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

Regular Meeting
Monday, November 18, 2019, 2:00 p.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010

AGENDA

CALL TO ORDER

PLEDGE OF ALLEGIANCE

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.

CONSENT

1. **Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of October 28, 2019 and Special Meeting Minutes of November 1, 2019.**

   Staff: Maddie Gutierrez, CMC – Clerk of the Commission

   RECOMMENDATION: Approve the minutes.

2. Amendment of Electronic Communications Policy

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Adopt revisions to the e-mail policy to provide criteria for the use of non VCMMCC email addresses

3. Chief Diversity Officer Consultant

Staff: Scott Campbell, General Counsel.

RECOMMENDATION: Approve the extension of the CDO contract.

4. Additional Funding Approval Service Order 01 – Lourdes G. Campbell, Interpreting and Translation Services

Staff: Nancy Wharfield, M.D., Chief Medical Officer
Lupe Gonzalez, Ph.D., M.P.H., Director of Health Education, Cultural and Linguistic Services

RECOMMENDATION: Staff recommends the addition of $48,000 to the existing agreement (Service Order 02) with Lourdes G. Campbell Interpreting and Translating Services.

REPORTS

5. Chief Executive Officer (CEO) Update

Staff: Health Management Associates

RECOMMENDATION: Receive and file the update.

PRESENTATIONS:

6. Engaging Member In Postpartum Care

Staff: Nancy Wharfield, M.D., Chief Medical Officer
Kathy Neal, RN, DNP, Executive Director of Health Services
Lupe Gonzalez, PhD., MPH, Director of Health Education, Cultural and Linguistic Services

RECOMMENDATION: Receive and file the presentation.

FORMAL ACTION

7. Establishment of a Personnel Subcommittee

Staff: Scott Campbell, General Counsel

RECOMMENDATION:

8. October Financials Report

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Receive, approve and file the October financials report.

REPORTS

9. Chief Medical Officer (CMO) Update

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

RECOMMENDATION: Receive and file the update.

10. Chief Diversity Officer (CDO) Update

Staff: Ted Bagley, Chief Diversity Officer

RECOMMENDATION: Receive and file the update.

APPENDIX

CLOSED SESSION

11. CONFERENCE WITH LEGAL COUNSEL –ANTICIPATED LITIGATION
Initiation of litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: 2 cases

12. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (4) of Section 54956.9: One Case

13. PUBLIC EMPLOYEE APPOINTMENT
Title: Interim Chief Executive Officer

14. PUBLIC EMPLOYEE PERFORMANCE EVALUATIONS
Titles: Interim Chief Executive Officer

OPEN SESSION

15. Approval of HMA Contract for Interim CEO Services

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Find that the criteria for sole source contracting exists and award contract to HMA.

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on January 27, 2020 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: Maddie Gutierrez, Clerk to the Commission

DATE: November 18, 2019

SUBJECT: Meeting Minutes of October 28, 2019 Regular Commission Meeting and November 1, 2019 Special Commission Meeting

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the October 28, 2019 Regular Commission Meeting minutes and copy of the November 1, 2019 Special Commission Meeting minutes.

Ventura County Medi-Cal Managed Care Commission

(VCMMCC)

dba Gold Coast Health Plan (GCHP)

October 28, 2019 Regular Meeting Minutes

CALL TO ORDER

Commissioner Antonio Alatorre called the meeting to order at 2:00 p.m., in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

PLEDGE OF ALLEGIANCE

Commissioner Alatorre led the Pledge of Allegiance.

ROLL CALL

Present: Commissioners Antonio Alatorre, Fred Ashworth, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Dee Pupa and Supervisor John Zaragoza.

Commissioners Laura Espinosa, Jennifer Swenson, and Gagan Pawar, M.D. were not present at Roll Call. Commissioner Espinosa arrived at 2:02 p.m. and Commissioner Swenson arrived at 2:04 p.m. Commissioner Gagan Pawar, M.D. arrived at 2:10 p.m.

Absent: None.

PUBLIC COMMENT

None.

Commissioner Laura Espinosa arrived at 2:02 p.m.

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of September 23, 2019.

Staff: Maddie Gutierrez, CMC, Clerk of the Commission.

RECOMMENDATION: Approve the minutes.

2. Adoption of Policy requiring Findings for Awards of Contracts

Staff: Scott Campbell, General Counsel

RECOMMENDATION: That the Commission adopt the draft policy, Required Findings for Awards of Contracts.

Commissioner Ashworth motioned to approve Consent Agenda Items 1 and 2. Commissioner Dial seconded.

AYES: Commissioners Antonio Alatorre, Fred Ashworth, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Dee Pupa, and John Zaragoza.

NOES: None.

ABSENT: Commissioners Pawar and Swenson.

Commissioner Alatorre declared the motions carried.

Commissioner Jennifer Swenson arrived at 2:04 p.m.

3. Chief Executive Officer (CEO) Update

Staff: Dale Villani, Chief Executive Officer

RECOMMENDATION: Receive and file the report.

Chief Administrative Officer, Melissa Scrymgeour stated that CEO Villani was not present due to a family emergency. He asked that staff share some important updates with the commission on his behalf.

GCHP Quality Performance: Chief Medical Officer, Nancy Wharfield, M.D. provided and update on GCHP quality performance. She stated that GCHP is now in the top 1/3 of health plans in terms of performance in DHCS' Aggregated Quality Factor Score, which measures preventive care. This is a reflection of the strong work of our providers and their investment in patient health.

Beacon Health Options: Sr. Director of Network Management, Steve Peiser, updated the commission on contract negotiations with Beacon Health Options. The current contract has been extended through Dec. 31, 2019 and staff is developing a strategy for behavioral health services, which includes a Request for Information (RFI) and a formal Request for Proposal (RFP). Beacon is currently under three corrective action plans. Commissioner Espinosa asked for more information on why the Beacon contract is being negotiated with an extension through the end of the year and a possible longer term through the end of 2020. Sr. Director Peiser

explained there have been three total extensions. He added his perspective that Beacon performs better clinically than administratively. Chief Compliance Officer Brandy Armenta stated that Beacon Health has financial sanctions and corrective action plans around claims, call center, and utilization. She added that Beacon needs to meet their contractual obligations.

Commissioner Gagan Pawar arrived at 2:10 p.m.

Proposition 56 Value-Based Payment Behavioral Health Integration Program: CMO Wharfield provided an overview of the program. DHCS issued a draft proposal of the program, which includes a number of projects targeted toward improved integration of mental and behavioral health with traditional medical care. This is a grant-like program that would be available to primary care, perinatal, hospital-based, and behavioral health providers. Key dates: DHCS application release date on 11/4/2019, applications due to managed care plans by 1/21/2020, and DHCS awards issued by 3/16/2020.

Ground Emergency Medical Transport (GEMT): Sr. Director Peiser provided an update on GEMT. DHCS released an APL for an add-on rate for Ground Emergency Medical Transport (GEMT), which will be paid at $339. Rogers rate for CPT codes is the minimum rate a managed care can pay to a GEMT provider. Ambulance companies have figured out they can be paid more by not being a contracted provider. We have two ambulance companies that are currently under contract. We don't expect this issue will affect our members. The potential end result will have a financial impact to the Plan.

Historical Medical Expense Review: Chief Financial Officer, Kashina Bishop provided a summary of the review of plan's medical expense increases discussed at the October 3, 2019 Executive / Finance Committee meeting. CFO Bishop explained there was a significant increase in medical expenses in 2017/2018 that drove financial losses. Key factors drove the losses including membership decreases and contracting changes to key providers. Sr. Director Peiser added that the TNE policy was set to bring TNE down to levels between 400% - 500%, which in retrospect, should have been phased in over a period of time. Additionally, during that timeframe, two hospitals faced potential termination, which led to difficult negotiations in order to avoid termination and negative impact to members. We need to focus on what was learned from this issue and move on to stabilizing.

Commissioner Atin asked if we lost $50 million over the transition period. CFO Bishop responded yes. Commissioner Atin stated it was difficult to understand based on the information in the slide. CFO Bishop stated losses started in 2017/18. Medical expenses contributed to the loss. Medical expenses are an estimate; there could have been more of a loss but revenue continued to come in. In 2017/18, expenses were under estimated. Commissioner Atin clarified some of the $50 million loss was attributed to the 2017/18 year. CFO Bishop responded yes. Commissioner Atin stated some of this was foreseeable. The revenue was not

keeping up with contracts. Commissioner Swenson commented that the commission did not have a clear understanding at the time about how the contract negotiations would impact the financials, adding that staff should have been more specific in how the contract changes would lead to the financial losses the plan experienced. Sr. Director Peiser then reviewed an action plan around provider contracting rate re-adjustment strategies that was discussed with the Executive Finance Committee at the October 3, 2019 meeting. The plan includes strategies around rates adjustments for community and tertiary hospitals, full capitation for narrowed networks such as outpatient lab and DME, and delegated networks, partial capitation and rates adjustments for specialty services. Sr. Peiser added that savings will be seen in phases over the fiscal year, not immediately.

HR Update: Executive Director of Human Resources, Jean Halsell, provided an update on performance reviews, head count, attrition, terminations, turnover, workers compensation and benefits. Highlights include:

- ED Halsell noted there is a 3% pool for merit increases budgeted annually. Commissioner Alatorre asked if there was a 3% increase given for all employees. Ms. Halsell replied, no, that some employees may receive more or less based on their performance. However, the total merit amount awarded this year was less than the 3% budgeted.
- The majority of the plan's resources are in Health Services. Notable head count increases by department are a result of re-allocation of departments to other executive leaders in the organization as a result of the recent elimination of the chief operations officer role.
- GCHPs attrition rate is lower than industry standard.
- Termination totals were higher in 2016 at 27, and have averaged around 19 for 2017-2019. Executive Director Halsell added that leadership is holding employees accountable for performance, and there may be more terminations in 2019.
- Turnover rates by tenure are higher for employees in the 2-3 year range. This is something HR will look into further to understand the drivers.
- Staff is currently working on the employee survey and has received input from members of the commission. The goal is to launch it in December.

Commissioner Alatorre asked if it was possible that the employee may not go out in December. Ms. Halsell stated she didn't want to rush through it and is pushing for the first two weeks in December. But it may be delayed by one month because of the holidays. Commissioner Ashworth asked about leave of absences. Ms. Halsell stated there were a lot of leaves of absences in previous years, but the frequency has decreased.

Commissioner Espinosa requested to see how many employees are contracted versus full-time. Ms. Halsell stated she would provide that information at the next commission meeting.

Commissioner Dial motioned to approve the CEO Update. Commissioner Ashworth seconded.

AYES: Commissioners Antonio Alatorre, Fred Ashworth, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson and John Zaragoza.

NOES: None.

ABSENT: None.
Commissioner Alatorre declared the motion carried.

Commissioner Alatorre asked the Commission if they were in favor of moving items in the agenda in order to accommodate presenters for the FY 2018-19 financial audit results. The Commission was in agreement.

FORMAL ACTION

8. Fiscal Year: 2018-2019 Audit Results

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Approve and accept the FY2018-19 Financial Audit results.

CFO Bishop introduced Moss Adams representatives Stelian Damu and Kimberly Sokoloff, who would present the FY2018/19 audited financial results. CFO Bishop led the discussion with an update to the year-end financials, indicating that an additional adjustment of $4,603,035 was made, bringing the final loss for the fiscal year to $56,510,433. The adjustment was related to the final reconciliation for the FY 16/17 Adult Expansion Medical Loss Ratio requirement, and medical expenses that were disallowed. �s Zaragoza expressed his concerns around the size of the total losses. CFO Bishop stated that the issues with AB85 funding added to the loss, resulting in the plan owing more money back to the state.

Mr. Damu then reviewed the scope of the audit, the firm's audit responsibilities and summary of the audit schedule, noting the plan met all deadlines were met. Mr. Damu stated that the plan's accounting policies were verified and consistent with U.S. GAAP. He noted it is difficult to predict and evaluate based on current information. Commissioner Zaragoza asked what year was being reviewed. Mr. Damu responded the review was for fiscal year July 1, 2018 – June 30, 2019.

Audit summary findings from the Moss Adam's audit report "2019 Audit Results: Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan":

- Significant management estimates impacted the financial statements including the following: medical claims liabilities and Payable to the State of California, which includes the estimate related to the medical loss ratio requirements. Moss Adams deems them to be reasonable.

  CFO Bishop commented that the MLR requirement has created risk, as small errors can cause large financial impacts.

- The disclosures in the financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statements users; however Moss Adams does not believe any of the footnotes are particularly sensitive.

- Corrected adjustments – No significant adjustment noted.

- Uncorrected adjustments – To recognize the prior year impact of an error corrected in the current year, related to the prior year MLR liability reconciliation. Decrease beginning net position and increase revenues by $3.8M. Moss Adams concurred with management's assessment that the uncorrected adjustment is immaterial to the financial statements taken as a whole.

- Deficiencies in internal control – No material weaknesses noted. Significant deficiency noted for Conduent, Inc. claims processing. Ms. Sokoloff explained this is a repeat finding around the timing of Conduent's SOC audit. Other minor deficiencies and recommendations were communicated to management.

Commissioner Pupa commented that the statements of revenue show a 57% reduction in the TNE, which is a tremendous change and is concerning.

Ms. Sokoloff noted additional areas of audit review, adding that when audit findings are made, they are noted as corrected adjustments. One uncorrected adjustment from the prior year was a $3.6 million accrual. However, it did not warrant a review of the prior year financial as it wasn't a material adjustment. Commissioner Atin asked how much is paid to Conduent. CFO Bishop replied around $20 million annual, which comprises 40% of the plan's administrative expenses. She added that staff is working to hold them accountable for their work. Commissioner Atin asked about the premium tax and whether it was a pass-through. CFO Bishop stated it was a pass-through.

Commissioner Pupa motioned to approve the audit results. Commissioner Swenson seconded.

AYES: Commissioners Antonio Alatorre, Fred Ashworth, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson and John Zaragoza.

NOES: None.

ABSENT: None.

Commissioner Alatorre declared the motion carried.

PRESENTATIONS

4. Compensation Analysis Review

Staff: Jean Halsell, Executive Director of Human Resources

RECOMMENDATION: Receive and file the presentation.

Executive Director Halsell introduced Steve Smith, Director of Client Solutions for LTC Performance Strategies, Inc. Ms. Halsell explained that the Plan's last compensation analysis was last conducted two years ago and it is typical practice to update it every couple of years.

Mr. Smith then provided a presentation on the plan's compensation analysis strategy which comprises total rewards: salary and benefits, career development opportunities, and culture. He reviewed achievable goals and action steps, including role clarification, job descriptions and benchmarking. Mr. Smith explained that not all jobs are benchmarked; anchor roles are used for the market benchmarks. Mr. Smith added that as part of the analysis, he will revisit the structure and grouping of the job families and pay bands make recommendations. Commissioner Atin commented that he would like to see the benchmark analysis before any changes are made. He added that the commission should have additional insight into staff promotions, merit increases, and salary decisions based on market analysis, as it relates to compensation strategy. He stressed that job descriptions and salaries should be compared to comparable industries and that while the plan is not a traditional government agency, is also not a traditional insurance plan. That should be taken into consideration. Commissioner Espinosa asked whether pay bands include salary only or related positions. Mr. Smith explained that there are many positions in a given market band; these are positions with comparable external market rates. Commissioner Espinosa had a comment for the board, stating that compensation analysis raises expectations of staff. Given the financial position of the plan, did the board have any comments? Commissioner Atin asked that Mr. Smith to check in with the commission before finalizing his report. Mr. Smith stated he would do so.

Commissioner Dial motioned to approve the presentation. Commissioner Espinosa seconded.

AYES: Commissioners Antonio Alatorre, Fred Ashworth, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson and John Zaragoza.

NOES: None.

ABSENT: None.

Commissioner Alatorre declared the motion carried.

5. HIF/MET One Year Later: Proactive Case Management for New Members

Staff: Nancy Wharfield, Chief Medical Officer
Kathy Neal, Executive Director of Health Services
Rachel Lambert, Case Management Manager

Staff provided a presentation on the HIF/MET program. Program details and highlights:

- Program started in 2017
- 2018 was used as a benchmark for outcomes analysis
- The HIF/MET form has 10 questions, and is mailed to all new members; form helps to determine if member could benefit from case management.
- Members receive a robo-call to remind them to complete and return forms.
- Case management looks to bridge the gap between primary care and community-based resources to address the social determinants of health.

2018 Analysis and Impact:

- ~31k forms mailed/ 21% returned (~6,400)
- Of the returned forms, 76% (~4,860) resulted in a care management referral
- CM referrals resulted in care coordination (39%), care management (30%), and health education (12%), 19% opted out or were unreachable.
- Of those engaged in care management (~3,900 members), 71% of engaged member had no ED visits in the measurement year.
- Average ED use for all GCHP members during this review period was 472/1,000; ED use for member engaged in care management through HIF/MET was 291/1,000 suggesting that HIF/MET response and CM doe's impact ED usage.

New members drive utilization. This program encourages member engagement; that they follow through on their health care.

Ms. Neal noted that if people re-enroll in Medi-Cal after a six-month absence, they are considered a new member and they receive the form. Ms. Neal stated there are some changes she would like to make to the form, such as including questions on mental health.

PUBLIC COMMENT

Kathy Krul spoke on behalf of the Oxnard Family Circle Adult Day Health Care Center. She thanked the commission for this presentation.

Commissioner Dial motioned to approve the presentation. Commissioner Zaragoza seconded.

AYES: Commissioners Antonio Alatorre, Fred Ashworth, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson and John Zaragoza.

NOES: None.

ABSENT: None.

Commissioner Alatorre declared the motion carried.

FORMAL ACTION

6. Proposed Appointment of a Commissioner as a Fifth Committee Member to the Bylaws Subcommittee of the Commission to Review Bylaws and Delineation of Authority Policy

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Staff recommends the Commission appoint a fifth Commissioner to the Bylaws Subcommittee.

Mr. Campbell announced Commissioner Pupa has volunteered to join the Bylaws Committee.

Commissioner Zaragoza motioned to approve the appointment of Commissioner Pupa. Commissioner Dial seconded.

AYES: Commissioners Antonio Alatorre, Fred Ashworth, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson and John Zaragoza.

NOES: None.

ABSENT: None.

Commissioner Alatorre declared the motion carried.

PUBLIC COMMENT

Dr. Sandra Aldana stated she wanted to commend the commission for following best practices and noted it was important to review bylaws and good to stay with best practices.

7. Quality Improvement Update

Staff: Nancy Wharfield, Chief Medical Officer

RECOMMENDATION: Accept and approve the 2018 Quality Improvement Program Evaluation.

CMO Wharfield introduced Kim Timmerman, Quality Improvement Director. Ms. Timmerman reviewed key highlights of the presentation slides. Goals that achieved metric(s) in 2018:

- Initial health Assessment (IHA) - rates increased from 18% in fourth quarter of 2017 to 56% in fourth quarter of 2018.
- Postpartum Care – rates increased over 9% from 68.38% in MY2017 to 75.78 in MY2018.
- Childhood Immunization Status/Combo 3 – rate increased over 5% from 70.53% in MY2017 to 75.67% in MY 2018.
- Opioid Prescriptions – 22% reduction in total number of opioid users and 26% reduction in opioid users with doses above 90mg MEDD
- Network Adequacy – all metrics for ratios of physician to members and distance met in 2018.

Goals not achieving metric(s) in 2018:

- Tobacco cessation – intervention using counseling and/or medication decreased from 36.34% in Q4 2017 to 33.86% in Q4 2018.
- Cervical Cancer Screening (CCS) – rate decreased 1.38% points from 57.46% in MY2017 to 56.08% in MY2018.
- Children and Adolescents' Access to Primary Care Practitioner (CAP) – 3 of 4 sub-measures improved but did not reach 5% improvement goal.
- Call Center Monitoring – ASA increased 58 seconds from 51 seconds in 2017 to 109 seconds in 2018.
- Abandonment rate increased 2.61% from 2.49% in 2017 to 5.11% in 2018.
- Provider Satisfaction – survey not completed in 2018 due to strategic and state regulatory reporting priorities.

Commissioner Swenson asked why the access to primary care measure was not met. Ms. Timmerman stated it was possibly due to issues with access or capturing data. Ms. Timmerman noted there are new member incentives for members ages 3 – 21 who visit their doctor. They can receive a $15 gift card to Amazon, Target or Walmart.

The HEDIS results were also reviewed. GCHP scored well – GCHP advanced 20 spaces in 2017/18 and received an award for most improved. For 2018/19 GCHP moved up 11 spaces. We are waiting for awards to be announced.

PUBLIC COMMENT

Dr. Sandra Aldana stated she has a new role for the State CAC. She noted provider education/interface is needed in this community.

Commissioner Alatorre requested a three-minute break prior to Closed Session. The break began at 5:06 p.m.

The Commission adjourned to Closed Session at 5:09 p.m. regarding the following items:

CLOSED SESSION

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

14. CONFERENCE WITH LEGAL COUNSEL – INITIATION OF LITIGATION

Initiation of litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: Number of potential cases: Three cases.

15. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer.

Commissioner Cho left the meeting at 6:03 p.m.

16. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Ventura County Medi-Cal Managed Care Commission Commissioners.
Non-represented employee: Chief Executive Officer

17. PUBLIC EMPLOYMENT
Title: Chief Executive Officer.

OPEN SESSION

The regular meeting reconvened at 6:24 p.m.
General Counsel, Scott Campbell, stated there was no reportable action.

FORMAL ACTION

9. August September Financials Report

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Receive, approve and file the August/September financials.

CFO Bishop explained that she can present both August and September financials due to process improvements that have been implemented. In the past, staff presented financials from the prior two months (e.g. September financials would be presented at the November commission meeting), but she has been able to catch up so we are able to present September financials in October. Because the November commission meeting is scheduled earlier in the month due to the Thanksgiving holiday, it will be challenging to have the October financials ready for the meeting. She explained that financial information will not be available until November 15, so she may not have a report. Should that occur, she will provide the commission a verbal update.

CFO Bishop reviewed the financial results for August and September with the commission. Capitation rates, trending and supplemental payments were reviewed. She noted a loss in August of $1.7 million, stating that the Plan is over budget by 5%, but it is only highly estimated at this time since we are only three months into the fiscal year. She expects some seasonality to reduce medical expenses, but it is too early in the year to estimate. Commissioner Pupa asked if inpatient expenses included IBNR. CFO Bishop responded, yes, and added that she will not know the increase on long-term care until January 2020 - it is currently 1% over budget. She added that pharmacy expenses are over budget by $1.4 million and directed payments are over by $2 million. There was an adjustment of $500,000 in capitation. CFO Bishop noted it is early in the fiscal year and she does not have an update for projections on how the plan will end the fiscal year. Commissioner Ashworth noted a 4.5% conservatism is built into the current numbers. CFO Bishop stated that she budgeted to break even and because of that, the Plan will feel "bumps in the road" throughout the fiscal year. Commissioner Ashworth suggested having a baseline and seeing it layered every month. CFO Bishop agreed.

Commissioner Atin noted the 12% increase in payments from the state. He commented that the first quarter of the year has gone by and the Plan is still losing money. He is not hearing what will change dynamically. CFO Bishop stated she is not seeing the same trend that led to the losses in FY 2018/19. She added that staff managing administrative expenses by holding Conduent accountable for their contract performance. Staff is working on contract changes to reduce medical expenses, but cautioned that the plan cannot be too aggressive as members need to have access to services. Commissioner Ashworth noted that it is not just rate

cuts. Staff should evaluate utilization, per diem costs, etc. He suggested that staff needs to look at measurement points and issue a stop-loss. There are additional ways to figure out strategies and what is projected for managing that next level of expense.

CFO Bishop stated that GCHP is working with less staff and increased work, especially around regulatory requirements. Commissioner Atin asked for clarification because in the reports provided, he sees the same amount of staff. CFO Bishop suggested that CMO Wharfield comment on staffing for her department. CMO Wharfield stated the footprint in her department has not changed; she has not created more positions. CFO Bishop stated there has been a hiring frost/freeze since she arrived at GCHP and staff is struggling to keep up, as regulatory requirements have increased. Executive Director Halsell stated the plan has lost staff. Chief Compliance Officer, Brandy Armenta, reminded everyone that DHCS previously placed the plan on a corrective action plan, partly for inadequate staffing. Commissioner Atin stated it was not noted there was a reduction in staff and asked to be shown the reduction. He said the commission asked for that information and the totals are not given. Executive Director Halsell stated she would provide the requested information.

REPORTS

11. Chief Medical Officer (CMO) Update

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

RECOMMENDATION: Receive and file the update.

12. Chief Diversity Officer (CDO) Update

Staff: Ted Bagley, Chief Diversity Officer

RECOMMENDATION: Receive and file the update.

Commissioner Ashworth motioned to receive and file the August/September Financials report, the CMO and CDO Updates. Commissioner Dial seconded.

AYES: Commissioners Antonio Alatorre, Fred Ashworth, Shawn Atin, Laura Espinosa, Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson and John Zaragoza.

NOES: None.

ABSENT: Commissioner Theresa Cho, M.D.

Commissioner Alatorre declared the motion carried.

10. Contract Award Approval – Health Management Systems, Inc.

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: To award the three-year agreement to the highest scoring bidder, Health Management Systems Inc., based on fair and open competition.

Commissioner Espinosa motioned to award the contract as presented. Commissioner Swenson seconded.

AYES: Commissioners Antonio Alatorre, Fred Ashworth, Shawn Atin, Laura Espinosa, Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson and John Zaragoza.

NOES: None.

ABSENT: Commissioner Theresa Cho, M.D.

Commissioner Alatorre declared the motion carried.

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

Commissioner Alatorre adjourned the meeting at 7:12 p.m.

Approved:

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Maddie Gutierrez, CMC
Clerk to the Commission

Ventura County Medi-Cal Managed Care Commission

(VCMMCC)

dba Gold Coast Health Plan (GCHP)

November 1, 2019 Special Meeting (via Conference Call) Minutes

CALL TO ORDER

General Counsel, Scott Campbell announced there was a quorum. Commissioner Alatorre called the meeting to order at 9:11 a.m., in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

ROLL CALL

Via Telephone Conference:	Commissioner Antonio Alatorre, Fred Ashworth, Theresa Cho, M.D., Laura Espinosa, Gagan Pawar, M.D., Jennifer Swenson and Supervisor John Zaragoza.

Commissioner Laura Espinosa was not present at time of roll call. Commissioner Espinosa called in at 9:14 a.m.

Present:	Commissioners Shawn Atin and Dee Pupa.
Absent:	Commissioner Lanyard Dial, M.D.

PUBLIC COMMENT

Roberto S. Juarez, Clinicas del Camino Real CEO, stated he was a former Commissioner. Mr. Juarez stated he had received a letter from a woman alleging sexual harassment and abuse by Dale Villani, Chief Executive Officer. Mr. Juarez stated the Human Resource Director had knowledge, and no action was taken. Mr. Juarez stated the CEO contract should be terminated for cause if there is cause. He stated tax dollars should not be used to continue to pay the CEO contract.

Mr. Juarez stated there is a $57 million deficit, yet Mr. Villani has given raises up to twenty five percent (25%) to people for only a title change. The cost of health care, and increased hospital costs have been blamed for this deficit. Clinicas del Camino Real has not received an increase in rates for four (4) years, therefore it is not due to them. He stated the Commission needs to protect the public. Mr. Juarez stated the Commission does not follow policy. The public is looking at the Commission to protect public money.

REPORTS

1. Report of Closed Session Action Pursuant to Government Code Section 54957.1

Staff: Scott Campbell, General Counsel

On Monday, October 28, 2019, in Closed Session the Commission unanimously voted not to renew the contract of CEO Dale Villani.

The Commission adjourned to Closed Session at 9:18 a.m. regarding the following items:

CLOSED SESSION

2. PUBLIC EMPLOYEE DISCIPLINE/DISMISSAL/RELEASE

3. PUBLIC EMPLOYEE APPOINTMENT
Title: Interim Chief Executive Officer.

4. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Ventura County Medi-Cal Managed Care Commission/Commissioners
Non-represented employee: Interim Chief Executive Officer.

OPEN SESSION

The regular meeting reconvened at 10:49 a.m.

REPORTABLE ACTION

General Counsel Scott Campbell stated there were several action items taken:

The Commission voted to accept the resignation of the Chief Executive Officer effective immediately. The vote is as follows:

AYES: Commissioners Fred Ashworth, Shawn Atin, Theresa Cho, M.D., Dee Pupa, Jennifer Swenson and Supervisor John Zaragoza.

NOES: Commissioners Antonio Alatorre, Laura Espinosa and Gagan Pawar, M.D.

ABSENT: Commissioner Lanyard Dial, M.D.

The Commission unanimously appointed Health Management Associates (HMA), Margaret Tatar, as Interim CEO for Gold Coast Health Plan.

Chief Administrative Officer Melissa Scrymgeour asked for clarification regarding HMA: she asked if there was a specific individual who would be on site Monday, November 4, 2019. General Counsel responded there would be four or five people who would be on

an initial team. They will be meeting with staff for next two (2) weeks and would present their findings on the needs and challenges of the Plan in Closed Session on November 18, 2019. The team will be on site beginning Monday morning, November 4, 2019.

COMMENTS FROM COMMISSIONERS

Commissioner Atin asked for clarification on the public comments made during this meeting. General Counsel Scott Campbell stated an investigation has been done on the allegations of harassment and sexual harassment. The investigation concluded there was no harassment or sexual harassment. The investigation was completed. Commissioner Atin stated the Chief Diversity Officer performed the investigation.

ADJOURNMENT

General Counsel Scott Campbell adjourned the meeting at 10:53 a.m.

Approved:

____

Maddie Gutierrez, CMC

Clerk to the Commission

AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: November 18, 2019

SUBJECT: Amendment of Electronic Communications Policy

SUMMARY:

The current email policy of the Ventura County Medi-Cal Managed Care Commission ("Commission") provides that Commissioners should use Gold Coast Health Plan created emails for Commission business, which has created some difficultly in receiving Commission related emails. The proposed amendment would provide that Commissioners can use their own emails for Commission business, as long as the emails are placed in a separate electronic folder and retained pursuant to the current email retention policy.

BACKGROUND:

On June 26, 2017, the Commission adopted an Electronic Communications Policy to ensure compliance with the California Supreme Court's 2017 decision, *City of San Jose v. Superior Court* (2017) 2 Cal.5th 608. That decision held that communications by public agency employees made using private electronic devices or personal email accounts are probably disclosable under the Public Records Act if those communications concern the public's business.

The Electronic Communications Policy provided that Plan officials and employees be assigned a Plan-specific electronic messaging account, and discouraged officials and employees from using a separate personal account for the creation, transmission or storage of any electronic communications regarding Plan business. For Commissioners, who have responsibilities and jobs outside of the Commission, logging on and off a specially created account has often delayed the receipt of information and at times resulted in Commissioners not timely receiving important communications.

To ensure prompt receipt of Commission related communications, the revised policy allows Commissioners to use their regular email accounts for Commission business if they keep such emails in a separate electronic folder so that if Public Records Act requests are received, the Commission related emails can easily be retrieved. Additionally, such Commission related emails must be retained consistent with the retention schedules for Plan-related documents. Currently, there is a hold on deleting such emails due to pending legal matters.

In response to a Public Records Act request for any responsive records regarding Plan business that may be stored on an individual's personal electronic messaging account, a response must include a written declaration attached to the Electronic Communications Policy, signed under penalty of perjury, that all potentially responsive records were located for purposes of review and possible disclosure and provided to Plan staff for processing.

FISCAL IMPACT:

N/A

RECOMMENDATION:

Staff recommends that the Commission approve the amended Electronic Communications Policy attached as Exhibit "A" with the changes marked in redline and adopt a resolution amending the policy.

CONCURRENCE:

N/A

ATTACHMENTS

Exhibit No. 1 – Revised Electronic Communications Policy (redline)
Exhibit No. 2 – Revised Electronic Communications Policy (clean)
Attachment A – Declaration attached to Electronic Communications Policy
Exhibit No. 3 – Resolution No. 2019-003

Exhibit No. 1 – Revised Electronic Communications Policy (redline)

SUBJECT: BUSINESS PRACTICES	POLICY: #4-__
POLICY: ELECTRONIC COMMUNICATIONS POLICY	EFFECTIVE: 11/18/2019

BACKGROUND AND PURPOSE:

The Ventura County Medi-Cal Managed Care Commission, dba Gold Coast Health Plan, hereby amends the following policy regarding the conduct of Gold Coast Health Plan business via electronic communications by Agency Commissioners, officials and employees. Specifically, this policy is adopted in light of the holding in *City of San Jose v. Superior Court* (2017) 2 Cal.5th 608, which held that a city employee's communications related to the conduct of public business do not cease to be public records under the California Public Records Act, simply because they were sent or received using a personal account or personal device.

Existing and emerging electronic communication technologies have become an integral part of the ability of Agency officials and staff members to efficiently and effectively conduct Agency business. Such technology has the potential to enhance communications with the public and provide a higher level of service to the public and members of the Agency. However, with such technology in the work environment, the Agency must ensure it continues to meet its legal obligations with respect to transparency in the conduct of the people's business, including in the area of public records disclosure and retention requirements. To that end, the following protocol will be followed.

DEFINITIONS:

For purposes of this policy, the following definitions apply:

"Agency" means the Ventura County Medi-Cal Managed Care Commission, dba Gold Coast Health Plan.

"Agency business" shall be construed broadly to mean information relating to the conduct of the public's business or communications concerning matters within the subject matter of the Agency's jurisdiction, including, but not limited to, pending or potential Agency projects, past or prospective Agency agenda items, or Agency budgets or expenditures involving Agency funds. Resolution of the question will involve an examination of several factors, including: (a) the content itself; (b) the context in, or purpose for which, it was written; (c) the audience to whom it was directed; (d) the purpose of the communication; and (e) whether the writing was prepared by an Agency official acting or purporting to act within the scope of his or her employment.

"Agency Commissioners" means all individuals appointed to serve on the Ventura County Medi-Cal Managed Care Commission.

“Agency personnel” means any employees and officials employed by the Agency, but does not include Agency Commissioners.

