansion and SPD have increased above what we budgeted.

Medical Expense was reviewed. Fiscal year to date, healthcare costs are $490.3 million which is $25 million over budget. The medical loss ratio is running at 94.7%. Of that budget variance, portions are related to Prop. 56, which is over budget by $15.3 million but we have revenue offset, so there is not a net impact. Pharmacy expense was over $10.9 million prior to January. We are seeing COVID-19 related increases or changes that we saw in prior months. There are increases to lab and radiology, home and community-based services, long-term care, mental and behavioral health, savings in some areas are off-set due to these increases.

Inpatient Medical Expenses were reviewed. We are under budget by $4 million, 4%. This is a two year per member per month (PMPM) historical look at costs. We anticipated a reduction in our medical expenses for September and a significant estimate for the last few months, they have stayed steady and a slight increase in January 2021.

Long-Term Care Expenses were reviewed, due to the state required 10% increase we are over budget by $4.6 million or 6%, but utilization has been steady over the past several months.

Outpatient expenses are under budget by $2.3 million or 6% that's COVID-19 related and with the expansion of membership. Emergency room expenses continue to run under budget $5.8 million or 31%. There was a decrease on a per member per month (PMPM) in our utilization for ER and is being seen across the State.

Mental and Behavioral Health is over budget by $2.4 million or 17%. It decreased in March and April and increased steadily staying at the higher level for several months.

In summary, in January we had a gain of $1.5 million fiscal year to date, with a net loss of $780,000 which is a budget variance of $13 million. Our TNE is at $76.5 million our required is $35.8 million, which equals 214% of the required.

Supervisor Ramirez motioned to approve agenda item 6. Commissioner Swenson seconded.

AYES: Commissioners Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Supervisor Carmen Ramirez, and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Shawn Atin and Scott Underwood, M.D.

Commissioner Pupa declared the motion carried.

PRESENTATIONS

7. Provider Advisory Committee (PAC) Yearly Overview

Staff: Marlen Torres, Executive Director of Strategy and External Affairs
David Fein, PAC Committee Chair

RECOMMENDATION: Accept and file the presentation.

Marlen Torres, Executive Director of Strategy and External Affairs, introduced Dave Fein, PAC Chair, who will present a yearly overview of what (PAC) has worked on.

Mr. Fein thanked the Commission for letting PAC provide an update. The committee works with the health plan to give advice and recommendations on the various policies and programs that GCHP is putting together. We work together from our different disciplines to present provider issues and discuss how GCHP can fulfill its mission in the County. The PAC is a very diverse and robust group from various areas of care. There is an individual from Community-Based Adult Services (CBAS) transportation, durable medical equipment (DME), Federally Qualified Health Center (FQHC), skilled nursing, home health and one member is from a hospital system.

Over the past year, the PAC has provided feedback to GCHP on four key areas. The first is provider satisfaction and access survey, second, the healthcare interoperability, third is Medi-Cal Rx and fourth would be the Solvency Action Plan.

The providers were surveyed on overall satisfaction and audited on member access to care. The survey questions were reviewed and feedback was provided to GCHP. This ensures GCHP was utilizing best practices, utilizing incentives and where appropriate, maximize the survey to the fullest getting provider response.

Healthcare Interoperability refers to the secure exchange of health data to allow complete access interchange and use of electronic information. The feedback on this initiative was to ensure PAC could review the workplan timeline and continue to share developments of the interoperability project.

PAC provided guidance and feedback on the Medi-Cal Rx transition. As mentioned, the State was transitioning pharmacy responsibilities from managed care to Magellan. We needed to ensure the ability to ask questions and get answers on how providers would bill using Magellan and key information providers would need, how members can appeal denials, and how providers would be notified. The State has postponed the State Fair hearing indefinitely but is giving providers an opportunity to comment on that initiative.

The Solvency Action Plan is important to PAC. In 2020, PAC expressed a desire to provide feedback to GCHP on the Solvency Action Plan and get to basics as much as possible on different items involved in the action plan. An ad hoc committee was created with a few members so we could talk offline from our normal quarterly meetings, and get detail and opportunity for providers to give feedback, so we aren't caught by surprise, and try to maximize the opportunity for providers to be informed.

The PAC Charter will be revised to ensure that it is up to date and that we are doing the necessary to serve the members in Ventura County on the HSP MediTrac (system conversion). Mr. Fein thanked the Commission for the opportunity to be part of the Strategic Plan, it was insightful to see what is important to the Commission and what GCHP is focusing on for the future.

8. Community Advisory Committee (CAC) Yearly Overview

Staff: Marlen Torres, Executive Director of Strategy and External Affairs
Ruben Juarez, CAC Acting Committee Chair

Mr. Ruben Juarez introduced himself as acting chair for the GCHP Community Advisory Committee (CAC). CAC represents the whole person care program with the health care agency. This committee shares important issues that affect Medi-Cal members in Ventura County. The eleven members of this committee represent the various constituencies served by GCHP. The CAC members include a representative from Ventura County (VC) Health Care Agency, Casa Pacifica, Rainbow Connection, the ARC of Ventura, VC Area Agency on Aging, VC Human Services Agency and Amigo Baby. Mr. Juarez thanked former members for their service, Rita Duarte-

Weaver, VC Health Care for Kids, Estelle Cervantes, Beneficiary Member, and Norma Gomez, Mixteco / Indigena Community Organizing Project (MICOP).

CAC is accepting new members. In 2020 seven CAC members renewed their two-year terms and four did not, which created openings. An ad hoc committee was formed to review new member applications. This committee includes Ruben Juarez, CAC Acting Chair, Ventura County Health Care Agency, Whole Person Care, Curtis Updike, Ventura County Human Services Agency, and Victoria Jump, Ventura County Area on Aging Agency. The member recruitment was launched by posting the application for new members at various city halls and public libraries, GCHP website and newsletter and the GCHP Community Relations staff announced the openings at various coalition and networking meetings in the community.

CAC members provided feedback regarding COVID-19, including the Nurse Advice line and the service is promoted to members. Mr. Juarez stated he had a telehealth appointment, which was a good experience, and is able to promote to community members and co-workers. CAC members provided feedback on vaccine concerns expressed in the community.

The GCHP Health Education, Cultural and Linguistic Services Department met with the CAC in May 2020 to discuss the Populations Needs Assessment (PNA), which is required by the Department of Health Services (DHCS). CAC provided feedback on how to improve members health by providing timely access to Primary Care Physician visits, medication, and developing user friend information.

CAC has received regular updates on Medi-Cal Rx and provided feedback. This included the 90-60-30 day DHCS member notices. Notices will be provided in English and Spanish for members. CAC members confirmed a transition of care period for members with special medications and a comparison of current formulary versus the proposed DHCS formulary.

Strategies to improve Managed Care Accountability Sets (MCAS) / Healthcare Effectiveness Data and Information Set (HEDIS) quality measures was reviewed. GCHP must create improvement plans for measures that are low performing and do not meet minimum performance level established by DHCS. Recommendations included share of best practices with health plans who have shown success in these measures, incentivize providers, provider education, consider a similar approach in the postpartum care program and create a provider sub-committee for the well-care exam quality metrics.

Care Management Coordinators (CMC) perform a Risk Assessment Survey (RAS) at the beginning of the Care Management process to determine a baseline risk level for members. The RAS is a tool to help nurses work with members to develop member-centric goals appropriate for member's risk and level of engagement in their care. The CAC recommendations are to follow-up with members after their survey was

conducted, conduct outreach for members with chronic conditions and identify how inequities affect the member's access to health care.

The CAC Member Community Relations recommendations are to translate the Building Community Newsletter in Spanish and announcements be placed at the top of the newsletter, continue with the sponsorship program to serve the community as GCHP continues to implement the Solvency Action Plan, assist community based organization, promote health equity and continue sharing GCHP resources with the community.

CAC Involvement for 2021 will be providing feedback on the following projects. GCHP Strategic Plan, health equity proposal, CalAIM proposal, member communication strategies and health information exchange.

Supervisor Ramirez thanked Mr. Juarez and the committee for their work. Commissioner Espinosa thanked Mr. Juarez and wanted to call attention to the vaccine portion. Commissioner Espinosa stated there are many questions in the community about the vaccine. Commissioner Espinosa mentioned River Haven and noted it is a crime area that does not have the best outreach services but added Mr. Juarez is there so that is a positive. There needs to be a more realistic perspective of what is going on and help relieve frustration if we can be transparent and upfront about what the public is going through. Mr. Juarez stated there are many concerns and questions mainly for employees/staff. River Haven has existed three years and every Monday provides services, showers, nursing assistance, promotes social distancing, offer masks and sanitizer to all. We are aware of questions and we tell them we have received the vaccine and everything is great.

Ms. Torres stated there are a lot of concerns in the community. There are concerns expressed from seniors on how to receive the vaccine and the protocol taking place in the community. There were also concerns from individuals who have developmental disabilities and how they get the vaccine. There is a lot of concern about what the vaccine is and hesitancy, many questions, but not enough information.

Commissioner Espinosa stated some people have appointments but there are long lines, some seniors are not able to stand for long periods of time and there are no chairs or water provided. She asked if GCHP could provide assistance. Supervisor Ramirez stated she is fielding questions and requests for assistance in appointments and conditions at various locations and asked that she be contacted at carmen.ramirez@ventura.org. There is a distinction between County and State-run vaccination locations, people do not understand the difference. Individuals also struggle with transportation.

Commissioner Espinosa motioned to accept and file agenda items 7 and 8. Commissioner Swenson seconded.

AYES: Commissioners Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Supervisor Carmen Ramirez, and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Shawn Atin and Scott Underwood, M.D.
Commissioner Pupa declared the motion carried.

9. Chief Executive Officer (CEO) Report

Staff: Margaret Tater, Chief Executive Officer

RECOMMENDATION: Receive and file the report.

CEO Margaret Tatar thanked Ruben Juarez and David Fein for their service to the management team and the Commission. These groups keep us connected to our community and advise us with regard to the optimal levels of service and approach to service for beneficiaries and providers in Ventura County. CEO Tatar also welcomed our new Commissioner Andrew Lane.

In response to Commissioners Ramirez and Espinosa, we are fast tracking the vaccine distribution efforts both in our community, state, and nationwide. GCHP is committed to not only serve our community with sponsorships, etc. but also help promote the vaccination effort.

It was noted that West Virginia is among the top five locations worldwide for the efficacy of vaccination efforts, second only to Alaska for roll-out. GCHP manages the non-emergency transportation benefit and our members need to understand securing transportation to a vaccination site is a benefit that we provide.

The CEO report is undergoing slight reformatting and will be complete in the next two reports submitted in March and April. The Chief Compliance Officer will provide a standalone report next month and will also do a report later in the calendar year.

External Affairs – on the executive side from the federal government, there is going to be an extension of the enrollment period for the exchanges from February through May to ensure as many as possible avail themselves of health insurance and coverage through the exchanges on the State side.

State Budget Update - The State and the governor have proposed a significant augmentation to the medical budget of over a billion dollars in this fiscal year that will address modifications and improvements to the Medi-Cal program specifically around Cal-AIM. There are also executive decisions originating from Governor Newsom to make telehealth permanent.

Last March 2020 when the pandemic hit, one of the emergency authorities extended by Governor Newsom's administration was to ensure telehealth would be a benefit during this time. The administration is now proposing to make it permanent. The Newsom administration is proposing new protections for members who are seeking transgender services. In review of legislative bills, if enacted, would extend Medi-Cal eligibility to persons in the state regardless of immigration status. There is also a bill that would establish rapid genome testing as a benefit. Another bill in 2022 would be a new tax for Californians, the proceeds would be to support homelessness and to provide service for homeless Californians (Bringing California Home Act). There is also a bill aimed to establish the effects of racism on public health. We are following that bill and will continue to follow all of the bills that impact not only GCHP, the community, but the Medi-Cal program at large.

As everyone knows, we are still remote, and engagement has to stay as aggressive as always. We are not allowing the fact that we work from home to prevent us from engagement with our community. Our report on Grievances and Appeals is part of our regular summary of internal operations and is outlined. New provider additions to our network have also been included.

We have been working collaboratively with AmericasHealth Plan (AHP) pursuant to the pilot program this Commission authorized. The plan has been working with AHP on readiness activities and the review of all readiness documentation/member facing materials submission for approval to DHCS. We are looking forward to getting DHCS final approval so we can jointly launch this pilot program which has been in the works for quite some time.

One item we were unable to include in the CEO report prior to print is we are in receipt from DHCS, among many other stakeholders, what DHCS is calling the model contract for purposes of how DHCS wants Medi-Cal plans to administer the two new benefits that we will be able to administer as a result of CalAIM. The whole person care program will eventually be delivered through enhanced case management benefit and in lieu of service (ILOS) in life services and the enhanced case management benefit. The State is asking for comments on the model contract terms. By March 12, 2021, we will share with all of our communities of interest and we will comment to DHCS on those model contract terms and keep the Commission, CAC and PAC apprised of input and what DHCS does with the comments. Whole Person Care has been a successful program for those who are in most need of integrated care.

10. Chief Medical Officer (CMO) Report

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

RECOMMENDATION: Receive and file the report.

CMO Wharfield discussed how the mental health benefit is administered in California and on current reporting from DHCS. Before 2014 there was the benefit for treatment of serious mental illness that resided with the County mental health programs as it still does. There was not a lot of care available for mild to moderate care where a member may not meet criteria to be served by that system. In 2014 there was a new benefit for mild to moderate care and that was conferred to the managed care plans and became a GCHP benefit a few years later.

In 2017 AB470 was passed and this is the Mental Health Equity Act which requires tracking and evaluation of mental health services for Medi-Cal beneficiaries to ensure equitable and quality services. The California Pan-Ethnic Health Network (CPEHN) was the main advisory stakeholder that reported out. They noted there were obvious disparities in the penetration rates of various groups. DHCS published their second report at the end of last year regarding mental health benefits and CPEHN is also commenting on the most current report and where we should go from here. There is good reporting and a lot of data flowing but we are not getting a clear picture on inequalities, access outcomes, and whether people are getting good quality, and respectful care. More demographic detail is needed and there is opportunity around LGBTQ and communities of color, they would like to use these reports to make recommendations for improvements.

When benefits started in 2014 it was around 2% and has gone up. In FY2017-2019 it went from 2% to 3.3%. In terms of our beneficiaries accessing mild to moderate care benefit at GCHP, we look slightly better than the DHCS data. Our most recent ranges are 3.78% to 4.63% penetration, we are slightly higher than the state average. Latinos, Asian/Pacific Islanders access is at the lowest rate for both mild to moderate benefit and specialty mental health. Spanish speaking members, Vietnamese speaking Cantonese, have access rates that are less than half of English-speaking members. GCHP has a similar profile for our threshold language of Spanish.

The Managed Care Plans for mental health access has grown. Over the years it has come down a little on the SMI level and is due to the fact that the County mental health programs were treating some members that didn't quite meet their criteria and are now served in the other systems by Managed Care Plan. From 2018 to the third quarter of 2020, we have continued to have a mild increase but now plateaued. On the county side most of the ethnicities that were identified, there is less penetration of mild to moderate care with the exception of Latinos. With members who access service, English speaking is the highest followed by Spanish. CMO Wharfield stated we have a long way to go but it will help us as we interface with our county mental health systems and our members to try and improve access to care.

The State of California has made an agreement with Blue Shield to help in the distribution of the vaccine for counties, pharmacies, and private healthcare entities. CMO Wharfield participated in an Amigo Babies sponsored event with the Department of Developmental Services Facebook Live Event. This was an opportunity to talk

about the myths of vaccine hesitancy. In regard to the concerns Commissioner Espinosa spoke about seniors receiving their vaccine, we heard from families represented by the regional center for Amigo Baby, that these large scale events may not be a good environment for people who may not be able to tolerate the activity, confusion, noise and stimulation. It is important to hear from our Commissioners about concerns members may have and any barriers to receiving the vaccine so that we can forward to public health and design ways to resolve problems.

Proactive Care Management was discussed. GCHP has a program called Health Information Form/Member Evaluation Tool (HIF/MET) which is a 10-question survey sent to all new members every month. We red flag new members who have concerns and may have an urgent need for clinical intervention to get medicine, DME or oxygen. We do a lot of screening for social determinants and barriers to care. Compared to the total population, members who are engaged in this care management process had 29% fewer emergency room visits than the HIF/MET members who did not engage with the process. We want our care management nurses to continue with this.

Supervisor Ramirez stated she would like to discuss some recommendations with CMO Wharfield on services that are available to people in her district for mental health. Commissioner Espinosa stated for several years there has been a Latino Disparities Committee that has met with the County of Ventura Behavioral Health. Commissioner Johnson has recently been chairing a revised version of the committee and is open and receptive to ideas from the community.

CMO Wharfield stated that the big change is Medi-Cal Rx will not go-live. Dr. Anne Freese, Pharmacy Director, said Medi-Cal Rx has been delayed further. The information in the CMO report is outdated and went to print before the latest information became available to GCHP. There is no new implementation date from the State. Earlier this year there was news that the pharmacy benefit manager (PBM) contractor the state selected to administer the Medi-Cal Rx benefit was purchased by Centene and they operate a managed care plan in the State of California for the Department of Health Care. A communication plan has begun via radio and in print media to ensure our members are notified the date has changed. Information will be received from the State on what their communication protocol will be with members and providers. A member letter is expected to go out and GCHP will be working through all our different processes, protocols, and communication pathways to ensure the information is widely available.

Our PBM has been notified that Medi-Cal Rx was delayed and our current contract with Optum extends in the near future. More information is expected in May on Medi-Cal Rx and the new timeline.

Previously the pharmacy benefit was limited to a 30/31-day supply. Maintenance medications have been increased to 90 days and we are seeing an increase in the number of 90-day supplies members are filling. Two of the trends being monitored

are prescriptions per member per month and then per utilizer per month. Members are utilizing a consistent number of medications each month. A new normal will be developed as members start filling three months instead of one month.

One of the trends that has been noticed is the uptick in opioid graphs. Research is being done to see if the shift from 30-day to 90-day supply is the driver. More information is expected to see if there is a true uptick or if it's a shift because of the 30-day to 90-day supplies.

Commissioner Pupa stated that the Ventura County Health Care Plan is regulated by the Department of Managed Health Care and they imposed limits on opioid fills to seven days, she asked if DHCS impose the same limit. It is concerning to hear 30- and 60-day fills where the regulated Knox Keene plans have a limit of seven days. Dr. Freese stated DHCS does not limit us to a seven day supply but we have incorporated that into our benefit in a couple of ways and the seven day supply is generally restricted to members new to therapy versus existing therapy and how those shift and change over time. If the prescription is over seven days, it is kicked back to the pharmacy for additional information so we can validate that they should be receiving more than a seven-day supply or less. This can be overwritten by the pharmacist depending on what is going on with the member (acute injury or surgery). This has been incorporated into our benefit. Prescriptions are reviewed for opioids and how they align with the CDC guidelines.

11. Chief Diversity Officer (CDO) Report

Staff: Ted Bagley, Interim Chief Diversity Officer

RECOMMENDAITON: Receive and file the report.

Ted Bagley, Interim Chief Diversity Officer, stated he has been asked to serve on the Police Reform Committee for Simi Valley. CDO Bagley stated it is good to see some of the police locations are starting to look at a more diverse cadre of candidates for commander positions.

Mr. Bagley was the keynote speaker for the King Day celebration and also for the Democratic Club of Ventura County. These were interesting sessions and there is a need for more diversity in the County.

A meeting was held with Phin Xaypangna, the new Executive Deputy Officer for the Ventura County Office of Diversity and Inclusion. Some of the findings have been forwarded to CEO Tatar with suggestions.

At CEO Tatar's request, there was a meeting with individual leaders from the LHPC Group to find out what others are doing from the standpoint of Health Equity. Mr. Bagley stated he found we are a bit ahead of the game, although we are doing a lot

on Health Equity and he will be spending more time with them sharing ideas on how we can become better diversity proponents in Ventura County. He also met with the Advisory Board of Los Robles Medical Center, they also seem to be doing a few things on Health Equity.

Currently there is one case; it is not formal or external and is being investigated by Human Resources.

More time will be spent with Mike Power and Shawn Atin, along with mayors in surrounding cities to discuss Health Equity. This issue will require resources as well as financial resources to determine what Health Equity means.

Commissioner Espinosa thanked Mr. Bagley for his comprehensive report. She asked if we are looking at the diversity of CAC and PAC committees and are we hitting all of our equity objectives. She requested this be added to the monthly report. Mr. Bagley stated that he and Ms. Torres have spent time talking and they are working hand in hand on outreach to the community along with Dr. Wharfield's department. In response to Commissioner Espinosa's question, CDO Bagley is unable to answer at this point because we haven't attacked it from that standpoint. The presentation put together for CEO Tatar, will be presented to the Commission, PAC and CAC, they will be instrumental in helping us roll out on a County level. Mr. Bagley stated he will have an answer as it relates to CAC and PAC at the next Commission meeting.

Commissioner Espinosa stated we really wants this to be fully integrated in all of our public and healthcare agencies. Supervisor Ramirez stated she was very appreciative of Mr. Bagley's work and suggested the Commissioners take a look at the proceedings for the US Attorney General, and domestic terrorism which is closely related to people who are white supremacists and the discussion held with some of the senators about understanding racism, equity versus equality, systematic bias and institutional racism. Mr. Bagley stated we need more people to make their feelings and positions known and until that is done, we won't be able to change the scenarios.

12. Executive Director of Human Resources (HR) Report

Staff: Michael Murguia, Executive Director of Human Resources

RECOMMENDATION: Receive and file the report.

Michael Murguia, Executive Director of Human Resources, discussed the employee survey completed one year ago. An area of interest is communications and he recommended to the executive staff a roadshow approach for all executive leaders to not only participate in all of our staff meetings, which are held every other month, but to attend each other's staff meetings. These recommendations were presented to CEO Tatar and the executive team and they approved, we will be working on logistics together. Another recommendation was to publish organizational charts on our

internal website and this was also approved. We are working on a plan on how to put those on the Compass home page and have those assigned to each functional area in the Plan.

The second topic was to have an all staff meeting every two months and thus far are keeping that commitment. At our last presentation in October, we had 188 people participate and view the presentations, which is almost 100% of all employees. We tried an experiment at this meeting where we had a "good news video" that talked about key messages passed from the executive staff and things that had a positive impact to our plan, promotions of staff and that video was well received. We also recognized Gold Bar recipients, which is an internal nomination where an employee can nominate another employee for behavior. Committee members normally take turns in presenting but we decided to have executive leaders present their own employees. There were presentations from Chiefs and from the Executive Director, Strategy and External Affairs who gave an overview of our Strategic Plan. We also had a Q&A executive team panel to take questions that were collected prior to the meeting. We surveyed the employees at the end of each meeting and last time our overall score average was 4.3, we moved up to 4.6.

In the Executive Finance Committee meeting, we discussed ongoing effort to find a Chief Operating Officer. We did an internal search last year and were unable to successfully find the right candidate. The recommendation was made to work with an outside search firm, Morgan Consulting, and the Executive Finance Committee approved. CEO Tatar and I met with Morgan Consulting on February 10, 2021 and we discussed the profile, salary range and our culture. We work with them on a bi-weekly basis to review candidates and hopefully find a Chief Operating Officer. We will keep the Commission updated on the search.

We have had one resignation; no retirements and we are only backfilling positions that are critical and those are reviewed by executive staff. As CDO Bagley mentioned, we have one case, it is a former employee lawsuit and there is a report in the Commission package that outlines details. We feel comfortable with our position and action, we have reviewed with Scott Campbell and the employment lawyer. We had one workers' compensation case.

Employees who need to come in for mail and other purposes go through a screening process and it is going well.

Commissioner Swenson motioned to receive and file agenda items 9-12. Commissioner Cho seconded.

AYES: Commissioners Theresa Cho, M.D., Laura Espinosa, Dr. Sevet Johnson, Andrew Lane, Gagan Pawar, M.D., Dee Pupa, Supervisor Carmen Ramirez, and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Shawn Atin and Scott Underwood, M.D.

Commissioner Pupa declared the motion carried.

ADJOURNMENT

Commissioner Pupa adjourned the meeting at 4:31 p.m.

Approved:

_____
Deborah Munday
Associate Clerk to the Commission/Sr. Executive Assistant

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AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: March 22, 2021

SUBJECT: Adopt a Resolution to Renew Resolution No. 2021-002, to Extend the Duration of Authority Empowered in the CEO to issue Emergency Regulations and Take Action Related to the Outbreak of Coronavirus ("COVID-19")

SUMMARY:

Adopt Resolution No. 2021-003-to:

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

BACKGROUND/DISCUSSION:

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

In the short period of time following the Governor's proclamation, COVID-19 has rapidly spread through California necessitating more stringent action. On March 19, 2020, Governor Newsom issued Executive Order N-33-20 (commonly known as "Safer at Home") ordering all residents to stay at home to slow the spread of COVID-19, except as needed to maintain continuity of operation of the federal critical infrastructure sectors.

The following day, the Ventura County Health Officer issued a County-wide "Stay Well at Home", order, requiring all County residents to stay in their places of residence subject to certain exemptions set forth in the order.

Prompted by the increase of reported cases and deaths associated with COVID-19, the Commission adopted Resolution No. 2020-001 declaring a local emergency and empowering the interim CEO with the authority to issue emergency rules and regulations to protect the health of Plan's members, staff and providers. Specifically, section (2) of Resolution No. 2020-001 describes the emergency powers delegated to the CEO which include, but are not limited to: entering into agreements on behalf of the Plan, making and implementing personnel or other decisions, to take all actions necessary to obtain Federal and State emergency assistance, and implement preventive measures to preserve Plan activities and protect the health of Plan's members, staff and providers.

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

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

On May 4, 2020, Governor Newsom issued Executive Order N-60-20, declaring that California is prepared to move into the early phase of "Stage 2" of California's Roadmap to Pandemic Resilience to permit the gradual reopening of lower risk businesses and open spaces commencing on Friday, May 8, 2020, with modifications. As the state moves forward with reopening of certain businesses and spaces, Executive Order N-60-20 directs the State Public Health Officer to establish criteria and procedures, as set forth in the order, to determine whether and how local jurisdictions may implement local measures that depart from statewide directives.

Following the Governor's order, the Ventura County Health Officer modified its County-wide Stay Well at Home order on May 7, 2020, to align itself with the State's reopening process announced on May 4, 2020. Under the County Health Officer's May 7th order, certain low risk businesses such as florists, clothing stores, book stores, and sporting goods stores are permitted to re-open with modifications.

On May 18, 2020, the Commission adopted Resolution No. 2020-003 to renew and reiterate the enumerated powers granted to the CEO in Resolution No. 2020-002 above, and to: (1) authorize the CEO, with the advice counsel, to implement a staggered return to work

program for Plan personnel; and (2) extend the duration of authority empowered in the CEO to issue emergency regulations and take action. Resolution No. 2020-003 expired on June 22, 2020.

Following the Commission's adoption of Resolution No. 2020-003, the State has permitted new specified businesses and recreation areas to reopen subject to modifications designed to implement social distancing and prevent the further spread of the disease. To help guide businesses and outdoor recreation areas as they reopen, the State Public Health Officer issues individual reopening protocols for each industry that is permitted to reopen. The individual protocols require these spaces to implement industry-specific safety measures to help combat COVID-19.

In line with the State's directives, the County Health Officer updated its May 7, 2020 order again on May 20th, May 22nd, May 29th, and June 11, 2020. As with the previous County Health Officer orders, the June 11th order permits specified new industries to re-open in line with the State's directives.

In the following weeks however, the State and County Health Department reported a sharp increase in new confirmed COVID-19 cases and hospitalizations. Evidence demonstrates that the timing of these increases is in line with the reopening of "high risk" businesses where individuals may congregate with members who are not part of the same household and remove their face coverings to eat and drink. The uptick in cases prompted the County Health Officer to issue an order on July 2, 2020, ("July 2nd Order") to require the closure of bars, and the temporary closure of County beaches in anticipation of large crowds that were expected and did gather during the Fourth of July weekend.

