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

Special Meeting
Monday, December 4, 2017, 2:00 p.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010

AMENDED 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.

PRESENTATIONS

1. AmericasHealth Plan (AHP) Pilot Proposal

CONSENT CALENDAR (ROLL CALL VOTE REQUIRED)

2. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of October 23, 2017

Staff: Tracy Oehler, Clerk of the Board

RECOMMENDATION: Approve the minutes.

3. Approval of the 2018 Ventura County Medi-Cal Managed Care Commission Meeting Calendar

Staff: Tracy Oehler, Clerk of the Board

RECOMMENDATION: Approve the 2018 Commission meeting calendar.

4. Accept and File the September 2017 Year to Date Financials

Staff: Lyndon Turner, Interim Chief Financial Officer

RECOMMENDATION: Accept and file September 2017 Fiscal Year to Date Financials.

5. Approval of Contract Extension and Additional Funding for Emagined Security, Managed Security Services – Service Orders No. 1 and 4

Staff: Melissa Scrymgeour, Chief Administrative Officer

RECOMMENDATION: Authorize the Chief Executive Officer to execute (1) an amendment to Emagined Security Service Order No. 1 to extend the term from February 1, 2018 to January 31, 2020 for on-demand information security engineering and architecture services at a not-to-exceed amount of $152,000 for such period; and (2) a new Service Order No. 4 for additional managed security operations center (SOC) services for the period of January 1, 2018 to December 31, 2018, with a 12-month renewal option and a not-to-exceed amount of $178,750 for the two-year period. The total amount for the two Service Orders is $330,750.

FORMAL ACTION ITEMS

6. Quality Improvement Committee 2017 Third Quarter Report

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

RECOMMENDATION: Accept and file the Quality Improvement Committee 2017 Third Quarter Report.

7. State of California Department of Health Care Services Contracts Amendment A25 for Capitation Rates for Fiscal Year 2015-16

Staff: Dale Villani, Chief Executive Officer

RECOMMENDATION: Approve and authorize the Chief Executive Officer to execute Department of Health Care Services Amendment A25.

8. State of California Department of Health Care Services Contracts Amendment A26 for Capitation Rates for Fiscal Year 2016-17

Staff: Dale Villani, Chief Executive Officer

RECOMMENDATION: Approve and authorize the Chief Executive Officer to execute Department of Health Care Services Amendment A26.

9. State of California Department of Health Care Services Contracts Amendment A27 for Capitation Rates for Fiscal Year 2014-15

Staff: Dale Villani, Chief Executive Officer

RECOMMENDATION: Approve and authorize the Chief Executive Officer to execute Department of Health Care Services Amendment A27.

10. Approval of Consulting Services Agreement and Statement of Work with TBJ Consulting for Interim Chief Diversity Officer Services

Staff: Joseph Ortiz, General Counsel's Office

RECOMMENDATION: Approve the Consulting Services Agreement and Statement of Work with TBJ Consulting for Interim Chief Diversity Officer services.

11. Approval of Office Sublease Agreement for 711 East Daily Drive, Suites 105 and 107, Camarillo, California

Staff: Ruth Watson, Chief Operating Officer

RECOMMENDATION: Authorize and direct the Chief Executive Officer to execute an agreement with NAI Capital to represent Gold Coast Health Plan as the Plan's exclusive agent for sublease of Suites 105 and 107 at 711 East Daily Drive, Camarillo, California.

12. Approval to Begin Process to Secure Additional Medi-Cal funds through an Intergovernmental Transfer (IGT)

Staff: Dale Villani, Chief Executive Officer

RECOMMENDATION: Authorize and direct the Chief Executive to provide the Department of Health Care Services with a proposal, including information from the funding entity, to the State of California.

REPORTS

13. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

14. Compliance Update

RECOMMENDATION: Accept and file the report.

15. Chief Operating Officer (COO) Update

RECOMMENDATION: Accept and file the report.

16. Internal Audit Updates: AB85 Auto-Assignment; Human Resources and Payroll; and Accounts Payable

RECOMMENDATION: Accept and file the report

17. Chief Medical Officer (CMO) Update

RECOMMENDATION: Accept and file the report.

18. Human Resources Compensation Plan

RECOMMENDATION: Accept and file the report.

19. Chief Diversity Officer (CDO) Update

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

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

21. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATION LITIGATION
Initiation of litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: One Case

22. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

23. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Scott Campbell, General Counsel and Gold Coast Health Plan Commissioners
Unrepresented employee: Chief Executive Officer

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on January 22, 2018, 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 Monday prior to the meeting by 3 p.m. to enable the Clerk of the Board to make reasonable arrangements for accessibility to this meeting.

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

October 23, 2017 Regular Meeting Minutes

CALL TO ORDER

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

PLEDGE OF ALLEGIANCE

Commissioner Lee led the Pledge of Allegiance.

ROLL CALL

Present: Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa (arrived at 2:03 p.m.), Peter Foy (arrived at 2:03 p.m.), Michelle Laba, M.D., Darren Lee, Gagan Pawar, M.D., Catherine Rodriguez, and Jennifer Swenson.

Absent: None.

PUBLIC COMMENT

None.

The Commission unanimously agreed to pull Agenda Item Nos. 3 through 7 for individual consideration.

CONSENT CALENDAR (ROLL CALL VOTE REQUIRED)

1. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Special Minutes of August 30, 2017

Staff: Tracy Oehler, Clerk of the Board

RECOMMENDATION: Approve the minutes.

2. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of September 25, 2017

Staff: Tracy Oehler, Clerk of the Board

RECOMMENDATION: Approve the minutes.

Commissioner Swenson moved to approve the recommendations. Commissioner Atin seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Foy and Espinosa.

Commissioner Lee declared the motion carried.

Commissioners Foy and Espinosa arrived at 2:03 p.m.

The Commission unanimously agreed to hear Agenda Item No. 15 – Pharmacy Benefits Manager (PBM) Update.

REPORTS

15. Pharmacy Benefits Manager (PBM) Update

RECOMMENDATION: Accept and file the report.

There were seven public speakers.

April Miles, a representative for OMAC Pharmacy, expressed concern over the PBM reimbursement rates.

Kent Miles, a representative for Home Care Pharmacy, expressed concern over the PBM reimbursement rates.

Joe Hoffman, a representative for Oxnard Drug, expressed concern over the PBM reimbursement rates.

Jeffrey T. White expressed concern over the PBM reimbursement rates.

Ali Farandish expressed concern over the PBM reimbursement rates.

Rajindar Rai expressed concern over the PBM reimbursement rates.

Robert Andonian, a representative for Farmacia Estrella, expressed concern over the PBM reimbursement rates.

Anne Freese, PharmD, Director of Pharmacy, gave an update on the PBM implementation. The agreement with Kaiser has not been executed, but members are not being impacted. The 340B program coding issue is still outstanding.

The Commission expressed concern over whom the responsible party is for the 340B program coding costs as well as when the coding will be completed.

Dr. Freese introduced OptumRx representative Denise Olson, Vice President of Provider Relations.

Ms. Olson introduced OptumRx representative Josh Van Ginkle, Director of Network Contracting.

Mr. Van Ginkle stated OptumRx has meet with 20 pharmacies over the past two and a half weeks and gave an overview of the maximum allowable cost (MAC) review process. Clarification was made on how the reviews were for the individual drugs and not for each claim submitted.

A discussion followed between the Commissioners and staff regarding dispensing fees, costs, and the definition of terms. The overpayment of approximately $1.8 million to 48 pharmacies, due to an error in June of 2017 and was corrected in July of 2017, was also discussed. The overpayment will need to be recouped and OptumRx will be working with the impacted pharmacies over the next couple of months.

Mr. Campbell announced Closed Session Item No. 16 Report Involving Trade Secret – Pharmacy Benefits Manager Rates and under the Ralph M. Brown Act, the earliest the rates may be disclosed is three years; Closed Session Item No. 17 – Anticipated Litigation involving the letter received from the pharmacies; and Closed Session Item No. 18 – Existing Litigation involving the Script Care lawsuit.

CLOSED SESSION

The Commission adjourned to Closed Session at 3:12 p.m.

16. REPORT INVOLVING TRADE SECRET
Discussion will concern: Pharmacy Benefits Manager Rates
Estimated date of disclosure: In three years, at the earliest.

17. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION

Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: One Case

18. CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION
Name of Case: Script Care v. Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan, Case No. 56-2017-00492349 CV-WM-VTA

The Regular Meeting reconvened at 4:45 p.m.

Mr. Campbell stated there was no reportable action.

OPEN SESSION

REPORTS

15. Pharmacy Benefits Manager (PBM) Update

RECOMMENDATION: Accept and file the report.

Commissioner Lee stated Gold Coast Health Plan has had to pay penalties due to overpayment of pharmacy benefits and the overall strategy of the Request for Proposals was to reduce costs in order to avoid being penalized by the State of California. Two-thirds of the reduction came from administrative costs and one-third of the reduction was passed onto the pharmacies. After the review of specific data, some pharmacies received more on brand, some pharmacies received more on generic, some pharmacies' reimbursements were relatively the same, and some pharmacies received less in both categories. The Commission expects OptumRx to continue to work with the pharmacy services administrative organizations (PSAOs) and Dr. Freese regarding these issues and to communicate proactively. Lastly, since the MACs were not properly implemented, there was an overpayment of approximately $1.8 million to the pharmacies, which will be recouped by the end of this calendar year.

Commissioner Dial moved to approve the recommendation. Commissioner Atin seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

The Commission unanimously agreed to hear Agenda Item Nos. 3 through 5 together.

CONSENT CALENDAR

3. Approval of Contract Extension and Additional Funding with Foothills Consulting Group for Information Technology Consulting and Staff Augmentation Services – Service Order 01 IT Senior Business Systems Analyst

Staff: Melissa Scrymgeour, Chief Administrative Officer

RECOMMENDATION: Approve a contract extension to June 30, 2018, with Foothills Consulting Group for information technology consulting and staff augmentation services for $105,000 with a not to exceed amount of $200,000.

4. Approval of Additional Funding for the Foothills Consulting Group Contract for Information Technology Consulting and Staff Augmentation Services – Service Order 02 IT Senior Business Systems Analyst

Staff: Melissa Scrymgeour, Chief Administrative Officer

RECOMMENDATION: Approve additional funding for the Foothills Consulting Group Contract for information technology consulting and staff augmentation services for $135,000 with a not to exceed amount of $234,875.

5. Approval of Additional Funding for the Teksystems Contract for Information Technology Consulting and Staff Augmentation Services – Service Order 05 IT Senior Developer

Staff: Melissa Scrymgeour, Chief Administrative Officer

RECOMMENDATION: Approve additional funding for the Teksystems contract for information technology consulting and staff augmentation services for $95,000 with a not to exceed amount of $194,500.

Melissa Scrymgeour, Chief Administrative Officer, stated the contracts extend the funding for the resources necessary for the active portfolio projects.

A discussion followed between the Commissioners and staff regarding the funding is cost neutral as it is already in the budget and no additional funding is being requested.

Commissioner Rodriguez moved to approve the recommendation. Commissioner Egan seconded.

AYES: Commissioners Atin, Egan, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: Commissioners Alatorre and Espinosa.

ABSTAIN: None.

ABSENT: Commissioner Dial.

Commissioner Lee declared the motion carried.

6. Approval of Additional Funding for the Current Contract Term and a Contract Extension with Pacific Interpreters, Inc., for Telephone Interpreting and Video Remote Interpreting Services

Staff: Lupe González, Ph.D., M.P.H., Director of Health Education, Outreach, Cultural and Linguistic Services

RECOMMENDATION: Approve additional funding for the current contract term and a twelve-month contract extension with Pacific Interpreters, Inc., for telephone interpreting and video remote interpreting services for $105,400 with a not to exceed amount of $202,400.

Commissioner Atin moved to approve the recommendation. Commissioner Rodriguez seconded.

AYES: Commissioners Alatorre, Atin, Egan, Espinosa, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Dial.

Commissioner Lee declared the motion carried.

7. Approval of Additional Funding for the Dial Security Contract for Security Controls Services

Staff: Ruth Watson, Chief Operating Officer

RECOMMENDATION: Approve additional funding for the Dial Security contract for security controls services for $124,536 with a not to exceed amount of $575,000.

The Commission directed staff to research cost effective options that can be implemented once the current contract ends.

Commissioner Atin moved to approve the recommendation. Commissioner Rodriguez seconded.

AYES: Commissioners Alatorre, Atin, Egan, Espinosa, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Dial.

Commissioner Lee declared the motion carried.

FORMAL ACTION ITEMS

8. Request to Approve Resolution No. 2017-004 Adopting a Records Management Program Policy and Records Retention Schedule

RECOMMENDATION: Approve Resolution No. 2017-004 adopting a Records Management Program Policy and Records Retention Schedule.

Commissioner Espinosa moved to approve the recommendation. Commissioner Egan seconded.

AYES: Commissioners Alatorre, Atin, Egan, Espinosa, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Dial.

Commissioner Lee declared the motion carried.

9. Accept and Approve the Fiscal Year 2016-17 Audit Results

RECOMMENDATION: Accept and approve the Fiscal Year 2016-17 Audit results.

Lyndon Turner, Senior Financial Officer, stated Moss Adams, LLP had reported the results of the audit at the earlier Audit Committee meeting today. Due to a scheduling conflict, Mr. Stelian Damu, the representative from Moss Adams, LLP, had to leave and would not be able to give the presentation.

Commissioner Rodriguez moved to approve the recommendation. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Egan, Espinosa, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Dial.

Commissioner Lee declared the motion carried.

10. August 2017 Year to Date Financials

RECOMMENDATION: Accept and file August 2017 Fiscal Year to Date Financials.

Mr. Turner stated the August fiscal year to date health care costs were $115.7 million or $9.5 million higher than budget and the medical loss ratio (MLR) was 100.4% versus 92.7% for budget. By October, the forecast for the tangible net equity (TNE) will be at 300%, which is below the required amount and will most likely result in a financial corrective action plan (CAP).

A discussion followed between the Commissioners and staff regarding correcting the deficit. Commissioner Rodriguez directed staff to form a strategic plan committee. The Commission and staff agreed the Executive/Finance Committee could perform this assignment and would begin to address this issue at its next meeting in November.

Commissioner Lee moved to approve the recommendation. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Egan, Espinosa, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Dial.

Commissioner Lee declared the motion carried.

REPORTS

11. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

Dale Villani, Chief Executive Officer, inquired if there were any questions regarding the update.

12. Chief Operating Officer (COO) Update

RECOMMENDATION: Accept and file the report.

Ruth Watson, Chief Operating Officer, stated membership was down 456 members and staff has been meeting with AmericasHealth Plan (AHP) weekly.

Commissioners Alatorre and Pawar recused themselves at 5:56 p.m. due to a potential conflict of interest.

Ms. Watson stated AHP had proposed members would come from Clinicas Del Camino Real at a rate of 1,250 per month for ten months. This exceeds the number of members the Commission had previously approved, which is 5,000 members.

Commissioner Swenson left the meeting at 5:59 p.m.

Commissioners Alatorre and Pawar returned to the meeting at 6:00 p.m.

13. Chief Administrative Officer (CAO) Update

RECOMMENDATION: Accept and file the report

Melissa Scrymgeour, Chief Administrative Officer, reviewed the 2017-2020 GCHP Strategic Plan.

14. Chief Medical Officer (CMO) Update

RECOMMENDATION: Accept and file the report.

Nancy Wharfield, M.D., Chief Medical Officer, stated staff is available for questions on the health services and pharmacy updates.

Commissioner Espinosa moved to approve the recommendation to accept and file Agenda Item Nos. 11 through 14. Commissioner Egan seconded.

AYES: Commissioners Alatorre, Atin, Egan, Espinosa, Foy, Laba, Lee, Pawar, and Rodriguez.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Dial and Swenson.

Commissioner Lee declared the motion carried.

Mr. Campbell announced the closed session agenda items as listed below.

CLOSED SESSION

The Commission adjourned to Closed Session at 6:05 p.m.

19. PUBLIC EMPLOYEE APPOINTMENT
Title: Chief Diversity Officer

20. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Scott Campbell, General Counsel and Gold Coast Health Plan Commissioners
Unrepresented employee: Chief Diversity Officer

21. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

22. CONFERENCE WITH LABOR NEGOTIATORS

Agency designated representatives: Scott Campbell, General Counsel and Gold Coast Health Plan Commissioners
Unrepresented employee: Chief Executive Officer

Commissioner Lee and Mr. Villani left closed session at 6:25 p.m.

Mr. Campbell left closed session at 6:40 p.m.

Mr. Campbell returned to closed session at 6:46 p.m.

Mr. Campbell left closed session at 7:04 p.m.

Commissioner Lee returned to closed session at 7:19 p.m.

Mr. Campbell returned to closed session at 7:28 p.m.

Mr. Villani returned to closed session at 7:30 p.m.

OPEN SESSION

The Regular Meeting reconvened at 7:47 p.m.

Mr. Campbell stated there was no reportable action.

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

The meeting was adjourned at 7:48 p.m.

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Tracy J. Oehler, Clerk of the Board

DATE: December 4, 2017

SUBJECT: Request to Approve the 2018 Ventura County Medi-Cal Managed Care Commission Meeting Calendar

SUMMARY:

To establish the Commission meeting dates for the calendar year 2018.

BACKGROUND:

Meetings of legislative bodies are governed by California Government Code Section 54952 et seq. As such, the Ventura County Medi-Cal Managed Care Commission is required by law to establish regular meeting dates. Historically, these meeting dates have been the fourth Monday of each calendar month with the exception of December, as there is no meeting scheduled.

However, each year the November Commission meeting conflicts with the Thanksgiving holiday resulting in its cancellation and the need to reschedule. Staff is proposing to eliminate the November meeting and to schedule the meeting for December 3, 2018. Additionally, the 2018 May meeting conflicts with the Memorial Day holiday and staff is proposing to move the meeting to May 21, 2018. Lastly, the annual Strategic Meeting has been added to the calendar for March 15, 2018. The attached 2018 Commission Meeting Calendar reflects the proposed changes.

FISCAL IMPACT:

N/A

RECOMMENDATION:

Approve the 2018 Commission Meeting Calendar.

CONCURRENCE:

N/A

ATTACHMENT:

Exhibit No. 1 – 2018 Commission Meeting Calendar

EXHIBIT NO. 1

2018 Ventura County Medi-Cal Managed Care Commission Meetings

Gold Coast Health Plan℠
A Public Entity

Commission Meeting
Strategic Meeting

711 E. Daily Drive, Community Room, Camarillo, CA
Meeting time is at 2:00 p.m.

January

S	M	T	W	T	F	S
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November

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December

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30	31					

Back to Agenda

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Lyndon Turner, Interim Chief Financial Officer

DATE: December 4, 2017

SUBJECT: September 2017 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached September 2017 fiscal year-to-date (FYTD) financial statements (unaudited) of Gold Coast Health Plan ("Plan") for the Commission to accept and file. These financials were reviewed by the Executive/Finance Committee on November 17, 2017, where the Executive/Finance Committee recommended that the Commission accept and file these financials.

BACKGROUND/DISCUSSION:

The staff has prepared the September 2017 FYTD 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 three month period ended September 30, 2017, the Plan's performance was a decrease in net assets of $6.5 million, which was $6.7 million higher than budget. Cost of health care was higher than budget by $9.2 million, which was driven by higher contracted rates and high-cost Inpatient claims. The medical loss ratio increased to 97.1 percent of revenue, which was 4.5 percent higher than the budget. Administrative savings were realized through lower than projected administrative expenses. The administrative cost ratio was 0.04 percent lower than budget.

Membership – September membership of 205,695 was 1,035 members higher than budget due higher than expected membership in the Adult Expansion category of aid.

Revenue – September FYTD net revenue was $173.3 million or $1.5 million higher than budget, On a PMPM basis, revenue was $2.80 PMPM above budget due to membership mix, with higher than expected Adult Expansion membership.

MCO Tax – MCO tax is a pre-determined liability in accordance with Senate Bill X2-2 passed in October 2016. The Plan's MCO tax liability for FY 2018 is $89.3 million, accrued at a rate of approximately $7.4 million per month. The second quarterly installment of MCO tax for the fiscal year is scheduled for payment in January 2018.

Health Care Costs – September FYTD health care costs were $168.3 million or $9.2 million higher than budget. The medical loss ratio (MLR) was 97.1 percent versus 92.6 percent for budget.

Adult Expansion Population 85% Medical Loss Ratio – The Balance Sheet contains a $131.3 million reserve for return of potential Medi-Cal capitation revenue to the DHCS under the terms of the MLR contract language.

	Expansion Population				Classic Population
	1/1/2014 - 6/30/2015	7/1/2015 - 6/30/2016	7/1/2016 - 6/30/2017	7/1/2016 - 9/30/17	7/1/2016 - 9/30/17
	MLR Period 1	MLR Period 2	MLR Period 3	MLR Period 4	
Total Revenue	361,237,234	293,173,426	268,060,238	66,534,242	106,730,775
Total Estimated Medical Expense	206,719,452	237,729,974	234,431,483	65,041,506	103,336,875
	57.2%	81.1%	87.5%	97.8%	96.8%
Total MLR Reserve	**118,168,494**	**13,101,452**			

Administrative Expenses – For the fiscal year ended September 30, administrative costs were $12.4 million or $270,000 below budget. As a percentage of revenue, administrative costs (or ACR) were 7.1 percent versus 7.4 percent for budget.

Cash and Investments – At September 30, the Plan had $444.7 million in cash and short-term investments. The AE overpayment due to DHCS (related to incorrect rate payments and to achieve 85% MLR) totals $234.5 million. For the fiscal year ended September, the State has recouped a total of $45.8 million related to AE rate overpayment.

Investment Portfolio – At September 30, 2017, the value of the investments (all short term) was $250.9 million. The portfolio included Cal Trust $51.1 million; Ventura County Investment Pool $86.1 million; LAIF CA State $63.7 million; Bonds and Commercial Paper $50 million.

RECOMMENDATION:

Staff requests that the Commission accept and file the September 2017 financial package.

CONCURRENCE:

November 17, 2017

ATTACHMENT:

September 2017 Financial Package

Gold Coast Health Plan℠
A Public Entity

FINANCIAL PACKAGE
For the month ended September 30, 2017

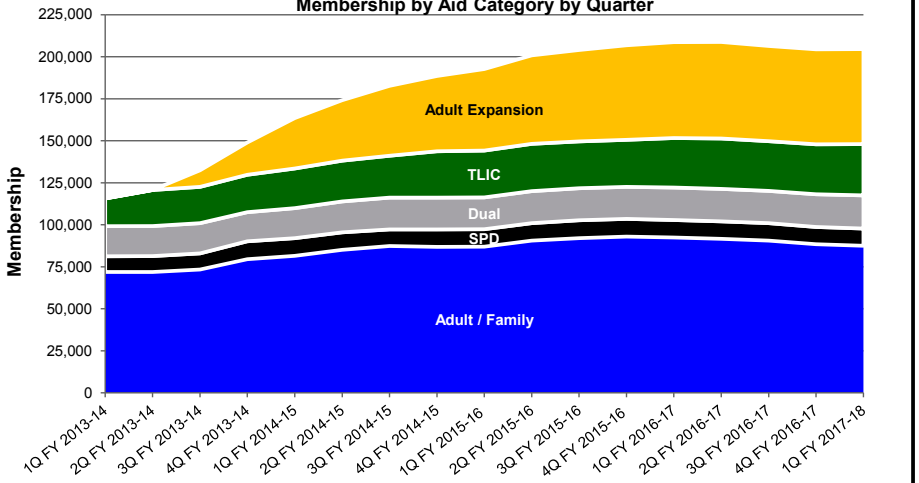
TABLE OF CONTENTS

APPENDIX

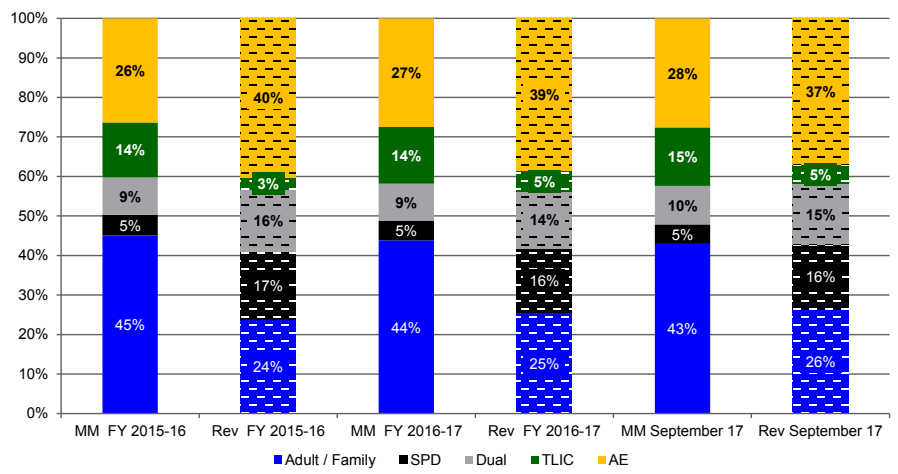
Description	AUDITED FY 2015-16	AUDITED FY 2016-17	FY 2017-18 JUL 17	AUG 17	SEP 17	FYTD SEP 17	Budget Comparison Budget FYTD	Variance Fav / (Unfav)
Member Months	**2,413,136**	**2,485,202**	**203,077**	**205,002**	**205,695**	**613,774**	**614,409**	(635)
Revenue	**675,629,602**	**680,255,278**	**57,560,932**	**57,633,531**	**58,070,555**	**173,265,018**	**171,724,917**	1,540,101
pmpm	*279.98*	*273.72*	*283.44*	*281.14*	*282.31*	*282.29*	*279.50*	2.80
Health Care Costs	**583,149,780**	**645,931,276**	**57,605,616**	**58,083,191**	**52,607,136**	**168,295,943**	**159,064,086**	(9,231,857)
pmpm	*241.66*	*259.91*	*283.66*	*283.33*	*255.75*	*274.20*	*258.89*	(15.31)
% of Revenue	86.3%	95.0%	100.1%	100.8%	90.6%	97.1%	92.6%	-4.5%
Admin Exp	**38,256,908**	**51,176,317**	**4,246,896**	**4,115,955**	**4,018,408**	**12,381,259**	**12,651,130**	269,870
pmpm	*15.85*	*20.59*	*20.91*	*20.08*	*19.54*	*20.17*	*20.59*	0.42
% of Revenue	5.7%	7.5%	7.4%	7.1%	6.9%	7.1%	7.4%	0.2%
Non-Operating Revenue / (Expense)	**1,790,949**	**3,254,139**	**302,433**	**282,279**	**328,847**	**913,559**	**228,967**	684,593
pmpm	*0.74*	*1.31*	*1.49*	*1.38*	*1.60*	*1.49*	*0.37*	1.12
% of Revenue	0.3%	0.5%	-0.5%	-0.5%	-0.6%	-0.5%	-0.1%	-0.4%
Total Increase / (Decrease) in Unrestricted Net Assets	**56,013,863**	**(13,598,175)**	**(3,989,147)**	**(4,283,336)**	**1,773,858**	**(6,498,625)**	**238,668**	(6,737,293)
pmpm	*23.21*	*(5.47)*	*(19.64)*	*(20.89)*	*8.62*	*(10.59)*	*0.39*	(10.98)
% of Revenue	8.3%	2.0%	-6.9%	-7.4%	3.1%	-3.8%	0.1%	3.9%
YTD								
100% TNE	25,246,284	29,231,052	30,067,645	30,129,010	29,888,218	29,888,218	29,490,525	397,693
% TNE Required	100%	100%	100%	100%	100%	100%	100%	
Minimum Required TNE	25,246,284	29,231,052	30,067,645	30,129,010	29,888,218	29,888,218	29,490,525	397,693
GCHP TNE	**155,959,127**	**142,360,951**	**138,371,804**	**134,088,469**	**135,862,326**	**135,862,326**	**142,599,619**	(6,737,292)
TNE Excess / (Deficiency)	**130,712,843**	**113,129,900**	**108,304,160**	**103,959,459**	**105,974,109**	**105,974,109**	**113,109,094**	(7,134,985)
% of Required TNE level	**618%**	**487%**	**460%**	**445%**	**455%**	**455%**	**484%**	

FINANCIAL PERFORMANCE DASHBOARD
FOR MONTH ENDING SEPTEMBER 30, 2017

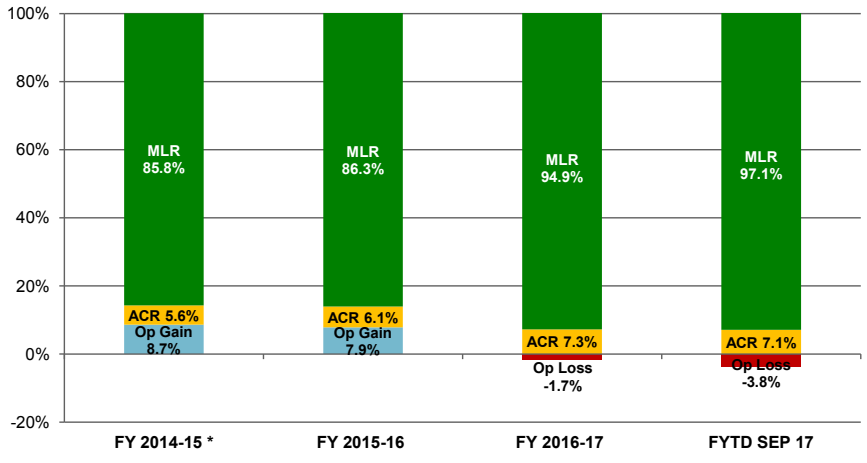
Membership and Growth
Membership by Aid Category by Quarter



Membership Mix and Revenue Impact

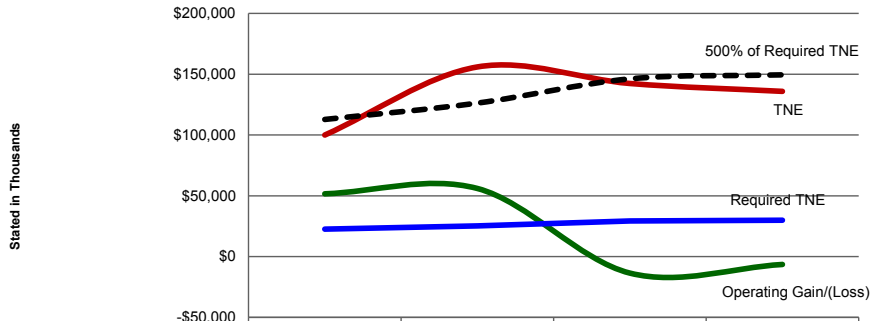


Key Performance Indicators



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

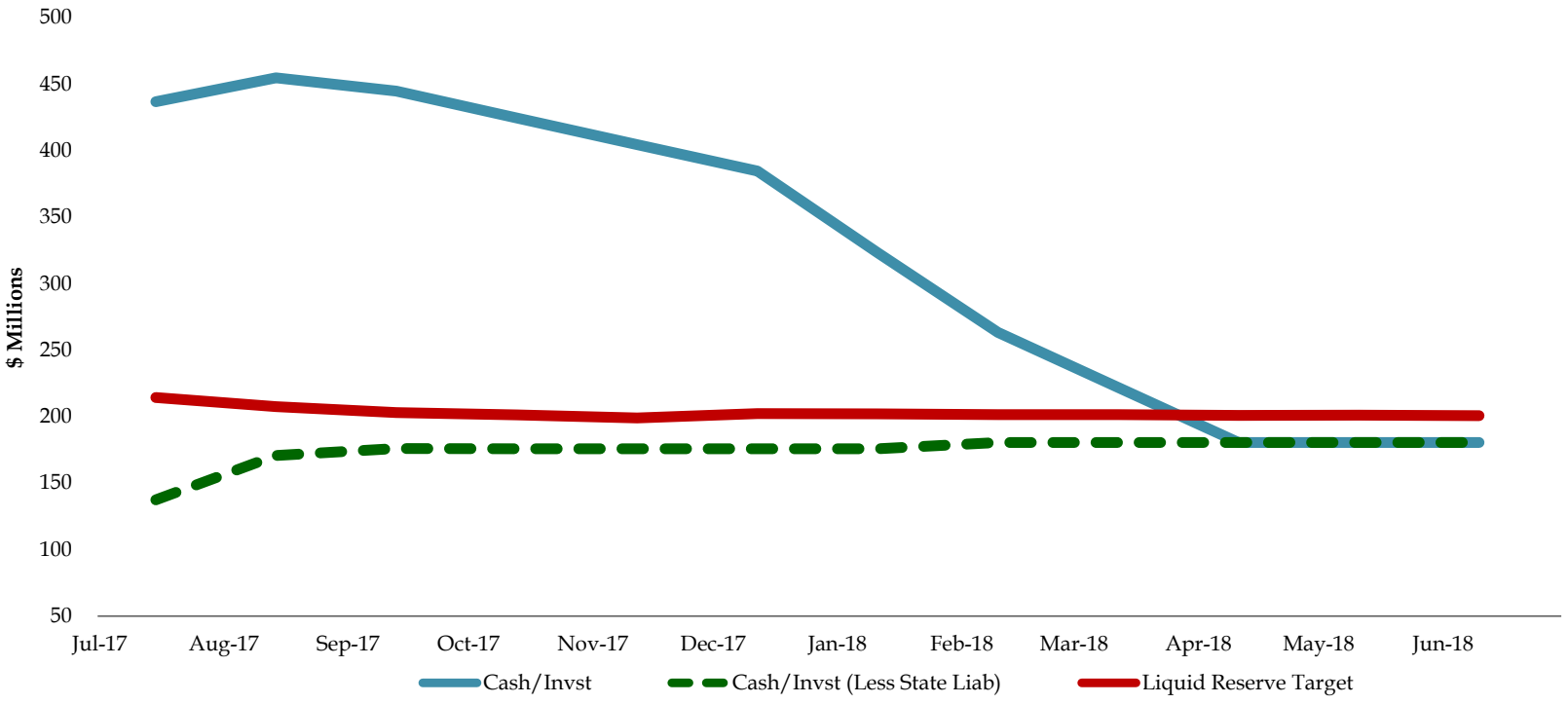


	FY 2014-15 *	FY 2015-16	FY 2016-17	FYTD SEP 2017
Operating Gain/(Loss)	$51,610	$56,014	$(13,598)	$(6,499)
TNE	$99,945	$155,959	$142,361	$135,862
Required TNE	$22,557	$25,246	$29,231	$29,888
500% of Required TNE	$112,783	$126,231	$146,155	$149,441

* 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
FY 2017 - 18

Cash & Operating Expense Requirements



Assumes payback to DHCS for AE rate overpayment and MLR (85%) capitation to be completed by April 2018.

