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

Regular Meeting
Monday, April 27, 2026 2:00 p.m.
Meeting Location: Community Room
711 E. Daily Drive #110
Camarillo, CA 93010

Members of the public can participate using the Conference Call Number below.

Conference Call Number: 1-805-324-7279
Conference ID Number: #

Para interpretación al español, por favor llame al: 1-805-322-1542 clave: 1234

121 N. Fir Street #C
Ventura, CA 93003

80 Hilcrest Dr #200
Thousand Oaks, CA 91360

2400 S. C Street
Oxnard, CA 93033

AGENDA

CLERK ANNOUNCEMENT

All public is welcome to call into the conference call number listed on this agenda and follow along for all items listed in Open Session by opening the GCHP website and going to ***About Us > Ventura County Medi-Cal Managed Care Commission > Scroll down to Commission Meeting Agenda Packets and Minutes***

CALL TO ORDER

INTERPRETER ANNOUNCEMENT

OATH OF OFFICE

Douglas Kleam – Private Hospital / Healthcare Representative
Loretta Denering, Dr PH, MS – Ventura County Health Care Agency Representative.
Yohan Perera, MD - Beneficiary Representative
Mark Sewell - County CEO Representative

RECOGNITION OF COMMISSION VICE CHAIR DEE PUPA

ROLL CALL

PUBLIC COMMENT

The public has the opportunity to address Ventura County Medi-Cal Managed Care Commission (VCMMCC) and Committee doing business as Gold Coast Health Plan (GCHP) on the agenda.

Persons wishing to address VCMMCC and Committee are limited to three (3) minutes unless the Chair of the Commission extends time for good cause shown. Comments regarding items not on the agenda must be within the subject matter jurisdiction of the Commission and Committee.

Members of the public may call in, using the numbers above, or can submit public comments to the Commission and Committee via email by sending an email to ask@goldchp.org. If members of the public want to speak on a particular agenda item, please identify the agenda item number. Public comments submitted by email should be under 300 words.

CONSENT

1. **Approval of Ventura County Medi-Cal Managed Care Regular Commission meeting minutes February 26, 2026, and Special Meeting minutes of March 18, 2026.**

   Staff: Maddie Gutierrez, MMC Sr. Clerk to the Commission

   RECOMMENDATION: Approve the minutes as presented.

2. Adoption of Resolution 2026-001 Authorizing the Chief Executive Officer, Interim Chief Financial Officer and Chief Policy and Program Officer to initiate banking and fund management transactions as well as sign and execute contractual documents, management transactions.

Staff: Scott Campbell, General Counsel
Jeff Register, Interim Chief Financial Officer / Controller

RECOMMENDATION: Staff recommends the Commission adopt Resolution 2026-001.

UPDATES

3. Operations Update

Staff: Suma Simcoe, Chief Operations Officer

RECOMMENDATION: Receive and file the update

4. D-SNP Update

Staff: Eve Gelb, Chief Innovation Officer
Kimberly Marquez-Johnson, Sr. Director Duals Special Needs Plan

RECOMMENDATION: Receive and file the update

PRESENTATION

5. Member Retention Presentation / Strategic Plan Quarterly Update

Staff: Marlen Torres, Chief Member Experience & External Affairs Officer

RECOMMENDATION: Receive and file the presentation.

FORMAL ACTION

6. Election of Chairperson and Vice-Chairperson to serve two-year terms and appointments to the Executive/Finance Committee

Staff: Scott Campbell, General Counsel

RECOMMENDATION:

1. Elect a Commissioner to serve as Chairperson for a two-year term.
2. Elect a Commissioner to serve as Vice-Chairperson for a two-year term.
3. Make any necessary appointments to the Executive/Finance Committee as follows:
   a. Chairperson (same as Commission Chairperson).
   b. Vice-Chairperson (same as Commission Vice-Chairperson)
   c. Private Hospital Healthcare Representative (if required).
   d. Ventura County Medical Health System Representative (if required).
   e. Clinicas Del Camino Real Representative (if required).

7. Compliance Oversight Committee Appointments

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Staff requests that the Commission determine how it wants to fill the vacancies in the Compliance Oversight Committee

8. Advance Payment Agreement to Ventura County Health Care Agency

Staff: Felix L. Nunez, M.D., Chief Executive Officer

RECOMMENDATION: GCHP staff recommend that the Ventura County Medi-Cal Managed Care Commission authorize the CEO to execute an Advance Payment Agreement in the amount of $30,000,000 with the Ventura County Health Care Agency.

9. Baker Tilly Audit Information

Staff: Jeff Register, Interim Chief Financial Officer / Controller

RECOMMENDATION: Receive and file the audit report

10. March 2026 Financials

Staff: Jeff Register, Interim Chief Financial Officer - Controller
Felix L. Nunez, M.D., Chief Executive Officer

RECOMMENDATION: Receive and file the financials as presented.

REPORTS

11. Chief Executive Officer (CEO) Report

Staff: Felix L. Nunez, M.D., MPH, Chief Executive Officer

RECOMMENDATION: Receive and file the report

12. Chief Medical Officer (CMO) Report

Staff: James Cruz, M.D., Chief Medical Officer

RECOMMENDATION: Receive and file the report

13. Human Resources (HR) Report

Staff: Paul Aguilar, Chief Human Resources & Organizational Performance Officer

RECOMMENDATION: Receive and file the report

CLOSED SESSION

14. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
Initiation of Litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9:
One case.

15. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer.

ADJOURNMENT

The next meeting will be held on May 18, 2026, at 2:00 p.m., in the Community Room located at GCHP 711 E. Daily Dr. Suite 110, Camarillo, CA 93010

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

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 the Monday prior to the meeting by 1:00 p.m. to enable the Clerk of the Commission to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO.1

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Maddie Gutierrez, MMC, Sr. Clerk for the Commission

DATE: April 27, 2026

SUBJECT: Regular Meeting Minutes of February 23, 2026, and special meeting minutes of March 18, 2026.

RECOMMENDATION:

Approve the minutes.

ATTACHMENT:

Copy of Commission meeting minutes for February 23, 2026 and March 18, 2026.

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
Commission Meeting
Regular Meeting In-Person and via Teleconference

February 23, 2026

CALL TO ORDER

Committee Vice Chair Dee Pupa called the meeting to order at 2:03 p.m. in the Community Room located at 711 E. Daily Drive, Suite 110, Camarillo, CA 93010

INTERPRETER ANNOUNCEMENT

The interpreter made her announcement.

ROLL CALL

Present: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Anna Monroy, Dee Pupa, Roger Robinson, Sara Sanchez, and Scott Underwood, D.O.

Absent: Commissioners Robert Bravo, Laura Espinosa, Supervisor Vianey Lopez, and Timothy Myers

Attending the meeting for GCHP were Felix L. Nunez, M.D., CEO James Cruz, M.D., CMO, CPPO Erik Cho, CFO Sara Dersch, Paul Aguilar, Chief of Human Resources, Robert Franco CCO, Eve Gelb, Chief Innovation Officer, Ted Bagley, CDO, Marlen Torres, Chief Member Experience & External Affairs, and Scott Campbell, General Counsel,

Also in attendance were the following GCHP Staff: Lupe Gonzalez, Susana Enriquez-Euyoque, Vicki Wrighster, TJ Piwowarski, Holly Krull, Ellen Rudy, Corey Stephenson, Veronica Estrada, Patrick Warfield, Lily Yip, Joanna Hioureas, Nathan Norbryhn, Pshyra Jones, Victoria Warner, Pauline Preciado, Jerry Wang, Lupe Harrion, Zed Haydar, Susan Rudshagen, Ben Lacy, Kris Schmidt, Brenda Gomez-Garcia, Chris Dulan, Josephine Gallella, Kim Timmerman, Shannon Robledo, Paul VerHaar, Jef Register, Erin Slack, David Tovar, David Kirkpatrick, Adriana Sandoval, and Kim Marquez-Johnson

County of Ventura Guests: John Fankhauser, M.D., Demitric Franklin, Gilian Stucki

PUBLIC COMMENT

None.

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Regular Commission meeting minutes November 17, 2025.

Staff: Maddie Gutierrez, MMC Sr. Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

Commissioner Abbas motioned to approve Consent item 1. Commissioner Sanchez seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Dee Pupa, Roger Robinson, Sara Sanchez, and Scott Underwood, D.O.

NOES: None.

ABSTAIN: Commissioners Anna Monroy

ABSENT: Commissioners Robert Bravo, Laura Espinosa, Supervisor Vianey Lopez, and Timothy Myers

Motion carried.

2. Written Summary of Quality Improvement & Health Equity Activities – Q4 2025

Staff: James Cruz, MD, Chief Medical Officer
Kim Timmerman, MHA, CPHQ, Executive Director of Quality Improvement

RECOMMENDATION: Staff recommend that the Ventura County Medi-Cal Managed Care Commission accept and file the Quarter 4, 2025 Quality Improvement and Health Equity Committee summary.

Commissioner Abbas motioned to approve Consent item 2. Commissioner Corwin seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Anna Monroy, Dee Pupa, Roger Robinson, Sara Sanchez, and Scott Underwood, D.O.

NOES: None.

ABSENT: Commissioners Robert Bravo, Laura Espinosa, Supervisor Vianey Lopez, and Timothy Myers

Motion carried.

Supervisor Vianey Lopez arrived at the meeting at 2:07 p.m.

Commission Chair Laura Espinosa joined the meeting at 2:09 p.m.

UPDATES

3. Total Care Advantage Update

Staff: Eve Gelb, Chief Innovation Officer
Sara Dersch, Chief Financial Officer

RECOMMENDATION: Receive and file the update.

Eve Gelb, Chief Innovation Officer, stated that we are almost two months into our Total Care Advantage. She wanted to share the current state and some things that will be happening soon. For Medicare, you must build a plan, run a plan and then build the plan for the next year because it changes yearly. The first quarter of every year is always a busy time. We are checking and validating the building of the plan that was just implemented, and we are starting to plan for the following year. At the end of March, all the consultants that helped with the implementation will roll off and we will be doing this on our own. The consultants have been a great help, and we could have done this alone.

Every month we will present our roster / enrollment status. Our analytics team has built a dashboard so that we can see who our members are, their age, their demographic factors, and aid categories. Every member has a care navigator that is assigned to them. Their care navigator is either a nurse or a social worker. A member's health complexity may require a higher level of expertise.

For a D-SNP, people who have both Medicare and Medi-Cal – if they lose their Medi-Cal we are required to carry them while they are in this gap period for at least three months. Here at GCHP we have decided to carry them for four months to support the members and they get their Medi-Cal eligibility re-enrolled. If they cannot regain their eligibility within four months, then they will be disenrolled. We will work with the members through our enrollment team to support them in re-enrolling. Our target is 3% disenrollment and currently we are a little less than 3%.

Commissioner Pupa asked if we are on the enrollment trajectory that we had anticipated. CIO Gelb responded yes, our target enrollment for each month is eighty members. In February we hit one hundred ten members. We are lagging a bit this month, but we anticipate being close to, if not, over five hundred members by the end of the month.

Commissioner Corwin stated he thought the budget was a little lower. CIO Gelb stated that it is tracking our budget. Commissioner Abbas asked what the criteria for denial is. CIO Gelb stated that we follow CMS criteria; the members may not have full Medi-Cal, or they live in the wrong county, or they do not have Part A or Part B. CMS gives us the denial, and they also cancel it. If the member calls and says they want to withdraw, in that case we would cancel it. Commissioner Monroy asked if there are trends for disenrollment. CIO Gelb stated it is too soon to know.

CIO Gelb stated that we do not have a lot of providers that some of the members want, so when they join on, we try to engage that provider, specialist, or whoever it might be, but that provider can choose not to contract with us. One reason folks leave is because we cannot get that particular provider. Commissioner Monroy asked about the care navigator and at what point do they have contact with the member. She asked if it was during enrollment, or if it was ongoing, and members are reminded that they are available. CIO Gelb stated the care navigator is the first person to reach out to the member because they are the ones that complete the health risk assessment, which is done within ninety days of enrollment. The Welcome packet also has a number to call if members want to connect with their care navigator.

CIO Gelb reviewed Key Performance Indicators for Total Care Advantage soon. We will be tracking annual Wellness visit completion. Clinicas already has some Wellness visits scheduled, and VCMC will begin tracking in April. We are not ready to start tracking Five Star Measures. We have a variety of compliance metrics. We tried to cross the entire organization so that every work stream or department has a compliance metric that will be tracked. We have a processing timeline for applications, turnaround time to make decisions on authorizations and we met the target for January. We are on track for both standard and expedited health risk assessments, which are required within ninety days. We are meeting all the claim's timeliness turnaround time. We are 34% complete for our staff's model of care training. Commissioner Corwin asked if the PCP enrollment is capped or if it is fee for service. CIO Gelb stated it is fee for service. CIO Gelb stated Commissioner Abbas had requested we do a Performa revision, and we adjusted the membership based on where we were in January and based on our targets. We adjusted the risk adjustment factor based on the risk adjustment we have seen so far, and even though we have fewer members our loss is about the same. Our target will be to meet our membership targets and other targets this year, focus on growth for 2027 and then be able to do a revision to Performa. CFO Sara Dersch stated this is very conservative. We are just starting this product line and there are many variables in how we could frow and increase the risk score. We are now beginning to understand who our members are. We have many teams engaged in figuring out the best plan of care for all these members. In financials, we plan for the worst, hope for the best outcome, and do everything we can to achieve the better outcome.

CIO Gelb stated that we are building the bid for 2027 and if we put rich benefits in, that will change the numbers, if we decide to scale back on benefits that will change the number in the other direction. We will present the bid in April/May for commission review in Closed Session. Commissioner Pupa stated that we must be very careful about

adjusting benefits due to our competition. We want competitive benefits, but we do not want yo-yo our benefits. We do not want to offer a fancy benefit then have to pull it back because we cannot afford it. CEO Felix L. Nunez, M.D. stated that we are targeting our member on the Medi-Cal line of business, so that the better we do on the Medi-Cal side, more people will want to stay with us and retain coverage with us.

CIO Gelb noted that the state is currently piloting "Automatic Enrollment" where a member ages into Medicare and they are automatically enrolled in that plan's dual special needs plan, but it has not rolled out across the state yet. CCO Robert Franco did point out that Kaiser up North did participate in this pilot and we can expect the same thing here when it opens in Ventura County.

Currently we have 479 members, and at the end of this year we plan to have approximately 1500 members, and by the end of next year our goal is to have 3,000 by the end of that year but the average number of members would be 2100. It is a big jump between 2027 and 2028.

Commissioner Blaze motioned to approve agenda item 3. Commissioner Pupa seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, Roger Robinson, Sara Sanchez, and Scott Underwood, D.O.

NOES: None.

ABSENT: Commissioners Robert Bravo, and Timothy Myers

Motion carried.

PRESENTATION

4. Advancing Children's Health

Staff: James Cruz, M.D., Chief Medical Officer
Marlen Torres, Chief Member Experience & External Affairs Officer

RECOMMENDATION: Receive and file the presentation.

Marlen Torres, Chief Member Experience & External Affairs Officer, stated that we are trying something new, which is to present various deep dives of the populations that we serve. This month we chose Children's Health. We serve one and two children between the ages of zero to five. When looking at our membership aid category we cover over 55,000 members just under this age category. We want to ensure that children are

receiving the care that they need in addition to the increased focus from a regulatory perspective. There is a focus around well-child visits, immunizations, etc. We will also share how we are working to retain this population and all the efforts and initiatives through the implementation of HR1. We also want to continue to provide care and coordinate care.

Chief Medical Officer, James Cruz, M.D. stated GCHP wants to ensure that Medi-Cal children have access to quality care and preventative services. Children often encounter barriers to accessing healthcare, especially social and other structural barriers. Federal law is creating barriers to our children. Kim Timmerman will provide an overview of quality improvement and managed care accountability, as well as past strategies that have resulted in success. The Plan has partnerships with community agencies, county community programs, and county agencies that amplify the impact of quality improvement efforts. Dr. Lupe Gonzalez will share the importance of work the Health Education team performs to ensure our children, their parents, guardians, and caregivers fully understand the importance of accessing care and completing preventative services, along with ensuring that they understand their rights to access services. Pshyra Jones will share key health equity targets that we have identified through our data as well as strategies that we are mapping out to mitigate these barriers. He noted that the relationships we have developed have bolstered the work that we have on advancing children's healthcare at Gold Coast.

Ms. Timmerman gave an overview of our performance on well-child measures in the MCAS measure set. Our preliminary rates for MY25 will be finalized and reported in June. She noted that we have had vast improvement since MY 21 and MY22. We achieved the 50th percentile in MY23. In MY24 we achieved the 75th percentile and anticipated achieving it again for MY2025. Ms. Timmerman reviewed performance scores and noted marked improvement every year. She stated that in topical fluoride in children GCHP has ranked as the highest performing Medi-Cal plan by DHCS for two consecutive years (MY23 and MY24) and our goal is to achieve that again for MY25. We have had significant gains in well-child visits in the first 15 months, and for well-child visits from 15 months to 30 months there has been improvement, and we have sustained seventy-five percentiles since MY23.

Finally, our HPV vaccine is for nine- to thirteen-year-olds and they are incentivized for receiving their second dose. Interventions include our collaboration with our QI entities and community base organizations. We are engaging in performance improvement projects developed in collaboration with IHI, with WIC, and MICOP to target disparate populations. We have health education workshops with First Five to promote well-care visits and immunizations as well as focus groups to identify barriers to completing well child visits and immunizations. Ms. Timmerman noted that our measured performance in childhood immunizations status measure has steadily declined after MY21. There is a slight improvement for MY25. She noted this could be attributed to the lowered NCQA benchmarks indicative of decreased immunization rates nationwide. We attribute the childhood vaccine decline being caused by vaccination hesitancy, distrust, and misinformation, partly a result of the pandemic, and generalized barriers to preventive

care. We need to work to provide clear messaging and align with providers on vaccine schedule recommendations and payment coverage. Despite CDC guidance, we need to increase and enhance member education. We plan to incentivize the flu shot and we will consider expansion to other vaccines depending on rate tracking and budgetary allowance.

Erin Slack discussed some of the work that Population Health management is doing with community partners. She highlighted ongoing collaboration with the Ventura County Community Health Improvement Collaborative. VCHIC brings together partners from across the county including contracted providers, health systems, government agencies, and other community-based organizations. This effort began in 2016 led by Ventura County Public Health to unite organizations with statutory community health assessments requirements. This has evolved into a county-wide partnership, and this is vital at GCHP because it enables us to concentrate where we will have the greatest impact. By working together, we have increased our ability to address pressing health needs within our community while fulfilling DHCS regulatory requirements. In 2025 it was the first time we were able to get a Community Health Assessment Survey to members in our community. We helped review, shape the report, and coordinate and facilitate community focus groups. As part of the data collection process, we shared data and identified priority health areas. There were three priority areas: behavioral health, older adult health, and women's health. These three areas are priorities for the next three-year improvement planning cycle. GCHP has staff participating in each of these work groups to ensure that our organization helps to shape the strategies that will address these priority health issues over the next three years.

Gold Coast along with Kaiser provided the funding to ensure that the health assessment was translated into Spanish and make more accessible to members in the community. GCHP has also hosted a quarterly birth equity stakeholder meeting to strengthen cross-sector coordination to support pregnant and parenting women. GCHP began bringing partners together once DHCS launched the birth equity population of focus for Enhanced Care Management. These meetings help shape our perinatal and early childhood program planning at Gold Coast.

Ms. Slack stated that new mandates have come out from DHCS that focus on providing wraparound support and early identification of pregnant women and follow them through the twelve-month postpartum process. She also reviewed the Doula pilot program with MICOP. We have received deep appreciation for this pilot program. She noted participants have improved confidence, advocacy, and support through the birth experience.

Ms. Slack also reviewed the Ventura County Community Information Exchange, which is a care coordination and data sharing network which brings together partners across healthcare, social services, housing, behavioral health, education, and other community sectors so that there is a collaboration around a person's social needs. She noted that we have many strong and meaningful partnerships within the community.

Dr. Lupe Gonzalez stated the Health Education Cultural Linguistics Department is actively working to improve childhood immunization through partnerships and strategic outreach initiatives by collaborating with WIC, First 5, schools, public health department, and other organizations to promote child health initiatives among a shared population through provider engagement and working with Quality Improvement and Community Relations. This department works to support health fairs and provide point of contact health screenings so that members receive information in their primary language. They also explore opportunities for audio and video presentations to ensure that GCHP benefits, preventative services, and grievances are conveyed. Focus groups are also part of the intervention strategies. Members who participate receive an incentive. The goal is to identify challenges and understand concerns.

Ms. Pshyra Jones continued with the theme of children's health. She noted that the immunization rates show clear disparities across geography, clinic system, race and ethnicity indicating uneven access and engagement across the county. The lowest rates are concentrated in specific communities. Children without a primary care provider show low completion rates. Racial and ethnic disparities are pronounced and the data highlights priority populations for targeted outreach. There is a need for culturally responsive communication, stronger medical home connections and community-based strategies. Ms. Jones then reviewed potential approaches to address the disparities and next steps.

Commissioner Abbas motioned to approve agenda item 4. Commissioner Monroy seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, Roger Robinson, Sara Sanchez, and Scott Underwood, D.O.

NOES: None.

ABSENT: Commissioners Robert Bravo, and Timothy Myers

Motion carried.

FORMAL ACTION

5. Project Approvals for 2026 Budget: Santa Rosa Office and Operations Stabilization

Staff: Sara Dersch, Chief Financial Officer
Suma Simcoe, Chief Operations Officer
Paul Aguilar, Chief of Human Resources & Organization Performance Officer

RECOMMENDATION: Approve the 4880 Santa Rosa Road and Operations Stabilization Projects and respective budgets and provide authority to the CEO to enter contracts implementing the Projects in the budgeted amounts

CEO Nunez stated COO Simcoe was not available and Ms. Holly Krull, Sr. Director of Strategies & Operations, would be available to answer questions if necessary. CEO Nunez that although this project is within budget, has been approved by the commission, and is in the budget report, we want to be in compliance with our finance policy which dictates that if a project is not presented in detail and approved separately by the Commission then every time the project has a transaction that exceeds $100,000 we would need to present to the commission for approval on that transaction.

Commissioner Espinosa thanked everyone for the transparency and noted there is a $100,000 limit.

Chief Financial Officer Sara Dersch stated that this item is being presented because there was not a detailed line item in the original budget presented. We cannot identify costs for nails or drywall, but we know what the total amount will be. The same thing is true for the operation stabilization. Our Chief Operations Officer, Suma Simcoe, has just joined the organization but we put in additional funding for her to support the mitigation work that she had uncovered and were going to need to implement. We now have a much clearer visibility to what that is.

CFO Dersch stated we will be revising the finance policy and presenting it in April. We are looking at what an appropriate threshold will be. We are consulting with other COHS to ensure that what we do is consistent with what our sister organizations are doing.

Commissioner Espinosa asked if any other items that exceed the $100,000 threshold will be presented to the Commission. CFO Dersch replied no, it is only the ones that are not currently in the budget. We do not expect to have any additional spending that is not in the budget. Most of our spending is on medical costs and we have substantial dollars in the incentives which have already been itemized in the budget. Commissioner Espinosa asked if the Santa Rosa and Operation Stabilization was not specifically itemized when the budget was approved. CFO Dersch stated the total was in the budget, but we did not have a line item in the budget. General Counsel, Scott Campbell, stated this was a policy adopted ten years ago out of a concern that expenditure over $100,000 would come to the Commission. If there was a specific project in the budget

that was described in the budget when the commission approved the budget and the project and all transactions associated with that project were approved. Both items are in budgeted amounts, and we now have what the costs are for these two projects. We now have the numbers for the projects. We are presenting the information to conform to the policy and make certain that these projects are approved and the commission knows what we are spending the money on regarding these projects.

Commissioner Blaze stated that she recalled approval of the move because it was going to be a cost save, she asked if anything had changed. Mr. Campbell stated nothing had changed. She also asked if there was some "wiggle room" if it cost more than anticipated. CFO Dersch stated there was a small contingency, but we are hoping to be on budget and on time.

Paul Aguilar stated he would give an update on the move project which is now called Project Nexus. He noted that objectives are a key aspiration, to create collaboration space which is a bit more open and people can work more effectively together. We are going to be placing some of the functions together on various floors that commonly work together and that is in the design. He noted that the community room would be much larger and more effective. We will also reduce the cost of our operating space over terms of the lease. Last summer we were in two operating spaces. We shut down one space and were operating in one space (711) which is approximately 40,000 square feet. The new building has the same footage, but it allows us to create new spaces that include hub rooms, community, conference rooms, and open space for people to work more effectively. Our intention is to also expand within the community and in Ventura County. We will be exploring options for community resource centers, which is part of our budget and part of our strategy – this will be a longer-term plan.

Mr. Aguilar states that we are currently on track with the move. We took control of the building in January and are now amid having it renovated and set for occupancy which is scheduled for June of this year. He noted that the building is three stories, and we are working on the footprint.

We have purchased some new furniture, but we also acquired furniture from the previous tenant. We will repurpose as much as possible, but it will be a nice work location. He noted there will be dedicated office spaces for those who go on site on a regular basis and hoteling spaces for those who come on site.

We are planning the physical move in phases, we have not gotten the details yet but a lot of it will be managed over the weekend so that once everything is complete, we can go into the new building and hit the ground running.

Commissioner Pupa stated we currently have approximately four hundred to four hundred fifty employees, she asked how many would be back on site. Mr. Aguilar stated we have twenty-two office spaces that are dedicated, and the rest will be more hoteling space. There are ninety-three workstations for those in the call center – they will have a dedicated space. There are approximately one hundred staff that routinely come into

work, and others come on at least a couple of days per week. We will have lockers and locking cabinets as well. People will be able to float as needed.

Commissioner Monroy asked about the status of the permit – she asked if it was already in progress. Mr. Aguilar stated the city of Camarillo has been very cooperative.

Commissioner Abbas motioned to approve agenda item 5. Commissioner Monroy seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, Roger Robinson, Sara Sanchez, and Scott Underwood, D.O.

NOES: None.

ABSENT: Commissioners Robert Bravo, and Timothy Myers

Motion carried.

6. Quality Improvement and Health Equity Committee 2026 First Quarter Report

Staff: James Cruz, MD, Chief Medical Officer
Kim Timmerman, Executive Director of Quality Improvement

RECOMMENDATION: Approve the 2026 QIHET Program Description, 2026 QIHET Work Plan, and 2026 Quality Improvement Duals-Special Needs Plan (D-SNP) Work Plan as presented. Receive and file the complete report as presented.

Kim Timmerman, Executive Director of Quality Improvement, stated she would be presenting some items for approval. We have the 2026 Quality Improvement in Health Equity Transformation program description and work plan. She will also have the Medicare D-SNP Quality Improvement work plan, which is a road map that outlines our goals, our multidisciplinary objectives, and activities. These are focused on improving key performance indicators for the Medi-Cal and Medicare D-SNP populations. She also described key updates that were made to the QIHET program description. This included integration of the Dual Special Needs Plan. For Health Equity content was added to address improving health literacy that meets both DHCS and CMS standards for Medi-Cal and D-SNP. Content was also aligned with the new 2026 NCQA Health Outcome standards for the program organization, oversight, resources and evaluation. The committee was updated along with QI reporting structures. She noted there are ten subcommittees that report to the Quality Improvement and Health Equity Committee.

Ms. Timmerman stated that they also changed the MCAS Operations Steering Committee to the Quality Measures Operations Steering Committee, and they will expand quality strategy to not only focus on MCAS but additionally NCQA HEDIS measures as well as Medicare Stars. To expand on the updates made for the D-SNP we added the D-SNP Model of Care or MOC and Enhanced Care Management or ECM integration to align with CMS regulations and CQA standards and DHCS requirements.

The terms of the 2026 QI Work plan have fifty focus areas reviewed and are included in five objectives. The Medicare D-SNP QI work plan goals and activities are based on the CMS Model of Care and the CMS Star rating measures. Ms. Timmerman reviewed the focus areas for objectives. She noted that two MCAS measures were removed – Chlamydia screening and Asthma medication ratios, but four measures were added. Those measures are around depression screening and a replacement asthma measure. Tobacco cessation was removed as a QI work plan measure for tracking but will still be assessed. She also reviewed the Five Star rating measures.

Ms. Timmerman stated there are reading materials if the commission wanted a detailed summary.

Commissioner Corwin motioned to approve agenda item 6. Commissioner Abbas seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, Roger Robinson, Sara Sanchez, and Scott Underwood, D.O.

NOES: None.

ABSENT: Commissioners Robert Bravo, and Timothy Myers

Motion carried.

REPORTS

7. Chief Executive Officer (CEO) Report

Staff: Felix L. Nunez, M.D., MPH, Chief Executive Officer

RECOMMENDATION: Receive and file the report

Chief Executive Officer Felix L. Nunez, M.D., stated his report was brief and is focused on what is our greatest challenge this year and the coming years. He noted that a lot was going on in healthcare. The full effect of HR1 has not taken place yet in Ventura

County Medi-Cal enrollment. Additional measures are anticipated and will also be a challenge. Over the last two months we have seen a great drop in enrollment and Medi-Cal since January 1 of this year. After the initial passage of HR1 we anticipated disenrollment and disenfranchisement related to active ICE activities and concerns of the population, especially among our UIS population and those mixed status households which represent approximately 20% of our SIS population. This held people back from enrolling. Our enrollment status does fluctuate over the course of the month. We are concerned over the impact this will have on our organization, there will be financial impacts and benefit impacts. We will do our analysis to see further challenges in the months to come before HR1 is fully executed. We will continue analysis and do a deeper dive into the numbers to gain insight and will present information to the commission.

CEO Nunez noted that Ms. Marlen Torres and her team will be responsible for helping to execute our program to maintain enrollment which is the big theme for this year. We will also maintain our financial discipline. He noted that we have already implemented some administrative changes to attempt to maintain administrative costs within our target. He noted that our hiring pause until we see more stabilization.

Ms. Torres organized our Ventura County Healthcare Coalition, and we hosted our first meeting on February 10th. It was a very successful meeting with participation across the floor from our providers, and organizations within Ventura County. Supervisor Lopez was present and made opening remarks. We brought together a large spectrum of providers, community members, and advocates all with the same mindset.

Commissioner Robinson stated that he wanted to point out that the full scope enrollment freezes for individuals nineteen and older with UIS started January 1, so that has already come into play. If they currently have Medi-Cal and they are enrolled or CalFresh and they are enrolled and fall off because they do not submit documentation, they will not be able to get it back. Beginning July 1, dental benefits will be eliminated. Commissioner Robinson stated the County also has a hiring freeze, but they are trying to prepare to have a training class to help with enrollment.

Commissioner Abbas motioned to approve agenda item 7. Commissioner Corwin seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, Roger Robinson, Sara Sanchez, and Scott Underwood, D.O.

NOES: None.

ABSENT: Commissioners Robert Bravo, and Timothy Myers

Motion carried.

8. Chief Operations Officer (COO) Report

Staff: Suma Simcoe, Chief Operations Officer
Holly Krull, Sr. Director of Strategy & Operations

RECOMMENDATION: Receive and file the report

Holly Krull, Sr. Director of Strategy & Operations, stated Chief Operations Officer Suma Simcoe will be providing information monthly on her projects. Ms. Krull stated that in January the department held an event, produced a package of projects, and started looking at how we can improve our claims, accuracy, audio adjudication etc. In February they met for another event and did deeper dives into each one of those topics and started working out the plan for each. One of the projects is the authorization claim linkage, which is a configuration and implementation project. We need to be able to evaluate whether an authorization was required for a claim before we pay.

The par data management cleanup has lingered since Go-Live of our initial HRP implementation, and we need to do a data point analysis of what we have in the system and what is present and simpler, which is our contract management tool. We will also initiate the quality tower program – we have not had internal operations and audit team to audit our claims, postmortem audits on claims. COO Simcoe will be presenting more information on the Quality Tower in the future, as well as retro eligibility, which is a sweep system. It is a configuration and implementation project sweeping the system for retro-eligibility when people go on and off eligibility. Claims may not have been paid, or we may have paid claims, but we need to recoup them.

We want to meet our regulatory requirement for PDRs. When we implemented in June of 2024, we build a business process that we have since examined and found that we are slowing ourselves down, so to stay compliant we want to do process improvement so that we are always in compliance with all the PDR processing. There is more to come and more will be discussed in Closed Session.

Commissioner Sanchez motioned to approve agenda item 8. Supervisor Lopez seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, Roger Robinson, Sara Sanchez, and Scott Underwood, D.O.

NOES: None.

ABSENT: Commissioners Robert Bravo, and Timothy Myers

Motion carried.

The Commission took a five-minute break and Closed Session began at 4:35 p.m.

CLOSED SESSION

9. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
Initiation of Litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: One case.

10. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer.

There was no reportable action.

ADJOURNMENT

With no other business to conduct, the meeting was adjourned at 5:41 p.m.

Approved:

_____
Maddie Gutierrez, MMC
Clerk to the Commission

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
Commission Meeting
Special Meeting via Teleconference

March 18, 2026

CALL TO ORDER

Committee Chair Laura Espinosa called the meeting to order at 2:07 p.m. The meeting was held remotely via Teams. The Clerk was in the Community Room located at 711 E. Daily Drive, Suite 110, Camarillo, CA 93010

INTERPRETER ANNOUNCEMENT

The interpreter made her announcement.

ROLL CALL

Present: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Tim Myers, Dee Pupa, Roger Robinson, and Sara Sanchez.

Absent: Commissioners Robert Bravo, and Scott Underwood, D.O.

Attending the meeting for GCHP were Felix L. Nunez, M.D., CEO James Cruz, M.D., CMO, CPPO Erik Cho, CFO Sara Dersch, Paul Aguilar, Chief of Human Resources, Robert Franco CCO, Eve Gelb, Chief Innovation Officer, Ted Bagley, CDO, Marlen Torres, Chief Member Experience & External Affairs, Suma Simcoe, COO, Alan Torres, CIO, Scott Campbell, General Counsel, and Leeann Habte of BBK Law,

Also in attendance were the following GCHP Staff: Lupe Gonzalez, Susana Enriquez-Euyoque, Vicki Wrighster, TJ Piwowarski, Holly Krull, Ellen Rudy, Patrick Warfield, Joanna Hioureas, Nathan Norbryhn, Pshyra Jones, Victoria Warner, Pauline Preciado, Lupe Harrion, Zed Haydar, Ben Lacy, Kris Schmidt, Brenda Gomez-Garcia, Chris Dulan, Josephine Gallella, Kim Timmerman, Shannon Robledo, Jeff Register, David Tovar, Adriana Sandoval, Madiha Ghaznavi, Jeff Yarges, Rachel Segovia, Ross Hooper, Chris Beeson, Michelle Espinoza, Nicole Kanter, Carolyn Harris, Margaret LeRoy and Valerie Paz

Guests: Demitric Franklin, Shawna Morris, and Michael Taylor

PUBLIC COMMENT

None.

FORMAL ACTION

1. Preliminary Financial Results for Sub Period and January 2026 Financials

Staff: Sara Dersch, Chief Financial Officer
Felix L. Nunez, M.D., Chief Executive Officer

RECOMMENDATION: Receive and file.

CEO Felix L. Nunez, M.D., thanked the Commission for adjusting their schedules to meet for this special meeting. He noted that updates would be presented regarding GCHP 's financial position. He stated the information would be unaudited financials for the close of the stub period and are subject to change. He stated it was important that information regarding our stub period be share as well as some results from January financials. February details are not available yet. He noted that we are looking at a deficit for stub period 2025. The deficit is currently estimated to be $53.5 million. The factors that lead to this deficit are not structural in nature. Many of them are one-time issues. There are multiple components to the deficit. There are four consequential drivers contributing to the deficit which were presented at a high level over the last year and now will be presented in detail, so the commission is aware of the contributing factors to the deficit. The first was the unexpected and unbudgeted take back from DHCS related to our UIS risk corridor for 2024. Another factor is the accruals related to anticipated settlements over claim payments. These are provider disputes that we are looking to settle. CFO Dersch will share why they are being recognized in fiscal year 2025 even though the settlements are not complete. There are various stages of remediation and negotiation, but we must take a liability in 2025 related to the settlements. There is also the medically supported food program. He noted there is a need to support this program in the future and the need to bring more fiscal discipline around this program to make sure that it is there for those that need it going forward. The last one is our claims interest payments related to our operational inefficiencies that we were struggling though last year. When we do not pay our claims correctly and timely we accrue interest that we owe back to the providers, and we must note that as a liability.

Chief Financial Officer, Sara Dersch, stated the financial results of this stub period reflect challenges; challenges with the implementation of our claims adjudication system, challenges with rolling out mandated programs. She stated there is nothing new in the numbers, nothing surprising. She will review the results with the key focus on the drivers. She will review the actions taken to eliminate or reduce the impact of those drivers. She noted that we are seeing positive results from those actions. She will also give a brief review of preliminary January results. CFO Dersch reminded the commission that the financials are preliminary and subject to change pending audit closure. Our audit will be officially closed only after we submit our final IBNR for March. Audit rules require three months of claims completion after the fiscal year ends to ensure that our final stated claims liabilities are complete for statistical purposes. We need to close March before our auditors finally sign off on the audit and on the financial statements for our stub period

of July through December 2025. Our March IBNR will be submitted to our auditors during the second week of April, until then these results are subject to change although we do not anticipate any. These are unaudited preliminary results, and we might see some final adjustments.

