

Ventura County Medi-Cal Managed Care Commission (VCMCC) dba Gold Coast Health Plan Commission Meeting

DATE: Monday, September 26, 2011

TIME: 3:00-5:00 pm

PLACE: 2240 E. Gonzales Road, Suite 200, Oxnard CA 93036

AGENDA

Call to Order, Welcome and Roll Call

Public Comment / Correspondence

1. **Approve Minutes**
 - a. Meeting of July 25, 2011 *Action Required*
 - b. Meeting of August 22, 2011 *Action Required*
2. **Accept and File Management Update** *For Information*
3. **Accept and File Financial Report** *For Information*
4. **Management Recommendations & Reports**
 - a. Phase II Media Buy *Action Required*
 - b. Commission Bylaws *Action Required*
 - c. Co-Payment Policy *Action Required*
 - d. PCP Auto-Assignment & Self-Selection Audits *For Discussion*

Comments from Commissioners

Adjourn to Closed Session

CLOSED SESSION: GC § 54957 - CEO Performance Evaluation

Return to Open Meeting / Adjournment

Meeting agenda available at <http://www.goldcoasthealthplan.org>

**Ventura County Medi-Cal Managed Care Commission
(VCOMMCC) dba Gold Coast Health Plan (GCHP)
Commission Meeting Minutes
July 25, 2011**

(Not official until approved)

CALL TO ORDER

Chair Dial called the meeting to order at 3:01 p.m. in Suite 200 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE

Maylee Berry, Medi-Cal Beneficiary Advocate

Anil Chawla, MD, Clinicas del Camino Real, Inc.

Lanyard Dial, MD, Ventura County Medical Association

Laurie Eberst, RN, Private Hospitals / Healthcare System

John Fankhauser, MD, Ventura County Medical Center Executive Committee

Robert Gonzalez, MD, Ventura County Health Care Agency

Rick Jarvis, Private Hospitals / Healthcare System

Roberto S. Juarez, Clinicas del Camino Real, Inc.

Kathy Long, Ventura County Board of Supervisors

Catherine Rodriguez, Ventura County Medical Health System

EXCUSED / ABSENT COMMISSIONERS

David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program

STAFF IN ATTENDANCE

Earl Greenia, CEO

Tin Kin Lee, Legal Counsel

Traci R. McGinley, Clerk of the Board

Charlie Cho, MD, Chief Medical Officer

Andre Galvan, Project Management Specialist

Lupe Gonzalez, Health Educator

Darlane Johnsen, Chief Financial Officer

Steven Lalich, Communications Director

Candice Limousin, Human Resources Director

Audra Lucas, Administrative Assistant

Aimee Sziklai, Operations Director

Paul Roberts, Provider Relations and Contracting Director

Language Interpreting and Translating services provided by GCHP from Lourdes González Campbell of Lourdes González Campbell and Associates.

PUBLIC COMMENT / CORRESPONDENCE

David Cruz, HELA President, stated that callers to his radio show have posed questions regarding the Primary Care Physician "PCP" selection process. He requested an audit of the process.

Christiania Velasco, Clinicas del Camino Real, Inc., CFO, expressed her concern, up to 60% of Clinicas' patients are not on their provider roster and are receiving complaints from patients regarding auto assignment. She requested information on how the auto assignments were made, and an audit of the process.

Debbie Zelaya, Mini Pharmacy, Los Angeles, voiced her concern that they have lost patients since GCHP began operations in Ventura County and 2,000 or more can no longer receive services from her Pharmacy. She expressed disappointment that ScriptCare will not consider offering a contract until November.

1. APPROVAL OF MINUTES – JUNE 27, 2011

Traci R. McGinley, Clerk of the Board, noted that the minutes will be corrected to reflect Commissioner Eberst as being present; and that the motion for 4.c. will be changed from Commissioner Long to Eberst. Commissioner Juarez moved to approve the June 27, 2011 minutes with the corrections as noted, Commissioner Gonzalez seconded. The motion carried. **Approved 10-0.**

2. ACCEPT AND FILE MANAGEMENT UPDATE

CEO Greenia reviewed highlights from his written report and emphasized the successful kickoff celebration event held on July 19th. GCHP staff recently attended the DHCS meeting for Managed Care Plans in Sacramento where they discussed Medi-Cal budget reductions and the proposed use of co-pays due to State budget cuts. He noted that GCHP staff is developing a process to audit the auto-assignment and self-selection processes.

3. ACCEPT AND FILE FINANCIAL REPORT

CFO Johnsen reported that the year-end report will be submitted to the Executive / Finance Committee at the August 10th meeting. The line-of-credit agreement with Rabobank will be executed soon.

4. MANAGEMENT RECOMMENDATIONS

a. Commission Bylaws

Counsel Lee advised the Commission that proposed bylaws amendments must be submitted to the Commission at least two weeks prior to the vote on the proposed amendment.

The parameters and definitions of Safety-Net were discussed, but no agreement was reached for an amendment.

Concern was raised regarding the Executive / Finance Committee's authority (Article IV, Section (b), Standing Committees, Executive / Finance Committee). The defined areas of authority adopted June 28, 2010 were compared to the recommended changes. It was also recommended that a quorum of the Executive / Finance Committee consist of three (3) members, not four (4) as presented by Counsel.

It was recommended that Article VI, Conduct of Meetings, be amended to reflect that abstention is acceptable except when it would cause a tie vote.

In response to a question regarding the Chair voting, Counsel Lee advised the Commission that Roberts Rules of Order specifically allows a Chair to vote in Boards comprised of less than 13 members.

Counsel Lee will amend the items as discussed to be considered at a future meeting.

b. Co-Payment Policy

CEO Greenia stated that he anticipates that the Centers for Medicare and Medicaid Services (CMS) will approve the State's request to reduce provider payment rates by ten percent (10%) and the imposition of beneficiary co-payments. The State has announced that it will allow fee-for-service Providers to collect co-payments from beneficiaries. For managed care, the State is allowing the Plans the discretion to determine their policy.

CEO Greenia highlighted the position of other COHS models and stated that plans would have 60 days to implement changes once approved by CMS.

Discussion was held regarding the amount co-pays should be for each service, caps on hospitalization fees and prescription fees for chronic patients.

It was noted that it would not be necessary to amend our contracts with providers because there is blanket language regarding changes in law or regulation; however, GCHP would send notification regarding any changes.

Management will provide further information concerning co-pays at a future meeting.

c. Conflict of Interest

Commissioner Juarez expressed concern with Counsel's opinion regarding various conflict of interest issues and requested an opinion from a different attorney.

Counsel Lee suggested that it should be from an attorney that specializes in "Conflict of Interest" and cautioned that such a review would be time-intensive and the cost could be significant. He emphasized that each situation could require clarification.

Commissioner Juarez moved that Management seek an outside review of the four opinions of Counsel. Commissioner Chawla seconded. Commissioners Gonzalez, Chawla, Eberst and Juarez voted in favor of the motion; Commissioners Berry, Dial, Fankhauser, Jarvis, Long and Rodriguez voted against. The motion **failed 4-6**.

d. Auto-Assignment

CEO Greenia reported that the auto-assignment of members that did not select a Primary Care Physician (PCP) was initiated using the 3-to-1 weighting for the safety-net providers as recommended at the first meeting of the Study Group. Of our 100,000+ members, 67,663 are required to select a PCP (the remainder are “administrative” members and do not select a PCP). As of July 8th, 20,344 (30%) selected a PCP, the remainder were auto-assigned.

There have been a few reports that members have sought care from their customary provider and discovered they were auto-assigned to a different provider. When this occurs, they can call Member Services and can immediately change their PCP. The PCP selection forms that have arrived since go-live have been honored (the auto-assignment reversed and the preferred PCP assigned). CEO Greenia reiterated that staff will audit the auto-assignment and self-selection processes, further, ACS will write a narrative description of the auto-assignment process.