Gold Coast Health Plan℠
A Public Entity

For the month ended September 30, 2017

APPENDIX

- Statement of Financial Position
- YTD Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Cash Flows
- Membership
- Paid Claims and IBNP Composition

STATEMENT OF FINANCIAL POSITION

	09/30/17	08/31/17	07/31/17
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**$ 193,796,041**	**$ 203,943,722**	**$ 167,132,712**
Total Short-Term Investments	**250,896,509**	**250,730,805**	**269,555,019**
Medi-Cal Receivable	92,245,791	94,731,725	122,618,874
Interest Receivable	516,998	459,850	518,205
Provider Receivable	557,467	667,563	705,630
Other Receivables	1,500,000	1,500,000	1,500,000
Total Accounts Receivable	**94,820,256**	**97,359,139**	**125,342,709**
Total Prepaid Accounts	1,614,382	1,893,643	1,794,254
Total Other Current Assets	135,560	135,560	135,560
Total Current Assets	**541,262,749**	**554,062,870**	**563,960,255**
Total Fixed Assets	**2,216,537**	**2,260,874**	**2,305,131**
Total Assets	**$ 543,479,286**	**$ 556,323,744**	**$ 566,265,386**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 56,345,708	$ 52,073,578	$ 53,141,812
Claims Payable	23,839,533	28,239,908	18,179,523
Capitation Payable	57,160,872	57,125,863	57,354,194
DHCS - Reserve for Capitation Recoup	131,269,946	131,269,946	131,269,946
Accounts Payable	2,268,304	9,034,195	16,052,879
Accrued ACS	1,688,638	1,707,424	1,691,408
Accrued Expenses	112,140,057	127,422,461	142,483,948
Accrued Premium Tax	20,492,764	13,047,415	5,602,074
Accrued Payroll Expense	1,390,368	1,293,442	1,096,483
Total Current Liabilities	**406,596,190**	**421,214,233**	**426,872,267**
Long-Term Liabilities:			
Other Long-term Liability-Deferred Rent	1,020,770	1,021,042	1,021,315
Total Long-Term Liabilities	**1,020,770**	**1,021,042**	**1,021,315**
Total Liabilities	**407,616,960**	**422,235,276**	**427,893,582**
Net Assets:			
Beginning Net Assets	142,360,951	142,360,951	142,360,951
Total Increase / (Decrease in Unrestricted Net Assets)	(6,498,625)	(8,272,483)	(3,989,147)
Total Net Assets	**135,862,326**	**134,088,469**	**138,371,804**
Total Liabilities & Net Assets	**$ 543,479,286**	**$ 556,323,744**	**$ 566,265,386**

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR THREE MONTHS ENDED SEPTEMBER 30, 2017

	SEPTEMBER 2017 Year-To-Date		Variance
	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	613,774	614,409	(635)
Revenue			
Premium	$ 195,601,048	$ 195,356,739	$ 244,309
MCO Premium Tax	(22,336,030)	(23,631,822)	1,295,792
Total Net Premium	**173,265,018**	**171,724,917**	**1,540,101**
Total Revenue	**173,265,018**	**171,724,917**	**1,540,101**
Medical Expenses:			
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	15,555,073	16,265,533	710,460
FFS Claims Expenses:			
Inpatient	31,724,766	32,891,286	1,166,520
LTC / SNF	30,001,315	28,983,033	(1,018,283)
Outpatient	13,817,390	12,972,481	(844,909)
Laboratory and Radiology	1,105,378	687,313	(418,065)
Emergency Room	8,193,191	6,286,912	(1,906,279)
Physician Specialty	13,604,726	12,819,163	(785,563)
Primary Care Physician	4,520,326	3,637,760	(882,566)
Home & Community Based Services	3,640,622	4,551,571	910,949
Applied Behavior Analysis Services	1,983,107	1,173,235	(809,872)
Mental Health Services	1,571,783	2,340,316	768,533
Pharmacy	35,345,808	27,993,075	(7,352,733)
Other Medical Professional	848,154	1,200,646	352,492
Other Medical Care	6,240	0	(6,240)
Other Fee For Service	2,574,219	1,988,281	(585,938)
Transportation	569,572	367,585	(201,987)
Total Claims	149,506,595	137,892,657	(11,613,938)
Medical & Care Management Expense	2,824,510	3,560,340	735,830
Reinsurance	756,685	1,345,556	588,871
Claims Recoveries	(346,920)	0	346,920
Sub-total	3,234,274	4,905,896	1,671,621
Total Cost of Health Care	**168,295,943**	**159,064,086**	**(9,231,857)**
Contribution Margin	**4,969,075**	**12,660,831**	**(7,691,756)**
General & Administrative Expenses:			
Salaries, Wages & Employee Benefits	5,631,544	5,993,882	362,338
Training, Conference & Travel	66,921	172,774	105,853
Outside Services	6,476,271	6,919,913	443,642
Professional Services	1,081,801	895,500	(186,301)
Occupancy, Supplies, Insurance & Others	1,650,977	2,229,400	578,423
ARCH/Community Grants	298,254	0	(298,254)
Care Management Credit	(2,824,510)	(3,560,340)	(735,830)
Total G & A Expenses	**12,381,259**	**12,651,130**	**269,870**
Total Operating Gain / (Loss)	**$ (7,412,184)**	**$ 9,701**	**$ (7,421,885)**
Non Operating			
Revenues - Interest	913,559	228,967	684,593
Total Non-Operating	913,559	228,967	684,593
Total Increase / (Decrease) in Unrestricted Net Assets	**$ (6,498,625)**	**$ 238,668**	**$ (6,737,293)**
Net Assets, Beginning of Year	142,360,951		
Net Assets, End of Current Period	135,862,326		

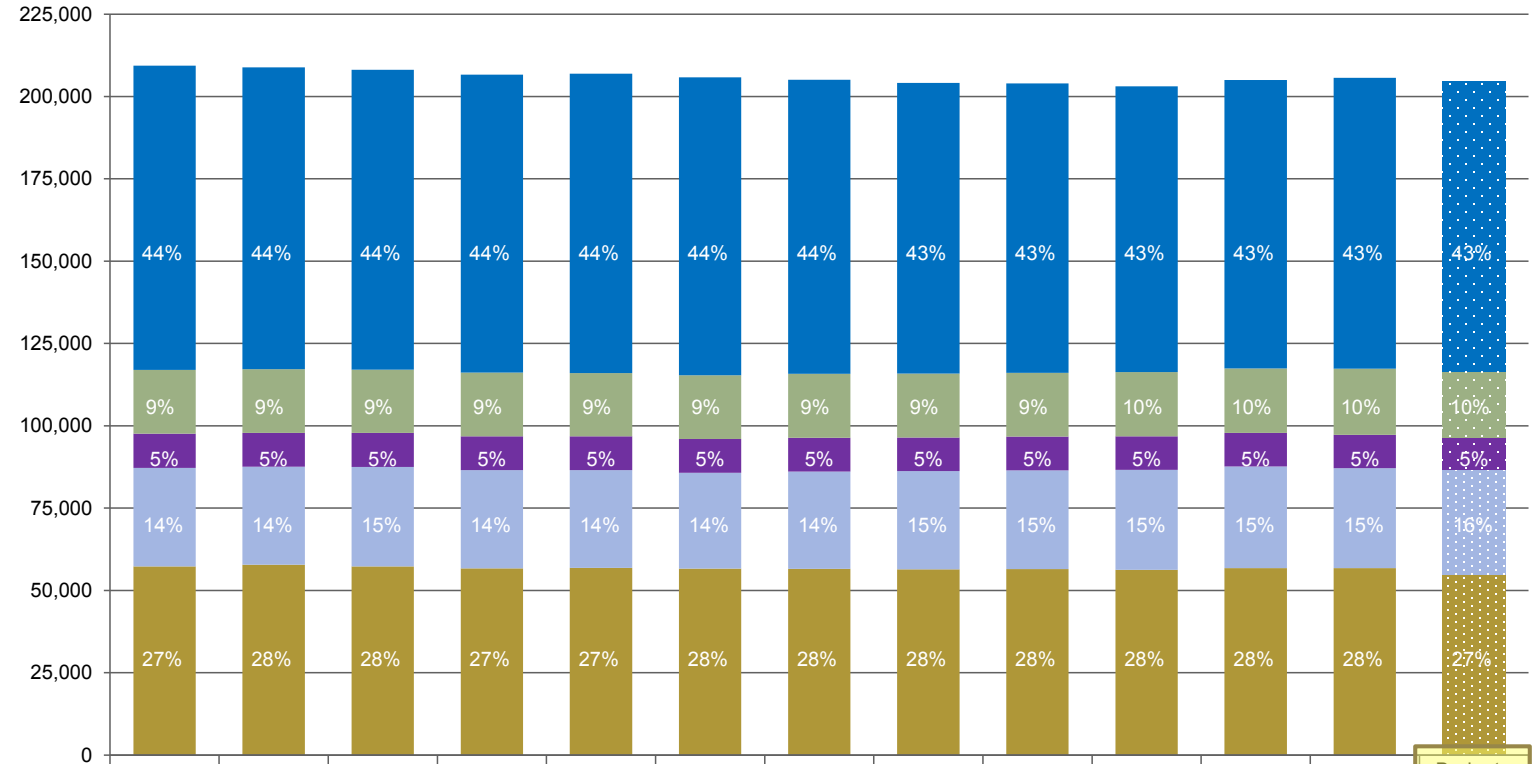
STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2016-17	FY 2017-18 Monthly Trend		Current Month		
	Jun 17	Jul 17	Aug 17	SEPTEMBER 2017		Variance
				Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	203,990	203,077	205,002	205,695	204,660	1,035
Revenue:						
Premium	$ 62,406,054	$ 65,006,273	$ 65,078,872	$ 65,515,904	$ 65,051,905	$ 463,998
MCO Premium Tax	(7,333,552)	(7,445,341)	(7,445,341)	(7,445,348)	(7,871,774)	426,426
Total Net Premium	**55,072,502**	**57,560,932**	**57,633,531**	**58,070,555**	**57,180,131**	**890,424**
Total Revenue	**55,072,502**	**57,560,932**	**57,633,531**	**58,070,555**	**57,180,131**	**890,424**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	5,296,649	5,196,768	5,162,964	5,195,341	5,412,808	217,467
FFS Claims Expenses:						
Inpatient	8,603,936	11,930,937	11,586,395	8,207,433	10,947,673	2,740,240
LTC / SNF	10,552,442	10,602,658	10,114,354	9,284,303	9,649,015	364,712
Outpatient	3,812,264	3,455,473	5,607,078	4,754,839	4,319,221	(435,617)
Laboratory and Radiology	211,239	432,458	350,157	322,764	228,858	(93,905)
Physician ACA 1202	370,381	0	0	0	0	0
Emergency Room	2,211,124	2,077,878	3,020,035	3,095,278	2,092,463	(1,002,815)
Physician Specialty	4,741,892	4,524,338	4,665,076	4,415,312	4,268,892	(146,421)
Primary Care Physician	1,708,898	1,402,259	1,302,571	1,815,495	1,211,346	(604,149)
Home & Community Based Services	1,475,139	1,078,625	1,072,894	1,489,103	1,520,222	31,119
Applied Behavior Analysis Services	684,387	627,661	757,729	597,717	390,562	(207,155)
Mental Health Services	697,153	664,607	426,848	480,327	778,856	298,529
Pharmacy	12,698,077	13,244,829	11,428,152	10,672,826	9,314,312	(1,358,514)
Other Medical Professional	368,748	287,126	294,355	266,673	399,900	133,227
Other Medical Care	0	0	6,240	0	0	0
Other Fee For Service	842,709	801,567	960,938	811,715	662,332	(149,383)
Transportation	391,072	147,303	247,980	174,290	122,281	(52,008)
Total Claims	49,369,463	51,277,719	51,840,803	46,388,074	45,905,932	(482,141)
Medical & Care Management Expense	1,113,973	862,769	1,015,943	945,798	1,136,347	190,549
Reinsurance	252,147	251,985	251,278	253,422	448,205	194,783
Claims Recoveries	(672,140)	16,376	(187,798)	(175,499)	0	175,499
Sub-total	693,979	1,131,130	1,079,423	1,023,721	1,584,552	560,831
Total Cost of Health Care	**55,360,092**	**57,605,616**	**58,083,191**	**52,607,136**	**52,903,293**	**296,157**
Contribution Margin	**(287,590)**	**(44,684)**	**(449,660)**	**5,463,419**	**4,276,839**	**1,186,580**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	1,949,388	1,745,912	1,986,761	1,898,872	1,967,351	68,479
Training, Conference & Travel	26,061	22,722	20,631	23,568	59,075	35,507
Outside Services	2,276,567	2,099,910	2,197,098	2,179,263	2,304,920	125,657
Professional Services	587,108	354,196	391,965	335,641	281,058	(54,582)
Occupancy, Supplies, Insurance & Others	858,173	588,671	535,444	526,862	603,332	76,469
ARCH/Community Grants	1,202,990	298,254	0	0	0	0
Care Management Credit	(1,113,973)	(862,769)	(1,015,943)	(945,798)	(1,136,347)	(190,549)
Total G & A Expenses	**5,786,313**	**4,246,896**	**4,115,955**	**4,018,408**	**4,079,389**	**60,981**
Total Operating Gain / (Loss)	**(6,073,903)**	**(4,291,580)**	**(4,565,615)**	**1,445,011**	**197,449**	**1,247,562**
Non Operating:						
Revenues - Interest	323,968	302,433	282,279	328,847	76,240	252,607
Total Non-Operating	**323,968**	**302,433**	**282,279**	**328,847**	**76,240**	**252,607**
Total Increase / (Decrease) in Unrestricted Net Assets	**(5,749,936)**	**(3,989,147)**	**(4,283,336)**	**1,773,858**	**273,689**	**1,500,168**
Full Time Employees				**180**	**184**	**4**

STATEMENT OF CASH FLOWS	July 17	Aug 17	Sept 17	FYTD 17-18
Cash Flows Provided By Operating Activities				
Net Income (Loss)	(3,989,147)	(4,283,336)	1,773,858	(6,498,625)
Adjustments to reconciled net income to net cash provided by operating activities				
Depreciation on fixed assets	44,685	44,257	44,337	133,279
Amortization of discounts and premium	(28,951)	(26,201)	(22,098)	(77,250)
Changes in Operating Assets and Liabilites				
Accounts Receivable	2,361,682	27,983,570	2,538,883	32,884,134
Prepaid Expenses	1,704,743	(99,389)	279,261	1,884,615
Accounts Payable	(2,245,306)	(21,867,467)	(21,970,428)	(46,083,201)
Claims Payable	(4,662,380)	9,832,054	(4,365,366)	804,307
MCO Tax liablity	(13,573,650)	7,445,341	7,445,348	1,317,039
IBNR	(224,535)	(1,068,234)	4,272,130	2,979,361
Net Cash Provided by Operating Activities	(20,612,860)	17,960,595	(10,004,074)	(12,656,340)
Cash Flow Provided By Investing Activities				
Proceeds from Restricted Cash & Other Assets				
Proceeds from Investments	50,000,000	19,000,000	-	69,000,000
Proceeds for Sales of Property, Plant and Equipment				
Payments for Restricted Cash and Other Assets				
Purchase of Investments	(40,068,401)	(149,585)	(143,607)	(40,361,592)
Purchase of Property and Equipment	(7,750)			(7,750)
Net Cash (Used In) Provided by Investing Activities	9,923,849	18,850,415	(143,607)	28,630,658
Cash Flow Provided By Financing Activities				
None	-	-	-	-
Net Cash Used In Financing Activities	-	-	-	-
Increase/(Decrease) in Cash and Cash Equivalents	(10,689,011)	36,811,010	(10,147,681)	15,974,318
Cash and Cash Equivalents, Beginning of Period	177,821,723	167,132,712	203,943,722	177,821,723
Cash and Cash Equivalents, End of Period	167,132,712	203,943,722	193,796,041	193,796,041

GOLD COAST HEALTH PLAN

Membership - Rolling 12 Month

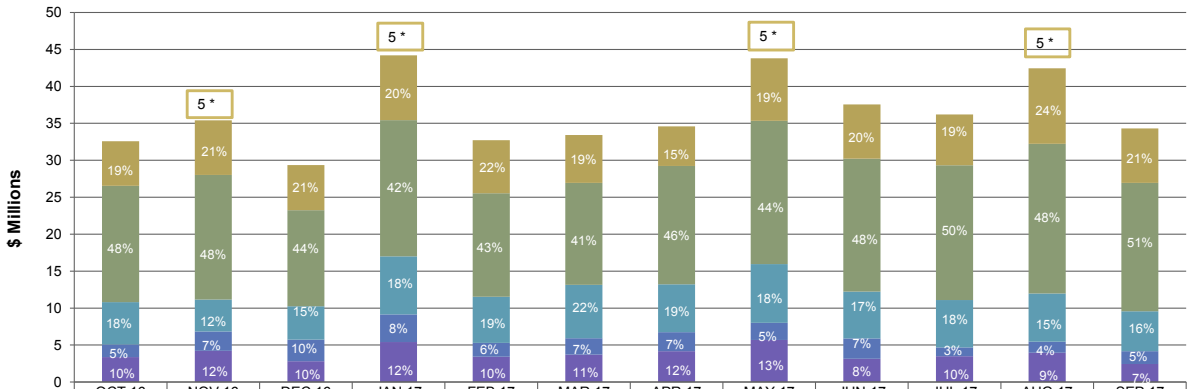


	OCT 16	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17	APR 17	MAY 17	JUN 17	JUL 17	AUG 17	SEP 17	Budget - Sep 17
Total	209,381	208,890	208,148	206,664	206,970	205,829	205,106	204,140	203,990	203,077	205,002	205,695	204,660
FAMILY	92,364	91,653	91,071	90,477	90,911	90,456	89,311	88,281	87,925	86,774	87,609	88,327	88,017
DUALS	19,381	19,376	19,250	19,352	19,213	19,329	19,401	19,375	19,321	19,448	19,573	20,105	20,062
SPD	10,438	10,277	10,282	10,246	10,321	10,326	10,319	10,219	10,236	10,215	10,150	10,125	9,867
TLIC	29,858	29,788	30,238	29,858	29,682	29,038	29,495	29,831	30,047	30,390	30,868	30,357	31,723
AE	57,340	57,796	57,307	56,731	56,843	56,680	56,580	56,434	56,461	56,250	56,802	56,781	54,991

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

GOLD COAST HEALTH PLAN
SEPTEMBER 2017

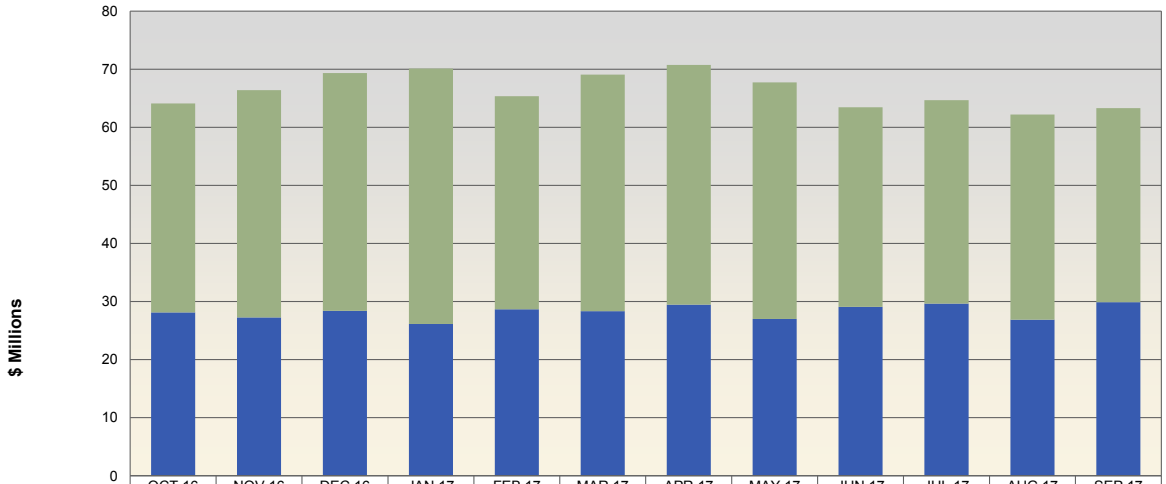
Paid Claims Composition (excluding Pharmacy and Capitation Payments)



	OCT 16	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17	APR 17	MAY 17	JUN 17	JUL 17	AUG 17	SEP 17
Current	6.03	7.39	6.12	8.76	7.17	6.49	5.35	8.44	7.35	6.89	10.23	7.37
30	15.73	16.84	12.98	18.43	14.01	13.80	16.01	19.39	17.97	18.24	20.24	17.35
60	5.73	4.32	4.51	7.87	6.24	7.21	6.47	7.96	6.35	6.40	6.53	5.42
90	1.73	2.64	2.92	3.73	1.87	2.23	2.59	2.31	2.76	1.19	1.50	1.71
120+	3.36	4.21	2.82	5.42	3.42	3.70	4.16	5.69	3.13	3.49	3.95	2.45

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)



	OCT 16	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17	APR 17	MAY 17	JUN 17	JUL 17	AUG 17	SEP 17
Prior Month Unpaid	35.98	39.12	40.94	43.98	36.66	40.73	41.27	40.74	34.37	35.01	35.32	33.39
Current Month Unpaid	28.14	27.26	28.41	26.14	28.68	28.34	29.47	26.99	29.07	29.65	26.89	29.90
Total Unpaid	64.12	66.38	70.12	62.14	65.34	69.07	70.74	67.73	63.44	64.65	62.21	63.29

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

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Melissa Scrymgeour, Chief Administrative Officer

DATE: December 4, 2017

SUBJECT: Contract Approval – Approval of Contract Extension and Additional Funding for Emagined Security, Managed Information Security Services, Service Order Nos. 1 and 4

SUMMARY:

This contract is with Emagined Security. It includes (1) an extension from February 1, 2018 to January 31, 2020 to Service Order No. 1 for on-demand information security engineering and architecture services at a not-to-exceed amount of $152,000 for such period, and (2) a new Service Order No. 4 for additional managed security operations center (SOC) services for the period of January 1, 2018 to December 31, 2018, with a 12-month renewal option and a not-to-exceed amount of $178,750 for the two-year period. The total amount for the two Service Orders is $330,750 (See Table 1.)

BACKGROUND/DISCUSSION:

GCHP has an obligation to protect the privacy of our members' health care information, maintain regulatory and contractual compliance with HIPAA and HITECH.

Cyberattacks and data breaches in the healthcare industry are on the rise. The 2017 Ponemon Institute Annual Cost of Breach Study reported 106 major healthcare security breaches in 2016, impacting 13.5 million records at a total cost to the industry of $2.8B. The study also reports the average cost per breach per individual healthcare record is $380.

GCHP must fortify our information security capabilities while maximizing the Plan's information security investments to respond to the current and emerging information security threats to health care entities.

The background on the specific services will be provided in an Attorney-Client Privileged memorandum that will be separately emailed to Commission members.

FISCAL IMPACT:

The current Service Order No. 1 for security services is funded for $173,000, with funding expected to be depleted by mid-January 2018. The additional estimated cost for continuing

these services through January 2020 is $152,000. This is a time and materials service order and is only billed if GCHP requires the services.

The cost for the new two-year agreement for Service Order No. 4 is $178,750. Yr. 1 costs are estimated at $100,625, and Yr. 2 costs at $78,125.

The total additional funding for both the Service Orders 1 and 4 is $330,750 over two years. (See Table 1.)

Table 1: Info Sec Managed Services Costs Summary

	Year 1	Year 2	Total Yr1/Yr2
Service Order No. 4	$100,625	$78,125	$178,750
Service Order No. 1	$76,000	$76,000	$152,000
Total Additional Funding	$176,625	$154,125	$330,750

RECOMMENDATION:

It is the Plan's recommendation to authorize the CEO to:

1. Execute an amendment to Emagined Security Service Order No. 1 to extend the term to 2/1/2018 to 1/31/2020 and fund an additional $152,000, and
2. Execute a new Emagined Security Service Order No. 4 for the period of 1/1/2018 to 12/31/2018, with a 12-month renewal option and a not to exceed amount of $178,750 for the two-year period.

If the Commission desires to review these contracts, they are available at Gold Coast Health Plan's Finance Department.

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, Chief Medical Officer

DATE: December 4, 2017

SUBJECT: Quality Improvement Committee Report

The Department of Health Care Services requires Gold Coast Health Plan (GCHP) to implement an effective quality improvement system and to ensure that the governing body routinely receives written progress reports from the quality improvement committee. This report contains a summary of activities of the quality improvement committee and its subcommittees.

APPROVAL ITEMS

- Beacon Health Options 2016 Quality Program Evaluation
- Beacon Health Options 2017 Quality Program Description
- Beacon Health Options 2017 Quality Improvement Work Plan
- QI-002 External Accountability Set Performance Measures
- QI-003 Primary care Provider Facility Site Review

OTHER QUALITY IMPROVEMENT ACTIVITIES

HEDIS

Data collection for MY2017 is currently in progress. Performance feedback reports are being distributed on a bi-monthly basis and outreach to clinic managers completed by the QI RN. The following measures are being monitored closely:

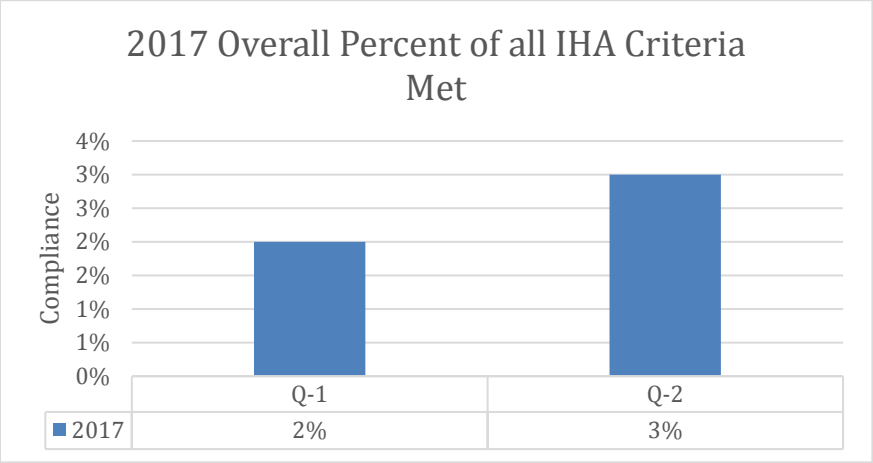
- Annual Monitoring for Patients on Persistent Medications
  - Ace Inhibitors or ARBS
    - Rate improved from 32.67 in Q1 to 60.70 in Q2
  - Diuretics
    - Rate improved from 45.24 in Q1 to 63.37 in Q2
- Comprehensive Diabetes Care
  - HbA1c Poor Control >9%
    - Rate improved from 91.08 in Q1 to 85.65 in Q2 (a lower rate indicates better performance)
  - HbA1c Adequate Control <8%
    - Rate improved from 6.76 in Q1 to 11.75 in Q2
  - Retinal Eye Exam
    - Rate improved from 16.46 in Q1 to 26.01 in Q2
- Childhood Immunization Status
  - Rate improved from 39.80 in Q1 to 49.40 in Q2

The National Committee of Quality Assurance (NCQA) is moving towards leveraging new data and a new process for reporting quality. NCQA is moving towards using Electronic Clinical Data Systems for reporting of HEDIS measures. Data sources used in ECDS includes the following:

- Electronic health records
- Health information exchanges
- Case management registry
- Administrative claims

DHCS now requires GCHP to report the HEDIS ECDS measure; Depression Screening and Follow-Up for Adolescents and Adults

IHA Monitoring (IHA)
An IHA must be completed within 120 days of enrollment in GCHP. There was a slight improvement from Q1 to Q2.



Primary reasons for not achieving 100 % on medical record audits: Incomplete, unsigned, or no Staying Healthy Assessment in the medical record and/or age appropriate preventive health screenings were missing documentation in the medical record.
Interventions during Q2 2017:

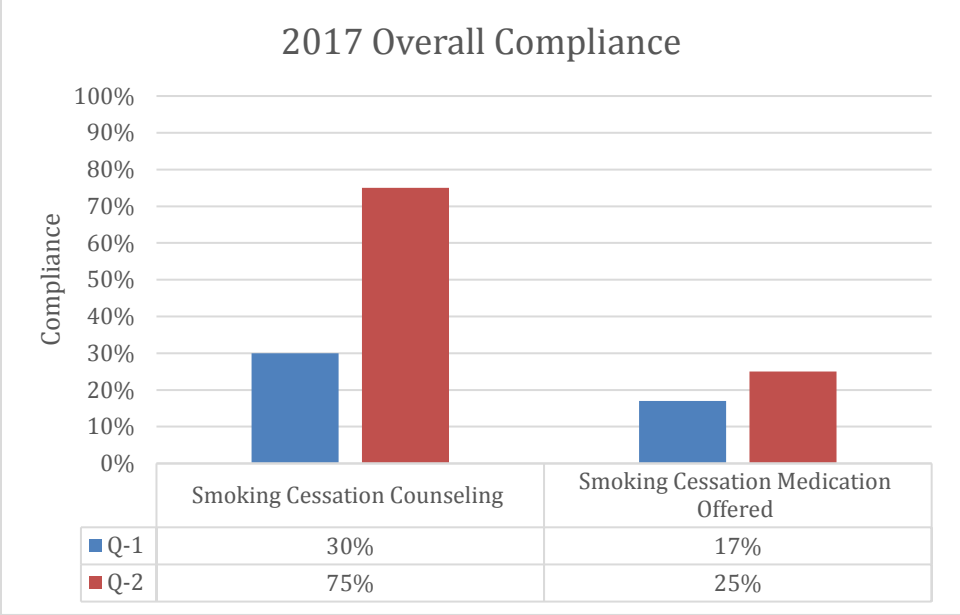
- Declines in medical record review compliance continue to be reviewed with medical providers and clinic managers at the end of each monthly review.
- Copies of each medical record review performed includes explanations in a comment column explaining to the provider what was missing in the medical record.
- Each summary score sheet includes instruction on the requirements for a completed SHA form.
- Continue to identify providers or clinics with problems.
- Continue Network Provider Operations Department and Quality Improvement Department monthly meetings.

- Continue to assist provider sites with concerns, problems, and provider efforts to improve IHA performance.

Facility Site Review
Two (2) initial FSRs and 31 periodic FSRs were conducted in Q2 2017. All providers received passing scores.

No Interim FSRs were due in Q2 2017.

Smoking Cessation



Rates for counseling improved from 30% in Q1 to 75% in Q2. Offering of cessation medications also saw improvement from Q1 to Q2.

Compliance Delegation Oversight
- No report presented; all metrics met

Pharmacy
- 16 drugs reviewed
  - 7 were approved to be added to the formulary because they represent significant clinical advantages

Credentials/Peer Review
- Monitoring of Medical Board of California actions
  - Reviewed the status of 8 contracted providers with either Medical Board of California actions or legal actions by the court.
  - 1 provider's case with the Nevada State Board of Medical Examiners accepted and approved a Settlement Agreement which ordered that the provider receive

a public reprimand, complete 3 hours of CME, in addition to their statutory CME requirements for licensure, and reimburse the Board's fees and costs incurred in the investigation and prosecution of the case against them.
    - 1 provider with a legal case is scheduled for a court date on October 18, 2017

- Credentialing
    - 15 new providers were approved
    - 34 providers were recredentialed; one was pended
    - 45 facilities were credentialed
    - 1 facility was ineligible for credentialing due to inconsistencies on their application

- Peer Review
    - 5 new PQI cases
        - 4 are complete and closed
        - 1 remaining open requiring a response from the provider, open in medical record pursuit or review phase

Cultural and Linguistics
- 56 outreach events
- 4000 individuals reached
- 14 in person interpreting services
- 46 translation services
- 108 sign language requests

Grievance and Appeals
- 608 Administrative grievances – top reason – Provider Disputes
- 40 Clinical – top reasons were quality of care and accessibility
- 17 Clinical Appeals: 9 upheld, 4 overturned, 4 withdrawn

Member Services
- Interactive Voice Response (IVR) 82% indicated that the IVR was "helpful" or "very helpful"
- Call Center Metrics – average speed to answer and abandonment rate goals were met

Network Operations
- Provider visits metric not met due to critical regulatory project (274) and departure of one provider representative

Health Services Utilization Management Committee
- Turn around times met or exceeded goals
- Denial rate remains consistent from quarter to quarter
- Readmission rate has drifted up slightly and will continue to be closely monitored

- Reapproved Home Health Guidelines and Intravenous Sedation & General Anesthesia for Dental Service Guideline
- Revised and approved Diabetes Clinical Practice Guidelines

Medical Advisory Committee (MAC)
The following guidelines were approved at MAC:

- Custodial Care Guideline
- Acute Rehabilitation Therapy Guideline
- Transgender Services Guidelines
- Chiropractic Services Guidelines

The Quality Improvement Dashboard can be found in the following pages.

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

Gold Coast Health Plan HEDIS Measures -- *Quality of Care Indicators*

Legend:

- **Performance ≥ P90 Percentile**
- **Performance < P90 Percentile**
- **Performance ≤ P75 Percentile**
- **Performance ≤ P50 Percentile**
- **Performance ≤ P25 Percentile**

Measure	Description	Responsible Department	Benchmark Source	2014[3] Rate	2015[4] Rate	2016[6] Rate	2017 Q1	2017 Q2	2017[8] P25 (MPL)	2017[8] P50	2017[8] P75	2017[8] P90 (HPL)	Annual Trend	Interventions
(MPM) Annual Monitoring for Patients on Persistent Medications														
ACE Inhibitors or ARBs	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.	Quality Improvement	HEDIS	82.14	86.94	85.09	32.67	60.70	85.93	87.45	89.92	92.79		1) Bi-monthly clinic reports: HEDIS rates and performance feedback reports.performance feedback reports sent to clinics on 08/25/17. 2) Lab reminder letters mailed to members in the MPM measure on 8/23/17.
Digoxin				56.25	50.00	62.71								
Diuretics				83.27	87.37	85.14	45.24	63.37	85.52	87.53	90.04	92.47		
Total				82.30	86.74	84.95	41.16	61.16	85.21	87.25	89.59	91.84		

Gold Coast Health Plan HEDIS Measures -- *Quality of Care Indicators*

Legend:

- **Performance ≥ P90 Percentile**
- **Performance < P90 Percentile**
- **Performance ≤ P75 Percentile**
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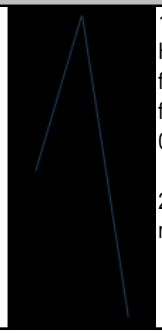
Measure	Description	Responsible Department	Benchmark Source	2014[3] Rate	2015[4] Rate	2016[6] Rate	2017 Q1	2017 Q2	2017[8] P25 (MPL)	2017[8] P50	2017[8] P75	2017[8] P90 (HPL)	Annual Trend	Interventions
(CDC) Comprehensive Diabetes Care														
CDC: A1c Testing	The percentage of members that received a subset of services essential to diabetes management	Quality Improvement	HEDIS	90.51	88.56	86.86	25.20	54.28	84.25	85.96	89.43	92.82		1) Bi-monthly clinic reports: HEDIS rates and performance feedback reports.performance feedback reports sent to clinics on 08/25/17.
CDC: Poor A1c control (> 9.0%); lower rate is better [5]				32.85	37.71	54.50	91.08	85.65	48.57	43.92	36.95	29.07		1) Bi-monthly clinic reports: HEDIS rates and performance feedback reports.performance feedback reports sent to clinics on 08/25/17.
CDC: Good A1c control (< 8.0%); higher rate is better				57.91	54.50	36.98	6.76	11.75	41.94	46.72	52.55	59.12		1) Bi-monthly clinic reports: HEDIS rates and performance feedback reports.performance feedback reports sent to clinics on 08/25/17.
CDC: Diabetic Eye Exam				60.10	81.51	50.61	16.46	26.01	47.57	53.49	61.69	68.33		1) Bi-monthly clinic reports: HEDIS rates and performance feedback reports.performance feedback reports sent to clinics on 08/25/17.
CDC: LDL Testing							0.00	0.00						
CDC: LDL Control (<100 mg/dL)							0.00	0.00						
CDC: Nephropathy Monitoring				83.70	91.24	89.05	53.94	72.28	88.56	90.51	91.97	93.27		1) Bi-monthly clinic reports: HEDIS rates and performance feedback reports.performance feedback reports sent to clinics on 08/25/17.
CDC: Blood Pressure (<140/90 mm Hg)				63.75	65.69	48.66			52.70	59.61	68.61	75.91		1) Bi-monthly clinic reports: HEDIS rates and performance feedback reports.performance feedback reports sent to clinics on 08/25/17.

