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

DATE: Monday, February 28, 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 - January 24, 2011 Meeting**	*Action Required*
2.		**Accept and File CEO Update**	
	a.	Workplan Efforts / Go Live Date, etc.	*For Information*
	b.	Milestone Status Report	*For Information*
	c.	State Deliverable Status Report	*For Information*
3.		**Accept and File Financial Report**	
	a.	Updated Cash Flow	*For Information*
4.		**Management Recommendations**	
	a.	Procedure for Public Comment	*Action Required*
	b.	Credentialing Committee	*Action Required*
	c.	PCP Capitation Services List	*Action Required*
	d.	Medical Management System Selection	*Action Required*
	e.	Policy: Marketing Standards for Providers	*Action Required*

Comments from Commissioners

Adjourn

Meeting agenda available at http://www.vchca.org/financial-information/cohs.aspx

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT, IF YOU NEED SPECIAL ASSISTANCE TO PARTICIPATE IN THIS MEETING, PLEASE CONTACT TRACI AT 805/981-5320. REASONABLE ADVANCE NOTIFICATION OF THE NEED FOR ACCOMMODATION PRIOR TO THE MEETING (48 HOURS ADVANCE NOTICE IS PREFERABLE) WILL ENABLE US TO MAKE REASONABLE ARRANGEMENTS TO ENSURE ACCESSIBILITY TO THIS MEETING

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Commission Meeting Minutes
January 21, 2011
(Not official until approved)

CALL TO ORDER

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

1. ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
Maylee Berry, Medi-Cal Beneficiary Advocate (arrived at 3:05 p.m.)
Anil Chawla, MD, Clinicas del Camino Real, Inc.
Lanyard Dial, MD, Ventura County Medical Association
John Fankhauser, MD, Ventura County Medical Center Executive Committee (arrived at 3:05 p.m.)
Rick Jarvis, Private Hospitals / Healthcare System
Roberto S. Juarez, Clinicas del Camino Real, Inc.
Kathy Long, Ventura County Board of Supervisors
Tim Maurice, Private Hospitals / Healthcare System (arrived at 3:05 p.m.)
Michael Powers, Ventura County Health Care Agency
Catherine Rodriguez, Ventura County Medical Health System

STAFF IN ATTENDANCE
Earl Greenia, CEO
Tin Kin Lee, Legal Counsel (arrived at 3:20 p.m.)
Traci R. McGinley, Clerk of the Board
Charlie Cho, M.D., Interim Chief Medical Officer
Guillermo Gonzalez, Government Affairs Director
Darlane Johnsen, Interim Chief Financial Officer
Pamela Kapustay, RN, Health Services Director
Candice Limousin, Human Resources Director
Audra Lucas, Administrative Assistant
Paul Roberts, Provider Relations and Contracting Director
Lezli Stroh, Administrative Assistant

2. APPROVAL OF MINUTES – DECEMBER 20, 2010

Commissioner Long moved to approve the December 20, 2010 minutes, Commissioner Juarez seconded.

Commissioner Rodriguez requested clarification to Agenda Item #5, *Financial Report,* showing that that a correction had been made to the cash flow report, the final column "Total" was eliminated.

Commissioner Juarez and Powers stressed the importance of the minutes reflecting the Conflict of Interest clarification with regard to Legal Counsel Lee's Memorandum; Clinicas was not being singled out, it was merely being used as an example.

Commissioner Rodriguez moved to approve the December 20, 2010 minutes as amended, Commissioner Juarez seconded. The motion carried. **Approved 8-0**.

3. PUBLIC COMMENT / CORRESPONDENCE

Ramsey Ulrich, M.D., Ventura County Medical Center (VCMC) indicated that the doctors at the Clinics offer a full spectrum of care and the Clinic's mission is to provide care, whether the patient can pay or not. Last year the Clinic saw 45,000 patients, a large percentage of those are Medi-Cal and suffer from mental illness and / or substance abuse. The doctors also provide care at local schools; as well as, provide dental and dietitian services

Marco Benítes (through Translator Dora Montestiague of Lourdes González Campbell and Associates provided by GCHP), stated that he is interested in the care of older people. He added that only the doctors from the Health Department are attending the meetings. There may be better representation of the Hispanic or Mixteco community if the meetings were held after 6 p.m.

Reverend Ron Threatt requested the education, selection and enrollment processes information.

David Cruz, HELA, asked that the entire meetings be translated not just the speakers. The education of community needs to be a priority.

Rodolfo Alamillo (using Translator), stated that he needs to be informed for his father. He also requested that the entire meeting be translated and felt more people would come and we could benefit.

4. CEO UPDATE

(The CEO's report was translated by Dora Montestiague of Lourdes González Campbell and Associates). CEO Greenia introduced staff and individuals from local elected official's offices in attendance. In response to Reverend Threatt and Mr. Cruz's request for information, he replied that the information cannot be provided until approved by the State. Discussion was held regarding the processes of State notification and information being provided to beneficiaries.

CEO Greenia added that management's goal is to execute provider contracts by the end of the month. Discussion was held regarding the processing and determination of benefits under Medi-Cal through the Ventura County Human Services Agency.

No Commission action was required.

5. FINANCIAL REPORT

a. ACS Proposal

CEO Greenia advised the Commission that staff was working with ACS on a new proposal and would return to the Commission once that process was complete.

b. Updated Cash Flow

Interim CFO Johnsen explained that staff is working to spread out the payment of the medical management software over a six month period.

6. MANAGEMENT RECOMMENDATIONS

a. Procedure for Public Comment

After discussion, there was Commission consensus that this item be brought back for further review.

b. Provider Advisory Group

CEO Greenia advised the Commission that background information on the individuals was provided in the backup material. The goal was to have broad representation on the Group.

Commissioner Long moved to approve the members of the Provider Advisory Group, Commissioner Berry seconded. The motion carried. **Approved 7-1**, with Commissioner Juarez voting no.

Commissioner Juarez stated that he did not believe there should be County representation on the Group, Commissioners advised Commissioner Juarez that Ordinance No. 4409 calls for a County representative on the Provider Advisory Group.

7. COMMENTS FROM COMMISSIONERS

Discussion was held regarding capitation rates.

Public participation in Gold Coast Health Plan advisory committees was discussed. CEO Greenia stated that management is actively seeking representative for the Consumer Advisory Committee.

ADJOURN TO CLOSED SESSION - CMO AND CFO APPOINTMENT / SELECTION PROCESS

The Commission adjourned to Closed Session 3:26 p.m.

RETURN TO OPEN SESSION

The Regular Meeting reconvened at 4:40 p.m. with Commissioner Long and Powers absent. Chair Dial reported that the Commission had unanimously selected Darlane Johnsen as Chief Financial Officer and confirmed the search for the Chief Medical Officer was re-opened.

ADJOURNMENT

The meeting adjourned at 4:45 p.m.

AGENDA ITEM 2

Chief Executive's Monthly Report to Commission
February 28, 2011

62 Days until Go-Live!

PEOPLE (Organizational Structure)

- Since our last meeting, we have hired two provider relations representatives and hired a communications director as part of our senior management team. Steven Lalich is a seasoned communications professional and successful healthcare entrepreneur who has worked with a variety of healthcare brands. He ran SGL Consulting, a public relations and marketing communications consultancy, focused on branding and media outreach campaigns designed to maximize organizational goals. Previously, he held senior marketing and public relations positions at Ogilvy Public Relations Worldwide (where his clients included Amgen, Aradigm and Glaxo Smith Kline) and Baxter Bioscience.
- Our search for a Chief Medical Officer. We have received several resumes and are in the process of conducting screening interviews of qualified candidates.
- Tenant improvement, space planning and interior design continues to progress.
- Selected Lourdes Campbell, a certified interpreter, to attend Commission meetings and provide headsets and translation services for the Commission meetings.
- The procedure for Public Comment has been updated based on feedback during the last Commission meeting and is included in this month's agenda.