On July 13, 2020, the State Public Health Officer issued a state-wide order to require the immediate closure of: (1) indoor and outdoor operations of bars, pubs, brewpubs and breweries; and (2) indoor operation of restaurant dining, movie theaters, zoos, museums, cardrooms, wineries and tasting rooms. The order also imposes more stringent requirements on specified counties, including Ventura County that have appeared on the State's monitoring list for three consecutive days to prohibit the indoor operations of: gyms and fitness centers, places of worship, protests, offices for non-critical infrastructure sectors, personal care services, hair salons, barbershops, and malls. Also on July 13, 2020, the County Health Officer issued an order, requiring the closure of indoor operations of the following establishments: gyms and fitness centers, worship services, protests, offices for non-essential sectors, personal care services (e.g., nail salons, body waxing, and tattoo parlors), hair salons and barbershops, and malls.

On July 16, 2020, the County Health Officer amended its July 2nd Order to permit bars that serve food, wineries, and wine tasting rooms to reopen provided that they operate outdoors and abide by applicable State orders and guidance, and additional local requirements set forth in the County order.

Since the adoption of Resolution No. 2020-003, the Commission has renewed and reiterated the emergency powers granted to the CEO on July 27th, August 24th, September 28th, October 26th, January 25th, and more recently on, February 22, 2021 by adopting Resolution No. 2021-002. Resolution No. 2021-002 expires today, March 22, 2021.

On August 28, 2020, the State Health Officer issued a new order that sets forth an updated framework that is intended to guide the gradual reopening of businesses and activities in the state while reducing the increased community spread of the disease. The new framework is entitled, "California's Plan for Reducing COVID-19 and Adjusting Permitted Sector Activities to Keep Californians Healthy and Safe". Under this updated framework, every county in California is assigned to a tier based on how prevalent COVID-19 is in each county and the extent of community spread—Purple (Widespread), Red (Substantial), Orange (Moderate) and Yellow (Minimal). The color of each respective tier indicates what sectors may reopen.

When ICU bed capacity was rapidly decreasing throughout California, the Governor issued a State Regional Stay at Home Order on December 3, 2020, that triggered greater restrictions on a region consisting of multiple counties depending on that region's ICU hospital bed availability. Once a region had less than 15 percent ICU availability, all counties within the region were required to follow the State Regional Stay at Home Order within 24 hours for at least three weeks.

On January 5, 2021, the State Public Health Officer issued a new order that is intended to reduce pressure on strained hospital systems and redistribute the responsibility of medical care across the state so patients can continue to receive lifesaving care. To preserve services, the public health order requires some non-essential and non-life-threatening surgeries to be delayed in counties with 10 percent or less of ICU capacity under the Regional Stay at Home Order where the regional ICU capacity is at 0 percent.

On January 25, 2021, the California Department of Public Health ended the Regional Stay at Home Order, lifting the order for all regions statewide, including Southern California. This action allowed all counties to return to the Blueprint for a Safer Economy framework which uses color-coded tiers to indicate which activities and businesses can open based on local case rates and test positivity. As of the date of this report, Ventura County is still in the strictest tier—the Purple tier.

Although there are now several vaccines that have proven to help combat the disease in adults, the vaccine is not yet available to the general public. The disease can still spread rapidly through person-to-person contact and those in close proximity.

This resolution will continue to empower the CEO with the authority to issue orders and regulations necessary to prevent the further spread of the disease and protect the health and safety of Plan members and staff through April 26, 2021, the next regularly scheduled Commission meeting. As mentioned above, pursuant to Resolution No. 2020-002, the Plan's

Local Emergency proclamation shall remain effective through the duration of the Governor's State of Emergency proclamation or when the Commission terminates its declaration of Local Emergency, whichever occurs last.

FISCAL IMPACT:

None.

RECOMMENDATION:

1. Adopt Resolution No. 2021-003 to extend the duration of authority empowered in the CEO through April 26, 2021.

ATTACHMENT:

1. Resolution No. 2021-003.

RESOLUTION NO.2021-003

A RESOLUTION OF THE VENTURA COUNTY MEDICAL MANAGED CARE COMMISSION, DOING BUSINESS AS THE GOLD COAST HEALTH PLAN (“PLAN”), TO RENEW AND RESTATE RESOLUTION NO. 2021-002 TO EXTEND THE DURATION OF AUTHORITY EMPOWERED IN THE INTERIM CHIEF EXECUTIVE OFFICER OR CHIEF EXECUTIVE OFFICER ("CEO") RELATED TO THE OUTBREAK OF CORONAVIRUS ("COVID-19")

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

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

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

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

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

WHEREAS, since the adoption of Resolution No. 2020-003, the Commission has renewed and reiterated the emergency powers granted to the CEO on July 27th, August 24th, September 28th, October 26th, January 25th and February 22, 2021, by adopting Resolution No. 2021-002. Resolution No. 2021-002 expires today, March 22, 2021; and

WHEREAS, on August 28, 2020, the State Health Officer issued a new order that sets forth an updated framework that is intended to guide the gradual reopening of businesses and activities in the state while reducing the increased community spread of the disease, entitled “California’s Plan for Reducing COVID-19 and Adjusting Permitted Sector Activities to Keep Californians Healthy and Safe”; and

WHEREAS, under this updated framework, every county in California is assigned to a tier based on how prevalent COVID-19 is in each county and the extent of community spread—Purple (Widespread), Red (Substantial), Orange (Moderate) and Yellow (Minimal) and the color of each respective tier indicates what sectors may reopen. As of the date of this Resolution, Ventura County is in the Purple tier; and

WHEREAS, when Intensive Care Unit (“ICU”) bed capacity rapidly decreasing throughout California, the Governor issued a State Regional Stay at Home Order on December 3, 2020, that triggered greater restrictions on a region consisting of multiple counties depending on that region’s ICU hospital bed availability. Once a region had less than 15 percent ICU availability, all counties within the region were required to follow the State Regional Stay at Home Order within 24 hours for at least three weeks; and

WHEREAS, on January 5, 2021, the State Public Health Officer issued a new order that is intended to reduce pressure on strained hospital systems and redistribute the responsibility of medical care across the state so patients can continue to receive lifesaving care. To preserve services, the public health order requires some non-essential and non-life-threatening surgeries to be delayed in counties with 10 percent or less of ICU capacity under the Regional Stay at Home Order where the regional ICU capacity is at 0 percent; and

WHEREAS, on January 25, 2021, the California Department of Public Health ended the Regional Stay at Home Order, lifting the order for all regions statewide, including Southern California. This action allowed all counties to return to the Blueprint for a Safer Economy framework which uses color-coded tiers to indicate which activities and businesses can open based on local case rates and test positivity. Ventura County is in the strictest tier—the Purple tier.

WHEREAS, unless renewed by the Commission, the delegation of authority empowered in the CEO, pursuant to Resolution No. 2021-002 shall expire today, March 22, 2021; and

WHEREAS, this resolution will continue to empower the CEO with the authority to issue orders and regulations necessary to prevent the further spread of the disease and protect the health and safety of Plan members and staff through April 26, 2021, the next regularly scheduled Commission meeting; and

WHEREAS, although there are now several vaccines—that have proven to help combat the disease in adults, the vaccine is not yet available to the general public. The disease can spread rapidly through person-to-person contact and those in close proximity; and

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

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

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

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

WHEREAS, the Plan is a public entity pursuant to Welfare and Institutions Code section 14087.54 and as such, the Plan may empower the CEO with the authority under sections 8630

and 8634 to issue rules and regulations to prevent the spread of COVID-19 and preserve Plan activities and protect the health and safety of its members, staff and providers; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 6. On May 4, 2020, California Governor, Gavin Newsom issued Executive order N-60-20, to modify its state-wide Safer at Home order and allow the state to move into Stage 2 of the reopening process to permit certain low risk businesses and open spaces to open with modifications. Executive Order N-60-20, also directs the State Public Health Officer to establish and criteria and procedures, as set forth in the order to determine how local jurisdictions may implement public health measures that depart from state-wide directives of the State Public Health Officer.

Section 7. Since the adoption of Resolution No. 2020-003, the Commission has renewed and reiterated the emergency powers granted to the CEO on July 27th, August 24th, September 28th, October 26th, January 25th, and more recently on February 22, 2021, by adopting Resolution No. 2021-002. Resolution No. 2021-002 expires today, March 22, 2021.

Section 8. The Commission now seeks to renew and reiterate the authority granted to the CEO approved in Resolution No. 2021-002 through April 26, 2021.

Section 9. Unless renewed by the Commission, the delegation of authority empowered in the CEO, pursuant to this Resolution shall expire on April 26, 2021.

PASSED, APPROVED AND ADOPTED by the Ventura County Medi-Cal Managed Care Commission at a regular meeting on the 22nd day of March 2021, by the following vote:

AYE:

NAY:

ABSTAIN:

ABSENT:

_____

Chair:

Attest:

_____

Clerk of the Commission

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel
Maddie Gutierrez, Clerk to the Commission

DATE: March 22, 2021

SUBJECT: Revised 2021 Meeting Dates for Executive Finance Committee, and Strategic Planning Session.

Request Direction from Commission for 2021 After Hours/Evening Meetings for the Community.

SUMMARY

This request pertains to changing the dates of the Executive Finance (”Committee”) meetings to allow the Executive Finance Committee to review the financial statements prior to their submission to the Commission for approval and the Strategic Planning Date to accommodate the Commissioners’ schedule. Additionally, the Board counsel seeks Commission direction on whether one or more of the upcoming Commission meetings should be scheduled to start at 6:00.

BACKGROUND/DISCUSSION

During a recent Committee meeting, the Committee noted that because of the dates established for meetings, the Committee has been presented with financial statements that had already been brought to the full Commission. This schedule prevents the Committee from reviewing financial statements before they are presented to the Commission because it takes several weeks from the end of the month to prepare the statements. Moving the Committee dates to the Thursday before the Commission meeting will allow the CFO to prepare financial reports and present them to the Committee prior to the submission to the Commission. Because the Commission established the dates for the Committee meetings, the Commission must approve any changes in the dates. Under the proposed schedule, the new dates of the Committee would be: April 21, June 24, August 19, October 20 and December 9, 2021.

The Commission’s Strategic Planning meeting is currently scheduled on December 14, 2021. The Ventura County Board of Supervisors also meets that date, creating a conflict

for some Commission members. It is proposed that the Strategic Planning meeting be moved to Thursday, December 16, 2021 to avoid conflicts.

Lastly, the Commission has indicated that it would like to have at least two meetings a year at locations in the County other that at the Plan's offices and have those meetings at nights. During the pandemic, the meetings have been available via telephone conference and members of the public can participate by calling in or emailing public comments. Once the pandemic is over, meetings at other locations can resume. For the Commission's consideration now is whether the Commission wants to have one or more meetings commence at 6:00 pm during the pandemic. If that is the Commission's desire, the Commission should select one or more dates for this to occur.

RECOMMENDATION:

Approve the revised 2021 meeting dates for the Executive Finance Committee in order to review financials prior to regular Commission meetings, and approve moving the Strategic Planning meeting to December 16, in order not to conflict with the Board of Supervisors meeting.

Staff also requests direction from the Commission on scheduling meeting dates for the after-hours/evening Commission meetings for calendar year 2021.

ATTACHMENT:

Copy of Revised 2021 meeting dates for the Executive Finance Committee and December 2021 Strategic Planning meeting.

Gold Coast Health Plan℠
A Public Entity

2021 REVISED (3/22/21)
Ventura County Medi-Cal Managed Care
Commission & Committee Meetings

Commission Meeting
Executive/Finance Meeting
Strategic Planning Retreat

January

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June

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November

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December

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✦ These meetings will be held at a different location and will begin at 6PM

Return to Agenda

Agenda Item No. 4

To: Ventura County Medi-Cal Managed Care Commission

From: Scott Campbell, General Counsel
Cathy Deubel Salenko, Health Care Counsel

Date: March 22, 2021

RE: Member Auto-Assignment to a Primary Care Physician Policy

SUMMARY:

The Commission adopted the Member Auto-Assignment to a Primary Care Physician Policy ("Policy") initially in 2011 ("Original Policy"). Since that time, the Policy has been amended by Gold Coast Health Plan ("GCHP") several times to comply with various requirements and the Department of Health Care Services ("DHCS") direction. *The amendments to the Policy have not, to our knowledge, been brought to the Commission for approval.* GCHP amended the Policy in accordance with DHCS direction to add Sections 9 and 10, and later Section 11 to address the primary care physician auto assignment logic driven by DHCS as part of AB85 Adult Expansion. GCHP further amended the Policy to make various corrections and non-substantive revisions. In 2021, GCHP amended the Policy to add Section 12 to reference a recent update in reporting requirements for APL 20-017 and has been submitted to DHCS for approval.

DISCUSSION:

Although amendments to the Policy have not, to our knowledge, been brought to the Commission for approval, amendments to the Policy should be approved by the Commission. For historical understanding, except as required by DHCS with regard to the AB85 Adult Expansion, the amendments to the Policy have had no impact upon the actual assignment of Members to a Primary Care Physician as compared to such assignments made under the Original Policy. GCHP incorporated these AB85 Adult Expansion revisions into the Policy to comply with AB85 pursuant to DHCS direction.

FISCAL IMPACT:

None.

RECOMMENDATION:

Staff recommends the Commission ratify the current Policy (which includes prior amendments to the Policy) and the Policy amended in 2021 that is pending DHCS approval. The current Policy is effective until DHCS approves the 2021 Policy, which will be effective on DHCS

approval. Further, staff recommends that the Commission require that any revisions to the Policy be approved by the Commission.

ATTACHMENTS:

Member Auto-Assignment to a Primary Care Physician Policy (Current Version).
Member Auto-Assignment to a Primary Care Physician Policy (Amended 2021).

Title: Member Auto-Assignment to a Primary Care Physician	Policy Number: MS-005
Department: Member Services	Effective Date: 05/31/2011
CEO Approved:	Revised: 12/06/2018

Purpose:
To describe the process by which new Members who do not select a Primary Care Provider (PCP) on their own are assigned to one.

Policy:
Gold Coast Health Plan (GCHP) will ensure that new Members who do not select a PCP on their own are assigned to one in accordance with all applicable statutory, regulatory and contractual requirements. A Member may select a different PCP by contacting GCHP Member Services. Administrative Members are not required to select a PCP, they can obtain care from any willing GCHP Provider in Ventura County.

Definitions:

Seniors and Persons with Disabilities (SPD): A member categorized as Seniors and Persons with Disabilities based on the aid codes established by the State for this Member category.

Administrative Members: An eligible Medi-Cal beneficiary who is not required to select a Primary Care Provider (PCP).

The following are considered Administrative Members:

- Share of Cost (SOC): A Member who has Medi-Cal with a Share of Cost requirement.
- Long-Term Care (LTC): A Member who is residing in a skilled or intermediate-care nursing facility and has been assigned an LTC Aid Code.
- Out of Area: A Member who resides outside GCHP's service area but whose Medi-Cal case remains in Ventura County.
- Other Health Coverage: A Member who has other health insurance that is primary to their Medi-Cal coverage; this includes Members with both Medi-Cal and Medicare, as well as Members with both Medi-Cal and commercial insurance. Medi-Cal is the payer of last resort; therefore, GCHP Members with other health coverage must access care through their primary insurance.
- Members who are enrolled under special aid categories such as Breast and Cervical Cancer Treatment Program.
- Hospice: If Medi-Cal enrollment file indicates a Hospice Restricted Services Code.

Title: Member Auto-Assignment to a Primary Care Physician	Policy Number: MS-005
Department: Member Services	Effective Date: 05/31/2011
CEO Approved:	Revised: 12/06/2018

The term "Administrative Member" will be printed on the GCHP ID card in the PCP section, rather than the name of a doctor or clinic. The change of a Member's status from Enrolled to Administrative is not automatic - GCHP must be informed of the Member's circumstances by Medi-Cal.

Enrolled Member: An individual who has selected or been assigned to a PCP and will have the name of the PCP Physician or Clinic Provider on the Member's ID card. These individuals are sometimes referred to as "Linked Members." Members with an administrative status are also considered to be an enrolled member.

Newly Eligible Member: An individual who is not yet assigned to a specific Participating Primary Care Physician or Clinic and, therefore, may see any willing Medi-Cal Provider within the Plan's service area.

Safety Net Provider: Recognized disproportionate share hospitals, federally qualified health centers and rural health centers.

Traditional Provider: Providers that have served Ventura County Medi-Cal beneficiaries for at least three years, and with a patient population/payer mix of at least 30% Medi-Cal and/or uninsured/charity care.

Procedure:

1. At the end of each month, after the Department of Health Care Services (DHCS) monthly eligibility file is downloaded and processed, all newly eligible Members who have not selected a PCP within the last thirty (30) days will be assigned to a PCP. The assignment will be done through the GCHP System PCP auto-assignment program.

   The auto-assignment program logic considers the following factors:

   - Mother – Child and Family Link
   - Zip code of Member's residence and location of PCP facility
   - Age of Member
   - Gender of Member
   - Member's preferred language (Based on GCHP contracted threshold language)
   - Provider status in terms of safety-net versus traditional Medi-Cal versus non safety-net or traditional, capacity, practice type and any historical ties to the Member (such as previous patient of specific Participating Providers, etc.)

2. The auto-assignment program reads the Member data-set and checks each record to see if the Provider number is blank. If the Provider number is blank, it finds every Member with that particular family number who is not already linked to a PCP. The program will assign all Members with the same family number to the same PCP, taking into consideration age, gender and Provider capacity restrictions.

3. The Provider data-set for this program contains only those PCPs contracted with GCHP and allowed to participate in the auto-assignment program. The Provider data set contains any age, gender and capacity restrictions.

4. For each zip code in the GCHP service area, there is a corresponding list of PCPs accepting auto-assignment. This enables each Member requiring auto- assignment to be linked to a PCP located near the Member's residence.

5. GCHP will assign a returning Member to the last known PCP if the Member becomes eligible again within twelve (12) months from the prior eligibility termination date. For members returning within 6 months and who previously were assigned to Kaiser as a PCP, the member will be reassigned to Kaiser. If a previous Kaiser member returns after 6 months, the member follow the regular assignment process.

6. If there are no open PCPs in a Member's area, the Member will be left unassigned and a detailed report will be generated for staff to review.

7. The PCP auto-assignment program logic is weighted to give preference to traditional and safety-net Providers. Safety-Net Providers will be assigned three (3) Members for every one (1) Member assigned to a Traditional Provider.

8. If a Member is dissatisfied with the Provider he/she has been auto-assigned to, he/she can select a different PCP by contacting GCHP Member Services. Any change requested by the last business day of the month will be effective the first day of the following month.

9. If the Member is categorized as a Seniors and Persons with Disabilities (SPD), the Member has the right to choose a Specialist or clinic as their PCP. If the Member does not make a selection within thirty (30) days, GCHP shall use FFS utilization data and other data sources, including electronic data if available, to establish existing provider relationships for the purpose of PCP assignment, including a specialist or clinic if an SPD beneficiary indicates a preference for either.

If the SPD member's current PCP is an out-of-network provider, the member may continue to see their current PCP for up to twelve (12) months provided that the PCP agrees to accept GCHP or Medi-Cal rates, whichever is higher, in accordance with W&I Code, 14182(b)(13) and (14). An ongoing relationship shall be determined by GCHP by identifying a link between a newly enrolled SPD beneficiary and an out-of-network provider using FFS utilization data provided by DHCS. After twelve (12) months, the member must choose an in-network PCP.

10. If the Member is a transitioning Targeted Low-Income Child (TLIC), the Member will be allowed to remain with his/her existing PCP and not assigned a new PCP. If the transitioning TLIC Member's current PCP is in the GCHP network, the TLIC Member will not be required to change PCPs unless he/she requests a change.

    If the transitioning TLIC Member's PCP is not in the GCHP Network, or part of the subcontractor's provider network, but there are no known quality of care issues and the provider will accept GCHP or Medi-Cal FFS rates, whichever is higher, the TLIC Member shall be allowed to remain with their out-of-network PCP. The TLIC Member shall be allowed to remain with the out-of-network PCP for a period of no more than twelve (12) months from the date of the Medi-Cal transition, at which time they will be required to select an in-network PCP. If the Member fails to select a new PCP at the end of the twelve (12) month period, a PCP will be assigned.

11. For the three-year period beginning on January 1, 2014, and ending on December 31, 2016, at least 75 percent of the New Adult Expansion Members (in the M1 and 7U eligibility aid codes), and on January 1, 2017, at least 50 percent of the New Adult Expansion Members who do not select a PCP shall be assigned to PCPs within the county public hospital health system, until the county public hospital health system either: 1) meets its Enrollment Target, as defined in W&I Code § 14199.1(b)(3); or 2) notifies the Managed Care Plan that it is at capacity to accept assignment of default members.

Attachments:

References:
W&I Code 14182(b)(13) and (14)
W&I Code § 14199.1(b)(3)

Title: Member Auto-Assignment to a Primary Care Physician	Policy Number: MS-005
Department: Member Services	Effective Date: 05/31/2011
CEO Approved:	Revised: 12/06/2018

Revision History:

Review Date	Revised Date	Approved By
05/31/2011		Earl Greenia
09/28/2012		Michael Engelhard
	01/08/2015	Tami Lewis
04/21/2015		PRC
06/23/2015		DHCS (Default)
06/30/2015		Dale Villani (CEO)
	06/08/2018	Luis Aguilar
11/07/2018		Dale Villani
	12/06/2018	Luis Aguilar
01/02/2019		Dale Villani, CEO

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Procedure:

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Title: Member Auto-Assignment to a Primary Care Physician	Policy Number: MS-005
Department: Member Services	Effective Date: 05/31/2011
CEO Approved:	Revised: ~~12/06/2018~~ 01/04/2021

2. The auto-assignment program reads the Member data-set and checks each record to see if the Provider number is blank. If the Provider number is blank, it finds every Member with that particular family number who is not already linked to a PCP. The program will assign all Members with the same family number to the same PCP, taking into consideration age, gender and Provider capacity restrictions.

3. The Provider data-set for this program contains only those PCPs contracted with GCHP and allowed to participate in the auto-assignment program. The Provider data set contains any age, gender and capacity restrictions.

4. For each zip code in the GCHP service area, there is a corresponding list of PCPs accepting auto-assignment. This enables each Member requiring auto- assignment to be linked to a PCP located near the Member's residence.

5. GCHP will assign a returning Member to the last known PCP if the Member becomes eligible again within twelve (12) months from the prior eligibility termination date. For members returning within 6 months and who previously were assigned to Kaiser as a PCP, the member will be reassigned to Kaiser. If a previous Kaiser member returns after 6 months, the member follow the regular assignment process.

6. If there are no open PCPs in a Member's area, the Member will be left unassigned and a detailed report will be generated for staff to review.

7. The PCP auto-assignment program logic is weighted to give preference to traditional and safety-net Providers. Safety-Net Providers will be assigned three (3) Members for every one (1) Member assigned to a Traditional Provider.

8. If a Member is dissatisfied with the Provider he/she has been auto-assigned to, he/she can select a different PCP by contacting GCHP Member Services. Any change requested by the last business day of the month will be effective the first day of the following month.

9. If the Member is categorized as a Seniors and Persons with Disabilities (SPD), the Member has the right to choose a Specialist or clinic as their PCP. If the Member does not make a selection within thirty (30) days, GCHP shall use FFS utilization data and other data sources, including electronic data if available, to establish existing provider relationships for the purpose of PCP assignment, including a specialist or clinic if an SPD beneficiary indicates a preference for either.

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Department: Member Services	Effective Date: 05/31/2011
CEO Approved:	Revised: ~~12/06/2018~~ 01/04/2021

If the SPD member's current PCP is an out-of-network provider, the member may continue to see their current PCP for up to twelve (12) months provided that the PCP agrees to accept GCHP or Medi-Cal rates, whichever is higher, in accordance with W&I Code, 14182(b)(13) and (14). An ongoing relationship shall be determined by GCHP by identifying a link between a newly enrolled SPD beneficiary and an out-of-network provider using FFS utilization data provided by DHCS. After twelve (12) months, the member must choose an in-network PCP.

10. If the Member is a transitioning Targeted Low-Income Child (TLIC), the Member will be allowed to remain with his/her existing PCP and not assigned a new PCP. If the transitioning TLIC Member's current PCP is in the GCHP network, the TLIC Member will not be required to change PCPs unless he/she requests a change.

    If the transitioning TLIC Member's PCP is not in the GCHP Network, or part of the subcontractor's provider network, but there are no known quality of care issues and the provider will accept GCHP or Medi-Cal FFS rates, whichever is higher, the TLIC Member shall be allowed to remain with their out-of-network PCP. The TLIC Member shall be allowed to remain with the out-of-network PCP for a period of no more than twelve (12) months from the date of the Medi-Cal transition, at which time they will be required to select an in-network PCP. If the Member fails to select a new PCP at the end of the twelve (12) month period, a PCP will be assigned.

11. For the three-year period beginning on January 1, 2014, and ending on December 31, 2016, at least 75 percent of the New Adult Expansion Members (in the M1 and 7U eligibility aid codes), and on January 1, 2017, at least 50 percent of the New Adult Expansion Members who do not select a PCP shall be assigned to PCPs within the county public hospital health system, until the county public hospital health system either: 1) meets its Enrollment Target, as defined in W&I Code § 14199.1(b)(3); or 2) notifies the Managed Care Plan that it is at capacity to accept assignment of default members.

12. Reporting

Effective July 1,2021 GCHP will comply with reporting requirements in APL 20-017 for PCP assignments.

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Attachments:

References:

W&I Code 14182(b)(13) and (14)

W&I Code § 14199.1(b)(3)

APL 20-017 Requirements for Reporting Managed Care Program Data (Supersedes APLs 14-013 (Revised) and 14-012)

Title: Member Auto-Assignment to a Primary Care Physician	Policy Number: MS-005
Department: Member Services	Effective Date: 05/31/2011
CEO Approved:	Revised: ~~12/06/2018~~ 01/04/2021

Revision History:

Review Date	Revised Date	Approved By
05/31/2011		Earl Greenia
09/28/2012		Michael Engelhard
	01/08/2015	Tami Lewis
04/21/2015		PRC
06/23/2015		DHCS (Default)
06/30/2015		Dale Villani (CEO)
	06/08/2018	Luis Aguilar
11/07/2018		Dale Villani
	12/06/2018	Luis Aguilar
01/02/2019		Dale Villani, CEO
	01/04/2021	Luis Aguilar, Member Services Manager
01/12/2020		PRC

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AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Eileen Moscaritolo, Principal, HMA Consultant
Nancy Wharfield, MD, Chief Medical Officer

DATE: March 22, 2021

SUBJECT: Provider Contracting and Credentialing Management ("PCCM") System Implementation

SUMMARY:

Gold Coast Health Plan ("GCHP") leadership is requesting a revised not-to-exceed-amount approval to complete an in-progress, critical Provider Contracting, Credentialing, and provider data Management ("PCCM") system implementation.

Medi-Cal Managed Care Health Plans ("MCPs") have responsibility for managing and reporting on a vast amount of information about provider identification and practice locations, provider contracts, and provider credentialing status. GCHP developed a customized, in-house data base to support production of provider directories and provider network data reporting to the Department of Health Care Services ("DHCS"). Today, credentialing efforts are 100% manual and rely upon the use of Excel spreadsheets. These custom and highly manual approaches are not scalable or configurable to keep pace with increasingly frequent changes to regulatory requirements. To address this, GCHP released a Request for Proposals ("RFP") for a Provider Credentialing, Contracting, and Provider Data Management business-technology platform in 2017.

In October of 2018, the GCHP Commission approved the Plan entering into a contract with a yet to be identified qualified vendor for a 5-year contract estimated to be $1.25 million. The RFP considered separate platforms for credentialing, contracting, and provider data as well as an all-in-one solution. GCHP selected Symplr as an all-in-one, integrated solution that provided equivalent software capabilities with improved process efficiencies, decreased implementation time, and lower total costs. Symplr offers features such as eApply, eSearch, and eStatus which support primary source verification, tracking and verifying the education, work history, licensing, renewals, affiliations and references, continuing education, expirations (licenses, insurance, boards, sanctions) and much more with the original source of a specific qualification. All these functions have previously been supported manually. GCHP staff anticipated completing implementation of this new platform in February 2021.

After GCHP management completed contract negotiations with Symplr, it secured a more accurate picture of annual maintenance, hosting, and implementation costs. Further, it obtained

the variance from the original estimate, after which in October 2020, the GCHP Commission approved a new not-to-exceed ("NTE") total of $1,592,700 over 5 years.

