

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

DATE: Monday, August 22, 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 – July 25, 2011 Meeting** *Action Required*
2. **Accept and File Management Update** *For Information*
3. **Accept and File Financial Report** *For Information*
4. **Management Recommendations & Reports**
 - a. Adult Day Health Care Program Elimination *For Discussion*
 - b. Commission Bylaws *Action Required*
 - c. Co-Payment Policy *Action Required*
 - d. Auto-Assignment *For Discussion*

Comments from Commissioners

Adjourn to Closed Session

CLOSED SESSION: GC § 54957 - CEO Performance Evaluation

Return to Open Meeting / Adjournment

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

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
(VCOMMCC) dba Gold Coast Health Plan (GCHP)
Commission Meeting Minutes
July 25, 2011**

(Not official until approved)

CALL TO ORDER

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

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE

Maylee Berry, Medi-Cal Beneficiary Advocate

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

Lanyard Dial, MD, Ventura County Medical Association

Laurie Eberst, RN, Private Hospitals / Healthcare System

John Fankhauser, MD, Ventura County Medical Center Executive Committee

Robert Gonzalez, MD, Ventura County Health Care Agency

Rick Jarvis, Private Hospitals / Healthcare System

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

Kathy Long, Ventura County Board of Supervisors

Catherine Rodriguez, Ventura County Medical Health System

EXCUSED / ABSENT COMMISSIONERS

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

STAFF IN ATTENDANCE

Earl Greenia, CEO

Tin Kin Lee, Legal Counsel

Traci R. McGinley, Clerk of the Board

Charlie Cho, MD, Chief Medical Officer

Andre Galvan, Project Management Specialist

Lupe Gonzalez, Health Educator

Darlane Johnsen, Chief Financial Officer

Steven Lalich, Communications Director

Candice Limousin, Human Resources Director

Audra Lucas, Administrative Assistant

Aimee Sziklai, Operations Director

Paul Roberts, Provider Relations and Contracting Director

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

PUBLIC COMMENT / CORRESPONDENCE

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

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

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

1. APPROVAL OF MINUTES – JUNE 27, 2011

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

2. ACCEPT AND FILE MANAGEMENT UPDATE

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

3. ACCEPT AND FILE FINANCIAL REPORT

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

4. MANAGEMENT RECOMMENDATIONS

a. Commission Bylaws

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

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

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

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

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

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

b. Co-Payment Policy

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

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

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

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

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

c. Conflict of Interest

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

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

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

d. Auto-Assignment

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

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

COMMENTS FROM COMMISSIONERS

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

ADJOURNMENT

The meeting adjourned at 4:52 p.m.



**Chief Executive's Monthly Report to Commission
August 22, 2011**

I open this report by thanking those who have assisted with the transition from fee-for-service to managed care. This is an exciting and challenging time! There is no doubt that the change has created confusion and anxiety for our members, providers and the community. This report highlights some of those challenges and the team's response.

PEOPLE (Organizational Structure)

- We have added additional talent to our team:
 - Pharmacy Director: Dina Atalla-Mikhail,
 - Provider Relations Representative: Kathleen Garner.
- Recruitment and selection is accelerating for: Sr. Claims Auditor, Sr. Financial Analyst, Compliance Specialist and a QI Specialist
- We initiated additional office moves to realign space and office allocations given the growth in headcount. We anticipate seeking additional space in near future to accommodate growth.

SERVICE (Member & Provider Satisfaction, Government Affairs)

Community Outreach & Education

- Community outreach, education, marketing and advertising continued in August:
 - We sponsored and attended the Mixteco/Indígena Community Organizing Project's (MICOP) gala event celebrating their tenth anniversary.
 - We made a presentation to various Intermediate Care Facilities.
 - Facilitated a training and outreach meeting with approximately 65 Ventura County Human Service Agency Medi-Cal Eligibility Workers regarding GCHP policies & procedures. Discussion focused on changing primary care physicians, appeals, out-of-area coverage, and continuum of care.
- We are formulating the second phase of a strategic market buy of radio and television time with our advertising vendor Gold Coast Broadcasting, LLC.
- The JVP Group has initiated Phase 1 of our website redesign.

Government Affairs

- Attached to this update is a listing of the various State reporting requirements – highlighting the intense level of government oversight and regulation.

- Staff attended conference calls and meetings with the Department of Health Care Services to discuss the elimination of the Adult Day Health Care benefit from the Medi-Cal Program effective December 1, 2011 (See separate memo in this packet).
- We have designed and distributed a survey instrument to assess knowledge and attitudes of our Consumer Advisory Committee members regarding the State's proposed Medi-Cal co-payments. The results of the survey will be presented to the Commission at a future meeting.

Member Services

- Attached to this update is a "Thank You" note from a member.
- For those members who have made changes to their PCP selection or assignment, updated ID cards are being mailed out on a weekly basis.
- Effective September 1, when a member selects a new PCP, the change will take effect the first calendar day of the following month, in accordance with our policy. As a courtesy to both members and providers, we waived the effective date policy for both July and August; i.e., the change was made retro-active to July 1.
- We have received reports from providers that members have sought care from their customary provider only to discover that they were auto-assigned to a different provider. There have also been reports that members selected a PCP and later discovered that the PCP was changed to a different provider. In reviewing the issue we learned that the State, without providing any notice, changed the format of the daily eligibility file, which created the error. ACS reversed the erroneous changes; there will be no negative effect on provider capitation payments. One particular provider has submitted approximately 60 change requests – GCHP is working with ACS to ensure that all requests are addressed quickly.
- Member Services continues to refine the "Frequently Asked Questions" document that is used to educate, train and coach call center staff.

