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

Regular Meeting
Monday, September 28, 2026 2:00 p.m.
Meeting Locations: 4880 Santa Rosa Rd
Camarillo, CA 93012
Community Room

2220 E. Gonzales Road
Oxnard, CA 93036

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

Conference Call Number: 1-805-324-7279
Conference ID Number 332 929 961#:

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

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

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.

CLOSED SESSION

1. **CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION**
   Initiation of Litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: Two cases.

2. **CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION**
   (Paragraph (1) of subdivision (d) of Section 54956.9)
   Name of Case: Dignity Health dba St. John's Regional Medical Center et al v. Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan, et al. Case Number 2026CUBC071894

CONSENT

3. **Approval of Ventura County Medi-Cal Managed Care Regular Commission meeting minutes of August 24, 2026**

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

   RECOMMENDATION: Approve the minutes as presented.

4. Written Summary of Quality Improvement & Health Equity Activities: Q2 2026

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

RECOMMENDATION: Staff recommend that the Ventura County Medi-Cal Managed Care Commission receive and file the Quarter 2, 2026 Quality Improvement and Health Equity Committee summary.

5. Recuperative Care Sustainability Project Amendment

Staff: Erik Cho, Chief of Staff & Strategy Officer

RECOMMENDATION: The Plan recommends that the Ventura County Medi-Cal Managed Care Commission authorize the CEO to execute the Amended and Restated Funding Agreement Regarding Recuperative Care Facilities.

REPORTS

6. Chief Diversity Officer (CDO) Report

Staff: Ted Bagley, Chief Diversity Officer

RECOMMENDATION: Receive and file the report

7. Chief Executive Officer (CEO) Report

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

RECOMMENDATION: Receive and file the report

8. Chief Operations Officer (COO) Report

Staff: Suma Simcoe, Chief Operations Officer

RECOMMENDATION: Receive and file the report

9. Chief Medical Officer (CMO) Report

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

RECOMMENDATION: Receive and file the report

PRESENTATION

10. Network Provider Presentation

Staff: Suma Simcoe, Chief Operations Officer
Michelle Espinoza, Exec. Director of Provider Network Operations & Strategies

RECOMMENDATION: Receive and file the report.

FORMAL ACTION

11. All Languages Interpreting & Translating Inc., Additional Funds Required

Staff: Lupe Gonzalez, PhD, MPH, Sr. Director Health Education, Cultural & Linguistic Services

RECOMMENDATION: The Plan is recommending the Ventura County Medi-Cal Managed Care Commission approves the request to add an additional amount of $225,000 to the existing contract and purchase order through the current expiration date of June 30, 2027. The new cumulative amount of the contract is $940,628.47.

12. Quality Improvement and Health Equity Committee 2026 Third Quarter Report

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

RECOMMENDATION: Approve the 2025 QIHET Program Evaluation. Receive and file the complete report as presented.

13. Contract Approval – ClarisHealth, Inc., Claims Payment Integrity Services

Staff: Suma Simcoe, Chief Operations Officer

RECOMMENDATION: It is the Plan's recommendation that the Commission authorize the Procurement Director to execute a contract with ClarisHealth, Inc. The term of the contract will be three years commencing October 1, 2026, and expiring on September 30, 2029, for an amount not to exceed $13M.

14. July Year-To-Date 2026 Financials

Staff: Christopher Lee, Chief Financial Officer

RECOMMENDATION: Accept the financial information as presented

ADJOURNMENT

The next meeting will be the Strategic Planning Retreat which will be held on Thursday , October 29, 2026, from 10a.m. to 3 p.m. at the **NEW** GCHP Building located at 4880 Santa Rosa Rd. Camarillo, CA 93012 in the Community Room

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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.

Gold Coast Health Plan℠
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omisión de Atención Administrada de Medi-Cal del Condado de Ventura (VCMMCC)
Que ejerce su actividad como Gold Coast Health Plan

Reunión Ordinaria
Lunes, 28 de septiembre de 2026 2:00 p.m.
Ubicaciones de la Reunión: 4880 Santa Rosa Rd
Camarillo, CA 93012
Sala Comunitaria

2220 E. Gonzales Road
Oxnard, CA 93036

Los miembros del público pueden participar utilizando los Números de Conferencia Telefónica que aparecen a continuación.

Número de Conferencia Telefónica: 1-805-324-7279
Número de Identificación de la Conferencia: 332 929 961#:

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

AGENDA

ANUNCIO DE LA SECRETARIA

Todos los miembros del público son bienvenidos a llamar al número de conferencia telefónica que aparece en esta agenda y a seguir todos los asuntos enumerados en la Sesión Abierta, visitando el sitio web de GCHP y dirigiéndose a ***About Us > Ventura County Medi-Cal Managed Care Commission > Desplácese hacia abajo hasta "Commission Meeting Agenda Packets and Minutes"***

LLAMADA AL ORDEN

ANUNCIO DE INTÉRPRETE

PASE DE LISTA

COMENTARIOS DEL PÚBLICO

El público tiene la oportunidad de dirigirse a la Comisión de Atención Administrada de Medi-Cal del Condado de Ventura (VCMMCC) y al Comité que ejerce su actividad como Gold Coast Health Plan (GCHP) sobre los asuntos de la agenda.

Las personas que deseen dirigirse a la VCMMCC y al Comité tienen un límite de tiempo de tres (3) minutos, a menos que la Presidencia de la Comisión amplíe el tiempo por causa justificada debidamente acreditada. Los comentarios sobre asuntos que no estén en la agenda deben estar comprendidos dentro del ámbito de competencia de la Comisión y del Comité.

Los miembros del público pueden llamar, utilizando los números anteriores, o pueden enviar comentarios del público a la Comisión y al Comité por correo electrónico, enviando un correo a ask@goldchp.org. Si los miembros del público desean hablar sobre un asunto particular de la agenda, se ruega que identifiquen el número de asunto de la agenda. Los comentarios del público presentados por correo electrónico deben ser de menos de 300 palabras.

SESIÓN A PUERTA CERRADA

1. **CONFERENCIA CON EL ASESOR JURÍDICO—LITIGIOS PREVISTOS**
   Inicio de litigios de conformidad con el párrafo (4) de la subdivisión (d) de la Sección 54956.9: Dos casos.

2. **CONFERENCIA CON EL ASESOR JURÍDICO—LITIGIOS EXISTENTES**
   (Párrafo (1) de la subdivisión (d) de la Sección 54956.9)
   Nombre del caso: Dignity Health dba St. John's Regional Medical Center et al v. Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan, et al. Número de caso 2026CUBC071894

ASUNTOS DE CONSENTIMIENTO

3. **Aprobación de las Actas de la Reunión Ordinaria de la Comisión de Atención Administrada de Medi-Cal del Condado de Ventura del 24 de agosto de 2026**

   Personal: Maddie Gutierrez, MMC Secretaria sénior de la Comisión

   RECOMENDACIÓN: Aprobar las actas tal y como se presentan.

4. **Resumen escrito de las actividades de Mejora de la Calidad y Equidad en Salud: segundo trimestre de 2026**

Personal**:** James Cruz, MD, Director Médico
Kim Timmerman, MHA, CPHQ, Directora Ejecutiva de Mejora de la Calidad

RECOMENDACIÓN: El personal recomienda que la Comisión de Atención Administrada de Medi-Cal del Condado de Ventura reciba y archive el resumen del Comité de Mejora de la Calidad y Equidad en Salud correspondiente al segundo trimestre de 2026.

5. Enmienda al Proyecto de Sostenibilidad de Cuidados de Recuperación

Personal: Erik Cho, Jefe de Gabinete y Director de Estrategia

RECOMENDACIÓN: El Plan recomienda que la Comisión de Atención Administrada de Medi-Cal del Condado de Ventura autorice al Director Ejecutivo a celebrar el Acuerdo de Financiamiento Enmendado y Reformulado relativo a Centros de Cuidados de Recuperación.

INFORMES

6. Informe del Director de Diversidad (CDO)

Personal: Ted Bagley, Director de Diversidad

RECOMENDACIÓN: Recibir y archivar el informe

7. Informe del Director Ejecutivo (CEO)

Personal: Felix L. Nunez, M.D., MPH, Director Ejecutivo

RECOMENDACIÓN: Recibir y archivar el informe

8. Informe de la Directora de Operaciones (COO)

Personal: Suma Simcoe, Directora de Operaciones

RECOMENDACIÓN: Recibir y archivar el informe

9. Informe del Director Médico (CMO)

Personal: James Cruz, M.D., Director Médico

RECOMENDACIÓN: Recibir y archivar el informe

PRESENTACIÓN

10. Presentación sobre Proveedores de la Red

Personal: Suma Simcoe, Directora de Operaciones

RECOMENDACIÓN: Recibir y archivar el informe.

ACTUACIONES FORMALES

11. All Languages Interpreting & Translating Inc., Fondos Adicionales Necesarios

Personal: Lupe Gonzalez, PhD, MPH, Directora Sénior de Educación para la Salud y Servicios Culturales y Lingüísticos

RECOMENDACIÓN: El Plan recomienda que la Comisión de Atención Administrada de Medi-Cal del Condado de Ventura apruebe la solicitud de añadir una cantidad adicional de $225,000 al contrato y a la orden de compra existentes hasta la fecha de vencimiento actual del 30 de junio de 2027. El nuevo importe acumulado del contrato es de $940,628.47.

12. Informe del tercer trimestre de 2026 del Comité de Mejora de la Calidad y Equidad en Salud

Personal: James Cruz, MD, Director Médico
Kim Timmerman, MHA, CPHQ, Directora Ejecutiva de Mejora de la Calidad

RECOMENDACIÓN: Aprobar la Evaluación del Programa QIHET de 2025. Recibir y archivar el informe completo tal y como se presenta.

13. Aprobación de contrato – ClarisHealth, Inc., Servicios de Integridad de Pagos de Reclamaciones

Personal: Suma Simcoe, Directora de Operaciones

RECOMENDACIÓN: El Plan recomienda que la Comisión autorice al Director de Adquisiciones a celebrar un contrato con ClarisHealth, Inc. El plazo del contrato será de tres años, con vigencia del 1 de octubre de 2026 al 30 de septiembre de 2029, por un importe que no exceda los $13 millones.

14. Datos financieros acumulados hasta julio de 2026

Personal: Christopher Lee, Director Financiero

RECOMENDACIÓN: Aceptar la información financiera tal y como se presenta

LEVANTAMIENTO DE SESIÓN

La próxima reunión será el Retiro de Planificación Estratégica, que se celebrará el jueves, 29 de octubre de 2026, de 10 a.m. a 3 p.m. en el **NUEVO** Edificio de GCHP ubicado en 4880 Santa Rosa Rd. Camarillo, CA 93012, en la Sala Comunitaria

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Los Informes Administrativos relativos a esta agenda están disponibles en 711 East Daily Drive, Suite #106, Camarillo, California, durante horario normal de oficina, y en la página http://goldcoasthealthplan.org. Los materiales relacionados con un asunto de la agenda presentado al Comité tras la distribución del paquete de la agenda están disponibles para revisión del público durante horario normal de oficina, en la oficina de la Secretaría de la Comisión.

En cumplimiento de la Ley de Estadounidenses con Discapacidades, si usted necesita ayuda para participar en esta reunión, por favor, contacte al (805) 437-5512. Las notificaciones para adaptaciones deben hacerse a más tardar a la 1:00 p.m. del lunes anterior a la reunión para permitir que la Secretaría de la Comisión tome las medidas razonables necesarias para garantizar la accesibilidad a esta reunión.

AGENDA ITEM NO.3

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: September 28, 2026

SUBJECT: Regular Meeting Minutes of August 24, 2026

RECOMMENDATION:

Approve the minutes.

ATTACHMENT:

Copy of Commission meeting minutes for August 24, 2026

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
Commission Meeting
Regular Meeting

August 24, 2026

CALL TO ORDER

Committee Chair Laura Espinosa called the meeting to order at 5:33 p.m. The meeting was held at the Museum of Ventura County located at 100 E. Main Street in Ventura, CA 93001.

INTERPRETER ANNOUNCEMENT

The interpreter made her announcement.

ROLL CALL

Present: Commissioners Anwar Abbas, Allison Blaze, M.D., Dr. Loretta Denering, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Tim Myers, Yohan Perera, M.D., Roger Robinson, Mark Sewell, and Scott Underwood, D.O.

Absent: Commissioner Douglas Kleam.

Attending the meeting for GCHP were Felix L. Nunez, M.D., CEO, CPPO Erik Cho, Interim CFO Jeff Register, CFO Christopher Lee, Robert Franco CCO, Eve Gelb, Chief Innovation Officer, Ted Bagley, CDO, Alan Torres, CIO, Marlen Torres, CMEEAO, Paul Aguilar, CHRO, Suma Simcoe, COO, Jacqueline Segal, BBK, and Scott Campbell, General Counsel.

Also in attendance were the following GCHP Staff: Bob Bushey, Lupe Gonzalez, TJ Piwowarski, Holly Krull, Joanna Hioureas, Pshyra Jones, Pauline Preciado, Kris Schmidt, Brenda Gomez-Garcia, Chris Dulan, Josephine Gallella, Kim Timmerman, Shannon Robledo, David Tovar, Adriana Sandoval, Michelle Espinoza, Nicole Kanter, Kim Marquez-Johnson, Veronica Estrada, Lupe Nunez, Nathan Norbryhn, Vicki Wrighster, Rachel Segovia, Lupe Harrion, Serio Cuevas, Susana Enriquez-Euyoque, and Alejandro Ambriz.

Guests: Dr. John Fankhauser– County of Ventura

PUBLIC COMMENT

1. **Chris Espinosa, Santa Paula resident, public policy professional, and community activist Subject:** General support for leadership in hospital advocacy. He noted that closing the hospital does not eliminate the underlying need for care.

2. **Cynthia Salas, OSD Board of Trustee (Ms. Salas noted that the views she is sharing are her own) Subject:** Santa Paula Hospital closure – the conditions that brought the hospital to this point were unknown, seismic deadlines were known. The infrastructure needs were known. The demographics of Santa Clara Valley are known,

longstanding health care disparities were known for years, yet the response to these concerns were slow.

Ms. Salas requested three things from Gold Coast: 1) Place this matter on a commission agenda, 2) return within 60 days with a public record report on member utilization, patient distribution, network adequacy, hospital capacity, transportation, continuity of care and impacts on vulnerable communities across Ventura County, and 3) convene a public town hall with residents, hospitals, and school districts.

3. **Letter from LULAC Chief Civil Rights Investigator, Dr. Jaime Casillas – LULAC Council 3231** Copies of the letter were distributed to both the Commission and GCHP Executive Team **Subject**: County action on Santa Paula Hospital closure and diminished capacity to a less than comprehensive medical treatment center is viewed as a type of corruption and failure to serve.

4. **Cynthia Salas, OSD Board of Trustee Subject**: Santa Paula Hospital closure. Ms. Salas noted the public should be shown the data; residents should be able to ask questions and institutions responsible for maintaining action should answer questions directly. The closing of the hospital will impact on the quality of care across Ventura County. She requested the commission consider having a countywide analysis of how these decisions will impact Medi-Cal recipients.

5. **Rick Castaniero, Santa Paula Town Hall President Subject**: request that GCHP actively monitor, advocate, and support continued availability of comprehensive care and hospital level services for Medi-Cal members in Santa Paula, Fillmore, Piru and the Santa Clara Valley. The Santa Clara Valley represents a significant Medi-Cal population in Ventura County. Mr. Castaniero made requests: 1) monitor the County of Ventura's plans for Santa Paula Hospital and evaluate their potential impact on GCHP members in the Santa Clara Valley, 2) advocate for continuity of hospital level and emergency health care services, 3) evaluate the impact of any proposed reduction in services on Medi-Cal beneficiaries, particularly seniors, children, people with disabilities, low-income working families, and residents without reliable transportation 4) support racial and geographic health equity when considering future funding partnerships, contracts, programs and health care investments affecting the Santa Clara Valley 5) engage directly with Santa Paula, Fillmore and Piru residents and community organizations before supporting decisions that could substantially affect health care access 6) support preserving, retrofitting and modernizing Santa Paula Hospital as a bridge to the future while Ventura County develops a long-term health care and social service infrastructure plan for the Santa Clara Valley.

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Regular Commission meeting minutes of June 29, 2026

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

RECOMMENDATION: Approve the minutes as presented.

Commissioner Abbas motioned to approve the corrected meeting minutes of June 29, 2026. Commissioner Monroy seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Dr. Loretta Denering, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Tim Myers, Yohan Perera, M.D., Roger Robinson, Mark Sewell, and Scott Underwood, D.O.

NOES: None.

ABSENT: Commissioner Douglas Kleam

Motion carried.

2. Approval of Credentials / Peer Review Committee Member

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

RECOMMENDATION: Approve Amelia Breckenridge, M.D., as an active member of the Credentials / Peer Review Committee

Commissioner Abbas motioned to approve Amelia Breckenridge, M.D., as an active member of the Credentials / Peer Review Committee. Commissioner Underwood seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Dr. Loretta Denering, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Tim Myers, Yohan Perera, M.D., Roger Robinson, Mark Sewell, and Scott Underwood, D.O.

NOES: None.

ABSENT: Commissioner Douglas Kleam

Motion carried.

PRESENTATION

3. Member Experience

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

RECOMMENDATION: Receive and file the presentation.

Marlen Torres, Chief Member Experience & External Affairs Officer stated this presentation as an update on member experience, specifically the retention /enrollment work under our strategic goals for 2026. She noted that monthly updates are presented. The focus of this presentation is on strategic initiatives and the implementation that has been done. The Pathways to Wellness Grants Program aimed to be able to support our members as we work through several changes observed under member benefits eligibility due to HR1. We have seen a continuous decrease in membership due to a statewide perspective with the enrollment freeze of members that we had under the unsatisfactory immigration status (UIS) and the reinstatement of the asset limit test in January of 2026 with the enactment of the new budget. We also saw changes in the community and what was experienced through enforcements by the Department of Homeland Security. There are also upcoming changes to the public charge, which impacted the way members were thinking about care and whether they would continue to be eligible to receive services. We also experienced increased misunderstandings from members regarding the HR1 changes and when they would take effect.

In October of 2026 we received approval from the commission to begin the Pathways to Wellness program to provide additional support to our members. We looked at strategies that we could begin to implement. Our strategies are working so far, and we will continue to monitor membership.

What has been done so far between the months of February to May we launched our awareness campaign about Medi-Cal eligibility changes. We have done messaging on billboards, buses, inside bus shelters, DMV locations, digital platforms, newspaper, radio, and social media. We also had boots on the ground for our community relations team to begin workshops out in the community, designed to support our members and continue to partner with our Pathways to Wellness grantees. We also have done Swap meet Justice at Oxnard College. We have also launched the Ventura County Healthcare Access Coalition to be able to work together and garner support. Between June and September, we hired ten call center temp agents to begin to conduct monthly calls to all households there were up for renewal in particular months.

Erik Cho, Policy & Programs Officer dedicated RISE Grant funds to continue to support from a community grant perspective. We are also developing communications tool kit in which we would be able to reach members through texting, having FAQs, flyers, etc. We have also been in lockstep with outreach strategies that DHCS has conducted. We have seen the final rule that came from CMS. There have been a lot of activity from the district

attorney's office, general office, general counsel, and others who have raised concerns over the final rule and the definition around medically frail and who would be exempt from those requirements. We have also begun to strategize on how we are going to support these members.

Ms. Torres stated that at the beginning of 2027, the adult expansion population will need to be re-enrolled every six months, and we are preparing to be able to support them with those efforts.

During the June through July time frame over 11,000 members have been outreached by the Pathways to Wellness grantees. One of the grantees was MICOP, Ms. Juana Zaragoza and Ms. Vanessa Teran reviewed the work they have been able to do through the Pathways Grant. She noted that with the grant they have been able to continue supporting families in Ventura County – primarily with their Medi-Cal processes and bring information directly to families.

Jessica Bishop from Many Mansions stated the Pathways grant has helped by allowing them to continue to assist residents. She noted that housing is only one part of a person's ability to thrive. Many Mansions look at the whole person, identify what stands between them and stability and help remove those barriers. The Pathways to Wellness Grant ensures that residents are supported at every step of their journey towards wellness and stability.

In January of 2026 the Ventura County Health Care Access Coalition was launched because we recognize that we cannot do this work alone. Although we have made great efforts, it is still not enough to maintain member enrollment – it will take a community and a countywide effort. We have also launched workgroups within the coalition. There are several members who have been working to see how else we can attract additional funding to support retention enrollment efforts and for those that may be losing coverage. Ms. Torres noted that the workgroups are comprised of multiple partners that are stepping up and engaging and thinking outside of the box. We will present more updates at future commission meetings.

The last piece she wanted to present was there was a lot of activity that happened during May Revise with the transition ultimately of our members that were categorized under UIS to transition them from managed care into fee-for-service beginning January 2027. We are looking to see how we are best going to transition these members and we have begun to meet as a plan. One of our first deliverables is provider communications which will inform all providers that this change is occurring. Ms. Torres noted that the state is also not slated to send their letter to members until December 1. We know that members need to be informed sooner and there needs to be a tie-in as the providers are being informed. We are working through what our outreach and communications plan will look like and advocating from a DHCS perspective. All our materials need to go to DHCS – they need to be approved. We have also been advocating for universal language that we would be able to adopt as opposed to waiting for them to approve materials. We will continue to develop plans, and we will continue to share updates.

Commission Chair Espinosa stated the report was very comprehensive, and she appreciated our community partners. She also stated that she was glad that Gold Coast is at the forefront of not only recruitment but also retention of members. She thanked the speakers and Ms. Marlen Torres for an excellent presentation.

Marlen Torres, Chief Member Experience & External Affairs Officer stated that she wanted to thank our cross-functional team who have been collaborating and providing support. She thanked our project management team, information technology team, her team which is communications, community relations, member engagement and the Health Education team who also supported with the member journey, our grants team who have been key, as well as the Executive Team.

Commissioner Abbas thanked Ms. Torres for a wonderful presentation. He stated he had one question regarding HR1: Commissioner Abbas noted that there are certain members who are critically ill – he asked if they are automatically approved for Medi-Cal services. He also asked if staff had any idea of how many members are in that category. Ms. Torres stated she has started looking at the numbers and she can present information at the next commission meeting. She also noted that one of the pieces that must be considered was the interim final rule and some of the members that we thought would be eligible under medically frail are not going to be due to the interim final rule. Ms. Torres stated that whatever we have accounting for that rule at the next commission meeting. CIO Eve Gelb stated that the rule has become more stringent, requiring not only to demonstrate that there is a chronic condition that is disabling, but demonstrates that you have deficits in your activities of daily living which is a very hard thing to prove. Ms. Torres stated that is a concern for the Plan as well.

Commissioner Franklin motioned to approve the presentation. Commissioner Robinson seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Dr. Loretta Denering, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Tim Myers, Yohan Perera, M.D., Roger Robinson, Mark Sewell, and Scott Underwood, D.O.

NOES: None.

ABSENT: Commissioner Douglas Kleam

Motion carried.

FORMAL ACTION

4. Reconstitute the Strategic Planning Ad Hoc Committee

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

RECOMMENATION: Staff recommend that the Commission reconstitute the Strategic Planning Ad Hoc Committee and select up to five Commissioners who will serve in the ad hoc committee. Additionally, staff recommend that the Strategic Planning Retreat be held in person this year.

Marlen Torres, Chief Member Experience & External Affairs Officer, stated that we have requested over the last several years the reconvening of the strategic planning AdHoc committee. She noted that this year is a bit different because we are finishing up our five-year strategic plan and will begin our three-year strategic plan. We will meet in October for our Strategic Plan Retreat. We request volunteers for this committee to provider staff with feedback as we prepare for the retreat. Last year the commissioners that participated were Commissioners Espinosa, Pupa, Monroy, Abbas, and Myers. She noted that last year we had the majority of the Executive Finance Committee and we had to post the AdHoc meetings as Brown Act.

General Counsel, Scott Campbell stated that if we have three members of Executive Finance, we must post. He also noted that the AdHoc can have up to five members. Commissioner Blaze stated she would like to be on the committee, Commissioner Espinosa stated she will be on the committee, Commissioner Robinson stated he would like to join the committee. Both Commissioners Abbas and Myers also stated they would like to participate as well.

Supervisor Lopez motioned to approve the members of the Strategic Planning AdHoc Committee. Commissioner Blaze seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Dr. Loretta Denering, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Tim Myers, Yohan Perera, M.D., Roger Robinson, Mark Sewell, and Scott Underwood, D.O.

NOES: None.

ABSENT: Commissioner Douglas Kleam

Motion carried.

5. Quality Improvement and Health Equity Committee 2026 Second Quarter Report

Staff: James Cruz, M.D., Chief Medical Officer
Kim Timmerman, Executive Director of Quality Improvement

RECOMMENDATION: Receive and file the second quarter Quality Improvement and Health Equity Committee report as presented.

CEO Nunez stated CMO Cruz was on vacation, and Ms. Kim Timmerman would present the report.

Kim Timmerman, Executive Director of Quality Improvement, stated the focus will be on our MCAS and HEDIS results for measurement year 2025. She reviewed the MCAS/HEDIS 2025 achievement highlights. She noted all our measures met the minimum performance level which is called the MPL for the first time in Gold Coast history. The MPL is the NCQA National Medicaid 50th percentile and that is the level set by DHCS for minimum performance. 17 out of 18 measures that we were held to MPL improved compared to measurement year 2024. We had 13 measures at the 75th percentile or above, which was 72% compared to 61% in measurement year 2024. We saw an 11% improvement.

Another highlight is that asthma medication ratio measure or AMR increased from the 10th to the 75th percentile and saw a 14.4% improvement in that rate. We had never met the minimum performance level for asthma medication ratio and that represents a partnership with our providers. Four measures met the high-performance level - which is the 90th percentile benchmark. This means that our score or measurement is higher than 90% of our peer Medicaid plans and it also means that we scored in the top 10% for four of the measures.

Each year we set our internal targets. We know the minimal target is 50th percentile but we set our internal targets to be aspirational goals for these managed care accountabilities set for HEDIS measures. This year our goal for our 90th percentile is called the Magnificent Seven measures. In measurement year 2025 we did achieve that 90th percentile for three of the seven measures. We achieved it for postpartum care, glycemic status for our diabetic members – A1C, and for breast cancer screening. For four of the measures, we achieved 75th percentile – cervical cancer screening, lead screening in children, prenatal care, and well-child visits for our 15-to-30-month infants.

Ms. Timmerman reviewed a detailed table for our 2025 rate performance. She noted that across the board we had improvement in all measures except for follow-up after emergency department visits for mental illness measured at 30 days follow-up. She then reviewed all the measures we had improved on and their percentile levels. She noted that through our improved rates, additional members are served. It is not just about performance rate, it is about the people, it is about our members. We closed almost 6,000 care gaps compared to the prior year. Other key takeaways in looking at the mass of data, the quality improvement pool and program have demonstrated

effectiveness in continuing to drive quality improvement and strong provider partnerships aligned on common goals.

Ms. Timmerman also stated that NCQA specification changes impact rate improvement and require additional strategic adjustments to maintain performance. We need to be strategic about NCQA changes that affect our outcomes.

Ms. Timmerman stated she wanted to give a sneak peek into our measurement year 2026 managed care accountability set and HEDIS measures and status. At this point we have 60% or 12 of our 20 – we have 20 measures now held to the MPL, meeting our internally established targets. Seven of the 20 measures are performing better than at the same time last year

We are now the Elite Eight because we have eight measures that we are striving to achieve the 90th percentile. Currently we do have one measure at the 90th – which is immunization for adolescents, and we have two measures currently performing at the 75th - lead screening and well-child visits. Cervical cancer screening is currently at the 66th percentile and breast cancer screening is at the 50th. We have four measures that are targeted and currently we have two measures meeting or exceeding that level. For MPL we have eight measures that are targeted and we currently have five that are meeting MPL, and some of our depression screening measures are at 95th and 75th percentile so we are progressing well for measurement year 2026.

Commissioner Perera stated that as a primary physician he wanted to commend GCHP because it is a large undertaking to just accomplish in one clinic but to do it across all the members is a great accomplishment and should be celebrated. Supervisor Lopez noted the presentation was very informative and numbers were very specific. She asked if there was a breakdown by community, by neighborhood, by region and how that informs those targeted outreach and efforts in partnerships. Ms. Timmerman stated there are additional dashboards that are not shown in the presentation, there is a breakdown by zip code and different geographic areas.

Commissioner Abbas motioned to approve the second quarter report. Commissioner Monroy seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Dr. Loretta Denering, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Tim Myers, Yohan Perera, M.D., Roger Robinson, Mark Sewell, and Scott Underwood, D.O.

NOES: None.

ABSENT: Commissioner Douglas Kleam

Motion carried.

6. Request For Proposal Number GCHP10232025: Notice of Non-Award, Rejection of All Bids and Renewal of Work with Inovalon for HEDIS and Risk Adjustment Services

Staff: Eve Gelb, Chief Innovation Officer
Kim Timmerman, Executive Director Quality Improvement

RECOMMENDATION: It is the Plan's recommendation that the Ventura County Medi-Cal Managed Care Commission approve the Notice of Non-Award and reject all bids for Request For Proposal Number GCHP10232025 and approve a three-year contract amendment to renew four, (4) Statement of Works, (SOWs #4, 5, 6 & 7), for these services commencing January 1, 2027, and ending on December 31, 2029, at a reduced amount, for an amount not-to-exceed $5.7M, with Inovalon.

Eve Gelb, Chief Innovation Officer, stated that staff are recommending that 1) the Commission a notice of non-award for a request for proposal that was out in the marketplace, and 2) a continuation approval to renew an existing contract for significantly lower costs than previous service. We went out to bid for an organization to support us in tracking all the quality data that Ms. Timmerman just presented. We currently work with Inovalon and have been with them for a long time. Due to the addition of our new line of business, Medicare Advantage, we went to market to see if there would be a better choice for us. During the process we did identify vendors, but we are at the point where the incumbent is more cost-effective, from a price standpoint as well as from implementation. Because they are an incumbent, we do not incur implementation costs for a new vendor. We can also save staff time. Staff would have been pulled away to do the implementation, and they can now instead work on member retention, operations optimization and other things. We are asking for a non-award to that requested proposal and to continue to renew with the existing incumbent.

Kim Timmerman, Executive Director Quality Improvement stated that Cotivity was the top scoring vendor, and negotiations began but concerns ramped up when the negotiations stalled. We also noted that service that we received from Inovalon had improved, they were more responsive, and we also had the opportunity to see their Medicare STARS forecasting tool. By switching to Cotivity, we would lose our provider-facing portal. Our providers can log into Inovalon, they can see their members' gaps in care, and they can see their specific rates. Our staff report also provides additional details about the terms of the agreement. Inovalon agreed to negotiate a lower rate which gave us $3million cost savings. We did not receive a protest; therefore, we are asking for approval and continuation of the Inovalon agreement.

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

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Dr. Loretta Denering, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Tim Myers, Yohan Perera, M.D., Roger Robinson, Mark Sewell, and Scott Underwood, D.O.

NOES: None.

