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

Regular Meeting
Monday, January 26, 2026 2:00 p.m.
Meeting Location: Community Room
711 E. Daily Drive #110
Camarillo, CA 93010

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

Conference Call Number: 1-805-324-7279
Conference ID Number: 281 154 553#

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

121 N. Fir Street #C
Ventura, CA 93003

2800 South C Street
Oxnard, CA 93033

AGENDA

CLERK ANNOUNCEMENT

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

CALL TO ORDER

INTERPRETER ANNOUNCEMENT

OATH OF OFFICE Robert Bravo Deputy Executive Officer/Board of Supervisors Representative.
Roger Robinson, HSA Director – HSA Representative

ROLL CALL

PUBLIC COMMENT

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

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

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

CONSENT

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

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

RECOMMENDATION: Approve the minutes as presented.

PRESENTATIONS

2. Strategic Plan for 2026

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

RECOMMENDATION: Receive and file the presentation.

UPDATES

3. Update on the Creation of the Ventura County HealthCare Coalition

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

RECOMMENDATION: Receive and file the update.

FORMAL ACTION

4. November 2025 Financials

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests the Commission receive and file the November 2025 financials.

5. 2026 Proposed Budget

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests the Commission approve the 2026 proposed budget.

6. Revision to Tangible Net Equity (TNE) Policy

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests that Commission approve the revision to the TNE Policy.

REPORTS

7. Chief Executive Officer (CEO) Report

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

RECOMMENDATION: Receive and file the report

8. Chief Medical Officer (CMO) Report

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

RECOMMENDATION: Receive and file the report

9. Chief Diversity Officer (CDO) Report

Staff: Ted Bagley, Chief Diversity Officer

RECOMMENDATION: Receive and file the report

10. Human Resources (H.R.) Report

Staff: Paul Aguilar, Chief of Human Resources & Organization Performance Officer

RECOMMENDATION: Receive and file the report

CLOSED SESSION

11. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Paragraph (1) of subdivision (d) of Section 54956.9)
Name of Case: California Retina Consultants v. Ventura County Medi-Cal Managed Care Commission, dba Gold Coast Health Plan

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

13. LIABILITY CLAIMS
Claimants: Ventura Orthopedics Medical Group, Inc. and Dignity Health
Agency Claimed Against: Ventura County Medi-Cal Managed Care Commission, dba Gold Coast Health Plan.

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

15. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Paul Agular, Chief Human Resources and Organizational Performance Officer
Unrepresented Employee: Chief Executive Officer

ADJOURNMENT

The next meeting will be on held on the next meeting will be on held on February 23, 2026, at 2:00 p.m., in the Community Room located at GCHP 711 E. Daily Dr. Suite 110, Camarillo, CA 93010

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

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5512. Notification for accommodation must be made by the Monday prior to the meeting by 1:00 p.m. to enable the Clerk of the Commission to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO.1

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: January 26, 2026

SUBJECT: Regular Meeting Minutes of November 17, 2025.

RECOMMENDATION:

Approve the minutes.

ATTACHMENT:

Copy of Commission meeting minutes of November 17, 2025.

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

November 17, 2025

CALL TO ORDER

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

INTERPRETER ANNOUNCEMENT

The interpreter made her announcement.

ROLL CALL

Present: Commissioners Allison Blaze, M.D., James Corwin, Jamie Duncan, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, and Sara Sanchez

Absent: Commissioners Tim Myers and Scott Underwood, D.O.

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

Also in attendance were the following GCHP Staff: Lupe Gonzalez, Susana Enriquez-Euyoque, Pauline Preciado, Vicki Wrighster, Michelle Espinoza, Rachel Ponce, TJ Piwowarski Lucy Marrero, Pshyra Jones, Alison Jewell, Kim Timmerman, Joanna Hioureas, Nicole Kanter, Kim Marquez-Johnson, David Tovar, Alison Armstrong, Ellen Rudy, Bianca Naron, Mayra Hernandez, Holly Krull, Lily Yip, Chris Dulan, Kelly Laban, Jeff Yarges, Carolyn Harris, Jerry Wang, Nathan Norbryn, Victoria Warner, Zed Haydar, Lupe Harrion, Sandi Walker, and Karina Ramirez

INTERPRETER ANNOUNCEMENT

PUBLIC COMMENT

None.

MOMENT OF RECOGNITION

Quality Awards Presentation
James Cruz, M.D., Chief Medical Officer
Kim Timmerman, Executive Director, Quality Improvement

Gold Coast Health Plan has their annual Superhero Awards. We are recognizing five of our network providers for their outstanding efforts and achievements, making our members healthier.

Our first awardee is Community Memorial for behavioral health, specifically for their outstanding achievement and high rates of follow-up after emergency department visits for mental illness (FUM) and follow-up after emergency visit for a substance use (FUA). Dr. Streeter accepted the award. He thanked the team and acknowledged Maureen Hodge, who leads the behavioral health team, as well as Kristine Supple, who is VP for Population Health.

Second award went to CDCR for most improved managed care accountability set performance. CDCR specifically had the greatest improvement of their managed care accountability in measurement year 2024 for measures at the minimum performance level.

Third award went to Buena Medical Clinic for best performance by an independent provider for well care visits of the ages 3 to 21 years of age. They improved well care visits by 5%.

The next award goes to a single individual, Kiana Robles, CDCR, she is a one of the health center managers at Clinicas. She took on the role of managing incentive in the organization, she manages the entire distribution of gift cards.

The final award is for Outstanding Managed Care Accountability Set Performance for Measurement year 2024. The award goes to Ventura County Medical Systems. They had the greatest number of MCAS measures above, at or above the minimum performance level – 17 out of eighteen measures.

Commissioner Duncan joined the meeting at 2:12 p.m.

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Regular Commission meeting minutes of September 22, 2025, and October 30, 2025.

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

RECOMMENDATION: Approve the minutes as presented.

2. Adoption of Commission Meeting Schedule for 2026

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

RECOMMENDATION: Approve the 2026 Commission meeting calendar as presented.

3. Ratification of State and Federal Contracts and Amendments for the D-SNP and Medi-Cal Programs

Staff: Robert Franco, Chief Compliance Officer

RECOMMENDATION: Staff recommends that the Ventura County Medi-Cal Managed Care Commission ratify the SMAC, CMS MA and DHCS Contracts.

4. Written Summary of Quality Improvement and Health Equity Committee Activities – Q3 2025

Staff: Kim Timmerman, MHA, CPHQ, Executive Director of Quality Improvement

RECOMMENDATION: Staff recommends that the Ventura County Medi-Cal Managed Care Commission accept and file the Quarter 3, 2025 Quality Improvement and Health Equity Committee summary.

James Cruz, M.D., Chief Medical Officer, stated there were some key activities that he wanted to highlight. He stated that first was the approval of Carelon, our behavioral health partner approval of their 2025 quality improvement program, description, and work plan. It has expanded the provision of mental health services in the county. Services included are telehealth, as well as types of mechanisms that will be used to evaluate the level of care that our members are receiving. Second, is that all of our GCHP departments report and provide updates at each of those quality improvement health equity committees including population health, behavioral health, UM, care management, member services, provider network operations, Health Education, Linguistics, Grievance and appeals, Pharmacy and Therapeutics, credentialing and peer review. All those departments present their activities and the status which are all in alignment with our vision and our mission of GCHP.

5. Career Framework and Salary Ranges

Staff: Paul Aguilar, Chief of Human Resources & Organization Performance

RECOMMENDATION: Accept and file the 2026 position leveling salary range matrix as presented.

Paul Aguilar, Chief of Human Resources & Organization Performance, stated that HR has been working with our compensation consultant, LTC on the biannual compensation review. This year there, based on feedback received from employees we are providing better information around career planning and will provide more structure around how employees think about their career and progression. We have introduced a career framework that has three career paths. Once is management, the other is professional path, and third is around an associate path. HR has also condensed the number of bands in the organization. At one point there were forty-six bands, and we have it down to fifteen

with some structure around each of the bands that provide a level guide. It will add clarity around expectations and salary ranges are tied to those bands. This will be live on December 13th.

Mr. Aguilar stated that as we get into 2026, the focus is going to be around education. Skill trainings that will develop around various competencies which will set the framework to move forward.

Commissioner Espinosa asked if there will be an opportunity for employee feedback once this has rolled out. Mr. Aguilar stated there are some focus groups that are reviewing the level guides. He stated he expects that as information evolves it will provide better clarity.

Commissioner Monroy asked if the leveling represents any type of impact to the budget. She asked if there will be adjustments made as employees level up. Mr. Aguilar stated the found less than ten adjustments.

Commissioner Espinosa stated she would be interested in hearing any outstanding feedback that can be provided. Mr. Aguilar stated he will keep the commission informed.

Commissioner Abbas motioned to approve Consent items 1 through 5. Commissioner Monroy seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Allison Blaze, M.D., James Corwin, Jaime Duncan, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, and Sara Sanchez

NOES: None.

ABSENT: Commissioners Tim Myers and Scott Underwood, D.O.

Motion carried.

General Counsel, Scott Campbell, stated that he would like feedback on meeting calendar for 2025. He stated that staff was requesting to cancel the December 15, 2025, commission meeting as there are no business items and unless something comes up, we would like to cancel the meeting. The clerk will send out a notice of cancellation to everyone and it will be posted on the website and the building.

PRESENTATIONS

6. Pathways to Wellness Grants Program

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

RECOMMENDATION: Receive and file the presentation.

Marlen Torres, Chief Member Experience & External Affairs Officer stated the commission received a memo earlier this summer because several community needs had arisen due to the political climate that we are experiencing, and we wanted to be able to support the community. There has been discussion and support for a number of food venture providers around SNAP or Cal-Fresh benefits pausing. We launched a Pathways to Wellness, a Community Grants program. We awarded a total of $625,000 out into the community. We received over twenty-two applications; we received good proposals, and we reviewed every one of them. We funded seven community-based organizations that support basic needs such as food distribution, medical navigation, and navigation benefit services. There are several changes around enrollment eligibility happening as soon as January 2026 because of the governor's inactive budget. We are also interacting with our members as we work through our member journey mapping. Ms. Torres noted there was a summary and description of the types of work and scope of work that these seven organizations will be engaging in. The work that will be done will be across the county, so it is a wide array of demographic areas not just a single demographic region.

Commissioner Blaze asked if there will be a lot of reporting that the organizations will need to do to get the money to do the work. Ms. Torres stated that they will have to meet a number of measures that tie into whatever was in their scope of work. If they are going to be supporting with our members around benefit navigation, they need to show how many members they supported and engaged with. That will also be tied to funding to receive a total of three payments. The first payment is for startup costs and the second and third payments are tied to metrics that they need to meet to receive the funding.

Commissioner Monroy motioned to approve agenda item 6. Commissioner Pupa seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Allison Blaze, M.D., James Corwin, Jaime Duncan, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, and Sara Sanchez

NOES: None.

ABSENT: Commissioners Tim Myers and Scott Underwood, D.O.

Motion carried.

FORMAL ACTION

7. Approval of Revised Code of Conduct

Staff: Robert Franco, Chief Compliance Officer
Bianca Naron, Compliance Program Manager

RECOMMENDATION: Staff recommends that the Commission approve and adopt the revised Code of Conduct as presented. The updated Code will serve as the practical resource for employees and stakeholders, reinforcing ethical standards and compliance obligations.

Robert Franco, Chief Compliance Officer, introduced Bianca Naron, Compliance Program Manager. Ms. Naron stated our Code of Conduct has always been a solid foundation for how we operate. As the organization has grown it has become clear that the code needed to do more that just outline the rules. It needed to reflect who we are. We brought together a cross-functional group to look at the code, The goal was to turn the code into a practical guide that supported everyday decision-making, not just a policy document. That led us to eight key changes. Each of the updates reflects what we wanted the code to be; a guide that connects our values, culture, and compliance expectations to everyday decisions. They ensure accountability and regulatory standards are clear. These changes shift the code from a policy document to a practical resource that supports real-world decision making. Turning the code from a policy document to a practical guide adds real value. It bridges the gap between compliance.

CCO Franco stated there is a copy of the draft for the commission to review. Commissioner Espinosa asked if this is something that is reviewed at an employee's performance review annually. Paul Aguilar, Chief of Human Resources & Organization Performance stated the items in the Code of Conduct can be added in to 2026 reviews.

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

Roll Call Vote as follows:

AYES: Commissioners Allison Blaze, M.D., James Corwin, Jaime Duncan, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, and Sara Sanchez

NOES: None.

ABSENT: Commissioners Tim Myers and Scott Underwood, D.O.

Motion carried.

8. 2026 Dual-Eligible Special Needs Plan (D-SNP) Update & 2027 D-SNP Program

Staff: Eve Gelb, Chief Innovation Officer
Kimberly Marquez-Johnson, D-SNP Operations Director

RECOMMENDATION: Staff recommends that the Ventura County Medi-Cal Managed Care Commission approve the program.

Eve Gelb, Chief Innovation Officer stated that we already beginning to plan for 2027 now. She also announced that we have completed all milestones, and we are not waiting for Ready to Service which will begin January 1, 2026. We are live with Ready to Enroll and Ready to Sell. We are now at over one hundred members accepted by CMS and another sixty members in the pipeline between us and CMS waiting for approval. CIO Gelb thanked Ms. Torres' team, our sales team, our marketing team, and our enrollment team for processing this. We created a new set of competencies to sell and enroll for Medicare Advantage. CIO Gelb stated that 100% of our applications have been processed timely. We have seven days to get that application from the time we receive it to CMS. Another item She highlighted was the Call Center. The call center is required to be open seven days a week from 8AM to 8PM between October 1 and March 31. We have expanded not only our contact center but also launched a tele sales phone number. We have a steady flow of calls. Thanks to our marketing team we have done an outreach to our members, and we have seen a spike in calls when those mailings go out. Communication has been good, but also in terms of staging, so that we do not overwhelm our call center. We sent a few thousand mailings each day so that we can begin to really let our community know that we are here. Our sales team has been out in the community doing presentations in senior living facilities, senior centers, and other places to get the word out.

Our next and last milestone is Ready to Serve. This means we are ready to do all the clinical functions that we need to do to support our members, ready to do the business functions like pay claims and do all the required reporting.

We are focusing on being transparent and making sure that we know what we need to do and what we are going to be able to do by January 1. We also want to focus on maintaining enrollments for our members.

CIO Gelb noted that this is the first time in a while that we have had a pharmacy benefit manager, a PBM plan. She stated there are many reports (141) that must go back and forth between GCHP and this PBM. There is a lot of training that needs to be done, and we are now focused on trainings. CIO Gelb noted that both claims and core administration is red, but we will hit our target. It is red because there are many decisions that need to be made and testing that needs to be done. We are working on testing as much as possible because we want this to be smooth. We want to get it right with no abrasion with our providers who are also new to this Medicare product. We are working hard to hit critical path, critical timelines and still have enough time to assess. We want

to make sure all our processes go well. We will prioritize what must go live on January 1.

Supervisor Lopez asked if there should be any issues, is there a Plan B or Plan Cif something is not done or not ready, CIO Gelb replied that for everything that is or might be a concern, we can do things manually. For things that we process manually we want to have a second set of eyes look at it before we release it.

Commissioner Blaze asked what the goal number is. CIO Gelb stated our goal is 2500 members by the end of 2026. We can enroll members year-round. Our target for January 1 was approximately nine hundred members, we will not hit that number. We revised our target and will hit four hundred members. She noted that fewer members are better while we are getting started if we have sufficient members to assess our processes. Commissioner Blaze also asked if these members who aged in, just turning sixty-five or are these members that we have enrolled existing dual members. CIO Gelb stated there is a process to outreach to our members that are aging in. We have set up a process where each month we will know who is going to be turning sixty-five in the next three months and we send them communications.

Commissioner Abbas stated there is one year to get two thousand members, which is a heavy task. He questioned if we are going to revise financial benefits for this project. CIO Gelb stated that we would like to hit the 10,000 number by the end of year four, and we believe that we will hit that at end of year four. We do not want to spend marketing dollars and other things to get to a higher number than we feel comfortable with right now. Membership is not the only factor in getting to a break even or profitable status. There are two other factors: there is the star rating and the risk adjustment factor score. We do not get a star score until year three, and we cannot get additional dollars for that quality stare score until then. That is important for break even. The risk adjustment factor is dependent on our provider partners being able to accurately code all the diagnoses that are relevant to payment for our membership. In order to break even we need to get a risk adjustment factor of 1.32 with a four-star rating. Getting to break even is not just the membership, it is the qua. y scores and the risk adjustment. We will still target for year four. CFO Dersch stated we need to do this in a thoughtful orchestrated move. We are on track and there has been a lot of communications. It has been a smooth implementation. Commissioner Abbas asked if a revision of financial projection could be made for the next meeting. He would like to see the differences to how it is going to escalate the cost. Once we see the data then we can see how we can make it better. We do the projection; we do the ROI. We never do the ROI after or during the implementation process CIO Gelb stated she will do that. The thing to remember is when our actuaries presented to the commission, we will lose $457 per member per month for every member enrolled in this plan the first year if we meet our target risk adjustment factor. The fewer members we have, the less money we lose. We have projected a loss of $16,000,000 in the first year that would come out of our TNE, out of our reserves.

Commissioner Corwin stated the key is what is going to be the HCC, coding initiative, the tools given to providers, Most are used to some sort of HCC so they will jump on it,

but it is going to be our ability to get coders to really help educate them. Get a real tool for them to use, and once you get those codes you will get some of the retro payments that come from the default. That is the break even. CIO Gelb stated we can bring the risk adjustment program to the commission so we can focus on it. We are going to be watching the claims as they come in and looking at diagnosis to make sure they match; we are going to be very proactive in trying to manage this to where we have an accurate coding.

Commissioner Espinosa stated that the enrollment period ends December 7th, but we can continue to enroll throughout the entire year – she asked what about the provider network – is there a period where they can either join or drop. CIO Gelb stated that is ongoing if we meet network adequacy. The state also has a requirement that we have a 90% crossover on our primary care network with our Medi-Cal plan. We will continue to add providers, our primary care network will remain stable. Commissioner Espinosa asked if there are shortages in a particular specialty over another, and she noted that allergy is a specialty that is hard for us to get. Wait times for appointments, especially specialists is a long time. CIO Gelb stated that according to CMS we have an adequate network, it goes through a system called Quest Analytics and it the same system that does analysis for all the Medicare Advantage plans. Even though we have an adequate network, it does not mean that member will not have access to care issues. One of the excellent features of this product is that every member has a care navigator, so they have their own personal advocate.

Kimberly Marquez-Johnson, D-SNP Operations Director, stated that just as we are getting ready to go live with our D-SNP, CMS and DHCS cycle starts for 2027. We are going to be submitting our network adequacy because CMS and DHCS want to see that overlap. We will be doing the submission in the first quarter. Along with that, going forward in 2026, we will start to report and collect on our Part C and Part D data validation – which is all the data regarding claims authorizations, grievances and appeals that CMS wants to track, which goes to our five stars, so we will be monitoring. For next year, we will start our bid submission again for 2027. We will have our kick-off this year just as we did last year for 2026, it is the same process. We will also have our annual state Medicaid agency contract that we do annually for that subsequent year, 2027 and again in 2028 and DHCS works closely with CMS on making any changes to that contract on regulatory requirements. That is a requirement that we will have and that will come in the third quarter. After that we go right into preparing for Ready to Sell, Ready to Enroll, and Ready to Serve, just as we are doing now. We will be looking at our work plan and our quality improvement program work plan in 202 for 2027. The one thing that we do not do for three years is change our Model of Care because we scored 100% with out network advocacy and that comes with a three-year approval. If we do change our Model of Care, we will have to submit that the following year. This year we do not have to submit.

Ms. Marquez-Johnson stated that we might be able to bring out network to the commission before we need to submit in February, but we will present our bid, it might be a first draft, but we will make sure that the commission has a line of sight into all of the key activities that we have.

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

Roll Call Vote as follows:

AYES: Commissioners Allison Blaze, M.D., James Corwin, Jaime Duncan, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, and Sara Sanchez

NOES: None.

ABSENT: Commissioners Tim Myers and Scott Underwood, D.O.

Motion carried.

9. Quality Improvement and Health Equity Committee 2025 Third Quarter Report

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

RECOMMENDATION: Approve the 2024 QIHET Program Evaluation. Receive and file the complete report as presented.

Kim Timmerman, Executive Director of Quality Improvement stated she will give a high-level review of the third quarter report for Quality Improvement and Health Equity Committee. She shared that GCHP received an award for outstanding performance on measurement year 2024 Medi-Cal Managed Care Accountability set for the Children's Health domain. We met minimum performance level for all the child health measures in MCAS. She also noted that KCS sent out the comparative plan performance for MY24 – it is broken down by 22 managed care plans and for the second consecutive ear we were the top performing plan for topical fluoride in children and we were the second scoring plan for Cancer screening, #3 for lead screening in children and we were fifth highest performing for cervical cancer screening. This is due to the tremendous partnership we have strengthened over the years with our providers.

NCQA is just around the corner for us and next week is our virtual file review. We have submitted all our documentation on October 7th, and it looks like there is limited risk based on the written documentation piece, now we just need to get through the file review. November 24th is our actual file audit.

Today we are requesting approval for the 2024 Quality Improvement and Health Equity Transformation program evaluation. The program ensures a culture of continuous quality improvement. We look at the effectiveness of our program initiatives, evaluate accountability and compliance. These documents continue to provide framework and help us develop the subsequent program and work plan. 2024 informs what we

developed for 2025 and all under the adherence of DHCS and recognition of CalAIM and CQA standards.

2024 highlight the twenty-four program initiatives successfully achieved overall goals for organization-wide commitment to quality through the Model of Care to meet the needs of our members.

In terms of the Managed Care Accountability set, there were almost 8,000 more care gaps closed in 2024 compared to 2023. There were forty-one MCAS measure reported. 17 out of 18 measures were met or exceeded the DHCS MPL had three measures that met the 90%, right that met 75% and six that met the 50%. The rate for sixteen measures improved, some with a significant rate improvement. One measure that did not meet DHCS MPL is asthma medication ratio and that is the AMR measure. It did improve 11%, but still did not climb to achieve DHCS MPO. This is mostly a primary care focused measure. This is a measure that looks at the ratio of controller to rescue medications, and it is an imbalance. Usually too many recue meds not being prescribed. And it has been a challenge. Asthma is a measure that the rate goes down as the year goes on because ratios go out of skew. We feel that we will meet the MPL this year. She noted that this measure is being retired and being replaced with a measure that looks at UM follow up visit after ED exacerbation. Part of that is because that complexity of the technicalities of the controller and the rescue medications that HCQA has recognized that this is much more complex than was anticipated. This measure is being retired and something more reflective will be done.

Ms. Timmerman highlighted some interventions from 2024 in Quality Incentive Pool and Program or TYPP provider grants. We have several rewards programs that through mail and point of care member outreach campaigns to schedule appointment and close care gaps. Enhanced behavioral healthcare coordination for follow up to the ED, robust provider and member education campaigns, data improvements, and collection of new supplemental data sources and health fairs. We meet members where they are which is through clinic sponsored events.

Commissioner Espinosa motioned to approve agenda item 9. Commissioner Sanchez seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Allison Blaze, M.D., James Corwin, Jaime Duncan, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, and Sara Sanchez

NOES: None.

ABSENT: Commissioners Tim Myers and Scott Underwood, D.O.

Motion carried.

The Commission took at break at 3:51 p.m. The meeting continued at 4:00 p.m.

10. Review of September 2025 Financial Performance

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Receive and file the financials

Sara Dersch, Chief Financial Officer noted there was an information handout for the Commission. It was recently produced by California Association of Health Plans which presents information on the importance of holding reserves and for what they are used. It was thought this information would be useful information since there had been conversations around the appropriate level of a reserve, appropriate utilization reserve for TNE.

