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

Regular Meeting
Monday, November 16, 2026 2:00 p.m.
Meeting Locations: 4880 Santa Rosa Rd
Camarillo, CA 93012
Community Room

855 Partridge Drive
Ventura, CA 93003

2220 E. Gonzales Dr
Oxnard, CA 93036

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

2400 South C Street
Oxnard, CA 93033

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

Conference Call Number: 1-805-324-7279
Conference ID Number 201 153 321#:

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

AGENDA

CLERK ANNOUNCEMENT

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

CALL TO ORDER

INTERPRETER ANNOUNCEMENT

ROLL CALL

PUBLIC COMMENT

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

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

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

CLOSED SESSION

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

2. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: One
Gold Coast Health Plan has received correspondence which, on the advice of legal counsel, and based upon existing facts and circumstances, there is a significant exposure to litigation against Gold Coast Health Plan. A copy of the letter, redacted to protect certain information, is attached to the agenda.

CONSENT

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

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

RECOMMENDATION: Approve the minutes as presented.

4. Adoption of Commission Meeting Schedule for 2027

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

RECOMMENDATION: Approve the 2027 meeting calendar as presented

5. Approval of Salary Range

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

RECOMMENDATION: Receive and file the 2027 salary range as presented.

6. Written Summary of Quality Improvement & Health Equity Committee: Q2 and Q3 2026.

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

RECOMMENDATION: Staff recommend that the Ventura County Medi-Cal Managed Care Commission receive and file the Quarter 2 and Quarter 3, 2026 Quality Improvement and Health Equity Committee summary.

REPORTS

7. Chief Executive Officer (CEO) Report

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

RECOMMENDATION: Receive and file the report

8. Chief Operations Officer (COO) Report

Staff: Suma Simcoe, Chief Operations Officer

RECOMMENDATION: Receive and file the report

FORMAL ACTION

9. Annual Compliance Plan Updates & Compliance Committee Charter

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

RECOMMENDATION: Approve the Annual Compliance Plan Updates & Compliance Committee Charter as presented.

10. Quality Improvement and Health Equity: 2025 QIHET Program Evaluation

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

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

11. Consideration of Termination of Contract with Netmark and Contracting with Health Edge for Claim Payments and Configuration Operations

Staff: Suma Simcoe, Chief Operations Officer

RECOMMENDATION: Staff's recommendation is that the Commission authorize the Plan to (a) terminate the existing statements of work with Netmark without cause and direct the Chief Executive Officer and Legal staff to negotiate the timeframe and plan for transition services, and (b) authorize the Procurement Director to amend the existing contract with Health Edge to include claims payment and configuration operations.

12. List of Organizations to Promote Public Participation

Staff: Scott Campbell, General Counsel
Marlen Torres, Chief Communications & Community Affairs Officer

RECOMMENDATION: Receive and file.

13. Baker Tilly Audit Results and Summary

Staff: Christopher Lee, Chief Financial Officer
Baker Tilly Representatives

RECOMMENDATION: Receive and file the report.

14. Consideration of Recommendation for Claims Payment Advance and Provider Advance Policies

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

RECOMMENDATION: Staff recommend that the Executive Finance Committee review and provide Input on the Claims Payment Advance and Provider Advance Policies as presented and recommend the Commission approve the policies.

15. Investment 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 Investment Policy as presented and recommend the Commission approve the policy.

16. 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.

17. September Year-To-Date 2026 Financials

Staff: Christopher Lee, Chief Financial Officer

RECOMMENDATION: Accept the financial information as presented

18. 2027 Budget Review

Staff: Christopher Lee, Chief Financial Officer

RECOMMENDATION: Receive and recommend approval of the 2027 budget.

19. 2027 Contract Renewal List

Staff: Christopher Lee, Chief Financial Officer
Bob Bushey, Exec. Director Procurement

RECOMMENDATION: Receive and file

20. 2026 Q3 Procurement Summary

Staff: Christopher Lee, Chief Financial Officer
Bob Bushey, Exec. Director Procurement

RECOMMENDATION: Receive and File

21. 2026 Contract Renewal List

Staff: Christopher Lee, Chief Financial Officer
Bob Bushey, Exec. Director Procurement

RECOMMENDATION: Receive and file

ADJOURNMENT

The next meeting will be held on January 25, 2027 at 2:00 p.m., at the GCHP Building located at 4880 Santa Rosa Rd. Camarillo, CA 93012 in the Community Room

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Administrative Reports relating to this agenda are available at 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 Commission.

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

October 1, 2026

Ventura County Medi-Cal Managed Care Commission
4880 Santa Rosa Road
Camarillo, CA 93012

ATTN: Clerk of the Board

Dear Commissioners,

Please find enclosed two letters for your review regarding a matter involving Gold Coast Health Plan:

1. **A letter from member** [redacted] outlining his authorization for me to assist with his care coordination and his concerns regarding the circumstances that led to my termination.
2. **A companion letter from myself,** [redacted] summarizing the process that occurred, the lack of fact-finding prior to the decision, and my request for oversight review.

These documents are being submitted to the Ventura County Medi-Cal Managed Care Commission because the situation involves issues related to member rights, HIPAA interpretation, dispute-handling procedures, and compliance oversight. We respectfully request that the Commission review the circumstances surrounding this matter and determine whether Gold Coast Health Plan followed appropriate processes and policies.

Thank you for your time and consideration. Please let me know if any additional information or documentation is needed.

Sincerely, [redacted]

October 1, 2026

Ventura County Medi-Cal Managed Care Commission

4880 Santa Rosa Road

Camarillo, CA 93012

ATTN: Clerk of the Board

Dear Ventura County Managed Care Commission,

My name is [redacted] and I am a [redacted] member enrolled with Gold Coast Health Plan. I am writing to bring forward a serious matter involving [redacted] who worked for Gold Coast Health Plan for [redacted]. She was terminated after accessing my member file at my direct request. I respectfully ask the Commission to review the circumstances surrounding this decision.

I understand Gold Coast Health Plan has a policy prohibiting employees from accessing the records of [redacted] However, I believe reasonable consideration should be given when a member—in this case, myself—has a [redacted] Under HIPAA, a patient may authorize a family member to access their Protected Health Information (PHI), and this authorization may be verbal or written. HIPAA also permits disclosure to family members involved in the patient's care when the patient agrees or does not object. I gave [redacted] verbal consent to access my records because I was [redacted] I have also signed written authorizations allowing [redacted] to speak on my behalf and access my PHI with [redacted] Gold Coast Health Plan. Her access was compliant with HIPAA and was done solely to assist me.

[redacted] My [redacted] only to discover that [redacted] I was [redacted] In addition to [redacted]

[redacted] I contacted [redacted] and told her [redacted] and was [redacted] tried to determine next steps.

A Gold Coast Health Plan case manager had contacted [redacted] the week before [redacted] because her phone number is listed on my records. [redacted] informed the case manager of my [redacted]

[redacted] I contacted the Gold Coast case manager, who confirmed the referral. I then contacted [redacted]

She scheduled an [redacted] I did not make the appointment, and I was not honest with [redacted] about missing it.

[redacted] asked if she could speak with [redacted] and I gave her the phone number. [redacted] with no return call. She informed [redacted] in one message that if she did not receive a response, [redacted] Gold Coast Health Plan. Instead of returning the call, [redacted] That [redacted] led to [redacted] termination.

I have filed counter-disputes with Gold Coast Health Plan because this was not a data breach. Under HIPAA, a patient's authorized representative may access PHI when the patient requests it, and I explicitly requested and authorized [redacted] to do so. She did not alter or misuse any information. [redacted] has supported me for years— [redacted] She has been my primary support system.

Even after being terminated, [redacted] was the one who [redacted] She located a [redacted] She worked with [redacted] I have been [redacted] and it has been a lifesaver.