We are ending the year with a deficit of $53.5 million versus a very minor surplus of $900,000. Most of the drivers are attributed to one-time events. We do not have a structural deficit. What we have is the risk corridor take back. We are working with the State on refiling that and we do expect to have some remediation. We also have pending provider settlements, having an accrual is normal for any health plan due to some of the challenges and delays that we have had in getting all the provider claims paid accurately and timely. We have seen our Provider Dispute Resolutions Solutions inventory grow, which will result in potential additional litigation which we do have to consider any settlement that is estimable and likely. If we know something is coming and we can project within a fair amount of confidence what the amount is, principles say we must book that. We are looking at a small uptick in that amount. Another one-timer was the medically supportive foods, it is an ongoing program, but it is called a one-timer because it was a growing pain with understanding how to effectively run this benefit. There was not much guidance given by the state, and we erred providing additional meals for our members based on feedback we received from the state.

Commissioner Abbas stated he was looking at the numbers and $53.5 million is a big deficit, but when he added the numbers of $21.1 million, $13.2, and $12.9 comes out to be $47.2 million and you have shown $53.5 He asked where the difference of $6.3 million is. CFO Dersch stated we have dollars in our claims interest. We have significant overage in our claims interest paid, and there are always puts and takes within the numbers, results might be $100,000 over here, $300,000 under there - we are looking at the primary drivers, there are four. Commissioner Abbas stated $6.3 million is a significant difference. He asked if there is something else the commission should be aware of. He stated he is concerned.

CFO Dersch stated she understood his concern and noted there is a table in her presentation that details add in the claims and that it gets within $3million. Commissioner Abbas asked about the other $3million – that is missing somewhere. CFO Dersch stated it is not missing; we know that there are pressures on IBNR, there have always been pressures on our IBNR because of the claims processing challenges. CFO Dersch stated that with any budget we have over one-hundred-line items that some are positive to budget, some are negative to budget, all immaterial amounts. Commissioner Abbas stated that as his fiduciary responsibility he would like to see in detail where the $6.3 million is. CEO Nunez stated we will present the details to Commissioner Abbas.

CFO Dersch stated there were some highlights from the stub period. The membership loss was less than projected. Administrative expenses remained within budget, even with the claims interest expense unfavorable. We have also had some programming enhancements. We have had introduction of chronic disease management capabilities through a new vendor which will help us bend our cost curve down, and utilization

workflow reengineering. We also had successful implementation of our Workday ERP, which is the finance, HR and procurement modules which will allow us to maximize efficiency and redirect some administrative expenses towards supporting our members. There is claim stabilization efforts that are trending towards positive.

CFO Dersch moved on to our income statement view – our membership was positive; our revenue was positive not only on a nominal perspective from a total revenue but also from a per member per month perspective which is due to our member mix. Our medical costs are experiencing pressure again because of the claim's stabilization. Those are high We are coming in under budget on administrative cost, it is 10.8% versus a budget at 11.2%. From the beginning of the stub period, we saw that our claims expenses were going to be higher than anticipated. We did begin to invoke opportunities for reducing administrative spend so that we would try to minimize what the stub period deficit would be. Our investment income is coming in slightly lower than projection, primarily because our cash balances and those investment accounts are less cash. Less cash is going to generate less return. We are spending more on quality and grants in January that we had budgeted. Our December TNE is sitting at 499%, this is not our current TNE.

Commissioner Pupa asked if CFO Dersch knew what the IBNR margin is. CFO Dersch stated our IBNR is starting to come down, it came down by a fair amount in January. It is holding flat for February, which I good because we do not like to see volatility in our IBNR. Commissioner Pupa asked if once our IBNR is actuarially certified, there is typically a margin between 5 – 30%. She asked if we know what our IBNR margin is, in that there is a cushion above and beyond what we should be reserving. CFO Dersch stated it is referred to as the PAD, which is the Provision for Adverse Development. We are at a 10% PAD.

CFO Dersch reviewed a table displayed on screen. She stated that it shows a more detailed breakout that reflects revenue take back, medically supported foods, the claims interest expense and the settlement reserve which shows $50.3 million, and with the $3.2 million she will provide a lengthy document that shows all the variances for all the accounts. CEO Nunez stated the document will be shared with the entire commission as well as at our April Commission meeting.

CEO Nunez pointed out that on a positive note, we were able to maintain our ALR (Administrative Loss Ratio) well below budget, even considering the interest charge of the claims interest which was charged to our administrative loss ratio. CFO Dersch stated that if you strip out the impacts of that claims interest expense the ALR would go down from 10.8 to 10.1%.

Commissioner Monroy commented that there were gaps in guidance from DHCS for the medically supported foods program and the benefit, but she believed there was an opportunity to more closely monitor utilization and cost. We need to call out ownership and potentially some processes internally that could have been sharpened. CFO Dersch stated it was a lesson learned for the organization. She stated CPPO, Erik Cho, will talk about the management of this program.

Commissioner Corwin stated that in November we were negative $35 to $36 million and now we are at $53 million, he asked what the main driver was for that one month. TNE was in the 570% range and now we are below 500%. He asked what the biggest driver in that one month and much of it was latent information booked in December versus current month operations in the month of December. CFO Dersch stated December represents the final month of the year. We finalized what that provider settlement accrual should be – that was one of the drivers, we did add to that in December. Our IBNR also went up in that month, though it is going down now. We had several hundred thousand dollars in claims interest which continued to drive unfavorable development from November to December. Commissioner Corwin asked if we did not have the $21.1 in there. He stated we had something for a revenue take back through the November financials. CFO Dersch stated we had the revenue take back, we did not have the entire provider settlement accrual booked in November, there was an increase in that accrual amount for the month of December. There was a $10 million increase in the provider settlement between November and December.

CFO Dersch stated that we are recalculating the UIS Risk corridor as the claims complete. We are going to resubmit our 2024 MLR filing to DHCS. We will know what the impact will be on that within the next couple of weeks. Commissioner Pupa asked about the advocacy on the 21.1 million and efforts across the state regarding the take back and how aggressively we are trying to rectify this take back. CFO Dersch stated that we have been instructed to refile our 2024 MLR report that is the official calculation of that revenue take back and once the state receives, reviews, and agrees with it, that is the new disposition of that take back. The state wants to make sure we are whole from a UIS risk corridor perspective. They have indicated that they have no desire to withhold any additional funds than what they should base on the final claims. Many other health plans have expressed concern with this cohort. We were instructed to refile the 2024 MLR report when we have more credible claims data. The state is collaborating with us on the refiling. We still do not have an amount that we can estimate. There is no official appeal process. Commissioner Pupa stated this is a significant hit that could impact our providers and she is concerned about the decision at the state level.

Commissioner Espinosa asked about a potential reimbursement after the refiling. CFO Dersch stated there will be a mid-year rate adjustment coming in May or June. We always know there is a mid-year adjustment as we submit additional completed claims. We submit multiple times throughout the year and as those resubmissions come through, more completed claims occur, then our rates are adjusted. Historically we have not seen rates go down over the prior few years because the experience shows that as the claims are complete, we have higher costs on a PMPM basis. The challenge that we have had is due to the issues with our claims adjudication system, we have not been able to submit 100% of completed claims, even though they could be more than three to four months old because we have had so many that are backlogged and many that are in the provider dispute resolution queue. What we discovered and did not know at the time is that there were additional claims that we had incurred throughout that year that had not been paid, that did not have a final disposition of accurate payment.

CFO Dersch asked CPPO Erik Cho to speak about the medically supported food program. CPPO Cho stated he was going to speak to some numbers that are on the cost. The costs at this point mirror the number of meals served. He stated that it is uncharted terrain for a plane like ours to be a provider of meals. There was a very rapid advancement in the meals that became a part of the program and the costs ramped up. It was a learning experience in hindsight, reacting even sooner would have been ideal. From April 2024 to August there was a 40% increase in cost of medically supported food. The cost ran away in a short time frame, and we came together as a team to discuss how we make sure that people who need the service keep receiving the service, but we change how we roll this out in a way without moving over to grocery boxes but tighten controls in general. Once we saw there was a problem, we made changes and have re-evaluated the value proposition in our contracts with local providers. We found a way to have more direct oversight and a sustainable number of meals.

Commissioner Myers stated that it sounds like there was a push on the meals, and looking back, he asked if that push was above the state guidelines or was it in line with the state guidelines, which they have now changed and pulled back. CPPO Cho stated there was no specific or exact number per member. We went beyond and a lot of that was driven by the providers of the meals. We went beyond what was the intent of the program and now we have scaled back to where we are in line with what it should be. Commissioner Myers also asked if there was a dietician that reviews the number of meals. CPPO Cho stated we have a dietitian who has been integral to this program. There are also nutritional consults for members receiving the meals.

Commissioner Blaze asked CPPO Cho what the total cost was. CPPO Cho stated he did not have that number at hand. Commissioner Espinosa stated that CPPO Cho had stated at a meeting a few months ago that the cost was approximately $25 per meal. The rates were retained from the rates that were in place when these providers were directly contracted with the county. CPPO Cho stated that the cost had to be sustainable, and we met with three local providers to discuss and reduce rates. CEO Nunez stated we believe in this program and believe that there is a return on investment for the members. He noted we were over budget by approximately $13 million that is consequential and important for us to get under control programmatically. We are not going to solve the problem of food insecurity, but this is an opportunity for us to bridge members to food insecurity programs where they need longer term support. We are going to focus on doing a better job. Commissioner Corwin stated we need to get a better rate but also keep the meals around the $200,000 mark per month and try to lower our costs. CEO Nunez stated that we do not have a line item specifically for the meals – this is within the community supports line item, 90% of which we budget towards the meals, which is how we got to the $13 million overage. We need to live within the budget.
CFO Dersch stated that we received approximately $12.00 per member per month for meals and we were charged $18 to $25 per meal so that is not sustainable. This will be one of our areas of rate advocacy during our mid-year rate adjustment.

CFO Dersch stated the claims interest is starting to trend down. The February number is not complete yet, because we have not fully closed February, but it is not going to go

up. We are trending in the right direction. She noted that 90% of our January claims were paid, 90% of the clean claims were paid within thirty days. CFO Dersch stated that we have been through challenging times, but we are starting to see efforts pay off. Commissioner Pupa stated that she appreciated the efforts made for claims.

CFO Dersch stated that CEO Nunez will present the mitigation efforts, remediation, and impacts.

CEO Nunez stated we face challenges this year in enrollment that will continue to get worse as we go into 2027. He did note that we are anticipating a claw-back on the $21.1 million take back from the state, we do not have an amount yet, but we do anticipate a return on a portion of that $21.1 million being returned to Gold Coast. CEO Nunez stated there is no way around the claims – the more work that we do in optimizing, the better we will be able to minimize our liability secondary to claims interest. We will tighten community support; we need to tighten up our programs constantly yet look for the most value for our members. We also have a pause in new hires and back fills in place. It has been in effect since January 1, 2026. This is about trying to maintain our administrative loss ratio. CEO Nunez noted that Marlen Torres and her team are working to maintain enrollment of our members. That work requires financing, and support – we are holding for now until we get more data to understand and make a trend. There is pressure on the team, and we need to assess that as soon as possible.

CEO Nunez stated that we are currently collaborating with vendors and looking for opportunities to recover overpayments. We will be doing an RFP this year to help us find a new vendor that could provide us with greater value in terms of going after those overpayments. We must do a better job of managing utilization and medical costs and we are looking at existing guidelines, existing processes, tightening up those processes and working closer with our network partners for opportunities to find lower cost alternatives. We are working to tighten utilization controls, not to create barriers.

Our priority is to maintain enrollment. It is critical work that we need to establish this year in preparation for what is to come in 2027/2028. We have already initiated a work plan internally around supporting internal enrollment around advocacy, education, and then direct engagement.

CFO Dersch noted that our revenue was favorable even though our membership was not. Our medical costs came in less than budgeted on both the Medi-Cal and Medicare side. Our administrative costs came in at 11.7% versus 12.6%. We had projected a $5.4 million loss for January, and we came in at a $1.9 million loss. From a February perspective our membership attrition rate is less that it has been for the prior two months – this is a positive sign and our IBNR is remaining flat, which again is positive.

Commissioner Abbas motioned to approve Agenda Item 1. Commissioner Corwin seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Tim Myers, Dee Pupa, Roger Robinson, and Sara Sanchez,

NOES: None.

ABSENT: Commissioners Robert Bravo, and Scott Underwood, D.O.

Motion carried.

REPORTS

2. Chief Executive Officer (CEO) Report

Staff: Felix L. Nunez, M.D., Chief Executive Officer

RECOMMENDATION: Receive and file the report.

CEO Nunez reviewed enrollment loss. He stated we lost approximately 1,600 members in March, and the loss will continue. We are tracking as we go on throughout the year with an effort to coordinate and work on maintaining enrollment.

Commissioner Pupa stated there needs to be advocacy for our population and all Medi-Cal populations. It is a burden and a barrier in the process of applying, and she hopes that at the state level there will be some grace for not only our population but all the populations across California.

Marlen Torres, Chief Member Experience & External Affairs Officer, stated we plan to engage with our elected officials as they are going through the budget process to see if there is something that we can do. We will see in the May revise all the marketing efforts that will come through DHCS as well as some potential additional funding for all the Human Services agencies across the state to be able to see if there is some additional funding for staff to be able to support. In April we will show our work plan, where we are with membership and what we plan to do as well as include our advocacy efforts.

Commissioner Pupa stated she has concerns at the state level for decision makers we need to be heard.

Commissioner Robinson stated that the California CWDA (California Welfare Directors Association) is advocating at the state level and CSAC is advocating at the state level as well. There is advocacy at all levels, and it is a hot topic.

Commissioner Espinosa stated that in a past campaign in Sana Paula there was a request for kiosks for the probation agency so that people who lack transportation could go to these kiosks and check in rather than going into the probation office. She asked Commissioner Robinson if this might be an option to have kiosks to accept early paperwork, have kiosks at libraries, community colleges and school drop off areas to expedite the process a bit. Commissioner Robinson stated the county is working with county partners and across the region. He noted there are different administrative changes and they are making the application process more difficult.

CEO Nunez stated the remainder of his report has already been covered in the finance report. He noted that we will continue to work closely with the county and reassure the Commission that we are fully engaged and will remain engaged with all our network partners.

Commissioner Abbas motioned to approve Agenda Item 2. Commissioner Monroy seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Tim Myers, Dee Pupa, Roger Robinson, and Sara Sanchez,

NOES: None.

ABSENT: Commissioners Robert Bravo, and Scott Underwood, D.O.

Motion carried.

ADJOURNMENT

With no other business to conduct, the meeting was adjourned at 3:41 p.m.

Approved:

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Maddie Gutierrez, MMC
Clerk to the Commission

AGENDA ITEM 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel
Jeff Register, Interim Chief Financial Officer

DATE: April 27, 2026

SUBJECT: Adoption of Resolution 2026-001 Authorizing the Chief Executive Officer, Interim Chief Financial Officer and Chief Policy and Program Officer to initiate banking and fund management transactions as well as sign and execute contractual documents. management transactions.

SUMMARY

The newly named Interim Chief Financial Officer will require authorization to be an Authorized Designator for Gold Coast Health Plan's (GCHP or Plan) banking and investment accounts with BMO Bank in order to execute the duties of the Chief Financial Officer. To have all authorized persons approved in a single document, the resolution also lists Felix L. Nunez, M.D., Chief Executive Officer ,and Erik Cho, Chief Policy and Programs Officer, as Authorized Designators.

BACKGROUND / DISCUSSION

The fulfillment of Interim Chief Financial Officer duties includes the ability to access, approve, and transfer funds to and from any banking and investment account held by GCHP with BMO Bank. These duties also include the ability to sign and execute contractual agreements between GCHP and BMO Bank. Note that while Felix Nunez, MD, MPH, the Chief Executive Officer, will also have the responsibility as Authorized Designators for banking and investment fund management at BMO, it is considered a best practice for the Chief Financial Officer to hold fiscal signatory rights on said accounts, thus the need to extend these rights to the Interim Chief Financial Officer. Additionally, in case two signatures are required for certain transactions, the Resolution also adds Erik Cho, Chief Policy and Program Officer to the list of authorized personnel. The Resolution seeks to update these designations.

FISCAL IMPACT

None. The Resolution simply authorizes the proper GCHP personnel to initiate banking and fund management transactions as well as sign and execute contractual documents.

RECOMMENDATION

Staff recommends the Commission adopt Resolution 2026-001.

ATTACHMENTS

Resolution 2026-001 Authorizing the Interim Chief Financial Officer as an Authorized Designator with BMO Bank N.A.

RESOLUTION NO. 2026-001

A RESOLUTION OF THE VENTURA COUNTY MEDI-CAL MANAGED COMMISSION, DBA GOLD COAST HEALTH PLAN AUTHORIZING THE CHIEF EXECUTIVE OFFICER, INTERIM CHIEF FINANCIAL OFFICER AND CHIEF POLICY AND PROGRAM OFFICER AS AUTHORIZED DESIGNATORS WITH BMO BANK N.A.

WHEREAS, the Commissioners of the Ventura County Medi-Cal Managed Care Commission, doing business as Gold Coast Health Plan, named Jeff Register as Interim Chief Financial Officer, replacing Sara Dersch who is no longer employed by Gold Coast Health Plan. Such Interim Chief Financial Officer will be charged with signing financial documents and contracts and desires that such authority be granted by adoption of a resolution of the Commission.

WHEREAS Felix L. Nunez has replaced Nick Liguori as Gold Coast Health Plan's Chief Executive Officer and Erik Cho is currently serving as Chief Policy and Programs Officer.

NOW THEREFORE, BE RESOLVED, by the Ventura County Medi-Cal Managed Care Commission as follows:

Section 1. BMO Bank N.A. ("Bank") is designated as an authorized depository of the Ventura County Medi-Cal Managed Care Commission ("Commission") and that one or more checking, savings, or other deposit accounts be opened and maintained with Bank.

Section 2. Sara Dersch and Nick Ligouri shall be removed as an "Authorized Designators" of the Commission. Felix L. Nunez, Jeff Register and Erik Cho shall be designated as Authorized Designators.

Section 4. Each of the individuals serves as an Authorized Designator from time to time and any other person designated by any such Authorized Designator, whose identity and signature is certified to Bank hereunder is authorized on behalf of the Gold Coast Health Plan and in its name to do any of the following:

A. Waive presentment, demand, protest and notice of protest or dishonor or any check(s), instrument(s), draft(s), acceptance(s), or other evidences of indebtedness made, drawn or endorsed by the Gold Coast Health Plan; to engage Bank to provide services to Gold Coast Health Plan and otherwise to deal with Bank in connection with the foregoing activities.
B. Open or close any deposit or other account with Bank (the "Accounts") and to sign signature cards, authorization, set-up, and other documentation and agreements with Bank with respect to any of the Accounts and any services related to the Accounts.

C. Provide instructions to Bank regarding the Gold Coast Health Plan's address (including electronic address), account titles and subtitles, and duplicate statements and changes thereto as they may see fit.
D. Issue written, telephonic, electronic, or oral instructions with respect to the transfer or payment of funds of Gold Coast Health Plan on deposit with Bank (or at any other financial institution) by manual, wire, internet, electronic, or other means.
E. Designate, and advise Bank of the identity of people who have:
    - some or all the authority of an Authorized Designator, as described in this Resolution.
    - authority to receive and administer user procedures, client and user numbers and codes, password and other identification data and procedures.
    - authority to instruct Bank on set-up and security procedures, authority to receive and administer user procedures, client and user number and codes, passwords and other identification data and procedures including wire transfer authorization.
    - authority to transact business with Bank and the scope of such authority; and
    - authority to revoke or modify the authority of any such person.

It being understood that such people may be agents of service providers to Gold Coast Health Plan. Such authority may be evidenced by any means, including pursuant to authorization forms required by Bank or similar documentation delivered by or on behalf of Gold Coast Health Plan to Bank.

Section 5. Bank is authorized to rely on the full and unrestricted authority as provided in this resolution of any one Authorized Designator unless otherwise certified to Bank.

Section 6. The opening and maintaining of the Accounts and all transactions in connection with the Accounts will be governed by the provisions of the agreements pertaining to such Account, as provided by Bank, and by such rules and regulations as Bank shall, from time to time, promulgate and establish; and that each of the Authorized Designators and persons designated by an Authorized Designator are authorized to sign and execute such signature cards, applications, forms and agreements required by Bank in connection with the Accounts.

Section 7. Gold Coast Health Plan is authorized to obtain banking services from Bank, including cash management services, and to enter into such agreement or agreements pertaining to any such services as are required by Bank from time to time, including a Global Treasury Management Master Services Agreement, Schedule of Services and Service Documentation, and other agreements as Bank shall deem appropriate from time to time.

Section 8. The foregoing authority shall not be limited to the above-identified or described Authorized Designators or other representatives of the Commission but shall extend to such additional or different individual(s) as are named as being so

authorized in any letter, form, or other written or oral notice by any Authorized Designator or other representative of Gold Coast Health Plan designated by an Authorized Designator.

Section 9. An authorized individual shall deliver a certified copy of this resolutions to Bank and certify to Bank the name, title and specimen signature of each Authorized Designator; that the authorized individual or Authorized Designator may deliver to Bank such additional certifications as are necessary to reflect additional Authorized Designators and changes in any previous certification; and that Bank is entitled to rely upon, and be fully protected in relying on such certifications.

PASSED, **APPROVED AND ADOPTED**

by the Ventura County Medi-Cal Managed Care Commission dba the Gold Coast Health Plan at a special meeting on the 27th day of April 2026, by the following vote:

AYE:

NAY:

ABSENT:

ABSTAIN:

_____

Commission Chair, Laura Espinosa

_____

Maddie Gutierrez, MMC Sr. Clerk to the Commission

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Suma Simcoe, Chief Operating Officer

DATE: April 27, 2026

SUBJECT: Operations Update

PowerPoint with Verbal Presentation

ATTACHMENTS:

Commission Meeting_April

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Gold Coast Health Plan

April 21,2026

Suma Simcoe, Chief Operating Officer

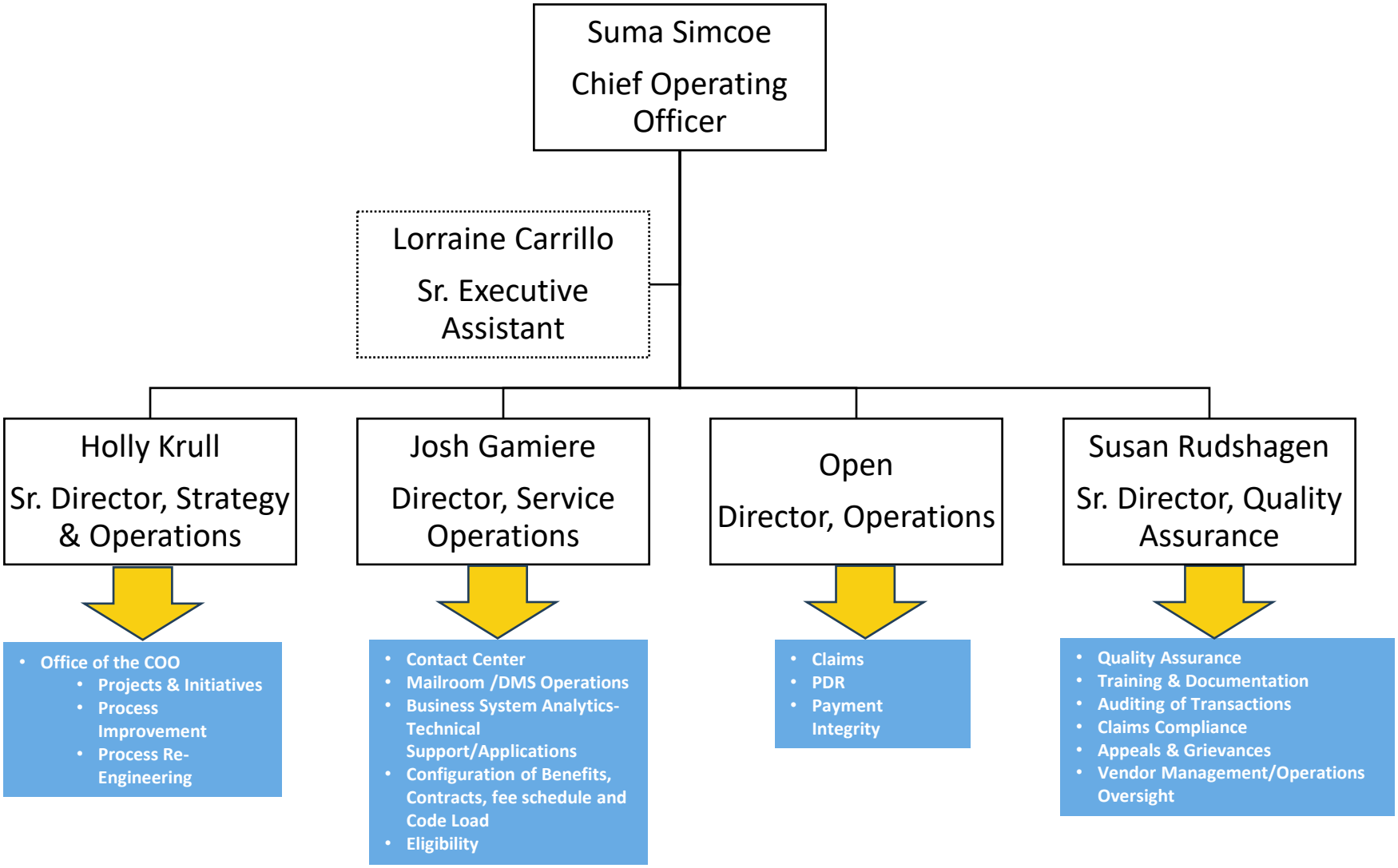
Integrity

Accountability

Collaboration

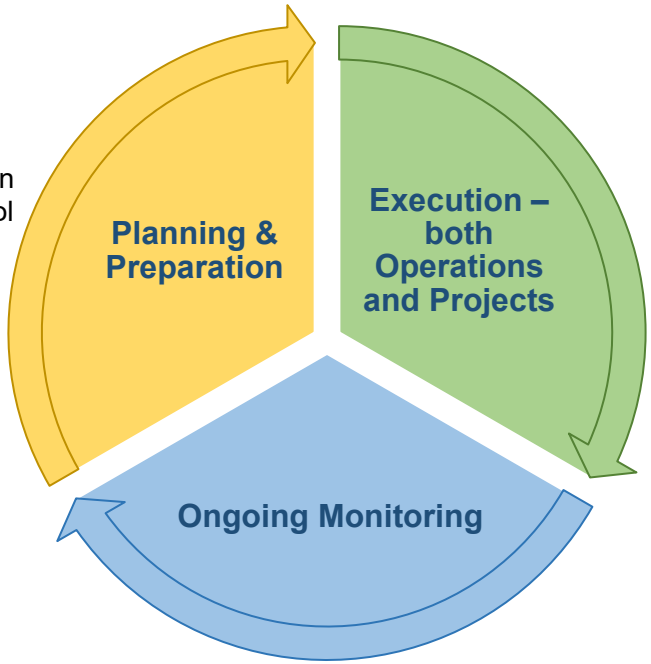
Trust

Respect


Suma Simcoe
Chief Operating Officer
Lorraine Carrillo
Sr. Executive Assistant
Holly Krull
Sr. Director, Strategy & Operations
Josh Gamiere
Director, Service Operations
Open
Director, Operations
Susan Rudshagen
Sr. Director, Quality Assurance
Office of the COO
Projects & Initiatives
Process Improvement
Process Re-Engineering
Contact Center
Mailroom /DMS Operations
Business System Analytics-Technical Support/Applications
Configuration of Benefits, Contracts, fee schedule and Code Load
Eligibility
Claims
PDR
Payment Integrity
Quality Assurance
Training & Documentation
Auditing of Transactions
Claims Compliance
Appeals & Grievances
Vendor Management/Operations Oversight

Quality Stages

- Regulatory intake & monitoring
- Business Changes
- Requirements Validation
- Process Change Control initiation
- Workflows
- Process Controls
- Documentation



- Testing
- Training
- Process Change Control management
- Vendor Oversight

- Auditing (departmental)
- Regulatory audits
- CAPs management
- Metrics / KPIs
- Review Committees

Quality Assurance Governance, a.k.a. “Process Change Control”

The way we work: Transparency + Collaboration = Trust

Persistency: Consistent documentation, document storage, artifact organization

Operations Updates

Program/ Strategy

- Transitioned five Ops consultants work to in-house resources. Realized Cost saving for 2026: $1.5M
- Recovery process as it relates to other insurances : recovered over $404K for this year

Coordination of Benefits (COB)

- Activating cost avoidance - COB Pre-pay program
- Business rules and final scope definition, done by April 3
- ETA for small batch is June

Anomalous Claims

- Established weekly cross-functional workgroup to mitigate utilization, rising costs, and potential anomalies requiring review.
- Currently formalizing the project governance framework, including the charter and RACI
- 9 entities have been reviewed
  - 4 entities have been deemed fraudulent. Paid amount = $305.8K
  - 5 entities are under review. Paid amount = $715K

Claims Operations

- A 20,000-case PDR backlog identified in early January was fully resolved by March 16 through coordinated overtime efforts and targeted bulk and manual closures.
- The PDR team is conducting ongoing case reviews and partnering with the claims team to identify emerging trends and issues, with the goal of ensuring all adjustments are finalized prior to dispute deadlines.
- Drafting DSNP policies and adding DSNP language to existing policies
- Claims turn around time is 99% compliant for Medi-Cal and DSNP for March 2026

Service Operations

Interactive Voice Response (IVR)

- Active ~4 weeks:
- 6,583 claims status completed
- 1,428 eligibility verifications completed
- 478 Explanation of Payment (EOP) requests completed
- Avg 320+ self-service provider requests per day
- Avg 150 calls handled daily for Provider Contact Center (PCC) prior to March 11
- New Auths support team handling 175-200

Quality Assurance

- Claims Lifecycle Auditing has been initiated using an audit-the-auditor approach for vendor-processed claims
- Grievance & Appeals: process gaps in GCHP State Fair Hearing process were closed in collaboration with Healthcare Services

Documentation & Training:

- Kicked off Knowledge Base and Process Documentation discovery and design sessions
- Initiated a Policy & Procedure management process in which Operations QA supports all Operations towers with timely policy creation/updates

Operational Oversight

- Opened 93 Change Control Documents (CCDs) YTD.
- 48 CCD have been closed YTD, most aged from prior years

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Eve Gelb, Chief Innovation Officer

DATE: April 27, 2026

SUBJECT: D-SNP Update

PowerPoint with Verbal Presentation

ATTACHMENTS:

Total Care Advantage D-SNP Update

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Total Care Advantage Duals Special Needs Plan (D-SNP) Update

April 29, 2026

Eve Gelb, Chief Innovation Officer
Kimberley Marquez-Johnson, Senior Director D-SNP

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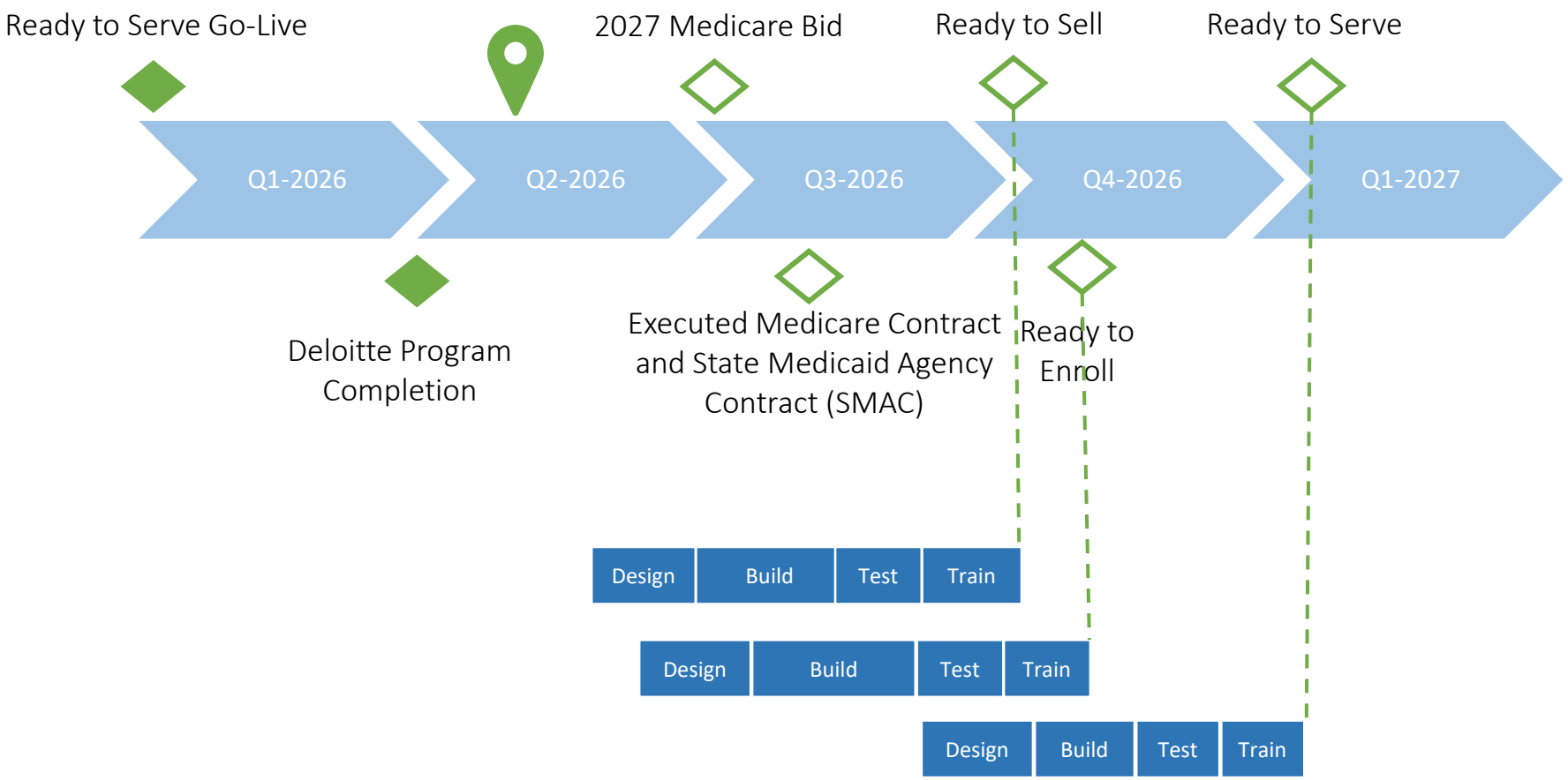
Program Status



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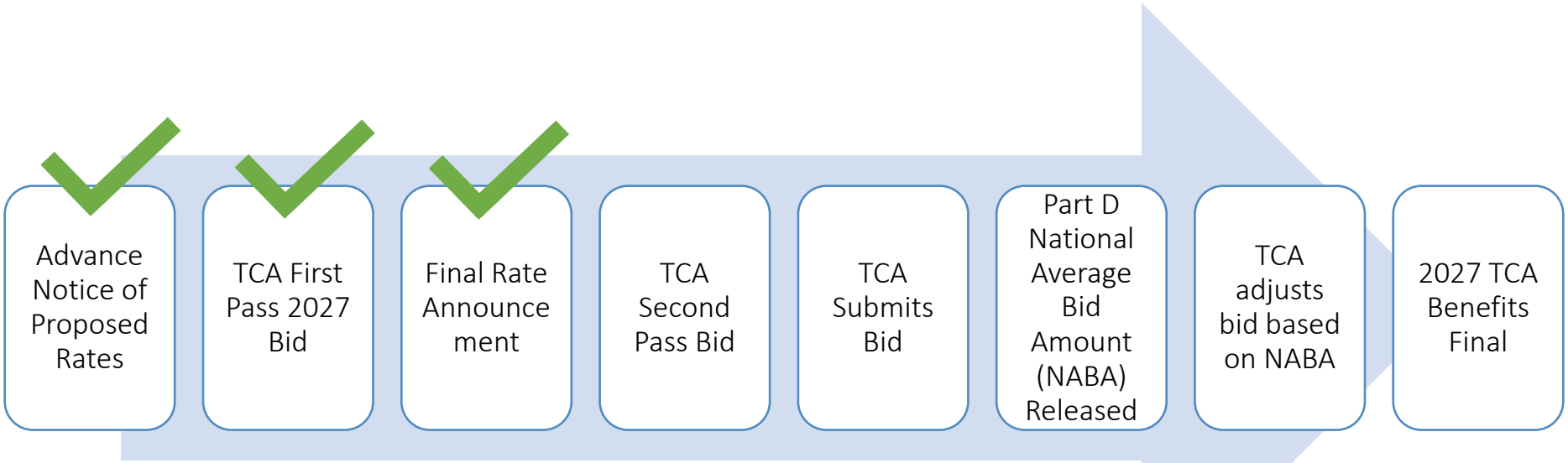
2027 Bid Process



The Centers for Medicare and Medicaid Services (CMS) released the 2027 Rate Announcement which contains 2027 Medicare Advantage (MA) capitation rates and Part C and Part D payment policies.

- The final national effective growth rate is 5.33%, a slight increase from the advance notice estimate at 4.97% and a decrease from the growth rate in CY 2026 at 9.03%.
- The benchmark for Ventura county grew at a slower rate than the national average, 4.53% vs. 5.33%. This is roughly on par to what was assumed for first pass of the bid.
- For the Part C risk scores, CMS will not be implementing the proposed 2027 risk adjustment model.
- For Part D risk scores, CMS updated the model to reflect changes from the Inflation Reduction Act
- CMS is finalizing the exclusion of diagnoses from audio-only encounters and unlinked chart review records (CRRs), i.e., diagnoses not associated with a specific beneficiary encounter.

