



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

**Executive Finance Committee
AGENDA**

Regular Meeting

Thursday, October 22 2026 – 3:00 p.m.

4880 Santa Rosa Road Camarillo, CA 93012 Community Room

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

Conference Call Number: 805-324-7279

Conference ID Number: 758 561 578 #

Los Robles Health System
215 W Janss Road
Thousand Oaks, CA 91360

2901 N Ventura Rd, Suite 200, Oxnard CA 93036

233 CorteLinda Santa Paula CA 93060

AGENDA

CALL TO ORDER

ROLL CALL

PUBLIC COMMENT

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

Persons wishing to address VCMMCC 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.

Members of the public may attend the meeting in person, call in, using the numbers above, or can submit public comments to the 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 Executive Finance Committee meeting minutes of April 23, 2026 and August 20, 2026.**

Staff: Maddie Gutierrez, MMC, Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented

FORMAL ACTION

- 2. 2026 8+4 Reforecast**

Staff: Christopher Lee, Chief Financial Officer

RECOMMENDATION: Receive and file. Staff recommend that the Executive Finance Committee approve the 2026 8+4 Reforecast, and recommend the Commission approve the reforecast as presented.

- 3. Consideration of Recommendation for a Provider Advance Policy**

Staff: Christopher Lee, Chief Financial Officer
Scott Campbell, General Counsel

RECOMMENDATION: Staff recommend that the Executive Finance Committee review and Provide Input on the Provider Advance Policy as presented and recommend the Commission approve the policy.

ADJOURNMENT

Administrative Reports relating to this agenda are available at 4880 Santa Rosa Road, 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 Board.

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5512. Notification for accommodation must be made by the Tuesday prior to the meeting by 3 p.m. will enable the Clerk of the Board to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO. 1

TO: Executive Finance Committee (EFC)
FROM: Maddie Gutierrez, MMC – Sr. Clerk of the Board
DATE: October 22, 2026
SUBJECT: Meeting Minutes for EFC meetings of April 23, 2026, and August 20, 2026.

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the Executive Finance Committee meeting minutes of April 23, 2026 and August 20, 2026.

**Ventura County Medi-Cal Managed Care Commission (VCMMCC)
Executive/Finance Committee
Regular Meeting**

April 23, 2026

CALL TO ORDER

Committee Chair Laura Espinosa called the meeting to order at 3:04 p.m. The meeting was held in the Community Room, 711 E. Daily Drive, Suite 110, Camarillo, California.

ROLL CALL

Present: Commissioners Anwar Abbas, Laura Espinosa, Anna Monroy and Dee Pupa

Absent: None.

GCHP Executive Team in attendance: CEO Felix Nunez, M.D., CHR Paul Aguilar, CIO Eve Gelb, CPPO Erik Cho, CCO Robert Franco, CDO Ted Bagley, CMO James Cruz, COO Suma Simcoe, Interim CFO / Controller Jeff Register, and General Counsel, Scott Campbell.

GCHP Staff In attendance: Bob Bushey, David Kirkpatrick, Kris Schmidt, Lupe Gonzalez, James Althen, Susana Enriquez-Euyoque, Lupe Harrion, Paul VerHaar, Josephine Gallella, Vicki Wrighster, Victoria Warner, Michelle Espinoza, Kimberly Timmerman, Pshyra Jones, Sandi Walker, Lily Yip, Kimberley Marquez-Johnson, and Pauline Preciado.

Guests: Baker Tilly Representatives: Stelian Damu, Kimberly Sokoloff, and Ashley Merda.

PUBLIC COMMENT

None.

CONSENT

- 1. Approval of Executive Finance Committee regular meeting minutes of Executive Finance meetings of January 22, 2026, and special meeting minutes of February 19, 2026.**

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

RECOMMENDATION: Approve the minutes as presented.

Commissioner Pupa motioned to approve the minutes as presented. Commissioner Monroy seconded the motion.

Roll Call Vote:

AYES: Commissioners Anwar Abbas, Laura Espinosa, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: None.

The clerk declared the motion carried.

PRESENTATION

2. Baker Tilly Audit Information

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

RECOMMENDATION: Accept and file the presentation

Kimberly Sokoloff, Audit Engagement Principal, Baker Tilly, reviewed the stub period financial statement audit, which is an audit of a period of time that is less than a full 12-month fiscal year period. The stub period for the six months ended December 31, 2025, was required in contemplation of the shift in fiscal year end from the historical June 30 fiscal year to the December 31 fiscal year. After this audit period, the annual 12-month audit period ending December 31 will resume. Under our auditing standards, we are required to communicate the non-attest services that are provided to the plan. The non-attest services are professional services that do not have an audit report attached to them. These are permissible services under our professional auditing standards. Every year and before we embark on each new audit, we evaluate whether the completion of these services would impair our independence, and we concluded that completion of the standard non-attest services does not impair our independence or ability to serve as your independent external auditor. We have a requirement to communicate to you what is termed under auditing standards as “significant risks.” These do not convey that we believe there are vulnerabilities at the plan in these areas. This is audit terminology that audit teams across any industry need to identify areas of the financial statements to go deeper in applying audit procedures over. For transparency purposes, we have outlined our key audit procedures and the results in these areas. Our audit procedures were completed in these areas. We do not have any notable findings that resulted from the audit procedures.

Ashley Merda, Audit Senior Manager, Baker Tilly, stated we are required to communicate our responsibility regarding the financial statement audit under U.S. auditing standards. We are responsible for forming and expressing an opinion on whether the financial statements have been prepared by management in all material respects in accordance with accounting

principles generally accepted in the U.S. However, it is important to note that our audit does not relieve you as the finance committee or management of your responsibilities surrounding the financial statements. The audit was conducted in accordance with U.S. auditing standards in which we exercise professional judgment and maintain professional skepticism throughout the audit. The audit includes obtaining an understanding of the plan's internal controls to properly design our audit procedures, but not for the sole purpose of expressing an opinion on the effectiveness of those internal controls or specifically to identify deficiencies in design or operations of those internal controls. We are responsible for communicating significant matters related to the audit that are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design specific procedures for the purpose of identifying any matters to communicate to you. There were no significant unusual transactions, no significant difficulties, and no disagreements with management encountered during our audit.

Ms. Sokoloff said during the financial statement audit, as management finished their financial close and as they received subsequent information relevant to the period under audit, they presented additional financial adjustments to the December 2025 period. Adjustments were reflected in the financial statements based upon those audit discussions. If adjustments were identified that we believe should be made to the financial statements to comply perfectly with the U.S. accounting standards, if the dollar amount of those were material to the financial statements, we would request those adjustments be made to the financial statements to still issue a clean opinion. There are several times where adjustments are proposed, but they are not deemed material to the financial statements and therefore management has the option to pass on those to avoid making additional late adjustments to the financial statements. There was one item discussed with management that we agreed is not material to the financial statements that relates to a receivable balance on the financial statements that is intended to represent claim payments that were made as of December 31, 2025. History and industry experience shows there is an opportunity to collect an overpayment once those activities take place in fiscal year 2026. That receivable may be valid, but the auditable support received for that balance was short by approximately three and a half million. This is an audit documentation item, which we agree is not material to the financial statements and concur with management's decision to pass on the adjustment. Past adjustments discussed with the Executive Finance Committee for the June 2025 financial statement audit were additional net income impacts that arose based on information that was not available to management when they closed the end of the year. Because it was subsequent information and the amounts were not deemed to be material, management passed on those entries for the June 2025 audit. This represents that these effects were recorded in this stub period 2025. Individually and in aggregate, we concur that these adjustments are not material to the financial statements and therefore plan to issue a clean audit opinion. There was no material corrected misstatements identified. Part of the audit finalization process involves obtaining representations from management on the day that we issue the audit report. These representations are matters such as they represent that they have furnished all the audit information requested, and they believe the financial statements are fairly presented in

accordance with the underlying accounting standards. There are no control recommendations that rose to a level that would be required to communicate with this group. In the June 2025 audit, we did identify an aggregate of some late financial close activities that were communicated to this group as a significant deficiency, primarily driven from employee turnover within the accounting team. We do not have the same finding or control recommendation to communicate for the December 2025 step period audit. We did find that the financial close activities were conducted in a timely manner and in accordance with our expectations.

Interim CFO / Controller Jeff Register shared that he enjoyed working with the team and appreciates the degree of scrutiny applied to help keep things clean. He stated there is a good partnership and he appreciates their expertise and collaboration to bring this to a timely conclusion.

Commissioner Abbas motioned to accept and approve the report. Commissioner Monroy seconded the motion.

Roll Call Vote:

AYES: Commissioners Anwar Abbas, Laura Espinosa, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: None.

The clerk declared the motion carried.

FORMAL ACTION

3. Signature Authority and Procurement Policy Revisions

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

RECOMMENDATION: It is the Plan's recommendation that the Executive Finance Committee recommend the Ventura County Medi-Cal Managed Care Commission to, 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 or Director of Procurement 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.

General Counsel, Scott Campbell stated this presentation is to ask for input on increasing certain limits in the purchasing authority in addition to sole source. It has been approximately 10 years since the numbers were adjusted for contracts that need to go to the commission, and what contracts we need to bid on versus doing a sole source. The report summarizes that there are many transactions that take a lot of time and staff work that do not significantly impact the numbers spent and diminish the Commission authority. There are approximately 40% of transactions, if the limits were increased could be eliminated from staff would have a relatively minor effect on the overall spend, and would free up more time of staff to focus on things. This item is being presented for your consideration and input. Based on what the Executive Finance Committee does, changes would be shared at the May Commission meeting for approval.

Bob Bushey, Executive Director of Procurement, said it has been approximately 10 years since the policies were reviewed and aligned for best practice. On a day-to-day operational basis, the organization feels some of this transactional management. The recommendations are using facts and objective logic for making the recommendation change. Currently, the maximum of the chief executive officer (CEO) signature authority is \$100,000 and then it goes to the Commission. We are recommending changing that to \$300,000, and we are asking for the delegation to sign contracts to be delegated to the either the chief financial officer (CFO) or the director of procurement. That would relieve the CEO from signing all the transactions and contracts as an external commitment. The third request is to change the competitive bidding threshold from \$50,000 to \$200,000.

Mr. Bushey said the first recommendation is to increase the thresholds from \$100,000 as the CEO limit up to \$300,000. He stated approximately 53% of the spend is going to a CFO above, then to the Commission for approval, which represents 98% of the spend. By making the change the transactional spend changes to 29% of the overall transaction volume and keeps the spend available for review and approval at 94%. This will reduce the transaction volume significantly, but keep the visibility, involvement, review, and approval of these transactions, contracts, or external commitments at 94%.

Commissioner Anna Monroy asked if there are regulatory requirements around the thresholds for bidding.

Mr. Bushey responded there are no requirements. It is up to GCHP to write policies and to adhere to the policies.

Commissioner Dee Pupa asked if we know the County of Ventura's threshold for single source.

Mr. Bushey responded that when he joined GCHP 10 years ago, he wrote the policy to align to the \$50,000. He is not aware if it has changed.

Mr. Campbell indicated he will research and share the information when it is brought to the Commission.

Commissioner Anwar Abbas asked if that is a normal practice at other health plans.

Mr. Bushey responded that when he worked as a procurement executive for major health plans 10 years ago, the competitive bidding thresholds were at \$250,000.

Mr. Campbell stated that page 84 of the meeting presentation shows that other plans currently have the CEO limit between \$200,000 and \$250,000.

Mr. Bushey stated the second request is to delegate the authority to sign the contracts to the CFO. Once the internal authorizations are in place and they are approved, the external commitment is commenced by signing the contract. That is a transaction that we recommend be delegated to the director of procurement or the CFO.

Mr. Campbell stated that the same procedures will be followed and will go through the same mechanisms for authorization levels. Once it has been approved by the Commission or on staff level, rather than having the CEO sign the document, the CFO or procurement can sign the documents.

Mr. Bushey explained that the CEO signs approximately 288 documents a year.

Commissioner Abbas stated that he recommends having the CFO sign the contracts.

Commissioner Monroy agreed that the CFO should be the signer. She asked if the CEO receives a quarterly report to know what the spend is.

Mr. Bushey responded that every transaction goes through Workday electronic approvals. It is all automated. When it hits the threshold of \$50,000 and needs a CFO review and approval, it automatically goes to the CFO, then it goes up to the CEO. Next it goes to a role called the Commission. After the Commission approves, the CEO approves on behalf of the Commission. It is all auditable and electronic.

Commissioner Monroy asked how there will be oversight of leadership. She asked if there is a quarterly report with the procurement team done for spend and budget review.

Mr. Bushey responded that reports can be run on all transactions from any period that needed approval at any level.

Interim CFO / Controller Jeff Register stated that the intended supplier is listed in the budget ahead of time. As monthly reviews are done with the chiefs of the different areas and for the company as a whole, the budget is reviewed.

Mr. Bushey said the third recommendation is to move the competitive bidding threshold from \$50,000 to \$200,000. It takes between two to six months to run a request for proposals (RFP). A large percent of the spend is over \$50,000 and is approximately 51% of our transactions. If the threshold is changed to \$200,000, the number of transactions is reduced to 25%. It shifts our organization into focusing on the big dollars and running RFP where needed and competitively bidding to spend and not focused on transactions and trying to get savings out of a \$50,000 issue.

Committee Chair Laura Espinosa stated in the past there was concern with the presentation of the dollar amounts to the Commission that were not fully transparent, which is why the lower threshold has remained. After 10 years, it is a good practice to move on.

Mr. Bushey explained that there is a section in the policy that states contract renewals are brought to the Commission. That is what we historically presented during the budget period. That is pre-approved and does not require Commissioner approval because they are part of the budget. If we take these things to the marketplace, I want you to know that we are doing that and I want to keep it visible to you.

Mr. Campbell summarized the discussion that it is fine to increase the threshold to \$300,000 but return with information on the County's threshold. For the signature policy, the CFO should sign the documents. It is fine to raise the sole source from \$50,000 to \$200,000.

Committee Chair Laura Espinosa asked if the language indicates "the CFO or the CEO" for the signature or is it only the CFO.

Mr. Campbell responded the change would be "or" the CFO. There are certain contracts that are excluded in your policy that require CEO approval, but the day-to-day transactions would be delegated to the CFO, but there are certain transactions that still will require the CEO. Anytime a contract comes to the Commission for approval, you have the option of authorizing the CFO or CEO to sign.