SERVICE (Member & Provider Satisfaction, Government Relations)

- Outreach and education efforts continue; some recent examples:
    - On January 31, we participated in a Spanish radio talk show (KOXR 910 AM) to inform the public about what GCHP is and how the COHS will be implemented.
    - On February 7, staff participated in another Spanish Radio talk-show (1590 AM) and provided information about GCHP in Spanish.
    - On February 1, staff attended the Community Network meeting at St. John's Hospital in Oxnard – these meetings are designed to facilitate the dissemination of information through community-based groups to the larger Oxnard and Ventura County population. Our team met with approximately 30 government and non-government agency representatives and answered questions about GCHP. Meeting participants were given a tri-fold handout that highlighted key facts about GCHP.
    - Staff met with David Rodriguez of the League of United Latin American Citizens (LULAC). Mr. Rodriguez expressed the importance of providing Medicaid Beneficiaries with sufficient opportunity to choose providers.
    - We provided briefings to Brian Miller (Congressman Gallegly's District Chief of Staff), Vanessa Hernandez (Congresswoman Capps' District Representative) and Oxnard

Councilman Timothy Flynn. We highlighted how Ventura County Medi-Cal beneficiaries will be served and how the COHS model improves quality and reduces cost.
    - On February 2nd and February 16th, we attended the Oxnard School District Board of Trustees meeting to correct some misunderstanding about the role of the plan. On February 16th the Ventura County Star published an edited version of our response to Mr. Denis O'Leary's letter-to-the-editor. Copies are included in this report.
    - On Saturday, February 26th we will attend the Health Fair-Community Outreach event at Thomas Aquinas Catholic Church in Ojai.
    - We will hold our first community town hall-style meeting on Wednesday, March 2d at 5:30 pm. At Freedom Center in Camarillo.
- Our Member Handbook, provider selection forms, and a Welcome Letter were submitted to the state for review. The Welcome Letter has been approved. We continue to update the Provider Directory as contracts are signed.
- Continue to make progress on identifying potential members for the Consumer Advisory Committee, various agencies and organizations (such as County Human Services Agency, Center of Aging and LULAC).
- Bids have been received from local radio stations for our radio-outreach campaign to inform our future members and the general public about GCHP.
- A policy addressing Provider Marketing efforts has been drafted and is included in this packet for Commission review and approval.
- Progress has been made in for the Claims Processing function; for example:
    - Benefits Configuration: 40% of the benefit categories have been addressed.
    - Content for Claims and Benefits sections of the Provider Manual and Member Handbook have been written.

QUALITY (Comprehensive Medical Management)

- It was learned at the last Commission meeting that the PCP Capitation Services list had not been finalized. Dr. Cho, through a series of one-on-one discussions with numerous physicians, revised and finalized that list. The list was accepted by the Executive/Finance Committee and is included in this packet for ratification by the Commission.
- Dr. Cho identified and screened many candidates for our Credentialing Committee and has recruited seven well-respected clinical experts from the community. That list is included in this packet for Commission consideration and approval.
- Management has reviewed several Medical Management systems and has identified a robust system that integrates various all care management programs to support a member's total health management needs. A summary of the process and systems is included in this packet.
- Efforts continue to recruit members for our QA/UR/Peer Review Committee.

ACCESS (Robust Provider Network)

Efforts continue to establish relations with interested providers; informing them of our plans and goals; addressing issues and concerns; interpreting contractual provisions; responding to their requests; etc. We continue to recruit providers for our network and negotiating Service Agreements with doctors and hospitals both in and out of our service area.

FINANCE (Optimize Rates, Ensure Long-Term Viability)
We continue to make good progress towards the target "go-live" date of May 1. To date, we have submitted approximately 98% of the state deliverables. The State DHCS will render a "go" or "no go" decision on or about March 7.

The week of February 21 was used as an operational checkpoint. We initiated an in-depth review and planning session for the major functions (Claims, Provider Services, Medical Management, Member Services, IT, Administration, and Finance). We identified external dependencies, quantified percentage of work completed and resulting outflows, and each unit's critical path. Each major operational area drilled down to the workflow detail level for each process required at go-live. Resourcing constraints were identified, as well as a number of key operational decision points that will require both GCHP and ACS follow up-prior to finalizing workflows. This detailed review has revealed that achieving the May 1 go-live date will be challenging – with little "wiggle room" for delays. Once we finalize workflows we will be able to determine if the go-live date needs to be adjusted.

For discussion purposes the projected cash-flow report does not account for payments from the State. This will allow for discussion of adjusting the go-live date.

There is an issue that may impact the state's decision on our proposed May 1 go-live date:

- On or about January 3, there was a telephonic conference with GCHP and DHCS staff. GCHP was tasked by DHCS to submit a business plan. There were ten components of that plan, Item 7 addressed, "Working Capital - Demonstrate that the working capital is adequate, including provisions for contingencies. In the event that the State has a Budget impasse and is unable to pay contractors for the initial 2-4 months of the 20011-12 State fiscal year, demonstrate the Plan's ability to fulfill the obligations under the contract during this period of a potential budget impasse."
- The GCHP business plan was submitted to DHCS on February 8. For item 7, we responded that insufficient cash flow would be managed by delaying payment to vendors and providers. We also included a letter from our bank confirming that State-issued warrants would be honored.
- On February 23, DHCS initiated a follow-up conference call to discuss GCHP's business plan. DHCS informed us that delaying payments to providers was not permitted and that the bank's commitment to honor warrants was not sufficient. DHCS advised that GCHP must have access to $48 million (approximately two months of revenue) – this could be satisfied via a line of credit with a commercial lender or a guaranty from the County. On February 24, DHCS sent a letter (included in this packet) via e-mail summarizing their concerns and establishing a response deadline of February 28.
- On February 24, GCHP requested DHCS (via e-mail) to provide specific section citation of the Patient Protection and Affordable Care Act (PPACA) relating to provider payment requirements and the statute or regulation for cash on hand / access to funds requirements.
- On February 25, GCHP initiated a call with State Controller John Chiang and staff to discuss the situation and possible alternatives. State Controller Office (SCO) staff stated that Medi-Cal payments to providers are a priority. Providers under the Medi-Cal program fall under three general categories: institutional providers, non-institutional providers and vendors. In the

absence of an extreme state fiscal crisis, non-institutional providers receive payment regardless of a state budget impasse; however, institutional providers would not necessarily receive timely payment from the state, rather these providers would be issued “registered warrants” or IOUs. SCO said they would need to determine and research as to what category a county organized health system such as GCHP would fall under i.e. institutional vs. non institutional provider.

Respectfully submitted,

Earl G. Greenia
Chief Executive Officer

GOLD COAST HEALTH PLAN		Go-Live Milestones	Updated: 25 February 2011		
		Action Steps	Due Date	Status	%
1	**Establish COHS**		---	**Completed**	**100%**
2	**Establish Governance**		---	**Completed**	**100%**
3	**Establish Management Structure**				
	3.1	Secure planning/development funding	---	**Completed**	**100%**
	3.2	Execute Staffing Plan	4/30/2011	In process	**40%**
	3.3	Develop Facilities Plan; Negotiate Lease	---	**Completed**	**100%**
	3.4	Acquire/Install furniture & equipment	4/30/2011	In process	**90%**
	3.5	Tenant Improvements	4/30/2011	In process	**95%**
4	**Key DHCS Deliverables**				
	4.1	Review Medi-Cal volume and payment data	---	**Completed**	**100%**
	4.2	Submit Required Policies/Documentation	3/4/2011	In process	**98%**
	4.3	DHCS Contract: rate negotiation, contract execution	1/31/2011	In process	**75%**
5	**Financial Resources Management**				
	5.1	Review/Negotiate Vendor Contracts	1/31/2011	In process	**70%**
	5.2	Develop Investment and Risk Management Policies/Strategies	1/31/2011	In process	**75%**
	5.3	Establish Banking Relationship	---	**Completed**	**100%**
	5.4	Review/Select Accounting System	---	**Completed**	**100%**
	5.5	Develop/Implement Financial Systems	3/4/2011	In process	**25%**
	5.6	Develop Provider Compensation Arrangements	1/21/2011	In process	**85%**
6	**Member Services**				
	6.1	Assess Language/Cultural Needs & Capabilities	2/15/2011	In process	**75%**
	6.2	Establish relationships with community and social service agencies	4/30/2011	In process	**50%**
	6.3	Medi-Cal Field Office Transition Planning	2/15/2011	In process	**50%**
	6.4	Establish Consumer Advisory Committee	3/1/2011	In process	**60%**
	6.5	Develop/Implement Community / Member Outreach Plan	4/30/2011	In process	**50%**
	6.6	Create Member Enrollment / Provider Directory / Welcome Package	2/15/2011	In process	**95%**
7	**Provider Network Development**				
	7.1	Develop Provider Network Strategy	---	**Completed**	**100%**
	7.2	Develop Standard Provider Contract & Reimbursement Templates	---	**Completed**	**100%**
	7.3	Develop Credentialing Process and Tools	1/21/2011	In process	**75%**
	7.4	Execute Provider Contracts	2/18/2011	In process	**60%**
	7.5	Create Provider Manual; Obtain DHCS Approval	3/4/2011	In process	**70%**
	7.6	Conduct provider orientation meetings and workshops	4/15/2011		**0%**
8	**Medical Management Operations**				
	8.1	Develop Quality Management & Assurance Programs	2/15/2011	In process	**95%**
	8.2	Evaluate/Select Medical Management System	1/31/2011	In process	**95%**
	8.3	Establish Provider Advisory Committee and Peer Review Structure	2/28/2011	In process	**80%**
	8.4	Develop Process/Tools for Facility Site Reviews	1/31/2011	In process	**90%**
	8.5	Establish MOUs with Public Health and Service agencies	1/31/2011	In process	**60%**
	8.6	Establish Drug Formulary & Protocols	2/18/2011	In process	**60%**
	8.7	Conduct Primary Care Facility Site Reviews	3/6/2011		**0%**
	8.8	Develop Health Education Programs	2/15/2011	In process	**95%**
	8.9	Develop Case Management / Utilization Management Programs	2/15/2011	In process	**95%**
	8.10	Management of Carved-Out Services	1/31/2011	In process	**50%**
9	**Claims Management & IT Operations**				
	9.1	IT System Development, Testing & Implementation	3/15/2011	In process	**25%**
	9.1.1	- Eligibility Verification system	3/15/2011	In process	**30%**
	9.1.2	- Member Benefits System Configuration	3/15/2011	In process	**40%**
	9.1.3	- Provider Database / Payment System Configuration	3/15/2011	In process	**25%**
	9.1.4	- Data Loads	3/15/2011	In process	**10%**
	9.2	Data Warehouse Implementation	3/15/2011	In process	**10%**
	9.3	ACS Staff Selection, Hiring & Training	3/15/2011	In process	**20%**
	9.4	Call Center Implementation	3/1/2011	In process	**20%**
	9.5	Develop/Implement Vendor Oversight Program	3/15/2011	In process	**45%**