CFFO Dersch stated that we continue with no surprises in our financials. We had a good month comparative to July and August. We broke even for the month. We were only at $100,000 deficit, given the size of our budget is less than a rounding error of the budget variance. Our deficit suggests that our work to control our medical costs through the backlogs is working. We do have the primary theme in our medical cost is our IBMP. It has gone down for three months in a row, so we are happy to see that our current IBMP is approximately $140 million. It was under $145million in August and in June it was at $161 million, so this has been an improvement.

We have also had pressure in our medical costs related to our medically tailored meals, offset by a sanction against our transportation provider for not being able to meet quality metrics. She noted that our administrative expense approximates our budget. From a year-to-date perspective it brings our net loss to $14.3 million which is unfavorable by 17.4 She also stated that the common themes we do have favorability in our revenues. The attrition of membership is not what we had projected, it is better. With the medically tailored meals we see some pressures in our targeted rate increase that we are working through and should be able to mitigate.

Currently we are at approximately 240,000 members versus a budgeted value of 227. If you look at our revenue PMPM that is slightly favorable at $396.47 versus $393.76 We look at that because it tells us how we are doing on a comparable basis. We do not look at volume, we look at membership mix. We have a slight favorability in our membership mix versus budget. Our medical cost continues to approach the 90% threshold, and we are working hard to get it to come done. It is going down month over month. CFO Dersch stated the percent of dollars that we spend on admin expense is down versus budget - we had projected to spend 10.9 % and we are at 10.4%. She also noted that our TNE is up 17% from last month. TNE is at 621 and we are glad to see that it is starting to add back up. As our IBMP goes down, as our future projections go down, and as we go through the claims backlog, we are paying claims accurately and our IBMP will continue to go down and we will reach 700% which is the target.

When looking at our operating income, year to date we are still spending more than we are bringing in. A lot of this is driven by IBMP. As we get our revised rates, we will get an increase / or at least a material increase based on revised utilization.

CFO Dersch reviewed results by category of service which shows a breakdown of how we are spending our medical dollars and the types of services that are highlighted are areas where we continue to see pressures. She noted there is a lag in reimbursement rates for long-term care, and SNF. The rates will go up and the payments will go up long before we receive revenue for it. The perspective of that is changing in 2026, DHCS has told us that it will no longer be the case. They will give us the revenue first and then raise the rates after.

CFO Dersch stated that we have instituted some additional structure, and control on how we are administering our home and community-based services to ensure that we are spending the dollars that we receive effectively. As we continue to process the claims, we are getting more insight into what the trends truly are, and we will be able to bring more insight to the commission in the upcoming months.

Commissioner Espinosa asked if CFO Dersch knew what the claw back estimation might be. CFO Dersch responded that she did not think we will have a 2025 claw back because of our utilization and the way our rates are currently running. She does expect to see an increase in retroactive 2025 rates. We have received our 2026 rates which are higher. Our costs have risen over the last six to twelve months, we submit data to DHCS, and they compare the original rates, and they try to get us as close to being whole as possible. We are seeing our rates start to go up. There is nothing to claw back since we have been running the deficit. Commissioner Pupa asked if when we do our rate development it is based off cost, actual claims paid. CFO Dersch stated that is correct Commissioner Pupa then asked for the financials because we have had a sort of claims migration and there have been some challenges, how much margin was guilt into the IBNR for any potential outstanding claims. CFO Dersch stated we put in$10 million into our RBMP to account for claims that we know are out there or that we might have underpaid. We cannot pinpoint yet but most of our IBMP is informed by our actual claims payments that go out the door. Some of our claim's payments have been inflated because we were not processing them accurately, but we were not pricing them accurately. We are working through the claims and getting some final disposition on our claims system. Commissioner Blaze asked what the actual number is you want to have for our TNE. CFO Dersch stated she would like to see TNE between 550 to 650%. That leaves enough to where if there is some extraordinary action we as an organization can continue to operate. If there is an extraordinary action in our community, we can intervene immediately and help out. With a higher TNE that says that we are not spending enough money on our providers on our community, on healthcare, and as a public entity, which is our responsibility to take tax dollars and turn them into wisely spent healthcare dollars to have a healthier community. Commissioner Blaze asked what the state requirement for TNE is. CFO Dersch stated the Department of Managed Healthcare has a goal of 600% but that is not an official requirement from the state, but

that is the threshold. There are two regulators there is DHCS and now DMHC has their defined TNE, and we must meet the minimum requirement. Currently it is $40 to $43 million. DMHC uses that same definition, but they say that you must maintain at least 250% of that number. If you get to less than 300% of TNE DHCS starts paying attention and they start asking for regular reports. We are starting to have conversations about whether we want to petition DHCS to up the required TNE. Do we want to look at days cash on hand. It is purely a liquid number. The commission set our TNE at 700% and that is the target that we shoot for. We did that when we were at 1000% and we knew we were going to start investing. We then said let us keep it around seven hundred, but CFO Dersch stated that she did not know if we accounted for all the transition on IT and all the issues. Now you must accrue more because you do not know, and you must be safe. We do not know where we are going to land when the dust clears. Commissioner Corwin stated that 621 is still a healthy number, but we still must flush out some things. The days of cash on hand would give a better sense of what those reserves really are in terms of what they mean regarding operations. If all things fail, how long can we sustain operations as a plan. There is a difference between what is a reserve and what is TNE reserve. A TNE is a metric that describes your organization. We have done an excellent job at getting dollars in the hands of providers for two reasons. One is so providers can give quality care to our members, second is so that when we submit our claims experience or rate setting, we are reimbursed at that appropriate rate. Commissioner Pupa stated that we reduced our TNE which resulted in a better outcome for the providers and a better outcome for GCHP because our rates have increased so it is a balance for our members because of the quality. CFO Dersch stated the only reason our TNE got to 1000% was because of the pandemic. We were not spending appropriately. We were receiving premiums for people who were not receiving care.

Paul Aguilar, Chief of Human Resources & Organization Performance will highlight some labor items. He stated that we are at approximately 455 employees, which is under budget. From a contingent labor standpoint, temperatures have dropped and stayed at 10 for the last couple of months, which is manageable. The substantial number is the contractors – which is about 103 with Deloitte and Ironwood being the predominant ones. By the end of the year, as we get into the first quarter that number will start to diminish. May of Deloitte resources are testing resources, which is currently where we are now, and those resources will begin to taper off starting in January and the contract with Deloitte ends in March.

CFO Dersch moved onto headwinds and tailwinds for the last six weeks left in the year. The impact of federal immigration actions on our members will unfortunately continue. We do have resumption of some payment integrity activities, so we will start to see some recoveries coming in. This will help our medical cost. We do have a possible 2025 retroactive rate increase, and we will know within the next month. CFO Dersch noted that COO Suma Simcoe has been working with our HRP Vendor to facilitate necessary fixes in that system to let the claims adjudication system process claims accurately. Commissioner Abbas asked what the adjudication rate is now. CFO Dersch stated it is at approximately 20 percent. COO Simcoe stated 57.3 is the number that Net Mark has

shared. She stated that there is a meeting to further investigate what it really is. General Counsel, Scott Campbell stated that will be discussed in Closed Session.

11. CY2026 Budget Targets

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Receive and file the information

Sara Dersch, Chief Financial Officer stated this is our first pass at targets. This is not our budget yet. This is the foundation of our budget. We are targeting a net income of $19.1 million. From a membership perspective it has been reduced 4.5% from our current levels and that is primarily based on restrictions in the unverified immigration status enrollment which goes into effect on January 1, 2026. For any currently enrolled adult aged nineteen and over that has unverified immigration, they can maintain their coverage. We cannot enroll any new adults. Our premium rates are up from 2025 levels, and they will continue to evolve over the year. Initial rates came in at 4.5% over our 2025 rates. She also shared that we got an increase, and we got the final analysis which will give us an additional considerable bump. We will be starting the year in a good fiscal position from a revenue standpoint.

Programs that are beginning now or we will be rolling out, as well as claims recoveries in additional operational cleanup, payment integrity will start mid-year. We are budgeting separately for the D-SNP plan, therefore projections presented are solely Medi-Cal related. It is important to keep them separate due to start-up costs. CFO Dersch noted that the official budget for 2026 will be very detailed. She stated that the ask for today is commission alignment with our methodology and how we are targeting our dollars. She then reviewed the 88-10-2. For every dollar that we receive from the state eighty-eight cents goes to medical cost, 10% goes to administrative expenses and 2% stays with us. Commissioner Abbas asked why we cannot give the 2% to providers and let them do a better job. CFO Dersch stated there were internal conversations regarding this point. The provider incentives are embedded in the medical cost. Commissioner Abbas asked about additional incentive based on performance, especially with D-SNP coming up. We need to have the resources; we have discussed extended hours for clinics to be open to provide services. CFO Dersch stated we would be planning for a quality spend in our 2026 budget. Currently we have a 414 million deficit so that is one reason that we want to retain some of our margin the help cover the unexpected. It is prudent to build some amount up and then begin distributing. We need to see where we are in three months, see how much we have and then we can talk about doing something over and above what we have already planned for in our budget. We keep the 2% now and then over the course of the year as our position improves then we can do something such as distribute to the community, distribute to providers. We can no longer use the MCO tax to qualify for matching federal funds and that is going to hurt – that could hurt our bottom line.

CEO Nunez stated this budget is partly art, partly science. The science that is in this is that we had issues with our claims and trying to work though those issues. We do not

know what is going to happen with enrollment going into next year and it is a challenge. We are seeing a decrease in SIS enrollment in addition to UIS enrollment and the challenge is trying to prognosticate into the future where we have a lot of uncertainty. It is difficult to put a budget together that does what we want for quality and access to care. There is so much uncertainty and lack of clarity. CEO Nunez stated he is more inclined to plan for the worst and hope for the best in terms of budgeting. He noted that D-SN will be losing money, and we are planning for it and trying to determine how we support the providers. There must be a balance. We want to continue to do the work, but we must do it with a tighter budget - it is more constrained.

Commissioner Pupa stated she had questions. We all agreed to pay a certain amount in the incentives which was $55,000,000 over three years, she asked where we with that are. Second, it does not feel good that we are keeping more. We are keeping $19,000,000 and it looks like the quality strategy is only $17.5 million. It does not feel good when our TNE is 600% and we just heard good news about rates. She asked if there was a way to share more of the $19,000,000 with providers. She does understand we need to be conservative. CFO Dersch stated these are initial targets and do not reflect the increase in rates, but in January it will reflect the rates and from a positive perspective any increase in rates will open more dollars to spend on quality. We must keep our obligations to the state. We must pay the doctors for claims they are submitting. We must pay to keep the lights on. We must pay to have people in key positions. Everything else is at our discretion, how we want to spend it. Commissioner Abbas stated that he agrees with Commissioner Pupa.

CEO Nunez stated that we may need to meet in December. CFO Dersch stated that we will not be ready until January with the budget. These are only the targets. We have the second version of 2026 rates to work in. We do not want to wait until after the year starts to have some type of financial guideline for the organization. We cannot start a year without any kind of budget, or any kind of forecast. We will present what you would expect to see out of a budget packet, line by line detail by spend with vendor information. Commissioner Pupa stated she is interested because all approved the $55,000,000 over three years and see where we are at and if the $17.5 million aligns in with that $55,000,000. We made a commitment, and we need to keep those commitments. CEO Nunez stated that we are keeping those commitments. CFO Dersch stated the $17.5 is the commitment. Those commitment remains in place. Commissioner Corwin asked what is the twenty-one two. CFO Dersch stated that is the percent of the administrative spend that we can reclassify to medical costs for MLR reporting purposes, it includes incentives.

General Counsel, Scott Campbell stated that we must execute contracts by January1, so we will take direction from the commission on spending. We cannot adjust those contracts after January. The dollar amount on those contracts must be set before the beginning of that period. January is the period that we are going to start the quality incentive program. It must be prior to the date of onset of that program.

CFO Dersch stated that we have gone from TNE of 1000% to approximately 600% in 24 months. We want to be cognizant and not get down to 300% because we will have a problem with our regulator. It is critical that we spend our money wisely and put money where it is most effective. We need to support our providers and if we need to reprioritize some things internally, then that is what an organization does. It is what health insurance companies all over the country are looking at right now. This is back to leaner times, tightening out belts. The challenge is how do we make all this happen and still run at least at break even, so we do not run into challenges with regulators. We will come back in January with revised numbers.

Commissioner Abbas motioned to approve agenda items 10 and 11. Commissioner Pupa seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Allison Blaze, M.D., James Corwin, Jaime Duncan, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, and Sara Sanchez

NOES: None.

ABSENT: Commissioners Tim Myers and Scott Underwood, D.O.

Motion carried.

REPORTS

12. Chief Executive Officer (CEO) Report

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

14. Chief Compliance Officer (CCO) Report

Staff: Robert Franco, Chief Compliance Officer

RECOMMENDATION: Receive and file the report

Commissioner Monroy motioned to approve agenda items 12 through 14. Commissioner Abbas seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Allison Blaze, M.D., James Corwin, Jaime Duncan, Laura Espinosa, Supervisor Vianey Lopez, Anna Monroy, Dee Pupa, and Sara Sanchez

NOES: None.

ABSENT: Commissioners Tim Myers and Scott Underwood, D.O.

Motion carried.

The Commission took a short break and then entered Closed Session at 5:05 p.m.

CLOSED SESSION

15. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
(Paragraph (1) of subdivision (d) of Section 54956.9)
Name of Case: California Retina Consultants v. Ventura County Medi-Cal Managed Care Commission, dba Gold Coast Health Plan

16. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Initiation of Litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: One Case.

17. LIABILITY CLAIMS
Claimant: Ventura Orthopedics Medical Group, Inc.
Agency Claimed Against: Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan

General Counsel, Scott Campbell stated there was not reportable action.

ADJOURNMENT

With no other business to conduct, the meeting was adjourned at 6:14 p.m.

Approved:

_____
Maddie Gutierrez, MMC
Clerk to the Commission

AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: January 26, 2026

SUBJECT: 2026 Strategic Plan

PowerPoint with Verbal Presentation

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Gold Coast Health Plan's 2026 Strategic Goals

Marlen Torres
Chief Member Experience and External Affairs Officer

Integrity
Accountability
Collaboration
Trust
Respect

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What to expect from today's session

...in the context of continuous strategic implementation

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

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

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

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Our Why…

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Strategic Anchors

Enhance Member Experience

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

Optimize Provider Relationships

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

Advance Quality of Care

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

Return to Agenda

Strategic Goals: Medi-Cal Program

Goal	Key Results	Executive Sponsor
1. ENHANCE MEMBER EXPERIENCE: Improve CAHPS score for Adult and Child survey	5 percentage points between Press Ganey Mock Survey 1 in Q1 to Survey 2 in Q3 - Getting Needed Care questions for Adults and Children	Marlen
	5 percentage points between Press Ganey Mock Survey 1 in Q1 to Survey 2 in Q3 - Getting Care Quickly questions for Adults and Children	Marlen
2. ENHANCE MEMBER EXPERIENCE: Retain targeted average Medi-Cal membership	233,000 Medi-Cal members for 2026	Marlen
3. OPTIMIZE PROVIDER RELATIONSHIPS: Pay claims correctly the first time, every time. Build the Basics focusing on Timeliness, Accuracy, Compliance and Financials.	First Pass Claims Accuracy Rate 98% • Controllable Interest Payment Reduction by 50% by 12/31/26 • Controllable Claims Adjustment Rate Reduction Industry Standard 4-6% • Reduction in PDR Rate TBD by TBD	Suma
	Retro eligibility transaction processing resolution	Suma
	Maintain regulatory requirements for average speed of answer <30 seconds, hold times <2 minutes	Suma
	Meet regulatory requirement: PDR Acknowledgement Letter <15 business days, PDR Disposition Letter <45 business days by Q3 2026	Suma
4. ADVANCE QUALITY OF CARE: Achieve 70% of MCAS Targets MY 2026	8 Measures at the 90th percentile	Dr. Cruz
	4 Measures at the 75th percentile	Dr. Cruz
	8 Measures at the MPL	Dr. Cruz

Foundational Goals: Medi-Cal Program

Goal	Key Results	Executive Sponsor
FOUNDATIONAL		
Transform Our Culture	Culture Pulse survey in Nov. 2026 Feedback focused on manager goal of 3-2-1 with a positive score of 80% or higher by Dec. 2026	Paul
Meet Financial Targets – Medi-Cal	3.4% operating margin for Medi-Cal in 2026	Sara
Meet Compliance Targets – Medi-Cal	90% Compliance Member Impact compliance metrics by Q4 (e.g., call center stats, ID card mailings, Continuity of Care (CoC) turnaround times)	Robert

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Enhance Member Experience Goals

Marlen Torres, Chief Member Experience & External Affairs Officer

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California Policy Changes for Unsatisfactory Immigration Status (UIS) Population

Policy	Summary of Changes	Implementation Date
Enrollment Freeze	Beginning Jan. 1, 2026, there will be no new adult enrollees (ages 19+) who are UIS. Those who are currently enrolled in full scope Medi-Cal must complete their annual renewal on time to remain enrolled.	Jan. 1, 2026
Dental Benefit Elimination	As of July 1, 2026, most adults (19 and older) with UIS will lose dental benefits. Emergency dental care, and dental benefits for children and pregnant individuals, will still be covered.	July 1, 2026
Monthly Premiums	Starting July 1, 2027, eligible adults (19-59) with UIS and full scope Medi-Cal coverage will be required to pay a $30 monthly premium.	July 1, 2027
Limited Scope Medi-Cal	No Change. Some individuals with UIS who lose full-scope Medi-Cal may be eligible for limited-scope coverage.	N/A
Emergency Services	No Change. Emergency services will still be covered for everyone, regardless of immigration status.	N/A

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HR 1 Member Eligibility Changes to Medicaid for Expansion Population

Policy	Summary of Changes	Implementation Date
Enacting Community Engagement Requirements	Requires Medicaid beneficiaries ages 19-64 to complete community engagement requirements. For example, an individual must demonstrate they worked at least 80 hours per month. It exempts certain adults, including parents with children ages 13 and under and those who are medically frail.	By Dec. 31, 2026
Increased Eligibility Verification	Requires states to conduct eligibility verifications for single adults ages 19-64 every 6 months.	By Dec. 31, 2026
Modifies Retroactive Coverage During Presumptive Eligibility	Modifies the retroactive eligibility policy for beneficiaries ages 19-64 from three months of retroactive coverage to one month. For all other beneficiaries, it modifies retroactive eligibility from three months of coverage to two months.	Effective for applications made on or after the first day of the first quarter that begins after Dec. 31, 2026.
Cost Sharing for Expansion Population	Requires states to enact cost sharing for beneficiaries ages 19-64 with incomes greater than 100% of federal poverty level (FPL). Cost-sharing levels would be left to the discretion of the states but would be capped at $35 per service; certain services are exempt from cost-sharing.	Beginning Oct. 1, 2028

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ENHANCE MEMBER EXPERIENCE

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

Voice of Member / CAHPS

WHAT ARE WE DOING

Gain deep understanding of our members and use this knowledge to improve their experience

- *Press Ganey CAHPS Mock Survey in Q1 and Q2*

WHAT TO EXPECT

- *Implement CAHPS Improvement Plan and present findings*
- *Plan additional focus groups for other programs and topics*
- *Quarterly Member Advisory Committee Meetings to share analysis and gain insights*

Member Services Everywhere – Community Care / Membership Retention Efforts

WHAT ARE WE DOING

Educate members on the new eligibility changes and support them with completing the necessary requirements to remain enrolled in Medical

- *Planning Event for Scope of Work Q1 2026*
- *Work with Ventura County Human Services Agency and Health Care Agency to devise a joint plan for membership retention*

WHAT TO EXPECT

- *Pop-up health fairs*
- *Resource Center feasibility study*
- *Next Round of Grantees to Support with Redetermination Efforts Q3/Q4 2026*
- *Launch Education / Communications Campaign Q4 2026*
- *Begin conducting outreach to members for those with a renewal date of Jan. 2027 Q4 2026*
- *Engage with CDCR and CMH to support with outreach efforts Q2 2026*

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Provider Partnership Goals

Suma Simcoe, Chief Operating Officer

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Provider Partnership Goals

- Improve claims payment accuracy
- Retro eligibility transaction processing resolution
- Maintain regulatory requirements for average speed of answer and hold times
- Meet regulatory requirement for Provider Dispute Resolutions (PDR)

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Enhance Quality Goals

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

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MCAS Measures MY 2026

Key Changes from MY 2025:

- **20** Measures held to **Minimum Performance Level** (vs. 18 in MY 2025)
  - **New** measures held to MPL:
    - Colorectal Cancer Screening
    - Depression Screening for Adolescents and Adults
    - Prenatal Depression Screening
    - Postpartum Depression Screening

- Chlamydia Screening in Women (CHL) removed

- Asthma Medication Ratio (AMR) retired

- **1 Report Only** Measure (vs. 13 in MY 2025)
  - Follow-Up After Acute and Urgent Care Visits for Asthma

MCAS Managed Care Accountability Set — 2026 Quality Measures Achieved by Connecting Members with Care — Gold Coast Health Plan

Connecting Children Ages 0-21 with Care	
MEASURE	DESCRIPTION
WCV	Child and Adolescent Well-Care Visits — At least one well-care visit annually.
W30-6+	Well-Child Visits in the First 0-15 Months of Life – 6+ Well-Child Visits — Six or more well-child visits.
W30-2+	Well-Child Visits in the First 15-30 Months of Life – 2+ Well-Child Visits — Two or more well-child visits.
CIS-10	Childhood Immunization Status – Combo 10 — Completion of 10 specific vaccine series before turning 2.
IMA-2	Immunizations for Adolescents – Combo 2 — Completion of the Meningococcal, Tdap, and HPV vaccinations before turning 13.
DEV	Developmental Screening in the First Three Years of Life — Screening for risk of developmental, behavioral, and social delays.
LSC	Lead Screening in Children — Blood lead test before turning 2.
TFL	Topical Fluoride for Children — At least two topical fluoride applications.
Connecting Women with Care	
MEASURE	DESCRIPTION
PPC-Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care — One prenatal care visit in first trimester or within 42 days of enrollment with GCHP.
PND – S	Prenatal Depression Screening — Depression screening for pregnant members before delivery.
PDS – S	Postpartum Depression Screening — Depression screening between 7 and 84 days after delivery.
PPC-Pst	Prenatal and Postpartum Care: Postpartum Care — One postpartum care visit between 7 and 84 days after delivery.
Connecting Members with Cancer Screening	
MEASURE	DESCRIPTION
BCS	Breast Cancer Screening — Screening for breast cancer.
CCS	Cervical Cancer Screening — Screening for cervical cancer.
COL	Colorectal Cancer Screening — Colorectal cancer screening for men and women.
Connecting Members Ages 6 and up with Behavioral Health Care	
MEASURE	DESCRIPTION
FUA	Follow Up After an ED Visit for a Substance Use Disorder – 30 Days — Members who receive a follow-up visit within 30 days of an ED visit.
FUM	Follow Up After an ED Visit for Mental Health – 30 days — Members who receive a follow-up visit within 30 days of an ED visit.
DSF – S	Depression Screening — Depression screening for adolescents and adults.
Connecting Members Ages 5-85 with Care to Manage Chronic Conditions	
MEASURE	DESCRIPTION
CBP	Controlling High Blood Pressure — Blood pressure control (<140/90).
GSD	Glycemic Status Assessment for Patients with Diabetes — Blood sugar control, measured by an HbA1c test or continuous glucose monitoring.