“Electronic communications” includes any and all electronic transmissions, and every other means of recording upon any tangible thing in any form of communication or representation, including letters, words, pictures, sounds, or symbols, or combinations thereof, and any record thereby created, regardless of the manner in which the record has been stored. Without limiting the nature of the foregoing, “electronic communications” include e-mails, texts, voicemails, and also includes communications on or within commercial applications (apps) such as Facebook Messenger, Twitter, WhatsApp, etc.

“Electronic messaging account” means any account that creates, sends, receives or stores electronic communications.

POLICY:

All Agency Commissioners and Agency personnel shall be assigned an Agency electronic messaging account that includes a corresponding Agency email address (“Agency accounts”).

Agency accounts shall be used to conduct Agency business by all Agency personnel. Agency personnel shall not use personal electronic messaging accounts for the creation, transmission or storage of electronic communications regarding Agency business.

The Agency account, along with the attendant access to the Agency’s account server, are for use by Agency personnel to conduct Agency business, and shall not be used for personal business or political activities. Incidental use of Agency electronic messaging accounts for personal use by Agency personnel is permissible, though not encouraged.

If Agency personnel receive an electronic message regarding Agency business on a non-Agency, personal electronic messaging account (including gmail, yahoo, etc.), or circumstances require such person to conduct Agency business on a non-Agency account, Agency personnel shall ensure one of the following two Options is followed:

- 1) copy (“cc”) any communication from the Agency official’s personal electronic messaging account to his/her Agency account; or
- 2) forward the associated electronic communication to his/her Agency account no later than 10 days after the original creation or transmission of the electronic communication.

The recommended practice for Agency personnel is to instruct persons sending electronic communications regarding Agency business to a non-Agency, personal electronic messaging account to instead utilize the Agency official’s account and likewise instruct a person sending an electronic communication regarding non-Agency business to use the Agency official’s personal or non-Agency electronic messaging account.

Agency Commissioners, in addition to the two available options described above when receiving an electronic message regarding Agency business on a non-Agency, personal electronic

messaging account (including gmail, yahoo, etc.), have an additional third option. Specifically, Agency Commissioners can, upon notification to the Commission Clerk:

- 3) create a separate folder within their non-Agency personal electronic messaging account where all electronic communications regarding Agency business sent or received are stored and can be easily retrieved, and retain those electronic messages regarding Agency business in line with the Agency's record retention schedule and policy.

Any Agency Commissioners who choose to utilize Option No. 3 described above will be required to complete the written declaration attached to this policy, described in greater detail herein, in response to any Public Records Act request for any responsive records regarding Agency business that may be stored on a non-Agency personal electronic messaging account. Any Agency personnel who retain any electronic communications regarding Agency business on personal electronic messaging accounts will also be required to complete the written declaration attached to this policy in response to any pertinent Public Records Act request.

Agency Commissioners and Agency personnel understand they have no expectation of privacy in the content of any electronic communication sent or received on an Agency account, when utilizing Agency servers, or on a non-Agency personal electronic messaging account, to the extent that account is being used to transmit electronic communications regarding Agency business. Agency-provided electronic devices, including devices for which the Agency pays a stipend or reimburses the Agency official, are subject to Agency review and disclosure of electronic communications regarding Agency business. Agency officials understand that electronic communications regarding Agency business that are created, sent, received or stored on an electronic messaging account, may be subject to disclosure under the Public Records Act, even if created, sent, received, or stored on a personal account or personal device.

In the event a Public Records Act request is received by the Agency seeking electronic communications of named Agency personnel or Agency Commissioners, the Agency Clerk's office shall promptly transmit the request to the applicable individuals whose electronic communications are sought. The Agency Clerk shall communicate the scope of the information requested to the applicable individuals, and an estimate of the time within which the Agency Clerk intends to provide any responsive electronic communications to the requesting party.

It shall be the duty of any Agency personnel or Agency Commissioners receiving such a request from the Agency Clerk to promptly conduct a good faith and diligent search of his/her personal electronic messaging accounts and devices for responsive electronic communications. Agency personnel or Agency Commissioners shall then promptly transmit any responsive electronic communications to the Agency Clerk. Such transmission shall be provided in sufficient time to enable the Agency Clerk to adequately review and provide the disclosable electronic communications to the requesting party.

In the event Agency personnel or Agency Commissioners do not possess, or cannot with reasonable diligence recover, responsive electronic communications from any electronic messaging accounts, the individual shall so notify the Agency Clerk, by way of a written

declaration, attached to this policy, and signed under penalty of perjury. In addition, Agency personnel or Agency Commissioners who withholds any electronic communication identified as potentially responsive must submit that declaration under penalty of perjury with facts sufficient to show the information is "personal business" and not "public business" under the Public Records Act. The form of the declaration is attached hereto as Attachment A.

It shall be the duty of the Agency Clerk, in consultation with the Agency's Legal Counsel, to determine whether a particular electronic communication, or any portion of that electronic communication, is exempt from disclosure. To that end, any responding Agency personnel or Agency Commissioner shall provide the Agency Clerk with all responsive electronic communications, and, if in doubt, shall err on the side of caution and should "over produce." If an electronic communication involved both Agency ("public") business and a personal communication, any responding Agency personnel or Agency Commissioners may redact the personal communication portion of the electronic communication prior to transmitting the electronic communication to the Agency Clerk. Any responding Agency personnel or Agency Commissioners shall provide facts sufficient to show that the information is "personal business" and not "public business" by declaration. In the event a question arises as to whether or not a particular communication, or any portion of it, is a public record or purely a personal communication, Agency personnel or Agency Commissioners should consult with the Agency Clerk or the Legal Counsel. Any responding Agency personnel or Agency Commissioners shall be required to sign a declaration, in a form acceptable to the Legal Counsel, attesting under penalty of perjury, that a good faith and diligent search was conducted and that any electronic communication, or portion thereof, not provided in response to the Public Records Act request is not Agency business.

Agency provided AB 1234 (ethics) training should include a discussion of the impacts of the City of San Jose case and this policy. Such training should include information on how to distinguish between public records and personal records. Agency personnel or Agency Commissioners who receive AB 1234 training from other providers should actively solicit training from the alternative provider on the impacts of the City of San Jose case.

Agency personnel or Agency Commissioners understand that electronic communications regarding Agency business are subject to the Agency's records retention policy, even if those electronic communications are or were created, sent, received or stored on a personal electronic messaging account. It is a felony offense to destroy, alter or falsify a "public record." As such, unless Agency personnel or Agency Commissioners have cc'd/transmitted electronic communications in accordance with the procedure described above, that individual must retain all electronic communications regarding Agency business, in accordance with the Agency's adopted records retention policy, regardless of whether such electronic communication is originally sent or received on a personal electronic messaging account.

Failure by Agency personnel or Agency Commissioners to abide by this policy, following its adoption, may result in one or more of the following:

- Disciplinary action, up to and including termination (for Agency personnel);

- Censure (for Agency Commissioners);
- Revocation of electronic device privileges (including revocation of stipend or reimbursement); and
- Judicial enforcement against the individual directly, by the requesting party.

This policy does not waive any exemption to disclosure that may apply under the California Public Records Act.

Exhibit No. 2 – Revised Electronic Communications Policy (clean)

SUBJECT: BUSINESS PRACTICES	POLICY: #4-__
POLICY: ELECTRONIC COMMUNICATIONS POLICY	EFFECTIVE: 11/18/2019

BACKGROUND AND PURPOSE:

The Ventura County Medi-Cal Managed Care Commission, dba Gold Coast Health Plan, hereby amends the following policy regarding the conduct of Gold Coast Health Plan business via electronic communications by Agency Commissioners, officials and employees. Specifically, this policy is adopted in light of the holding in *City of San Jose v. Superior Court* (2017) 2 Cal.5th 608, which held that a city employee's communications related to the conduct of public business do not cease to be public records under the California Public Records Act, simply because they were sent or received using a personal account or personal device.

Existing and emerging electronic communication technologies have become an integral part of the ability of Agency officials and staff members to efficiently and effectively conduct Agency business. Such technology has the potential to enhance communications with the public and provide a higher level of service to the public and members of the Agency. However, with such technology in the work environment, the Agency must ensure it continues to meet its legal obligations with respect to transparency in the conduct of the people's business, including in the area of public records disclosure and retention requirements. To that end, the following protocol will be followed.

DEFINITIONS:

For purposes of this policy, the following definitions apply:

"Agency" means the Ventura County Medi-Cal Managed Care Commission, dba Gold Coast Health Plan.

"Agency business" shall be construed broadly to mean information relating to the conduct of the public's business or communications concerning matters within the subject matter of the Agency's jurisdiction, including, but not limited to, pending or potential Agency projects, past or prospective Agency agenda items, or Agency budgets or expenditures involving Agency funds. Resolution of the question will involve an examination of several factors, including: (a) the content itself; (b) the context in, or purpose for which, it was written; (c) the audience to whom it was directed; (d) the purpose of the communication; and (e) whether the writing was prepared by an Agency official acting or purporting to act within the scope of his or her employment.

"Agency Commissioners" means all individuals appointed to serve on the Ventura County Medi-Cal Managed Care Commission.

"Agency personnel" means any employees and officials employed by the Agency, but does not include Agency Commissioners.

"Electronic communications" includes any and all electronic transmissions, and every other means of recording upon any tangible thing in any form of communication or representation, including letters, words, pictures, sounds, or symbols, or combinations thereof, and any record thereby created, regardless of the manner in which the record has been stored. Without limiting the nature of the foregoing, "electronic communications" include e-mails, texts, voicemails, and also includes communications on or within commercial applications (apps) such as Facebook Messenger, Twitter, WhatsApp, etc.

"Electronic messaging account" means any account that creates, sends, receives or stores electronic communications.

POLICY:

All Agency Commissioners and Agency personnel shall be assigned an Agency electronic messaging account that includes a corresponding Agency email address ("Agency accounts").

Agency accounts shall be used to conduct Agency business by all Agency personnel. Agency personnel shall not use personal electronic messaging accounts for the creation, transmission or storage of electronic communications regarding Agency business.

The Agency account, along with the attendant access to the Agency's account server, are for use by Agency personnel to conduct Agency business, and shall not be used for personal business or political activities. Incidental use of Agency electronic messaging accounts for personal use by Agency personnel is permissible, though not encouraged.

If Agency personnel receive an electronic message regarding Agency business on a non-Agency, personal electronic messaging account (including gmail, yahoo, etc.), or circumstances require such person to conduct Agency business on a non-Agency account, Agency personnel shall ensure one of the following two Options is followed:

- 1) copy ("cc") any communication from the Agency official's personal electronic messaging account to his/her Agency account; or
- 2) forward the associated electronic communication to his/her Agency account no later than 10 days after the original creation or transmission of the electronic communication.

The recommended practice for Agency personnel is to instruct persons sending electronic communications regarding Agency business to a non-Agency, personal electronic messaging account to instead utilize the Agency official's account and likewise instruct a person sending an electronic communication regarding non-Agency business to use the Agency official's personal or non-Agency electronic messaging account.

Agency Commissioners, in addition to the two available options described above when receiving an electronic message regarding Agency business on a non-Agency, personal electronic messaging account (including gmail, yahoo, etc.), have an additional third option. Specifically, Agency Commissioners can, upon notification to the Commission Clerk:

- 3) create a separate folder within their non-Agency personal electronic messaging account where all electronic communications regarding Agency business sent or received are stored and can be easily retrieved, and retain those electronic messages regarding Agency business in line with the Agency's record retention schedule and policy.

Any Agency Commissioners who choose to utilize Option No. 3 described above will be required to complete the written declaration attached to this policy, described in greater detail herein, in response to any Public Records Act request for any responsive records regarding Agency business that may be stored on a non-Agency personal electronic messaging account. Any Agency personnel who retain any electronic communications regarding Agency business on personal electronic messaging accounts will also be required to complete the written declaration attached to this policy in response to any pertinent Public Records Act request.

Agency Commissioners and Agency personnel understand they have no expectation of privacy in the content of any electronic communication sent or received on an Agency account, when utilizing Agency servers, or on a non-Agency personal electronic messaging account, to the extent that account is being used to transmit electronic communications regarding Agency business. Agency-provided electronic devices, including devices for which the Agency pays a stipend or reimburses the Agency official, are subject to Agency review and disclosure of electronic communications regarding Agency business. Agency officials understand that electronic communications regarding Agency business that are created, sent, received or stored on an electronic messaging account, may be subject to disclosure under the Public Records Act, even if created, sent, received, or stored on a personal account or personal device.

In the event a Public Records Act request is received by the Agency seeking electronic communications of named Agency personnel or Agency Commissioners, the Agency Clerk's office shall promptly transmit the request to the applicable individuals whose electronic communications are sought. The Agency Clerk shall communicate the scope of the information requested to the applicable individuals, and an estimate of the time within which the Agency Clerk intends to provide any responsive electronic communications to the requesting party.

It shall be the duty of any Agency personnel or Agency Commissioners receiving such a request from the Agency Clerk to promptly conduct a good faith and diligent search of his/her personal electronic messaging accounts and devices for responsive electronic communications. Agency personnel or Agency Commissioners shall then promptly transmit any responsive electronic communications to the Agency Clerk. Such transmission shall be provided in sufficient time to enable the Agency Clerk to adequately review and provide the disclosable electronic communications to the requesting party.

In the event Agency personnel or Agency Commissioners do not possess, or cannot with reasonable diligence recover, responsive electronic communications from any electronic messaging accounts, the individual shall so notify the Agency Clerk, by way of a written declaration, attached to this policy, and signed under penalty of perjury. In addition, Agency personnel or Agency Commissioners who withholds any electronic communication identified as potentially responsive must submit that declaration under penalty of perjury with facts sufficient

to show the information is "personal business" and not "public business" under the Public Records Act. The form of the declaration is attached hereto as Attachment A.

It shall be the duty of the Agency Clerk, in consultation with the Agency's Legal Counsel, to determine whether a particular electronic communication, or any portion of that electronic communication, is exempt from disclosure. To that end, any responding Agency personnel or Agency Commissioner shall provide the Agency Clerk with all responsive electronic communications, and, if in doubt, shall err on the side of caution and should "over produce." If an electronic communication involved both Agency ("public") business and a personal communication, any responding Agency personnel or Agency Commissioners may redact the personal communication portion of the electronic communication prior to transmitting the electronic communication to the Agency Clerk. Any responding Agency personnel or Agency Commissioners shall provide facts sufficient to show that the information is "personal business" and not "public business" by declaration. In the event a question arises as to whether or not a particular communication, or any portion of it, is a public record or purely a personal communication, Agency personnel or Agency Commissioners should consult with the Agency Clerk or the Legal Counsel. Any responding Agency personnel or Agency Commissioners shall be required to sign a declaration, in a form acceptable to the Legal Counsel, attesting under penalty of perjury, that a good faith and diligent search was conducted and that any electronic communication, or portion thereof, not provided in response to the Public Records Act request is not Agency business.

Agency provided AB 1234 (ethics) training should include a discussion of the impacts of the City of San Jose case and this policy. Such training should include information on how to distinguish between public records and personal records. Agency personnel or Agency Commissioners who receive AB 1234 training from other providers should actively solicit training from the alternative provider on the impacts of the City of San Jose case.

Agency personnel or Agency Commissioners understand that electronic communications regarding Agency business are subject to the Agency's records retention policy, even if those electronic communications are or were created, sent, received or stored on a personal electronic messaging account. It is a felony offense to destroy, alter or falsify a "public record." As such, unless Agency personnel or Agency Commissioners have cc'd/transmitted electronic communications in accordance with the procedure described above, that individual must retain all electronic communications regarding Agency business, in accordance with the Agency's adopted records retention policy, regardless of whether such electronic communication is originally sent or received on a personal electronic messaging account.

Failure by Agency personnel or Agency Commissioners to abide by this policy, following its adoption, may result in one or more of the following:

- Disciplinary action, up to and including termination (for Agency personnel);
- Censure (for Agency Commissioners);

- Revocation of electronic device privileges (including revocation of stipend or reimbursement); and
- Judicial enforcement against the individual directly, by the requesting party.

This policy does not waive any exemption to disclosure that may apply under the California Public Records Act.

ATTACHMENT A

DECLARATION

[attached on following page]

The policies in this manual are intended for all employees of GCHP. The organization reserves the right to revise, change, or terminate policies or procedures at any time, with or without notice.

In the matter of: California Public Records Act Request Pursuant to Gov. Code § 6250 *et seq*. Re: ___________________________________ ______________________________________ Insert shorthand name of record request, including request number, if applicable. Requester: ____________________________ Print or type name of requester	STATE OF CALIFORNIA COUNTY OF VENTURA Declaration of: ______________________________ Print or type name of official **Regarding Search of Personal Electronic Messaging Account**

VENTURA COUNTY MEDI-CAL MANAGED HEALTH CARE COMMISSION, DBA GOLD COAST HEALTH PLAN

I, ____ declare:
Print name

1. I received notice of a California Public Records Act ("CPRA") request regarding a search of my personal electronic messaging account(s). 2. I understand that the CPRA request seeks:

____
Insert text of CPRA request.

3. I am the owner or authorized user of the following personal electronic messaging account and have the authority to certify the records:

____
Insert description of personal electronic messaging account(s).

4. I have made a good faith, diligent, thorough, and complete search of the above-mentioned personal electronic messaging account(s) for all electronic communications potentially responsive to the above-mentioned CPRA request.

5. Any responsive electronic communications discovered, and referenced below, were prepared or used by me in the ordinary course of business at or near the time of the act, condition or event.

6. Any responsive electronic communications discovered, and referenced below, are true copies of all records described in the above-mentioned CPRA request.

Check the applicable box:

☐ I certify that I do not possess responsive electronic communications.

☐ I certify that I cannot reasonably recover responsive electronic communications.

____
____
____
____
____

Explain efforts to retrieve responsive electronic communications and why you were unable to recover responsive electronic communications.

☐ I certify that I discovered potentially responsive electronic communications from my personal electronic messaging account, but I am withholding that information because the information is "personal" business. This is for the following reasons:

____
____
____
____
____

Describe with sufficient facts why the contested information is personal business and not subject to the CPRA. Attach additional pages, if necessary.

☐ I certify that I discovered potentially responsive electronic communications from my personal electronic messaging account. I am providing all responsive information. However, some information is nonresponsive and I am withholding that information, because the information is

____
____
____
____
____

Describe with sufficient facts why the contested information is personal business and not subject to the CPRA. Attach additional pages, if necessary.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that I have personal knowledge of the facts set forth above.

Executed this ___ day of _______________ 20___ , in ______________________, California.

By:____________________________________

Print Name:____________________________

EXHIBIT NO. 3

RESOLUTION NO. 2019-003

A RESOLUTION OF THE VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION, DOING BUSINESS AS THE GOLD COAST HEALTH PLAN, ADOPTING AN AMENDED ELECTRONIC COMMUNICATIONS POLICY

WHEREAS, the Ventura County Medi-Cal Managed Care Commission, doing business as the Gold Coast Health Plan ("Plan") adopted on June 26, 2017 an Electronic Communications Policy in light of the California Supreme Court's decision in the *City of San Jose* case, holding that public employees' communications related to the conduct of public business do not cease to be public records under the California Public Records Act simply because they were sent or received using a personal account or personal device; and

WHEREAS, Ventura County Medi-Cal Managed Care Commissioners ("Commissioners") have been impeded in the timely receipt of Plan business, transmitted electronically, to the extent those communications are received on Plan electronic messaging accounts that are not otherwise used by Commissioners in their professional or personal lives; and

WHEREAS, the Ventura County Medi-Cal Managed Care Commission, now seek to amend that Electronic Communications Policy to reflect the continued use of non-Plan electronic messaging accounts by Plan Commissioners, while ensuring a proper procedure for the collection and retention of those records to the extent they describe the public's business in line with State law principles.

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

Section 1. Determination of Recitals. The Plan hereby finds and determines that all of the recitals set forth above are true and correct. The above recitals are hereby incorporated as substantive findings of this Resolution.

Section 2. The Plan hereby adopts the amended "Electronic Communications Policy," a copy of which is attached hereto as "Exhibit A" and incorporated herein by reference.

Section 3. Severability. The provisions of this Resolution are severable and if any provision of this Resolution is held invalid, that provision shall be severed from the Resolution and the remainder of this Resolution shall continue in full force and effect, and not be affected by such invalidity.

Section 4. Effective Date. This Resolution shall take effect upon its adoption.

Section 5. Certification. The Clerk of the Board shall certify to the adoption of this Resolution.

PASSED, APPROVED AND ADOPTED by the Ventura County Medi-Cal Managed Care Commission at a regular meeting on the ____ day of _____, 2019, by the following vote:

AYE:
NAY:
ABSTAIN:
ABSENT:

____
Chair

Attest:

____
Clerk of the Board

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Joseph T. Ortiz, Best Best & Krieger LLP- Diversity Counsel

DATE: November 18, 2019

SUBJECT: Chief Diversity Officer Consultant

SUMMARY:

At the Commissioner meeting in September, the Commission agreed to continue to the contract with Theodore Bagley dba TBJ Consulting ("TBJ Consulting") to serve as Gold Coast Health Plan's Chief Diversity Officer ("CDO"). The agenda item is for formal approval of the amendment to the contract with TBJ Consulting to continue such CDO services.

BACKGROUND/DISCUSSION:

On October 6, 2015, the Ventura County Board of Supervisors adopted Ordinance 4481, which required that the Plan to establish a Cultural Diversity Program. Section 1382 of Ordinance 4481 also called for the creation of the CDO position to oversee the program. The prior CDO left the position as of September 8, 2017, and the Commission contracted with TBJ Consulting for CDO services

The Commission will recall that in 2017, following negotiations, TBJ Consulting agreed to provide CDO services at an hourly rate of $250.00 per hour of work. The contract was extended in October of 2018 to December 2019. At the September, 2019 meeting, the Commissioner agreed to extend the contract until terminated by the Commission. The contract can be terminated at any time by providing fourteen (14) days notice. All other terms remain the same. TBJ Consulting anticipates the working two days per week (or 64 hours per month), totally approximately $16,000 per month or $192,000.00 annually. TBJ Consulting would like to continue to have the option of an additional day per week, as needed. The original Consulting Services Agreement and first Amendment are attached hereto as Exhibit 1. The proposed Second Amendment to the Agreement to the Consulting Services Agreement is attached hereto as Exhibit 2.

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Per the requirements of the CDO position, TBJ Consulting will report directly to the Commission and will issue reports to the Commission and the Ventura County Board of Supervisors. Should this contract be accepted,

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FISCAL IMPACT:

Approximately $200,000 in annual fees.

RECOMMENDATION:

Staff recommends that the Commission approve the proposed Second Amendment to the Consulting Services Agreement and Statement of Work.

CONCURRENCE:
N/A

ATTACHMENT:
Exhibit 1: The 2017 Consulting Services Agreement and the First Amendment.
Exhibit 2: The proposed Second Amendment to the Consulting Services Agreement.

711 East Daily Drive, Suite 106, Camarillo, CA 93010-6082 | Member Services: 888-301-1228 | Administration: 805-437-5500 | Fax: 805-437-5132

GOLD COAST HEALTH PLAN
SECOND AMENDMENT TO CONSULTING SERVICES AGREEMENT

This First Amendment to CONSULTING SERVICES AGREEMENT (this "First Amendment") between the Ventura County Medi-Cal Managed Care Commission dba. Gold Coast Health Plan, a public entity (hereinafter "PLAN") and TBJ Consulting, an independent contractor (hereinafter "Consultant") is entered into this 18th day of November 2019.

Except as modified in this Second Amendment and the preceding First Amendment, the Consulting Services Agreement originally dated November 9, 2017 ("Agreement") between the Plan and Consultant shall remain in full force and effect.

The parties to this Second Amendment agree to the following changes:

1. Section I entitled "Services" references a Statement of Work No. 3, attached to Subsection 1.1 as "Attachment A". This Amendment shall replace the original Attachment A with the version of Attachment A enclosed with this Second Amendment.

2. Section V entitled "Term and Termination" is hereby amended to revise Subsection 5.1 to reflect a single year term:

> "5.1 Term. The term of this Agreement shall begin on the date set forth on the first page of the Agreement and continue until the Agreement is terminated by PLAN of Consultant as set forth below."

The Plan and the Employee have duly executed this Second Amendment as of the date first written above.

Ventura County Medi-Cal Managed Care Commission d.b.a. Gold Coast Health Plan	**TBJ Consulting**
Signature: ____________________	Signature: ______________________ Ted Bagley, CEO/ Pres.
Date: ________________________	Date: __________________________

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ATTACHMENT A

STATEMENT OF WORK NO. 3

THIS STATEMENT OF WORK NO. 3 is made as of this 1st day of November, 2019 Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan, a California public entity established under the laws of the State of California, (hereinafter "PLAN") The parties entered into Consulting Services Agreement dated as of November 9, 2017 ("Agreement"). The parties have adopted amendments to that Agreement in both 2019 and 2020. The terms and conditions of the Agreement are incorporated into this Statement of Work No. 3 by this reference thereto and this Statement of Work No. 3 is subject to such terms and conditions. If there is a conflict between a specific term in this Statement of Work No. 3 and the terms of the Agreement, the specific term of the Agreement shall control.

1. BACKGROUND

A short summary of the project's history and proposed approach, including:

Short statement of the problem to be resolved
Time line or review of major dates in the project development process
Client organizational units and key individuals involved in advancing the project
Alternative solutions or implementation strategies evaluated proposed approach

1.1. Objectives

The key end results that the project will achieve when successfully executed. Measurable performance indicators for anticipated benefits may also be listed here.

1.2. Reference Materials

Insert a list of all documents or portions of documents referenced in the Statement of Work

2. SCOPE OF WORK

The Detailed Scope includes a list of the specific requirements that the project must satisfy. It also includes a listing of the deliverables that will be generated by the Project Team, as well as those deliverables that are specifically excluded from the scope.

2.1. Consultant Responsibilities

Identify and list the Consultant's responsibilities

2.2. PLAN Responsibilities

Identify and list the PLAN's responsibilities

2.3. Deliverables

List all deliverables referenced in the Project Schedule and provide a brief description of the related acceptance criteria for each. Provide a copy of the completed Log as an Appendix to this document.

3. PROJECT SCHEDULE

PROJECT SCHEDULE	
Milestone or Major Project Deliverable	**Completion Date**
Perform all duties of the Chief Diversity Officer as required	TBD
Investigate all Diversity related issues in a timely manner	TBD

The PLAN acknowledges that Consultant is not required to engage in day-to-day human resources planning, process, and implementation, except so far as Diversity-related issues are relevant. Where no such Diversity-related issues are relevant, Consultant will defer to PLAN human resources staff.

3.1. Assumptions

Insert certain assumptions upon which the Statement of Work is based

4. TERM

4.1. The Initial Term of this Statement of Work shall be from November 1st, 2019 until December 31, 2020 or until a permanent Chief Diversity Officer is hired by the PLAN or until otherwise terminated pursuant to the terms of the Services Agreement.

Or

4.2. Start Date: November 1st 2019 End Date: December 2020

5. COMPENSATION

5.1. **Compensation.** For Services rendered as outlined herein, Consultant shall be compensated as follows:

5.1.1. Fixed Fee: The fixed fee to PLAN for the delivery of the Services is, $250.00 an hour as planned. Additional hours are at the discretion of the plan and as needed for effective performance of the duties of this position.

5.1.2. Payment Terms*:* PLAN shall pay Consultant for the Services in accordance with the following fixed fee payment schedule.

Project Task/Milestone	Payment to Consultant
Establish a successful diversity environment within the Plan.	As stated above
Development internal and external relationships for efficiency and effectiveness	As stated above
Conduct fair and equitable investigations	As stated above
Operate in conjunction with the officers of the Plan	As stated above

Or

5.1.3. Time and Materials Fees. Except as otherwise agreed, Consultant agrees to invoice PLAN the labor hour fee's listed below.

Skill-Set	Estimated Number of Hours	Hourly Fee
Business and diversity experience	2 days/ week; opt'l additional day as needed	$250.00

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-Investigation		
-Training		
Build a diversity culture with assistance from GCHP		

5.1.4. ☐ **Travel & Expenses:** (check if applicable) **as needed**

5.1.5. **Total Compensation.** The total compensation for the project under this Statement of Work No. 3 shall not exceed $225,000.00.

6. ACCEPTANCE

Insert acceptance criteria which will trigger payment

In witness whereof, the parties have caused this Statement of Work to be executed by their respective duly authorized representatives.

Ventura County Medi-Cal Managed Care Commission dba. Gold Coast Health Plan	**TBJ Consulting** **71 Golden Glen Drive** **Simi Valley, CA 93065**
BY: ________________________	BY: TBJ Consulting
NAME: Dale Villani	*NAME: Ted Bagley*
TITLE: Chief Executive Officer	*TITLE: CEO/President*
DATE: ______________________	*DATE:* __________________

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AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, M.D., Chief Medical Officer
Lupe González, Ph.D., M.P.H., Director of Health Education, Cultural and Linguistic Services

DATE: November 18, 2019

SUBJECT: Additional Funding Approval – Service Order 01, Lourdes G. Campbell, Interpreting and Translating Services

SUMMARY:

Lourdes G. Campbell Interpreting and Translating Services provides in-person interpretation and translation services to the Plan's members and providers. The Plan has been using these services since 2012 and the current agreement commenced on November 10, 2015 and expires on October 31, 2020.

The current agreement is a non-requirements contract, which allows the Plan to use services ad-hoc at the rates specified. The agreement can be terminated for convenience at any time with fifteen (15) day written notice.

This request is to add additional funding to the existing agreement with Lourdes G. Campbell Interpreting and Translating Services for the remaining fiscal year. To ensure fair market value, the Plan will prepare and issue an RFP for these services in early 2020.

FISCAL IMPACT:

There is no fiscal impact with this request. Staff is requesting that the budgeted dollar amount of $48,000 be applied to the current purchase order funding the agreement.

	Amount	Period	Budgeted
Prior Commission approval (August 2018)	$176,800	11/10/2015 – 10/31/2020	Y
Additional Funding Recommended	$48,000		Y
Total Cumulative Spend (Years. 1-5)	**$224,800**		**Y**

RECOMMENDATION:

Staff recommends the addition of $48,000 to the existing agreement (Service Order 01) with Lourdes G. Campbell Interpreting and Translating Services.

If the Commission desires to review this contract, it is available at Gold Coast Health Plan's Finance Department.

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Health Management Associates

DATE: November 18, 2019

SUBJECT: Chief Executive Officer Update

CEO SUMMARY: Verbal Update.

Government Relations Update

California Advancing and Innovating Medi-Cal (CalAIM)
On October 28, the Department of Health Care Services (DHCS) released its concept paper on how it plans to reform the Medi-Cal Program. The new initiative is called California Advancing and Innovating Medi-Cal (CalAIM). Its goals are to identify and manage member risk and need through a more holistic approach and addressing the social determinants of health. Also, the initiative strives to move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility. Finally, CalAIM is intended to improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.
The initiative is outlined in a 180-page document. In addition, DHCS is hosting stakeholder meetings over the next several months to address the following CalAIM initiatives:

- Requiring Medi-Cal managed care plans to submit Population Health Management strategies and moving to annual Medi-Cal managed care plan open enrollment.

- Adding a new Enhanced Care Management benefit and a set of In Lieu of Services, designed to focus on critical populations such as children, high-cost/high-need populations, and the homeless, among others.

- Behavioral Health payment reform and delivery system transformation, with particular emphasis on how to improve critical needs for children.

- Requiring the National Committee on Quality Assurance (NCQA) accreditation for Medi-Cal managed care plans.

- Considerations for creation of Full Integration Plans where one entity would be responsible for the physical, behavioral, and oral health needs of their members.

One of the primary goals of CalAIM is to better coordinate care for Medi-Cal enrollees who have complex medical conditions requiring care from multiple delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental, and In Home Supportive

Services, etc.). In this regard, County Organized Health Systems (COHS) are uniquely qualified to provide input in the stakeholder process, and ultimately succeed in achieving the goals of CalAIM, as coordinating care is a core principle of the COHS model.
CalAIM will look to the successes of waiver demonstrations such as the Whole Person Care and the Coordinated Care Initiative as the basis for many of its suggested reforms. Preventive care will also be an emphasis, which again is a guiding principle of the COHS model.

There also appears to be an emphasis on care for and treating the growing homeless population and even identifying populations that could become homeless. Behavior health and expanding health plans' ability to assist in coordinating housing opportunities are important goals of CalAIM.

Also included in the initiative is better care planning and mandatory enrollment for inmates as they prepare for release. Adding oral health and better coordinate care for foster youth are also stated goals of the initiative.

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS is recommending requiring all Medi-Cal managed care plans and their subcontractors (delegated entities) to be National Committee for Quality Assurance (NCQA) accredited by 2025. DHCS would use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain state and federal Medicaid requirements. This proposal could be problematic for some health plans as NCQA certification is a long, rigorous, and expensive process. It may be even more of a concern for delegated entities.

Another major initiative for COHS could be the recommendation to shift Medi-Cal managed care plan rates from a single county rate to a regional rate model, which will coincide with a shift of the rating period from the state fiscal year to the calendar year beginning in 2020. The proposed simplification will afford DHCS the flexibility to continue to pursue strategies that support advancements and innovations within the program.

DHCS plans to finalize all proposals for submission to the federal government sometime between May and July 2020 depending on input from stakeholders.

GCHP staff is actively evaluating the impact of the CalAIM proposal and participating in the stakeholder workgroups. Staff has proactively begun reviewing the plan's strategic goals and ensuring that they are in alignment with the CalAIM objectives. More information to come during the December strategic planning session.

Community Relations Update
Gold Coast Health Plan in the Community

In the last month, GCHP awarded sponsorships to the following organizations:

- **Community Action of Ventura County:** A sponsorship was awarded to "The Partners in Action: Building Community Capacity from Assessment to Change". Proceeds from the event will help support critical services to assist people move out of poverty and make the community a better place to live.

- **Food Forward:** A sponsorship was awarded to their annual fundraising event "Branch Out". Proceeds of the event will assist with fighting food disparity in Ventura County by connecting surplus produce with the food insecure people in the community.

- **Boys & Girls Club of Greater Oxnard and Port Hueneme**: A sponsorship was awarded to 30th Annual Donald K. Facciano Kids Auction & Gala. Proceeds of the event benefits 17 Boys & Girls Club locations of Ventura County.