COMMENTS FROM COMMISSIONERS

Chair Dial congratulated staff for 25 days of experience as a COHS, as well as for a great Grand Opening Ceremony.

ADJOURNMENT

The meeting adjourned at 4:52 p.m.

**Ventura County Medi-Cal Managed Care Commission
(VCOMMCC) dba Gold Coast Health Plan (GCHP)
Commission Meeting Minutes
August 22, 2011
(Not official until approved)**

CALL TO ORDER

Chair Dial called the meeting to order at 3:13 p.m. in Suite 200 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE

David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
Anil Chawla, MD, Clinicas del Camino Real, Inc.
Lanyard Dial, MD, Ventura County Medical Association
John Fankhauser, MD, Ventura County Medical Center Executive Committee
Robert Gonzalez, MD, Ventura County Health Care Agency
Roberto S. Juarez, Clinicas del Camino Real, Inc.

EXCUSED / ABSENT COMMISSIONERS

Maylee Berry, Medi-Cal Beneficiary Advocate
Laurie Eberst, RN, Private Hospitals / Healthcare System
Rick Jarvis, Private Hospitals / Healthcare System
Kathy Long, Ventura County Board of Supervisors
Catherine Rodriguez, Ventura County Medical Health System

STAFF IN ATTENDANCE

Earl Greenia, CEO
Tin Kin Lee, Legal Counsel
Traci R. McGinley, Clerk of the Board
Brandy Armenta, Quality Improvement Specialist
Charlie Cho, MD, Chief Medical Officer
Sonia DeMarta, Accounting and Finance Manager
Andre Galvan, Project Management Specialist
Guillermo Gonzalez, Government Affairs Director
Lupe Gonzalez, Health Educator
Darlane Johnsen, Chief Financial Officer
Steven Lalich, Communications Director
Candice Limousin, Human Resources Director
Aimee Sziklai, Operations Director
Paul Roberts, Provider Relations and Contracting Director

The Pledge of Allegiance was recited.

Language Interpreting and Translating services provided by GCHP from Lourdes González Campbell of Lourdes González Campbell and Associates.

PUBLIC COMMENT / CORRESPONDENCE

Sandra Reza, from Clinicas del Camino Real, Inc., shared a document and expressed her concern that up to 60% of Clinicas' patients do not show on their provider roster. She added that Clinicas is receiving complaints from patients regarding auto-assignment. She requested information on how the auto assignments were made and an audit of the process.

Chair Dial asked if this document had been presented to GCHP Administration, to which CEO Greenia responded that it had not. Commissioner Juarez asked if GCHP was aware of the issues, to which CEO Greenia responded that they were aware of most of the issues and have responded to Clinicas management as issues were presented.

Mike Lurie, Community Memorial Hospital (CMH) Vice-President of Planning and Managed Care, stated that they operate 9 clinics and have accepted Medi-Cal since inception. He noted that they have still not received capitation payment and noted that in managed care, capitation is typically received up front. Mr. Lurie expressed his belief that GCHP should reimburse for Urgent Care services.

CFO Johnsen responded that GCHP will mail capitation payments within a few days. The August payment will go out the 1st week of September. Chair Dial confirmed that it is GCHP's intention to make payments within a few weeks.

Lisa Powell, Walgreens Nurse, announced that they provide full scope home infusions, and that Walgreens has always accepted Medi-Cal. With the creation of GCHP, Walgreens can send nurses to patients' homes. They have patients with MS and in the past the patient would have to go to a facility for services, but now a nurse can be sent a couple times per week as this takes several hours. She added that she has contacted providers and they are very pleased to hear that Walgreens can provide these services.

Christine Velasco, Clinicas del Camino Real, Inc., CFO, stated that she attended last month's meeting and asked for an audit on the auto-assignment and to date has not heard from CEO Greenia. She added that Clinicas patients are unhappy and are suffering. There are thousands of patients that are not showing up on the Clinicas roster.

Sandra Young, MICOP, thanked GCHP staff for ongoing outreach efforts. She commended GCHP for taking on the issue of health coverage for the migrant workers and doing such a great job. She added that Guillermo Gonzalez had organized a meeting with MICOP, GCHP and the Health Agency. She noted that it was her understanding that there is a proposal to remedy the challenges that occur when migrant workers move from area to area.

The Chair, CEO and Counsel discussed the lack of a quorum. Counsel Lee advised that discussion could be held on items; however no action could be taken.

1. **APPROVAL OF MINUTES – JULY 25, 2011**

No Comments.

2. **ACCEPT AND FILE MANAGEMENT UPDATE**

CEO Greenia highlighted various operational challenges since go-live. Approximately 500-600 PCP change requests have been received; it was anticipated that this would be updated by the end of August. The Call Center lost several Spanish-speaking representatives; ACS is in the process of filling those positions. CEO Greenia confirmed that the first check from the State arrived later than anticipated as it was delivered to the wrong address and therefore delayed payment to providers. Discussion was held regarding the complexity of the Medi-Cal vision coverage, the reimbursement limits, eye glass frames and lenses. CEO Greenia noted that staff is obtaining proposals from different vision plans.

3. **ACCEPT AND FILE FINANCIAL REPORT**

Balance Sheet. CFO Johnsen reported that the line of credit from Rabobank was not utilized because RGS allowed GCHP to delay payment for four months.

Income Statement. CFO Johnsen noted that the Income Statement reflects 8 months as the office was first staffed in November. She added that the postage costs were higher than anticipated as the mailings were expedited.

Cash Flow. The timeline for achieving tangible net equity requirements was discussed.

It was brought to the Commissions attention that the Executive / Finance Committee recommended that management secure bids for a formal, external audit.

4. **MANAGEMENT RECOMMENDATIONS**

a. **Adult Day Health Care Program Elimination**

CEO Greenia noted that there are four (4) major providers in Ventura County that approximately 1,100 GCHP members utilize. The State is looking to the Plans to take over any required services our members are obtaining from these facilities.

b. **Commission Bylaws**

Discussion was deferred.

c. **Co-Payment Policy**

CEO Greenia noted that GCHP will be soliciting information from beneficiaries via the Consumer Advisory Committee.

CFO Cho added that there was a telephone conference with other Plans, Cal-Optima announced its intention to implement a 5% reduction in reimbursement rates beginning January 1, 2012

Should CMS approve this, the State affords the managed care plans to make the decision to allow or disallow providers charging co-pays.

A correction was noted on Page 4c-2 of the Agenda Packet, under the Emergency Room Visits, the Co-Payment should be \$50, not \$5 and the Financial Impact should be \$3,100,150 which affects the **Total Finance Impact** corrected to **\$8,081,577**. The number of occurrences was obtained from the State's historical data.

d. Audit of PCP Auto-Assignment and Self-Selection Processes

CEO Greenia announced that management has initiated a review of PCP of 1,000 beneficiaries (500 auto-assigned and Self-Selection).

COMMENTS FROM COMMISSIONERS

Commissioner Gonzalez noted there have been problems providing payments to providers and hoped that issues will be resolved shortly. With regard to the vision plan, he noted that he would not support any plan that would not include Clinicas.

ADJOURNMENT

The meeting adjourned at 4:22 p.m.



**Chief Executive's Monthly Report to Commission
September 26, 2011**

PEOPLE (Organizational Structure)

- We have added additional talent to our team:
 - Claims Auditor: Emirose Villareyes
 - Compliance Specialist: Brandy Armenta (internal transfer from Quality)
- A formal recruitment process has been initiated to fill the Senior Director of Operations position on a “regular” basis. Our interim incumbent, Aimee Sziklai, is a candidate.
- Recruitment continues for: Sr. Claims Auditor, Sr. Financial Analyst, and QI Manager.
- We initiated office moves to realign space and office allocations given the growth in headcount. We have had preliminary meetings with a lease broker to review available space and properties for future expansion or move.

