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

Regular Meeting
Monday, June 29, 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 741 167 333#:

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

220 E Gonzales Rd,
Oxnard, CA 93036

80 Hilcrest Dr #200
Thousand Oaks, CA 91360

300 Hillmont Ave
Ventura, CA 93003

233 Corte Linda
Santa Paula, CA 93060

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 Demitric Franklin, Chief Deputy Director, Ventura County Health Care Agency

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 of May 18, 2026

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

RECOMMENDATION: Approve the minutes as presented.

PRESENTATION

2. Maternal Focus

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

RECOMMENDATION: Receive and file the presentation.

FORMAL ACTION

3. New Brown Act Requirements and Resolution Adopting Public Participation and Community Outreach and Disruption of Meetings Policies

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Receive and file the presentation and Adopt Resolution 2026-003.

4. 2026 4+8 Reforecast

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

RECOMMENDATION: Approve the 2026 4+8 Reforecast

5. May Year-To-Date 2026 Financials

Staff: Jeff Register, Interim Chief Financial Officer - Controller

RECOMMENDATION: Accept the financial information as presented

REPORTS

6. Chief Executive Officer (CEO) Report

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

RECOMMENDATION: Receive and file the report

7. Chief Operations Officer (COO) Report

Staff: Suma Simcoe, Chief Operations Officer

RECOMMENDATION: Receive and file the report

8. Human Resources (HR) Report

Staff: Paul Aguilar, Chief Human Resources & Performance

RECOMMENDATION: Receive and file the report

CLOSED SESSION

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

ADJOURNMENT

The next meeting will be held on August 24, 2026, at 2:00 p.m., at a location TBD

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: June 29, 2026

SUBJECT: Regular Meeting Minutes of May 18, 2026

RECOMMENDATION:

Approve the minutes.

ATTACHMENT:

Copy of Commission meeting minutes for May 18, 2026

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

May 18, 2026

CALL TO ORDER

Committee Chair Laura Espinosa called the meeting to order at 2:06 p.m. The meeting was held in the Community Room located at 711 E. Daily Drive, Suite 110, Camarillo, CA 93010

INTERPRETER ANNOUNCEMENT

The interpreter made her announcement.

ROLL CALL

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

Absent: Tim Myers and Yohan Perera, M.D.

Commissioner Perera missed roll call. He joined the meeting at 2:15 p.m.

Attending the meeting for GCHP were Felix L. Nunez, M.D., CEO, James Cruz, M.D., CMO, CPPO Erik Cho, Interim CFO Jeff Register, Robert Franco CCO, Eve Gelb, Chief Innovation Officer, Ted Bagley, CDO, Alan Torres, CIO, and Scott Campbell, General Counsel.

Also in attendance were the following GCHP Staff: Bob Bushey, Lupe Gonzalez, TJ Piwowarski, Holly Krull, Patrick Warfield, Joanna Hioureas, Pshyra Jones, Victoria Warner, Pauline Preciado, Ben Lacy, Kris Schmidt, Brenda Gomez-Garcia, Chris Dulan, Josephine Gallella, Kim Timmerman, Shannon Robledo, David Tovar, Adriana Sandoval, Ross Hooper, Michelle Espinoza, Nicole Kanter, Kim Marquez-Johnson, Paul VerHaar, Allison Jewell, Veronica Estrada, Corey Stephenson, Erin Slack, Lauren Burnette, David Kirkpatrick, Lupe Nunez, Joel Sanchez, Nathan Norbryhn, Gene Kirkland, Julie Martinez, Kevin Ortloff, Kriscilla Walker, Carolyn Harris, and Lily Yip.

Guests: Michelle Mendoza, Student Behavioral Health Incentive Program (SBHIP) Scholarship Recipient
Dr. Gagan Pawar – Clinicas del Camino Real
Dr. John Fankhauser and Michael Taylor – County of Ventura

PUBLIC COMMENT

None.

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Regular Commission meeting minutes of April 27, 2026.

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

RECOMMENDATION: Approve the minutes as presented.

Commissioner Blaze noted a correction to the public comment made by Dr. John Fankhauser. The April 27, 2026, meeting minutes indicate that Dr. Fankhauser stated the "VC medical system is losing money year after year." Commissioner Blaze stated that Dr. Fankhauser said that there is public opinion that the county system is losing money year after year; however, in the last five years, there has only been one year with a negative balance. She requested to have Dr. Fankhauser's public comment corrected in the minutes.

Commissioner Abbas motioned to approve the corrected meeting minutes of April 27, 2026. Commissioner Monroy seconded the motion.

Roll Call Vote as follows:

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

NOES: None.

ABSENT: Commissioners Tim Myers and Yohan Perera, M.D.

Motion carried.

PRESENTATION

2. Mental Health Presentation

Staff: James Cruz, M.D., Chief Medical Officer
Erik Cho, Chief Policy, and Program Officer
Pauline Preciado, Executive Director of Population Health & Equity

RECOMMENDATION: Receive and file the presentation.

James Cruz, M.D., Chief Medical Officer (CMO), explained that for Medi-Cal recipients, Behavioral Health is both a benefit and a clinical program. The Gold Coast Health Plan (GCHP) Behavioral Health Program has three unique elements, which distinguishes it from other Medi-Cal benefits and programs. First, the Behavioral Health Program is a shared, unified accountability between the Population Health Management Team, that is led by the Chief of

Policy and Program Officer, Mr. Erik Cho, along with the Population Health Management Executive Director, Ms. Pauline Preciado, and the Health Care Services Care Management team led by myself and the Executive Director of Health Services, Ms. Nicole Kanter. The second distinguishing element is that the Department of Health Care Services (DHCS) requires that GCHP and Ventura County Behavioral Health work across systems to coordinate the benefit and behavioral health services for our shared Medi-Cal recipients. The third element is that GCHP Behavioral Health must ensure clinical and social services wrap around the members to address each Medi-Cal social drivers of health, which significantly impact their behavioral health wellness outcomes. Dr. Cruz introduced Ms. Preciado and Behavioral Health team leader, Ms. Lauren Burnette, who will present an overview of the plan's Behavioral Health Program. Dr. Cruz indicated a special guest is present to share her journey as an emerging mental health professional. Dr. Cruz shared a member success story that demonstrated the importance and impact of shared responsibility and collaboration between GCHP and Ventura County Behavioral Health that executed on the unique behavioral health program elements.

Pauline Preciado, Executive Director of Population Health and Equity, stated that one in five members are suffering from one mental health condition. Impact compounds when there is a delay in care. There is urgency to improve access to behavioral health services. Under HR1, many Medi-Cal members will qualify for exemption for the workforce requirements that will be introduced in 2027. However, the members will need to know that they qualify and will be required to document and report their clinical condition to navigate the process. Without proactive outreach, some members will self-disqualify unintentionally. It is critical for us to have focused efforts to promote these services. There is a deep connection with our maternal and child health priorities for this organization. We know mental illness and substance use are the leading causes of pregnancy related deaths across the nation and most of them are preventable. If outreach is a challenge, we need to rethink how we are outreaching and engaging these members, which the interagency improvement project with the Institute of Healthcare Improvement (IHI) is all about. One of the challenges is that many of our members engage us during a behavioral health crisis in the emergency room. By the time we are aware of the visit, we have missed that critical window the engage the member ideally at the point of crisis. Some of the work that has been done is, instead of having members look for services from us, we bring services to the membership. Once they enter the system, we have clinicians to stabilize the medical condition, offer navigation support, provide someone who speaks their language, and know how to navigate the complexities of substance use disorder (SUD) treatment and mental health illness. They will meet the members in the emergency department (ED) and will follow them up to 30 days after and will follow them to stand up additional support services such as housing, food insecurity, and transportation to their follow-up visits. The ability to identify all the partners to create a cohesive care coordination system makes this pilot project special and has been recognized nationally and statewide with DHCS. In 2024, over 440 members received support, and more than 1,700 navigation services were delivered to help connect them to needed care. This work directly supports some of the quality work and quality metrics evaluated by the Managed Care Accountability Set (MCAS). During measurement year (MY) 2024, performance for the Follow-Up Visit after an ED Visit (FUM) increased from the fifth percentile to the 50th percentile, and performance for the Follow-Up Visit for Members Diagnosed with Substance Use (FUA) improved from the 25th percentile to the 75th percentile, placing GHCP among the top performing plans. In 2025 the work expanded to reach over 850

members and delivered over 2,300 navigation services. Work continues to bring services directly to members and how Carelon, our third-party vendor that services mild to moderate behavioral health members, can support building infrastructure and get into more hospitals and community locations.

Committee Chair Laura Espinosa said she is not familiar with the nonprofit organizations offering mental health services. She asked if the numbers shared are reflective of a first-time assessment.

Ms. Preciado responded that in addition to facilitating the collaboration between the organizations, they are also aligning them with policy and regulation. Building a network to support enhanced care management (ECM) services that specialize in supporting this population, the community-based organization for this specific pilot was Conejo Health, who piloted a program and provided services within the community, as well as leveraging the community health worker benefit. A major part of this program was to build a sustainability plan, which is why the yearly growth has been tracked.

Ms. Preciado shared that due to the work being done, GCHP has been selected to partner with Centers for Medicare and Medicaid Services (CMS) in a national maternal health pilot program focused on mental health and substance abuse. The leading cause of pregnancy-related deaths in the US are preventable. The intent of this effort is to ensure that mothers do not feel punitive and are supported. Work is being done on early identification of these mothers and connecting them with quality ECM providers that can provide wraparound services that work with high-risk populations to help support care coordination services.

Lauren Burnette, LCSW, PPSC, Behavioral Health Manager, said the wellness centers that stood up some years ago are still up and running. There are two, member care ambassadors assigned to two of the Student Behavioral Health Incentive Program (SBHIP) school districts. The member care ambassadors have shared that children and parents ask questions about Medi-Cal and have received support completing their applications and getting access to care. The partnership with the Office of Education has been maintained. The goal is to expand the Behavioral Health workforce and to continue to support children and families within the communities and school districts. In 2025 we worked with our internal communication department to stand up a Mental Health Awareness Month social media campaign. We have partnered with Dr. Melissa Gonzalez, a social media influencer originally from Ventura County and a psychiatry resident attending Stanford. GCHP worked with Dr. Gonzalez on scripting the messaging, and reached 159,000 accounts in the Ventura, Los Angles, and Oxnard areas. The partnership with Dr. Gonzalez will continue this year. All social media posts are available in both Spanish and English.

Ms. Burnette shared that $1.5 million of the SBHIP incentive fund was allocated to scholarships to improve culturally and linguistically identifiable providers within the community. We want people who are interested in behavioral health professions to have the ability to further their education at all levels of education from associates all the way up to doctorate programs. Once they graduate from school, we want them to come back to the area and provide services in the areas in which they reside and grew up.

Ms. Burnette introduced Michelle Mendoza, Student Behavioral Health Incentive Program (SBHIP) Scholarship Recipient.

Michelle Mendoz stated she recently graduated from Azusa Pacific University with a Master of Social Work degree and a certificate in human service management. She explained she is a first-generation college student and a lifelong resident of Ventura County. She said she is honored to have received the GCHP Behavioral Health Scholarship. The scholarship had a tremendous impact on her educational journey and future career path. Her passion for behavioral health comes from her own lived experience, which gives her a passion to help others, children, adolescents, families, and underserved communities in Ventura County. She thanked GCHP for investing in students like her and for supporting the future of behavioral health in the community.

Committee Chair Espinosa congratulated Ms. Mendoza on her tremendous success. She is glad that GCHP could be a little piece of that.

Commissioner Dr. Loretta Denering thanked the executive team, Ms. Preciado, and Mr. Cho, for the work of the last eight years which transformed the specialty system and the work with GCHP in a plan-to-plan relationship. She explained that Ventura County Behavioral Health has been recognized by their state and federal colleagues for having a unique relationship for the specialty program with their managed care plan (MCP). Dr. Denering responded to Chair Espinosa that the metrics shared at the beginning of the presentation include County Behavioral Health numbers with shared measurements that are being reported. Dr. Denering said network adequacy is important for all of us. She asked how the mild-to-moderate network will be expanded to help people who may end up needing services that do not rise to the level of specialty services.

Erik Cho, Chief Policy and Program Officer (CPPO), responded that there has been progress in the partnership with Carelon in access, driven by an incentive structure with them. It gives them some additional performance guarantees that they must meet, or they get penalized. The performance incentives enable them to receive incentive dollars for increasing access. There is approximately a 10% increase in unique utilizers over the last year. There is also a greater number of active clinicians in the medium or high active space. There has been an increase in the active number of Spanish speaking clinicians.

CMO Cruz shared that GCHP is partnering with health fairs to provide a variety of services and ensure that attendees know how to get help on how to submit Medi-Cal documentation so their coverage will not lapse. GCHP is using every possible public avenue to ensure people are informed of how to get help.

Chair Espinosa shared her concern that Carelon is on a list of providers that is consistently audited. She felt that was indicative of network inadequacy. She asked if they are the only entity out there and why only they have the contract. She felt it had gone on too long after too many complaints about Carelon.

CMO Cruz shared that the reason for complaints has changed, and the number of complaints has diminished.

Ms. Preciado responded that the pilot program being initiated is to ensure continuity and access to services.

CEO Nunez offered to bring back data to show the work that is being done. He said a lot has been done to make Carelon more accountable for access and to improve quality of care.

Supervisor Vianey Lopez asked about the member care ambassadors assigned to the school districts and clinics.

CEO Nunez said specific data regarding the member care ambassadors and where they are assigned can be brought back to the Commission.

Commissioner Denering motioned to receive and file Agenda Item 2. Commissioner Abbas seconded the motion.

Roll Call Vote as follows:

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

NOES: None.

ABSENT: Commissioner Tim Myers.

Motion carried.

FORMAL ACTION

3. Signature Authority and Procurement Policy Revisions

Staff: Bob Bushey, Executive Director, Procurement

RECOMMENDATION: It is the Plan's recommendation that the Ventura County Medi-Cal Managed Care Commission, 1) increase the General Authorization Limit of the existing Signature Authority policy to the limits noted in Table 2, 2) assign the Chief Financial Officer as the Plan's authorized agent to sign all non-claims related contracts and purchase orders, and 3) revise the single/sole source competitive bidding threshold in the Procurement policy from $50,000 to $200,000.

Scott Campbell, General Counsel, said it has been 11 years since the levels of policies, purchasing, and bringing things to the Commission have been adjusted. When the numbers were run, there are some administrative tasks being done that take a lot of time but do not

occupy a lot of funding. Bob Bushey, Executive Director of Procurement, is looking to adjust the funding levels to reduce the administrative tasks being done. This was sent to the Executive Finance Committee, and it was their unanimous recommendation that this be approved.

Bob Bushey, Executive Director of Procurement, said he is recommending three changes to the procurement authority policies. First is to increase the general authorization limits and signature authority policy. The second is to designate the Chief Financial Officer (CFO) as the Plan's authorized agent to sign non-claim-related contracts. The third recommendation is to revise the single or sole source or competitive bidding threshold in the procurement policy. Mr. Bushey explained that in 2015, there was one policy which included both signature authority content and procurement policy information. In 2026, those were revised and split into two separate policies. The signature authority policy is internal facing and supports internal controls. The procurement policy is external facing and relates to how goods and services are acquired for the organization. Both policies are aligned and are interdependent of each other, but it is better that there are two separate policies. The first concern with the policies is that they are 10 years old. The level of authorization within the plan is up to $100,000 for the chief executive officer (CEO) and everything above $100,000 must be reviewed and approved by the Commission. The second concern is that the CEO currently signs all contracts, which is a big administrative burden and task. The third concern is that the competitive bidding of our single sole source threshold is $50,000, which is a low threshold. It is a slow process for the organization which can take 35 to 60 days for Commission approval for a single transaction. The procurement resources are focused on transactional and compliance activities versus strategic spending initiatives. There are three recommendations. The first recommendation is to increase the general authorization limits. The second recommendation is to delegate signature from the CEO to the CFO. The third recommendation is to increase the dollar threshold for a single sole source or a competitive bidding threshold from $50,000 to $200,000.

Mr. Bushey shared that the current signature authority policy gives the CEO internal authorization up to $100,000 for administrative services for vendor-related contracts, they are not provider related. The budget is presented annually with a list of contract renewals, a list of projects that must be pre-approved by the Commission that eliminates some of the transaction approval. That will remain in the policy. He explained that 53% of all transaction volume is being approved at a CFO and CEO level, but represents 98.5% of our spend, which is a large amount of our transaction volume. Transactions go to the CFO and the CEO for review and approval, then the CEO approves and signs every contract. In some sister plans, the CEO general authorization limits are $200,000. The County is $200,000 for the Board of Supervisors. If we move to the $300,000 threshold, it will keep 94.4% of our spend visible to the Commission and the CFO and CEO, but it reduces the transaction volume to 29% of the overall transactions. Mr. Bushey said the recommendation is to move the authorization to sign contracts from the CEO to the CFO. The third recommendation is to increase the competitive bidding thresholds from $50,000 to $200,000. This will keep the team focused on the spend, focused on competition, and keep resources active and strategic thinking.

Commissioner Douglas Kleam asked if the CEO or the CFO could sign contracts.

Mr. Bushey responded that currently the CEO signs. He explained that the Executive Finance Committee requested that only the CFO sign.

Commissioner Kleam asked if a delegate will be assigned if the CFO is absent and the CEO is not authorized to sign.

Mr. Bushey responded there is a policy that supports delegating.

Commissioner Kleam asked if the levels below the chiefs had changed.

Mr. Bushey responded that all approval levels have changed. He shared that in Table One, a manager has up to $5,000 worth of internal authorization. A director has up to $25,000. The Chief has $50,000. When it hits $50,000, the CFO also must review it. The CFO reviews everything over $50,000 to $100,000. Then the CEO has up to $100,000 worth of authorization. All approvals are done electronically in our system. It is all automated, electronic, and auditable by cost center.

Commissioner Allison Blaze, M.D., asked a question of the Executive Finance Committee. She said the limit was increased to $300,000 to align with best practice, but she does not see any other plans that high.

Mr. Bushey responded that the limit for sister plans is $200,000. For commercial plans, the board levels are remarkably high.

Commissioner Kleam asked if the percentage of transactions was reviewed to reduce the administrative burden, so they aligned with the percentage of transactions.

Mr. Bushey responded that it is the objective. It was reviewed from a transactional basis to ensure that much of the spend was captured at the right dollar value for visibility and transparency purposes. If it were run again for $200,000 it would not make a lot of difference at $200,000 or $300,000.

Commissioner Sewell said he is supportive of this. He asked if there is currently an avenue for the sole source agreement to come back on a regular basis to review the rationale and justification for the decisions, to ensure checks and balances for the sole source justifications. He shared he thinks there is value in the oversight piece and feels it will save the CEO some time. He asked if controls are in place or if there is an additional set of controls that will be established if the limits are increased.

Mr. Bushey responded that the sole source is part of the current policy. He offered to share the policy with Commissioner Sewell. He said if there are a group of suppliers that make up the spend, we take that spend to the marketplace and consolidate it and will bring that to you. We take longer-term agreements and leverage our spending.

Mr. Campbell explained that there are criteria for sole source. Factors must be met, a justification must be written and then signed by procurement and legal. All the sole source

determinations are reviewed by my office to approve. For all contracts that have been entered into that will continue, with every budget cycle there is a list of those contracts that currently exist and will continue into the next year that have gone through a competitive process. We list what those contracts are for and what the budget amount is for the next year. When it goes through the budget, the Commission can ask questions about each of the contracts to review or ask to rebid and go to the market. In addition, there is a list of projects that come with the budget. In the past, the Commission will approve the budget for those projects and any contracts under those projects are approved. Then the approved non-provider contracts will appear on the list the Commission reviews. If the amount exceeds the contracts, they come back to the Commission to ask for additional dollars. Then next month the revision of the budget with all the contracts and any projects we are asking to be added with the contract amount will be reviewed, so there is continual oversight of the process.

Commissioner Sewell asked if the proposal to move the $50,000 to $200,000 on the sole source, would there be some between the $50,000 and $200,000 that would no longer be in the segregated process.

Mr. Bushey confirmed that it is correct.

Commissioner Sewell suggested reviewing after six months to find out which ones fell in between to determine if the Commission is comfortable with what has occurred.

Mr. Campbell said the next full-year budget will be in January. Along with the January budget, we will report on from the time this policy changed through to January, what sole source contracts were entered between $50,000 and $200,000, and provide a report. Then the Commission can decide to revisit this.

Mr. Bushey explained that suppliers are categorized as preferred or contracted. He has a set of suppliers that are by category for consulting, or they are contracted and already under a master agreement. He tries to route all customers to a preferred vendor or contracted vendor because they are pre-negotiated and risk adverse.

Commissioner Anna Monroy asked if due diligence is being done ahead of time to build what people can select from.

Mr. Bushey confirmed that it is correct. He proactively tries to look at the spend by category and take the spend to marketplace, source it, then bring that to the Commission to approve the sourcing initiative. Then they will be labeled and categorized as a preferred vendor.

Commissioner Sewell asked if the $300,000 limit were approved, would that be per fiscal year.

Mr. Campbell responded that it would be the full contract amount. Anything about the $300,000 must be on the list or go to the Commission separately.

Commissioner Sewell said he thought they said there is an electronic procurement system with auditable workflows. He asked if this is the act of putting ink on a piece of paper. In the electronic

system the workflow is documented. I would be open to allowing more than just those two positions if staff felt that was essential.

Commission Chair Espinosa responded that the point for the Commission was the transparency. We know a specific individual has oversight before signing it. One of the things the Commission preferred and feels good about is that every vendor is listed, which is helpful for oversight.

