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

Regular Meeting
Monday, January 25, 2016 – 3:00 PM
County of Ventura Government Center – Hall of Administration
Multi-Purpose Room, 800 South Victoria Avenue, Ventura, CA 93009

AGENDA

CALL TO ORDER / 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 minutes. Comments regarding items not on the agenda must be within the subject matter jurisdiction of the Commission.

CONSENT ITEMS

1. Minutes

Staff: Interim Clerk of the Board

RECOMMENDATION

Approve minutes of regular meetings of September 26, 2015, November 16, 2015 and Special meeting of October 13, 2015.

2. Financials – October and November 2015

Staff: Patricia Mowlavi, Chief Financial Officer

RECOMMENDATION

To accept the Financial Reports as presented for October and November of 2015.

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

3. Internal Audit Plan

Staff: Patricia Mowlavi, Chief Financial Officer

RECOMMENDATION

To accept the Audit Plan as presented.

4. Financial Audit Contract for Fiscal Year 2015-2016

Staff: Patricia Mowlavi, Chief Financial Officer

RECOMMENDATION

To accept the appointment of Moss Adams as presented.

FORMAL ACTION ITEMS

5. Election of Chair and Vice Chair

Staff: Dale Villani, Chief Executive Officer
Scott Campbell, General Counsel

6. Total Net Equity (TNE) and Working Capital Reserve Fund Policy

Staff: Patricia Mowlavi, Chief Financial Officer

7. Furniture for Office Expansion

Staff: Ruth Watson, Chief Operations Officer

8. State of California Contract Amendment No. A03 to Agreement No. 10-87129

Staff: Dale Villani, Chief Executive Officer

9. Appointment of Executive Finance Commissioners

Staff: Dale Villani, Chief Executive Officer
Scott Campbell, General Counsel

10. Appointment of Commissioners to Screen Candidate for the Chief Diversity Officer

Staff: Scott Campbell, General Counsel

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

REPORTS

11. Chief Executive Officer (CEO) Update

RECOMMENDATION

To accept the information as presented.

12. Chief Medical Officer (CMO) Update

RECOMMENDATION

To accept the CMO Report as presented.

13. Health Services Update

RECOMMENDATION

To accept the Health Services Report as presented.

14. Chief Financial Officer (CFO) Update

RECOMMENDATION

To accept the CFO Report as presented.

15. Chief Operations Officer (COO) Update

RECOMMENDATION

To accept the COO Report as presented.

16. Chief Information and Strategy Officer (CISO) Update

RECOMMENDATION

To accept the CISO Report as presented.

17. Human Resources Cultural Diversity Sub-Committee Update

RECOMMENDATION

To accept the Report as presented.

CLOSED SESSION

a. CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION
Paragraph (1) of subdivision (d) of Section 54956.9
Clinicas Del Camino Real Inc. v. Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan, Ventura County Superior Court Case No. 56-2014-00456149-CU-BC-VTA

b. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: One Case

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on February 22, 2016 in the County of Ventura Government Center, Hall of Justice – Pacific Conference Room, 800 South Victoria Avenue, Ventura, CA 93009.

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) 437-5512. Notification for accommodation must be made by Thursday, January 21, 2016 by 3 p.m. will enable the Clerk of the Board to make reasonable arrangements for accessibility to this meeting.

This agenda was posted on Wednesday, January 20, 2016 at 3 p.m. at the Gold Coast Health Plan Notice Board, and on the internet.

AGENDA ITEM NO. 1

To: Gold Coast Health Plan Commission

From: Magdalen Gutierrez-Roberts, Exec. Assistant to Ruth Watson / Interim Clerk

Date: January 25, 2016

Re: Approval of Minutes

RECOMMENDATION:

Staff requests that the Commission approve the regular meeting minutes of September 28, 2015, November 16, 2015 and Special meeting of October 13, 2015 as prepared by Traci McGinley.

ATTACHMENTS:

Regular Meeting Minutes: September 28, 2015
November 16, 2015

Special Meeting Minutes: October 13, 2015

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Commission Meeting Minutes
September 28, 2015
(Not official until approved)

CALL TO ORDER

Chair Araujo called the meeting to order at 3:02 p.m. Hall of Administration – Lower Plaza Assembly Room at the County of Ventura Government Center, 800 S. Victoria Avenue, Ventura, CA 93009.

The Pledge of Allegiance was recited.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE
Antonio Alatorre, Clinicas del Camino Real, Inc.
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
Barry Fisher, Ventura County Health Care Agency
Peter Foy, Ventura County Board of Supervisors
David Glyer, Private Hospitals / Healthcare System
Michelle Laba, MD, Ventura County Medical Center Executive Committee
Gagan Pawar, MD, Clinicas del Camino Real, Inc.
Dee Pupa, Ventura County Health Care Agency

EXCUSED / ABSENT COMMISSION MEMBERS
Lanyard Dial, MD, Ventura County Medical Association
Darren Lee, Private Hospitals / Healthcare System
Vacant, Medi-Cal Beneficiary Advocate

STAFF IN ATTENDANCE
Dale Villani, Chief Executive Officer
Patricia Mowlavi, Chief Financial Officer
Traci R. McGinley, Clerk of the Board
Scott Campbell, Legal Counsel
Brandy Armenta, Compliance Officer / Director
Susana Enriquez, Public Relations Manager
Anne Freese, Pharmacy Director
Jeffery Gauthier, Facilities Manager
Lupe Gonzalez, Director of Health Education, Outreach, Cultural and Linguistic Services
Steven Lalich, Communications Director
Vickie Lemmon, Health Services Director
Tami Lewis, Operations Director
Kim Osajda, Quality Improvement Director
Al Reeves, MD, Chief Medical Officer
Melissa Scrymgeour, Chief Information Officer

Lyndon Turner, Financial Analysis Director
Rodney Waiters, Financial Analyst
Ruth Watson, Chief Operations Officer
Nancy Wharfield, MD, Associate Chief Medical Officer

PUBLIC COMMENT

The following individuals expressed their pride in working for the Plan: GCHP Health Services Director, Vickie Lemmon; Senior Decision Support Services Analyst Ritchie Nojadera on behalf of Decision Support Services Manager Kris Schmidt; Financial Analyst Rodney Waiters on behalf of 68 employees of the Plan; and Sherri Bennett, a previous employee of GCHP.

1. APPROVE MINUTES

a. Regular Meeting of August 24, 2015

Commissioner Fisher moved to approve the Regular Meeting Minutes of August 24, 2015. Commissioner Pupa seconded. The motion carried with the following votes:

AYE:	Alatorre, Araujo, Fisher, Glyer, Laba, Pawar and Pupa.
NAY:	None.
ABSTAIN:	Foy
ABSENT:	Dial and Lee.

2. APPROVAL ITEMS

a. Appointment to Consumer Advisory Committee (CAC)

COO Watson reviewed the report with the Commission.

Commissioner Foy moved to approve the appointments to the Consumer Advisory Committee. Commissioner Fisher seconded. The motion carried with the following votes:

AYE:	Alatorre, Araujo, Fisher, Foy, Glyer, Laba, Pawar and Pupa.
NAY:	None.
ABSTAIN:	None.
ABSENT:	Dial and Lee.

b. Appointment to Provider Advisory Committee (PAC)

COO Watson reviewed the report with the Commission.

Commissioner Foy moved to approve the appointments to the Provider Advisory Committee. Commissioner Alatorre seconded. The motion carried with the following votes:

AYE:	Alatorre, Araujo, Fisher, Foy, Glyer, Laba, Pawar and Pupa.
NAY:	None.
ABSTAIN:	None.
ABSENT:	Dial and Lee.

c. Department of Health Care Services (DHCS) Contract Amendment (Number to be determined)

CEO Villani reviewed the report with the Commission explaining that the amendment extends the length of the contract for six months, to December 31, 2015.

Commissioner Fisher moved to approve and authorize the CEO to execute the DHCS contract amendment. Commissioner Foy seconded. The motion carried with the following votes:

AYE:	Alatorre, Araujo, Fisher, Foy, Glyer, Laba, Pawar and Pupa.
NAY:	None.
ABSTAIN:	None.
ABSENT:	Dial and Lee.

d. Adoption of Audit Committee Charter

CEO Villani stressed the importance of having an internal auditor as well as checks and balances to monitor performances, risk assessments and controls within GCHP. He added that CFO Mowlavi identified a consultant with the knowledge and experience to assist GCHP in identifying and putting those controls into place. CFO Mowlavi briefly reviewed her report before introducing Marty Haisma of Etonien Financial Consultants.

Marty Haisma was present to answer any questions. Provided an overview of his background in auditing and accounting, establishing levels of internal controls and reviewing corporate governance and policies.

Commissioner Glyer requested clarification regarding the Committee's $500,000 purchasing authority. CFO Mowlavi explained that the $500,000 per fiscal year would encompass anything needed to give the Committee adequate financial ability to contract with external auditors and if needed, any services for investigations.

With regard to GCHP's contracting threshold policy, Chair Araujo and Commissioner Alatorre asked if the Plan had obtained three bids or if anyone else had been considered for the consulting services. CEO Villani explained that the consulting services were to assist the Plan to establish and set up the policies, procedures and infrastructure. The internal auditor would be a GCHP employee. CFO Mowlavi confirmed that the contract was under the $50,000 threshold.

In response to questions from Chair Araujo, CEO Villani and CFO Mowlavi explained that the internal auditor was a new position which was approved in the FY 2015-16 budget as a Risk Manager therefore the position will be Risk Manager / Internal Auditor.

Chair Araujo asked if the Commission wished to change the Committee's purchasing threshold. Commissioner Glyer noted that he was comfortable with the figure after obtaining the answers to his questions and the fact that it is a subcommittee of the Commission.

Commissioner Foy moved to adopt the Audit Committee Charter. Commissioner Glyer seconded. The motion carried with the following votes:

AYE: Alatorre, Araujo, Fisher, Foy, Glyer, Laba, Pawar and Pupa.
NAY: None.
ABSTAIN: None.
ABSENT: Dial and Lee.

e. Adoption of a Cultural Diversity Program, Including the Creation of an Human Resources, Cultural Diversity Subcommittee to Among Other Things, Initiate a Diversity Intervention Project, a Cultural Diversity Hotline and Potential Agreement with the Ventura County Human Resources Division or a Third Party to Facilitate the Initiation of the Diversity Intervention Project

As a preliminary matter, Legal Counsel Campbell explained that Best Best and Krieger and County Counsel agreed that current members of the Commission are allowed under the Conflict of Interest rules, to participate in the consideration of a contract with the County's Human Resources Department for implementation of a diversity program.

Legal Counsel Campbell reviewed the staff report, reported that the County had introduced an ordinance that if adopted would substitute the Ventura County Medical Center Family Medicine Director position, currently held by Dr. Araujo, for a position to be nominated by the County. The County has indicated that the person that will be appointed at this time is Shawn Atin, Ventura County Human Resources Director. The Ordinance will also establish a Chief Diversity Officer which would report to the Commission. That Officer would have the ability to take disciplinary action for violation of the Diversity Program that will be developed by the Human Resources Cultural Diversity Committee. That Committee, which the Commission was in the process of establishing based in part on the recommendations that came out of the recent internal investigation handled by the Special Investigation Ad Hoc Committee, is on the agenda for approval. The item for Commission consideration is the establishment of the Human Resources Cultural Diversity Committee and appointments thereto.

Shawn Atin, Ventura County Human Resources Director, spoke in favor of the establishment of a Cultural Diversity Program.

Commissioner Foy asked how Mr. Atin could be appointed to the ad hoc committee prior to the official appointment to the Commission. Legal Counsel Campbell explained that Mr. Atin could serve in an advisory role in the interim.

CEO Villani added that some of the recommendations align with the directives previously laid out to the Commission. One of the most important items is having a Senior Director of Human Resources. That position has been filled and will be on staff by November 2, 2015 and will work closely with the Chief Diversity Officer.

CEO Villani reported on the following areas: 1) GCHP contracts with NAVEX Global for the Fraud Waste and Abuse hotline and the Cultural Diversity hotline can be added to their services for approximately $2,000 per year. 2) GCHP is in the process of

contracting for diversity training. 3) As part of an annual employee survey, questions will be asked to ensure GCHP obtains the information needed from the surveys.

Commissioner Glyer raised a concern that the Chief Diversity Officer would have the ability to bypass the CEO and take independent disciplinary action against employees. Commissioner Foy stated that the County CEO had explained it as a cooperative situation.

CEO Villani added that he hoped that the Commission and the subcommittee would always ask for input by the CEO regarding any action brought forward.

Commissioner Glyer stated that the ordinance should not be adopted as worded. Commissioner Foy agreed

Commissioner Foy moved to establish the Human Resources Cultural Diversity Committee. Commissioner Glyer seconded. The motion carried with the following votes:

AYE:	Alatorre, Araujo, Fisher, Foy, Glyer, Laba, Pawar and Pupa.
NAY:	None.
ABSTAIN:	None.
ABSENT:	Dial and Lee.

Commissioner Foy moved that the Human Resources Cultural Diversity Committee be comprised of three Commission Members. Commissioner Pupa seconded. The motion carried with the following votes:

AYE:	Alatorre, Araujo, Fisher, Foy, Glyer, Laba, Pawar and Pupa.
NAY:	None.
ABSTAIN:	None.
ABSENT:	Dial and Lee.

Commissioner Fisher nominated Shawn Atin, contingent upon appointment to the Commission by the Ventura County Board of Supervisors. Commissioner Foy nominated Commissioner Glyer. Commissioner Pawar nominated Commissioner Alatorre. Chair Araujo suggested consideration of Commissioner Lee.

Commissioner Foy moved to appoint Shawn Atin, Commissioner Glyer and Commissioner Alatorre to the Human Resources Cultural Diversity Committee. Commissioner Glyer seconded. The motion carried with the following votes:

AYE:	Alatorre, Araujo, Fisher, Foy, Glyer, Laba, Pawar and Pupa.
NAY:	None.
ABSTAIN:	None.
ABSENT:	Dial and Lee.

Discussion was held regarding the Diversity hotline

Commissioner Fisher asked if the Committee would receive a report regarding the calls to the hotline. CEO Villani responded that the Chief Diversity Officer would review the calls, and the routing of the call information and the frequency of those reports would have to be determined. In response to Commissioner Fisher's question, Legal Counsel Campbell explained that discussion regarding the specific calls would not necessarily be handled in Closed Session of the Human Resources Cultural Diversity Committee.

Chair Araujo asked about contracting with the County. Legal Counsel Campbell responded that there were four options for the Commission: 1) Contract with the County of Ventura for the function; 2) Contract with a third party vendor to assist in establishing a diversity program; 3) It could be kept internally with Ms. Hewlitt, Legal Counsel Ortiz and the Human Resources Cultural Diversity Committee; and 4) The Commission could wait until a Chief Diversity Officer is hired.

Commissioner Foy moved to direct CEO Villani to meet with the County of Ventura Human Resources Department and other potential vendors, do a comparison of the programs and costs and provide a recommendation to the Commission. Commissioner Fisher seconded. The motion carried with the following votes:

AYE:	Alatorre, Araujo, Fisher, Foy, Glyer, Laba, Pawar and Pupa.
NAY:	None.
ABSTAIN:	None.
ABSENT:	Dial and Lee.

3. ACCEPT AND FILE ITEMS

a. CEO Update

CEO Villani reviewed his report with the Commission, additional material was provided to the Commission. He highlighted the upcoming strategic planning meeting with Jennifer Kent of DHCS and GCHP's consultant. Leadership will present the foundation, goals and recommended direction for 2015-16. GCHP's behavioral health provider, Beacon Health Strategies (Beacon), has been sent additional compliance notices. Beacon has been unable to provide specific reports needed and there are concerns that Beacon cannot process claims as per their contract. A request for information has been sent out to see if there are other potential vendors that could meet GCHP's performance standards because this is a risk to Plan.

Compliance Director Armenta added that, as reported at the last Commission Meeting, Beacon is on a financial sanction as a result of non-compliance with their Corrective Action Plan (CAP).

b. Update – June 2015 Financials

CFO Mowlavi updated the Commission on the external audit. McGladrey should complete the FY 2013-14 audit the following week. GCHP selected Moss Adams for the FY 2014-15 audit, upon McGladrey's decision to exit the Medi-Cal market. Moss Adams, specializes in Medi-Cal and handles 75% of Medi-Cal managed care plans in California. Moss Adams has completed as much pre-work as possible but cannot move forward until McGladrey issues FY 2013-14 audited financials. Moss Adams and GCHP are

working diligently to complete the audit by the due date to DHCS which is October 28, 2015.

CFO Mowlavi reported that GCHP will be paying ACA 1202 through the end of the calendar year. Approximately $361,000 of ACA 1202 payments are scheduled to go out the following week. There are coding issues with another set of providers for approximately $100,000 and letters will be going out to the providers that have not yet submitted their W-9's.

In response to questions from Commissioner Glyer, CFO Mowlavi explained that the June Financials contained audit entries recommended by McGladrey. Retroactive revenue was moved back to the affected year. Actual claim experience was recognized in FY 2013-14, allowing GCHP to rely less on the Incurred But Not Reported (IBNR) estimates. No future audit adjustments were anticipated.

CFO Mowlavi introduced the Financial Performance Dashboard which depicts past, current and future indicators for membership, revenue, key ratios, operating gain and tangible net equity (TNE). There were strong bottom line gains, over the past two fiscal years, as a result of Adult Expansion (AE), which strengthened TNE. However, operating gains are expected to decline as a result of pressure on rates (DHCS reduced AE rates by 23% in July), increasing healthcare costs, benefits and new programs.

Commissioner Foy asked what would be done to protect the margin. CFO Mowlavi responded that GCHP is reviewing the cost of health care programs and the rate development template to maximize rates for GCHP.

CEO Villani added that GCHP is continuing to look at operating efficiencies and there are some larger contracts that GCHP believes could be done better.

COO Watson noted that GCHP built rate changes into the AE program with providers, and is able to change the rates should the rates from the State go down.

Financial Analysis Director Turner added that the two years that had healthy net operating results are remarkable and will not likely repeat. This fiscal year is more typical of how the State builds rates.

Commissioner Pupa asked for an updated grid showing GCHP's TNE compared to other COHS in the State. CFO Mowlavi added that GCHP is developing a policy around the TNE and will bring that to the Commission as well.

Commissioner Fisher asked if there had been any discussions with the State regarding lifting of the financial CAP due to the current TNE level and solid financial ground. COO Watson responded that the State is not only looking at sustainable financials, but also sustainable staffing at the executive level.

c. COO Update

COO Watson presented the COO report highlighting membership, space expansion, claim turnaround time and grievances. October membership has not yet been received

by the State, but GCHP anticipates only marginal growth. GCHP is still negotiating for additional space in Daily Drive campus. GCHP has been working closely with Xerox regarding claim turnaround time and the call center to address issues caused by changes within Xerox as well as the increased membership.

Commissioner Foy asked if there were guarantees in the contract. COO Watson confirmed that guarantees were in the contract and GCHP did reduce the payment while the requirements were not being met.

COO Watson explained that the grievance charts would be updated to reflect balance billing as a member complaint and not as a member grievance. The number of member grievances received per 1,000 members was 0.04.

d. CIO Update

CIO Scrymgeour reviewed her report. The Plan is entering into a strategic pricing agreement with Insight for the purpose of Microsoft products, computing equipment and peripherals. The Plan is leveraging purchasing power through a provision in the California Public Contract Code by participating in a software cooperative agreement for enterprise Microsoft licensing as negotiated by the County of Riverside. Insight is a Microsoft certified value added reseller and was selected by the Plan due to their ability to warehouse and distribute purchased hardware product. CIO Scrymgeour highlighted the anticipated savings through this agreement, which is roughly 20% this fiscal year on budgeted software and hardware spend. In reviewing the projects, CIO Scrymgeour reported that some projects are being required to be pushed forward due to resource constraints

e. CMO / Health Services Update

CMO Dr. Reeves reviewed Associate Chief Medical Officer Dr. Wharfield's report. The Commission previously had questions regarding diagnoses. An overwhelming 50% of hospitalizations had to do with pregnancies. ER utilization went up but remains good compared to other plans. Authorizations have significantly increased due to membership levels. The number of members using behavioral health providers increased, GCHP believes it correlates with members learning of the benefit and PCP's are referring members.

Lupe Gonzalez, Director of Health Education, Outreach, Cultural and Linguistic Services reported on Outreach and Sponsorships.

f. Compliance Update

Compliance Officer / Director Armenta reviewed the Compliance Update, noting that GCHP is still under a financial Corrective Action Plan (CAP) from the State and continues to have monthly submission requirements.

The State previously conducted medical audits every three years, but are now conducted annually. Receipt of the final CAP from the annual medical audit from review period December 1, 2014 through November 30, 2014 has been delayed. GCHP is concerned that there will not be adequate time to implement changes identified in the CAP before the next scheduled audit. The State has verbally committed to ensuring adequate time provided to the Plan between the issuance of the CAP and the next scheduled audit so that the Plan can implement changes identified by the audit.

GCHP is contractually obligated to actively monitor delegated functions provided by subcontractors. The Plan currently has two CAPs open for the Managed Behavioral Healthcare Organization (MBHO) and the specialty contract. GCHP is working with each delegate to ensure successful closure of the CAP once compliance is achieved. The Plan remains vigilant and continues to enforce the robust oversight program.

Commissioner Foy moved to accept and file the CEO, CFO (June 2015 Financials), COO, CIO, CMO / Health Services and Compliance Updates. Commissioner Fisher seconded. The motion carried with the following votes:

AYE:	Alatorre, Araujo, Fisher, Foy, Glyer, Laba, Pawar and Pupa.
NAY:	None.
ABSTAIN:	None.
ABSENT:	Dial and Lee.

COMMENTS FROM COMMISSIONERS

Chair Araujo expressed his appreciation that employees of the Plan came forward in support of the Plan.

Commissioner Foy added that the Commission believes in the organization and that one or two people do not define an organization.

Commissioner Pupa thanked GCHP staff for speaking with the Commission.

CLOSED SESSION

Legal Counsel Campbell explained the purposes of the Closed Session Items.

CLOSED SESSION ADJOURNMENT

The Commission adjourned to Closed Session at 5:09 p.m. regarding the following items

a. **Public Employee Performance Evaluation**
Pursuant to Government Code Section 54957
Title: Chief Executive Officer

b. **Conference with Legal Counsel –** Existing Litigation
Name of Case: Guillermo Gonzalez v. Gold Coast Health Plan, EEOC Claim Nos. 480201402364 and 480201501070

c. Conference With Legal Counsel – Anticipated Litigation
Significant Exposure to Litigation Pursuant to Paragraph (2) of Subdivision (d) of Section 54956.9
Number of Cases: 3

RETURN TO OPEN SESSION

The Regular Meeting reconvened at 6:25 p.m.

Legal Counsel Campbell announced that no reportable action was taken in Closed Session.

ADJOURNMENT

Meeting adjourned at 6:26 p.m.

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Commission Meeting Minutes
November 16, 2015
(Not official until approved)

CALL TO ORDER

Vice-Chair Alatorre called the meeting to order at 3:07 p.m. Hall of Justice – Pacific Room at the County of Ventura Government Center, 800 S. Victoria Avenue, Ventura, CA 93009.

The Pledge of Allegiance was recited.

SWEAR IN OF NEW COMMISSIONER

New Commissioner Shawn Atin was sworn in by Clerk McGinley.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE
Antonio Alatorre, Clinicas del Camino Real, Inc.
Shawn Atin, County of Ventura
Lanyard Dial, MD, Ventura County Medical Association
Barry Fisher, Ventura County Health Care Agency
David Glyer, Private Hospitals / Healthcare System
Michelle Laba, MD, Ventura County Medical Center Executive Committee
Darren Lee, Private Hospitals / Healthcare System
Gagan Pawar, MD, Clinicas del Camino Real, Inc.
Dee Pupa, Ventura County Health Care Agency

EXCUSED / ABSENT COMMISSION MEMBERS
Peter Foy, Ventura County Board of Supervisors
Vacant, Medi-Cal Beneficiary Advocate

STAFF IN ATTENDANCE
Dale Villani, Chief Executive Officer
Patricia Mowlavi, Chief Financial Officer
Traci R. McGinley, Clerk of the Board
Scott Campbell, Legal Counsel
Brandy Armenta, Compliance Director
Anne Freese, Pharmacy Director
Danita Fulton, Senior Human Resources Director
Vicki Hewlett, Interim Chief Diversity Officer
Steven Lalich, Communications Director
Tami Lewis, Operations Director
Kim Osajda, Quality Improvement Director
Al Reeves, MD, Chief Medical Officer

Melissa Scrymgeour, Chief Information Officer
Lyndon Turner, Financial Analysis Director
Ruth Watson, Chief Operations Officer
Nancy Wharfield, MD, Associate Chief Medical Officer

PUBLIC COMMENT

GCHP employee Traci McGinley spoke regarding concerns she had with the Personnel policies as proposed.

1. APPROVE MINUTES

a. Special Meeting of October 29, 2015

Commissioner Lee moved to approve the Special Meeting Minutes of October 29, 2015. Commissioner Pupa seconded. The motion carried with the following votes:

AYE: Alatorre, Atin, Dial, Fisher, Glyer, Laba, Lee and Pupa.
NAY: None.
ABSTAIN: Pawar.
ABSENT: Foy.

2. CONSENT ITEMS

a. Financials – September 2015

CFO Mowlavi provided a brief review of the financial performance of the first quarter of FY 2015-16 which had been presented at the Executive and Finance Committee Meeting. Commissioner Pupa moved to approve and file the September 2015 Financials. Commissioner Pawar seconded. The motion carried with the following votes:

AYE: Alatorre, Atin, Dial, Fisher, Glyer, Laba, Lee, Pawar and Pupa.
NAY: None.
ABSTAIN: None.
ABSENT: Foy.

3. APPROVAL ITEMS

a. FY 2014-15 Audit Results (Presented by Moss Adams)

CFO Mowlavi introduced John Blakey and Stelian Damu of Moss Adams. The previous audit firm McGladrey was exiting the Medi-Cal market, but the Plan was able to quickly engage Moss Adams for the FY 2014-15 audit and leverage their Medi-Cal specialization to complete the audit. Moss Adams is the auditor for approximately 75% of Medi-Cal managed care plans in California.

John Blakey and Stelian Damu of Moss Adams provided an overview of the draft Financial Statement and Audit Report. They explained that areas where significant and critical misstatements can occur were reviewed using a risk based approach. Their experience in health care plans and hospitals allows them to understand the unique

risks that health plans face and it assists them in efficiently designing audits to identify those risks. Based on the testing performed by Moss Adams, the revenue and receivables have been reported appropriately; no major misstatements or unusual items were found; and previous material weaknesses were corrected.

John Blakey explained to the Commission that Moss Adams goes through a robust client acceptance process. This was a first year engagement so they had to gain an understanding of Plan's internal processes, checks and balances. They also considered findings from the prior year audit as well as the allegations in 2014 involving workplace issues and financial improprieties.

They noted that the prior year audit reported several significant deficiencies and material weaknesses in the internal controls. Moss Adams reviewed McGladrey's draft report and list of reported deficiencies, gained an understanding of the nature of the errors and built that into their audit process. Moss Adams found that those issues had been remediated and testing did not show similar control deficiencies.

Moss Adams also considered the financial allegations from 2014; the nature and severity of the allegations, as well as what GCHP did to address those allegations. Moss Adams drew their own conclusions about how that impacted management's integrity, the integrity of the controls, the financial reporting system and whether Moss Adams could render a fair opinion. They concluded that there was no evidence to support the allegations and they were satisfied with the depth of the independent review that the Commission directed and the findings from that independent review Moss Adams tested the areas surrounding financial issues that were identified in the independent review and confirmed that GCHP had addressed those items. The allegations not related to financial issues were not necessarily reviewed, but considered as part of management's integrity. Moss Adams also considered whether certain allegations could have a material impact. GCHP has gone through significant changes in management, systems and controls. The issues where highlighted, addressed in the audit and Moss Adams was satisfied that the deficiencies outlined or alleged have been remediated.

John Blakey and Stelian Damu of Moss Adams reported that there were no significant adjustments needed which spoke highly of management and the work that was put into this audit. One significant deficiency was found around segregation of duties: an individual had access to different modules of the payroll system that really should be segregated. GCHP does have compensating controls in place to monitor payroll payments and it does not appear that it could impact financial payments; however, it is something management should address and fix.

b. FY 2013-14 Audit Results

CFO Mowlavi informed the Commission that Moss Adams reviewed the material weaknesses reported in the McGladrey FY 2013-14 Audit Results and found them no longer relevant.

Commissioner Glyer moved to approve the FY 2013-14 and FY 2014-15 Audit Results. Commissioner Pupa seconded. The motion carried with the following votes:

AYE: Alatorre, Atin, Dial, Fisher, Glyer, Laba, Lee, Pawar and Pupa.
NAY: None.
ABSTAIN: None.
ABSENT: Foy.

c. Appointment of Audit Committee

CFO Mowlavi reviewed the report with the Commission. General discussion was held regarding the needs of the Committee and its functions.

Commissioner Fisher moved to appoint Commissioners Alatorre, Glyer and Pupa to the Audit Committee. Commissioner Atin seconded. The motion carried with the following votes:

AYE: Alatorre, Atin, Dial, Fisher, Glyer, Laba, Lee, Pawar and Pupa.
NAY: None.
ABSTAIN: None.
ABSENT: Foy.

d. Approval of Resolution Amending / Revising and Ratifying Personnel Rules, Regulations and Policies

Senior Human Resources Director Fulton reviewed the presentation with the Commission. Discussion was held regarding vacation tiers, accrual of sick leave, and administrative days.

Commissioner Atin expressed concern that the Chief Diversity Officer's (CDO) role was not contained in the Whistle Blower Policy. CEO Villani explained that any Personnel Policies that require modification once the CDO is hired will be brought back to the Commission. Legal Counsel Campbell added that the Cultural Diversity Program itself will contain specific rules and regulations.

Commissioner Atin moved to approve the Resolution contingent upon clarification in the policies regarding the CDO duties. Commissioner Lee seconded. The motion carried with the following votes:

AYE: Alatorre, Atin, Fisher, Glyer, Laba, Lee, Pawar and Pupa.
NAY: None.
ABSTAIN: None.
ABSENT: Dial and Foy.

RESOLUTION NO. 2015-007

A RESOLUTION OF THE VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION DBA GOLD COAST HEALTH PLAN, REPEALING RESOLUTION NO. 2012-001 (ADOPTING RULES AND REGULATIONS FOR THE ADMINISTRATION OF THE PERSONNEL SYSTEM) AND ADOPTING PERSONNEL RULES, REGULATIONS, AND POLICIES

e. Quality Improvement Committee Report – 3rd Quarter 2015

CMO Reeves reviewed the Quality Improvement Committee Report with the Commission. The following items were highlighted:

- Quality Improvement Projects (QIP):
  - HEDIS:
    - Diabetic Retinal Eye Exam Member Incentive
    - Cervical Cancer Screening – reminder letters
    - Children and Adolescents Access to primary care providers member incentive
    - Postpartum Exam member incentive
    - Medication Management in People on Persistent Medications
  - CAHPS Satisfaction Improvement: - Focus Groups
- California Performance Improvement Project (PIP) Transition Plan: Department of Health Care Services (DHCS) retired the statewide QIP on readmissions. Each plan will now be required to do two Performance Improvement Projects (PIP): The Quality Improvement Committee selected immunizations of 2 year olds from the four available topics as the first PIP. The second PIP must be plan specific, provided to DHCS by January 2016 and then approved by DHCS.
- Facility Site Reviews – Initial and Interim: GCHP is required to monitor providers for the adequacy of their offices, physical access and medical records. CMO Reeves provided an overview of the initial and interim Facility Site Reviews, the 3rd Quarter 2015 Initial Health Assessment (IHA) Medical Record Reviews regarding IHA Monitoring and the Potential Quality Issues.
- CMO Reeves reviewed the Quality Improvement Dashboard detailing the measures, what they entailed and the scoring.

Commissioner Pupa asked about the increase in requests for translation services. CMO Reeves explained that it was good as it shows that providers and members are becoming more aware of the service.

CMO Reeves continued to highlight the report as follows:

- Pharmacy Benefit Manager (PBM) oversight.
- Inter-Rater Reliability (IRR) Review.

- Changes to the Formulary: six drugs were added due to significant clinical advantages and 15 brand name drugs were removed due to new generics now available.
- Monitoring of Medical Board of California (MBC) Actions against GCHP providers.
- Potential Quality Issues (PQI) Peer Review Referrals. Five cases were highly rated cases or cases of concern that resulted in a letter to the provider.
- Credentialing and Recredentialing.
- GCHP Credentialing and Recredentialing Internal Audits
- Medical Advisory Committee (MAC) approved six new policies.
- Health Education and Outreach.
- Grievance and Appeals statistics were reviewed.

Commissioner Pawar asked if any of the 23 Quality of Care Grievances were significant. CMO Reeves explained that all grievances are reviewed by a clinical nurse and 10 were referred to the Quality Committee as PQIs for review. Commissioner Pawar asked if they were investigated. CMO Reeves responded that they are in the process of being reviewed or have been concluded and could be included in the five PQIs.

In response Commissioner Fisher's question, CMO Reeves responded that the Plan bears the cost of State Fair Hearings.

CMO Reeves continued, and the following areas were highlighted.

- Network Planning:
  - Required Provider to Member Ratios
    - PCP - 1:2000
    - Total Physicians - 1:1200
  - GCHP August Ratios
    - PCP - 1:819
    - Total Physicians - 1:136
- Provider Access Survey – in process
- Provider Satisfaction Survey – in process
- Network Planning: Call Center Statistics
- Utilization Management Statistics: Beacon Mental Health Utilization
- Delegation Oversight

In response to Commissioner Pawar's question regarding delegated oversite, CMO Reeves responded that in addition to Clinicas del Camino Real, Inc., Ventura County Medical Center (VCMC) also has delegated oversite.

Vice-Chair Alatorre asked which entities had utilization management delegation. CMO Reeves responded Kaiser and Beacon.

Commissioner Pupa moved to approve the Quality Improvement Committee Report - 3rd Quarter 2015. Commissioner Pawar seconded. The motion carried with the following votes:

AYE: Alatorre, Atin, Dial, Fisher, Glyer, Laba, Lee, Pawar and Pupa.
NAY: None.
ABSTAIN: None.
ABSENT: Foy.

f. Provider Credentialing Policy and Organizational Providers Credentialing Policy

CMO Reeves reviewed the report with the Commission.

Commissioner Atin moved to approve the Provider Credentialing Policy and Organizational Providers Credentialing Policy. Commissioner Pupa seconded. The motion carried with the following votes:

AYE: Alatorre, Atin, Dial, Fisher, Glyer, Laba, Lee, Pawar and Pupa.
NAY: None.
ABSTAIN: None.
ABSENT: Foy.

g. Chief Diversity Officer Job Description and Salary

Legal Counsel Ortiz reviewed the report with the Commission providing an update of the Committee's actions.

Commissioner Lee expressed concern that the job description was broader in scope than required by the County Ordinance and asked why it was changed to include responsibilities that are traditionally handled by Human Resources and specifically excludes Human Resources involvement in those areas.