The [redacted] was accepted by Gold Coast Health Plan without first speaking to [redacted] or understanding the circumstances. Gold Coast Health Plan was created by the Ventura County Board of Directors to serve the county's most vulnerable residents. [redacted] was helping me, and her actions were authorized and compliant with HIPAA. Her termination has caused harm to both of us.

I am reaching out to the Ventura County Medi-Cal Managed Care Commission, the body responsible for overseeing Gold Coast Health Plan's compliance functions. I respectfully request that the Commission investigate this matter and review the circumstances surrounding [redacted] termination.

Thank you for your time and consideration.

Sincerely,

[redacted]

October 1, 2026

Ventura County Medi-Cal Managed Care Commission
4880 Santa Rosa Road
Camarillo, CA 93012

ATTN: Clerk of the Board

Dear Ventura County Medi-Cal Managed Care Commission,

My name is [redacted], and I am writing in reference to the letter submitted by [redacted] regarding the circumstances that led to my termination from Gold Coast Health Plan. I served Gold Coast Health Plan [redacted] and am requesting that the Commission review the process and decisions surrounding my separation from employment.

[redacted] I was terminated for accessing [redacted] member file. Gold Coast Health Plan cited a violation of the policy prohibiting employees from accessing the records of [redacted] I understand this policy and have always respected privacy and compliance requirements. However, in this situation, [redacted] explicitly requested my assistance and provided verbal authorization. [redacted]

At no point did I alter, misuse, or disclose any information. My sole intent was to help [redacted] obtain the care [redacted] he urgently needed. My access was limited, purpose-driven, and aligned with his authorization under HIPAA, which permits disclosure to family members involved in a patient's care when the patient agrees or does not object.

The dispute that triggered my termination [redacted] after multiple unsuccessful attempts to obtain a return call regarding [redacted] Gold Coast Health Plan accepted the complaint without first speaking with me or reviewing the circumstances. I was not interviewed, counseled, or given an opportunity to provide context. [redacted] of service, the decision was made without a full or fair process.

I am requesting the Commission's review because this situation involves more than a personnel matter. It concerns:

- **Member rights and authorized representation**
- **Proper interpretation of HIPAA allowances**
- **Gold Coast Health Plan's dispute-handling procedures**
- **Whether leadership acted without verifying facts or intent**
- **Whether the policy was applied without considering member vulnerability**

[redacted] is one of the county's [redacted]. He relied on me for support, and I acted in good faith to assist him. His letter provides the member perspective that Gold Coast Health Plan did not consider before taking action.

I respectfully request that the Commission review this matter, including the process followed, the reliance on an unverified external complaint, and the interpretation of HIPAA and Gold Coast policy as it relates to authorized family involvement in member care.

Thank you for your time and consideration.

Sincerely, [redacted]

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: November 16, 2026

SUBJECT: Commission Meeting Minutes of October 29, 2026

RECOMMENDATION:

Approve the minutes.

ATTACHMENT:

Copy of Commission meeting minutes for October 29, 2026

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

October 29, 2026

CALL TO ORDER

Committee Chair Laura Espinosa called the meeting to order at 10:11 a.m. The meeting was held in the Community Room located at 4880 Santa Rosa Road Camarillo, CA 93012.

INTERPRETER ANNOUNCEMENT

The interpreter made her announcement.

ROLL CALL

Present: Commissioners Allison Blaze, M.D., Laura Espinosa, Demitric Franklin, Supervisor Vianey Lopez, Anna Monroy, Tim Myers, Roger Robinson, and Mark Sewell.

Absent: Commissioner Doulas Kleam and Yohan Perera, M.D

Attending the meeting for GCHP were Felix L. Nunez, M.D., CEO, COS Erik Cho, CFO Christopher Lee, Robert Franco CCO, Eve Gelb, Chief Product Officer, Ted Bagley, CDO, Marlen Torres, CCCAO, Paul Aguilar, CHRO, Suma Simcoe, COO, James Cruz, CMO, Leeann Habte of BBK Law, and Scott Campbell, General Counsel.

Also in attendance were the following GCHP Staff: Lupe Gonzalez, Holly Krull, Joanna Hioureas, Pauline Preciado, Kris Schmidt, Brenda Gomez-Garcia, Chris Dulan, Josephine Gallella, Kim Timmerman, David Tovar, Adriana Sandoval, Michelle Espinoza, Nicole Kanter, Kim Marquez-Johnson, Nathan Norbryhn, Vicki Wrighster, Lupe Harrion, Kevin Ortloff, Ben Lacy, Paul VerHaar, Susana Enriquez-Euyoque, Xochitl Boehm, Veronica Estrada, John Shi, Jeff Register, Alexis Maddox, Lupe Nunez, Shaker Eissa, Bianca Naron, Murray Borkan, Supheap Sea, Chelsea Lesure-Gomez, Carolyn Harris, Alison Jewell, Erica Rocha, Joanna Cruz, Julie Martinez, Michael Fish, Patricia Lingasin, Monica Hernandez, Adriana Valladolid, Raj Kasireddy, Mayra Hernandez, and Sandi Walker

PUBLIC COMMENT

- Dr. Gabino Aguirre – Against the Closure of Santa Paula Hospital
- Christina & Alex Velasco – Against the Closure of Santa Paula Hospital & lack of services to Santa Clara River Valley

Commissioner Yohan Perera, M.D. arrived to the meeting at 10:21 a.m.

- Antonio Alatorre – Protecting access to Hospital in Santa Clara Valley

- Christina Villasenor – Against the Closure of Santa Paula Hospital & need for healthcare in the Santa Clara Valley
- Rosie's Taxi / Ben – Questioning sole contract with Ventura Transportation
- Norma Perez-Sanford – Santa Paula Hospital needed

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care special Commission meeting minutes of October 5, 2026

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

RECOMMENDATION: Approve the minutes as presented.

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

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Laura Espinosa, Demitric Franklin, Douglas Kleam, Supervisor Vianey Lopez, Anna Monroy, Roger Robinson, and Mark Sewell

NOES: None.

ABSTAIN: Commissioners Yohan Perera, M.D., and Scott Underwood, D.O.

ABSENT: Commissioner Douglas Kleam

Motion carried.

2. Recuperative Care Sustainability Project Amendment

Staff: Erik Cho, Chief of Staff & Strategy Officer

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

The following commissioners were recused from voting on agenda item 2.

- Commissioner Allison Blaze, M.D.
- Commissioner Demitric Franklin
- Yohan Perera, M.D.
- Commissioner Scott Underwood, D.O.

Commissioner Douglas Kleam left the meeting at 11:05 a.m.

Due to lack of a quorum for agenda item 2, the item was tabled until later in the day.

The Strategic Planning Retreat began immediately after.

Commissioner Scott Underwood, D.O., left the strategic planning retreat at 11:58 a.m.

The Commission meeting restarted at 3:10 p.m.

PUBLIC COMMENT

- Cynthia Salas - Against the Closure of Santa Paula Hospital & need for healthcare in the Santa Clara Valley
- MaryAnn Krause – Wrote a five page public comment which was ready by the Clerk and distributed to all Commissioners and the GCHP Executive Team.

2. Recuperative Care Sustainability Project Amendment

Staff: Erik Cho, Chief of Staff & Strategy Officer

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

Commissioner Abbas motioned to approve the Recuperative Care Sustainability Project Amendment as presented. Commissioner Robinson seconded the motion.

Roll Call Vote as follows:

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

NOES: None.

ABSTAIN: Commissioners Allison Blaze, M.D., Demitric Franklin, and Yohan Perera, M.D.

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

Motion carried.

ADJOURNMENT

With no other business to conduct, the meeting was adjourned at 3:36 p.m.

