

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

DATE: Monday, October 24, 2011

TIME: 3:00-5:00 pm

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

AGENDA

Call to Order, Welcome and Roll Call

Public Comment / Correspondence

1. Approve Minutes
 - a. Meeting of September 26, 2011 *Action Required*
2. Accept and File Management Update *For Information*
3. Accept and File Financial Report
 - a. Re-forecasted Budget *Action Required*
 - b. September Financials *For Information*
4. Management Recommendations & Reports
 - a. ScriptCare Presentation *For Information*
 - b. Decision Support System Selection *Action Required*
 - c. Compliance Software *Action Required*
 - d. CEO Authority to Negotiate and Executive Provider Contracts *Action Required*
 - e. Commission Bylaws *Action Required*

Comments from Commissioners

Adjourn to Closed Session (if needed)

CLOSED SESSION: GC § 54957 - CEO Performance Evaluation

Return to Open Meeting / Adjournment

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

**Ventura County Medi-Cal Managed Care Commission
(VCMMCC) dba Gold Coast Health Plan (GCHP)
Commission Meeting Minutes
September 26, 2011
(Not official until approved)**

CALL TO ORDER

Vice-Chair Gonzalez called the meeting to order at 3:04 p.m. in Suite 200 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE

David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
(arrived at 3:06 p.m.)

Maylee Berry, Medi-Cal Beneficiary Advocate

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

John Fankhauser, MD, Ventura County Medical Center Executive Committee

Robert Gonzalez, MD, Ventura County Health Care Agency

Rick Jarvis, Private Hospitals / Healthcare System

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

Kathy Long, Ventura County Board of Supervisors

Catherine Rodriguez, Ventura County Medical Health System

EXCUSED / ABSENT COMMISSIONERS

Lanyard Dial, MD, Ventura County Medical Association

Laurie Eberst, RN, Private Hospitals / Healthcare System

STAFF IN ATTENDANCE

Earl Greenia, CEO

Tin Kin Lee, Legal Counsel

Traci R. McGinley, Clerk of the Board

Brandy Armenta, Quality Improvement Specialist

Sonia DeMarta, Accounting and Finance Manager

Andre Galvan, Project Management Specialist

Guillermo Gonzalez, Government Affairs Director

Lupe Gonzalez, Health Educator

Darlane Johnsen, Chief Financial Officer

Pamela Kapustay, RN, Health Services Director

Steven Lalich, Communications Director

Aimee Sziklai, Operations Director

The Pledge of Allegiance was recited.

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

PUBLIC COMMENT / CORRESPONDENCE

David Cruz, HELA President, requested information regarding the audit of the enrollment process. He added that he received reports that some families were divided and enrolled in different clinics and asked if those incidents had been addressed.

1. APPROVAL OF MINUTES

a. Meeting of July 25, 2011

Commissioner Juarez moved to approve the July 25, 2011 minutes, Commissioner Long seconded. The motion carried. **Approved 9-0.**

b. Meeting of August 22, 2011

Due to the lack of quorum at the August 22, 2011 meeting, it was decided that the minutes cannot be formerly approved, but can be accepted. There was consensus that the minutes be accepted with CMO Cho's title being corrected under Item 4c.

2. MANAGEMENT UPDATE

CEO Greenia referred the Commission to his written report and also noted that information regarding the PCP audit was provided within the report. He further explained that staff continues to honor PCP change requests.

Discussion was held regarding the number of beneficiaries, progress with contracting with UCLA and the Call Center.

3. FINANCIAL REPORT

Balance Sheet. CFO Johnsen explained that the report was for July and August. GCHP advanced providers \$4 million which will be offset against future claims. Because mature claims data has not yet been established estimates are continuing to be utilized, with the exception of pharmacy information because that is recorded in real time.

Income Statement. Discussion was held regarding the dollar amount of claims received versus how much has been paid. It was requested that the statistics be included in the next report. CFO Johnsen explained that there is a difference in Membership, it was estimated that 71% of members were adult, but it is 74% and they are paid at the lowest per month category.

It was requested that in the future this report show the variance to the budget. There were discussions regarding budget figures for patients. It was noted that we are above budget for long-term care due to in-patient days.

The pharmacy costs were reviewed; to which CEO Greenia responded that the figures may be lower in the future because of the 60 day continuity and seasonality.

Cash Flow. CFO Johnsen provided an overview of the Statement of Cash Flow and discussed the concept of IBNR (Incurred But Not Recorded) costs.

4. MANAGEMENT RECOMMENDATIONS

a. Phase II Media Buy

CEO Greenia explained that this was an expansion of the previous Media Outreach. This would be another 6-week campaign and will reach an estimated 265,500 listeners. The campaign is part of the “branding” process of GCHP directed at both members and providers. Director Lulich added that different media campaigns have different toll-free numbers so specific campaigns can be tracked. It was Management’s recommendation to contract with the same vendor used for Phase I.

Commissioner Long moved to approve the continuation of the market buy of radio time and newsprint ads with media vendor Gold Coast Broadcasting, Commissioner Juarez seconded. The motion carried. **Approved 9-0.**

b. Commission Bylaws

Counsel Lee reviewed the previous changes to the Bylaws. Discussion was held regarding the Duties of the Executive / Finance Committee and the rights the Commission has to create Ad Hoc Committees.

It was agreed that #11 of the Executive / Finance Committee duties would be deleted or changed to “Develop CEO review process” and another duty would be added to include the Strategic Business Plan.

Counsel Lee will make changes to be presented to the Commission at a future meeting.

c. Co-Payment Policy

CEO Greenia explained that Management drafted this Policy in response to Department of Health Care Services (DHCS) request to Centers for Medicare and Medicaid Services (CMS) to implement co-payments in California. CEO Greenia added that staff solicited information from the members of the Consumer Advisory Commission and provided an overview of the questions and results of that survey.

The estimated financial impact on providers was reviewed. There was consensus that this item be considered by the Commission at a future meeting should it be approved by CMS.

d. PCP Auto-Assignment and Self-Selection Audits

CEO Greenia advised the Commission that GCHP staff developed the process to review and audit the ACS system and are satisfied that ACS appropriately applied the process.

GCHP was notified by Providers that some changes were retro only to August 1st, but it is our intent to have it July 1st.

Commissioner Chawla asked if staff had checked into families being split up and auto-assigned to different Clinics. CEO Greenia responded that those situations when brought to the attention of GCHP staff are rectified.

Vice-Chair Gonzalez stated that he had expected more information from the audit; and requested that ACS be available at a future meeting to answer questions on this process.

COMMENTS FROM COMMISSIONERS

Commissioner Chawla requested that utilization data, such as the most common diagnoses for hospital admissions, be presented to the Commission. She also suggested that the Plan offer outreach / education to the Specialist physicians regarding the referral process and that the process be streamlined to reduce redundancy.

Vice-Chair Gonzalez added that Providers who have Medi-Medi patients do not know what to do either.

ADJOURN TO CLOSED SESSION – CEO EVALUATION

The Commission adjourned to Closed Session at 5:05 p.m.

RETURN TO OPEN SESSION

The Regular Meeting reconvened at 6:04 p.m. Vice-Chair Gonzalez reported that the Commission determined that Vice-Chair Gonzalez and Commissioner Juarez would develop CEO review criteria for recommendation to the Commission.

ADJOURNMENT

The meeting adjourned at 6:06 p.m.



**Chief Executive's Monthly Report to Commission
October 24, 2011**

PEOPLE (Organizational Structure)

- We have added additional talent to our team:
 - Sr. Financial Analyst: Lyndon Turner, CPA
 - Health Services Coordinators: Rebeccah Farfan, RN, Nicole Kanter, RN, and Martin Martinez, RN.
- Recruitment continues for: QI Director (offer extended), Sr. Director, Operations (reviewing applicants), Member Services Outreach Coordinator (qualified candidates interviewed), and a Sr. Accountant.
- We have reviewed several properties for future expansion or move.

SERVICE (Member & Provider Satisfaction, Government Affairs, Compliance)

Community Outreach & Education

- Recent community outreach, education, marketing and advertising:
 - October 4: Presentation to staff at Oxnard Family Circle, an adult day health care facility.
 - October 5: Presentation to staff at Among Friends, an ADHC facility in Oxnard.
 - October 7: Presentation to parents at McKenna Elementary School in Oxnard.
 - October 11: Presentation to staff at Millennium, an ADHC facility in Simi Valley.
 - October 20: Presentation to healthcare professionals at the Ventura Home Care Association's second annual symposium. We joined physicians, social workers and other healthcare executives in educating the audience regarding GCHP.
 - October 22: Presentation to case managers and discharge planners from hospitals, SNFs and home health agencies.
 - Staff conducted informational meeting at the Mixteco Indigena Community Organizing Project to announce GCHP agreements that will allow GCHP members access to health care services in Santa Cruz and Monterey Counties.
 - The Phase 2 educational outreach campaign started. This radio, television and newsprint campaign will run for 6 consecutive weeks on nine radio stations and five television networks.

Government Affairs

- Staff continues to participate in weekly conference calls with the State Department of Health Care Services concerning the elimination of the Adult Day Health Care (ADHC) benefit from the Medi-Cal Program.
- Responded to inquiries from DHCS on a variety of matters including member service, claim payments, and provider relations. Ongoing outreach efforts continue with staff in the Governor's office, and Representatives Capps and Gallegly.

- GCHP representatives recently attended the annual conference of the California Association of Health Plans and quarterly meeting of Association for Community Affiliated Plans.

State Medicaid Rates

- On September 28, the Centers for Medicare & Medicaid Services (CMS) “stopped the clock” on the 90 day deadline to rule on California’s proposed changes by submitting an official request to the State of California for additional information.
- On October 12, the California Association of Health Plans (CAHP) received a formal response from CMS regarding AB 97 (Medicaid Provider Rate Reduction, Co-payments and Service Caps). CAHP’s legal counsel argued that AB 97 violated the federal actuarial soundness statute as it mandated a reduction in Medi-Cal Managed Care rates due only to a desire to achieve budget savings and not a programmatic change or decrease in cost. CMS’s response made it clear that if DHCS can find an actuary to certify the rate reduction, CMS will not consider the state in violation of federal law. A copy of the CMS response is included in this package.

Information Technology

- The integration of ICMS (utilization and medical management interface) and iKA (claims platform) is in the final stage. Full production is expected on October 31. This integration will allow GCHP the ability to identify areas of necessity and opportunity, and provide the foundation to better manage patient care and cost.

Member Services

- A favorable outcome was accomplished with GCHP’s second State Fair Hearing case ending with withdrawal of the complaint by the member.
- Updates to the Member Handbook are underway; an updated version will go to production in December.

Compliance

- Staff is in the process of building a comprehensive compliance program including the establishment of a compliance committee.
- Developing a Fraud, Waste and Abuse policy and a Code of Conduct.
- Currently evaluating vendors for a compliance hotline.
- Staff evaluated various compliance software vendors. A separate report, requesting Commission approval, is included in this package.

Auto-Assignment

- At the last Commission meeting, a request was made for the auto-assignment volumes by major provider group. On July 9, the 47,319 members who did not select and were assigned to a PCP. (Note, there were 20,344 members that self-selected a PCP and 34,370 “administrative” members that do not select a PCP).

	VCMC	Clinicas	CMH	TOTAL
Assigned	31,754	9,333	6,232	47,319
Percent	67.1%	19.7%	13.2%	

QUALITY (Comprehensive Medical Management)

- Our Health Services and Medical Management teams have been actively developing plans and programs to ensure that care is effective and efficient; some recent highlights include:
 - Health Education Referral Form – for use by PCPs and other staff to refer members for Health Education Services through GCHP.
 - One-on-One Health Education Services – From October 1 through 18, GCHP Health Educator received three health education referrals (2 from nurses and 1 from a provider) for diabetic education classes.
 - Established a referral process for children identified as obese to receive medical and nutritional education.
 - Providing extended health education services to members with special needs (i.e. transportation, dialysis, and nutrition services).
 - Community Resources Directory – English Directory currently posted on the GCHP website, Spanish Directory pending translation will be posted soon.
 - Provider Education – preparing in-service, in collaboration with Provider Relations, on performing the IHA and IHEBA, utilization of the Health Education Referral Form, and available community resources.
 - Cultural and Linguistic Services – GCHP will conduct a Health Education and Cultural & Linguistic Group Needs Assessment. Approximately 5,000 surveys in English and Spanish will be mailed to randomly selected members.
 - High-Dollar Review - All claims \$25,000 or more are reviewed by a nurse to verify that appropriate charges were billed for authorized level of care services. The claims are then reviewed by the HSD and discussed with the CFO as to release of payment or not. All potential high-dollar cases (i.e. organ transplants, extended length of stay, NICU, etc.) are brought to the weekly “High-Dollar Case Review.” Additional initiatives to manage cost include: Medical Director review of length of stays longer than seven days and review of those cases where hospital placement days exceed three days.

Adult Day Health Care (ADHC)

- GCHP has identified a Health Risk Assessment (HRA) tool that will be used to assess the appropriate needs and level of care for ADHC members. GCHP will be using an outside vendor to conduct face-to-face assessments of all ADHC clients who are members of GCHP. GCHP will utilize the ADHC Individual Patient Care Plan and ADHC Discharge Health Plans provided by the State as supplemental tools in assessing the health needs of members.
- GCHP has reached out to all five ADHC Centers in Ventura County. GCHP has conducted informational meetings at four of the five facilities to inform administrative, medical, and social support staff at each of ADHC facilities about Gold Coast Health Plan services and benefits to members. To date, one center has declined to meet with GCHP pending outcome of the litigation against the State.

ACCESS (Robust Provider Network)

- We continue to expand the contracted provider network both in Ventura and contiguous areas of Los Angeles and Santa Barbara counties, especially for unique covered services that are not available locally. For example, staff recently met with LA

County Health Agency officials to secure agreements to allow GCHP Members access to services such as the burn center and physical rehabilitation.

- Staff continues to address provider issues and modify our systems as needed based on early operations experience.
- Management has finalized (pending State approval) the urgent care services policy. Under this policy, if service is sought during the member's PCP's usual business hours then the Plan will contact the assigned PCP for decision whether the patient should be treated by the urgent care center or directed to the PCP. If the PCP direction is to have the urgent care center to treat the patient, he must provide a TAR (Treatment Authorization Request). If the PCP does not authorize, then the claim will be denied. If the service is provided afterhours, the claim will be approved. Physician practice patterns will be monitored and we will adjust the policy if necessary.
- The next Provider Advisory Committee meeting has been scheduled for November 10.

FINANCE (Optimize Rates, Ensure Long-Term Viability)

- Created a Claims Research Unit at the Plan level to respond to claims-related provider inquiries to augment ACS' Claims research team.
- GCHP submitted the statutorily-required August financial statements to the State.
- We have re-forecasted revenue and health care costs based on emerging enrollment trends. With only three months of payment history, it is too early to accurately extrapolate billing and payment patterns; however, health costs have been modified reflecting anticipated enrollment levels. We have updated the administrative cost budget based on first quarter experience and input from departmental management. The re-forecasted budget for the current fiscal year is included in this packet for Commission review and action.
- Staff from our IT, Finance, Medical Management and Health Services departments completed their review of vendors to assist in the creation and maintenance of a decision-support system/ data warehouse to ensure accurate capture of financial and utilization data to address State-mandated reporting requirements. A separate report, requesting Commission approval, is included in this package.

Respectfully submitted,

Earl G. Greenia
Chief Executive Officer

GOLD COAST HEALTH PLAN
Executive Summary
Re-forecasted Financial Plan
October 21, 2011

Summary

As a result of emerging membership data and enhanced understanding of the operational requirements, the company has prepared a reforecast of its fiscal year 2011-2012 financial plan. While it is too early to make any significant revisions to original health care cost assumption, we have made adjustments to enrollment, revenue and general and administrative expenses. The first two months of the reforecast include the actual financial results from July and August.

Membership

Average membership and total member months forecasted to be 98,624 and 1,183,491 respectively. Based on the membership through the first quarter of fiscal year 2011-12, the reforecast has revised average membership to 101,614 and total member months to 1,219,362; and increase of 3.0%. The membership mix by aid category differs than originally forecasted. The current reforecast also revises the membership distribution.

Aid Category	Revised Member Months	Revised Average Membership	% of Total	Original Member Months	Original Average Membership	% of Total
Adult/Family	899,178	74,932	73.7%	846,623	70,552	71.5%
Aged - Medi-cal	14,801	1,233	1.2%	116,699	9,725	9.9%
Disabled - Medi-Cal	93,436	7,786	7.7%	13,349	1,112	1.1%
Long Term Care - Medi-Cal	787	66	0.1%	2,215	185	0.2%
Aged - Dual	109,134	9,095	9.0%	95,403	7,950	8.1%
Disabled - Dual	88,612	7,384	7.3%	95,670	7,973	8.1%
Long Term Care - Dual	10,411	868	0.9%	13,026	1,086	1.1%
BCCTP	3,004	250	0.2%	598	50	0.1%
Total	1,219,362	101,614	100.0%	1,183,583	98,632	100.0%

Revenue

The original forecast of Premium Revenue was \$299,306,209 for the current fiscal year or \$252.90 on a per member per month basis. Revenue in the current reforecast is revised to \$302,399,730 reflecting the increased membership and the change in membership mix; an increase of 1%. While membership increased by 3%, revenue on a per-member-per-month basis decreased 2% to \$248.00 given membership mix changes.

Health Care Costs

Underlying assumptions for health care costs have not been revised with the exception of Pharmacy. Health care costs in the original budget were forecasted at \$258,185,698. The revised estimate is \$260,165,408, an increase of about 1.0%. While increased membership drove an increase in health care costs, these increases were partially offset by July and August actual costs. For both months pharmacy and primary care capitation have had positive variances to budget. Capitation is lower partially as a result of how it was originally budgeted.

GOLD COAST HEALTH PLAN
Executive Summary
Re-forecasted Financial Plan
October 21, 2011

The original assumption was that capitation was estimated for total membership in the three eligible aid categories; Adult/Family, Aged and Disabled. Actual capitation is lower because within these categories there are share of cost members in the categories that do not require the selection of a primary care physician.

Pharmacy costs for the first two months also have a favorable variance from the original budget. Analysis of these costs indicate that utilization is lower than expected with less than 20% of the membership utilizing the benefit. While utilization is trending slightly upward, there is a downward trend in the cost per prescription as the 60 day continuity of care has expired. Thus, the forecast for pharmacy costs has been reduced by slightly less than 1%.

General & Administrative Expense

The general and administrative expense forecast has been revised to reflect emerging operational requirements. The overall increase of approximately \$645,000 represents an increase of 2.7% from the original plan; however, the increase is only .02% of net revenue. The most significant changes in terms of percent change and dollar change are: Salaries and Benefits, ACS, Scriptcare, and CQS.

Salaries & Benefits: The increase reflects staffing increases in the areas of Medical Management, Health Services, Claims, Provider Relations, Operations and Community Outreach. Also included is an annual merit increase that was not included in the original plan. The impact of the increase is less than \$250,000.

Outside Services – ACS: Fees are based on a per-member-per-month basis; as membership increases, so does the cost. Increased membership accounted for approximately \$300,000 of the increase. The remaining \$500,000 is an estimate of the financial impact of change orders.

Outside Services – Scriptcare: The reforecast adjusts for the reduced volume experienced. Forecasted fees for Scriptcare have been reduced significantly based on emerging actual fees. Fees are lower for two reasons:

- Lack of data to estimate the volume of prescriptions resulted in an assumption of substantially higher fees.
- Current utilization is lower than forecasted

Outside Services – CQS: Fees are based on a per member per month basis. The financial impact of increased membership is minimal; approximately \$40,000. The projected costs for CQS is the result of the addition of 8 nurses; 4 for management of the Adult Day Health Care population in December and another for at the end of the year in anticipation of the assumption of the Seriously and Persistently Disabled (SPD) population in 2012. Per the CQS contract any additional staffing is reimbursed at cost.

Gold Coast Health Plan
Fiscal Year July 1, 2011 - June 30, 2012
Reforecasted P & L - 10.21.2011

	<u>9.2011 Reforecast</u>	<u>Original Budget</u>	<u>Variance Inc/(Dec)</u>	<u>% Change</u>
Member Months	1,219,362	1,183,491	35,871	3.0%
Average Membership	101,614	98,624	2,989	3.0%
 <u>Revenue</u>				
Premium	302,399,730	299,306,219	3,093,511	1.0%
Interest Income	145,290	631,077	(485,787)	-77.0%
Other Income	459,996	-	459,996	
Total Gross Revenue	303,005,016	299,937,296	3,067,720	1.0%
MCO Tax	6,977,096	7,033,698	(56,602)	-0.8%
Net Revenue	296,027,920	292,903,598	3,124,322	1.1%
			-	
 <u>Health Care Costs</u>				
Capitation	8,520,047	9,784,244	(1,264,197)	-12.9%
			-	
Claims				
Inpatient	126,859,453	122,922,032	3,937,421	3.2%
Outpatient	33,622,065	32,806,669	815,396	2.5%
Professional	25,855,637	25,057,241	798,396	3.2%
Pharmacy	42,564,419	46,885,297	(4,320,878)	-9.2%
Other	21,634,167	20,730,215	903,952	4.4%
Reinsurance	1,109,619	-	1,109,619	
Reinsurance Recoveries				
Total Claims	251,645,361	248,401,454	3,243,907	1.3%
			-	
Total Health Care Costs	260,165,408	258,185,698	1,979,710	0.8%
			-	
<u>Administrative Expenses</u>	24,861,159	24,216,977	644,182	2.7%
			-	
Net Income	11,001,353	10,500,923	500,430	4.8%

Impact on TNE:

Required TNE	<u>16,065,814</u>	<u>16,406,665</u>
Phased in Requirement	5,783,693	5,906,399
Excess TNE	3,060,870	2,560,440

Gold Coast Health Plan
Fiscal Year July 1, 2011 - June 30, 2012
Reforecasted G&A 10.21.2011

	<u>Revised</u>	<u>Original</u>	<u>Change</u> <u>Inc/(Dec)</u>	<u>% Change</u>
Salaries & Benefits	5,144,054	3,780,530	1,363,524	36.1%
Other Employee Expenses	207,201	78,000	129,201	165.6%
Outside Services - ACS	11,343,305	10,492,015	851,290	8.1%
Outside Services - Scriptcare	3,150,974	6,764,223	(3,613,249)	-53.4%
Outside Services - CQS	2,670,067	1,290,112	1,379,955	107.0%
Outside Services - RGS	226,243	243,947	(17,704)	-7.3%
Outside Services - Other	326,162	60,000	266,162	443.6%
Other Professional Services	167,941	360,000	(192,059)	-53.3%
Meetings & Events	9,514	-	9,514	
Travel - Airlines	78,298	12,000	66,298	552.5%
Non-Capital Furniture & Equipment	55,220	18,216	37,004	203.1%
Non-Capital Equipment - Computer	45,090	21,600	23,490	108.8%
Software Licenses	137,170	87,240	49,930	57.2%
Lease - Office	234,720	169,580	65,140	38.4%
Office & Operating Supplies	97,878	88,800	9,078	10.2%
Shipping & Postage	115,264	274,611	(159,347)	-58.0%
Printing	272,983	357,589	(84,606)	-23.7%
Telephone Services/Internet Charges	28,005	-	28,005	
Advertising & Promotions Expense	247,399	-	247,399	
Insurance	35,508	60,000	(24,492)	-40.8%
Committee & Advisory Fees	33,600	-	33,600	
Professional Dues, Fees, & Licenses	65,934	-	65,934	
Subscriptions & Publications	33,219	-	33,219	
Depreciation/ Amortization Expense	17,532	-	17,532	
Interest Expense	33,175	28,514	4,661	16.3%
Other Misc Expense	84,704	30,000	54,704	182.3%
Total	24,861,159	24,216,977	644,182	2.7%



**Gold Coast
Health PlanSM**
A Public Entity

AGENDA ITEM 3-B

To: Ventura County Medi-Cal Managed Care Commission

From: Earl Greenia, CEO

Date: October 24, 2011

Re: September Financials

TO BE PROVIDED AT MEETING



Gold Coast Health Plan

Pharmacy Plan Analysis
July 1, 2011 – September 31, 2011



SCRIPT CARE, LTD.

Plan Overview

This is the high level view of your plan. We look at cost trends during the plan year and compare your plan costs to the previous period and to Script Care's Book-of-Business.



