Ventura County MediCal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)

Regular Meeting
Monday, October 24, 2016, 2:00 p.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010

AGENDA

CALL TO ORDER

PLEDGE OF ALLEGIANCE

ROLL CALL

PUBLIC COMMENT

The public has the opportunity to address Ventura County Medi-Cal Managed Care Commission (VCMMCC) doing business as Gold Coast Health Plan (GCHP) on the agenda. Persons wishing to address VCMMCC should complete and submit a Speaker Card.

Persons wishing to address VCMMCC are limited to three (3) minutes. Comments regarding items not on the agenda must be within the subject matter jurisdiction of the Commission.

CONSENT CALENDAR

1. Approval of the 2017 Commission Meeting Calendar

Staff: Tracy Oehler, Clerk of the Board

RECOMMENDATION: Approve the 2017 Commission Meeting Calendar.

FORMAL ACTION ITEMS

2. Fiscal Year 2015-16 Audit Results

Staff: Patricia Mowlavi, Chief Financial Officer

RECOMMENDATION: Approve and accept the Fiscal Year 2015-16 Audit Results.

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

3. August 2016 Fiscal Year to Date Financials

Staff: Patricia Mowlavi, Chief Financial Officer

RECOMMENDATION: Accept and file August 2016 Fiscal Year to Date Financials.

4. Signature Authority and Procurement Policy

Staff: Bob Bushey, Procurement Officer

RECOMMENDATION: 1) Delete Agenda Item 4A-1 Policy "CEO Signing Authority for Contractual Agreements for Administrative Goods and Services" and approve the Signature Authority and Procurement Policies; and 2) Any future revisions to these policies be reviewed and approved by the Ventura County Medi-Cal Managed Care Commission.

5. Discussion and Direction Regarding Community Resource Center Options

Staff: Dale Villani, Chief Executive Officer

RECOMMENDATION: Direct staff to move forward with the lease of a satellite location in downtown Oxnard for the purpose of establishing a GCHP Community Resource Center; approve the Chief Executive Officer to negotiate and execute a lease; and direct staff to move forward with all planning activities necessary to open a Community Resource Center located in downtown Oxnard.

6. Appointment of Audit Committee Member to Serve the Remainder of Commissioner Pupa's Term

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Appoint a new member to the Audit Committee.

7. Appointment of Commission Vice Chairperson to Serve the Remainder of Commissioner Pupa's Two-Year Term and Appointment of Executive/Finance Committee Members to Serve the Remainder of Commissioner Pupa and Fisher's Terms

Staff: Scott Campbell, General Counsel

RECOMMENDATION: 1) Elect a Commissioner to serve as Vice Chairperson for a two-year term; and 2) Make appointments to the Executive/Finance Committee as follows: a) Vice Chairperson and b) Ventura County Medical Health System Representative.

8. Appointments to Chief Diversity Officer (CDO) Interview Panel

Staff: Joseph T. Ortiz, Cultural Diversity Subcommittee Counsel

RECOMMENDATION: Appoint the CDO Interview Panel.

9. Approval of Contract for Pharmacy Benefits Manager Services

Staff: Anne Freese, Pharmacy Director

RECOMMENDATION: Staff is presenting a revised contract, per Commission direction, for approval.

CLOSED SESSION

10. REPORT INVOLVING TRADE SECRET
Discussion will concern: Pharmacy Benefits Manager Rates

Estimated date of public disclosure: Three years from execution of contract pursuant to Welfare and Institutions Code Section 14087.58

RECONVENE TO OPEN MEETING

REPORTS

11. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

12. Chief Operations Officer (COO) Update

RECOMMENDATION: Accept and file the report.

13. Chief Medical Officer (CMO) Update

RECOMMENDATION: Accept and file the report.

14. Chief Information Strategy Officer (CISO) Update

RECOMMENDATION: Accept and file the report.

15. Human Resources/Cultural Resources Subcommittee Update

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

16. PUBLIC EMPLOYEE APPOINTMENT
Title: Chief Diversity Officer

17. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Scott Campbell, General Counsel
Unrepresented employee: Chief Diversity Officer

18. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

19. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Scott Campbell, General Counsel
Unrepresented employee: Chief Executive Officer

20. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: Two Cases

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on November 28, 2016, at Gold Coast Health Plan at 711 E. Daily Drive, Suite 106, Community Room, Camarillo, CA 93010.

Administrative Reports relating to this agenda are available at 711 East Daily Drive, Suite #106, Camarillo, California, during normal business hours and on http://goldcoasthealthplan.org. Materials related to an agenda item submitted to the Commission after distribution of the agenda packet are available for public review during normal business hours at the office of the Clerk of the Board.

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5509. Notification for accommodation must be made by the Thursday prior to the meeting by 3 p.m. to enable the Clerk of the Board to make reasonable arrangements for accessibility to this meeting.

The agenda was posted on October 19, 2016, at the Gold Coast Health Plan Notice Board and on its website.

Gold Coast Health Plan℠
A Public Entity

AGENDA ITEM NO. 1
Ventura County Medi-Cal Managed Care Commission Meetings

711 E. Daily Drive, Community Room, Camarillo, CA

Commission meetings are held on the 4th Monday every month with the exception of December.

January

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

February

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28				

March

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

April

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

May

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

June

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

July

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

August

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

September

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

October

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

November

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

December

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

AGENDA ITEM NO. 2

TO: Gold Coast Health Plan Commission

FROM: Patricia Mowlavi, CFO
PRESENTED BY: Moss Adams, LLP

DATE: October 24, 2016

SUBJECT: Fiscal Year 2015-16 Audit Results

SUMMARY:

The Plan's auditor, Moss Adams LLP (Moss Adams) is presenting the results and findings of the Fiscal Year (FY) 2015-16 (07/01/2015 - 06/30/2016) financial audit of Gold Coast Health Plan (Plan) for review by the Commission.

Auditor's report reflects and "unmodified opinion" (i.e., there were no issues that would impact the financials.

The Plan engaged Moss Adams to perform a financial audit for FY 2015-16. Performing an annual audit is a requirement of the Plan's contract with the State of California's Department of Health Care Services.

BACKGROUND/DISCUSSION:

The primary purpose of the audit is for stakeholders to gain assurance that the Plan's financial statements are properly presented, are free of material misstatements and have been prepared in conformity with accounting principles generally accepted in the U.S. The auditor's report for FY2015-16 resulted in an unmodified opinion; no issues were reported that would have an adverse effect on the Plan's financial results.

A secondary (but important) purpose of the audit is to test and comment on the Plan's design, implementation and maintenance of a system of internal controls that have a relationship with financial reporting.

FISCAL IMPACT:

Plan's auditor, Moss Adams, will be presenting the FY 2015-16 audited results of the change in net assets and tangible net equity (TNE).

RECOMMENDATION:

Staff proposes that the Commission approve and accept the FY 2015-16 audit results.

CONCURRENCE:

N/A

AGENDA ITEM NO. 3

TO: Gold Coast Health Plan Commission

FROM: Patricia Mowlavi, CFO

DATE: October 24, 2016

SUBJECT: August 2016 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached August fiscal year-to-date 2016 financial statements (unaudited) of Gold Coast Health Plan (Plan) for the Commission to accept and file. These financials have not been reviewed by the Executive/Finance Committee.

BACKGROUND / DISCUSSION:

The staff has prepared the August fiscal year-to-date 2016 financial package, including statements of financial position, statement of revenues, expenses and changes in net assets, and statement of cash flows.

FISCAL IMPACT:

Financial Highlights

Overall Performance – For the two months ended August, 2016, the Plan's performance was a gain in net assets of $1.8 million which was $2.7 million higher than budget. The variance was largely due to the retroactive true-up of long term care (LTC) and skilled nursing facility (SNF) claims associated with final AB1629 rates. The true-up adjusted claims retroactively through August 2015.

Tangible Net Equity – The Plan's fiscal year-to-date operating performance increased Tangible Net Equity (TNE) to approximately $154.9 million, which was $2.7 million higher than budget.

Membership – August membership of 208,680 was below budget by 1,091 members. There were fewer Adult members than budgeted although this was partially offset by higher than expected Adult Expansion (AE) membership.

Revenue – August fiscal year-to-date net revenue was $118.4 million or $5.0 million higher than budget. The variance was driven by higher than anticipated membership for AE with higher capitation rates.

Revenue includes a $5.2 million reserve for rate reductions associated with AE. This reserve represents an expected refund, to the Department of Health Care Services ("DHCS"), for rate overpayments (as DHCS continues to pay at the January 1, 2015 rates

rather than the July 1, 2015 and July 1, 2016 published rates) and the anticipated refund of revenue to achieve a medical loss ratio ("MLR") of 85%, for this aid category. (The MLR is calculated by dividing health care costs by revenue). The combined total due back to the DHCS, for both rate overpayment and 85% MLR portion, is $228.8 million. Beginning in January 2016, the DHCS started to recoup the AE rate overpayment through monthly reductions of its payment to the Plan. Thus far, a total of $70.8 million has been deducted.

Health Care Costs – Health care costs through August were $109.6 million or $3.6 million over budget. MLR was 92.6% versus budget of 93.5%.

Some health care cost items of note include:

- Capitation – Includes the AE enhancement program which concluded in July 2016.
- Fee for Service – Includes the retroactive true-up of LTC and SNF claims associated with AB1629 finalized rates.

Administrative Expenses – August fiscal year-to-date administrative costs were $7.4 million or $1.2 million below budget. The variance is primarily due to timing of projects.

The administrative cost ratio ("ACR") for FYTD August was 6.2% versus 7.6% for budget. (The ACR is calculated by dividing administrative expenses by total revenue.)

Cash and Medi-Cal Receivable – At August 31, the Plan had $448.4 million in cash and short term investments and $57.3 million in Medi-Cal Receivable for an aggregate amount of $505.7 million. In the month of August, $9 million in long term bonds were reclassified to short term investments with the maturity date in August 2017.

Investment Portfolio – As of August 31, 2016, the value of the investments were as follows:

- Short-term Investments $213.3 million: Cal Trust $50.6 million; Ventura County Investment Pool $85.5 million; LAIF CA State $63.2 million; Bonds $14.0 million.
- Long-term Investments (Bonds) $10.3 million.

RECOMMENDATION:

Staff requests that the Commission accept and file the August 2016 year to date financials.

CONCURRENCE:

Not Applicable

ATTACHMENT:

August 2016 Financial Package

Gold Coast Health Plan℠
A Public Entity

FINANCIAL PACKAGE
For the month ended August 31, 2016

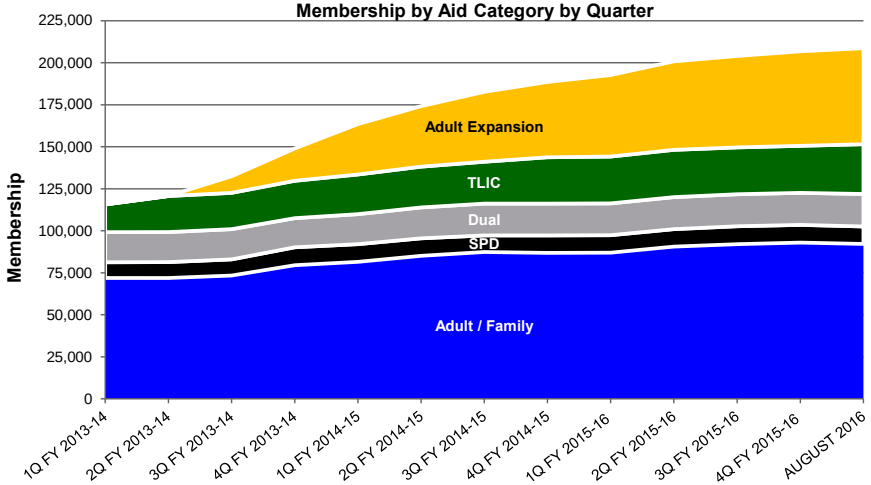
TABLE OF CONTENTS

APPENDIX

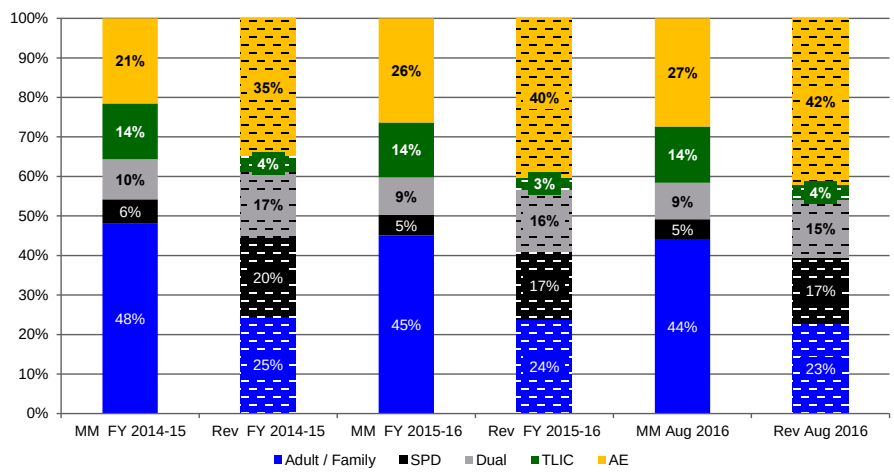
Description	AUDITED FY 2011-12	AUDITED FY 2012-13	AUDITED FY 2013-14	AUDITED FY 2014-15	UNAUDITED FY 2015-16	FY 2016-17 JUL 16	FY 2016-17 AUG 16	FY 2016-17 FYTD AUG 16	Budget Comparison Budget FYTD	Budget Comparison Variance Fav / (Unfav)
Member Months	**1,258,189**	**1,223,895**	**1,553,660**	**2,130,979**	**2,413,136**	**208,714**	**208,680**	**417,394**	**418,988**	(1,594)
Revenue	**304,635,932**	**315,119,611**	**402,701,476**	**595,607,370**	**675,629,602**	**59,902,266**	**58,462,967**	**118,365,232**	**113,356,090**	5,009,143
pmpm	*242.12*	*257.47*	*259.20*	*279.50*	*279.98*	*287.01*	*280.16*	*283.58*	*270.55*	13.03
Health Care Costs	**287,353,672**	**280,382,704**	**327,305,832**	**509,183,268**	**583,149,780**	**52,248,022**	**57,299,670**	**109,547,693**	**105,978,003**	(3,569,690)
pmpm	*228.39*	*229.09*	*210.67*	*238.94*	*241.66*	*250.33*	*274.58*	*262.46*	*252.94*	(9.52)
% of Revenue	94.3%	89.0%	81.3%	85.5%	86.3%	87.2%	98.0%	92.6%	93.5%	0.9 %
Admin Exp	**18,891,320**	**24,013,927**	**31,751,533**	**34,814,049**	**41,158,879**	**3,584,488**	**3,804,586**	**7,389,074**	**8,570,347**	1,181,273
pmpm	*15.01*	*19.62*	*20.44*	*16.34*	*17.06*	*17.17*	*18.23*	*17.70*	*20.45*	2.75
% of Revenue	6.2%	7.6%	7.9%	5.8%	6.1%	6.0%	6.5%	6.2%	7.6%	1.3 %
Non-Operating Revenue / (Expense)					**1,790,949**	**219,866**	**186,649**	**406,516**	**345,693**	60,823
pmpm					*0.74*	*1.05*	*0.89*	*0.97*	*0.83*	0.15
% of Revenue					0.3%	0.4%	0.3%	0.3%	0.3%	0.0 %
Total Increase / (Decrease) in Unrestricted Net Assets	**(1,609,063)**	**10,722,980**	**43,644,110**	**51,610,053**	**53,111,892**	**4,289,622**	**(2,454,641)**	**1,834,982**	**(846,568)**	2,681,549
pmpm	*(1.28)*	*8.76*	*28.09*	*24.22*	*22.01*	*20.55*	*(11.76)*	*4.40*	*(2.02)*	6.42
% of Revenue	-0.5%	3.4%	10.8%	8.7%	7.9%	7.2%	-4.2%	1.6%	-0.7%	2.3%
YTD										
100% TNE	16,769,368	16,138,440	17,867,986	22,556,530	25,246,284	25,819,419	26,920,299	26,920,299	26,201,389	718,909
% TNE Required	36%	68%	100%	100%	100%	100%	100%	100%	100%	
Minimum Required TNE	6,036,972	10,974,139	17,867,986	22,556,530	25,246,284	25,819,419	26,920,299	26,920,299	26,201,389	718,909
GCHP TNE	**(6,031,881)**	**11,891,099**	**55,535,211**	**107,145,264**	**153,057,156**	**157,346,778**	**154,892,138**	**154,892,138**	**152,210,588**	**2,681,549**
TNE Excess / (Deficiency)	**(12,068,853)**	**916,960**	**37,667,225**	**84,588,734**	**127,810,872**	**131,527,359**	**127,971,839**	**127,971,839**	**126,009,199**	**1,962,640**
% of Required TNE level			**311%**	**475%**	**606%**	**609%**	**575%**	**575%**	**581%**	

FINANCIAL PERFORMANCE DASHBOARD
FOR MONTH ENDING August 31, 2016

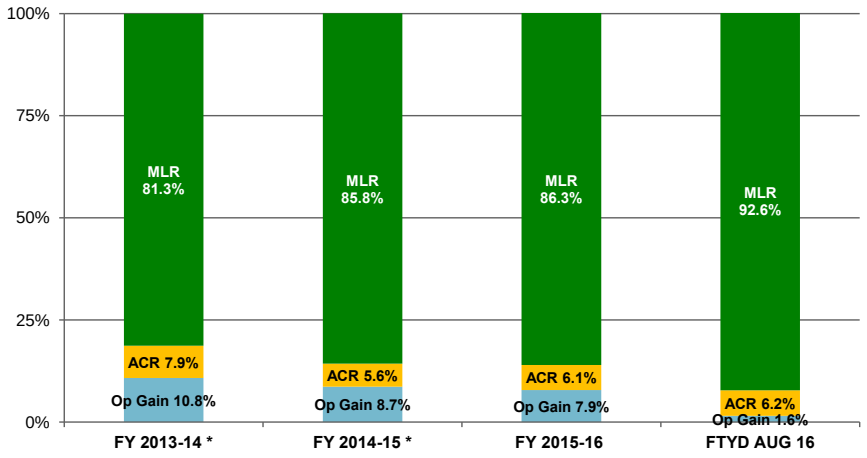
Membership and Growth
Membership by Aid Category by Quarter



Membership Mix and Revenue Impact

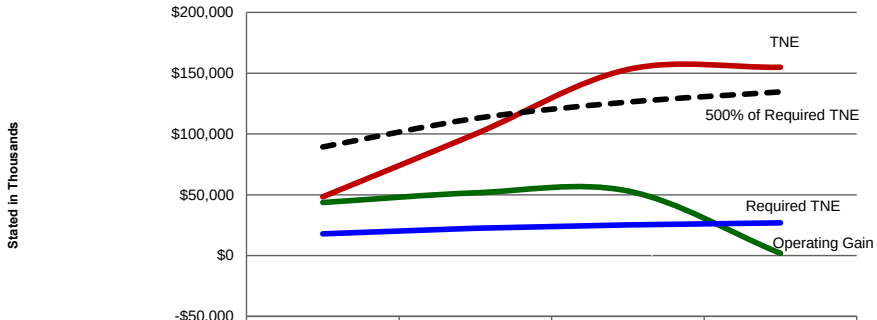


Key Performance Indicators



Note: FY 14 and FY 15 differs from Budget Presentation due to Auditors' Adjustments.
Medical Loss Ratio (MLR), Administrative Cost Ratio (ACR)

Operating Gain and Tangible Net Equity

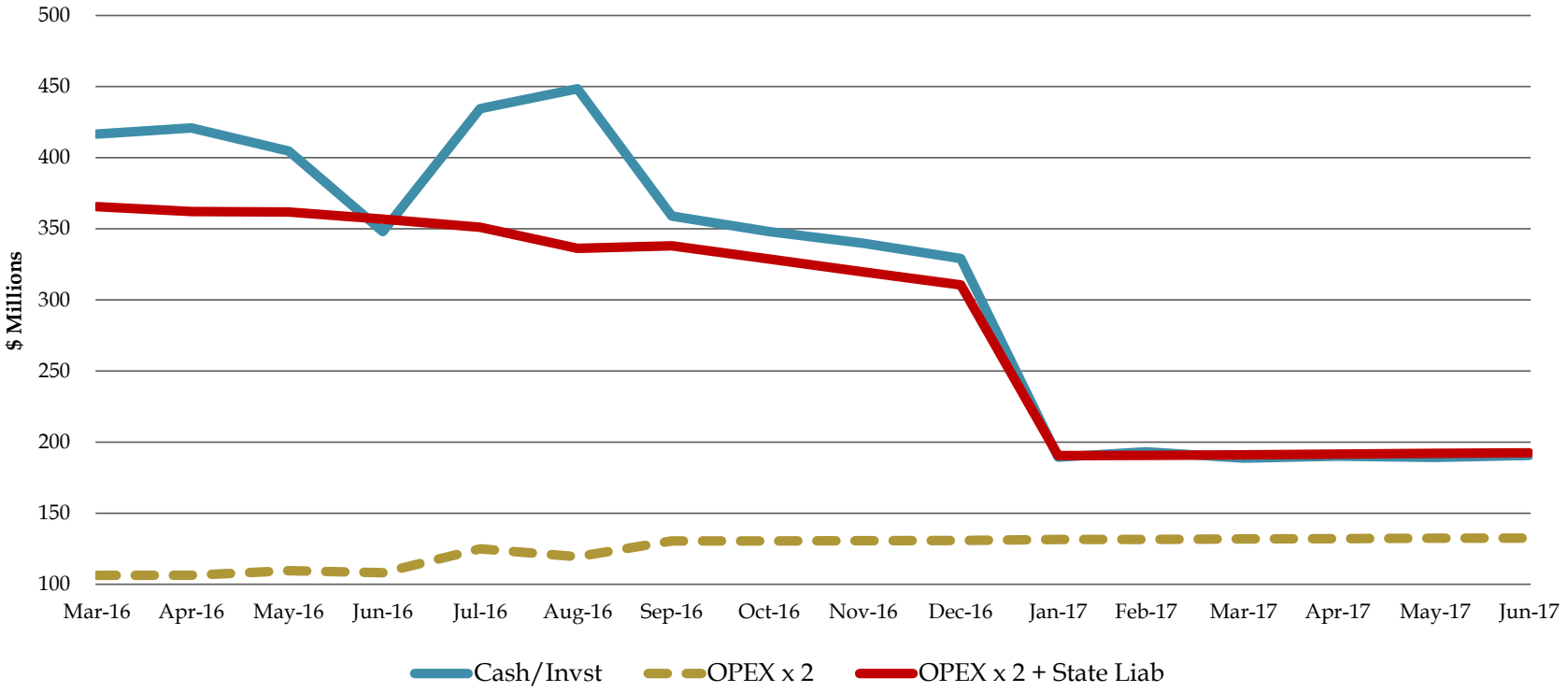


	FY 2013-14 *	FY 2014-15 *	FY 2015-16	FYTD AUG 2016
Operating Gain	$43,644	$51,610	$53,112	$1,835
TNE	$48,335	$99,945	$153,057	$154,892
Required TNE	$17,868	$22,557	$25,246	$26,920
500% of Required TNE	$89,340	$112,783	$126,231	$134,601

* FY 14 and FY 15 differs from Budget Presentation due to audit adjustments. FY 16 updated for Operating Gain and TNE Only
TNE excludes LOC ($7.2M)

GOLD COAST HEALTH PLAN
AUGUST 2016

Cash & Operating Expense Requirements



Note: May & June 16 - Decline in cash due to delay in revenue payment from DHCS. July 16 - Received May and June 16 payment from DHCS. August 16 - Long term bond reclassified to short term investment.

Gold Coast Health Plan℠
A Public Entity

For the month ended August 31, 2016

APPENDIX

- Statement of Financial Positions
- YTD Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Revenues, Expenses and Changes in Net Assets
- YTD Cash Flow
- Monthly Cash Flow
- Membership
- Paid Claims and IBNP Composition
- Pharmacy Cost & Utilization Trends

STATEMENT OF FINANCIAL POSITION

	08/31/16	07/31/16	06/30/16
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**$ 235,142,045**	**$ 230,175,977**	**$ 144,092,466**
Total Short-Term Investments	**213,302,816**	**204,248,691**	**203,912,197**
Medi-Cal Receivable	57,297,261	69,779,279	144,641,270
Interest Receivable	290,596	232,104	373,512
Provider Receivable	4,906,650	4,783,513	4,800,784
Other Receivables	(156)	0	0
Total Accounts Receivable	**62,494,351**	**74,794,896**	**149,815,566**
Total Prepaid Accounts	1,906,249	2,067,847	1,605,126
Total Other Current Assets	133,545	133,545	133,545
Total Current Assets	**512,979,006**	**511,420,957**	**499,558,901**
Total Fixed Assets	**2,628,258**	**2,555,908**	**2,544,740**
Total Long-Term Investments	**10,289,860**	**19,334,445**	**19,355,567**
Total Assets	**$ 525,897,125**	**$ 533,311,310**	**$ 521,459,209**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 61,311,025	$ 58,143,338	$ 56,311,392
Claims Payable	13,274,982	13,866,931	12,752,210
Capitation Payable	56,698,658	56,685,739	52,510,957
Physician ACA 1202 Payable	1,608,014	1,608,014	1,702,500
AB 85 Payable	1,475,381	1,463,358	3,832,229
Accounts Payable	230,427	233,285	2,529,931
Accrued ACS	1,725,565	1,686,392	1,683,732
Accrued Expenses	103,534,528	103,186,237	95,312,257
Accrued Premium Tax	(66,538)	5,599,855	5,575,996
Accrued Payroll Expense	977,875	880,272	763,698
Total Current Liabilities	**240,769,917**	**243,353,421**	**232,974,902**
Long-Term Liabilities:			
DHCS - Reserve for Capitation Recoup	129,379,946	131,779,946	134,619,946
Other Long-term Liability-Deferred Rent	855,124	831,165	807,205
Total Long-Term Liabilities	**130,235,070**	**132,611,111**	**135,427,151**
Total Liabilities	**371,004,988**	**375,964,531**	**368,402,053**
Net Assets:			
Beginning Net Assets	153,057,156	153,057,156	99,945,264
Total Increase / (Decrease in Unrestricted Net	1,834,982	4,289,622	53,111,892
Total Net Assets	**154,892,138**	**157,346,778**	**153,057,156**
Total Liabilities & Net Assets	**$ 525,897,125**	**$ 533,311,310**	**$ 521,459,209**

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR TWO MONTHS ENDING AUGUST 31, 2016

	August 2016 Year-To-Date		Variance
	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	417,394	418,988	(1,594)
Revenue			
Premium	$ 113,148,404	$ 127,393,880	$ (14,245,477)
Reserve for Rate Reduction	5,240,000	(404,331)	5,644,331
MCO Premium Tax	(23,171)	(13,633,459)	13,610,288
Total Net Premium	**118,365,232**	**113,356,090**	**5,009,143**
Total Revenue	**118,365,232**	**113,356,090**	**5,009,143**
Medical Expenses:			
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	14,127,739	9,978,538	(4,149,201)
FFS Claims Expenses:			
Inpatient	21,778,341	20,976,350	(801,991)
LTC / SNF	22,026,555	19,136,682	(2,889,873)
Outpatient	7,613,277	8,139,817	526,540
Laboratory and Radiology	415,876	480,822	64,946
Emergency Room	3,377,362	3,573,243	195,881
Physician Specialty	10,127,849	9,470,532	(657,317)
Primary Care Physician	2,523,261	3,093,733	570,472
Home & Community Based Services	2,403,892	2,596,048	192,156
Applied Behavior Analysis Services	460,858	238,541	(222,317)
Mental Health Services	1,370,472	686,474	(683,998)
Pharmacy	18,967,973	19,438,302	470,329
Provider Reserve	0	2,009,360	2,009,360
Other Medical Professional	445,208	412,502	(32,706)
Other Medical Care	429	0	(429)
Other Fee For Service	1,464,707	1,257,141	(207,566)
Transportation	258,244	257,283	(961)
Total Claims	93,234,305	91,766,832	(1,467,473)
Medical & Care Management Expense	2,520,697	3,235,442	714,744
Reinsurance	51,787	997,191	945,405
Claims Recoveries	(386,834)	0	386,834
Sub-total	2,185,649	4,232,633	2,046,984
Total Cost of Health Care	**109,547,693**	**105,978,003**	**(3,569,690)**
Contribution Margin	**8,817,540**	**7,378,086**	**1,439,453**
General & Administrative Expenses:			
Salaries, Wages & Employee Benefits	2,062,297	2,223,675	161,379
Training, Conference & Travel	33,662	72,483	38,821
Outside Services	3,826,385	4,003,341	176,957
Professional Services	547,743	1,353,243	805,500
Occupancy, Supplies, Insurance & Others	918,987	917,604	(1,384)
ARCH/Community Grants	0	0	0
Total G & A Expenses	**7,389,074**	**8,570,347**	**1,181,273**
Total Operating Gain / (Loss)	**$ 1,428,466**	**$ (1,192,260)**	**$ 2,620,726**
Non Operating			
Revenues - Interest	406,516	345,693	60,823
Total Non-Operating	406,516	345,693	60,823
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 1,834,982**	**$ (846,568)**	**$ 2,681,549**
Net Assets, Beginning of Year	153,057,156		
Net Assets, End of Year	154,892,138		

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2015-16 Monthly Trend		FY 2016-17	Current Month		
	MAY 16	JUN 16	JUL 16	AUGUST 2016		Variance
				Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	206,495	208,533	208,714	208,680	209,771	(1,091)
Revenue:						
Premium	$ 62,191,840	$ 62,954,954	$ 57,086,068	$ 56,062,336	$ 63,766,943	$ (7,704,607)
Reserve for Rate Reduction	(2,100,000)	925,000	2,840,000	2,400,000	(208,134)	2,608,134
MCO Premium Tax	(3,124,187)	(2,417,843)	(23,802)	630	(6,825,078)	6,825,709
Total Net Premium	**56,967,654**	**61,462,112**	**59,902,266**	**58,462,967**	**56,733,730**	**1,729,236**
Other Revenue:						
Miscellaneous Income	38,333	44,341	0	0	0	0
Total Other Revenue	38,333	44,341	0	0	0	0
Total Revenue	**57,005,987**	**61,506,453**	**59,902,266**	**58,462,967**	**56,733,730**	**1,729,236**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	9,097,311	9,085,110	9,125,043	5,002,696	4,995,485	(7,211)
FFS Claims Expenses:						
Inpatient	8,925,561	11,902,400	11,033,539	10,744,802	10,502,382	(242,420)
LTC / SNF	9,470,377	7,153,458	7,801,798	14,224,757	9,569,888	(4,654,870)
Outpatient	3,529,950	3,672,953	3,364,303	4,248,974	4,075,154	(173,820)
Laboratory and Radiology	204,947	232,035	191,806	224,070	240,768	16,698
Physician ACA 1202	0	(7,405,463)	0	0	0	0
Emergency Room	1,875,789	2,090,005	1,459,397	1,917,965	1,788,994	(128,971)
Physician Specialty	4,928,264	3,995,126	5,375,241	4,752,608	4,742,360	(10,248)
Primary Care Physician	1,080,895	1,397,119	1,106,857	1,416,404	1,549,090	132,686
Home & Community Based Services	1,371,387	1,406,513	1,002,240	1,401,652	1,300,108	(101,545)
Applied Behavior Analysis Services	164,519	245,756	212,939	247,919	119,355	(128,565)
Mental Health Services	342,867	(6,789,601)	286,098	1,084,374	343,612	(740,762)
Pharmacy	9,346,520	10,149,501	9,102,568	9,865,405	9,730,113	(135,292)
Provider Reserve	0	0	0	0	1,005,757	1,005,757
Other Medical Professional	287,442	260,837	165,463	279,745	206,510	(73,235)
Other Fee For Service	689,885	531,084	587,802	876,905	629,183	(247,722)
Transportation	131,080	140,621	127,673	130,571	128,764	(1,807)
Total Claims	42,349,482	28,982,344	41,818,154	51,416,151	45,932,035	(5,484,116)
Medical & Care Management Expense	1,287,168	1,308,170	1,243,095	1,277,602	1,607,815	330,213
Reinsurance	293,872	294,686	259,438	(207,651)	499,255	706,906
Claims Recoveries	(145,898)	(255,139)	(197,707)	(189,127)	0	189,127
Sub-total	1,435,143	1,347,718	1,304,826	880,823	2,107,070	1,226,247
Total Cost of Health Care	**52,881,936**	**39,415,171**	**52,248,022**	**57,299,670**	**53,034,590**	**(4,265,080)**
Contribution Margin	**4,124,051**	**22,091,281**	**7,654,244**	**1,163,296**	**3,699,140**	**(2,535,844)**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	1,194,268	1,281,462	998,932	1,063,365	1,110,621	47,256
Training, Conference & Travel	32,400	58,872	22,955	10,708	24,003	13,296
Outside Services	1,853,570	1,854,770	1,869,751	1,956,634	1,970,277	13,643
Professional Services	207,481	199,864	154,986	392,757	539,696	146,940
Occupancy, Supplies, Insurance & Others	427,843	860,874	537,864	381,123	445,864	64,741
ARCH/Community Grants	110,000	0	0	0	0	0
Total G & A Expenses	**3,825,562**	**4,255,842**	**3,584,488**	**3,804,586**	**4,090,462**	**285,876**
Total Operating Gain / (Loss)	**298,489**	**17,835,439**	**4,069,756**	**(2,641,290)**	**(391,322)**	**(2,249,968)**
Non Operating:						
Revenues - Interest	180,175	198,717	219,866	186,649	172,846	13,803
Total Non-Operating	**180,175**	**198,717**	**219,866**	**186,649**	**172,846**	**13,803**
Total Increase / (Decrease) in Unrestricted Net Assets	**478,664**	**18,034,156**	**4,289,622**	**(2,454,641)**	**(218,476)**	**(2,236,165)**
Full Time Employees				**185**	**186**	**1**

PMPM - STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2015-16 Monthly Trend			AUGUST 2016		Variance
	MAY 16	JUN 16	JUL 16	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	206,495	208,533	208,714	208,680	209,771	(1,091)
Revenue:						
Premium	301.18	301.89	273.51	268.65	303.98	(35.33)
Reserve for Rate Reduction	(10.17)	4.44	13.61	11.50	(0.99)	12.49
MCO Premium Tax	(15.13)	(11.59)	(0.11)	0.00	(32.54)	32.54
Total Net Premium	**275.88**	**294.74**	**287.01**	**280.16**	**270.46**	**9.70**
Other Revenue:						
Miscellaneous Income	0.19	0.21	0.00	0.00	0.00	0.00
Total Other Revenue	0.19	0.21	0.00	0.00	0.00	0.00
Total Revenue	**276.06**	**294.95**	**287.01**	**280.16**	**270.46**	**9.70**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	44.06	43.57	43.72	23.97	23.81	(0.16)
FFS Claims Expenses:						
Inpatient	43.22	57.08	52.86	51.49	50.07	(1.42)
LTC / SNF	45.86	34.30	37.38	68.17	45.62	(22.54)
Outpatient	17.09	17.61	16.12	20.36	19.43	(0.93)
Laboratory and Radiology	0.99	1.11	0.92	1.07	1.15	0.07
Emergency Room	9.08	10.02	6.99	9.19	8.53	(0.66)
Physician Specialty	23.87	19.16	25.75	22.77	22.61	(0.17)
Primary Care Physician	5.23	6.70	5.30	6.79	7.38	0.60
Home & Community Based Services	6.64	6.74	4.80	6.72	6.20	(0.52)
Applied Behavior Analysis Services	0.80	1.18	1.02	1.19	0.57	(0.62)
Mental Health Services	1.66	(32.56)	1.37	5.20	1.64	(3.56)
Pharmacy	45.26	48.67	43.61	47.28	46.38	(0.89)
Provider Reserve	0.00	0.00	0.00	0.00	4.79	4.79
Other Medical Professional	1.39	1.25	0.79	1.34	0.98	(0.36)
Other Medical Care	0.00	0.00	0.00	0.00	0.00	0.00
Other Fee For Service	3.34	2.55	2.82	4.20	3.00	(1.20)
Transportation	0.63	0.67	0.61	0.63	0.61	(0.01)
Total Claims	205.09	138.98	200.36	246.39	218.96	(27.42)
Medical & Care Management Expense	6.23	6.27	5.96	6.12	7.66	1.54
Reinsurance	1.42	1.41	1.24	(1.00)	2.38	3.38
Claims Recoveries	(0.71)	(1.22)	(0.95)	(0.91)	0.00	0.91
Sub-total	6.95	6.46	6.25	4.22	10.04	5.82
Total Cost of Health Care	256.09	189.01	250.33	274.58	**252.82**	**(21.76)**
Contribution Margin	**19.97**	**105.94**	**36.67**	**5.57**	**17.63**	**(12.06)**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	5.78	6.15	4.79	5.10	5.29	0.20
Training, Conference & Travel	0.16	0.28	0.11	0.05	0.11	0.06
Outside Services	8.98	8.89	8.96	9.38	9.39	0.02
Professional Services	1.00	0.96	0.74	1.88	2.57	0.69
Occupancy, Supplies, Insurance & Others	2.07	4.13	2.58	1.83	2.13	0.30
ARCH/Community Grants	0.53	0.00	0.00	0.00	0.00	0.00
	0.00	0.00	0.00	0.00	0.00	0.00
Total G & A Expenses	18.53	20.41	17.17	18.23	19.50	1.27
Total Operating Gain / (Loss)	1.45	85.53	19.50	(12.66)	(1.87)	(10.79)
Non Operating:						
Revenues - Interest	0.87	0.95	1.05	0.89	0.82	0.07
Total Non-Operating	0.87	0.95	1.05	0.89	0.82	0.07
Total Increase / (Decrease) in Unrestricted Net Assets	2.32	86.48	20.55	(11.76)	(1.04)	(10.72)

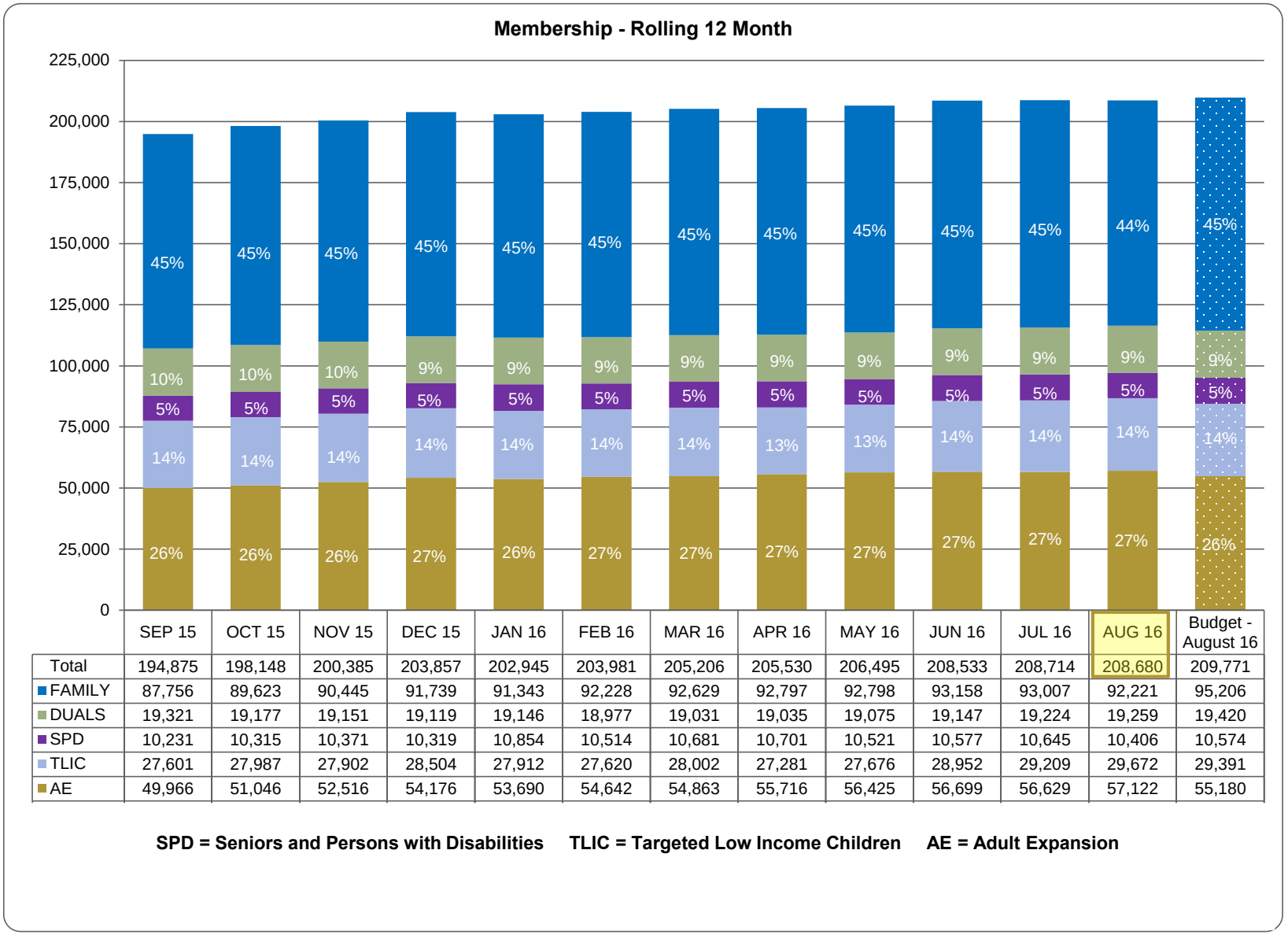
STATEMENT OF CASH FLOWS - FYTD

	AUG 16
Cash Flow From Operating Activities	
Collected Premium	$ 208,456,270
Miscellaneous Income	293,787
State Pass Through Funds	5,452,824
Paid Claims	
Medical & Hospital Expenses	(73,362,458)
Pharmacy	(14,782,474)
Capitation	(9,617,283)
Reinsurance of Claims	(518,979)
State Pass Through Funds Distributed	(5,295,587)
Paid Administration	(13,502,275)
MCO Taxes Received / (Paid)	(5,665,649)
Net Cash Provided / (Used) by Operating Activities	**91,458,177**
Cash Flow From Investing / Financing Activities	
Net Acquisition / Proceeds from Investments	(324,912)
Net Discount / Premium Amortization of Investments	112,728
Net Acquisition of Property / Equipment	(196,415)
Net Cash Provided / (Used) by Investing / Financing	**(408,599)**
Net Cash Flow	**$ 91,049,578**
Cash and Cash Equivalents (Beg. of Period)	144,092,466
Cash and Cash Equivalents (End of Period)	235,142,045
	$ 91,049,578
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income / (Loss)	1,834,982
Depreciation & Amortization	112,896
Net Discount / Premium Amortization of Investments	(112,728)
Decrease / (Increase) in Receivables	87,321,216
Decrease / (Increase) in Prepaids & Other Current Assets	(301,123)
(Decrease) / Increase in Payables	3,727,443
(Decrease) / Increase in Other Liabilities	(5,192,081)
Change in MCO Tax Liability	(5,642,533)
Changes in Claims and Capitation Payable	4,710,473
Changes in IBNR	4,999,633
	91,458,177
Net Cash Flow from Operating Activities	**$ 91,458,177**

STATEMENT OF CASH FLOWS - MONTHLY

	AUG 16	JUL 16	JUN 16
Cash Flow From Operating Activities			
Collected Premium	$ 68,556,255	$ 139,900,015	$ -
Miscellaneous Income	177,109	116,679	88,734
State Pass Through Funds	1,463,369	3,989,455	-
Paid Claims			
Medical & Hospital Expenses	(44,399,056)	(28,963,402)	(27,969,909)
Pharmacy	(4,427,362)	(10,355,112)	(14,835,213)
Capitation	(4,828,298)	(4,788,985)	(4,748,403)
Reinsurance of Claims	(259,540)	(259,438)	(295,919)
State Pass Through Funds Distributed	(1,463,358)	(3,832,229)	-
Paid Administration	(4,058,374)	(9,443,901)	(6,465,043)
MCO Tax Received / (Paid)	(5,665,649)	-	(2,142,737)
Net Cash Provided / (Used) by Operating Activities	**5,095,095**	**86,363,082**	**(56,368,491)**
Cash Flow From Investing / Financing Activities			
Net Acquisition / Proceeds from Investments	(9,541)	(315,372)	29,890,017
Net Discount / Premium Amortization of Investments	9,541	103,188	109,983
Net Acquisition of Property / Equipment	(129,028)	(67,387)	(367,442)
Net Cash Provided / (Used) by Investing / Financing	**(129,028)**	**(279,571)**	**29,632,559**
Net Cash Flow	**$ 4,966,067**	**$ 86,083,511**	**$ (26,735,932)**
Cash and Cash Equivalents (Beg. of Period)	230,175,977	144,092,466	170,828,399
Cash and Cash Equivalents (End of Period)	235,142,045	230,175,977	144,092,466
	$ 4,966,067	**$ 86,083,511**	**$ (26,735,932)**
Adjustment to Reconcile Net Income to Net Cash Flow			
Net (Loss) Income	(2,454,641)	4,289,622	18,034,156
Net Discount / Premium Amortization of Investments	(9,541)	(103,188)	(109,983)
Depreciation & Amortization	56,677	56,219	55,991
Decrease / (Increase) in Receivables	12,300,545	75,020,670	(83,473,852)
Decrease / (Increase) in Prepaids & Other Current Ass	161,598	(462,721)	(842,539)
(Decrease) / Increase in Payables	494,232	3,233,211	6,485,123
(Decrease) / Increase in Other Liabilities	(2,376,041)	(2,816,040)	(939,374)
Change in MCO Tax Liability	(5,666,392)	23,859	1,087,215
Changes in Claims and Capitation Payable	(579,030)	5,289,503	10,088,580
Changes in IBNR	3,167,687	1,831,946	(6,753,808)
	5,095,095	86,363,082	(56,368,491)
Net Cash Flow from Operating Activities	**5,095,095**	**86,363,082**	**(56,368,491)**

GOLD COAST HEALTH PLAN

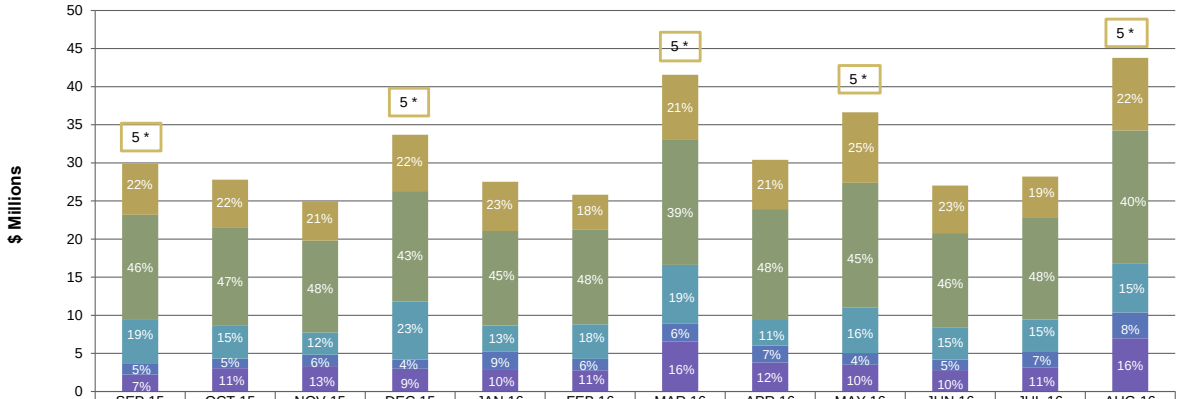


	SEP 15	OCT 15	NOV 15	DEC 15	JAN 16	FEB 16	MAR 16	APR 16	MAY 16	JUN 16	JUL 16	AUG 16	Budget - August 16
Total	194,875	198,148	200,385	203,857	202,945	203,981	205,206	205,530	206,495	208,533	208,714	208,680	209,771
FAMILY	87,756	89,623	90,445	91,739	91,343	92,228	92,629	92,797	92,798	93,158	93,007	92,221	95,206
DUALS	19,321	19,177	19,151	19,119	19,146	18,977	19,031	19,035	19,075	19,147	19,224	19,259	19,420
SPD	10,231	10,315	10,371	10,319	10,854	10,514	10,681	10,701	10,521	10,577	10,645	10,406	10,574
TLIC	27,601	27,987	27,902	28,504	27,912	27,620	28,002	27,281	27,676	28,952	29,209	29,672	29,391
AE	49,966	51,046	52,516	54,176	53,690	54,642	54,863	55,716	56,425	56,699	56,629	57,122	55,180

SPD = Seniors and Persons with Disabilities TLIC = Targeted Low Income Children AE = Adult Expansion

GOLD COAST HEALTH PLAN
AUGUST 2016

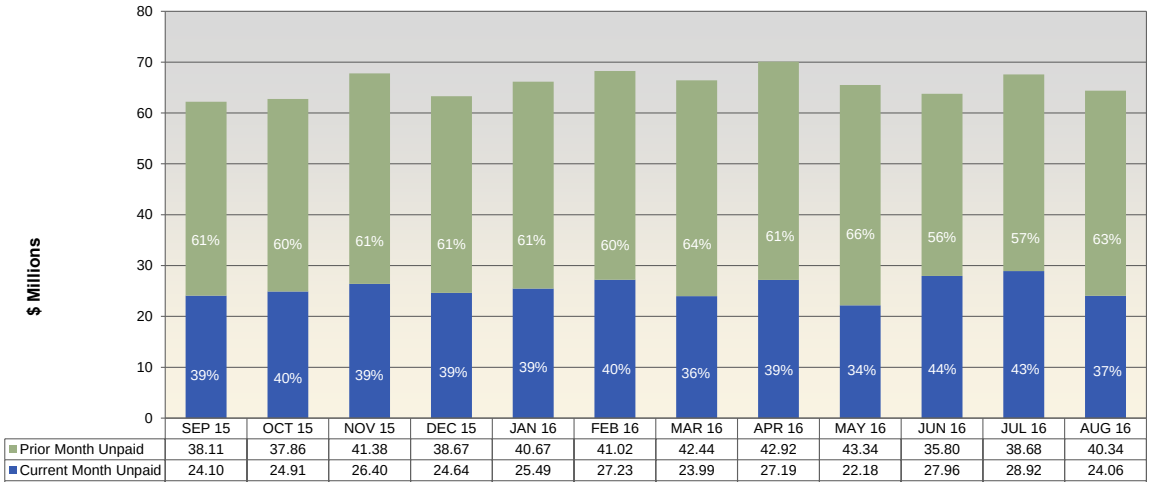
Paid Claims Composition (excluding Pharmacy and Capitation Payments)



	SEP 15	OCT 15	NOV 15	DEC 15	JAN 16	FEB 16	MAR 16	APR 16	MAY 16	JUN 16	JUL 16	AUG 16
Current	6.72	6.22	5.17	7.40	6.47	4.61	8.56	6.46	9.24	6.24	5.31	9.51
30	13.70	12.95	12.05	14.50	12.40	12.40	16.40	14.57	16.40	12.42	13.47	17.52
60	5.76	4.30	2.94	7.60	3.45	4.54	7.73	3.34	5.95	4.18	4.23	6.38
90	1.51	1.26	1.50	1.20	2.38	1.50	2.33	2.24	1.51	1.38	2.03	3.38
120+	2.22	3.06	3.32	3.00	2.82	2.78	6.56	3.80	3.52	2.81	3.17	6.99

Note: Paid Claims Composition - reflects adjusted medical claims payment lag schedule.
Months Indicated with 5* represent months for which there were 5 claim payments. For all other months, 4 claim payments were made.