Recently the Plan required an increased level of effort associated with the implementation of the project that requires an estimated additional cost of $331,305 including a 15% contingency. The increased level of effort, cost, and duration is attributed to competing enterprise initiatives. The revised go live target date is June 2021.

FISCAL IMPACT:

The revised projects costs will impact the FY2020-2021 budget by an additional amount of $331,305. There is sufficient available funding in GCHP's commission approved enterprise project portfolio budget to cover this expense.

Financial Itemization:

October 2020 5 Year Project Approval:

VCMMCC Approval October 2020	
Description	**Pricing**
Year 1 Licensing Hosting & Implementation Fees	$1,078,600
Year 2 Hosting & Maintenance Fees	$104,000
Year 3 Hosting & Maintenance Fees	$110,600
Year 4 Hosting & Maintenance Fees	$114,000
Year 5 Hosting & Maintenance Fees	$117,500
Contingency	$68,000
5 YEAR TOTAL	**$1,592,700**

Revised 5 Year Project Costs:

VCMMCC Required Approval February 2021	
Description	**Pricing**
Year 1 Licensing Hosting & Implementation Fees	$1,413,116
Year 2 Hosting & Maintenance Fees	$103,325
Year 3 Hosting & Maintenance Fees	$107,160
Year 4 Hosting & Maintenance Fees	$108,680
Year 5 Hosting & Maintenance Fees	$111,790
Contingency	$79,934
5 YEAR TOTAL	**$1,924,005**

RECOMMENDATION:

GCHP staff recommend the Commission approve and delegate to the CEO the authority to execute agreement amendments and/or change orders with Symplr with a new NTE amount of $1,924,005 for the duration of the five-year agreement.

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kashina Bishop, Chief Financial Officer

DATE: March 22, 2021

SUBJECT: February 2021 Fiscal Year to Date Financials

SUMMARY:

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

BACKGROUND/DISCUSSION:

The staff has prepared the unaudited February 2021 FYTD financial package, including statements of financial position, statement of revenues and expenses, changes in net assets, and statement of cash flows.

FINANCIAL OVERVIEW:

GCHP experienced a gain of $4,336,431 for the month of February 2021, bringing the FYTD net gain to $3,556,175. This is a significant improvement from the budget projections that had indicated an anticipated loss of ~$13 million in the first eight months of the fiscal year. The improvement from budget projections is attributed to increased revenue due to changes in prior year membership estimates and favorable CY2021 rates, administrative savings, and medical expense estimates that are currently less than budget by a narrow margin.

SOLVENCY ACTION PLAN (SAP) UPDATE:

To ensure the long-term viability of GCHP and consistent with Commission direction, your management team remains focused on the SAP. Further, your management team remains committed to implementation of solvency-related actions in a manner that respects the provider community and mitigates any adverse impact on our providers. The SAP is comprised of three main categories: cost of healthcare, internal control improvements and contract strategies. The primary objectives within each of these categories is as follows:

1. Cost of healthcare – to ensure care is being provided at the optimal place of service which both reduces costs and improves member experience.
2. Internal control improvements – to ensure GCHP is operating effectively and efficiently which will result in administrative savings and safeguard against improper claim payments.
3. Contracting strategies – to ensure that GCHP is reimbursing providers within industry standard for a Medi-Cal managed care plan and moving toward value-based methodologies.

In addition to the comprehensive list of internal control improvements provided as an appendix to the Strategic Plan, GCHP management has made the following progress in connection with the Commission-approved SAP:

Category	Current Focus	Annualized impact in savings
Cost of Healthcare	Revision to Non-Pharmacy Dispensing Site Policy	$7-10 million
Internal Control Improvements	Interest expense reduction/PDR turnaround time	$500,000
	HMS Implementation	$2.3 million
	Formalization of internal control workgroup	N/A
	Formalization of the contract steering committee	N/A
	Provider settlement review	TBD
Contracting Strategies	Reduction of LTC facility rates to 100% of the Medi-Cal rate	$1.8 million
	Rate reduction to tertiary hospital	$1.3 million
	Reduction of adult expansion PCP rates*	$4.5 million
	TOTAL ANNUAL SAVINGS	**$17.4-20.4 million**

* internal issue prevented this from being finalized in October; it is now in process.

The focus going forward will be on phase 2 of the Solvency Action Plan, which involves the below initiatives. We are pleased to report that the GCHP Provider Advisory Committee has created a subcommittee to propose changes for Phase 2 of the SAP. Your management team acknowledges the Commission recommendation that we (a) assess the impacts of the identified interventions and (b), based thereon, forecast future excess TNE levels resulting from the interventions. We are, of course, committed to that process and, accordingly, when we can responsibly forecast the impact of an intervention, we do. We are also, however, committed to implementation of solvency-related actions in a manner that respects the providers and mitigates any adverse impact on them (and in turn our members). To that end and mindful of the initiatives identified below, we will have to assess intervention impact as we refine the specific approach we are employing to achieve the intervention. Further, we owe it to the community to continue the hard work of tightening our internal controls and improving our contracting efforts, including

our contract terms and conditions, our amendment process, our processes for recoupment, and our processes for DOFR and DOAR negotiation and documentation.

Category	Current Focus	Annualized impact in savings
Cost of Healthcare	LANE – avoidable ER analysis	TBD
	Pro-active transplant management approach	TBD
	Analysis of leakage to out of area providers	TBD
Internal Control Improvements*	Review of provider contracts for language interpretation and validation	N/A
	Develop revised provider contract templates and a standard codified DOFR template	N/A
	Ensure appropriate approval on all contract amendments	TBD
	Improve quality and completeness of encounter data	Revenue implications
	California Children's Services – ED Diversion	$500,000
	Implementation of additional claims edit system (CES) checks to minimize payment errors	TBD
Contracting Strategies	Expansion of capitation arrangements	Required TNE and risk reductions
	LANE/HCPCS analysis	TBD
	Outlier rate analysis	TBD
	Consideration of across the board reductions	TBD

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

The management team has concluded that it is imperative that GCHP have a keen focus on fundamental activities that are essential to our success. While the intensive work on internal control improvement continues, some strategies under phase 2 will be temporarily on hold, to mitigate risk and potential provider abrasion. The fundamental initiatives are:

1. HSP System Conversion
2. Americas Health Plan
3. Behavioral Health Integration
4. Cal Aim
5. Major provider contract renewals
6. Continuation of internal control improvement activities

Staff will keep the Commission informed on the progress of these initiatives and the impacts to Phase 2 of the SAP. We anticipate there will be increased bandwidth for Phase

2 in the third quarter of 2021. Over the next several of months, we will continue to finalize the approach and forecast the impact to the TNE where feasible.

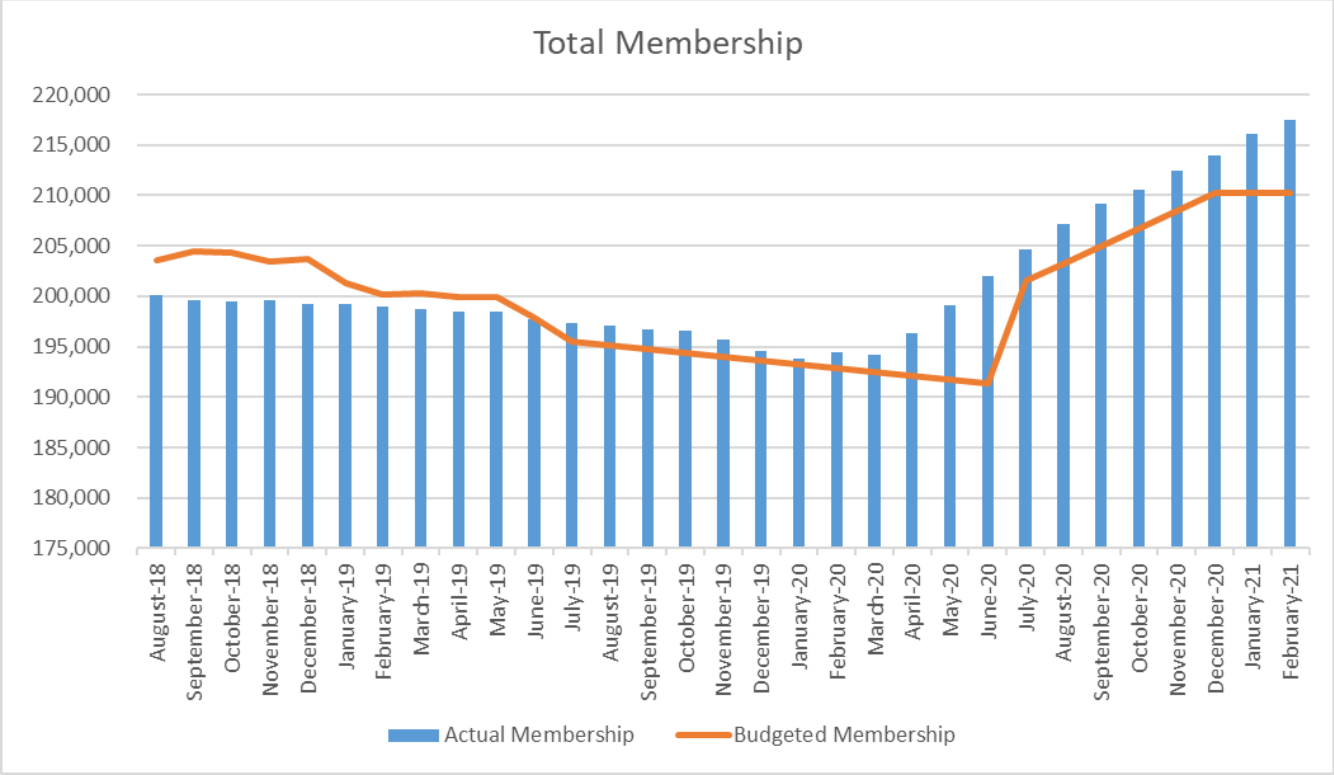
Financial Report:

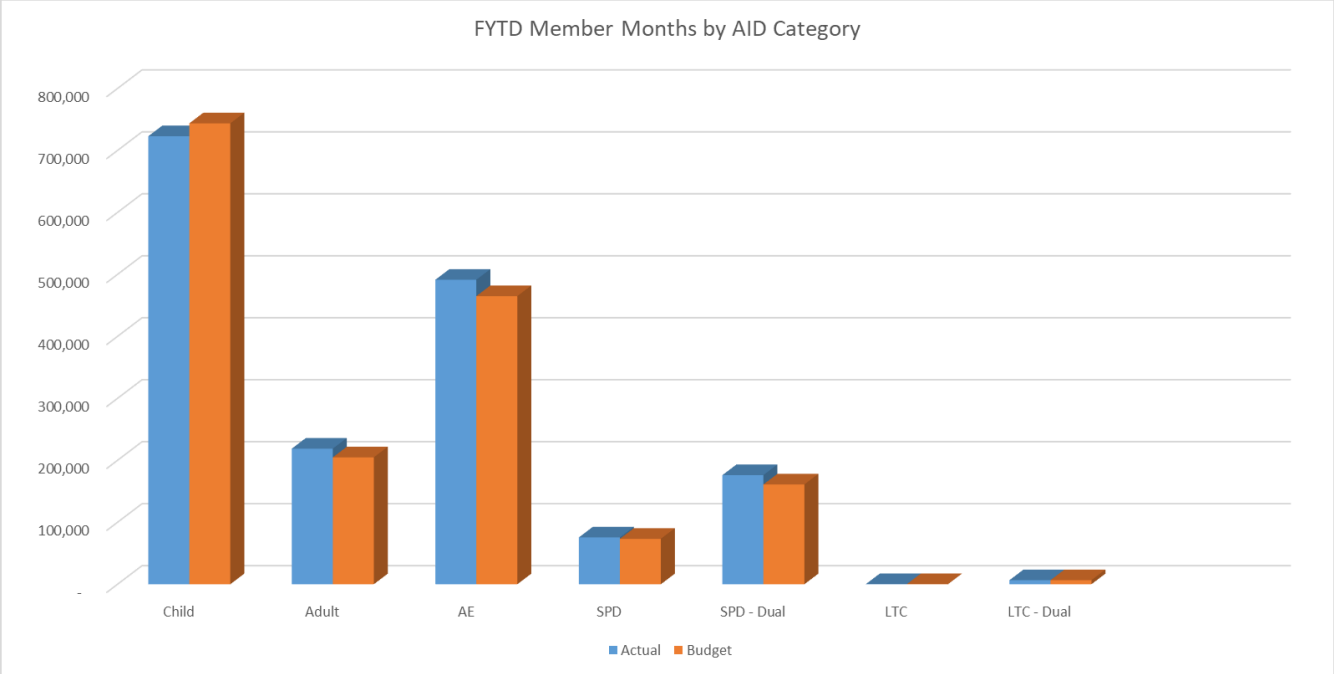
GCHP experienced a net gain of $4,336,431 for the month of February 2021.

February 2021 FYTD Highlights:

1. Net loss of $3,556,175, a $16.3 million favorable budget variance.
2. FYTD net revenue is $597.4 million, $50.8 million over budget.
3. FYTD Cost of health care is $561.2 million, $39.0 million over budget.
4. The medical loss ratio is 93.9% of revenue, 1.6% less than the budget.
5. FYTD administrative expenses are $33.1 million, $4.7 million under budget.
6. The administrative cost ratio is 5.5%, 1.8% under budget.
7. Current membership for February is 217,436.
8. Tangible Net Equity is $80.9 million which represents approximately 30 days of operating expenses in reserve and 227% of the required amount by the State.

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





Revenue

Net Premium revenue is $597.4 million; a $50.8 million and 9% favorable budget variance. The primary drivers of the budget variance are revenue associated with directed payments, CY2021 rates that are more favorable than projected, and revenue account for pharmacy expenses that were anticipated to be carved out this month.

Health Care Costs

FYTD Health care costs are $561.2 million; a $39.0 million and 7% unfavorable budget variance.

Notable variances from the budget are as follows:

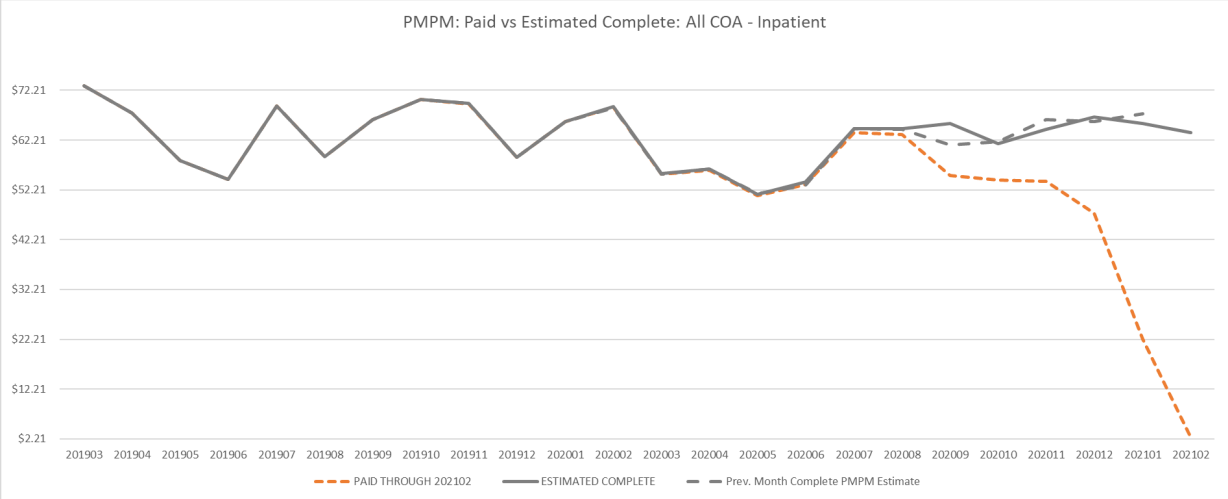
1. Directed payments for Proposition 56 are over budget by $17.6 million. GCHP did not budget for Proposition 56 expenses as the May revise of the State budget had removed funding for Proposition 56. The State budget in June ultimately included Proposition 56 funding. GCHP receives funding to offset the expense.

2. Pharmacy is over budget by $22.9 million. GCHP budgeted for pharmacy to be carved-out effective 1/1/2021 but, that transition has since been postponed. DHCS added back in the pharmacy component to the rates through March, and will be further revising the CY 2021 rates due to the continued delay.

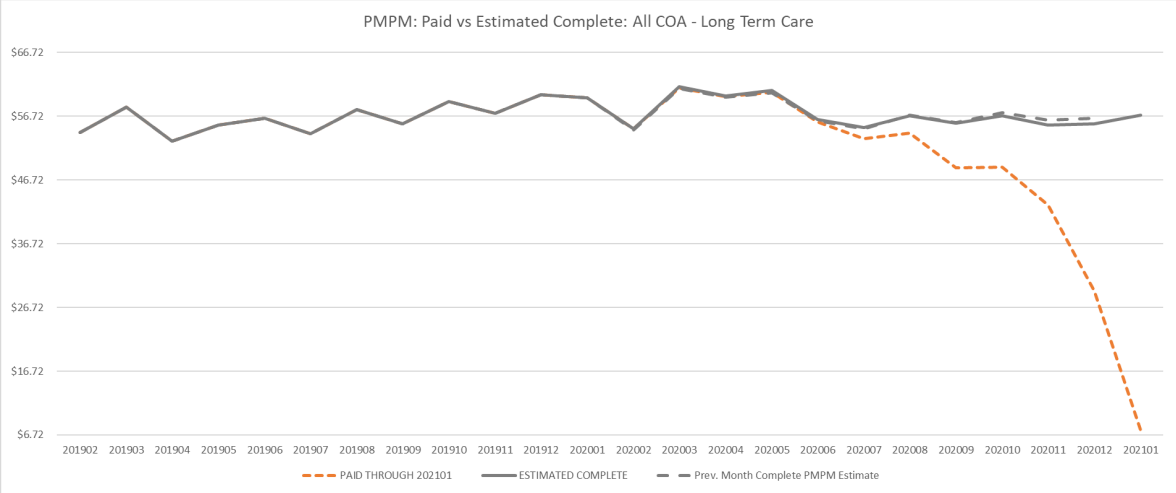
3. Laboratory and Radiology expense are over budget by $2.4 million due to COVID testing. DHCS has recognized the increased cost for lab and radiology and increased the CY 2021 rates accordingly.

4. Home & Community Based Services are over budget by $2.5 million due to an increase in Community Based Adult Service utilization. The delivery approach was modified to allow for services to be provided at home due to COVID. GCHP has noted an increase in days following this change.

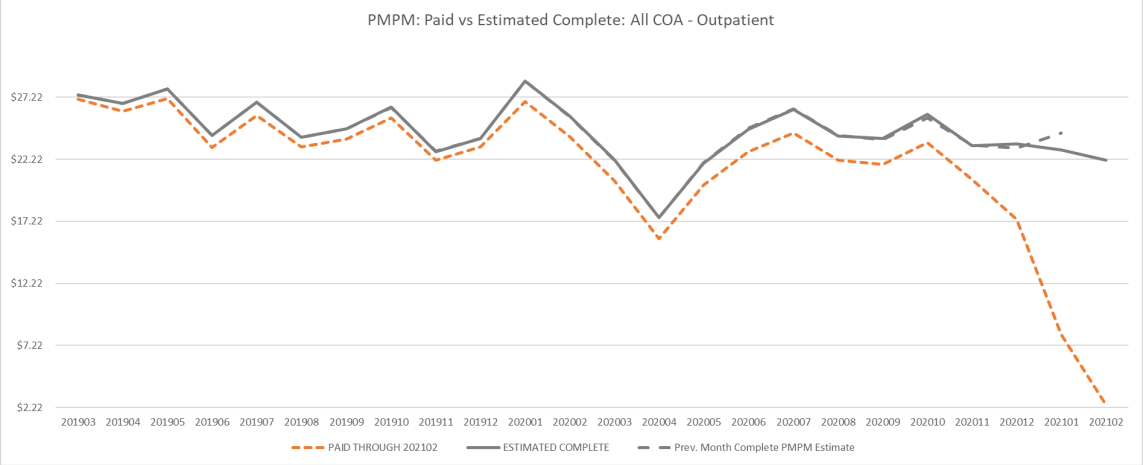
5. Inpatient hospital costs are under budget by $4.3 million (4%) due to decreased utilization from COVID-19 and the increase in membership.



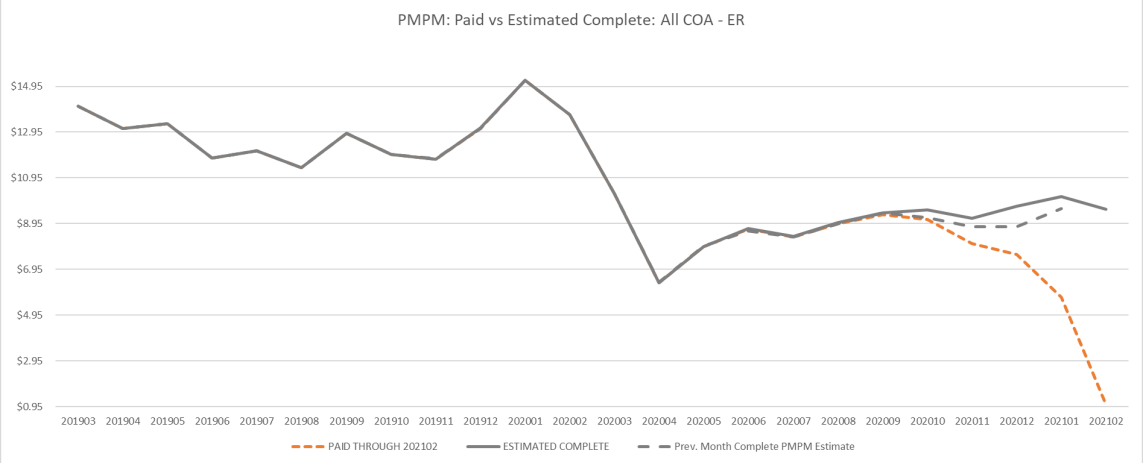
6. Long term care (LTC) expenses are over budget by $3.2 million (3%). The State increased facility rates by 10% effective March 1, 2020 through the emergency. The full impact was mitigated through the Solvency Action Plan and the reduction of LTC contractual rates to 100% of the Medi-Cal fee schedule. DHCS has recognized the increased cost and increased the CY 2021 rates accordingly.



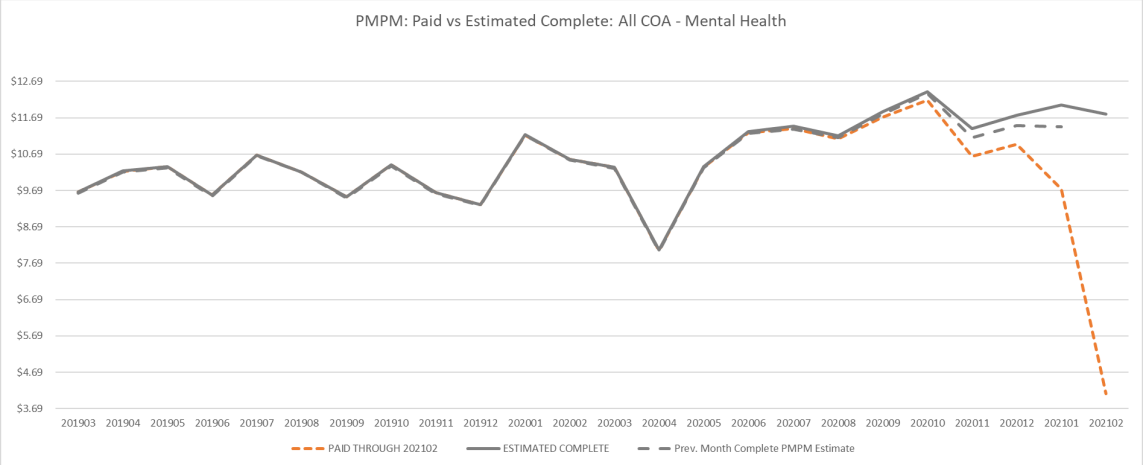
7. Outpatient expenses are under budget by $3.1 million (7%) due to COVID-19 and the increased membership.



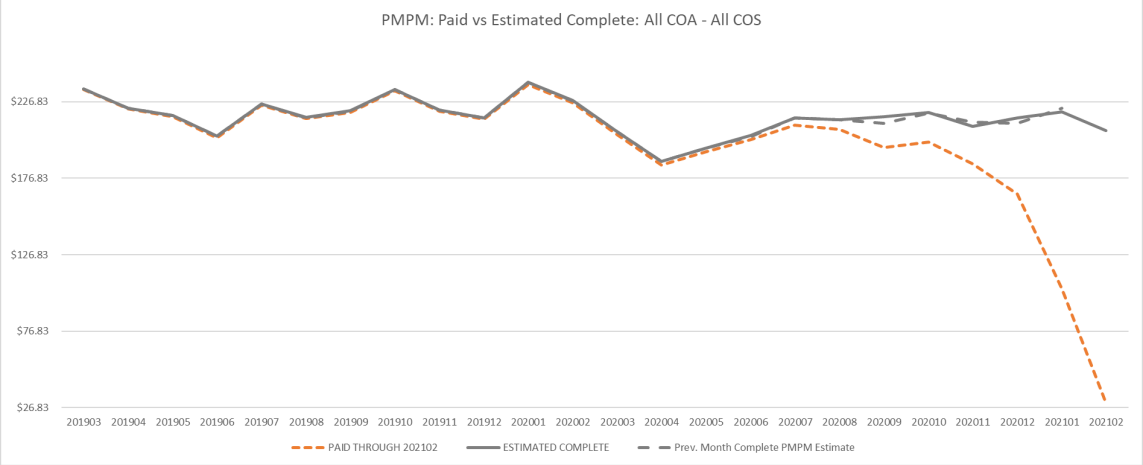
8. Emergency Room expenses are under budget by $6.0 million (27%) due to decreased utilization associated with COVID-19.



9. Mental and behavioral health services are over budget by $3.2 million (19%) due to additional services being provided during the pandemic.



10. Total fee for service health care pmpm costs excluding capitation and pharmacy, and considering date of service, are under budget by $9.91 PMPM (4.3%).



Note: Medical expenses are calculated through a predictive model which examines the timing of claims receipt and claims payments. It is referred to as “Incurred But Not Paid” (IBNP) and is a liability on the balance sheet. On the balance sheet, this calculation is a combination of the Incurred But Not Reported and Claims Payable. The total liability is the difference between the estimated costs (the orange line above) and the paid amounts (in grey above).

Administrative Expenses

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

For the fiscal year to date through February, administrative costs were $33.1 million and $4.7 million below budget. As a percentage of revenue, the administrative cost ratio (or ACR) was 5.5% versus 7.3% for budget.

Cash and Short-Term Investment Portfolio

At February 28, the Plan had $150.2 million in cash and short-term investments. The investment portfolio included Ventura County Investment Pool $43.2 million; LAIF CA State $206,750; the portfolio yielded a rate of 2.5%.

Medi-Cal Receivable

At February 28, the Plan had $109.4 million in Medi-Cal Receivables due from the DHCS.