Current Plan

	Jul-Sep 2011
Total Cost	\$7,725,303
Member Paid	\$0
Plan Paid	\$7,725,303
Rx	155,809
Generics - Total Cost	\$2,638,934
Member Paid	\$0
Plan Paid	\$2,638,934
Rx	123,727
Months	3
Average Enrollment	107,310

Total cost to the plan was
\$7,725,303 for the first 3
months of the program

	Jul-Sep 2011
Average Enrollment	107,310
Total Cost Per Month	\$2,575,101
Member Paid Per Month	\$0
Plan Paid Per Month	\$2,575,101
Total Cost PMPM	\$24.00
Member Paid PMPM	\$0.00
Plan Paid PMPM	\$24.00
Total Cost Per Rx	\$49.58
Member Paid Per Rx	\$0.00
Plan Paid Per Rx	\$49.58
Rx PMPM	0.48
Member Paid/Total Cost	0.00%
Generic Utilization - Total Cost	34.16%
By Plan Paid	34.16%
By Rx	79.41%

Generic utilization was
79.41%



Summary

July 2011	
Total Cost	\$2,276,259
Member Paid	\$0
Plan Paid	\$2,276,259
Rx	43,380
Generics - Total Cost	\$725,182
Member Paid	\$0
Plan Paid	\$725,182
Rx	33,835
Months	1
Average Enrollment	107,168

August 2011	
Total Cost	\$2,701,995
Member Paid	\$0
Plan Paid	\$2,701,995
Rx	54,029
Generics - Total Cost	\$899,611
Member Paid	\$0
Plan Paid	\$899,611
Rx	42,558
Months	1
Average Enrollment	107,335

September 2011	
Total Cost	\$2,747,049
Member Paid	\$0
Plan Paid	\$2,747,049
Rx	58,400
Generics - Total Cost	\$1,014,141
Member Paid	\$0
Plan Paid	\$1,014,141
Rx	47,334
Months	1
Average Enrollment	107,427

Plan cost have increased 20.7% from July to September

Prescription volume has increased from 43,380 in July to 58,400 in September, or 34.6%



Statistics

	July 2011
Average Enrollment	107,168
Utilizing Members	16,659
Total Cost Per Month	\$2,276,259
Member Paid Per Month	\$0
Plan Paid Per Month	\$2,276,259
Total Cost PMPM	\$21.24
Member Paid PMPM	\$0.00
Plan Paid PMPM	\$21.24
Total Cost Per Rx	\$52.47
Member Paid Per Rx	\$0.00
Plan Paid Per Rx	\$52.47
Rx PMPM	0.40
Member Paid/Total Cost	0.00%
Generic Utilization - Total Cost	31.86%
By Plan Paid	31.86%
By Rx	78.00%

	August 2011
Average Enrollment	107,335
Utilizing Members	19,421
Total Cost Per Month	\$2,701,995
Member Paid Per Month	\$0
Plan Paid Per Month	\$2,701,995
Total Cost PMPM	\$25.17
Member Paid PMPM	\$0.00
Plan Paid PMPM	\$25.17
Total Cost Per Rx	\$50.01
Member Paid Per Rx	\$0.00
Plan Paid Per Rx	\$50.01
Rx PMPM	0.50
Member Paid/Total Cost	0.00%
Generic Utilization - Total Cost	33.29%
By Plan Paid	33.29%
By Rx	78.77%

	September 2011
Average Enrollment	107,427
Utilizing Members	20,769
Total Cost Per Month	\$2,747,049
Member Paid Per Month	\$0
Plan Paid Per Month	\$2,747,049
Total Cost PMPM	\$25.57
Member Paid PMPM	\$0.00
Plan Paid PMPM	\$25.57
Total Cost Per Rx	\$47.04
Member Paid Per Rx	\$0.00
Plan Paid Per Rx	\$47.04
Rx PMPM	0.54
Member Paid/Total Cost	0.00%
Generic Utilization - Total Cost	36.92%
By Plan Paid	36.92%
By Rx	81.05%

Utilizing members of the pharmacy benefit increased from 16,659 in July to 19,421 in August and 20,769 in September

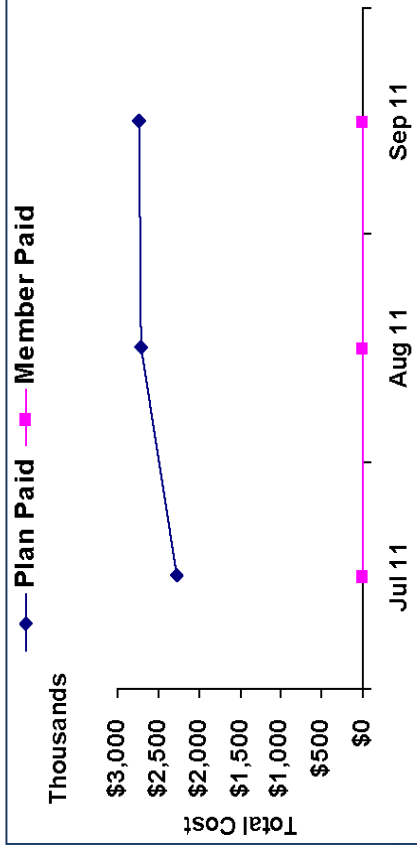


Total cost per prescription has decreased from \$52.47 to \$47.04 over the

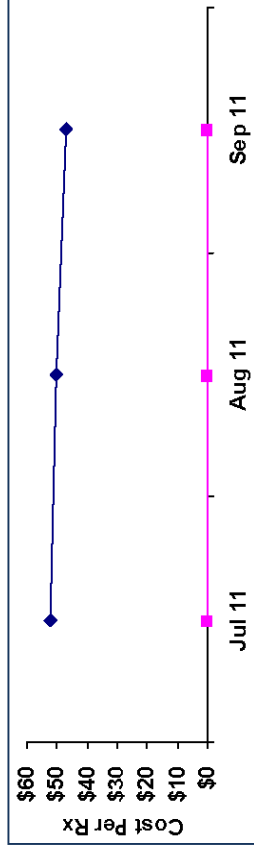
Generic utilization has increased every month and was 81.05% in September

Total Cost Trends

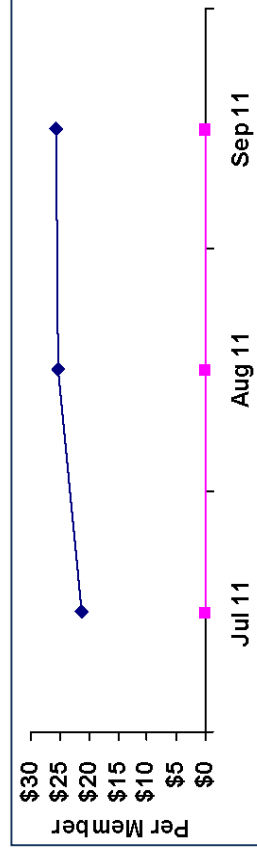
Average total drug spend was \$2,575,101 per month. Annualized at \$30,901,212 based on quarter one run rate



Average total drug spend was \$49.58 per prescription



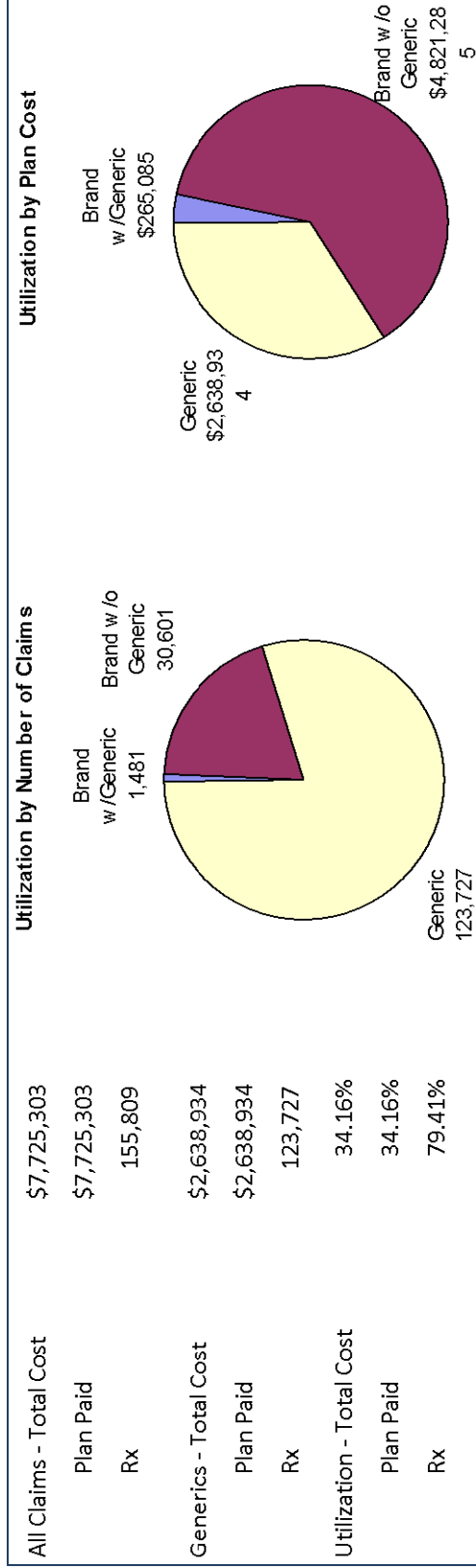
Average total cost was \$24.00 PMPM. Extremely low due to percentage of utilizing members



Generic Utilization

Generic fill rate was 79.41% and cost the plan 34.2% of the total cost

Single source brands, including specialty products, accounted for 19.6% of the prescriptions and 62.4% of the total cost



Enrollment Statistics

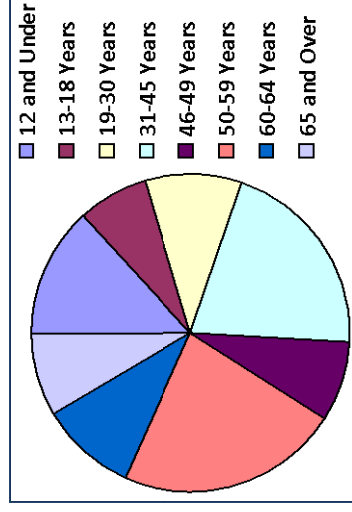
Understanding your membership composition



Utilization By Age

Range	Rx	Member Paid	Plan Paid	% of Total	Per Rx
12 and Under	26,003	\$0	\$1,040,492	13.47%	\$40.01
13-18 Years	10,901	\$0	\$539,165	6.98%	\$49.46
19-30 Years	18,060	\$0	\$757,418	9.80%	\$41.94
31-45 Years	30,004	\$0	\$1,597,860	20.68%	\$53.25
46-49 Years	11,487	\$0	\$622,378	8.06%	\$54.18
50-59 Years	29,558	\$0	\$1,759,977	22.78%	\$59.54
60-64 Years	12,617	\$0	\$756,020	9.79%	\$59.92
65 and Over	17,179	\$0	\$651,993	8.44%	\$37.95
Total	155,809	\$0	\$7,725,303	100.00%	\$49.58

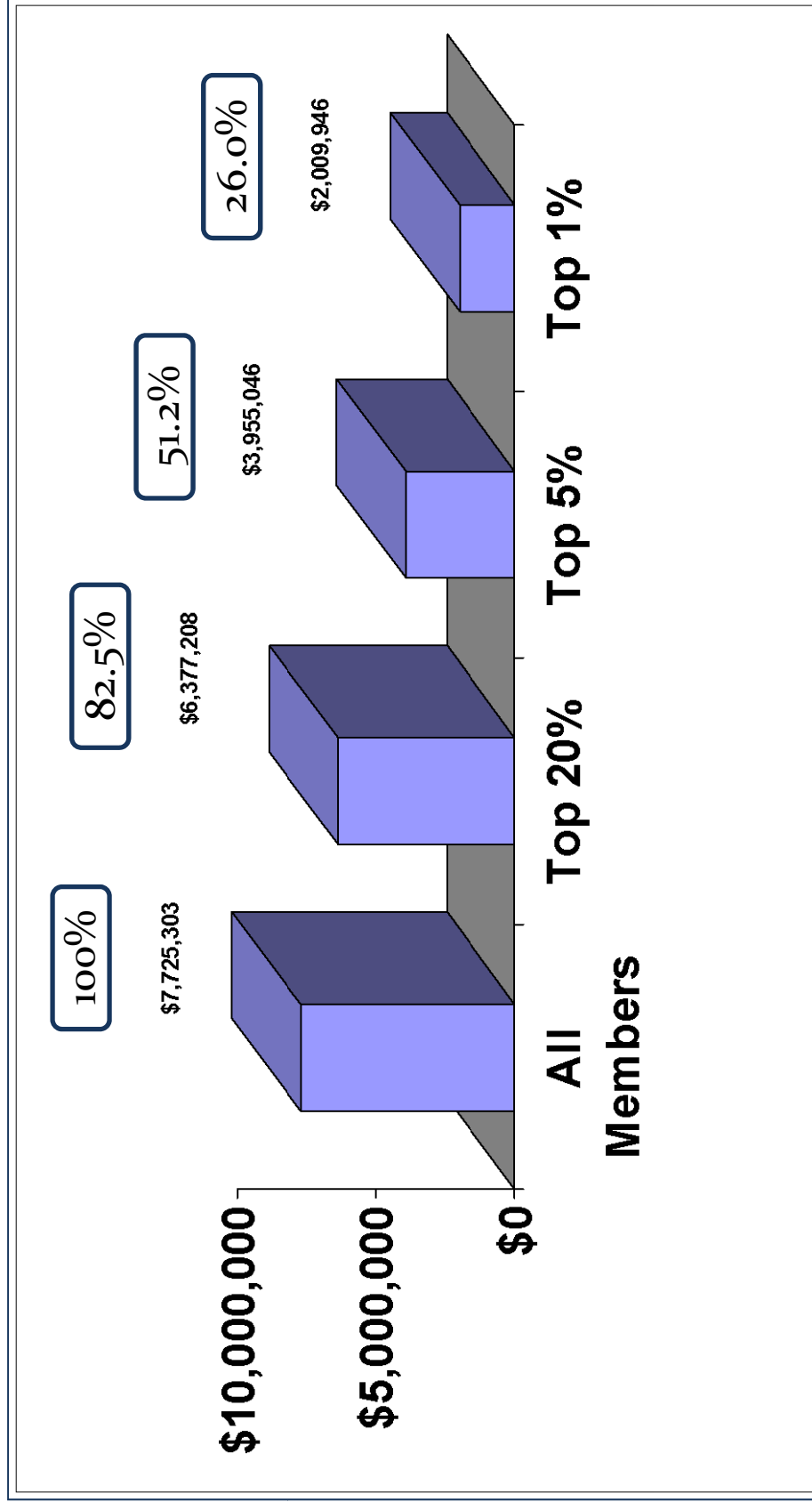
Plan Paid



The 50-59 age group spent 22.78% of the total drug spend



Utilization by Highest Users



Providers

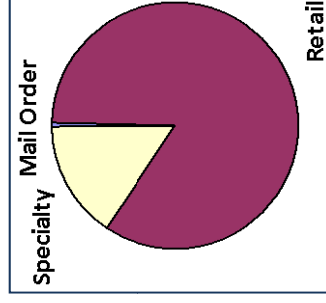
Most plans offer a variety of provider types to their membership



Provider Utilization

	<u>Rx</u>	<u>%</u>	<u>Plan Paid</u>	<u>%</u>
Retail				
Brand w/o Generic	30,114	19.33%	\$3,710,259	48.03%
Brand w/Generic	1,438	0.92%	\$225,556	2.92%
Generic	123,417	79.21%	\$2,542,372	32.91%
Total	154,969	99.46%	\$6,478,187	83.86%
Mail Order				
Brand w/o Generic	24	0.02%	\$39,855	0.52%
Generic	24	0.02%	\$5,778	0.07%
Total	48	0.03%	\$45,633	0.59%
Specialty				
Brand w/o Generic	463	0.30%	\$1,071,170	13.87%
Brand w/Generic	43	0.03%	\$39,529	0.51%
Generic	286	0.18%	\$90,784	1.18%
Total	792	0.51%	\$1,201,483	15.55%
Grand Total	155,809	100.00%	\$7,725,303	100.00%

Plan Paid



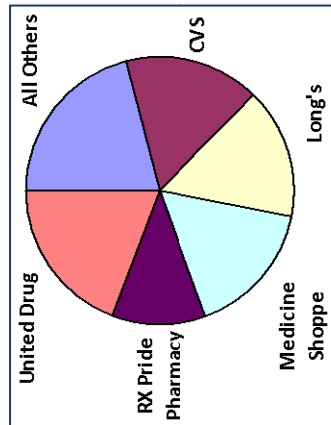
For the initial quarter there were 48 mail order prescriptions

The 792 specialty prescriptions was .51% of the prescription volume and 15.55% of the total cost



Retail Chain Utilization

Chain	Rx	Copay	Plan Paid	% of All
United Drug	21,468	\$0	\$1,248,757	16.16%
CVS	21,621	\$0	\$949,103	12.29%
Medicine Shoppe	21,874	\$0	\$938,214	12.14%
Long's	21,250	\$0	\$890,854	11.53%
RX Pride Pharmacy	16,086	\$0	\$625,527	8.10%
Safeway Pharmacy	6,373	\$0	\$318,305	4.12%
Target Pharmacy	7,624	\$0	\$285,105	3.69%
Wal Mart Pharmacy	6,983	\$0	\$237,899	3.08%
Acme, Lucky, Osco, Sav- on	2,609	\$0	\$147,316	1.91%
Caremark Pharmacy Services	32	\$0	\$142,528	1.84%



Between United Drug, CVS, Medicine Shoppe and Long's they processed 55.3% of the total prescriptions

United Drugs and Medicine Shoppe are both independents



Specialty Statistics

July 2011	
Average Enrollment	107,168
Utilizing Members	179
Total Cost Per Month	\$285,411
Member Paid Per Month	\$0
Plan Paid Per Month	\$285,411
Total Cost PMPM	\$2.66
Member Paid PMPM	\$0.00
Plan Paid PMPM	\$2.66
Total Cost Per Net Rx	\$1,427.05
Member Paid Per Net Rx	\$0.00
Plan Paid Per Net Rx	\$1,427.05
Rx PMPM	0.00
Member Paid/Total Cost	0.00%

August 2011	
Average Enrollment	107,335
Utilizing Members	208
Total Cost Per Month	\$419,436
Member Paid Per Month	\$0
Plan Paid Per Month	\$419,436
Total Cost PMPM	\$3.91
Member Paid PMPM	\$0.00
Plan Paid PMPM	\$3.91
Total Cost Per Net Rx	\$1,657.85
Member Paid Per Net Rx	\$0.00
Plan Paid Per Net Rx	\$1,657.85
Rx PMPM	0.00
Member Paid/Total Cost	0.00%

September 2011	
Average Enrollment	107,427
Utilizing Members	255
Total Cost Per Month	\$496,636
Member Paid Per Month	\$0
Plan Paid Per Month	\$496,636
Total Cost PMPM	\$4.62
Member Paid PMPM	\$0.00
Plan Paid PMPM	\$4.62
Total Cost Per Net Rx	\$1,596.90
Member Paid Per Net Rx	\$0.00
Plan Paid Per Net Rx	\$1,596.90
Rx PMPM	0.00
Member Paid/Total Cost	0.00%

Utilizing members of specialty pharmacy increased from 179 members in July to 208 in August and 255 in September

Cost per month has increased from \$285,411 in July to \$419,436 in August and \$496,636 in September

Cost per specialty prescription has averaged \$1,572.62 for the quarter



Therapeutic Utilization

Usage by Therapeutic Class



Drug Variance – Top 15 Drugs

July 2011			August 2011			September 2011		
	Rx	Plan Paid		Rx	Plan Paid		Rx	Plan Paid
NEXIUM - Ulcer Drugs	504	\$97,463	NEXIUM - Ulcer Drugs	446	\$85,381	SINGULAIR - Antiasthmatic	491	\$71,226
ADVAIR DISKU - Antiasthmatic	268	\$57,704	SINGULAIR - Antiasthmatic	436	\$63,268	ADVAIR DISKU - Antiasthmatic	259	\$55,896
SINGULAIR - Antiasthmatic	377	\$54,352	ADVAIR DISKU - Antiasthmatic	296	\$61,602	ACTOS - Antidiabetic	266	\$54,456
LEXAPRO - Antidepressants	334	\$42,901	ONETOUCH - Diagnostic Products	555	\$52,649	DIVALPROEX - Anticonvulsant	428	\$52,056
ACTOS - Antidiabetic	199	\$42,745	ACTOS - Antidiabetic	235	\$48,463	ONETOUCH - Diagnostic Products	514	\$47,252
LANTUS - Antidiabetic	268	\$39,483	BENEFIX - Misc. Hematological	1	\$47,414	NEXIUM - Ulcer Drugs	240	\$46,664
ONETOUCH - Diagnostic Products	370	\$36,284	DIVALPROEX - Anticonvulsant	391	\$43,241	COPAXONE - Misc.	12	\$43,239
DIVALPROEX - Anticonvulsant	308	\$35,022	LANTUS - Antidiabetic	289	\$41,774	Psychotherapeutic and Neurological Agents		
LIPITOR - Antihyperlipidemic	245	\$34,357	LEXAPRO - Antidepressants	316	\$41,379	LANTUS - Antidiabetic	313	\$43,047
CYMBALTA - Antidepressants	149	\$28,379	ENBREL SRCLK - Analgesics-Anti- Inflammatory	18	\$35,511	ENBREL - Analgesics-Anti- Inflammatory	20	\$39,393
VENLAFAXINE - Antidepressants	185	\$27,614	LIPITOR - Antihyperlipidemic	246	\$34,262	LANSOPRAZOLE - Ulcer Drugs	276	\$39,200
ENBREL - Analgesics-Anti- Inflammatory	13	\$25,993	VENLAFAXINE - Antidepressants	225	\$33,182	PROAIR HFA - Antiasthmatic	871	\$36,601
HUMALOG - Antidiabetic	146	\$25,696	CYMBALTA - Antidepressants	160	\$32,505	TRACLEER - Misc. Cardiovascular	6	\$35,225
KADIAN - Analgesics-Narcotic	39	\$25,066	OXYCONTIN - Analgesics-Narcotic	39	\$29,703	VENLAFAXINE - Antidepressants	241	\$34,643
ENBREL SRCLK - Analgesics-Anti- Inflammatory	12	\$24,233	LANSOPRAZOLE - Ulcer Drugs	206	\$28,636	FLUTICASONE - Systemic And Topical Nasal Products	682	\$31,100
	3,417	\$597,292		3,859	\$678,971	XELODA - Antineoplastic	14	\$30,056
							4,633	\$660,055

In July there were 4 drugs that require step therapy; Nexium, Lexapro, Lipitor, and Cymbalta. In September after the continuum of care Nexium is the only one in the top 15



Therapeutic Class Variance

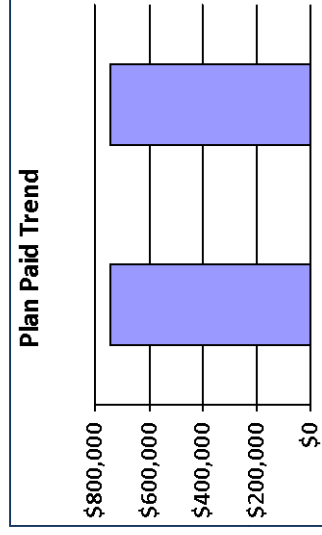
July 2011			August 2011			September 2011		
	Rx	Plan Paid		Rx	Plan Paid		Rx	Plan Paid
Antiasthmatic	2,271	\$219,934	Antiasthmatic	2,795	\$251,455	Antiasthmatic	3,277	\$271,633
Antidiabetic	2,037	\$173,415	Antidiabetic	2,609	\$208,141	Antidiabetic	2,804	\$217,036
Anticonvulsant	2,933	\$168,056	Anticonvulsant	3,465	\$195,299	Anticonvulsant	3,703	\$188,171
Ulcer Drugs	1,518	\$161,505	Antidepressants	3,640	\$176,930	Ulcer Drugs	2,088	\$152,474
Antidepressants	2,957	\$160,803	Ulcer Drugs	1,960	\$172,730	Antidepressants	3,681	\$151,734
Analgesics-Narcotic	2,880	\$129,619	Analgesics-Narcotic	3,379	\$134,311	Stimulants/Anti-Obesity	884	\$137,580
Stimulants/Anti-Obesity	666	\$106,391	Stimulants/Anti-Obesity	841	\$131,503	Anorexiants		
Anorexiants			Anorexiants			Analgesics-Narcotic	3,704	\$128,291
Antihyperlipidemic	1,317	\$88,288	Analgesics-Anti-Inflammatory	2,494	\$104,512	Antineoplastics	221	\$117,117
Antineoplastics	141	\$85,029	Antineoplastics			Analgesics-Anti-Inflammatory	2,784	\$110,629
Analgesics-Anti-Inflammatory	2,234	\$82,641	Antihyperlipidemic	203	\$93,695	Antihyperlipidemic	1,924	\$81,956
Inflammatory			Antihyperlipidemic	1,658	\$88,951	Misc. Psychotherapeutic and Neurological Agents	108	\$81,168
Diagnostic Products	787	\$61,286	Diagnostic Products	1,135	\$85,728	Diagnostic Products		
Assorted Classes	113	\$53,610	Misc. Cardiovascular	27	\$70,897	Assorted Classes	1,066	\$77,505
Antihypertensive	1,792	\$49,353	Misc. Hematological	113	\$63,318	Misc. Cardiovascular	171	\$71,061
Ophthalmic	755	\$44,878	Antiviral	183	\$62,464	Antiviral	23	\$67,255
Dermatological	1,698	\$43,473	Dermatological	2,555	\$61,861	All Others	180	\$65,714
All Others	19,281	\$647,980	All Others	26,972	\$800,200		31,782	\$827,724
	43,380	\$2,276,259		54,029	\$2,701,995		58,400	\$2,747,049

Antiasthmatics, Antidiabetics and Anticonvulsants were the top 3 therapeutic classes by cost



Therapeutic Class Variance I

Antiasthmatic Variances	Jul-Sep 2011
Total Cost/Rx	\$89.06
Percentage Paid By Plan	100.00%
Rx/Util. Mmbr Per Month	0.71
Utilizing Members	3,892
# Months	3
Plan Paid	\$743,021

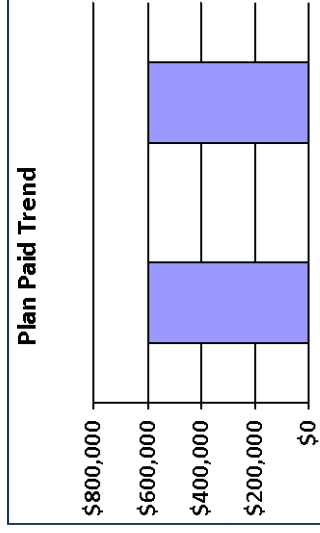


Top 'Antiasthmatic' Medications	Jul-Sep 2011	
	Rx	Plan Paid
SINGULAIR TAB 10MG	748	\$106,773
ADVAIR DISKU AER 250/50	469	\$101,339
PROAIR HFA AER	1,868	\$77,226
SINGULAIR CHW 5MG	318	\$47,260
ADVAIR DISKU AER 100/50	246	\$44,134
SPIRIVA CAP HANDIHLR	195	\$42,230
XOPENEX HFA AER	738	\$41,520
ADVAIR DISKU AER 500/50	108	\$29,729
SINGULAIR CHW 4MG	199	\$29,031
BUDESONIDE SUS 0.5MG/2	83	\$20,906
	4,972	\$540,149



Therapeutic Class Variance II

Antidiabetic Variances	Jul-Sep 2011
Total Cost/Rx	\$80.35
Percentage Paid By Plan	100.00%
Rx/Util. Mmbr Per Month	1.09
Utilizing Members	2,276
# Months	3
Plan Paid	\$598,591

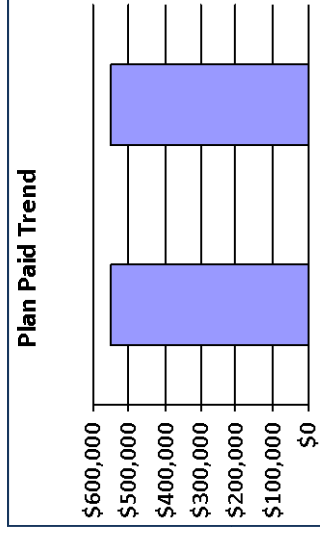


Top 'Antidiabetic' Medications	Jul-Sep 2011	
	Rx	Plan Paid
LANTUS INJ 100/ML	784	\$107,037
HUMALOG INJ 100/ML	447	\$81,376
ACTOS TAB 30MG	300	\$70,653
ACTOS TAB 45MG	154	\$38,410
ACTOS TAB 15MG	246	\$36,601
JANUVIA TAB 100MG	153	\$29,533
LEVEMIR INJ	141	\$23,755
ACTOPLUS MET TAB 15/850MG	101	\$20,996
LANTUS INJ SOLOSTAR	86	\$17,267
NOVOLOG INJ 100/ML	82	\$16,614
	2,494	\$442,242



Therapeutic Class Variance III

Anticonvulsant Variances	Jul-Sep 2011
Total Cost/Rx	\$54.60
Percentage Paid By Plan	100.00%
Rx/Util. Mmbr Per Month	0.99
Utilizing Members	3,408
# Months	3
Plan Paid	\$551,527

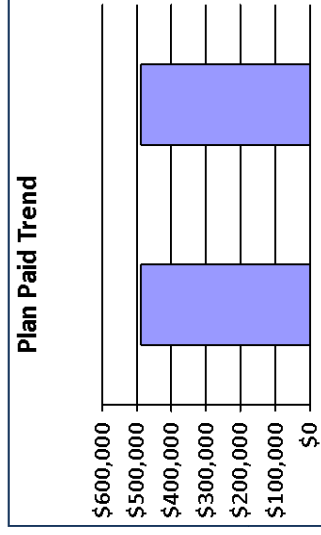


Top 'Anticonvulsant' Medications	Rx	Plan Paid
DIVALPROEX TAB 500MG ER	610	\$92,856
GABAPENTIN TAB 600MG	327	\$21,220
DIVALPROEX TAB 500MG DR	239	\$19,150
TOPIRAMATE TAB 100MG	419	\$17,847
LEVETIRACETA SOL 100MG/ML	190	\$17,740
OXCARBAZEPIN TAB 300MG	101	\$16,772
OXCARBAZEPIN TAB 600MG	73	\$16,438
DEPAKOTE ER TAB 500MG	57	\$13,481
LEVETIRACETA TAB 500MG	262	\$12,466
VIMPAT TAB 50MG	28	\$12,435
	2,306	\$240,405



Therapeutic Class Variance IV

Antidepressants Variances	Jul-Sep 2011
Total Cost/Rx	\$47.62
Percentage Paid By Plan	100.00%
Rx/Util. Mmbr Per Month	0.86
Utilizing Members	3,993
# Months	3
Plan Paid	\$489,467

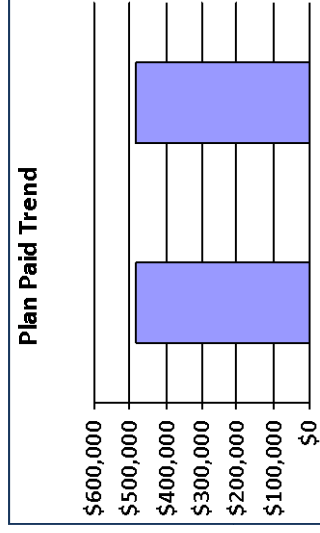


Top 'Antidepressants' Medications	Jul-Sep 2011	
	Rx	Plan Paid
LEXAPRO TAB 20MG	497	\$67,051
VENLAFAXINE CAP 75MG ER	307	\$53,434
CYMBALTA CAP 60MG	271	\$50,796
LEXAPRO TAB 10MG	350	\$42,224
BUPROPN HCL TAB 150MG XL	260	\$39,268
CYMBALTA CAP 30MG	133	\$27,698
VENLAFAXINE CAP 150MG ER	202	\$27,038
BUPROPN HCL TAB 300MG XL	236	\$25,101
BUPROPION TAB 150MG SR	259	\$16,221
SERTRALINE TAB 100MG	114	\$9,780
	2,629	\$358,610



Therapeutic Class Variance V

Ulcer Drugs Variances	Jul-Sep 2011
Total Cost/Rx	\$87.44
Percentage Paid By Plan	100.00%
Rx/Util. Mmbr Per Month	0.63
Utilizing Members	2,938
# Months	3
Plan Paid	\$486,710



Top 'Ulcer Drugs' Medications	Jul-Sep 2011	
	Rx	Plan Paid
NEXIUM CAP 40MG	1,064	\$205,224
LANSOPRAZOLE CAP 30MG	481	\$67,624
PANTOPRAZOLE TAB 40MG	436	\$31,108
FAMOTIDINE SUS 40MG/5ML	119	\$25,351
NEXIUM CAP 20MG	123	\$23,746
OMEPRazole CAP 40MG	462	\$22,946
OMEPRazole CAP 20MG	850	\$22,785
DEXILANT CAP 60MG DR	172	\$21,665
LANSOPRAZOLE CAP 15MG	66	\$9,133
GLYCOPYRROL TAB 1MG	82	\$7,728
	3,855	\$437,310



Gold Coast Health Plan

Diabetic Overview

Usage from 7/1/11-9/30/11

- 2,276 Members on medication for Diabetes
- 2,419 Members used testing supplies
- 13,704 Prescriptions processed
 - 7,450 processed for medications
 - 6,254 processed for supplies
- \$869,331 plan cost (11.25% of total drug spend)



Gold Coast Health Plan

- Non-Diabetic
 - Total Drug Spend \$5,689,305
 - Total Members 28,898
 - \$65.63 Per Member Per Month
- Diabetic
 - Total Drug Spend \$2,035,998
 - Total Members 3,611
 - \$187.94 Per Member Per Month

Annually, health care costs for a person with Diabetes are three times more than a person without Diabetes



Diabetic Overview, Cont.