ABSENT: Commissioner Douglas Kleam

Motion carried.

7. Contract Approval – Cotivity – Implementation and Software License, Interoperability 57F & APL 26-008 Requirements

Staff: Alan Torres, Chief Information Officer

RECOMMENDATION: It is the Plan's recommendation that the Commission authorize the CEO to execute a contract with Cotivity. The term of the contract will be 5 years of services commencing September 1, 2026, and expiring on August 31, 2031, for an amount not to exceed $2.6M.

Alan Torres, Chief Information Officer stated we are asking for approval of the execution of additional contracts with Cotivity, previously known as Edifecs, for software and implementation services to address the new DHCS and CMS compliance requirements related to interoperability prior authorization rule. Cotivity acquired Edifecs in March 2025. The term of the contract will be five years of services commencing September 1, 2026, and expiring August 21, 2031, for an amount not to exceed $2.6million.

It is important to note that we are adding a new license to the Cotivity-based product. Instead of going to market for a product to support just certain requirements, we are leveraging our existing strategic investments and using technical data integration approaches that have been developed, which will save us time and money by avoiding moving to a new vendor. Mr. Torres also noted there is no expense impact to the 2026 budget. There will be an annual amortization cost of approximately $570,000 per year starting in 2027 and ending in 2031.

Commissioner Perera stated that technology and healthcare moves very rapidly, and he asked if Cotivity guaranteed that any updates to their software as things change over the next five years – will they continue to maintain the highest level of service that they are promising now. He asked if they would keep up with the increasing speed, increasing data transfers. Five years is a long contract. CIO Torres stated they do stay current. Ten of our sister plans use the product today. As part of the contract they are committed to keeping up with the CMS regulations and any changes that may occur.

Commissioner Espinosa stated the Executive Finance Committee brought up the same concern, and it was explained that they are reviewed annually. Commissioner Monroy asked if this was for the Medi-Cal product only or also for D-SNP. Mr. Torres stated it will support both.

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

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Dr. Loretta Denering, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Tim Myers, Yohan Perera, M.D., Roger Robinson, Mark Sewell, and Scott Underwood, D.O.

NOES: None.

ABSENT: Commissioner Douglas Kleam

Motion carried.

8. Continuation of Approval of Contract Renewal List

Staff: Jeff Register, Interim Chief Financial Officer / Controller
Bob Bushey, Executive Director of Procurement

RECOMMENDATION: It is recommended that the Commission approve the contract renewal list.

Jeff Register, Interim Chief Financial Officer / Controller, stated that in the June meeting staff presented a contract renewal list which the commission had approved contracts that were expiring through August, with the understanding that the remainder of those contracts would be presented for further review today. There was discussion about the format/layout of the presentation. We are providing an updated layout.

Mr. register stated the GCHP signature policy stated the commission must approve all contracts with a lifetime expenditure of $300,000 or greater. The list being provided is only for contracts expiring during 2026 that have not been previously approved; therefore, it is a shorter list than what was presented in June. We have also re-evaluated some of those contracts and removed a few that we are not going to renew. We are asking for approval of the renewal period amounts. The current period demonstrates the current run rate on the contract for the most recent annual period. The relationship columns demonstrate how long the relationship has been active with this vendor and the lifetime spend. We are trying to provide some context. There was additional feedback for some other enhancements that we can make, and we intend to bring those to the 2027 budget contract renewal list. It is also our intention to only present one contract renewal list a year in the future.

Bob Bushey, Executive Director of Procurement, reviewed the list. The list includes the vendor's name, the award methodology (under our bidding threshold, if it is competitively bid, or sole source) We have identified how this contract was awarded, and a description of services or goods that we are procuring for the contract, along with start and end dates, the amount, the annual spend for the current contract. There is also a renewal period and the amount that we are asking for that renewal period, the percent change from the current base. The percent change is a projected percent change – it is not the actual. It reiterates our COLA amount that we think that we are going to have or may incur in the renewal period. There is also a relationship section that addresses the cumulative amount over the entire life of the contract. He noted that we will need a more disciplined approach going forward and taking some of those to the marketplace. He also noted this is a much easier format to read and understand.

Commissioner Franklin asked about the timeframe to present contracts to the Commission and if there will be enough time to review. He asked about the proper process. Mr. Bushey stated our general approach in the past has been presented when the annual budget has been presented, we present the contract renewal list in conjunction with the budget. Not all the contract dates end on the budget schedule and there are some projections for some of those items. This past year we did not present the budget until January; it is our intention to bring the 2027 budget to you before 2027. It is our intention to be transparent, and to give enough time to evaluate. He asked if the commission would like to have the contractor list in conjunction with the annual budget or would they like to separate it. We will continue to present updates more than at the end of the year to show the actual spend so the commission has an up-to-date view. We have not overspent any money that had been authorized. We want the commission to provide input and feedback on contract renewals.

Commissioner Abbas requested a separate meeting to go over some of the items, along with his concerns. General Counsel, Scot Campbell stated a separate meeting will be scheduled.

Commissioner Myers motioned to approve the presentation. Supervisor Lopez seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Allison Blaze, M.D., Dr. Loretta Denering, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Tim Myers, Yohan Perera, M.D., Roger Robinson, Mark Sewell, and Scott Underwood, D.O.

ABSTAIN: Commissioner Abbas

NOES: None.

ABSENT: Commissioner Douglas Kleam

Motion carried.

CEO Felix L. Nunez, M.D., stated he wanted to thank Mr. Register for stepping in as Interim Chief Financial Officer. He has done double duty for the past five months as controller and Interim CFO. He has done an excellent job. CEO Nunez also introduced Christopher Lee, new Chief Financial Officer for GCHP. Mr. Lee stated that as he listens to the meeting it is great to see the level of engagement from the Commission.

9. June Year-To-Date 2026 Financials

Staff: Jeff Register, Interim Chief Financial Officer - Controller

RECOMMENDATION: Accept the financial information as presented

Jeff Register, Interim Chief Financial Officer – Controller, presented the June Yar to Date financials. He stated that June Medicaid membership is unfavorable to budget approximately 3,700 members and has declined 13,100 since December 31, 2025. Overall year to date performance is $10.7million favorable to budget. He noted that net income is $12.6 million compared to a budget of $1.9million. He stated that prior year adjustments of $17.6 million are favorably impacting current year's results.

Our revenue is $4.7million favorable to budget, which is driven by favorable member mix. Medical expenses are $0.7mill favorable to budget. The financial statement MLR is 84.4% versus a budget of 85.2% Quality strategy costs are carved out for tracking purposes but they qualify as MLR related costs. Administrative expenses are $5.9million favorable to budget and TNE is currently 549% of the state requirement and is within the target range set by the Commission. Mr. Register also noted that we have added a new metric: Days cash on hand, which is 107. It is a more liquid measure of the same viability as TNE. He stated that cash on hand does bounce around quite a bit. It depends on how long the month was, when our last claims run was, and what day of the week it is. Many things can influence that. It is a number that should be used, trended over time, not any one point in time.

Mr. Register stated that GCHP continues working on a series of initiatives aimed at operational efficiency and medical utilization that will yield improved results He also gave a quick finance department update. He stated that we have achieved a 10-business day close for June, that is now three months in a row, and he is very pleased with the finance team. He noted that we went live on Workday this year and whenever there is a system change it impacts everything you do. The goal is to consistently close in ten business days and have reporting and analysis available by business day 14. All our quarterly regulatory reports have been successfully filed. We continue to find opportunities to improve efficiency for the DHCS quarterly financial reporting package. The package used to be 80 to 100 hours a quarter to prepare, and we were able to cut that time down by 40 hours

Commissioner Abbas motioned to approve the financials. Commissioner Monroy seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Dr. Loretta Denering, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Tim Myers, Yohan Perera, M.D., Roger Robinson, Mark Sewell, and Scott Underwood, D.O.

NOES: None.

ABSENT: Commissioner Douglas Kleam

Motion carried.

PUBLIC COMMENT

6. **Vanessa Teran, MICOP Subject:** Commission meeting times. Ms. Teran requested that public notices regarding commission meetings be published for the public with a 30-day notice to more fully engage and provide the community and our members to give feedback on impacts due to changes that are coming soon.

Commission Chair Laura Espinosa requested that in the interest if limited time, that reports 10 through 13 be tabled and presented at the beginning of the agenda for the September Commission meeting.

REPORTS

10. Chief Diversity Officer (CDO) Report

Staff: Ted Bagley, Chief Diversity Officer

RECOMMENDATION: Receive and file the report

11. Chief Executive Officer (CEO) Report

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

RECOMMENDATION: Receive and file the report

12. Chief Operations Officer (COO) Report

Staff: Suma Simcoe, Chief Operations Officer

RECOMMENDATION: Receive and file the report

13. Chief Medical Officer (CMO) Report

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

RECOMMENDATION: Receive and file the report

Commission went into Closed Session.

CLOSED SESSION

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

15. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

General Counsel, Scott Campbell stated there was no reportable action.

ADJOURNMENT

With no other business to conduct, the meeting was adjourned at 9:40 p.m.

Approved:

_____
Maddie Gutierrez, MMC
Sr. Clerk of the Commission

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: September 28, 2026

SUBJECT: Written Summary of Quality Improvement and Health Equity Activities – Q2 2026

RECOMMENDATION:

Staff recommend that the Ventura County Medi-Cal Managed Care Commission accept and file the Quarter 2, 2026 Quality Improvement and Health Equity Committee summary.

ATTACHMENT:

1) Quality Improvement and Health Equity Committee (QIHEC) Meeting Quarter 2 2026 Summary Report

Quality Improvement and Health Equity Committee (QIHEC) Meeting
2026 Quarter 2 Summary Report

Overview

The Gold Coast Health Plan (GCHP) Quality Improvement and Health Equity Committee (QIHEC) meets six times per year, with ad hoc meetings scheduled as needed. The QIHEC is chaired and facilitated by the Chief Medical Officer (CMO), with committee members comprised of internal leadership, the chairs from the ten QIHEC Subcommittees, one Commissioner, at least one practicing physician in the community, and a behavioral healthcare practitioner. This report is a summary of the May 12, 2026 QIHEC meeting.

May 12, 2026 QIHEC

Action Items

1. Action Item #69: Blood lead screening reporting on positive screening results
   - Guidance on the 30-day blood lead screening reporting requirement was submitted to the Department of Health Care Services (DHCS) on April 14 and a response is currently pending.
2. Action Item #70: Blood lead screening timeline requirements in children
   - Clarification on the DHCS blood lead screening guidelines regarding the catch-up blood lead screening timeline for children, 12 and 24 months, and the catch-up period between 12-24 months and 24-72 months, was submitted to DHCS two weeks ago and a response is currently pending.
3. Action Item #71: Blood lead screening timeline requirements in children
   - Feedback on the DHCS blood lead screening timeline requirements was also requested at the Local Health Plans of California (LHPC) Quality Directors' meeting. Other health plans interpreted the guidelines to mean that lead screenings completed after 12 or 24 months fell into the next compliance bracket (12–24 months and 24–72 months, respectively) and there is no defined grace period for meeting the requirements.
4. Action Item #72: Health Risk Assessments (HRA) Outreach
   - The workflow to send the HRA outreach reports from Carenet to the Compliance department is complete.
5. Action Item #73: Health Risk Assessments by Seniors and Person with Disability (SPD)
   - The Population Health Management Department confirmed that the request for stratification by SPD was for the Care Management Assessments and not the HRA. It was determined that this request was no longer needed.
6. Action Item #74: Colorectal Cancer Screening
   - Utilization of Cologuard screenings by preferred language was shared with the Chief Medical Quality Officer at Ventura County Healthcare Agency.
7. Action Item #75: Contact Center Member Satisfaction
   - The Senior Manager of the Contact Center met with the Chief Medical Officer to review opportunities for soliciting member satisfaction. Key highlights will be reported at the July QIHEC.

8. Action Item #76: Network Operations Access and Availability
   - At the July 2026 QIHEC meeting, the Network Operations department will address identified access and availability issues, including establishing target dates to elevate performance measures above the 80% threshold.

Approval Items - None

Presentations

1. **2025 Quality Improvement and Health Equity Transformation (QIHET) Evaluation**
   Departments were reminded to finalize their sections of the 2025 QIHET Work Plan Evaluation by June 30, 2026. The evaluations will assess outcomes of annual goals, drive strategic improvement, and ensure compliance with DHCS and NCQA regulatory and accreditation standards.

2. **Pharmacy Updates**
   Medi-Cal Rx will require prescribers to be enrolled in Medi-Cal using their Type 1 National Provider Identifier (NPI) for pharmacy claims to be processed and paid. Effective Fall 2026, ICD-10-CM diagnosis codes will become mandatory for all prescriptions and refills. For dual-eligible beneficiaries in skilled nursing facilities, diabetic testing supplies are covered under the Medi-Cal Rx benefit rather than Medicare Part B. Detailed information on these updates are available at the Medi-Cal Rx 24/7 customer service center and on the DHCS Medi-Cal Rx website.

3. **2025 Provider Satisfaction Survey**
   Between November 2025 and January 2026, contracted network providers were surveyed via mail, telephone, and internet for the annual Provider Satisfaction Survey which measured how well Gold Coast Health Plan met its providers' expectations. The results were compared against established industry benchmarks.

   Overall provider satisfaction with Gold Coast Health Plan reached a 60.7% net score, with top performance noted in network/coordination of care (81st percentile) and overall willingness to recommend (65th percentile). Significant improvements were observed in key areas such as reimbursement consistency, claims dispute resolution, and call center service, with no measures decreasing significantly. Strategic opportunities for improvement include enhancing the accuracy and timeliness of claims processing, as well as increasing the efficiency of the Provider Relations department.

   Overall provider satisfaction rebounded by 9% in 2025, recovering much of the 12% drop experienced in 2024, but remaining slightly below the 2023 levels. Provider Network Operations aims to sustain this upward trend by leveraging technical tools like interactive voice response (IVR), and by focusing on targeted outreach, new provider forums, ongoing educational meetings, and actively listening to provider feedback to implement actionable changes that best accommodate both provider and member needs.

4. **Total Care Advantage Dual Eligible Special Needs Plan (D-SNP) Quality Update**
   The 2026 D-SNP Star Measure target-setting process accounted for historical MCAS/HEDIS performance and industry shifts to ensure the goals are both ambitious and attainable. The

strategy includes focus on measures with controllable processes (including Adult Well-Care Exams, Health Risk Assessments, data integration, and pharmacy benefit manager delegation), GCHP's high priority measures, and incentive programs that support improved performance. Successful execution of these targets aims for a Star Rating of 3.16 without weighting, and 3.13 with weighting applied.

Total Care Advantage's early 2026 D-SNP prospective rates reflect the predicted performance expected from a newly implemented product line and volatility is largely driven by data maturity and denominator growth. Planned priorities include improving care for older adult workflows, scheduling annual wellness visits, and conducting monthly data analysis.

The 2026 Total Care Advantage Member Incentive Program rewards members with a choice of a $50 gift card to Target or Walmart for completing key preventive services between January 1 and December 31, 2026. This initiative is designed to encourage the completion of essential health screenings. As of April 30, 2026, 55 gift cards have been rewarded: 37 for annual wellness visits, 7 for breast cancer screenings, and 11 for HbA1c tests.

5. Population Health Management (PHM)

Population Health Management Strategy

In accordance with the National Committee for Quality Assurance (NCQA) Population Health Management (PHM) standards, GCHP conducted an annual Population Needs Assessment (PNA) to identify risks and unmet needs and develop targeted PHM Strategies that undergo continuous evaluation to ensure ongoing quality improvement. Programs included in the PHM Strategy include (1) Keeping members healthy; (2) Patient safety or outcomes across settings; (3) Managing members with emerging risk; and (4) Management of multiple chronic conditions. Following is a summary of findings from the PNA.

- A review of the top ten most prevalent chronic conditions revealed lipid metabolism disorders and uncomplicated hypertension, affecting 18.4% and 15.2% of members, respectively. Mental health and behavioral issues were also highly significant, with anxiety, depression, and major depression all ranking among the top seven conditions. Included in the top ten were metabolic and physical ailments such as obesity, Type 2 diabetes, degenerative joint disease, and asthma.

- A review of the top ten most common primary diagnoses revealed a mix of chronic conditions and routine preventive care. While routine pediatric exams had the highest number of participating members (39,116), opioid dependence generated the most visits by a significant margin, accounting for 182,413 total encounters despite a lower unique member count (1,784). Other prevalent diagnoses driving high visit volumes included essential hypertension (56,561), Type 2 diabetes (55,327), and autism spectrum disorder (42,307).

- As of June 2025, 14,018 members were diagnosed with substance use, with the majority being adults aged 21 to 64. The demographic breakdown revealed a prominent Hispanic or Latino representation alongside significant percentages of English and Spanish

speakers. However, nearly 20% of the data lacked demographic identification, which underscores a gap in reporting across both race and ethnicity metrics.

- Among 93,174 youth and young adults aged 0 - 20, gingivitis was the most prevalent chronic condition, affecting 9.4% of members. Obesity and developmental disorders followed closely, impacting 8.3% and 7.3% of the demographic, respectively. Additional, but slightly less prevalent conditions included anxiety (6.4%), asthma (6.3%), and various spectrum (3.8%) or attention disorders (3.4%).

- Persistent mental illness affected 19.9% (48,533) of the population. The most prevalent conditions among these members were anxiety and neuroses, impacting 63.9% of the group. Depression and major depression followed closely, each affecting approximately 32% of the diagnosed members.

- Among the 3,171 analyzed Black or African American members, essential hypertension was the most frequent primary diagnosis, affecting 8.9% of individuals. Routine child and adult health examinations were the next most common reasons for medical visits, accounting for 8.4% and 5.6% of the population, respectively. Other prevalent diagnoses included Type 2 diabetes and various nonspecific symptoms like chest pain, cough, and shortness of breath.

- Data on HEDIS® measures revealed notable differences across demographic groups., Hispanic/Latino patients exhibited the highest rates in Colorectal Cancer Screening (35.23%) and Well-Child Visits (57.71%). White patients show the strongest performance in Controlling High Blood Pressure (71.21%) and Prenatal Care Timeliness at (94.59%). Conversely, Black or African American patients demonstrate the lowest compliance in Colorectal Cancer Screening (24.93%) and Controlling Blood Pressure (60%) but achieve the highest recorded rate for Postpartum Care at (100.00%).

Wellth Program

The Wellth Utilization Program significantly improved preventative care by boosting primary care visits by 7%-8% above expected levels. Participating members also reduced their inpatient days by nearly 50%, but these reductions began to wane by the third 180-day post-period.

6. Health Disparities Bi-Annual Report

Health Equity Portfolio Overview

GCHP's health equity portfolio is a targeted, data-driven framework of initiatives designed to eliminate disparities in health care access, quality, and outcomes by addressing both clinical needs and social determinants of health. To improve stratified reporting, GCHP is improving the collection of Race, Ethnicity, Language (REaL), Sexual Orientation/Gender Identity (SOGI), and Social Determinants of Health (SDoH) data through standardized call scripts. Maternal health initiatives aim to identify pregnancies early to connect priority populations with maternal care and doula support. To combat vaccine hesitancy, targeted outreach using culturally relevant messaging will be deployed across multiple media channels. Additionally, GCHP will align and advance equity-focused communications across member and provider communication channels.

2026 NCQA Changes to Health Equity Accreditation

The Department of Health Care Services (DHCS) will not require Medi-Cal Managed Care plans to meet accreditation for the revised NCQA Health Outcomes Accreditation standards, after the current 2027-2028 Health Equity Accreditation period ends. This shift stems from NCQA removing the equity-focused standards, rendering the new NCQA framework misaligned with California's specific health equity goals. DHCS will update its contract language and GCHP will continue to build on internal systems and resources to monitor and reduce health disparities.

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Erik Cho, Chief of Staff and Strategy Officer

DATE: September 28, 2026

SUBJECT: Recuperative Care Sustainability Project Amendment

Executive Summary

- With the approval of the Commission, Gold Coast Health Plan (GCHP) and the County of Ventura entered into a funding agreement to create recuperative care facilities at 2323 Knoll Drive, City of Ventura, and 1400 Vanguard Drive, City of Oxnard. on December 5, 2023. For this, GCHP would use funds earned through the Housing and Homelessness Incentive Program (HHIP). Once launched, the recuperative care facilities would be utilized and overseen by the County's Health Care Agency.

- The Parties now desire to amend and restate the terms and conditions of the Funding Agreement.
    - The County proposes to develop a 50-bed Recuperative Care facility at 2323 Knoll Drive ("Knoll Project") which will replace the existing recuperative care center at Motel 6, located at 2145 East Harbor Boulevard in the City of Ventura.
    - Additional funding will go to expanding the City of Thousand Oaks' Thrive Grove Navigation Center to add 20 additional dwelling units to 30 units currently available, for a total of 50 units. The City of Thousand Oaks will ensure that persons being served by the additional beds would be GCHP members.

BACKGROUND/ DISCUSSION:

Project Summary

Through this request, GCHP staff is asking the Ventura County Medi-Cal Managed Care Commission to amend the grant approved in 2023 to update the projects in scope to include the recuperative care facility build in Ventura as well as the Thrive Grove Project expansion in Thousand Oaks. The County agrees that it, through its Health Care Agency, shall begin providing recuperative care services at the Knoll location no later than November 30, 2027, and ensure recuperative care operations for 20 years from commencement. Creating a long-term solution for recuperative care in Ventura County remains a need for GCHP members. The demand for Recuperative Care services has far exceeded the local capacity since the program's inception. The County's current recuperative program is in a temporary location that requires significant monthly funding to continue.

Thrive Grove is an interim supportive housing community offering safety, dignity, and a path forward for individuals experiencing unsheltered homelessness, located in the City of Thousand Oaks. Its navigation center serves as a critical access point and gateway to assist individuals experiencing homelessness. It is the first interim supportive housing solution in East Ventura County and opened in June 2025. There is significant need for the additional units this funding would support.

Recuperative Care Services

Ensuring access to recuperative care, also known as medical respite care, is a priority for GCHP. Recuperative care is a California Advancing and Innovating Medi-Cal ("CalAIM") Community Support that provides short-term residential care for individuals who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. Recuperative care is allowable Community Support if it is necessary to achieve or maintain medical stability and prevent hospital admission or re-admission. Under the recuperative care Community Support, individuals can remain in the recuperative care setting for up to 90 days of continuous duration. GCHP currently offers Recuperative Care as a Community Support to all members who qualify regardless of network assignment or hospital discharge. Members in Recuperative Care are offered connections to Enhanced Care Management and supportive services during their stays.

According to the Hospital Association of Southern California ("HASC"), a hospital can significantly reduce the costs (about $1,200 per day) associated with caring for homeless inpatients by transitioning them to recuperative care.

Summary of Funding Sources

GCHP is utilizing funding earned through the Department of Health Care Services' ("DHCS") Housing and Homelessness Incentive Program for this project. HHIP funding is intended to reduce and prevent homelessness. HHIP funds are necessary to develop and expand capacity and partnerships to connect our members to needed housing services. HHIP funding comes from both State and federal dollars through DHCS.

In September 2022, GCHP submitted its HHIP Investment Plan to DHCS, demonstrating its plan for achieving measures and targets in collaboration with the County and other local partners. In its Investment Plan, GCHP included a recuperative care investment activity that would support the expansion and sustainability of recuperative care beds in the County. DHCS approved GCHP's Investment Plan in early 2023.

FINANCIAL IMPACT:

There is no anticipated additional financial impact based on the changes in this amendment. GCHP has already transferred a total of $10,000,000 to the County, and no further cost would

be incurred. This amendment serves to update the required timelines for recuperative care and add the Thrive Grove Project in place of another proposed recuperative care site.

RECOMMENDATION:

The Plan recommends that the Ventura County Medi-Cal Managed Care Commission authorize the CEO to execute the Amended and Restated Funding Agreement Regarding Recuperative Care Facilities.

ATTACHMENTS:

Amended and Restated Funding Agreement Regarding Recuperative Care Facilities

AMENDED AND RESTATED FUNDING AGREEMENT REGARDING RECUPERATIVE CARE FACILITIES AT 2323 KNOLL DRIVE IN CITY OF VENTURA AND THRIVE GROVE NAVIGATION CENTER AT 1205 LAWRENCE DRIVE IN CITY OF THOUSAND OAKS

This Amended and Restated Funding Agreement Regarding Recuperative Care Facilities ("Amended and Restated Funding Agreement") is entered into as of XXXXXXX, 2026 (the "Effective Date"), by and between the COUNTY OF VENTURA, a political subdivision of the State of California ("County") and Ventura County Medi-Cal Managed Care Commission d/b/a Gold Coast Health Plan ("GCHP") with reference to the following facts. County and GCHP are referred to as "Parties."

RECITALS

A. The Parties entered into their original "Funding Agreement Regarding Recuperative Care Facilities at 2323 Knoll Drive, City of Ventura, and 1400 Vanguard Drive, City of Oxnard" ("Funding Agreement") which took effect on December 5, 2023 ("Funding Agreement Effective Date").

B. The Parties now desire to amend and restate the terms and conditions of the Funding Agreement so that this Amended and Restated Funding Agreement replaces and supersedes the Funding Agreement in its entirety.

C. As of the Effective Date, the County owns real property located at 2323 Knoll Drive in the City of Ventura.

D. The County proposes to develop a 50-bed Recuperative Care facility at 2323 Knoll Drive ("Knoll Project") which will replace the existing recuperative care center at Motel 6, located at 2145 East Harbor Boulevard in the City of Ventura.

E. The City of Thousand Oaks ("City") owns the real property of the Thrive Grove Navigation Center located at 1205 Lawrence Drive in City of Thousand Oaks. This facility is a 30-bed shelter and is currently operational. The City is actively proceeding with expansion of the center to 20 additional beds, for a total of 50 beds ("Thrive Grove Project"). A separate funding agreement between the County and City will ensure the GCHP funds transferred to the City meet the requirements provided herein. The City will ensure that persons being served by the additional beds would be GCHP members.

F. Both the Knoll Project and Thrive Grove Project will support underserved residents of Ventura County, including but not limited to residents that are members of GCHP or are eligible to become members of GCHP.

G. GCHP is a County Organized Health System that operates a Managed Care Plan for providing Medi-Cal services to residents of Ventura County.

H. The California Department of Health Care Service's ("DHCS") Housing and Homelessness Incentive Program ("HHIP") aims to improve health outcomes and access to services by addressing housing insecurity and instability as a social determinant of health for the Medi-Cal population. HHIP funds are utilized to reduce and prevent homelessness and to ensure that Medi-Cal managed care plans like GCHP develop the necessary capacity and partnerships to connect their members to needed housing services.

I. GCHP has established its Investment Plan to implement HHIP priorities including expansion of recuperative care capacity in Ventura County.

J. GCHP has obtained HHIP funding through DHCS's submission of the Home and Community Based Services ("HCBS") Spending Plan to the federal government which resulted in approved and allocated funding to GCHP through the American Rescue Plan Act ("ARPA").

K. GCHP has previously provided a $10,000,000 contribution to County to support the Vanguard and Knoll recuperative care projects.

L. With the County's cancellation of its Vanguard project, the parties have determined that the $10,000,000 contribution should instead be directed to the Knoll Project and Thrive Grove Project as follows:

- $9,100,000 to the Knoll Project
- $900,000 to the Thrive Grove Project

M. In addition to the $10,000,000 GCHP payment, the County has identified full funding to plan, design, and construct the Knoll Project. The City is actively identifying funding in addition to the contribution by GCHP to proceed with the Thrive Grove Project, which has a total current budget of approximately $2,500,000.

NOW, THEREFORE, in consideration of the Recitals hereof and the mutual promises and covenants set forth in this Amended and Restated Funding Agreement, the Parties agree as follows:

AGREEMENT

Section 1. Transfer of Funds. GCHP previously provided the County with two one-time payments: (1) $7,500,000 was provided sixty (60) calendar days after the original Funding Agreement took effect and (2) $2,500,000 was provided sixty (60) calendar days after GCHP received the second disbursement of HHIP funds. County deposited the funds in a segregated account and shall solely use the funds for the planning, design, and construction costs of the Knoll Project and Thrive Grove Projects allocating the funds as follows: $9,100,000 to the Knoll Project, and $900,000 to the Thrive Grove Project.

Section 2. Drawdowns. County may draw upon the funds at any time for any purpose allowed by this Amended and Restated Funding Agreement. County shall only use the funds for payment of costs of the Knoll Project and Thrive Grove Project and shall not reallocate the funds to any other accounts or any other uses. The funding shall not be used to pay County's or City's administrative costs or for costs of County or City employees. The County shall not remit any portion of the $900,000 Thrive Grove Project contribution to the City until after the County enters into an agreement with the City which meets and incorporates the requirements set forth herein pertaining to the Thrive Grove Project.

Section 3. Financial Records and Updates. County and City, as applicable, shall maintain records of all expenditures for the Knoll Project and Thrive Grove Project, respectively, which records shall be sufficient for auditing purposes and shall include invoices for all goods and services paid for with the funds. County shall submit a quarterly statement to GCHP indicating the status of the account and all expenditures of funds by County and City for their respective projects. By mutual written agreement, the Parties may agree to have statements at less-regular intervals. County shall maintain all records for at least four (4) years following the final expenditure.

Section 4. Progress Reports. County shall submit quarterly progress reports to GCHP that describe the planning, design, and construction activities associated with the development of the Knoll Project and Thrive Grove Project. By mutual written agreement, the Parties may agree to have progress reports at less-regular intervals.

Section 5. Compliance. County acknowledges that GCHP's funds come from ARPA through DHCS and the HCBS and that GCHP may have other regulatory requirements as a result of its role as a Medi-Cal managed care plan. County agrees to cooperate with GCHP in providing any information required by any federal or State regulatory agencies or to fulfill the requirements of ARPA. GCHP agrees to, upon request, provide County with information related to funding source or regulatory compliance. Additionally, the Parties agree that the intent of the Parties is to utilize the funding in accordance with all applicable funding and regulatory requirements.

Section 6. Thrive Grove Project Expenditures. All funds shall be expended for the Thrive Grove Project no later than December 31, 2030. For purposes of this section "expend" shall mean that the funds are committed for project use. If Thrive Grove Project funds are not expended by this deadline, then the County and GCHP shall confer and attempt to identify and agree upon alternate projects in Ventura County to which to reallocate any unexpended Thrive Grove Project funds under this Amended and Restated Funding Agreement.

Section 7. Knoll Project Expenditures. All funds shall be expended for the Knoll Project no later than December 31, 2030. For purposes of this section "expend" shall mean that the funds are committed for use. All funds not expended by this deadline shall be returned to GCHP.

Section 8. Timely Completion.

a. County shall begin providing recuperative care services at the Knoll Project no later than November 30, 2027. In the event that construction delays or other unforeseen circumstances prevent timely completion and operation, County may request that GCHP approve an extension of the completion time, which approval GCHP shall not unreasonably withhold. For purposes of this Section, GCHP shall approve an extension if County intends to complete the Knoll Project in good faith and is continuing to proceed in good faith toward completion.

b. City shall open the additional 20 beds at the Thrive Grove Project no later than December 31, 2030. In the event that construction delays or other unforeseen circumstances prevent timely completion and operation, County may request that GCHP approve an extension of the completion time, which approval GCHP shall not unreasonably withhold. For purposes of this Section, GCHP shall approve an extension if City intends to complete the Thrive Grove Project in good faith and is continuing to proceed in good faith toward completion.