Chair Espinosa stated the Executive Finance Committee unanimously approved recommending this to the full Commission. She asked for a motion and second to approve the recommendation.

Commissioner Abbas motioned to approve Agenda Item 3. Commissioner Kleam seconded the motion.

Commissioner Sewell offered a friendly amendment to the motion to have flexibility through procurement to have more than the CFO and CEO sign. Commissioner Abbas and Commissioner Kleam accepted the amendment to the motion.

The Commission voted on the original motion with the amendment.

Roll Call Vote as follows:

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

NOES: None.

ABSENT: Commissioner Tim Myers

Motion carried.

4. Advance Payment Agreement to Ventura County Health Care Agency

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

RECOMMENDATION: Approve the Advance Payment to the Ventura County Health Care Agency.

Mr. Campbell explained that for Agenda Item 4, those who work directly with the Health Care Agency or whose spouses work for the Health Care Agency will be recused from the discussion. Commissioner Perera, who is participating, will be muted and should turn off the camera but can listen to the discussion. Commissioner Robinson, who is participating virtually, can participate in the discussion.

The following Commissioners were recused from the discussion: Allison Blaze, M.D., Loretta Denering, Yohan Perera, M.D., and Scott Underwood, D.O.

Chief Executive Officer, Felix L. Nunez, M.D., stated the presentation is at the request of our county partners for a $30 million advance to assist our county partners and safety net provider in the county with their ability to maintain and stay on mission to serve our members and other members of the community who depend on that safety net provider for critical health care services. The amount requested is $30 million. The terms of the $30 million advance would commence on June 26, 2026, and end on September 30, 2026. This item has been brought to Executive Finance Committee twice. It was initially presented at the April 23, 2026, Executive Finance Committee meeting. Executive Finance Committee members at the time made recommendations for modifications to the terms and requested staff to bring back this item after discussion with the County. It was also presented at Commission where it was moved to continue the item to the May 13, 2026, Executive Finance Committee meeting, following discussion with our county partners on the terms of the agreement. The terms that were discussed and what was presented to the Executive Finance Committee for this agreement will be presented. The recommendation of Executive Finance Committee was to move forward with those terms with one modification.

CEO Nunez explained that the terms of the agreement for the $30 million is an advance, not a loan. It is not a gift of public funds. The statutory clearance we have from state welfare institutions code county ordinance, in addition to our bylaws, help to support this advance payment to the county. This is an advance on claims and services to be performed pursuant to the primary care provider specialist and hospital provider agreements. This is made necessary due to the state funding cycles for state directed payments, which are anticipated to come in the Fall of this year. These cycles are delayed at the state level by two years. If the advance payment has not been fully repaid by September 30, 2026, Gold Coast Health Plan may offset any unpaid amounts against capitation payments, fee-for-service payments relating to claims submitted or processed for payment or any other amounts due to Ventura County Health Care Agency for subsequent months at a rate of $10 million a month. Parties agreed to collaborate on strategic planning activities with the goal of improving equity and advancing health in the Santa Clara River Valley. The section that spoke to the greater county in terms of collaboration was deleted to narrow the focus on Santa Clara River Valley. In addition, the parties agreed to good standing language. Good standing language is good standing with federal California legal requirements that relate to the county as a network provider and not to engage in litigation against the Plan during the term of the advance payment agreement. In addition, the staff initially recommended that we waive any administrative fees related to this advance. It was the recommendation of the Executive Finance Committee that that administrative fee be reinstated in the amount of $189,440. This administrative fee reflects the lost opportunity had those funds remained in an interest-bearing account.

Mr. Campbell stated that there was one additional recommendation that the staff bring forth a policy for future advanced payments that will be approved by the Commission. We are going to try to bring that to the Commission in August or September to have that policy reviewed so that in the future there are criteria set forth for consideration of these advanced payments for any provider that asks for them.

Commissioner Sewell shared a word of caution in suggesting that this reduces the reserves of Gold Coast Health Care Plan. It reduces the cash, but it increases receivable. It is my understanding that it is reportable because it is a short-term expectation of getting it back, and the liquidity would come down, but it gets replaced with an asset and reserves would be unaffected. It is another reason GCHP believes this is achievable and would not put them in damage.

Interim Chief Financial Officer Jeff Register affirmed that statement. It would reduce our liquidity, but it will not reduce our balance sheet. We will be moving from a highly liquid asset to a less liquid asset on a temporary basis, and then the cash will be replenished at the end of that term.

Commissioner Roger Robinson shared that he knows of other plans that have had similar activities, and they did not charge the administrative fee. If it truly is to help support the safety net programs, the administrative fee, $189,000 is at least two temporary positions that can be used to help assist and offset some of the issues with enrollment with HR-1 coming up. At our level, having two staff available that are temporary could go a long way to ensure our numbers do not reduce when the redeterminations and work requirements are implemented with HR-1.

Commission Chair Espinosa responded by pointing out that the County of Ventura charges each of their departments a fee as well. We are working consistently with what the County of Ventura does with its own departments.

Commissioner Robinson said that there are times when our payments are delayed back to the County and we do not charge the administrative fees.

Commissioner Sewell shared that there is not so much an administrative fee charged between departments. He believes Chair Espinosa may be referring to the current agreement regarding the general fund advance and the Ventura Medical System, whereby the money that is advanced to the medical system from the general fund does accrue interest. That has been in place for 18 months. The other nuance to consider is the general fund contributes almost $30 million annually to the Ventura County medical system. The general fund is contributing more to the medical system than it receives back in interest, but there are no administrative fees charged between county departments.

Commission Chair Espinosa responded that the question is moot because the County has agreed to this in the renegotiation.

Mr. Campbell responded that the County agreed to pay but would always prefer not to pay. They will agree to the Commission’s recommendations.

Commissioner Kleam said we are setting a precedent which will come forth in a policy in the future that any provider can get an advance and here are the criteria and how we would manage it.

Mr. Campbell said last year when this advance was made to the County, there was an administrative fee. The policy that we would develop would have the administrative fee attached

to it. Originally, we thought this time because of the fiscal crisis and the crunch that everyone is facing, staff originally recommended no administrative fee, but the Executive Finance Committee unanimously said to impose the fee, so we are taking that recommendation to the Commission.

Commissioner Anwar Abbas asked why the policy is not mentioned in the document that is going to be approved.

Mr. Campbell responded that after the Executive Finance Committee meeting, he sent an email to the Commission with the action of the Executive Finance Committee, which included the development of the policy.

CEO Nunez said the policy will be developed and the Finance department is already working on the policy.

Chair Espinosa called out the focus on the Santa Clara River Valley. There is a critical crisis pending in the Santa Clara River Valley. The County is facing a deadline to retrofit the Santa Paula Hospital by 2030. There is a potential closure of the only hospital in the Santa Clara Valley, and the expected cuts from HR-1, which is projected to be over $400 million over the next several years. There is a lot at stake, and we want the County to be healthy. This cash flow problem is not only centered on the county. It is all our providers and health care systems. How the national health care system operates needs to be corrected because it is burdensome to all the providers.

Supervisor Vianey Lopez asked if the current source of funding is in an interest-bearing account.

Mr. Campbell responded that the administrative fee was calculated using the account that had the lowest interest rate.

Supervisor Lopez said that due to wearing two hats, serving as a Commission and as a county supervisor and seeing where things are headed, she supports the staff recommendation to waive the fee.

Chair Espinosa asked for a motion and second to approve the recommendation of the Executive Finance Committee, including the fee.

Commissioner Monroy motioned to approve Agenda Item 4. Chair Espinosa seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Laura Espinosa, Douglas Kleam, Supervisor Vianey Lopez, Anna Monroy, Roger Robinson, and Mark Sewell.

NOES: None.

RECUSED: Allison Blaze, M.D., Loretta Denering, Yohan Perera, M.D., and Scott Underwood, D.O.

ABSENT: Commissioner Tim Myers

Motion carried.

Commissioners Allison Blaze, M.D., Loretta Denering, Yohan Perera, M.D., and Scott Underwood, D.O., returned to the meeting.

5. April Year-To-Date 2026 Financials

Staff: Jeff Register, Interim Chief Financial Officer - Controller

RECOMMENDATION: Accept the financial information as presented.

Interim CFO Jeff Register said he does not have a slide deck prepared yet since they have just finished closing the month and are working on analysis and reconciliations. Overall, year-to-date performance through the end of April, net income is $3.8 million compared to a budget of $2.7 million. Last month, we were a little bit behind budget on net income. This month, we are a little bit ahead, so it was a favorable month. Revenue was $.8 million favorable to budget. April membership was unfavorable to budget by 2,300 members, or about 1%, and has declined to approximately 9,300 members, or 3.9% since December 2025. The revenue was favorable to budget, driven by member mix, because some of the members we received greater premium for. As the member mix changes, that can influence a rate basis whether we are favorable or unfavorable, and it is partially offset by unfavorable volume because of the lower membership. Medical expenses are 3.8 million unfavorable to budget, and our MLR (Medical Loss Ratio) is currently sitting at 85.7% versus a budget of 84.9. Revenue is up a little bit. Medical expenses are up a little bit more. Our administrative expenses are $4.8 million favorable to budget. Our administrative loss ratio is 10.3% compared to the budgeted administrative loss of 11.4. We continue to tightly control those directly controllable expenses through activities such as closely monitoring year spend and continuing with the hiring pause that we have been engaged in this year. Our tangible net equity (TNE) is currently 536% of the state requirement and is therefore within the target range set by the Commission. We remain tracking closely to budget overall, and we remain tracking closely to budget in each category on the income statement. As membership continues to develop, we will keep a close eye on that. We will also have greater insights into the 3 + 9-year forecast that we plan to bring to the next Executive Finance Committee meeting and the next Commission meeting.

Commissioner Scott Underwood, D.O., asked to have the notes shared with the Commissioners.

Interim CFO Register responded that he would share his notes with the Commissioners.

Commissioner Monroy motioned to receive and file Agenda Item 5. Commissioner Kleam seconded the motion.

Roll Call Vote as follows:

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

NOES: None.

ABSENT: Commissioner Tim Myers

Motion carried.

REPORTS

6. Chief Executive Officer (CEO) Report

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

RECOMMENDATION: Receive and file the report

CEO Nunez shared that many of our partners are concerned about the loss of enrollment that has continued month-over-month, with an increase in the rate of loss over this last year. As of May 1, 2026, there was a net loss of 2,405 members. We have been tracking this drop month-over-month, starting in August after HR-1 passed. It is multifactorial and hard to pin down to one thing that has changed. It includes ICE (Immigration and Customs Enforcement) enforcement activities, changes in flexibility at the state level that the state reversed following the COVID pandemic, and the general sense of confusion following HR-1 regarding Medi-Cal and Medicaid eligibility that contribute to the ongoing drop in enrollment. Acceleration started in January with 1.4%, 1% in February, 0.6% in March, and 1% in May. We anticipate this will continue over the course of the year. We continue to monitor and activate around this. We formed a coalition in Ventura County around retaining coverage as the main goal of the coalition. Th coalition has met in person twice and are breaking into work groups focused on three primary areas: advocacy, outreach and education, and direct member engagement. HR-1 is a reality that we are facing as a health plan in California. We have met with state and national partners to discuss these things happening across the nation. This is something we will be facing for years to come. It is my belief that we have opportunities to mitigate those losses. We are seeing losses not only in the UIS (Unsatisfactory Immigration Status) population, but also in our SIS (Satisfactory Immigration Status) population. Since January of this year, SIS population lost 6,000 members who are fully eligible for the federal Medicaid program. Since January of this year, we have lost 3,000 UIS members. By January, work requirements of 80 hours per month will start, unless they have a medical frailty that exempts them from work requirements or educational and volunteer requirements. Additionally, the increased enrollment cycle to every six months will start next year. We need to activate now to develop a strategy not just for this year but for the next four years. We anticipate this to be a long-term proposition. We need to institutionalize our thinking around enrollment as part of our work to help maintain

enrollment and access. The coalition is activated to maintain enrollment to the maximum extent possible to try to stem the losses and mitigate some of the effects of HR-1. I hope because we have an amazing staff who are activated and see this as an opportunity to engage with members and help them on their journey to assess health. The coalition is activated as a united group to maintain access within the entire county. The entire healthcare infrastructure is at risk because of these changes. This activation is an opportunity for us to focus on healthcare access, Medicaid, healthcare enrollment, and in the future for the coalition to focus on improving access and quality of care. Updates will be shared with the Commission on the work of the coalition as key indicators are tracked. CEO Nunez asked Commissioner Robinson to share his thoughts on the effects of HR-1 in the coming year.

Commissioner Robinson said a Memorandum of Understanding (MOU) has been developed with Gold Coast Health Plan to share our member information so they can alert their members when their applications are due. It is going to be all hands-on deck because the Human Service Agency (HSA) cannot do this alone and will need the help of the community and GCHP. On June 1, the work requirements for Cal Fresh start. That will show what the work requirements will look like for Medi-Cal starting January 1, 2027, along with the redeterminations that need to be done every six months. If we communicate appropriately to the community and let them know if they get the yellow envelope to make sure to update their information and reapply, we can avoid people falling off Medi-Cal. It is going to be difficult, and people are going to lose their benefits. It is going to be vital for the Human Services Agency to provide support to the community. That is why we are working on a program to extend our hours to 7:30 pm so clients can come in after hours to access these services. We have also revamped our training and structure because if we do not have staff who can accommodate this, it will not only affect the community, but it will affect the managed care plan, Behavioral Health, and the entire continuum of care.

Commissioner Blaze said Marlen Torres, Chief Member Experience & External Affairs, talked about how we were impacting the member. Commissioner Blaze asked if GCHP has done any Question and Answer or fax or mailed anything to the members.

CEO Nunez said DHCS just approved an outreach plan. Billboards and advertising are already up. The executive team has given approval to hire additional temporary staff to collaborate directly with members and engage them. Those staff are still being trained and need to be certified. HSA has a certification process for people who provide Medi-Cal application assistance. We will be doing outreach to our members who are eligible for the upcoming renewal. We already have staff trained and certified. One of our staff is a trainer as well. Our current plan is to have staff begin outreach calls to our members. We are activating as quickly as we can. Despite our hiring pause, the executive team thought this is a critically important mission responsibility. We have given approval to hire ten temporary staff for the specific function of reaching out to members to assist with applications, answering questions, and dealing with misinformation, whether deliberate or accidental, that exists regarding Medi-Cal eligibility. The UIS adult expansion population is not taking new enrollments. The UIS population who drop enrollment will not be allowed to come back in. In the May revise, the Governor gave his vision for the UIS population, which is a shift entirely to fee-for-service for the entire population with a $100 monthly premium. This will present a barrier and a challenge.

Commissioner Blaze asked if only dental will change on July 1. She said many think they are going to lose their Medi-Cal. She suggested sharing an FAQ (Frequently Asked Questions) via the mail and with all the clinics so they can talk to their patients.

Commissioner Monroy suggested focusing on what does remain available. Share that the benefit is changing but is not going away. Clinicas is choosing to focus on that because it is complex, and patients may not understand which benefits they have and which they do not.

CEO Nunez agreed with Commissioner Monroy. He said that deliberate misinformation is being shared that we need to fight against. The FAQs are a fantastic idea. GCHP can prepare those and get them to provider networks, so they are aware and can dispel some myths and misinformation about eligibility.

Commissioner Monroy asked if data can be shared because they do not have a line of sight into when people are coming due.

Eve Gelb, Chief Innovation Officer, responded that one of the work groups of our coalition is a data-focused work group, so we can put that on the agenda.

CEO Nunez said data sharing would be ideal. He needs to get clarification on how to operate that.

Commissioner Robinson responded that data sharing would be limited to who it could be shared with. Data could be shared with GCHP because they are the managed care plan. However, outside of GCHP, because of HIPPA, data sharing is limited.

Erik Cho, Chief Policy and Program Officer, suggested more discussion about what is possible to be shared. It may not be data directly from HSA due to prohibitions they have. GCHP has some data which the state has shared, which is less accurate regarding termination times.

CEO Nunez said the point of the coalition is to pool as many resources as possible. We need to be strategic with the resources we have; we must dig into the data and target those groups who are likely to re-enroll if they have assistance. We do not have that data yet. It is data that we need to develop and get skilled very soon.

CPPO Cho responded to Commissioner Blaze's point. If people believe they will lose Medi-Cal when their dental benefit ends, that is important to address now, not into next year.

Commissioner Abbas asked CEO Nunez if he has an accurate level of the anticipated membership loss.

CEO Nunez responded that work is being done on the projections but is not ready to be presented yet. It will be brought to the Commission once the numbers are solidified. We are going to try to do a three-year projection.

Chair Espinosa asked Commissioner Monroy if the people at the clinics assisting with enrollment and re-enrollment are Clinicas' employees.

Commissioner Monroy responded that they are employees who are enrollment specialists at clinics that help with renewals, not just for Medi-Cal but also for Cal Fresh. We have a group of fourteen that we try to rotate to ensure that every clinic has coverage at any given point throughout the month.

Robert Franco, Chief Compliance Officer, said Ms. Torres's team is working on a dashboard of information coming from HSA. The plan is to share the data they receive with each of the respective clinics, which will capture the aid codes, the UIS and the SIS status. That information is forthcoming.

Supervisor Lopez motioned to receive and file Agenda Item 6. Commissioner Kleam seconded the motion.

Roll Call Vote as follows:

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

NOES: None.

ABSENT: Commissioner Tim Myers

Motion carried.

Closed session began at 4:21 p.m.

CLOSED SESSION

7. REPORT INVOLVING TRADE SECRET:
Discussion will concern: Proposed new service/program
Estimated Date of Public Disclosure: October 1, 2026

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

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

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

ADJOURNMENT

With no other business to conduct, the meeting was adjourned at 6:23 p.m.

Approved:

_____
Deborah Munday, MMC
Associate Clerk of the Board

AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: June 29, 2026

SUBJECT: Maternal Focus

PowerPoint with Verbal Presentation

ATTACHMENTS:

Maternity Services for Pregnant & Postpartum Medi-Cal Members

Gold Coast Health Plan℠
A Public Entity

Maternity Services for Pregnant & Postpartum Medi-Cal Members

Integrity

Accountability

Collaboration

Trust

Respect

All Plan Letter (APL) 26-005:
Maternity Services for Pregnant & Postpartum Medi-Cal Members

DHCS released APL 26-005: Maternity Services for Pregnant & Postpartum Women

APL 26-005 introduces **a major modernization of maternity care requirements, expanding expectations for clinical quality, behavioral health integration, and postpartum continuity of care**.

These changes require significant updates across GCHP's entire organization to ensure comprehensive support from early pregnancy through 12 months postpartum.

Key Points:

- Modernized regulatory framework
- Expanded clinical and BH expectations
- Full-year postpartum support
- Cross-department operational impact

While the APL introduces some net-new requirements, many of these requirements have been in place since 2022 or earlier.

Why This Matters:
Maternal & Infant Health in California

Around 70 birthing people and 1642 infants died in California in 2023 – most of these deaths were preventable.

01 **Maternal mortality and infant mortality are connected**

1,642 infants lost in California in 2023. Black infants die at 2.8× the rate of white infants. When a birthing person doesn't receive prenatal care, consistent Care Management support, or timely intervention — both lives are at risk.

02 **These disparities are not natural — they are designed**

Black birthing people in California die at 2.8–3.6× the rate of other groups. Rates fell for every other group in 2023. For Black birthing people, they went up. **Inequity this persistent is structural — and it can be disrupted by deliberate design.**

03 **The health plan is one of the most powerful levers we have**

Medi-Cal covers 40%+ of California births. The families behind these numbers are our members. How we design this program — who we reach, when, and how — has direct impact on outcomes.
GCHP has 3500 births per year and supports 7000 postpartum members annually.

04 **Prevention works — when we actually wrap around the member**

80%+ of these deaths were preventable. The question is whether our collective systems are designed to let them slip through the cracks – or to to catch them. That is the intention of APL 26-005 and what we are designing today.

High Priority Areas of Focus

Based on APL 26-005 regulatory requirements and the completed gap assessment, the areas below are GCHP's highest priority areas of focus.

GCHP's implementation strategy focuses on aligning internal operations, strengthening provider partnerships, and improving member engagement. These priorities ensure compliance while advancing maternal health outcomes.

Area of Focus	Phase 1: Changes within GCHP's Current Capacity	Phase 2: Requires Staffing, Workflow, or Tech Enhancements
Early Pregnancy Identification & Outreach	In Progress	Yes, assessment is underway
End-to-End Maternity Care Management Program Build, including Transitional Care Services (TCS)	In Progress	Yes, assessment is underway
End-to-End Doula Operationalization	In Progress	Yes, assessment is underway
Behavioral Health Integration	In Progress	Yes, assessment is underway
Provider Network & Oversight, including Medical Record Review	In Progress	Likely, assessment is underway
Provider & Member Communications	In Progress	Unlikely, assessment is underway
Standing Maternal Health Steering Committee to continue cross-collaboration, prioritization, alignment and awareness	In Progress	Unlikely, assessment is underway

Timeline:
Where We've Been · Where We Are · Where We're Headed

GCHP teams have made significant progress redesigning and fully implementing APL 26-005. Incremental change will not get us to compliance. It requires a coordinated, resourced implementation plan.