Commissioner Atin stated that the Ordinance gives the CDO independent authority to take disciplinary action against employees, with the exception of the CEO, for failure to comply with the Cultural Diversity Program. The Committee wanted to ensure the job description clearly reflected the CDO's duties and authority provided by the Ordinance.

Commissioner Lee stated that according to the Ordinance there are the following four requirements: 1) implement a cultural diversity program; 2) have the CDO report directly to the Commission; 3) that the CDO has the authority to discipline; and 4) that the CDO will provide quarterly reports to the Ventura County Board of Supervisors, through the County's Chief Executive Officer. He then expressed concern that the job description was directive in nature but should be worded in more of a collaborative nature, promoting a diversity program and then holding people accountable.

Commissioner Atin stated that the job description should clearly define what the job entails. For an individual in that position to be successful within GCHP, the person needs to be collaborative; however, the nature of the job description is to delineate the position's authority to hold individuals accountable.

Legal Counsel Ortiz explained that due to the concerns previously raised in the community, the Committee wanted to take a strong proactive approach. A needs assessment has not yet been done so the program will initially need to be flexible. It is the Commission's discretion at any time to reassess the program needs, change the duties of the CDO and to determine if the position needs to be expanded or folded into another position.

Commissioner Lee added that it was not uncommon to have one part of an organization be in charge of the investigation and another to have the authority to implement and execute corrective action. Commissioner Fisher stated that there would need to be collaboration with Human Resources on some issues.

Commissioner Dial suggested that the CDO be required to have essential Human Resources background.

Legal Counsel Ortiz noted that an experienced CDO would have a Human Resources or similar background. There are a number of ways that the CDO position can be structured to impact the organization and still have independence whether they direct or have oversight of an investigation.

Commissioner Lee stressed that he wanted to ensure the structure and processes put into place drive the desired changes to the organization.

Commissioner Fisher added to hear the thoughts from the other two Committee Members. Commissioner Glyer and Vice-Chair Alatorre responded they were satisfied with the job description as presented and believe it reflects the intent of the Board of Supervisors.

CEO Villani stated that it was his thought that the focus of the CDO would be cultural diversity, where Title 7 categories are much broader. He wanted to ensure that the CDO job description is extremely clear as to whether it is very broad, specific to employment issues, or just Cultural Diversity.

Commissioner Atin stated that he believed the Board of Supervisors intent was to be broad because discrimination can occur in a wide range of areas and it was clearly the Board of Supervisors intent to take the responsibility out of Human Resources.

Commissioner Lee noted that he would like changes to the job description and have further discussions. Commissioner Dial suggested having one additional Commissioner meet with the Committee.

After further discussion, Legal Counsel Campbell confirmed that there was Commission consensus to have Commissioner Lee work with the Committee on changes to the CDO job description and should Commissioner Lee be satisfied with the changes the job description was approved.

Commissioner Fisher suggested the salary range be reviewed. Commissioner Atin reported that the Committee discussed that it be the same salary range as the SeniorHuman Resources Director. Further discussion was held regarding the salary range.

Commissioner Dial moved to adopt salary range #29. Commissioner Fisher seconded. The motion carried with the following votes:

AYE:	Alatorre, Atin, Dial, Fisher, Glyer, Laba, Lee, Pawar and Pupa.
NAY:	None.
ABSTAIN:	None.
ABSENT:	Foy.

Legal Counsel Campbell reported that the Committee recommended having an interview panel of five people,

Discussion was held regarding LULAC being on the interview panel.

Legal Counsel Campbell advised the Commission that it would have to determine whether an appointment from LULAC to the selection committee would have an appearance of impropriety. There is still an ongoing active matter with the Attorney General and there have been statements in correspondence from LULAC threatening litigation or criticizing individuals in management.

Discussion was held regarding someone from GCHP staff or someone with diversity experience being on the selection committee.

CEO Villani recommended LULAC not be on the selection committee and that it would send the wrong messages to employees. He recommended looking at other organizations.

Commissioner Atin stated that there was considerable discussion at the Committee Meeting regarding the composition of the initial interview panel. Commissioner Lee asked if there had been any consultation with LULAC regarding this matter. Commissioner Atin responded that he and other individuals at the County had been contacted by LULAC. Commissioner Lee stated that he was not comfortable with LULAC being involved.

Commissioner Atin moved to accept the Committee's recommendation for the interview process. Commissioner Pawar seconded. The motion carried with the following votes:

AYE:	Alatorre, Atin, Fisher, Glyer, Laba, Pawar and Pupa.
NAY:	Dial and Lee.
ABSTAIN:	None.
ABSENT:	Foy.

RECESS
A recess was called at 5:45 p.m. The meeting was reconvened at 5:55 p.m.

4. ACCEPT AND FILE ITEMS

a. CEO Update

CEO Villani reviewed his report with the Commission and provided a high level overview of the events since he was appointed six months ago.

He discussed the strength of the leadership team, the strong financial performance, the clinical enhancements made in disease management and the pending pharmacy RFP. While the workforce is stable and highly motivated there is noted anxiety around the role of the CDO. He also discussed the uncertainties in Sacramento and the need to maintain a conservative approach to TNE and financial risk management. He indicated a TNE policy would be brought forward to the January Executive/Finance Committee for consideration.

He added that employee morale in general has improved. The goal is to make GCHP a great place to work; however, there is an element of anxiety around the CDO.

b. CFO Update

CFO Mowlavi updated the Commission, she highlighted the financial performance for the last quarter, the Tangible Net Equity (TNE) and the Adult Expansion (AE) Medical Loss Ratio (MLR).

c. COO Update

COO Watson presented the COO report; membership is up to 198,000. GCHP anticipates being very close to 200,000 by the end of the year. She added that GCHP will be conducting an RFP for a consultant to review the Plan's current Administrative Services Organization (ASO) arrangement to determine if GCHP should continue with the current arrangement or bring out source services in-house..

d. CIO Update

CIO Scrymgeour reviewed her report and highlighted projects that may be added at the beginning of the calendar year.

e. CMO / Health Services Update

Associate CMO Wharfield received her report with the Commission. She highlighted utilization, admissions and authorizations.

Commissioner Lee moved to accept and file the CEO, CFO, COO, CIO, CMO / Health Services Updates. Commissioner Fisher seconded. The motion carried with the following votes:

AYE:	Alatorre, Atin, Dial, Fisher, Glyer, Laba, Lee, Pawar and Pupa.
NAY:	None.
ABSTAIN:	None.
ABSENT:	Foy.

4. INFORMATIONAL ITEMS

a. Salary Survey

Senior Human Resources Director Fulton reviewed the salary survey information.

b. General Counsel Discussion on Commission and Staff Relationship

Legal Counsel Campbell explained that BB&K provides updates approximately once per month to public entities. There was Commission consensus that Legal Counsel would send updates to the Commission as they become available.

c. Diversity Committee Report

This item was discussed during Agenda Item 3g, *Chief Diversity Officer Job Description and Salary.*

COMMENTS FROM COMMISSIONERS

None.

CLOSED SESSION

Legal Counsel Campbell explained the purposes of the Closed Session Items.

ADJOURN TO CLOSED SESSION

The Commission adjourned to Closed Session at 6:22 p.m. regarding the following items

a. Public Employee Performance Evaluation
Pursuant to Government Code Section 54957
Title: Chief Executive Officer

b. Conference with Legal Counsel - Existing Litigation
Pursuant to Paragraph (1) of Subdivision (d) of Government Code Section 54956.9
Clinicas Del Camino Real Inc. v. Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan. Ventura County Superior Court Case Number 56-2014-00456149-CU-BC-VTA

RETURN TO OPEN SESSION

The Regular Meeting reconvened at 7:00 p.m.

Legal Counsel Campbell stated that no reportable action was taken in Closed Session.

ADJOURNMENT

Meeting adjourned at 7:01 p.m.

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Special Commission Meeting Minutes
October 13, 2015
(Not official until approved)

Notice of said meeting was duly given in the time and manner prescribed by law. Affidavit of compliance is on file in the Clerk of the Board's Office.

CALL TO ORDER

Chair Araujo called the meeting to order at 10:07 a.m. in the ____ Room at the Courtyard by Marriott, 600 East Esplanade Drive, Oxnard, CA 93036.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE
Antonio Alatorre, Clinicas del Camino Real, Inc.
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program (left at 12:45 p.m.)
Lanyard Dial, MD, Ventura County Medical Association (arrived at 12:45 p.m.)
Barry Fisher, Ventura County Health Care Agency (left at 3:41 p.m.)
Peter Foy, Ventura County Board of Supervisors (left at 3:41 p.m.)
David Glyer, Private Hospitals / Healthcare System
Michelle Laba, MD, Ventura County Medical Center Executive Committee
Darren Lee, Private Hospitals / Healthcare System
Gagan Pawar, MD, Clinicas del Camino Real, Inc. (arrived at 10:36 a.m.)
Dee Pupa, Ventura County Health Care Agency

EXCUSED / ABSENT COMMISSION MEMBERS
Vacant, Medi-Cal Beneficiary Advocate

STAFF IN ATTENDANCE
Dale Villani, Chief Executive Officer
Lyndon Turner, Financial Analysis Director
Traci R. McGinley, Clerk of the Board
Scott Campbell, Legal Counsel
Brandy Armenta, Compliance Director
Anne Freese, Pharmacy Director
Jeffrey Gauthier, Facilities Manager
Lupe Gonzalez, Director of Health Education, Outreach, Cultural and Linguistic Services
Steven Lalich, Communications Director
Vickie Lemmon, Health Services Director

Tami Lewis, Operations Director
Kim Osajda, Quality Improvement Director
Al Reeves, MD, Chief Medical Officer
Cathy Salenko, Legal Counsel
Melissa Scrymgeour, Chief Information Officer
Ruth Watson, Chief Operations Officer
Nancy Wharfield, MD, Associate Chief Medical Officer
Danita Fulton, Senior Human Resources Director
Vicki Hewlett, Interim Human Resources Director

Jennifer Kent, Department of Health Care Services (DHCS) Director
Margaret Tatar, Health Management Associates, GCHP Consultant

PUBLIC COMMENT

None.

1. APPROVAL ITEMS

a. Consideration of Strategic Plan

Staff reviewed the Strategic Plan with the Commission.

DHCS Director Kent provided an overview of activities occurring at DHCS.

Discussion was held regarding GCHP's CAP. DHCS Director Kent explained that the State wants to see several years of financial and executive stability before considering lifting the CAP.

DHCS Director Kent noted that Members of the Commission must separate themselves and look at what is best for the Plan and not necessarily as providers, the Commission needs to understand their role.

RECESS:
A recess was called at 12:02 p.m. The meeting was reconvened at 12:45 p.m.

Commissioner Foy suggested that the Vision be reworded to be: Compassionate care, accessible to all, a healthy community.

Discussion was held as to what information would be helpful in the packets, as well as the meeting packets no longer being provided in paper and only being provided electronically, GCHP has tablets available should any Commissioner need one.

RECESS:
A recess was called at _____p.m. The meeting was reconvened at 3:27 p.m.

Commissioner

moved to approve the Strategic Plan as amended. Commissioner

seconded. The motion carried with the following votes:

AYE:	Alatorre, Araujo, Fisher, Glyer, Laba, Lee and Pupa.
NAY:	None.
ABSTAIN:	None.
ABSENT:	Dial, Foy and Pawar.

ADJOURNMENT

Meeting adjourned at 3:55 p.m.

AGENDA ITEM NO. 2

To: Gold Coast Health Plan Commission

From: Patricia Mowlavi, CFO

Date: January 25, 2016

Re: Financials – October and November, 2015

SUMMARY:

Staff is presenting the attached fiscal year to date November 2015 financial statements (unaudited) of Gold Coast Health Plan (Plan) for the Commission to accept and file. These financials were review by the Executive / Finance Committee on January 7, 2016, where the Executive / Finance Committee recommended that the Commission accept and file these financials.

BACKGROUND / DISCUSSION:

The staff has prepared the fiscal year to date November 2015 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 five months ending November 30, 2015, the Plan's gain in unrestricted net assets was approximately $22.8 million compared to the $6.0 million budget. The favorable variance was largely due to higher than expected growth in membership in the Adult Expansion (AE) category of aid. Also contributing to the variance was lower than anticipated health care and administrative costs.

Tangible Net Equity – Favorable operating results contributed to a Tangible Net Equity (TNE) level of approximately $130.0 million, which exceeded the budget of $85.9 million by $44.0 million. November's TNE was 541% of the State required TNE, excluding the $7.2 million County of Ventura lines of credit (LOC). The sharp rise in the TNE multiple reflects an increase in capitated arrangements which are excluded from the required TNE calculation.

Membership – November membership of 200,385 exceeded budget by 5,474 members. The increase was primarily in the Adult Expansion (AE) category, which grew by 4,654 members this fiscal year. October membership also exceeded budget by 4,347.

Revenue – For the month ending November, fiscal year to date net revenue was $268.7 million or $6.8 million favorable to budget. The positive variance was primarily due to increase in membership with higher capitation rates (Adult Expansion).

Revenue includes a $12.6 million reserve for rate reductions associated with AE. This reserve represents an expected refund, to DHCS, of rate overpayments (DHCS was paying at July 1, 2014 rates rather than the July 1, 2015 published rates) and the anticipated refund of revenue to achieve a medical loss ratio (MLR) of 85%, for this aid category. (The MLR is calculated by dividing health care costs by revenue.) In November, DHCS began using the new reduced AE rates to calculate current month's revenue.

Health Care Costs – For the month ending November, fiscal year to date health care costs were $231.3 million or $7.7 million favorable to budget. Health care costs increased by $3.3 million or 7% in November over October driven by increased Inpatient utilization. The MLR for the fiscal year is 86%. Additional detail by major line item follows:

- Capitation – For the fiscal year, capitation was $40.0 million or $9.6 million unfavorable to budget. The unfavorable variance was driven by the Enhanced Adult Expansion Capitation program, which was revised effective July 2015, as well as higher than budgeted capitated membership growth.
- Fee for Service – For the fiscal year, total claims expense was $184.9 million compared to a budget of $198.5 million. While there was some movement of services between categories, the overall variance is driven by lower than expected Inpatient, LTC/SNF and Specialty Physician costs.
- Pharmacy – For the fiscal year, overall Pharmacy was $37.7 million or $67,000 favorable to budget driven by lower than budgeted costs in Adult and Family aid categories.
- Physician ACA 1202 – An ACA 1202 payment of $360,000 was made in October. An additional $560,000 payment was made in December.

Administrative Expenses – For the month ending November, fiscal year to date administrative costs totaled $14.7 million or $2.3 million favorable to budget. Costs associated with Outside Services, which is driven by membership, was offset by savings in personnel expenses.

The administrative cost ratio (ACR) is 5.5% or 1% favorable to budget. (The ACR is calculated by dividing administrative expenses by total revenue.)
Cash and Medi-Cal Receivable – Total Cash and Medi-Cal Premium Receivable balance was $463.7 million, as of November 30, 2015. This includes pass-through

payments for AB 85 of $1.8 million and Managed Care Organizations (MCO) tax of $4.1 million. Excluding the impact of the pass through amount, the total of Cash and Medi-Cal Receivable balance as of November 30, 2015 was $457.8 million or $36.6 million over the budgeted level of $421.1 million.

Investment Portfolio – As of November 30, 2015, the value of the investments were as follows:

- Short-term Investments $260.3 million: Cal Trust $80.2 million; Ventura County Investment Pool $80.1 million; LAIF CA State $50.0 million; Commercial paper and bonds $50.0 million (Commercial Paper will mature in December with value of $45 million).
- Long-term Investments (Bonds) $24.5 million.

RECOMMENDATION:

Staff requests that the Commission accept and file the October and November 2015 financial statements.

CONCURRENCE:

January 7, 2016 Executive / Finance Committee

ATTACHMENTS:

October and November 2015 Financial Package

Gold Coast Health Plan℠
A Public Entity

FINANCIAL PACKAGE
For the month ended November 30, 2015

TABLE OF CONTENTS

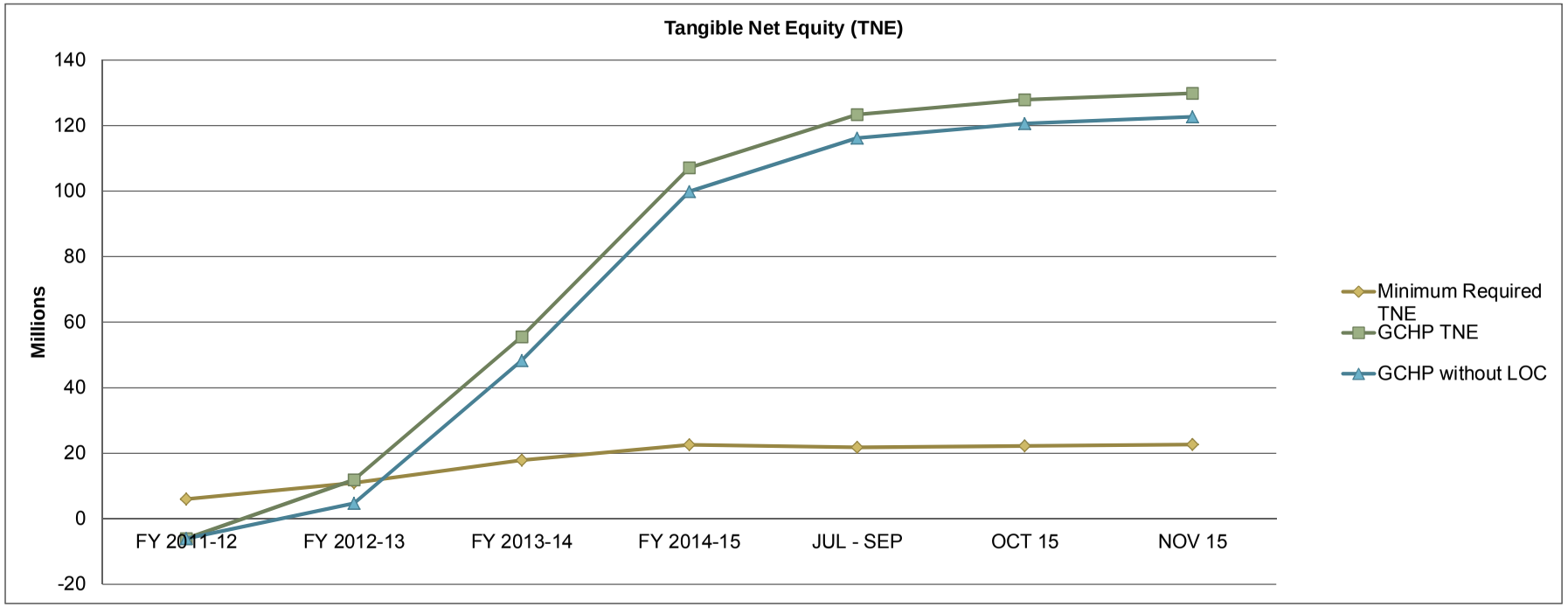
APPENDIX

GOLD COAST HEALTH PLAN
FINANCIAL RESULTS SUMMARY

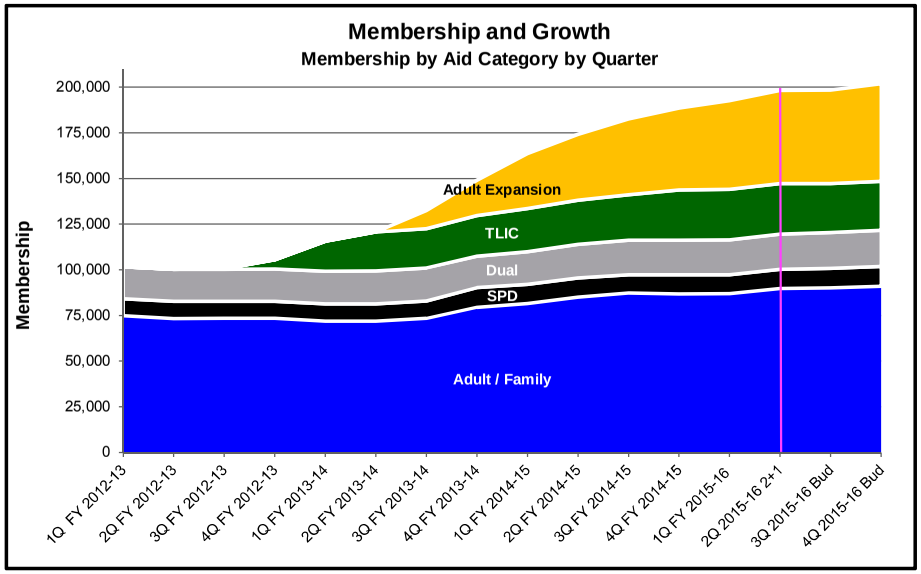
Description	AUDITED FY 2011-12	AUDITED FY 2012-13	AUDITED FY 2013-14	AUDITED FY 2014-15	FY 2015-16 JUL - SEP	FY 2015-16 OCT 15	FY 2015-16 NOV 15	FY 2015-16 NOV 15 FYTD	Budget Comparison Budget FYTD	Budget Comparison Variance Fav / (Unfav)	Budget Comparison Variance Fav / (Unfav)%
Member Months	**1,258,189**	**1,223,895**	**1,553,660**	**2,130,979**	**578,056**	**198,148**	**200,385**	**976,589**	**963,528**	13,061	1.4 %
Revenue	**304,635,932**	**315,119,611**	**402,701,476**	**595,607,370**	**162,960,677**	**52,508,015**	**53,274,568**	**268,743,260**	**261,931,947**	6,811,313	2.6 %
pmpm	*242.12*	*257.47*	*259.20*	*279.50*	*281.91*	*264.99*	*265.86*	*275.19*	*271.85*	3.34	1.2 %
Health Care Costs	**287,353,672**	**280,382,704**	**327,305,832**	**509,183,268**	**137,845,237**	**45,086,757**	**48,350,456**	**231,282,450**	**238,945,762**	7,663,312	3.2 %
pmpm	*228.39*	*229.09*	*210.67*	*238.94*	*238.46*	*227.54*	*241.29*	*236.83*	*247.99*	11.16	4.5 %
% of Revenue	94.3%	89.0%	81.3%	85.5%	84.6%	85.9%	90.8%	86.1%	91.2%	5.2 %	5.7 %
Admin Exp	**18,891,320**	**24,013,927**	**31,751,533**	**34,814,049**	**8,827,059**	**2,951,994**	**2,901,309**	**14,680,361**	**17,026,568**	2,346,207	13.8 %
pmpm	*15.01*	*19.62*	*20.44*	*16.34*	*15.27*	*14.90*	*14.48*	*15.03*	*17.67*	2.64	14.9 %
% of Revenue	6.2%	7.6%	7.9%	5.8%	5.4%	5.6%	5.4%	5.5%	6.5%	1.0 %	16.0 %
Total Increase / (Decrease) in Unrestricted Net Assets	**(1,609,063)**	**10,722,980**	**43,644,110**	**51,610,053**	**16,288,381**	**4,469,265**	**2,022,803**	**22,780,450**	**5,959,617**	16,820,833	282.2 %
pmpm	*(1.28)*	*8.76*	*28.09*	*24.22*	*28.18*	*22.56*	*10.09*	*23.33*	*6.19*	17.14	277.1 %
% of Revenue	-0.5%	3.4%	10.8%	8.7%	10.0%	8.5%	3.8%	8.5%	2.3%	6.2%	272.6 %
YTD											
100% TNE	16,769,368	16,138,440	17,867,986	22,556,530	21,819,072	22,266,192	22,698,761	22,698,761	24,539,354	(1,840,593)	(7.5)%
% TNE Required	36%	68%	100%	100%	100%	100%	100%	100%	100%		
Minimum Required TNE	6,036,972	10,974,139	17,867,986	22,556,530	21,819,072	22,266,192	22,698,761	22,698,761	24,539,354	(1,840,593)	(7.5)%
GCHP TNE	**(6,031,881)**	**11,891,099**	**55,535,211**	**107,145,264**	**123,433,646**	**127,902,910**	**129,925,714**	**129,925,714**	**85,938,888**	**43,986,825**	**51.2 %**
TNE Excess / (Deficiency)	**(12,068,853)**	**916,960**	**37,667,225**	**84,588,734**	**101,614,573**	**105,636,718**	**107,226,953**	**107,226,953**	**61,399,535**	**45,827,418**	**74.6 %**
% of Required TNE level			**311%**	**475%**	**566%**	**574%**	**572%**	**572%**	**350%**		
% of Required TNE level (excluding $7.2 million LOC)			**271%**	**443%**	**533%**	**542%**	**541%**	**541%**	**321%**		

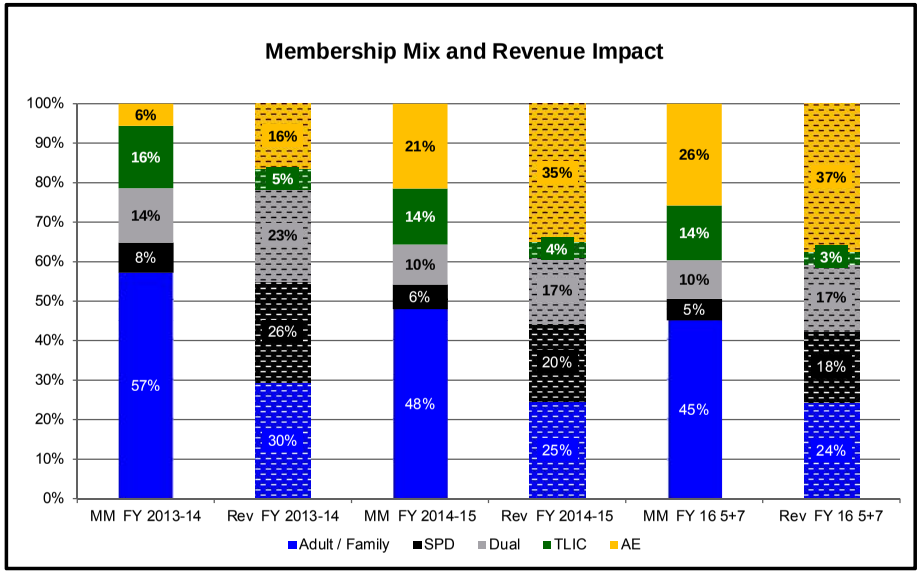
Note: TNE amount includes $7.2 million related to the Lines of Credit (LOC) from Ventura County.

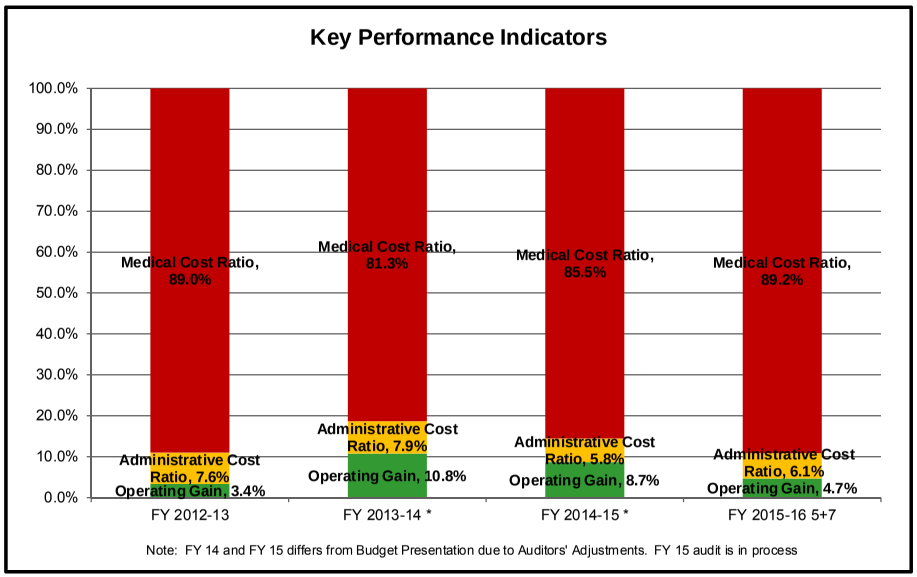
GOLD COAST HEALTH PLAN
TANGIBLE NET EQUITY (TNE) CHART



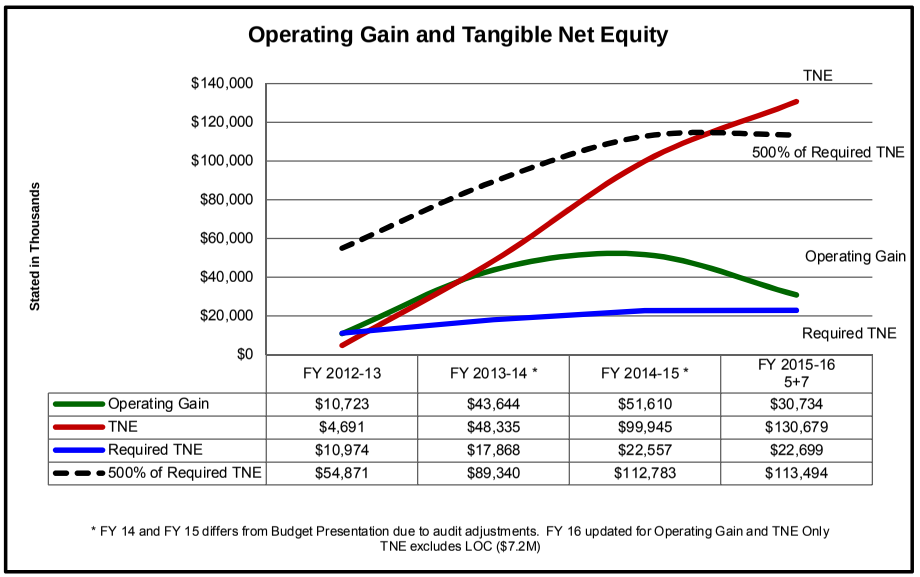
FINANCIAL PERFORMANCE DASHBOARD
FOR MONTH ENDING NOVEMBER 30, 2015







Note: FY 14 and FY 15 differs from Budget Presentation due to Auditors' Adjustments. FY 15 audit is in process



	FY 2012-13	FY 2013-14 *	FY 2014-15 *	FY 2015-16 5+7
Operating Gain	$10,723	$43,644	$51,610	$30,734
TNE	$4,691	$48,335	$99,945	$130,679
Required TNE	$10,974	$17,868	$22,557	$22,699
500% of Required TNE	$54,871	$89,340	$112,783	$113,494

* 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)

Note: 5+7 indicates 5 months of actual results followed by 7 months of forecasts

Gold Coast Health Plan℠
A Public Entity

For the month ended November 30, 2015

APPENDIX

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

STATEMENT OF FINANCIAL POSITION

	11/30/15	10/31/15	09/30/15	Audited FY 2014 -15
ASSETS				
Current Assets:				
Total Cash and Cash Equivalents	**$ 142,007,241**	**$ 113,497,885**	**$ 89,376,678**	**$ 57,218,141**
Total Short-Term Investments	**260,280,302**	**260,218,693**	**260,184,464**	**165,090,357**
Medi-Cal Receivable	61,369,356	62,291,090	64,573,064	129,782,958
Interest Receivable	441,372	358,970	302,757	208,010
Provider Receivable	932,608	618,992	596,315	579,482
Other Receivables	172,025	172,044	171,740	979,647
Total Accounts Receivable	**62,915,360**	**63,441,096**	**65,643,876**	**131,550,096**
Total Prepaid Accounts	1,540,371	1,338,926	1,673,177	766,831
Total Other Current Assets	133,545	81,702	81,702	81,702
Total Current Assets	**466,876,820**	**438,578,301**	**416,959,896**	**354,707,127**
Total Fixed Assets	**956,135**	**981,894**	**1,004,681**	**1,084,113**
Total Long-Term Investments	**24,531,226**	**24,554,488**	**24,577,733**	**24,647,362**
Total Assets	**$ 492,364,181**	**$ 464,114,682**	**$ 442,542,310**	**$ 380,438,602**
LIABILITIES & NET ASSETS				
Current Liabilities:				
Incurred But Not Reported	$ 60,459,311	$ 55,476,902	$ 61,456,059	$ 52,372,146
Claims Payable	11,683,971	11,320,074	6,002,510	13,747,426
Capitation Payable	29,096,440	28,417,041	27,247,178	34,466,106
Physician ACA 1202 Payable	10,600,928	10,600,928	10,965,642	10,965,642
AB 85 Payable	1,779,287	3,275,907	3,243,135	3,818,147
Accounts Payable	2,507,055	565,247	5,166,071	3,449,087
Accrued ACS	1,604,232	1,593,827	0	1,480,556
Accrued Expenses	106,251,563	10,094,486	9,437,545	6,249,194
Accrued Premium Tax	4,122,354	4,742,315	4,047,112	3,641,573
Accrued Interest Payable	90,109	84,179	80,835	70,711
Current Portion of Deferred Revenue	268,333	306,667	345,000	460,000
Accrued Payroll Expense	978,546	960,437	881,101	1,152,720
Total Current Liabilities	**229,442,130**	**127,438,011**	**128,872,189**	**131,873,310**
Long-Term Liabilities:				
DHCS - Reserve for Capitation Recoup	132,379,703	208,190,569	189,686,725	140,970,602
Other Long-term Liability-Deferred Rent	616,634	583,193	549,751	449,427
Deferred Revenue - Long Term Portion	0	0	0	0
Notes Payable	7,200,000	7,200,000	7,200,000	7,200,000
Total Long-Term Liabilities	**140,196,337**	**215,973,761**	**197,436,476**	**148,620,029**
Total Liabilities	**369,638,467**	**343,411,772**	**326,308,665**	**280,493,338**
Net Assets:				
Beginning Net Assets	99,945,264	99,945,264	99,945,264	48,335,211
Total Increase / (Decrease in Unrestricted Net A	22,780,450	20,757,646	16,288,381	51,610,053
Total Net Assets	**122,725,714**	**120,702,910**	**116,233,646**	**99,945,264**
Total Liabilities & Net Assets	**$ 492,364,181**	**$ 464,114,682**	**$ 442,542,310**	**$ 380,438,602**

FINANCIAL INDICATORS				
Current Ratio	2.03 : 1	3.44 : 1	3.24 : 1	2.69 : 1
Days Cash on Hand	235	233	217	67
Days Cash + State Capitation Rec	271	271	257	107
Days Cash + State Capitation Rec (less Tax Lia	268	268	255	106

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR FIVE MONTHS ENDING NOVEMBER 30, 2015