Section 9. Abandonment of Project.

a. If the County Board of Supervisors does not approve the Knoll Project following completion of environmental review, or if the Knoll Project is not approved or otherwise developed to completion, then the County and GCHP shall confer and attempt to identify and agree upon alternate County projects to develop facilities providing the total of 50 recuperative care beds in Ventura County under this Amended and Restated Funding Agreement. Upon completion of the Knoll Project, and/or other alternative project(s) agreed upon by County and GCHP (which Knoll Project and potential alternative projects are referred to hereinafter as “Facility” and/or “Facilities” under this Amended and Restated Funding Agreement), and further provided that Facilities have been constructed providing the total of 50 recuperative care beds in Ventura County (exclusive of the Thrive Grove Project or City alternative projects) under this Amended and Restated Funding Agreement, the County shall continue to maintain any remaining unused portion of the $9,100,000 Knoll Project portion of the GCHP payment in a segregated account and solely use the funds on furnishings or equipment, repair and maintenance, and/or operational needs of the Facilities until the GCHP payment is expended in full, or until the expenditure deadline set forth in Section 7 above, whichever occurs first. County shall maintain records documenting expenditure of the GCHP payment which shall be provided to GCHP upon request.

b. If the Thousand Oaks City Council does not approve the Thrive Grove Project following completion of environmental review, or if the Project is not approved or otherwise developed to completion, then the County and GCHP shall confer and attempt to identify and agree upon alternate projects in Ventura County under this

Amended and Restated Funding Agreement. Upon completion of the Thrive Grove Project, and/or other alternative project(s) agreed upon by County and GCHP, and further provided that such projects have been constructed providing the total of 20 beds in Ventura County (exclusive of the Knoll Project or alternative Facilities) under this Amended and Restated Funding Agreement, the County shall continue to maintain any remaining unused portion of the $900,000 Thrive Grove Portion of the GCHP payment in a segregated account and solely use the funds on furnishings or equipment, repair and maintenance, and/or operational needs of Thrive Grove or alternative projects until the GCHP payment is expended in full, or until the expenditure deadline set forth in Section 6 above, whichever occurs first. County shall maintain records documenting expenditure of the GCHP payment which shall be provided to GCHP upon request.

Section 10. Reduction of Beds.

a. GCHP is providing the $9,100,000 payment to the County for the purpose of funding the development of Knoll Project or alternate Facilities to provide a total 50 recuperative care beds in Ventura County, which equals funding of $182,000 per bed. In the event that County modifies the Knoll Project, or is otherwise unable to expend the payment to develop a total of 50 recuperative care beds by the deadline set forth in Section 7 above, including at alternative Facilities agreed upon by the Parties pursuant to Section 9(a) above, County shall return to GCHP a proportional share of the funds calculated at $182,000 for each bed fewer than 50 total beds at all Facilities that are developed.

b. GCHP is providing the $900,000 payment to the County for the benefit of the City to fund the development of Thrive Grove Project or alternative projects to provide a total of 20 transitional housing beds in Ventura County, which equals funding of $45,000 per bed. In the event that the City modifies the Thrive Grove Project, or is otherwise unable to expend the payment to develop a total of 20 beds by the deadline set forth in Section 6 above, including alternative projects agreed upon by the Parties pursuant to Section 9(b) above, County shall return to GCHP a proportional share of the funds calculated at $45,000 for each bed fewer than 20 total beds at all projects that are developed.

Section 11. Access to Recuperative Care. County acknowledges that GCHP is entering into this Amended and Restated Funding Agreement for the purpose of increasing access to recuperative care and transitional housing services for GCHP Members and residents who are eligible to become GCHP Members. As such, County shall ensure that GCHP Members and uninsured individuals that are eligible for GCHP Membership are not denied access to services at the Thrive Grove Project or Knoll Project or are not given lower priority of access than other individuals. To the extent that the services at the Thrive Grove Project or Knoll Project are operated under contract, County and City, as applicable, shall pass through this requirement to the contract service provider.

Section 12. GCHP Access to Facility. [RESERVE]

Section 13. Change of Use of Knoll Project.

a. By accepting funding from GCHP for the Knoll Project, County commits to ensure operation of the Knoll Project or alternate Facilities selected pursuant to Section 9(a) above as providing at least 50 total recuperative care beds, or a mutually beneficial alternative use as may be agreed upon by the Parties, for 20 years from the commencement of recuperative care operations at each respective Facility. If County conveys or converts the Knoll Project or alternate Facilities to another use prior to the end of this 20-year period thereby reducing the total number of recuperative care beds at all such Facilities to less than 50, the Parties shall negotiate and attempt to reach agreement on a mutually beneficial change of use. In the event the Parties do not reach agreement on a mutually beneficial change of use, County shall return to GHCP a proportional amount of the funds as described in subsection (b) below. For purposes of this Section, "convey" means that either (1) County sells a Facility for value without restricting future use of the Facility, or (2) County enters into a lease of a Facility that does not restrict the use to a recuperative care facility. In the event that County sells or leases a Facility with the intent that it remain a recuperative care facility, or other agreed-upon mutually beneficial use, County shall record a regulatory agreement or other deed restriction and/or security interest that shall be enforceable by GCHP.

b. If County owes a payment to GCHP under this Section, the payment shall be calculated as follows: (1) the percentage of time that County did not meet its 20-year commitment for each bed fewer than 50 total beds at all Facilities (rounded to the next month) and; (2) multiplying that percentage by an initial amount $182,000 per deficient bed as reduced for depreciation purposes by five (5) percent per year or fraction thereof. For example, if County conveys a Facility at the end of year 10 resulting in the loss of 50 beds, and the Facility would not be used for an alternative mutually beneficial use as agreed upon by the Parties at that time, County would owe GCHP $2,275,000 calculated as follows: 50% [percentage reduction from 20-year commitment] x ($91,000 [depreciated value per bed] x 50 deficient beds). Such payment shall be made to GCHP within sixty (60) calendar days after GCHP's notice of demand for repayment.

Section 14. Change of Use of Thrive Grove Project.

a. By accepting funding from GCHP, County commits to ensure operation of the Thrive Grove Project or alternate project selected pursuant to Section 9(b) above as providing at least 20 additional beds of transitional housing, or a mutually beneficial alternative use as may be agreed upon by the Parties, for 10 years from the commencement of operations. If the City conveys or converts the Thrive Grove Project or alternate project to another use prior to the end of this 10-year period thereby reducing the total number of expanded beds at all such projects to less than 20, the Parties shall negotiate and attempt to reach agreement on a mutually beneficial change of use. In the event the Parties do not reach agreement on a

mutually beneficial change of use, County shall return to GHCP a proportional amount of the funds as described in subsection (b) below. For purposes of this Section, "convey" means that either (1) City sells a project property for value without restricting future use, or (2) City enters into a lease of a a project property that does not restrict the use to a transitional housing facility. In the event that City sells or leases a project property with the intent that it remain a transitional housing facility, or other agreed-upon mutually beneficial use, the County will require the City to record a regulatory agreement or other deed restriction and/or security interest that shall be enforceable by GCHP.

b. If County owes a payment to GCHP under this Section, the payment shall be calculated as follows: (1) the percentage of time that County/City did not meet its 10-year commitment for each bed fewer than 20 total beds at the Thrive Grove Project or alternate project selected pursuant to Section 9(b) (rounded to the next month) and; (2) multiplying that percentage by an initial amount $45,000 per deficient bed as reduced for depreciation purposes by ten (10) percent per year or fraction thereof. For example, if the City conveys a project property at the end of year 5 resulting in the loss of 20 beds, and the property would not be used for an alternative mutually beneficial use as agreed upon by the Parties at that time, County would owe GCHP $225,000 calculated as follows: 50% [percentage reduction from 10-year commitment] x ($22,500 [depreciated value per bed] x 20 deficient beds). Such payment shall be made to GCHP within sixty (60) calendar days after GCHP's notice of demand for repayment.

Section 15. Relationship of Parties. Nothing in this Amended and Restated Funding Agreement shall be interpreted or understood by either of the Parties, or by any third persons, as creating the relationship of employer and employee, principal and agent, limited or general partnership, or joint venture between the County and GCHP or GCHP's agents, employees, or contractors regarding the subject matter hereof. The County shall be solely responsible for its own acts and those of its agents and employees regarding the development, construction, and operation of the Knoll Project, Thrive Grove Project, or alternate Facilities or projects referred to herein.

Section 16. Defense and Indemnification. The County agrees to indemnify, protect, hold harmless, and defend (by counsel satisfactory to GCHP) GCHP and its agents from and against any and all third-party suits, actions, claims, causes of action, costs, demands, judgments, and liens arising out of or related to this Amended and Restated Funding Agreement including the development, construction, and operation of the Knoll Project, Thrive Grove Project, or alternate Facilities or projects referred to herein, except to the extent caused by GCHP's sole active negligence or willful misconduct.

Section 17. Prevailing Wages. The County agrees and acknowledges that funding from GCHP constitutes public funds and all construction, alteration, demolition, installation, repair, or maintenance work performed as part of the project will be subject to the payment of prevailing wages in accordance with Labor Code section 1720 et seq.,

1770 et seq., and implementing regulations (the "Prevailing Wage Laws"). In contracting for any public work related to the project that is the subject of this Amended and Restated Funding Agreement, County shall ensure that the contracts, and all subcontracts, include express language requiring compliance with the Prevailing Wage Laws. GCHP shall not be considered an "awarding body" or a "hiring party" for purposes of the Prevailing Wage Laws or in any filings with the Department of Industrial Relations related to the Prevailing Wage Laws.

Section 18. Payment Bond. County shall ensure that all contractors and subcontractors deliver a payment bond where required by law, in accordance with Civil Code sections 9550 *et seq.* and Labor Code section 1771. In addition to its other defense and indemnification obligations under this Amended and Restated Funding Agreement, County shall further defend and indemnify GCHP for any costs related to any stop payment notice issued to GCHP by any contractor, subcontractor, supplier, or other person or entity working on the Project.

Section 19. Notices. Formal notices between the County and GCHP shall be sufficiently given if and shall not be deemed given unless dispatched by registered or certified mail, postage prepaid, return receipt requested, or delivered by express delivery service, return receipt requested, or delivered personally, to the principal office of the County and GCHP as follows:

County of Ventura:	Gold Coast Health Plan:
County of Ventura	Ventura County Medi-Cal Managed Care Commission
County Executive Office	DBA: Gold Coast Health Plan
Attn: Dr. Sevet Johnson	Attn: Felix L. Nuñez, MD, MPH
800 S. Victoria Ave., L1940	711 E Daily Dr # 106
Ventura, CA 93009	Camarillo, CA 93010
(805) 654-3656 (TEL)	

Such written notices, demands, and communications may be sent in the same manner to such other addresses as the affected party may from time to time designate by mail as provided in this Section. Receipt shall be deemed to have occurred on the date shown on a written receipt for delivery or refusal of delivery.

Section 20. Specific Performance. The Parties acknowledge that money damages and remedies at law generally are inadequate and specific performance and other non-monetary relief are particularly appropriate remedies for the enforcement of this Amended and Restated Funding Agreement and should be available to both Parties.

Section 21. Audit. GCHP may, at its own cost and expense, perform an audit of the funds and expenditures at any time that County holds the funds until four years following the final expenditure. County shall cooperate with any audit and shall allow access during normal business hours and with reasonable advance notice to all relevant records for the purpose of completing any audit.

Section 22. No Third-Party Beneficiaries. This Amended and Restated Funding Agreement is intended for the benefit of the Parties hereto and their successors, and not for the benefit of, nor may any provision hereof be enforced by, any other person including but not limited to the City.

Section 23. Publicity.

a. In all written materials for public distribution prepared in association with construction of facilities funding through this Amended and Restated Funding Agreement, County and City, as applicable, shall include the following statement: "This project is funded in part by Gold Coast Health Plan and will benefit low-income and uninsured residents of Ventura County."

b. County and City, as applicable, shall name GCHP as founding donor in all communications relating to any project funded through this Amended and Restated Funding Agreement.

c. Permanent signage recognizing GCHP will be posted in a conspicuous location at or near the entrance of any facilities funded through this Amended and Restated Funding Agreement; this signage will recognize GCHP as a founding donor or language to that effect.

d. In using any GCHP trademarks or logos, County and City, as applicable, shall comply with GCHP's branding policies. If mutually agreed, GCHP and County will prepare and issue joint press releases that recognize GCHP's contribution and its importance to addressing community needs.

e. GCHP may include information regarding this Amended and Restated Funding Agreement on GCHP's external website.

f. County and direct project partners, if any, will include information (in a form approved by GCHP) regarding this Amended and Restated Funding Agreement on their external websites and on any associated or affiliated websites, and include a link to GCHP's website.

Section 24. Termination with Cause.

a. At GCHP's sole discretion, GCHP may terminate this Amended and Restated Funding Agreement for cause if it demonstrates that: (a) funds were used for any purpose other than those specified under this Amended and Restated Funding Agreement; (b) County is unable to carry out the purposes of this Amended and Restated Funding Agreement; or (c) County fails to comply with a material obligation of this Amended and Restated Funding Agreement, including but not limited to providing GCHP with timely and accurate expenditure reporting pursuant to Section 3 above.

b. Prior to terminating this Amended and Restated Funding Agreement for cause GCHP shall: (1) first meet and confer with County regarding the noncompliance in a good faith attempt to resolve the issue; (2) next provide County with written notice, pursuant to Section 19, specifying the noncompliance and providing County with at least sixty (60) calendar days to cure; and (3) if the County fails to cure within the specified period, which may be extended by GCHP at its sole discretion, GCHP must then provide County with a written notice of termination for cause pursuant to Section 19.

c. If the Amended and Restated Funding Agreement is terminated for cause County shall, within sixty (60) calendar days of receipt of the notice of termination: (1) reimburse GCHP any unexpended funds if the termination occurs prior to the expenditure deadline set forth in Section 6 and/or 7; and/or (2) repay any funds that GCHP has demonstrated were not used by County for purposes authorized in this Amended and Restated Funding Agreement

Section 25. Amendments. No amendment, alteration or variation of the terms or conditions of this Amended and Restated Funding Agreement shall be valid unless agreed to in writing by the Parties.

Section 26. Entire Understanding of the Parties. This Amended and Restated Funding Agreement constitutes the entire understanding and agreement of the Parties with respect to all matters stated herein, and supersedes and replaces in its entirety the original Funding Agreement between the Parties.

Section 27. Multiple Originals; Counterpart. This Amended and Restated Funding Agreement may be executed in multiple originals, each of which is deemed to be an original, and may be signed in counterparts, including with electronic signatures.

WHEREFORE, this Amended and Restated Funding Agreement has been entered into by the undersigned as of the Effective Date.

County of Ventura	Gold Coast Health Plan
_____	_____
Authorized Signature	Authorized Signature
_____	_____
Printed Name	Printed Name
_____	_____
Title	Title
_____	_____
Date	Date

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Chief Diversity Officer

DATE: September 28, 2026

SUBJECT: Chief Diversity Officer (CDO) Report

PowerPoint with Verbal Presentation

ATTACHMENTS:

Chief Diversity Report

Chief Diversity Officer Report

Ted Bagley, Chief Diversity Officer
September 28, 2026

GOLD COAST HEALTH PLAN TOTAL Care ADVANTAGE℠

Gold Coast Health Plan℠ A Public Entity

Return to Agenda

GCHP Historical

- Ordinance created by the Board of Supervisors Ventura County to address the diversity issues that were present within GCHP 2016-2017.

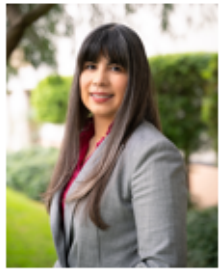
- TBJ Consulting was contracted to stabilize the environment and decrease the number of cases going externally.

- Community interview team developed to hire a CDO to address sensitive issues and establish a foundation for Diversity at GCHP.

- Establishment of a Diversity Council to address issues on a continual basis.

DEI Council Members

Ted Bagley
Chief Diversity Officer



Marlen Torres
Chief Member Experience &
External Affairs Officer

Shannon Robledo
Director, Finance

Rebecca Mastrangelo
RN, Utilization Management III

Pshyra Jones
Executive Director,
Health Equity

Annelie Ginn
Manager, Clinical Care
Management

Chris Martinez
Manager, Contact Center

Kris Schmidt
Senior Manager, Finance

Percy Mayfield
Compliance Analyst II

Edgar Santos
RN, Clinical Care Manager I

TJ Piwowarski
Project Manager I

Chris Beeson
Workforce Strategy & Talent
Acquisition Lead

GOLD COAST HEALTH PLAN TOTAL Care ADVANTAGE℠

Gold Coast Health Plan℠ A Public Entity

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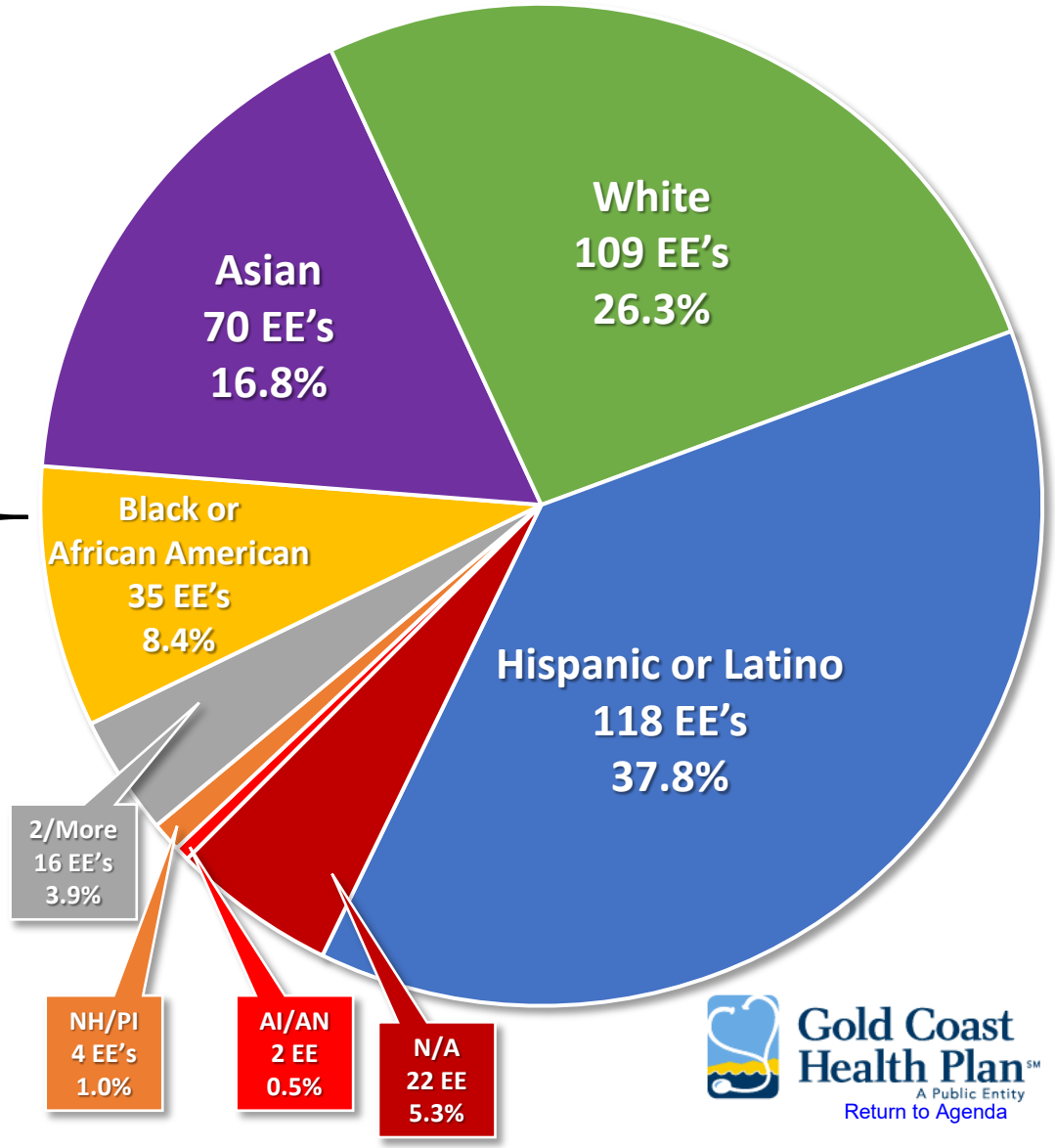
GCHP Diversity Breakdown as of 7/01/26

- 415 Employees

Race/Ethnicity	Female	Male	Total	
Hispanic or Latino	118	39	157	37.8%
White	62	47	109	26.3%
Asian	43	27	70	16.8%
Black or African American	25	10	35	8.4%
I do not wish to answer.	19	3	22	5.3%
Two or more races (Not Hispanic or Latino)	13	3	16	3.9%
Native Hawaiian or Other Pacific Islander	2	2	4	1.0%
American Indian or Alaska Native	2	0	2	0.5%
Grand Total	284 (68%)	131 (32%)	415	

*Chief Diversity Officer included in FTE counts



Gold Coast Health Plan℠
A Public Entity

Return to Agenda

Ventura County Demographics

In Ventura County, these are the data points that we compare our internal numbers with:

	Ventura County	GCHP
Hispanics	45.3 - 45.6	37.8
Whites	40.6 - 41.7	26.3
Asians	8.6 - 9.1	16.8
Blacks	1.6 - 2.6	8.4

GCHP Activities

- Working with HR to monitor equity in hiring, promotions, discipline, terminations, and pay. (**Paul Agular**)
- Coordinating with Community Relations activities when possible. (**Marlen Torres)**
- Adopt-A-School process.(**Diversity Council**)
- Lunch-N-Learn educational tool. (**Diversity Council**)
- Coaching and Counselling as needed across the organization.
- Created communication tool, “TED Talk”, to address current events potentially affecting the GCHP population at the Federal, State and Local levels.

GOLD COAST HEALTH PLAN TOTAL Care ADVANTAGE℠

Gold Coast Health Plan℠ A Public Entity

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Summary

Many organizations have chosen a path of least resistance from the Federal Government and have eliminated their Diversity Position. GCHP have chosen to continue our efforts to its benefit.

Benefit

1. Equity impact assessments before major decisions.
2. DEI-focused environment scans to identify disparities and measure outcomes.
3. Partner with Health Equity and the organization to ensure that training and services are culturally relevant and accessible.
4. Support public-sector funding of worthy organizations.

GCHP remains deeply embedded in the Ventura Community and seeks to minimize leadership distractions that can be a major obstacle to operation's efficiency.

AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Felix L. Nunez, MD, Chief Executive Officer

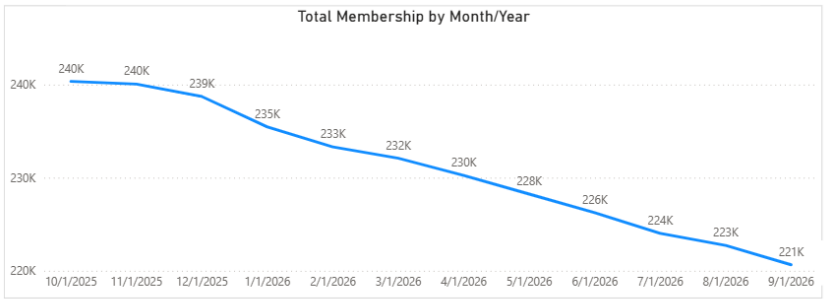
DATE: September 28, 2026

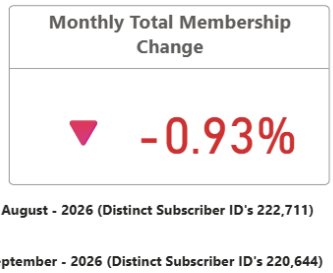
SUBJECT: Chief Executive Officer (CEO) Report

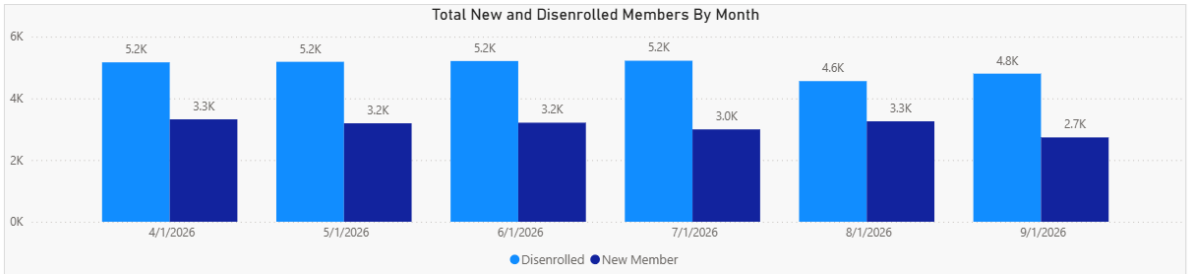
Chief Executive Officer (CEO) Update

Membership update

As we approach the end of the third quarter, membership remains a key area of focus as Gold Coast Health Plan (GCHP) continues to navigate a dynamic and challenging policy and enrollment environment. While the plan experienced a 0.9% decrease in membership since last month, we are closely monitoring the factors contributing to enrollment shifts and continuing to assess and strengthen strategies that support retention, targeted outreach, and continuity of care for eligible members.







Preparation for the transition of members with state-only Medi-Cal (UIS) to fee-for-service remains a priority. This work includes continued readiness planning, close monitoring of state guidance, and engagement with providers to better understand anticipated network capacity limitations and fee-for-service Medi-Cal participation. These efforts are intended to help support a safe and coordinated transition for members, with particular attention to those with high-risk or

complex care needs. We encourage our UIS members to remain enrolled and continue to utilize services, including preventive primary care, through the end of their GCHP enrollment.

As we approach the close of 2026, member retention, the anticipated impacts of H.R. 1, and the transition of state-only Medi-Cal members to fee-for-service will remain central to our operational planning and external engagement. We will continue to prioritize clear communication, cross-functional coordination, and timely support for members and providers as these changes move forward. We have worked closely with our state advocacy organization, Local Health Plans of California (LHPC), to remain abreast of statewide approaches and strategies intended to support ongoing Medi-Cal enrollment in the face of H.R. 1 barriers. Our Ventura County Health Care Access Coalition continues to develop local coordinated strategies to address the devastating effects of H.R. 1 on continuous Medi-Cal enrollment for eligible populations.

Speaking opportunities, board meetings, and conferences

I had the opportunity to speak at the Ventura County Board of Supervisors meeting on Aug. 18, 2026, about the future healthcare model for the Santa Clara River Valley. I emphasized the importance of supporting meaningful access to care for residents of that region and reinforced GCHP's role as a local partner committed to strengthening the county's healthcare safety net.

On Aug. 26, 2026, I participated in the Local Health Plans of California (LHPC) Board strategy meeting in Sacramento. The discussion focused on the need for local health plans to be more intentional and assertive in communicating their value in an increasingly complex, competitive, and policy-driven environment. It is my assertion that as community-based managed care organizations, local health plans bring a distinct model of care that is rooted in transparency, stewardship, local accountability, public purpose, and deep connection to the communities they serve.

A key takeaway from the meeting was the importance of building stronger relationships with policymakers, legislative leaders, and other decision-makers who shape the healthcare landscape. We must continue making the case for why local health plans matter, what differentiates us from other models, and how we deliver value to members, providers, and the broader safety net. It is critical that we distinguish ourselves from other Medi-Cal managed care organizations that face pressures to address shareholder equity in the face of the consequential changes facing the Medi-Cal business environment. This work requires consistent engagement, clear messaging, and a willingness to tell our story with greater clarity and purpose.

To that end, we continue to raise awareness of the impact of H.R. 1 and GCHP's role in helping members maintain their coverage and access to care. Recent speaking opportunities included a healthcare luncheon hosted by the West Ventura County Business Alliance on Sept. 2, 2026, where I spoke alongside Commissioner Doug Kleam and Dr. Gagan Pawar, CEO of Clinicas del Camino Real. On Sept. 17, 2026, I also participated in a healthcare panel co-hosted by the Ventura County Medical Association and the Moorpark Chamber of Commerce. The Ventura County Star covered the event in an article titled 'Rethink everything:' Local health leaders take pulse of challenges.

These forums provide important opportunities to explain who we are, elevate the distinct value of a community-based managed care organization, and strengthen relationships with business, healthcare, and civic leaders across Ventura County. They also allow us to reinforce GCHP's commitment to clear communication and partnership during a period of significant policy and operational change.

This broader strategy will also inform our participation in upcoming industry convenings, including the Association for Community Affiliated Plans (ACAP) conference from Sept. 29 through Oct. 3 in Washington, D.C., and the California Association of Health Plans (CAHP) conference from Oct. 19-21 in Palm Desert. These gatherings will provide opportunities to engage with peer plans, state and national policy leaders, and partners focused on the future of Medicaid, local health plans, and safety net healthcare. They will also help ensure that GCHP remains connected to statewide and national conversations that may shape policy, funding, and care delivery in the months ahead.

Relocation

On Sept. 1, 2026, we moved to our new building at 4880 Santa Rosa Road in Camarillo. This move represents an important organizational milestone for GCHP and provides a workspace designed to support greater in-person collaboration, planning, and connection among teams. In the weeks since our move, we have already held several strategic planning sessions at the new location, reinforcing the value of a shared environment that supports coordination across departments.

Employee appreciation event

Our employee appreciation event is scheduled for Sept. 23, 2026, and will serve as a meaningful opportunity to recognize staff contributions and celebrate the team spirit that continues to define GCHP's culture. As the organization manages significant operational, policy, and community priorities, taking time to acknowledge employees reinforces the importance of connection, morale, and shared purpose. This recognition is especially important as staff continue to support members, providers, and one another through a period of meaningful change.

I. External Affairs

Overview: This report provides a month-end update on three related policy areas affecting Gold Coast Health Plan (GCHP):

A. The enacted fiscal year 2026-27 State Budget
B. Implementation of the transition of members with unsatisfactory immigration status (UIS) from managed care to Medi-Cal fee-for-service (FFS)
C. Final activity from the 2025-26 Legislative Session

State budget update:

The fiscal year 2026-27 California Budget Act preserves Medi-Cal as a statewide priority while emphasizing implementation, program sustainability, and administrative efficiency. For GCHP, the most significant impact remains the implementation of federal H.R. 1 requirements, the Jan. 1, 2027 UIS transition to Medi-Cal fee-for-service, and continued uncertainty surrounding Medi-Cal financing.