The following table identifies the number of Gold Coast Health Plan members who have co-morbidities. This is the number of concurrent disease states.

Diabetes Only	2 co-morbidities	3 co-morbidities	4 co-morbidities	5 co-morbidities
1,429	876	800	366	140

The following table identifies the co-morbidities of Gold Coast Health Plan members with diabetes.

Hypertension	Hyperlipidemia	Depression	Ulcers	Asthma
1,564	1,086	530	542	430





AGENDA ITEM 4-B

To: Ventura County Medi-Cal Managed Care Commission

From: Earl Greenia, CEO

Date: October 24, 2011

Re: Decision Support / Data Warehouse Vendor Selection

Recommendation: That the Commission authorize management to proceed with contracting for a Decision Support / Data Warehouse Vendor.

Background: A robust system with integrated reporting capabilities is essential to effective plan management and critical to the decision making process.

How It Works:

- Incorporates data from multiple sources into a single integrated model.
- Data and finding can be reconciled across all departments and functional areas.
- Provides analytic tools and robust and timely benchmark data.
- Combines the expertise of both medical management and actuarial.

Functional Capabilities:

- IBNR and Reserve Management
- Health Plan Management
- Claims Auditing
- Patient Health Risk Analysis with Evidence Based Measures
- Utilization and Cost Analysis with Benchmarking
- Provider Network Management

Discussion:

Management has reviewed several systems, the major criteria for evaluation for the final three are summarized below:

	Milliman	Verisk	CQS/ICMS
Pricing	<ul style="list-style-type: none"> Implementation: \$75,000 – 125,000 Annual Fees: \$125,000 No charge for additional source data until exceeds 6. 	<ul style="list-style-type: none"> Implementation: \$67,000 Annual Fees(MI): \$288,000 Annual Fees(HEDIS): \$110,000 Charge based on number of members 	<ul style="list-style-type: none"> Implementation: Annual Fees: Included in CQS contract
Project Timeline	<ul style="list-style-type: none"> 90 days 	<ul style="list-style-type: none"> 60 ~ 90 days 	<ul style="list-style-type: none"> 90 days
Functionality	<ul style="list-style-type: none"> Web based reporting portal Finance Analysis and reporting Medical Management Analysis and reporting Pharmacy Analysis reporting HEDIS measurement report Financial and medical management functionality is fully integrated 	<ul style="list-style-type: none"> Web based reporting portal HEDIS reporting Medical Management Analysis engine 	<ul style="list-style-type: none"> Web based reporting tool Simple Medical Management Analysis and reporting. Simple Pharmacy Analysis reporting.
Current Installation and Utilization sites	<ul style="list-style-type: none"> Deseret Mutual Benefit Administrators Oregon Healthcare Quality Corporate 	<ul style="list-style-type: none"> Central California Alliance for Health 	
System profile	<ul style="list-style-type: none"> System is built on SQL Server database and Dimension reporting tool 	<ul style="list-style-type: none"> Using Oracle database and JAVA development programming language 	

Pros and Cons

	Milliman	Verisk	CQS/ICMS
Pros	<ul style="list-style-type: none"> Complete Financial Analysis system User driven reporting functionalities Customization of reporting Option of client site data hosting Financial and medical management functionality is integrated. 	<ul style="list-style-type: none"> Well-designed Medical Management system NCAQ certified HEDIS reporting Provider monitoring based on procedure code and drug category Cost saving analysis functionalities. 	Includes pharmacy analysis system.
Cons	<ul style="list-style-type: none"> Only provides HEDIS measurement data Not NCQA certified vendor for HEDIS 	<ul style="list-style-type: none"> Data hosting must be on vendor site No Financial Analysis feature Less flexibility for customization 	<ul style="list-style-type: none"> Claim number is not included in any report. It makes difficult for report and data validation. Requires significant customization to address GCHP business reporting requirements. No Finance Analysis feature. No HEDIS measurement or reporting functionality.



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

AGENDA ITEM 4-C

To: Ventura County Medi-Cal Managed Care Commission

From: Earl Greenia, CEO

Date: October 24, 2011

Re: Compliance Software

Recommendation: That the Commission authorize Management to proceed with contracting for a Compliance software system.

Background: GCHP currently uses manual processes to manage vendor and provider contracts and organization policies and procedures. In both cases, these documents are tracked on Excel spreadsheets and SharePoint which are maintained intermittently and prone to misinformation or missing documentation. The review and tracking of these contracts is also manual, resulting in the misplacement of contracts during the review process. There is no system in place to monitor renewal or termination dates. Compliance risks to GCHP will be monitored by the Compliance Committee once the committee is established as well as internal monitoring by staff. Specifically, all of the reports required by DHCS are tracked through an Excel spreadsheet, and reminders are tracked through personal Outlook/e-mail calendars. Non-compliance with reporting requirements, or failure to respond to corrective action plans issued as a result of audits, could lead to administrative sanctions. In the absence of a compliance management system, the Compliance Committee (once established) will not have the capability to provide robust reports of risks assessments and compliance activities to the Commission, a function that is required in a Compliance Plan.

Discussion:

Management has reviewed several systems; the major criteria for evaluation for the final three are summarized on the next page.

The preferred solution is "Compliance 360". It is the program of choice for many Medi-Cal Managed Care Plans in California, including Inland Empire Health Plan, Alameda Alliance for Health, San Mateo Health Plan, CalOptima, and CenCal Health (Santa Barbara). As GCHP evolves, Compliance 360 will assist in managing the increased workload, and will allow the Compliance Officer and the Privacy & Security Officer to be more efficient and effective in maintaining compliance.

	ComplyTrak	PolicyTech	Compliance 360
Pricing	Subscription service; the approximate cost for 3 years is \$142,000 (cost is based on number of designated users).	This software is so limited, it is not being considered as an option	Costs for license fees, set-up, and professional services and Lexis/Nexus integration range from \$124,000 for a 3 year term to \$180,000 for a 5 year term. License agreement covers an unlimited number of users.
Functionality	ComplyTrak is a product of Wolters Kluwer Law & Business, part of a national firm with worldwide offices. ComplyTrak's focus is on Medicare, billing and coding compliance and most of its clients are hospitals. Although it provides access to state and federal regulations, it does not incorporate the DHCS Contract requirements.	PolicyTech offers a Policy & Procedure Manager that imports healthcare regulations for use in policy development, review and tracking. The product does not offer any reporting or incident management capabilities, gap analysis or contract management tools.	Compliance 360 delivers its capabilities in an "on-demand" fashion, and offers components that are tailored for health plan compliance.
Current Installation and Utilization sites	All training is done online.	Licenses are purchased by number of users and have specific hardware requirements.	GCHP IT involvement is minimal; Compliance 360 is a WEB based application accessible with MS Explorer 6/0 SP2 and above.

Benefits of preferred software product:

- Compliance Workspace: This unique feature not only centrally stores laws & regulations, but also state Medi-Cal contract. It can be organized into a folder structure by clause so that you are able to assign responsibility to compliance tasks related to each provision. Additionally, all evidence such as Policies & Procedures, Assessments, Incidents, Corrective Actions, etc., can be linked to each contract requirement in the Virtual Evidence Room.
- Compliance 360 Regulatory Intelligence: The Compliance 360 software provides the ability to seamlessly pull regulatory content (laws and regulations) into a central content repository with automated alerts of changes to those laws and regulations. Upon receiving notifications of changes, the compliance software enables automated assessments to identify the extent of gaps in compliance and subsequent risks.
- Policy Management: The Compliance 360 Policies application helps organizations create, organize, and manage the complete life cycle of policies and procedures and includes automated, customizable workflow for collaboration and approval processes as well as version control and audit trail features. There is the ability to link policies and procedures to laws and regulations using the Virtual Evidence Room as evidence of compliance in support of audits. Policies are available to employees using an online search capability and communication and attestation is facilitated using automated surveys of employees to ensure they have read and understand each policy.
- Project Management: C360's Project Management module allows for corrective action project and remediation tasks which can automatically alert responsible parties of their tasks. Management oversight of the projects can be easily tracked with graphical dashboard pie-charts and tabular reporting. Projects can be linked back to the underlying laws, regs, or requirements in the Compliance Workspace.
- Executive Dashboard: The compliance software includes a highly configurable home page that includes graphical reports with drill-down capability for tracking all compliance activities. Think of this as your "My Compliance" page. At a glance, you can quickly identify hot spots needing attention. The system then directs you as you identify underlying causes and enact resolutions.
- Compliance 360 provides a highly configurable set of applications to assist the Compliance and Privacy Officer identify compliance gaps, eliminate duplicate efforts and maintain the records needed to demonstrate full compliance.



AGENDA ITEM 4-D

To: Ventura County Medi-Cal Managed Care Commission

From: Earl Greenia, CEO

Date: October 24, 2011

Re: CEO Authority to Negotiate and Execute Provider Contracts

Recommendation: It has been requested that the Commission discuss and clarify the CEO's authority to execute provider contracts.

Background:

On December 20, 2010, the Commission delegated authority to the CEO to negotiate and execute provider contracts. Given the sensitive nature of provider contracts and potential for conflict-of-interest, the Commission adopted the following policy: "Contracts with healthcare providers for the delivery of services to Medi-Cal beneficiaries are not subject to Commission review or approval, provided that the contract does not vary significantly from the model contract. Contracts that have been modified must be reviewed by legal counsel before execution."

Currently, there are model contracts for:

- Institutional-based care, such as hospital and long-term care facilities. The primary payment mechanism is a negotiated per-diem rate.
- Primary Care Physician Services with individual providers as well as groups. Payment mechanism is a flat per-member-per-month amount (capitated approach) for defined services plus the Medi-Cal scale payment for any other eligible, covered services.
- Specialty Care Physician Services, with individual providers as well as groups, using a fee-for-service payment based on the Medi-Cal fee schedule for eligible, covered services.
- Ancillary Services, such as home health, hospice, laboratory, imaging, durable medical equipment, etc., using a fee-for-service payment based on the Medi-Cal fee schedule for eligible, covered services.

GCHP also developed a model multi-specialty capitation contract that has been reviewed by legal counsel. The model contract is attached.

The only administrative service currently delegated to providers is for medical staff credentialing. This has been delegated only to those systems that have demonstrated capabilities as evidenced by ongoing maintenance of Joint Commission accreditation.

GCHP has contracted with ACS for various administrative services, such as claims processing and payment, mailroom services, telephone call center, internet web hosting, as well as the electronic medical management system.

GCHP has contracted with ScriptCare to manage our pharmacy benefit program.

GCHP has had ongoing discussions with one provider system regarding a multi-specialty capitation service agreement. To date, GCHP has not executed a multi-specialty capitation contract with any provider.

A question was recently raised whether the CEO has the authority to execute a contract for multi-specialty physician services under a capitated model.

Discussion:

As GCHP continues to evolve as a managed-care organization, providers and health plans will seek various risk-sharing agreements. A natural next-step in our evolution is to expand capitation arrangements into specialty physician care.

Under such an arrangement, GCHP and Contractor would negotiate various terms and conditions. This would include: rates and the division of financial and administrative responsibilities (i.e., claims and financial management, member and provider services, quality & utilization management, regulatory compliance), etc.

The Contractor would be held to same regulatory standards that apply to GCHP. GCHP would be responsible for general oversight of the contractor (and any sub-contractor) and would have full access to the Contractor's administrative and financial records and reports as well as Member's medical information. Further, the Contractor would be subject to a comprehensive "due diligence" review (conducted by GCHP) before execution of contract to ensure that the Contractor (and any sub-contractors) can fulfill all contractual and legal obligations.

Finally, it is important to note that the Member would be entitled to the same rights and benefits and level of services and care. For example, the Member would retain the ability to change their primary care physician at any time.

ROBERT GONZALEZ, MD
Health Care Agency Director

"Setting the standard in health care excellence"

October 19, 2011

Dr. Earl G. Greenia
Chief Executive Officer
Gold Coast Health Care Plan
2220 E. Gonzalez Road, Suite 200
Oxnard, CA 93036

Re: Gold Coast Health Plan/Delegation of Management Services

Dear Dr. Greenia:

I am aware that, in your capacity as Chief Executive Officer appointed by the Ventura County Medi-Cal Managed Care Commission ("Commission"), you have entered into numerous provider contracts. I would like you to disclose to the commission whether any of these contracts involve more than medical services. Specifically, have you agreed to delegation of administrative or managed care services to providers? Of particular concern would be services currently done by Plan staff or contracted with ACS or others in Commission approved contracts. I believe these types of arrangements could affect the Plan's contractual relationships and potentially, the long-term viability of the Plan and its provider network. I do not represent that I oppose these types of arrangements, but in the spirit of transparency, I ask that this be brought to the Board for open discussion. A preliminary report on any contracts requiring transfer of duties from GCHP staff or currently contracted providers should be included on the agenda for the October 24, 2011 Board meeting.

I have additional concern regarding the interpretation of the guidelines agreed upon by the Commission in the delegation of authority given to you for contracting and oversight of plan operations.

I further request that an action item be placed on the October 24, 2011 agenda concerning the scope of your authority to enter into contracts on behalf of the Commission. Because of the potential impact of these issues on the Gold Coast Health Plan, its providers, and members, it is important that this matter be considered by the Board at the earliest possible opportunity.

Sincerely,



Robert Gonzalez, M.D.
Commission Member,
Gold Coast Health Plan

pc: Lanyard Dial, M.D., Chair, Ventura County Medi-Cal Managed Care Commission
Tin Kin Lee, Esq.

Joan R. Araujo
Deputy Director
VCMC Ambulatory Care Administrator

Barry Fisher
Public Health Director

Paul E. Lorenz
Deputy Director
VCMC Hospital Administrator
Compliance Officer

Sheila Murphy
Public Information Officer

Ronald L. O'Halloran, MD
Medical Examiner/Coroner

Narcisa Reyes-Egan
Deputy Director
Chief Financial Officer

Meloney Roy
Behavioral Health Director

Terrie Stanley
Deputy Director
Managed Care Director

Maria Teran
Health Care Agency
Human Resources Director

MEDICAL SERVICES AGREEMENT

Between VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION

and

<MEDICAL GROUP>

This Medical Services Agreement (this "Agreement") is made effective as of the 1st day of _____, 2011 (the "Effective Date"), by and between the VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION (dba Gold Coast Health Plan), a public entity, hereinafter referred to as "Plan," and <MEDICAL GROUP NAME>, hereinafter referred to as "Medical Group."

Upon execution of this contract, any and all contracts previously executed by and between the Plan and the Medical Group, are terminated.

IN WITNESS WHEREOF, the following Agreement between Plan and Medical Group is entered into by and between the undersigned parties.

Medical Group:

<MEDICAL GROUP NAME>

Executed by:

Signature

Printed Name

Title

Date

Address for Notices:

Plan:

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

Executed by:

Signature

Earl G. Greenia

Chief Executive Officer

Date

Address for Notices:

2220 East Gonzales Road
Suite 200
Oxnard, CA 93035

**VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION
MEDICAL SERVICE AGREEMENT**

TABLE OF CONTENTS

RECITALS	3
SECTION 1 – DEFINITIONS	3
SECTION 2 – QUALIFICATIONS, OBLIGATIONS AND COVENANTS	8
SECTION 3 – SCOPE OF SERVICES	14
SECTION 4 – EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES	17
SECTION 5 – REIMBURSEMENT	19
SECTION 6 – MEDICAL RECORDS, INSPECTIONS, SUBCONTRACTING, REPORTING AND RECOVERIES	21
SECTION 7 – INSURANCE AND INDEMNIFICATION	25
SECTION 8 – GRIEVANCES AND APPEALS	26
SECTION 9 – TERM, TERMINATION, AND AMENDMENT	28
SECTION 10 – GENERAL PROVISIONS	30
SECTION 11 – RELATIONSHIP OF PARTIES	32
SECTION 12 – LEGAL REQUIREMENTS AND CREDENTIALS	33

Attachment A – Primary Care and Physicians Case Management Protocol

Attachment B –Capitation Payment Rates

Attachment B1 – Primary Care Physician - Scope of Capitated Services

Attachment C – Financial Responsibility Matrix for Covered Medical Services

Attachment D – Medical Specialty Network Adequacy

Attachment E – Responsibility Matrix for Administrative Services

Attachment F – Officers, Owners, and Stockholders

Attachment G – Medical Group Facilities

Attachment H – Health Insurance Portability and Accountability Act Business Associate Requirements

RECITALS

- A. WHEREAS, Plan is a County Organized Health System established pursuant to Welfare & Institutions Code §14087.54.
- B. Whereas Plan has entered into and will maintain contracts (the “Medi-Cal Agreements”) with the State of California, Department of Health Care Services in accordance with the requirements of W&I Code, Section 14200 et seq.; Title 22, CCR, Section 53000 et seq.; and applicable federal and State laws and regulations, under which Ventura County Medi-Cal Beneficiaries assigned to Plan as Members, will receive all medical services hereinafter defined as "Covered Services", through the Plan.
- C. Whereas Plan will arrange for Covered Services for its Medi-Cal Members under the case management of designated Primary Care Physicians chosen by such Medi-Cal Members or to whom such Medi-Cal Members are assigned, and all Specialist Physician Services will be delivered only with authorization from Plan or its delegated entity if services being provided require prior authorization.
- D. Whereas Medical Group is a <Type of Model> in good standing under the laws of the State of California, which will provide services hereunder through its physicians, employees and independent contractors.
- E. Whereas Medical Group will participate in providing Covered Services to Medi-Cal Members and will receive payment from Plan for the rendering of those Covered Services.

IN CONSIDERATION of the foregoing recitals and the mutual covenants and promises contained herein, receipt and sufficiency of which are hereby acknowledged, the parties set forth in this agreement agree and covenant as follows:

SECTION 1 – DEFINITIONS

As used in this agreement, the following terms will have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended. Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Section.

- 1.1 Administrative Member. Medi-Cal Members enrolled with Plan who are not required to select a Primary Care Physician; these include: members in long-term care facility (skilled or intermediate nursing care) for more than 30 days; those with a Medi-Cal with a Share of Cost; those living outside of Ventura County; those with other health insurance; and those receiving hospice care.
- 1.2 Agreement. This agreement and all of the Exhibits attached hereto and incorporated herein by reference.
- 1.3 Attending Physician. (a) any physician who is acting in the provision of Emergency Services to meet the medical needs of the Member (b) any physician who is, through referral from the Member's Primary Care Physician, actively engaged in the treatment or evaluation of a Member's condition or (c) any physician designated by the Medical Director to provide services for Administrative Members.
- 1.4 Authorization Request Form (ARF). The form approved by Plan for the provision of Outpatient Services set forth in the Provider Manual.

- 1.5 California Children's Services (CCS). A public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Section 41800.
- 1.6 Capitation Payment. The prepaid monthly amount that Plan pays to Medical Group as compensation for those Covered Medical Services which are set forth in Attachment C, attached to and incorporated herein.
- 1.7 Case Managed Members. Medi-Cal Members who have been assigned or who chose a Primary Care Physician for their medical care; i.e., all plan beneficiaries excluding Administrative Members as defined above.
- 1.8 Case Management. The responsibility for primary and preventive care, and for the referral, consultation, ordering of therapy, admission to hospitals, provision of Medi-Cal covered health education and preventive services, follow-up care, coordinated hospital discharge planning that includes necessary post-discharge care, and maintenance of a medical record with documentation of referred and follow-up services.
- 1.9 Child Health and Disability Prevention Services (CHDP). Those health care preventive services for beneficiaries under 21 years of age provided in accordance with the provisions of Health and Safety Code Section 124025, et. seq., and Title 17, CCR, Sections 6842 through 6852.
- 1.10 Complex Case. Members requiring comprehensive care management and coordination of services. Such Members may be identified through pre-certification requests by utilization management and inpatient concurrent review, those with complex care needs, and those with high acute impact scores or high forecasted costs. Criteria include: complex health conditions, barriers, and/or risks needing ongoing intervention. Frequently managed conditions, diseases or high-risk groups include, but are not limited to: AIDS, cancer, chronic illnesses that result in high utilization or under-utilization of health care resources, congenital anomalies, multiple chronic illnesses, serious trauma, spinal injuries, and transplants.
- 1.11 Contract Year. The 12-month period following the effective date of this Agreement between Medical Group and Plan and each subsequent 12-month period following the anniversary of the agreement. If the date of commencement of operations is later than the effective date, the Plan operational date will apply.
- 1.12 County Organized Health System (COHS). A plan serving either a single or multiple county areas.
- 1.13 Covered Services. All Medically Necessary services to which Members are entitled from Plan as set forth in the Member Handbook, including Primary Care Services, medical, hospital, preventive, ancillary, emergency and health education services. Covered Services includes Covered Medical Services.
- 1.14 Covered Medical Services. Those Covered Services that are set forth in Attachment C as the financial responsibility of the Medical Group and are to be provided to, or arranged for, Members by the Medical Group, within the scope of its licensure, pursuant to this Agreement.

- 1.15 Direct Referral Authorization Form (DRAF). The Plan's form, evidencing referral by PCP or Medical Director, or designee for initial specialist consultation or return follow-up with forty-five (45) days.
- 1.16 DHCS. The State of California Department of Health Care Services.
- 1.17 Eligible Beneficiary. Any Medi-Cal beneficiary who receives Medi-Cal benefits under the terms of one of the specific aid codes set forth in the Medi-Cal Agreement, who resides in the Plan Service Area and who is certified as eligible for Medi-Cal by the county agency responsible for determining the initial and continuing eligibility of persons for the Medi-Cal program's Service Area.
- 1.18 Emergency Medical Condition. A medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent lay-person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.
- 1.19 Emergency Services. Those health services needed to evaluate or stabilize an Emergency Medical Condition.
- 1.20 Encounter Form. The CMS-1500 claim form used by Medical Group to report to the Plan provision of covered services to Medi-Cal Members.
- 1.21 Enrollment. The process by which an Eligible Beneficiary selects or is assigned to the Plan.
- 1.22 Excluded Services. Those services for which the Plan is not responsible and for which it does not receive a capitation payment as outlined in Section 4 of this Agreement.
- 1.23 Fee-For-Service Payment (FFS). (1) The maximum Fee-For-Service rate determined by DHCS for services provided under the Medi-Cal Program; or (2) the rate agreed to by Plan and the provider. All Covered Services that are not Capitated Services, as described in Attachment B1, authorized by Plan pursuant to this Agreement will be compensated by Plan at the lowest allowable Fee-For-Service rate.
- 1.24 Fiscal Year. The 12 month period starting July 1.
- 1.25 Governmental Agencies. Any agency that has legal jurisdiction over Plan, Medi-Cal or Medicaid, such as: the Department of Managed Health Care ("DMHC"), DHCS, United States Department of Health and Human Services ("DHHS"), United States Department of Justice ("DOJ"), and California Attorney General.
- 1.26 Hospital. Any acute general care or psychiatric hospital licensed by DHCS.
- 1.27 Identification Card. The card that is prepared by the Plan which bears the name and symbol of Plan and contains: a) Member name and identification number, b) Member's Primary Care Physician or clinic, and c) other identifying data. The card is not proof of Member eligibility with Plan or proof of Medi-Cal eligibility.

- 1.28 Limited Service Hospital. Any hospital which is under contract to the Plan, but not as a Primary Hospital.
- 1.29 Medical Director. The Medical Director of Plan or his/her designee, a physician licensed to practice medicine in the State of California, employed by Plan to monitor the quality assurance and implement Quality Improvement Program of Plan.
- 1.30 Medically Necessary. Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. These services will be in accordance with professionally recognized standards of medical practice and not primarily for the convenience of the Member or the participating provider.
- 1.27 Medi-Cal Managed Care Program. The program that Plan operates under its Medi-Cal Agreement with the DHCS for the Service Area.
- 1.28 Medi-Cal Provider Manual. The Medical Services Provider Manual of the DHCS, issued by the DHCS Fiscal Intermediary.
- 1.29 Medical Transportation. "Medical transportation services" means the transportation of the sick, injured, invalid, convalescent, infirm or otherwise incapacitated persons by ambulances, litter vans or wheelchair vans licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances or regulations. Medical transportation services do not include transportation of beneficiaries by passenger car, taxicabs or other forms of public or private conveyances.
- 1.30 Member. An Eligible Medi-Cal Beneficiary who is enrolled in the Plan.
- 1.31 Member Handbook. The Plan Medi-Cal Combined Evidence of Coverage and Disclosure Form that sets forth the benefits to which a Medi-Cal Member is entitled under the Medi-Cal Managed Care Program, the limitations and exclusions to which the Medi-Cal Member is subject and terms of the relationship and agreement between Plan and the Medi-Cal Member.
- 1.32 Non-Medical Transportation. Transportation services required to access medical appointments and to obtain other Medically Necessary Covered Services by Member who do not have a medical condition necessitating the use of medical transportation as defined in Title 22, CCR, Section 51323.
- 1.33 Non Physician Medical Practitioner. A physician assistant, nurse practitioner, or certified midwife authorized to provide primary care under physician supervision.
- 1.34 Operations Manual. The Manual of Operational Policies and Procedures for the Plan Medi-Cal Managed Care Program.
- 1.35 Other Services. Other covered services not included in the Specialty Care and Inpatient Hospital Services sub-accounts, as described in this Agreement.
- 1.36 Out-of-Area. The geographic area outside Ventura County.