Gold Coast Health Plan HEDIS Measures -- *Quality of Care Indicators*

Legend:
Performance ≥ P90 Percentile
Performance < P90 Percentile
Performance ≤ P75 Percentile
Performance ≤ P50 Percentile
Performance ≤ P25 Percentile

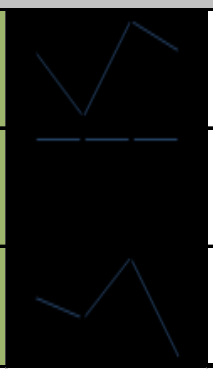
									2017[8]					
Measure	Description	Responsible Department	Benchmark Source	2014[3] Rate	2015[4] Rate	2016[6] Rate	2017 Q1	2017 Q2	P25 (MPL)	P50	P75	P90 (HPL)	Annual Trend	Interventions
(CIS) Childhood Immunization Status														
CIS: Combo 3	The percentage of children 2 years of age that had DTaP, IPV, MMR, HiB, HepB, VZV, Pneumococcal Conjugate	Quality Improvement	HEDIS	**69.97**	**75.43**	**64.96**	**39.80**	**49.40**	65.25	71.06	75.60	79.32		1) Bi-monthly clinic reports: HEDIS rates and performance feedback reports.performance feedback reports sent to clinics on 08/25/17. 2) Provider chid immunization memo on 07/11/17.

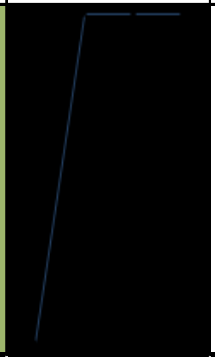
Quality Improvement										
Legend:										
Met or exceeded Benchmark										
Did not meet Benchmark										
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2014**	**2015**	**2016**	**2017 Q1**	**2017 Q2**	**Quarterly Trend**	**Interventions**
Facility Site Audit (Medi-Cal) - Scoring	The overall percentage of applicable DHCS site audit criteria met.	DHCS/ Title 22	80%	**99%**	**92%**	**99%**	**96%**	**100%**		
Facility Site Audit (Medi-Cal) - Compliance	The percentage of providers that passed facility audits without or following completion of a corrective action plan.	DHCS/ Title 22	NA	**100%**	**100%**	**100%**	**100%**	**100%**		
Medical Record Quality Audit (Medi-Cal) - Scoring	The overall percentage of applicable DHCS medical record audit criteria met.	DHCS/ Title 22	80%	**96%**	**88%**	**94%**	**96%**	**97%**		
Medical Record Quality Audit (Medi-Cal) - Compliance	The percentage of providers that passed medical record audits without or following completion of a corrective action plan.	DHCS/ Title 22	NA	**100%**	**88%**	**100%**	**100%**	**100%**		
Coordination of Care	The overall percentage of applicable DHCS Coordination of Care criteria met as determined by medical record audits.	NA	Tracking	**100%**	**93%**	**99%**	**83%**	**100%**		On site instruction at time of medical record audit.
IHA Monitoring [1]	The overall percentage of all IHA criteria met	DHCS	100%	**NR**	**NR**	**21%**	**2%**	**3%**		Written instruction with each monthly audit. 1 on 1 training to new provider sites. Group presentations to staff & provider groups when needed and/or requested.

Delegation Oversight : *Assessment of Delegated Quality Activities*									
Legend:									
Met or exceeded Benchmark									
Did not meet Benchmark									
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016**	**2017 Q1**	**2017 Q2**	**Quarterly Trend**	**Interventions**
Delegation of UM	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 5; NCQA Standard UM 15	DHCS Contract	**100%**[1]	**100%**[4]	**100%**	**100%**		
Delegation of CR	Number required & percentage of current delegates assessed	Exhibit A, Attachment 4; NCQA Standard CR 9	DHCS Contract 10-87128	**100%**[2]	**100%**[5]	**100%**	**100%**		
Delegation of QI	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCQA Standard QI 12	DHCS Contract	**100%**[3]	**100%**[6]	**100%**	**100%**		
Delegation of RR	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCQA Standard RR 7	DHCS Contract	**100%**[3]	**100%**[6]	**100%**	**100%**		
Delegation of Claims	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 8	DHCS Contract	**100%**	**100%**[7]	**100%**	**100%**		

Pharmacy										
Legend:										
Met or exceeded Benchmark										
Did not meet Benchmark										
Measure	**Description**	**Responsible Department**	**Compliance Source**	**Benchmark**	**2015**	**2016**	**2017 Q1**	**2017 Q2**	**Quarterly Trend**	**Interventions**
PA Accuracy	All prior authorization requests were decided in accordance with GCHP clinical criteria.	Pharmacy	DHCS Contract	99%	**98%**	**98.76%**	**99%**	**100%**		Weekly meetings with the PBM to clarify criteria and expectations for the decisions. Any approvals that the plan believes should have been denied, will remain and not be overturned. Any denials that the plan believes should have been approved are overturned and the member and physician are made aware of the approval.
PA Timliness	All prior authorization requests were completed within 1 business day.	Pharmacy	DHCS Contract	99%	**98%**	**100%**	**100%**	**100%**		
Appropriate Decision Language on PA	All denied prior authorization requests contained appropriate and specific rationale for the denial	Pharmacy	DHCS Contract	99%	**98%**	**99.54%**	**99%**	**99%**		GCHP is reviewing the denial language that is sent out and making revisions to the pre-set language as needed; this is an annual exercise and will continue going forward. Existing interventions include a second review of the language for all spelling, punctuation and grammar checks.
Annual Review of all UM Criteria	The P&T committee must review all utilization management criteria at least annually.	Pharmacy	GCHP	Met	**Met**	**Met**		**Met**		
Review of New FDA Approved Drugs	The P&T committee must review all new FDA approved drugs and/or all drugs added to the Medi-Cal FFS Contract Drug List.	Pharmacy	DHCS Contract	Met	**Met**	**Met**		**Met**		

Credentials									
Legend:									
Met or exceeded Benchmark									
Did not meet Benchmark									
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016**	**2017 Q1**	**2017 Q2**	**Quarterly Trend**	**Interventions**
Access Indicators									
Monitoring of Medicare/Medicaid sanctions	An OIG query is performed on every provider at the time of intitial and re-credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	**100%**	**100%**	**100%**	**100%**		
Monitoring of sanctions and limitations on licensure	An Medical Board of California (MBOC) query is performed on every provider at the time of initial and re-credentialing. Other state licensing boards are also queried as needed	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	**100%**	**100%**	**100%**	**100%**		
Monitoring of Complaints	Member complaint data is considered during re-credentialing.	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	**NA**	**NA**	**NA**	**NA**		
Monitoring of adverse events	Quality of Care concerns are reviewed at a minimum of every 6 months and are forwarded to Credentials/Peer Review Committee (CPRC) as indicated.	DHCS/ Title 22	Biannually	**100%**	**100%**	**100%**	**100%**		
	HIPDB queries are performed within 180 days prior to the date of initial and re-credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	**100%**	**100%**	**100%**	**100%**		
Timeliness of provider notification of credentialing decisions	Providers will be notified of the credentialing decision in writing within 60 days	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	**100%**	**100%**	**100%**	**100%**		
Timeliness of verifications	All credentialing verifications are performed within 180 days prior to the credentialing date, as required	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	**98%**	**98%**	**99%**	**98%**		Q2: Several factors contribued to drop in percentage. Main factors High volume of practitioners being credentialed this year, practitioners not submintting needed attestation within a timely manner.
# of provider terminations for quality issues	Credentials/Peer Review Committee (CPRC) denial of a credentialing application for quality issues will cause termination of the provider from the network	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	None	None	None	None		

Credentials									
Legend:									
Met or exceeded Benchmark									
Did not meet Benchmark									
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016**	**2017 Q1**	**2017 Q2**	**Quarterly Trend**	**Interventions**
Access Indicators									
Timeliness of processing of initial applications	Initial applications will be processed within 90 days	DHCS/ Title 22	Standard met for 90% of applications received	**93%**	**97%**	**99%**	**96%**		
Timeliness of processing of re-credentialing applications	Recredentialing applications will be processed within 90 days	DHCS/ Title 22	Standard met for 90% of applications received	**95%**	**96%**	**98%**	**90%**		
Timeliness of Physician Recredentialing	Percent of physicians recredentialed within 36 months of the last approval date	NCQA: CR Standards	Standard met for 90% of providers	**93%**	**94%**	**99%**	**98%**		
Continuous Monitoring of Allied Providers	Percent of allied providers' expirable elements that are current	NA	Standard met for 90% of elements	**100%**	**100%**	**100%**	**100%**		
Timeliness of Organization Reassessment	Percent of organizations reassessed within 36 months of the last assessment	NCQA: CR Standards	Standard met for 90% of providers	**98%**	**95%**	**100%**	**90%**		

Cultural & Linguistics (C&L)								
Legend:								
Met or exceeded Benchmark								
Did not meet Benchmark								
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2016**	**2017 Q1**	**2017 Q2**	**Quarterly Trend**	**Interventions**
Sign Language Services	Percent of sign language services fulfilled	DHCS/Title 22	100%	**89%**	**100%**	**100%**		

Grievance & Appeals									
Legend:									
Met or exceeded Benchmark									
Did not meet Benchmark									
Measure	**Description**	**Compliance Source**	**Benchmark**	**2015**	**2016**	**2017 Q1**	**2017 Q2**	**Quarterly Trend**	**Interventions**
Resolution Turnaround Times (TAT) Grievances	100% TAT within 30 calendar days	GCHP	100%	76%	99%	77%	99%		
Post Service TAR Provider Appeals Processing Time - Resolution	The percentage of provider appeals processed within 30 business days from receipt.	GCHP	100%	100%	99%	97%	100%		
Provider Grievances: Complaint, Appeal, or Inquiry	Timely resolution of provider grievances	GCHP	100%	66%	99%	99%	99%		
Monitoring of Complaints	Member complaints are monitored at a minimum of every six months to assess for trends/outliers	GCHP	Monitoring	100%	100%	100%	100%		

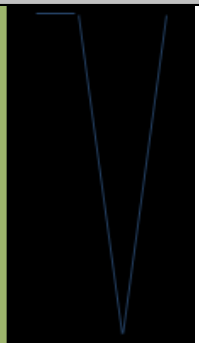
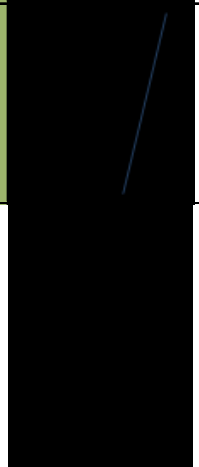
Member Services

Legend:

Met or exceeded Benchmark

Did not meet Benchmark

Measure	Description	Compliance Source	Benchmark	2015	2016	2017 Q1	2017 Q2	Quarterly Trend	Interventions
Call Center - Aggregate Average Speed of Answer (ASA)	Average Speed to Answer (in seconds)		<= 30 seconds	57.5	29.5	23.0	22.3		
Call Center - Aggregate Abandonment Rate	Percentage of aggregate Abandoned calls to Call Center		<= 5%	16.7%	1.30%	1.30%	1.02%		
Call Center - Aggregate Call Center Call Volume	Monitored to ensure adequate staffing and identification of systemic issues.			117,039	121,068	34,882	33,705		
Call Center - IVR Satisfaction Survey	Combined percentage of callers who answered "Very Helpful" and "Helpful" to their IVR satisfaction				80.29%	83.69%	82.30%		

Network Operation QI Dashboard - Access and Availability												
Legend:												
Met or exceeded Benchmark												
Did not meet Benchmark												
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q2**	**2016 Q3**	**2016 Q4**	**2016**	**2017 Q1**	**2017 Q2**	**Quarterly Trend**	**Interventions**
Access to Network / Availability of Practitioners												
# & geographic distribution of PCPs	Network of PCPs located within 30 minutes or 10 miles of a member's residence to ensure each member has a PCP who is available and physically present at the service site for sufficient time to ensure access for assigned members upon member's request or when medically required and to personally manage the member on an on-going basis.	DHCS, Exhibit A, Attachment 6	Standard met for minimum 95% of members	Met		**99.9%**	**99.9%**	**99.9%**	**99.8%**	**99.9%**		
# & geographic distribution of SCPs	Adequate numbers and types of specialists within the network through staffing, contracting, or referral to accommodate members' need for specialty care.	DHCS, Exhibit A, Attachment 6	Standard met for minimum 95% of members	Met		**99.6%**	**99.6%**	**99.6%**	**99.7%**	**99.9%**		
Ratio of members to physicians	1:1200	DHCS, Exhibit A, Attachment 6	Standard met for 100% of members	Met		**1:193**	**1:217**	**1:205**	**1:217**	**1:39**		Reduction in ratio due to the inclusion of new specialist physicians from CHLA, City of Hope (COH) & UCLA.
Ratio of members to PCPs	1:2000	DHCS, Exhibit A, Attachment 6	Standard met for 100% of members	Met		**1:867**	**1:848**	**1:856**	**1:848**	**1:504**		
Acceptable driving times and/or distances to primary care sites	30 minutes or 10 miles of member's residence	DHCS, Exhibit A, Attachment 6	Standard met for minimum 95% of members	Met		**Met**	**Met**	**Met**	**99.8%**	**99.9%**		

Network Operation QI Dashboard - Access and Availability												
Legend:												
Met or exceeded Benchmark												
Did not meet Benchmark												
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q2**	**2016 Q3**	**2016 Q4**	**2016**	**2017 Q1**	**2017 Q2**	**Quarterly Trend**	**Interventions**
Access to Network / Availability of Practitioners												
After Hours Access	Providers have answering machine or service for after-hours member calls	DHCS, Exhibit A, Attachment 9	Standard met for 100% of members						72.2%			72.2% met the criteria however still fell short of benchmark. Providers who did not meet standards, a plan to educate/correct those who did not meet timely access After-Hours standard is in development. Awaiting meeting set-up with Vendor to discuss next steps / timeframe of surveys.
After Hours Access	After-hours machine messages or service staff is in threshold languages	DHCS, Exhibit A, Attachment 9	Standard met for 100% of members									Provider After-Hour (SPH Analytics) Script missing language threshhold, therefore not surveyed. Will include in next survey, also remind those who did not meet timely access After-Hours standard recordings must be in English and Spanish. Awaiting meeting set-up with Vendor to discuss next steps / timeframe of surveys.
	After-hours answering machine message or service includes instructions to call 911 or go to ER in the event of an emergency	DHCS, Exhibit A, Attachment 9	Standard met for 100% of members	NA					71.2%			Awaiting meeting set-up with Vendor to discuss next steps / timeframe of surveys.

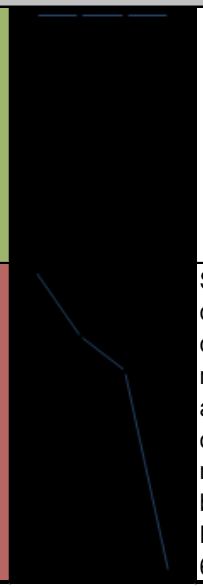
Network Operation QI Dashboard - Access and Availability

Legend:

Met or exceeded Benchmark

Did not meet Benchmark

Measure	Description	Benchmark Source	Benchmark	2015	2016 Q2	2016 Q3	2016 Q4	2016	2017 Q1	2017 Q2	Quarterly Trend	Interventions
Access to Network / Availability of Practitioners												
Time Elapsed Standards	Urgent Care appointments for services that do not require prior authorization: within 48 hours of the request for appointment	DHCS, Exhibit A, Attachment 9	Standards met for minimum of 90% of providers	NA					**100%**			Based on DMHC standard of 48 hrs.
	Non-urgent appointments for primary care: within 10 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA					**90.2%**			Awaiting meeting set-up with Vendor to discuss next steps / timeframe of surveys.
	Non-urgent appointments with specialist physicians: within 15 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA					**48.4%**			Awaiting meeting set-up with Vendor to discuss next steps / timeframe of surveys.
	Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA					**23.5%**			Awaiting meeting set-up with Vendor to discuss next steps / timeframe of surveys.
Appointment Availability	Availability of appointments within GCHP's standards by type of encounter	DHCS, § 7.5.4	Standards met for minimum of 95% of providers	NA								In discussion with vendor to repeat survey for Q4, awaiting meeting set-up with Vendor to discuss next steps / timeframe of surveys.
Provider Surveys	Measure provider satisfaction	GCHP	Satisfaction expressed in each of 6 areas for 80% of providers	**Not Met**								In discussion with vendor to repeat survey for Q4, awaiting meeting set-up with Vendor to discuss next steps / timeframe of surveys.

Network Operation QI Dashboard - Access and Availability												
Legend:												
Met or exceeded Benchmark												
Did not meet Benchmark												
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q2**	**2016 Q3**	**2016 Q4**	**2016**	**2017 Q1**	**2017 Q2**	**Quarterly Trend**	**Interventions**
Access to Network / Availability of Practitioners												
Provider Training	Number of new PCPs / Providers receiving orientation within 10 days of contracting (Note: Provider is offered an orientation within 10 days, but may be completed within 30 days, or if provider declines training, a declination req'd)	DHCS Exhibit A, Attachment 7	100% within 10 days of contracting	**Met**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**		
Provider Visits	Number of Provider Services Representative provider visits	GCHP	Department goal = 100/quarter (400/year) *Based on 2 PR Reps.*	**Met**	**167**	**121**	**104**	**392**	**95**	**42**		Slight decrease in department goal per quarter due to critical regulatory project (274) as well as a departure of one of the provider reps. Current benchmark based on 1 PR Rep. Dept. goal = 60/quarter (240/year).

AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: December 4, 2017

SUBJECT: State of California Contract Amendment A25

SUMMARY:

The State of California Department of Health Care Services (DHCS) establishes monthly capitation payments by major Medi-Cal population groups and updates them periodically to reflect policy changes and other adjustments. Amendment A25 reflects expected changes to Gold Coast Health Plan (GCHP or Plan) capitation rates for FY2015-16.

BACKGROUND/DISCUSSION:

GCHP received a contract amendment from DHCS on October 30, 2017, which updates the Plan's FY2015-16 capitation rates for certain Medi-Cal aid codes as follows:

- The amendment memorializes the FY2015-16 rates for the Classic and Adult Expansion (AE) populations. The AE rate also includes additional rate range funding for the county facility pursuant to Assembly Bill (AB) 85.
- The amendment adds new rates for Hepatitis C drugs and BHT Services during FY2015-16. Rates are the basis for supplemental payments for each member that utilizes these services.
- The amendment also adds six aid codes to the existing Adult and Child aid category.

FISCAL IMPACT:

Amendment A25 memorializes rates included in a rate package received by GCHP on various dates throughout the year. The capitation rates for the FY2015-16 apply to the Classic and AE populations. As the Plan had recorded revenue based on the rates in the rate package, there is no impact to the Plan's net assets. The AB85 funding included in the AE rates has been treated as a pass-through item and has not impacted the Plan's net assets.

RECOMMENDATION:

Staff is recommending the Commission approve and authorize the CEO to execute DHCS contract Amendment A25.

CONCURRENCE
N/A

Attachments
None

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: December 4, 2017

SUBJECT: State of California Contract Amendment A26

SUMMARY:

The State of California Department of Health Care Services (DHCS) establishes monthly capitation payments by major Medi-Cal population groups and updates them periodically to reflect policy changes and other adjustments. Amendment A26 reflects changes to Gold Coast Health Plan (GCHP or Plan) capitation rates for FY2016-17.

BACKGROUND/DISCUSSION:

GCHP received a contract amendment from DHCS on October 30, 2017, which updates the Plan's FY2016-17 capitation rates for certain Medi-Cal aid codes as follows:

- The amendment revises the FY2016-17 rates for the Classic and Adult Expansion (AE) populations to include funding for MCO tax.
- The amendment adds new rates for Hepatitis C drugs and BHT Services during FY2016-17. Rates are the basis for supplemental payments for each member that utilizes these services.

FISCAL IMPACT:

Amendment A26 memorializes rates included in a rate package received by GCHP on December 6, 2016. The capitation rates for the FY2016-17 apply to the Classic and AE populations. As the Plan had recorded revenue based on the rates in the rate package, there is no impact to the Plan's net assets.

RECOMMENDATION:

Staff is recommending the Commission approve and authorize the CEO to execute DHCS contract amendment A26.

CONCURRENCE:

N/A

ATTACHMENTS:

None

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: December 4, 2017

SUBJECT: State of California Contract Amendment A27

SUMMARY:

The State of California Department of Health Care Services (DHCS) establishes monthly capitation payments by major Medi-Cal population groups and updates them periodically to reflect policy changes and other adjustments. Amendment A27 reflects changes to Gold Coast Health Plan (GCHP or Plan) capitation rates for FY2014-15.

BACKGROUND/DISCUSSION:

GCHP received a contract amendment from DHCS on October 30, 2017, which updates the Plan's FY2014-15 capitation rates for certain Medi-Cal aid codes as follows:

- The amendment adjusts the FY2014-15 rates for the second half of the fiscal year (January 1, 2015 to June 30, 2015) to include the Hospital Quality Assurance Fee (HQAF) pursuant to Senate Bill (SB) 239 for the Adult Expansion population.

FISCAL IMPACT:

Amendment A27 increased capitation rates for the FY2014-15 SB239 funds, and enabled GCHP to receive approximately $11.6 million for distribution to various hospitals that serve Medi-Cal and uninsured patients. The allocations of distributions was determined by the California Hospital Association. As a pass-through item, there was no impact to the Plan's net assets.

RECOMMENDATION:

Staff is recommending the Commission approve and authorize the CEO to execute DHCS contract amendment A27.

CONCURRENCE:

N/A

ATTACHMENTS:

None

AGENDA ITEM NO. 10

TO: Gold Coast Health Plan Commission

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

DATE: December 4, 2017

SUBJECT: Chief Diversity Officer

SUMMARY:

The Diversity Subcommittee is pleased to announce that Theodore Bagley dba TBJ Consulting ("TBJ Consulting") has agreed to work on an capacity as Gold Coast Health Plan's Chief Diversity Officer ("CDO"). TBJ Consulting has previously provided interim CDO services to Gold Coast Health Plan ("Plan").

Following negotiations, TBJ Consulting has agreed to the following terms, subject to approval by the Commission: (1) an hourly rate of $250.00 per hour of work; with (2) an anticipation of twenty[1] hours per month, totaling approximately $5,000.00 per month. Thus, the anticipated annual impact shall be approximately $60,000.00. The proposed Consulting Services Agreement is attached hereto as Exhibit 1.

Pursuant to Statement of Work, TBJ Consulting will perform all duties as outlined in the CDO job description, including but not limited to the investigation and reporting on all diversity-related issues. Per the requirements of the CDO position, TBJ Consulting will report directly to the Commission and will issue quarterly reports to the Commission and the Ventura County Board of Supervisors. Should this contract be accepted, TBJ Consulting will start work immediately and will continue until the Plan hires a permanent CDO.

BACKGROUND/DISCUSSION:

On October 6, 2015, the Ventura County Board of Supervisors adopted Ordinance 4481, which required that the Plan to establish a Cultural Diversity Program. Section 1382 of Ordinance 4481 also called for the creation of the CDO position to oversee the program. After creating the job description, the Plan used consultants, including TBJ Consulting, to provide CDO services while recruitment efforts for a permanent CDO were underway. After an extensive recruitment

[1] While the contract anticipates twenty (20) hours per month on a regular basis, Mr. Bagley will orally request that the Commission authorize up to forty (40) hours per month for the first two months of the contract. The additional time is requested in order to re-establish community ties and ramp back up the GCHP diversity program. Should the request be approved, there will be $10,000 of added annual impact.

effort, the Plan hired Douglas Freeman as CDO on April 10, 2017. Unfortunately, Mr. Freeman left the position as of September 8, 2017, and the Plan is in need of CDO services.

FISCAL IMPACT:

Approximately $60,000 in annual consulting fees.

RECOMMENDATION:

Staff recommends that the Commission approve and ratify the proposed Consulting Services Agreement and Statement of Work.

CONCURRENCE:

N/A

ATTACHMENT:

Exhibits 1

EXHIBIT 1

CONSULTING SERVICES AGREEMENT

THIS CONSULTING SERVICES AGREEMENT ("Agreement"), entered into on the 9th day of November, 2017, between Ventura County Medi-Cal Managed Care Commission d.b.a. Gold Coast Health Plan, a public entity (hereinafter "PLAN"), and TBJ Consulting, an independent contractor (hereinafter "Consultant") to provide consulting services to the PLAN on matters related to the Chief Diversity Officer's position at GCHP.

WHEREAS, PLAN is a County Organized Health System (COHS) model of managed care organization under contract to the State of California, Department of Health Care Services, (DHCS) pursuant to which it has enrolled Medi-Cal beneficiaries into its Health Plan (hereinafter "Members"); and

WHEREAS, PLAN desires to engage consultant to provide PLAN with professional consulting services on matters related to audio

WHEREAS, Consultant has experience and expertise necessary to provide such services;

NOW, therefore, be it resolved that in consideration of the mutual promises set forth below, the Parties hereby agree as follows:

I. Services

1.1 During the term of this Agreement, Consultant shall furnish the services set forth in Attachment A (Statement of Work) of this Agreement, which is attached and incorporated herein (the "Services"). The Services shall be performed by Consultant as an independent contractor and not as an agent or employee of PLAN. Consultant and PLAN may enter into one or more Statements of Work, and each Statement of Work shall be governed by and made a part of this Agreement and shall be deemed attached to and incorporated into this Agreement upon execution.

1.2 Consultant shall perform all Services provided pursuant to this Agreement in compliance with: (i) all applicable standards set forth by law or ordinance or established by the rules and regulations of any federal, state or local agency, commission, association or other pertinent governing, or accrediting body, having authority to set standards for health plans and county organized health systems; and (ii) all PLAN rules, regulations, policies and procedures.

1.3 Consultant shall at all times maintain such licenses or certifications as may be necessary to perform the Services in the State of California (the "State").

1.4 Consultant represents and warrants to PLAN as follows: (i) Consultant's licenses or certifications required under this Agreement have never been denied, suspended, revoked, terminated, relinquished under threat of disciplinary action, or restricted in any way; (ii) Consultant's professional privileges granted by any other organization, if any, have never been denied, suspended, revoked, terminated, relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction; (iii) Consultant has not in the past conducted, and is not presently conducting business or professional practice in such a manner as to cause Consultant to be suspended, excluded, debarred or sanctioned under the Medicare or Medicaid Programs, or any government licensing agency, nor has Consultant ever been charged with or convicted of a criminal offense related to health care, or listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation; and (iv) each of the representations and warranties set forth herein shall be continuing and in the event any such representation or warranty fails to remain true and accurate during the term of this Agreement,

Consultant shall immediately notify PLAN.

II. Compensation

2.1 PLAN will pay Consultant according to the fees and payment schedule for the Services outlined in each Statement of Work.

Consultant shall be responsible for payment of all expenses and costs related to the execution of these Services, such as consultation time with PLAN, mileage, and miscellaneous out-of-pocket expenses, unless otherwise approved by PLAN. Consultant shall keep PLAN reasonably apprised on the progress of his activities related to performance of the Services.

2.2 Payment for the Services rendered and reimbursement for expenses (to the extent approved by PLAN) shall be made by PLAN to Consultant upon timely submission of invoices. Invoices shall be submitted to the attention of the Chief Executive Officer at the address provided in Section IX, Notices. The invoices will include the dates in which the Services were performed and hours performing the Services. Payment shall be made within thirty (30) days of receipt of a properly submitted invoice.

2.3 Consultant is responsible for paying all income taxes, including estimated taxes, incurred as a result of the compensation paid by PLAN for Services rendered under this Agreement. Consultant shall indemnify PLAN for any claims, costs, losses, fees, penalties, interest, or damages suffered by PLAN resulting from Consultant's failure to comply with this tax payment provision.

III. Independent Contractor

Consultant shall perform the services set forth above as an independent contractor of PLAN. Consultant is not and will not become an employee, agent or principal of PLAN as a result of the performance of the Services. Consultant is not entitled to the rights or benefits afforded to PLAN employees, including disability or unemployment insurance, workers' compensation medical insurance, sick leave, or any other employment benefit. Consultant is responsible for providing, at his own expense, and to the extent required, workers' compensation insurance, training, permits and licenses in addition to the insurance indicated below.

IV. Indemnification and Insurance

4.1 Indemnification by PLAN. PLAN shall hold harmless, indemnify and defend Consultant for any and all claims resulting from any injury, disability or death arising out of or related to Consultant's performance of the Services or operating of PLAN, except to the extent such injury, disability or death arises out of or is related to Consultant's willful, reckless, fraudulent or criminal conduct.

4.2 Indemnification by Consultant. Consultant shall hold harmless, indemnify and defend PLAN for any and all claims resulting from any injury, disability or death arising out of or related to Consultant's performance of the Services or operating of PLAN, to the extent such injury, disability or death arises out of or is related to Consultant's willful, reckless, fraudulent or criminal conduct.

4.3 Consultant Insurance. Consultant shall procure and maintain for the duration of the Agreement, at Consultant's own expense, the following insurance against claims for injuries to persons or damage to property which may arise from or in connection with the performance of the Services: (a) automobile liability insurance with a minimum combined single limit for bodily injury

and property damage of $1,000,000 per accident, and (b) workers compensation insurance as may be required by the laws of the State. Consultant's insurance coverage shall be primary insurance as respect to PLAN. Any insurance or self-insurance maintained by PLAN shall be excess of Consultant's insurance and shall not contribute with it. Upon request by PLAN, Consultant shall provide the PLAN with evidence of the insurance required herein.

4.4 PLAN Insurance. PLAN shall maintain, at PLAN's expense, comprehensive general liability, directors and officers, and professional liability insurance, or an equivalent program of self-insurance, against claims for injuries to persons or damage to property which may arise from or in connection with the performance of the Services. Upon request by PLAN, Consultant shall provide the PLAN with evidence of the insurance required herein.

V. Term and Termination

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

5.2 Termination for Convenience. Consultant may terminate this Agreement at any time for any reason or for no reason with at least fourteen (14) days prior written notice to PLAN. PLAN may terminate this Agreement at any time for any reason or for no reason with at least fourteen (14) days prior written notice to Consultant.

5.3 Termination for Cause. PLAN may terminate this Agreement immediately by written notice to Consultant upon Consultant's failure to satisfy the representations and warranties in Section 1.4, upon Consultant's material breach of the HIPAA Business Associate Agreement executed by the parties, or upon Consultant's material breach of the provisions of Articles VI or VII of this Agreement.

VI. Confidentiality of Member Information

6.1 Consultant shall preserve as confidential and shall use only in connection with Consultant's performance of the Services, all privileged information acquired from PLAN in the performance of this Agreement. The term "privileged information" shall include without limitation unpublished information and data related to operations of PLAN, any and all beneficiary information and plans, methods, processes, internal specifications and reports.

6.2 Notwithstanding any other provision of the Agreement, the names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with 42, CFR, §431.300 et. seq. and §14100.2, Welfare and Institutions Code (W&I Code) and regulations adopted thereunder. For the purpose of this Agreement, Consultant and his staff will protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Agreement and pertaining to Members.

6.3 With respect to any identifiable information concerning a Member under this Agreement that is obtained by the Consultant, the Consultant:

(a) will not use any such information for any purpose other than carrying out the express terms of the Agreement,

(b) will promptly transmit to PLAN all requests for disclosure of such information,

(c) will not disclose except as otherwise specifically permitted by the Agreement, any such information to any party other than PLAN, the U S Department of Health and Human Services, or the Department of Health Care Services (DHCS) without prior written authorization specifying that the information is releasable under 42 C.F.R. § 431.300 et. seq., W&I Code §14100.2, and regulations adopted thereunder, and

(d) will, at the expiration or termination of the Agreement, return all such information to PLAN or maintain such information according to written procedures sent to PLAN by DHCS for this purpose.

6.4 Consultant and PLAN shall make any and all efforts and take any and all actions necessary to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, and the regulations promulgated thereunder (collectively, "HIPAA Requirements"). Consultant shall take such actions and develop such capabilities as are required to support PLAN compliance with HIPAA Requirements, including, if applicable, acceptance and generation of appropriate electronic files in HIPAA compliant standards formats.

6.5 Consultant shall execute and comply with the PLAN Business Associate Agreement in addition to this Agreement and any other instruments as may be required by HIPAA Requirements.

VII. Non-Discrimination

During the performance of the Services under this Agreement, Consultant and his staff shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, sexual orientation, gender identity or expression, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40), marital status, veteran status, and use of family care leave. Consultant and his staff shall ensure that the evaluation and treatment of Consultant's employees and applicants for employment are free of such discrimination and harassment.

VIII. Disputes

8.1 Judicial Reference. At the election of either party to this Agreement (which election shall be binding upon the other party), a dispute between Consultant and PLAN 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.

8.2 Limitations. Consultant 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 PLAN. If no such Government Code claim is submitted, no action against PLAN 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.

8.3 Venue. Unless otherwise specified in this Section, all actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state courts located in the County of Ventura, State of California.

IX. Notices

Any notice or other communication required or permitted in this Agreement shall be in writing and shall be deemed to have been duly 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 to a nationally recognized overnight courier, to the person and address noted below or to such other person or address as a party may designate in writing from time to time. The addresses for notice shall be changed in the manner provided for in this Section IX.

If served on PLAN, it should be addressed to:

Chief Executive Officer
Gold Coast Health Plan
711 E. Daily Drive, Suite 106
Camarillo, CA 93010

With copy to: Scott Campbell, Esq.
Best Best & Krieger LLP
300 South Grand Avenue
25th Floor
Los Angeles, CA 90071

If served on Consultant, it should be addressed to:

TBJ Consulting
71 Golden Glen Drive
Simi Valley, CA 93065

X. General Provisions

10.1 Amendment. All amendments must be agreed to in writing by PLAN and Consultant.

10.2 No Third-Party Beneficiaries. The obligations created by this Agreement shall be enforceable only by the parties hereto, and no provision of this Agreement is intended to, nor shall it be construed to, create any rights for the benefit of or be enforceable by any third party, including but not limited to any Member.