Priority area	Budget direction	GCHP impact and focus
UIS and H.R. 1	Implements federal eligibility changes and the Jan. 1, 2027 transition of affected UIS members from managed care to FFS.	Member identification and outreach, county and provider coordination, continuity of care, enrollment changes, and capitation impacts.
MCO Tax and financing	Continued reliance on the Managed Care Organization Tax, subject to federal approval and future state implementation decisions.	Monitor plan liability, rate development, capitation effects, and subsequent state or federal financing actions.
Enhanced Care Management (ECM) Community Supports and Utilization Management	Maintains CalAIM programs while implementing refinements, savings, and utilization-management changes.	Assess the state Department of Health Care Services (DHCS) guidance for changes to eligibility, authorization, provider requirements, reporting, and member access.
Quality incentives and provider investments	Eliminates the quality incentive component beginning in 2027 while continuing selected investments in providers and health systems.	Assess fiscal and quality-strategy effects and monitor whether investments support local network capacity and stability.

Overall assessment: The budget's effect on GCHP is cumulative rather than tied to one new program. Near-term priorities remain implementation readiness, continuity of care, financial-impact assessment, member and provider communications, and early identification of unintended consequences.

A. UIS Transition Policy Guide Version 2.0

DHCS released Version 2.0 of the UIS Transition Policy Guide in September 2026. The update materially expands the transition from a data-and-communications effort into a cross-functional implementation affecting eligibility logic, care management, utilization management, California

Children's Services (CCS), provider engagement, member communications, analytics, and compliance. The transition remains effective Jan. 1, 2027.

- Population rules and exclusions: Version 2.0 clarifies the treatment of Qualified Non-Citizen populations following H.R. 1.
- Expanded continuity responsibilities: The guide places greater emphasis on active care-management support, provider continuity, and member navigation through Dec. 31, 2026, including assistance locating FFS providers when continuity cannot be maintained.
- Broader affected services: Transition planning now explicitly includes Enhanced Care Management, Complex Integrated Care Management, Complex Care Management, Transitional Care Services, Community Supports, and Community Health Worker (CHW) services.
- High-risk member framework: DHCS replaces the prior special-population approach with a high-risk framework and revises the criteria to include ECM members, members receiving chemotherapy or radiation, and members with seizure or neurological disorders. Final DHCS identification and reporting specifications remain forthcoming.
- Authorization and provider readiness: A Treatment Authorization Request (TAR) Special Handling Process becomes available Oct. 1, 2026. Provider communications must be tailored for primary care, care-management providers, Community Supports, CHWs, long-term care facilities, and CCS providers.
- Data and CCS workstreams: Version 2.0 establishes fixed and recurring data requirements, one-time member-identification and utilization files due Dec. 7, and additional CCS transition planning and reporting requirements.

Key Transition Milestones

Date	Milestone	Status and significance
Oct. 1 2026	TAR Special Handling Process available; CCS member list expected from DHCS.	Provider FAQs and additional CCS guidance remain pending.
Oct. 15 2026	Program-level CCS transition plan due to DHCS.	Confirm the CCS and Whole Child Model (WCM) requirements applicable to GCHP.
Nov. 1 2026	Member-level CCS Transition of Care Plans due if applicable.	May require case-level review and direct county coordination.
Dec. 1 2026	CCS record-transfer attestation due if applicable.	DHCS attestation template remains forthcoming.

Date	Milestone	Status and significance
Dec. 7 2026	One-time transitioning-member identification and utilization files due.	Final template and unresolved data specifications require continued monitoring.
Jan. 1 2027	Affected UIS members transition from managed care to Medi-Cal FFS.	Member, provider, care, operational, and financial readiness must converge before go-live.

Monitoring Focus: External Affairs will continue to monitor unresolved DHCS items, including high-risk member methodology and disposition reporting, transportation-file specifications, the transitioning-member template, CCS and WCM guidance, replacement FFS care management options, standardized provider messaging, and the pre- and post-transition escalation process.

B. Legislative Session

The Legislature completed its 2025-26 session work and entered final recess. As of Sept. 18, two priority Medi-Cal measures have been chaptered and three additional measures affecting health-plan operations remain pending with the Governor. The Government Relations Team will monitor final action by the Governor and subsequent DHCS implementation guidance.

Bill	Status	Summary	GCHP impact
AB 1126 Patterson	**Chaptered** Sept. 15, 2026 Chapter 193	Aligns billing requirements for noncontracted fee-for-service providers when Medi-Cal is the payer of last resort and limits when letters of agreement may be required.	Review other-health-coverage coordination, noncontracted-provider billing, claims configuration, prior authorization, continuity-of-care processes, provider education, and member materials.
AB 2161 Bonta	**Chaptered** Sept. 15, 2026 Chapter 209	Refines state implementation of federal work and community-engagement requirements, including exemptions, verification, notices, and continued coverage during review.	Coordinate with Ventura County, prepare for possible plan data requests, align outreach and Member Services readiness, and monitor coverage loss and churn.
AB 173 Health Trailer Bill	**Awaiting Governor action** Presented Sept. 8, 2026	Implements health budget changes affecting qualified non-citizen and UIS coverage, restricted-scope dialysis, adult dental benefits, provider oversight, assisted living, behavioral health crisis funding, California's 988 system, and CBAS reporting.	**High impact.** Confirms qualified non-citizens will retain full-scope Medi-Cal through June 30, 2027, while transitioning from managed care to FFS beginning Jan. 1, 2027. GCHP should prepare for member identification and notices, continuity-of-care planning, dialysis and transportation coordination, and future dental-benefit communications. Monitor additional DHCS guidance.

Bill	Status	Summary	GCHP impact
AB 2756 Ahrens	**Awaiting Governor action** Presented Aug. 28, 2026	Requires DHCS to establish Medi-Cal vision quality and access measures, publish performance data, and report complaints and grievances using existing data.	Monitor vision-service measures, data readiness, access and utilization trends, delegated vision-plan oversight, and potential quality expectations.
SB 874 Weber Pierson	**Awaiting Governor action** Presented Aug. 27, 2026	Requires DHCS to obtain stakeholder feedback regarding Medi-Cal behavioral health treatment policy and implementation.	May create additional opportunities for plan and provider input and affect behavioral health policy, provider requirements, or implementation guidance.
AB 2348 Bonta	**Awaiting Governor action** Presented Aug. 31, 2026	Recasts the Enhanced Care Management definition and requires additional DHCS guidance, stakeholder engagement, plan policy adoption, provider education, and public utilization reporting.	Potentially significant Enhanced Care Management and Community Supports policy, provider training, reporting, oversight, and implementation impacts.
SB 1202 Weber Pierson	**Did not advance** Held Aug. 13, 2026	Would have required a Medi-Cal dashboard and additional outreach and data-sharing activities related to eligibility changes.	No immediate requirement. The proposal may inform future transparency, outreach, and eligibility-data legislation.
AB 2431 Patel	**Did not advance** Held May 14, 2026	Would have established requirements related to downcoding medical claims.	No immediate operational change. Similar future proposals could affect claims review and physician-oversight workflows.

Next Steps

- Monitor action by the Governor on AB 173, AB 2756, SB 874, and AB 2348, and update leadership after final outcomes are known.
- Track DHCS all-plan letters, county guidance, provider bulletins, and implementation timelines for chaptered measures.
- Coordinate internally to identify policy, claims, utilization-management, data, communication, provider-education, and delegated-oversight impacts.
- Continue coordination with trade associations, Ventura County, providers, and community partners, and elevate material implementation risks to leadership and the Commission.

C. Community Relations: Sponsorships

Through its sponsorship program, Gold Coast Health Plan (GCHP) continues to support the efforts of community-based organizations in Ventura County to help Medi-Cal members and other vulnerable populations. The following organizations were awarded in August 2026 to current:

Organization	Description	Amount
Santa to the Sea	Santa to the Sea's annual holiday running event brings together participants, volunteers, local businesses, and community partners to raise funds for holiday toys for children, scholarships for local students, and year-round support for local families. Funds raised remain in Ventura County, with a special focus on underserved communities, including Nyeland Acres.	$1,000
Ventura County Medical Association	The Ventura County Medical Association will host its annual State of Healthcare Summit, bringing together healthcare professionals, community partners, and industry leaders to discuss current trends, emerging challenges, and the evolving healthcare landscape. Featured speakers will share insights on key issues impacting healthcare delivery and the future of the industry. The summit also provides an opportunity to strengthen collaboration and share perspectives on improving healthcare throughout Ventura County.	$2,500
Vision y Compromiso	Visión y Compromiso will host its 24th Annual Conference in Palm Springs, bringing together promotoras, community health workers, advocates, funders, and community partners committed to advancing health equity and community well-being. The conference will feature educational sessions, hands-on workshops, networking, and community-driven discussions focused on strengthening collaboration and culturally responsive approaches to healthier communities. Funding support will help provide opportunities for individuals to participate in the conference and benefit from its training, resources, and professional development.	$1,000
West Ventura County Business Alliance	The West Ventura County Business Alliance will host its quarterly luncheon series, bringing together business and community leaders to discuss topics impacting Ventura County. This quarter's luncheon will focus on healthcare, with local health leaders discussing industry changes and challenges and their impact on businesses, the workforce, and the community. Featured speakers will include Gold Coast Health Plan's Dr. Felix Nuñez and leadership from Clínicas del Camino Real. Funding will support the luncheon series and opportunities for continued education, collaboration, and engagement among local leaders.	$750

Organization	Description	Amount
I'm a Kid Who Can	I'm a Kid Who Can will host its annual holiday event to support underserved children and families throughout Ventura County. The event provides local youth and families with holiday gifts, resources, and opportunities to celebrate the season while strengthening community connections. Funding will assist with event costs and the purchase of gifts and other essential items distributed to participating children and families.	$1,000
TOTAL		**$6,250**

D. Community Relations: Community Meetings and Events

Community Relations attended events throughout the county in August and early September, supporting families with resources and assistance connecting them to GCHP services. The team participated in collaborative meetings, food distribution events, community resource fairs, and GCHP-partnered health fairs.

Collaborative Meetings	
Community representatives share resources, announcements, and upcoming community events.	
Geo Group Community Connections Collaborative Meeting (Ventura)	Aug. 4, 2026
Partnership for Safe Families and Communities (Online)	Aug. 5, 2026
Partnership for Safe Families and Communities (Online)	Sept. 2, 2026
Healthy Smiles Collaborative Back-to-School (Online)	
Community Events	
Eighth Annual Stronger Families Safer Kids 5k and Resource Fair (Oxnard)	Aug. 1, 2026
Westminster Free Clinic Back-to-School Fair (Oxnard)	Aug. 5, 2026
Family Connections Day Resource Fair (Camarillo)	Aug. 6, 2026
La Cosecha Back-to-School Fair (Oxnard)	Aug. 8, 2026

Community Events (con't)	
Westminster Free Clinic Back-to-School Fair (Oxnard)	Aug. 11, 2026
People Self-Help Housing Fair at Cypress Place (Oxnard)	Aug. 14, 2026
Rio Real Middle School Back-to-School Night (Oxnard)	Aug. 27,2026
Blanchard Elementary School Back-to-School Night (Santa Paula)	
Early Start Transition Fair (Oxnard)	Aug. 29, 2026
Sheridan Way Elementary Resource Fair (Ventura)	
McKevett Elementary Back-to-School Night (Santa Paula)	Sept. 1, 2026
Sierra Linda Elementary Open House Event (Oxnard)	Sept. 2, 2026
Grace Thill Elementary Back-to-School Night (Oxnard)	
Cesar E. Chavez Elementary Back-to-School Night (Oxnard)	Sept. 3, 2026
Harrington Elementary Back-to-School Night (Oxnard)	
Santa Paula High School Back-to-School Night (Santa Paula)	
Juan Soria Elementary Back-to-School Night (Oxnard)	Sept. 8, 2026
Lemonwood Elementary Back-to-School Night (Oxnard)	
Barbara Webster Elementary Back-to-School Night (Santa Paula)	
Fremont Jr. High Back-to-School Night (Oxnard)	Sept. 10, 2026
Bedell Elementary Back-to-School Night (Santa Paula)	
Rio Del Valle Elementary Back-to-School Night (Oxnard)	
Frontier High School Back-to-School Night (Camarillo)	

Health Fairs	
Ventura County Medical Center Las Islas Clinic Mammogram Health Fair (Oxnard)	Aug. 4, 2026
Clinicas De Camino Real Meta Clinic Mammogram Health Fair (Oxnard)	Aug. 7, 2026
Community Memorial Hospital Santa Paula Clinic Health Fair (Santa Paula	Aug. 11, 2026
Clinicas De Camino Real Moorpark Clinic Mammogram Health Fair (Moorpark)	Aug. 13, 2026
Ventura County Medical Center Moorpark Clinic Health Fair (Moorpark)	Aug. 15, 2026
Gold Coast Health Plan/Ventra County Health Care Agency Partnered Health Fair (Ventura)	Aug. 22, 2026
Food Distribution Events	
Salvation Army Food Distribution (Simi Valley)	Aug. 4, 2026
El Rio Food Distribution (Oxnard)	Aug. 7, 2026
One Step A La Vez Food Distribution (Fillmore)	Aug. 12, 2026
Catholic Charities Food Distribution (Ventura)	Aug. 13, 2026
San Salvador Mission Food Distribution (Piru)	Aug. 19, 2026
Samaritan Center Food Distribution (Simi Valley)	Aug. 20, 2026
Many Mansions Rancho Sierra Food Pantry (Camarillo)	Aug. 25, 2026
Salvation Army Food Distribution (Simi Valley)	Sept. 1, 2026
Cristo Rey Church Food Pantry (Oxnard)	Sept. 3, 2026
El Rio Food Distribution (Oxnard)	Sept. 7, 2026
Westminster Food Distribution (Oxnard)	Sept. 8, 2026
One Step A La Vez Food Distribution (Fillmore)	Sept. 9, 2026

E. Community Relations: Medi-Cal Renewal Workshops

In August, GCHP staff hosted workshops to help members with their Medi-Cal renewal process and assist them to connect to their benefits and services. These take place in various locations throughout Ventura County. Locations include low-income housing properties, food distribution centers, and community centers.

Workshops	
Promotoras y Promotores Workshop (Santa Paula)	Aug. 6, 2026
Westminster Free Clinic Workshop (Oxnard)	Aug. 11, 2026
Ventura Housing Authority at Mission Apartments Workshop (Ventura)	Aug. 12, 2026
Saticoy Food Hub Workshop (Saticoy)	Aug. 18, 2026
Ventura Housing Authority at The Palms Workshop (Ventura)	
Poder Popular Workshop (Santa Paula)	Aug. 20, 2026
Many Mansions at Rancho Sierra Workshop (Camarillo)	Aug. 25, 2026
Swap Meet Justice Workshop (Oxnard)	Aug. 30, 2026

F. Community Relations: Speakers Bureau

In August, GCHP staff conducted presentations throughout Ventura County organizations. Staff presented an overview of GCHP services and benefits and nutrition education to community members.

Speakers Bureau	
Mixteco Indigena Community Organizing Project – MICOP (Oxnard)	Aug. 6, 2026
First 5 Neighborhoods for Learning (Oxnard)	Aug. 13, 2026
First 5 Neighborhoods for Learning (Oxnard)	Aug. 17, 2026

II. Plan Operations

A. 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, 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 Aug. 31, 2026.

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Prime Therapeutics	2026 Q1 Utilization Management and Grievances and Appeals Audit	Open	7/14/2026	Under CAP	N/A
Ventura Transit System (VTS)	2026 Annual Policies and Procedures, Non-Medical Transportation / Non-Emergency Medical Transportation (NMT/NEMT) Call Center (CC), Door to Door Driver (D2D), Credentialing (CR), Downstream subcontract (DS)	Open	4/22/2026	Under CAP	N/A
VTS	Semi-Annual NMT/NEMT Vehicle	Open	6/30/2026	Under CAP	NA

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
VTS	2026 Q1 Call Center Audit	Open	6/9/2026	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**
Clinicas del Camino Real (CDCR)	Claims Timeliness	Open	4/22/2025	Open	Q1 2026 metrics were not met for 90% within 30 days or 45 days. April metrics for 90% within 30 days were not met; May metrics were met. Q2 metrics were met for 90% within both 30 and 45 days.
Prime Therapeutics	Correct Language on Prior Authorization Letters	Open	7/14/2026	Under CAP	N/A

RECOMMENDATION:

Receive and file.

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Suma Simcoe, Chief Operations Officer

DATE: September 28, 2026

SUBJECT: Chief Operations Officer (COO) Report

PowerPoint with Verbal Presentation

ATTACHMENTS:

Monthly Operations Report

Gold Coast Health Plan℠
A Public Entity

Gold Coast Health Plan

Integrity
Accountability
Collaboration
Trust
Respect

COO Report
September 2026

Suma Simcoe, Chief Operating Officer
Open Session Commission

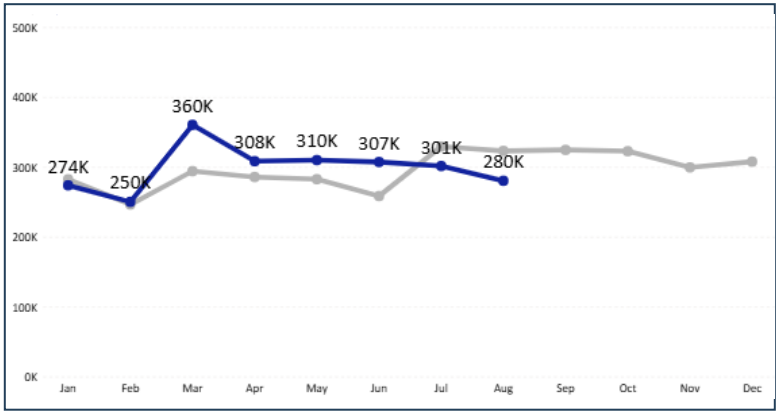
Operations KPI
Medi-Cal

Claims Received – Medi-Cal

Claims Received Jan-2025 to August-2026

Total Claims Volume Received

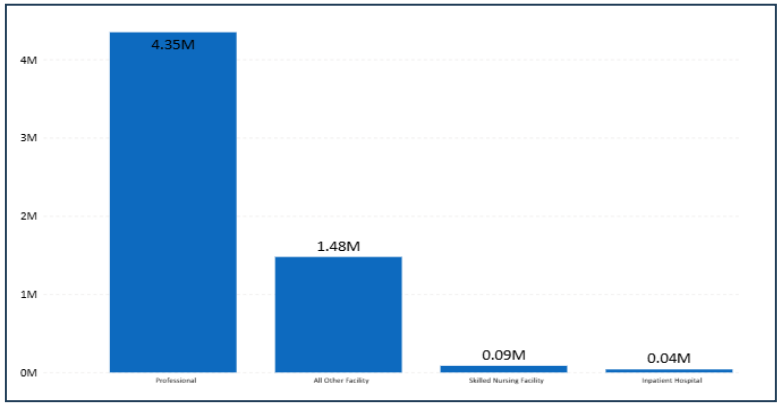
Total volume of all claim's statuses (Final, Denied, Rejected, etc.)



Trend Analysis: Reduction in membership attributed to a lower volume of claims received.

Total Claims Volume by Type

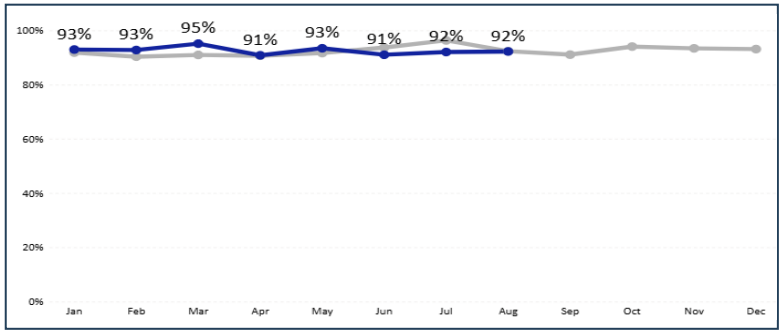
Count of all distinct claims (past 12 months, with a 3-month lag)



Trend Analysis: The graph shows the majority of claims the plan received were professional claims, followed by outpatient facility claims both making up around 84% of our total claim submissions.

% of Claims Submitted Electronically

All claim sources non-Paper or unknown



Trend Analysis: Performance remains stable, with no significant change in trend

Charts based on Receipt Date

Chart Legend: 2025 2026

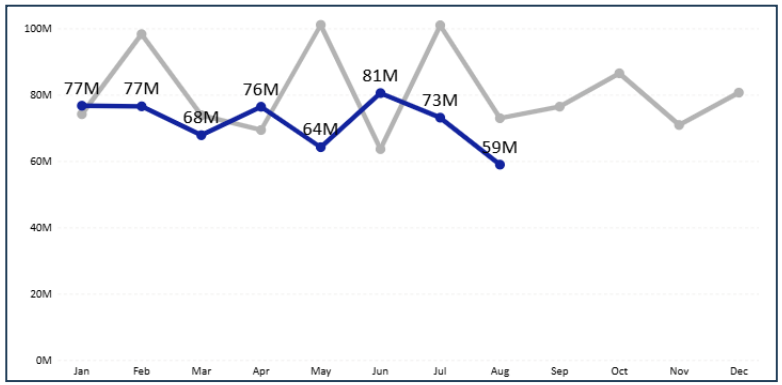
Return to Agenda

Claims Payment and Processing – Medi-Cal

Payment Processing Jan-2025 to August-2026

Total Paid ($)

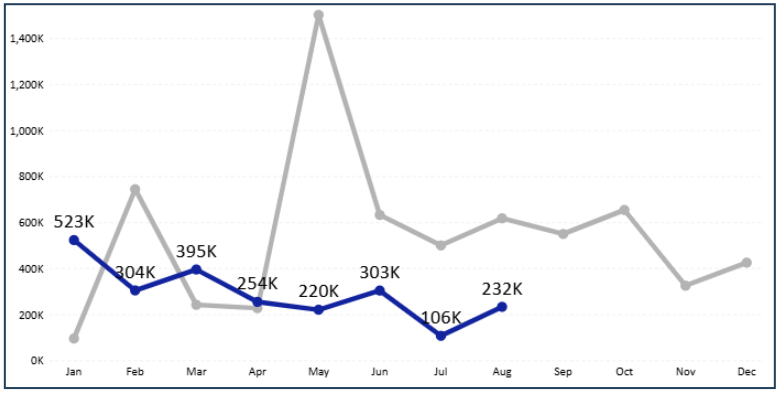
Total paid on final claim based on the month claim was paid



Trend Analysis: The graph represents a drop from June to August of ~20M due to no additional high dollar legal claim adjustments and the reduction in claim submissions based off reduced membership.

Total Interest Paid ($)

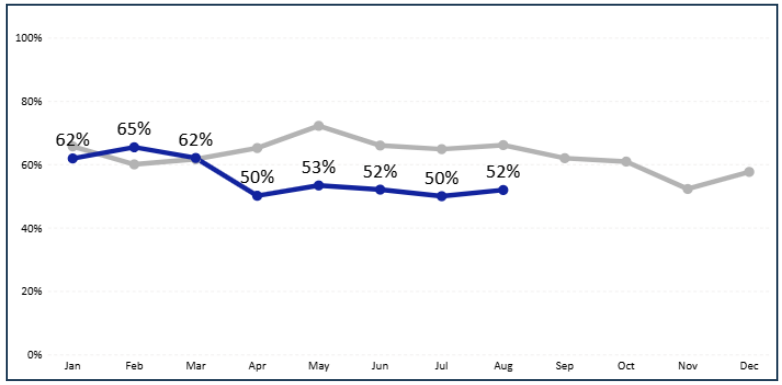
Total interest on final claim based on the month the claim was paid



Trend Analysis: The interest in August spiked by 30K due to a DHCS delay in releasing the APR-DRG pricing files that were effective 7/1/2026. Adjustments were completed in August after DHCS published the new rates. The County of Ventura is our largest provider on APR-DRG which attributed to the majority of interest paid in August.

% of First-Pass Claims Auto-Adjudicated

Distinct final claims where first pass auto-adjudicated based on receipt date



Trend Analysis: Performance remains stable, with no significant change in trend

Charts based on Paid Date

Chart Legend: 2025 2026

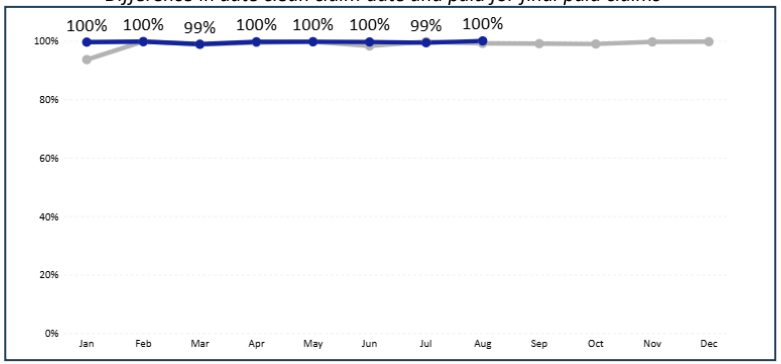
Return to Agenda

Claims Payment Timeline – By Process Date

Claims Payment Timeline – By Process Date Jan-2025 to August-2026

% Paid within 30 Calendar Days

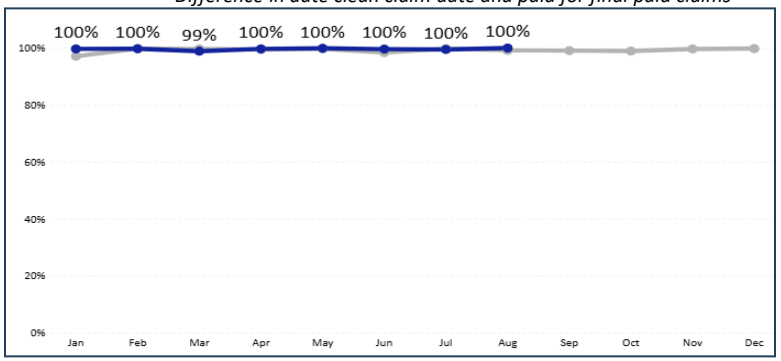
Difference in date clean claim date and paid for final paid claims



Trend Analysis: Performance remains stable, with no significant change in trend

% Paid within 45 Calendar Days

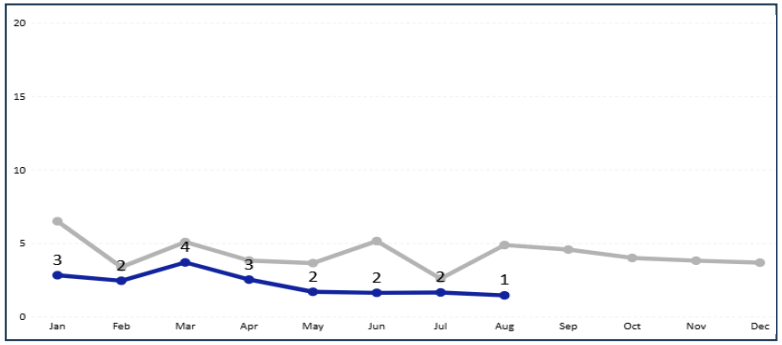
Difference in date clean claim date and paid for final paid claims



Trend Analysis: Performance remains stable, with no significant change in trend

Average Days to Paid

Average difference between clean claim date and paid date on clean claims



Trend Analysis: Performance remains stable, with no significant change in trend.

Charts based on Paid Date

Chart Legend: 2025 2026

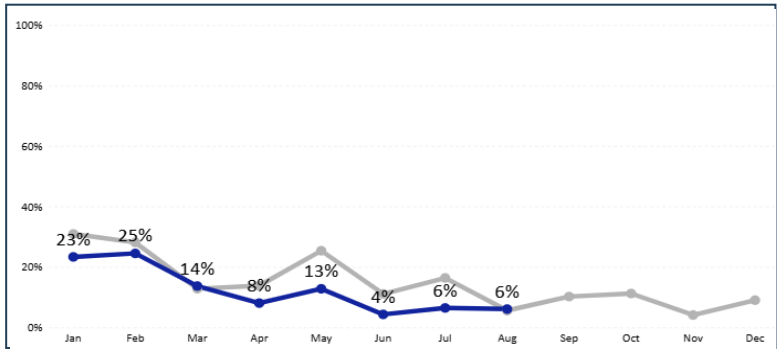
Return to Agenda

Denials, Adjustments & Rejected – Medi-Cal

Claims Denials & Adjustments Jan-2025 to August 2026

% of Total Claims Processed that are Adjustments

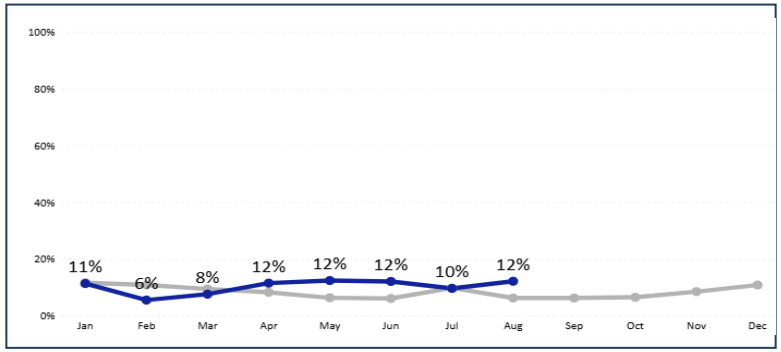
Regardless of final status with any adjustment based on receipt date



Trend Analysis: The % of claims processed that are adjustments have dropped from 13% in May to 6% in July due to validating contract configuration in HRP to ensure the claim is processed correctly the first time.

% Denials

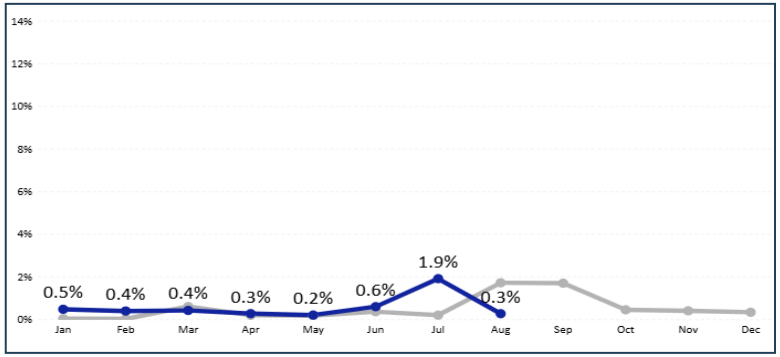
Percentage of claims volume with most recent process status = denied



Trend Analysis: Performance remains stable, with no significant change in trend

% Rejected

Percentage of claims which have a final status of Rejected



Trend Analysis: The % of rejected claims decreased in August due to provider education regarding membership billing errors that caused a spike in claim rejections in July.