- 1.37 Participating Referral Provider. Any health professional or institution contracted with Plan that meets the Standards for Participation in the State Medi-Cal Program to render medical services to Medi-Cal Members.
- 1.38 Plan. The Medi-Cal Managed Care Program governed by the Ventura County Medi-Cal Managed Care Commission and serving Ventura County Medi-Cal Eligible Beneficiaries.
- 1.39 Physician. Either an Attending Physician or a Primary Care Physician, who has entered into an Agreement with Plan and who is licensed to provide medical care by the Medical Board of California and is enrolled in the State Medi-Cal Program and who has contracted with Plan to provide medical services to Medi-Cal members.
- 1.40 Physician Patient Load Limitation. The maximum number of Members for whom the Medical Group has contracted to serve, which has been accepted by the Plan. Such limit may be changed from time-to-time by Plan.
- 1.41 Primary Care Physician or PCP. A physician duly licensed by the Medical Board of California and enrolled in the State Medi-Cal Program. The Primary Care Physician is responsible for supervising, coordinating, and providing Primary Care Services to Members; initiating referrals; and for maintaining the continuity of care for the Members who select or are assigned to the Primary Care Physician. Primary care physicians include general and family practitioners, internists, Obstetrician-Gynecologists and pediatricians.
- 1.42 Primary Care Services. Those services provided to Members by a Primary Care Physician. These services constitute a basic level of healthcare usually rendered in ambulatory settings and focus on general health needs.
- 1.43 Primary Hospital. Any hospital affiliated with Medical Group that has entered into an Agreement with the Plan.
- 1.44 Provider Manual. The Plan's Manual describing operational policies and procedures relevant to Providers.
- 1.48 Quality Improvement Program (QIP). Systematic activities to monitor and evaluate the clinical and non-clinical services provided to Members according to the standards set forth in statute, regulations, and Plan Agreement with the DHCS. The QIP consists of processes, which measure the effectiveness of care, identifies problems, and implements improvement on a continuing basis towards an identified, target outcome measurement.
- 1.49 Referral Physician. Any qualified physician, duly licensed in California who meets the Standards of Participation, has been enrolled in the State Medi-Cal Program in accordance with Article 3, Title 22, CCR. Exception to this requirement must be authorized by Plan CEO and/or Medical Director. A Referral Physician must have an Agreement with Plan or Medical Group. Primary Care Physician may refer any Member for consultation or treatment to a Referral Physician.
- 1.50 Referral Services. Covered services, which are not Primary Care Services, provided by physicians on referral from the Primary Care Physician or provided by the Primary Care Physician as a non-capitated service.
- 1.51 Service Area. The County of Ventura.

- 1.52 Treatment Authorization Request or TAR. The Plan's form for the provision of inpatient Non-Emergency Services as set forth in the Provider Manual.
- 1.53 Urgent Care Services. Medical services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (e.g., sore throat, fever, minor lacerations, and some broken bones).
- 1.54 Utilization Management Program. The program(s) approved by Plan, which are designed to review and monitor the utilization of Covered Services. Such program(s) are set forth in the Plan's Provider Manual.
- 1.55 Vision Care. Routine basic eye examinations, lenses and frames provided every 24 months.

SECTION 2 –QUALIFICATIONS, OBLIGATIONS AND COVENANTS

- 2.1 Medical Group is responsible for the following:
 - 2.1.1 Standards of Care. Provide Covered Medical Services for those complaints and disorders of Members with the same standards of care, skill, diligence and in the same economic and efficient manner as are generally accepted practices and standards prevailing in the professional community.
 - 2.1.2 Licensure. Warrant that each Physician that is employed by or contracted with Medical Group has, and will continue to have as long as this Agreement remains in effect, a currently valid unrestricted license to practice medicine or osteopathy in the State of California to provide Covered Medical Services under the terms of this Agreement. Warrant that each such Physician has the personal capacity to perform pursuant to the terms of this Agreement; and will satisfy any continuing professional education requirements prescribed by state licensure and/or certification regulations or by Plan. Warrant that the Physician has, and will continue to have as long as this Agreement remains in effect, eligibility to participate in the Medi-Cal Program in accordance with the program Standards of Participation as contained in Article 3, Chapter 3, Subdivision 1, Division 3, of Title 22 of the California Code of Regulations. Medical Group shall maintain all licenses required by law to operate its facilities and all certifications necessary for Medical Group to participate in Medicaid (Medi-Cal). Medical Group agrees to notify Plan promptly in the event any action is taken against any such licenses or certifications.
 - 2.1.3 Provision of Covered Medical Services and Coordinating other Covered Services. Provide or arrange for the provision of Covered Medical Services to Members and coordinate the provision of other Covered Services set forth in Attachment C to Members.
 - 2.1.4 Referrals.
 - a. Supervising, coordinating, and providing primary medical care to Case Managed Members; initiating non-emergent referrals for specialist care; maintaining the continuity of patient care; education of Case Managed Members regarding appropriate health prevention measures; and the appropriate maintenance of medical records, including, as necessary, admission to institutional care and referral to specialists and the coordination of these and other types of care

- through diverse resources.
- b. Referrals to contracting providers outside the County may be made only after authorization has been obtained from the Plan Medical Director or designee.
- c. Referrals for outpatient services not provided by Medical Group or its contracted network may be made only after authorization has been obtained from the Plan Medical Director or designee.
- d. Medical Group will consult with Plan's Medical Director as soon as possible when a Medi-Cal Member who, for conscientious or other personal reasons, refuses to follow or undergo one or more procedures or courses of treatment recommended by the attending Physician if the attending Physician determines no professionally acceptable alternatives to such recommended procedures or courses of treatment exists as a Covered Service under the Medi-Cal Managed Care Program. Medical Group shall comply with the referral procedures set forth in the Case Management Protocols which are included as Attachment A and the Operations Manual, in effect at the time of referral and shall not directly or indirectly engage in self-referral or any other method of referral not specifically authorized by the Case Management Protocols and the Operations Manual in effect.

2.1.5 Case Management. Provide medical case management services to ensure the coordination of Medically Necessary health care services, ensure the provision of preventive services in accordance with established standards and periodicity schedules and ensure the continuity of care for Case Managed Members. Such medical case management services include health risk assessment, treatment plans, coordination of medical services, initiation and follow-up of all referrals, follow-up and monitoring of appropriate services and resources required to meet the Case Managed Member's health care needs.

- a. Medical Group agrees to abide by the Case Management Protocols which are included as Attachment A to this Agreement and are incorporated herein by this reference.
- b. Medical Group agrees to abide by the Plan's Provider Manual policies and procedures which may be amended from time to time by Plan with thirty (30) days notice to Medical Group.
- c. Medical Group agrees to abide by changes to Case Management Protocols and/or Plan's Provider Manual that are mandated by state or federal law or regulation.
- d. Medical Group shall cause Primary Care Physician and any Attending Physician or Referral Physician to whom the Primary Care Physician has delegated the authority by a referral to proceed with treatment or the use of resources, will be responsible for coordinating medical services performed or prescribed through them for the Member.
- e. Referrals to contracting providers outside the County may be made only after authorization for such has been obtained from Plan Utilization Management Department.
- f. Medical Group acknowledges that Plan's Medical Director will assist in the management of Complex Cases. Medical Group will fully cooperate with Plan's Medical Director by providing information that may be required in the transfer of a Member into medical facilities designated by Plan for the care of Complex Cases, including but not limited to, prompt notification of known or suspected Complex Cases.

- 2.1.6 Accessibility and Hours of Service. Provide Covered Medical Services to Medi-Cal Members on a readily available and accessible basis in accordance with Plan policies and procedures as set forth in the Plan's Provider Manual during normal business hours at Medical Group's usual place of business and will arrange for Emergency Services and Urgent Care Services as medically necessary.
- 2.1.7 Appointment Wait Times. Medical Group must comply with appointment standard requirements established by Title 28, California Code of Regulations, §1300.67.2.2.
- 2.1.8 Hospital Privileges. Cause its Physicians to maintain active medical staff privileges and to remain a member in good standing of the medical staff of at least one Primary Hospital contracting with Plan or has been specifically excluded from this requirement by the Plan Medical Director.
- 2.1.9 Credentialing. In the absence of a delegated credentialing agreement, Medical Group agrees to cause its participating Physicians to provide Plan or its designee with a completed credentialing form, use best efforts to notify Plan in advance of any change in such information, and successfully complete a facility site review, if deemed necessary by Plan in accordance with DHCS Medi-Cal Agreement.
- 2.1.10 Certifications. Cause its participating Obstetricians to obtain and maintain certification to participate in the California Comprehensive Perinatal Services Program (CPSP). Cause its participating Physicians providing medical care and services to children to obtain and maintain certification to participate in the California Child Health and Disability Prevention Program (CHDP).
- 2.1.11 Officers, Owners and Stockholders. Providing information regarding officers, owners and stockholders as set forth in Attachment F, attached to and incorporated herein.
- 2.1.12 Maximum Number of Assigned Members. Accepting all of its current patients who become Case Managed Members and all Medi-Cal Members who select or who are assigned to Primary Care Physician/Provider for no more than the maximum number of Members established by the Physician Patient Load Limitation. Plan will notify Medical Group when it appears that maximum number of Case Managed Members may soon be reached.
- a. The maximum will be 2,000 Members per full-time equivalent Primary Care Physician.
 - b. The maximum ratio for a non-physician medical practitioner under the supervision of a primary care physician will be 1:1000 members.
 - c. The number of non-physician medical practitioners who may be supervised by a single primary care physician is limited to the full-time equivalent of one of the following:
 1. Four (4) nurse practitioners
 2. Four (4) physician's assistants
 3. Four (4) non-physician medical practitioners in any combination which does not include more than three (3) nurse midwives or two (2) physician assistants.
- 2.1.13 Actions Against Medical Group. Medical Group will adhere to the requirements as set forth in the Plan's Policies and Procedures and notify Plan by certified mail within five (5) days of Medical Group's learning of any action taken which results in restrictions on

Medical Group staff privileges, membership, employment for a medical disciplinary cause or reason as defined in the California Business & Professions Code, Section 805, regardless of the duration of the restriction or exclusion from participating in the Medi-Cal Program in accordance with the Standards of Participation.

- 2.1.14 Financial and Accounting Records. Maintain, in accordance with generally accepted accounting principles, financial and accounting records relating to services provided or paid for hereunder as will be necessary and appropriate for the proper administration of this Agreement, the services to be rendered, and payments to be made hereunder or in connection herewith. Submit reports as required by DHCS and/or as specified by Plan's Provider manual.
- 2.1.15 Compliance with Member Handbook. Medical Group acknowledges that Medical Group is not authorized to make nor will Medical Group make any variances, alterations, or exceptions to the terms and conditions of the Member Handbook.
- 2.1.16 Promotional Materials. Medical Group will consent to be identified (with its contracted and employed providers) in written materials published by Plan, including without limitation, marketing materials prepared and distributed by Plan and, display promotional materials provided by Plan within its providers' offices.
- 2.1.17 Medical Group shall provide, as applicable, the ownership disclosure statement(s), the business transactions disclosure statement(s), the convicted offenses disclosure statement(s), and the exclusion from state or federal health programs disclosure statement(s), prior to the Effective Date, on an annual basis, upon any change in information, and upon request, if required by law or by the Medi-Cal Agreements. Legal requirements include, but are not limited to, Title 22 CCR Section 51000.35, 42 USC Sections 1320 a-3 (3) and 1320 a-5 et seq., and 42 CFR Sections 455.104, 455.105 and 455.106. Medical Group shall also provide, as applicable, the "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions" and shall comply with its instructions, if required by law or by the Medi-Cal Agreements. Such Debarment Certification and its instructions are set forth in the Provider Manual.
- 2.1.18 Compliance with Plan Policies and Procedures. Medical Group agrees to comply with all Plan policies and procedures, as may be modified from time to time by Plan in its sole discretion. In the event such Plan policies and procedures are inconsistent with the terms of this Agreement, the terms of this Agreement shall prevail.
- 2.1.19 Cultural and Linguistic Services. Medical Group shall provide Services to Members in a culturally, ethnically and linguistically appropriate manner. Medical Group shall recognize and integrate Members' practices and beliefs about disease causation and prevention into the provision of Covered Services. Medical Group shall comply with Plan's language assistance program standards developed under California Health and Safety Code Section 1367.04 and Title 28 CCR Section 1300.67.04 and shall cooperate with plan by providing any information necessary to assess compliance. Plan shall retain ongoing administrative and financial responsibility for implementing and operating the language assistance program. Medical Group shall provide 24 (twenty-four) hours, 7 (seven) days a week access to telephonic interpretive services outlined in policies and procedures as set forth in Plan Provider Manual.

2.1.20 Claims Adjudication and Payment. Medical Group shall accept and adjudicate claims for Covered Medical Services provided to Plan Members assigned to Medical Group in accordance with the provisions of §§ 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, 1371.8 of the California Health & Safety Code and Title 28 of the California Code of Regulations §§ 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4.

- a. Specifically, Medical Group shall pay claims for Covered Medical Services within thirty (30) calendar days of receipt of a clean claim. Medical Group agrees to permit Plan to examine and audit Medical Group's claims payment procedures and records when deemed necessary by Plan and upon reasonable notice to Medical Group. If Medical Group fails to pay claims when due, Plan reserves the right to make such payment on behalf of Medical Group and deduct the amount of such payment, plus an additional ten percent (10%) of such amount as an administration fee for such expenditure from the monthly Capitation Payment due to the Medical Group.
- b. If a claim is received by Medical Group payment of which is not the responsibility of Medical Group, Medical Group shall forward the claim to the Plan within ten (10) working days of its receipt of the claim.
- c. Plan is authorized to assume responsibility for the processing and timely reimbursement of provider claims in the event that Medical Group fails to timely and accurately reimburse its claims (including the payment of interest and penalties), and may make an offsetting deduction including administrative costs, incurred from the next monthly Capitation Payment due to Medical Group on an ongoing basis as necessary.
- d. Medical Group shall submit a Quarterly Claims Payment Performance Report ("Quarterly Claims Report") to Plan within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose Medical Group's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the California Code of Regulations. The Quarterly Claims Payment Performance Report shall also report Medical Group's compliance with the Medi-Cal claims payment timeliness requirement of thirty (30) calendar days.
 - (1) Medical Group shall ensure that each Quarterly Claims Report is signed by and includes the written verification of a principal officer, as defined by Section 1300.45(o) of Title 28 of the California Code of Regulations, of Medical Group, stating that the report is true and correct to the best knowledge and belief of the principal officer.
 - (2) Medical Group's Quarterly Claims Report shall include a tabulated record of each provider dispute it received, categorized by date of receipt, and including the identification of the provider, type of dispute, disposition and working days to resolution, as to each provider dispute received. Each individual dispute contained in a provider's bundled notice of a provider dispute shall be reported separately to Plan

2.1.21 Dispute Resolution Mechanisms: Medical Group shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of §§ 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 of the California Health & Safety Code and Title 28 of the California Code of Regulations §§ 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4. Medical Group shall designate a principal officer, as defined by 28 CCR 1300.45 (o), to be primarily responsible for the maintenance of the Medical Group's provider dispute resolution mechanism, for the review of its operations and for noting any emerging patterns of provider disputes to improve administrative capacity, Medical Group-provider relations, claim payment procedures and patient care.

- a. Any provider that submits a claim dispute to Medical Group's dispute resolution mechanism(s) involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to Plan's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Medical Group's Date of Determination, pursuant to the provisions of Title 28 §1300.71.38(a)(4).
- b. Medical Group shall make available to Plan or DHCS, upon request, all records, notes and documents regarding its provider dispute resolution mechanism(s) and the resolution of its provider disputes.
- c. Plan is authorized to assume responsibility for the administration of Medical Group's dispute resolution mechanism(s) and for the timely resolution of provider disputes in the event that Medical Group fails to timely resolve its provider disputes including the issuance of a written decision.

2.1.22 Reporting on Claims Payment and Dispute Resolution. Medical Group shall submit a Quarterly Claims Payment Performance Report ("Quarterly Claims Report") to Plan within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose Medical Group's compliance status with §§ 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, 1371.8 of the California Health & Safety Code and Title 28 of the California Code of Regulations §§1300.71, 1300.71.38, 1300.71.4, and 1300.77.4.

- a. Medical Group's Quarterly Claims Report shall include a tabulated record of each provider dispute it received, categorized by date of receipt, and including the identification of the provider, type of dispute, disposition and working days to resolution, as to each provider dispute received. Each individual dispute contained in a provider's bundled notice of provider dispute shall be reported separately to Plan.
- b. Each Quarterly Claims Report must be signed by and include the written verification of a principal officer, as defined by Title 28 §1300.45(o) of Medical Group, stating that the report is true and correct to the best knowledge and belief of the principal officer.

2.1.23 Financial Information; Access to Books and Records.

- (a) Financial Information: Medical Group must maintain adequate financial resources to meet its obligations as they become due. Medical Group shall prepare quarterly financial statements in accordance with Generally Accepted Accounting principles (GAAP). These quarterly financial statements shall be submitted to Plan no later than forty-five (45) calendar days after the close of

each quarter. On an annual basis, Medical Group shall submit its financial statements, audited by an independent Certified Public Accounting Firm, to Plan within one hundred and fifty (150) calendar days after the close of the fiscal year. Medical Group shall be solvent at all times, and shall maintain the following minimum financial solvency standards:

- (1) Maintain at all times a positive Working Capital (current assets net of related party receivable less current liabilities).
- (2) Maintain at all times a positive Tangible Net Equity (TNE) as defined in Title 28, California Code of Regulations, Section 1300.76 (e).
- (3) Maintain a “cash to claims ratio” (cash, readily available marketable securities and receivables, excluding all risk pool, risk-sharing, incentive payment program and pay-for-performance receivables, reasonably anticipated to be collected within 60 days divided by the organization’s unpaid claims (claims payable and incurred but not reported (IBNR) claims) liability as listed per SB 260 Title 28, California Code of Regulations.
- (4) Reimburse, contest or deny at least ninety five percent (95%) of claims within contractual or regulatory timeframes.
- (5) Estimate and document, on a monthly basis, the organization’s liability for incurred but not reported (IBNR) claims using an actuarial sound lag study as validated annually by external auditors..

Medical Group shall actively monitor its contracted providers to measure their financial stability. Copies of all reports, including findings, recommendations, corrective action plans, and other information regarding Medical Group’s monitoring of its contracted providers shall be provided to Plan within a reasonable time upon request.

Medical Group shall immediately notify Plan if Medical Group’s financial condition fails to meet the ratios or other standards set forth above. The notice to be provided hereunder shall be in writing, shall state the reason for the failure, and shall state the corrective action to be taken by Medical Group. If the proposed corrective action is unacceptable to the Plan, then Plan may terminate this Agreement immediately upon written notice to Medical Group or take such other action as may be reasonably required by Plan to ensure the continued provision of Provider Services to its Members, including, but not limited to, the withholding of capitation and de-delegation of functions in accordance with this Agreement.

- (b) Access and Maintenance. Plan shall have the right, upon five (5) business days’ prior notice to periodically schedule audits during normal business hours to ensure compliance with the above requirements. The audit shall take place at Medical Group’s principal business office location. Since the financial solvency standards apply to the entity as a whole, the audits will be conducted for all books of business, not only for the line(s) of business (es) contracted with Plan. Medical Group shall also permit the inspection of financial books and records by

State and Federal regulatory agencies as may be required by law. Representatives of Medical Group shall facilitate access to records necessary to complete audit without limitation. Medical Group shall retain accounting and administrative books and records for five (5) years after the date such financial records are created or as otherwise required by law or the Agreement. The obligation shall survive the termination of this Agreement.

(c) Financial Organization Information. To the extent required by law, Medical Group shall comply with the requirements of Title 28, California Code of Regulations (or “Rules”), Section 1300.75.4.2, including but not limited to the following requirements:

- (1) Submit to DMHC quarterly and annual financial survey reports, including but not limited to Statements of Organization and a written verification of each report.
- (2) Notify the DMHC and the Plan no later than five (5) business day after discovering that the Medical Group has experienced any event that materially alters its financial situation or threatens its solvency.
- (3) Permit the DMHC to make any examination that the DMHC deems reasonable and necessary to implement Section 1375.4 of the Act and provide the DMHC, upon request, with any books or records deemed relevant to implementing the requirements in Section 1375.4 of the Act.
- (4) The Medical Group understands and agrees that its failure to fully comply with the contractual requirements required by the DMHC Solvency Regulations shall constitute a material breach of this Agreement.
- (5) The Medical Group understands and agrees to comply with the DMHC’s corrective action plan process as set forth in Title 28, California Code of Regulations Section 1300.75.4.8.

2.1.24 Physician Incentive Plans. Medical Group shall disclose any physician incentive plans as required by State and Federal regulations, and shall upon request, provide to Plan the requested information as Plan may deem reasonably necessary to comply with such regulations.

2.2 Plan is responsible for:

2.2.1 Member Assignment. Assigning Medi-Cal Members in the Medi-Cal Managed Care Program to a Primary Care Physician, Clinic or Provider, following which such Members are thereafter referred to as a Case Managed Member.

- a. The Medi-Cal Member can select from the Primary Care Physicians, Clinic or Provider contracting with Plan.
- b. The Medi-Cal Member will seek all medical services, except those outlined in Section 4 from their assigned Primary Care Physician, Clinic or Provider.
- c. If the Medi-Cal Member does not select a Primary Care Physician, Clinic or Provider, then Plan will assign Member in a systematic manner in accordance

with established protocol.

2.2.2 Listing. Plan or its designee will enter the name of each contracted Primary Care Physician onto a list or provider directory from which Medi-Cal Members may choose a Primary Care Physician. Such a list may contain the following information in order to allow for an appropriate Primary Care Physician selection procedure:

- a. Name
- b. Address(es)
- c. Office hours
- d. Scope of services (specialty)
- e. Member age and sex limitations, if any
- f. Clinic or medical group affiliation, if any
- g. Hospital Affiliation
- h. Language Capabilities
- i. Building access for people with disabilities
- j. Medical Specialty
- k. Board Certification Status (Optional)
- l. Medical School (Optional)

2.2.3 Member Eligibility. Medical Group will verify Medi-Cal Member eligibility with Plan prior to admission for inpatient services and prior to rendering medical services. Prior Authorization from Plan is not a guarantee of Medi-Cal Member eligibility with Plan or eligibility in the State Medi-Cal Program.

2.2.4 Change of Primary Care Physician. Beneficiaries may change Primary Care Physicians in accordance with procedures established by the Plan.

- a. The PCP may request Plan to reassign a Medi-Cal Member to another Primary Care Physician if a satisfactory physician-patient relationship cannot be developed between the Primary Care Physician and the Medi-Cal Member.
- b. If Plan is unable to make such arrangements, Primary Care Physician will use his or her best professional judgment and continue to provide medical services to the Member according to Plan's policies and procedures and until Plan is able to effect a change of the Member's Primary Care Physician.
- c. Primary Care Physicians may not request Medi-Cal Member reassignment based on the medical condition requiring increased care.

2.3 Member Eligibility. Plan will notify Medical Group on or before the tenth (10th) of each month of those Members entitled to receive Covered Medical Services from Medical Group and for whom the Capitation is due.

2.3.1 The notification will be provided via telephone, facsimile, mail or electronic media, to Medical Group listing all pertinent data regarding the eligibility of Medi-Cal Members who have chosen or have been assigned to Medical Group. Such data will be updated on or about the twenty-fifth (25th) of each month.

- 2.3.2 Plan will maintain (or arrange to have maintained) records and establish and adhere to procedures as will reasonably be required to accurately ascertain the number and identity of Medi-Cal Members.

SECTION 3 - SCOPE OF SERVICES

- 3.1 Management of Care. With the exception of Excluded Services described in Section 4 of this Agreement, it is the responsibility of Medical Group to determine, to provide, to prescribe, and to manage Covered Services for Medi-Cal Members in accordance with professionally recognized standards, medical necessity and of a quality consistent with community standards of care.
- 3.1.1 Covered Services are as specified in the Member Handbook, including Primary Care Services, medical, hospital, preventive, ancillary, emergency and health education services.
- 3.1.2 Except as otherwise provided herein, it will be the responsibility of Medical Group to render or provide referral for Covered Services for each Medi-Cal Member which has been determined to be medically necessary and appropriate for the control of disease, illness, or disability.
- 3.1.3 Medical Group will abide by Provider Manual, Case Management Policies and Procedures, incorporated into this agreement as Attachment A.
- 3.2 Consultation with Medical Director. Medical Group or any other provider may at any time seek consultation with Plan's Medical Director concerning the treatment of the Member.
- 3.3 Covered Services. Covered Services are covered under the California State Medi-Cal program and the Medi-Cal Agreement when they are necessary and appropriate for the care of that member. Covered Services include but are not limited to:
- 3.3.1 Accessibility and Hours of Service. Provide Covered Services to Case Managed Members on a readily available and accessible basis in accordance with Plan policies and procedures as set forth in the Plan's Provider Manual during normal business hours at Medical Group's usual place of business and will arrange for Emergency Services and Urgent Care Services at all other times. Any Emergency Services shall be subject to the terms set forth in the Provider Manual regarding Contracting and Non-Contracting Emergency Service Providers and Post-Stabilization. Medical Group will make suitable arrangements for personal contact with the Member, or for services by appropriate personnel in accordance with customary medical practice and with the law including referrals for a second professional opinion.
- 3.3.2 Initial Health Assessment (IHA) and Individual Health Education Behavioral Assessment (IHEBA). Ensure that all Case Managed Members assigned to Medical Group are scheduled for an IHA, to include an IHEBA, within 120 days after enrollment for Case Managed Members over the age of 21 years and as soon as possible for Case Managed Members under the age of 21 years. Medical group shall make repeated attempts, if necessary, to contact a Member and schedule an IHA. At a minimum, an initial health assessment will include a comprehensive history and physical, weight and height data, and blood pressure. The assessment will also include those preventive health screens and tests set forth in the Plan's Provider Manual; a discussion of appropriate preventive measures; and the provision for future follow-up appointments as indicated and a plan of care that reflects the findings and risk factors determined during the IHA. The IHA

should be completed and maintained in the Member's Medical Record and available during subsequent health visits.

- 1) Medical group shall make at least three documented attempts that demonstrate medical group's unsuccessful efforts to contact a Member and schedule an IHA. Contact methods must include at least one telephone and one mail notification.
- 2) Medical group must document all attempts to perform an IHA at subsequent office visit(s) until all components of the IHA are completed.

3.3.3 Specialty Provider Network. Medical Group will, at all times, provide and maintain an adequate network of medical specialties, as detailed in Attachment D. Medical Group shall be required to have a written policy regarding member notification when a specialist terminates his or her contract with Medical Group. In accordance with the National Committee of Quality Assurance (NCQA), the written policy must include the following elements:

- 1) Medical Group must notify Plan in writing ninety (90) days prior to the effective date of a specialist termination
- 2) Medical Group must identify Members who have regularly seen the terminating specialist or have an open authorization to receive services from the terminating specialist.
- 3) Identified Members must be notified by the Medical Group in writing and the notification must be made immediately upon notification of termination but no later than sixty (60) calendar days prior to the effective date of the specialist's termination. Medical Group shall send Plan a copy of such notice.
- 4) Medical Group must help Members transition to a new specialist within the Medical Group's contracting network of providers or if none are available within Medical Group's network, then to another appropriate specialist.

Medical Group shall also notify Plan ninety (90) days prior to the termination of any contracted Primary Care Physician.