IBNP Composition (excluding Pharmacy and Capitation)

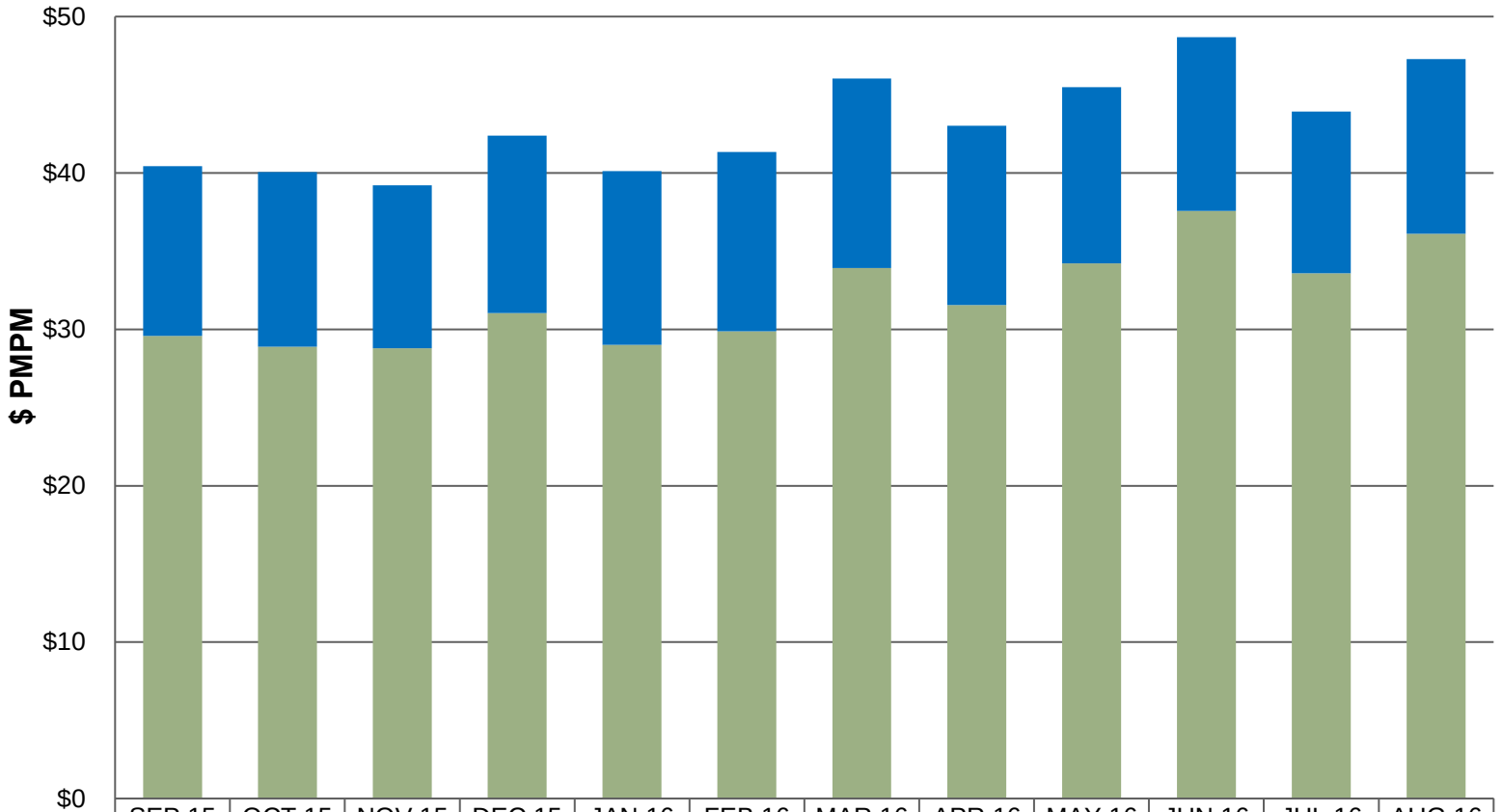


	SEP 15	OCT 15	NOV 15	DEC 15	JAN 16	FEB 16	MAR 16	APR 16	MAY 16	JUN 16	JUL 16	AUG 16
Prior Month Unpaid	38.11	37.86	41.38	38.67	40.67	41.02	42.44	42.92	43.34	35.80	38.68	40.34
Current Month Unpaid	24.10	24.91	26.40	24.64	25.49	27.23	23.99	27.19	22.18	27.96	28.92	24.06

Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.

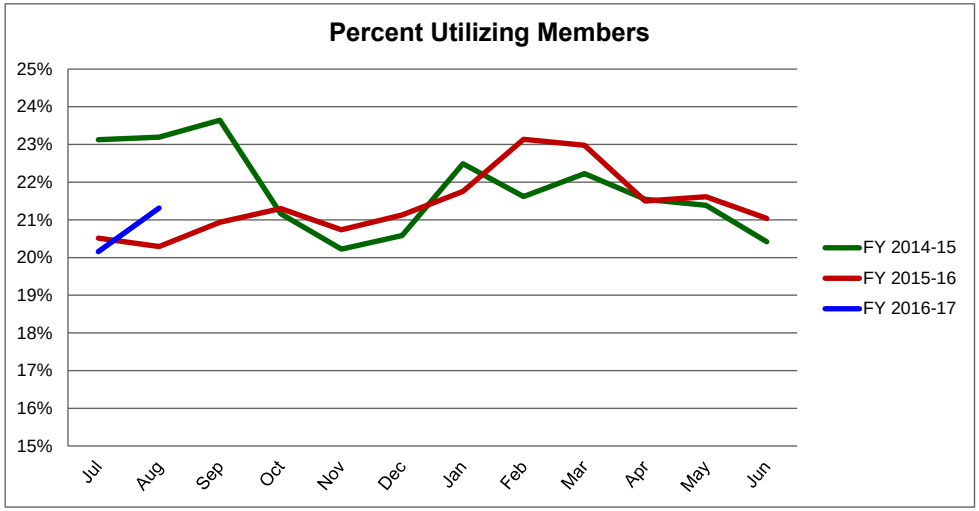
GOLD COAST HEALTH PLAN

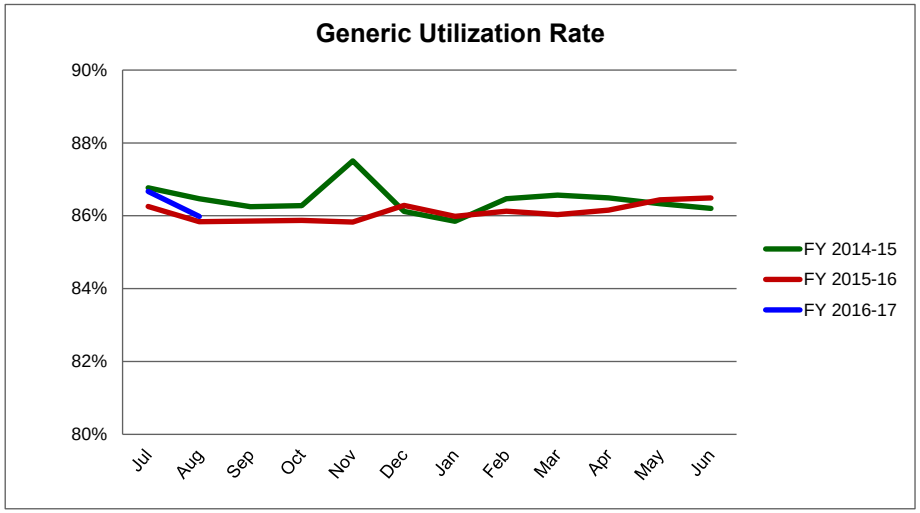
Pharmacy Cost Trend



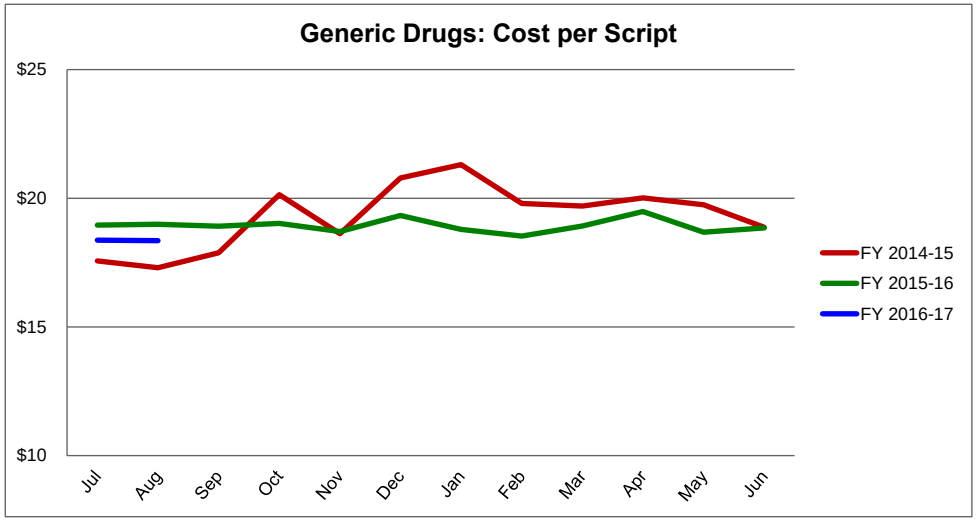
	SEP 15	OCT 15	NOV 15	DEC 15	JAN 16	FEB 16	MAR 16	APR 16	MAY 16	JUN 16	JUL 16	AUG 16
AVG PMPM	$40.43	$40.07	$39.21	$42.39	$40.11	$41.33	$46.03	$43.01	$45.48	$48.67	$43.93	$47.28
GENERIC	$10.86	$11.17	$10.42	$11.35	$11.11	$11.45	$12.11	$11.47	$11.26	$11.09	$10.34	$11.17
BRAND	$29.58	$28.90	$28.79	$31.04	$29.00	$29.88	$33.92	$31.55	$34.22	$37.58	$33.59	$36.11

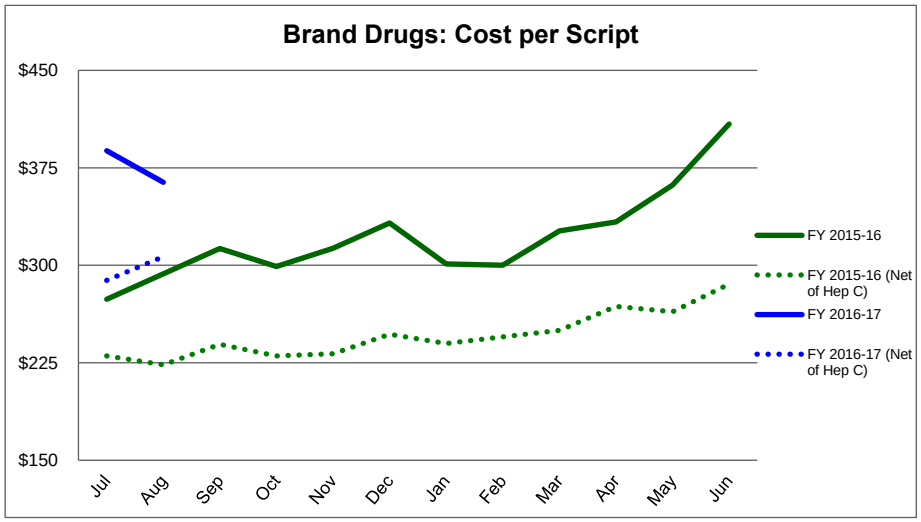
GOLD COAST HEALTH PLAN
PHARMACY ANALYSIS





Effective Oct 14, Dual members were responsible for prescription copays, lowering the percentage of utilizing members.





AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Bob Bushey, Procurement Officer

DATE: October 24, 2016

SUBJECT: Signature Authority and Procurement Policy

SUMMARY:

Internal authorizations and external bidding practices are currently governed under Agenda Item 4A-1 dated June 28, 2010. Staff is recommending replacing the internal authorization concepts of this document with a Signature Authority Policy. This Signature Authority Policy will clarify certain language associated with the term “annually” as written in Agenda Item 4A-1.

BACKGROUND/DISCUSSION:

With regard to internal authorizations, Agenda Item 4A-1 states:

“The Ventura County Medi-Cal Managed Care Commission CEO/Interim CEO shall have the authority to enter into contractual agreements and/or Memorandums of Understanding for administrative goods and services, inclusive of Information Technology (IT), up to a $100,000 annually.”

The use of the term “annually” may be interpreted in a number of ways including, fiscal year, calendar year or contract year as an example. The new signature Authority Policy uses the cumulative projected or committed contractual total as the level of internal authorization. The CEO will have the authority to enter into contractual agreements and/or Memorandums of Understanding for administrative goods and services, inclusive of Information Technology (IT) with a *cumulative amount of up to* $100,000. The Ventura County Medi-Cal Managed Care Commission will review and approve all contractual agreements and/or Memorandums of Understanding for administrative goods and services, inclusive of Information Technology (IT) with the *cumulative amount over* $100,000. Summary authorization levels within the policy are below:

The applicable General Authorization, as set forth in the following table, is based on the GCHP job level. **General Authorization is granted only to Procurement, Cardholders or Manager and above job levels.**	
GENERAL AUTHORIZATION	
Job Level	**Authorization Limit**
Ventura County Medi-Cal Managed Care Commission*	Over $100,000
Chief Executive Officer	Up to $100,000
Chief Financial Officer	All transactions over $50,000 and under $100,000
Department Chief	All transactions over $25,000 and up to $50,000
Department Director	Up to $25,000
Department Manager	Up to $5,000
Procurement Cardholders	Up to $1,000

With regard to bidding practices, Agenda Item 4A-1 states:

"Agreements shall be based on obtaining a minimum of three bids. Services with an aggregate total value of $50,000 or less will not require the bidding process. In the event that there is only a single or sole source for the goods or services in excess of $50,000 required, documentation shall be kept on file to substantiate the following:

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

The language of requiring competitive bidding at the $50,000 threshold is referenced in Sections 2.4, 2.5, a) and 2.5 b) of the Procurement Policy. The use of a sole source memo is referenced in Section 2.5.1 of the Procurement Policy.

FISCAL IMPACT:

The benefits to the Ventura County Medi-Cal Managed Care Commission and the Plan include:

- Clarity. Clear understanding of the internal control process associated with contracting for administrative goods and services.
- Transparency. Greater transparency of the projected or commitment contractual amounts over the term of the agreement.
- Visibility. Greater visibility of what, how and where public funds are being contracted.

RECOMMENDATION:

Staff is recommending the Ventura County Medi-Cal Managed Care Commission delete Agenda Item 4A-1 and approve the Signature Authority and Procurement Policies. Staff is also recommending that any future revisions to these policies be reviewed and approved by the Ventura County Medi-Cal Managed Care Commission.

CONCURRENCE:

N/A

ATTACHMENTS:

Agenda Item 4A-1
Signature Authority Policy
Procurement Policy
Sole Source Memo

Title: Signature Authority Policy	Policy Number**: FI-XXX**
Department: Finance	Effective Date: 10/24/2016
CEO Approved:	Revised:

1.0 Background:

Good internal controls require proper authorization of disbursement transactions to ensure that funds are expended in conformity with management's intentions.

Gold Coast Health Plan ("GCHP") grants specific levels of signature authority to certain employees to authorize and approve the commitment or expenditure of GCHP funds ("GCHP Commitments"). This policy is intended to ensure that any GCHP Commitment is properly authorized prior to being made.

2.0 Definitions:

"Signature" means written in the hand of the authorizing individual or an approved electronic signature format within GHCP's documents. Signature stamps are not accepted.

3.0 Purpose:

The purpose of this policy is to establish consistent company-wide control over accounts payable disbursements, wire transfers, purchases and contractual commitments made on the behalf of GCHP that are generally non-claim related. It is essential that potential transactions have all required approvals prior to GCHP making a commitment with the associated vendor or other outside party.

This policy attempts to balance the need for corporate approval of transactions that could potentially have a material effect on GCHP as a whole against the need for departments to conduct their operations efficiently.

4.0 Scope:

This policy is made on behalf of GCHP, applies to new transactions that will ultimately result in the use of GCHP assets. These transactions include, but are not limited to, purchase requisitions, check requests, purchase orders, contracts, leases, and capital expenditures – regardless if such transactions were budgeted or unbudgeted. Exceptions include claims payments that are NOT processed and paid through GCHP accounts payable system; provider contracts and capitation contracts which are the responsibility of the associated Chief Officer to the extent they are routine and within budgetary expectations; and payments of pass-through items designated by DHCS as available for disbursement to providers through various government programs. Invoice transactions that have been previously authorized by a contract summary and approval form and/or a requisition/PO do not require Signature approval.

All transactions are required to have the proper level of authorization prior to GCHP making a commitment with a vendor or other outside party. The proper level of authorization for transactions is defined as, "The signature of at least one employee with authorization for the related cost center and an authorization limit greater than or equal to the total amount of the transaction." Reference to paragraph 6.1 for authorized spending limits. The approver or his/her designee is responsible for ensuring that the transaction represents a proper use of GCHP funds.

5.0 Policy Statement:

GCHP's Finance Department is responsible for administering this policy. It is the responsibility of the requesting employee or business unit to obtain all necessary approvals prior to submitting the purchase requisition, check request, purchase order, contracts, leases, capital expenditures, etc. to Procurement or Finance Department. **No funds should be disbursed or purchase orders issued until the required approvals have been obtained. Any revisions to this policy must be approved by the Ventura County Medi-Cal Managed Care Commission.**

6.0 Authorization Limits:

The appropriate approval level is determined by the amount of the total transaction, regardless of whether the transaction is submitted using one purchase requisition/check request/purchase order/contract summary and approval form or multiple smaller transactions. The following approval rules applies to all change orders to amend an existing open purchase order:

- Purchase orders may be increased up to the lesser of five percent (5%) of the total original purchase order amount or $500 without additional approvals. For example, if the total of the original purchase order total price is $45,000; the maximum amount that can be increased without additional approvals is $45,500.
- Changes required above the 5% or $500 threshold, require approval for the total amount of the transaction, including the change order. In the above example, if the change order amount were $501, then the approval amount would be for $45,501.

In situations where the appropriate level of management is not available for approval, the next higher level of management within the operating unit will apply. For control purposes, e-mails, should only be used in place of actual signatures for purchase order changes, allowing GCHP to amend the same purchase order number. Where the original document bears the original signatures, faxed/scanned copies are acceptable on an exception basis for urgent payment requests. The original document should be forwarded to the Procurement or Accounts Payable, ("A/P") department and marked for "file only, previously faxed/scanned on mm/dd/yy".

6.1 General Authorization:

Employees are identified with authorization limits up to a specified amount based on their job title within GCHP (e.g., manager, director, chief, Ventura County Medi-Cal Managed Care Commission). General disbursement authorization limits are designated in Table1 below.

The applicable General Authorization, as set forth in the following table, is based on the GCHP job level. **General Authorization is granted only to Procurement, Cardholders or Manager and above job levels.**

GENERAL AUTHORIZATION

Job Level	Authorization Limit
Ventura County Medi-Cal Managed Care Commission*	Over $100,000
Chief Executive Officer	Up to $100,000
Chief Financial Officer	All transactions over $50,000 and under $100,000
Department Chief	All transactions over $25,000 and up to $50,000
Department Director	Up to $25,000
Department Manager	Up to $5,000
Procurement Cardholders	Up to $1,000

**** Note The Ventura County Medi-Cal Managed Care Commission may delegate approval to the Chief Executive Officer.***

7.0 Delegation of Authority:

Authority to approve check requests or requisitions/purchase orders under this Signature Authority Policy may be temporarily delegated to another employee during periods of planned absences. Delegation must be to a direct report at a Manager or above job level. Delegation requests are initiated using the attached Delegation of Authority form. This form is also located in the Finance Department section on SharePoint.

Individuals below Director job level cannot temporarily delegate authority. Notwithstanding delegation, the responsibility for all actions remains with the originally authorized associate. At the time of signing any authorization to expend GCHP's funds, the employee to whom authority has been delegated must indicate on whose behalf the associate is exercising authority; i.e., "Joe Smith for Jane Doe."

8.0 Contracts and Authorized Agents:

The Chief Executive Officer (CEO), is GCHP's authorized agent to sign all non-claims related contracts. Properly authorized requisitions/purchase orders from originating departments, serve as the internal authorization for the CEO to make external funding commitments with vendors of administrative goods and services. The CEO may only temporarily delegate his/her authority to a Chief or the Procurement Officer during periods of planned absences.

9.0 Legal Review of Contracts:

Where practical, all contractual negotiations should be initiated from legally pre-approved standard agreements. Circumstances may arise where standard contract templates are not applicable. In these situations, a standard contract template may be modified or a different contract format may be used. In every situation, if there are changes to a legally pre-approved contract, the Legal Department must review and approved of such changes. If the contract is a service order/schedule against a pre-approved master agreement and the terms and conditions contained in the service order/schedule do not conflict with the master agreement terms and conditions the Legal Department does not need to review the service order/schedule/statement of work.

Title: Signature Authority Policy	Policy Number: **FI-XXX**
Department: Finance	Effective Date: 10/24/16
CEO Approved:	Revised:

Exhibit A

DELEGATION OF AUTHORITY LETTER

By means of this letter, I, [name and title], hereby temporarily delegate my signature authority as described in the Signature Authority Policy to [position title and name], on the following terms and conditions:

1. In accordance with the Signature Authority Policy, [name and title] may review and sign, on my behalf, check requests, requisitions/purchase orders in an amount and duration not to exceed [insert dollar limit] from [starting date] until [end date].

2. The authority delegated in this document cannot be sub-delegated.

I hereby acknowledge and agree that the responsibility for all actions remains with the delegating party.

[signature]
_____ Date:
[Name]
Title [delegating official]

Acknowledged and agreed:

[signature]
_____ Date:
Name
Title [delegate]

Approved:

[signature]
_____ Date:
[Title] **

** The signed form must be sent to A/P.

AGENDA ITEM 4A - 1
POLICY
VCMMCC CEO Signing Authority for Contractual Agreements for Administrative Goods and Services

The Ventura County Medi-Cal Managed Care Commission CEO/Interim CEO shall have the authority to enter into contractual agreements and/or Memorandums of Understanding for administrative goods and services, inclusive of Information Technology (IT), up to a $100,000.00 annually. Agreements shall be based on obtaining a minimum of three bids. Services with an aggregate total value of $50,000 or less will not require the bidding process. In the event that there is only a single or sole source for the goods or services in excess of $50,000 required, documentation shall be kept on file to substantiate the following:

1 Why the selected product and/or vendor was chosen.

2. What the unique performance factors of the selected product/service are.

3. Why the specific factors are required.

4. Other products/services examined and rejected and the reasons they were rejected.

5. Why other sources providing like goods or services were found to be unacceptable.

The CEO/Interim shall sign administrative services and goods contracts and or agreements above these limits at the direction of the Commission.

Contracts with providers for the delivery of needed and required health care services to beneficiaries shall be exempt from this process.

Approved by Commission
June 28, 2010

Title: Procurement Policy	Policy Number**: FI-XXX**
Department: Finance	Effective Date: 10/24/2016
CEO Approved:	Revised:

Policy Statement:

Gold Coast Health Plan ("GCHP") utilizes a wide variety of goods and services provided by external vendors. This policy supports GCHP's commitment to proactively control its cost base, and ensures optimal value for GCHP in how goods and services are acquired in support of its business operations.

Purchases that do not adhere to the GCHP's procurement procedures may:

- Place the company at undue risk
- Reduce the impact of Preferred Vendor agreements
- Cause GCHP to incur higher transaction costs
- Not leverage buyers' trade skills to objectively select vendors and negotiate agreements

All purchases are required to have proper levels of internal GCHP authorization in accordance with the Signature Authority Policy prior to making a commitment to a vendor.

Purpose:

The purpose of this policy is to educate employees on the optimal methods to acquire goods and services.

This policy is also intended to recognize the importance of objective vendor selection, cost-effective and efficient procurement processes, fact-based analysis, and cross-functional decision making.

Scope:

All goods and services obtained from external vendors are included within the scope of this policy.

This policy does not include the purchasing and contracting with healthcare providers involved in the actual delivery of healthcare services. Other exclusions include, legal services, membership dues, grant agreements, sponsorships, employee benefits, utilities, insurance, business licenses and regulatory fees.

Definitions:

- ***Buyer –*** Procurement department employees designated with buying authority for GCHP
- ***IT –*** (the ***"***Information Technology Department") If the procurement includes Technology, the Information Technology Department together with the Project Management Office, ("PMO"), must first review and approve the purchase prior to contracting with external vendors.
- ***Order*** – An official, contractual commitment to a vendor for goods or services (ex. Purchase order, signed contract, etc.)
- ***Preferred Vendor*** – Vendor with a current Master Agreement that may include all security requirements, a Business Associate Agreement and pre-negotiated enterprise wide pricing.
- ***Contract Summary and Approval Form*** –Paper based or electronic form that describes the contract including a summary of the goods and/or services being contracted and their associated costs. The Contract Summary and Approval Form is used to obtain all internal

authorizations associated with executing contracts in accordance with the Signature Authority Policy.

- ***Requisition/PO*** – Paper based or electronic requisition document used when a contract is not required for the procurement. The Requisition/PO describes the goods and/or services and their associated costs. The Requisition/PO is used to obtain all internal authorizations in accordance with the Signature Authority Policy.
- ***Requestor*** – An employee of GCHP requesting the purchase of goods and/or services
- ***Technology*** – Includes any of the following:
    - Software
        i. Software subscriptions (Software as a Service, "SaaS", "Cloud")
        ii. Software licenses to run on GCHP premises or on vendor premises
    - Services
        i. Installation of hardware and software
        ii. Implementation of hardware and software
        iii. Support for hardware and software
        iv. Configuration & Programming
        v. Consultation on hardware and software use
        vi. Information Security consultation, investigation, or testing
    - Equipment

      Any equipment that requires any one or more of the following to function properly:
        1. Computer connection
        2. Network connection
        3. Internet connection
        4. Network configuration

      Equipment examples include: PCs, Monitors, Laptops, Tablets, Notebooks, Printers, Copiers, Scanners, Fax machines, Projectors, Digital Cameras, Video Cameras, Digital recording and transmission devices, anything with a USB or Firewire connection, Communications Equipment (e.g. telephones, cell phones, telephone interfaces or desk sets intended to be connected to GCHP's VOIP /Shoretel telephone system).
    - Exceptions – IT approval is NOT required for purchase of:
        i. Keyboards and pointing devices (mice, trackballs)
        ii. Speakers and headsets
- ***Vendor*** – An external organization providing goods or services

Title: Procurement Policy	Policy Number: **FI-XXX**
Department: Finance	Effective Date: 10/24/2016
CEO Approved:	Revised:

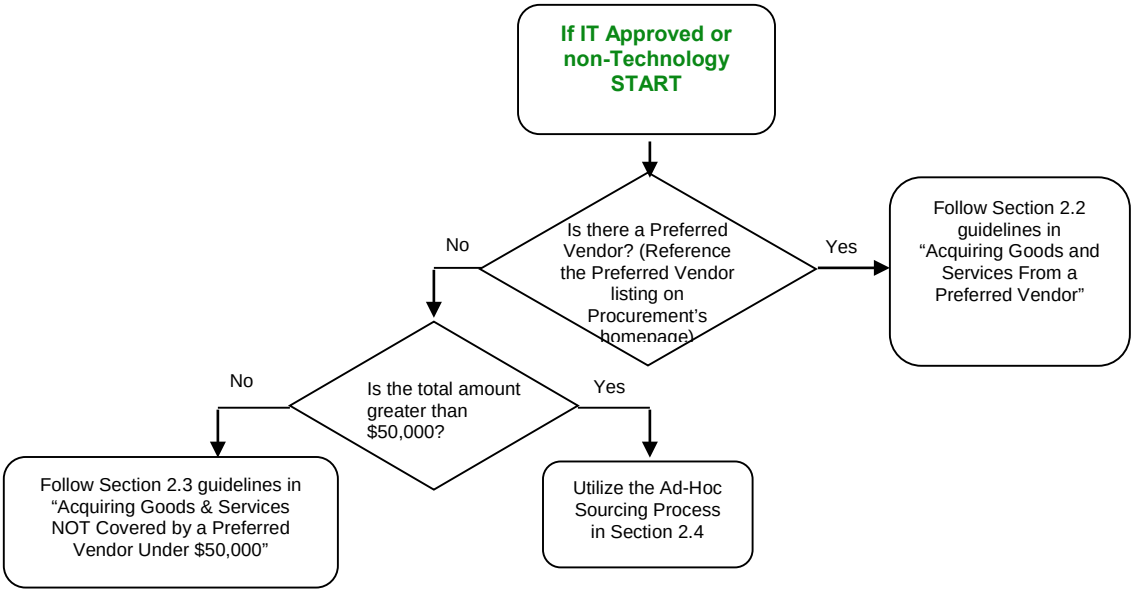
PURCHASING PROCEDURE

1.0 ACQUIRING GOODS AND SERVICES

The optimal method to acquire goods and service is depicted below. Wherever possible the fastest and easiest method to procure goods or services is through the GCHP's Preferred Vendors identified in the Preferred Vendor Listing, located on the Procurement intranet homepage.

The process flowchart below in Figure 1 shows the proper steps for obtaining goods and services.

Figure 1: Bidding Determination Process



1.1 Supplier Diversity

GCHP is committed to be a valuable member of the communities in which it operates. To that end, equal opportunity will be afforded to Women and Minority Business Enterprises (WMBEs) to participate with us as vendors, contractors and subcontractors of goods and services.

1.2 Behavioral Standards of Procurement

Vendors are important assets to GCHP, as they both provide vital goods and services and represent potential customers. When dealing with vendors, ALL GCHP employees must adhere to the ethical and legal standards for vendor relationships as detailed in the Gold Coast Health Plan Ethics Policy, Policy Number: HR-006.

In addition to these standards, employees shall:

- Consider the interests of GCHP in all transactions and abide by its established policies
- Buy without prejudice, seeking to obtain the maximum ultimate value for each dollar of expenditure
- Subscribe to and work for honesty and truth in buying and selling, and report all forms and manifestations of commercial bribery
- Avoid sharp practice, which is best defined as presenting inflated quantity needs to a vendor to obtain the lowest unit price (see Section 1.3.2)

1.2.1 Conflict of interest

The Political Reform Act of 1974 prohibits an employee from making, participating in the making, or using their position to influence a company decision where it is reasonably foreseeable that the decision may have a financial effect on the employee's economic interests. **Reference Exhibit B**. In order to proactively avoid a potential conflict of interest, an employee participating in the strategic sourcing process may be required to sign a Conflict of Interest Compliance Certification in the form of **Exhibit C**.

1.3.1 Disclosure of Confidential Information

Employees must protect all confidential and privileged procurement-related information that has been entrusted to them. Although employees' fundamental responsibility is to protect GCHP, employees also have a responsibility to the vendors and firms with whom GCHP does business. Employees must avoid statements that would injure or discredit a vendor or divulge confidential information that would give an unfair advantage to specific vendors who are involved in a competitive bidding process.

1.3.2 Misuse of Buying Power

Employees must not misapply the purchasing power represented by their ability to award orders to vendors. It is unethical, for example, to obtain low pricing based on discussions of large volume when the intent is to buy only a small quantity. Under the Federal Robinson-Patman Act, it is unlawful for employees to induce or obtain more favorable prices, terms, or conditions of purchase than those available to competing buyers.

1.3.3 Unfair Buying Tactics

Unfair buying involves purchases made based on an associate's favoritism for a vendor. Friendship cannot be a basis for placing an order. ***Orders must be placed based on predefined qualitative and quantitative factors, and practical consideration factors including cost, quality, risk, and service.*** Any buying decision that runs counter to these considerations puts the interest of the GCHP second to the interest of the vendor and is therefore improper.

1.3.4 Samples from Vendors

All samples are the property of GCHP and must not accrue to the personal benefit of any associate. Samples are defined as solicited or unsolicited products submitted to GCHP for the purpose of evaluation.

1.4 Policy Exceptions

Exceptions to this policy are provided under Section 2.5.1.

2.0 PROCESS FOR PURCHASING GOODS AND SERVICES

GCHP's procurement procedures ensure the purchase of goods and services from external vendors who provide the most cost effective, technically capable solution with favorable terms and conditions. Procurement seeks to pool GCHP-wide demand volume, reduce the number of vendors, and to standardize goods and services.

This section provides a description of the procedures that employees should follow when requisitioning goods and services and requesting change orders to existing purchase orders.

2.1 Determining How/Where to Obtain Goods and Services

When possible employees should follow the process flowchart in ***Figure 1*** (Section 1.0) to determine the required steps for obtaining all goods and services and use a Requisition/Purchase Order to requisition the good or service.

2.2 Acquiring Goods and Services from a Preferred Vendor

NOTE: If the purchase includes Technology, the Information Technology Department must first review and approve the purchase prior to contracting with external vendors.

Procurement establishes legally approved Master Agreements with Preferred Vendors that if applicable, will include privacy and security requirements, including a Security Risk Assessment and Business Associate Agreement. These Preferred Vendor agreements often also contain enterprise wide pre-negotiated pricing. Preferred Vendors are reviewed and updated regularly based on strategic sourcing projects and the evaluation of work performed. The only exception to this review practice is the immediate substitution or removal of a Preferred Vendor for the following reasons:

- Instability of a vendor
- Regulatory requirements
- Unethical business practices
- Direct or indirect competition with a GCHP business
- Vendor is acquired by others

The Preferred Vendor list is published on the Finance Department section on SharePoint. The use of these vendors will significantly reduce GCHP's administrative costs through, reduced procurement cycle time, reduced risk through legally approved contracts, and utilization of enterprise wide demand for lower negotiated pricing. Using a Preferred Vendor over contracting with a new vendor will generally provide a faster and overall better customer experience.

Once the procurement is approved by IT the Requestor may contact the Preferred Vendor and request a budgetary quote and submit the budgetary quote to any Buyer in the Procurement Department. The Buyer will finalize any required contracting and work with the Requestor to prepare the Requisition/PO in obtaining all internal approvals.

2.3 Acquiring Goods & Services NOT Covered by a Preferred Vendor under $50,000

NOTE: If the purchase includes Technology, the Information Technology Department must first review and approve the purchase prior to contracting with external vendors.

Goods and services that are ***not*** available through a Preferred Vendor and that total less than $50,000 may **not** need to go through the strategic sourcing process discussed in Section 2.5.

Instead, for items up to $49,999 requestors should create a Contract Summary and Approval Form or the Requisition/PO and include the vendor budgetary quote when necessary. **NOTE:** ***The cycle time for Procurement to finalize a contract with legal may take up to three, (3) months.***

2.4 Acquiring Goods & Services NOT Covered by a Preferred Vendor That Total $50,000 or More

NOTE: If the purchase includes Technology, the Information Technology Department together with the Project Management Office, ("PMO"), must first review and approve the purchase prior to contracting with external vendors.

Once IT has approved a purchase, procurements requiring goods and services totaling $50,000 or more that are ***not*** covered by a Preferred Vendor, must utilize the ad-hoc strategic sourcing process discussed in Section 2.5(a). Anytime during the ad-hoc strategic sourcing process, the Requestor may submit a Contract Summary and Approval Form or the Requisition/PO describing the goods or services being procured. The Contract Summary and Approval Form and the Requisition/PO forms are located on the Finance Department section on SharePoint.

NOTE: ***The cycle time for Procurement to finalize this process and negotiate a contract with legal may take up to six, (6) months.***

2.5 Strategic Sourcing Process

Strategic sourcing is an objective, fact based process that utilizes an assembled Sourcing Team (that includes end user representatives) to define sourcing requirements and to select the vendors that offer GCHP the best overall value. There are two types of strategically sourced scenarios:

a) ***Ad-Hoc Purchase*** – Used by Requestors to objectively procure non-recurring/unique goods and services. The size and composition of the team is determined by the Requestor based upon factors such as impacted stakeholders or any unique requirements for the organization. The roles and responsibilities of the Sourcing Team are documented in the table, see ***Figure 2 below***. The Requestor is responsible for initiating the process, and Procurement is responsible for facilitating the process. This process requires soliciting a minimum of three potential bidders.

b) ***Repetitive*** – Used by Procurement to consolidate GCHP-wide demand for repetitive purchases of goods and services using a Sourcing Team that includes key business owners throughout the organization. This scenario is used to establish Preferred Vendors. Procurement is responsible for initiating the process, forming the Sourcing Team and facilitating the process. This process requires soliciting a minimum of three potential bidders.

Procurement is the primary department to distribute Requests For Information (RFI), Requests For Proposal (RFP) and Requests For Quote (RFQ).

The following six strategic sourcing steps are the same for both the ad-hoc purchase and repetitive sourcing scenarios. However, the steps are expedited ("fast tracked") for the ad-hoc purchase scenario. For example, if there is insufficient time to conduct a formal RFI, a fast track approach will be used to obtain a vendor bid list.

Figure 2: Strategic Sourcing Process Roles & Responsibilities

Steps		Tasks/Responsibilities		Key Decisions
		Sourcing Team	Procurement	
1	***Develop Category Profile (Repetitive purchases)***	Determine: • What we buy • Who we buy it from • When we buy • Unit cost		
2	***Generate Industry Profile***	• Identify industry leading vendors • Determine vendors value-added capabilities • Identify industry trends		
3	***Develop Sourcing Strategy***		• Develops a sourcing strategy that utilizes a Total Cost of Ownership, (TCO) model (*If purchase is IT related IT will complete*) • Assess bargaining position • Evaluate alternative strategies*	
4	***Implement Sourcing Strategy***	• Provides the major selection factors and relative weights • Provides requirements for RFx • Approves the RFI, and the RFI list • Approves the RFP and the RFP list • Scores the RFP proposal responses** • Approves the short list vendor recommendation	• Facilitates the development of the selection evaluation matrix • Authors and distributes the RFI • Communicates with vendors • Collects and co-scores the RFI • Consolidates the RFI Sourcing Team's scores • Authors and distributes the RFP • Issues the Security Risk Assessment Questionnaire, (if applicable) with RFP	Which vendors to include in the RFI Which vendors to include in the RFP Which vendors to conduct final negotiations

			• Communicates with vendors • Collects and co-scores the RFP • Consolidates RFP team scores • Develops the short list recommendation based on evaluation matrix scoring	
5	***Negotiate and Select Vendors***	• Approves the negotiation strategy • Chooses whether to participate in negotiation	• Develops the negotiation strategy • Draft agreement with Legal • Conducts the negotiations	Which vendor(s) will receive the final award
6	***Implement Agreements***	• Implements the agreement • Participate in the vendor management program if applicable	• Contract is executed by CEO • Measure and report results and trends	

* There may be cases where an alternate vendor selection strategy may be used. Depending on the requirement and unique situation, single sourcing, partnering, continuity, learning curves, standardization, and/or other business considerations may determine vendor selection. GCHP relies on the expertise and judgment of Procurement to employ the proper methods to obtain the optimum value relationship with its vendors.