Overall Target is 80% by March 1st and 100% by April 30

Deliverable Number	Description	GCHP Status	DHCSStatus
1. Organization and Administration of Plan			
1.A	Submit documentation of employees (current and former State employees) who may present a conflict of interest.	**Completed**	**Approved**
1.B	Submit a complete organizational chart.	**Completed**	**Approved**
1.C	Submit the following information reflecting current operation status:	**Completed**	**Approved**
	1. Type of Organization (Corporation, Partnership, Sole Proprietor, Public Agency, or Other Organization)		
	2. Individual Information Sheet on each natural person identified above.		
	3. Contracts with Affiliated person, Principal Creditors and Providers of Administrative Services		
	4. Other Controlling Persons.		
	5. Contractor shall demonstrate compliance with requirements of Title 22, CCR, Sections 53874 and 53600. Identify any individual named in item b. above that was an employee of the State of California in the past 12 months. Describe their job position and function while a State employee.		
1.D	Submit Contracts for Administrative Services.	**Completed**	**Approved**
2. Financial Information			
2.A	Submit most recent audited annual financial reports.	**Completed**	**Approved**
2.B	Submit quarterly financial statements with the most recent quarter prior to execution of the Contract.	Submitted 01/27/2011	In Review
2.C	Submit the following documentation reflecting Projected Financial Viability:	Submitted 02/07/2011	In Review
	1)Projected financial statements reflecting actual and projected changes which have, or which are expected to occur between the date of the most recent financial statements and the date to begin operations in the expanded area. 2)Projected financial statements as of the close of each month during initial period of operations, and as of the close of each quarter for the following year, in the expanded area. 3)In addition, include projected Medi-Cal enrollment for each month and cumulative Member months for quarterly financial projections.		
2.D	Submit Provision for Extraordinary Losses. Include the following:	Submitted 02/01/2011	AIR
	1) Evidence of adequate insurance coverage or self-insurance to respond to claims for damages arising out of furnishing health care services		
	2) Evidence of adequate insurance coverage or self-insurance to respond to claims for other tort claims		
	3) Evidence of adequate insurance coverage or self-insurance to protect Contractor against losses of facilities upon which it has the risk of loss due to fire or other causes.		
	4) Evidence of fidelity bond coverage in the form of a primary commercial blanket bond or a blanket position bond written by an insurer licensed by the California Insurance Commissioner		
	5) Evidence of adequate workmen's compensation insurance coverage		
2.E	Describe any risk sharing or incentive arrangements. Explain any intent to enter into a stop loss option with DHCS. Also describe any reinsurance and risk-sharing arrangements with any subcontractors shown in this Proposal. Submit copies of all policies and agreements. For regulations related to Assumption of Financial Risk and Reinsurance, see Title 22, CCR, Sections 53863 and 53868.	**Completed**	**Approved**
2.F	Fiscal Arrangements: Submit documentation reflecting current operation status related to:	Submitted 02/07/2011	In Review
	1) Maintenance of Financial Viability		
	2) Capitation Payments to Providers		
	3) Risk of Insolvency		
	Describe systems for ensuring that subcontractors who are at risk for providing services to Medi-Cal Members, as well as any obligations or requirements delegated pursuant to a subcontract, have the administrative and financial capacity to meet its contractual obligations.		
2.G		Submitted 02/03/2011	In Review
2.H	Submit financial policies that relate to Contractor's systems for budgeting and operations forecasting. The policies should include comparison of actual operations to budgeted operations, timelines used in the budgetary process, number of years prospective forecasting is performed, and variance analysis and follow-up procedures.	Submitted 01/19/11	**Approved**
2.I	Submit policies and procedures for a system to evaluate and monitor the financial viability of all subcontracting entities.	Submitted 02/03/2011	In Review
3. Management Information System			
3.A	Submit a completed MCO Baseline Assessment Form.	Submitted 01/13/11	In Review
3.B	When procuring a new MIS or modifying a current system, provide a detailed implementation plan that includes:	Resubmitted 01/24/2011	In Review
	1) Outline of the tasks required; 2) The major milestones; 3) The responsible party for all related tasks.		
	4) A full description of the acquisition of software and hardware, including the schedule for implementation;		
	5) Full documentation of support for software and hardware by the manufacturer or other contracted party;		
	6) System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results;		
	7) Documentation of system changes related to pending HIPAA requirements.		
	8) An Encounter data test produced from real or dummy data processed by the MIS must be submitted. Required for monthly encounter submissions.		
	9) Submit a detailed description of the proposed and/or existing MIS as it relates to the following subsystems:		