In furtherance of the foregoing, Medical Group shall notify Plan of all changes to its network of contracted providers ninety (90) calendar days prior to such change and shall provide periodic updates as requested by Plan of its network in an electronic format or such other format as may be reasonably requested by Plan. The information provided in this section shall include the linguistic capabilities of the contracted providers. The parties acknowledge that changes in the network may result from time to time but Medical Group agrees not to make any unilateral material changes to the network without Plan's prior written consent, which shall not be unreasonably withheld.

3.3.4 Preventive Health Care. Provide Case Managed Members regular preventive health examinations and procedures, including but not limited to routine physical examinations, immunizations, and health screenings, in accordance with CHDP guidelines and with Preventive Health guidelines. Medical Group will ensure that a CHDP appointment is made for the Case Managed Member to be examined within four weeks of request.

- 3.3.5 Facilities, Equipment and Personnel. Provide and maintain sufficient facilities, equipment, personnel, and administrative services to perform the duties and responsibilities as set forth in this Agreement. Medical Group agrees to provide at least 60 days notice to Plan prior to the opening of any new location and 90 days prior to the closing of any location. Medical Group shall provide the information set forth in Attachment F hereto with respect to each of its facilities.
- 3.3.6 Medical Transportation Ambulance (Medical Transportation). Arrange services when medically necessary and in accordance with Title 22, CCR, Section 51323 and Plan's Provider Manual policies and procedures. Medical transportation services do not include transportation of beneficiaries by passenger car, taxicabs or other forms of public or private conveyances.
- 3.3.7 Health Education. Offer Case Managed Members appropriate health education, including but not limited to, nutrition counseling, family planning and counseling, and accident prevention counseling.
- 3.3.8 Other Medically Necessary Services. Other necessary durable medical equipment rental, and medical supplies determined by Medical Group to be medically necessary for the purpose of diagnosis, management or treatment of diagnosed health impairment, or rehabilitation of the Medi-Cal Member. All services and goods required or provided hereunder will be consistent with sound professional principles, community standards of care, covered Medi-Cal benefits and medical necessity.
- 3.3.9 Interpreter Services. Arrange interpreter services, to include language, sight-impaired and hearing impaired, as necessary, for Members at all facilities.
- 3.4 Prescription Drugs. Medical Group shall comply with the Plan drug formulary as approved by Plan, policies and subject to the restrictions on the Plan Drug Formulary regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals, in conformance with generally accepted medical and surgical practices and standards prevailing in the professional community.
 - 3.4.1 If for medical reasons, the Medical Group believes a generic equivalent should not be dispensed, the Medical Group agrees to obtain prior authorization from the Plan's Medical Director.
 - 3.4.2 Medical Group acknowledges the authority of Plan's participating pharmacists to substitute generics for trade name drugs, as specified in Section 4073 of the California Business & Professions Code, and Title 22 CCR Section 51313, unless otherwise indicated.
- 3.5 Quality Improvement and Utilization Management Programs
 - 3.5.1 Medical Group will participate in Plan's Quality Improvement and Utilization Management Programs, including credentialing and re-credentialing, peer review and any other activities required by Plan, the Government Agencies and any other regulatory and accrediting agencies, and will comply with the policies and procedures associated with these Programs. This includes participation in office reviews, chart and access audits and focused reviews. In addition, the Medical Group will participate in the development of,

and implement, corrective action plans for any areas that fall below Plan standards and ensuring medical records are readily available to the Plan's staff as requested.

- a. In the interest of program integrity or the welfare of Members, Plan may from time to time introduce additional utilization controls as may be necessary as determined by Plan.
 - b. In the event of such change, a thirty (30) day notice will be given to Medical Group.
 - c. The standards and requirements shall include, without limitation:
 1. Healthcare Quality Measures: patient satisfaction, patient access, emergency room utilization, grievance response compliance, credentialing issues, and health education compliance.
 2. HEDIS measures including but not limited to: childhood immunizations, breast cancer screening, cervical cancer screening, well child visits and lead screening.
 3. Encounter Data Compliance: Timely and accurate encounter data submission which meets expected volume thresholds. CMS-1500 forms or electronic transfer are to be used for the submission of encounter data as documentation of Capitated Covered Services provided to Case Managed Members by Medical Group. All encounter data shall be submitted by Medical Group within thirty (30) days from the end of the month that service was provided, and shall contain the data elements as outlined in the Operations Manual.
 4. Utilization Management – Aggregate claims expenses related to all Members assigned to Medical Group for each review period should be within an acceptable range either above or below the average costs of Medical Group's peers, as determined by Plan. This measure is intended to monitor that there is no over utilization and/or under utilization of specialist, hospital or ancillary services.
 - d. Scope of Delegated Utilization Management Activities: Medical Group understands that the utilization management functions delegated to the Medical Group include, but are not limited to, the following:
 1. Referral process of PCP to specialist or to other ancillary provider.
 2. Outpatient procedures/surgery (In conjunction with Plan's authorization).
 3. Inpatient admits (In conjunction with Plan's authorization).
 4. Case management collaboration.
 5. UM monthly and quarterly reports.
- 3.5.2 Plan may periodically review Medical Group's compliance with the foregoing, which review will include a minimum of two (2) quarters of data for the purposes of evaluating such compliance. Non-compliance with the foregoing by Medical Group may result, at Plan's sole option (i) in the modification by Plan of Medical Group compensation schedules; (ii) offset or deduction, in whole or in part, from the compensation otherwise due Medical Group for the services in question, according to the policies of the Plan and as required by Plan; (iii) de-delegation of any such delegated activities; and/or (iv) termination of this Agreement.
- 3.5.3 Plan may at any time elect in its sole discretion to de-delegate any or all functions that have been assigned or delegated to Medical Group under this Agreement in which event, Plan will reduce Medical Group's capitation payment based upon Plan's costs associated

with performing the previously delegated function. If Medical Group disagrees with the de-delegation and/or reduction in capitation payments, Medical Group's sole remedy shall be to terminate this Agreement without cause.

3.6 Disciplinary Action and Termination. Medical Group acknowledges and agrees that under this Agreement, Plan has the right, without limiting any of Plan's rights or remedies under this Agreement, to impose the following sanctions singly or in any combination:

3.6.1 De-delegation. Plan may de-delegate a function assigned to the Medical Group that has led to an administrative, financial clinical and/or other issue which does, or threatens to, seriously and adversely impact Member care or access to care or Covered Services. In addition to de-delegating a function, Plan will reduce the Medical Group's capitation payment based upon Plan's costs associated with performing the previously delegated function.

3.6.2 Restrict Enrollment or Assignment of Members. Plan may restrict the Medical Group's enrollment, receipt of or assignment of Members (e.g., limit enrollment in a specific geographic area, cease default enrollment/assignment, or impose full enrollment/assignment restriction).

3.6.3 Withhold Capitation. Plan may withhold a portion of capitation payment based upon Plan's analysis of the impact of the performance deficiency or issue, including but not limited to costs incurred to mitigate the impact of the performance deficiency or issue. Any such capitation withhold, or portion thereof, may be restored to the Medical Group upon Plan's determination of satisfactory correction of the performance deficiency or issue.

3.6.4 Monetary Sanctions. Plan may impose monetary sanctions for performance deficiencies or issues, in the same manner as provided in law, regulation and Plan's Medi-Cal Agreement with DHCS for non-performance or non-compliance of contractual or regulatory requirements, which may be deducted from capitation payments at the discretion of Plan.

SECTION 4 - EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES

4.1 Exclusions. Members in need of services which are not Covered Services as described in the Member Handbook, will not be reimbursed by the Plan. However, Medical Group will continue to coordinate the Medi-Cal Member's medical care or refer the Medi-Cal Member for the following services in accordance with generally accepted medical and surgical practices and standards prevailing in the professional community, and in conformance with Plan policies and procedures.

4.2 Services Neither Covered nor Compensated. Subject to those exclusions from Covered Services as set forth in the Medi-Cal Agreement, Medical Group understands that Medical Group will not be obligated to provide Medi-Cal Members with, and the Plan will not be obligated to reimburse Medical Group for, the following Excluded Services (for which Plan does not receive capitation payment from the DHCS):

- (a) Dental Services, as defined in Title 22 CCR Section 51307 and Early Periodic Screening Diagnosis and Treatment supplement dental services as described in Title 22 CCR Section 51340.1(a). However, medical services necessary to support dental services are Covered Benefits for Medi-Cal Members and are not excepted;
- (b) Home and community based services and Department of Developmental Services Administered Medicaid Home and Community Based Services, Multipurpose Senior Services as defined in the California Welfare and Institutions Code Section 9400 et seq., Adult Day Health Care Services as defined in Title 22 CCR Section 54001, Pediatric Day Health Care Services as defined in Title 22 CCR Section 51184(j), alcohol and drug treatment program services (including outpatient heroin detoxification), and Local Education Authority Services as defined in Title 22 CCR Sections 51360 and 51190.
- (c) Short-Doyle/Medi-Cal mental health services (inpatient and outpatient), Medi-Cal specialty mental health services and services provided by specialty mental health providers (inpatient and outpatient); provided, however, the following are Covered Benefits for Medi-Cal Members and are not excepted: (i) outpatient mental health services within the Primary Care Physician's scope of practice, (ii) emergency room professional services except services provided by specialty mental health providers, (iii) facility charges for emergency room visits which do not result in a psychiatric admission, (iv) laboratory and radiology services necessary for the diagnosis, monitoring or treatment of a Medi-Cal Member's mental health condition, (v) emergency medical transportation for emergency mental health services, (vi) certain prescribed non-emergency medical transportation services to access mental health services, (vii) initial health history and physical assessments required upon admission for psychiatric inpatient hospital stays and consultations related to Medically Necessary Covered Services, and (viii) psychotherapeutic drugs that are covered by the Medi-Cal Program and that are not excluded by the State Medi-Cal Contract.
- (d) California Children's Services ("CCS");
- (e) Services rendered in a State or Federal governmental hospital;
- (f) Laboratory services provided under the State serum alpha-fetoprotein testing program administered by the Genetic Disease Branch of the Department of Health Care Services;
- (g) Fabrication of optical lenses;
- (h) Personal Care Services defined in Title 22 CCR Sections 51183 and 51350;
- (i) Childhood lead poisoning case management services provided by the Local Health Department;
- (j) Certain Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS), drugs as set forth in the State Medi-Cal Contract; and
- (k) Drug benefits for full-benefit dual eligible Medi-Cal Members who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 United States Code ("USC") Section 1395w-101 et seq.), except as set forth in the State Medi-Cal Contract.
- (l) Other Services as may be determined by the DHCS and the Plan, and as noticed to Medical Group. In the event of such a change, a thirty (30) day notice will be given to Medical Group.

4.3 Restricted Services/Special Reimbursement

- 4.3.1 Medical Group will ensure that services provided to Medi-Cal Members will be in conformance with the limitations and procedures listed in the Medi-Cal Provider Manual and the Operations Manual unless notified of modification to that policy by DHCS or Plan. The Medi-Cal Provider Manual specifies certain restrictions and limitations with respect to abortion and sterilization. These services shall be subject to the limitations specified therein.

- 4.3.2 Primary Care Physician referral and/or Plan authorization are not required for reimbursement by Plan to providers of the following services.
- a. The provision and reimbursement of Limited Services will be in conformance with the policies and procedures of the Medi-Cal Fee-For-Service Program.
 - b. Family Planning Services are excluded from Primary Care Physician capitated services and may be obtained by patient self-referral in accordance with 42 Code of Federal Regulations Section 441.20. Family Planning services are defined in the Provider Manual and services include: birth control supplies, pregnancy testing and counseling, HIV testing and counseling, STD treatment and counseling, follow-up care for complications related to contraceptive methods, sterilization, and termination of pregnancy.
 - c. Medical Group acknowledges that Plan Medical Director will oversee the management of Complex Cases. Medical Group will fully cooperate by providing information that may be required in the transfer of a Case Managed Member into medical facilities designated by Plan for the care of Complex Cases, including but not limited to, prompt notification of known or suspected Complex Cases.
- 4.3.3 Primary care physician referral is not required for beneficiaries designated as Administrative Members.
- 4.3.4 California Children's Services (CCS) must be authorized by the Ventura County CCS Program. Medical Group is responsible for identification, referral and coordination of care.
- 4.3.5 Genetically Handicapped Persons Program (GHPP) services must be authorized by the GHPP program. Medical Group is responsible for identification, referral and coordination of care.

SECTION 5 - REIMBURSEMENT

- 5.1 Capitation Payment. Plan's obligation to pay Medical Group any payment amount hereunder shall be subject to Plan's corresponding receipt of funding from DHCS, CMS or any other governmental agency providing revenue to Plan, as applicable. Plan will pay a Capitation Payment to Medical Group, within fifteen (15) days following Plan's receipt of its corresponding capitation payment from the DHCS, for Medi-Cal Members who selected or are assigned to Medical Group based on the most current enrollment information as transmitted by the DHCS. Medical Group will accept such Capitation Payments from Plan as payment in full and discharge of Plan's financial liability for the provision of Covered Medical Services by Medical Group hereunder.
- 5.1.1 A summary report will accompany each check identifying those Medi-Cal Members who are eligible to receive Covered Medical Services from Medical Group and the appropriate amount of reimbursement.
 - 5.1.2 The Medi-Cal Member is eligible for Covered Services on the first day of the month for which Plan receives capitation based on the most current enrollment information from the DHCS.

- 5.1.3 The full Capitation amounts for Medical Group are set forth in Attachment B of this Agreement with the scope of Covered Medical Services set forth in Attachment C of this Agreement.
- 5.2 Capitation Reconciliation and Adjustments.
- 5.2.1 Reconciliation. Within thirty (30) days of the receipt of the eligibility reports from DHCS, Capitation Payments will be reconciled and an appropriate adjustment of overpayments or underpayments will be made. In the event of termination of this Agreement, final settlement of all applicable payments will be made within one hundred twenty (120) days from the effective date of termination of this Agreement.
- 5.2.2 Capitation Adjustments. The Capitation Payment due may be increased to account for retroactive additions or reduced to account for retroactive deletions of Medi-Cal Members by DHCS, i.e., for persons who are retroactively added to or deleted from the list of eligible Medi-Cal Members assigned to Plan as of a date preceding the month for which that eligibility report is generated and Capitation Payments are made. Plan shall credit the amount due in accordance with Attachment B for such retroactively added Medi-Cal Members and debit the amount due for such retroactively deleted Medi-Cal Members on the next Capitation Payment schedule after notification of the addition or deletion by DHCS. An example of a retroactive addition is a person who is retroactively added by DHCS. Retroactive deletions may occur for reasons such as misrepresentation or fraud. Plan shall not be permitted to retroactively add or delete individuals from its eligibility or enrollment lists with an effective date that is more than twelve (12) months prior to the date of the then most current eligibility or enrollment list.
- 5.2.3 Hold Status. DHCS does not pay Capitation Payments for persons listed as Hold status on an eligibility report. Hold status may be due to a lag in Medi-Cal eligibility verification or other reasons and may continue for several days, weeks or months. If Plan receives retroactive capitation from DHCS for Medi-Cal Members who change from Hold to eligible status, Plan will make Capitation Payments to Medical Group as a retroactive addition, in accord with the preceding paragraphs of this section.
- 5.3 Entire Payment. Medical Group accepts the Capitation Payment as payment in full for Covered Medical Services as described in Attachment C herein. Medical Group will not seek any Surcharges (copayment) from Case Managed Members for Covered Medical Services under any circumstances, except as may be permitted by State or Federal law.
- 5.3.1 Except as otherwise provided herein, Medical Group will accept such compensation as complete and full discharge of the liability of Plan and its Medi-Cal Members with respect to compensation for Covered Medical Services.
- 5.3.2 Plan has the sole authority to determine reimbursement policies and methodology of reimbursement under this Agreement, which includes reduction of reimbursement rates if rates from the State to Plan are reduced.
- 5.4 Payment for Services Provided to Administrative Members. Medical Group will be reimbursed the prevailing Medi-Cal fee for service rates for all properly documented primary care Covered Medical Services provided to Administrative Members.

- 5.5 Notwithstanding anything to the contrary set forth in this Agreement, Plan may reduce the rates or other compensation payable to Medical Group at any time or from time-to-time during the term of this Agreement as determined by Plan to reflect implementation of State or federal laws or regulations, changes in the State budget or changes in DHCS or CMS policies, changes in Covered Services, or changes in rates implemented by the DHCS, CMS or any other governmental agency providing revenue to Plan, or any other change that results in decreases to the rates or level of funding paid to Plan. The amount of such adjustment shall be determined by Plan and need not be in proportion to or in the same amount as the decrease to the rates or level of funding paid to Plan. All other rate changes or adjustments shall be made only if the parties have executed a formal amendment to Agreement to provide for same.

SECTION 6 - MEDICAL RECORDS, INSPECTIONS, SUBCONTRACTING, REPORTING AND RECOVERIES

- 6.1 Medical Record. Medical Group shall ensure that a medical record will be established and maintained for each Medi-Cal Member who has received Covered Medical Services. Each Medi-Cal Member's medical record will be established upon the first visit to Medical Group. The record will contain information normally included in accordance with generally accepted practices and standards prevailing in the professional community.
- 6.1.1 Medical Group will facilitate the sharing of medical information with other providers in cases of referrals, subject to all applicable laws and professional standards regarding the confidentiality of medical records.
- 6.1.2 Medical Group will ensure records are available to authorized Plan personnel in order for Plan to conduct its Quality Improvement and Utilization Management Programs. Plan shall have access to practitioner's medical records to the extent permitted by law.
- 6.1.3 Medical Group will ensure that medical records are legible.
- 6.1.4 Medical Group will maintain such records for at least seven years from the close of the State's fiscal year in which this Agreement was in effect.
- 6.2 Records and Records Inspection.
- 6.2.1 Access to Records. Medical Group will permit Plan's Medical Director, or officers or their designees, any agency having jurisdiction over Plan, including and without limitation the Governmental Agencies, to inspect the premises, records and equipment of Medical Group and review all operational phases of the medical services provided to Members.
- a. Medical Group will make all of Medical Group's books and records, and papers ("Records") relating to the provision of goods and services to Members, to the cost of such goods and services, and to payments received by Medical Group from Medi-Cal Members or from others on their behalf available for inspection, examination and copying by Plan and all other state and federal agencies with jurisdiction over Plan or this Agreement, including without limitation, Governmental Agencies, at all reasonable times at Medical Group's place of business or at such other mutually agreeable location in California.

- b. Medical Group shall permit Plan, Government Agencies and any other regulatory and accrediting agencies, with or without notice, during normal business hours, to interview employees, to inspect, audit, monitor, evaluate and review Medical Group's work performed or being performed hereunder, Medical Group's locations(s) (including security areas), information systems, software and documentation and to inspect, evaluate, audit and copy Records and any other books, accounts and materials relevant to the provisions of services under this Agreement. Medical Group will provide all reasonable facilities, cooperation and assistance during such inspection and reviews, including for the safety and convenience of the authorized representatives in the performance of their duties. Medical Group shall allow such inspections and reviews for the Records retention time of seven years. The State reserves the right to conduct unannounced validation reviews to verify compliance with State and federal regulations and contract requirements.

6.2.2 Maintenance of Records. Medical Group will maintain records in accordance with the general standards applicable to such book and record keeping and in accordance with applicable law, and Plan directives.

- a. Records will include all encounter data, working papers, reports submitted to Plan, financial records, all medical records, medical charts and prescription files, and other documentation pertaining to medical and non-medical services rendered to Members for a period of at least seven (7) years.
- b. All Records will be retained by Medical Group for a period of at least seven (7) years from the close of the State's fiscal year in which this Agreement was in effect.
- c. Medical Group's obligations set forth in this Section will survive the termination of this Agreement, whether by rescission or otherwise.
- d. The Medical Group will not charge the Member for the copying and forwarding of their medical records to another provider.

6.3 Disclosure to Government Officials. Medical Group shall comply with all provisions of law regarding access to books, documents and records. Without limiting the foregoing, Medical Group shall maintain, provide access to, and provide copies of Records, this Agreement and other information to the Director of DMHC, DHCS, External Quality Review Organizations, the State Bureau of Medi-Cal Fraud, the State Managed Risk Medical Insurance Board, the Bureau of State Audits, the State Auditor, the Joint Legislative Audit Committee, the California Department of General Services, the California Department of Industrial Relations, certified Health Plan Employer Data Information Set ("HEDIS") auditors from the National Committee on Quality Assurance, the California Cooperative Healthcare Reporting Initiative, the U.S. Department of Justice, the Secretary of the U.S. Department of Health and Human Services, the U.S. Comptroller General, the Centers for Medicare and Medicaid Services, Peer Review Organizations, their designees, representatives, auditors, vendors, consultants and specialists and such other officials entitled by law or under Membership Contracts (collectively, "Government Officials") as may be necessary for compliance by Plan with the provisions of all state and federal laws and contractual requirements governing Plan, including, but not limited to, the Act and the regulations promulgated thereunder and the requirements of Medicare and Medi-Cal programs. Such information shall be available for inspection, examination and copying at all

reasonable times at Medical Group's place of business or at some other mutually agreeable location in California. Copies of such information shall be provided to Government Officials promptly upon request. The disclosure requirement includes, but is not limited to, the provision of information upon request by DHCS, subject to any lawful privileges, relating to threatened or pending litigation by or against DHCS. Medical Group shall use all reasonable efforts to immediately notify Plan of any subpoenas, document production requests, or requests for records received by Medical Group related to this Agreement.

6.4 Patient Confidentiality.

- a) Notwithstanding any other provision of the Agreement, names of persons receiving public social services are confidential information and are to be protected from unauthorized disclosure in accordance with Title 42, CFR, Section 431.300 et. seq. and Section 14100.2, Welfare and Institutions Code and regulations adopted thereunder.
- b) For the purpose of this Agreement, all information, records, data and data elements collected and maintained for the operation of the Agreement and pertaining to Beneficiaries will be protected by the Medical Group and its staff from unauthorized disclosure.
- c) Medical Group may release Medical Records in accordance with applicable law pertaining to the release of this type of information.
- d) With respect to any identifiable information concerning a Medi-Cal Member under this Agreement that is obtained by the Medical Group, the Medical Group: (1) will not use any such information for any purpose other than carrying out the express terms of the Agreement, (2) will promptly transmit to the Plan all requests for disclosure of such information, (3) will not disclose except as otherwise specifically permitted by the Agreement, any such information to any party other than Plan, the federal government including the Department of Health and Human Services and Comptroller General of the United States, the Department of Justice Bureau of Medi-Cal Fraud, the Department of Health Care Services or any other government entity which is statutorily authorized to have oversight responsibilities the COHS program and contracts, without prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 et. seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder, (4) will, at the expiration or termination of the Agreement, return all such information to the Plan or maintain such information according to written procedures sent the Plan by the Department of Health Care Services for this purpose.

6.5 Subcontracts

- 6.5.1 All subcontracts between Medical Group and Medical Group's Subcontractors will be in writing, and will be entered into in accordance with the requirements of the Medi-Cal Agreement, Health and Safety Code Section 1340 et seq.; Title 10, CCR, Section 1300 et seq.; W & I Code Section 14200 et seq.; Title 22, CCR, Section 53000 et seq.; and applicable federal and State laws and regulations.
- 6.5.2 All subcontracts and their amendments will become effective only upon written approval by Plan, and will fully disclose the method and amount of compensation or other consideration to be received by the Subcontractor from the Medical Group. Medical Group will notify Plan when any subcontract is amended or terminates. Medical Group will make available to Plan and Governmental Agencies, upon request, copies of all agreements between Medical Group and Subcontractor(s) for the purpose of providing Covered Services.

6.5.3 All agreements between Medical Group and any Subcontractor will require Subcontractor to comply with the following:

- a. Records and Records Inspection - Make all applicable books and records available at all reasonable times for inspection, examination or copying by the Governmental Agencies; and, retain such books and records for a term of at least seven (7) years from the close of State's fiscal year in which the Subcontract is in effect and submit to Medical Group and Plan all reports required by Medical Group, Plan or DHCS, and timely gather, preserve and provide to DHCS any records in Subcontractor's possession, in accordance with the Provider Manual, Records Related to Recovery for Litigation.
- b. Surcharges – Subcontractor will not collect a Surcharge for Covered Services for a Medi-Cal Member or other person acting on their behalf. If a Surcharge erroneously occurs, Subcontractor will refund the amount of such Surcharge to the Medi-Cal Member within fifteen (15) days of the occurrence and will notify Plan of the action taken. Upon notice of any Surcharge, Plan will take appropriate action consistent with the terms of this Agreement to eliminate such Surcharge, including, without limitation, repaying the Medi-Cal Member and deducting the amount of the Surcharge and the expense incurred by Plan in correcting the payment from the next payment due to Medical Group.
- c. Notification - Notify Plan in the event the agreement with Subcontractor is amended or terminated. Notice will be given in the manner specified in Section 10.4 Notices.
- d. Assignment - Agree that assignment or delegation of the subcontract will be void unless prior written approval is obtained from Plan.
- e. Additional Requirements - Be bound by the provisions of Section 9.7, Survival of Obligations After Termination, and Section 7.5, Medical Group Indemnification and Hold Harmless.

6.6 Coordination of Benefits. Medi-Cal is the payor of last resort recognizing Other Health Coverage as primary carrier. Medical Group must bill the Other Health Coverage (primary) carrier before billing Plan for reimbursement of Covered Services and, with the exception of authorized Medi-Cal share of cost payments, will at no time seek compensation from Medi-Cal Members or from DHCS. The Medical Group may bill the Member for non-covered services. Medical Group has the right to collect all sums as a result of Coordination of Benefits efforts for Covered Services provided to Medi-Cal Members with Other Health Coverage.

6.6.1 The determination of liability will be in accordance with the usual procedures employed by the appropriate Governmental Agencies and applicable law, the Medi-Cal Provider Manual, and the Plan's Provider Manual.

6.6.2 The authority and responsibility for Coordination of Benefits will be carried out in accordance Title 22, CCR, Section 51005, and the Medi-Cal Agreement with Plan.

6.6.3 Medical Group will report to Plan the discovery of third party insurance coverage for a Medi-Cal Member within ten (10) days of discovery.

6.6.4 Medical Group will recover directly from Medicare for reimbursement of medical services rendered. Medicare recoveries are retained by the Medical Group, but will be reported to the Plan on the Encounter Form or encounter tape.

- 6.7 Third Party Liability. In the event that Medical Group provides services to Medi-Cal Members for injuries or other conditions resulting from the acts of third parties, the State of California will have the right to recover from any settlement, award or recovery from any responsible third party the value of all Covered Services which have been rendered by Medical Group pursuant to the terms of this Agreement.
- 6.7.1 Medical Group will cooperate with the DHCS and Plan in their efforts to obtain information and collect sums due to the State of California as result of third party liability tort, including Workers' Compensation claims for Covered Services.
- 6.7.2 Medical Group will report to Plan the discovery of third party tort action or potential tort action for a Medi-Cal Member within ten (10) days of discovery.