Enrollments (as of 4/15/2026)

Members by Age Group

Age Group	Members	% Members
00-64	70	12.5%
65-69	232	41.4%
70-74	117	20.9%
75-79	78	13.9%
80-84	36	6.4%
85-89	20	3.6%
90-94	5	0.9%
95-99	3	0.5%
Total	**561**	**100.0%**

Members by Language

Language	Members	% Members
Spanish	328	58.5%
English	224	39.9%
Tagalog	4	0.7%
Arabic	1	0.2%
Mandarin (China)	1	0.2%
No Valid Data Reported	1	0.2%
Other	1	0.2%
Russian	1	0.2%
Total	**561**	**100.0%**

Members by City

City	Members	% Members
OXNARD	224	39.9%
VENTURA	64	11.4%
SIMI VALLEY	57	10.2%
SANTA PAULA	47	8.4%
CAMARILLO	32	5.7%
FILLMORE	30	5.3%
OJAI	25	4.5%
THOUSAND OAKS	22	3.9%
PORT HUENEME	21	3.7%
MOORPARK	15	2.7%
NEWBURY PARK	11	2.0%
OAK VIEW	8	1.4%
OAK PARK	2	0.4%
PIRU	2	0.4%
SOMIS	1	0.2%
Total	**561**	**100.0%**

Members by Category of Aid

Category of Aid	Members	% Members
SPD	500	89.1%
Adult Expansion	51	9.1%
Adult/Family	9	1.6%
Long Term Care	1	0.2%
Total	**561**	**100.0%**

Members by Sex

Sex	Members	% Members
F	315	56.1%
M	246	43.9%
Total	**561**	**100.0%**

Members by Ethnicity

Ethnicity	Members	% Members
Hispanic or Latino	357	63.6%
Not Hispanic or Latino	98	17.5%
Decline to Answer	78	13.9%
Asian	15	2.7%
Unknown	13	2.3%
Total	**561**	**100.0%**

Members by VCBH Status

VCBH Status	Members	% Members
	549	97.9%
Currently enrolled	12	2.1%
Total	**561**	**100.0%**

Members by PCP System

PCP System	Members	% Members
CLINICAS	351	62.6%
VCMC	209	37.3%
	1	0.2%
Total	**561**	**100.0%**

Members by Case Type

Case Type	Members	% Members
General	465	82.9%
CICM	84	15.0%
No Case	12	2.1%
Total	**561**	**100.0%**

Members by HRA Status

Has HRA	Members	% Members
	199	35.5%
Y	362	64.5%
Total	**561**	**100.0%**

Key Performance Indicators (KPI)

Domain	KPI	Current Performance
Membership	Achieve membership of 1200 to 2500 by 12/31/2026 Disenrollment of less than 3%	561 enrolled to date. 7.5% disenrollment.
Provider Engagement	65% of members have completed Annual Wellness Visit in 2026	Metric reporting will begin in April 2026
Quality/5 Star	80% of star measures meeting performance targets for 2026 Measurement Year	Metric reporting will begin in April 2026
Financial Performance	Less than $11M loss for 2026	Metric reporting will begin in April 2026
Compliance	85% of prioritized Member Impact compliance metrics meeting compliance targets for 2026	There are 27 compliance measures. All will begin reporting in April 2026. For 9 measures currently reporting, all are meeting targets.

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Marlen Torres, Chief Member Experience and External Affairs Officer

DATE: April 27, 2026

SUBJECT: Member Retention Presentation / Strategic Plan Quarterly Update

PowerPoint with Verbal Presentation

ATTACHMENTS:

Gold Coast Health Plan's 2026 Strategic Goals

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Gold Coast Health Plan's 2026 Strategic Goals

Marlen Torres
Chief Member Experience and External Affairs Officer

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Collaboration
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Respect

What to expect from today's session

...in the context of continuous strategic implementation

The Commission held its annual strategic planning retreat on Oct. 30, 2026. At the end of the retreat, the GCHP Executive Team committed to presenting the 2026 Strategic Goals to the Commission for review and approval.

Discuss and approve the 2026 strategic goals and solidify the strategic direction that GCHP will embark on this year.

GCHP staff will give quarterly updates at Commission meetings to review the progress made on the approved goals.

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Strategic Anchors

Enhance Member Experience

1. Retain Medi-Cal membership
2. Improve Consumer Assessment of Healthcare Providers and Systems (CAHPS) score for Adult and Child Survey
3. Increase Total Care Advantage Members

Optimize Provider Relationships

1. Stabilize and Optimize Operations
2. Optimize Total Care Advantage Provider Relationships

Advance Quality of Care

1. Achieve Managed Care Accountability Set (MCAS) Targets
2. Achieve Total Care Advantage Quality Targets

Enhance Member Experience Goals

Marlen Torres, Chief Member Experience & External Affairs Officer

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ENHANCE MEMBER EXPERIENCE

GCHP members engaged in their health care and empowered to take action to live a full life.

Retain Medi-Cal Membership

223,000 – 233,000 Medi-Cal Members for 2026

Accomplishments

- ✓ *Launched the Ventura County Health Care Coalition*
- ✓ *Pathways to Wellness grantees have outreached to more than 9,000 members and supported about 2,000 members in completing renewal applications*
- ✓ *Education & Outreach campaign approved by DHCS; outdoor, print, radio, digital, and social media ads began in April*
- ✓ *Shared member renewal dates by provider system*

Challenges

- *Engaging members to complete the application remains a challenge. Working with the Coalition members to brainstorm how to better support members.*
- *Time it takes to implement*

Improve CAHPS Score for Adult & Child Survey

5 Percentage Points Improvement between Mock Survey 1 Q2 to Mock Survey 2 Q4 for Getting needed care & Getting care quickly

Accomplishments

- ✓ *Mock Survey submitted to DHCS for approval*
- *Looking to include both Medi-Cal & Total Care Advantage lines of business*
- *Tracking of Key Results to begin after survey results in Q2*

Challenges

- *Approval time from DHCS impacts our timeline*
- *Response rate: Partnering with Press Ganey to increase response rate.*

Timeline

2026 Q1	Q2	Q3	Q4	2027 Q1	Q2	Q3	Q4	2028 Q1	Q2	Q3	Q4

Health Care Coalition Launched

Awareness and outreach campaign approved by DHCS

Awareness Elig Changes Toolkits, Texting DHCS Cov Ambassadors & Navigators

Hire Temps

Awareness and outreach campaign begins (outdoor, print, radio, digital, social media ads)

5/1/26
Submit additional outreach materials, call and texting scripts, additional ads to DHCS

1/1/27
New Adult Group Work Requirements, Increased Elig Verifications

Modify Retro Active Coverage during presumptive Elig

Support Members

Collaborate with Partners

3/1/27
6-MONTH Renewals begin in California

10/1/28
Enact cost-sharing for new Adult Group

Broad Messaging

- Billboards
- Bus shelters (Oxnard, Santa Clara Valley, Simi Valley)
- Bus – inside
- DMV
- Digital (websites)
- Newspapers (Vida, El Latino, Santa Paula Times, Fillmore Gazzette)
- Radio
- Social Media

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Advance Quality Goals

Dr. James Cruz, Chief Medical Officer
Kim Timmerman, Executive Director of Quality Improvement

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Advance Quality of Care

Note: See Acronym Glossary on Slide 21

Achieve 70% MCAS Targets for Measurement Year (MY) 2026

8 Measures at the 90th Percentile

Elite Eight: BCS, CCS, GSD, PPC-Pre, PPC-Post, LSC, W30-2+, IMA

- *Key Strategic Interventions*
  - *QIPP / Provider Collaboration*
  - *BCS, CCS, GSD, LSC, IMA (HPV) Member Incentive*
  - *BCS Mobile Mammography*
  - *CCS, W30-2+, PPC-Post Gaps in Care outreach*
  - *GSD Arine Pilot*
  - *PPC-Pre enhance data capture to identify pregnant members*

MY 2026 MCAS Rate Reporting to launch in May 2026

4 Measures at the 75th Percentile

Better Performance: CIS, W30-6+, FUA, CBP

- *Key Strategic Interventions*
  - *QIPP / Provider Collaboration*
  - *CIS Flu Shot Member Incentive*
  - *W30-6+ Gaps in Care outreach and Well Baby Passport (Ventura County Medical Center / Community Memorial Health System)*
  - *FUA Health Navigators in the emergency department*
  - *CBP Wellth Program*

MY 2026 MCAS Rate Reporting to launch in May 2026

8 Measures at the Minimum Performance Level (MPL)

MPL: WCV, TFL, DEV, FUM, DSF, PND, PDS, COL

- *Key Strategic Interventions*
  - *QIPP/Provider Collaboration*
  - *WCV Member Incentive and Gaps in Care outreach*
  - *FUM Health Navigators in ED*
  - *COL partnership with Exact Sciences / Cologuard*
  - *PND & PDS enhance data capture to identify members due for follow-up*

MY 2026 MCAS Rate Reporting to launch in May 2026

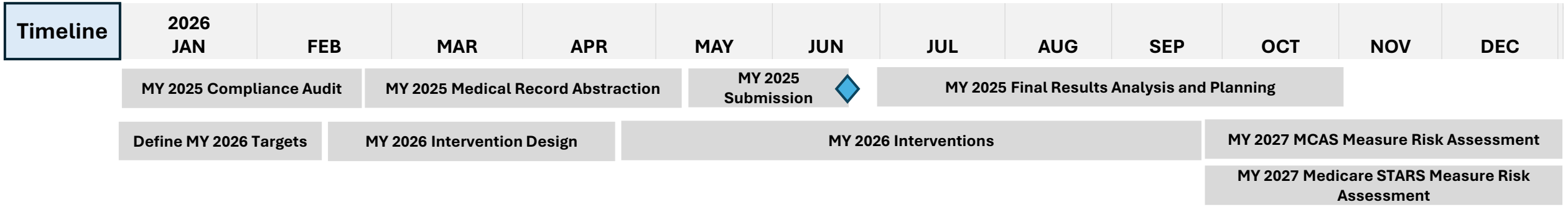
Quality Measures

Our Deliverables

- Complete Measurement Year (MY) 2025 MCAS / Healthcare Effectiveness Data and Information Set (HEDIS) Project
- Successfully Pass MY 2025 HEDIS Compliance Audit
- Define MY 2026 targets
- Design MY 2026 intervention plan
- Implement interventions aimed at meeting MY 2026 targets
- Anticipate and plan for Health Plan Ranking HEDIS Measures
- Assess targets and risks for MY 2027

Expected Business Outcomes

- Achieve MY 2025 MCAS Targets by June 30, 2026
- Achieve MY 2026 MCAS Targets by June 30, 2027
- Prepare for optimal MY 2027 Target achievement



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Total Care Advantage Goals

Eve Gelb, Chief Innovation Officer

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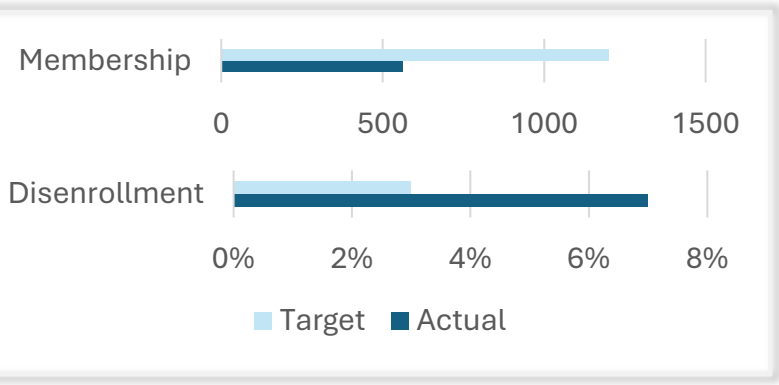
Total Care Advantage

Increase Total Care Advantage Membership

1,200 – 2,500 Total Care Advantage Members by Dec. 31, 2026

- *On track for membership but experiencing larger-than-expected disenrollment*
- *Increasing outreach and clarifying marketing materials to reduce disenrollment*



Optimize Total Care Advantage Provider partnership

65% of members completed Annual Wellness Visit (AWV) in 2026

- *Completed quality coding training for more than 200 clinicians and clinic staff*
- *Providers have built AWV in their electronic health records (EHR)*
- *Live with Inovalon Risk Adjustment module*
- *Next up is developing the AWV reporting*

Metric Reporting will begin at end of April 2026

Achieve Total Care Advantage Quality Targets

80% of Star Measures meeting performance targets for Measurement Year (MY) 2026

- *Developed Star Measure Targets*
- *Live with Inovalon 5-Star module*
- *Next up is developing the 5 Star reporting*

Metric Reporting will begin at end of April 2026

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Total Care Advantage

Meet Financial Target

Less than $11M Loss for Total Care Advantage in 2026

- *Implemented Revenue 360 to reconcile financials to membership*
- *Next up is implementing allocation methodology in new financial tools*
- *Working on 2027 bid*

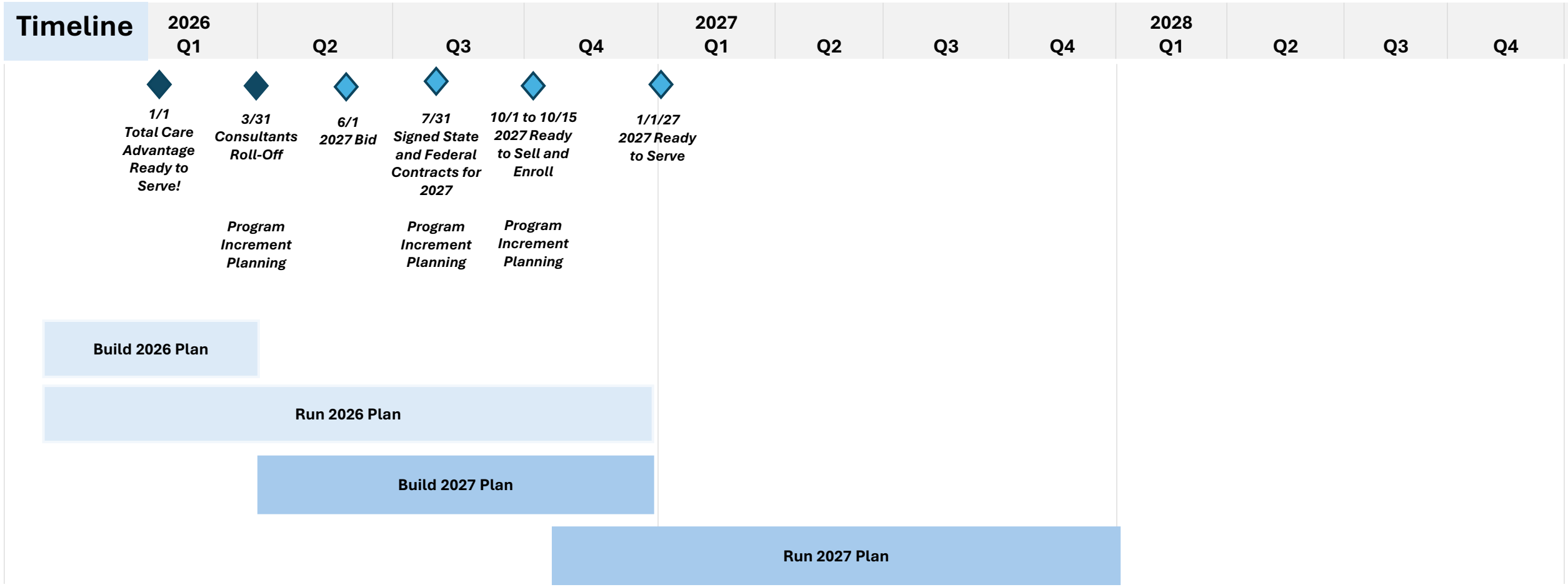
On track year-to-date. See Financials.

Meet Compliance Targets

85% of prioritized Member Impact Compliance Metrics meeting compliance targets for 2026

- *Identified 31 Member Impact Compliance Metrics and have reporting in place for 5 metrics*
- *Next up is developing reporting for remaining metrics*

- ✓ *3 Utilization Management Metrics meeting targets*
- ✓ *1 Care Management Metric meeting targets*
- ✓ *1 Staff Training Metric meeting target*
- *Other Metric Reporting will begin at the end of April 2026*



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Appendix

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Goal	Key Results
1. Retain targeted average Medi-Cal membership	• 223,000 - 233,000 Medi-Cal members for 2026
2. Improve Consumer Assessment of Healthcare Providers and Systems (CAHPS) score for Adult and Child survey	• 5 percentage points improvement between Press Ganey Mock Survey 1 in Q2 to Survey 2 in Q4 - Getting Needed Care questions for Adults and Children - Getting Care Quickly questions for Adults & Children
3. Pay claims correctly the first time, every time. Build the Basics focusing on Timeliness, Accuracy, Compliance and Financials.	• First Pass Claims Accuracy Rate 98% - Controllable Interest Payment Reduction by 50% by 12/31/26 - Controllable Claims Adjustment Rate Reduction Industry Standard 4% - 6% - Reduction in PDR Rate TBD by TBD
	• Retro eligibility transaction processing resolution
	• Maintain Regulatory requirements for average speed of answer <30 secs, Hold times <2 mins
	• Meet regulatory requirement by Q3 2026 - PDR Acknowledgement Letter <15 Business Days - PDR Disposition Letter <45 Business Days
4. Achieve 70% MCAS Targets for Measurement Year (MY) 2026	• 8 Measures at the 90th percentile
	• 4 Measures at the 75th percentile
	• 8 Measures at the minimum performance level (MPL)

Goal	Key Results
5. Increase Total Care Advantage membership	1,200 to 2,500 Total Care Advantage members by 12/31/26 • Monthly Enrollment - 80 members • Monthly Disenrollment – Less than 3%
6. Optimize Total Care Advantage Provider Partnership	65% of members have completed Annual Wellness Visit in 2026 • Q1 – 20% of members complete Annual Wellness Visit • Q2 – 35% of members complete Annual Wellness Visit • Q3 – 50% of members complete Annual Wellness Visit • Q4 – 65% of members complete Annual Wellness Visit
7. Achieve Total Care Advantage Quality Targets	80% of Star Measures meeting performance targets for Measurement Year 2026 • Specific Star Measure Targets set by 4/1/26 • Star Measure Performance Reporting in place by 5/1/26

Goal	Key Results
8. Meet Financial Targets	• **Medi-Cal** 3.4% Operating Margin
	• **Total Care Advantage** Less than $11M Loss for 2026 • Less than $916,000 loss per month
9. Meet Compliance Targets	• **Medi-Cal** 90% Compliance Member Impact compliance metrics by Q4 (e.g., Call Center Stats, ID Card Mailings, CoC turnaround times, etc.)

	• **Total Care Advantage** 85% of prioritized Member Impact compliance metrics meeting compliance targets for 2026
	  • Compliance metrics and reporting in place and prioritized Member Impact compliance metrics identified by 4/1/2026
	  • Q2 – 80% of prioritized Member Impact compliance metrics meet targets
	  • Q3 – 85% of prioritized Member Impact compliance metrics meet targets
	  • Q4 – 90% of prioritized Member Impact compliance metrics meet targets

10. Transform Our Culture	• Culture Pulse survey in November • Feedback focused on manager goal of 3-2-1 with a positive score of 80% or higher by December 2026

Acronym Glossary (for slide 11)

BCS	**Breast Cancer Screening**	**LSC**	**Lead Screening in Children**
CBP	Controlling High Blood Pressure	**PDS**	Postpartum Depression Screening and Follow-Up
CCS	Cervical Cancer Screening	**PND**	Prenatal Depression Screening and Follow-Up
CIS	Childhood Immunization Status	**PPC-Pre**	Prenatal Care
COL	Colorectal Cancer Screening	**PPC-Post**	Postpartum Care
DEV	Developmental Screening in the First Three Years of Life	**TFL**	Topical Fluoride for Children
DSP		**QIPP**	Quality Incentive Pool & Program
FUA	Follow-Up After Emergency Department Visit for Substance Use	**W30-2+**	Well-Child Visits in the First 30 Months of Life
FUM	Follow-Up After Emergency Department Visit for Mental Illness	**W30-6+**	Well-Child Visits in the First 30 Months of Life
GSD	Glycemic Status Assessment for Patients with Diabetes	**WCV**	Child and Adolescent Well-Care Visits
IMA	Immunizations for Adolescents		

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AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: April 27, 2026

SUBJECT: Election of Chairperson and Vice-Chairperson to serve two-year terms and appointments to the Executive/Finance Committee

SUMMARY:

Pursuant to the bylaws, the Commission must elect from its membership a Chairperson and a Vice-Chairperson to serve two-year terms the first meeting after the County of Ventura makes appointments and reappointments to the Commission. This is the meeting to have the election. The Chairperson and Vice-Chairperson of the Commission also both serve on the five-person Executive/Finance Committee. Once these officers are elected, the Commission will need to make appointments to fill the balance of the Executive/Finance Committee, also in accordance with the bylaws.

BACKGROUND/DISCUSSION:

The Commission's bylaws require that the Chairperson and Vice-Chairperson be elected to a two-year term by a majority vote of its members, and that no individual may serve more than two consecutive terms in either position. (See Bylaws, Art. III). The bylaws also provide that the Vice Chairperson will become the Chairperson if the position of Chairperson is vacant. The current Chairperson Laura Espinoza is eligible to serve another term as she has served only one two-year term. Vice-Chairperson Dee Pupa is retiring and thus leaving the Commission to the Vice Chair seat is open to any Commissioner.

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's absence and performing such other responsibilities as agreed upon with the Chairperson. The bylaws do not contain any specific nominating process; Staff recommends that the Commission nominate a Commissioner for Chairperson and then vote to approve that appointment as set forth in the bylaws. The Commission should then nominate a Commissioner for the Vice Chairperson position and, once all names are nominated, a vote should be taken. No second is necessary for a nomination.

The bylaws also establish the five-person Executive/Finance Committee. The Executive/Finance Committee consists of the Commission Chairperson, Vice-Chairperson, and three other Commission members. The bylaws also provide that the Executive/Finance Committee must have at least one member from the following represented groups: a private hospital/healthcare representative, a Ventura County Medical Health System representative, and a Clinicas Del Camino Real representative. (See Bylaws, Art. IV, section (b)(ii).) If the Chairperson and/or Vice-Chairperson is a representative from one of these agencies, then the Commission "may appoint any one of its members to fill" the remaining open Committee positions. (See Bylaws, Art. IV, section (b)(ii).) Appointments to the Executive/Finance Committee must be made at either the regular meeting in which the Chairperson and Vice-Chairperson are elected, or at the next regular meeting thereafter. Elections for the Executive/Finance Committees should be held after the election of the Chairperson or Vice-Chairperson.

The Executive/Finance Committee is an advisory committee to the Commission and reviews key contracts and initiatives, serves as the interview committee for certain executive positions and make recommendations to the Commission on various matters, including the budget.

FISCAL IMPACT:

None.

RECOMMENDATION:

1. Elect a Commissioner to serve as Chairperson for a two-year term.
2. Elect a Commissioner to serve as Vice-Chairperson for a two-year term.
3. Make any necessary appointments to the Executive/Finance Committee as follows:
   a. Chairperson (same as Commission Chairperson).
   b. Vice-Chairperson (same as Commission Vice-Chairperson)
   c. Private Hospital Healthcare Representative (if required).
   d. Ventura County Medical Health System Representative (if required).
   e. Clinicas Del Camino Real Representative (if required).

CONCURRENCE:

N/A.

ATTACHMENT:

Gold Coast Health Plan Bylaws

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

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

Approved: October 24, 2011
Amended: April 25, 2022

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

ARTICLE I

Name and Mission

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

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

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

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

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

(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 (12) voting members. It is desirable that members of the VCMMCC possess skills and knowledge necessary in the design and operation of 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. Two members shall be practicing physicians who serve a significant number of Medi-Cal beneficiaries in Ventura County. One shall be nominated by the Ventura County Medical Association, and one shall be nominated 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 nominated 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 nominated by the Ventura County Medical Center System 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 Representatives. Two members shall be representatives of Clinicas del Camino Real nominated by the Clinicas del Camino Real Chief Executive Officer.

(f) Ventura County Health Care Agency Representative. One member shall be the Ventura County Health Care Agency Director or designee nominated by the Health Care Agency Director.

(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) County of Ventura Representative. 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.

Selection and Terms of Commissioners

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

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

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

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

ARTICLE III

Officers

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

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

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

Election

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

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

(c) The Vice-Chair shall automatically become Chair when the position of Chair becomes available, if the Vice Chair is still one of the Commissioners.

(d) Notwithstanding the normal election process detailed in paragraphs (a),(b) and (c) 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.
3. Amended Bylaws - GCHP

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). If the Chairperson and/or Vice-Chairperson is a private hospital/healthcare system representative, then the Commission may appoint any one of its members to fill this position.

4. Ventura County Medical Center Health System representative. If the Chairperson and/or Vice-Chairperson is a Ventura County Medical Center Health System representative, then the Commission may appoint any one of its members to fill this position.

5. Clinicas Del Camino Real representative. If the Chairperson and/or Vice-Chairperson is a Clinicas Del Camino Real representative, then the Commission may appoint any one of its members to fill this position.

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

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

iii. Duties of the Executive/Finance Committee.

1. Advise the governing board Chairperson on requested matters.

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

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

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

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

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

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

   - PCP
   - Specialists
   - Hospitals o LTC
   - Ancillary Providers

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

9. Review and recommend provider incentive program structure.

10. Review investment strategy and make recommendations.

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

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

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

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

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

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

1. Adopting, amending or repealing any bylaw.

2. Making final determinations of policy.

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

4. Filling vacancies or removing any Commissioner.

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

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

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

ARTICLE V

Special Committees

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

ARTICLE VI

Meetings

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

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

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

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

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

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

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

Conduct of Meetings

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

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

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

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

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

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

(g) Where these Bylaws do not afford an adequate procedure in the conduct of a meeting, the Chairperson may defer to the most current edition of *Rosenberg'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.

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: April 27, 2026

SUBJECT: Compliance Oversight Committee Appointments

SUMMARY:

As part of the Corporate Integrity Agreement, the Ventura County Medi-Cal Managed Care Commission (Commission), dba Gold Coast Health Plan (GCHP) has established a Compliance Oversight Committee (Committee) with four members of the Commission. As former Commissioner Jim Corwin served on the Committee, and Dee Pupa will be leaving the Commission after this meeting due to her retirement, the Commission needs to appoint at least one Commissioner to the Committee.

RECOMMENDATION:

Staff requests that the Commission determine how it wants to fill the vacancies in the Compliance Oversight Committee, caused by the termination of former Commissioner Jim Corwin's service on the Commission and Vice Chair Pupa's retirement. The Committee meets quarterly, usually an hour before a Commission meeting, and provides general oversight of GCHP compliance functions and the Corporate Compliance Agreement in particular. A copy of the Corporate Compliance Agreement is attached.

The current remaining members of the Committee are Commissioners Lopez and Espinosa. At least one more Commissioner needs to be appointed but the Commission may add a fourth which will allow more flexibility in scheduling meetings if a Commissioner cannot make a meeting.

Staff requests that the Commission appoint at least one Commissioner to the Committee and determine if it wants to add a fourth member to the Committee and if so, appoint such a member.

ATTACHMENT:

OFFICE OF INSPECTOR GENERAL CORPORATE COMPLIANCE AGREEMENT

CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION

I. PREAMBLE

Ventura County Medi-Cal Managed Care Commission d/b/a Gold Coast Health Plan ("Gold Coast") hereby enters into this Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) to promote compliance with the statutes, regulations, and written directives of Medicaid and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) (Federal health care program requirements). Contemporaneously with this CIA, Gold Coast is entering into a Settlement Agreement with the United States.

II. EFFECTIVE DATE, TERM, AND DEFINITIONS

A. Effective Date. The "Effective Date" of this CIA shall be the signature date of the final signatory to this CIA.

B. Term. The term of this CIA shall be five years from the Effective Date, except that Sections VII and X shall continue for 120 days after OIG's receipt of: (1) Gold Coast's final Annual Report or (2) any additional documentation relating to the final Annual Report requested by OIG, whichever is later. In addition, if OIG issues a Stipulated Penalties Demand Letter pursuant to Section X.C.1 or a Notice of Material Breach and Intent to Exclude pursuant to Section X.E.2 prior to the expiration of the 120 day period, then Section X shall remain in effect until the Stipulated Penalties Review described in Section X.E.2 or the Exclusion Review described in Section X.E.3 is completed, and Gold Coast complies with the decision.

C. Definitions.

1. "Arrangements" means:

a. every arrangement or transaction that involves, directly or indirectly, the offer, payment, solicitation, or receipt of anything of value and is between Gold Coast and (i) any actual or potential source of health care business or referrals to Gold Coast or (ii) any actual or potential recipient of health care business or referrals from Gold Coast.

i. "Source of health care business or referrals" means any individual or entity that refers, recommends, arranges for,

orders, leases, or purchases any good, facility, item, or service for which payment may be made in whole or in part by a Federal health care program.

ii. "Recipient of health care business or referrals" means any individual or entity (a) to whom Gold Coast refers an individual for the furnishing or arranging for the furnishing of any item or service, or (b) from whom Gold Coast purchases, leases or orders or arranges for or recommends the purchasing, leasing, or ordering of any good, facility, item, or service, for which payment may be made in whole or in part by a Federal health care program.

2. "Certifying Employees" means the following: Chief Executive Officer, Chief Financial Officer, Chief Compliance Officer, and Chief Medical Officer, and Chief Operating Officer.[1]

3. "Covered Persons" means: (a) all owners who are natural persons, officers, board members, and employees of Gold Coast; and (b) all contractors who furnish patient care items or services or perform billing, coding, and state Medicaid rate development or reporting functions on behalf of Gold Coast, but excluding healthcare providers or suppliers contracted by Gold Coast for the delivery of Medicaid services as part of Gold Coast's network subject to the standards at 42 C.F.R. § 438.68.

4. "Disclosure Program" means a program that enables individuals to disclose to the Compliance Officer or some other person who is not in the disclosing individual's chain of command any potential violations of criminal, civil, or administrative law related to the Federal health care programs or any issues or questions associated with Gold Coast's policies, conduct, practices, or procedures.

5. "Exclusion Lists" means the HHS/OIG List of Excluded Individuals/Entities (LEIE) (available at http://www.oig.hhs.gov) and state Medicaid program exclusion lists that are publicly available.

6. "Ineligible Person" means an individual or entity who: (a) is currently excluded from participation in any Federal health care program or (b) has been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a) (mandatory exclusion) but has not yet been excluded from participation in any Federal health care program.

7. "Overpayment" means any funds that Gold Coast receives or retains under any Federal health care program to which Gold Coast, after applicable reconciliation, is not entitled under such Federal health care program.

8. "Reportable Event" means: (a) a substantial Overpayment; (b) a matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which criminal penalties or civil monetary penalties under Section 1128A or 1128B of the Social Security Act (the "Act") or exclusion under Section 1128 of the Act may be authorized; (c) the employment of or contracting with a Covered Person who is an Ineligible Person; or (d) the filing of a bankruptcy petition by Gold Coast.

9. "Reporting Period" means each one-year period during the term of this CIA, beginning with the one-year period following the Effective Date.

10. "Training Plan" means a written plan that outlines the steps Gold Coast will take to ensure that Covered Persons receive training on a periodic basis during the term of the CIA regarding Gold Coast's CIA requirements and compliance program and the applicable Federal health care program requirements, including the requirements of 42 U.S.C. § 1320a-7b(b) (the Anti-Kickback Statute).

11. "Transition Plan" means a plan to address whether and how Gold Coast's compliance program will continue to include the compliance program requirements set forth in Section III of the CIA, following the end of the CIA's term.

III. COMPLIANCE PROGRAM REQUIREMENTS

Gold Coast shall establish and maintain a compliance program that includes the following elements:

A. Compliance Officer, Compliance Committee, Board Oversight, and Management Certifications.

1. *Compliance Officer*. Within 90 days after the Effective Date, Gold Coast shall appoint a Compliance Officer who is an employee and a member of senior management of Gold Coast. The Compliance Officer shall report directly to the Chief Executive Officer of Gold Coast and shall not be or be subordinate to the General Counsel or Chief Financial Officer or have any responsibilities that involve acting in any capacity as legal counsel or supervising legal counsel functions for Gold Coast. The Compliance Officer shall be authorized to report to the Governing Board of Gold Coast (Board) regarding compliance matters at any time. The Compliance Officer shall be responsible for, without limitation:

a. developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and with Federal health care program requirements;

b. making at least quarterly reports regarding compliance matters to the Board;

c. monitoring the day-to-day compliance activities engaged in by Gold Coast; and

d. all reporting requirements of this CIA.

The Compliance Officer shall not have any noncompliance job responsibilities that, in OIG's discretion, may interfere or conflict with the Compliance Officer's ability to perform the duties outlined in this CIA.

Gold Coast shall report to OIG, in writing, any changes in the identity, duties, or job responsibilities of the Compliance Officer within five business days after such a change.

2. *Compliance Committee*. Within 90 days after the Effective Date, Gold Coast shall appoint a Compliance Committee that is chaired by the Compliance Officer. The Compliance Committee shall include, at a minimum, the members of senior management necessary to meet the requirements of this CIA. The Compliance Committee shall be responsible for, among other things, reviewing the policies and procedures required by Section III.B below at least annually, reviewing the training required by Section III.C below at least annually, implementation and oversight of the risk assessment and internal review process required by Section III.E below, and the development and implementation of the Transition Plan required by Section III.J below. The Compliance Committee shall meet at least quarterly.

Gold Coast shall report to OIG, in writing, any changes to the membership of the Compliance Committee within 15 business days after such a change.

3. *Board Oversight.* The Board (or the Reimbursement Compliance Committee of the Board ("Board Committee") shall be responsible for the review and oversight of Gold Coast's compliance with Federal health care program requirements and the requirements of this CIA. The Board must include independent (i.e., non-employee and non-executive) members.

The Board shall, at a minimum, be responsible for the following:

a. meeting at least quarterly to review and oversee Gold Coast's compliance program, including but not limited to the performance of the Compliance Officer and Compliance Committee;

b. submitting to OIG a description of the materials it reviewed and any additional steps taken, such as the engagement of an independent advisor or other third-party resources, in its oversight of the compliance program and in support of making the resolution below during each Reporting Period; and

c. for each Reporting Period of the CIA, adopting a resolution approved by each member of the Board regarding its review and

oversight of Gold Coast's compliance with Federal health care program requirements and the requirements of this CIA.

At minimum, the resolution shall include the following language:

> "The Board has made a reasonable inquiry into the operations of Gold Coast's compliance program, including the performance of the Compliance Officer and the Compliance Committee. Based on its inquiry and review, the Board has concluded that, to the best of its knowledge, Gold Coast has implemented an effective compliance program to meet Federal health care program requirements and the requirements of Gold Coast's Corporate Integrity Agreement with the Office of Inspector General of the Department of Health and Human Services."

If the Board is unable to adopt such a resolution, the Board shall provide a written explanation of the reasons why it is unable to adopt the resolution and the steps the Board is taking to implement an effective compliance program at Gold Coast.

Gold Coast shall report to OIG, in writing, any changes in the membership of the Board, within 15 business days after such a change.

4. *Management Certifications.* The Certifying Employees shall monitor compliance within the divisions or departments for which they are responsible and annually certify that the applicable Gold Coast division or department is in compliance with applicable Federal health care program requirements and the requirements of this CIA. For each Reporting Period, each Certifying Employee shall certify as follows:

> "I have been trained on and understand the compliance requirements and responsibilities as they relate to [insert name of division or department], an area under my supervision. My job responsibilities include ensuring [insert name of division or department]'s compliance with all applicable Federal health care program requirements, requirements of the Corporate Integrity Agreement, and Gold Coast's policies and procedures. To the best of my knowledge, the [insert name of division or department] is in compliance with all applicable Federal health care program requirements and the requirements of the Corporate Integrity Agreement. I understand that this certification is being provided to and relied upon by the United States."

If any Certifying Employee is unable to provide this certification, the Certifying Employee shall provide a written explanation of the reasons why he or she is unable to provide the certification.

Within 90 days after the Effective Date, Gold Coast shall develop and implement a written process for Certifying Employees to follow for the purpose of completing the certification required by this section (e.g., reports that must be reviewed, assessments that must be completed, sub-certifications that must be obtained, etc. prior to the Certifying Employee making the required certification).

B. Written Standards. Within 90 days after the Effective Date, Gold Coast shall develop and implement written policies and procedures (Policies and Procedures) that address the following: (1) the operation of Gold Coast's compliance program, including the compliance program requirements outlined in this CIA; (2) Gold Coast's compliance with Federal health care program requirements, including but not limited to compliance with the Anti-Kickback Statute, and the regulations and other guidance documents related to these statutes; (3) a written review and approval process for Arrangements, the purpose of which is to ensure that all Arrangements do not violate the Anti-Kickback Statute; and (4) the identification, quantification, and repayment of Overpayments. Gold Coast shall enforce its Policies and Procedures and make compliance with its Policies and Procedures an element of evaluating the performance of all Covered Persons. The Policies and Procedures shall be made available to all Covered Persons.

The Compliance Committee shall review the Policies and Procedures at least annually and update the Policies and Procedures as necessary. Any new or revised Policies and Procedures shall be made available to all Covered Persons. All Policies and Procedures shall be made available to OIG upon request.

C. Training and Education.

1. *Covered Persons Training.* Within 90 days after the Effective Date, Gold Coast shall develop a Training Plan that includes the following information: (a) training topics: (b) categories of Covered Persons required to attend each training session; (c) length of the training session(s); (d) schedule for training; and (e) format of the training. The Compliance Committee shall review the Training Plan at least annually and update the Training Plan as necessary.