RECOMMENDATION:

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

CONCURRENCE:

N/A

ATTACHMENT:

February 2021 Financial Package

Gold Coast Health Plan℠
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FINANCIAL PACKAGE
For the month ended February 28, 2021

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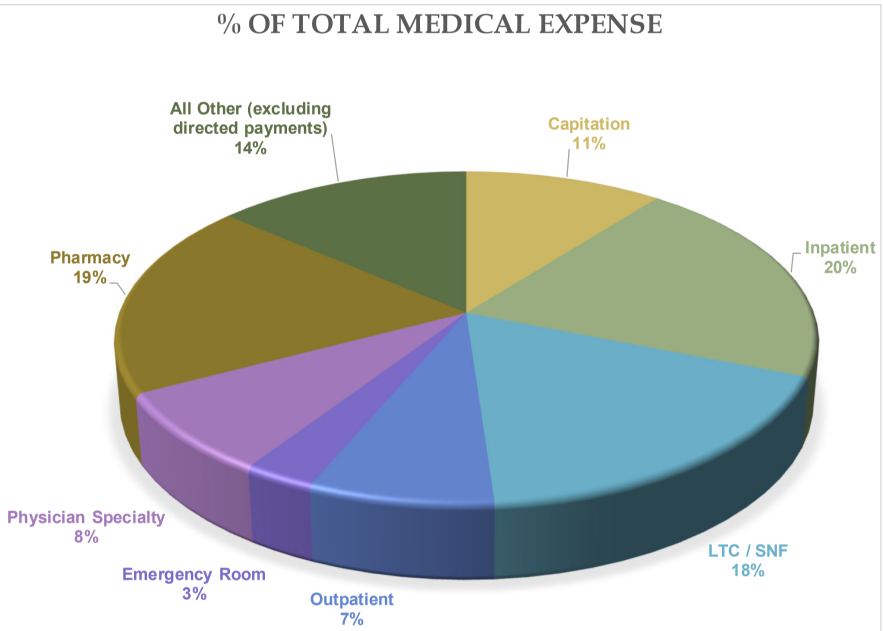
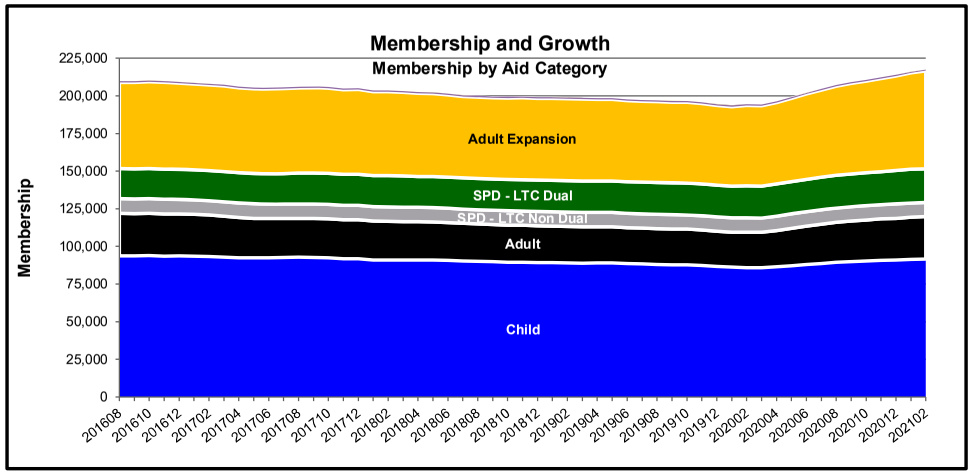
Gold Coast Health Plan

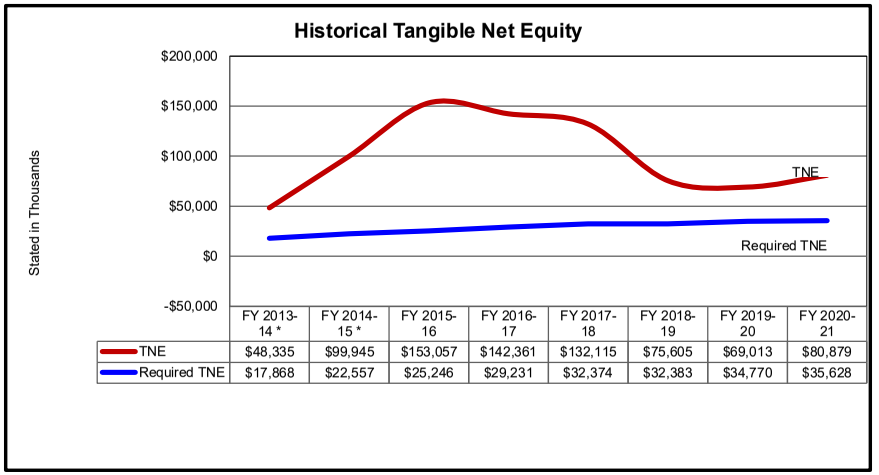
Executive Dashboard as of February 28, 2021

	FYTD 20/21 Budget*	FYTD 20/21 Actual	FY 19/20 Actual	FY 18/19 Actual
Average Enrollment	206,955	209,640	196,012	198,140
PMPM Revenue	$ 325.59	$ 356.23	$ 348.73	$ 299.23
Medical Expenses				
Capitation	$ 33.57	$ 34.18	$ 24.93	$ 23.90
Inpatient	$ 69.03	$ 66.54	$ 65.19	$ 62.09
LTC / SNF	$ 55.73	$ 57.72	$ 59.20	$ 56.06
Outpatient	$ 26.12	$ 24.33	$ 25.81	$ 25.88
Emergency Room	$ 12.99	$ 9.44	$ 11.97	$ 12.14
Physician Specialty	$ 26.00	$ 25.90	$ 27.63	$ 26.71
Pharmacy	$ 48.16	$ 61.86	$ 61.05	$ 56.60
All Other *(excluding directed payments)*	$ 32.04	$ 44.16	$ 41.07	$ 38.20
Total Per Member Per Month	$ 303.64	$ 324.13	$ 316.86	$ 301.58
Medical Loss Ratio	95.5%	93.9%	94.6%	102.0%
Total Administrative Expenses	$ 37,817,086	$ 33,109,950	$ 50,821,685	$ 46,655,880
% of Revenue	7.3%	5.5%	6.2%	6.6%
TNE	$ 50,232,476	$ 80,879,445	$ 71,272,142	$ 75,604,948
Required TNE	$ 27,745,713	$ 35,627,666	$ 34,685,521	$ 32,382,791
% of Required	181%	227%	205%	233%

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







	FY 2013-14 *	FY 2014-15 *	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
TNE	$48,335	$99,945	$153,057	$142,361	$132,115	$75,605	$69,013	$80,879
Required TNE	$17,868	$22,557	$25,246	$29,231	$32,374	$32,383	$34,770	$35,628

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STATEMENT OF FINANCIAL POSITION

	02/28/21	01/31/21	12/31/20
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**106,772,924**	**144,110,772**	**97,792,784**
Total Short-Term Investments	**43,441,526**	**43,409,825**	**43,409,502**
Medi-Cal Receivable	109,370,411	90,173,253	84,310,160
Interest Receivable	145,355	156,071	189,586
Provider Receivable	951,352	1,301,727	2,363,308
Other Receivables	7,625,070	6,670,713	6,320,713
Total Accounts Receivable	**118,092,188**	**98,301,764**	**93,183,767**
Total Prepaid Accounts	1,480,851	1,842,980	2,726,173
Total Other Current Assets	153,789	153,789	153,789
Total Current Assets	**269,941,279**	**287,819,130**	**237,266,015**
Total Fixed Assets	**1,327,072**	**1,370,008**	**1,414,594**
Total Assets	**$ 271,268,351**	**$ 289,189,138**	**$ 238,680,609**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 80,477,902	$ 76,265,360	$ 68,604,964
Claims Payable	22,860,140	16,283,531	11,919,700
Capitation Payable	16,626,226	16,548,187	16,539,426
Physician Payable	20,776,690	19,767,166	18,300,877
DHCS - Reserve for Capitation Recoup	6,068,585	6,068,815	5,141,295
Accounts Payable	1,582,942	25,485	27,563
Accrued ACS	1,568,665	4,721,851	3,231,712
Accrued Provider Reserve	1,137,972	1,069,161	1,001,143
Accrued Pharmacy	19,855,515	13,065,074	14,436,387
Accrued Expenses	3,244,600	49,262,305	1,986,328
Accrued Premium Tax	12,939,480	6,469,740	18,804,221
Accrued Payroll Expense	2,223,150	2,066,213	2,617,843
Total Current Liabilities	**189,361,866**	**211,612,890**	**162,611,460**
Long-Term Liabilities:			
Other Long-term Liability-Deferred Rent	1,027,039	1,033,233	1,039,427
Total Long-Term Liabilities	**1,027,039**	**1,033,233**	**1,039,427**
Total Liabilities	**190,388,906**	**212,646,123**	**163,650,887**
Net Assets:			
Beginning Net Assets	77,323,271	77,323,271	77,323,271
Total Increase / (Decrease in Unrestricted Net Assets)	3,556,175	(780,256)	(2,293,549)
Total Net Assets	**80,879,445**	**76,543,015**	**75,029,722**
Total Liabilities & Net Assets	**$ 271,268,351**	**$ 289,189,138**	**$ 238,680,609**

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR MONTH ENDED February 28, 2021

	February 2021	February 2021 Year-To-Date		Variance	Variance	February 2021 Year-To-Date		Variance
	Actual	Actual	Budget	Fav / (Unfav)	%	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	214,710	1,677,121	1,655,644	21,477	1%	PMPM - FYTD		
Revenue								
Premium	$ 87,612,590	$ 651,502,430	$ 546,664,802	$ 104,837,629	19%	$ 388.46	$ 330.18	$ 58.28
Reserve for Cap Requirements	(1,300,000)	(2,300,000)	-	(2,300,000)	0%	(1.37)	-	(1.37)
MCO Premium Tax	(6,469,740)	(51,757,920)	-	(51,757,920)	0%	(30.86)	-	(30.86)
Total Net Premium	**79,842,850**	**597,444,510**	**546,664,802**	**50,779,709**	**9%**	**356.23**	**330.18**	**26.05**
Other Revenue:								
Miscellaneous Income	-	468	-	468	0%	0.00	-	0.00
Total Other Revenue	-	468	-	468	0%	0.00	-	0.00
Total Revenue	**79,842,850**	**597,444,979**	**546,664,802**	**50,780,177**	**9%**	**356.23**	**330.18**	**26.05**
Medical Expenses:								
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	7,436,817	57,329,976	56,360,377	(969,599)	-2%	34.18	34.04	(0.14)
FFS Claims Expenses:								
Inpatient	14,891,129	111,590,765	115,903,794	4,313,029	4%	66.54	70.01	3.47
LTC / SNF	11,025,375	96,796,929	93,564,419	(3,232,510)	-3%	57.72	56.51	(1.20)
Outpatient	4,917,776	40,796,424	43,849,778	3,053,354	7%	24.33	26.49	2.16
Laboratory and Radiology	759,676	5,568,323	3,165,708	(2,402,616)	-76%	3.32	1.91	(1.41)
Directed Payments - Provider	2,234,562	17,554,387	-	(17,554,387)	0%	10.47	-	(10.47)
Emergency Room	2,695,503	15,835,028	21,810,227	5,975,199	27%	9.44	13.17	3.73
Physician Specialty	5,497,408	43,437,912	43,655,513	217,601	0%	25.90	26.37	0.47
Primary Care Physician	1,515,188	12,047,617	10,410,633	(1,636,985)	-16%	7.18	6.29	(0.90)
Home & Community Based Services	2,125,890	15,860,541	13,320,700	(2,539,841)	-19%	9.46	8.05	(1.41)
Applied Behavioral Analysis/Mental Health Service	2,935,850	20,051,992	16,858,776	(3,193,215)	-19%	11.96	10.18	(1.77)
Pharmacy	11,998,178	103,754,735	80,864,227	(22,890,508)	-28%	61.86	48.84	(13.02)
Provider Reserve	68,811	879,916	770,000	(109,916)	-14%	0.52	0.47	(0.06)
Other Medical Professional	305,513	2,402,836	3,020,074	617,238	20%	1.43	1.82	0.39
Other Medical Care	9,410	31,315	-	(31,315)	0%	0.02	-	(0.02)
Other Fee For Service	1,028,703	6,104,924	5,689,010	(415,914)	-7%	3.64	3.44	(0.20)
Transportation	270,535	2,389,760	1,328,868	(1,060,892)	-80%	1.42	0.80	(0.62)
Total Claims	62,279,507	495,103,403	454,211,726	(40,891,678)	-9%	295.21	274.34	(20.87)
Medical & Care Management Expense	1,267,444	9,986,013	9,716,973	(269,040)	-3%	5.95	5.87	(0.09)
Reinsurance	137,032	2,127,386	1,912,268	(215,118)	-11%	1.27	1.16	(0.11)
Claims Recoveries	(258,603)	(3,388,271)	-	3,388,271	0%	(2.02)	-	2.02
Sub-total	1,145,873	8,725,128	11,629,241	2,904,113	25%	5.20	7.02	1.82
Total Cost of Health Care	**70,862,198**	**561,158,507**	**522,201,344**	**(38,957,163)**	**-7%**	**334.60**	**315.41**	**(19.19)**
Contribution Margin	**8,980,652**	**36,286,472**	**24,463,458**	**11,823,014**	**48%**	**21.64**	**14.78**	**6.86**
General & Administrative Expenses:								
Salaries, Wages & Employee Benefits	1,958,305	16,376,361	17,575,253	1,198,893	7%	9.76	10.62	0.85
Training, Conference & Travel	263	10,813	101,137	90,325	89%	0.01	0.06	0.05
Outside Services	2,211,402	16,648,192	16,991,196	343,004	2%	9.93	10.26	0.34
Professional Services	712,660	3,343,964	2,420,387	(923,577)	-38%	1.99	1.46	(0.53)
Occupancy, Supplies, Insurance & Others	626,730	4,617,959	6,325,068	1,707,109	27%	2.75	3.82	1.07
Care Management Reclass to Medical	(1,267,444)	(9,986,014)	(9,716,973)	269,041	-3%	(5.95)	(5.87)	0.09
G&A Expenses	4,241,915	31,011,274	33,696,068	2,684,794	8%	18.49	20.35	1.86
Project Portfolio	432,275	2,098,676	4,121,018	2,022,342	49%	1.25	2.49	1.24
Total G&A Expenses	**4,674,190**	**33,109,950**	**37,817,086**	**4,707,136**	**12%**	**19.74**	**22.84**	**3.10**
Total Operating Gain / (Loss)	**4,306,463**	**3,176,521**	**(13,353,628)**	**16,530,150**	**-124%**	**1.89**	**(8.07)**	**9.96**
Non Operating								
Revenues - Interest	29,968	378,567	600,000	(221,433)	-37%	0.23	0.36	(0.14)
Gain/(Loss) on Sale of Asset	-	1,086	-	1,086	0%	0.00	-	0.00
Total Non-Operating	**29,968**	**379,653**	**600,000**	**(220,347)**	**-37%**	**0.23**	**0.36**	**(0.14)**
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 4,336,431**	**$ 3,556,175**	**$ (12,753,628)**	**$ 16,309,803**	**-128%**	**$ 2.12**	**$ (7.70)**	**$ 9.82**

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FYTD PMPM BUDGET TO ACTUAL ANALYSIS - FEE FOR SERVICE BY AID CATEGORY

	Adult				Child				Adult Expansion			
	Budget	Actual	Variance	%	Budget	Actual	Variance	%	Budget	Actual	Variance	%
Inpatient	$ 127.70	$ 119.02	$ (8.68)	-7%	$ 5.89	$ 4.88	$ (1.01)	-17%	$ 115.84	$ 103.66	$ (12.18)	-11%
Outpatient	45.36	42.12	(3.24)	-7%	$ 4.32	2.41	(1.91)	-44%	$ 38.37	36.45	(1.92)	-5%
ER	17.37	14.92	(2.45)	-14%	$ 10.05	4.76	(5.29)	-53%	$ 16.72	14.28	(2.44)	-15%
LTC	8.07	16.12	8.05	100%	$ 0.31	0.45	0.14	47%	$ 22.60	22.62	0.02	0%
PCP	6.55	8.79	2.24	34%	$ 5.83	5.16	(0.67)	-12%	$ 5.75	7.47	1.72	30%
Specialty	45.27	44.44	(0.83)	-2%	$ 4.15	5.03	0.88	21%	$ 41.43	38.59	(2.84)	-7%
Pharmacy	68.36	97.92	29.56	43%	$ 8.70	10.18	1.48	17%	$ 82.56	107.60	25.04	30%
Mental Health/ABA	5.58	7.24	1.66	30%	$ 8.93	11.53	2.60	29%	$ 5.61	6.89	1.28	23%
All Other	10.56	12.58	2.02	19%	1.37	2.19	0.82	59%	12.53	14.44	1.91	15%
Total	$ 334.82	$ 363.15	$ 28.33	8%	$ 49.56	$ 46.59	$ (2.97)	-6%	$ 341.41	$ 352.00	$ 10.59	3%
FYTD Member Months	204,759	218,043	13,284	6%	743,689	713,477	(30,212)	-4%	464,908	485,897	20,989	5%

	Seniors and Persons with Disabilities (SPD)				SPD - Dual				Long Term Care (LTC)			
	Budget	Actual	Variance	%	Budget	Actual	Variance	%	Budget	Actual	Variance	%
Inpatient	$ 278.17	$ 321.52	$ 43.35	16%	$ 20.40	$ 22.27	$ 1.87	9%	$ 718.09	$ 995.24	$ 277.15	39%
Outpatient	99.53	102.48	2.95	3%	20.40	21.81	1.41	7%	240.92	118.05	(122.87)	-51%
ER	28.22	23.79	(4.43)	-16%	1.93	1.56	(0.37)	-19%	16.68	13.63	(3.05)	-18%
LTC	152.21	142.35	(9.86)	-6%	97.20	88.57	(8.63)	-9%	7,879.08	9,457.75	1,578.67	20%
PCP	14.91	23.40	8.49	57%	4.51	4.32	(0.19)	-4%	11.22	6.81	(4.41)	-39%
Specialty	79.50	93.58	14.08	18%	21.15	19.02	(2.13)	-10%	236.64	268.23	31.59	13%
Pharmacy	231.05	334.35	103.30	45%	3.95	6.47	2.52	64%	256.33	231.52	(24.81)	-10%
Mental Health/ABA	76.89	82.39	5.50	7%	1.19	1.41	0.22	18%	3.61	-	(3.61)	-100%
All Other	77.36	85.51	8.15	11%	51.46	72.82	21.36	42%	528.69	321.83	(206.86)	-39%
Total	$ 1,037.84	$ 1,209.37	$ 171.53	17%	$ 222.20	$ 238.25	$ 16.05	7%	$ 9,891.25	$ 11,413.06	$ 1,521.81	15%
FYTD Member Months	73,336	82,008	8,672	12%	161,000	163,442	2,442	2%	272	433	161	59%

	LTC - Dual			
	Budget	Actual	Variance	%
Inpatient	$ 61.57	$ 259.33	$ 197.76	321%
Outpatient	13.60	5.05	(8.55)	-63%
ER	0.72	0.62	(0.10)	-14%
LTC	7,405.59	7,392.13	(13.46)	0%
PCP	0.55	0.26	(0.29)	-53%
Specialty	11.60	10.91	(0.69)	-6%
Pharmacy	0.06	0.16	0.10	181%
Mental Health/ABA	0.64	0.37	(0.27)	-43%
All Other	153.44	165.64	12.20	8%
Total	$ 7,647.78	$ 7,834.47	$ 186.69	2%
FYTD Member Months	6,544	6,530	(14)	0%

FFS expenses budgeted based on CY 2019 PMPM data, with the following trend assumptions:

Inpatient - 1% annual trend and known contractual changes.
ER - 1% annual trend and known contractual changes.
LTC - 2.5% estimated fee schedule change
Specialty Physician - 1% estimated fee schedule change
Mental Health/ABA - 2% annual increase due to utilization.
Pharmacy - 5% overall annual increase.
Home and Community Based Services - 2% annualized increase due to utilization.

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STATEMENT OF CASH FLOWS	February 2021	FYTD 20-21
Cash Flows Provided By Operating Activities		
Net Income (Loss)	$ 4,336,431	$ 3,556,176
Adjustments to reconciled net income to net cash provided by operating activities		
Depreciation on fixed assets	42,936	330,117
Disposal of fixed assets	-	9,684
Amortization of discounts and premium	-	-
Changes in Operating Assets and Liabilites		
Accounts Receivable	(19,790,425)	(8,222,068)
Prepaid Expenses	362,129	270,922
Accrued Expense and Accounts Payable	(40,603,671)	2,114,603
Claims Payable	7,664,171	12,442,145
MCO Tax liablity	6,469,740	(21,565,800)
IBNR	4,212,542	28,708,564
Net Cash Provided by (Used in) Operating Activities	(37,306,147)	17,644,343
Cash Flow Provided By Investing Activities		
Proceeds from Restricted Cash & Other Assets		
Proceeds from Investments	(31,701)	(401,302)
Purchase of Investments plus Interest reinvested	-	-
Purchase of Property and Equipment	-	(56,546)
Net Cash (Used In) Provided by Investing Activities	(31,701)	(457,848)
Increase/(Decrease) in Cash and Cash Equivalents	(37,337,848)	17,186,495
Cash and Cash Equivalents, Beginning of Period	144,110,772	89,586,429
Cash and Cash Equivalents, End of Period	106,772,924	106,772,924

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February 2021 Financial Statements

March 22, 2021

Kashina Bishop
Chief Financial Officer

Integrity
Accountability
Collaboration
Trust
Respect

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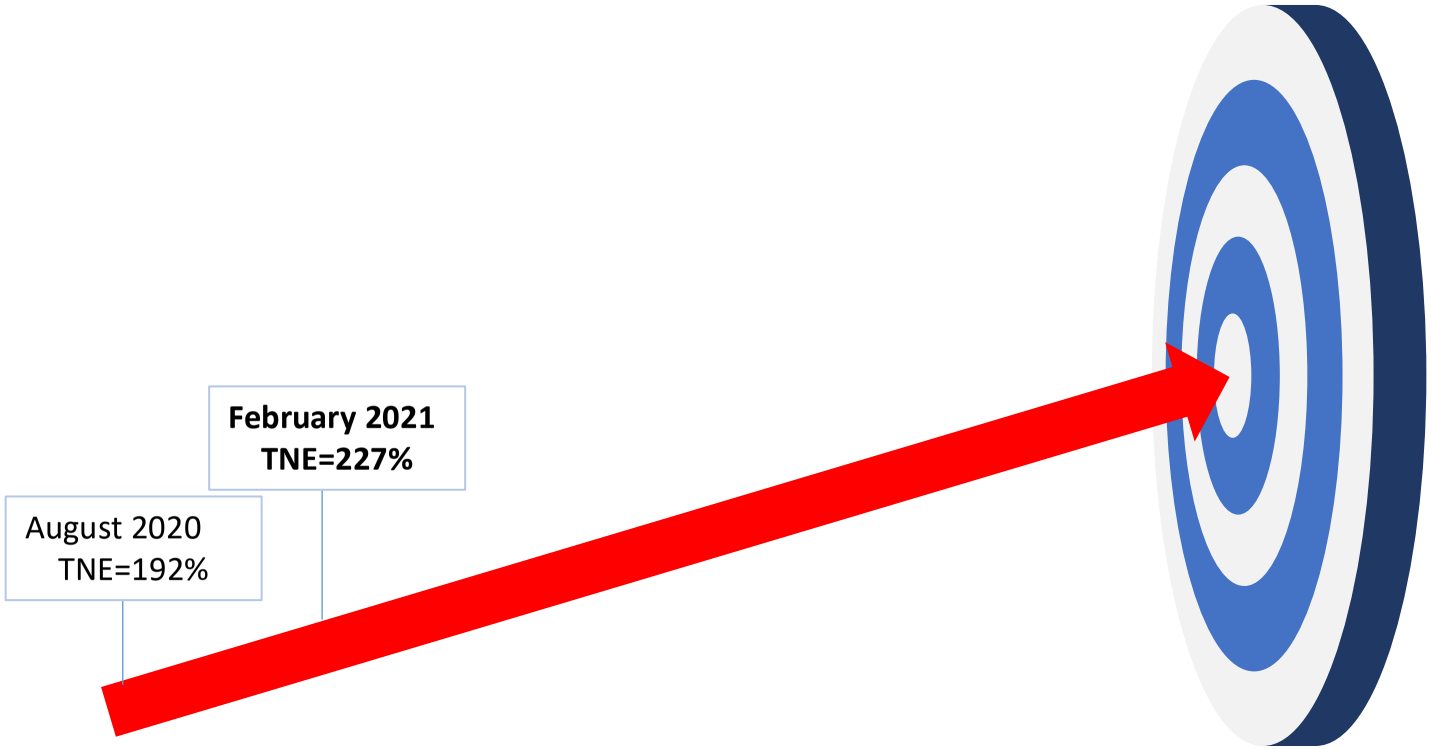
Financial Overview:

	February NET GAIN	$ 4.3 M
	FYTD NET LOSS	$3.6 M
	TNE is $80.9 M and 227% of the minimum required	
	MEDICAL LOSS RATIO	93.9%
	ADMINISTRATIVE RATIO	5.5%

Solvency Action Plan

Target: TNE % = 400-500% of Required



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Update on the Solvency Action Plan:

Category	Current Focus	Annualized impact in savings
Cost of Healthcare	Revision to Non-Pharmacy Dispensing Site Policy	$7-10 million
Internal Control Improvements	Interest expense reduction/PDR turnaround time	$500,000
	HMS Implementation	$2.3 million
	Formalization of internal control workgroup	N/A
	Formalization of the contract steering committee	N/A
	Provider settlement review	TBD
Contracting Strategies	Reduction of LTC facility rates to 100% of the Medi-Cal rate	$1.8 million
	Rate reduction to tertiary hospital	$1.3 million
	Reduction of adult expansion PCP rates*	$4.5 million
	TOTAL ANNUAL SAVINGS	**$17.4-20.4 million**

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Next steps -Solvency Action Plan

Category	Current Focus	Annualized impact in savings
Cost of Healthcare	LANE – avoidable ER analysis	TBD
	Pro-active transplant management approach	TBD
	Analysis of leakage to out of area providers	TBD
Internal Control Improvements	Review of provider contracts for language interpretation and validation	N/A
	Develop revised provider contract templates and a standard codified DOFR template	N/A
	Ensure appropriate approval on all contract amendments	TBD
	Improve quality and completeness of encounter data	Revenue implications
	California Children's Services – ED Diversion	$500,000
	Implementation of additional claims edit system (CES) checks to minimize payment errors	TBD
Contracting Strategies	Expansion of capitation arrangements	Required TNE and risk reductions
	LANE/HCPCS analysis	TBD
	Outlier rate analysis	TBD
	Consideration of across the board reductions	TBD

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Revenue

Net Premium revenue is $597.4 million, over budget by $50.8 million and 9%.