Cultural and Linguistic Services

- GCHP has established a Cultural and Linguistic workgroup and held our first meeting on July 27. They are developing a work plan that will be presented to the Consumer Advisory Committee for review and approval. In addition, staff is working with the Greater Los Angeles Agency on Deafness Program in Ventura County, to assess the needs of GCHP members that are deaf and/or hearing impaired.
- We received reports that Spanish-speaking members were experiencing delays ranging from 20 to 45 minutes when calling the Call Center. A review of high-level call-center data was reassuringly positive; for example: average time to answer a call was 6 seconds, average hold time 39.6 seconds, and average "talk time" 8.90 minutes. ACS was asked to review the complaint. ACS tasked their Spanish-speaking quality auditor to test the call center and Spanish lines throughout the day for a week to better

understand the issues. It was discovered that when someone calls into the English line (either in error or after an English-speaking person finishes their inquiry and hands the phone back to a Spanish-speaking member) there can be a delay in transferring the call to a Spanish-speaking agent. However, with this transfer process, the caller is not returned to queue and it is not possible to track calls and delays. Currently, ACS has 13 agents who speak Spanish and is recruiting for four more. There are times when call-volume significantly increases; for example, after the recent release of member identification cards. In response to surge volume, additional staff, often from the quality and supervisory team, are temporarily re-tasked to assist.

- GCHP staff worked with MICOP to train seven bilingual (Mixtec-Spanish) health educators and community outreach workers, including two from the Ventura County Human Services Agency to assist Mixteco families complete and return their GCHP/PCP selection forms accurately and on a timely basis. These individuals were stationed at various health clinics and community and public sites throughout South Oxnard and Ventura. Together, these health educators and community outreach workers assisted over 3,500 indigenous families and individuals complete and submit their PCP selection forms.
- During our extensive outreach efforts, we became aware of the transient nature of Mixteco/Indigena community which creates gaps in their Medi-Cal coverage. While migrating north to Santa Cruz and Monterey Counties becomes the seasonal norm, it comes at the cost of vacating their Ventura County medical home. Chronic medical conditions, like hypertension and diabetes that were effectively managed by GCHP's provider network, rapidly declined when treatment stopped as Members followed the crop to new jurisdictions and couldn't find providers willing to accept their Medi-Cal benefit. Working with MICOP, the Ventura County Human Services Agency and the Central California Alliance for Health—a County Organized Health System (COHS) in Monterey County—we determined that the best way to remedy this problem was to direct our Members to Federally Qualified Health Centers in Monterey County. With the help of our sister COHS, we identified five facilities where our members can seek care when traveling outside Ventura County. GCHP has begun the process of reaching-out to those facilities to execute agreements, as well as working with MICOP to educate their community. Additionally, our members will be allowed to utilize their pharmacy benefit with contracted pharmacy providers in Monterey County. GCHP has notified our Pharmacy Benefit Manager (PBM) Script Care, LTD, to "turn on" the wrap-around agreement contained within their contract with Monterey County pharmacies.

QUALITY (Comprehensive Medical Management)

- Since go-live, the Health Services team has been addressing issues related to the continuation and transition of care.
- In our first two months of operation we received a significant number of prior-authorization requests, coupled with the time involved in building the interfaces

between three different systems, a backlog was anticipated. To ensure that care was not delayed, GCHP initially adopted a policy of “blanket” authorization for all preauthorization requests for July. We now expect the interfaces to be completed by the end of August, and have extended the blanket authorization policy through August.

- Our Health Educator continues to coordinate services for members accessing perinatal services through St. John’s Healthy Beginnings Program.
- September is Diabetes Awareness Month. Our Health Educator will participate in several community collaborative projects to promote nutrition, physical activity, and lifestyle changes.
- Analysis of pharmacy utilization data for our first month revealed that significantly fewer prescriptions were filled than expected and the expense was modestly lower than projected. We will continue to closely monitor this area.

ACCESS (Robust Provider Network)

- Efforts continue to expand the provider network; particularly for special medical professionals and facilities needed for our Developmentally Disabled and Developmentally Delayed beneficiaries (Long Term Care Facilities and Intermediate Care Facilities in Ventura County and out-of-area; dental surgeon and mobile anesthesiologist services unique to this population)
- Staff continues to resolve providers’ concerns associated with special programs and benefits issues. We regularly execute special “one-patient-only” provider agreements with out-of-area and non-contracted providers as required for continuity of care issues.
- Given the complex nature of Medi-Cal vision care benefits, we are in the process of soliciting competitive bids from various vendors (with Knox-Keene licenses) to administer this program. We are developing a tool to ensure formal, objective evaluation of all bids. Once this process is completed, and we have narrowed the number of finalists, a formal management recommendation will be presented to the Commission for consideration.
- We encountered challenges in securing contracts with major anesthesiology groups. One hospital system assisted with the resolution via an innovative four-party arrangement. The hospital system entered into a contract with the anesthesiologist group to provide the service; the hospital system, in turn, contracted with GCHP. The anesthesia claims are prepared and submitted to GCHP by an independent billing company.