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

Roll Call Vote:

AYES: Commissioners Anwar Abbas, Laura Espinosa, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: None.

The clerk declared the motion carried.

4. Advance Payment Agreement to County

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

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

Mr. Campbell stated that for Agenda Item 4, under state law, Vice Chair Pupa will be recused from the discussion because her department is involved in the transaction.

CEO Felix Nunez, M.D., stated that in partnership with the Ventura County Health Care Agency, we have been approached by the agency with a request for an advance payment to bridge a funding gap that happens periodically due to the cycles of state-directed payments and supplemental funding reimbursements. Such a cycle is happening again. GCHP received requests from the Ventura County Health Care Agency, to assist them with supplemental funding to bridge that gap in funding. The request is the amount of \$30 million to bridge the funding from June 26 through September 30, 2026, at which time that funding will be repaid. The terms of the agreement are similar to terms that we have presented in the past. This is a one-time advance payment agreement that we are asking the Executive Finance Committee to review and approve for advancement to the Commission for approval. It is a one-time funding advance. If approved, the payment would be made June 26, 2026. Funds are set to be repaid on September 30, 2026. If the advance has not been fully repaid by September 30, 2026, GCHP will offset any unpaid amount against capitation payments, fee-for-service payments relating to claims submitted or processed for payment, or any other amounts due to Ventura County Health Care Agency for subsequent months. At this time, GCHP is not recommending that an administrative fee be charged to the County for this advance payment. If the Commission chooses to impose such a fee, the recommended amount would be \$189,440, reflecting the lost opportunity in regard to investment gains that would have been secured during that time period. This does not constitute a gift of public funds. We have statutory support in regard to making this advance payment coming from three different levels. First, from the state welfare and institution code. The Commission is to meet the problems of the delivery of public assisted medical care in the county and to demonstrate ways of promoting quality care and efficiency. From our county ordinance, the Commission is to implement reimbursement mechanisms which promote long-term viability of locally operated Medi-Cal managed care systems and existing participating provider networks inclusive of "safety net providers" herein defined as Medi-Cal disproportionate share hospitals, county clinics, federally qualified health centers and licensed rural health clinics. And finally, Gold Coast Health Plan bylaws, which provide that the Commission shall deliver medical care via a contracted provider network that will improve access to primary, specialty, and ancillary services, and incorporate a plan of service delivery and implement reimbursement mechanisms which promote the long-term viability of locally operated Medi-

Cal managed care system and implement programs and procedures to ensure a high level of member satisfaction. Overall fiscal impact, there will be a temporary reduction in Gold Coast Health Plan reserves, and we will be losing the opportunity to gain interest on those funds for the period of time that they are advanced to the County. The recommendation of Gold Coast Health Plan staff is for the Executive Finance Committee to recommend to the Ventura County Medical Managed Care Commission authorization to the CEO to execute this advance payment agreement in the amount of \$30 million with the County of Ventura without an additional administrative fee to be charged.

Committee Chair Espinosa asked Mr. Campbell to explain why the waiver of the fee is not considered a gift of public funds.

Mr. Campbell responded that one of the purposes of the GCHP mission is to help providers in GCHP, provide services to members, have stable delivery systems, and have reimbursement mechanisms for those providers. This program would allow a transfer to the County. Because the County would benefit by getting this money and not having to pay that extra money back, that is increasing the funds available for the County to provide services to its members, which is an allowable use of public funds by GCHP. You still have the ability and you could make that demand that the County do this as a condition, but it is not required because the providing of the giving of services by the county to its members is one of the goals of GCHP, and it is enhanced by waiving that administrative fee. I will note that when you did this last year, you did impose that administrative fee. The County paid it back. It is not required under the law, but the Commission can require it as part of its consideration.

Commissioner Abbas stated we would have received \$189,000 if this money were in the bank. The question becomes, why should we take a debt liability on us? Are our funds okay? We are helping them to run their business. A precedence is also being set because not another provider may come later and request an advance. We need to be consistent because we did it last time.

CEO Nunez responded that he looks at it from two perspectives. The first is the overall financial cost of \$189,000 is a significant amount of money, but in the overall scope of the budget it represents a relatively small amount. The second is currently all our systems are feeling extraordinary financial pressure based on the enrollment issues we are facing. The County is a safety net facility experiencing the burden of uncompensated care. The sense is that waiving the administrative fee will promote goodwill and good partnership with the County.

Committee Chair Espinosa stated she agrees with Commissioner Abbas and looks for consistency. She stated that since GCHP is under a monitoring decree, the next provider will expect the same treatment as the County. We may not be in the same position at that time to be so generous. She questioned the wording in the proposal. She explained this is the third "one time" advancement. It is no longer one time. She recognized the safety net

designation, but it is going to get worse in 2027. She anticipates additional calls for these types of loans. She stated that maybe some conditions should be included to be fair and to look at equity.

Commissioner Monroy agreed with both comments regarding precedence and equity. It places the Commission under a scope from other systems. We are all going into uncharted territory for the rest of the year and the following years regarding eligibility and enrollment. We need to tread carefully. We should remain consistent if everyone is in agreement with the advance payment. She asked if there are concerns regarding their ability to repay.

Committee Chair Espinosa stated this is not going to be a one-time thing because the state is always behind on their payments to providers. It is up to each entity to factor that in their budgets. I am trying to be fair as possible to all providers. We are concerned about the County hospital being able to sustain itself. It is not just the \$189,000. I think \$30 million is substantial. It may not be substantial to those dealing with very large numbers, but it is to the average person. We need to develop trust with the community. This may require more discussion. She stated she is not feeling confident in this action.

Commissioner Monroy stated she agreed with Committee Chair Espinosa regarding conditions and on how to approach this in terms of the overall amount.

CPPO Erik Cho stated the last time a motion like this went to the Commission, there was a presence from the director of the Health Care Agency at the Commission. It is reasonable to ask from involvement from the people who are asking for this advance to give details to the Executive Finance Committee and to the Commission to further understand their situation.

Committee Chair Espinosa responded that she does not need more information. She made a motion to have staff go back and attempt to negotiate further conditions and make it clear that these are not “one time” anymore.

Commissioner Monroy stated that every system should be in planning mode knowing how these cycles work in terms of reimbursements, so that every system does its best to ensure that they continue to be viable without these types of advance payments.

CEO Nunez clarified that he did not say that this was not a lot of money. To him, \$189,000 is a lot of money. Relative overall to our budget, \$189,000 does not represent a significant amount, but to anyone in the room it is a lot of money. We need to be very careful about our language. This is not a loan. This is not a gift of public funds. This is an advanced payment agreement based on incoming payments from the State of California, which is a state directed payment. Regarding extending this opportunity to other providers, our safety net providers represent a special class of providers, which includes federally qualified health centers, and to the extent that we are able to provide support in this way to any of our safety net providers, we do have an obligation, in my read of the ordinance from the County of Ventura, to support

our safety net providers and make certain that they are able to execute on their missions, which are critically important to our members. If you asked me, would I be willing to do that for any of our safety net providers as defined in the ordinance, my response would be, “yes.” I would support that for any of our safety net providers, given the special place that they have in our infrastructure here in the County. They represent a unique provider type. I certainly would support that. Where we have the ability to do that, I would support us doing that as an organization. Prior advances have all been repaid by the County. We have made prior advances, and in the past, we have set certain terms on those. They have all been repaid in the past by the County.

Commissioner Abbas asked how they are doing financially. He stated that there are some issues in the Santa Paula hospital and asked if there are other issues in Ventura County. If there are other issues, we need to know so they will be prepared.

CEO Nunez responded that the County is in the best position to answer those questions.

Mr. Campbell said the recommendation is to try and negotiate some terms in addition to the administrative payment, then come back for approval in May. On Monday, we will take that recommendation to the Commission as a whole, the County will be there to provide information, and the Commission can accept this motion or make a different decision.

Committee Chair Espinosa said her motion may have been misrepresented. The motion she made is to have staff go back, remove this item from the agenda for Monday, and see if there might be some other conditions, or have a discussion with the County that there is some concern with the Executive Finance Committee. The biggest issue is not the \$189,000; It is the 30 million plus the fact that this is the third advanced payment they have requested. They have satisfied repayment of those advances, but there needs to be some more discussion about it. I would not want this on the agenda for Monday until there is some more discussion. I take my fiduciary duty seriously. Chair Espinosa asked how much it would be altogether, including if this one were approved.

Mr. Register responded that there was an advance in December 2024 for \$10 million, then a subsequent advance in May or June 2025 for \$26 million, and the entire \$36 million was repaid in September 2025. Including the \$30 million being considered, that would be a total of \$66 million that has been requested.

CEO Nunez asked, in addition to the administrative charge, what the other conditions are that may apply to the advanced payment agreement.

Committee Chair Espinosa responded that we need to figure out what the County is going to do with the Santa Paula hospital.

CEO Nunez confirmed that Committee Chair Espinosa would like to see the work plan for Santa Paula.

Committee Chair Espinosa confirmed that is correct.

Mr. Campbell stated that procedurally, the agenda has already been posted for Monday. It can be a recommendation from the Executive Finance Committee to take it off, but it is not in the powers of the Executive Finance Committee to remove something from the Commission agenda after it has been posted. That can be brought to the Commission as a recommendation to postpone it and not have any discussion. The Commission can decide whether to have any discussion and postpone it or just postpone it. It would then come back to the Executive Finance Committee again. An Executive Finance Committee meeting could be scheduled in May.

Committee Chair Espinosa stated there is a motion on the floor. She asked if there is a second. She stated we could come back as described at the May Executive Finance Committee to discuss further.

Commission Monroy asked Madam Chair if she was okay with postponing the conversation and leaving it on the agenda for Monday.

Mr. Campbell stated he is going to make a recommendation to the Commission to postpone on Monday and that there will be further discussions at the Executive Finance Committee meeting in May where in the meantime, staff will work with the County to come up with conditions that they can recommend to the Executive Finance Committee, then bring that forward to the Commission in May.

Committee Chair Espinosa asked what the desires of the other two Commissioners are.

Commissioner Abbas agreed with Mr. Campbell.

CEO Nunez stated it will be brought back to staff for further discussion and negotiation.

Mr. Campbell stated the Commission will be asked to postpone the discussion to allow further negotiations with staff, bring the recommendations to the Executive Finance Committee in May, and the Commission on May 18, 2026.

Commissioner Abbas asked Madam Chair if she was okay with the motion.

Committee Chair Espinosa accepted the motion as stated by Mr. Campbell. Commissioner Monroy seconded the motion.

Roll Call Vote:

AYES: Commissioners Anwar Abbas, Laura Espinosa, and Anna Monroy.

NOES: None.

ABSTAIN: Commissioner Dee Pupa.

ABSENT: None.

The clerk declared the motion carried.

Mr. Campbell stated that a member of the public arrived to the meeting late and would like to speak with the Commission. He will have the opportunity to speak for three minutes.

PUBLIC COMMENT

Ben, the owner of the company Rosie Tax Cabs / Health Rides. He stated he has an important issue to discuss. He built his company in 2014 and reached out hoping to contract with Gold Coast Health Plan. Since 2014, his company has been repeatedly rejected. He would like to understand why. His company provides transportation, which is needed for GCHP members. He said GCHP only works with one transportation company, Ventura Transit System. He asked for a chance to prove himself and build a relationship with GCHP. He stated it is not normal for a health plan to only work with one transportation company. He asked the Executive Finance Committee to revise the contract and open the contract to other potential providers. He stated there are areas that Ventura Transit System cannot cover, like Fillmore and Santa Paula. Waiting times for a ride from Santa Paula hospital or Ventura are difficult and there can be a 45-minute waiting time. He stated he can order a ride in 15 minutes. He believes his company can help the health plan to cover areas where the older transportation provider cannot. He asked to be given a chance to do business with GCHP.

Committee Chair Espinosa thanked Ben for helping to inform the Commission. She said that if requested, staff can go over the procurement process and procedures.

CHR Paul Aguilar said he will meet with Ben to get his contact information and make sure the appropriate person from procurement is able to contact him and discuss next steps.

5. March Financials

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

RECOMMENDATION: Approve the financials as presented.

Mr. Register provided an executive summary for results from January 1, 2026 through March 31, 2026. GCHP is on target with the budgeted projections in every category. There is slight unfavourability to budget overall, but each category is basically on target. Revenue, medical expenses, administrative expenses, and net income are close to budget. An 11.7% increase was received in the premiums paid by the Department of Healthcare Services (DHCS) in 2026 compared to 2025. Quarter end membership is approximately 1,000 members unfavorable to budget and has declined approximately 7,000 members since December 2025. The tangible net equity (TNE) is currently 543% of the state requirement and is within the 500 to 700% range set by the Commission.

Mr. Register stated he was asked by team members to explain what member months are. Membership is how people were involved at the end of a particular period. Member months is if one member is enrolled for 12 months and we are measuring that period in our financials, that equals 12 member months. It is a cumulative number of members serving the time period that makes the "PMPM," per member per month calculations more meaningful. Looking at the \$315.4 million in revenue, and divide it by 697,927, that is the revenue PMPM of \$451.95. The PMPM takes the volume issues out of comparison. We are approximately 800 member months below budget. Revenue is approximately \$1.00 PMPM, unfavorable to budget. Overall, the medical cost is \$383.43 per member per month. That brings us to a medical loss ratio of about 84.8%, which is in line with what is budgeted for this time of the year. Administrative costs are slightly favorable, 11.2% per member per month. Investment income is down slightly for the year, 2.6 million, compared to a prediction of 3 million. That is due to lower interest rates and lower balances. Our commitment to our quality strategy remains strong. Our expense here today is 12.8 million versus a budget of 12.4. Net income is \$2.3 million year-to-date versus a budget of 2.5 million. We are aligned with the budget projections that were given to the Commission in February.

Commissioners Pupa and Monroy thanked Mr. Register for sharing March financials.

CEO Nunez thanked Mr. Register for stepping in and filling the role as interim CFO. He explained financials are critical, and the organization is in an administrative saving mode and is looking for opportunities to save on administrative costs. A hiring pause in place since January remains. It is an organizational effort to maintain the administrative costs and keep them in check. The administrative savings mode will remain for the foreseeable future to ensure budgetary expectations are met.