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
Current State Assessment												
Design Session 1: Gap Analysis & Prioritization			3/24									
High Priority Gap Solutioning												
APL 26-005 Requirements Mapped (116) & Gap Analysis Complete												
P&Ps Updated per APL 26-005 *~40 P&Ps reviewed and updated*						72% Done			Due to DHCS 9/21			
Design Session 2: Future State Design of four focus areas*					5/27							
Continued Future State Design & Phased Implementation						**Implement changes achievable within GCHP teams' current capacity**						
Cross-functional Maternity Services Steering Committee												
Ongoing gap remediation + implementation (staffing, process, IT systems)							**Implement changes to bring GCHP to full compliance – requires organizational prioritization & strategic investment** *Work is likely to phase into 2027*					

**Four Focused Areas: (1) Maternity CM, Doula, Behavioral Health, Transitional Care Services*

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: June 29, 2026

SUBJECT: Resolution Approving and Adopting Public Participation and Community Outreach and Disruption of Meetings Policies

RECOMMENDED ACTION(S): Adopt a resolution approving and adopting Public Participation and Community Outreach and Disruption of Meetings Policies in compliance with SB 707.

REPORT SUMMARY: Senate Bill 707 (SB 707) amended the Brown Act to require eligible legislative bodies to take certain actions to encourage residents, including those in underrepresented communities and non-English-speaking communities, to participate in public meetings. SB 707 also require that the Commission adopt policies to encourage public participation and community outreach and how to handle meeting disruptions.

To comply with SB 707, the General Counsel's Office drafted two policies for the Commission's consideration and adoption.

Public Participation and Community Outreach Policy
This Policy establishes the reasonable efforts that Gold Coast Health Plan ("Plan") will take to invite groups that do not traditionally participate in public meetings to attend its meetings under the Brown Act (Government Code § 54953.4(b)(3)(C)). This Policy is intended to support inclusive public engagement while preserving the Plan's discretion to determine and adjust appropriate outreach methods based on local needs, priorities, and available resources.

Within 6 months of the adoption of this Policy, Plan Staff will prepare and present to the Commission a list of organizations, media outlets, and other entities that may assist in expanding awareness of the Commission's meetings. This list may include, but is not limited to,

- Media organizations that provide news coverage, including media organizations that serve non-English-speaking communities; and
- Community-based organizations such as good government groups, civil rights organizations, civic engagement organizations, neighborhood associations, and other community or cultural groups active in the Plan's jurisdiction, including organizations active in non-English-speaking communities.

The list may be updated periodically as determined appropriate by the Commission or designated staff.

The Commission may periodically review its outreach practices and make adjustments as appropriate. In doing so, it may consider factors such as community feedback, participation levels, resource availability, and evolving communication practices.

In addition to the outreach efforts described in this Policy, the Brown Act establishes additional public access requirements intended to support broad participation in public meetings of eligible legislative bodies like the Commission. These requirements include, among other things: provisions related to the translation of meeting agendas into applicable languages (if applicable), the availability of a public meetings webpage with specified information in required languages (if applicable), systems for requesting agendas and meeting materials, and accommodations that facilitate public participation, including assistance for interpretation.

The policy may be amended by the Commission at its discretion.

Disruption of Meetings Policy
This policy establishes procedures for responding to a disruption in the telephonic or internet services that provide two-way remote public access to meetings of the Commission, as required by the Brown Act (Government Code section 54953.4). The policy ensures transparency, public participation, and the continuation of meetings during technological disruptions.

This policy applies to all open and public meetings of the Commission at which remote public participation is required under the Brown Act.

When remote public access is required under the Brown Act, the Commission shall provide members of the public with an opportunity to attend and participate in the meeting using a two-way audiovisual platform or a two-way telephonic service, provided that adequate telephonic or internet service is operational at the meeting location.

Members of the public participating remotely shall be provided the same opportunity to provide public comment as members of the public attending in person, including the same time allotment.

The policy also addresses what actions must be taken in response to a service disruption, and the response to members of the public that may cause a disturbance to a meeting.

This policy may be amended by the Commission at their discretion.

FISCAL IMPACTS: N/A.

CONSEQUENCES OF NOT FOLLOWING RECOMMENDED ACTION: The Plan may be out of compliance with State Law.

FOLLOW UP ACTION: Maintain a copy of the policy on file with the Plan Clerk and available to the public. The final Public Participation and Community Outreach and Disruption of Meetings Policies shall be effective immediately upon adoption and approval.

ADVERTISING, NOTICE AND PUBLIC CONTACT: The item was properly listed on the posted agenda pursuant to the Brown Act.

ATTACHMENT(S):

1. SB 707 PowerPoint
2. Resolution and Policies

Disruption of Meetings Policy

1. Background

Senate Bill 707 (2025) amended the Brown Act to require eligible legislative bodies to adopt, on or before July 1, 2026, a policy addressing how the agency will respond to disruptions in telephonic or internet service that prevent members of the public from participating remotely. Additionally, the Brown Act has certain guidelines on disruption of meetings caused by members of the public that should be incorporated into this policy.

2. Purpose

This policy establishes procedures for responding to a disruption in the telephonic or internet services that provide two-way remote public access to meetings of the Ventura County Medi-Cal Managed Care Commission (Commission) as required by the Brown Act (Government Code section 54953.4). The policy ensures transparency, public participation, and the continuation of meetings during technological disruptions. This policy also incorporates guidelines on how to handle certain disruptions caused by members of the public.

3. Definitions

"Service Disruption" means any failure, outage, or other interruption to the Commission's remote access services that prevents members of the public from participating in a Commission meeting through the remote access services.

"Disrupting" means engaging in behavior during a meeting of the Commission that actually disrupts, disturbs, impedes, or renders infeasible the orderly conduct of the meeting and includes, but is not limited to one of the following:

a. A failure to comply with reasonable and lawful regulations adopted by the Commission or requests from the Commission pertaining to conduct at a meeting.

b. Engaging in behavior that constitutes use of force or a true threat of force.

"Remote access services" means the two-way telephonic service and/or two-way audiovisual platform used to provide real-time remote public attendance and observation of meetings.

"Two-way audiovisual platform" means an online platform that provides participants with the ability to participate in a meeting via both an interactive video conference and a two-way telephonic service.

"Two-way telephonic service" means a telephone service that does not require internet access and allows participants to dial a telephone number to listen and verbally participate.

"True threat of force" means a threat that has sufficient indicia of intent and seriousness, that a reasonable observer would perceive it to be an actual threat to use force by the person making the threat.

4. Applicability

This policy applies to all open and public meetings of the Commission at which remote public participation is required under the Brown Act. Consistent with the Brown Act, this policy shall not apply to the following meetings:

a. Meetings held to attend a judicial or administrative proceeding to which the Commission is a party.

b. Meetings held to inspect real or personal property provided that the topic of the meeting is limited to items directly related to the real or personal property.

c. Meetings held to meet with elected or appointed officials of the United States or the State of California, solely to discuss a legislative or regulatory issue affecting the Gold Coast Health Plan and over which the federal or state officials have jurisdiction.

d. Meetings held to meet in or nearby a facility owned by the Gold Coast Health Plan provided that the topic of the meeting is limited to items directly related to the facility.

e. Meetings held in an emergency situation pursuant to Government Code section 54956.5.

5. Remote Public Access Generally

When remote public access is required under the Brown Act, the Commission shall provide members of the public with an opportunity to attend and participate in the meeting using a two-way audiovisual platform or a two-way telephonic service, provided that adequate telephonic or internet service is operational at the meeting location.

If adequate telephonic or internet service is not operational at the meeting location, the Commission shall not be required to provide remote access. If adequate telephonic or internet service is operational for only a portion of the meeting, the Commission shall provide remote access during that portion of the meeting.

If a two-way audiovisual platform is used, the Commission shall:

a. Publicly post and provide a call-in option as well; and

b. Activate any automatic captioning function that is available in the audiovisual platform.

If a two-way audiovisual platform is not provided, the Commission shall provide a two-way telephonic service.

Members of the public participating remotely shall be provided the same opportunity to provide public comment as members of the public attending in person, including the same time allotment.

6. Response to Service Disruption

If the CEO, Chair or Commission becomes aware of a service disruption:

a. The CEO, Chair or Commission shall immediately announce the service disruption to the public.

b. The Chair shall call for a recess of the open session and may convene the legislative body in an authorized closed session, consistent with the Brown Act. The recess shall last for one hour or until service is restored, whichever is earlier.

c. During the recess, Gold Coast Health Plan staff shall make a good faith effort to diagnose and restore the disrupted service.

7. Reconvening the Open Session

After the expiration of the hour, if service has not been restored, the CEO, Chair or Commission shall report on the status of staffs efforts to restore remote access services, and the Commission may reconvene to:

a. Adjourn the meeting;

b. Extend the recess to allow staff more time to make a good faith/ effort to restore remote access services; or

c. Continue the open session portion of the meeting by adopting, by roll call vote, the following or a substantially similar finding:

"Gold Coast Health Plan has made good faith efforts to restore telephonic or internet service in accordance with its adopted policy, and the public interest in continuing the meeting outweighs the public interest in remote public access."

Upon adoption of the finding, the Commission may continue the open session portion of the meeting despite the fact that remote access services have not been restored.

8. Recordkeeping

The Board shall enter a brief statement into the meeting minutes, including:

- The nature and time of the service disruption;

- The time the meeting was reconvened (if applicable);
- Any finding adopted pursuant to Section 7.

9. Response to Members of the Public Disrupting a Meeting

If the CEO, Chair or Commission becomes aware of a member of the public who is attending the meeting through remote access services and is disrupting the meeting or otherwise preventing other members of the public from attending and participating or observing the meeting remotely or in-person:

a. The Chair shall warn the person who is participating through remote access services that he or she is disrupting the meeting and his or her failure to cease that behavior may result in his or her removal.

b. If the person to whom the Chair gave the above warning persists in disrupting the meeting, the Chair shall order staff to:

(i) mute or otherwise limit the individual's ability to disrupt the meeting, while allowing the individual to continue to observe and attend the meeting; or

(ii) remove the individual from the meeting if paragraph (a) does not address the disrupting behavior or is not available using the remote access service.

10. Review and Updates

This policy may be amended by the Commission at a noticed public meeting in open session and may not be placed on the consent calendar.

RESOLUTION NO. 2026 - 003

RESOLUTION OF THE VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION, APPROVING AND ADOPTING PUBLIC PARTICIPATION AND COMMUNITY OUTREACH AND DISRUPTION OF MEETINGS POLICIES IN COMPLIANCE WITH SENATE BILL 707

WHEREAS, Senate Bill 707 (SB 707) amended the Brown Act to require eligible legislative bodies to take certain actions to encourage residents, including those in underrepresented communities and non-English-speaking communities, to participate in public meetings; and

WHEREAS, SB 707 requires the adoption of policies regarding disruptions at meetings and public participation and community outreach; and

WHEREAS, the policies establish the reasonable efforts the Ventura County Medi-Cal Managed Care Commission ("Commission") and Gold Coast Health Plan ("Plan") will take to invite groups that do not traditionally participate in public meetings to attend its meetings under the Brown Act (Government Code § 54953.4(b)(3)(C)); and

WHEREAS, the policies additionally establish procedures for responding to a disruption in the telephonic or internet services that provide two-way remote public access to meetings of the Commission, as required by the Brown Act (Government Code section 54953.4 and other disruptions caused by persons attending Commission meetings; and

WHEREAS, the goal of the policies is to ensure transparency, public participation, and the continuation of meetings during disruptions; and

WHEREAS, the Commission may amend these policies at their discretion during the General Business Session of a regular meeting of the Commission.

NOW, THEREFORE, BE IT RESOLVED, BY THE COMMISSION:

Section 1. The does hereby approve and adopt the proposed Public Participation and Community Outreach and Disruption of Meetings Policies in compliance with Senate Bill 707, copies of which are attached hereto and shall be on file with the Commission Clerk and available to the public for inspection and copying during regular business hours,

Section 2. The said Public Participation and Community Outreach and Disruption of Meetings Policies shall become effective immediately upon adoption and approval.

PASSED, APPROVED AND ADOPTED at a regular meeting of the Commission this 29th of June, 2026, by the following vote:

AYES:
NOES:
ABSTAIN:
ABSENT:

SB 707

SB 707

- SB 707 is a major restructuring of the Brown Act
- Requires the adoption of policies regarding Technological Disruptions at meetings and Community Outreach
- Establishes new Rules for Meeting Notices and websites

What Has Not Changed

- Actions must be at noticed meeting
- Retains ability to teleconference
- Mandates Public Participation
- Mandates Notice requirement
- Maintains Closed Session Exceptions

New Requirement: Technology

- Must have two-way telephone or video platform so the public can participate remotely.
- If audio-visual system is used, any automatic captioning must be activated.

Agenda: Translation Requirements

- Agenda must be translated into “applicable” languages: Spanish
- Only agenda notice, not the entire package
- Location where agendas are posted must make room for additional agendas in different languages
- Internet posting must also have translations with a prominent direct link posted on website homepage

Meeting Translation Requirements

- Agency must "reasonably assist members of the public" who wish to translate meeting
- Agency must publish instructions on how to request translation assistance
- Assistance may include:
  1. Space for translators
  2. Extra time to translate
  3. Allow public to use own translation equipment or commercially available services

Meeting Translation Requirements (cont.)

- Actual translation services are not required but may be provided
- Actions to encourage Residents, including those from underrepresented communities, to participate in public meetings
    1. Establish a system for electronically accepting and fulfilling requests for agenda packets
    2. Create webpage dedicated to public meetings with information on such meetings
    3. Make reasonable efforts, as determined by policy adopted by the agency, to invite groups that do not traditionally participate in public meetings

Teleconferencing Participation After Agenda is Posted is Still Available

- Proclaimed emergencies
- Just case exceptions
  - Illness, childcare, medical emergency
- Must participate with audio and video on at all times
- Must identify adults in room
- 2 times a year

Other New Provisions

- Disruptive public participation by video can be cut off
- All Department Heads salaries which are determined in closed session must be disclosed

BBK
BEST BEST & KRIEGER LLP

Questions?

Scott Campbell

scott.campbell@bbklaw.com | 213-617-7489

QR Code Destination

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Jeff Register, Interim Chief Financial Officer-Controller

DATE: June 29, 2026

SUBJECT: 2026 4+8 Reforecast

SUMMARY:

Staff is presenting the attached 2026 4+8 Reforecast of Gold Coast Health Plan ("GCHP").

ATTACHMENT:

2026 4+8 Reforecast Package

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

2026 4+8 Reforecast

Ventura County Medi-Cal Managed Care Commission
June 29, 2026

Jeff Register, Interim Chief Financial Officer-Controller

Executive Summary

- Total revenues of $1.2B
- Reforecasted $10.1M Consolidated Net Loss
  - $1.4M decline, or -0.1% of Consolidated revenue, from the original Budgeted $8.7M Consolidated Net Loss
- Medicare is largely unchanged and appears on track for a $10.5M Net Loss
  - $0.3M improvement, or 1.7% of Medicare revenue over the original Budgeted $10.8M Net Loss
- Medicaid is largely unchanged and appears on track for a $0.5M Net Income
  - $1.7M decline, or -0.1% of Medicaid revenue, from the original Budgeted $2.1M Net Income

- Medicaid Key Points:
  - 50.6K reduction in anticipated member months, driving reductions in revenue and medical expenses
  - $11.0M of the $15.9M reduction in medical expense is driven by prior year favorable development in medical expense reserves
  - Net Operating Income improvement of $9.7M, offset by increases in expenses reported under Net Non-Operating Income

- Projected 2026 TNE is $236.4M, or 510% of the required minimum TNE

Return to Agenda

Commission Approved 2026 Consolidated Budget - Original

Commission Presented / Approved

	Consolidated Revenues	Consolidated Expenses
Premium Revenue	1,244,493,691	
Medical Costs: FFS		990,242,650
Medical Costs: Cap		55,692,191
Medical Costs: Other		8,370,349
Medical Costs: Quality Improvement		23,085,454
Gross Margin	1,244,493,691	1,077,390,644
Admin Expense		158,091,462
Quality Improvement Credit		(23,085,454)
Net Admin		135,006,008
Operating Income		32,097,039
Interest Income	12,000,000	
Quality Strategy		43,000,000
Amortization		9,786,264
Net Non-Operating Income	12,000,000	(40,786,264)
Net income		(8,689,225)

MLR	86.6%
ALR	10.8%
NNOIR	3.3%
Total	100.7%

Proposed 2026 4+8 Consolidated Reforecast

	Consolidated 4+8 Reforecast Revenues	Expenses
Premium Revenue	1,239,101,441	
Medical Costs: FFS		986,036,701
Medical Costs: Cap		51,984,891
Medical Costs: Other		-
Medical Costs: Quality Improvement		24,894,645
Gross Margin	1,239,101,441	1,062,916,237
Admin Expense		159,127,815
Quality Improvement Credit		(24,894,645)
Net Admin		134,233,170
Operating Income		41,952,034
Interest Income	11,562,419	
Quality Strategy		48,617,154
Amortization		14,951,810
Net Non-Operating Income	11,562,419	(52,006,546)
Net income		(10,054,512)

MLR	85.8%
ALR	10.8%
NNOIR	4.2%
Total	100.8%

Proposed 2026 4+8 Medicare Reforecast

	Medicare 4+8 Reforecast Revenues	Expenses
Premium Revenue	17,892,411	
Medical Costs: FFS		17,251,997
Medical Costs: Cap		274,713
Medical Costs: Other		-
Medical Costs: Quality Improvement		799,693
Gross Margin	17,892,411	18,326,403
Admin Expense		10,487,384
Quality Improvement Credit		(799,693)
Net Admin		9,687,690
Operating Income		(10,121,683)
Interest Income	-	
Quality Strategy		203,750
Amortization		186,898
Net Non-Operating Income	-	(390,648)
Net income		(10,512,331)

MLR	102.4%
ALR	54.1%
NNOIR	2.2%
Total	158.8%

Proposed 2026 4+8 Medicaid Reforecast

	Medicaid 4+8 Reforecast Revenues	Expenses
Premium Revenue	1,221,209,031	
Medical Costs: FFS		968,784,704
Medical Costs: Cap		51,710,178
Medical Costs: Other		-
Medical Costs: Quality Improvement		24,094,951
Gross Margin	1,221,209,031	1,044,589,834
Admin Expense		148,640,431
Quality Improvement Credit		(24,094,951)
Net Admin		124,545,480
Operating Income		52,073,717
Interest Income	11,562,419	
Quality Strategy		48,413,404
Amortization		14,764,913
Net Non-Operating Income	11,562,419	(51,615,898)
Net income		457,818

MLR	85.5%
ALR	10.2%
NNOIR	4.2%
Total	100.0%

2026 4+8 Consolidated Reforecast vs. Original Budget

2026 4+8 Reforecast - Consolidated													
	Actuals Jan	Actuals Feb	Actuals Mar	Actuals Apr	4+8 FCST May	4+8 FCST Jun	4+8 FCST Jul	4+8 FCST Aug	4+8 FCST Sep	4+8 FCST Oct	4+8 FCST Nov	4+8 FCST Dec	4+8 FCST Total
Membership	233,705	231,199	228,577	228,389	225,240	222,840	222,240	221,640	221,040	220,365	219,665	219,115	2,694,015
Revenue	106,750,870	105,442,906	103,232,961	106,380,467	101,646,987	100,610,730	102,972,060	102,833,809	102,695,964	102,412,510	102,080,771	102,041,408	1,239,101,441
Med Exp	89,278,586	86,312,231	85,327,922	88,788,736	87,411,693	86,821,057	86,994,365	87,171,770	87,344,835	84,106,613	84,096,662	84,367,123	1,038,021,592
Medical Cost: Quality Improvement	2,438,524	929,919	1,669,567	4,596,531	1,935,035	1,926,865	1,918,831	1,910,976	1,903,281	1,895,724	1,888,329	1,881,063	24,894,645
Gross Margin	15,033,760	18,200,755	16,235,472	12,995,200	12,300,259	11,862,808	14,058,864	13,751,063	13,447,847	16,410,172	16,095,780	15,793,223	176,185,204
Admin	14,167,057	13,918,743	10,300,992	11,883,811	13,636,850	12,884,901	13,602,621	13,326,608	13,563,740	14,320,662	13,684,306	13,837,524	159,127,815
Quality Improvement Credit	(2,438,524)	(929,919)	(1,669,567)	(4,596,531)	(1,935,035)	(1,926,865)	(1,918,831)	(1,910,976)	(1,903,281)	(1,895,724)	(1,888,329)	(1,881,063)	(24,894,645)
Net Admin	11,728,533	12,988,823	8,631,425	7,287,281	11,701,815	10,958,037	11,683,790	11,415,632	11,660,459	12,424,938	11,795,977	11,956,461	134,233,170
Net Operating Income/(Loss)	3,305,227	5,211,932	7,604,047	5,707,920	598,444	904,771	2,375,074	2,335,431	1,787,388	3,985,234	4,299,804	3,836,762	41,952,034
Non Operating													
Interest Income	935,980	804,336	840,679	981,423	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	11,562,419
Quality Strategy	4,373,285	4,186,803	4,186,803	3,985,585	3,985,585	3,985,585	3,985,585	3,985,585	3,985,585	3,985,585	3,985,585	3,985,585	48,617,154
Amortization	1,226,970	1,191,534	1,199,084	1,219,473	1,192,317	1,197,612	1,289,670	1,288,440	1,287,590	1,287,590	1,285,765	1,285,765	14,951,810
Net Non-Operating Income	(4,664,275)	(4,574,000)	(4,545,208)	(4,223,635)	(4,177,902)	(4,183,197)	(4,275,255)	(4,274,025)	(4,273,175)	(4,273,175)	(4,271,350)	(4,271,350)	(52,006,546)
Net Income/(Loss)	(1,359,048)	637,932	3,058,839	1,484,285	(3,579,458)	(3,278,426)	(1,900,181)	(1,938,594)	(2,485,787)	(287,941)	28,454	(434,588)	(10,054,512)