Approved:

_____
Maddie Gutierrez, MMC
Sr. Clerk of the Commission

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Maddie Gutierrez, MMC – Sr. Clerk to the Commission

DATE: November 16, 2026

SUBJECT: Adoption of Commission Meeting Schedule for 2027,

SUMMARY:

This item will establish dates for the Ventura County Medi-Cal Managed Care Commission (Commission) meetings for 2027.

RECOMMENDATION:

Approve the 2027 Commission meeting calendar as presented.

ATTACHMENT:

Copy of the 2027 Commission meeting calendar.

Gold Coast Health Plan℠
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2027
Commission Meetings

Commission Reg Meeting 2Pl
Strategic Planning Retreat
March, July & Dec are dark months

January

Su	M	Tu	W	Th	F	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

February

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28						

March

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April

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June

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July

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August

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September

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This meeting will begin at 6PM

October

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November

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December

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Return to Agenda

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: November 16, 2026

SUBJECT: Approval of Salary Range

SUMMARY:

The attached is the 2027 salary range schedule which is required to be provided to the Commission every year by the delineation of authority.

RECOMMENDATION:

Receive and File the 2027 salary range as presented.

2027 GCHP Pay Bands

Job Profile	Pay Rate Type	Compensation Grade	Compensation Range		
			Minimum	Midpoint	Maximum
Contact Center Care Coordinator I	Hourly	1	$22.04	$26.45	$30.85
Mailroom Associate	Hourly	1	$22.04	$26.45	$30.85
Administrative Assistant	Hourly	2	$25.04	$30.05	$35.06
Care Management Coordinator I	Hourly	2	$25.04	$30.05	$35.06
Clinical Operations Assistant I	Hourly	2	$25.04	$30.05	$35.06
Contact Center Care Coordinator II	Hourly	2	$25.04	$30.05	$35.06
Facilities Administrative Technician	Hourly	2	$25.04	$30.05	$35.06
Grievance and Appeals Intake Coordinator I	Hourly	2	$25.04	$30.05	$35.06
Health Navigator I	Hourly	2	$25.04	$30.05	$35.06
Member Care Ambassador	Hourly	2	$25.04	$30.05	$35.06
Pharmacy Technician	Hourly	2	$25.04	$30.05	$35.06
Provider Network Operations Associate	Hourly	2	$25.04	$30.05	$35.06
Care Management Coordinator II	Hourly	3	$28.05	$33.65	$39.26
Care Navigator	Hourly	3	$28.05	$33.65	$39.26
Claims Analyst II	Hourly	3	$28.05	$33.65	$39.26
Claims Intake Specialist	Hourly	3	$28.05	$33.65	$39.26
Clinical Operations Assistant II	Hourly	3	$28.05	$33.65	$39.26
Communications Specialist I	Hourly	3	$28.05	$33.65	$39.26
Grievance and Appeals Specialist I	Hourly	3	$28.05	$33.65	$39.26
Health Navigator II	Hourly	3	$28.05	$33.65	$39.26
Operations Liaison	Hourly	3	$28.05	$33.65	$39.26
Purchasing Coordinator	Hourly	3	$28.05	$33.65	$39.26
Quality Improvement Coordinator	Hourly	3	$28.05	$33.65	$39.26
Senior Administrative Assistant	Hourly	3	$28.05	$33.65	$39.26
Senior Contact Center Care Coordinator	Hourly	3	$28.05	$33.65	$39.26
Senior Member Care Ambassador	Hourly	3	$28.05	$33.65	$39.26
Senior Pharmacy Technician	Hourly	3	$28.05	$33.65	$39.26
Service Desk Technician II	Hourly	3	$28.05	$33.65	$39.26

Job Profile	Pay Rate Type	Compensation Grade	Compensation Range		
			Minimum	Midpoint	Maximum
Care Management Coordinator III	Hourly	4NE	$32.05	$38.46	$44.87
Claims Operations Analyst	Hourly	4NE	$32.05	$38.46	$44.87
Clinical Operations Assistant III	Hourly	4NE	$32.05	$38.46	$44.87
Grievance and Appeals Specialist II	Hourly	4NE	$32.05	$38.46	$44.87
Health Navigator III	Hourly	4NE	$32.05	$38.46	$44.87
Medicare D-SNP Telesales Agent	Hourly	4NE	$32.05	$38.46	$44.87
Operations Data Analyst	Hourly	4NE	$32.05	$38.46	$44.87
Operations Liaison II	Hourly	4NE	$32.05	$38.46	$44.87
Operations Oversight Analyst	Hourly	4NE	$32.05	$38.46	$44.87
Provider Data Coordinator	Hourly	4NE	$32.05	$38.46	$44.87
Provider Dispute Resolution Analyst	Hourly	4NE	$32.05	$38.46	$44.87
Quality Assurance Analyst	Hourly	4NE	$32.05	$38.46	$44.87
Security Analyst	Hourly	4NE	$32.05	$38.46	$44.87
Senior Administrative Analyst	Hourly	4NE	$32.05	$38.46	$44.87
Senior Care Navigator	Hourly	4NE	$32.05	$38.46	$44.87
Senior Service Desk Technician	Hourly	4NE	$32.05	$38.46	$44.87
Operations Oversight Analyst II	Hourly	5NE	$38.06	$45.67	$53.29
Quality Assurance Analyst II	Hourly	5NE	$38.06	$45.67	$53.29
Senior Claims Auditor	Hourly	5NE	$38.06	$45.67	$53.29
Senior Claims Operations Analyst	Hourly	5NE	$38.06	$45.67	$53.29
Senior Facilities Administrative Tech	Hourly	5NE	$38.06	$45.67	$53.29
Senior Operations and Provider Support Analyst	Hourly	5NE	$38.06	$45.67	$53.29
Senior Provider Dispute Resolution Analyst	Hourly	5NE	$38.06	$45.67	$53.29
SharePoint Administrator	Hourly	5NE	$38.06	$45.67	$53.29
AP- Payroll Specialist	Salary	4E	$66,667.00	$80,000.00	$93,333.00
Behavioral Health Program Specialist I	Salary	4E	$66,667.00	$80,000.00	$93,333.00
Communications Specialist II	Salary	4E	$66,667.00	$80,000.00	$93,333.00
Community Relations Specialist	Salary	4E	$66,667.00	$80,000.00	$93,333.00
Provider Contracts Specialist I	Salary	4E	$66,667.00	$80,000.00	$93,333.00

Job Profile	Pay Rate Type	Compensation Grade	Compensation Range		
			Minimum	Midpoint	Maximum
Provider Data Specialist I	Salary	4E	$66,667.00	$80,000.00	$93,333.00
Provider Network Operations Specialist	Salary	4E	$66,667.00	$80,000.00	$93,333.00
Quality Improvement Specialist	Salary	4E	$66,667.00	$80,000.00	$93,333.00
Sales Agent	Salary	4E	$66,667.00	$80,000.00	$93,333.00
Senior Cultural and Linguistic Specialist	Salary	4E	$66,667.00	$80,000.00	$93,333.00
AP- Payroll Specialist II	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Behavioral Health Program Specialist II	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Behavioral Health Program Specialist II	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Communications Specialist III	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Compliance Specialist	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Credentialing Specialist II	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Delegation Oversight Auditor I	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Health Educator	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Internal Auditor	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Operations Compliance Specialist	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Payment Integrity Analyst	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Policy Analyst	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Project Manager I	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Provider Contracts Specialist II	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Provider Data Specialist II	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Provider Network Regulatory & Compliance Analyst	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Provider Relations Representative - Internal	Hourly	5E	$79,167.00	$95,000.00	$110,833.00
Senior Health Navigator-Educator	Salary	5E	$79,167.00	$95,000.00	$110,833.00
Associate Clerk of the Board-Senior Executive Assistant	Salary	6	$91,667.00	$110,000.00	$128,333.00
Compliance Analyst II	Salary	6	$91,667.00	$110,000.00	$128,333.00
Credentialing Specialist III	Salary	6	$91,667.00	$110,000.00	$128,333.00
Delegation Oversight Auditor II	Salary	6	$91,667.00	$110,000.00	$128,333.00
IT Lead Applications Administrator	Salary	6	$91,667.00	$110,000.00	$128,333.00
LCSW Clinical Care Manager I	Salary	6	$91,667.00	$110,000.00	$128,333.00