	November 15 Year-To-Date		Variance
	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	976,589	963,528	13,061
Revenue			
Premium	$ 292,377,101	$ 292,484,168	$ (107,067)
Reserve for Rate Reduction	(12,615,000)	(20,015,431)	7,400,431
MCO Premium Tax	(11,512,349)	(10,728,456)	(783,893)
Total Net Premium	**268,249,752**	**261,740,281**	**6,509,471**
Other Revenue:			
Miscellaneous Income	493,508	191,666	301,842
Total Other Revenue	493,508	**191,666**	301,842
Total Revenue	**268,743,260**	**261,931,947**	**6,811,313**
Medical Expenses:			
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	40,001,699	30,421,139	(9,580,560)
FFS Claims Expenses:			
Inpatient	44,382,779	48,701,429	4,318,650
LTC / SNF	41,885,063	45,113,962	3,228,899
Outpatient	17,393,897	15,758,880	(1,635,017)
Laboratory and Radiology	1,598,818	1,107,857	(490,961)
Emergency Room	6,940,575	6,426,712	(513,863)
Physician Specialty	17,454,481	20,653,962	3,199,481
Primary Care Physician	5,543,498	6,541,123	997,625
Home & Community Based Services	5,626,226	6,175,870	549,644
Applied Behavior Analysis Services	251,480	492,224	240,744
Mental Health Services	1,991,496	2,208,313	216,818
Pharmacy	37,689,498	37,756,250	66,752
Provider Reserve	0	2,841,699	2,841,699
Other Medical Professional	827,782	1,024,863	197,081
Other Medical Care	739	0	(739)
Other Fee For Service	2,720,518	2,981,297	260,779
Transportation	630,086	708,128	78,042
Total Claims	184,933,123	198,492,569	13,559,446
Medical & Care Management Expense	6,572,559	8,669,674	2,097,115
Reinsurance	763,586	1,362,380	598,794
Claims Recoveries	(988,517)	0	988,517
Sub-total	6,347,628	10,032,054	3,684,426
Total Cost of Health Care	**231,282,450**	**238,945,762**	**7,663,312**
Contribution Margin	**37,460,811**	**22,986,185**	**14,474,626**
General & Administrative Expenses:			
Salaries and Wages	3,594,712	4,233,372	638,660
Payroll Taxes and Benefits	966,623	1,250,853	284,230
Travel and Training	77,644	300,944	223,300
Outside Service - ACS	7,844,355	7,452,866	(391,489)
Outside Services - Other	716,246	870,775	154,529
Accounting & Actuarial Services	88,590	197,000	108,410
Legal	172,680	437,500	264,820
Insurance	170,539	135,840	(34,699)
Lease Expense - Office	330,171	434,700	104,529
Consulting Services	292,169	578,367	286,198
Advertising and Promotion	48,199	31,020	(17,179)
General Office	705,077	1,200,166	495,089
Depreciation & Amortization	102,814	157,652	54,838
Printing	22,710	60,045	37,335
Shipping & Postage	38,919	64,615	25,696
Interest	127,796	106,819	(20,977)
Total G & A Expenses	**15,299,244**	**17,512,534**	**2,213,290**
Total Operating Gain / (Loss)	**$ 22,161,566**	**$ 5,473,651**	**$ 16,687,915**
Non Operating			
Revenues - Interest	638,281	500,000	138,281
Expenses - Interest	19,398	14,034	(5,364)
Total Non-Operating	618,883	485,966	132,917
Total Increase / (Decrease) in Unrestricted Net Assets	$ 22,780,450	$ 5,959,617	$ 16,820,833
Net Assets, Beginning of Year	99,945,264		
Net Assets, End of Year	122,725,714		

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2015-16 Monthly Trend			Current Month		
	AUG 15	SEP 15	OCT 15	NOVEMBER 2015		Variance
				Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	193,867	194,875	198,148	200,385	194,911	5,474
Revenue:						
Premium	$ 57,880,936	$ 61,599,815	$ 58,478,429	$ 59,641,624	$ 59,587,360	$ 54,264
Reserve for Rate Reduction	(350,000)	(1,360,000)	(4,008,000)	(4,057,000)	(4,143,915)	86,915
MCO Premium Tax	(2,279,062)	(2,425,493)	(2,302,588)	(2,348,389)	(2,183,086)	(165,303)
Total Net Premium	**55,251,874**	**57,814,322**	**52,167,841**	**53,236,235**	**53,260,359**	**(24,124)**
Other Revenue:						
Miscellaneous Income	38,333	38,333	340,175	38,333	38,333	(0)
Total Other Revenue	38,333	38,333	340,175	38,333	38,333	(0)
Total Revenue	**55,290,207**	**57,852,656**	**52,508,015**	**53,274,568**	**53,298,692**	**(24,125)**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	8,374,655	7,787,648	8,769,026	8,427,985	6,213,513	(2,214,472)
FFS Claims Expenses:						
Inpatient	12,017,812	8,229,483	6,591,724	9,783,188	9,947,990	164,802
LTC / SNF	7,700,632	7,865,679	9,041,831	8,114,443	9,097,027	982,584
Outpatient	2,643,296	3,102,655	3,745,058	3,888,244	3,208,431	(679,813)
Laboratory and Radiology	285,529	407,192	245,011	417,957	226,128	(191,829)
Emergency Room	1,469,605	1,337,763	1,377,596	1,408,873	1,306,554	(102,319)
Physician Specialty	3,229,913	3,704,106	3,323,918	3,574,803	4,212,973	638,170
Primary Care Physician	1,152,060	1,246,805	1,080,484	1,058,710	1,326,658	267,948
Home & Community Based Services	1,314,514	1,243,477	1,046,240	1,161,347	1,245,417	84,070
Applied Behavior Analysis Services	47,436	49,314	47,495	67,271	163,955	96,684
Mental Health Services	259,327	344,811	298,755	278,330	448,729	170,399
Pharmacy	7,245,754	7,879,357	7,939,073	7,785,843	7,687,359	(98,484)
Adult Expansion Reserve	0	0	0	0	0	0
Provider Reserve	0	0	0	0	576,498	576,498
Other Medical Professional	111,134	176,404	192,042	213,077	208,783	(4,294)
Other Medical Care	0	0	341	0	0	0
Other Fee For Service	401,396	570,136	604,476	554,146	604,248	50,102
Transportation	78,685	122,272	152,765	137,567	144,203	6,636
Total Claims	37,957,093	36,279,454	35,682,998	38,443,800	40,404,953	1,961,153
Medical & Care Management Expense	1,440,569	1,238,703	1,322,188	1,276,963	1,738,051	461,088
Reinsurance	273,383	276,955	(342,165)	284,242	278,888	(5,354)
Claims Recoveries	(202,687)	(250,030)	(345,290)	(82,534)	0	82,534
Sub-total	1,511,265	1,265,628	634,733	1,478,672	2,016,939	538,267
Total Cost of Health Care	**47,843,013**	**45,332,729**	**45,086,757**	**48,350,456**	**48,635,405**	**284,949**
Contribution Margin	**7,447,194**	**12,519,927**	**7,421,259**	**4,924,112**	**4,663,287**	**260,825**
General & Administrative Expenses:						
Salaries and Wages	773,532	715,375	724,858	664,080	888,009	223,929
Payroll Taxes and Benefits	193,404	195,413	193,656	186,552	262,356	75,804
Travel and Training	12,243	18,388	19,290	16,969	55,946	38,977
Outside Service - ACS	1,632,136	1,578,000	1,594,863	1,642,121	1,507,116	(135,005)
Outside Services - Other	138,017	155,310	128,132	161,411	177,530	16,119
Accounting & Actuarial Services	0	5,930	25,280	17,380	20,000	2,620
Legal	91,347	(35,214)	(30,846)	47,671	87,500	39,829
Insurance	32,645	35,303	34,973	34,973	27,168	(7,805)
Lease Expense - Office	66,034	66,034	66,034	66,034	86,940	20,906
Consulting Services	87,665	70,228	97,990	19,345	137,268	117,923
Advertising and Promotion	5,613	8,447	0	6,116	9,640	3,524
General Office	151,257	120,298	158,598	126,141	189,663	63,522
Depreciation & Amortization	20,463	20,463	20,768	20,768	37,394	16,626
Printing	5,911	1,849	12,756	1,512	3,410	1,898
Shipping & Postage	87	883	22,202	2,938	4,379	1,441
Interest	28,058	17,407	28,884	33,702	21,587	(12,115)
Total G & A Expenses	**3,238,411**	**2,974,114**	**3,097,438**	**3,047,714**	**3,515,906**	**468,192**
Total Operating Gain / (Loss)	**4,208,783**	**9,545,813**	**4,323,821**	**1,876,398**	**1,147,381**	**729,017**
Non Operating:						
Revenues - Interest	111,384	138,558	148,789	152,335	100,000	52,335
Expenses - Interest	3,590	3,247	3,344	5,930	2,843	(3,087)
Total Non-Operating	**107,794**	**135,311**	**145,444**	**146,405**	**97,157**	**49,248**
Total Increase / (Decrease) in Unrestricted Net Assets	**4,316,578**	**9,681,123**	**4,469,265**	**2,022,803**	**1,244,538**	**778,266**
Full Time Employees				**167**	**200**	**33**

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

	AUG 15	SEP 15	OCT 15	NOVEMBER 2015 Actual	NOVEMBER 2015 Budget	Variance Fav / (Unfav)
Membership (includes retro members)	193,867	194,875	198,148	200,385	194,911	5,474
Revenue:						
Premium	298.56	316.10	295.13	297.64	305.72	(8.08)
Reserve for Rate Reduction	(1.81)	(6.98)	(20.23)	(20.25)	(21.26)	1.01
MCO Premium Tax	(11.76)	(12.45)	(11.62)	(11.72)	(11.20)	(0.52)
Total Net Premium	**285.00**	**296.67**	**263.28**	**265.67**	**273.25**	**(7.59)**
Other Revenue:						
Interest Income	0.00	0.00	0.00	0.00	0.00	0.00
Miscellaneous Income	0.20	0.20	1.72	0.19	0.20	(0.01)
Total Other Revenue	0.20	0.20	1.72	0.19	0.20	(0.01)
Total Revenue	**285.20**	**296.87**	**264.99**	**265.86**	**273.45**	**(7.59)**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	43.20	39.96	44.25	42.06	31.88	(10.18)
FFS Claims Expenses:						
Inpatient	61.99	42.23	33.27	48.82	51.04	2.22
LTC / SNF	39.72	40.36	45.63	40.49	46.67	6.18
Outpatient	13.63	15.92	18.90	19.40	16.46	(2.94)
Laboratory and Radiology	1.47	2.09	1.24	2.09	1.16	(0.93)
Emergency Room	7.58	6.86	6.95	7.03	6.70	(0.33)
Physician Specialty	16.66	19.01	16.77	17.84	21.61	3.78
Primary Care Physician	5.94	6.40	5.45	5.28	6.81	1.52
Home & Community Based Services	6.78	6.38	5.28	5.80	6.39	0.59
Applied Behavior Analysis Services	0.24	0.25	0.24	0.34	0.84	0.51
Mental Health Services	1.34	1.77	1.51	1.39	2.30	0.91
Pharmacy	37.37	40.43	40.07	38.85	39.44	0.59
Adult Expansion Reserve	0.00	0.00	0.00	0.00	0.00	0.00
Provider Reserve	0.00	0.00	0.00	0.00	2.96	2.96
Other Medical Professional	0.57	0.91	0.97	1.06	1.07	0.01
Other Medical Care	0.00	0.00	0.00	0.00	0.00	0.00
Other Fee For Service	2.07	2.93	3.05	2.77	3.10	0.33
Transportation	0.41	0.63	0.77	0.69	0.74	0.05
Total Claims	195.79	186.17	180.08	191.85	207.30	15.45
Medical & Care Management Expense	7.43	6.36	6.67	6.37	8.92	2.54
Reinsurance	1.41	1.42	(1.73)	1.42	1.43	0.01
Claims Recoveries	(1.05)	(1.28)	(1.74)	(0.41)	0.00	0.41
Sub-total	7.80	6.49	3.20	7.38	10.35	2.97
Total Cost of Health Care	246.78	232.62	227.54	241.29	**249.53**	**8.24**
Contribution Margin	**38.41**	**64.25**	**37.45**	**24.57**	**23.93**	**0.65**
General & Administrative Expenses:						
Salaries and Wages	3.99	3.67	3.66	3.31	4.56	1.24
Payroll Taxes and Benefits	1.00	1.00	0.98	0.93	1.35	0.42
Travel and Training	0.06	0.09	0.10	0.08	0.29	0.20
Outside Service - ACS	8.42	8.10	8.05	8.19	7.73	(0.46)
Outside Services - Other	0.71	0.80	0.65	0.81	0.91	0.11
Accounting & Actuarial Services	0.00	0.03	0.13	0.09	0.10	0.02
Legal	0.47	(0.18)	(0.16)	0.24	0.45	0.21
Insurance	0.17	0.18	0.18	0.17	0.14	(0.04)
Lease Expense - Office	0.34	0.34	0.33	0.33	0.45	0.12
Consulting Services	0.45	0.36	0.49	0.10	0.70	0.61
Translation Services	0.00	0.00	0.00	0.00	0.00	0.00
Advertising and Promotion	0.03	0.04	0.00	0.03	0.05	0.02
General Office	0.78	0.62	0.80	0.63	0.97	0.34
Depreciation & Amortization	0.11	0.11	0.10	0.10	0.19	0.09
Printing	0.03	0.01	0.06	0.01	0.02	0.01
Shipping & Postage	0.00	0.00	0.11	0.01	0.02	0.01
Interest	0.14	0.09	0.15	0.17	0.11	(0.06)
Other/ Miscellaneous Expenses	0.00	0.00	0.00	0.00	0.00	0.00
Total G & A Expenses	16.70	15.26	15.63	15.21	18.04	2.83
Total Operating Gain / (Loss)	21.71	48.98	21.82	9.36	5.89	3.48
Non Operating:						
Revenues - Interest	0.57	0.71	0.75	0.76	0.51	0.25
Expenses - Interest	0.02	0.02	0.02	0.03	0.01	(0.02)
Total Non-Operating	0.56	0.69	0.73	0.73	0.50	0.23
Total Increase / (Decrease) in Unrestricted Net Assets	22.27	49.68	22.56	10.09	6.39	3.71

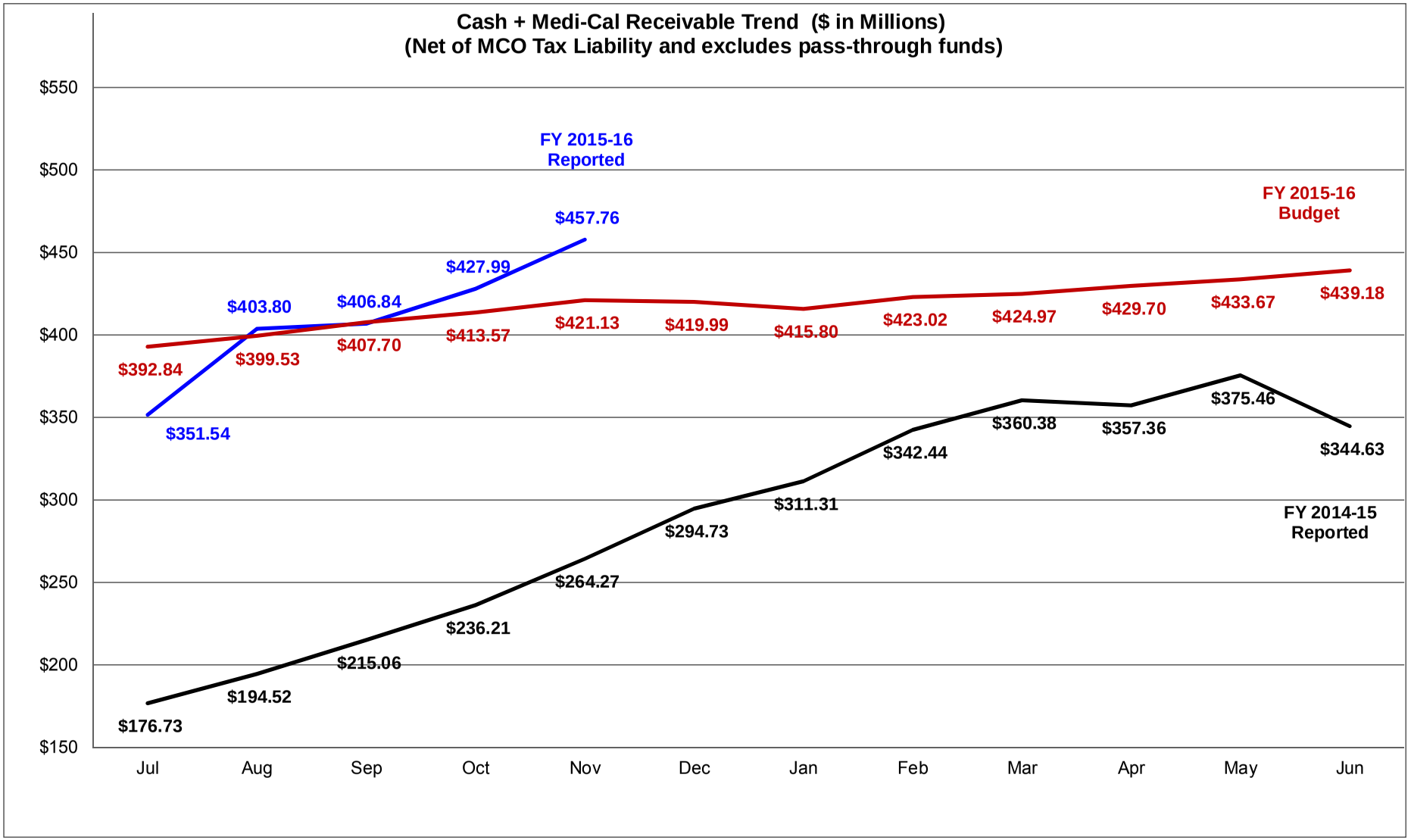
STATEMENT OF CASH FLOWS - FYTD

	NOV 15
Cash Flow From Operating Activities	
Collected Premium	$ 429,184,841
Miscellaneous Income	564,472
State Pass Through Funds	47,231,323
Paid Claims	
Medical & Hospital Expenses	(146,288,652)
Pharmacy	(39,783,740)
Capitation	(48,685,146)
Reinsurance of Claims	(1,384,716)
State Pass Through Funds Distributed	(26,216,344)
Paid Administration	(19,096,292)
MCO Taxes Received / (Paid)	(15,691,018)
Net Cash Provided / (Used) by Operating Activities	**179,834,728**
Cash Flow From Investing / Financing Activities	
Net Acquisition of Investments	(95,073,809)
Net Dis/Prem Amortization of Investments	73,809
Net Acquisition of Property / Equipment	(45,628)
Net Cash Provided / (Used) by Investing / Financing	**(95,045,628)**
Net Cash Flow	**$ 84,789,100**
Cash and Cash Equivalents (Beg. of Period)	57,218,141
Cash and Cash Equivalents (End of Period)	142,007,241
	$ 84,789,100
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income / (Loss)	22,780,450
Depreciation & Amortization	173,606
Net Dis/Prem Amortization of Investments	(73,809)
Decrease / (Increase) in Receivables	68,634,736
Decrease / (Increase) in Prepaids & Other Current Assets	(825,383)
(Decrease) / Increase in Payables	96,625,662
(Decrease) / Increase in Other Liabilities	(8,615,358)
Change in MCO Tax Liability	480,781
Changes in Claims and Capitation Payable	(7,433,122)
Changes in IBNR	8,087,165
	179,834,728
Net Cash Flow from Operating Activities	**$ 179,834,728**

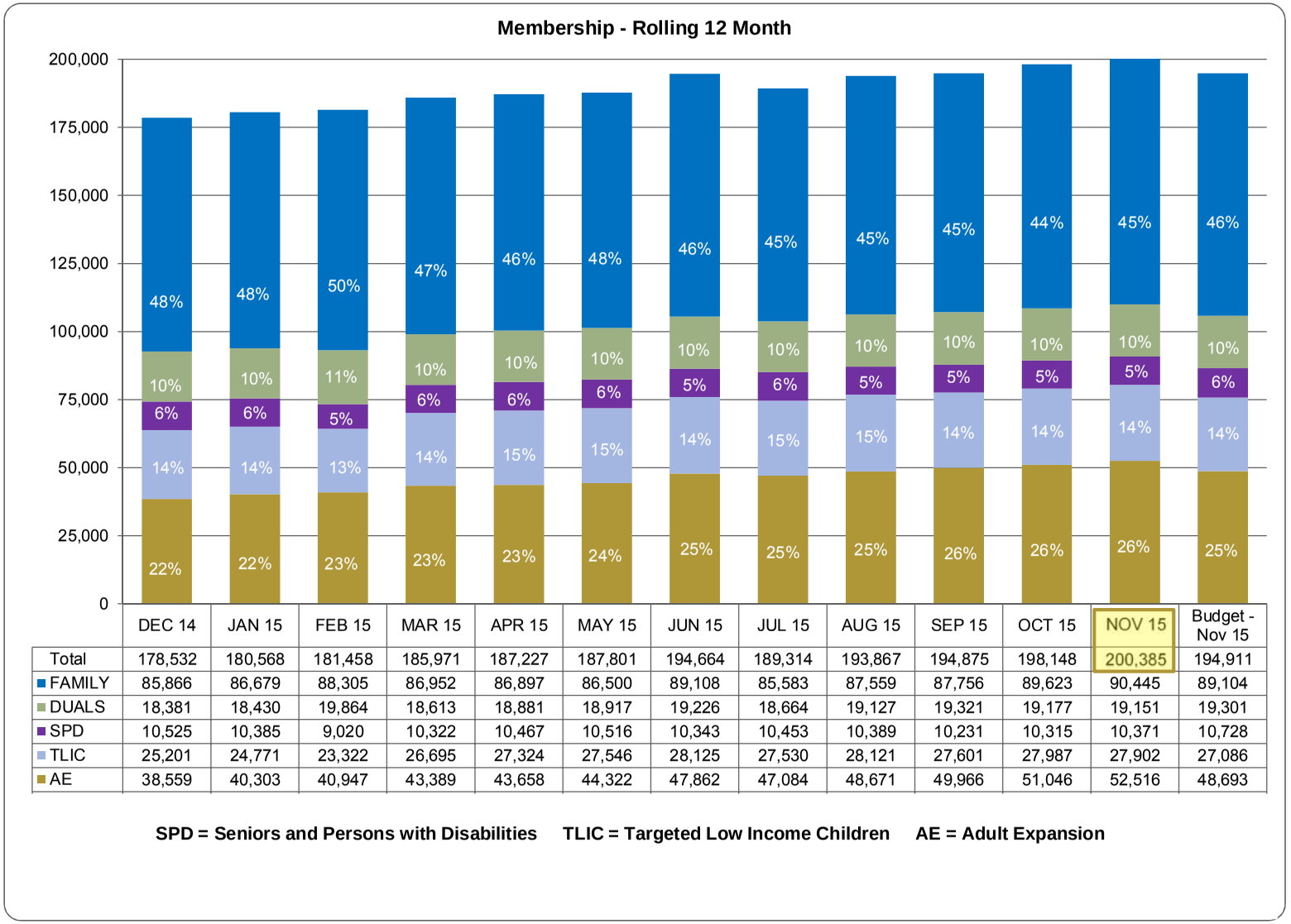
STATEMENT OF CASH FLOWS - MONTHLY

	NOV 15	OCT 15	SEP 15
Cash Flow From Operating Activities			
Collected Premium	$ 76,117,540	$ 75,884,536	$ 68,284,834
Miscellaneous Income	113,988	137,805	123,815
State Pass Through Funds	1,796,588	17,612,139	4,517,957
Paid Claims			
Medical & Hospital Expenses	(25,481,591)	(28,454,257)	(30,834,324)
Pharmacy	(8,587,538)	(8,251,177)	(7,880,591)
Capitation	(7,839,138)	(7,599,163)	(25,287,425)
Reinsurance of Claims	(284,242)	(278,965)	(276,955)
State Pass Through Funds Distributed	(1,725,782)	(15,888,984)	(3,244,866)
Paid Administration	(1,909,868)	(6,161,977)	(2,234,571)
MCO Tax Received / (Paid)	(3,681,432)	(2,866,610)	(9,135,503)
Net Cash Provided / (Used) by Operating Activi	**28,518,525**	**24,133,346**	**(5,967,628)**
Cash Flow From Investing / Financing Activities			
Net Acquisition of Investments	(38,347)	(10,984)	(14,743)
Net Dis/Prem Amortization of Investments	38,347	10,984	14,743
Net Acquisition of Property / Equipment	(9,168)	(12,139)	(11,131)
Net Cash Provided / (Used) by Investing / Finar	**(9,168)**	**(12,139)**	**(11,131)**
Net Cash Flow	**$ 28,509,357**	**$ 24,121,207**	**$ (5,978,760)**
Cash and Cash Equivalents (Beg. of Period)	113,497,885	89,376,678	95,355,438
Cash and Cash Equivalents (End of Period)	142,007,241	113,497,885	89,376,678
	$ 28,509,357	**$ 24,121,207**	**$ (5,978,760)**
Adjustment to Reconcile Net Income to Net Cash Flow			
Net (Loss) Income	2,022,803	4,469,265	9,681,123
Net Dis/Prem Amortization of Investments	(38,347)	(10,984)	(14,743)
Depreciation & Amortization	34,927	34,927	34,621
Decrease / (Increase) in Receivables	525,735	2,202,780	(5,459,203)
Decrease / (Increase) in Prepaids & Other Curr	(253,289)	334,251	(74,222)
(Decrease) / Increase in Payables	96,636,709	(2,599,318)	(13,856,973)
(Decrease) / Increase in Other Liabilities	(75,815,757)	18,498,952	15,463,661
Change in MCO Tax Liability	(619,960)	695,203	(5,277,645)
Changes in Claims and Capitation Payable	1,043,296	6,487,426	(10,358,404)
Changes in IBNR	4,982,409	(5,979,156)	3,894,156
	28,518,525	24,133,346	(5,967,628)
Net Cash Flow from Operating Activities	**28,518,525**	**24,133,346**	**(5,967,628)**

GOLD COAST HEALTH PLAN
NOVEMBER 2015



GOLD COAST HEALTH PLAN

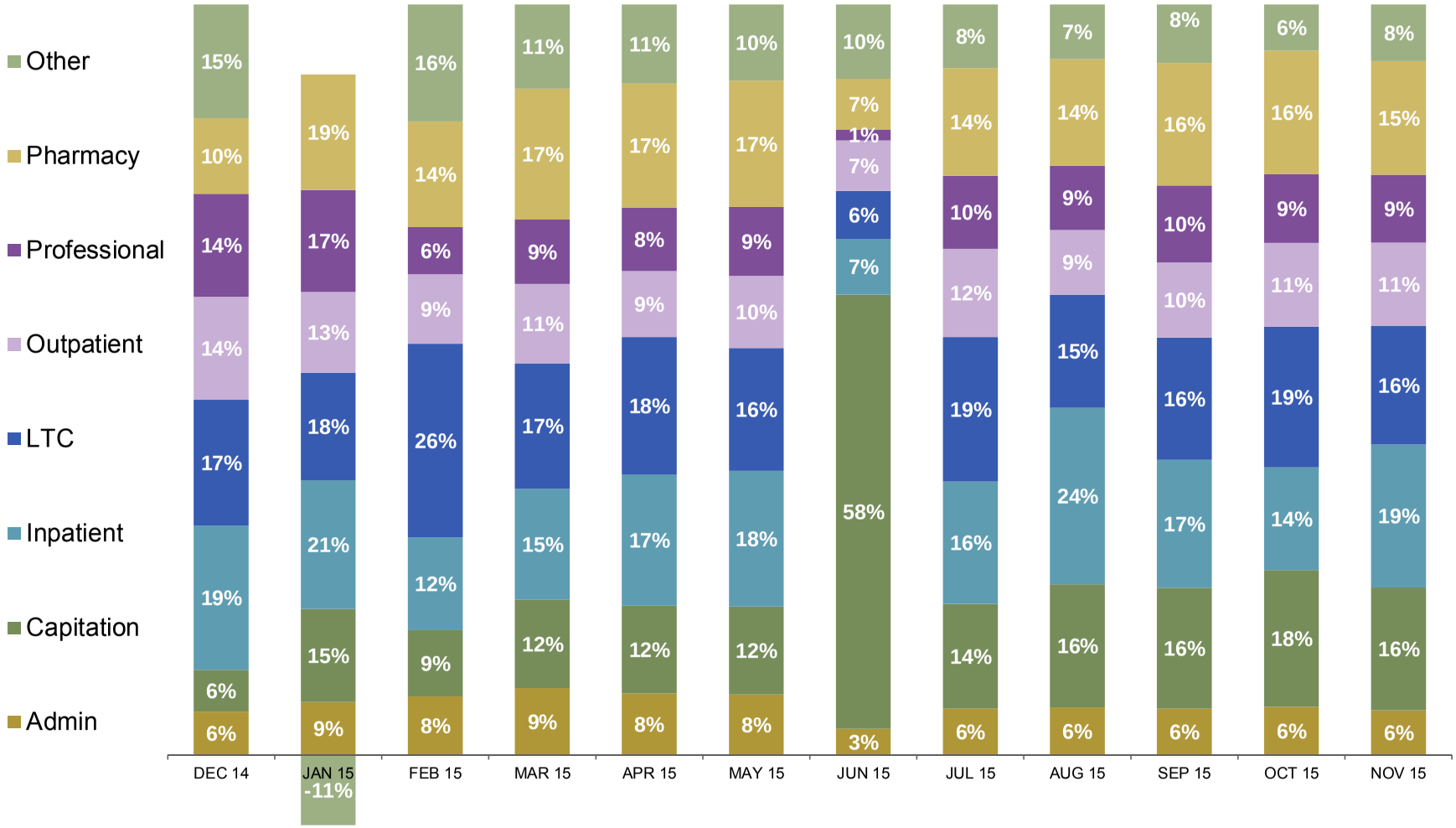


	DEC 14	JAN 15	FEB 15	MAR 15	APR 15	MAY 15	JUN 15	JUL 15	AUG 15	SEP 15	OCT 15	NOV 15	Budget - Nov 15
Total	178,532	180,568	181,458	185,971	187,227	187,801	194,664	189,314	193,867	194,875	198,148	200,385	194,911
FAMILY	85,866	86,679	88,305	86,952	86,897	86,500	89,108	85,583	87,559	87,756	89,623	90,445	89,104
DUALS	18,381	18,430	19,864	18,613	18,881	18,917	19,226	18,664	19,127	19,321	19,177	19,151	19,301
SPD	10,525	10,385	9,020	10,322	10,467	10,516	10,343	10,453	10,389	10,231	10,315	10,371	10,728
TLIC	25,201	24,771	23,322	26,695	27,324	27,546	28,125	27,530	28,121	27,601	27,987	27,902	27,086
AE	38,559	40,303	40,947	43,389	43,658	44,322	47,862	47,084	48,671	49,966	51,046	52,516	48,693

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

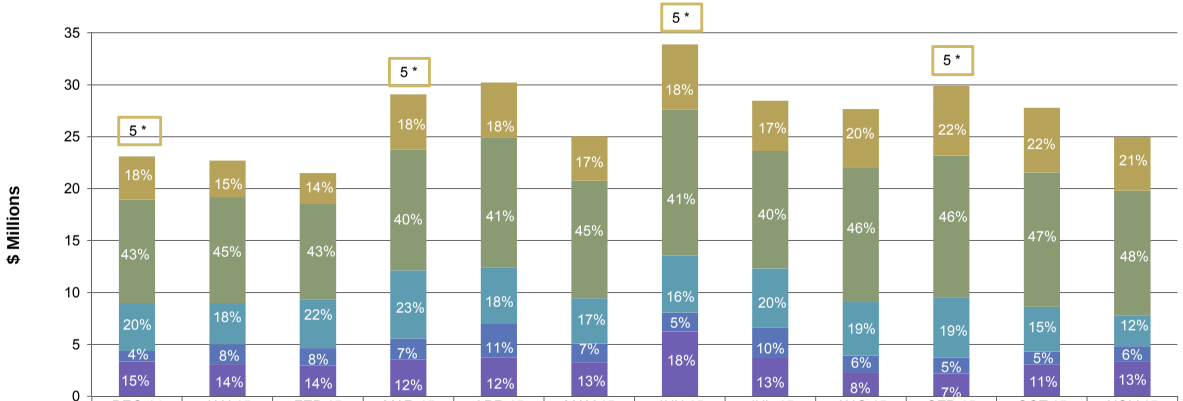
GOLD COAST HEALTH PLAN

Total Expense Composition



Note: January 15 reflects an adjustment to Adult Expansion reserve resulting in a reduction to IBNR.
June 15 reflects the Enhanced Adult Capitation program and reclassification of fee-for-service expense to capitation expense.

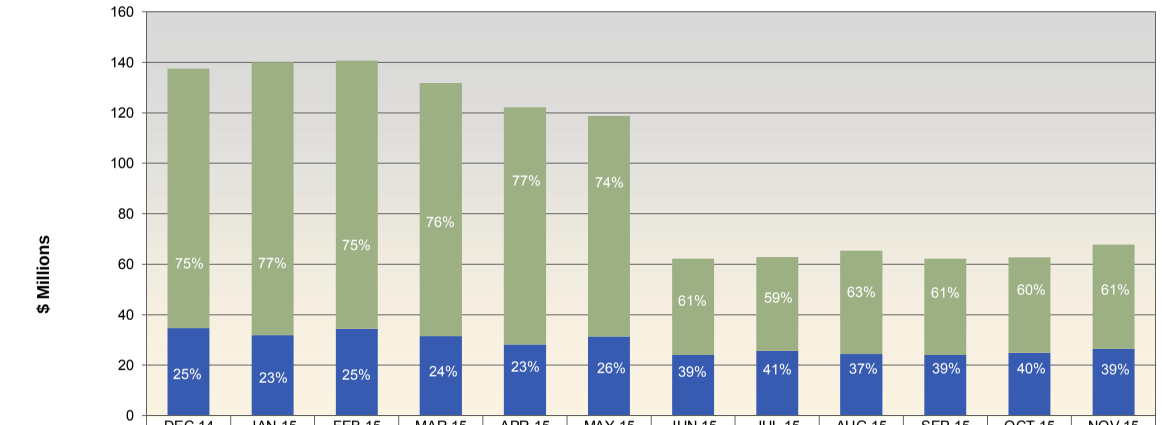
Paid Claims Composition (excluding Pharmacy and Capitation Payments)



	DEC 14	JAN 15	FEB 15	MAR 15	APR 15	MAY 15	JUN 15	JUL 15	AUG 15	SEP 15	OCT 15	NOV 15
Current	4.14	3.50	2.91	5.30	5.32	4.30	6.26	4.85	5.65	6.72	6.22	5.17
30	9.96	10.20	9.30	11.63	12.52	11.31	14.05	11.29	12.83	13.70	12.95	12.05
60	4.61	4.00	4.64	6.56	5.34	4.36	5.50	5.67	5.22	5.76	4.30	2.94
90	1.03	1.90	1.68	2.01	3.31	1.81	1.81	2.89	1.61	1.51	1.26	1.50
120+	3.35	3.10	2.97	3.57	3.73	3.28	6.26	3.77	2.33	2.22	3.06	3.32

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.