2026 4+8 Reforecast vs. Reforecast - Consolidated					
	Act Apr YTD	Fcst May - Dec	4+8 Full Year	Original Budget Full Year	B / (W) Full Year
Membership	921,870	1,772,145	2,694,015	2,744,617	(50,602)
Revenue	421,807,204	817,294,238	1,239,101,441	1,244,493,691	(5,392,250)
Med Exp	349,707,475	688,314,117	1,038,021,592	1,054,305,189	16,283,597
Medical Cost: Quality Improvement	9,634,541	15,260,104	24,894,645	23,085,454	(1,809,191)
Gross Margin	62,465,188	113,720,017	176,185,204	167,103,048	9,082,157
Admin	50,270,603	108,857,212	159,127,815	158,091,462	(1,036,353)
Quality Improvement Credit	(9,634,541)	(15,260,104)	(24,894,645)	(23,085,454)	1,809,191
Net Admin	40,636,062	93,597,108	134,233,170	135,006,008	772,838
Net Operating Income/(Loss)	21,829,126	20,122,908	41,952,034	32,097,039	9,854,995
Non Operating					
Interest Income	3,562,419	8,000,000	11,562,419	12,000,000	(437,581)
Quality Strategy	16,732,475	31,884,679	48,617,154	43,000,000	(5,617,154)
Amortization	4,837,061	10,114,749	14,951,810	9,786,264	(5,165,546)
Net Non-Operating Income	(18,007,118)	(33,999,428)	(52,006,546)	(40,786,264)	(11,220,282)
Net Income/(Loss)	3,822,008	(13,876,520)	(10,054,512)	(8,689,225)	(1,365,288)

MLR	85.8%
ALR	10.8%
NNOIR	4.2%
Total	100.8%

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2026 4+8 Medicare Reforecast vs. Original Budget

2026 4+8 Reforecast - Medicare	Actuals Jan	Actuals Feb	Actuals Mar	Actuals Apr	4+8 FCST May	4+8 FCST Jun	4+8 FCST Jul	4+8 FCST Aug	4+8 FCST Sep	4+8 FCST Oct	4+8 FCST Nov	4+8 FCST Dec	4+8 FCST Total
Membership	259	498	474	549	625	725	825	925	1,025	1,050	1,050	1,200	9,205
Revenue	472,573	905,859	1,017,954	1,041,791	1,216,686	1,411,356	1,606,026	1,800,696	1,995,366	2,044,033	2,044,033	2,336,038	17,892,411
Med Exp	25,840	1,332,162	1,168,784	1,115,169	1,168,750	1,355,751	1,542,751	1,729,751	1,916,751	1,963,501	1,963,501	2,244,001	17,526,710
Medical Cost: Quality Improvement	36,578	13,949	25,044	57,457	83,333	83,333	83,333	83,333	83,333	83,333	83,333	83,333	799,693
Gross Margin	410,155	(440,252)	(175,874)	(130,834)	(35,397)	(27,728)	(20,058)	(12,388)	(4,718)	(2,801)	(2,801)	8,704	(433,992)
Admin	3,636,210	622,393	(1,815,432)	871,150	892,192	835,142	870,071	920,203	957,594	955,498	869,790	872,573	10,487,384
Quality Improvement Credit	(36,578)	(13,949)	(25,044)	(57,457)	(83,333)	(83,333)	(83,333)	(83,333)	(83,333)	(83,333)	(83,333)	(83,333)	(799,693)
Net Admin	3,599,632	608,444	(1,840,475)	813,694	808,858	751,808	786,737	836,870	874,261	872,165	786,456	789,240	9,687,690
Net Operating Income/(Loss)	(3,189,477)	(1,048,696)	1,664,602	(944,528)	(844,256)	(779,536)	(806,795)	(849,258)	(878,979)	(874,966)	(789,257)	(780,536)	(10,121,683)
Non Operating													
Interest Income	-	-	-	-	-	-	-	-	-	-	-	-	-
Quality Strategy	-	100,000	3,750	100,000	-	-	-	-	-	-	-	-	203,750
Amortization	15,337	14,894	14,989	15,243	14,904	14,970	16,121	16,106	16,095	16,095	16,072	16,072	186,898
Net Non-Operating Income	(15,337)	(114,894)	(18,739)	(115,243)	(14,904)	(14,970)	(16,121)	(16,106)	(16,095)	(16,095)	(16,072)	(16,072)	(390,648)
Net Income/(Loss)	(3,204,815)	(1,163,590)	1,645,863	(1,059,772)	(859,160)	(794,506)	(822,916)	(865,363)	(895,074)	(891,060)	(805,329)	(796,608)	(10,512,331)

2026 4+8 Reforecast vs. Reforecast - Medicare	Act Apr YTD	Fcst May - Dec	4+8 Full Year	Original Budget Full Year	B / (W) Full Year
Membership	1,780	7,425	9,205	9,122	83
Revenue	3,438,177	14,454,234	17,892,411	18,551,127	(658,716)
Med Exp	3,641,955	13,884,755	17,526,710	17,896,553	369,844
Medical Cost: Quality Improvement	133,027	666,667	799,693	1,000,000	200,307
Gross Margin	(336,805)	(97,188)	(433,992)	(345,426)	(88,566)
Admin	3,314,322	7,173,062	10,487,384	10,911,752	424,368
Quality Improvement Credit	(133,027)	(666,667)	(799,693)	(1,000,000)	(200,307)
Net Admin	3,181,295	6,506,395	9,687,690	9,911,752	224,062
Net Operating Income/(Loss)	(3,518,100)	(6,603,583)	(10,121,683)	(10,257,178)	135,496
Non Operating					
Interest Income	-	-	-	-	-
Quality Strategy	203,750	-	203,750	75,958	(127,793)
Amortization	60,463	126,434	186,898	500,000	313,102
Net Non-Operating Income	(264,214)	(126,434)	(390,648)	(575,958)	185,310
Net Income/(Loss)	(3,782,313)	(6,730,017)	(10,512,331)	(10,833,136)	320,805

MLR	102.4%
ALR	54.1%
NNOIR	2.2%
Total	158.8%

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2026 4+8 Medicaid Reforecast vs. Original Budget

2026 4+8 Reforecast - Medicaid													
	Actuals Jan	Actuals Feb	Actuals Mar	Actuals Apr	4+8 FCST May	4+8 FCST Jun	4+8 FCST Jul	4+8 FCST Aug	4+8 FCST Sep	4+8 FCST Oct	4+8 FCST Nov	4+8 FCST Dec	4+8 FCST Total
Membership	233,446	230,701	228,103	227,840	224,615	222,115	221,415	220,715	220,015	219,315	218,615	217,915	2,684,810
Revenue	106,278,297	104,537,047	102,215,007	105,338,676	100,430,300	99,199,373	101,366,034	101,033,113	100,700,598	100,368,477	100,036,738	99,705,370	1,221,209,031
Med Exp	89,252,746	84,980,070	84,159,138	87,673,567	86,242,942	85,465,307	85,451,614	85,442,019	85,428,084	82,143,113	82,133,161	82,123,122	1,020,494,882
Medical Cost: Quality Improvement	2,401,946	915,970	1,644,523	4,539,074	1,851,702	1,843,531	1,835,498	1,827,642	1,819,948	1,812,391	1,804,996	1,797,729	24,094,951
Gross Margin	14,623,605	18,641,007	16,411,346	13,126,035	12,335,656	11,890,536	14,078,922	13,763,452	13,452,565	16,412,973	16,098,581	15,784,519	176,619,197
Admin	10,530,847	13,296,349	12,116,424	11,012,661	12,744,659	12,049,760	12,732,551	12,406,405	12,606,146	13,365,164	12,814,516	12,964,951	148,640,431
Quality Improvement Credit	(2,401,946)	(915,970)	(1,644,523)	(4,539,074)	(1,851,702)	(1,843,531)	(1,835,498)	(1,827,642)	(1,819,948)	(1,812,391)	(1,804,996)	(1,797,729)	(24,094,951)
Net Admin	8,128,900	12,380,379	10,471,900	6,473,587	10,892,957	10,206,229	10,897,053	10,578,762	10,786,198	11,552,773	11,009,520	11,167,221	124,545,480
Net Operating Income/(Loss)	6,494,704	6,260,628	5,939,445	6,652,448	1,442,699	1,684,307	3,181,870	3,184,689	2,666,368	4,860,200	5,089,061	4,617,298	52,073,717
Non Operating													
Interest Income	282,182	354,140	1,944,674	981,423	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	11,562,419
Quality Strategy	4,373,285	4,086,803	4,183,052	3,885,585	3,985,585	3,985,585	3,985,585	3,985,585	3,985,585	3,985,585	3,985,585	3,985,585	48,413,404
Amortization	1,211,633	1,176,639	1,184,096	1,204,230	1,177,413	1,182,642	1,273,550	1,272,335	1,271,495	1,271,495	1,269,693	1,269,693	14,764,913
Net Non-Operating Income	(5,302,736)	(4,909,302)	(3,422,474)	(4,108,392)	(4,162,998)	(4,168,227)	(4,259,134)	(4,257,920)	(4,257,080)	(4,257,080)	(4,255,278)	(4,255,278)	(51,615,898)
Net Income/(Loss)	1,191,968	1,351,326	2,516,971	2,544,056	(2,720,299)	(2,483,920)	(1,077,265)	(1,073,231)	(1,590,712)	603,120	833,783	362,020	457,818

2026 4+8 Reforecast vs. Reforecast - Medicaid					
	Act Apr YTD	Fcst May - Dec	4+8 Full Year	Original Budget Full Year	B / (W) Full Year
Membership	920,090	1,764,720	2,684,810	2,735,495	(50,685)
Revenue	418,369,027	802,840,004	1,221,209,031	1,225,942,564	(4,733,533)
Med Exp	346,065,521	674,429,362	1,020,494,882	1,036,408,636	15,913,753
Medical Cost: Quality Improvement	9,501,514	14,593,437	24,094,951	22,085,454	(2,009,497)
Gross Margin	62,801,992	113,817,204	176,619,197	167,448,474	9,170,723
Admin	46,956,281	101,684,151	148,640,431	147,179,710	(1,460,721)
Quality Improvement Credit	(9,501,514)	(14,593,437)	(24,094,951)	(22,085,454)	2,009,497
Net Admin	37,454,767	87,090,713	124,545,480	125,094,256	548,776
Net Operating Income/(Loss)	25,347,226	26,726,491	52,073,717	42,354,218	9,719,499
Non Operating					
Interest Income	3,562,419	8,000,000	11,562,419	12,000,000	(437,581)
Quality Strategy	16,528,725	31,884,679	48,413,404	42,924,042	(5,489,362)
Amortization	4,776,598	9,988,315	14,764,913	9,286,264	(5,478,649)
Net Non-Operating Income	(17,742,904)	(33,872,994)	(51,615,898)	(40,210,306)	(11,405,592)
Net Income/(Loss)	7,604,321	(7,146,503)	457,818	2,143,911	(1,686,093)

MLR	85.5%
ALR	10.2%
NNOIR	4.2%
Total	100.0%

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2026 4+8 Reforecast Drivers

	B / (W) Medicaid	B / (W) Medicare	B / (W) Consolidated
Membership	(50,685)	83	(50,602)
Revenue	(4,733,533)	(658,716)	(5,392,250)
Med Exp	15,913,753	369,844	16,283,597
Care Management Expense	(2,009,497)	200,307	(1,809,191)
Gross Margin	9,170,723	(88,566)	9,082,157
	-	-	-
Admin	(1,460,721)	424,368	(1,036,353)
Care Management Credit	2,009,497	(200,307)	1,809,191
Admin (Net of Care Mgt Credit)	548,776	224,062	772,838
Net Operating Income/(Loss)	9,719,499	135,496	9,854,995
	-	-	-
Non Operating	-	-	-
Interest Income	(437,581)	-	(437,581)
Quality Strategy	(5,489,362)	(127,793)	(5,617,154)
Amortization	(5,478,649)	313,102	(5,165,546)
Net Non-Operating Income	(11,405,592)	185,310	(11,220,282)
	-	-	-
Net Income/(Loss)	(1,686,093)	320,805	(1,365,288)

- 2026 4+8 Reforecast Drivers
- Gross Margin
  - Revenue change of ($5.4M) driven by lower-than-expected volume partially offset by higher rates due to member mix
  - Net Medical Expense favorability of $14.5M driven by prior year reserve favorability and lower volume, partially offset by higher rates
- Operating Expenses
  - Successfully executed companywide effort to lower controllable administrative expenses
  - Operations Optimization – Investing in future efficiency and effectiveness
    - More accurate and timely payments
    - Lower claims interest expense
- Non-Operating Expenses
  - Increase Quality Investment Strategy Expense
  - Increase Amortization
  - Decreased Interest Income

2026 Contract Renewals

Vendor	Description	Contract Start Date	Contract Expiration Date	Current Approved Amount (As of 12/31/2025)	Contract Renewal Term (Months)	Contract Renewal Projected Cost	Contract Renewal End Date	Contract Projected Cumulative Approval Amount
Edifecs	IT interoperability software	1/1/2021	12/31/2025	687,906	12	187,200	12/31/2026	875,106
KP LLC	D-SNP Printing	4/7/2025	2/28/2026	330,000	12	436,800	2/28/2027	679,467
OpenText Inc.	Fax software	5/12/2015	4/30/2026	544,102	12	110,853	4/30/2027	520,319
Ellit Group LLC	Operations consulting services	10/30/2023	5/1/2026	476,580	12	166,370	5/1/2027	516,733
Baker Tilly Advisory Group LP	HR Consulting services	6/21/2025	5/31/2026	128,000	12	208,338	5/31/2027	391,969
Edifecs, Inc.	IT interoperability software	6/22/2019	6/21/2026	879,641	12	126,527	6/21/2027	1,075,070
Edifecs, Inc.	IT interoperability software	6/30/2021	6/29/2026	547,697	12	107,525	6/29/2027	676,917
Intelligent Content Solutions LLC dba ICS	Mailroom scanning software	7/1/2025	6/30/2026	360,000	12	374,400	6/30/2027	734,400
Netmark Business Services	D-SNP claims processing services	4/14/2025	6/30/2026	138,625	12	187,200	6/30/2027	372,422
The Mihalik Group, LLC	NCQA certification services	7/1/2024	6/30/2026	420,000	12	374,369	6/30/2027	902,361
UpToDate, Inc.	Pharmacy software	8/1/2023	6/30/2026	403,597	12	206,086	6/30/2027	694,147
Wellth Inc.	Disease management services	7/13/2023	6/30/2026	9,374,724	12	2,995,200	6/30/2027	12,233,909
SMI Concepts, Inc.	New building engineering services	9/1/2017	6/30/2026	149,213	12	253,146	6/30/2027	455,987
Quest Analytics LLC	Provider address software	8/12/2024	8/11/2026	479,766	12	163,401	8/11/2027	559,898
Simpledatalabs inc dba Prophecy Inc.	IT software	10/1/2023	9/30/2026	600,000	12	208,000	9/30/2027	958,000
Edelstein Gilbert Robson & Smith LLC	Lobbyist services	10/9/2012	10/8/2026	316,400	12	63,024	10/8/2027	346,921
Milliman	Actuarial services	10/31/2025	10/31/2026	525,000	12	549,120	10/31/2027	989,120
Ellit Group LLC	Operations consulting services	10/9/2023	10/31/2026	747,160	12	316,134	10/31/2027	1,243,613
Carol Hsu	Medical records review services	3/1/2023	10/31/2026	683,002	12	120,985	10/31/2027	666,564
Affiliated Monitors Inc. [AMI]	Corporate integrity agreement services	11/1/2022	11/1/2026	339,600	12	92,733	11/1/2027	456,852
Pharmaceutical Strategies Group	PBM services	3/12/2025	11/30/2026	1,572,143	12	1,527,814	11/30/2027	2,874,445

2026 Contract Renewals

Vendor	Description	Contract Start Date	Contract Expiration Date	Current Approved Amount (As of 12/31/2025)	Contract Renewal Term (Months)	Contract Renewal Projected Cost	Contract Renewal End Date	Contract Projected Cumulative Approval Amount
TopBlock LLC	Workday support services	1/12/2026	12/11/2026	37,800	12	237,120	12/11/2027	453,087
Perfect Gift, LLC	Gift cards	12/13/2021	12/12/2026	4,596,784	12	1,284,244	12/12/2027	7,054,136
Partners In Leadership LLC dba Culture Partners	Culture training services	12/20/2024	12/19/2026	621,500	12	372,788	12/19/2027	1,078,736
Deloitte Consulting LLP	Finance Workday implementation services	6/16/2025	12/26/2026	330,000	12	474,753	12/26/2027	1,040,298
Infomedia Group dba Carenet Healthcare Services	Outreach services	1/1/2024	12/30/2026	1,160,004	12	394,050	12/30/2027	1,361,042
James Vincent Pezzullo II dba The JVP Group	Website services	12/4/2014	12/30/2026	401,665	12	102,818	12/30/2027	496,501
Inovalon, Inc.	D-SNP risk assessment services	10/1/2025	12/31/2026	170,944	12	177,840	12/31/2027	359,486
Ironwood Health LLC	D-SNP implementation and ongoing support services	5/1/2025	12/31/2026	1,090,000	12	1,680,931	12/31/2027	4,240,040
Stacy Miller Public Affairs Inc.	Public relations services	8/1/2024	12/31/2026	984,000	12	424,633	12/31/2027	1,307,077
Health Management Associates Inc. dba HMA	Finance services (RDT)	12/1/2023	12/31/2026	3,900,000	12	943,892	12/31/2027	3,741,596
Inovalon, Inc.	Data lake used for quality risk assessment scores	8/1/2022	12/31/2026	5,706,283	12	1,425,298	12/31/2027	6,663,647
TBJ Consulting	Chief Diversity Officer	1/1/2022	12/31/2026	1,869,565	12	352,248	12/31/2027	2,154,627
Pacific Interpreters Language Line Services	Interpreting services	8/1/2020	12/31/2026	695,509	12	247,214	12/31/2027	1,070,774
Inovalon, Inc.	Quality and risk assessment reporting (indices)	7/1/2019	12/31/2026	2,380,237	12	325,771	12/31/2027	2,205,455
Inovalon, Inc.	Quality and risk assessment software platform	7/1/2019	12/31/2026	4,608,093	12	927,090	12/31/2027	4,724,254
AArete	Operations consulting services	6/3/2026	11/30/2026	572,000	12	1,190,592	11/30/2027	1,762,592

2026 Projects - Operations

Business Transformation Continuity – Extension – $350K

GCHP is driving a set of high priority Operations Transformation initiatives that require continued execution discipline, accountable owner support, and targeted analytics to sustain momentum, reduce risks and bottlenecks, and ensure leadership has the visibility and governance required to make timely decisions. This is an extension of work that has already started, and is intended to provide hands on, tactical execution support for critical initiatives.

Salesforce Buildout – $450K

GCHP is advancing a set of Salesforce Health Cloud, Service Cloud, OmniStudio, and Experience Cloud initiatives to support organization improvement across GCHPs operations. GCHP is currently using OmniStudio components within Salesforce Health Cloud for member and provider-facing services and is seeking to extend this capability into Service Cloud and related Salesforce layers to better support internal operations workflows. As a result of this effort, GCHP expects to improve the interconnectedness of data across Salesforce records, reduce inefficiencies related to swivel-chair activity, support more modular Salesforce development patterns, and create a scalable operating model for future provider, member, and operations-facing workflows.

Payment Integrity Project – $6.6M

GCHP is seeking a modern, scalable pre-payment and post-payment solution, with data mining, to enhance operational efficiency and prevent improper payments before they occur. Moving from a reactive "pay-and-chase" model to a proactive "shift-left" strategy, this solution will integrate with our HealthEdge claims system via an API to verify claims accuracy, compliance, and medical necessity in real-time. As a result of this effort, GCHP fully expects to, by leveraging advanced analytics and automated editing, significantly reduce costs, enhance fraud, waste and abuse analytics, lower administrative burdens, and strengthen provider relationships by minimizing payment disputes.