- **Big Brothers Big Sisters of Ventura County:** A sponsorship was awarded to their annual fundraising event "Bags, Bling, & Bubbly". Proceeds of the event go towards continuing facilitating 1,500 one-to-one mentoring relationships for children.

- **Kids & Families Together:** A sponsorship was awarded to their annual event "A Home for the Holidays". Proceeds of the event benefits children that have experienced trauma, abuse, neglect, loss, and multiple placements.

- **Conejo Valley Foundation:** A sponsorship was awarded to the Thanksgiving Day meal distribution event. Proceeds from this sponsorship benefit approximately 600 families in Ventura County by providing them with a full Thanksgiving meal.

- **Santa Paula Latino Town Hall:** A sponsorship was awarded to the Santa Paula Latino Town Hall Annual Awards Dinner. Proceeds from the event will help support youth by providing scholarships, career educational seminars, and youth leadership conferences.

- **Santa by the Sea:** A sponsorship was awarded to the Santa to the Sea Half Marathon. Proceeds from the event will go towards college scholarships, holiday toy giveaway, and providing food for 50 families a month.

The Wilson Center Walking Club, held in Oxnard, is an event that encourages senior citizens to reduce health risks through a weekly walking program. The Community Relations team participated in the walk encouraging a healthy lifestyle through daily activity. The team answered questions and had an opportunity to invite participants to the Member Benefit Orientation. GCHP donated pedometers and water bottles to all participants.

The Oxnard Medical Screening, held in Oxnard is an event that provides medical, vision and dental screenings at no cost for community members. Free eye exams and glasses were provided to participants. The team educated participants about GCHP and the various benefits available to our members.

The Ventura College Health Fair, held in Ventura, is an event for students to obtain free health screenings and learn about services available in the community. Several students made their way around the booths asking questions to learn more about the community organizations participating in the event. Students approached the GCHP booth asking about what services we offer. The team provided information about care management, transportation, and grievance and appeals.

The Flight Influenza event held in the City of Oxnard hosted by the Ventura County Public Health Immunization Program provided influenza vaccines at no charge. The Community Relations team offered participants information about members' rights and responsibilities, transportation benefit, member orientation, and care management.

Taking It To The Teachers Mini Fair, held in the Ventura County Office of Education is an opportunity for teachers and district representatives to learn more about community services available to disabled young adults. The GCHP team provided a brief overview of the plan and benefits available. Participants took informational material about care management, transportation and member orientation meeting flyers.

Community Recognition

The Community Relations team in collaboration with the Chief Diversity Officer and the Diversity and Inclusion Council participated in the **24th Annual Multicultural Festival** in the City of Oxnard. A special recognition ceremony will be held on November 18, recognizing GCHP for its sponsorship.

On November 2, Hip Hop Help recognized Gold Coast Health Plan for its sponsorship during their annual showcase. The sponsorship gave several children the opportunity to learn the art of breakdancing. The youth program is a highly interactive performing arts program designed to promote self-confidence, teamwork, and personal development.

The Community Relations team will participate in several events in the coming months:

Event Name	Organization	Location
Ventura County Annual Transition Fair	The Ventura County Transition Project	Camarillo
MICOP Annual Health Fair Meeting	MICOP	Oxnard
Resource Fair and Dinner	Lions Club	Oxnard
CSUCI Resource Fair	CSUCI	Camarillo
Homeless Resource Fair	City of Ventura	Ventura
Oxnard Christmas Parade	Oxnard Downtowners	Oxnard
Tamale Festival	City of Oxnard	Oxnard
Santa by the Sea Half Marathon	Santa by the Sea	Oxnard
Southwinds Neighborhood Meeting	Southwinds Neighborhood Council	Oxnard
Homeless Resource Fair	City of Ventura	Ventura

COMPLIANCE UPDATE

DHCS Annual Medical Audit:

Audits and Investigation (A&I) conducted the annual medical audit June 3, 2019 through June 7, 2019. Staff received the final report from A&I on September 13, 2019. The Plan submitted our CAP responses to DHCS on October 14, 2019 and the response is currently under review by DHCS. The Plan's goal is to resolve the findings timely. The Plan will continue to keep the commission apprised.

The Joint Legislative Audit released the final audit report on August 15, 2019. The Audit report has two recommendations:

1) To ensure that the public clearly understands the commission's decisions, the commission should report its reasoning for awarding contracts or the legal basis, if any, for choosing not to do so.
2) To ensure that it addresses any significant performance issues by its contractors in a timely manner, Gold Coast should establish a process to immediately require contractors to take necessary corrective action to resolve issues and ensure that they do not recur.

The Plan is required to respond in 60 days, 6 months and 1 year about the steps it took to implement the recommendations that are within statutory authority. Per the direction by JLAC the response included timelines and who or whom is the responsible party for implementing

the recommendations. The Plan submitted the response to JLAC on October 14, 2019 with both items classified as partially implemented.
For item number one, a policy and procedure tailored towards the commission was approved at the October 28, 2019 Commission meeting.
For item number two, a policy and procedure specific to Pharmacy Benefit Manager oversight was submitted to JLAC for review. Concurrently the policy was also submitted to DHCS for review and approval as it encompasses elements of the Plans DHCS contract requirements. Once approved by DHCS, JLAC will consider it implemented. The Plan will continue to keep the commission apprised.

DHCS conducted facility site review audits on 11 provider sites September 9, 2019 through September 12, 2019. DHCS issued the Plan a CAP on October 14, 2019. Eight (8) findings were on the facility side component and five (5) findings were on the medical record review component. The CAP response is due to DHCS on November 18, 2019. The Plan will keep the commission apprised of the status.

DHCS Contract Amendments:

The draft DHCS contract amendment has included multiple revisions based on CMS review. The contract amendment is still pending approval by CMS and the Plan is pending the final amendment for signature. GCHP has received additional requirements from the Mega Reg via All Plan Letters and has had multiple deliverables due to DHCS to ensure compliance. GCHP is operating under the requirements of the draft amendment as required by DHCS and GCHP is audited by DHCS to those standards.

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Delegation Oversight:

Delegate	Audit Year/Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Conduent	2017 Annual Claims Audit	Open	December 28, 2017		Issue will not be resolved until new claims platform conversion
Kaiser	2018 Annual Claims Audit	Open	9/23/2018	Under CAP	
Conduent	2018 Annual Claims Audit	*Open	6/20/2018	Under CAP	Ongoing monitoring imposed
Beacon Health Options	2018 Annual Claims Audit	*Open	6/26/2018	Under CAP & Under Financial Sanctions	
Beacon Health Options	2018 6 month Claims (focused) Audit	*Open	11/21/2018	Under CAP & Under Financial Sanctions	
Clinicas del Camino Real, Inc.	2018 Annual Claims Audit	*Open	12/28/2018	Under CAP	Ongoing monitoring imposed
Cedars	2019 Annual Credentialing	Open	July 11, 2019	Under CAP	
Children's Hospital	2019 Annual Credentialing	Closed	July 16, 2019	October 29, 2019	
City of Hope	2019 Annual Credentialing	Closed	June 10, 2019	October 29, 2019	
Optum	2019 Annual Audit (C&L, FWA, HIPAA, UM, Credentialing)	Open	March 4, 2019	Under CAP	
Kaiser	2019 Annual Claims Audit	Open	September 23, 2019	Under CAP	
Beacon Health Options	2019 Annual Call Center Audit	Open	May 23, 2019	Under CAP	
VTS	2019 Annual Call Center Audit	Open	April 26, 2019	Under CAP	
CDCR	2019 Concurrent UM Quarterly Audit	Closed	August 29, 2019	N/A (CAP not issued)	

Beacon Health Options	2019 Concurrent UM Quarterly Audit	Open	October 11, 2019	Under CAP	
VSP	2019 Annual Claims Audit	Open	October 29, 2019	Under CAP	

Gold Coast Health Plan (GCHP) is contractually required to perform oversight of all functions delegated through subcontracting arrangements. Oversight includes but is not limited to:

- Monitoring/reviewing routine submissions from subcontractors
- Conducting onsite audits
- Issuing a Corrective Action Plan (CAP) when deficiencies are identified

**Ongoing monitoring denotes delegate is not making progress on a CAP issued and/or audit results were unsatisfactory and GCHP is required to monitor the delegate closely as it is a risk to the Plan when delegates are unable to comply.*

Compliance will continue to monitor all CAP(s) issued. GCHP's goal is to ensure compliance is achieved and sustained by our delegates. It is a DHCS requirement for GCHP to hold all delegates accountable. The oversight activities conducted by GCHP is evaluated during the DHCS annual medical audit. DHCS auditors review GCHP's policies and procedures, audit tools, audit methodology, and review audits conducted and corrective plans issued by GCHP during the audit period. DHCS continues to emphasize the high level of responsibility Plans have in oversight of delegates.

Opioid Class Action:

Following acceptance of the CEO Report by the Commission on October 28th pertaining to the Plan's intent to participate in an opioid multi-district litigation (MDL), on October 29, 2019, the Plan moved forward in retaining the law firms of Solowsky & Allen, P.L. and Mansfield, Bronstein & Stone, LLP (collectively referred to as Allen & Mansfield) to represent GCHP. As previously reported, the MDL is seeking to recover costs incurred by GCHP associated with the opioid crisis because opioid manufacturers and their distributors, and in the case of Purdue Pharma, its owners (members of the Sackler family) lied to convince the medical community that it was safe for patients to use opioids for long-term treatment of chronic pain programs. Allen & Mansfield's fee is twenty-five (25%) percent of all amounts and benefits recovered on GCHP's behalf, including actual damages, punitive or exemplary damages, treble damages, interest, and attorneys' fees, but excluding any recovery of costs awarded to reimburse out-of-pocket expenses incurred in bringing your claims. GCHP will not be responsible for any fees, costs, expenses, or disbursements in the event the litigation is unsuccessful. The contingency fee is only due if we recover damages or other benefits as a result of this matter, unless we terminate the engagement before the matter is concluded. GCHP anticipates its complaint(s) will be filed on or before November 22, 2019. On behalf of GCHP's General Counsel's office, Rich Egger, will manage this outside litigation.

Also, please note that this is not a "Class Action" as my summary last month for Dale's October report to the Commission was mis-corrected to be captioned. It is a "Multi-District Litigation." A class action is a single lawsuit with many different plaintiffs who have suffered similar harm; whereas an MDL involves multiple lawsuits filed by different people. We will be one of more than 2,000 plaintiffs in the MDL. It is an important distinction because with MDL it is possible GCHP may be faced with a decision to pursue its litigation alone. Certain lead plaintiffs are selected to move forward with "bellwether" trials, and often a global settlement is reached for all litigants in the MDL with plaintiffs. But, if not, the litigants much reach a decision whether or not to withdraw their action or proceed to trial as an individual lawsuit. The bellwether plaintiffs have long been selected, and GCHP will not be one. You can read more about MDLs here: https://www.classaction.org/learn/what-is-an-mdl

Grievance and Appeals:
Please refer to the attached grievance and appeals graphs.

Grievance Monthly Member Totals Yearly Comparison Graph-
Staff is currently analyzing the increase from 17/18 to 18/19 to identify if the increase is thematic or if any additional correlations exist. DHCS made a policy change where a member must first exhaust the grievance and appeal level at the Plan prior to filing a State Fair Hearing. An increase is a positive as the Plan encourages and educates members on their rights to file a grievance when they experience dissatisfaction. At the same time staff has identified a decrease in the month of September 2019 however, a correlation of cause is under review. By filing a grievance, the Plan has the opportunity to resolve the issue and mitigate a future occurrence. The Plans goal is to ensure members have an optimal experience when accessing benefits.

Grievance Monthly Provider Totals Yearly Comparison Graph:
Staff has identified a decrease i in the month of September and is researching the decrease to derive if specific providers are driving volume or are providers leveraging the grievance process less because of the majority of provider grievances being upheld. Staff is researching the volume of provider grievances the Plan upholds as opposed to the volume overturned. In addition, staff is conducting a root cause analysis on those provider grievances that the Plan overturned. The intent is to gauge if what the Plan is overturning is a systemic issue that we can address, a manual process issue or training issue. By identifying, the core issue it will help the Plan move to a solution which will allow the Plan to alleviate provider abrasion.

Clinical Appeal Monthly Yearly Comparison Graph:
Clinical appeals have remained steady over the last two months and staff continues to work collaboratively with the Chief Medical Officer, Medical Director and nurses,

Vendor Management Conduent:
Staff is in the discovery phase of various facets of the Conduent Contract performance. A weekly cross-functional team has been established to meet with Conduent and address high priority issues. By working together, we are able to alleviate impact to other departments

within the organization and it allows additional visibility into Conduents contract performance. As the discovery phase evolves, the report on Conduent will as well. The Plan has identified some opportunities for improvement in claims processing, grievance and appeals and call center functions. Currently as the Plan works together internally and with Conduent, we were able to identify themes. Themes the Plan has identified include the following, which is not all-inclusive: high dependability on manual processes, system configuration limitations, call center associate training, staffing competency and attrition in claims and call center departments. Staff is reviewing the contract in depth and deciphering functions that are delegated versus those that are not delegated to try to maximize efficiencies and minimize duplication of functions on the Plan side. The vendor management function will continue to evolve and additional reporting will be provided in the future.

HUMAN RESOURCES

Executive Director of Human Resouces, Jean Halsell with review the attached graph (please see next page).

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Positions by Department	Actual	Budget		Temps/Consultants/Contractors	Vacant Positions
Diversity	0	0		**1** Part Time CDO Consultant	
Executive	8	10	1	**1** ETP Executive Consultant, **1 PT** ETP management	COO position eliminated, no plans to fill
Human Resources	6	6			
Compliance	10.5	10		**1 PT** Consultant (Conduent Vendor Management)	
Operations		2	2		1 vacancy Dir Ops eliminated, no plans to fill
Grievance & Appeals	5	5			
Operations Support Services	5	5			
Member Services	5	7			**2** vacancies due to transfer and retirement, no plans to fill
Claims	5	6			**1** vacancy due to 1 transfer, no plans to fill
Facilities	3	3			
Network Operations	11	11		**3** temps for PCCM impmentation	
Communications	2	2			
Accounting and Finance	6	7			**1** vacancy
Procurement	3	3			
Decision Support Services	6	7			**1** Vacancy
Project Management Office	3	2			
Information Technology	3	4		**.5** - Contractor Database Administrator	
Infrastructure	5	5		**2** Helpdesk, **3** - Windows 10 project until Feb	
Solution Services	6	9		**2** Contractors BSA, **1** Developer, **.25** DevOps Eng (ETP, Enterprise Portfolio)	
Gov and Comm Relations	3	3			
Quality	11	10		**1** HEDIS temp (filling now)	
Pharmacy	2.5	2.5			
Health Services	82	85			3 Vacancies
Total FTE	**191**	**204.5**		**Total 15.75**	

1. Actual budget was 11 positions, one of those was supposed to reside in Finance, transferred back to Finance.

2. Director of Operations position was eliminated. One transferred to PMO.

OPEN - Eliminations	Department
Clinical Analyst	DSS
PT Health Education Specialist	Health Services
Health Navigator	Health Services
Claims Analyst II	Operations
Project Manager	DSS
Member Service Specialist	Operations
Member Sevcs Quality Auditor	Operations
Pharmacist	CMO

Position Eliminations	
RN Delegation Oversight Auditor	Compliance
Financial Analyst	DSS
COO	Executive
Director Operations	Executive
Total 12 (6.3% of total employee count)	

Some eliminated positions were removed from budgeted FTE prior to budget finalization

NETWORK OPERATIONS

Regulatory:

There were no requests from DHCS

Provider Contracting Update:

- **Medical Cost Reduction Contract Strategy:**
  - Currently in negotiations with 5 community and 4 tertiary hospitals
    - Discussions on target and finalizing agreements with 2 hospitals
    - Narrowed Network initiative
      - Outpatient lab- Capitated arrangement. Negotiations completed. Contract being prepared for signature
    - Specialty services (mainly tertiary professional and ancillary PT)- Negotiations in process and on target

- **New Contracts:** None this month. Agreements pending.
  - **Amendments:**
    - VCMC – addition of 3 public health clinics
    - Two Trees Physical Therapy – addition of physical therapist
    - National Seating and Mobility – addition of new location
    - Kindred Healthcare – addition of Paramount location formerly owned by Promise Healthcare

- **Provider Additions and Terminations**

October 2019 Provider Additions- 32 Total

Midlevel	3
Primary Care Provider	1
Specialist	28

October 2019 Provider Terminations – 26 Total

Midlevel	3
PRIMARY CARE PROVIDER	1
Specialist	22

- **American Medical Response Termination**

  - DHCS APL 19-007 issued June 14, 2019
  - Non-contracted versus contracted reimbursement rates
  - Term Notice received from American Medical Response (AMR)
  - Two ambulance providers still contracted
  - No impact on ambulance services for members
  - Received demand letter from AMR for payment of add-on fee of $339 per transport.
  - Apparent conflict in APL 19-007 vs. State Plan Amendment 18-004
    - APL 19-007 requires managed care plans ("MCPs") to pay non-contracted ground emergency medical transport ("GEMT") providers the Roger's Rate, which equals $339.00 for each emergency transport billed under specified codes between July 1, 2018 and June 30, 2019 ("SFY 2019"). That APL did not require MCPs to pay any specific rates to contracted GEMTs.

    - At the same time, the State Plan Amendment ("SPA") 18-004 related to APL 19-007 increases the GEMT total payment FFS amounts by including an add-on to the FFS base rates for SFY 2019. With the add-on to the base rate, the total FFS payment amount equals $339.00, which is the same as the Roger's Rate for non-contracted providers.
  - DHCS clear that APL-19-007 was intended for non-contracted providers
  - GCHP received GEMT funding and have made appropriate payments to non-contracted GEMT providers, however DMHC did not adequately fund the Plan(s) to pay contracted providers.
  - GCHP outside counsel is now involved in this dispute

- **Better Doctors** – The Plan continues to meet weekly with Quest Analytics as a touch base to ensure that the process continues to move smoothly.

  We also continue to verify the demographic information obtain from Better Doctors. The following reviews were performed:
  - 1112 providers were completed and updated in Provider Network Database (PNDB).
  - 1196 provider records were audited to ensure the providers were loaded accurately in PNDB and IKA (GCHP Claims system).
  - 10 provider contracts were updated in based on data received from Better Doctors

Provider Contract review: 17 files reviewed for accuracy and system updates.

Provider Contracting and Credentialing Management System (PCCM) –

- Symplir-EVips Database Project:

  Team has attended bi-weekly meetings with internal GCHP staff and Symplir staff to discuss and make decisions required to support the eVIPs conversion and process configuration. This project includes the review and updating of the Provider Relations Shared Drive. It also includes the testing of the eVIPs system to ensure that information transfer from GCHP systems is accurate in the eVIPs system setup.

- No Test Cases completed during this period as new system conversion items are being updated by Symplar.

  Provider Network Database Updates (Current GCHP Provider System):
  Provider Network Operations continues to update its current Provider Network Database to aid in the conversion of data to the Symplir Database system. Provider Network Operations is reviewing and updating information created in the system since July 2011.

- Records Reviewed -5135
- Data Fields Updated - 4136

  Temporary Staff – PNO has brought on 3 temporary employees who are currently assisting in the transition to the eVIPS implementation. They have been focused on provider data updates, as required by the new system.

- **Provider Satisfaction/Provider Access Survey In process** –

  The Plan has employed SPH analytics to perform provider satisfaction and access surveys.
  - **Provider Access Survey**: Provider outreach completed and SPH is currently in data auditing and report composition phase. Estimate delivery of report back to Plan is expected EOM November.
  - **Provider Satisfaction Survey**: Provider outreach started 2nd week of October. Raw response rates as of 11/7/2019 was reported to be at 7.13%

These 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, fellows have finished with their clinical rotations.

RECOMMENDATION:

Accept and file the CEO Update.

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, Chief Medical Officer

DATE: November 18, 2019

SUBJECT: Engaging Member in Postpartum Care

SUMMARY:

Postpartum care addressing physical and emotional problems is an important determinant of quality health outcomes for women giving birth. Gold Coast Health Plan engaged members through a Health Navigator – Promotores de Salud framework which resulted in moving this DHCS quality measure from the 50th to the 90th percentile in 1 measurement year.

RECOMMENDATION:

Receive and file the presentation.

Gold Coast Health Plan[SM]
A Public Entity

Engaging Members in Postpartum Care

Lupe González, PhD, MPH
Director of Health Education, Cultural and Linguistic Services
October 2019

Integrity
Accountability
Collaboration
Trust
Respect

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

Agenda

- Postpartum Care as a Quality Improvement Initiative
- Engaging Members through the Health Navigator – Promotores de Salud Framework
- Hospital Discharge Visits to Promote Postpartum Care – Member Incentive Program
- Establishing a Network of Champions on Postpartum Care
- DHCS Quality Improvement Award 2018

Return to Agenda

Postpartum Care

- Collaborative between Quality Improvement and Health Education Departments

- Program Goal

  - Increase the percentage of postpartum visit on or between 21 and 56 days after delivery

  - Member Incentive Program

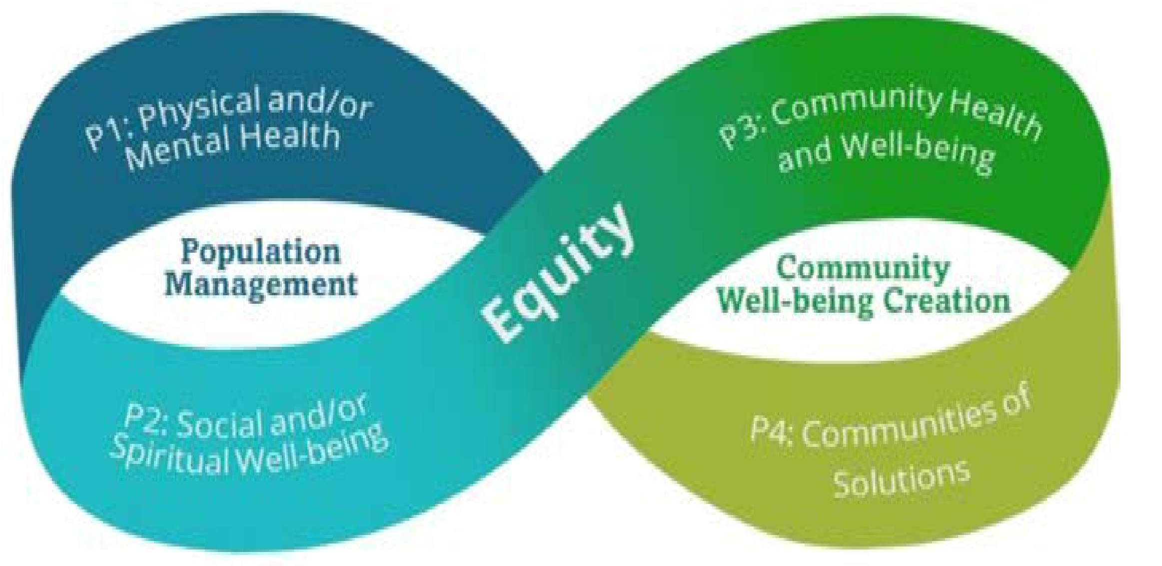
Return to Agenda

Engaging Members
Promotores de Salud/Health Promoters

- Promotores de Salud/Health Promoters – community health workers, peer educators or health navigators
- Strong understanding of their community and cultural health beliefs and behaviors
- Identify community leaders working in the community

Return to Agenda

Population Health Framework



Source: : http://www.ihi.org/resources/Pages/OtherWebsites/Pathways-to-Population-Health.aspx

Health Navigators to Improve Quality Measures

- Quality Improvement and Health Education Collaborative
- Postpartum visit can address adverse physical effects and emotional issues after giving birth
- How can the Health Navigator Program work to improve quality health care measures such as postpartum care

Postpartum Visit (PPV) Health Navigator Program

Health Navigators

- Hospital Daily Census Report
- Check Eligibility
- Admission & Discharge

Hospital Outreach

- Hospital Discharge Visit by Health Navigators
- Hospital Baby Tours
- Stress Importance of PPV
- Review Member Incentive Form

Partnerships

- Member Follow-up Call
- Member Reminder Calls
- Member Incentive Form Re-mail
- Provider Follow-up (PCPs & CPSP)

Member Incentive Program Outcomes

Study Period January - December	Member Participation	QI Mailed Form to Members	Participation Rate	Total Hospital Visits
2015	21	506	4.2%	0
2016	98	2142	4.6%	0
2017	158	1897	8.3%	0
2018	258	1823	14.2%	108

Source: Quality Improvement Quarterly Report 2019

Gold Coast Health Plan℠
A Public Entity

Program Outcomes by DHCS Percentile Ranking

<10th/10th	25th	50th	75th	90th
0	5	19	6	1
CAP1219*	CDC-Neph	CBP	CDC- >9%	PPC-Post
	IMA-Mening	CDC-HT	CDC- <8%	
	IMA-Tdap/Td	CDC-Eye	CIS-DTaP	
	AMR	CDC-BP	CIS-Combo 3	
	LBP	CIS-IPV	WCC-Nut	
	CCS*	CIS-MMR	WCC-PA	
	CAP-1224*	CIS-HiB		
	CAP-256*	CIS-HepB		
	CAP-711*	CIS-VZV		
		CIS-PC		
		IMA-HPV		
		IMA-Combo 2		
		PPC-Pre		
		W34		
		AAB		
		BCS		
		MPM-ACE/ARB		
		MPM-Diu		
		MPM-Total		

DHCS Percentiles

* For these measures, the Department of Health Care Services (DHCS) does not hold Managed Care Plans accountable for the minimum performance level or MPL. The MY 2018 MPL was equal to the 25th percentile. The Percentile rankings are determined by DHCS.

Network of Champions

- VCMC - Hospital Labor and Delivery Staff
- VCHCA – Comprehensive Perinatal Services Program (CPSP)
- Primary Care Providers (PCPs) and Clinic Staff
- Health Navigators
- Quality Improvement Team
- Health Services UM Team

Certificate of Appreciation

GOLD COAST HEALTH PLAN

PRESENTS THIS

Certificate of Appreciation

TO

Kristina Swaim

For Your Dedication and Commitment to
Providing Postpartum Care to Moms and Babies

July 9, 2019

Date

Gold Coast Health Plan[SM]
A Public Entity

Lupe González, MPH, PhD
Director of Health Education,
Cultural and Linguistic Services

DHCS Quality Award

DHCS
HealthCareServices

California Department of Health Care Services

Quality Strategy Focus Areas Most Improved Award 2019

Presented to

Gold Coast Health Plan – Ventura County

On October 30, 2019

In recognition of your efforts for going above and beyond for Medi-Cal managed care members on behalf of the Managed Care Quality and Monitoring Division, Department of Health Care Services.

Richard Figueroa, Acting Director, DHCS

Key Strategies

- ❑ Build a model that works for your health plan or program
- ❑ Know your community and key leaders
- ❑ Understand the cultural values of your members
- ❑ Recognize partnerships for their contributions
- ❑ Build trust and add value to the shared goals

Return to Agenda

VCMC – Postpartum Team

Ventura County - CPSP Team

DHCS - Quality Strategy Focus Area Award 2019

AGENDA ITEM 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: November 18, 2019

SUBJECT: Proposed Creation of a Personnel Subcommittee of the Commission, requested by Chairperson Antonio Alatorre and Appointment of Members to the Subcommittee.

SUMMARY:

The Gold Coast Health Plan (Plan) and the Commission are committed to providing appropriate oversight of all standing and special committees and subcommittees, including appointment of qualified candidates to each, as set forth under the Plan's Bylaws. Chairperson Alatorre has requested a discussion be agendized on the possible creation by the Commission of a new subcommittee dedicated to personnel.

BACKGROUND / DISCUSSION:

The Commission is responsible for establishing committees and advisory boards. (See Bylaws Art. IV, section (a).) Separately, the Commission's Bylaws describe a process by which Commission members may be asked to "participate on a subcommittee, task force or special project as part of their responsibilities." (See Bylaws Art. V.)

Chairperson Alatorre has requested a discussion on the possible creation of a subcommittee of the Commission dedicated to personnel matters. Such a subcommittee could be set up and organized under either Article IV or Article V of the Bylaws. A personnel subcommittee could, for example, propose guidelines, considerations, and factors that the Commission may use related to hiring and retention of agency employees and contractors. The subcommittee could also meet annually or bi-annually to review and receive reports from the Director of Human Resources and Chief Diversity Officer.

Additionally, there is a Plan Policy, amended on November 28, 2011, that delineates authority between the Commission and the Plan CEO. One such responsibility that has been delegated to the Plan CEO by the Commission is the: "[a]uthority to select, hire, evaluate, terminate and compensate all employees, including the Chief Medical Officer and Chief Financial Officer." A subcommittee to evaluate the delineation of authority has been created. Pending any changes in the delineation of authority, the Personnel Subcommittee could provide overall guidance and direction on personnel issues.

The Commission should discuss whether they are in favor of the creation of a personnel subcommittee. If the Commission wishes to create a personnel subcommittee, it should provide direction for Staff on how that subcommittee would be organized, including its size and membership of Commission members.

FISCAL IMPACT:

Establishment of a personnel subcommittee will not result in any immediate fiscal impacts.

RECOMMENDATION:

Staff recommends the following:

1. That the Commission discuss and consider Chairperson Alatorre's request for a personnel subcommittee, possibly create the subcommittee and appoint members to the subcommittee and provide further direction to Staff.

CONCURRENCE:

N/A

ATTACHMENTS:

Bylaws
Delineation of Authority Policy.

ATTACHMENT 1

POLICY

DELINEATION OF AUTHORITY

1. Any actions not specified as being the responsibility of the Commission are delegated to the CEO including, but not limited to:
   - Negotiation, execution and termination of provider contracts. As new model contracts are developed, Management will present such models to the Executive / Finance Committee as an information item.
   - Negotiation and execution of vendor contracts, subject to thresholds established by the Commission (See Attached: VCMMCC CEO Signing Authority for Contractual Agreements for Administrative Goods and Services, approved on June 28, 2010).
   - Authority to select, hire, evaluate, terminate and compensate all employees, including the Chief Medical Officer and Chief Financial Officer.
   - Management will inform the Commission of changes in senior executive positions.
   - Authority to establish and amend the staffing plan, provided that any changes to the staffing plan do not change the number of budgeted full-time equivalent employees by more than 10% and that the change does cause exceed the total budget.
   - Management will develop a salary range schedule for each established position. While the schedule is not subject to Commission approval, it will be presented to the Commission on an annual basis as an information item.

Amended: November 28, 2011

ATTACHMENT 2

POLICY

DELINEATION OF AUTHORITY

1. Any actions not specified as being the responsibility of the Commission are delegated to the CEO including, but not limited to:
   - Negotiation, execution and termination of provider contracts. As new model contracts are developed, Management will present such models to the Executive / Finance Committee as an information item.
   - Negotiation and execution of vendor contracts, subject to thresholds established by the Commission (See Attached: VCMMCC CEO Signing Authority for Contractual Agreements for Administrative Goods and Services, approved on June 28, 2010).
   - Authority to select, hire, evaluate, terminate and compensate all employees, including the Chief Medical Officer and Chief Financial Officer.
   - Management will inform the Commission of changes in senior executive positions.
   - Authority to establish and amend the staffing plan, provided that any changes to the staffing plan do not change the number of budgeted full-time equivalent employees by more than 10% and that the change does cause exceed the total budget.
   - Management will develop a salary range schedule for each established position. While the schedule is not subject to Commission approval, it will be presented to the Commission on an annual basis as an information item.

Amended: November 28, 2011

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

VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION (dba Gold Coast Health Plan)

Approved: October 24, 2011
Amended: January 23, 2017

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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;

(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. The term of each subsequent appointment shall be deemed to commence on March 15 of the year of the appointment.

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 VCMMC 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) The VCMMCC shall elect officers by majority vote of the members present.

(b) The election of officers shall be held at the first regular meeting of the VCMMCC after March 15 (or after the date upon which the Board of Supervisors appoints Commissioners for the present term if later than March 15) in every even-numbered year. The two-year terms of office shall be deemed to commence on March 15 of the year of the election, regardless of when the election actually occurs. The officers of the prior term shall continue to preside over any meetings and perform all other functions of their offices until new officers are elected.

(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. 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. 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 on all of its activities to the governing board at the next regular meeting of the governing board.

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). If the Chairperson and/or Vice-Chairperson is a private hospital/healthcare system representative, then the Commission may appoint any one of its members to fill this position.

4. Ventura County Medical Center Health System representative. If the Chairperson and/or Vice-Chairperson is a Ventura County Medical Center Health System representative, then the Commission may appoint any one of its members to fill this position.

5. Clinicas Del Camino Real representative. If the Chairperson and/or Vice-Chairperson is a Clinicas Del Camino Real representative, then the Commission may appoint any one of its members to fill this position.

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

Appointments to the Committee shall be made at either the regular meeting in which the Chairperson and Vice-Chairperson are elected or at the next regular meeting immediately thereafter. Appointments may also be made at any regular meeting where the appointment is necessitated by a resignation, termination, vacancy, special election of officers, or other event which results in the Committee lacking full membership.

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:

   - PCP
   - Specialists
   - Hospitals o LTC
   - 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. On an annual basis, develop the CEO review process and criteria.

12. Serve as Interview Committee for CEO/CMO/CFO.

13. 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.

14. Develop long-term and short-term business plans for review and approval by the governing board.

15. Undertake such other activities as may be delegated from time-to-time by the governing board.

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.

6. Hiring or firing of senior executives, but may make recommendations to the governing board as to their appointment, dismissal or ongoing performance.

7. Taking any action on behalf of the governing board unless expressly authorized by the governing board.

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. 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

(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 Commissioner 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 *Rosenberg's Rules of Order*, to resolve parliamentary questions.

(h) 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. 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 NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kashina Bishop, Chief Financial Officer

DATE: November 18, 2019

SUBJECT: October 2019 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached October 2019 fiscal year-to-date (FYTD) financial statements of Gold Coast Health Plan ("Plan") for the Commission to accept and file.