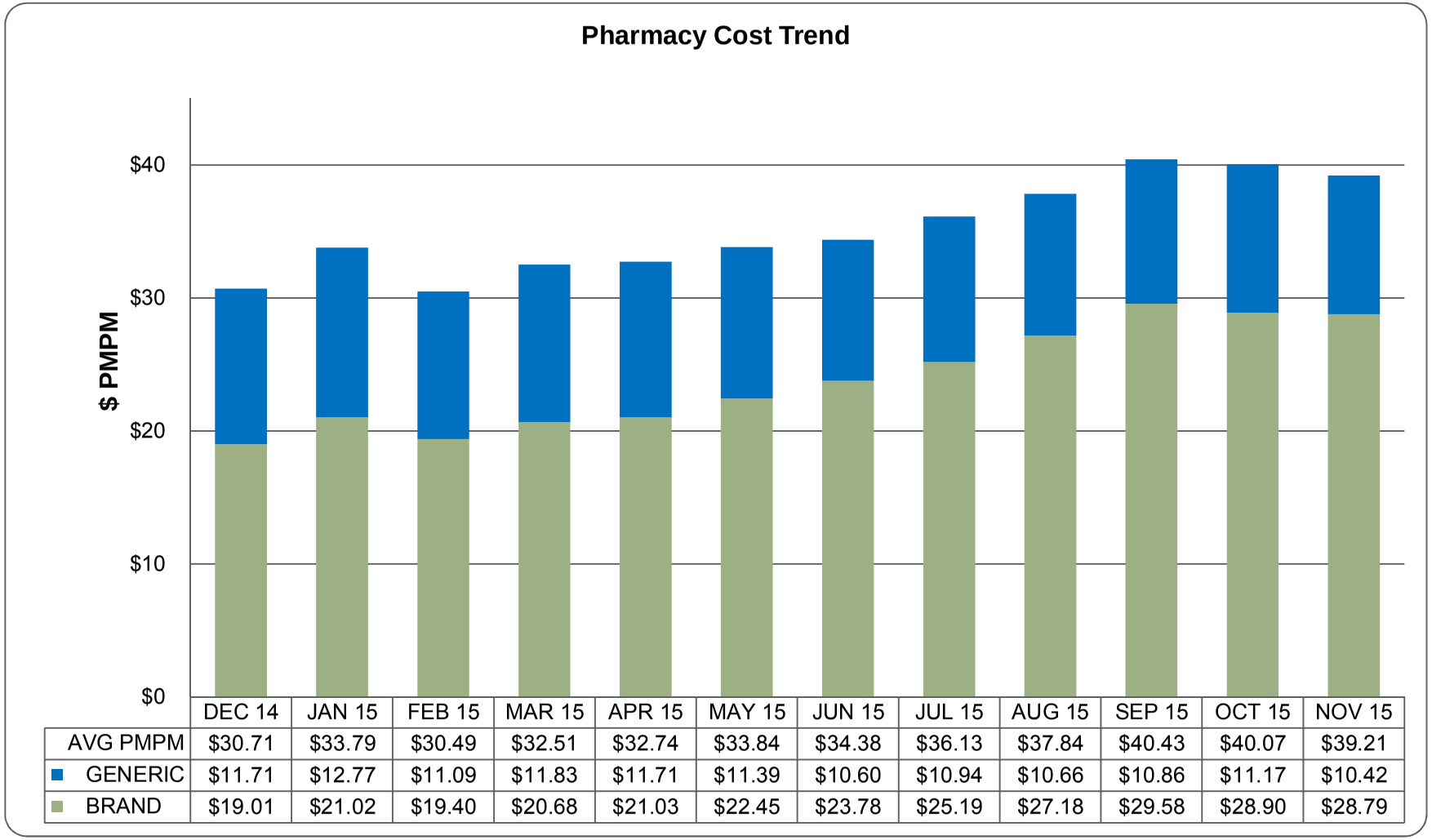
IBNP Composition (excluding Pharmacy and Capitation)



	DEC 14	JAN 15	FEB 15	MAR 15	APR 15	MAY 15	JUN 15	JUL 15	AUG 15	SEP 15	OCT 15	NOV 15
Prior Month Unpaid	102.84	108.19	106.23	100.37	94.05	87.42	38.18	37.18	40.91	38.11	37.86	41.38
Current Month Unpaid	34.71	31.86	34.48	31.46	28.17	31.40	23.99	25.68	24.48	24.10	24.91	26.40
Total Unpaid	137.55	140.05	140.71	131.82	122.22	118.82	62.17	62.86	65.40	62.21	62.77	67.78

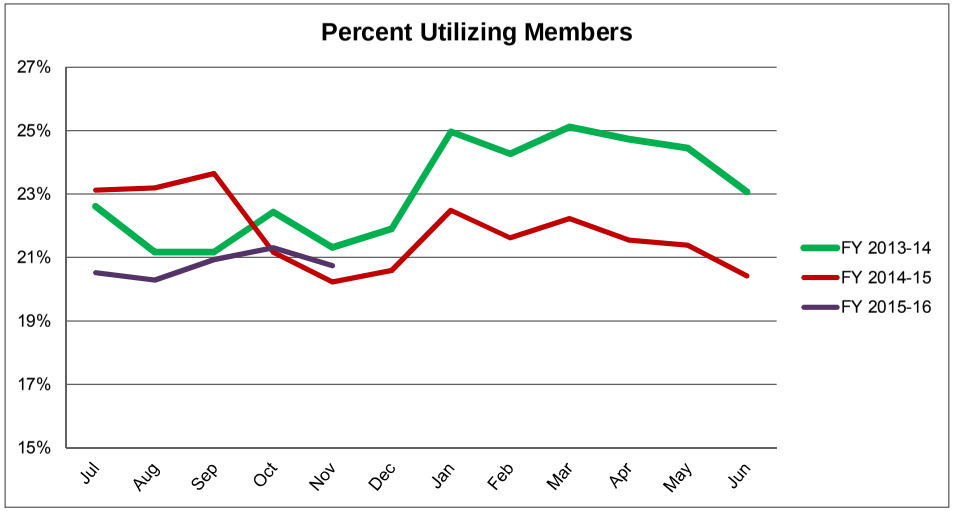
Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.
June 2015 - reflects the Enhanced Adult Capitation program and reclassification of fee-for-service expense to capitation expense.

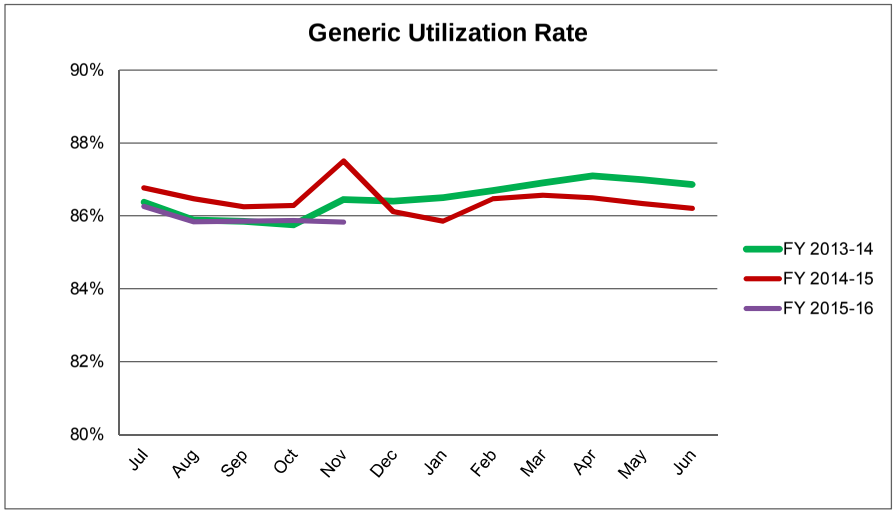
GOLD COAST HEALTH PLAN



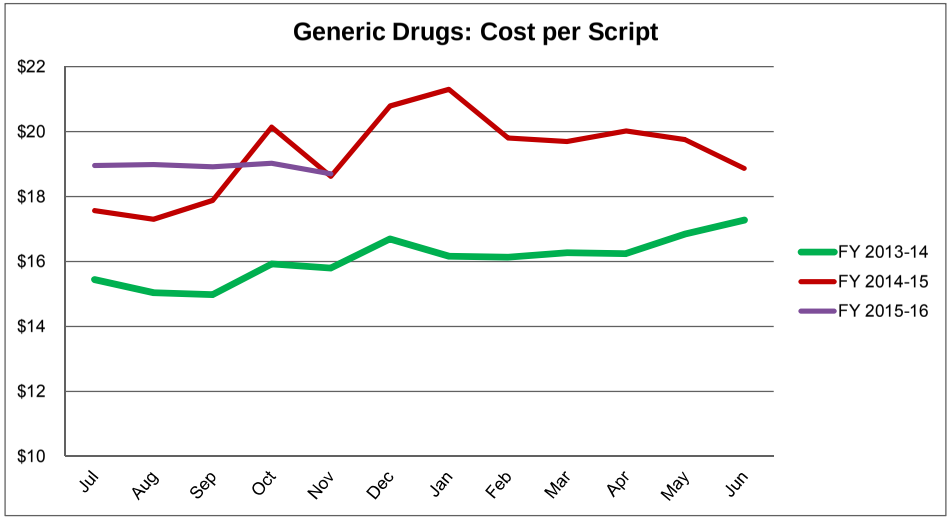
	DEC 14	JAN 15	FEB 15	MAR 15	APR 15	MAY 15	JUN 15	JUL 15	AUG 15	SEP 15	OCT 15	NOV 15
AVG PMPM	$30.71	$33.79	$30.49	$32.51	$32.74	$33.84	$34.38	$36.13	$37.84	$40.43	$40.07	$39.21
GENERIC	$11.71	$12.77	$11.09	$11.83	$11.71	$11.39	$10.60	$10.94	$10.66	$10.86	$11.17	$10.42
BRAND	$19.01	$21.02	$19.40	$20.68	$21.03	$22.45	$23.78	$25.19	$27.18	$29.58	$28.90	$28.79

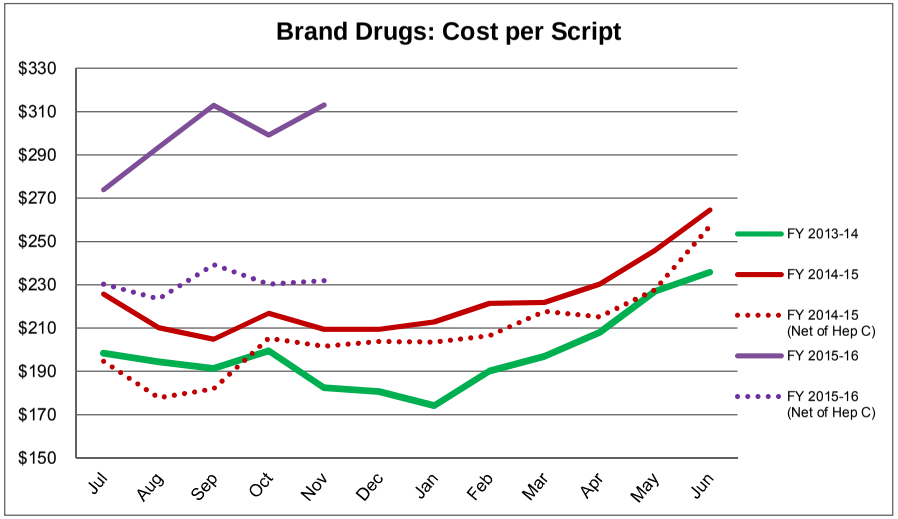
GOLD COAST HEALTH PLAN
PHARMACY ANALYSIS





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





AGENDA ITEM NO. 3

To: Gold Coast Health Plan Commission

From: Patricia Mowlavi, CFO

Date: January 25, 2016

Re: Internal Audit Plan

SUMMARY:

Staff is presenting the Internal Audit Plan for the Commission to accept and file. The Internal Audit Plan was reviewed and approved by the Audit Committee on January 7, 2016.

BACKGROUND / DISCUSSION:

The Internal Audit Plan provides independent, objective assurance of the Plan's risk management, internal controls and governance and the processes in place for ensuring effectiveness, efficiency and economy.

FISCAL IMPACT:

The establishment of the Internal Audit Plan will not result in any immediate fiscal impact.

RECOMMENDATION:

Staff recommends approval of the Internal Audit Plan.

CONCURRENCE:

January 7, 2016 Audit Committee

ATTACHMENT:

Internal Audit Plan

Internal Audit Plan

Internal audit provides independent, objective assurance over an organization's risk management, internal control and governance and the processes in place for ensuring effectiveness, efficiency and economy.

Each audit plan will be different and tailored to the organization's needs. However, there are common elements that the audit committee should expect to see when reviewing the audit plan, albeit in practice these elements might be presented in many different ways. These elements are discussed below.

Overview of the audit approach

The audit committee should expect the audit planning document to set out that the audit plan has been developed by:

- Taking account of the risks identified by the organization
- Using the internal auditor's experience of the organization and the sector more generally to identify other areas of risk which may warrant attention
- Discussing all identified risks and other relevant issues with the organization's management to identify the potential scope of internal audit.

Risk-focused internal audit coverage

Where the organization's risk management policy allocates each risk a likelihood and impact rating between 'high' and 'low', the audit plan might for example focus on 'high' and 'medium' priority risks over (say) a three-year period. However the internal audit is focused, the audit committee should be fully informed of:

- which areas are being addressed
- how many audit days have been allocated to each area
- when the fieldwork is being undertaken
- when the internal auditors will report their findings.

Exhibit 1 (below) illustrates which risks identified by the organization are addressed by the internal audit plan.

Other reviews

The internal audit strategy may address some *ad hoc* areas that do not feature as a high or medium risk. These are nevertheless areas where the organization would benefit from an internal audit review, or they are being reviewed to provide assurance to the audit committee and external auditors regarding operation of the key financial and management information systems. The audit days, fieldwork and reporting expectations for these areas should also be identified in the audit plan.

Contingencies

It is important to adopt a flexible approach in determining internal audit resources, in order to accommodate any unforeseen audit needs. The audit plan should give an indication as to how many 'person days' have been allowed for contingencies.

Follow-up

For internal audit to be as effective as possible, its recommendations need to be implemented. Specific resources should be included within the plan to provide assurance to the organization and the audit committee that agreed audit recommendations have been implemented effectively and on a timely basis.

Planning, reporting and liaison

The audit committee should expect the internal audit plan to identify a number of audit days relating to the following:

- quality control review by director
- production of reports, including the strategic plan and annual internal audit report
- attendance at audit committee meetings
- regular contact with the organization's management
- liaison with external audit
- internal quality assurance reviews.

Timing

The audit plan should set out the timing of the fieldwork and confirm the form and timeliness of reports to management and the audit committee. For example:

- a report for each area of work undertaken within X days of finishing the fieldwork
- a progress report for each audit committee meeting

- an annual report on internal audit coverage to the audit committee (reporting to fit in with the committee meeting dates).

Internal audit performance indicators

The internal auditor might propose a series of performance indicators against which management and the audit committee can measure the audit's performance. An example of proposed indicators is included as Exhibit 3.

Exhibit 1: Internal audit plan – focus on the organization's key risks
KEY RISKS – 2016

1. Recent Accounting Pronouncements (TBD)
2. Use of Estimates
3. Cash Concentration
4. New Systems
    a. TBD
5. Subsequent Events
6. Regulatory environment/changes
7. Industry challenges
    a. Decreased reimbursements
    b. Clinical innovation
    c. Transformations of care delivery models
    d. Physician relationships, compensation models
    e. Bundled payments
    f. Business continuity
        i. Supply chain disruptions
    g. Reducing operating costs
    h. Engaging consumers in preventative health
    i. Integrating non-acute services
    j. Managing in uncertainty
    k. Building new non-conventional relationships with commercial payers
    l. Demand for nurses
    m. Value based purchasing
    n. New workforce models
    o. Population health management
8. Technology and privacy
9. Consumer expectations
    a. Convenience
    b. Pricing transparency
    c. Quality reporting
    d. Consumerism – finding greater value for each healthcare dollar spent
    e. Increased consumer interest in public scorecards
10. Reputation
    a. Governance
    b. Organizational culture
    c. Cost control – needs not wants
    d. Business justification for expenses
11. Social factors
    a. Demographic changes
    b. Political polarization

12. External factors
    a. Joint Ventures
    b. Business Associates
    c. Vendor relationships
    d. Outsourced vendors
13. Fraud and abuse prevention
    a. Ghost employees and ghost vendors
    b. Cash diversion
    c. Supply chain (purchasing schemes)
    d. Warehouse
    e. Conflicts of interest/kickbacks from vendors

Exhibit 2: Audit Plan 2016

No.	Project Name	Project Start Date	Project End Date	Duration (Days)	Resources			Budgeted Hours
					Director	Consultant	Consultant	
					Martin Haisma	TBD	TBD	
1	Purchasing/Expenditures	1/15/16	2/15/15	20	0.100	0.400	0.000	160
2	State Action Plan Review	2/16/15	3/15/15	20	0.100	0.400	0.000	160
3	Revenue	3/16/15	4/16/15	20	0.050	0.100	0.100	160
4	IT General Controls	4/16/15	6/16/15	40	0.200	0.500	0.500	320
Totals								800

Exhibit 3: Performance indicators

Performance indicator	Target
Percentage of audit work delivered by qualified staff	60%
Operational plan to be submitted by September each year	September of each year
Follow-ups to be performed within 1 year of the audit taking place	Within 1 year of assignments
Issue of draft reports within 30 days of work being completed	30 working days
Issue of final report within 10 working days of receipt of management responses	10 working days
Recommendations made compared with recommendations accepted	80%
Internal audit attendance at audit committee meetings	100%
Issue of internal audit annual report	September of each year

AGENDA ITEM NO. 4

To: Gold Coast Health Plan Commission

From: Patricia Mowlavi, Chief Financial Officer

Date: January 25, 2016

Re: Financial Audit Contract for Fiscal Year 2015-2016

SUMMARY:

The Audit Committee appointed Moss Adams LLP (Moss Adams) on January 7, 2016 to perform Gold Coast Health Plan's (GCHP) FY 2015-16 financial audit and provide accounting expertise. Staff requests the Commission to accept and file the appointment of Moss Adams.

BACKGROUND / DISCUSSION:

The Plan's contract with DHCS requires an annual audit be performed on the Plan's financial statements. This audit provides confidence to the community and the Commission that the Plan's financial condition is accurately represented and that proper controls are in place. To meet these needs, the Plan hires a firm qualified to perform this annual financial audit.

Moss Adams was selected to perform the Plan's FY 2014-15 financial audit due to their Med-Cal expertise. The Plan's former auditors, McGladrey LLP, no longer provides support for Medi-Cal health plans..

FISCAL IMPACT:

The financial audit and anticipated expertise and support is estimated not to exceed $150,000.

RECOMMENDATION:

Staff requests the Commission approve the appointment of Moss Adams LLP for the FY 2015-16 external audit.

Concurrence:

January 7, 2016 Audit Committee

AGENDA ITEM NO. 5

To: Gold Coast Health Plan Commission

From: Dale Villani, Chief Executive Officer
Scott Campbell, General Counsel

Date: January 25, 2016

RE: Chairperson and Vice Chairperson Election

SUMMARY:

The Commission is due to elect a Chairperson and Vice Chairperson to serve for calendar years 2016 and 2017. Alternatively, because the County will be appointing (or reappointing) for Commission positions in March, the Commission may choose to table the election until the new (or reappointed) Commissioners take office.

BACKGROUND / DISCUSSION:

Ventura County Ordinance No. 4481, which established the Ventura County Medi-Cal Managed Care Commission, requires the Commission to establish bylaws containing procedures for the conduct of business that is not otherwise specified in the Ordinance. (Ord. 4481, as amended on October 6, 2015 is attached hereto; see section 1381-4.) The Ordinance does not specify the officers of the Commission or how the Officers are selected.

Under Article III, section (b), of the bylaws, the Commission must elect two officers: a Chairperson and a Vice Chairperson. The election is done by a majority vote of the Commissioners in attendance at the meeting where the election takes place. The election generally takes place in December and the term of office begins on January 1. In this case, as the calendar has already has begun, the term will commence immediately.

The Chairperson is responsible for presiding at all meetings, executing all documents approved by the Commission, seeing that all actions of the Commission are implemented, and maintaining consultation with the Chief Executive Officer. The Vice Chairperson is responsible for performing the duties of the Chairperson in the Chairperson absence and performing such other responsibilities as agreed upon with the Chairperson. Additionally the Chairperson and the Vice Chairperson serve on the Executive/Finance Committee, and the election will affect the make-up of the Finance Committee. (For further discussion of the Executive/Finance Committee appointments, see staff report for Agenda Item No. 9.)

Because the County appointed the initial Commission in March of 2010, and Commissioners serve staggered four-year terms, new Commissioners may take office in March of every other year. Rather than appointing officers at this meeting, the Commission may consider aligning the appointment of new officers with the establishment of a new Commission. If so, the Commission may table this item until after March 15 and direct staff to prepare a draft amendment to the bylaws indicating that the Chairperson and Vice Chairperson shall be appointed at the meeting in which new Commissioners take office. For reference, The Commissioners whose terms end in March are: Commissioner Foy, Commissioner Pupa, Commissioner Glyer, and Commissioner Dial.

One other option is the Commission may refer the matter to the Executive/Finance Committee to make nominations for each office as noted in the Commission's bylaws. If the Commission chose this option, the Commission would still have to approve the nominations by a majority vote of Commissioners in attendance and could still choose to select officers who were not nominated. However, while this is an option, it does create a conundrum because the Chairperson and Vice Chairperson serve on the Committee.

FISCAL IMPACT:

None.

RECOMMENDATION:

Staff recommends that the Commission take one of two actions: (1) elect a Chairperson and Vice Chairperson to serve for calendar years 2016 and 2017, or (2) table the election until the appointments are made. Additionally, staff seeks direction to prepare a draft amendment to the bylaws to reflect that the Chairperson and Vice Chairperson shall be elected in the first meeting after March 15 of even numbered years.

CONCURRENCE:

N/A.

ATTACHMENTS:

Ventura County Ordinance No. 4481
Gold Coast Health Plan Bylaws

ORDINANCE NO. 4481

AN ORDINANCE OF THE VENTURA COUNTY BOARD OF SUPERVISORS, REPEALING AND REENACTING, AS AMENDED, ARTICLE 6, CHAPTER 3, DIVISION 1 OF THE VENTURA COUNTY ORDINANCE CODE (COUNTY ORGANIZED HEALTH SYSTEM)

The Board of Supervisors of the County of Ventura ordains as follows:

SECTION 1: Repeal of Existing Ventura County Organized Health System Ordinance

Ordinance No. 4409 of the County of Ventura, which enacted Article 6 of Chapter 3 of Division 1 of the Ventura County Ordinance Code, is hereby repealed.

SECTION 2: Enactment of Ventura County Organized Health System Ordinance

Article 6 of Chapter 3 of Division 1 of the Ventura County Ordinance Code is hereby amended and reenacted as follows:

Chapter 3.

Article 6. County Organized Health System

1380 General Provisions.

1380-1.

Pursuant to Welfare and Institutions Code section 14087.54, there is hereby formed a commission, referred to in this Article as the Ventura County Medi-Cal Managed Care Commission.

1380-2.

The Ventura County Medi-Cal Managed Care Commission is empowered to negotiate and enter into exclusive contracts with the State of California Department of Health Care Services pursuant to Welfare and Institutions Code section 14087.5, and to arrange for the provision of health care services under Division 9, Part 3, Chapter 7 of the Welfare and Institutions Code. The Ventura County Medi-Cal Managed Care Commission is also authorized to:

(a) Enter into contracts for the provision of health care services to persons who are eligible to receive medical benefits, subject to the limitations of Welfare and Institutions

Code section 14087.54, subdivision (b)(2);

(b) Provide health care delivery systems for:

(1) persons who are eligible to receive medical benefits under both the Medicare program as defined in title 18 of the Federal Social Security Act (42 U.S.C. §1395 et seq.) and under the Medicaid program as defined in title 19 of the Federal Social Security Act (42 U.S.C.§ 1396 et seq.), and or

(2) persons who are eligible to receive medical benefits under the Medicaid program as defined in title 19 of the Federal Social Security Act (42 U.S.C.§1396 et seq.);

(c) File the statement required by Government Code section 53051;

(d) Acquire, possess, and dispose of real or personal property, as may be necessary for the performance of its functions;

(e) Employ personnel and contract for services required to meet its obligations;

(f) Sue and be sued;

(g) Enter into agreements under Chapter 5 (commencing with section 6500) of Division 7 of Title 1 of the Government Code.

1380-3.

The Ventura County Medi-Cal Managed Care Commission shall for all purposes be an entity separate from the County of Ventura, and shall be deemed a public entity for purposes of Division 3.6 (commencing with section 810) of Title 1 of the Government Code. Any obligations of the Ventura County Medi-Cal Managed Care Commission (statutory, contractual, or otherwise) shall be the obligations solely of the Ventura County Medi-Cal Managed Care Commission and shall not be obligations of the County of Ventura or the State of California.

1380-4.

The Ventura County Medi-Cal Managed Care Commission shall design and operate a program or programs, whose mission is to improve the health of its members through the provision of the best possible quality care and services. This will be accomplished by:

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

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

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

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

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

(f) Ensuring that all obligations, statutory, contractual or otherwise, shall be the obligations of the Ventura County Medi-Cal Managed Care Commission and shall not be the obligations of the County of Ventura or the State of California;

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

1381 Board of Directors (Commission)

1381-1.

The governing board of the Ventura County Medi-Cal Managed Care Commission shall consist of eleven (11) voting members who shall be legal residents of the County of Ventura. Members of the

Ventura County Medi-Cal Managed Care Commission shall possess the requisite skills and knowledge necessary to design and operate a publicly managed health care delivery system.

1381-2.

Members of the Ventura County Medi-Cal Managed Care Commission shall be appointed by a majority vote of the Board of Supervisors and shall consist of the following:

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

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

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

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

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

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

g. One member shall be a Medi-Cal beneficiary and/or a representative of an advocacy organization that serves the Medi-Cal population and is not otherwise represented on the Ventura County Medi-Cal Managed Care Commission. This member shall be appointed from applications submitted to the Ventura County Executive Office after a posting of public notice for the open position. (Consumer Representative)

h. One member shall be a representative of the County of Ventura nominated by the Ventura County Executive Officer and approved by the Board of Supervisors. (Ventura County Representative)

1381-3.

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

A member may be removed from the Ventura County Medi-Cal Managed Care Commission by a 4/5 vote of the Board of Supervisors.

Nominations to the Ventura County Medi-Cal Managed Care Commission shall be submitted to the Ventura County Executive Office, which shall be responsible for screening nominees and presenting candidates to the Ventura County Board of Supervisors. Appointments will be based on the individuals' knowledge of the

healthcare needs of women, children, seniors, and/or the disabled, and business, finance and/or political experience.

1381-4.

Procedures for the conduct of business not otherwise specified in this Article shall be contained in bylaws adopted by the Ventura County Medi-Cal Managed Care Commission.

1381-5.

The Ventura County Medi-Cal Managed Care Commission may establish a committee(s) or advisory board(s) for any purpose that will be beneficial in accomplishing the work of the Ventura County Medi-Cal Managed Care Commission. At a minimum, two (2) committees/advisory boards shall be established, one member/consumer based and one provider based.

1382 Cultural Diversity Program

The Ventura County Medi-Cal Managed Care Commission shall establish a Cultural Diversity Program to insure that employees, contractors and recipients of health care services are treated with respect and without discrimination. The governing board of the Ventura County Medi-Cal Managed Care Commission shall appoint a Chief Diversity Officer, who shall be responsible for implementation of the Cultural Diversity Program, and shall provide staff and resources for the Chief Diversity Officer as necessary and appropriate. The Chief Diversity Officer shall report directly to the governing board of the Ventura County Medi-Cal Managed Care Commission, and shall have the authority, independent of any other executive officer, to take disciplinary action against any employee, except the chief executive officer, for failure to comply with the Cultural Diversity Program. The Chief Diversity Officer shall also provide reports to the Ventura County Board of Supervisors, through the County's Chief Executive Officer, on a quarterly or more frequent basis.

SECTION 3: This ordinance shall take effect and be in full force and effect thirty (30) days after its passage. Before the expiration of fifteen (15) days after passage of this ordinance it shall be published once with the names of the members of the Board of Supervisors voting for and against the ordinance in the Ventura County Star, a newspaper of general circulation published in the State of California.

PASSED AND ADOPTED this 6th day of October, 2015, by the following vote:

AYES: Bennett, Parks, Foy, Zaragoza, and Long

NOES:

ABSENT:

Kathy Long
CHAIR, BOARD OF SUPERVISORS

ATTEST: MICHAEL POWERS,
Clerk of the Board of Supervisors,
County of Ventura, State of California.

By: SPfeliciano
Deputy Clerk of the Board

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

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

Approved: October 24, 2011

Table of Contents

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

ARTICLE I

Name and Mission

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

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

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

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

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

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

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

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

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

ARTICLE II

Commissioners

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

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

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

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

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

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

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

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

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

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

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

Selection and Terms of Commissioners

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

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

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

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

ARTICLE III

Officers

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

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

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

Election

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

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

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

Duties

(a) The Chairperson shall:

1. Preside at all meetings;

2. Execute all documents approved by the VCMMCC;

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

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

(b) The Vice-Chairperson shall:

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

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

ARTICLE IV

Standing Committees

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

(b) Executive/Finance Committee.

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

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

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

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

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

iii. Duties of the Executive/Finance Committee.

1. Advise the governing board Chairperson on requested matters.

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

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

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

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

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

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

    - PCP
    - Specialists
    - Hospitals
    - LTC
    - Ancillary Providers

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

9. Review and recommend provider incentive program structure.

10. Review investment strategy and make recommendations.

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

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

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

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

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

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

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

1. Adopting, amending or repealing any bylaw.
2. Making final determinations of policy.
3. Approving changes to the budget or making major structural or contractual decisions (such as adding or eliminating programs).
4. Filling vacancies or removing any Commissioner.
5. Changing the membership of, or filling vacancies in, the Executive/Finance Committee.
6. Hiring or firing of senior executives, but may make recommendations to the governing board as to their appointment, dismissal or ongoing performance.
7. Taking any action on behalf of the governing board unless expressly authorized by the governing board.

ARTICLE V

Special Committees

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

ARTICLE VI

Meetings

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

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

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

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

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

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

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

Conduct of Meetings

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

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

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

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

(e) Without objection, the Chairperson may continue or withdraw any item. In the event of an objection, a motion to continue or reset an item must be passed by a majority of

the members present. A motion to continue or reset an item shall take precedence over all other motions except for a point of order.

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

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

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

ARTICLE VII

Powers and Duties

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

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

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

(c) Provide for financial oversight through various actions and methodologies such as the preparation and submission of an annual statement of financial affairs and an estimate of the amount of funding required for expenditures, approval of an annual budget, receipt of monthly financial briefings and other appropriate action in support of its financial oversight role;

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

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

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

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

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

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

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

ARTICLE VIII

STAFF

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

Chief Executive Officer

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

The CEO shall:

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

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

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

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

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

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

Clerk

The Clerk shall:

(a) Perform the usual duties pertaining to secretaries;

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

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

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

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

Assistant Clerk

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

ARTICLE IX

Rules of Order

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

ARTICLE X

Amendments

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

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

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

ARTICLE XI

Nondiscrimination Clause

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

ARTICLE XII

Conflict of Interest and Ethics

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

ARTICLE XIII

Dissolution

Pursuant to California Welfare & Institutions Code, section 14087.54:

(a) In the event the Commissioners determine that VCMMCC may no longer function for the purposes for which it was established, at the time that VCMMCC's then existing obligations have been satisfied or VCMMCC's assets have been exhausted, the Board of Supervisors may by ordinance terminate the VCMMCC.

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

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

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

AGENDA ITEM NO. 6

To: Gold Coast Health Plan Commission

From: Patricia Mowlavi, Chief Financial Officer

Date: January 25, 2016

Re: Tangible Net Equity and Working Capital Reserve Funds Policy

SUMMARY:

Staff is presenting the Tangible Net Equity (TNE) and Working Capital Reserve Fund Policy for the Commission to accept and file. The Policy reviewed and approved by the Executive / Finance Committee on January 7, 2016.

BACKGROUND / DISCUSSION:

This policy establishes guidelines around Tangible Net Equity (TNE) and Working Capital Reserve Funds (liquid reserve funds) in support of the long-term financial stability of Gold Coast Health Plan (GCHP or Plan).

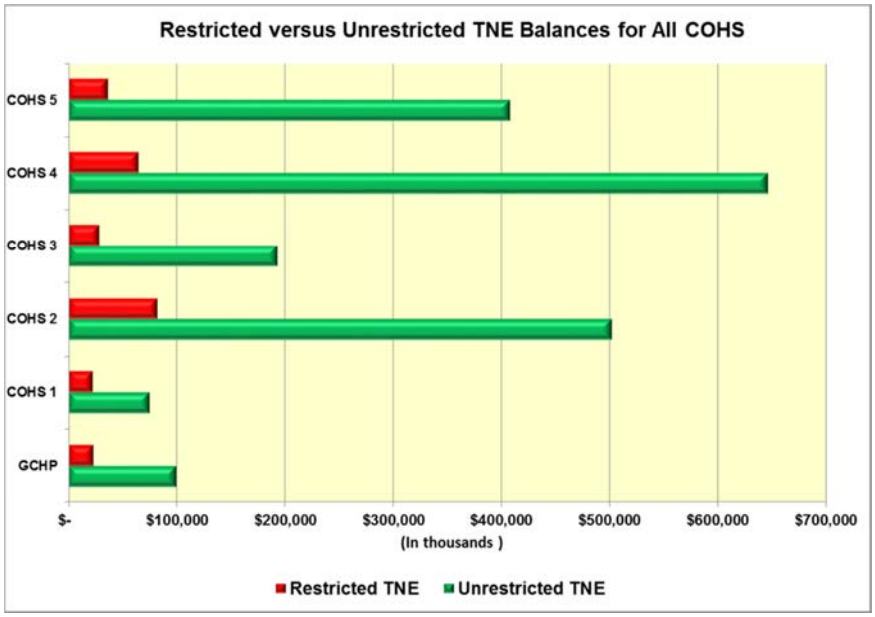
Key elements of the policy include:

- Establishing a minimum TNE maintenance target goal.
- Establishing and maintaining liquid reserve funds.
- Establishing a payment protocol for delays in receipt of State Capitation Revenue.

A more in-depth review of the elements of the policy follows.

<u>Establishing a minimum TNE maintenance target goal</u>
The Plan's goal is to maintain a minimum TNE amount of at least 500% of the State required TNE calculation. This goal was established based on input from the state, consideration of economic cycles, the Plan's maturity, financial commitments, financial longevity and future business needs as well as a review of other County Organized Health Systems (COHS) TNE position.

As of November 30, 2015, GCHP TNE was approximately $123 million or 541% of the State required TNE, excluding the $7.2 million County of Ventura lines of credit (LOC). The chart below, shows the TNE position in relation to other COHS and details the Restricted TNE (statutorily required) portion. GCHP has the second to lowest TNE compared to all other COHS.