** The Sourcing Team creates weighted decision matrices to help select the vendor offering the most cost effective, business and/or technical solution with favorable terms and conditions.

2.5.1 Single or Sole Source

In the event that there is only a single or sole source for the goods or services in excess of $50,000 required, documentation shall be kept on file to substantiate the following:

1 Why the selected product and/or vendor was chosen.

2. What the unique performance factors of the selected product/service are.

3. Why the specific factors are required.

4. Other products/services examined and rejected and the reasons they were rejected.

5. Why other sources providing like goods or services were found to be unacceptable.

2.5.2 Government Contracts

If eligible, GCHP may enroll in pre-negotiated state and municipal agreements. These agreements leverage much larger volume and may include price discounts and favorable terms and conditions that generally may not be available directly to GCHP. By enrolling in these agreements, GCHP does **not** need to use the strategic sourcing process to establish market competition and by default, the vendors of these agreements become a Preferred Vendor.

2.5.3 Customer Directed Purchase

There may be legitimate business reasons to acquire goods and services without using the services of Procurement. If Procurement is not fully engaged in the full spectrum of the process, the Requestor shall acknowledges that they have performed the appropriate process to protect the company from any undue risk and that they have elected to not utilize an existing Preferred Vendor. These exceptions shall be tracked and reported to senior management as a "Customer Directed Purchase". Where these exceptions occur, the Chief of the Requester's department must complete and sign the Customer Directed Purchase Exception Form attached as **Exhibit A**, prior to any purchase of goods or services. If the Customer Directed Purchase is already executed by the Requestor, Procurement will file and retain the contract record in the department's contract repository. If a Customer Directed Purchase Exception Form is completed prior to contract execution, Procurement will route the contract for execution and retain the contract record in the department's contract repository.

NOTE: ***Employees should not sign contracts, GCHP's Chief Executive Officer is the ONLY authorized agent to execute non-claims related agreements.***

2.6 Internal Authorization to Enter Into Commitments with Vendors

Prior to making a commitment with a vendor, all purchases are required to have proper levels of internal GCHP authorization in accordance with the Signature Authority Policy. Requisitions/PO serve as internal authorization for GCHP to enter into commitments with vendors of administrative goods and services. For a Non Standard Sourced Agreement, the Requestor is responsible for ensuring that the procurement is compliant to GCHP policy, including but not limited to, internal authorizations, privacy and security policies.

2.7 Contracts and Legal Requirements

Where practical, all contractual negotiations should be initiated from legally pre-approved standard agreements. Circumstances may arise where standard contract templates are not applicable. In these situations, a standard contract template may be modified or a different contract format may be used. In every situation, if there are changes to a legally pre-approved contract, the Legal Department must review the changes. If the contract is a service order/schedule against a pre-approved master agreement and the terms and conditions contained in the service order/schedule do not conflict with the master agreement terms and conditions, the Legal Department does not need to review the service order/schedule.

Once a contract has been signed, Procurement will maintain a repository of all contracts and manage activities. Such activities are to include but not limited to, expiration date notification, renewals, posting new contracts to the repository, and monitoring contract compliance.

2.8 Purchase Orders, Invoices, and Payments

After the Contract Summary and Approval Form or the Requisition/PO is approved, the selected vendor is issued a purchase order and purchase order number. Vendor invoices must reference the purchase order number provided to them. The Requestor is responsible for performing all receiving in the form of approving an invoice. Approving an invoice confirms that the goods have been received or services have been rendered. The invoice for received goods and/or services is paid against the purchase order by Accounts Payable.

2.9 Change Orders to Goods or Services Already Procured

Change orders are required when Requestors want to make changes to existing purchase orders, or when goods and/or services are no longer required. Whenever possible, change orders for additional goods and/or services should be anticipated when initially drafting an agreement through the inclusion of renewal terms and predetermined extension pricing.

Change order requests require approval based on the authorization limits provided in the Signature Authority policy. The approval amount is the initial purchase order amount plus or minus all subsequent changes. Change orders to existing purchase orders are handled in the following manner:

- To request a purchase order change, submit a Requisition/PO identifying the current purchase order number.
  a. Increases up to the lesser of five percent (5%) of the total order or $500 do not require additional signature authority approval (e.g., Order total price is $45,000, the maximum increase of the purchase order change amount without incurring additional signature authority approval is $500).
  b. Increases required above the 5% or $500 threshold, will be routed for signature authority based on the newly combined purchase order value.

Upon receiving approval, the responsible Buyer updates the related Order to reflect approved changes. Change orders are not intended to compensate for significant changes in scope or to start a new project with an incumbent vendor.

2.10 Procurement Service Levels

Requests should be initiated with Procurement as soon as the needs arise. Project durations for ad-hoc strategic sourcing projects ranges from ten to twenty four weeks, based on the scope and complexity of the sourcing initiative. Factors specific to the project will be taken into consideration when establishing work plans and estimating project duration.

3.0 RESPONSIBILITIES

3.1 Departments, and Employees (Requestors)

a) Obtain all proper authorized approvals

b) Adhere to GCHP's ethical standards and legal requirements when dealing with vendors.

c) Obtain goods and services in conformance with this policy.

d) Management approves the Contract Summary and Approval Form or the Requisition/PO in accordance with their respective Authority levels provided in the Signature Authority Policy.

e) When required, work with Procurement to establish Sourcing Teams for goods and services obtained through GCHP's Ad-hoc purchase Sourcing process, including developing RFx's participating in vendor proposal evaluation scoring and negotiations.

f) Abide with vendor selection results based on pre-defined qualitative and quantitative factors.

g) Escalate disagreements on the final outcome of the sourcing selection process to the Chief and Procurement Officer level.

h) Receive goods and/or services through invoice review and approval, if necessary.

i) Communicate any order issues to the responsible Procurement Buyer.

j) Initiate Change Orders and obtain proper authorized approval.

3.2 Procurement

a) Adhere to GCHP's ethical standards and legal requirements when dealing with vendors.

b) Initiate and conduct the vendor selection process for repetitively sourced goods and services. Facilitate Requestors obtaining goods and services through the ad-hoc purchase sourcing process.

c) Review the Contract Summary and Approval Form or the Requisition/PO requests for completeness and best practices.

d) When appropriate, make recommendations and suggest alternatives regarding the goods and services requested.

e) Work with Requestors involved in the sourcing process to develop a TCO model, sourcing strategy, RFI, RFP and RFQ (if appropriate).

f) Manage all vendor relationships and communications, including distribution of RFIs, RFPs, and RFQs.

g) Research vendor base and assist Requestors with vendor selection for the RFIs and RFPs.

h) Initiate, conduct and conclude negotiations leading to the acquisition of all goods and services.

i) Work with Requestors and vendors to resolve issues.

j) Review change orders for completeness and best practices.

k) Update purchase orders to reflect changes requested in the approved change orders.

l) Periodically reassess Preferred Vendor relationships.

m) Monitor compliance with this policy.

n) Handle unsolicited vendor inquiries.

o) Procurement Officer gets involved in resolving Requestor disagreements regarding the final outcome of the sourcing selection process.

3.3 Legal Department

a) Reviews and approves alterations or amendments to the terms and conditions of GCHP's purchase orders or standard templates as well as all other types of agreements.

3.4 Accounts Payable

a) Redirects payment requests that do not follow the procedures outlined in this policy.

b) Pays invoices against purchase orders after proper matching of invoices, purchase orders and receipt of goods/services is performed by the employee (if required).

Title: Procurement Policy	Policy Number: **FI-XXX**
Department: Finance	Effective Date: 10/24/2016
CEO Approved:	Revised:

Exhibit A

Customer Directed Purchase Exception Form

Requestor					
Name:		Phone:		Date:	
Department Name:		E-Mail:			
Procurement Contact:		Vendor or Contract:			

Acknowledgement

- Requestor acknowledges that they have assumed the responsibility to protect GCHP from any undue risk (i.e., business, legal, information security, and privacy).
- Requestor acknowledges that they have elected to not utilize an existing Preferred Vendor.

Acceptance

I understand and accept the acknowledgements in this Customer Directed Purchase Exception Form. I also acknowledge that I understand the Purchasing Policy which can be found in GCHP's Compliance 360 Policy Library.

Name:	Title:	Date:	Signature:

Title: Procurement Policy	Policy Number: **FI-XXX**
Department: Finance	Effective Date: 10/24/2016
CEO Approved:	Revised:

Exhibit B

CONFLICT OF INTEREST CODE FOR VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION dba Gold Coast Health Plan

The Political Reform Act, Government Code section 81000 et seq., requires local government agencies to adopt and promulgate Conflict of Interest Codes. The Fair Political Practices Commission has adopted a regulation (Cal. Code Regs.. Title 2 § 18730) which contains the terms of a standard Conflict of Interest Code ("Standard Code..), which may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act after public notice and hearings.

The terms or California Code of Regulations, Title 2, section §18730 and any amendment to it duly adopted by the Fair Political Practices Commission are hereby incorporated by reference as the Conflict of Interest Code for the VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION ("VCMMCC"), and along with the designated positions requiring disclosure, constitute the Conflict of Interest Code of the VCMMCC dba Gold Coast Health Plan (the "Code").

Pursuant to Section 4 of the Standard Code and Government Code section § 87500. subd. (j) and (o), persons holding a designated positions described below shall file originals of their statements or economic interests with the VCMMCC. With respect to the statements for each Commission Member and for the Chief Executive Officer, VCMMCC shall retain copies thereof and forward the originals to the Clerk of the Ventura County Board of Supervisors (unless VCMMCC is instructed otherwise). For all other persons holding the designated positions described below. VCMMCC shall retain the originals of such statements.

This Code establishes no additional filing requirements for public officials specified by Government Code section § 87200 if they are designated in this Code in that same capacity or if the geographical jurisdiction of the VCMMCC is the same as or is wholly included within the jurisdiction in which those persons must report their economic interest pursuant to Government Code sections § 87200, et seq.

A person holding a designated position with an assigned disclosure category shall:
(i) submit an initial statement of economic interest" within 30 days after the effective date of this Code and (ii) file annual statements of economic interest and other required statements pursuant to Section 5 of the Code as set forth in California Code of Regulations. title 2 section § 18730. Such statements shall be available for public inspection and reproduction as required by law, (Government Code Section § 81008).

Exhibit C

Gold Coast Health Plan
Conflict of Interest Compliance Certification

1. Gold Coast Health Plan (GCHP) intends to avoid conflicts of interest involving the RFP respondent (the "Contractor") or its subcontractors, or the employees, officers directors or agents of the Contractor or its subcontractors.

2. GCHP reserves the right to determine, in its sole discretion, whether a conflict of interest exists.

3. Conflicts of interest may include, but are not limited to, the following circumstances:

    a. A GCHP official has a financial interest in the Contractor or its subcontractors and the official makes, participates in the making of, or uses his or her official position to influence the making of a decision having a foreseeable and material financial effect on the Contractor or its subcontractors.

    b. A GCHP official has a financial interest in the Contractor or its subcontractors and the official participates in the making of a contract with the Contractor.

    c. The Contractor or its subcontractors, or any employee, officer, director or agent of the Contractor or its subcontractors, serves as a consultant to GCHP and such consultant makes, participates in the making of, or uses its position to influence the making of a GCHP decision involving an entity in which the consultant has a foreseeable and material financial interest. (Negotiating the terms of one's own contract does not, by itself, create a conflict of interest.)

4. For the purpose of this Certification, having a "financial interest" in an individual or entity includes, but is not limited to:

    a. Having an investment interest of $2,000 or more in a business entity.

    b. Having an ownership or leasehold interest of $2,000 or more in real property of an individual or entity.

    c. Receiving income or promised income aggregating to $500 or more in the previous 12 months from an individual or an entity.

    d. Receiving gifts aggregating to $460 or more in the previous 12 months from an individual or entity.

e. Financial interests include the community property interest in the investment, real property interest, income or gift, of the individual's spouse or registered domestic partner.

5. If GCHP becomes aware of a potential conflict of interest, the Contractor will be given the opportunity to submit additional information or, if possible, to resolve the potential conflict. A Contractor with a potential conflict of interest will have five (5) business days from the date of notification of the potential conflict by GCHP to provide complete information regarding the potential conflict. If GCHP determines that an actual conflict of interest exists that cannot be resolved to GCHP's satisfaction, GCHP may reject the proposal and/or terminate the contract.

6. The Contractor shall place this Certification in its response to the RFP. This Certification shall contain the original signature of an official or employee of the Contractor who is authorized to bind the Contractor.

7. This Certification will be incorporated into the contract, if any, awarded from this RFP. It is understood that this requirement shall be in effect for the entire term of the contract. The Contractor shall obtain a completed Certification from any proposed subcontractor and submit it to GCHP prior to approval of the subcontractor by GCHP.

8. If circumstances exist that may constitute a conflict of interest, or which may create the appearance of a conflict of interest, the Contractor shall attach to this form a description of the circumstances, together with a plan for addressing the potential or apparent conflict of interest.

The undersigned hereby certifies that: (check one)

☐ Contractor understands and agrees with the foregoing. Contractor certifies that no conflict of interest exists, and no appearance of a conflict of interest exists.

☐ Contractor understands and agrees with the foregoing. A potential conflict of interest, or the appearance of a conflict of interest, may exist, and additional information is attached along with a plan to address the potential conflict of interest or appearance of conflict of interest.

Signed:_____

Title:_____

Date: _____

Type or Print Name of
Authorized Representative:_____

SOLE SOURCE FORM

Services with an aggregate total value of $50,000 or more require the bidding process. In the event that there is only a single or sole source for the goods or services in excess of $50,000, this Sole Source Form must be completed and documentation shall be kept on file to substantiate the following:

- Why the selected vendor was chosen?
- What the unique performance factors of the selected good/service are?
- Why the specific factors are required?
- Other good/services examined and rejected and the reasons they were rejected.
- Why other sources providing like good/services were found to be unacceptable?

Complete the Sole Source Form and submit it to the Procurement Department.

SOLE SOURCE FORM

Department Date

Vendor Approx Spend

We have thoroughly researched and determined that the vendor/brand requested in this documentation is the only acceptable vendor/brand for the product/services that will fit my/our particular requirement.

Check all boxes that apply:

- ☐ Used Equipment
- ☐ Auction, Closeout, Bankruptcy, or Similar
- ☐ Emergency
- ☐ Prototype (test purposes)
- ☐ Compatibility
- ☐ Professional Expertise
- ☐ Donor Specific
- ☐ Supplier Qualifications
- ☐ Follow-Up Work
- ☐ Other (explain below)
- ☐ Proprietary Item(s)
- ☐ Standardization
- ☐ Qualified Products List
- ☐ Only Approved Source

The product/service is required to:

SOLE SOURCE FORM

Why was the selected vendor chosen?

What are the unique performance factors of the selected good/service?

SOLE SOURCE FORM

Why are the specific factors required?

Describe other good/services examined and rejected and the reasons they were rejected:

SOLE SOURCE FORM

Why were other sources providing like good/services found to be unacceptable?

* Requires approval from the CEO and CFO.

I certify that I have no personal or financial interest and no present or past employment or activity which would be incompatible with my participation in any activity related to the planning or procurement processes applicable to this Sole Source Form.

Date

Signature

Print name

Title

CFO Signature

CEO Signature

AGENDA ITEM NO. 5

TO: Gold Coast Health Plan Commission

FROM: Dale Villani, Chief Executive Officer

DATE: October 24, 2016

SUBJECT: Discussion and Direction Regarding Community Resource Center Options

SUMMARY:

Gold Coast Health Plan's (GCHP's) mission is "to improve the health of our members through the provision of high quality care and services:" As Ventura County's Managed Medi-Cal Plan we are committed to a Member-first focus geared to maintaining the health of our members and meeting the needs of our local community. The health of any population is determined in part by the resources and support available in our homes, schools, neighborhoods and communities.

As we learn more about health disparities and the social determinants of health, the Plan looks to have a closer connection to our member's in the neighborhoods they live in, while providing services beyond traditional Medi-Cal benefits. To that end, Staff has explored the possibility of launching a Community Resource Center in a location within Ventura County where a large percentage of Plan members reside.

BACKGROUND:

Staff has identified space in the Downtown Oxnard Historic district available for lease for the purpose of establishing a Community Resource Center. This space is in an ideal location, close to Heritage Square and within walking distance of two senior living complexes, Oxnard City Hall, an Adult Day Care Center, the Social Security Office and Oxnard's School District office. It is also a block and a half from the bus and train terminals.

Plans are to build out this multi-purpose space to accommodate walk-in traffic for GCHP members or interested community residents to learn more about GCHP, plan benefits and how to navigate the county healthcare system. Health education and community outreach events such as health fairs, diabetic screenings, nutritional demonstrations and exercise classes designed around improving the health outcomes of our members will also be scheduled. Our strategy includes partnering with community based organizations and county agencies who serve GCHP members and potential members to provide needed services within the local neighborhood.

Detailed staffing plans, hours of operations and event schedules are still in the planning stages. Occupancy is estimated for February or March 2017 as significant tenant improvements will be required.

FISCAL IMPACT:

The cash expenditures for a 5-year lease including rent, tenant improvements, office furniture, security access, insurance, janitorial and utility expenses, vendor services, computer equipment, cabling, telephone and networking fees is estimated at $575,000 for year one (includes startup costs) and $500,000 per annum for the remaining life of the lease. This estimate does not include any staffing costs that may need to be added.

RECOMMENDATION:

It is the Plan's recommendation to move forward with the lease of a satellite location in downtown Oxnard for the purpose of establishing a GCHP Community Resource Center. Staff requests Commission approval for the Chief Executive Officer to negotiate and execute a lease and to instruct staff to move forward with all planning activities necessary to open a Community Resource Center located in downtown Oxnard.

CONCURRENCE:

N/A

ATTACHMENTS:

None

AGENDA ITEM NO. 6

TO: Gold Coast Health Plan Commissioners

FROM: Scott Campbell, General Counsel

DATE: October 24, 2016

SUBJECT: Appointment of Audit Committee Member to Serve the Remainder of Commissioner Pupa's Term

SUMMARY:

Former Commissioner Dee Pupa had been serving on the Audit Committee prior to the end of her tenure with the Commission. The Commissioners may choose to appoint a new member to the Audit Committee to take her place.

BACKGROUND/DISCUSSION:

The Commission established the Audit Committee in order to maintain oversight for the financial reporting process, the system of internal controls, the audit process, the process for monitoring compliance with laws and regulations and Gold Coast Health Plan's (GCHP) Code of Conflict and all approving internal audit policies and procedures, as well as performing such other duties as are set forth in the Audit Committee Charter (attached) applicable conflicts of interest laws and regulations. The Audit Committee is responsible for reviewing financial statements, reviewing the effectiveness of internal controls, and

The Audit Committee consists of at least three and no more than six members of the Commission. The Commission appoints the Committee members. The current members are Antonio Alatorre and Jennifer Swenson.

Each Committee member must be "financially literate", which the Charter defines as being able to read and understand fundamental financial statements, including a company's balance sheet, income statement, and cash flow statement. Additionally, at least one member of the Committee is to be designated as the "financial expert", having past employment experience in finance or accounting, requisite professional certification in accounting, or any other comparable experience or background that results in the individual being financially sophisticated. Commissioner Pupa was the financial expert, and therefore the Commission will also need to designate a new expert.

FISCAL IMPACT:

None.

RECOMMENDATION:

Staff recommends that the Commission appoint a new member to the Audit Committee.

CONCURRENCE:

N/A

ATTACHMENTS:

Audit Committee Charter

AUDIT COMMITTEE CHARTER

PURPOSE

To assist the Commission in fulfilling its oversight responsibilities for the financial reporting process, the system of internal controls, the audit process, the process for monitoring compliance with laws and regulations and Gold Coast Health Plan's (GCHP) Code of Conflict and all applicable conflicts of interest laws and regulations.

AUTHORITY

The Audit Committee has authority to conduct or authorize investigations into any matters within its scope of responsibility. It is empowered to:

- Appoint, compensate, and oversee the work of any registered public accounting firm employed by the organization up to $500,000.
- Resolve any disagreements between management and the auditor regarding financial reporting.
- Pre-approve all audit activities including projects that may not be in the audit plan.
- Retain counsel, accountants, or others to advise the Committee or assist in the conduct of an investigation, in accordance with GCHP procurement policy.
- Request and obtain information from the Plan that it requires – said requests shall be made of the Chief Executive Officer.
- Meet with Plan's officers, external auditors, or counsel, as necessary.

COMPOSITION

The Audit Committee will consist of at least three and no more than six members of the Commission. The Commission will appoint Committee members. Unless a chair is elected by the Commission, the members of the Committee may designate a chair by majority vote of the Committee.

Each Committee member will be "financially literate", as defined as being able to read and understand fundamental financial statements, including a company's balance sheet, income statement, and cash flow statement. At least one member shall be designated as the "financial expert", as defined by having past employment experience in finance or accounting, requisite professional certification in accounting, or any other comparable experience or background that results in the individual being financially sophisticated. This would include having been a chief executive officer, chief financial officer, or other senior officer with financial oversight responsibilities.

Each Committee member must be able to function independently, in the best interests of GCHP, with no conflict of interest and in conformance with GCHP's Code of Conduct and all applicable conflict of interest laws and regulations.

MEETINGS
The Committee will meet at least two times a year, with authority to convene additional meetings, as circumstances require in accordance with the Brown Act. All Committee members are expected to attend each meeting. The Committee will invite members of management, auditors or others to attend meetings and provide pertinent information, as necessary.

RESPONSIBILITIES
The Committee will carry out the following responsibilities:

Financial Statements

- Review significant accounting and reporting issues, including complex or unusual transactions and other areas of higher concern for the Committee, and recent professional and regulatory pronouncements, and understand their impact on the financial statements.
- Review with management and the external auditors the results of the audit, including any findings or difficulties encountered.
- Review the annual financial statements, and consider whether it is complete, consistent with information known to Committee members, and reflect appropriate accounting principles.
- Review other sections of the annual report and related regulatory filings before release and consider the accuracy and completeness of the information.
- Review with management and the external auditors all matters required to be communicated to the Committee under generally accepted auditing standards.
- Understand how management develops interim financial information, and the nature and extent of internal and external auditor involvement.

Internal Control

- Understand the scope of internal and external auditors' review of internal control over financial reporting, and obtain reports on significant findings and recommendations, together with management's response.
- Consider the effectiveness of the Plan's internal control system, including information technology security and controls.
- Consider efficiencies of satisfying compliance and other regulatory requirements through effective internal controls.

Internal Audit

- Approve the Internal Audit Policy and Procedures.
- Approve the annual audit plan and all major changes to the plan. Review the internal audit activity's performance relative to its plan.
- Review with the Internal Auditor (known as Chief Audit Executive [CAE] in Best Practices) the internal audit budget, resource plan, activities, and organizational structure of the internal audit function.

- Review the effectiveness of the internal audit function, including conformance with The Institute of Internal Auditors' Definition of Internal Auditing, Code of Ethics, and the *International Standards for the Professional Practice of Internal Auditing.*

Compliance

- Review the effectiveness of the system for monitoring compliance with laws and regulations and the results of management's investigation and follow-up (including disciplinary action) of any instances of non-compliance.
- Review the findings of any examinations by regulatory agencies, and any auditor observations.
- Review the process for communicating the Code of Conduct to Plan personnel, and for monitoring compliance therewith.
- Obtain regular updates from management and Plan legal counsel regarding compliance matters.

Reporting Responsibilities

- Regularly report to the Commission about Committee activities, issues, and related recommendations.
- Provide an open avenue of communication between internal audit, the external auditors, and the Executive/Finance Committee and the Commission.
- Report annually to the Commission, describing the Committee's composition, responsibilities, and how they were discharged, and any other information required by rule, including approval of non-audit services.
- Review any other reports concerning organization issues that relate to Committee responsibilities.

Other Responsibilities

- Perform other activities related to this charter as requested by the Commission.
- Institute and oversee special investigations as needed.
- Review and assess the adequacy of the Committee's charter annually, any changes to said charter must be presented to the Commission for approval and ensure appropriate disclosure as may be required by law or regulation.
- Confirm annually that all responsibilities outlined in this charter have been carried out.

AGENDA ITEM NO. 7

TO: Gold Coast Health Plan Commission

FROM: Scott Campbell, General Counsel

DATE: October 24, 2016

SUBJECT: Appointment of Commission Vice Chairperson to Serve the Remainder of Commissioner Pupa's Two-Year Term and Appointment of Executive/Finance Committee Members to Serve the Remainder of Commissioner Pupa and Fisher's Terms

SUMMARY:

The resignations of Commissioners Pupa and Fisher have created vacancies in the positions on the Commission and Finance Committee they held. Pursuant to the bylaws, the Commission must elect from its membership a Vice Chairperson to serve a two-year term. The Vice Chairperson will also serve on the Executive/Finance Committee. Once this officer is elected, the Commission will need make appointments to fill the balance of the Executive/Finance Committee in accordance with the bylaws.

BACKGROUND/DISCUSSION:

The bylaws adopted at the April 25, 2016 Commission meeting made changes in the bylaws which now require: (1) that the Commissioner terms begin on March 15; (2) that the Officers must be elected at the first regular meeting following the appointment of Commissioners for a new term; (3) that Executive/Finance Committee appointments will be made at either the regular meeting in which new officers are elected or at the next regular meeting.

Because the Commissioner Dee Pupa had been serving as the Vice Chairperson prior to the end of her tenure, the Commission must now elect a new Vice Chairperson. (See Bylaws, Art. III.) The Vice Chairperson is responsible for performing the duties of the Chairperson in the Chairperson's absence and performing such other responsibilities as agreed upon with the Chairperson. The bylaws do not contain any specific nominating or appointment process, and therefore the officer shall be established by a majority vote of the Commissioners. Staff recommends that the Commission nominate names for Vice Chairperson (no second is needed) and then vote on each name nominated. If no majority is reached, the list of names can be reduced to the top two vote recipients until a majority is reached.

Commissioners Pupa and Fisher both sat on the Executive/Finance Committee and their seats must be filled. The bylaws established the five-person Executive/Finance Committee, which must consist of the Chairperson, Vice Chairperson, one private hospital/healthcare representative, one Ventura County Medical Health System representative, and one Clinicas Del Camino Real representative. (See Art. IV, section (b).)The bylaws provide that if the Chairperson and/or Vice Chairperson is a representative from one of these three agencies, then the Commission ***must*** appoint another representative from that agency to serve on the Committee as well. The private hospital/healthcare representative position rotates between the two Commissioners holding these seats.

The Executive/Finance Committee is an advisory committee to the Commission. It cannot take any action on behalf of the Commission, but it does serve a number of functions. The Committee assists the CEO with planning and presentation of items to the full board, reviewing of policies, monitoring the Plan's economic performance.

FISCAL IMPACT:

None.

RECOMMENDATION:

1. Elect a Commissioner to serve as Vice Chairperson for a two-year term; and
2. Make appointments to the Executive/Finance Committee as follows:
    a. Vice Chairperson
    b. Ventura County Medical Health System Representative

CONCURRENCE:

N/A

ATTACHMENT:

Gold Coast Health Plan Bylaws

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

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

Approved: October 24, 2011
Amended: April 25, 2016

Table of Contents

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

ARTICLE I

Name and Mission

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

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

(a) Delivering medical care via a contracted provider network that will improve access to primary, specialty and ancillary services;

(b) Establishment of mechanisms to assure that medical care services meet appropriate quality of care standards;

(c) Incorporating a plan of service delivery and implementing reimbursement mechanisms which promote the long-term viability of a locally operated Medi-Cal managed care system and the existing participating provider networks inclusive of "Safety Net" providers herein defined as Medi-Cal disproportionate share hospitals, county clinics, federally qualified health centers, and licensed rural health clinics;

(d) Implementing a financial plan which includes the creation of a prudent reserve and which provides that if additional surplus funds accrue, they shall be used to expand access, improve benefits and augment provider reimbursement in Ventura County;

(e) Placing a high priority on prevention, education, early intervention services and case management for enrolled recipients;

(f) Ensuring that all obligations, statutory, contractual or otherwise, shall be the obligations of the VCMMCC and shall not be the obligations of the County of Ventura or the State of California; and

(g) Implementing programs and procedures to ensure a high level of member satisfaction.

ARTICLE II

Commissioners

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

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

(a) Physician Representatives. Three members shall be practicing physicians who serve a significant number of Medi-Cal beneficiaries in Ventura County. One shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Association, one shall be selected from a list with a minimum of three (3) nominees submitted by Clinicas Del Camino Real and one shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Center Executive Committee.

(b) Private Hospital/Healthcare System Representatives. Two members shall be representatives of private hospitals and healthcare systems operating within Ventura County and shall be selected from a list with a minimum of three (3) nominees submitted by the Hospital Association of Southern California. Nominees shall be from different hospitals and healthcare systems. The two appointed members shall not be affiliated with the same hospital or healthcare system.

(c) Ventura County Medical Center Health System Representative. One member shall be a representative of the Ventura County Medical Center Health System and shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Center administration.

(d) Public Representative. One member shall be a member of the Board of Supervisors, nominated and selected by the Board of Supervisors.

(e) Clinicas Del Camino Real Representative. One member shall be the chief executive officer of Clinicas del Camino Real or designee nominated by the Clinicas del Camino Real chief executive officer and approved by the Ventura County Board of Supervisors.

(f) County Official. One member shall be the Ventura County Health Care Agency Director or designee nominated by the Health Care Agency Director and approved by the Board of Supervisors.

(g) Consumer Representative. One member shall be a Medi-Cal beneficiary and/or a representative of an advocacy organization that serves the Medi-Cal population and is

not otherwise represented on the Ventura County Medi-Cal Managed Care Commission. This member shall be appointed from applications submitted to the Ventura County Executive Office after a posting of public notice for the open position.

(h) Ventura County Medical Center Health System Representative. One member shall be the Ventura County Medical Center Family Medicine Residency Program Director or Faculty Designee and approved by the Board of Supervisors.

Selection and Terms of Commissioners

In order to stagger terms with the intent of maintaining experienced members, in the initial cycle of appointments, the following appointees shall serve two-year terms: one of the Ventura County Medical Center Health System Representatives, the Physician Representative nominated by the Ventura County Medical Association, the Public Representative, and one Private Hospital/Healthcare System Representative. All other initial appointments and all subsequent appointments to the VCMMCC shall be for four-year terms. No member may serve more than two consecutive four-year terms. Any vacancy will be filled by the Board of Supervisors for the remainder of the unexpired term and shall maintain the balance of representation on the VCMMCC. The term of each subsequent appointment shall be deemed to commence on March 15 of the year of the appointment.

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

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

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

ARTICLE III

Officers

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

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

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

Election

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

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

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

Duties

(a) The Chairperson shall:

1. Preside at all meetings;

2. Execute all documents approved by the VCMMCC;

3. Be responsible to see that all actions of the VCMMCC are implemented; and

4. Maintain consultation with the Chief Executive Officer (CEO).

(b) The Vice-Chairperson shall:

1. Exercise all the responsibilities of the Chairperson in the absence of the Chairperson; and

2. In agreement with the Chairperson, perform all responsibilities mutually agreed upon.

ARTICLE IV

Standing Committees

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

(b) Executive/Finance Committee.

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

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

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

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

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

respectively, of the governing board, then, the other Ventura County Medical Center Health System representative and the physician representative nominated by Clinicas Del Camino Real shall be appointed to fill the respective designated seat on the Executive/Finance Committee.

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

iii. Duties of the Executive/Finance Committee.

1. Advise the governing board Chairperson on requested matters.

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

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

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

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

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

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

- PCP
- Specialists
- Hospitals o LTC
- Ancillary Providers

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

9. Review and recommend provider incentive program structure.

10. Review investment strategy and make recommendations.

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

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

13. Assist the governing board and/or the CEO in determining the appropriate committee, if any, to best deal with questions or issues that may arise from time-to-time.
14. Develop long-term and short-term business plans for review and approval by the governing board.

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

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

1. Adopting, amending or repealing any bylaw.

2. Making final determinations of policy.

3. Approving changes to the budget or making major structural or contractual decisions (such as adding or eliminating programs).

4. Filling vacancies or removing any Commissioner.

5. Changing the membership of, or filling vacancies in, the Executive/Finance Committee.

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

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

ARTICLE V

Special Committees

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

ARTICLE VI

Meetings

(a) All meetings shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code relating to meetings of local agencies ("Brown Act").

(b) A regular meeting shall be held monthly. The VCMMCC shall by resolution establish the date, time and location for the monthly meeting. A regular meeting may, for cause, be rescheduled by the Chairperson with 72 hour advance notice.

(c) Closed session items shall be noticed in compliance with Government Code section 54954.5.

(d) Special meetings may be called, consistent with the Brown Act, by the Chairperson or by a quorum of the VCMMCC. Notice of such special meeting shall conform to the Brown Act.

(e) Any meeting at which at least a quorum cannot attend, or for which there is no agenda item requiring action may be cancelled by the Chairperson with 72 hour advance notice.

(f) A quorum shall be defined as one person more than half of the appointed members of the VCMMCC. For these purposes, "appointed members" excludes unfilled positions and those vacated by resignation or removal. Unless otherwise expressly stated in these bylaws, a majority vote of members present and constituting a quorum shall be required for any VCMMCC action.

(g) After three (3) absences of any member during a fiscal year, the reasons for the absences will be reviewed by the VCMMCC and it may notify the Board of Supervisors of the absences, if it deems this action appropriate. Three or more absences from regular meetings may be cause for the VCMMCC to recommend dismissal of that member to the Board of Supervisors.

Conduct of Meetings

(a) The Chairperson shall adhere to the order of items as posted on the agenda. Modifications to the order of the agenda may be made to the extent that (on the advice of counsel) the rearrangement of the agenda items does not violate the spirit or intent of the Brown Act.

(b) All motions or amendments to motions require a second in order to be considered for action. Upon a motion and a second the item shall be open for discussion before the call for the vote.

(c) Voice votes will be made on all items as read. An abstention will not be recognized except for a legal conflict of interest. In furtherance of the foregoing, an abstention or refusal to vote (not arising from a legal conflict of interest) shall be deemed a vote with the majority of those Commissioners who do vote, except when there is a tie vote and the motion or action fails. For example, if there are 7 Commissioners present at a meeting (none of whom are subject to a legal conflict of interest), (i) a motion passes with 3 votes in favor and 4 Commissioners abstaining, (ii) a motion passes with 3 votes in favor, 2 votes against and 2 Commissioners abstaining; and (iii) a motion fails with 3 votes in favor, 3 votes against and 1 Commissioner abstaining.

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

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

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

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

(h) The Chairperson shall be permitted to make motions and vote on all matters to the same extent and subject to the same limitations as other Commissioners.

ARTICLE VII

Powers and Duties

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

(a) Advise the Chief Executive Officer (CEO) and request from the CEO information it deems necessary;

(b) Conduct meetings and keep the minutes of the VCMMCC;

(c) Provide for financial oversight through various actions and methodologies such as the preparation and submission of an annual statement of financial affairs and an estimate of the amount of funding required for expenditures, approval of an annual

budget, receipt of monthly financial briefings and other appropriate action in support of its financial oversight role;

(d) Evaluate business performance and opportunity, and review and recommend strategic plans and business strategies;

(e) Establish, support and oversee the quality, service utilization, risk management and fraud and abuse programs;

(f) Encourage VCMMCC members to actively participate in VCMMCC committees as well as subcommittees;

(g) Comply with and implement all applicable federal, state and local laws, rules and regulations as they become effective;

(h) Provide for the resolution of or resolve conflict among its leaders and those under its leadership;

(i) Respect confidentiality, privacy and avoid any real or potential conflict of interest; and

(j) Receive and take appropriate action, if warranted, based upon reports presented by the CEO (or designated individual). Such reports shall be prepared and submitted to the VCMMCC at least annually.

ARTICLE VIII

STAFF

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

Chief Executive Officer

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

The CEO shall:

(a) Direct the planning, organization, and operation of all services and facilities;

(b) Direct studies of organizations, operations, functions and activities relating to economy, efficiency and improvement of services;

(c) Direct activities which fulfill all duties mandated by federal or state law, regulatory or accreditation authority, or VCMMCC board resolution, and shall bring any conflict between these laws, regulations, resolutions or policy to the attention of the VCMMCC;

(c) Appoint and supervise an executive management staff, and such other individuals as are necessary for operations. The CEO may delegate certain duties and responsibilities to these and other individuals where such delegated duties are in furtherance of the goals and objectives of the VCMMCC;

(d) Retain and appoint necessary personnel, consistent with all policies and procedures, in furtherance of the VCMMCC's powers and duties; and

(f) Implement and enforce all policies and procedures, and assure compliance with all applicable federal and state laws, rules and regulations.

Clerk

The Clerk shall:

(a) Perform the usual duties pertaining to secretaries;

(b) Cause to be kept, a full and true record of all VCMMCC meetings and of such special meetings as may be scheduled;

(c) Cause to be issued notices of regular and special meetings;

(d) Maintain a record of attendance of members and promptly report to the VCMMCC any member whose position has been vacated; and

(e) Attest to the Chair or Vice-Chair's signature on documents approved by the VCMMCC.

Assistant Clerk

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

ARTICLE IX

Rules of Order

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

ARTICLE X

Amendments

(a) These Bylaws may be amended by an affirmative vote of a majority of the voting members of the VCMMCC. A full statement of a proposed amendment shall be submitted to the VCMMCC at least two weeks prior to the meeting at which the proposed amendment is scheduled to be voted upon.

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

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

ARTICLE XI

Nondiscrimination Clause

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

ARTICLE XII

Conflict of Interest and Ethics

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

ARTICLE XIII

Dissolution

Pursuant to California Welfare & Institutions Code, section 14087.54:

(a) In the event the Commissioners determine that VCMMCC may no longer function for the purposes for which it was established, at the time that VCMMCC's then existing

obligations have been satisfied or VCMMCC's assets have been exhausted, the Board of Supervisors may by ordinance terminate the VCMMCC.

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

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

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

AGENDA ITEM NO. 8

To: Gold Coast Health Plan Commissioners

From: Joseph T. Ortiz, Best Best & Krieger LLP, Cultural Diversity Subcommittee Counsel

Date: October 24, 2016

Re: Appointments to Cultural Diversity Officer Interview Panel

SUMMARY:

In order to proceed with the selection process of a Chief Diversity Officer (CDO), the Commission is asked to appoint a winnowing panel for candidates.

BACKGROUND/DISCUSSION:

In order to assist the Commission in its search for a Chief Diversity Officer, the Commission established a five (5) person panel to narrow the candidates for the Chief Diversity Officer. That panel selected three candidates to be interviewed by the entire Commission and the candidate eventually selected by the Commission turned down the Commission's officer. The Commission should reconvene such a panel to restart the selection process. Previously, the three members of the Diversity Subcommittee Panel, Commissioners Alatorre, Atin and Lee, Dr. Jamie Casillas, as a representative from LULAC; and M. Ed Aaron P. Hinojosa from APU served on the panel. The CDO Interview Panel will be tasked with reviewing applicant resumes and performing preliminary interviews for the purpose of winnowing down the applicant pool to two or three finalists. The Commission, as a whole, will then interview and select from the finalists. The Commission is now asked to select panelists to review and narrow done applications. The search firm Korn Ferry has been retained to help solicit and gather resumes for the position.

FISCAL IMPACT:

None at this time.

RECOMMENDATION:

Staff recommends the Commission appoint the CDO Interview Panel.

CONCURRENCE:

N/A

AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Anne Freese, PharmD, Director of Pharmacy

DATE: October 24, 2016

SUBJECT: Approval of Contract for Pharmacy Benefits Manager Services

SUMMARY:

The Commission may take action to approve the contract with OptumRx for Pharmacy Benefits Manager (PBM) Services. At its previous meeting, the Commission conditionally awarded the PBM contract to OptumRx if OptumRx would agree to certain changes to the contract. Per Commission request, Gold Coast Health Plan staff conducted further contract negotiations with OptumRx regarding the payment terms for claims invoices and performance guarantees for 340B drug pricing implementation. At the time of this report, negotiations are not yet complete, but staff anticipates the contract will be final prior to the Commission's meeting so that the Commission may grant final approval.

BACKGROUND:

The Commission directed staff to solicit a Request for Proposal (RFP) for PBM services and to provide the RFP to three vendors: OptumRx, Inc., Magellan Rx Management, Inc., and ScriptCare, LTD. Each of the three companies submitted proposals, and the proposals were scored by a core team of Plan staff. At the Commission's meeting on September 26, 2016, staff presented the proposals and the scoring to the Commission. Each of the vendors was also given the opportunity to present to the Commission. In awarding the contract, the Commission considered all relevant factors, including the scoring, the vendors' presentations, the pricing, the contract terms, and the anticipated benefits to the Plan's consumers, providers, and other stakeholders.

The scoring of the RFP revealed that each of the vendors met the minimum qualifications necessary to be selected as the Plan's PBM and that the differences between the vendors were relatively minor. The Commission considered the information presented, determined that OptumRx would be the preferred vendor to serve the Plan, and elected to award the contract to OptumRx on the condition that OptumRx agreed to certain contract changes. Though Magellan scored the highest based on staff's scoring methodology, the Commission found that several factors weighed in favor of OptumRx. In particular, and among other considerations, OptumRx offered to provide the lowest pricing and offered to put the most dollars at risk in terms of performance guarantees. OptumRx's presentation was also well-received by the Commission, and the representatives responded to questions regarding the proposal.

In conditionally awarding the contract to OptumRx, the Commission requested two key changes to the draft PBM Agreement. During the meeting, OptumRx verbally agreed to include these changes. First, OptumRx had initially insisted on the Plan's payment of network provider claims within 14 days. In response to the Commission's request, OptumRx agreed to modify this to payment within 30 days. (The Commission should note that this provision only applies to the payment of *network provider claims*; payment of *administrative fees* is unchanged and is due within 45 days.)

Second, during the September 26 meeting, the Commission expressed concern about how a transition to a new PBM would impact the existing 340B program that is utilized by some of the Plan's network pharmacies. The RFP and the initial draft PBM Agreement both require the PBM to adjudicate 340B claims, and thus the requirement to provide this service was part of the originally contemplated scope of work. The Commission requested that OptumRx provide additional performance guarantees specifically related to the 340B claims, and OptumRx agreed to do so. Since the September 26 meeting, staff has been working diligently with OptumRx to develop performance guarantees related to the 340B program, and staff anticipates that a final performance guarantee exhibit will be ready to present to the Commission. Because provider rates are not subject to public disclosure, the performance guarantee rates will be presented in closed session.

Finally, in addition to the two changes requested by the Commission, staff also included terms to consider implementation of the transition. If finalized and approved by the Commission, the PBM Agreement will take effect on November 1, 2016. The commencement of services from OptumRx will begin on June 1, 2017. Between November and June, OptumRx will be required to begin implementation to ensure a smooth transition. In this interim period, ScriptCare – the existing PBM – will still be under contract and will be required to continue providing PBM services to the Plan. The Plan has the option to continue extending ScriptCare's current contract until June 30, 2017.

In sum, the draft Professional Services Agreement and Service Order with OptumRx are attached to this memo item, and the Performance Guarantee and Service Fee exhibits will be provided in closed session. The changes within the Professional Services Agreement are as follows:

- Change of invoice due date on claims to be thirty (30) days per the commission's request.
- Inclusion of Effective Date of the contract as November 1, 2016.

The changes within the Service Order are as follows:

- Inclusion of Implementation Date of contract as June 1, 2017.
- Definition of Service Years 1, 2, and 3.

RECOMMENDATION:

In accordance with the prior direction of the Commission, and provided that staff is prepared to recommend approval of additional performance guarantees related to 340B claims, staff recommends that the Commission approve the contract for PBM Services with OptumRx. In the event that OptumRx does not provide acceptable performance guarantees for the Commission to consider, staff will recommend that the item either be continued or that the Commission provide alternative direction.

AGREEMENT FOR PROFESSIONAL SERVICES
BETWEEN VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION
DOING BUSINESS AS GOLD COAST HEALTH PLAN
AND
OPTUMRX, INC.

THIS AGREEMENT, is made as of November 1, 2016 (the "Effective Date"), by and between Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan, a California public entity established under the laws of the State of California, (hereinafter "GCHP") and OptumRx, Inc., a California corporation, (hereinafter "CONTRACTOR").