10.3 Waiver. To be effective, the waiver of any provision or the waiver of the breach of any provision of this Agreement must be set forth specifically in writing and signed by the giving party. Any such waiver shall not operate or be deemed to be a waiver of any prior or future breach of such provision or of any other provision. It is understood and agreed that no failure or delay by PLAN in exercising any right, power or privilege hereunder shall operate as a waiver thereof, nor shall any single or partial exercise thereof preclude any other or further exercise thereof or the exercise of any right, power or privilege hereunder.

10.4 Severability. Should any provisions of this Agreement be declared or found to be illegal, unenforceable, ineffective, or void (by any federal or state courts in a final order or judgment that has not been appealed, or in a final determination by an appellate court), then each party shall be relieved of any obligation arising in that provision; the balance of this Agreement, if capable of performance, shall remain in full force and effect.

10.5 Entire Agreement. This Agreement and its attachments, and any Business Associate Agreement, constitutes the entire agreement between the parties with respect to its subject matter and constitutes and supersedes all prior agreements, representations and understandings of the parties, written or oral.

10.6 Governing Law. This Agreement shall be construed in accordance with and governed by the laws of the State of California.

XI. Special Terms and Conditions

Consultant agrees to comply with the special terms and conditions set for in Attachment B (Special Terms and Conditions).

IN WITNESS WHEREOF the parties hereto have signed this Agreement as of the date set forth below by their authorized representative.

Ventura County Medi-Cal Managed Care Commission d.b.a. Gold Coast Health Plan	**TBJ Consulting**
Signature: _____ Dale Villani, CEO	Signature: _____
Date: _____	Date: _____

ATTACHMENT A

STATEMENT OF WORK

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

1. BACKGROUND

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

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

1.1. Objectives

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

1.2. Reference Materials

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

2. SCOPE OF WORK

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

2.1. Consultant Responsibilities

Identify and list the Consultant's responsibilities

2.2. PLAN Responsibilities

Identify and list the PLAN's responsibilities

2.3. Deliverables

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

3. PROJECT SCHEDULE

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

3.1. Assumptions

Insert certain assumptions upon which the Statement of Work is based

4. TERM

4.1. The Initial Term of this Statement of Work shall be from November 9th, 2017 until contract end. The current term shall be month-to-month until termination by either party.

Or

4.2. Start Date: November 9th, 2017 End Date: TBD

5. COMPENSATION

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

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

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

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

or

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

Skill-Set	Estimated Number of Hours	Hourly Fee
Business and diversity experience	20 hrs monthly[1]	$250.00

[1] Consultant requests authorization of up to 40 hours per month for the first two months of this Agreement's term. The additional time is intended for program ramp up and outreach. Such additional time shall be agreed to upon written authorization from the PLAN Commission or CEO.

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

5.1.4. ☐ **Travel & Expenses:** (check if applicable) **$ N/A**

5.1.5. **Total Compensation.** The total compensation for the project under this Statement of Work No. ___ shall not exceed $_____.

6. ACCEPTANCE

Consultant shall provide regular invoices for review and payment by the PLAN.

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

Ventura County Medi-Cal Managed Care Commission d.b.a. Gold Coast Health Plan

BY: _____

NAME: Dale Villani

TITLE: Chief Executive Officer

DATE: _____

TBJ Consulting
71 Golden Glen Drive
Simi Valley, CA 93065

BY: TBJ Consulting

NAME: Ted Bagley

TITLE: CEO/President

DATE: November 9th, 2017

ATTACHMENT B
SPECIAL TERMS AND CONDITIONS

1. EQUAL OPPORTUNITY REQUIREMENTS

(a) The Consultant 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 Consultant will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, gender identity and expression, 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 Consultant 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 Consultant's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

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

(c) The Consultant 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 Consultant's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

(d) The Consultant will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment

Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

(e) The Consultant 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.

(f) In the event of the Consultant'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 Consultant may be declared ineligible for further Federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

(g) Consultant 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.

2. HUMAN SUBJECTS USE REQUIREMENTS

By signing this Agreement, Consultant agrees that if any performance under this Agreement or any subcontract 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 USC 263a (CLIA) and the regulations thereto.

3.

DEBARMENT AND SUSPENSION CERTIFICATION

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

(b) By signing this Agreement, the Consultant 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.(2) 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 CFR 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 Consultant is unable to certify to any of the statements in this certification, the Consultant shall submit an explanation to PLAN.

(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 Consultant knowingly violates this certification, in addition to other remedies available to the Federal Government, PLAN may immediately terminate this Agreement for cause.

4. 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 law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law 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 law 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, Consultant 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) Consultant further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

5. COVENANT AGAINST CONTINGENT FEES

The Consultant 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 Consultant for the purpose of securing business. For breach or violation of this warranty, PLAN 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.

6. 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.

7. PROHIBITED USE OF STATE FUNDS FOR SOFTWARE

Consultant certifies that is has appropriate systems and controls in place to ensure that PLAN 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.

8. ALIEN INELIGIBILITY CERTIFICATION

By signing this Agreement, the Consultant 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 USC 1601, et seq.)

9. AUDITS AND INSPECTIONS

(a) Consultant will maintain such books and records necessary to disclose how Consultant discharged its obligations under this Agreement. These books and records will disclose the quantity of Services provided under this Agreement, the quality of those Services, the manner and amount of payment made for those Services, the entities or individuals receiving the Services, the manner in which Consultant administered in daily business, and the cost thereof. These books and records shall be maintained for a minimum of five (5) years from the end of the year in which the applicable book or record was created or used, unless a longer period is required by law, or in the event Consultant has been notified that PLAN, the State, the federal government, or their authorized agencies or representatives have commenced an audit or investigation of the Agreement, until such time as the matter under audit or investigation has been resolved, whichever is later.

(b) Consultant shall, through the end of the records retention period specified in subsection 9(a), at any time during normal business hours, allow PLAN, the State, the federal government, or their authorized agencies or representatives, to inspect Consultant's facilities, books and records with respect to the matters covered by this Agreement.

(c) For the purpose of this Section 9, books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance of the Services under this Agreement, including working papers, reports, financial records, books of account, medical records, prescription files, subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members.

—

AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: December 4, 2017

SUBJECT: Office Sublease Agreement, 711 Daily Drive Suites 105 and 107.

SUMMARY:

Gold Coast Health Plan (GCHP) currently leases space at 711 Daily Drive and 770 Paseo Camarillo in Camarillo. As Medi-Cal membership across the state and in Ventura County has decreased, the accompanying staffing projections and space needs have also decreased. Consequently, GCHP leadership staff has identified two suites on the first floor at 711 Daily Drive that present potential sublease opportunities.

BACKGROUND/DISCUSSION:

The Plan has sought and been granted permission by the 711 building ownership to sublet two suites currently leased to GCHP, relocating impacted employees to available space on the 2nd floor. Suite 105 consists of 2,578 rentable square feet (RSF) while suite 107 comprises 1,303 RSF. Staff has begun working with NAI Capitol to develop two proforma scenarios showing projecting gross revenue if the space is sublet.

It is the Plan's recommendation to pursue the sublease of suites 105 and 107 at 711 Daily Drive in Camarillo, utilizing William Kiefer at NAI Capitol to conduct a marketing campaign on behalf of GCHP and allow the CEO to enter into a 3-year agreement with a potential sub-lessor to occupy the above-mentioned space.

FINANCIAL IMPACT:

Projected Economics* - attached are two spreadsheets showing gross revenue for two proforma scenarios with the following terms:

- 3-year term
- modest rent ($1.85 per RSF is 12% less than market due to the nature of a sublease)
- one-half month rent discount for each lease year
- nominal Tenant Improvement costs ($1 per RSF) and
- 7% broker commission (half likely to cooperating broker)

- Suite #105 shows $155,600 Cumulative Cash Flow
- Suite #107 shows $78,600 Cumulative Cash Flow

*These numbers represent savings to our current rent obligation

RECOMMENDATION:

Subject to review by legal counsel, authorize and direct the Chief Executive Officer to execute an agreement with NAI Capital to represent GCHP as the Plan's exclusive agent for sublease of Suites 105 and 107 at 711 East Daily Drive.

CONCURRENCE:

None

ATTACHMENTS:

None

Proposal Cash Flow Owner Perspective

711 E Daily Dr - Camarillo Business Center II
Camarillo, CA 93010

DEAL: Proforma Sublease Economics | Suite #105
MODEL: Projected Sublease Terms

SPACE DETAILS

Use:	Office
Suite:	#105
Rentable SF:	2,578
Useable SF (Core %):	2,404 (7.24%)

LEASE TERMS

Lease Start:	1/1/2018	Free Rent:	1.5 Months ($7,154)
Lease End:	12/31/2020	Service Type:	Full Service (No Pass-Thru)
Term:	3 Years	Operating Exp:	N/A
Starting Rent:	$1.85 / RSF	Commission:	7.00%
Rent Increases:	3% Annual Steps	Improvements:	$1.00 / RSF (Landlord Allowance)

	Year 1	Year 2	Year 3	Total
Base Rent	57,232	57,232	57,232	171,695
Escalations	-	1,717	3,485	5,202
Free Rent	(7,154)	-	-	(7,154)
Total Base Rent	50,078	58,949	60,717	169,743
Total Rent	50,078	58,949	60,717	169,743
Net Operating Income	50,078	58,949	60,717	169,743
Lease Commissions	11,518	-	-	11,518
Improvement Allowance	2,578	-	-	2,578
Total Other Costs	14,096	-	-	14,096
Cash Flow	35,982	58,949	60,717	155,647
Cumulative Cash Flow	35,982	94,930	155,647	155,647

Proposal Input Detail Owner Perspective

711 E Daily Dr - Camarillo Business Center II
Camarillo, CA 93010

DEAL: Proforma Sublease Economics | Suite #105
MODEL: Projected Sublease Terms

SPACE DETAILS

Use:	Office
Suite:	#105
Rentable SF:	2,578
Useable SF (Core %):	2,404 (7.24%)

LEASE TERMS

Lease Start:	1/1/2018	Free Rent:	1.5 Months ($7,154)
Lease End:	12/31/2020	Service Type:	Full Service (No Pass-Thru)
Term:	3 Years	Operating Exp:	N/A
Starting Rent:	$1.85 / RSF	Commission:	7.00%
Rent Increases:	3% Annual Steps	Improvements:	$1.00 / RSF (Landlord Allowance)

BASE RENT (Full Service (No Pass-Thru))

	Date	Amount		Increase		
Month	Date	$ / RSF	$ / Month	$ / RSF	$ / Month	%
1	1/1/2018	1.85	4,769			
13	1/1/2019	1.91	4,912	0.06	143	3.00
25	1/1/2020	1.96	5,060	0.06	147	3.00

FREE RENT

Lease Month	# of Months	% Free
1	1.5	100%

RECOVERIES

Service Type: Full Service (No Pass-Thru)

TENANT IMPROVEMENTS

	$ / RSF	Amount
Improvement Costs	1.00	2,578
Less: Landlord Contribution	1.00	2,578
Net Cost to Tenant	0.00	0

INFLATION

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Global Inflation	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
Consumer Price Index (CPI)	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%

SETTINGS

Discount Rate:	5%
IRR Investment Basis:	None
IRR Exit Cap Rate:	None
Base Rent Input:	Monthly Basis
Fiscal Year End:	December
Currency:	US Dollars
Area Measure:	Square Feet

Proposal Input Detail Owner Perspective

711 E Daily Dr - Camarillo Business Center II
Camarillo, CA 93010

DEAL: Proforma Sublease Economics | Suite #105
MODEL: Projected Sublease Terms

DEAL DETAILS

General Comments

Sample proforma economics for new 36 month sublease.

Proposal Cash Flow Owner Perspective

711 E Daily Dr - Camarillo Business Center II
Camarillo, CA 93010

DEAL: Proforma Sublease Economics | Suite #107
MODEL: Projected Sublease Terms

SPACE DETAILS

Use:	Office
Suite:	#105
Rentable SF:	1,303
Useable SF (Core %):	1,215 (7.24%)

LEASE TERMS

Lease Start:	1/1/2018	Free Rent:	1.5 Months ($3,616)
Lease End:	12/31/2020	Service Type:	Full Service (No Pass-Thru)
Term:	3 Years	Operating Exp:	N/A
Starting Rent:	$1.85 / RSF	Commission:	7.00%
Rent Increases:	3% Annual Steps	Improvements:	$1.00 / RSF (Landlord Allowance)

	Year 1	Year 2	Year 3	Total
Base Rent	28,927	28,927	28,927	86,780
Escalations	-	868	1,762	2,629
Free Rent	(3,616)	-	-	(3,616)
Total Base Rent	25,311	29,794	30,688	85,793
Total Rent	25,311	29,794	30,688	85,793
Net Operating Income	25,311	29,794	30,688	85,793
Lease Commissions	5,821	-	-	5,821
Improvement Allowance	1,303	-	-	1,303
Total Other Costs	7,124	-	-	7,124
Cash Flow	18,186	29,794	30,688	78,669
Cumulative Cash Flow	18,186	47,981	78,669	78,669

Proposal Input Detail Owner Perspective

711 E Daily Dr - Camarillo Business Center II
Camarillo, CA 93010

DEAL: Proforma Sublease Economics | Suite #107
MODEL: Projected Sublease Terms

SPACE DETAILS

Use:	Office
Suite:	#105
Rentable SF:	1,303
Useable SF (Core %):	1,215 (7.24%)

LEASE TERMS

Lease Start:	1/1/2018	Free Rent:	1.5 Months ($3,616)
Lease End:	12/31/2020	Service Type:	Full Service (No Pass-Thru)
Term:	3 Years	Operating Exp:	N/A
Starting Rent:	$1.85 / RSF	Commission:	7.00%
Rent Increases:	3% Annual Steps	Improvements:	$1.00 / RSF (Landlord Allowance)

BASE RENT (Full Service (No Pass-Thru))

	Date	Amount		Increase		
Month	Date	$ / RSF	$ / Month	$ / RSF	$ / Month	%
1	1/1/2018	1.85	2,411			
13	1/1/2019	1.91	2,483	0.06	72	3.00
25	1/1/2020	1.96	2,557	0.06	74	3.00

FREE RENT

Lease Month	# of Months	% Free
1	1.5	100%

RECOVERIES

Service Type: Full Service (No Pass-Thru)

TENANT IMPROVEMENTS

	$ / RSF	Amount
Improvement Costs	1.00	1,303
Less: Landlord Contribution	1.00	1,303
Net Cost to Tenant	0.00	0

INFLATION

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Global Inflation	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
Consumer Price Index (CPI)	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%

SETTINGS

Discount Rate:	5%
IRR Investment Basis:	None
IRR Exit Cap Rate:	None
Base Rent Input:	Monthly Basis
Fiscal Year End:	December
Currency:	US Dollars
Area Measure:	Square Feet

Proposal Input Detail Owner Perspective

711 E Daily Dr - Camarillo Business Center II
Camarillo, CA 93010

DEAL: Proforma Sublease Economics | Suite #107
MODEL: Projected Sublease Terms

DEAL DETAILS

General Comments

Sample proforma economics for new 36 month sublease.

AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: December 4, 2017

SUBJECT: Begin Process to Secure Additional Medi-Cal Funds through an Intergovernmental Transfer (IGT)

SUMMARY:

Authorize and direct the Chief Executive Officer to submit a proposal to the California Department of Health Care Services (DHCS) to begin the process to secure additional Medi-Cal Funds through an Intergovernmental Transfer (IGT). The proposal would include a voluntary letter of interest and additional documentation from the funding entity (i.e., Ventura County Medical Center (VCMC) or other appropriate County agency).

BACKGROUND:

Intergovernmental Transfers (IGTs) are a mechanism for Medi-Cal managed care plans, counties and certain types of public hospitals to work with the State of California to bring federal Medicaid matching dollars to the local level.

To accomplish an IGT, a "funding entity" provides funds to the State Department of Health Care Services (DHCS). A funding entity can be counties, cities and State University teaching hospitals, or any other political subdivision of the State, as long as they meet the requirements as defined by 42 C.F.R. Section 433, Subpart B for the funding of IGTs. The federal government then matches those funds according to a set formula. The State uses these combined funds to increase the rates it pays to the local Medi-Cal managed care plan consistent with the Plan's actuarially determined payment rates. The funding entity recoups the original outlay of funds and the federal match to those funds.

DISCUSSION:

The proposed IGT is expected to be structured similar to prior years' IGTs with the added requirement that the ultimate payments must be tied to covered Medi-Cal services for enrolled beneficiaries. An initial transfer of funds from the funding entity to DHCS will be required. The DHCS would then use a portion of these funds to leverage a federal match at the Federal Medical Assistance Percentages (FMAP) rate in effect during Fiscal Year 2017-18. A portion of the funds (20%) would be paid to DHCS as an assessment fee. Subsequently, Gold Coast Health Plan (GCHP or Plan) would receive an increased capitation via a rate amendment to

the Primary Agreement between GCHP and DHCS. The Plan would return the funds received via the increased capitation rate to the funding entity, after withholding an administrative fee (expected to be 2%).

GCHP received a letter from DHCS on November 15th that required the Plan and funding entities to provide the required materials no later than December 14, 2017. GCHP would need to provide the State with a proposal that would include:

- the Plan's contact person, funding entity and participation levels (i.e., expected percentage of dollars to fund); and
- the funding entity's voluntary letter of interest.

The funding entity is also required to submit specified cost data to DHCS by the due date.

FISCAL IMPACT:

The impact to the Plan's FY2017-18 revenue due to the IGT is estimated to be $695,000.

RECOMMENDATION:

Authorize and direct the Chief Executive Officer to provide DHCS with a proposal (including information from the funding entity) to the State of California.

CONCURRENCE:

N/A.

ATTACHMENTS:

None.

AGENDA ITEM NO. 13

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: December 4, 2017

SUBJECT: Chief Executive Officer Update

Continued Diligence on TNE and Healthcare Expenses

As discussed, GCHP continues to monitor health care expenses against revenue as part of our TNE plan. The higher health care expenses are driven primarily by higher provider contract rates. These higher rates allowed GCHP to bring down our reserves to the approved TNE policy levels. However, the Plan must now renegotiate or restructure these rates to maintain appropriate reserves.

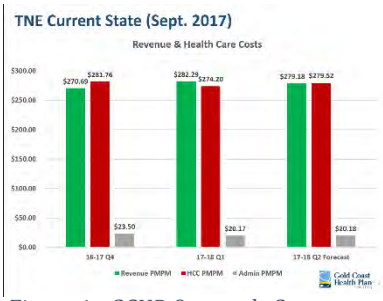


Figure 1 - GCHP Quarterly Summary

GCHP is moving to alternative reimbursement models (APMs) to be consistent with CMS and DHCS direction. We are also assessing contracted out of area tertiary care services, which encompass approximately 21% of the hospital related healthcare expenses. The Plan is also assessing narrow networks for ancillary care services, which could provide preferred pricing.

The executive/finance committee reviewed the current health care expense trends and discussed alternative options for bringing expenses in line with our budgeted MLR. The committee directed to meet monthly for the next six months to review Plan actions.

GCHP in the Community

Oxnard Chamber of Commerce


Figure 2 - Oxnard Chamber health care panel

Last month, the Oxnard Chamber of Commerce, held its annual Oxnard Business Outlook event. Loren Kaye, President of the California Foundation for Commerce and Education was the keynote speaker. Mr. Kaye provided a brief overview of the voter survey recently conducted by the California Chamber of Commerce. The survey revealed that the most pressing issues for Californians were around public roads, jobs, and housing.

The second half of the program was comprised of a panel of local health care experts providing their own insight around the future of healthcare. The panel was comprised by:

- Dale Villani, CEO of Gold Coast Health Plan
- Darren Lee, President and CEO of St. John's Regional Medical Center
- Kelly Bruno, President and CEO of the National Health Foundation
- Adam Cavallero, MD, Assistant Clinical Professor of Medicine at the David Geffen School of Medicine at UCLA

The panel discussed the importance of addressing the social determinants of health, access to care, and universal healthcare.

Federal Update

Children Health Insurance Program (CHIP) Update

Last month, the House passed H.R.3922, the Championing Healthy Kids Act of 2017. The bill would provide a 5-year funding extension for CHIP, but would eliminate the enhanced federal match provided under the Affordable Care Act (ACA). The bill also would eliminate the reductions in Medicaid Disproportionate Share Hospital funding scheduled for FY 2018 and 2019 as well as extend funding for community health centers, the National Health Service Corps and other public health programs. The House bill included a number of funding offsets, including a significant reduction in funds for the Affordable Care Act's (ACA) Prevention and Public Health Trust Fund.

The Senate version of the bill, which has moved out of the Finance Committee, does not include any offsets, and Senate staff continue to discuss potential funding sources for the bill. Because the bill will need 60 votes to pass the Senate, it is unclear whether they will be able to come to an agreement on acceptable offsets; it is likely the final CHIP bill will reflect the Senate Finance Committee version of the bill.

Association of Community Affiliated Plans (ACAP) Board Meeting

In November, ACAP held its quarterly Board/Marketplace meeting. Board members had the opportunity to listen to various experts in health policy discuss current legislative issues and upcoming policy trends for next year. Issues discussed were the following:

- CHIP: The program will most likely will be included in the end-of-the-year omnibus package.
- Buy-In Proposals: Senator Brian Schatz (D-HI) and House Representative Michelle Lujuan (D-NM) introduced S.2001 and H.R. 4129, which would allow individuals to buy-into the Medicaid program. Senator Bernie Sanders (D-VT) introduced S. 1804, which would create a single-payer health care program.
- Medicaid Workforce Requirements: During the National Association of Medicaid Directors meeting, Seema Verma, Administrator for the Center for Medicare and

Medicaid Services (CMS), indicated that the federal government would support states' proposals to impose work or community engagement requirements to their Medicaid program.

- State Flexibility: the National Conference of State Legislatures briefed ACAP plans on the flexibility that 1115 and 1332 waivers provide to states and the possible role these waivers will have in the future.

The Government Relations team will monitor the items discussed above and provide updates in the upcoming year, as new information is available.

State Update

Despite the California Legislature being out of session, committees have held various hearing around universal healthcare coverage and maintaining adequate provider networks. Below is a summary of both hearings.

Universal Coverage Hearings

The Assembly Select Committee on Healthcare Delivery Systems and Universal Coverage held the first two of a series of hearings designed to develop a plan for California to achieve universal coverage.

Committee members heard from various policy experts and academicians on issues ranging from the financing of existing health care markets, California's uninsured population, and models for achieving universal coverage from other countries. The hearings were not intended to deliberate SB 562, the single-payer bill that was held in the Assembly this past legislative session.

The co-chairs of the select committee stated that follow-up hearings would focus on implementation challenges to universal coverage and comparing and contrasting different proposals.

Hearing dates are forthcoming.

Senate Budget Subcommittee on Health and Human Services

The Senate Budget Subcommittee on Health and Human Services held an oversight hearing last month entitled "Achieving and Maintaining Adequate Provider Networks in Medi-Cal Managed Care."

The Chair of the Subcommittee Senator Richard Pan (D-Sacramento) stated in his opening remarks that the purpose of the hearing was to focus on how Medi-Cal managed care plan rates are established and what is done to oversee the adequacy of provider networks. Senator Pan added that with an estimated 80 percent of the Medi-Cal population in managed care, it is critical to monitor how it is working.

Mari Cantwell, Chief Deputy Director of Health Care Programs, Department of Health Care Services was the first witness. Director Cantwell provided an overview of the rate setting process and complimented the success of the standing workgroup that was established to develop rates for the expansion population. She then walked through the Medicaid Final Rules promulgated by the federal government and how she will be responsible for certifying network standards. She went over the network oversight tools and the process that DHCS has in place; including the monthly provider file, technical assistance, and corrective action plans.

The second panel was comprised of Medi-Cal managed care plans. It included representatives from local and commercial plans. The panel explained how health plans develop their networks and how they address network adequacy issues.

The third panel provided a forum for interest groups to discuss the issues they see around provider networks and beneficiary access. Among their issues was a perceived lack of oversight and monitoring for independent practice associations (IPAs). Additional comments were made regarding slow responses to consumer complaints, long appointment wait times, lack of specialty provider types, and translation services.

Senator Pan closed the hearing after public comments and announced that the next oversight hearing will be on mental health.

AGENDA ITEM NO. 14

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Brandy Armenta, Compliance Officer

DATE: December 4, 2017

SUBJECT: Compliance Update

DHCS Annual Medical Audit:

Audits and Investigations (A&I) conducted the annual onsite medical audit during the weeks of June 5, 2017 through June 16, 2017. Gold Coast Health Plan (GCHP) is anticipating a draft report which A&I has confirmed for a release of the report in January 2018.Staff will keep the commission apprised as GCHP receives information.

DHCS Contract Amendments:

The draft DHCS contract amendment (version 2) was sent to Plans in April of 2017. The amendment is still under review by CMS and the Plan is pending the final amendment for signature. The amendment incorporates approximately 156 Mega Reg provisions. Approximately 63 items remained TBD for the State to define and 28 items are TBD and not in the contract amendment. Additional provisions and requirements will be forthcoming via additional contract amendments, all plan letters, policy letters etc. GCHP was required to submit Final Rule (Mega Reg) deliverables to DHCS based on the draft contract amendment in May 2017.

Delegation Oversight:

GCHP is required to monitor functions delegated to all entities who perform a function on behalf of the Plan. Compliance is responsible for ensuring functions in which are delegated are performed in compliance with all applicable regulations and requirements. GCHP monitors delegates through ongoing contractual reporting/monitoring as well as conducting onsite audits. During an onsite audit if a subcontractor does not meet contractual requirements or substantial deficiencies are identified, a six-month onsite follow up audit is conducted. The audit results and report outcomes is a standard report to the GCHP Compliance Committee and Quality Improvement Committee. The information provided below outlines delegation activity conducted by GCHP for calendar year 2017.

DO General Overview

Corrective Action Plans (CAPs) issued CY2017	3
CAPs closed	4
CAPs being monitor	2
Audits Conducted CY 2017	12

Corrective Action Plans (CAPs)

As referenced in the table above, Compliance issued three CAPs during CY 2017. GCHP issued a CAP to Kaiser for failure to meet contractual service level agreement (SLA) of ninety percent (90%) of claims adjudicated within thirty (30) days. As a condition of the CAP, Kaiser was required to provide routine project improvement updates on a monthly basis. Kaiser was able to meet the required SLA and adjudicate over 90% of claims within 30 days for 2 consecutive quarters. GCHP closed the CAP in November 2017.

Compliance issued a CAP to Beacon Health Options (Beacon) after identifying a deficiency in acknowledging paper claims. Beacon was able to remedy the finding by allocating additional resources to claims processing. Beacon demonstrated sustained significant improvements and compliance. Compliance was able to lift the financial sanction imposed on Beacon based on a 2016 audit as well as close out the CAP from 2016 and 2017.

Compliance issued a CAP to VSP in 2015 for failure to comply with the Medi-Cal 'Six-month Billing Limit'. VSP's opposition to the finding subsequently resulted in GCHP contacting the California Department of Health Care Services (DHCS) for interpretation and guidance. DHCS provided its interpretation in support of GCHP and confirmed GCHP is accurate in requesting VSP, who is a downstream entity, to comply with the Medi-Cal 'Six-Month Billing Limit'. VSP was able to correct deficiency and comply with the finding. The CAP was closed in 2017.

Compliance is currently monitoring (2) open CAPs. Ventura Transit System (VTS) was issued a CAP in 2016 for failing to meet a Security Risk Assessment as described under the Business Associates Agreements (BAA). GCHP accepted the proposal by VTS to hire an independent firm to assist them in the assessment and remediation. GCHP continues to work with VTS and the firm through the remediation process. The second CAP open was issued to Conduent after deficiencies were identified during the annual onsite audit. The CAP will remain open until all deficiencies are closed. Staff is working diligently with each delegate to achieve compliance.

Audits Conducted CY 2017

The table below illustrates all of the audits conducted, closed CY 2017 as well as upcoming in January 2018.

Delegate Name	Audit Type	Audit Date	Status
Beacon Health Options	2017 Annual Claims	January 2017	Closed
	2016 Six month Follow-up Claims	May 2016	Closed
	Clinical; QI, UM, RR	February 2017	Closed
Conduent	2017 Annual Claims	April 2017	Open
CHLA	2017 Credentialing	November 2017	Open
Clinicas del Camino Real, Inc.	2017 Annual Claims	November 2017	Open
	2017 Credentialing	January 2017	Closed
	2018 Credentialing	January 2018	Pending
	Clinical; QI, UM, RR	December 2017	Open
Ventura County Medical Center	2017 Credentialing	January 2017	Closed
	2018 Credentialing	January 2018	Pending
Community Memorial Health System	2017 Credentialing	January 2017	Closed
	2018 Credentialing	January 2018	Pending
Vision Service Plan	2017 Claims	December 2017	Open
Ventura Transit Systems	NEMT Annual Audit	January 2017	Open

Pending: Audit(s) are scheduled for a future date and pre-audit letter and material have been sent.
****Open:*** Audit is completed and results are in process.

Privacy Program:

GCHP is required under state and federal laws to notify individuals of any event that compromises the confidentiality of protected health Information ("PHI") and personally identifiable information ("PII"). Any reported privacy incident related to PHI and PII is investigated and determined if any impermissible access, use, or disclosure of confidential information occurred according to the standards under Privacy Program Policy ***HI-020 Privacy Incident Reporting, Investigations, and Mitigation*** and ***HI-025 Breach Determination and Notification***.

The following is a summary of the reported privacy incidents and the outcomes of the investigations by the GCHP Compliance Department during for the 2017 reporting period.

January through September 2017 Privacy Incident Findings

- On average 2.6 incident reports were received a month for the 2017 reporting period.
- 24 privacy incidents were reported, which was an increase of 7 more incidents than the first 3 quarters of 2016.
- A total of 5 privacy incidents were determined to be a breach of unsecured PHI that required notification to members under the HIPAA Breach Notification Rule during the reporting period.
- 22% of the total confirmed privacy incidents for 2017 were breaches of unsecured PHI, which is similar to percentage of breaches for 2016 privacy incidents (16%). (See HIPAA Breach Incidents Compared to Total Incidents Chart)
- Unauthorized Disclosure – Claim Process (57%) is the primary categories for confirmed privacy incidents occurring in 2017. (See Confirmed Privacy Incidents by Incident Category Type Chart)
- Business Associates were the cause of the majority of the confirmed privacy incidents occurring during the reporting period (70%) which is just up from 2016 (60%). (See Privacy Incidents by Source of Privacy Incident Chart)

Privacy Program Continue:

Workstation Security Audits ("Audits") are conducted by the Compliance Department of employee workstations after normal working hours. The Audits are performed to ensure compliance with the standards to safeguard the confidentiality of Protected Health Information ("PHI") and Confidential Information under GCHP Privacy Policy ***HI-019 Workstation Safeguards & Security***.

The following six "Safeguard Compliance Factors" are reviewed during the Audit:

1. PHI/Confidential Records Not Secured – Workstation drawers/cabinets are checked to determine if they are locked, and if unlocked, to determine if PHI/Confidential records are stored in the unsecured drawer/cabinet.
2. PHI/Confidential Info On Desktop – Workstation desktop checked to determine if any PHI/Confidential information is left unattended on desktop which should be secured.
3. Passwords Not Secured – Workstation is checked for any apparent passwords that should be secured.
4. Computer Screen Not Locked – Computer is checked to determine if password is locked or user logged off.
5. PHI/Confidential Info in Trash or Recycle Bin – Workstation trash and recycle bins checked for any PHI/Confidential records that should be secured or placed in locked shred bin for destruction.
6. Laptop/Device Not Secured – Workstations with laptops are checked to determine if the laptop is either taken home or secured to docking station along with any portable devices that should be secured.

Key Performance Indicators (KPI) for Audit:

Employee Audit Score	**90%**	Safeguard Factors Audit Score	**95%**

The following is a summary of the 3rd Quarter 2017 Audit Results for all employees audited:

Total Employee Workstations Audited	108	Total Safeguard Factors Checked	574
Total Employee Workstations Not Passing the Audit	5	Total Safeguard Factors with Compliance Deficiencies	6
Employee Audit Score	**95.4%**	Safeguard Factors Audit Score	**99.0%**

Actions Taken in Response to Audits

- Full results of each department's Audit communicated to department management including any recommendations for improvement.
- All employees audited received a Workspace Security Walkthrough Label that either listed they maintained a "secure workspace" or they were given a notice of which Safeguard Compliance Factor was found out of compliance during the audit for immediate feedback.
- Reoccurring issues found may result in department corrective actions or employee sanctions as necessary.

Privacy Incident Reporting & Investigations Summary

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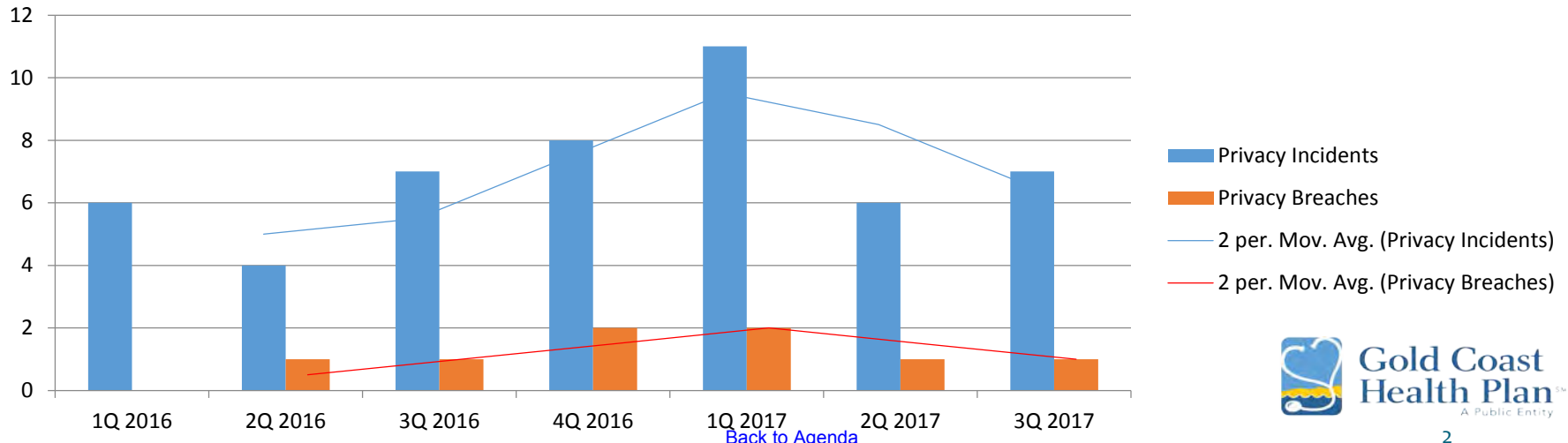
Summary of Total Privacy Incidents 2016 - 2017

	2016					2017				
	1Q	2Q	3Q	4Q	Total	1Q	2Q	3Q		Total
Total Privacy Incidents Reported	6	4	7	8	25	11	6	7		24
Total Privacy Incidents Requiring Breach Notification	0	1	1	2	4	2	2	1		5



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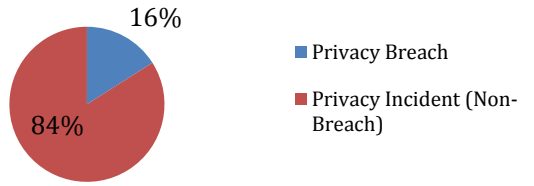
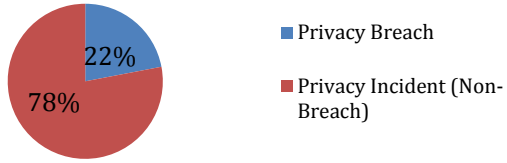
Summary of Privacy Incidents Reported and Investigated in 2017

	Privacy Incidents Reported	Incidents Reported to DHCS	Confirmed Privacy Incidents	Privacy Incidents Involving PHI	HIPAA Breach Notification	Number of Members Notified
January	6	6	6	6	2	2
February	2	2	2	2	0	0
March	3	3	3	3	0	0
April	1	1	1	1	0	0
May	3	3	3	3	1	1
June	2	2	2	1	1	1
July	5	5	5	5	1	1
August	1	1	1	1	0	0
September	1	1	0	0	0	0
2017 Totals	24	24	23	22	5	5

2016 HIPAA Breach Incidents Compared to Total Confirmed Privacy Incidents



2017 HIPAA Breach Incidents Compared to Total Confirmed Privacy Incidents

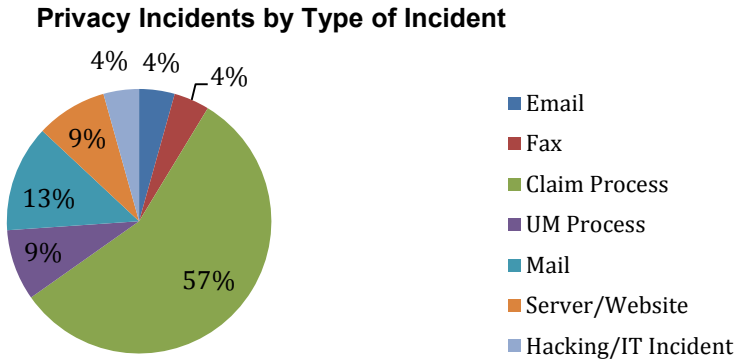


[1] Confirmed Privacy Incidents are incidents that after investigation were determined to be unauthorized access, use, or disclosures of confidential information.