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Gold Coast Health Plan℠
A Public Entity

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Jeff Register, Interim Chief Financial Officer-Controller

DATE: June 29, 2026

SUBJECT: May 2026 Year to Date Financial Results

SUMMARY:

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

ATTACHMENT:

May 2026 Financial Package

APPENDIX:

- Income Statement YTD
- Balance Sheet
- Statement of Cash Flow
- Statement of Investments and Cash Balances

Gold Coast Health Plan℠
A Public Entity

May 2026 YTD Results

Ventura County Medi-Cal Managed Care Commission
June 29, 2026

Dr. Felix Nunez, Chief Executive Officer
Jeff Register, Interim Chief Financial Officer-Controller

Integrity
Accountability
Collaboration
Trust
Respect

Executive Summary

- May Medicaid membership is unfavorable to budget by approximately 2,500 members, or 1.1%, and has declined by approximately 11,000 members, or 4.6%, since December 2025

- Overall YTD performance is favorable to budget
  - Net Income is $12.3M, compared to a budget of $2.4M
    - Prior year adjustments of $12.6M are favorably impacting current year results

- Revenue is $5.1M favorable to budget, driven by favorable member mix, partially offset by unfavorable volume

- Medical Expenses are $1.7M Favorable to budget
  - The Financial Statement MLR is 83.9% versus a budget of 85.1%
    - Quality Strategy costs are carved out in this presentation for tracking purposes, but they do qualify as MLR related costs
      - The MLR including Quality Strategy is 88.1% versus a budget of 89.0%

- Administrative Expenses are $4.9M Favorable to budget
  - The ALR is 10.4%, compared to the budgeted ALR of 11.5%

- Tangible Net Equity (TNE) is currently 551% of the State requirement, and is within the target range set by the Commission

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

May 2026 Year-to-Date Financial Results

Item	Actual	Budget
Member Months	1,154,486	1,159,631
Revenue	$530.3M	$525.2M
Revenue pmpm	*$459.35*	*$452.93*
Medical Cost	$445.1M	$446.8M
Medical Costs pmpm	*$385.55*	*$385.32*
Medical Loss Ratio	83.9%	85.1%
Administrative Cost	$55.3M	$60.2M
Admin Cost PMPM	*$47.91*	*$51.90*
Administrative Loss Ratio	10.4%	11.5%
Operating Results	**$29.9M**	**$18.2M**
Investment Income	$4.4M	$5.0M
Quality Strategy (Grants/Incentives)	$22.0M	$20.8M
Non Operating Results	**($17.6M)**	**($15.8M)**
Net Income/(Loss)	**$12.3M**	**$2.4M**
TNE	$258.7M	$248.8M

May YTD Results are favorable to budget

Highlights

- Membership is 1.1% below budget, driving volume related decreases in revenue and medical expense
- Medical Loss Ratio, 83.9% is favorable to budgeted expectations of 85.1%, driven by prior year favorable IBNP restatement
- Administrative costs variance is $4.9M, or 8.1%, favorable to budget
- Investment income is $600K, or 12.0%, unfavorable to budget due to lower interest rates and balances
- Continued strong investment in Quality Strategy initiatives
- The May TNE is 551% of the state requirement

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

May 2026 Year-to-Date - Adjusted Financial Results

Item	Actual	Budget	Explanation
Net Income/(Loss)	**$12.3M**	**$2.4M**	
Prior Year favorable IBNP development	($15.5M)		2025 medical expenses paid in 2026 are less than the amount reserved as of 12/31/2025
Net other unfavorable Prior Year activity	$2.9M		Various 2025 expenses paid in 2026 that were not accrued as of 12/31/2025
Net Income/(Loss), net of Prior Year Activity	($0.3M)	$2.4M	Slightly behind budget, after adjusting for Prior Year activity

- May YTD results show significant favorability to budget
  - These results are positively impacted by a net $12.6M of prior year activity, primarily from favorable development in IBNP, partially offset by other prior year activity (such as payments to various vendors that were not accrued in 2025)

- Adjusting for this prior year favorability, YTD 2026 results, net of prior year impact, are slightly unfavorable to budget, driven primarily by increases in medical expense
  - The Adjusted MLR is 86.6% -vs- the 83.9% reported on a financial statement basis
  - Adjusted 2026 results represent a significant improvement over 2025 results

- GCHP continues working on a series of initiatives aimed at operational efficiency and medical utilization that will yield improved results as these efforts bear fruit

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

Medicaid Membership Volumes and Rates

COA	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Rates
Adult Expansion - SIS	64,916	62,871	63,939	63,353	62,983	62,291	$ 464.43
Adult - SIS	21,982	21,919	21,406	21,145	20,967	20,700	$ 411.21
Child - SIS	79,263	78,084	77,894	77,899	77,506	83,894	$ 151.35
SPD - SIS	9,532	9,670	9,269	9,144	9,146	9,401	$ 1,474.57
SPD Dual - SIS	25,949	25,175	24,019	24,076	23,851	23,963	$ 661.69
Long Term Care - SIS	41	41	41	41	46	42	$ 1,474.57
Long Term Care - Dual - SIS	696	709	669	680	665	660	$ 661.69
Adult Expansion - UIS	14,287	13,782	13,655	13,288	13,036	12,778	$ 679.05
Adult - UIS	15,544	14,945	14,808	14,578	14,282	14,205	$ 350.38
Child- UIS	3,437	4,900	4,267	4,040	4,019	(3,083)	$ 135.34
SPD - UIS	1,906	1,820	1,810	1,765	1,747	1,707	$ 1,560.75
SPD Dual - UIS	279	339	283	309	293	279	$ 827.64
Long Term Care - UIS	11	13	15	15	17	14	$ 1,560.75
Long Term Care - Dual - UIS	5	6	7	7	7	7	$ 827.64
Total	**237,848**	**234,274**	**232,082**	**230,340**	**228,565**	**226,858**	

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

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Finance Department Update

Achievements:

- Achieved a 10 Business Day (BD) close for May
  - The goal is to consistently close within 10 BD and have reporting and analysis available by BD 14
- Completed 4+8 Reforecast process and presentation
- Negotiated increased money market interest rates with both banks to improve interest income earnings
  - Depending on average cash balances, this is expected to yield approximately $850,000 annually in additional interest income
- Completed April regulatory reporting

Windshield View:

- Continue Workday Adaptive roll out for Budget and Reforecast processes
  - Develop/improve Adaptive reporting
  - Prepare for 6+6 Reforecast process to be executed on the new platform
- Continue to improve Workday General Ledger set up to improve efficiency and accuracy for the DHCS Quarterly Financial Reporting package
- Begin to build out additional Workday and Adaptive financial reports to improve monthly reporting capabilities and analysis
  - This process will likely take several months to build out and properly test
- May regulatory reporting

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

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STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	For the Month Ended May 2026				Fiscal Year to Date Through May 2026			
	May 2026 ACTUALS	May 2026 BUDGET	Fav /(Unfav)	%	May 2026 ACTUALS	May 2026 BUDGET	Fav /(Unfav)	%
Membership	227,445	229,976	(2,531)	-1.1%	1,154,486	1,159,631	(5,145)	-0.4%
Revenue								
Premium	$ 143,057,931	$ 138,754,319	$ 4,303,612	3.1%	$ 705,202,892	$ 699,510,021	$ 5,692,871	0.8%
Facility Expense AB85			-			-	-	
Reserve for Cap Requirements	(486,536)	(244,129)	(242,406)	-99.3%	(2,468,826)	(1,234,022)	(1,234,804)	-100.1%
Incentive Revenue	-	-	-		-	-	-	
MCO Premium Tax	(34,068,443)	(34,292,447)	224,004	0.7%	(172,424,535)	(173,041,096)	616,561	0.4%
Total Net Premium	**108,502,952**	**104,217,743**	**4,285,210**	**4.1%**	**530,309,531**	**525,234,903**	**5,074,628**	**1.0%**
						-		
Other Revenue:								
Miscellaneous Income	87	-	87		712	-	712	
Total Other Revenue	87	-	87		712	-	712	
Total Revenue	**108,503,039**	**104,217,743**	**4,285,297**	**4.1%**	**530,310,243**	**525,234,903**	**5,075,340**	**1.0%**
Medical Benefits:								
Capitation:								
PCP, Specialty, Kaiser, NEMT & Vision	3,547,449	4,448,055	900,605	20.2%	18,425,071	22,528,020	4,102,949	18.2%
ECM	1,999,468	1,056,028	(943,440)	-89.3%	9,083,800	5,330,580	(3,753,221)	-70.4%
Total Capitation	**5,546,917**	**5,504,082**	**(42,835)**	**-0.8%**	**27,508,871**	27,858,599	**349,728**	**1.3%**
FFS Claims:								
Inpatient	18,421,814	19,826,342	1,404,528	7.1%	102,006,293	99,764,324	(2,241,969)	-2.2%
LTC / SNF	13,331,330	16,750,589	3,419,258	20.4%	73,337,087	83,922,121	10,585,034	12.6%
Outpatient	9,760,767	9,697,804	(62,964)	-0.6%	45,773,164	48,520,900	2,747,736	5.7%
Laboratory and Radiology	1,052,606	849,349	(203,256)	-23.9%	7,238,842	4,310,394	(2,928,448)	-67.9%
Directed Payments - Provider	776,013	808,965	32,952	4.1%	3,924,653	4,063,931	139,277	3.4%
Emergency Room	4,898,397	4,385,737	(512,660)	-11.7%	23,246,521	21,872,973	(1,373,548)	-6.3%
Physician Specialty	9,939,909	7,257,412	(2,682,497)	-37.0%	50,344,265	36,529,204	(13,815,061)	-37.8%
Primary Care Physician	6,645,398	7,397,326	751,928	10.2%	27,937,139	37,022,377	9,085,238	24.5%
Home & Community Based Services	2,753,811	4,620,461	1,866,650	40.4%	15,061,974	22,909,049	7,847,075	34.3%
Medically Supportive Food	1,474,379	-	(1,474,379)		9,973,194	-	(9,973,194)	
Applied Behavior Analysis Services	6,295,759	5,518,375	(777,385)	-14.1%	29,737,073	27,168,776	(2,568,297)	-9.5%
Pharmacy	274,742	190,542	(84,200)	-44.2%	1,105,702	707,900	(397,802)	-56.2%
Quality Incentive Provider Program (QIPP)	4,326,383	3,241,932	*(1,084,451)*	*-33.5%*	17,498,448	16,202,975	(1,295,473)	*-8.0%*
Other Medical Professional	389,614	1,830,125	1,440,511	78.7%	3,779,766	9,186,921	5,407,156	58.9%
Other Fee For Service	984,584	1,999,882	1,015,298	50.8%	9,328,328	10,017,937	689,609	6.9%
Settlements - Medical	(2,730,050)	-	2,730,050		1,112,041	-	(1,112,041)	
Transportation	500,500	492,967	(7,533)	-2%	2,193,862	2,470,696	276,834	11%
Total Claims	**79,095,956**	**84,867,807**	**5,771,852**	**6.8%**	**423,598,352**	**424,670,479**	**1,072,127**	**0.3%**
Provider Grant Program	858,808	925,497	66,689	7%	4,480,521	4,575,243	94,722	2%
Medical & Care Management	3,262,959	1,935,035	(1,327,924)	-69%	12,897,500	9,760,385	(3,137,115)	-32%
Reinsurance	217,089	303,624	86,536	29%	(755,278)	1,536,376	2,291,654	149%
Claims Recoveries	(105,192)	(158,333)	(53,141)	34%	(642,360)	(791,667)	(149,307)	19%
Sub-total	**4,233,663**	**3,005,823**	**(1,227,840)**	**-41%**	**15,980,383**	**15,080,337**	**(900,046)**	**-6%**
Total Medical Benefits	88,876,536	93,377,713	4,501,176	4.8%	467,087,607	467,609,416	521,809	0.1%
Contribution Margin	**19,626,503**	**10,840,030**	**8,786,473**	**81.1%**	**63,222,636**	**57,625,487**	**5,597,150**	**9.7%**
General & Administrative Expenses:								
Salaries, Wages & Employee Benefits	6,147,042	7,060,493	913,451	13%	33,954,350	35,302,467	1,348,118	4%
Training, Conference & Travel	29,178	52,500	23,322	44%	328,304	262,500	(65,804)	-25%
Outside Services	4,688,539	2,470,733	(2,217,806)	-90%	11,711,776	12,353,665	641,888	5%
Professional Services	808,839	1,406,687	597,849	43%	4,417,826	7,033,437	2,615,611	37%
Occupancy, Supplies, Insurance & Others	2,905,848	2,754,097	(151,751)	-6%	15,235,295	13,770,486	(1,464,809)	-11%
ARCH/Community Grants	146,811	183,975	37,164	20%	184,700	919,873	735,174	80%
Sponsorships	19,500	61,325	41,825	68%	36,000	306,624	270,624	88%
Care Management Reclass to Medical	(3,262,959)	(1,935,035)	1,327,924	69%	(12,897,500)	(9,760,385)	3,137,115	32%
G&A Expenses	**11,482,798**	**12,054,775**	**571,978**	5%	**52,970,751**	**60,188,668**	**7,217,917**	**12%**
D-SNP	488,556	-	(488,556)		2,337,147	-	(2,337,147)	
Project Portfolio	**488,556**	**-**	**(488,556)**		**2,337,147**	**-**	**(2,337,147)**	
Total G&A Expenses	**11,971,353**	**12,054,775**	**83,422**	**1%**	**55,307,898**	**60,188,668**	4,880,770	8%
Total Operating Gain / (Loss)	**7,655,150**	**(1,214,745)**	**8,869,895**	730%	**7,914,739**	**(2,563,181)**	**10,477,920**	**408.8%**
Retro Premium Adj	-	-	-		-	-	-	
Non Operating								
Revenues - Interest	837,377	1,000,000	(162,623)	-16.3%	4,399,795	5,000,000	(600,205)	-12%
Expenses - Interest	-	-	-		-	-	-	
Gain/(Loss) on Sale of Asset	-	-			-			
Total Non-Operating	**837,377**	**1,000,000**	(162,623)	-16.3%	**4,399,795**	**5,000,000**	(600,205)	-12%
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 8,492,526**	**$ (214,745)**	**$ 8,707,271**	**4055%**	**$ 12,314,534**	**$ 2,436,819**	**$ 9,877,715**	**405%**

STATEMENT OF FINANCIAL POSITION		
	As of Month Ending, May 2026	As of Month Ending, December 2025
ASSETS		
Current Assets:		
Total Cash and Cash Equivalents	**$ 273,542,614**	**$ 294,296,392**
Total Short-Term Investments	**108,426,265**	**106,685,365**
Medi-Cal Receivable	167,912,162	156,518,148
Interest Receivable	527,551	808,060
Provider Receivable	11,977,626	13,571,218
Other Receivables	10,098,478	8,823,232
Total Accounts Receivable	**190,515,817**	**179,720,658**
Total Prepaid Accounts	10,191,995	8,959,028
Total Other Current Assets	405,361	320,402
Total Current Assets	**583,082,052**	**589,981,845**
Total Fixed Assets	**63,671,580**	**66,277,453**
Total Assets	**$ 646,753,632**	**$ 656,259,298**
LIABILITIES & NET ASSETS		
Current Liabilities:		
Incurred But Not Reported	$ 139,679,708	$ 131,690,924
Claims Payable	7,639,815	7,252,812
Capitation Payable	4,923,492	8,073,833
Physician Payable	15,265,963	11,519,669
DHCS - Reserve for Capitation Recoup	49,663,629	53,643,320
Lease Payable- ROU	6,251,271	7,376,788
Accounts Payable	1,270,037	(50)
Accrued ACS	368,182	407,101
Accrued Provider Incentives/Reserve	17,721,165	18,558,113
Accrued Expenses	18,234,692	25,109,584
Accrued Premium Tax	74,066,922	106,146,397
Accrued Payroll Expense	23,933,798	10,929,318
Quality Withhold	8,133,382	5,482,803
Total Current Liabilities	**367,795,188**	**386,618,343**
Long-Term Liabilities:		
Lease Payable - NonCurrent - ROU	20,233,498	23,230,757
Total Long-Term Liabilities	**20,233,498**	**23,230,757**
Total Liabilities	**388,028,686**	**409,849,100**
Net Assets:		
Beginning Net Assets	250,232,420	237,702,927
Total Increase / (Decrease in Unrestricted Net Assets)	8,492,526	8,707,271
Total Net Assets	**258,724,946**	**246,410,198**
Total Liabilities & Net Assets	**$ 646,753,632**	**$ 656,259,298**

STATEMENT OF CASH FLOWS

	For the Month Ended May 2026	Fiscal Year to Date Through May 2026
Cash Flows Provided By Operating Activities		
Net Income (Loss)	$ 8,492,526	$ 12,314,534
Adjustments to reconciled net income to net cash provided by operating activities		
Depreciation on fixed assets	1,187,387	(1,073,502)
Changes in Operating Assets and Liabilities		
Accounts Receivable	(2,053,612)	(10,795,158)
Prepaid Expenses	4,348,975	(1,332,966)
Accrued Expense and Accounts Payable	(123,723)	3,744,375
Current Portion of Deferred Revenue	-	-
Claims Payable	4,863,400	982,957
MCO Tax liability	34,068,443	(32,079,475)
IBNR	2,055,815	7,988,784
Net Cash Provided by (Used in) Operating Activities	**52,839,211**	**(20,250,451)**
Cash Flow Provided By Investing Activities		
Proceeds from Investments	(1,024,184)	(1,740,900)
Purchase of Property and Equipment	(250,510)	3,694,415
Net Cash (Used In) Provided by Investing Activities	**(1,274,694)**	**1,953,515**
Cash Flow Provided By Financing Activities		
Lease Payable - ROU	-	(2,456,887)
Net Cash Used In Financing Activities	**-**	**(2,456,887)**
Increase/(Decrease) in Cash and Cash Equivalents	51,564,517	(20,753,823)
Cash and Cash Equivalents, Beginning of Period	221,978,097	294,296,437
Cash and Cash Equivalents, End of Period	**273,542,614**	**$ 273,542,614**

SCHEDULE OF INVESTMENTS AND CASH BALANCES

	Market Value as of Month Ending, May 2026	Account Type
Local Agency Investment Fund (LAIF)	$ 46,958,949	Investment
Ventura County Investment Pool	$ 20,558,506	Investment
CalTrust	$ 40,908,810	Short-term investment
Bank of Montreal	$ 254,324,902	Money market account
Columbia Bank	$ 19,217,712	Operating accounts
Investments and monies held by GCHP	***$ 381,968,879***	

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

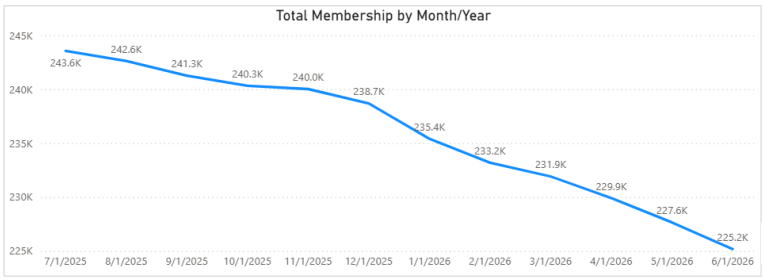
FROM: Felix Nunez, MD, Chief Executive Officer

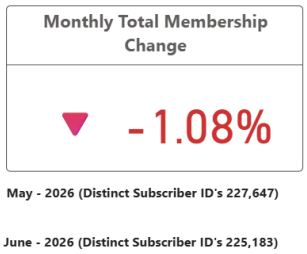
DATE: June 29, 2026

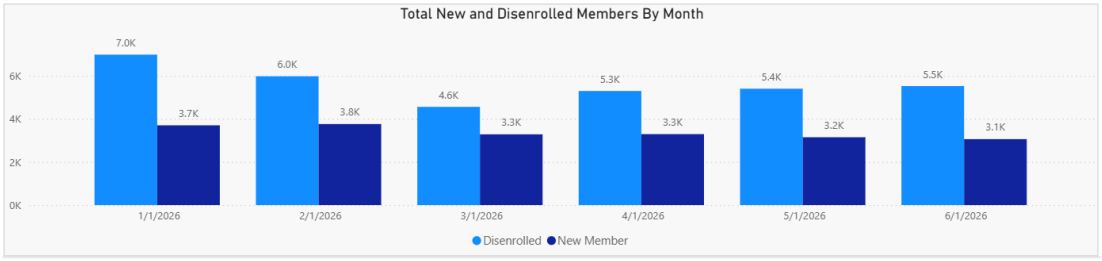
SUBJECT: Chief Executive Officer (CEO) Report

Chief Executive Officer (CEO) Update

Our ongoing loss of membership has continued without pause. As of June 14, 2026, Gold Coast Health Plan (GCHP) has 225,162 members. Since last month, GCHP has lost 5,519 members and gained 3,046 new members, leading to a net loss of 2,473 members.







Advocacy

Of utmost urgency has been the retention of our members with Unsatisfactory Immigration Status (UIS) who are all threatened with disenrollment from managed care. This would mean that the 31,000 members we currently have enrolled would be transitioned to a yet-to-be defined fee-for-service system without coordination or continuity of their care. We remain actively engaged in advocacy efforts to push for the continued enrollment of these members. Our trade association, Local Health Plans of California, has proposed an alternative hybrid solution that allows this population to remain connected with their health plan for primary and specialty care, while the state pays directly for emergency, hospital, and pregnancy services. After careful consideration, it is our opinion that this approach is the best plan to help keep our members

connected to their care networks, meet federal compliance requirements, meet budgetary targets set by the governor, and can be feasibly implemented by Jan. 1, 2027.

For the last month, I have actively participated in daily meetings with the chief executive officers of our sister health plans and leaders from LHPC to monitor developments on the state budget, share information about the traction of the alternative proposal, and continue to align on advocacy strategies.

To support that effort, I have participated in the following activities:

- June 3, 2026: I met with Assemblymember Steve Bennett to discuss the potential impacts of moving about 32,000 GCHP UIS members to fee-for-service on our community and advocate for LHPC proposal to keep them enrolled in managed care.
- June 4, 2026: I spoke alongside Chair Laura Espinosa and other community leaders at a healthcare rally about the importance of preserving healthcare access for our immigrant communities. The rally was held in Oxnard outside of the building where the offices of Sen. Monique Limon and Assemblymember Bennett are located.
- June 10, 2026: The VC Star published my opinion piece urging our legislative leaders to reject Gov. Gavin Newsom's proposal and meet with healthcare leaders to discuss the alternative proposal.
- June 12, 2026: I teamed up with Marina Owen, the CEO of CenCal Health in Santa Barbara, to meet with Marjorie Swartz from Sen. Limon's office to offer our insights into the challenges of implementing a state-wide fee-for-service program and the implications for the healthcare infrastructure of our respective communities. We advocated for the alternative proposal put forth by LHPC and provided information about rate development and underwriting to ensure those aren't seen as barriers to implementation.
- June 17, 2026: I had a meeting with Ms. Yajaira Gates, legislative director for state Sen. Susan Rubio (D-West Covina), who I had an opportunity to meet at a recent event in Los Angeles. I provided the senator's staff with details regarding the LHPC proposal and the feasibility of the plan to keep our UIS under a managed care model that protects access and continuity, while maintaining quality and care coordination standards.

We are continuing to work closely with our lobbyists to advance our priorities and communicate the local impacts of proposed policy and funding changes. I have attached materials from LHPC that include more information about the alternative proposal.