Charts based on Paid Date

Chart Legend: 2025 2026

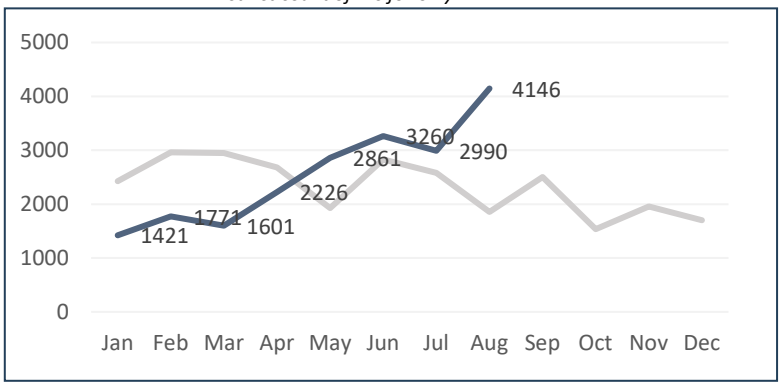
Return to Agenda

Provider Dispute Resolution Processing- all LOBs

Provider Dispute Resolution Processing Jan-2025 to August-2026

PDR Volume Received

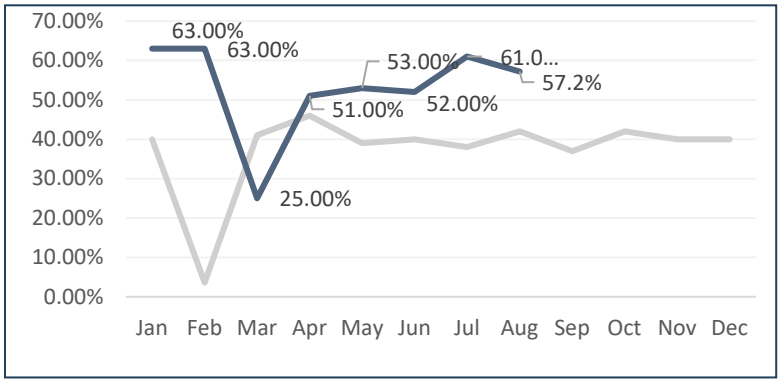
Distinct count of IDs for only PDR



Trend Analysis: August volume increased due to batch submissions from high-volume providers, primarily involving disputes with multiple like claims.

% of Closed PDR Cases that are Upheld

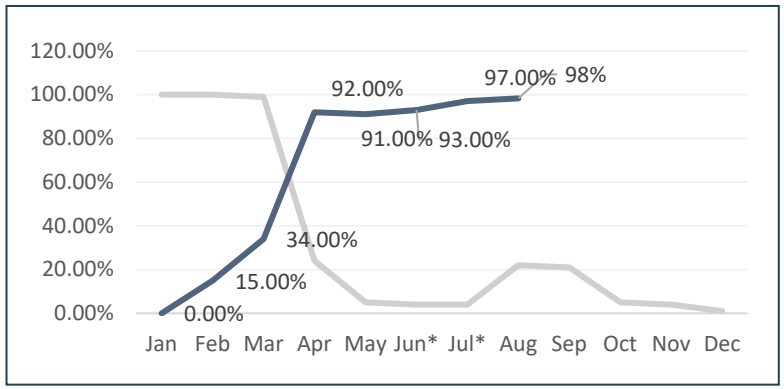
Closed cases with an outcome of Previous Decision Upheld



Trend Analysis: The upheld rate remains relatively stable. August decreased slightly to 57.2%, primarily due to the mix of high-volume providers and higher overturn rates for certain providers.

% Closed within 45 Business Days

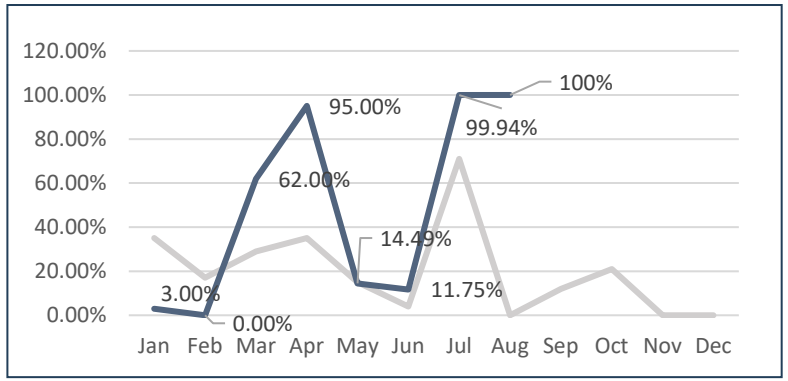
Comparison of AAG Received and Resolution dates



Trend Analysis: Performance remains stable, with no significant change in trend

% PDRs Acknowledged within 15 Business Days

Comparison of AAG Received and Acknowledged dates



Trend Analysis: 100% performance due to automation of acknowledgement letters

PDR Volume based on Receipt Date
Other charts based on Resolution and Acknowledgement Date

Chart Legend: 2025 2026

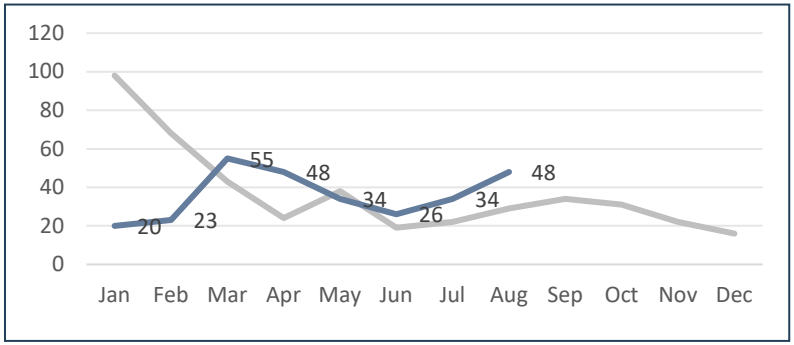
Return to Agenda

Call Center – all LOBs

Call Center – By Process Date Jan-2025 to August-2026

Member Average Speed to Answer (ASA)

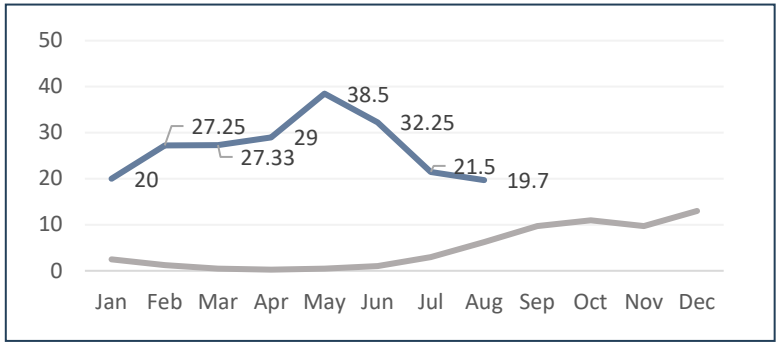
Avg time (seconds) member calls answered in



Trend Analysis: A 15% increase in call volume accounted for a slight uptick in ASA caused by combination of factors inbound call volume from 3rd party vendor calling in on the member line for Auth & Eligibility and/or other Provider needs.

Provider Average Speed to Answer (ASA)

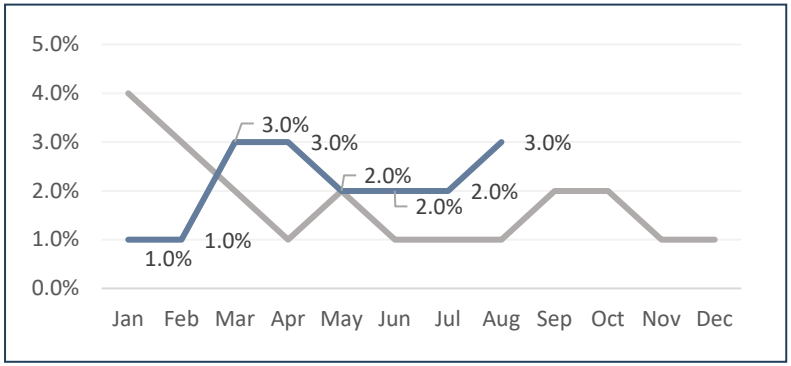
Avg time (minutes) provider calls were answered in



Trend Analysis:

Member Call Abandon %

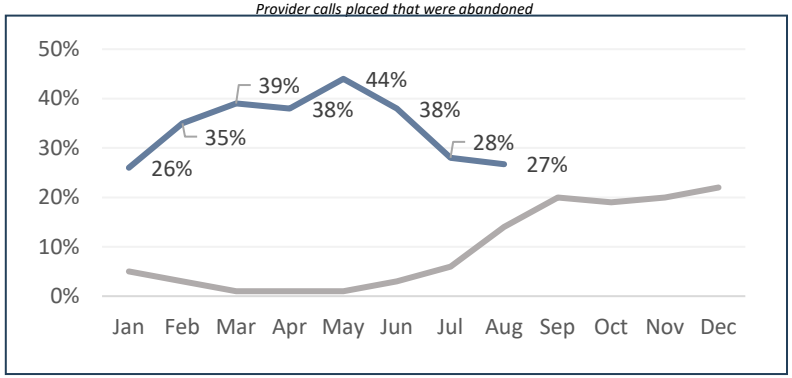
Member calls placed that were abandoned (<5% Target)



Trend Analysis: A 15% increase in call volume accounted for a slight uptick in abandon percentage caused by combination of factors inbound call volume from 3rd party vendor calling in on the member line for Auth & Eligibility and/or other Provider needs.

Provider Call Abandon %

Provider calls placed that were abandoned



Trend Analysis:

Charts based on Call Date
Call Center Data is for all LOBs

Chart Legend: 2025 2026

Return to Agenda

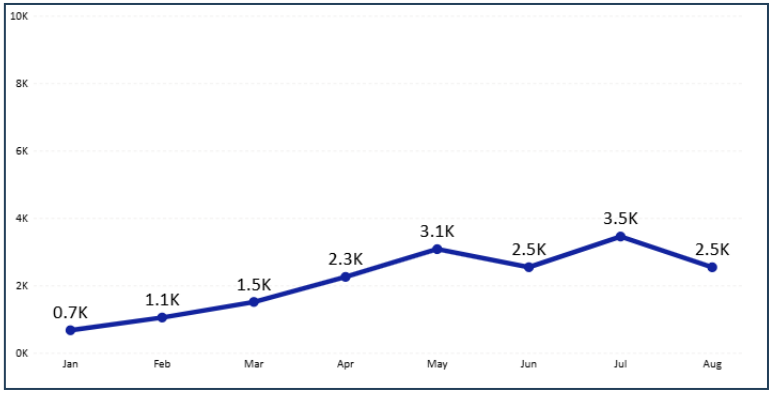
Operations KPI DSNP

Claims Received – DSNP

Claims Received Jan-2025 to August-2026

Total Claims Volume Received

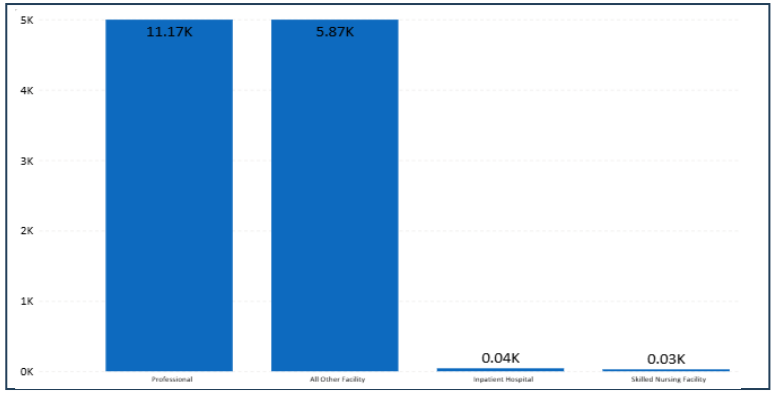
Total volume of all claim's statuses (Final, Denied, Rejected, etc.)



Trend Analysis: The graph reflects July being the highest volume of claims received since DSNP go-live. The numbers increase monthly as members begin to see their providers.

Total Claims Volume by Type

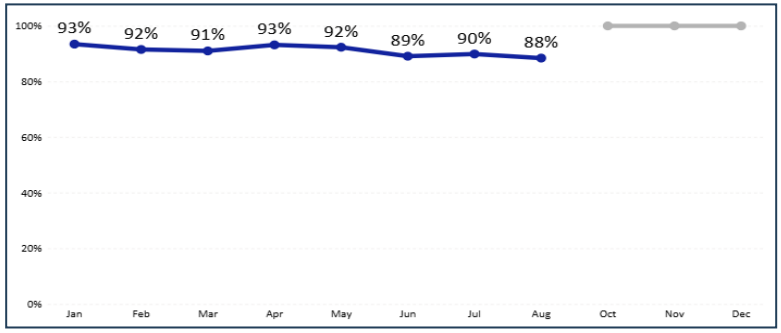
Count of all distinct claims (past 12 months, with a 3-month lag)



Trend Analysis: Performance remains stable, with no significant change in trend

% of Claims Submitted Electronically

All claim sources non-Paper or unknown



Trend Analysis: Performance remains stable, with no significant change in trend.

Charts based on Receipt Date

Chart Legend: 2026

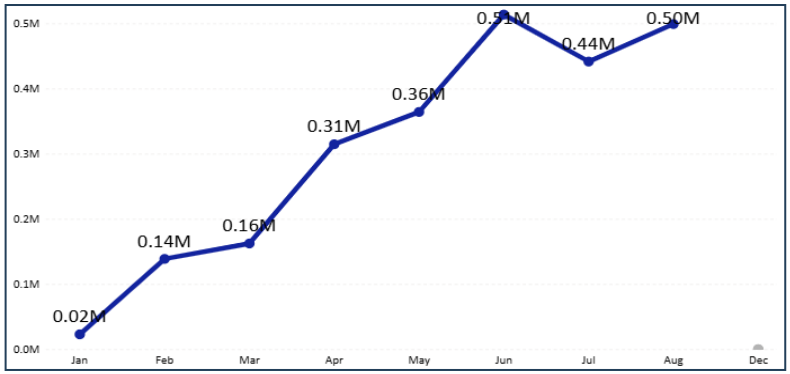
Return to Agenda

Claims Payment and Processing – DSNP

Claims Payment Timeline – By Process Date Jan-2025 to August-2026

Total Paid ($)

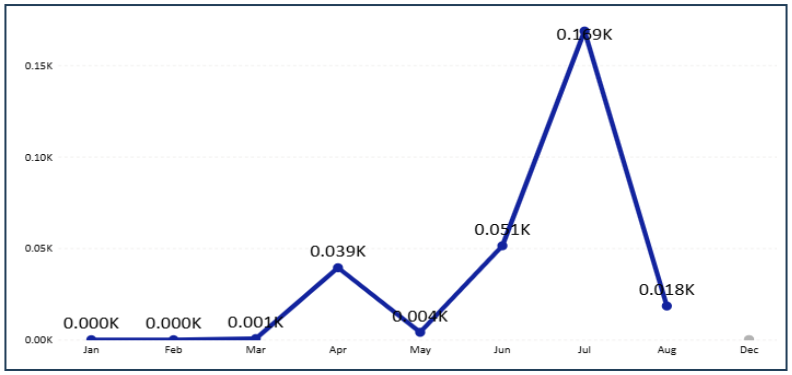
Total paid on final claim based on the month claim was paid



Trend Analysis: The data shows a slight increase in August due to multiple inpatient claims being paid which reflect a higher cost value than outpatient claims.

Total Interest Paid ($)

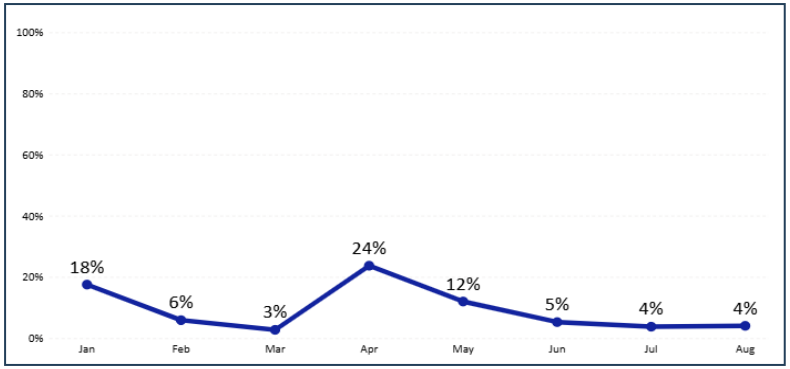
Total interest on final claim based on the month the claim was paid



Trend Analysis: The interest has decreased to a normal dollar amount after the spike in July due to DSNP claims that were held up in the mailroom.

% of First-Pass Claims Auto-Adjudicated

Distinct final claims where first pass auto-adjudicated based on receipt date



Trend Analysis: Performance remains stable, with no significant change in trend

Charts based on Paid Date

Chart Legend: 2026

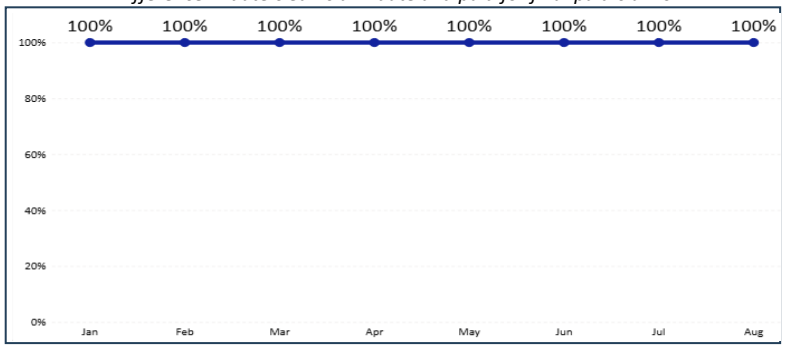
Return to Agenda

Claims Payment Timeline – By Process Date

Claims Payment Timeline – By Process Date Jan-2025 to August-2026

% Paid within 30 Calendar Days

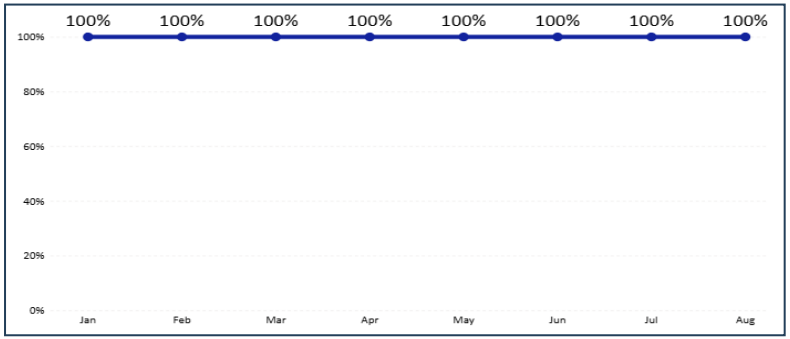
Difference in date clean claim date and paid for final paid claims



Trend Analysis: Performance remains stable, with no significant change in trend.

% Paid within 45 Calendar Days

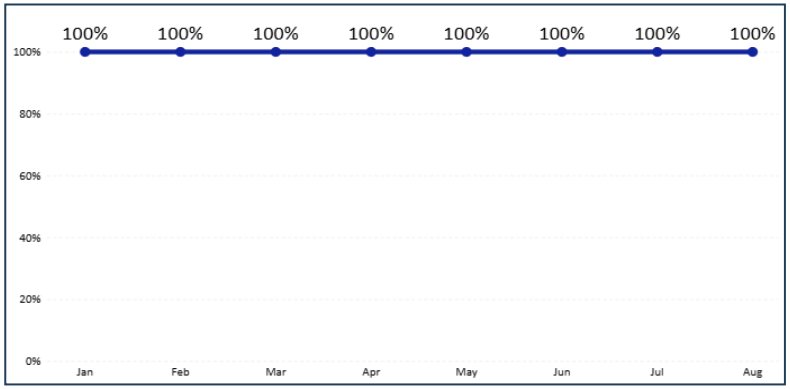
Difference in date clean claim date and paid for final paid claims



Trend Analysis: Performance remains stable, with no significant change in trend.

% Paid within 90 Calendar Days

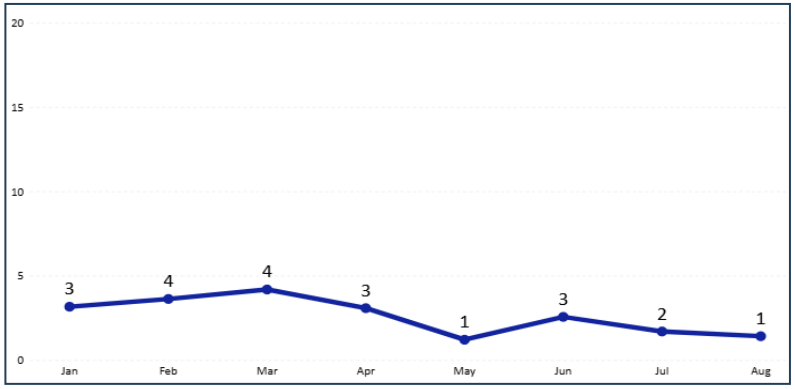
Difference in date clean claim date and paid for final paid claims



Trend Analysis: Performance remains stable, with no significant change in trend.

Average Days to Paid

Average difference between clean claim date and paid date on clean claims



Trend Analysis: Performance remains stable, with no significant change in trend.

Charts based on Paid Date

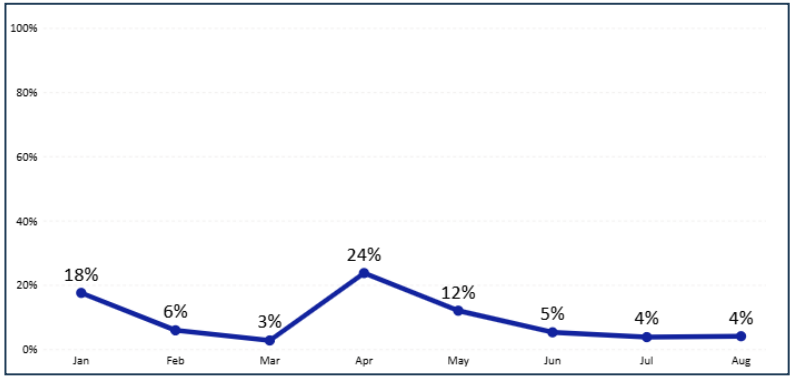
Charts Legend:

Denials, Adjustments & Rejected – DSNP

Claims Denials & Adjustments Jan-2025 to August-2026

% of Total Claims Processed that are Adjustments

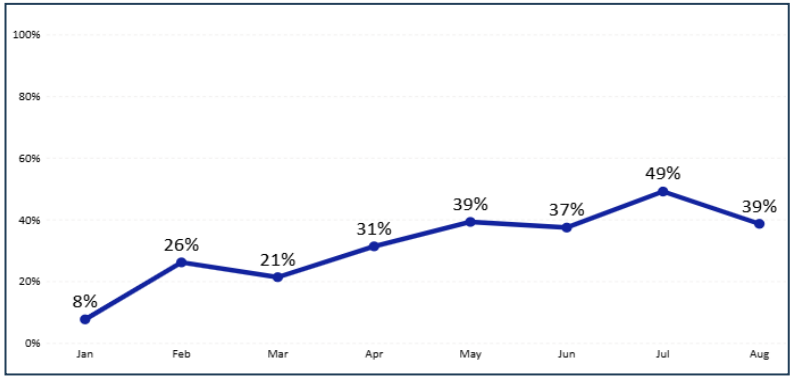
Regardless of final status with any adjustment based on receipt date



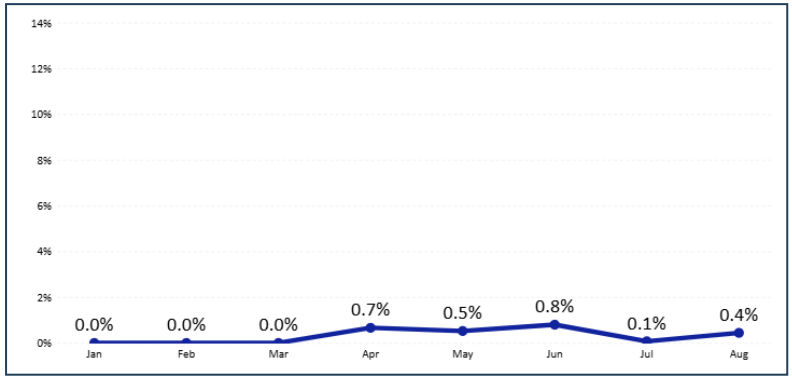
Trend Analysis: Performance remains stable, with no significant change in trend.

% Denials

Percentage of claims volume with most recent process status = denied



Trend Analysis: Denials increased in July due to higher clinical and outpatient grouper edits, as well as an increase in duplicate claim submissions. These have been reduced in August due to provider education to reduce outpatient grouper edits.



Trend Analysis: Performance remains stable, with no significant change in trend.

Charts based on Paid Date

Chart Legend:

AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: James Cruz, MD, Chief Medical Officer (CMO)

DATE: September 28, 2026

SUBJECT: Chief Medical Officer (CMO) Report

CMO COMMISSION REPORT – September 2026

Federal and state health care policies have created substantial operational uncertainty and budget pressures for California managed care plans. In response, GCHP has restructured its operating model to support the sustainable delivery of high-quality care to its members. As part of this change, the Population Health and Health Education/Culture and Linguistics teams have moved to the Office of the CMO. This transition goes beyond shifting staff and resources; it creates an opportunity to better align these teams within Health Services and Health Equity. The Executive Directors of Health Services and Health Equity have begun meeting with team members to identify underused strengths and redirect them toward broader priorities, including Enhanced Care Management (ECM) and Clinical Quality Improvement.

Department Updates
The CMO is delighted to share the following:

Pharmacy: There are several Medi-Cal Rx updates. The specific details are included in the slide deck. In summary, Medi-Cal Rx has updated their list of drugs that may require a new prior authorization (PA) due to changes in their PA policy.

- Medi-Cal Rx has implemented early refill override limits for members 21 years of age and older.
- Medi-Cal Rx has updated their measles, mumps, rubella, and varicella (MMRV) vaccine reimbursement for children under 4 years of age.
- Medi-Cal Rx has updated their coordination of benefits billing process for GLP-1 drugs.
- Medi-Cal Rx will update their policy for out-of-state and out-of-country pharmacy providers.

Quality Improvement: Each year, the National Committee for Quality Assurance (NCQA) calculates and resets measure performance rate benchmarks after health plans submit their prior measurement year rates in June. Their benchmarks are based on national health plan performance for each line of business and plan type (e.g., Medicaid HMO). For example, measurement year 2026 Managed Care Accountability Set (MCAS) measures are held to benchmarks based on national measurement year (MY) 2025 performance. This August,

NCQA released their new benchmarks for measurement year 2026 and 18 MCAS measure benchmarks increased except for Follow Up Mental Illness (FUM). Overall, GCHP experienced a modest impact on the Plan's current performance:

- **Performance on 10 measures dropped by one percentile**
  - **Women's Health**: Breast Cancer Screening, Cervical Cancer Screening, Prenatal/Postpartum
  - **Children's Health**: Well Child Visits 15-30 months, Immunizations for Adolescents
  - **Chronic Conditions**: Glycemic Status Assessment for Patients with Diabetes, Controlling High Blood Pressure
  - **Cancer Prevention**: Colorectal Cancer Screening
  - **Behavioral Health**: Follow Up after Emergency Department (ED) for Mental Illness
- **60% (12 of 20)** of MCAS measures currently meet overall targets vs. **70% (14 of 20) prior to benchmark update**

To mitigate the impact of these new benchmarks, the GCHP QI team has implemented several aggressive Q4 Push Priority Initiatives which focus on the following: auditing provider coding to identify remediation opportunities; launching a Q4 member incentive; supporting clinic health fairs and after-hours scheduling; and integrating data captured by third party vendors.

For GCHP Total Care Advantage STARS, each year the Centers for Medicare and Medicaid Services (CMS) sets cut points based on how all health plans performed during that specific measurement year. Cut points turn a health plan's percentage score into a 1-to-5 Star rating.

As a new Dual Eligible Special Needs Plan (D-SNP) in MY 2026, Total Care Advantage (TCA) will not receive an official Star Rating until 2028.

Strategy: To ensure success in 2028, TCA sets internal targets using current year Star Rating cut points:

- **In MY 2026:** Set targets/measure performance against the 2026 cut points (released in October 2025)
- **In MY 2027:** Update targets to measure performance against the 2027 cut points (released in October 2026)
- **In MY 2028:** The 2028 cut points (released in October 2027) are the thresholds TCA's performance data will be measured against to determine our first Star Rating of 2028

26 Star Measures have an assigned target; 16 of those measures have adequate denominators **11 of 16** Star Measures meeting denominators are **meeting target (68.75%) To ensure TCA continues to improve our measure performance, 3 key strategies have been implemented:**

a. Monthly Medicare STARS Executive Summary Dashboard.
b. Annual Wellness Strategy.

c. Gap Closure improvement initiatives.

Strategy details are described in the QI slide deck included in the CMO report.

Health Services and Health Equity: The CMO will report on both units as Health Services and Health Equity have inherited the population health and the health education/culture-linguistics teams. Health Services and Health Equity leaders are working earnestly with their inherited team members to integrate them meaningfully into ongoing initiatives and programs in the two units. For health services the integration of the Population Health Management team strengthens alignment with Health Services and establishes a clearer operating structure for ECM/CS. This change supports faster decision-making, improved accountability, and more consistent execution across key priorities, including staffing alignment, backlog resolution, and referral intake modernization. Priorities are focused on stabilizing operations, reducing avoidable administrative burden, and ensuring clinical resources are directed to activities requiring clinical judgment. As these changes mature, health services will be better positioned to strengthen provider oversight, improve throughput, and reduce avoidable utilization among high-cost, high-need populations. Similarly, for Health Equity, the staffing additions from Health Education Cultural and Linguistics and Population Health Management teams have strengthened health equity's capacity to lead cross-functional initiatives, support data-driven interventions, and accelerate progress toward equitable health outcomes. Additionally, Health Equity area continues to advance GCHP's organizational efforts to reduce health disparities across our membership. Specifically, in partnership with the Quality Improvement team, four priority MCAS measures were identified for targeted intervention: **Childhood Immunization Status (CIS), Glycemic Status for Patients with Diabetes (GSD), Child and Adolescent Well-Child Visits (WCV), and Colorectal Cancer Screening (COL)**. These measures were selected based on demonstrated disparities and opportunities for improvement through coordinated plan, provider, and community engagement.

That concludes the GCHP CMO report to the Commission for September 2026. Thank you.