WHEREAS, GCHP is a County Organized Health System ("COHS") established pursuant to Welfare & Institutions Code §14087.54;

WHEREAS, GCHP has entered into and maintains contracts with the State of California, Department of Health Care Services (the "Medi-Cal Agreements"), under which Ventura County Medi-Cal beneficiaries, assigned to GCHP as members ("Members"), receive certain health care services hereinafter defined as "Covered Services;

WHEREAS, the Covered Services provided to Members includes benefits for prescription drugs and certain devices and supplies dispensed by pharmacists;

WHEREAS, GCHP has released a Request for Proposal ("RFP") entitled Request for Proposal Number GCHP060316, to which CONTRACTOR has responded;

WHEREAS, CONTRACTOR provides pharmacy benefit management ("PBM") services, including services in connection with the payment of pharmacy claims on behalf of clients, and CONTRACTOR has submitted a response to the RFP in the form of a proposal dated July 5, 2016, and entitled "OptumRx Response to Request for Proposal Benefit Management Services RFP – GCHP060316" ("Proposal");

NOW THEREFORE in consideration of the above-referenced recitals, the mutual covenants, promises, terms and provisions herein set forth, GCHP and CONTRACTOR agree as follows:

1. DESCRIPTION OF SERVICES

a) CONTRACTOR shall provide PBM services, including but not limited to administrative, management, consultative, claims processing and other general pharmacy benefit management support services to GCHP in conjunction with administration and operation of GCHP's Medi-Cal managed care benefit plan that includes a prescription drug benefit for Medi-Cal Members ("Services"). The scope of the Services shall be more fully set forth in one or more project authorizations duly executed by GCHP and CONTRACTOR, which shall be incorporated into this Agreement by this reference (hereinafter, "Service Order" or "Service Orders"). The initial Service Order shall be substantially in the form attached hereto as Exhibit A and shall become effective only upon the issuance of an

implementing purchase order by an authorized member of GCHP's Procurement Services organization (the "Authorized Procurement Representative"). Each Service Order is subject to all terms and conditions contained in this Agreement unless expressly stated otherwise in the Service Order.

b) Precedence. Any inconsistency in this Agreement shall be resolved by giving precedence in the following order: (1) this Agreement; (2) An applicable Service Order, including any attachments, exhibits or other component parts of the Service Order; (3) the Business Associate Agreement; (4) the RFP; and (5) CONTRACTOR's Proposal. Each document identified in this section is a part of this Agreement and is incorporated herein by this reference. Any requirement or obligation of CONTRACTOR set forth in the RFP shall be deemed a part of the general terms and conditions of this Agreement unless the Parties expressly agree to exclude any such requirement from this Agreement.

2. QUALIFICATIONS

a) CONTRACTOR hereby represents and warrants to GCHP that: (a) it has the experience and skill to perform the Services hereunder; (b) it shall comply with all applicable federal, state and local laws in effect at the time Services are performed, including all professional licensing and registration requirements; (c) it shall perform the Services in accordance with generally accepted professional standards and in an expeditious and economical manner, consistent with sound professional practices; (d) it is adequately financed to meet any financial obligation it may be required to incur hereunder; and (e) it maintains, and shall continue to maintain for the term of this Agreement, an active, unrestricted PBM URAC accreditation.

b) Each of CONTRACTOR's professional workforce members, including but not limited to independent contractors hired by CONTRACTOR to perform work under this Agreement, who render professional services pursuant to this Agreement ("Professionals") shall: (a) hold applicable, current and unrestricted professional licenses or certifications from, or licenses or certifications recognized by, the licensing authorities of the State of California; and (b) meet such other credentialing requirements and conditions as GCHP may from time to time reasonably establish. During the term of this Agreement, CONTRACTOR shall notify GCHP immediately but not later than two (2) business days , followed by written notice within ten (10) calendar days, upon its discovery of (i) any action which results in suspension or limitation of CONTRACTOR's, or a Professional's, license, permit, accreditations, or ability to conduct the applicable business or profession, (ii) any action which results in restriction, limitation, suspension or termination of a Professional's privileges, if any, at a licensed facility; (iii) any malpractice or professional liability action against a Professional that is adversely concluded by settlement or judgment; (iv) any action which results in the loss or restriction of a Professional's DEA permit; (v) any action against a Professional to exclude or suspend its participation in any federal or state health care program, including but not limited to the Medicare or Medicaid programs, or any other payor programs; or (vi) any lapse in a Professional's professional liability insurance or reduction below the limits required herein; (vii) any other occurrence as set forth in any applicable Service Order.

c) CONTRACTOR acknowledges that CONTRACTOR was selected by GCHP, in part, on the basis of qualifications of particular staff identified in CONTRACTOR's response to GCHP's solicitation, hereinafter referred to as "Key Staff." CONTRACTOR shall ensure that Key Staff are available for Services as long as said Key Staff are in CONTRACTOR's employ. With the exception of voluntary resignation, promotion, involuntary termination for cause, illness, disability, or death, CONTRACTOR will obtain prior written acceptance of GCHP to change Key Staff. CONTRACTOR shall provide GCHP with such information as necessary to determine the suitability of proposed new Key Staff. GCHP will act reasonably in evaluating Key Staff qualifications.

3. GCHP POLICIES AND PROCEDURES

CONTRACTOR agrees to comply with GCHP'S rules, policies and procedures that have been established as of the Effective Date, or will be established and have been provided to CONTRACTOR with at least thirty (30) days in advance of implementation, including rules, policies and procedures regarding: quality improvement/management; utilization management, including but not limited to, precertification procedures, referral process or protocols, and reporting of clinical data; member grievances; provider credentialing.

4. COMPENSATION AND PAYMENT

a) Compensation. The total compensation payable to CONTRACTOR for Services under any Service Order shall not exceed the services fees, allowable expenses, and other compensation expressly set forth within the Service Order. No compensation shall be allowed unless expressly set forth in a Service Order.

b) Payment. Unless otherwise provided by the issuing Service Order or otherwise requested by GCHP's Authorized Person in writing, CONTRACTOR shall submit invoices to GCHP on or about the first day of each calendar month for services rendered and expenses incurred under each outstanding Service Order during the preceding calendar month. GCHP shall pay each invoice as follows:

i) For administrative services, within thirty (30) days after receipt thereof from CONTRACTOR, subject to Sections 4(c) and 4(d) and any other applicable conditions and limitations hereof.

ii) For payment of network pharmacy claims, within thirty (30) days after notification of the amount due from CONTRACTOR, subject to Section 4(c) and any other applicable conditions and limitations hereof. In lieu of submitting monthly invoices, CONTRACTOR may submit two (2) invoices per month for network pharmacy claims on the first and fifteenth of each month.

c) Availability of Funds. Payment to CONTRACTOR is subject to GCHP's corresponding receipt of funding from DHCS, CMS or any other governmental agency providing revenue to GHCP, as applicable. In the event funding to GCHP is terminated or delayed or is otherwise insufficient, GCHP's payment to CONTRACTOR may be terminated or delayed. GCHP shall have the option to provide written notification to CONTRACTOR of the lack of funding or of the insufficiency of funding, and after providing such notification,

GCHP shall have no obligation to pay or otherwise compensate CONTRACTOR for future performance unless GCHP provides a subsequent written notification that adequate funding is established. If the lack of sufficient funding is the result of a delay in GCHP's payment from DHCS, then GCHP's payment obligation will automatically suspend and will only resume within fifteen (15) days following GCHP's receipt of its payment from DHCS for the applicable time period. Notwithstanding the foregoing, CONTRACTOR shall receive payment for services already rendered and obligations already incurred and may, upon ten (10) days written demand for cure, suspend performance of services during any continuous period of non-payment lasting at least thirty (30) days beyond the date that the payment was initially due.

d) Expense Reimbursement. GCHP shall not be responsible for reimbursement of CONTRACTOR's expenses incurred in the performance of Services pursuant to this Agreement unless the issuing Service Order so provides. If, and to the extent, that the Service Order provides that GCHP shall reimburse any such expenses of CONTRACTOR, such reimbursement shall be subject to the GCHP's Reimbursable Expense Guidelines, attached hereto as Exhibit C and incorporated herein by reference as set forth in full. Under no circumstances will reimbursement for expenses exceed the "Maximum Amount" specified in the Service Order, unless the Service Order is modified to increase such maximum.

e) Invoice Detail. Each invoice shall show: (a) the Service Order number to which the invoice relates; (b) the Purchase Order Number of the GCHP Purchase Order relating to the Service Order; (c) the GCHP billing information identified on the applicable Service Order; and (d) the specific items billed, including hours billed for each CONTRACTOR personnel performing under each Service Order. Sales and use taxes, if applicable, shall be listed as separate items on each invoice. GCHP, at its sole discretion, may refuse to pay any invoice not containing the required detail and, instead, return the invoice to CONTRACTOR within thirty (30) days of receipt. In such event, GCHP shall not be obligated to pay any sums billed by such returned invoice until thirty (30) days after GCHP receives a properly corrected invoice therefor.

f) Mailing of Invoices. Each invoice shall be mailed, in duplicate, to GCHP at the following address:

GOLD COAST HEALTH PLAN
711 E DAILY DRIVE
CAMARILLO, CA 90310
Attention: Accounts Payable

g) E-mail Invoices. Invoices may also be submitted to GCHP using the following e-mail address: Accountspayable@goldchp.org

h) Time Limit for Invoice Submission. CONTRACTOR must submit, and GCHP must actually receive, an invoice for any Service or part thereof not later than ninety (90) days after the end of the month in which such Service or part thereof has been performed or GCHP shall have no obligation or liability to pay CONTRACTOR for such Service or part thereof, unless GCHP has otherwise specifically agreed in writing.

i) Sales and Use Taxes. GCHP shall be solely responsible for the payment of any and all sales and use taxes assessed by any governmental authority with respect to the Services performed under this Agreement.

5. ADJUSTMENTS TO PAYMENT

GCHP may review and audit any and all claims for payment prior to or subsequent to payment to ensure that such payment is in accordance with this Agreement. If any claim or payment is not in accordance with this Agreement, GCHP reserves the right to deny, reduce or otherwise adjust such claim or payment, as applicable to the extent necessary to make such claim or payment conform to this Agreement. If an audit conducted by GCHP shows that CONTRACTOR for any reason owes monies to GCHP, then GCHP will notify CONTRACTOR and CONTRACTOR shall refund such overpayment to GCHP within thirty (30) business days after receipt of such notice. If CONTRACTOR does not within such period either refund such overpayment or notify GCHP that CONTRACTOR contests such overpayment, then GCHP is hereby authorized to offset the amount of the overpayment against any amounts owed to CONTRACTOR to the maximum extent permitted by applicable law. If this Agreement is terminated for any reason prior to GCHP's full recovery of such an overpayment, the remaining amount shall become due and owing immediately upon the effective date of the termination. This Section shall survive Termination of this Agreement.

6. EXTRA SERVICES

a) Additional Services. CONTRACTOR shall not be entitled to compensation for any services other than or in addition to the Services specified in any Service Order issued pursuant hereto, unless an implementing change order in the form of Exhibit B hereto for such other or additional services is issued and signed by GCHP's and CONTRACTOR's respective Project Managers and an implementing purchase order change order is issued to CONTRACTOR by GCHP's Authorized Procurement Representative prior to commencement of any such additional Services.

b) Increase in Scope. If directed by GCHP to change or increase the scope of any Services, and if CONTRACTOR determines that such change or increase in scope will result in an increase in the total of charges to GCHP under the applicable Service Order, CONTRACTOR shall provide to GCHP a written proposal for such change or increase in scope. If such proposal is accepted and authorized by an implementing change order in accordance this Agreement, CONTRACTOR shall be compensated at the rates set forth in the Service Order and/or at such other fixed price mutually agreed upon in writing.

7. SUBCONTRACTORS

All subcontracts pertaining to the provision of the Services shall be in writing, and will be entered into in accordance with the requirements of this Agreement, the Medi-Cal Agreements, and applicable federal and State laws and regulations. All such subcontracts and their amendments shall become effective only upon written approval by GCHP. The following Services shall not be subcontracted: prescription claim adjudication, prior authorization/coverage determinations, network contracting, and member call center/pharmacy help desk. The Services identified in this

section shall be performed in the United States.

8. NO ASSIGNMENT

This Agreement is not assignable by CONTRACTOR without the GCHP's prior consent in writing.

9. CONFIDENTIALITY

a) To the extent the services to be performed by the CONTRACTOR are of a confidential nature, all services performed by CONTRACTOR under this Agreement shall be in strict conformance with all applicable Federal, State of California and/or local laws and regulations relating to confidentiality, including but not limited to, California Civil Code section 56 et seq., California Welfare and Institutions Code sections 5328, 10850 and 14100.2, Health and Safety Code sections 11977 and 11812, 22 California Code of Regulations section 51009, and 42 Code of Federal Regulations § 2.1 et seq. CONTRACTOR shall submit to GCHP's monitoring of said compliance with all State of California and Federal statutes and regulations regarding confidentiality. The parties shall execute and comply with GCHP's Business Associate Agreement, which is attached as Exhibit D and incorporated herein.

b) Information that GCHP receives from CONTRACTOR, including any formula, pattern, compilation, program, device, method, technique, or process, that derives economic value to CONTRACTOR from not being generally known to the public, that CONTRACTOR has taken reasonable efforts to maintain secret from the public, and that may be marked by CONTRACTOR as proprietary or confidential, shall be maintained as confidential by GCHP, except to the extent that GCHP is required to disclose the information under the California Public Records Act (Gov. Code §§ 6250, et seq.) or other applicable law or by court order.

10. INDEMNITY AND INSURANCE

Indemnification. CONTRACTOR shall indemnify, hold harmless and defend GCHP, its directors, officers, employees, agents and affiliates from and against all third party claims, actions, suits, demands, damages, liabilities, obligations, settlements or judgments, (including without limitation reasonable attorneys' fees and costs) ("Claims") arising out of or in connection with any breach of any representation or warranty of CONTRACTOR contained in this Agreement, or any breach of any covenant or other obligation or duty of CONTRACTOR under this Agreement or under applicable law, excluding Claims to the extent resulting from the negligence or wrongful acts of GCHP. GCHP shall promptly notify CONTRACTOR of any Claim for which indemnification is sought, following actual knowledge of such Claim, provided however that the failure to give such notice shall not relieve CONTRACTOR of its obligations hereunder except to the extent that CONTRACTOR is materially prejudiced by such failure. In the event that any third party Claim is brought, GCHP shall tender its defense to CONTRACTOR, and

CONTRACTOR will provide qualified attorneys, consultants, and other appropriate professionals to represent GCHP's interests at CONTRACTOR's expense. CONTRACTOR agrees that any settlement, compromise or resolution CONTRACTOR enters into arising as a result of the Claims will not include any admission of wrongdoing by GCHP. GCHP shall have the right to participate in the defense and settlement of the claim at GCHP's cost and expense. The indemnification requirements set forth herein shall survive the termination of this Agreement.

a) Insurance. CONTRACTOR shall, at CONTRACTOR's sole cost and expense and throughout the term of this Agreement and any extensions thereof, carry adequate insurance to protect CONTRACTOR from claims under workers compensation acts that meets statutory requirements and the following insurance:

   i) Commercial General Liability with a minimum limit of $1 million per occurrence/claim and a $2 million annual aggregate.

   ii) Comprehensive automobile liability insurance with limits for bodily injury of not less than $500,000 per person and $1 million per occurrence. Coverage shall include owned and non-owned vehicles used in connect with this Agreement.

   iii) Professional error and omission insurance, with a minimum limit of $3 million per occurrence/claim and a $5 million annual aggregate.

   iv) GCHP and its officers, directors, employees and agents shall be named as additional insured on all insurance except for Worker's Compensation and Professional Liability insurance.

In all situations arising out of this Agreement, the parties shall attempt to avoid and minimize the damages resulting from the conduct of the other party.

11. RELATIONSHIP OF THE PARTIES

The relationship of the parties to this Agreement shall be that of independent contractors and in no event shall CONTRACTOR be considered an officer, agent, servant or employee of GCHP. GCHP has no right to control or supervise or direct the manner or method by which CONTRACTOR performs the services. The CONTRACTOR shall be solely responsible for any and all workers compensation insurance, withholding taxes, unemployment insurance and any other employer obligations or benefits associated with the described work/services.

12. CORRECTIONS

In addition to the above indemnification obligations, the CONTRACTOR shall correct, at its expense, all errors in the work which may be disclosed during the GCHP's review of the CONTRACTOR's report/plans/work deliverables. Should CONTRACTOR fail to make such correction in a reasonably timely manner, such correction shall be made by GCHP, and the cost thereof shall be charged to CONTRACTOR. Claims will not be paid for ineligible persons. Notwithstanding the foregoing, CONTRACTOR shall not be liable for any prescriptions filled or

processed for any person ineligible for GCHP coverage due to incorrect eligibility date provided by GCHP to CONTRACTOR.

13. FINANCIAL AND ACCOUNTING RECORDS

a) CONTRACTOR shall maintain, in accordance with standard and accepted accounting practices, all financial, accounting, claims and payment records relating to services provided or paid for hereunder as is necessary and appropriate for the proper administration of this Agreement, the Services to be rendered, and payments to be made hereunder or in connection herewith.

   Upon GCHP's written request, CONTRACTOR will furnish to GCHP an annual Balance Sheet and Profit and Loss Statement prepared in accordance with generally accepted accounting principles consistently applied and, if available, the annual audit report of an independent certified public accountant.

b) The records maintained in accordance with this section shall be maintained for a period of not less than five (5) years from the date when the applicable claim, payment or other transaction was made. The records maintenance requirements set forth herein shall survive the termination of this Agreement.

14. AUDITS AND INSPECTIONS

CONTRACTOR shall make available for examination all of its records and data with respect to the matters covered by this Agreement, at any time during normal business hours, and as often as deemed necessary by GCHP, to GCHP, the California Department of Health Care Services, the U.S. Department of Health and Human Services, the Comptroller General of the United States, the California Department of Justice, Bureau of Medi-Cal Fraud, the Department of Managed Health Care, and other authorized California state agencies, or their duly authorized representatives. The foregoing obligation of CONTRACTOR shall survive the termination of this Agreement.

15. REPORTS

Upon GCHP's written request, and at no additional charge, CONTRACTOR shall provide regular prescription claims data, any reports required by an applicable Service Order, and periodic or ad hoc reports and information pertaining to the Services, with such content and in such format(s) as reasonably requested by GCHP. For purposes of clarity, ad hoc reporting services that can be generated from queries available in CONTRACTOR's online reporting system are provided at no additional charge. If GCHP needs custom reports that require system programming, needs complex customized report programming, or needs plan-specific templates, then additional fees will apply as set forth in the applicable Service Order. At no additional charge, CONTRACTOR shall provide any reports required by DHCS or the Medi-Cal Agreements as soon as reasonably practical upon GCHP's request or within any timeframes required by an applicable Service Order.

16. TERMINATION

a) Mutual Termination. This Agreement may be terminated by mutual consent of the Parties.

b) Termination by GCHP Without Cause after Notice. GCHP may terminate this Agreement without cause by giving written notice of termination to CONTRACTOR not less than ninety (90) calendar days prior to the effective date of the termination. Termination shall be effective on the ninety-first (91st) day after such notice. In the event GCHP terminates all or a portion of this Agreement without cause pursuant to this provision, it is understood that GCHP shall pay CONTRACTOR for services rendered in compliance with the terms of this Agreement prior to the effective date of termination, but not in excess of the amount payable pursuant to the terms of this Agreement.

c) Immediate Termination by GCHP Without Cause. GCHP may terminate this Agreement without cause by giving written notice in the event that:

   i) Any provision of this Agreement is reasonably determined to place either party in probable violation of any criminal statute, and the parties are not able to promptly amend the Agreement as necessary to alleviate such violation.

   ii) GCHP's Medi-Cal Agreement terminates or expires.

   iii) Governmental appropriated funding to GCHP is suspended, terminated, withdrawn or otherwise fails or there is a lack of sufficient funding for any activities or functions contained within the scope of this Agreement.

d) Termination by GCHP For Cause After Notice. GCHP may terminate this Agreement for cause after GCHP provides CONTRACTOR with prior written notice of any failure by CONTRACTOR to perform any requirement of this Agreement and CONTRACTOR shall have no less than twenty-one (21) calendar days to cure such failure prior to termination by GCHP.

e) Immediate Termination by GCHP for Cause. GCHP may terminate this Agreement immediately for cause in the event that:

   i) CONTRACTOR fails to perform any requirement of this Agreement and CONTRACTOR's failure cannot be cured.

   ii) CONTRACTOR admits in writing its inability to pay its debts generally as they become due; applies for or consents to the appointment of a receiver, trustee or liquidator of all or a substantial part of its assets; files a voluntary petition in bankruptcy; makes a general assignment for the benefit of creditors; files a petition or answer seeking reorganization or arrangement with creditors; or if any order, judgment, or decree shall be entered by any court of competent jurisdiction on the application of a creditor or otherwise adjudicating such party bankrupt or approving a petition seeking reorganization of such party or appointment of a receiver, trustee, or liquidator of such party, or of all or a substantial part of its assets, and such order, judgment or decree shall continue unstayed and in effect for sixty (60) calendar days after its entry.

iii) CONTRACTOR fails to adhere to laws, rules, ordinances or orders of any public authority having jurisdiction over CONTRACTOR and/or this Agreement and such violation prevents or substantially impairs performance of CONTRACTOR's duties under this Agreement.

iv) GCHP discovers that there has been a material error, material misstatement or material omission by CONTRACTOR in the information provided to GCHP.

v) CONTRACTOR breaches any provision of HIPAA, the HIPAA Regulations, the HITECH Act, or other applicable laws concerning confidentiality with respect to the Services, or breaches the Business Associate Agreement.

f) Termination By CONTRACTOR Without Cause. CONTRACTOR may terminate this Agreement without Cause only after the initial term. CONTRACTOR shall give not less than 180 days' notice of termination and such termination shall be effective as of the last day of GCHP's fiscal year following expiration of the 180-day notice period. The last day of the fiscal year shall be June 30, unless GCHP gives notice of a change to its fiscal year.

g) Termination by CONTRACTOR For Cause. CONTRACTOR may terminate this Agreement for cause after CONTRACTOR provides GCHP with prior written notice of any failure by GCHP to perform any material obligation of this Agreement and GCHP shall have no less than ninety (90) calendar days to cure such failure prior to termination by CONTRACTOR.

h) Transition Period. Upon the expiration or termination of this Agreement for any reason, GCHP shall have the unilateral right to renew this Agreement for three (3) consecutive Renewal Terms of three (3) months each by giving CONTRACTOR written notice of renewal at least sixty (60) days prior to the expiration of the then-current term.

i) Service Orders. All termination provisions contained in this Section shall apply to the full Agreement as well as to any Service Orders. Any right to terminate held by either Party shall be construed as a right to terminate either a particular Service Order or this full Agreement.

17. POST-TERMINATION

The parties agree that, upon termination or expiration of this Agreement or of any applicable Service Order under this Agreement, the following shall occur:

a) CONTRACTOR shall have no further obligation to provide Services, except that CONTRACTOR shall continue to provide such Services as are reasonably necessary to ensure an orderly wind down of the arrangement contemplated by this Agreement or any applicable Service Order and to ensure that Services furnished to GCHP Members during the applicable term are fully and completely administered ("Runout Services"). CONTRACTOR's duties related to Runout Services may be more specifically defined by Service Order.

b) CONTRACTOR shall use its best efforts to facilitate a complete and efficient transfer of all Services to GCHP or its designated agents to ensure the smooth and continued operation of Services. CONTRACTOR shall cooperate fully and completely with GCHP and any of its contractors and agents both during and after the termination and transfer process.

c) CONTRACTOR shall ensure continued insurance coverage in the same minimum amounts specified in this Agreement or otherwise ensure continued insurance coverage of its liabilities arising out of this Agreement, including CONTRACTOR's obligations to process claims after termination of this Agreement.

d) CONTRACTOR shall provide to GCHP promptly upon GCHP's written request and at no cost to GCHP, electronic copies of the records pertaining to CONTRACTOR's provision of Services. In the event the copies cannot be provided electronically, they may be provided in hard copy. CONTRACTOR shall grant to GCHP for the purpose of preparing for any actual or anticipated legal proceeding or for any other reasonable purpose, access to any other pertinent information regarding CONTRACTOR's performance of its duties under this Agreement during the term of this Agreement.

e) The terms of this Agreement relating to confidentiality of Member confidential information and access to records shall survive termination or expiration of this Agreement in accordance with applicable law. The terms of this Agreement relating to indemnity provisional remedies and representations and warranties shall survive termination or expiration of this Agreement.

f) The provisions of this Agreement which by their sense and context are intended to survive completion of performance, expiration or termination of this Agreement, or provisions that otherwise require or contemplate performance or applicability after such completion of performance, expiration or termination shall be enforceable notwithstanding the termination. Without limiting the foregoing, the provisions that are intended to survive and remain enforceable after termination of this Agreement include, but are not limited to the following: the terms of this Agreement relating to confidentiality of Member confidential information (including but not limited to the Business Associate Agreement and related obligations), access to records, indemnity, provisional remedies and representations and warranties.

g) In the event of termination of this Agreement, a final accounting and settlement shall be made taking into account the charges set forth in any Service Order and any other costs and expenses reimbursable by one party to the other under this Agreement. Final settlement may be deferred at the option of GCHP for no longer than one hundred eighty (180) days following the later of (1) termination of this Agreement or (2) completion by CONTRACTOR of any post-termination or runout services provided by CONTRACTOR.

h) Immediately following the termination or expiration of this Agreement, CONTRACTOR shall deliver to GCHP at no charge an electronic copy, in a format mutually agreed by the parties, of all records required under this Agreement, including but not limited to billing amount and reports to verify the provision of claims for Services, documentation

concerning eligibility and claims data information.

18. WAIVER; REMEDIES CUMULATIVE

Failure by a party to insist upon the strict performance of any of the provisions of this Agreement by the other party, irrespective of the length of time for which such failure continues, shall not constitute a waiver of such party's right to demand strict compliance by such other party in the future. No waiver by a party of a default or breach of the other party shall be effective or binding upon such party unless made in writing by such party, and no such waiver shall be implied from any omissions by a party to take any action with respect to such default or breach. No express written waiver of a specified default or breach shall affect any other default or breach, or cover any other period of time, other than any default or breach and/or period of time specified. All of the remedies permitted or available to a party under this Agreement, or at law or in equity, shall be cumulative and alternative, and invocation of any such right or remedy shall not constitute a waiver or election of remedies with respect to any other permitted or available right of remedy.

19. NO CONFLICT OF INTEREST

CONTRACTOR represents and warrants that no GCHP employee or GCHP official, or their spouse or registered domestic partner, has a financial interest in CONTRACTOR's business, or that any such financial interest has been fully disclosed to GCHP prior to the Effective Date. For the purpose of this representation and warranty, having a "financial interest" includes, but is not limited to:

a) Having an investment interest of $2,000 or more in a CONTRACTOR;

b) Having an ownership or leasehold interest of $2,000 or more in real property of CONTRACTOR;

c) Receiving income or promised income aggregating to $500 or more in the previous 12 months from CONTRACTOR; or

d) Receiving gifts aggregating to $460 or more in the previous 12 months from an CONTRACTOR.

20. NONDISCRIMINATION AND EQUAL OPPORTUNITY

a) CONTRACTOR shall not differentiate nor discriminate on the basis of race, color, National origin, ancestry, religion, sex, marital status, Medical condition, mental or physical disability, sexual orientation, age, or any other basis protected by federal or California law.

b) CONTRACTOR shall ensure compliance with Title VI of the Civil Rights Act of 1964 and other implementing regulations (42 USC Section 2000d and 45 CFR Part 80) that prohibit recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

c) Equal Opportunity Requirements

i) The CONTRACTOR will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The CONTRACTOR will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sexual orientation, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following; employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The CONTRACTOR agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government California Department of Health Care Services setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 *38 USC 4212). Such notices shall state the CONTRACTOR's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sexual orientation, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

ii) The CONTRACTOR will, in all solicitations or advancements for employees placed by or on behalf of the CONTRACTOR, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sexual orientation, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

iii) The CONTRACTOR will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State of California, advising the labor union or workers' representative of the CONTRACTOR's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

iv) The CONTRACTOR will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

v) The CONTRACTOR will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375,

'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

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

d) CONTRACTOR shall comply with all applicable Federal requirements in Section 504 of the Rehabilitation Act of 1973 (29 USC §794) Nondiscrimination under Federal grants and programs; Title 45 CFR Part 84 Nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance; Title 28 CFR Part 36 Nondiscrimination on the basis of disability by public accommodations and in commercial facilities; Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 the Age Discrimination Act of 1975; and all other laws regarding privacy and confidentiality.

21. HUMAN SUBJECTS USE REQUIREMENTS

By signing this Agreement, CONTRACTOR agrees that if any performance under this Agreement, or any subcontract, that includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 41 U.S.C. § 263a (CLIA) and the regulations thereto.

22. DEBARMENT AND SUSPENSION CERTIFICATION

a) By signing this Agreement, the CONTRACTOR agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 C.F.R. § 3017, 45 C.F.R. § 76, 40 C.F.R. § 32, or 34 C.F.R. § 85.

b) By signing this Agreement, the CONTRACTOR certified to the best of its knowledge and belief, that it and its principals:

i) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

ii) Have not within a three-year period preceding this Agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

iii) Are not presently indicted for or otherwise criminally or civilly charged by a governmental Entity (Federal, State or local) with commission of any of the offenses enumerated in Sub-provision (b)(ii) herein;

iv) Have not within a three-year period preceding this Agreement had one or more public transactions (Federal, State or local) terminated for cause or default;

v) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 C.F.R. § 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

vi) Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

c) If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to the GCHP program funding this Agreement.

d) The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

e) If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the Federal Government, the GCHP may terminate this Agreement for cause or default.

23. SMOKE-FREE WORKPLACE CERTIFICATION

a) Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 19, if the services are funded by Federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The Act also applies to children's services that are provided in indoor facilities that are

constructed, operated, or maintained with such federal funds. The Act does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.

b) Failure to comply with the provisions of the Act may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

c) By signing this Agreement, CONTRACTOR certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

d) CONTRACTOR further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

24. COVENANT AGAINST CONTINGENT FEES

The CONTRACTOR warrants that no person or selling agency has been employed or retained to solicit/secure this Agreement upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by the CONTRACTOR for the purpose of securing business. For breach or violation of this warranty, GCHP shall have the right to annul this Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover, the full amount of, such commission, percentage, and brokerage or contingent fee.

25. OFFICIALS NOT TO BENEFIT

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this Agreement, or to any benefit that may arise therefrom. This Provision shall not be construed to extend to this Agreement if made with a corporation for its general benefits.

26. PROHIBITED USE OF STATE FUNDS FOR SOFTWARE

CONTRACTOR certifies that is has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

27. ALIEN INELIGIBILITY CERTIFICATION

By signing this Agreement, the CONTRACTOR certifies that he/she is not an alien that is ineligible for State and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 U.S.C. § 1601, et seq.)

28. DATA CERTIFICATIONS

a) CONTRACTOR shall comply with data certification requirements set forth in 42 C.F.R. § 438.604 and 42 C.F.R. § 438.606.

b) With respect to any report, invoice, record, papers, documents, books of account, or other Agreement required data submitted, pursuant to the requirements of this Agreement, the CONTRACTOR's Representative or his/her designee will certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Agreement required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief.

29. TRACKING SUSPENDED PROVIDERS

a) CONTRACTOR shall comply with Title 42 C.F.R. Section § 438.610. Additionally, CONTRACTOR is prohibited from employing, contracting or maintaining a contract with Physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs.

b) A list of suspended and ineligible providers is maintained in the Medi-CalProvider Manual, which is updated monthly and available on line and in print at the GCHP Medi-Cal website (www.medi-cal.ca.gov) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded individuals and Entities (http://oig/hhs.gov). CONTRACTOR is deemed to have knowledge of any providers on these lists.

c) CONTRACTOR must notify the Medi-Cal Managed Care Program/Program Integrity Unit within ten (10) State working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program.

30. FALSE CLAIM COMPLIANCE

CONTRACTOR shall comply with 42 U.S.C. Section 1396a(a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this Agreement. Upon request by GCHP, CONTRACTOR shall demonstrate compliance with this provision, which may include providing GCHP with copies of CONTRACTOR's applicable written policies and procedures and any relevant employee handbook excerpts.

31. DISABLED VETERAN BUSINESS ENTERPRISES (DVBE)

CONTRACTOR shall comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Section 10115 of the Public Contract Code.

32. DISPUTE RESOLUTION

a) Judicial Reference. At the election of either party to this Agreement (which election shall be binding upon the other party), a dispute between CONTRACTOR and GCHP arising out of this Agreement shall be heard and decided by a referee appointed pursuant to California Code of Civil Procedure Section 638 (or any successor provision thereto, if applicable), who shall hear and determine any and all of the issues in any such action or proceeding, whether of fact or law, and to report a statement of decision, subject to judicial review and enforcement as provided by California law, and in accordance with Chapter 6 (References and Trials by Referees), of Title 8 of Part 2 of the California Code of Civil Procedure, or any successor chapter. The referee shall be a retired judge of the California superior or appellate courts determined by agreement between the parties, provided that in the absence of such agreement either party may bring a motion pursuant to the said Section 638 for appointment of a referee before the appropriate judge of the Ventura Superior Court. The parties acknowledge that they forego any right to trial by jury in any judicial reference proceeding. Any counterpart or copy of this Agreement, filed with such Court upon such motion, shall conclusively establish the agreement of the parties to such appointment. The parties agree that the only proper venue for the submission of claims to judicial reference shall be the courts of general jurisdiction of the State of California located in Ventura County. The parties reserve the right to contest the referee's decision and to appeal from any award or order of any court. The designated non-prevailing party in any dispute shall be required to fully compensate the referee for his or his services hereunder at the referee's then respective prevailing rates of compensation.

b) Limitations. CONTRACTOR must comply with the claim procedures set forth in the Government Claims Act (Government Code Section 900, et. seq.) prior to filing any legal proceeding, including judicial reference, against GCHP. If no such Government Code claim is submitted, no action against GCHP may be filed. Notwithstanding anything to the contrary contained in this Agreement, any suit, judicial reference or other legal proceeding must be initiated within one (1) year after the date the facts giving rise to a dispute occurred or such dispute shall be deemed waived and forever barred; provided that, if a shorter time period is prescribed under the Government Claims Act, then, the shorter time period (if any) prescribed under the Government Claims Act shall apply.

c) Cut-Off for Disputes Against GCHP. Within one hundred twenty (120) days of the expiration or termination of this Agreement or any Service Order under this Agreement, CONTRACTOR shall provide to GCHP formal written notice of any unresolved disputes CONTRACTOR has against GCHP relating to this Agreement or to the applicable Service Order. The formal written notice shall describe any unresolved dispute and identify the amount CONTRACTOR demands in satisfaction of the dispute, and it shall include any supporting documentation. CONTRACTOR's failure to submit timely notice shall constitute a waiver of all unresolved disputes against GCHP. To the extent a dispute arises after the time for providing notice, and CONTRACTOR could not have timely discovered the dispute, CONTRACTOR shall provide formal written notice within ten (10) days of discovery. Nothing herein shall modify CONTRACTOR's duty to comply with the Government Claims Act and subsection "b" above.

33. AUTHORITY

Each corporate entity executing this Agreement represents and warrants that all necessary corporate action has been taken, including the due adoption of a resolution by its board of directors, sufficient to enable such corporation to enter into this Agreement, to be bound thereby and to perform fully as required hereunder. Each person executing this Agreement on behalf of CONTRACTOR represents and warrants that he/she has been duly authorized to enter into this Agreement on behalf of said party.

34. OWNERSHIP OF INTELLECTUAL PROPERTY AND DATA

a) Work Product**.** CONTRACTOR shall own all of its systems, software, and intellectual property developed prior to, during, and after the term of this Agreement.

b) Data**.** Except for CONTRACTOR's systems, software, and intellectual property, the parties agree that GCHP shall own all data and other records and deliverables specific to GCHP that are created or maintained pursuant to this Agreement. Additionally, the parties agree that CONTRACTOR shall own all of its operating records, pharmacy records and data.

35. PUBLICITY

a) Name and Mark. CONTRACTOR shall acquire no right under this Agreement to use, and shall not use, the name, service mark or design of GCHP in any advertising, publicity, promotion or other material disseminated by CONTRACTOR, or to express or imply any endorsement of CONTRACTOR or any of CONTRACTOR's products or services in any manner or for any purpose whatsoever, unless CONTRACTOR has first obtained the written permission of GCHP, which permission may be withheld by GCHP in its sole discretion. Additionally, GCHP shall not use promotional material referencing or referring to CONTRACTOR, without CONTRACTOR's consent; provided, however, that GCHP may publicize that CONTRACTOR provides PBM services to GCHP.

b) Survival. The provisions of this Section shall survive termination or expiration of this Agreement.

36. RECRUITMENT

GCHP agrees not to hire, or attempt to hire, "Full-Time Employees" of CONTRACTOR (the term "Full-Time Employees" refers only to personnel who are employed on an ongoing basis, and does not include personnel who are only treated as CONTRACTOR employees while on a contracted assignment), without CONTRACTOR's prior written consent, during the term of this Agreement and during the six (6)-month period after the expiration or termination of the Service Order under which a CONTRACTOR's employee was performing Services. If CONTRACTOR grants such consent, then GCHP agrees to pay the CONTRACTOR a recruitment fee at a rate to be negotiated in good faith (but, in no event greater than 35%) based on the annualized starting base salary at GCHP of such former employee of CONTRACTOR.

37. FORCE MAJEURE

Neither of the parties shall be deemed to be in default of or to have breached any provision of this Agreement as a result of any delay, failure in performance or interruption of service resulting directly or indirectly from acts of God, acts of civil or military authorities, civil disturbances, wars, fires, transportation contingencies, laws, regulations, acts or orders of any government or agency or official thereof, or any other similar occurrences beyond such party's reasonable control. In every case, the delay or failure in performance or interruption of service must be without the fault or negligence of the party claiming excusable delay, and the party claiming excusable delay must promptly notify the other party of such delay. Performance time under this Agreement shall be considered extended for a period of time equivalent to the time lost because of any delay that is excusable, provided, however, that if any such delay continues for a period of more than sixty (60) days, the party not claiming excusable delay shall have the option of terminating this Agreement immediately upon written notice to the party claiming excusable delay.

38. NOTICES

a) Any and all notices, demands, requests or other communications required or permitted by this Agreement or by law to be served on, given to or delivered to any party hereto by any other party to this Agreement shall be in writing and shall be deemed duly served, given or delivered upon delivery by (1) facsimile transmission or other electronic means (if duplicated by any of the alternative notice methods that follow), (2) a national overnight courier service, fee prepaid (with proof of service), (3) hand delivery or (4) certified or registered mail (return receipt requested and first-class postage prepaid) and addressed as follows (or as later changed in a manner required by this section):

Gold Coast Health Plan
711 E. Daily Drive, Suite #106
Camarillo, CA 93010-6082
Attn: Anne Freese
Title: Director of Pharmacy
Email: afreese@goldchp.org

CONTRACTOR:
OptumRx, Inc.
1600 McConnor Parkway
Schaumburg, IL 60173
Attn: General Counsel
Fax: (XXX)XXX-XXXX
Email: EMAIL ADDRESS]

b) Any notice that is address and delivered in the manner herein provided shall be conclusively presumed to have been duly given to the party to which it is addressed at the close of business, local time of the recipient: (i) upon delivery if by hand, (ii) on the third day after the day it is so placed in the mail, (iii) the next business day following delivery national overnight courier service, (iv) the next business day following delivery by facsimile transmission or other electronic means (if confirmed by any of the methods above) or (v) upon the intended recipient's refusal to accept delivery. Any party may change their address for the purposes of this Agreement by giving notice of the change,

in the manner required by this section, to the other party.

39. CONSTRUCTION OF LANGUAGE OF AGREEMENT; GOVERNING LAW; MODIFICATIONS; CAPTIONS; SEVERABILITY:

a) This Agreement, and the rights and obligations of the parties, shall be governed and interpreted in accordance with the laws of the State of California and Federal laws and regulations as applicable. The parties agree that should legal or administrative proceedings arise as a result of this Agreement and performance under this Agreement that jurisdiction for venue shall be Ventura County, California. The captions or headings in this Agreement are for convenience only and in no other way define, limit or describe the scope or intent of any provision or section of the Agreement. Except for CONTRACTOR's proposals and submitted representations for obtaining this Agreement, this Agreement supersedes any other agreements, either oral or in writing, between the parties hereto with respect to the rendering or services, and contains all of the covenants and agreements between the parties with respect to said services. Any modifications of this Agreement will be effective only if it is in writing and signed by all parties.

b) CONTRACTOR also agrees to the following:

i) If it is necessary to interpret this Agreement, all applicable laws may be used as aids in interpreting the Agreement. However, the parties agree that any such applicable laws shall not be interpreted to create contractual obligations upon GCHP, unless such applicable laws are expressly incorporated into this Agreement in some section other than this provision, Governing Law. This Agreement is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Agreement, both parties shall be deemed authors of this Agreement.

ii) Any provision of this Agreement that is in conflict with Current or future applicable Federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Agreement shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

iii) All Policy and All Plan Letters issued by DHCS subsequent to the Effective Date shall provide clarification of CONTRACTOR's obligations pursuant to this Agreement, and/or inform and provide clarification to CONTRACTOR regarding mandated changes in State or Federal law or regulations, or pursuant to judicial interpretation, but shall not add new obligations to the Agreement.

iv) Unless the context of this Agreement clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

v) The provisions of this Agreement are severable. The invalidity or unenforceability of any one provision in the Agreement shall not affect the other provisions.

In concurrence and witness whereof, this Agreement has been executed by the parties effective on the date and year first above written.

Ventura County Medi-Cal Managed Care Commission d.b.a. Gold Coast Health Plan	OptumRx, Inc.
Date:_____	Date:_____
Signature: _____	Signature:_____
Title: Chief Executive Officer	Title:_____

Exhibit A

SERVICE ORDER

EXHIBIT B

to PROFESSIONAL SERVICES AGREEMMENT

Change Order No. ___ for Service Order ___

Between Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan, a California public entity established under the laws of the State of California, and (CONTRACTOR)

This Change Order No. XXX hereby modifies and is made an integral part of Service Order XXX between Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan, a California public entity established under the laws of the State of California, ("GCHP") and **(CONTRACTOR)**,("CONTRACTOR"), which was issued under Professional Services Agreement dated XXXX-XXXX ("Agreement") between GCHP and CONTRACTOR.

CHANGE ORDER

This is Change Order No. XXX to a Service Order issued by GCHP to CONTRACTOR under which CONTRACTOR is to provide GCHP with a [Insert Project Name] Solution ("Solution"). The following item(s) is/are hereby modified as follows:

[Note: Include only the sections of the Service Order that are being changed. Do not include sections not being modified. Changes should be clearly identified as "From" (copy/paste from current Service Order section) and "To" (fully describe the change(s) to the referenced section). Here is an example, using Service Order section 1.]

This Change Order No. XXX is issued pursuant to and, upon execution, shall become incorporated in the Service Order which is incorporated in the Agreement In the event of conflict of terms, the Professional Services Agreement shall supersede all other agreements and terms. The foregoing is the complete and final expression of the agreement between the parties to modify the Service Order and cannot be modified, except by a writing signed by duly authorized representatives of both parties hereto. ALL OTHER TERMS AND CONDITIONS OF THE REFERENCED SERVICE ORDER REMAIN UNCHANGED.

By signing below, the authorized parties agree to the terms of this Change Order No. XXX, effective (INSERT EFFECTIVE DATE).

Ventura County Medi-Cal Managed Care Commission d.b.a. Gold Coast Health Plan	**OptumRx, Inc.**
Date:_____	Date:_____
Signature:_____	Signature:_____

Title: Chief Executive Officer Title:_____

EXHIBIT C

REIMBURSABLE EXPENSE GUIDELINES

These REIMBURSABLE EXPENSE GUIDELINES ("Guidelines") shall apply to certain expenses that CONTRACTOR may incur, pursuant to the agreement entered into by and between GCHP and CONTRACTOR dated as of DATE 01, 2015 entitled AGREEMENT FOR PROFESSIONAL SERVICES ("Agreement"). With respect to such expenses, when incurred by CONTRACTOR specifically for purposes of the Agreement, GCHP and CONTRACTOR hereby agree as follows:

1. GENERAL

1.1 When practical to do so, CONTRACTOR shall book all travel for the sole purpose of fulfilling on-site service obligations described in the GCHP Service Order. CONTRACTOR should communicate to GCHP's Project Manager all associated travel costs prior to finalizing any/all travel arrangements. CONTRACTOR shall provide the travel service name and telephone number and agent assigned to CONTRACTOR by GCHP. Any airline ticket, car rental and hotel charges should be paid directly by CONTRACTOR, with available discounts applied.

1.2 For purposes of reimbursement hereunder, CONTRACTOR must submit original receipts to receive reimbursement of air travel expenses.

2. AIR TRAVEL

All personnel of CONTRACTOR ("Travelers") will fly coach class. Original airline receipts are required for reimbursement in all cases.

3. HOTELS

3.1 Requests by Travelers for specific hotels will be honored only at the discretion of GCHP's Project Manager and only if the rates of such hotels are the same as or lower than current industry averages.

3.2 Lodging expenses shall include the cost of a Traveler's room plus applicable taxes, but shall not include room service, recreation, or any other direct charges to the room. (See Section 5 of the Guidelines for further discussion of these charges.)

4. AUTOMOBILE EXPENSE

4.1 Rental car charges shall be billed directly to each Traveler.

4.1.1 Reimbursement will cover no more than the cost of a mid-size rental car. ***Limousine service is expressly prohibited.***

4.1.2 Additional insurance coverage, as provided in the rental car agreement,

will not be reimbursed.