Ventura County Healthcare Access Coalition

Our work continues to bring together countywide stakeholders to pool resources and align strategies to mitigate the devastating impacts of H.R. 1 and any corresponding state policy changes which are in part responsible for the current loss of enrollment. In June, we held the first of our Coalition workgroup meetings, which will develop goals and provide updates and recommendations to the larger Coalition.

The Advocacy workgroup met on June 10, 2026. The group established a purpose: Align and focus decision makers (including local, state, national elected leaders) on the needs of Medi-Cal beneficiaries and the wide-reaching impact of proposed changes through direct engagement, grassroots, and public campaigns. Our first goal is to achieve Medi-Cal coverage for primary and specialty care (care beyond hospitals, emergency departments, and pregnancy care) by state adoption of the LHPC alternative coverage model for the UIS population by the end of June 2026. In addition, the Advocacy Workgroup has proposed recommendations for advocacy and engagement to inform and activate our members and community regarding the changes coming as a result of H.R. 1 to the Medi-Cal program. These will be shared with the Coalition as a whole at their next meeting.

The Outreach and Education workgroup met on June 17, 2026. The purpose of the group is to inform members, providers, community-based organizations, and employers to ensure understanding of state and federal changes and how / when different groups are impacted. Recommendations will be shared with the Coalition.

The Direct Member Engagement workgroup meeting is scheduled for June 24, 2026.

To support members with their renewals, GCHP has hired temporary staff dedicated to making outbound calls to members to support them with their renewals. These team members, which started on June 1, 2026, are prioritizing calls to members who missed their renewals and are now in a grace period. The team will also make calls to members whose renewal date is approaching. The team will ramp-up call volume over the coming weeks while refining workflows and system processes to improve member contact rates and strengthen performance over time. We will also plan to gather data on the impact of these calls on member enrollment to improve our outreach efforts.

Through these direct engagement efforts, GCHP aims to educate members about the renewal requirements that apply to them, help them maintain their coverage, and connect them with any necessary resources.

GCHP will continue monitoring enrollment trends and evaluating the effectiveness of these interventions while pursuing additional opportunities to support member retention and preserve access to care throughout Ventura County.

MEDI-CAL FFS FOR UIS POPULATION JEOPARDIZES CRITICAL HEALTH CARE SERVICES & ACCESS

OVERVIEW

The Administration's May Revise proposal to transition 1.8 million UIS Medi-Cal members out of managed care and into the antiquated Fee-For-Service (FFS) delivery system significantly diminishes access to health care and will result in this population delaying or forgoing care altogether.

This loss of services is accounted for in the Administration's budget proposal, scoring over $700 million annually in savings for reduced medical visits while conversely assuming a 16% increase in emergency and inpatient care.

Local plans, providing coverage to over 85% of all Medi-Cal's UIS members, along with a coalition of safety net providers, have a **plan that maintains compliance with federal guidance while preserving access to critical services and avoiding the devastating impacts of individuals losing access to care**. The data below is derived from local plans' UIS population.

Total UIS Members Enrolled in Local Plans	**1,594,499**

UIS Medi-Cal members receiving services (2025)		**Description**
Specialty Care Access	**689,000** ~44% of all UIS Medi-Cal members	A very large percentage of UIS members are accessing specialists for acute and chronic illnesses, diagnoses for conditions, surgery and other services. Losing the connection to their specialists due to specialists not participating with Medi-Cal FFS could significantly impact their treatment and health status, and result in delays for needed tests or procedures.
Cancer Diagnosis	**34,000**	Most cancer diagnoses require on-going timely and accessible treatment and services. Interrupting their current care or active treatments due to the loss of their provider would be devastating and potentially result in premature death.
Behavioral Health Services *Mental health treatments: outpatient therapy, psychiatric services, etc.*	**70,000**	Plans' coverage of services for mild to moderate mental health conditions created broad networks of providers with profoundly improved access compared to FFS Medi-Cal. Going back to very poor access with FFS would seriously impact UIS members' mental health, with a corresponding negative impact on their overall health, families and their ability to work.
Dialysis	**16,000**	Kidney dialysis is a lifesaving procedure that must be done every week, multiple times a week. Any significant interruption of this critical service can result in serious health impacts to the individual, often resulting in ED or acute inpatient visits/admissions. Transitioning people receiving dialysis requires timely and comprehensive care coordination, which does not exist in the Medi-Cal FFS system.

LHPC
Local Health Plans of California

MEDI-CAL FFS FOR UIS POPULATION JEOPARDIZES CRITICAL HEALTH CARE SERVICES & ACCESS

UIS Medi-Cal members receiving services (2025)		Description
Well-Child Visits	**106,000**	Children need regular well child visits with vaccinations, assessment of their development and physical well-being. Interrupting their regular well-child visits due to access difficulties could set them behind in their immunizations and delay diagnoses of early childhood developmental delay or other conditions.
Hospice	**7,000**	Hospice care is compassionate and comprehensive care for people facing a short time to live. Interrupting the care with their hospice provider would have a major impact on the person's quality of life, including their level of pain and suffering from their illness. Hospice care is very personal, so continuity with the hospice staff is critical.
Major Organ Transplants *Received transplant or on a list*	**780**	The care coordination, treatment planning and transplant process for major organs is very complex and involves multiple specialists and facilities. Any interruption of this complicated and critical pathway due to specialists or facilities not participating in Medi-Cal FFS could result in restarting or ending the persons pathway to the transplant. That would have serious impacts on their health and even eventual ability to get the transplant needed.
California Children's Services (CCS)	**11,000**	Children in the CCS program have serious chronic illnesses, cancer and other significant diagnoses. The Whole Child Model (WCM) program creates organized and comprehensive care coordination for all of the child's health and other needs. Moving these children back into Medi-Cal FFS for their CCS services will significantly disrupt their care coordination and result in duplication and potentially missing services that are needed.

Ensure Access and Plan Continuity for Unsatisfactory Immigration Status Medi-Cal Members

Legislative Request

1. Reject the Administration's proposal to move Medi-Cal members with unsatisfactory immigration status (UIS) wholesale into fee-for-service.
2. Direct the Department of Healthcare Services (DHCS) to implement a separate state-only contract with Medi-Cal plans that retains coordinated and accessible coverage for Unsatisfactory Immigration Status (UIS) members, with a targeted carve-out of federally payable services to FFS.

Medi-Cal FFS coverage alone is not access. Access requires providers willing to see members, systems that help members navigate care, and accountability for outcomes. Coalition partners have emphasized that few providers, and even fewer specialists, accept FFS Medi-Cal, creating the risk of coverage without meaningful access, particularly for children, older adults, and people with complex needs.

Problem	Solution
Federal Compliance. The state must respond to federal direction regarding federal financial participation for emergency Medicaid services.	DHCS has acknowledged that this solution is compliant.
Budget savings. The state has been directed to identify savings in a constrained budget environment.	Our solution represents nearly 2/3 of the savings assumed by the Administration.
Timing. The solution must be implementable before January 1, 2027.	Preserving existing plan infrastructure is more operationally realistic than moving nearly two million members into FFS.

UIS members remain in coordinated Medi-Cal coverage under a separate state-only contract, while services that are eligible for federal financial participation are carved out and paid through the State's fee-for service (FFS) system.

Design Element	Proposed Approach
Enrollment	UIS members remain with their existing health plan to deliver carved-in benefits, preserving continuity with their plan, provider network, member services, care coordination infrastructure, and access supports.
State-only contract	DHCS executes a separate state-only contract with Medi-Cal health plans for the UIS population. Plans receive prospective state-only capitation for carved-in services, benefit administration, care coordination and overall population management.
State-paid carve-out	The state assumes the financial risk of and pays fee-for-service for services that may be eligible for federal financial participation or are under federal scrutiny: hospital inpatient and hospital-based outpatient services, and emergency department services, including professional, and OB services, including prenatal care, labor, and delivery.
Plan role	Plans continue to manage and pay for carved-in Medi-Cal services, including non-hospital based outpatient care, preventive care, behavioral health, rehabilitative and habilitative services, laboratory services, LTC, member services, network access, care coordination, utilization management, quality monitoring, and provider payment arrangements.

Quality and oversight	Plans work with DHCS to develop appropriate access and quality metrics for the population.

Fiscal Framework: Reasonable Savings Without an Access Crisis. The LHPC model recognizes the state's budget reality. It is not a request to preserve the status quo without concessions. It maintains nearly 2/3 of the savings scored by the Administration while avoiding larger, less predictable downstream costs, ensures continuity of care, and promotes cost-effective preventative care. We urge the Legislature to fund the $190 million shortfall to avoid major access and care disruptions impacting members and the sustainability of the safety net.

Savings / Cost Issue	May Revision / Risk	LHPC Alternative
ECM and Community Supports	May Revision assumes savings from eliminating ECM and Community Supports for UIS members.	LHPC model maintains those May Revision savings assumptions: **$50.1 million** for ECM and **$39.2 million** for Community Supports.
Emergency / inpatient utilization	Administration assumes increased ED and inpatient utilization, while also relying on lower overall utilization. The risk is that FFS access gaps produce higher acute care costs than assumed.	**Eliminates the $244.7 million GF offset** anticipated for higher IP/ED utilization without adding state-dollar cost. Maintains outpatient access, primary/specialty care pathways, complex case management, CHW services, and overall coordination of care including referral to counties, when appropriate.
Plan administration and underwriting gain	Current proposal removes capitation entirely but requires the state to absorb a major FFS administrative build and operational risk.	Assumes **$187 million savings** by reducing administrative cost paid to plans for a narrower carved-in package, plan concessions such as underwriting gain (profit) reduction **($25 million in savings)**, and creates opportunities to right-size rates where UIS MLR is at or below 85% **($12 million in savings)**.
State administrative burden	FFS transition requires state systems, claims capacity, call center support, provider network build, provider support, authorization processes, dispute resolution, fair hearings support, and member communications for nearly two million people.	Preserves existing plan infrastructure for carved-in services, reducing the operational burden on DHCS and the risk of implementation failure.

Impact on Providers, Counties, and Members

- **Physicians and clinics:** preserves managed care relationships, referral pathways, payment arrangements for carved-in services, care coordination, and utilization support - instead of forcing members to independently find FFS providers willing to accept lower payment rates.
- **Counties:** reduces downstream pressure on behavioral health, public health, housing, eligibility, and indigent care systems.
- **Members:** preserves continuity with the plan they know, the providers they trust, and the local systems that help them navigate care.
- **Hospitals:** provides clarity that carved-out inpatient, hospital-based outpatient, emergency department, emergency professional, and OB services would be paid directly by the state, while managed care continues working to keep members connected to outpatient care before they deteriorate into crisis.
    - Our plan does not fully address hospitals' need for sustainable payment levels, which will require further attention to support the stability of the broader delivery system. It also does not resolve the long-term financial viability of public hospitals, which remain essential to

meeting the healthcare needs of our communities. While our model provides a compliant alternative that enables both hospitals and public health systems to optimize DSH funding, it does not by itself ensure their long-term sustainability. Addressing these needs is critical to preserving comprehensive access for all populations.

LHPC UIS Alternative Proposal: Feasibility Fact Sheet

The UIS alternative proposal proposed by the Local Health Plans of California (LHPC) preserves access to care by retaining the managed care delivery system for the population with unsatisfactory immigration status (UIS) while carving out services eligible for federal funding. This fact sheet outlines how and why LHPC's federally compliant proposal can be implemented by January 1, 2027, the date by which states must comply with the new federal guidance.

In discussions about LHPC's proposal, rate setting timelines and processes have been presented as a barrier to feasibility. Although we acknowledge that rate setting would need to be accelerated, we see a clear path for DHCS and its actuaries to implement the alternative proposal by the compliance deadline.

LHPC worked with Edrington Health Consulting, an actuarial firm that has supported Medi-Cal managed care for the last 20 years with a focus on capitation rate development, to outline a pathway to feasibility which includes the following:

1. **Utilize data already reported by plans and leverage DHCS' existing rate setting process.** UIS data has already been submitted to DHCS for the CY 2027 rating period, and DHCS' actuaries are currently in the process of setting rates for the next calendar year.
2. **Utilize existing rate setting methodologies.** The LHPC proposal simplifies implementation by carving out services which largely align with existing reporting structures or analyses to identify eligible benefits. This will limit the need to develop new, complex allocation methodologies to set rates.
3. **Implement a risk corridor or amend rates retrospectively to minimize risk to the State.** To the extent DHCS is concerned about the accuracy of UIS rates under LHPC's alternative proposal, it could choose to implement risk protection or choose to set interim rates that could later be amended. This is common practice today in Medi-Cal and nationally.
4. **Leverage flexibility on timelines for rate setting given the state-only rates do not require CMS review or certification.** Although rate setting will need to occur prior to January and follow accepted actuarial principles, there is more flexibility within the rate setting process because CMS' requirements for rate setting do not apply to state-only rates.

The rate setting process outlined above, and discussed in more detail in our fact sheet, routinely occurs within short timeframes in response to changes made as a part of the State Budget process which dictates Medi-Cal benefits and covered populations. Therefore, the question before policymakers is not whether this proposal can be implemented, but whether the State wishes to preserve existing care coordination, provider relationships, continuity of coverage, and standards of access for UIS members through existing managed care infrastructure.

Data and Rate Development Framework Already Exist

The LHPC proposal does not require DHCS or its actuaries to collect new data, develop new reporting structures, or create a new rate-setting framework.

DHCS and Mercer have already received relevant UIS data through the existing Rate Development Templates (RDTs). This data has already been reviewed, validated, and incorporated into the Medi-Cal rate development process. As a result, the underlying utilization and cost data necessary to develop rates already exists and has been subject to the same actuarial review and validation processes used for all Medi-Cal managed care rates. While we recognize not all of the historical cost data would be utilized in a state only non-emergency capitated rate structure, we believe DHCS and Mercer have sufficient information to parse covered and carved out services accordingly.

Furthermore, the LHPC proposal was intentionally designed to simplify implementation. Many services would remain entirely within managed care or be entirely carved out to fee-for-service (FFS) and identifiable within existing Category of Service (COS) reporting structures in the RDT. For more nuanced exclusions like federally funded pregnancy-related and emergency services, Mercer has previously developed analyses that have already been incorporated in relevant encounter data available now for rate development. These analyses provide a foundation for identifying the portion of services proposed to remain within managed care and the portion proposed to be carved out to FFS. This structure limits the need for complex allocation methodologies and allows DHCS and Mercer to rely heavily on existing data, existing methodologies, and existing operational structures.

Additionally, evaluating and adjusting assumptions pertaining to administrative load and underwriting gain is not a new or unique analytical requirement created by the proposal. Regardless of whether UIS services remain partially within managed care or are fully carved out to FFS, DHCS and its actuaries must evaluate the appropriate administrative load and underwriting gain assumptions associated with the resulting membership and benefit changes in accordance with actuarial standards of practice. This is a required process of broader Medi-Cal rate development that DHCS will need to perform regardless of which UIS implementation approach is selected.

Existing Implementation Tools Further Reduce Risk

DHCS has established tools available to facilitate implementation. Several practical options are available that would allow the proposal to move forward while limiting actuarial or operational risk; including:

- *Prospective rate development using existing UIS experience.* Mercer can develop rates using validated UIS experience already reported through the RDT process and existing encounter data analyses, with adjustments reflecting the proposed carve-out of specific services.
- *Prospective rates with temporary risk-sharing protections.* If DHCS believes there is uncertainty regarding the exact allocation of services between managed care and FFS, the Department could implement prospective rates accompanied by a temporary risk corridor or similar risk-sharing mechanism during the initial contract period. This approach would

allow rates to be developed and implemented on schedule while limiting financial risk until actual experience is available.

- *Interim funding rates with subsequent rate refinement.* DHCS could establish initial placeholder capitation rates designed to ensure timely plan funding and uninterrupted member access beginning January 1, 2027, while allowing additional time to refine the final rate structure. Once implementation details and supporting analyses are finalized, the Department could update rates prospectively or retrospectively reconcile payments.

These mechanisms are routinely used within Medi-Cal and Medicaid Managed Care nationally to accommodate policy decisions and program changes occurring during the rate development cycle and provide additional flexibility should implementation require refinements following initial rate development.

State-Only Financing Provides Additional Implementation Flexibility

The LHPC proposal contemplates a separate state-only contract funded exclusively with state dollars. Because the proposal does not rely on federal financial participation for the services remaining under managed care, many of the federal documentation, review, and oversight requirements associated with federally funded managed care rates would not apply. The proposal would not require the same CMS review and approval processes associated with traditional federally funded managed care capitation rates.

As a result, DHCS may have greater flexibility with respect to rate development, implementation timelines, and contract administration than would otherwise exist under a federally funded managed care arrangement in alignment with actuarial standards of practice.

This Type of Rate Adjustment is a Routine Component of Medi-Cal Rate Development

The LHPC proposal can be implemented using the same types of data adjustments that DHCS and its actuaries routinely make throughout any rate development process. For example, the state's actuaries already deal with these challenges when changes to benefits and services occur through the state's annual Budget process.

Each year, managed care rates are updated to reflect changes in covered benefits, populations, program requirements, utilization assumptions, provider payment initiatives, and other policy decisions. These adjustments are incorporated into rates using existing base data, encounter data analyses, and established actuarial methodologies. The LHPC proposal requires one additional adjustment to reflect covered benefits that is otherwise part of a routine process that includes upwards of twenty similar adjustments.

June 15, 2026

Hon. Monique Limón
President Pro Tempore California Senate
1021 O Street, Suite 8518
Sacramento, CA 95814

Hon. Robert Rivas
Speaker of the California State Assembly
State Capitol Building, Room 219
Sacramento, CA 95814

Hon. John Laird
Chair, Senate Budget Committee
Capitol Office, 1021 O Street, Suite 8720
Sacramento, CA 95814

Hon. Jesse Gabriel
Chair, Assembly Budget Committee
Capitol Office, 1021 O Street, Suite 8230
Sacramento, CA 95814

Hon. Caroline Menjivar
Chair, Senate Budget Committee on Health
Capitol Office, 1021 O Street, Suite 6630
Sacramento, CA 95814

Hon. Dawn Addis
Chair, Assembly Budget Subcommittee on Health
Capitol Office, 1021 O Street, Suite 4120
Sacramento, CA 95814

Re: Adopt an Alternative Solution to Retain Coordinated Care for Medi-Cal Members with Unsatisfactory Immigration Status

Dear Senators Limón, Laird, Menjivar and Assemblymembers Rivas, Gabriel and Addis,

Our organizations strongly urge the Legislature to reject the proposal to move Medi-Cal beneficiaries with Unsatisfactory Immigration Status (UIS) out of managed care and into the Fee-For-Service (FFS) delivery system and instead adopt our proposal to retain coordinated and accessible Medi-Cal coverage for UIS Medi-Cal members. This proposal is compliant with federal guidance, maintains a large portion of the Administration's assumed savings, and is achievable by January 1, 2027.

The Administration's proposed shift would dismantle the coordinated care infrastructure that UIS beneficiaries rely on and **replace it with a fragmented system offering limited care management, reduced provider options, and significantly higher long-term costs.** The consequences would be immediate and severe. Reduced access to managed care providers will drive increased emergency room utilization, disrupt preventive and chronic care, and overwhelm the already strained safety net system. Far from reducing expenses, these proposals simply shift costs to more acute and expensive settings, thereby creating avoidable crises for families and greater financial pressure on counties, hospitals and community providers. These outcomes are not theoretical; they are baked into the savings and cost assumptions in the Administration's budget proposal.

Our proposal is straightforward: **maintain continuity, preserve provider rates for managed care services, and avoid the disruption of care for nearly 2 million vulnerable Medi-Cal members.** Under this model, UIS members would remain connected to their existing health plan, provider network, care coordination infrastructure, member services, and access supports, while the state would directly pay for the federally sensitive carve-out services through their proposed FFS system.

This approach **addresses the federal directive without eliminating meaningful access to care**, through a state-only contract with plans to manage outpatient, preventative and specialty care carved-in services and a targeted FFS carve-out for federally payable services. It also protects the safety net by avoiding the Administration's projected utilization consequences — including the proposed **16% increase in inpatient care and 12% increase in emergency room use** — because plans would continue managing outpatient access, primary and specialty care pathways, complex case management, community health worker services, and local care coordination.

Importantly, we are not asking to preserve the status quo. Plans are agreeing to give up approximately **$224 million** through reduced administrative costs, underwriting gain concessions, and opportunities to right-size rates where UIS medical loss ratios are at or below 85%. The proposal **maintains nearly two-thirds** of the Administration's assumed savings, while avoiding larger downstream costs to hospitals, clinics, physicians, counties, and members. Importantly, it preserves physician rates for managed care services paid now by health plans.

We respectfully urge the Legislature to invest the approximately $190 million necessary to preserve the safety net and direct DHCS to implement this compliant approach by January 1, 2027. California can address the federal directive and achieve meaningful savings without eliminating access to comprehensive, local, coordinated care for nearly 2 million Medi-Cal members.

While we are not naïve to the operational efforts of health plans, the Department of Health Care Services, and Medi-Cal providers necessary to implement this proposal, **we are confident it is achievable and the tradeoff is untenable.** The May Revision proposal is silent on the current readiness of the FFS system and the additional state resources that would be required to serve an additional 2 million Medi-Cal members in FFS. A dramatic increase in FFS member volume, combined with lower reimbursement rates that discourage provider participation, would place unsustainable strain on the FFS system and create significant access barriers.