Deliverable Number	Description	GCHP Status	DHCSStatus
	a) Financial b) Member/Eligibility c) Provider d) Encounter/Claims e) Quality Management/Utilization		
	10) Submit a sample and description of the following reports generated by the MIS:		
	a) Member roster b) Provider Listing c) Capitation payments d) Cost and Utilization		
	e) System edits/audits f) Claims payment status/processing g) Quality Assurance h) Utilization		
	i) Monitoring of Complaints		
3.C	Submit a detailed description of how Contractor will monitor the flow of encounter data from provider level to the organization.	Submitted 01/19/2011	In Review
3.D	Submit policies and procedures for the complete, accurate, and timely submission of Encounter-level data.	Submitted 01/20/2011	In Review
3.E	Submit the data security, backup, or other data disaster processes used in the event of a MIS failure.	Submitted 01/20/11	In Review
4.Quality Improvement System			
4.A	Submit a written description of the QIS, including:	**Completed**	**Approved**
	1) A flow chart and/or organization chart identifying all components of the QIS and who is involved and responsible for each activity		
	2) A description of the responsibility of the Governing Body in the QIS		
	3) A description of the QI Committee including membership, activities, roles and responsibilities		
	4) A description of how providers will be kept informed of the written QIS, its activities and outcomes		
	5) A description of how Plan reports any disease or condition to public health authorities.		
4.B	Submit policies and procedures related to the delegation of the QIS activities.	**Completed**	**Approved**
4.C	Submit boilerplate subcontract language showing accountability of delegated QIS functions and responsibilities.	Resubmitted 02/03/2011	In Review
4.D	Policies and procedures to address how the Contractor will meet the requirements of:	Submitted 01/20/2011	In Review
	1) External Accountability Set (EAS) Performance Measures		
	2) Quality Improvement Projects		
	3) Consumer Satisfaction Survey		
4.E	Submit policies and procedures for performance of Primary Care Provider site reviews.	Submitted 02/11/2011	In Review
4.F	Submit a list of sites to be reviewed prior to initiating plan operation, existing or in expanded areas.	Submitted 02/22/2011	In Review
4.G	Submit the aggregate results of pre-operational, existing or in expanded areas site review to DHCS at least six (6) weeks prior to Plan operation. The aggregate results shall include all data elements defined by DHCS.	**Not Submitted**	
4.H	Submit policies and procedures for credentialing and re-credentialing.	Submitted 01/31/2011	AIR
5. Utilization Management			
5.A	Submit written description of UM program that describes appropriate processes to be used to review and approve the provision of medical services. Include:	Resubmitted 01/27/2011	In Review
	1) Procedures for pre-authorization, concurrent review, and retrospective review		
	2) A list of services requiring prior authorization and the utilization review criteria		
	3) Procedures for the utilization review appeals process for providers and members		
	4) Procedures that specify timeframes for medical authorization		
	5) Procedures to detect both under- and over-utilization of health care services.		
5.B	Submit policies and procedures showing how delegated activities will be regularly evaluated for compliance with Contract requirements and, that any issues identified through the UM program are appropriately resolved, and that UM activities are properly documented and reported.	Submitted 02/03/2011	In Review
6. Provider Network			
6.A	Submit complete provider network that is adequate to provide required Covered Services for Members in Service Area.	Submitted 02/17/2011	In Review
6.B	Submit policies and procedures describing how Contractor will monitor provider to patient ratios to ensure they are within specified standards.	**Completed**	**Approved**
6.C	Submit policies and procedures regarding physician supervision of non-physician medical practitioners.	**Completed**	**Approved**
6.D	Submit policies and procedures for providing emergency services.	**Completed**	**Approved**
6.E	Submit a complete list of specialists by type within the Contractor's network.	Submitted 02/15/2011	In Review
6.F	Submit policies and procedures for how Contractor will meet Federal requirements for access and reimbursement for in-Network and/or out-of-Network FQHC services.	**Completed**	**Approved**
6.G	Submit a GeoAccess report (or similar) showing that the proposed provider network meets the appropriate time and distance standards set forth in the Contract.	Submitted 02/15/2011	AIR
6.H	Submit a policy regarding the availability of a health plan or contracting physician 24-hours a day, 7-days a week, and procedures for communicating with emergency room personnel.	Submitted 02/01/2011	In Review
6.I	Submit a report containing the names of all subcontracting provider groups.	Submitted 02/15/2011	In Review
6.J	Submit an analysis demonstrating the ability of the Contractor's provider network to meet the ethnic, cultural, and linguistic needs of the Contractor's Members.	**Completed**	**Approved**
6.K	Submit all boilerplate subcontracts, signature page of all subcontracts and reimbursement rates.	Submitted 01/10/11	**Approved**
6.L	Submit policies and procedures that establish Traditional and Safety-Net Provider participation standards.	**Completed**	**Approved**
7. Provider Relations			

Deliverable Number	Description	GCHP Status	DHCSStatus
7.A	Submit policies and procedures for provider grievances.	Resubmitted 02/11/2011	In Review
7.B	Submit protocols for payment and communication with non-contracting providers.	**Completed**	**Approved**
7.C	Submit copy of provider manual.	**Not Submitted**	
8. Provider Compensation Arrangements			
8.A	Submit description of any physician incentive plans.	**Completed**	**Approved**
8.B	Submit policies and procedures for processing and payment of claims.	Submitted 01/10/11	In Review
8.C	Submit excerpt from the Provider Manual that describes the prohibition of a claim or demand for services provided under the Medi-Cal managed care contract, to any Medi-Cal member.	Submitted 01/31/2011	In Review
8.D	Submit Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Service Facilities subcontracts.	Submitted 02/14/2011	In Review
8.E	Submit Policies and Procedures for the reimbursement of non-contracting Certified Nurse Midwives and Certified Nurse Practitioners.	Submitted 02/02/2011	In Review
	Submit schedule of per diem rates and/or Fee-for-service rates for each of the following provider types;		
8.F		**Not Submitted**	
	1) Primary Care Providers		
	2) Medical Groups and Independent Practice Associations		
	3) Specialists		
	4) Hospitals		
	5) Pharmacies		
9. Access and Availability			
9.A	Submit policies and procedures that include standards for:	Resubmitted 02/07/2011	In Review
	1) Appointment scheduling		
	2) Routine specialty referral		
	3) First prenatal visit		
	4) Waiting times		
	5) Urgent care		
	6) After-hours calls		
	7) Specialty services		
9.B	Submit policies and procedures for the timely referral and coordination of Covered Service to which the Contractor or subcontractor has objections to perform or otherwise support.	Submitted 01/10/11	AIR
9.C	Submit policies and procedures for standing referrals.	**Completed**	**Approved**
9.D	Submit policies and procedures regarding 24-hr./day access without prior authorization, follow-up and coordination of emergency care services.	Resubmitted 01/20/2011	In Review
9.E	Submit policies and procedures regarding access to Nurse Midwives and Nurse Practitioners.	**Completed**	**Approved**
9.F	Submit policies and procedures regarding access for disabled members pursuant to the Americans with Disabilities Act of 1990.	**Completed**	**Approved**
9.G	Submit policies and procedures regarding Contractor and subcontractor compliance with the Civil Rights Act of 1964.	**Completed**	**Approved**
9.H	Submit a written description of the Cultural and Linguistic Services Program. Include:	**Completed**	**Approved**
	1) Policies and procedures for providing cultural competency, sensitivity or diversity training for staff, providers, and subcontractors		
	2) Policies and procedures for monitoring and evaluation of the Cultural and Linguistic Services Program.		
9.I	Submit policies and procedures for the provision of 24-hour interpreter services at all provider sites.	**Completed**	**Approved**
10. Scope of Service			
10.A	Submit policies and procedures for providing Initial Health Assessments (IHA) and Individual Health Education Behavioral Assessment (IHEBA).	Submitted 01/31/2011	In Review
10.B	Submit policies and procedures, including standards, for the provision of the following services for Members under Twenty-One (21) years of age:	Submitted 01/25/2011	In Review
	1) Preventive services;		
	2) Immunizations;		
	3) Blood Lead screens;		
	4) Screening for Chlamydia;		
	5) EPSDT supplemental services.		
10.C	Submit policies and procedures for the provision of adult preventive services, including immunization.	Submitted 02/03/2011	In Review
10.D	Submit policies and procedures for the provision of services to pregnant Members, including:	Submitted 02/07/2011	In Review
	1) Prenatal care;		
	2) Use of American College of Obstetricians and Gynecologists (ACOG) standards and guidelines;		
	3) Comprehensive risk assessment tool for all pregnant Members;		
	4) Referral to specialists.		
10.E	Submit a list of appropriate hospitals available within the provider network that provide necessary high-risk pregnancy services.	**Completed**	**Approved**
10.F	Provide a detailed description of health education system including policies and procedures which address:	Submitted 01/31/2011	In Review