FINANCE (Optimize Rates, Ensure Long-Term Viability)

- Staff worked with ACS onsite at their facilities in Lexington, KY and Indianapolis, IN to assist with additional training and oversight for our front line staff. We continue to make great strides in closing gaps within our operations and operational platforms, from both a functional and technical perspective. For example:
 - Enhancements to our Provider Portal to provide greater ease of use

- Enhancement of electronic funds transfer and electronic remittance advice capabilities to reduce paper and provide better efficiencies for our providers.
- Our Claims Department added a full time Auditor and now has two full time Claims Auditors and a full time Provider Grievance Specialist. The Auditors are responsible for oversight and monitoring ACS claims processing performance, adjudication quality review and compliance.
- We have developed a comprehensive Claims Inventory and Reconciliation Report which includes tracking all claims from receipts of claims through the payment cycle.
- ACS Claims Department successfully addressed challenges with provider claims submissions where the provider identifiers did not match information loaded in the system which caused a temporary delay in claims processing.
- We issued our first provider payment within two days of receiving payment from the State on August 8. Since that time, there have been at least six check runs, including the first capitation payment to providers scheduled for August 19.
- Through July and to date, ACS successfully worked through the State financial and member eligibility (FAME) file challenges despite lack of documentation and test data from the State. The eligibility information is current through early August.
- We closed the books for the first year of operations. Unaudited Financial Statements are included in this packet.
- An analysis of the impact of proposed co-payments is also included in this packet.
- Preliminary data-points for July:
 - Membership (including August retroactivity): 102,033
 - Revenue: \$25.2 Million (includes a \$700K receivable)
 - Payment Received: \$24.5 Million
 - Healthcare Costs: \$20.5 Million
 - Approximately \$7.8 million paid in claims and capitation through 08/19
- Staff is developing reports to analyze revenue and healthcare costs, and modeling the impact of potential legislative changes (provider rate decrease, co-pays etc.).

Respectfully submitted,

Earl G. Greenia
Chief Executive Officer

Report/Document	Reviewer	Frequency	Date Expected				Contract Section	
Formulary Report	Pharm. Director	Annual	7/30				Exhibit A – Attachment 10	
MOU Report (As required, per language- if required)	CM	Quarterly	11/30	2/28	5/30	8/30	Exhibit A – Attachment 12	
Member Services Guide/EOC	CM/MMJ/MRP IU	Annual	7/30				Exhibit A – Attachment 13	
Call Center Report	MRPIU	Quarterly	11/30	2/28	5/30	8/30	Exhibit A – Attachment 13	
Grievance Log/Report	MRPIU/PMU	Quarterly	11/30	2/28	5/30	8/30	Exhibit A – Attachment 14	
Cost Avoidance & Post-Payment Recovery of Other Health Care Svcs.	ITSD	Within 10 days of discovery	As necessary				Exhibit E – Attachment 2	
Termination of Contract	CM	180 days prior to termination	As necessary				Exhibit E – Attachment 2	
Fraud and Abuse	MRPIU	Within 10 days of discovery	As necessary				Exhibit E – Attachment 2	
Notification of Dispute	Contracting Officer	Within 15 days of dispute	As necessary				Exhibit E – Attachment 2	
Prohibition of external disclosures of lists of beneficiaries	CM	Annual (& within 30days of contract start date)	7/30				Exhibit G – Section 2.C	
Notification of Breach	Privacy Office	Within 24 Hours of Suspected or Actual Breach	As necessary				Exhibit G – Section 3.6.H	
Policies & Procedures (All Medi-Cal Related P&P's)*	CM/Other Applicable Unit(s)	Preceding implementation or revision	monthly					
Commission Meeting Minutes	CM	Monthly	8/30	9/30	10/30	11/30	8/30	J J U L
Member Newsletter	CM	Quarterly	11/30				8/30	
Board Packets	CM	Monthly	AUG	SEP	OCT			J J U L
Provider Directory	CM	Every 6 mos.	1/30	7/30				

PLAN REPORTING REQUIREMENTS (Contract)

Report/Document	Reviewer	Frequency	Date Expected	Contract Section
Organizational Chart	CM	Upon Request	Quarterly 11/30 (Q1) 2/28 (Q2) 5/30 (Q3) 8/30 (Q4)	Multiple Sections
Key Personnel (Disclosure Form)	CM	Annual	7/30	Exhibit A – Attachment 1
Medical Director Change	MPS/MMU/ Clerical	Within 10 Calendar Days	As Required	Exhibit A – Attachment 1
Financial Audit Report	FMU	Annual	120 days from close of fiscal year (10/30/2012)	Exhibit A – Attachment 2
Projected Revenue, Expenses, and Net Worth	FMU	Annual (No later than 6/30)	After passing of budget by State (and release of rates); and approval of budget by plan commission	Exhibit A – Attachment 2
Quarterly Financial Reports	FMU	Quarterly	11/15/2011 2/15/2012 5/15/2012 8/15/2012	Exhibit A – Attachment 2
Statement of Revenue, Expenses, & Net Worth	FMU	Quarterly	11/15/2011 2/15/2012 5/15/2012 8/15/2012	Exhibit A – Attachment 2
Monthly Financial Statement	FMU	Monthly	8/30 9/30 O N D J F M A M J J C O E A E A P A M J T V C N B R R Y N L	Exhibit A – Attachment 2
Encounter & Paid Claims Information	ITSD/PMU	Monthly	8/30 9/30 O N D J F M A M J J C O E A E A P A M J T V C N B R R Y N L	Exhibit A – Attachment 3
QI Committee Meeting Minutes	PMU	Quarterly	11/30 2/28 5/30 8/30	Exhibit A – Attachment 4
QI Annual Report	PMU	Annual	Upon approval by Quality Committee	Exhibit A – Attachment 4
Site Review Data	MMU/MRPIU	Every 6 mos.	As Available	Exhibit A – Attachment 4
Provider Network Report	CM	Weekly until further notification		Exhibit A – Attachment 6
Subcontracting Provider Groups	CM/FMU	Quarterly	11/30 2/28 5/30 8/30	Exhibit A – Attachment 6
Provider Manual	CM/MPS	Annual	7/30/2012	Exhibit A – Attachment 7
Changes in Availability or Location of Covered Services	CM	60 Days prior to proposed effective date	As required	Exhibit A – Attachment 9
GNA Summary Report	CM/Health Educator	Every 5 years	As Required	Exhibit A – Attachment 10

(Received via e-mail. Personal Identification information removed to maintain privacy)

Dear Mr. Greenia,

I am writing to express my deepest gratitude for the help that I have received from your Member Services representative Sonji Lopez.