SERVICE (Member & Provider Satisfaction, Government Affairs)

Community Outreach & Education

- Community outreach, education, marketing and advertising continued in September:
 - Presentation to Medi-Cal beneficiaries and staff from Tri-County GLAD, a subsidiary of the Greater Los Angeles Agency on Deafness.
 - Presentation to parents and staff at the Mira Monte Pre-School.
 - Met with GCHP members residing in the Many Mansions Thousand Oaks and Simi Valley facilities to address questions about the transition to managed care.
 - Met with Ventura County Hematology-Oncology Specialists to answer questions, address and clarify process flows for pharmacy and health services.
- The JVP Group has completed the redesign of our homepage. ACS is in the process of implementing the changes.
- We have finalized our plan for the Phase 2 educational outreach campaign via radio, television and newsprint. This campaign will run for 6 consecutive weeks on 9 radio stations (104.7 KCAQ-FM, 105.5 KFYV-FM, 103.7 KMLA-FM, 95.9 KOCP-FM, 910 KOXR-AM, 1590 KUNX-AM, 102.9 KXLM-FM, 96.7 KLJR-FM, 100.7 KHAY) as well as 5 television networks (TNT, USA, NICK, Galavisión, abc KEYT3). A separate report, requesting Commission approval, is included in this package.

Government Affairs

- Staff attended the quarterly Department of Health Care Services’ “All-Plan CEO Meeting” on August 25. This meeting provides an open forum for the health plans and DHCS to discuss the issue facing Medi-Cal Managed Care.
 - Director Toby Douglas provided an update on the implementation of AB 97 – Medi-Cal 10% provider rate reduction, service caps and copayments. DHCS expects approval of the rate cut within 4 to 6 weeks but sees significant delays

in the approval for the increased cost-sharing. Although DHCS does not have approval in hand, Mr. Douglas emphasized the need for plans to prepare for a retroactive application of the reductions to July 1, 2011.

- The transition of Adult Day Health Care (ADHC) beneficiaries into Medi-Cal Managed Care was also discussed. The ADHC benefit will be eliminated on December 1, 2011. Many ADHC beneficiaries will be automatically enrolled into Managed Care on October 1st in order to allow health plans time to transition members to other services and assess beneficiary health care needs before ADHC is eliminated. DHCS will be holding weekly calls with the health plans in order to monitor progress and work through the wide range of outstanding issues. The COHS plans currently have these members in their health plans and will be receiving data for these members shortly. DHCS hopes the COHSs' experience in advance of the other Medi-Cal Managed Care models will provide a template for other counties and inform plans as to the need and acuity of the population. DHCS remains firmly committed to the managed care model.
- GCHP's Director of Government Affairs met with Ventura County Supervisors or staff to brief them on the pending Adult Day Health Care program changes. Staff continues to participate in conference calls and meetings with the Department of Health Care Services to discuss the elimination of the program.
- On September 19, DHCS sent notice that the Multipurpose Senior Service Program (MSSP) will be not be a viable option to replace services to the ADHC population. DHCS cited long waiting lists and minimum funding availability as reasons for DHCS choosing not to use the MSSP Program. According to staff at the Ventura County MSSP Program, there are currently 40 people on the wait list for the MSSP Program.

Member Services

- Member Services continues to resolve issues from members, providers and vendors via incoming phone calls by answering questions or concerns in a timely manner.
- GCHP had a favorable outcome with its first Fair Hearing case. The Administrative Law Judge noted appropriate due diligence on the part of the Plan. The member agreed with the outcome and better understands the pharmacy benefit.
- Grievances and appeals continue to be addressed; in the next few days, 40 acknowledgment letters and 25 resolution letters will be mailed to members.
- ACS continues to educate and train call center representatives about member issues, such as eligibility and benefits as well as provider issues, such as billing and claims. Recent training reviewed the changes associated with GCHP's agreements with three Monterey County safety net providers that allow migrate seasonal farm workers who are GCHP members traveling from Ventura to Monterey to receive care.
- The Consumer Advisory Committee held its second meeting on September 12th. Ruben Juarez was elected Co-Chair to assist Andre Galvan. The committee discussed co-payments, goals and objectives, and how to better serve the deaf community.
- The PCP second auto-assignment (for new members) occurred on September 15. Going forward, this will occur monthly. In addition, we have sent updated and replacement ID cards as well as for any members requesting a new one.
- The audits of the PCP auto assignment and self-selection processes were completed; a separate report is included in this package.

- The co-payment survey was completed; a separate report is included in this package.

QUALITY (Comprehensive Medical Management)

- The Health Services team continues to develop and refine policies and processes to address the complex needs of our members. Examples of their recent efforts include:
 - Transplant Management: Nurse assigned to identify, assess for medical necessity and continuity of care needs, and coordinate with out-of-network transplant centers to transition members appropriately to in-network transplant centers in coordination with GCHP Associate Medical Director.
 - Bariatric Surgery Management: Nursing staff identifying, assessing for medical necessity and continuity of care needs, and coordinating with out-of-network facilities to transition bariatric surgery members, as appropriate, to in-network facilities in coordination with GCHP Associate Medical Director.
 - Obese Children: Referral process established for identified members to receive medical and nutrition education through Las Islas Family Diabetic Clinic and Mandalay Bay Women & children's Medical Group.
 - Prenatal Care: Collaborating with Ventura County Public Health, Children Health Promotion Services to distribute "New Parent Kits" (in English and Spanish). Kits include a DVD, sensor book for children, and medical guide for new parents. All materials are free and have been approved by the California Department of Public Health.
 - Breastfeeding: Preparing a breastfeeding resource guide for GCHP members.
 - Asthma: Researching other COHS Asthma programs and services.
 - Diabetes Education: Ongoing collaboration to develop a resource guide.
 - Deaf and Hearing Impaired: Reached out to the Braille Institute for the conversion of health education and member materials into braille and/or audio.
 - Cultural and Linguistic services: Work plan being developed; final version will be presented to the Consumer Advisory Committee for review.
- A review of pharmaceutical utilization identified significant expenses for the brand name drug, Nexium. In our first two months of operations: nearly \$200,000 has been spent on this medication. Because there are on several less expensive, yet equally effective alternative drugs on our formulary, the drug will be removed from our formulary effective October 1.
- GCHP is in the early process of exploring the possibility to partner with other organizations to take advantage of "340B pharmaceutical pricing" that could reduce overall drug costs for the Plan. The 340B Drug Pricing Program came about from the enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. Section 340B limits the cost of covered outpatient drugs to certain federal grantees, federally qualified health center look-alikes and qualified hospitals. The general purpose of the 340B Program is to enable eligible entities to establish a pharmacy component to reach more patients, provide more comprehensive services and, thus, improve patient compliance and health outcomes. Drug costs acquired under this program are generally 30% to 50% less than non-340B acquired pharmaceuticals.

ACCESS (Robust Provider Network)

- GCHP has secured agreements with three of five clinic and hospital systems in Monterey and Santa Cruz Counties to provide access to care for GCHP Members who migrate temporarily to these counties for seasonal agricultural work. An agreement is pending with the Monterey County Health Agency which includes six rural health clinics and Natividad Regional Medical Center and Hospital.
- GCHP has initiated contract discussions with the American Indian Health Clinic in Santa Barbara. This clinic sub-contracts with the Indian Health Service (IHS) and provides culturally appropriate health services to approximately 200 Native Americans living in Ventura County.

FINANCE (Optimize Rates, Ensure Long-Term Viability)

- We continue to make improvements in our claims processing system, as well as progress towards systems integration with the Medical Management systems. We expect to complete User Acceptance Testing of the integration by October 1. System enhancements include EDI submission and remittance, continued expansion of configuration and business rules for increased auto-adjudication and ongoing claims processor training to edit and adjust complex claims.
- We are currently reviewing potential vendors to assist in the creation and maintenance of a data warehouse to ensure accurate capture of financial and utilization data to address State-mandated reporting requirements.
- Submitted statutorily-required July financial statements to the State.
- Staff continue to analyze revenue and healthcare costs, and modeling the impact of potential legislative changes (provider rate decrease, co-pays etc.).
- We are in process of preparing first reforecast and anticipate that we will present an updated budget to the Executive-Finance Committee and Commission in October.
- An updated analysis of the impact of proposed co-payments is included in this packet.