SECTION 7 - INSURANCE AND INDEMNIFICATION

- 7.1 Insurance. Throughout the term of this Agreement and any extension thereto, Medical Group will maintain appropriate insurance programs or policies as follows:
- 7.1.1 Medical Group will secure and maintain, at its sole expense, liability insurance of at least One Million Dollars (\$1,000,000) per person per occurrence, and Three Million Dollars (\$3,000,000) per person per occurrence in the aggregate, including "tail coverage" in the same amounts whenever claims made malpractice coverage is involved. Notification of Plan by Medical Group of cancellation or material modification of the insurance coverage or the risk protection program will be made to Plan at least thirty (30) days prior to any cancellation. Documents evidencing professional liability insurance or other risk protection required under this Subsection will be provided to Plan upon execution of this Agreement.
- 7.2 General Liability Insurance. In addition to Subsection 7.1 above, Medical Group will also maintain, at its sole expense, a policy or program of comprehensive liability insurance with minimum coverage including and no less than Three Hundred Thousand Dollars (\$300,000) per person for Medical Group's property, together with a Combined Single Limit Body Injury and Property Damage Insurance of not less than Three Hundred Thousand Dollars (\$300,000). Documents evidencing such coverage will be provided to Plan upon request. The Medical Group will arrange with the insurance carrier to have automatic notification of insurance coverage termination or modification given to Plan.
- 7.3 Workers' Compensation. Medical Group's employees will be covered by Workers' Compensation Insurance in an amount and form meeting all requirements of applicable provisions of the California Labor Code. Documents evidencing the foregoing coverage will be provided to Plan upon request. Medical Group will arrange with the insurance carrier to have automatic notification of insurance coverage termination or modification given to Plan.
- 7.4 Plan Insurance. Plan at its sole cost and expense, will procure and maintain a professional liability policy to insure Plan and its agents and employees, acting within the scope of their duties, in connection with the performance of Plan's responsibilities under this Agreement.
- 7.5 Medical Group Indemnification. Medical Group shall indemnify, defend and hold harmless Plan its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by

reason of the acts or omissions of Medical Group and its officers, directors, shareholders agents, employees and subcontractors acting alone or in collusion with others. Medical Group also agrees to hold harmless both the State and Members in the event that Plan cannot or will not pay for services performed by Medical Group pursuant to this Agreement. The terms of this section shall survive the termination of this Agreement.

- 7.6 Plan Indemnification. Plan shall indemnify, defend and hold harmless Medical Group its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of Plan and its officers, directors, shareholders agents, employees and subcontractors acting alone or in collusion with others. The terms of this section shall survive the termination of this Agreement.

SECTION 8 - GRIEVANCES AND APPEALS

8.1 Appeals and Grievances.

8.1.1 Medical Group complaints, concerns, or differences, which may arise as a health care provider under contract with Plan will be resolved as outlined in the Appeals and Grievance policies as set forth in the Plan's Provider Manual. Medical Group and Plan agree to and will be bound by the decisions of Plan grievance and appeal mechanisms.

8.1.2 Medical Group will cooperate with Plan in identifying, processing and resolving all Member complaints and grievances in accordance with the Plan grievance procedure set forth in the Plan's Provider Manual.

- 8.2 Responsibility. It is the responsibility of the Plan's Chief Executive Officer, or designee, for maintenance, review, formulation of policy changes, and procedural improvements of the grievance system.

8.3 Dispute Resolution.

8.3.1 For disputes unresolved by the Plan provider appeals process, Plan and Medical Group agree to meet and confer in good faith to resolve any disputes that may arise under or in connection with this Agreement. In all events and subject to the provisions of this Section which follow, Medical Group shall be required to comply with the provisions of the Government Claims Act (Government Code Section 900, et. seq.) with respect to any dispute or controversy arising out of or in any way relating to this Agreement or the subject matter of this Agreement (whether sounding in contract or tort, and whether or not involving equitable or extraordinary relief) (a "Dispute").

8.3.2 Judicial Reference. At the election of either party to this Agreement (which election shall be binding upon the other party), a Dispute shall be heard and decided by a referee appointed pursuant to California Code of Civil Procedure Section 638 (or any successor provision thereto, if applicable), who shall hear and determine any and all of the issues in any such action or proceeding, whether of fact or law, and to report a statement of decision, subject to judicial review and enforcement as provided by California law, and in accordance with Chapter 6 (References and Trials by Referees), of Title 8 of Part 2 of the California Code of Civil Procedure, or any successor chapter. The referee shall be a retired judge of the California superior or appellate courts determined by agreement

between the parties, provided that in the absence of such agreement either party may bring a motion pursuant to the said Section 638 for appointment of a referee before the appropriate judge of the Ventura Superior Court. The parties acknowledge that they forego any right to trial by jury in any judicial reference proceeding. Any counterpart or copy of this Agreement, filed with such Court upon such motion, shall conclusively establish the agreement of the parties to such appointment. The parties agree that the only proper venue for the submission of claims to judicial reference shall be the courts of general jurisdiction of the State of California located in Ventura County. The parties reserve the right to contest the referee's decision and to appeal from any award or order of any court. The designated nonprevailing party in any Dispute shall be required to fully compensate the referee for his or her services hereunder at the referee's then respective prevailing rates of compensation.

8.3.3 Limitations. Notwithstanding anything to the contrary contained in this Agreement, any suit, judicial reference or other legal proceeding must be initiated within one (1) year after the date the Dispute arose or discovery of such Dispute shall be deemed waived and forever barred; provided that, if a shorter time period is prescribed under the Government Claims Act (Government Code Section 900, et. seq.), then, the shorter time period (if any) prescribed under the Government Claims Act shall apply.

8.3.4 Venue. Unless otherwise specified in this Section, all actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state or federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Ventura, State of California.

8.4 Peer Review and Fair Hearing Process. Providers determined hereto to constitute a threat to the health, safety or welfare of Medi-Cal Members will be referred to the Plan Peer Review Committee. The Provider will be afforded an opportunity to address the committee. The Provider will be notified in writing of the Peer Review Committee Recommendations and of their rights to the Fair Hearing process. The Peer Review Committee can recommend to suspend, restrict or terminate the provider affiliation, to institute a monitoring procedure, or to implement continuing educational requirements.

8.5 Credentialing. Plan's Credentialing Committee will review all provider files to determine whether a provider meets the Plan credentialing or re-credentialing requirements. The Provider will be afforded an opportunity to address this committee if there is an adverse recommendation by the Committee regarding the provider's credentials. The Provider will be advised in writing of the Credentialing Committee's recommendation and notified of their rights to the Fair Hearing process. The Credentialing Committee can recommend denial of a provider's initial application or can deny the re-credentialing of a current provider.

SECTION 9 - TERM, TERMINATION, AND AMENDMENT

9.1 Initial Term and Renewal. This Agreement shall be effective as of the Effective Date and shall remain in effect for a term of one (1) year, and will thereafter renew automatically for one (1) year terms unless terminated sooner as set forth below.

9.2 Termination Without Cause. Either party upon one hundred twenty (120) days prior written notice to the other party may terminate this Agreement without cause.

- 9.3 Immediate Termination for Cause by Plan. The Plan may terminate this Agreement immediately by written notice to the Medical Group upon the occurrence of any of the following events:
- 9.3.1 The suspension or revocation of Medical Group's license to practice medicine in the State of California; or suspension from the State Medi-Cal Program; or loss of malpractice insurance; or
 - 9.3.2 If Plan determines, pursuant to procedures and standards adopted in its Utilization Management or Quality Improvement Programs, that Medical Group has provided or arranged for the provision of services to Medi-Cal Members which are not Medically Necessary or provided or failed to provide Covered Services in a manner which violates the provisions of this Agreement or the requirements of the Plan's Provider Manual; or
 - 9.3.4 If Plan determines that the continuation hereof constitutes a threat to the health, safety or welfare of any Medi-Cal Member; or
 - 9.3.5 If Plan determines that Medical Group has filed a petition for bankruptcy or reorganization, insolvency, as defined by law; or Plan determines that Medical Group is unable to meet financial obligations as described in this Agreement; or the Medical Group closes its office and no longer provides medically necessary services, or
 - 9.3.6 If Medical Group breaches Article 10.10, Marketing Activity and Patient Solicitation.

An immediate termination for cause made by Plan pursuant to this Section 9.3 will not be subject to the cure provisions specified in Section 9.4 Termination for Cause with Cure Period.

- 9.4 Termination for Cause With Cure Period. In the event of a material breach by either party other than those material breaches set forth in Section 9.3, Immediate Termination for Cause by Plan above of this Agreement, the non-breaching party may terminate this Agreement upon thirty (30) days written notice to the breaching party setting forth the reasons for such termination; provided, however, that if the breaching party cures such breach to the reasonable satisfaction of the non-breaching party during the thirty (30) day period, then this Agreement will not be terminated because of such breach.
- 9.5 Continuation of Services Following Termination. Should this Agreement be terminated, Medical Group will, at Plan's option, continue to provide Covered Medical Services to Medi-Cal Members who are under the care of Medical Group at the time of termination in accordance with this Section and agrees to adhere to Plan policies and procedures. Medi-Cal Members are allowed to receive ongoing care for a chronic or acute medical condition for up to 90 days after this agreement has terminated. Members in their second or third trimester of pregnancy have access to Specialty care through the post-partum period. Medical Group will ensure an orderly transition of care for Members, including but not limited to the transfer of Member medical records. Payment by Plan for the continuation of services by Medical Group after the effective date of termination will be subject to the terms and conditions set forth in this Agreement including, without limitation, the compensation provisions herein.
- 9.6 Medi-Cal Member Notification Upon Termination. Notwithstanding Section 9.3, Immediate Termination for Cause by Plan, upon the receipt of notice of termination by either Plan or Medical Group, and in order to ensure the continuity and appropriateness of medical care to Medi-Cal Members, Medical Group will notify members 30 days prior to the effective date of termination. Plan at its option, may immediately inform Medi-Cal Members of such termination

notice. Such Medi-Cal Members will be required to select another Primary Care Physician prior to the effective date of termination of this Agreement.

- 9.7 Survival of Obligations After Termination. Termination of this Agreement will not affect any right or obligations hereunder which will have been previously accrued, or will thereafter arise with respect to any occurrence prior to termination. Such rights and obligations will continue to be governed by the terms of this Agreement. The following obligations of Medical Group will survive the termination of this Agreement regardless of the cause giving rise to termination and will be construed for the benefit of the Medi-Cal Member: 1) Section 9.5, Continuation of Services Following Termination; 2) Section 6.2.2, Records and Records Inspection; and, 3) Section 7.5, Medical Group Indemnification. Such obligations and the provisions of this Section will supersede any oral or written agreement to the contrary now existing or hereafter entered into between Medical Group and any Medi-Cal Member or any persons acting on their behalf. Any modification, addition, or deletion to the provisions referenced above or to this Section will become effective on a date no earlier than thirty (30) days after the DHCS has received written notice of such proposed changes. Medical Group will assist Plan in the orderly transfer of Medi-Cal Members to the Primary Care Physician they choose or to whom they are referred. Furthermore, Medical Group shall assist Plan in the transfer of care as set forth in the Provider Manual, in accordance with the Phaseout Requirements set forth in the Medi-Cal Contract.
- 9.8 Access to Medical Records Upon Termination. Upon termination of this Agreement and request by Plan, Medical Group will allow the copying and transfer of medical records of each Medi-Cal Member to the physician assuming the Medi-Cal Member's care at termination. Such copying of records will be at Plan expense if termination was not for cause. Plan will continue to have access to records in accordance with the terms hereof.
- 9.9 Termination or Expiration of Plan's Medi-Cal Agreement. In the event the Medi-Cal Agreement terminates or expires, prior to such termination or expiration, Medical Group will allow DHCS and Plan to copy medical records of all Medi-Cal Members, at DHCS' expense, in order to facilitate the transition of such Medi-Cal Members to another health care system. Prior to the termination or expiration of the Medi-Cal Agreement, upon request by DHCS, Medical Group will assist DHCS in the orderly transfer of Medi-Cal Member's medical care by making available to DHCS copies of medical records, patient files, and any other pertinent information, including information maintained by any of the Medical Group's Subcontractors, necessary for efficient case management of Medi-Cal Members, as determined by DHCS. Costs of reproduction of all such medical records will be borne by DHCS. In no circumstances will a Medi-Cal Member be billed for this service.

SECTION 10 - GENERAL PROVISIONS

- 10.1 Assignment. This Agreement and the rights, interests and benefits hereunder will not be assigned, transferred, pledged or hypothecated in any way by the Medical Group and will not be subject to execution, attachment or similar process, nor will the duties imposed on Medical Group be set, contracted or delegated without the prior written approval of Plan and DHCS. Subcontractor's agreements that assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHCS.
- 10.2 Amendment. This Agreement may be amended at any time upon written agreement of both parties subject to review and approval by the DHCS, if required. This Agreement may also be amended by the Plan upon thirty (30) days written notice to Medical Group.

- 10.2.1 If the Medical Group does not give written notice of termination within sixty (60) days, as authorized by Section 9.2, Medical Group agrees that any such amendment by Plan will be a part of the Agreement.
- 10.2.2 Unless Medical Group, or DHCS notifies Plan that it does not accept such amendment, the amendment will become effective sixty (60) days after the date of Plan's notice of proposed amendment.
- 10.2.3 Amendments to the compensation, services or term provisions of this Agreement, will be forwarded to DHCS.
- 10.2.4 Notwithstanding the foregoing, Plan may amend this Agreement with prior written notice to Medical Group in order to maintain compliance with State and Federal Law and the Medi-Cal Agreement. Such amendment shall be binding upon Medical Group and shall not require the consent of Medical Group.
- 10.3 Severability. If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.
- 10.4 Notices. All notices required or permitted to be given by this Agreement shall be in writing and may be delivered personally, by certified or registered U.S. Postal Service mail, return receipt requested, postage prepaid, or by U.S. Postal Service Express mail, Federal Express or other overnight courier that guarantees next day delivery, and shall be deemed sufficiently given if served in the manner specified in this Section. Notices shall be delivered or mailed to the parties at the addresses set forth beneath their respective names on the signature page of this Agreement. Each party may change its address by giving notice as provided in this Section. Notices given by certified or registered mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the U.S. Postal Service, Federal Express or overnight courier.
- 10.4.1 Plan will notify DHCS in the event this Agreement is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached. A copy of the written notice will also be mailed as first-class registered mail to:
- California Department of Health Care Services,
Medi-Cal Managed Care Division
1501 Capitol Avenue, Suite 71.4001
MS 4407, P.O. Box 997413
Sacramento, CA 95899-7413
- 10.5 Entire Agreement. This Agreement, together with the Exhibits and the Plan's Provider Manual, contains the entire agreement between Plan and Medical Group relating to the rights granted and the obligations assumed by this Agreement. Any prior agreement, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

- 10.6 Headings. The headings of articles and paragraphs contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.
- 10.7 Governing Law. The validity, construction, interpretation and enforcement of this Agreement will be governed by the laws of the State of California, the United States of America, and the contractual obligations of Plan. Any provision required to be in this Agreement by law, regulation, or the Medi-Cal Agreement will bind Plan and Medical Group whether or not provided in this Agreement.
- 10.8 Affirmative Statement, Treatment Alternatives. Practitioners may freely communicate with patients regarding appropriate treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.
- 10.9 Reporting Fraud and Abuse. Medical Group is responsible for reporting all cases of suspected fraud and abuse, as defined in 42 CFR, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred by Medi-Cal Members or by Contracted Physicians within ten (10) days to Plan for investigation.
- 10.10 Marketing Activity and Patient Solicitation. Medical Group will not engage in any activities involving the direct marketing of Eligible Beneficiaries, who are not current Members of the Medical Group, without the prior approval of Plan.
- 10.10.1 Medical Group will not engage in direct solicitation of new Eligible Beneficiaries for enrollment, including but not limited to door-to-door marketing activities, mailers and telephone contacts.
- 10.10.2 During the period of this Agreement and for a one year period after termination of this Agreement, Medical Group and Medical Group's employees, agents or Subcontractors will not solicit or attempt to persuade any Medi-Cal Member not to participate in the Medi-Cal Managed Care Program or any other benefit program for which Medical Group renders contracted services to Plan Members.
- 10.10.3 In the event of breach of this Section 10.10, in addition to any other legal rights to which it may be entitled, Plan may at its sole discretion, immediately terminate this Agreement. This termination will not be subject to Section 9.4, Termination for Cause with Cure Period.
- 10.11 Nondisclosure and Confidentiality. Medical Group will not disclose the payment provisions of this Agreement except as may be required by law.
- 10.12 Proprietary Information. With respect to any identifiable information concerning a Member that is obtained by Medical Group or its Subcontractors, Medical Group and its Subcontractors will not use any such information for any purpose other than carrying out the express terms of this Agreement; will promptly transmit to Plan all requests for disclosure of such information, except requests for medical records in accordance with applicable law; will not disclose any such information to any party other than DHCS without Plan's prior written authorization, except as specifically permitted by this Agreement or the Plan Medi-Cal Agreement with DHCS, specifying that the information is releasable by law as set forth in the Medi-Cal Agreement; and,

will, at expiration or termination of this Agreement, return all such information to Plan or maintain such information according to written procedures provided by Plan for this purpose.

- 10.13 Non-Exclusive Agreement. To the extent compatible with the provision of Covered Services to Medi-Cal Members for which Medical Group accepts responsibility hereunder, Medical Group reserves the right to provide professional services to persons who are not Members including Eligible Beneficiaries. Nothing contained herein will prevent Medical Group from participating in any other prepaid health care program.
- 10.14 Counterparts. This Agreement may be executed in two (2) or more counterparts, each one (1) of which will be deemed an original, but all of which will constitute one (1) and the same instrument.
- 10.15 HIPAA. Medical Group and Plan each acknowledge that it is a “Covered Entity” as that term is defined in the Standards for Privacy of Individually Identifiable Health Information adopted by the U.S. Department of Health and Human Services, as modified (the “HIPAA Privacy Rule”). Each party shall adequately protect the confidentiality of individually identifiable health information and shall comply with the HIPAA Privacy Rule and with all State and Federal Laws governing the confidentiality of Members’ individually identifiable health information. If the Medical Group identifies any inappropriate uses of or breach of the HIPAA Privacy Rule with respect to Plan or Members, the Medical Group must notify Plan’s Privacy Officer immediately. In furtherance of the foregoing, Medical Group shall comply with all of its obligations as a “Business Associate” as set forth in Attachment G hereto.

SECTION 11 – RELATIONSHIP OF PARTIES

- 11.1 Overview. None of the provisions of this Agreement are intended, nor will they be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement; neither is this Agreement intended, except as may otherwise be specifically set forth herein, to create a relationship of agency, representation, joint venture or employment between the parties. Unless mutually agreed, nothing contained herein will prevent Medical Group from independently participating as a provider of services in any other health maintenance organization or system of prepaid health care delivery. In such event, Medical Group will provide written assurance to Plan that any contract providing commitments to any other prepaid program will not prevent Medical Group from fulfilling its obligations to Medi-Cal Members under this Agreement, including the timely provision of services required hereunder and the maximum capacity allowed under the Medi-Cal Agreement.
- 11.2 Oversight Functions. Nothing contained in this Agreement will limit the right of Plan to perform its oversight and monitoring responsibilities as required by applicable state and federal law, as amended.
- 11.3 Physician-Patient Relationship. This Agreement is not intended to interfere with the professional relationship between any Medi-Cal Member and his or her Primary Care Physician. Medical Group will be responsible for maintaining the professional relationship with its assigned Members and are solely responsible to such Members for all Covered Medical Services provided. Plan will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member resulting from the acts or omissions of Medical Group.

SECTION 12 - LEGAL REQUIREMENTS AND CREDENTIALS

12.1 Compliance With Laws.

12.1.1 Medical Group represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable local, State and federal laws and regulations as they become effective, including, but not limited to, those (i) regarding licensure and certification, (ii) necessary for participation in the Medicare and Medi-Cal programs, including the antifraud and abuse laws and regulations and the patient self-determination amendments of the Omnibus Budget Reconciliation Act of 1990, (iii) regarding advance directives including, but not limited to, Title 42 CFR Sections 422.128 and 438.6(i) and California Probate Code Sections 4673 to 4678 and Sections 4800 to 4806, and applicable regulations, (iv) regulating the operations and safety of facilities, including but not limited to, Title 22 CCR Section 53230, (v) regarding federal and State Occupational Health and Safety Administration (OSHA) standards, (vi) regarding communicable disease and immunization reporting, (vii) regarding not allowing smoking within any portion of any indoor facility used for the provision of health services for children as specified in the U.S. Pro-Children Act of 1994 (20 United States Code Section 6081 and following), (viii) regarding the provision of information to Members concerning Prostate Specific Antigen testing consistent with the standard set forth in California Business and Professions Code Section 2248, (ix) regarding provisions of the Health Insurance Portability and Accountability Act of 1996 and regulations, and provisions of the California Confidentiality of Medical Information Act, (x) set forth in Public Contract Code Section 6108 relating to the Sweat-free Code of Conduct, and (xi) relating to copyright laws. Payment under this Agreement will not be used for the acquisition, operation or maintenance of computer software in violation of copyright laws.

12.1.2 As required by Title 31 U.S.C. Section 1352, if payments under this Agreement are \$100,000 or more, Medical Group certifies to the best of its knowledge and belief that no Federally appropriated funds have been paid or will be paid, by or on behalf of Medical Group, to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Agreement, and the extension, continuations, renewal, amendment, or modification of this Agreement. If payments under this Agreement are \$100,000 or more, Medical Group shall submit to PLAN the "Certification Regarding Lobbying" set forth in the Provider Manual. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Agreement, Medical Group shall complete and submit to PLAN standard form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions. Medical Group shall file such disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed by Medical Group. Medical Group shall require that the language of this certification be included in all subcontracts at all tiers which exceed

\$100,000 and that all subcontractors shall certify and disclose accordingly. All such disclosure forms of subcontractors shall be forwarded to PLAN.

- 12.1.3 Medical Group shall not employ, maintain a contract with or contract with directly or indirectly, entities or individuals excluded, suspended or terminated from participation in the Medicare or Medicaid programs, for the provision of any Services to Members, including but not limited to, health care services, utilization review, medical social work, or administrative services with respect to Members.
- 12.1.4 Medical Group shall provide, as applicable, the ownership disclosure statement(s), the business transactions disclosure statement(s), the convicted offenses disclosure statement(s), and the exclusion from state or federal health programs disclosure statement(s), prior to the Effective Date, on an annual basis, upon any change in information, and upon request, if required by law or by PLAN's Contract with the State of California for the provision of Medi-Cal Services. Legal requirements include, but are not limited to, Title 22 CCR Section 51000.35, 42 USC Sections 1320 a-3 (3) and 1320 a-5 et seq., and 42 CFR Sections 455.104, 455.105 and 455.106. Medical Group shall also provide, as applicable, the "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions" and shall comply with its instructions, if required by law or by PLAN's Contract with the State of California for the provision of Medi-Cal Services.. Such Debarment Certification and its instructions are set forth in the Provider Manual.
- 12.1.5 If Medical Group uses economic profiling information related to any of its individual physicians or other health care Practitioners, it shall provide a copy of such information related to an individual Practitioner, upon request, to that Practitioner in accordance with the requirements of Section 1367.02 of the California Health and Safety Code. Additionally, Medical Group, upon request, shall make available to PLAN its policies and procedures related to economic profiling used by Medical Group. The term "economic profiling" as used in this Section 7.1 (e) shall be defined in the same manner as that term is defined in Section 1367.02 of the Health and Safety Code. The requirement of this Section 7.1 (e) to provide a copy of economic profiling information to an individual Practitioner shall survive termination of this Agreement in accordance with Section 1367.02 of the Health and Safety Code.
- 12.1.6 Medical Group shall immediately notify PLAN of (i) investigations of Medical Group in which there are allegations relating to fraud, waste or abuse, and (ii) suspected cases where there is reason to believe that an incident of fraud, waste or abuse has occurred. Medical Group shall comply with PLAN's antifraud Plan, including its policies and procedures relating to the investigation, detection and prevention of and corrective actions relating to fraud, waste and abuse. Medical Group represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable State and federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse including, but not limited to, applicable provisions of the federal and State civil and criminal law, Program integrity requirements at 42 CFR Section 438.608, the Federal False Claims Act (31 USC Section 3729 et seq.), Employee Education About False Claims Recovery (42 USC Section 1396a(a)(68)), the California State False Claims Act (California Government Code Section 12650 et seq.), and the anti-kickback statute (Section 1128B(b) of the Social Security Act).

- 12.1.7 If required by Health and Safety Code Section 1375.4, (1) Medical Group shall meet the financial requirements that assist PLAN in maintaining the financial viability of arrangements for the provision of Services in a manner that does not adversely affect the integrity of the contract negotiation process, (2) Medical Group shall abide by PLAN's process for corrective action Plans if there is a deficiency, and (3) PLAN shall disclose information to Medical Group that enables Medical Group to be informed regarding the financial risk assumed under this Agreement. In cases where the Solvency Regulations apply (28 CCR Sections 1300.75.4 through 1300.75.4.8), PLAN and Medical Group shall meet the requirements set forth in such Regulations. Members may request general information from PLAN or Medical Group about any bonuses or incentives paid by PLAN, if applicable.
- 12.1.8 Medical Group shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations. If applicable, Medical Group shall submit financial information consistent with the filing requirements of DMHC unless otherwise specified by DHCS. If Medical Group is required to file monthly financial statements with DMHC, then Medical Group shall simultaneously file monthly financial statements with DHCS. In addition, Medical Group shall file monthly financial statements with DHCS upon request.
- 12.1.9 If payments under this Agreement are in excess of \$100,000, Medical Group shall comply with the following provisions unless this Agreement is exempt under 40 CFR Part 30. (i) Medical Group shall comply with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act (42 USC Section 1857 (h)), section 508 of the Clean Water Act (33 USC Section 1368), Executive Order 11738, and the Environmental Protection Agency regulations (40 CFR Part 15). (ii) Medical Group shall comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC Section 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC Section 1251 et seq.), as amended.

12.2 Non-Discrimination.

- 12.2.1 Medical Group shall not discriminate against Members or deny benefits to Members, on the basis of race, color, creed, religion, language, sex, gender, marital status, political affiliation, ancestry, sexual orientation, sexual preference, national origin, health status, age (over 40), physical or mental disability, medical condition (including cancer), pregnancy, childbirth, or related medical conditions, veteran's status, income, source of payment, status as a Member of PLAN, or filing a complaint as a Member of PLAN. Members may exercise their patient rights without adversely affecting how they are treated by Medical Group. Medical Group shall not condition treatment or otherwise discriminate on the basis of whether a Member has executed an advance directive. Medical Group shall fully comply with all federal, state and local laws which prohibit discrimination, including but not limited to, Title VI of the Civil Rights Act of 1964, Title 45 CFR Part 91 the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act of 1973, 42 U.S.C. Section 2000(d), 45 C.F.R. Part 80 and 84, Title 28 CFR Part 36, Title IX of the Educational Amendments of 1973, California Government Code Section 11135, California Civil Code Section 51 and rules and regulations promulgated thereto, and all other laws regarding privacy and confidentiality. For the purpose of this Section, physical handicap also includes the carrying of a gene, which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse affects on the carrier. Such gene include, but are not limited to, Tay-Sach trait,

sickle-cell trait, Thalassemia trait, and X-linked hemophilia. Discrimination will include but is not limited to: denying any Case Managed Member any Covered Service or availability of a Facility; providing to a Case Managed Member any Covered Service which is different, or is provided in a different manner or as a different time from that provided to other Members under this Contract except where medically indicated; subjecting a Case Managed Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; restricting a Case Managed Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving many Covered Services, treating a Case Managed Member differently from others in determining whether he or she satisfied any admission, enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Services; the assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, or the physical or mental handicap of the participants to be served. Medical Group shall provide reasonable access and accommodation to persons with disabilities to the extent required of a health services provider under the Americans with Disabilities Act and regulations, guidelines issued pursuant to the ADA, any applicable state law, and the Medi-Cal Contract.

- 12.2.2 During the performance of this Agreement, Medical Group, its employees and agents, shall not unlawfully discriminate, deny benefits to, harass, or allow harassment against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical disability including Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and AIDS-Related Complex (ARC), mental disability, medical condition (including health impairments related to or associated with cancer for which a person has been rehabilitated or cured), marital status, political affiliation, age (over 40), sex, gender, sexual preference, sexual orientation, pregnancy, childbirth, or related medical conditions, or the use of family and medical care leave and pregnancy disability leave pursuant to state and federal law. Contractor, its employees and agents, shall insure that the evaluation and treatment of its employees and applicants for employment are free of such discrimination and harassment. Contractor, its employees and agents, shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 (a-f), and following) and the applicable regulations promulgated there under (California Code of Regulations, Title 2, Section 7285.0 and following). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Contractor shall give written notice of its obligations under this clause to labor organizations with which it has a collective bargaining or other agreement.