2. *Board Training*. Within 90days after the Effective Date, members of the Board shall receive training regarding their responsibilities for corporate governance and review and oversight of the compliance program. The training shall address the specific responsibilities of health care board members, including the risks, oversight areas, and approaches to conducting effective oversight of a health care entity and shall include a discussion of the OIG's guidance on board member responsibilities. Each member of the Board also shall receive the training described in Section III.C.1.

New members of the Board shall receive the training described in this Section III.C.2 within 30 days after becoming a member or within 90 days after the Effective Date, whichever is later. The Compliance Committee shall review the Board training at least annually and update the Board training as necessary.

3. *Training Records*. Gold Coast shall make available to OIG, upon request, training materials and records verifying that the training described in Sections III.C.1 and III.C.2 has been provided.

D. Review Procedures.

1. *General Description.*

a. *Engagement of Independent Review Organization*. Within 90 days after the Effective Date, Gold Coast shall engage an entity (the "Independent Review Organization" or "IRO") that meets the qualifications and requirements outlined in Appendix A to this CIA, which is incorporated by reference, to perform the reviews described in this Section III.D.

b. *Retention of Records*. The IRO and Gold Coast shall retain and make available to OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports exchanged between the IRO and Gold Coast related to the reviews described in this Section III.D.

c. *Access to Records and Personnel.* Gold Coast shall ensure that the IRO has access to all records and personnel necessary to complete the reviews listed in this Section III.D and that all records furnished to the IRO are accurate and complete.

2. *Medical Loss Ratio (MLR) Element Review.* The IRO shall review a MLR Numerator Element to determine whether Gold Coast's calculation and reporting of the selected element was accurate, supported by underlying documentation, consistent with generally accepted accounting principles, and otherwise complied with the terms of its contract with the California Department of Health Care Services (DHCS) and the applicable Medicaid laws, regulations, and guidance and shall prepare a Review Report, as outlined in Appendix B to this CIA, which is incorporated by reference.

3. *Independence and Objectivity Certification*. The IRO shall include in its report(s) to Gold Coast a certification that the IRO has (a) evaluated its professional independence and objectivity with respect to the reviews required under this Section III.D and (b) concluded that it is, in fact, independent and objective, in accordance with the requirements specified in Appendix A to this CIA. The IRO's certification shall include a summary of all current and prior engagements between Gold Coast and the IRO.

E. Risk Assessment and Internal Review Process. Within 90 days after the Effective Date, Gold Coast shall develop and implement a centralized annual risk assessment and internal review process to identify and address risks associated with Gold Coast's participation in the Federal health care programs, including but not limited to the risks associated with the submission of claims for items and services furnished to Medicaid program beneficiaries and the Anti-Kickback Statute risks associated with Arrangements. The Compliance Committee shall be responsible for implementation and oversight of the risk assessment and internal review process. The risk assessment and internal review process shall be conducted at least annually and shall require Gold Coast to: (1) identify and prioritize risks, (2) develop work plans or audit plans (as

appropriate) related to the identified risk areas, (3) implement the work plans and audit plans, (4) develop corrective action plans in response to the results of any internal audits performed, and (5) track the implementation of the work plans and any corrective action plans and assess the effectiveness of such plans.

F. Disclosure Program. Within 90 days after the Effective Date, Gold Coast shall establish a Disclosure Program. Gold Coast shall appropriately publicize the existence of the Disclosure Program (e.g., via periodic e-mails to employees or by posting the information in prominent common areas). The Disclosure Program shall include a reporting mechanism for anonymous communications for which appropriate confidentiality shall be maintained. The Disclosure Program shall prohibit retaliation against Covered Persons relating to use of the Disclosure Program and Gold Coast shall not retaliate against Covered Persons for use of the Disclosure Program. The Compliance Officer (or designee) shall conduct a review of each disclosure received through the Disclosure Program, including gathering all relevant information from the disclosing individual, and ensure that appropriate follow-up is conducted.

The Compliance Officer (or designee) shall record all disclosures (whether or not related to a potential violation of criminal, civil, or administrative law related to the Federal health care programs) in a written disclosure log within two business days of receipt of the disclosure. The disclosure log shall include the following information: (1) a summary of each disclosure received (whether anonymous or not), (2) the date the disclosure was received, (3) the individual or department responsible for reviewing the disclosure, (4) the status of the review, (5) any corrective action taken in response to the review, and (6) the date the disclosure was resolved.

G. Ineligible Persons.

1. *Screening Requirements.* Gold Coast shall:

a. screen all prospective Covered Persons against the Exclusion Lists prior to engaging their services and, as part of the hiring or contracting process shall require such Covered Persons to disclose whether they are Ineligible Persons;

b. screen all current Covered Persons against the Exclusion Lists within 90 days after the Effective Date and on a monthly basis thereafter; and

c. require all Covered Persons to disclose immediately to the Compliance Officer (or designee) if they become an Ineligible Person.

2. *Removal Requirement*. If Gold Coast has actual notice that a Covered Person has become an Ineligible Person, Gold Coast shall remove such Covered Person from any position for which the Covered Person's compensation or the items or services furnished, ordered, or prescribed by the Covered Person are paid for in whole or part, directly or indirectly, by any Federal health care program(s) from which the Covered Person has been excluded, at

least until such time as the Covered Person is reinstated into participation in such Federal health care program(s). Items or services furnished, ordered, or prescribed by excluded persons are not payable by Federal health care programs and Gold Coast may be liable for overpayments and/or criminal, civil, and administrative sanctions for employing or contracting with an excluded person regardless of whether Gold Coast meets the requirements of Section III.G.

H. Notification of Government Investigation or Legal Proceeding. Gold Coast shall notify OIG, in writing, of any ongoing investigation or legal proceeding by a governmental entity or its agents involving an allegation that Gold Coast has committed a crime or has engaged in fraudulent activities, within 30 days of Gold Coast receiving notice of such investigation or legal proceeding. This notification shall include a description of the allegation(s), the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. Within 30 days after resolution of the matter, Gold Coast shall notify OIG, in writing, of the resolution of the investigation or legal proceeding.

I. Reportable Events. Gold Coast shall notify OIG, in writing, within 30 days after determining that a Reportable Event exists, as follows:

1. *Substantial Overpayment.* The report to OIG shall include:

   a. a complete description of all details relevant to the Reportable Event, including, at a minimum, the types of claims, transactions, or other conduct giving rise to the Reportable Event; the period during which the conduct occurred; and the names of individuals and entities believed to be implicated, including an explanation of their roles in the Reportable Event;

   b. the Federal health care programs affected by the Reportable Event;

   c. a description of the steps taken by Gold Coast to identify and quantify the Overpayment; and

   d. a description of Gold Coast's actions taken to correct the Reportable Event and prevent it from recurring.

Within 60 days of identification of the substantial Overpayment, Gold Coast shall repay the Overpayment, in accordance with the requirements of 42 U.S.C. § 1320a-7k(d) and any applicable regulations and Centers for Medicare and Medicaid Services (CMS) guidance, and provide OIG with documentation of the repayment.

2. *Probable Violation of Law.* The report to OIG shall include:

   a. a complete description of all details relevant to the Reportable Event, including, at a minimum, the types of claims, transactions or other conduct giving rise to the Reportable Event; the period during which the conduct occurred; and the names of individuals

and entities believed to be implicated, including an explanation of their roles in the Reportable Event;

b. a statement of the Federal criminal, civil or administrative laws that are probably violated by the Reportable Event;

c. the Federal health care programs affected by the Reportable Event;

d. a description of the steps taken by Gold Coast to identify and quantify any Overpayments; and

e. a description of Gold Coast's actions taken to correct the Reportable Event and prevent it from recurring.

If the Reportable Event involves an Overpayment, within 60 days of identification of the Overpayment, Gold Coast shall repay the Overpayment, in accordance with the requirements of 42 U.S.C. § 1320a-7k(d) and any applicable regulations and CMS guidance, and provide OIG with documentation of the repayment.

3. *Ineligible Person.* The report to OIG shall include:

a. the identity of the Ineligible Person and the job duties performed by that individual;

b. the dates of the Ineligible Person's employment or contractual relationship;

c. a description of the Exclusion Lists screening that Gold Coast completed before and/or during the Ineligible Person's employment or contract and any flaw or breakdown in the screening process that led to the hiring or contracting with the Ineligible Person;

d. a description of how the Ineligible Person was identified; and

e. a description of any corrective action implemented to prevent future employment or contracting with an Ineligible Person.

4. *Bankruptcy.* The report to OIG shall include documentation of the bankruptcy filing and a description of any Federal health care program requirements implicated.

J. Transition Plan. Prior to the end of the fourth Reporting Period, Gold Coast shall develop a Transition Plan that is reviewed and approved by the Board. The Transition Plan shall be implemented following the end of the CIA's term. A copy of Gold Coast's approved Transition Plan shall be included in Gold Coast's fourth Annual Report.

IV. SUCCESSOR LIABILITY

If, after the Effective Date, Gold Coast proposes to (a) sell any or all of its business, business units, or locations (whether through a sale of assets, sale of stock, or other type of transaction) relating to the furnishing of items or services that may be reimbursed by a Federal health care program; or (b) purchase or establish a new business, business unit, or location relating to the furnishing of items or services that may be reimbursed by a Federal health care program, the CIA shall be binding on the purchaser of any business, business unit, or location and any new business, business unit, or location (and all Covered Persons at each new business, business unit, or location) shall be subject to the requirements of this CIA, unless otherwise determined and agreed to in writing by OIG. Gold Coast shall notify OIG, in writing, of such sale or purchase within 30 days following the closing of the transaction and shall notify OIG, in writing, within 30 days of establishing such new business, business unit, or location.

If Gold Coast wishes to obtain a determination by OIG that a proposed purchaser or proposed acquisition will not be subject to the CIA requirements, Gold Coast must notify OIG in writing at least 30 days in advance of the proposed sale or purchase. This notification shall include a description of the business, business unit, or location to be sold or purchased, a brief description of the terms of the transaction and, in the case of a proposed sale, the name and contact information of the prospective purchaser.

V. IMPLEMENTATION REPORT AND ANNUAL REPORTS

A. Implementation Report. Within 120 days after the Effective Date, Gold Coast shall submit a written report (Implementation Report) to OIG that includes, at a minimum, the following information:

1. the name, business address, business phone number, and position description of the Compliance Officer required by Section III.A.1, and a detailed description of any noncompliance job responsibilities;

2. the names and positions of the members of the Compliance Committee required by Section III.A.2;

3. the names of the Board members who are responsible for satisfying the Board compliance requirements described in Section III.A.3;

4. the names and positions of the Certifying Employees required by Section III.A.4 and a copy of the written process for Certifying Employees to follow in order to complete the certification required by Section III.A.4;

5. a list of the Policies and Procedures required by Section III.B;

6. the Training Plan required by Section III.C.1 and a description of the Board training required by Section III.C.2 (including a summary of the topics covered, the length of the training, and when the training was provided);

7. the following information regarding the IRO(s): (a) identity, address, and phone number; (b) a copy of the engagement letter; (c) information to demonstrate that the IRO has the qualifications outlined in Appendix A to this CIA; and (d) a certification from the IRO regarding its professional independence and objectivity with respect to Gold Coast that includes a summary of all current and prior engagements between Gold Coast and the IRO;

8. a description of the risk assessment and internal review process required by Section III.E;

9. a description of the Disclosure Program required by Section III.F;

10. a description of the Ineligible Persons screening and removal process required by Section III.G;

11. a description of Gold Coast's corporate structure, including identification of any parent and sister companies, subsidiaries, and their respective lines of business;

12. a list of all of Gold Coast's locations (including mailing addresses), the corresponding name under which each location is doing business; and

13. a certification by the Compliance Officer and Chief Executive Officer that:

a. to the best of his or her knowledge, except as otherwise described in the report, Gold Coast has implemented and is in compliance with all of the requirements of this CIA;

b. he or she has reviewed the report and has made reasonable inquiry regarding its content and believes that the information in the report is accurate and truthful; and

c. he or she understands that the certification is being provided to and relied upon by the United States.

B. Annual Reports. Gold Coast shall submit to OIG a written report (Annual Report) for each of the five Reporting Periods that includes, at a minimum, the following information:

1. any change in the identity, position description, or noncompliance job responsibilities of the Compliance Officer; a current list of the Compliance Committee members, a current list of the Board members who are responsible for satisfying the Board compliance requirements, and a current list of the Certifying Employees, along with the identification of any

changes made during the Reporting Period to the Compliance Committee, Board, or Certifying Employees;

2. the dates of each meeting of the Compliance Committee (copies of the meeting minutes shall be made available to OIG upon request);

3. the dates of each report made by the Compliance Officer to the Board (written documentation of such reports shall be made available to OIG upon request);

4. the Board resolution required by Section III.A.3 and a description of the materials reviewed by the Board and any additional steps taken in its oversight of the compliance program and in support of making the resolution;

5. a description of any changes to the written process for Certifying Employees to follow in order to complete the certification required by Section III.A.4;

6. the certifications of Certifying Employees required by Section III.A.4;

7. a list of any new or revised Policies and Procedures required by Section III.B. developed during the Reporting Period;

8. a description of any changes to the Training Plan required by Section III.C, and a summary of all training furnished to Covered Persons and Board members during the Reporting Period;

9. a complete copy of all reports prepared pursuant to Section III.D and Gold Coast's response to the reports, along with corrective action plan(s) related to any issues raised by the report, and documentation of Gold Coast's refund of the Estimated Overpayment (as defined in Appendix B to this CIA);

10. a certification from the IRO regarding its professional independence and objectivity with respect to Gold Coast, including a summary of all current and prior engagements between Gold Coast and the IRO;

11. a description of any changes to the risk assessment and internal review process required by Section III.E, including the reason(s) for such changes;

12. a summary of the following components of the risk assessment and internal review process during the Reporting Period: (a) risk areas identified, (b) work plans and internal audit plans developed, (c) internal audits performed, (d) corrective action plans developed in response to internal audits, and (e) steps taken to track the implementation of the work plans and corrective action plans. Copies of any work plans, internal audit reports, and corrective action plans shall be made available to OIG upon request;

13. a summary of the disclosures in the disclosure log required by Section III.F that relate to Federal health care programs, including at least the following information: (a)

a description of the disclosure, (b) the date the disclosure was received, (c) the resolution of the disclosure, and (d) the date the disclosure was resolved. The complete disclosure log shall be made available to OIG upon request;

14. a description of any changes to the Ineligible Persons screening and removal process required by Section III.G, including the reason(s) for such changes;

15. a summary of any ongoing investigation or legal proceeding required to have been reported pursuant to Section III.H that includes a description of the allegation(s), the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding;

16. a summary of all Reportable Events required to have been reported pursuant to Section III.I during the Reporting Period;

17. (in the fourth Annual Report), a copy of the Transition Plan required by Section III.J;

18. a summary of any audits conducted during the applicable Reporting Period by any state Medicaid program contractor or any government entity or contractor, involving a review of Federal health care program claims, and Gold Coast's response and corrective action plan (including information regarding any Federal health care program refunds) relating to the audit findings;

19. a description of all changes to the most recently provided list of Gold Coast's locations (including addresses) as required by Section V.A.12;

20. a description of any changes to Gold Coast's corporate structure, including any parent and sister companies, subsidiaries, and their respective lines of business; and

21. a certification by the Compliance Officer and Chief Executive Officer that:

a. to the best of his or her knowledge, except as otherwise described in the report, Gold Coast has implemented and is in compliance with all of the requirements of this CIA;

b. he or she has reviewed the report and has made reasonable inquiry regarding its content and believes that the information in the report is accurate and truthful; and

c. he or she understands that the certification is being provided to and relied upon by the United States.

The first Annual Report shall be received by OIG no later than 60 days after the end of the first Reporting Period. Subsequent Annual Reports shall be received by OIG no later than the anniversary date of the due date of the first Annual Report.

C. Designation of Information. Gold Coast shall clearly identify any portions of its submissions that it believes are trade secrets, or information that is commercial or financial and privileged or confidential, and therefore potentially exempt from disclosure under the Freedom of Information Act (FOIA), 5 U.S.C. § 552. Gold Coast shall refrain from identifying any information as exempt from disclosure if that information does not meet the criteria for exemption from disclosure under FOIA.

VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

All notifications and reports required under this CIA shall be submitted using the following contact information:

OIG:

Administrative and Civil Remedies Branch
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, S.W.
Washington, DC 20201
Telephone: 202.619.2078
Email Address: officeofcounsel@oig.hhs.gov

Gold Coast:

Richard Egger
Best Best & Krieger, LLP
2855 E. Guasti Rd.,
Suite 400
Ontario, CA 91761
(909) 466-4915
Richard.egger@bbklaw.com

Unless otherwise requested by OIG, all notifications and reports required by this CIA shall be submitted electronically. OIG shall notify Gold Coast in writing of any changes to the OIG contact information listed above. Gold Coast shall notify OIG in writing within two business days of any changes to the Gold Coast contact information listed above.

VII. OIG INSPECTION, AUDIT, AND REVIEW RIGHTS

In addition to any other rights OIG may have by statute, regulation, or contract, OIG or its duly authorized representative(s) may conduct interviews, examine and/or request copies of or copy Gold Coast's books, records, and other documents and supporting materials, and conduct on-site reviews of any of Gold Coast's locations, for the purpose of evaluating: (a) Gold Coast's compliance with the requirements of this CIA and (b) Gold Coast's compliance with the requirements of the Federal health care programs. The documentation described above shall be made available by Gold Coast to OIG or its duly authorized representative(s) at all reasonable times for inspection, audit, and/or reproduction. For purposes of this provision, OIG or its duly authorized representative(s) may interview any of Gold Coast's owners, employees, contractors, and Board members who consent to be interviewed at the individual's place of business during normal business hours or at such other place and time as may be mutually agreed upon between the individual and OIG. Gold Coast shall assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. Gold Coast's owners, employees, contractors, and Board members may elect to be interviewed with or without a representative of Gold Coast present.

VIII. DOCUMENT AND RECORD RETENTION

Gold Coast shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs and to compliance with this CIA for six years (or longer if otherwise required by law) from the Effective Date.

IX. DISCLOSURES

Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, OIG shall make a reasonable effort to notify Gold Coast prior to any release by OIG of information submitted by Gold Coast pursuant to this CIA and identified upon submission by Gold Coast as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, Gold Coast shall have the rights set forth at 45 C.F.R. § 5.42(a).

X. BREACH AND DEFAULT PROVISIONS

A. Stipulated Penalties. OIG may assess:

1. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.A;

2. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.B;

3. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.C;

4. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.D;

5. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.E.;

6. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.F;

7. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.G;

8. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.H;

9. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.I;

10. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section III.J;

11. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section IV;

12. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section V;

13. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section VII;

14. A Stipulated Penalty of up to $2,500 for each day Gold Coast fails to comply with Section VIII; or

15. A Stipulated Penalty of up to $50,000 for each false certification or false statement made to OIG by or on behalf of Gold Coast under this CIA.

B. Timely Written Requests for Extensions. Gold Coast may, in advance of the due date, submit a timely written request for an extension of time to perform any act or file any notification or report required by this CIA. If OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one day after Gold Coast fails to meet the revised deadline set by OIG. If OIG denies such a timely written request, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until three business days after Gold Coast receives OIG's written denial of such request or the original due date, whichever is later. A "timely written request" is defined as a request in writing received by

OIG at least five business days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

C. Payment of Stipulated Penalties.

1. *Demand Letter*. If OIG determines that a basis for Stipulated Penalties under Section X.A exists, OIG shall notify Gold Coast of: (a) Gold Coast's failure to comply and (b) OIG's demand for payment of Stipulated Penalties. (This notification shall be referred to as the "Demand Letter.")

2. *Response to Demand Letter.* Within 15 business days after the date of of the Demand Letter, Gold Coast shall either: (a) pay the applicable Stipulated Penalties or (b) request a hearing before an HHS administrative law judge (ALJ) to dispute OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.E.

3. *Form of Payment*. Payment of the Stipulated Penalties shall be made by electronic funds transfer to an account specified by OIG in the Demand Letter.

D. Exclusion for Material Breach.

1. *Definition of Material Breach*. A material breach of this CIA means:

a. failure to comply with any of the requirements of this CIA for which OIG has previously issued a demand for Stipulated Penalties under Section X.C, unless such Stipulated Penalty was overturned by an ALJ on appeal pursuant to the procedures described in Section X.E below;

b. failure to comply with Section III.A.1;

c. failure to comply with Section III.D;

d. failure to comply with Section III.I;

e. failure to comply with Section V;

f. failure to respond to a Demand Letter in accordance with Section X.C;

g. a false statement or false certification made to OIG by or on behalf of Gold Coast under this CIA;

h. failure to pay Stipulated Penalties within 20 days after an ALJ issues a decision ordering Gold Coast to pay the Stipulated Penalties or within 20 days after the HHS Departmental Appeals

Board (DAB) issues a decision upholding the determination of OIG; or

i. failure to come into compliance with a requirement of this CIA for which OIG has demanded Stipulated Penalties, pursuant to the deadlines listed in Section X.E.2.

2. *Notice of Material Breach and Intent to Exclude*. The parties agree that a material breach of this CIA by Gold Coast constitutes an independent basis for Gold Coast's exclusion from participation in the Federal health care programs. The length of the exclusion shall be in the OIG's discretion, but not more than five years for each material breach. Upon a preliminary determination by OIG that Gold Coast has materially breached this CIA, OIG shall notify Gold Coast of: (a) Gold Coast's material breach and (b) OIG's intent to exclude Gold Coast. (This notification shall be referred to as the "Notice of Material Breach and Intent to Exclude.")

3. *Response to Notice*. Gold Coast shall have 30 days from the date of the Notice of Material Breach and Intent to Exclude to submit any information and documentation for OIG to consider before it makes a final determination regarding exclusion.

4. Exclusion Letter. If OIG determines that exclusion is warranted, OIG shall notify Gold Coast in writing of its determination to exclude Gold Coast. (This letter shall be referred to as the "Exclusion Letter.") Subject to the Dispute Resolution provisions in Section X.E, below, the exclusion shall go into effect 30 days after the date of the Exclusion Letter. The effect of the exclusion shall be that no Federal health care program payment may be made for any items or services furnished, ordered, or prescribed by Gold Coast, including administrative and management services, except as stated in regulations found at 42 C.F.R. §1001.1901(c). The exclusion shall have national effect. Reinstatement to program participation is not automatic. At the end of the period of exclusion, Gold Coast may apply for reinstatement by submitting a written request for reinstatement in accordance with the provisions at 42 C.F.R. §§ 1001.3001-.3004.

E. Dispute Resolution.

1. *Review Rights*. Upon OIG's issuing a Demand Letter or Exclusion Letter to Gold Coast, and as an agreed-upon remedy for the resolution of disputes arising under this CIA, Gold Coast shall be afforded certain review rights comparable to the ones that are provided in 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005. Specifically, OIG's determination to demand payment of Stipulated Penalties or to seek exclusion shall be subject to review by an HHS ALJ and, in the event of an appeal, the DAB, in a manner consistent with the provisions in 42 C.F.R. § 1005.2-1005.21, but only to the extent this CIA does not provide otherwise. Notwithstanding the language in 42 C.F.R. § 1005: (a) the request for a hearing involving Stipulated Penalties shall be made within 15 business days after the date of the Demand Letter and the request for a hearing involving exclusion shall be made within 25 days after the date of the Exclusion Letter and (b) no discovery shall be available to the parties. The procedures relating to the filing of a

request for a hearing can be found at
http://www.hhs.gov/dab/divisions/civil/procedures/divisionprocedures.html

2. *Stipulated Penalties Review*. Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CIA shall be: (a) whether Gold Coast was in full and timely compliance with the requirements of this CIA for which OIG demands payment and (b) the period of noncompliance. Gold Coast shall have the burden of proving its full and timely compliance. If the ALJ upholds the OIG's determination that Gold Coast has breached this CIA and orders Gold Coast to pay Stipulated Penalties, Gold Coast must (a) come into compliance with the requirement(s) that resulted in the OIG imposing Stipulated Penalties and (b) pay the Stipulated Penalties within 20 days after the ALJ issues a decision, unless Gold Coast properly and timely requests review of the ALJ decision by the DAB. If the ALJ decision is properly and timely appealed to the DAB and the DAB upholds the determination of OIG, Gold Coast must (a) come into compliance with the requirement(s) that resulted in the OIG imposing Stipulated Penalties and (b) pay the Stipulated Penalties within 20 days after the DAB issues its decision.

3. *Exclusion Review*. Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a material breach of this CIA shall be whether Gold Coast was in material breach of this CIA. If the ALJ sustains the OIG's determination of material breach, the exclusion shall take effect 20 days after the ALJ issues the decision. If the DAB finds in favor of OIG after an ALJ decision adverse to OIG, the exclusion shall take effect 20 days after the DAB decision. Gold Coast shall waive its right to any notice of such an exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB. If the DAB finds in favor of Gold Coast, Gold Coast shall be reinstated effective on the date of the original exclusion.

4. *Finality of Decision.* The review by an ALJ or DAB provided for above shall not be considered to be an appeal right arising under any statutes or regulations. The parties to this CIA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this CIA and Gold Coast agrees not to seek additional review of the DAB's decision (or the ALJ's decision if not appealed) in any judicial forum.

XI. EFFECTIVE AND BINDING AGREEMENT

Gold Coast and OIG agree as follows:

A. This CIA constitutes the complete agreement between the parties and may not be amended except by written consent of the parties to this CIA.

B. All requirements and remedies set forth in this CIA are in addition to and do not affect (1) Gold Coast's responsibility to follow all applicable Federal health care program requirements or (2) the government's right to impose appropriate remedies for failure to follow applicable Federal health care program requirements.

C. The undersigned Gold Coast signatories represent and warrant that they are authorized to execute this CIA. The undersigned OIG signatories represent that they are signing this CIA in their official capacities and that they are authorized to execute this CIA.

D. This CIA may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same CIA. Electronically transmitted copies of signatures shall constitute acceptable, binding signatures for purposes of this CIA.

ON BEHALF OF VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION D/B/A GOLD COAST HEALTH PLAN

Nicholas Liguori

NICHOLAS LIGUORI
Chief Executive Officer
Gold Coast Health Plan

July 29, 20222
DATE

Charles J. Stevens

CHARLES J. STEVENS
Gibson, Dunn & Crutcher
Counsel for Gold Coast Health Plan

August 1, 2022
DATE

ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Lisa M. Re /RMP

LISA M. RE
Assistant Inspector General for Legal Affairs
Office of Inspector General
U.S. Department of Health and Human Services

8/10/2022
DATE

Sarah Kessler

SARAH KESSLER
Senior Counsel
Office of Inspector General
U.S. Department of Health and Human Services

8/11/2022
DATE

APPENDIX A

INDEPENDENT REVIEW ORGANIZATION

This Appendix contains the requirements relating to the Independent Review Organization (IRO) required by Section III.D of the CIA.

A. IRO Engagement

1. Gold Coast shall engage an IRO that possesses the qualifications set forth in Paragraph B, below, to perform the responsibilities in Paragraph C, below. The IRO shall conduct the review in a professionally independent and objective fashion, as set forth in Paragraph E. Within 30 days after OIG receives the information identified in Section V.A.7 of the CIA or any additional information submitted by Gold Coast in response to a request by OIG, whichever is later, OIG will notify Gold Coast if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, Gold Coast may continue to engage the IRO.

2. If Gold Coast engages a new IRO during the term of the CIA, that IRO must also meet the requirements of this Appendix. If a new IRO is engaged, Gold Coast shall submit the information identified in Section V.A.7 of the CIA to OIG within 30 days of engagement of the IRO. Within 30 days after OIG receives this information or any additional information submitted by Gold Coast at the request of OIG, whichever is later, OIG will notify Gold Coast if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, Gold Coast may continue to engage the IRO.

B. IRO Qualifications

The IRO shall:

1. assign individuals to conduct the Medical Loss Ratio (MLR) Element Review who have expertise in the medical loss ratio standards and calculations required by 42 C.F.R. § 438.8 and the applicable medical loss ratio calculation and reporting requirements of the California Department of Health Care Services; and

2. have sufficient staff and resources to conduct the reviews required by the CIA on a timely basis.

C. IRO Responsibilities

The IRO shall:

1. perform each MLR Element Review in accordance with the specific requirements of the CIA;

2. follow all applicable Medicaid program requirements as well as the terms of Gold Coast's contract with the California Department of Health Care Services (DHCS) in making assessments in the MLR Element Review;

3. request clarification from the Medicaid program or DHCS if in doubt of the application of a particular program policy or regulation or contractual provision;

4. respond to all OIG inquires in a prompt, objective, and factual manner; and

5. prepare timely, clear, well-written reports that include all the information required by Appendix B to the CIA.

D. Gold Coast Responsibilities

Gold Coast shall ensure that the IRO has access to all records and personnel necessary to complete the reviews listed in III.D of this CIA and that all records furnished to the IRO are accurate and complete.

E. IRO Independence and Objectivity

The IRO must perform the MLR Element Review in a professionally independent and objective fashion, as defined in the most recent Government Auditing Standards issued by the U.S. Government Accountability Office.

F. IRO Removal/Termination

1. *Gold Coast and IRO*. If Gold Coast terminates its IRO or if the IRO withdraws from the engagement during the term of the CIA, Gold Coast must submit a notice explaining (a) its reasons for termination of the IRO or (b) the IRO's reasons for its withdrawal to OIG, no later than 30 days after termination or withdrawal. Gold Coast must engage a new IRO in accordance with Paragraph A of this Appendix and within 60 days of termination or withdrawal of the IRO.

2. *OIG Removal of IRO*. In the event OIG has reason to believe the IRO does not possess the qualifications described in Paragraph B, is not independent and objective as set forth in Paragraph E, or has failed to carry out its responsibilities as described in Paragraph C, OIG shall notify Gold Coast in writing regarding OIG's basis for determining that the IRO has not met the requirements of this Appendix. Gold Coast shall have 30 days from the date of OIG's written notice to provide information regarding the IRO's qualifications, independence or performance of its responsibilities in order to resolve the concerns identified by OIG. If, following OIG's review of any information provided by Gold Coast regarding the IRO, OIG determines that the IRO has not met the requirements of this Appendix, OIG shall notify Gold Coast in writing that Gold Coast shall be required to engage a new IRO in accordance with Paragraph A of this Appendix. Gold Coast must engage a new IRO within 60 days of its receipt of OIG's written notice. The final determination as to whether or not to require Gold Coast to engage a new IRO shall be made at the sole discretion of OIG.

APPENDIX B

MEDICAL LOSS RATIO ELEMENT REVIEW

A. Medical Loss Ratio (MLR) Element Review. The IRO shall perform the MLR Element Review for each Reporting Period.

1. *Definitions*.

a. "Annual MLR Report" means the report described in section 42 C.F.R. § 438.8(k).

b. "MLR Numerator Element" means any of the following: Incurred Claims, Non-Claims Costs, expenditures for Activities that Improve Health Care Quality, or Fraud Prevention Activities.[1]

c. "Activities that Improve Health Care Quality" mean the categories of activities identified in 42 C.F.R. § 438.8(e)(3), which include, among others, those primarily designed to:

i. improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations;

ii. prevent hospital readmissions through a comprehensive program for hospital discharge;

iii. improve patient safety, reduce medical errors, and lower infection and mortality rates; or

iv. implement, promote, and increase wellness and health activities.

d. "Non-Claims Costs" means those expenses for administrative services that are not: Incurred Claims; expenditures on Activities that Improve Health Care Quality; or licensing and regulatory fees, or Federal and State taxes, defined in 42 C.F.R. § 438.8(b).

e. "Incurred Claims" means any of the following, as defined in 42 C.F.R. § 438.8(e):

i. Direct claims that Gold Coast paid to providers (including under capitated contracts with network providers) for services supplies

[1] Fraud Prevention Activities are a MLR Numerator Element subject to review under this Appendix B to the extent that CMS requires that Fraud Prevention Activities be incorporated into the MLR calculation for the applicable Reporting Period. See 42 C.F.R. § 438.8(e)(4) and 85 Fed. Reg. 72754 at 72792 (Nov. 30, 2020).

covered under the contract and services meeting the requirements of 42 C.F.R. § 438.3(e) provided to enrollees.

ii. Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported.

iii. Withholds from payments made to network providers.

iv. Claims that are recoverable for anticipated coordination of benefits.

v. Claims payments recoveries received as a result of subrogation.

vi. Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.

vii. Changes in other claims-related reserves.

viii. Reserves for contingent benefits and the medical claim portion of lawsuits.

2. *MLR Element Review.* At least 90 days prior to the end of each Reporting Period, the OIG shall select the MLR Numerator Element to be reviewed by the IRO and notify Gold Coast of its selection (Selected Element). Within 60 days of OIG's notification to Gold Coast, the IRO shall develop and submit to OIG a workplan that outlines the IRO's detailed methodology (including any sampling proposals) for determining whether Gold Coast's calculation and reporting of the Selected Element was accurate, supported by underlying documentation, consistent with generally accepted accounting principles, and otherwise complied with the terms of its contract with the California Department of Health Care Services (DHCS) and the applicable Medicaid laws, regulations, and guidance. The OIG shall have 30 days from its receipt of the IRO's workplan to provide any comments or to raise any objections to the workplan. The IRO shall implement the workplan once all of OIG's comments and objections have been addressed to the OIG's satisfaction.

3. *Supplemental Materials.* The IRO shall request all documentation required for its review of the Selected Element and Gold Coast shall furnish such documentation to the IRO prior to the IRO initiating its review of the Selected Element. If the IRO accepts any supplemental documentation from Gold Coast after the IRO has completed its initial review of the Selected Element (Supplemental Materials), the IRO shall include the following in the MLR Element Review Report: (i) a description of the Supplemental Materials, (ii) the date the Supplemental Materials were accepted, (iii) the IRO's reason(s) for accepting the Supplemental Materials, and (iv) the relative weight the IRO gave to the Supplemental Materials in its review.

B. MLR Element Review Report. The IRO shall prepare a MLR Element Review Report for each MLR Element Review that includes the following information:

1. *Review Methodology.*

   a. Review Objective. A statement of the objective intended to be achieved by the MLR Element Review.

   b. Selected Element. A description of the Selected Element subject to the MLR Element Review.

   c. Source of Data. A description of the documentation reviewed, any personnel interviewed, and other information sources relied on by the IRO when performing the MLR Element Review (e.g., Annual MLR Report, Rate Development Templates, Gold Coast's historical paid claims or encounter data, Gold Coast's contract with DHCS, financial statements or Annual MLR Reports for prior years, Gold Coast's contracts with providers or third party vendors, CMS Informational Bulletins, and other policies, regulations, or directives, etc.).

   d. Review Protocol. A narrative description of how the MLR Element Review was conducted, the standards used, and what was evaluated.

   e. Supplemental Materials. The information regarding any Supplemental Materials required by A.3., above.

2. *Review Findings.*

   a. Narrative Results.

      i. A description of Gold Coast's process for calculating and reporting each Selected Element in its Annual MLR Report, including the identification, by position description, of the personnel involved in calculating and reporting the MLR.

      ii. A description of controls in place at Gold Coast to ensure that each Selected Element is accurately calculated and reported consistent with the terms of Gold Coast's contract with the DHCS and the applicable Medicaid laws, regulations, and guidance.

      iii. A narrative explanation of the results of the IRO's review of the Selected Element, including an explanation of the IRO's findings and recommendations regarding Gold Coast's calculation and reporting of the Selected Element in the Annual MLR Report.

   b. Quantitative Results.

      i. A spreadsheet that includes the following information for the Selected Element:

1. Name of Medi-Cal MCO
2. MLR Reporting Year
3. Incurred Period
4. Expenses actually paid for the Selected Element
5. Expenses reported on the Annual MLR Report for the Selected Element
6. The dollar difference between the expenses actually paid for the Selected Element and the expenses reported for the Selected Element.

c. Recommendations. The IRO's MLR Element Review Report shall include any recommendations for improvements to Gold Coast's MLR classification, calculation and reporting or to Gold Coast's controls for ensuring that all Annual MLR Reports by Gold Coast contain revenues, expenditures, and amounts that are appropriately identified, classified, calculated, and reported based on the findings of the MLR Element Review.

3. *Credentials*. The names and credentials of the individuals who: (1) developed the review methodology utilized for the MLR Element Review and (2) performed the MLR Element Review.

C. Reporting of Findings. Within 60 days of receipt, Gold Coast shall provide a copy of the MLR Element Review Report to DHCS. The MLR Element Review Report shall also be included in Gold Coast's Annual Report for that Reporting Period, along with documentation to demonstrate that Gold Coast provided a copy of the MLR Element Review Report to DHCS. OIG, in its sole discretion, may refer the findings of the MLR Element Review Report to CMS for appropriate follow up.

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Felix L. Nunez, M.D., Chief Executive Officer

DATE: April 27, 2026

SUBJECT: Advance Payment Agreement to Ventura County Health Care Agency

Summary and Background

Gold Coast Health GCHP (GCHP) management asks that the Commission approve an advance payment to the Ventura County Health Care Agency (VCHCA). This Advance Payment Agreement (APA) would be effective June 26, 2026. The APA would specify terms for a one-time payment in the amount of thirty million dollars ($30,000,000.00) made by GCHP to the County of Ventura as payment made in advance of VCHCA services to be performed pursuant to the primary care provider, specialist, and hospital Provider Agreements and GCHP's complete processing of applicable claims. This funding is allowable for reasons stated below, including that it is to a governmental entity for the public purpose of supporting the continued operation and viability of a Safety Net Provider, which is essential to the ability of GCHP to provide an adequate network for its members. The Executive Finance Committee heard this matter on Thrusday April 23, and its recommendation will be forwarded to the Commission prior to the meeting.

The APA details an Advance Payment that would be repaid by September 30, 2026. The Advance Payment would support VCHCA's critical operational expenses and is necessary due to a cash flow strain impacted by delays in supplemental funding reimbursement from the State of California.