Respectfully submitted,

Earl G. Greenia
Chief Executive Officer

**Gold Coast Health Plan
Balance Sheet
Period Ended August 31, 2011**

Total Cash and Cash Equivalents	36,393,452
Medical Receivable	855,663
Accounts Receivable	4,085,303
Total Prepaid Accounts	41,280
Total Other Current Assets	0
Total Current Assets	41,375,699
Total Fixed Assets	84,717
Total Assets	41,460,415
<u>Current Liabilities</u>	
Incurred But Not Reported	22,687,760
Claims Payable	10,558,210
Capitation Payable	582,177
Accounts Payable	124,612
Accrued Expenses	78,068
Accrued Interest Payable	0
Accrued ACS	2,065,521
Accrued RGS	17,772
Accrued Scriptcare	104,295
Accrued CQS	311,158
Accrued Premium Tax	1,179,380
Current Portion Of Long Term Debt	500,000
Current Portion of Deferred Revenue	460,000
Accrued Payroll Expense	377,990
Total Current Liabilities	39,046,943
<u>Long-Term Liabilities</u>	
Other Long-term Liability	416,667
Advance - Long Term Debt	1,763,333
Notes Payable	0
Total Long-Term Liabilities	2,180,000
Total Liabilities	41,226,943
<u>Fund Balance</u>	
Net Income Current Year	4,656,291
Fund Balance Prior Year	(4,422,819)
Ending Fund Balance	233,472
Total Liabilities & Fund Balance	41,460,415

GOLD COAST HEALTH PLAN
Income Statement
For the Month Ending August 31, 2011

	<u>JUL 2011</u>	<u>AUG 2011</u>	<u>YTD</u>
Members	102,033	101,487	203,520
Revenues			
Premium	25,231,919	25,179,158	50,411,077
Interest Income	0	5,816	5,816
Gain/(Loss) on Investment	0	0	0
Grant Income	0	0	0
Miscellaneous Income	38,333	38,333	76,667
Total Revenues	25,270,252	25,223,308	50,493,560
MCO Tax	591,954	587,426	1,179,380
Net Revenue	24,678,298	24,635,882	49,314,180
Cost of Health Care			
<u>Capitation</u>	588,173	582,177	1,170,350
<u>Claims</u>			
Inpatient	10,596,127	10,768,103	21,364,230
Outpatient	2,593,679	2,879,396	5,473,075
Professional	2,160,039	2,190,217	4,350,256
Pharmacy	2,276,259	2,701,995	4,978,254
Reinsurance	92,850	92,353	185,203
Reinsurance Recoveries	0	0	0
Incentives - P4P	0	0	0
Other	2,021,274	1,815,336	3,836,610
<u>Total Claims</u>	<u>19,740,228</u>	<u>20,447,400</u>	<u>40,187,628</u>
Total Cost of Health Care	20,328,400	21,029,577	41,357,978
Administrative Expenses			
Total Salaries Benefits and Compensation	324,060	377,990	702,050
Total Travel and Training	7,618	8,217	15,835
Outside Service - ACS	1,037,190	816,018	1,853,208
Outside Service - CQS	78,125	100,742	178,867
Outside Service - RGS	8,457	9,560	18,017
Outside Service - Scrip Care	149,833	186,407	336,239
Outside Services - Other	1,974	3,740	5,713
Accounting & Actuarial Services	2,725	10,216	12,941
Legal Expense	0	0	0
Insurance	2,959	2,959	5,917
Lease Expense -Office	13,040	13,040	26,080
Consulting Services Expense	3,176	8,749	11,925
Translation Services	1,031	0	1,031
Advertising and Promotion Expense	51,870	5,019	56,889
General Office Expenses	24,664	34,075	58,739
Depreciation Expense & Amortization Exp.	1,461	1,461	2,921
Printing Expense	1,874	0	1,874
Shipping & Postage Expense	22,365	(15,876)	6,489
Interest Exp	3,205	1,970	5,175
Gain/(Loss) on Disposal of Assets	0	0	0
Other/ Miscellaneous Expenses	0	0	0
Total Administrative Expenses	1,735,625	1,564,286	3,299,911
Net Income	2,614,273	2,042,019	4,656,291

GOLD COAST HEALTH PLAN
Statement of Cash Flow
For the Month Ending August 31, 2011

Cash Flow From Operating Activities

Collected Premium	25,179,158
Miscellaneous Income	44,149
<u>Paid Claims</u>	
Inpatient	-10,768,103
Outpatient	-2,879,396
Professional	-2,190,217
Pharmacy	-2,701,995
Capitation	-582,177
All Others FFS	-1,815,336
Reinsured Claims	-92,353
Reinsurance Recoveries	0
Payment of Withhold / Risk Sharing Incentive	0
Paid Administration	-1,564,286
Repay Initial Net Liabilities	33,526,341
MCO Taxes Paid	0
Net Cash Provided by Operating Activities	36,155,785

Net Cash Flow

36,155,785

Cash and Cash Equivalents (Beg. of Period)

237,667

Cash and Cash Equivalents (End of Period)

36,393,452

36,155,785

Adjustment to Reconcile Net Income to Net

Cash Flow

Net (Loss) Income	2,042,019
Depreciation & Amortization	1,461
Decrease/(Increase) in Receivables	20,313,279
Decrease/(Increase) in Prepays & Other Current Assets	5,007
(Decrease)/Increase in Payables	-226,001
(Decrease)/Increase in Borrowings	-160,000
Change in Income Tax Liability	587,426
Changes in Claims and Capitation Payable	3,114,684
Changes in IBNR	10,477,912
	36,155,785
Net Cash Flow from Operating Activities	36,155,785



**Gold Coast
Health Plan**SM
A Public Entity

AGENDA ITEM 4-A

To: Ventura County Medi-Cal Managed Care Commission

From: Earl Greenia, CEO

Date: September 26, 2011

Re: GCHP Educational Outreach

Recommendation: Management requests that the Commission approve the continuation (Phase 2) of GCHP's multi-phased strategic market buy of radio time and newsprint ads with media vendor Gold Coast Broadcasting, LLC. Approval is sought because continued use (if approved) of this vendor would exceed the established \$100,000 threshold.

Background: February, 2011 GCHP reached out to three vendors: Lazer Broadcasting Corporation (Vendor A); Gold Coast Broadcasting, LLC (Vendor B); KMLA-FM La "M" (Vendor C). Vendor A owns and operates 18 Spanish language radio stations in 10 California markets, plus two affiliated stations in Medford, Oregon and Lancaster, California. Vendor B's parent company (Point Broadcasting) owns and operates 20 Spanish and English language radio stations in the California market. Vendor C is independently owned and operates station KMLA, a 6,000 watt Spanish language radio station billed as the voice of the Hispanic Community in Ventura County.

GCHP received proposals from these vendors and after carefully review selected Vendor B. The decision was based on various factors: overall market knowledge, ability to purchase a variety of media (radio, television, newsprint) on behalf of the Plan; ability to reach Spanish and English speaking Members; the added value of a comprehensive newsprint campaign reaching Spanish and English speaking Members via the Ventura County Star and Vida Newspaper. Vendor B's bid was 21.6% less than Vendor A and more comprehensive than Vendor C. Vendor B's ability to leverage our public entity status securing Public Service Announcements (PSA), a 33% added value premium at no extra cost to the Plan.

GCHP instructed Vendor B to purchase time on three Spanish Language Radio Stations owned by Vendor A (KXLM 102.9FM, KLJR 96.7FM, KOXR 910 AM, as well as independently owned Vendor B (KMLA 103.7 FM—in an effort to best serve the Member and to demonstrate a good faith effort to work with alternative vendors in our community.