Job Profile	Pay Rate Type	Compensation Grade	Compensation Range		
			Minimum	Midpoint	Maximum
Lead Claims Operations Analyst	Salary	6	$91,667.00	$110,000.00	$128,333.00
Lead Service Desk Tech	Salary	6	$91,667.00	$110,000.00	$128,333.00
Medicare Claims Analyst Lead	Salary	6	$91,667.00	$110,000.00	$128,333.00
Operations Business Analyst I	Salary	6	$91,667.00	$110,000.00	$128,333.00
Operations Data Analyst I	Salary	6	$91,667.00	$110,000.00	$128,333.00
Operations Policy Specialist & Copy Editor	Salary	6	$91,667.00	$110,000.00	$128,333.00
Program Analyst	Salary	6	$91,667.00	$110,000.00	$128,333.00
Provider Contracts Specialist III	Salary	6	$91,667.00	$110,000.00	$128,333.00
Provider Dispute Resolution Lead	Salary	6	$91,667.00	$110,000.00	$128,333.00
Provider Network Operations Analyst II	Salary	6	$91,667.00	$110,000.00	$128,333.00
Quality Improvement Data Analyst II	Salary	6	$91,667.00	$110,000.00	$128,333.00
Quality Improvement Program Manager	Salary	6	$91,667.00	$110,000.00	$128,333.00
RN, Clinical Care Manager I	Salary	6	$91,667.00	$110,000.00	$128,333.00
RN, Quality Improvement I	Salary	6	$91,667.00	$110,000.00	$128,333.00
RN, Utilization Management I	Salary	6	$91,667.00	$110,000.00	$128,333.00
Sales Lead	Salary	6	$91,667.00	$110,000.00	$128,333.00
Senior Claims Operations Analyst (Encounters)	Salary	6	$91,667.00	$110,000.00	$128,333.00
Senior Executive Assistant	Salary	6	$91,667.00	$110,000.00	$128,333.00
Senior Payment Integrity Analyst	Salary	6	$91,667.00	$110,000.00	$128,333.00
Senior Policy Analyst	Salary	6	$91,667.00	$110,000.00	$128,333.00
Senior Procurement Specialist	Salary	6	$91,667.00	$110,000.00	$128,333.00
Senior Quality Assurance Analyst	Salary	6	$91,667.00	$110,000.00	$128,333.00
Senior Staff Accountant	Salary	6	$91,667.00	$110,000.00	$128,333.00
System Administrator II	Salary	6	$91,667.00	$110,000.00	$128,333.00
AP- Payroll Lead	Salary	7	$100,000.00	$125,000.00	$150,000.00
Business Systems Analyst II	Salary	7	$100,000.00	$125,000.00	$150,000.00
Configuration Analyst	Salary	7	$100,000.00	$125,000.00	$150,000.00
Data Analyst II	Salary	7	$100,000.00	$125,000.00	$150,000.00
Delegation Oversight Auditor Lead	Salary	7	$100,000.00	$125,000.00	$150,000.00

Job Profile	Pay Rate Type	Compensation Grade	Compensation Range		
			Minimum	Midpoint	Maximum
Health Services Trainer	Salary	7	$100,000.00	$125,000.00	$150,000.00
Human Resources Operations Specialist	Salary	7	$100,000.00	$125,000.00	$150,000.00
LCSW Clinical Care Manager II	Salary	7	$100,000.00	$125,000.00	$150,000.00
Lead Policy Analyst	Salary	7	$100,000.00	$125,000.00	$150,000.00
Manager, Contact Center	Salary	7	$100,000.00	$125,000.00	$150,000.00
Manager, Operations -Configuration	Salary	7	$100,000.00	$125,000.00	$150,000.00
Operations Business Analyst II	Salary	7	$100,000.00	$125,000.00	$150,000.00
Operations Data Analyst II	Salary	7	$100,000.00	$125,000.00	$150,000.00
Payment Integrity Analyst Lead	Salary	7	$100,000.00	$125,000.00	$150,000.00
Population Health Program Manager	Salary	7	$100,000.00	$125,000.00	$150,000.00
Provider Relations Representative - External	Salary	7	$100,000.00	$125,000.00	$150,000.00
Quality Improvement Program Manager II	Salary	7	$100,000.00	$125,000.00	$150,000.00
RN, Clinical Care Manager II	Salary	7	$100,000.00	$125,000.00	$150,000.00
RN, Delegation Oversight Auditor	Salary	7	$100,000.00	$125,000.00	$150,000.00
RN, Quality Improvement II	Salary	7	$100,000.00	$125,000.00	$150,000.00
RN, Utilization Management II	Salary	7	$100,000.00	$125,000.00	$150,000.00
Senior Clerk of the Board	Salary	7	$100,000.00	$125,000.00	$150,000.00
Senior Data Analyst EDI	Salary	7	$100,000.00	$125,000.00	$150,000.00
Senior Financial Analyst	Salary	7	$100,000.00	$125,000.00	$150,000.00
Senior Health Services Business Analyst	Salary	7	$100,000.00	$125,000.00	$150,000.00
Senior IT Quality Control Analyst	Salary	7	$100,000.00	$125,000.00	$150,000.00
Senior Program Analyst	Salary	7	$100,000.00	$125,000.00	$150,000.00
Senior Provider Network Operations Specialist	Salary	7	$100,000.00	$125,000.00	$150,000.00
Senior Specialist, Talent Mgmt & Training	Salary	7	$100,000.00	$125,000.00	$150,000.00
Senior Systems Administrator	Salary	7	$100,000.00	$125,000.00	$150,000.00
Special Investigation Unit Investigator Lead	Salary	7	$100,000.00	$125,000.00	$150,000.00
Clinical Compliance Program Manager	Salary	8	$120,000.00	$150,000.00	$180,000.00
Clinical Pharmacist	Salary	8	$120,000.00	$150,000.00	$180,000.00
Compliance Program Manager	Salary	8	$120,000.00	$150,000.00	$180,000.00