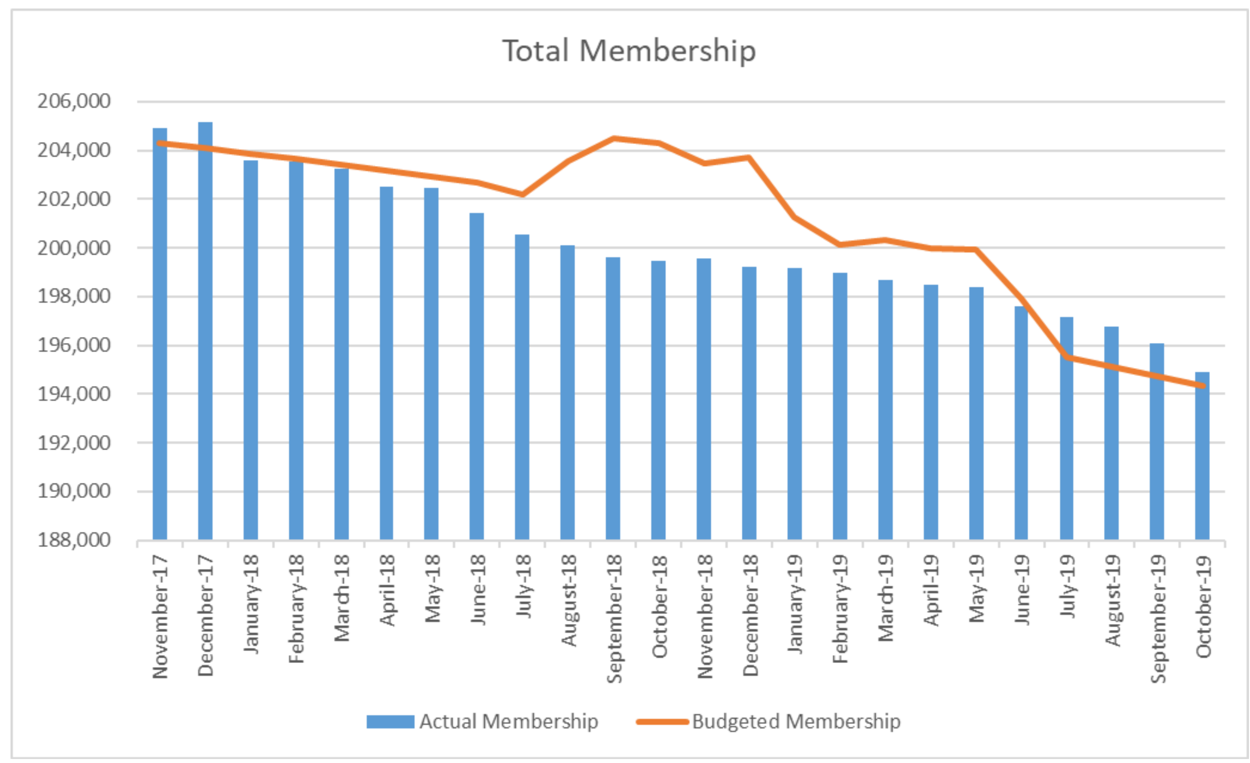
BACKGROUND/DISCUSSION:

The staff has prepared the unaudited October 2019 FYTD financial package, including statements of financial position, statement of revenues, expenses and changes in net assets, and statement of cash flows.

FISCAL IMPACT:

FYTD Financial Highlights

- Net loss of $1.5 million; a $1.2 million budget variance.
- October FYTD net revenue is $271.1 million, $10.4 million higher than budget.
- FYTD Cost of health care is $229.1 million, $16.3 million higher than budget.
- The medical loss ratio is 95.0% of revenue, which is 2.5% higher than the budget.
- The administrative cost ratio is 5.9%, 1.8% lower than budget.
- Current membership for October is 194,896. Member months for the year are at 784,945 which 1% greater than budget.
- Tangible Net Equity is $74.1 million which represents approximately 33 days of operating expenses in reserve and 227% of the required amount by the State.



Financial Report:

In the month of October 2019, Gold Coast Health Plan is reporting a net gain of $94,847. Overall medical costs in aggregate are consistent with the prior month, noting the following variance:

- Capitation increased by approximately $500,000. Staff discovered that Kaiser had not been paid for supplemental payments for behavioral health and hepatitis C, with the issue going back several years.

Revenue

Premium revenue is over budget by $10.4 million and 4%. The budget variance is being driven by the following:

- Membership is over budget by 1%.
- Due to increasing risk of the population, GCHP received revised draft capitation rates from the State which were 1.7% higher than budgeted.
- Due to increased utilization, supplemental payments for Behavioral Health services is $4 million higher than budgeted.

Health Care Costs

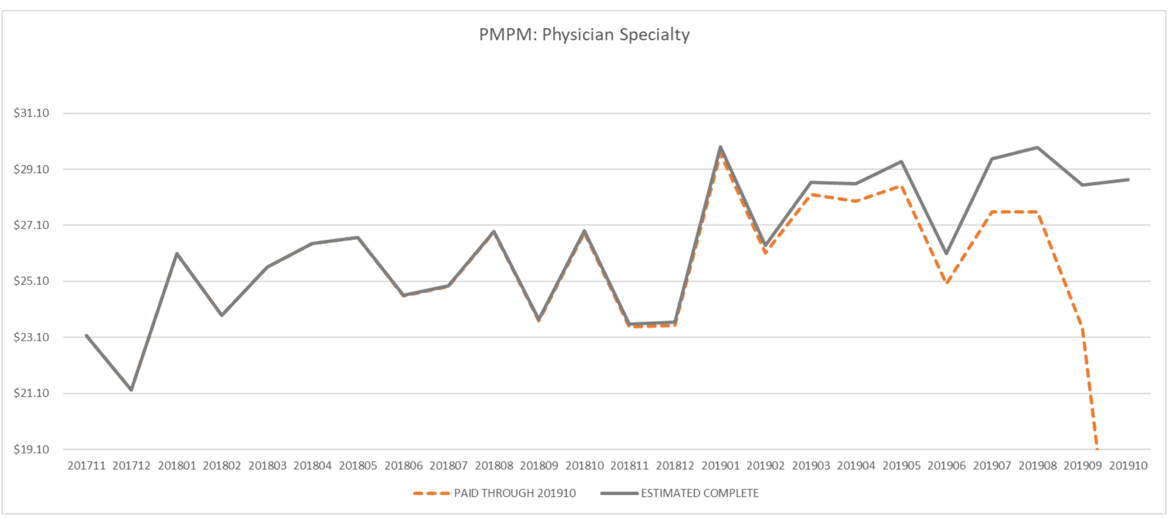
FYTD Health care costs are $257.4; over budget by $16.3 million and 7%.

Notable variances from the budget are as follows:

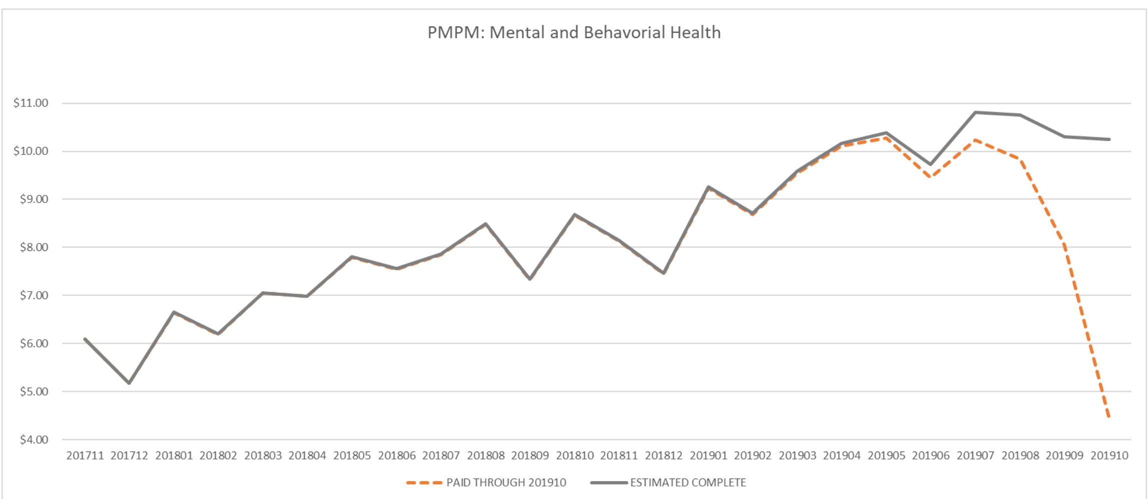
- Membership is over budget by 1% which will impact the anticipated medical expenses, this is offset by revenue.

- Directed payments (for Proposition 56) are over budget by $2.0 million. The majority of the variance is driven by prior year changes in estimate.

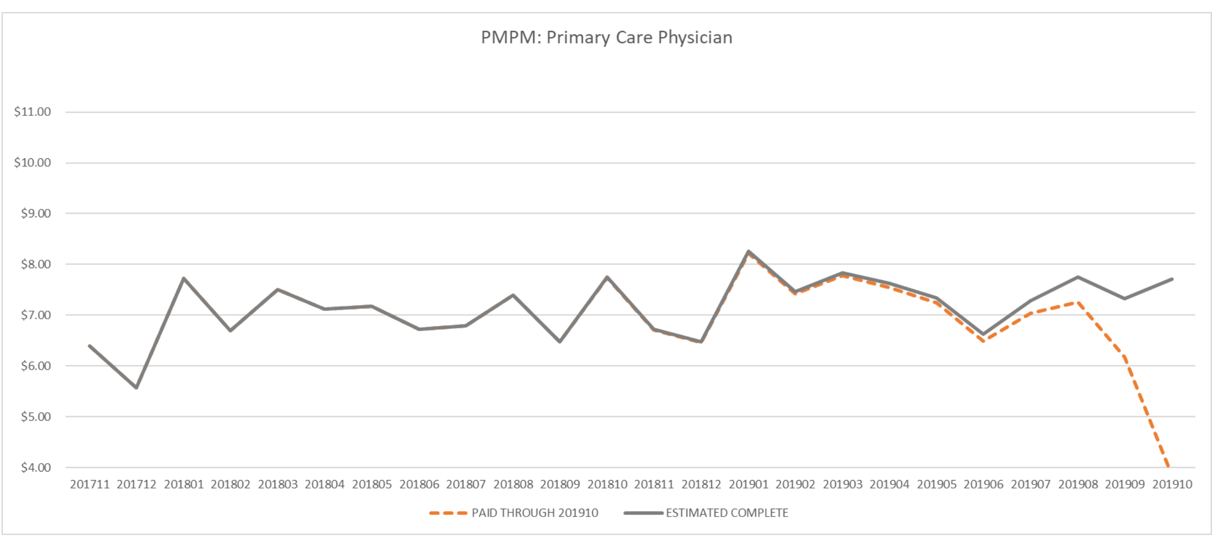
- Physician Specialty is over budget by $3.9 million. As discussed in prior meetings, the service types with the most significant increases in the prior year are Physical Therapy and Dermatology. The most recent months are still considered an estimate and are based on historical costs, which also had a seasonal increase in the first quarter of 2019. GCHP has taken steps that should reduce these costs but it will take some time to reflect in the financial statements.



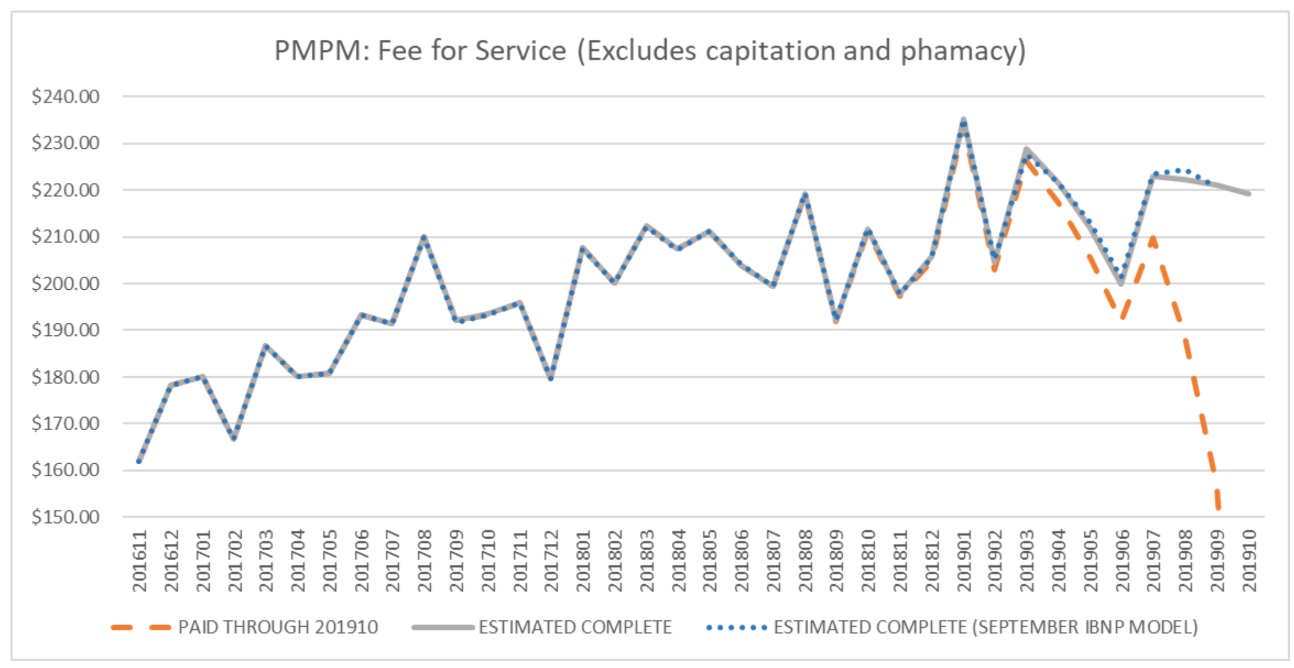
- Behavioral and mental health utilization has increased significantly in the most recent months which could indicate a need to revise per member per month cost expectations for the current fiscal year. The budget is $8.16 per member per month and the average expense in the first quarter of FY 19-20 $10.53 per member per month. If it continues at this rate, the annual increase in cost would be approximately $4.5 million. The increased cost will be partially offset by supplemental payments from the State for Behavioral Health treatment.

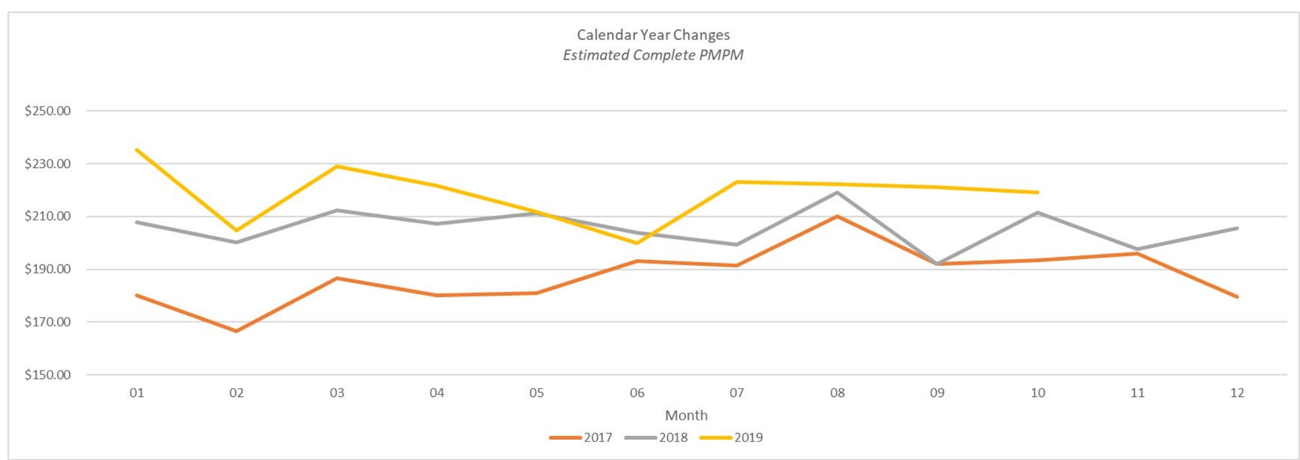


- Primary Care Physician is over budget by $1.53 pmpm (27%). This appears to be an improvement in the pull of data as the overall pmpm on a monthly basis is very consistent.



- Total fee for service health care costs, considering date of service, are over budget by $10.25 pmpm (5%). As noted in the next graph, we typically see variances in overall medical expense on a month to month basis. The Incurred But Not Paid model is assuming that medical expenses increase slightly in July and then remain stable, to be conservative. The spike in July dates of service are primarily driven by high dollar inpatient cases, with one claim of $1.4 million related to a heart failure case.





Note: Medical expenses are considered a significant estimate due to the delay between the time the medical service is provided and when the claim is paid. This is calculated through a predictive model which 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).

Looking Forward:

If the current trend in both Fee for Service medical expenses and Pharmacy continued, this would equate to a medical expense budget variance of approximately $30 million. That said, we anticipate the seasonal lower months will improve the impact as well as higher than budgeted premium revenue (this was due to recognition from the State that the acuity level of the members has increased), higher than budgeted supplemental revenue for Behavioral Health, and internal initiatives to reduce medical expenses.

Staff is making considerable process on some of the cost savings initiatives previously discussed with the Commission. Contract negotiations are near being finalized that are estimated to be approximately $7 million in annual savings. In addition, one provider was terminated from the network in November which staff anticipates will reduce both physician specialty and pharmacy expenses.

Administrative Expenses – For the fiscal year to date through October, administrative costs were $16.1 million and $4.1 million below budget. As a percentage of revenue, the administrative cost ratio (or ACR) was 5.9% versus 7.7% for budget.

Cash and Short Term Investment Portfolio – At October 31st, the Plan had $99.7 million in cash and short-term investments. The investment portfolio included Ventura County Investment Pool $42.2 million; LAIF CA State 5.1 million; the portfolio yielded a rate of 2.3%.

Medi-Cal Receivable – At October 31st, the Plan had $95.3 million in Medi-Cal Receivables due from the DHCS.

RECOMMENDATION:

Staff requests that the Commission accept and file the October 2019 financial package.

ATTACHMENT:

October 2019 Financial Package

Gold Coast Health Plan[SM]
A Public Entity

FINANCIAL PACKAGE
For the month ended October 2019

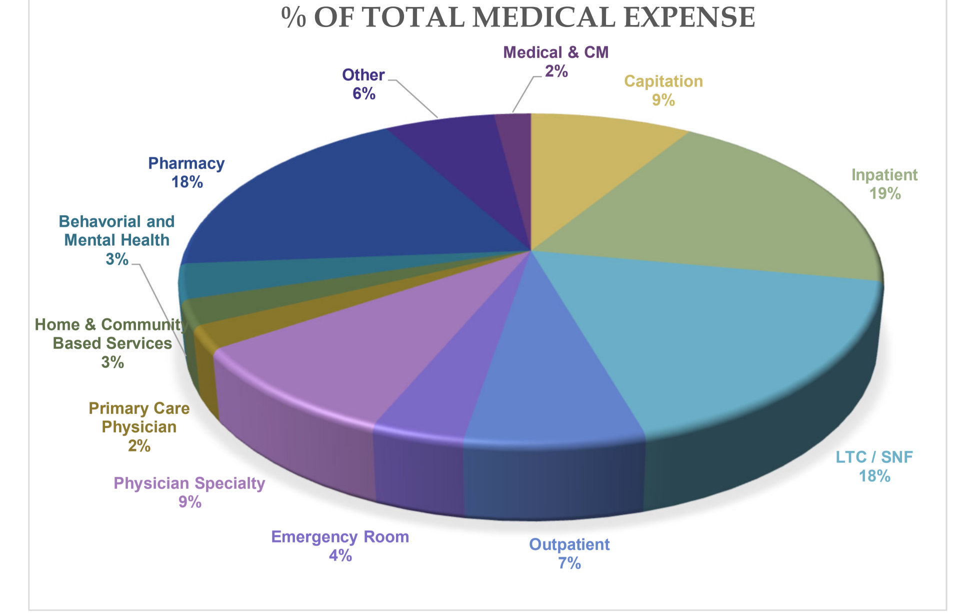
TABLE OF CONTENTS

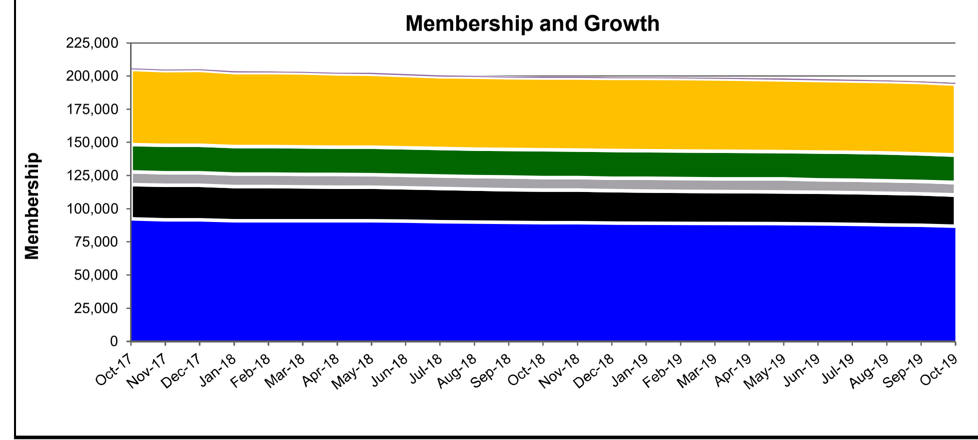
- Executive Dashboard
- Statement of Financial Position
- Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Cash Flows

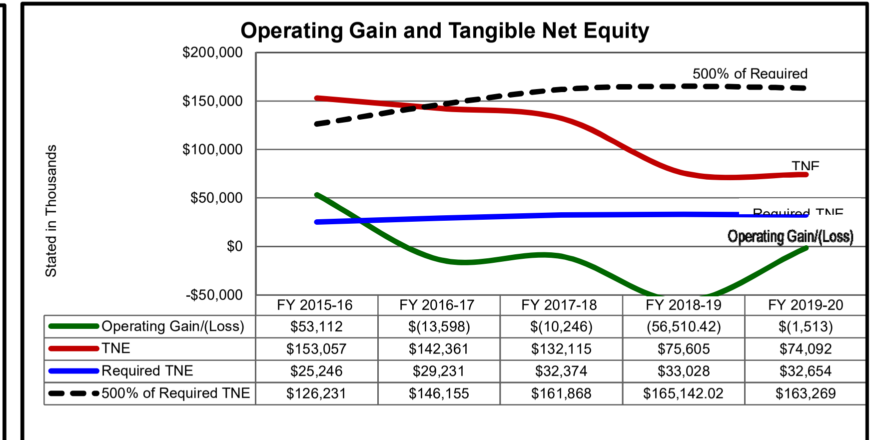
Gold Coast Health Plan

Executive Dashboard as of October 31, 2019

	FYTD 19/20 Budget	FYTD 19/20 Actual	FY 18/19 Actual	FY 17/18 Actual
Average Enrollment	194,943	196,236	198,140	202,748
Revenue	$ 334.27	$ 345.35	$ 303.88	$ 284.60
Capitation	$ 26.53	$ 28.88	$ 25.14	$ 13.90
Inpatient	$ 61.66	$ 62.77	$ 62.09	$ 58.98
LTC / SNF	$ 57.00	$ 57.61	$ 56.06	$ 51.30
Outpatient	$ 25.69	$ 23.31	$ 25.88	$ 25.74
Emergency Room	$ 11.92	$ 12.13	$ 12.14	$ 12.77
Physician Specialty	$ 25.52	$ 30.36	$ 26.71	$ 23.82
Primary Care Physician	$ 5.85	$ 7.39	$ 7.36	$ 6.78
Home & Community Based Services	$ 8.04	$ 8.11	$ 8.14	$ 6.88
Behavorial and Mental Health	$ 8.15	$ 11.29	$ 8.69	$ 6.37
Pharmacy	$ 57.10	$ 59.81	$ 56.60	$ 49.76
Other	$ 14.86	$ 19.72	$ 13.33	$ 9.48
Medical & CM	$ 6.97	$ 6.59	$ 5.92	$ 4.79
Total Per Member Per Month	$ 309.28	$ 327.96	$ 308.05	$ 270.57
% of Revenue	92.5%	95.0%	101.4%	95.1%
Total Administrative Expenses	$ 20,158,176	$ 16,070,475	$ 46,655,880	$ 49,015,352
% of Revenue	7.7%	5.9%	6.5%	7.1%
TNE	$ 93,700,000	$ 74,092,089	$ 80,207,972	$ 132,115,371
Required TNE	$ 33,464,286	$ 32,653,711	$ 32,802,236	$ 32,373,536
% of Required	280%	227%	245%	408%







	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Operating Gain/(Loss)	$53,112	$(13,598)	$(10,246)	(56,510.42)	$(1,513)
TNE	$153,057	$142,361	$132,115	$75,605	$74,092
Required TNE	$25,246	$29,231	$32,374	$33,028	$32,654
500% of Required TNE	$126,231	$146,155	$161,868	$165,142.02	$163,269

STATEMENT OF FINANCIAL POSITION

	10/31/19	09/30/19	08/31/19
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**$ 52,317,686**	**92,280,061**	**$ 78,472,639**
Total Short-Term Investments	**47,421,645**	**47,389,970**	**47,389,963**
Medi-Cal Receivable	95,298,896	83,147,845	76,324,504
Interest Receivable	359,599	293,045	194,827
Provider Receivable	442,704	611,342	478,044
Other Receivables	7,826,204	7,826,204	7,826,204
Total Accounts Receivable	**103,927,403**	**91,878,436**	**84,823,579**
Total Prepaid Accounts	2,031,705	2,043,725	1,979,466
Total Other Current Assets	153,789	153,789	153,789
Total Current Assets	**205,852,229**	**233,745,981**	**212,819,436**
Total Fixed Assets	**1,812,848**	**1,819,330**	**1,852,302**
Total Assets	**$ 207,665,077**	**$ 235,565,311**	**$ 214,671,738**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 51,577,047	56,836,101	$ 54,940,117
Claims Payable	9,558,471	15,520,141	13,419,244
Capitation Payable	26,181,539	26,265,298	26,684,218
Physician Payable	4,867,814	3,987,130	3,048,194
DHCS - Reserve for Capitation Recoup	18,442,789	15,611,208	15,611,208
Accounts Payable	472,934	2,871,606	323,802
Accrued ACS	5,099,512	3,399,362	3,289,709
Accrued Provider Reserve	1,700,000	1,700,000	1,700,000
Accrued Pharmacy	12,670,778	17,753,988	18,702,982
Accrued Expenses	886,816	14,979,442	324,247
Accrued Premium Tax	-	-	-
Accrued Payroll Expense	1,005,684	1,531,304	1,562,408
Total Current Liabilities	**132,463,384**	**160,455,579**	**139,606,130**
Long-Term Liabilities:			
Other Long-term Liability-Deferred Rent	1,109,605	1,112,492	1,115,379
Total Long-Term Liabilities	**1,109,605**	**1,112,492**	**1,115,379**
Total Liabilities	**133,572,989**	**161,568,070**	**136,118,484**
Net Assets:			
Beginning Net Assets	75,604,948	75,604,948	75,604,948
Total Increase / (Decrease in Unrestricted Net Assets)	(1,512,859)	(1,607,706)	(1,654,717)
Total Net Assets	**74,092,089**	**73,997,242**	**73,950,231**
Total Liabilities & Net Assets	**$ 207,665,077**	**$ 235,565,311**	**$ 214,671,738**

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR MONTH ENDED October 31, 2019

	Oct 2019	Oct 2019 Year-To-Date		Variance	Variance	Oct 2019 Year-To-Date		Variance
	Actual	Actual	Budget	Fav / (Unfav)	%	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	194,896	784,945	779,771	5,174	1%	PMPM - FYTD		
Revenue								
Premium	$ 67,885,397	$ 271,082,996	$ 260,655,507	$10,427,489	4%	$ 345.35	$ 334.27	$ 11.08
Total Net Premium	**67,885,397**	**271,082,996**	**260,655,507**	**10,427,489**	**4%**	**345.35**	**334.27**	**11.08**
Other Revenue:								
Miscellaneous Income	10,589	10,589	-	10,589	0%	0.01	-	0.01
Total Other Revenue	10,589	10,589	-	10,589	0%	0.01	-	0.01
Total Revenue	**67,895,986**	**271,093,585**	**260,655,507**	**10,438,078**	**4%**	**345.35**	**334.27**	**11.09**
Medical Expenses:								
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	5,966,642	22,669,133	20,690,176	(1,978,958)	-10%	28.88	26.53	(2.35)
FFS Claims Expenses:								
Inpatient	11,582,601	49,273,985	48,077,364	(1,196,621)	-2%	62.77	61.66	(1.12)
LTC / SNF	10,574,162	45,217,260	44,448,533	(768,727)	-2%	57.61	57.00	(0.60)
Outpatient	4,512,146	18,298,961	20,032,191	1,733,230	9%	23.31	25.69	2.38
Laboratory and Radiology	544,744	1,578,059	1,332,864	(245,195)	-18%	2.01	1.71	(0.30)
Directed Payments - Provider	1,491,128	8,038,161	6,039,261	(1,998,900)	-33%	10.24	7.74	(2.50)
Emergency Room	2,428,628	9,523,617	9,292,407	(231,210)	-2%	12.13	11.92	(0.22)
Physician Specialty	6,276,799	23,830,036	19,896,161	(3,933,875)	-20%	30.36	25.52	(4.84)
Primary Care Physician	1,499,244	5,797,380	4,562,630	(1,234,749)	-27%	7.39	5.85	(1.53)
Home & Community Based Services	1,545,762	6,362,735	6,269,968	(92,766)	-1%	8.11	8.04	(0.07)
Applied Behavioral Analysis/Mental Health Service	2,105,778	8,863,402	6,356,021	(2,507,381)	-39%	11.29	8.15	(3.14)
Pharmacy	12,103,454	46,943,746	44,521,025	(2,422,721)	-5%	59.81	57.10	(2.71)
Provider Reserve	-	(295,681)	605,342	901,022	149%	(0.38)	0.78	1.15
Other Medical Professional	348,772	1,454,826	1,273,353	(181,473)	-14%	1.85	1.63	(0.22)
Other Medical Care	-	13,551	-	(13,551)	0%	0.02	-	(0.02)
Other Fee For Service	866,270	3,542,805	3,115,475	(427,330)	-14%	4.51	4.00	(0.52)
Transportation	128,165	611,943	565,916	(46,027)	-8%	0.78	0.73	(0.05)
Total Claims	56,007,652	229,054,786	216,388,512	(12,666,274)	-6%	291.81	277.50	(14.31)
Medical & Care Management Expense	1,426,020	5,170,921	5,432,548	261,626	5%	6.59	6.97	0.38
Reinsurance	281,588	1,129,808	321,673	(808,134)	-251%	1.44	0.41	(1.03)
Claims Recoveries/Budget Reduction	(34,317)	(595,815)	(1,666,667)	(1,070,851)	64%	(0.76)	(2.14)	(1.38)
Sub-total	1,673,290	5,704,914	4,087,555	(1,617,359)	-40%	7.27	5.24	(2.03)
Total Cost of Health Care	**63,647,585**	**257,428,834**	**241,166,242**	**(16,262,591)**	**-7%**	**327.96**	**309.28**	**(18.68)**
Contribution Margin	**4,248,402**	**13,664,751**	**19,489,265**	**(5,824,513)**	**-30%**	**17.40**	**24.99**	**(7.60)**
General & Administrative Expenses:								
Salaries, Wages & Employee Benefits	2,276,986	8,751,374	9,160,906	409,533	4%	11.15	11.75	0.60
Training, Conference & Travel	18,169	80,802	262,420	181,618	69%	0.10	0.34	0.23
Outside Services	2,247,399	8,420,907	9,171,167	750,260	8%	10.73	11.76	1.03
Professional Services	201,577	930,796	1,435,800	505,004	35%	1.19	1.84	0.66
Occupancy, Supplies, Insurance & Others	838,899	2,671,214	3,002,468	331,254	11%	3.40	3.85	0.45
Care Management Credit	(1,426,020)	(5,170,921)	(5,432,548)	(261,626)	5%	(6.59)	(6.97)	(0.38)
G&A Expenses	4,157,010	15,684,172	17,600,213	1,916,042	11%	19.98	22.57	2.59
Project Portfolio	204,131	386,304	2,557,963	2,171,659	85%	0.49	3.28	2.79
Total G&A Expenses	**4,361,141**	**16,070,475**	**20,158,176**	**4,087,701**	**20%**	**20.47**	**25.85**	**5.38**
Total Operating Gain / (Loss)	**(112,740)**	**(2,405,724)**	**(668,911)**	**(1,736,813)**	**260%**	**(3.08)**	**(0.86)**	**(2.22)**
Non Operating								
Revenues - Interest	207,587	892,865	347,541	545,324	157%	1.14	0.45	0.69
Total Non-Operating	207,587	892,865	347,541	545,324	157%	1.14	0.45	0.69
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 94,847**	**$ (1,512,859)**	**$ (321,371)**	**$ (1,191,489)**	**371%**	**$ (1.94)**	**$ (0.41)**	**$ (1.53)**

STATEMENT OF CASH FLOWS	Oct 2019	FYTD 19-20
Cash Flows Provided By Operating Activities		
Net Income (Loss)	$ 94,847	$ (1,512,859)
Adjustments to reconciled net income to net cash provided by operating activities		
Depreciation on fixed assets	39,723	122,492
Amortization of discounts and premium	-	-
Changes in Operating Assets and Liabilites		-
Accounts Receivable	(12,151,051)	(24,270,284)
Prepaid Expenses	12,020	12,365
Accounts Payable	(4,650,300)	11,740,678
Claims Payable	(5,164,745)	(5,385,374)
MCO Tax liablity	-	(23,626,246)
IBNR	(5,259,053)	(180,865)
Net Cash Provided by (Used in) Operating Activities	(27,078,560)	(43,100,092)
Cash Flow Provided By Investing Activities		
Proceeds from Restricted Cash & Other Assets		
Proceeds from Investments	-	-
Proceeds for Sales of Property, Plant and Equipment		-
Payments for Restricted Cash and Other Assets		-
Purchase of Investments plus Interest reinvested	(31,675)	(427,405)
Purchase of Property and Equipment	-	(234,330)
Net Cash (Used In) Provided by Investing Activities	(31,675)	(661,735)
Increase/(Decrease) in Cash and Cash Equivalents	(27,110,235)	(43,761,827)
Cash and Cash Equivalents, Beginning of Period	115,605,355	132,256,947
Cash and Cash Equivalents, End of Period	$ 88,495,120	$ 88,495,120

AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, Chief Medical Officer

DATE: November 18, 2019

SUBJECT: Chief Medical Officer Update

GCHP Recognized at Annual DHCS Quality Conference

Gold Coast Health Plan (GCHP) participated in the California Department of Health Services (DHCS) - Health Services Advisory Group (HSAG) joint conference on October 30, 2019 entitled *Health Equity: Promoting Quality and Access for All*.