Major terms of the APA are as follows:

- A one-time Advance Payment would be made on June 26, 2026.
- The funds will be repaid by September 30, 2026.
- If the advance payment has not been fully repaid by September 30, 2026, GCHP may offset any unpaid amount against capitation payments, fee-for-service payments relating to claims submitted or processed for payment, or any other amounts due to VCHCA for subsequent months.
- GCHP is not recommending requiring an administrative fee to reimburse GCHP for the additional costs of administering this Advance Payment to demonstrate its partnership with the County. Should the Commission decide to impose such a fee of, a fee in the amount $189,440 is what could be imposed.

This Advance Payment Funding Agreement does not constitute a gift of public funds because (1) the funds advanced will be fully recouped within five months as described above, and (2) the advance payment would allow the County to continue to deliver medical care without disruption, promotes the long-term viability of the provider network and will help maintain member satisfaction. (Cal Const art XVI, Section 6, *City and County of San Francisco* (1932) 216 C 187, 193), and further such funding further serves a purpose of GCHP, the donor agency. (*Golden Gate Bridge & Hwy. Dist. v. Luehring*, 4 Cal.App.3d 204 (1970).)

This request for an advance on capitation and claims payments is specifically within the authority and purpose of the Commission. The statutory purpose of the Commission is to "meet the problems of the delivery of publicly assisted medical care in the county and to demonstrate ways of promoting quality care and cost efficiency." (Welf. & Inst. Code §14087.53.) The County Board of Supervisors ordinance establishing the Commission requires the Commission to, among other things, implement "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" (Ord. 4613, Art. 6, 1380-4(c).). GCHP's bylaws provide that the Commission shall deliver "medical care via a contracted provider network that will improve access to primary, specialty and ancillary services, …[incorporate] a plan of service delivery and [implement] reimbursement mechanisms which promote the long-term viability of a locally operated Medi-Cal managed care system [and]…implement programs and procedures to ensure a high level of member satisfaction."

Financial Impact

The Advance Payment will result in a temporary reduction in GCHP's reserves.

Recommendation

GCHP staff recommend that the Ventura County Medi-Cal Managed Care Commission authorize the CEO to execute an Advance Payment Agreement in the amount of $30,000,000 with the Ventura County Health Care Agency.

AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Jeff Register, Interim Chief Financial Officer / Controller
Baker Tilly Representatives

DATE: April 27, 2026

SUBJECT: Baker Tilly Audit Information

PowerPoint with Verbal Presentation

ATTACHMENTS:

Baker Tilly Documents

Report of Independent Auditors
and Financial Statements

Ventura County Medi-Cal Managed Care Commission
dba Gold Coast Health Plan

For the Period July 1, 2025, to December 31, 2025, and Year Ended
June 30, 2025

Table of Contents

Management's Discussion and Analysis

Ventura County Medi-Cal Managed Care Commission
dba Gold Coast Health Plan
Management's Discussion and Analysis

The intent of the Management's Discussion and Analysis is to provide readers with an overview of the Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan's (GCHP or the Plan) financial activities for the six-month period ended December 31, 2025 and fiscal year ended June 30, 2025. This overview is provided in conjunction with the Plan's six-month period ended December 31, 2025 and fiscal year ended June 30, 2025, financial statements. Readers should review this overview in conjunction with GCHP's financial statements and accompanying notes to the financial statements to enhance their understanding of the financial performance.

Gold Coast Health Plan Overview

On June 2, 2009, the Ventura County Board of Supervisors approved the implementation of a county-organized health system (COHS) model to transition Ventura County Medi-Cal members from a fee-for-service model to a managed care model. Ordinance No. 4409 (April 2010) established the Ventura County Medi-Cal Managed Care Commission as an oversight entity. The Commission's 12 members oversee a single plan—Gold Coast Health Plan—to serve Ventura County Medi-Cal beneficiaries.

As a COHS, the Plan has an exclusive contract (the Contract) with the State of California (the State) Department of Health Care Services (DHCS) to arrange for the provision of health care services to Ventura County's approximately 240,000 Medi-Cal beneficiaries at December 31, 2025. The Plan receives virtually 100% of its revenue in the form of capitation from the State of California.

Overview of the Financial Statements

This annual report consists of financial statements and notes to those statements, which reflect GCHP's financial position and results of operations for the six-month period ended December 31, 2025 and fiscal year ended June 30, 2025. The financial statements of GCHP include the statements of net position, statements of revenues, expenses, and changes in net position, statements of cash flows, and notes to the financial statements.

- The statements of net position include all GCHP's assets and liabilities, using the accrual basis of accounting.
- The statements of revenues, expenses, and changes in net position present the results of operating activities during the fiscal year and the resulting change in net position.
- The statements of cash flows report on the net cash provided by operating activities, as well as other sources, and uses of cash from investing, capital, and related financing activities.

The following discussion and analysis addresses GCHP's overall program activities.

Financial Highlights

The table below presents condensed statements of net position of the Plan as of December 31, 2025, and June 30, 2025, and 2024:

Table 1 – Condensed Statements of Net Position as of Fiscal Periods Ended

(Dollars in Thousands)

	December 31, 2025	June 30, 2025	June 30, 2024	Change: December 31, 2025 - June 30, 2025 Amount	Change: December 31, 2025 - June 30, 2025 Percentage	Change: June 30, 2025 - 2024 Amount	Change: June 30, 2025 - 2024 Percentage
ASSETS							
Current assets and other assets	$ 674,178	$ 727,607	$ 757,240	$ (53,429)	(7.3)%	$ (29,633)	(3.9)%
Capital assets, net	175	295	553	(120)	(40.7)%	(258)	(46.7)%
Total assets	$ 674,353	$ 727,902	$ 757,793	$ (53,549)	(7.4)%	$ (29,891)	(3.9)%
LIABILITIES							
Current liabilities	$ 404,712	$ 402,869	$ 391,342	$ 1,843	0.5 %	$ 11,527	2.9 %
Noncurrent liabilities	23,231	25,180	3,677	(1,949)	(7.7)%	21,503	584.8 %
Total liabilities	427,943	428,049	395,019	(106)	(0.0)%	33,030	8.4 %
NET POSITION							
Invested in capital assets	26,343	295	553	26,048	8829.8 %	(258)	(46.7)%
Restricted net position	322	316	-	6	100.0 %	316	0.0 %
Unrestricted net position	219,745	299,242	362,221	(79,497)	(26.6)%	(62,979)	(17.4)%
Total net position	246,410	299,853	362,774	(53,443)	(17.8)%	(62,921)	(17.3)%
Total liabilities and net position	$ 674,353	$ 727,902	$ 757,793	$ (53,549)	(7.4)%	$ (29,891)	(3.9)%

Six-month Period Ended December 31, 2025

- As of December 31, 2025 and June 30, 2025, total assets were $674,353,000 and $727,902,000, respectively, a decrease of $53,549,000 or 7.4% due to a decreases in the Medi-Cal receivable from the State and provider receivables and prepaid expenses and other assets, partially offset by increases in cash and cash equivalents and Intangible right to use subscription assets.

- Total liabilities as of December 31, 2025, $427,943,000, were flat compared with $428,049,000 as of June 30, 2025. Decreases in medical claims liability and accounts payable were offset by increases payable to the State of California, accrued expenses and capitation payable.

- The Plan's total net position decreased by $53,443,000, or 17.8%, during the six-month period ended December 31, 2025. This decrease in net position was primarily attributable to the impact of the Calendar Year 2024 UIS Risk Corridor, estimated provider settlements and increased medical expenses.

- Tangible Net Equity (TNE) at December 31, 2025, was 510% of the DHCS required minimum of $48,329,000.

Fiscal Year 2025

- As of June 30, 2025 and 2024, total assets were $727,902,000 and $757,793,000, respectively, a decrease of $29,891,000 or 3.9% due to a decrease in cash and cash equivalents partially offset by increases in the Medi-Cal receivable from the State and provider receivables.

- Total liabilities as of June 30, 2025, were $428,049,000 compared with $395,019,000 as of June 30, 2024, an 8.4% increase. The increase was primarily driven by an increase in medical claims liability because of short-term delays in claims payments due to the implementation of major new operational technological infrastructure.

- The Plan's total net position decreased by $62,921,000, or 17.3%, during fiscal year 2025. This planned decrease in net position was attributable to a commitment to community reinvestment through the use of provider quality incentives tied directly to State thresholds as defined by the California Department of Healthcare Services' Managed Care Accountability Set metrics, grants to support local placement of clinical specialists, continued investment in GCHP's technological infrastructure, and the operational readiness to support a mandated Medicare Dual-Special Needs Program line of business required by January 1, 2026.

- Tangible Net Equity (TNE) at June 30, 2025, was 647% of the DHCS required minimum of $46,327,000.

Results of Operations

As mentioned above, GCHP's six-month period ended December 31, 2025, operations and nonoperating revenues and expenses, net, resulted in a $53,443,000 decrease in net position. As mentioned above, GCHP's fiscal year 2025 operations and nonoperating revenues and expenses, net, resulted in a $62,921,000 decrease in net position. The following table shows the changes in revenues and expenses for six-month period ended December 31, 2025, compared to fiscal year 2025 and 2025 compared to 2024:

Table 2 – Revenues, Expenses, and Changes in Net Position for
(Dollars in Thousands)

	December 31,	June 30,		Change: December 31, 2025 - June 30, 2025		Change: June 30, 2025 - 2024	
	2025	2025	2024	Amount	Percentage	Amount	Percentage
Capitation revenues	$ 778,464	$1,545,925	$1,488,842	$(767,461)	(49.6)%	$ 57,083	3.8 %
Total operating revenues	778,464	1,545,925	1,488,842	(767,461)	(49.6)%	57,083	3.8 %
Provider capitation	50,694	93,841	101,503	(43,147)	(46.0)%	(7,662)	(7.5)%
Claim payments to providers and facilities	462,597	910,836	805,271	(448,239)	(49.2)%	105,565	13.1 %
Other medical	31,166	36,246	44,720	(5,080)	(14.0)%	(8,474)	(18.9)%
Reinsurance, net of recoveries	2,504	1,241	(6,615)	1,263	101.8 %	7,856	(118.8)%
Total health care expenses	546,961	1,042,164	944,879	(495,203)	(47.5)%	97,285	10.3 %
Salaries, benefits, and compensation	30,615	50,427	43,968	(19,812)	(39.3)%	6,459	14.7 %
Professional fees	37,572	79,716	76,398	(42,144)	(52.9)%	3,318	4.3 %
General administrative fees	9,367	22,057	9,588	(12,690)	(57.5)%	12,469	130.0 %
Supplies, occupancy, insurance, and other	1,027	2,830	2,124	(1,803)	(63.7)%	706	33.2 %
Premium tax	204,788	410,247	422,751	(205,459)	(50.1)%	(12,504)	(3.0)%
Depreciation	4,661	14,782	4,114	(10,121)	(68.5)%	10,668	259.3 %
Total administrative expenses	288,030	580,059	558,943	(292,029)	(50.3)%	21,116	3.8 %
Total operating expenses	834,991	1,622,223	1,503,822	(787,232)	(48.5)%	118,401	7.9 %
Operating (loss) income	(56,527)	(76,298)	(14,980)	19,771	(25.9)%	(61,318)	409.3 %
Interest income	6,794	18,555	19,155	(11,760)	(63.5)%	(600)	(3.2)%
Interest expense	(3,710)	(5,178)	(1,353)	1,468	(28.4)%	(3,825)	282.7 %
Total nonoperating revenues and expenses, net	3,084	13,377	17,802	(10,293)	(77.1)%	(4,425)	(24.9)%
(Decrease) increase in net position	(53,443)	(62,921)	2,822	9,478	(15.1)%	(65,743)	(2329.7)%
Total net position, beginning of year	299,853	362,774	359,952	(62,921)	(17.3)%	2,822	0.8 %
Total net position, end of year	$ 246,410	$ 299,853	$ 362,774	$ (53,442)	(17.8)%	$(62,921)	(17.3)%

Enrollment, Capitation Revenue, and Health Care Expenses

Enrollment

Enrollment is divided into aid categories, which correspond to specific rates of capitation to be received by the Plan from the State. During the six months ended December 31, 2025, the Plan served an average of 240,328 members per month, compared to an average of 244,294 members per month in fiscal year 2025 and 249,944 per month in fiscal year 2024. The enrollment changes from fiscal year 2025 to December 31, 2025 are attributed to the impact of normal population fluctuations as well as the impact of external actions, including legislation and immigration enforcement. The enrollment changes from fiscal year 2024 to 2025 are attributed to normal population fluctuations.

Table 3 – Medi-Cal Enrollment by Aid Category
(Shown as Average Member Months)

Enrollment Category	December 31, 2025	June 30, 2025	June 30, 2024
Child	83,843	87,388	92,023
Adult	37,912	39,208	40,260
Adult Expansion	80,113	80,935	82,524
Seniors and Persons with Disabilities (SPD)	11,382	11,317	11,454
SPD - Dual	26,324	24,705	22,968
Long Term Care (LTC)	50	60	54
LTC - Dual	704	681	661
Total average monthly enrollment	240,328	244,294	249,944

Significant aid categories are defined as follows:

1. Child: Qualifying members under age 21.

2. Adult: Qualifying members between the ages of 21 and 64.

3. Adult Expansion (AE): Refers to members who became eligible for the Medi-Cal program effective January 1, 2014, as a result of the implementation of the Affordable Care Act (ACA) and the expanded eligibility criteria for Medicaid.

4. Senior and Persons with Disabilities (SPD)*: Includes individuals who are 65 years of age and older who receive supplemental security income (SSI) checks, or are medically needy if their income and resources are within the Medi-Cal limits, and individuals who met the criteria for disability set by the Social Security Administration and the State Program-Disability and Audit Program Division.

5. Long-Term Care (LTC)*: Includes frail, elderly, nonelderly adults with disabilities and children with developmental disabilities, and other disabling conditions requiring long-term care services.

* "Dual" coverage refers to enrollees who are eligible for both Medi-Cal and Medicare Parts A, B, and D.

Six-month period ended December 31, 2025

Capitation Revenue

Capitation revenue (capitation received by the Plan from the State) is determined by rates set by the State at the beginning of the plan year and generally are effective for the entire year. The State may, on occasion, provide updated rates during the fiscal year. Total revenue for the six months ended December 31, 2025, was $778,464,00, a 49.6% decrease from fiscal 2025 due to a 6 month period of time. Extrapolated to a full 12 months, this would be $1,556,928,000 and represents a 0.7% rate increase from the prior year. The increase was primarily attributable to a general increase in expected medical costs. Note that the capitation revenue was reduced by $21,124,000 related to the impact of the Calendar Year 2024 UIS Risk Corridor.

Health Care Expenses

Aggregate health care expenses for the six months ended December 31, 2025, were $546,961,000, a 47.5% decrease from fiscal 2025 due to a 6 month period of time. Extrapolated to a full 12 months, this would be $1,093,923,000 compared to $1,042,165,000 in fiscal year 2025, which represents an increase of 5.0%. The Plan's medical loss ratio, or health care expenses as a percent of operating revenues (net of MCO taxes), was 95.3% in the six months ended December 31, 2025, compared to 91.8% in fiscal year 2025. Note that the health care expenses include $13,555,000 in estimated provider settlement expenses.

Note the following regarding the components of health care expenses:

1. Provider capitation represents monthly payments for members assigned to primary care providers who have agreed to accept risk to provide specific services (when needed) to their members. Rates are fixed by contract and are generally known at the beginning of the fiscal year. Capitation expense for the six months ended December 31, 2025, was $50,694,000, a 46.0% decrease from fiscal 2025 due to a 6 month period of time. Extrapolated to a full 12 months, this would be $101,388,000, or $7,547,000 higher than in fiscal year 2025. The increase was primarily due to an increase in the capitation rates paid to providers, partially offset by a decrease in capitated membership.

2. Other medical, including care management expense was $31,166,000 for the six months ended December 31, 2025, a 14.0% decrease from fiscal 2025 due to a 6 month period of time, and includes $13,555,000 in estimated one-time provider settlement expenses. Excluding the one-time expenses and extrapolating to a full 12 months, this would be $35,222,000, or $1,024,000 and 2.8% lower than in fiscal year 2025.

3. Total reinsurance, net of recoveries and provider refunds resulted in a $2,504,000 increase to health care expenses in the six months ended December 31, 2025, versus a $1,241,000 increase in fiscal year 2025.

Administrative Expenses

Total administrative expenses were $288,029,000 for the six months ended December 31, 2025, a 50.3% decrease from fiscal 2025 due to a 6 month period of time. Extrapolated to a full 12 months, this would be $576,058,000 compared to $580,059,000 in fiscal year 2025, for a decrease of $4,001,000. The decrease was driven by a decrease in depreciation and amortization expense, partially offset by continuing development of an infrastructure to support the required Medicare Dual-Special Need Program line of business to be offered effective January 1, 2026.

Fiscal Year 2025

Capitation Revenue

Capitation revenue (capitation received by the Plan from the State) is determined by rates set by the State at the beginning of the plan year and generally are effective for the entire year. The State may, on occasion, provide updated rates during the fiscal year. Total revenue for fiscal year 2025 was $1,545,925,000, a 3.8% increase from the prior year. The increase was primarily attributable to a general increase in expected medical costs.

Health Care Expenses

Aggregate health care expenses were $1,042,164,000 in fiscal year 2025, compared to $944,879,000 in fiscal year 2024, which is an increase of 10.3%. The Plan's medical loss ratio, or health care expenses as a percent of operating revenues (net of MCO taxes), was 91.8% in fiscal year 2025, compared to 88.6% in fiscal year 2024. Note that the health care expenses include $36,200,000 in provider incentives and grants.

Note the following regarding the components of health care expenses:

1. Provider capitation represents monthly payments for members assigned to primary care providers who have agreed to accept risk to provide specific services (when needed) to their members. Rates are fixed by contract and are generally known at the beginning of the fiscal year. Capitation expense for fiscal year 2025 was $93,841,000 or $7,662,000 lower than in fiscal year 2024. The decrease was primarily due to lower capitated membership than the prior year.

2. Other medical, including care management, expense was $36,246,000 in fiscal year 2025, or $8,474,000 and 18.9% lower than in fiscal year 2024. The continued material spend was primarily due to the continuation of the Quality Incentive Pool and Program.

3. Total reinsurance, net of recoveries and provider refunds resulted in a $1,241,000 increase to health care expenses in fiscal year 2025, versus a $6,615,180 reduction in fiscal year 2024.

Administrative Expenses

Total administrative expenses were $580,059,000 in fiscal year 2025, compared to $558,943,000 in fiscal year 2024, for an increase of $21,116,000. The increase was predominantly due staffing and augmentation associated with the supporting the new claims and enrollment processing capabilities that went live on July 1, 2024. To a lesser extent, the operational and technological development of an infrastructure to support the required Medicare Dual-Special Need Program line of business to be offered effective January 1, 2026, also influenced the increase in administrative expenses.

Tangible Net Equity

GCHP is required by DHCS to maintain certain levels of TNE. Regulatory TNE levels are determined by formula and are based on specified percentages of revenue and medical expenses. Driven by its operating performance, the Plan's TNE at December 31, 2025, was $246,410,000, which exceeded the required TNE amount of $48,329,000. The Plan's TNE at June 30, 2025, was $299,853,000, which exceeded the required TNE amount of $46,327,000.

Table 4 – Tangible Net Equity (TNE)
(Dollars in Thousands)

	December 31, 2025	June 30, 2025	June 30, 2024
Actual TNE, beginning balance	$ 299,853	$ 362,774	$ 359,952
Change in net position	(53,443)	(62,921)	2,822
Actual TNE, ending balance	$ 246,410	$ 299,853	$ 362,774
Required TNE	$ 48,329	$ 46,327	$ 37,010

Requests for Information

This financial report has been prepared in the spirit of full disclosure to provide the reader with an overview of GCHP's operations. If the reader has questions or would like additional information about GCHP, please direct the request to GCHP, 711 East Daily Drive, Suite 106, Camarillo, CA 93010, or call 805-437-5500.

Report of Independent Auditors

(Placeholder)

Financial Statements

Ventura County Medi-Cal Managed Care Commission
dba Gold Coast Health Plan
Statements of Net Position
December 31, 2025 and June 30, 2025

	December 31, 2025	June 30, 2025
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 312,068,151	$ 290,718,208
Short-term investments	106,685,365	104,396,027
Capitation receivable	156,518,148	213,250,889
Provider receivables	13,571,218	34,764,364
Reinsurance and other receivables	9,631,292	9,357,192
Prepaid expenses and other assets	18,607,280	29,928,112
Total current assets	617,081,454	682,414,792
RESTRICTED DEPOSIT	321,510	315,518
CAPITAL ASSETS, net	174,371	294,447
INTANGIBLE RIGHT TO USE LEASE, net of accumulated amortization	1,742,361	2,326,265
INTANGIBLE RIGHT TO USE SUBSCRIPTION, net of accumulated amortization	55,032,872	42,550,737
Total assets	$ 674,352,568	$ 727,901,759
LIABILITIES AND NET POSITION		
LIABILITIES		
Medical claims liability	$ 155,298,660	$ 205,452,176
Capitation payable	21,796,691	7,526,516
Payable to the State of California	59,126,121	36,908,360
Accounts payable	-	6,704,869
Accrued payroll and employee benefits	10,929,318	9,850,497
Accrued premium tax	106,146,397	105,862,040
Accrued expenses and other	44,037,425	23,528,657
Current portion of lease and subscription liability	7,376,788	7,035,804
Total current liabilities	404,711,400	402,868,919
LEASE AND SUBSCRIPTION LIABILITY, net of current portion	23,230,757	25,180,339
Total liabilities	427,942,157	428,049,258
NET POSITION		
Net invested in capital assets	26,342,059	294,447
Restricted	321,510	315,518
Unrestricted net position	219,746,842	299,242,536
Total net position	246,410,411	299,852,501
Total liabilities and net position	$ 674,352,568	$ 727,901,759

See accompanying notes.

Ventura County Medi-Cal Managed Care Commission
dba Gold Coast Health Plan
Statements of Revenues, Expenses, and Changes in Net Position
Period from July 1, 2025 to December 31, 2025 and Year Ended June 30, 2025

	Six Months Ended December 31, 2025	Year Ended June 30, 2025
OPERATING REVENUES		
Capitation revenues	$ 778,463,987	$1,545,925,340
Total operating revenues	778,463,987	1,545,925,340
OPERATING EXPENSES		
Health care expenses		
Provider capitation	50,694,364	93,841,260
Claim payments to providers and facilities	462,596,963	910,835,843
Other medical	31,166,117	36,246,182
Reinsurance, net of recoveries	2,503,916	1,241,262
Total health care expenses	546,961,360	1,042,164,547
ADMINISTRATIVE EXPENSES		
Salaries, benefits, and compensation	30,614,649	50,427,447
Professional fees	37,571,631	79,715,691
General administrative fees	9,366,522	22,056,617
Supplies, occupancy, insurance, and other	1,026,796	2,830,108
Premium tax	204,788,367	410,247,122
Depreciation and amortization	4,661,352	14,782,481
Total administrative expenses	288,029,317	580,059,466
Total operating expenses	834,990,677	1,622,224,013
Operating loss	(56,526,690)	(76,298,673)
NONOPERATING REVENUES AND EXPENSES, NET		
Interest income	6,794,265	18,554,583
Interest expense	(3,709,665)	(5,177,860)
Total nonoperating revenues and expenses, net	3,084,600	13,376,723
Decrease in net position	(53,442,090)	(62,921,950)
NET POSITION, beginning of year	299,852,501	362,774,451
NET POSITION, end of year	$ 246,410,411	$ 299,852,501

See accompanying notes.

Ventura County Medi-Cal Managed Care Commission
dba Gold Coast Health Plan
Statements of Cash Flows
Period from July 1, 2025 to December 31, 2025 and Year Ended June 30, 2025

	Six Months Ended December 31, 2025	Year Ended June 30, 2025
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation revenues received	$ 857,414,488	$ 1,487,099,691
Reinsurance premiums paid	(2,503,916)	(4,633,735)
Payments to providers and facilities	(559,375,422)	(1,018,606,714)
Payments of premium tax	(204,504,010)	(443,154,219)
Payments of administrative expenses	(52,375,863)	(141,216,182)
Net cash provided by (used in) operating activities	38,655,277	(120,511,159)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchases of capital assets	(20,000)	(88,451)
Interest payments	(3,709,665)	(5,177,860)
Payments on subscription liability	(16,954,992)	(26,626,794)
Payments on lease liability	(757,776)	(1,423,798)
Net cash used in capital and related financing activities	(21,442,433)	(33,316,903)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of deposit	(321,510)	(315,518)
Interest income	4,458,609	13,887,483
Net cash provided by investing activities	4,137,099	13,571,965
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	21,349,943	(140,256,097)
Cash and cash equivalents, beginning of year	290,718,208	430,974,305
Cash and cash equivalents, end of year	$ 312,068,151	$ 290,718,208
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating loss	$ (56,526,690)	$ (76,298,673)
Adjustments to reconcile operating loss to net cash provided by (used in) operating activities		
Depreciation and amortization	4,661,352	14,782,481
Changes in assets and liabilities		
Receivables	77,698,104	(64,635,273)
Prepaid expenses and other assets	11,320,832	(662,476)
Medical claims liability	(50,153,516)	47,706,081
Capitation payable	14,270,175	(3,486,431)
Payable to the State of California	22,217,762	(19,485,928)
Accounts payable	(6,704,920)	2,032,918
Accrued premium tax	284,357	(32,907,097)
Accrued payroll and employee benefits	1,078,820	2,695,454
Accrued expenses and other	20,509,001	9,747,785
Net cash provided by (used in) operating activities	$ 38,655,277	$ (120,511,159)

See accompanying notes.

Note 1 – Organization and Operations

Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan (GCHP or the Plan) is a county-organized health system (COHS) organized to serve Medi-Cal beneficiaries living in Ventura County, California. The formation of GCHP was approved by the Board of Supervisors of the County of Ventura in December 2009 through the adoption of Ordinance No. 4409.

As a COHS, GCHP maintains an exclusive contract (the Contract) with the State of California Department of Health Care Services (DHCS) to arrange for the provision of health care services to Ventura County's approximately 240,000 Medi-Cal beneficiaries. All of GCHP's revenues are earned from the State of California (the State) in the form of capitation payments. Revenue is primarily based on enrollment and capitation rates as provided for in the Contract. The Plan began providing services to Medi-Cal beneficiaries in July 2011. In August 2013, the State of California transferred the Healthy Families Program members in Ventura County into the Medi-Cal program, Targeted Low Income Program. In January 2014, the federal Affordable Care Act (ACA) expanded health coverage to certain adults age 19 or older and under 65 and resulted in new enrollment through Adult Expansion (AE) and other population groups. In January 2022, the DHCS launched a new program to improve the health and wellbeing of Medi-Cal members beyond traditional medical services, make services work together better, and improve the quality of services called California Advancing and Innovating Medi-Cal (CalAIM). Upon implementation of the program, the Plan began offering a new benefit, Enhanced Care Management (ECM), and new services called Community Supports.

Note 2 – Compliance with the DHCS, Concentration Risk, Tangible Net Equity, and Restricted Net Position

As a limited licensure plan under Knox-Keene Health Care Service Plan Act of 1975, GCHP is required to maintain a minimum deposit balance. As of December 31, 2025, and June 30, 2025, approximately $322,000 and $316,000, respectively, is presented as a restricted deposit and restricted net position on the accompanying statements of net position.

GCHP's contract with the DHCS includes several financial and nonfinancial requirements. As established by the contract, GCHP is required to meet and maintain a minimum level of tangible net equity (TNE). TNE is defined as the excess of total assets over total liabilities, excluding subordinated liabilities and intangible assets.

Required and actual TNE are as follows:

	Six Months Ended December 31, 2025	Year Ended June 30, 2025
	(in thousands)	
Actual TNE, beginning balance	$ 299,853	$ 362,774
Change in net position	(53,443)	(62,921)
Reportable TNE	$ 246,410	$ 299,853
Required TNE	$ 48,329	$ 46,327

The ability of GCHP to continue as a going concern is dependent on its continued compliance with the DHCS requirements. The loss of this contract would have an adverse effect on GCHP's future operations.

Note 3 – Summary of Significant Accounting Policies

Basis of presentation – GCHP is a county-organized health system governed by a 12-member Ventura County Medi-Cal Managed Care Commission appointed by the Ventura County Board of Supervisors. Effective for the fiscal year ended June 30, 2011, GCHP began reporting as a discrete component unit of the County of Ventura, California. The County made this determination based on the County Board of Supervisors having the right to elect 100% of the GCHP Commissioners.

Basis of accounting – GCHP uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis, using the economic resources measurement focus. The accompanying financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB).

Use of estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP) requires management to make estimates and assumptions that affect the amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Fair value of financial instruments – The carrying amounts of cash and cash equivalents approximate fair value because of the short maturity of these financial instruments. The carrying amounts reported in the statement of net position for capitation receivable, provider receivables, reinsurance and other receivables, prepaid expenses and other assets, medical claims liability, capitation payable, accounts payable, payable to the State of California, accrued payroll and employee benefits, accrued premium tax, and other liabilities approximate their fair values as they are expected to be realized within the next fiscal year.

Cash and cash equivalents – Cash and cash equivalents include highly liquid instruments purchased with an original maturity of three months or less when purchased.

Custodial credit risk-deposits – Custodial credit risk is the risk that in the event of a bank failure, GCHP may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the state law. As of December 31, 2025 and June 30, 2025, all accounts were covered by posted collateral.

Investments – Investments are stated at fair value in accordance with GASB Codification Section 150. The fair value of investments is estimated based on quoted market prices, when available. For debt securities not actively traded, fair values are estimated using values obtained from external pricing services or are estimated by discounting the expected future cash flows, using current market rates applicable to the coupon rate, credit, and maturity of the investments. Certain external investment pools are carried at amortized cost.

All investments with an original maturity of one year or less when purchased are recorded as current investments, unless designated or restricted for long-term purposes.

Capitation receivable – Capitation receivable represents capitation revenue for the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, received subsequent to December 31, 2025 and June 30, 2025, respectively. Capitation receivable also includes final revenue rate adjustments based on communications from the DHCS. Management determines the allowance for doubtful accounts by regularly evaluating individual receivables and considering payment history, financial condition, and current economic conditions. Subsequent adjustments to the contracted rates or enrollments are recognized in the period the adjustment is determined.

Provider receivables – Provider receivables are recorded for all claim refunds or advance payments due from providers. Management determines the allowance for doubtful accounts by regularly evaluating individual receivables and considering payment history, financial condition, and current economic conditions. As of June 30, 2025, the provider receivable balance included approximately $34,000,000 outstanding from a provider advance to a related party, which was paid in full during the six-month period ended December 31, 2025.

Reinsurance – In the normal course of business, the Plan seeks to reduce the loss that may arise from events that cause unfavorable medical claim results by reinsuring certain levels of risk in various areas of exposure with a reinsurer. Amounts recoverable from reinsurance are estimated in a manner consistent with the development of the medical claim liability.

Amounts recoverable from reinsurers that relate to paid claims are classified as assets and as a reduction to medical expenses incurred. Reinsurance premiums paid are included in medical expenses.

Capital assets – Capital assets are stated at cost at the date of acquisition. The costs of normal maintenance, repairs, and minor replacements are expensed when incurred. Capital assets acquired but not yet placed into service are reported as construction in progress. Construction-in-progress assets are not depreciated until they are placed into service.

Depreciation is calculated using the straight-line method over the estimated useful lives of the assets. Long-lived assets are periodically reviewed for impairment. The estimated useful lives of three to seven years are used for furniture, fixtures, computer equipment, and software. Leasehold improvements are depreciated over the life of the lease or estimated useful life, whichever is shorter. Depreciation expense for the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, was approximately $140,000 and $347,000, respectively.

Intangible right to use subscription assets are initially measured at an amount equal to the initial measurement of the related subscription liability plus any contract payments made to the Subscription-Based Information Technology Arrangements (SBITA) vendor at the commencement of the subscription term and capitalizable initial implementation costs, less any incentive payments received from the SBITA vendor at the commencement of the subscription term. The subscription assets are amortized on a straight-line basis over the shorter of the subscription term or the useful life of the underlying assets. Refer to Note 8 for additional information.

Medical claims liability, capitation payable, and medical expenses – GCHP establishes a claims liability based on estimates of the ultimate cost of claims in process and a provision for claims incurred but not yet reported, which is actuarially determined based on historical claims payment experience and other operational changes. In cases where adequate historical claims payment experience does not yet exist for a new population, a book-to-budget methodology is used in which GCHP relies on state-developed medical rates or medical loss ratios to estimate claims liabilities.

Such reserves are continually monitored and reviewed, with any adjustments made as necessary in the period the adjustment is determined. Management believes that the claims liability is adequate and fairly stated; however, this liability is based on estimates, and the ultimate liability may differ from the amounts provided.

GCHP has provider services agreements with several health networks in Ventura County, whereby the health networks provide care directly to covered members or through subcontracts with other health care providers. Payment for the services provided by the health networks is on a fully capitated basis. The capitation amount is based on contractually agreed-upon terms with each health network. GCHP may withhold amounts from providers at an agreed-upon percentage of capitation payments made to ensure the financial solvency of each contract. The capitation expense is included in provider capitation in the statements of revenues, expenses, and changes in net position.

Medical claims payments to a related party amounted to approximately $71,103,000 and $106,790,000 during the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, respectively and are included in claim payments to providers and facilities on the accompanying statements of revenues, expenses, and changes in net position.

Payable to the State of California – The liability as of December 31, 2025 and June 30, 2025, was approximately $59,126,000 and $36,908,000, respectively, due to State of California funding programs that have minimum Medical Loss Ratio (MLR) requirements and potential amounts due back to the State. The majority of the balance as of December 31, 2025 represents an estimate due back to the State of California for the Unsatisfactory Immigration Status risk corridor for the period January 1, 2024 through December 31, 2024, ECM risk corridor for the period of January 1, 2023 through December 31, 2025, and an estimate for premium rate adjustments and overpayments. The majority of the balance as of June 30, 2025, represents an estimate due back to the State of California for the ECM risk corridor for the period of January 1, 2023 through June 30, 2025, and an estimate for premium rate adjustments and overpayments. As of December 31, 2025 and June 30, 2025, the estimated amount due related to the ECM risk corridor was approximately $17,749,000 and $16,799,000, respectively. The liability may vary depending on actual claims experience and final reconciliation and audit results. This liability is presented in the payable to the State of California in the accompanying statements of net position.

Accounts payable and accrued expenses – GCHP is required to estimate certain expenses, including accrued payroll, payroll taxes, and professional services fees, as of each statement of net position date and make appropriate accruals based on these estimates. Estimates are affected by the status and timing of services provided relative to the actual level of services performed by the service providers. The date on which certain services commence, the level of services performed on or before a given date, and the cost of services are often subject to judgment. These judgments are based upon the facts and circumstances known at the date of the financial statements. For the periods presented in the financial statements, there were no material adjustments to the estimates for accrued payroll, payroll taxes, and professional services fees.

Premium deficiency reserves – GCHP performed an analysis of its expected future health care and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve would be accrued. A premium deficiency reserve was not required as of December 31, 2025 and June 30, 2025.

Accrued compensated absences – GCHP accrues compensated absences in accordance with GASB Statement No. 101, Compensated Absences (GASB 101) GASB 101 requires that liabilities for compensated absences be recognized for (1) leave that has not been used, and (2) leave that has been used but not yet paid in cash or settled through noncash means. A liability should be recognized for leave that has not been used if (a) the leave is attributable to services already rendered, (b) the leave accumulates, and (c) the leave is more likely than not to be used for time off or otherwise paid in cash or settled through noncash means. This statement requires that a liability for certain types of compensated absences, including parental leave, military leave, and jury duty leave, not be recognized until the leave commences. It also requires that a liability for specific types of compensated absences not be recognized until the leave is used.

GCHP's policy permits eligible employees to accrue vacation based on their individual employment agreements. Unused vacation may be carried over into subsequent years, up to limits indicated in their employment agreements. Accumulated vacation will be paid to the employee upon separation from service with GCHP. All compensated absences are accrued and recorded in accordance with GASB 101 and are included in accrued payroll and employee benefits in the accompanying statements of net position. GCHP provides paid sick leave. Unused sick hours carry over from one year to the next. Unused time under this policy is not paid out at the time of separation from employment.

Premium taxes – On December 15, 2023, the Centers for Medicare and Medicaid Services (CMS) approved the MCO tax authorized by Assembly Bill 119 (Chapter 13, Statutes of 2023) and submitted by DHCS on June 29, 2023. The MCO tax was approved with an effective date of April 1, 2023, through December 31, 2026, as provided in AB 119 and requested by DHCS. The MCO tax model is based on enrollment in each applicable health plan using data for January 1, 2022, through December 31, 2022, year, as modified by DHCS, and for known or anticipated changes that will affect Medi-Cal enrollment on or after January 1, 2024. GCHP's MCO tax liability for the period July 1, 2025 to December 31, 2025, is approximately $204,788,000, of which $106,146,000 remains unpaid as of December 31, 2025. GCHP's MCO tax liability for the year ended June 30, 2025, is approximately $410,247,000, of which $105,862,000 remains unpaid as of June 30, 2025.

Net position – Net position is broken down into three categories, defined as follows:

Net invested in capital assets – This component of net position consists of capital assets, including restricted capital assets, net of accumulated depreciation, and is reduced by the outstanding balances of any bonds, notes, or other borrowings that are attributable (if any) to the acquisition, construction, or improvement of those assets.