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MY 2026 Priority Measures and Goals

Continue to focus on improvement, sustain achievement, & monitor new measures

<u>Elite Eight</u>: 90th percentile target (HPL)

- Continue to include Magnificent Seven – BCS, CCS, GSD, PPC-Pre, PPC-Post, LSC, & W30-2+
- Move IMA from Better Performance to 90th percentile target
  - Currently at the 95th %ile, performing over 4% HPL benchmark

Better Performance: 75th percentile target

- Continue to include CIS, W30-6+, & FUA
- Move CBP from MPL target
  - Reaching 80% of Star Measure targets

Minimum Performance Level: 50th percentile target (MPL)

- Continue to include WCV, TFL, DEV, & FUM
- Add new MY 2026 measures
  - Depression Screening (DSF)
  - Prenatal Depression Screening (PND)
  - Postpartum Depression Screening (PDS)
  - Colorectal Cancer Screening (COL)

Retired in MY 2026

- Asthma Medication Ratio (AMR)
- Chlamydia Screening in Women (CHL)

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Total Care Advantage Goals

Eve Gelb, Chief Innovation Officer

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Strategic Goals: Total Care Advantage

Goal	Key Results	Executive Sponsor
1. ENHANCE MEMBER EXPERIENCE: Increase Total Care Advantage membership	1,200 to 2,500 Total Care Advantage members by 12/31/26 • Monthly Enrollment: 80 members • Monthly Disenrollment: Less than 3%	Eve and Marlen
2. OPTIMIZE PROVIDER RELATIONSHIPS: Optimize Total Care Advantage Provider Partnerships	65% of members have completed Annual Wellness Visit in 2026 • Q1 – 20% of members complete Annual Wellness Visit • Q2 – 35% of members complete Annual Wellness Visit • Q3 – 50% of members complete Annual Wellness Visit • Q4 – 65% of members complete Annual Wellness Visit	Eve
3. ADVANCE QUALITY OF CARE: Achieve Total Care Advantage Quality Targets	80% of Star Measures meeting performance targets for 2026 Measurement Year • Specific Star Measure Targets set by 4/1/26 • Star Measure Performance Reporting in place by 5/1/26	Eve

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Foundational Goals: Total Care Advantage

Goal	Key Results	Executive Sponsor
FOUNDATIONAL		
Meet Financial Target - Total Care Advantage	Less than $11M Loss for Total Care Advantage 2026 • Less than $916,000 loss per month	Eve
Meet Compliance Targets – Total Care Advantage	85% of prioritized Member Impact compliance metrics meeting compliance targets for 2026 • Compliance metrics and reporting in place and prioritized Member Impact compliance metrics identified by 4/1/2026 • Q2 – 80% of prioritized Member Impact compliance metrics meet targets • Q3 – 85% of prioritized Member Impact compliance metrics meet targets • Q4 – 90% of prioritized Member Impact compliance metrics meet targets	Eve

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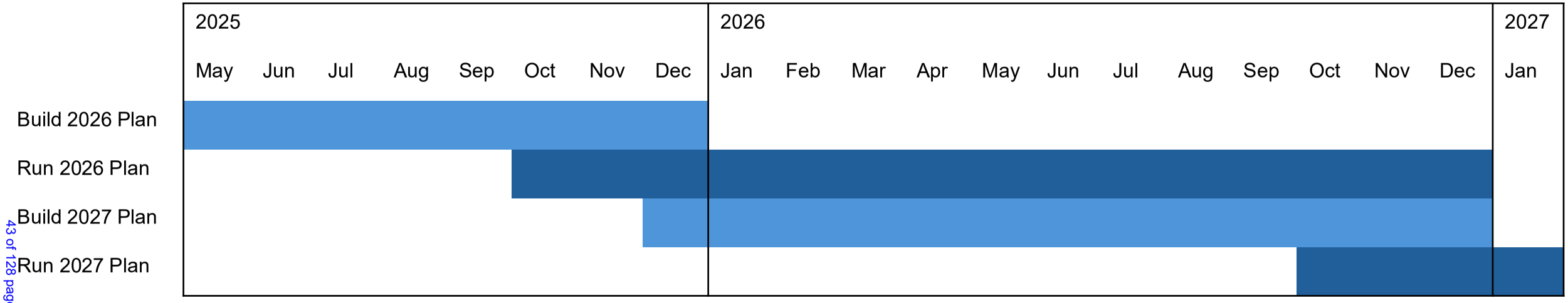
Total Care Advantage: Build-Run Cycle



- Build of the 2026 was run as a program with 14 months' support from the PMO and multiple consultants.
- For the running of 2026 Plan and building the 2027 plan we are proposing a structure with dedicated resources and some PMO and consulting support.
- Program will develop a workplan including timelines and responsible parties will be in place by 3/1/2026 that:
  - Outlines all activities required to meet 2026 KPIs
  - Outlines all activities required to meet compliance deliverables
  - Outlines all activities required to transition from Deloitte-supported activities to GCHP-supported activities, including business and IT ownership of systems and processes
  - Outlines all activities required for 2027 Plan Build for Ready to Sell, Ready to Enroll and Ready to Serve

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GOLD COAST HEALTH PLAN TOTAL Care ADVANTAGE

Next Steps

Marlen Torres, Chief Member Experience and External Affairs Officer
Paul Aguilar, Chief HR and Organizational Performance Officer

Return to Agenda

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AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: January 26, 2026

SUBJECT: Update on the creation of the Ventura County Health Care Coalition

SUMMARY:

On July 4, 2025, President Donald Trump signed H.R. 1, known as the "One Big Beautiful Bill," which proposes cutting about $1 trillion of Medicaid funding over the next decade. For California, this means a loss of about $30 billion every year over the next 10 years. Here in Ventura County, the $1 billion in funding that Gold Coast Health Plan (GCHP) contributes to the local economy is at risk.

H.R. 1 aims to achieve these savings by:

1. Enacting work requirements for those ages 19-64;
2. Increasing eligibility verification for the adult expansion population to every six months;
3. Modifying retroactive coverage during presumptive eligibility;
4. Adding cost sharing for the expansion population;
5. Implementing limits on state provider taxes and state directed payments.

In Ventura County, this legislative bill will have a significant impact on the health and quality of life of more than 240,000 GCHP members and other county residents. Mitigating the impact of H.R. 1 will have on our members and community will only be possible by working with our trusted community partners.

After the passage of H.R. 1, GCHP staff met with key health care leaders in Ventura County to prepare for the upcoming changes. At the Aug. 25, 2025, Commission meeting, GCHP staff introduced the Advocacy and Policy Guiding Principles for feedback and support from the Commission so that GCHP may continue to advocate and prepare for the changes prompted by the implementation of H.R. 1.

Through discussions with various community leaders, it was evident that a coalition of key stakeholders was necessary to prepare for the changes and address the challenges that H.R. 1 will have in Ventura County. Thus, GCHP staff is preparing to launch the first meeting of the Ventura County Health Care Coalition.

The focus of The Coalition will include the following:

1. Continued advocacy against any further funding and enrollment cuts in the Medicaid Program.

2. Address access concerns / barriers in coverage for most at-risk populations, such as:
   a. Adult Expansion
   b. Members without adequate immigration status
   c. Older adults
   d. Children and families

3. Education and Outreach on H.R. 1 Eligibility Changes:
   a. Education and communication campaigns to support members as they navigate the proposed changes in coverage, including meeting work requirements and completing increased eligibility renewals.

Accordingly, based on feedback from the Coalition, GCHP will work with its trade associations to inform and influence state and federal lawmakers and agencies on the implementation of H.R. 1. GCHP staff will also leverage our state lobbyists and the Public Relations firm we work with for continued advocacy and member education / outreach efforts.

Finally, the Coalition further supports GCHP's strategic goal on member retention efforts outlined in the strategic goals Commission agenda item.

RECOMMENDATION: Receive and file the report.

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Sara Dersch, Chief Financial Officer

DATE: January 26, 2026

SUBJECT: November 2025 Fiscal Year to Date Financials

SUMMARY:
Staff is presenting the attached November 2025 fiscal year-to-date ("FYTD") unaudited financial statements of Gold Coast Health Plan ("GCHP") for review and approval.

ATTACHMENT:
November 2025 Financial Package

APPENDIX:
- Income Statement FYTD
- 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 November 2025				Fiscal Year to Date Through November 2025			
	Actual	Stub Budget	Fav /(Unfav)	%	Actual	Stub Budget	Fav /(Unfav)	%
	11/1/25	11/1/25	11/1/25	11/1/25	11/1/2025	11/1/25	11/1/25	11/1/25
Membership	239,361	225,156	14,205	6.3%	1,202,206	1,137,206	65,000	5.7%
Revenue								
Premium	$ 129,351,393	$ 88,680,136	$ 40,671,256	45.9%	$ 661,862,255	$ 448,859,976	$ 213,002,280	47.5%
Facility Expense AB85	-	-			-	-	-	
Reserve for Cap Requirements	2,133,568	(211,377)	2,344,945	-1109.4%	303,017	(1,070,266)	1,373,283	-128.3%
Incentive Revenue	198,921	-	198,921		198,921	-	198,921	
MCO Premium Tax	(33,979,095)	-	(33,979,095)		(170,927,328)	-	(170,927,328)	
Total Net Premium	**97,704,786**	**88,468,759**	**9,236,027**	**10.4%**	**491,436,865**	**447,789,710**	**43,647,155**	**9.7%**
Other Revenue:								
Miscellaneous Income	150	-	150		660	-	660	
Total Other Revenue	150	-	150		660	-	660	
Total Revenue	**97,704,936**	**88,468,759**	**9,236,177**	**10.4%**	**491,437,525**	**447,789,710**	**43,647,815**	**9.7%**
Medical Benefits:								
Capitation:								
PCP, Specialty, Kaiser, NEMT & Vision	$ 7,125,461	$ 6,488,245	$ (637,216)	-9.8%	$ 35,849,803	$ 33,073,195	$ (2,776,608)	-8.4%
ECM	1,261,148	1,325,813	64,665	4.9%	6,121,828	6,704,990	583,162	8.7%
Total Capitation	**8,386,610**	**7,814,058**	**(572,551)**	**-7.3%**	**41,971,631**	39,778,185	**(2,193,446)**	**-5.5%**
FFS Claims:								
Inpatient	$ 20,959,988	$ 16,832,022	$ (4,127,967)	-24.5%	$ 112,143,625	$ 84,753,410	$ (27,390,215)	-32.3%
LTC / SNF	12,561,320	14,612,882	2,051,562	14.0%	78,032,601	72,840,565	(5,192,036)	-7.1%
Outpatient	13,718,890	8,006,185	(5,712,704)	-71.4%	50,730,810	40,061,153	(10,669,658)	-26.6%
Laboratory and Radiology	1,031,120	692,654	(338,466)	-48.9%	4,924,227	3,492,640	(1,431,587)	-41.0%
Directed Payments - Provider	826,476	779,041	(47,435)	-6.1%	1,140,770	3,981,057	2,840,288	71.3%
Emergency Room	4,540,081	3,347,382	(1,192,700)	-35.6%	19,969,374	16,841,949	(3,127,425)	-18.6%
Physician Specialty	144,908	5,588,525	5,443,617	97.4%	32,161,617	27,962,723	(4,198,894)	-15.0%
Primary Care Physician	(8,712,882)	4,011,173	12,724,054	317.2%	8,233,682	20,164,089	11,930,407	59.2%
Home & Community Based Services	7,012,386	3,553,390	(3,458,996)	-97.3%	36,912,939	17,608,267	(19,304,672)	-109.6%
Applied Behavior Analysis Services	6,989,441	4,678,360	(2,311,080)	-49.4%	29,292,645	22,917,220	(6,375,425)	-27.8%
Quality Incentive Provider Program (QIPP)	3,173,183	*3,583,370*	*410,187*	*11.4%*	12,489,798	17,916,849	5,427,051	*30.3%*
Other Medical Professional	847,817	378,378	(469,439)	-124.1%	3,171,272	1,891,954	(1,279,318)	-67.6%
Other Fee For Service	2,111,980	2,356,336	244,356	10.4%	9,845,598	11,828,032	1,982,433	16.8%
Transportation	285,500	430,888	145,388	33.7%	(1,350,350)	2,161,923	3,512,273	162.5%
Total Claims	**65,490,207**	**68,850,585**	**3,360,377**	**4.9%**	**397,698,610**	**344,421,832**	**(53,276,778)**	**-15.5%**
Provider Grant Program	943,745	1,178,500	234,755	20%	9,111,099	5,892,500	(3,218,599)	-55%
Medical & Care Management	6,171,607	2,275,943	(3,895,664)	-171%	15,168,662	11,379,713	(3,788,949)	-33%
Reinsurance	414,498	303,720	(110,778)	-36%	33,017	1,534,943	1,501,926	98%
Claims Recoveries	(1,288,197)	(100,000)	1,188,197	-1188%	(4,028,536)	(500,000)	3,528,536	-706%
Sub-total	**6,241,652**	**3,658,162**	**(2,583,490)**	**-71%**	**20,284,242**	**18,307,156**	**(1,977,086)**	**-11%**
Total Medical Benefits	80,118,469	80,322,805	204,336	0.3%	459,954,482	402,507,173	(57,447,310)	-14.3%
Contribution Margin	**17,586,467**	**8,145,954**	**9,440,513**	**115.9%**	**31,483,042**	**45,282,537**	**(13,799,495)**	**-30.5%**
General & Administrative Expenses:								
Salaries, Wages & Employee Benefits	6,362,733	4,327,465	(2,035,268)	-47%	32,236,498	21,680,923	(10,555,574)	-49%
Training, Conference & Travel	32,590	147,744	115,154	78%	293,286	1,107,701	814,415	74%
Outside Services	1,394,524	2,980,233	1,585,710	53%	9,773,311	15,757,921	5,984,610	38%
Professional Services	820,627	1,111,010	290,383	26%	4,885,594	5,064,373	178,779	4%
Occupancy, Supplies, Insurance & Others	2,594,643	2,631,238	36,595	1%	16,396,839	12,202,031	(4,194,809)	-34%
ARCH/Community Grants	-	104,166	104,166	100%	4,500	520,830	516,330	99%
Sponsorships	52,000	39,583	(12,417)	-31%	83,500	197,915	114,415	58%
Care Management Reclass to Medical	(6,171,607)	(2,275,943)	3,895,664	-171%	(15,168,662)	(11,379,713)	3,788,949	-33%
G&A Expenses	**5,085,509**	**9,065,496**	**3,979,987**	44%	**48,504,867**	**45,151,981**	**(3,352,885)**	**-7%**
Project Portfolio (OOTF)	-	773,855	773,855	100%	-	3,869,277	3,869,277	100%
D-SNP	565,922	180,857	(385,066)	-213%	4,077,303	904,283	(3,173,019)	-351%
Project Portfolio	**565,922**	**954,712**	**388,790**	**41%**	**4,077,303**	**4,773,560**	**696,257**	15%
Total G&A Expenses	**5,651,432**	**10,020,208**	**4,368,776**	**44%**	**52,582,169**	**49,925,541**	(2,656,628)	-5%
Total Operating Gain / (Loss)	**11,935,035**	**(1,874,254)**	**13,809,289**	-737%	**(21,099,127)**	**(4,643,004)**	**(16,456,123)**	**-354.4%**
Retro Premium Adj	(21,096,712)	-	$ (21,096,712)		(21,412,007)	-	$ (21,412,007)	
Non Operating								
Revenues - Interest	898,950	1,500,000	$ (601,050)	-40.1%	5,736,590	7,500,000	(1,763,410)	-24%
Expenses - Interest	-	-						
Gain/(Loss) on Sale of Asset	-	-						
Total Non-Operating	**898,950**	**1,500,000**	$ (601,050)	-40.1%	**5,736,590**	**7,500,000**	(1,763,410)	-24%
Total Increase / (Decrease) in Unrestricted Net Assets	**$ (8,262,727)**	**$ (374,254)**	**$ (7,888,472)**	**-2108%**	**$ (36,774,545)**	**$ 2,856,996**	**$ (39,631,540)**	**1387%**

STATEMENT OF FINANCIAL POSITION		
	As of Month Ending, November 2025	As of Month Ending, June 2025
ASSETS		
Current Assets:		
Total Cash and Cash Equivalents	**$ 236,426,759**	**$ 291,033,725**
Total Short-Term Investments	**106,391,943**	**104,396,027**
Medi-Cal Receivable	250,664,105	213,250,889
Interest Receivable	630,659	761,742
Provider Receivable	3,948,455	34,764,364
Other Receivables	8,595,449	8,595,449
Total Accounts Receivable	**263,838,668**	**257,372,444**
Total Prepaid Accounts	9,983,550	14,810,767
Total Other Current Assets	320,402	133,545
Total Current Assets	**616,961,322**	**667,746,508**
Total Fixed Assets	**61,632,516**	**60,155,248**
Total Assets	**$ 678,593,838**	**$ 727,901,756**
LIABILITIES & NET ASSETS		
Current Liabilities:		
Incurred But Not Reported	$ 112,153,036	$ 166,097,652
Claims Payable	18,345,175	18,345,175
Capitation Payable	7,664,577	7,239,849
Physician Payable	10,930,617	13,406,843
DHCS - Reserve for Capitation Recoup	53,973,170	31,573,252
Lease Payable- ROU	6,720,010	7,035,805
Accounts Payable	7,315,381	6,704,869
Accrued Provider Incentives/Reserve	5,012,454	7,889,172
Accrued Expenses	15,124,490	22,928,272
Accrued Premium Tax	140,453,362	105,862,040
Accrued Payroll Expense	11,466,547	9,850,498
Quality Withhold	5,032,163	5,335,108
Total Current Liabilities	**394,531,224**	**402,868,902**
Long-Term Liabilities:		
Lease Payable - NonCurrent - ROU	20,984,641	25,180,339
Total Long-Term Liabilities	**20,984,641**	**25,180,339**
Total Liabilities	**415,515,865**	**428,049,241**
Net Assets:		
Beginning Net Assets	299,852,518	307,740,987
Total Increase / (Decrease in Unrestricted Net Assets)	(36,774,545)	(7,888,472)
Total Net Assets	**263,077,973**	**299,852,515**
Total Liabilities & Net Assets	**$ 678,593,838**	**$ 727,901,756**

STATEMENT OF CASH FLOWS	For the Month Ended November 2025	Fiscal Year to Date Through November 2025
Cash Flows Provided By Operating Activities		
Net Income (Loss)	$ (8,262,727)	$ (36,774,545)
Adjustments to reconciled net income to net cash provided by operating activities		
Depreciation on fixed assets	1,098,071	2,474,330
Changes in Operating Assets and Liabilities		
Accounts Receivable	(34,988,695)	(6,466,223)
Prepaid Expenses	1,986,233	4,640,360
Accrued Expense and Accounts Payable	19,083,353	9,501,514
Claims Payable	(286,265)	(2,051,498)
MCO Tax liability	33,979,095	34,591,322
IBNR	(14,023,495)	(53,944,616)
Net Cash Provided by (Used in) Operating Activities	**(1,414,430)**	**(48,029,356)**
Cash Flow Provided By Investing Activities		
Proceeds from Investments	(617,164)	(1,995,916)
Purchase of Property and Equipment	(516,171)	(3,951,598)
Net Cash (Used In) Provided by Investing Activities	**(1,133,335)**	**(5,947,514)**
Cash Flow Provided By Financing Activities		
Lease Payable - ROU	(127,122)	(630,097)
Net Cash Used In Financing Activities	**(127,122)**	**(630,097)**
Increase/(Decrease) in Cash and Cash Equivalents	(2,674,887)	(54,606,967)
Cash and Cash Equivalents, Beginning of Period	239,101,646	291,033,725
Cash and Cash Equivalents, End of Period	**236,426,759**	**$ 236,426,759**

SCHEDULE OF INVESTMENTS AND CASH BALANCES	Market Value as of Month Ending, November 2025	Account Type
Local Agency Investment Fund (LAIF)	$ 45,490,850	Investment
Ventura County Investment Pool	$ 20,449,904	Investment
CalTrust	$ 40,451,189	Short-term investment
Bank of Montreal	$ 251,250,689	Money market account
Pacific Premier Bank	$ (14,823,929)	Operating accounts
Investments and monies held by GCHP	***$ 342,818,702***	

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Integrity
Accountability
Collaboration
Trust
Respect

November MTD and FYTD Financial Results

Commission Meeting
January 26, 2026
Sara Dersch, Chief Financial Officer

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711 East Daily Drive, Suite 106, Camarillo, CA 93010 www.goldcoasthealthplan.org

Executive Summary November 2025

- **MTD Operating Loss** is ($8.3M) which is ($7.9M) unfavorable to budget due to:
  - Prior period Unsatisfactory Immigration Status (UIS) Risk Corridor revenue take-back of ($21.1M) offset by $23.3M release in Targeted Rate Increase reserve for Federally Qualified Health Centers
  - Claims payment stabilization efforts continue to unfavorably influence Net Income/(Loss)
  - Administrative expense is $4.4M favorable to budget primarily due to YTD $3.8M reclassification of administrative Quality Improvement reclassification to medical costs
  - Note: Payment Integrity and Prior Authorization activities will positively influence Net Income/(Loss) in CY2026

- **YTD Operating Loss** is ($36.8M) which is ($39.7M) unfavorable to budget due to:
  - UIS CY2024 revenue take-back
  - Continued claims system stabilization
  - Interest expense due to paying claims late
  - Medically-tailored meals costs greater than State premium rate payments
  - Long Term Care (LTC) retroactive rate increases
  - TNE stands at 570% of DHCS minimum required amount

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Financial Results November MTD Summary

Item	Actual	Budget	Explanation
Membership	239,361	225,156	Adult and and Adult Expansion drive favorability in August membership
Revenue *Revenue pmpm*	$76.6M *$320.05*	$88.5M *$392.92*	CY2024 $21.1M UIS risk corridor revenue take-back drives revenue unfavorability, partially offset by favorable membership volume and rate mix
Medical Cost *Medical Costs pmpm* Medical Loss Ratio	$76.0M *$317.52* 99.2%	$75.6M *$335.59* 85.4%	The slight unfavorability in medical cost reflects continued claims clean-up payment pressures and excessive medically-tailored meals spend offset by the release of $23.3M in TRI reserves related to the federally qualified health centers (FCHQ)
Administrative Cost *Admin Cost PMPM* Administrative Loss Ratio	$5.7M *$23.61* 7.4%	$10.0M *$44.50* 11.3%	YTD $3.8M reclassification of administrative quality expenses to medical accounts for majority of favorability
Operating Results	**($5.0M)**	**$2.9M**	
Investment Income	$0.9M	$1.5M	Lower cash balances generate less-than-expected interest income
Quality Strategy (Grants/Incentives)	$4.1M	$4.8M	Variance related to timing of grant spend
Non Operating Results	**($3.2M)**	**($3.3M)**	
Net Income/(Loss)	**($8.3M)**	**($0.4M)**	
TNE	$263.1M	$316.9M	TNE is currently 570% of State Requirement

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Financial Results November YTD Summary

Item	Actual	Budget	Explanation
Membership	239,361	225,156	Adult and Adult Expansion categories drive the favorability
Revenue *Revenue pmpm*	$470.0M *$390.97*	$447.8M *$393.76*	YTD member mix favorability offset by CY2024 $21.1M UIS risk corridor revenue take-back
Medical Cost *Medical Costs pmpm* Medical Loss Ratio	$438.4M *$364.62* 93.3%	$378.7M *$333.01* 84.6%	Unfavorability result of claims-processing stabilization, long term care rates higher than expected, and overruns in medically-tailored meals
Administrative Cost *Admin Cost PMPM* Administrative Loss Ratio	$52.6M *$43.74* 11.2%	$49.9M *$43.90* 11.1%	Administrative spend approximates projections on a percent-of-revenue basis
Operating Results	**($20.9M)**	**$19.2M**	
Investment Income	$5.7M	$7.5M	Lower cash balances generate less-than-expected interest income
Quality Strategy (Grants/Incentives)	$21.6M	$23.8M	Variance is associated with timing of grant spend
Non Operating Results	**($15.9M)**	**($16.3M)**	
Net Income/(Loss)	**($36.8M)**	**$2.9M**	
TNE	$263.1M	$316.9M	TNE is currently 570% of State Requirement

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November Financial Results: Categories of Service