ATTACHMENT:
Chief Medical Officer Update PPT

Gold Coast Health Plan℠
A Public Entity

Chief Medical Officer Update

September 28, 2026

James Cruz, MD
Chief Medical Officer

Integrity
Accountability
Collaboration
Trust
Respect

Gold Coast Health Plan℠
A Public Entity

Pharmacy Services Report

September 2026

Lily Yip, PharmD, MBA, APh, CDCES, BCACP, CPHQ
Director of Pharmacy

Integrity
Accountability
Collaboration
Trust
Respect

Medi-Cal Rx Reminders

- **Requirement for Provider Enrollment in Medi-Cal:** Effective at a future date **Q1 2027**, Prescribers must be enrolled in Medi-Cal using their Type 1 NPI for pharmacy claims to be processed and paid at the pharmacy. DHCS/Medi-Cal Rx has started to provide more **information** to various stakeholders on the "Provider Enrollment Requirement" section on the **Education & Outreach** page. **Link** to FAQs and a **flyer**. Future **Town Hall meeting** will be held on **Sep 24, 2026** from **10:30 – 12pm**.
- **ICD-10-CM Diagnosis Codes on Pharmacy Claims**: Effective at a future date **TBD**, 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 "ICD-10-CM Diagnosis Code Requirement" section on the **Education & Outreach** page.

https://medi-calrx.dhcs.ca.gov/provider/pharmacy-news/

New Medi-Cal Rx Updates

- Medi-Cal Rx has updated their list of drugs that may require a new prior authorization (PA) due to changes in their PA policy. For more details, review **this link** (**Effective Sep 1, 2026**)
- Medi-Cal Rx has implemented early refill override limits for members 21 years of age and older. For more details, review **this link** **(Effective Aug 21, 2026)**
- Medi-Cal Rx has updated their MMRV vaccine reimbursement for children under 4 years of age. For more details, review **this link** **(Effective Aug 21, 2026)**
- Medi-Cal Rx has updated their coordination of benefits billing process for GLP-1 drugs. For more details, review **this link** **(Effective Aug 17, 2026)**
- Medi-Cal Rx will update their policy for out-of-state and out-of-country pharmacy providers. For more details, review **this link** **(Effective Oct 1, 2026)**

https://medi-calrx.dhcs.ca.gov/provider/pharmacy-news/

Pharmacy Services - Updates

- The Pharmacy team continues to meet weekly with our Pharmacy Benefit Manager (PBM), Prime Therapeutics, and monthly with DHCS/Medi-Cal Rx to discuss upcoming changes to policies/procedures, ask questions and receive updates on regulatory requirements.
- The 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.
- The Pharmacy team continues to provide education about the Medi-Cal Rx/TCA pharmacy benefits to pharmacies, provider's offices, GCHP staff via the GCHP website, pharmacy newsletter, Provider Operations Bulletins, and various committee meetings.
- The Pharmacy team also successfully completed the FFY 2025 Medicare Managed Care Drug Utilization Review (DUR) Annual Survey in June 2026.
- 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.

Pharmacy Services - D-SNP Updates

- The Pharmacy team remains on track with completing tasks in our Annual Readiness project plan with Prime Therapeutics (PBM) to prepare for CY2027.
- The Director of Pharmacy has been actively supporting and completing key CY2027 D-SNP bid and formulary development activities in collaboration with Prime Therapeutics and GCHP leadership and staff.
- The Pharmacy team has completed and received approval from the Policy Review Committee for 5 new policies and procedures for D-SNP in August to help prepare us for a CMS program audit.
- The Pharmacy team continues to perform oversight of the PBM's delegated functions by completing monthly internal audits to ensure the PBM is compliant with CMS requirements.
- The Pharmacy team continues to work closely with the Compliance department to ensure that the PBM, Prime Therapeutics, is meeting their contractual obligations and key performance indicators by performing daily PBM monitoring and oversight.

Gold Coast Health Plan℠
A Public Entity

CMO Report
Quality Improvement Update

September 28, 2026

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

Integrity
Accountability
Collaboration
Trust
Respect

MY 2026 MCAS Update

- **Benchmarks for MY 2026 released by NCQA August 28th**
  - Benchmarks are calculated by NCQA annually after plans submit prior measurement year rates in June
  - Benchmarks are developed from national health plan performance for each line of business and plan type (e.g., Medicaid HMO)
    - MY 2026 measures are held to benchmarks based on national MY 2025 measure performance

- **Impact of benchmark update:**
  - **All 18 HEDIS measure benchmarks increased** except FUM HPL (90th percentile)
  - **Performance on 10 measures dropped by one percentile**
    - **Women's Health**: Breast Cancer Screening, Cervical Cancer Screening, Prenatal/Postpartum
    - **Children's Health**: Well Child Visits 15-30 months, Immunizations for Adolescents
    - **Chronic Conditions**: Glycemic Status Assessment for Patients with Diabetes, Controlling High Blood Pressure
    - **Cancer Prevention**: Colorectal Cancer Screening
    - **Behavioral Health**: Follow Up after ED for Mental Illness
  - **60% (12 of 20)** of MCAS measures currently meeting overall targets vs. **70% (14 of 20) prior to benchmark update**

MY 2026 MCAS Update – Q4 Push Priority Initiatives

PPC – Postpartum

- Conduct coding audit and follow up on remediation opportunities
- Explore community partnership to provide car seats to promote visit completion

PPC – Prenatal

- Conduct coding audit and follow up on remediation opportunities
- Utilize enhanced reporting to identify pregnant members for outreach by Case Management

Colorectal Cancer Screening

- Expand Cologuard to VCMC and large independent clinics

Well Child Visits (WCV/W30)

- Remediate identified coding deficiencies
- Support clinic health fairs and after-hours scheduling through incentive funding

Glycemic Status Assessment for Patients with Diabetes

- Launch Q4 point-of-care member incentive

Controlling Blood Pressure

- Integrate BP data from Wellth participants
- Remediate identified CPT-II coding deficiencies with providers and promote tip sheet

MY 2026 Star Measure Update

CMS sets thresholds (called cut points)

- CMS sets annual cut points based on how all health plans performed during that specific measurement year. Cut points turn a health plan's percentage score into a 1-to-5 Star rating.
  - ➢**As a new D-SNP in MY 2026,** Total Care Advantage (TCA) will not receive an official Star Rating until 2028
    - **Strategy:** To ensure success in 2028, TCA sets internal targets using current year Star Rating cut points
      - **In MY 2026:** Set targets/measure performance against the 2026 cut points (released in October 2025)
      - **In MY 2027:** Update targets to measure performance against the 2027 cut points (released in October 2026)
      - **In MY 2028:** The 2028 cut points (released in October 2027) are the thresholds TCA's performance data will be measured against to determine our first Star Rating of 2028

MY 2026 Targets

- 26 Star Measures have an assigned target; 16 of those measures have adequate denominators
- **11 of 16** Star Measures meeting denominator are **meeting target (68.75%)**

MY 2026 Star Measure Priority Initiatives

Medicare Stars Monthly Executive Summary Dashboard is live

- Function: Centralizes HEDIS, pharmacy, and administrative metrics for operational tracking

Annual Wellness Visit (AWV) Strategy

- Reporting: Monthly member level completion data to providers
- Meeting in-person with provider groups to identify and resolve key operational barriers to completion

Gap Closure/Improvement Initiatives

- Care Navigator Gap Closure Assessment in medical management system in development
- Providing targeted Gap Closure lists to provider groups
- Target actionable screening measures - explore resources for outreach calls
- Data Capture and Mapping:
  - Reviewing Diabetic Eye Exam and Controlling High Blood Pressure data capture with providers
  - Mapped Care Management data (COA Functional Assessment, Pain Screening) to HEDIS software to maximize performance
  - Mapping Electronic Health Record (EHR) medication review documentation to COA-Medication Review measure-compliant codes to improve accurate data capture and maximize performance

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Health Services & Population Health Update

September 28, 2026

Pshyra Jones
Executive Director, Health Equity
Nicole Kanter
Executive Director, Health Services

EXECUTIVE SUMMARY

ECM/CS redesign shifts operations from transactions to performance oversight

Population Health Management now sits under the CMO, strengthening alignment with Health Services.

01

Stabilize operations

Clear the 3,400+ authorization backlog by December 2026 and create capacity for incoming workload.

02

Modernize referral intake

Use VCCIE as a centralized point of referral entry to reduce handoffs, duplication, and routing delay.

03

Align work to skill

Move appropriate non-clinical work out of clinical roles so licensed staff can focus on judgment and oversight.

Executive implication | Faster decisions • clearer accountability • better throughput • lower avoidable utilization

PRIORITY 1 | STABILIZE

Backlog elimination is the critical path to a sustainable operating model

3,400+
authorizations in backlog

TARGET • DECEMBER 2026

What clearing the backlog unlocks

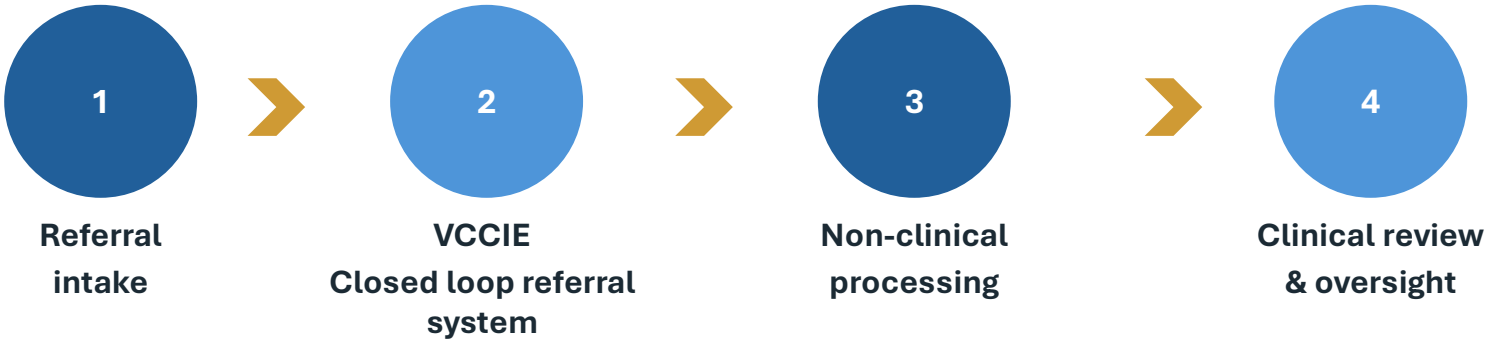
01 **Less duplicate processing**
Reduce avoidable rework and administrative friction.

02 **More throughput**
Move authorizations through the system with greater consistency.

03 **Capacity for new workload**
Create room for additional volume beginning in October.

PRIORITY 2 | MODERNIZE & REALIGN

Centralized routing returns clinical capacity to clinical work



≈45% **of authorizations now handled by clinical staff do not require clinical judgment**

Capacity redirects to

- Provider support
- Quality monitoring
- Program oversight

Implementation requires

- Non-clinical capacity
- Policy updates
- Targeted training

STRATEGIC NEXT STEPS

Sequence the next phase around stabilization, workflow clarity, and measurable oversight

01 **Monitor operational stabilization**
Track backlog reduction and escalate barriers to the December 2026 target.

02 **Finalize the VCCIE workflow**
Set routing logic, ownership, and timeliness and accuracy metrics.

03 **Approve the staffing alignment strategy**
Size non-clinical capacity while protecting quality and compliance.

04 **Strengthen governance infrastructure**
Update policies, workflows, training, and accountability.

05 **Build performance oversight reporting**
Track throughput, provider performance, utilization, and outcomes.

Expected utilization impact [1]

23% fewer inpatient admissions

18% lower Emergency Department use

Use the ECM/CS dashboard to convert these expected outcomes into visible, accountable performance.

[1]DHCS Benchmarks are based on: DHCS 1915b annual report of ILOS STC B20 2025

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Health Equity Department Update

September 28, 2026

Pshyra Jones
Executive Director, Health Equity

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Advancing Health Equity Through Targeted Interventions

2026-2027 Priority HEDIS Measures

- Childhood Immunization Status (CIS)
- Glycemic Status for Patients with Diabetes (GSD)
- Child & Adolescent Well-Child Visits (WCV)
- Colorectal Cancer Screening (COL)

Why These Measures?

- Identified disparities across member populations
- Opportunities for improvement through coordinated health plan, provider, and community partnerships

Looking Ahead

- These measures represent the initial phase of a broader Health Equity strategy
- Additional priorities will be identified and advanced through 2027 and beyond

Organizational Readiness & Building Capacity

- Expanded team with expertise from:
  - Health Education Cultural & Linguistic Services
  - Population Health Management
- Strengthening cross-functional collaboration and data-driven interventions to improve equitable health outcomes

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AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Suma Simcoe, Chief Operations Officer
Michelle Espinoza, Exec. Director of Provider Network Operations & Strategies

DATE: September 28, 2026

SUBJECT: Provider Network Presentation

PowerPoint with Verbal Presentation

ATTACHMENTS:

Provider Network

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Gold Coast Health Plan Provider Network Operations

September 28, 2026

Michelle Espinoza
Executive Director Provider Network Operations & Strategies

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KEY FOCUS AND MISSION STATEMENT

What We Do

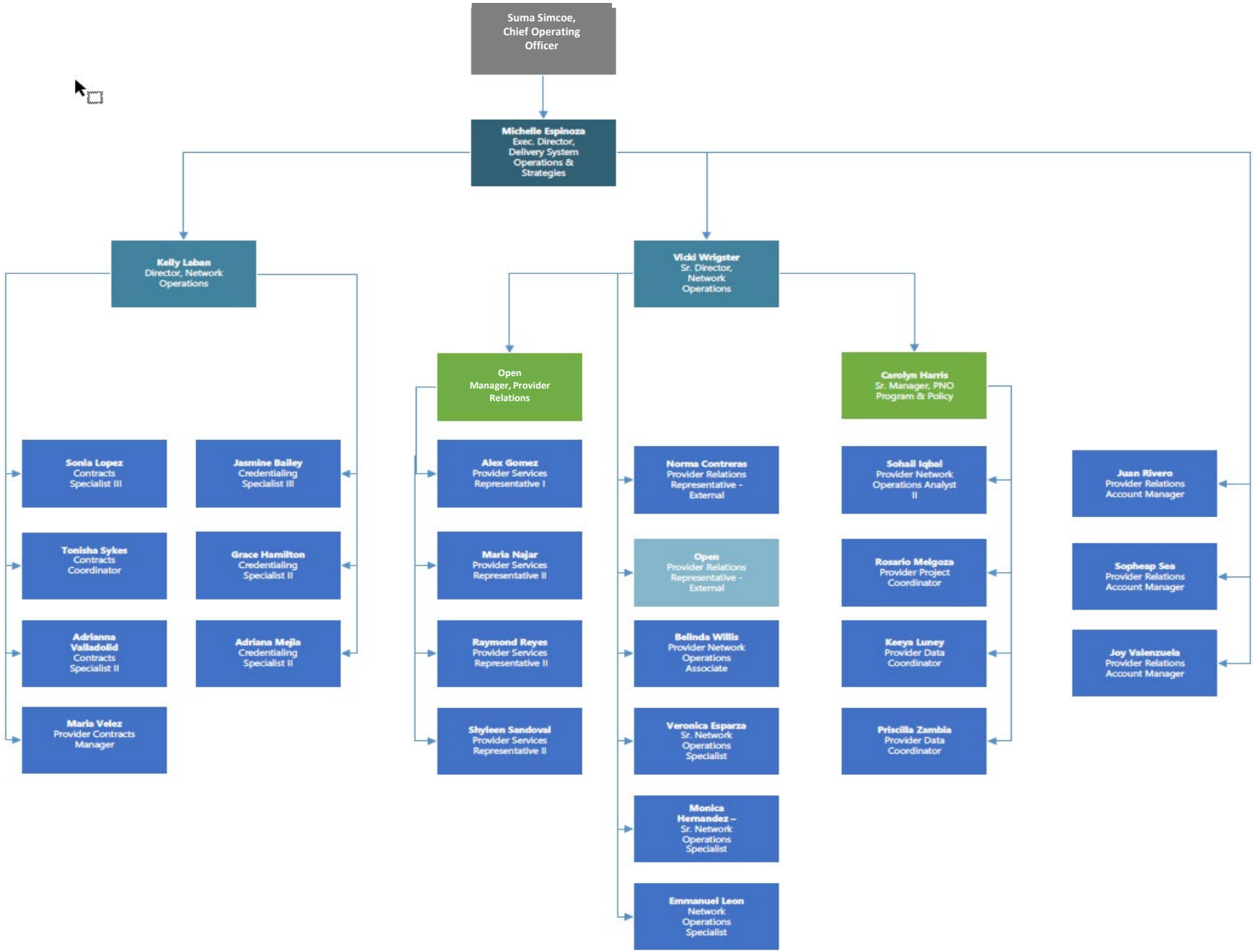
Provider Network Operations acts as the central touchpoint between providers and GCHP for provider recruitment, education, credentialing, contracting, reporting and the maintenance of an adequate provider network while addressing the everyday concerns of our providers.

Mission Statement

Provider Network Operations is committed to improving the health outcomes for the community of members we serve through:

- Provision of high-quality healthcare through our network of providers
- Collaborate, educate, train and partner with providers
- Drive transformation and innovation in provider networking

PNO Organization



PNO Functional Areas

Provider Relations

- Serve as provider advocates and primary points of contact
- Conduct orientations, site visits, and ongoing provider education

Support contract operational compliance and issue resolution

Collaborate with internal departments to meet DHCS, CMS and other regulatory requirements

Provider Contracting

- Negotiate, execute and manage provider agreements
- Ensure contract terms meet DHCS and CMS requirements
- Support network expansion and rate negotiations
- Coordinate with Credentialing, Provider Relations & Operations during onboarding

Credentialing

- Verify provider qualifications, licensure, training and sanctions
- Conduct initial credentialing and recredentialing per DHCS, CMS and NCQA Standards
- Maintain credentialing data

Provider Regulatory & Analytics

- Monitor and report network adequacy for Medi-Cal (DHCS) and D-SNP (CMS)
- Manage provider directories (printed and online)
- Lead provider network regulatory deliverables (ANC, SNC, NAV, HSD, CMS Aligned Template, Medicare templates)

MediCal Network – Traditional Health

Provider Type	Total Counts
Hospitals:	25
- Acute Care	19
- Long-Term Acute Care (LTAC)	1
- Tertiary	5
Providers:	9,484
- Primary Care Providers (PCPs) & Mid-levels	508
- Specialists	8,036
- Hospitalists	940
Ancillary:	657
- Ambulatory Surgery Center (ASC)	10
- Community-Based Adult Services (CBAS)	14
- Durable Medical Equipment (DME)	95
- Home Health	38
- Hospice	21
- Laboratory	38
- Occupational Therapy (OT) / Physical Therapy (PT) / Speech Therapy (ST)	190
- Radiology / Imaging	60
- Skilled Nursing Facility (SNF) / Long-Term Care (LTC) / Intermediate Care Facility (ICF)	84

Return to Agenda

MediCal Network – CalAIM

Provider Type	Total Counts
Enhanced Care Management	13
Community Health Worker	6
Doula Services	11
Community Supports :	
- Recuperative Care	2
- Asthma Remediation	2
- Community & Nursing Facility Transition/Diversion to Assisted Living	4
- Community Transition	14
- Environmental Accessibility/Home Modification	3
- Housing Deposits/Tenancy & Sustaining/Transition Services	4
- Medically Supported/Tailored Meals	4
- Personal Care & Homemaker Services	4
- Respite	7
- Transitional Rent	1

Supplemental Vendors

- Carelon Behavioral Health (MediCal and DSNP)
- Vision Service Plan (MediCal and DSNP)
- Ventura Transit System (MediCal and DSNP)
- TruHearing (DNSP)
- American Specialty Network (Chiro & Acupuncture) (DSNP)
- Connect America (Emergency Response) (DSNP)

Network Adequacy (Medi-Cal vs. D-SNP)

Medi-Cal Requirements	D-SNP Requirements
Governed by **DHCS**	Governed by **CMS**
Uses **Time & Distance** standards for **PCPs, specialists, hospitals, and behavioral health** within plan's service area	Uses **Time & Distance** standards specific to **Medicare population** within plan's service area
Network capacity/provider-to-member ratios and coverage of full scope benefits (**60**%)	Percent of members with access within time/distance standards (**90**% in metro county)
Annual Network Certification (**ANC**) and Network Adequacy Validation (**NAV**) Audit	Aligned Network and Medicare Provider Network Templates
274 Provider Network File	Health Service Delivery (**HSD**) Template
Monthly, quarterly & annual monitoring	Annual and ad-hoc monitoring
Requires **biannual provider directory submission**	No directory submission beyond initial D-SNP application process

Medi-Cal Network Adequacy

PCP Access (Adult / Ped)	Hospitals Access	Core Specialists Access	Behavioral Outpatient (Adult / Ped)	Provider-to-Member Capacity (DHCS 60%)
100.0% | 100.0%	**100.0%**	**100.0%**	**100.0% | 100.0%**	**PCP: 1:381 ✓ Spec: 1:21 ✓**
Standard 10 mi / 30 min	Standard 15 mi / 30 min	Standard 30 mi / 60 min	Standard 30 mi / 60 min	Base: Ventura Medi-Cal = 182,889

Time & Distance (DHCS Standard)

County	Provider Type	Required	Achieved	% Members	Status
Ventura	PCP (Adult)	10 / 30	17.4 / 18.9	100.0%	✓ Meets
Ventura	PCP (Pediatric)	10 / 30	22.8 / 24.8	100.0%	✓ Meets
Ventura	Hospital	15 / 30	17.0 / 20.4	100.0%	✓ Meets
Ventura	OB/GYN	30 / 60	22.9 / 24.9	100.0%	✓ Meets
Ventura	Specialist (Core)	30 / 60	33.0 / 39.1	100.0%	✓ Meets
Ventura	Behavioral Outpt (Adult)	30 / 60	17.0 / 18.9	100.0%	✓ Meets
Ventura	Behavioral Outpt (Pediatric)	30 / 60	21.4 / 23.3	100.0%	✓ Meets

PCP source: Geo Access Adult & Pediatric PCPs — Ventura. Max Dist/Time Adult 17.4/18.9, Ped 22.8/24.8.

Provider Counts

Provider-to-Member Capacity
PCP: 1:381 ✓ Specialist: 1:21 ✓

Validation & Sources
Quest Analytics

Next: Member gaps
Return to Agenda

D-SNP Network Adequacy

PCP Access
100.0%
Standard 10 mi / 15 min

Hospital Access
100.0%
Standard 30 mi / 45 min

Specialist Access
94.0%
Grouped CMS standards

Behavioral Health Access
99.3%
Adult practitioners only

Provider-to-Member Capacity
PCP 1:8 | Spec 1:1
Informational only — no D-SNP capacity standard

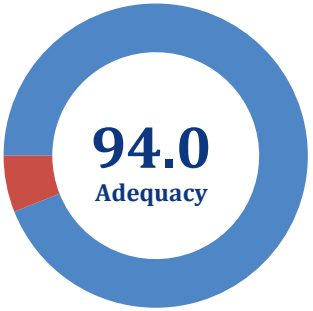
Time & Distance (CMS)

Ventura County adequacy by grouped D-SNP standards

County	Provider Type	Required	Achieved	% Members	Status
Ventura	PCP	10 / 15	1.1 mi	100.0%	✓ Meets
Ventura	Spec 20/30 Group	20 / 30	4.4 mi	100.0%	✓ Meets
Ventura	Spec 30/45 Group	30 / 45	6.5 mi	100.0%	✓ Meets
Ventura	Spec 40/60 Group	40 / 60	5.8 mi	100.0%	✓ Meets
Ventura	Hospitals	30 / 45	10.9 mi	100.0%	✓ Meets
Ventura	BH Adult	30 / 45	14.7 mi	99.3%	Review

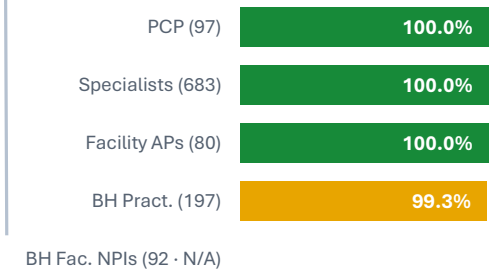
D-SNP Adequacy Summary

Ventura County D-SNP Access Summary



Grouped CMS standards met

Network Counts + Member Access



BH Fac. NPIs (92 · N/A)

Medi-Cal Appointment Access & Availability (2025)

PCPs have the highest rates of compliance for Urgent Care (97.6%) and Urgent Care (prior authorization required) (88.9%).

Specialists have the highest rate of compliance for office wait time (84.4%).

LTSS facilities have a compliance rate of 76.9%.

Q#	Audit Item	PCP				Specialist			
		Total Answering	Total Compliant	Total Non-compliant	Compliance Rate	Total Answering	Total Compliant	Total Non-compliant	Compliance Rate
Q2/Q2B	Urgent Care - Overall Compliance	250	244	6	97.6%	3926	2540	1386	64.7%
Q2_2/Q2_2B	Urgent Care (prior authorization required) - Overall Compliance	253	225	28	88.9%	3379	2297	1082	68.0%
Q3/Q3B	Non-Urgent Appt. - Overall Compliance	258	210	48	81.4%	4081	2301	1780	56.4%
Q6	Routine Care (Physical/Well-Woman Exam/Initial Visit)	207	127	80	61.4%	4056	1992	2064	49.1%
Q7	Preventive Check-Up/Well-Child Exam	242	147	95	60.7%	—	—	—	—
Q7A	Well-Woman Exam (OBGYN)	—	—	—	—	285	136	149	47.7%
Q4	Office Wait Time	253	201	52	79.4%	4081	3446	635	84.4%
Q5	Patient Call Back Time	258	153	105	59.3%	3943	2107	1836	53.4%

Q#	Audit Item	LTSS			
		Total Answering	Total Compliant	Total Non-compliant	Compliance Rate
Q12	LTSS Patient Admission	13	10	3	76.9%

Note: "Total Answering" is the number of providers who answered the question with either a compliant or noncompliant response. "Total Compliant" represents the number of providers who gave a compliant response for the given question. "Total Noncompliant" represents the number of providers who answered in a noncompliant manner. "Compliance Rate" represents the percentage of provider offices that answered in a compliant manner for the given question.

PROVIDER SATISFACTION (2025)

The Provider Satisfaction survey was administered via mail, telephone and internet. Qualified respondents were providers contracted with the plan. A synopsis of the data collection methodology is outlined below:

2025 RESPONSE RATES

Provider type	Sample size	Completed surveys				2025 Response rates	2024 Response rates
		Mail	Phone	Internet	Total		
PCP	75	2	27	2	31	41.3%	17.6%
Specialist	656	83	261	82	426	64.9%	6.0%
Other+	69	0	37	0	37	53.6%	25.0%
Total	**800**	**85**	**325**	**84**	**494**	**61.8%**	**8.8%**

+ Consists of completed surveys from providers classified as an Allied Health Professional, Optometry Provider or Urgent Care Provider.

$$\text{Response Rate} = \frac{\text{Completed surveys}}{\text{Sample size}}$$

Statistical references and notes:

- All statistical testing is performed at the 95% confidence level.
- Percentages less than 10.0% are not shown in graphs where space does not permit.
- Composite benchmarks are not shown for areas in which the plan does not subscribe to the standard measures.
- Totals reported in graphs and tables may not be equal to the sum of the individual components due to the rounding of all figures.
- A caret (^) indicates a base size smaller than 20. Interpret with caution.

PROVIDER SATISFACTION (2025)

Changes from 2024

TRENDING UP

Measures that increased significantly from 2024

- **13A.** Consistency of reimbursement fees with your contract rates
- **13B.** Accuracy of claims processing
- **13C.** Timeliness of claims processing
- **13D.** Resolution of claims payment problems or disputes
- **14F.** Degree to which the plan covers and encourages preventive care and wellness
- **15A.** Number of specialists in this plan's provider network
- **15B.** Quality of specialists in this plan's provider network
- **15C.** Timeliness of feedback/reports from specialists
- **16C.** Helpfulness of plan call center staff in obtaining referrals
- **16D.** Overall satisfaction with health plan's call center service
- **17.** Have a Provider Relations representative assigned to practice
- **17A.** Quality of encounter with a Provider Relations Representative during an in-person site visit
- **17B.** Helpfulness of your assigned Provider Relations Representative
- **18A.** Ease of reaching a Provider Relations representative
- **18B.** Timeliness of feedback from a Provider Relations representative
- **18D.** Provider Relations' facilitation of Joint Operations Meetings
- **18E.** Procedures for obtaining New Provider Orientation information
- **19A.** Overall satisfaction with Provider Relations Department

TRENDING DOWN

Measures that decreased significantly from 2024

None of the measures decreased significantly

Measure Name	2025 Summary Rate Score	2024 PG Medicaid BoB %tile
Willingness to Recommend (%Yes)	89.1%	65th
All Other Plans (Comparative Rating) *(%Well or Somewhat above average)*	46.3%	84th
Overall Satisfaction *(%Completely or Somewhat Satisfied)*	74.4%	64th
Finance Issues *(%Well or Somewhat above average)*	31.9%	51st
Utilization and Quality Management *(%Well or Somewhat above average)*	35.1%	63rd
Network/Coordination of Care *(%Well or Somewhat above average)*	37.3%	81st
Health Plan Call Center Service Staff *(%Well or Somewhat above average)*	37.4%	57th
Provider Relations *(%Well or Somewhat above average)*	55.3%	NA

Net Satisfaction Score: 60.7%

Net Loyalty Score: 64.2%

SatisAction™ KEY DRIVER STATISTICAL MODEL

Key Drivers of Overall Satisfaction with Health Plan

POWER *(Top 4)*

Promote and Leverage Strengths

- **13A** Consistency of reimbursement fees with your contract rates
- **13D** Resolution of claims payment problems or disputes
- **16D** Overall satisfaction with health plan's call center service
- **16C** Helpfulness of plan call center staff in obtaining referrals

OPPORTUNITIES *(Top 4)*

Focus Resources on Improving Processes That Underlie These Items

- **13C** Timeliness of claims processing
- **13B** Accuracy of claims processing
- **16A** Ease of reaching health plan call center staff over the phone
- **18C** Provider Relations representative's ability to provide guidance and education

PNO Accomplishments

- DSNP Launch with full Network Adequacy
- CMS approval of 2026 Triennial Report
- CMS/HSAG Audit – No Findings
- DHCS NAV Audit – No Findings
- Completion of all contracting/compliance needs for successful achievement of NCQA
- Successful development of CalAim (Community Supports and Enhanced Care Management) provider network

PNO 2026 Initiatives

- Finalize 2026 Renewals prior to 1/1/2027
- Continued expansion of DSNP Network to meet DHCS “Overlap” Requirements
- Medical Supply Capitation
- Provider Data Audit and Remediation (Source of Truth System)
- Provider Access & Availability Survey
- Provider Satisfaction Survey
- Required Provider Training (Model of Care)
- Supplemental Vendor Agreements (New and Renewal) for DSNP 2027 benefits
- Provider Visits per DHCS Requirements
- Medicare Plan Finder Directory Requirements

PNO One – Three Year Outlook

- Launch Oversight Model to include ongoing monitoring that aligns with delegated activities, monitoring, SLAs, APLs, regulatory requirements
- Development of new contract templates to incorporate latest regulatory requirements and updated operational/organizational policy/guidelines
- Transition of all current contracted providers to latest template versions through: New Agreements or Amendments
- Transition to single source provider network operations and management system (end-to-end management of all PNO processes from intake – credentialing – contracting – servicing data management – ongoing maintenance)
- Develop key provider partnerships that support DSNP Risk Adjustment and Annual Wellness
- Continued expansion into Value Based Contracting opportunities
- Prepare for NCQA re-accreditation
- Support ongoing GCHP goals based on new initiatives that support growth and financial strength

THANK YOU & QUESTIONS

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AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Lupe González, PhD., MPH, Senior Director of Health Education, Cultural and Linguistic Services

DATE: September 28, 2026

SUBJECT: All Languages Interpreting & Translating Inc., Additional Funds Required

SUMMARY: The Plan is requesting the Commission approve adding additional funds to the existing contract with Lourdes Campbell & Associates dba All Languages Interpreting & Translating Inc.