Restricted – This component of net position consists of external constraints placed on net asset used by creditors (such as through debt covenants), grantors, contributors, or law or regulations of other governments. It also pertains to constraints imposed by law or constitutional provisions or enabling legislation. There was approximately $322,000 and $316,000 classified as restricted net position based upon constraints imposed by enabling legislation as of December 31, 2025 and June 30, 2025, respectively.

Unrestricted – This component of net position consists of net position that does not meet the definition of "restricted" or "net invested in capital assets."

Revenue recognition – Capitation revenue received under the Contract is recognized during the period in which GCHP is obligated to provide medical service to the beneficiaries. This revenue is based on estimated enrollment provided monthly by the DHCS and capitation rates as provided for in the DHCS Contract. Enrollment and the capitation rates are subject to retrospective changes by the DHCS. As such, capitation revenue includes an estimate for amounts receivable from or refundable to the DHCS for these retrospective changes in estimates. These estimates are continually monitored and reviewed, with any changes in estimates recognized in the period when determined.

During the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, GCHP received approximately $11,000 and $21,742,000, respectively, of supplemental fee revenue from the DHCS as a hospital quality assurance fee (HQAF) as a result of SB 229. This program uses hospital fees assessed by the State to draw down federal matching funds, that are then distributed to qualifying hospitals.

DHCS implemented a managed care Designated Public Hospital (DPH) Quality Incentive Pool (QIP) that was expanded effective July 1, 2020, under which managed care plans were directed to make QIP payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The QIP payments are linked to delivery of services under the managed care plan contracts and increase the amount of funding tied to quality outcomes. During the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, GCHP received approximately $59,700,000 and $119,818,000, respectively, in QIP payments.

DHCS also established a Directed Payments DPH Enhanced Payment Program (EPP) under which managed care providers were directed to reimburse California's 21 DPHs for network contracted services delivered by DPH systems, enhanced by either a uniform percentage or dollar increment based on actual utilization of network contracted services. The State will evaluate the extent to which enhanced payments are achieving the goals identified. During the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, GCHP received approximately $19,429,000 and $17,959,000, respectively, through the EPP.

DHCS also established a Private Hospital Directed Payment Program (PHDPP) under which managed care providers were directed to reimburse private hospitals, as defined in WIC 14169.51, based on actual utilization of contracted services. The enhanced payment is contingent upon hospitals providing adequate access to service, including primary, specialty, and inpatient (both tertiary and quaternary) care. During the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, GCHP received approximately $47,718,000 and $32,918,000, respectively, through the PHDPP.

GCHP passed these HQAF, QIP, EPP, and PHDPP funds through to providers. These amounts were not reflected in the accompanying financial statements for the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, as the amounts passed through to the providers do not meet requirements for revenue recognition under accounting standards issued by the GASB.

GCHP has an agreement with the DHCS to receive an intergovernmental transfer (IGT) through a capitation rate increase of $48,289,000 and $44,899,000 recorded in the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, respectively. Under the agreement, these funds that are distributed to providers are not reported on the statements of revenues, expenses, and changes in net position, or the statements of net position, as these amounts do not meet requirements for revenue recognition under accounting standards issued by GASB. GCHP retained $241,000 and $226,000 the IGT during the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, for administrative costs.

DHCS has established the CalAIM Incentive Payment Program (IPP). Under the program, GCHP is eligible to receive incentive payments from DHCS based on the successful completion of DHCS-established development goals, objectives, and measures of the program's priority areas. During the period July 1, 2025, to December 31, 2025, the Plan did not receive funds under this program, and no related revenue was recognized. The Plan received approximately $8,001,000 in December 2024. The amount was recognized as revenue during the year ended June 30, 2025.

Operating revenues and expenses – GCHP's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with arranging for the provision of health care services. Operating expenses are all expenses incurred to arrange for the provision of health care services, as well as the costs of administration. Claims adjustment expenses are an estimate of the cost to process the claims and are included in operating expenses. Nonexchange revenues and expenses are reported as nonoperating revenues and expenses.

Administrative expenses – Administrative expenses are recognized as incurred and consist of administrative expenses that directly relate to the implementation and operation costs of the Plan. Capitation contract acquisition costs are expensed in the period incurred.

Defined contribution plan – GCHP has adopted, and its employees are participants in, the California Public Agencies Self-Directed Tax-Advantaged Retirement System (CPA STARS). CPA STARS is a California public trust organized under the laws of the State of California and includes the STARS 401(a) Retirement Plan (the 401 Plan), which is a retirement plan under Section 401(a) of the Internal Revenue Code. GCHP participation in the 401 Plan is defined by the 401(a) Trust Agreement and the 401 Plan Agreement between GCHP and CPA STARS.

All regular employees participate in the CPA STARS 401 Plan. Employee contributions to the 401 Plan are not allowed. GCHP makes employer contributions to the 401 Plan in an amount annually determined under the 401 Plan Agreement. For the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, GCHP contributions to the 401 Plan were $2,842,000 and $4,894,000, respectively.

Deferred compensation plan – GCHP has adopted, and its employees are participants in, the CPA STARS 457(b) deferred compensation plan (the 457 Plan). The 457 Plan was created in accordance with Internal Revenue Code Section 457 and permits employees to defer a portion of their annual salary until future years. GCHP participation in the 457 Plan is defined by the 457 Trust Agreement between GCHP and CPA STARS. Employee participation in the 457 Plan is voluntary, and GCHP has not made any contributions. As such, there were no GCHP employer contributions for the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025.

Leases – GCHP recognizes lease contracts or equivalents that have a term exceeding one year, the cumulative future payments on the contract exceed $50,000, and that meet the definition of an other than short-term lease. GCHP uses a discount rate that is explicitly stated or implicit in the contract. When a readily determinable discount rate is not available, the discount rate is determined using GCHP's incremental borrowing rate at start of the lease for a similar asset type and term length to the contract. Short-term lease payments are expensed when incurred.

Income taxes – GCHP operates under the purview of the Internal Revenue Code, Section 501(a) and corresponding California Revenue and Taxation Code provisions. As such, GCHP is not subject to federal or state taxes. Accordingly, no provision for income tax has been recorded in the accompanying financial statements.

Risk management – GCHP is exposed to various risks of loss from torts, business interruption, errors and omissions, and natural disasters. Commercial insurance coverage is purchased by GCHP for claims arising from such matters. No claims have exceeded commercial coverage.

Reclassifications – Certain reclassifications have been made to the June 30, 2025, financial statements to conform to the December 31, 2025, presentation, with no impact to net position or change in net position.

Recent accounting pronouncements – In April 2024, the GASB issued Statement No. 103, *Financial Reporting Model Improvements* (GASB 103). GASB 103 requires additional presentation and disclosure changes in the areas of management discussion & analysis, unusual or infrequent items, proprietary fund statement of revenues, expenses, and changes in fund net position, major component units, and budgetary comparison information. GCHP has elected to change its fiscal year-end from June 30 to December 31, effective December 31, 2025. As a result, there will be a six-month stub period ending December 31, 2025. The requirements of GASB 103 are effective for fiscal years beginning after June 15, 2025. GCHP is reviewing the impact of the adoption of GASB 103 for the fiscal year ending December 31, 2026.

In September 2024, GASB issued Statement No. 104, *Disclosure of Certain Capital Assets* (GASB 104). The objective of GASB 104 is to provide users of government financial statements with essential information about certain types of capital assets. GASB 104 requires certain types of capital assets to be disclosed separately in the capital assets note disclosures required by Statement 34. Lease assets recognized in accordance with Statement No. 87, *Leases,* and intangible right to use assets recognized in accordance with Statement No. 94, *Public-Private and Public-Public Partnerships and Availability Payment Arrangements*, should be disclosed separately by major class of underlying asset in the capital assets note disclosures. Subscription assets recognized in accordance with Statement No. 96, *Subscription- Based Information Technology Arrangements* (SBITAs), also should be separately disclosed. In addition, this Statement requires intangible assets other than those three types to be disclosed separately by major class. GASB 104 also requires additional disclosures for capital assets held for sale. A capital asset is a capital asset held for sale if (a) the government has decided to pursue the sale of the capital asset and (b) it is probable that the sale will be finalized within one year of the financial statement date. Governments should consider relevant factors to evaluate the likelihood of the capital asset being sold within the established time frame. This Statement requires that capital assets held for sale be evaluated each reporting period. Governments should disclose (1) the ending balance of capital assets held for sale, with separate disclosure for historical cost and accumulated depreciation by major class of asset, and (2) the carrying amount of debt for which the capital assets held for sale are pledged as collateral for each major class of asset. GASB 104 is effective for GCHP during the year ending December 31, 2026. Management is evaluating the implementation of this statement on their financial statements.

Note 4 – Cash and Investments

Investments – The Plan invests in obligations of the U.S. Treasury, other U.S. government agencies and instrumentalities, state obligations, corporate securities, and money market funds.

Interest rate risk – In accordance with its Annual Investment Policy (investment policy), GCHP manages its exposure to decline in fair value from increasing interest rates by matching maturity dates to the extent possible with the Plan's expected cash flow draws. Its investment policy limits maturities to five years, while also staggering maturities. The Plan maintains a low-weighted average maturity strategy, targeting a portfolio with maturities of three years or less, with the intent of reducing interest rate risk. Portfolios with low weighted average maturities are less volatile because they are less sensitive to interest rate changes. As of December 31, 2025 and June 30, 2025, the weighted average maturity of GCHP's investments, including cash equivalents was approximately 1 day.

The Plan's investments as of December 31, 2025, are summarized as follows:

Investment Type	Carrying Value	Maximum Maturity*	Weighted Average Maturity (Years)	Weighted Average Maturity (Days)
CalTrust Investment Fund	$ 40,636,009	N/A	-	1
Local Agency Investment Fund	45,490,850	N/A	-	1
Ventura County Investment Pool	20,558,506	N/A	-	1
	$ 106,685,365		-	1

* Per investment policy (Gov't code section 53601)

The Plan's investments as of June 30, 2025, are summarized as follows:

Investment Type	Carrying Value	Maximum Maturity*	Weighted Average Maturity (Years)	Weighted Average Maturity (Days)
CalTrust Investment Fund	$ 39,763,943	-	-	1
Local Agency Investment Fund	44,511,614	-	-	1
Ventura County Investment Pool	20,120,470	-	-	1
	$ 104,396,027		-	1

* Per investment policy (Gov't code section 53601)

Credit risk – GCHP's investment policy conforms to the California Government Code as well as to customary standards of prudent investment management. Credit risk is mitigated by investing in only permitted investments. The investment policy sets minimum acceptable credit ratings for investments from two nationally recognized rating services: Standard and Poor's Corporation (S&P) and Moody's Investor Service (Moody's). For an issuer of short-term debt, the rating must be no less than "A-1" (S&P) or "P-1" (Moody's), while an issuer of long-term debt shall be rated no less than an "A."

Credit ratings for investments and cash equivalents as of December 31, 2025, are summarized below:

Investment Type	Carrying Value	Minimum Legal Rating*	Ratings as of Year-End (S&P / Moody's)				
			Exempt From Rating	A-1 / P-1	A1 / AA+	A1 / A+	A2 / A
CalTrust Investment Fund	$ 40,636,009	None	$ 40,636,009	$ -	$ -	$ -	$ -
Local Agency Investment Fund	45,490,850	None	45,490,850	-	-	-	-
Ventura County Investment Pool	20,558,506	None	20,558,506	-	-	-	-
	$ 106,685,365		$ 106,685,365	$ -	$ -	$ -	$ -

* Per investment policy (Gov't code section 53601)

Credit ratings of investment and cash equivalents as of June 30, 2025, are summarized below:

Investment Type	Carrying Value	Minimum Legal Rating*	Ratings as of Year-End (S&P / Moody's)				
			Exempt from rating	A-1 / P-1	A1 / AA+	A1 / A+	A2 / A
CalTrust Investment Fund	$ 39,763,943	None	$ 39,763,943	$ -	$ -	$ -	$ -
Local Agency Investment Fund	44,511,614	None	44,511,614	-	-	-	-
Ventura County Investment Pool	20,120,470	None	20,120,470	-	-	-	-
	$ 104,396,027		$ 104,396,027	$ -	$ -	$ -	$ -

* Per investment policy (Gov't code section 53601)

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of the Plan's investment in a single issuer. GCHP's Policy does not contain any specific provisions to limit exposure to concentration of credit risk, but conforms to the California Government Code section 53601 to meet the percentage limits of investment holdings.

The Plan's percentage of portfolio as of December 31, 2025, is summarized below:

Investment Type	Issuer	Carrying Value	Percentage of Portfolio
CalTrust Investment Fund	Wells Fargo	$ 40,636,009	38.1%
Local Agency Investment Fund	State of California Treasurer	45,490,850	42.6%
Ventura County Investment Pool	County of Ventura Treasurer	20,558,506	19.3%
Total Funds Available for Investments		$ 106,685,365	100.0%

The Plan's percentage of portfolio as of June 30, 2025, is summarized below:

Investment Type	Issuer	Carrying Value	Percentage of Portfolio
CalTrust Investment Fund	Wells Fargo	$ 39,763,943	38.1%
Local Agency Investment Fund	State of California Treasurer	44,511,614	42.6%
Ventura County Investment Pool	County of Ventura Treasurer	20,120,470	19.3%
Total Funds Available for Investments		$ 104,396,027	100.0%

Investments – GCHP categorizes its fair value investments within the fair value hierarchy established by U.S. GAAP. The hierarchy for fair value measurements is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date.

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for an asset or liability, either directly or indirectly.

Level 3 – Significant unobservable inputs.

The following is a description of the valuation methodologies used for instruments at fair value on a recurring basis and recognized in the accompanying statements of net position, as well as the general classification of such instruments pursuant to the valuation hierarchy.

External investment pools – CalTrust is organized as a Joint Powers Authority established by public agencies in California for the purpose of pooling and investing local agency funds. A board of trustees supervises and administers the investment program of the trust. CalTrust has four pools: money market account, short-term, medium-term, and long-term. The Plan has deposits in the Short-Term Fund. Investments in CalTrust Short-Term Fund are highly liquid, as deposits can be converted to cash within 24 hours without loss of interest.

The Plan is a voluntary participant in CalTrust. The Plan's investment in this pool is reported in the accompanying financial statements at amortized cost, based on the Plan's pro rata share of the respective pool as reported by CalTrust. As of December 31, 2025 and June 30, 2024, the Plan held approximately $40,636,000 and $39,764,000 in CalTrust, respectively.

The California State Treasurer's Office makes available the Local Agency Investment Fund (LAIF) through which local governments may pool investments. Each governmental entity may invest up to $65,000,000 in the fund. Investments in the LAIF are highly liquid, as deposits can be converted to cash within 24 hours without loss of interest. The Plan is a voluntary participant in the LAIF. The value of the Plan's investments in the LAIF is reported in the accompanying financial statements based on the Plan's pro rata share of the amortized cost value provided by the LAIF for the entire LAIF portfolio. As of December 31, 2025 and June 30, 2025, the Plan held approximately $45,491,000 and $44,512,000 in LAIF, respectively.

The Ventura County Investment Pool (VCIP) is available to local public governments, agencies, and school districts within Ventura County (the County). Wells Fargo Bank NA serves as custodian for the pool's investments. The portfolio is typically comprised of U.S. agency securities and high-quality, short-term instruments, resulting in a relatively short-weighted average maturity. Value calculations are based on market values provided by the County's investment custodian. Investments in the VCIP are highly liquid, as deposits can be converted to cash within 24 hours without loss of interest. The Plan is a voluntary participant in the VCIP. The value of the Plan's investments in the VCIP is reported in the accompanying financial statements based on the Plan's pro rata share of the amortized cost value provided by the VCIP for the entire VCIP portfolio. As of December 31, 2025 and June 30, 2025, the Plan held approximately $20,559,000 and $20,120,000, respectively, in VCIP.

The following tables present the fair value measurements of assets recognized in the accompanying statements of net position measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall.

The Plan had the following recurring fair value measurements as of December 31, 2025:

		Fair Value Measurements Using		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments not subject to fair value hierarchy				
CalTrust Investment Fund	$ 40,636,009			
Local Agency Investment Fund	45,490,850			
Ventura County Investment Pool	20,558,506			
	$ 106,685,365			

The Plan had the following recurring fair value measurements as of June 30, 2025:

		Fair Value Measurements Using		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments not subject to fair value hierarchy				
CalTrust Investment Fund	$ 39,763,943			
Local Agency Investment Fund	44,511,614			
Ventura County Investment Pool	20,120,470			
	$ 104,396,027			

Note 5 – Administrative Services Agreements

Conduent, Inc. (Conduent), formerly Affiliated Computer Services – GCHP entered into an agreement with Conduent on June 28, 2017, to provide certain operational services, for a two-year term with 4- to 6-month extensions beginning July 1, 2017. On May 1, 2019, GCHP and Conduent entered into a new agreement extending service through June 30, 2024. On July 1, 2024, GCHP and Conduent entered into a new agreement extending service through June 30, 2025. Included in the extension is a project to replace the existing technology platform with a new system and realign business processes. Compensation for these services is based on a per-member, per-month cost at varying membership levels. These costs are recorded as expenses in the period incurred. Total expenses for services provided for the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, were approximately $731,000 and $5,231,000, respectively, and are reported in professional fees on the accompanying statements of revenues, expenses, and changes in net position.

Carelon Behavioral Health, LLC (Carelon) – On April 14, 2014, GCHP entered into a two-year agreement with Carelon, previously known as Beacon Health Strategies, to provide administrative services to arrange for and support the administration of behavioral health services for GCHP. The agreement with Carelon was extended through December 31, 2025. Total expenses for Carelon were approximately $4,413,000 and $4,404,000 for the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, respectively, and are included in professional fees on the accompanying statements of revenues, expenses, and changes in net position.

Netmark Business Services, LLC (Netmark) – GCHP entered into an agreement with Netmark on September 26, 2023, to provide services as its Business Processing Organization for its claims processing. Total expenses for Netmark were approximately $2,559,000 and $1,348,000 for the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, respectively, and are included in professional fees on the accompanying statements of revenues, expenses, and changes in net position.

Note 6 – Capital Assets

Capital asset activity during the period July 1, 2025 to December 31, 2025, consisted of the following:

	Balance June 30, 2025	Increases	Transfers	Decreases	Balance December 31, 2025
Capital assets					
Leasehold improvements	$ 1,804,976	$ -	$ -	$ (19,901)	$ 1,785,075
Software and equipment	2,779,177	-	-	(1,395,741)	1,383,436
Furniture and fixtures	1,252,545	20,000	-	(992,762)	279,783
Total capital assets	5,836,698	20,000	-	(2,408,404)	3,448,294
Less accumulated depreciation and amortization for					
Leasehold improvements	1,745,510	83,889	-	(77,214)	1,752,185
Software and equipment	2,582,368	50,677	-	(1,328,852)	1,304,193
Furniture and fixtures	1,214,373	5,510	-	(1,002,338)	217,545
Total accumulated depreciation	5,542,251	140,076	-	(2,408,404)	3,273,923
Total capital assets, net	$ 294,447	$ (120,076)	$ -	$ -	$ 174,371

Capital asset activity during the year ended June 30, 2025, consisted of the following:

	Balance June 30, 2024	Increases	Transfers	Decreases	Balance June 30, 2025
Capital assets					
Leasehold improvements	$ 1,804,976	$ -	$ -	$ -	$ 1,804,976
Software and equipment	2,745,821	33,356	-	-	2,779,177
Furniture and fixtures	1,197,450	55,095	-	-	1,252,545
Total capital assets	5,748,247	88,451	-	-	5,836,698
Less accumulated depreciation and amortization for					
Leasehold improvements	1,586,891	158,619	-	-	1,745,510
Software and equipment	2,402,873	179,495	-	-	2,582,368
Furniture and fixtures	1,205,824	8,549	-	-	1,214,373
Total accumulated depreciati	5,195,588	346,663	-	-	5,542,251
Total capital assets, net	$ 552,659	$ (258,212)	$ -	$ -	$ 294,447

Note 7 – Medical Claims Liability

Medical claims liability and capitation payable consist of the following:

	Six Months Ended December 31, 2025	Year Ended June 30, 2025
Claims payable or pending approval	$ 7,252,812	$ 18,345,175
Capitation payable	21,796,691	7,526,516
Provisions for claims incurred but not yet reported and other	131,690,924	166,097,653
Directed payments to providers payable	16,354,924	21,009,348
	$ 177,095,351	$ 212,978,692

The cost of health care services is recognized in the period in which care is provided and includes an estimate of the cost of services that has been incurred but not yet reported. GCHP estimates accrued claims payable based on historical claims payments and other relevant information. Estimates are continually monitored and reviewed, and as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate amount of claims paid is dependent on future developments, management is of the opinion that the accrued medical claims payable is adequate.

The following is reconciliation of the medical claims liability and capitation payable activity for the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025:

	December 31, 2025	June 30, 2025
Medical claims liability and capitation payable at beginning of year	$ 212,978,692	$ 168,759,042
Incurred		
Current	561,456,970	1,034,336,516
Prior	(15,017,802)	(5,454,766)
Total incurred	546,439,168	1,028,881,750
Paid		
Current	418,971,987	851,212,516
Prior	163,350,522	133,449,584
Total paid	582,322,509	984,662,100
Medical claims liability and capitation payable at end of year	$ 177,095,351	$ 212,978,692

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities at any year end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established prior reporting period liability. Negative amounts reported for incurred, related to prior years, result from claims being adjudicated and paid for amounts less than originally estimated. Results for the the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, included decreases of prior year incurred of approximately $15,018,000 and $5,455,000, respectively. Original estimates are increased or decreased as additional information becomes known regarding individual claims.

Note 8 – Commitments and Contingencies

Lease commitments – GCHP leases office space and equipment under long-term operating lease agreements. A summary of the principal and interest amounts for the remaining leases is as follows as of December 31, 2025:

Years Ending December 31,	Minimum Lease Principal	Interest
2026	$ 1,125,517	$ 99,246
2027	1,056,432	44,876
2028	274,939	2,409
2029	-	-
2030	-	-
	$ 2,456,888	$ 146,531

Intangible right to use lease asset – The Plan reported approximately $1,165,000 and $1,164,000 as amortization expense on the statements of revenues, expenses, and changes in net position in the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, respectively. Accumulated amortization was approximately $6,553,000 and $5,969,000 as of December 31, 2025 and June 30, 2025, respectively.

Subscription-based information technology arrangements – The Plan has several subscription contracts that expire at various dates through 2027, some of which have renewal options. For those contracts where renewal options are reasonably certain to be exercised, the Plan recognizes renewal option periods in the determination of its intangible right to use subscription asset and liability balances. The Plan uses an average rate of 2.92% to determine the present value of its subscription liabilities. The Plan reported approximately $3,937,000 and $13,268,000 as amortization expense on the statements of revenues, expenses and changes in net position in the period July 1, 2025 to December 31, 2025 and year ended June 30, 2025, respectively. Accumulated amortization was approximately $15,084,000 and $11,751,000 as of December 31, 2025 and June 30, 2025, respectively.

GCHP had the following intangible right to use subscription asset and subscription liability activities for the period July 1, 2025, to December 31, 2025:

	Balance June 30, 2025	Increase	Decrease	Balance December 31, 2025	Current Liability	Long-Term Liability
Intangible right to use subscription asset	56,222,876	16,419,508	(2,525,025)	$ 70,117,359		
Less accumulated amortization	(13,672,139)	(3,937,373)	2,525,025	(15,084,487)		
Total intangible right to use subscription asset, net	42,550,737	12,482,135	-	55,032,872		
Subscription liability	29,001,481	4,627,286	(5,478,110)	$ 28,150,657	$ 6,251,271	$ 21,899,386

GCHP had the following intangible right to use subscription asset and subscription liability activities for the year ended June 30, 2025:

	Balance June 30, 2024	Increase	Decrease	Balance June 30, 2025	Current Liability	Long-Term Liability
Intangible right to use subscription asset	6,755,096	54,778,549	(5,310,769)	$ 56,222,876		
Less accumulated amortization	(5,714,896)	(13,268,012)	5,310,769	(13,672,139)		
Total intangible right to use subscription asset, net	1,040,200	41,510,537	-	42,550,737		
Subscription liability	1,450,095	29,801,278	(2,249,893)	$ 29,001,480	$ 5,648,478	$ 23,353,002

A summary of the principal and interest amounts for the subscription payments is as follows as of December 31, 2025:

Years Ending December 31,	Minimum Subscription Principal	Interest
2026	$ 6,251,271	$ 813,071
2027	6,357,020	650,057
2028	6,574,215	460,279
2029	6,287,848	264,239
2030	2,680,303	79,321
	$ 28,150,657	$ 2,266,967

Litigation – Through the course of ordinary business, the Plan became party to various administrative proceedings, mediations, and was party to various legal actions and subject to various claims arising as a result. During the period July 1, 2025 to ended December 31, 2025, the Plan has successfully resolved some matters, and other administrative and legal matters are still proceeding. As a result of pending administrative and legal matters, the Plan has recorded a liability for these contingencies. It is the opinion of management that the ultimate resolution of such claims will not have a material adverse effect on the financial statements.

Regulatory matters – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties. Management believes that GCHP is in compliance with fraud and abuse, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

The Plan is also subjected to risks and uncertainties arising from potential changes in federal health care policy, funding, and budgetary adjustments affecting Medicare and Medicaid programs. Proposed and potential reductions in Medicaid funding could indirectly impact Medicare beneficiaries by placing additional strain on state budgets. Cuts to Medicaid, including the elimination of the enhanced federal match rate for expansion enrollees or the introduction of work requirements, could result in significant coverage losses, particularly among low-income individuals, persons with disabilities, and those with chronic health conditions. In response to reduced federal funding, states may increase taxes or reduce funding for other essential programs. Potential policy changes under consideration include reductions in the federal Medicaid matching rate, implementation of work requirements, more frequent eligibility redeterminations leading to disenrollments, the adoption of per-capita caps on federal funding, and the elimination of provider taxes that help offset Medicaid costs. If enacted, such changes could compel states to reduce benefits, lower provider reimbursement rates, and increase financial pressures on state budgets, which may adversely affect the Plan's operations, network adequacy, and financial performance. However, the timing, likelihood, and specific impact of these policy changes remain uncertain.

Patient Protection and Affordable Care Act (PPACA) – The ACA allowed for the expansion of Medicaid members in the State of California. Any future federal or state changes in eligibility requirements or federal and state funding could have an impact on the Plan. With the changes in the executive branch, the future of PPACA and impact of future changes in Medicaid to the Plan are uncertain at this time.

bakertilly

Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan

December 31, 2025 Stub Period Audit Results

Discussion with Management, the Executive Finance Committee, and the Commission

Agenda

1. Scope of Services
2. Significant Risks Identified
3. Matters Required to be Communicated with Those Charged with Governance
4. Your Service Team
5. About Baker Tilly

Scope of Services

We have performed the following services for Gold Coast Health Plan:

Annual Audit

- Audit of the financial statements for the period of July 1, 2025 to December 31, 2025

Non-Attest Services

- Assist management with drafting the financial statements for the period of July 1, 2025 to December 31, 2025, excluding management's discussion and analysis
- Consulting services associated with Adaptive Insights financial and budgeting solution
- Medical loss ratio review

Significant Risks Identified

During the planning of the audit we have identified the following significant risks:

Significant Risks	Procedures
Capitation Revenue Recognition	We tested internal controls around revenue recognition, vouched membership, and rates to supporting documentation, and reconciled revenue recognized to monthly cash payments from the State of California. No findings noted.
Medical Claims Liability	We tested internal controls over the claims process, performed a lookback analysis on the prior year medical claims liability estimate, reviewed the actuarial specialist's model and report, and performed analytical procedures around the current year estimate. No findings noted.
Management Override of Controls	We performed inquiries of accounting and operational personnel, performed risk assessment procedures, and tested risk-based manual journal entry selections. No findings noted.

Matters Required to be Communicated with Those Charged with Governance

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

Matters Required to be Communicated with Those Charged with Governance

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS). As part of an audit conducted in accordance with U.S. GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit.

Matters Required to be Communicated with Those Charged with Governance

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

Our audit of the financial statements included obtaining an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control or to identify deficiencies in the design or operation of internal control. Accordingly, we considered the entity's internal control solely for the purpose of determining our audit procedures and not to provide assurance concerning such internal control.

Matters Required to be Communicated with Those Charged with Governance

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We are also responsible for communicating significant matters related to the financial statement audit that are, in our professional judgment, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Matters Required to be Communicated with Those Charged with Governance

Significant Accounting Practices:

Our views about qualitative aspects of the entity's significant accounting practices, including accounting policies, accounting estimates, and financial statement disclosures

The quality of the entity's accounting policies and underlying estimates are discussed throughout this presentation. There were no changes in the entity's approach to applying the critical accounting policies.

Matters Required to be Communicated with Those Charged with Governance

Significant Unusual Transactions:	No significant unusual transactions were identified during our audit of the entity's financial statements.

Matters Required to be Communicated with Those Charged with Governance

Significant Difficulties Encountered During the Audit:

We are to inform those charged with governance of any significant difficulties encountered in performing the audit. Examples of difficulties may include significant delays by management, an unreasonably brief time to complete the audit, unreasonable management restrictions encountered by the auditor or an unexpected extensive effort required to obtain sufficient appropriate audit evidence.

No significant difficulties were encountered during our audit of the entity's financial statements.

Matters Required to be Communicated with Those Charged with Governance

Disagreements With Management:

Disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the entity's financial statements, or the auditor's report.

There were no disagreements with management.

Matters Required to be Communicated with Those Charged with Governance

Circumstances that affect the form and content of the auditor's report:	There were no circumstances that affected the form and content of the auditor’s report.

Matters Required to be Communicated with Those Charged with Governance

Other findings or issues arising from the audit that are, in the auditor's professional judgment, significant and relevant to those charged with governance regarding their oversight of the financial reporting process:	There were no other findings or issues arising from the audit to report.

Matters Required to be Communicated with Those Charged with Governance

Uncorrected Misstatements:

Uncorrected misstatements, or matters underlying those uncorrected misstatements, as of and for the six-month period ended December 31, 2025 could potentially cause future-period financial statements to be materially misstated, even though we have concluded that the uncorrected misstatements are immaterial to the financial statements, including disclosures, under audit.

There was one judgmental uncorrected misstatement identified as of December 31, 2025:

Dr. Claim Payments Expense	$3.5 million	
Cr. Provider Receivable		$3.5 million

Judgmental entry to reduce payment integrity receivable based on documented audit evidence received

Current period reversals of the June 30, 2025 uncorrected misstatements:

Dr. Capitation Revenue	$2.5 million	
Cr. Beginning Net Position		$2.5 million

Maternity receivable true-up at June 30, 2025, based upon subsequent cash receipts

Dr. Amortization Expense	$2.0 million	
Cr. Beginning Net Position		$2.0 million

Software subscription arrangement amortization true-up at June 30, 2025, based upon subledger reconciliation

Matters Required to be Communicated with Those Charged with Governance

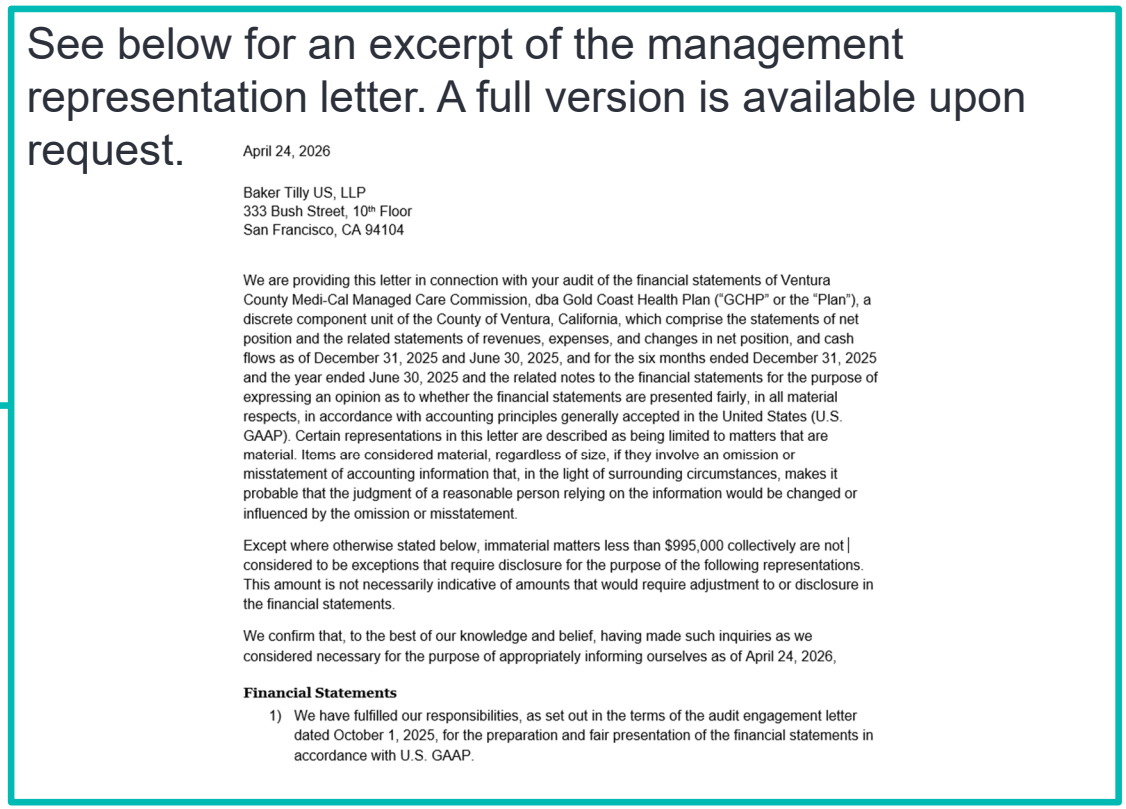
Material, Corrected Misstatements:	There were no material corrected misstatements identified.

Matters Required to be Communicated with Those Charged with Governance

Representations Requested of Management

We requested certain representations from management that are included in the management representation letter that will be dated April 24, 2026.

See below for an excerpt of the management representation letter. A full version is available upon request.



April 24, 2026

Baker Tilly US, LLP
333 Bush Street, 10th Floor
San Francisco, CA 94104

We are providing this letter in connection with your audit of the financial statements of Ventura County Medi-Cal Managed Care Commission, dba Gold Coast Health Plan ("GCHP" or the "Plan"), a discrete component unit of the County of Ventura, California, which comprise the statements of net position and the related statements of revenues, expenses, and changes in net position, and cash flows as of December 31, 2025 and June 30, 2025, and for the six months ended December 31, 2025 and the year ended June 30, 2025 and the related notes to the financial statements for the purpose of expressing an opinion as to whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States (U.S. GAAP). Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Except where otherwise stated below, immaterial matters less than $995,000 collectively are not considered to be exceptions that require disclosure for the purpose of the following representations. This amount is not necessarily indicative of amounts that would require adjustment to or disclosure in the financial statements.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of April 24, 2026,

Financial Statements

1) We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated October 1, 2025, for the preparation and fair presentation of the financial statements in accordance with U.S. GAAP.

Matters Required to be Communicated with Those Charged with Governance

Management's Consultation with Other Accountants:

When we are aware that management has consulted with other accountants about significant auditing or accounting matters, we discuss with those charged with governance our views about the matters that were the subject of such consultation.

We are not aware of instances where management consulted with other accountants about significant auditing or accounting matters.

Matters Required to be Communicated with Those Charged with Governance

Significant issues arising from the audit that were discussed, or the subject of correspondence with management:	No significant issues arose during the audit that have not been addressed elsewhere in this presentation.

Matters Required to be Communicated with Those Charged with Governance

AU-C 265, *Communicating Internal Control Related Matters Identified in an Audit*

No material weaknesses were reported and no significant deficiencies to communicate.

Your Service Team

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bakertilly

About Baker Tilly

CONTINUED EXCELLENCE

Our resources, your goals

Baker Tilly will continue to successfully guide our clients through changing landscapes with skills, stability, and strength as one of the oldest and largest advisory, tax, and assurance firms in the United States.

6th
largest U.S. accounting firm

11,000+
team members, 1,000+ principals

100+
years in business

~3,400
Certified Public Accountants

$3B+
firm revenue in FY2024

100+
worldwide office locations

300+
workplace and culture awards

INDUSTRY EXPERTISE

Committed to health care

The demand for vital health care services continues to rise amid a multitude of challenges that impact the quality, accessibility, and efficiency of care.

From helping you comply with new regulations to easing your tax burden to exploring new care models, our dedicated health care professionals have the experience and expertise to help you navigate a complex new world.

Nearly
6,500
HEALTH CARE CLIENTS
across the nation

Nearly
500
PROFESSIONALS
specializing in health care

More than
60
PRINCIPALS
specializing in health care

LEADERSHIP INVOLVEMENT
with AICPA Health Care Expert Panel and HFMA National Principles and Practice Board

Health care advisory services

Audit and tax are vital. But you have complex needs that go beyond these core functions. Our dedicated health care consulting team provides a range of services to address all your emerging needs—both now and in the future.