12.2.3 Federal Equal Opportunity Requirements.

- (a) Medical Group will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Medical Group will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following:

employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Medical Group shall post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC Section 4212). Such notices shall state Medical Group's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

- (b) Medical Group will, in all solicitations or advancements for employees placed by or on behalf of Medical Group, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.
- (c) Medical Group will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Medical Group's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
- (d) Medical Group will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.
- (e) Medical Group will comply with and furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.
- (f) In the event of Medical Group's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are

referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Agreement may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

- (g) Medical Group will include the provisions of subparagraphs (c)(1) through (c)(7) in every subcontract unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 USC 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor. Medical Group will take such action with respect to any subcontract as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event Medical Group becomes involved in, or is threatened with litigation by a subcontractor as a result of such direction by DHCS, Medical Group may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

ATTACHMENT A
PRIMARY CARE AND SPECIALIST PHYSICIANS
CASE MANAGEMENT PROTOCOL

Table of Contents

1.0	Primary Care and Specialist Physician Case Management Protocol.....	41
1.1	Definition of Case Management.....	41
1.2	Objectives.....	41
1.3	Case Management System	42
1.4	PCP Responsibilities	42
1.4.1	Responsibilities	
1.4.2	Request for Change of Primary Care Physician	
	A. Physician Initiated	
	B. Member Initiated	
	C. Transfer Request During Active Treatment	
1.5	Authorization of Services.....	44
1.5.1	General Procedure	
1.5.2	Emergency Service Authorization	
1.5.3	Non-Emergency Care Services	
1.5.4	Eligibility Verification	
1.5.5	Payment for Authorized Services	
1.5.6	Second Medical Opinions	
1.5.7	Other Coverage or Third Party Liability	
1.6	Specialist Physician Responsibilities	46
1.6.1	Responsibilities	
1.6.2	Patient Medical Record Data	
1.6.3	Authorization for Additional Data Needs	
1.6.4	Additional Consultation Treatment Authorization	
1.7	Non Physician Medical Practitioners	47
1.8	Out-of-Area Service Claims	48
1.9	Twenty-Four Hour Case Management Coverage.....	48
1.10	Delegation of Treatment Responsibility.....	49
1.11	Utilization Controls	49
1.12	Production and Distribution of Case Management List	49
1.13	Monitoring and Evaluation.....	49

1.0 Primary Care and Specialist Physician Case Management Protocol

1.1 Definition of Case Management

The California Department of Health Care Services defines case management as, "Guiding the course of resolution of a personal medical problem (including the "problem" of the need for health education, screening or preventive services) so that the recipient is brought together with the most appropriate provider at the most appropriate times, in the most appropriate setting."

1.2 Objectives

The objectives of physician case management of Member's medical care are as follows:

- 1.2.1 To foster continuity of care and longitudinal provider/patient relationships for Medi-Cal beneficiaries (also referred to subsequently as "Members").
- 1.2.2 To coordinate the care of Members in order to achieve satisfactory care results.
- 1.2.3 To contribute to the reduction in the use of hospital emergency rooms as a source of non-emergency, first-contact and urgent medicine by Members.
- 1.2.4 To reduce unnecessary referral of Members to specialty providers.
- 1.2.5 To discourage inappropriate use of pharmacy and drug benefits by Members.
- 1.2.6 To facilitate the Member's understanding and use of health promotion, disease prevention practices, and early diagnostic services.
- 1.2.7 To provide a structure for physicians to manage services to the Medi-Cal population by means of the following:
 - A. Selection of medical specialists based upon quality of care and adherence to the case management system to promote the cost effective delivery of services.
 - B. Reimbursement to physicians through a payment structure based upon measurement of individual and group physician utilization and quality of care performance.
- 1.2.8 To facilitate the smooth transition of members from one PCP to another when necessary.

1.3 Case Management Systems

The following requirements that are necessary for the case management system to function properly are as follows:

The following requirements are necessary for the case management system to function. These are the following:

- 1.3.1 Medi-Cal beneficiaries (also referred to herein as "Members") are required to select a primary care physician, clinic or provider or be assigned to one.
 - 1.3.2 Participating Primary Care and Specialist Physicians are required to contract with the Plan or Medical Group for provision of the services at rates established by the Plan and by the Department of Health Care Services Medi-Cal fee-for-service program.
 - 1.3.3 Through the referral process, primary care physicians will control Member referral to all services except Emergency and Limited Services as defined in the Medical Service Agreement.
 - 1.3.4 To facilitate accessibility of care to Members of the Plan, individual and group practice Primary Care Physicians, in private and public settings, will be geographically located throughout the county.
 - 1.3.5 Providers must meet the Medi-Cal Program Standards of Participation and be credentialed by Plan or an entity that the Plan has established a formal delegation agreement.
- 1.4 PCP Responsibilities
- 1.4.1 The responsibilities of the PCP are the following:
 - A. As specified in the Medical Service Agreement, to provide the scope of primary care services to health plan members who have designated the physician as his or her PCP.
 - B. To refer all medically necessary non-emergency hospital and/or outpatient surgery services to the Plan for review and authorization.
 - C. To refer all medically necessary specialist care to Providers who contract with the Plan or Medical Group.
 - D. To coordinate and direct appropriate care for members by means of initial diagnosis and treatment, consultation with specialists, and follow-up of care to assess the results of the primary care, medication regimen and special treatment within the framework of integrated, continuous care.
 - E. To record legibly and completely any information about patient visits, efforts to contact patients, treatment, referral and consultation reports in the medical record.
 - F. To maintain a follow-up system of referrals to determine whether or not the member obtained referral and the results of such referral.
 - G. To facilitate and ensure patient quality of care by establishing procedures to contact Members when they miss appointments, requiring rescheduling for additional visits, or confirming referrals to a specialist for care.
 - H. To maintain patient medical records for the members consistent with standard medical practice and to make the individual patient medical records available

upon request for audit/review by the staff of the Plan, the California Department of Health Care Services and the U.S. Department of Health and Human Services.

- I. To participate in and accept the Plan's continuing peer review of case managed and referred medical services.
- J. To participate in Plan Quality Improvement and Utilization Management Programs.
- K. To use as appropriate the appeal procedures for providers as established by Plan.
- L. To preserve the dignity of the Member.
- M. To maintain confidentiality of medical information about the Member.
- N. To coordinate Member discharge planning and referral to long term care with Plan staff.

1.4.2 Request for Change of PCP

- A. A physician's request to transfer the Member to another PCP requires Plan's approval.
- B. Such requests will be granted for the following reasons:
 - (1) Significant lack of cooperation, understanding and/or communication between doctor and patient. In such cases, the PCP and Plan will use their best efforts to provide the Member with the opportunity to be served by a PCP with whom a satisfactory physician-patient relationship can be developed. If the Plan is unable to make such arrangements and the member is in active care, the PCP will continue to serve the member according to the PCP's best professional judgment until the Plan is able to change the member's PCP, a period not to exceed two months.
 - (2) Requests to transfer a member to another PCP due to high cost or frequent visits will not be granted.
 - (3) The PCP must notify Provider Relations in writing regarding the PCP's desire to disenroll a member in their practice. Complete documentation regarding the nature of the problem must be included with the request. Requests to disenroll a member will be considered based on criteria outlined in Plan's Provider Manual.
 - (4) Requests will be reviewed and PCP will be notified of the decision. Once the PCP has been notified of the disenrollment, it is expected that the PCP will notify the member in writing regarding the PCP's decision to terminate the member from their practice and that the PCP will no longer be responsible for the member's medical care effective the date of the disenrollment. Plan will contact the patient to facilitate enrollment with a new PCP.

- (5) A physician can cease providing care for a non-assigned member when the physician/patient relationship becomes unsatisfactory. In these cases, the physician must notify the member in writing that they will no longer provide care for the member. The physician should assist the member in choosing another physician and transfer appropriate office medical records to that physician.
 - (6) A specialist physician can cease providing care for any member when the physician/patient relationship becomes unsatisfactory. In these cases, the specialist physician must notify both the PCP and the patient that they will no longer provide care to the patient. The PCP will refer the member to another specialist care for treatment if specialist care still is necessary.
- 1.4.3 Member Requests for change of PCP will be processed by Plan's Member Services Department.
- 1.4.4 Member requests for change of PCP during active treatment require special review by the Plan's Medical Director to ensure continuity of care.
- 1.5 Authorization of Services
 - 1.5.1 General Procedure
 - A. Plan will pay for properly prior authorized claims only according to the specific contract terms with each physician, hospital, and other provider. Providers should obtain the identification information from the Member. The Member should have a Plan Identification Card with the name and telephone number of the PCP and a Medi-Cal card.
 - B. PCPs will use Plan's referral procedures when referring a Member to a specialist.
 - C. Specialists must obtain a Direct Referral Authorization Form (DRAF) from the PCP in order to be paid for the care given. Exceptions are as follows:
 - (1) Emergency care, routine radiology including ultrasound, and laboratory services do not require a Direct Referral Authorization Form (DRAF).
 - (2) The following services do not require a TAR or completion of a DRAF by the PCP: Family planning services involving delaying and preventing pregnancy, vasectomy, tubal ligation, STD diagnosis and treatment, abortions, pregnancy testing and HIV testing, when provided by a family planning provider.
 - (3) Obstetrical Services do not require a formal referral or completion of a DRAF by the PCP unless services are accessed outside the county.
 - D. The referring physician must complete the original and attached copies of the DRAF. The eligibility of the member and number of visits, services and/or period of service to be rendered must appear in the proper location on the DRAF.
 - E. The PCP files his/her copy and the respective reports in the patient's medical

record.

- F. Specialist or other provider retains the specified copy for his/her file.
- G. A copy is sent to the Plan
- H. When submitting claims, the DRAF or TAR authorization number should be indicated on the claim form.

1.5.2 Emergency Service Notification

- A. Emergency services are defined in the Physician Agreement as those health services required for an Emergency Medical Condition, which is defined as a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent lay-person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.
- B. Emergency services rendered at hospitals do not require prior authorization.
- C. When a member presents with an emergency condition to the Emergency Department, the attending physician/hospital must do the following:
 - (1) Verify member eligibility, as well as PCP or Member status.
 - (2) Notify the PCP or alternate provider and Plan as soon as possible, but not later than 24 hours following service.
- D. When a member with an emergency condition is admitted for in-patient services, the attending Physician/hospital will notify the PCP and Plan within 24 hours of the admission.

1.5.3 Non-Emergency Use of Hospital Emergency Room or Urgent Care Facility

When a Member uses a hospital emergency room or urgent care facility for a non-emergent medical condition, the Medical Group will forward a copy of the face to the Plan within one business day.

1.5.4 Eligibility Verification

- A. PCP's, specialists, and ancillary providers must verify both Medi-Cal eligibility of the Member and the assignment of PCP for the month of service.
- B. The PCP should consult the monthly list of Members furnished by Plan at the beginning of each month that designates members for whom the physician has assumed case management responsibility.

1.5.5 Payment for Authorized Services

- A. Payment for services rendered by a specialist physician, hospital or other provider requires the following:
 - (1) Direct Referral Authorization Form (DRAF) from the PCP for specialist referral.
 - (2) Treatment Authorization Request (TAR) approved by the Plan for inpatient hospital or outpatient surgery services.
 - (3) Authorization Request Form (ARF) approved by the Plan for any other services that requires Plan pre-authorization.
- B. When submitting claims for authorized services, the DRAF number and/or TAR control number must be indicated on the Medi-Cal claim form.

1.5.6 Second Medical Opinions

- A. Members have the right to request a second opinion if they have been referred to a specialist and feel that such evaluation was unsatisfactory. A Member's first request for a second opinion may not be denied.
- B. When the PCP requests a second opinion, the PCP submits a DRAF for the second specialist visit in the same method as all specialty referrals.
- D. When the member requests a third opinion, which the PCP does not believe to be necessary, the PCP will refer the request to the Plan Medical Director for review and action.
- E. In response to a Treatment Authorization Request (TAR), the Plan Medical Director/designee may require a second opinion to assist with the approval decision.

1.5.7 Other Coverage or Third Party Liability

- A. In the event the Member has other coverage or third-party liability is involved, the physician will follow procedures outlined in the current Medi-Cal Provider Manual to bill the appropriate parties prior to billing Plan. Medi-Cal and Plan are secondary payors for services rendered. Claims for payment from Plan will be mailed to the Plan - NOT THE FISCAL INTERMEDIARY FOR MEDI-CAL.
- B. Claims for other Title XIX reimbursable services not covered by Plan (e.g. Dental) will be billed to the appropriate program.

1.6 Specialist Responsibilities

1.6.1 The responsibilities of the specialist are as follows:

- A. Upon receipt of the referral authorization form and verification of member eligibility, the specialist will provide to member those authorized medical services normally performed in his/her practice.

- B. Upon receipt of the referral authorization form and verification of beneficiary eligibility, the specialist may serve as a consultant to the PCP.
- C. Upon completion of the initial examination of the member and subsequent authorized treatment, the specialist will:
 - (1) Advise the PCP of the patient's condition, proposed procedures, and prognosis throughout the period of treatment; and
 - (2) Provide to the PCP a written report, and other oral reports as appropriate, regarding the diagnosis, treatment, other findings and prognosis within thirty (30) days after patient contact. (The PCP office should maintain a "tickler file" on all requested referrals, to ensure a report is received by the 30-day turnaround time.)
- D. To secure a referral from the PCP prior to rendering treatment.
- E. To participate in and accept continuing peer review of the medical or surgical services provided for members.
- F. To participate in Quality Improvement and Utilization Management Programs as defined by the Plan
- G. To permit review/audit of services provided to Members by the staff of Plan, the California Department of Health Care Services (DHCS), and the Department of Managed Health Care (DMHC) according to federal and state regulatory requirements and guidelines issued by Plan
- H. To use as appropriate the appeal procedures for providers as established by Plan.
- I. To preserve the dignity of the member.

1.6.2 Member Medical Record Data

In addition to issuing a Direct Referral Authorization Form (DRAF), the PCP will provide to the specialist significant physical findings, radiographic or laboratory results from the Member's general medical record which may assist the consultation process.

1.6.3 Authorization for Additional Data Needs

- A. If the specialist requires radiographic, laboratory or other diagnostic studies in order to evaluate the patient's condition or to make a diagnosis, the specialist may arrange for such studies which do not unnecessarily duplicate materials that were made available by the PCP or do not contradict the scope of referral granted by the PCP. Specialist is required to obtain appropriate authorization from Plan for services that require prior authorization per Plan authorization requirements.
- B. All covered services provided at the specialist's office will be billed by the specialist to Medical Group.
- C. If any of the services are rendered by a provider other than the specialist, the

provider must obtain the proper referral from the PCP.

- D. All such referrals must be made to providers who contract with Medical Group

1.6.4 Additional Consultation/Treatment Authorization

- A. Additional consultation/treatment beyond that authorized by the original DRAF may be required to bring the patient to a satisfactory level of health. The specialist must obtain authorization for all services when required.
- B. Such additional treatment will conform to accepted medical or surgical standards and to Plan and Medi-Cal coverage limitations. The specialist will bill Medical Group for payment for authorized services.
- C. The PCP may issue additional referrals for further treatment by the specialist or arrange another course of action which is satisfactory to the member and the PCP.

1.7 Non-Physician Medical Practitioners

- 1.7.1 When a PCP employs a physician assistant, nurse practitioner or certified nurse midwife, the non-physician medical practitioner will be directed according to Medi-Cal regulations and other written policies of Plan
- 1.7.2 The Supervising Physician will have an appropriate certification from the California Medical Quality Board to supervise the physician assistant. The Physician Assistant will hold a current license to practice.
- 1.7.3 The nurse practitioner or nurse midwife will hold a current professional license for the position and act according to protocols and interface requirements cited in the Medi-Cal regulations.
- 1.7.4 Services rendered by non-physician medical practitioners are recognized by Plan as professional services to be billed as a physician service according to the contract with Plan.
- 1.7.5 If the non-physician medical practitioner provides after-hours coverage, that practitioner must be supervised by a licensed M.D. or D.O. who is immediately available by telephone to the covering non-physician practitioner.

1.8 Out Of Area Service Claims

- 1.8.1 Plan will pay for medical claims for the care of any member who receives medically necessary emergency treatment rendered outside Ventura County.
- 1.8.2 PCP's will discuss out-of-area emergency coverage with their members. The out-of-area emergency care does not require prior authorization.

1.9 Twenty-Four Hour Coverage

- 1.9.1 The PCP will assure access to physician care for case-managed members 24 hours per

day, 7 days per week. After business hours the PCP or attending physician for case managed members may designate a covering practitioner to provide after-hours care. The on-call practitioner must be available by telephone to respond to call from members, organizational providers and other practitioners. After business hours it is expected that the answering service contact the practitioner or designee within 30 minutes for urgent questions. The practitioner on-call for the practice is expected to call the answering service within 30 minutes of contact by the answering service. The practitioner on call is required to call the member back within 60 minutes for probable urgent problems and within 4 hours for probable non-urgent matters.

- 1.9.2 The PCP will designate a backup physician when unavailable to render care.
- 1.9.3 The PCP will provide to Plan a list with the names and telephone numbers of backup physicians.
- 1.9.4 Should the backup physician render any services to the PCP's members, the backup physician will send the claims to Medical Group for payment. Prior to rendering care, the backup physician will confirm member eligibility.
- 1.9.5 Following care of any of the PCP's Plan members, the backup physician will update the PCP on any treatment rendered as well as any questions or concerns regarding the patient. Further follow-up of the patient is now the responsibility of the PCP.
- 1.9.6 A PCP may elect to have a mid-level clinician or registered nurse who is part of the PCP's practice take after hours calls provided they follow standardized protocols and a physician is always available for back-up.

1.10 Delegation of Treatment Responsibility

Certain patient conditions may demand ongoing treatment by a specialist physician (e.g., OB-GYN).

- A. The PCP may delegate the responsibility for continuing specialty care to a specialist for a specified time (6 months). The PCP must issue a DRAF for a delegated specialist. The PCP will remain the PCP to the Member.
- B. Any hospitalization of the member which may be recommended or required, however, will be prior authorized by the PCP. The specialist will request such authorizations from the Plan. Hospitalization authorization procedures will apply to this request.
- C. As required for all consultations the physician rendering care will provide written reports of the patient's condition, treatment, prognosis, etc. to the PCP within thirty (30) days of service.

1.11 Utilization Controls

In the interest of program integrity and the welfare of members, Plan may introduce utilization controls as may be necessary. In the event such changes are made, the physician will be given 30 days advance notice by Plan

1.12 Production and Distribution of Case Management List

- 1.12.1 Case management lists are the monthly lists of members selected or assigned to the PCP.
- 1.12.2 Case management lists are produced prior to the first day of each calendar month. Each PCP with selections receives an individual list of eligible members for that month.
- 1.13 Monitoring and Evaluation
 - 1.13.1 A periodic random sample of medical records may be audited for appropriateness of case management activities

ATTACHMENT B

CAPITATION PAYMENT RATES

Per Member, Per Month Payment by Aid Category			
Aid Category	Adults & Family	Aged	Disabled
Primary Care			
Specialty Care			
Administrative Services			
Total			

ATTACHMENT B1

Primary Care Physician - Scope of Capitated Services

The services listed in this Attachment are included in the Primary Care Physician capitation payment. Medical Group is expected to provide these services to Members as deemed medically appropriate. In the event that a Primary Care Physician needs to provide Covered Services that fall outside this list, the Medical Group may submit a claim to the Plan; services will be reimbursed at the prevailing Medi-Cal fee-for-service rate schedule. If the service is included in the list of services requiring Prior Authorization as described in the Gold Coast Health Plan Provider Manual then the Medical Group must obtain Prior Authorization in order to provide the service.

OFFICE VISITS

CPT Code – New Patient

99201	Problem focused history and exam; straight forward; 10 minutes
99202	Expanded problem focused history and exam; straight forward; 20 minutes
99203	Detailed history and exam; low complexity; 30 min
99204	Comprehensive history and exam; moderate complexity; 45 minutes
99205	Comprehensive history and exam; high complexity; 60 minutes

Established Patient

99211	Minimal Problem; physician supervised services; 5 minutes
99212	Problem focused history and exam; straight forward; 10 minutes
99213	Expanded problem focused history and exam; straight forward; 15 minutes
99214	Detailed history and exam; moderate complexity; 25 minutes
99215	Comprehensive history and exam; high complexity; 40 minutes

PREVENTIVE MEDICINE SERVICES (if not covered by CHDP)

99381	Initial Evaluation and Management of Healthy Individual
99382	Early Childhood – age 1 to 4 years
99383	Late Childhood – age 5 to 11 years
99384	Adolescent – age 12 to 17 years
99385	18 – 39 years
99386	40 – 64 years
99387	65 years and older

Established Patient

99391	Periodic Reevaluation and management of Healthy Individual
99392	Early Childhood – age 1 to 4 years
99393	Late Childhood – age 5 to 11 years
99394	Adolescent – age 12 to 17 years
99395	18 – 39 years
99396	40 – 64 years
99397	65 years and older

MINOR SURGICAL AND OTHER MISCELLANEOUS PROCEDURES

Surgical Procedures

10060	Drainage of Boil
10080	Drainage of Pilonidal Cyst
10120	Remove Foreign
10140	Drainage of Hematoma
10160	Puncture Drainage of Lesion
11740	Drain Blood from under Nail
11900	Injection into Skin Lesions
16000	Initial Treatment of Burn(s)
20600	Arthrocentesis, Aspiration and/or Injection; Small Joint, Burns or Ganglion Cyst
26720	Treat Finger Fracture, Each
28490	Treat Big Toe Fracture
28510	Treatment of Toe Fracture

Splints

29105	Application of long arm splint (shoulder to hand)
29125	Application of short arm splint (forearm to hand); static
29126	dynamic
29130	Application of finger splint; static
29131	dynamic
29505	Application of long leg splint (thigh to ankle or toes)
29515	Application of short leg splint (calf to foot)

Strapping – Any Age

29200	Strapping; thorax
29220	low back
29240	shoulder (eg. Velpeau)
29260	elbow or wrist
29280	hand or finger
29520	Strapping; hip
29530	knee
29540	ankle
29550	toes
46600	Diagnostic Anoscopy
51701	Insertion of non-indwelling bladder catheter
51702	Insertion of temporary indwelling bladder catheter
65205	Removal of Foreign Body, Eye
69200	Clear Outer Ear Canal
69210	Remove Impacted Ear Wax

Laboratory

81000	Urinalysis with Microscopy
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81002	Routine Urine Analysis
81005	Urinalysis; Chemical, qualitative
81205	Urine Pregnancy Test, by Visual Color Comparison Methods
82270	Blood; Occult, Feces
82271	Blood; Occult – Other Sources
82948	Stick Assay Blood Glucose
82947	Glucose; Quantitative
85014	Hematocrit
85018	Hemoglobin, Colorimetric
85025	Automated Hemogram
86580	TB Intradermal Test
87081/87084	Bacteria Culture screen only, e.g., Rapid Strep test
87205	Smear, Stain & Interpretation - Routine Stain
87210	Smear, Stain & Interpretation – Wet Mount
87220	Tissue Examination for Fungi (KOH Slide)

ECG, HEARING TEST, SUPPLIES

93005	Electrocardiogram, tracing only
93041	Rhythm ECG, Tracing
92567	Tympanometry
Z0316	Tympanometry codes
99070	Special Supplies

IMMUNIZATION

990471 Administration of vaccine*

*Administration of vaccines only. Cost of the vaccine may be reimbursed with invoice. The immunization needed to be addressed for this list but was overlooked in past discussions. Therefore, this code is added.

ATTACHMENT C

FINANCIAL RESPONSIBILITY MATRIX FOR COVERED SPECIALTY MEDICAL SERVICES

For those Covered Services that are designated, “Plan Pays,” the Plan shall be responsible for the corresponding Covered Services.

Service/Procedure	Plan Authorizes	Plan Pays	Covered	Comments
Abortions 0-12 weeks:				
Professional				
Facility				
Abortions 13+ weeks:				
Professional				
Facility				
Acupuncture				Carve out
Adult Day Healthcare Services				Carve out
AIDS/HIV:				
Professional				
Facility				
Allergy:				
Testing				
Serum				
Ambulance:				
In-Area Emergency (Ventura County)				
Out-of Ventura County (OOA) Emergency				
Non-Emergency Specialized Transportation				
Anesthesiologist/Nurse Anesthetist:				
Professional - Outpatient				
Professional – Inpatient				
Audiology:				
Screening and Exam				
Behavioral Health				Carve out
Blood or Blood Products:				
Autologous Blood Donation				
Storage				Not a covered benefit
California Children’s Services (CCS)				Carve out
Cardiac Rehab (CORF and CARF):				
Outpatient – Professional and Facility				
Chemical Dependency Detox Inpatient:				
Professional				Carve out
Facility				Carve out
Chemical Dependency Treatment Outpatient				Carve out
Chemotherapy - Outpatient:				
Professional				
Medications - See Medication (Outpatient) Specialty Pharmaceuticals				

Service/Procedure	Plan Authorizes	Plan Pays	Covered	Comments
Chemotherapy - Inpatient:				
Professional				
Facility				
Child Health and Disability Prevention				
Chiropractic Medicine:				Carve out
Circumcision - Medically Indicated:				
Professional				
Facility				
Dental Services:				
Elective				Carve out
Emergent – Trauma to natural teeth				Carve out
Anesthesiologist				
Facility				
Diabetic Supplies – glucometer , test strips and lancets per Plan Formulary				
Dialysis, including hemodialysis, peritoneal and other				
Dialysis - Outpatient:				
O/P Professional and Facility				
O/P Medications – See Medication (Outpatient) Specialty Pharmaceuticals				
Dialysis - Inpatient:				
I/P Facility				
I/P Professional				
Durable Medical Equipment:				
Outpatient				
Inpatient				
Emergency Services - Out of Ventura County				
Facility				
Attending Physician				
Anesthesiologist				
Pathology				
Radiology				
Consults				
Interpretations				
Emergency Services – In Ventura County:				
Facility				
Attending Physician				
Pathology				
Radiologist				
Consults				
Interpretations				
Employment Ins. Court ordered Physical				Not a covered benefit
Endoscopic Studies:				
Office procedure				

Service/Procedure	Plan Authorizes	Plan Pays	Covered	Comments
Professional				
Facility				
Experimental Procedures				Not a covered benefit
Family Planning:				
Oral/Topical Contraceptives				
All Other Contraceptives				
Genetic Counseling				
Health Education – Non CPSP				
Hearing Aid Device				Carve Out
Home Health:				
Professional Services				
Infusion Therapy (including IV Antibiotics, TPN/PPN)				
Hospice Care – In Home				
Hospice Care – Facility-Based:				
Professional Services				
Facility				
Immunizations:				
Pediatric				
Adult - see Medication (Outpatient) specialty pharmaceuticals				
Work/travel immunizations				Not a covered benefit
Infant Special Formula				Plan Responsibility - Scriptcare
Infertility Services				Not a covered benefit
Inpatient Services:				
Facility				
Attending Physician				
Anesthesiologist				
Pathologist				
Radiologist				
Consults				
Interpretations				
Laboratory Services - Outpatient				
Lithotripsy:				
Professional				
Facility				
Long-Term Care - Inpatient				
Medical Supplies – Outpatient, Disposable				
Medication – Specialty Outpatient:				
Injections/infusion – Professional (admin.)				
Injectable chemotherapeutic medications and injectable adjunct pharmaceutical therapies for side effects				
Injectable medications or blood products used for hemophilia				
Injectable medications related to transplant				

Service/Procedure	Plan Authorizes	Plan Pays	Covered	Comments
services				
Adult vaccines – Admin Only				
Self-Injectable medications (excluding insulin)				
Medication (outpatient) (i.e. oral, topical medications dispensed by retail pharmacy)				
Mental Health: History and Physical (H&P)				
Neonatology				
Nuclear Medicine:				
O/P Professional				
O/P Facility				
I/P Professional				
I/P Facility				
Radiopharmaceuticals				
Nutritional Counseling				
Obstetrical Services:				
California Comprehensive Perinatal Services Program (CPSP)				
Alfa Fetal Protein (State Program)				Carve Out
Amniocentesis				
Ultrasound – Outpatient				
Fetal Monitoring - Outpatient				
Fetal Monitoring-Professional				
Prenatal Care				
Postpartum Care				
I/P Facility				
Office Visits - All Specialties:				
Professional				
Supplies				
Optometry:				
Screening				
Lenses				
Frames				
Dispense Fee – Lenses and frames				
Refractions				
Contact lenses – medically necessary				
Orthotics				
Ostomy Supplies				
Outpatient Diagnostic Services:				
Angiograms – Professional				
CT Scans – Professional				
2D Echo – Professional				
EEG – Professional				
EKG – Professional				
Mammography – Professional				
MRI – Professional				
PET Scans – Professional				

Service/Procedure	Plan Authorizes	Plan Pays	Covered	Comments
Thallium & Adenosine – Professional				
Ultrasound – Professional				
X-Ray – Professional				
Outpatient Surgery:				
Professional				
Facility				
Pathology (Clinical/Anatomical):				
All Outpatient				
I/P Professional				
Perinatology				
Prayer and Spiritual Healing				
Prosthetic Devices:				
Surgically Implanted				
Non-Surgically Implanted				
Radiation Therapy				
I/P Professional				
O/P Professional				
Reconstructive Surgery for the following conditions only:				
a. Due to accidental injury or to improve the function of a malformed body part				
b. Reconstructive Breast surgery is covered for mastectomy and to produce a symmetrical appearance				
Professional				
Facility				
Rehabilitation – (PT, ST, OT)				
Outpatient – Professional and Facility				
Skilled Nursing Facility/Sub-Acute Care (Up to 62 days):				
Specialty Care (Within Medical Group's Contracted Network)				
Specialty Care (Outside Medical Group's Contracted Network - Non-Emergent, Non-Complex Case)				
Sterilization (Tubal Ligation/Vasectomy):				
Professional				
Inpatient Facility				
Transfusion Services:				
Outpatient				
Inpatient				
Transplant – other than Kidney:				
Professional				
Facility				
Transplant – Kidney				Carve out
Urgent Care (Free Standing)				

Service/Procedure	Plan Authorizes	Plan Pays	Covered	Comments
In-Area				
Out of Ventura County				

ATTACHMENT D
MEDICAL SPECIALTY NETWORK ADEQUACY

Physician Specialty	Minimum Providers Per _____ Members
AIDS/HIV	
Allergy	
Cardiology	
Dermatology	
Endocrinology	
Gastroenterology	
General Surgery	
Hematology-Oncology	
Infectious Disease	
Neonatology	
Nephrology	
Neurological Surgery	
Neurology	
Nuclear Medicine	
OB-Gynecology	
Ophthalmology	
Orthopedic Surgery	
Otolaryngology	
Pain Management	
Pediatric Allergy	
Pediatric Cardiology	
Pediatric Neurology	
Pediatric Surgery	
Pediatrics	
Perinatology	
Physical Medicine & Rehabilitation	
Plastic Surgery	
Pulmonology	
Radiation Therapy	
Radiology	
Rheumatology	
Thoracic / Vascular Surgery	
Urology and Urological Surgery	

ATTACHMENT E

RESPONSIBILITY MATRIX FOR ADMINISTRATIVE SERVICES

For those Administrative Services that are designated “Group” via an “x” in the chart below, the Medical Group shall be responsible for providing the corresponding services at its cost and expense. For those Administrative Services that are designated “Plan” via an “x” in the chart below, the Plan shall be responsible for the service.