Mr. Register stated that work is being done to ensure Medically Supportive Foods is in line with program expectations and that state guardrails around the program are being adhered to. Utilization has come back down to historically normal levels. Contracting changes have been initiated with the Medically Supportive Food providers.

CPPO Erik Cho stated contracts were maintained with two of the local providers who provide the meals at a much lower cost and with a delivery provider already at a lower cost. GCHP also has access to the grocery boxes. In addition to the utilization numbers decreasing through March, as that stabilizes, the per unit cost has started to go down, and will decrease in April with the onset of the new terms. This will be a positive development for impact to our costs throughout this year.

Mr. Register explained a lot of work has gone into right-sizing the program to ensure it fulfills its mission in a cost-effective manner. Membership has been experiencing steady attrition. There have been discussions on how to member outreach and ensure people are not disenrolling due to administrative or procedural issues. There is more work to be done. It is important to ensure the people who need the care can access it.

Mr. Register shared that the Finance Department went live on the Workday platform on December 13. The financial platform when live on January 1, 2026. The entire organization, Human Resources (HR), and Finance, is now on Workday. It was a big lift for the Procurement, Accounts Payable, and General Ledger teams. The goal is to be able to consistently close in 10 business days and have reporting and analysis ready by business day 14. The 2025 stub-period audit has been successfully completed. We received a clean audit opinion, and no internal control deficiencies were known at this time. We now have the stub-period regulatory reporting due by April 30, which includes regulatory reporting to DHCS, Department of Managed Health Care (DMHC), and Centers for Medicare and Medicaid Services (CMS). Then two weeks after that, the quarter one, regulatory reporting is due to DHCS, DHCS and CMS. One more implementation currently happening is the Workday Adaptive, which will be our budgeting and forecasting tool, is scheduled to go live in early May. It was necessary that we finish with the financial implementation so that the budget tool can be brought into alignment with the final implementation of the financials so that there will be a seamless native integration between those two systems. The 3 + 9 Reforecast presentation is scheduled to be presented to the Commission in the May 18 meeting. The Finance Department is supporting the completion of the 2027 Medicare bid, which is due by June 1. The Finance Department also supports the Medicare Risk Adjustment Audits, which are internal audits to ensure that the records align with the services being provided to ensure appropriate risk score assignment.

Commissioner Monroy motioned to receive the March Financials. Commissioner Abbas seconded the motion.

Roll Call Vote:

AYES: Commissioners Anwar Abbas, Laura Espinosa, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: None.

The clerk declared the motion carried.

Mr. Campbell asked if the Commission decides on the advance if the afternoon of May 13 would work for a remote Executive Finance Committee meeting.

The members of the Executive Finance Committee all confirmed May 13 worked for them.

ADJOURNMENT

Commissioner Anwar Abbas motioned to adjourn the meeting at 4:49 p.m.

Approved:

Maddie Gutierrez, MMC
Sr. Clerk to the Commission

**Ventura County Medi-Cal Managed Care Commission (VCMMCC)
Executive/Finance Committee
Regular Meeting
August 20, 2026**

CALL TO ORDER

Committee Chair Laura Espinosa called the meeting to order at 3:02 p.m. The meeting was held via teleconference. The Clerk was in the Community Room, 711 E. Daily Drive, Suite 110 Camarillo, California.

ROLL CALL

Present: Commission Chair Laura Espinosa, Commissioners, Tim Myers, and Mark Sewell

Absent: Commissioner Anwar Abbas and Allison Blaze, M.D.,

GCHP Executive Team in attendance: CEO Felix Nunez, M.D., CHR Paul Aguilar, CIO Eve Gelb, CPPO Erik Cho, CCO Robert Franco, CDO Ted Bagley, CIO Alan Torres, CMEEAO Marlen Torres, COO Suma Simcoe, Interim CFO / Controller Jeff Register, CFO Christopher Lee, and General Counsel, Scott Campbell.

GCHP Staff In attendance: Bob Bushey, David Kirkpatrick, Kris Schmidt, Lupe Gonzalez, Susana Enriquez-Euyoque, Lupe Harrion, Paul VerHaar, Josephine Gallella, Vicki Wrighster, Victoria Warner, Michelle Espinoza, Kimberly Timmerman, Pshyra Jones, Lily Yip, Mayra Hernandez, Michelle Lacy, Lupe Nunez, Joanna Hioureas, Gene Kirkland, and Chris Dulan.

PUBLIC COMMENT

None.

CONSENT

- 1. Approval of Executive Finance Committee special meeting minutes of June 30, 2026.**

Staff: Maddie Gutierrez, MMC, Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented

Commissioner Sewell motioned to approve the minutes as presented. Commissioner Espinosa seconded the motion.

Roll Call Vote:

AYES: Commissioners Laura Espinosa, Timothy Myers, and Mark Sewell

NOES: None.

ABSENT: Commissioners Anwar Abbas and Allison Blaze, M.D.

The clerk declared the motion carried.

FORMAL ACTION

2. Request For Proposal Number GCHP10232025: Consideration of Recommendation for a Rejection of All Bids and Renewal of Work with Inovalon for HEDIS and Risk Adjustment Services

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

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

Eve Gelb, Chief Innovation Officer, gave background information on this item. She stated that Gold Coast uses a vendor called Inovalon for our quality data and risk adjustment reporting. They ingest and analyze data and produce outputs so we can identify where we need to focus and how we need to support our members and providers to improve quality outcomes. We have used Inovalon for quite some time. As best practice we thought it was important to go out to market. She noted that with the introduction of D-SNP there is a risk adjustment component that was new. We put out an RFP and had seven vendors apply and six responded. We identified our top vendors and went through the demos. The results of our evaluation turned out that there was one vendor that was top. We began negotiations and tried to come to terms with this in place for 2027. The process was long and took quite a while to negotiate. CIO Gelb noted that Inovalon was performing functions for us who were going to RFP. We found that the new vendor would cost a lot in terms of going through a new implementation. Inovalon had begun to show better performance. They have a new customer management approach that has shown outcomes that meet our needs. We found that it would cost more with a new vendor for start-up. General Counsel, Scott Campbell stated that from a legal aspect, once we determined that were going to a

non-award and rejecting all bids we reached out to all vendors to advise that we were not going to go forward with them and there was no protest.

CIO Gelb stated the procurement team met with the existing vendor and negotiated a 34% reduction in our terms and costs, which is approximately a \$3million savings over three years.

Commissioner Sewell noted that Inovalon was ranked fifth – he asked if it was due to their price proposal. CIO Gelb stated the RFP process - it is hard to demonstrate how the product is going to work. When we decided to go through the RFP, we had not used Inovalon's risk adjustment platform because it was brand new. We were looking for functionality could be out in the market with respect to the ways that the vendors demonstrate their products – it varies depending on who is demonstrating the product. After the use of the product, we determined that it did meet our needs.

Kim Timmerman, Executive Director of Quality Improvement, stated that over the last year we noticed a high level of improvement and more attention to detail. They were more proactive in meeting our needs. Other software solutions did not have a provider facing dashboard to look at gaps in care.

Commissioner Espinosa congratulated staff on the 34% reduction and noted it was very good negotiations. She asked was the analysis, the dollar figure, and the cost savings. CIO Gelb stated she did not recall the startup cost, we had Total Cost of Ownership (TCO) pricing from the marketplace, which included implementation costs and run rate.

Commissioner Sewell asked what else were they not good at to only score 5th. He then stated that maybe this exercise made them realize that they needed to keep GCHP as a customer.

Commissioner Sewell motioned to approve agenda item 2 as presented. Commissioner Myers seconded the motion.

Roll Call Vote:

AYES: Commissioners Laura Espinosa, Timothy Myers, and Mark Sewell

NOES: None.

ABSENT: Commissioners Anwar Abbas, and Allison Blaze, M.D.

The clerk declared the motion carried.

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

Staff: Alan Torres, Chief Information Officer

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

Chief Information Officer, Alan Torres, stated that staff are seeking approval to acquire additional software licenses from Cotivity and implementation services to address new compliance regulations from both DHCS and CMS for interoperability and the prior authorization rule. He noted that Cotivity acquired Edifecs in March of 2025. They are an existing vendor that we have today at GCHP. The term of the contract will be five years of services commencing at the start of implementation, September 1, 2026, and expiring August 31, 2031, for an amount not to exceed \$2.6million. This covers both software licenses and the implementation costs.

We have made significant investments starting in 2020 around interoperability and we have built many data interfaces into this capability. This year CMS and DHCS aligned their interoperability's approach and have mandated that by January 1 of 2027 the health plans need to implement this new prior authorization capability. We are adding new licenses to the Cotivity -base product. To support this set of requirements we will leverage existing investments that we have made existing technical data integration approaches. This will save us time and money by avoiding moving towards a new vendor, not just for this requirement but for all existing interoperability services and capabilities. The intent is to reduce administrative burdens, eliminate system redundancies, and empower individuals to manage their own health care.

We have implemented the infrastructure of the foundation with the technology infrastructure, the patient access, API application program, as well as the provider data application program. We have also implemented the provider directory bulk, payer-to-payer access which will be implemented in January 2027.

The financial impact of the incremental cost to add and implement this additional software over the projected useful life of a four-to-six-month implementation period and a five-year license term. It is projected not to exceed \$2.6million. There is no expense impact to the 2026 budget. There will be an annual amortization cost of approximately \$570,000 per year starting in 2027 and ending in 2031.

Commissioner Myers stated five years is a long time and things change. He questions if the five-year period is a significant contract period, and if what if requirements

change before that. He asked if the vendor would work with amendments. Bob Bushey, Sr. Director of Procurement, stated the majority of our agreements are five years of useful life. In a SAS agreement they are non-terminated, they are not cancellable, it is financial commitment for the term. It is a five-year useful life leverage – the longer-term period for better discount especially if it is a regulatory requirement. They do keep up with the regulatory requirements; they are part of the contract and part of the commitment.

Commissioner Sewell stated that it was mentioned that this is an extension from an existing agreement. He asked if the five-year line up with the current agreement and are they both turning at the same point. CIO Torres stated the existing ones are on an annual review cycle. He stated the existing ones - we have two, and there is a third, are all now reaching five years. Commissioner Sewell stated that if there is a desire to change in the future, we will not be “handcuffed” into one portion of this we could look at there are multiple vendors who provide this service. CIO Torres stated we have the underlying infrastructure and there are additional modules or licenses that add to it so if we go to market, we will be looking for an entirely new solution. Commissioner Sewell stated this could be considered as a sole source. General Counsel, Scott Campbell stated that because we did not go out to market there is a requirement to fill out a sole source form that procurement has to file to justify why and that is reviewed by legal.

Commissioner Sewell motioned to approve agenda item 3 as presented. Commissioner Espinosa seconded the motion.

Roll Call Vote:

AYES: Commissioners Laura Espinosa, Timothy Myers, and Mark Sewell

NOES: None.

ABSENT: Commissioners Anwar Abbas, and Allison Blaze, M.D.

The clerk declared the motion carried.

4. June Year-To-Date Financials

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

RECOMMENDATION: Approve the June financials as presented.

CEO Felix L. Nunez, M.D., stated that before the financials are presented, he wanted to thank Mr. Register for all his diligence and hard work. He was doing double-duty

as controller and acting CFO. We will be transitioning to our new CFO in a week, and we have a transition plan ready for him.

Jeff Register, Interim Chief Financial Officer / Controller stated that he was planning to present the 6+6 financial forecast, but we ran into some technical issues with putting the information together, but it will be presented at a future meeting.

Mr. Register reviewed the June 2026 year to date results. He noted that we continue to struggle with Medi-Cal membership declining. We have been down approximately 13,100 members since December 31, 2025. Our overall year to date performance is favorable to budget \$10.7 million with net income of \$12.6 million compared to a budget of \$1.9million. We do have prior year adjustments of \$17.6 million which are favorably impacting our current year results. Revenue is \$4.7 million favorable to budget driven by favorable member mix.

Medical Expenses are \$0.7 million favorable to budget. MLR is 84.4% versus a budget of 85.2%. He noted that quality strategy costs are carved out for tracking purposes. The MLR including Quality Strategy is 88.4% versus a budget of 89.2%

Administrative expenses are \$5.9million favorable to budget. The ALR is 10.5% compared to the budgeted ALR of 11.5%. TNE is currently 549% of the state requirement and is within the target range set by the Commission. He noted that Days Cash on Han is 107.

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.

Commissioner Sewell motioned to approve agenda item 4 as presented. Commissioner Myers seconded the motion.

Roll Call Vote:

AYES: Commissioners Laura Espinosa, Timothy Myers, and Mark Sewell

NOES: None.

ABSENT: Commissioners Anwar Abbas, and Allison Blaze, M.D.

The clerk declared the motion carried.

Commissioner Blaze arrived at 3:59 p.m.

5. Continuation of Approval of Contract Renewal List

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

RECOMMENDATION: It is recommended that the Executive Finance Committee recommend the Commission approve the contract renewal list.

Mr. Register stated this agenda item is a carryover from the previous month. The format has been revised for the contract renewal list. He stated that he invites additional input and feedback on how to improve the format going forward.

Mr. Register stated that the Gold Coast Signature Authority Policy states that the Commission must approve all contracts with a lifetime spent of \$300,000. The updated format is intended to provide more clarity. We have presented the current contract year and the upcoming contract year and there is also information on the life of the relationship and the total dollars expended under the contract arrangement. It is hopeful that this will provide a clearer view of contracts and greater comparability period.

We are currently asking for the approval of the renewal period amounts. The current period of relationship contract information is provided for context and continuity over the life of our relationship with each vendor. Mr. Register noted that not all the renewals have been executed, some of them are estimated actual amount authorized, not necessarily budgeted amounts for these contracts. It is our intention to present a comprehensive list with the calendar year 2027 budget to mitigate the need for general lists during the year. He stated that any new contracts that come up during the year that exceeds the threshold will be presented to the commission.

Mr. Bushey stated the numbers were the same as presented in June. The format of the list is what has been revised. He reviewed each of the columns and the information that can be found in each of them. There is a description of the contract services, products acquired, the current contract period with start and end dates and amounts for the annual period. A COLA is also included – this is projected for the annual period.