BACKGROUND/DISCUSSION: All Languages Interpreting & Translating Inc. provides language interpreting and translation services for the Plan. These services include the following:

- Telephonic and in-person interpreting, document translation and virtual interpreting during public meetings.
- Effective communication with deaf, hard of hearing or deaf-blind persons who are covered by section 504 of the Rehabilitation Act, Americans and Disabilities Act and similar state and federal laws requiring the provision of auxiliary aids and services, in-person and by video remote technology.
- Sign Language offered in-person by qualified interpreters.
- Translated documents that are culturally and linguistically appropriate and that meet the readability level of GCHP members.

The current contract with All Languages Interpreting & Translating Inc. was awarded through a competitive Request for Proposal (RFP) process and expires on June 30, 2027. The contract is a non-requirement, (non-committal) fixed price, pricing agreement. Utilization or demand for these services drives the amount of dollars required and the Plan has seen an increase in the usage of these services.

The California Brown Act (Senate Bill707) requires public agencies to provide interpreting services during meetings and translate materials into the threshold language, which is Spanish in Ventura.

FISCAL IMPACT:

The additional amount required through the contract expiration date of June 30, 2027, is $225,000.

Current Approved Amount	Additional Amount Required	Total Required Amount
$715,628.47	$225,000	$940,628.47

RECOMMENDATION:

The Plan is recommending the Ventura County Medi-Cal Managed Care Commission approves the request to add an additional amount of $225,000 to the existing contract and purchase order through the current expiration date of June 30, 2027. The new cumulative amount of the contract is $940,628.47.

If the Commission desires to review this contract, it is available at Gold Coast Health Plan's Finance Department.

AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission

FROM: James Cruz, M.D., Chief Medical Officer
Kim Timmerman, MHA, CPHQ, Executive of Quality Improvement

DATE: September 28, 2026

SUBJECT: Quality Improvement and Health Equity Committee 2026 Third Quarter Report

SUMMARY:

The Department of Health Care Services ("DHCS") requires Gold Coast Health Plan ("GCHP") to implement an effective quality improvement system and to ensure that the governing body routinely receives written progress reports from the Quality Improvement and Health Equity Committee ("QIHEC").

The attached PPT report contains a summary of activities of the QIHEC and its subcommittees.

APPROVAL ITEMS:

- 2025 Quality Improvement and Health Equity Transformation ("QIHET") Program Evaluation

FISCAL IMPACT:

None

RECOMMENDATION:

Staff recommend that the Ventura County Medi-Cal Managed Care Commission approve the 2025 QIHET Program Evaluation as presented and receive and file the complete report as presented.

ATTACHMENTS:

1) Timmerman, K., (2026). Quality Improvement, Ventura County Medi-Cal Managed Care Commission, Quality Improvement and Health Equity Committee 2026 Third Quarter Report, Presentation Slides.

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Quality Improvement and Health Equity Committee Report Q3 2026

September 28, 2026

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

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Q3 2026 Quality Improvement Update

2025 Quality Improvement and Health Equity Transformation (QIHET) Program Evaluation

Approval Requested

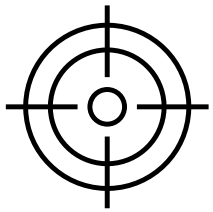
Annual QIHET Program & Work Plan Evaluation: Alignment and Purpose

Return to Agenda

2025 QIHET Program Evaluation Highlights

2025 QIHET Program Initiatives

- Refined EHR integration from major clinic systems accompanied by targeted data audits and discrepancy remediation.
- Hosted quarterly QI Collaboration Meetings and monthly JQPCs/JQOMs for clinical strategy alignment, distributed RISE Grants to enhance care access, and conducted specialized Provider Lunch & Learns on pediatric and behavioral health care.
- Provider and Specialist access and satisfaction surveys
- Advanced key initiatives in health equity through DHCS/IHI pediatric collaborative, child well-care/immunization focus groups, and Diversity, Equity and Inclusion (DEI) training.
- Closed pediatric, maternal, and chronic disease care gaps through telephonic outreach, WIC text-messaging partnership, and a colorectal cancer screening pilot with Exact Sciences.
- Deployed member incentives targeting pediatric and adolescent immunizations, blood lead screenings, diabetes blood glucose management, and women's preventive cervical cancer and breast cancer screenings.
- Collaborated with clinic systems to sponsor health fairs, mobile mammography events, and continued the Wellth digital behavioral economics platform to incentivize healthy habits.



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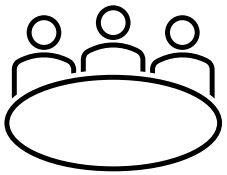
2025 QIHET Program Evaluation Highlights

2025 Committee Structure

- Maintained robust oversight and stakeholder engagement.
- Monitored strategic alignment, evaluated quality improvement metrics, and ensured adherence to regulatory mandates.
- Reviewed MCAS rates, population health outcomes, and updates to quality improvement and health equity programs and cultural/linguistic services.
- Evaluated care management activities, transitional care expansions for post-emergency behavioral health, and pharmacy utilization.



2025 Resources

- Resources for the QIHET Program were comprised of multidisciplinary GCHP staff with leadership from the Chief Medical Officer (CMO).
- The resources dedicated to the QIHET Program effectively supported organizational goals and initiatives.
- Initiated an organization-wide Culture Compass Journey aimed at building a sustainable, resilient workplace that drives GCHP's mission, while advancing goals towards achieving an NCQA 4-Star rating.
- Hired staff to prepare for the new D-SNP product line.

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2025 QIHET Program Evaluation Highlights

2025 Managed Care Accountability Set (MCAS) Measures

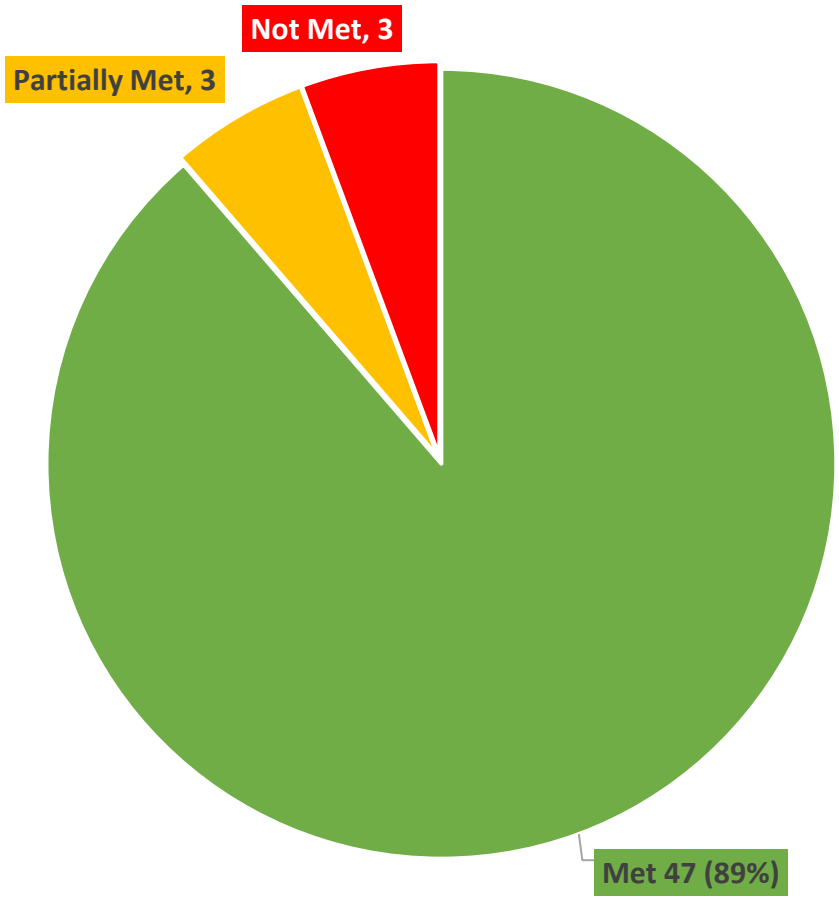
- **Met and exceeded the MPL** on **all 18** performance-driven measures with 17 improving compared to prior year.
- **72% of measures** held to MPL **reached the 75th** National Medicaid percentile or higher (up from 61% in MY 2024) and **four measures met the 90th** National Medicaid percentile.
- **Closed 5,500 additional care gaps** in pediatric care, maternal health, behavioral health follow-up, and chronic disease management.

Intervention Focus

- Data infrastructure and analytics
- Network strategies and provider collaborations
- Clinical and regulatory improvement projects
- Member outreach and engagement
- Member experience

Return to Agenda

2025 QIHET Work Plan Had 53 Strategic Goals



2025 QIHET Work Plan: Goals Met

1. 2025 QIHET Program Description
2. 2025 QIHET Work Plan
3. 2024 QIHET Program Evaluation
4. 2025 CLAS Program and Work Plan
5. 2024 CLAS Program Evaluation
6. 2025 HEDIS® Compliance Audit
7. Population Needs Assessment
8. Wellth Program
9. Health Risk Assessments
10. Clinical Practice Guidelines
11. Complex Care Management
12. Care Management Gap Closures
13. Initial Health Appointments
14. Reduction in Potential Unsafe Opioid Prescriptions
15. Follow-Up After ED for Mental Illness
16. Follow-Up After ED for Substance Use
17. 2024-2025 DHCS/IHI Behavioral Health Collaborative with VCBH
18. 2025-2026 Perinatal Substance Use Collaborative
19. 2023-2026 SUD/SMH PIP
20. Breast Cancer Screening
21. Colorectal Cancer Screening
22. Asthma Medication Ratio
23. 2025 DHCS Asthma Improvement Project
24. Controlling Blood Pressure
25. Glycemic Status Assessment for Diabetes
26. Chlamydia Screening in Women
27. Childhood Immunization Status
28. Immunizations for Adolescents
29. Developmental Screening in Children
30. Topical Fluoride Varnish
31. Child and Adolescent Well-Care Visits
32. 2023-2026 W30-6+ Hispanic/Latinx PIP
33. 2024-2025 DHCS/IHI Well-Child Health Equity
34. 2025-2026 DHCS/IHI Well-Child Health Equity
35. Cultural and Linguistic Needs and Preferences
36. Network Adequacy
37. After Hours Availability Survey
38. Provider Satisfaction Survey
39. Credentialing / Re-Credentialing
40. Facility Site Review Requirements
41. Physical Accessibility Review Surveys
42. Grievances and Appeals
43. Call Center Monitoring
44. CAHPS: Surveys
45. CAHPS: Access to Specialty Care
46. CAHPS: Improvement Projects
47. Delegation Oversight

2025 QIHET Work Plan: Goals Partially Met

1. Tobacco Cessation Counseling and Medication
   - **Met**: Tobacco users receiving cessation medication met the 10.00% goal.
   - **Not met:** Tobacco users receiving cessation counseling decreased by 1.50% (to 40.32%) and **did not meet the 45% goal.**
     - **Analysis:** Number of tobacco user increased by 943 members.
     - **Next steps:** Enhancements to tobacco report and provider education.

2. Prenatal and Postpartum Care (PPC)
   - **Met**: Postpartum care rose 1.46 points (from 92.70 to 94.16) and met the 90th percentile HPL goal.
   - **Not met:** Prenatal care rose 0.24 points (from 90.27 to 90.51) and met the 75th percentile but **missed the 90th percentile HPL goal.**
     - **Analysis:** Gap to 90th percentile was 6 members in the hybrid sample that did not have prenatal care within the first trimester.
     - **Next steps:** Discuss workflow enhancements with providers and coordinating care with CPSP. Developed new early prenatal identification report used by Care Management.

3. Well-Child Visits in the First 30 Months of Life (W30)
   - **Met**: W30-6+ rose 0.51 points (from 68.35% to 68.86%) and met the 75th percentile goal.
   - **Not met:** W30-2+ rose 2.09 points (from 77.72% to 79.81%) and met the 75th percentile but **missed the 90th percentile HPL goal.**
     - **Analysis:** Gap to the 90th percentile was 73 out of 3,130 children who did not complete two well-care exams or timely well-care exams between 15 to 30 months of age.
     - **Next steps:** Support providers with gap closure (QIPP, health fairs, after hour incentives) and coding improvement.

2025 QIHET Work Plan: Goals Not Met

1. Cervical Cancer Screening (CCS)
   - **Not met:** The **CCS rate decreased** 2.61 points (from 65.45% to 62.84%) and **met the 75th** percentile but **did not meet the 90th percentile HPL goal.**
   - **Analysis:** The rate calculation methodology transitioned from a sample-based hybrid measure to an eligible-population based Electronic Clinical Data Systems (ECDS) measure.
   - **Next steps:** Evaluate admin non-adherent members for coding and data deficiencies to institute remediation efforts.

2. Lead Screening in Children
   - **Not met:** The **LSC rate increased 1.27 points** (from 78.14% to 79.41%) and **met the 75th** percentile but **did not meet the 90th percentile HPL goal**.
   - **Analysis:** Gap to 90th percentile was 108 out of 3,128 children who did not receive lead screenings or timely lead screenings prior to their second birthday.
   - **Next steps:** Continue member incentives, promote POC lead screening, and monitoring provider compliance with lead screening requirements. Clinical Quality team to provide support/education to providers.

3. Primary and Specialty Care Access:
   - **Not met:** Primary care and specialist physicians fell short of **appointment availability standards.**
   - **Analysis: Non urgent and urgent access standards for PCPs and specialists were not met**.
   - **Next steps:** Provider Network Operations department implemented targeted provider engagement strategies.

2026 QIHET Program and Work Plan Enhancements and Strategic Focus

2026 QIHET Program Description

D-SNP Integration: Incorporated the new Dual Special Needs Plan product and a dedicated strategic Steering Committee.

Governance Restructuring: Incorporate all product lines (Medi-Cal and DSNP) and quality program oversight.

Equity and Literacy: Enhanced strategies targeting health disparities and communication standards to meet the unique needs of both Medi-Cal and D-SNP populations.

2026 QIHET Medi-Cal Work Plan

Strategic Health Priorities: Continue measure target setting and aspirational goals to advance quality for GCHP members.

Planning for Future State: Utilize forecasting and enhanced data analyses to focus on low performance for quality improvement efforts.

Assess healthcare landscape for upcoming headwinds and develop remediation plans.

Drive Member Retention: Implement strategic initiatives based on member satisfaction outcomes designed specifically to retain members, improve member experience, and maintain continuous engagement.

2026 QI DSNP Work Plan

Strategic Health Priorities: Improve care for Medi-Cal / Medicare Dual-Eligible members to enhance health care delivery.

Enhance Care Coordination & Support: Utilize structured health assessments and care management to actively close care gaps and address social drivers of health like food, housing, and transportation.

Drive Member Satisfaction: Implement strategic initiatives based on member satisfaction outcomes designed to improve member experience and maintain continuous engagement.

Appendix

Objective 1

Improve Quality and Safety of Clinical Care Services

Objective 1: Improve Quality and Safety of Clinical Care Services

(1) 2025 Quality Improvement & Health Equity Transformation (QIHET) Program Description ***Goal: Update the 2025 QIHET Program Description.***	
The 2025 QIHET Program Description was reviewed and approved by the QIHEC on 01/21/25 and Commission on 01/27/25.	Met

(2) 2025 Quality Improvement and Health Equity Transformation Work Plan ***Goal: Update the 2025 QIHET Work Plan.***	
The 2025 QIHET Work Plan was reviewed and approved by the QIHEC on 01/21/25 and Commission on 01/27/25.	Met

(3) 2024 Quality Improvement and Health Equity Program and Work Plan Evaluation ***Goal: Complete the 2024 QIHET Program and Work Evaluation.***	
The 2024 QIHET Program and Work Plan Evaluation was reviewed and approved by the QIHEC on 09/16/25 and Commission on 11/17/25.	Met

Objective 1: Improve Quality and Safety of Clinical Care Services

(4) 2025 Culturally and Linguistically Appropriate Services (CLAS) Program Description and Work Plan ***Goal: Update the 2025 CLAS Program Description and Work Plan.***	
The 2025 CLAS Program Description and Work was reviewed and approved by the QIHEC on May 13, 2025	Met

(5) 2024 Culturally and Linguistically Appropriate Services (CLAS) Program and Work Plan Evaluation ***Goal: Complete the 2024 CLAS Program and Work Plan Evaluation.***	
The 2024 CLAS Program Evaluation was incorporated in the QIHET Program Evaluation that was approved at the QIHEC on 09/15/25.	Met

(6) 2025 HEDIS® Compliance Audit™ ***Goal: Successfully complete and pass the annual HEDIS® Compliance Audit™ and receive "reportable" status for all measures.***	
Successfully passed the annual audit for the 14th consecutive year and received reportable status for all measures.	Met

Objective 1: Improve Quality and Safety of Clinical Care Services

(7) Population Health: Population Needs Assessment (PNA) ***Goal: Maintain NCQA compliant PNA as part of the Population Health Strategy Report submitted to DHCS.***	
Maintained NCQA compliant PNA as part of the Population Health Strategy Report submitted to DHCS. The PNA evaluated member characteristics by stratifying demographic and social determinants of health data by age, race, ethnicity, language, sex, geography, and specific risk factors.	Met

(8) Population Health: Wellth Program ***Goal: Maintain and expand QI focused program with Wellth for full-scope Medi-Cal members who are 18+ years of age, are taking at least one medication and have multiple care gaps for which GCHP is held to the DHCS MPL (50th percentile).***	
The Wellth incentive program increased primary care engagement and reduced inpatient utilization, facilitating a shift toward proactive outpatient care.	Met

(8) Population Health: Risk Assessment ***Goal: Further develop and expand use of the HRA to meet the CalAIM annual requirement.***	
Achieved a 19% completion rate on monthly health risk assessments outreach.	Met

Objective 1: Improve Quality and Safety of Clinical Care Services

(10) Utilization Management: Clinical Practice Guidelines ***Goal: Complete annual review and adoption of evidence-based Preventive Health Guidelines (PHG), including Diabetes and Asthma Clinical Practice Guideline (CPG).***	
Updated PHGs and CPGs and ensured alignment with the Provider Manual and applicable policies.	Met

(11) Care Management: Complex Case Management ***Goal: Maintain and monitor a standardized turn-around-time (TAT) process for members identified as eligible for complex case management per NCQA CCM requirements.***	
Continued updating policies, standardized workflows, staff training, monitoring and evaluating benchmarks to ensure timeliness of complex case management.	Met

(12) Care Management: Care Gap Closure ***Goal: Implement strategies to close care gaps for MCAS measures.***	
Supported gap closure interventions using the MCAS Care Gaps dashboard to inform members about their care gaps and help schedule appointments.	Met

Objective 1: Improve Quality and Safety of Clinical Care Services

(13) Advance Prevention: Tobacco Cessation ***Goal: Increase rate of tobacco cessation interventions in members identified as tobacco users.***	
Provider utilization rates for both tobacco cessation medication and counseling decreased and missed their target goals. The rate of tobacco users receiving cessation medication dropped by 0.49% (to 10.00%), while the rate for those receiving cessation counseling decreased by 1.50% (to 40.32%).	Partially Met

(14) Advance Prevention: Initial Health Appointment (IHA) ***Goal: Increase compliance of Initial Health Appointment (IHA) completion by providers.***	
The Clinical Quality Improvement Department worked on modernizing the Initial IHA tracking by exploring secure data transfer methods and partnering with IT to build a claims-based dashboard.	Met

(15) Pharmacy: Reduction in Potential Unsafe Opioid Prescriptions ***Goal: Monitor member opioid utilization via pharmacy claims from Medi-Cal Rx and monitor for any trends where the utilization exceeds more than a 5% increase from the prior quarter.***	
Overall utilization remained stable meeting the quarterly performance goals for 2025.	Met

Objective 1: Improve Quality and Safety of Clinical Care Services

(16) Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness – 30 Days ***Goal: Increase the FUM-30 rate to meet or exceed the DHCS MPL (50th percentile).***	
The FUM-30 rate decreased -3.39% points from 60.98% in 2024 to 57.59% in 2025 but met the 50th percentile MPL.	Met

(17) Behavioral Health: Follow-Up After Emergency Department Visit for Substance Use – 30 Days ***Goal: Increase the FUA-30 rate to meet or exceed DHCS MPL (50th percentile).***	
The FUA-30 rate increased +5.56% points from 45.81% in 2024 to 51.37% in 2025 and met the 75th percentile goal.	Met

(18) Behavioral Health: 2024-2025 DHCS/IHI Behavioral Health Collaborative with VCBH ***Goal: By June 2025, improved care coordination processes and data exchange will increase the rate of follow-up BH services by 5% for Ventura County Gold Coast Health Plan Medi-Cal beneficiaries with BH-related ED visits.***	
GCHP and VCBH began collaboration to enhance care coordination and delivery processes, GCHP, VCBH, and partners clarified organizational roles, trained specialized staff, and mapped workflows to ensure timely follow-up care and smooth transitions for emergency department members.	Met

Objective 1: Improve Quality and Safety of Clinical Care Services

(19) Behavioral Health: 2025-2026 Perinatal Substance Use CMS Affinity Group ***Goal: Increase referrals of pregnant and post-natal members (up to 1 year post-delivery) with identified substance use treatment needs to ECM by 10% from baseline by December 31st, 2026.***	
Internal and external stakeholders established a formal charter designed to increase enhanced care management referrals for pregnant and postpartum members that included developing a framework for the Plan-Do-Study-Act that will launch in 2026.	Met

(20) Behavioral Health: 2023-2026 PIP Non-Clinical Topic: Percentage of Provider Notifications for Members with SUD/SMH Diagnoses within 7 Days of an ED Visit ***Goal: Improve the percentage of provider notifications for members with substance use disorder (SUD) and / or specialty mental health (SMH) diagnoses following or within 7 days of emergency department (ED) visit.***	
The rate of weekly notifications sent to providers within 7 days of a member's ED visit for an SUD or SMH condition increased from 41.89% in 2024 to 71.88% in 2025 resulting in a 29.99% improvement. Data enhancements included expanding FUA/FUM Emergency Department (ED) encounter surveillance through claims data integration, capturing visits from previously inaccessible locations and increasing weekly provider notifications by 250% from an average of 24 to 84 per week.	Met

Objective 1: Improve Quality and Safety of Clinical Care Services

(21) Cancer Prevention: Breast Cancer Screening (BCS-E) ***Goal: Increase the percentage of women 50-74 years of age who had a mammogram to meet or exceed the DHCS HPL (90th percentile).***	
The BCS-E rate increased 1.25% points from 66.50% in 2024 to 67.75% in 2025 and met the 90th percentile goal.	Met

(22) Cancer Prevention: Cervical Cancer Screening (CCS-E) ***Goal: Increase percentage of women 21-64 years of age who were screened for cervical cancer to meet or exceed the DHCS HPL (90th percentile).***	
The CCS-E rate decreased 2.61% points from 65.45% in 2024 to 62.84% in 2025 and met the 75th percentile but did not meet the 90th percentile goal. This decline was attributed to changes in the methodology for calculating the CCS-E rate which transitioned from a sample-based hybrid measure to an Electronic Clinical Data Systems (ECDS) measure starting in MY 2025.	Not Met

(23) Cancer Prevention: Colorectal Cancer Screening (COL-E) ***Goal: Increase the percentage of members 45 to 75 years of age who had an appropriate screening for colorectal cancer screening.***	
The COL-E rate increased +8.74% points from 33.75% in 2024 to 42.49% in 2025.	Met

Objective 1: Improve Quality and Safety of Clinical Care Services

(24) Chronic Disease Management: Asthma Medication Ratio (AMR) ***Goal: Increase the MY 2025 AMR rate for members, 5 to 64 years of age, who had persistent asthma and had a ≥ 0.50 ratio of controller medications to total asthma medications to meet or exceed the DHCS MPL (50th percentile).***	
The AMR rate increased 14.39% points from 57.93% in 2024 to 72.32% in 2025 and met the 75th percentile, exceeding the 50th percentile goal.	Met

(25) Chronic Disease Management: 2025 DHCS Lean Quality Improvement and Health Equity Improvement Project ***Goal: Implement multi-disciplinary continuous quality improvement activities to improve the Asthma Medication Ratio.***	
Implemented five provider, member and data-driven interventions and met goals to improve the AMR rate.	Met

(26) Chronic Disease Management: Health Equity Controlling Blood Pressure (CBP) ***Goal: Increase the CBP rate for members 21-44 years of age to meet or exceed the DHCS MPL (50th percentile).***	
The CBP rate increased 2.19% points from 66.67% in 2024 to 68.86% in 2025 and met the MPL.	Met

Objective 1: Improve Quality and Safety of Clinical Care Services

(27) Chronic Disease Management: Glycemic Status Assessment for Patients with Diabetes (>9.0%) (GSD) ***Goal: Decrease the percentage of members with diabetes who are 18-75 years of age and have GSD > 9.0% to meet the DHCS HPL (90th percentile).***	
The GSD > 9.0% rate decreased 2.92% points from 25.79% in 2024 to 22.87% in 2025 and met the HPL. A lower rate indicates better performance.	Met

(28) Women's Health: Chlamydia Screening in Women (CHL) ***Goal: Increase the rate of chlamydia screening in members 16 to 24 years of age to meet or exceed the 75th national Medicaid percentile established by NCQA.***	
The CHL rate increased 3.72% points from 64.59% in 2024 to 68.31% in 2025 and met the 75th percentile.	Met

(29) Women's Health: Prenatal and Postpartum Care ***Goal: Increase the percentage of women with live birth deliveries who completed prenatal and postpartum exams to meet or exceed the DHCS HPL (90th percentile).***	
The PPC-Pre rate increased 0.24% points from 90.27% in 2024 to 90.51% in 2025 and met the 75th percentile but did not meet the 90th percentile HPL goal. The PPC- Post rate increased 1.46% points from 92.70% in 2024 to 94.16% in 2025 and met the 90th percentile.	Partially Met

Objective 1: Improve Quality and Safety of Clinical Care Services

(30) Children's Health: Childhood Immunization Status – Combo 10 (CIS-10-E) ***Goal: Increase the percentage of members, two- years of age, who completed all Combo-10 immunizations by their 2nd birthday to exceed the 75th national Medicaid percentile established by NCQA.***	
The CIS-10 rate increase 2.33% points from 29.93% in 2024 to 32.26% in 2025 and met the 75th percentile goal.	Met

(31) Children's Health: Immunizations for Adolescents – Combo 2 (IMA-2-E) ***Goal: Increase the percentage of adolescents who completed all IMA-2 immunizations by their 13th birthday to meet or exceed the 75th national Medicaid percentile established by NCQA.***	
The IMA-2 rate increased 6.22% points from 45.11% in 2024 to 51.33% in 2025 and met the 90th percentile, exceeding the 75th percentile goal.	Met

(32) Children's Health: Developmental Screening in the First Three Years of Life (DEV) ***Goal: Increase the DEV rate by 3% compared to the prior measurement year.***	
The DEV rate increased 9.84% points from 55.93% in 2024 to 66.77% in 2025 and met the MPL.	Met

(33) Children's Health: Lead Screening in Children (LSC) ***Goal: Increase the percentage of children who had one or more capillary or venous blood lead tests for lead poisoning by their 2nd birthday to meet or exceed the DHCS HPL (90th percentile).***	
The LSC rate increased 1.27% points from 78.14% in 2024 to 79.41% in 2025 and met the 75th percentile but did not meet the 90th percentile goal.	Not Met

Objective 1: Improve Quality and Safety of Clinical Care Services

(34) Children's Health: Topical Fluoride Varnish (TFL) ***Goal: Increase the percentage of members, ages 1 through 20, who received at least two topical fluoride applications during the measurement year to meet or exceed the DHCS MPL (50th).***	
The TFL rate increased 3.83% points from 32.99% in 2024 to 36.82% in 2025 and met the DHCS MPL.	Met

(35) Children's Health: Well-Child Visits in the First 30 Months of Life (W30) ***Goal: Increase the W30-6+ rate to meet the 50th percentile and increase the W30-2+ rate to meet the 75th percentile.***	
The W30-6+ rate increased 0.51% points from 68.35% in 2024 to 68.86% in 2025 and met the 75th percentile. The W30-2+ rate increased 2.09% points from 77.72% in 2024 to 79.81% in 2025 and met the 75th percentile but did not meet the 90th percentile goal.	Partially Met

(36) Children's Health: Child and Adolescent Well-Care Visits (WCV) ***Goal: Increase the MY 2024 WCV rate to meet or exceed the DHCS MPL (50th percentile).***	
The WCV rate increased 2.42% points from 55.44% in 2024 to 57.86% in 2025 and met the DHCS MPL.	Met

Objective 1: Improve Quality and Safety of Clinical Care Services

(37) Children's Health: 2023-2026 PIP Clinical Topic: W30-6+ among Hispanic/Latinx Members ***Goal: Submit Modules as directed by DHCS/HSAG for approval.***	
GCHP expanded partnerships with clinics and community organizations—including MICOP, First Five, and Carenet—to educate members on well-child visits, resulting in a nearly 10 percentage point compliance increase for the Latin/Hispanic population over three years.	Met

(38) Children's Health: 2024-2025 DHCS/IHI Well-Child Health Equity Project ***Goal: Increase the number of well-child visits completed by members assigned to CDCR KRB clinic, who are English speaking and between 12 and 17 years of age.***	
By partnering with local organizations like the Boys and Girls Clubs and Oxnard Pals to host educational workshops, Gold Coast Health Plan (GCHP) successfully served as a bridge between clinics and the community, ultimately exceeding its goal to increase adolescent well-child visits to 43.22%.	Met

(39) Children's Health: 2024-2025 DHCS/IHI Well-Child Health Equity Project ***Goal: Partner with two clinics to improve well-baby visits.***	
GCHP is partnering with two clinics to implement three structured scheduling and resource-connection interventions.	Met

Objective 2

Improve Quality and Safety of Non-Clinical Care Services

Objective 2: Improve Quality and Safety of Non-Clinical Care Services

(40) Cultural and Linguistic Needs & Preferences ***Goal: Expand training modules to include DHCS-compliant DEI curriculum and deliver these trainings to GCHP staff and at least three Network Provider offices.***	
The HECL department successfully developed and piloted its state-approved 2025 DEI Curriculum and Training Plan by structuring it around key cultural themes and collaborating with internal and external stakeholders to meet DHCS requirements.	Met

(41) Primary and Specialty Care Access ***Goal: Ensure primary and specialty care standards are met for minimum of 80% of providers.***	
Primary care and specialist physicians fell short of appointment availability standards, prompting the Provider Network Operations department to implement targeted provider engagement strategies.	Not Met

(42) Network Adequacy ***Goal: Assess and improve network adequacy as demonstrated by availability of practitioners.***	
Network adequacy time and distance standards were met.	Met

(43) After Hours Availability ***Goal: Conduct surveys to ensure members can reach a provider after hours.***	
After-hours surveys were completed. Network Operations provided outreach and education to providers that did not meet standards.	Met

Objective 2: Improve Quality and Safety of Non-Clinical Care Services

(44) Provider Satisfaction ***Goal: Field provider survey and develop action plan(s) to improve areas of low performance.***	
Provider satisfaction surveys completed and addressed provider feedback and concerns. Providers reported timely access challenges driven by staffing shortages, salary demands, capacity limits, and rising in-person appointment volumes	Met

(45) Credentialing/Recredentialing ***Goal: Maintain a well-defined credentialing and recredentialing process for evaluating practitioners / providers to provide care to members.***	
All credentialing and re-credentialing standards were met 100% and supported by Symplr system optimizations to improve efficiency, reporting, and compliance tracking.	Met

(46) Facility Site Review Requirements ***Goal: Maintain 100% compliance with Facility Site Review (FSR) requirements.***	
Completed and documented the initial, interim, and tri-annual Facility Site Reviews timely.	Met

(47) Physical Accessibility Review Surveys (PARS) ***Goal: Complete Physical Accessibility Reviews (PARs) 100% on time.***	
Completed PARS for the initial, interim, and tri-annual Facility Site Reviews timely	Met

Objective 3

Improve Quality of Services

Objective 3: Improve Quality of Services

(48) Grievances and Appeals ***Goal: Monitor all member grievances and appeals to review for trending issues that will be communicated to various departments to develop action plans to improve the member experience.***	
Quality of care was the most common grievance, especially in Outpatient Physical Health, followed by transportation and inpatient services, which led to interventions focused on tracking trends and creating improvement plans.	Met

(49) Call Center Monitoring **Goal:** ***Meet call center benchmarks to ensure members have timely access to call center staff and implement interventions on any deficient benchmarks. (1) ASA: 30 seconds or less; (2) Abandonment Rate: 5% or less; (3) Phone Quality Results: ≥ 95%.***	
The Contact Center successfully met its operational and phone quality targets by Q4 through key interventions, including staffing adjustments, intensive coaching, and migrating to the Genesys CX Cloud application.	Met

Objective 4

Assess and Improve Member Experience

Objective 4: Assess and Improve Member Experience

(50) CAHPS: Surveys ***Goal: Coordinate with DHCS and HSAG to complete the Adult and Child CAHPS member surveys to monitor and improve CAHPS scores.***	
The Adult and Child CAHPS surveys were completed, and result were analyzed and compared against historical performance and national benchmarks to isolate statistical shifts and identify localized areas of improvement and decline.	Met

(51) CAHPS: Access to specialty care ***Goal: Improve access to specialty care for adults and children.***	
To improve specialty care access, a strategic plan targeted provider recruitment in rural shortage areas like Ojai, Fillmore, and Santa Paula while boosting retention through flexible contracts and streamlined clinic workflows.	Met

(52) CAHPS: Getting Care Quickly and Getting Needed Care ***Goal: Improve CAHPS Scores based on MY 2024 CAHPS outcomes.***	
In 2025, the Member Advisory Committee (MAC) and Consumer Advisory Committee (CAC) met quarterly to improve member experience, health equity, and CAHPS scores by focusing on language access, including Mixteco speaker, preventive care, communication strategies, and Medi-Cal policy updates.	Met

Objective 5

Ensure Organizational Oversight of Delegated Activities

Objective 5: Ensure Organizational Oversight of Delegated Activities

(53) Delegation Oversight ***Goal: 100% of all audits completed with corrective action plans (CAPs) closed timely.***	
The Compliance Department's Delegation Oversight Audit team successfully completed 100% of their 2025 scheduled audits on time across ten key functional areas and implemented a standardized, end-to-end lifecycle process that improved efficiency, quality, and corrective action tracking.	Met

Questions?