[2] Breach determinations and notifications for PHI incidents are required to be conducted within 60 days from the discovery date to notify individuals. Because of this, data reported on privacy breaches may change from month to month.

2017 Confirmed Privacy Incidents by Incident Category Type

	Unauthorized Disclosure – Email/Fax Error	Unauthorized Disclosure – Fax Error	Unauthorized Disclosure – Claim Process	Unauthorized Disclosure – UM Process	Unauthorized Disclosure – Mail/Postal Service	Unauthorized Disclosure – Authorization Required	Unauthorized Disclosure – Server/Website	Hacking/IT Incident
January	0	0	3	1	0	0	2	0
February	0	0	2	0	0	0	0	0
March	0	0	3	0	0	0	0	0
April	0	0	1	0	0	0	0	0
May	1	0	1	1	0	0	0	0
June	0	0	0	0	1	0	0	1
July	0	0	3	0	2	0	0	0
August	0	1	0	0	0	0	0	0
September	0	0	0	0	0	0	0	0
2017 Totals	1	1	13	2	3	0	2	1



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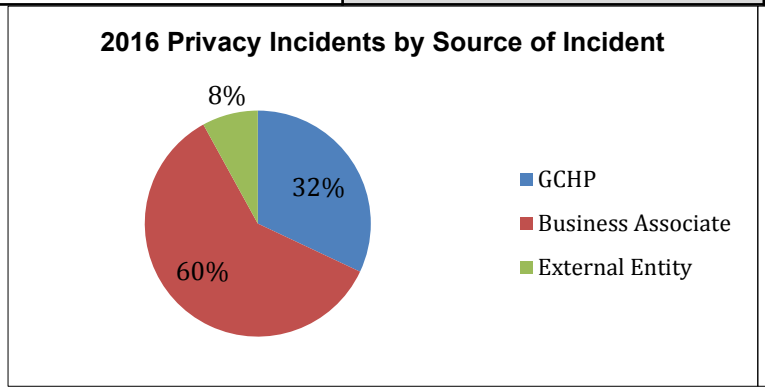
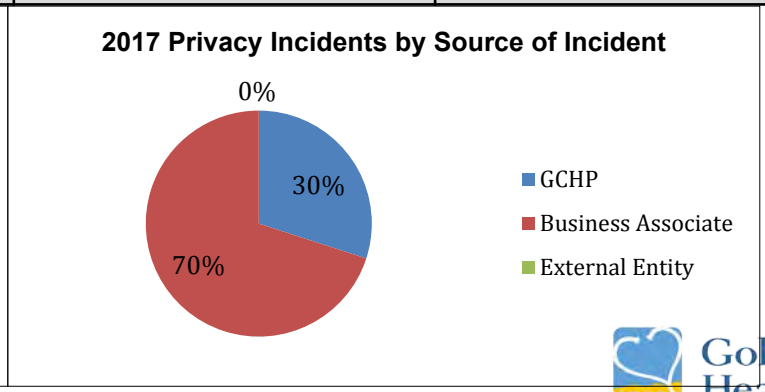
2017 Confirmed Privacy Incidents by Source of Privacy Incident

	GCHP Incidents	Business Associate Incidents	External Entity (No BA relationship)
January	1	5	0
February	0	2	0
March	0	3	0
April	0	1	0
May	2	1	0
June	1	1	0
July	2	3	0
August	1	0	0
September	0	0	0
Totals	7	16	0





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Workstation Privacy Safeguards Audit Program

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Workstation Privacy Safeguards Audit Program

Workstation Security Audits ("Audits") are conducted by the Compliance Department of employee workstations after normal working hours. The Audits are performed to ensure compliance with the standards to safeguard the confidentiality of Protected Health Information ("PHI") and Confidential Information under GCHP Privacy Policy ***HI-019 Workstation Safeguards & Security***.

The following six "Safeguard Compliance Factors" are reviewed during the Audit for each workstation:

1. PHI/Confidential Records Not Secured
2. PHI/Confidential Info On Desktop
3. Passwords Not Secured
4. Computer Screen Not Locked
5. PHI/Confidential Info in Trash or Recycle Bin
6. Laptop/Device Not Secured

Key Performance Indicators (KPI) for Audit:

Employee Audit Score	**90%**	Safeguard Factors Audit Score	**95%**

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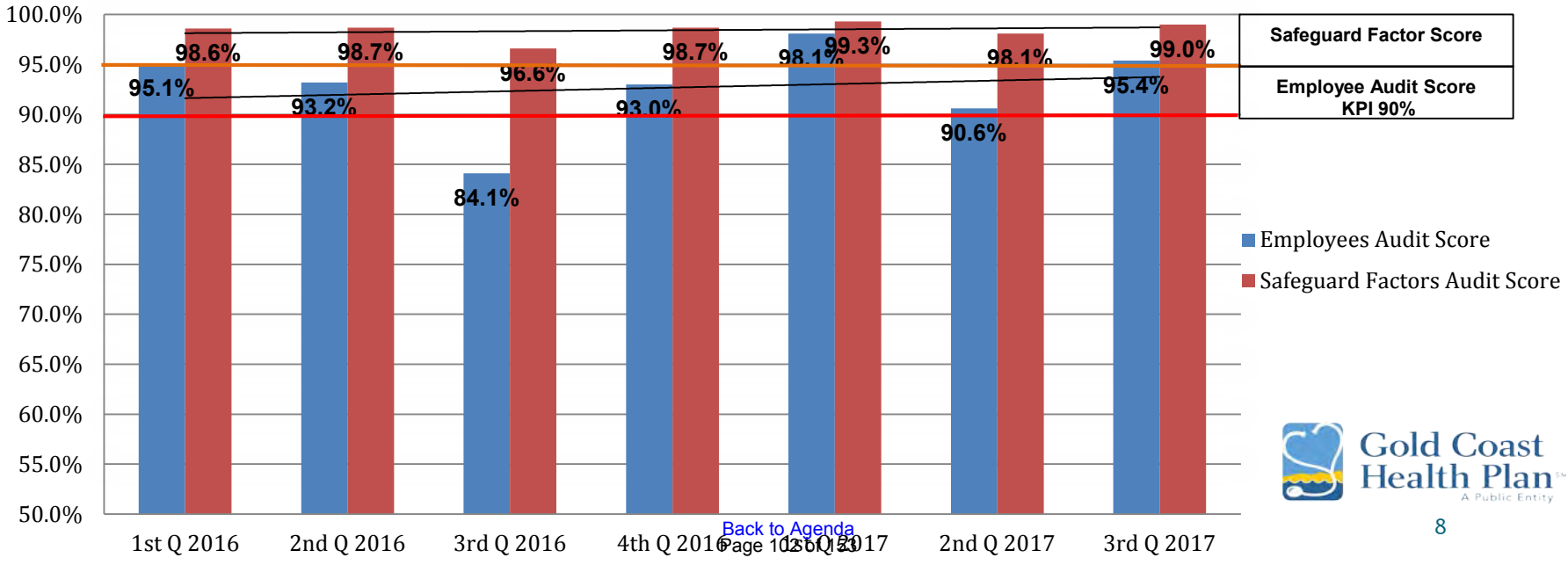
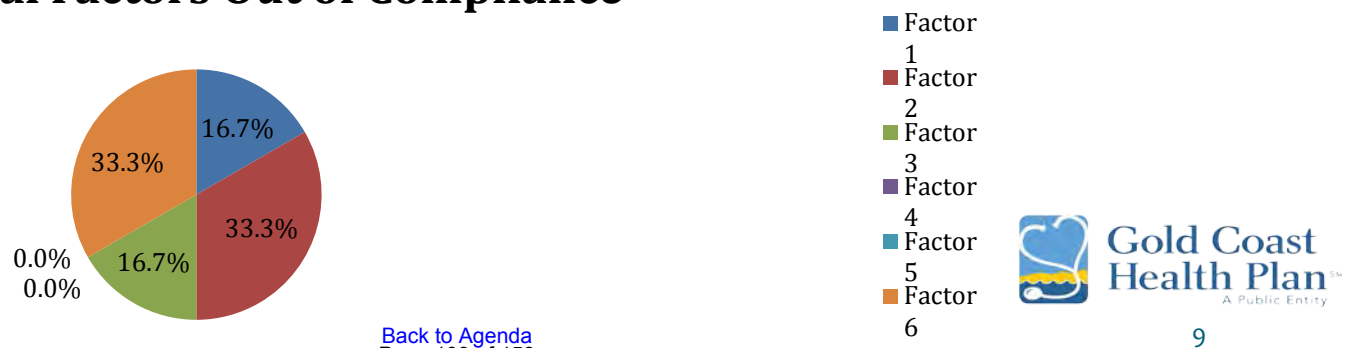
Workstation Audit Summary Results 2016 -2017

	1st Q 2016	2nd Q 2016	3rd Q 2016	4th Q 2017	1st Q 2017	2nd Q 2017	3rd Q 2017
Employee Audit Score	95.1%	93.2%	84.1%	93.0%	98.1%	90.6%	95.4%
Safeguard Factors Audit Score	98.6%	98.7%	96.6%	98.7%	99.3%	98.1%	99.0%



Summary of Workstation Audit Factors
3rd Quarter 2017 Audit Results

Audit Factor	Total Factors Audited	Total Factors Out of Compliance	Safeguard Factors Audit Score
Factor 1 PHI/Confidential Records Not Secured	108	1	99.1%
Factor 2 PHI/Confidential Info on Desktop	108	2	98.1%
Factor 3 Passwords Not Secured	108	1	99.1%
Factor 4 Computer Screen Not Locked	108	0	100%
Factor 5 PHI/Confidential Info in Trash or Recycle Bin	108	0	100%
Factor 6 Laptop/Device Not Secured	34	2	94.1%



AGENDA ITEM NO. 15

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: December 4, 2017

SUBJECT: Chief Operating Officer Update

OPERATIONS UPDATE

Membership Update

Gold Coast Health Plan (GCHP) membership is a product of Ventura County residents who are eligible for Medi-Cal and who choose to sign up for our plan. Membership is fluid, as people must re-determine each year, move in and out of the county, become ineligible based on income or move to Medi-Cal fee for service.

As of November 1, 2017, Gold Coast Health Plan's (GCHP's) total membership was 200,584. The Plan experienced a net loss of 1,590 members over the previous month. We attribute the loss to the following potential impacts:

- Lack of redeterminations;
- Movement of members out of the county;
- Increases to income rendering member ineligible for plan participation.

AB 85 Auto Assignment- State Assembly Bill 85 (AB 85) requires that the Plan assign 50% of new Adult Expansion (AE) members who have not chosen a PCP within 30-days of enrollment to the County Public Hospital System, VCMC. In the month of November, GCHP assigned 401 new members to VCMC, while the remaining 402 new members were assigned to providers in compliance with the VCMMCC Auto Assignment policy (MS-005). VCMC has 29,959 AE members assigned as of November 1, 2017. VCMC's target enrollment, as established by DHCS, is 65,765 and is currently at 45.56% of the target.

Monthly Adult Expansion (AE) Membership Lookback (by aid code)

	L1	M1	7U	7W	7S	Total
Nov 17	402	55,311	22	7	78	55,820
Oct 17	421	55,993	25	7	82	56,528
Sep 17	432	56,042	32	7	84	56,597
Aug 17	447	56,028	58	14	87	56,634
Jul 17	464	55,407	80	30	94	56,075

Jun 17	484	55,462	83	31	91	56,151
May 17	505	55,331	92	35	113	56,076
Apr 17	520	55,333	94	44	163	56,154
Mar 17	560	55,539	100	48	210	56,457
Feb 17	590	55,667	113	55	243	56,668
Jan 17	646	55,551	141	50	203	56,591
Dec 16	695	55,820	521	123	240	57,399

Member Orientation Meetings

One Hundred and thirty-five (135) total members (83 English, 23 Spanish) attended Member Orientation meetings between January and October 2017. Of the 135 members, 65 indicated they learned about the meeting through the informational flyer included in each new member packet.

Other methods of notification included:

- Website
- TCRC
- HSA
- MICOP

Claims Update

Claims Inventory represents the number of claims received during the month. Claims Inventory for October is 182,684. This equates to a Days Receipt on Hand (DROH) of 2.436 days in October compared to a DROH maximum goal of 5 days. October is reflecting a decrease in DROH over the previous month. GCHP received an average of 8,304 claims per day in October.

Monthly Claims Receipts

Month	Total Monthly Claims Received	Average Daily Claims Receipts
October 2017	182,684	8,304
September 2017	174,104	8,705
August 2017	206,314	8,970
July 2017	167,905	8,395
June 2017	183,581	8,345
May 2017	200,595	9,118
April 2017	164,613	8,231
March 2017	208,407	9,061
February 2017	171,343	9,018
January 2017	168,660	8,433
December 2016	190,686	9,080
November 2016	170,209	8,510

Claims Processing Results – Conduent has several Service Level Agreements (SLAs) in place with GCHP to ensure that claims processed meet the minimum state and generally accepted service levels for claim processing. GCHP measures three (3) SLAs for claim processing:

- **Claims Turnaround Time (TAT) -** The number of days needed to process a claim from date of receipt to date of determination. The target is determination of 90% of original clean claims processed within 30 calendar days of receipt.
- **Financial Claims Processing Accuracy-** Percentage of correct payments against the total payments made in a month. The target is ≥ 98%
- **Procedural Claims Processing Accuracy-** The number of claims without any procedural errors (non-financial) against the total number of claims processed. The target is ≥ 97%.

Conduent met all claim SLAs for the month of October.

Monthly Claims SLA Performance

Month: October		
Service Level Agreement	**Expected Outcome**	**Actual Outcome**
Claim Turnaround Time	90%	99.20%
Financial Claims Processing Accuracy	98%	99.90%
Procedural Claim Processing Accuracy	97%	99.86%

Claims Denials rate is 13.87% of total volume, which is within industry expectations.

Top Claims Denial Reasons

- Service is included in Monthly Capitation per contract with provider
- Duplicate line item
- Primary Carrier EOB Required
- Charges incurred after term date
- Denied base on system edit
- Services are the financial responsibility of Clinicas

Encounter Update

Encounter Data Quality Summary– GCHP collects monthly encounter data, which we submit to DHCS. These data determine, in part, the rates GCHP receives from the state to manage member care. GCHP measures three (3) aspects of encounter data on a monthly and quarterly basis:

- **Submitted** – the total number of encounter records submitted to GCHP each month.
- **Errors** – the total number of encounters submitted with invalid data such as formatting, errors, utilization of out of date coding or missing data.
- **Percent of Errors** – the number of errors divided by the total number of encounters submitted.

Monthly Encounter Data

Month: October			
Encounter Type	**Submitted**	**Errors**	**% of Errors**
Professional	92,666	1,721	1.9%
Institutional	70,506	605	0.9%
Pharmacy	143,621	2,918	2.0%
Total	**306,793**	**5,244**	**1.7%**

Reasons for the errors include:

- Not Valid code
- Duplicate encounter
- No Medi-Cal eligibility
- Procedure date
- Admission date

Note: SLAs do not apply to encounter data.

Call Center Update

Call Center Results – Conduent is responsible for taking level one calls from members and providers. The volumes reported reflect only Conduent call data. Additional calls are taken by the GCHP member services team, which includes calls routed from Conduent, considered escalated or second level calls, calls from providers and members directly to the GCHP member services team and any calls to members or providers who request a call back from the GCHP member services team. Conduent has three (3) call queues: provider, member (English), member (Spanish).

GCHP monitors and reports on two (2) specific areas that help identify the Conduent Call Center work effort:

- **Call Volume** – Call volume measures the number of calls taken in a month's time. October call volume was 12,950.

- **Average Call Length** – Call length measures the amount of time a call center representative spends on a call with a member or provider. Call length is a function of the call type and may be shorter or longer depending on the type of call and type of caller. GCHP measures the average call length only as an indicator of how long the call center representatives are spending with our callers. October average call length was 6.54 minutes per call.

GCHP currently has three (3) SLAs that measure Conduent's call center efficacy on a monthly basis. Conduent met all one (1) of three (3) targets in the month of October.

- **Average Speed to Answer (ASA) –** The number of seconds a caller waits in a queue until the call is answered by a call center representative.
  - Target – ≤30 seconds
- **Abandonment Rate –** Abandonment rate measures the percentage of calls disconnected by a caller prior to the call being answered by a Customer Service Representative.
  - Target - ≤ 5%.
- **Call Center Call Quality** – Conduent and GCHP staff work collaboratively to calibrate selected calls each week and use a standardized scoring tool to measure the percentage of calls answered accurately.
  - Target - 95% or higher.

Monthly SLA Performance

Month: October		
Service Level Agreement	**Expected Outcome**	**Actual Outcome**
Average Speed To Answer	≤30 seconds	203 sec
Abandonment Rate	≤5%	10.86%
Call Center Call Quality	≥95%	95.06%

Average Speed to Answer exceeded 30 seconds in the month of October. Conduent expressed the following as contributing factors to the missed SLAs

- A 40% decrease in staff coupled with a hiring freeze;
- Increased call volume;
- Increased talk time related to member call due to additional information requirements;

GCHP is working closely with Conduent leadership regarding the impacts to the SLAs and has identified staffing attrition and increased talk time as root causes. Conduent has hired and trained five new agents, who are taking calls. Performance levels for these trainees will be low until they complete their training period. During this training period, Conduent has

taken an “all hands on deck” approach to engage supervisors, trainers and additional internal resources to take calls in an effort to insure that member and provider needs are met.

GCHP will continue to work with Conduent to improve Call Center performance for quality, timeliness and accuracy.

Grievance and Appeals Update

Conduent is responsible for responding to level one Provider Dispute Resolution (PDR) requests when providers disagree with the manner in which a claim was processed. GCHP manages all first level member appeals should a member submit an issue regarding a claim payment or denial, provider access or any other situation the member has experienced. Should the member or provider choose to continue to a second level action, those requests are resolved by GCHP. The Grievance and Appeals team at GCHP also processes any clinical appeals in conjunction with the GCHP Health Services team.

GCHP received two (2) clinical appeals for the month of September. Both of the clinical appeals were overturned.
During September, GCHP attended four (4) State Fair Hearing cases. One (1) was withdrawn, and three (3) were dismissed.

GCHP received 23 member grievances and 233 provider grievances in the month of September. Member grievances equate to 0.11 grievances per 1,000 members, with a slight increase in the last three months.

Monthly Member Grievances

Month: September	
Type of Member Grievances	**Number of Grievances**
Accessibility	1
Benefits	3
Denials/Refusals	1
Quality of Care	16
Quality of Service	2
Total Member Grievances	**23**

Note: G&A results are reported 2 months in arrears

GCHP received 23 Quality of Care member grievances, which consisted of the following issues:

- Delay of Care
- Poor provider/staff attitude

NETWORK OPERATIONS UPDATE OCTOBER 2017

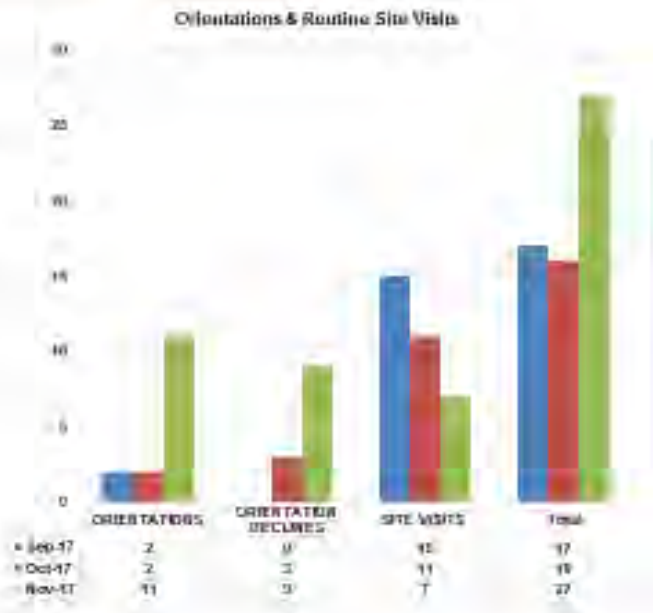
A. PROVIDER SITE VISIT RESULTS

Provider Site Visits and Orientations

Provider Relations Representatives perform Orientations with newly GCHP contracted Providers and routinely visit provider offices. These visits create opportunities for providers to ask questions and for the representatives to deliver current information and materials. Visits may be pre-scheduled at the providers request to discuss specific issues or concerns and may include representation from other GCHP business areas.

Delegated groups are responsible to provide Orientation with new providers within ten (10) days of the providers effective date of hire.

A total of 12 physician's declined Orientation in Q3 due to joining an established contracted group with GCHP. Established groups participated in previous Orientations therefore are familiar with GCHP policies and procedures.



- Orientations: 14 new provider orientations were conducted by GCHP Provider Relations Staff over the last 3 months. This figure is up approximately 33% from the previous quarter.

- 12 Physicians declined orientation during this reporting period due to joining an established contracted group with GCHP. Established groups such as delegated providers have participated in previous orientations; they are familiar with GCHP policies and procedures and have the staff and capability to perform the orientation function on their own.

- Site Visits: 33 provider site visits were completed by Network Operations-Provider Relations staff. This figure is up approximately 167% from the previous quarter as we have re-filled a provider relations position and returned to our standard visit goal of 40 visits per month.

B. KEY PROJECTS:

1. MANAGED CARE PROVIDER DATA IMPROVEMENT PROJECT (MCPDIP) 274-UPDATE

- Three (3) new enhancements provided by the state will be put into production for the February 2018 submission to the state. We are on schedule to meet this timeline.

2. SB 137 PROVIDER DIRECTORIES

- Network Operations has completed all SB 137 updates to the printed directory for the upcoming 12/30 pull.

3. PROVIDER NETWORK DATA BASE & CREDENTIALING SYSTEM RFP

The Plan has conducted a Request for Proposal (RFP) and is in the process of vendor selection for the purchase and implementation of a tool to improve the management of provider data, contracting and credentialing functions. The Plan's existing provider database management (PDM) tool is an in-house solution with limited functionality and scalability requiring significant manual intervention. The vendor tool will provide automation to improve data base accuracy, create process efficiency and support state and federal regulatory requirements. Staff will present a request for approval to the Commission by the 3rd quarter of Fiscal Year(FY) 2018. Current procurement status is as follows:

- Determination of high level pricing estimates
- Statement of work
- Business requirements development
- Contract review

C. PROVIDER ADDS & TERMINATIONS- September 15, 2017- October 31, 2017

Provider Adds: 50

- **Hospitals: 0**

- **Providers**: **45**
  - PCPs & Mid-levels: 14
  - Specialists 27
  - Hospitalists: 4
- **Ancillary: 5**
  - Occupational Therapy: 1

- Physical Therapy: 1
- Radiology: 2
- Speech Therapy:1

Provider Terms: 15

- Ambulatory Surgery Ctrs:1 **Impact:** None. 8 ASC's contracted Term due to failure to submit re-credentialing documentation.
- Hospitalist: 1 **Impact:** None. This provider terms was from a tertiary center in LA.
- PCP's and Mid-Levels: 5 **Impact:** Small. Terms mainly due to provider terms from 3 main clinics.170 FP's, 48 peds and 36 IM PCP's remain actively contracted. Number excludes mid-levels.
- Specialists: 8 **Impact:** None: Terms due to provider clean-up and Physicians re-locating.

D. CONTRACTING AND PROVIDER RELATIONS:

- Finalizing contracts with:
  - 1 major orthopedic provider group in county
  - 2 urgent care centers in county
  - 1 Ambulatory Surgery Center
- Joint Operations meetings with:
  - Home Health providers
  - CMH
  - VCMC (12/1)
  - Clinicas del Camino Real
- Process Improvement Initiatives
  - Better mapping with our geo-access reporting system to meet new regulatory access requirements
  - Coordinated meetings with operations to determine claims root cause issues to reduce claims adjustments and interest payments

E. VALUE BASED INITIATIVES:

- Camarillo Health Care District Transition of Care Program: Program initiated 8/1/2017

  The pilot is designed to enhance 30 to 90 day care transition interventions to members discharged from Community Memorial Health System ("CMHS"). Each member will receive an inpatient visit from a transitional health coach, one to three home visits and weekly check-in calls following each visit. Additionally, pilot staff will collaborate with and offer support to the home health agencies and other community health partners involved in the care of the member post discharge.

  It is the goal of this this pilot to keep the targeted population of members out of the emergency room and help avoid hospital re-admissions when possible. This pilot allows both Gold Coast Health Plan and provider to address the broader aspect of a member's care, not only for medical conditions, but also for day-to-day improvement of functional abilities, cognitive status and social supports that will allow a member to thrive at home and in the community.

- Signed new Amendment for renewal of Asthma Pilot Program with County of Ventura. Effective 10/1/2017

  This initiative is designed to manage asthma for Members identified as high risk, so the member or parents/caregivers can reduce the frequency of uncontrolled asthma attacks, avoid unnecessary trips to the emergency room, and reduce the number of hospital admissions for a member at high risk for uncontrolled asthma. It is the intent of this pilot program to provide adult and pediatric Members and caregivers with this knowledge through an in-home assessment and asthma education program for High Risk Asthma Members and parents/caregivers. Given the success of the initial pilot the program has been expanded to include up to an additional 10 members or 60 total Members.

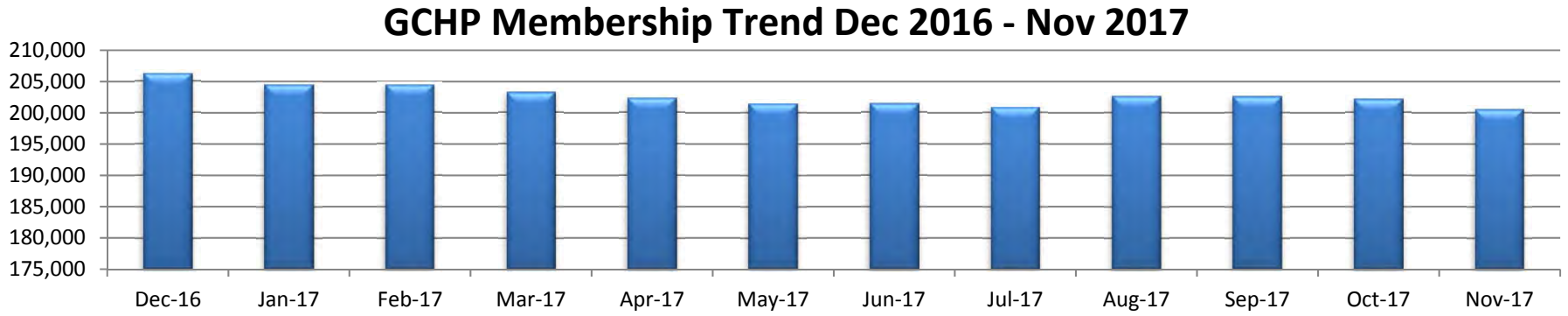
- Working with Ventura County Medical Center (VCMC) to implement CA 1115 Waiver- Public Hospital Redesign and Incentives in Medi-Cal PRIME project and metrics protocols.

  - Five (5) year grant by DHCS
  - DHCS has committed that 60% of all Medi-Cal managed care beneficiaries will receive a portion of their care through systems paid under alternative payment methodologies by the end of the demonstration period in 2020.
  - Evaluating key target metrics
  - Contract discussions in process

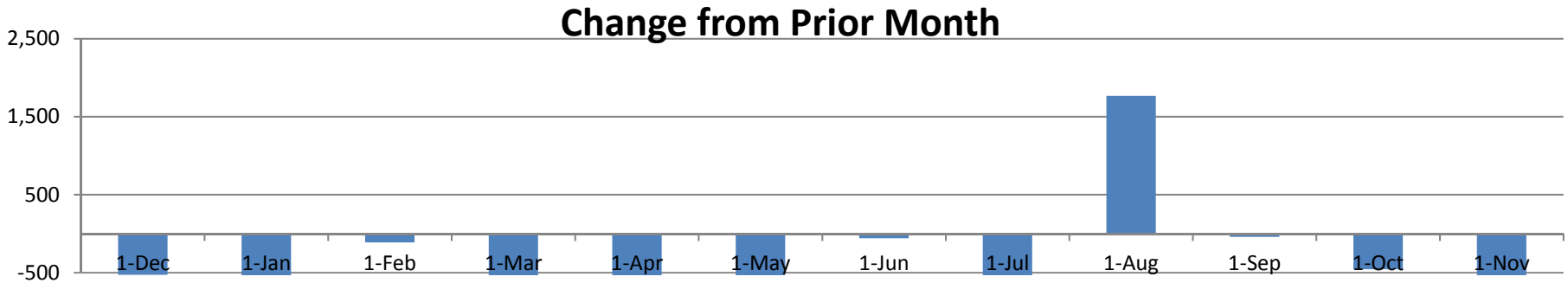
GCHP Membership

Total Membership as of Nov 1, 2017 – 200,584

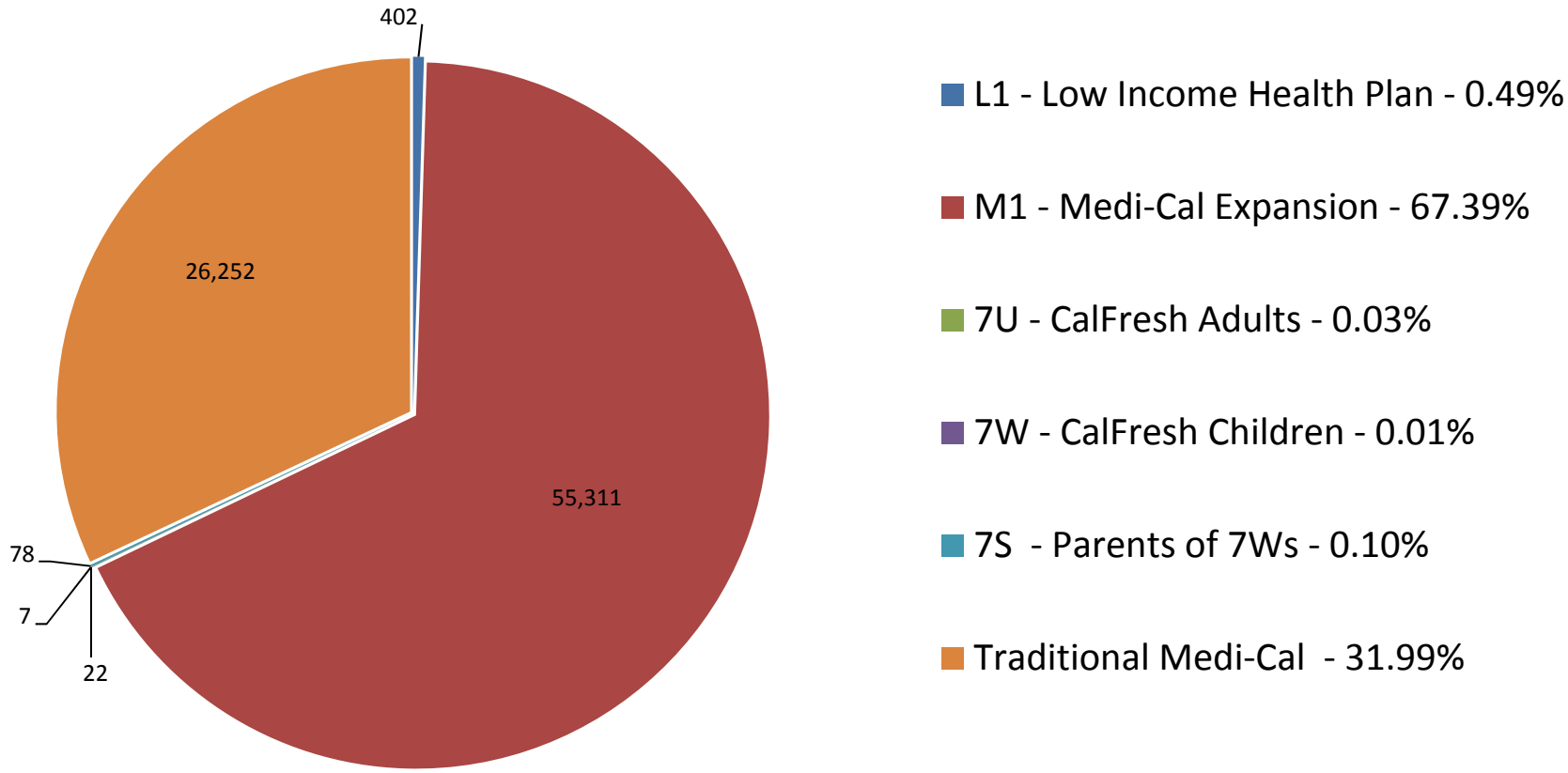
*New Members Added Since January 2014 – 82,072



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Active Membership	206,252	204,529	204,417	203,243	202,338	201,514	201,455	200,903	202,670	202,630	202,174	200,584