Job Profile	Pay Rate Type	Compensation Grade	Compensation Range		
			Minimum	Midpoint	Maximum
Delegation Oversight Program Manager	Salary	8	$120,000.00	$150,000.00	$180,000.00
Developer III	Salary	8	$120,000.00	$150,000.00	$180,000.00
Executive Administrator	Salary	8	$120,000.00	$150,000.00	$180,000.00
FP&A Product Development Manager	Salary	8	$120,000.00	$150,000.00	$180,000.00
Human Resources Program Manager	Salary	8	$120,000.00	$150,000.00	$180,000.00
LCSW Clinical Care Manager III	Salary	8	$120,000.00	$150,000.00	$180,000.00
Lead Operations Analyst-EDI & Eligibility	Salary	8	$120,000.00	$150,000.00	$180,000.00
Manager, Accounting and Finance	Salary	8	$120,000.00	$150,000.00	$180,000.00
Manager, Behavioral Health	Salary	8	$120,000.00	$150,000.00	$180,000.00
Manager, Care Management & Special Programs	Salary	8	$120,000.00	$150,000.00	$180,000.00
Manager, Clinical Care Management	Salary	8	$120,000.00	$150,000.00	$180,000.00
Manager, Communications	Salary	8	$120,000.00	$150,000.00	$180,000.00
Manager, Community Relations	Salary	8	$120,000.00	$150,000.00	$180,000.00
Manager, Delegation Oversight Audit	Salary	8	$120,000.00	$150,000.00	$180,000.00
Manager, Government Relations	Salary	8	$120,000.00	$150,000.00	$180,000.00
Manager, Internal Audit	Salary	8	$120,000.00	$150,000.00	$180,000.00
Manager, Operations	Salary	8	$120,000.00	$150,000.00	$180,000.00
Manager, Operations Support Services	Salary	8	$120,000.00	$150,000.00	$180,000.00
Manager, Provider Relations	Salary	8	$120,000.00	$150,000.00	$180,000.00
Manager, Utilization Management	Salary	8	$120,000.00	$150,000.00	$180,000.00
Medicare Compliance Manager	Salary	8	$120,000.00	$150,000.00	$180,000.00
Medicare Marketing and Communication Manager	Salary	8	$120,000.00	$150,000.00	$180,000.00
Medicare STARS Program Manager	Salary	8	$120,000.00	$150,000.00	$180,000.00
Microsoft Sharepoint Manager	Salary	8	$120,000.00	$150,000.00	$180,000.00
Program Manager, Medicare D-SNP Enrollment	Salary	8	$120,000.00	$150,000.00	$180,000.00
Provider Contracts Manager	Salary	8	$120,000.00	$150,000.00	$180,000.00
Provider Relations Account Manager	Salary	8	$120,000.00	$150,000.00	$180,000.00
Quality Data Engineer	Salary	8	$120,000.00	$150,000.00	$180,000.00
Quality Improvement Program Manager III	Salary	8	$120,000.00	$150,000.00	$180,000.00

Job Profile	Pay Rate Type	Compensation Grade	Compensation Range		
			Minimum	Midpoint	Maximum
RN, Clinical Care Manager III	Salary	8	$120,000.00	$150,000.00	$180,000.00
RN, Quality Improvement III	Salary	8	$120,000.00	$150,000.00	$180,000.00
RN, Utilization Management III	Salary	8	$120,000.00	$150,000.00	$180,000.00
Senior Business Systems Analyst	Salary	8	$120,000.00	$150,000.00	$180,000.00
Senior Data Analyst	Salary	8	$120,000.00	$150,000.00	$180,000.00
Senior Healthcare Data Analyst	Salary	8	$120,000.00	$150,000.00	$180,000.00
Senior Project Manager	Salary	8	$120,000.00	$150,000.00	$180,000.00
Senior Test Automation Engineer	Salary	8	$120,000.00	$150,000.00	$180,000.00
Senior, IT Business Systems Analyst	Salary	8	$120,000.00	$150,000.00	$180,000.00
Database Administrator Architect	Salary	9	$142,000.00	$177,500.00	$213,000.00
Human Resources Solutions Architect	Salary	9	$142,000.00	$177,500.00	$213,000.00
Manager, Member Engagement	Salary	9	$142,000.00	$177,500.00	$213,000.00
Medicare PBM Senior Operations Manager	Salary	9	$142,000.00	$177,500.00	$213,000.00
Principal Business Systems Analyst	Salary	9	$142,000.00	$177,500.00	$213,000.00
Principal Data Analyst	Salary	9	$142,000.00	$177,500.00	$213,000.00
Principal Developer Data Engineer	Salary	9	$142,000.00	$177,500.00	$213,000.00
Principal Project Manager	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Clinical Compliance Program Manager	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Clinical Pharmacist	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Compliance Program Manager	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Data Operations Engineer	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Data Validation Program Manager	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Human Resources Business Partner	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Manager Clinical Care Management	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Manager of Operations Payment Integrity	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Manager, Accounting	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Manager, Claims Business Operations	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Manager, Clinical Quality Improvement	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Manager, Facilities	Salary	9	$142,000.00	$177,500.00	$213,000.00

Job Profile	Pay Rate Type	Compensation Grade	Compensation Range		
			Minimum	Midpoint	Maximum
Senior Manager, Finance	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Manager, Operations	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Manager, Procurement	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Manager, Provider Network Operations - Program &	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Manager, Quality Improvement	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Medical Policy Manager	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Program Manager, Business Strategies	Salary	9	$142,000.00	$177,500.00	$213,000.00
Senior Manager Contact Center	Salary	9	$142,000.00	$177,500.00	$213,000.00
Director Operations, Claims Execution	Salary	10	$157,303.00	$210,000.00	$262,697.00
Director, Business Solutions	Salary	10	$157,303.00	$210,000.00	$262,697.00
Director, Contact Center	Salary	10	$157,303.00	$210,000.00	$262,697.00
Director, Dual Special Needs Plan DSNP	Salary	10	$157,303.00	$210,000.00	$262,697.00
Director, EDI	Salary	10	$157,303.00	$210,000.00	$262,697.00
Director, Finance	Salary	10	$157,303.00	$210,000.00	$262,697.00
Director, Human Resources	Salary	10	$157,303.00	$210,000.00	$262,697.00
Director, IT Infrastructure and Security Operations	Salary	10	$157,303.00	$210,000.00	$262,697.00
Director, Medicare Sales & Enrollment	Salary	10	$157,303.00	$210,000.00	$262,697.00
Director, Network Operations	Salary	10	$157,303.00	$210,000.00	$262,697.00
Director, Org Performance & Change Leadership	Salary	10	$157,303.00	$210,000.00	$262,697.00
Director, Pharmacy	Salary	10	$157,303.00	$210,000.00	$262,697.00
Director, Population Health	Salary	10	$157,303.00	$210,000.00	$262,697.00
Director, Portfolio and Project Management	Salary	10	$157,303.00	$210,000.00	$262,697.00
Director, Risk Adjustment	Salary	10	$157,303.00	$210,000.00	$262,697.00
Director, Vendor Management	Salary	10	$157,303.00	$210,000.00	$262,697.00
Grants Administration and Oversight Director	Salary	10	$157,303.00	$210,000.00	$262,697.00
Principal Business Relationship Manager	Salary	10	$157,303.00	$210,000.00	$262,697.00
Principal Enterprise Architect	Salary	10	$157,303.00	$210,000.00	$262,697.00
Principal Program Manager, DSNP	Salary	10	$157,303.00	$210,000.00	$262,697.00
Principal Solution Architect	Salary	10	$157,303.00	$210,000.00	$262,697.00

Job Profile	Pay Rate Type	Compensation Grade	Compensation Range		
			Minimum	Midpoint	Maximum
Privacy Officer	Salary	10	$157,303.00	$210,000.00	$262,697.00
Medical Director	Salary	11	$183,750.00	$245,000.00	$306,250.00
Senior Director, Architecture	Salary	11	$183,750.00	$245,000.00	$306,250.00
Senior Director, Audit, Investigation & Privacy	Salary	11	$183,750.00	$245,000.00	$306,250.00
Senior Director, Communications and Marketing	Salary	11	$183,750.00	$245,000.00	$306,250.00
Senior Director, Compliance	Salary	11	$183,750.00	$245,000.00	$306,250.00
Senior Director, Dual Special Needs Plan	Salary	11	$183,750.00	$245,000.00	$306,250.00
Senior Director, Enterprise Analytics & Insights	Salary	11	$183,750.00	$245,000.00	$306,250.00
Senior Director, Health Education, C & L	Salary	11	$183,750.00	$245,000.00	$306,250.00
Senior Director, HR & Organzation Performance	Salary	11	$183,750.00	$245,000.00	$306,250.00
Senior Director, Innovation	Salary	11	$183,750.00	$245,000.00	$306,250.00
Senior Director, Network Operations	Salary	11	$183,750.00	$245,000.00	$306,250.00
Senior Director, Operations	Salary	11	$183,750.00	$245,000.00	$306,250.00
Senior Director, Quality Data	Salary	11	$183,750.00	$245,000.00	$306,250.00
Senior Director, Strategy & Operations	Salary	11	$183,750.00	$245,000.00	$306,250.00
Controller	Salary	12	$213,750.00	$285,000.00	$356,250.00
Executive Director, Health Equity	Salary	12	$213,750.00	$285,000.00	$356,250.00
Executive Director, Health Services	Salary	12	$213,750.00	$285,000.00	$356,250.00
Executive Director, IT	Salary	12	$213,750.00	$285,000.00	$356,250.00
Executive Director, Operations	Salary	12	$213,750.00	$285,000.00	$356,250.00
Executive Director, Population Health and Equity	Salary	12	$213,750.00	$285,000.00	$356,250.00
Executive Director, Procurement	Salary	12	$213,750.00	$285,000.00	$356,250.00
Executive Director, Provider Network Ops & Strategies	Salary	12	$213,750.00	$285,000.00	$356,250.00
Executive Director, Quality Improvement	Salary	12	$213,750.00	$285,000.00	$356,250.00
Chief Communications and Community Affairs Officer	Salary	E1	$258,750.00	$345,000.00	$431,250.00
Chief Compliance Officer	Salary	E1	$258,750.00	$345,000.00	$431,250.00
Chief Diversity Officer	Salary	E1	$258,750.00	$345,000.00	$431,250.00
Chief Financial Officer	Salary	E1	$258,750.00	$345,000.00	$431,250.00
Chief HR & Organizational Performance Officer	Salary	E1	$258,750.00	$345,000.00	$431,250.00