Recommendation:

Approve the 2025 QIHET Program Evaluation

Thank you

Gold Coast Health Plan℠
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AGENDA ITEM NO. 13

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Suma Simcoe, Chief Operating Officer

DATE: September 28, 2026

SUBJECT: Contract Approval – ClarisHealth, Inc., Claims Payment Integrity Services

Executive Summary

With this request, GCHP staff are asking that the Commission award a competitively bid contract for Claims Payment Integrity Services that will deliver claims processing efficiencies with an enhanced provider and member experience.

BACKGROUND/DISCUSSION

Procurement, together with Operations, initiated a Request For Proposal (RFP) for Payment Integrity Services. Payment Integrity services examine provider claims (those not excluded by the terms of the Provider agreement) for accuracy and completeness, and when appropriate and supported by data and regulation either edit the claim (pre-payment), send it for clinical review (pre-payment and post payment) or seek recovery (post payment). The scope of services for this contract includes:

- Second Pass Front End Pre-Pay Editing
- Post Pay Data Mining
- Pre-Pay and Post Pay Clinical Auditing including but not limited to DRG, Readmission, High Dollar Review, Itemized Bill Review, etc.

Procurement Background

On May 1, 2026, Procurement issued a Request For Proposal, (RFP) for Payment Integrity services to the following nine vendors:

Advice	ClarisHealth
Cotiviti	HMS Gainwell
Lyric.ai	Nokomis
Zelis	

The RFP was also posted on GCHP's website; DRG Claims, Gynisus and HealthEdge submitted proposals based on the posting. Set forth below is the schedule utilized for the RFP. DRG dropped from the RFP process before submissions were due.

Event	Date
RFP Released	5/1/2026
Intent to Propose Notification Due By	5/6/2026
Questions Due	5/14/2026
Questions Answered	6/5/2026
Proposal Due Date	6/29/2026
Short List Established and Contractual Discussions Begin	7/17/2026

GCHP received nine responsive proposals. A cross functional evaluation team comprised of representation from Operations, Finance, Compliance, IT, Procurement and Legal evaluated the proposals, using predetermined evaluation criteria and weights. The team scored each proposal; the scores were tabulated and summarized based on independent review of each vendor's responses to the RFP's qualitative and quantitative requirements.

The scoring results from the evaluation team using the GCHP's Evaluation Matrix is as follows:

Evaluation Matrix Scores (High to Low):

Rank	Vendor	Score
1	GYNISUS	62.62
2	CLARISHEALTH	56.53
3	COTIVITI	56.36
4	HEALTHEDGE	53.77
5	ZELIS	53.34
6	NOKOMIS	53.10
7	ADVICE	52.75
8	HMS GAINWELL	52.00
9	LYRIC.AI	48.53

The short list was established to include Gynisus, ClarisHealth and Cotiviti. The team then requested scripted presentations from each of the short-listed vendors. Each vendor presented for two hours on Tuesday and Wednesday, July 28th, and July 29th. At the conclusion of the presentations, Gynisus was eliminated as the team determined that they could not provide critical elements of the solution.

Reference calls were held in August with CenCal, Maryland's Physicians Health and CalOptima (Cotiviti) and Inland Empire Health Services, Kern Family Health Care and LA Care (ClarisHealth). After a thorough analysis of both internal and external capabilities, and ability to timely meet critical path milestones, the team decided that ClarisHealth was the preferred solution.

Contract Negotiations

The RFP requested each vendor to review and redline GCHP's standard form master agreements. Gynisus, ClarisHealth and Cotiviti all provided minimal contractual changes with their Proposals. Cotiviti, a current vendor of GCHP, had an existing Master Services Agreement and Business Associate Agreement. ClarisHealth required negotiations of the Master Services Agreement, the Business Associate Agreement, and the applicable Statement of Works. Cotiviti only required the SOW's

negotiations but negotiations were slower than expected than ClarisHealth. Negotiations were finalized with ClarisHealth at the end of August.

Pricing

As requested in the RFP, ClarisHealth and Cotiviti both submitted contingency-based pricing for the services. ClarisHealth's pricing is as follows:

Table 1: Contingent Fees Charged Against Savings

Service Area	CLARISHEALTH	COTIVITI
1ST PASS PRE-PAY DATA MINING	15%	19.50%
2ND PASS PRE-PAY	16%	23.36%
CLINICAL AUDIT AND REVIEW	20%	22.93%

ClarisHealth rates are market competitive for these services.

ClarisHealth's Overall Value and Reason for Recommendation

GCHP staff is recommending the contract be awarded to ClarisHealth for the following reasons:

- Ability to provide all necessary services;
- Technology – Pareo Software – Provides the technology needed to build a hybrid insource/outsource operating model in the future
- Speed to market – Implementation timeline more favorable;
- Pricing advantage;

FISCAL IMPACT:

This competitive procurement has a gain-sharing price structure where recoveries are shared based on a percentage basis. The total projected recovery amount is $69.7M, with $12.2M of shared fees, a net positive amount to GCHP of $57.5M. The projected financial detail of the three-year contract is below:

		2026	2027		2028		2029		TOTALS	
	Percent Of Recovery		Projected Recovery Amount	Year One Projected Vendor Fee	Projected Recovery Amount	Year Two Projected Vendor Fee	Projected Recovery Amount	Year Three Projected Vendor Fee	Projected Recovery Amount	Total Projected Vendor Fee
IMPLEMENTATION		$125,000								$125,000
1ST PASS PRE-PAY DATA MINING	15%		$2,677,500	$401,625	$2,811,375	$421,706	$3,443,934	$516,590	$8,932,809	$1,339,921
2ND PASS PRE-PAY	16%		$8,925,000	$1,428,000	$11,714,063	$1,874,250	$14,759,719	$2,361,555	$35,398,782	$5,663,805
CLINICAL AUDIT AND REVIEW	20%		$7,140,000	$1,428,000	$8,434,125	$1,686,825	$9,839,813	$1,967,963	$25,413,938	$5,082,788
		$125,000	**$18,742,500**	**$3,257,625**	**$22,959,563**	**$3,982,781**	**$28,043,466**	**$4,846,108**	**$69,745,529**	**$12,211,514**

RECOMMENDATION:

It is the Plan's recommendation that the Commission authorize the Procurement Director to execute a contract with ClarisHealth, Inc. The term of the contract will be three years commencing October 1, 2026, and expiring on September 30, 2029, for an amount not to exceed $13M.

If the Commission desires to review this contract, it is available at Gold Coast Health Plan's Finance Department.

AGENDA ITEM NO. 14

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Christopher Lee, Chief Financial Officer

DATE: September 28, 2026

SUBJECT: August 2026 Year to Date Financial Results

SUMMARY:

Staff is presenting the attached August 2026 year-to-date ("YTD") unaudited financial statements of Gold Coast Health Plan ("GCHP").

ATTACHMENT:

August 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 August 2026				Fiscal Year to Date Through August 2026			
	ACTUALS	BUDGET	Fav/(Unfav)		ACTUALS	BUDGET	Fav/(Unfav)	
Membership	222,549	227,296	(4,747)	-2.1%	1,826,483	1,844,160	(17,677)	-1.0%
Revenue								
Premium	$ 139,894,928	$ 137,262,216	$ 2,632,712	1.9%	$ 1,119,405,590	$ 1,112,765,505	$ 6,640,085	0.6%
Facility Expense AB85			-			-	-	
Reserve for Cap Requirements	-	(240,301)	240,301	100.0%	-	(1,958,714)	1,958,714	100.0%
Incentive Revenue	-	-	-		-	-	-	
MCO Premium Tax	(33,251,616)	(33,847,183)	595,567	1.8%	(273,027,577)	(275,021,918)	1,994,341	0.7%
Total Net Premium	**106,643,313**	**103,174,732**	**3,468,580**	**3.4%**	**846,378,013**	**835,784,872**	**10,593,141**	**1.3%**
						-		
Other Revenue:								
Miscellaneous Income	701,982	-	701,982		(1,278,147)	-	(1,278,147)	
Total Other Revenue	701,982	-	701,982		(1,278,147)	-	(1,278,147)	
Total Revenue	**107,345,294**	**103,174,732**	**4,170,562**	**4.0%**	**845,099,865**	**835,784,872**	**9,314,993**	**1.1%**
Medical Benefits:								
Capitation:								
PCP, Specialty, Kaiser, NEMT & Vision	2,307,502	4,366,040	2,058,538	47.1%	20,702,081	35,707,235	15,005,154	42.0%
ECM	2,747,491	1,041,518	(1,705,974)	-163.8%	16,241,595	8,469,511	(7,772,085)	-91.8%
Total Capitation	**5,054,993**	**5,407,558**	**352,565**	**6.5%**	**36,943,677**	44,176,746	**7,233,069**	**16.4%**
FFS Claims:								
Inpatient	14,722,701	20,041,125	5,318,424	26.5%	151,194,397	159,668,154	8,473,757	5.3%
LTC / SNF	16,678,245	17,006,185	327,941	1.9%	123,307,624	134,683,985	11,376,361	8.4%
Outpatient	9,449,606	9,890,244	440,638	4.5%	73,804,262	77,997,187	4,192,924	5.4%
Laboratory and Radiology	1,621,324	831,289	(790,035)	-95.0%	11,723,539	6,822,103	(4,901,435)	-71.8%
Directed Payments - Provider	770,614	803,785	33,171	4.1%	6,445,532	6,480,325	34,793	0.5%
Emergency Room	4,322,252	4,492,271	170,019	3.8%	35,669,750	35,242,457	(427,293)	-1.2%
Physician Specialty	10,104,688	7,195,020	(2,909,669)	-40.4%	77,171,479	58,175,274	(18,996,206)	-32.7%
Primary Care Physician	5,830,134	7,401,890	1,571,756	21.2%	46,163,873	59,222,149	13,058,276	22.0%
Home & Community Based Services	3,241,394	4,682,778	1,441,384	30.8%	23,014,119	36,893,858	13,879,739	37.6%
Medically Supportive Food	1,080,828	-	(1,080,828)		12,871,860	-	(12,871,860)	
Applied Behavior Analysis Services	6,608,811	5,653,497	(955,315)	-16.9%	48,786,594	43,991,920	(4,794,674)	-10.9%
Pharmacy	969,207	282,002	(687,205)	-243.7%	2,748,953	1,462,445	(1,286,508)	-88.0%
Quality Incentive Provider Program (QIPP)	6,285,054	3,244,430	*(3,040,624)*	*-93.7%*	**29,851,056**	25,933,769	(3,917,287)	*-15.1%*
Other Medical Professional	912,791	1,820,247	907,456	49.9%	6,305,006	14,657,286	8,352,281	57.0%
Other Fee For Service	3,329,806	1,995,257	(1,334,549)	-66.9%	16,329,724	16,008,097	(321,627)	-2.0%
Settlements - Medical	-	-	-		1,112,041	-	(1,112,041)	
Transportation	1,858,017	491,568	(1,366,449)	-278%	12,389,382	3,946,708	(8,442,675)	-214%
Total Claims	**87,785,473**	**85,831,588**	**(1,953,885)**	**-2.3%**	**678,889,192**	**681,185,717**	**2,296,526**	**0.3%**
Provider Grant Program	625,938	58,020	(567,919)	-979%	**6,597,505**	5,616,972	(980,533)	-17%
Medical & Care Management	2,250,008	1,910,976	(339,032)	-18%	20,210,823	15,517,056	(4,693,766)	-30%
Reinsurance	374,678	298,627	(76,051)	-25%	145,651	2,437,155	2,291,504	94%
Claims Recoveries	1,278,746	(158,333)	(1,437,079)	908%	2,568,941	(1,266,667)	(3,835,607)	303%
Sub-total	**4,529,370**	**2,109,289**	**(2,420,081)**	**-115%**	**29,522,919**	**22,304,516**	**(7,218,403)**	**-32%**
Total Medical Benefits	97,369,836	93,348,435	(4,021,401)	-4.3%	745,355,788	747,666,980	2,311,192	0.3%
Contribution Margin	**9,975,458**	**9,826,297**	**149,161**	**1.5%**	**99,744,077**	**88,117,892**	**11,626,185**	**13.2%**
General & Administrative Expenses:								
Salaries, Wages & Employee Benefits	5,923,000	7,060,493	1,137,493	16%	53,164,501	56,483,948	3,319,447	6%
Training, Conference & Travel	28,998	52,500	23,502	45%	392,446	420,000	27,554	7%
Outside Services	2,091,468	2,470,733	379,265	15%	17,727,007	19,765,863	2,038,857	10%
Professional Services	745,217	1,406,687	661,470	47%	7,500,459	11,253,500	3,753,041	33%
Occupancy, Supplies, Insurance & Others	3,124,955	2,754,097	(370,858)	-13%	24,326,765	22,032,777	(2,293,987)	-10%
ARCH/Community Grants	16,667	183,975	167,308	91%	223,794	1,471,797	1,248,003	85%
Sponsorships	1,000	61,325	60,325	98%	43,500	490,599	447,099	91%
Care Management Reclass to Medical	(2,250,008)	(1,910,976)	339,032	18%	(20,210,823)	(15,517,056)	4,693,766	30%
G&A Expenses	**9,681,297**	**12,078,835**	**2,397,538**	20%	**83,167,648**	**96,401,428**	**13,233,780**	**14%**
D-SNP	38,732	-	(38,732)		3,180,759	-	(3,180,759)	
Project Portfolio	**38,732**	**-**	**(38,732)**		**3,180,759**	**-**	**(3,180,759)**	
Total G&A Expenses	**9,720,029**	**12,078,835**	**2,358,806**	**20%**	**86,348,407**	**96,401,428**	10,053,020	10%
Total Operating Gain / (Loss)	**255,429**	**(2,252,537)**	**2,507,966**	111%	**13,395,670**	**(8,283,536)**	**21,679,206**	**261.7%**
Retro Premium Adj	-	-	-		-	-	-	
Non Operating								
Revenues - Interest	1,145,329	1,000,000	145,329	14.5%	7,501,467	8,000,000	(498,533)	-6%
Expenses - Interest		-	-			-	-	
Gain/(Loss) on Sale of Asset	-	-			-			
Total Non-Operating	**1,145,329**	**1,000,000**	145,329	14.5%	**7,501,467**	**8,000,000**	(498,533)	-6%
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 1,400,758**	**$ (1,252,537)**	**$ 2,653,295**	**212%**	**$ 20,897,137**	**$ (283,536)**	**$ 21,180,673**	**7470%**

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STATEMENT OF FINANCIAL POSITION		
	As of Month Ending, August 2026	As of Month Ending, December 2025
ASSETS		
Current Assets:		
Total Cash and Cash Equivalents	**$ 214,557,979**	**$ 294,296,392**
Total Short-Term Investments	**109,498,280**	**106,685,365**
Medi-Cal Receivable	166,866,249	156,518,148
Interest Receivable	636,299	808,060
Provider Receivable	38,004,522	13,571,218
Other Receivables	12,295,381	8,823,232
Total Accounts Receivable	**217,802,451**	**179,720,658**
Total Prepaid Accounts	11,668,821	8,959,028
Total Other Current Assets	752,180	320,402
Total Current Assets	**554,279,711**	**589,981,845**
Total Fixed Assets	**73,138,672**	**66,277,453**
Total Assets	**$ 627,418,383**	**$ 656,259,298**
LIABILITIES & NET ASSETS		
Current Liabilities:		
Incurred But Not Reported	$ 138,933,637	$ 131,690,924
Claims Payable	8,643,855	7,252,812
Capitation Payable	5,615,687	8,073,833
Physician Payable	14,992,192	11,519,669
DHCS - Reserve for Capitation Recoup	24,594,510	53,643,320
Lease Payable- ROU	6,414,170	7,376,788
Accounts Payable	3,527,024	(50)
Accrued ACS	799,594	407,101
Accrued Provider Incentives/Reserve	16,269,487	18,558,113
Accrued Expenses	8,620,239	25,109,373
Accrued Premium Tax	72,417,960	106,146,397
Accrued Payroll Expense	23,882,816	10,929,318
Quality Withhold	4,665,731	5,482,802
Total Current Liabilities	**330,424,845**	**386,618,131**
Long-Term Liabilities:		
Lease Payable - NonCurrent - ROU	29,685,991	23,230,757
Total Long-Term Liabilities	**29,685,991**	**23,230,757**
Total Liabilities	**360,110,836**	**409,848,888**
Net Assets:		
Beginning Net Assets	246,410,410	225,513,273
Total Increase / (Decrease in Unrestricted Net Assets)	20,897,137	20,897,137
Total Net Assets	**267,307,547**	**246,410,410**
Total Liabilities & Net Assets	**$ 627,418,383**	**$ 656,259,298**

Cash and Short Term Investments	$	324,056,259
Less: MCO Tax Liability	$	(72,417,960)
Less: Directed Payments Liability	$	(14,992,192)
Less: Payable to State	$	(24,594,510)
Available Cash on Hand	$	212,051,597
Operating Expense		107,089,865
Non Cash Expenses		
Depreciation & Amortization Expense		1,254,590
Average Daily Opex	$	3,414,041
Days Cash on Hand		**62**

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STATEMENT OF CASH FLOWS		
	For the Month Ended August 2026	Fiscal Year to Date Through August 2026
Cash Flows Provided By Operating Activities		
Net Income (Loss)	$ 1,400,758	$ 20,897,137
Adjustments to reconciled net income to net cash provided by operating activities		
Depreciation on fixed assets	1,301,851	2,778,508
Disposal of fixed assets	-	-
Amortization of discounts and premium	-	-
Changes in Operating Assets and Liabilities		
Accounts Receivable	(849,888)	(38,081,794)
Prepaid Expenses	414,952	(3,109,792)
Accrued Expense and Accounts Payable	(25,860,440)	(32,967,194)
Current Portion of Deferred Revenue	(1,263,328)	-
Claims Payable	4,350,619	2,405,421
MCO Tax liability	33,251,616	(33,728,438)
IBNR	9,612,514	7,242,713
Net Cash Provided by (Used in) Operating Activities	**22,358,654**	**(74,563,439)**
Cash Flow Provided By Investing Activities		
Proceeds from Restricted Cash & Other Assets		
Proceeds from Investments	(189,610)	(2,812,916)
Proceeds for Sales of Property, Plant and Equipment		
Payments for Restricted Cash and Other Assets		
Purchase of Investments plus Interest reinvested		
Purchase of Property and Equipment	(680,065)	(9,671,505)
Net Cash (Used In) Provided by Investing Activities	**(869,675)**	**(12,484,421)**
Cash Flow Provided By Financing Activities		
Lease Payable - ROU	33,416	7,309,401
Net Cash Used In Financing Activities	**33,416**	**7,309,401**
Increase/(Decrease) in Cash and Cash Equivalents	21,522,395	(79,738,459)
Cash and Cash Equivalents, Beginning of Period	193,035,584	294,296,437
Cash and Cash Equivalents, End of Period	**214,557,979**	**$ 214,557,979**

SCHEDULE OF INVESTMENTS AND CASH BALANCES

		Market Value as of Month Ending, August 2026	Account Type
Local Agency Investment Fund (LAIF)	$	48,030,964	Short-term investment
Ventura County Investment Pool	$	20,558,506	Short-term investment
CalTrust	$	40,908,810	Short-term investment
Bank of Montreal	$	161,476,951	Money market account
Columbia Bank	$	53,081,028	Operating accounts
Investments and monies held by GCHP	***$***	***324,056,259***	

Gold Coast Health Plan℠
A Public Entity

August 2026 YTD Results

Ventura County Medi-Cal Managed Care Commission
September 28, 2026

Christopher Lee, Chief Financial Officer

Integrity
Accountability
Collaboration
Trust
Respect

August enrollment trends suggest membership attrition may be moderating, while the adjusted MLR is projected at 86.8%, or 1.1 percentage points above the 85.7% budget due to higher-than-expected claims experience.

Membership: After averaging approximately 1.9k membership losses per month through July, August enrollment declined by fewer than 1k members, suggesting membership attrition may be moderating.

MLR: Adjusted for the unexpected prior-year claims and revenue impacts, the MLR is projected to be 86.8%, 1.1% above budget of 85.7%, reflecting higher-than-expected claims experience.

Revenue: Revenues are $9.3M favorable to budget, driven by **2024** UIS Risk Corridor reconciliation $2.4M, **2025** UIS Risk Corridor reserve adjustment $5.5M, **2025** Quality Premium Withhold reserve release $2.8M, and **2026** favorable member mix $6.6M, partially offset by unfavorable membership volume ($8.0M).

Medical Expenses: Medical expenses are $7.2M favorable to budget, reflecting the favorable impact of a $15.4M prior-year IBNP release, partially offset by elevated claims experience of ($8.7M).

Administrative Expenses: Administrative expenses are $10.1M, or 1.3% favorable to budget, with an ALR of 10.2%, driven by lower spending on consulting services $3.8M, labor costs due to the hiring freeze $3.3M, community grants and sponsorships $1.6M, and other administrative cost reductions $4.7M offset by ($3.3M) of prior-year expenses. These reductions reflect management actions taken in preparation for the anticipated UIS and SIS membership declines in 2027 and the corresponding need to align administrative spending with a smaller membership base.

Tangible Net Equity (TNE): TNE is 557% of the State requirement and remains within the Commission's target range.

Note: The financial results presented are unaudited, preliminary, and subject to restatement.

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August YTD Net Income is $21.2M favorable to budget; excluding $22.9M of prior-year claims and revenue adjustments, adjusted Net Income is ($1.7M) unfavorable, driven by higher claims costs and lower membership volume, partially offset by favorable member mix, lower administrative expenses, and increased spending on Quality Strategy Initiatives.

($Millions)	Actual	Budget	Fav/ (Unfav)
Ending Membership	222,549	227,296	(4,747)
Revenue	$845.1M	$835.8M	$9.3M
Revenue pmpm	*$462.69*	*$453.21*	*$9.49*
Medical Cost	$708.9M	$716.1M	$7.2M
Medical Costs pmpm	*$388.13*	*$388.32*	*$0.19*
Medical Loss Ratio	83.9%	85.7%	1.8%
Administrative Cost	$86.3M	$96.4M	$10.1M
Admin Cost PMPM	*$47.28*	*$52.27*	*$5.00*
Administrative Loss Ratio	10.2%	11.5%	1.3%
Operating Results	**$49.8M**	**$23.3M**	**$26.6M**
Investment Income	$7.5M	$8.0M	$0.5M
Quality Strategy (Grants/Incentives)	$36.4M	$31.6M	($4.9M)
Non Operating Results	**($28.9M)**	**($23.6M)**	**($5.4M)**
Net Income/(Loss)	**$20.9M**	**($0.3M)**	**$21.2M**
TNE	$267.3M	$246.1M	$21.2M
Adjusted Days Cash on Hand (1)	**62**		

(1) Adjusted Days Cash on Hand represents the organization's true available cash position by removing amounts designated for directed payments and taxes.

Highlights

- Membership is 2.1% below budget, reducing both revenue and medical expenses. August membership declined by 955 members, including only 89 SIS members, indicating attrition may be moderating.
- Revenue, excluding $10.7M of prior-year adjustments, is ($1.4M) unfavorable to budget, driven by lower membership volume ($8.0M), partially offset by favorable member mix and risk adjustment revenue $6.6M.
- Medical expenses are favorable; however, excluding the unanticipated $15.4M prior-year IBNP release, medical costs are ($8.2M) unfavorable, reflecting higher-than-expected claims experience.
- Administrative expenses, excluding $3.3M of prior-year expenses, are $13.4M favorable to budget, reflecting proactive cost management in preparation for anticipated UIS and SIS membership declines in 2027.
- Investment income is $7.5M, or 6.2%, unfavorable to budget due to lower interest rates and balances
- Continued strong investment in Quality Strategy initiatives
- The August TNE is 557% of the state requirement

Note: The financial results presented are unaudited, preliminary, and subject to restatement.

Excluding one-time, unanticipated prior-year claims and revenue adjustments, adjusted YTD Net Income is ($1.7M) unfavorable to budget, driven by higher claims costs ($8.2M), lower revenue ($1.4M), and increased investment in Quality Strategy Initiatives ($5.4M), partially offset by lower administrative expenses $13.4M.

Item	Actual	Budget	Fav/ (Unfav)	Explanation
Net Income/(Loss)	**$20.9M**	**($0.3M)**	**$21.2M**	
Revenue	($10.7M)			UIS Risk Corridor: 2024 ($2.4M), 2025 ($5.5M). ($2.8M) relates to 2025 Quality Premium Withhold
Claims (IBNP)	($15.4M)			2025 medical expenses paid in 2026 are less than the amount reserved as of 12/31/2025.
Other	$3.3M			The $3.3M Various 2024 and 2025 activity reported in 2026 that was not accrued as of 12/31/2025
Net Income/(Loss), net of Prior Year Activity	**($2.0M)**	**($0.3M)**	**($1.7M)**	Adjusted for PY activity Net Income decreases from $20.9M to ($2M)
MLR - Adjusted	86.8%	85.7%	(1.1%)	The net PY activity changes the MLR from 83.9% to 86.8%

- August YTD favorable results to budget are the result of $22.9M in prior-year activity
  - Revenue adjustments ($10.7M) are from unanticipated prior-year risk corridors reconciliation and Quality Premium Withhold reserve release
  - The IBNP reserves were reduced by ($15.4M) which related to claims prior to 12/31/25
  - Other expenses of $3.3M are activity from prior to 2026 that was not accrued in the period incurred

- Adjusting for the favorability, 2026 Adjusted YTD Net Income would be a Net Loss of ($2.0M)
  - The Adjusted MLR is 86.8% -vs- the 83.9% reported on a financial statement basis

Note: The financial results presented are unaudited, preliminary, and subject to restatement.

Risks and Opportunities

Risks:

- Risk of higher-than-expected Q4 claims costs due to seasonal flu and RSV activity, which may increase emergency room utilization, inpatient admissions, and overall medical expenses.

- Unanticipated provider disputes and payments.

- Membership attrition could remain above forecast, resulting in additional revenue pressure.

Opportunities:

- Continued administrative savings reflect proactive cost management and position the organization for anticipated 2027 UIS and SIS membership declines.

- August membership declines were lower than recent trends, indicating attrition may be moderating and enrollment may outperform forecast assumptions.

Note: The financial results presented are unaudited, preliminary, and subject to restatement.

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Medicaid Membership Volumes and Rates

COA	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Rates
Adult Expansion - SIS	63,599	62,992	62,262	61,554	60,995	60,739	$ 464.43
Adult - SIS	21,157	20,927	20,734	20,577	20,404	20,311	$ 411.21
Child - SIS	78,666	78,345	78,104	77,546	76,932	76,445	$ 151.35
SPD - SIS	9,329	9,217	9,152	9,107	9,062	9,125	$ 1,474.57
SPD Dual - SIS	24,359	24,239	24,095	23,988	23,790	24,022	$ 661.69
Long Term Care - SIS	47	42	42	40	38	34	$ 1,474.57
Long Term Care - Dual - SIS	668	664	646	651	653	646	$ 661.69
Adult Expansion - UIS	13,287	13,027	12,653	12,251	11,803	11,810	$ 679.05
Adult - UIS	14,604	14,362	14,082	13,743	13,337	13,431	$ 350.38
Child- UIS	3,591	3,530	3,437	3,367	3,276	3,280	$ 135.34
SPD - UIS	1,775	1,763	1,741	1,691	1,649	1,638	$ 1,560.75
SPD Dual - UIS	302	311	315	308	309	321	$ 827.64
Long Term Care - UIS	17	15	14	11	11	11	$ 1,560.75
Long Term Care - Dual - UIS	7	7	8	8	8	8	$ 827.64
Total	**231,408**	**229,441**	**227,285**	**224,842**	**222,267**	**221,821**	

Note: The financial results presented are unaudited, preliminary, and subject to restatement.

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