My disabled parents, who currently reside in Thousand Oaks, are totally dependent upon Medi-Cal benefits and medical care from Los Angeles county doctors. Due to reorganization of Medi-Cal system, they were not able to receive their prescribed medications for the month of July.

Sonji went the extra mile and contacted doctor and pharmacy in order to provide consultative support and explain how the new system works.

I am so grateful to Sonji for her expertise, patience and perseverance in helping me resolve this problem.

I would like to thank for her outstanding professionalism, patience, energy and consideration. I met good attitude from absolutely wonderful person who devoted her time and helped me with my problem.

I appreciate the quick, timely service and professional manner in which your employee displayed. I am amazed at the prompt and effective solution to my problem. Thanks again for a very good job, help and support.

I wish to place on record my deep sense of appreciation to Sonji Lopez and also wish her all the best in her career.

Thank you,

Tatyana M

**Gold Coast Health Plan
Balance Sheet
Period Ended June 30, 2011**

Total Cash and Cash Equivalents	660,697
Total Accounts Receivable	9,155
Total Prepaid Accounts	40,127
Total Other Current Assets	0
Total Current Assets	709,979
Total Fixed Assets	87,638
Total Assets	797,617
Incurred But Not Reported Claims Payable	0
	0
Accounts Payable	47,377
Accrued Expenses	201,553
Accrued ACS	1,251,738
Accrued RGS	1,301,643
Accrued CQS	78,125
Other Current Liabilities	0
Total Current Liabilities	2,880,436
<u>Long-Term Liabilities</u>	
Other Long-term Liability	500,000
Advance - Long Term Debt	1,840,000
Notes Payable	0
Total Long-Term Liabilities	2,340,000
Total Liabilities	5,220,436
Equity	
<u>Retained Earnings</u>	
Net Income Current Year	(4,422,819)
Retained Earnings Current Year	(4,422,819)
Retained Earnings Prior Years	0
Total Retained Earnings	(4,422,819)
Total Equity	(4,422,819)
Total Liabilities & Equity	797,617

Gold Coast Health Plan
12 Month Income Statement
Year Ended June 30, 2011

	<u>Actual</u>	<u>FY2011 Budget</u>	<u>Variance</u>
Members			
Revenues			
Premium	0.00	0.00	0.00
Interest Income	0.00	0.00	0.00
Miscellaneous Income	0.00	0.00	0.00
Total Revenues	0.00	0.00	0.00
MCO Tax	0.00	0.00	0.00
Net Revenue	0.00	0.00	0.00
Cost of Health Care			
Capitation	0.00	0.00	0.00
Claims	0.00	0.00	0.00
Total Cost of Health Care	0.00	0.00	0.00
Administrative Expenses			
Total Salaries Benefits and Compensation	2,013,206	1,561,047	(452,159)
Total Travel and Training	36,077	3,000	(33,077)
Outside Service - ACS	1,018,850	-	(1,018,850)
Outside Service - CQS	78,125	-	(78,125)
Outside Service - RGS	46,785	104,875	58,090
Outside Service - Script Care	-	-	-
Outside Services - Other	12,085	-	(12,085)
Accounting & Actuarial Services	147,733	60,000	(87,733)
Legal Expense	63,684	30,000	(33,684)
Insurance	9,163	30,033	20,870
Lease Expense -Office	58,560	88,057	29,497
Consulting Services Expense	27,556	72,000	44,444
Translation Services	438	-	(438)
Advertising and Promotion Expense	43,826	-	(43,826)
General Office Expenses	359,246	185,734	(173,512)
Depreciation Expense	-	42,043	42,043
Printing Expense	201,356	320,000	118,644
Shipping & Postage Expense	293,938	214,500	(79,438)
Interest Exp	10,913	-	(10,913)
Gain/(Loss) on Disposal of Assets	-	-	-
Other/ Miscellaneous Expenses	1,279	30,000	28,721
Total Administrative Expenses	4,422,819	2,741,289	(1,681,530)
Net Income	(4,422,819)	(2,741,289)	(1,681,530)

**Gold Coast Health Plan
Statement of Cash Flows
Period Ended June 30, 2011**

Cash Flow From Operating Activities	
Collected Premium	-
Interest Received	-
Paid Claims	-
Paid Administration	(4,422,819)
Repay Initial Liabilities	2,371,154
MCO Taxes Paid	-
Net Cash Provided by Operating Activities	<u>(2,051,665)</u>
Cash Flow From Investing/Financing Activities	
Proceeds from Paid in Surplus/Issuance of Stock	-
Costs of Capitalization	2,800,000
Net Acquisition of Property/Equipment	(87,638)
Net Cash Provided by Investing/Financing	<u>2,712,362</u>
Net Cash Flow	<u><u>660,697</u></u>
Cash and Cash Equivalents (Beg. of Period)	<u>-</u>
Cash and Cash Equivalents (End of Period)	<u><u>660,697</u></u>
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income	(4,422,819)
Depreciation	-
Amortization	-
Decrease/(Increase) in Receivables	(49,281)
(Decrease)/Increase in Payables	2,420,436
Increase in borrowings	2,800,000
Purchase of fixed Assets	(87,638)
Changes in Withhold / Risk Incentive Pool	-
Change in Income Tax Liability	-
Changes in Claims Payable	-
Changes in IBNR	-
Net Cash Flow from Operating Activities	<u><u>660,697</u></u>



AGENDA ITEM 4-A

To: Ventura County Medi-Cal Managed Care Commission

From: Earl Greenia, CEO

Date: August 22, 2011

Re: Elimination of Adult Day Health Care Program

Issue: The California Department of Health Care Services (DHCS) and the California Department of Aging (CDA) have established a plan and timeline to eliminate the ADHC Program and transition 35,000 enrollees into other systems of care including Medi-Cal Managed Care by December 1, 2011.