Health care consulting

STRATEGY & INTEGRATION

- Provider risk analysis, contracting & operational design
- M&A support
- Feasibility studies
- Market intelligence & benchmarking
- Strategic planning & implementation
- Managed care assessment & negotiation
- Service line enhancement & analyses

INFORMATION TECHNOLOGY

- HIPAA security & privacy
- Network security & penetration testing
- HITRUST assessment & certification
- Disaster recovery planning
- PCI DSS audits
- SOC pre-audit gap analysis & readiness
- SOC audits

PROVIDER REIMBURSEMENT ENTERPRISE SERVICES

- Medicare & Medicaid
- Provider-based licensure & certification
- Medical education
- Uncompensated care
- Wage index reviews
- Contract compliance

OPERATIONAL IMPROVEMENT

- Revenue cycle enhancement
- Claims recovery
- Litigation support
- Employer health benefits
- Financial turnaround
- Performance excellence
- Valuations

GOVERNMENT COMPLIANCE

- Regulatory compliance
- Coding validation
- Coding department redesign
- EHR internal controls
- Corporate compliance

LEAN TRANSFORMATION

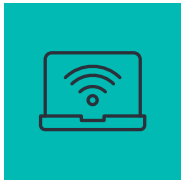
- 3P & innovation
- Lean strategic planning & strategy deployment (hoshin kanri)
- Lean management systems & operations
- Quality & patient safety
- Internal infrastructure development

An array of resources

In today's fast-paced world, we know how precious your time is. We also know that knowledge is key. These resources offer what you need to know, when you need to know it, and are presented in the format that fits your life.

Articles & alerts

Industry-specific insight and important tax and assurance updates

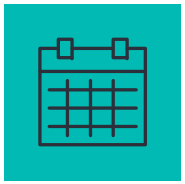


Webcasts

On-demand and live sessions with our professionals on technical and timely topics

Reports & guides

A more in-depth look at significant changes and subjects across the accounting landscape



Events

Seminars, destination conferences, networking receptions, and charity events, among others

Thank you

AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Jeff Register, Interim Chief Financial Officer-Controller

DATE: April 27, 2026

SUBJECT: March 2026 Year to Date Financial Results

SUMMARY:

Staff is presenting the attached March 2026 year-to-date ("YTD") unaudited financial statements of Gold Coast Health Plan ("GCHP") as presented to the Executive Finance Committee on April 23, 2026.

ATTACHMENT:

March 2026 Financial Package

APPENDIX:

- Income Statement YTD
- Balance Sheet
- Statement of Cash Flow
- Statement of Investments and Cash Balances

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	For the Month Ended March 2026				Fiscal Year to Date Through March 2026			
	Mar 2026 ACTUALS	Mar 2026 BUDGET	Fav /(Unfav)	%	Mar 2026 ACTUALS	Mar 2026 BUDGET	Fav /(Unfav)	%
Membership	230,874	231,889	(1,015)	-0.4%	697,927	698,748	(821)	-0.1%
Revenue								
Premium	$ 139,677,070	$ 139,859,925	$ (182,855)	-0.1%	$ 420,843,178	$ 421,480,235	$ (637,057)	-0.2%
Facility Expense AB85			-			-	-	
Reserve for Cap Requirements	(539,315)	(246,783)	(292,532)	118.5%	(1,493,508)	(744,447)	(749,060)	100.6%
Incentive Revenue	-	-	-		-	-	-	
MCO Premium Tax	(35,905,164)	(34,604,855)	(1,300,309)	3.8%	(103,923,303)	(104,301,624)	378,320	-0.4%
Total Net Premium	**103,232,591**	**105,008,287**	**(1,775,696)**	**-1.7%**	**315,426,367**	**316,434,164**	**(1,007,797)**	**-0.3%**
						-		
Other Revenue:								
Miscellaneous Income	145	-	145		370	-	370	
Total Other Revenue	145	-	145		370	-	370	
Total Revenue	**103,232,736**	**105,008,287**	**(1,775,551)**	**-1.7%**	**315,426,737**	**316,434,164**	**(1,007,427)**	**-0.3%**
Medical Benefits:								
Capitation:								
PCP, Specialty, Kaiser, NEMT & Vision	4,056,418	4,505,101	448,683	10.0%	11,280,487	13,603,627	2,323,140	17.1%
ECM	1,804,063	1,066,043	(738,020)	-69.2%	4,878,456	3,213,552	(1,664,905)	-51.8%
Total Capitation	**5,860,482**	**5,571,144**	**(289,338)**	**-5.2%**	**16,158,943**	16,817,179	**658,235**	**3.9%**
FFS Claims:								
Inpatient	18,313,727	19,940,064	1,626,337	8.2%	62,784,623	60,064,125	(2,720,499)	-4.5%
LTC / SNF	14,915,959	16,781,314	1,865,355	11.1%	48,640,189	50,407,905	1,767,716	3.5%
Outpatient	8,391,203	9,696,673	1,305,470	13.5%	28,199,338	29,131,421	932,084	3.2%
Laboratory and Radiology	2,004,188	861,957	(1,142,231)	-132.5%	4,327,939	2,605,450	(1,722,488)	-66.1%
Directed Payments - Provider	829,385	812,672	(16,713)	-2.1%	2,338,613	2,444,169	105,557	4.3%
Emergency Room	5,472,643	4,371,588	(1,101,055)	-25.2%	14,338,319	13,110,801	(1,227,518)	-9.4%
Physician Specialty	10,892,081	7,303,781	(3,588,300)	-49.1%	29,014,555	21,992,408	(7,022,148)	-31.9%
Primary Care Physician	6,417,734	7,401,048	983,314	13.3%	16,080,081	22,228,184	6,148,103	27.7%
Home & Community Based Services	(2,365,403)	4,580,793	6,946,195	151.6%	9,630,246	13,688,107	4,057,861	29.6%
Medically Supportive Food	6,668,495	-	(6,668,495)		6,668,495	-	(6,668,495)	
Applied Behavior Analysis Services	5,944,488	5,432,088	(512,400)	-9.4%	15,769,637	16,175,482	405,844	2.5%
Pharmacy	231,303	137,190	(94,113)	-68.6%	566,086	357,304	(208,782)	-58.4%
Quality Incentive Provider Program (QIPP)	3,506,516	3,240,475	*(266,041)*	*-8.2%*	9,829,049	9,719,943	(109,105)	*-1.1%*
Other Medical Professional	432,904	1,837,185	1,404,282	76.4%	2,477,458	5,523,184	3,045,726	55.1%
Other Fee For Service	1,764,097	2,003,402	239,305	11.9%	5,637,134	6,016,452	379,318	6.3%
Settlements - Medical	(15,093)	-	15,093		(15,093)	-	15,093	
Transportation	250,017	494,072	244,055	49%	1,220,017	1,484,226	264,209	18%
Total Claims	**83,654,243**	**84,894,302**	**1,240,059**	**1.5%**	**257,506,686**	**254,949,162**	**(2,557,524)**	**-1.0%**
Provider Grant Program	943,745	915,161	(28,583)	-3%	3,017,716	2,729,353	(288,363)	-11%
Medical & Care Management	1,669,567	1,951,893	282,326	14%	5,038,010	5,881,991	843,981	14%
Reinsurance	(724,302)	307,217	1,031,519	336%	(884,347)	927,359	1,811,706	195%
Claims Recoveries	(126,246)	(158,333)	(32,087)	20%	(384,320)	(475,000)	(90,680)	19%
Sub-total	**1,762,764**	**3,015,939**	**1,253,175**	**42%**	**6,787,060**	**9,063,703**	**2,276,643**	**25%**
Total Medical Benefits	91,277,488	93,481,384	2,203,896	2.4%	280,452,689	280,830,043	377,354	0.1%
Contribution Margin	**11,955,248**	**11,526,902**	**428,345**	**3.7%**	**34,974,048**	**35,604,121**	**(630,073)**	**-1.8%**
General & Administrative Expenses:								
Salaries, Wages & Employee Benefits	6,722,629	7,060,493	337,864	5%	20,794,866	21,181,480	386,614	2%
Training, Conference & Travel	18,190	52,500	34,310	65%	279,332	157,500	(121,832)	-77%
Outside Services	1,579,766	2,470,733	890,967	36%	5,180,478	7,412,199	2,231,721	30%
Professional Services	837,641	1,406,687	569,046	40%	2,404,750	4,220,062	1,815,313	43%
Occupancy, Supplies, Insurance & Others	3,764,366	2,754,097	(1,010,269)	-37%	10,299,273	8,262,291	(2,036,981)	-25%
ARCH/Community Grants	-	183,975	183,975	100%	37,889	551,924	514,035	93%
Sponsorships	5,000	61,325	56,325	92%	9,500	183,975	174,475	95%
Care Management Reclass to Medical	(1,669,567)	(1,951,893)	(282,326)	14%	(5,038,010)	(5,881,991)	(843,981)	14%
G&A Expenses	**11,258,026**	**12,037,918**	**779,892**	6%	**33,968,077**	**36,087,441**	**2,119,364**	**6%**
D-SNP	(1,505,725)	-	1,505,725		1,294,296	-	(1,294,296)	
Project Portfolio	**(1,505,725)**	**-**	**1,505,725**		**1,294,296**	**-**	**(1,294,296)**	
Total G&A Expenses	**9,752,301**	**12,037,918**	**2,285,617**	**19%**	**35,262,374**	**36,087,441**	825,067	2%
Total Operating Gain / (Loss)	**2,202,947**	**(511,015)**	**2,713,962**	-531%	**(288,326)**	**(483,320)**	**194,994**	**40.3%**
Retro Premium Adj	-	-	-		-	-	-	
Non Operating								
Revenues - Interest	840,679	1,000,000	(159,321)	-15.9%	2,580,995	3,000,000	(419,005)	-14%
Expenses - Interest	-	-	-		-	-	-	
Gain/(Loss) on Sale of Asset	-	-			-			
Total Non-Operating	**840,679**	**1,000,000**	(159,321)	-15.9%	**2,580,995**	**3,000,000**	(419,005)	-14%
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 3,043,626**	**$ 488,985**	**$ 2,554,641**	**522%**	**$ 2,292,669**	**$ 2,516,680**	**$ (224,011)**	**-9%**

STATEMENT OF FINANCIAL POSITION		
	As of Month Ending, March 2026	As of Month Ending, December 2025
ASSETS		
Current Assets:		
Total Cash and Cash Equivalents	**$ 364,880,276**	**$ 294,296,437**
Total Short-Term Investments	**107,163,467**	**106,685,365**
Medi-Cal Receivable	164,638,183	156,518,148
Interest Receivable	1,176,673	808,060
Provider Receivable	10,523,962	13,571,218
Other Receivables	10,011,071	8,823,232
Total Accounts Receivable	**186,349,889**	**179,720,658**
Total Prepaid Accounts	14,901,960	8,959,028
Total Other Current Assets	320,246	320,402
Total Current Assets	**673,615,838**	**589,981,890**
Total Fixed Assets	**65,388,266**	**66,277,453**
Total Long-Term Investments		
Total Assets	**$ 739,004,104**	**$ 656,259,343**
LIABILITIES & NET ASSETS		
Current Liabilities:		
Incurred But Not Reported	$ 144,358,086	$ 131,690,924
Claims Payable	3,003,882	7,252,812
Capitation Payable	4,835,153	8,073,833
Physician Payable	13,376,997	11,519,669
DHCS - Reserve for Capitation Recoup	52,060,417	53,643,320
Lease Payable- ROU	6,551,084	7,376,788
Accounts Payable	67,714,008	(50)
Accrued ACS	391,536	407,101
Accrued Provider Incentives/Reserve	18,035,255	18,558,113
Accrued Expenses	16,684,804	25,109,584
Accrued Premium Tax	107,817,696	106,146,397
Accrued Payroll Expense	19,946,757	10,929,318
Quality Withhold	12,310,044	5,482,803
Total Current Liabilities	**467,689,545**	**386,618,343**
Long-Term Liabilities:		
Lease Payable - NonCurrent - ROU	22,611,644	23,230,757
Total Long-Term Liabilities	**22,611,644**	**23,230,757**
Total Liabilities	**490,301,189**	**409,849,100**
Net Assets:		
Beginning Net Assets	245,659,289	243,855,602
Total Increase / (Decrease in Unrestricted Net Assets)	3,043,626	2,554,641
Total Net Assets	**248,702,915**	**246,410,243**
Total Liabilities & Net Assets	**$ 739,004,104**	**$ 656,259,343**

STATEMENT OF CASH FLOWS		
	For the Month Ended March 2026	Fiscal Year to Date Through March 2026
Cash Flows Provided By Operating Activities		
Net Income (Loss)	$ 3,043,625	$ 2,292,669
Adjustments to reconciled net income to net cash provided by operating activities		
Depreciation on fixed assets	(1,209,115)	1,405,359
Changes in Operating Assets and Liabilities		
Accounts Receivable	11,914,082	(6,629,230)
Prepaid Expenses	4,457,366	(5,942,932)
Accrued Expense and Accounts Payable	61,766,513	72,130,309
Current Portion of Deferred Revenue	(980,271)	-
Claims Payable	1,445,886	(5,630,281)
MCO Tax liability	35,905,164	1,671,298
IBNR	5,000,830	12,667,161
Net Cash Provided by (Used in) Operating Activities	**121,344,081**	**71,964,353**
Cash Flow Provided By Investing Activities		
Proceeds from Investments	(88,101)	(478,102)
Purchase of Property and Equipment	(2,443,489)	(516,016)
Net Cash (Used In) Provided by Investing Activities	**(2,531,590)**	**(994,118)**
Cash Flow Provided By Financing Activities		
Lease Payable - ROU	(129,361)	(386,396)
Net Cash Used In Financing Activities	**(129,361)**	**(386,396)**
Increase/(Decrease) in Cash and Cash Equivalents	118,683,130	70,583,839
Cash and Cash Equivalents, Beginning of Period	246,197,146	294,296,437
Cash and Cash Equivalents, End of Period	**$ 364,880,276**	**$ 364,880,276**

SCHEDULE OF INVESTMENTS AND CASH BALANCES		
	Market Value as of Month Ending, March 2026	Account Type
Local Agency Investment Fund (LAIF)	$ 45,696,151	Investment
Ventura County Investment Pool	20,558,506	Investment
CalTrust	40,908,810	Short-term investment
Bank of Montreal	367,225,070	Money market account
Columbia Bank	(2,344,794)	Operating accounts
Investments and monies held by GCHP	***$ 472,043,743***	

Gold Coast Health Plan℠
A Public Entity

March 2026 YTD Results

Ventura County Medi-Cal Managed Care Commission
April 27, 2026

Felix L. Nunez,M.D., Chief Executive Officer
Jeff Register, Interim Chief Financial Officer-Controller

Integrity
Accountability
Collaboration
Trust
Respect

Executive Summary

- 2026 Capitated Premium Rates reflect a net 11.7% increase over 2025 Capitated Premium Rates
  - The magnitude of the adjustment acknowledges that prior rates were insufficient to adequately support medical expenses and administration of the plan
- Quarter end membership is unfavorable to budget by 1,015 members, or 0.4%, and has declined by approximately 7,000 members, or 2.9% since December 2025
- Overall performance for the quarter, although slightly unfavorable to budget, is largely in line with expectations
- Tangible Net Equity (TNE) is currently 543% of the State requirement, and is within the target range set by the Commission

Note: The financial results presented are unaudited, preliminary, and subject to restatement.

March 2026 Year-to-Date Financial Results

Item	Actual	Budget
Member Months	697,927	698,748
Revenue *Revenue pmpm*	$315.4M *$451.95*	$316.4M *$452.86*
Medical Cost *Medical Costs pmpm* Medical Loss Ratio	$267.6M *$383.43* 84.8%	$268.4M *$384.09* 84.8%
Administrative Cost *Admin Cost PMPM* Administrative Loss Ratio	$35.3M *$50.52* 11.2%	$36.1M *$51.65* 11.4%
Operating Results	**$12.6M**	**$12.0M**
Investment Income	$2.6M	$3.0M
Quality Strategy (Grants/Incentives)	$12.8M	$12.4M
Non Operating Results	**($10.3M)**	**($9.4M)**
Net Income/(Loss)	**$2.3M**	**$2.5M**
TNE	$248.7M	$248.9M

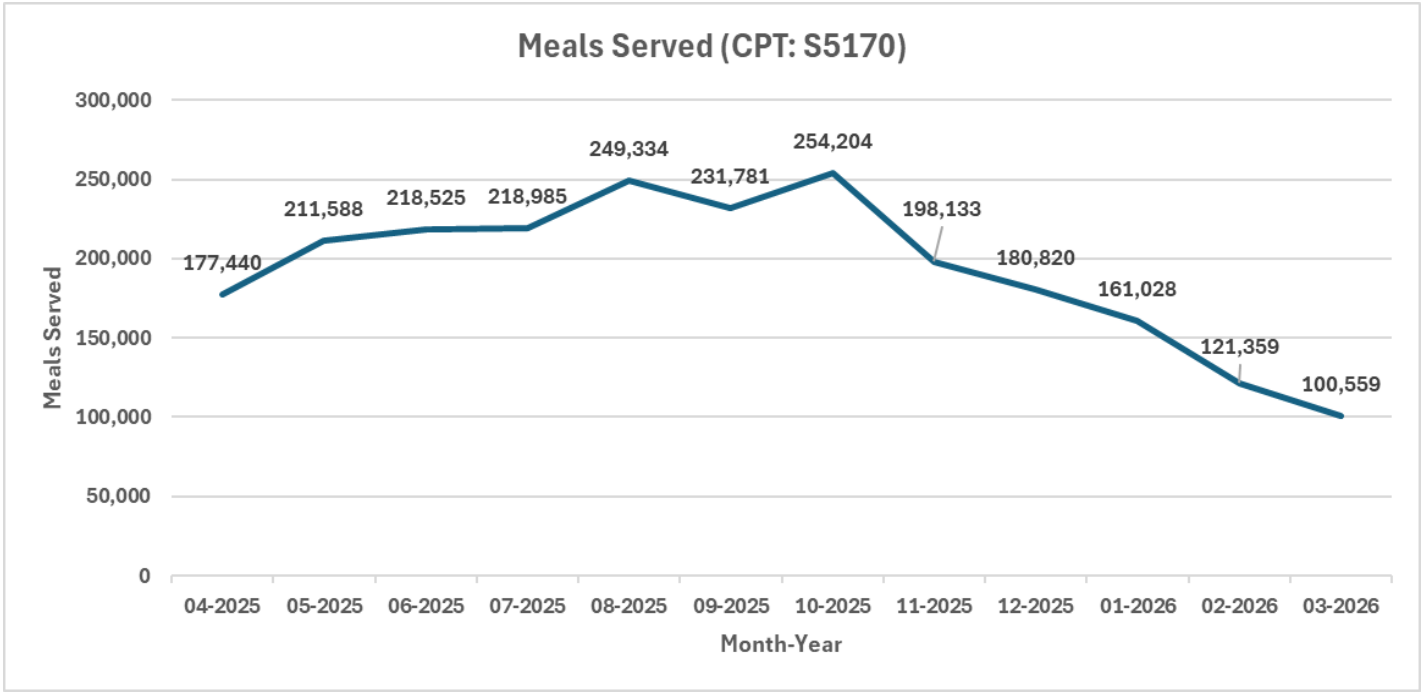
March YTD Results are largely tracking with budget across all categories:

Highlights

- Membership is slightly below budget, driving volume related decreases in revenue and medical expense
- Medical Loss Ratio is aligned with budgeted expectations
- Administrative costs is $0.8M, or 0.2%, favorable to budget
- Investment income is $400K, or 14%, unfavorable to budget due to lower interest rates and balances
- Continued strong investment in Quality Strategy initiatives
- The March TNE is 543% of the state requirement

Note: The financial results presented are unaudited, preliminary, and subject to restatement.

Medically Supportive Food Utilization



Reduction in utilization attributed to renewed program management and following state guidelines.

Goal is to maximize utilization and value without exceeding state premium payments.

Note: March utilization not yet fully reported.

Note: The financial results presented are unaudited, preliminary, and subject to restatement.

Membership Volumes and Rates

COA	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Rates
Adult Expansion - SIS	66,041	66,073	65,651	65,204	64,398	64,123	$ 464.43
Adult - SIS	21,618	21,641	21,492	21,111	20,824	20,750	$ 411.21
Child - SIS	80,158	80,130	79,743	79,407	78,748	78,273	$ 151.35
SPD - SIS	9,156	9,115	9,093	9,030	8,974	8,934	$1,474.57
SPD Dual - SIS	26,457	26,420	26,353	24,385	24,042	23,866	$ 661.69
Long Term Care - SIS	32	33	32	31	31	34	$1,474.57
Long Term Care - Dual - SIS	716	719	725	687	692	688	$ 661.69
Adult Expansion - UIS	14,717	14,685	14,625	14,236	13,792	13,568	$ 679.05
Adult - UIS	15,432	15,323	15,081	14,831	14,393	14,115	$ 350.38
Child- UIS	4,524	4,385	4,310	4,213	4,080	4,026	$ 135.34
SPD - UIS	1,822	1,822	1,818	1,807	1,789	1,739	$1,560.75
SPD Dual - UIS	351	353	352	338	298	321	$ 827.64
Long Term Care - UIS	14	14	14	15	17	17	$1,560.75
Long Term Care - Dual - UIS	8	8	8	8	7	8	$ 827.64
Total	**241,046**	**240,721**	**239,297**	**235,303**	**232,085**	**230,462**	

Note: The financial results presented are unaudited, preliminary, and subject to restatement.

Return to Agenda

Finance Department Update

Achievements:

- Finance successfully went live in the new Workday platform effective January 1, 2026 for the following modules:
  - Procurement
  - Accounts Payable
  - General Ledger
- Achieved a 12 Business Day (BD) close in our third month on the new system
  - The goal is to consistently close within 10 BD and have reporting and analysis available by BD 14
- 2025 Stub Period Audit successfully completed

Windshield View:

- 2025 Stub Period regulatory reporting due by April 30th
  - DHCS
  - DMHC
  - CMS
- 2026 Q1 regulatory reporting due by May 15th
  - DHCS
  - DMHC
  - CMS
- Workday Adaptive (budgeting and forecasting tool) scheduled to go-live in early May
- 3 + 9 Reforecast presentation scheduled for the May 18th Commission meeting
- Completion of 2027 Medicare Bid on track for June 1st submission to CMS
- Medicare risk adjustment audits to ensure appropriate member risk score assignment

Note: The financial results presented are unaudited, preliminary, and subject to restatement.

AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

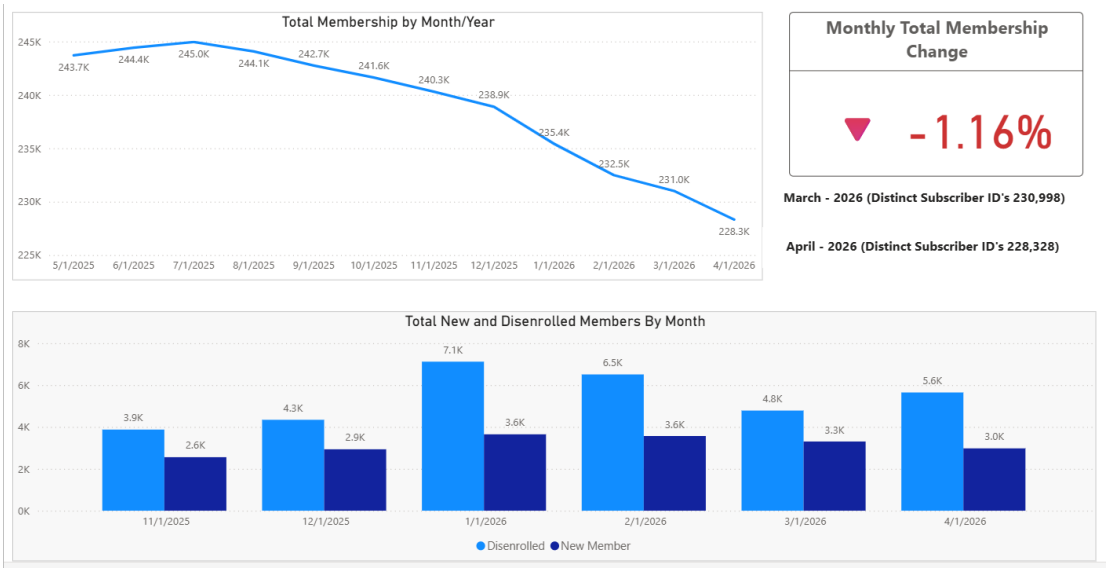
FROM: Felix L. Nunez, MD, Chief Executive Officer

DATE: April 27, 2026

SUBJECT: Chief Executive Officer (CEO) Report

Chief Executive Officer (CEO) Update

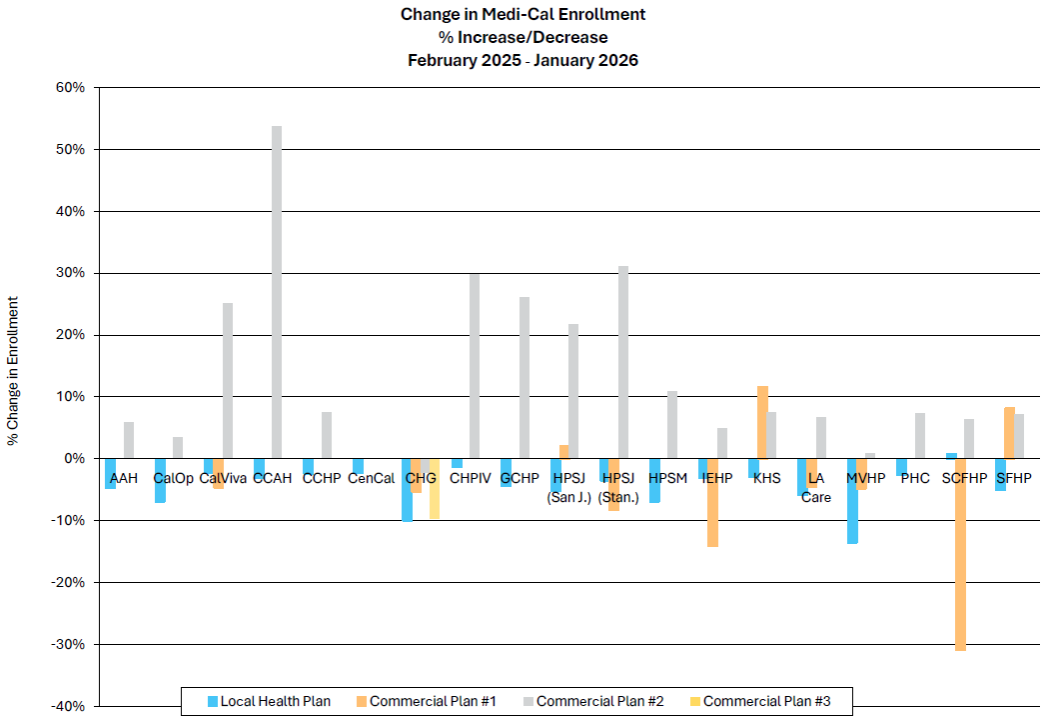
In April, Gold Coast Health Plan (GCHP) continued to see a downward trend in membership. GCHP lost 5,647 members and gained 2,977 new members, leading to a net loss of 2,670 members. Total enrollment is now at 228,328 members.



On April 7, 2026, our trade association, Local Health Plans of California (LHPC), issued a report that provided analysis of Medi-Cal enrollment in the state's local and commercial health plans from February 2025 to January 2026. The graph below shows that local health plans throughout the state are experiencing losses similar to GCHP. Two of the three commercial plans are also losing members, with the exception of "Commercial Plan #2" – Kaiser Permanente – which has gained members in nearly every county (San Diego County is the only exception). Through a special arrangement with the state Department of Health Care Services (DHCS), Kaiser Permanente has specific parameters it must follow for enrollment.

Local Health Plan of California

January 2026



The local health plans must seek to understand the goals and objectives that DHCS has related to Medi-Cal enrollment and the role that County Organized Health Systems (COHS) and commercial plans play. We believe that COHS plans bring value to their members and the communities they serve through the support they provide to the safety net and broader health care infrastructure. The funding COHS plans receive is reinvested in communities through provider payments, grant programs, and sponsorships. Commercial plans, on the other hand, may not have financial objectives aligned with community priorities.

As we evaluate membership losses, we must do all we can to engage our members and help them stay connected to care. DHCS recently approved our Medi-Cal enrollment outreach and awareness campaign to let our members know that there are changes to Medi-Cal and we can help them keep their coverage. The English and Spanish ads will be on billboards and bus shelters, inside buses, in print publications, on the radio, and on digital platforms, including social media. We are also leveraging our long-standing community partnerships to get our message out. We have partnered with Swap Meet Justice to hold workshops for anyone who needs help with their re-enrollment. We are also working with our grantees to conduct outreach to members to ensure they understand the changes and maintain their health care coverage.

Our Ventura County Health Care Coalition work continues to evolve and is equally important, as we partner with a broader network of health care providers, county agencies, and community-based organizations around urgent areas of advocacy to secure more funding and resources for our county. Our next coalition meeting is scheduled for April 23, 2026.

You will hear more about these efforts during the Member Retention Presentation / Strategic Plan Quarterly Update presentation by Marlen Torres, Chief Member Experience and External Affairs Officer.

Hospice Compliance Reviews

On April 8, 2026, DHCS and the California Department of Public Health (CDPH) announced onsite compliance reviews at a hospice location in Los Angeles County in response to fraud claims. They issued the following news release about their findings: California Cracks Down on Hospice Fraud in Los Angeles, Debunks Viral Claims. The following day, state Attorney General Rob Bonta announced charges against 21 people suspected of hospice fraud (Attorney General Bonta Dismantles Los Angeles Hospice Fraud Ring Responsible for $267 Million in Fraud, 21 Charged).

Despite the politically driven narrative that fraud is rampant in hospice care, it is important to clarify that hospice care is not inherently fraudulent. It is an invaluable, clinically necessary service for people who are at the end of their life. It is a service we have to provide as a health plan, and we don't want to put any unnecessary barriers in place to keep people from accessing it. The hospice issues we are seeing highlighted are related to Medicare, as the state has not issued new hospice licenses since 2021.

As responsible stewards of public funds, we are aligned with the state's approach to review hospice care claims to ensure that care is being provided appropriately and that proper safeguards are in place to prevent fraud and maintain the integrity of the program.

At any time, GCHP providers, members, vendors, and employees can report suspected fraud, waste, or abuse either online, through the mail, or in person. Information about how to submit a report is posted on the GCHP Compliance page.

Upcoming meetings

To continue to stay connected to and aligned with other health plan leaders on advocacy efforts and approaches to overarching issues impacting health care, I will be attending the LHPC board meeting on April 20 in Sacramento and the Association for Community Affiliated Plans (ACAP) CEO meeting April 21-22, 2026, in Berkeley.

I. External Affairs

A. State Budget Update

February Legislative and Budget Update

The state Legislature returned from spring recess and immediately entered an intensive three-week hearing period focused on budget oversight, H.R . 1 implementation, and early policy hearings. While bill activity remains moderate, the broader policy environment is highly active, driven by federal H.R .1 requirements, ongoing fiscal uncertainty, and continued pressure on reproductive health, behavioral health, and long-term care systems. Legislative committees continue to express concern that the Gov. Gavin Newsom's budget relies on optimistic assumptions without sufficient contingency planning, particularly around California's Managed Care Organization (MCO) Tax, H.R. 1 workload, and homelessness funding.

Key Hearing Summaries

Gender-Affirming Care Oversight Hearing

The Legislature held a joint oversight hearing on access to gender-affirming care. California reaffirmed that gender-affirming care is medically necessary and protected under state law, with strong privacy and shield-law protections. Much of the discussion centered on federal threats, including proposed federal rules that could restrict Medicaid / Children's Health Insurance Plan funding or exclude providers. The state is preparing for litigation and exploring state-only funding models if needed.

The discussion highlighted system gaps, including the lack of a provider designation for gender-affirming care, limited ability to track access or network adequacy, and declining provider availability. Themes included continuity-of-care concerns for youth, data gaps in utilization and provider capacity, and the tension between strong legal protections and limited system infrastructure.

H.R. 1 Implementation Updates

H.R . 1 remains the dominant driver of legislative and budget activity. The H.R. 1 Trailer Bill aligns state law with new federal requirements and authorizes the state Department of Health Care Services (DHCS) to implement major eligibility and administrative changes.

- Key elements include:
  - Work and community engagement requirements
  - Six-month renewals for Modified Adjusted Gross Income (MAGI) adults beginning March 2027
  - New medically frail exemption framework requiring provider attestations
  - Expanded automation, ex-parte processing, and standardized notices
  - County readiness assessments and system updates throughout 2026
- Legislators continue to raise concerns about increased churn, county workload, and uncompensated care pressures. The Legislative Analyst's Office (LAO) warned that the budget remains "precariously balanced," even under optimistic assumptions.

Gov. Gavin Newsom's Budget

The governor's January budget remains a workload budget, maintaining core programs while avoiding major new investments. Both the Department of Finance (DOF) and LAO emphasized persistent structural deficits beginning in Fiscal Year 2027-28. Legislators continue to request parallel budget scenarios to reflect downside risk. Key pressures include:

- H.R. 1 Implementation costs
- MCO Tax redesign uncertainty
- Hospital financial instability
- Homelessness and behavioral health funding gaps

A. Priority Bill Updates – April 2026

Bill	Summary	Last Action	GCHP Impact
AB 1126	Aligns managed care plan (MCP) administrative requirements with Medi-Cal Fee-For-Service for members with other health coverage; limits letters of agreement (LOAs); requires DHCS clarification on noncontracted billing	Advanced Jan. 29, 2026; now in Senate	May require updates to Other Health Coverage (OHC) coordination, LOA processes, and claims workflows
AB 2756	Establishes Medi-Cal vision performance measures; requires DHCS to develop benchmarks and reporting standards	Amended March 28, 2026	Potential reporting and quality measure impacts; may require data readiness work
SB 1202	Requires DHCS to publish H.R. 1 implementation dashboards and share redetermination data with MCPs	Amended March 12, 2026	Supports plan outreach and data alignment for H.R . 1 compliance

Bill	Summary	Last Action	GCHP Impact
SB 874	Establishes a behavioral health treatment workforce workgroup; proposes background check requirements for unlicensed behavioral health technicians	Hearing held March 15, 2026	May affect behavioral health provider enrollment pathways and contracting
AB 2348	Revises Community Supports (CS) requirements; removes proposed three-year lock-in for CS offerings	Amendments pending as of April 2026	Maintains flexibility in CS implementation
AB 2431	Defines “downcoding” and establishes requirements for claims review; may require physician review for certain determinations	DHCS fiscal analysis requested March 2026	Could increase administrative burden and impact claims workflows
Immigration Legal Aid Bill (Bonta)	Expands state-funded legal representation to undocumented adults in deportation proceedings; builds on 2025 youth representation law	First committee hearing held March 2026	No direct MCP impact; relevant to safety-net access and county partnerships
SB 250	Requires DHCS to publish and maintain an updated skilled nursing facility (SNF) directory by managed care plan	Signed into law Oct. 13, 2025	Minimal operational impact; may require periodic SNF network validation
SB 306	Exempts services from prior authorization (PA) if 90%+ are approved; requires public posting of exempt services	Signed into law	May require PA workflow adjustments and public posting compliance
SB 530	Strengthens DHCS oversight of time-and-distance standards; extends enforcement authority to 2029	Signed into law	Continued monitoring of network adequacy compliance

Bill	Summary	Last Action	GCHP Impact
SB 707	Modernizes Brown Act requirements, including audio / visual (A/V) access and language equity provisions	Signed into law Oct. 3, 2025	Impacts Commission meeting procedures and public access requirements
AB 543	Allows MCPs to offer services via street medicine providers	Signed into law	May require updates to provider contracting and Enhanced Care Management (ECM) workflows
AB 2466	Strengthens network adequacy and timely access requirements	Effective Jan. 1, 2026	May require network monitoring and reporting adjustments
AB 815	Protects vehicles used for social services from certain insurance classifications	Effective Jan. 1, 2026	Minimal impact; may affect contracted transportation providers
SB 1120	Requires transparency and evidence-based criteria for AI used in utilization review	Effective Jan. 1, 2026	May require updates to Utilization Management policies and vendor oversight
AB 2860	Expands the Mexico Physician / Dentist Program pilot	Effective Jan. 1, 2026	Minimal direct impact; may affect provider availability in certain regions
AB 3275	Requires clean claims to be reimbursed within 30 workdays; requires notice within 30 days if contested	Effective Jan. 1, 2026	Significant programming changes needed; impacts claims timelines and Fraud, Waste, and Abuse prepayment review
AB 2703	Adds psychological associates as reimbursable providers under Federally Qualified Health Centers (FQHC) / Rural Health Clinics (RHC)	Effective Jan. 1, 2026	May expand behavioral health provider types in network

Bill	Summary	Last Action	GCHP Impact
SB 516	Establishes infrastructure financing district for Sacramento	Effective Jan. 1, 2026	No direct impact on GCHP operations

B. All-Plan Letters (APLs)

All-Plan Letter	Summary
APL 26-005: Maternity Services for Pregnant and Postpartum Medi-Cal Members	The purpose of this APL is to consolidate and update guidance for Medi-Cal managed care plans (MCPs) on the maternity benefits that MCPs are required to provide to pregnant and postpartum members.
APL 26-006: Skilled Nursing Facility Workforce Quality Incentive Program (SNF WQIP)	The purpose of this APL is to provide Medi-Cal MCPs with instructions on the payment and data sharing process required for the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) for Rating Periods between Jan. 1, 2023, and Dec. 31, 2025.