(In Millions except membership)	For the Month Ended November 2025 Actual	Budget	Fav / (Unfav)	Fiscal Year to Date Through November 2025 Actual	Budget	Fav / (Unfav)
Member Months	239,361	225,156	14,205	1,202,206	1,137,206	65,000
Capitation:						
Primary Care Physician (PCP)	$7.1	$6.5	($0.6)	$35.8	$33.1	($2.8)
Enhanced Care Management (ECM)	$1.3	$1.3	$0.1	$6.1	$6.7	$0.6
Total Capitation	**$8.4**	**$7.8**	**($0.6)**	**$42.0**	**$39.8**	**($2.2)**
FFS Claims:						
Inpatient	$21.0	$16.8	($4.1)	$112.1	$84.8	($27.4)
LTC / SNF	$12.6	$14.6	$2.1	$78.0	$72.8	($5.2)
Outpatient	$13.7	$8.0	($5.7)	$50.7	$40.1	($10.7)
Laboratory and Radiology	$1.0	$0.7	($0.3)	$4.9	$3.5	($1.4)
Directed Payments - Provider	$0.8	$0.8	($0.0)	$1.1	$4.0	$2.8
Emergency Room	$4.5	$3.3	($1.2)	$20.0	$16.8	($3.1)
Physician Specialty	$0.1	$5.6	$5.4	$32.2	$28.0	($4.2)
Primary Care Physician	($8.7)	$4.0	$12.7	$8.2	$20.2	$11.9
Home & Community Based Services	$7.0	$3.6	($3.5)	$36.9	$17.6	($19.3)
Applied Behavior Analysis Services	$7.0	$4.7	($2.3)	$29.3	$22.9	($6.4)
Other Medical Cost	$6.1	$6.3	$0.2	$25.5	$31.6	$6.1
Transportation	$0.3	$0.4	$0.1	($1.4)	$2.2	$3.5
Total Claims	**$65.5**	**$68.9**	**$3.4**	**$397.7**	**$344.4**	**($53.3)**
Other Medical Expense						
Provider Grant Program	$0.9	$1.2	$0.2	$9.1	$5.9	($3.2)
Medical & Care Management	$6.2	$2.3	($3.9)	$15.2	$11.4	($3.8)
Reinsurance	$0.4	$0.3	($0.1)	$0.0	$1.5	$1.5
Claims Recoveries	($1.3)	($0.1)	$1.2	($4.0)	($0.5)	$3.5
Total Other Medical Expense	**$6.2**	**$3.7**	**($2.6)**	**$20.3**	**$18.3**	**($2.0)**
Total Medical Cost	**$80.1**	**$80.3**	**$0.2**	**$460.0**	**$402.5**	**($57.4)**
Medical Margin	**$17.6**	**$8.1**	**$9.4**	**$31.5**	**$45.3**	**($13.8)**
Margin (w/o Grants and Incentives)	**$21.7**	**$12.9**	**$8.8**	**$53.1**	**$69.1**	**($16.0)**

Inpatient
High dollar inpatient claims and higher DHCS fee schedule rates drive the unfavourability

Long Term Care Center (LTC)
YTD unfavourability is due to retroactive rate changes

Outpatient
Unfavourability is due to the backlog of claims and increased DHCS fees schedule rates

Home and Community Based Services
Unfavourability is due to new CalAIM requirements, specifically medically tailored meals utilization

PPC
Favorability from removal of TRI FQHC reserve

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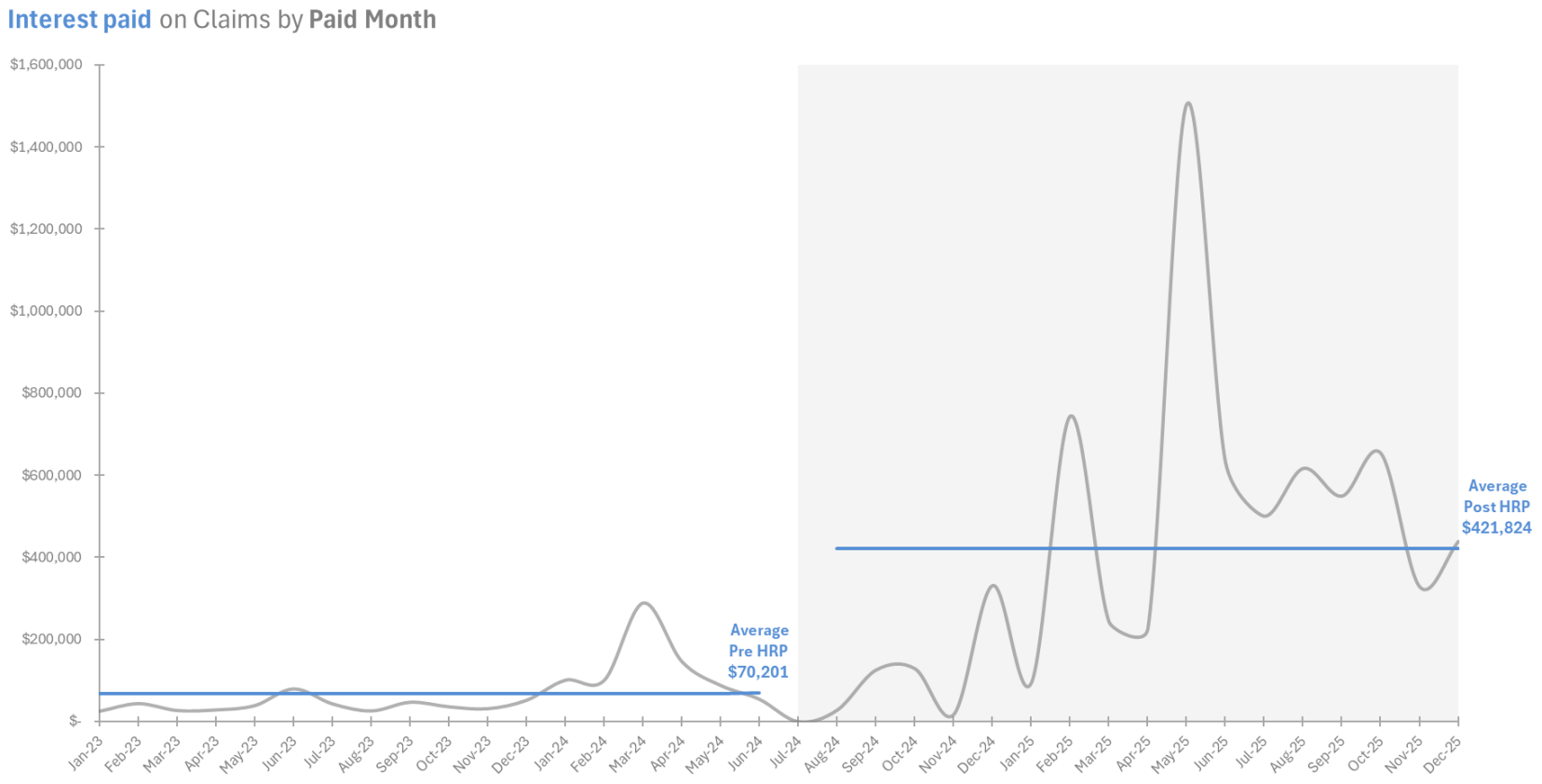
Claims Interest Expense: 2-Year Comparison



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Labor Expense by Category November FYTD

Gold Coast Health Plan - Position Count Stub Period 2025
SP25 - Nov 30, 2025

	EMPLOYEE COUNT					
Function	**Active Headcount**	**Open Requisitions**	**Total Active + Open Requisitions**	**2026 Budget YE Headcount**	**Variance to 2026 YE Headcount**	**Percentage of Total Headcount**
Health Services	137	3	140	140	0	30%
Operations	106	2	108	108	0	23%
Information Tech	43	0	43	43	0	9%
Policy & Programs	44	1	45	45	0	10%
Compliance	21	1	22	22	0	5%
Finance & Accounting	38	0	38	38	0	8%
Executive & Administration	14	0	14	14	0	3%
Member Experience and Ext Affairs	39	1	40	40	0	9%
HR & Facilities	12	0	12	12	0	3%
Innovation / DSNP	4	0	4	4	0	1%
Strategic Initiatives	0	0	0	0	0	0%
Grand Total	**458**	**8**	**466**	**466**	**0**	**100%**

	POSITION COUNT	CONTINGENT WORKERS			TOTAL RESOURCES	
Function	**Total Active + Open Requisitions**	**Temp Roles**	**Contractor / Consultant Roles**	**Total Contingent Workers†**	**Total Resources**	**Percentage of Total Resources**
Health Services	140	0	4	4	144	24%
Operations	108	5	10	15	123	20%
Information Tech	43	0	3	3	46	8%
Policy & Programs	45	0	0	0	45	7%
Compliance	22	1	0	1	23	4%
Finance & Accounting	38	3	3	6	44	7%
Executive & Administration	14	0	3	3	17	3%
Member Experience and Ext Affairs	40	1	0	1	41	7%
HR & Facilities	12	2	6	8	20	3%
Innovation / DSNP	4	4	101	105	109	18%
Strategic Initiatives	0	0	0	0	0	0%
Grand Total	**466**	**16**	**130**	**146**	**612**	**100%**

†Outsourced Labor (BPO) excluded: 83 in Operations - Netmark

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2025 Rates: Membership and Premium Rates

Category of Aid	2024 Rates	2025 Rates (Budget)	2025 Initial (Oct)	2025 Initial (Dec)	2025 Final (Dec)	2025 Final Membership
Adult - SIS	$ 339.69	**$ 368.95**	$ 328.27	$ 334.88	**$ 341.29**	24,750
Adult - UIS	$ 480.75	**$ 551.79**	$ 413.61	$ 420.93	**$ 385.37**	15,065
Adult Expansion - SIS	$ 339.63	**$ 343.99**	$ 344.10	$ 351.27	**$ 405.72**	67,403
Adult Expansion - UIS	$ 559.76	**$ 557.23**	$ 552.00	$ 563.25	**$ 558.41**	12,434
Child - SIS	$ 108.75	**$ 109.51**	$ 110.58	$ 112.96	**$ 129.44**	87,333
Child - UIS	$ 102.30	**$ 125.01**	$ 104.05	$ 106.25	**$ 107.12**	3,958
LTC Dual - SIS	$ 650.41	**$ 649.34**	$ 618.72	$ 630.68	**$ 596.26**	630
LTC Dual - UIS	$ 502.67	**$ 502.13**	$ 606.01	$ 620.27	**$ 724.65**	6
LTC Non-Dual - SIS	$ 1,268.91	**$ 1,281.00**	$ 1,193.38	$ 1,216.03	**$ 1,248.60**	29
LTC Non-Dual - UIS	$ 1,290.23	**$ 1,325.12**	$ 1,446.82	$ 1,478.10	**$ 1,539.34**	20
SPD - SIS	$ 1,311.31	**$ 1,282.78**	$ 1,203.30	$ 1,222.19	**$ 1,248.60**	6,035
SPD - UIS	$ 1,348.14	**$ 1,337.48**	$ 1,446.65	$ 1,477.88	**$ 1,539.34**	1,307
SPD Dual - SIS	$ 655.58	**$ 649.29**	$ 618.72	$ 630.68	**$ 596.26**	25,532
SPD Dual - UIS	$ 513.29	**$ 502.37**	$ 606.01	$ 620.27	**$ 724.65**	119
FY 2025 Final Projected Membership						**244,620**

Note: Font color in "2025 Final" column indicates favorable (green) or unfavorable (red) change from original budget projections.

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- Appendix 2: November Balance Sheet: Assets
- Appendix 3: November Balance Sheet: Liabilities
- Appendix 4: November Statement of Cash Flow
- Appendix 5: November Investments and Cash

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Appendix 1: TNE Overview

DEFINITION:

Tangible Net Equity is the total assets of a health plan minus:

- its total liabilities
- the value of its intangible assets
- unsecured obligations of officers, directors, owners, or affiliates

TNE is fluid and will change based on a health plan's cash position, receivables, liabilities, and delegated model. GCHP recalculates required TNE quarterly.

REQUIRED TNE CALCULATION:

8% of the first $150M of annualized healthcare expenditures, except those paid on a capitated or managed hospital basis	+	4% of annualized healthcare expenditures in excess of $150M except those paid on a capitated or managed hospital basis	+	4% of the annualized hospital expenditures paid on a managed hospital payment basis	=	Required TNE

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Appendix 2: November Balance Sheet: Assets

STATEMENT OF FINANCIAL POSITION		
	As of Month Ending, November 2025	As of Month Ending, June 2025
ASSETS		
Current Assets:		
Total Cash and Cash Equivalents	**$ 236,426,759**	**$ 291,033,725**
Total Short-Term Investments	**106,391,943**	**104,396,027**
Medi-Cal Receivable	250,664,105	213,250,889
Interest Receivable	630,659	761,742
Provider Receivable	3,948,455	34,764,364
Other Receivables	8,595,449	8,595,449
Total Accounts Receivable	**263,838,668**	**257,372,444**
Total Prepaid Accounts	9,983,550	14,810,767
Total Other Current Assets	320,402	133,545
Total Current Assets	**616,961,322**	**667,746,508**
Total Fixed Assets	**61,632,516**	**60,155,248**
Total Assets	**$ 678,593,838**	**$ 727,901,756**

- Total Asset balance of $678.6M represents a decrease of $49.3M vs last fiscal year end is attributed to the following:
  - Lower Cash Equivalents and Short-Term Cash (Normal operations)
  - Compounded by a decrease in Medi-Cal and Provider Receivable associated with operational functions

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Appendix 3: November Balance Sheet: Liabilities

STATEMENT OF FINANCIAL POSITION		
LIABILITIES & NET ASSETS	As of Month Ending, November 2025	As of Month Ending, June 2025
Current Liabilities:		
Incurred But Not Reported	$ 112,153,036	$ 166,097,652
Claims Payable	18,345,175	18,345,175
Capitation Payable	7,664,577	7,239,849
Physician Payable	10,930,617	13,406,843
DHCS - Reserve for Capitation Recoup	53,973,170	31,573,252
Lease Payable- ROU	6,720,010	7,035,805
Accounts Payable	7,315,381	6,704,869
Accrued ACS	-	-
Accrued Provider Incentives/Reserve	5,012,454	7,889,172
Accrued Expenses	15,124,490	22,928,272
Accrued Premium Tax	140,453,362	105,862,040
Accrued Payroll Expense	11,466,547	9,850,498
Quality Withhold	5,032,163	5,335,108
Total Current Liabilities	**394,531,224**	**402,868,902**
Long-Term Liabilities:		
Lease Payable - NonCurrent - ROU	20,984,641	25,180,339
Total Long-Term Liabilities	**20,984,641**	**25,180,339**
Total Liabilities	**415,515,865**	**428,049,241**
Net Assets:		
Beginning Net Assets	299,852,518	307,740,987
Total Increase / (Decrease in Unrestricted Net Assets)	(36,774,545)	(7,888,472)
Total Net Assets	**263,077,973**	**299,852,515**
Total Liabilities & Net Assets	**$ 678,593,838**	**$ 727,901,756**

- Total Liabilities: $12.5M decrease vs last fiscal year end is primarily attributed to the following:
  - $53.9M decrease in Incurred But Not Yet Paid (IBNP) claims
  - An increase in DHCS reserve capitation recoup of $22.4M
  - An increase of Premium tax accrual of $34.6M
  - All other offsetting variances drivers are the result of normal operations

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Appendix 4: November Statement of Cash Flow

STATEMENT OF CASH FLOWS	For the Month Ended November 2025	Fiscal Year to Date Through November 2025
Cash Flows Provided By Operating Activities		
Net Income (Loss)	$ (8,262,727)	$ (36,774,545)
Adjustments to reconciled net income to net cash provided by operating activities		
Depreciation on fixed assets	1,098,071	2,474,330
Changes in Operating Assets and Liabilities		
Accounts Receivable	(34,988,695)	(6,466,223)
Prepaid Expenses	1,986,233	4,640,360
Accrued Expense and Accounts Payable	19,083,353	9,501,514
Claims Payable	(286,265)	(2,051,498)
MCO Tax liability	33,979,095	34,591,322
IBNR	(14,023,495)	(53,944,616)
Net Cash Provided by (Used in) Operating Activities	**(1,414,430)**	**(48,029,356)**
Cash Flow Provided By Investing Activities		
Proceeds from Investments	(617,164)	(1,995,916)
Purchase of Property and Equipment	(516,171)	(3,951,598)
Net Cash (Used In) Provided by Investing Activities	**(1,133,335)**	**(5,947,514)**
Cash Flow Provided By Financing Activities		
Lease Payable - ROU	(127,122)	(630,097)
Net Cash Used In Financing Activities	**(127,122)**	**(630,097)**
Increase/(Decrease) in Cash and Cash Equivalents	(2,674,887)	(54,606,967)
Cash and Cash Equivalents, Beginning of Period	239,101,646	291,033,725
Cash and Cash Equivalents, End of Period	**236,426,759**	**$ 236,426,759**

- The Total Year-to-Date decrease in cash of $54.6M is due to the following:
  - Year-to-Date Net Loss
  - Decrease in the IBNP
  - Partially offset by increased receivables

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Appendix 5: November Investments and Cash

SCHEDULE OF INVESTMENTS AND CASH BALANCES			
		Market Value as of Month Ending, November 2025	Account Type
Local Agency Investment Fund (LAIF)	$	45,490,850	Investment
Ventura County Investment Pool	$	20,449,904	Investment
CalTrust	$	40,451,189	Short-term investment
Bank of Montreal	$	251,250,689	Money market account
Pacific Premier Bank	$	(14,823,929)	Operating accounts
Investments and monies held by GCHP	***$***	***342,818,702***	

- Cash balances fluctuate daily; the balances as of November 2025, reflect normal operations
- Cash and short-term investments balance sits at $342.8M
- The investment portfolio includes:
  - LAIF CA State $45.5M
  - Ventura County Investment Pool $20.5M
  - Cal Trust $40.5M
  - Bank of Montreal balance of $251.3M is the operational account
  - The negative balance in Pacific Premier Bank represent outstanding checks

Gold Coast Health Plan℠
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AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Sara Dersch, Chief Financial Officer

DATE: January 26, 2026

SUBJECT: 2026 Budget

PowerPoint with Verbal Presentation

ATTACHMENTS:

2026 Proposed Budgett

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

2026 Proposed Budget

Ventura County Medi-Cal Managed Care Commission Meeting
January 26, 2026
Sara Dersch, Chief Financial Officer

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711 East Daily Drive, Suite 106, Camarillo, CA 93010 www.goldcoasthealthplan.org

2026 Budget Executive Summary

Overall economics of the organization are contracting as a result of reduction in membership. The budget is informed by this new reality.

Medi-Cal

- We are currently projecting $1.2B in revenue and $1.1B in medical cost, reflecting an 86.3% MLR
- We are targeting administrative costs at $147.2M, which is 10.2% of revenue
- Net income at $2.1M is essentially break-even
- Membership reductions are planned for most of the Unsatisfactory Immigration Status (UIS) categories of Aid based on Federal Actions; we expect 233K members by year-end; we will continue to revise projections throughout the year as, and if, material membership changes emerge
- This budget includes $9.3M of amortized expenses associated with system and product implementations

Medicare

- We are projecting 1,200 members by year-end

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2026 Potential Headwinds and Tailwinds

Headwinds

- Continued adverse regulatory changes coming from both State and Federal governments
- Significant Federal/State budgetary constraints
- Change in risk pool composition as a result of membership changes
- Continuation of Operating improvements resulting in additional costs
- Competing with Kaiser for membership

Tailwinds

- 2026 mid-year premium rate increases
- Member attrition not as high as projected
- Potential for value-based contracting
- Completion of claims clean-up resulting in reduction in IBNR
- Impacts of implementing prior authorization matching

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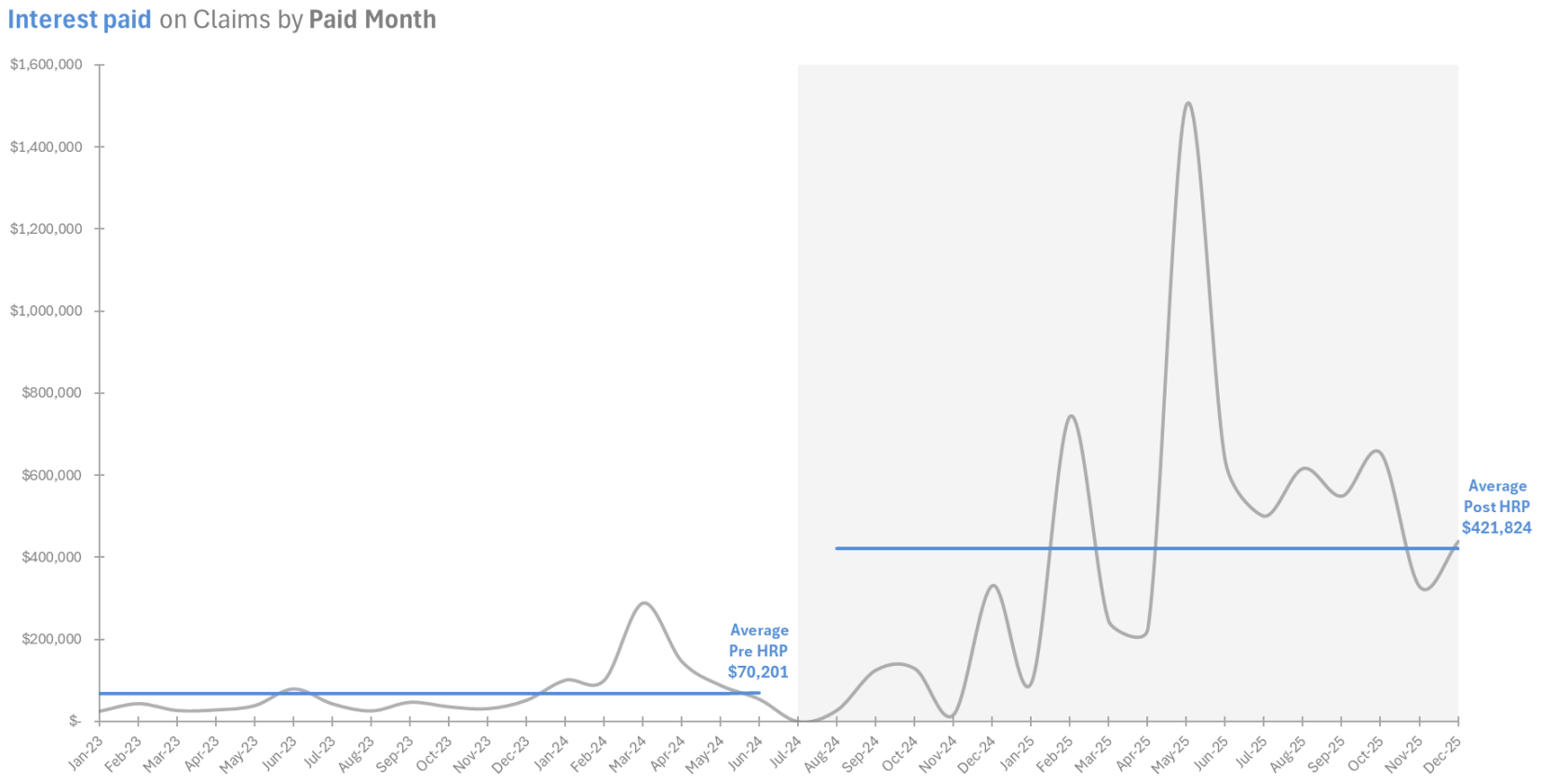
Claims Interest Expense: 3-Year Comparison



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COHS/Sister Plan Enrollment Drops

SANTA CLARA FAMILY HEALTH PLAN			
LOCAL PLAN SURVEY			
ENROLLMENT CHANGE: JAN-26 VS. DEC-25			
AS OF 01/07/26			
		Monthly Enrollment Reduction	**Comments**
1	Alameda Alliance	1.7%	
2	Cal Optima	1.5%	
3	Cal Viva	1.1%	
4	CenCal	1.0%	
5	Central CA Alliance	0.4%	
6	CHG	1.0%	
7	Contra Costa	2.0%	
8	Gold Coast	0.1%	
9	HPSJ	2.0%	
10	HPSM	2.8%	Lost about 5% UIS in Jan-26
11	IEHP	0.5%	
12	Imperial	1.1%	
13	Kern	1.5%	
14	LA Care	1.5%	
15	Partnership		
16	SFHP		
17	SCFHP	2.0%	(ignoring partly-offsetting Anthem member inflow)
	Non-Weighted Average	1.3%	