4.2 Mileage for travel in CONTRACTOR's vehicles or in Travelers' personal vehicles shall be reimbursed at the same per-mile rate in effect from time to time for reimbursement of mileage incurred by GCHP's own employees. Toll-road charges will be reimbursed only if incurred for office-to-office travel between CONTRACTOR's offices and GCHP's. Mileage and tolls should be supported by appropriate, contemporaneous logs of such charges maintained by Travelers.

5. MISCELLANEOUS TRAVEL EXPENSES

5.1 Original receipts must be submitted for expenses including the following: meals; taxi and hotel shuttle fares; parking; and other costs for which receipts can be typically obtained. Expenses such as tips (for which receipts are usually are not provided) should be reasonable for the services provided and supported by a personal log or other contemporaneous record kept by the Traveler.

5.1.1 Travelers' expense reports submitted as documentation for reimbursement are to be signed by appropriate management personnel of CONTRACTOR and are to include copies of applicable receipts as supporting documentation.

5.1.2 Documentation of each business meal should include the names of all Individuals for whom the meal was ordered, the date of the meal, the business purpose, the relationships between or among the individuals, and a summary of the business discussion.

5.2 A per diem allowance is offered for meals, tips, and incidentals, when agreed to in advance in writing by GCHP Management, shall be in lieu of any other reimbursement for such expenses and shall not exceed the maximum per traveler rates established by the U.S. General Services Administration: http://www.gsa.gov/portal/category/100120

6. OTHER EXPENSES

If incurred by CONTRACTOR exclusively for purposes of the Agreement, other costs (such as for document reproduction, computer time, air freight, postage telephone, and facsimile) will be reimbursed by GCHP only upon submission in advance of documentation satisfactory to GCHP. Such documentation may include office logs that identify specific costs with specific services performed by CONTRACTOR under the Agreement.

7. SUBCONTRACTORS

If CONTRACTOR contracts with a third party ("Subcontractor") for purposes of performing CONTRACTOR's obligations under the Agreement, these Guidelines shall apply to travel expenses incurred by a Subcontractor and which CONTRACTOR is obligated to reimburse to the Subcontractor. GCHP shall not be responsible to pay

CONTRACTOR any amount in excess of CONTRACTOR's actual cost of reimbursing a Subcontractor, or the maximum amount permitted by these Guidelines, whichever is less. In no event shall GCHP pay CONTRACTOR any percentage, fee, administrative charge or other mark-up.

EXHIBIT D

BUSINESS ASSOCIATE AGREEMENT

This BUSINESS ASSOCIATE AGREEMENT ("Agreement") is entered into effective November 1, 2016, by and between Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan ("GCHP") and OptumRX, Inc., a California corporation ("Business Associate").

RECITALS

A. GCHP is a Covered Entity as defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and is therefore subject to HIPAA and its implementing regulations, including the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") and the Security Standards for the Protection of Electronic Protected Health Information (the "Security Rule"), and Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH") enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA) and HITECH Omnibus Rule, 78 Fed. Reg. 5,566 (Jan. 25, 2013) (collectively, HIPAA, the Privacy Rule, Security Rule, HITECH and HITECH Omnibus Rule shall be referred to herein as the "HIPAA Rules and Regulations").

B. Protected Health Information received from GCHP or created or received by Business Associate on behalf of GCHP ("PHI") may be needed for Business Associate to perform the <TYPE OF SERVICES TO BE PROVIDED> services (the "Services") requested by GCHP and described in any underlying agreement between the parties (the "Underlying Agreement").

C. To the extent Business Associate needs to access PHI to perform the Services, it will be acting as a Business Associate of GCHP and will be subject to certain provisions of the HIPAA Rules and Regulations.

D. To the extent the Underlying Agreement is a subcontract of a California Department of Health Care Services contract ("DHCS Subcontract"), Business Associate will be subject to certain California Department of Health Care Services ("DHCS") information privacy and security requirements.

E. GCHP and Business Associate wish to set forth their understandings with regard to the use and disclosure of PHI by Business Associate so as to comply with the HIPAA Rules and Regulations and GCHP's contract with DHCS.

AGREEMENTS

For valuable consideration received and the above referenced Recitals which are incorporated herein as if set forth in full and the mutual conditions, terms and promises set forth in these Agreements below, the parties agree as follows:

1. Defined Terms. Capitalized terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the HIPAA Rules and Regulations: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations,

Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary of Health & Human Services, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific Definitions:

(a) Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean Business Associate.
(b) Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean GCHP.
(c) HIPAA Rules and Regulations. "HIPAA Rules and Regulations" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules and Regulations at 45 CFR Part 160 and 164.
(d) Member. "Member" shall mean an Individual who is enrolled in the Gold Coast Health Plan.

2. Business Associate's Obligations and Permitted Activities.

Business Associate agrees to the following:

(a) That this Agreement shall apply to all agreements between and among GCHP and Business Associate;

(b) That Business Associate shall not use or disclose PHI other than:
(i) as permitted to perform the Services set forth in this Agreement or the Underlying Agreement; or
(ii) for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate. Business Associate may disclose PHI for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities only if the disclosure is required by law, or Business Associate obtains reasonable assurances from the person or organization to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person or organization, and the person or organization notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(c) That Business Associate shall use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI, to prevent use or disclosure of PHI other than as provided for by this Agreement and the Underlying Agreement and shall develop, implement, maintain, and use appropriate administrative procedures, and physical and technical safeguards, to preserve and protect the confidentiality, integrity and availability of electronic PHI;

(d) Without any reasonable delay, and in any event no more than forty-eight (48) hours, Business Associate shall report to and notify GCHP of any Breach of unsecured PHI upon discovery of such Breach, as required by 45 CFR 164.410. Under 45 CFR 164.410, a Breach is deemed to be discovered by a business associate "as of the first day on which such

breach is known to the business associate or, by exercising reasonable diligence, would have been known to the business associate";

(e) For any Breach of Unsecured PHI, as defined in 45 CFR 164.402, following the initial notification of any such Breach, Business Associate shall provide a report to GCHP, within five (5) business days of the discovery of the Breach, that includes, to the extent possible: (1) a brief description of what happened, including the date of occurrence and the date of the discovery by Business Associate; (2) a description of the PHI affected, including the names of any Individuals whose PHI has been or is reasonably believed to have been accessed, acquired or disclosed and the types of PHI involved (such as full name, social security number, date of birth, home address, account numbers, etc.); and (3) a brief description of what Business Associate has done to investigate the Breach, to mitigate harm to Individuals, and to protect against any further Breaches. Further, Business Associate shall provide to GCHP any other available information GCHP is required to include in its notification to affected Individual(s);

(f) Business Associate will report to GCHP any Security Incident relating to electronic PHI, not more than twenty four (24) hours after Business Associate's discovery of such security incident, including any attempted or successful (A) unauthorized access, use, disclosure, modification, or destruction of GCHP's electronic PHI or (B) interference with Business Associate's system operations in Business Associate's information systems, of which Business Associate becomes aware that extend beyond routine, unsuccessful attempts. Routine, unsuccessful attempts include but are not limited to pings on Business Associate's firewall, port scans, attempts to log on to Business Associate's system to enter a database with an invalid password or username, denial-of-service attacks that do not result in a server being taken off-line and malware (e.g., worms, viruses). Examples of reportable security incidents include, but are not limited to: (i) the exposure of Business Associate's information systems to malicious code, such as a virus or worm, that places electronic PHI at risk; (ii) unauthorized access granted to or obtained by servers or workstations that contain electronic PHI; (iii) Business Associate becomes aware that electronic PHI is being used, copied, or destroyed inappropriately; and (iv)
Business Associate experiences a "denial of service" attack or the compromise of a server or workstation containing electronic PHI that requires the server or workstation to be taken offline;

(g) Business Associate agrees to ensure that any of its agents or subcontractors that create, receive, maintain, or transmit GCHP's PHI of GCHP, agree to the restrictions, conditions, and requirements at least as restrictive as those that apply to Business Associate through this Agreement and the Underlying Agreement with respect to such PHI;

(h) Business Associate shall make its internal policies, procedures and records relating to the use and disclosure of PHI reasonably available to the Secretary of Health and Human Services or to GCHP if necessary or required to assess Business Associate's, it subcontractors, or the GCHP's compliance with the HIPAA Rules and Regulations;

(i) Business Associate shall, within ten (10) business days of a request by GCHP, make available PHI in a Designated Record Set on behalf of GCHP as necessary to satisfy GCHP's obligations under 45 CFR 154.524;

(j) Business Associate shall, within ten (10) business days of a request by GCHP, make any amendments to such PHI in a Designated Record Set as directed or agreed

to by GCHP pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy GCHP obligations under 45 CFR 164.526;

(k) Business Associate shall maintain and make available to GCHP the information required to provide an accounting of disclosures as necessary to satisfy GCHP's obligations under 45 CFR 164.528, including recording for each required accounting: (i) the disclosure date, (ii) the name and (if known) address of the person or entity to whom Business Associate made the disclosure, (iii) a brief description of the PHI disclosed, and (iv) a brief statement of the purpose of the disclosure; and Business Associate must have available for GCHP such disclosure information for the six (6) years preceding GCHP's request for the disclosure information (except Business Associate need have no disclosure information for disclosures occurring before the Effective Date of this Agreement);

(l) To the extent Business Associate is to carry one or more of GCHP's obligations under Subpart E of 45 CFR 164, Business Associate shall comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligations under this Agreement or the Underlying Agreement.

3. DHCS Contract Requirements. To the extent the Underlying Agreement is a subcontract of a DCHS Contract, Business Associate agrees to the following:

(a) General Security Controls.

i. Confidentiality Statement. All Business Associate workforce members shall sign a confidentiality statement supplied by Business Associate. The statement shall include, at a minimum, general use, security and privacy safeguards, unacceptable use, and enforcement policies. The statement shall be signed by the workforce member prior to access of PHI. The statement shall be renewed annually.

ii. Background check. Before a member of the Business Associate's workforce may access PHI, Business Associate shall conduct a thorough background check of that worker and evaluate the results to assure that there is no indication that the worker may present a risk for theft of confidential data.

iii. Workstation/Laptop/Remote Access encryption. All processes that provide remote access to PHI, and all workstations and laptops that process and/or store PHI shall be encrypted in accordance with the U.S. Department of Health and Human Services (DHHS), Guidance to Render Unsecured Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals, or any superseding guidance issued by DHHS. Such guidance may be found at: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brguidance.html. The internet link provided above is provided for the convenience of the parties and is subject to change. All remote access must be limited to the minimum necessary and least privilege principles.

iv. Business Associate shall download only the minimum necessary amount of PHI to a laptop or hard drive, and shall do so only when absolutely necessary for business purposes.

v. Removable media devices. All electronic files that contain PHI must be encrypted by Business Associate when stored on any removable media type device (e.g., USB thumb drives, floppies, CD/DVD, etc.).

vi. Email security. All emails that include PHI shall be sent by Business Associate in an encrypted method using encryption processes for data in motion complying, as applicable, with National Institute of Standards and Technology (NIST) Special Publications 800-52, Guidelines for the Selection and Use of Transport Layer Security (TLS) Implementations; 800-77, Guide to IPsec VPNs; or 800-113, Guide to SSL VPNs, or other encryption processes which are Federal Information Processing Standards (FIPS) 140-2 validated.

vii. Antivirus software. Business Associate shall install a commercial third-party anti-virus software solution with a minimum daily automatic update on all workstations, laptops and other systems that process and/or store PHI.

viii. Patch Management. Business Associate shall have security patches applied and up-to-date on all workstations, laptops and other systems that process and/or store PHI.

ix. User IDs and Password Controls. All of Business Associate's users of electronic PHI must be issued a unique user name for accessing electronic PHI. Passwords shall: (1) not to be shared, (2) be at least eight characters, (3) not be stored in readable format on the computer, (4) be changed every 60 days, (5) be changed if revealed or compromised, and (6) be composed of characters from at least three of the following four groups from the standard keyboard: upper case letters, lower case letter, Arabic numerals or non-alphanumeric characters (punctuation symbols).

x. Data Destruction. Except as otherwise provided in subsection 5(c)(ii) below, all PHI shall be returned or destroyed using Department of Defense standard methods for data destruction when the PHI is no longer needed.

(b) System Security Controls.

i. System Timeout. Business Associate's workstations with access to PHI shall provide an automatic timeout after no more than 20 minutes of inactivity.

ii. Warning Banners. Business Associate systems processing or maintaining PHI shall display a warning banner stating that data is confidential, system access is logged, and system use is for business purposes only. Users shall be directed to log off the system if they do not agree with these requirements.

iii. System Logging. Business Associate systems maintaining or processing PHI shall log success and failures of user authentication at all layers. Such systems shall log all system administrator/developer access and changes, and shall log all user transactions at the database layer if such database maintains or processes PHI.

iv. Access Controls. Business Associate systems maintaining or processing PHI shall use role based access controls for all user authentication, applying the principle of least privilege.

v. Transmission Encryption. All Business Associate transmissions of electronic PHI shall be encrypted end-to-end using encryption processes conforming with those specified in Section 3(a)(vi) of this Agreement.

vi. Host Based Intrusion Detection. All Business Associate systems maintaining or processing PHI that are accessible via the Internet shall use a comprehensive third-party real-time host based intrusion detection and prevention program.

(c) Audit Controls.

i. System Security Review. All Business Associate systems maintaining or processing PHI shall have at least an annual system security review. Reviews shall include administrative and technical vulnerability scanning tools.

ii. Log Reviews. All Business Associate systems maintaining or processing PHI shall apply a routine procedure to review system logs for unauthorized access. Log records of each access occurrence shall be maintained for six years.

iii. Change Control. All Business Associate systems maintaining or processing PHI shall have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

(d) Business Continuity / Disaster Recovery Controls.

i. Emergency Mode Operation Plan. Business Associate shall establish a written plan to enable continuation of critical business processes and protection of the security of electronic PHI in the event of an emergency.

ii. Data Backup Plan. Business Associate shall have established written procedures to backup data to maintain retrievable copies electronic PHI maintained by Business Associate. The plan shall include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and the amount of time to restore data should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of data.

(e) Paper Document Controls.

i. Supervision of Data. Business Associate shall have a policy that:

1) PHI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information.

2) PHI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

ii. Escorting Visitors. Business Associate shall escort visitors in areas where PHI is contained. PHI shall be kept out of sight while visitors are in the area, unless the visitors are authorized to view the PHI.

iii. Confidential Destruction. PHI in paper form, when disposed of by Business Associate, shall be disposed of through confidential means, such as shredding and pulverizing.

iv. Removal of Data. PHI shall not be removed by Business Associate from Business Associate's premises except for necessary business purposes.

v. Faxing. Faxes containing PHI shall not be left unattended by Business Associate and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified by Business Associate before sending faxes.

vi. Mailing. PHI shall only be mailed by Business Associate using secure methods. Large volume mailings of PHI shall be by a secure, bonded courier with signature required on receipt. Disks and other transportable media sent through the mail must be encrypted.

(f) Member Contact Information. Business Associate shall document and provide to GCHP a list of third parties to which Business Associate discloses Members' names and contact information. This list of third parties shall be provided within thirty (30) calendar days of the execution of this Agreement and annually thereafter and as otherwise requested by GCHP.

4. GCHP's Obligations.

(a) GCHP shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule or the Security Rule if done by GCHP.

(b) GCHP shall make reasonable efforts not to provide Business Associate with more PHI than that which is minimally necessary for Business Associate to provide the Services.

(c) GCHP shall notify Business Associate of any change in, or the withdrawal of, the consent or authorization of an Individual regarding the use or disclosure of PHI to the extent that such change or withdrawal may affect Business Associate's use or disclosure of PHI.

5. Term and Termination.

(a) Term. This Agreement shall be effective as of the date first written above, and shall terminate when all PHI is destroyed or returned to GCHP. If Business Associate determines, in accordance with subsection 5(c)(ii) below, that it is infeasible to return or destroy PHI, the protections of this Agreement with respect to such PHI shall remain in effect until such PHI is returned or destroyed.

(b) Termination. Upon a party's knowledge of a material breach by the other party, the non-breaching party shall either:

(i) Provide an opportunity for the breaching party to cure the breach or end the violation within a period of time specified by the non-breaching party, with the understanding that if the breaching party does not cure or end the violation in the specified period of time, the non-breaching party may terminate the Agreement; or

(ii) Immediately terminate this Agreement if the breaching party has breached a material term of this Agreement and cure is not possible.

(c) Effect of Termination.

(i) Except as otherwise provided in subsection 5(c)(ii) below, within 30 days of termination of this Agreement for any reason, Business Associate shall return or destroy all PHI. This provision shall also apply to PHI that is in the possession of subcontractors or agents of Business Associate.

(ii) If the parties determine upon reasonable consultation that returning or destroying any or all PHI is infeasible, the protections of this Agreement shall continue to apply to such PHI, and Business Associate shall limit further uses and disclosures of PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. GCHP hereby acknowledges and agrees that infeasibility includes Business Associate's need to retain PHI for purposes of complying with its work product documentation standards and Business Associate shall:

A. Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or carry out is legal responsibilities;
B. Return to GCHP the remaining PHI that Business Associate still maintains in any form;
C. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;
D. Not use or disclose PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at subsection (h) and (i) of Section 2, above, which applied prior to termination; and
E. Return to GCHP, if not destroyed the, PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

(d) Survival. The obligations of Business Associate under this Section shall survive the termination of this Agreement.

6. Indemnification. Business Associate shall indemnify, defend, and hold harmless the GCHP and its officers, agents, contractors, and employees from any third party claims, damages, costs, losses, lawsuits, liabilities, or expenses (including but not limited to legal fees and costs in enforcing this indemnity) arising out of or resulting from the performance of this

Agreement, or the breach of any provision of this Agreement by Business Associate or any of its officers, agents, contractors, or employees. In the event that any third party Claim is brought, GCHP shall tender its defense to CONTRACTOR, in which case CONTRACTOR will provide qualified attorneys, consultants, and other appropriate professionals to represent GCHP's interests at CONTRACTOR's expense. CONTRACTOR agrees that any settlement, compromise or resolution CONTRACTOR enters into arising as a result of the Claims will not include any admission of wrongdoing by GCHP. GCHP shall have the right to participate in the defense and settlement of the claim at GCHP's cost and expense.

7. Miscellaneous.

(a) Regulatory References. A reference in this Agreement to a section in the HIPAA Rules and Regulations means the section as in effect or as amended, and for which compliance is required.

(b) Amendment. Upon the effective date of any final regulation or amendment to the HIPAA Regulations, this Agreement shall be deemed automatically amended so that the obligations it imposes on the parties remain in compliance with such regulations. Following amendment of the Agreement in this manner, the parties shall, as necessary, work together to clarify their respective obligations with respect to any new requirements under the modified HIPAA Regulations.

(c) Notice. Any notice, report or other communication to GCHP by Business Associate required or permitted in this Agreement shall be in writing and shall be deemed to have been given on the day of service if served personally or by facsimile transmission with confirmation, or three (3) days after mailing if mailed by registered or certified mail, or two (2) days after delivery by a nationally recognized overnight courier, to the GCHP Compliance Officer at the address noted below or to such other person or address as GCHP may designate in writing from time to time:

Gold Coast Health Plan
711 E. Daily Drive, Suite #106
Camarillo, CA 93010-6082

Fax: (805) 437-5132

(d) Independent Contractors. Business Associate and GCHP are independent contractors and this Agreement will not establish any relationship of partnership, joint venture, employment, franchise or agency between Business Associate and GCHP. Neither Business Associate nor GCHP will have the power to bind the other or incur obligations on the other party's behalf without the other party's prior written consent, except as otherwise expressly provided in this Agreement.

(e) Conflicts. In the event that any terms of this Agreement are inconsistent with the terms of the Underlying Agreement, then the terms of this Agreement shall control.

(f) Entire Agreement. This Agreement shall constitute the entire agreement of the parties hereto with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties hereto relating to such subject matter.

(g) Governing Law and Venue. The governing law and venue for disputes arising under this Agreement shall be the same as set forth in the Underlying Agreement.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed as of the date first written above.

Ventura County Medi-Cal Managed Care Commission d.b.a. Gold Coast Health Plan	**OptumRx, Inc.**
Date:_____	Date:_____
Signature:_____	Signature:_____
Title: Chief Executive Officer	Title:_____

EXHIBIT A

SERVICE ORDER

THIS SERVICE ORDER NO. 01 ("Service Order") is made as of November 1, 2016 ("Service Order Effective Date"), by and between Ventura County Medi-Cal Managed Care Commission doing business as GCHP Health Plan, a California public entity established under the laws of the State of California (hereinafter "GCHP"), and OptumRX, Inc., a California corporation ("CONTRACTOR"). The parties entered into Agreement For Professional Services dated as of November 1, 2016 ("Agreement"). The terms and conditions of the Agreement are incorporated into this Service Order by this reference thereto. If there is a conflict between a specific term in this Service Order and the terms of the Agreement, the specific term of the Agreement shall control.

1. DEFINITIONS

1.1 **"*AWP*"** means the average wholesale price, as reflected on the Pricing Source, of a Prescription Drug or other pharmaceutical products or supplies based on the NDC of the Drug dispensed. Contractor will rely on the Pricing Source as updated by Contractor no less frequently than every seven (7) days to determine AWP for purposes of establishing the pricing provided to GCHP under this Service Order.

1.2 **"*Benefit Plan*"** means the Medi-Cal managed care benefit plan sponsored by GCHP that includes the prescription drug benefit for Medi-Cal Members as reflected, under which GCHP is obligated to provide Covered Prescription Services, and such other benefit plans as determined by GCHP.

1.3 **"*Brand Drug*"** means a single-source or multi-source Prescription Drug that (1) is designated as a "Brand Drug" based upon indicators included in Medi-Span with a multisource indicator of "M", "N" or "O", and (2) has received its marketing approval from the FDA under a New Drug Application (NDA) or a Biological License Application (BLA), and (3) cannot be identified as a Generic Drug under the terms of this Agreement. All three of the above factors must apply for the Prescription Drug to be considered a Brand Drug.

1.4 "***Clean Claim***" means a Prescription Claim prepared in accordance with the NCPDP-promulgated standard format that contains all information necessary for processing for a Prescription Claim and submitted for payment no later than thirty (30) days after the date of service, or a longer period of time if required by law.

1.5 ***"Clinical Documentation Form"*** means the document describing the clinical services elected by GCHP to be provided by Contractor as mutually agreed in writing to by the Parties.

1.6 **"*Compound Prescription Drug*"** means a Prescription Drug that is prepared by a pharmacist who mixes or adjusts one or more Prescription Drugs which are not already available in a commercially made product to customize a medication to meet a Member's individual medical needs. GCHP's payment to Contractor for providing a Compound Prescription Drug to a Member will include the Network

Pharmacy contracted rate for each Prescription Drug included in the medication and one contracted dispensing fee minus any Cost-Sharing amount.

1.7 **"*Cost-Sharing Amount*"** means the coinsurance, copay, deductible or other cost sharing amount, either a specified dollar amount or a percentage of eligible expenses, that a pharmacy may collect from a Member for Covered Prescription Services in accordance with the Member's Benefit Plan.

1.8 **"*Covered Prescription Services*"** means Prescription Drugs or other pharmaceutical products, services or supplies dispensed by a pharmacy to a Member for which coverage is provided in accordance with the Member's Benefit Plan.

1.9 "**DHCS**" means the State of California Department of Health Care Services.

1.10 **"*Drug Manufacturer*"** means an entity that manufactures, sells, markets or distributes Prescription Drugs and operates under FDA approval.

1.11 **"*FDA*"** means United States Food and Drug Administration.

1.12 ***"Formulary"*** means the list of Prescription Drugs covered by the applicable Benefit Plan as developed and adopted by GCHP for use with the Benefit Plans. The Formulary will be made available to physicians, pharmacies and other healthcare persons or entities to guide the prescribing, dispensing, sale and coverage of Covered Prescription Services.

1.13 ***"Generic Drug"*** means 1) Prescription Drugs that are approved or brought to market under an ANDA, 2) Prescription Drugs that are brought to market under an NDA but listed as "authorized generics" in the FDA NDC Directory, or 3) Prescription Drugs identified as a generic drug in the Medi-Span drug database with a multisource code "Y – considered generic multiple sources." A Generic Drug does not need to meet all three definitions. If any of the above three definitions apply, then the Prescription Drug shall be considered a Generic Drug.

1.14 **"*Governmental Authority*"** means the Federal government, any state, county, municipal or local government or any governmental department, political subdivision, agency, bureau, commission, authority, body or instrumentality or court that regulates the applicable party's activities or operations.

1.15 **"*MAC*"** means the maximum allowable cost of a Prescription Drug as specified on a list established by Contractor. Contractor will employ a single universal MAC list for each Network Pharmacy, which is subject to Contractor's periodic review and modification in its sole discretion. GCHP will have access to any MAC list at all times and shall be given no less than thirty (30) days' prior notice of any material changes to the MAC list(s).

1.16 **"*Mail Order Pharmacy*"** means a facility that is duly licensed to operate as a pharmacy at its location and to dispense Prescription Drugs via postal or commercial courier delivery to individuals, including Members. Mail Order Pharmacy includes pharmacies that Contractor owns or operates.

1.17 "**Medi-Cal Agreement**" means the agreement entered into by and between GCHP and DHCS under which GCHP has agreed to arrange for or provide health benefits under the Medi-Cal Managed Care Program to Medi-Cal beneficiaries who may enroll in GCHP's Medi-Cal Managed Care Program. The required elements of this Service Order will, among other things, conform to the Medi-Cal Agreement.

1.18 **"*Member*"** means an eligible individual legitimately enrolled in a Benefit Plan.

1.19 **"*NCPDP*"** means the National Counsel for Prescription Drug Programs.

1.20 **"*NDC*"** means the National Drug Code that is the identifying Prescription Drug number maintained by the FDA.

1.21 **"*Network Pharmacy*"** means a retail pharmacy, Mail Order Pharmacy, Specialty Pharmacy or other facility that is duly licensed to operate as a pharmacy at its location and to dispense Prescription Drugs to individuals, including Members, and for third-party pharmacies, have entered into a Network Pharmacy Agreement. Contractor, when acting solely in its capacity as a Mail Order Pharmacy or Specialty Pharmacy, is a Network Pharmacy of GCHP.

1.22 **"*Network Pharmacy Agreement*"** means the Agreement between a Network Pharmacy and Contractor or GCHP to provide Covered Prescription Services.

1.23 "***Paid Claim***" means a Prescription Drug claim that is approved for payment during Contractor's semi-monthly billing cycle or is a reversal during this semi-monthly billing cycle of a Prescription Drug Claim that was approved for payment during a prior semi-monthly billing cycle. A rejected or denied claim or a claim approved for payment and reversed during the same semi-monthly billing cycle is not a Paid Claim.

1.24 ***"Pharmacy and Therapeutics Committee"*** means the committee formed by GCHP that reviews a legend drug for inclusion on the Formulary and creates criteria, policies and procedure for such inclusion including, but not limited to, clinically-appropriate quantity restrictions, step therapies and prior authorizations.

1.25 **"*PHI*"** means any information Contractor receives or provides on behalf of the Plan that is considered Protected Health Information, as defined in the privacy regulations of the Health Insurance Portability and Accountability Act of 1996.

1.26 **"*Plan Specifications*"** means GCHP's requirements for its prescription drug benefit plan that Contractor utilizes to carry out its obligations under this Service Order as reflected in Contractor's Plan design document and approved in writing by both parties, including written Benefit Plan descriptions, Member eligibility and identification requirements, benefit definitions, Formulary, Pharmacy Network, utilization management programs, applicable Cost-Sharing Amounts, number of days' supply for acute and maintenance medications, dispensing and other limitations, manuals and other Benefit Plan or Member information.

1.27 **"*Prescription Claim*"** means a single request for payment for, or a bill or invoice relating to, a Covered Prescription Service that a Network Pharmacy, other health

care provider or Member submits, whether the request, bill or invoice is paid or denied.

1.28 **"*Prescription Drug*"** means a Generic Drug or Brand Drug that is approved by the FDA and required under law to be dispensed only as authorized by a written or oral order to dispense a Prescription Drug by an appropriately licensed and qualified health care professional in accordance with law.

1.29 ***"Pricing Source"*** means the Medi-Span Prescription Pricing Guide (with supplements) or another nationally recognized pricing source determined by Contractor and agreed upon in writing by GCHP.

1.30 **"*Rebate*"** means any and all funds/payments/revenue received by Contractor from any and all third party sources (e.g., manufacturers (brand or generic), wholesalers, pharmacies, etc.) associated with the Prescription Drug utilization of GCHP and its Members. A Rebate does not include any discount, price concession or other direct or indirect remuneration Contractor receives for direct purchase of a Prescription Drug.

1.31 "***Service Fees***" means those fees and charges set forth in Schedule A-2 Service Fees and Charges, attached hereto.

1.32 **"*Specialty Drugs*"** means the Prescription Drugs including: (a) biotechnology drugs; (b) orphan drugs used to treat rare diseases; (c) typically high-cost drugs; (d) drugs administered by oral or injectable routes, including infusions in any outpatient setting; (e) drugs requiring on-going frequent patient management or monitoring; or (f) drugs that require specialized coordination, handling and distribution services for appropriate medication administration. For means of pricing, Specialty Drugs will be Prescription Drugs maintained on the Specialty Drug price list that are mutually agreed upon in writing by the parties and periodically updated throughout the life of the Service Order.

1.33 **"*Specialty Pharmacy*"** means a facility that is duly licensed to operate as a pharmacy at its location and to dispense Specialty Drugs to individuals, including Members. Specialty Pharmacy includes pharmacies that Contractor owns or operates.

1.34 **"*Usual and Customary Charge*"** or "***U&C***" means the price, including all applicable customer discounts, such as special customer, senior citizen and frequent shopper discounts, that a cash paying customer pays a pharmacy for Prescription Drugs.

2. SCOPE OF WORK

2.1 Administrative Support

2.1.1 Services. Contractor agrees to use reasonable care and diligence in the performance of its duties under this Service Order and will provide administrative, management, consultative, claims processing and other general pharmacy benefit management support services to GCHP in conjunction with administration and operation of the Benefit Plans as set

forth in this Service Order ("Services"). Contractor shall perform all functions necessary to administer and operate the Benefit Plan. Contractor will administer and support the Benefit Plans in accordance with the most current Plan Specifications that GCHP has provided to Contractor as required by this Service Order. Contractor will collaborate with GCHP to assist GCHP in ensuring that such Plan Specifications meet the requirements to operate the Benefit Plan in accordance with applicable law and the Medi-Cal Agreement. The parties anticipate that Contractor will commence the provision of Covered Prescription Services to Members on June 1, 2017 (the "Implementation Date").

2.1.1.1 Services will include, but are not limited to:

- Provider Network Management
- Information Processing System
- Claims Adjudication
- Clinical Services
- Decision Support and Management Reporting System
- Prior Authorizations
- Financial Management
- Fraud, Waste and Abuse
- Quality Assurance
- Dedicated Account Management
- Pharmacy Auditing Services
- Rebate Management
- Medicaid
- Pharmacy Call Center
- 340B
- Member Services
- Reporting
- Mail order Pharmacy
- Specialty Pharmacy
- Infusion Services
- Drug Utilization Management

2.1.2 Account Management. Contractor shall provide GCHP account management services, including an account manager who shall, among other things, oversee Contractor's provision of Services under this Service Order and serve as GCHP's day-to-day contact. Such account manager and all account management personnel shall be trained, experienced account service resources to serve as liaison between GCHP and Contractor for the purpose of facilitating operational activities, resolving issues, and providing consultative support. Account management support includes scheduling conference calls to monitor and discuss outstanding priorities. Account management staff will act as the primary contact to GCHP after the implementation process is completed. Contractor's account management team will be available during normal business hours in the Pacific Time Zone, 8 am to 5 pm Monday to Friday. Contractor will assign to GCHP an account manager acceptable to GCHP, and GCHP will have prior approval of any such manager assigned to it. The parties will meet and confer should GCHP determine and request that a change in any

such manager's assignment to GCHP should be made, so that Contractor may review and accommodate such request.

2.1.3 Member Customer Service. Member customer service provides Members with information regarding pharmacy locations, eligibility, drug coverage, Copayment, prior authorization requirements, Benefit Plan guidelines, appeals process, direct member reimbursement instructions, benefit status, claims submission and status, claims payment and general information regarding their prescription benefit plan. Member customer service is a toll-free phone line available 24 hours a day, 7 days a week, 365 days a year. Contractor's call center is and will be located in the United States during the term of this Service Order. Contractor will be able to support all Department of Health Care Services mandated threshold languages in written materials.

2.1.4 On-Line Member Services. Contractor will provide Members with access to a Member portal that will provide them with resources and tools to assist in understanding their pharmacy benefit, manage their medications and make informed decisions about their health. Key services available to Members through the Member portal include the following:

2.1.4.1 View real-time benefits, including coverage amounts, copayments, plan and Member payment amounts, deductibles, and drug spend.

2.1.4.2 Access detailed claims history.

2.1.4.3 Search the drug information tool to learn about appropriate dosage guidelines, possible side effects and other general information about specific medications.

2.1.4.4 Use the formulary look-up tool to confirm coverage of specific medications by Benefit Plan.

2.1.4.5 Locate nearby pharmacies using the pharmacy locator tool.

2.1.4.6 Access an extensive library of educational materials.

2.1.4.7 Designate a head of household to view benefit information for multiple family members through a single profile.

2.1.4.8 Submit requests for new, refill and transfer home delivery pharmacy prescriptions.

2.1.4.9 Review customized medication reminders.

2.1.4.10 Conduct drug cost comparisons and search for alternatives through our Drug Pricing and Alternatives tool, including: drug pricing specific to the member's benefit, deductible status, and pharmacy selected, lower cost alternative drugs, plan pay and member savings amount.

2.1.5 Implementation Support. Contractor shall provide GCHP implementation services, including an implementation project manager who shall, among other things, lead Contractor's implementation team and facilitate the successful implementation of all aspects of Contractor's provision of Services under this Service Order. Such implementation project manager and all implementation support personnel shall be trained, experienced project management resources to serve as liaison between GCHP and Contractor and to manage the implementation process. A Contractor implementation project manager will act as the primary contact to GCHP during implementation. Implementation support shall include establishing a project plan; identifying necessary activities to support the implementation; and coordinating internally, within Contractor, to identify and resolve implementation issues. Contractor will assign to GCHP a project implementation manager acceptable to GCHP, and GCHP will have prior approval of any such manager assigned to it. The parties will meet and confer should GCHP determine and request that a change in any such manager's assignment to GCHP should be made, so that Contractor may review and accommodate such request.

2.1.6 On-Site Meetings. Contractor will participate in such meetings or teleconferences with GCHP as requested by GCHP at no additional cost to GCHP. It is anticipated that GCHP will require on-site management meetings with Contractor at least quarterly. Contractor's senior management will attend Commission meetings to respond to questions regarding Contractor's performance of this Service Order. In addition, Contractor will participate in meetings or teleconferences that are scheduled by the DHCS through the term of this Service Order and as necessary thereafter to provide for the exchange of information relative to the implementation and operation of the Benefit Plan.

2.1.7 Reporting.

2.1.7.1 In addition to the reporting requirements set forth in Section 15 of the Agreement, Contractor will provide GCHP with Contractor's standard reporting package and reports. GCHP will also have access to Contractor's on-line reporting system. Contractor will provide online reporting tool training to GCHP as follows: (i) training manuals will be provided to GCHP's staff members who access the system; and (ii) GCHP staff members will receive one day of extensive system training. Contractor will conduct one day of training on-site at the location of GCHP's choice. Contractor's on-line reporting system's minimum functionality will include: drill-down capabilities; date, group, physician, member, and drug classification parameter manipulation capabilities; and user scheduled customized batch reporting capabilities. Ad hoc reporting services that can be generated from queries available in the online reporting system are provided at no additional charge. If GCHP requests custom reports that require system programming, complex customized report programming, or plan-specific templates, then additional fees may apply as set forth in Schedule A-2 Service Fees and Charges. Notwithstanding the

foregoing, any report requested or required by DHCS or the Medi-Cal Agreement will be provided by Contractor within the required timelines or as soon as reasonably practical upon request by GCHP at no charge to GCHP.

2.1.7.2 Contractor will provide GCHP, its administrative service organization (ASO), medical management teams and/or its consultant with monthly detailed claims data at no additional fees and in the format necessary for each entity. Contractor shall ensure that adequate information is captured during the claim payment process to allow GCHP to evaluate individual and overall health care utilization in the Benefit Plan. The claims database shall contain for each claim all applicable claim information, as identified in the National Council for Prescription Drug Program ("NCPDP") standards, which at a minimum must include an identification number; claim number; dates of service; date of claim submission; NDC; generic product indicator ("GPI"); brand name; generic name; brand/generic indicators; prescribing provider name, National Provider identification ("NPI") number, and Drug Enforcement Agency ("DEA") number; pharmacy name, National Association of Boards of Pharmacy ("NABP") number, and NPI number; amount billed; amount allowed; amount paid; AWP; U&C; other health coverage costs (coordination of benefits) including amount paid and member cost share; and Member responsibility. The database shall have the capability of producing a variety of reports concerning utilization of Covered Prescription Services as directed by GCHP. In all respects, claims and utilization data shall be maintained, and available for reporting to and analysis by GCHP or any designee, in a manner consistent with industry standards for comparable pharmacy benefit managers.

2.1.7.3 Contractor will provide quarterly ongoing reporting on compliance with the pricing and performance guarantees set forth in the Performance Guarantee Schedule, attached to this Service Order as Schedule A-1, including yearly reconciliations and true-up reports.

2.1.7.4 Contractor will submit all DHCS required encounter data related to Covered Prescription Services claims on behalf of GCHP to DHCS in the manner and frequency necessary to meet or exceed all quality measures contained within the DHCS reference materials as set forth in Attachment 9 of the RFP. This shall include file development, testing, submission, resubmission, file loads, file tracking, remediation, and reporting of all pharmacy encounter data. This also includes the submission, resubmission and passing of pharmacy encounter files and response files generated by a delegate(s) of GCHP and DHCS to DHCS, GCHP and the delegate(s).

2.1.8 GCHP Administrative Responsibility. GCHP has full and final authority concerning for the Benefit Plan and its operation, including the disposition of disputed claims. Contractor shall have no power to act on behalf of GCHP in connection with the Benefit Plan, except as expressly stated in this Service Order or as otherwise directed by GCHP. GCHP has authority over the administration and management of the Benefit Plan as provided by and in accordance with the Medi-Cal Agreement, and applicable federal and state laws.

2.1.9 Benefit Plan Eligibility Data. GCHP will provide Contractor with electronic eligibility data in NCPDP format, or another format agreed to by the parties, as well as Member personal address, phone number and email and work email, if available, for all Members who are entitled to Covered Prescription Services under the Benefit Plans. Contractor will load correctly formatted Member eligibility data no later than one (1) business day after receipt from GCHP. Contractor will be entitled to rely on the accuracy and completeness of the Member eligibility data. GCHP will be solely responsible for any errors in Member eligibility data that GCHP furnishes to Contractor. If requested by GCHP, Contractor will transfer complete and accurate electronic claim history, eligibility data, open prior authorizations and open fill mail order and/or specialty pharmacy files to GCHP or its authorized representatives at no additional cost monthly and before and after termination of this Service Order, including run-out claims. GCHP will have access to eligibility and claims information through Contractor's web-based Internet Direct Access system, which allows GCHP to view claims transactions in real time allowing GCHP to: (i) view, update and add Member eligibility; (ii) view pharmacy information; (iii) access Member benefit maximums and deductible information; (iv) enter overrides and prior authorizations; and (v) verify GCHP-specific plan designs. Contractor will not sell GCHP's claim data to any third party vendor.

2.1.10 Member Notification. GCHP will make available to Members information regarding the type, scope, restrictions, limitations and duration of Covered Prescription Services to which Members are entitled under an applicable Benefit Plan. GCHP will provide and distribute, as appropriate, ID cards, a list of Network Pharmacies, mail service brochures, the Formulary and other pharmacy benefit related materials to Members.

2.1.11 Covered Prescription Services Information. Contractor will:

2.1.11.1 Provide information to physicians, pharmacists, other health care professionals, and Members about the factors that affect formulary system decisions, including, but not limited to: cost containment measures, such as step therapy; the procedures for obtaining non-formulary drugs; and the importance of formulary compliance to improving quality of care and restraining health care costs; and

2.1.11.2 Provide educational materials or information to Members that explain how formulary decisions are made, how Members can efficiently and effectively utilize Covered Prescription Services,

the process and procedures to obtain medically necessary pharmaceuticals under the Benefit Plan, and the roles and responsibilities of the Member relating to Covered Prescription Services.

2.1.12 Plan Specifications. GCHP will provide Contractor with the Benefit Plan technical assistance and information Contractor reasonably needs to perform the Services, including information regarding Members, Benefit Plans and Plan Specifications. GCHP will provide Contractor with the Plan Specifications no later than forty-five (45) days before the Implementation Date unless the parties otherwise agree. GCHP may amend the Plan Specifications upon two (2) business day notice to Contractor if a standard amendment and upon a time period mutually agreed upon in writing by the parties for a complex amendment, unless a Governmental Authority requires that the amendment occur in a shorter time period. GCHP may terminate the Plan Specifications upon forty-five (45) days' prior notice to Contractor, unless a Governmental Authority requires that the termination occur in a shorter time period. GCHP's failure to provide the Plan Specifications within the time periods stated in this section may delay Contractor's implementation of the Services and performance guarantees. GCHP is responsible for the accuracy, completeness and timeliness of all Plan Specifications, and acknowledges Contractor's reliance on, the Plan Specifications.

2.2 Pharmacy Network Administration

2.2.1 Pharmacy Network. Contractor will establish and maintain a network of pharmacies to provide the Services to GCHP ("Pharmacy Network"). Contractor will maintain a Pharmacy Network reasonably necessary to provide services under the Benefit Plan. Contractor will meet and maintain the GCHP pharmacy access standards to ensure that Members have adequate access to Covered Prescription Services. Contractor will provide to GCHP a current list of Network Pharmacies in the Pharmacy Network with all necessary data to meet DHCS required provider network data standards for monthly DHCS submissions and weekly website postings. Contractor may add or remove Network Pharmacies located in the California Counties of Ventura, Los Angeles, Kern, and Santa Barbara from the Pharmacy Network only upon written approval from GCHP. Contractor will allow GCHP to include or exclude certain pharmacies or chains from the Pharmacy Network. Should material changes in the Pharmacy Network impact the pricing guarantees set forth in Schedule A-2 Service Fees and Charges, Contractor will provide GCHP of any such proposed pricing impact upon GCHP's request and within five (5) days of GCHP's notification to Contractor of a change in the Pharmacy Network should the parties agree that such change is material.

2.2.2 Network Pharmacy Credentialing. Contractor will establish and maintain a reasonable process for credentialing Network Pharmacies in accordance with URAC PBM credentialing standards. Contractor will conduct annual audits of all pharmacy credentialing policies, documents, and activities to ensure compliance with these standards.

2.2.3 Desk and On-Site Audits. Contractor will, in accordance with its standard audit program and as required by law, conduct real-time and retrospective desk audits and selected on-site audits of the Network Pharmacies to determine whether the Network Pharmacies are submitting appropriate billings for payment by GCHP or Members. Contractor will report the results of the audits to GCHP. Subject to the fee set forth in Exhibit A-2, Contractor will pay GCHP, or apply as a credit to invoices payable by GCHP to Contractor, the 100% of the amounts Contractor recovers from these audits. The costs associated with real-time and retrospective desk audits will be the responsibility of Contractor. The cost of selected on-site audits will be the responsibility of Contractor for up to twelve (12) on site audits each year.

2.2.4 Confirmation of Member Eligibility. Prior to providing Covered Prescription Services to Members, Contractor and Network Pharmacies shall confirm the Members' eligibility status

2.2.5 Notifications. Unless an Exiting Pharmacy (as hereinafter defined) is removed from the Pharmacy Network in a shorter period of time for fraud, waste, abuse, or other reasons deemed by Contractor as potentially harmful to GCHP or its Members, Contractor will provide advance notification of Network Pharmacies that will no longer participate in the Pharmacy Network ("Exiting Pharmacy") at least forty-five (45) days prior to the date of any such Exiting Pharmacy's termination and in accordance with the Network Pharmacy Agreement. Contractor will provide All Members who have utilized that Exiting Pharmacy for fulfillment of Covered Prescription Services shall be notified in writing of the date of the termination and closest available Network Pharmacies. The Member notification shall be made at least thirty (30) days prior to the Exiting Pharmacy's termination date to the extent possible and in accordance with this Service Order and the Network Pharmacy Agreement.