Proposal: GCHP is prepared to begin Phase 2 of its radio advertising campaign beginning middle to late October. This campaign will run for six consecutive weeks on eight radio stations (104.7 KCAQ-FM, 105.5 KFYV-FM, 103.7 KMLA-FM, 95.9 KOCP-FM, 910 KOXR-AM, 1590 KUNX-AM, 102.9 KXLM-FM, 96.7 KLJR-FM) with each station running thirty 60 second commercials per week for a total of 198 commercials per station and a eight station, six week grand total of 1,584 commercials. In the Metro Area (Oxnard, Camarillo, Ventura, Port Hueneme, Santa Paula, Fillmore, Ojai), this six week schedule will reach 265,500 listeners (ages 12 and above) an average of 14.6 times.

Additionally, we will promote GCHP on “La Hora Mixteca” hosted by Alma Mendoza on KUNX 1590 AM. This weekly Independent radio show will run three times over the six week campaign in one hour segments. The program will showcase Gold Coast Health Plan’s educational efforts to the Mixteca Community by providing a unique platform to present listeners with information on the Plan.

Finally, print ads will be placed three times over the six week campaign in the Ventura County Star and Vida Newspaper.

Financial Impact: The cost of the Phase 2 strategic market buy of radio time is \$46,050. The cost of the newspaper ads is \$3,750. Total cost is \$49,800.

Confidential Attorney Work Product
Attorney-Client Privileged

Exempt from Public Records Act disclosure pursuant to
Gov. Code §6254(k)

DRAFT
8/10/11

AMENDED AND RESTATED BYLAWS FOR THE OPERATION OF THE
VENTURA COUNTY ORGANIZED HEALTH SYSTEM

(dba Gold Coast Health Plan)

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AMENDED AND RESTATED BYLAWS FOR THE OPERATION OF THE VENTURA COUNTY ORGANIZED HEALTH SYSTEM (dba Gold Coast Health Plan)

ARTICLE I

Name and Mission

The name of this Commission shall be the Ventura County Medi-Cal Managed Care Commission, hereafter referred to in these Bylaws as the VCMMCC. VCMMCC shall operate under the fictitious name, Gold Coast Health Plan.

The VCMMCC shall design and operate a program or programs, whose mission is to improve the health of its members through the provision of the best possible quality care and services. This will be accomplished by:

- (a) Delivering medical care via a contracted provider network that will improve access to primary, specialty and ancillary services;
- (b) Establishment of mechanisms to assure that medical care services meet appropriate quality of care standards;
- (c) Incorporating a plan of service delivery and implementing reimbursement mechanisms which promote the long-term viability of a locally operated Medi-Cal managed care system and the existing participating provider networks inclusive of "Safety Net" providers herein defined as Medi-Cal disproportionate share hospitals, county clinics, federally qualified health centers, and licensed rural health clinics, ~~and any other providers designated as such by the VCMMCC;~~
- (d) Implementing a financial plan which includes the creation of a prudent reserve and which provides that if additional surplus funds accrue, they shall be used to expand access, improve benefits and augment provider reimbursement in Ventura County;
- (e) Placing a high priority on prevention, education, early intervention services and case management for enrolled recipients;
- (f) Ensuring that all obligations, statutory, contractual or otherwise, shall be the obligations of the VCMMCC and shall not be the obligations of the County of Ventura or the State of California; and
- (g) Implementing programs and procedures to ensure a high level of member satisfaction.

ARTICLE II

Commissioners

The governing board of the VCMMCC shall consist of eleven (11) voting members (“members” or “Commissioners”) who shall be legal residents of Ventura County. Members shall possess the requisite skills and knowledge necessary to design and operate a publicly managed health care delivery system.

Members of the VCMMCC shall be appointed by a majority vote of the Board of Supervisors and shall consist of the following:

- (a) Physician Representatives. Three members shall be practicing physicians who serve a significant number of Medi-Cal beneficiaries in Ventura County. One shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Association, one shall be selected from a list with a minimum of three (3) nominees submitted by Clinicas Del Camino Real and one shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Center Executive Committee.
- (b) Private Hospital/Healthcare System Representatives. Two members shall be representatives of private hospitals and healthcare systems operating within Ventura County and shall be selected from a list with a minimum of three (3) nominees submitted by the Hospital Association of Southern California. Nominees shall be from different hospitals and healthcare systems. The two appointed members shall not be affiliated with the same hospital or healthcare system.
- (c) Ventura County Medical Center Health System Representative. One member shall be a representative of the Ventura County Medical Center Health System and shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Center administration.
- (d) Public Representative. One member shall be a member of the Board of Supervisors, nominated and selected by the Board of Supervisors.
- (e) Clinicas Del Camino Real Representative. One member shall be the chief executive officer of Clinicas del Camino Real or designee nominated by the Clinicas del Camino Real chief executive officer and approved by the Ventura County Board of Supervisors.
- (f) County Official. One member shall be the Ventura County Health Care Agency Director or designee nominated by the Health Care Agency Director and approved by the Board of Supervisors.
- (g) Consumer Representative. One member shall be a Medi-Cal beneficiary and/or a representative of an advocacy organization that serves the Medi-Cal population and is not otherwise represented on the Ventura County Medi-Cal Managed Care Commission. This member shall be appointed from applications submitted to the Ventura County Executive Office after a posting of public notice for the open position.
- (h) Ventura County Medical Center Health System Representative. One member shall be the Ventura County Medical Center Family Medicine Residency Program Director or Faculty Designee and approved by the Board of Supervisors.

Selection and Terms of Commissioners

In order to stagger terms with the intent of maintaining experienced members, in the initial cycle of appointments, the following appointees shall serve two-year terms: one of the Ventura County Medical Center Health System Representatives, the Physician Representative nominated by the Ventura County Medical Association, the Public Representative, and one Private Hospital/Healthcare System Representative. All other initial appointments and all subsequent appointments to the VCMMCC shall be for four-year terms. No member may serve more than two consecutive four-year terms. Any vacancy will be filled by the Board of Supervisors for the remainder of the unexpired term and shall maintain the balance of representation on the VCMMCC.

A member may resign effective on giving written notice to the Clerk of the VCMMCC, unless the notice specifies a later date for his/her resignation to become effective. Upon receipt of such notice, the Clerk shall notify the Chairperson and the Board of Supervisors. The Clerk of the VCMMCC shall enter the notice in the proceedings of the Commission. The acceptance of a resignation shall not be necessary to make it effective.

A member may be removed from the VCMMCC by a 4/5 vote of the Board of Supervisors.

Nominations to the VCMMCC shall be submitted to the Ventura County Executive Office, which shall be responsible for screening nominees and presenting candidates to the Board of Supervisors.

ARTICLE III

Officers

(a) Officers of the VCMMCC shall be a Chairperson and Vice-Chairperson.

(b) The Chairperson and the Vice-Chairperson shall be elected by majority vote of the members in attendance at the first meeting of the VCMMCC to serve for the remainder of the calendar year in which the first meeting occurs. Officers subsequently elected to these offices, pursuant to the procedures outlined under "Election" below, shall serve a term of two years or until their successor(s) has/have been duly elected.

(c) No individual shall serve more than two consecutive terms in any of the elected officer positions.

Election

(a) During the December meeting in which an officer's term is set to expire, the VCMMCC shall elect officers by majority vote of the members present.

(b) The officers elected at the December meeting will take their respective offices on January 1st of the following year.

(c) Notwithstanding the normal election process detailed in paragraphs (a) and (b) above, when circumstances warrant it, an election may be held at any time during the year. Circumstances that would warrant a special election include: one or more of the officers wishes to resign as an officer, or one or more of the officers is terminated.