- **Revenue for Proposition 56 is $18.5 million.**
- **Increase in revenue related to FY 19-20.**
- **Favorable CY 2021 rates and inclusion of pharmacy component.**

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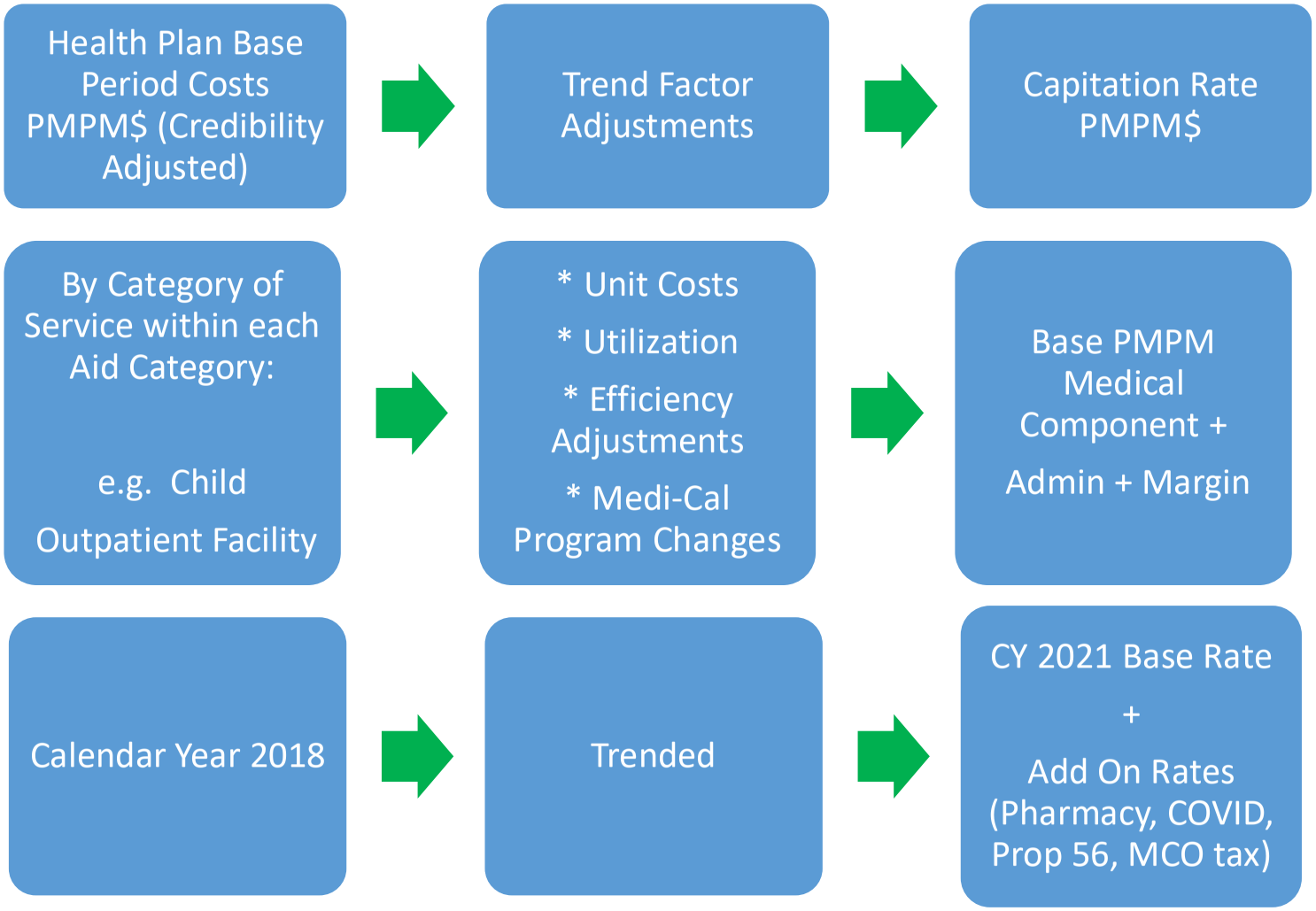
Revenue



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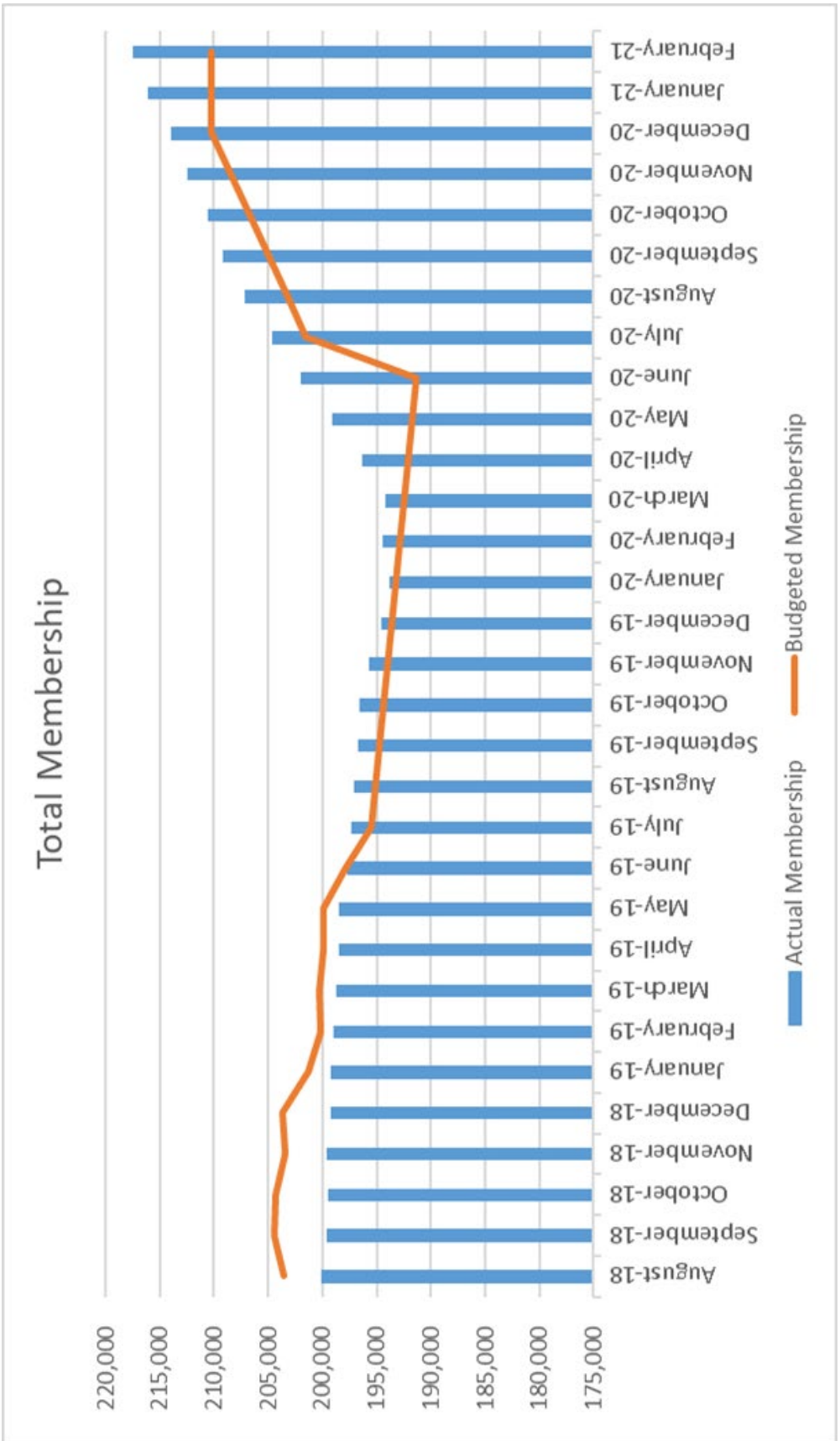
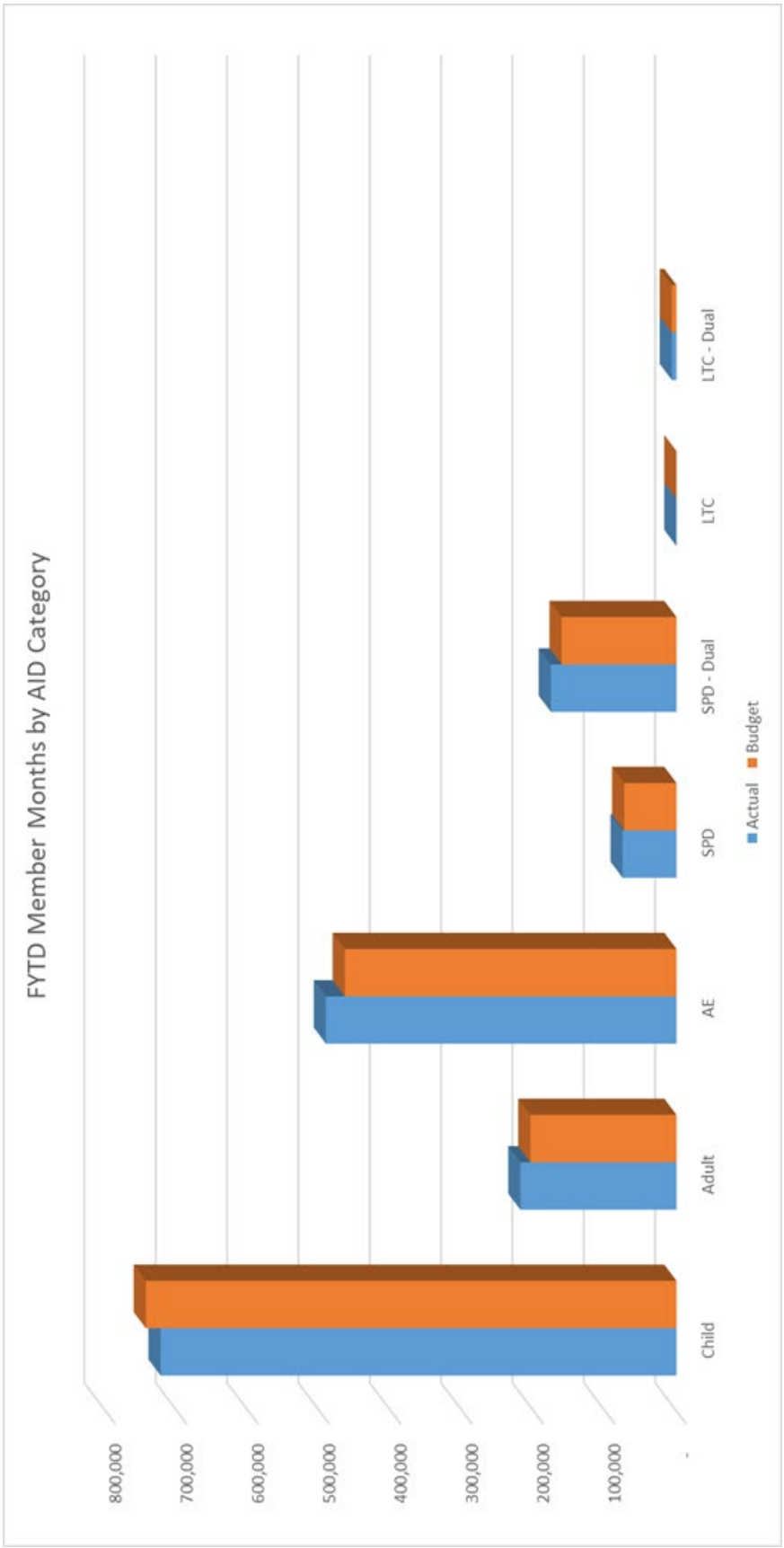
Membership trends



Membership trends



Medical Expense

FYTD Health care costs are $561.2 million and $39.0 million over budget. Medical loss ratio is 93.9%, a 1.6% budget variance.

- **Directed payments over budget by $17.6 M.**
- **Pharmacy expense over budget by $22.9 M.**
- **COVID related increases to lab and radiology, home and community based services, long term care, and mental and behavioral health services are offsetting savings. Medical expense in line with budget in aggregate.**

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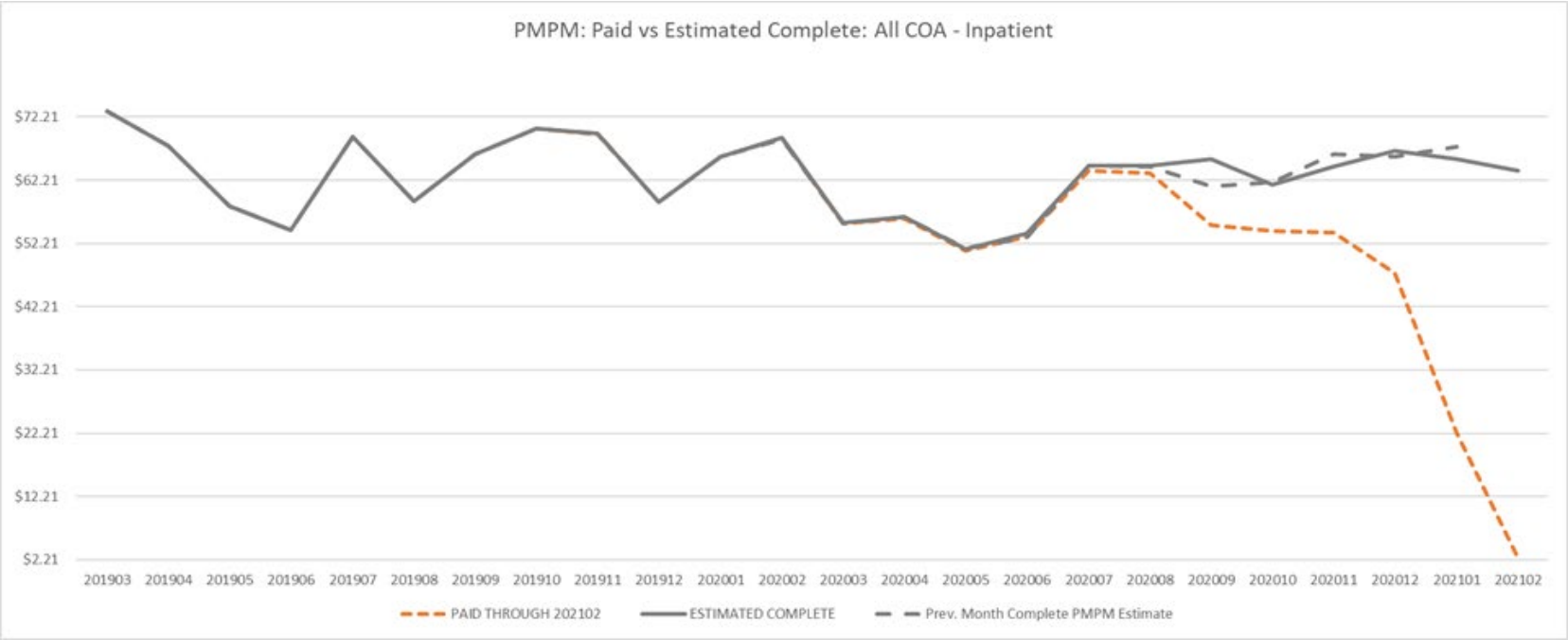
Inpatient Medical Expenses: Under Budget by $4.3 Million (4%)



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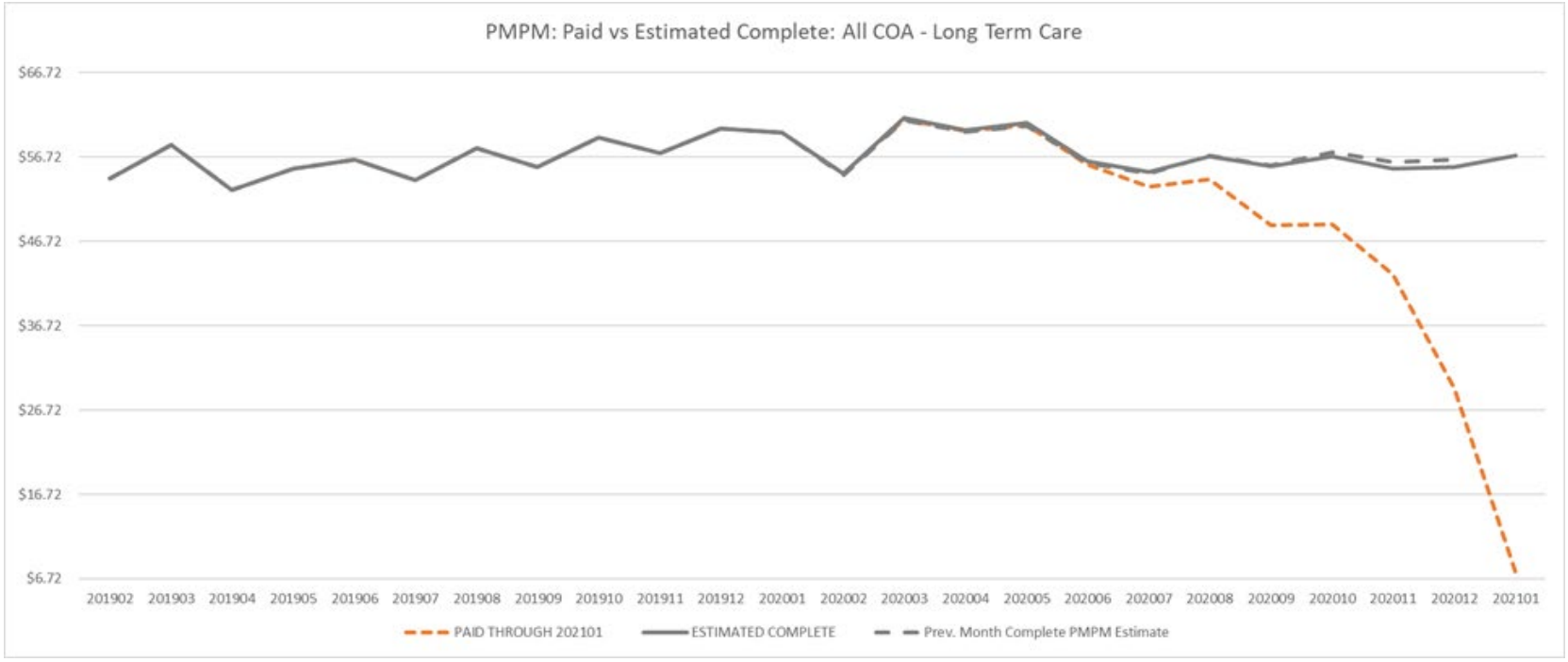
Long Term Care Expenses: Over budget by $3.2 million (3%)



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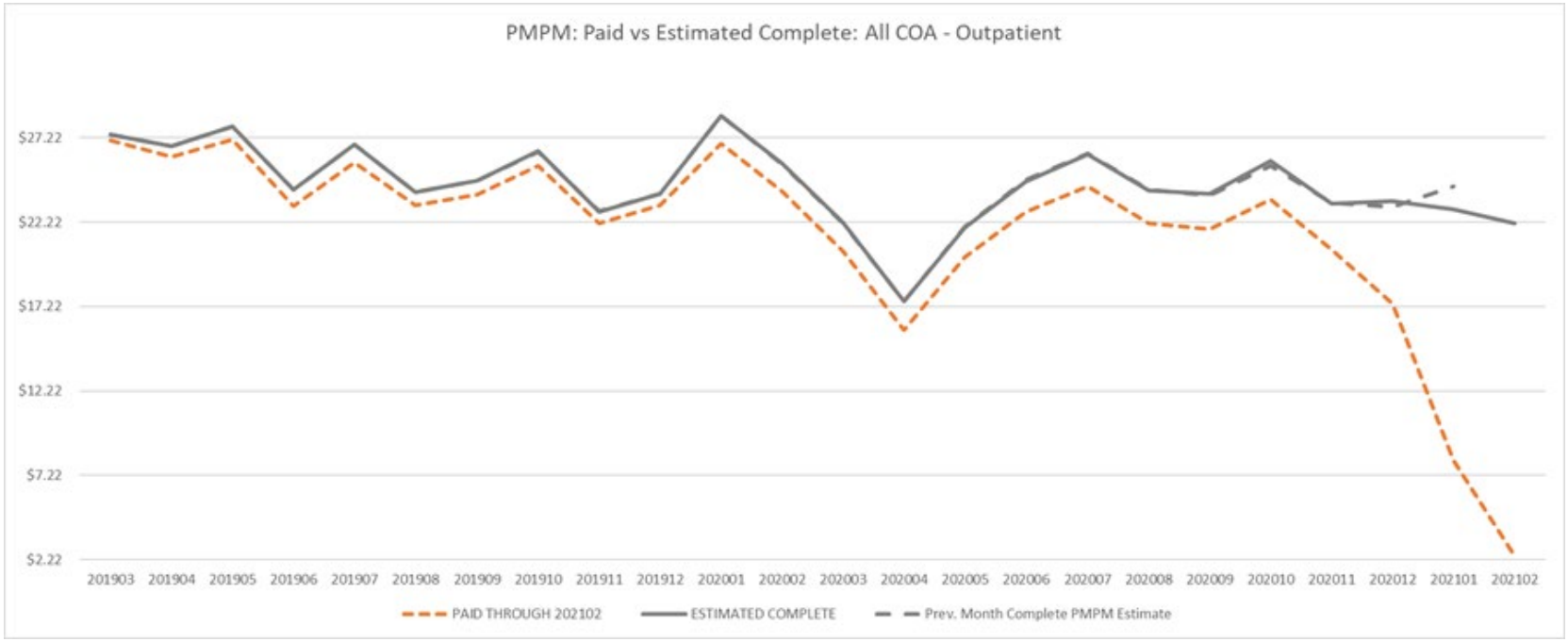
Outpatient Expenses: Under budget by $3.1 million (7%)



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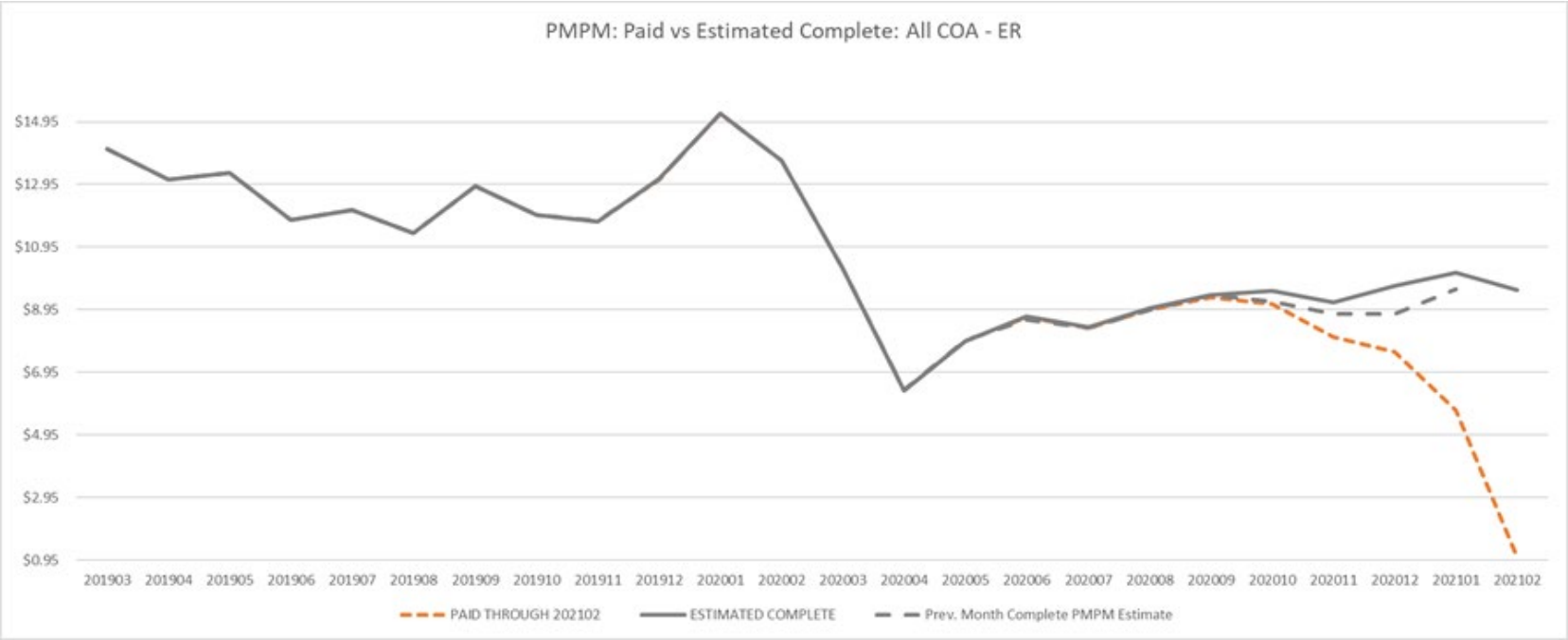
Emergency Room Expenses: Under budget by $6.1 million (27%)



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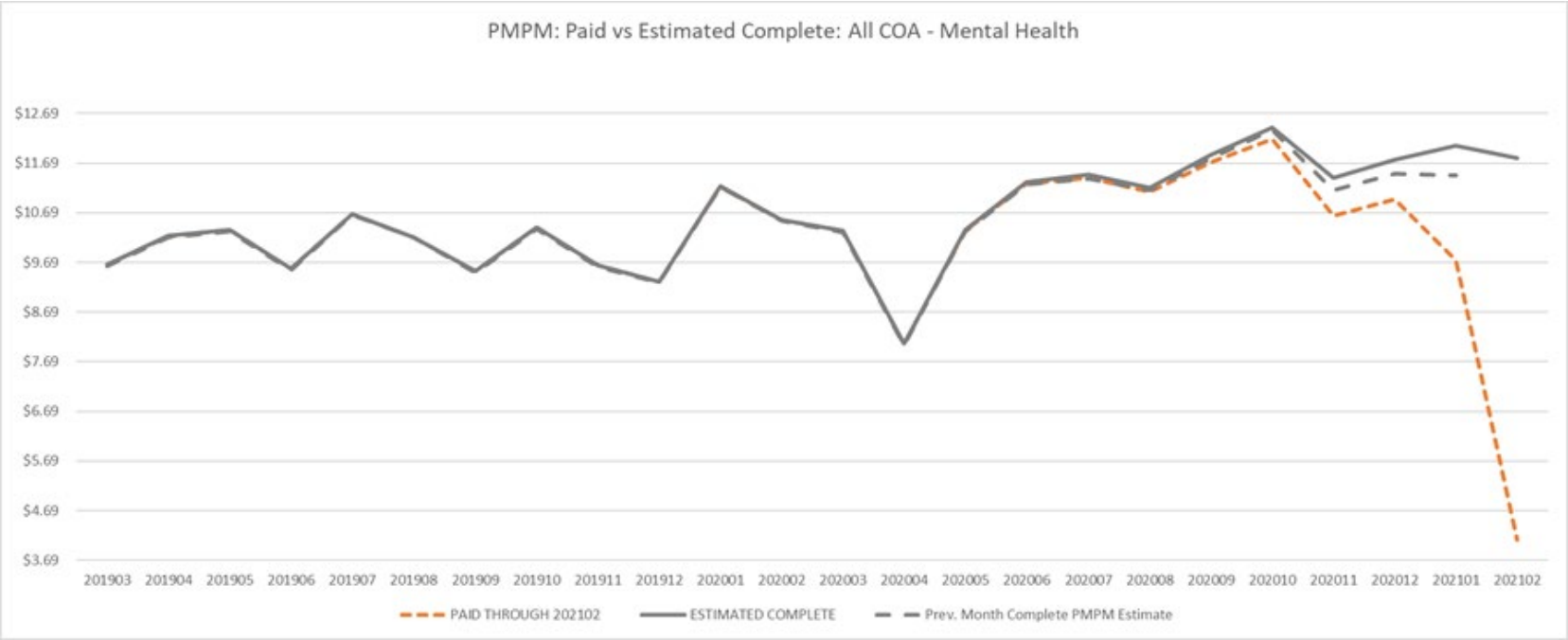
Mental and Behavioral Health: Over budget by $3.2 million (19%)



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Financial Statement Summary

	February 2021	FYTD	FYTD Budget	Budget Variance
Net Capitation Revenue	$ 79,842,850	$ 597,444,979	$ 546,664,802	$ 50,780,177
Health Care Costs	70,862,198	561,158,507	522,201,344	38,957,163
Medical Loss Ratio		**93.9%**	**95.5%**	
Administrative Expenses	4,674,190	33,109,950	37,817,086	(4,707,136)
Administrative Ratio		**5.5%**	**7.3%**	
Non-Operating Revenue/(Expense)	29,967	379,652	600,000	(220,347)
Total Increase/(Decrease) in Net Assets	$ 4,336,431	$ 3,556,175	$ (12,753,628)	$ 16,309,803
Cash and Investments	$ 150,214,450			
GCHP TNE	$ 80,879,445			
Required TNE	$ 35,627,666			
% of Required	**227%**			

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QUESTIONS?

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

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AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, MD, Chief Medical Officer
Anne Freese, PharmD, Director of Pharmacy

DATE: March 22, 2021

RE: Pharmacy Benefits Manager Contract Amendment

SUMMARY:

Gold Coast Health Plan ("GCHP") contracts with OptumRx, a Pharmacy Benefits Manager ("PBM"), to provide pharmacy benefit services to GCHP's members. The State has indefinitely delayed the implementation of Medi-Cal Rx pending review of conflict avoidance protocols for the Medi-Cal Rx pharmacy benefit manager, Magellan. A new contract amendment is needed to extend this contract pending additional information received from DHCS regarding the Medi-Cal Rx implementation timeline.

DISCUSSION:

Amendment #6: "Extension Agreement"
Staff is negotiating a contract amendment that adds the following provisions to the contract with the PBM:

1. Adds an additional term for a 5th Service Year from June 1, 2021 to May 31, 2022;
2. Maintains current structure for administrative fees, pricing and rebate guarantees, and performance guarantees; and
3. Provides GCHP with flexibility to address the indefinite timeline for implementation of Medi-Cal Rx by:
    a. Reduces GCHP's prior notice requirement for termination of the contract from 45 days to 30 days for GCHP's termination related to Medi-Cal Rx implementation only;
    b. Provides GCHP the option to unilaterally extend the contract for an additional 2 Service Years, June 1, 2022 to May 31, 2023 and June 1, 2023 to May 31, 2024;
    c. Provides GCHP the option to extend the contract for time periods of up to 3 months upon delay or extension of implementation of Medi-Cal Rx.