2.3 Claims Process

2.3.1 Claims Adjudication. Contractor will adjudicate, process or pay Prescription Claims for Covered Prescription Services in accordance with the Plan Specifications. Contractor will pay in accordance with Plan Specifications, on GCHP's behalf, only Clean Claims (a) submitted by the Network Pharmacies in a timely manner through Contractor's point-of-service system in accordance with NCPDP guidelines and (b) properly submitted by Members as requests for reimbursement for Covered Prescription Services. For each Clean Claim submitted by a Network Pharmacy, Contractor will reimburse the Network Pharmacy the amount specified in the Network Pharmacy Agreement for the dispensed Prescription Drug less any Cost-Sharing Amounts. Contractor's claim adjudication will have, at a minimum, the following capabilities: (i) prior authorizations; (ii) multi-step (3+) step therapies; (iii) age restrictions (both above and below); (iv) benefit exclusions; (v) quantity limits based on all of the following: (a) metric decimal quantities; (b) morphine equivalent dosing (MED); and (c) total accumulated acetaminophen dosing; (vi) administrative prior authorizations; (vii) maximum dollar or quantity

edits per script with abilities to provide customized drug-specific exception lists; and (viii) point of sale DUR edits employment soft and hard edits.

2.3.2 Delays. Contractor will not be responsible for any loss, omission or delay of any Prescription Claim by a Network Pharmacy (other than Contractor's Mail Order Pharmacy or Specialty Pharmacy) or other health care professional.

2.3.3 Coordination of Benefits. GCHP is the payer of last resort and recognizes other health coverage as the primary carrier. Contractor and Network Pharmacies shall bill the primary carrier before billing GCHP for reimbursement for Covered Prescription Services to Members. Contractor and Network Pharmacies shall not bill Members for Covered Prescription Services, except for those Members with an authorized Cost Sharing Amounts. Contractor and Network Pharmacies may look to Members for payment of prescription drug services not part of the Benefit Plan. The coordination of benefits shall be made in accordance with GCHP's policies and procedures, which are outlined more specifically in Section 2.3.3.1, below. Contractor shall notify GCHP of the discovery of third party insurance coverage for a Member within ten (10) business days of discovery.

2.3.3.1 Claims processed for GCHP where GCHP is the secondary payer will follow the following guidelines with respect to other payers:

2.3.3.1.1 Medicare Part D: any claims for which the claim is eligible for coverage under Medicare Part D, regardless if the Member has active coverage under Medicare Part D, may not be paid in any part by GCHP;

2.3.3.1.2 Medicare Part B: any prescription claim for which the claim is eligible for coverage under Medicare Part B, GCHP is only to pay the portion of the Member cost share that, when summed with coverage by Medicare Part B, would equate to the total amount that GCHP would have paid if GCHP had been the primary payer. This coordination of benefits may result in GCHP not paying any portion of the claim and the Member shall have no remaining cost share.

2.3.3.1.3 Commercial Health Coverage: any claims for which the claim is eligible to for coverage under commercial coverage, GCHP shall be responsible for the Member's cost sharing. If the commercial coverage will not cover any portion of the claim, GCHP shall pay the entire portion of the claim only after all appeals processes through the other commercial coverage have been fully exhausted.

2.3.4 Third Party Liability. In the event that Contractor or Network Pharmacies render Covered Prescription Services to Members for injuries or other conditions resulting from the acts of third parties, the State has the right to recover from any settlement, award, or recovery from any responsible third party the value of all Covered Prescription Services which have been rendered by Contractor or Network Pharmacies pursuant to the terms of this Agreement. Contractor will report to GCHP the discovery of any third party tort action or potential tort action for a Member within ten (10) days of discovery. Contractor and Network Pharmacies will cooperate with DHCS and GCHP in their efforts to obtain information and collect sums due the State as a result of third party tort liability, including but not limited to workers compensation claims for Covered Prescription Services.

2.3.5 Administrative Grievances and Appeals. At GCHP's request, Contractor will process initial Benefit Plan coverage determinations and exception requests and support GCHP in connection with Benefit Plan appeals and grievances in accordance with Plan Specifications and this Section 2.3.5 and to the extent required by law.

2.3.6 Prior Authorization Appeals. GCHP staff (including licensed pharmacist and physicians) will conduct and make determinations of all appeals. Contractor shall be responsible for the maintenance of appeal documentation and provision of approved Member, prescriber, and pharmacy notifications. All appeals will be conducted in accordance with GCHP policies and procedures.

2.4 Benefits Administration and Support

2.4.1 Utilization Management Program

2.4.1.1 *Development and Support*. GCHP may implement, upon written agreement, Contractor's custom utilization management programs for the Benefit Plans designed to promote cost-effective drug utilization management and to discourage Prescription Drug over and under-utilization. Contractor may, on behalf of GCHP, (a) communicate with Members to describe health-related products or services (or payment for the products or services) provided by or included in the Benefit Plan through the Services, including communications about Network Pharmacies, replacement or enhancement to the Plan, and health-related products or services available only to Members that add value to and are not part of the Benefit Plan; (b) conduct population-based activities relating to improving the health of Members and reducing their healthcare costs; and (c) contact Members with health education information and information about Prescription Drugs, treatment alternatives, and related functions. Upon GCHP's request and at an additional charge to GCHP in accordance with the Clinical Documentation Form, Contractor, in consultation with GCHP, will develop non-standard utilization management policies, procedures, guidelines or programs for the Benefit Plans. Upon GCHP's request, Contractor will

communicate GCHP's utilization program requirements to Members through GCHP-approved information and outreach materials.

2.4.1.2 *Contractor's Prior Authorization Services*. Contractor will respond to properly submitted prior authorization requests from providers, Members and pharmacies using utilization management standards and guidelines established by GCHP. GCHP retains complete and exclusive discretionary authority over approval of prior authorization requests, including Benefit Plan override.

2.4.2 GCHP Prior Authorization, Overrides, and Appeals. If GCHP chooses to perform prior authorizations, benefit overrides, and/or appeals, then Contractor will provide GCHP access to the information in Contractor's computer systems that GCHP needs to perform these functions.

2.4.3 Quality Assurance Program. Contractor will implement its standard quality assurance program for the Benefit Plans that includes quality measures and reporting systems targeted at reducing medical errors and adverse drug interactions. In addition, Contractor will develop and implement systems or require Network Pharmacies to implement systems to: (a) offer Member counseling, when appropriate; (b) identify and reduce internal medication errors; and (c) maintain up-to-date Member quality assurance and patient safety program information.

2.4.4 Targeted Disease Intervention Program. Upon GCHP's request and for an additional charge to GCHP as referenced in the Clinical Documentation Form, Contractor will help GCHP develop and operate a targeted disease intervention program for the Benefit Plans that is designed to promote appropriate use of medications and improve therapeutic outcomes for targeted Members. Contractor, on GCHP's behalf, will coordinate and implement the targeted disease intervention program. Also, upon GCHP's request and at an additional cost to GCHP, Contractor will communicate with Members about the targeted disease intervention program through GCHP-approved information and outreach materials.

2.4.5 Other Clinical Services. Upon GCHP's request and for an additional charge to GCHP, Contractor will help GCHP develop and implement additional quality initiatives, intervention programs or other clinical services.

2.5 Formulary

2.5.1 Formulary. GCHP maintains its own custom Formulary and Pharmacy and Therapeutics Committee.

2.5.2 Formulary Management Support. Contractor will support the development and maintenance of GCHP's Formulary, including Pharmacy and Therapeutics Committee support, drug monograph development, communication and publication through Contractor's formulary

management tool. Contractor will provide GCHP with documentation of formulary updates and testing documents.

2.5.3 Formulary Changes. Contractor will include in the Formulary new FDA-approved medications as specified in the Plan Specifications according to the following schedule: (a) if an open formulary, all new covered FDA-approved medications (formulary and non-formulary) will be included in the Formulary upon publication in the Medi-Span pricing index and loading into Contractor's systems or (b) if a closed formulary, all new covered FDA-approved medications (formulary only) will be included in the Formulary after review and addition to the Formulary by Pharmacy and Therapeutics Committee. Following changes to the Formulary, Contractor, at GCHP's request, will provide or make available appropriate notifications of Formulary changes to GCHP, Members, prescribing physicians, Network Pharmacies and state pharmaceutical assistance programs as required by law and agreed to by the parties.

2.6 Rebate Management

2.6.1 Rebate Eligibility. Contractor will remit Rebates to GCHP if: (a) GCHP satisfies the minimum Rebate contract criteria and has included the Drug Manufacturer's Prescription Drug on its Formulary; (b) Contractor has received Rebates resulting directly from GCHP's satisfaction of the foregoing clause (a); and (c) GCHP has agreed in writing that Contractor will act on its behalf to obtain rebates. GCHP, in its sole and absolute discretion, may enter into agreements for rebates concerning Prescription Drugs on its Formulary. In addition, Contractor, in its sole and absolute discretion, may enter into agreements for Rebates concerning Prescription Drugs on Contractor's or any of its customers' formularies, including GCHP; provided, however, that Contractor's rebates agreements do not interfere with GCHP's rebate agreements. Claims that will not be eligible to receive Rebates include Prescription Claims: (a) with invalid service provider identification or prescription numbers; (b) where, after meeting the deductible, the Member's Cost-Sharing Amount under the applicable Benefit Plan requires the Member to pay more than 50% of the Prescription Claim; (c) for devices without a Prescription Drug component; (d) that are re-packaged NDCs; (e) or portion thereof, that includes utilization for which a price concession is payable by a Drug Manufacturer under section 340B of the Public Health Service Act; (f) from entities eligible for federal supply schedule prices (e.g., Department of Veterans Affairs, U.S. Public Health Service, Department of Defense); (g) Claims eligible to receive Rebates from Medicaid, Medicare or other state or federal health care programs; or (h) that are not for Prescription Drugs (except for insulin or diabetic supplies).

2.6.2 Collection. Contractor will use commercially reasonable efforts to collect Rebates. Contractor will not be responsible for any non-payments or partial payments of amounts owing under an agreement for Rebates. To the extent of any undisputed overpayment or erroneous payment to GCHP by Contractor, GCHP will refund the payment or Contractor may recoup the payment from other sums due GCHP within thirty (30) days after prior

written notice from Contractor to GCHP requesting reimbursement of the overpayment or erroneous payment and information documenting such overpayment or erroneous payment.

2.6.3 Disbursement. Provided GCHP is in compliance with the terms of this Service Order, Contractor will disburse GCHP's Rebate payments as follows. Rebate payments will be due to GCHP one hundred eighty (180) days after the close of a given calendar quarter. Contractor will remit Rebate payments to GCHP no later than thirty (30) days after the close of such one hundred eighty (180) day period. By way of example, Rebates earned during the first quarter of a given calendar quarter would be paid to GCHP by October 31 of such contract year. Rebate reconciliation and payment of any necessary true-up will be performed within ten (10) months after the close of a given calendar quarter.

2.6.4 Eligible Rebate Data. GCHP shall use its reasonable best efforts to clearly identify to Contractor all Members it has knowledge of whose drug utilization or claims have been otherwise submitted to pharmaceutical manufacturers or whose claims have been or will be filed for reimbursement with other government plans, as well as the affected claims. GCHP shall have no responsibility for providing information to Contractor with regard to any rebates submitted by or received by the state of California. If GCHP fails to identify such known Members or Claims and any pharmaceutical manufacturer's audit of its rebate program reveals improperly calculated Rebates involving such Members or Claims, then GCHP shall be responsible for the reimbursement of any Rebates improperly made or calculated and any corresponding costs or penalties associated with the audit to the extent the right to reimbursement results from GCHP's gross negligence or willful misconduct.

2.7 **E-Prescribing**. Upon GCHP's request and as set forth in Exhibit A-2 Service Fees and Charges, Contractor will provide prescribers with electronic access to Member Benefit Plan information, including: (a) Member eligibility status: (b) Member medication history; (c) Formulary status of the Prescription Drug being prescribed; (d) listing of Generic Drug or Brand Name Formulary alternative medications; (e) Member coverage information where applicable; (f) applicable Cost-Sharing Amount; and (g) drug classification information required by the Centers for Medicare & Medicaid Services or successor Governmental Authority.

2.8 **Mail Order Pharmacy Services**

2.8.1 Mail Order Services. Contractor, in its capacity as a Mail Order Pharmacy, will provide GCHP with Mail Order Pharmacy Covered Prescription Services to Members in accordance with the Plan Specifications. Once a prescription for a Covered Prescription Service has been transmitted to Contractor in accordance with law, in its capacity as Mail Order Pharmacy, Contractor will promptly prepare, package and ship the applicable Covered Prescription Service to the Member or other authorized person or entity. Contractor will provide customer service support for Members who use Mail

Order Pharmacy Services. Upon request, Contractor will make available to GCHP mail service brochures for distribution to Members.

2.8.2 Control by Contractor. Contractor will solely and exclusively control and supervise the operation and maintenance of Contractor's Mail Order Pharmacies and their respective facilities and equipment and provision of Mail Order Covered Prescription Services. All decisions respecting the provision of Mail Order Covered Prescription Services by Contractor's Mail Order Pharmacies will be made solely by Contractor and its duly authorized personnel, and not by GCHP. The relationship between a Member and a Mail Order Pharmacy will be subject to the rules, limitations and privileges incident to the pharmacist-patient relationship. Contractor may exclude from coverage by a Mail Order Pharmacy under this Service Order a Prescription Drug that cannot be dispensed under Contractor's mail order pharmacy dispensing protocols or requires special record-keeping procedures.

2.8.3 Mail Order Postage Rates. If GCHP requests or requires expedited or alternative shipping methods other than Contractor's standard method, GCHP will be solely responsible for those costs.

2.9 Specialty Pharmacy Services

2.9.1 Specialty Services. Contractor will provide GCHP with Specialty Drug Covered Prescription Services to Members as follows:

2.9.2 Specialty Pharmacy Program. If GCHP is part of Contractor's Specialty Pharmacy Program, GCHP will receive Specialty Drugs as a Covered Prescription Service from Contractor's Specialty Pharmacy as specified in Schedule A-2 Service Fees and Charges.

2.9.3 Open Specialty Pharmacy Program. If GCHP is part of Contractor's Open Specialty Pharmacy Program, Contractor will provider Specialty Drug Covered Prescription Services from a Network Pharmacy, including Contractor's Specialty Pharmacy. Limited Distribution Drugs not dispensed by Contractor's Specialty Pharmacy are excluded from the Specialty Services or excluded from any Specialty Drug pricing guarantees. For purposes of this Section, Limited Distribution Drugs are medications that are distributed to either one or a very limited number of pharmacies and wholesalers.

2.9.4 Addition or Removal of Newly Acquired or Approved Specialty Drugs

2.9.4.1 From the date a newly acquired or approved Specialty Drug ("New Specialty Drug") becomes available until GCHP rejects the New Specialty Drug as specified in Section 2.9.4.2 of this Service Order, GCHP authorizes and directs Contractor to make the New Specialty Drug available to Members as part of the Specialty Drug Covered Prescription Services in accordance with Formulary and utilization management policies. Contractor will be required to make available to GCHP or Members in accordance with

Formulary and utilization management policies a new limited distribution or market access, such as a New Specialty Drug with one distributor or manufacturer but the cost of the such drug will be excluded from the Specialty Services or any Specialty Drug pricing guarantee.

2.9.4.2 On a periodic basis, Contractor will review the Specialty Drugs covered under this Service Order and provide GCHP with the name and price of any New Specialty Drugs to be added to this list of Specialty Drugs. From the date of GCHP's receipt of this notice, GCHP will have thirty (30) days to provide Contractor with notice of rejection of additions to the Specialty Drugs covered under this Service Order. Alternatively, on a periodic basis, GCHP will review the Specialty Drugs covered under this Service Order and provide notice to Contractor with the name of any specialty drugs that need to be removed from the list of Specialty Drugs.

2.9.4.3 No later than forty-five (45) days after Contractor's receipt of GCHP's notice of rejection of New Specialty Drugs, Contractor shall remove the New Specialty Drugs covered under this Service Order and cease dispensing the New Specialty Drugs to Members at the pricing specified in Contractor's notice. If GCHP does not notify Contractor of its rejection of the New Specialty Drugs, Contractor will continue to include the New Specialty Drugs as a Specialty Drug made available to Members.

2.9.4.4 No later than thirty (30) days after Contractor's receipt of GCHP's notice of Specialty Drug removals, Contract will remove the identified specialty drugs from the list of Specialty Drugs and remove any other access restrictions made on such drugs.

2.9.5 Contractor Control. Contractor will solely and exclusively control and supervise the operation and maintenance of Contractor's Specialty Pharmacies and their respective facilities and equipment and provision of Covered Prescription Services. All decisions respecting the provision of Covered Prescription Services by Contractor's Specialty Pharmacies will be made solely by Contractor and its duly authorized personnel, and not by GCHP. The relationship between a Member and a Specialty Pharmacy will be subject to the rules, limitations and privileges incident to the pharmacist-patient relationship.

2.10 **Audit**. In addition to the audit requirements set forth in Section 14 of the Agreement, GCHP may conduct such audits as necessary to verify Contractor's compliance with the terms of this Service Order and Agreement. Such audit rights shall include auditing 100% of claims, Rebates, prior authorizations, pharmacy credentialing, documents, and Formulary changes, down to the individual claim level. Any audit conducted pursuant to this Section will be in compliance with the terms of Section 14 of the Agreement.

3. TERM

3.1 The term of this Service Order shall be from November 1, 2016 to May 31, 2017 ("Implementation Term") during which time the parties shall prepare for the implementation of this Service Order. After the Implementation Term, the term of this Service Order shall continue from June 1, 2017, until May 31, 2018 ("Service Year 1"), and shall continue from June 1, 2018, to May 31, 2019 ("Service Year 2"), and thereafter from June 1, 2019, to May 31, 2020 ("Service Year 3"). (Service Year 1, Service Year 2 and Service Year 3 may be individually referred to herein as "Service Year" or collectively as "Service Years".) Upon the expiration of Service Year 3, GCHP shall have the unilateral right to renew this Service Order for consecutive renewal terms (each a "Renewal Term") of twelve (12) months each, not to exceed a maximum of two (2) Renewal Terms, by giving CONTRACTOR written notice of renewal at least ninety (90) days prior to the expiration of the then-current term.

3.2 After the first anniversary of the Implementation Date of this Service Order, GCHP may terminate this Service Order without cause upon ninety (90) days prior written notice of termination to Contractor.

3.3 Upon the expiration or termination of this Service Order for any reason, GCHP shall have the unilateral right †o renew this Service Order for three (3) consecutive Renewal Terms of three (3) months each by giving Contractor written notice of renewal at least sixty (60) days prior to the expiration of the then-current term.

4. PERFORMANCE GUARANTEE

Contractor shall be subject to the Performance Guarantees outlined in Performance Guarantee Schedule A-1, attached hereto. The liquidated damage payments specified in the Performance Guarantees Schedule A-1, shall be in addition to all other remedies available to GCHP in accordance with law for Contractor's breach of its obligations under any term of this Service Order. GCHP may pursue such Performance Guarantees and liquidated damages for Contractor's failure to meet such Performance Guarantees or may pursue such other remedies available and appropriate for Contractor's breach of any other term of this Service Order. The Parties agree that GCHP may collect the liquidated damages set forth in Schedule A-2 by deducting such payment from the Service Fee due Contractor or by any other legal means.

5. PAYMENT FOR SERVICES.

GCHP will pay Contractor for Contractor's provision of Services the Service Fees.

6. MARKET CHECK.

Commencing one (1) year after the Implementation Date and every year thereafter during the term of the Service Order, GCHP may review the financial terms of this Service Order to comparable financial offerings available in the marketplace. GCHP may conduct a market check analysis to confirm its pricing is competitive with that of substantially similar customers and for substantially similar PBM services, plan design, financial assumptions, lines of business and other terms and conditions ("comparables"). GCHP may submit to Contractor a market check report providing information that allows Contractor to evaluate

in sufficient detail the comparable customers and the other financial offers (summarized or names redacted) to substantiate the market check conclusion. Contractor will review GCHP's market check request and respond to GCHP within thirty (30) days of receipt of the market check report. If the market check report validates an aggregate annualized savings of greater than three percent (3%), the parties will discuss, in good faith, revisions to the Service Fees. Any revisions to the Service Fees resulting from the parties' negotiations will be effective as of the next anniversary of the Implementation Date unless otherwise agreed to by the parties, but no sooner than thirty (30) days after completion of the market check report and upon execution of an Amendment to this Service Order. If the parties do not agree on any resulting revisions to Service Fees after good faith negotiations, GCHP may terminate this Service Order upon ninety (90) days' prior notice of termination to Contractor.

7. <u>NOTICES TO GCHP</u>.

Contractor shall notify GCHP as follows:

7.1 In writing at least forty-five (45) days prior to the occurrence of any of the following, or if under the circumstances such notice is not reasonably possible, then as much notice as is reasonably possible under the circumstances of any of the following:

7.1.1 Any change in Contractor's business address, business phone number, office hours, or tax identification number; or

7.1.2 Any material change in Contractor's management or ownership. For purposes of this Section, a material change is a transfer of twenty percent (20%) or more of share ownership or the right to control the selection of the board of directors of Contractor or the sale of substantially all of the assets of Contractor.

7.2 Orally, immediately but not later than three (3) calendar days followed by written notice within ten (10) calendar days, of the occurrence of any of the following:

7.2.1 Any formal action taken (and the reasons therefore) to restrict, suspend or revoke any of Contractor's licenses, permits, accreditations or ability to conduct its business; or

7.2.2 Any finding of wrongdoing by any federal or state regulator; or

7.2.3 Contractor's knowledge, with due inquiry, of any action taken (and the reasons therefore) which results in restrictions or exclusion of Contractor from participation in the any federal or state health care program, including but not limited Medicare or Medicaid, in accordance with the standards of participation for such program; or

7.2.4 Any changes in Contractor's Key Staff; or

7.2.5 Any material change in Contractor's business organization that may impact Contractor's performance of its obligations under this Service Order.

7.2.6 Any event under which Contractor is no longer capable of providing Services on a timely basis; or

7.2.7 Any other event which would materially affect Contractor's ability to carry out its duties and obligations under this Service Order.

7.3 Contractor shall promptly provide GCHP with such additional information as GCHP may request. The notices required under this Section are in addition to any other notices provided for in this Agreement.

8. RUNOUT SERVICES

8.1 **Runout Services**. The Runout Services Period shall be six (6) months long and shall begin the day after the expiration or termination of the Service Order ("Runout Services Period"). Effective the first day of the Runout Services Period, Contractor and its subcontractors shall have no further obligation to provide or maintain a Pharmacy Network to provide Members with access to Network Pharmacies or to otherwise provide, or arrange for the provision of, Covered Prescription Services to Members under the Benefit Plan. As of the first day of the Runout Services Period, Network Pharmacies shall no longer provide Covered Prescription Services to Members under the Benefit Plan (unless pursuant to an arrangement other than this Service Order). Throughout the Runout Services Period, Contractor shall provide such Runout Services as reasonably necessary to administer the provision of Covered Prescription Services furnished to Members during the term of this Service Order and otherwise to ensure an orderly wind down of the arrangement contemplated by this Service Order ("Runout Services"). Such Runout Services, shall include, but not be limited to:

8.1.1 Claims Processing and Payment. Subject to GCHP's providing Contractor with the required funds to pay such claims, Contractor agrees to process claims for Covered Prescription Services furnished during the term of this Service Order in accordance with the terms and conditions of this Service Order.

8.1.2 Member Health Care Appeals. Contractor shall perform its obligations relating to Member appeals with respect to Covered Prescription Services furnished to Members during the term of this Service Order, in accordance with the terms and conditions of this Service Order.

8.1.3 Customer Service for Members. Contractor shall provide customer service functions and customer service call center accessibility as outlined in Section 2.1.3.

8.1.4 Limited Network Pharmacy and Provider Technical Support. Contractor shall provide limited Network Pharmacy and provider technical support functions including the provision of limited provider service call center accessibility, as reasonably necessary to administer payment for Covered Prescription Services furnished to Members during the term of this Service Order and otherwise as mutually agreed by the parties.

8.1.5 Limited Network Pharmacy Dispute Resolution. Contractor shall provide limited Network Pharmacy dispute resolution functions, as reasonably necessary to resolve disputes regarding payment for Covered Prescription Services furnished to Members during the term of this Service Order and otherwise as mutually agreed by the parties.

8.1.6 Audits, Reporting and Reconciliation. Contractor shall provide reports and participate in audits and reconciliations pursuant to the terms of this Service Order and Agreement.

8.1.7 Mutual Agreement. Contractor shall provide such additional services as mutually agreed by the parties.

8.2 **Payment for Covered Prescription Services**. The parties agree that notwithstanding any termination of this Service Order, GCHP shall remain obligated, in accordance with the terms of the Service Order, to pay Contractor for claims for Covered Prescription Services furnished during the term of this Service Order under the terms of this Service Order and in accordance with the time periods prescribed in the Benefit Plan and GCHP policies and procedures for payment of claims for Covered Prescription Services.

9. LETTER OF CREDIT

9.1 **Terms of Letter of Credit**. Contractor will obtain and maintain for the term of the Agreement an irrevocable standby letter of credit naming GCHP as the beneficiary to secure or guaranty the successful bidder's performance under the terms of the Agreement ("Letter of Credit"). The face amount of the Letter of Credit would be a minimum of one million dollars ($1,000,000) and shall be in form and substance satisfactory to GCHP. The Letter of Credit shall permit GCHP to draw against the Letter of Credit and use the proceeds of any draw should Contractor not perform all of its obligations under the Agreement and this Service Order.

9.2 **Issuing Banking Institution**. The Letter of Credit shall be issued by a national banking institution or other comparable financial institution acceptable to GCHP, and preferably through a branch office located in Ventura County but, if needed, Los Angeles County.

9.3 **Replacement Letter of Credit**. Contractor may not replace the Letter of Credit without the prior written approval of GCHP. Any replacement or substitute Letter of Credit shall meet all of the requirements applicable to the Letter of Credit being replaced unless otherwise approved by GCHP in writing and shall be effective and delivered or transmitted to GCHP at least thirty (30) days before the date of expiration of the Letter of Credit being replaced. Upon GCHP's request, Contractor shall within thirty (30) days obtain and deliver to GCHP a replacement or substitute Letter of Credit meeting all of the requirements applicable to the Letter of Credit pursuant to this Section.

9.4 **Process for GCHP's Approval**. Within thirty (30) days prior to the Implementation Date, Contractor shall have provided GCHP with the Letter of Credit described in this Section to be effective on the Implementation Date, and all related documents and agreements in draft form for GCHP's review and approval. Any such Letter of

Credit issued without the prior review and approval of GCHP shall be deemed to be noncompliant with the terms of this Service Order. Contractor shall obtain GCHP's prior written approval of the draft of such Letter of Credit and related documents and agreements prior to issuance of the Letter of Credit. Such Letter of Credit shall be issued on or before the Implementation Date.

10. FRAUD AND ABUSE

10.1 **Operating Procedures**. Contractor shall develop operating procedures to prevent, detect and recover (when applicable and allowable) and immediately report to GCHP incidences of waste, fraud and abuse as well as potential abusers, including Network Pharmacies, providers and Members, of the Benefit Plan. Potential abusers may be identified through review of claims suspended for manual review or through referrals, complaints or inquiries received by Contractor. Contractor shall use commercially reasonable efforts to recover all expenditures from third parties, including providers and Members, for Covered Prescription Services provided to persons in the case of fraudulent activities. Contractor shall cooperate with GCHP and state and federal law enforcement authorities in cases involving waste, fraud and abuse. Contractor shall implement industry standard fraud prevention and detection strategies.

10.2 **Prevention and Detection Program**. Contractor shall conduct a program to assess its vulnerability to fraud and abuse and shall operate a system designed to detect and eliminate internal fraud and abuse by Contractor employees and subcontractors, providers providing goods or services to Members. The Contractor shall:

10.2.1 Include provisions for cost avoidance as well as fraud detection, along with criteria for follow-up actions;

10.2.2 Include mandatory anti-fraud and abuse training for Contractor staff, and claims processing edits to identify cases and pharmacy claims costs, with a high potential to be fraud, waste, or abuse;

10.2.3 Monitor claims for under- and over-utilization and indications of potential fraud; and

10.2.4 Have or develop the capability to identify providers with whom to intervene based on identified patterns of health service claims and utilization that may be indications of potential fraud, waste and abuse.

10.3 **Documentation of Fraud Prevention Program and Quality Assurance Procedures**. Contractor shall keep complete records of its fraud prevention program and quality assurance procedures and the results of program implementation. Contractor shall make such records available to GCHP as required by GCHP.

10.4 **Reporting**. Contractor shall submit to GCHP an annual analysis of the costs and benefits of its fraud and abuse program. Contractor shall submit quarterly reports to GCHP consistent with industry standards, addressing the following:

10.4.1 Cases opened;

10.4.2 Dollars identified as lost and recovered on active cases;

10.4.3 Actual and projected savings on active cases;

10.4.4 Active cases referred to law enforcement (other than GCHP);

10.4.5 Active cases referred to GCHP;

10.4.6 Active cases resolved administratively;

10.4.7 Percentage of active cases where the Benefit Plan is the only or primary line of business affected;

10.4.8 Number of GCHP network providers who are in payment suspension; and

10.4.9 Number of active cases that have been referred to law enforcement and/or other regulatory authorities.

Contractor shall demonstrate that a statistically valid sampling technique is routinely used prior to or after processing randomly sampled claims against Contractor for quality assurance/fraud and abuse prevention standards.

10.5 **Member Complaints Regarding Fraud or Abuse**. Contractor shall establish and maintain procedures to respond to a Member's written complaint regarding fraud or abuse within twenty (20) days from date of receipt.

10.6 **Correction of Deficiencies**. In response to a GCHP order for a correction of deficiency in Contractor's quality assurance program, fraud prevention program, or anti-dumping efforts, Contractor shall take prompt, necessary action to implement GCHP's order.

APPROVALS

GOLD COAST HEALTH PLAN	**OPTUMRX, INC.**
BY: _____	BY: _____
NAME: Dale Villani	NAME: _____
TITLE: Chief Executive Officer	TITLE: _____

AGENDA ITEM NO. 11

TO: Gold Coast Health Plan Commission

FROM: Dale Villani, Chief Executive Officer

DATE: October 24, 2016

SUBJECT: Chief Executive Officer Update

GCHP Awarded 2016 NAACP Community Empowerment – Corporate Award

On October 8, 2016, at the NAACP Ventura County 2016 Freedom Fund Banquet, GCHP was awarded the NAACP Corporate Award. This award is presented to a small business or corporation that has worked tirelessly for the well-being of the community focusing on economic growth, educational quality, or political and social justice. CEO Villani accepted the award on behalf of the employees of GCHP expressing his sincere appreciation for this prestigious honor.

California Association of Health Plans (CAHP) Annual Conference and LHPC Board Meeting Key Take-Aways

CAHP and LHPC hosted their meetings during the week of October 10th and a number of key issues and changes were discussed which will impact GCHP over the next 6-18 months.

- CMS Mega-Rule (Medicaid and CHIP Managed Care Plan Final Rule) will result in at least one large contract amendment which impacts all plans, delegates, vendors and providers.
    - Medical loss ratio requirements
    - Actuarial soundness and rate development
    - Pass through payments to providers
    - Supplemental payments and pay-for-performance
    - Program integrity
    - Provider enrollment
    - Provider directories and plan formularies
    - Network adequacy
    - Quality of Care
    - Encounter data reporting

- DHCS is increasing focus on Quality performance. The current DHCS Performance Dashboard shows that local health plans have the highest quality scores across all 22 Medi-Cal Plans.

- NCQA Accreditation becoming an industry standard for quality ratings (CalOptima recognized by NCQA in its Medicaid Health Insurance Plan Ratings 2016-2017

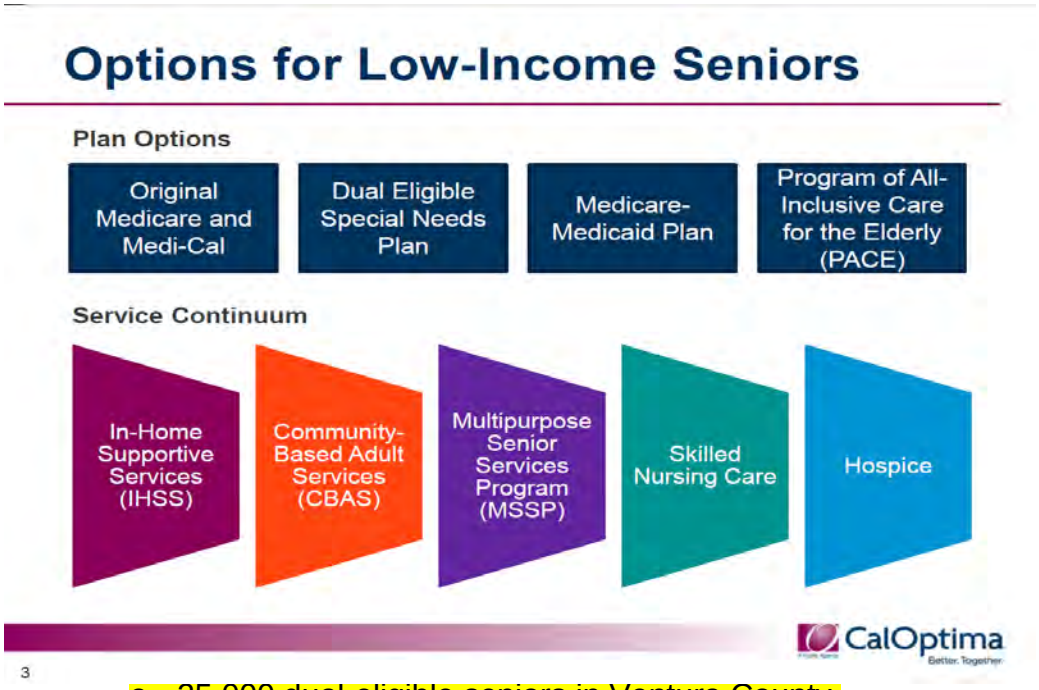
MEDI-CAL HEALTH PLANS NCQA ACCREDITATION STATUS

NCQA Accredited	Currently Seeking	Not Yet Accredited
1. Alameda Alliance 2. CalOptima 3. Community Health Group 4. Contra Costa 5. Health Plan San Joaquin 6. Inland Empire 7. LA Care	1. CenCal 2. Central Coast Alliance for Health 3. Health Plan San Mateo 4. San Francisco Health Plan	1. CalViva 2. GCHP* 3. Kern Family Health Plan 4. Partnership 5. Santa Clara Family Health Plan

*GCHP may consider seeking NCQA accreditation

- New DHCS Quality Rating System (QRS) implementation underway
- Managing delegated networks (IPAs, MSOs, health plans) more complicated
- Some plans seeing significant membership decreases. DHCS recertification process lagging.
- Plans increasing focus on the "member experience" and adding resources to increase access including:
  - Nurse advice line
  - Walk-in Minute Clinics
  - Tele-Health
  - E-Consult
- Senior Care Strategies being implemented at many plans (implications for GCHP)

SLIDE PRESENTED BY CALOPTIMA AT CAHP CONFERENCE



o 25,000 dual-eligible seniors in Ventura County.

Knox Keene License and DMHC Director Shelley Rouillard. Director Rouillard is visiting County Organized Health System (COHS) CEOs to better understand how the local plans operate. Director Rouillard has visited a number of the COHS and will be visiting with GCHP in the near future. In speaking directly with Director Rouillard she indicates a strong desire for all COHS to be full scope Knox Keene licensed in the very near future. This is something GCHP will have to give strong consideration to in the next 12-months.

Information management and reporting needs for health plans and partners are increasing and initiatives such as population health, whole person care, and integrated care are driving many plans to invest in **health information exchange (HIE)**.

Hospital Association of Southern California (HASC) Medi-Cal Task Force Meeting #4. CEO Villani attended the final task force meeting on October 19, 2016 in the Los Angeles offices of the HASC. The final meeting compiled the task force recommendations and developed next steps on the issues identified.

California Legislature

Approved Legislative Bills by Governor Brown

Friday, September 30, was the last day for Governor Brown to approve or veto bills sent over to him by the Legislature. Governor Brown approved the following Medi-Cal related bills:

- AB 1696 (Holden) Tobacco Cessation: Would require plans to cover tobacco cessation products.
- AB 2207 (Wood) Medi-Cal/Denti-Cal: Would require a number of changes and improvements to Denti-Cal.
- AB 2394 (Garcia) Non-Medical Transportation: Would require plans to cover non-medical transportation for all members as specified.
- SB 586 (Hernandez) CCS Bill Carve-In: Extends the current CCS carve out until 2022 except for specified COHS counties.
- SB 999 (Pavley): Requires plans on or after January 1, 2017 to cover a 12 month supply of contraceptives.

For a complete list of approved and vetoed Medi-Cal related bills by Governor Brown, please see the Tracking Legislative Bills Table. Also, included is an update regarding the 2016 General Election and California Ballot Initiatives from the GCHP lobbyists.

Gold Coast Health Plan's Priority Tracking Legislative Bills Table

September 2016

Bill # & Subject	Description	Location & Notes
Autism		
SB 1034 (Mitchell) Health Care Coverage: Autism	SB 1034 would require a treatment plan be reviewed no more than once every six months, unless a shorter period is recommended by the qualified autism service provider. Prohibits lack of parent or caregiver participation from being used to deny or reduce medically necessary behavioral health treatment. Prohibits the setting, location, or time of the treatment from being used as a reason to deny treatment. Prohibits this provision from being construed to require coverage for services that are included in a member's individualized education program.	• Held in Assembly Appropriations Committee
Mandates		
AB 1763 (Gipson) Health Care Coverage: Colorectal Cancer Screening	Requires coverage of new screenings and diagnostics with three levels of screenings: standard, high risk, and over 50.	• Vetoed by Governor Brown. • Bill imposes a no cost sharing mandate on health plans and insurance policies for colorectal cancer screening services that exceeds the requirements of the ACA. • Sets this cancer apart from other cancers • Increases everyone's healthcare costs.
AB 1831 (Low) Health Care Coverage: Prescription Drugs: Refills	Requires ophthalmic product refills at 70% of the predicted days use.	• Vetoed by Governor Brown • In most instances of spillage or loss, health plans or pharmacists provide an early refill to those who need it. • New mandates, even small ones, add to the high cost of health care.
AB 2507 (Gordon) Telehealth: Access	Adds video communications, telephone communications, email communications, and synchronous text or chat conferencing to the definition of telehealth, and allows	• Held in Assembly Appropriations Committee

	required prior consent for telehealth services to be digital as well as oral or written.	
SB 999 (Pavley) Contraceptives: Annual Supply	Requires plans on or after January 1, 2017, to cover, and authorizes pharmacists to dispense, a 12-month supply of FDA-approved, self-administered hormonal contraceptives dispensed at one time by a prescriber, pharmacy, or onsite at a location licensed or authorized to dispense drugs or supplies.	• Signed by Governor Brown as part of a bill package to strengthen consumer health and safety protections in California.
Reproductive Health		
SB 960 (Hernandez, Leno and McGuire) Medi-Cal: Telehealth: Reproductive Health Care	SB 960 would expand access to reproductive services by requiring Medi-Cal reimbursement for those services delivered through telehealth.	• Held in the Senate Appropriations Committee
Health Plan Regulations		
SB 1135 (Monning) Notice of Timely Access to Care	Requires health plans, including Medi-Cal managed care plans, to notify enrollees and contracted providers about information on timely access to care standards and interpreter services, at least annually.	• Signed by Governor Brown as a part of a bill package to strengthen consumer health and safety protections in California.
Provider Issues/Networks		
AB 2372 (Burke) Health Care Coverage: HIV Specialists	Allows for an enrollee to choose a specialist physician, including an AIDS specialist, as their PCP.	• Held in the Assembly Appropriations Committee
Medi-Cal/Public Programs		
AB 1696 (Holden) Tobacco Cessation	Requires tobacco cessation services to include the following: a minimum of four quit attempts per year, at least four tobacco cessation counseling sessions per quit attempt, and 12 week treatment regimen of any medication approved by the FDA.	• Signed by Governor Brown. • Bill was largely amended to align with the guidance issued by DHCS in APL 14-006.
AB 1795 (Atkins) Health Care Programs: Cancer	Extends coverage for breast and cervical cancer for low-income uninsured or underinsured individuals to include individuals of any age who are symptomatic and age 40	• Signed by Governor Brown

	and older, and removes the timeframe of 24 months to "as meets eligibility requirements."	
AB 2084 (Wood with co-author Senator Stone) Comprehensive Medication Management	Establishes a comprehensive medication management (CCM) program as a covered benefit in the Medi-Cal program.	• Held in the Assembly Appropriations Committee
AB 2207 (Wood) Medi-Cal Dental Program	Requires Medi-Cal managed care plans to provide dental health screenings for eligible beneficiaries and refer them to appropriate Medi-Cal dental providers.	• Signed by Governor Brown
AB 2394 (Garcia, Eduardo) Medi-Cal: nonmedical transportation	SB 2394 would add to the schedule of benefits nonmedical transportation, as defined, subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services.	• Signed by Governor Brown

County Organized Health Systems
2016 General Election Preview / Initiative Edition

by Don Gilbert, Mike Robson, Trent Smith, and Jason Ikerd

October 13, 2016

October 10 marks the day when absentee ballots are mailed to voters in California, thus voting will commence immediately thereafter right up until polls close on November 8. Given that nearly 60 percent of all ballots cast will be done through the mail, it is likely that most elections will be decided before the campaigns finish their messaging. Of course votes will not be counted until after the polls close at 8 p.m. on election night.

While most media is focused on the Presidential election and its associated drama, those paying attention to California electoral politics speculate on how the race for President will impact the down-ticket races and ballot measures. Much of that speculation is focused on whether the Presidential election will energize California Democrats, who historically vote in higher numbers in Presidential election years, to turn out to vote in even higher numbers than normal.

Another factor that drives election turnout are statewide ballot initiatives. High profile and contentious issues tend to bring out voters. However, with 17 initiatives on the statewide ballot that have collectively spent more than $350 million, it is hard for any one initiative to dominate the public's attention.

Below is a discussion on a handful of some of the more high profile initiatives on the ballot.

Proposition 55 -- Tax Extension to Fund Education and Healthcare.
In 2012, with California government in deep deficit, the California Legislature could not cut enough services to bring the budget into balance. At that time, Governor Brown with significant support from the teachers union, public employees and business successfully passed Proposition 30 to temporarily raise income tax on couples making over $500,000 per year and to temporarily increase the statewide sales tax. This measure passed and yielded significant new revenues which has since helped the Legislature pass a balanced budget in a timely manner, without cutting services.

Proposition 55 will continue the increased income tax until 2030, while allowing the sales tax increase to expire. If passed, the state would continue to see between $4 billion to $9 billion in revenues, of which half would go to K-14 education. If Proposition 55 does not pass, the California Legislature would likely find it difficult to find replacement revenues and/or make the necessary budget cuts to balance future state budgets.

Proposition 64 -- Legalize Recreational Use of Marijuana.
Marijuana for medical use is already allowed in California. Proposition 64 would allow non-medical use, sale, and cultivation in California. If approved, this measure could generate more

than $1 billion in annual state and local tax revenue over time. Initial state tax revenue would come from a new state tax on marijuana growing and production plus a new excise tax at the retail level. There would also be additional revenues from applying the existing sales tax at the retail level and state and local governments would be allowed to impose other taxes as well.

The initiative specifically does not preclude employers from having anti-marijuana workplace policies and nothing prohibits drug testing of employees and prospective employees in accordance with federal law. If passed, however, these questions will begin to emerge in the future.

Proposition 54 Legislative Transparency
This Constitutional Amendment is a bit of inside-baseball as it pertains to the California Legislature and the legislative process. It is being pushed by Republicans and open-government advocates and would require that all legislation be in print and online for 72 hours before the Legislature could vote on the bill. It would also require all public meetings to be recorded and available to the public via the internet.

The main goal of this initiative is to slow the legislative process down and to make sure that all legislation is afforded a level of public scrutiny that is sometimes lost in the hectic, waning hours of the legislative session.

Proposition 61 State Drug Purchasing
This proposition would prohibit state agencies from paying more on any prescription drug than what is paid by the United States Department of Veteran Affairs. Proponents argue that this measure will save the state money through lower drug costs. Opponents argue that it could actually lead to higher drug costs. The independent Legislative Analyst argues that savings are purely speculative.

Proposition 56 Tobacco Tax
This ballot measure would raise the state excise tax on tobacco products $2.00 from 87 cents per pack of cigarettes to $2.87. If passed by voters it would generate over $1 billion in new revenues to the state that would be earmarked primarily to support the Medi-Cal program and to make up for tobacco tax revenues that have been lost due to the reduction in smoking.

Proposition 52 – Hospital Fee.
This measure would make permanent the existing Hospital Quality Assurance Fee which is due to expire in 2018. Fee revenue is used to support public and private hospital's care for Medi-Cal services to children and offsets state General Fund dollars that would otherwise be needed to pay for these services. This new revenue also helps draw down an equal amount of federal revenue thereby doubling the support for hospitals.

COMPLIANCE UPDATE

Gold Coast Health Plan was notified on February 25, 2016 by Audits & Investigations (A&I) the annual medical audit for 2016 will take place, April 25, 2016 through May 6, 2016. GCHP had to submit pre-audit documentation material to A&I by March 18, 2016. The review period for the medical audit is April 1, 2015 through March 31, 2016. GCHP received the draft CAP report on September 6, 2016. The final CAP report will be sent to the Plan in October and at that time will be published on the DHCS website. GCHP is pleased with the draft CAP report as it reflects and exemplifies the hard work by staff over the last three years. Each year the audit results have improved and it is a result of the staff's hard work and dedication.