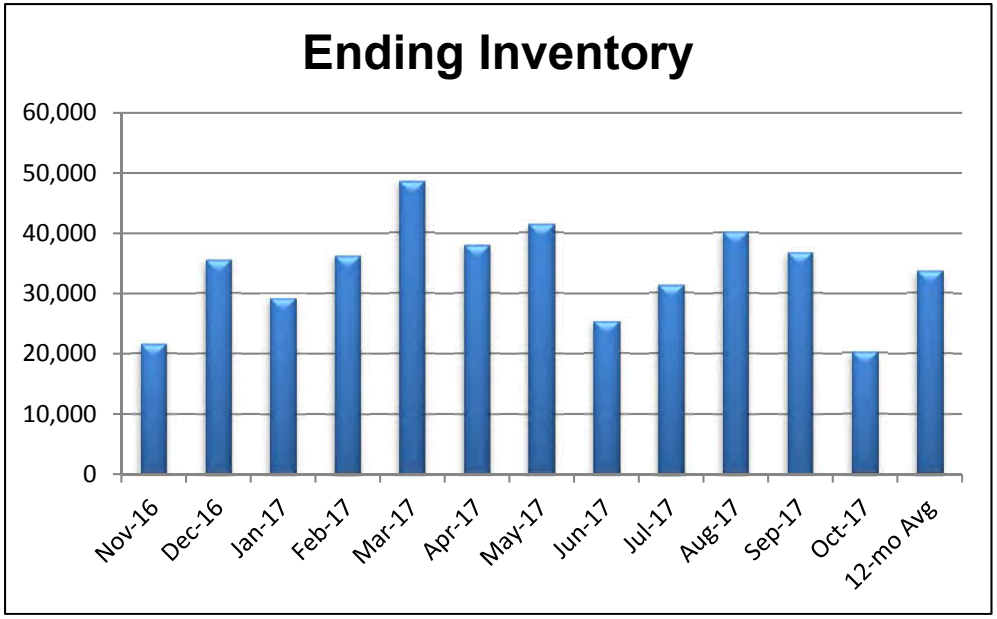


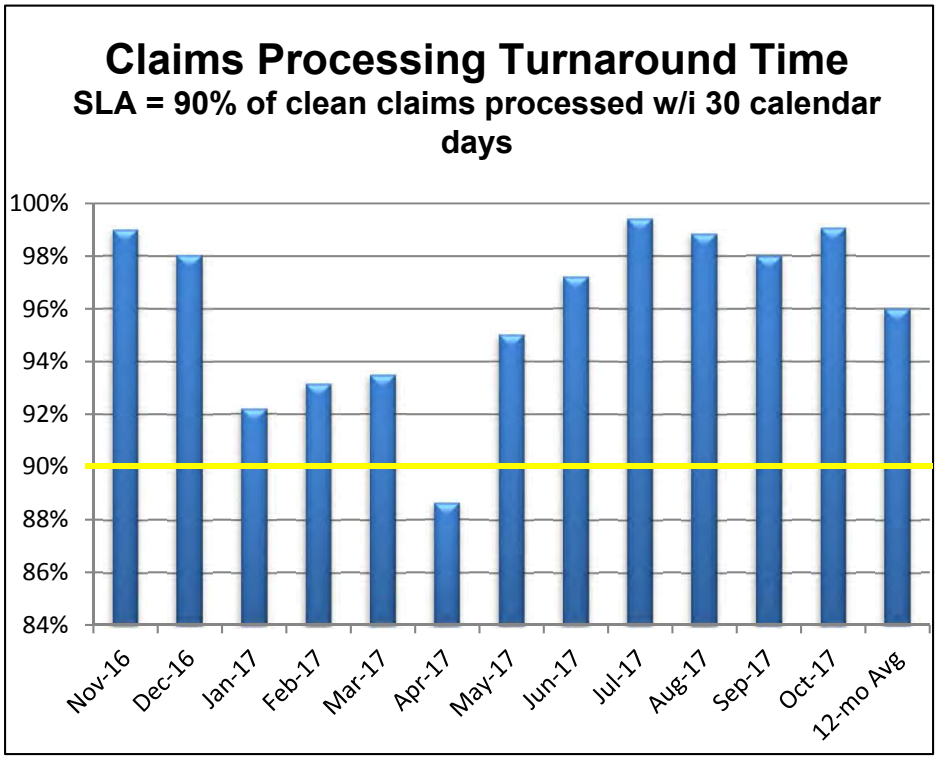
Membership Growth

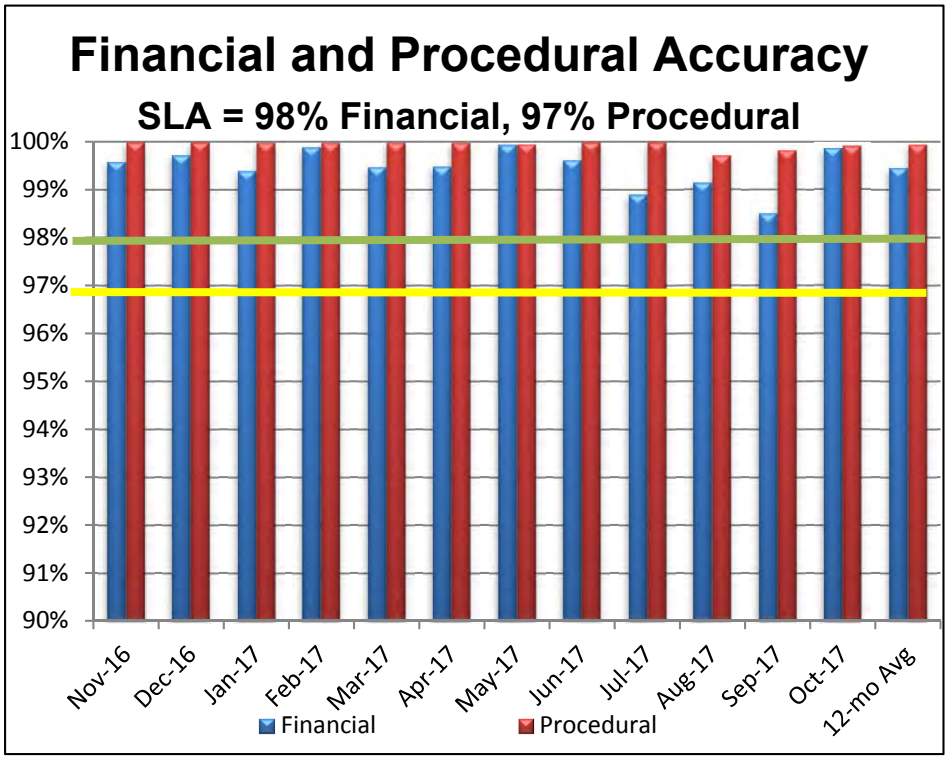


GCHP Claims Metrics – October 2017

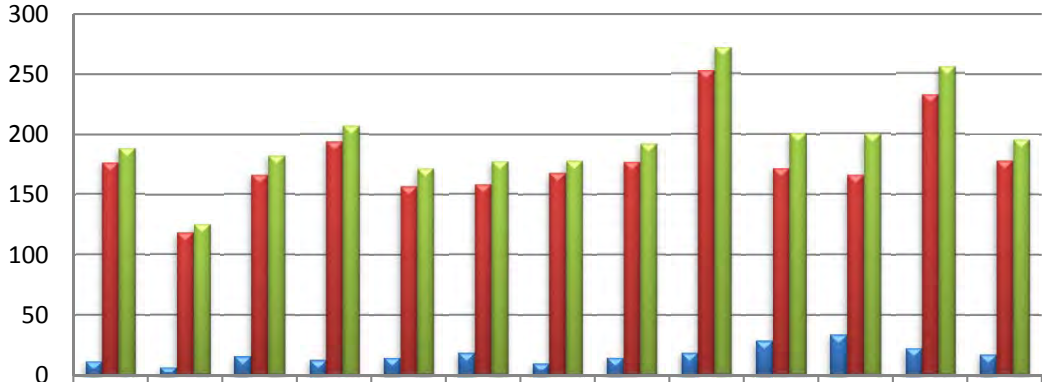
- The 30 Day Turnaround Time (TAT) was compliant with the expected service level. 99.05% of clean claims were processed timely with the minimum requirement at 90%.
- Ending Inventory was 20,230 which equates to a Days Receipt on Hand (DROH) of 2.44 days vs a target DROH ≤ 5 days
- Service Level Agreements (SLAs) for Financial Accuracy (99.86%) and Procedural Accuracy (99.90%) were both met in October







Total Grievances per Month

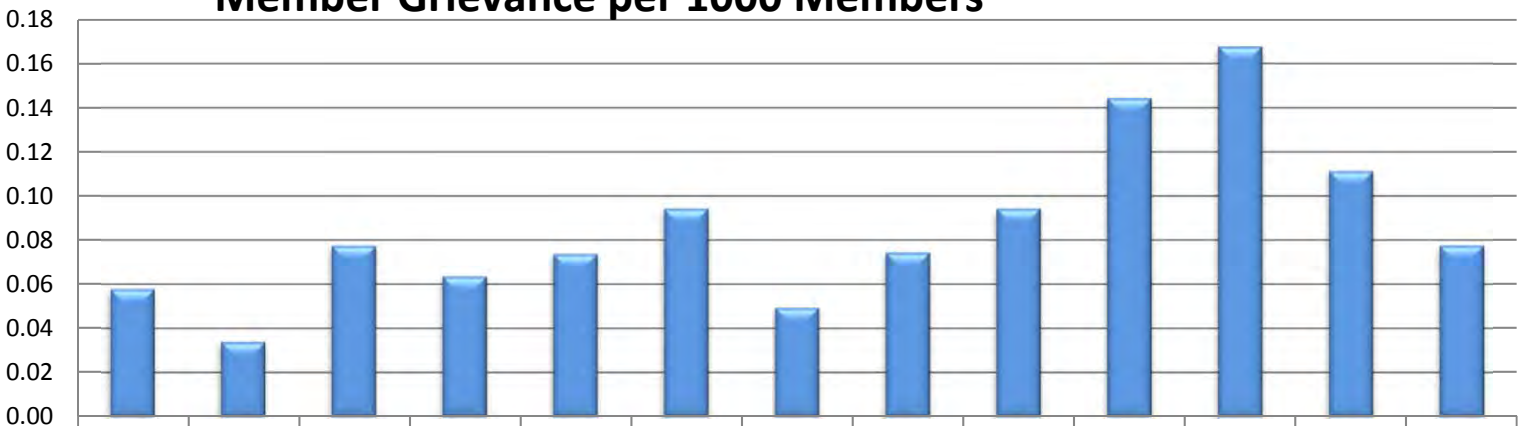


	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	12-mo Avg
Member	12	7	16	13	15	19	10	15	19	29	34	23	18
Provider	176	118	166	194	157	158	168	177	253	172	166	233	178
Combined	188	125	182	207	172	177	178	192	272	201	200	256	196

GCHP Grievance & Appeals Metrics – Sept. 2017

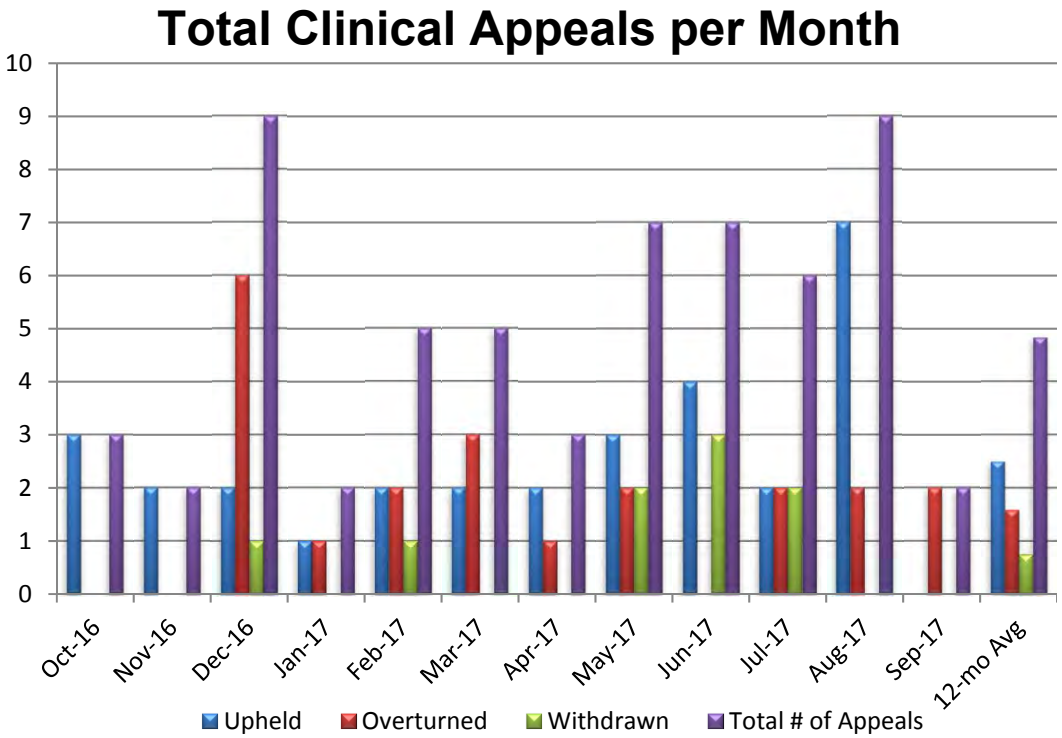
- GCHP received 23 member grievances (0.11 grievances per 1,000 members) and 233 provider grievances during September 2017
- GCHP's 12-month average for total grievances is 178
  - 19 member grievances per month
  - 196 provider grievances per month

Member Grievance per 1000 Members



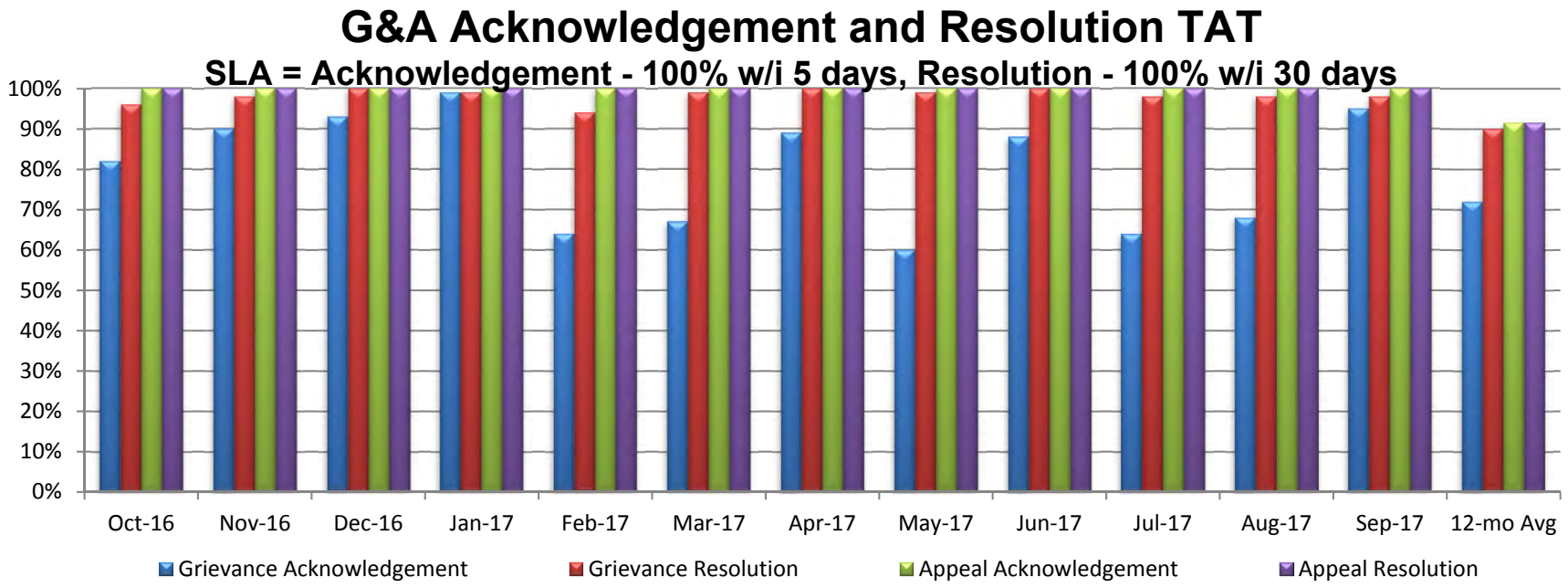
	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	12-mo Avg
# of Grievance per 1000 Members	0.06	0.03	0.08	0.06	0.07	0.09	0.05	0.07	0.09	0.14	0.17	0.11	0.08

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	12-mo Avg
Membership Count	207,188	206,780	206,252	204,529	203,243	201,514	202,338	201,514	201,455	200,903	202,670	206,672	186,532
Total Member Grievances Filed	12	7	16	13	15	19	10	15	19	29	34	23	16
# of Grievance per 1000 Members	0.06	0.03	0.08	0.06	0.07	0.09	0.05	0.07	0.09	0.14	0.17	0.11	0.08



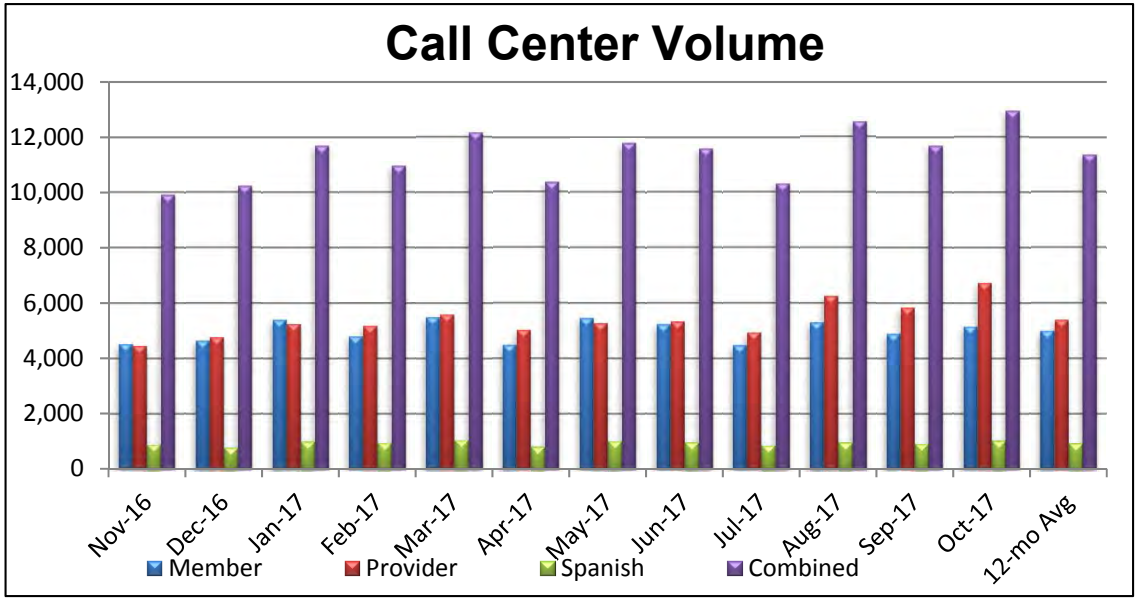
GCHP Grievance & Appeals Metrics – September 2017

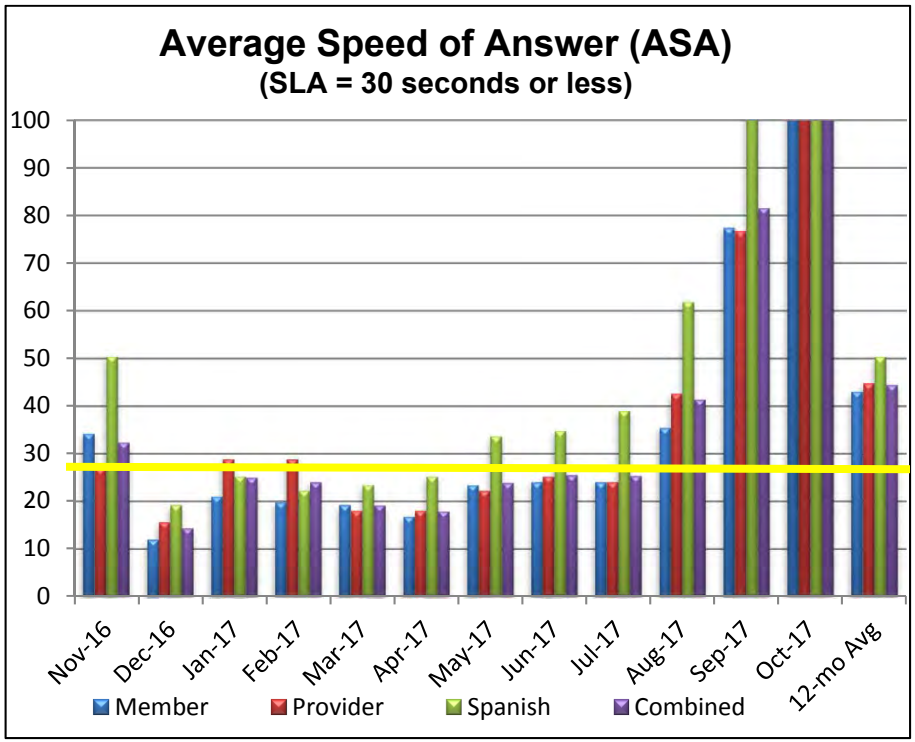
- GCHP had 2 clinical appeals in Sept; The 2 reported were Overturned
- TAT for grievance acknowledgement was at 95%
- TAT for grievance resolution was at 98%
- TAT for appeal acknowledgement and resolution were compliant at 100%.
- 4 State Fair Hearings were reported in Sept 2017, 1 was Withdrawn and 3 Dismissed

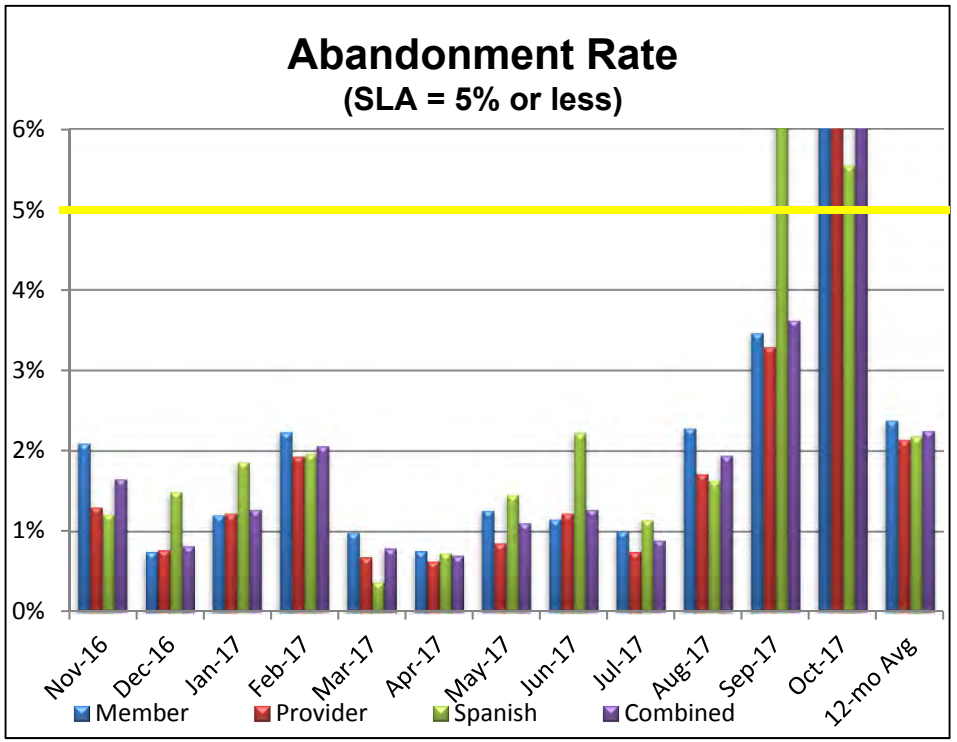


GCHP Call Center Metrics – Oct 2017

- Call volume remained above 10,000 during the month; GCHP received 12,950 calls during October
- Service Level Agreements (SLA) for ASA (202.8 seconds vs the contractual requirement of ≤ 30 seconds) and Abandonment Rate (10.86% vs the contractual requirement of ≤ 5%) ASA and Abandonment Rate were not met for October







Gold Coast Health Plan
Weekly Claims Processing Dashobard
July 5, 2017 - Oct 25,2017

	07/05/17	07/12/17	07/19/17	07/26/17	08/02/17	08/09/17	08/16/17	08/23/17	08/30/17	09/06/17	09/17/17	09/20/17	09/27/17	10/04/17	10/11/17	10/18/17	10/25/17
Corrective Action Plan Tracking																	
CAP Reference																	
3c - Percentage of Claims Denied (1)	12.07%	14.99%	12.08%	12.64%	11.85%	13.14%	12.64%	15.25%	16.44%	12.56%	13.65%	15.81%	12.86%	13.67%	12.86%	13.30%	12.81%
3e - Number of Claim Adjustments (2)	586	1,000	1,041	1,035	942	1,028	1,411	1,375	1,110	901	1,195	971	918	1,368	1,880	1,011	968
3f - Number of Claims Processing FTEs (3)	44	44	44	43	43	43	42	42	41	40	40	40	39	42	40	39	40
3g - Auto Adjudication Rate (4)	50.56%	40.10%	57.45%	52.78%	55.12%	53.40%	49.71%	53.04%	50.83%	50.26%	44.33%	55.60%	54.42%	49.34%	52.57%	55.99%	46.36%
3g - Auto Adjudication Rate including Autobot (4)	69.23%	58.20%	71.53%	68.65%	67.80%	66.86%	73.62%	68.91%	63.76%	65.97%	59.56%	68.26%	68.50%	66.08%	67.44%	70.72%	62.00%
4a - Number of Items in ACS Refund Check Queue (5)	33	69	8	27	0	0	6	11	0	0	16	35	17	33	17	1	0
4a - Number of Items in ACS Refund Check Queue > 20 Days TAT	3	1	0	0	0	0	1	0	0	0	0	0	0	1	0	1	0
4a - Number of Items in Non-Indexed Refund Check Queue (5)	25	37	55	43	37	65	89	62	118	181	85	22	27	17	13	5	68
Claim Receipts																	
Total Claim Receipts	35,511	39,366	42,239	40,343	42,283	55,122	40,934	41,920	41,661	40,668	35,172	47,804	43,281	42,922	40,056	46,543	38,645
Average Claims Receipts (6)	8,539	8,208	7,978	7,960	7,873	8,212	8,999	8,934	9,013	8,982	8,259	7,971	8,265	8,346	8,459	8,703	8,640
Mailroom Inventory on Hand																	
Items in EDGE to be worked (8)	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9
Claims with Front-end Errors (9)	412	571	757	865	722	1,046	544	546	667	1,009	700	834	596	753	531	671	541
IKA Inventory on Hand																	
Pended Inventory	22,783	22,572	24,178	25,789	29,663	39,049	34,965	36,069	33,222	31,232	27,763	30,413	32,261	32,053	31,166	27,565	21,341
Working Inventory (10)	**23,204**	**23,152**	**24,944**	**26,663**	**30,394**	**40,104**	**35,518**	**36,624**	**33,898**	**32,250**	**28,472**	**31,256**	**32,866**	**32,815**	**31,706**	**28,245**	**21,891**
Claims Ready to Pay (11)	1,284	7,216	4,229	5,001	2,626	6,209	3,653	3,624	3,220	3,603	4,598	4,756	3,851	4,899	3,271	3,126	3,875
Current Inventory	**24,488**	**30,368**	**29,173**	**31,664**	**33,020**	**46,313**	**39,171**	**40,248**	**37,118**	**35,853**	**33,070**	**36,012**	**36,717**	**37,714**	**34,977**	**31,371**	**25,766**
DROH Working Inventory (10, 12)	2.7	2.8	3.1	3.3	3.9	4.9	3.9	4.1	3.8	3.6	3.4	3.9	4.0	3.9	3.7	3.2	2.5
DROH Current Inventory (12)	2.9	3.7	3.7	4.0	4.2	5.6	4.4	4.5	4.1	4.0	4.0	4.5	4.4	4.5	4.1	3.6	3.0
Clean Claims Aging (7)																	
31 to 60 Days	1,032	1,045	1,056	992	983	1,005	1,035	1,086	1,184	1,228	1,221	1,259	948	858	934	869	882
61 to 90 Days	0	0	0	0	0	0	0	3	2	1	3	0	0	1	1	1	2
90+ Days	1	1	0	1	1	1	1	2	2	1	5	4	2	3	2	1	3
Total Clean Claims Aged > 30 Days	**1033**	**1046**	**1056**	**993**	**984**	**1006**	**1036**	**1091**	**1188**	**1230**	**1229**	**1263**	**950**	**862**	**937**	**871**	**887**
Contested Claims Aging (7)																	
0 to 30 Days	451	330	323	343	415	419	290	264	289	317	348	280	269	329	292	612	408
31 to 60 Days	8	2	10	9	4	2	4	9	6	8	5	7	3	2	2	3	3
61 to 90 Days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
90+ Days	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Aging of Total Contested Claims	**460**	**333**	**334**	**353**	**420**	**422**	**295**	**274**	**296**	**326**	**354**	**288**	**273**	**332**	**295**	**617**	**413**
Productivity																	
EDI Claims Rejected	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1297	1539
Deleted Claims (13)	897	700	885	1,061	1,174	1,033	978	818	946	1,028	821	826	1,176	904	764	938	1,028
Denied Claims	5,092	5,175	5,065	4,845	4,786	5,276	5,990	6,228	7,138	4,983	5,075	7,348	5,501	5,504	5,356	5,738	5,233
Allowed Claims	37,082	29,348	36,860	33,497	35,589	34,875	41,413	34,622	36,273	34,690	32,109	39,116	37,286	34,761	36,301	37,396	35,610
Actual Weekly Production (14)	42,174	34,523	41,925	38,342	40,375	40,151	47,403	40,850	43,411	39,673	37,184	46,464	42,787	40,265	41,657	43,134	40,843
Total Weekly Production (15)	**43,072**	**35,223**	**42,811**	**39,403**	**41,549**	**41,184**	**48,381**	**41,668**	**44,357**	**40,701**	**38,005**	**47,290**	**43,963**	**41,169**	**42,421**	**45,369**	**43,410**
Average Daily Production (16)	8,646	8,446	8,400	8,138	8,085	8,016	8,197	8,497	8,570	8,809	8,625	8,284	8,574	8,530	8,586	8,676	8,500
DWOH Working Inventory (10, 17)	2.7	2.7	3.0	3.3	3.8	5.0	4.3	4.3	4.0	3.7	3.3	3.8	3.8	3.8	3.7	3.3	2.6
DWOH Current Inventory (17)	2.8	3.6	3.5	3.9	4.1	5.8	4.8	4.7	4.3	4.1	3.8	4.3	4.3	4.4	4.1	3.6	3.0

Gold Coast Health Plan
Weekly Claims Processing Dashobard
July 5, 2017 - Oct 25,2017

Notes:

(1) Percentage of Claims Denied is calculated as the number of Denied claims divided by Actual Weekly Production (total denied and allowed claims for the week)
(2) Number of Claims Payment Adjustments processed in the ika claims system as reported by Xerox on the claims Financial Transaction Summary Report
(3) Number of Xerox claims processing FTEs as reported in the Roster Report provided by Xerox.
(4) Auto Adjudication Rate calculated from "Inventory Tracking to Date" using week to date productivity totals as of Wednesday of each week.
Auto Adjudication Rate including Autobot includes claims processed with Autobot, which allows for systematic processing of claims
(5) Number of Items in Refund Queue reflects the number reported by Xerox in the "Queue Aging Report" as of Wednesday of each week
(6) Average Claims Receipts is calculated as the number of receipts in the past four weeks divided by 20 days.
(7) Reflects the aging reported by Xerox on the "Claims Aging Report" as of Wednesday of each week.
(8) Count of items still in EDGE process that have not been loaded into KWIK or ika.
(9) Includes claims that need additional research to determine whether or not they can be loaded into ika
(10) Working inventory includes mailroom inventory on hand and pending claims inventory. It does not include claims that have been adjudicated and have a status of ready to pay
(11) Claims Ready to Pay have been adjudicated and are ready for payment stream.
(12) Days Receipt on Hand (DROH) is calculated as the Working/Current Inventory divided by the Average Claim Receipts.
(13) Deleted claims have been replaced by a new claim. Deleted claims are still in ika; however, the status has been changed to deleted so the new claim can be worked
(14) Actual Weekly Production is the total number of Denied and Allowed claims.
(15) Total Weekly Production includes Deleted, Denied and Allowed claims.
(16) Average Daily Production is calculated as the total production in the past four weeks divided by 20 days
(17) Days Work on Hand (DWOH) is calculated as the Working/Current Inventory divided by the Average Daily Production.

Sources: Claims Financial Transaction Summary Report, GCHP Inventory Tracking to Date, Claims Aging Report, Queue Aging Report, Xerox Roster Report

AGENDA ITEM NO. 16

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Lyndon Turner, Interim Chief Financial Officer

DATE: December 4, 2017

SUBJECT: Internal Audit Updates: AB85 Auto-Assignment; Human Resources and Payroll; and Accounts Payable

HANDOUT WILL BE AVAILABLE AT THE MEETING

AGENDA ITEM NO. 17

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, MD, Chief Medical Officer

DATE: December 4, 2017

SUBJECT: Chief Medical Officer Update

HEALTH SERVICES UPDATE

Utilization data in the Health Services quarterly 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 2017 are similar to CY 2016.

BED DAYS:

Bed days/1000 members have declined by about 43%, from Plan's inception in 2011 through CY 2016. Bed days/1000 for CYTD 2017 are unchanged from CY2016 (207). The proportion of bed days utilized by AE members increased slightly (39% to 45%) in a year-to-year comparison of June 2016 to June 2017.

Bed days/1000 for SPD members for CYTD 2017 are also similar to CY 2016 (1006 v. 999). While the rate of bed days for SPD members is high, it does not have a strong effect on the overall plan rate of bed days per 1,000 members because SPD is such a small portion of our membership (5%).

Bed days/1000 benchmark: While there is no Medi-Cal Managed Care Dashboard report of bed days/1000 members, review of available published data from other managed care plans averages 238/1000 members. There is variability of reporting of Administrative Days among managed care plans.

AVERAGE LENGTH OF STAY:

Average length of stay for CY2016 was 4.2. Average length of stay for CYTD 2017 is 4.0.

Average length of stay benchmark: While there is no Medi-Cal Managed Care Dashboard report of bed days/1000 members, review of available published data from other managed

care plans averages 5. There is variability in reporting of Administrative Days among managed care plans.

ADMITS/ 1000:

Admits/1000 for CY2016 were 50/1000 members. Admits/1000 for CYTD2017 are 51/1000 members.

Admits/1000 SPD members are 195 for CYTD 2017.