Job Profile	Pay Rate Type	Compensation Grade	Compensation Range		
			Minimum	Midpoint	Maximum
Chief of Staff and Strategy	Salary	E1	$258,750.00	$345,000.00	$431,250.00
Chief Product Officer	Salary	E1	$258,750.00	$345,000.00	$431,250.00
Senior Medical Director	Salary	E1	$258,750.00	$345,000.00	$431,250.00
Chief Medical Officer	Salary	E2	$333,750.00	$445,000.00	$556,250.00
Chief Operating Officer	Salary	E2	$333,750.00	$445,000.00	$556,250.00
Chief Executive Officer	Salary	E3	$412,500.00	$550,000.00	$687,500.00

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: November 16, 2026

SUBJECT: Written Summary of Quality Improvement and Health Equity Committee – Q2 and Q3 2026

RECOMMENDATION:

Staff recommend that the Ventura County Medi-Cal Managed Care Commission accept and file the Quarter 2 and Quarter 3, 2026 Quality Improvement and Health Equity Committee summaries.

ATTACHMENTS:

1) Quality Improvement and Health Equity Committee (QIHEC) Meeting Quarter 2 2026 Summary
2) Quality Improvement and Health Equity Committee (QIHEC) Meeting Quarter 3 2026 Summary

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

Overview

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

May 12, 2026 QIHEC

Action Items

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

- The Senior Manager of the Contact Center met with the Chief Medical Officer to review opportunities for soliciting member satisfaction. Key highlights will be reported at the July QIHEC.

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

Approval Items - None

Presentations

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

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

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

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

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

4. **Total Care Advantage Dual Eligible Special Needs Plan (D-SNP) Quality Update**
The 2026 D-SNP Star Measure target-setting process accounted for historical MCAS/HEDIS performance and industry shifts to ensure the goals are both ambitious and attainable. The strategy includes focus on measures with controllable processes (including Adult Well-Care Exams, Health Risk Assessments, data integration, and pharmacy benefit manager delegation), GCHP's high priority measures, and incentive programs that support improved performance. Successful execution of these targets aims for a Star Rating of 3.16 without weighting, and 3.13 with weighting applied.

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

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

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

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

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

- As of June 2025, 14,018 members were diagnosed with substance use, with the majority being adults aged 21 to 64. The demographic breakdown revealed a prominent Hispanic or Latino representation alongside significant percentages of English and Spanish speakers. However, nearly 20% of the data lacked demographic identification, which underscores a gap in reporting across both race and ethnicity metrics.

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

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

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

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

Wellth Program

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

6. Health Disparities Bi-Annual Report

Health Equity Portfolio Overview

GCHP's health equity portfolio is a targeted, data-driven framework of initiatives designed to eliminate disparities in health care access, quality, and outcomes by addressing both clinical needs and social determinants of health. To improve stratified reporting, GCHP is improving the collection of Race, Ethnicity, Language (REaL), Sexual Orientation/Gender Identity (SOGI), and Social Determinants of Health (SDoH) data through standardized call scripts. Maternal health initiatives aim to identify pregnancies early to connect priority populations with maternal care

and doula support. To combat vaccine hesitancy, targeted outreach using culturally relevant messaging will be deployed across multiple media channels. Additionally, GCHP will align and advance equity-focused communications across member and provider communication channels.

2026 NCQA Changes to Health Equity Accreditation

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

Quality Improvement and Health Equity Committee (QIHEC) Meeting
2026 Quarter 3 Summary Report

Overview

The Gold Coast Health Plan (GCHP) Quality Improvement and Health Equity Committee (QIHEC) meets six times per year, with ad hoc meetings scheduled as needed. The QIHEC is chaired and facilitated by the Chief Medical Officer (CMO), with committee members comprised of internal leadership, the chairs from the ten QIHEC Subcommittees, one Commissioner, at least one practicing physician in the community, and a behavioral healthcare practitioner. This report summarizes the QIHEC meetings held on July 14 and September 15, 2026.

July 14, 2026 QIHEC

Action Items

1. Action Item 69: Blood lead screening reporting on positive screening results
   - Guidance on the 30-day blood lead screening reporting requirement was submitted to the Department of Health Care Services (DHCS) on April 14, and a response is currently pending.
   - Status: Open
2. Action Item 70: Blood lead screening in children timeline requirements
   - Clarification on the DHCS blood lead screening guidelines regarding the catch-up blood lead screening timeline for children, 12 to 24 months, and the catch-up period between 12 to 24 months and 24 to 72 months, was submitted to DHCS and a response is currently pending.
   - Status: Open
3. Action Item 76: Network Operations Access and Availability
   - At the July 2026 QIHEC meeting, the Network Operations department addressed access and availability issues, including establishing target dates to elevate performance measures above the 80% threshold.
   - Status: Closed

Approval Items

1. **QI-002 Quality Improvement and Health Equity Transformation Policy**
   The annual policy review clarified the broad scope of methodologies used for quality improvement projects and activities to reduce health disparities. The long-term care (LTC) measures were removed to align with measurement year 2026 DHCS Managed Care Accountability Set (MCAS) measures. The updates also included a timeline for the Quality Improvement and Health Equity Transformation Program evaluation period and a reference to the DHCS Quality Strategy.

Presentations

1. **Managed Care Accountability Set (MCAS) Rates for Measurement Year (MY) 2025 / Reporting Year (RY) 2026**

For MY 2025, all MCAS measures successfully met or exceeded the Minimum Performance Level (MPL). Notable achievements included 13 measures reaching the 75th percentile or higher and four measures meeting the 90th percentile / High-Performance Level (HPL), including an increase in the Asthma Medication Ratio (AMR) measure from the 10th to the 75th percentile. Almost 5,500 additional care gaps were closed across critical health areas, including child and adolescent screenings, chronic disease management, cancer screenings, and maternal care.

2. **Human Papillomavirus (HPV) Vaccine Provider Communication Training**
   GCHP participated in a two-year National HPV Vaccination Learning Collaborative with the American Cancer Society to increase HPV vaccination rates among children 9 to 13 years of age. This national initiative promoted the Announcement Approach Training (AAT), an evidence-based strategy that teaches healthcare providers how to deliver strong vaccine recommendations and address parental concerns using a presumptive approach. In a large, adolescent-focused trial, AAT boosted HPV vaccination rates by 5% in just three months. Because schools do not mandate the HPV vaccine and the two or three-dose series completion rates remain low, GCHP partnered with Community Memorial Health System (CMHS) to implement AAT at a pilot clinic, with plans to expand the training to other clinics.