Deliverable Number	Description	GCHP Status	DHCSStatus
	1) Administration and oversight of the Health Education System		
	2) Delivery of Health Education Programs, Services and Resources		
	3) Evaluation and Monitoring of the Health Education System		
	4) Submit a timeline and work plan for the development and performance of a Group Needs Assessment that shall be completed within 12 months of the startup of operations for each county within the contractor's service area.		
10.G	Provide a list and schedule of all health education programs (including classes) that are provided either directly or via subcontract by the plan.	Submitted 02/22/2011	In Review
10.H	Submit policies and procedures for the provision of:	Resubmitted 02/01/2011	In Review
	1) Hospice care		
	2) Vision care – Lenses		
	3) Mental health services		
	4) Tuberculosis services		
10.I	Submit standards and guidelines for the provision of Pharmaceutical services and prescribed Drugs.	Submitted 01/27/2011	In Review
10.J	Submit a complete drug formulary.	Submitted 02/03/2011	In Review
10.K	Submit a process for review of drug formulary.	Submitted 02/03/2011	In Review
10.L	Submit policies and procedures for conducting drug utilization reviews.	Submitted 02/03/2011	In Review
11. Case Management and Coordination of Care			
11.A	Submit procedures for monitoring the coordination of care provided to Members.	Submitted 01/25/2011	In Review
11.B	Submit policies and procedures for coordinating care of Members who are receiving services from a targeted case management provider.	Resubmitted 02/11/2011	In Review
11.C	Submit policies and procedures for the referral of Members under the age of 21 years that require case management services.	Submitted 02/4/2011	In Review
11.D	Submit policies and procedures for a disease management program. Include policies and procedures for identification and referral of Members eligible to participate in the disease management program.	**Completed**	**Approved**
11.E	Submit policies and procedures for referral and coordination of care for Members in need of Specialty Mental Health Services from the local Medi-Cal mental health plan or other community resources.	Submitted 01/25/2011	In Review
11.F	Submit policies and procedures for resolving disputes between Contractor and the local mental health plan.	Submitted 01/27/2011	In Review
11.G	Submit policies and procedures for identification, referral and coordination of care for Members requiring alcohol or substance abuse treatment services from both within and, if necessary, outside the Contractor's Service Area.	Submitted 01/20/2011	In Review
11.H	Submit a detailed description of Contractor's program for Children with Special Health Care Needs (CSHCN).	Submitted 02/04/2011	In Review
11.I	Submit policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program.	Submitted 01/27/2011	AIR
11.J	Submit policies and procedures for the identification, referral and coordination of care for Members with developmental disabilities in need of non-medical services from the local Regional Center and the DDS-administered Home and Community Based Waiver program.	Resubmitted 02/11/2011	In Review
11.K	Submit policies and procedures for the identification, referral and coordination of care for Members at risk of developmental delay and eligible to receive services from the local Early Start program.	Submitted 01/20/2011	In Review
11.L	Submit policies and procedures for case management coordination of care of LEA services, including primary care physician involvement in the development of the Member's Individual Education Plan or Individual Family Service Plan.	Submitted 01/20/2011	In Review
11.M	Submit policies and procedures for case management coordination of care of Members who receive services through local school districts or school sites.	Submitted 01/20/2011	In Review
11.N	Submit a description of the subcontracts or other cooperative arrangements Contractor has with the local school districts, including the subcontracts or written protocols/guidelines, if applicable.	**Completed**	**Approved**
11.O	Submit policies and procedures describing the cooperative arrangement that Contractor has regarding care for children in Foster Care.	**Completed**	**Approved**
11.P	Submit policies and procedures for identification and referral of Members eligible to participate in the HIV/AIDS Home and Community Based Waiver Program.	**Completed**	**Approved**
11.Q	Submit policies and procedures for the provision of dental screening and covered medical services related to dental services.	Submitted 01/25/2011	In Review
11.R	Submit policies and procedures for coordination of care and case management of Members with the LHD TB Control Officer.	Submitted 01/27/2011	AIR
11.S	Submit policies and procedures for the assessment and referral of Members with active TB and at risk of non-compliance with TB drug therapy to the LHD.	Submitted 01/27/2011	AIR
11.T	Procedures to identify and refer eligible Members for WIC services.	**Completed**	**Approved**
11.U	Submit policies and procedures for assisting Members eligible for the following services:	Resubmitted 02/01/2011	In Review
	1) Long-term care		
	2) Major organ transplants		
	3) Federal Medicaid Waiver programs		
12. Local Health Department Coordination			

Deliverable Number	Description	GCHP Status	DHCSStatus
12.A	Submit executed subcontracts or documentation substantiating Contractor's efforts to enter into subcontracts with the LHD for the following public health services:	Submitted 02/17/2011	In Review
	1) Family planning services;		
	2) STD services;		
	3) HIV testing and counseling;		
	4) Immunizations.		
12.B	Submit executed subcontracts, Memoranda of Understanding, or documentation substantiating Contractor's efforts to negotiate an agreement with the following programs or agencies:	Submitted 02/17/2011	In Review
	1) California Children Services (CCS);		
	2) Maternal and Child Health;		
	3) Child Health and Disability Prevention Program (CHDP);		
	4) Tuberculosis Direct Observed Therapy;		
	5) Women, Infants, and Children Supplemental Nutrition Program (WIC);		
	6) Regional centers for services for persons with developmental disabilities.		
12.C	Executed MOU or documentation substantiating Contractor's efforts to negotiate a MOU with the local mental health plan.	Submitted 02/17/2011	In Review
13. Member Services			
13.A	Submit policies and procedures that address Member's rights and responsibilities. Include method for communicating them to both Members and providers.	Resubmitted 02/15/2011	In Review
13.B	Submit policies and procedures for addressing advance directives.	**Completed**	**Approved**
13.C	Submit policies and procedures for the training of Member Services staff.	**Completed**	**Approved**
13.D	Submit policies and procedures regarding the development, content and distribution of information to Members. Address appropriate reading level and translation of materials.	**Completed**	**Approved**
13.E	Submit final draft of Member Identification Card and Member Services Guide (Evidence of Coverage and Disclosure Form).	Submitted 02/17/2011	In Review
13.F	Submit policies and procedures for Member selection of a primary care physician or non-physician medical practitioner.	**Completed**	**Approved**
13.G	Submit policies and procedures for Member assignment to a primary care physician.	Resubmitted 02/07/2011	**Approved**
13.H	Submit policies and procedures for notifying primary care provider that a member has selected or been assigned to the provider within 15-days.	**Completed**	**Approved**
13.I	Submit policies and procedures demonstrating how, upon entry into the Contractor's network, the relationship between traditional and safety-net providers and their patients is not disrupted, to the maximum extent possible	**Completed**	**Approved**
13.J	Submit policies and procedures for notifying Members for denial, deferral, or modification of requests for Prior Authorization.	**Completed**	**Approved**
14. Member Grievance System			
14.A	Submit policies and procedures relating to Contractor's Member Grievance System.	**Completed**	**Approved**
14.B	Submit policies and procedures for Contractor's oversight of the Member Grievance System for the receipts, processing and distribution including the expedited review of grievances. Please include a flow chart to demonstrate the process.	**Completed**	**Approved**
14.C	Submit format for Quarterly Grievance Log and Report.	**Completed**	**Approved**
15. Marketing			
15.A	Submit Contractor's marketing plan, including training program and certification of marketing representatives.	**Completed**	**Approved**
15.B	Submit copy of boilerplate request form used to obtain DHCS approval of participation in a marketing event.	**Completed**	**Approved**
16. Enrollments and Disenrollments			
16.A	Submit policies and procedures for how Contractor will assign Members to Primary Care Physicians or a Subcontracting Health Plan.	Submitted 01/13/2011	AIR
17. Confidentiality of Medical Information			
17.A	Submit policies addressing Member's rights to confidentiality of medical information. Include procedures for release of medical information.	**Completed**	**Approved**
18. Health Insurance Portability and Accountability Act (HIPAA)			
18.A	Submit policies and procedures for compliance with the Health Insurance Portability and Accountability Act of 1996.	**Completed**	**Approved**

Total Deliverables	112	
Approved	**45**	**40.2%**
Submitted to DHCS / Under Review	**56**	**50.0%**
Submitted to DHCS / Addtl Info Requested	**8**	**7.1%**
In Process / Not Submitted	**3**	**2.7%**

Gold Coast Health Plan℠
A Public Entity

February 2, 2011

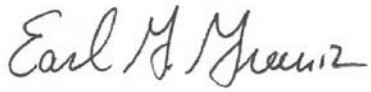
Oxnard School District
Board of Trustees

Public Comment
Agenda Item D1: Resolution #10-22, Support the Choice of Medical Services by Oxnard School District Parents

Thank you for the opportunity to provide comment on this proposed resolution. Unfortunately, there have been some misunderstandings concerning Gold Coast Health Plan. For the record, I offer these important facts to your Board to address these misunderstandings:

- Gold Coast Health Plan (GCHP) is not a County agency. While we were created by a County Ordinance as well as Federal legislation, we are a separate public entity, governed by an independent Commission.
- GCHP is fully committed to providing our members with choice of provider.
- GCHP is committed to enhancing healthcare services provided to the MediCal beneficiaries of Ventura County.
- GCHP is committed to enhancing access to healthcare.
- GCHP recognizes the importance of the patient-physician relationship.
- GCHP members will be given full opportunity to select their provider.
- GCHP is developing a comprehensive, bilingual outreach campaign to ensure that members understand the enrollment process.
- GCHP is actively working with established safety net providers and is committed to working with any provider that desires to serve the MediCal population.
- GCHP cannot recommend or endorse any particular MediCal provider.

Respectfully submitted,



Earl G. Greenia, Ph.D.
Chief Executive Officer

2220 E. Gonzales Road, Suite 200, Oxnard, CA 93036
Phone (805) 981-5320

Gold Coast Health Plan℠
A Public Entity

February 16, 2011

Oxnard School District
Board of Trustees

Public Comment
Resolution #10-22
Support the Choice of Medical Services by Oxnard School District Parents

Thank you for the opportunity to again provide comment on this proposed resolution. Let me make it clear that GCHP has no position on this resolution – we are neutral - we do not oppose this resolution nor can we endorse it. I again offer some key points about GCHP:

- Gold Coast Health Plan is a public entity, separate from the County, governed by an independent Commission.
- GCHP is **not** a "for profit" organization.
- GCHP is committed to enhancing healthcare services for MediCal beneficiaries.
- GCHP is committed to enhancing access to healthcare.
- There are many providers and organizations in our community who provide affordable and accessible medical services to the disadvantaged populations.
- Our goal is to be inclusive – GCHP continues to actively work with established safety net providers as well as other providers that serve or desire to serve the MediCal population.
- Enhancing access means enhancing choice.
- GCHP Members will have complete freedom of choice when selecting their primary care provider.
- However, GCHP cannot recommend or endorse any particular MediCal provider over any other provider.