Our plan does not fully address providers' need for sustainable payment levels, which will require further attention to support the stability of the broader delivery system. It also does not resolve the long-term financial viability of public hospitals, which remain essential to meeting the healthcare needs of our communities. While our model provides a compliant alternative that enables both hospitals and public health systems to optimize DSH funding, it does not by itself ensure their long-term sustainability. Similarly, there must be solution for sustainable support for community health centers/FQHCs as a core of the Medi-Cal delivery system. Supporting the safety net Medi-Cal providers will be essential to preserving comprehensive access for all populations.

We understand that the state is attempting to respond to federal guidance, but compliance does not require adopting this harmful policy. **We urge the Legislature to reject this proposal and instead adopt this solution that allow all populations, regardless of immigration status, to benefit from comprehensive and coordinated care.** We look forward to working with the Legislature to identify workable solutions that are both compliant with federal law and ensure true access to care.

Sincerely,

_____

Linnea Koopmans
Chief Executive Officer
Local Health Plans of California

_____

Dennis Cuevas-Romero, Esq.
Vice President of Government Affairs
California Primary Care Association

_____

Angela Hill
Legislative Advocate
California Medical Association

_____

Katie Rodriguez
Interim, President & Chief Executive Officer
California Association of Public Hospitals

_____

Charles Bacchi
Chief Executive Officer
California Association of Health Plans

_____

Avo Makdessian
Executive Director
First 5 Association of California

_____

Natalie Pita, MPH
Legislative and Policy Advocate
California Academy of Family Physicians

_____

Michelle Cabrera
Executive Director
County Behavioral Health Directors Association

_____

William “Bill” Barcellona
Executive Vice President of Government Affairs
America’s Physician Groups

_____

Anne McLeod
Chief Executive Officer
Private Essential Access Community Hospitals

_____

Dawn Ortiz Legg
Supervisor, San Luis Obispo County
President, Latino Caucus of California Counties

_____

Mike Odeh
Senior Director of Health
Children Now

_____

James Cruz, MD
Board President
Latinx Physicians of California

_____

Ryan Witz
Executive Director
District Hospital Leadership Forum

_____

Tara Gamboa-Eastman
Director of Government Affairs
Steinberg Institute

FAQs: LHPC UIS Alternative Proposal

What's wrong with the Administration's proposal to transition UIS members into Medi-Cal FFS? Why is an alternative necessary?
The Medi-Cal FFS system provides coverage but not access. We know that this population, if shifted into Medi-Cal FFS, will no longer be able to receive care from the providers they know and trust today. This is evidenced by DHCS' own budget estimates, which anticipates over $350M of savings to the State as a result of paying for fewer services.

The bottom line is that an alternative proposal is necessary to ensure that the vulnerable UIS population can continue to receive the health care services they need.

Is the proposal compliant?
Yes, DHCS has confirmed the LHPC proposal complies with federal rules. The LHPC proposal will ensure that the State can continue to maximize federal funding while maintaining access to care.

Can the LHPC proposal be implemented by January 1?
Yes, it will take expedited work by DHCS and its actuaries, but it is possible to implement by January 1. While DHCS has said the LHPC proposal is not feasible due to rate setting timelines and data, this is not accurate. Rate setting can be accelerated, and the state's actuaries have sufficient data to develop rates. Also note that DHCS' proposal requires substantial cost and operational preparation to implement by January 1, so we believe it is simply a matter of resource prioritization.

Does the LHPC proposal achieve cost savings?
Yes, our plan achieves 2/3 of the savings proposed by DHCS. The delta between DHCS' savings estimate and LHPC's savings estimate is largely because LHPC does not assume a significant drop in utilization as a result of individuals not being able to access care. In other words, the investment in LHPC's proposal is and investment in service delivery and care coordination.

How does the proposal reduce risk of disruption for two million members?
Medi-Cal FFS is not health care, it is an unorganized provider payment system. Approximately 1.8 million individuals currently enrolled in managed care will transition to Medi-Call FFS and lose access to their current providers and care resulting in bad outcomes for people with cancer, needing dialysis, mental health issues and many other chronic illnesses.

How will DHCS' proposal impact providers?
Under DHCS' proposal to transition the UIS population to Medi-Cal FFS, all providers will receive Medi-Cal FFS payments which are very low and part of the reason why access to care will drastically decrease. In addition, the Medi-Cal FFS system does not

provide care coordination or other critical member supports to ensure individuals can receive the care they need.

How will LHPC's proposal impact providers?
For services that will remain carved-in to managed care (e.g., the services the plans will be responsible for managing and paying for), providers will continue to receive the rates they receive from plans today and will also receive critical support for their patients in navigating care through care coordination. The vast majority of providers health plans pay more than Medi-Cal FFS (though still significantly less than commercial provider rates), and plans also provide supplemental payments to providers for achieving quality metrics or other performance goals related to patient care (i.e., Pay for Performance programs).

How does LHPC's proposal impact hospitals?
Under the DHCS proposal, the State has admitted that hospitals will see many more patients in their already very impacted ED and hospitals, all paid for at the low FFS rate rate. While the LHPC proposal cannot not solve for the low Medi-Cal FFS rates, the proposal will prevent overburdened hospitals from seeing a significant increase in ED and hospital visits as health plans will coordinate care for members so they receive the care they need.

How does this reduce state administrative burden?
Under their proposal the state will have to ramp up to serve 1.8 million more members under FFS. The DHCS Medi-Cal estimate also assumes this will cost the State $33M in new funding. The LHPC proposal keeps existing managed care plan support intact.

I. External Affairs

A. State Budget Update

Overview – H.R. 1 and Budget May Revision

Gov. Gavin Newsom released the May revision of the 2026-27 California State Budget on May 14, 2026, updating the January proposal to reflect new revenue estimates, caseload changes, and the fiscal impacts of H.R. 1. Despite an unexpected $16.5 billion increase in General Fund revenues, the Administration continues to emphasize that federal policy changes pose significant long-term fiscal risk. H.R. 1 remains the central driver of both budget and policy activity this year, shaping nearly every major Medi-Cal proposal in the May Revision.

Legislators across both houses have expressed concern that the May Revision relies heavily on eligibility tightening, cost shifts, and reductions that may reduce access to care, increase churn, and strain county and provider capacity. The Legislature passed a final budget on June 15, 2026. The Legislature will now negotiate with the governor to finalize the budget by June 27, 2026. Budget hearings throughout May have reflected a growing urgency to understand how H.R. 1 will affect Medi-Cal members, counties, and managed care plans.

Key May Revision Highlights

The May Revision proposes a $349.4 billion state budget, including $246.6 billion in General Fund spending and $29.9 billion in reserves. While revenues have improved, the Administration continues to project substantial pressures ahead, particularly as H.R. 1 is expected to result in 1.3 million Californians losing coverage, $1.5 billion in new state costs in the first year, and 336,000 individuals losing or facing reduced food assistance. These federal impacts are shaping the state's approach to cost containment and program restructuring.

Within Medi-Cal, the May Revision proposes a $216.7 billion budget for 2026-27, including $44.9 billion General Fund, which is $3.7 billion lower than the prior year due to caseload and cost adjustments. Medi-Cal enrollment is projected to decline to 13.9 million, down from 14.4 million, driven by the reinstated asset test, the enrollment freeze for undocumented adults, six-month redeterminations, and new work and community engagement requirements.

In alignment with a new interpretation of federal rules, the governor's budget revision proposes to transition approximately two million individuals with unsatisfactory immigration status (UIS) to fee-for-service Medi-Cal beginning Jan. 1, 2027. This proposed transition is purported to result in substantial state savings, but it is uncertain whether these savings will be realized, and it presents major operational and financial impacts for counties, plans, members, and the state. Managed care plans, trade associations, and other advocates have put forth an alternative proposal in which UIS individuals remain enrolled in the managed care program under a state-only contract, retain their existing network of healthcare providers, and carve out emergency services to fee-for-service. This plan meets the federal requirements, preserves the majority of state savings, and protects access to care for UIS individuals.

H.R. 1 Major Eligibility and Program Changes

H.R. 1 drives the most significant Medi-Cal changes in more than a decade. Work and community engagement requirements for Affordable Care Act (ACA) adults will take effect on Jan. 1, 2027, with the Administration projecting 43,000 disenrollments in the first year and 1.1 million by 2029-30. Six-month redeterminations, another major H.R. 1 requirement, will begin in FY 2027-28, with projected disenrollments reaching 278,600 by 2029-30. Additionally, retroactive Medi-Cal coverage will be reduced to one month for ACA adults and two months for all other members, further contributing to projected savings but increasing churn risk.

GCHP Advocacy Alignment and Stakeholder Engagement

Gold Coast Health Plan (GCHP) continues to work closely with Local Health Plans of California (LHPC), counties, and statewide partners as the Legislature evaluates the governor's revised budget and its interaction with H.R. 1. Across hearings and stakeholder discussions, there is broad agreement that the combined effects of work requirements, six-month redeterminations, the reinstated asset test, and the proposed transition of individuals with UIS will create significant coverage losses and place substantial strain on local systems. These concerns are consistent with the positions raised by the state Latino Legislative Caucus, which has urged the Legislature to prioritize protecting full-scope Medi-Cal access for immigrant, working, and low-income Californians who are most vulnerable to administrative and procedural barriers.

A major focus of statewide advocacy has been the proposal to move individuals with UIS from managed care to the fee-for-service delivery system. Stakeholders across the state, including counties, community clinics, and legislative caucuses, have emphasized that such a transition would dismantle long-standing care coordination structures, reduce access to language and navigation supports, and disrupt the integrated delivery systems that communities rely on. These concerns are particularly relevant in regions like Ventura County, where managed care plays a central role in connecting members to primary care, behavioral health, and California Advancing and Innovating Medi-Cal (CalAIM) services. Statewide partners have also raised concerns about the proposed $50 monthly premium for this population, noting that it will create financial hardship and contribute to avoidable disenrollment among individuals who already face significant barriers to accessing care.

GCHP has also aligned with counties and LHPC in emphasizing the need for adequate county administration funding to manage the increased eligibility workload associated with H.R. 1. Counties have cautioned that without sufficient staffing and resources, procedural disenrollments will rise sharply even among individuals who remain fully eligible for Medi-Cal. Ensuring counties have the capacity to process exemptions, verify work requirements, and complete six-month redeterminations is essential to maintaining continuity of coverage and preventing unnecessary strain on local safety-net providers. As budget negotiations continue, GCHP remains committed to advocating for policies that protect access to care, maintain stability for Ventura County's Medi-Cal members, and minimize the harm created by federal mandates.

On June 11, 2026, the state Senate and Assembly reached a two-party agreement that details the California Legislature's recommendations and proposals with respect to the state budget.

The two-party agreement amends several key healthcare provisions in the governor's proposed budget. For instance, with regard to the governor's proposal to transition the UIS population to fee-for-service, the two-party agreement allows the state additional time to investigate the feasibility of an alternative model that would retain managed care for the UIS population. This leaves the door open for the potential adoption of an alternative model in the final budget.

Additionally, regarding the governor's proposal to reinstate the Medi-Cal Asset Limit Test, the two-party agreement recommends delaying the reinstatement until July 1, 2027. The final Budget Act will be signed in late June when a three-party agreement is reached between the Senate, Assembly, and the governor. Until the final Budget Act is signed, advocacy efforts and negotiations will remain ongoing.

B. Priority Bills: June 2026

Bill	Summary	Last Action	GCHP Impact
AB 126	Establishes a federally compliant Managed Care Organization (MCO) provider tax for 2027–2029 and appropriates revenues to support Medi-Cal funding and provider rate increases	Budget Trailer bill under legislative consideration	Significant fiscal and operational impact on managed care plans; affects plan taxes, Medi-Cal financing, and provider payment investments
AB 2756	Establishes Medi-Cal vision performance measures; requires DHCS benchmarks and reporting	Amended March 28, 2026	Data readiness and reporting impacts
SB 1202	Requires DHCS to publish H.R. 1 dashboards and share redetermination data with managed care plans (MCP)	Amended March 12, 2026	Supports outreach and compliance alignment
SB 874	Creates behavioral health (BH) workforce workgroup; proposes background checks for unlicensed BH technicians	Hearing March 15, 2026	May affect BH provider enrollment and contracting
AB 2348	Revises Community Supports (CS) requirements; removes three-year lock-in	Amendments pending April 2026	Maintains CS flexibility
AB 2431	Defines *downcoding*; may require physician review for certain claims	DHCS fiscal analysis requested March 2026	Increased administrative burden; claims workflow impacts

Bill	Summary	Last Action	GCHP Impact
Immigration Legal Aid Bill (Bonta)	Expands state-funded legal representation for undocumented adults	First hearing March 2026	No direct MCP impact; relevant to safety net partnerships
SB 250	Requires DHCS to maintain updated skilled nursing facility (SNF) directory by MCP	Signed Oct. 13, 2025	Minimal impact; periodic SNF network validation
SB 306	Exempts services from prior authorization (PA) if 90%+ approved; requires public posting	Signed into law	PA workflow adjustments
SB 530	Strengthens DHCS oversight of time and distance standards	Signed into law	Continued network adequacy monitoring
SB 707	Modernizes Brown Act audio/visual and language access requirements	Signed Oct. 3, 2025	Impacts Commission meeting procedures
AB 543	Allows MCPs to offer services via street medicine providers	Signed into law	Updates to Enhanced Care Management and provider contracting
AB 2466	Strengthens network adequacy and timely access	Effective Jan. 1, 2026	Network monitoring adjustments
AB 815	Protects social service vehicles from certain insurance classifications	Effective Jan. 1, 2026	Minimal impact; transportation providers
SB 1120	Requires transparency for artificial intelligence (AI) used in utilization review	Effective Jan. 1, 2026	Utilization Management policy and vendor oversight updates
AB 2860	Expands Mexico Physician/Dentist Program pilot	Effective Jan. 1, 2026	Potential provider availability impacts
AB 3275	Requires clean claims paid within 30 workdays; notice within 30 days if contested	Effective Jan. 1, 2026	Major programming changes; impacts prepayment review to prevent Fraud, Waste, and Abuse (FWA)
AB 2703	Adds psychological associates as reimbursable federally qualified health centers/rural health clinics (FQHC/RHC) providers	Effective Jan. 1, 2026	Expands BH provider types

Bill	Summary	Last Action	GCHP Impact
SB 516	Establishes infrastructure financing district for Sacramento	Effective Jan. 1, 2026	No direct impact

B. Community Relations: Sponsorships

Through its sponsorship program, Gold Coast Health Plan (GCHP) supports the efforts of community-based organizations in Ventura County to help Medi-Cal members and other vulnerable populations. GCHP awarded the following organizations from May 2026 through present:

Organization	Description	Amount
Food Share	Food Share of Ventura County is hosting its fifth annual FED UP Shindig, dedicated to supporting hunger relief efforts throughout Ventura County. Attendees will tour Food Share's facilities and learn how the organization distributes more than 20 million pounds of food each year to individuals and families in need. Funds raised from this event will help Food Share continue to provide critical food assistance to low-income residents across Ventura County.	$1,000
Westminster Free Clinic	Westminster Free Clinic is hosting annual back-to-school health fairs to advance health and educational equity for low-income Latino children and families throughout Ventura County. These events address social determinants of health through educational support, access to healthy foods, and culturally and linguistically responsive health and prevention services. Funds raised will directly support these essential services and provide school supplies and other resources to local children.	$3,000
Rainbow Connection Family and Empowerment Center: A Program of Tri-Counties Regional Center	Rainbow Connection is hosting its fourth annual Down Syndrome Awareness Walk, designed to bring together individuals with Down Syndrome, their families, and local support organizations. The event features informational resource booths, community partner exhibits, and opportunities for families to connect with local services and programs. Funds raised will support ongoing efforts to provide resources and education to individuals and families throughout Ventura County.	$1,000

Organization	Description	Amount
Partnership for Safe Families and Communities of Ventura County	Partnership for Safe Families is hosting its eighth annual 5K, an event celebrating wellness, movement, and community connection in Ventura County. The event will feature a community resource fair and back-to-school giveaways for local families. Funding will support event logistics, outreach efforts, volunteer coordination, and community resources.	$1,000
Santa Paula Art Museum	The Santa Paula Art Museum is hosting its annual Family Day, a program offering no-cost, bilingual arts experiences that inspire creativity and bring Ventura County families together through hands-on activities led by local teaching artists. Funding will support outreach efforts, program materials, and expanded access to enriching cultural experiences for children and families throughout the community.	$1,000
TOTAL		**$7,000**

C. Community Relations: Community Meetings and Events

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

Collaborative Meetings	
Community representatives share resources, announcements, and upcoming community events.	
Partnership for Safe Families and Communities	May 6, 2026
GCHP Community Insight Coalition Meeting (Camarillo)	May 12, 2026
Tri Counties Collaborative Planning Meeting	May 21, 2026
Santa Paula Social Services Coalition Collaborative Meeting	
Partnership for Safe Families and Communities	June 3, 2026

Community Events	
Poder Popular “Dia del Nino Y De Las Madres” Resource Fair (Santa Paula)	May 2, 2026
Goodwill / One Step a La Vez Resource Fair (Santa Paula)	May 5, 2026
Pacifica High School Health Fair (Oxnard)	May 7, 2026
Rio Mesa Wellness Center Health Fair (Oxnard)	May 8, 2026
Oxnard Union Resource Fair (Oxnard)	
Steps To Emotional Wellness Conference Event (Ventura)	May 15, 2026
Compas at UCLA Health Fair (Oxnard)	May 16, 2026
Fillmore Health and Wellness Fair (Fillmore)	
La Cosecha Health Fair (Oxnard)	
Valentine Road Health and Wellness Fair (Oxnard)	May 19, 2026
Community Memorial Health Saviers Clinic Health Fair (Oxnard)	May 28, 2026
Reiter Affiliated Companies (RAC) Employee Resource Fair (Oxnard)	May 29, 2026
Ventura County Medical Center Las Islas Health Fair (Oxnard)	May 30, 2026
Mental Wellness Festival (Ventura)	June 6, 2026

Community Events	
Reentry Resource Fair (Ventura)	June 9, 2026
Tri-Counties Regional Center The In's & Out's of Informed Decision Making Event (Oxnard)	June 10, 2026
Candela Group Town Hall Resource Fair (Ventura)	June 11, 2026
Food Distribution Events	
Salvation Army Food Distribution (Simi Valley)	May 5, 2026
Cristo Rey Church Food Pantry (Oxnard)	
Many Mansions Food Distribution (Thousand Oaks)	May 6, 2026
El Rio Food Distribution (Oxnard)	May 7, 2026
Many Mansions Food Pantry at Rancho Sierra (Camarillo)	May 12, 2026
Westminster Food Distribution (Oxnard)	
One Step A La Vez Food Distribution (Fillmore)	May 13, 2026
Catholic Charities Food Distribution (Ventura)	May 14, 2026
San Salvador Mission Food Distribution (Piru)	May 20, 2026
Catholic Charities Food Distribution (Moorpark)	May 21, 2026
Many Mansions food Distribution (Thousand Oaks)	May 27, 2026
Westminster Clinic Food Distribution (Oxnard)	June 9, 2026
One Step A La Vez Food Distribution (Fillmore)	June 10, 2026
Catholic Charities Food Distribution (Ventura)	June 11, 2026

D. Community Relations: Medi-Cal Renewal Workshops

In May and early June, GCHP staff hosted workshops to help members with GCHP-related topics, with a focus on renewals. These take place in various locations throughout Ventura County. Locations include low-income housing properties, food distribution centers, and community centers. As GCHP continues Medi-Cal renewal efforts, Community Relations will continue to play a central role in these educational workshops.

Workshops	
Many Mansions – Shadow Hills (Thousand Oaks)	May 6, 2026
Cabrillo Economic Development Corporation – Santa Paula Apartments (Santa Paula)	
Cabrillo Economic evelopment Corporation – Dolores Huerta Gardens (Oxnard)	May 11, 2026
Many Mansions – Rancho Sierra (Camarillo)	May 12, 2026
Cabrillo Economic Development Corporation – Working Artist of Ventura (Ventura)	May 14, 2026
Cabrillo Economic Development Corporation – Camino Esperanza (Simi Valley)	May 15, 2026
Westminster Clinic Workshop (Oxnard)	May 19, 2026
Many Mansions – Casa de Paz (Simi Valley)	May 20, 2026
Westminster Free Clinic (Thousand Oaks)	
Many Mansions – Rancho Sierra (Camarillo)	May 21, 2026
Cabrillo Economic Development Corporation – Azahar Apartments (Saticoy / Ventura)	
Many Mansions – Shadow Hills (Thousand Oaks)	May 27, 2026
Swap Meet Justice (Oxnard)	May 31, 2026

Workshops	
Cabrillo Economic Development Corporation – Working Artist of Ventura (Ventura)	June 2, 2026
Many Mansions – Casa de Paz (Simi Valley)	June 9, 2026
Cabrillo Economic Development Corporation Workshop at Rodney Fernandez Gardens (Santa Paula)	June 11, 2026
Center for Employment Training (Oxnard)	June 12, 2026

E. Community Relations: Speakers Bureau

In May, GCHP staff conducted presentations throughout Ventura County primarily in low-income housing properties managed by Many Mansions and other organizations. Staff presented an overview of GCHP services and benefits and education on nutrition to community members.

Speakers Bureau	
Mixteco Indigena Community Organizing Project (Oxnard)	May 12, 2026
Hueneme Elementary School (Port Hueneme)	May 20, 2026
Many Mansions – Casa de Paz (Simi Valley)	May 21, 2026
Community Memorial Health (Oxnard)	May 26, 2026
Many Mansions – Casa de Paz (Simi Valley)	May 28, 2026
Mixteco Indigena Community Organizing Project (Oxnard)	May 30, 2026
First Five (Moorpark)	June 3, 2026
Child Development Resource (Oxnard)	June 5, 2026
First Five (Camarillo)	June 11, 2026

II. Plan Operations

A. Provider Network Operations (PNO)

Regulatory / Audit Updates

Provider Network Operations (PNO) is preparing for a federal Network Adequacy Validation (NAV) audit. The audit focuses on provider network adequacy, and the state Department of Health Care Services (DHCS) requires its completion. DHCS hired Health Services Advisory Group (HSAG) to conduct the audit, which is similar to the annual medical audit in which GCHP must provide documentation of processes, procedures, and systems, and participate in a virtual interview. The deadline for NAV audit documentation is June 18, 2026, with a virtual interview with HSAG scheduled for July 7, 2026.