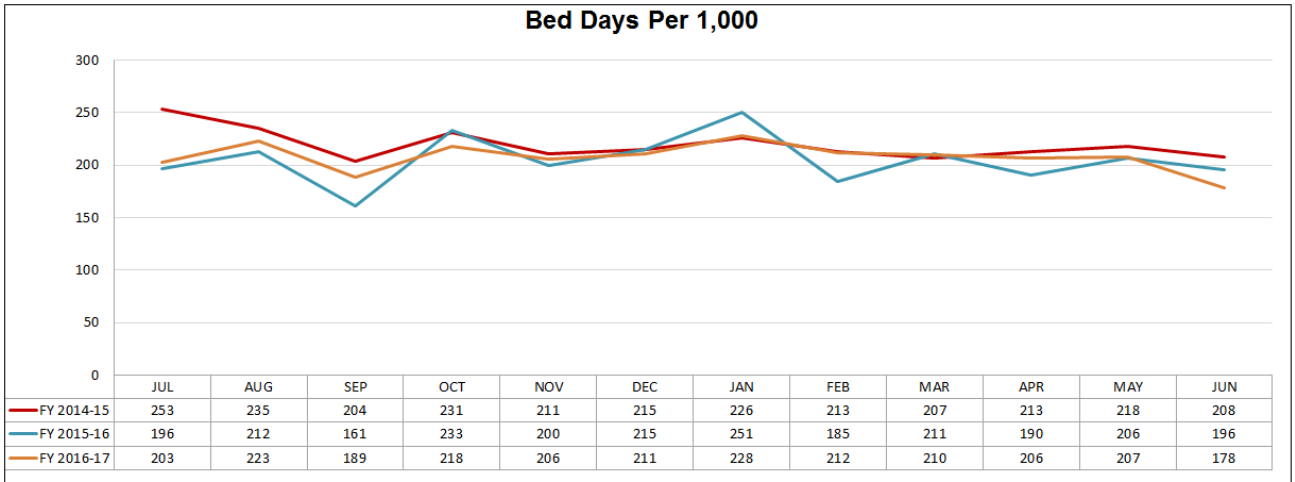
Admits/1000 benchmark: The DHCS average for admits/1000 members is 54. The DHCS average admits/1000 for SPD members is 458. This variation between GCHP and DCHS may be explained by the relative youth of GCHP SPD members versus DHCS SPD members. (Only 33% of GCHP SPD members are age 40 – 64 years versus 42% for the DHCS SPD population.

ED UTILIZATION/1000:

ED utilization/1000 members typically peaks in January or February. CYTD 2017 ED utilization/1000 members increased from CY2016 (478 v. 447). For June 2017, the Family aid code group continues to show the highest ED utilization (46%) followed by AE (35%). This utilization pattern is essentially unchanged from CY 2016.

ED utilization/1000 for SPD members for CYTD 2017 is also increased from CY 2016 (852 v. 802). This represents approximately 10% of ED utilization.

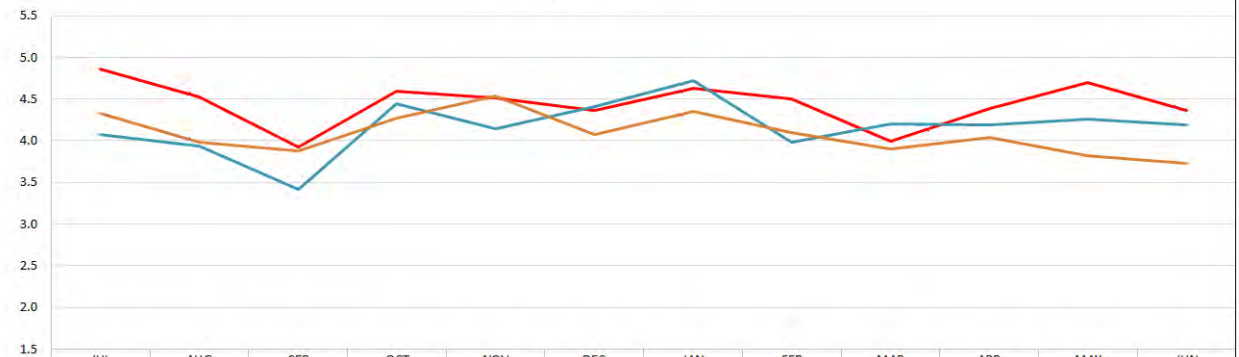
ED utilization benchmark: The HEDIS mean for managed Medicaid plans for ED utilization/1000 members is 587. The March 2017 Medi-Cal Managed Care Performance Dashboard reported average SPD ED utilization to be 1065/1000 members.



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
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	190	206	196
FY 2016-17	203	223	189	218	206	211	228	212	210	206	207	178

*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.

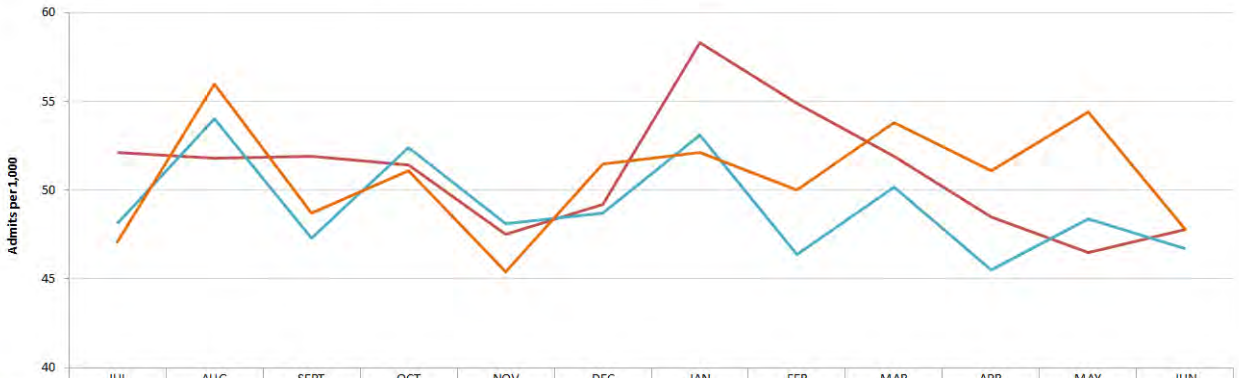
Average Length of Stay



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 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	4.3	4.2
FY 2016-17	4.3	4.0	3.9	4.3	4.5	4.1	4.4	4.1	3.9	4.0	3.8	3.7

*Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.

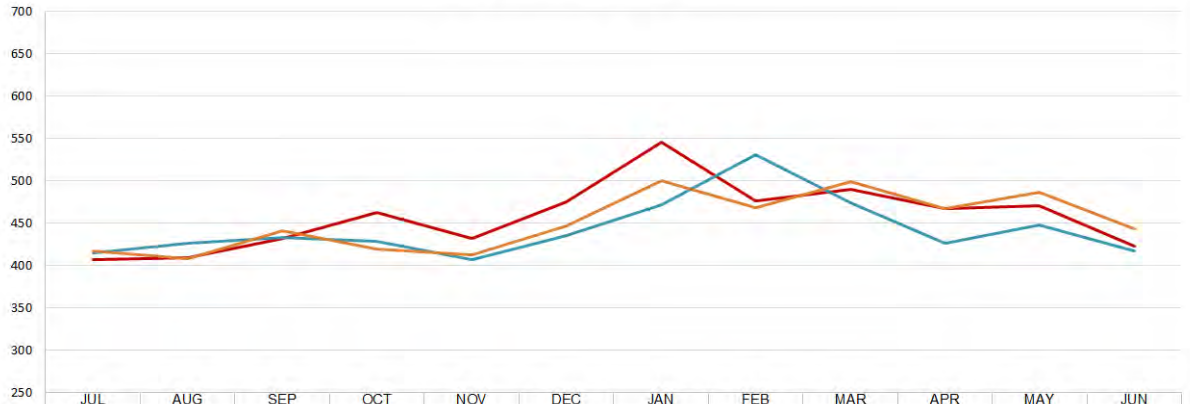
Acute Inpatient Admissions/1000 Members



	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 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	47
FY 2016-17	47	56	49	51	45	52	52	50	54	51	54	48

*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 10/12/2017

ER Utilization Per 1,000

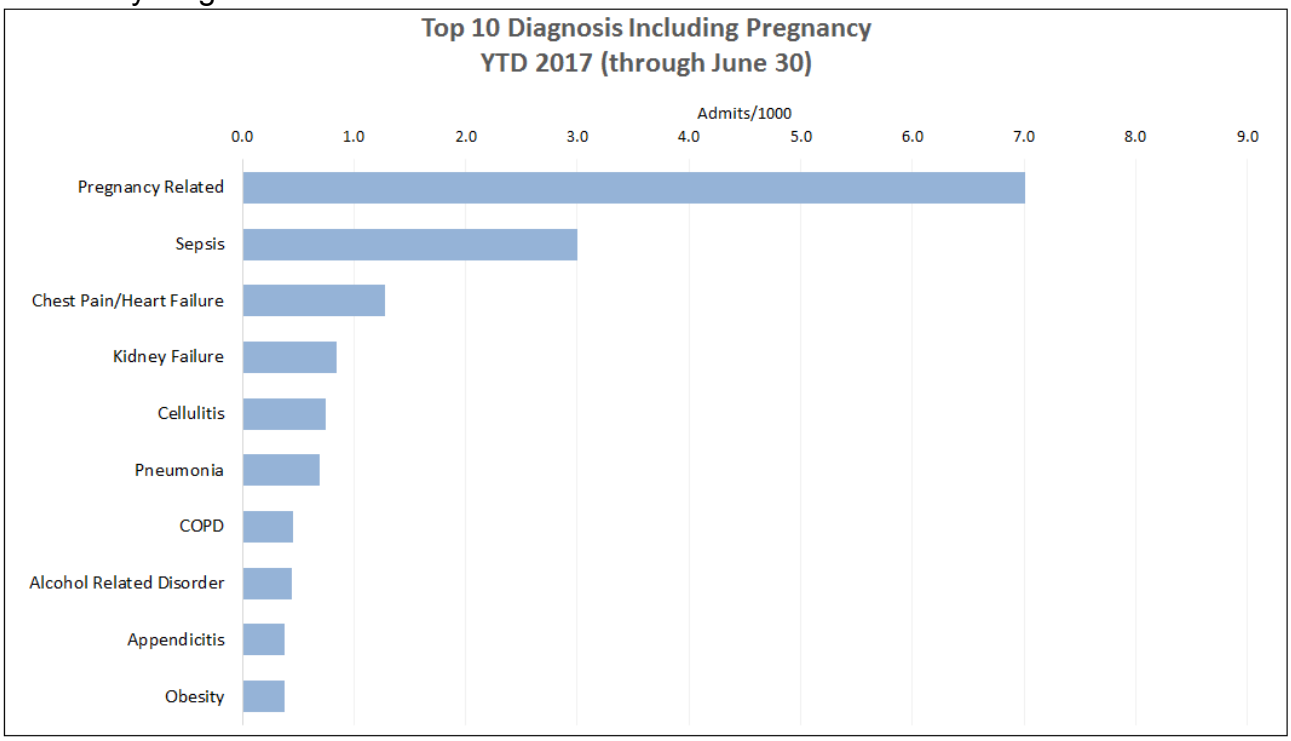


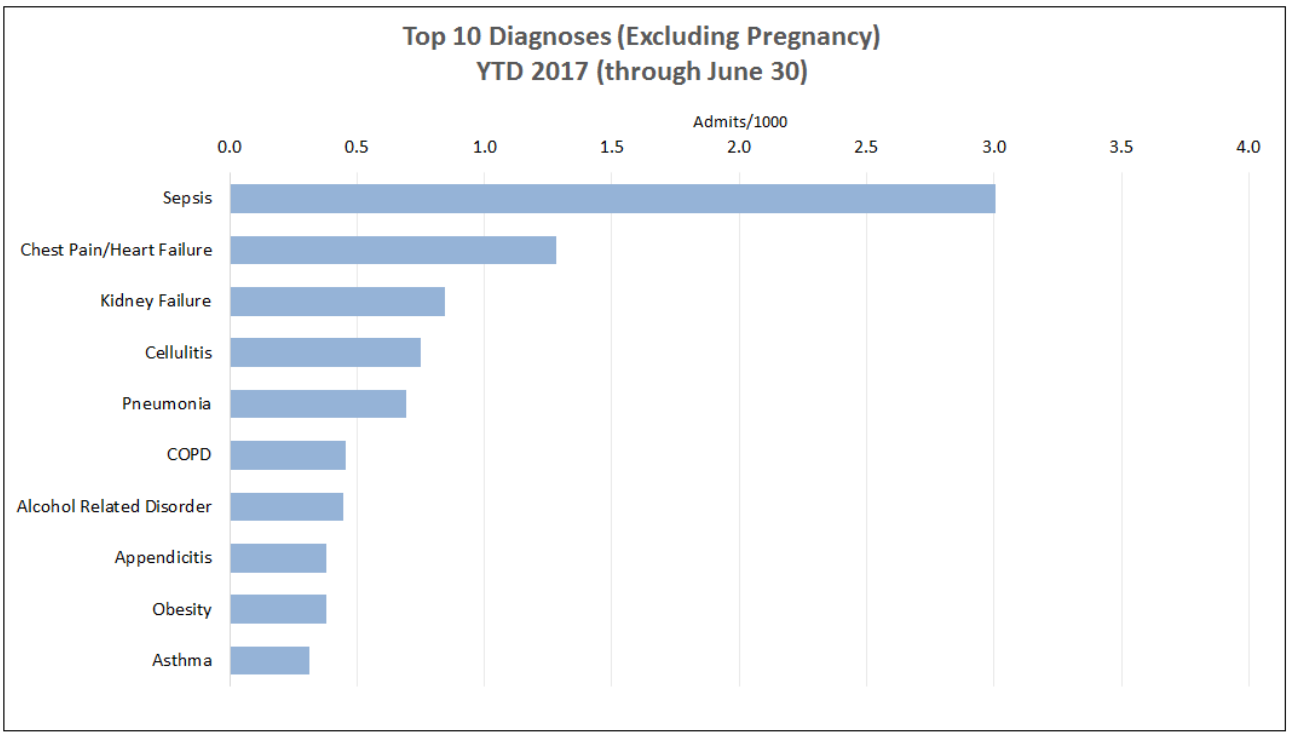
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2014-15	407	410	432	462	432	475	546	477	490	468	470	422
FY 2015-16	415	427	433	429	407	436	472	531	474	427	448	418
FY 2016-17	417	408	441	420	413	447	500	468	500	467	487	444

*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts are not included in this data.
*ER Utilization calculated on visits without an IP admit

TOP ADMITTING DIAGNOSES

Pregnancy related diagnoses and sepsis continued to dominate top admitting diagnoses for CY 2016 and CYTD 2017. For members admitted with a primary diagnosis of sepsis, secondary diagnoses were cancer, heart disease, liver or renal transplant, and diabetes were secondary diagnoses.

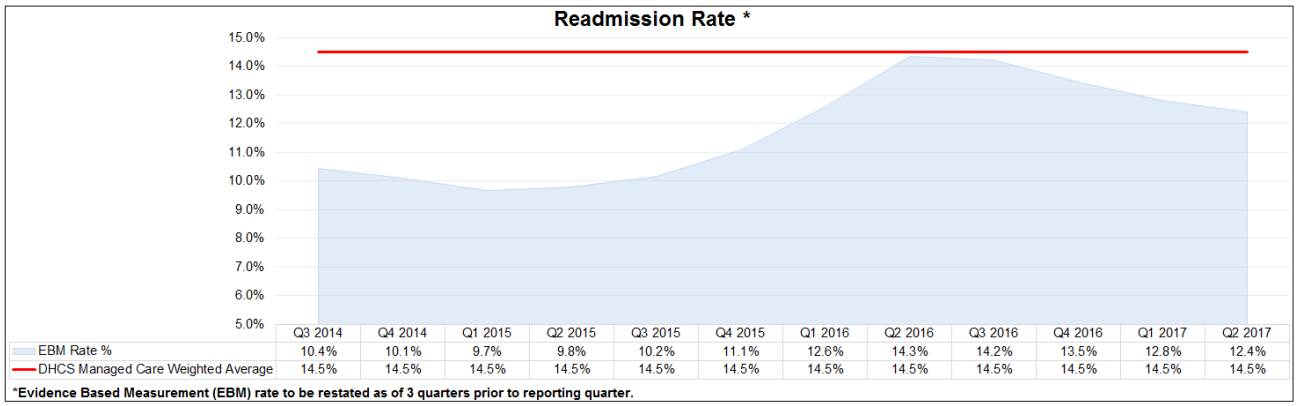




READMISSION RATE

The quarterly readmission rate has declined from a recent peak in Q2 of 2016 (13.6%) to an average of 12.6% for CYTD 2017.

Readmission rate benchmark: The DHCS Managed Care weighted average for readmission is 14.5%.



CLINICAL GRIEVANCES AND APPEALS

For CY2016, there were an average of 30 grievances/ quarter. The average number of clinical grievances/quarter for CYTD 2017 has increased to 47. Most grievances (85%) were characterized as quality of care issues. Only 2% of grievances were characterized as access issues for CY 2016. Access issues comprised 3% of grievances for Q3 2017.

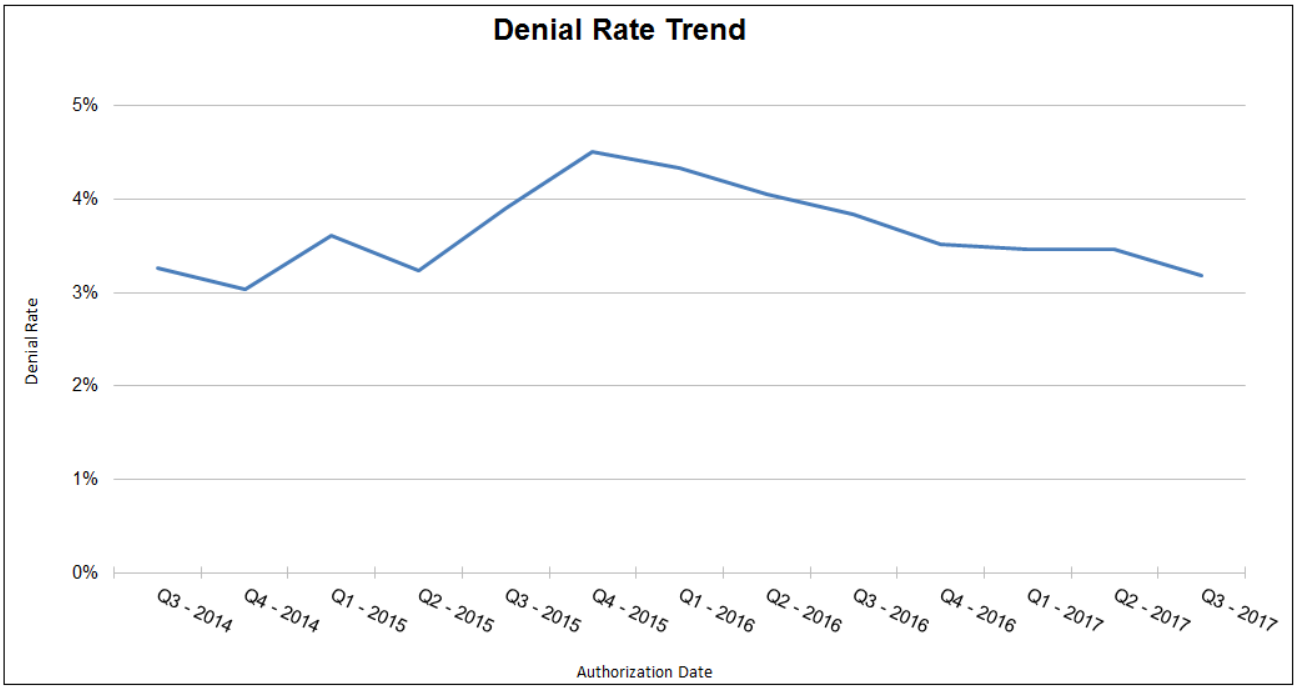
QTR	Grievance Total	Appeals Total	Upheld	Partial Overturn	Overturned	Withdrawn	Dismissed
2016							
Q1	26	9	3 (34%)	-	4 (44%)	1 (11%)	1 (11%)
Q2	32	9	7 (78%)	-	2 (22%)	-	-
Q3	33	24	7 (29%)	-	14 (58%)	1 (5%)	-
Q4	27	21*	7 (33%)	-	6 (29%)	1 (5%)	-
2017							
Q1	34	15	6 (40%)	-	8 (53%)	1 (7%)	-
Q2	40	17	9 (54%)	-	4 (23%)	4 (23%)	-
Q3	66	17	9 (53%)	-	6 (35%)	2 (12%)	-

*Q4 2016 total appeals includes 7 (33%) in progress.

DENIAL RATE

Denial rate is calculated by dividing all not medically necessary denials by all requests for service. Denials for duplicate requests, member ineligibility, rescinded requests, other health coverage, or CCS approved case are not included in this calculation.

The denial rate has ranged between 2.7% and 4.5% since 2013. The average denial rate for CY 2016 was 3.9% and for CYTD 2017 is 3.4%.



HEALTH EDUCATION UPDATE

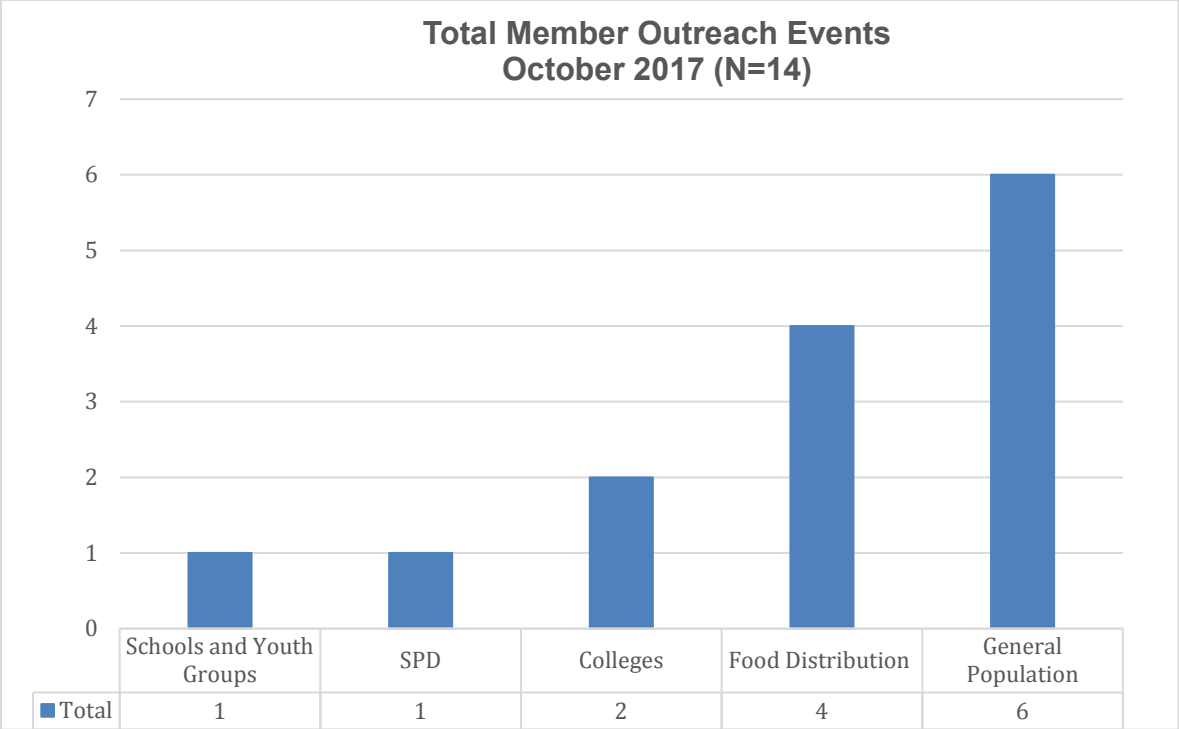
Summary

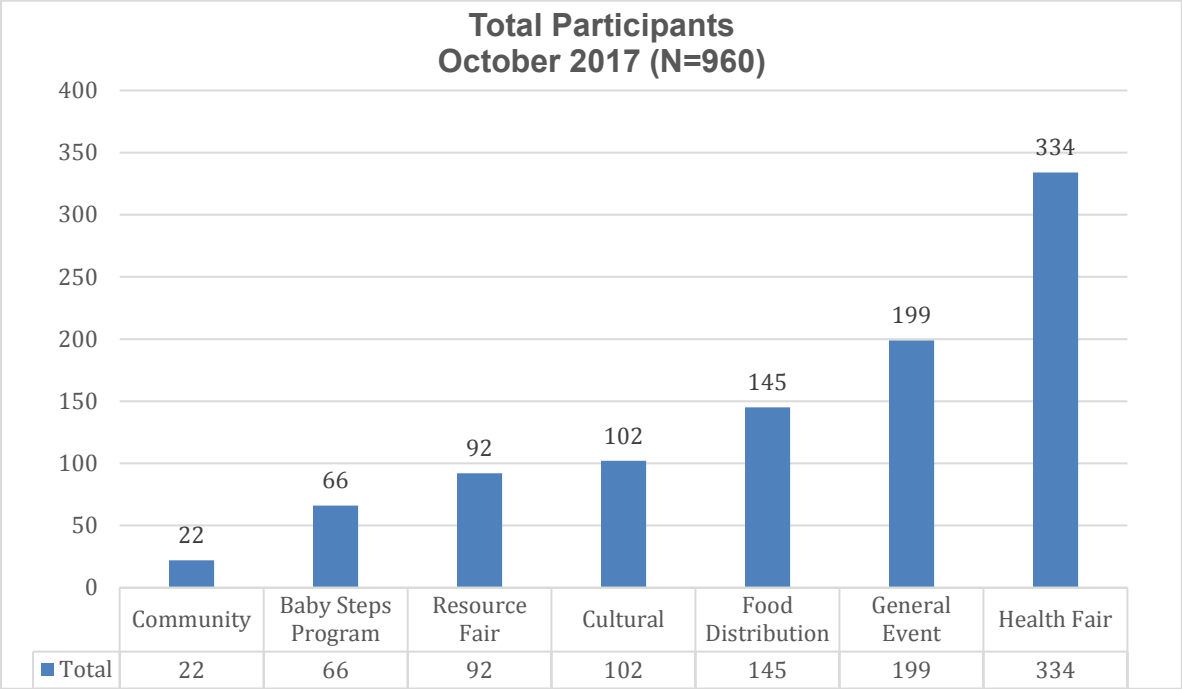
Gold Coast Health Plan (GCHP) continues to participate in community education and outreach activities throughout the county. The health education and outreach teams maintain a positive presence in the community by working with various county public health departments, community-based organizations, schools, senior centers, faith-based centers and social service agencies.

Outreach Events

Below is a list of activities during the month of October:

October 2017	List of Activities
10/5/2017	College Health Fair / Ama tu Vida, Oxnard
10/6/2017	Sharing the Harvest/Produce Giveaway, Santa Paula
10/7/2017	City of Oxnard 22nd Multicultural Festival, Plaza Park, Oxnard
10/10/2017	Baby Steps Program, hosted by Ventura County Medical Center, Ventura
10/14/2017	Tooth Fairy 5k/10k/1k Kids Fun Run & Community Health Expo, hosted by The Free Cljnic of Simi Valley
10/14/2017	Oxnard Revival Center Community Resource Fair 3rd Annual “My Community First, Rio Real Elementary School, Oxnard
10/15/2017	SAI BABA Medical Camp, Our Lady of Guadalupe Church, Oxnard
10/15/2017	Binational Health Week “Health Unites Us All”, Our Lady of Guadalupe Church, S.Paula
10/17/2017	Baby Steps Program, hosted by Santa Paula Hospital
10/18/2017	Monthly Food Distribution Program & Health Services, hosted by Westpark Community Center
10/21/2017	2017 Senior Summit, Cal State Channel Islands, Camarillo
10/24/2017	Ventura College Health Fair, Ventura
10/26/2017	Community Market Produce Giveaway, hosted by Moorpark/Simi Valley Neighborhood for Family Learning, Moorpark
10/26/2017	Community Market Produce Giveaway, hosted by Moorpark/Simi Valley Neighborhood for Family Learning, Simi Valley


Total Member Outreach Events
October 2017 (N=14)
7
6
5
4
3
2
1
0
Schools and Youth Groups
SPD
Colleges
Food Distribution
General Population
Total
1
1
2
4
6


Total Participants
October 2017 (N=960)
400
350
300
250
200
150
100
50
0
22
66
92
102
145
199
334
Community
Baby Steps Program
Resource Fair
Cultural
Food Distribution
General Event
Health Fair
Total
22
66
92
102
145
199
334

Health Education

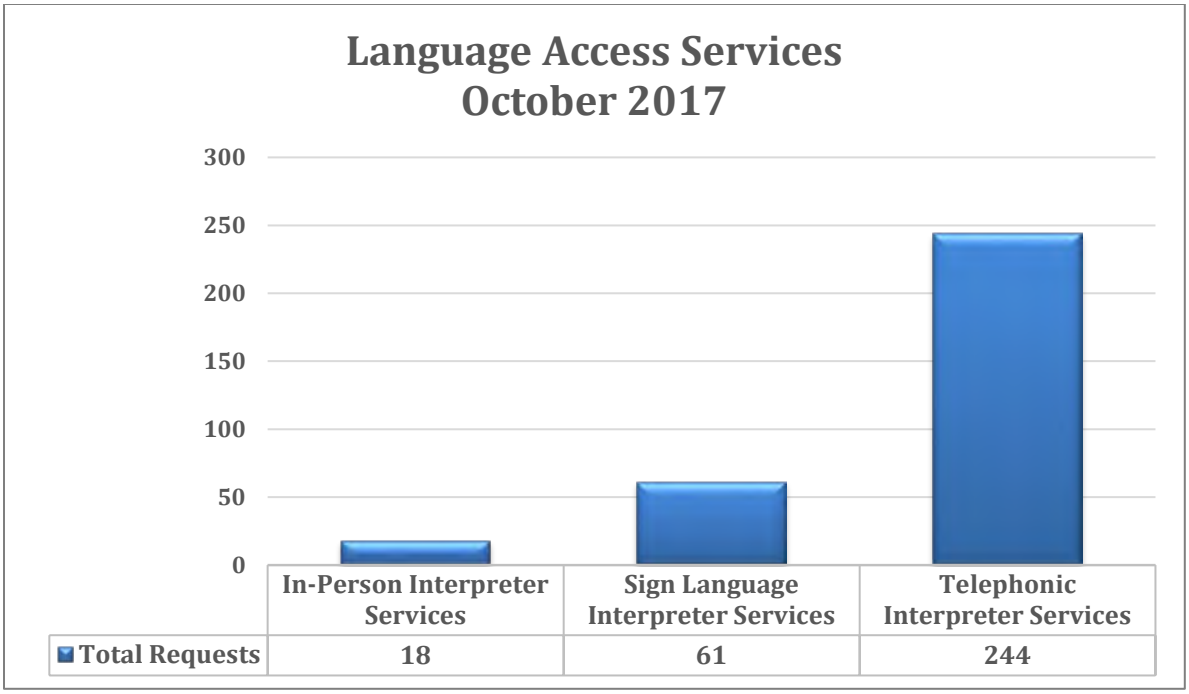
The Health Education Department continues to educate members throughout the community on various health topics. During the month of October, a total of 12 Health Education classes were conducted on the following topics: breast cancer awareness, healthy living, nutrition and physical activity. GCHP health navigators will call members after an event if they have completed a health education referral and are active GCHP members.

Below is a list of classes during the month of October:

October 2017	List of Classes	# Participants
10/3/2017	Healthy Living, Fillmore Active Adult Center	3
10/4/2017	Healthy Living Workshop, Housing Authority of the City of San Buenaventura	7
10/5/2017	Healthy Living Workshop, Housing Authority of the City of San Buenaventura	10
10/10/2017	Breast Cancer Awareness Month Workshop, Centers for Family Health (CMH)	16
10/10/2017	Healthy Living Workshop, Housing Authority of the City of San Buenaventura	4
10/11/2017	Breast Cancer Awareness Month Workshop, Housing Authority of the City of San Buenaventura	12
10/12/2017	Breast Cancer Awareness Month Workshop, Among Friends ADHC Center, Oxnard	28
10/17/2017	Healthy Living Workshop, Housing Authority of the City of San Buenaventura	6
10/18/2017	Migrant Ed Meeting, Oxnard Union High School District	33
10/19/2017	GCHP Informational Booth - Healthy Living, Mexican Consulate, Oxnard	9
	TOTAL PARTICIPANTS:	**128**

Cultural and Linguistic Services

GCHP Health Education Department, Cultural Linguistic Services coordinates interpreting and translation services for members. GCHP offers interpreting services at no cost and in over 200 languages, including sign language. GCHP monitors requests for interpreting and translation services daily. Below are the totals for the month of October:



Sponsorship Program

The GCHP Sponsorship Program approved $1000 to North Oxnard Warriors Youth Football during the month of October. *Note: all future sponsorship requests are on hold at this time.*

Agency/Organization	Approved Award Amount	Event/Org Summary
North Oxnard Warriors Youth Football	$1000	This football/cheer program aims to provide safe, supervised sports activities for the underserved local youth community by sponsoring families to help with dues, field fees, uniforms/equipment and an end of year banquet with trophies for the teams. The program has seven football teams ranging in age from 6 to 14, and a cheer squad of 18 that range in age from as young as 4 years of age to 14 year old kids.

PALLIATIVE CARE UPDATE

SUMMARY

Gold Coast Health Plan (GCHP) will implement a new Palliative Care Benefit effective January 1, 2018 in accordance to Senate Bill 1004 and APL 17-015.

BACKGROUND

The goal of palliative care is to help people with a serious illness cope with medical, emotional, social and spiritual challenges they may be facing. It improves the quality of life and reduces utilization of inpatient and emergency room services. Patients can remain under the care of their regular doctor and still receive treatment for their disease.

In an effort to focus on patient choice and optimize quality of life, GCHP is working to strengthen the Palliative Care Benefit for members suffering from severe congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), liver disease, and advanced cancer with a life expectancy of 6 months or less. GCHP is striving to build a strong provider network of qualified, multidisciplinary teams dedicated to provide patient and family-centered care that address the physical, intellectual, emotional, social, and spiritual needs of our vulnerable population in the most compassionate way possible.