Respectfully submitted,

Earl G. Greenia, Ph.D.
Chief Executive Officer

2220 E. Gonzales Road, Suite 200, Oxnard, CA 93036
Phone (805) 981-5320

Ventura County Star

Gold Coast Health Plan
Posted February 15, 2011 at 10:12 a.m.

Re: Denis O'Leary's Jan. 17 commentary, "Families, clinics deserve fairness"

First and foremost, Gold Coast Health Plan (GCHP) is committed to ensuring that MediCal beneficiaries of Ventura County receive quality healthcare services. We are also committed to enhancing their access to healthcare.

Members will have freedom to choose their primary care provider. It is correct that if a member fails to select a provider in a timely manner, that member will be assigned to a provider based on a state-approved policy. Keep in mind, members will be able to change providers. It is important to note that GCHP is planning a comprehensive outreach campaign to educate members about this important responsibility.

We recognize the importance of maintaining established patient-physician relationships. To that end, we are committed to working with any provider in our community that desires to serve the MediCal population. However, GCHP cannot recommend or endorse any particular MediCal provider. Further, GCHP will not "dictate" rates and services, but rather negotiate these (subject to State MediCal requirements) with any provider willing to enter into a contract and serve MediCal beneficiaries.

On the issue of conflict-of-interest, no commissioner was asked to recuse him/herself. The topic was broadly discussed and an example was highlighted. The attorney representing GCHP cited some specific areas regarding contracts with providers, in which commissioners may need to recuse him/herself. Like other County Organized Health System Commissions throughout the State, ours is comprised of safety net providers - nearly all of which, at some point, could have a conflict of interest. There already have been voluntary recusals by Commissioners for certain votes in which there was a potential or perceived conflict of interest.

Earl G. Greenia
Chief Executive Officer
Gold Coast Health Plan
Oxnard

http://www.vcstar.com/news/2011/feb/15/gold-coast-health-plan/#ixzz1Ez51YWRP

Gold Coast Health Plan **AGENDA ITEM 3 A**
Cash Flow Projection- Preoperational Period
Revised 2/28/2011

	January	February	March	April	May	June	July	August	September
Cumulative Enrollment	0	0	0	0	0	0	0	0	0
Total Staff	12	18	22	36	37	37	37	37	37
Incremental Staff Increase	3	6	4	14	1	0	0	0	0
Beginning Cash Balance	**443,102**	**324,077**	**331,737**	**136,983**	**642,715**	**312,333**	**(126,019)**	**(562,747)**	**(999,474)**
Cash In-Flow									
Revenue from State									
ACS - LOC*		265,000	395,000	980,000					
Total Receipts	**-**	**265,000**	**395,000**	**980,000**	**-**	**-**	**-**	**-**	**-**
Cash Out-Flows									
Salaries & Benefits	33,192	114,520	148,996	181,204	232,068	362,946	362,946	362,946	362,946
Other Benefits		19,300	25,000	5,000	5,000	5,000	5,000	5,000	5,000
Consultants	6,450	3,025	3,025	2,000	2,000	2,000	2,000	2,000	2,000
Consultants - FSR			13,000	13,000					
Other Professional Services									
RGS Fees*			3,234	4,624	7,224	9,842	9,842	9,842	9,842
Occupancy Office Lease			14,640	14,640	14,640	14,640	14,640	14,640	14,640
Furniture & Equipment	13,385	30,372	1,000						
Computers, Monitors, Printers (Non- Capitalized)	595	9,819	9,132	4,800	16,800	1,200	-	-	-
Computer Equipment (Capitalized)		19,301							
Telecommunications Equipment	3,355	1,081	2,550	1,700	5,950	425	-	-	-
General Liability Insurance									
Info Systems - License Fees	38,700	11,600	5,100	5,100	5,100	5,100	5,100	5,100	5,100
Info Systems (Depreciation)									
Info Systems - Software					-				
Info Systems - Maintenance & Expenses		104							
Pharmacy Mgt Expense									
Travel & Entertainment		519	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Supplies	4,461	7,178	10,800	13,200	21,600	22,200	22,200	22,200	22,200
Phone/Internet									
ACS Fees									
Printing outsourcer			105,000						
Printing			209,000	2,500	2,500	2,500	2,500	2,500	2,500
Postage		-	-	210,000	3,000	3,000	3,000	3,000	3,000
Prof Liab, D&O Insurance									
Errors & Ommisssions Insurance			20,000						
Legal fees	2,996	11,200	3,000	3,000	3,000	3,000	3,000	3,000	3,000
Actuary fees	14,600	27,528	15,000	12,000	10,000	5,000	5,000	5,000	5,000
Audit fees									
Miscellaneous Operating Fees	1,291	1,793	277	500	500	500	500	500	500
Sub Total Administrative Expense	**119,025**	**257,340**	**589,754**	**474,268**	**330,382**	**438,353**	**436,728**	**436,728**	**436,728**
ENDING CASH BALANCE	**324,077**	**331,737**	**136,983**	**642,715**	**312,333**	**(126,019)**	**(562,747)**	**(999,474)**	**(1,436,202)**

LOC Draws are based on the following assumptions:

March - assumes 100% of deliverables will have been sent to the state (phase 1 @ 200K) and Provider Network is set up (phase 2 @ 15%)
April - assumes code, build and configuration will be completed (phase 2 @ 10%), Assumes Contract has been Signed (phase 1 @ $200K) and testing has been completed (phase 2 @ 20%)
Also assumes ACS will provide final payment for implementation once the DHCS provides the plan with approval of it's "go live" status.

State of California-Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

February 23, 2011

Mr. Earl G. Greenia
Chief Executive Officer
Gold Coast Health Plan
2220 East Gonzales Road, Suite 200
Oxnard, CA 93036

RE: Financial Deliverables

Dear Mr. Greenia,

The Department of Health Care Services (DHCS) is currently in the process of reviewing the deliverables recently submitted by Gold Coast Health Plan (GCHP). In order to complete our assessment of GCHP's current and projected financial condition, DHCS will require GCHP to provide clarification on the following:

1. The business plan submitted by GCHP indicates that provider payments may be delayed in the event of a budget impasse. Please note that all payments to providers must be in accordance with the Patient Protection and Affordable Care Act (PPACA). Please state how GCHP intends to comply with the PPACA with respect to the provider payments delays noted in the business plan.

2. DHCS typically requires that start-up plans have sufficient cash on hand or access to a funds either through an irrevocable county guaranty or a line of credit equal to two months capitation. In recent years, the State Budget has not been approved by July 1. Please state how GCHP intends to fund administrative and medical operations if:

   - A one month budget impasse occurs;
   - A two month budget impasse occurs;
   - A three month budget impasse occurs;
   - A four month budget impasse occurs.

   Please be specific as to the actual funding resources the plan will have access to effective May 1, 2011.

3. Please describe in detail the basis for the lag assumptions submitted with the business plan; the explanation should be on a category of service basis.

Medi-Cal Managed Care Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

4. After the first year of operations, GCHP's Incurred But Not Reported (IBNR) estimated claims liability is higher than the current County Organized Health Systems and the majority of Medi-Cal managed care plans in the Two-Plan and Geographic Managed Care models. Please provide a detailed description of the assumptions used for the IBNR calculation provided with the business plan..

5. The assumption of a 4.8% rate increase from DHCS for each of the two years following the initial year of operation is overly aggressive given the Budget uncertainties in California. This is a significant assumption and may not be attainable. Please describe the steps that GCHP will implement in the event that DHCS does not increase the rates at the level assumed and how it will impact the projected income statement, balance sheet, and tangible net equity calculations.

Given that the GCHP is scheduled to commence operations effective May 1, 2011, it is imperative that a written response is provided no later than the close of business on February 28, 2011. Please send the written response to the attention of:

Javier Portela, Chief
Plan Management Branch
Medi-Cal Managed Care Division
1501 Capitol Avenue, MS 4408
P.O. Box 997413
Sacramento, CA 95899-7413

If you have any questions regarding these requests, feel free to contact Calvin Oshiro, Chief of the Fiscal Monitoring Unit at 916-449-5237 or calvin.oshiro@dhcs.ca.gov.