Background: ADHC facilities provide a variety of services including meals, health, therapeutic, and case management services to clients at risk of being institutionalized. Transportation is usually provided to and from the ADHC site.

In March 2011, the California Legislature and Governor approved legislation (AB 97) which authorized the elimination of the Medi-Cal Adult Day Health Care Program (ADHC). The federal government granted approval on July 1, 2011, with the elimination to be effective September 1, 2011. DHCS subsequently postponed the elimination of the ADHC benefit until December 1, 2011. The movement of ADHC clients into managed care is widely seen as a prelude to other statewide efforts that are expected to occur after 2012.

In late July 2011, Governor Brown vetoed legislation that would have established an alternate program for patients with the greatest need and risk of being institutionalized. State funding for the alternate program would have been capped at \$85 million, half of the original ADHC Program's annual cost of \$169 million. In his veto message, the Governor said the state lacked the funds to continue services it offered in the past. The senior advocacy group, Disability Rights California, has filed suit to block the termination of the ADHC Program and a court hearing has been scheduled for November 1st to allow both sides to present their arguments.

In Ventura County there are five major ADHC facilities with a total enrollment of approximately 1,125 Medicare/Medi-Cal beneficiaries. DHCS reported that as of June 30th about 743 of these are Medicare/Medi-Cal eligible. An additional 151 are considered Medi-Cal eligible only, and the remaining 231 have dropped out of the ADHC Program during the same period. A list of Ventura County providers and Enrollment Report are attached to this memo.

Time Line

- On August 17, the first of two letters was sent from DHCS to the ADHC beneficiaries informing them that the ADHC Program will be eliminated on December 1, 2011. This letter targeted dual Medicare-MediCal beneficiaries. The letter included enrollment forms and language urging beneficiaries whose primary insurance is Medicare to choose a

managed care plan by September 16 or be auto-enrolled into a Medi-Cal managed care plan on October 1. An opt-out process will be in place that allows duals to opt-out of managed care and return to a fee-for service arrangement at any time.

- On August 30, a reminder notice will be sent to the same beneficiaries, but will not include enrollment forms.

Med-Cal Managed Care Beneficiaries

- In mid-September, Medi-Cal beneficiaries enrolled in a managed care plan, such as GCHP, will receive a different notice from the State – a sample letter is attached.
- On October 1, 2011- Enrollment of ADHC beneficiaries into managed care plans begins. ADHC beneficiaries who are dually eligible for Medicare and Medi-Cal may opt out of enrollment into a managed care system and remain as a fee-for-service beneficiary.
- December 1, 2011- the Medi-Cal ADHC Benefit and Program ends.

Fiscal Impact

Medi-Cal managed care plans will be paid \$60 per ADHC member per month (this is in addition to any other capitated payment for Medi-Cal beneficiaries). DHCS has announced their intention to develop “pay-for-performance” rewards and penalties; however, no criteria have been established yet. While Health plans are not expected to provide the ADHC benefit or provide In Home Supportive Services (IHSS), an assessment of IHSS capabilities and limitations will be necessary. Plans will be required to determine the most appropriate use of the additional funds to meet the care needs of the members through the following services:

- **Health Risk Assessment:** A comprehensive health risk assessment within 45 days of each members’ transition into managed care. This assessment can be conducted in person or over the phone depending on the preference of the beneficiary.
- **Care Coordination:** During the months of October and November health plans will be required to identify appropriate services for individual ADHC-transitioned clients/members.
- **Case Management:** Managed care plans are required to provide “ADHC-like” services that support the avoidance of nursing home placement. The plan may choose to provide these services through an individual provider or via contracts with a former ADHC provider.
- **Tracking and Reporting:** Plans will be required to track outcomes of former ADHC clients and report on the institutionalization of members.

Major Adult Day Health Care Centers in Ventura County

Advanced Day Health Care

2315 Kuehner Drive, Suite 121
Simi Valley, CA 93063
Phone: (805) 526-7629

Among Friends

851 South A Street
Oxnard, CA 93030
Phone: (805) 385-7244

Millennium ADHC

2150 Winifred Street
Simi Valley, CA 93063
Phone: (805) 583-0859

Oxnard Family Circle ADHC

5000 South C Street
Oxnard, CA 93033
Phone: (805) 385-4180

Ventura County ADHC

1700 N. Lombard Street, #150
Oxnard, CA 93030
Phone: (805) 278-4321

ADHC Enrollment by County- Managed Care Only

Department of Health Care Services				Dept of Aging
County	Count of Dual Medicare/Medi-Cal Eligibles	Count of Medi-Cal Only Eligibles	Total May 2011	Total June 30, 2011
Alameda	646	54	700	712
Contra Costa	170	39	209	288
Fresno	568	299	867	1,008
Kern	140	70	210	274
Los Angeles	18,884	3,319	22,203	23,603
Madera	26	0	26	
Marin	33	2	35	52
Mendocino	25	2	27	37
Merced	76	10	86	82
Monterey	3	0	3	
Napa	39	6	45	106
Orange	1,452	252	1,704	2,067
Riverside	342	133	475	556
Sacramento	624	201	825	545
San Bernardino	433	170	603	429
San Diego	1,948	593	2,541	2,928
San Francisco	1,216	91	1,307	1,198
San Joaquin	28	7	35	68
San Luis Obispo	9	2	11	
San Mateo	108	19	127	157
Santa Barbara	34	7	41	59
Santa Clara	762	58	820	1,089
Santa Cruz	109	11	120	136
Solano	44	7	51	36
Sonoma	33	0	33	43
Stanislaus	78	37	115	145
Ventura	743	151	894	1,125
Yolo	141	39	180	328