Administrative Service	Plan	Group	Comments
Financial Management:			
Capitation Reporting			
1099 Production and Disbursement			
Member Services:			
Benefit Option and Co-pays Loading			
Electronic Eligibility Loading			
Eligibility Reconciliation			
Eligibility Reporting to Clinic			
Incoming Inquiry Calls			
Member Satisfaction Surveys			
Provider Services:			
Incoming Inquiry Calls			
Provider Choice Letters			
Provider Contracting			
Provider Credentialing			
Provider Databank Costs and Site Reviews			
Provider In Services			
Provider Manual Maintenance and Distribution			
Provider Marketing			
Provider Notifications			
Provider Satisfaction Surveys			
Quality & Utilization Management:			
Authorization Management			
Case Management – Outpatient only			
Case Management – Complex			
Continued Stay Review			
Discharge Planning			
Data Reporting (as defined by Plan)			
Denials Management – Professional Only			
Denials Management – all others			
Disease Management			
Grievance and Appeals			
Health Education Program			

Administrative Service	Plan	Group	Comments
Health Plan Audits & Reporting			
Referral Management			
Claims Management:			
Adjudication			
Auditing			
Coding Maintenance			
Data Reporting (as required by Plan)			
DOFR Maintenance and Verification			
Encounter Data reporting			
Fee Set Maintenance			
In loading of Claims			
Off-site data storage and/or back-up			
Provider Database Management			
Overpayment Recovery			
Regulatory & Compliance:			
Audit Preparation			
Fraud and Abuse Monitoring & Reporting			
HIPAA Monitoring & Reporting			
Other Regulatory Monitoring & Reporting			

ATTACHMENT F

DISCLOSURE FORM (Welfare and Institutions Code Section 14452)

<NAME OF MEDICAL GROUP>
Name of Medical Group

The undersigned hereby certifies that the following information regarding the Medical Group is true and correct as of the date set forth below:

Form of Medical Group (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

If a proprietorship, Co-Owner(s). If a partnership, partners.

If a corporation, stockholders owning more than ten percent (10%) of the stock of the Provider

If a corporation, President, Secretary, Treasurer, Directors and Other Officers:

Stockholders owning more than ten percent (10%) of the stock of the Provider:

Major creditors holding more than five (5) percent of Provider debt:

If not already disclosed above, is Medical Group, or a co-owner, partner, stockholder, director or officer either directly or indirectly related to or affiliated with Plan? Please explain:

Dated: _____

Signature: _____

Name: _____
(Please type or print)

Title: _____
(Please type or print)

ATTACHMENT G

MEDICAL GROUP FACILITIES

List for each Medical Group facility or clinic site, each physician's name, location(s) and hours of operation, mid-level practitioners supervised and languages spoken.

ATTACHMENT H

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE REQUIREMENTS

Medical Group, as a Business Associate of the Plan (“Associate” for the purpose of this Attachment) agrees to comply with the following requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and 45 CFR Parts 160 through 164 (“HIPAA Regulations”) as it relates to Business Associate and to include such provisions in all agreements between Associate and any health care providers from which Associate obtains usual or frequently used health care services on behalf of Plan Members.

1. **Obligations of Associate.**

- a. **Permitted Uses and Disclosures.** Associate shall not use or disclose Protected Information except as allowed under the Agreement and this Addendum. Associate shall not use or disclose Protected Information in any manner that would constitute a violation of the HIPAA Regulations if such use or disclosure is made by Plan, except that Associate may use Protected Information (i) for the proper management and administration of Associate and (ii) to carry out the legal responsibilities of Associate.
- b. **Disclosures to Third Parties.** To the extent that Associate discloses Protected Information to a third party, Associate shall obtain, prior to making any such disclosure, (i) reasonable assurances from such third party that such Protected Information will be held confidential as provided pursuant to this Addendum and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and (ii) an agreement from such third party to immediately notify Associate of any breaches of confidentiality of the Protected Information, to the extent it has obtained knowledge of such breaches.
- c. **Appropriate Safeguards.** Associate shall implement appropriate safeguards as are necessary to prevent the use or disclosure of Protected Information other than as permitted by this Attachment. Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Associate's operations and the nature and scope of its activities, which Associate shall provide to Plan upon Plan's request.
- d. **Reporting of Improper Use or Disclosure.** Associate shall report to Plan in writing of any use or disclosure of Protected Information not provided for or allowed by this Attachment within three (3) business days of the day in which Associate becomes aware of such use or disclosure.
- e. **Associate's Agents.** Associate shall ensure that any of its agents or subcontractors, to whom it provides Protected Information agree to the same restrictions and conditions that apply to Associate as provided for by this Addendum with respect to such PHI. Associate shall implement and maintain sanctions against any agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation.
- f. **Access to Protected Information by Plan Members.** Associate shall make Protected Information maintained by Associate or its agents or subcontractors in Designated Record Sets available to Plan for inspection and copying within ten (10) business days of a request by Plan to enable Plan to fulfill its obligations to Plan Members under the HIPAA Regulations,

including, but not limited to those contained in 45 CFR Section 164.524. If an individual requests such Protected Information directly from Associate or its agents or subcontractors, Associate shall notify Plan in writing within five (5) business days of the request. Associate understands and agrees that only the Plan, as the Covered Entity under HIPAA, has the right to deny access to Protected Information maintained by Associate or its agents or subcontractors in Designated Record Sets.

- g. Amendment of PHI by Plan Members.** Within ten (10) business days of receipt of a request from Plan for an amendment of Protected Information or a record relating to an individual in a Designated Record Set, Associate or its agents or subcontractors shall make such Protected Information available to Plan for amendment and incorporate any such amendment to enable Plan to fulfill its obligations under the HIPAA Regulations, including, but not limited to, 45 CFR Section 164.526. If any individual requests an amendment of Protected Information directly from Associate or its agents or subcontractors, Associate shall notify Plan in writing within five (5) business days of the request. Associate understands and agrees that only the Plan, as the Covered Entity under HIPAA, has the right to deny amendment of Protected Information maintained by Associate or its agents or subcontractors in Designated Record Sets.
- h. Accounting Rights of Plan Members.** Within ten (10) business days of notice by Plan of a request by a Plan Member for an accounting of disclosures of Protected Information allowed by the HIPAA Regulations, Associate and its agents or subcontractors shall make available to Plan the information required to provide an accounting of disclosures to enable Plan to fulfill its obligations under the HIPAA Regulations. Associate agrees to implement a process that allows for an accounting whereby information on uses and disclosures subject to an accounting are collected and maintained by Associate and its agents or subcontractors for at least six (6) years prior to the request, but not before the compliance date of the HIPAA Regulations. At a minimum, such information shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. In the event that the request for an accounting is delivered directly to Associate or its agents or subcontractors by a Plan Member, Associate shall within five (5) business days of a request forward it to Plan in writing. It shall be Plan's responsibility to prepare and deliver any such accounting requested. Associate shall not disclose any Protected Information except as set forth in Sections 3(a) and 3(b) of this Addendum.
- i. Governmental Access to Books and Records.** Associate shall make its internal practices, books and records relating to the use and disclosure of PHI received from Plan (or created or received by Associate on behalf of Plan), available to the Secretary of the U.S. Department of Health and Human Services ("Secretary") or the Secretary's designee for purposes of determining compliance with the HIPAA Regulations. Associate shall provide to Plan a copy of any Protected Information that Associate provides to the Secretary concurrently with providing such Protected Information to the Secretary.
- j. Minimum Necessary.** Associate, or any of its agents or subcontractors, shall only request, use and disclose the minimum amount of Protected Information necessary to accomplish the purpose of the request, use or disclosure.

- k. Data Ownership.** Associate acknowledges that Associate has no ownership rights with respect to the Protected Information whether de-identified or otherwise.
- l. Retention of Protected Information.** Notwithstanding Section 5(c) of this Addendum, Associate and its agents or subcontractors shall retain all Protected Information for the duration of the Agreement and shall continue to maintain the information required under Section 3(h) of this Attachment for a period of six (6) years after termination of the Agreement.
- m. Inspection of Policies, Procedures and Applicable Subcontracts.** Within ten (10) business days of a written request by Plan, Associate and its agents or subcontractors shall allow Plan to inspect its policies, procedures and applicable subcontracts relating to the use or disclosure of Protected Information pursuant to this Addendum for the purpose of determining whether Associate has complied with this Addendum.
- n. Special Provisions for EPHI:**
 - (1) With respect to EPHI, implement Administrative, Physical, and Technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the EPHI that Associate creates, receives, maintains, or transmits on behalf of Plan as required by 45 CFR Part 164, Subpart C.
 - (2) With respect to EPHI, ensure that any agent, including a subcontractor, to whom Associate provides EPHI, agrees to implement reasonable and appropriate safeguards to protect the EPHI.
 - (3) With respect to EPHI, report to Plan any Security Incident of which Provider becomes aware.

2. **Obligations of Plan.**

- a. Maintenance of Safeguards.** Plan shall be responsible for using appropriate safeguards to maintain and ensure the confidentiality, privacy and security of PHI transmitted to Associate by Plan, in accordance with the standards and requirements of the HIPAA Regulations, until such PHI is received by Associate.
- b. Notification of Authorizations or Restrictions Placed by Plan Members.** Plan shall promptly inform Associate of any authorizations and restrictions, and changes or withdrawals thereof placed by Plan Members on use or disclosure of their PHI to the extent that such authorizations or restrictions affect Associate's use or disclosure of PHI of such Plan Member.
- c. Plan to Provide Copies of Its Notice(s) of Privacy Practices.** Plan shall provide Associate with copies of Plan's Notice(s) of Privacy Practices prepared in compliance with the HIPAA Regulations and made available to Plan Members.

3. **Termination.**

- a. Material Breach.** A breach by Associate of any provision of this Attachment, as determined by Plan, shall constitute a material breach of the Agreement and shall provide grounds for immediate termination of the Agreement by Plan.

- b. Associate to Take Reasonable Steps to Cure Breach.** If Plan knows of a pattern of activity or practice of Associate that constitutes a material breach or violation of the Associate's obligations under the provisions of this Attachment, Plan shall provide Associate immediate notice of Plan's discovery of such breach and Associate shall take reasonable steps to cure such breach within ten (10) business days of notice by Plan to the satisfaction of Plan, or Plan shall either (i) terminate the Agreement, if feasible; or (ii) if termination of the Agreement is not feasible, report Associate's breach or violation to the Secretary.
 - c. Effect of Termination.** Upon termination of the Agreement for any reason, Associate shall, if feasible, return or destroy all Protected Information or any copies thereof received from Plan that Associate or its agents or subcontractors still maintains in any form. Associate shall further certify in writing within thirty (30) days from the date of termination or expiration of the Agreement that all PHI has been returned or destroyed. If return or destruction is infeasible, Associate or its agents or subcontractors shall: (i) provide to Plan notification of the conditions that make return or destruction infeasible; (ii) continue to extend the protections of this Attachment to such information; and (iii) limit further use of such Protected Information to those purposes that make the return or destruction of such Protected Information infeasible.
- 4. **Amendment(s) to this Attachment.** The Parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Attachment may be required to provide for procedures to ensure compliance with such developments. The Parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA and the HIPAA Regulations and other applicable laws relating to the security or confidentiality of PHI. Plan may terminate the Agreement upon thirty (30) days written notice in the event (i) Associate does not promptly enter into negotiations to amend this Addendum when requested by Plan pursuant to this Section or (ii) Associate does not enter into an amendment to this Addendum providing assurances regarding the safeguarding of PHI that Plan, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA Regulations or other applicable laws.
- 5. **Assistance in Litigation or Administrative Proceedings.** Associate shall make itself, and any of its agents, subcontractors, or employees assisting Associate in the performance of its obligations under the Agreement and this Attachment, available to Plan, at no cost to Plan, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against Plan, its directors, officers or employees based upon an alleged violation of HIPAA, the HIPAA Regulations or other laws relating to security and privacy, except where Associate or any of its agents, subcontractors, or employees is a named adverse party.
- 5. **Indemnification.** Associate shall indemnify and shall hold Plan, or any of its employees, harmless from any and all claims, losses, damages, liabilities, costs, expenses, attorney's fees and liability to third parties arising from or in connection with any breach of this Attachment or from any negligence or wrongful acts or omissions, including failure to perform its obligations under the HIPAA Regulations, by Associate or any of its agents, subcontractors or employees. Associate's obligation to indemnify Plan shall survive the expiration or termination of this Addendum without regard to the reason of the expiration or termination.
- 7. **No Third Party Beneficiaries.** Nothing express or implied in this Attachment is intended to confer, nor shall anything herein confer, upon any person other than Plan, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

8. **Disclaimer.** Plan makes no warranty or representation that compliance by Associate with this Attachment will be adequate or satisfactory for Associate's own compliance with HIPAA, the HIPAA Regulations, or other state and federal confidentiality of information laws including California Department of Health rules on restrictive disclosure of information relating to Medi-Cal beneficiaries. Associate is solely responsible for all decisions made by Associate regarding the safeguarding of PHI.
8. **Injunctive Relief.** Notwithstanding any rights or remedies provided for in this Attachment, , Plan retains the right to seek injunctive relief to prevent or stop any unauthorized use or disclosure of PHI by Associate or any of its agents, contractors, subcontractors, or third parties that receives PHI from Associate.
9. **Interpretation.** The provisions of this Attachment shall prevail over any provisions in the Agreement that may conflict or be inconsistent with any provision in this Attachment. This Attachment and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and the HIPAA Regulations.
10. **Non-Conflicting Provisions of Agreement to Remain Unchanged.** All non-conflicting terms and provisions of the Agreement, as amended by any other previous amendments, shall remain unchanged.

Confidential Attorney Work Product
Attorney-Client Privileged

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

DRAFT
8/10/20/11

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

(dba Gold Coast Health Plan)

Table of Contents

ARTICLE I	3
Name and Mission	3
ARTICLE II	4
Commissioners	4
Selection and Terms of Commissioners	5
ARTICLE III	5
Officers	5
Election	6
Duties	6
ARTICLE IV	6
Standing Committees	6
ARTICLE V	9
Special Committees	9
ARTICLE VI	9
Meetings	9
Conduct of Meetings	10
ARTICLE VII	11
Powers and Duties	11
ARTICLE VIII	11
STAFF	11
Chief Executive Officer	12
Clerk	12
Assistant Clerk	12
ARTICLE IX	13
Rules of Order	13
ARTICLE X	13
Amendments	13
ARTICLE XI	13
Nondiscrimination Clause	13
ARTICLE XII	13
Conflict of Interest and Ethics	13
ARTICLE XIII	14
Dissolution	14

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.

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

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

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

Duties

(a) The Chairperson shall:

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

(b) The Vice-Chairperson shall:

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

ARTICLE IV

Standing Committees

(a) At a minimum, the VCMMCC shall establish two (2) committees/advisory boards, one member/consumer based and one provider based. 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 ~~action taken by it~~ of its activities

to the governing board at its next regular meeting ~~succeeding the taking of such action.~~

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

1. Chairperson
2. Vice-Chairperson
3. Private hospital/healthcare system representative (to rotate between the two representatives following the representative's resignation from the committee)
4. Ventura County Medical Center Health System representative
5. Clinicas Del Camino Real representative

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

If the private hospital/healthcare system representative, the Ventura County Medical Center Health System representative and/or the Clinicas Del Camino Real representative are also the Chairperson and/or Vice-Chairperson of the governing board, then, the other Commissioner who is a representative of the same constituency or organization as the Commissioner serving as Chairperson or Vice-Chairperson shall be appointed to the Executive/Finance Committee to fill that reserved seat. For example, if the Ventura County Medical Center Health System representative and the Clinicas Del Camino Real representative are also the Chairperson and Vice-Chairperson, respectively, of the governing board, then, the other Ventura County Medical Center Health System representative and the physician representative nominated by Clinicas Del Camino Real shall be appointed to fill the respective designated seat on the Executive/Finance Committee.

iii. Duties of the Executive/Finance Committee.

1. Advise the governing board Chairperson on requested matters.
2. Assist the CEO in the planning or presentation of items for governing board consideration.
3. Assist the CEO or VCMMCC staff in the initial review of draft policy statements requiring governing board approval.
4. Assist the CEO in the ongoing monitoring of economic performance by focusing on budgets for pre-operational and operational periods.

5. Review proposed State contracts and rates, once actuary has reviewed and made recommendations.
6. Review proposed contracts for services over the assigned dollar value/limit of the CEO.
7. Establish basic tenets for payment-provider class and levels as related to Medi-Cal rates:
 - o PCP
 - o Specialists
 - o Hospitals
 - o LTC
 - o Ancillary Providers
8. Recommend auto-assignment policies for beneficiaries who do not select a Primary Care Provider.
9. Review and recommend provider incentive program structure.
10. Review investment strategy and make recommendations.

~~11. Evaluate CEO performance and bring forth to full governing board for action.~~

11. On an annual basis, develop the CEO review process and criteria.

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

13. Serve as the Nominating Committee for the purpose of confirmation of candidates for Chairperson and Vice Chairperson of the VCMMCC.

14. Assist the governing board and/or the CEO in determining the appropriate committee, if any, to best deal with questions or issues that may arise from time-to-time.

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

16. 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~~s~~ abstaining.

(d) A call for a point of order shall have precedence over all other motions on the floor.

(e) Without objection, the Chairperson may continue or withdraw any item. In the event of an objection, a motion to continue or reset an item must be passed by a majority of the members present. A motion to continue or reset an item shall take precedence over all other motions except for a point of order.

(f) An amendment to a motion must be germane to the subject of the motion, but it may not intend an action contrary to the motion. There may be an amendment to the motion and an amendment to an amendment, but no further amendments. In the event the maker of the original motion accepts the amendment(s), the original motion shall be deemed modified. In the event the maker of the original motion does not accept the amendment(s), the amendment(s) shall be voted separately and in reverse order of proposal.

(g) Where these Bylaws do not afford an adequate procedure in the conduct of a meeting, the Chairperson may defer to the most current edition of Robert's Rules of Order, to resolve parliamentary questions.

(h) 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.

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DRAFT
10/20/11

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

(dba Gold Coast Health Plan)

Table of Contents

ARTICLE I	3
Name and Mission	3
ARTICLE II	4
Commissioners	4
Selection and Terms of Commissioners	5
ARTICLE III	5
Officers	5
Election	6
Duties	6
ARTICLE IV	6
Standing Committees	6
ARTICLE V	9
Special Committees	9
ARTICLE VI	9
Meetings	9
Conduct of Meetings	10
ARTICLE VII	11
Powers and Duties	11
ARTICLE VIII	11
STAFF	11
Chief Executive Officer	12
Clerk	12
Assistant Clerk	12
ARTICLE IX	13
Rules of Order	13
ARTICLE X	13
Amendments	13
ARTICLE XI	13
Nondiscrimination Clause	13
ARTICLE XII	13
Conflict of Interest and Ethics	13
ARTICLE XIII	14
Dissolution	14

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.

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

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

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

ARTICLE III

Officers

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

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

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

Election

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

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

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

Duties

(a) The Chairperson shall:

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

(b) The Vice-Chairperson shall:

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

ARTICLE IV

Standing Committees

(a) At a minimum, the VCMMCC shall establish two (2) committees/advisory boards, one member/consumer based and one provider based. 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 its next regular meeting.

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

1. Chairperson
2. Vice-Chairperson
3. Private hospital/healthcare system representative (to rotate between the two representatives following the representative's resignation from the committee)
4. Ventura County Medical Center Health System representative
5. Clinicas Del Camino Real representative

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

If the private hospital/healthcare system representative, the Ventura County Medical Center Health System representative and/or the Clinicas Del Camino Real representative are also the Chairperson and/or Vice-Chairperson of the governing board, then, the other Commissioner who is a representative of the same constituency or organization as the Commissioner serving as Chairperson or Vice-Chairperson shall be appointed to the Executive/Finance Committee to fill that reserved seat. For example, if the Ventura County Medical Center Health System representative and the Clinicas Del Camino Real representative are also the Chairperson and Vice-Chairperson, respectively, of the governing board, then, the other Ventura County Medical Center Health System representative and the physician representative nominated by Clinicas Del Camino Real shall be appointed to fill the respective designated seat on the Executive/Finance Committee.

iii. Duties of the Executive/Finance Committee.

1. Advise the governing board Chairperson on requested matters.
2. Assist the CEO in the planning or presentation of items for governing board consideration.
3. Assist the CEO or VCMMCC staff in the initial review of draft policy statements requiring governing board approval.
4. Assist the CEO in the ongoing monitoring of economic performance by focusing on budgets for pre-operational and operational periods.

5. Review proposed State contracts and rates, once actuary has reviewed and made recommendations.
 6. Review proposed contracts for services over the assigned dollar value/limit of the CEO.
 7. Establish basic tenets for payment-provider class and levels as related to Medi-Cal rates:
 - o PCP
 - o Specialists
 - o Hospitals
 - o LTC
 - o Ancillary Providers
 8. Recommend auto-assignment policies for beneficiaries who do not select a Primary Care Provider.
 9. Review and recommend provider incentive program structure.
 10. Review investment strategy and make recommendations.
 11. On an annual basis, develop the CEO review process and criteria.
 12. Serve as Interview Committee for CEO/CMO/CFO.
 13. Serve as the Nominating Committee for the purpose of confirmation of candidates for Chairperson and Vice Chairperson of the VCMMCC.
 14. Assist the governing board and/or the CEO in determining the appropriate committee, if any, to best deal with questions or issues that may arise from time-to-time.
 15. Develop long-term and short-term business plans for review and approval by the governing board.
 16. 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 Robert'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.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid, CHIP and Survey & Certification

SEP 30 2011

AFil

Patrick Johnston
Chief Executive Officer
California Association of Health Plans
1415 L Street, Suite 850
Sacramento, CA 95814

Dear Mr. Johnston:

Thank you for your letter to Administrator Berwick regarding California's Assembly Bill (AB) 97 – Medicaid Provider Rate Reduction, Copayments and Service Caps that are outlined in the legal analysis included with your letter. We understand this is an area of concern among the health plans within your association and will provide feedback where appropriate. The Administrator has asked me to respond on his behalf.

Your attorney outlined several legal concerns regarding the implementation of the proposed managed care rate reduction including possible violations of Federal statute.

While the Centers for Medicare & Medicaid Services (CMS) agrees that the State would be out of compliance with Federal law to pay rates to managed care plans that are determined not to be actuarially sound, it remains to be seen whether any cuts resulting from a cap, as imposed in AB 97, would fall entirely outside the range of what an actuary might certify as actuarially sound. Therefore, if the rates proposed through AB 97 are certified by an actuary as meeting the requirements outlined in 42 CFR 438, CMS could approve those rates and provide Federal financial participation accordingly.

For any potential contract adherence issues or issues related to compliance with laws outside of the scope of CMS's review, the health plan will need to discuss those issues directly with the State.

We appreciate your comments regarding this issue and hope that this response addresses your concerns.

Sincerely,

Cindy Mann
Director

cc: Toby Douglas, Director, California Department of Health Care Services
Gloria Nagle, ARA, DMCHO, Region IX

Gold Coast Health Plan launches service for traveling farmworkers

Staff Reports

Tuesday, October 4, 2011

The Gold Coast Health Plan has arranged a way for Ventura County agricultural workers to get medical care when they travel to and from Monterey County for work, which is common for local farmworkers.

"This has been a long-standing problem for seasonal farmworkers, and I'm delighted with this solution," said Sandy Young, president of the Mixteco Indigena Community Organizing Project.

Anywhere from 500 to 1,000 farmworkers will benefit from this arrangement, according to Gold Coast, a locally run managed health care system designed to serve MediCal patients in Ventura County.

Seasonal farmworkers and their families have traditionally been unable to get or continue medical treatment as they travel county to county to go where the jobs are.

Gold Coast worked with the Ventura County Human Services Agency and the Central Alliance for Health in Monterey County and found five facilities in Monterey County where Gold Coast patients can get treatment. All of the health care facilities are what's known as federally qualified health centers.

"It's important that members have access not only to treat chronic conditions like diabetes and hypertension, but for well visits and preventive care," said Dr. Charles Cho, chief medical officer of the Gold Coast Health Plan.

Gold Coast is in the process of educating local farmworkers about the new arrangement.



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