The conference included 2019 Quality Updates by Nathan Nau, Chief, Managed Care Quality and Monitoring Division, which included the following:

- GCHP was among eleven Managed Care Plans (MCP) above the minimum performance level (MPL) on all indicators for measurement year (MY) 2018
- For MY 2018, for all MCPs:
    - High performance areas included Comprehensive Diabetes Care measures (eye exam, HbA1c Control and blood pressure control) and Weight Assessment & Counseling in Children and Adolescents – Physical Activity.
    - Improvements were noted in the following measures:
        - Breast Cancer Screening
        - Timeliness of Prenatal Care
        - Postpartum Care
    - Small declines were noted in Asthma Medication Ratio (AMR) and Well Child Visits in the 3rd-6th Years of Life (W34).
    - Childhood Immunization Status (CIS-3) performance remained unchanged.

The 2019 Quality Awards were announced and GCHP proudly received the following two awards:

- **Greatest Overall Improvement in One Year Winner 2019**
    - GCHP is proud to win this award two years in a row! This award goes to the MCP with the most significant improvement from the prior year based on performance across all External Accountability Set (EAS) Indicators for which DHCS holds MCPs to the Minimum Performance Levels (MPLs).

- DHCS applied a point system similar to the Aggregated Quality Factor Score as the basis for determining the MCPs with the highest scores based on HEDIS performance.
- Points for each indicator are computed from the EAS indicators for which DHCS holds MCPs to the Minimum Performance Levels (MPLs) to calculate an overall score for each MCP reporting unit.
- The score at the MCP reporting unit is compared to previous calendar year's score to determine MCP with the greatest improvement in one year.

- **Quality Strategy Focus Areas Most Improved Award 2019**

  - GCHP is a first-time winner in this category. The award goes to the MCP with the most significant improvement from the prior year based on performance in four Quality Strategy Focus Areas:

    1. Comprehensive Diabetes Care (an average of 6 indicators)
    2. Controlling High Blood Pressure
    3. Childhood Immunizations Status – Combination 3
    4. Prenatal and Postpartum Care – Postpartum Care

  - DHCS applied a point system similar to the Aggregated Quality Factor Score as the basis for determining the MCPs with the highest scores based on HEDIS performance.
  - Points for each Quality Strategy Focus Area (QSFA) indicator are computed to calculate an overall score for each MCP reporting unit.
  - The QSFA score at the MCP reporting unit is compared to previous calendar year's score to determine MCP with the greatest improvement in one year.

From MY 2017 to MY 2018, GCHP demonstrated improvement in the four Quality Strategy Focus Areas as follows:

Measure	MY 2017/ RY 2018	MY 2018/ RY 2019
Comprehensive Diabetes Care – Medical Attention for Nephropathy	10th percentile	25th percentile
Controlling High Blood Pressure	25th percentile	50th percentile
Childhood Immunizations Status – Combination 3	25th percentile	75th percentile
Postpartum Care	50th percentile	90th percentile

Diabetes Prevention Program (DPP) Update

More than 30 million Americans have diabetes and more than 84 million have prediabetes. Health care costs for people with diabetes are between two and three times the cost of care for those without diabetes. Over the five-year period from 2012 to 2017, the cost of diabetes care increased 26%. To address this issue, DHCS mandated that Medi-Cal Managed Care Plans provide a diabetes prevention benefit based on an evidence-based Centers for Disease Control (CDC) program.

On November 4th, 2019, Solera Health initiated targeted outreach to over 15,000 pre-diabetic members to introduce them to the GCHP Diabetes Prevention Program. The new DPP benefit offers a CDC-recognized lifestyle change program, which can prevent or delay the onset of Type II diabetes among individuals at risk or diagnosed with prediabetes.

Adult pre-diabetic members received letters and phone calls promoting this benefit. The program consists of 22 peer-coaching sessions over a one-year period with the desired outcome of lifestyle change leading to weight loss.

A customized, co-branded website is available in English and Spanish, which provides members an opportunity to take a brief eligibility quiz, lean more about the program, obtain referrals to online or community programs, or speak to a live agent.

Vaping Related Lung Illness

As of November 5, 2019, the Centers for Disease Control and Prevention (CDC) is reporting over 2,000 lung injury cases from 49 states. There have been 8 confirmed cases in Ventura County. The lung injury can be serious and even fatal with 39 deaths confirmed in 24 states. Most of the injuries involve young people (median age 23) and tested products commonly contain THC. Vitamin E acetate, and additive to THC-containing products has been identified as a chemical of potential concern.

The CDC recommends that people should not:

- Use e-cigarette, or vaping, products that contain THC.
- Buy any type of e-cigarette, or vaping, products, particularly those containing THC, off the street.
- Modify or add any substances to e-cigarette, or vaping, products that are not intended by the manufacturer, including products purchased through retail establishments.

Pharmacy Update

Medi-Cal Rx

The California Department of Health Care Services (DHCS) will be carving out all prescription benefits from the Managed Care Plans (MCP) as of January 1, 2021. This change will result in GCHP no longer offering a prescription benefit to members. DHCS has called this program Medi-Cal Rx. Upon implementation, all prescription claims will be submitted directly to the state via a new PBM contracting directly with Medi-Cal. MCPs will continue to be responsible for care coordination and drug therapy management programs. DHCS recently released a Notice of Intent to Award for Magellan Medicaid Administration, Inc. DHCS is holding stakeholder and technical workgroups with representation from the MCP regarding the implementation of this benefit. The pharmacy department will provide additional information as it becomes available.

Pharmacy Benefit Cost Trends

GCHP's pharmacy trend shows an overall price increase of 8.8% from September 2018 to September 2019. 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 show significant increases in pharmacy costs.

Factor	National Trend	GCHP Trend
Unit Cost	• Price inflation is a top contributor, outpacing utilization growth 4:1.[1] • Average price increase per drug was 10.5% in the first half of 2019.[2]	• Unit cost increased 6.9% from Q2 2018 to Q2 2019.
Utilization	• The number of prescriptions increased 21% from 2014 to 2017.[5]	• RxPMPM increased 5.8% from 2018 to 2019.
Drug Mix	• 59 new drug approval in 2018 – new all-time record high, 28% increase from 2017.[3] • Pharma TV ad spending increased to $3.73B in 2018.[4]	• Specialty drugs increased 4.5% from 2018 to 2019.

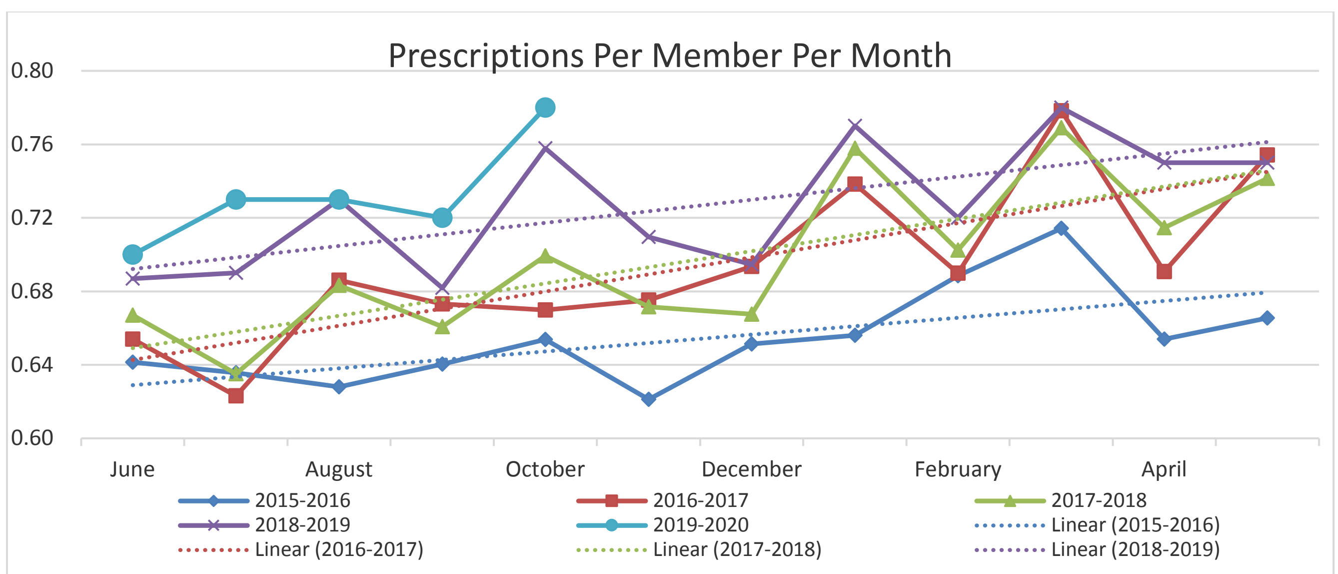
GCHP Annual Trend Data

Unit Cost Trends:

OptumRx reported that GCHP's unit cost trends from 2018Q2 to 2019Q2 was a 6.9% increase in unit cost.

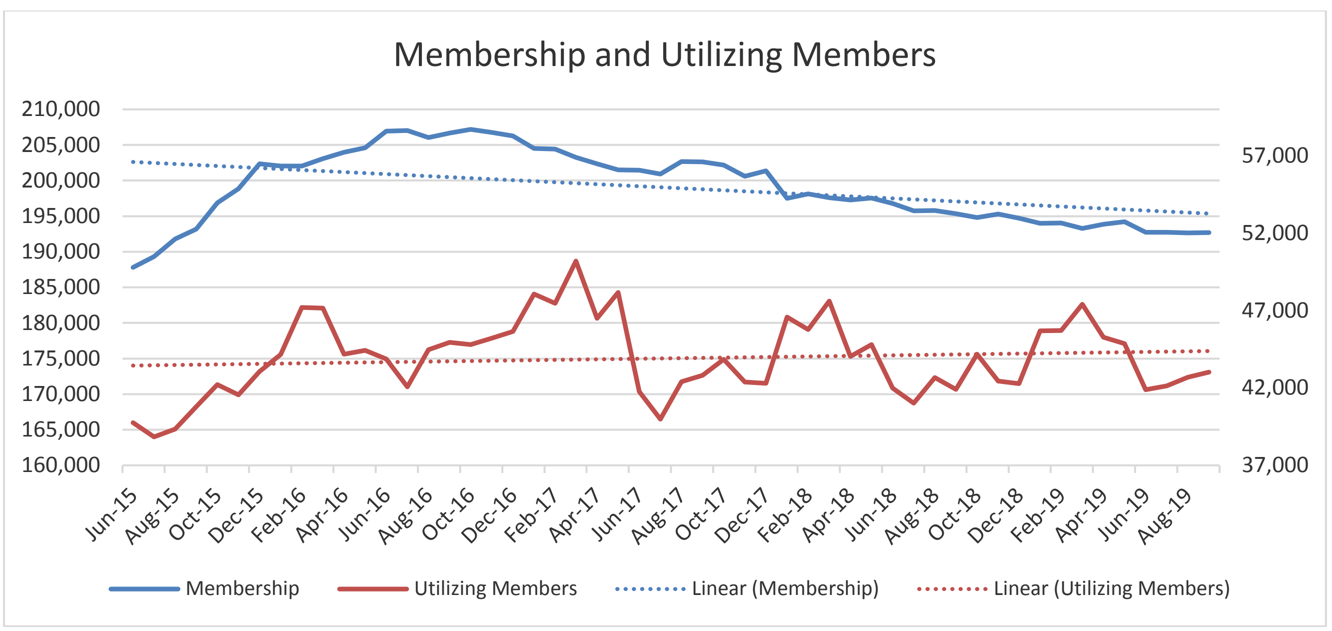
Utilization Trends:

GCHP's utilization is increasing as demonstrated by the number of members using prescriptions and the number of prescriptions each member is using while GCHP's total membership continues to decline.



Number of prescriptions per member continues to increase year over year:

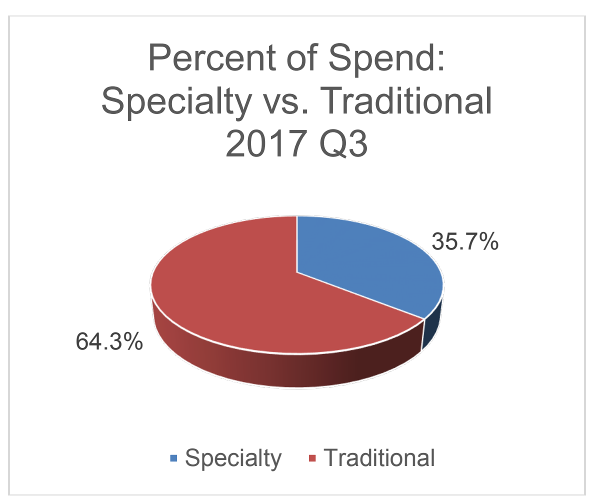
	July RxPMPM	Percent Change
2015	0.64	-
2016	0.62	-3.1%
2017	0.64	3.2%
2018	0.69	7.8%
2019	0.73	5.8%

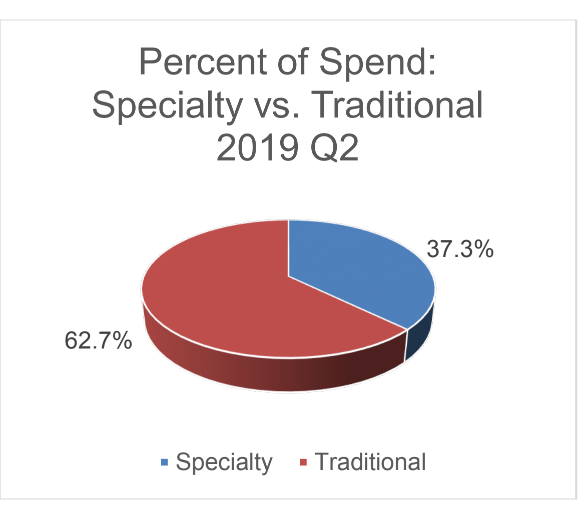


Number of GCHP's members filling prescriptions slowly increases while the total number of GCHP members declines.

	July Utilizing Members	Percent Change	July Membership	Percent Change
2015	38,838	-	189,321	-
2016	42,070	8.3%	207,019	9.3%
2017	39,975	-5.0%	200,903	-3.0%
2018	41,016	2.6%	195,755	-2.6%
2019	42,127	2.7%	192,756	-1.5%

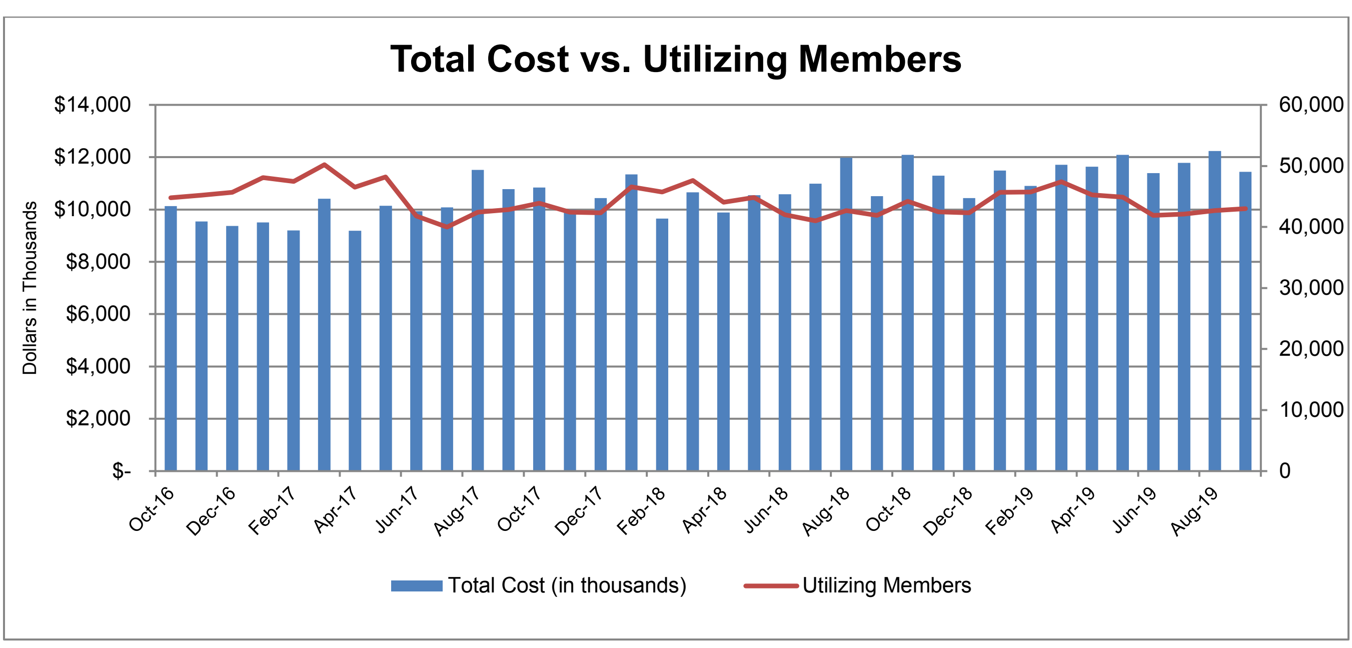
Drug Mix:
GCHP's members are utilizing more specialty drugs with an average cost of $4,672 in Q2 2019.

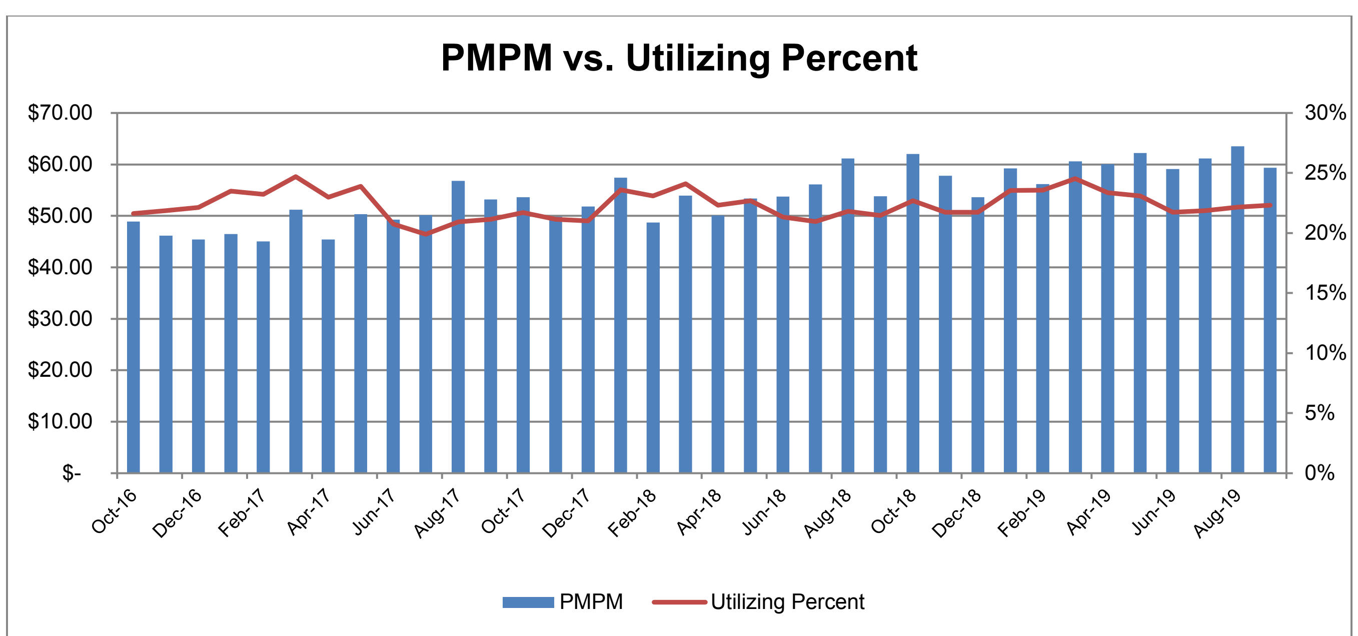


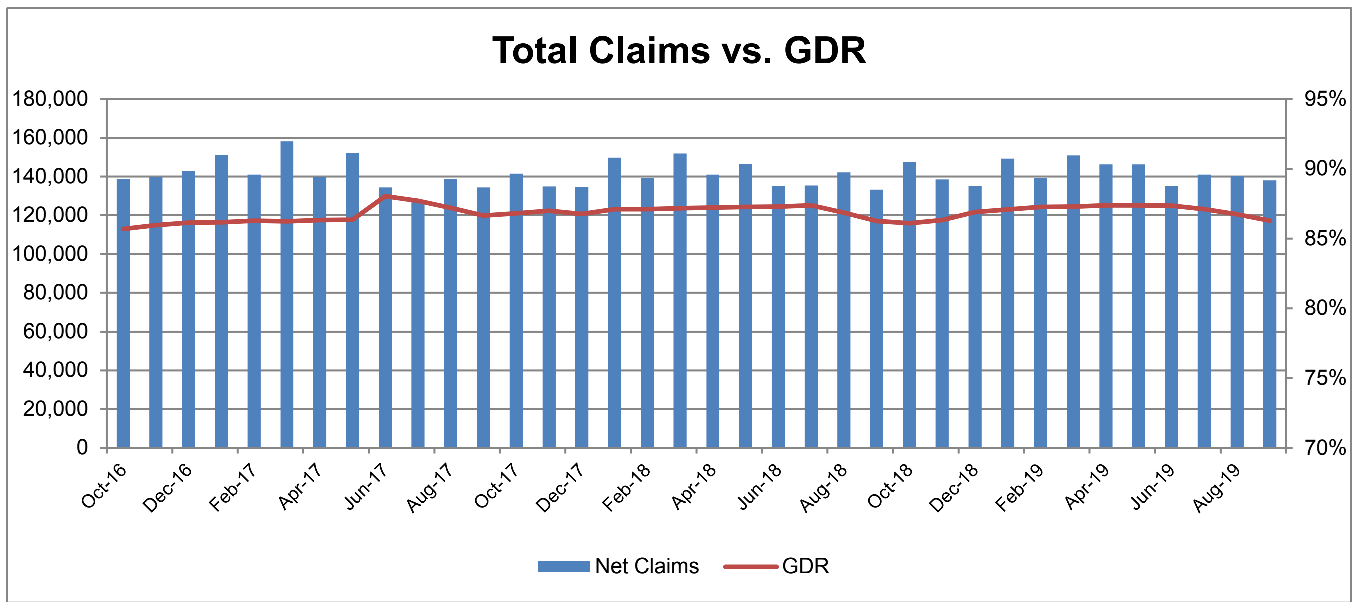


Specialty costs, as a percent of total spending, has increased 4.5% from the second half of 2017 to the first half of 2019. This increase is caused by ~850 more prescriptions and represents an added $3.3M in spend.

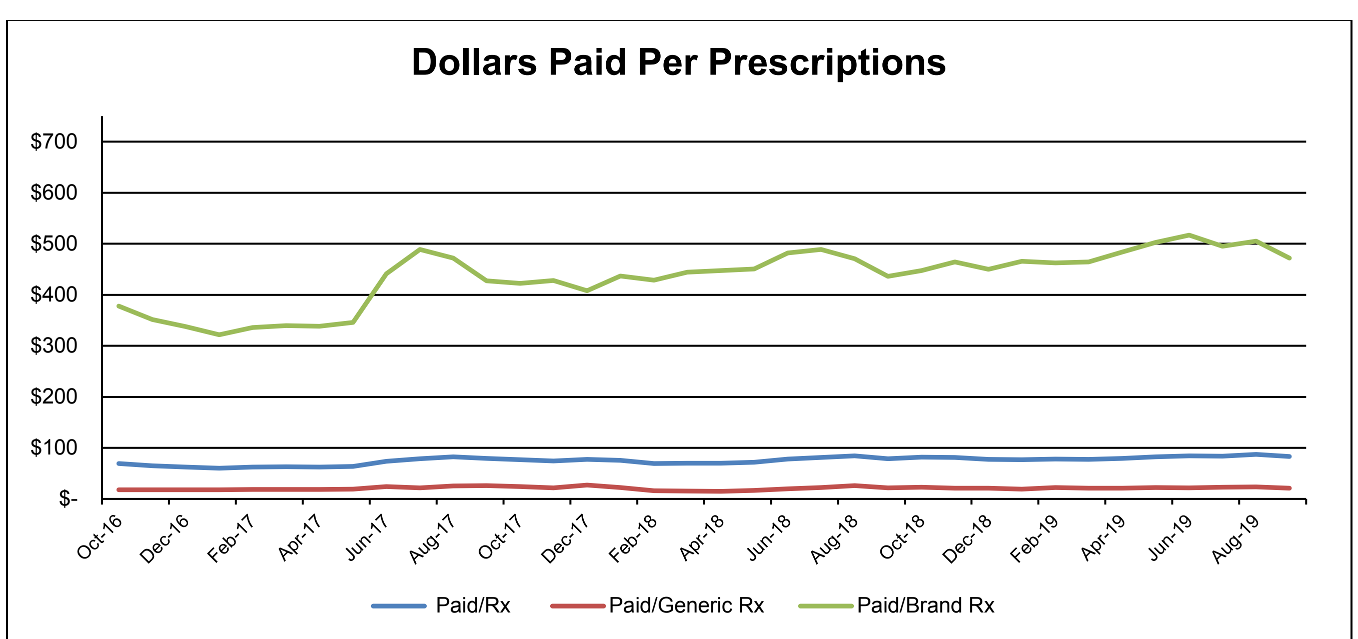
Pharmacy Monthly Cost Trends:





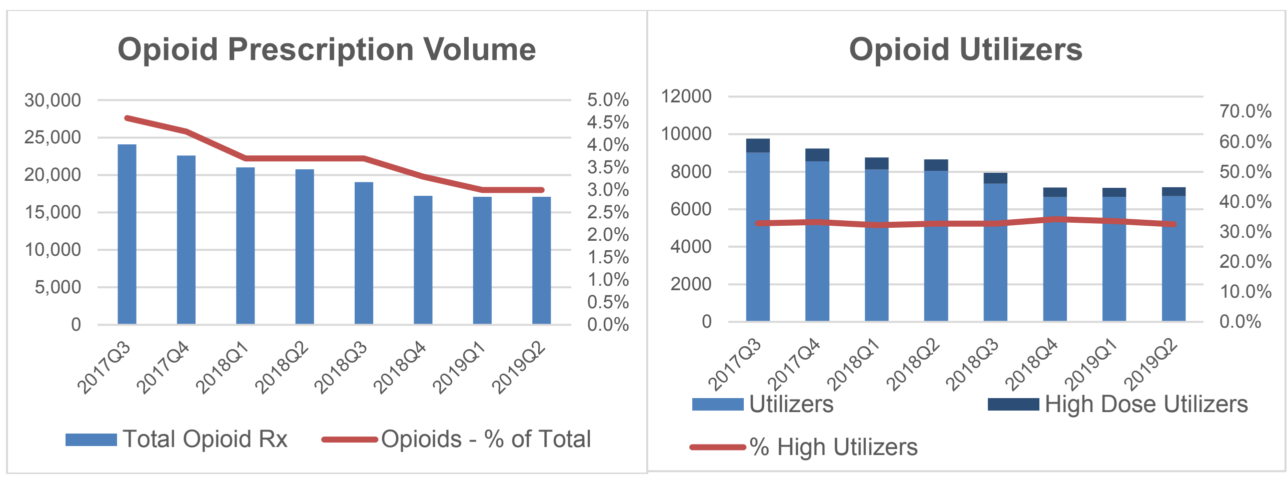


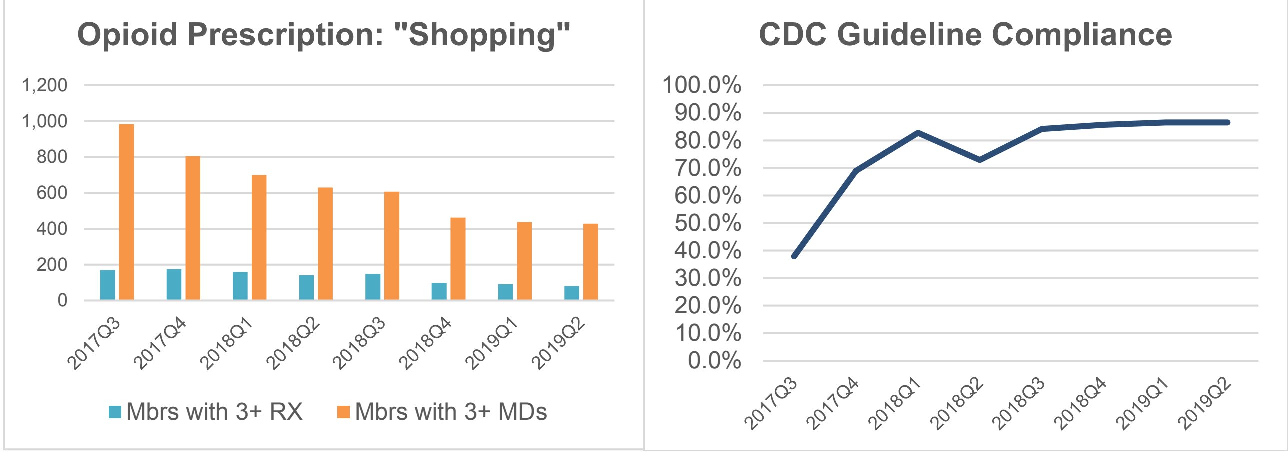
*Claim totals prior to June 2017 are adjusted to reflect net claims.



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 August 2019. Although minor changes may occur to the data going forward due to the potential of claim adjustments from audits and/or member reimbursement requests, the data is generally considered complete due to point of sale processing of pharmacy data.

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. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Interim Chief Diversity Officer

DATE: Nov. 18, 2019

SUBJECT: Chief Diversity Officer Update
(Unfortunately unable to attend meeting related to travel.)

Monthly Actions:

Community Relations

- Sponsored and attended Hip Hop Help event in Ventura in support of our Community Relations efforts. Hip Hop Help is an organization that focuses learning through music and dance for at-risk-youth.

Case Investigations

- Investigation was completed on two old harassment cases with findings communicated. Both cases were thoroughly investigated and appropriate action taken. A follow up discussion was held with both charging parties as well as the individual that was the subject of the complaints. Actions were taken to close cases. Both cases closed during the month.

Other Activities

- The Book, **Women Seen and Heard,** was distributed to all who attended the session in celebration of Hispanic Heritage Month. One of the authors of the book, Anita-Perez Ferguson, was a key note speaker along with Supervisor Zaragoza.

Office Visit activity

- 1 walk-in for career discussion
- 3 performance rating related concerns
- 2 mentor/mentee visits
- 3 discussions related to Diversity Council activities
- 1 job responsibilities related case referred back to HR

If there is any information needed prior to meeting to clarify any of the above points, please don't fail to check with me. 805-437-5758

AGENDA ITEM 15

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: November 18 2019

SUBJECT: Approve Agreement ("Agreement") with Health Management Associates ("HMA") for the Appointment of Margaret Tatar and HMA as Interim Chief Executive Officer ("Interim CEO")

SUMMARY:

At the November 1, 2019 meeting, the Gold Coast Health Plan Commission ("Commission") unanimously appointed Health Management Associates ("HMA") as interim Chief Executive Officer ("CEO"). Margaret Tatar will serve as the Interim CEO. The agenda item will approve the actual contract between the Commissioner and HMA to provide Interim CEO services while the Commission searches for a permanent replacement. The Commission seeks approval of the Agreement pursuant to the Commission's Single or Sole Source Procurement Policy.

BACKGROUND/DISCUSSION:

Former CEO of the Commission, Dale Villani, resigned on November 1, 2019. Mr. Villani's resignation followed the Ventura County Medi-Cal Managed Care Commission's decision not to renew his contract on October 28, 2019. At the November 1 meeting, HMA was appointed interim CEO by a unanimous vote of the Commission. Attached as Exhibit 1 is the proposal for HMA's services.

The Commission's decision to appoint HMA as interim CEO was based on the Commission's long standing relationship with HMA and HMA's decades of experience in the healthcare industry. Prior to HMA's appointment, the Commission worked closely with HMA on matters related to strategic planning, including analysis of plan to plan matters. The Commission has also utilized HMA's expertise to address other concerns on an as-needed basis, including analysis of a plan to plan contract arrangement.

HMA's has an established reputation in and expansive knowledge of, the healthcare industry. HMA is an independent national research and consulting firm. Its members have previously served in various leadership positions across the publicly funded healthcare arena. Dedicated to serving vulnerable populations, HMA has successfully tackled a wide variety of

healthcare issues by working directly with federal, state and local government agencies to effect change. These skills are critical to collaborating with the Commission to meet the Commission's overarching goal of delivering "Member-First" focused health care services while strengthening its ties to the communities it serves.

Based upon this expertise and experience with the Commission, the Commission appointed HMA Interim CEO. At the November 18, 2019 meeting in closed session, the Commission will consider the process for the hiring of a permanent CEO. The selection process may last for an extended period of time and the Commission needs to have a designated CEO during this interim period. Margaret Tatar of HMA has worked with the Commission and Gold Coast Health Plan's staff for many years and is familiar with both the issues and personnel and is in a unique position to provide service during this period. Further, no other firm has the experience and knowledge of Commission and Plan issues sufficient to allow them to immediately assume the position of Interim CEO and delaying the selection of the CEO would leave the Plan without a CEO. The Plan is currently in the midst of several contract negotiations and review of its strategic plan and HMA is uniquely qualified to immediately assist with these projects. Further, additional regulations are anticipated from the State of California and Federal Government, of which HMA and its personnel are aware of and uniquely qualified to address. Additionally, HMA's extensive experience with County Operated Health Systems will allow it to evaluate the current functioning of the Plan and provide the Commission guidance on the challenges ahead. No other firm has such immediate knowledge and while bringing another potential firm or person up to speed will impede the Plan's ability to immediately make decisions and implement them.