September 2011



JOHN SAMPLE
1234 SAMPLE STREET
ANYTOWN CA 90000

Important Medi-Cal Changes Notice of Elimination of ADHC Medi-Cal Benefit

Dear ADHC Participant,

There is a change in state law. **Medi-Cal** will no longer pay for Adult Day Health Care (ADHC) beginning December 1, 2011. The law that changed is California Welfare & Institutions Code section 14589.5.

This *does not* change your:

- Medicare coverage
- Doctors and specialists you see outside an ADHC center.
- Social Security benefits

Here is what you should know:

What benefits and services will Medi-Cal no longer pay for?

Medi-Cal will not pay for you to get services at an ADHC center after December 1, 2011.

What if I still need the care I get at my ADHC after the benefit ends?

Your health plan can help you get care and arrange for the services you need. They will call you soon to find out what care you need.

How do I find these services?

Your health plan can tell you about other services that may be available in the community. If you get In-Home Support Services (IHSS), contact your social worker to find out if you can get more IHSS hours. If you are in the Multipurpose Senior Service Program (MSSP), contact your caseworker for help. If you are a client of a Regional Center, contact your caseworker for assistance.

What if my center has closed before I find the care I need?

Your health plan can help you now. Call your health plan to help you find the care and services you need.

-over-

Where can I learn more about this?

You can learn more on the DHCS website at: <http://DHCS.ca.gov/ADHCtransition>

You may also call your health plan’s member services line or Health Care Options. Health Care Options representatives are available between the hours of 8:00 am - 5:00 pm, Monday - Friday.

English		1-800-430-4263	Korean	한국어	1-800-576-6883
Arabic	اللغة العربية	1-800-576-6881	Mandarin	國語	1-800-576-6885
Armenian	Հայերեն	1-800-840-5032	Russian	Русский	1-800-430-7007
Cambodian	ភាសាខ្មែរ	1-800-430-5005	Spanish	Español	1-800-430-3003
Cantonese	粵語	1-800-430-6006	Tagalog	Tagalog	1-800-576-6890
Farsi	فارسی	1-800-840-5034	Vietnamese	Tiếng Việt	1-800-430-8008
Hmong	Hmoob	1-800-430-2022	Other Languages		1-800-430-4263

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DRAFT
8/10/11

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

(dba Gold Coast Health Plan)

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

ARTICLE I

Name and Mission

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

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

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

ARTICLE II

Commissioners

The governing board of the VCOMMCC 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 VCOMMCC 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

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

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

~~[Confirm:] The Executive / Finance Committee shall be comprised of no more than five (5) Commissioners, and shall include the Chairperson and Vice Chairperson who shall serve in the same positions on the Executive / Finance Committee. The remaining members shall be appointed by the governing board, and as needed from time to time to fill any vacancy. Unless removed by the governing board, each member of the Executive / Finance Committee may serve for as long as he or she is a Commissioner. A quorum of the Committee will consist of four (4) members.~~

All meetings of standing committees shall be subject to the provisions of the Brown Act.

(a) Executive / Finance Committee.

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

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

1. Chairperson

2. Vice-Chairperson

3. Private hospital / healthcare system representative

4. Public hospital / healthcare system representative

5. Clinic

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

iii. Duties of the Executive / Finance Committee.

1. Advise the governing board Chairperson on requested matters.

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

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

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

5. Review proposed State contracts and rates, once actuary has reviewed and made recommendations.

6. Review proposed contracts for services over the assigned dollar value / limit of the CEO.

7. Establish basic tenets for payment-provider class and levels as related to Medi-Cal rates:

- o PCP
- o Specialists
- o Hospitals
- o LTC
- o Ancillary Providers

8. Recommend auto-assignment policies for beneficiaries who do not select a Primary Care Provider.

9. Review and recommend provider incentive program structure.

10. Review investment strategy and make recommendations.

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

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

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

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.

~~4.6.~~ Hiring or firing of senior executives, but may make recommendations to the governing board as to their appointment, dismissal or ongoing performance.

ARTICLE V

Special Committees

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

ARTICLE VI

Meetings

- (a) All meetings shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code relating to meetings of local agencies ("Brown Act").
- (b) A regular meeting shall be held monthly. The VCMMCC shall by resolution establish the date, time and location for the monthly meeting. A regular meeting may, for cause, be rescheduled by the Chairperson with seventy-two (72) hour advance notice.