Sincerely,

Anthony Hipolito, CPA
Chief of the Policy and Financial Management Branch
Medi-Cal Managed Care Division

AGENDA ITEM 4 A

To: Ventura County Medi-Cal Managed Care Commission

From: Earl Greenia, CEO

Date: February 28, 2011

Re: Procedure for Public Comment at Meetings

Recommendation: That the Commission approve the proposed policy / process for receiving Public Comment and Input.

Background: As a public entity all GCHP meetings are subject to the Brown Act. With regard to public comment / input at GCHP meetings, section 54954.3a of the Brown Act states that every agenda for regular meetings shall provide an opportunity for members of the public to directly address the Commission on any matter under the Commission's jurisdiction. However, Section 54954.2 of the Brown Act states that the agenda need not provide an opportunity to members of the public to address the Commission on any item that has already been considered by a committee composed exclusively of members of the Commission. Specifically, at a public meeting where members of the public were afforded the opportunity to address the committee on the item, before or during the committee's consideration of the item, unless the item has been substantially changed since the committee heard the item.

The following is Management's Recommendation for receiving public input and comment at public meetings.

Proposed Policy:
Anyone wishing to speak or provide written testimony during public comment on a particular item will be requested to complete a "Request to Speak" form (which may be located on the counter and are available in English and Spanish). Request to Speak Forms must be turned in prior to the public comment portion of the meeting.

The public comment period will generally be early in the agenda. The chair will have the discretion to recognize and allow members of the public to provide additional comments once the public comment period has closed. Comments will be limited to three (3) minutes. Speakers will be alerted when they have one (1) minute remaining and when their time is up. Speakers will then asked to return to their seats and no further comments will be permitted.

Remarks from those seated or standing in other parts of the room will not be permitted. All those wishing to speak, including Commission / Committee Members and Staff need to be recognized by the Chair before speaking.

Under provisions of the Brown Act, the Commission / Committee is prohibited from taking action on items not on the agenda. Also, in accordance with State Law, remarks during public comment are to be limited to topics within the Commission's / Committee's jurisdiction.

AGENDA ITEM 4 B

To: Ventura County Medi-Cal Managed Care Commission

From: Earl Greenia, CEO

Date: February 28, 2011

Re: Credentialing Committee

Recommendation: Management requests that the Commission appoint the Credentialing Committee as recommended below.

Background: On April 26, 2010, the Commission established parameters for the Credentialing Committee. The committee will consist of a minimum of 8 voting members, appointed by the Commission and representative of the composition of the contracted provider network. Each of the appointed members serves a two-year term and may reapply for additional terms, as there are no term limits. Chaired by the Chief Medical Officer, the committee includes physicians from major disciplines, including primary care and specialty practices. The committee has the option of inviting additional specialists, if necessary, to review case records, either in writing or in person. Participants are bound by confidentiality and conflict of interest rules.

Discussion: Dr. Cho identified and screened many candidates for our Credentialing Committee, with the goal to recruit well-respected clinical experts from the community. We have identified seven members:

1) **Miguel Cervantes, M.D. Family Medicine**
   UCLA School of Medicine: M.D., 1988
   VCMC Family Practice Residency: 1988 – 1991
   VCMC Family Practice Faculty: 1991 to Present
   VCMC Chief of Staff: 7/2003 to 6/2004
   Las Islas Family Medical Group: Medical Director: 1991 to Present

2) **John Fankhauser, M.D. Family Medicine**
   University of Washington School of Medicine: M.D., 1989
   VCMC Family Practice Residency: 1990 – 1993
   UCLA Assistant Clinical Professor in Family Medicine: 2004 to Present
   Medical Director VCMC and Santa Paula Hospitals From 2007 to Present

3) **Stanley Frochzwajg, M.D. Family Medicine**
   UC Irvine College of Medicine: M.D., 1977
   VCMC Family Practice Residency: 1977 - 1980
   Private Practice in Ventura since 1981
   VCMC Chief of Staff - 1995
   CMH Chief of Staff – 2006
   CMH Chief Medical Officer since 2008

Ventura County Medical Association President - 2011

4) Eugene Fussell, M.D. Orthopedic Surgeon

Meharry Medical College, Nashville, TN: M.D. 1964
Chief of Orthopedic Surgery at U.S. Naval Hospital, San Diego, CA 1970-1972
Private Practice in Oxnard: 1972 – 2000
VP/Chief Medical Officer, St. John's Regional Medical Center: 2001 to Date

5) John Keats, M.D. Obstetrics-Gynecology

Brown University: M.D.
UCLA Medical Center for Obstetrics and Gynecology Residency: 1978 - 1982
Medical Director of Buenaventura Medical Group for 10 years
California Health First Physicians, President & Medical Director, 2007 to Date

6) Richard Reisman, M.D. Obstetrics-Gynecology

Emory University Medical School, Atlanta, GA: M.D. 1974
UCLA Residency in Obstetrics and Gynecology: 1974-1978
Private Practice of OB-GYN in Ventura and Oxnard since 1978
Since 1993 various administrative duties at CMH including Medical Director from 1999-2003; VP for the Center for Family Health 2008-January 2010, and VP for Ambulatory Medicine since January 2010.

7) Guillermo Rios-Rios, M.D. Pediatrics

School of Medicine Universidad Autonoma de Guadalajara, Mexico: 1979-1982
Puerto Rico University Pediatric Program, PL-1 Pediatric Resident, 07/92 – 06/93
Saint Mary's Hospital PL-II and PL-III Pediatric Resident; Yale University Pediatric Program B, Waterbury Hospital: 07/95 – 11/95
Clinicas del Camino Real: 1995 to Present

AGENDA ITEM 4 C

Primary Care Physician - Scope of Capitated Services

The services listed in this Attachment are included in your monthly Member capitation payment. You are expected to provide these services to your Member Patients as deemed medically appropriate. In the event that a Primary Care Physician needs to provide Covered Services that fall outside this list, the PCP should 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 PCP 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
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.

AGENDA ITEM 4 D

To: Gold Coast Health Plan Executive / Finance Committee

From: Earl Greenia, CEO

Date: February 9, 2011

Re: Purchase Medical Management System

Recommendation: That the Committee recommend to the Commission the authorization for management to proceed with contracting for a Medical Management system.

Background: A robust Medical Management system provides a clinical platform that supports the integration of all care management programs to support a member's total health management needs.

How It Works:

- Utilizes leading edge capabilities
- Starts with data from comprehensive member and provider profiles
- Applies insights on consumer and provider engagement
- Connects members to the interventions most likely to change behaviors
- Allows the nurse/coach to efficiently monitor member needs

What It Does:

- Leverages information, insights, and tools to facilitate integrated clinical management activities for members and providers
- Optimizes engagement strategies based on member risk and impact for successful engagement
- Fosters long-term relationship management across member's needs

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

Gold Coast Health Plan℠
A Public Entity

	ACS/Care and Quality Solutions (CQS)	MEDecision/Alineo	Altruista Health/Comprehensive Care Solutions
Pricing	ACS system and staffing @ membership of 100,000 = $1,140,000 annually (includes implementation, 10 seats, licenses, no fees until go-live) $0.11 PMPM for reporting	$ 0.33 PMPM including implementation Gold Coast Staffing $801,400 Reporting suite and reporting - additional fee	Implementation $ 225,000 Annual Fees $ 310,000 Gold Coast Staffing $ 801,400 Year one $1,336,400 Recurring $ 951,400 Reporting fee additional fee
Functionality	Analytics engine has reporting for utilization management decisions Includes Milliman Care and Chronic Care Guidelines for Care Management and Ingenix symmetry for predictive modeling. Integration will be managed by ACS System migration to CH Mack over the next 2 years	Analytics engine – Business Objects Includes Milliman Care and Chronic Care Guidelines for Care Management and Thompson Reuters Groupers, DXCG predictive modeling tool	Strong reporting engine with reports that can be shared on the web with physician providers Requires that Gold Coast manage integration of applications
Current Installation and Utilization sites	Kentucky, Missouri, Indiana Medicaid, high-risk pools, and commercial plans nation-wide	8 Blues plans; 2 TPAs; 4 Qualis plans; 3 KePro plans and 6 additional health plans	Presence in California Medicaid sites currently
Staffing Options	ACS will provide CM/UM staffing and system for a minimum period of 2 years. After 2 years GCHP has the option to maintain current system but staff internal. One of 4 URAC accredited total solution companies nation-wide in CM, UM, and DM	No staffing alternative available	Provided through Comprehensive Care Solutions (in-and out-patient UM, concurrent review and discharge planning, CM, 24/7 nurseline, “safety net” population experience, and patient education