FISCAL IMPACT:

Due to the State's delay of implementation of Medi-Cal Rx, GCHP will remain responsible for PBM administrative fees and drug costs until implementation of Medi-Cal Rx. Administrative fees

remain the same as the existing fee and pricing structure of the current contract. Although drug pricing is anticipated to remain similar to the current contract, drug costs may fluctuate depending on utilization.

RECOMMENDATION:

Staff recommends the Commission authorize the execution of an amendment reflecting the items discussed in this report.

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AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Robert Franco, Chief Compliance Officer

DATE: March 22, 2021

SUBJECT: Compliance Overview

PowerPoint with Verbal Presentation

ATTACHMENTS:

Compliance Overview PowerPoint

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Integrity
Accountability
Collaboration
Trust
Respect

Compliance Overview

Robert Franco, Chief Compliance Officer

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

Overview

1. 7 Elements of an Effective Compliance Program
2. The GCHP Compliance Organization
3. GCHP Compliance Accomplishments 2020
4. GCHP Goals 2021

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Seven Elements of Effective Compliance Program

1. Oversight by Compliance Officer, Board of Directors and Management
2. Standards and Procedures
3. Training and Education
4. Monitoring and Auditing
5. Reporting
6. Enforcement and Discipline
7. Response and Prevention

Source: HHCA-OIG Measuring Compliance Program Effectiveness: A Resource Guide.

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GCHP's Compliance Organization

7 Elements of best in class Compliance	GCHP's approach
Oversight by Compliance Officer, Board of Directors and Management	Internal Control Workgroup, increased targeted communications
Standards and Procedures	Policy Review Committee
Training and Education	Annual Compliance & Privacy Training
Monitoring and Auditing	Internal Audits, Focused Reviews & Peer reviews
Reporting	Compliance Hotline, Shared Compliance Email and targeted communications
Enforcement and Discipline	Socializing existing processes through targeted communications
Response and Prevention	Compliance reporting through newly established workgroups

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2020 Compliance Review

Core functions	Accomplishments 2020

Fraud Waste & Abuse	• 143 Cases (159, 2019)
	  • Lost ID Cards
	  • EOB generated call
	  • DHCS referred cases
	  • Non-FWA cases

Compliance 360 (C360) P&P Administration Delegate Reporting	• 261 Policies currently in C360 • 10 Delegates submit reports as contractually required.
Delegation Oversight Audits Clinical Audits Operational Audits – Claims, Call Center & NEMT/NMT Credentialing	21 Delegation Completed Audits • 7 Credentialing Audits • 5 Claims Audits • 4 Utilization Management Audits • 1 Member Rights Audit • 1 NEMT Audit

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2020 Compliance Review

Core functions	Accomplishments 2020
Privacy Officer Required Annual Compliance Training	• 44 Privacy incidents • 180 Associates (26 New) received Required Training – Code of Conduct, FWA and Privacy & Security
DHCS Point of Contact 2020 Focus Pharmacy Benefit Management (PMB) Audit Contractual Reporting	• Successfully completed the 2020 Focus PBM Audit and received great comments regarding the support of the audit. • Assigned a new contract manager and building a strong collaborative relationship
Audit Readiness Program	• Launched an Audit Readiness Program in anticipation of the 2020 Focus PBM Audit.

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Internal Controls Workgroup

In the fourth quarter of 2020, a workgroup was formed to strengthen GCHP's internal controls by assisting with the prioritization and tracking of escalated issues, the implementation of improvements, and execution of ongoing projects.

The Internal Control process was introduced during the 2020 Strategic Planning Retreat, along with a comprehensive list of controls that have already been addressed in 2020 (see slides 64-83 of the Strategic Planning Retreat presentation).

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Internal Controls Workgroup

Goal	Outcomes
Goal # 1 Identification of Issues by Department	• Root Cause • Remediation • Implication (Downstream Impact) • Importance (Prioritization)
Goal # 2 Track Internal Improvement	• Not related to remediation of a specific issue • Description • Importance (Prioritization)
Goal # 3 Focus on Planned Improvements	• Description • Timeline • Importance (Prioritization)

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Internal Control - Compliance

- Internal Audit
  - Identify the documented process
  - Review the practices to ensure they match our process
  - Update P&P's and processes as appropriate
  - Documented Training of the associates
  - Ensure sustained compliance

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Next Steps

- Establish Internal Controls Workgroup meeting cadence
- Level set with Internal Business Areas to provide standard updates
- Prioritization of issues, improvements and execution
- Quarterly updates to Executive/Finance & Commission

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Questions

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Appendix

Internal Controls to be Addressed in 2021			
Internal Control Issue	**Root Cause**	**Resolution**	**Implications/Importance**
Compliance			
1. Regular Compliance reporting to commission			
2. Regular CAC reporting to commission			
3. Regular PAC reporting to commission			
4. Disciplined review of all policies and procedures			
DSS			
5. Encounter Data Quality Improvement		Map Encounter Data process, end to end Q2 FY 20-21 Identify Gaps Q2 FY 20-21 Build Plan to address gaps Q2 FY 20-21 Execute plan Q4 FY 20/21	More complete and accurate encounter data in support of RDT, MCAS, and Health Improvement initiatives
6. RDT Data Provision Improvement		Map RDT process, end to end Q2 FY 20-21 Identify Gaps Q2 FY 20-21 Build Plan to address gaps Q2 FY 20-21 Execute plan Q4 FY 20/21	Ensure revenue is maximized Improved financial monitoring and reporting
7. 274 Timeliness	Timeframe to deliver is short Delayed files from provider partners/ vendors Manual processes lead to human error or delays Transunion delays Roles & responsibilities are unclear	Meet with Ops Support/IT & PNO to delineate responsibilities. Q3 FY 20/21 Codify process and follow process to the letter. Q3 FY 20/21 Implement escalation process Q3 FY 20/21 IT developing mechanism to reduce human intervention Q3 FY20/21	274 delivery on or before the 10th of every month is a DHCS regulatory requirement.
8. Prop 56 Payment Process	Complex calculations; processes heavily manual. Multiple data streams feeding the process, causing delays. Reporting is difficult.	Work in progress to transition process fully over to Conduent; within HSP. Day Two requirement within Project. In parallel, development of a database to capture all payment data in order to easily generate reporting, both DHCS required and ad hoc.	Providers receiving Prop 56 payments in a timelier manner. Accurate and timely delivery of reporting to DHCS

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Appendix

Internal Controls to be Addressed in 2021			
Internal Control Issue	**Root Cause**	**Resolution**	**Implications/Importance**
Finance			
9. Regular Internal Audits and Focused Reviews			
10. 820 File Reconciliations		To develop a processing procedure for our 820 files where Finance can easily review member-level detail for payments and reconcile against receivables.	To ensure that DHCS is paying us timely and accurately for month premium, MCO taxes, supplemental payments and intergovernmental transfers
11. Capitation Reconciliation		To compare the aid category of capitation we pay to providers versus the aid category that we are paid for.	To ensure accuracy of capitation payments to providers
12. IBNP End-to-End Workflow Documentation		To document what IBNP entries are and what the current process is (involves cross-functional departments and external consultant.	To eventually be able to transition process back to internal GCHP resources from external consultant.
13. Finance Policies and Procedures Manual Development		To review and update existing Finance Policies and Procedures and identify new areas that might need to be documented and consolidate into a Manual	To ensure that we have current documentation of important Finance procedures to support compliance to GAAP, etc.
14. Pre-Close Cross Functional IBNP Meeting		To implement a pre-close cross functional IBNP meeting which would include Finance, Claims, PNO, External Consultants, etc. that can provide updates on claims issues/projects, contracting changes, etc. that could impact or taken into consideration when developing monthly IBNP reserves	Important to financials to create the best possible estimates for medical claims not yet received.

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Appendix

Internal Controls to be Addressed in 2021			
Internal Control Issue	**Root Cause**	**Resolution**	**Implications/Importance**
Operations			
15. Inefficient/inadequate and manual processes in place for provider contracting, credentialing, and data management	Manual processes established at plan start-up	Implement provider contracting, credentialing, and data management solution (PCCM) for launch in Feb 2021	Increase efficiency, accuracy, and effectiveness of provider contracting, credentialing, and data management functions
16. CCD process			
17. Joint operating committee controls (who should attend, should be agendized)			
18. Encounter controls (receipt of controls and submission to DHCS)			
19. Provider Directory controls			
20. Call center controls (including all call centers for all partners)			
21. Conduent - Reporting of SLAs			
22. APL work			
IT			
23. CASB			
24. SWG			
25. Service Desk	Operational	11/18/2020	Faster, reliable, easy platform for support needs
26. PCCM/eVIPs			
27. ETP			
28. MCPIDIP			
29. Medi-Cal Rx			
30. HMS Claims Recovery			
31. AHP			
32. SSI-SDI			Cost Savings through data mining
33. AB1114			Pharmacists proscribing meds.

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AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Margaret Tatar, Chief Executive Officer

DATE: March 22, 2021

SUBJECT: CEO Report

I. EXTERNAL AFFAIRS:

On March 15, 2021, California's health and human services leaders issued the following joint statement on the Biden Administration's announcement that it will no longer enforce the 2019 public charge final rule.

"Immigrants and their loved ones across California can seek and accept medical care, food assistance and public housing without fear or confusion, thanks to changes in federal policy. They won't be forced to choose between getting help for basic needs and their ability to stay with their families in the United States.

To immigrant families in California, we want you to know that California fought to end this shameful policy and you should continue to use available public services that help you and your family thrive and be healthy. Remember that medical testing, treatment and preventative services for COVID-19, including vaccines, will not be considered for public charge purposes. If you have questions, you can find a list of nonprofit organizations providing legal immigration services on the California Department of Social Services website.

To providers across California administering health and social services programs, thank you! We are grateful for all you do to ensure that everyone has access to basic services. Your efforts further our collective work to build a healthy, vibrant, and inclusive California for All."

For more information on federal changes to the public charge rule click here.

A. Federal:

Federal Budget (as of March 8,2021)	Implications
On March 6, 2021, the Senate passed the American Rescue Plan. The legislative bill will head back to the House of Representatives for a final vote and is expected to be signed by President Biden by March 14, 2021. The bill includes: 1. $1,400 per person checks including additional money for dependents claimed on their most recent tax filings. Income thresholds are now: a. $75,000 for individuals b. $112,500 for head of household. c. $150,000 for couples filing jointly. 2. More money for rural hospitals. 3. Additional funding to expand broadband. 4. Additional funds for FEMA to help the homeless. 5. A slightly revised state and local formula that will help smaller population states and boosts the minimum they will receive. 6. $300 weekly unemployment benefits through Sept. 6, 2021. 7. Provisions Affecting COBRA, ACA Plans a. Help with ACA exchange premiums and subsidies. b. The bill eliminates the "subsidy cliff" that stops subsidies abruptly for people with incomes over 400% of the poverty level. 8. The bill allows for pregnant women eligible for Medicaid because of their pregnancy to extend their eligibility to one year.	No direct implications for GCHP.
The Health Resources & Services Administration (HRSA) has launched a plan to ensure equity in vaccine distribution for FQHCs.	Approximately 1 million vaccines were ordered for FQHCs nationwide. Locally, 11 of Ventura County's 18 FQHCs are providing approximately 2,100 vaccines per week to vulnerable populations.

B. State:

DHCS Actions as of (as of March 8, 2021)	Implications
On Feb. 16, 2021, DHCS released a set of draft Enhanced Care Management (ECM) and In Lieu of Services (ILOS) Requirement Documents for public comment. Comments are due by Friday, March 12, 2021. DHCS released the following documents: 1. DHCS-MCP ECM and ILOS Contract Template 2. ECM and ILOS Standard Provider Terms and Conditions 3. CalAIM ECM and ILOS Model of Care Template 4. ECM and ILOS Coding Guidance	1. GCHP submitted comments regarding the released draft documents on March 12, 2021. 2. GCHP will submit the Model of Care Template (Part I) by July 1, 2021. 3. GCHP will submit the Model of Care Template (Part 2) by Oct. 1, 2021. **4.** GCHP will launch ECM/ILOS program by Jan. 1, 2022.

Key Legislative Bills (as of Feb. 5, 2021)	Implications
AB 4 (Arambula D) Medi-Cal: eligibility. Introduced: Dec. 7, 2020 Status: Jan. 11, 2021-Referred to Committee on Health. Summary: The bill would extend eligibility for full-scope Medi-Cal benefits to anyone who would otherwise qualify if not for their immigration status.	Potential increase in GCHP membership.
AB 265 (Petrie-Norris D) Medi-Cal: reimbursement rates. Introduced: Jan. 15, 2021 Status: Jan. 28, 2021-Referred to Committee on Health. Summary: This bill deletes provisions relating to the 80% standard lowest maximum allowance established by the federal Medicare Program standard.	Currently analyzing potential impact to GCHP.

Key Legislative Bills (as of Feb. 5, 2021)	Implications
AB 383 (Salas D) Mental health: older adults. Introduced: Feb. 2, 2021 Status: Feb. 12, 2021-Referred to committees on Aging & L.T.C. and Health. Summary: Would establish within DHCS an Older Adult Mental Health Services Administrator to oversee mental health services for older adults.	No implications for GCHP.
AB 1131 (Wood D) Health information exchange. Introduced: Feb. 18, 2021 Status: Feb. 18, 2021-Read first time. To print. Summary: Would require, by Jan. 1, 2023, health plans, hospitals, medical groups, testing laboratories, and nursing facilities, to contribute to, access, exchange, and make available data through the network of health information exchanges for every person, as a condition of participation in a state health program, including Medi-Cal, Covered California, and CalPERS. The bill would expand the use of clinical and administrative data to build on implementing a statewide health information exchange.	No implications for GCHP.
AB 1178 (Irwin D) Medi-Cal: serious mental illness: drugs. Introduced: Feb. 18, 2021 Status: Feb. 18, 2021-Read first time. To print. Summary: This bill would delete the prior authorization requirement for any drug prescribed for the treatment of a serious mental illness, as defined, for a period of 365 days after the initial prescription has been dispensed for a person over 18 years of age who is not under the transition jurisdiction of the juvenile court.	No implications for GCHP.
SB 17 Office of Racial Equity. Introduced: Dec. 7, 2020 Status: Feb. 25, 2021 From committee with author's amendments. Read second time and amended. Re-referred to Committee on RLS. Summary: This bill would establish an Office of Racial Equity, an independent public governed by a Racial Equity Advisory and Accountability Council.	No implications for GCHP.
SB 56 (Durazo D) Medi-Cal: eligibility. Introduced: Dec. 7, 2020 Status: Feb. 17, 2021-Set for hearing March 10. Summary: Effective July 1, 2022, this bill would extend eligibility for full-scope Medi-Cal benefits to individuals who are 65 years of age or older and who are otherwise eligible for those benefits except for their immigration status.	Potential increase in GCHP membership.

C. Community Relations – Building Community Newsletter

GCHP's Building Community newsletter highlights the contributions GCHP makes in the community, member services, and any legislative updates that impact Medi-Cal. Planning has started for the April issue of the newsletter. The Gold News Council, a multi-functional team that shares good news stories from the various departments within GCHP, recently met to identify topics for the newsletter. Click here to read the most recent issue of Building Community.

D. Provider Relations – COVID-19 Provider Outreach

The Network Operations team continues to reach out to providers twice a week by phone and email to determine any pandemic-related closures or impacts to member access. During the period of Feb. 1-28, 2021, long-term care and skilled nursing facilities reported increases in bed availability.

II. Provider Network Operations:

A. Membership

	VCMC	CLINICAS	CMH	PCP-OTHER	DIGNITY	ADMIN MEMBERS	NOT ASSIGNED	KAISER
Feb-21	83,624	41,478	31,284	5,138	5,944	15,606	4,051	6,249
Jan-21	83,016	41,247	31,110	5,128	5,841	14,941	4,363	6,156
Dec-20	83,467	41,215	31,321	5,137	5,837	13,166	3,477	6,098

Notes:

1. The 2020 Admin Member numbers will differ from the member numbers below as both reports represent a snapshot of eligibility.
2. Unassigned members are those who have not been assigned a PCP and have 30 days to choose one. If a member does not choose a PCP, GCHP will assign a PCP to the member.

Administrative Member Details

Category	March 2021
Total Administrative Members	40,715
Share of Cost	1,709
Long Term Care	758
BCCTP	81
Hospice (REST-SVS)	131
Out of Area (Not in Ventura)	626
Other Health Care	
DUALS (A, AB, ABD, AD, B, BD)	25,118
Commercial OHI (Removing Medicare, Medicare Retro Billing and Null)	14,965

Note:
Total in boxes will not add up to distinct count that corresponds to the total Administrative Members, as members can be represented in multiple boxes. For example, a member can be both Share of Cost and live Out of Area. They are counted in both of those boxes.

Methodology

For this report, Administrative Members were identified as anyone with active coverage with the benefit code ADM01. Additional criteria were as follows:

1. Share of Cost (SOC-AMT) > zeros
    a. AID Code is not 6G, 0P, 0R, 0E, 0U, H5, T1, T3, R1 or 5L

2. LTC members identified by AID codes 13, 23, and 63.
3. BCCTP members identified by AID codes 0M, 0N, 0P, and 0W.
4. Hospice members identified by the flag (REST-SVS) with values of 900, 901, 910, 911, 920, 921, 930, or 931.
5. Out of Area members were identified by the following zip codes:
    a. Ventura Zip Codes include: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93000-12, 93015-16, 93020-24, 93030-36, 93040-44, 93060-66, 93094, 93099, 93225, 93252
    b. If no residential address, the mailing address for this determination
6. Other commercial insurance was identified by a current record of commercial insurance for the member.

B. Provider Contracting Update:

GCHP works with providers through:

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

From February 1-28, 2021, the following contracting actions were taken:

Contract Agreements - Total: 1		
Provider	**Specialty**	**Action Taken**
Miguel Salazar MD	Cardiology	Provider's Simi Valley location fills a specialty gap in the east county.
Contract Amendments - Total: 7		
Provider	**Specialty**	**Action Taken**
Joel M Corwin MD a Proof dba Miramar Eye Specialist Med Grp, Interim LOA	Ophthalmology	Amendment to update an additional servicing location for the two ophthalmologists that are currently servicing members while pending credentialing.

Provider	Specialty	Action Taken
Ventura Advanced Surgical Associates	Surgery	Amendments to remove one terminated physician from the group's Interim LOA.
Planned Parenthood California Central Coast	Sensitive Services	Amendment to add additional physicians that are currently pending credentialing for over 120 days due to COVID 19.
Chilton and Leste Management Inc dba Tender Loving Care Home Hospice	Hospice	Amendment to complete name change.
Ventura Orthopedic Medical Group Inc.	Orthopedics	Amendment to add one therapist to group's Interim LOA.
Central Coast Center for Gynecology Oncology	Gynecology Oncology	Amendment to add one physician while pending credentialing.
Stefany Wolfsohn, MD	Anesthesiology	Amendment to update servicing location.
Interim Letters of Agreement (LOA) – Total: 1		
Provider	**Specialty**	**Action Taken**
San Joaquin Valley Pulmonary	Pediatric Pulmonary and Nephrology	Interim LOA in place to meet the DHCS Alternative Access.
Letters of Agreement – Total: 8		
Provider	**Specialty**	**Action Taken**
McClay Health Center	Long Term Care	LOA for member who is a long-term care resident at the facility. LOA is to increase to skilled level 2 to include speech therapy to increase the member's diet.
LA Center for Oral and Maxillofacial Surgery	Oral Maxillofacial Surgeon	LOA for member that is inpatient at Cedar's who requires oral maxillofacial surgery with an out-of-network physician.
Accredo Health	Home Infusion	Home infusion therapy and nursing visits.
Daavlin Phototherapeutic Products	DME	NBUVB photo therapy unit for home (UV light therapy system in 6-foot cabinet that includes bulbs, lamps, timer, and eye protection).

Provider	Specialty	Action Taken
Arise Congregate Living Inc.	Congregate Living Facility	Homeless member unable to care for self and unable to find placement at contracted facility due to past SNF history of leaving previous facilities.
Arise Congregate Living Inc.	Arise Congregate Living Inc.	Member suffering from traumatic brain injury that needs IV antibiotics to treat brain abscess. Patient is not accepted at local SNFs because of prior history.
Arise Congregate Living Inc.	Congregate Living Facility	Extension of previous LOA for member that requires IV antibiotics to treat brain abscess.
Conejo Valley Health Care	Congregate Living Facility	Extension of previous LOA for LTC care.

Network Operations Department Projects

Project	Status
BetterDoctor: BetterDoctor is a product that performs outreach to providers to gather and update provider demographic information. This is an ongoing initiative.	Network Operations continues to meet weekly with Quest Analytics. In Feb. 2021, the team verified demographic information from BetterDoctor: 1. 2,003 provider records were reviewed 2. 20 contracting records were reviewed 3. 890 provider records were audited
Provider Contracting and Credentialing Management System (PCCM): Referred to as eVIPs, this software will allow consolidation of contracting, credentialing and provider information management activities. The project is scheduled to be implemented by the 2nd Quarter of 2021.	The Network Operations team is working on the following processes: 1. Desk-level Procedures 2. Dynamic Import Utility (DIU) - Roster Import Training 3. Data Corrections / Maintenance 4. eApply Overview 5. eSearch Overview 6. Reporting requirements review and revisions

Provider Additions: Feb. 2021 – 46 Total

Provider Type	In-Area Providers	Out-of-Area Providers
Midlevel	3	4
PCP	0	0
Specialist	11	25
Specialist-Hospitalist	1	2
Total	15	31

Provider Terminations: Feb. 2021 – 27 Total

Provider Type	In-Area Providers	Out-of-Area Providers
Midlevel	2	1
PCP	0	0
Specialist	4	17
Specialist-Hospitalist	3	0
Total	9	18

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

C. Compliance

GCHP is contractually required to perform oversight of all functions delegated through subcontracting arrangements. Oversight includes, but is not limited to:

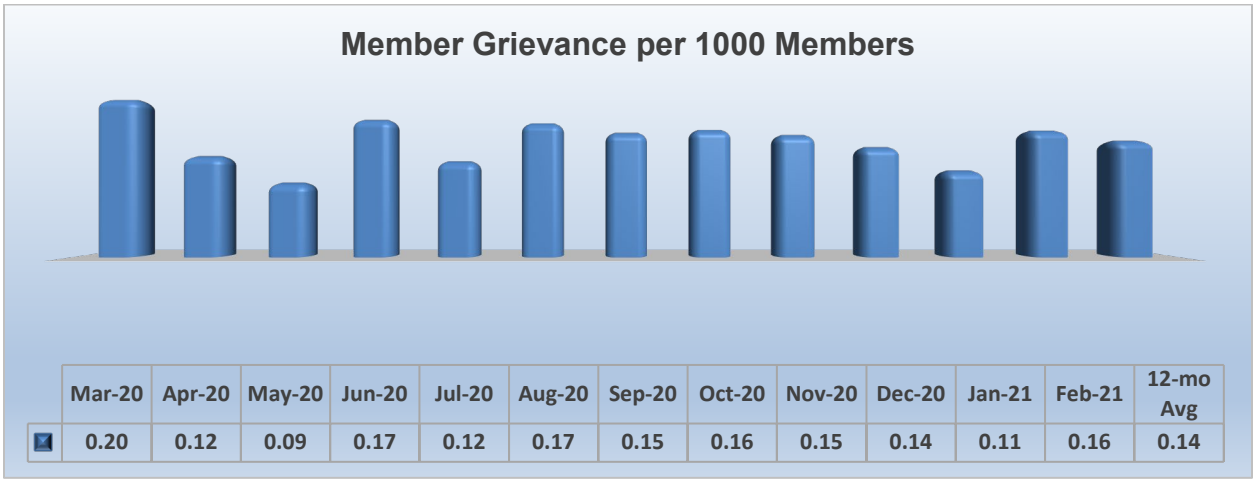
1. Monitoring / reviewing routine submissions from subcontractors.
2. Conducting onsite / desk review audits.
3. Issuing a Corrective Action Plan (CAP) when deficiencies are identified.

The Compliance audit table includes open Delegation Oversight Audits. Closed audits are removed after being reported to the Commission. The table reflects activity from Feb. 1-28, 2021.

Delegate	Audit Year/Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Conduent	2017 Annual Claims Audit	Open	Dec. 28, 2017		Issue will not be resolved until new claims platform conversion.
VSP	2019 Annual Claims Audit	Open	Oct. 29, 2019	Under CAP	CAP issued Nov. 10, 2020. Pending discussion with Claims Department.
VSP	2020 Annual Claims Audit	Open	Nov. 20, 2020	Under CAP	
Beacon	2020 Call Center Audit	Open	Sept. 1, 2020	Under CAP	
Beacon	2020 Annual Claims Audit	Open	April 21, 2020	Under Cap	
Beacon	2021 Quarterly UM Audit	Closed	Jan. 25, 2021	Jan. 26, 2021	CAP closed during audit
CDCR	2021 Quarterly UM Audit	Closed	NA	NA	Completed on Jan. 29, 2021. No findings.
CDCR	2020 Claims Audit	Closed	Dec. 18, 2020	02/08/21	
Conduent	2020 Call Center Audit	Open	Dec. 7, 2020	Pending	
VCMC	2021 Annual Credentialing Recredentialing Audit	Open	Pending	Pending	Audit Completed, CAP Issue TBD
CMHS	2021 Annual Credentialing Recredentialing Audit	Open	Pending	Pending	Audit Completed, CAP Issue TBD

Delegate	Audit Year/Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
CDCR	2021 Annual Credentialing Recredentialing Audit	Open	N/A	N/A	Desktop Audit in Process
USC	2021 Annual Credentialing Recredentialing Audit	Open	NA	NA	Audit Scheduled

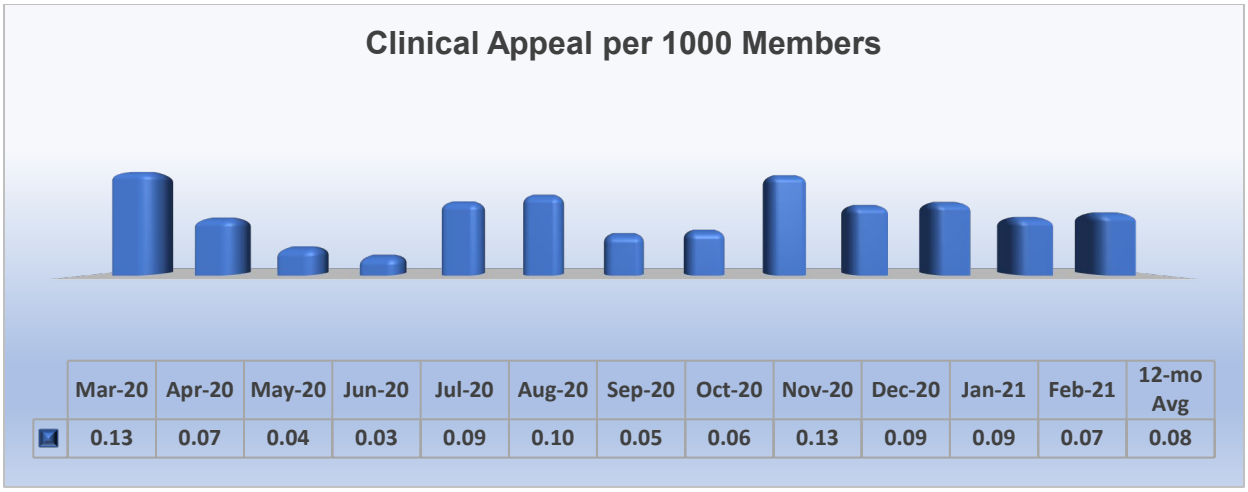
Grievance and Appeals



Member Grievances per 1,000 Members

The data shows GCHP's volume of grievances is low in comparison to the number of members enrolled with the plan. The 12-month average of enrollees is 204,817 with an average annual grievance rate of .14 grievances per 1,000 members.

In Feb. 2021, there were 34 member grievances. The top reason was "Quality of Care" due to a delay in care.



Clinical Appeals per 1,000 Members
The data comparison volume is based on the 12-month average of .08 appeals per 1,000 members.