3. **National Committee for Quality Assurance (NCQA) Member Experience (ME) 3C: Assessing Member Understanding**
   GCHP surveyed new members to evaluate their understanding of onboarding packets with focus on covered benefits, accessing care, and navigating GCHP systems and policies. The 14-question survey was included in 23,176 new member packets distributed between June 1, 2025, and May 31, 2026. GCHP received 353 responses (68% English, 32% Spanish), which indicated overall member satisfaction. GCHP identified several opportunities for improvement with reviewing prior authorization language to clarify which services require approval, ensuring onboarding packet accuracy, and improving clarity by simplifying technical terms and lowering reading levels.

Department / Sub-Committee Updates

1. **Compliance/Delegation Oversight**
   The Q1 2026 audits evaluated 13 suppliers across focused, annual, and pre-delegation reviews covering various survey periods. A total of 40 findings were identified resulting in Corrective Action Plans (CAPs) for the majority of suppliers. While nine suppliers either successfully closed their CAPs or recorded zero findings, four suppliers [Wellth, Carelon (Call Center and Utilization Management/Grievances & Appeals), and Ventura Transit System (Total Care Advantage / Dual Eligible Special Needs Plan)] had open CAPs. Carelon's Utilization Management, Quality Improvement, Network, and Member Experience audits presented the highest volume of compliance issues with 13 findings. However, four suppliers achieved perfect reviews with no findings reported during their pre-delegation and desktop policy evaluations.

2. **Credentials/ Peer Review Committee (C/PRC)**
   All credentialing/recredentialing metrics met or exceeded all turnaround benchmarks and maintained full compliance with NCQA and internal standards. Credentialing/recredentialing applications were completed within 30 to 60 days and operations were further enhanced

through the Symplr System Optimization Initiative, which successfully improved workflow efficiency, document tracking, and compliance reporting.

The C/PRC approved pediatric therapy and Total Care Advantage/Dual Eligible Special Needs Plan (TCA/D-SNP) clinical practice guidelines. The C/PRC also approved 56 practitioner credentials (15 initial, 41 recredential) and 15 facility credentials (4 initial, 11 recredential), while actively monitoring 52 open Potential Quality Issues (PQIs).

3. **Pharmacy & Therapeutics (P&T) Committee**
   The Q1 2026 pharmacy coverage updates highlighted key performance metrics, action plans, and regulatory compliance across Medi-Cal and TCA/D-SNP. For Medi-Cal, opioid utilization remained stable under the 5% target, though slight increases were noted in members using multiple pharmacies and prescribers, prompting provider outreach for 30 high-risk cases. For TCA/D-SNP a low initial Medication Therapy Management (MTM) completion rate of 7.1% was due to low Q1 2026 TCA/DSNP enrollment, which increased to 10.3% by May 2026 through direct member outreach by Prime. The Pharmacy department also drafted six new policies and added 22 drugs to the Medicare Part B Physician Administered Drug (PAD) list.

4. **Grievances & Appeals (G & A) Committee**
   The Grievance and Appeals department successfully met all performance metrics for Q1 2026; however, a recent audit revealed historic inaccuracies in previously reported turn-around-time (TAT) measures, leading to corrections for the 2024 and 2025 TATs. To maintain compliance and proactively mitigate future risks, the G & A department has improved monitoring and is updating Job Aid Manuals (JAMS) and policies. Concurrently, the team is reviewing 2025 lookback assessments for NCQA and evaluating processes for continuous improvement while awaiting final DHCS audit findings.

5. **Health Education and Cultural Linguistics Committee**
   Cultural and Linguistic Services saw a 12% increase in language assistance utilization in Q1 2026 and met 100% of the benchmarks for interpreting and translation services. This growth was driven by a rise in monthly requests from January to March 2026, alongside an increase in telephonic interpreting among Carelon providers. The Health Education department was engaged in workshops and community events while preparing to launch new member outreach services in Q2 2026. An increase in readability reviews was driven by the new TCA/D-SNP product line. The majority of mailed materials consisted of case management requests for postpartum and tobacco cessation resources.

6. **NCQA Accreditation / NCQA Key Stakeholder Forum**
   During the June 4, 2026 meeting, DHCS announced Medi-Cal Managed Care Plans (MCPs) will no longer be required to maintain NCQA Health Equity Accreditation (HEA) after the current HEA accreditation period ends because the revised NCQA Health Outcomes standards lack sufficient rigor. DHCS is assessing options to integrate core HEA expectations into MCP contracts and plans to collaborate with Chief Health Equity Officers to draft contract language, targeting potential updates for 2027.

In 2026, GCHP began preparing for the next NCQA Health Plan Accreditation by developing a timeline and workplan, educating business owners on new requirements, and launching Utilization Management mock audits to assess readiness. Current focus is on updating policies and procedures while collaborating with The Mihalik Group (TMG) consultant to ensure ongoing compliance.

7. **Provider Network Operations Committee**
   Provider Network Operations successfully met timeliness standards for 98% of welcome letters and new provider orientations, with minor delays caused by retroactive contract dates and scheduling conflicts. The 2024/2025 annual Provider Access and After-Hours survey revealed deficiencies in after-hours access, non-urgent care access, and Long-Term Services and Support (LTSS) patient admissions. To address the deficiencies, remediation plans will be issued for all providers falling below the 80% compliance threshold, with a focus on repeat trends. Provider compliance will be reinforced through targeted site visits, Joint Operations Meetings, and the publication of requirements in the Provider Operation Bulletins. Progress will be monitored quarterly with the goal of raising all performance measures above 80%.

8. **Member Advisory Committee**
   The Member Advisory Committee (MAC) met on March 26, 2026, and key topics reviewed included legal compliance briefing on stipends and presentations on the upcoming structural changes to Medi-Cal Member eligibility requirements.

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September 15, 2026 QIHEC

Action Items

1. Action Items 69 & 70: DHCS Blood lead screening timeline requirements in children
   - Following inquiries with DHCS and other Medi-Cal Managed Care Plans, the Clinical QI department confirmed that compliance with the DHCS childhood blood lead screening requirements does not expire on a child's 12th or 24th birthday; instead, providers have the entire 12th and 24th months to complete the screenings. The Clinical QI Team will share this clarification through upcoming policy updates, provider newsletters, and Joint Quality Operation Meetings. These communications will also explicitly contrast the differences between the DHCS guidelines with NCQA HEDIS specifications for Lead Screening in Children, which require one or more blood lead screening to be completed on or before the child's 24th month birthday.
   - Status: Closed

2. Action Item 74: Vaccine Access Mapping
   - The Director of Pharmacy is working on messaging that will be sent to providers to clarify where both Medi-Cal and TCA/D-SNP members can receive vaccines.
   - Status: Open

Approval Items

1. **2025 Quality Improvement and Health Equity Transformation Program Evaluation**
   The 2025 QIHET Program successfully advanced GCHP's mission by aligning key initiatives with strategic priorities to optimize operational processes and elevate clinical outcomes. Through the 2025 QIHET Work Plan, GCHP monitored 53 organization-wide goals across five core objectives dedicated to improving clinical and non-clinical services, enhancing member experience, and ensuring oversight of delegated functions. GCHP achieved notable success, meeting 47 goals and partially meeting three. Leadership drove this momentum through the "Model of Care" initiative, expanding provider partnerships, improving data processing systems, and utilizing targeted collaboration meetings. Network strategies were further strengthened by expanding the Quality Incentive Pool & Program (QIPP) to include all 18 MCAS measures held to MPL, alongside the launch of the three-year Resilience, Innovation, Sustainability & Equity (RISE) Grant Program, which funded 16 organizations to address critical gaps in physical and behavioral healthcare.