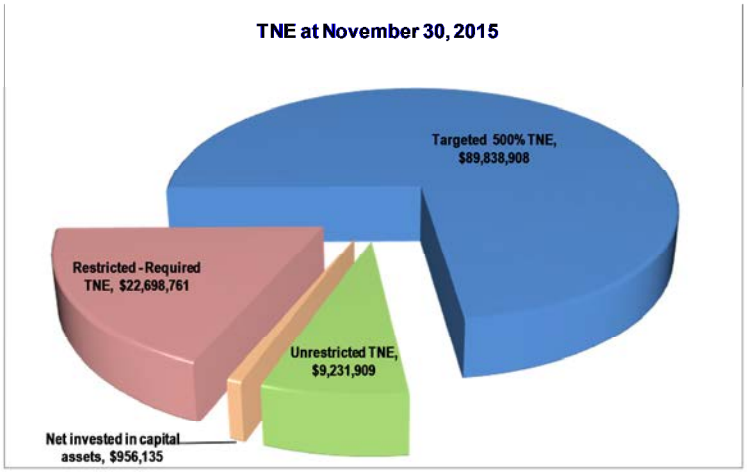


GCHP's TNE position is further refined in the table and chart below which identify the components of total TNE and reflects $9 million in excess TNE over the targeted goal (541% - 500% goal), as of November 30, 2015. The Plan is currently exploring various options including alternative payment strategies, such as value based payments and other opportunities in support of GCHP's mission.

TNE at November 30, 2015

Net invested in capital assets	$	956,135
Restricted - Required TNE	$	22,698,761
Targeted 500% TNE	$	89,838,908
Unrestricted TNE	$	9,231,909
Total TNE	$	122,725,714
GCHP TNE 500% Target	$	113,493,805
Amount Over Target	$	9,231,909

Note: TNE excludes LOC



Establishing and maintaining working capital reserve (liquid reserve funds)
In order to meet the Plan's current and future financial obligations, a working capital or liquid reserve fund will be established to cover 3 months of medical and administrative expenses. In addition, liquid reserve funds will be maintained to ensure that financial obligations for Commission approved capital projects and other long term liabilities whose payments are projected for the current operating cycle are met.

Establishing a payment protocol for delays in receipt of State Capitation Revenue
Should capitation revenue from the state be delayed and the Plan's unrestricted cash proves to be inadequate to pay health care providers and vendors, liquid reserve funds will be used for two months or until the liquid reserve funds reach a level equaled to one month's projected working capital requirement. When the level of liquid reserve funds falls to one month's projected working capital requirement, management may cease payments to health care providers and vendors until such time as the State restores capitation revenue to the Plan.

The policy also allows for management to create additional reserve funds as necessary to ensure the long-term wellness of the Plan.

FISCAL IMPACT:

Policy establishes guidelines to support GCHP's long-term financial solvency and supports a key strategy of being a responsible fiscal steward of public funds.

RECOMMENDATION:

Staff seeks the Commission's approval of the Tangible Net Equity and Working Capital Reserve Fund Policy.

CONCURRENCE:

January 7, 2016 Executive / Finance Committee

ATTACHMENT:

Tangible Net Equity and Working Capital Policy

Title: Tangible Net Equity and Working Capital Reserve Funds	**Policy Number:**
Department: Accounting and, Financial Planning and Analysis	**Effective Date:**
CEO Approved:	**Revised:**

1. Policy:

Gold Coast Health Plan's ("GCHP" or "Plan") policy is to establish, maintain, and utilize Tangible Net Equity ("TNE") and Working Capital Reserve funds for the benefit of GCHP's long-term financial solvency.

a. It is the Plan's policy to comply with all provisions of its contract with the California Department of Health Care Services ("DHCS") as a County Organized Health System ("COHS"), including maintenance of statutorily required levels of tangible net equity ("TNE") as defined in Title 28, Managed Health Care, California Code of Regulations §1300.76 ("CCR Section 1300.76"). The required statutory TNE amount is a stated legal "capitalization" amount and is not reflective of the amount of actual working capital required by the Plan to ensure continuance of operations and/or long-term financial sustainability.

b. It is the Plan's policy to comply with requirements related to reservations of TNE as outlined in Title 28, Managed Health Care, California Code of Regulations §1300.84.3 ("CCR Section 1300.84.3").

c. In addition to setting aside funds to meet TNE requirements, GCHP shall establish, and maintain appropriate levels of working capital reserves (more commonly referred to as "liquid reserve funds") to ensure that current and future financial obligations of the Plan are met.

2. Required Tangible Net Equity

CCR Section 1300.76 requires the TNE amount to be calculated based on either revenue or medical cost. Because of its current business structure, Gold Coast calculates its required TNE amount based on medical cost.

a. Except for that provided for a newly established COHS as detailed in subsection 2b following, CCR Section 1300.76 states that the required TNE be at least equal to the greater of:

   1) $1 million; or

   2) The sum of two percent of the first $150 million of annualized premium revenues plus one percent of annualized premium revenues in excess of $150 million; or

   3) An amount equal to the sum of:

a) Eight percent of the first $150 million of annualized health care expenditures except those paid on a capitated basis or managed hospital payment basis; plus

b) Four percent of the annualized health care expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of $150 million; plus

c) Four percent of annualized hospital expenditures paid on a managed hospital payment basis.

b. CCR Section 1300.76 provides for a TNE phase-in period for a newly established COHS. The phase-in period is a progressive TNE milestone schedule allowing for the new COHS to operate for a period of time at less than 100% required TNE. The new COHS must achieve minimum TNE amounts by specific milestone dates as defined in paragraphs 1) through 6) as follow:

a) 20 percent of the TNE amount required as per above subsection 2a of this policy within 6 months of the COHS' inception date.

b) 36 percent of the TNE amount required as per above subsection 2a of this policy within 12 months of the COHS' inception date.

c) 52 percent of the TNE amount required as per above subsection 2a of this policy within 18 months of the COHS' inception date.

d) 68 percent of the TNE amount required as per above subsection 2a of this policy within 24 months of the COHS' inception date.

e) 84 percent of the TNE amount required as per above subsection 2a of this policy within 30 months of the COHS' inception date.

f) 100 percent of the TNE amount required as per above subsection 2a of this policy within 36 months of the COHS' inception date.

c. CCR Section 1300.84.3 defines certain specific situations that require reservations of TNE.

3. <u>Actual Tangible Net Equity</u>

For the purpose of this section "*net equity*" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the DHCS. *TNE* means *net equity* reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not

fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates and which are not past due; long term prepayments of deferred charges, and nonreturnable deposits. An obligation is fully secured for the purposes of this subsection if it is secured by tangible collateral, other than by securities of the Plan or an affiliate, with equity of at least 130 percent of the amount owing (reference CCR Section 1300.76 (e).

a. To ensure financial longevity, it is the Plan's goal to maintain a minimum TNE amount of at least 500% of the required TNE amount.

4. Accounting For Tangible Net Equity

a. Tangible Net Equity is reported in account 900-3000 in the general ledger. Increases to TNE result from net income for the fiscal period. Decreases to TNE result from net loss for the fiscal period.

b. TNE is comprised of three components:

1) *Net invested in capital assets.* This amount is the aggregate net book value ("NBV") of the Plan's capital assets. NBV is the original cost of an asset, less any accumulated depreciation, accumulated depletion, or accumulated amortization, and less any accumulated impairment. The Plan's Capital Assets Policy should be referenced for additional information on asset cost, depreciation, depletion, amortization and impairment.

2) *Restricted – Required Tangible Net Equity.* CCR Section 1300.76 states that this is the statutorily required TNE amount for the Plan. Reference to above Section 2 of this policy for discussion on the methodology used to compute the required TNE amount.

3) *Unrestricted net position*. The unrestricted net position amount is total TNE (reference to above Section 3) less *net invested in capital assets* (from paragraph 4.b.1) above) and less *restricted – required tangible net equity* (from paragraph 4.b.2) above).

c. *Net invested in capital assets* and *restricted-required tangible net equity* are considered statutory required reserve funds of the Plan's TNE.

5. Financial Reporting of TNE

a. The Director of Finance is responsible for ensuring the propriety of the Plan's TNE and required TNE amounts.

b. The CFO or designee shall update the Commission on the Plan's TNE and required TNE amounts. The TNE amount, including any accumulated reserve for allocation, shall be shown on GCHP's balance sheet.

6. Working Capital or Liquid Reserve Funds

The Plan shall establish and maintain liquid reserve funds to ensure that it is able to meet its current and future financial obligations. Liquid reserve funds are accounts or securities that can be easily converted to cash at little or no loss of value. Examples of liquid reserve funds include: cash, money in bank accounts, money markets mutual funds, U.S. treasury bills, etc.

a. It shall be the goal of the Plan to maintain liquid reserve funds whose amount is no less than the greater of the combined budgeted medical and administrative expenses for the ensuing three months period; or, the combined actual medical and administrative expenses for the most recent three months period.

b. The Plan shall also maintain liquid reserve funds to ensure that financial obligations arising from unfinished or in-process Commission approved capital projects carried-over from prior fiscal years, Commission approved capital projects for the current fiscal year and other long term liabilities whose payments are projected for the current operating cycle are met.

c. If Capitation Revenue from the State is Delayed:

1) In the event of a delay in the Plan's receipt of capitation revenue from the State and the Plan's unrestricted cash falls to a level requiring the use of liquid reserve funds for continuous payments to health care providers and vendors for medical and administrative expenses incurred in the operations of the Plan, management is authorized to use liquid reserve funds for two months or until the liquid reserve funds amount reaches a level equaled to one-month's projected working capital requirement.

a) Examples of medical and administrative expenses eligible for payment by liquid reserve funds include wages payable and other payroll related expenses, liabilities owed to health care providers and vendors, MCO tax liability, and other expenses incurred in the operations of the Plan

2) When the level of liquid reserve funds falls to one-month's projected working capital requirement, management may cease payments to health care providers and vendors until such time as the State restores capitation revenue to the Plan.

3) Once capitation from the State is resumed, restoration of liquid reserve funds to its appropriate amount shall be a priority.

d. Management may create additional reserve funds as necessary to ensure the long-term wellness of the Plan.

Attachments:
None

References:

Title 28, California Code of Regulations, Sections 1300.76 and 1300.84.3.

Title: Tangible Net Equity and Working Capital Reserve Funds	**Policy Number:**
Department: Accounting and, Financial Planning and Analysis	**Effective Date:**
CEO Approved:	**Revised:**

Revision History:

Review Date	Revised Date	Approved By

AGENDA ITEM NO. 7

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operating Officer

Date: January 25, 2016

Re: Furniture for Office Expansion

Significant membership growth and additional regulatory requirements has driven increased staffing to meet service demands. As a result, GCHP's existing office space has reached full capacity. On October 29, 2015 a Special Meeting of the Commission was held to approve the lease for expansion space at 770 Paseo Camarillo. Construction is in progress and the projected move date is March 2016. The new space accommodates 20 individual offices, 62 cubicles, 5 conference rooms, 3 huddle rooms, 1 large break room and 1 large meeting/training room.

An RFP for furniture has been issued and responses were received on Friday, January 15, 2016. Staff is evaluating the responses received and will present the Plan's recommendation for contracting at the January 25, 2016 Commission meeting.

The budget for this expenditure was included in the Fiscal Year 2015-16 Operating and Capital budget which was approved by the Commission at the June 22, 2015 Commission Meeting.

AGENDA ITEM NO. 8

To: Gold Coast Health Plan Commission

From: Dale Villani, Chief Executive Officer

Date: January 25, 2016

Re: State of California Contract Amendment 10-87129 A03

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 10-87129 A03 is a replacement to the current Amendment 10-87129 A02 and reflects an update to the Adult/Family Hyde supplemental capitation rate.

BACKGROUND / DISCUSSION:

Gold Coast Health Plan (GCHP or Plan) received the following contract amendment from the DHCS on January 6, 2016:

- A03 – This a replacement to the current Amendment 02 and updates the Adult and Adult Expansion Hyde capitation rates, effective July 1, 2015. A03 also eliminates Hyde capitation rates for the Child and Family categories. The contract amendment memorializes Hyde rates included in state rate packages received in June 2015. The Hyde capitation rates are paid to GCHP for non-Federally covered abortions.

FISCAL IMPACT:

The updated Amendment A03 capitation rates were known by the Plan and have been used to record Hyde capitation revenue during the current fiscal year. Accordingly, there is no fiscal impact.

RECOMMENDATION:

Staff is recommending the Commission approve and authorize the CEO to execute DHCS contract amendment A03.

CONCURRENCE:

None.

AGENDA ITEM NO. 9

To: Gold Coast Health Plan Commission

From: Dale Villani, Chief Executive Officer
Scott Campbell, General Counsel

Date: January 25, 2016

Re: Appointment of Members to Executive/Finance Committee

SUMMARY:

The Commission's bylaws provide for an Executive/Finance Committee (Committee) to assist the CEO and the Commission. The Committee consists of five members of the Commission as fixed by the bylaws. The Chairperson and Vice Chairperson of the Commission automatically serve on the Committee. Additionally, at least one seat each is guaranteed to the Committee to the private hospital/healthcare, the Ventura County Medical Health System and Clinicas Del Camino Real representatives, respectively. As the election of the Chairperson and Vice Chairperson determines the Committee's constitution, the Commission should appoint the remainder of the Committee upon selection of a Chairperson and Vice Chairperson.

BACKGROUND / DISCUSSION:

Ventura County Ordinance No. 4481, which established the Ventura County Medi-Cal Managed Care Commission, requires the Commission to establish bylaws containing procedures for the conduct of business that is not otherwise specified in the Ordinance. (Ord. 4481, as amended on October 6, 2015 is attached hereto; see section 1381-4.) The Ordinance authorizes the commission to establish committees. (See section 1381-5.)

The bylaws establish the Executive/Finance Committee, which must consist of the Chairperson, Vice Chairperson, one private hospital/healthcare representative, one Ventura County Medical Health System representative, and one Clinicas Del Camino Real representative. (See Art. IV, section (b).) The bylaws provide that if the Chairperson and/or Vice Chairperson is a representative from one of these three agencies, then the Commission ***must*** appoint the other representative from that agency to serve on the Committee as well. Thus, the Commission should elect a Chairperson or Vice Chairperson before considering Committee appointments because the election will affect the potential membership of the Committee.

The Committee is an advisory committee to the Commission. It cannot take any action on behalf of the Commission (unless expressly authorized), but it does serve a number of functions. The Committee assists the CEO with planning and presentation of items to the full board, reviewing of policies, monitoring the Plan's economic performance. It also advises the Chairperson, reviews certain proposed contracts, develops the CEO review process, and can serves as the interview committee for executive officers. It develops the Plan's strategies related to business planning, investments, provider incentives, auto-assignment policies for beneficiaries, and establishes basic tenets for payment-provider class and levels.

Because the Commission is electing a Chairperson and Vice Chairperson, the Commission must also choose the membership of the Executive/Finance Committee. If it elects a Chairperson and Vice Chairperson, and neither is a representative of private hospital/healthcare system, Ventura County Medical Health System or Clinicas Del Camino Real, then the Commission must appoint a representative from such agency to comply with the bylaws requirement that at least one member from such agency serve on the Committee. If the elected Chairperson or Vice Chairperson is from one of these agencies, then the Commission will also have to appoint the other representative from these agencies to serve on the Committee as well.

If the election is tabled, then the Commission should consider tabling Committee appointments.

FISCAL IMPACT:

None.

RECOMMENDATION:

Staff recommends that the Commission take one of two actions: (1) if of the Chairperson and Vice Chairperson of the Commission are elected today, appoint members to the Committee or (2) if the election is tabled, then table the appointments to the Committee until after the Chairperson and Vice Chairperson are elected.

CONCURRENCE:

N/A

ATTACHMENTS:

Ventura County Ordinance No. 4481
Gold Coast Health Plan Bylaws

ORDINANCE NO. 4481

AN ORDINANCE OF THE VENTURA COUNTY BOARD OF SUPERVISORS, REPEALING AND REENACTING, AS AMENDED, ARTICLE 6, CHAPTER 3, DIVISION 1 OF THE VENTURA COUNTY ORDINANCE CODE (COUNTY ORGANIZED HEALTH SYSTEM)

The Board of Supervisors of the County of Ventura ordains as follows:

SECTION 1: Repeal of Existing Ventura County Organized Health System Ordinance

Ordinance No. 4409 of the County of Ventura, which enacted Article 6 of Chapter 3 of Division 1 of the Ventura County Ordinance Code, is hereby repealed.

SECTION 2: Enactment of Ventura County Organized Health System Ordinance

Article 6 of Chapter 3 of Division 1 of the Ventura County Ordinance Code is hereby amended and reenacted as follows:

Chapter 3.

Article 6. County Organized Health System

1380 General Provisions.

1380-1.

Pursuant to Welfare and Institutions Code section 14087.54, there is hereby formed a commission, referred to in this Article as the Ventura County Medi-Cal Managed Care Commission.

1380-2.

The Ventura County Medi-Cal Managed Care Commission is empowered to negotiate and enter into exclusive contracts with the State of California Department of Health Care Services pursuant to Welfare and Institutions Code section 14087.5, and to arrange for the provision of health care services under Division 9, Part 3, Chapter 7 of the Welfare and Institutions Code. The Ventura County Medi-Cal Managed Care Commission is also authorized to:

(a) Enter into contracts for the provision of health care services to persons who are eligible to receive medical benefits, subject to the limitations of Welfare and Institutions

Code section 14087.54, subdivision (b)(2);

(b) Provide health care delivery systems for:

(1) persons who are eligible to receive medical benefits under both the Medicare program as defined in title 18 of the Federal Social Security Act (42 U.S.C. §1395 et seq.) and under the Medicaid program as defined in title 19 of the Federal Social Security Act (42 U.S.C.§ 1396 et seq.), and or

(2) persons who are eligible to receive medical benefits under the Medicaid program as defined in title 19 of the Federal Social Security Act (42 U.S.C.§1396 et seq.);

(c) File the statement required by Government Code section 53051;

(d) Acquire, possess, and dispose of real or personal property, as may be necessary for the performance of its functions;

(e) Employ personnel and contract for services required to meet its obligations;

(f) Sue and be sued;

(g) Enter into agreements under Chapter 5 (commencing with section 6500) of Division 7 of Title 1 of the Government Code.

1380-3.

The Ventura County Medi-Cal Managed Care Commission shall for all purposes be an entity separate from the County of Ventura, and shall be deemed a public entity for purposes of Division 3.6 (commencing with section 810) of Title 1 of the Government Code. Any obligations of the Ventura County Medi-Cal Managed Care Commission (statutory, contractual, or otherwise) shall be the obligations solely of the Ventura County Medi-Cal Managed Care Commission and shall not be obligations of the County of Ventura or the State of California.

1380-4.

The Ventura County Medi-Cal Managed Care Commission shall design and operate a program or programs, whose mission is to improve the health of its members through the provision of the best possible quality care and services. This will be accomplished by:

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

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

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

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

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

(f) Ensuring that all obligations, statutory, contractual or otherwise, shall be the obligations of the Ventura County Medi-Cal Managed Care Commission and shall not be the obligations of the County of Ventura or the State of California;

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

1381 Board of Directors (Commission)

1381-1.

The governing board of the Ventura County Medi-Cal Managed Care Commission shall consist of eleven (11) voting members who shall be legal residents of the County of Ventura. Members of the

Ventura County Medi-Cal Managed Care Commission shall possess the requisite skills and knowledge necessary to design and operate a publicly managed health care delivery system.

1381-2.

Members of the Ventura County Medi-Cal Managed Care Commission shall be appointed by a majority vote of the Board of Supervisors and shall consist of the following:

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

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

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

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

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

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

g. One member shall be a Medi-Cal beneficiary and/or a representative of an advocacy organization that serves the Medi-Cal population and is not otherwise represented on the Ventura County Medi-Cal Managed Care Commission. This member shall be appointed from applications submitted to the Ventura County Executive Office after a posting of public notice for the open position. (Consumer Representative)

h. One member shall be a representative of the County of Ventura nominated by the Ventura County Executive Officer and approved by the Board of Supervisors. (Ventura County Representative)

1381-3.

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

A member may be removed from the Ventura County Medi-Cal Managed Care Commission by a 4/5 vote of the Board of Supervisors.

Nominations to the Ventura County Medi-Cal Managed Care Commission shall be submitted to the Ventura County Executive Office, which shall be responsible for screening nominees and presenting candidates to the Ventura County Board of Supervisors. Appointments will be based on the individuals' knowledge of the

healthcare needs of women, children, seniors, and/or the disabled, and business, finance and/or political experience.

1381-4.

Procedures for the conduct of business not otherwise specified in this Article shall be contained in bylaws adopted by the Ventura County Medi-Cal Managed Care Commission.

1381-5.

The Ventura County Medi-Cal Managed Care Commission may establish a committee(s) or advisory board(s) for any purpose that will be beneficial in accomplishing the work of the Ventura County Medi-Cal Managed Care Commission. At a minimum, two (2) committees/advisory boards shall be established, one member/consumer based and one provider based.

1382 Cultural Diversity Program

The Ventura County Medi-Cal Managed Care Commission shall establish a Cultural Diversity Program to insure that employees, contractors and recipients of health care services are treated with respect and without discrimination. The governing board of the Ventura County Medi-Cal Managed Care Commission shall appoint a Chief Diversity Officer, who shall be responsible for implementation of the Cultural Diversity Program, and shall provide staff and resources for the Chief Diversity Officer as necessary and appropriate. The Chief Diversity Officer shall report directly to the governing board of the Ventura County Medi-Cal Managed Care Commission, and shall have the authority, independent of any other executive officer, to take disciplinary action against any employee, except the chief executive officer, for failure to comply with the Cultural Diversity Program. The Chief Diversity Officer shall also provide reports to the Ventura County Board of Supervisors, through the County's Chief Executive Officer, on a quarterly or more frequent basis.

SECTION 3: This ordinance shall take effect and be in full force and effect thirty (30) days after its passage. Before the expiration of fifteen (15) days after passage of this ordinance it shall be published once with the names of the members of the Board of Supervisors voting for and against the ordinance in the Ventura County Star, a newspaper of general circulation published in the State of California.

PASSED AND ADOPTED this 6th day of October, 2015, by the following vote:

AYES: Bennett, Parks, Foy, Zaragoza, and Long

NOES:

ABSENT:

Kathy Long
CHAIR, BOARD OF SUPERVISORS

ATTEST: MICHAEL POWERS,
Clerk of the Board of Supervisors,
County of Ventura, State of California.

By: SPfeliciano
Deputy Clerk of the Board

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

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

Approved: October 24, 2011

Table of Contents

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

ARTICLE I

Name and Mission

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

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

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

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

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

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

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

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

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

ARTICLE II

Commissioners

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

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

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

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

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

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

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

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

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

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

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

Selection and Terms of Commissioners

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

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

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

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

ARTICLE III

Officers

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

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

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

Election

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

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

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

Duties

(a) The Chairperson shall:

1. Preside at all meetings;

2. Execute all documents approved by the VCMMCC;

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

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

(b) The Vice-Chairperson shall:

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

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

ARTICLE IV

Standing Committees

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

(b) Executive/Finance Committee.

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

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

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

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

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

iii. Duties of the Executive/Finance Committee.

1. Advise the governing board Chairperson on requested matters.

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

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

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

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

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

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

    - PCP
    - Specialists
    - Hospitals
    - LTC
    - Ancillary Providers

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

9. Review and recommend provider incentive program structure.

10. Review investment strategy and make recommendations.

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

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

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

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

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

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

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

1. Adopting, amending or repealing any bylaw.
2. Making final determinations of policy.
3. Approving changes to the budget or making major structural or contractual decisions (such as adding or eliminating programs).
4. Filling vacancies or removing any Commissioner.
5. Changing the membership of, or filling vacancies in, the Executive/Finance Committee.
6. Hiring or firing of senior executives, but may make recommendations to the governing board as to their appointment, dismissal or ongoing performance.
7. Taking any action on behalf of the governing board unless expressly authorized by the governing board.

ARTICLE V

Special Committees

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

ARTICLE VI

Meetings

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

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

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

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

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

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

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

Conduct of Meetings

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

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

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

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

(e) Without objection, the Chairperson may continue or withdraw any item. In the event of an objection, a motion to continue or reset an item must be passed by a majority of

the members present. A motion to continue or reset an item shall take precedence over all other motions except for a point of order.

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

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

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

ARTICLE VII

Powers and Duties

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

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

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

(c) Provide for financial oversight through various actions and methodologies such as the preparation and submission of an annual statement of financial affairs and an estimate of the amount of funding required for expenditures, approval of an annual budget, receipt of monthly financial briefings and other appropriate action in support of its financial oversight role;

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

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

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

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

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

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

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

ARTICLE VIII

STAFF

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

Chief Executive Officer

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

The CEO shall:

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

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

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

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

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

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

Clerk

The Clerk shall:

(a) Perform the usual duties pertaining to secretaries;

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

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

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

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

Assistant Clerk

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

ARTICLE IX

Rules of Order

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

ARTICLE X

Amendments

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

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

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

ARTICLE XI

Nondiscrimination Clause

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

ARTICLE XII

Conflict of Interest and Ethics

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

ARTICLE XIII

Dissolution

Pursuant to California Welfare & Institutions Code, section 14087.54:

(a) In the event the Commissioners determine that VCMMCC may no longer function for the purposes for which it was established, at the time that VCMMCC's then existing obligations have been satisfied or VCMMCC's assets have been exhausted, the Board of Supervisors may by ordinance terminate the VCMMCC.

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

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

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

AGENDA ITEM NO.10

To: Gold Coast Health Plan Commissioners

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

Date: January 25, 2016

Re: Appointment of Commissioners to CDO Interview Panel

SUMMARY:

In order to proceed with the selection process of a Chief Diversity Officer, the Commission is asked to appoint three Commissioners that will serve on a 5 person winnowing panel for candidates.

BACKGROUND / DISCUSSION:

On November 16, 2015, the Commission instructed the Cultural Diversity Subcommittee (Subcommittee) to work with Commissioner Lee to draft a final, approved job description for the proposed Chief Diversity Officer (CDO) position. On December 21, 2015, the Subcommittee prepared that final job description. A copy is attached hereto as Exhibit A. The CDO position recruitment is now formally underway.

Pursuant to the approved process, the Plan will now establish a 5-person CDO Interview Panel that will include (1) three Commissioners, appointed by the Commission; (2) Dr. Jamie Casillas, as a representative from LULAC; and (3) a third party panelist with CDO experience. The CDO Interview Panel will be tasked with reviewing applicant resumes and performing preliminary interviews for the purpose of winnowing down the applicant pool to two or three finalists. The Commission, as a whole, will then interview and select from the finalists. The Commission is now asked to identify the three Commissioner appointments so that the Interview Panel may begin reviewing applications.

FISCAL IMPACT:

None at this time.

RECOMMENDATION:

Staff recommends the Commission appoint three Commissioners to the CDO Interview Panel.

CONCURRENCE:

N/A

ATTACHMENTS:

Exhibit A.

GOLD COAST HEALTH PLAN

TITLE: Job Description – Chief Diversity Officer
Dated: December 21, 2015
Exempt, Contracted, At-Will
Salary Range: Level 29

POSITION SUMMARY

The Chief Diversity Officer (CDO) will be responsible for the design and implementation of a Cultural Diversity Program to insure that employees, contractors and recipients of health care services are treated with respect and without discrimination. The CDO will collaborate with GCHP leadership and human resources to design, implement and maintain the Diversity Program. The ideal candidate will have extensive experience in human resources and related regulations and law, developing and managing diversity and inclusion programs, and will excel at establishing and maintaining both internal and external partnerships that drive success. The incumbent will help drive engagement, strategy, execution, and accountability for all diversity and inclusion initiatives across Gold Coast Health Plan (GCHP). The CDO shall report directly to the Commission overseeing the GCHP.

ESSENTIAL FUNCTIONS

Design and implement a Cultural Diversity Program to insure that employees, contractors and recipients of health care services are treated with respect and without discrimination and actively promote a culture that supports said program.

Provide reports to the Gold Coast Health Plan's Commission, through the County's Chief Executive Officer, on a quarterly or more frequent basis.

Exercise authority independent of any other executive officer, to take disciplinary action against any employee, except the chief executive officer, for failure to comply with the Cultural Diversity Program.

Actively promote dignity and professionalism in the workplace in a manner that protects the right of employees to be free from illegal discrimination, harassment, and retaliation due to any protected status. Illegal discrimination includes but is not limited to discrimination on the basis of sex, race, color, ancestry, religion, national origin, ethnicity, age (40 and older), disability, sexual orientation, gender identity and expression, marital status, medical condition, veteran status or any other characteristic protected by state or federal employment law.

Collaborate with all stakeholders to establish and maintain a workplace culture where all GCHP employees comply with the Cultural Diversity Program, and where failure to do so will lead to prompt and appropriate corrective action including, but not limited to,

counseling, training, written warning, written reprimand, suspension, demotion, or dismissal.

Additionally, the CDO will:

- Consult with GCHP staff, community members, and/or other interested parties to develop periodic recommendations for policy and procedural changes designed to implement the Cultural Diversity Program and ensure compliance with applicable law, including but not limited to both Title VII of the Civil Rights Act and the California Fair Employment and Housing Act.

- Investigate/review and evaluate allegations of employment-related, illegal discriminatory acts/statements/omissions in, or arising from, the GCHP workplace or causes such to occur.

- Identify and conduct employment-related audits of the GCHP workplace environment (or cause the same to be conducted).

- Review and evaluate GCHP Management's response to employee complaints and/or directions given it by the CDO.

- Consult with and advise GCHP Management, Supervision, and/or line-staff on employment-related matters to avoid actual, or (if possible) perceived, illegality with respect to employment decisions and to thus limit GCHP's exposure to employment related lawsuits.

- Consult, advise, and take independent action, if necessary, regarding the GCHP response to inappropriate acts/statements/omissions by GCHP staff, up to and possibly including dismissal from employment.

- Coordinate responses to employment-related inquiries/allegations from employees, the EEOC, the DFEH, or private attorneys representing active, past, or former employees.

- Efficiently supervise the activities of assigned staff and/or contractors in support or pursuit of the foregoing activities.

- Provide periodic and/or special confidential, personnel/employment-related reports to the Commission on GCHP employment-related matters.

ANCILLARY FUNCTIONS

- Consult with management, human resources, and legal counsel regarding diversity issues.

- Arrange diversity-related training classes, workshops, and conference trips.
- Attend Commission and Diversity Subcommittee meetings.
- Perform related duties and responsibilities as required.

QUALIFICATIONS

- Bachelor's degree, along with 5-10 years of human resources, progressive diversity, and inclusion experience with a health plan/business or experience managing strategic company-wide Diversity and Inclusion initiatives; managed care experience a plus.
- Ability to work independently and in groups, while managing multiple priorities in a fast paced, fluid environment.
- Excellent interpersonal and influencing skills, including the ability to effectively coach leaders, build relationships and leverage resources within the department and across the organization to advance GCHP's strategy.
- Experience with change management, organizational design, talent/performance management, and strategic planning.
- Strong internal customer relationship management skills.
- Understands the challenges of, and thrives in, a heavily regulated organization.
- Ability to work collaboratively and openly with cross-functional teams.
- Creative approach to problem solving with a humble, team-oriented and optimistic attitude.
- Superior communication and presentation skills.

PHYSICAL REQUIREMENTS

Ability to communicate orally with the Commission, Plan management, staff, and the public in face-to-face, one-on-one and group settings. Regularly use a telephone for communication. Use office equipment such as a personal computer, copier and facsimile machines. Sit and/or stand for extended time periods. Hearing and vision required to be within normal ranges. Carry, push, pull, reach and lift up to 25 lbs. routinely. Read at, above, and below shoulder height. Occasionally stoop, kneel or crouch. Sufficient manual dexterity required to operate equipment.

CONDUCT STANDARD

Interact with the Commission, Plan Staff, Plan employees, customers, and the public in a positive, cooperative, and supportive manner. Maintain the highest standards regarding diversity and inclusion.

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 11

To: Gold Coast Health Plan Commission

From: Dale Villani, Chief Executive Officer

Date: January 25, 20116

Re: Chief Executive Officer Update

KEY STAFF CHANGES:

Traci McGinley, Clerk of the Commission resigned her position at Gold Coast Health Plan effective 1/8/16 to pursue other opportunities. We are actively recruiting her replacement. In the interim, Maddie Gutierrez-Roberts, Executive Assistant to the COO will be fulfilling the clerk activities.

PROCUREMENT UPDATE:

We are close to selecting the final vendors for two of our key strategic partners. The HEDIS vendor contract and the Pharmacy Benefits Manager contracts, currently at the best and final offer stage, and we would like to make a recommendation to the Commission at our February 22nd Commission meeting. It has been our custom to bring these detailed contract discussions to the Executive/Finance Committee prior to bringing to the full commission. We have requested the Executive/Finance Committee to hold a special session on February 11th to review these important contracts.

EMPLOYEE SURVEY:

The Plan contracted Amplitude Research to conduct an Employee Survey of Gold Coast Health Plan employees. The survey will be electronically distributed during the week of January 25. The survey will assess the overall work environment, leadership and concerns of employees as well as address diversity specific questions. There are approximately 70 questions of which 16 are diversity specific. Results will be available by the end of February and focus groups will be established to address 1) diversity issues and 2) employee satisfaction. The results will be shared with the Commission.

PER DIEM EMPLOYEES:

We are creating a new category of employee – Per Diem – to be used selectively to support UM/QM and compliance related reviews. The budget impact will be minimal. These employees may be used on an “as-needed” basis for a non-specified period. Employment in this class will be re-evaluated at appropriate intervals to determine if

the employment relationship will be continued. Per Diem staff will be utilized at the CEO's discretion with his approval for placement. Per Diem staff will be recruited through the Plan's current recruiting processes.

Per Diem employees do not work a defined/regular schedule. They are, generally, limited to 1000 regular hours per fiscal year. Participation in benefit programs is limited to eligibility for worker's compensation benefits.

Per Diem employees will be paid by the hour - usually at a higher rate than a full-time employee on a regular work schedule. A Per Diem worker, however, gets no medical insurance, vacation time or other benefits. Additionally, Per Diem employees have no guarantee of work and can be terminable at will.

COMPLIANCE UPDATE:

Gold Coast Health Plan (GCHP) had auditors from Audits & Investigations (A&I) a division within the Department of Health Care Services (DHCS) onsite from February 17- February 25, 2015.The purpose of the onsite audit is to perform the annual medical audit which includes but is not limited to: interviewing staff & providers, file reviews and evaluating plan policies & processes. The review period of the audit was December 1, 2013 through November 30, 2014. The Plan is working with DHCS on deficiencies identified in the draft report and the final report is slated to be released at a future date.

The DHCS corrective action plan, Financial (Addendum A) remains open and the plan continues to submit items on a monthly basis as required and defined by the CAP.

Compliance continues to monitor and ensure all employees and temporary employees are trained and retrained on HIPAA and Fraud, Waste & Abuse. Compliance staff has revised and created new HIPAA privacy policies and procedures. Compliance staff has developed a comprehensive privacy program. A privacy work plan is in the process of being implemented for 2016, and staff is working on all facets of the work plan to ensure goals are achieved.

GCHP continues to meet all regulatory contract submission requirements. In addition to routine deliverables GCHP provides weekly and monthly reports to DHCS as a part of ongoing monitoring activities. All regulatory agency inquiries and requests are handled timely and requested information is provided within the specified required timeframe(s). Compliance staff is actively engaged in sustaining contract compliance.