Commissioner Blaze stated that at the last meeting there was a concern about the percent change. She asked if it is an automatic 4% increase or if it is requested. Mr. Bushey stated this is projected; we ask the commission to approve the projected dollars. We will try to negotiate the same rate. We have maximum percent increases in all our contracts; it is the lesser of a CPI. What we try to do is forecast. We add in a 4% increase, but we always try to stay in the current run rate or below the current run rate.

Commissioner Sewell stated it would be helpful to consider some form of approach to either how long we have been with one vendor for a specific service, or if that specific service has grown over time so that is appropriate that the CEO be clear on where it is appropriate to continue without a bid or where it might be appropriate to have a conversation and be clear with the commission about what that calculus is, because not everything needs to be bid every year. It is a waste of time and effort, but having more understanding would be helpful. Mr. Bushey stated that he went back and looked at everything that was presented in June. There was nothing that exceeded the approved amount. Approval was for January through June contracts. This is the remaining second half of the year's list.

Commissioner Blaze asked why Inovalon was separate. Mr. Bushey stated it was placed in two places, earlier we recommended renewing Inovalon for three years so this was on the contract renewal list just in case we did not renew, so it is in two places, and it will come off the list. It is listed four times for four individual statements of work. They encompass all the services associated with HEDIS and risk adjustment.

The goal is to do this list once a year with the budget. If there are contracts that exceed the amount that is authorized, we will bring those separately to the commission.

Commissioner Myers motioned to approve agenda item 5 as presented. Commissioner Blaze seconded the motion.

Roll Call Vote:

AYES: Commissioners Laura Espinosa, Allison Blaze, M.D., Timothy Myers, and Mark Sewell

NOES: None.

ABSENT: Commissioner Anwar Abbas

The clerk declared the motion carried.

ADJOURNMENT

There was no reportable action. The meeting adjourned at 4:12 p.m.

Approved:

Maddie Gutierrez, MMC
Clerk to the Commission



AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Executive Finance Committee
FROM: Christopher Lee, Chief Financial Officer
DATE: October 22, 2026
SUBJECT: 2026 8+4 Reforecast

SUMMARY:

Staff are presenting the 2026 8+4 Reforecast of Gold Coast Health Plan to the Executive/Finance Committee.

RECOMMENDATION:

Receive and file. Staff recommend that the Executive Finance Committee approve the 2026 8+4 Reforecast, and recommend the Commission approve the reforecast as presented.

ATTACHMENT:

2026 8+4 Reforecast Package

2026 8+4 Reforecast

Executive Finance Committee
October 22, 2026

Christopher Lee, Chief Financial Officer

Integrity

Accountability

Collaboration

Trust

Respect

8+4 Forecasted performance remains favorable to budget due largely to prior-year reserve development. When underlying current-year operations are isolated, financial performance is significantly less favorable and varies considerably by population segment. The Medi-Cal SIS population remains the primary area of concern, with elevated MLRs driving negative operating margins.

- The 8+4 Forecast projects a net loss of (\$4M), representing a \$6M improvement from the 4+8 Forecast and a \$5M favorable variance to budget. This favorable overall result is driven primarily by \$43M of favorable prior-year reserve development.
- While prior-year reserve development strengthens the reported financial position, underlying Medi-Cal operations remain challenged. Excluding this benefit, Medi-Cal is projected to generate a net loss of (\$35M), resulting in a (\$40M) unfavorable variance to budget, while Medicare remains relatively in line with budget expectations.
- The Medi-Cal shortfall is driven largely by SIS membership attrition, which has increased the acuity and cost profile of the remaining population. As a result, the SIS population is projected to generate a net loss of (\$40M), accounting for the majority of the Medi-Cal variance.

8+4 Forecast reflects a (\$4.1M) net loss, an improvement of \$6M to the 4+8 Forecast, driven by Risk Corridor and Quality Withhold revenue \$10M, administrative cost reductions \$2M, and favorable membership volume and mix \$2M offset by increased Quality Strategy investments (\$6M) and 2025 Rate true up (\$3M).

	Budget	4+8 Forecast	8+4	Fav/(Unfav)	
			Forecast Total	8+4 F vs Budget	8+4 F vs 4+8 F
Membership (Dec)	223,866	219,115	219,832	(4,034)	717
Membership	2,744,617	2,694,015	2,708,939	(35,678)	14,924
Revenue	\$1,244.5M	\$1,239.1M	\$1,253.9M	\$9.4M	\$14.8M
Med Exp	\$1,054.3M	\$1,040.1M	\$1,045.0M	\$9.3M	(\$4.9M)
Medical Cost: Quality Improvement	\$23.1M	\$24.9M	\$30.5M	(\$7.4M)	(\$5.6M)
Gross Margin	\$167.1M	\$174.1M	\$178.5M	\$11.4M	\$4.4M
Admin	\$158.1M	\$156.9M	\$155.2M	\$2.9M	\$1.7M
Quality Improvement Credit	(\$23.1M)	(\$24.9M)	(\$30.5M)	\$7.4M	\$5.6M
Net Admin	\$135.0M	\$132.0M	\$124.7M	\$10.3M	\$7.3M
Net Operating Income/(Loss)	\$32.1M	\$42.1M	\$53.7M	\$21.7M	\$11.7M
Non Operating					
Interest Income	\$12.0M	\$11.6M	\$11.5M	(\$0.5M)	(\$0.1M)
Quality Strategy	\$43.0M	\$48.7M	\$54.4M	(\$11.4M)	(\$5.8M)
Amortization	\$9.8M	\$15.0M	\$14.9M	(\$5.1M)	\$0.1M
Net Non-Operating Income	(\$40.8M)	(\$52.1M)	(\$57.9M)	(\$17.1M)	(\$5.7M)
Net Income/(Loss)	(\$8.7M)	(\$10.1M)	(\$4.1M)	\$4.6M	\$5.9M
Operational Metrics					
MLR	86.6%	85.9%	85.8%	0.8%	0.2%
ALR	10.8%	10.7%	9.9%	0.9%	0.7%
Op Margin	2.6%	3.4%	4.3%	1.7%	0.9%
MLR Incl. Quality Strategy	90.0%	89.9%	90.1%	(0.1%)	(0.2%)
ALR Incl. Amortization	11.6%	11.9%	11.1%	0.5%	0.7%
Adjusted Op Margin	(1.7%)	(1.7%)	(1.2%)	0.4%	0.5%

2026 8+4 vs 4+8 Variance

Revenue:

Favorable increase of \$18M is primarily due to 2024/2025 Risk Corridor and 2025 Quality Withhold Premiums \$10M and volume of \$6M and member mix \$2M offset by 2025 Rate true up (\$3M).

Medical Expense:

Unfavorable increase of (\$5M) is primarily driven by Provider recontracting (\$5M), volume of (\$4M), offset by favorable prior year reserve release \$1M, and membership mix and trend \$3M

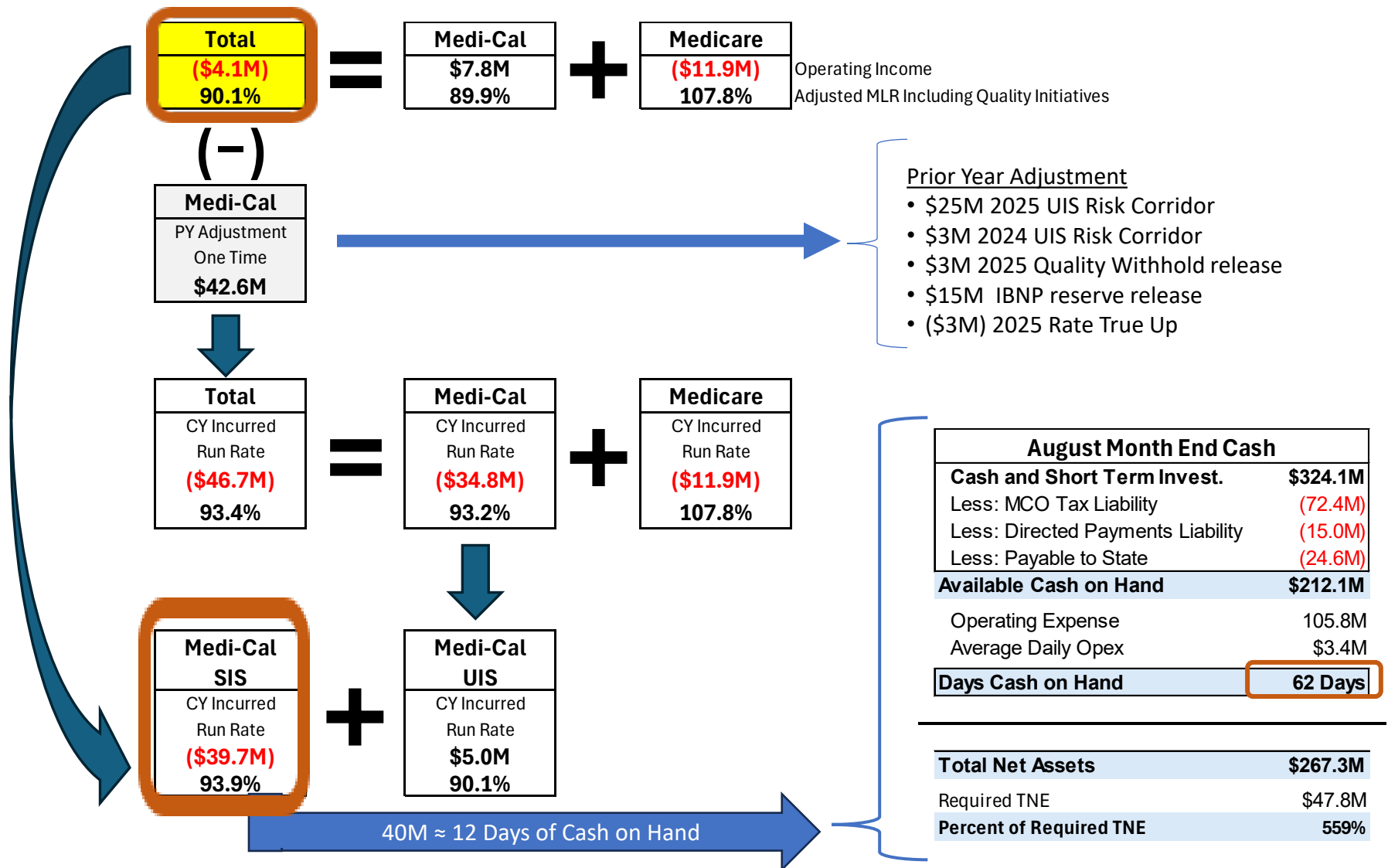
Admin:

Favorable \$2M driven by management actions taken in preparation for the anticipated UIS and SIS membership declines in 2027

Quality Strategy:

Unfavorable (\$6.0M) reflecting higher provider incentive payments resulting from performance exceeding quality targets.

Prior-Year Reserve Development Masks Underlying Medi-Cal SIS Losses. While the 8+4 Forecast reflects a net loss of only (\$4M), this result is significantly supported by \$43M of favorable prior-year reserve development. Excluding these one-time adjustments, underlying current-year operations are substantially less favorable, with the Medi-Cal SIS population generating a projected net loss of (\$40M) and remaining the primary driver of overall financial pressure.



Medi-Cal accounts for (\$35M) of the projected (\$47M) 2026 8+4 Consolidated Run Rate net loss, which is (\$38M) unfavorable to budget due primarily to lower enrollment, unanticipated provider contract changes, higher claims trend, increased Quality Strategy investments tied to provider performance, and higher amortization expense.

	Budget	8+4 Forecast	Fav/(Unfav) 8+4 F vs Budget		8+4 Run Rate			Fav/(Unfav) Budget vs 8+4 RR
					Medi-Cal	Medicare	Total	
Membership (Dec)	223,866	219,832	(4,034)	Removing Prior Year Adjustments	218,767	1,065	219,832	(4,034)
Membership	2,744,617	2,708,939	(35,678)		2,700,687	8,252	2,708,939	(35,678)
Revenue	\$1,244.5M	\$1,253.9M	\$9.4M		\$1,213.3M	\$15.3M	\$1,228.6M	(\$15.9M)
Med Exp	\$1,054.3M	\$1,045.0M	\$9.3M		\$1,046.8M	\$15.4M	\$1,062.2M	(\$7.9M)
Medical Cost: Quality Improvement	\$23.1M	\$30.5M	(\$7.4M)		\$30.1M	\$0.3M	\$30.5M	(\$7.4M)
Gross Margin	\$167.1M	\$178.5M	\$11.4M		\$136.4M	(\$0.5M)	\$135.9M	(\$31.2M)
Admin	\$158.1M	\$155.2M	\$2.9M		\$146.5M	\$8.7M	\$155.2M	\$2.9M
Quality Improvement Credit	(\$23.1M)	(\$30.5M)	\$7.4M		(\$30.1M)	(\$0.3M)	(\$30.5M)	\$7.4M
Net Admin	\$135.0M	\$124.7M	\$10.3M		\$116.4M	\$8.3M	\$124.7M	\$10.3M
Net Operating Income/(Loss)	\$32.1M	\$53.7M	\$21.7M		\$20.0M	(\$8.8M)	\$11.2M	(\$20.9M)
Non Operating								
Interest Income	\$12.0M	\$11.5M	(\$0.5M)		\$11.5M	\$0.0M	\$11.5M	(\$0.5M)
Quality Strategy	\$43.0M	\$54.4M	(\$11.4M)		\$53.7M	\$0.7M	\$54.4M	(\$11.4M)
Amortization	\$9.8M	\$14.9M	(\$5.1M)		\$12.5M	\$2.4M	\$14.9M	(\$5.1M)
Net Non-Operating Income	(\$40.8M)	(\$57.9M)	(\$17.1M)		(\$54.8M)	(\$3.1M)	(\$57.9M)	(\$17.1M)
Net Income/(Loss)	(\$8.7M)	(\$4.1M)	\$4.6M		(\$34.8M)	(\$11.9M)	(\$46.7M)	(\$38.0M)
Operational Metrics								
MLR	86.6%	85.8%	0.8%		88.8%	103.1%	88.9%	(2.4%)
ALR	10.8%	9.9%	0.9%		9.6%	54.7%	10.2%	0.7%
Op Margin	2.6%	4.3%	1.7%		1.6%	(57.7%)	0.9%	(1.7%)
MLR Incl. Quality Strategy	90.0%	90.1%	(0.1%)		93.2%	107.8%	93.4%	(3.3%)
ALR Incl. Amortization	11.6%	11.1%	0.5%		10.6%	70.3%	11.4%	0.3%
Adjusted Op Margin	(1.7%)	(1.2%)	0.4%		(3.8%)	(78.1%)	(4.7%)	(3.1%)

2026 8+4 Run Rate vs Budget Variance

Revenue:

Run rate is unfavorable (\$16M) to budget primarily due to lower enrollment offset by increase in member risk adjustment and favorable mix.