Duties

(a) The Chairperson shall:

1. Preside at all meetings;
2. Execute all documents approved by the VCMMCC;
3. Be responsible to see that all actions of the VCMMCC are implemented; and
4. Maintain consultation with the Chief Executive Officer (CEO).

(b) The Vice-Chairperson shall:

1. Exercise all the responsibilities of the Chairperson in the absence of the Chairperson; and
2. In agreement with the Chairperson, perform all responsibilities mutually agreed upon.

ARTICLE IV

Standing Committees

~~(a) At a minimum, the VCMMCC shall establish two (2) committees/advisory boards, one member/consumer based and one provider based. [COHS-VCMMCC](#) staff will be responsible to gather a list of potential appointments and make recommendations to the VCMMCC for membership on these boards. Each of the boards shall submit a charter to the VCMMCC for approval.~~

~~(b) [Executive/Finance Committee](#). [The Executive/Finance Committee shall be a standing committee of the VCMMCC, which shall support the governing board in the performance of its duties and responsibilities between regularly scheduled governing board meetings, and to implement the policy decisions of the governing board. Except for the power to amend the Bylaws, the Executive/Finance Committee shall have all of the powers and authority of the governing board in the intervals between meetings of the governing board, subject to the direction and control of the governing board.](#)~~

~~**[Confirm:]** [The Executive/Finance Committee shall be comprised of no more than five \(5\) Commissioners, and shall include the Chairperson and Vice Chairperson who shall serve in the same positions on the Executive/Finance Committee. The remaining members shall be appointed by the governing board, and as needed from time to time to fill any vacancy. Unless](#)~~

~~removed by the governing board, each member of the Executive/Finance Committee may serve for as long as he or she is a Commissioner. A quorum of the Committee will consist of four (4) members.~~

~~(e)(a)~~ All meetings of standing committees shall be subject to the provisions of the Brown Act.

(b) Executive/Finance Committee.

i. Purpose. The role of the Executive/Finance committee shall be to assist the CEO and VCMMCC accomplish its work in the most efficient and timely way. Meetings of this committee shall be at the request of the Chairperson or CEO to evaluate time sensitive matters. The Committee shall report all action taken by it to the governing board at its next regular meeting succeeding the taking of such action.

ii. Membership. The Executive/Finance Committee shall be comprised of the following five (5) Commissioners:

1. Chairperson

2. Vice-Chairperson

3. Private hospital/healthcare system representative (to rotate between the two representatives following the representative's resignation from the committee)

4. Ventura County Medical Center Health System representative

5. Clinicas Del Camino Real representative

The CEO and Finance Director will serve as Ex-Officio members to Co-Chair the committee.

iii. Duties of the Executive/Finance Committee.

1. Advise the governing board Chairperson on requested matters.

2. Assist the CEO in the planning or presentation of items for governing board consideration.

3. Assist the CEO or VCMMCC staff in the initial review of draft policy statements requiring governing board approval.

4. Assist the CEO in the ongoing monitoring of economic performance by focusing on budgets for pre-operational and operational periods.

5. Review proposed State contracts and rates, once actuary has reviewed and made recommendations.
6. Review proposed contracts for services over the assigned dollar value/limit of the CEO.
7. Establish basic tenets for payment-provider class and levels as related to Medi-Cal rates:
 - o PCP
 - o Specialists
 - o Hospitals
 - o LTC
 - o Ancillary Providers
8. Recommend auto-assignment policies for beneficiaries who do not select a Primary Care Provider.
9. Review and recommend provider incentive program structure.
10. Review investment strategy and make recommendations.
11. Evaluate CEO performance and bring forth to full governing board for action.
12. Serve as Interview Committee for CEO/CMO/CFO.
13. Serve as the Nominating Committee for the purpose of confirmation of candidates for Chairperson and Vice Chairperson of the VCOMMCC.
14. Assist the governing board and/or the CEO in determining the appropriate committee, if any, to best deal with questions or issues that may arise from time-to-time.

iv. Limitations on Authority. The Executive/Finance Committee shall not have the power or authority in reference to any of the following matters:

1. Adopting, amending or repealing any bylaw.
2. Making final determinations of policy.
3. Approving changes to the budget or making major structural or contractual decisions (such as adding or eliminating programs).
4. Filling vacancies or removing any Commissioner.
5. Changing the membership of, or filling vacancies in, the Executive/Finance Committee.

- 1.6. [Hiring or firing of senior executives, but may make recommendations to the governing board as to their appointment, dismissal or ongoing performance.](#)

ARTICLE V

Special Committees

Members may be asked to participate on a subcommittee, task force or special project as part of their responsibilities. The VCMMCC may establish a committee(s) or advisory board(s) for any purpose that will be beneficial in accomplishing the work of the VCMMCC.

ARTICLE VI

Meetings

- (a) All meetings shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code relating to meetings of local agencies (“Brown Act”).
- (b) A regular meeting shall be held monthly. The VCMMCC shall by resolution establish the date, time and location for the monthly meeting. A regular meeting may, for cause, be rescheduled by the Chairperson with 72 hour advance notice.
- (c) Closed session items shall be noticed in compliance with Government Code section 54954.5.
- (d) Special meetings may be called, consistent with the Brown Act, by the Chairperson or by a quorum of the VCMMCC. Notice of such special meeting shall conform to the Brown Act.
- (e) Any meeting at which at least a quorum cannot attend, or for which there is no agenda item requiring action may be cancelled by the Chairperson with 72 hour advance notice.
- (f) A quorum shall be defined as one person more than half of the appointed members of the VCMMCC. For these purposes, “appointed members” excludes unfilled positions and those vacated by resignation or removal. ~~A- Unless otherwise expressly stated in these bylaws, a~~ majority vote of members present and constituting a -quorum shall be required for any VCMMCC action.
- (g) After three (3) absences of any member during a fiscal year, the reasons for the absences will be reviewed by the VCMMCC and it may notify the Board of Supervisors of the absences, if it deems this action appropriate. Three or more absences from regular meetings may be cause for the VCMMCC to recommend dismissal of that member to the Board of Supervisors.

Conduct of Meetings

~~[Note: The following section was relocated from Article X (Amendments) and remains unchanged with the exception of subsections (c) and (h), as noted below]~~

- (a) The Chairperson shall adhere to the order of items as posted on the agenda. Modifications to the order of the agenda may be made to the extent that (on the advice of counsel) the rearrangement of the agenda items does not violate the spirit or intent of the Brown Act.
- (b) All motions or amendments to motions require a second in order to be considered for action. Upon a motion and a second the item shall be open for discussion before the call for the vote.
- (c) Voice votes will be made on all items as read. An abstention will not be recognized except for a legal conflict of interest. In furtherance of the foregoing, an abstention or refusal to vote (not arising from a legal conflict of interest) shall be deemed a vote with the majority of those Commissioners who do vote, except when there is a tie vote and the motion or action fails. For example, if there are 7 Commissioners present at a meeting (none of whom are subject to a legal conflict of interest), (i) a motion passes with 3 votes in favor and 4 Commissioners abstaining, (ii) a motion passes with 3 votes in favor, 2 votes against and 2 Commissioners abstaining; and (iii) a motion fails with 3 votes in favor, 3 votes against and 1 Commissioners abstaining.
- (d) A call for a point of order shall have precedence over all other motions on the floor.
- (e) Without objection, the Chairperson may continue or withdraw any item. In the event of an objection, a motion to continue or reset an item must be passed by a majority of the members present. A motion to continue or reset an item shall take precedence over all other motions except for a point of order.
- (f) An amendment to a motion must be germane to the subject of the motion, but it may not intend an action contrary to the motion. There may be an amendment to the motion and an amendment to an amendment, but no further amendments. In the event the maker of the original motion accepts the amendment(s), the original motion shall be deemed modified. In the event the maker of the original motion does not accept the amendment(s), the amendment(s) shall be voted separately and in reverse order of proposal.
- (g) Where these Bylaws do not afford an adequate procedure in the conduct of a meeting, the Chairperson may defer to the most current edition of Robert's Rules of Order, to resolve parliamentary questions.
- (h) **[New subsection:]** The Chairperson shall be permitted to make motions and vote on all matters to the same extent and subject to the same limitations as other Commissioners.