GCHP compliance committee continues to meet in accordance with the compliance committee charter. In Q4 2015, the committee reviewed a status update by compliance staff relative to a delegate who was under a financial sanction. The financial sanction was lifted on January 20, 2016. The Plan is committed to holding all delegates accountable.

The Plan is required to conduct oversight audits on functions which the Plan delegates. Below is a grid which outlines recent delegation oversight audit activities:

Delegate	Onsite Audit (Clinical)	*CAP Issued (Clinical)*	*CAP Closed (Clinical)*	*Onsite Audit (Non-Clinical)*	*CAP Issued (Non-Clinical)*	*CAP Closed (Non-Clinical)*
Vision	*10/19-10/21* ***2015***	*11/20/2015*	*01/08/2016*	*10/19-10/21* ***2015***	*11/10/2015*	*Closure Pending*
NEMT				*12/01-12/04* ***2015***	*12/14/2015*	*01/04/2016*
MBHO	*11/16-11/18* ***2015***	*12/23/2015*	*Response to CAP due* ***1/13/2016***	*11/16-11/18* ***2015***	*12/04/2015*	*Closure Pending*
Specialty Contract	*06/09-6/10* ***2015***	*07/13* ***2015***	*11/13* ***2015***	*09/28-09/29* ***2015***	*10/06/2015*	*10/26/2015*
ASO	*N/A*	*N/A*	*N/A*	*01/06-01/08* ***2016***	*Audit results are in process*	

The Plan currently delegates credentialing to three entities: Ventura County Medical Center (VCMC), Clinicas del Camino Real (CDCR), and Community Memorial Health System (CMH). Onsite audits are scheduled for January 2016: CMH onsite audit (01/25/2016), CDCR onsite audit (01/27/2016) and VCMC onsite audit (01/29/2016).

The Plan continues to monitor delegates through contractual required reporting. Reports are reviewed and when deficiencies are identified the Plan issues letters of non-compliance. This process is monitored, tracked and reported to the compliance committee. In addition the aggregate information is provided to the commission on the compliance dashboard.

GOVERNMENT RELATIONS UPDATE:
(Marlen Torres, Manager Government and External Relations)

Governor Brown's Proposed 2016-17 Budget
On January 7, Governor Brown released his 2016-17 proposed budget. The total Medi-Cal budget accounts for 62.5 percent of the total Health and Human Services budget. Major highlights pertaining to the Medi-Cal program are the following:

- **Caseload**-It is projected that 13.5 million members will be enrolled in Medi-Cal by the end of Fiscal Year (FY) 2016-17.
- **Managed Care Organization (MCO) Tax**-The budget did not incorporate a specific tax model but the Governor expressed he would like an MCO tax to be

finalized by the end of January 2016. A two-thirds vote in the Legislature is needed in order to implement an MCO tax. The MCO tax would be extended for three years, beginning in 2016, and it will also fund the In-Home Supportive Services (IHSS) seven percent restoration rate.

- **Coordinated Care Initiative (CCI)**-The program will continue through 2016. However, if an MCO tax is not finalized and if the opt-in participation rate in the program does not improve by January 2017, the program will cease effective January 2018. Currently the program has an opt-out rate of 69 percent. The administration will work with stakeholders this upcoming year to increase the opt-in participation rate.
- **Full-Scope Medi-Cal Coverage for Undocumented Children**-The budget includes $182 million ($142 million GF) to provide full-scope coverage to 170,000 children, under 19 years of age, starting May 1, 2016.
- **State Share of Medi-Cal Expansion**- Starting in 2017, the State will assume a five percent share of cost for the Medi-Cal expansion population. By 2020, the State's share will increase to ten percent (the federal government will pay for 90 percent of the cost). The budget assumes costs of $14.1 billion ($740.2 million GF) for the expansion share of costs in 2016-17.
- **Medi-Cal 2020 Waiver**-The waiver has been approved for five years. Starting January 1, 2016-December 31, 2020. Total funding for the waiver is $6.2 billion with a potential for additional funding in the Global Payment Program.

Medi-Cal 2020 Waiver
On December 30, the Centers for Medicare and Medicaid Services (CMS) approved California's 1115 waiver renewal, called Medi-Cal 2020, which includes $6.2 billion in federal funding to support the state's Medi-Cal program. The waiver is effective beginning January 1, 2016 through December 31, 2020.

Major highlights are the following:

- **Public Hospital Redesign and Incentives in Medi-Cal (PRIME)**-The PRIME program builds on the success of the Delivery System Reform Incentive Program (DSRIP). Under PRIME, the Designated Public Hospital (DPH) systems and District Municipal Public Hospitals (DPHs) will be required to achieve greater outcomes in areas in physical and behavioral health integration and outpatient primary and specialty care delivery. Additionally, PRIME requires DPHs to transition managed care payments to alternative payment methodologies, moving toward value-based payment structures over the course of the waiver. Federal funding for PRIME for DPHs is $3.27 billion and for DMPHs is $466.5 million.
- **Global Payment Program (GPP)**-Under the GPP, DPHs are incentivized to provide ambulatory primary and preventive care to the remaining uninsured through a value-based payment structure that rewards the provision of care in

more appropriate settings. The federal funding for GPP will be a combination of the DSH funding for participating DPHs and $236 million in federal funding for the first year from the prior Safety Net Care Pool Payments. The non-DSH funding for two years through year five will be determined following an independent assessment of uncompensated care which will be completed in the spring of 2016.

- **Dental Transformation Initiative (DTI)**-The DTI provides incentive payments to Medi-Cal dental providers who meet certain requirements and benchmarks in critical focus areas such as preventive services and continuity of care. Over the course of the waiver, up to $750 million in annual funding is available for the DTI.
- **Whole Person Care (WPC) Pilots**-The goal of WPC pilots is the integration of systems that provide physical health, behavioral health, and social services to improve members' overall health and well-being, with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. The waiver renewal authorized up to $1.5 billion in federal funding over five years

Additionally, the waiver contains several independent analyses of the Medi-Cal program and evaluations of the waiver programs, including an assessment of access in the Medi-Cal managed care and studies of uncompensated care in hospitals.

AGENDA ITEM NO. 12

To: Gold Coast Health Plan Commission

From: C. Albert Reeves, MD, Chief Medical Officer

Date: January 25, 20116

Re: Chief Medical Officer Update

Summary:

Gold Coast Health Plan (GCHP) participates in community education and outreach activities throughout the county. The health education and outreach team maintains a positive presence in the community by working with various county public health departments, community based organizations, schools, senior centers, faith base centers and social service agencies.

Below is a summary of activities during the months of November and December 2015.

Outreach Activities - November 2015:

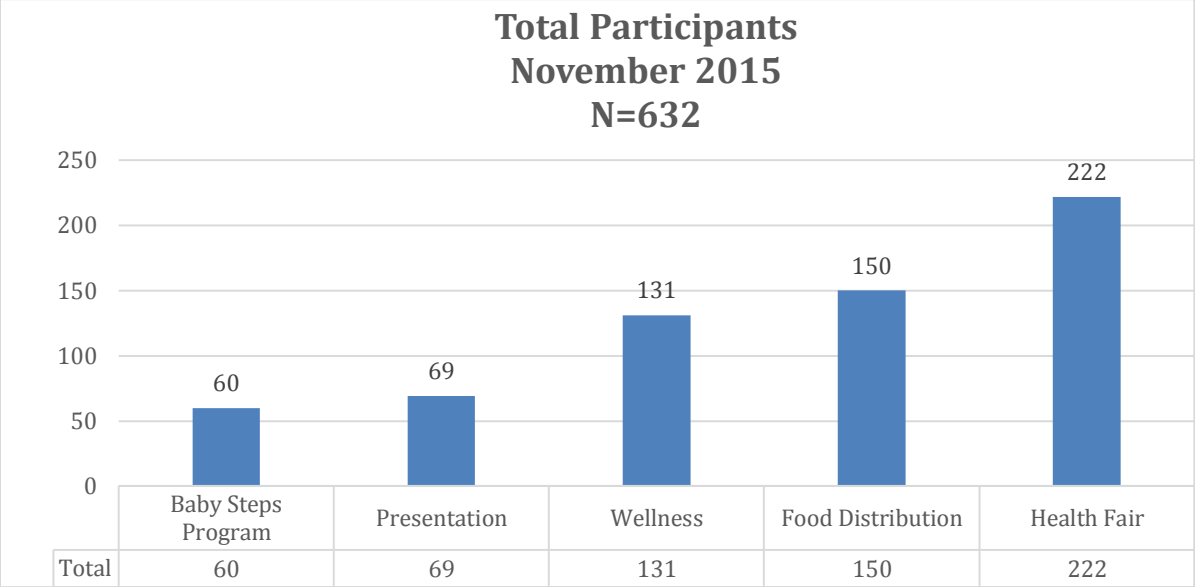
GCHP participated in the 2015 Senior Summit held at California State University Channel Islands on Saturday November 14, 2015. The Plan provided an information booth and distributed health education materials to 130 participants. The Ventura County Board of Supervisors presented GCHP with a certificate of appreciation for participation in the Senior Summit. (See the attached certificate) GCHP also was a sponsor of this event

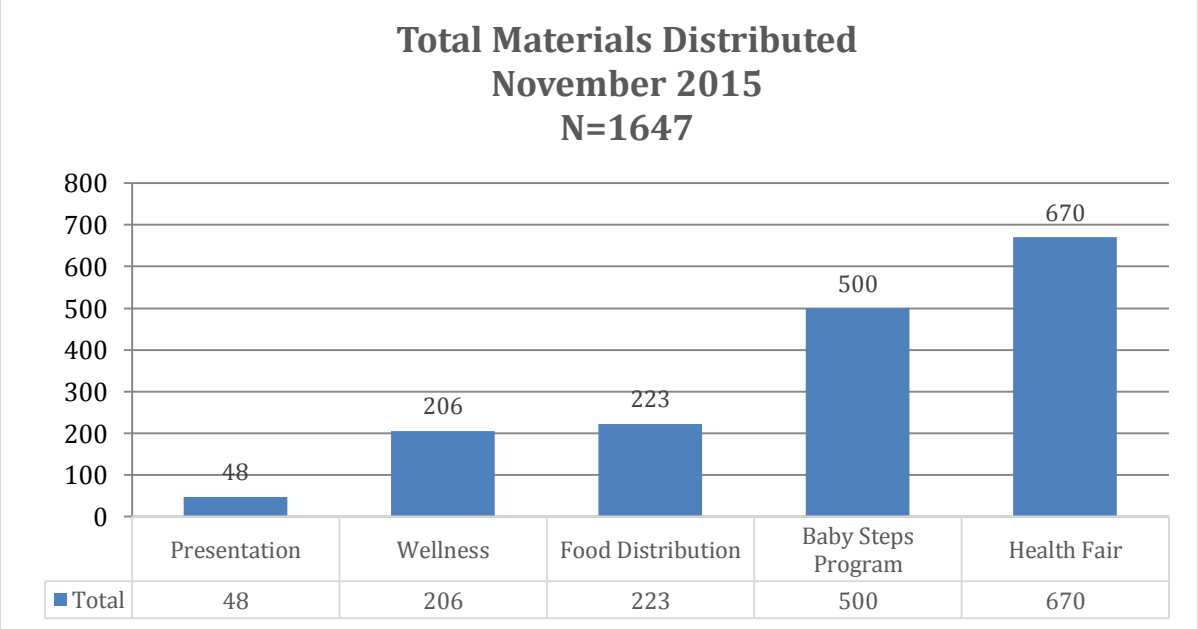
GCHP held its 3rd Annual Community Diabetes Education Health Fair on Saturday, November 7, 2015, at the Oxnard Public Library. GCHP hosted more than 10 local community-based organizations that focused on diabetes health screenings, eye exams, and nutrition education. Nearly 60 community members attended the event. Language assistance and interpreting services was also provided.

In addition to the community diabetes health fair, GCHP implemented a member incentive program to increase retinal eye exams among diabetic members enrolled in GCHP. Eligible members who completed their annual retinal eye exam would receive a twenty-five dollar movie theater gift card.

GCHP participated in 12 community health education and outreach events. The majority of individuals reached were from events that focused on reaching the general population and low-income families. A total of 632 participants were reached and 1,647 health information materials were distributed.

Below are two charts that highlight the total number of participants reached and materials distributed during the month of November.



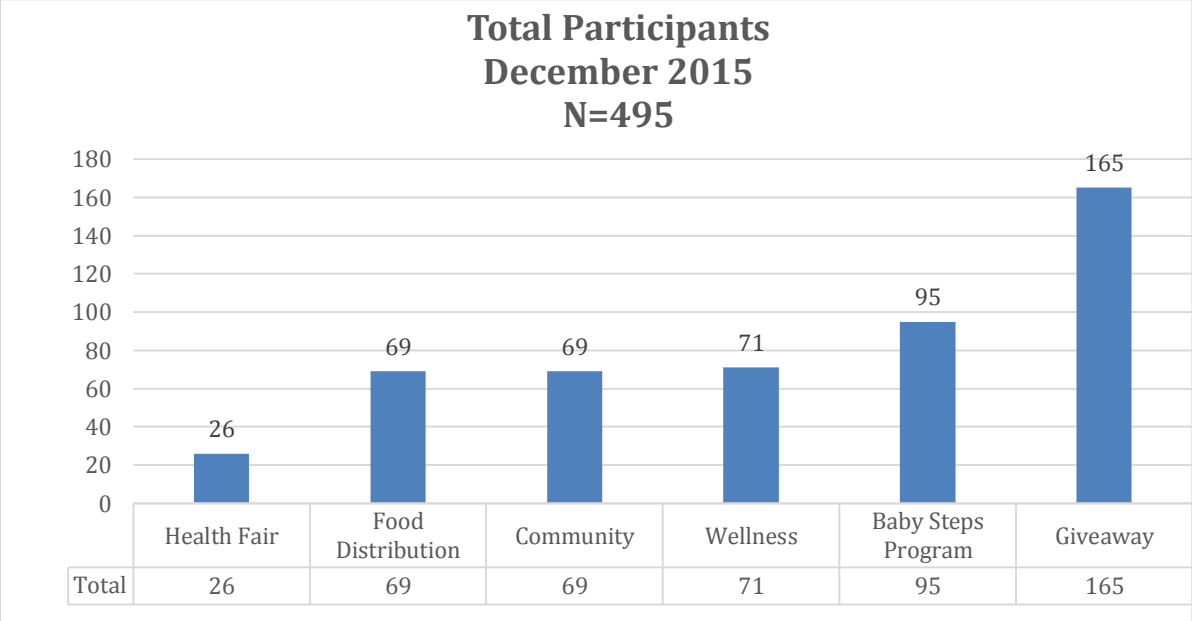


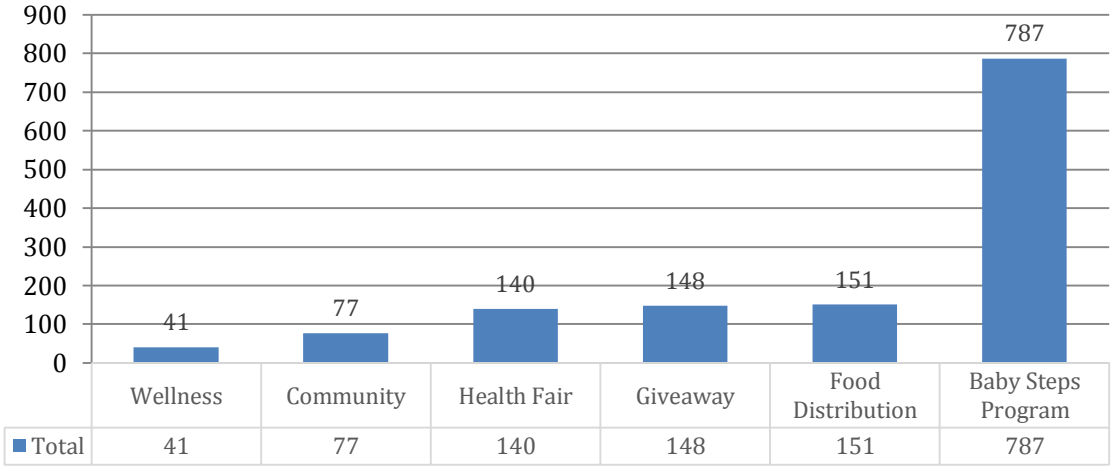
Outreach Activities – December 2015:

GCHP participated in 9 different community events and health fairs held throughout the county. The majority of individuals reached were from outreach events that focused on the general population and low-income families. GCHP also distributed health information materials at various food distribution events held throughout the county.

In addition to participating in community outreach events and health fairs, GCHP is active in conducting community health education classes and workshops throughout the county. During the reporting period, GCHP held five community health education classes and reached approximately 152 individuals.

A total of 495 individuals were reached and approximately 1,344 health information materials were distributed during outreach events and to various organizations throughout the county. Below are two charts that highlight the total number of participants reached and materials distributed during the month of December.




Total Materials Distributed
December 2015
N=1344
900
800
700
600
500
400
300
200
100
0
41
77
140
148
151
787
Wellness
Community
Health Fair
Giveaway
Food Distribution
Baby Steps Program
Total
41
77
140
148
151
787

BOARD OF SUPERVISORS

COUNTY OF VENTURA

STATE OF CALIFORNIA

Recognizes with great appreciation

Gold Coast Health Plan

2015 Senior Summit

There's No Place Like Home!

Thank you for your sponsorship of the 2015 Senior Summit.
You helped make it an over the rainbow success!

Steve Bennett, 1st District

Linda Parks, 2nd District

Kathy I. Long, 3rd District
Chair of the Board

Peter C. Foy, 4th District

John C. Zaragoza, 5th District

AGENDA ITEM NO. 13

To: Gold Coast Health Plan Commission

From: Nancy Wharfield, Associate Chief Medical Officer

Date: January 25, 2016

Re: Health Services Update

HEALTH SERVICES UPDATE:

Utilization data in the Health Services monthly update to the Commission is based on paid claims compiled by date of service and is lagged by 3 months to allow for partial run out of claims data. Claims data is complete at approximately 6 months. While incomplete, a 3 month lagged snapshot allows us to see an estimate of utilization without waiting for a more complete 6 month report. Administrative days are included in these calculations. Dual eligible members, Skilled Nursing Facility (SNF), and Long Term Care (LTC) data is not included in this presentation.

UTILIZATION SUMMARY:

Inpatient utilization metrics for YTD 2015 are slightly improved compared with CY 2014. Emergency Department (ED) utilization / 1000 members is essentially unchanged (461 ER visits / 1000 members) compared to CY 2014 (463 visits / 1000 members).

Benchmark: The September 17, 2015 DHCS Medi-Cal Managed Care Performance Dashboard reported 36 ER visits / 1000 member months statewide for all managed care plans for October 2013 – September 2014. GCHP ER utilization / 1000 member months for the same period was 38.

Utilization Per 1000		
	2014	2015 YTD (Jan – Aug)
Inpatient		
Bed days/1000	224	209.2
Admits/1000	51	48.8
Average LOS	4.4	4.29
ED Utilization		
ED Cases/1000	462.7	461

* Data from MedInsight 11/24/15. Data excludes Duals, LTC and SNF.

Total Volume:		
	2014 Total	2015 YTD (Jan – Aug)
Inpatient		
Bed days	30,456	23,260
Admissions	6,920	5,428
ED Utilization		
ED Cases	62,803	51,263

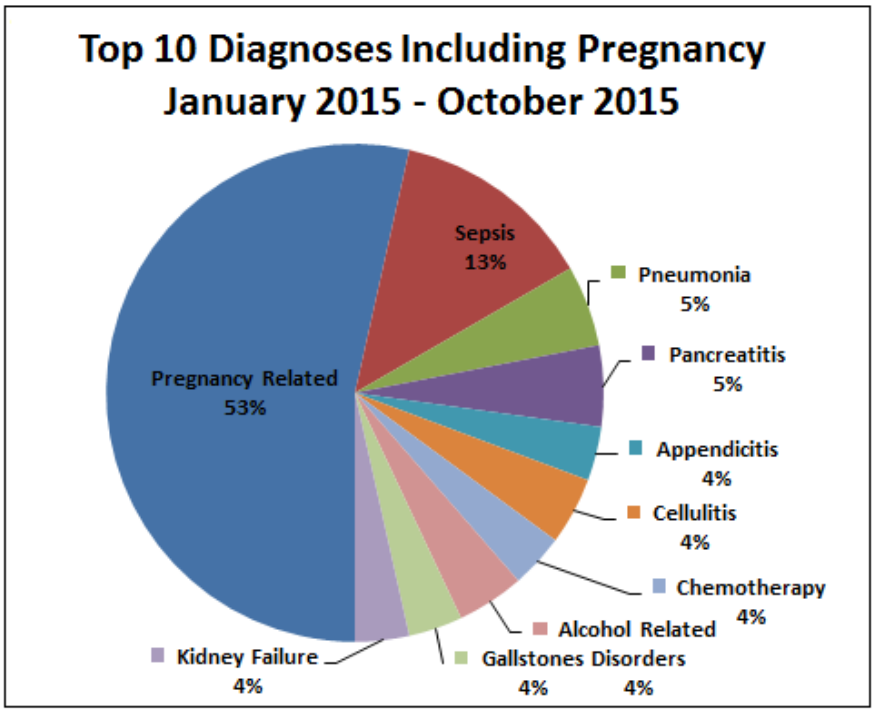
* Data from MedInsight 11/24/15. Data excludes Duals, LTC and SNF.

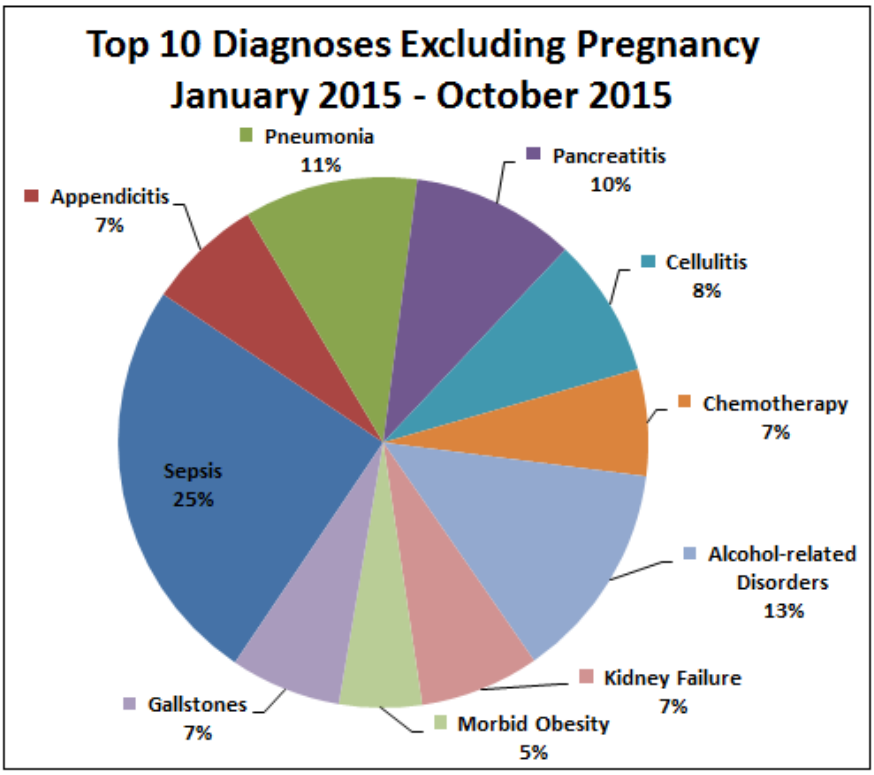
Monthly Averages		
	2014	2015 YTD (Jan – Aug)
Inpatient		
Bed days	2,538	2,908
Admissions	577	678.5
ED Utilization		
ED Cases	5,234	6,408

* Data from MedInsight 11/24/15. Data excludes Duals, LTC and SNF.

TOP ADMITTING DIAGNOSES:

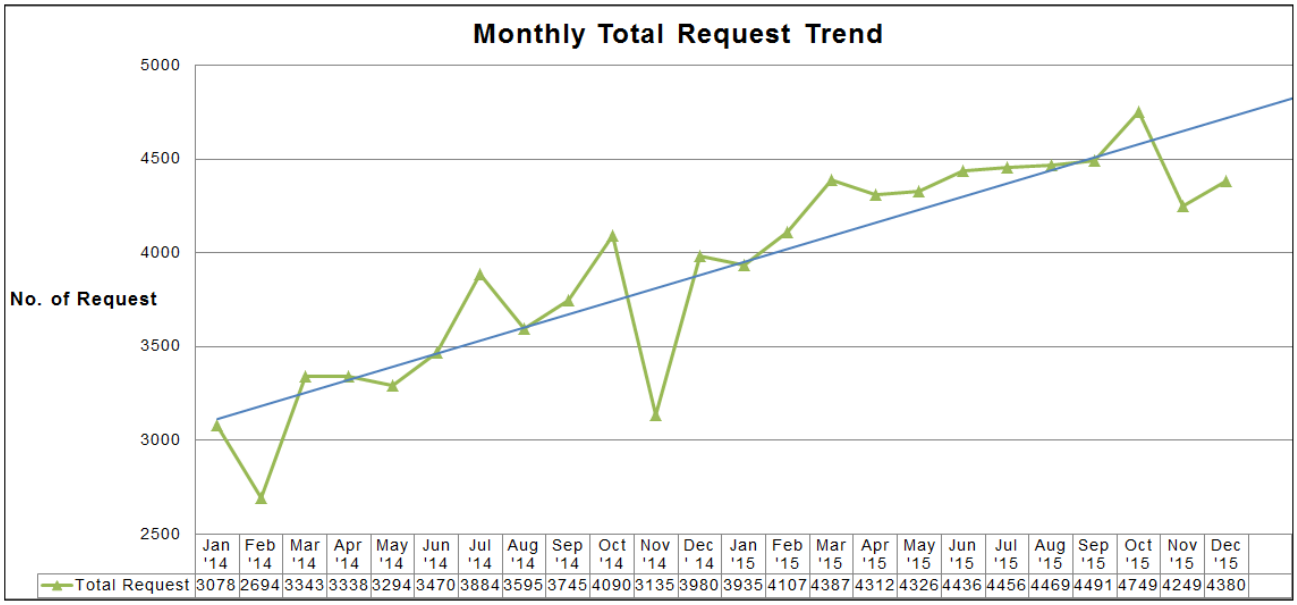
Pregnancy related diagnoses overshadow all other diagnoses for CY 2014 and YTD CY2015. Pneumonia and sepsis were also top diagnoses for CY 2014 and 2015. When pregnancy is excluded, sepsis, alcohol-related disorders, pneumonia, and pancreatitis are the leading diagnoses for YTD 2015.


Top 10 Diagnoses Including Pregnancy
January 2015 - October 2015
Sepsis
13%
Pneumonia
5%
Pancreatitis
5%
Appendicitis
4%
Cellulitis
4%
Chemotherapy
4%
Alcohol Related
4%
Gallstones Disorders
4%
Kidney Failure
4%
Pregnancy Related
53%

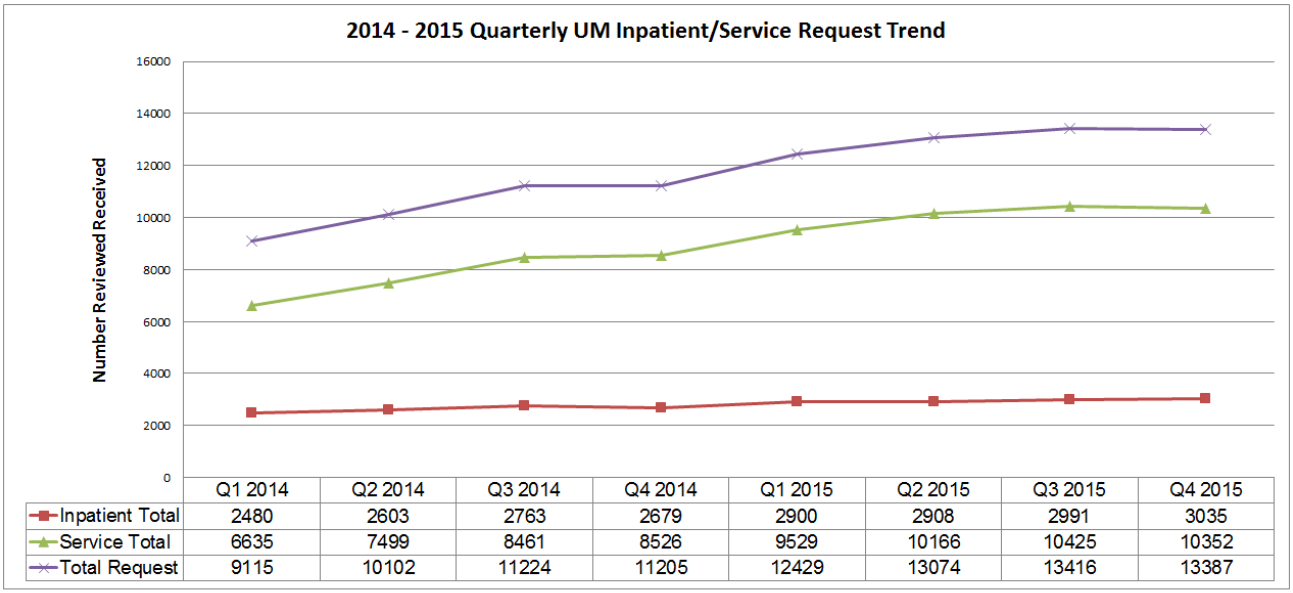

Top 10 Diagnoses Excluding Pregnancy
January 2015 - October 2015
Pneumonia
11%
Pancreatitis
10%
Appendicitis
7%
Cellulitis
8%
Chemotherapy
7%
Sepsis
25%
Alcohol-related
Disorders
13%
Kidney Failure
7%
Gallstones
7%
Morbid Obesity
5%

AUTHORIZATION REQUESTS:

Requests for outpatient service continue to outnumber requests for inpatient service. Outpatient service requests for YTD CY 2015 were 214 / 1000 members compared to 213 /1000 members for CY 2014. Requests for inpatient service for YTD 2015 are 62 / 1000 members compared to 71 / 1000 members for CY 2014.



	Jan '14	Feb '14	Mar '14	Apr '14	May '14	Jun '14	Jul '14	Aug '14	Sep '14	Oct '14	Nov '14	Dec ' 14	Jan '15	Feb '15	Mar '15	Apr '15	May '15	Jun '15	Jul '15	Aug '15	Sep '15	Oct '15	Nov '15	Dec '15
Total Request	3078	2694	3343	3338	3294	3470	3884	3595	3745	4090	3135	3980	3935	4107	4387	4312	4326	4436	4456	4469	4491	4749	4249	4380



	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015
Inpatient Total	2480	2603	2763	2679	2900	2908	2991	3035
Service Total	6635	7499	8461	8526	9529	10166	10425	10352
Total Request	9115	10102	11224	11205	12429	13074	13416	13387

Increase comparison from 2014 Quarter to 2015 Quarter in Percentage

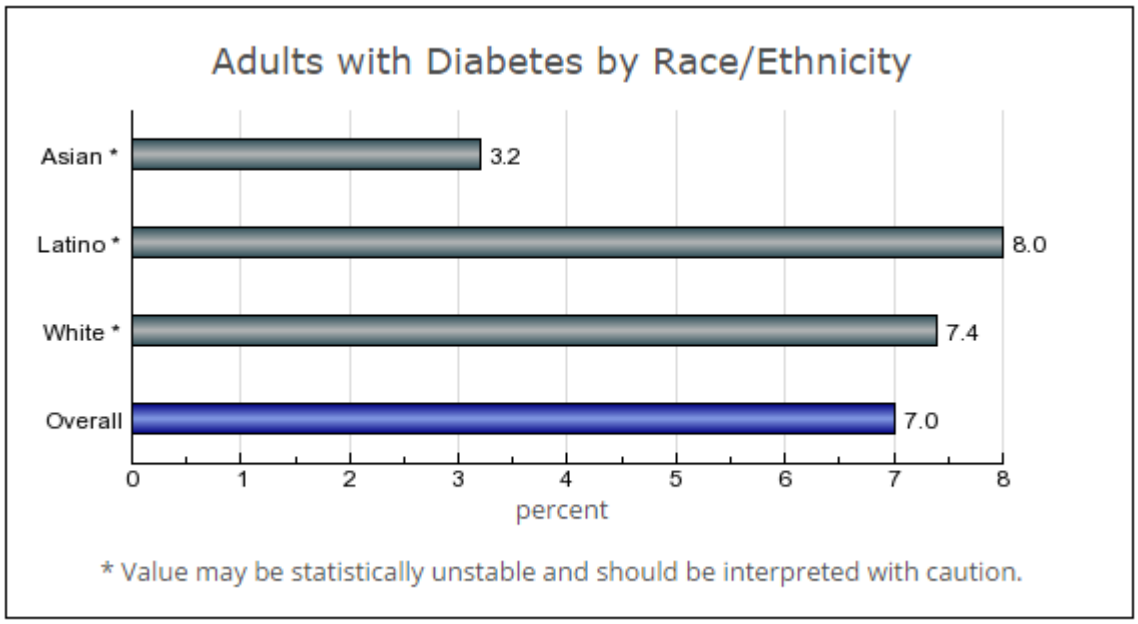
	Q1	Q2	Q3	Q4
Inpatient Request	16.94%	11.72%	8.25%	13.29%
Service Request	43.62%	35.56%	23.21%	21.42%
Total Request	36.36%	29.42%	19.53%	19.47%

DIABETES DISEASE MANAGEMENT SPOTLIGHT:

Over 29 million Americans or 9.3% of the population have diabetes. It's estimated that 8.1 million people have undiagnosed diabetes. GCHP has identified approximately 11,000 members with diabetes (type I or II), pre-diabetes, or gestational diabetes. On average, medical expenses for a person with diabetes are more than twice as much as the expenses of a person without diabetes. To address this issue, GCHP launched a disease management program in November 2015 which links members to educational materials, classes, and nurse coaching.