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

Conduct of Meetings

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

- (a) The Chairperson shall adhere to the order of items as posted on the agenda. Modifications to the order of the agenda may be made to the extent that (on the advice of counsel) the rearrangement of the agenda items does not violate the spirit or intent of the Brown Act.
- (b) All motions or amendments to motions require a second in order to be considered for action. Upon a motion and a second the item shall be open for discussion before the call for the vote.
- (c) Voice votes will be made on all items as read. An abstention will not be recognized except for a legal conflict of interest. In furtherance of the foregoing, an abstention or refusal to vote (not arising from a legal conflict of interest) shall be deemed a vote with the majority of those Commissioners who do vote, except when there is a tie vote and the motion or action fails. For example, if there are 7 Commissioners present at a meeting (none of whom are subject to a legal conflict of interest), (i) a motion passes with 3 votes in favor and 4

Commissioners abstaining, (ii) a motion passes with 3 votes in favor, 2 votes against and 2 Commissioners abstaining; and (iii) a motion fails with 3 votes in favor, 3 votes against and 1 Commissioners abstaining.

- (d) A call for a point of order shall have precedence over all other motions on the floor.
- (e) Without objection, the Chairperson may continue or withdraw any item. In the event of an objection, a motion to continue or reset an item must be passed by a majority of the members present. A motion to continue or reset an item shall take precedence over all other motions except for a point of order.
- (f) An amendment to a motion must be germane to the subject of the motion, but it may not intend an action contrary to the motion. There may be an amendment to the motion and an amendment to an amendment, but no further amendments. In the event the maker of the original motion accepts the amendment(s), the original motion shall be deemed modified. In the event the maker of the original motion does not accept the amendment(s), the amendment(s) shall be voted separately and in reverse order of proposal.
- (g) Where these Bylaws do not afford an adequate procedure in the conduct of a meeting, the Chairperson may defer to the most current edition of Robert's Rules of Order, to resolve parliamentary questions.
- (h) **[New subsection:]** The Chairperson shall be permitted to make motions and vote on all matters to the same extent and subject to the same limitations as other Commissioners.

ARTICLE VII

Powers and Duties

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

- (a) Advise the Chief Executive Officer (CEO) and request from the CEO information it deems necessary;
- (b) Conduct meetings and keep the minutes of the VCMMCC;
- (c) Provide for financial oversight through various actions and methodologies such as the preparation and submission of an annual statement of financial affairs and an estimate of the amount of funding required for expenditures, approval of an annual budget, receipt of monthly financial briefings and other appropriate action in support of its financial oversight role;

- (d) Evaluate business performance and opportunity, and review and recommend strategic plans and business strategies;
- (e) Establish, support and oversee the quality, service utilization, risk management and fraud and abuse programs;
- (f) Encourage VCOMMCC members to actively participate in VCOMMCC 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 VCOMMCC at least annually.

ARTICLE VIII

STAFF

The VCOMMCC shall employ personnel and contract for services as necessary to perform its functions. The permanent staff employed by the VCOMMCC 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 VCOMMCC. 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 VCOMMCC board resolution, and shall bring any

conflict between these laws, regulations, resolutions or policy to the attention of the VCMMCC;

- (d) 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;
- (e) Retain and appoint necessary personnel, consistent with all policies and procedures, in furtherance of the VCMMCC's powers and duties; and
- (f) Implement and enforce all policies and procedures, and assure compliance with all applicable federal and state laws, rules and regulations.

Clerk

The Clerk shall:

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

Assistant Clerk

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

ARTICLE IX

Rules of Order

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

ARTICLE X

Amendments

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

ARTICLE XI

Nondiscrimination Clause

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

ARTICLE XII

Conflict of Interest and Ethics

VCMMCC members are subject to conflict of interest laws, including Government Code section 1090 and the 1974 Political Reform Act (Government Code section 8100 et seq.), as modified by Welfare and Institutions Code section 14087.57, and must identify and disclose any conflicts and refrain from participating in any manner in such matters in accordance with the applicable statutes. Members of the VCMMCC agree to adhere to all relevant standards established by state or federal law regarding ethical behavior.

ARTICLE XIII

Dissolution

Pursuant to California Welfare & Institutions Code, section 14087.54:

- (a) In the event the Commissioners determine that VCMMCC may no longer function for the purposes for which it was established, at the time that VCMMCC's then existing obligations have been satisfied or VCMMCC's assets have been exhausted, the Board of Supervisors may by ordinance terminate the VCMMCC.
- (b) Prior to the termination of the VCMMCC, the Board of Supervisors shall notify the State Department of Health Care Services ("DHCS") of its intent to terminate VCMMCC. The DHCS shall conduct an audit of VCMMCC's records within 30 days of the notification to determine the liabilities and assets of VCMMCC. The DHCS shall report its findings to the Board of Supervisors within 10 days of completion of the audit. The Board of Supervisors shall prepare a plan to liquidate or otherwise dispose of the assets of VCMMCC and to pay the liabilities of VCMMCC to the extent of VCMMCC's assets, and present the plan to the DHCS within 30 days upon receipt of these findings.
- (c) Upon termination of the VCMMCC by the Board of Supervisors, the County of Ventura shall manage any remaining assets of VCMMCC until superseded by a DHCS-approved plan. Any liabilities of VCMMCC shall not become obligations of the County of Ventura upon either the termination of the VCMMCC or the liquidation or disposition of VCMMCC's remaining assets.
- (d) Any assets of VCMMCC shall be disposed of pursuant to provisions contained in the contract entered into between the state and VCMMCC.