Medical Expense:

Run rate is unfavorable (\$8M) to budget primarily due to provider contract changes and higher-than-expected increase in claims trend.

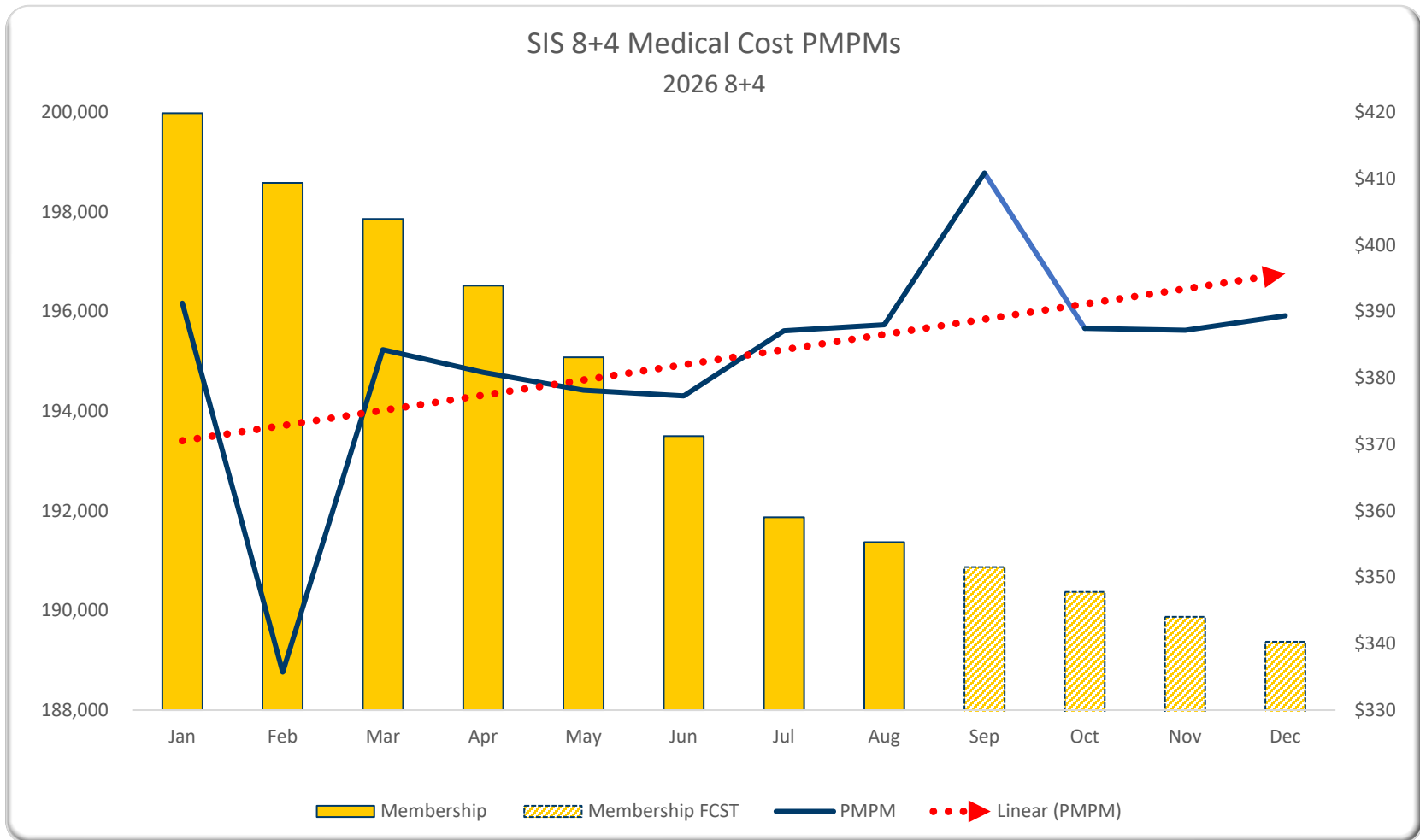
Non-Operating Income:

Run rate is unfavorable \$17M primarily due to Amortization Expense \$5M and increase Quality Strategy \$11M resulting from performance exceeding quality targets.

2026 8+4 Forecast performance deterioration is primarily driven by a projected Medi-Cal SIS net loss of (\$40M) of the total Medicaid net loss of (\$35M), reflecting ongoing SIS membership attrition and the resulting increase in the acuity and cost profile of the remaining population.

	8+4 Forecast				8+4 Run Rate				8+4 Forecast vs 8+4 Run Rate		
	SIS	UIS	Total		SIS	UIS	Total		SIS	UIS	Total
Membership (Dec)	189,374	29,393	218,767		189,374	29,393	218,767				
Membership	2,323,973	376,714	2,700,687		2,323,973	376,714	2,700,687				
Revenue	\$1,002.3M	\$236.4M	\$1,238.6M		\$997.3M	\$216.0M	\$1,213.3M		(\$4.9M)	(\$20.4M)	(\$25.3M)
Med Exp	\$851.7M	\$177.9M	\$1,029.6M		\$864.7M	\$182.1M	\$1,046.8M		(\$13.0M)	(\$4.3M)	(\$17.2M)
Medical Cost: Quality Improvement	\$26.0M	\$4.2M	\$30.1M		\$25.9M	\$4.2M	\$30.1M		-	-	-
Gross Margin	\$124.6M	\$54.3M	\$179.0M		\$106.8M	\$29.6M	\$136.4M		(\$17.9M)	(\$24.7M)	(\$42.6M)
Admin	\$126.2M	\$20.3M	\$146.5M		\$126.1M	\$20.5M	\$146.5M		\$0.2M	(\$0.2M)	-
Quality Improvement Credit	(\$26.0M)	(\$4.2M)	(\$30.1M)		(\$25.9M)	(\$4.2M)	(\$30.1M)		-	-	-
Net Admin	\$100.3M	\$16.1M	\$116.4M		\$100.1M	\$16.2M	\$116.4M		\$0.1M	(\$0.1M)	-
Net Operating Income/(Loss)	\$24.3M	\$38.2M	\$62.6M		\$6.6M	\$13.4M	\$20.0M		(\$17.7M)	(\$24.8M)	(\$42.6M)
Non Operating											
Interest Income	\$9.9M	\$1.6M	\$11.5M		\$9.9M	\$1.6M	\$11.5M		-	-	-
Quality Strategy	\$45.5M	\$8.3M	\$53.7M		\$45.5M	\$8.3M	\$53.7M		-	-	-
Amortization	\$10.8M	\$1.8M	\$12.5M		\$10.8M	\$1.8M	\$12.5M		-	-	-
Net Non-Operating Income	(\$46.3M)	(\$8.4M)	(\$54.8M)		(\$46.3M)	(\$8.4M)	(\$54.8M)		-	-	-
Net Income/(Loss)	(\$22.0M)	\$29.8M	\$7.8M		(\$39.7M)	\$5.0M	(\$34.8M)		(\$17.7M)	(\$24.8M)	(\$42.6M)
Operational Metrics											
MLR	87.6%	77.0%	85.6%		89.3%	86.3%	88.8%		(1.7%)	(9.3%)	(3.2%)
ALR	10.0%	6.8%	9.4%		10.0%	7.5%	9.6%		(0.0%)	(0.7%)	(0.2%)
Op Margin	2.4%	16.2%	5.1%		0.7%	6.2%	1.6%		(1.8%)	(10.0%)	(3.4%)
MLR Including Quality Strategy	92.1%	80.5%	89.9%		93.9%	90.1%	93.2%		(1.8%)	(9.6%)	(3.3%)
ALR Including Amortization	11.1%	7.6%	10.4%		11.1%	8.3%	10.6%		(0.0%)	(0.8%)	(0.2%)
Adjusted Op Margin	(3.2%)	11.9%	(0.3%)		(5.0%)	1.6%	(3.8%)		(1.8%)	(10.4%)	(3.5%)

Declining SIS Enrollment and Higher PMPM Costs Drive Underlying Performance Deterioration

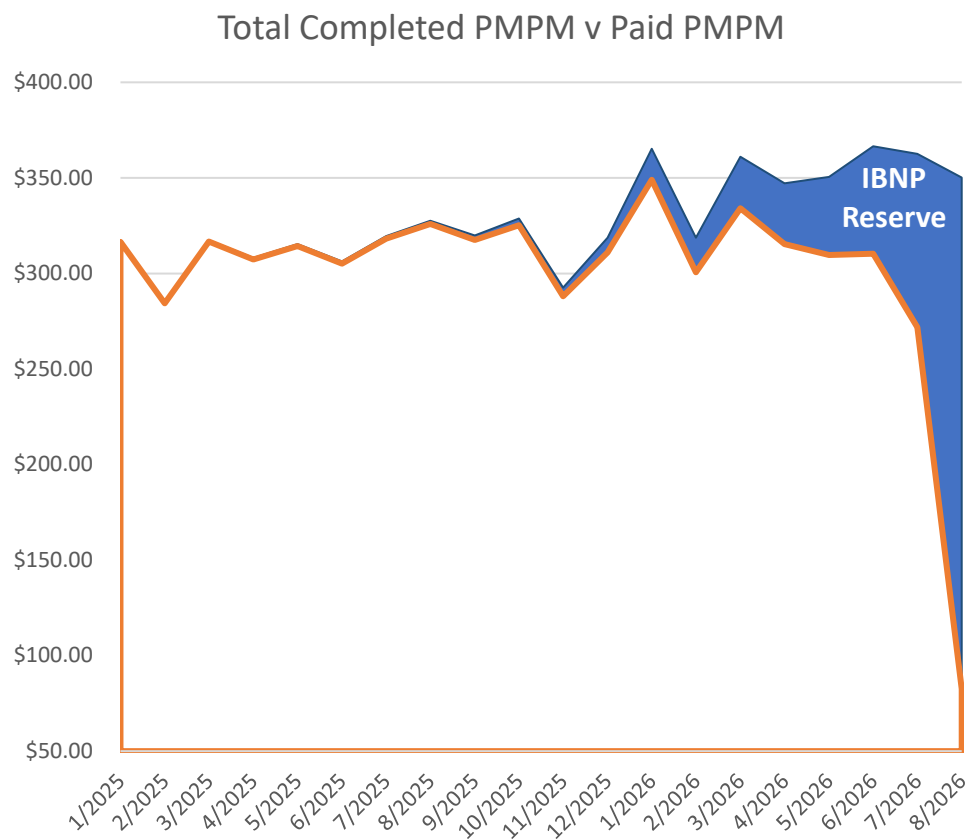


Balance Sheet Reserve Review

August Balance Sheet Reserve Liabilities

Amounts	Account	Activity	Description
\$ 138,933,637	Incurred But Not Reported	IBNP	Actuarially estimated cost of healthcare services that members have already received but that have not yet been submitted or processed as claims.
8,643,855	Claims Payable	Claims in-process	Processed and approved claims that are awaiting payment to providers.
5,615,687	Capitation Payable	Monthly accrual for pending PCP/ECM/CS cap payments	Amounts owed to capitated provider groups, delegated entities, or vendors under per-member-per-month payment arrangements.
14,992,192	Physician Payable	\$14M Prop 56 Risk Corridor accrual - additional Medi-Cal provider payments funded by California's Proposition 56 (Tobacco Tax Act of 2016) \$1M Ground Emergency Medical Transport (GEMT) IBNP	Amounts owed directly to physicians and physician organizations for healthcare services rendered.
24,594,510	DHCS - Reserve for Capitation Recoup	\$10M ECM Risk Corridor (2023-2026), \$9M FY22/23 Premium Retro Overpayment reserve \$5m FY 20/21 Covid-19 Risk Corridor liability	Estimated liability for amounts expected to be repaid to DHCS resulting from capitation overpayments, reconciliations, or other settlement adjustments.
6,414,170	Lease Payable- ROU	Value of leased property for the next 12 months	Current portion of lease obligations due within the next 12 months, recorded under ASC 842 Right-of-Use (ROU) accounting rules.
3,527,024	Accounts Payable	Invoices in process	Unpaid vendor invoices for goods and services already received.
799,594	Accrued NetMark	Netmark claim processing invoice accrual	Accrued liability for NetMark services provided but not yet invoiced or
16,269,487	Accrued Provider Incentives/Reserve	Provider incentives for various programs and contracts, and some speciality reserves	Estimated amounts owed to providers based on quality, performance, shared savings, risk-sharing, or other incentive arrangements.
8,620,239	Accrued Expenses	QIPP (\$5M) and passthrough funding (in this case 2025 SNF WQIP)	General operating expenses incurred but not yet invoiced or paid as of the reporting date.
72,417,960	Accrued Premium Tax	MCO Tax	Estimated liability for California's Managed Care Organization (MCO) Tax. This represents state-assessed taxes incurred based on covered member months that have not yet been remitted.
1,047,943	Accrued Interest Payable	Subscription-Based Information Technology Arrangement (SBITA) interest	Under GASB Statement No. 96, a subscription liability is measured at the present value of future subscription payments expected to be made over the subscription term, and it continuously incurs interest expense as the liability is amortized over time. This account holds the as-yet unpaid accumulated interest.
23,882,816	Accrued Payroll Expense	Employee salary and benefit items, as well as payables deducted from employee compensation	Salaries, PTO, payroll taxes, benefits, and other employee compensation earned but not yet paid.
4,665,731	Quality Withhold	0.25% of 2025 and 2026 premium reserves for potential failure to earnback all of the DHCS 1% revenue withheld.	Amounts associated with the DHCS Quality Withhold Program. DHCS withholds a portion of plan funding that can be earned back through achievement of quality, access, health equity, and performance targets. The balance reflects reserves against recognized revenue to cover possible failure to earn back 100% of withheld revenue.
29,685,991	Long-Term Liabilities: Lease Payable - NonCurrent - ROU	Value of leased property for contract term, per Right-of-Use (ROU) accounting rules, less the value of the next 12 months	Current portion of lease obligations due within the next 12 months, recorded under ASC 842 Right-of-Use (ROU) accounting rules.
360,110,836			