The appointment and contract are consistent with the Commission's Procurement Policy for Single or Sole Source services. That policy provides that single or sole source service agreements may be entered into when documents substantiating five factors exists. These five factors are:

1. Why the selected product and/or vendor was chosen.
2. What the unique performance factors of the selected product/service are.
3. Why the specific factors are required.
4. Other products/services examined and rejected and the reasons they were rejected.
5. Why other sources providing like goods or services were found to be unacceptable.

The contract will be in place until a permanent CEO is selected or upon 15 days' notice to HMA by the Plan. HMA may terminate the contract by giving the Plan 45 days' notice.

FISCAL IMPACT:

The fiscal impact is undetermined at this time as it will vary depending on the amount of services provided by HMA and how long the search for a new CEO will take. . Hourly rates

and travel time will be billed to the Commission as indicated in the attached Agreement and listed below:

TITLE	PROFESSIONAL HOURLY RATES	TRAVEL TIME RATES
Managing Principal	$385 to $450	$225 to $265
Principal	$360 to $390	$215 to $230
Senior Consultant	$310	$185
Consultant	$210	$125
Research Assistant	$160	$95
Clerical and Staff Support	$95	N/A

RECOMMENDATION

Staff recommends the following:

To approve the Agreement appointing HMA and Margaret Tatar as interim CEO pursuant to Section 2.5.1 of the Commission's Procurement Policy that governs Single or Sole Source services in excess of $50,000 by finding that the factors in such Section are meet due to the reasons listed above and summarized below:

- Due to the resignation of Dale Villani, there was a need to immediately appoint an interim CEO.
- HMA and Ms Tatar are familiar with Plan, it's personnel and the current challenges facing the Plan based upon years of work with the Plan..
- .HMA and Ms. Tatar are familiar with County Operated Health Systems and impending State regulations.
- HMA can evaluate current issues and staffing and provide immediate input to the Commission.

If the Commission desires to review this contract, it is available at the Plan's Finance Department.

CONCURRENCE:

N/A

ATTACHMENT:

Attachment 1: Proposal from HMA

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October 31, 2019

Commissioner Antonio Alatorre
Ventura County Medi-Cal Managed Care Commission
711 East Daily Drive
Suite 106
Camarillo, CA 93010

Re: Gold Coast Health Plan

Dear Commissioner Alatorre:

On behalf of HMA, I would like to express our gratitude to the Gold Coast Health Plan (GCHP) Commission and Best, Best, and Krieger (BBK) for extending an opportunity for us to offer candidates to provide GCHP interim leadership at this critical time.

As a follow-up to our discussion, we propose the following Letter Agreement.

SCOPE OF SERVICES

I am deeply committed to GCHP's success but am unable to extricate myself completely from all other client engagements to offer myself as a full-time leader for GCHP. However, I can partner with any of our candidates in a shared arrangement. If we were to proceed in such manner, I could commit to being on-site one to two days per week, with the lead HMA executive being on-site for three to four days per week. Jonathan Freedman, Vice-President, with deep experience in public plans and public systems is also available under such terms.

While the HMA candidates have several ongoing obligations, they are prepared to transition those obligations and be available to GCHP on Monday, November 4, 2019.

HMA understands that our primary obligation is to serve the Commission and collaborate with BBK during this critical period as the Commission initiates a recruitment to identify a new CEO. Every member of the HMA team will operate pursuant to this overarching goal. Each member of the HMA team has deep Medi-Cal experience and strong ties to the Department of Health Care Services (DHCS).

Attached at the end of this proposal are resumes for the following HMA executives:

James Cruz, MD

- Former Medi-Cal MCO CMO for Molina Health Plan
- Over 25 years of executive leadership with safety net providers and managed care health plans focused on Medi-Cal and dual eligible populations
- Deep experience working with safety net providers transforming their operational and service processes to improve care access, member experience satisfaction, and measures of clinical quality performance
- Executive physician successfully leading Medi-Cal managed care health plans to identify and address social determinants of health including homelessness, behavioral health, and substance use disorder (SUD)

- High level experience working with California Department of Health Care Services (DHCS) leadership, as well as DHCS managed care plan regulatory policies and procedures

Patricia Tanquary

- Former Medi-Cal MCO CEO for the Contra Costa Health Plan
- As a Local Initiative CEO, lead an inter-divisional management team in Contra Costa County to develop integrated health programs for Contra Costa County
- 18 years of experience with Kaiser in increasingly responsible executive managed care positions in California and nationwide
- Deep experience collaborating with the DHSC leadership, as well as DHCS and DMHC managed care plan regulatory policies and procedures

Eileen Moscaritolo

- Brings C-suite and executive leadership in *all models of managed care* in California
- CIO for CalOptima, the largest COHS in California
- Vice-President for AltaMed, directly responsible for IS/IT, Program Management Office (PMO), Technical Training, Medical Informatics/Business Intelligence, Health Information Management/Medical Records, Enterprise Call Centers, Privacy & Security Officer, and directly involved in Cal Medi-Connect, Covered California, PACE, and ACA implementation
- COO for Coast Health Care, responsible for IS/IT, Enrollment, Claims, Call Center, Informatics/Business Intelligence, EDI Inbound & outbound transactions, Quality Incentives (HEDIS, P4P, HCC)
- Executive driver for BSC to lead effort to Migrate 14 Care1st Medi-Cal systems onto Blue Shield of California systems, support for LTSS/MMSP, Cal-MediConnect, and Medicare programs

Margaret Tatar

- Brings C-suite health plan and State DHCS executive leadership
- Executive Director Public Affairs for CalOptima, California's largest COHS
- Appointed by Governor Brown to lead DHCS' delivery systems, including managed care, long term care, and PACE
- Extensive experience in all aspects of managed care operations and Medi-Cal covered services in California

Jonathan Freedman

- Brings C-suite and executive leadership in managed care in California
- Chief of Strategy and Interim COO at L.A. Care Health Plan, the largest publicly-governed MCO in California (2 million members).
- Extensive public management experience in California county government with roles in the Los Angeles Chief Executive Office and health agencies.
- Expert in all aspects of California health and human services policy, programming, administration, and finance.

Per your request, attached are resumes for the HMA colleagues.

SCHEDULE & TERM OF AGREEMENT

This Agreement will begin on October 31, 2019 and shall continue in effect until March 1, 2020, unless terminated earlier by either party giving the other party thirty (30) days written notice of termination. If this Agreement is terminated by a party's written notice of termination, you agree to compensate HMA for all services rendered prior to HMA's actual knowledge of termination and for all out of pocket expenses incurred to date. Upon your request, HMA will cease the provision of services and incur no further costs upon receipt of written notice of termination. The staffing arrangements and the scope of work stated in this letter apply to this project only.

Prior to the commencement of services, HMA requires that GCHP provide documentation that Health Management Associates, Inc. and its employees named in this proposal are listed as an additional insured on your Directors and Officers insurance for the duration of the interim services contract.

PROJECT FEES

The services described above will be provided on a time-and-materials basis. In addition, all out-of-pocket expenses will be reimbursed. Professional hourly rates and travel time will be billed as indicated in the table below. We will submit invoices monthly for services provided in the previous month. These invoices will be payable upon receipt.

Title	Professional Hourly Rates	Travel Time Rates
Managing Principal	$385 to $450	$225 to $265
Principal	$360 to $390	$215 to $230
Senior Consultant	$310	$185
Consultant	$210	$125
Research Assistant	$160	$95
Clerical and Staff Support	$95	N/A

It is customary for HMA to increase our rates annually on January 1. The increase typically does not exceed four (4) percent. You will be notified in advance of any rate increases.

CONFIDENTIALITY, NON-DISCLOSURE, CONFLICTS AND GENERAL TERMS

HMA often serves multiple clients within a certain industry or market, including those with potentially opposing interests, and HMA’s relationship with you will not be an exclusive relationship. Accordingly, HMA may have served, may currently be serving, or may in the future serve, other companies whose interests may be adverse to yours. In all such situations, HMA is committed to maintaining the confidentiality of each client’s information, and ensuring that your interests, proprietary and otherwise, are protected. To that end, HMA strictly adheres to our Policy and Guidelines Related to Conflicts of Interest and Proprietary Information which contain nondisclosure procedures (such as firewall protocols and other safeguards) for the purpose of maintaining each client’s confidential information and ensuring that your interests are protected.

Both parties acknowledge that, in the course of performing work under this Agreement, a party may learn of or receive confidential, trade secret, or other proprietary information concerning the other party or third parties to whom the party has an obligation of confidentiality (Confidential Information).

Each party agrees to take at least such reasonable precautions to protect the other party's Confidential Information as it takes to protect its own Confidential Information, and agrees to not disclose to any third party any Confidential Information belonging to the other party.

All of the services will be performed by HMA as an independent contractor. This Agreement does not create a relationship between the parties of employment, joint venture, or agency. You agree that, for a period of two (2) years from the date of termination of this Agreement, neither you nor any of your representatives will entice away, solicit for employment, or employ any current or former employee of HMA without the express written consent of HMA. With prior notice, HMA may change the staff assigned to provide the Consulting Services with staff of equal abilities and qualifications. HMA may enter into subcontractor agreements for the performance of the services.

Attached are our standard terms and conditions for the provision of services ("Terms and Conditions"), which are incorporated into this Letter Agreement. This Letter Agreement and the Terms and Conditions will constitute the entire agreement between HMA and Gold Coast Health Plan related to the project described above. We are happy to discuss the proposed services and terms with you or provide any additional information you may require. The proposed services, staffing arrangements, and this Letter Agreement are valid for sixty days from the date of HMA's signature, after which the project fees and staff availability may be subject to change.

If this Letter Agreement is acceptable to you, please sign and return to HMA's contracts director, Jeff DeVries via email, fax, or mail to the following address.

Jeff DeVries
Health Management Associates
120 N. Washington Square, Suite 705
Lansing, MI 48933
contracts@healthmanagement.com
517-482-0920 (fax)

Questions can be directed to me at 916-329-8223 or mtatar@healthmanagement.com.

Sincerely,

Margaret Tatar

(Signature page follows)

Approved by:

Kelly Johnson, Vice President
Health Management Associates, Inc.

For Gold Coast Health Plan

October 31, 2019
Date

Date

Please complete for invoicing purposes:

Name: ______________________________
Address: ____________________________
____
____
Phone: ________________________
E-Mail: ________________________
☐ Receive invoices via e-mail

STAFF EXPERIENCE

James E. Cruz, MD
Principal
Costa Mesa, California

RANGE OF EXPERIENCE

- Over 25 years of executive leadership with safety net providers and managed care health plans focused on Medi-Cal and dual eligible populations
- Deep experience working with safety net providers and medical groups transforming their operational and service processes to improve care access, member experience satisfaction, and measures of clinical quality performance
- Executive physician successfully leading Medi-Cal managed care health plans to identify and address social determinants of health including housing and homelessness, behavioral health, and substance use disorder (SUD)
- High level experience working with California Department of Health Care Services (DHCS) leadership, as well as DHCS managed care plan regulatory policies and procedures
- Design and implementation of systems to evaluate, implement and improve provider operations and billing, provider training, incorporate state policies into health plan utilization management (UM) and care management processes
- Experience with multi-organization healthcare providers, academic medical centers, safety net hospitals, Tax Equity and Fiscal Responsibility Act (TEFRA) hospitals, community hospitals, and physician practice plans
- Data driven, transformative leader able to initiate and execute creative solutions to improve UM, transitions of care, and provider network performance resulting in improved Medicare cost report (MCR), member satisfaction, and measures of quality
- Accomplished at evidence-based physician practice and hospital-physician collaborations which strengthen provider networks, improve access to care, and reduce total cost of care

PROFESSIONAL AND BUSINESS HISTORY

HEALTH MANAGEMENT ASSOCIATES, INC., November 2017-present

Working extensively with health plans and medical groups on care management, measures of quality, access to care, and provider reimbursement

- Supervise and provided technical assistance to a managed care delivery system health services department regarding policy and procedures related to UM and case management
- Provided technical assistance in data collection, and development of initiatives for quality improvement initiatives Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers & Systems (CAHPS)

- Served as medical director for Agilon's health services department regarding authorization requests from providers for members in Fresno, Los Angeles, Riverside, San Bernardino and San Diego counties
- Supported local managed care health plan as medical director. Provided leadership and technical assistance regarding RN care manager training, development of individual care plans for members, restructuring the care management interdisciplinary care team case conference format and process. Designed and developed programmatic changes to correct Medicare audit citations

MOLINA HEALTHCARE OF CALIFORNIA, Long Beach, CA, Senior Medical Director/Chief Medical Officer, 2014-October 2017

- Led multidisciplinary teams to develop and implement performance improvement initiatives targeting dual eligible members resulting in a 15 percent improvement in the total cost of care for dual eligible members
- As a newly promoted CMO, immediately addressed DHCS citations for Medi-Cal HEDIS scores below the DHCS minimum performance level for three consecutive years. Completely restructured the plan's quality improvement department; hired a new quality improvement associate vice president; supervised the reorganization of HEDIS data collection processes, implemented a practice facilitation program in collaboration with key medical groups, and augmented pay-for-performance incentives. Molina subsequently achieved compliance with the DHCS citation benchmarks one year ahead of schedule, and was presented with two awards for quality performance from DHCS in 2016
- Developed Molina's first telepsychiatry program targeting custodial and skilled nursing care members with one or more behavioral health diagnoses; there was a 30 percent improvement in the total cost of care for targeted members within one year

MOLINA HEALTHCARE OF CALIFORNIA, Long Beach, CA, Medical Director, 2010-2014

- Reviewed ambulatory and acute care authorization requests from contracted medical groups and contracted facilities
- Reviewed contracted medical group utilization performance reports of key ambulatory and inpatient utilization metrics, including quality outcomes data and Hierarchical Condition Category (HCC) scores, and identified opportunities for improvement
- Collaborated with contracted medical groups to improve clinical process to meet quality and cost benchmarks for different product lines

ARCADIAN MANAGEMENT SERVICES, San Dimas, CA, Associate Vice President Health Services and Medical Director, 2009-2010

- Oversaw all UM nursing functions, case management, utilization data analysis, and the quality improvement program
- Provided ambulatory and acute care authorization review, claims review, and review of provider appeals and grievances
- Reviewed medical group performance reports and identified opportunities for focused operational and/or clinical quality improvement
- Collaborated with contracted medical groups to educate, modify, and recommend medial group adjustments and physician practice behavior to meet an 83 percent MCR quality and cost benchmark

- Monitored compliance of the health services department with all state, federal, and health plan regulatory requirements; developed and managed a $3 million departmental budget and oversaw the evaluation and performance of 36 staff members and five direct reports

EDUCATION

University of California, San Diego School of Medicine

Residency: White Memorial Medical Center Family Medicine Residency Program

CERTIFICATION

American Board of Family Medicine

Patricia Tanquary, MPH, PhD

Principal

Sacramento, California

RANGE OF EXPERIENCE

- Seasoned healthcare executive with a strong collaborative style and relevant experience at the payer and provider levels.
- CEO of large health plan with the oldest government sponsored federally qualified health plan in the state of California
- In-sourced the low-moderate mental health benefit into the county mental health department and operated this benefit with other county intra-divisional management teams under the Contra Costa County Board of Supervisors
- Supported the development of California's Whole Person Care Waiver and the Drug Medi-Cal Waiver in Contra Costa County to maintain linkages with the health plan's membership
- Transitioned the Medi-Cal autism benefit from regional centers into the health plan and contracted with 136 ABA providers to provide care

PROFESSIONAL EXPERIENCE

HEALTH MANAGEMENT ASSOCIATES, INC., February 2019-present

- Developed a dual eligible special needs plan for Medicare-Medicaid beneficiaries
- Provided commercial insurance for county employees, CHIP, Access for Infants and Mothers, and In-Home Supportive Services workers
- Co-developed a primary care program for the uninsured with community federally qualified health center (FQHC) partners and served as the third-party administrator for that program

CONTRA COSTA HEALTH PLAN, Chief Executive Officer, 2007-2019

- Directed and managed the activities of the Contra Costa Health Plan
- Part of inter-divisional management team, assisting in the planning, development, and administration of the health programs and management activities of the Health Services Department and Contra Costa County

CONTRA COSTA HEALTH PLAN, Deputy Executive Director, 2005-2007

- Monitored and reviewed the operations of the Contra Costa Health Plan for consistency and propriety relative to departmental goals, policies, and procedures

KAISER PERMANENTE, Director of National Continuing Care Contracting, 2001-2005

- Managed all national contracts that integrated with the continuum of care delivery service within Kaiser Permanente
- Accountable for $500 million total spend under contract
- Developed contract strategy; led multi-regional teams to negotiate major multi-year contracts and manage those partnerships/relationships through national joint steering committees

representing the various Kaiser Health Plan regions, with local joint committees, and the respective national vendors

- Managed contract negotiations and oversights of third party administrators for provision of payment of $235 million spend in ambulance claims
- Responsible for a team of contracting and provider relations staff that negotiated and maintained national provider contracts and provided National Provider Relations functions with the regions and contracted providers
- Provided consultation to all regions on national contract strategy and development
- Liaison with product and benefit simplification for benefit and co-pay redesign and contract development
- Developed strategy creating an interface between NCCC contracts and Broadlane contracts generating additional savings and rebates for Kaiser Permanente
- Achieved results in NCCC Customer Satisfaction Survey of 82 percent in 2003
- Achieved results in NCC Employee Satisfaction Survey of 81 percent in 2003
- Developed website for all NCCC contracts for program-wide users
- Developing additional contract options for KPIC with current national providers

KAISER PERMANENTE, Director, Divisional Contracting, 1998–2000

- Responsible for all statewide health plan provider contracting across northern and southern California
- Managed a team of contracting and provider-relations staff that negotiated and maintained contracts for ambulance, home health, hospice, durable medical equipment (DME) prosthetics and orthotics
- Facilitated a process with northern and southern California contracting department that developed a standard quality process and component for statewide provider
- Responsible for operations of the San Rafael Hospital and coordination of impatient with outpatient activities at the medical center; led planning for Kaiser Permanente's presence and activities in the community; budget responsibility for $83 million; implemented a successful turnaround, the San Rafael hospital generated a surplus over budget of $45,000
- Facilitated architectural development and completed two new buildings in construction
- Promoted a new cultural climate that emphasized collaboration between departments, Medical group, group health plan, and hospital
- Initiated an integrated TPMG Kaiser Foundation Hospital, and Kaiser Foundation Health Plan local member retention and recruitment committee that began programs of members at open enrollment; committee also established, planned, and coordinated three employer health councils that identified key issues around worker's compensation and mental health, which were addressed in partnership with these employers
- Focused on implementation awareness, recognition, and staff involvement in diversity appreciation events

KAISER PERMANENTE, Continuing Care Services Leader, 1994-1998

Continuing care services leader for South Bay at Kaiser Permanente consisting of Kaiser hospitals at Redwood City, Santa Clara and Santa Teresa, a service area population of 520,000 members; administrative accountability for the cost effectiveness, efficient delivery of the following continuing care services functions: claims, referrals, ambulance and emergency medical services, DME, skilled nursing facilities (SNF), home health, hospice, social services, case management of high-risk populations, and contract management. Managed a $114 million budget.

Led a group of staff managers and physicians across the service area in a redesign initiated in 1995 resulting in:

- Development of case management of four high-risk populations: frail elderly, frail pediatrics, chronically ill adults, and chronic mentally ill
- Integrated home health and Hospice management and staff across service area
- Consolidated home health agencies into one agency with branch offices
- Created partnership contracts with skilled nursing facilities at four locations with seven-day-a-week SNF admission and consolidated SNF intake
- Successful implementation of psychiatric hospital alternative services with positive financial net savings 1995-1998 in five medical centers (San Francisco, South San Francisco, Redwood City, Santa Clara and Santa Teresa)
- Annual expenses decreased from $12 million to $9 million over these years
- Created Continuing Care After Hours Support Services – All continuing care functions provided seven-day-a-week services and had 24-hour-a-week access through the continuing care after hours support services
- Negotiated and implemented the outsourced critical care bed contract with San Jose Medical Center for winter season 1998

KAISER PERMANENTE, Hospital Strategy Implementation Coordinator, 1996-1997

- Assumed the role of South Bay Hospital strategy implementation coordinator; assisted the South Bay team in coordinating with regional staff and negotiating sessions at Stanford and CHW hospitals; local strategy consensus was developed and presented to TPMG and KFH regional offices

KAISER PERMANENTE, Interim Facilities Planning, 1997

- Accountability for interim facilities planning; led a team that developed the South Bay 10-year capital plan; successful in decreasing this plan from $652 million to $400 million through strategic analysis modeling and reached consensus with PICs and area managers; new plan met new cash flow targets and new financial metrics including debt to equity ratios

KAISER PERMANENTE, Network Implementation, 1998

- Further served as the KFH representation with regional staff in development and strategic discussions with hospitals and medical groups in Monterey, Salinas and Santa Cruz counties for network model expansion

KAISER PERMANENTE, Hospital/Health Plan Administrator, 1992-1994

Senior hospital and health plan administrator for the San Rafael service area (Mann and Petaluma counties)

- Responsible for collaborative benefit and service delivery improvements for service area population of 83,000 members
- Responsible for operations of the San Rafael Hospital and coordination of impatient with outpatient activities at the Medical Center; led planning for Kaiser Permanente's presence and activities in the community; budget responsibility for $83 million
- Implemented a successful turnaround; San Rafael hospital generated a surplus over budget of $45,000
- Facilitated architectural development and completed two new buildings in construction

- Promoted a new cultural climate that emphasized collaboration between departments, medical group, group health plan, and hospital
- Initiated an integrated TPMG Kaiser Foundation Hospital, and Kaiser Foundation Health Plan Local Member Retention and recruitment committee that began programs of members at open enrollment; committee also established, planned, and coordinated three employer health councils that identified key issues around worker's compensation and mental health, which were addressed in partnership with these employers
- Fostered a collaborative relationship with medical group; established the first quality council at San Rafael Medical Center
- Focused on implementation awareness, recognition, and staff involvement in diversity appreciation events

KAISER PERMANENTE, Director of Health Plan Member Services, Northern California, 1987-1992

- Managed 23 departments of health plan member services and member relations located throughout northern California serving 2.4 million members; coordinated and monitored existing programs and implemented new programs that improved member satisfaction and retention throughout the region
- Health plan liaison to The Permanente Medical Group to assure benefit consistency in the service delivery system
- Managed the regional member appeals committee
- Administrator for innovative new approaches to coverage and operational issues: designed and developed the "In Lieu of Hospitalization" program for ventilator dependent patients desiring to stay home; developed the dues subsidy program – a subsidization of health plan dues for financially needy population (former Kaiser members, graduates of state GAIN program and Federal Job Training Partnership Act Program)
- Created a team of area managers and supervisors who planned and assisted in employee training and productivity improvements through the tool of customer-based service standards
- Led a process where the regional staff and area managers created databases of benefit interpretive inconsistencies; facilitated consistency resolution with regional TPMG, health plan peer groups, and the benefits committee to improve benefit clarification and acceptance of operational coverage, i.e.: acupuncture, biofeedback, port wine stains, and mental health
- Initialed and co-led the Regional AIDS Committee to develop HIV strategy and services throughout northern California

FRENCH HOSPITAL MEDICAL CENTER, San Francisco, CA, Associate Director/Acting Chief Operating Officer, 1982-1987

French Hospital/Health Plan was a Knox-Keene licensed HMO and a 197-bed acute care hospital

- Associate administrator for all non-nursing hospital departments and administrative liaison to health plan, medical staff, and board
- Directed development of contracting and licensing as well as managed several new units, i.e.: psychiatric unit, substance abuse, acute rehabilitation unit, and emergency department licensing upgrade from standby to basic

FRENCH HOSPITAL MEDICAL CENTER, San Francisco, CA, Administrative Director, 1981-1982

- Managed all professional services and quality and utilization committees for hospital
- Provided training program for DRG implementation

FRENCH HOSPITAL MEDICAL CENTER, San Francisco, CA, MPH Administrative Resident, (3 months) 1981

- Administrative resident to chief executive officer and attended all health plan and hospital board meetings
- Completed a project on patient satisfaction, which served as an employee/customer services training tool

SAN LUIS REY HOSPITAL, Encinitas, CA, Social Work Consultant, 1977-1979

- Responsible for individual and adolescent counseling and group work for psychiatric inpatient hospital
- Supervised social work graduate students and assisted hospital planning committees in quality assurance and utilization management activities

SAN DIEGO STATE UNIVERSITY, Social Work Instructor/Coordinator, 1975-1979

- Responsible for social work undergraduate field program across San Diego County
- Instructor for social work and health courses

ALVARADO HOSPITAL, San Diego, CA, Director of Social Work, 1973-1975

- Responsible for all direct counseling and placement of patients and hospitals; served as consultant to Alvarado Home Health Department and Alvarado Rehabilitation Hospital
- Developed community-based self-help group for patients and families with cancer

EDUCATION

Doctor of Philosophy, Social Welfare, University of California Berkeley, Berkeley, California

Master of Public Health, Public Health Planning and Administration University of California Berkeley - Berkeley, California

Master of Science in Social Work, Social Welfare, San Diego State University, San Diego, California

Bachelor of Arts, Social Welfare, San Diego State University, San Diego, California

MEMBERSHIP AND AFFILIATIONS

- American Cancer Society, San Rafael Chapter
  - Board Member: 1991-1994
  - President Elect: 1991-1994
- American Public Health Association member: 1973-2004
- California Health Care Collaborative Board Member: 1996-2004
- Drew College Prep High School
  - Board Member 1991-1996
  - Co-Founder of Parents Association 1991-1996
- Marin Hospital Association Section Chair: 1993-1994
- National Association of Social Work Member (served as state delegate: 1975): 1972-1982
- San Mateo County EMS Redesign Task Force: 1996-1997
- San Mateo Hospital Consortium Member: 1995-1998
- San Rafael Chamber of Commerce Board Member: 1993-1994
- San Rafael County AIDS Advisory Commission Commissioner: 1991-1994
- University of California at Berkeley, School of Social Welfare, Lecturer: 1991

- West Bay Hospital Conference Member: 1983-1998
- Association for Community Affiliated Plans (ACAP): 2005-present
- California Association of Health Plans (CAHP): 2005-present
- Local Health Plans of California (LHPC): 2005-present

PAPERS, PRESENTATIONS, AND PUBLICATIONS

2009 Speaker at California Association of Health Plans (CAHP) annual meeting

2009 Speaker at PerformRx

2008 Speaker at Association for Community Affiliated Plans (ACAP) on SNPs

2007 Speaker on Acute and Long-Term Care Integration (ALTCI)

2004 Testified to Senate Finance Committee staff on motorized wheelchairs

2003 Speaker on Panel for Contracting for DME for MediCal in California

1997 Speaker at West Coast EMS Conference. Presented paper on a pilot public/private partnership model between EMAS, managed care, and ambulance vendor for ambulance demand management

1996 Speaker on SNF Strategic Partnership at Kaiser Permanente inter-regional conference

1995 Speaker on Case Management Models Regional Conference, northern California

1993 Speaker, Marin Town Hall, Health Care Reform

1987 PhD Thesis: *Comparative Analysis of Benefits to Cancer Patients and Caregivers from Self-Help Groups in California*

1984 Speaker, Medical Ethics Committee in Hospitals Conference, San Francisco, CA 1979-1981

Research Associate on various research projects at U.C. Berkeley

1973 Co-Author, Tel Med Topics, San Diego County

1973 Master's Thesis: *Analysis of Outcomes of Foster Parenthood in San Diego County*

Eileen Moscaritolo

Principal

Costa Mesa, California

RANGE OF EXPERIENCE

- CIO for CalOptima, the largest COHS in California
- Vice-President for AltaMed, directly responsible for IS/IT, Program Management Office (PMO), Technical Training, Medical Informatics/Business Intelligence, Health Information Management/Medical Records, Enterprise Call Centers, Privacy & Security Officer, and directly involved in Cal Medi-Connect, Covered California, PACE, and ACA implementation
- COO for Coast Health Care, responsible for IS/IT, Enrollment, Claims, Call Center, Informatics/Business Intelligence, EDI Inbound & outbound transactions, Quality Incentives (HEDIS, P4P, HCC)
- Executive driver for BSC to lead effort to Migrate 14 Care1st Medi-Cal systems onto Blue Shield of California systems, support for LTSS/MMSP, Cal-MediConnect, and Medicare programs

PROFESSIONAL EXPERIENCE

HEALTH MANAGEMENT ASSOCIATES, INC., August 2019–present

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN (previously Care1st Health Plan), Monterey Park, CA, Executive Driver, July 2017–August 2019

- Co-led effort to migrate 14 Care1st onto Blue Shield of California systems
- Provided extensive expertise for Medi-Cal, LTSS/MMSP, Cal-Medi-Cal and Medicare programs
- Led internal and external name change from Care1st to Blue Shield of California Promise Health Plan
- Led the divesture of Care1st Texas Medicare Business defining a run out strategy
- Primary liaison with regulatory agencies

HEALTH CONNECT, LLC, Owner/Principal, March 2017–July 2017

Sample engagements included:

- End to end encounter review and evaluation for several providers groups/management services organizations
- Insourced administrative clinical services for a clinic system

COAST HEALTH CARE, LLC, Cypress, CA, Chief Operating Officer, February 2016–March 2017

- Provided MSO organizational oversite to nine IPAs with 15 contracted health plans
- Responsible for information services/technology, enrollment, claims, call center, informatics/business intelligence, EDI inbound & outbound transactions, quality incentives (HEDIS, P4P, HCC)
- Led success relocation of organization with no downtime
- Facilitated extensive end to end process improvement initiatives resulting in significant revenue enhancement and expense reduction

ALTAMED HEALTH SERVICES, Commerce, CA, Vice President of Enterprise Services, January 2013–February 2016

- Responsible for information services/technology, program management office (PMO), technical training, medical informatics/business intelligence, health information management/medical records, enterprise call centers (marketing, clinical call center & member services), privacy & security officer
- Extensive experience with managed care, Cal Medi-Connect, Covered California, PACE, Medicare and Medi-Cal leading organizational efforts for Medi-Cal expansion, Cal Medi-Conant and ACA implementation

CALOPTIMA, Orange, CA, Executive Director/CIO, Information Services, February 2008–January 2013

- Responsible for organizational wide information services
- Chief Security Officer
- Installed EHRs to over 1,000 Orange County primary care providers
- Comprehensive knowledge of ARRA, HIT, HIEs/HIOs, regional extension centers, meaningful use requirements
- Participate in and led several California statewide HIT planning teams
- Board Member for Cal eRX
- Served on several DHCS committees
- Executive Committee member for Access OC eConsult Initiative
- Committee member for State eHealth HIT Collaboration Committee
- Member of LA Care's Technical Advisory Committee

CALIFORNIA STATE UNIVERSITY – Fullerton

Guest Lecturer

- Health Information Technology Curriculum
- Health Care Reform
- Managed Care 101 – Medi-Cal & Medicare

ORANGE COUNTY REGIONAL HEALTH INFORMATION ORGANIZATION, Privacy Officer and Board Member, March 2008–February 2016

HEALTH NET, Woodland Hills, CA, November 2004–February 2008

Director of Transaction Projects, March 2007–February 2008

- Responsible for organizational wide systems consolidation effort

Director of Strategic Support and Planning, November 2004–February 2007

- Responsible for claims customer service, enrollment, information services and system configuration departments, consultant on organizational projects and initiatives

INDEPENDENT CONSULTANT**, November 1999–November 2004**

Sample engagements have included:

- **Imaging System Selection and Implementation** – Facilitated and managed the selection and implementation of an imaging system for a large Medicaid plan in Arizona
- **Managed Care System Selection** – Conducted a managed care system selection for a large southern California MSO

- **Technical Services Organization Startup** – Completed assessment, wrote, and executed a business plan for a startup technical services organization in San Diego that includes system hosting, project management, and consulting services for community clinics
- **Interim Vice President of Claims** – Successfully led claims turnaround effort for a large management services organization, Medical Pathways, that encompassed backlog reduction, writing policies and procedure, business process reengineering and staff supervision and development; supported efforts to move business from the Amisys managed care system to Diamond; supported integration of Medical Pathways into NAMM
- **Project Manager** – Led effort to select and install a practice management and electronic medical record system for nine affiliated community clinics and over 100 community providers; efforts included contract negotiation, process improvement/workflow redesign, system configuration, training, testing, and implementation support
- **Business Office Reengineering** – Conducted assessment for a large anesthesia billing office that was experiencing billing challenges; implemented business processing reengineering that included workflow modification, policy and procedures and staff training program that resulted in an estimated 30 percent increase in revenue
- **HIPAA compliance** – Worked with several health plans and management services organizations to define their HIPAA programs, policies, and procedures and implement transaction sets
- **Managed Care System** - Led effort for the Trizetto Group to install the QCSI - QMACS managed care system at Maxicare Health Plan of California

KPC INFORMATION TECHNOLOGIES, INC., Executive Project Director, Anaheim, CA, October 1999–November 2000

Projects included:

- **Start Up** – led efforts in creation of business plan, budget, and financial model for president
- **Web Initiative** - sponsor and monitor for the design, development of www.healthemanager.com, a B2B and B2C transaction-based Healthcare web site. Successful launch May 1, 2000. Continued responsibility for content, alliance partners, developing functionality and reviewing site presentation.
- **The Medical Manager System** – successful, on time, and within budget conversion and implementation of three legacy practice management systems to The Medical Manager system at 34 sites in twelve weeks
- **Marketing** - Initial contact for cold calls and leads for increasing the ASP line of business, consulting, and website services. Created proposals and contract agreements for existing and potential customers ranging in services from hardware and software selection to operational improvements within healthcare-based organizations

MEDPARTNERS, INC., Long Beach, CA, Senior Vice President/CIO, Information Systems, November 1998–September 1999