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2024-2026 Membership and Rates

Category of Aid	2024		2025		2026 v1		2026 v2	
	Rates	Membership	Rates	Membership	Rates	Membership	Rates	Membership
Adult - SIS	$ 339.69	23,870	$ 341.29	22,097	$ 378.96	20,411	$ 481.54	22,940
Adult - UIS	$ 480.75	15,699	$ 385.37	15,735	$ 326.57	14,671	$ 421.94	13,296
Adult Expansion - SIS	$ 339.63	67,604	$ 405.72	65,526	$ 429.93	58,936	$ 487.89	62,113
Adult Expansion - UIS	$ 559.76	13,447	$ 558.41	14,394	$ 650.75	12,440	$ 704.79	10,812
Child - SIS	$ 108.75	83,215	$ 129.44	79,331	$ 142.57	79,949	$ 142.57	81,572
Child - UIS	$ 102.30	4,708	$ 107.12	5,054	$ 129.06	4,374	$ 164.54	2,923
LTC Dual - SIS[1]	$ 650.41	698	$ 596.26	44	$ 647.95	-	$ 669.10	-
LTC Dual - UIS[1]	$ 502.67	7	$ 724.65	12	$ 815.04	-	$ 833.92	-
LTC Non-Dual - SIS[1]	$ 1,268.91	38	$ 1,248.60	697	$ 1,397.32	-	$ 1,497.60	-
LTC Non-Dual - UIS[1]	$ 1,290.23	21	$ 1,539.34	8	$ 1,476.52	-	$ 1,569.97	-
SPD - SIS	$ 1,311.31	10,281	$ 1,248.60	9,548	$ 1,397.32	8,927	$ 1,497.60	9,152
SPD - UIS	$ 1,348.14	1,544	$ 1,539.34	1,811	$ 1,476.52	1,781	$ 1,569.97	1,596
SPD Dual - SIS	$ 655.58	24,394	$ 596.26	25,742	$ 647.95	27,133	$ 669.10	28,312
SPD Dual - UIS	$ 513.29	101	$ 724.65	328	$ 815.04	100	$ 833.92	242
		245,627		**240,327**		**228,722**		**232,958**

Note:

1. LTC and SPD COAs have been combined effective 2026

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2026 Medi-Cal Budget

		Revenues	Expenses
Operating Income	Premium Revenue	$ 1,225,942,564	
	Medical Costs: FFS		$ 975,051,132
	Medical Costs: Cap		$ 52,911,198
	Medical Costs: Other		$ 8,370,349
	Medical Costs: Quality Improvement		$ 22,085,454
	gross margin	$ 1,225,942,564	$ 1,058,418,132
	Admin Expense		$ 147,179,710
	Quality Improvement credit		$ (22,085,454)
	net admin	$ -	$ 125,094,256
	Operating Income	**$ -**	**$ 42,430,175**
Non-Operating Income	Interest Income	$ 12,000,000	
	Quality Strategy		$ 43,000,000
	Amortization		$ 9,286,264
	Net Non-Operating Income	**$ 12,000,000**	**$ (40,286,264)**
	Net Income		**$ 2,143,911**

MLR	86.3%
ALR	10.2%
NNOIR	3.3%
Retained savings	0.2%
	100.0%

- Medical costs are based on utilization through October 2025
- Payment integrity recoveries are not included, nor is prior authorization matching, though this matching will be in place beginning in February; this could result in a medical cost reduction
- Provider and Hospital Quality Incentives are fully-funded

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2026 Medicare Budget

		Revenues	Expenses
Operating Income	Premium Revenue	$ 18,551,127	
	Medical Costs: FFS		$ 15,191,518
	Medical Costs: Rx		$ 2,780,993
	Medical Costs: Other		$ -
	Medical Costs: Quality Improvement		$ 1,000,000
	gross margin	$ 18,551,127	$ 18,972,511
	Admin Expense		$ 10,911,752
	Quality Improvement credit		$ (1,000,000)
	net admin	$ -	$ 9,911,752
	Operating Income	**$ -**	**$ (10,333,136)**
Non-Operating Income	Interest Income	$ -	
	Quality Strategy Amortization		$ 500,000
	Net Non-Operating Income	**$ -**	**$ (500,000)**
	Net Income		**$ (10,833,136)**

MLR	102.3%
ALR	53.4%
NNOIR	2.7%
Retained savings	-58.4%
	100.0%

- 1200 members projected by year-end
- Medical costs are based on Bid per member per month projections
- Most administrative costs are fixed (not related to volume)

2026 Consolidated Budget

		Revenues	Expenses
Operating Income	Premium Revenue	$ 1,244,493,691	
	Medical Costs: FFS		$ 990,242,650
	Medical Costs: Rx		$ 2,780,993
	Medical Costs: Capitation		$ 52,911,198
	Medical Costs: Other		$ 8,370,349
	Medical Costs: Quality Improvement		$ 23,085,454
	gross margin	$ 1,244,493,691	$ 1,077,390,643
	Admin Expense		$ 158,091,462
	Quality Improvement credit		$ (23,085,454)
	net admin		$ 135,006,008
	Operating Income		**$ 32,097,039**
Non-Operating Income	Interest Income	$ 12,000,000	$ -
	Quality Strategy		$ 43,000,000
	Amortization		$ 9,786,264
	Net Non-Operating Income		**$ (40,786,264)**
	Net Income		**$ (8,689,225)**

MLR	86.6%
ALR	10.8%
NNOIR	3.3%
Retained	-0.7%
	100.0%

- Retained earnings in Medi-Cal used to offset first year Medicare deficit

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2026 Budget by Cost Center & Executive

2026 Budget		
Cost Center	Executive	Budget
CC100 Administration	CFO	$ 9,286,264
CC105 Executive	CEO	9,404,641
CC101 Finance and Accounting	CFO	6,213,429
CC102 Procurement	CFO	817,249
CC110 IT- Data Warehouse	CISMO	1,961,543
CC112 IT-Infrastructure and Security	CISMO	8,647,199
CC113 IT- Architecture and Testing	CISMO	10,016,196
CC103 Project Management	CFO	4,008,437
CC114 IT- Information Technology	CISMO	6,918,806
CC115 IT-Population Health Enablement	CISMO	1,512,220
CC120 Operations	COO	22,350,573
CC121 Grievance and Appeals	COO	715,289
CC122 Ops Quality and Dispute Resolution	COO	1,193,822
CC123 Operations Oversight	COO	781,550
CC124 Members Services	COO	330,984
CC125 Member Contact Center	COO	3,087,028
CC126 Provider Contact Center	COO	3,621,281
CC130 Network Operations	CPPO	14,216,001
CC150 Quality	CMO	5,669,681
CC140 Government Relations	CMEEA	8,318,521
CC141 Health Education	CMEEA	1,745,113
CC151 Pharmacy	CMO	1,414,849
CC142 Communications	CMEEA	4,054,932
CC127 Claims	COO	2,547,240
CC152 Health Services	CMO	5,596,200
CC153 Utilization Management	CMO	8,738,827
CC154 Care Management	CMO	8,533,254
CC131 Population Health	CPPO	5,856,244
CC132 Behavioral Health	CPPO	614,920
CC160 Compliance	CCO	4,257,713
CC180 Human Resources	CHROPO	3,924,808
CC170 Diversity	CDO	360,000
CC181 Facilities	CHROPO	4,765,412
CC190 Dual Special Needs Plan	CIO	10,911,752
Gold Coast Total		$ 182,391,977

2026 Budget	
Executive	Budget
COO	$ 34,627,767
CMO	29,952,811
CISMO	29,055,964
CPPO	20,687,166
CFO	20,325,379
CMEEA	14,118,565
CIO	10,911,752
CEO	9,404,641
CHROPO	8,690,220
CCO	4,257,713
CDO	360,000
Gold Coast Total	$ 182,391,977

Note: this roll-up does not include a $15M targeted savings still being identified

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2026 Personnel by Cost Center & Executive

Cost Center	2026 Position Budget Executive	Chief	Director	Manager	Line	Total
CC101 Finance and Accounting	CFO	-	1	5	11	17
CC102 Procurement	CFO	-	1	1	2	4
CC103 Project Management	CFO	-	1	-	10	11
CC105 Executive	CEO	10	-	-	4	14
CC110 IT- Data Warehouse	CISMO	-	-	-	9	9
CC112 IT-Infrastructure and Security	CISMO	-	-	-	9	9
CC113 IT- Architecture and Testing	CISMO	-	-	-	7	7
CC114 IT- Information Technology	CISMO	-	6	-	5	11
CC115 IT-Population Health Enablement	CISMO	-	-	1	13	14
CC120 Operations	COO	-	5	4	22	31
CC121 Grievance and Appeals	COO	-	-	-	3	3
CC122 Ops Quality and Dispute Resolution	COO	-	-	1	6	7
CC123 Operations Oversight	COO	-	-	1	4	5
CC124 Members Services	COO	-	-	-	2	2
CC125 Member Contact Center	COO	-	1	2	22	25
CC126 Provider Contact Center	COO	-	1	2	25	28
CC127 Claims	COO	-	-	2	9	11
CC130 Network Operations	CPPO	-	3	3	23	29
CC131 Population Health	CPPO	-	4	2	6	12
CC132 Behavioral Health	CPPO	-	-	1	3	4
CC140 Government Relations	CMEEA	-	3	4	18	25
CC141 Health Education	CMEEA	-	-	-	8	8
CC142 Communications	CMEEA	-	1	3	3	7
CC150 Quality	CMO	-	-	2	10	12
CC151 Pharmacy	CMO	-	1	1	5	7
CC152 Health Services	CMO	-	6	-	5	11
CC153 Utilization Management	CMO	-	-	3	54	57
CC154 Care Management	CMO	-	-	5	48	53
CC160 Compliance	CCO	-	1	3	18	22
CC180 Human Resources	CHROPO	-	2	2	6	10
CC181 Facilities	CHROPO	-	-	1	2	3
CC190 Dual Special Needs Plan	CIO	-	2	-	2	4
Total		10	39	49	374	472

Executive	2026 Position Budget Chief	Director	Manager	Line	Total
COO	-	7	12	93	112
CMO	-	7	11	122	140
CISMO	-	6	1	43	50
CPPO	-	7	6	32	45
CFO	-	3	6	23	32
CMEEA	-	4	7	29	40
CIO	-	2	0	2	4
CEO	10	0	0	4	14
CHROPO	-	2	3	8	13
CCO	-	1	3	18	22
CDO	-	0	0	0	0
Gold Coast Total	10	39	49	374	472

Executive	2026 Position Budget (Open Positions) Chief	Director	Manager	Line	Total
COO	-	2	0	5	7
CMO	-	1	0	1	2
CISMO	-	0	0	2	2
CPPO	-	0	0	1	1
CFO	-	0	0	2	2
CMEEA	-	1	2	1	4
CIO	-	0	0	0	0
CEO	-	0	0	0	0
CHROPO	-	0	0	1	1
CCO	-	0	0	1	1
CDO	-	0	0	0	0
Gold Coast Total	-	4	2	14	20

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2026 Contract Renewal List

Contract Id	Vendor Name	Ownership	Bid Type	Services Provided	GCHP Business Owner	Cost Center and Department	Contract Term Start Date	Contract Expiration Date	PO #	Total /contract Term (months)	Contract Amount	2026 Budget Amount
Contract_2025_01179	540 Consulting LLC	Women-Owned	Sole Source	Consulting services. Hospice benefits in Medi-Cal and Medicare	Holly Krull	CC120 Operations	12/9/2025	2/27/2026	1387	3 mos.	$ 27,500	$ 20,625
Contract_2025_01178	IPD Analytics, LLC	None	Sole Source	Pharmacy SaaS	Eve Gelb	CC190 Dual Special Needs Plan	1/1/2026	12/31/2028	1391	37 mos.	$ 149,250	$ 49,068
Contract_2025_01177	Emagined Security, Inc.	None	Sole Source	Monitoring security	Kevin Ortloff	CC112 IT-Infrastructure and Security	12/28/2025	12/27/2026	1185	12 mos.	$ 224,715	$ 222,246
Contract_2025_01175	TopBlock LLC	None	Sole Source	Workday post go live services	Jan Schmitt	CC101 Finance and Accounting	1/12/2026	4/11/2026	1381	3 mos.	$ 37,800	$ 38,225
Contract_2025_01172	AArete, LLC	None	Sole Source	Consulting services - Operations	Holly Krull	CC120 Operations	12/2/2025	1/26/2026	1380	2 mos.	$ 115,000	$ 62,727
Contract_2025_01171	Marcella Young RN	Women-Owned	Sole Source	Medical Reviews	Nicole Kanter	CC152 Health Services	11/1/2025	10/30/2026	1389	12 mos.	$ 10,500	$ 8,678
Contract_2025_01170	MCG Health, LLC	None	Sole Source	IT Software - Medical Management	Nicole Kanter	CC152 Health Services	12/15/2025	12/14/2026	1390	12 mos.	$ 3,546	$ 3,215
Contract_2025_01168	Momentum Telecom Inc	None	Sole Source	Telecom services	Kevin Ortloff	CC112 IT-Infrastructure and Security	12/1/2025	12/1/2026	1379	12 mos.	$ 101,400	$ 91,677
Contract_2025_01166	Navex Global, Inc.	None	Sole Source	Policy software platform	Robert Franco	CC160 Compliance	12/10/2025	2/9/2026	829	2 mos.	$ 108,115	$ 53,171
Contract_2025_01165	Emagined Security, Inc.	None	Sole Source	IT Security software and services	Kevin Ortloff	CC112 IT-Infrastructure and Security	12/9/2025	12/27/2026	1184	13 mos.	$ 102,300	$ 96,157
Contract_2025_01164	SHI International Corp	None	RFP	IT Software	Kevin Ortloff	CC112 IT-Infrastructure and Security	1/1/2026	12/31/2026	1199	12 mos.	$ 55,330	$ 54,722
Contract_2025_01163	Optum360 LLC	None	Sole Source	Medical coding to support claims processing	Chris Dulan	CC113 IT- Architecture and Testing	10/1/2025	9/30/2030	1374	61 mos.	$ 647,648	$ 127,755
Contract_2025_01160	CBRE, Inc.	Hispanic	Sole Source	Management - Construction stage	Jeffery Gauthier	CC181 Facilities	12/1/2025	6/30/2026	1367	7 mos.	$ 85,441	$ 72,888
Contract_2025_01159	NTT DATA Americas Inc.[formerly Transaction Applications Data]	None	RFP	Provider Portal changes as part of DSNP implementation	Eve Gelb	CC190 Dual Special Needs Plan	10/1/2025	3/31/2026	1375	6 mos.	$ 46,129	$ 22,937
Contract_2025_01158	Milliman	None	Sole Source	Consulting Services -MA bid development support of actuarial projections for DNSP.	Eve Gelb	CC190 Dual Special Needs Plan	10/31/2025	10/31/2026	1373	12 mos.	$ 525,000	$ 431,507
Contract_2025_01157	Infocrossing LLC dba WIPRO	None	RFP	Implement software modules, Revenue360, related to Medicare Advantage lines of business.	Eve Gelb	CC190 Dual Special Needs Plan	9/22/2025	12/31/2026	1366	16 mos.	$ 386,320	$ 299,086
Contract_2025_01156	SHI International Corp	None	RFP	IT software	Kevin Ortloff	CC112 IT-Infrastructure and Security	11/20/2025	11/20/2028	1371	37 mos.	$ 2,213	$ 727
Contract_2025_01155	Baker Tilly Advisory Group LP	None	Sole Source	HR Services	Rachel Segovia	CC180 Human Resources	6/21/2025	2/28/2026	1343	8 mos.	$ 128,000	$ 30,476
Contract_2025_01154	SHI International Corp	None	RFP	IT software	Kevin Ortloff	CC112 IT-Infrastructure and Security	12/9/2025	12/9/2028	1361	37 mos.	$ 20,526	$ 6,742
Contract_2025_01153	Crunchafi	None	Sole Source	Print services	Shannon Robledo	CC101 Finance and Accounting	10/8/2025	10/7/2028	1362	37 mos.	$ 13,340	$ 4,386
Contract_2025_01152	KP LLC	None	RFP	DSNP Printed materials and postage	Anna Sproule	CC120 Operations	9/18/2025	9/18/2026	1345	12 mos.	$ 125,000	$ 92,466
Contract_2025_01151	Netmark Business Services	None	RFP	Manage and implement new DSNP CES ruleset or policies.	Eve Gelb	CC190 Dual Special Needs Plan	10/1/2025	3/31/2026	1368	6 mos.	$ 90,000	$ 44,751
Contract_2025_01150	Baker Tilly Advisory Group LP	None	Sole Source	Financial Audit for period ending 12/31/25	Jeff Register	CC101 Finance and Accounting	10/1/2025	4/30/2026	1358	7 mos.	$ 102,000	$ 58,009
Contract_2025_01149	Compliance Resource Center LLC	Woman-Owned	Sole Source	Sanctioned vendor screening	Sara Dersch	CC101 Finance and Accounting	10/1/2025	9/30/2026	1355	12 mos.	$ 2,650	$ 1,966
Contract_2025_01148	Inovalon, Inc.	None	RFP	D-SNP risk assessment/adjustment software.	Eve Gelb	CC190 Dual Special Needs Plan	10/1/2025	12/31/2026	1358	15 mos.	$ 102,000	$ 80,526
Contract_2025_01147	KP LLC	None	RFP	Document translation services and Translate documents	Lupe Gonzalez	CC141 Health Education	9/1/2025	10/1/2026	1357	13 mos.	$ 10,500	$ 7,177
Contract_2025_01145	Edifecs, Inc.	None	RFP	IT software	Chris Dulan	CC113 IT- Architecture and Testing	7/1/2024	6/30/2026	898	24 mos.	$ 5,957,940	$ 1,471,096
Contract_2025_01144	Culture Amp	None	Sole Source	Culture training services	Rachel Segovia	CC180 Human Resources	10/5/2025	10/4/2026	751	12 mos.	$ 47,602	$ 35,309
Contract_2025_01140	Netmark Business Services	None	RFP	D-SNP implementation services	Eve Gelb	CC190 Dual Special Needs Plan	9/8/2025	3/31/2026	1342	7 mos.	$ 30,000	$ 13,235
Contract_2025_01138	HabitNu	Woman-Owned	Sole Source	Promote GCHP's eligible members' enrollment in the DPP Program	Lupe Gonzalez	CC141 Health Education	9/1/2025	8/31/2026	1341	12 mos.	$ 15,500	$ 10,220
Contract_2025_01135	One Pass Solutions Inc.	None	Sole Source	D-SNP benefit	Eve Gelb	CC190 Dual Special Needs Plan	9/1/2025	12/31/2028	1325	41 mos.	$ 226,596	$ 67,029
Contract_2025_01130	Hygiena, LLC	None	Sole Source	Facility services	Jeffery Gauthier	CC181 Facilities	8/27/2025	8/26/2026	1141	12 mos.	$ 3,098	$ 2,042
Contract_2025_01129	Casenet LLC	None	RFP	Support DSNP expansion	Eve Gelb	CC190 Dual Special Needs Plan	4/30/2025	6/30/2026	1254	14 mos.	$ 10,000	$ 4,225
Contract_2025_01127	Edifecs, Inc.	None	RFP	IT Software CAQH FHIR Endpoint Directory SaaS	Chris Dulan	CC113 IT- Architecture and Testing	6/25/2025	6/24/2026	1335	12 mos.	$ 20,000	$ 9,890
Contract_2025_01125	SHI International Corp	None	RFP	IT software services	Kevin Ortloff	CC112 IT-Infrastructure and Security	8/21/2025	8/20/2028	1320	37 mos.	$ 133,855	$ 44,007
Contract_2025_01124	SHI International Corp	None	RFP	IT software services	Kevin Ortloff	CC112 IT-Infrastructure and Security	7/1/2025	6/30/2026	1324	12 mos.	$ 25,503	$ 12,611
Contract_2025_01123	DEXUR Enterprises Inc.	None	Sole Source	Software:Provider quality software	Ellen Rudy	CC130 Network Operations	8/1/2025	7/31/2028	1328	37 mos.	$ 94,575	$ 31,093
Contract_2025_01121	Stericycle, Inc. dba Shred-It	None	Sole Source	Shredding services	Vanessa Ramos	CC120 Operations	6/17/2025	7/20/2026	1323	13 mos.	$ 11,440	$ 6,036
Contract_2025_01119	Stericycle, Inc. dba Shred-It	None	Sole Source	Shred services for Mailroom - Operations	Anna Sproule	CC120 Operations	7/20/2025	7/20/2026	1323	12 mos.	$ 11,440	$ 6,582
Contract_2025_01118	OneSource Virtual, Inc	None	Sole Source	Payroll services	Sara Dersch	CC101 Finance and Accounting	1/1/2026	12/31/2028	1322	37 mos.	$ 147,440	$ 48,473
Contract_2025_01115	KSB Consulting Inc.	None	Sole Source	Facility Site Review system - subscription/license	James Cruz	CC152 Health Services	6/1/2025	5/31/2027	1275	24 mos.	$ 34,000	$ 16,790
Contract_2025_01114	Intelligent Content Solutions LLC dba ICS	None	Sole Source	Support services (mailroom)	Alan Torres	CC113 IT- Architecture and Testing	7/1/2025	6/30/2026	1312	12 mos.	$ 360,000	$ 178,022
Contract_2025_01113	Michael Mitchell	Hispanic	Sole Source	Consulting services	Felix Nunez	CC190 Dual Special Needs Plan	7/1/2025	3/31/2026	1314	9 mos.	$ 80,000	$ 26,374
Contract_2025_01112	HealthEdge Software Inc.	None	RFP	D-SNP implementation services	Felix Nunez	CC190 Dual Special Needs Plan	7/7/2025	1/31/2026	1310	7 mos.	$ 128,000	$ 18,462
Contract_2025_01111	Salesforce Inc.	None	RFP	IT software	Alan Torres	CC113 IT- Architecture and Testing	7/14/2025	12/31/2028	1309	42 mos.	$ 51,953	$ 14,773
Contract_2025_01109	Intelligent Content Solutions LLC dba ICS	None	Sole Source	Service/maintenance for Scanners "ScanCare 24/7	Anna Sproule	CC120 Operations	2/1/2025	1/31/2026	1306	12 mos.	$ 11,200	$ 923
Contract_2025_01106	Public Health Institute	None	Sole Source		Erin Slack	CC152 Health Services	6/18/2025	8/30/2026	1303	15 mos.	$ 47,642	$ 26,105
Contract_2025_01103	ABMS Solutions, LLC	None	Sole Source	Access to online CertiFACTS subscription	Carolyn Harris	CC130 Network Operations	6/14/2025	6/15/2027	1302	24 mos.	$ 4,100	$ 2,019