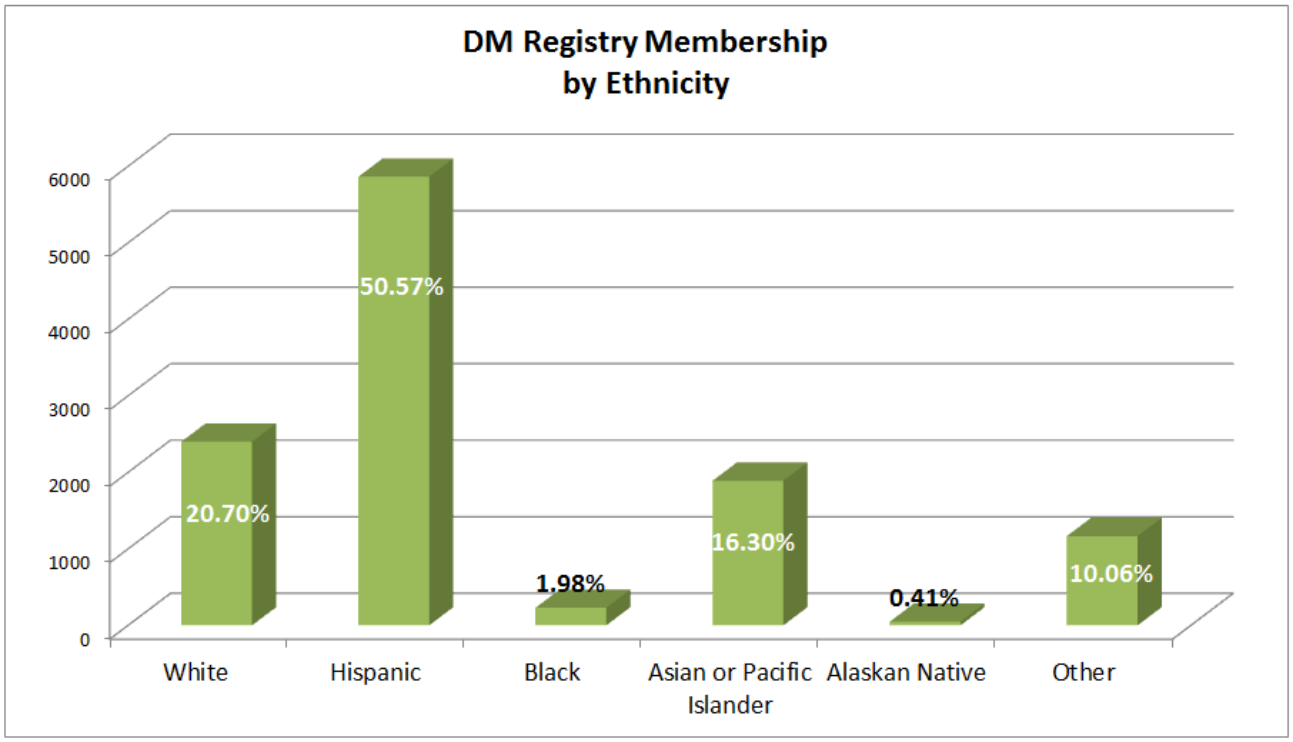
The Office of Minority Health reports that Hispanics are almost twice as likely as non-Hispanic whites to be diagnosed with diabetes. Hispanics have higher rates of complications of diabetes and are 40% more likely to die from diabetes than non-Hispanic whites.

Ventura County Public Health reports 7% of adults in the county have diabetes. Racial and ethnic differences are also demonstrated in our county.



Website: Ventura County Public Health :: Community Dashboard :: Adults with Diabetes

GCHP has identified that approximately 6.3% of our membership has diabetes. There are nearly 2 ½ times as many Hispanics as non-Hispanic whites in our diabetic population. Hispanics also had higher rates of complications from diabetes (eye and kidney disease and amputations).



* Other includes "other" as well as "no response/declined"

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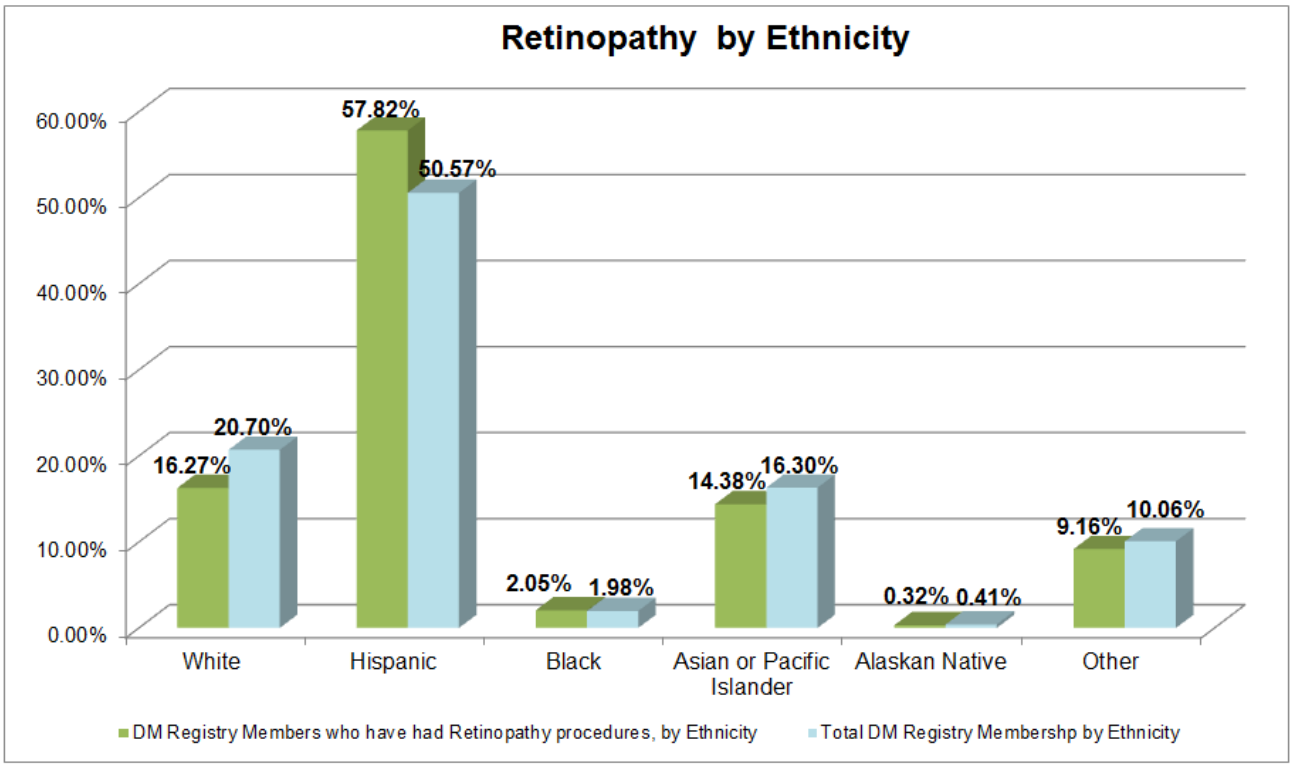
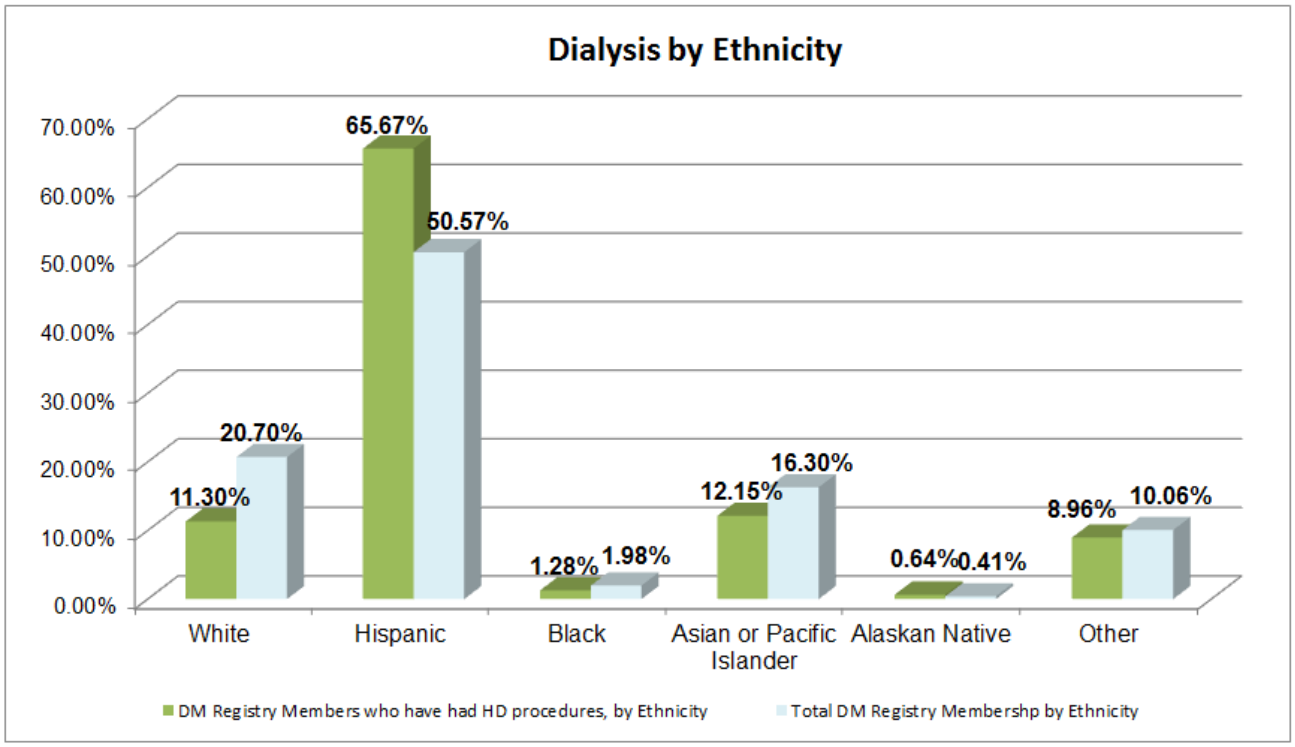
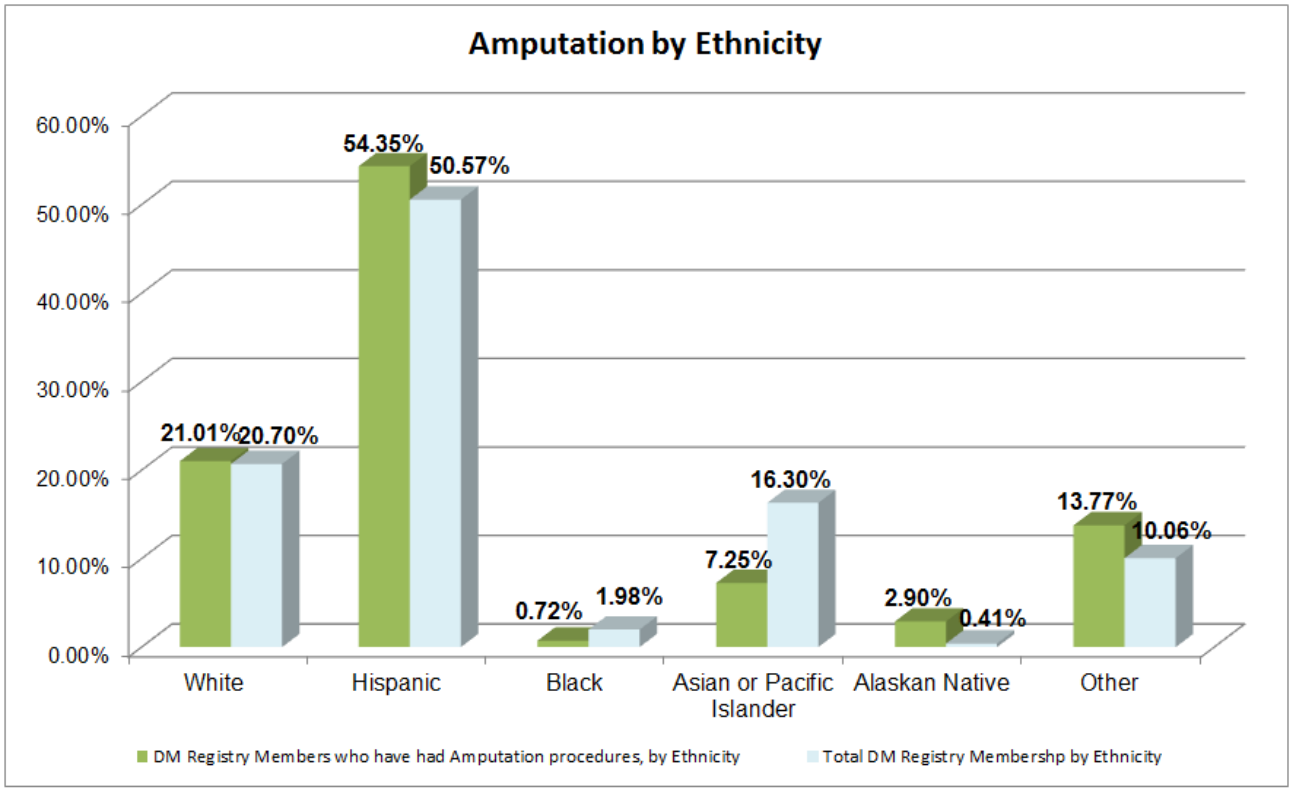



Dialysis by Ethnicity
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
65.67%
50.57%
20.70%
11.30%
1.28%
1.98%
12.15%
16.30%
0.64%
0.41%
8.96%
10.06%
White
Hispanic
Black
Asian or Pacific Islander
Alaskan Native
Other
DM Registry Members who have had HD procedures, by Ethnicity
Total DM Registry Membershp by Ethnicity


Amputation by Ethnicity
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
54.35%
50.57%
21.01%
20.70%
0.72%
1.98%
7.25%
16.30%
2.90%
0.41%
13.77%
10.06%
White
Hispanic
Black
Asian or Pacific Islander
Alaskan Native
Other
DM Registry Members who have had Amputation procedures, by Ethnicity
Total DM Registry Membershp by Ethnicity

AGENDA ITEM NO. 14

To: Gold Coast Health Plan Commission

From: Patricia Mowlavi, Chief Financial Officer

Date: January 25, 2016

Re: CFO Update

Overall Financial Performance – For the five months ended November 30, 2015, the Plan's gain in unrestricted net assets was $22.8 million and was favorable to budget by $16.8 million. The favorable variance was largely due to higher than expected growth in membership in the Adult Expansion (AE) category of aid. Also contributing to the variance was lower than anticipated health care and administrative costs.

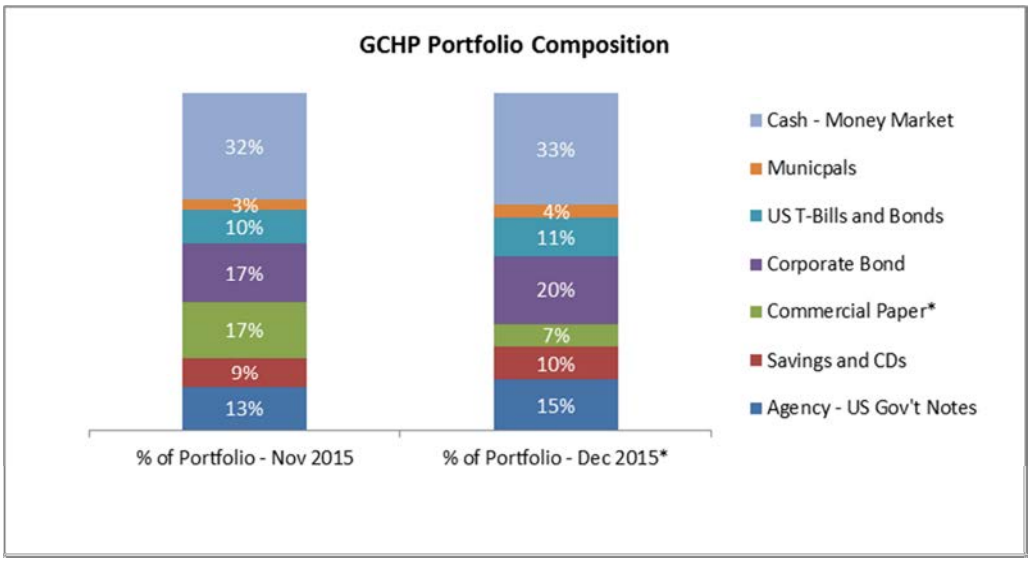
Membership – Fiscal year 2015-2016 membership continued to grow but at a flatter rate compared to the rapid growth seen over the past two fiscal years with the AE and Targeted Low Income Children (TLIC) transition. In the near future, we are looking forward to the addition of 2,900 children with limited scope coverage to join the Plan in May 2016 with full benefits.

Membership Mix and Revenue – As of November, the Family aid category comprised the majority of membership at 45 percent followed by AE which grew to 26 percent of total membership. From a revenue standpoint, AE contributed the majority of revenue followed by the Family aid category.

Key Performance Indicators – The Medical Loss Ratio (MLR) is targeted to be between 85 and 91 percent of revenue. Through November the MLR was 86 percent of revenue and has been increasing over the fiscal year with the month of November at 91 percent of revenue. The Administrative Cost Ratio (ACR) is targeted to be between 5 and 8 percent of revenue. Through November, the ACR was at 6 percent which was favorable to the budget. This favorable variance was driven primarily by labor related savings.

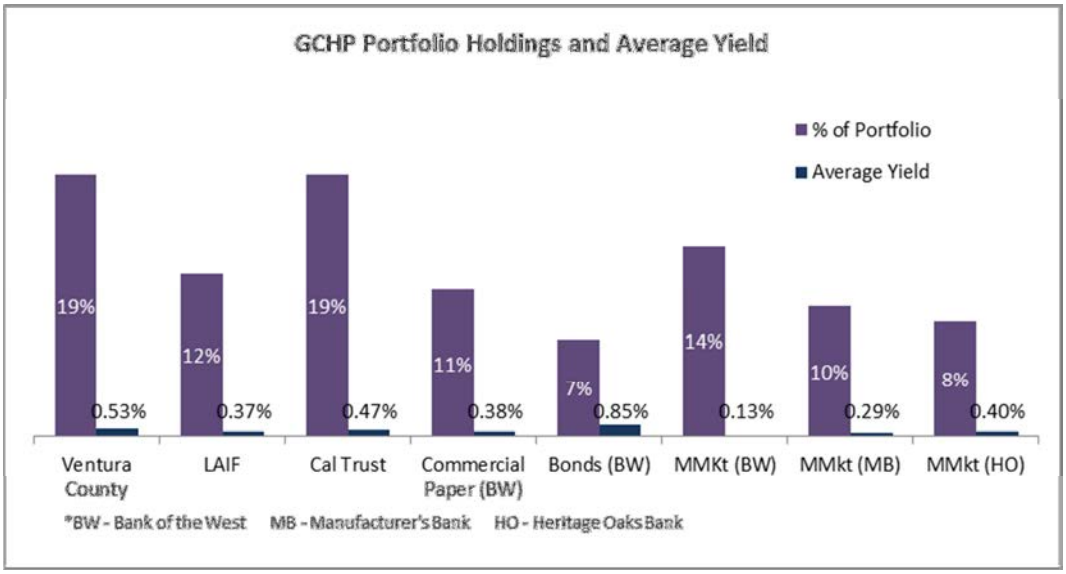
Tangible Net Equity (TNE) – TNE is targeted to be at least 500 percent of the State requirement. As of November, TNE was $123 million or 541 percent, excluding the $7.2 million County of Ventura lines of credit.

Investment Portfolio – The investment portfolio composition as of November and December is shown in the chart below.



In December, $45 million of commercial paper matured which coincides with the scheduled recoupment of the approximately $96.3 million (at November 30, 2015) in AE rate overpayments, which will be paid back to the state beginning in January 2016.

The investment holdings including money market and the respective yields are shown in the graph below.

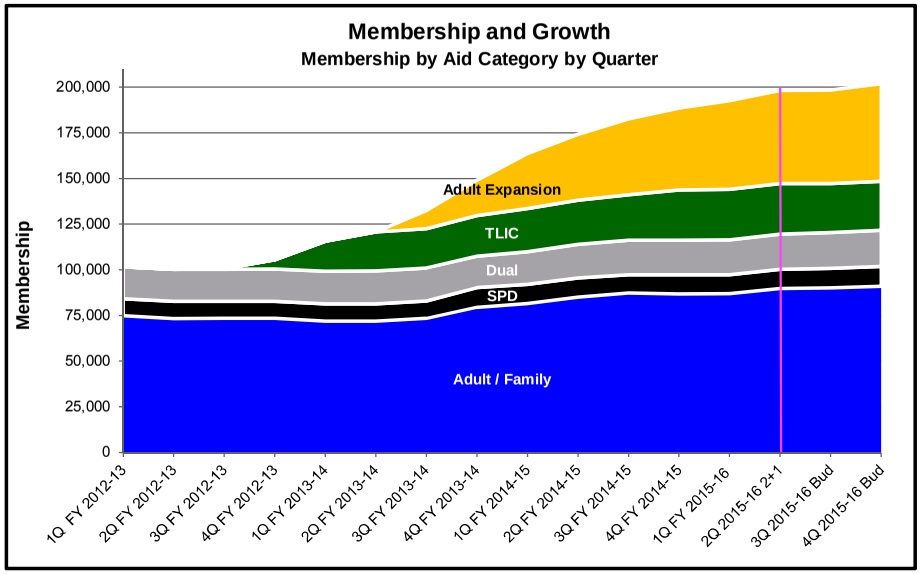


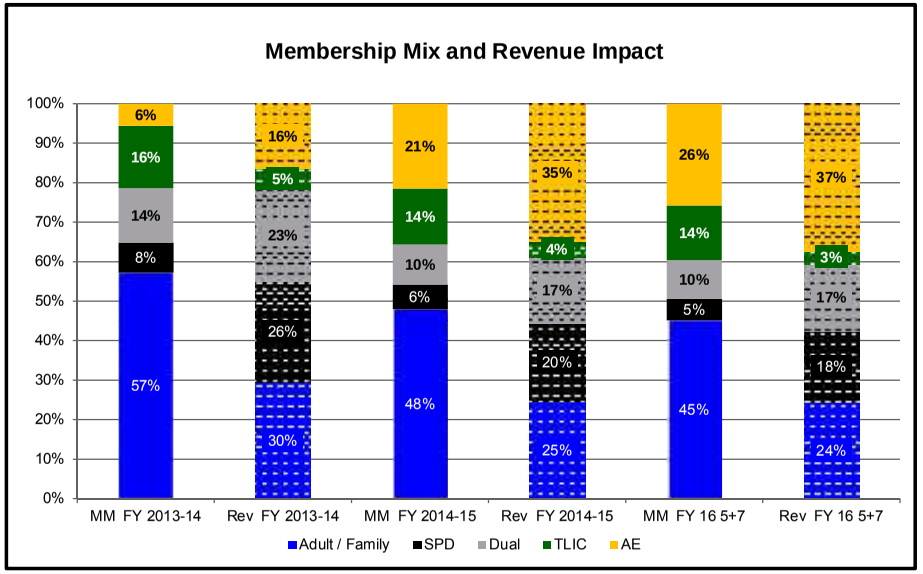
GOLD COAST HEALTH PLAN
FINANCIAL RESULTS SUMMARY

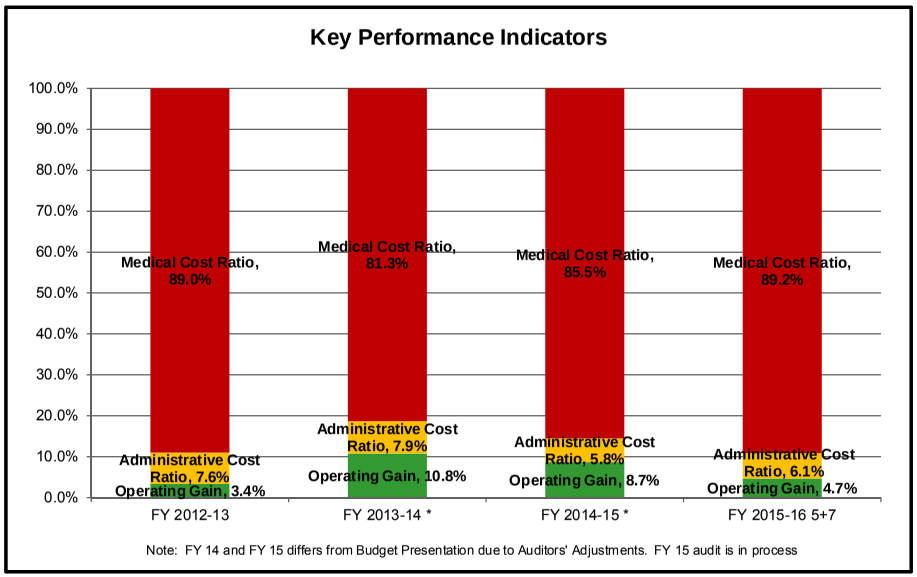
Description	AUDITED FY 2011-12	AUDITED FY 2012-13	AUDITED FY 2013-14	AUDITED FY 2014-15	FY 2015-16 JUL - SEP	FY 2015-16 OCT 15	FY 2015-16 NOV 15	FY 2015-16 NOV 15 FYTD	Budget Comparison Budget FYTD	Budget Comparison Variance Fav / (Unfav)	Budget Comparison Variance Fav / (Unfav)%
Member Months	**1,258,189**	**1,223,895**	**1,553,660**	**2,130,979**	**578,056**	**198,148**	**200,385**	**976,589**	**963,528**	13,061	1.4 %
Revenue	**304,635,932**	**315,119,611**	**402,701,476**	**595,607,370**	**162,960,677**	**52,508,015**	**53,274,568**	**268,743,260**	**261,931,947**	6,811,313	2.6 %
pmpm	*242.12*	*257.47*	*259.20*	*279.50*	*281.91*	*264.99*	*265.86*	*275.19*	*271.85*	3.34	1.2 %
Health Care Costs	**287,353,672**	**280,382,704**	**327,305,832**	**509,183,268**	**137,845,237**	**45,086,757**	**48,350,456**	**231,282,450**	**238,945,762**	7,663,312	3.2 %
pmpm	*228.39*	*229.09*	*210.67*	*238.94*	*238.46*	*227.54*	*241.29*	*236.83*	*247.99*	11.16	4.5 %
% of Revenue	94.3%	89.0%	81.3%	85.5%	84.6%	85.9%	90.8%	86.1%	91.2%	5.2 %	5.7 %
Admin Exp	**18,891,320**	**24,013,927**	**31,751,533**	**34,814,049**	**8,827,059**	**2,951,994**	**2,901,309**	**14,680,361**	**17,026,568**	2,346,207	13.8 %
pmpm	*15.01*	*19.62*	*20.44*	*16.34*	*15.27*	*14.90*	*14.48*	*15.03*	*17.67*	2.64	14.9 %
% of Revenue	6.2%	7.6%	7.9%	5.8%	5.4%	5.6%	5.4%	5.5%	6.5%	1.0 %	16.0 %
Total Increase / (Decrease) in Unrestricted Net Assets	**(1,609,063)**	**10,722,980**	**43,644,110**	**51,610,053**	**16,288,381**	**4,469,265**	**2,022,803**	**22,780,450**	**5,959,617**	16,820,833	282.2 %
pmpm	*(1.28)*	*8.76*	*28.09*	*24.22*	*28.18*	*22.56*	*10.09*	*23.33*	*6.19*	17.14	277.1 %
% of Revenue	-0.5%	3.4%	10.8%	8.7%	10.0%	8.5%	3.8%	8.5%	2.3%	6.2%	272.6 %
YTD											
100% TNE	16,769,368	16,138,440	17,867,986	22,556,530	21,819,072	22,266,192	22,698,761	22,698,761	24,539,354	(1,840,593)	(7.5)%
% TNE Required	36%	68%	100%	100%	100%	100%	100%	100%	100%		
Minimum Required TNE	6,036,972	10,974,139	17,867,986	22,556,530	21,819,072	22,266,192	22,698,761	22,698,761	24,539,354	(1,840,593)	(7.5)%
GCHP TNE	**(6,031,881)**	**11,891,099**	**55,535,211**	**107,145,264**	**123,433,646**	**127,902,910**	**129,925,714**	**129,925,714**	**85,938,888**	**43,986,825**	**51.2 %**
TNE Excess / (Deficiency)	**(12,068,853)**	**916,960**	**37,667,225**	**84,588,734**	**101,614,573**	**105,636,718**	**107,226,953**	**107,226,953**	**61,399,535**	**45,827,418**	**74.6 %**
% of Required TNE level			**311%**	**475%**	**566%**	**574%**	**572%**	**572%**	**350%**		
% of Required TNE level (excluding $7.2 million LOC)			**271%**	**443%**	**533%**	**542%**	**541%**	**541%**	**321%**		

Note: TNE amount includes $7.2 million related to the Lines of Credit (LOC) from Ventura County.

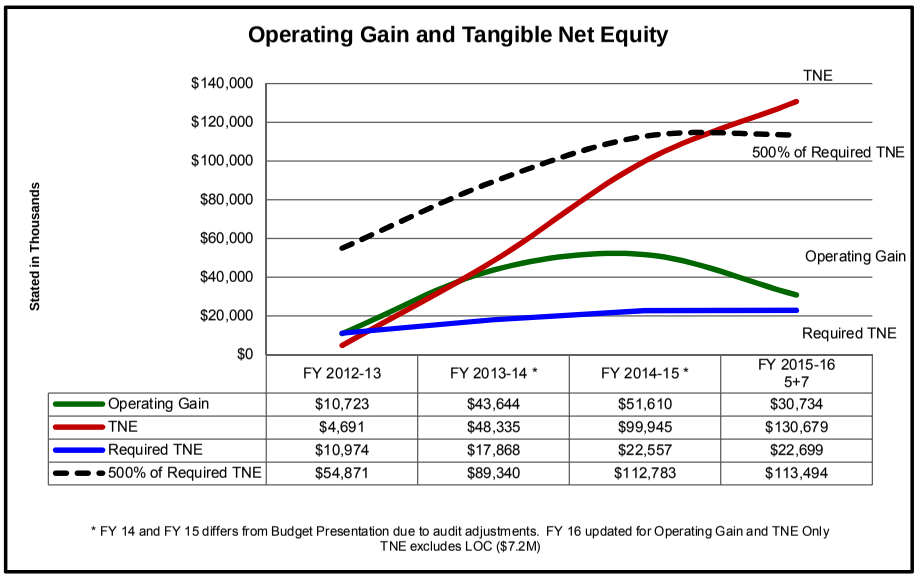
FINANCIAL PERFORMANCE DASHBOARD
FOR MONTH ENDING NOVEMBER 30, 2015







Note: FY 14 and FY 15 differs from Budget Presentation due to Auditors' Adjustments. FY 15 audit is in process



	FY 2012-13	FY 2013-14 *	FY 2014-15 *	FY 2015-16 5+7
Operating Gain	$10,723	$43,644	$51,610	$30,734
TNE	$4,691	$48,335	$99,945	$130,679
Required TNE	$10,974	$17,868	$22,557	$22,699
500% of Required TNE	$54,871	$89,340	$112,783	$113,494

* 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)

Note: 5+7 indicates 5 months of actual results followed by 7 months of forecasts

AGENDA ITEM NO. 15

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operations Officer

Date: January 25, 2016

Re: COO Update

OPERATIONS UPDATE:

Membership Update – January 2016

Gold Coast Health Plan (GCHP) experienced the first decrease in membership in more than two years; the net decrease from December was 325. As of January 1, 2016, GCHP has a membership of 202,037. Even with the minimal decrease, GCHP's membership has increased by 83,525 or 70.48% since January 2014. The cumulative new membership since January 1, 2014 is summarized as follows:

Aid Code	# of New Members
L1 – Low Income Health Plan (LIHP)	1,953
M1 – Adult Expansion	49,653
7U – CalFresh Adults	2,205
7W – CalFresh Children	608
7S – Parents of 7Ws	736
Traditional Medi-Cal	28,370
Total New Membership 1/1/14 – 1/1/16	83,525

Members assigned to the M1 aid code continue to increase. For the first time in several months, there were also increases in members with 7W and 7S aid codes. Inquiries to the Human Services Agency indicate that DHCS is using the 7S aid code as a transition code for members moving from Covered CA to Medi-Cal so these may not be true 7S members. GCHP had 167 new members that transitioned from Covered CA as of January 1, 2016.

	L1	M1	7U	7W	7S
Jan 16	1,953	49,653	2,205	608	736

	L1	M1	7U	7W	7S
Dec 15	2,129	49,456	2,285	573	287
Nov 15	2,298	47,527	2,395	628	354
Oct 15	2,515	46,138	2,525	682	354
Sep 15	2,698	44,260	2,654	733	360
Aug 15	3,039	42,465	2,766	746	380
Jul 15	3,218	40,948	2,918	770	355
Jun 15	3,413	39,283	2,986	781	353
May 15	3,908	37,519	3,083	813	379
Apr 15	4,102	35,582	3,162	831	381
Mar 15	4,965	34,350	3,236	856	396
Feb 15	6,128	31,203	3,342	872	442
Jan 15	6,508	30,107	3,390	872	478

	L1	M1	7U	7W	7S
Dec 14	6,972	27,176	3,204	589	15
Nov 14	7,289	24,060	3,254	599	14
Oct 14	7,443	23,569	3,312	296	11
Sep 14	7,568	21,944	3,368	606	5
Aug 14	7,726	18,585	3,400	624	4
Jul 14	7,839	15,606	3,453	667	4
Jun 14	7,975	10,910	3,515	691	3
May 14	8,118	7,279	3,680	714	0
Apr 14	8,134	4,514	3,584	684	0
Mar 14	8,154	2,482	1,741	0	0
Feb 14	8,083	1,550	0	0	0
Jan 14	7,618	183	0	0	0

AB 85 Capacity Tracking – VCMC has a total of 30,538 Adult Expansion members assigned to them as of January 2016. VCMC's target enrollment is 65,765 and is currently at 46.4% of the enrollment target.

Encounter Data Performance – Encounter data is a core component used by DHCS to effectively monitor its managed care program. Accurate and complete encounter data is essential for measuring and monitoring managed care plan quality, service utilization, financial performance and compliance with contract requirements. Encounter data is also a critical source of information used to set capitation rates and perform risk adjustment to account for differences in recipient health status across health plans. Encounter data submissions to DHCS include FFS claims and capitated encounters.
At the beginning of 2014, DHCS announced it would require the submission of Encounter Data after October 2014 in the healthcare industry standard 837P (medical-professional) & 837I (medical-institutional) and NCPDP 2.0 (pharmacy) formats only. This led to the creation of

GCHP's Encounter Data Improvement Project (EDIP) which was designed to meet DHCS' mandate as well as to improve the overall quality and quantity of GCHP's Encounter submissions to DHCS. Although DHCS did not schedule its initial meeting with GCHP's Encounter team until mid-July 2014, GCHP was still able to become the second health plan out of 31 plans statewide approved to submit encounters in the 837P and 837I formats to DHCS using the State's new PACES encounter system.

DHCS measures health plan encounter data on four components – Completeness, Accuracy, Reasonability and Timeliness. These measures are referred to as CART. Since the transition, GCHP has consistently submitted high quality encounter data to DHCS with an error rate of <1% compared to the DHCS requirement of less than 5%.