The DHCS corrective action plan, Financial (Addendum A) remains open and the plan continues to submit items on a monthly basis as required and defined by the CAP.

GCHP continues to meet all regulatory contract submission requirements. In addition to routine deliverables GCHP provides weekly and monthly reports to DHCS as a part of ongoing monitoring activities. All regulatory agency inquiries and requests are handled timely and requested information is provided within the specified required timeframe(s). Compliance staff is actively engaged in sustaining contract compliance.

GCHP compliance staff conducted a six month claims follow up audit on GCHP vision service provider and mental health behavioral organization (MBHO). The onsite audits occurred during the second and third week of May 2016. Both audits identified deficiencies and corrective action plans were issued and remain open. GCHP delegation oversight staff is working with each delegate on achieving compliance to address the deficiencies identified and ultimately close out the CAPs issued.

Centers for Medicare & Medicaid Services (CMS) published the Medicaid and CHIP Managed Care Final Rule on May 6th, 2016 in the Federal Register. This is the first major revision of the Medicaid managed care regulations since 2002. The rule includes but is not limited to: new monitoring requirements for network adequacy, new business requirements specific to medical loss ratio (MLR) and policy changes on pass-through payments. The intent of the mega rule is to align Medicaid with other payers, support a reform delivery system, improve program integrity and increase/strengthen member protections. The rule touches all aspects of the Medicaid managed care program. DHCS has informed all Health Plans that a significant contract amendment will be forthcoming. The contract amendment will require new deliverable submissions by the Plans and will necessitate revisions and updates to existing deliverables. The contract amendment, deliverable submission and contract compliance will create a countless amount of work by GCHP staff. GCHP staff will keep the commission apprised of the activities relative to the implementation of the mega rule.

The compliance dashboard is attached for reference and includes information on but is not limited to: staff trainings, fraud referrals, HIPAA breaches, delegate audits.

COMPLIANCE REPORT 2016

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Calendar Year Total
Hotline A confidential telephone and web-based process to collect info on compliance, ethics, and FWA	Referrals *one referral can be sent to multiple referral agencies*	9	4	10	7	6	2	5	12	2				57
Hotline Referral *FWA	Department of Health Care Services Program Integrity Unit / A&I	0	0	0	1	0	0	0	0	0				1
Hotline Referral *FWA	Department of Justice	0	0	0	0	0	0	0	0	0				0
Hotline Referral	Internal Department (i.e. Grievance & Appeals, Customer Services etc.)	9	4	7	5	6	2	4	12	2				51
Hotline Referral	External Agency (i.e. HSA)	0	0	0	0	0	0	0	0	0				0
Hotline Referral	Other * Legal, HR, DHCS (Division outside of PIU i.e. eligibility, note to reporter), etc.	0	0	3	1	0	0	1	0	0				5
Delegation Oversight	Delegated Entities	8	8	8	8	8	8	8	8	8				72
The committee's function is to ensure that delegated activities of subcontracted entities are in compliance with standards set forth from GCHP contract with DHCS and all applicable regulations	Reporting Requirements Reviewed **	62	64	54	86	70	82	95	66	71				650
	Audits conducted	4	0	1	0	2	0	0	0	0				7
Delegation Oversight	Letters of Non-Compliance	0	0	1	0	0	0	0	0	1				2
Delegation Oversight	Corrective Action Plan(s) Issued to Delegates	2	0	0	0	0	0	0	0	1				3
Audits	Total	0	1	0	1	0	0	0	0	0				2
External regulatory entities evaluate GCHP compliance with contractual obligations.	Medical Loss Ratio Evaluation performed by DMHC via interagency agreement with DHCS	0	0	0	0	0	0	0	0	0				0
	DHCS Facility Site Review & Medical Records Review *Audit was conducted in 2013*	0	0	0	0	0	0	0	0	0				0
	HEDIS Compliance Audit (HSAG)	0	1	0	0	0	0	0	0	0				1
	DHCS Member Rights and Program Integrity Monitoring Review *Review was conducted in 2012*	0	0	0	0	0	0	0	0	0				0
	DHCS Medical Audit	0	0	0	1	0	0	0	0	0				1
Fraud, Waste & Abuse	Total Investigations	9	4	11	6	6	2	5	12	2				57
The Fraud Waste and Abuse Prevention process is intended to prevent, detect, investigate, report and resolve suspected and /or actual FWA in GCHP daily operations and interactions, whether internal or external.	Investigations of Providers	0	0	0	1	1	0	0	2	1				5
	Investigations of Members	9	4	10	5	5	2	5	10	1				51
	Investigations of Other Entities	0	0	0	0	0	0	0	0	0				0
	Fulfillment of DHCS/DOJ or other agency Claims Detail report Requests	0	0	1	0	0	0	0	0	0				1

Back to Agenda

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Calendar Year Total
HIPAA	Referrals	1	4	2	3	0	1	3	2	2				18
Appropriate safeguards, including administrative policies and procedures, to protect the confidentiality of health information and ensure compliance with HIPAA regulatory requirements.	State Notification	1	4	2	3	0	1	3	2	2				18
	Federal Notification	0	4	0	0	0	0	0	0	0				4
	Member Notification	0	0	0	1	0	0	1	0	0				2
	HIPAA Internal Audits Conducted	0	1	0	0	0	1	0	0	1				3
Training	**Training Sessions**	15	25	27	17	15	54	50	129	12				344
Staff are informed of the GCHP's Code of conduct, Fraud Waste and Abuse Prevention Program, and HIPAA	Fraud, Waste & Abuse Prevention (Individual Training)	3	8	6	4	4	22	21	41	2				111
	Fraud, Waste & Abuse Prevention (Member Orientations)	6	6	6	6	6	6	6	6	6				54
	Code of Conduct	3	3	8	3	2	3	1	41	2				66
	HIPAA (Individual Training)	3	8	7	4	3	22	21	41	2				111
	HIPAA (Department Training)	0	0	0	0	0	1	1	0	0				2

** Reporting Requirements are defined by functions delegated and contract terms. Revised contracts, amendments or new requirements form DHCS may require additional requirements from subcontractors as a result the number is fluid

** Audits- Please note multiple audits have been conducted on the Plan, however many occurred in 2012 and 2013 and will be visible on the annual comparison dashboard

** This report is intended to provide a high level overview of certain components of the compliance department and does not include/reflect functions the department is responsible for on a daily basis.

***

AGENDA ITEM NO. 12

TO: Gold Coast Health Plan Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: October 14, 2016

SUBJECT: COO Update

OPERATIONS UPDATE

Membership Update – October 2016

Gold Coast Health Plan (GCHP) had a membership increase of 516 members this month which continues to point towards membership stabilization. GCHP's membership as of October 1, 2016 is 207,188 with an increase of 88,676 members (74.82%) since the beginning of Medi-Cal Expansion in January 2014. The cumulative new membership since January 1, 2014 is summarized as follows:

Aid Code	# of New Members
L1 – Low Income Health Plan (LIHP)	919
M1 – Adult Expansion	55,103
7U – CalFresh Adults	1,227
7W – CalFresh Children	254
7S – Parents of 7Ws	374
Traditional Medi-Cal	30,799
Total New Membership 1/1/14 – 9/1/16	88,676

Adult Expansion membership (aid code M1) continued to increase in September. M1 members represent 62.14% of GCHP's new membership since January 1, 2014.

	L1	M1	7U	7W	7S
Oct 16	919	55,103	1,227	254	374
Sep 16	1,015	54,740	1,370	280	336
Aug 16	1,162	54,237	1,470	307	361
Jul 16	1,261	53,767	1,593	346	397
Jun 16	1,349	53,864	1,703	386	424
May 16	1,407	52,898	1,820	433	478
Apr 16	1,596	51,769	1,910	462	549
Mar 16	1,800	50,648	2,015	510	620
Feb 16	1,873	50,185	2,110	549	579
Jan 16	1,953	49,653	2,205	608	736

	L1	M1	7U	7W	7S
Dec 15	2,129	49,456	2,285	573	287
Nov 15	2,298	47,527	2,395	628	354
Oct 15	2,515	46,138	2,525	682	354
Sep 15	2,698	44,260	2,654	733	360
Aug 15	3,039	42,465	2,766	746	380
Jul 15	3,218	40,948	2,918	770	355
Jun 15	3,413	39,283	2,986	781	353
May 15	3,908	37,519	3,083	813	379
Apr 15	4,102	35,582	3,162	831	381
Mar 15	4,965	34,350	3,236	856	396
Feb 15	6,128	31,203	3,342	872	442
Jan 15	6,508	30,107	3,390	872	478

	L1	M1	7U	7W	7S
Dec 14	6,972	27,176	3,204	589	15
Nov 14	7,289	24,060	3,254	599	14
Oct 14	7,443	23,569	3,312	296	11
Sep 14	7,568	21,944	3,368	606	5
Aug 14	7,726	18,585	3,400	624	4
Jul 14	7,839	15,606	3,453	667	4
Jun 14	7,975	10,910	3,515	691	3
May 14	8,118	7,279	3,680	714	0
Apr 14	8,134	4,514	3,584	684	0
Mar 14	8,154	2,482	1,741	0	0
Feb 14	8,083	1,550	0	0	0
Jan 14	7,618	183	0	0	0

AB 85 Capacity Tracking – 31,805 Adult Expansion members have been assigned to VCMC as of October 2016. VCMC's target enrollment is 65,765 and is currently at 48.36% of the enrollment target.

August 2016 Operations Summary

The **Claims Inventory** at the end of August was 25,084; this equates to a Days Receipt on Hand (DROH) of 3.20 days compared to a DROH maximum goal of 5 days. GCHP received approximately 7,828 claims per day in August. Monthly claim receipts from July 2015 through August 2016 are as follows:

Month	Total Claims Received	Receipts per Day
August 2016	180,049	7,828
July 2016	166,955	8,347
June 2016	177,246	8,057
May 2016	157,434	7,497
April 2016	162,287	7,728
March 2016	193,881	8,429
February 2016	176,656	8,833
January 2016	154,770	8,146
December 2015	170,897	7,768
November 2015	142,247	7,902
October 2015	156,109	7,095
September 2015	164,510	7,834
August 2015	152,840	7,278
July 2015	162,237	7,374

The **Claims Turnaround Time (TAT)** for August was 97.1% vs the regulatory requirement of processing 90% of original clean claims within 30 calendar days of receipt. The **Financial Claims Processing Accuracy** for August was 98.20% vs a goal of ≥ 98% and the **Procedural Claims Processing Accuracy** was 99.95% vs a goal of ≥ 97%.

The **Call Volume** increased above the 10,000 call threshold during the month. The number of calls received in August was 11,001. The 12-month average ending August 30th was 9,607 calls per month. The combined (Member, Provider and Spanish lines) **Average Speed to Answer (ASA)** for August was 6.0 seconds vs the SLA goal of ≤ 30 seconds. The combined **Abandonment Rate** was 0.39% vs the SLA goal of ≤ 5%. The combined **Average Call Length** increased slightly to 7.72 minutes from the prior month. **Call Center Phone Quality** for August decreased to 90% versus a goal of 95% or higher. Xerox has engaged a call center subject matter expert who is working with GCHP management to improve these results. The call center has hired a QA/Training Manager for the Lexington office. GCHP and Xerox are currently reviewing the call center training materials and are working to expand and improve the new hire training curriculum.

The **Grievance and Appeals** team received 18 member grievances and 107 provider claim payment grievances during August. The 18 member grievances equate to 0.09 grievances per 1,000 members.

Type of Member Grievances	Number of Grievances
Quality of Care	28
Quality of Service	6
Accessibility	3
Benefits/Coverage	3
Billing	2
Denials/Refusals	2
Total Member Grievances	**44**

There were 7 clinical appeals in August; 4 were overturned and 3 were upheld. There was 1 State Fair Hearing case in July.

Member Orientation Meetings

A total of 86 members (66 English, 20 Spanish) have attended Member Orientation meetings from January through August 2016. Of the 86 members, 46 indicated they learned about the meeting as a result of the informational flyer included in each new member packet.

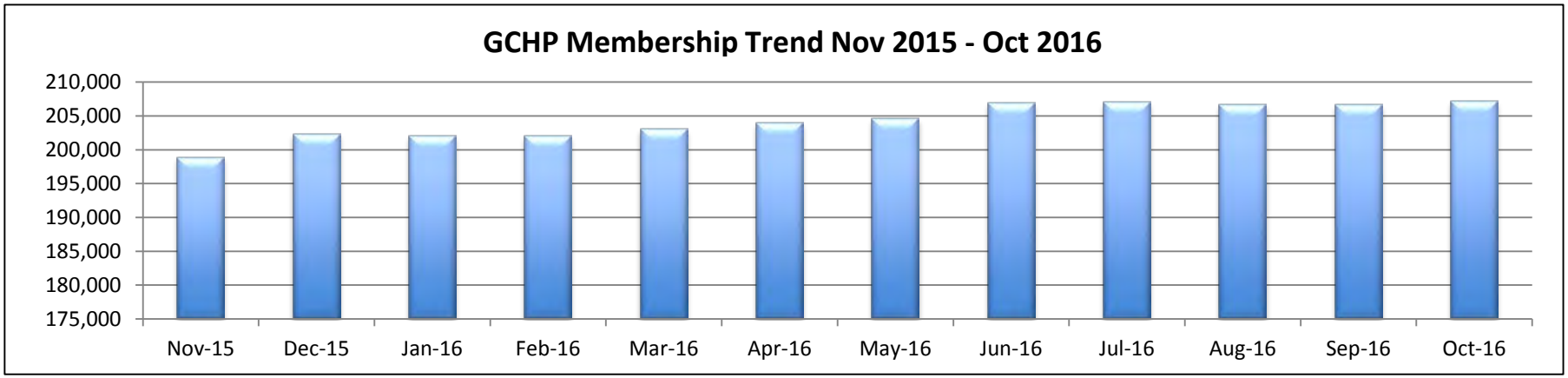
Xerox Contract Extension/New Contract Negotiation

The existing Administrative Services contract with Xerox expired on June 30, 2016. GCHP has extended the contract through October 31, 2016 under the existing terms. GCHP is preparing to negotiate a new contract with Xerox that focuses on separating the various administrative services provided by Xerox into "service towers." The goal would be to eliminate having all services bundled into one PMPM rate and instead have separate PMPM pricing for services such as mailroom, EDI, claims processing, call center, fulfillment, etc. Structuring the contract into service towers gives GCHP the flexibility to uncouple services and re-vend them or bring in-house should the decision be made to do so.

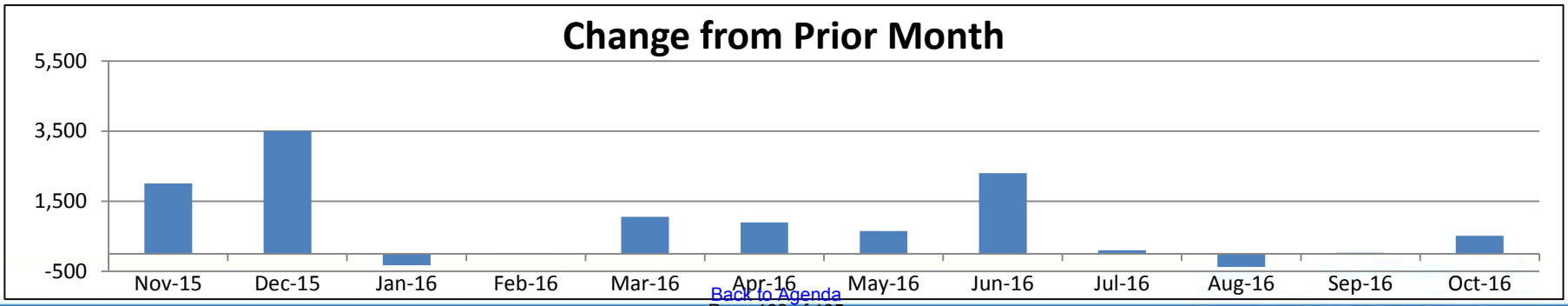
GCHP Membership

Total Membership as of October 1, 2016 – 207,188

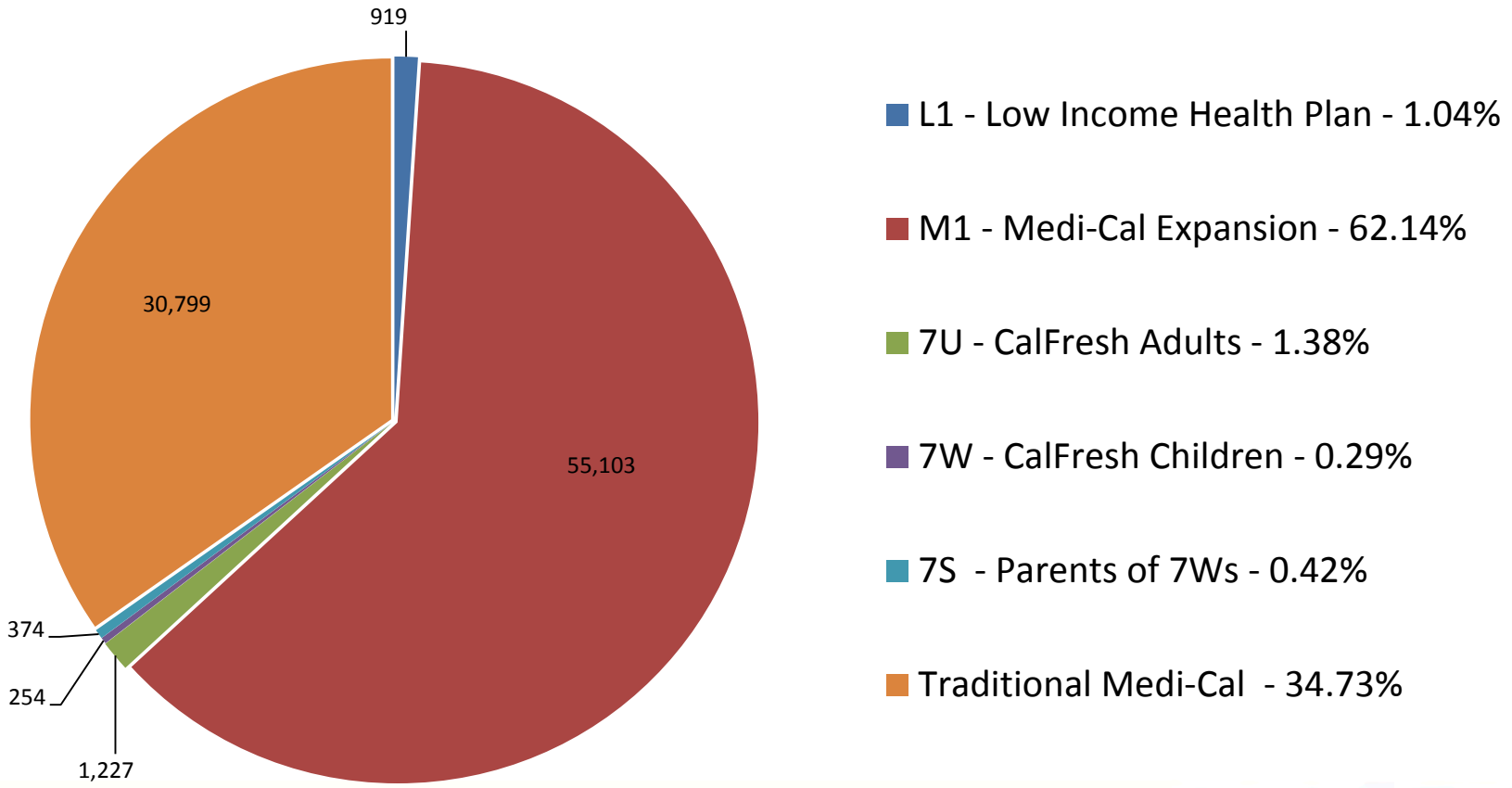
*New Members Added Since January 2014 – 88,676



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Active Membership	198,863	202,362	202,037	202,019	203,075	203,969	204,619	206,920	207,019	206,644	206,672	207,188



Membership Growth



GCHP Membership Churn Summary

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Membership from Prior Month	193,185	196,857	198,863	202,362	202,037	202,019	203,075	203,969	204,619	206,920	207,019	206,644	206,672
Prior Month Members Inactive in Current Month	3,371	4,141	3,236	6,906	6,139	6,078	5,723	5,642	5,584	5,881	6,182	6,083	5,575
Sub-total	189,814	192,716	195,627	195,456	195,898	195,941	197,352	198,327	199,035	201,039	200,837	200,561	201,097
Percentage of Inactive Members from Prior Month	1.74%	2.10%	1.63%	3.41%	3.04%	3.01%	2.82%	2.77%	2.73%	2.84%	2.99%	2.94%	2.70%
Current Month New Members	5,503	5,015	5,454	5,794	4,215	5,059	4,742	4,368	6,316	4,378	3,916	4,256	4,193
Sub-total	195,317	197,731	201,081	201,250	200,113	201,000	202,094	202,695	205,351	205,417	204,753	204,817	205,290
Percentage of New Members Reflected in Current Membership	2.80%	2.52%	2.70%	2.87%	2.09%	2.49%	2.32%	2.13%	3.05%	2.11%	1.90%	2.06%	2.02%
Retroactive Member Additions	1,540	1,132	1,281	787	1,906	2,075	1,875	1,924	1,569	1,602	1,891	1,855	1,898
Active Current Month Membership	**196,857**	**198,863**	**202,362**	**202,037**	**202,019**	**203,075**	**203,969**	**204,619**	**206,920**	**207,019**	**206,644**	**206,672**	**207,188**
Percentage of Retroactive Members Reflected in Current Membership	0.78%	0.57%	0.63%	0.39%	0.94%	1.02%	0.92%	0.94%	0.76%	0.77%	0.92%	0.90%	0.92%

GCHP Auto Assignment by PCP/Clinic as of October 1, 2016

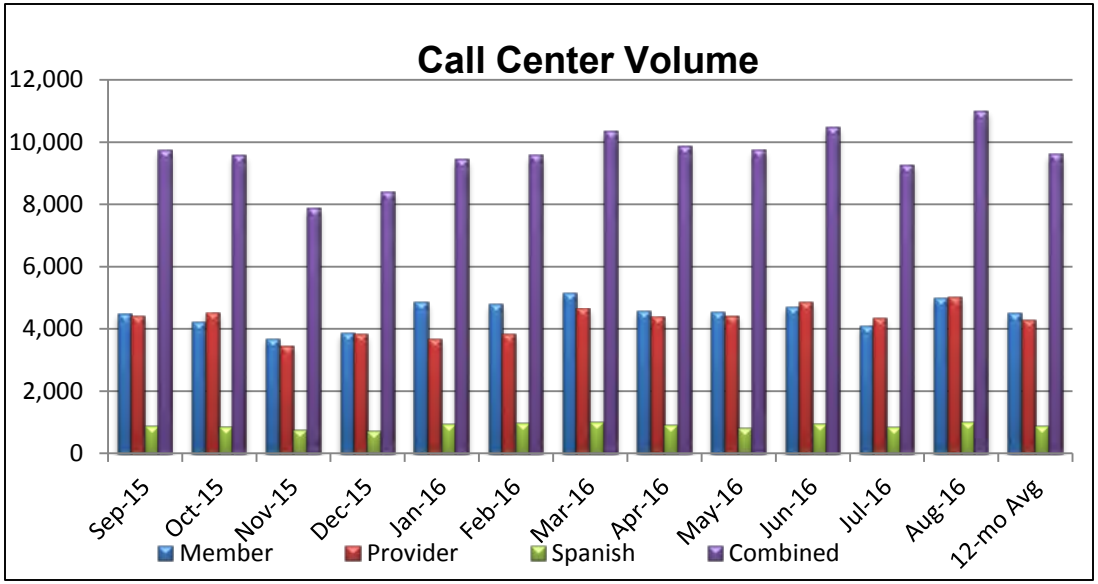
	Oct-16		Sep-16		Aug-16		Jul-16		Jun-16		May-16	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
AB85 Eligible	**919**		**979**		**1,081**		**1,039**		**1,075**		**1,329**	
VCMC	689	74.97%	734	74.97%	810	74.93%	779	74.98%	806	74.98%	996	74.94%
Balance	230	25.03%	245	25.03%	271	25.07%	260	25.02%	269	25.02%	333	25.06%
Regular Eligible	**935**		**989**		**1,085**		**1,577**		**815**		**1,317**	
Regular + AB85 Balance	**1,165**		**1,234**		**1,356**		**1,837**		**1,084**		**1,650**	
Clinicas	284	24.38%	293	23.74%	305	22.49%	391	21.28%	237	21.86%	396	24.00%
CMH	149	12.79%	149	12.07%	175	12.91%	210	11.43%	128	11.81%	171	10.36%
Independent	27	2.32%	21	1.70%	33	2.43%	42	2.29%	38	3.51%	52	3.15%
VCMC	705	60.52%	771	62.48%	843	62.17%	1,194	65.00%	681	62.82%	1,031	62.48%
Total Assigned	**1,854**		**1,968**		**2,166**		**2,616**		**1,890**		**2,646**	
Clinicas	284	15.32%	293	14.89%	305	14.08%	391	14.95%	237	12.54%	396	14.97%
CMH	149	8.04%	149	7.57%	175	8.08%	210	8.03%	128	6.77%	171	6.46%
Independent	27	1.46%	21	1.07%	33	1.52%	42	1.61%	38	2.01%	52	1.97%
VCMC	1,394	75.19%	1,505	76.47%	1,653	76.32%	1,973	75.42%	1,487	78.68%	2,027	76.61%

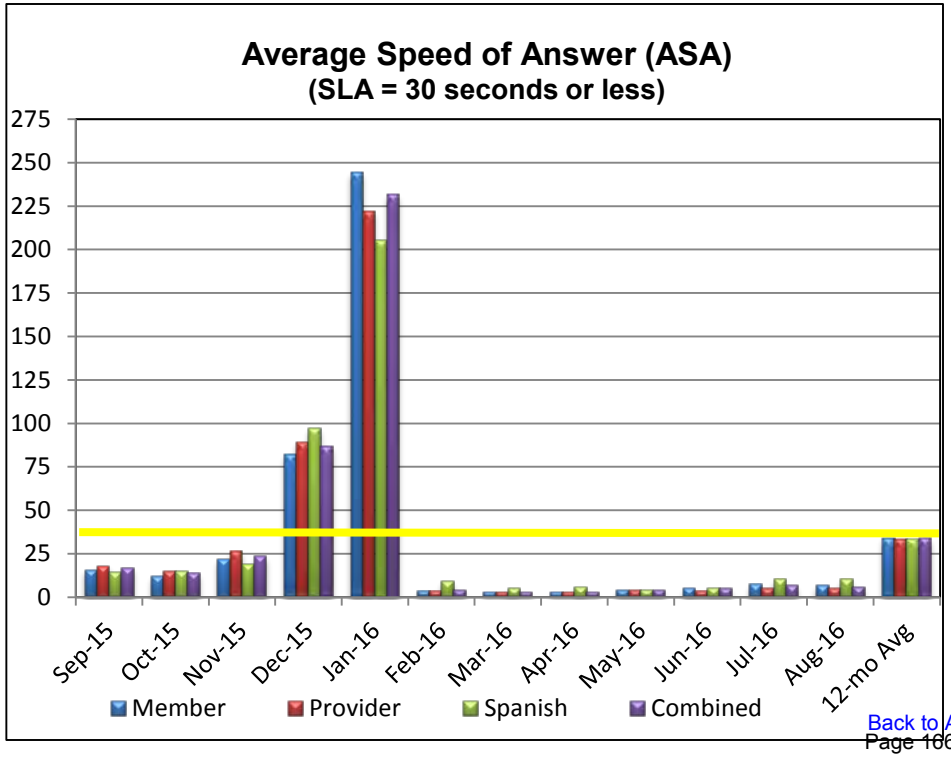
Auto Assignment Process

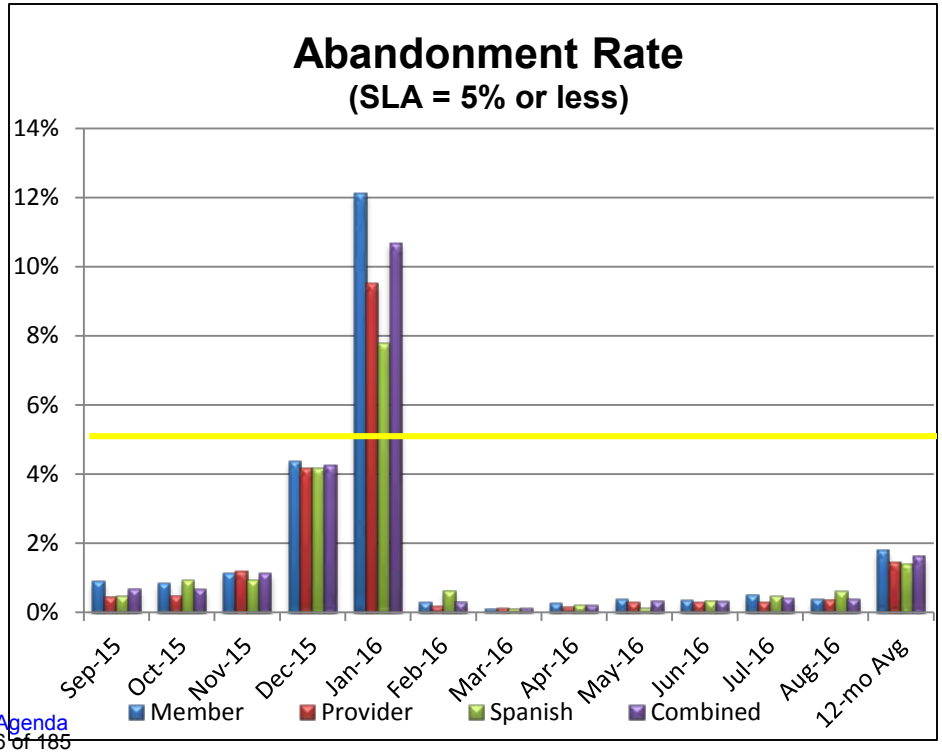
- 75% of eligible Adult Expansion (AE) members (M1 & 7U) are assigned to the County as required by AB 85
- The remaining 25% are combined with the regular eligible members and assigned using the standard auto assignment process, i.e., 3:1 for safety net providers and 1:1 for all others
- The County's overall auto assignment results will be higher than 75% since they receive 75% of the AE members plus a 3:1 ratio of all other unassigned members
- VCMC's target enrollment is 65,765
  - VCMC has 31,805 assigned Adult Expansion members as of October 1, 2016 and is currently at 48.36% of capacity

GCHP Call Center Metrics – August 2016

- Call volume increased above 10,000 during the month; GCHP received 11,001 calls during August
- Service Level Agreements (SLA) for ASA (6 seconds vs the goal of ≤ 30 seconds) and Abandonment Rate (0.39% vs the goal of ≤ 5%) were both met for August

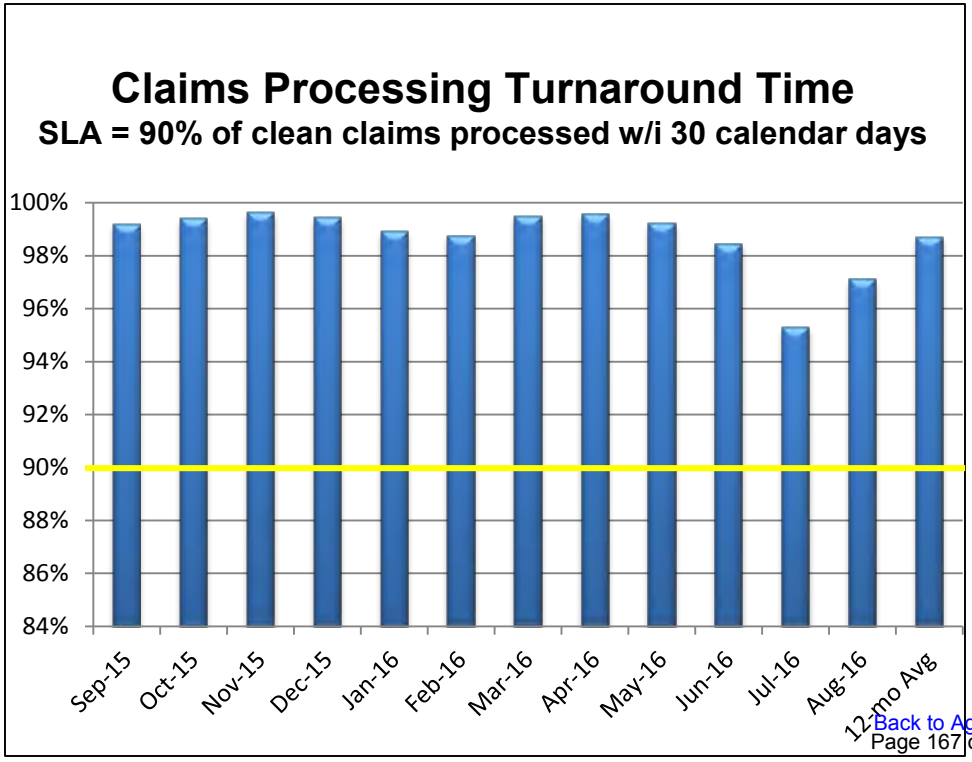


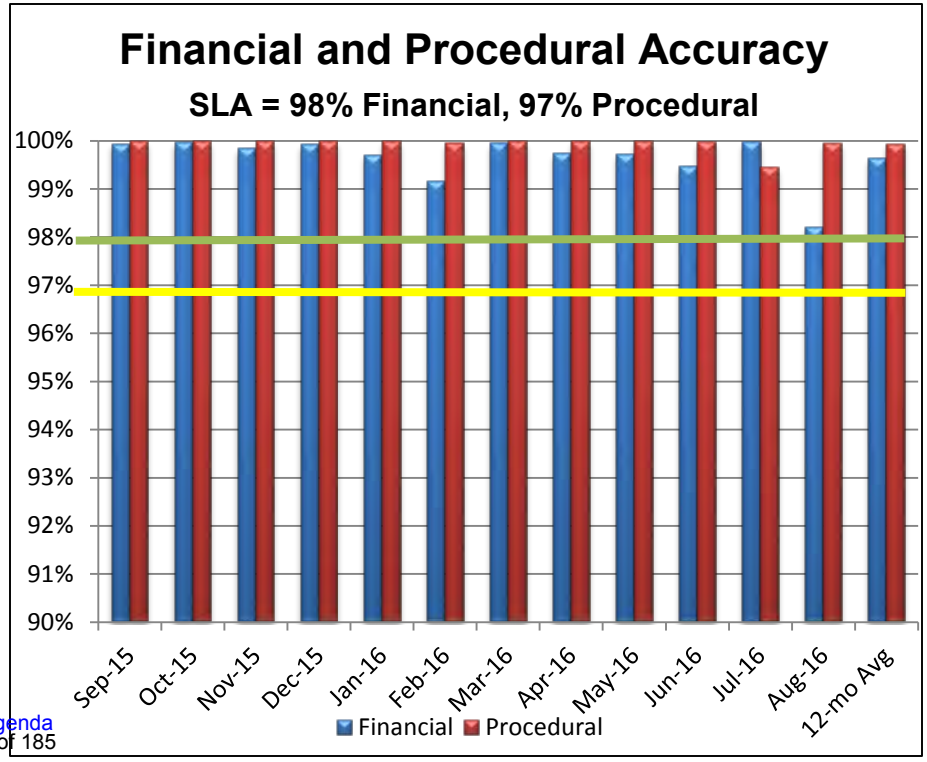


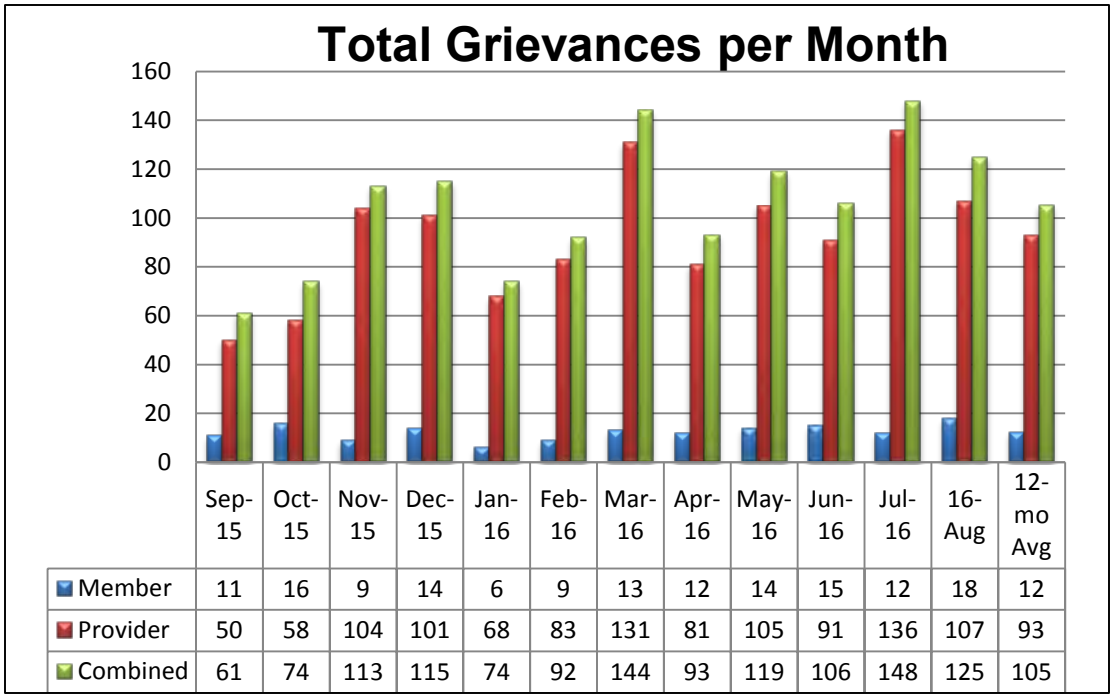


GCHP Claims Metrics – August 2016

- The 30 Day Turnaround Time (TAT) remained in compliance at 97.1%
- Ending Inventory was 25,084 which equates to a Days Receipt on Hand (DROH) of 3.20 days vs a DROH ≤ 5 days
- Service Level Agreements (SLAs) for Financial Accuracy (98.20%) and Procedural Accuracy (99.95%) were both met in August



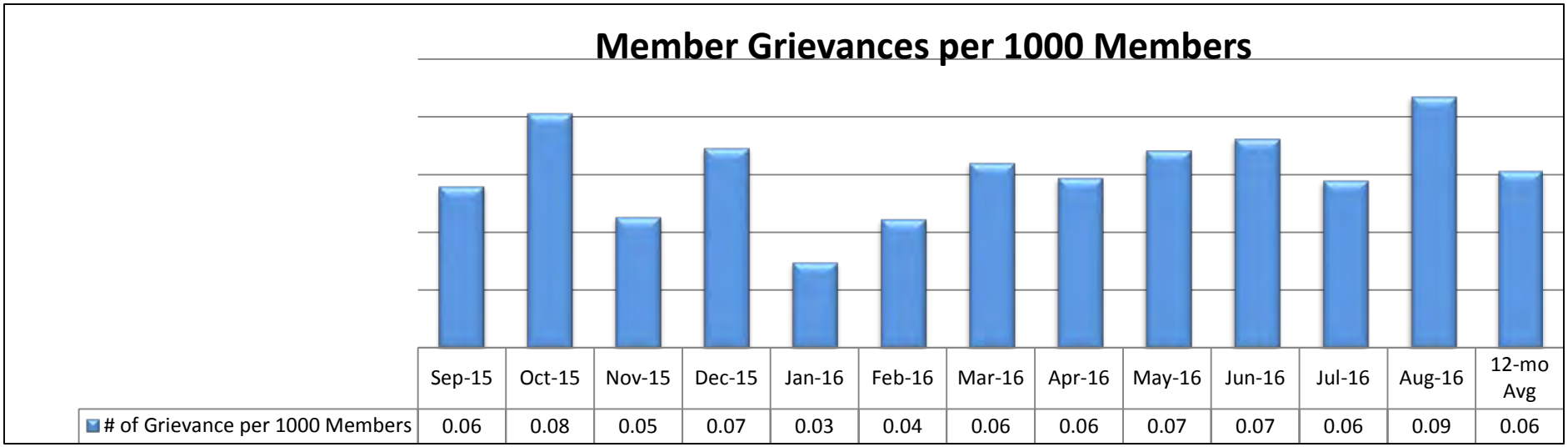




	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	16-Aug	12-mo Avg
Member	11	16	9	14	6	9	13	12	14	15	12	18	12
Provider	50	58	104	101	68	83	131	81	105	91	136	107	93
Combined	61	74	113	115	74	92	144	93	119	106	148	125	105

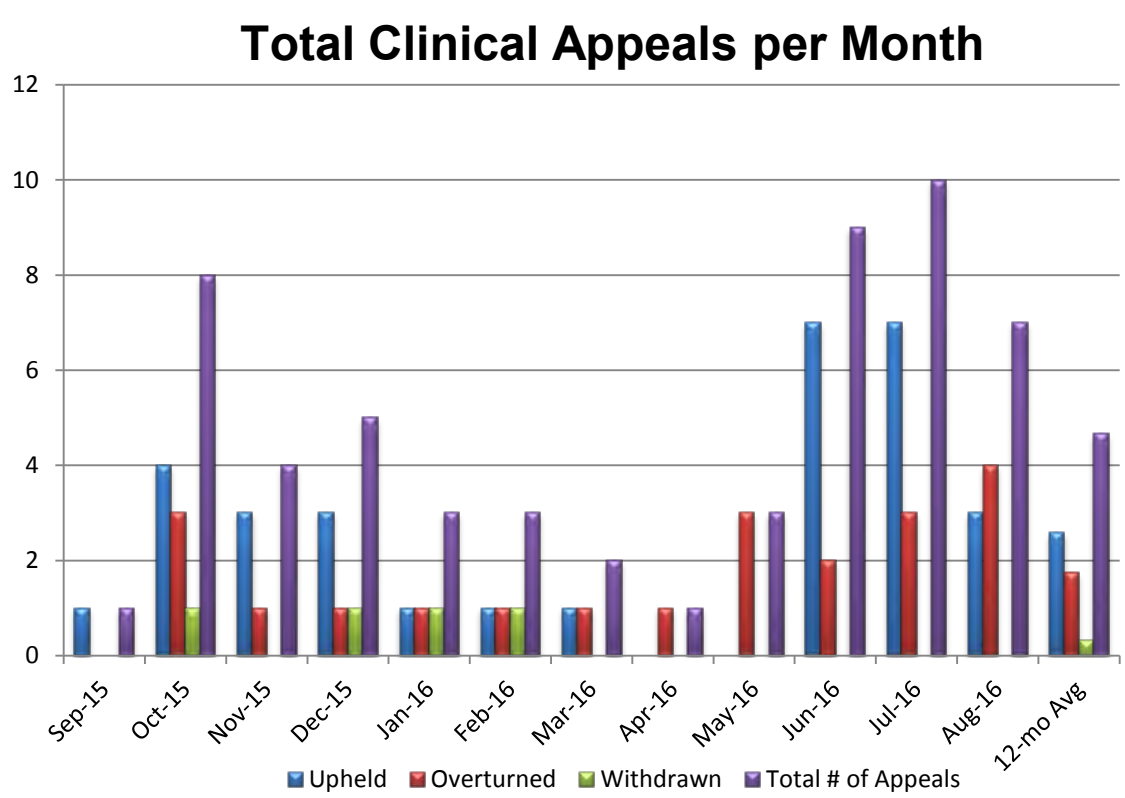
GCHP Grievance & Appeals Metrics – Aug 2016

- GCHP received 18 member grievances (0.09 grievances per 1,000 members) and 107 provider grievances during August 2016
- GCHP's 12-month average for total grievances is 105
  - 12 member grievances per month
  - 93 provider grievances per month



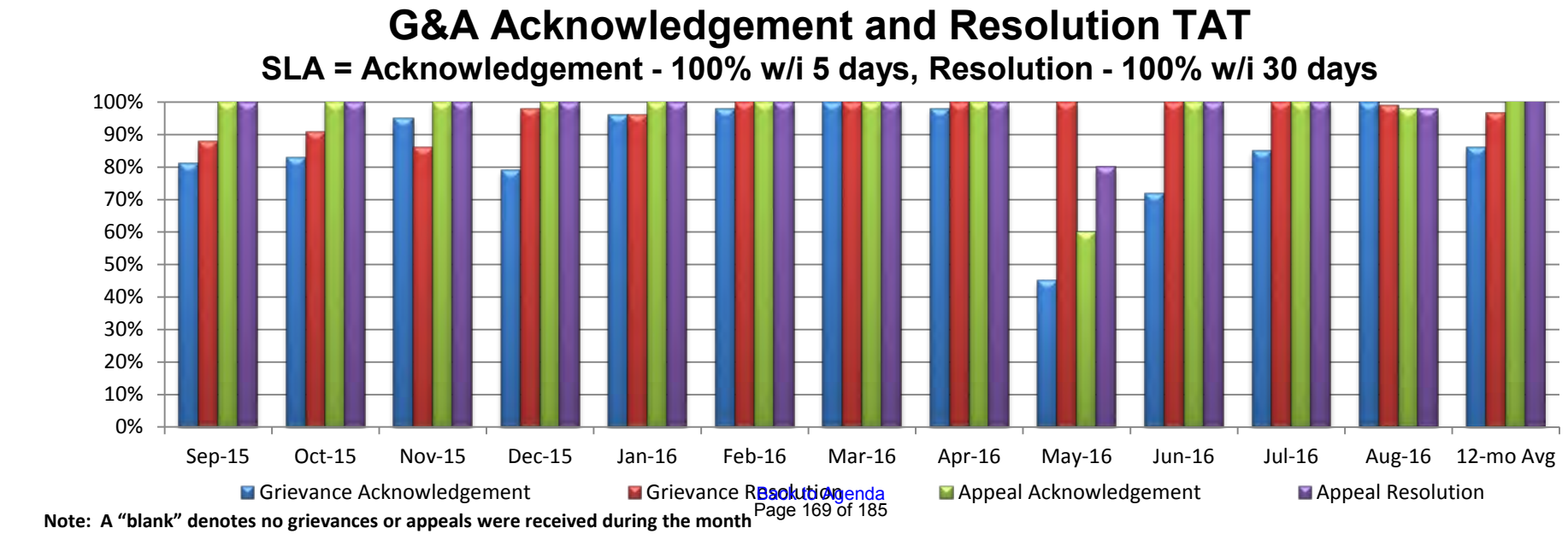
	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	12-mo Avg
# of Grievance per 1000 Members	0.06	0.08	0.05	0.07	0.03	0.04	0.06	0.06	0.07	0.07	0.06	0.09	0.06

	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	12-mo Avg
Membership Count	196,857	196,857	198,863	202,362	202,037	202,019	203,075	203,969	204,619	206,920	207,019	206,672	202,606
Total Member Grievances Filed	11	16	9	14	6	9	13	12	14	15	12	18	12
# of Grievance per 1000 Members	0.06	0.08	0.05	0.07	0.03	0.04	0.06	0.06	0.07	0.07	0.06	0.09	0.06



GCHP Grievance & Appeals Metrics – August 2016

- GCHP had 7clinical appeals in August; 4 were overturned and 3 upheld
- TAT for grievance acknowledgement was compliant at 100%
- GCHP and Xerox are implementing procedural changes to improve results
- TAT for grievance resolution was non-compliant at 99%
- TAT for appeal acknowledgement and resolution was non-compliant at 98% due to misrouted documentation.
- There was 2 State Fair Hearings in
- August, 1 was withdrawn and 1 denied.