E. Community Relations: Sponsorships

Through its sponsorship program, Gold Coast Health Plan (GCHP) supports the efforts of community-based organizations in Ventura County to help Medi-Cal members and other vulnerable populations. GCHP awarded the following organizations from March 2026 to present:

Organization	Description	Amount
Oxnard Performing Arts Center (OPAC)	OPAC is hosting Rooted: A Wellness Summit, a full-day community wellness event in partnership with Raising Mami Alchemy, bringing together movement, mindfulness, and creative workshops led by local instructors. The event creates an inclusive space for community members to recharge, connect, and support their mental, physical, and emotional well-being. Funds raised will directly support OPAC's year-round Ándale wellness and creativity program.	$1,000

Organization	Description	Amount
Big Brothers Big Sisters of Ventura County	Big Brothers Big Sisters of Ventura County is hosting its second annual Big Dreams Gala, an evening celebrating the power of mentoring in Ventura County. Funds will contribute to one-to-one mentor matches, youth enrichment opportunities, academic support, and ongoing program services for Ventura County youth.	$1,000
Pipiripau	Pipiripau is hosting its annual Palomazo event with live music and a festival in downtown Oxnard, bringing artists and the community together through performances, storytelling, and audience engagement. This year's event includes an art gallery. Sponsorship funding will help cover production costs, artist compensation, venue operations, and the expansion of programming.	$1,000
Moorpark College Foundation	Moorpark College Raider Central (Student Basic Needs Services) is a comprehensive resource center to support student wellness and basic needs. It provides essential items such as food, hygiene products, clothing, and diapers for student parents, while also connecting students to valuable on-campus and community resources. All services are free and available to currently enrolled Moorpark College students.	$1,000
TOTAL		**$4,000**

F. Community Relations: Community Meetings and Events

The Community Relations team attended various community events in March supporting families with resources and assistance to connect them to GCHP services. The team participated in a collaborative meeting and food distribution events.

Strengthening Families Collaborative Meeting	
Community representatives share resources, announcements, and upcoming community events.	
Partnership for Safe Families and Communities	March 4, 2026
Community Events	
First 5 Ventura County Home Visiting Summit (Oxnard)	March 5, 2026
Barbara Webster Elementary Kinder Round Ups (Santa Paula)	
E.O. Green Junior High Open House (Oxnard)	
Dia De La Mujer Feria De Recuerdos (Santa Paula)	March 7, 2026
Community Insight Coalition Meeting (Camarillo)	March 10, 2026
Channel Islands High School Health To Wellness (Oxnard)	
Ansgar Larsen Elementary Open House (Oxnard)	
Thelma Bedell Elementary Kinder Round Ups (Santa Paula)	March 11, 2026
Charles Blackstock Junior High Open House (Oxnard)	March 12, 2026
Rio Del Sol Parent Symposium Event (Oxnard)	
Oxnard Union High School District 41st Annual Career Expo (Oxnard)	March 13, 2026
Cabrillo Economic Development Corporation @ Paseo Del Rio Housing Resource Event (Oxnard)	March 16, 2026
Barbara Webster Elementary Kinder Round Ups (Santa Paula)	March 19, 2026
Boys & Girls Club – Santa Clara Valley Santa Paula Family Paint Nights (Santa Paula)	
College / Career Day at Rio Lindo Elementary (Oxnard)	March 20, 2026
Boys & Girls Club – Santa Clara Valley Family Paint Nights (Fillmore)	
City of Port Hueneme Annual 5K Health & Wellness Fair (Port Hueneme)	March 21, 2026
Victory's Closet Event (Oxnard)	
Sunkist Elementary Open House (Oxnard)	March 24, 2026
Parent Night at One Step A La Vez (Fillmore)	
Boys & Girls Club – Santa Clara Valley Family Paint Nights (Fillmore)	March 25, 2026
Member Advisory Committee (Camarillo)	March 26, 2026

Community Events	
Boys & Girls Club – Santa Clara Valley Family Paint Nights (Piru)	March 27, 2026
Community Services Expo (Ventura)	March 28, 2026
Swap Meet Justice (Oxnard)	March 29, 2026
Julien Hathaway Elementary Open House (Oxnard)	March 31, 2026
Fred L. Williams Elementary Open House (Oxnard)	
Food Distribution Events	
Salvation Army Food Distribution (Simi Valley)	March 3, 2026
Cristo Rey Food Pantry (Oxnard)	
Westminster Clinic Food Distribution (Oxnard)	March 10, 2026
One Step A La Vez Food Distribution (Fillmore)	March 11, 2026
Somis Food Distribution (Somis)	March17, 2026
San Salvador Mission Food Distribution (Piru)	March 18, 2026
Catholic Charities Food Distribution (Moorpark)	
Catholic Charities Food Distribution (Ventura)	March 19, 2026

G. Community Relations: Speakers Bureau

GCHP staff conducted various presentations throughout Ventura County primarily in low-income housing properties managed by Many Mansions, in March. Staff presented an overview of GCHP services and benefits and education on nutrition to community members.

Speakers Bureau	
Many Mansions – Rancho Sierra (Camarillo)	March 3, 2026
Many Mansions – Esseff Village (Thousand Oaks)	March 6, 2026
Many Mansions – Richmond Terrace (Thousand Oaks)	March 10, 2026
Many Mansions – Mountainview (Fillmore)	March 11, 2026
Many Mansions – Peppertree (Simi Valley)	March 17, 2026
Speakers Bureau	
Ventura County Public Health – Health Care for All	March 18, 2026
Many Mansions – Central Terrace (Oxnard)	March 19, 2026

Speakers Bureau	
Coffee with the Counselor (Haycox Elementary)	March 20, 2026
Many Mansions – Ormond Beach Villas (Oxnard)	
Many Mansions – Hillcrest Villas (Thousand Oaks)	March 24, 2026
Nyeland Promise – Health Ed. Nutrition (Oxnard)	March 25, 2026
Many Mansions – Casa de Paz (Simi Valley)	March 26, 2026

H. Pathways to Wellness Community Grants (PTW)

GCHP awarded seven organizations in October 2025 to support Medi-Cal redetermination efforts, food insecurity, and member journey mapping.

Medi-Cal Redetermination

- Renewals: 1,253
- Inquiries: 478

Food Insecurity

- Food Boxes Distributed: 1,483
- Pounds of Food Distributed: 6,063

II. PLAN OPERATIONS

A. Provider Network Operations (PNO)

Annual Provider Satisfaction Survey Results

GCHP conducts two annual surveys of its Medi-Cal network to evaluate provider experience and member access to care. The surveys reflect the previous year's performance and include the Provider Satisfaction Survey, which measures how well GCHP meets provider expectations and operational needs.

GCHP achieved an Overall Satisfaction score of 74.4%, a nine-point increase from the prior year. The Provider Appointment Availability and After-Hours Survey assessed access to urgent care and routine care appointments and the adequacy of after-hours emergency instructions. Compliance rates for urgent appointments were 97.6% for primary care providers (PCPs) and 64.7% for specialists, while routine (non-urgent) appointment compliance was 81.4% for PCPs and 56.4% for specialists. After-hours emergency instruction compliance reached 94.1% for PCPs and 57.8% for specialists.

GCHP is reviewing the results to identify providers with deficiencies and to partner with them to reinforce regulatory standards, understand operational barriers, and implement remediation actions.

Regulatory / Audit Updates

GCHP completed all required D-SNP Aligned Network deliverables, including the EAE D-SNP Network Template, the D-SNP Medicare Network Template, and the Language Gap Assessment. These reports collectively demonstrate the degree of alignment between GCHP's Medi-Cal and Medicare (D-SNP) networks and identify discrepancies in provider participation, network composition, and language access. Preparation of these deliverables required extensive validation of provider data, reconciliation of Medi-Cal and Medicare network files, and coordination across internal teams to ensure accuracy and completeness. GCHP identified network issues and will implement remediation actions as needed to meet DHCS requirements and support ongoing network alignment efforts.

Regulatory deliverables include:

- The state Department of Health Care Services (DHCS) approved the biannual directory submission.
- DHCS Timely Access Report: DHCS conducts quarterly surveys of Managed Care Plans (MCP) networks to assess appointment availability and directory accuracy, and requires MCPs to remediate all identified deficiencies.

Provider Network Developments: March 1- 31, 2026

GCHP Provider Changes	
Provider Additions and Terminations	**Count**
Additions	51
Terminations	12
Midwife	0

Note: The additions and terminations above are for GCHP tertiary providers and do not have a significant impact on member access to services.

GCHP Provider Network Additions and Total Counts by Provider Type			
Provider Type	**Network Additions**		**Total Counts**
	Feb-26	**Mar-26**	
Hospitals	**0**	**0**	**25**
Acute Care	0	0	19
Long-Term Acute Care (LTAC)	0	0	1
Tertiary	0	0	5
Providers	**35**	**8**	**9,200**
Primary Care Providers (PCPs) & Mid-levels	6	8	492
Specialists	21	0	7,774
Hospitalists	8	0	934
Ancillary	**0**	**7**	**678**
Ambulatory Surgery Center (ASC)	0	0	10
Community-Based Adult Services (CBAS)	0	0	14
Durable Medical Equipment (DME)	0	0	103
Home Health	0	0	35
Hospice	0	0	24
Laboratory	0	0	41
Optometry	0	2	109
Occupational Therapy (OT) / Physical Therapy (PT) / Speech Therapy (ST)	0	3	193
Radiology / Imaging	0	2	60

Skilled Nursing Facility (SNF) / Long-Term Care (LTC) / Congregate Living Facility (CLF) / Intermediate Care Facility (ICF)	0	0	89
Behavioral Health	**252**	**0**	**1160**

California Advancing and Innovating Medi-Cal (CalAIM) and Non-Traditional Providers	Feb-26	Mar-26	Total
Enhanced Care Management (ECM)	0	0	11
Community Supports (CS)	0	0	33
Community Health Worker (CHW)	0	0	5
Doulas	0	0	36

Note: This chart is based on data from March 2026.

C. Delegation Oversight

Gold Coast Health Plan (GCHP) is contractually required to perform oversight of all functions delegated through subcontracting arrangements. Oversight includes, but is not limited to:

- Monitoring / reviewing routine submissions from subcontractors
- Conducting onsite audits
- Issuing a corrective action plan (CAP) when deficiencies are identified

**Ongoing monitoring denotes the delegate is not making progress on a CAP issued and/or audit results were unsatisfactory. GCHP is required to monitor the delegate closely, as it is a risk to GCHP when delegates do not comply.*

Compliance monitors all CAPs. GCHP's goal is to ensure delegates achieve and sustain compliance. It is a state Department of Health Care Services (DHCS) requirement for GCHP to hold all delegates accountable. The oversight activities GCHP conducts are evaluated during the annual DHCS medical audit. DHCS auditors review GCHP's policies and procedures, audit tools, audit methodology, and audits conducted and CAPs issued by GCHP during the audit period. DHCS emphasizes the high level of responsibility plans have in the oversight of their delegates.

The following table includes audits and CAPs that are open and closed. Closed audits are removed after they are reported to the Commission. The table reflects changes in activity through March 31, 2026.

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Carelon	2025 Annual Audit Utilization Management (UM) Quality Improvement (QI), Network Management (NET), Cultural & Linguistics (C&L), Member Experience (ME)	Closed	10/6/2025	3/19/2026	N/A
Carelon	2025 Q3 & Q4 Utilization Management (UM) and G&A (Grievances and Appeals) File Audit	Open	2/27/2026	Under CAP	N/A
Carenet	2025 Focused Call Center Nurse Advice Line	Open	1/28/2026	Under CAP	N/A
Vision Service Plan (VSP)	2025 Annual Claims Audit	Open	1/6/2026	Under CAP	N/A
VSP	2025 Q4 Claims Audit	Open	3/24/2026	Under CAP	N/A
Ventura Transit System (VTS)	2025 Downstream Subcontractor Audit	Closed	9/11/2025	3/17/2026	N/A

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
VTS	2025 Annual Driver Credentialing Audit	Closed	7/23/2025	3/5/2026	N/A
VTS	2025 Annual Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) Vehicle Audit	Open	1/8/2026	Under CAP	N/A
VTS	Pre-delegation D-SNP Social Transportation Benefit Audit	Open	3/20/2026	Under CAP	N/A
University Southern California (USC) Medical Group	2025 Policy Review Credentialing Audit	Closed	9/24/2025	3/11/2026	N/A
Wellth	2026 Population Health Management (PHM) Annual Audit	Open	3/25/2026	Under CAP	N/A

Privacy and Security CAPs

Delegate	CAP Type	Status	Date CAP Issued	Date CAP Closed	Notes
N/A	N/A	N/A	N/A	N/A	N/A

Operational CAPs					
Delegate	**CAP Type**	**Status**	**Date CAP Issued**	**Date CAP Closed**	**Notes**
CDCR	Claims Timeliness	Open	4/22/2025	Open	Metrics of 90% in 30 days not met. 45 days not met for Q2, Q3, or Q4 of 2025. Q1-2026, Metrics of 90% in 30 days not met. 45 days not met for Q1 of 2026.

RECOMMENDATION:

Receive and file.

AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission

FROM: James Cruz, MD, Chief Medical Officer (CMO)

DATE: April 27, 2026

SUBJECT: Chief Medical Officer (CMO) Report

March and April have been very busy for the Office of the CMO departments. I am delighted to share a status report of the ongoing work performed by the Quality Improvement team, and the Health Services teams. Additionally, there are Pharmacy updates due to Department of Healthcare Services (DHCS) adjustment in drug coverage benefits, and Health Equity will share the ongoing work to ensure Gold Coast Health Plan (GCHP) identifies opportunities to elevate the quality of care for all of our members.

Quality Improvement

Great News! All 18 Measurement Year (MY) 2025 Managed Care Accountability Set (MCAS) measures are greater than or equal to the Minimum Performance Level (MPL)! 13/18 MCAS measures are exceeding last year's rates! For GCHP Total Care Advantage-work progresses on developing and implementing provider focused clinical tools, data collection processes, and member incentives. There is a significant National Committee for Quality Assurance (NCQA) accreditation update. NCQA buckled under pressure from the Federal government, and removed equity focused standards, and "rebranded" "NCQA Health Equity Accreditation" to "NCQA Health Outcomes Accreditation". These changes no longer align with DHCS' and GCHP's Health Equity goals. As a result, GCHP will not be seeking NCQA Health Outcomes Accreditation. DHCS is informing all Managed Care Plans that NCQA Health Outcomes Accreditation is no longer a DHCS requirement. Greater detail on this is in the GCHP Health Equity report.

Health Equity

The Health Plan continues to advance its health equity mandate through the leadership of the Chief Health Equity Officer, who drives integration of equity principles across policy, operations, quality improvement, and community engagement. Although DHCS is no longer requiring Managed Care Plans (MCPs) to obtain **NCQA Health Outcomes accreditation (previously Health Equity accreditation)**, the state's core expectations remain unchanged — and equity still matters. MCPs must continue identifying and addressing disparities, delivering culturally responsive care, and meeting equity related performance and reporting obligations. Current initiatives include community-based RISE grant projects, equity focused utilization reviews, targeted immunization outreach, and development of a maternity and child

health program centered on birth equity. This work underscores that while accreditation requirements may shift, the equity mandate remains central to Medi-Cal and to our operational priorities.

Health Services (UM and CM)

Key work is in flight to ensure GCHP is fully compliant with DHCS's Maternity Care requirements outlined in DHCS' recently announced big, bold Omnibus All Plan Letter (APL) 26-005. There are several slides in your packet which provides a focused summary on the depth of internal work in progress to fully implement APL 26-005.

Pharmacy

Lastly, there are several pharmacy updates to report. Medi-Cal has implemented requirements for the following:

a. Provider enrollment, which includes residents with a California medical license.
b. ICD-10-CM diagnostic codes for all pharmacy claims including refills.
c. Medical justification for approval of GLP-1 RA drugs.

Additionally, implementation of GCHP Total Care Advantage (TCA) pharmacy benefits continues without meaningful issues.

ATTACHMENT:
Chief Medical Officer Update PPT

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Chief Medical Officer Report

April 27, 2026

James Cruz, MD
Chief Medical Officer

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CMO Report
Quality Improvement Update

April 27, 2026

James Cruz, MD, Chief Medical Officer
Kim Timmerman, Executive Director Quality Improvement

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MY 2025 MCAS Project Update

- March administrative data refresh completed 3/19.
- Planning for April administrative data refresh.
- Currently conducting medical record review (MRR) for hybrid measures:
  - Glycemic Status Assessment for Patients With Diabetes (GSD)
  - Prenatal/Postpartum Care (PPC)
  - Controlling Blood Pressure (CBP)
- MRR Project closes 4/24.
- Final rates 6/15.

MY 2025 MCAS Current Rates

MCAS Measure/Data Element		MY2017 Rate	MY2018 Rate	MY2019 Rate	MY2020 Rate	MY2021 Rate	MY2022 Rate	MY2023 Rate	MY2024 Rate	MY2025 Rate
Magnificent Seven (HPL)										
Breast Cancer Screening (A)	BCS-E	59.01	60.78	61.84	57.29	52.78	56.00	59.65	66.50	67.75
Cervical Cancer Screening (A) *(Hybrid MY24, ECDS MY25)*	CCS-E	**57.46**	**56.08**	64.23	56.69	59.37	57.91	61.31	65.45	62.84
Glycemic Status Assessment for Patients with Diabetes—HbA1c Poor Control >9% (H)*	GSD			34.31	40.88	38.93	35.04	28.71	25.79	25.55
Lead Screening in Children (A)	LSC			N/A	N/A	64.48	65.69	69.87	78.14	79.41
Postpartum Care (H)	PPC-PPC	**68.35**	**77.39**	86.86	88.81	88.08	86.37	89.29	92.70	93.19
Timeliness of Prenatal Care (H)	PPC-TOPC	**82.45**	**86.17**	97.32	90.02	92.46	91.97	92.21	90.27	87.35
Well Child Visits in the First 30 Months of Life - 2 or more visits (A)	W30-2+			N/A	67.83	60.40	68.14	72.94	77.72	79.81
Better Performance Level (BPL)										
Childhood Immunization Status - Combo 10 (A) *(Hybrid MY24, ECDS MY25)*	CIS-CO10-E			42.09	39.66	42.82	40.88	32.85	29.93	32.26
Chlamydia Screening in Women (A)	CHL			56.02	52.72	53.48	53.26	63.59	64.59	68.32
Immunizations for Adolescents - Combo 2 (A) *(Hybrid MY24, ECDS MY25)*	IMA-CO2-E	**33.58**	**34.06**	37.96	41.85	41.36	35.77	41.61	45.11	51.33
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (A)	FUA-30 days			N/A	N/A	8.64	24.64	28.32	45.81	51.37
Well Child Visits in the First 15 Months of Life - Six or more visits (A)	W30-6+			N/A	21.28	21.12	47.38	60.70	68.35	68.86
Minimum Performance Level (MPL)										
Asthma Medication Ratio (A)	AMR	54.41	57.73	50.09	48.52	51.22	52.41	46.80	57.93	72.32
Controlling High Blood Pressure (H)	CBP	**54.40**	**63.26**	61.07	54.26	55.96	60.34	62.29	66.67	66.42
Developmental Screening in the First Three Years of Life (A)	DEV			32.31	36.03	39.58	38.95	47.85	55.93	65.77
Follow-Up After Emergency Department Visit for Mental Illness (A)	FUM-30 Days			N/A	N/A	29.56	29.35	23.59	60.98	57.59
Topical Fluoride for Children (A)	TFL-CH			N/A	N/A	N/A	0.64	28.10	32.99	25.48
Child and Adolescent Well-Care Visits (A)	WCV			N/A	30.89	33.94	42.33	49.79	55.44	57.86

MPL / HPL				
10th	25th	50th	75th	90th

Return to Agenda

MY 2025 MCAS Current Rate Highlights

- MPL MET FOR Follow-Up After Emergency Department Visit for Mental Illness (FUM)!
- All measures now at minimum performance level (MPL) or above
- Of 18 measures held to MPL, 13 are currently exceeding last year's rate (72%)
  - Asthma Medication Ratio (AMR) at 75th percentile
    - First time meeting/exceeding MPL, +14.39% compared to MY 2024
  - Cervical Cancer Screening (CCS) lower than MY 2024 due to methodology change from hybrid to ECDS (-2.61)
  - GSD (HbA1c), PPC-Prenatal lower, but still pursuing records in MRR project
  - Topical Fluoride Varnish (TFL) (-7.5) likely due to delayed DHCS files missing claims. New data file received - to be submitted with April data refresh.

MY 2025 MCAS Current Rate Highlights

- Magnificent Seven (HPL Target):
  - 2 Measures meeting HPL: BCS, PPC-Post
  - 3 Measures meeting 75th: CCS, LSC, W30-2+
  - 2 Measures meeting 50th: GSD, PPC-Prenatal – both are hybrid
- Better Performance Level (75th percentile target):
  - All 5 measures meeting/exceeding 75th percentile
  - IMA at HPL
- MPL (50th percentile target):
  - All 6 measures meeting/exceeding 50th percentile
  - AMR at 75th percentile

Total Care Advantage: Quality Update

Provider Incentive and Support – SNP QIPP

- Ramp Up Activities
- Annual Wellness Visit (AWV)/Initial Preventive Physical Exam (IPPE) Completion
- Quality Measures
  - Diabetes Blood Sugar
  - Controlled, Controlling Blood Pressure
  - Breast Cancer Screening
  - Colorectal Cancer Screening

Ramp Up Activity	Due Date	Status
Identify Clinical Champion	1/1/2026	Complete
Completion of Work Plan	1/31/2026	Complete
Build and implement MEAT workflows	2/28/2026	Both CDCR and VCMC Submitted - Under Review
Create AWV template in EHR	3/31/2026	Both CDCR and VCMC Submitted - Under Review
Train staff on Quality Coding and Metrics	4/30/2026	CDCR: Completed Non-Provider Training: Part 1 3/6, Part 2 3/16 Completed Provider Training: Part 1 3/11 Part 2 to be scheduled Coders/Billers TBD VCMC: Non-Provider and Provider Trainings Scheduled in April Coders/Billers TBD

Total Care Advantage: Quality Update

TCA Quality Improvement Support

Provider Star Measure Tip Sheets

- GCHP's Quality Improvement Department added prioritized Star measures to the reference guide and tip sheets on website

Data Tools: Inovalon Star Measure Monitoring

- Status: In Progress
  - **Data Integration:** All DSNP members have been successfully added to the data transfer feed
  - **Analytics:** Star measure gap identification functionality is currently being implemented
    - Star Measure Performance Data anticipated by end of April
  - **Dashboards:** Star Measure Dashboard functionality scheduled for rollout in Q3

Department Collaboration

- Providing targeted data analytics and supporting strategic interventions to drive Star ratings:
  - Care Management - Tip Sheet
  - Care Navigator Tips to drive Star measure success
  - PNO – Provider Training
  - Pharmacy – Guided Health Star measure interventions

Total Care Advantage: Quality Update

Quality/Risk Adjustment Provider Resources

- Provider Toolkit - Collaboration with Finance to align Quality with Risk
  - ➢In Progress/Draft Completed:
    - Quick Reference Guide for Quality Metrics Addressed in the AWV
    - Common Hierarchical Condition Categories (HCC) Reference Guide

Member Incentive

- Annual Wellness Visit
- HBA1c
- Breast Cancer Screening

Annual Medicare Visit Completion Report

- **Status**: Developed, tested > will roll out once published by IT
  - ➢Created to monitor visit completion, create gap lists, support internal auditing by tracking:
    - Type of Visit
    - Date of Most Recent Visit
    - Completion by Assigned PCP

NCQA: DHCS Guidance – 2026 Pivot from Health Equity Accreditation

2026 NCQA Changes to Health Equity Accreditation

- NCQA shift from Health Equity Accreditation (HEA) to Health Outcomes Accreditation no longer aligns with California's health equity goals.
  - Removal of equity-focused standards (e.g., gender identity, demographic representation, disparity identification)
  - Rebranding away from "equity"
- **DHCS is aligning with CA Public Purchasers to not require MCPs to achieve revised Health Outcomes Accreditation after current HEAs expire** (2027–2028)
- Next steps
  - Formal communication to MCPs
  - Update contract/APL language to reflect continued DHCS equity priorities
  - Build internal systems and resources for monitoring and enforcement

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Health Equity Department Updates

April 27, 2026

Pshyra Jones
Executive Director, Health Equity

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Health Equity Mandate Continues Beyond NCQA Health Equity Outcomes Requirements

- Although the Department of Healthcare Services (DHCS) is no longer requiring MCPs to obtain **NCQA Health Equity Outcomes accreditation**, the **state's core health equity mandates remain fully in effect**.
- MCPs must continue implementing robust health equity strategies, including:
  - Identifying and addressing health disparities
  - Advancing culturally responsive care
  - Engaging communities and cross-sector partners
  - Integrating equity into policy operations, and quality improvement
  - Meeting reporting and performance expectations tied to equity outcomes

Equity Work Still Matters

- DHCS continues to prioritize **eliminating health disparities** as a foundational Medi-Cal goal.
- Requirements embedded in contracts, quality initiatives, Social Determinants of Health (SDOH) expectations, and population health management **still obligate MCPs to act on equity**, regardless of accreditation status.
- The Chief Health Equity Officer role remains essential to **lead, coordinate, and ensure accountability** for these ongoing responsibilities.

Accreditation requirement changed- the equity mandate did not.

Operationalizing Equity Through Programs, Analytics, and Targeted Interventions

- **RISE Grant Initiatives**
  - Supporting community-based projects addressing SDOH, access barriers, and capacity building.
- **Over & Under Utilization Reviews with an Equity Lens**
  - Identifying disparities in utilization patterns and guiding targeted outreach and provider engagement.
- **Equitable Childhood Immunization (CIS) & Flu Campaign Interventions**
  - Deploying culturally and linguistically tailored outreach to improve vaccination rates in underserved communities.
  - Partnering with providers and CBOs to reduce access barriers.
- **Maternity Health Program Development (DHCS Omnibus APL Alignment)**
  - Designing a comprehensive perinatal program addressing disparities and integrating SDOH screening, care coordination, and community supports.

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APL 26-005: Maternity Services for Pregnant & Postpartum Women

Why This Matters

DHCS released APL 26-005: Maternity Services for Pregnant & Postpartum Women

APL 26-005 introduces a major modernization of maternity care requirements, expanding expectations for clinical quality, behavioral health integration, and postpartum continuity of care. These changes require significant updates across UM, CM, and provider workflows to ensure comprehensive support from early pregnancy through 12 months postpartum.

Key Points:

- Modernized regulatory framework
- Expanded clinical and BH expectations
- Full-year postpartum support
- Cross-department operational impact

What the APL Requires

The APL establishes a full-continuum model of maternity care with enhanced clinical, behavioral health, and screening standards. MCPs must ensure adherence to national guidelines, expanded screening protocols, and access to a broader range of reproductive and birth-related services.

Key Points:

- Risk assessments each trimester + postpartum
- Alignment with ACOG, CPSP, AAFP, ACNM, NACPM
- Dental/oral health assessments
- CA-PNS access before 21 weeks
- Newborn screening for 80 conditions
- Required depression screenings
- NSMHS + SUD coverage through 12 months postpartum
- Coverage for midwife-led care and abortion services

Implications for GCHP

With approximately 3,500 births annually, GCHP serves a high-impact population that will require earlier identification, stronger postpartum engagement, and expanded behavioral health coordination. The new requirements also increase expectations for provider readiness, network adequacy, and data integration.

Key Points:

- ~3,500 births per year
- Need for earlier pregnancy identification
- Expanded postpartum engagement
- Increased BH/SUD coordination
- Provider readiness + network adequacy
- Enhanced reporting and data needs

Strategic Priorities

GCHP's implementation strategy focuses on aligning internal operations, strengthening provider partnerships, and improving member engagement. These priorities ensure compliance while advancing maternal health outcomes.

Key Points:

- Early prenatal identification
- Cross-department maternal health convening
- Clear, culturally responsive member communication
- Actionable reporting and dashboards
- Staffing model aligned with regulatory scope

Timeline & Path Forward

Implementation is underway with a structured timeline leading to DHCS submission by June 24, 2026. Following policy updates, GCHP will focus on training, rollout, and ongoing compliance monitoring throughout the remainder of 2026.

Key Points:

- Apr–May: Gap analysis + workflow redesign
- June 24: P&P submission to DHCS
- Jul–Dec: Training, rollout, monitoring
- Continued evaluation of staffing, provider readiness, and data systems

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Pharmacy Services Report

April 27, 2026

Lily Yip, PharmD, MBA, APh, CDCES, BCACP, CPHQ
Director of Pharmacy

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Pharmacy Services – Medi-Cal Rx Updates

- **Medi-Cal Rx Updates**
  - **Policy Authorization Policy Updates**: Effective **March 6, 2026**, DHCS has implemented the following policy updates in alignment with the CCR, which may result in a new PA request being needed:
  - The lookback period for paid claims history has been updated from 450 days to 100 days to ensure recent or ongoing use of the medication and align with essential need and efficacy. If prior claims history is greater than 100 days, a new PA request may be required.
  - Code I limits will apply for certain maintenance drugs on the Medi-Cal Rx Contract Drugs List (CDL) (e.g. patient age, patient gender)
  - Historical PA requests approved under the Transition Policy will no longer bypass the utilization management (UM) limitations and may be denied and require a new PA request
  - Some drugs are now only approved up to a 12-month prior authorization (PA) approval period. Certain requests may be considered for a longer approval length on a case-by-case basis, dependent on meeting medical necessity and aligning with the CCR

https://medi-calrx.dhcs.ca.gov/provider/pharmacy-news/

Pharmacy Services – Medi-Cal Rx Updates

- **Medi-Cal Rx Updates**
  - **Requirement for Provider Enrollment in Medi-Cal:** Effective **June 26, 2026**, Prescribers must be enrolled in Medi-Cal using their Type 1 NPI for pharmacy claims to be processed and paid. As of February 25, 2026, Medi-Cal Rx has started to inform pharmacies of any pharmacy claims they receive from non-enrolled providers that if they do not enroll in Medi-Cal as a provider, their future pharmacy claims and prior authorizations will be denied on June 26, 2026. **Link** to FAQs.
  - **ICD-10-CM Diagnosis Codes on Pharmacy Claims**: Effective **Fall 2026**, ICD-10-CM diagnosis code(s) will be required for all pharmacy claims including refills. More detailed information including the implementation plan and resources will be published on the new ICD-10-CM Code Requirements tab on the Education & Outreach page.

https://medi-calrx.dhcs.ca.gov/provider/pharmacy-news/

Pharmacy Services – Medi-Cal Rx Updates

- **Medi-Cal Rx Updates**
  - **Provide Medical Justification for GLP-1 Drugs:** Reminder that GLP-1 drugs not covered by Medi-Cal Rx when used for weight loss or weight loss-related indications (effective **January 1, 2026**).
  - When submitting a PA request, the following information is needed: diagnosis, quantity/days' supply, other products tried and the reasons why they didn't meet member's needs, contraindications, allergies, chart notes, lab reports, supporting literature/guidelines if using for off label use
  - Medi-Cal Rx reviews and adjudicates prior authorizations (PAs) submitted for FDA approved indications on a case-by-case basis to establish medical necessity and to determine if the member's individual needs are met:
    - Wegovy® when used for cardiovascular disease (note effective 4/1/26, Wegovy will be covered for MASH with the appropriate ICD-10 diagnosis code)
    - Zepbound® when used for obstructive sleep apnea (OSA)

https://medi-calrx.dhcs.ca.gov/provider/pharmacy-news/

Pharmacy & Therapeutics Committee Updates

- The P&T committee meets quarterly. The next meeting will be held on **May 14, 2026**.
- The last P&T committee meeting was held on **February 12, 2026**. The committee reviewed and approved 37 new Part B drugs to be added to the Medicare Part B Drug List which will require prior authorization for D-SNP members. We also updated 4 Part B drugs with updated HCPCS codes. And the committee also removed 2 drugs and added 4 new drugs to the Medi-Cal Physician Administered Drugs (PAD) List with an effective date of June 15, 2026.
- The Total Care Advantage Medicare Part B Drug List and clinical guidelines have been updated on the GCHP website.
- The Medi-Cal Physician Administered Drugs (PAD) List and clinical guidelines have been updated on the GCHP website.

Pharmacy Services - D-SNP Updates

- Total Care Advantage (D-SNP) Part D pharmacy benefit went live on January 1, 2026.
- The Director of Pharmacy meets weekly with our Pharmacy Benefit Manager (PBM), Prime Therapeutics, to identify any potential issues and get timely resolutions to reduce/prevent any impacts to member care and access to their medications.
- Pharmacy team continues to provide direct outreach to both pharmacies and provider's offices to resolve any rejected claims that need prior authorization and/or help address other issues to help the member get their medications.
- Pharmacy team will continue to provide education about the TCA pharmacy benefits to pharmacies, provider's offices, GCHP staff via GCHP website, pharmacy newsletter, Provider Operations Bulletins, and various committee meetings.
- The Director of Pharmacy is also working closely with our Sr. Director, DSNP, Medicare Compliance Manager, and other GCHP departments to coordinate care for members and ensure compliance with regulatory requirements.

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AGENDA ITEM NO. 13

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Paul Aguilar, Chief Human Resources and Organizational Performance Officer

DATE: April 27, 2026

SUBJECT: Human Resources (HR) Report

Human Resources Activities

In the first quarter of 2026, the Human Resources (HR) team has focused on:

1. Resource Management and Talent Retention
2. Staff Engagement / Culture Transformation
3. Optimizing new Human Resources Information System (HRIS), Workday
4. Organizational Performance and Individual Goal Alignment

Resource Management and Talent Retention

At the beginning of 2026, the executive team implemented a hiring pause while the organization managed through the uncertainty of H.R. 1 changes. Only key operational roles continue to be filled, as the focus on bringing in new talent to optimize operations is a priority. Because of this targeted hiring, Gold Coast Health Plan (GCHP) only filled nine requisitions through the end of March. With this limited Operations hiring and the pause of 26 positions, the total count of employees has declined to 446, which is 34 employees below budget, or 93% capacity.

Managers are working with their teams to be resourceful by streamlining work activities and leveraging talent across the organization to make up the resource gaps that may exist because of the hiring pause. The table below provides a total Resource Summary, which includes Employees and Contingent Workers (temporary staff / contractors) by Function. Please note the decline in contingent workers, from 142 reported earlier in the year to 28 (an 80% reduction) at the end of March. This decline is primarily due to the completion of the Dual Special Needs Plan (D-SNP) contractors' support, effective March 31.

Gold Coast Health Plan - Headcount Analysis
March 31, 2026 Report

	EMPLOYEE COUNT						CONTINGENT WORKERS			TOTAL RESOURCES	
Function	**Active Headcount**	**Active Open Reqs**	**Positions Held**	**2026 Budget YE Headcount**	**Percentage of Total Headcount**	**Active HC Capacity**	**Temps**	**Contractor/ Consultant**	**Total Contingent**	**Total Resources**	**Percentage of Total Resources**
Health Services	135	0	7	142	30%	95%		5	5	147	29%
Operations	105	7	3	115	24%	91%		11	11	126	25%
Information Tech	40	0	2	42	9%	95%			0	42	8%
Policy & Programs	42	0	3	45	9%	93%			0	45	9%
Compliance	20	0	2	22	5%	91%	1		1	23	5%
Finance & Accounting	36	0	3	39	8%	92%	1	1	2	41	8%
Executive & Administration	13	1	0	14	3%	93%		3	3	17	3%
Member Experience and Ext Affairs	35	0	5	40	8%	88%	1		1	41	8%
HR & Facilities	12	0	1	13	3%	92%	1	0	1	14	3%
Innovation / DSNP	4	0	0	4	1%	100%	3	1	4	8	2%
Total	**442**	**8**	**26**	**476**	**100%**	**93%**	**7**	**21**	**28**	**504**	**100%**

Outsource Labor (BPO) excluded: 90 Netmark Claim Examiner operation roles

GCHP's attrition rate through March 2026 for the last 12 months is still low at 5.6%. The attrition rate is relatively flat when compared to the last three months. In 2026, there have been 10 voluntary terminations, with three due to retirement, three due to performance, and four for personal / career reasons. HR checks attrition trends each month to assess pending organizational risks or concerns.

Staff Engagement / Culture Transformation: All GCHP employees received training on GCHP's Culture journey as of March 31, 2026. To continue embedding knowledge of our culture, the Executive and Leadership teams and all managers attended a workshop titled *Leading Through Disruption*, which enables leaders to effectively manage change over the next two years.

Optimizing new Human Resources Information System (HRIS), Workday
GCHP launched Workday in December 2025. The new platform has positively impacted how we manage our work. Managers and employees are using Workday for 100% of all payroll and HR process tasks. The HR team continues to optimize the system to enhance reporting and small post-go-live process adjustment. In March, we introduced the Workday app to employees for easier access to key features such as recording time entry and access to pay statements and personal information anytime, anywhere.

Organizational Performance and Individual Goal Alignment
The Executive and Leadership teams finalized the 2026 priorities and developed organizational goals in January 2026. These goals align to our strategic goals and set the direction for GCHP over the next 12 months. The goals listed below are for both lines of business: Medi-Cal and Total Care Advantage.

Strategic Goals for Medi-Cal:

- Retain targeted average Medi-Cal members
- Improve Consumer Assessment of Healthcare Providers & Systems (CAHPS) score for adults and children
- Pay claims correctly the first time, every time
- Achieve Managed Care Accountability Sets (MCAS) targets

Strategic Goals for Total Care Advantage:

- Increase Total Care Advantage members
- Optimize Total Care Advantage provider relationships
- Achieve Total Care Advantage quality targets

GCHP Foundational Goals:

- Transform Our Culture
- Meet Financial Targets
- Meet Compliance Targets

It is important for employees to understand how our organizational goals impact GCHP's success and outcomes. The 2026 Performance Management Process (PMP) kicked off with a focus on the development of individual SMART (specific, measurable, achievable, relevant, and time-bound) goals for each employee. HR hosted employee and manager training sessions in February to provide an overview of the 2026 PMP process and lead the goal-setting process.

GCHP will optimize the organization at the functional and individual level to ensure we operate efficiently. Our emphasis will be on engaging and retaining employees by positioning team members in appropriate roles that advance GCHP priorities and create the best employee experience.

RECOMMENDATION:

Receive and file.