AGENDA ITEM 4-C

To: Ventura County Medi-Cal Managed Care Commission

From: Earl Greenia, CEO

Date: August 22, 2011

Re: GCHP Co-Pay Policy Follow-Up

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

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

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

Impact on Member Access

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

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

Considerations

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

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

Follow-Up

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

- 1) Consider using a beneficiary-based focus-group to solicit their opinions. To that end, we have designed and distributed a survey instrument to assess knowledge and attitudes of our Consumer Advisory Committee members regarding the State's proposed Medi-Cal copayments. The results of the survey should be available for the September meeting of the Commission.
- 2) An estimate of the magnitude of the financial impact on providers, based on historical utilization and the proposed co-payments. That analysis follows:

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

Type of Service	# of Occurrences	Co-Pay Amount	Financial Impact
Physician Visits	182,088	\$5	\$910,440
Emergency Room Visits (1)	62,003	\$5	\$310,015
Inpatient Visit - 1 Day LOS	3,140	\$100	\$314,000
Inpatient Visit > 1 Day LOS	5,292	\$100	\$529,200
Number of Drug Fills - Generic (2)	787,734	\$3	\$2,363,201
Number of Drug Fills - Non Generic	172,917	\$5	\$864,586
Total Financial Impact	1,213,174		\$5,291,442

Notes:

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



AGENDA ITEM 4-D

To: Ventura County Medi-Cal Managed Care Commission

From: Earl Greenia, CEO

Date: August 22, 2011

Re: Description of the Auto-Assignment Process

Overview

The Auto-Assignment process was developed to ensure appropriate distribution of those members who did not select a primary care provider (PCP). The process considered various factors including:

- Provider Capacity
 - Member-Specific Factors, such as:
 - Member Zip Code
 - Age,
 - Gender,
 - Language Preference
- Where possible, effort was made to assign residents of the same address to the same PCP

Of our 100,000+ members, nearly 68% are required to select a PCP (the remaining 32% are “administrative” members, for example, those with other insurance coverage, and do not select a PCP). By July 8, 20,344 (30%) selected a PCP. The remainder was auto-assigned on or about that date. The 30% selection rate is consistent with our expectations based on the experience of other plans. Because provider capacity is a factor in the assignment process, the safety-net providers received 86.8% of the unassigned members – nearly 7-to-1 vs. Management’s decision to afford a 3-to-1 assignment weighting for the safety-net providers.

System

A custom SQL routine was written to process the data for the initial assignment. Data were then exported to Excel for review and reporting purposes. The ongoing assignment of new members will follow the same logic, except in those cases where members have terminated and then reinstated within a six month period; under such circumstances the member will revert back to the prior designated PCP.

Zip Code Groupings

The County was divided into eight zip code groupings, to best accommodate access to care, including distance to providers. Within each of the zip code groupings, the total number of providers and clinics were identified by individual zip code. Within that sub-grouping, members were allocated based upon the number of providers within a given clinic, as actual assignment is at the clinic rather than provider level. This approach was used rather than individual zip codes in order to avoid “over” assignment to any particular provider. For example, if there was

only one provider in a particular zip code, the assignment of all members to that single provider could create unintentional overload. The breakdown of these zip codes is detailed below.

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

Language Capabilities

A secondary qualification for auto-assignment included language capabilities; for example, if the member indicated a Spanish-language preference, then such member would not be assigned to a provider with English-only capabilities. Language source for our data was based upon the information provided by the State via the data files. We have been apprised in a number of cases that the language designation field provided by the State is incorrect. In those cases, we make a designation change in our system, and advise the member to correct the designation by contacting their HSA caseworker. GCHP is unable to permanently alter a member's record within the State's data file.

Provider Assignment

Auto-assignment was limited to those safety-net and "traditional" Medi-Cal providers under contract and listed in the Provider Directory dated May 23, 2011. This is the directory that was distributed to membership via USPS along with a welcome letter describing the changes to Medi-Cal and instructions for completing the PCP Selection form. After correcting for reported errors or omissions, the initial auto-assignment of July 9th was based on the data in our files as of July 7.

Within each of the eight zip code groups the number of providers and clinics were identified by individual zip code. Within that sub-grouping, members were allocated based upon the number of providers within a given clinic, as actual assignment is at the clinic rather than provider level.

Like a telephone book, directories are updated regularly to reflect changes in the provider network or the correction of any possible errors. It is this document that will be used for future auto-assignment of new members.

Manual Review

Prior to the initial auto-assignment, both GCHP and ACS staff reviewed the data on earlier "draft runs" of the auto-assignment criteria and allocations, looking for outlier data in terms of the following criteria:

- Appropriate geographic distribution of membership to providers based upon logistical access to care (e.g., distance from member home zip code to Provider location)
- Appropriate distribution of membership per geographic area based upon language (e.g., Spanish language requirement)
- Appropriate distribution of membership per geographic area to Providers accepting new patients
- Appropriate membership count to ensure that all appropriate membership was accounted for, including both Administrative and self-select membership

The data was also reviewed post auto-assignment to ensure accuracy of the aforementioned criteria.

Challenges

Management recognizes that no approach is “perfect” and that the definition and concept of “fair” is subjective. For example, the validity of the member’s zip code could be challenged - we understand that members may delay reporting changes in physical residence and/or mailing address.

Nonetheless, Management is committed to ensuring that member choice is honored. To that end, we have responded and will continue to respond to both provider and member inquiries and change requests. For example, there have been reports that members have sought care from their customary provider only to discover that they were auto-assigned to a different provider. When this occurs, the provider or member is asked to call Member Services and they can immediately change their PCP. A small number of PCP selection forms “trickled” in since go-live – those forms have been honored. Through the months of July and August the auto-assignment was reversed with an effective date of July 1 and the preferred PCP assigned. Going forward, change requests will be accepted at any time and become effective on the first date of the following month.

Process Review

As noted previously, staff is conducting an audit of both the auto-assignment and self-selection processes. To ensure that the audit is credible and reliable, we are randomly selecting 500 records from each category – this will provide a 98% confidence interval.