IBNP Reserve information with completion



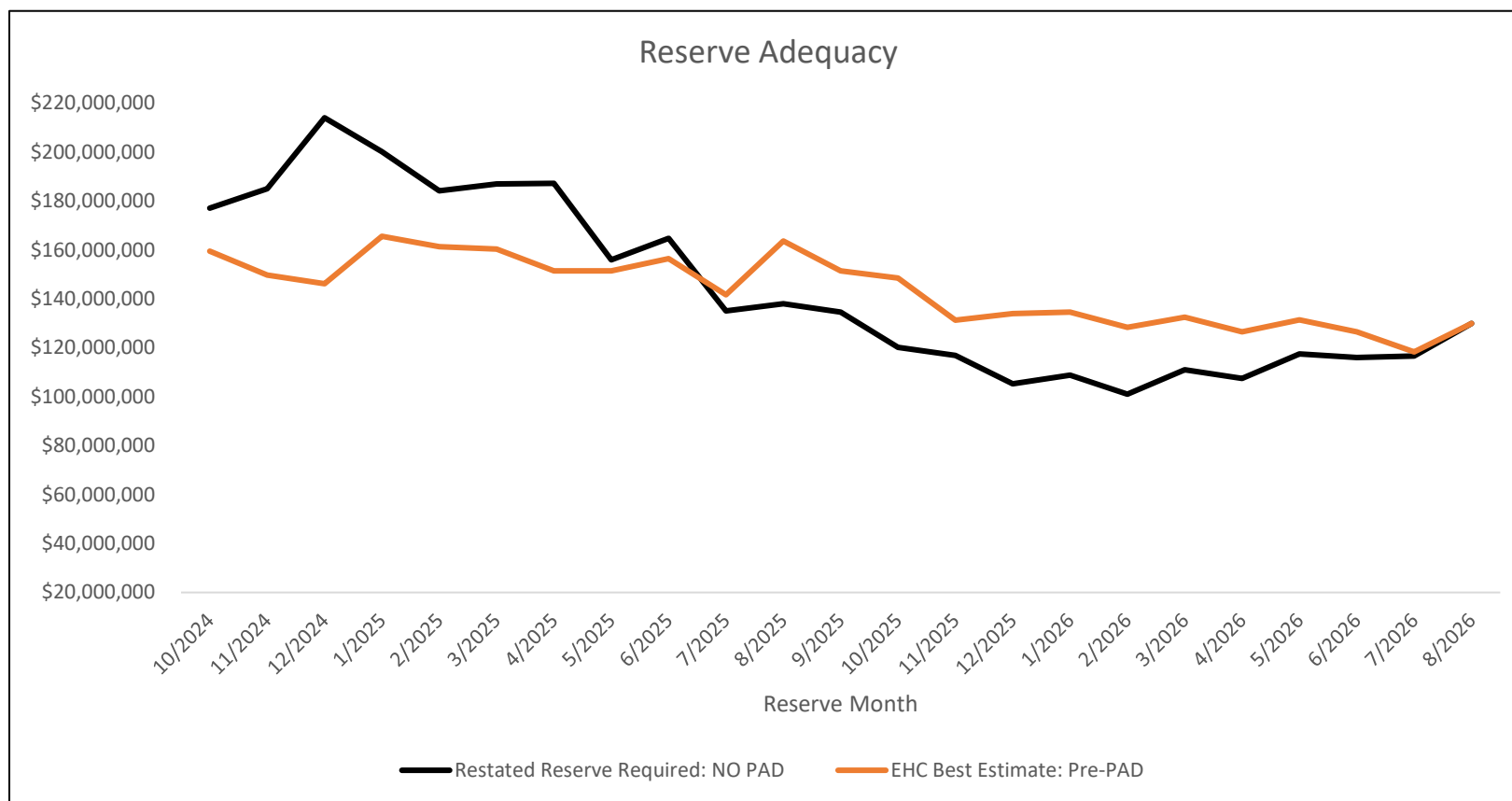
* PAD (Provision for Adverse Deviation) is an additional reserve margin above the actuarial best estimate intended to protect the Plan against unfavorable claim development and normal uncertainty in estimating unpaid claims.

MOS	MMs	Paid PMPM	Complete PMPM	Completion Rate	IBNP \$	IBNP with PAD
8/2024	247,745	\$ 289.22	\$ 289.23	100.0%	\$ 3,403	\$ 3,743
9/2024	247,167	\$ 267.06	\$ 267.10	100.0%	\$ 8,389	\$ 9,228
10/2024	245,976	\$ 303.01	\$ 303.09	100.0%	\$ 19,490	\$ 21,439
11/2024	244,930	\$ 284.96	\$ 285.14	99.9%	\$ 46,182	\$ 50,800
12/2024	247,057	\$ 290.94	\$ 291.22	99.9%	\$ 69,812	\$ 76,794
1/2025	246,741	\$ 316.47	\$ 316.87	99.9%	\$ 99,340	\$ 109,274
2/2025	245,571	\$ 284.33	\$ 284.78	99.8%	\$ 112,681	\$ 123,949
3/2025	243,590	\$ 316.74	\$ 317.39	99.8%	\$ 157,659	\$ 173,425
4/2025	242,560	\$ 307.26	\$ 308.07	99.7%	\$ 196,299	\$ 215,928
5/2025	242,352	\$ 314.34	\$ 315.31	99.7%	\$ 234,711	\$ 258,182
6/2025	242,857	\$ 305.16	\$ 306.31	99.6%	\$ 278,596	\$ 306,456
7/2025	243,235	\$ 318.13	\$ 319.59	99.5%	\$ 354,210	\$ 389,630
8/2025	242,297	\$ 325.84	\$ 327.64	99.5%	\$ 435,244	\$ 478,768
9/2025	241,231	\$ 317.58	\$ 319.81	99.3%	\$ 537,244	\$ 590,968
10/2025	240,411	\$ 325.24	\$ 328.78	98.9%	\$ 850,005	\$ 935,005
11/2025	240,185	\$ 288.00	\$ 292.53	98.5%	\$ 1,087,373	\$ 1,196,110
12/2025	238,833	\$ 310.95	\$ 318.75	97.6%	\$ 1,862,588	\$ 2,048,847
1/2026	235,558	\$ 348.98	\$ 365.29	95.5%	\$ 3,842,183	\$ 4,226,401
2/2026	233,403	\$ 300.53	\$ 318.66	94.3%	\$ 4,231,801	\$ 4,654,981
3/2026	232,184	\$ 334.08	\$ 361.01	92.5%	\$ 6,251,629	\$ 6,876,792
4/2026	230,312	\$ 315.35	\$ 347.14	90.8%	\$ 7,321,781	\$ 8,053,959
5/2026	228,340	\$ 309.65	\$ 350.56	88.3%	\$ 9,342,713	\$ 10,276,984
6/2026	226,313	\$ 310.31	\$ 366.53	84.7%	\$ 12,724,081	\$ 13,996,490
7/2026	224,003	\$ 271.72	\$ 362.60	74.9%	\$ 20,357,792	\$ 22,393,571
8/2026	222,547	\$ 82.51	\$ 350.23	23.6%	\$ 59,580,410	\$ 65,538,451

MOS	MMs	Paid PMPM	Complete PMPM	Completion Rate	IBNP \$	IBNP with PAD
CY2023	1,717,802	\$ 241.60	\$ 241.60	100.0%	\$ -	\$ -
CY2024	2,988,446	\$ 277.50	\$ 277.55	100.0%	\$ 147,275	\$ 162,003
CY2025	2,909,863	\$ 310.82	\$ 312.96	99.3%	\$ 6,205,948	\$ 6,826,543
Recent 12	2,793,320	\$ 293.90	\$ 339.72	86.5%	\$ 127,989,598	\$ 140,788,558
Total	9,448,771	\$ 282.73	\$ 296.49	95.4%	\$ 130,005,612	\$ 143,006,173

IBNP Reserve Adequacy Review

IBNP Reserve Adequacy Review: We evaluated the current best estimate of the Q4 2025 reserve against the reserve level established at the time of the restatement. The analysis indicates that the reserve was recorded above the amount ultimately needed, resulting in favorable reserve development and a corresponding reserve release. This favorable development is reflected in the positive prior-year adjustments reported today.



Risks and Opportunities

Risks:

- SIS enrollment declines continue to concentrate higher-acuity members within the remaining population, increasing medical cost pressure and contributing to projected operating losses.
- Medical cost trends may exceed current forecast assumptions, particularly within the SIS population.
- Further adverse shifts in membership mix could continue to erode Medi-Cal margins and overall financial performance.
- Provider contract renewals, amendments, and rate negotiations may result in higher-than-budgeted reimbursement rates and increased medical expenses.
- Changes to DHCS payment methodologies, risk-adjustment methodologies, or UIS and ECM risk corridor settlement calculations could materially impact future revenue and financial results.
- Increases in Quality Withhold performance thresholds, such as raising achievement levels from CY 2026 85% to CY 2027 95%, may increase financial exposure and reduce quality incentive earnings.
- Future regulatory and policy changes may create additional financial and operational uncertainty.

Opportunities:

- Payment integrity initiatives may generate medical cost savings through improved claims accuracy, recoveries, and fraud, waste, and abuse prevention.
- Workflow enhancement and process automation efforts may improve operational efficiency and reduce administrative expenses.
- Medical cost trend stabilization within the SIS population could improve underlying Medi-Cal performance.
- Membership retention efforts may mitigate further acuity deterioration.
- Additional favorable reserve development and quality incentive earnings could strengthen financial results.

Financial Appendix

2026 8+4 Consolidated Reforecast

2026 8+4 Reforecast - Consolidated														
	Actuals Jan	Actuals Feb	Actuals Mar	Actuals Apr	Actuals May	Actuals Jun	Actuals Jul	Actuals Aug	8+4 Sep	8+4 Oct	8+4 Nov	8+4 Dec	8+4 FCST Total	
Membership	234,533	232,520	230,874	229,114	227,445	225,369	223,511	222,549	221,679	221,064	220,449	219,832	2,708,939	
Revenue	106,750,870	105,442,906	103,232,961	106,380,467	108,503,039	103,505,797	103,939,369	107,345,294	100,409,647	102,977,391	102,803,766	102,626,779	1,253,918,287	
Med Exp	88,148,359	85,468,486	88,951,069	89,214,838	80,428,386	87,021,773	81,254,658	88,208,836	93,503,310	87,595,766	87,406,599	87,755,850	1,044,957,930	
Medical Cost: Quality Improvement	2,438,524	929,919	1,669,567	4,596,531	3,262,959	2,503,553	2,559,763	2,250,008	2,565,831	2,565,831	2,565,831	2,565,831	30,474,146	
Gross Margin	16,163,987	19,044,501	12,612,325	12,569,098	24,811,694	13,980,472	20,124,948	16,886,451	4,340,506	12,815,794	12,831,337	12,305,099	178,486,212	
Admin	14,167,057	13,918,743	8,556,541	11,443,729	14,049,244	12,335,115	11,478,096	10,710,218	14,113,962	15,111,147	14,620,455	14,706,146	155,210,453	
Quality Improvement Credit	(2,438,524)	(929,919)	(1,669,567)	(4,596,531)	(3,262,959)	(2,503,553)	(2,559,763)	(2,250,008)	(2,565,831)	(2,565,831)	(2,565,831)	(2,565,831)	(30,474,146)	
Net Admin	11,728,533	12,988,823	6,886,974	6,847,199	10,786,285	9,831,563	8,918,334	8,460,210	11,548,131	12,545,316	12,054,624	12,140,315	124,736,307	
Net Operating Income/(Loss)	4,435,454	6,055,677	5,725,351	5,721,900	14,025,409	4,148,909	11,206,615	8,426,241	(7,207,625)	270,478	776,713	164,784	53,749,905	
Non Operating														
Interest Income	935,980	804,336	840,679	981,423	837,377	1,066,483	889,022	1,145,329	1,000,000	1,000,000	1,000,000	1,000,000	11,500,629	
Quality Strategy	4,241,493	4,155,011	4,450,261	3,947,013	5,185,191	3,623,161	3,935,438	6,910,993	4,485,320	4,493,325	4,501,330	4,509,146	54,437,682	
Amortization	1,226,970	1,191,534	1,239,705	1,226,806	1,185,068	1,307,737	1,262,847	1,259,819	1,256,182	1,256,182	1,256,182	1,256,182	14,925,215	
Net Non-Operating Income	(4,532,483)	(4,542,208)	(4,849,287)	(4,192,396)	(5,532,883)	(3,864,415)	(4,309,263)	(7,025,483)	(4,741,502)	(4,749,507)	(4,757,512)	(4,765,328)	(57,862,268)	
Net Income/(Loss)	(97,029)	1,513,469	876,064	1,529,504	8,492,526	284,495	6,897,351	1,400,758	(11,949,128)	(4,479,029)	(3,980,799)	(4,600,545)	(4,112,363)	

2026 8+4 Reforecast vs. Reforecast - Medicaid						8+4 vs 4+8	8+4 vs Budget
	Actuals Aug YTD	FCST Sep- Dec	8+4 Full Year	4+8 Full Year	Original Budget Full Year	B / (W) Full Year	B / (W) Full Year
Membership	1,821,419	879,268	2,700,687	2,684,810	2,735,495	15,877	(34,808)
Revenue	836,818,770	401,830,634	1,238,649,404	1,221,209,031	1,225,942,564	17,440,374	12,706,840
Med Exp	680,343,634	349,212,996	1,029,556,630	1,022,155,104	1,036,408,636	(7,401,527)	6,852,006
Medical Cost: Quality Improvement	20,011,086	10,127,834	30,138,921	24,094,951	22,085,454	(6,043,969)	(8,053,467)
Gross Margin	136,464,049	42,489,804	178,953,853	174,958,975	167,448,474	3,994,878	11,505,379
Admin	92,368,688	54,157,136	146,525,824	146,892,805	147,179,710	366,981	653,887
Quality Improvement Credit	(20,011,086)	(10,127,834)	(30,138,921)	(24,094,951)	(22,085,454)	6,043,969	8,053,467
Net Admin	72,357,601	44,029,302	116,386,903	122,797,854	125,094,256	6,410,951	8,707,353
Net Operating Income/(Loss)	64,106,448	(1,539,498)	62,566,950	52,161,122	42,354,218	10,405,828	20,212,732
Non Operating							
Interest Income	7,500,479	4,000,000	11,500,479	11,562,419	12,000,000	(61,939)	(499,521)
Quality Strategy	36,084,443	17,635,402	53,719,844	48,462,446	42,924,042	(5,257,398)	(10,795,802)
Amortization	8,321,461	4,220,772	12,542,233	14,803,276	9,286,264	2,261,043	(3,255,969)
Net Non-Operating Income	(36,905,425)	(17,856,174)	(54,761,598)	(51,703,304)	(40,210,306)	(3,058,295)	(14,551,292)
Net Income/(Loss)	27,201,023	(19,395,671)	7,805,352	457,818	2,143,911	7,347,534	5,661,441