In Feb. 2021, GCHP received 16 clinical appeals:

1. Seven were overturned
2. Six were upheld
3. Two are still in review
4. One has been withdrawn

D. Special Projects

Project Name / Description	Status	Risks	Mitigation Steps
Enterprise Transformation (ETP): The Enterprise Transformation Project (ETP) is a full replacement of the IKA core claims system with HSP Meditrac. The system is scheduled to go-live May 1, 2021.	1. UAT testing completion by March 3, 2021. 2. End-to-end testing beginning. 3. On schedule for go-live.	1. Authorizations matching capabilities for claims payment. 2. Conduent system not aligned with industry standards.	1. Regular Management calls. 2. Daily conference call line for any questions. 3. Conduent agreed to enhance system to align with industry standards. 4. Amendment in process to reflect changes.

Project Name / Description	Status	Risks	Mitigation Steps
GCHP/Americas Health Plan, Plan-to-Plan Implementation	1. Member materials submitted to DHCS in Dec. 2020. 2. Provider Directory submitted to DHCS on March 5, 2021 3. Member mailing ready to drop upon DHCS approvals. 4. Pre-delegation audits 65% complete.		1. Daily huddles in place between GCHP and AHP.

RECOMMENDATION:

Receive and file

AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, Chief Medical Officer

DATE: March 22, 2021

SUBJECT: Chief Medical Officer Update

Cost of Homelessness in Ventura County

A 2020 report prepared by Social Finance, a nonprofit organization dedicated to developing outcomes-based financing strategies, highlights costs associated with high utilizers of homeless services, the criminal justice system, and health services in Ventura County. The report reveals how individuals experiencing homeless engaged with County services, the cost of these services over two fiscal years (2017-18), and which services were predominantly engaged. The report focuses on the top 25% of the highest utilizers with persistent homelessness identified through the County's Homeless Management Information System ("HMIS").

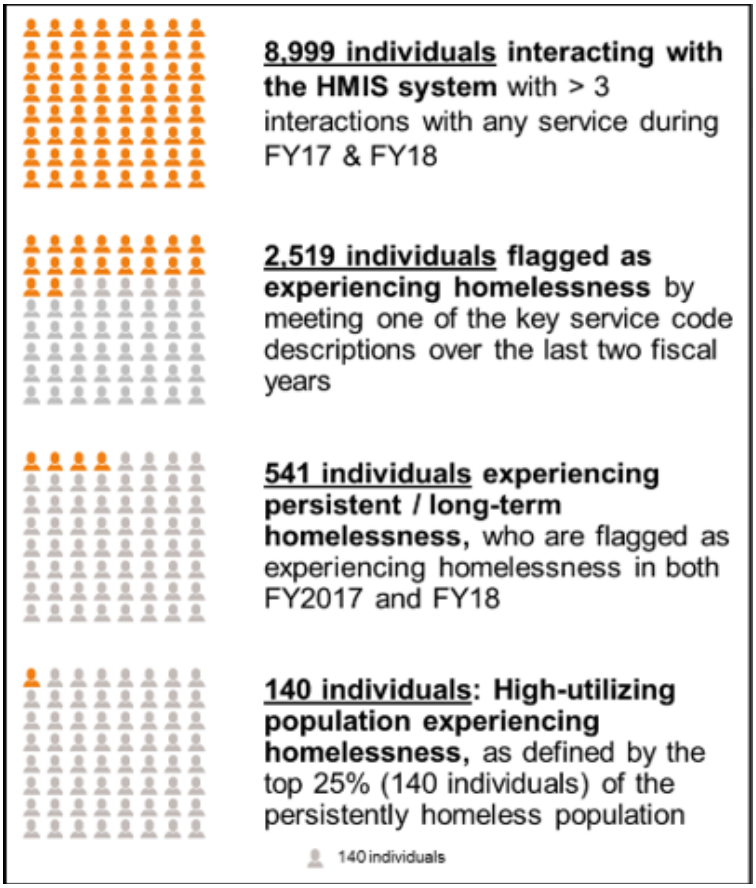
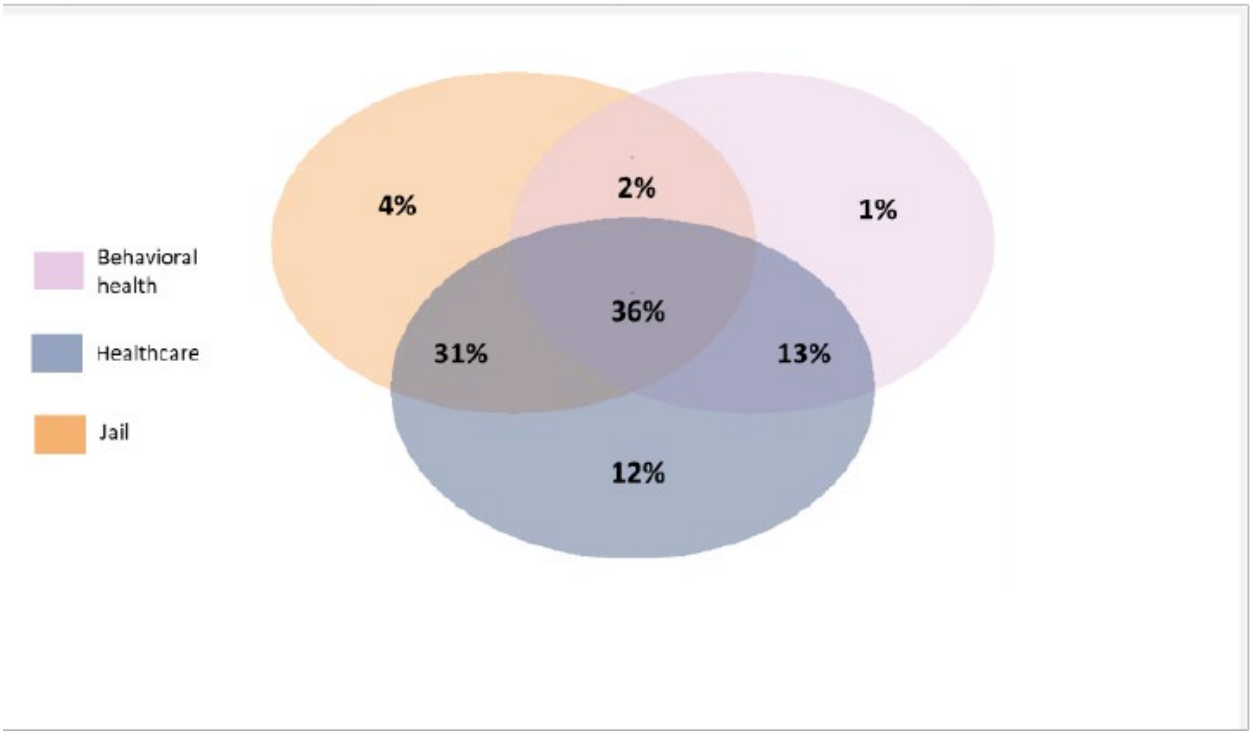


Figure 7: Overlap between systems use for high utilizers



Highlights from the report include the following:

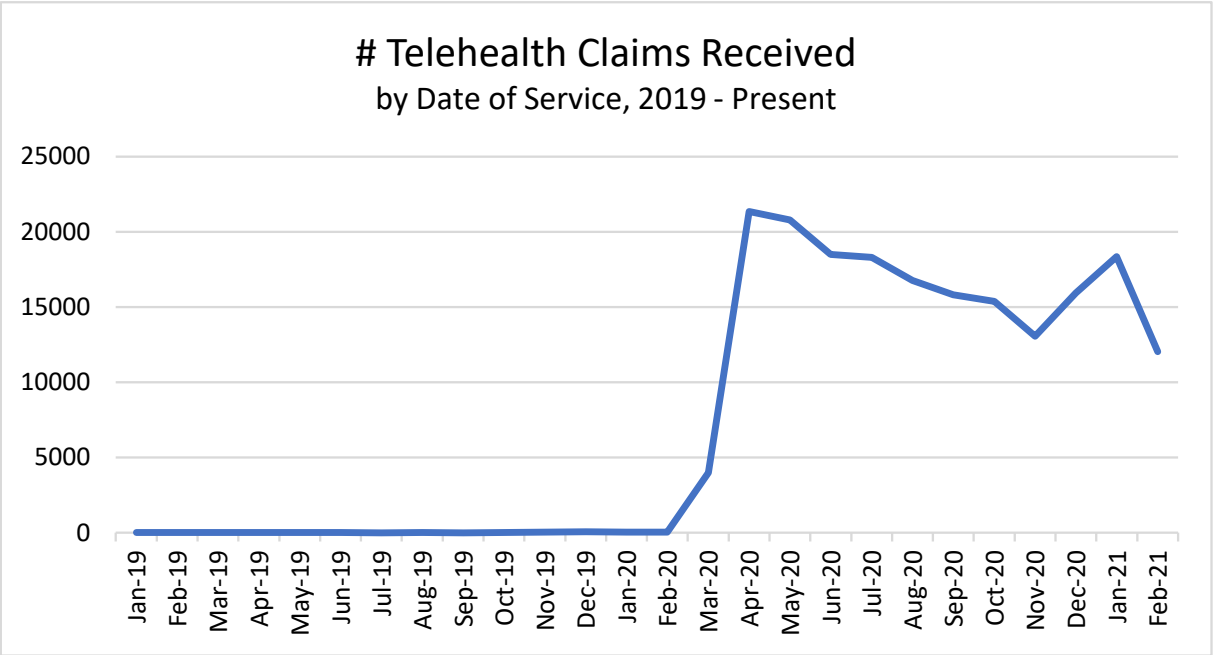
- The top 140 highest utilizers cost $5 – 8 million/year. Over 75% of expenditures were medical, behavioral health and jail costs. Nearly all used medical services, about half used behavioral health services and almost 70% were incarcerated.
- The highest utilizers are more likely to be involved with multiple service systems. Of the top 140 highest utilizers, 83% interacted with more than one service.
- The report concludes that combining Permanent Supportive Housing ("PSH") and supportive services with Intensive Case Management ("ICM") is an evidence-based approach to reduced costs of healthcare and other services and improve outcomes.

The full report can be accessed at: socialfinanceprojects.org/ventura

Utilization Update

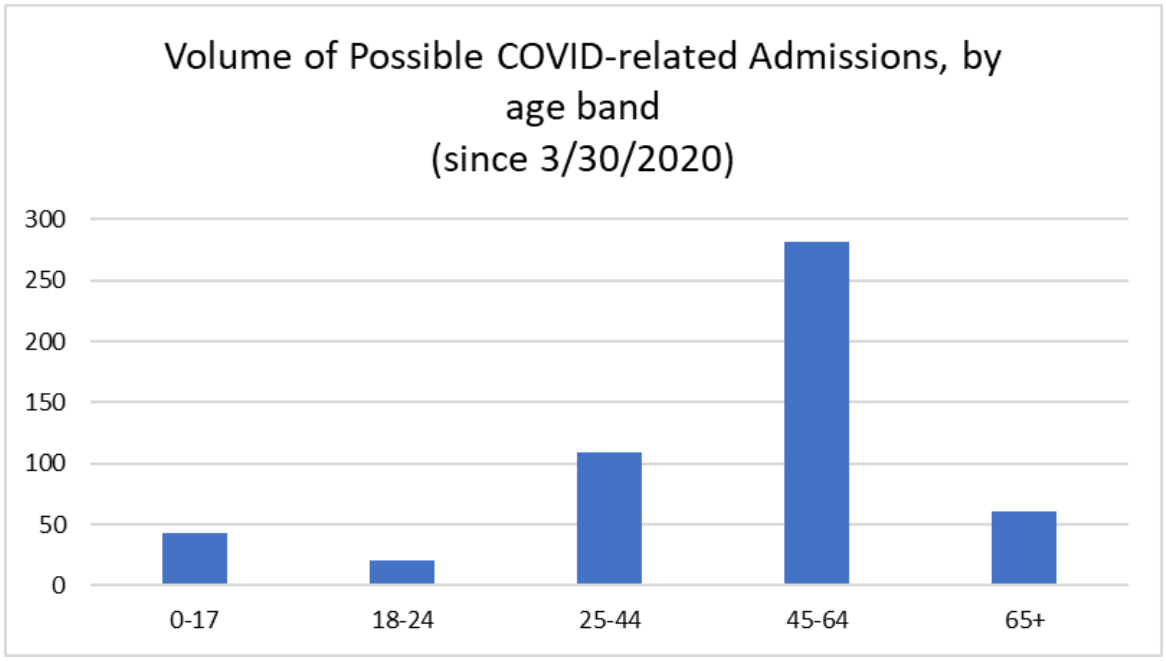
Telemedicine

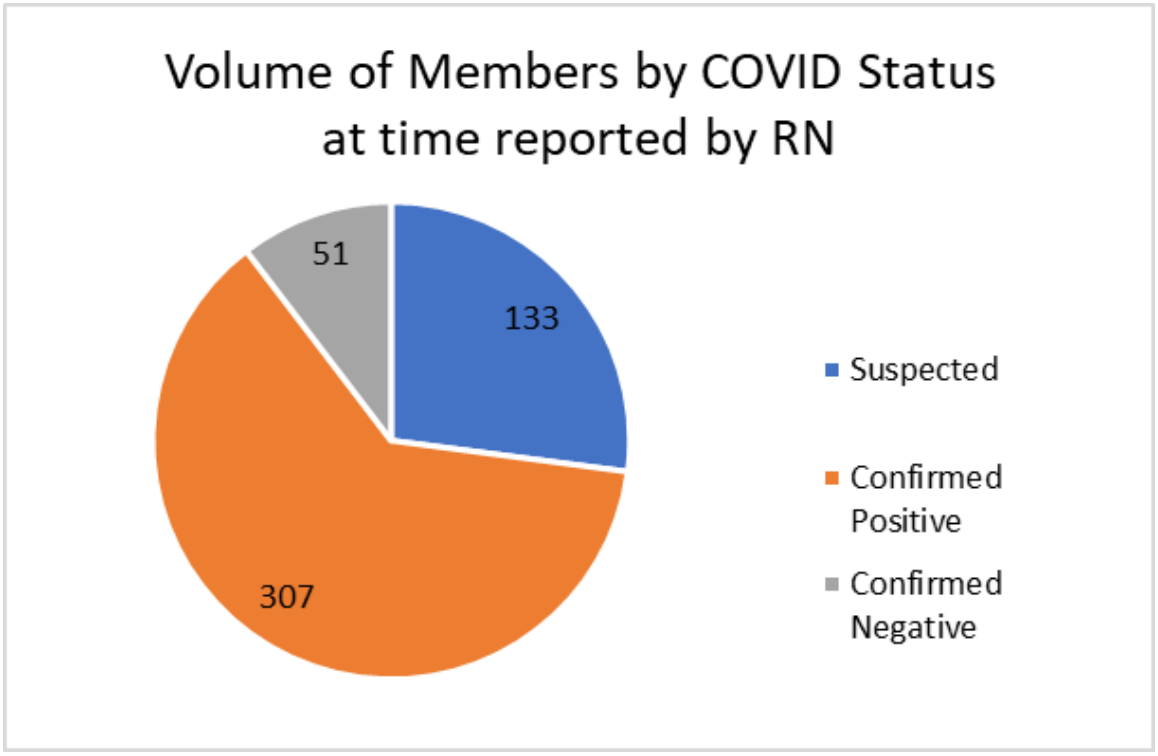
Telemedicine continues to be an essential tool for health care delivery during the pandemic. Telemedicine utilization for CY 2020 was 377 times greater than CY 2019! GCHP will continue to work with DHCS to support standardized and consistent reporting across all MCPs.

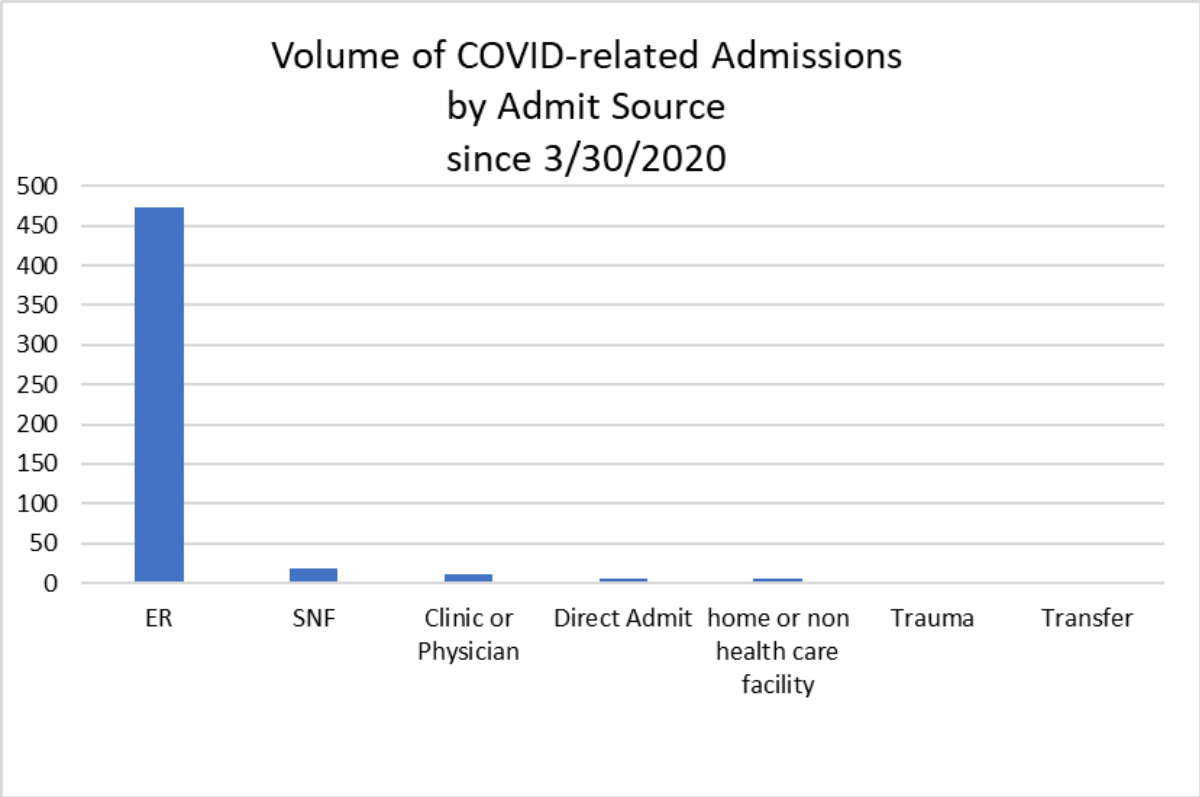


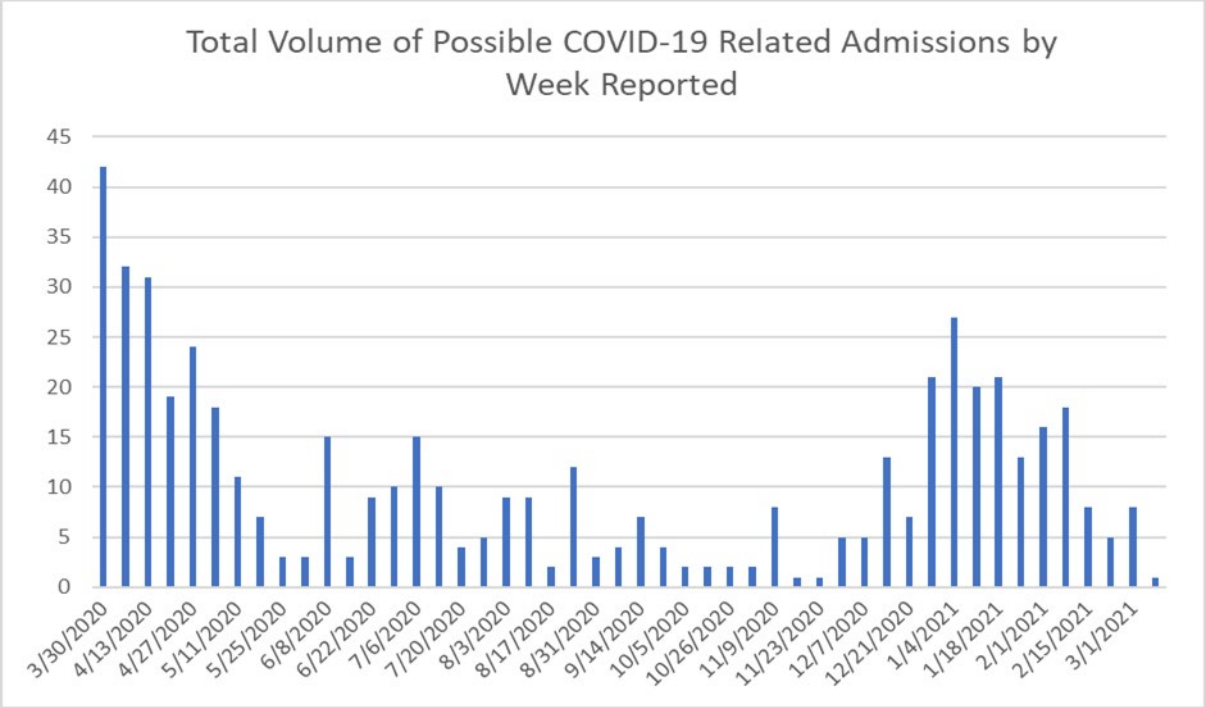
COVID-19 Related Admissions

As of March 8, 2021, Gold Coast Health Plan ("GCHP") staff have reported 516 COVID-19 related admissions to the Department of Health Care Services ("DHCS"). Most admissions continue to be for members in the 45-64 year old age group followed by the 25-44 year old age group. While final status of nearly one third of admissions is pending, about 60% all admissions were confirmed positive for COVID-19 and about 10% were confirmed negative. Most admissions continue to come through the Emergency Department and the volume of admissions has generally been decreasing since a peak in early January 2021.


Volume of Possible COVID-related Admissions, by age band
(since 3/30/2020)
300
250
200
150
100
50
0
0-17
18-24
25-44
45-64
65+

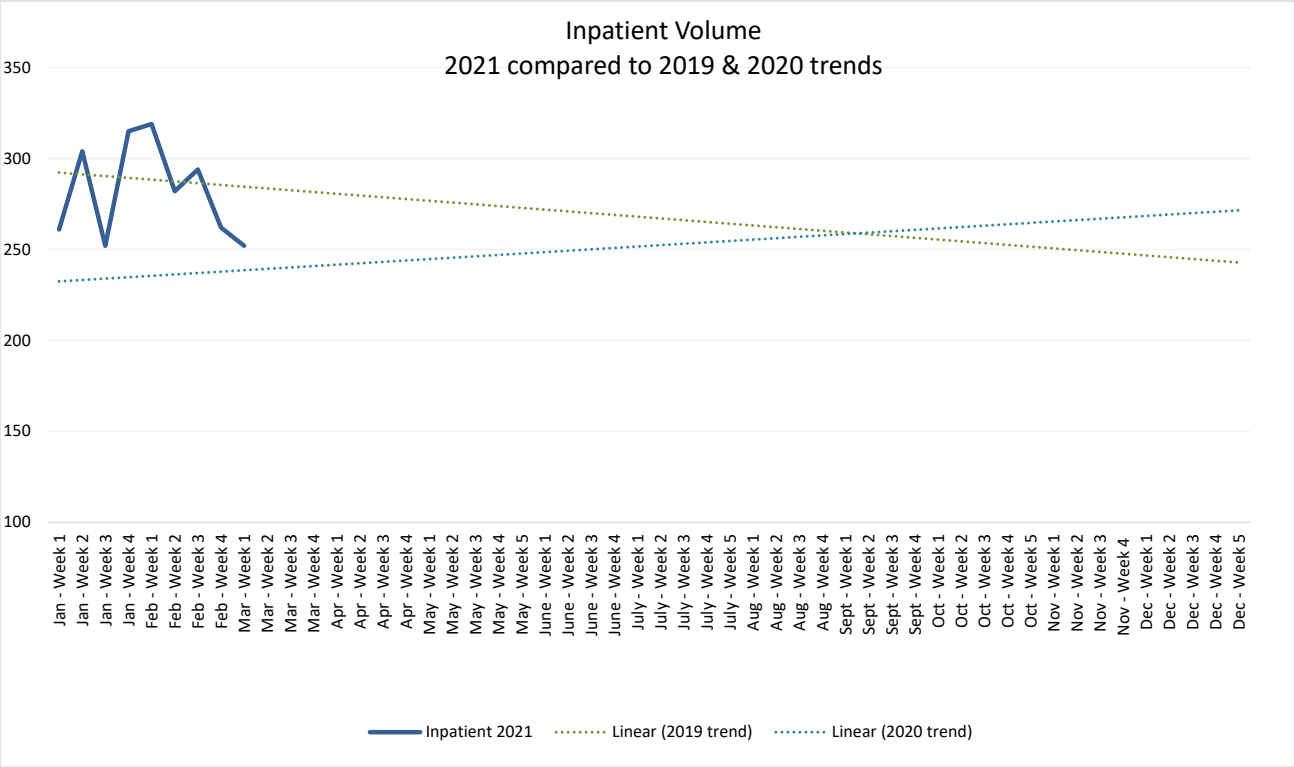

Volume of Members by COVID Status at time reported by RN
51
133
307
Suspected
Confirmed Positive
Confirmed Negative

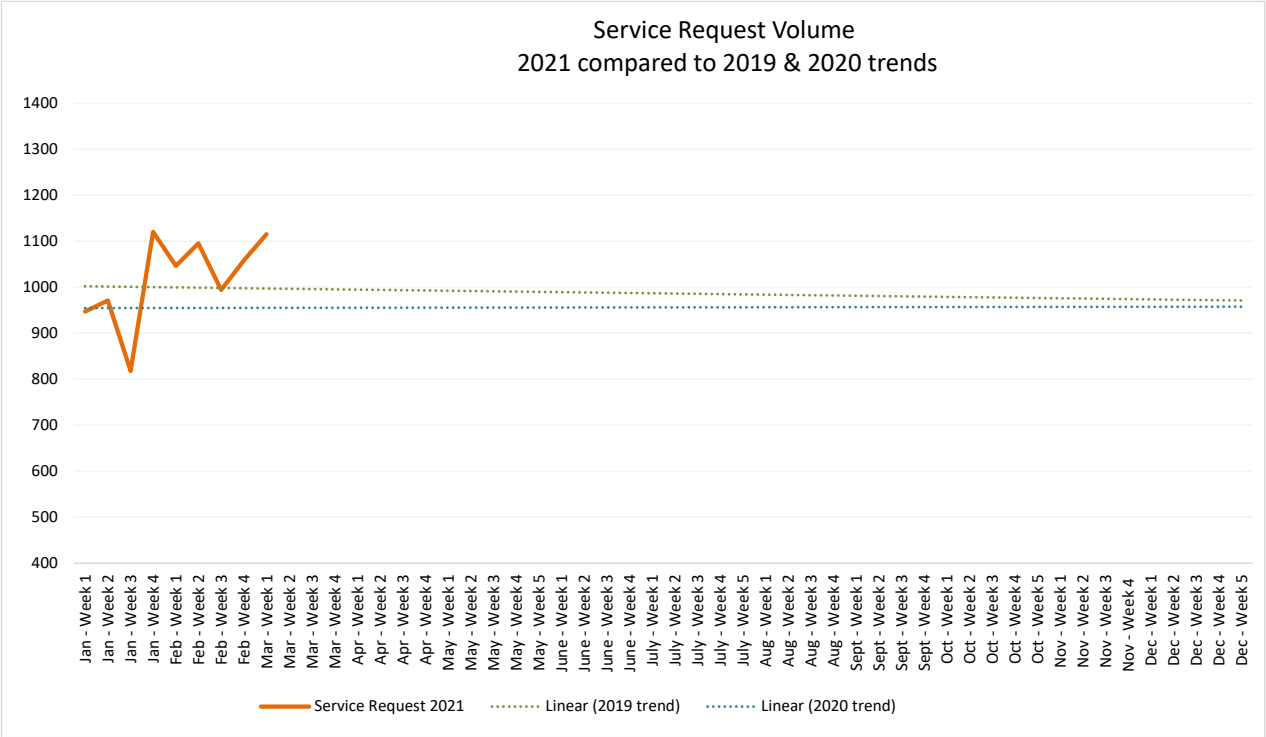

Volume of COVID-related Admissions
by Admit Source
since 3/30/2020
500
450
400
350
300
250
200
150
100
50
0
ER
SNF
Clinic or Physician
Direct Admit
home or non health care facility
Trauma
Transfer


Total Volume of Possible COVID-19 Related Admissions by Week Reported
45
40
35
30
25
20
15
10
5
0
3/30/2020
4/13/2020
4/27/2020
5/11/2020
5/25/2020
6/8/2020
6/22/2020
7/6/2020
7/20/2020
8/3/2020
8/17/2020
8/31/2020
9/14/2020
10/5/2020
10/26/2020
11/9/2020
11/23/2020
12/7/2020
12/21/2020
1/4/2021
1/18/2021
2/1/2021
2/15/2021
3/1/2021

Service Requests

Inpatient service requests for the first nine weeks of 2021 are similar to 2019 trends. Inpatient requests for Q1 CY2020 were lower than normal due to COVID-19. Outpatient service requests are similar to Q1 trends for CY2019 and CY2020.