GCHP completed all required Dual Eligible Special Needs Plan (D-SNP) Aligned Network deliverables, including the Exclusively Aligned Enrollment D-SNP Network Template, the D-SNP Medicare Network Template, and the Language Gap Assessment. These reports collectively demonstrate the degree of alignment between GCHP's Medi-Cal and Medicare networks and identify discrepancies in provider participation, network composition, and language access. Preparation of these deliverables required extensive validation of provider data, reconciliation of Medi-Cal and Medicare network files, and coordination across internal teams to ensure accuracy and completeness. GCHP identified network issues and will implement remediation actions as needed to meet DHCS requirements and support ongoing network alignment efforts.

Other regulatory deliverables:

- DHCS approved the biannual directory submission.
- D-SNP Health Service Delivery Table was submitted and is pending review and approval by Centers for Medicare & Medicaid Services.

Provider Network Developments: May 1 - 31, 2026

Network Developments for New Contracts	
Provider Additions Fulfilling Network Gaps	**Count**
Home Health	1
Physical Therapy	1

GCHP Provider Changes	
Provider Additions and Terminations	**Count**
Additions	45
Terminations	27
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.

California Advancing and Innovating Medi-Cal (CalAIM) and Non-Traditional Providers	**Total Count 85**
Enhanced Care Management	11
Community Supports	33
Community Health Worker	5
Doulas	36

GCHP Provider Network Additions and Total Counts by Provider Type			
Provider Type	**Network Additions**		**Total Counts**
	April 2026	**May 2026**	
Hospitals	**0**	**0**	**25**
Acute Care	0	0	19
Long-Term Acute Care	0	0	1
Tertiary	0	0	5
Providers	**2**	**113**	**9,311**
Primary Care Providers and Mid-levels	2	15	509
Specialists	0	98	7,869
Hospitalists	0	0	933
Ancillary	**2**	**6**	**675**
Ambulatory Surgery Center	0	0	10
Community-Based Adult Services	0	0	14
Durable Medical Equipment	0	0	102
Home Health	0	1	36
Hospice	0	0	24
Laboratory	0	0	38
Optometry	0	0	107
Occupational Therapy / Physical Therapy / Speech Therapy	0	5	198
Radiology / Imaging	2	0	62
Skilled Nursing Facility / Long-Term Care / Congregate Living Facility / Intermediate Care Facility	0	0	84
Behavioral Health	13	41	1,214

Note: This chart is based on data from May 2026.

B. Delegation Oversight

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

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

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

Compliance monitors all CAPs. GCHP's goal is to ensure delegates achieve and sustain compliance. It is a state Department of Health Care Services (DHCS) requirement for GCHP to hold all delegates accountable. The oversight activities GCHP conducts are evaluated during the annual DHCS medical audit. DHCS auditors review GCHP's policies and procedures, audit tools, audit methodology, audits conducted, and CAPs issued by GCHP during the audit period. DHCS emphasizes the high level of responsibility plans have in the oversight of their delegates.

The following table includes audits and CAPs that are open and closed. Closed audits are removed after they are reported to the Commission. The table reflects changes in activity through May 31, 2026.

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Carelon	2026 Q3 & Q4 Call Center Audit	Closed	4/3/2026	6/4/2026	N/A
Carelon	2025 Q3 & Q4 Utilization Management (UM) and Grievances and Appeals (G & A) File Audit	Closed	2/27/2026	5/11/2026	N/A

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Carenet	2025 Focused Call Center Nurse Advice Line	Closed	1/28/2026	3/20/2026	N/A
Vision Service Plan (VSP)	2025 Annual Claims Audit	Open	1/6/2026	Under CAP	N/A
VSP	2025 Q4 Claims Audit	Open	3/24/2026	Under CAP	N/A
Ventura Transit System (VTS)	2026 Annual Policies and Procedures, Non-Medical Transportation / Non-Emergency Medical Transportation (NMT/NEMT) Call Center (CC), Door to Door Driver (D2D), Credentialing (CR), Downstream subcontract (DS)	Open	4/22/2026	Under CAP	N/A
VTS	2025 Annual NMT and NEMT Vehicle Audit	Closed	1/8/2026	5/21/2026	N/A
VTS	Pre-delegation Dual Eligible Special Needs Plan (D-SNP) Social Transportation Benefit Audit	Open	3/20/2026	Under CAP	N/A
Wellth, Inc	2026 Population Health Management (PHM) Annual Audit	Closed	3/25/2026	5/5/2026	N/A

Privacy and Security CAPs					
Delegate	**CAP Type**	**Status**	**Date CAP Issued**	**Date CAP Closed**	**Notes**
N/A	N/A	N/A	N/A	N/A	N/A
Operational CAPs					
Delegate	**CAP Type**	**Status**	**Date CAP Issued**	**Date CAP Closed**	**Notes**
CDCR	Claims Timeliness	Open	4/22/2025	Open	Q1-2026, Metrics of 90% in 30 days not met. 45 days not met for Q1 of 2026.April Metrics of 90% in 30 days not met. May Metrics of 90% in 30 days met.

RECOMMENDATION:

Receive and file.

AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Suma Simcoe, Chief Operations Officer

DATE: June 26, 2026

SUBJECT: Chief Operations Officer (COO) Report

PowerPoint with Verbal Presentation

ATTACHMENTS:

COO Report

Gold Coast Health Plan℠
A Public Entity

Gold Coast Health Plan

Integrity

Accountability

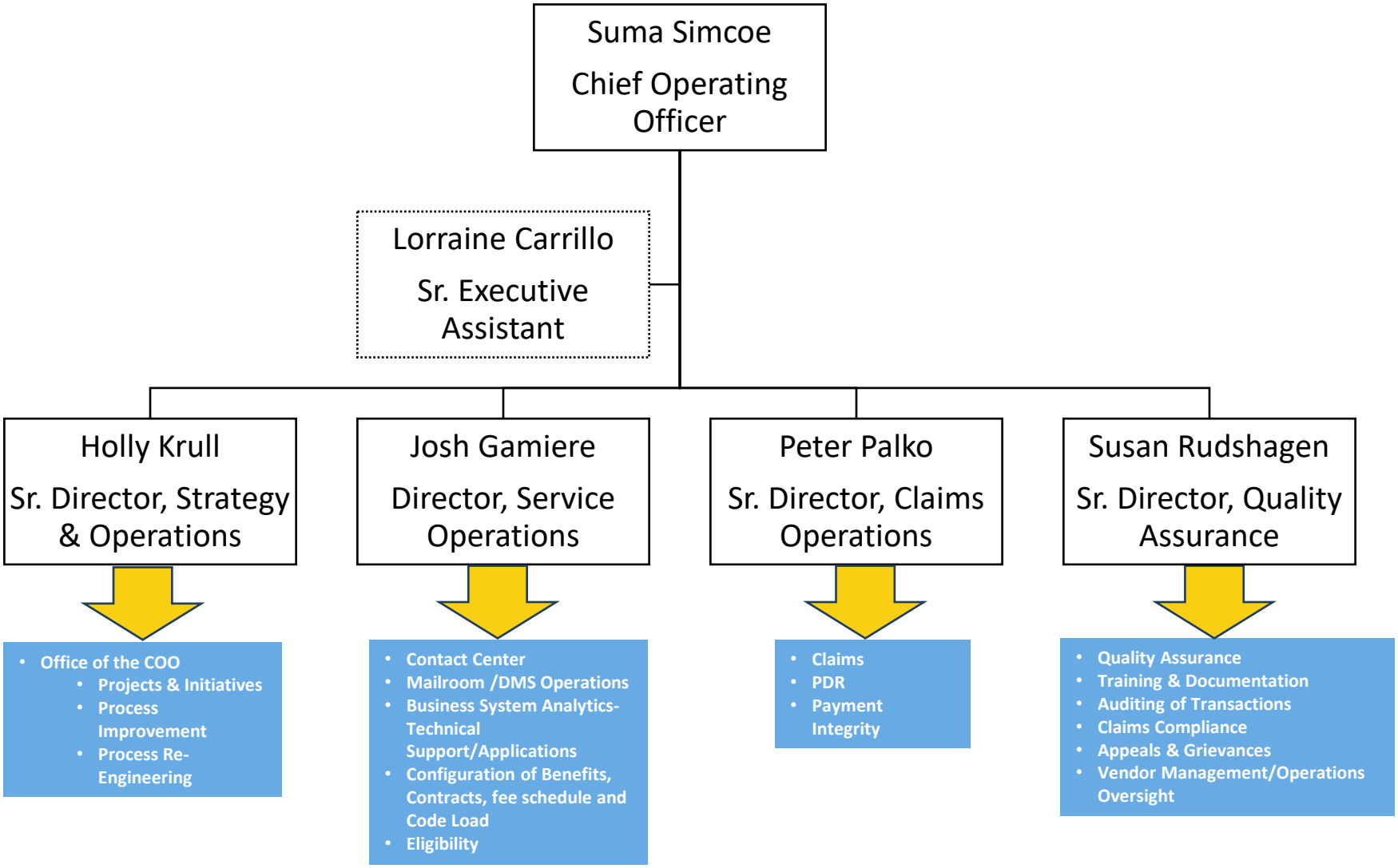
Collaboration

Trust

Respect

June 2026

Suma Simcoe, Chief Operating Officer


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

Operations Updates

Program/ Strategy

Organization Structure:

- On-boarded the Sr. Director of Operations and the Sr. Manager of Payment Integrity

Payment Integrity

- RFP responses have been sent out to vendors, Vendors to return responses by June 29th

Optimization Program Overview:

- Jan '26 -25 Baseball Cards Created

Activity Progression

Activity Stages	# of Projects
Baseball Card Created	2
Planning	2
Kick-off	1
Solution Building	12
Solution Design	6
Testing	1
Monitoring	4
Complete	8
Total	**36**

Claims Operations

Claims

- Claims turn around time is 99% compliant for Medi-Cal LOB for May 2026
- Claims turn around time is 100% compliance for DSNP LOB for May 2026
- Remaining DSNP policies (10) have been approved by the PRC

Interest Reduction Project

- Weekly review identifying root cause for interest payments and identifying solutions to reduce the total dollar amount

PDR

- Maintaining 90.1% compliance after recovering from the backlog

Service Operations

Configuration

- VCMC contract analysis complete; all provisioning errors identified and in scope for corrective action.
- VCMC fee component analysis 75% complete
- PAR Contract configuration audit continues

Mailroom

- System update completed 5/13, ongoing updates continue 6/20.
- Initial analysis shows significant reduction in manual validation required to scanned claims

IVR Update

- PDR status / Auth status additions slated for July release
- Active ~90 days:
- 22,000+ claims status completed
- 5,200+ eligibility verifications completed
- 1,500+ EOP reqs sent
- Avg 450+ self-service provider requests per day
- 200+ live provider calls still handled daily (Auths)

Quality Assurance

Grievances and Appeals

- In May GCHP received 95 grievances and 2 expedited grievances. Of those, 3 were discrimination cases. We received 2 State Hearing cases and closed 1 (total ongoing inventory of 7) and 1 Medicare CTM (marketing misrepresentation).

Audits

- Claims Lifecycle Audit initiated audit-the-auditor vendor review of findings for all Q1 2026 data. Vendor auditing was 98% correct in March and 95% correct in April. (Note: Vendor responses to GCHP findings are not yet finalized.)
- Contact Center average quality evaluation score remains above the 95% target.

Documentation & Training

- 15 policy updates in progress

Operational Oversight

- In May, 21 CCD tickets were opened; 1 was closed. Total inventory is 199, down 50% from end Q1. We continue to work down aging 2025 ticket inventory.
- 20 configuration changes were validated: 11 pre-production and 9 post-production.

Return to Agenda

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: June 29, 2026

SUBJECT: Human Resources (H.R.) Report

Human Resources Activities

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

1. Resource Management and Talent Retention
2. Staff Engagement: Culture Transformation
3. Training and Development

Resource Management and Talent Retention:

The current May 31, 2026, employee headcount (HC) total of 421 is significantly below the 476 2026 HC budget. Given the anticipated headwinds driven by HR1 and the projected Membership reduction, which directly impact our financial forecast, the executive team has implemented resource planning measures to establish a flexible workforce solution during this downturn.

1. Hiring Pause - All 2026 new roles and backfill are on "pause', with the exception to critical operational roles and the current CFO opening. Year-to-day, through the end of May, we have 53 positions held, with 43 roles held on "pause" and 10 roles eliminated during the March Operations Optimization Restructure. Of the 43 roles on "pause", there has been a YTD $1,756,875 salary and benefit savings
2. Flexible Interim Resource approach – the executive team has adopted a flexible resource approach to backfill critical roles required due to our current business volume. Contingent labor solutions will be leveraged in targeted areas due to current business volume, like Care Management, knowing volumes will be reduced in the future. As of May 31, 2026, there are 10 active temporary roles, with a year-to-date spend of $405,000. The temporary labor cost offsets the $1,756,875 paused roles spend for a net labor savings of $1,351,875

The Headcount Analysis below provides the Employee and Contingent Labor totals through the end of May. As a result of the Resource Management approach underway, the organization is operating with a 11.6% vacancy rate, or another way of assessing the workforce is that the organization is operating at 88.4% capacity. The vacancy rate and capacity for each function are reported on the analysis. As indicated above, for those functions with significant vacancy gaps, we are starting to leverage contingent labor to maintain a flexible workforce to manage current business volume.

Gold Coast Health Plan - Headcount Analysis												
May 31, 2026 Report												
	Employee Count							Contingent Workers			Total Active Resources	
Function	Active Headcount	Active Open Reqs	Positions Held	2026 Budget YE Headcount	Percentage of Total Headcount	Vacancy Rate	Active HC Capacity	Temps	Contractor/ Consultant	Total Active Contingent	Total Active Resources	Percentage of Total Resources
Health Services	123	0	19	142	30%	13.4%	86.6%	0	5	5	128	27%
Operations	99	1	15	115	24%	13.9%	86.1%	1	15	16	115	25%
Information Tech	39	0	3	42	9%	7.1%	92.9%	0	10	10	49	10%
Policy & Programs	42	0	3	45	9%	6.7%	93.3%	0	4	4	46	10%
Compliance	19	0	3	22	5%	13.6%	86.4%	1	0	1	20	4%
Finance & Accounting	36	0	3	39	8%	7.7%	92.3%	2	3	5	41	9%
Executive & Administration	13	1	0	14	3%	7.1%	92.9%	0	0	0	13	3%
Member Experience and Ext Affairs	35	0	5	40	8%	12.5%	87.5%	1	0	1	36	8%
HR & Facilities	11	0	2	13	3%	15.4%	84.6%	1	0	1	12	3%
Innovation / DSNP	4	0	0	4	1%	0.0%	100.0%	4	1	5	9	2%
Total	**421**	**2**	**53**	**476**	**100%**	**11.6%**	**88.4%**	**10**	**38**	**48**	**469**	**100%**
Outsourced Labor (BPO) Excluded: 110												

Attrition: Our attrition through May for the last 12 months is still low at 5.36%. The attrition rate is relatively flat when compared to the last three months. During 2026 there have been 15 volunteer terminations, with 5 due to retirement, 3 performance, and 7 personal / career reasons. Attrition trends are checked each month to assess pending organization risks or concerns.

Staff Engagement / Culture Transformation: In May, an Employee Culture Assessment survey was conducted to measure the progress made on our Culture journey, with over 52% of employees participating in the survey. With an Overall Positive Response Rate of 66%, the Gold Coast Health Plan Culture Assessment is generally positive. This score is 4 percentage points higher than the 2025 overall result, indicating progress in your culture transformation.

Below are key themes from the assessment, with the survey questions shown in the appendix:

Psychological Ownership Still a Strength

- Psychological Ownership had four out of five items score over 70% positive responses and all but one item saw improvement over 2025 levels. However, little more than half (55%) of individuals feel included in decisions that affect their job, so this is an area of focus for the future.

Engagement is Generally Positive

- Engagement had four out of five items scoring over 70% positive responses, especially for people feeling enthusiastic about coming to work. Keeping our people energized and engaged is essential to retention and keeping them motivated to achieve our Key Results.

Feedback Seeking Improved, But Still Needs Support

- Evey item in Feedback Seeking improved over 2025 levels, especially with individuals acknowledging when they contribute to problems. However, it was one of the only categories where at least four items received less than 66% positive responses. We will build on these gains and continue recognizing and encouraging people to ask for feedback and take accountability.

Culture Confidence Declined Slightly

- Less than half (42%) of respondents think the organization has the culture it needs to achieve Key Results. This is a slight decline from 2025 levels (44%), so more is needed to convince our people that our culture transformation will create the behaviors that will achieve Key Results.

Culture Strength Shows the Need for More Ownership

- While more people (74%) are seeing others getting recognized for demonstrating the desired cultural beliefs than in 2025, less than two-thirds of respondents (61%) see leaders reinforce the desired culture and barely more than half (53%) see all individuals prioritizing the organizational culture. Culture transformation only becomes embedded in an organization when everyone is living and owning the desired culture.

The Culture Assessment provided feedback on the areas of progress and the opportunities for continued focus and development. This data will be used by the Culture Committee to develop the roadmap for our continued cultural journey.

Training and Development

Engaging our employees in their development and offering various avenues for training has been our focus. Our three pillars of employee development and training are:

- E-Learning
- Management Fundamentals Training
- Culture Learning Sessions

E-Learning	Management Fundamentals Training	Culture Learning Sessions
Linked In Learning & Litmos	Training and Development Team	Culture Partner Consultants
401 hours, 388 employees	16 hours in-person/virtual	16 hours in-person/virtual
Learning Paths created for new, mid-level, senior manager skills, time management, critical thinking skills, collaborative teams etc.	Manager 101, HR escalations, payroll, benefits, LOA, process, systems updates, performance management etc,	Manager Accountability, Leading through Disruption, SOSD (See it, Own It, Solve it, Do it)
Ongoing, self-paced	Once every quarter	Once every quarter

Looking forward, we will continue to optimize the organization at a functional and individual level to ensure we operate efficiently. 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.

Appendix – 2026 Employee Culture Assessment Survey

GOLD COAST HEALTH PLAN MAY 2026 CULTURE ASSESSMENT

Accountability At-A-Glance

Question	% Positive
Feedback Seeking	
Individuals in my organization ask for feedback even when it may be hard to receive	55%
Individuals in my organization are willing to acknowledge when they contribute to problems	50%
My coworkers regularly ask me for feedback	64%
My supervisor regularly asks me for feedback	73%
When individuals in my organization receive feedback, they do not get defensive	56%
Psychological Ownership	
Individuals in my organization include me in decisions that may affect my job	55%
I am in agreement with the direction my organization is headed	73%
Individuals in my organization are willing to shift priorities to align their work with the key results	73%
Individuals in my organization are personally invested in achieving the key results	83%
Individuals in my organization willingly take on additional responsibility even if it is not their job	71%
Creative Problem Solving	
When faced with a problem, individuals in my organization try to look at it from different angles in order to come up with the best solution	71%
Individuals in my organization regularly ask for ideas from others, when trying to solve a problem	67%
Think "outside the box" is a phrase I would use to describe my organization's approach to problem solving	57%
Individuals in my organization are willing to take risks to find a better solution	57%
My organization supports individuals who deliver alternate solutions to problems	60%
Taking Effective Action	
Individuals in my organization accomplish the things they say they will do	75%
Progress on important initiatives are clearly communicated across the organization	75%
Individuals in my organization are willing to make hard decisions in order to accomplish what needs to be done	71%
Once a solution is chosen, a plan is developed for effective completion	69%
My organization works well cross-functionally to achieve what matters most	63%

GOLD COAST HEALTH PLAN MAY 2026 CULTURE ASSESSMENT

Employee Experience At-A-Glance

Question	% Positive
Culture Strength	
Individuals in my organization are aligned around the way we need to think and act in order to achieve our key business results	65%
The leaders in my organization consistently create experiences that reinforce our desired culture	61%
Across the organization we have a high level of trust	57%
Individuals in my organization are recognized when they behave in a way that is consistent with our desired culture	76%
Individuals at all levels in my organization see managing culture as a top priority	53%
Clarity of Results	
The organizational key results we are striving to achieve are clearly defined	85%
Individuals in my organization understand how performance is measured relative to the key results	77%
Responsibilities are clear to everyone across the organization	66%
My organization will achieve our key results without any significant change in the way we think and act	42%
Engagement	
Individual strengths are utilized across my organization	70%
Individuals across my organization have the resources needed to accomplish their jobs	58%
Individuals across my organization are recognized when they do a good job	75%
I am enthusiastic about going to work each day	76%
I would recommend my organization to friends and family as a great place to work	74%
Personal Development	
I see professional growth and career opportunities for myself in this organization	59%
My immediate manager is actively involved in my development	77%
I am provided with training and development opportunities	68%
I have received the training needed to perform my job successfully	72%
Speed & Agility	
The leaders in my organization have the courage to execute quickly on ideas	68%
My organization is seen as a speed to market leader in the industry	37%
New products or services launched by my organization are successful	60%
Individuals in my organization look for opportunities to learn from failures	64%
Individuals in my organization willingly navigate changing situations	71%