8+4 Medicaid

MLR	85.6%
ALR	9.4%
NNOIR	-4.4%

2026 8+4 Medi-Cal Reforecast

2026 8+4 Reforecast - Medicaid														
	Actuals Jan	Actuals Feb	Actuals Mar	Actuals Apr	Actuals May	Actuals Jun	Actuals Jul	Actuals Aug	8+4 Sep	8+4 Oct	8+4 Nov	8+4 Dec	8+4 FCST Total	
Membership	234,274	232,082	230,340	228,565	226,858	224,703	222,776	221,821	220,867	220,167	219,467	218,767	2,700,687	
Revenue (Net of MCO Premium)	106,278,297	104,537,047	102,215,007	105,338,676	107,412,738	102,356,852	102,607,670	106,072,482	98,899,156	101,308,783	100,977,040	100,645,656	1,238,649,404	
Med Exp	88,122,519	84,136,324	87,762,794	88,099,669	79,209,894	85,456,900	80,558,714	86,996,820	91,989,280	85,914,310	85,555,001	85,754,405	1,029,556,630	
Medical Cost: Quality Improvement	2,401,946	915,970	1,710,018	4,539,074	3,222,172	2,472,258	2,527,766	2,221,882	2,531,959	2,531,959	2,531,959	2,531,959	30,138,921	
Gross Margin	15,753,832	19,484,752	12,742,196	12,699,933	24,980,672	14,427,694	19,521,190	16,853,780	4,377,918	12,862,514	12,890,080	12,359,292	178,953,853	
Admin	10,530,847	13,296,349	10,912,824	10,759,871	13,611,056	11,662,280	11,126,867	10,468,594	12,952,064	13,985,997	13,602,996	13,616,080	146,525,824	
Quality Improvement Credit	(2,401,946)	(915,970)	(1,710,018)	(4,539,074)	(3,222,172)	(2,472,258)	(2,527,766)	(2,221,882)	(2,531,959)	(2,531,959)	(2,531,959)	(2,531,959)	(30,138,921)	
Net Admin	8,128,900	12,380,379	9,202,806	6,220,797	10,388,884	9,190,022	8,599,101	8,246,711	10,420,105	11,454,039	11,071,037	11,084,121	116,386,903	
Net Operating Income/(Loss)	7,624,931	7,104,373	3,539,389	6,479,136	14,591,788	5,237,672	10,922,089	8,607,068	(6,042,187)	1,408,476	1,819,043	1,275,171	62,566,950	
Non Operating														
Interest Income	935,980	804,336	840,679	981,423	837,377	1,066,483	888,872	1,145,329	1,000,000	1,000,000	1,000,000	1,000,000	11,500,479	
Quality Strategy	4,241,493	4,055,011	4,446,511	3,847,013	5,062,596	3,609,253	3,920,480	6,902,086	4,408,850	4,408,850	4,408,850	4,408,850	53,719,844	
Amortization	1,211,633	1,176,639	703,357	1,024,271	983,055	1,104,875	1,060,322	1,057,310	1,055,193	1,055,193	1,055,193	1,055,193	12,542,233	
Net Non-Operating Income	(4,517,146)	(4,427,314)	(4,309,189)	(3,889,860)	(5,208,274)	(3,647,645)	(4,091,930)	(6,814,067)	(4,464,043)	(4,464,043)	(4,464,043)	(4,464,043)	(54,761,598)	
Net Income/(Loss)	3,107,785	2,677,059	(769,799)	2,589,276	9,383,515	1,590,027	6,830,159	1,793,002	(10,506,231)	(3,055,568)	(2,645,000)	(3,188,873)	7,805,352	

2026 8+4 Reforecast vs. Reforecast - Medicaid						8+4 vs 4+8	8+4 vs Budget
	Actuals Aug YTD	FCST Sep- Dec	8+4 Full Year	4+8 Full Year	Original Budget Full Year	B / (W) Full Year	B / (W) Full Year
Membership	1,821,419	879,268	2,700,687	2,684,810	2,735,495	15,877	(34,808)
Revenue	836,818,770	401,830,634	1,238,649,404	1,221,209,031	1,225,942,564	17,440,374	12,706,840
Med Exp	680,343,634	349,212,996	1,029,556,630	1,022,155,104	1,036,408,636	(7,401,527)	6,852,006
Medical Cost: Quality Improvement	20,011,086	10,127,834	30,138,921	24,094,951	22,085,454	(6,043,969)	(8,053,467)
Gross Margin	136,464,049	42,489,804	178,953,853	174,958,975	167,448,474	3,994,878	11,505,379
Admin	92,368,688	54,157,136	146,525,824	146,892,805	147,179,710	366,981	653,887
Quality Improvement Credit	(20,011,086)	(10,127,834)	(30,138,921)	(24,094,951)	(22,085,454)	6,043,969	8,053,467
Net Admin	72,357,601	44,029,302	116,386,903	122,797,854	125,094,256	6,410,951	8,707,353
Net Operating Income/(Loss)	64,106,448	(1,539,498)	62,566,950	52,161,122	42,354,218	10,405,828	20,212,732
Non Operating							
Interest Income	7,500,479	4,000,000	11,500,479	11,562,419	12,000,000	(61,939)	(499,521)
Quality Strategy	36,084,443	17,635,402	53,719,844	48,462,446	42,924,042	(5,257,398)	(10,795,802)
Amortization	8,321,461	4,220,772	12,542,233	14,803,276	9,286,264	2,261,043	(3,255,969)
Net Non-Operating Income	(36,905,425)	(17,856,174)	(54,761,598)	(51,703,304)	(40,210,306)	(3,058,295)	(14,551,292)
Net Income/(Loss)	27,201,023	(19,395,671)	7,805,352	457,818	2,143,911	7,347,534	5,661,441

8+4 Medicaid

MLR	85.4%
ALR	9.4%
NNOIR	-4.4%

2026 8+4 Medicare Reforecast

2026 8+4 Reforecast - Medicare														
	Actuals Jan	Actuals Feb	Actuals Mar	Actuals Apr	Actuals May	Actuals Jun	Actuals Jul	Actuals Aug	8+4 Sep	8+4 Oct	8+4 Nov	8+4 Dec	8+4 FCST Total	
Membership	259	438	534	549	587	666	735	728	812	897	982	1,065	8,252	
Revenue	472,573	905,859	1,017,954	1,041,791	1,090,301	1,148,945	1,331,698	1,272,812	1,510,491	1,668,608	1,826,726	1,981,124	15,268,883	
Med Exp	25,840	1,332,162	1,188,275	1,115,169	1,218,493	1,564,873	695,944	1,212,016	1,514,030	1,681,456	1,851,597	2,001,445	15,401,299	
Medical Cost: Quality Improvement	36,578	13,949	(40,451)	57,457	40,787	31,294	31,997	28,125	33,872	33,872	33,872	33,872	335,225	
Gross Margin	410,155	(440,252)	(129,870)	(130,834)	(168,978)	(447,222)	603,758	32,671	(37,412)	(46,720)	(58,743)	(54,193)	(467,641)	
Admin	3,636,210	622,393	(2,356,283)	683,858	438,188	672,835	351,229	241,624	1,161,899	1,125,150	1,017,459	1,090,066	8,684,629	
Quality Improvement Credit	(36,578)	(13,949)	40,451	(57,457)	(40,787)	(31,294)	(31,997)	(28,125)	(33,872)	(33,872)	(33,872)	(33,872)	(335,225)	
Net Admin	3,599,632	608,444	(2,315,832)	626,402	397,401	641,541	319,232	213,499	1,128,026	1,091,278	983,587	1,056,194	8,349,404	
Net Operating Income/(Loss)	(3,189,477)	(1,048,696)	2,185,962	(757,236)	(566,380)	(1,088,763)	284,526	(180,828)	(1,165,438)	(1,137,998)	(1,042,330)	(1,110,387)	(8,817,045)	
Non Operating														
Interest Income	-	-	-	-	-	-	150	-	-	-	-	-	150	
Quality Strategy	-	100,000	3,750	100,000	122,595	13,908	14,958	8,907	76,470	84,475	92,479	100,296	717,838	
Amortization	15,337	14,894	536,349	202,535	202,014	202,862	202,525	202,509	200,989	200,989	200,989	200,989	2,382,982	
Net Non-Operating Income	(15,337)	(114,894)	(540,099)	(302,535)	(324,609)	(216,770)	(217,333)	(211,416)	(277,459)	(285,464)	(293,469)	(301,285)	(3,100,670)	
Net Income/(Loss)	(3,204,815)	(1,163,590)	1,645,863	(1,059,772)	(890,989)	(1,305,533)	67,193	(392,244)	(1,442,897)	(1,423,461)	(1,335,799)	(1,411,672)	(11,917,715)	

2026 8+4 Reforecast vs. Reforecast - Medicare						8+4 vs 4+8	8+4 vs Budget
	Actuals Aug YTD	FCST Sep- Dec	8+4 Full Year	4+8 Full Year	Original Budget Full Year	B / (W) Full Year	B / (W) Full Year
Membership	4,496	3,756	8,252	9,205	9,122	(953)	(870)
Revenue	8,281,934	6,986,949	15,268,883	17,892,411	18,551,127	(2,623,528)	(3,282,244)
Med Exp	8,352,771	7,048,529	15,401,299	17,941,765	17,896,553	2,540,466	2,495,254
Medical Cost: Quality Improvement	199,736	135,489	335,225	799,693	1,000,000	464,469	664,775
Gross Margin	(270,573)	(197,068)	(467,641)	(849,048)	(345,426)	381,406	(122,215)
					18,896,553		
Admin	4,290,055	4,394,574	8,684,629	10,050,477	10,911,752	1,365,848	2,227,123
Quality Improvement Credit	(199,736)	(135,489)	(335,225)	(799,693)	(1,000,000)	(464,469)	(664,775)
Net Admin	4,090,319	4,259,085	8,349,404	9,250,784	9,911,752	901,380	1,562,348
Net Operating Income/(Loss)	(4,360,892)	(4,456,153)	(8,817,045)	(10,099,832)	(10,257,178)	1,282,786	1,440,133
Non Operating							
Interest Income	150	-	150	-	-	150	150
Quality Strategy	364,118	353,720	717,838	216,011	75,958	(501,827)	(641,880)
Amortization	1,579,025	803,957	2,382,982	196,488	500,000	(2,186,493)	(1,882,982)
Net Non-Operating Income	(1,942,993)	(1,157,676)	(3,100,670)	(412,499)	(575,958)	(2,688,170)	(2,524,712)
Net Income/(Loss)	(6,303,886)	(5,613,829)	(11,917,715)	(10,512,331)	(10,833,136)	(1,405,384)	(1,084,579)

8+4 Medicare

MLR	103.1%
ALR	54.7%
NNOIR	-20.3%



AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Executive Finance Committee
FROM: Christopher Lee, Chief Financial Officer
Scott Campbell, General Counsel
DATE: October 22, 2026
SUBJECT: Consideration of Recommendation for a Provider Advance Policy

SUMMARY:

Staff is presenting the proposed Claims Payment Advance and Provider Advance Policy for Executive Finance Committee review and input. The policy establishes the guidelines, approval requirements, financial controls, and documentation standards governing Claims Payment Advances and Provider Advances issued by Gold Coast Health Plan. The policy is intended to support provider network stability and member access to care while ensuring prudent stewardship of public funds through defined eligibility criteria, financial review requirements, repayment standards, approval authorities, and ongoing oversight. Staff is seeking Executive Finance Committee input and a recommendation to the Commission for approval of the policy.

RECOMMENDATION:

Receive and file. Staff recommend that the Executive Finance Committee review and provide input on the Claims Payment Advance and Provider Advance Policy as presented and recommend that the Commission approve the policy.

ATTACHMENT:

Provider Advance Policy

POLICY AND PROCEDURE	
TITLE: Claims Payment Advance and Provider Advance Policy	
DEPARTMENT: Finance	POLICY #: F-Xxxxx
EFFECTIVE DATE: TBD	REVIEW/REVISION DATE: Not Set
COMMITTEE APPROVAL DATE: Not Set	RETIRE DATE: Not Set
PRODUCT TYPE: Medi-Cal	REPLACES: New Policy

I. Purpose

- A. The purpose of this policy is to establish the guidelines, approval requirements, financial controls, and documentation standards governing Claims Payment Advances and Provider Advances issued by Gold Coast Health Plan ("GCHP").
- B. GCHP recognizes that temporary payment disruptions or provider financial hardships may occur from time to time. GCHP also recognizes its fiduciary responsibility as a public entity to safeguard public assets while maintaining network adequacy, member access to care, and the long-term viability of Safety Net providers.
- C. This policy establishes the criteria under which financial assistance may be provided to contracted healthcare providers while ensuring prudent stewardship of GCHP resources.

II. Policy

- A. Provider financial assistance may be provided only under the circumstances described in this policy.
- B. Claims Payment Advances and Provider Advances are distinct transactions and shall be evaluated separately.
- C. No provider shall be entitled to receive an advance solely by virtue of participating in the GCHP network.
- D. All Claims Payment Advances and Provider Advances shall be evaluated on a case-by-case basis and shall be subject to documented financial review and approval requirements.
- E. The Provider Advance shall be secured through contractual repayment rights, offset rights, assigned receivables, documented repayment sources, or other repayment mechanisms acceptable to GCHP.