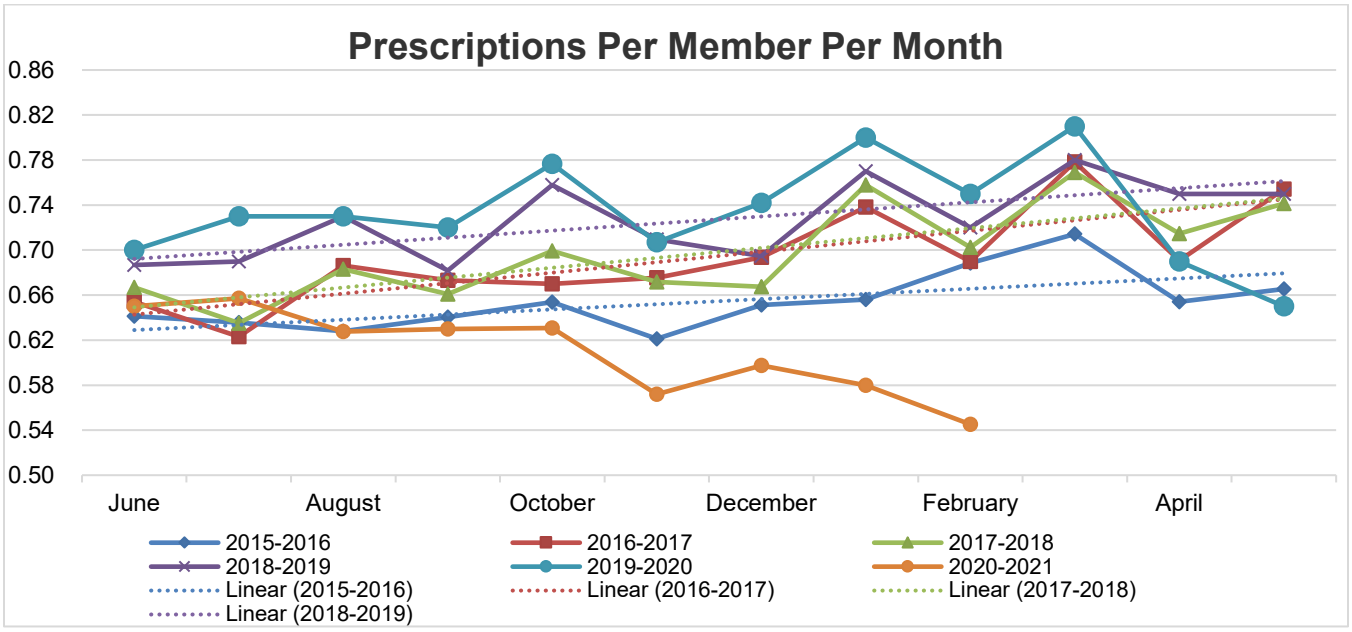


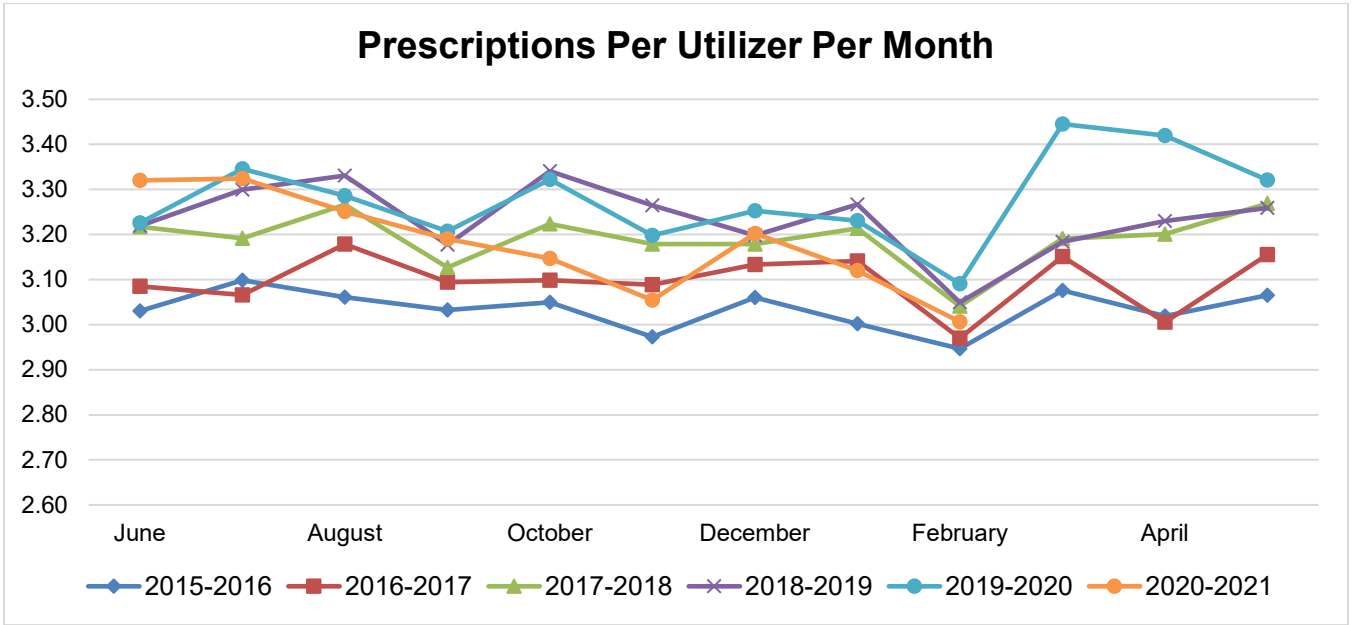
Pharmacy Benefit Cost Trends

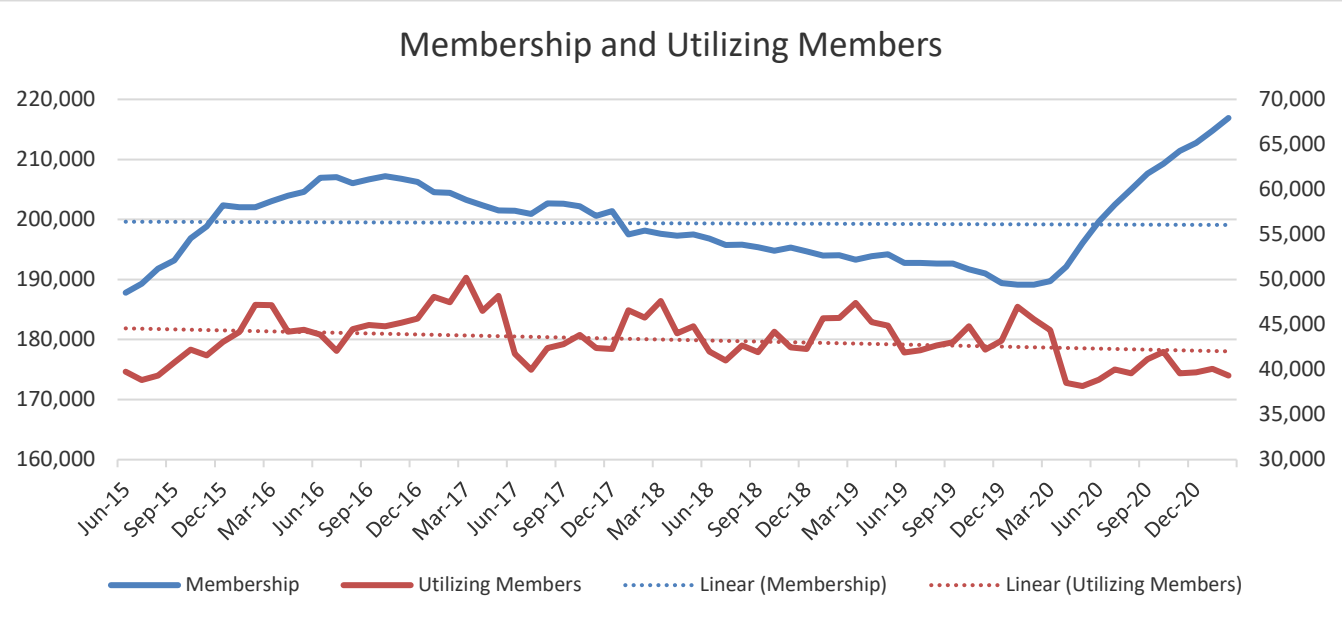
Gold Coast Health Plan's (GCHP) pharmacy trend shows in overall price increase of 15% from February 2020 to February 2021; this is a significant increase but is driven by increased membership and benefit changes made due to COVID-19. When looking at the per member per month costs (PMPM), the PMPM has decreased approximately 19% since its peak in March 2020. Pharmacy trend is impacted by unit cost increases, utilization, and the drug mix. Pharmacy costs are predicted to experience double digit increases (>10%) each year from now until 2025. GCHP's trends are in-line with state and national data that is also experiencing significant increases in pharmacy costs. Impact from COVID-19 is expected to increased costs further.

GCHP Annual Trend Data

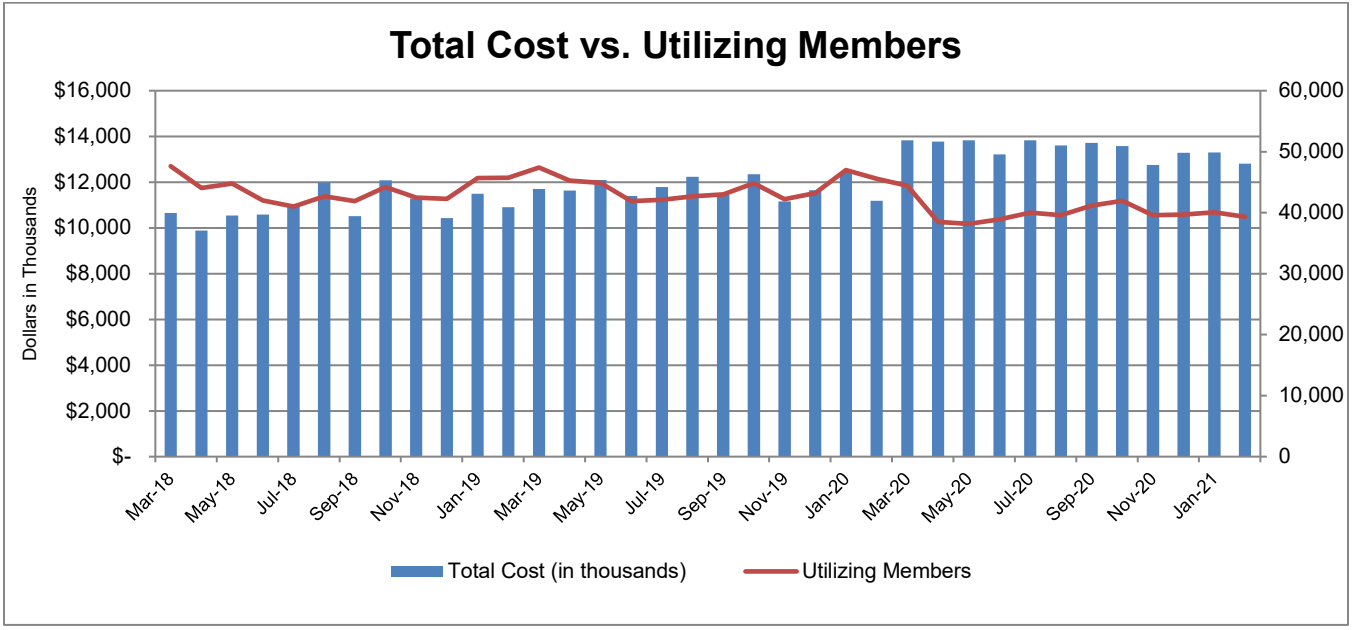
Utilization Trends:
Through March 2020, GCHP's utilization was increasing as demonstrated by the number of members using prescriptions and the number of prescriptions each member is using while GCHP's total membership continued to decline. However, the impact of COVID-19 has caused an increase in membership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

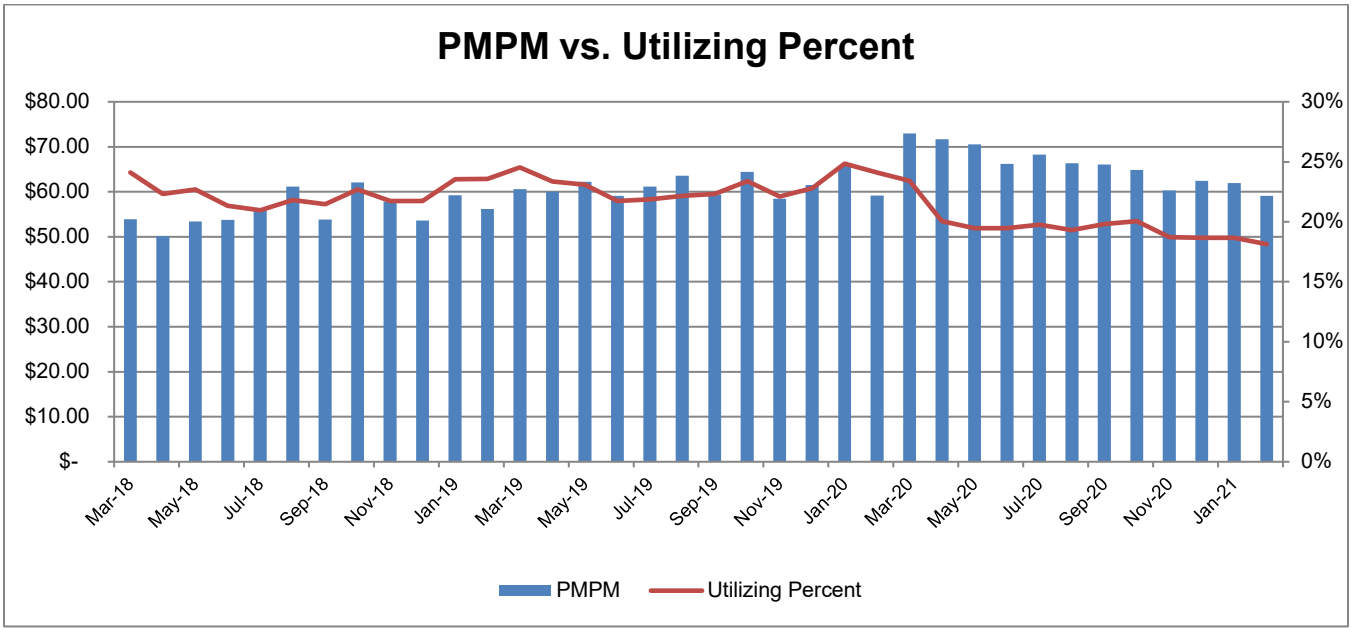

Prescriptions Per Member Per Month
0.86
0.82
0.78
0.74
0.70
0.66
0.62
0.58
0.54
0.50
June
August
October
December
February
April
2015-2016
2016-2017
2017-2018
2018-2019
2019-2020
2020-2021
Linear (2015-2016)
Linear (2016-2017)
Linear (2017-2018)
Linear (2018-2019)

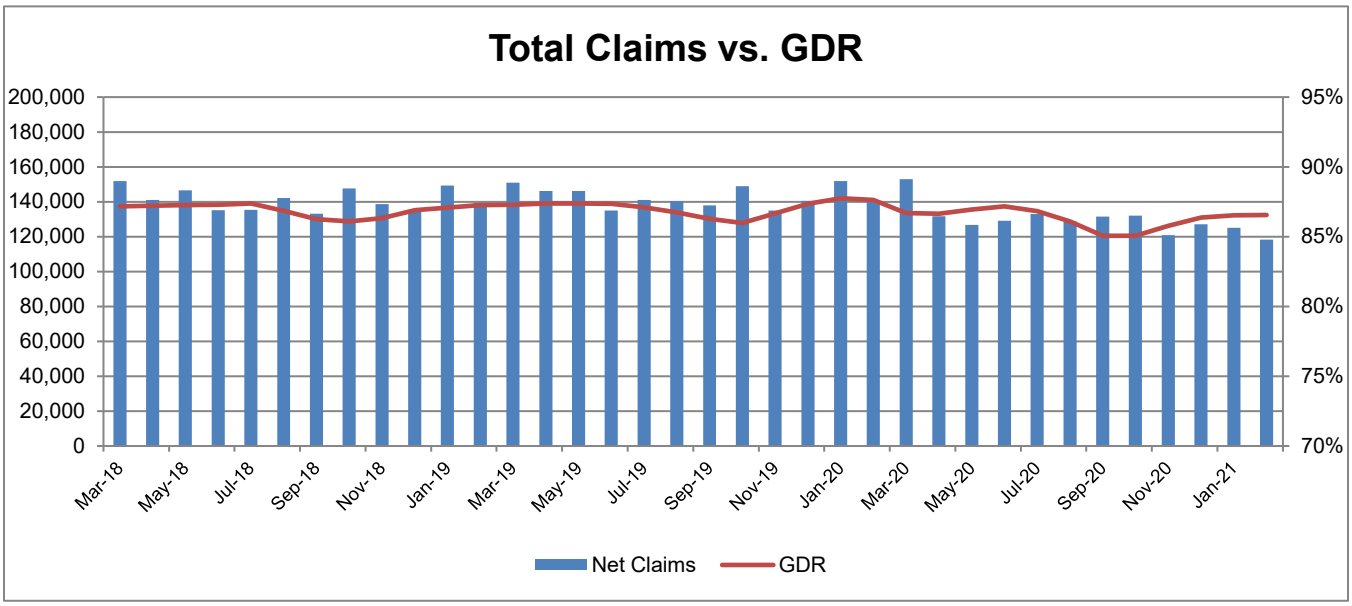

Prescriptions Per Utilizer Per Month
3.50
3.40
3.30
3.20
3.10
3.00
2.90
2.80
2.70
2.60
June
August
October
December
February
April
2015-2016
2016-2017
2017-2018
2018-2019
2019-2020
2020-2021



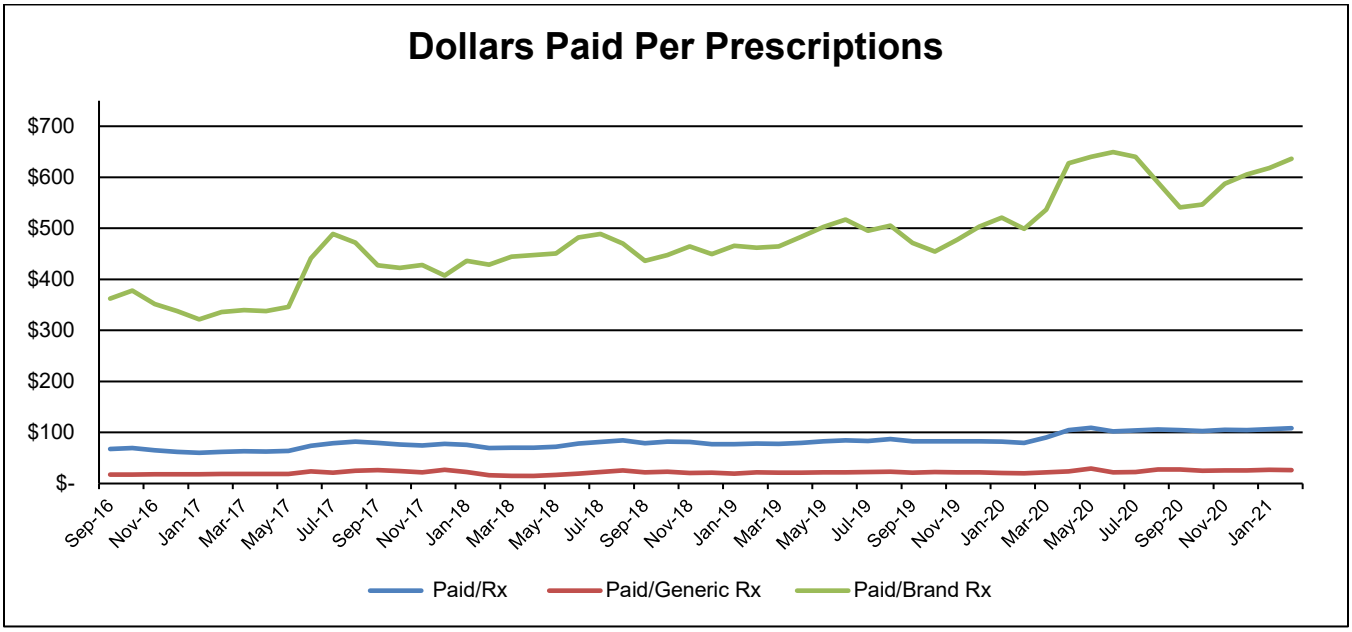
Pharmacy Monthly Cost Trends:





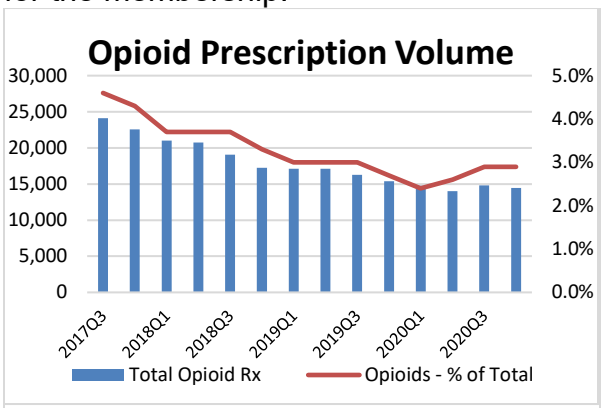


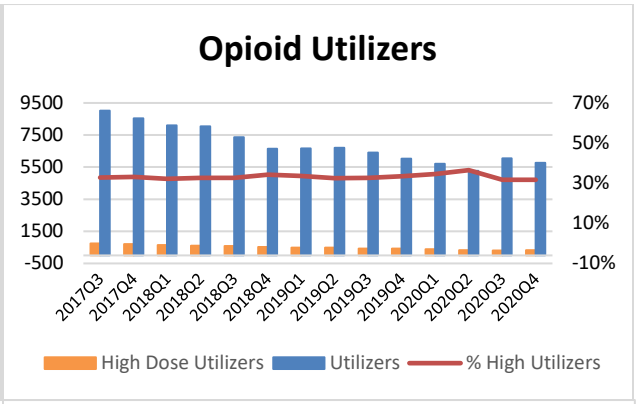
*Claim totals prior to June 2017 are adjusted to reflect net claims.

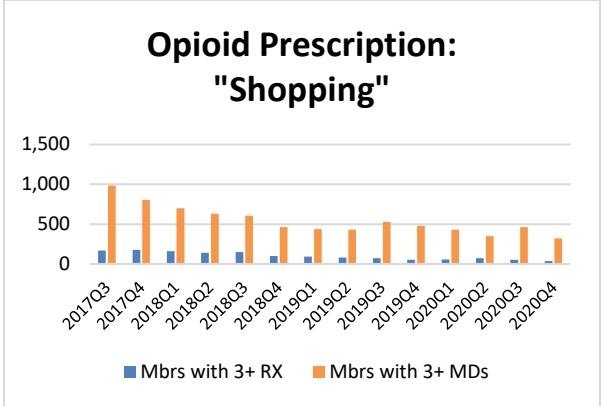


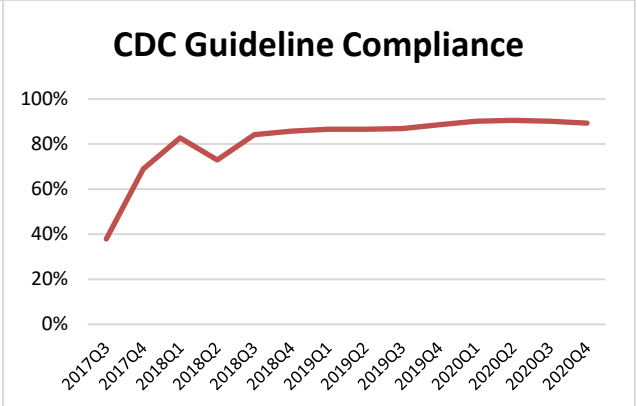
Pharmacy Opioid Utilization Statistics

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









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

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

Pharmacy utilization data is compiled from multiple sources including the pharmacy benefits manager (PBM) monthly reports, GCHP's ASO operational membership counts, and invoice data. The data shown is through the end of September 2020. The data has been pulled during the first two weeks of September which increases the likelihood of adjustments. Minor changes, of up to 10% of the script counts, may occur to the data going forward due to the potential of claim reversals, claim adjustments from audits, and/or member reimbursement requests.

References:
1. https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/?_sf_s=drug+spending#item-contribution-to-growth-in-drug-spending-by-growth-driver_2017
2. https://arstechnica.com/science/2019/07/big-pharma-raising-drug-prices-even-more-in-2019-3400-hikes-as-high-as-879/
3. US Food and Drug Administration. "2018 New Drug Therapy Approvals."
4. https://www.fiercepharma.com/marketing/another-record-year-for-pharma-tv-ads-spending-tops-3-7-billion-2018
5. https://www.kff.org/medicaid/issue-brief/utilization-and-spending-trends-in-medicaid-outpatient-prescription-drugs/

AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Interim Chief Diversity Officer

DATE: March 22, 2021

SUBJECT: Interim Chief Diversity Officer Update

Actions:

1. Community Relations

- Keynote speaker for the African American Youth Leadership Awards Fundraiser. This event sponsors Black and Brown college tours to key minority universities across the country helping to prepare graduating high school students for college life.

2. Case Investigations

- No new cases submitted during the month of March.

3. Diversity Activities

- Meetings with Phin Xaypangna, Deputy Executive Officer Diversity and Inclusion for Ventura County. Discussions centered around defining the Health Equity initiative.

- Met with Roxanne Alaniz of Alaniz Marketing in San Francisco related to Health Equity initiatives in the Bay area.

- Presented a draft presentation to CEO Margaret Tatar on my views regarding my Health Equity findings. Moving forward with a team consisting of a person from the county, community, medical, community relations and communications within Gold Coast.

- Met with the Diversity Inclusion and Values team with a focus on adopting a local school who may need assistance and reviewing all policies and practices to ensure that there is no discriminatory language used against any group within GCHP.

Other Activities

- Weekly meetings with HR to keep abreast of issues that have potential of becoming external problems.

AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Michael Murguia, Executive Director of Human Resources

DATE: March 22, 2021

SUBJECT: Human Resources Report

Human Resources Activities

We have launched our Compensation and Benefits Study with an estimated completion date of May 1, 2021

On March 18, 2021 we held a "Return to Work" meeting as an executive team. Our focus in this meeting was to identify "When" we can return to work in our physical location. Our priority will be our employee's safety and ensuring we have an appropriate return to work plan. We have previously committed to our employees that they will receive 90 days' notice prior to being asked to return to our work location. This is a very complex issue as we realize there may be a "New Reality" for our employees as we have been operating very effectively during the last year as a 100% remote Health Plan.

In our future meetings we will be discussing "How, What and Why" as we craft our Return to Work Strategy. This will also drive updates to our Remote Work Policies and Out of State Work Policies. Our primary focus will to be to continue to provide a high level of service to our members while also ensuring a safe and healthy work environment for our employees. We will review all recommendations with this Commission for final approval before implementation.

We have had two resignations, no terminations, and no new cases since our last update on February 22, 2021

Facilities / Office Updates

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

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