Pros and Cons

	Go with a New Build	Go with ACS/CQS System
Pros	Control over types of modules to be included	Speed to implementation – "out of the box" solution already tried and tested and being used in other similar Medicaid settings
	Control over delivery of customized requests	Implementation and integration of multiple systems handled by ACS
	Control over when to update core system	Maintenance issues handled by ACS
	Marketing advantages for services not offered by others	Advantage of already engaged, trained CQS CM/UM staff
		Advantage of ACS' analysis of 11 medical management systems leading to CH Mack selection and planned migration going forward
		Input in the development phase of CH Mack system for ACS
Cons	Resources to build are limited and may be pulled for other projects with higher priority	Limited control over types of modules to be included - if not already offered as part of standard features
	Cost of build	Control over delivery of customized requests
	Time required to build	Control over when to update core system
	Time needed to recruit, acquire and train CM/UM staff	Control over whether or not to include new functionality as an update on our schedule vs ACS/CQS decision and schedule
	Response to issues may be slow depending on priority by overall client base	Resources may not be available for custom coding from the vendor
	If we control updates this usually creates issues when core systems are updated without testing of customizations	

Gold Coast Health Plan	**Policies and Procedures**
Title: Marketing Standards for Providers /// D R A F T ///	**Policy Number: 15.C**

Purpose

To establish marketing standards for GCHP's health networks, physicians, and service providers.

Policy

Marketing Activities directed towards GCHP Members by any contracted health network, physician, or Service Provider must adhere to the standards defined in this policy. This policy also defines activities that are exempt from the definition of Marketing Activities and are not subject to prior approval.

If a health network, physician, or service provider engages in marketing activities in violation of this policy, it may be subject to sanctions under the terms of this policy or the Contract with Gold Coast Health Plan.

Nothing in this policy shall affect a Health Network, physician, or service provider's obligation to communicate with GCHP or a Member pursuant to contractual, statutory, regulatory, or GCHP policy requirements.

Definitions

Contract: Any written instrument between GCHP and physicians, hospitals, health maintenance organizations (HMOs), or other entities.

Contracted Membership: For a Health Network, Contracted Membership shall mean the Members enrolled in such Health Network. For a physician or Service Provider, Contracted Membership shall mean the Members who receive Covered Services from such physician or Service Provider.

Covered Services: Those services set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, which are included as Covered Services under GCHP's contract with the Department of Health Care Services (DHCS) and medically necessary as described in the Contract for Health Care Services.

Health Network: A physician-hospital consortia or health care service plan that contracts with GCHP to arrange for the provision of Covered Services to Members assigned to that Health Network.

Marketing Activities: Any product or activity intended to encourage retention of or an increase in Contracted Membership or any occasion during which Marketing Materials are presented to Members or persons who may become Members through verbal exchanges or the distribution of Marketing Materials. Marketing Activities may include, but are not limited to: health fairs, workshops on health

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promotion, after school programs, raffles, informational sessions hosted by Service Providers, or community-based social gatherings.

Marketing Materials: Any information or product that is intended for distribution, designed to encourage retention of or an increase in Contracted Membership, and is produced in a variety of print, broadcast, or direct marketing media that include, but are not limited to: radio, television, telephone, internet, billboards, newspapers, flyers, leaflets, informational brochures, videos, advertisements, letters, posters, and items of nominal value.

Member: A Medi-Cal eligible beneficiary enrolled in the GCHP program.

Service Provider: Any person or entity, other than a physician, that provides Covered Services to Members.

Procedure

A. Activities Not Considered Marketing Activities

The following are not considered to be Marketing Activities for the purposes of this policy:

1. Communication from a Health Network, physician, or Service Provider to a Member regarding clinical matters, including health education and wellness promotion;
2. Communication from a Health Network or physician to any Member who requests information or materials regarding a physician's Health Network affiliations; and
3. Communication from a physician to existing patients who are Members to notify them if and when the physician has changed Health Network affiliations or the location at which he or she provides Covered Services.

B. Marketing Standards.

All Marketing Materials and Marketing Activities shall meet the following standards:

1. Materials may not contain false, misleading, or ambiguous information.
2. Materials must address only the benefits, services, and performance of the Health Network, physician, or Service Provider proposing the materials.
3. Materials may not include representations that specifically identify or establish comparison to any competitor of the Health Network, physician, or Service Provider;
4. Materials may not include the GCHP name or logo or make any reference to GCHP unless prior written approval has been granted by GCHP.

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5. Materials may not include any statements that discriminate on the basis of race, creed, age, sex, religion, national origin, marital status, sexual orientation, physical or mental handicap, or health status; and
6. Materials should be at a sixth (6th) grade reading level or lower;
7. Materials should use a twelve (12) point type or larger.
8. Written Materials shall be made available in English and Spanish.
9. All Spanish-language marketing materials should be reviewed by a certified translator/interpreter.
10. Materials will identify the month and year on which they were last updated; the source of any representations, endorsements, or awards referred to; and the entity responsible for producing the Marketing Materials.

C. Approval of Marketing Activities and Marketing Materials

1. If a Health Network, physician, or Service Provider seeks to use Marketing Materials or engage in Marketing Activities, it shall submit documentation relating to such Marketing Materials and Marketing Activities to GCHP's Provider Relations Department for review and approval no later than thirty (30) calendar days prior to the date on which it intends to engage in the Marketing Activities or use the Marketing Materials. A Health Network, physician, or Service Provider shall submit such documentation to the following address:

   Gold Coast Health Plan
   Suite 200
   2220 East Gonzales Road
   Oxnard, CA 93036

2. GCHP will review the proposed Marketing Materials or Marketing Activities no later than ten (10) working days after receipt.

   a. If GCHP approves the Marketing Materials or Marketing Activities, it shall send a notice to the Health Network, physician, or Service Provider within ten (10) working days.
   b. If GCHP objects to the proposed Marketing Materials or Marketing Activities, it shall send a notice to the Health Network, physician, or Service Provider that describes its objection in detail within ten (10) working days after receipt.
      1) The Health Network, physician, or Service Provider may resubmit revisions of the Marketing Materials or Marketing Activities and all applicable translations to GCHP's Public Affairs Department within five (5) working days after receipt of the notice from GCHP.

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2) GCHP shall review and respond to the resubmitted materials within five (5) working days after receipt.

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D. Prohibited Activities.

A Health Network, physician, or Service Provider may not:

1. Offer or suggest the receipt of a financial or other incentive, bonus, or award to a Member for enrolling in a Health Network or receiving Covered Services from a physician or Service Provider;
2. Offer a financial or other incentive, bonus, or award to a Member or any other person for referring or encouraging others to enroll in a Health Network or obtain Covered Services from a physician or Service Provider;
3. Pay an organization, individual, or other entity for the purpose of referring Members for enrollment in a Health Network or referring Member to obtain Covered Services from a physician or Service Provider;
4. Purchase, acquire, or use mailing lists of Members, except a Health Network, physician, or Service Provider use of a list of its Contracted Membership for purposes otherwise allowable under this policy;
5. Use raffle tickets, event attendance logs, or sign-in sheets in order to develop mailing lists
6. Engage in face-to-face Marketing Activities without prior written approval from GCHP;
7. Engage in door-to-door Marketing Activities;
8. Engage in unsolicited telephone contact with a Member for the purpose of retaining or increasing Contract Membership;
9. Use logos or other identifying information used by a government or public agency, including GCHP, if such use could imply or cause confusion about a connection, affiliation, or endorsement by the governmental or public agency for the Health Network, physician, or Service Provider;
10. Use the term “free” in reference to Covered Services;
11. Discriminate based upon health status, the need for future health care, or a real or perceived disability; and
12. Engage in any activity that constitutes a violation of applicable state or federal laws governing communications between persons or entities and Members regarding a Member's enrollment in the GCHP program or a Health Network.

E. Failure to Comply

A Health Network, physician, or Service Provider may be subject to sanctions for:

1. Engaging in Marketing Activities or uses Marketing Materials that GCHP's Public Affairs Department has not approved in accordance with Section IV.C of this policy; or

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2. Engaging in activities that are prohibited as set forth in Section IV.D of this policy.

Sanctions may include financial sanctions, immediate suspension of use of all Marketing Materials for a period not to exceed six (6) months, imposition of an enrollment or membership cap, or Contract termination.

Revision History:

Review Date	Revised Date	Approved By