- Responsible for the national corporate support infrastructure for 84,000sf data center located in Anaheim, California
- Provided for the managed care system consolidation efforts, practice management process improvement efforts
- Represented information services as well as all operation departments in the sale of MedPartners, Inc., from June 1999 through August 1999

 Return to Agenda

Vice President, Managed Care Operations, July 1997–November 1998

Departments included claims, call center, business office and business systems support. Focus of position was to reduce outstanding accounts receivables and claims expense as well as increase customer service and enhance revenue. By directing and successfully completing a process improvement initiative in conjunction with Coopers & Lybrand Consulting, the net results were A/R and expenses went down fifty percent and revenues increased by thirty percent. Other significant results of the initiative were:

- Consolidation of 17 locations down to four within a six-month period. Locations were sized appropriately, from a staff of 650 people down to 375, resulting in a significant savings
- Developed and implemented EDI programs for inbound and outbound claims resulting in significant increase in revenue
- Selected and implemented bundling/unbundling software across seven systems resulting in millions of dollars reduction in claims expenses
- Operational improvements brought eight non-compliant claims operations into compliance

TUFTS HEALTH PLAN, Waltham, MA, January 1996–June 1997

Director, Managed Care Operations 1995– 1997

- Areas of responsibility included claims, call center, enrollment, premium billing, provider credentialing and support of other departments
- Championed the selection and implementation of the HSII Managed Care System resulting in the improvement of Managed Care operations and increased revenues

Director, Information Services 1993–1995

- Provided information services and support for all business units
- Led reengineering efforts throughout the organization
- Implemented EDI program for claims and billing installed and implemented new services, such as imaging and workflow management
- Increased line of business by expanding efforts into multiple states

Project Manager 1991–1993

- Tasks assigned were cross-functional projects including implementation of liability and recovery, fraud detection, capitation, behavioral health and care management systems
- Project lead for implementation of Massachusetts-based Secure Horizons Medicare Risk Product on HSD Diamond, in conjunction with PacifiCare Health Plan of California

Project Leader 1989–1991

- Responsible for medium-sized cross functional projects including implementation of a data warehouse and executive management desktop reporting tools and bundling/unbundling software systems

Senior Programmer Analyst 1988–1989

Programmer Analyst 1986–1988

- Supported business units with programming needs, business systems analysis, and provided training on new and enhanced products

EDUCATION

Bachelor of Science, Computer Science, Boston University

Margaret Nee Tatar, JD

Managing Principal

Sacramento, California

PROFESSIONAL EXPERIENCE

HEALTH MANAGEMENT ASSOCIATES, INC., October 2014-present

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES (DHCS), Assistant Deputy Director, Delivery Systems, 2012-September 2014

Responsible for four divisions: managed care, low income health program, long term care, and California children's services

Major managed care initiatives and successes, representing shift of the state's delivery system to managed care, include:

- Transition of over 300,000 seniors and persons with disabilities to managed care
- Transition of the Healthy Families program (895,000 enrollees) to managed care
- Expansion of California's remaining fee for service counties (28) to managed care
- Transition of low income health program (600,000 enrollees) to managed care
- California's Duals Demonstration program, Cal MediConnect, and managed long-term services and supports (MLTSS) in eight counties
- Medi-Cal expansion as authorized by the Affordable Care Act and the legislature, including policies for Medi-Cal managed care plan choice on the California exchange

Key management successes include:

- Introduced a matrix management to promote efficiencies/collaboration across divisions
- Development and promotion of training programs to promote enhanced understanding of managed care delivery systems
- Developed publicly accessible dashboards to measure efficacy of programs and promote transparency

CalOptima, Orange, CA, Executive Director, Public Affairs, 2003-2012

- Led all public affairs, key external communications, and strategic alliances for agency
- Managed all state and federal representatives, including Sacramento-based lobbyists, local communications consultants, and federal lobbyists
- Directed agency-wide marketing, branding, and communications strategies, including a successful rebranding initiative and website redesign
- Collaborated with chief financial officer and chief executive officer on all rate negotiations and directly responsible for managing all disputes relating to rates with the state
- Directed development and management of all plan policies and procedures, including internal committees to support effective and thorough policy review and approval

- To promote a culture of compliance with plan policies, developed and grew a successful training initiative for CalOptima employees on plan policies and program, called "CalOptima Boot Camp", which operated successfully for over four years
- Led program/policy development for several key initiatives to promote integrated care for duals in Orange County; included consolidation of county multipurpose senior services program sites, creation of an Aging and Disability Resource Center for Orange County, and internal lead on acute and long term care integration and successor initiatives
- Responsible for program development for Orange County's first Program of all-inclusive care for the elderly

COUNTY OF ORANGE, OFFICE ON AGING (AREA AGENCY ON AGING FOR ORANGE COUNTY), Policy and Planning Manager, 2001-2003

- Developed strategic planning goals for the Orange County Office on Aging
- Managed advocacy for the office and a 40-member advisory council representing interests of 400,000 older adults in the county
- Advised legislative staff regarding state and federal policies and laws impacting older adults

72ND CALIFORNIA ASSEMBLY DISTRICT ASSEMBLYWOMAN LYNN DAUCHER, District Office, California Assembly member, 2000-2001

- Represented assembly member before various state and local boards, commissions, and community groups
- Communications duties included: district newsletter, legislative summaries, press releases, constituents' relations, training materials for advocacy groups
- Responsible for community coalitions and town hall meetings

COLORADO GENERAL ASSEMBLY, Office of Legislative Legal Services, Denver, CO, Senior Legislative Attorney, 1993-1998

- Managed notable Colorado legislation including recodification of child welfare laws, Medicaid managed care, and welfare reform
- Coordinated negotiations among members, executive agency personnel, and lobbyists
- Analyzed impact of national legislation on current laws and pending legislation in Colorado

FEDERATED STATES OF MICRONESIA, Yap State Legislature, Chief Legislative Counsel, 1989-1993

- Drafted and analyzed bills for the Yap State Legislature in the FSM, a U.S. Territory, with an emphasis on economic development laws
- Devised the legislative strategy and advanced it, at both the state and national levels, for Yap State to implement its first major economic development project
- Represented Yap State in negotiations with Overseas Private Investment Corporation (OPIC) in Washington, D.C., to secure an OPIC loan guarantee

Private practice in Pennsylvania, 1985-1989

- Bell of Pennsylvania; Philadelphia, PA
- Sports law firm of Stanko and Miller; Reading, PA

EDUCATION/LICENSES:

Juris Doctor, Villanova University School of Law, Villanova, Pennsylvania

Member of the bar: PA, CO, and FSM

Bachelor of Arts, Bryn Mawr College, Bryn Mawr, Pennsylvania

L'Institut Des Etudes Francaises, Avignon, France

Jonathan Freedman

Vice President

Los Angeles, California

PROFESSIONAL EXPERIENCE

HEALTH MANAGEMENT ASSOCIATES, INC., June 2016-present

L.A. CARE HEALTH PLAN, Chief of Strategy, Regulatory and External Affairs, October 2012-May 2016, Interim Chief Operating Officer, May 2015-May 2016

- Executive responsible for regulatory compliance, government relations, strategic planning, community benefits programs, and corporate communications
- Areas of focus include interaction with state regulatory and Medicaid funding agencies; policy development and legislative activities related to Medicaid and safety net health care systems; development and implementation of Affordable Care Act Medicaid expansion and L.A. Care's Covered California product; and strategic planning activities for executive management and the L.A. Care Board of Governors
- Serving as interim chief operating officer, functional areas included provider network operations, member services, claims, information technology, facilities, and human resources
- Operational size:1.8 million health plan members, $6 billion annual operating budget

DEPARTMENT OF PUBLIC HEALTH, COUNTY OF LOS ANGELES, Chief Deputy Director, December 2007-September 2012

- Chief operating officer responsible for all aspects of departmental operations including communicable disease control, environmental health, public health clinical and field services, HIV services, substance abuse services, children's medical services, maternal and child health, human resources, contracting, budget and finance, and information systems
- Managed interactions with board of supervisors, chief executive officer, and county counsel, acted in absence of the director
- Operational size: $800 million, 4,000 full time equivalent positions

DEPARTMENT OF PUBLIC HEALTH, COUNTY OF LOS ANGELES, Director, Emergency Preparedness and Response, October 2006-December 2007

- Responsible for preparedness and response activities related to public health emergencies and disasters including emergency management coordination and operational readiness, all hazards planning and exercises, bioterrorism and pandemic influenza preparedness, coordination with local, state, and federal response agencies, and performance of related administrative and financial management functions
- Operational size: $40 million, more than 30 full time equivalent positions

CHIEF ADMINISTRATIVE OFFICE, COUNTY OF LOS ANGELES, Chief, State Legislative Policy, September 2001-October 2006

- Coordination of the County's state legislative program, development of legislative policies and strategies, preparation of legislative analyses and issue papers, communication with legislative offices and the administration, and collaboration with advocacy organizations on budget and policy issues including health and welfare funding, child and family services, parks and resources, public safety and juvenile justice, housing and community development, local government finance, and transportation

DEPARTMENT OF HEALTH SERVICES, COUNTY OF LOS ANGELES, Director, Family Health Programs and External Relations, June 2000-September 2001

- Responsible for administration, planning, and operation of maternal and child health, family planning, home visitation, childhood lead poisoning prevention, child abuse prevention, health insurance outreach, and California Children Services
- Point-of-contact to the county's Children's Planning Council, Proposition 10 Commission, the New Directions Task Force, and other collaboratives affecting children and families
- Operational size: $60 million annual budget, over 750 full time equivalent positions

CHIEF ADMINISTRATIVE OFFICE, COUNTY OF LOS ANGELES, Chief, Federal Policy, February 1997-June 2000

- Coordinated the county's federal legislative program, drafted analyses and issue papers, developed legislative polices and strategies, and communicated with congressional offices, the executive branch and Washington, D.C. representatives on a wide array of issues including welfare reform, Medicaid reform, criminal alien reimbursement, and transportation and public works funding

DEPARTMENT OF HEALTH SERVICES, COUNTY OF LOS ANGELES, Director, Medicaid Demonstration Project, February 1996-February 1997

- Directed a federal Medicaid demonstration project (1115 waiver) designed to financially stabilize the county health care system, and transition from hospital-based services toward community-based primary and preventive care services
- Central point of coordination internally and externally for all aspects of the demonstration project

DEPARTMENT OF HEALTH SERVICES, COUNTY OF LOS ANGELES, Deputy Director, Public Health Programs, May 1993-June 1996

- Responsible for administration, planning, and operation of child health, disease control and family health programs, and data collection and analysis
- Examples of specific programs include child and adolescent health, family planning, tuberculosis and sexually-transmitted disease control, vital records, and public health laboratory services
- Operational size: $70 million annual budget, over 550 full time equivalent positions

OFFICE OF HEALTH CRISIS MANAGEMENT, COUNTY OF LOS ANGELES, Chief of Staff, August 1995-February 1996

- Special assignment to organize and coordinate activities of the county's Health Crisis Management Office which was established to address a $655 million budget gap in health services financing in 1995-96

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- Activities included development of budget curtailment and revenue options, development and negotiation of a federal Medicaid demonstration project (1115 waiver), creation and negotiation of public-private partnerships for operation of county health centers, report on alternative governance structure for county health services, coordination with state and federal officials (executive and legislative) and local stakeholders (labor, community activists, private providers), media relations, and supervision of health crisis staff of seven

DEPARTMENT OF HEALTH SERVICES, COUNTY OF LOS ANGELES, Special Assistant to the Director of Health Services, April 1991-May 1993

- Adviser to the director on matters relating to the Department of Health Services
- Special policy projects included managed care, HIV/AIDS, capital financing, community relations, and health facility replacement and renovation

DEPARTMENT OF HEALTH SERVICES, COUNTY OF LOS ANGELES, Policy Analyst, AIDS Program Office, April 1990-April 1991

- Conducted analyses of HIV/AIDS-related policy, planning, and fiscal issues
- Responsible for executive and board assignments, oversight of budgets ($30 million), development of grant proposals to state and federal agencies ($12 million), and analyses of legislation

BOARD OF SUPERVISORS, COUNTY OF LOS ANGELES, Assistant Deputy to Supervisor Edmund D. Edelman, July 1986-April 1990

- Health, mental health, environmental, and welfare services adviser
- Specific issues included HIV/AIDS, drug abuse services, air quality, prenatal care, homelessness, indigent aid, waste disposal, and youth services
- Responsible for oversight, policy, ordinances, and budgets ($4 billion) for the Departments of Health Services, Mental Health, Beaches and Harbors, and Public Social Services, and the County Sanitation Districts

UCLA SCHOOL OF PUBLIC HEALTH, Research Assistant to Professor E. Richard Brown, PhD, December 1984-July 1986

EDUCATION

Master of Science, Public Health, UCLA School of Public Health

Bachelor of Arts, UCLA

ABOUT HEALTH MANAGEMENT ASSOCIATES

The HMA team is over 210 colleagues strong and growing, with experience that spans the healthcare industry and stretches across the nation. Dedicated to serving vulnerable populations, HMA successfully tackles a wide variety of healthcare issues, working directly with federal, state, and local government agencies, health systems, providers, health plans, foundations, associations and others to effect change. Our colleagues have held senior level positions in medical and behavioral health provider systems, public health agencies, community-based organizations, state and federal agencies, managed care and accountable care organizations. We offer a breadth and depth of experience we believe is valuable to our clients in helping them achieve their goals and effect change.

Founded in 1985, HMA is a private, for-profit "C" corporation, incorporated in the State of Michigan in good standing and legally doing business as Health Management Associates, Inc.

TERMS AND CONDITIONS

1. Compensation and Expenses. You agree to compensate HMA for the services to be provided by HMA ("Consulting Services") in accordance with the compensation schedule set forth in the Letter Agreement (the "Fees"). At its discretion, HMA may change the compensation schedule from time to time provided that (a) HMA may not change compensation quoted as a fixed price for an entire project for specified Consulting Services, and (b) individual hourly billing rates set forth in the Letter Agreement may not be increased more than once in any calendar year. You also agree to pay directly, or reimburse HMA, for HMA's reasonable and necessary out of pocket expenses incurred in rendering Consulting Services. Such reasonable and necessary expenses may include without limitation the expenses of telephone, photocopying, data acquisition, data generation, travel, lodging, meals, postage, overnight mail, and relevant supplies. HMA's expenses will be paid or reimbursed at HMA's cost, without any markup, margin, or profit to HMA.

2. Billing and Payment. At such intervals as are set forth in the Letter Agreement, HMA will send billing statements to you with a reasonable itemization of the Consulting Services performed by HMA, the expenses incurred by HMA, and the Fees payable by you for such Consulting Services. HMA's invoices are due upon receipt and become past due thirty (30) days after receipt. Past due invoices shall be subject to late charges of one percent (1%) per month. Until further notice from you, HMA's billing statements are to be sent by email, fax, and/or regular mail to the addressee of the Letter Agreement. You agree to pay each HMA billing statement in full within thirty (30) days of receiving the billing statement. Payments to HMA are preferred via electronic funds transfer (Bank: Bank of America, Account no. 375011515507 Account name: Health Management Associates, Inc. Routing no. 072000805 Wire routing no. 026009593), or, unless otherwise directed by HMA, mailed to the following address:

Becky Reffitt, Senior Accountant
Health Management Associates, Inc.
120 North Washington Square, Suite 705
Lansing, Michigan 48933

3. Contacts and Notices. For the purposes of this Agreement, each party agrees to identify a primary contact person to whom all Agreement matters and notices may be communicated. A party may change its contact person from time to time by written notice to the other party. Notice from one party to another relating to this Agreement is effective if made in writing (including fax and email) and delivered to the recipient's address, fax number, or email address. Until further notice, HMA's primary contact person and notice addresses are:

Jeffrey M. DeVries, Contracts Director
Health Management Associates, Inc.
120 North Washington Square, Suite 705
Lansing, Michigan 48933
Fax 517-482-0920
E Mail: jdevries@healthmanagement.com

Until further notice, your primary contact person and notice addresses are the addressee of the Letter Agreement.

4. Liability; Disclaimer of Warranty.

A. Subject to the limitations of this Section 4, each party agrees to be responsible for its own negligence, gross negligence, or deliberately wrongful acts and omissions and neither party will be liable to the other for consequential, punitive, special, incidental, and exemplary loss, damage or expenses (or for business interruption, lost business, lost profits or lost savings), whether based on breach of contract, tort (including negligence), strict liability, product liability, under statute or otherwise, even if it has been advised of the possibility of such damage.

B. Your exclusive remedy, and HMA's sole obligation, for any breach of this Agreement will be for HMA, upon receipt of written notice from you, to use commercially reasonable efforts to cure the breach at its own expense, or, if HMA is unwilling or unable to do so, to return any Fees paid to it by you for the Consulting Services related to such breach.

C. The limit of HMA's liability (whether in contract, tort, negligence, strict liability, product liability, under statute or otherwise) to you or to any third party concerning performance or non-performance by HMA, or in any manner related to this Agreement, for any and all claims, will not in the aggregate exceed the Fees and expenses paid by you to HMA hereunder.

D. All Consulting Services provided pursuant to this Agreement are provided on an "as is" basis. HMA makes and gives no warranty concerning the Consulting Services, express or implied, including any implied warranties of fitness for a particular purpose, all of which are hereby disclaimed.

E. This Section 4 will survive any termination of this Agreement.

5. Taxes. Each party is solely and completely responsible for any and all income taxes due and owing by it to any governmental entity or agency (local, state and/or federal) on any monies or compensation received by it. This paragraph will survive any termination of this Agreement.

6. Work Product & Residuals.

A. Definitions. The definitions set forth in this Section 6(A) shall apply to this Agreement:

(i) "Preexisting Work" shall mean all of a party's content, expression, materials, documentation, software and technology possessed by the party prior to this Agreement or developed independently of this Agreement.

(ii) "Residuals" shall mean all of HMA's ideas, know-how, approaches, methodologies, concepts, skills, tools, techniques and processes, and all intellectual property rights such as patent, trademark, and copyright, irrespective of whether possessed by HMA prior to, or acquired, developed or refined by HMA under this Agreement.

(iii) "Work Product" shall mean all written, graphic, stored, and/or recorded materials prepared or generated in connection with HMA's Consulting Services, whether individually by HMA or jointly with you.

B. Except as otherwise set forth in this Agreement and subject to the timely fulfillment of your payment obligations under this Agreement, you are, and shall be, the sole and exclusive

owner of all right, title and interest in and to the Work Product; provided, however, that you hereby grant HMA a license to use, copy, modify, prepare derivative works and otherwise commercially exploit in any way HMA deems fit (but subject to applicable confidentiality obligations) all such Work Product free of additional charge and on an irrevocable, nonexclusive, sublicensable, fully paid-up, royalty-free, worldwide and perpetual basis.

C. Notwithstanding the foregoing, HMA shall retain all right, title and interest in and to the Residuals and HMA's Preexisting Work. To the extent HMA has incorporated any of the Residuals or HMA's Preexisting Work into the Work Product, HMA grants to you an irrevocable, nonexclusive, perpetual (except as set forth in Section 6(D)) paid-up, worldwide license to use, copy, modify and prepare derivative works of such Residuals and Preexisting Work for your internal business purposes. You may not distribute or sublicense such Residuals or Preexisting Work to any third party, except to independent contractors who will use such Residuals and/or Preexisting Work solely for the benefit of you, and who have entered into a written agreement containing confidentiality provisions at least as protective of HMA's confidential information as those set forth in this Agreement or other confidentiality agreement between you and HMA.

D. If this Agreement is terminated due to your breach, all licenses granted to you hereunder shall terminate and any ownership right that you may have in or to the Work Product shall automatically revert to HMA.

E. HMA retains the right to use any generalized knowledge, ideas, concepts, techniques, methodologies, practices, processes and know-how learned by its personnel in the course of performing the Consulting Services under this Agreement, which are retained in intangible form in the unaided memory of HMA's personnel, without any obligation to account to you. If during the performance of this Agreement, you suggest to HMA any new features, concepts or improvements related to or based upon HMA's Preexisting Work or Residuals or the Work Product (the "Enhancements"), the Enhancements shall be the sole and exclusive property of HMA and shall be free from the confidentiality restrictions provided in the Agreement.

7. HIPAA. The parties understand and agree that this Agreement is subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Privacy Regulations, 45 C.F.R. Parts 160 and 164 issued under HIPAA. The parties agree to comply with HIPAA and the regulations issued under HIPAA and to execute any documents that may be required by HIPAA or the HIPAA Privacy Regulations.

8. Force Majeure. If, due to circumstances beyond the control of a party (such as war, act of God, flood, severe adverse weather conditions, riots, strikes, labor stoppages, natural disaster or fire), a party is unable to perform its obligations under this Agreement, then it will not be liable to the other party for failure to perform if it has, in good faith, used its best efforts to perform under the circumstances. A party will resume performance as soon as reasonably practical after the cessation of the circumstances that prevented its performance.

9. Publicity. HMA may, in the context of a written list containing its clients, publish the fact that you are its client.

10. Severability. If any clause, portion, provision, concept, or section of this Agreement is legally unenforceable or invalid for any reason, the parties acknowledge and agree that such unenforceability or invalidity shall not affect the enforceability or validity of the remainder of the Agreement.

11. Governing Law. This Agreement will be construed, governed, and enforced in accordance with the laws of the State of Michigan without giving effect to any choice or conflict of law provision or rule. The parties agree that, for purposes of jurisdiction and venue, all litigation arising under or in connection with this Agreement will be conducted in courts located in the State of Michigan.

12. Entire Agreement and Amendments. These Terms and Conditions and the attached Letter Agreement constitute the entire Agreement of the parties pertaining to the Consulting Services, and this Agreement supersedes and cancels all previous written or oral negotiations, proposals, agreements, or representations relating to the subject matter of the Consulting Services. This Agreement may not be amended unless the amendment is in writing and signed by both you and HMA.

13. Assignment. Neither party may assign this Agreement without the prior written consent of the other party, which consent may be granted or withheld for any reason or no reason. However, if a party is sold (through a sale of substantially all of its stock, membership interests, and/or assets), the sale transaction will not be treated as an assignment, the prior written consent of the other party is not required, and the selling party's successor in interest will be recognized as a party to this Agreement.

14. Non-Waiver. The failure of a party to insist in any one or more instances upon performance of any of the provisions of this Agreement, or the failure of a party to pursue its rights under this Agreement, will not be construed as a waiver of any such provisions or the relinquishment of any such rights.

15. Counterparts. This Agreement may be executed and delivered in two (2) or more counterparts (including by facsimile or PDF), each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

APPENDIX

HEALTH OF THE PLAN DASHBOARD

November 2019

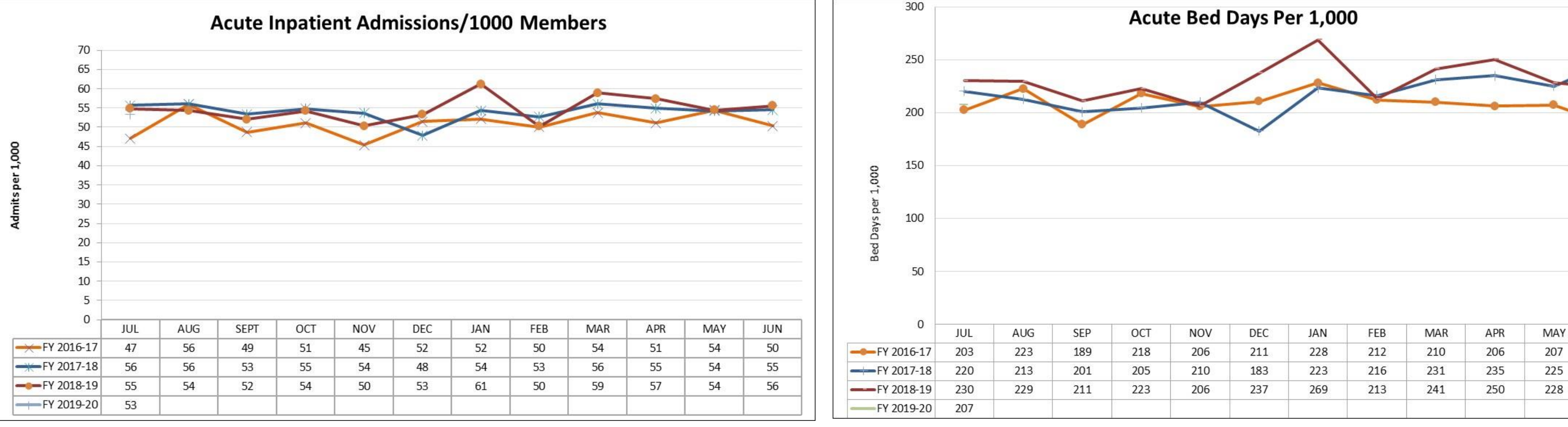
Utilization and Cost: Dates of Service July 2016 to July 2019
Eligible Membership as of November 1, 2019

Contents

Inpatient Utilization and Cost 1
Inpatient Utilization and Cost (cont'd) 2
Emergency Department Utilization and Cost 2
Eligible Membership 3

GCHP Decision Support Services
DSS@goldchp.org

Inpatient Utilization and Cost

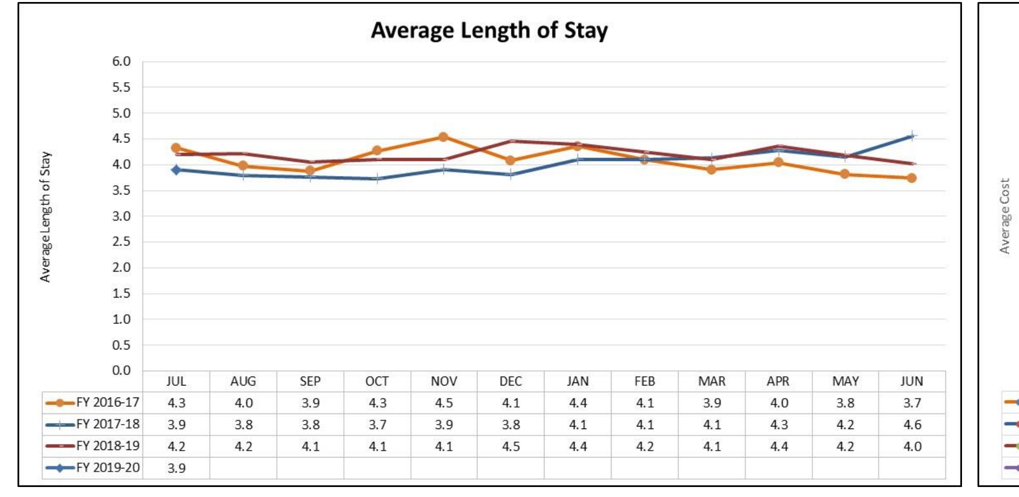


Acute Inpatient Admissions/1000 Members

	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2016-17	47	56	49	51	45	52	52	50	54	51	54	50
FY 2017-18	56	56	53	55	54	48	54	53	56	55	54	55
FY 2018-19	55	54	52	54	50	53	61	50	59	57	54	56
FY 2019-20	53											

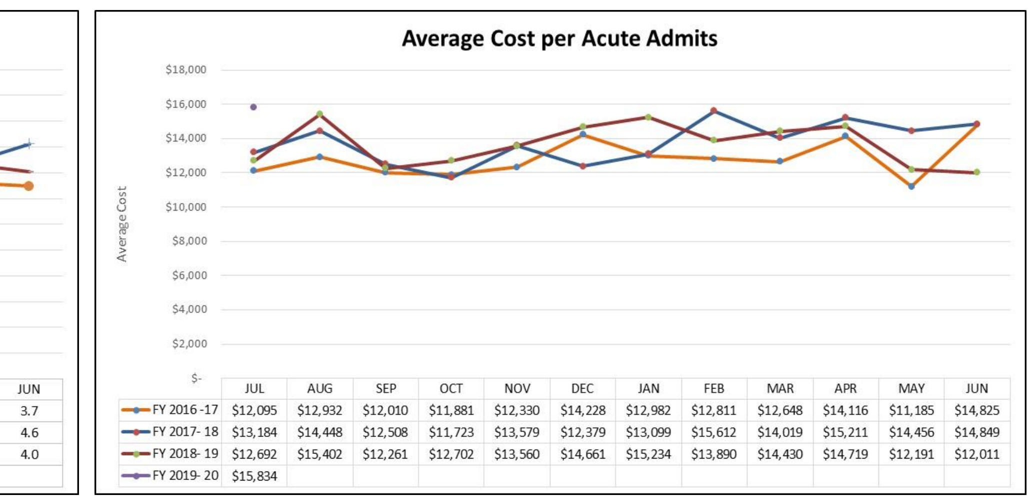
Acute Bed Days Per 1,000

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2016-17	203	223	189	218	206	211	228	212	210	206	207	188
FY 2017-18	220	213	201	205	210	183	223	216	231	235	225	249
FY 2018-19	230	229	211	223	206	237	269	213	241	250	228	223
FY 2019-20	207											



Average Length of Stay

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2016-17	4.3	4.0	3.9	4.3	4.5	4.1	4.4	4.1	3.9	4.0	3.8	3.7
FY 2017-18	3.9	3.8	3.8	3.7	3.9	3.8	4.1	4.1	4.1	4.3	4.2	4.6
FY 2018-19	4.2	4.2	4.1	4.1	4.1	4.5	4.4	4.2	4.1	4.4	4.2	4.0
FY 2019-20	3.9											



Average Cost per Acute Admits

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2016 -17	$12,095	$12,932	$12,010	$11,881	$12,330	$14,228	$12,982	$12,811	$12,648	$14,116	$11,185	$14,825
FY 2017- 18	$13,184	$14,448	$12,508	$11,723	$13,579	$12,379	$13,099	$15,612	$14,019	$15,211	$14,456	$14,849
FY 2018- 19	$12,692	$15,402	$12,261	$12,702	$13,560	$14,661	$15,234	$13,890	$14,430	$14,719	$12,191	$12,011
FY 2019- 20	$15,834											

1

The increases in the Average Cost per Acute Admit and the Average Cost per Bed Day are due to 4 claims for 3 members that exceeded $300K, ranging from $309K to $1.4M. Average Cost per Acute Admit increased by $3,823.68 and the Average Cost per Bed Day increased by $1,221.

Source: MedInsight Full Claims Cube – File load November 12, 2019
*Dates of Service between July 2016 and July 2019
Current date as of November, 2019
Excludes Dual Coverage members

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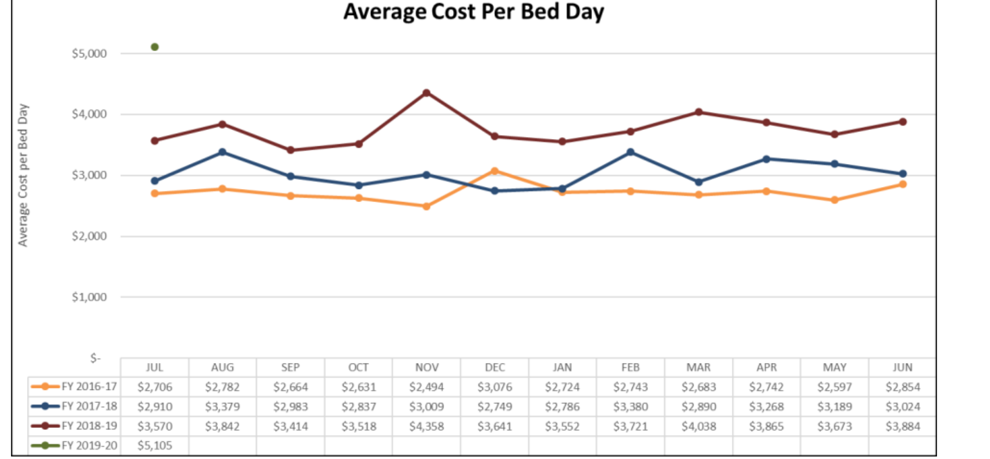
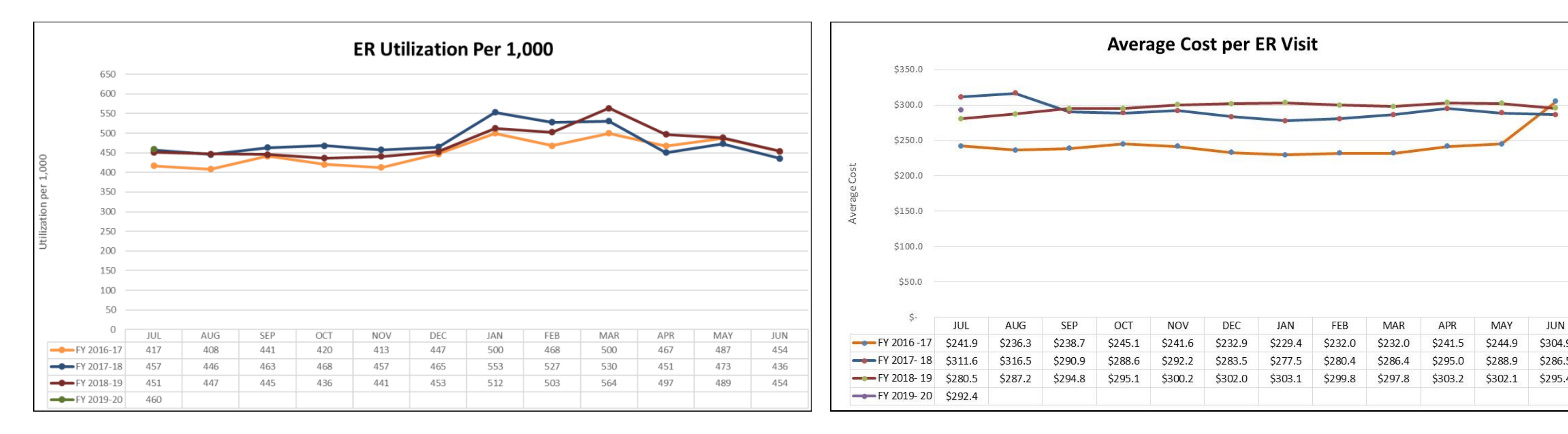
Inpatient Utilization and Cost (cont'd)



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2016-17	$2,706	$2,782	$2,664	$2,631	$2,494	$3,076	$2,724	$2,743	$2,683	$2,742	$2,597	$2,854
FY 2017-18	$2,910	$3,379	$2,983	$2,837	$3,009	$2,749	$2,786	$3,380	$2,890	$3,268	$3,189	$3,024
FY 2018-19	$3,570	$3,842	$3,414	$3,518	$4,358	$3,641	$3,552	$3,721	$4,038	$3,865	$3,673	$3,884
FY 2019-20	$5,105											

Emergency Department Utilization and Cost



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2016-17	417	408	441	420	413	447	500	468	500	467	487	454
FY 2017-18	457	446	463	468	457	465	553	527	530	451	473	436
FY 2018-19	451	447	445	436	441	453	512	503	564	497	489	454
FY 2019-20	460											

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2016 -17	$241.9	$236.3	$238.7	$245.1	$241.6	$232.9	$229.4	$232.0	$232.0	$241.5	$244.9	$304.9
FY 2017- 18	$311.6	$316.5	$290.9	$288.6	$292.2	$283.5	$277.5	$280.4	$286.4	$295.0	$288.9	$286.5
FY 2018- 19	$280.5	$287.2	$294.8	$295.1	$300.2	$302.0	$303.1	$299.8	$297.8	$303.2	$302.1	$295.4
FY 2019- 20	$292.4											

The increases in the Average Cost per Acute Admit and the Average Cost per Bed Day are due to 4 claims for 3 members that exceeded $300K, ranging from $309K to $1.4M. Average Cost per Acute Admit increased by $3,823.68 and the Average Cost per Bed Day increased by $1,221.