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2026 Contract Renewal List

Contract Id	Vendor Name	Ownership	Bid Type	Services Provided	GCHP Business Owner	Cost Center and Department	Contract Term Start Date	Contract Expiration Date	PO #	Total /contract Term (months)	Contract Amount	2026 Budget Amount
Contract_2025_01101	Central Courier LLC	Black	Sole Source	Courier services, Post office to mailroom	Anna Sproule	CC120 Operations	6/23/2025	6/22/2026	1307	12 mos.	$ 16,080	$ 7,952
Contract_2025_01099	Deloitte Consulting LLP	None	Sole Source	Provide Staff augmentation support for Workday. (Finance department)	Sara Dersch	CC101 Finance and Accounting	6/16/2025	12/26/2026	1295	19 mos.	$ 330,000	$ 212,903
Contract_2025_01098	Edifecs, Inc.	None	RFP	D-SNP Encounter Management SaaS.	Eve Gelb	CC190 Dual Special Needs Plan	6/15/2025	3/7/2029	1257	45 mos.	$ 526,298	$ 139,212
Contract_2025_01094	SHI International Corp	None	RFP	Provides various technologies used for our infrastructure such as IT ticketing system.	Kevin Ortloff	CC112 IT-Infrastructure and Security	6/30/2025	6/30/2026	1292	12 mos.	$ 29,485	$ 14,541
Contract_2025_01093	HealthEdge Software Inc.	None	RFP	Health Rules Payor [HRP] training and certification	Holly Krull	CC120 Operations	6/6/2025	6/5/2026	1297	12 mos.	$ 3,600	$ 1,484
Contract_2025_01090	TTEC Government Solutions, LLC	None	RFP	Digital Insights for Genesys Cloud	Chris Dulan	CC113 IT- Architecture and Testing	4/22/2025	3/29/2027	1274	24 mos.	$ 30,232	$ 15,415
Contract_2025_01089	Vendor Credentialing Svs LLC dba Symplr	None	RFP	T&M, Replicated Data Base, Project 101015	Chris Dulan	CC113 IT- Architecture and Testing	5/19/2025	5/18/2026	1285	12 mos.	$ 11,950	$ 3,940
Contract_2025_01088	Coffey Communications Inc.	None	Sole Source	Assist GCHP with Deloitte launch of Exclusively Aligned Enrollment D-SNP.	Susana Enriquez-Euyoque	CC142 Communications	5/19/2025	5/18/2026	1284	12 mos.	$ 36,600	$ 12,066
Contract_2025_01085	Infocrossing LLC	None	RFP	Medicare Advantage - software, implementation, administer processes	Eve Gelb	CC190 Dual Special Needs Plan	5/8/2025	9/30/2028	1273	41 mos.	$ 817,168	$ 237,051
Contract_2025_01082	TTEC Government Solutions, LLC	None	RFP	For DNSP: Genesys Cloud Customer Bundle Genesys Cloud Voice (GCV) subscriptions plus AI Exprience Tokens	Chris Dulan	CC113 IT- Architecture and Testing	4/28/2025	3/29/2027	1278	23 mos.	$ 13,890	$ 7,143
Contract_2025_01081	Deloitte Consulting LLP	None	RFP	Provide computer system integration services designed to meet the specific needs of health plans.	Eve Gelb	CC190 Dual Special Needs Plan	5/5/2025	3/31/2026	1277	11 mos.	$ 13,980,700	$ 3,812,918
Contract_2025_01077	Janitorial Manager, LLC	None	Sole Source	Janitorial services	Jeffery Gauthier	CC181 Facilities	4/9/2025	4/8/2026	1262	12 mos.	$ 5,000	$ 1,236
Contract_2025_01076	Press Ganey Assoc.	None	Sole Source	Survey: Provider satisfaction and access	Carolyn Harris	CC130 Network Operations	4/29/2025	2/28/2026	1251	10 mos.	$ 40,005	$ 7,870
Contract_2025_01075	Inovaare Corporation	Asian Pacific	Sole Source	Compliance Management System: Audit & Monitoring, CAP, Risk Management, Delegation Oversight and UMS Modules	Victoria Warner	CC160 Compliance	4/14/2025	4/30/2028	1263	37 mos.	$ 360,245	$ 116,626
Contract_2025_01073	The Infosoft Group Holding Co LLC dba Circa	None	Sole Source	Sourcing: AI Talent Sourcing Discover, job postings	Christopher Beeson	CC180 Human Resources	4/25/2025	4/24/2028	1267	37 mos.	$ 30,096	$ 9,894
Contract_2025_01067	Securitas Security Services Inc.	None	Sole Source	Security services on site	Jeffery Gauthier	CC181 Facilities	4/14/2025	5/25/2026	1270 , 1290	14 mos.	$ 54,050	$ 19,969
Contract_2025_01063	SHI International Corp	None	RFP	GCHP's Backup and Recovery Software	Kevin Ortloff	CC112 IT-Infrastructure and Security	4/18/2025	4/17/2028	1243	37 mos.	$ 120,521	$ 39,623
Contract_2025_01059	SHI International Corp	None	RFP		Kevin Ortloff	CC112 IT-Infrastructure and Security	4/23/2025	4/23/2026	1234	12 mos.	$ 5,436	$ 1,787
Contract_2025_01058	Karyn Spruill	Woman-Owned	Sole Source	Assist GCHP Utilization Management G&A team with maintaining regulatory turn-around times for Grievance, Appeals, PDR's and submission of PQI's.	Julie Martinez	CC152 Health Services	3/1/2025	3/1/2026	1242	12 mos.	$ 78,000	$ 64,800
Contract_2025_01055	Deloitte Consulting LLP	None	Sole Source		Jan Schmitt	CC113 IT- Architecture and Testing	2/2/2025	12/31/2050	N/A	315 mos.		$ -
Contract_2025_01054	The TransLatin@Coalition Institute	Woman-Owned	Sole Source	Training - to fulfill Evidence-based Transgender Diverse and/or Intersex (TGI) Cultural Competency.	Lupe Gonzalez	CC141 Health Education	2/24/2025	3/30/2027	1235	25 mos.	$ 41,190	$ 19,409
Contract_2025_01051	Michael Mitchell	None	Sole Source		Alan Torres	CC114 IT- Information Technology	7/1/2025	3/31/2026	1314	9 mos.	$ 50,050	$ 16,683
Contract_2025_01049	Shah Health LLC	Woman-Owned	Sole Source	Medical review and treatment plan	James Cruz	CC152 Health Services	3/1/2025	3/31/2026	1247	13 mos.	$ 260,000	$ 59,241
Contract_2025_01045	MitoKhon Advisors LLC	Woman-Owned	Sole Source	Medical Review and treatment plans	James Cruz	CC152 Health Services	3/1/2025	3/1/2026	1246	12 mos.	$ 260,001	$ 42,740
Contract_2025_01043	Prime Thrapeutics, LLC	None	RFP	Covered Drugs and Prescription Drug Services	Kimberley Marquez-Johnson	CC190 Dual Special Needs Plan	11/1/2024	12/31/2028	1253	51 mos.	$ 44,750,000	$ 10,591,716
Contract_2025_01042	SHI International Corp	None	RFP	Service/Warranty ext. APC Replacement Battery Cartridge	Kevin Ortloff	CC112 IT-Infrastructure and Security	12/20/2025	11/20/2029	1209	48 mos.	$ 929	$ 234
Contract_2025_01039	MRC Smart Technologies dba Mr. Copy Inc.	None	Sole Source	VersaLink C625, Printers and Maintenance for Mailroom	Anna Sproule	CC120 Operations	2/10/2025	2/9/2028	1224	36 mos.	$ 24,908	$ 8,196
Contract_2025_01038	Intelligent Content Solutions LLC dba ICS		Sole Source	Sales Order Q2025-CA005	Chris Dulan.	CC113 IT- Architecture and Testing	2/1/2025	1/31/2028	1217	36 mos.	$ 1,110,000	$ 365,265
Contract_2025_01037	Vendor Credentialing Svs LLC dba Symplr		RFP	Order From 133738-1	Carolyn Harris	CC130 Network Operations	2/1/2025	1/31/2026	1223	12 mos.	$ 3,900	$ 321
Contract_2025_01029	SHI International Corp		RFP	PO-Data Modeler	Kevin Ortloff	CC112 IT-Infrastructure and Security	2/20/2025	2/19/2026	1207	12 mos.	$ 27,079	$ 4,464
Contract_2025_01022	Arine Inc.	Woman-Owned	RFP	SOW 1	Pauline Preciado	CC131 Population Health	12/6/2024	7/31/2027	1092	32 mos.	$ 2,000,000	$ 744,571
Contract_2025_01013	SHI International Corp		RFP	SHI-Microsoft	Kevin Ortloff	CC112 IT-Infrastructure and Security	1/1/2025	12/1/2027	1195	35 mos.	$ 1,587,352	$ 537,074
Contract_2024_01010	Workday Inc.		Sole Source	SOW 00476007	Sara Dersch	CC101 Finance and Accounting	12/1/2024	2/9/2026	1183	15 mos.	$ 1,816,211	$ 125,256
Contract_2024_01007	National Auto Fleet Group		RFP	Maintenance - Ram Truck	Marlen Torres	CC140 Government Relations	12/2/2024	9/2/2026	1136	21 mos.	$ 61,262	$ 23,009
Contract_2024_01005	Quest Analytics LLC		Sole Source	Data Lic-Quest Accuracy	Chris Dulan	CC113 IT- Architecture and Testing	12/17/2018	12/31/2027	1167	110 mos.	$ 337,441	$ 36,801
Contract_2024_01003	EPIC Holdgs dba Pharmaceutical Strategies Group		RFP	SOW 2	Eve Gelb	CC190 Dual Special Needs Plan	11/1/2024	1/31/2026	1186	15 mos.	$ 1,971,207	$ 129,685
Contract_2024_01001	MRC Smart Technologies dba Mr. Copy Inc.		RFP	SSA Maintenance	Kevin Ortloff	CC112 IT-Infrastructure and Security	7/1/2024	12/30/2027	1106 , 1102	43 mos.	$ 31,676	$ 8,930

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2026 Contract Renewal List

Contract Id	Vendor Name	Ownership	Bid Type	Services Provided	GCHP Business Owner	Cost Center and Department	Contract Term Start Date	Contract Expiration Date	PO #	Total /contract Term (months)	Contract Amount	2026 Budget Amount
Contract_2024_00985	TTEC Government Solutions, LLC		RFP	SOW 2	Chris Dulan	CC113 IT- Architecture and Testing	11/1/2024	3/31/2027	1148	29 mos.	$ 253,604	$ 103,747
Contract_2024_00981	Salesforce Inc.		RFP	Order Form 09291627	Chris Dulan	CC113 IT- Architecture and Testing	11/1/2024	12/31/2028	1168	51 mos.	$ 806,627	$ 190,918
Contract_2024_00979	MRC Smart Technologies dba Mr. Copy Inc.		Sole Source	Sales & Service Agreement	Kevin Ortloff	CC112 IT-Infrastructure and Security	7/1/2024	6/30/2027	1106 , 1102	36 mos.	$ 31,676	$ 10,424
Contract_2024_00973	Quest Analytics LLC		Sole Source	Lic-Quest Enterprise, Analytics Suite-Geocode	Chris Dulan	CC113 IT- Architecture and Testing	8/12/2024	8/11/2027	1142	36 mos.	$ 479,766	$ 157,876
Contract_2024_00967	OptumInsight, Inc.		Sole Source	CES Software Schedule	Chris Dulan	CC113 IT- Architecture and Testing	7/1/2024	6/30/2030	1019	73 mos.	$ 4,570,855	$ 751,373
Contract_2024_00966	OptumInsight, Inc.		Sole Source	Prospective Pym Sys Product [PPS] Schedule	Chris Dulan	CC113 IT- Architecture and Testing	10/1/2023	6/19/2026	1019	33 mos.	$ 4,570,855	$ 829,389
Contract_2024_00964	Workday Inc.		Sole Source	Order Form 47098	Sara Dersch	CC101 Finance and Accounting	9/30/2024	9/29/2031	1144	85 mos.	$ 3,929,791	$ 553,708
Contract_2024_00958	KP LLC		RFP	SOW 2	Susana Enriquez-Euyoque	CC142 Communications	10/1/2024	9/30/2026	1143	24 mos.	$ 72,732	$ 26,938
Contract_2024_00956	MICOP aka Mixteco/Indigena Comm Org Proj	Hispanic	Sole Source	SOW 3	Lucy Marrero	CC132 Behavioral Health	9/15/2024	12/31/2029	1161	64 mos.	$ 43,000	$ 8,008
Contract_2024_00951	HealthEdge Software Inc.		RFP	SOW 3	Kevin Ortloff	CC112 IT-Infrastructure and Security	8/14/2024	6/30/2030	842	72 mos.	$ 26,123,945	$ 4,382,395

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AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Sara Dersch, Chief Financial Officer

DATE: January 26, 2026

SUBJECT: Revision to Tangible Net Equity (TNE) Policy

PowerPoint with Verbal Presentation

ATTACHMENTS:

Recommendation to Change Minimum TNE Requirement

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

Recommendation to Change Minimum TNE Requirement

Ventura County Medi-Cal Managed Care Commission Meeting
January 26, 2026
Sara Dersch, Chief Financial Officer

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711 East Daily Drive, Suite 106, Camarillo, CA 93010 www.goldcoasthealthplan.org

Situation & Background

Situation

- Current Commission directive mandates maintaining a minimum Tangible Net Equity (TNE) level equivalent to 700% of the California Department of Health Care Services (DHCS) required TNE

- TNE currently is 570% of the DHCS minimum; we do not anticipate TNE to be greater than 700% in the future

Background

- GCHP experienced significant growth in TNE as a direct result of federal freeze on member redetermination during the Covid-19 pandemic; TNE in 2023 was 1000% of the DHCS-required minimum

    - GCHP received premium payments for members who were not utilizing the GCHP Medi-Cal benefit, resulting in a substantial build-up of TNE

    - Member eligibility redetermination resumed in 2024, resulting in membership and revenue declines

    - GCHP implemented a 3-year $250M Quality Incentive Provider Program rewarding those providers who attain high levels of Managed Care Accountability Set (MCAS) levels; this program is funded through planned deficits which have resulted in reduction in TNE

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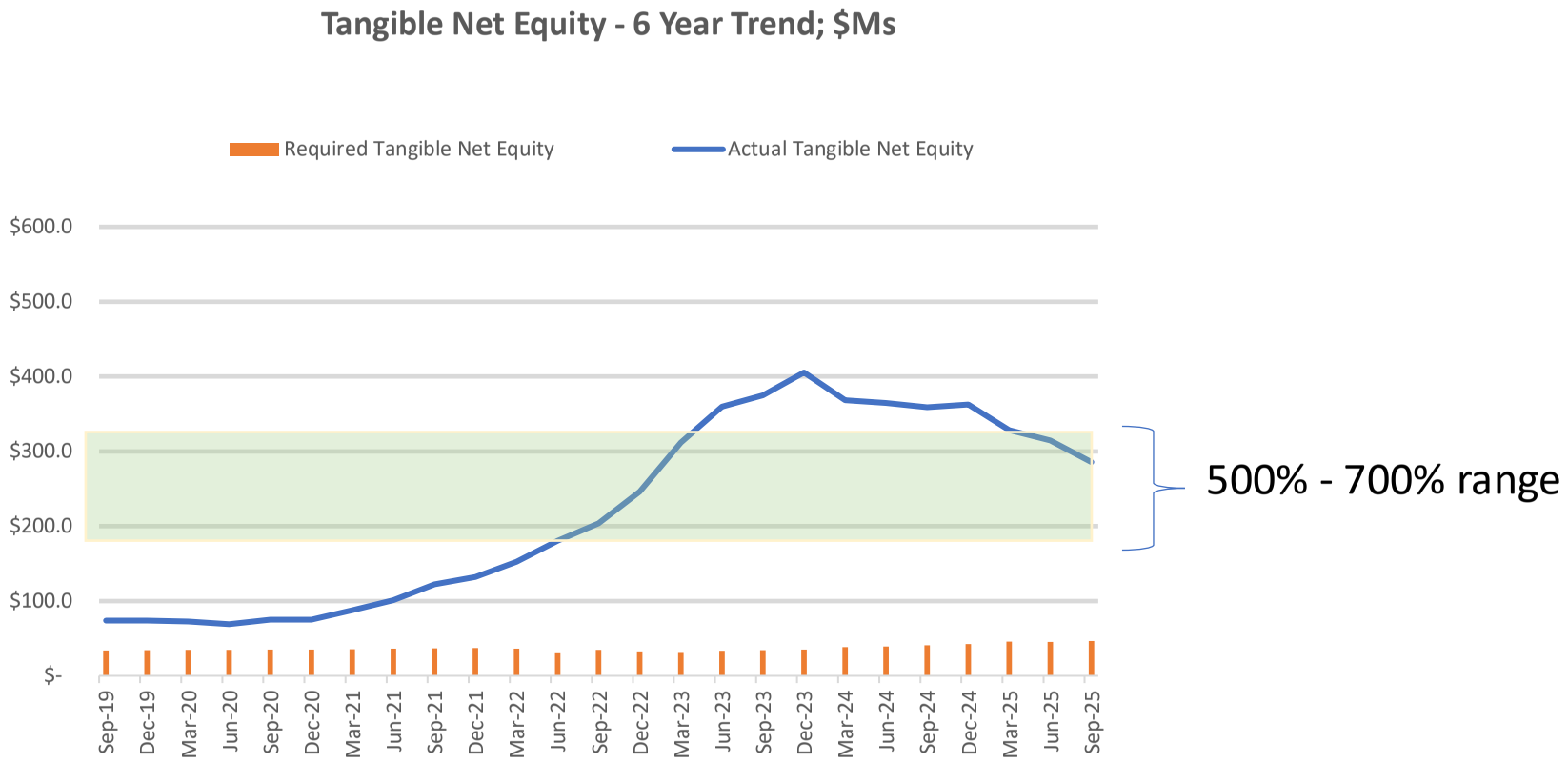
Analysis & Recommendation



Recommendation is to target 500% - 700% range as actual and minimum TNE fluctuate regularly. Future QIPP will be funded through current year premium revenue. Maintaining 500% - 700% will ensure GCHP retains sufficient capital to operate for approximately 3 months should the State not be able to fund premium payments for a given amount of time.

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AGENDA ITEM 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Felix Nunez, MD, Chief Executive Officer

DATE: January 26, 2026

SUBJECT: Chief Executive Officer (CEO) Report

Chief Executive Officer (CEO) Update

As we enter 2026, Gold Coast Health Plan (GCHP) will be operating in an increasingly complex and challenging environment. Our strategic imperative remains fulfilling our mission and vision by protecting access to care for our members and supporting them on their journey, while collaborating with our provider partners and other leaders to stabilize the health care ecosystem on which we all depend before the burden of uncompensated care puts us all at risk.

With this imperative in mind, as the principal Medi-Cal plan for Ventura County and a County Organized Health System, we have a responsibility to work alongside health care leaders and community advocates throughout the county to ensure that access to care is preserved as broadly as possible because we know that pressures on any one segment of the ecosystem – be it Medi-Cal, coverage purchased through Covered California, or private insurance – invariably will affect the others and undermine health care access for all residents. In the face of these challenges, we see an opportunity for us to come together to support each other and our community, working to innovate and collaborate to protect access to high-quality health care services.

In support of these collaborative efforts, it was my pleasure to participate in a strategic planning retreat led by our trade association, Local Health Plans of California (LHPC), in Sacramento on Dec. 2, 2025. Discussions with LHPC leadership and the CEOs of our sister plans centered on alignment around strategic priorities to maintain continuous enrollment for Medi-Cal members and the need for coordinated advocacy aimed at the state Department of Health Care for updated reimbursement methodologies that fully account for the rising costs health plans are increasingly absorbing to maintain access to high-quality care.

Advocacy in this area is essential to the long-term sustainability of the Medi-Cal program, as appropriate reimbursement is necessary to support continued investment in preventive services, care coordination, and other interventions that reduce health care costs in the long term. The LHPC group is gathering again this month to continue this discussion, and we anticipate that for the foreseeable future we will need to work with our LHPC sister plans to protect access and quality of care against external pressures. While the budget released by Gov. Gavin Newsom on Jan. 9, 2026, presented an improved outlook, the Medi-Cal population and providers will

continue to face threats from federal actions that will cut billions of dollars from the Medicaid program.

As we move forward as an aligned Executive Team and organization, we will focus on balancing the fulfillment of our mission by practicing increased financial discipline in anticipation of ongoing pressures from the federal and state governments. We will engage strategically with our regulators and elected leaders, maintain strong partnerships throughout the health care ecosystem, and keep you informed of emerging risks and opportunities that may impact access to care.

This new year will require us to advance our work in a way that protects access for our members, supports providers, and ensures the long-term sustainability of the organization. Despite significant headwinds, I have tremendous confidence in our mission-focused leaders and staff and take solace in knowing that in its 14 years, GCHP has weathered many challenges and has proven time and time again to be a resilient organization. This year will be no exception.

I. External Affairs

A. State Budget

On Thursday, Jan. 9, Gov. Gavin Newsom released the Fiscal Year (FY) 2026-27 state budget proposal totaling $348.9B ($248.3B GF). While the budget is balanced in FY 2026-27, with approximately $4.5B in total remaining budget reserves, the governor's proposal projects a deficit of approximately $22B in FY 2027-28 and shortfalls in the following two years, presenting difficult challenges to future budget-making for the state.

Most of the total state expenditures in FY 2026-27 will be allocated to health and human services ($143.1B), K-12 education ($88.6B), and higher education ($26B).

The January budget was aided by a surge in revenues of more than $42B above projections in the 2025 Budget Act. This influx of state revenue was driven by higher cash receipts and higher stock market performance, and it reflects an improved overall revenue outlook. Despite this influx of higher-than-projected revenue, the January budget does not commit to any new significant spending proposals. This is largely due to the state's:

- Constitutional funding requirements;
- Prior commitments of funds;
- Need to rebuild the discretionary budget reserve; and
- Higher program costs.

In addition, the lack of new spending proposals in the January budget gives credence to the pressures and uncertainty felt by the state due to several factors. First, the current federal government poses budgetary risks in the form of unpredictable policymaking, specifically regarding tariffs and immigration, which have potential impacts to inflation, the labor market, investment, and overall demand. Second, the possibility for stock market and/or asset price declines, which could result in a significant reduction in state revenue. A large portion of the increase to state revenue was driven by technology companies in the artificial intelligence (AI) space experiencing a considerable increase in their share prices, leading to increased personal income tax revenues paid by high-income earners that had investments in these companies. Due to the potential for volatility in the stock market, specifically in the technology sector, this revenue stream cannot be relied upon in consideration of future state budgets.

The budget also includes $343.6B ($94.4B GF) for all California Health and Human Services programs and $222.4B ($48.8B GF) is allotted for the Medi-Cal delivery system. The administration has opted to increase Medi-Cal GF spending by $2.4B in FY 2026-27 compared to the FY 2025-26 GF budget allocations ($46.4B). The increase in GF expenditures illustrates how the Medi-Cal delivery system remains a priority for the administration.

The January proposal anticipates that Medi-Cal will cover around 14 million Californians in FY 2026-27. The year-over-year change is approximately a 500,000 member-reduction compared to FY 2025-26. The projected caseload decline is primarily attributed to:

1. The reinstatement of asset limit testing, and
2. The full scope expansion enrollment freeze.

The projected caseload decline is further impacted by House Resolution (HR) 1, also called the "One Big Beautiful Bill," which requires six-month redeterminations and other programmatic changes that will increase disenrollment.

Despite the reduction in caseload, total spending on Medi-Cal is projected to increase by $25.7B, representing a 13.1% year-over-year increase.

Below are important FY 2026-27 budget proposals or adjustments that may impact GCHP operations and/or members. The GCHP Government Relations Team will continue to provide updates as more information becomes available.

Proposal Name	2026-27 Budget Plan	Summary
House Resolution (H.R.) 1	Budget adjustments resulting from H.R. 1: Community Engagement Requirements: An estimated reduction of $373M ($102M GF) in 2026-27 and $13.1B ($3.6B GF) by 2029-30. Medical Assistance Percentage for Emergency Services: A cost of $658M GF in 2026-27 and $872M GF by 2029-30 due to the federal match reduction from 90% to 50% for emergency services for Affordable Care Act (ACA) adult expansion members with Unsatisfactory Immigration Status (UIS). Restrictions on Immigrant Eligibility: Transitions certain non-citizens to restricted-scope Medi-Cal. If the state were to provide full-scope coverage to this population, the cost is estimated to be $786M GF in 2026-27 and $1.1B GF ongoing. Six-Month Redeterminations: A reduction of $463M ($74M GF) in 2026-27 and $3B ($474M GF) by 2029-30 for decreased caseload resulting from six-month redetermination frequency for expansion adults. Reduced Retroactive Medi-Cal Timeframes: A reduction of $23M ($10M GF) in 2026-27 and $48M ($20M GF) ongoing from the reduction of retroactive Medi-Cal coverage changes from three months to one month for the ACA adult expansion population and two months for all other members, effective no sooner than Jan. 1, 2027.	On July 4, 2025, Congress passed H.R. 1, also called the "One Big Beautiful Bill," a budget reconciliation package that has wide-reaching impacts on the Medi-Cal program, Supplemental Nutrition Assistance Program (SNAP), and other federal programs. Implementation of various H.R. 1 requirements will have ongoing repercussions for the Medi-Cal program.