Note: A "blank" denotes no grievances or appeals were received during the month

Gold Coast Health Plan℠
A Public Entity

Integrity

Accountability

Collaboration

Trust

Respect

NETWORK OPERATIONS

COO SUMMARY REPORT
1st Qtr FY 2017

PROVIDER NETWORK GROWTH FYE 2016 2nd Qtr- FY 2017 YTD

FY 2016 2nd Qtr		Current FY 2017-Oct
279	Total # of Primary Care Physicians	357
2,821	Total # of Specialty Physicians	2,863
HOSPITALS	**11** Acute Care **5** Tertiary Care	HOSPITALS
265	Total # of Behavioral Health Providers	265
101	Total # of Pharmacy Providers	235
385	Total # of All Other Providers (Home Health, Ancillaries, SNF's, CBAS, LTAC's)	387

Gold Coast Health Plan℠
A Public Entity

CONTRACT & ACCESS IMPROVEMENT
1st Quarter FY '16-17

STATUS	Hospitals	Physicians/ Medical Groups	Ancillary/ Outpatient	SNF/LTC
Finalized	➢ **4 Facilities** - Acute Care (2) - LTAC's (2)	➢ **7 Provider Groups** - Anesthesia (2) 28 - Burn 7 - Cardiology 6 - ER 6 - GI 4 - OB 5	➢ **7 Facilities/Providers** - Amb. Surg Center (2) - Asthma Pilot - Audiology - Hospice - Palliative Care - PT/OT/ST (2) - Pulm Rehab (2)	➢ **4 Providers** - Simi Valley - Ojai - Oxnard (2)
Pending	➢ **5 Facilities** - Tertiary care (2) - Acute Care (2) - LTAC	➢ **3 Provider Groups** - Multi-Specialty (2) 600+ - PCP 3	➢ **4 Facilities/Providers** - **Cardiac Rehab (3)** - **Pulmonary Rehab**	None at this time
Outreach	➢ **1 Facility** - Acute Care/Rehab	➢ **8 Provider Groups** - Multi-Specialty 50+ - Primary Care (2) 43 - Pediatrics (2) 7 - ENT 5 - GI 4 - Orthopedics 18	➢ **5 Facilities/Providers** - Acupuncture Services (24) - Bio-Reference Lab - Nutritional Services (12) - PT/OT/ST (2)	None at this time

Gold Coast Health Plan℠
A Public Entity

AGENDA ITEM NO. 13

TO: Gold Coast Health Plan Commission

FROM: C. Albert Reeves, Chief Medical Officer

DATE: October 24, 2016

SUBJECT: Chief Medical Officer Update

HEALTH SERVICES UPDATE

Utilization data in the Health Services monthly update to the Commission is based on paid claims compiled by date of service and is lagged by 3 months to allow for partial run out of claims data. Claims data is complete at approximately 6 months. While incomplete, a 3 month lagged snapshot allows us to see an estimate of utilization without waiting for a more complete 6 month report. Administrative days are included in these calculations. Dual eligible members, Skilled Nursing Facility (SNF), and Long Term Care (LTC) data is not included in this presentation.

UTILIZATION SUMMARY

Inpatient utilization metrics for CYTD 2016 continue to be similar to slightly improved compared with CY 2015.

Bed days/1000 for CYTD 2016 show a 2.8% decrease compared to CY 2015. Adult Expansion members utilize the greatest number of bed days (40%) followed by SPD (37%) and Family members (19%).

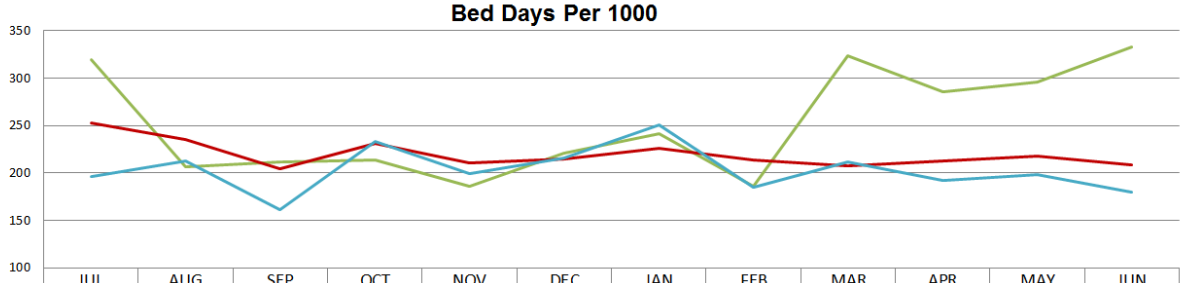
Average length of stay for CYTD 2016 is unchanged from CY 2015 (4.2).

Admits/1000 decreased nearly 6% from CY 2015 to CYTD 2016 (51 to 48).

ED utilization/1000 decreased by 4.6% from Jan – June 2015 compared with Jan – June 2016. The family aid code group continues to utilize half of all ED visits followed by AE members at 32%.

Benchmark: The September 17, 2015 DHCS Medi-Cal Managed Care Performance Dashboard reported 36 ER visits / 1000 member months statewide for all managed care plans for October 2013 – September 2014. GCHP ER utilization / 1000 member months for the same period was 38.

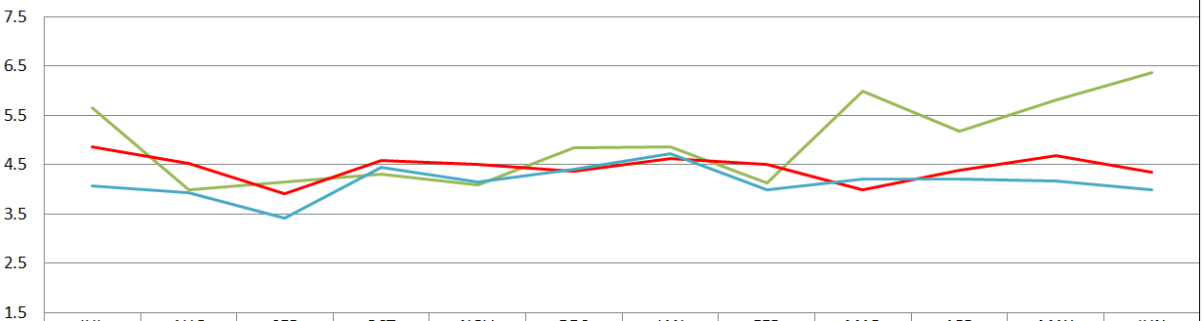
Bed Days Per 1000



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2013-14	319	206	212	214	186	221	241	186	323	285	296	333
FY 2014-15	253	235	204	231	211	215	226	213	207	213	218	208
FY 2015-16	196	212	161	233	200	215	251	185	211	192	198	179

*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.

Average Length of Stay



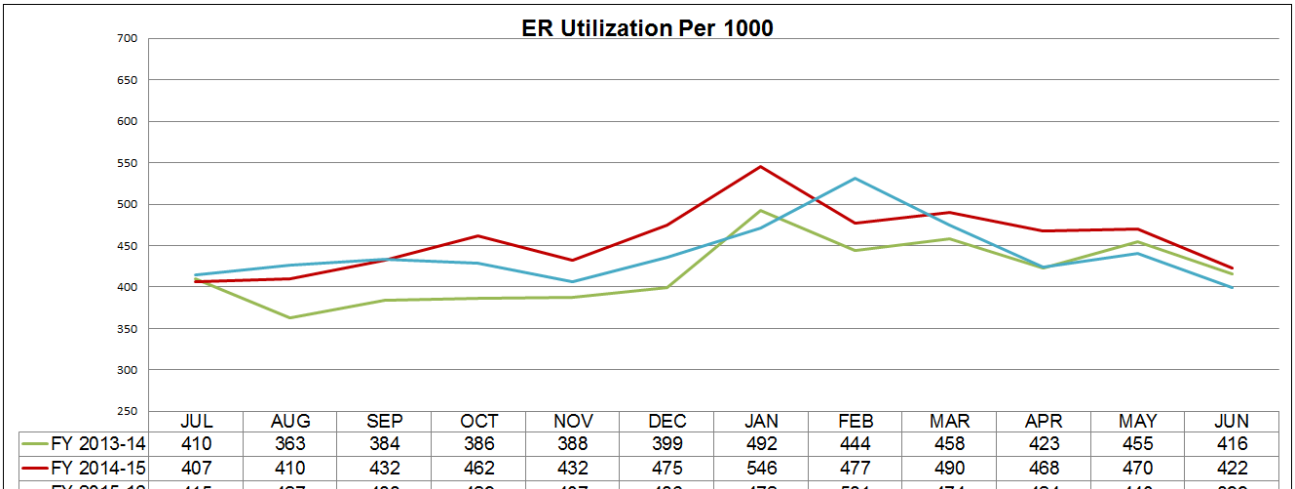
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2013-14	5.7	4.0	4.2	4.3	4.1	4.8	4.9	4.1	6.0	5.2	5.8	6.4
FY 2014-15	4.9	4.5	3.9	4.6	4.5	4.4	4.6	4.5	4.0	4.4	4.7	4.4
FY 2015-16	4.1	3.9	3.4	4.4	4.1	4.4	4.7	4.0	4.2	4.2	4.2	4.0

*Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.

Acute Inpatient Admissions/1000 Members

	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2013-14	56	50	50	48	45	45	49	45	52	55	49	52
FY 2014-15	52	52	52	51	48	49	58	55	52	49	47	48
FY 2015-16	48	54	47	52	48	49	53	46	50	46	48	45

*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.
*Data from MedInsight 9/9/2016

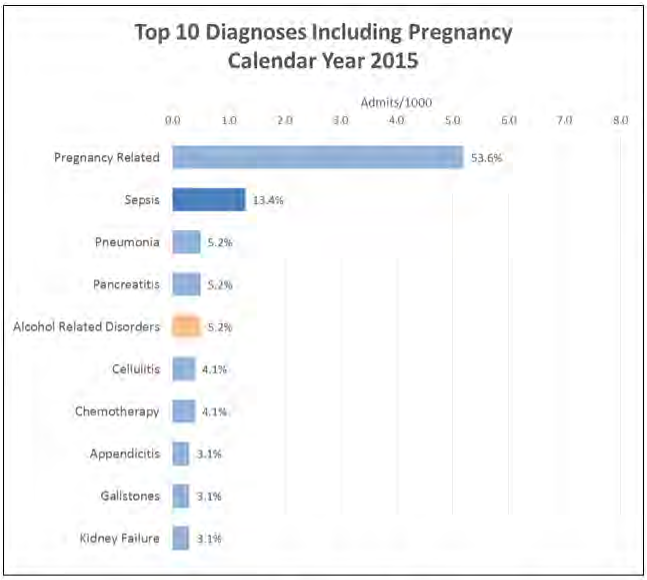


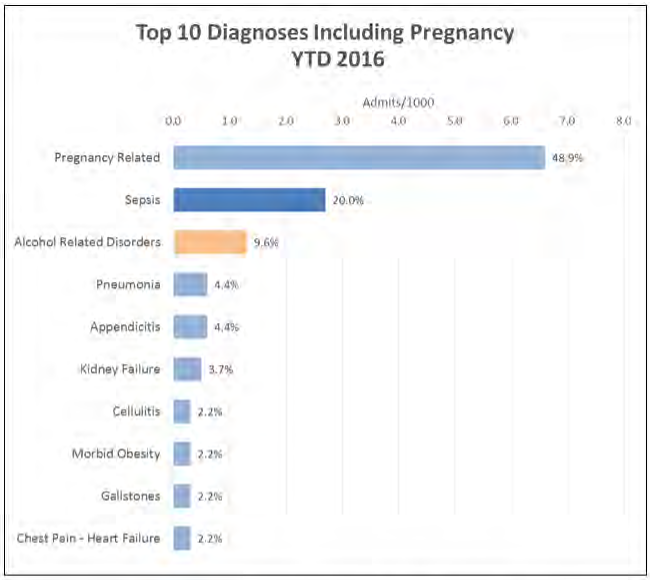
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2013-14	410	363	384	386	388	399	492	444	458	423	455	416
FY 2014-15	407	410	432	462	432	475	546	477	490	468	470	422
FY 2015-16	415	427	433	429	407	436	472	531	474	424	440	399

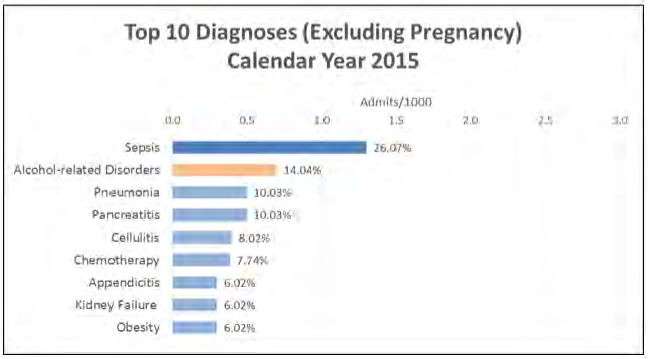
*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts are not included in this data.

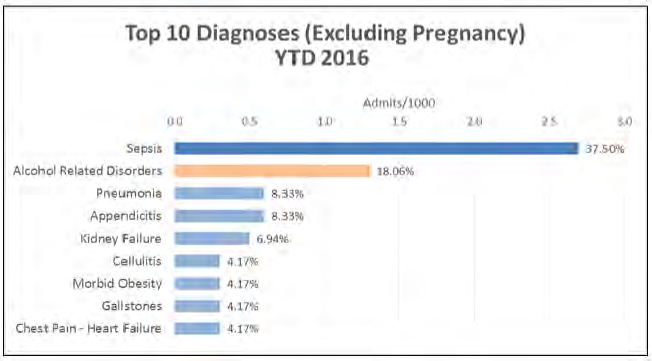
TOP ADMITTING DIAGNOSES

Pregnancy related diagnoses and sepsis continue to dominate top admitting diagnoses for 2016. For members admitted with a sepsis diagnosis, cancer, heart disease, post-liver and renal transplant, and diabetes were secondary diagnoses.



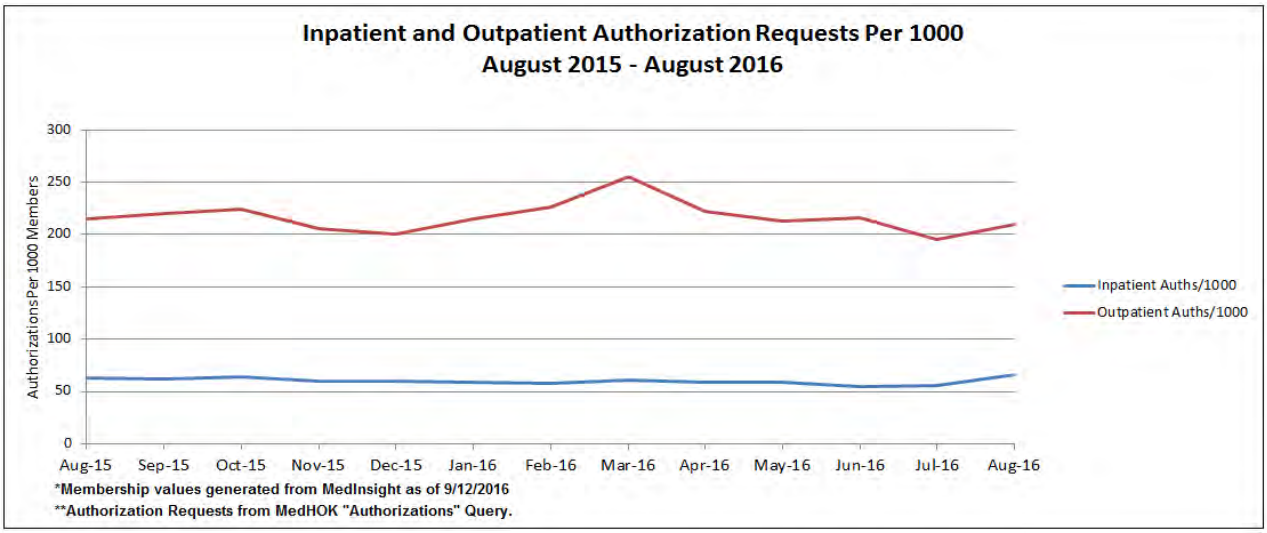


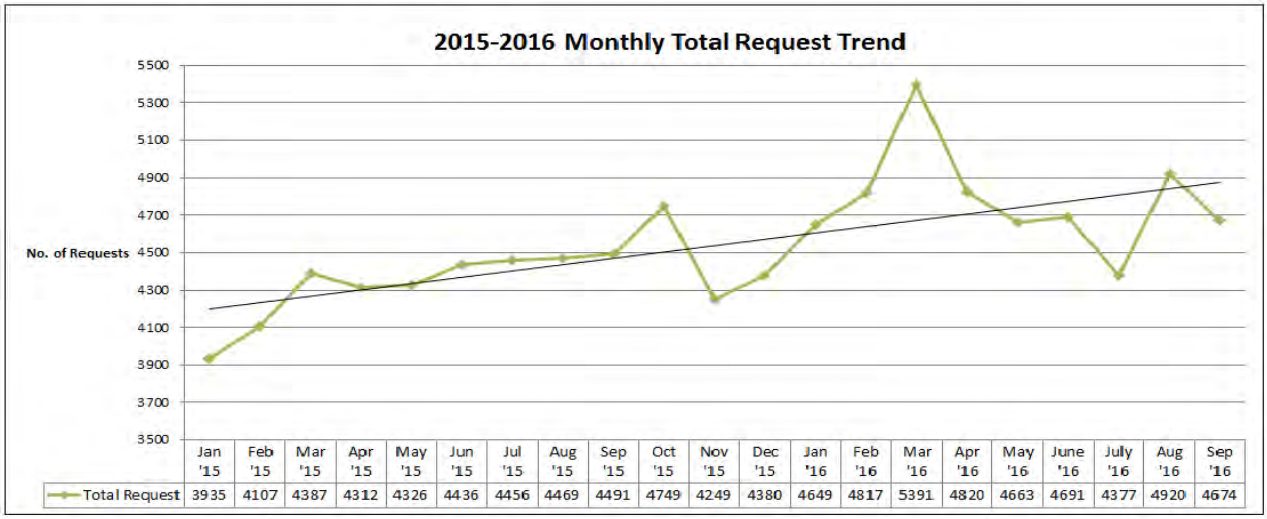




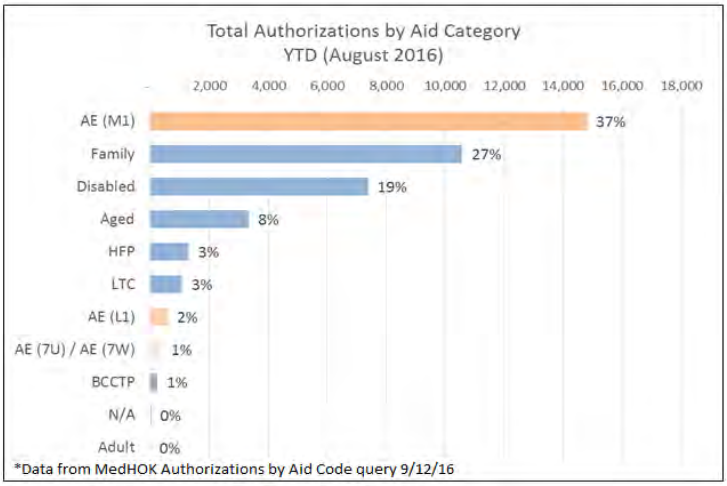
AUTHORIZATION REQUESTS

Requests for outpatient service outnumber requests for inpatient service by 3 ½ times. Requests for outpatient service have declined to 219 requests/1000 members in CY2016 since a peak of 255/1000 in March of 2016. Most outpatient service requests are for AE M1 members (37%) followed by Family members (27%).





	Jan '15	Feb '15	Mar '15	Apr '15	May '15	Jun '15	Jul '15	Aug '15	Sep '15	Oct '15	Nov '15	Dec '15	Jan '16	Feb '16	Mar '16	Apr '16	May '16	June '16	July '16	Aug '16	Sep '16
Total Request	3935	4107	4387	4312	4326	4436	4456	4469	4491	4749	4249	4380	4649	4817	5391	4820	4663	4691	4377	4920	4674



CARE DELIVERY SPOTLIGHT
Member Engagement – Mobile Texting Pilot

Like most Medicaid plans, Gold Coast Health Plan (GCHP) struggles to reach our members by phone or mail. One solution to this problem lies in the prevalence of mobile technology among underserved populations.

Eighty-four per cent of US adults in low-income households (annual incomes <$30,000) had cellphones by the end of 2014. Eight in 10 low-income people send or receive text messages using a cell phone as well as using the Internet or email at home. Remarkably, nearly one-half of low-income adults use the Internet or email mostly on a cell phone compared with only 27% of people in the highest –income group (>$75,000 household income). These cell phone users tend to be young adults, non-whites, less educated, and less affluent according to the Pew Research Center.

The adoption of mobile phone tools among safety-net providers has dramatically increased in recent years. Mobile technology has been used in this population for appointment reminders, care coordination, maternal and child health (Text4baby), smoking cessation (1-800-NO-BUTTS), and navigation of health care systems (Inland Empire Health Plan).

From May to July 2016, GCHP engaged mPulse Mobile in a bilingual texting pilot focused on 3 initiatives: Diabetes Disease Management (DM), Cervical Cancer Screening (HEDIS CCS), and Adult Preventive Care HEDIS AAP). Conclusions from this pilot include:

- 71% of our members can receive text
- Opt-out rates were less than half the industry average (2.9% vs. 5.9%)
- Texting was more effective than prior disease management outreach efforts (92% of members who call the DM phone line entered into the program)
- Member satisfaction rates were high (77% of English speakers and 100% of Spanish speakers found the text messages to be useful:
  Did you find these messages useful?
  “Absolutely! It is very encouraging and helpful it actually reminds me to keep moving”
  “Thank you and God bless. I didn’t know you cared”
  “Thank you for looking out for the public’s welfare”

GCHP anticipates expanding the role of texting in the future. We expect to participate in a California Health Care Foundation Innovation program with Harvard and mPulse to help launch an Asthma Disease Management program. We hope to improve our member’s experience with interactive 2-way messaging and educate members on how to navigate the health care system.

References:

“Cell Phone and Smartphone Ownership Demographics,” Pew Research Center, January 2014. Available at http://www.pewinternet.org/data-trend/mobile/cell-phone-and-smartphone-ownership-demographics/

Maeve Duggan and Aaron Smith, “Cell Internet User 2013,” Pew Research Center, September 16, 2013. Available at http://www.pewinternet.org/2013/09/16/cell-internet-use-2013/

COMMUNITY OUTREACH SUMMARY REPORT – SEPTEMBER 2016

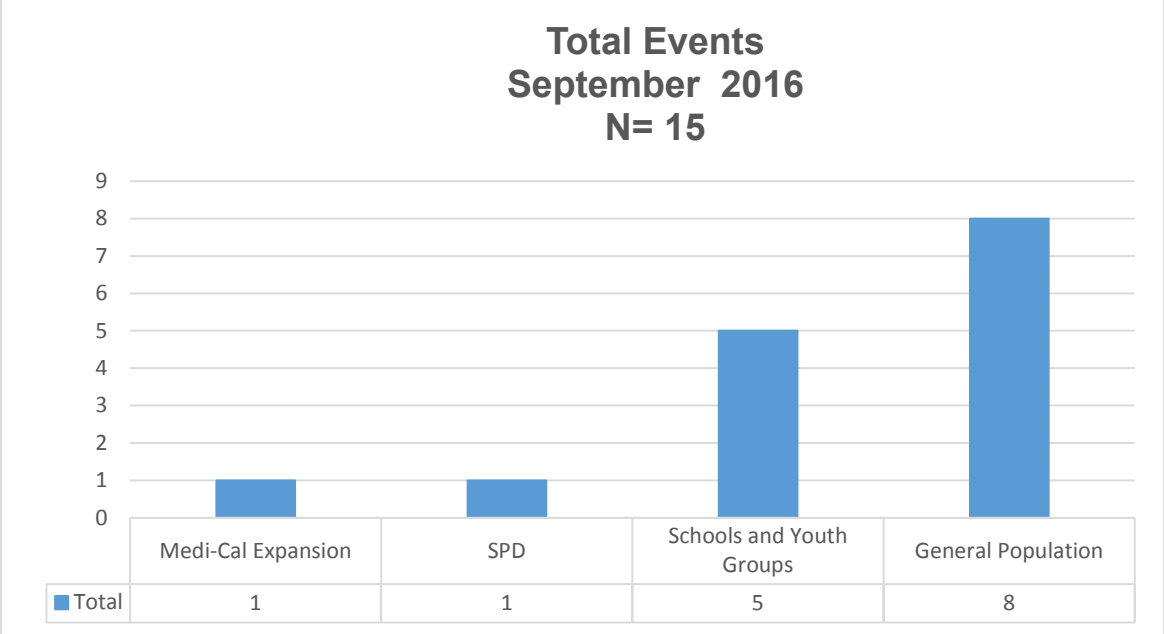
Summary

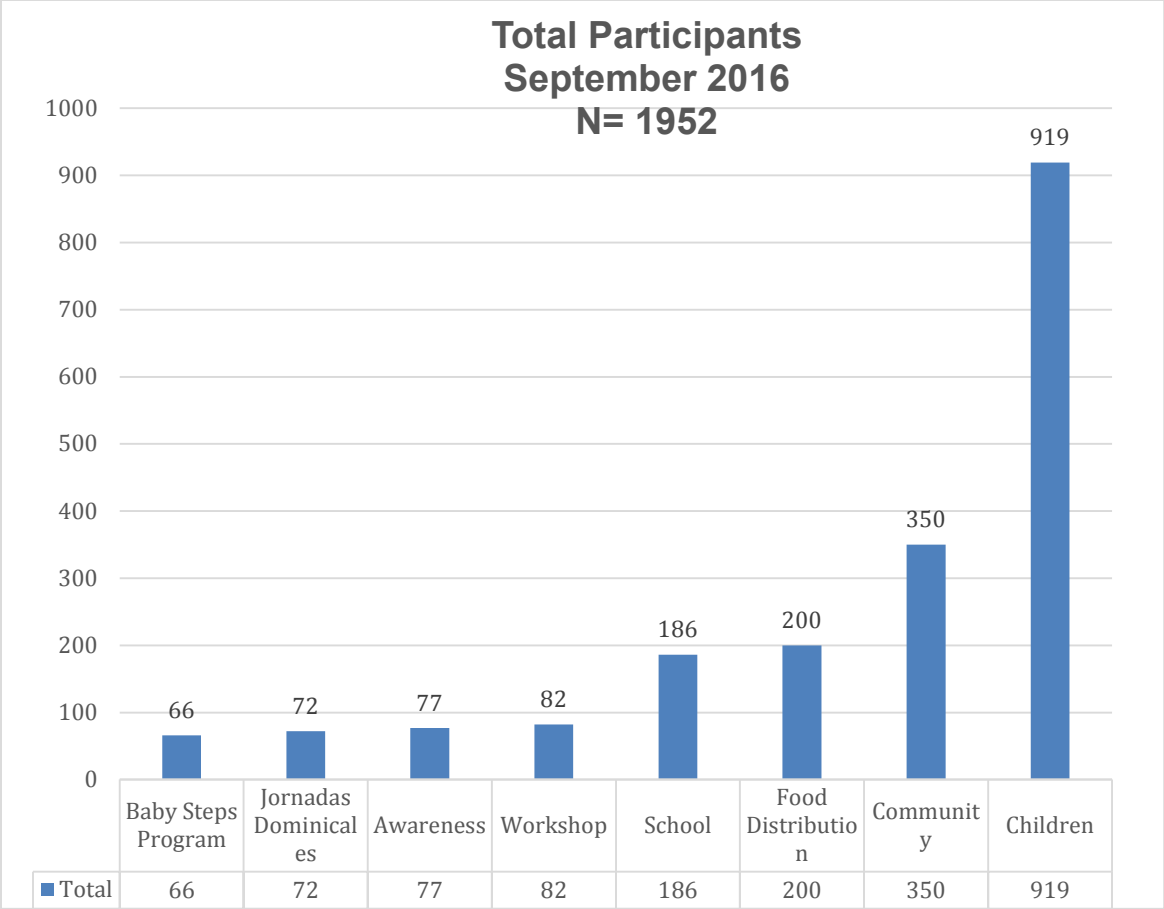
Gold Coast Health Plan (GCHP) continues to participate in community education and outreach activities throughout the county. The health education and outreach team maintains a positive presence in the community by working with various county public health departments, community based organizations, schools, senior centers, faith-based centers and social service agencies.

Below is a summary of activities during the month of September.

Outreach Activities – September 2016

Below are the charts that highlight the total number of events and participants for the month of September.





Outreach Events – September

Date	Event
9/2/2016	Sharing the Harvest, First 5 Santa Clara Valley Neighborhood for Learning
9/10/2016	2016 Family Health Fair, Senator Hannah-Beth Jackson and Assembly Member Das Williams in partnership with the Boys & Girls Club of Santa Clara Valley
9/10/2016	Day for Kids hosted by Boys and Girls club of Greater Oxnard and Port Hueneme
9/10/2016	8th Annual La Colonia 5K Community Walk, Cesar E. Chavez Elementary School and Ventura County Public Health – Champions for Change, Oxnard
9/13/2016	Baby Steps Program hosted by Ventura County Medical Center
9/13/2016	Curren School Open House and Community Fair, Oxnard
9/14/2016	Moving Beyond Trauma: Building Community Resilience, The Partnership for Safe Families and Communities of Ventura County. Thousand Oaks
9/20/2016	Baby Steps Program hosted by Santa Paula Hospital
9/21/2016	Monthly Food Distribution Program and Health Services, Westpark Community
9/22/2016	Community Market Produce Giveaway, First 5 Moorpark
9/22/2016	Community Market Produce Giveaway, First 5 Simi Valley
9/22/2016	Hueneme Elementary Back to School Night and Community Resource Fair

9/23/2016	Fall Prevention Forum, Thousand Oaks
9/24/2016	Oxnard School District's 5th Annual Event: Strengthening Our Families
9/25/2016	Jornada Dominical and Health Fair, Consulate of Mexico, Oxnard

Sponsorship Award Update

The Gold Coast Health Plan (GCHP) Sponsorship Committee funded three sponsorship requests during the month of September, and a total of $4,500 was awarded to the following agencies:

- **For The Troops**: The committee has approved sponsorship award of $1500 for the 6th Annual Heroes Golf Tournament to be held on October 27. For The Troops is an all- volunteer California 501(c)(3) non-profit corporation. The fundraising proceeds will be used to send "We Care" packages to our deployed U.S. Military service members.

- **The National Association for the Advancement for Color People (NAACP) Ventura County**: The committee approved a donation of $1500 to support of the Annual Freedom Fund Award Banquet, held on October 8, 2016. The NAACP Ventura County chapter encourages everyone in the community to focus on economical, health and educational issues that impact all citizens.

- **Vision y Compromiso, Consulado de Mexico**: The committee has also approved a donation of $1500 in support of the XVI Binational Health Week (BHW) Tri-County effort in Ventura, Santa Barbara and San Luis Obispo, which encompasses an annual week long series of health promotion and educational activities that include improving the health and well-being of the underserved and underinsured Hispanic population. Events during the BHW will be held during the month of October and will be posted on the GCHP community education calendar.

For information about community outreach events and/or health education classes, please refer to the GCHP website community calendar. Events are listed in English and Spanish.

AGENDA ITEM NO. 14

TO: Gold Coast Health Plan Commission

FROM: Melissa Scrymgeour, Chief Information and Strategy Officer

DATE: October 24, 2016

RE: CISO Update

The FY16/17 approved budget includes $2.8MM for projects. GCHP, through its project steering committee governance process, analyzed and prioritized a list of 20 projects based on the following criteria: regulatory requirements, lights-on (required to do business), and alignment with GCHP strategic objectives. The resulting prioritized portfolio uses a planning horizon of 22 months, through June 30, 2018.

Based on business drivers and resource capacity, the following seven projects are scheduled to start by the end of the 2016 calendar year:

- Optum PBM Implementation
- Budgeting and Forecasting Tool (Adaptive Insights) Implementation
- Medical Management System (MMS) MedHOK Upgrade
- Enterprise Data Warehouse (Phase I) - Develop, codify and adopt Master Data Management (MDM) governance and framework
- SharePoint Implementation (Phase II) - Establish intranet (Compass) governance and transition remaining departments onto the new platform
- Provider Credentialing, Contracting and Maintenance Tools – Procurement and implementation of software tools to facilitate, manage and provide efficiencies for Provider Network Management functions

Table 1: FY 16/17 GCHP Project Portfolio Strategic Plan Alignment (000)

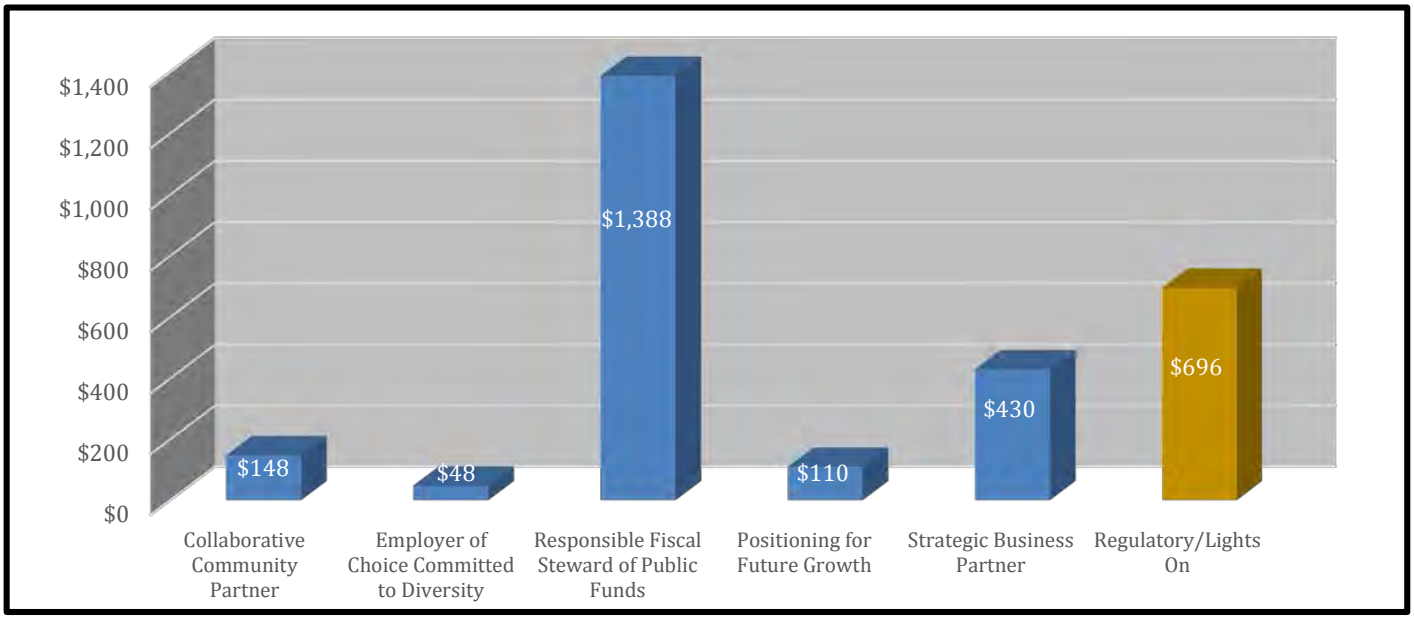
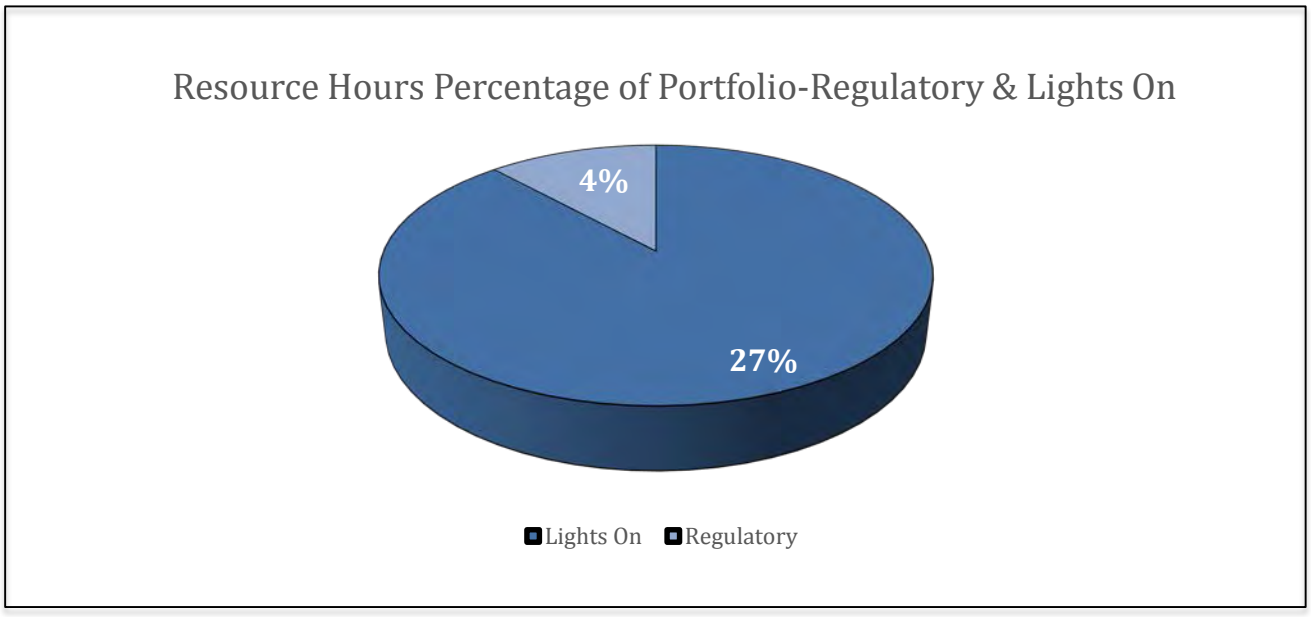


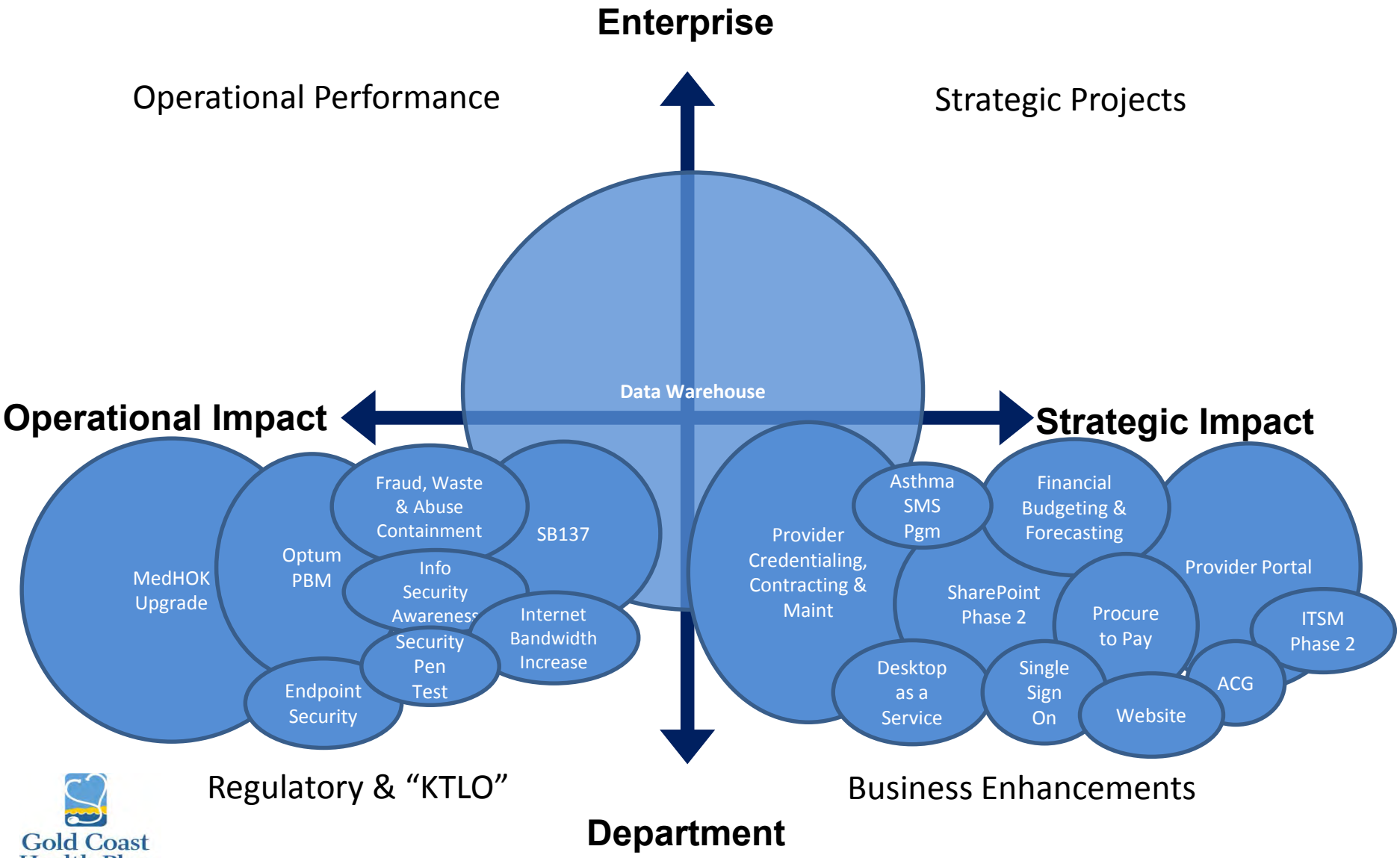
Table 2: Regulatory and "Lights On" Project Hours-Portfolio Allocation



In addition to the kickoff of the above FY16/17 projects, GCHP is currently working on a portfolio of 15 active projects carried over from FY15/16. Highlights include:

- Implementation of new HEDIS solution (Inovolan)
- Launched the new company intranet "Compass"
- Completed a mobile texting pilot for the Diabetes Disease Management Program

FY 16/17 Project Portfolio



Gold Coast Health Plan℠
A Public Entity

AGENDA ITEM NO. 15

TO: Gold Coast Health Plan Commission

FROM: Danita Fulton, Director of Human Resources

DATE: October 24, 2016

SUBJECT: Human Resources/Cultural Diversity Subcommittee Update

VERBAL PRESENTATION