Source: MedInsight Full Claims Cube – File load November 12, 2019
* Dates of Service between August 1, 2017 and July 31, 2019
Current date as of November 12, 2019
Excludes Dual Coverage members

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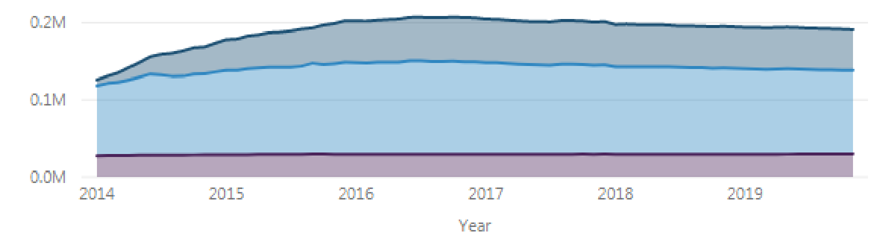
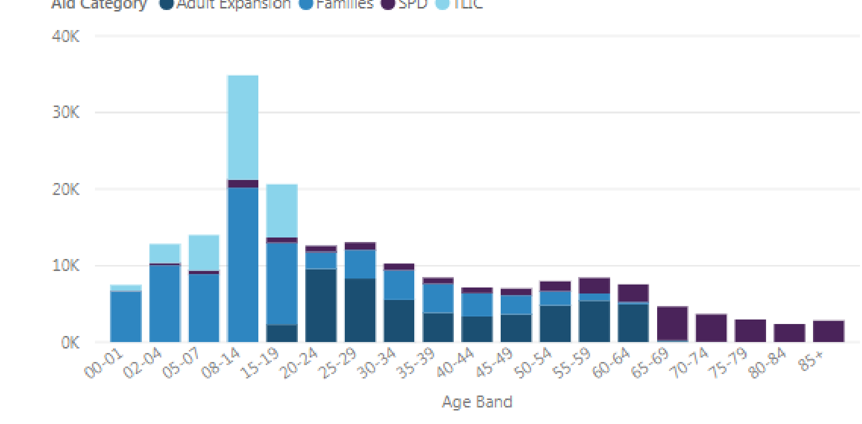
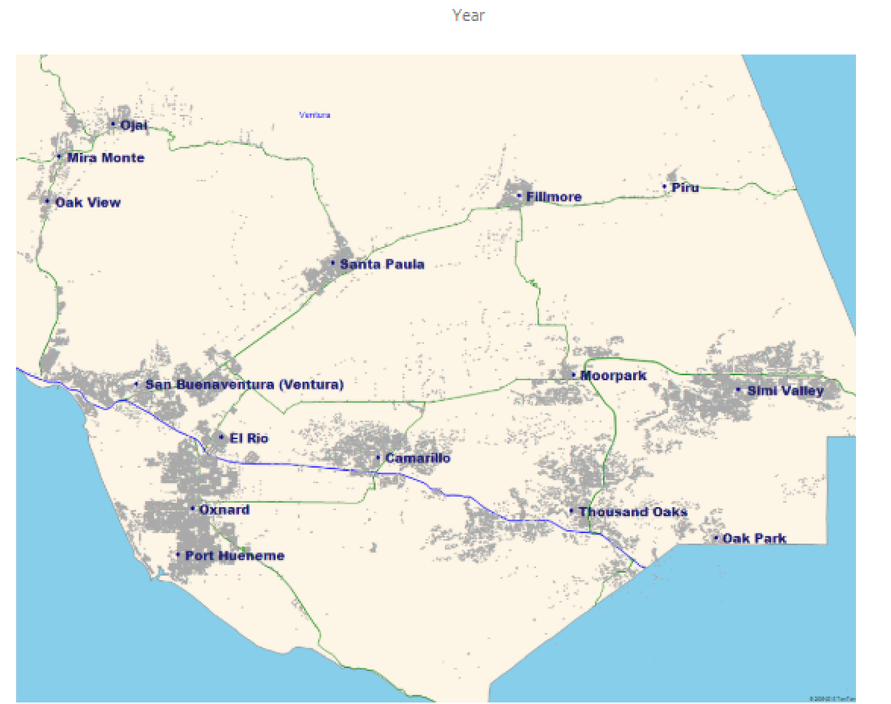
Eligible Membership







Eligible Membership as of November 2019
Source: GCHP Static Member Table

Member Count by Aid Category - Dual and Non Duals Included

Aid Category ● Adult Expansion ● Families ● SPD ● TLIC

40K
30K
20K
10K
0K
00-01 02-04 05-07 08-14 15-19 20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65-69 70-74 75-79 80-84 85+
Age Band

Source: GCHP Static Member Table
Current member counts reflective of November 01, 2019 eligibility data from DHCS
Excludes Share of Cost members

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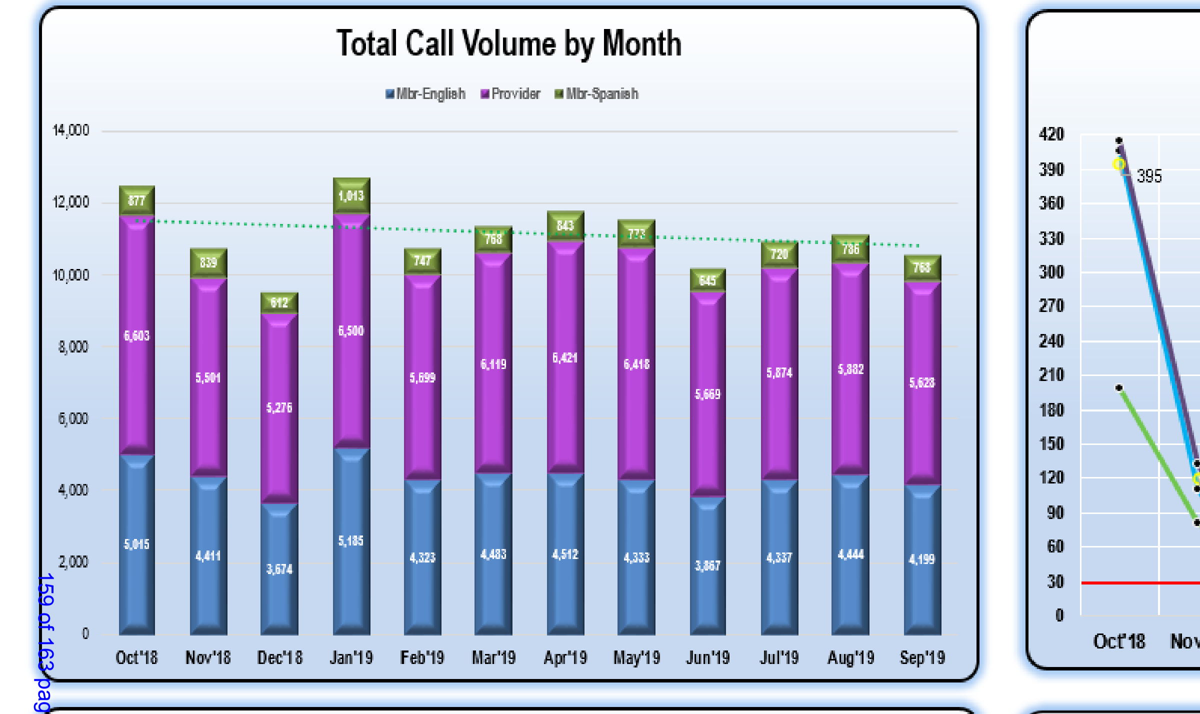
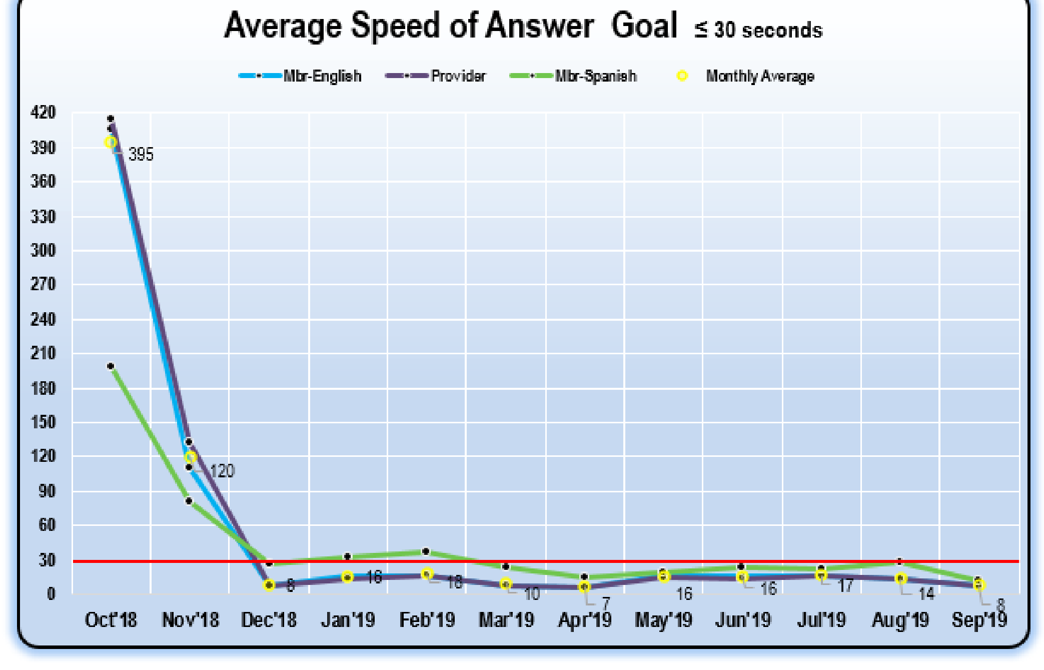
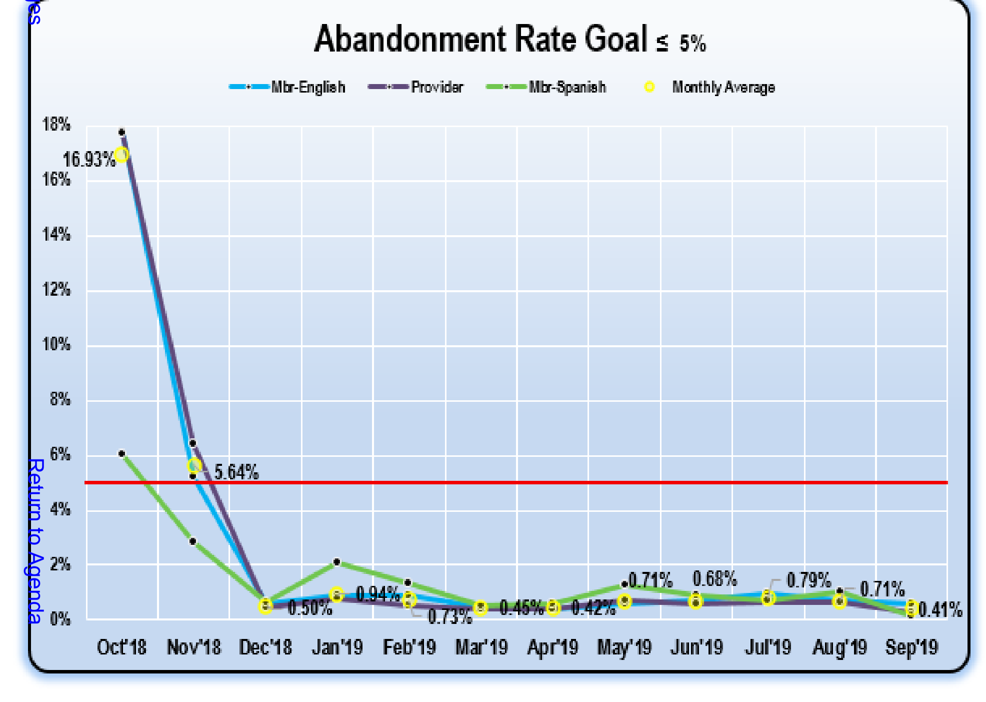
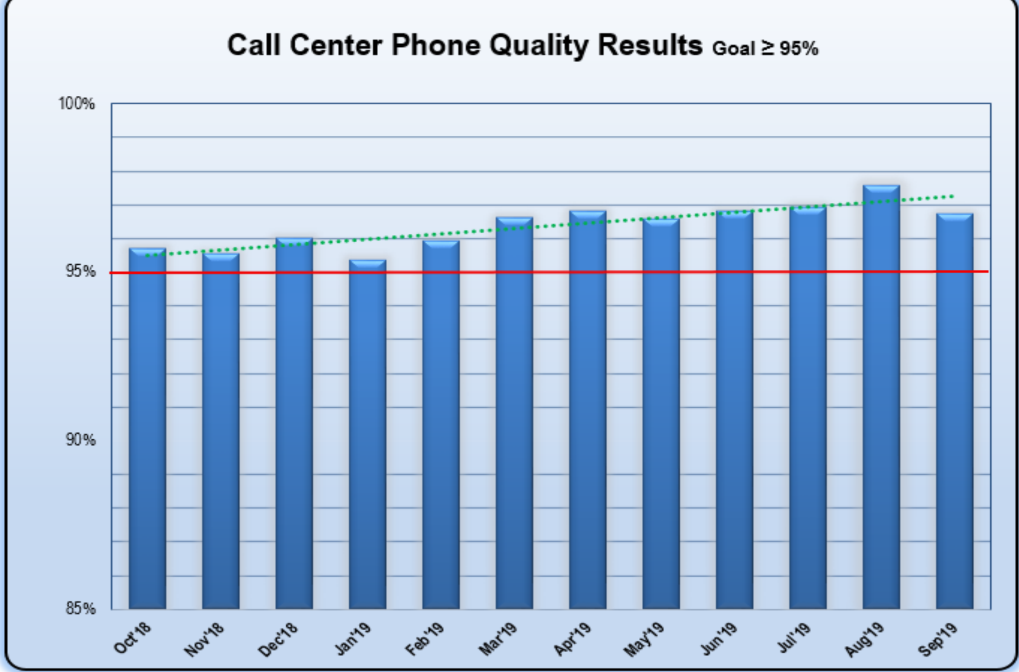
Call Center KPI Dashboard

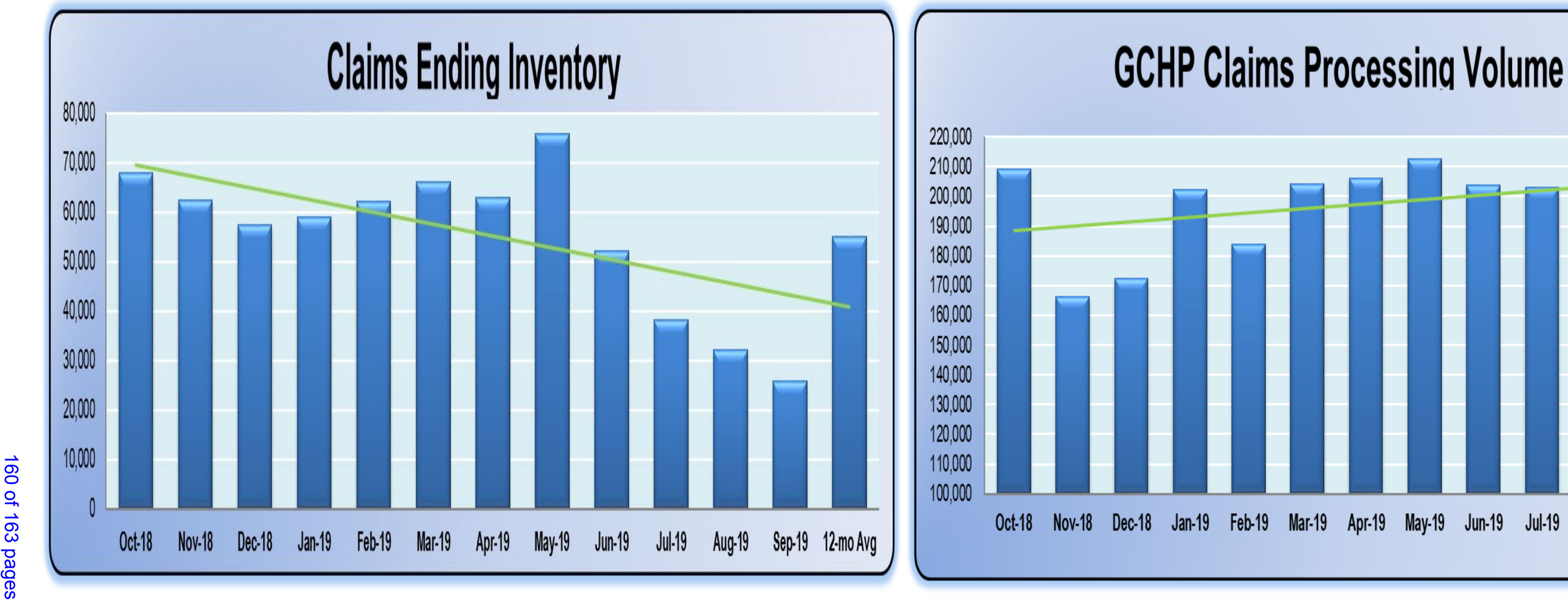


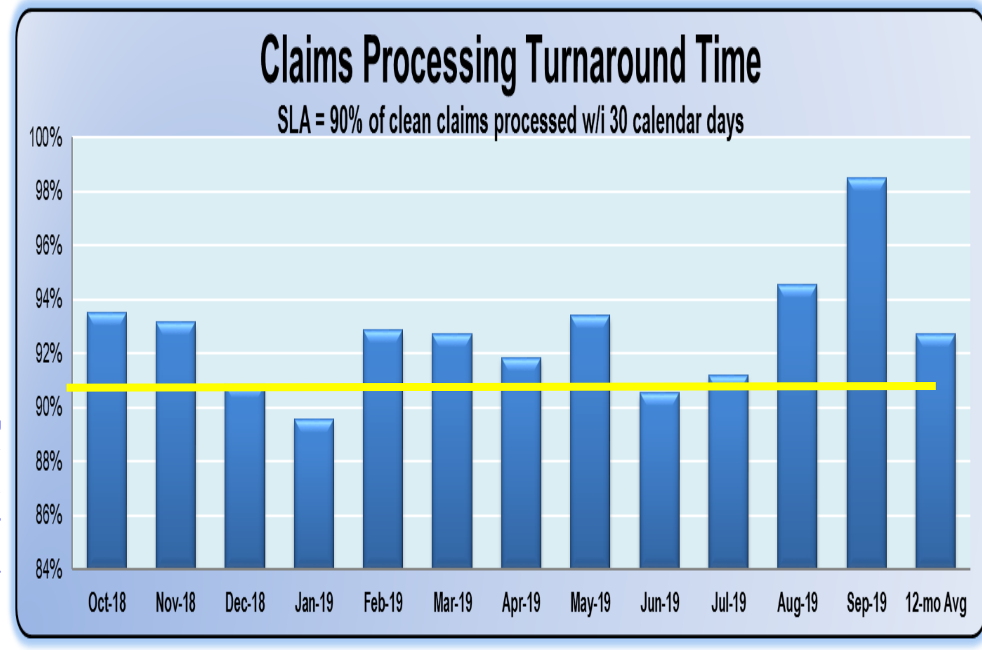


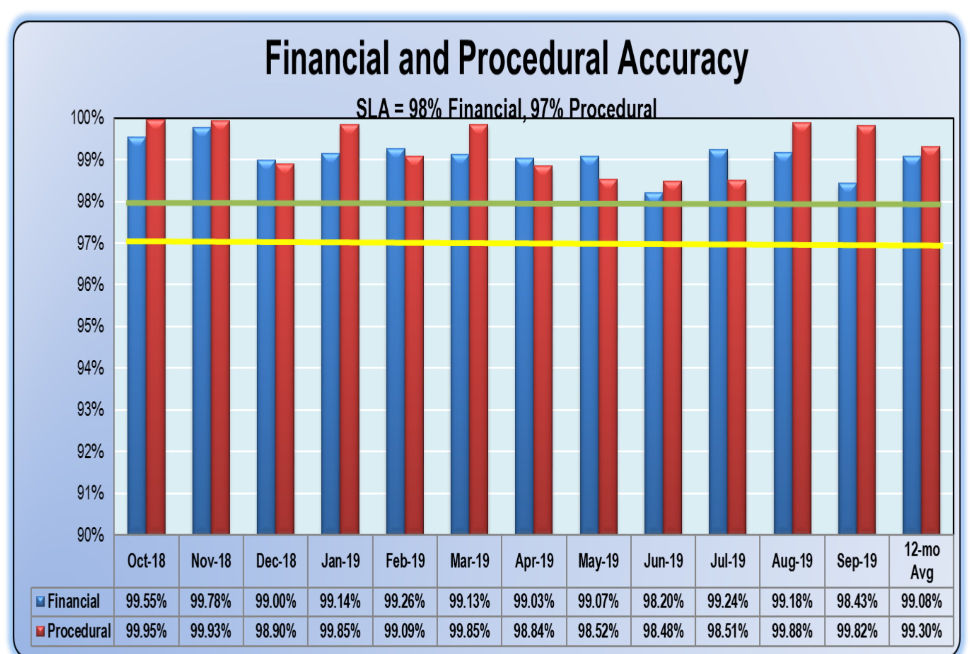




Claims KPI Dashboard

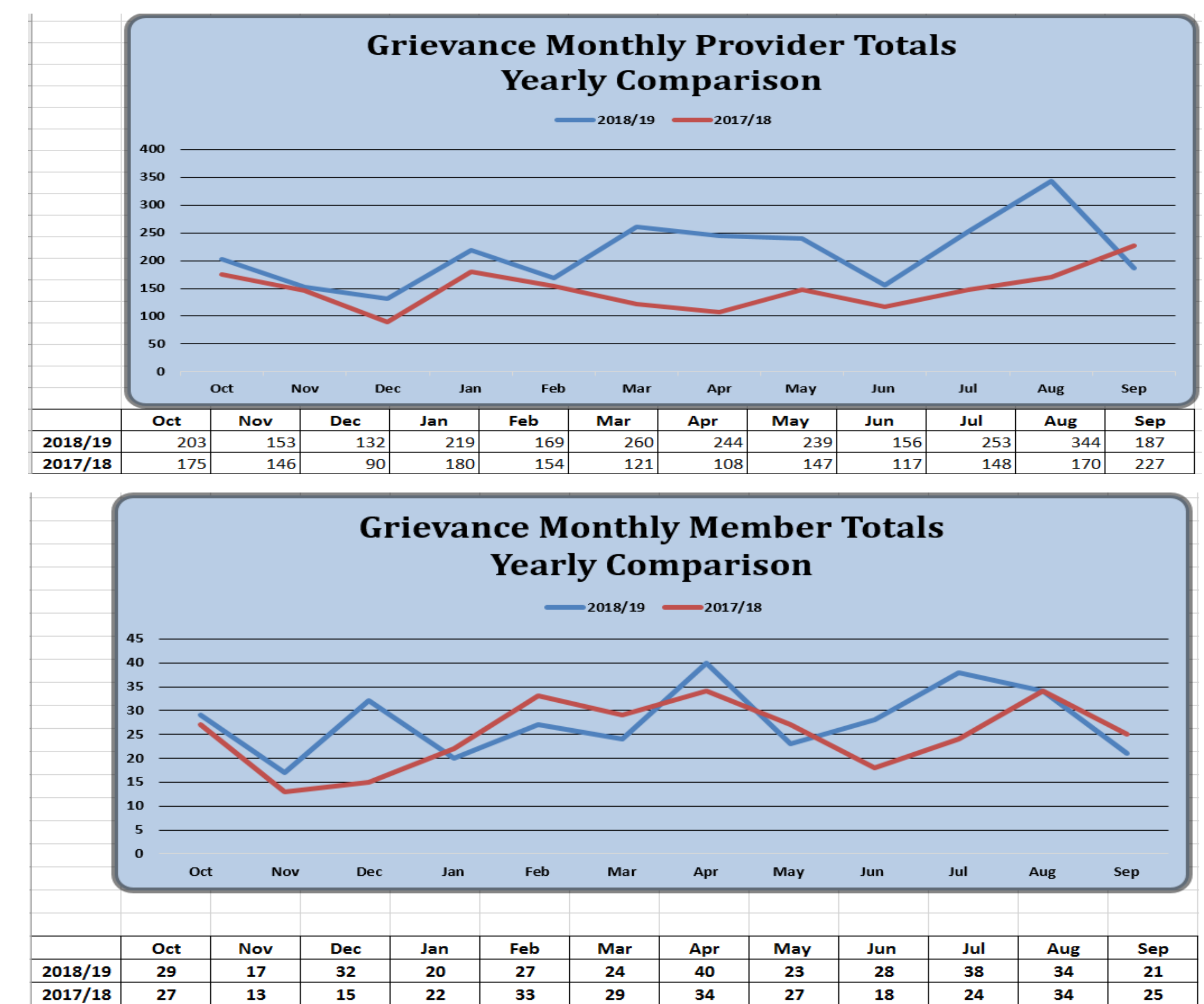






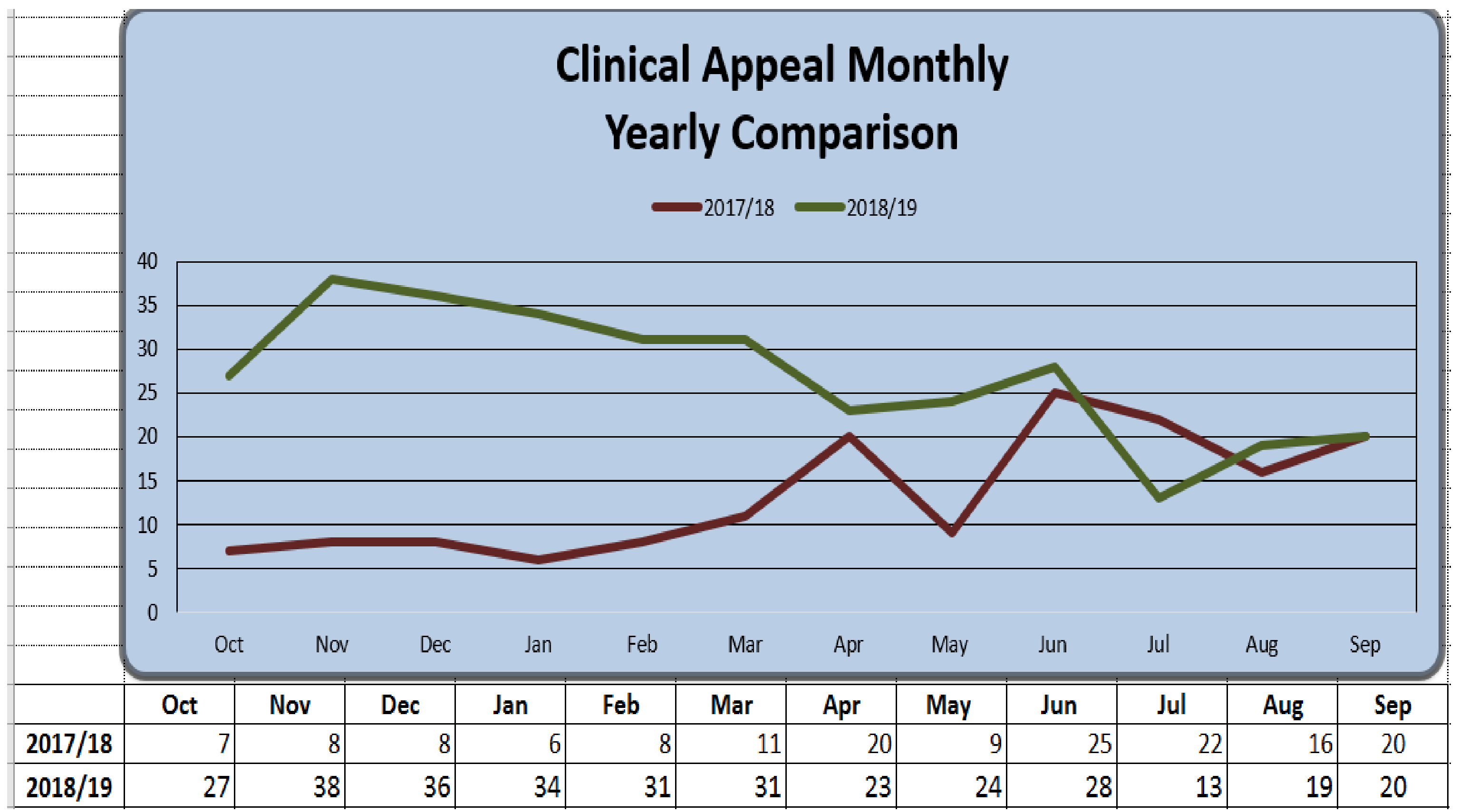
	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	12-mo Avg
Financial	99.55%	99.78%	99.00%	99.14%	99.26%	99.13%	99.03%	99.07%	98.20%	99.24%	99.18%	98.43%	99.08%
Procedural	99.95%	99.93%	98.90%	99.85%	99.09%	99.85%	98.84%	98.52%	98.48%	98.51%	99.88%	99.82%	99.30%

Grievance and Appeals KPI Dashboard



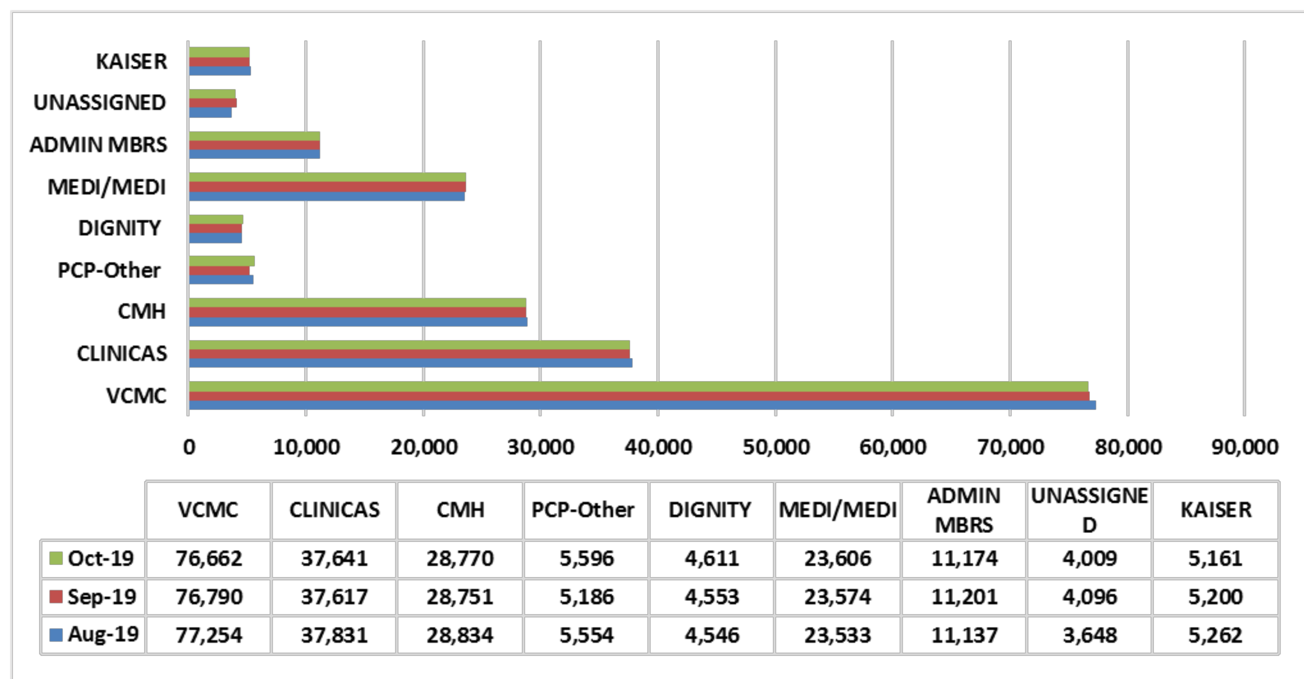
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2018/19	203	153	132	219	169	260	244	239	156	253	344	187
2017/18	175	146	90	180	154	121	108	147	117	148	170	227

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2018/19	29	17	32	20	27	24	40	23	28	38	34	21
2017/18	27	13	15	22	33	29	34	27	18	24	34	25



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2017/18	7	8	8	6	8	11	20	9	25	22	16	20
2018/19	27	38	36	34	31	31	23	24	28	13	19	20

Member PCP KPI Dashboard



	VCMC	CLINICAS	CMH	PCP-Other	DIGNITY	MEDI/MEDI	ADMIN MBRS	UNASSIGNED	KAISER
Oct-19	76,662	37,641	28,770	5,596	4,611	23,606	11,174	4,009	5,161
Sep-19	76,790	37,617	28,751	5,186	4,553	23,574	11,201	4,096	5,200
Aug-19	77,254	37,831	28,834	5,554	4,546	23,533	11,137	3,648	5,262