Proposal Name	2026-27 Budget Plan	Summary
Managed Care Organization (MCO) Tax and Prop 35	$7.9B in 2024-25, $4.5B in 2025-26, and $2.5B in 2026-27 in MCO Tax revenue to support the Medi-Cal program.	The MCO Tax is a state tax on health plans used to increase federal matching funds for the Medi-Cal program. The funds generated by the MCO Tax are used to pay for significant portions of the Medi-Cal program. However, the current MCO Tax is not compliant with the H.R. 1 requirement that prohibits taxing Medicaid providers at higher rates than non-Medicaid providers. The state will receive a transition period through June 30, 2026; however, the governor's proposed budget assumes a transition period through Dec. 31, 2026. H.R. 1 and Proposition 35 requirements significantly limit the potential size of a future MCO Tax, resulting in a substantial reduction in ongoing funding to support the Medi-Cal program.
MCO Tax Behavioral Health	$65M in 2025-26 and $95.5M in 2026-27	"MCO Tax Behavioral Health" describes the portion of MCO Tax revenue used for qualifying community-based mobile crisis services, transitional rent, and behavioral health rates from the 2025 behavioral health facility throughputs domain allocation.

Proposal Name	2026-27 Budget Plan	Summary
Hospital Quality Assurance Fee (HQAF)	$648M GF in 2025-26 and $1.3B GF in 2026-27.	The Hospital Quality Assurance Fee (HQAF) provides funding for supplemental payments to California hospitals that serve Medi-Cal and uninsured patients. Revenue from the HQAF provides funding for children's health care coverage, pays direct grants to public hospitals, and reimburses DHCS for the direct costs of administering the program. Based on the federal government's notification that California's HQAF waiver request would not be approved as submitted, the administration continues to evaluate options to modify the request for approval.

B. State Legislative Update

The Legislature convened on Jan. 6, 2026. The Senate began its session with an historic moment: The formal swearing-in of the new Senate Pro Tempore, Senator Monique Limon, who represents Santa Barbara and Ventura counties.

As the Legislature reconvened, legislative bill activity will remain limited during the early weeks. The following activity has been noted over the first week of session, AB 1126, which was re-referred to the Assembly Committee on Health following recent amendments (see the legislative bills table for more information). Several statewide Medi-Cal policy changes also took effect on Jan. 1, 2026, including updates to Medi-Cal Rx coverage and eligibility rules. GCHP staff will continue monitoring new bill introductions and any developments that may affect Medi-Cal managed care operations.

Bill	Summary	Status	Last Action	GCHP Impact
AB 1126	Aligns managed care plan (MCP) administrative requirements with Medi-Cal fee-for-service (FFS) for members with other health coverage; limits letters of agreement (LOAs); requires DHCS clarification on noncontracted billing.	Active – In Assembly	Re-referred to Assembly Health (Jan. 7, 2026)	May require updates to other healthcare coverage (OHC) coordination, LOA processes, and claims workflows.
SB 250	Requires DHCS to publish and maintain an updated skilled nursing facility (SNF) directory by managed care plan.	Chaptered	Signed into law	Minimal operational impact; may require periodic SNF network validation.
SB 306	Exempts services from prior authorization (PA) if 90%+ are approved; requires public posting of exempt services.	Chaptered	Signed into law	May require PA workflow adjustments and public posting compliance.
SB 530	Strengthens DHCS oversight of time-and-distance standards; extends enforcement authority to 2029.	Chaptered	Signed into law	Continued monitoring of network adequacy compliance.
SB 707	Modernizes Brown Act requirements, including audio-visual (AV) access and language equity provisions.	Chaptered	Signed into law	Impacts Commission meeting procedures and public access requirements.
AB 543	Allows MCPs to offer services via street medicine providers.	Chaptered	Signed into law	May require updates to provider contracting and Enhanced Care Management (ECM) workflows.
AB 2466	Strengthens network adequacy and timely access requirements.	Signed	Effective Jan. 1, 2026	May require network monitoring and reporting adjustments.
AB 815	Protects vehicles used for social services from certain insurance classifications.	Signed	Effective Jan. 1, 2026	Minimal impact; may affect contracted transportation providers.
SB 1120	Requires transparency and evidence-based criteria for artificial intelligence (AI) used in utilization review.	Signed	Effective Jan. 1, 2026	May require updates to utilization management (UM) policies and vendor oversight.

Bill	Summary	Status	Last Action	GCHP Impact
AB 2860	Expands the Mexico Physician / Dentist Program pilot.	Signed	Effective Jan. 1, 2026	Minimal direct impact; may affect provider availability in certain regions.
AB 3275	Requires clean claims to be reimbursed within 30 workdays; requires notice within 30 days if contested.	Signed	Effective Jan. 1, 2026	Significant programming changes needed; impacts claims timelines and fraud, waste, and abuse (FWA) prepayment review.
AB 2703	Adds psychological associates as reimbursable providers under Federally Qualified Health Centers (FQHC) / Rural Health Centers (RHC).	Signed	Effective Jan. 1, 2026	May expand behavioral health provider types in network.
SB 516	Establishes infrastructure financing district for Sacramento.	Signed	Effective Jan. 1, 2026	No direct impact on GCHP operations.

C. All-Plan Letters (APL) Listing

APL #	APL Release Date	Title
26-001	Jan. 1, 2026	Initial Health Appointment (IHA)
25-017	Dec. 26, 2025	2025-2027 Medi-Cal Managed Care Health Plan MEDS/834 Cutoff and Processing Schedule
25-016	Nov. 13, 2025	Alternative Format Selection for Members with Visual Impairments

In 2025, the Gold Coast Health Plan (GCHP) Community Relations Team strengthened engagement through strategic sponsorships for community-based organizations, actively participated in local events to share resources and information with GCHP members and the community, partnered with providers at health fairs to expand access to care to our members, and helped educate our members on various health-related topics through our Speakers Bureau. Despite increased challenges from the federal government, we continued to meet our members where they are, providing them with necessary services to help improve their health and access to care. Below is a further breakdown of the impact of this work.

D. Community Relations: Sponsorships

GCHP continues to support the efforts of community-based organizations in Ventura County to help Medi-Cal members and other vulnerable populations through its sponsorship program. In 2025, GCHP awarded funding to various community-based organizations focusing on food insecurity, health care access, education, and social services.

We provided 57 community-based organizations with $168,250 in funding to provide needed services to our community. In addition, we allotted $100,000 to address food insecurity: $100,000. We are committed to continuing to support our community in 2026.

E. Community Relations: Community Events and Meetings

The Community Relations Team attended various community events supporting families with resources and assistance to connect them with GCHP services. The team participated in collaborative meetings and partnered with provider systems to hold health fair screening events to decreasing care gaps for our members. Below is a summary these events:

Type of Event	Total
Community Events / Resource Fairs	54
Food Distributions	27
Community Collaborative Meetings	36
Open House / Back to School	27
Total	**140**

Through GCHP's provider partnered health fair program, the team conducted 33 health fairs to assist GCHP members to get their preventive health screenings during after-hours and weekends to expand access to health care services for our members. Below is a summary of the program's impact in 2025.

Health Fair Totals	
System	**Total**
Ventura County Medical Center (VCMC)	19
Clinicas del Camino Real (CDCR)	11
Community Memorial Health System (CMHS)	3

We distributed 2,217 gift cards – totaling $70,615 – to our members at these health fairs to reinforce the importance of completing annual screenings.

F. Community Relations: Speakers Bureau

GCHP staff participated in various speaking engagements, presentations, educational workshops, and held a press conference in partnership with Rep. Julia Brownley. Below is a summary of these efforts.

Type	Topic	Total
Educational Workshops	Well-child visits, diabetes, women's health, mental health, and nutrition	9
Presentations	Overview of GCHP benefits	7
Speaking Engagements	Member care ambassadors, impacts on budget cuts, impacts of loss of Medi-Cal membership	3
Press Conference	Impacts of government shutdown	1
Total		**20**

II. PLAN OPERATIONS

A. Membership

	VCMC	CLINICAS	CMH	PCP-OTHER	ADMIN MEMBERS	NOT ASSIGNED
Dec-25	93,403	55,096	34,951	1,033	44,865	3,536
Nov-25	93,673	55,063	34,536	1,032	45,323	3,923
Oct-25	93,819	55,053	34,652	4,287	45,365	3,827

NOTE:

Unassigned members are those who have not been assigned to a Primary Care Provider (PCP) and have 30 days to choose one. If a member does not choose a PCP, GCHP will assign one to them.

Administrative Member Details

Category	Dec 2025
Total Administrative Members	44,865
Share of Cost (SOC)	675
Long-Term Care (LTC)	776
Breast and Cervical Cancer Treatment Program (BCCTP)	20
Hospice (REST-SVS)	21
Out of Area (Not in Ventura County)	393
DUALS (A, AB, ABD, AD, B, BD)	18,076
Commercial Other Health Insurance (OHI) (Removing Medicare, Medicare Retro Billing, and Null)	17,927

NOTE:

The total number of members will not add up to the total number of Administrative Members, as members can be represented in multiple boxes. For example, a member can be both Share of Cost and Out of Area. They would be counted in both boxes.

METHODOLOGY

Administrative members for this report were identified as anyone with active coverage with the benefit code ADM01. Additional criteria follows:

1. Share of Cost (SOC-AMT) > zeros
    a. AID Code is not 6G, 0P, 0R, 0E, 0U, H5, T1, T3, R1 or 5L
2. LTC members identified by AID codes 13, 23, and 63.
3. BCCTP members identified by AID codes 0M, 0N,0P, and 0W.
4. Hospice members identified by the flag (REST-SVS) with values of 900, 901, 910, 911, 920, 921, 930, or 931.
5. Out of Area members were identified by the following zip codes:
    a. Ventura Zip Codes include: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93000-12, 93015-16, 93020-24, 93030-36, 93040-44, 93060-66, 93094, 93099, 93225, 93252
    b. If no residential address, the mailing address is used for this determination.
6. Other commercial insurance was identified by a current record of commercial insurance for the member.

B. Provider Network Operations (PNO)

PNO Department Transformation

In 2025, the PNO Department went through a transformation in an effort to support Gold Coast Health Plan's (GCHP) strategic anchor of "Optimizing Provider Relationships / Partnerships" by achieving the key result of a provider satisfaction survey score of 66%. This transformation was designed to ensure the department had clear job roles and responsibilities, job families to allow for career pathing, and job expectations that aligned with the organization's broader goals and expectations. Job titles, roles and responsibilities, and departmental expectations are developed with a focus on meeting the needs of our internal functional areas and our external provider network.

The PNO department was redesigned to build a more cohesive team environment in support of four functional areas:

1. Provider Contracting
2. Provider Relations
3. Provider Credentialing
4. Provider Regulatory and Analytics

PNO also partnered with the Provider Call Center to ensure consistency in how provider-facing teams interface with providers. This partnership resulted in alignment on a training process for all provider-facing staff. The robust platform includes training modules that include knowledge checks.

The PNO transformation was completed as planned by the end of 2025.

PNO is also preparing tracking tools to support departmental service level agreements centered around metrics that support provider engagement and outcomes. As the new processes take shape, PNO will provide statistics that reflect status and progress with the ultimate goal of positively impacting overall Provider Satisfaction.

Regulatory / Audit Updates

PNO is preparing its first annual network submission to the Centers for Medicare & Medicaid Services (CMS) for Gold Coast Health Plan Total Care Advantage (HMO D-SNP). This network submission is required annually to ensure our contracted provider network meets the network adequacy requirements. PNO is validating the network through the Quest Analytics software and will work to fill any identified gaps. The annual submission is expected to take place in February.

In addition, GCHP was selected to participate in the CMS Triennial Network Adequacy Review. This is a mandatory, three-year evaluation by CMS to confirm that the Total Care Advantage network is adequate and to ensure accurate provider directories. The formal audit will be conducted in June 2026. However, from Jan. 13-26, 2026, PNO will participate in a voluntary network submission trial review. This will allow us to go through the process and identify issues prior to the formal submission in June. Our data will be uploaded to the CMS portal, which will validate compliance with federal standards. With recent changes, especially for Medicare Advantage plans, it is important to take advantage of an early evaluation, as failure can lead to enforcement actions.

Other notable regulatory deliverables include:

- Biannual directory submission
- Sub-contractor network certification (SNC)

Gold Coast Health Plan Total Care Advantage (HMO D-SNP)

PNO continues to support Total Care Advantage through key regulatory and operational deliverables. PNO is monitoring the network to ensure we maintain adequacy. In addition, PNO is identifying additional network needs and working with internal stakeholders to identify continuity of care (CoC) needs, including CoC services for Enhanced Care Management (ECM), Community Supports (CS), and Community-Based Adult Services (CBAS).

Provider Network Developments: Dec. 1- 31, 2025

GCHP Provider Changes	
Provider Additions and Terminations	**Count**
Additions	81
Terminations	33
Midwife	0

Note: The additions and terminations above are for GCHP tertiary providers and do not have a significant impact on member access to services.

GCHP Provider Network Additions and Total Counts by Provider Type			
Provider Type	**Network Additions**		**Total Counts**
	Nov-25	**Dec-25**	
Hospitals	**0**	**0**	**25**
Acute Care	0	0	19
Long-Term Acute Care (LTAC)	0	0	1
Tertiary	0	0	5
Providers	**68**	**117**	**9,189**
Primary Care Providers (PCPs) and Mid-levels	3	7	480
Specialists	49	110	7,789
Hospitalists	16	0	920
Ancillary	**3**	**1**	**692**
Ambulatory Surgery Center (ASC)	0	0	10
Community-Based Adult Services (CBAS)	0	0	14
Durable Medical Equipment (DME)	1	0	105
Home Health	0	0	35
Hospice	0	0	25
Laboratory	0	0	41
Optometry	1	0	111
Occupational Therapy (OT) / Physical Therapy (PT) / Speech Therapy (ST)	0	0	195
Radiology / Imaging	0	0	67
Skilled Nursing Facility (SNF) / Long-Term Care (LTC) / Congregate Living Facility (CLF) / Intermediate Care Facility (ICF)	1	1	89
Behavioral Health	**5**	**0**	**1128**

California Advancing and Innovating Medi-Cal (CalAIM) and Non-Traditional Providers	Nov-25	Dec-25	Total
Enhanced Care Management (ECM)	4	0	11
Community Supports (CS)	0	0	33
Community Health Worker (CHW)	1	0	5
Doulas	2	0	11

C. Delegation Oversight

Gold Coast Health Plan (GCHP) is contractually required to perform oversight of all functions delegated through subcontracting arrangements. Oversight includes, but is not limited to:

- Monitoring / reviewing routine submissions from subcontractors
- Conducting onsite audits
- Issuing a corrective action plan (CAP) when deficiencies are identified

**Ongoing monitoring denotes the delegate is not making progress on a CAP issued and/or audit results were unsatisfactory. GCHP is required to monitor the delegate closely, as it is a risk to GCHP when delegates are unable to comply.*

Compliance will continue to monitor all CAPs. GCHP's goal is to ensure compliance is achieved and sustained by its delegates. It is a state Department of Health Care Services (DHCS) requirement for GCHP to hold all delegates accountable. The oversight activities conducted by GCHP are evaluated during the annual DHCS medical audit. DHCS auditors review GCHP's policies and procedures, audit tools, audit methodology, and audits conducted and corrective action plans issued by GCHP during the audit period. DHCS continues to emphasize the high level of responsibility plans have in the oversight of their delegates.

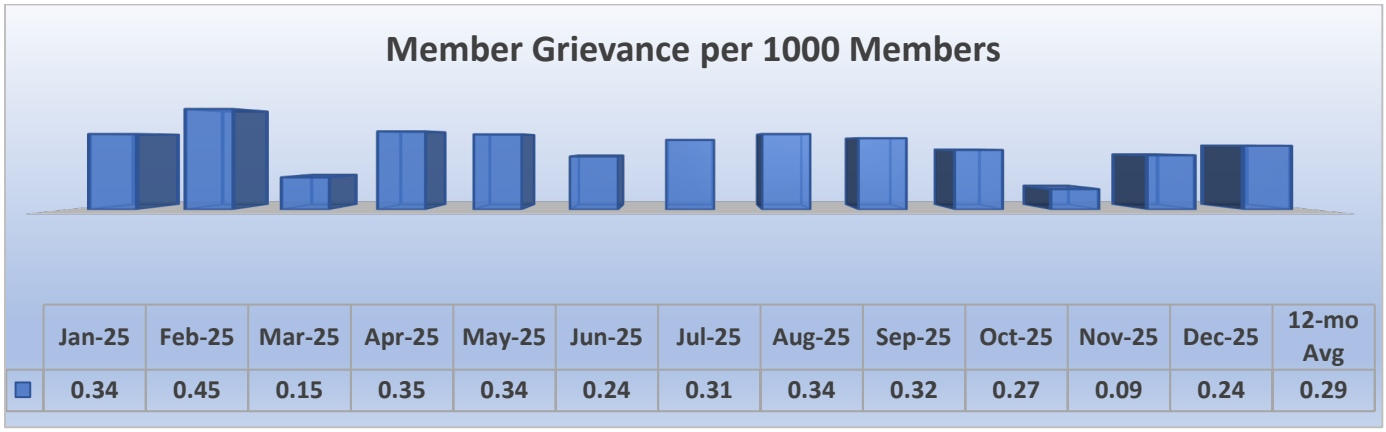
The following table includes audits and CAPs that are open and closed. Closed audits are removed after they are reported to the Commission. The table reflects changes in activity through December 31, 2025.

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Carelon	2025 Annual Claims Audit	Open	3/26/2025	Under CAP	N/A
Carelon	2025 Annual Call Center Audit	Closed	9/11/2025	12/1/2025	N/A

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Carelon	2025 Annual Credentialing Audit	Open	9/25/2025	Under CAP	N/A
Carenet	2025 Annual Call Center Nurse Advice Line	Closed	7/15/2025	8/13/2025	N/A
Clinicas del Camino Real (CDCR)	2024 Annual Claims Audit	Closed	1/30/2025	11/7/2025	N/A
CDCR	2025 Q1 Focused Claim Audit	Closed	4/22/2025	11/7/2025	N/A
CDCR	2025 Q2 Focused Claim Audit	Open	9/15/2025	Under CAP	N/A
Community Memorial Health Systems (CMHS)	2025 Focused Credentialing Audit	Closed	10/2/2025	11/21/2025	N/A
Vision Service Plan (VSP)	2025 Annual Credentialing Audit	Closed	9/22/2025	11/21/2025	N/A
Ventura Transit System (VTS)	2024 Downstream Subcontractor Audit	Open	8/30/2024	Under CAP	Merged to 2025 CAP
VTS	2025 Downstream Subcontractor Audit	Open	9/9/2025	Under CAP	N/A

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
VTS	2025 Annual Driver Credentialing Audit	Open	7/23/2025	Under CAP	N/A
VTS	2025 Annual Non-Medical Transporation (NMT) and Non-Emergency Medical Transporation (NEMT) Vehicle Audit	Open	1/8/2026	Under CAP	N/A
University of California, Los Angeles (UCLA)	2025 Focused Credentialing Audit	Open	9/24/2025	Under CAP	N/A
Privacy & Security CAPs					
Delegate	**CAP Type**	**Status**	**Date CAP Issued**	**Date CAP Closed**	**Notes**
N/A	N/A	N/A	N/A	N/A	N/A
Operational CAPs					
Delegate	**CAP Type**	**Status**	**Date CAP Issued**	**Date CAP Closed**	**Notes**
CDCR	Claims Timeliness	Open	4/22/2025	Open	Metrics of 90% in 30 days not met. 45 days not met for Q2, Q3, or Q4.

D. Grievance and Appeals

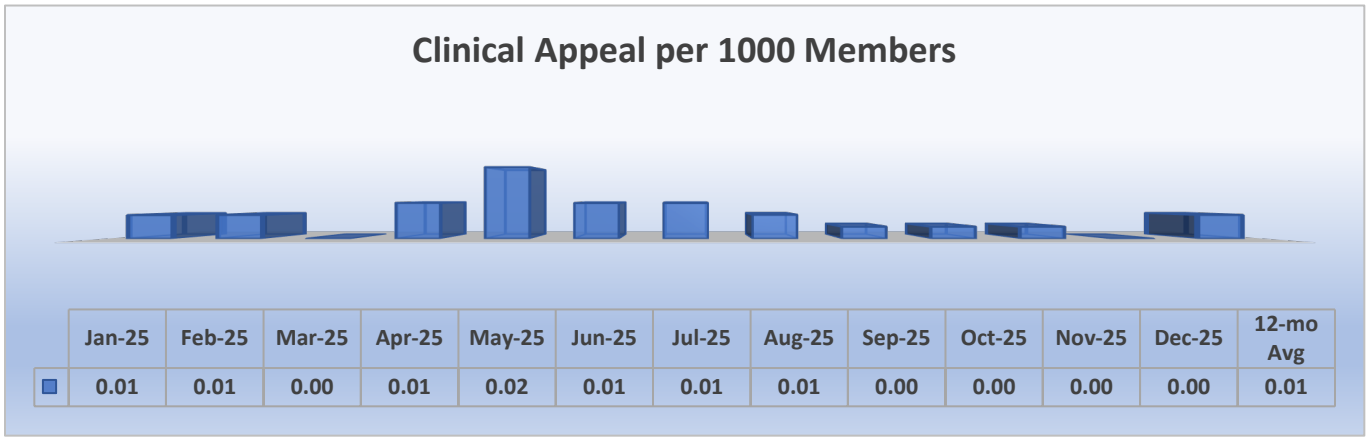


	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	12-mo Avg
■	0.34	0.45	0.15	0.35	0.34	0.24	0.31	0.34	0.32	0.27	0.09	0.24	0.29

Member Grievances per 1,000 Members

The data show GCHP's volume of grievances increased in Dec. 2025. In Dec. 2025, GCHP received 77 member grievances. Overall, the volume is still relatively low compared to the number of enrolled members. The 12-month average of enrolled members is 241,199, with an average annual grievance rate of .29 grievances per 1,000 members.

In Dec. 2025, the top reason reported was "Quality of Care," which is related to member concerns about the care they received from their providers.



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	12-mo Avg
■	0.01	0.01	0.00	0.01	0.02	0.01	0.01	0.01	0.00	0.00	0.00	0.00	0.01

Clinical Appeals per 1,000 Members

The data comparison volume is based on the 12-month average of .01 appeals per 1,000 members. In Dec. 2025, GCHP did not receive any clinical appeals.

RECOMMENDATION:

Receive and file.

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: January 26, 2026

SUBJECT: Chief Medical Officer Update

CMO COMMISSION REPORT – January 2026

In 2025, Gold Coast Health Plan (GCHP) Health Services made tremendous progress in utilization management, care management, pharmacy, quality improvement, and health equity. The GCHP CMO is proud and delighted to share an overview of the progress with the Commission:

Utilization Management

Health Services was reorganized by unifying both Utilization Management (UM) and Care Management (CM) under a single, impactful, progressive leader: Ms. Nicole Kanter. Under her guidance, Health Services accomplished the following:

1. Redesigned GCHP's concurrent review process by assigning teams of UM review nurses, care management nurses, and Transition of Care managers to cover specific hospitals and to work with an assigned GCHP medical director. The redesign goal is to:
   a. Improve member coordination of care and ensure appropriate care services and enhanced care management programs wrap around the member upon discharge.
   b. Ensure timely, safe discharges to an appropriate community setting.
   c. Ensure that UM concurrent review nurses and medical directors are thoughtfully managing resources and the overall cost of care.
   d. UM acute care bed day metrics and benchmarks have been revised to more accurately reflect UM performance expectations
2. Spearheaded the National Committee for Quality Assurance (NCQA) Health Plan Accreditation preparation of GCHP's delegated groups for the NCQA accreditation survey.
3. Reorganizing Health Services Care Management into specific units to more impactfully address Population Health needs: An Adult Unit, Maternal and Child Unit, and a Dual Special Needs Plan (D-SNP)/Frail adult Unit. These units are designed to develop teams that are subject matter expert teams in these specific areas.