- GCHP 2Q2015 error rate – 0.06% (statewide average for all Managed Care Plans was 10%)
- GCHP 3Q2015 error rate – 0.07% (statewide average for all Managed Care Plans was 6%)

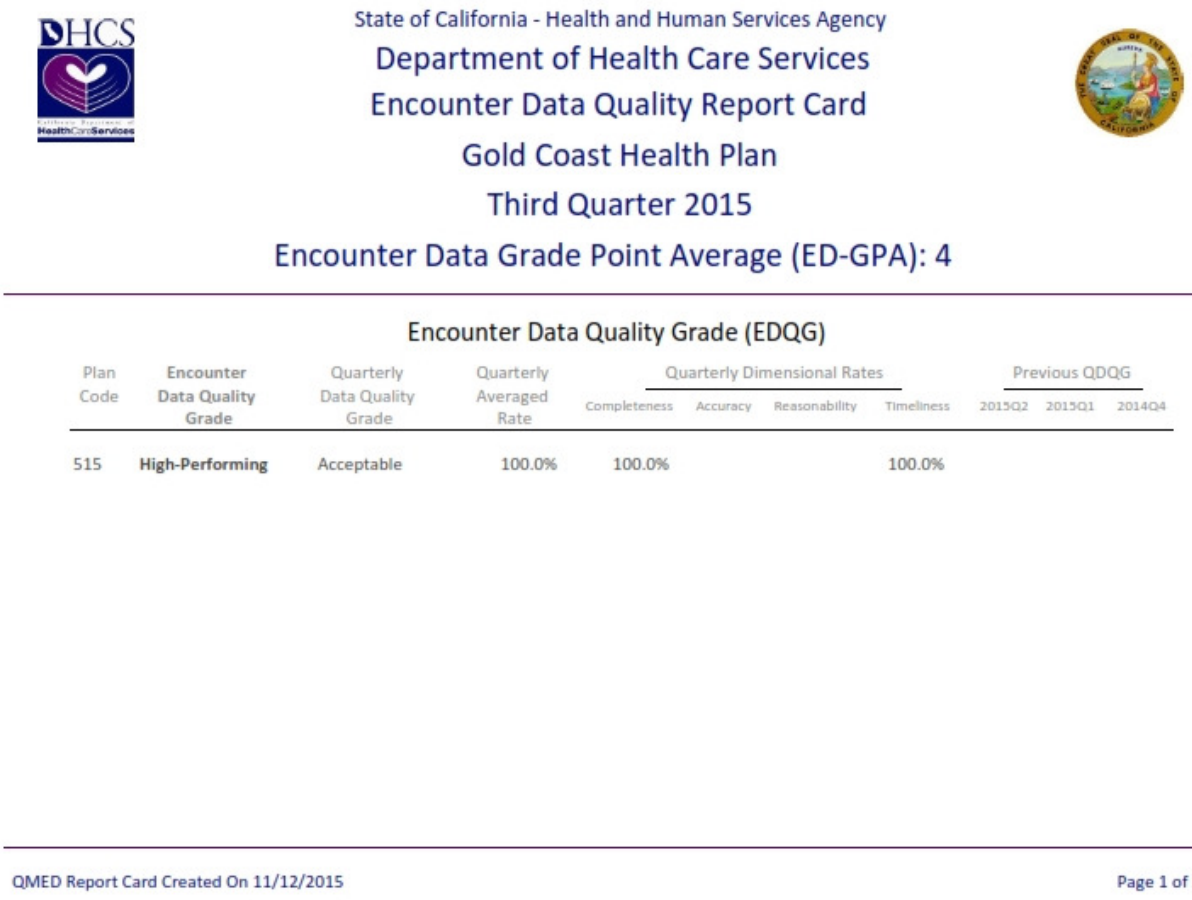
GCHP received an Encounter Data Grade Point Average (ED-GPA) of 4 for both 2Q2015 and 3Q2015; a 4 is the highest GPA available. We are rated as "High-Performing" with a Quarterly Averaged Rate of 100% (Q3 report card follows on the next page).

There are several factors that can be attributed to GCHP's highly successful Encounter submission result:

- GCHP runs a validation check of its own claims data from ika before submitting to DHCS
- GCHP requires its sub-contracted providers (vendors) to submit their capitated encounters to GCHP in the 837 format
    - Each vendor went through significant testing with GCHP before we approved the vendor's data to be acceptable for inclusion in data being submitted to DHCS
    - GCHP developed an internal validation system for incoming capitated encounters which was designed based on the actual DHCS encounter system
    - Vendors receive a report back indicating which encounters need to be corrected and resubmitted before GHCP will accept the encounter for submission to DHCS
    - GCHP works closely with its vendors to correct root causes of the errors on the vendor's encounter system. One vendor built their own validation logic based on GCHP's validation process and will not submit their encounters to GCHP until the encounters have "passed" through their internal validation.

DHCS made the decision that all procedure codes submitted must be valid, national standard codes. This led to the development of the Medi-Cal Local Codes Crosswalk group in which GCHP was an active participant and was recognized as a strong contributor. GCHP crosswalked all Local Codes from historical claims data using the approved DHCS Local Codes Crosswalk and continues to do so with any newly identified Local Code.

GCHP's Encounter Data team is committed to constant and never ending improvement. The team continues to identify areas of improvement and implement workable solutions to increase the quality of its encounter data submissions to DHCS.



State of California - Health and Human Services Agency
Department of Health Care Services
Encounter Data Quality Report Card
Gold Coast Health Plan
Third Quarter 2015
Encounter Data Grade Point Average (ED-GPA): 4

Encounter Data Quality Grade (EDQG)

Plan Code	Encounter Data Quality Grade	Quarterly Data Quality Grade	Quarterly Averaged Rate	Quarterly Dimensional Rates				Previous QDQG		
				Completeness	Accuracy	Reasonability	Timeliness	2015Q2	2015Q1	2014Q4
515	High-Performing	Acceptable	100.0%	100.0%			100.0%			

QMED Report Card Created On 11/12/2015

Page 1 of 31

November 2015 Operations Summary

Claims Inventory – ended November with an inventory of 16,662; this equates to Days Receipt on Hand (DROH) of 2.1 compared to a DROH goal of 5. GCHP received approximately 7,900 claims per day in November. Monthly claim receipts from December 2014 through November 2015 are as follows:

Month	Total Claims Received	Receipts per Day
November 2015	142,247	7,902
October 2015	156,109	7,095
September 2015	164,510	7,834
August 2015	152,840	7,278
July 2015	162,237	7,374
June 2015	171,806	7,809
May 2015	160,992	8,050
April 2015	146,198	6,645
March 2015	152,948	6,952
February 2015	130,559	6,528
January 2015	127,517	6,376
December 2014	128,087	6,099

Claims Turnaround Time (TAT) – the regulatory requirement of processing 90% of clean claims within 30 calendar days was met in November with a result of 99.6%.

Claims Processing Accuracy – the financial accuracy goal of 98% or higher was met in November with a result of 99.84%; procedural accuracy exceeded the goal of 97% in November at 99.98%.

Call Volume – call volume remained below 10,000 calls for the fourth straight month; the number of calls received in November was 7,864 which can be attributed to the November holidays. The 12-month average is 9,843 calls per month.

Average Speed to Answer (ASA) – the combined ASA result (Member, Provider and Spanish lines) for November was 23.4 seconds versus the Service Level Agreement (SLA) goal of 30 seconds or less.

Abandonment Rate – the combined result for November was 1.13% compared to a goal of 5% or less.

Average Call Length – the combined result of 7.65 minutes in November was above the goal of 7.0 minutes.

Call Center Phone Quality – GCHP requires that the quality of phone calls handled by the Xerox call center be at 95% or higher. Quality is measured on the following components:

- Communication skills: active listening and verbal communication
- Program knowledge: Medi-Cal/health plan guidelines
- Compliance: HIPAA authentication and guidelines
- Data entry accuracy
- Customer service etiquette

The results for November call quality were 97.3%.

Grievance and Appeals – GCHP received 9 member grievances and 104 provider grievances (related to claim payment disputes) during November. The number of member grievances received per 1,000 members was 0.05.

Type of Member Grievances	Number of Grievances
Accessibility – Lack of PCP Availability	2
Quality of Care	5
Quality of Service	1
Benefits and Coverages	1
Total Member Grievances	**9**

There were four clinical appeals in November; three were upheld and one was overturned. One State Fair Hearing was withdrawn in November and one was denied.

Member Orientation Meetings – Attendance at Member Orientation meetings started off strong the early part of the year but declined the remainder of 2015. A total of 167 members (130 English, 37 Spanish) plus 24 County Employees/Others attended meetings through November 2015. GCHP continues to include an informational flyer in each new member packet to make members aware of this opportunity to learn more about GCHP and their Medi-Cal benefits. We are also exploring the option of adding an informational message to the IVR that would be played during hold times to promote these meetings.

Behavioral Health Treatment (BHT) Transition – The transition of BHT services from the regional centers to managed care plans, scheduled for February 2016, is underway. GCHP members currently receiving BHT services at the regional center will be transitioned over a six-month period based on month of birth. GCHP is required to send 60-day and 30-day notices to all transitioning members and has sent out the following notices:

Transition Month	60-Day Notices Sent	30-Day Notices Sent
February 2016 (Jan & Feb birth month)	12/1/15	1/1/16
March 2016 (Mar & Apr birth month)	1/1/16	

The latest list provided by DHCS indicates there are 376 BHT beneficiaries in Ventura County currently receiving treatment at the regional center.

Noteworthy Activities – Additional projects/activities that Operations continues to lead or be involved in:

- ICD-10 Implementation – the compliance date of October 1, 2015 has come and gone and GCHP is successfully receiving and processing authorizations and claims in the ICD-10 format. GCHP continues to monitor claim submissions to determine if any providers are having difficulty submitting claims correctly and providing immediate feedback to any impacted provider. We have put processes in place to refer escalated issues to Network Operations so provider issues can be addressed quickly.
- Fraud, Waste and Abuse – GCHP will be launching a project aimed at identifying fraud, waste and abuse for certain claim types. The project will involve sending an Explanation of Benefits letter to members requesting them to contact GCHP's Fraud Hotline if they did not receive the services indicated in the letter.
- IVR Optimization – GCHP has reviewed the IVR set-up to identify changes that will focus on improving the customer experience for both members and providers. The target date to have these changes implemented is 4/30/16.

Gold Coast Health Plan℠
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AGENDA ITEM NO. 16

To: Gold Coast Health Plan Commission

From: Melissa Scrymgeour, CISO

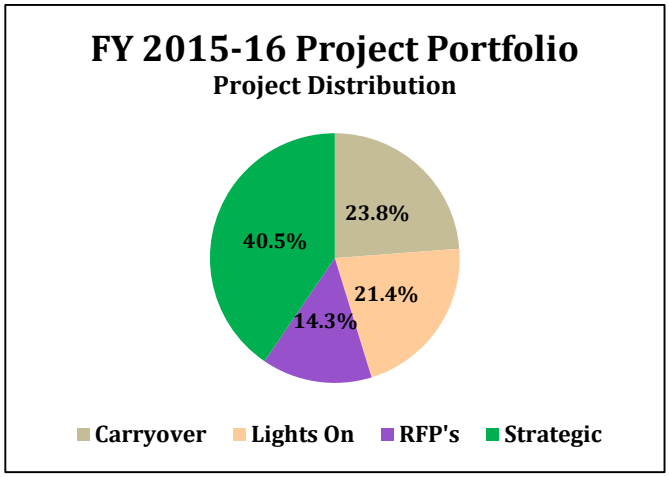
Date: January 25, 2016

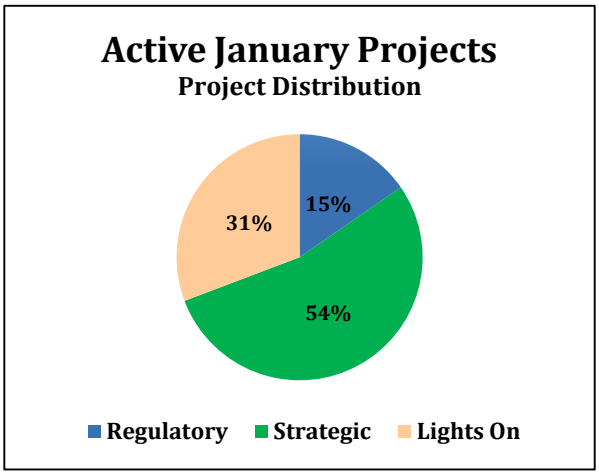
Re: CISO Update

Project Management Office (PMO):

The FY 2015-16 Project Portfolio consists of 42 approved initiatives as of January 2016. To date, 10 projects have been completed, and the PMO is managing 13 active initiatives.

Since November, one project has been added to the portfolio; Business Continuity Plan (BCP) Testing and Maintenance. This project will test critical pieces of the BCP and establish operational procedures for annual testing and ongoing maintenance.



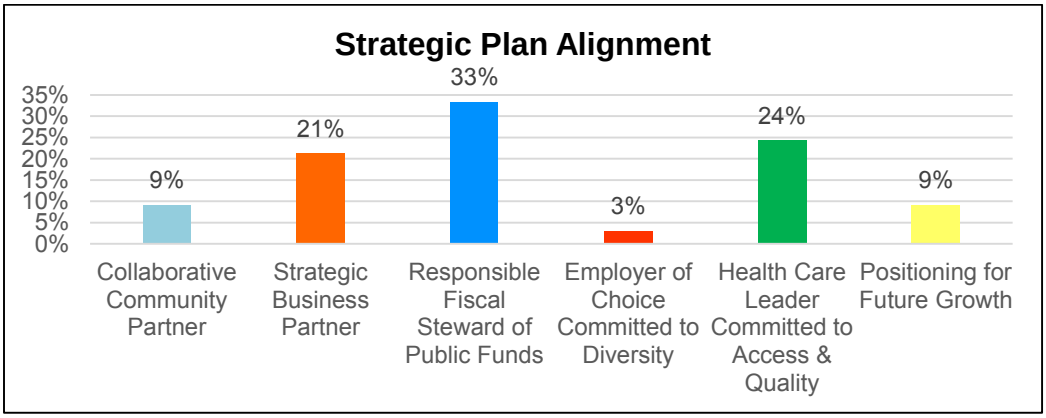


PMO Project Activity Highlights through December 2015:

- Closed Encounter Data Improvement Program
- Closed ICD-10 Transition
- Closed Disease Management Program
- Closed Provider Capitation and Rebasing Phase 2
- CORE-HIPAA / ACA Administrative Simplification Rules: Project implemented; CORE Certification application submitted and pending CAQH approval
- Kicked off Provider Data Management Optimization (PDMO) Program

Upcoming PMO Portfolio Activity:

- Planning and kick off for the following projects:
  - Potential HEDIS Implementation
  - Potential PBM Implementation
  - ASO Analysis
  - Data Warehouse
- Close SQL 2014 Upgrade
- Close BAC/BASC
- Obtain CORE certification and close project.



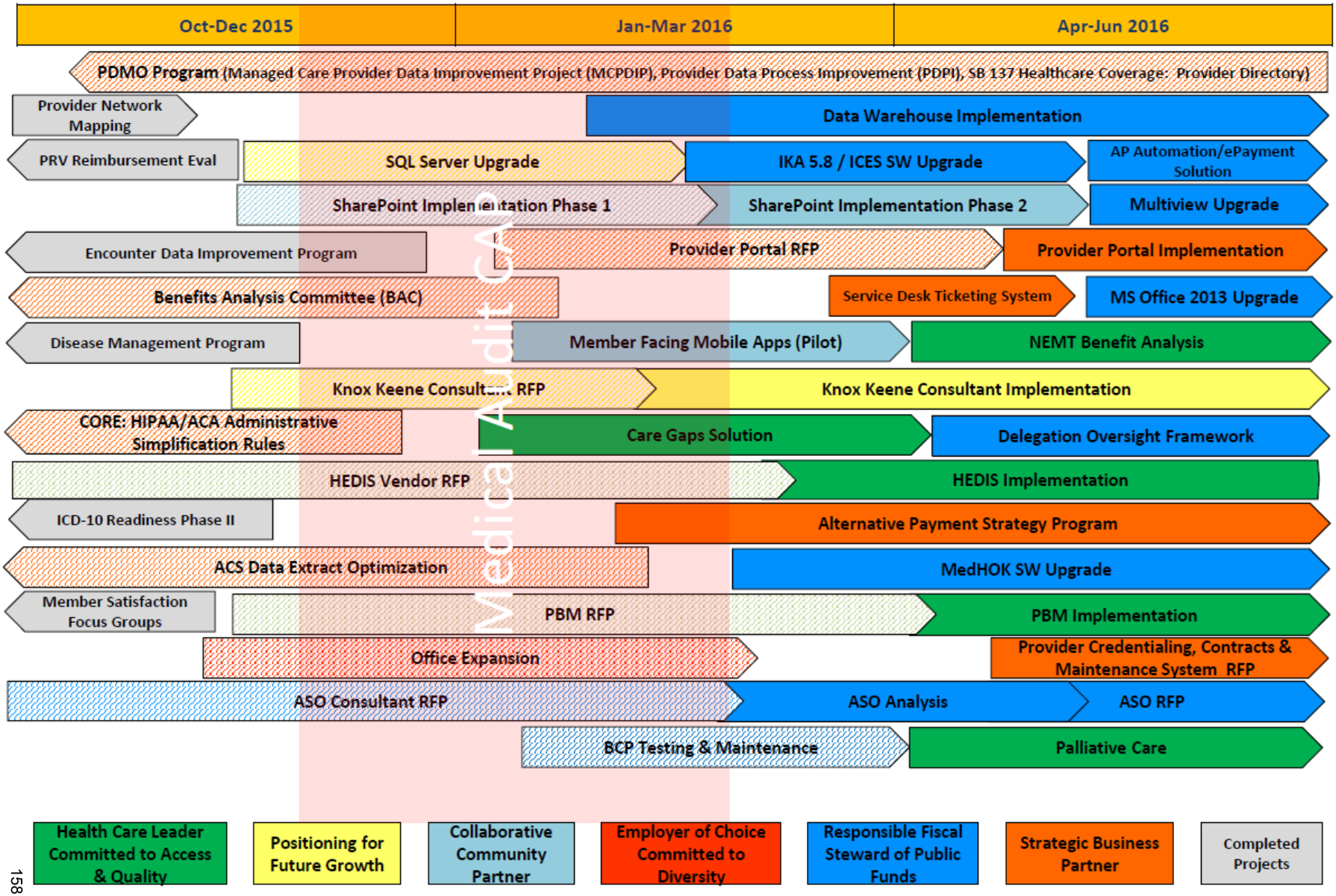
Health Care Leader Committed to Access & Quality		Positioning for Future Growth		Employer of Choice Committed to Diversity	
PBM RFP		SQL Environment Upgrade & Expansion		Office Expansion (Furniture & Fixtures-	
(Potential) PBM Implementation		Knox Keene Consultant RFP		$329K, Reconfiguration & Expansion-	
Diabetes DM Program		Knox Keene Implementation			
HEDIS RFP					
(Potential) HEDIS Implementation					
Mental Behavior Health Organization RFI					
Behavioral Health Transition					
Nonemergent Medical Transportation (NEMT) Benefit Evaluation					
Care Gaps					
Palliative Care					
Estimated Resource Hours*	**7,061**	**Estimated Resource Hours***	**2,232**	**Estimated Resource Hours***	**650+**
Estimated Cost	**$ 1,343,750.00**	**Estimated Cost**	**$ 198,500.00**	**Estimated Cost**	**$ 889,000.00**
Collaborative Community Partner		**Responsible Fiscal Steward of Public Funds**		**Strategic Business Partner**	
SharePoint Redesign-Phases 1 & 2		ASO Consultant RFP		CORE Administrative Simplification Rules	
Pilot Member Mobile Apps/SMS/Text		ASO Analysis		Benefit Analysis Committee	
		Delegation & Oversight Framework		Provider Data Management Optimization Program	
		Data Warehouse Implementation		Provider Portal RFP	
		AP Automation/ePayment eProcurement Solution		Provider Portal Implementation	
		Multiview Upgrade to Cloud		Alternate Payment Strategies	
		IKA/ICES Upgrade		Provider Credentialing, Contracting & Maintenance RFP	
		Service Desk Ticketing			
		BCP Maintenance			
Estimated Resource Hours*	**1,474**	**Estimated Resource Hours***	**14,497**	**Estimated Resource Hours***	**11,925**
Estimated Cost	**$480,000.00**	**Estimated Cost**	**$850,000.00**	**Estimated Cost**	**$794,000.00**
***Total Hours: ~39,000 Hours +/- 25%**					

FY 2015-16 GCHP Projects:

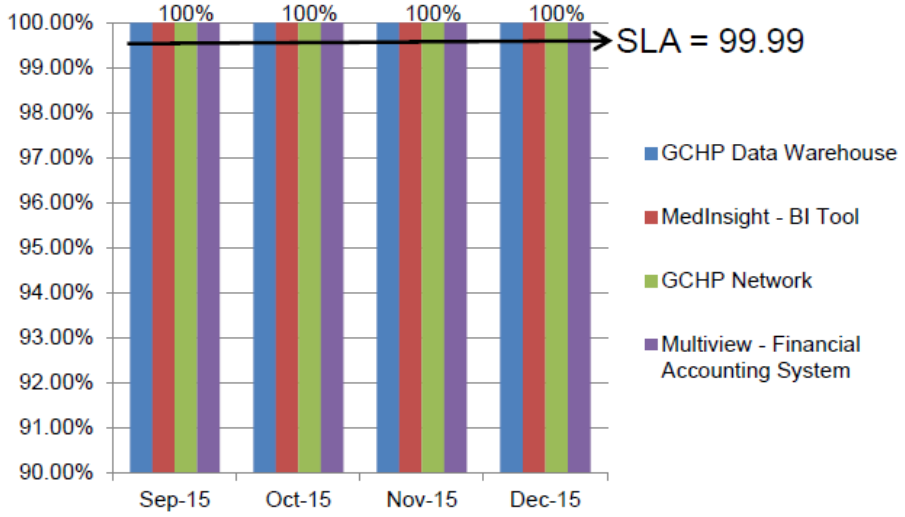
- **Healthcare Effectiveness Data and Information Set (HEDIS) Vendor Request for Proposal (RFP) and Implementation:** RFP and possible implementation of new HEDIS solution.
- **Care Gaps Implementation:** Implement Care Gaps module for member care coordination.
- **Provider Network Mapping Software:** Implement geographic mapping tool to analyze the GCHP health care network for optimized accessibility.
- **Provider Portal RFP and Implementation:** RFP and possible implementation of new provider portal.
- **Administrative Services Organization (ASO) Consultant RFP, Analysis and ASO RFP:** RFP for a consultant to help analyze and evaluate the GCHP core administrative services model, make recommendations, and support the ASO RFP process.
- **Pharmacy Benefits Manager (PBM) RFP and Implementation:** RFP and possible implementation of new PBM.
- **Provider Credentialing, Contracts and Maintenance System RFP & Implementation:** RFP and implementation of new system(s) to manage, support and optimize provider credentialing, contracting, and maintenance processes.
- **Non-Emergency Medical Benefit (NEMT) Analysis:** Analyze and evaluate alternatives to existing NEMT benefit.
- **SharePoint Redesign Phases 1 and 2:** Complete SharePoint environment redesign and deployment, including a GCHP intranet.
- **Accounts Payable (AP) Automation/ePayment Solution:** Evaluate and implement a solution to automate and streamline AP processes.
- **Data Warehouse:** Implementation of an enterprise data warehouse for optimized reporting and analytics.
- **Service Desk Ticketing System:** Implement solution to track, manage, and help streamline support of desktop and application issues.
- **Delegation Oversight Framework:** Institute standard delegation and oversight requirements, policies, and procedures for establishing provider contracts.
- **Member Facing Mobile Apps Pilot:** Analyze member engagement needs and pilot mobile communication apps.

- **Office Reconfiguration:** Office expansion project which will include the reconfiguration of the current location, in addition to acquiring new office space to accommodate growth and future expansion.
- **Microsoft SQL 2014 Upgrade:** Version upgrade and landscape redesign of GCHP SQL server environment.
- **Multiview Upgrade:** Software version upgrade for Multiview financial system.
- **Microsoft Office 2013 Upgrade:** Upgrade all employee machines to Microsoft Office 2013.
- **Ika/ICES Upgrade:** Software version upgrade for Xerox/ACS core administration processing and claims editing systems.
- **MedHOK Upgrade:** Software version upgrade for MedHOK medical management system.
- **MedInsight Upgrade:** Software version upgrade for MedInsight Business Intelligence (BI) tool; includes transition to hosted solution.
- **Member Satisfaction Focus Groups:** Conduct and analyze results of member focus groups to improve the Plan services**.**
- **Benefits Analysis Committee (BAC):** Establish framework and ongoing process to optimize benefits analysis for the Plan.
- **Business Continuity Plan (BCP) Maintenance:** Test critical pieces of the BCP and establish operational procedures for annual testing and ongoing maintenance.
- **Alternative Payment Strategy:** Implement new payment methodologies.
- **PDMO Program:** Evaluation, remediation and implementation of Provider data submissions to DHCS and internal Plan process improvements

GCHP FY 2015-16 Project Portfolio (Reforecast)

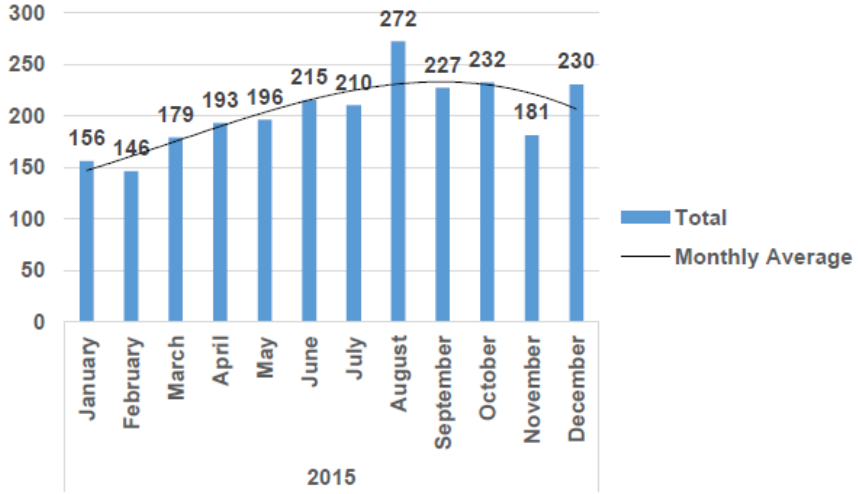


GCHP IT Metrics December 2015

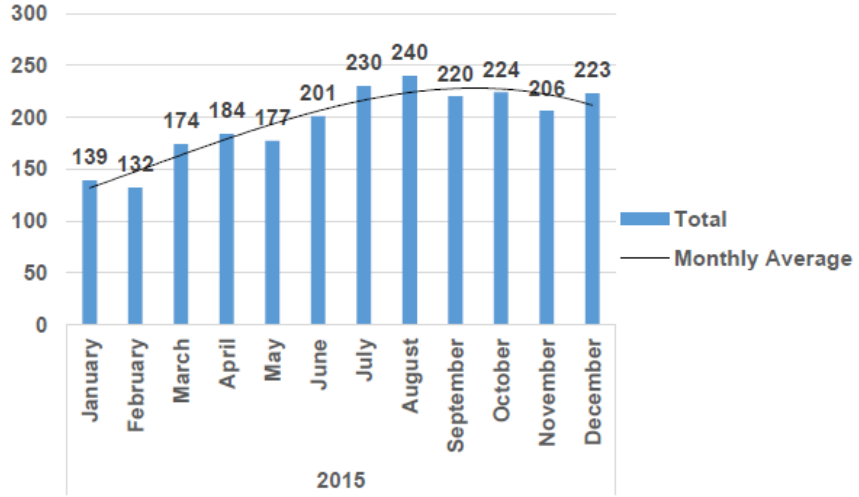


GCHP Helpdesk Service Ticket Trending

Total Tickets Opened Per Month



Total Tickets Closed Per Month



AGENDA ITEM NO. 17

To: Gold Coast Health Plan Commission

From: Scott Campbell, General Counsel

Date: January 25, 2016

Re: Diversity Subcommittee Status Report

SUMMARY:

This report summarizes the activities of the Cultural Diversity Subcommittee ("Subcommittee") since the last Commission meeting.

BACKGROUND / DISCUSSION:

At the Commission meeting on September 2, 2015, the Commission created a Cultural Diversity Subcommittee that was charged with, among other things, establishing a job description for the position of a Chief Diversity Officer and overseeing a Cultural Diversity Program. At the Commission meeting of November 16, 2015, the Commission directed the Subcommittee to work with Commissioner Darren Lee on the job description for the Chief Diversity Officer. The Subcommittee has met several times since the November 16, 2015 Commission meeting and the accomplishments activities of the Subcommittee are described below as well as other matters involving the Cultural Diversity Program.

- CDO Job Description: As of December 21, 2015, the Committee approved a job description that satisfied Commissioner Lee. Notably, the description highlights that while the position is independent, it will function with GCHP staff in an collaborative manner. A copy of the agreed upon job description is attached.

- Posting & Recruitment: The approved job description has now been posted and recruitment for the CDO is now beginning in earnest. Because the Plan will now begin to get applicants, it must now form the interview panel. Recall that the Subcommittee set up the process as having a 5-person panel: three Commissioners (to be appointed), one LULAC representative (Jamie Casillas), and one third party with CDO experience. Thus, the Commission needs to identify the three Commissioners who will serve on the panel. The panel will winnow down the applicant pool and present the final three or so to the Commission for final interviews and selection.

- Survey & Needs Assessment: As of January, staff and the Plan's diversity vendor (ClarusHR) has worked to include diversity questions within the pending employee survey. The survey will be rolled out in the next couple of months. This should give the Plan a good needs assessment on diversity issues. The survey results will inform the diversity training (see below).

- Diversity Training: ClarusHR has rolled out a potential schedule for diversity training. Currently, training should be going forward during the second week of March 2016. ClarusHR proposes to offer 14 sessions at various times throughout the day on March 9, 10, and 11th.

- Diversity Hotline: Almost immediately as the Diversity Subcommittee began meeting in October of 2015, the Plan instituted a Diversity Hotline to provide a forum for employees to bring forward any concerns or complaints related to diversity, discrimination, or harassment. Notably, despite the fact that it has been available for over three months now, no reports have been made through the hotline.

FISCAL IMPACT:

None.

RECOMMENDATION:

Accept the report and appoint, as part of the separate action item, three Commissioners to be interview panel.

CONCURRENCE:

None.

ATTACHMENTS:

Job Description for Chief Diversity Officer

GOLD COAST HEALTH PLAN

TITLE: Job Description – Chief Diversity Officer
Dated: December 21, 2015
Exempt, Contracted, At-Will
Salary Range: Level 29

POSITION SUMMARY

The Chief Diversity Officer (CDO) will be responsible for the design and implementation of a Cultural Diversity Program to insure that employees, contractors and recipients of health care services are treated with respect and without discrimination.. The CDO will collaborate with GCHP leadership and human resources to design, implement and maintain the Diversity Program. The ideal candidate will have extensive experience in human resources and related regulations and law, developing and managing diversity and inclusion programs, and will excel at establishing and maintaining both internal and external partnerships that drive success. The incumbent will help drive engagement, strategy, execution, and accountability for all diversity and inclusion initiatives across Gold Coast Health Plan (GCHP). The CDO shall report directly to the Commission overseeing the GCHP.

ESSENTIAL FUNCTIONS

Design and implement a Cultural Diversity Program to insure that employees, contractors and recipients of health care services are treated with respect and without discrimination and actively promote a culture that supports said program.

Provide reports to the Ventura County Board of Supervisors, through the County's Chief Executive Officer, on a quarterly or more frequent basis.

Exercise authority independent of any other executive officer, to take disciplinary action against any employee, except the chief executive officer, for failure to comply with the Cultural Diversity Program.

Actively promote dignity and professionalism in the workplace in a manner that protects the right of employees to be free from illegal discrimination, harassment, and retaliation due to any protected status. Illegal discrimination includes but is not limited to discrimination on the basis of sex, race, color, ancestry, religion, national origin, ethnicity, age (40 and older), disability, sexual orientation, gender identity and expression, marital status, medical condition, veteran status or any other characteristic protected by state or federal employment law.

Collaborate with all stakeholders to establish and maintain a workplace culture where all GCHP employees comply with the Cultural Diversity Program, and where failure to do so will lead to prompt and appropriate corrective action including, but not limited to,

counseling, training, written warning, written reprimand, suspension, demotion, or dismissal.

Additionally, the CDO will:

- Consult with GCHP staff, community members, and/or other interested parties to develop periodic recommendations for policy and procedural changes designed to implement the Cultural Diversity Program and ensure compliance with applicable law, including but not limited to both Title VII of the Civil Rights Act and the California Fair Employment and Housing Act.

- Investigate/review and evaluate allegations of employment-related, illegal discriminatory acts/statements/omissions in, or arising from, the GCHP workplace or causes such to occur.

- Identify and conduct employment-related audits of the GCHP workplace environment (or cause the same to be conducted).

- Review and evaluate GCHP Management's response to employee complaints and/or directions given it by the CDO.

- Consult with and advise GCHP Management, Supervision, and/or line-staff on employment-related matters to avoid actual, or (if possible) perceived, illegality with respect to employment decisions and to thus limit GCHP's exposure to employment related lawsuits.

- Consult, advise and take independent action, if necessary, regarding the GCHP response to inappropriate acts/statements/omissions by GCHP staff, up to and possibly including dismissal from employment.

- Coordinate responses to employment-related inquiries/allegations from employees, the EEOC, the DFEH, or private attorneys representing active, past, or former employees.

- Efficiently supervise the activities of assigned staff and/or contractors in support or pursuit of the foregoing activities.

- Provide periodic and/or special confidential, personnel/employment-related reports to the Commission on GCHP employment-related matters.

ANCILLARY FUNCTIONS

- Consult with management, human resources, and legal counsel regarding diversity issues.

- Arrange diversity-related training classes, workshops, and conference trips.
- Attend Commission and Diversity Subcommittee meetings.
- Perform related duties and responsibilities as required.

QUALIFICATIONS

- Bachelor's degree, along with 5-10 years of human resources, progressive diversity, and inclusion experience with a health plan/business or experience managing strategic company-wide Diversity and Inclusion initiatives; managed care experience a plus.
- Ability to work independently and in groups, while managing multiple priorities in a fast paced, fluid environment.
- Excellent interpersonal and influencing skills, including the ability to effectively coach leaders, build relationships and leverage resources within the department and across the organization to advance GCHP's strategy.
- Experience with change management, organizational design, talent/performance management, and strategic planning.
- Strong internal customer relationship management skills.
- Understands the challenges of, and thrives in, a heavily regulated organization.
- Ability to work collaboratively and openly with cross-functional teams.
- Creative approach to problem solving with a humble, team-oriented and optimistic attitude.
- Superior communication and presentation skills.

PHYSICAL REQUIREMENTS

Ability to communicate orally with the Commission, Plan management, staff, and the public in face-to-face, one-on-one and group settings. Regularly use a telephone for communication. Use office equipment such as a personal computer, copier and facsimile machines. Sit and/or stand for extended time periods. Hearing and vision required to be within normal ranges. Carry, push, pull, reach and lift up to 25 lbs. routinely. Read at,

above, and below shoulder height. Occasionally stoop, kneel or crouch. Sufficient manual dexterity required to operate equipment.

CONDUCT STANDARD

Interact with the Commission, Plan Staff, Plan employees, customers, and the public in a positive, cooperative, and supportive manner. Maintain the highest standards regarding diversity and inclusion.