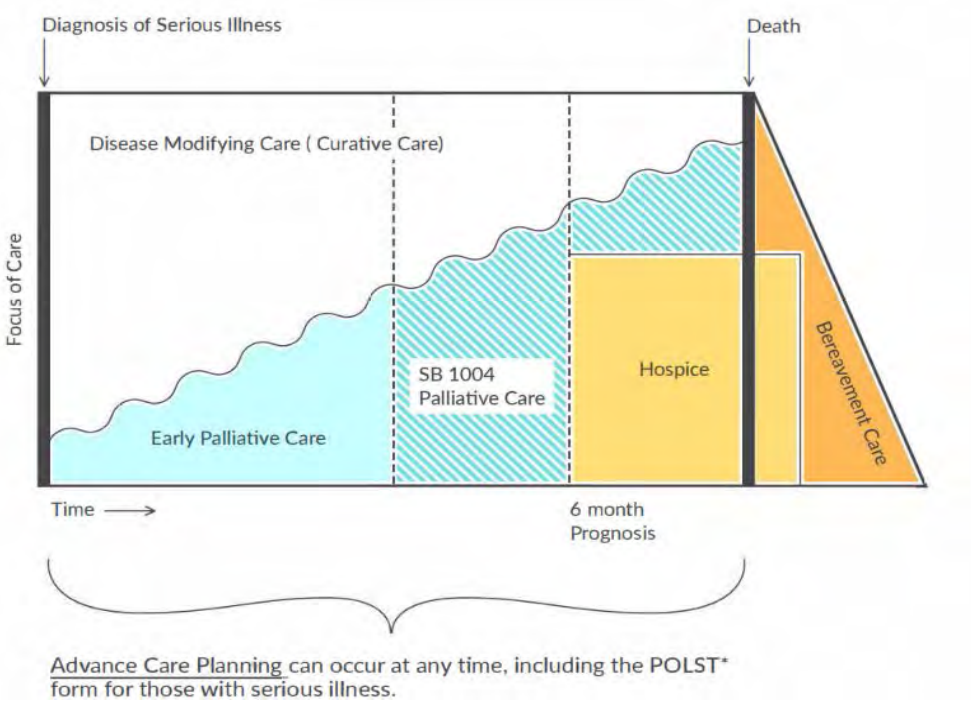
DISCUSSION

GCHP continues to actively engage the palliative care community in the development of the Program. Implementation strategies include the development of outreach and education efforts that address the specific needs of our palliative care population, including customized materials to recognize the various belief, values, and customs of our members. GCHP is actively collaborating with community-based organizations and external coalitions to align efforts towards promoting patient choice to optimize quality of life for our members.

Currently, outreach efforts to promote palliative care awareness and share resources available to our provider network are being developed. Accordingly, GCHP continues to offer provider opportunities to enhance workforce development, including CME and certification trainings through the California State University Program.

Additionally, GCHP will be developing a data collection system to monitor and collect palliative care enrollment and utilization data as required by APL 17-015. With the development of this data system, GCHP will be able to analyze the health status of this population and determine strategic interventions as needed.

Care Model of SB 1004 Medi-Cal Palliative Care:



(National Coalition for Hospice and Palliative Care, 2016)

The following illustrations are results from the *Partners in Care: Palliative Care Program* (PIPC) referenced by DHCS as implementation models. Based on these two methods of financial analysis, approximately $3 of hospital costs were avoided for each $1 spent on all costs associated with the PIPC pilot:

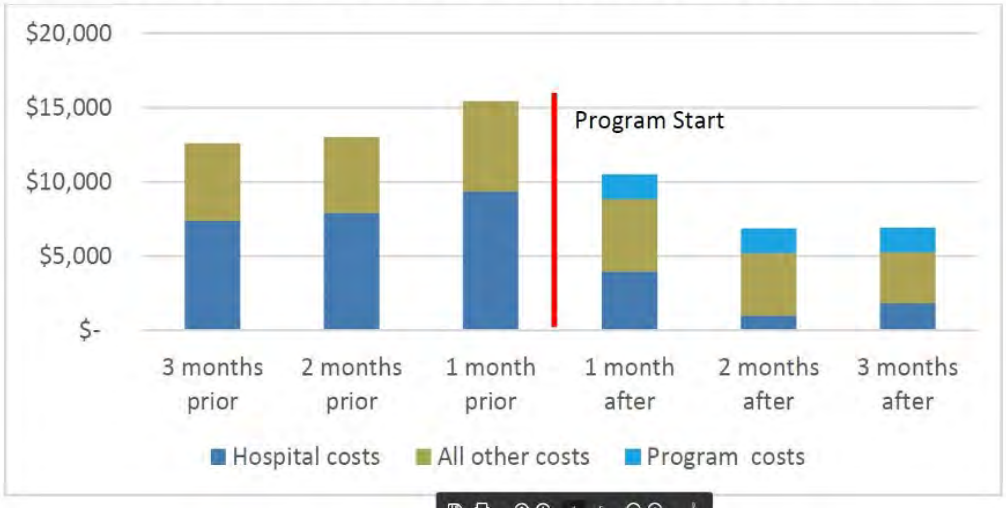
Total Costs of Care in the Last Six Months of Life:

(Partnership HealthPlan of California, 2015)

Costs Per Month, Before and After Palliative Care Pilot Enrollment

Partners in Palliative Care

Figure 1: Costs Per Month, Before and After Palliative Care Pilot Enrollment



(Partnership HealthPlan of California, 2015)

PHARMACY BENEFIT PERFORMANCE AND TRENDS

SUMMARY:

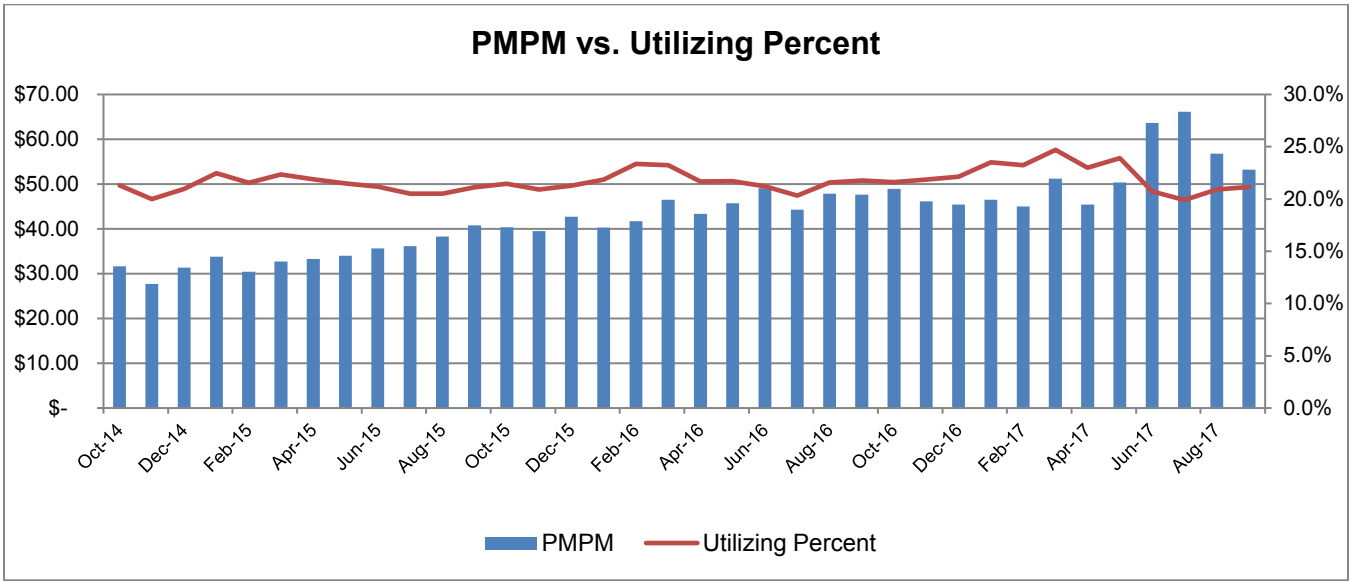
Pharmacy utilization data is compiled from multiple sources including the pharmacy benefits manager (PBM) monthly reports, GCHP's ASO operational membership counts, and invoice data. The data shown is through the end of September 2017. Although minor changes may occur to the data going forward due to the potential of claim adjustments from audits and/or member reimbursement requests, the data is generally considered complete due to point of sale processing of pharmacy data.

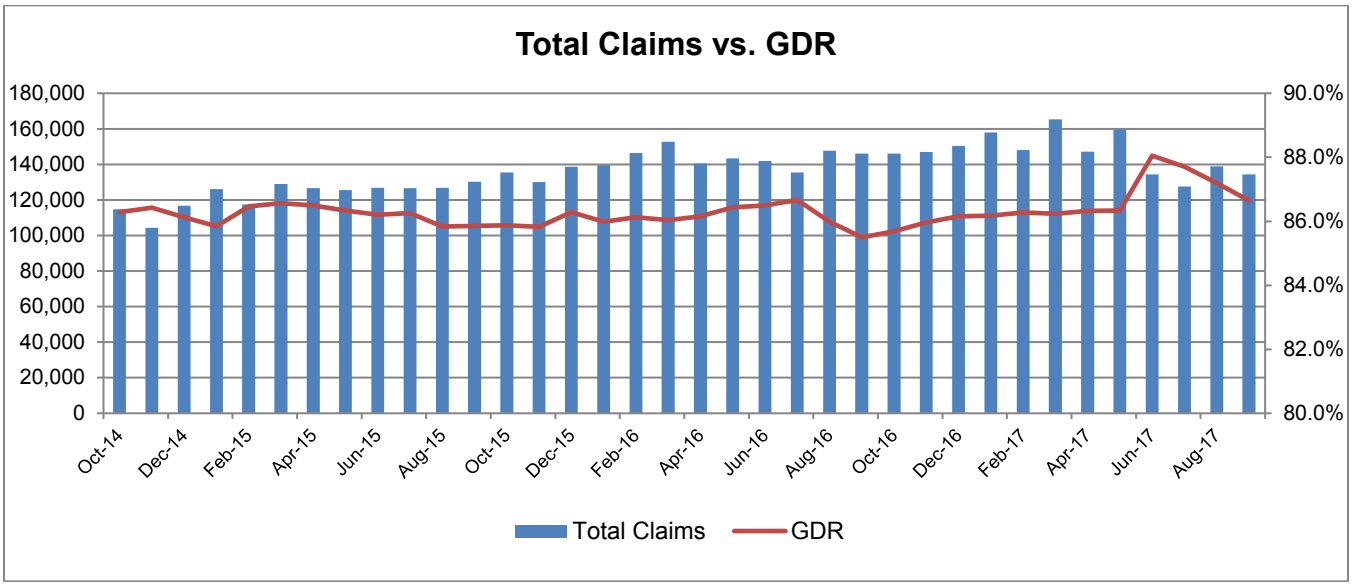
GCHP has seen a slight membership drop in 2017. Slight cost declines occurred in November and December 2016, however costs increased again in January, March, May and with the new PBM contract as of June 2017. It is important to note that the data for June, July and August is inaccurate due to drug rate set-up errors. Additional information regarding the errors will be provided verbally.

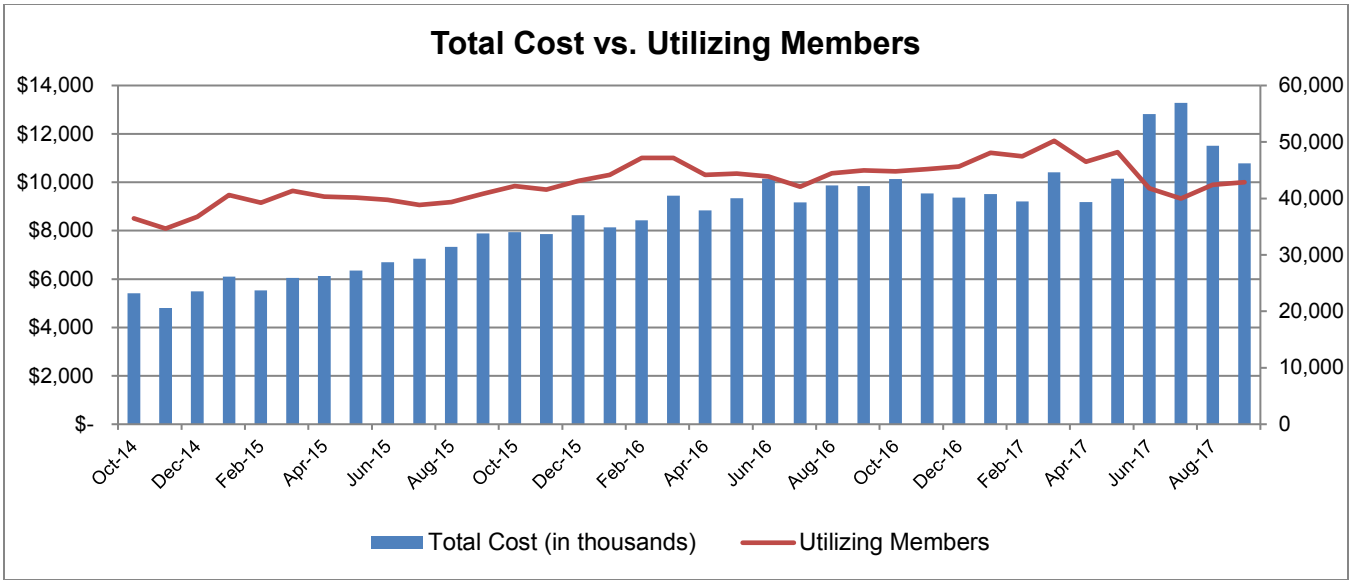
Hepatitis C continues to be a major driver of pharmacy costs though cost has decreased since the peak in May 2016. Formulary changes and the implementation of preferred products to align with DHCS kick payment utilization and cost assumptions have resulted in the Plan estimating to recoup all costs related to Hepatitis C from March 2017 through May 2017. A new hepatitis C drug was released with a much lower cost than all available agents. Due to this drug, the DHCS kickpayment is greatly reduced for FY 17-18. In response to this, GCHP has aligned its formulary status of hepatitis C agents with the DHCS usage assumption. In September, costs and reimbursement from DHCS are back in alignment.

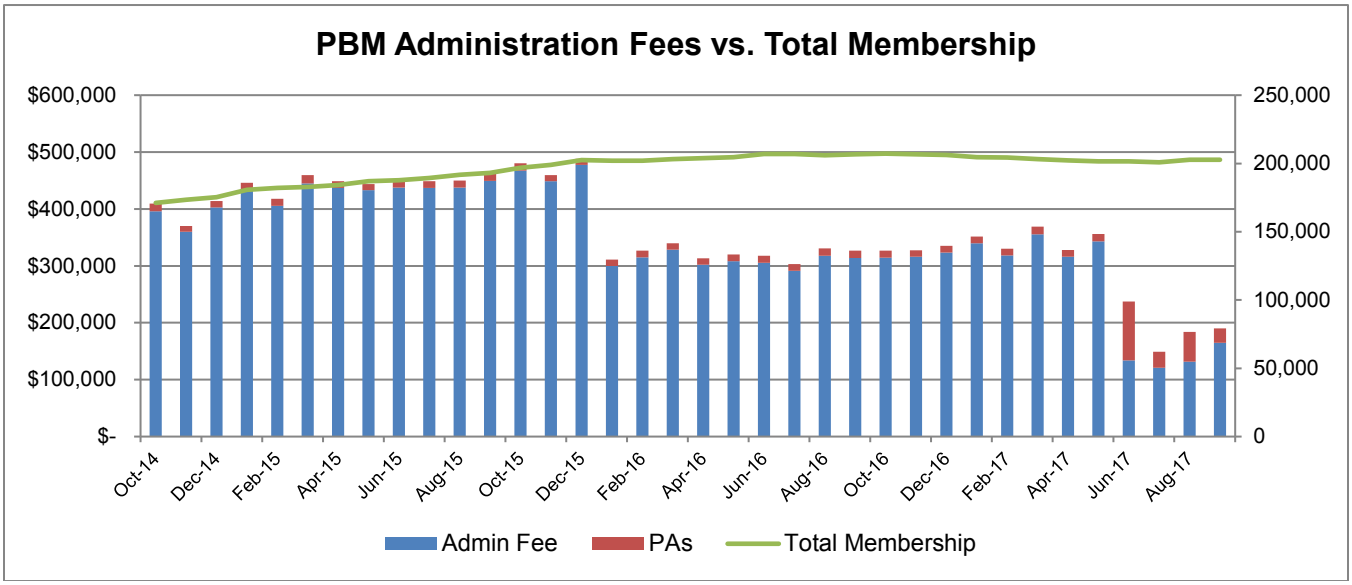
Abbreviation Key:
PMPM: Per member per month
PUPM: Per utilizer per month
GDR: Generic dispensing rate
PA: Prior authorization

PHARMACY COST TRENDS:

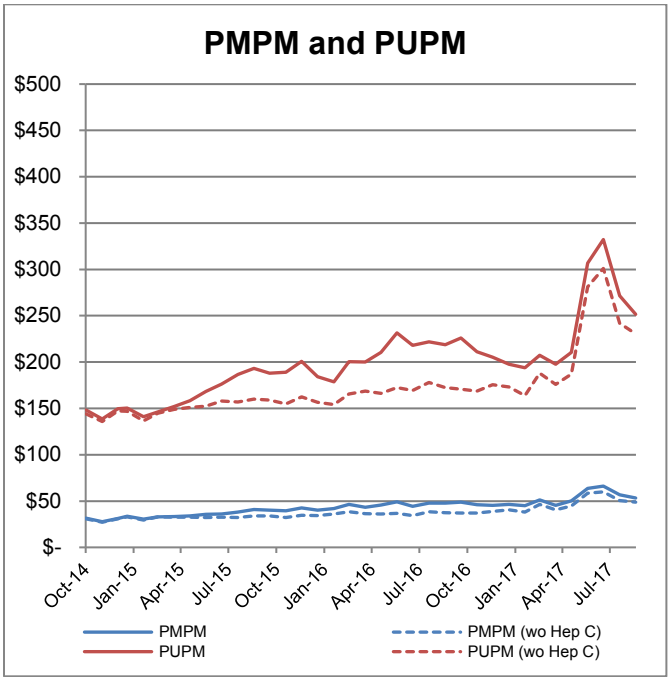


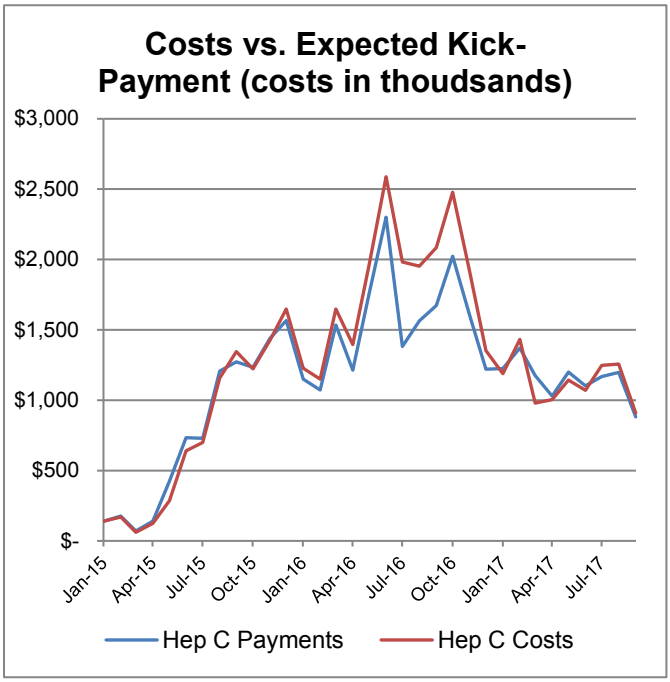



Total Cost vs. Utilizing Members
$14,000
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$-
60,000
50,000
40,000
30,000
20,000
10,000
0
Oct-14
Dec-14
Feb-15
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Oct-16
Dec-16
Feb-17
Apr-17
Jun-17
Aug-17
Total Cost (in thousands)
Utilizing Members

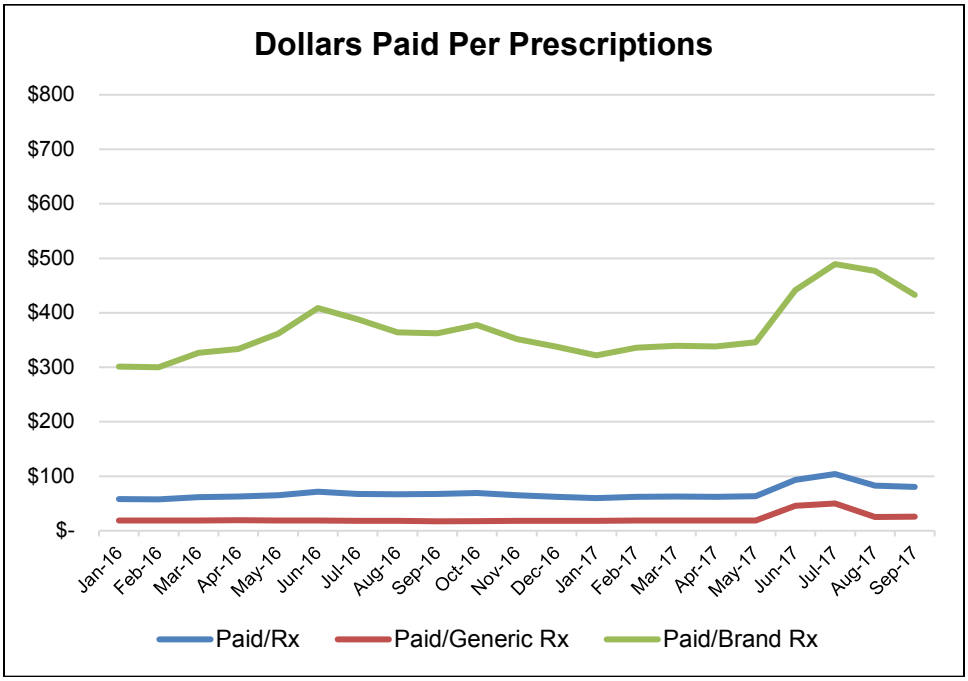

PBM Administration Fees vs. Total Membership
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$-
250,000
200,000
150,000
100,000
50,000
0
Oct-14
Dec-14
Feb-15
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Oct-16
Dec-16
Feb-17
Apr-17
Jun-17
Aug-17
Admin Fee
PAs
Total Membership

HEPATITIS C FOCUS:





PAID PER PERSCRIPTION:



IMPLEMENTATION OF NEW PBM: OPTUMRX

SUMMARY:

Gold Coast Health Plan (GCHP or the Plan) contracts with a Pharmacy Benefits Manager (PBM) in order to provide pharmacy benefit services to its members. The commission entered into a new contract with OptumRx (ORx) to be the PBM effective June 1, 2017.

BACKGROUND:

GCHP worked diligently with ORx on plan specifications to build out GHCP's pharmacy benefit within ORx's systems. This has been a detailed, complex and arduous process to ensure that the benefit is built to the same specifications as with the prior PBM.

DISCUSSION:

ORx's claim system went live for GCHP on June 1. At that time, GCHP and ORx conducted daily check-in calls to verify reports of identify issues and ensure that the benefit and systems were working properly. Through September 30, OptumRx has paid over 500,000 prescriptions claims for GCHP members.

There are several outstanding issues and verbal updates will be provided on the following items:

- Kaiser pharmacies
- 340B eligible drugs claims
- Pharmacy reimbursement

Additionally, the commission directed OptumRx meet with pharmacy owners, pharmacists and their Pharmacy Services Administrative Organizations. Experience and notes from these meetings will be provided verbally.

Gold Coast Health Plan℠
A Public Entity

Base Compensation Program

December 2017

Gold Coast Health Plan℠
A Public Entity

POLICY DELINEATION OF AUTHORITY

1. Any actions not specified as being the responsibility of the Commission are delegated to the CEO including, but not limited to:

- **Management will develop a salary range schedule for each established position. While the schedule is not subject to Commission approval, it will be presented to the Commission on an annual basis as an information item.**

Amended: November 28, 2011

Steve Smith, MBA

LTC Performance Strategies, Inc. is a 25-year old Los Angeles-based "boutique" organization specializing in Total Compensation & Performance Development. Serving hundreds of prominent public and private company brand leaders, across industry, the LTC Consulting team delivers exceptional value by providing timely, cost-effective and practical solutions that serve to attract, motivate and retain talented performers, while yielding a strong Return on Investment (ROI).

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Steve Smith serves as LTC Performance's Director of Client Solutions. Since joining LTC in 2009, Steve has consulted on hundreds of compensation initiatives. These initiatives include the design, development, and implementation of:

- **Executive Compensation Programs**
  - **Executive Base Pay**
  - **Management Incentive Plans**
  - **Stock & Phantom Equity Plans**
  - **Cash-Based Long-Term Incentive Plans**
  - **Executive Deferral Programs**
- **Sales Compensation Plans**
- **Company-wide Goals sharing Incentive Programs**
- **Salary Management Plans**

Steve's passion is working closely with clients to develop solutions that allow them to utilize their Total Compensation Program to attract & retain top caliber talent, while realizing a solid return on investment. Steve strives to ensure clients' plans achieve a strong pay-for-performance relationship, while being externally competitive & internally equitable.

Steve holds a Master's Degree in Business Administration (MBA) from Woodbury University and a Bachelor's Degree in Business Administration/ Law from California State University, Northridge.

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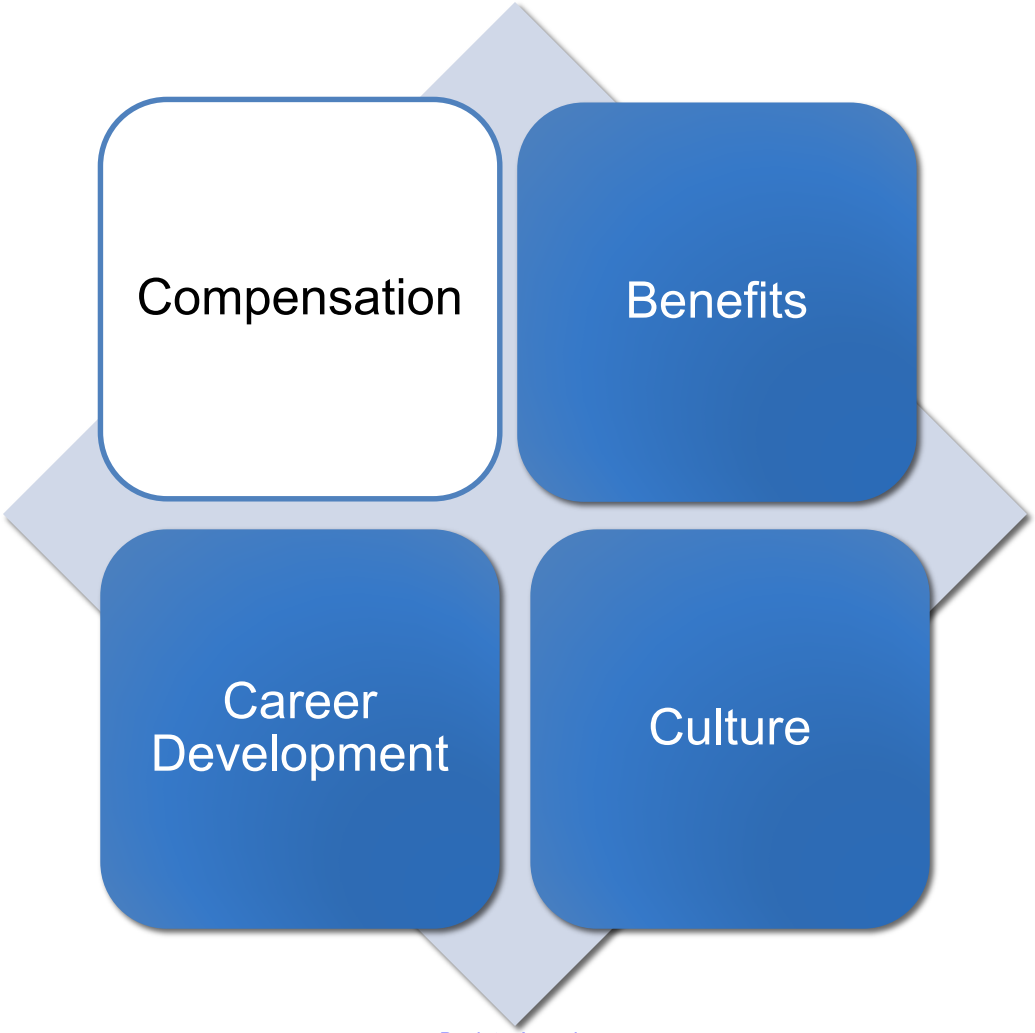
Total Rewards



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Goal

- To ensure the base compensation component of the total rewards program at Gold Coast:
  - Effectively provides market competitive, internally equitable base compensation opportunities, in line with Gold Coast's compensation positioning philosophy.

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Actions Taken

- Created simple compensation philosophy and set of target objectives
- Developed extensive survey market data for comparable roles in the external market
- Reviewed all job descriptions and employee compensation levels within those job titles
- Developed position leveling matrix to visually convey hierarchical pay relationships by department
- Developed pay structure
- Developed a simple tool for effective utilization of each pay range
- Created Compensation Guide for Supervisors

Philosophy/Target Objectives

PHILOSOPHY:

- Gold Coast Health Plan strives to provide competitive, market-based, total compensation opportunities, which are aligned with organizational and individual performance.

OBJECTIVES:

- Attract and retain high caliber, well-suited individuals
- Target internal base compensation pay grades near the 60th percentile of the relevant external market, while providing an appropriate pay range for each role to allow for variances based on incumbent background, skills & proficiency
- Strengthen the relationship between pay & performance
- Be externally competitive, internally equitable, and consistent in program administration
- Ensure roles are clear, yet flexible
- Ensure titles reflect roles and are positively perceived
- Identify/ build/ strengthen critical organizational competencies
- Provide opportunities for appropriate development and meaningful contribution
- Comply with applicable legislation
- Ensure the program is flexible to adapt to changing business and organizational circumstances
- Ensure the program is simple to administer and easy to understand
- Ensure the program is cost effective and provides a solid return on investment (ROI)

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Benchmarking

- Survey data was drawn from 3 reputable survey sources
- This data was tailored for the unique size, location and industry of Gold Coast.
- Job descriptions were reviewed and roles were clarified with managers
- Each role was then matched to an appropriate survey title in order to assess external market pay levels

Company Title	Department	Incumbent Base Pay (Avg)	Survey Title	Base Pay			Short-Term Incentive Paid			Total Cash Compensation		
				25th % ile	Median	75th % ile	25th % ile	Median	75th % ile	25th % ile	Median	75th % ile
Assistant, Administrative	Administration	$49,490	**Administrative Assistant**	$44,511	$48,688	$53,935	$958	$1,042	$1,153	$45,469	$49,730	$55,088
Coordinator, Legal	Administration	$63,128	**Legal Assistant/ Paralegal**	$63,690	$70,081	$78,239	$1,778	$1,957	$2,186	$65,468	$72,038	$80,425
Analyst, Claims II	Claims	$59,425	**Insurance Claims Analyst**	$48,247	$55,206	$64,828	$1,905	$2,347	$2,973	$50,152	$57,553	$67,801
Manager, Public Relations	Communications	$93,600	**Public Relations Manager**	$92,582	$101,702	$113,283	$6,094	$6,690	$7,448	$98,676	$108,392	$120,731

Position Leveling Process

- A position leveling matrix, such as the one below, was developed for each functional area
- The leveling process takes into account external market data, internal reporting relationships/ equity, and career pathing considerations

Position Leveling Matrix

Member Services

EXEMPT

PB 27	PB 28	PB 29	PB 30	PB 31	PB 32

PB 21	PB 22	PB 23	PB 24	PB 25	PB 26
Manager, Member Services					

PB 15	PB 16	PB 17	PB 18	PB 19	PB 20
	Sr. Auditor, Member Services				

NONEXEMPT

PB 7	PB 8	PB 9	PB 10	PB 11

PB 3	PB 4	PB 5	PB 6
Representative, Member Services		Auditor, Member Services I Specialist, Member Services	Auditor, Member Services II

Pay Structure

- Once all the roles were leveled, a pay structure was developed
- The structures contain the min, mid & max of each pay band
- The mid-point of each band generally correlates with the targeted 60th percentile of the external market for the positions contained within that band
- Bands are narrow enough to ensure ranges closely correlate with the market, while being broad enough to minimize internal disagreements regarding leveling relationships

2017/ 2018 Pay Structure

	PB	Minimum	Midpoint	Maximum	Spread
Exempt	32	$336,000	$420,000	$504,000	0.50
	31	$272,000	$340,000	$408,000	0.50
	30	$220,000	$275,000	$330,000	0.50
	29	$186,000	$232,500	$279,000	0.50
	28	$162,000	$202,500	$243,000	0.50
	27	$148,000	$185,000	$222,000	0.50
	26	$130,000	$162,500	$195,000	0.50
	25	$120,000	$150,000	$180,000	0.50
	24	$110,000	$137,500	$165,000	0.50
	23	$98,000	$122,500	$147,000	0.50
	22	$92,000	$115,000	$138,000	0.50
	21	$84,000	$105,000	$126,000	0.50
	20	$78,000	$97,500	$117,000	0.50
	19	$70,000	$87,500	$105,000	0.50
	18	$66,000	$82,500	$99,000	0.50
	17	$61,600	$77,000	$92,400	0.50
	16	$53,600	$67,000	$80,400	0.50
	15	$44,000	$55,000	$66,000	0.50
Nonexempt/ Hourly	11	$84,000 *$40.38*	$105,000 *$50.48*	$126,000 *$60.58*	0.50
	10	$78,000 *$37.50*	$97,500 *$46.88*	$117,000 *$56.25*	0.50
	9	$68,000 *$32.69*	$85,000 *$40.87*	$102,000 *$49.04*	0.50
	8	$58,000 *$27.88*	$72,500 *$34.86*	$87,000 *$41.83*	0.50
	7	$54,000 *$25.96*	$67,500 *$32.45*	$81,000 *$38.94*	0.50
	6	$48,000 *$23.08*	$60,000 *$28.85*	$72,000 *$34.62*	0.50
	5	$44,000 *$21.15*	$55,000 *$26.44*	$66,000 *$31.73*	0.50
	4	$42,000 *$20.19*	$52,500 *$25.24*	$63,000 *$30.29*	0.50
	3	$38,000 *$18.27*	$47,500 *$22.84*	$57,000 *$27.40*	0.50

Utilization of the Pay Bands

- The following graph illustrates the proposed usage of the pay bands
- This tool assists all managers in understanding where a given employee should ideally fit within their respective pay band, based upon their given level of proficiency, such that everyone is "calibrated" equally.

Pay Range Management Guidelines

Sample Pay Grade

	Minimum	Midpoint	Maximum
Pay Range	$48,000	$60,000	$72,000

Utilization of Pay Range

Proficiency	Entry Level		Evolving		Proficient			Superior		Exceptional	
Comp-Ratio	80%	84%	85%	90%	91%	100%	109%	110%	115%	116%	120%
Salary Range	$48,000	$50,400	$51,000	$54,000	$54,600	$60,000	$65,400	$66,000	$69,000	$69,600	$72,000

Questions, Anyone?

- Thank you for your time and attention
- What questions come to mind?

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AGENDA ITEM NO. 19

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Interim Chief Diversity Officer

DATE: December 4, 2017

SUBJECT: Interim Chief Diversity Officer Update

INITIAL UPDATE:

COMPLETED COMPLIANCE TRAINING

Completed all current required Compliance training with certificate signed and verified through the compliance department.

MEETING

Attended all managers meeting and all employee meetings with the intent of establishing a vision and diversity direction for the organization.

INTERNAL CURRENT STATE MEETINGS

In the process of establishing “current state” meetings with the chiefs and their designated leaders to establish trust, cooperation, and candor during investigations.

VISION

In order to establish a Diversity environment, trust and respect of the position has to be established. In the current state of available hours, the business is relegated to a defensive and reactionary posture verses an offensive proactive/aggressive approach.

PRIOR PREPARATION PREVENTS POOR PERFORMANCE