Quality Improvement

The Quality Improvement (QI) team continued to elevate GCHP's quality measure performance outcomes:

1. Quality Improvement team led the Plan's efforts to achieve NCQA Health Equity Accreditation, and NCQA Health Plan Accreditation. On December 31, 2025, NCQA notified GCHP that it achieved full health plan accreditation with a score of 100%. NCQA Health Equity Accreditation was achieved in November of 2025, with a 100% score. Dual NCQA Accreditation was necessary to participate in the Medicare D-SNP program.
2. GCHP Managed Care Accountability Set (MCAS) quality measure performance continues to increase. Since 2021, per DHCS Health Plan rankings, GCHP has risen from a low performing health plan, to now being one of California's top-performing Medi-Cal health plans. For Measurement Year (MY) 2025, all MCAS measures are performing better than the same time last year. Nine measures have already met target, and GCHP is projected to meet minimum performance level of all measures, except for risk for follow up after discharge for a mental health diagnosis (FUM).
3. For MCAS MY 2026, there are more measures and new measures. The QI team is working diligently developing a strategic intervention plan to ensure achieving at least a Minimum Performance Level rates for the additional, new measures.

Pharmacy

Pharmacy has worked tirelessly to prepare for the January 1, 2026, GCHP's Total Care Advantage go live date, and their efforts have paid off.

- Pharmacy claims went live starting January 1, 2026
- Pharmacy team has been reviewing and resolving rejected claims to help members access their medication needs.
- Delegated functions to GCHP's contracted Pharmacy Benefit Manager Prime were triggered without issues. Medicare Part D coverage determinations/appeals/grievances, Part B Diabetes Testing Supplies/Continuous Glucose Monitoring (CGM) Prior Authorization (PA) review and appeals, Medication Therapy Management (MTM) all worked without glitches.
- GCHP Total Care Advantage (HMO D-SNP) Pharmacy Services web page (formulary/list of covered drugs, pharmacies in network, mail order information and more) is fully functional.
- MyPrime.com Member Portal (online searchable formulary, pharmacy network, forms, PA criteria, etc.) is fully functional.
- Provider Training for Total Care Advantage – mostly e-learnings that are self-paced, some live classes for those that are invited is active and functioning.

Health Equity

1. Health Equity is fully engaged and working collaboratively with Department of Healthcare Services (DHCS) and other Medi-Cal health plans on the MediCal Child Health Equity Collaborative. The DHCS Medi-Cal Child Health Equity Sprint Collaborative focuses on building capacity of Managed Care Plans (MCPs) to improve health outcomes and quality of care for young children. Building on the previous Child Health Equity Collaborative, this current phase emphasizes adapting and implementing proven practices at scale across 18

counties, building on many bright spots and lessons learned. It focuses on improving two key measures:

- Well-Child Visits in the First 0-15 Months (W30-6+)
- Well-Child Visits in the First 15-30 Months (W30-2+)
- Each MCP is encouraged to develop their own aims around improving these measures with an emphasis on advancing equity and addressing disparities in care. Gold Coast has engaged **VCMC** (Ventura County Medical Center) and **CMH** (Community Memorial Hospital) as clinic partners in this effort.

2. GCHP's Executive Director of Health Equity is deeply experienced preparing health plan teams for DHCS audits. Ms. Pshyra Jones is supporting the Health Services team in preparing for the DHCS mock audit by reviewing technical specifications and developing mock interview sessions with department subject matter experts. These in progress efforts are aimed at strengthening audit readiness, clarifying compliance expectations, and ensuring teams feel confident and well prepared for the upcoming review.
3. Maternal Health Equity work is progressing on the implementation of the updated maternity program in alignment with the most recent DHCS Maternity omnibus All Plan Letter. GCHP's program is being developed with a strong emphasis on health equity, ensuring that members who experience the greatest disparities receive enhanced support throughout the perinatal period. Current activities include expanding access to culturally responsive services such as community-based doulas and establishing closed loop referral processes to ensure members are successfully connected to recommended resources.

ATTACHMENT:
Chief Medical Officer Update PPT

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Chief Medical Officer Update

January 26, 2026

James Cruz, MD
Chief Medical Officer

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Quality Improvement Update

January 14, 2026

Kim Timmerman, MHA, CPHQ
Executive Director, Quality Improvement

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MCAS MY 2025 Status

MY 2025 HEDIS season has commenced!

Upcoming Activities:

- Virtual HEDIS Compliance Audit scheduled March 4th
- Medical Record Review for Hybrid Measures – CBP, GSD, PPC-Pre, & PPC-Post
- Final rates reported June 15, 2026

MY 2025 Prospective Rate Tracking – November Run

Highlights:

- 3 Measures at 90th percentile: BCS*, PPC-Post*, IMA
- 8 Measures at 75th percentile:
  - LSC, CCS, W30-2+, FUA, CHL*, AMR*, W30-6*, CIS
- 2 Measures at MPL:
  - DEV, GSD*
- TFL* increased 9% and is now only 1.15% from MPL

Lowlights:

- 3 Measures at 33rd percentile: PPC-prenatal*, WCV*, FUM*
- 1 Measure at 25th percentile: CBP*

*Indicates improved percentile compared to October run

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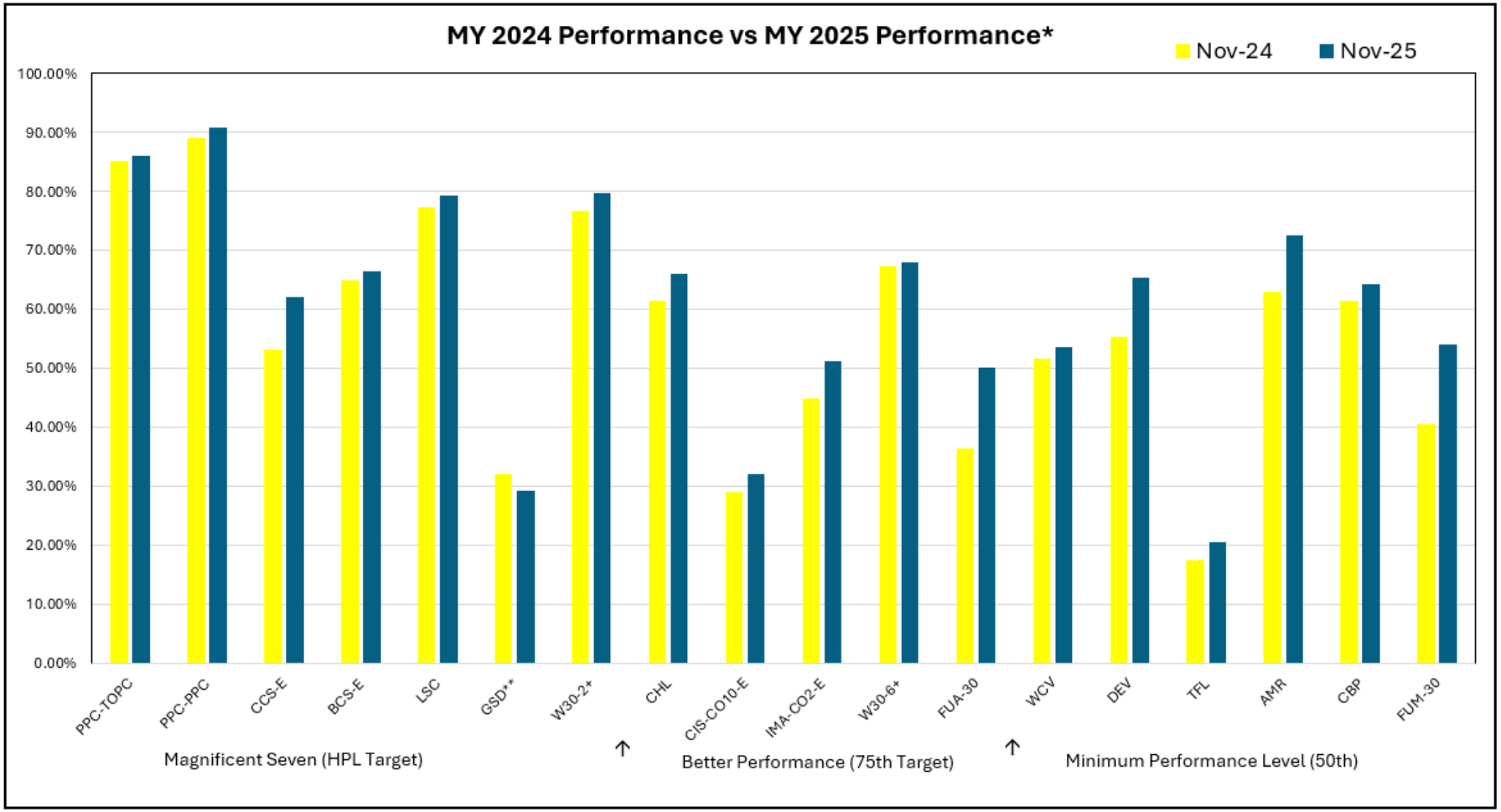
MCAS Prospective Rates
MY 2024 Rates vs. MY 2025 Rate Comparison

Data as of November 2025



* as of 11/30/2025
** a lower rate is better

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MCAS MY 2025 Key Takeaways

All measures performing better than same time last year

Nine measures have already met target:

BCS, PPC-Post, IMA, CHL, CIS, W30-6+, FUA, AMR, DEV

Projected to meet MPL for all measures, with the exception of risk for FUM

Risks:

- Hybrid rate lift may not be as great as in previous years due to more robust administrative data.
- Change in measure specifications for FUM affecting ability to meet MPL.

Mitigation Plans & Ongoing Activities:

- Further data refinements – code mapping, file refinements to capture services
- Additional data - December data inclusion, data refreshes to capture claims lag & files received from DHCS (e.g. lead screening and fluoride varnish)
- Advocating with LHPC on FUM, as NCQA has determined there is a break in benchmark trending.

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MCAS MY 2026 Measures

Total measure count for MY 2026: **21**

- **20** measures held to **Minimum Performance Level** (MPL)
- **New** measures held to MPL
  - Colorectal Cancer Screening
  - Depression Screening for Adolescents and Adults
  - Prenatal Depression Screening
  - Postpartum Depression Screening
- Chlamydia Screening in Women (CHL) removed
- Asthma Medication Ratio (AMR) retired
- **Report Only Measures** decreased to **1** (vs. 13 in MY 2025)
  - Follow-Up After Acute and Urgent Care Visits for Asthma (new NCQA measure)

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NCQA Accreditation

GCHP completed the **NCQA Health Equity Accreditation (HEA)** submission on **June 10, 2025**

Outcome:

- All elements scored as **MET**! 100% of standards points achieved.

Health Equity Accreditation is effective 8/25/2025-8/25/2028

- Next survey submission: May 30, 2028

GCHP completed the **NCQA Health Plan Accreditation (HPA)** submission on **October 7, 2025**

Outcome:

- All elements scored as **MET**! 100% of standards points achieved.

Health Plan Accreditation is effective 12/16/2025-12/16/2028

- Next survey : September 19, 2028 (survey tool submission)
  November 6-7, 2028 (file review)

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Pharmacy Services Department Updates

January 14, 2026

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

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Pharmacy Services – D-SNP Updates

- **Total Care Advantage (D-SNP) Updates**
  - Prime Therapeutics is our Pharmacy Benefit Manager (PBM)
  - Pharmacy claims went live starting 1/1/26
  - Pharmacy team has been reviewing and resolving rejected claims to help members
  - Delegated functions to Prime: Part D coverage determinations/appeals/grievances, Part B Diabetes Testing Supplies/CGMs PA review and appeals, Medication Therapy Management (MTM)
  - Prime Member Services 855-681-7966, open 24/7
  - GCHP Total Care Advantage (HMO D-SNP) Pharmacy Services web page (formulary/list of covered drugs, pharmacies in network, mail order information and more)
  - MyPrime.com Member Portal (online searchable formulary, pharmacy network, forms, PA criteria, etc)
  - Training for Total Care Advantage – mostly e-learnings that are self-paced, some live classes for those that are invited
  - Questions? – Email pharmacy@goldchp.org

Return to Agenda

Pharmacy Services – Medi-Cal Rx Updates

- **Medi-Cal Rx Updates** (effective Jan 1, 2026):
  - **COVID-19 Self-test Kits** will require PA except when written by CCS Paneled Provider for members < 21 years of age
    - New PA request required for each pharmacy claim, limited to 4 tests per month
  - **Drugs for weight loss and weight loss-related indications (including GLP-1 Drugs Wegovy, Zepbound, and Saxenda)** will be excluded from Medi-Cal Rx coverage for all Medi-Cal members
    - GLP-1s for diabetes and other FDA approved indications will continue to be covered (eg Wegovy for MASH or CVD, Zepbound for OSA with PA)
  - **Coverage policies for select OTC products** for Medi-Cal members 21 years of age and older under Medi-Cal Rx will be updated as follows:
    - Multivitamin combination products will no longer be covered.
    - Certain single-ingredient vitamins and dry eye products will require a PA demonstrating medical necessity.
    - First- and second-generation antihistamines coverage are restricted to generic formulations.
    - Single-ingredient vitamins and antihistamines are restricted to a 90- to 100-day supply per fill for all Medi-Cal members 21 years of age and older.
  - **Continuing care for certain drugs and products** that are currently paying as continuation of care exceptions will no longer be covered without an approved PA demonstrating medical necessity.

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Health Equity Department Updates

January 14, 2026

Pshyra Jones
Executive Director, Health Equity

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DHCS Medi-Cal Child Health Equity Collaborative Phase 2, (September 2025 -September 2026)

The DHCS Medi-Cal Child Health Equity Sprint Collaborative focuses on building capacity of MCPs to improve health outcomes and quality of care for young children. Building on the previous Child Health Equity Collaborative, this current phase emphasizes adapting and implementing proven practices at scale across 18 counties, building on many bright spots and lessons learned. It focuses on improving two key measures:

- Well-Child Visits in the First 0-15 Months (W30-6+)
- Well-Child Visits in the First 15-30 Months (W30-2+)

- Each MCP is encouraged to develop their own aims around improving these measures with an emphasis on advancing equity and addressing disparities in care. Gold Coast has engaged **VCMC** and **CMH** as clinic partners in this effort. Intervention 1: Milestone Goals and Intervention Ideas due for February 2026 meeting.

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DHCS Mock Audit Prep

Currently supporting the Health Services team in preparing for the DHCS mock audit by reviewing technical specifications and developing mock interview sessions with department subject matter experts. These in progress efforts are aimed at strengthening audit readiness, clarifying compliance expectations, and ensuring teams feel confident and well prepared for the upcoming review.

Return to Agenda

Maternity Program Implementation (Equity Focused)

Work is progressing on the implementation of the updated maternity program in alignment with the most recent DHCS Maternity omnibus APL. The program is being developed with a strong emphasis on health equity, ensuring that members who experience the greatest disparities receive enhanced support throughout the perinatal period. Current activities include expanding access to culturally responsive services such as community-based doulas and establishing closed loop referral processes to ensure members are successfully connected to recommended resources. These efforts reinforce regulatory compliance and strengthen the quality and coordination of maternity care across the continuum.

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DEI Provider Training – Phase 2 (APL 24 016)

Partnering with the Health Education team and the DEI Officer on Phase 2 of the DHCS required DEI provider training outlined in APL 24 016. Current work includes reconciling duplicate or overlapping training content, refining the training deck to ensure a consistent and unified voice, and developing key supporting materials. These materials include a provider checklist for those with existing DEI trainings, a DEI Provider Training Letter, an FAQ, and an attestation process for providers who decline to complete the training. These efforts support compliance with DHCS requirements and promote a more streamlined, accessible training experience for the provider network.

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AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Chief Diversity Officer

DATE: January 26, 2026

SUBJECT: Chief Diversity Officer (CDO) Report

PowerPoint with Verbal Presentation

ATTACHMENTS:

2026 Diversity Equity & Inclusion

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Diversity Equity and Inclusion 2026

Ted Bagley, Chief Diversity Officer

DEI Council Members

Ted Bagley
Chief Diversity Officer

Rebecca Bridges
Utilization Management
RN II

Shannon Robledo
Sr. Manager, Finance

Marlen Torres
Executive Director,
Strategy & External Affairs

Annelie Ginn
Manager, Clinical Care
Management

Edgar Santos
Case/Care Management
RN

Marlin Wiley
Manager, Operations
Analytics

Chris Martinez
Care Management
Coordinator III

Chris Beeson
HR Project Analyst

Percy Mayfield
Regulatory Affairs
Analyst

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Breakdown by Level: Chief 2026

Race	Female	Male	Grand Total	% of Level
American Indian or Alaska Native	0	0	0	0%
Asian	1	1	2	17% (20)
Black or African American	0	1	1	8% (0)
Hispanic or Latino	1	5	6	50% (60)
Native Hawaiian or Other Pacific Islander	0	0	0	0%
Two or more races (Not Hispanic or Latino)	0	0	0	0%
White	2	1	3	25% (20)
Grand Total	4	8	12	100%

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2026 CDO Action Plan
Diversity Equity and Inclusion

What	When	How
1 . Social senior team events outside of work.	Twice Yearly or when opportunity allows.	Various engagement Techniques – CDO/CHRO teaming
2. Meet with each area team's staff during their monthly meetings.	Twice yearly	Q & A session about DEI – CDO or DEI council member
3. Conduct DEI training in coordination with Health Equity	As required (NCQA/DHCS)	In –person or video/ virtual
4. Meet with Director Population. Dr Cruz is executive sponsor	Twice Yearly	Virtual/ Q&A CDO or council member
5. All staff update on DEI	Twice Yearly or as needed	Remote/CDO or Council Chair

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2026 CDO Action Planning

What	When	How
6. Diversity Council update to Senior Team.	Quarterly or as needed.	In person/Virtual-DEI Chair or CDO
7. CEO and senior team update on case(s)/concerns.	As needed based on subject matter.	Face-to-face without names. Update on lessons learned from investigations/ CDO and CHRO
8. Meet with CEO to update him on any concerns	Weekly or as needed	In person or virtual
Meeting with each senior team member 1x1 at least twice per year.	Per their schedule – We meet now on an as needed basis.	Open discussion 30-45 minutes CDO
Community Relations Activity	As needed in support of Marlen's (external Affairs) and Pshyra's(Health Equity) organizations.	• Speaking engagement • Community events • Coaching on campus(s) • Adopt-A-School

Return to Agenda

AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Paul Aguilar, Chief Human Resources and Organization Performance Officer

DATE: January 26, 2026

SUBJECT: Human Resources (H.R.) Report

Human Resources Activities

Over the last few months, the Human Resources team has been focused on:

1. Staff Engagement: New Career Framework / Culture Transformation
2. Acquiring and Retaining Talent
3. New Human Resource Information System (HRIS): Workday Launch
4. Organization Performance

Staff Engagement:

- **New Career Framework:** The new Career Framework was developed and implemented in Dec. 2025. The Career Framework is a structured system that outlines how employees can advance within an organization. It defines job levels, required skills and competencies, and provides a clear roadmap for career progression. Employees were trained on the following:
    - Clarify defined career paths (Management, Professional, and Associate)
    - Simplified number of job bands
    - Provided clarity and transparency on Job Level guides and related career progression
    - Market-based compensation salary ranges aligned to each band

	Specialized Skills and Support			Technical and Professional Expertise				Leadership and Strategy				Executive Direction and Strategy Design			
Band	1	2	3	4	5	6	7	8	9	10	11	12	E1	E2	E3
Management and Executive Leadership							Supervisor	Manager	Sr. Manager	Director	Sr. Director	Executive Director	Executive/Chief		
Technical and Professional				Entry	Specialist		Experienced	Advanced		Expert					
Associate (Non-Exempt)	Coordinator		Associate	Sr. Associate											

Continued employee training and education on career planning and skill development will be the focus for the remainder of this year.

- **Culture Transformation:** All GCHP employees were trained on our Culture Compass journey as of Oct. 2025. To continue embedding the transformation, the Executive and Leadership teams and all managers attended workshops: Focused Decisions and Accountability for Leaders. Moving forward, 2026 Q1 planning includes culture alignment session, culture survey, and workshop for all people managers.

Acquiring and Retaining Talent:
During the Stub Period, July 1 to Dec. 31, we filled 35 positions, which has increased GCHP's headcount to 447. All 11 of the budgeted roles 11 were filled. The table below provides a total Resource Summary, which includes Employee and Contingent Worker (Temps / Contractors) by Function. You will see the organization remains within the current employee budget of 466 roles and effectively managing 142 contingent workers, with many of the Dual Special Needs Plan (DSNP) contractors ending in the beginning of the new year.

The following are key hires and promotions made since the July 2025:
1. Chief Operating Officer: Suma Simcoe
2. Chief Medical Officer: James Cruz, MD (Promotion)
3. Senior Medical Director: Manisha Sharma, MD

Gold Coast Health Plan
Headcount Summary - December 31, 2025

	EMPLOYEE COUNT					CONTINGENT WORKERS			Total Resources	
Function	Active Headcount	Open Requisitions	Total Active + Open Requisition	2025 YE Budget	Percentage of Total Headcount	Temp Roles	Contractor / Consultant	Total Contingent Workers†	Total Resources	Percentage of Total Resources
Health Services	135	1	136	140	30%	0	4	4	139	24%
Operations	102	4	106	108	23%	5	13	18	120	20%
Information Tech	47	0	47	50	11%	0	3	3	50	8%
Policy & Programs	45	1	46	45	10%	0	0	0	45	8%
Compliance	21	0	21	22	5%	1	0	1	22	4%
Finance & Accounting	28	0	28	31	7%	2	3	5	33	6%
Executive & Administration	14	0	14	14	3%	0	0	0	14	2%
Member Experience and Ext Affairs	40	0	40	41	9%	1	0	1	41	7%
HR & Facilities	12	0	12	12	3%	2	3	5	17	3%
Innovation / DSNP	3	0	3	3	1%	4	101	105	108	18%
Grand Total	**447**	**6**	**453**	**466**	**100%**	**15**	**127**	**142**	**589**	**100%**

- **Attrition:** Our attrition for the last 12 months is still low at 5.57%. This is a slight increase from the last month, as voluntary terminations have increased. Attrition trends are checked each month to assess pending organization risks or concerns.

New Human Resource Information System (Workday):
The Human Resource and Finance teams successfully launched Workday on Dec. 13, 2025. The 18-month project resulted in the implementation of new HR, Finance and Procurement system and business processes. As a result, employees and managers now operate in a self-service environment that will make it easier, faster, with similar tools to access information and complete tasks. Detailed change management plans were used to communicate and train employees on the new tools and processes, through the use of workflow job-aids, short video

vignettes, and an innovative AI tool, or "bot," called HRi to help employees search for support. This success of this implementation was measured by the on-time and accurate Jan. 2, 2026, employee pay period. Considerable recognition to the HR, Finance, IT, Communications, and PMO teams for their work on this project.

Stub Period Organization Goals:
In July, the Executive and Leadership teams defined the priorities for the six-month Stub Period, which were used to form our Stub Period Organization Goals. Through the leadership of Josephine Gallella, Director of Portfolio and Project Management and her team, we successfully achieved 94% of the targeted year-end outcomes for the following goals:

1. Launch D-SNP Services
2. Fulfill CalAIM, Regulatory Requirements
3. Transform Provider Network Operations
4. Optimize Finance & HR Services with Workday Launch
5. Transform our Culture

The accomplishment of these goals was completed through the effective teamwork of our leadership and staff project teams. The Stub Period "One Team Incentive" of 4.7%, (94% of the targeted Up to 5% incentive) will be paid to eligible employees based on their eligible earnings during the six-month (July1st through December 31st) Stub-period in recognition for the completion of our Organization Goals.

Looking forward, we will continue to train employees on Career Planning and how best to develop the skill needed for continued success at GCHP. The emphasis on engaging and retaining employees to find opportunities to develop our staff by positioning them in the right roles that advance our priorities and create the best employee experience.

RECOMMENDATION:

Receive and file.