III. Definitions

- A. **Claims Payment Advance:** A temporary payment acceleration related to claims, encounters, capitation, or other amounts already earned or expected to be payable by GCHP to a provider. A Claims Payment Advance is intended to address administrative, claims processing, reconciliation, system configuration, or payment timing issues. A Claims Payment Advance is not considered a loan. Claims Payment Advance shall be fully recoverable through future settlements or offsets.
- B. **Provider Advance:** A temporary advance payment provided to a contracted provider experiencing cash flow difficulties. A Provider Advance is distinct from a Claims Payment Advance and is considered an advance payment transaction subject to financial review, approval requirements, collateral requirements, and repayment terms.
- C. **Safety Net Provider:** "Safety Net" providers herein are defined as Medi-Cal disproportionate share hospitals, county clinics, federally qualified health centers, and licensed rural health clinics

IV. Procedures

Section I: Claims Payment Advance

Eligibility

Claims Payment Advances may be approved when:

- Claims processing issues delay payment.
- System conversion issues delay reimbursement.
- Encounter reconciliation issues delay settlement.
- Other administrative circumstances prevent normal payment processing.

Requirements

The provider must demonstrate:

- The claims are valid and payable.
- The amount owed can be reasonably estimated.
- The advance amount does not exceed expected future payments.
- Reconciliation accounting and any recoupment can be completed within ninety (90) days.

Administration and Oversight

A Claims Payment Advance is an operational accommodation and is distinct from a Provider Advance.

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A Claims Payment Advance may be recommended by Operations Management when necessary to facilitate the timely resolution of provider payment issues and minimize disruption to participating providers.

Due to the operational nature and time-sensitive circumstances under which Claims Payment Advances may be required, they are exempt from the approval authority requirements applicable to Provider Advances. Notwithstanding the foregoing, issuance of a Claims Payment Advance requires the review and approval of the Chief Financial Officer (CFO)

Monitoring and Reporting

To provide oversight and visibility into outstanding Claims Payment Advances, Operations shall provide a quarterly report to the Chief Executive Officer and Chief Financial Officer identifying all outstanding Claims Payment Advances.

The report shall include:

- Provider name
- Amount outstanding
- Length of time the advance has been outstanding
- Brief description of the underlying issue requiring the advance
- Expected recoupment or recovery timeline

The purpose of this reporting requirement is to provide executive oversight of the Claims Payment Advances while preserving Operations' ability to efficiently administer and resolve provider payment issues as they arise.

Section II: Provider Advance

Eligibility

Provider Advances may only be considered when:

- The provider is a Safety Net Provider.
- The provider demonstrates temporary liquidity constraints.
- Failure to provide assistance would materially impact member access, network adequacy, or continuity of care.
- Repayment is reasonably assured.

Advance Payment Review Requirements

- Prior to approval, the Finance Department shall conduct a documented Pass/Fail Advance Payment Review.
- All mandatory requirements must be satisfied.

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- Any exception to satisfaction of the mandatory advance payment review criteria shall require Finance Committee approval regardless of amount.

Mandatory Advance Payment Review Criteria

A. Good Standing Test

Provider shall be in good standing with Plan and with federal and California legal requirements that relate to Provider as a network provider during the term of the Agreement.

For purposes of this policy, a Provider shall be considered in Good Standing if all of the following conditions are met:

- The Provider is not engaged in or pursuing litigation or arbitration or having a pending claim pursuant to the California Government Tort Claims Act (Cal. Gov. Code §§ 810, et. seq.), which is a claim that has been filed against Plan, with the exception of claims alleging fraud or willful injury to the person or property of Provider, a material violation of law, whether willful or negligent, or torts unrelated to its network provider agreement with Provider; and
- The Provider is not demonstrating Sustained Deficiencies or Serious Deficiencies with respect to either performance under the terms and conditions of its network provider agreement with Plan or federal or California legal requirements that relate to Provider as a network provider. Sustained Deficiencies are deficiencies that have continued for six (6) months or more where Plan or a California or federal authority has required corrective action and where Provider has not made good faith efforts to remedy such deficiencies. Serious Deficiencies include any deficiency that could result in serious adverse effects on the health or safety of Plan's members or documented threats to the safety of Plan's staff members.
- The Provider is eligible to participate in Medi-Cal and other applicable federal and state healthcare programs.
- The Provider is not subject to exclusion, suspension, debarment, or other participation restrictions imposed by any federal or state healthcare program.
- The Provider is not subject to a payment suspension resulting from a fraud, waste, or abuse investigation.
- The Provider is not in material breach of its provider agreement with GCHP.
- The Provider is compliant with material licensing, credentialing, accreditation, and regulatory requirements applicable to the services provided.

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- The Provider is not subject to litigation, investigations, audits, regulatory proceedings, or other matters that, in the judgment of Legal and Finance, materially impair repayment ability or increase repayment risk.

Result:

PASS / FAIL

B. Financial Viability Test

The Provider must demonstrate financial viability and the ability to repay the Provider Advance. Financial metrics shall be calculated and evaluated in accordance with Attachment A – Financial Viability Test Definitions and Calculation Standards. Attachment A contains the calculation methodologies, definitions, documentation requirements, examples, and evaluation criteria applicable to each metric. Provider must pass at least four (4) of the following five (5) requirements.

Parent Organization Evaluation

When the Provider is a division, department, agency, subsidiary, or other operating unit of a parent organization, governmental entity, or affiliated organization that is legally responsible for, guarantees, or otherwise provides financial support for repayment of the Provider Advance, GCHP may evaluate financial viability using the consolidated financial statements, financial resources, and repayment capacity of the parent organization, governmental entity, or guarantor.

If a Provider's standalone financial statements do not fully reflect the financial resources available to support repayment, GCHP may calculate the Financial Viability Test metrics using the consolidated financial statements of the parent organization, governmental entity, or guarantor. The financial statements used shall be consistent with the entity providing repayment support or bearing ultimate financial responsibility for the obligation.

The parent organization, governmental entity, or guarantor must provide documentation satisfactory to GCHP demonstrating its legal responsibility for repayment or its commitment to provide financial support. Finance and Legal shall jointly determine whether reliance on the financial resources of the parent organization, governmental entity, or guarantor is appropriate for purposes of satisfying the Financial Viability Test.

Metric	Passing Benchmark
Current Ratio	≥ 1.25
Days Cash on Hand	≥ 30 Days

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Debt Service Coverage Ratio	≥ 1.20
Positive Net Assets	Required
12-Month Cash Flow Forecast	Must demonstrate full repayment

Result:

4 or 5 Passed = PASS

3 or Less Passed = FAIL

C. Repayment Capacity Test

Provider must demonstrate:

Requirement 1: Documented repayment source.

Examples:

- Future claims payments
- Future capitation payments
- Assigned receivables
- Confirmed grant proceeds
- State Directed Payments (SDPs);
- State or federal supplemental payments that have been approved and are reasonably expected to be received
- Other documented payment sources acceptable to GCHP.

Result:

PASS / FAIL

Requirement 2 Coverage Ratio

(Expected Repayment Source ÷ Advance Amount)

Required Minimum: ≥ 3.0x

Result:

PASS / FAIL

D. Provider History Test

Provider must satisfy all of the following:

- No unresolved prior advances
- No defaults on prior repayment obligations
- No unresolved material audit findings related to payment activity that, in the judgment of Finance and Legal, may materially impair the Provider's financial condition, repayment ability, or compliance with applicable law.
- No history of fraudulent billing activity

Result:

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PASS / FAIL

E. Insolvency and Viability Test

Provider must not exhibit indicators of insolvency or inability to continue operations. Provider shall fail this test if any of the following exist:

- Bankruptcy filing
- Receivership or insolvency proceeding
- Going concern audit opinion
- Failure to provide requested financial information
- Existing default on a material repayment obligation
- Inability to demonstrate a documented repayment source acceptable to GCHP.

Result:

PASS / FAIL

F. Tangible Net Equity Safeguard Test

Provider Advance shall not be issued if the Provider's default on repayment would cause GCHP's TNE to fall below required minimum levels as set forth in GCHP's policies or state/federal regulations.

The purpose of this test is to ensure that the issuance of a Provider Advance does not impair GCHP's ability to maintain required regulatory capital levels or comply with Tangible Net Equity ("TNE") requirements established by applicable regulatory authorities and internal Board or Commission policy.

Result:

PASS / FAIL

G. A Provider Advance may only be approved if all the following receive a passing determination:

Test	Results
Good Standing Test	PASS
Financial Viability Test	PASS
Repayment Capacity Test ($\geq 3.0x$)	PASS
Provider History Test	PASS
Insolvency and Viability Test	PASS
Tangible Net Equity Safeguard Test	PASS

Provider Advance Limitations

Provider Advance shall not exceed the lesser of:

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- (a) Twenty-five percent (25%) of annual payments Provider received from GCHP in the previous 12 months.
or
- (b) Ninety (90) days of expected payments to Provider at the time of the request.

Term

- Initial term: Maximum 180 Days
- Extensions: One extension not to exceed 90 additional days.
- Repeat Advances: A Provider may receive a subsequent Provider Advance only after the prior Provider Advance has been repaid in full and a minimum of ninety (90) days has elapsed since the date of final repayment. Under no circumstances may a Provider have more than one (1) Provider Advance outstanding at any time.

Offset Rights

As a condition of receiving a Provider Advance, the Provider shall grant GCHP the right to offset any outstanding Provider Advance against future claims payments, capitation payments, State Directed Payments, supplemental payments, incentive payments, and any other amounts payable by GCHP to the Provider. Such offset rights shall survive the expiration or termination of the Provider Advance agreement until all obligations have been satisfied in full

Interest and Administrative Fee

Provider Advance shall be assessed:

- Administration Fee: The Provider Advance shall be assessed an administrative fee equal to the actual costs incurred by GCHP in evaluating, documenting, funding, monitoring, administering, and collecting the Provider Advance.

Recoverable costs may include:

- Finance Department underwriting and review costs;
- Legal review and documentation costs;
- Compliance and monitoring expenses;
- Collection and recovery costs; and
- Other reasonable costs directly attributable to the Provider Advance.

Administrative fees shall be based upon GCHP's actual costs associated with the Provider Advance.

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- The interest rate shall equal the weighted average yield earned on GCHP's current Money Market investments.

Approval Authority

Amount	Approval
Up to \$250,000	CFO
\$250,001 - \$1,000,000	CEO and CFO
\$1,000,000 - \$10,000,000	Finance Committee
Greater than \$10,000,000	Commission Approval

Documentation Requirements

The provider shall submit:

- Financial statements
- Interim financial reports
- Cash flow forecast
- Description of financial hardship
- Requested amount
- Repayment plan
- Collateral documentation

Finance shall maintain a complete advance payment review file for each Provider Advance.

References

Ventura County Organized Health System Ordinance provisions supporting the long-term viability of participating provider networks and Safety Net providers.

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ATTACHMENT A

Financial Viability Test Definitions and Calculation Standards

Purpose

This attachment establishes definitions, calculation methodologies, documentation requirements, and evaluation standards applicable to the Financial Viability Test.

1. Current Ratio

Current Assets ÷ Current Liabilities. Passing Benchmark: ≥ 1.25 .

Measure's ability to satisfy short-term obligations using short-term assets.

Example

Amount	Approval
Cash	\$2,500,000
Accounts Receivable	\$7,000,000
Other Current Assets	\$500,000
Total Current Assets	\$10,000,000
Current Liabilities	\$8,000,000

Calculation: $\$10,000,000 \div \$8,000,000 = 1.25$

Result: Current Ratio = **1.25; PASS**

The Provider has \$1.25 of current assets available for every \$1.00 of current liabilities.

2. Days Cash on Hand

Unrestricted Cash and Cash Equivalents ÷ Average Daily Operating Expenses.

Passing Benchmark: ≥ 30 Days. Measures operating liquidity.

Example

Item	Amount
Unrestricted Cash	\$6,000,000
Annual Operating Expenses	\$60,000,000

Average Daily Operating Expenses: $\$60,000,000 \div 365 = \$164,384$

Days Cash on Hand: $\$6,000,000 \div \$164,384 = 36.5$ Days

Result: Days Cash on Hand = **36.5 Days; PASS**

The Provider has sufficient unrestricted cash to fund approximately 36 days of operations.

3. Debt Service Coverage Ratio

Net Operating Income Available for Debt Service ÷ Total Annual Debt Service. Passing Benchmark: ≥ 1.20 .

Measure's ability to meet debt obligations

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Example

Item	Amount
Net Operating Income	\$12,000,000
Annual Principal Payments	\$7,000,000
Annual Interest Payments	\$3,000,000
Total Debt Service	\$10,000,000

Calculation: $\$12,000,000 \div \$10,000,000 = 1.20$

Result: DSCR = 1.20; PASS

The Provider generates \$1.20 of cash flow for every \$1.00 of debt service obligations.

4. Positive Net Assets

Total Assets minus Total Liabilities. Passing Benchmark: Positive Net Assets Required.

Net Assets = Total Assets – Total Liabilities

Example

Item	Amount
Total Assets	\$100,000,000
Total Liabilities	\$80,000,000

Calculation: $\$100,000,000 - \$80,000,000 = \$20,000,000$

Result: Net Assets = \$20,000,000; PASS

The Provider maintains a positive net asset position.

5. Twelve-Month Cash Flow Forecast

Forecast must demonstrate operating viability, sufficient liquidity, and full repayment of the Provider Advance within the approved term.

The twelve-month cash flow forecast demonstrates the Provider's ability to Maintain operations; Meet financial obligations; Repay the Provider Advance within the approved repayment term.

Example

Item	Amount
Beginning Cash Balance	\$2,000,000
Projected Operating Revenue	\$50,000,000
State Directed Payments	\$4,000,000
Operating Expenses	(\$48,000,000)

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Debt Service	(\$2,000,000)
Provider Advance Repayment	(\$1,000,000)
Ending Cash Balance	\$5,000,000

Result: The forecast demonstrates Continued operations; Positive cash balances; Ability to repay Provider Advance; **PASS**

Example of Financial Viability Test Evaluation

Metric	Benchmark	Actual	Result
Current Ratio	≥ 1.25	1.35	PASS
Days Cash on Hand	≥ 30	36.5	PASS
Debt Service Coverage Ratio	≥ 1.20	1.15	FAIL
Positive Net Assets	Required	Positive	PASS
12-Month Cash Flow Forecast	Repayment Demonstrated	Yes	PASS

Final Determination: 4 of 5 metrics passed. Positive Net Assets maintained. Cash Flow Forecast demonstrates full repayment.

Result; PASS

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