ARTICLE VII

Powers and Duties

The VCMMCC is responsible for all of the activities described in Article I of these Bylaws and in its enabling ordinance. In furtherance of such responsibility, the VCMMCC shall have the following powers and duties and shall:

- (a) Advise the Chief Executive Officer (CEO) and request from the CEO information it deems necessary;
- (b) Conduct meetings and keep the minutes of the VCMMCC;
- (c) Provide for financial oversight through various actions and methodologies such as the preparation and submission of an annual statement of financial affairs and an estimate of the amount of funding required for expenditures, approval of an annual budget, receipt of monthly financial briefings and other appropriate action in support of its financial oversight role;
- (d) Evaluate business performance and opportunity, and review and recommend strategic plans and business strategies;
- (e) Establish, support and oversee the quality, service utilization, risk management and fraud and abuse programs;
- (f) Encourage VCMMCC members to actively participate in VCMMCC committees as well as subcommittees;
- (g) Comply with and implement all applicable federal, state and local laws, rules and regulations as they become effective;
- (h) Provide for the resolution of or resolve conflict among its leaders and those under its leadership;
- (i) Respect confidentiality, privacy and avoid any real or potential conflict of interest; and
- (j) Receive and take appropriate action, if warranted, based upon reports presented by the CEO (or designated individual). Such reports shall be prepared and submitted to the VCMMCC at least annually.

ARTICLE VIII

STAFF

The VCMMCC shall employ personnel and contract for services as necessary to perform its functions. The permanent staff employed by the VCMMCC shall include, but not be limited to, a Chief Executive Officer (CEO), Clerk and Assistant Clerk.

Chief Executive Officer

The CEO shall have the responsibility for day to day operations, consistent with the authority conferred by the VCMMCC. The CEO is responsible for coordinating all activities of the County Organized Health System.

The CEO shall:

- (a) Direct the planning, organization, and operation of all services and facilities;
- (b) Direct studies of organizations, operations, functions and activities relating to economy, efficiency and improvement of services;
- (c) Direct activities which fulfill all duties mandated by federal or state law, regulatory or accreditation authority, or VCMMCC board resolution, and shall bring any conflict between these laws, regulations, resolutions or policy to the attention of the VCMMCC;
- (c) Appoint and supervise an executive management staff, and such other individuals as are necessary for operations. The CEO may delegate certain duties and responsibilities to these and other individuals where such delegated duties are in furtherance of the goals and objectives of the VCMMCC;
- (d) Retain and appoint necessary personnel, consistent with all policies and procedures, in furtherance of the VCMMCC's powers and duties; and
- (f) Implement and enforce all policies and procedures, and assure compliance with all applicable federal and state laws, rules and regulations.

Clerk

The Clerk shall:

- (a) Perform the usual duties pertaining to secretaries;
- (b) Cause to be kept, a full and true record of all VCMMCC meetings and of such special meetings as may be scheduled;
- (c) Cause to be issued notices of regular and special meetings;
- (d) Maintain a record of attendance of members and promptly report to the VCMMCC any member whose position has been vacated; and
- (e) Attest to the Chair or Vice-Chair's signature on documents approved by the VCMMCC.

Assistant Clerk

The Assistant Clerk shall perform the duties of the Clerk in the Clerk's absence.

ARTICLE IX

Rules of Order

The Chairperson shall be responsible for maintaining decorum during VCMMCC meetings. All motions, comments, and questions shall be made through the Chairperson. Any decision by the Chairperson shall be considered final unless an appeal of the decision is requested and passed by a majority of the VCMMCC members present.

ARTICLE X

Amendments

(a) These Bylaws may be amended by an affirmative vote of a majority of the voting members of the VCMMCC ~~[Note: The foregoing sentence suggests that 6 out of 11 votes are required to adopt a bylaw amendment, instead of a majority vote of members constituting a quorum which could be as few as 4 votes (i.e., 4 out of 7). This should be clarified].~~ A full statement of a proposed amendment shall be submitted to the VCMMCC at least two weeks prior to the meeting at which the proposed amendment is scheduled to be voted upon.

(b) The Bylaws shall be reviewed annually and amendments to the Bylaws may be proposed by any VCMMCC member.

(c) Bylaws may be suspended on an ad hoc basis upon the affirmative vote of a majority of the VCMMCC members present.

ARTICLE XI

Nondiscrimination Clause

The VCMMCC or any person subject to its authority shall not discriminate against or in favor of any person because of race, gender, religion, color, national origin, age, sexual orientation or disability with regard to job application procedures, hiring, advancement, discharge, compensation, training or other terms or condition of employment of any person employed by or doing business with the VCMMCC or any person subject to its direction pursuant to federal, state or local law.

ARTICLE XII

Conflict of Interest and Ethics

VCMMCC members are subject to conflict of interest laws, including Government Code section 1090 and the 1974 Political Reform Act (Government Code section 8100 et seq.), as modified by Welfare and Institutions Code section 14087.57, and must identify and disclose any conflicts and refrain from participating in any manner in such matters in accordance with the applicable

statutes. Members of the VCMMCC agree to adhere to all relevant standards established by state or federal law regarding ethical behavior.

ARTICLE XIII

Dissolution

Pursuant to California Welfare & Institutions Code, section 14087.54:

(a) In the event the Commissioners determine that VCMMCC may no longer function for the purposes for which it was established, at the time that VCMMCC's then existing obligations have been satisfied or VCMMCC's assets have been exhausted, the Board of Supervisors may by ordinance terminate the VCMMCC.

(b) Prior to the termination of the VCMMCC, the Board of Supervisors shall notify the State Department of Health Care Services ("DHCS") of its intent to terminate VCMMCC. The DHCS shall conduct an audit of VCMMCC's records within 30 days of the notification to determine the liabilities and assets of VCMMCC. The DHCS shall report its findings to the Board of Supervisors within 10 days of completion of the audit. The Board of Supervisors shall prepare a plan to liquidate or otherwise dispose of the assets of VCMMCC and to pay the liabilities of VCMMCC to the extent of VCMMCC's assets, and present the plan to the DHCS within 30 days upon receipt of these findings.

(c) Upon termination of the VCMMCC by the Board of Supervisors, the County of Ventura shall manage any remaining assets of VCMMCC until superseded by a DHCS-approved plan. Any liabilities of VCMMCC shall not become obligations of the County of Ventura upon either the termination of the VCMMCC or the liquidation or disposition of VCMMCC's remaining assets.

(d) Any assets of VCMMCC shall be disposed of pursuant to provisions contained in the contract entered into between the state and VCMMCC.



AGENDA ITEM 4-C

To: Ventura County Medi-Cal Managed Care Commission

From: Earl Greenia, CEO

Date: September 26, 2011

Re: GCHP Co-Pay Policy Follow-Up

Recommendation: Management requests that the Commission formulate a policy regarding the adoption and/or implementation of co-payments, should CMS approve the State's request to impose co-payments on Medi-Cal beneficiaries.

Background: The California Department of Health Care Services (DHCS) submitted a request to the Centers for Medicare & Medicaid Services (CMS) to implement co-payments on Medi-Cal beneficiaries regardless of whether they are participating in a fee-for-service or managed care model. There has been a flurry of provider advocacy activity and the CMS decision on provider rate reductions is "on hold." However, the CMS decision on co-pays is still pending, and if approved will be effective within 120 days of CMS approval.

Discussion: Management believes that CMS will approve the DHCS request to implement co-payments in California. DHCS has given the Medi-Cal managed care plans the discretion to establish their co-payment policy; however, it is important to note that providers will have no obligation to provide services to a Medi-Cal beneficiary who does not pay the co-payment at the point-of-service. The Commission should formulate a co-payment policy in advance of the CMS decision, since management will need sufficient lead time to address notification requirements and to implement a Medi-Cal co-pay policy.

Impact on Member Access

There are two theoretical perspectives regarding the use of co-payments:

- Co-pays could create an access barrier for those beneficiaries unable to pay.
- Co-pays steer members to appropriate access, and increase members' ownership of their care and health. For example, the higher co-payment level for emergency room services may provide an incentive for members to use their primary care providers rather than the ER. Similarly, the higher co-pay for brand drugs creates an incentive for member acceptance of the generic drug.

Considerations

There are some services that deserve consideration for exemption for co-payment:

- Preventive Services. That outpatient physician/clinic visits specifically for preventive care, e.g. immunizations, well baby checks, etc. This exemption would align with impending standard benefit guidelines under federal reform.
- "True" Emergencies. Services provided in the ER at a Level V code (highest acuity) and any emergency services immediately prior to an inpatient admission.

Follow-Up

At the July meeting of the Commission, it was requested that Management:

- 1) Estimate the magnitude of the financial impact on providers, based on historical utilization and the proposed co-payments. That analysis follows:

Using fee-for-service data from the twelve-month period ending March 30, 2010, the following impact was estimated. As verbally noted in the July meeting, the State's estimation of savings (unreasonably) assumes 100% collection of co-payments.

Type of Service	# of Occurrences	Co-Pay Amount	Financial Impact
Physician Visits	182,088	\$5	\$910,440
Emergency Room Visits (1)	62,003	\$50	\$3,100,150
Inpatient Visit - 1 Day LOS	3,140	\$100	\$314,000
Inpatient Visit > 1 Day LOS	5,292	\$100	\$529,200
Number of Drug Fills - Generic (2)	787,734	\$3	\$2,363,201
Number of Drug Fills - Non Generic	172,917	\$5	\$864,586
Total Financial Impact	1,213,174		\$8,081,577

Notes:

- (1) Does not adjust for ER Visits that Result in an Inpatient Admit
- (2) Assumes 82% of Drug Fills are Generic

- 2) Solicit opinions from a beneficiary-based focus-group. To that end, we designed and distributed a survey to assess knowledge and attitudes of our Consumer Advisory Committee members regarding the State's proposed Medi-Cal copayments. Results of that survey are summarized below:

Office Visit Co-Pays

- CAC members were asked if they were aware that Medi-Cal patients might be charged \$5.00 per office visit to see a doctor - 57% of respondents reported not being aware of the copayment fee and 44% responded that they were aware.
- The majority (67%) responded that a \$5.00 co-payment per office visit is "about right" and 22% felt that it was "too high", while 11% responded "not sure."
- 67% said that a copayment of \$5.00 would not prevent them from seeing a doctor.
- All (100%) felt that there should not be a limit on the number of doctor office visits.

Prescription Co-Pay

- 67% of respondents said they were not aware that Medi-Cal patients might be charged a \$3.00 to \$5.00 co-payment to fill a prescription; 33% said they were aware.
- 44% of the respondents said the co-payment is "about right", and 33% said it was "too high", 11% felt it was "too low," and 11% responded "not sure."

Emergency Room Co-Pay

- When asked about the \$50 copayment for emergency room visits, an equal number of respondents (44% in each category) felt it was "too high" or "about right" and the remainder were "not sure."

Summary of Open-Ended Responses/Comments

- The majority felt that a copayment is justified and that everyone should pay something.
- A few felt that a copayment might reduce unnecessary visits to the ER and doctor visits.
- Some felt that a co-payment system would be fair if based on income and ability to pay.
- One said that in the current economy many persons will not be able to pay copayments.



AGENDA ITEM 4-D

To: Ventura County Medi-Cal Managed Care Commission

From: Earl Greenia, CEO

Date: September 26, 2011

Re: Audit of PCP Auto-Assignment & Self-Selection Processes

In response to questions about the validity and reliability of primary care provider (PCP) auto-assignment and self-selection processes, management conducted an audit of both processes.

Auto-Assignment Audit

The primary objective of the study was to validate that the auto-assignment process was implemented as designed. The Auto-Assignment process was developed to ensure appropriate distribution of those members who did not select a primary care provider (PCP). The process considered various factors including: Provider Capacity, Member-Specific Factors, such as: Language Preference, Member Zip Code, Age and Gender. The County was divided into eight zip code groupings, to best accommodate access to care, including distance to providers. Within each of the zip code groupings, the total number of providers and clinics were identified by individual zip code. Within that sub-grouping, members were allocated based upon the number of providers within a given clinic, as actual assignment is at the clinic rather than provider level. This approach was used rather than individual zip codes in order to avoid “over” assignment to any particular provider. For example, if there was only one provider in a particular zip code, the assignment of all members to that single provider could create unintentional overload. The breakdown of these zip codes is detailed below:

Group	City/Town	Zip Codes
1	Fillmore, Piru, Frazier Park	93015, 93016, 93040, 93225
2	Chatsworth, Moorpark, Simi Valley, Santa Susana, Brandeis	91311, 93020, 93021, 93062, 93063, 93064, 93065, 93094, 93099
3	Oak View, Ojai, Maricopa	93022, 93023, 93024, 93252
4	Santa Paula	93060, 93061
5	Canoga Park, West Hills, Newbury Park, Thousand Oaks, Westlake, Hidden Valley, Sherwood , Agoura Hills, Oak Park	91304, 91307, 91319, 91320, 91358, 91359, 91360, 91361, 91362, 91377
6	Ventura	93001, 93002, 93003, 93004, 93005, 93006, 93007, 93009
7	Camarillo, Santa Rosa Valley, Somis	93010, 93011, 93012, 93066
8	Malibu, Oxnard, Port Hueneme, Point Mugu	90265, 93030, 93031, 93032, 93033, 93034, 93035, 93036, 93041, 93042, 93043, 93044

STUDY POPULATION: The 47,319 Members who were auto-assigned to a PCP on July 9, 2011. Excluded from the population were members who self-selected a PCP and those “administrative” members that do not select a PCP (for example, members that have Medicare and Medicaid coverage).

STUDY SAMPLE: A sample of 500 Members was selected at random using a random-number generator formula. This sample size provided a confidence level of 95%. The sample was separated into two subsets (English and Spanish) to ensure that language preferences were honored:

FINDINGS: The audit revealed that 487 (97.4%) of the 500 Members were appropriately assigned to providers. With a 95% confidence level and 98% confidence interval, Management is satisfied that the vendor appropriately applied the auto-assignment logic.

Self-Selection Audit

STUDY POPULATION: The 20,344 Members that selected a PCP, either via submission of the PCP selection form or telephone call, prior to July 9, 2011.

STUDY SAMPLE: A sample of 500 Members was selected at random using a random-number generator formula. This sample size provided a confidence level of 95%.

FINDINGS: The audit revealed that 470 (94%) of the 500 Members’ PCP selection was appropriately entered into the system by the vendor. With a 95% confidence level and 98% confidence interval, Management is satisfied that the vendor accurately processed the vast majority of member’s requests. Further the vendor is committed to honoring and processing members’ change requests.

Discussion

As stipulated previously, Management recognizes that no approach is “perfect” and that the definition and concept of “fair” is subjective. For example, the validity of the member’s zip code could be challenged - we understand that members may delay reporting changes in physical residence and/or mailing address. Nonetheless, Management is committed to ensuring that member choice is honored. To that end, we have responded and will continue to respond to both provider and member inquiries and change requests. For example, there have been reports that members have sought care from their customary provider only to discover that they were auto-assigned to a different provider. When this occurs, the provider or member is asked to call Member Services and change their PCP. A small number of PCP selection forms “trickled” in since go-live – those forms have been honored. Through the months of July and August the auto-assignment was reversed with an effective date of July 1 and the preferred PCP assigned. Change requests received on or after September 1 become effective on the first date of the following month.