   GCHP reported 31 MCAS measures in MY 2025, which included 13 report-only metrics and 18 performance-driven metrics subject to the DHCS MPL benchmark. All 18 performance-driven measures met or exceeded the MPL, with 17 showing improvement compared to 2024, 72% reaching the 75th percentile or higher, and four achieving 90th percentile / HPL, which resulted in closing 5,500 more care gaps in pediatric, preventive, maternal, chronic disease, and mental health services. These achievements were supported by comprehensive interventions that optimized enhancements in data integration, network strategies, clinical improvement projects, and member outreach.

Presentations

1. **Annual Assessment of Grievances & Appeals and Consumer Assessment of Healthcare Providers and Systems (CAHPS)**

Annual Assessment of Grievances & Appeals

The annual assessment of grievances and appeals evaluated member satisfaction and identified areas for improvement by analyzing GCHP's complaints and appeals data. To promote high-quality experience, the initiative set standard thresholds of fewer than five total complaints per 1,000 members and fewer than two complaints per 1,000 members within any specific category. The evaluation methodology sorted cases into five NCQA-required categories (Quality of Care, Access, Attitude and Service, Billing/Financial, and Office Site Quality). Rates were then calculated by dividing the average number of distinct members enrolled in 2025 by 1,000 to establish the baseline per-member ratio.

In 2025, GCHP achieved significant improvements in member complaint performance compared to 2024, successfully meeting all established goals by keeping member compliant rates below 2 per 1,000 members for each category and below 5 per 1,000 members overall. The total complaint volume decreased by 30%, dropping from 896 to 627 complaints, which lowered the overall complaint rate from 3.57 to 2.89 per 1,000 members. Although the volume of Quality of Care complaints declined from 366 to 340, it remained the leading complaint category in both years, with a rate of 1.46 per 1,000 members. Meanwhile, Access complaints saw the most significant drop, falling from 264 (1.05 per 1,000) to 136 (0.58 per 1,000). Declines were also recorded in Attitude and Service complaints, which dropped from 189 to 127, and Quality of Practitioner Office Site complaints, which fell from 27 to 13. The only category to experience an increase was Billing and Financial Issues, rising slightly from 50 to 59 complaints (0.20 to 0.25 per 1,000), but it remained within acceptable performance thresholds.

In 2025, GCHP significantly improved member appeals performance with the total number of appeals dropping by 69.3% from 127 in 2024 to 39 in 2025. Quality of Care was the only category that received any appeals, while all other categories received no appeals. Overall, GCHP met every appeal benchmark, demonstrating continued success in member satisfaction and service.

MY 2025 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Adult CAHPS survey experienced a sharp 52% decline in responses for MY 2025, dropping to 171 completed surveys compared to 355 completed in MY 2024. Additionally, 14 of the 20 survey questions were not scored due to insufficient data (fewer than 100 responses). Among the six questions that were scored, members reported a divergent experience: while the rating of personal doctors improved by 2.39 percentage points and reached the 75th percentile, ratings across the remaining five areas, including ease of getting care, routine appointments, health plan and health care ratings, and ease of forms, all declined. These mixed results suggest that while patient-provider relationships strengthened, members may have experienced challenges with navigating the healthcare system, such as long wait times to see a provider, access to care and coordination of care.

The Child CAHPS survey results showed positive overall outcomes with 13 rates increasing and 7 ranking at or above the 50th national Medicaid percentile, despite a small decline of 39 total

responses received. Members reported strong improvements in doctor interaction (specifically in listening, respect, and explaining things) as well as gains in customer service and information delivery. However, five areas declined, with significant drops occurring in access to specialists, access to routine appointments, and overall care coordination. Additionally, two key metrics regarding specialist ratings and getting care as soon as needed could not be scored due to the low number of respondents.

To improve CAHPS scores and increase survey participation, GCHP will launch off-season, mock CAHPS member surveys to capture real-time insights from a broader segment of GCHP's membership to help identify operational issues, address member concerns, and establish targeted interventions early. Additionally, GCHP will deploy multi-modal communications to boost member awareness and actively encourage higher survey engagement.

2. **MY 2026 NCQA Benchmarks**
NCQA released the MY 2026 national Medicaid benchmarks, which are established using nationwide health plan data from MY 2025. Benchmarks changed for the 18 MCAS measures held to MPL in MY 2026; the 50th and 75th percentiles rose for all 18 measures, while 90th percentile rose for 17 measures and declined for one. The most notable benchmark increases occurred in Prenatal Depression Screening, Postpartum Depression Screening, Depression Screening for Adolescents and Adults, Colorectal Cancer Screening, and Glycemic Status Assessment for Patients with Diabetes (>9%). Due to these changes, GCHP's percentile rankings for current MY 2026 prospective rates dropped across 10 measures spanning women's health, children's health, chronic conditions, cancer prevention, and behavioral health causing the overall portion of MCAS measures meeting targets to drop from 70% (14 of 20) to 60% (12 of 20). However, GCHP remains on track to achieve the 2026 One Team Incentive goal of meeting 70% of MCAS targets. Next steps include evaluating intervention strategies for the impacted measures, considering Q4 2026 push initiatives like incentives and health fairs where feasible, and partnering with providers on data improvement and intervention strategies.

Department / Sub-Committee Updates

1. **Quality Improvement: Managed Care Accountability Set (MCAS) & Medicare STARS**
In Q2 2026, 12 out of 20 MCAS measures met or exceeded the DHCS MPL. For report-only MCAS measures, DCHS added 8 new measures in June. For the Medicare STARS measures, 16 of the 26 assigned measures met the denominator criteria and 68% of those 16 measures met their targets. Plans to improve MCAS and STARS measures include optimizing data accuracy, evaluating and auditing interventions, and leveraging assessments, provider reports, and performance forecasting to maximize gap closure and improve outcomes.

The Quality Measures Operations Steering Committee met four times between January and June 2026 to review prospective rates and strategies for MCAS and Medicare STARS measures. Data improvement efforts focused on automating Electronic Clinical Data Set (ECDS) file validation and constructing new data pipelines to enhance infrastructure and operational efficiencies. Key clinical interventions centered on launching the Arine diabetes A1c program, expanding provider participation in the Cologuard screening program, addressing vaccine hesitancy, and embedding behavioral health navigators in emergency departments. The

committee also reviewed planning for the 2026 incentive programs, upcoming health fairs, and outreach strategies.

2. **Clinical Quality Improvement**
   In Q2 2026, all Facility Site Reviews (FSR) and Medical Record Reviews (MRR) were completed timely with no CAPS issued. Due to limited resources, a contracted DHCS Master Trainer / Certified Site Reviewer (MT/CSR) completed some FSR/MRR audits and the DHCS recertification of GCHP's MT/CSR, which is due in October, remains pending DHCS scheduling.

   To improve Initial Health Appointment (IHA) tracking, the Clinical QI team is continuing collaborations with the IT Department on developing a new claims-based compliance report while continuing to provide ongoing provider education. Additionally, the IHA Policy was revised to align with All Plan Letter (APL) 26-001 and Population Health Management (PHM) guidelines.

3. **Population Health Management**
   Participants enrolled in the Wellth Utilization Program have maintained an 81% engagement rate in daily check-ins. Members who were enrolled in the Wellth QI Program, which concluded in 2025, were given the option to transition to the Utilization Program. Additionally, starting in September 2026, Wellth will begin sharing member-reported blood pressure values with GCHP, which will be distributed to providers to optimize ongoing health monitoring.

   Health Risk Assessment (HRA) completions through Carenet reached 1,586 out of 11,536 total members, representing a 13.7% yield rate. However, reach rate was compromised due to incorrect or outdated member phone numbers. To reduce expenditures, there are plans to expand HRA outreach through the member portal, via text, and the Contact Center.

   The Cologuard Program with Exact Sciences received 111 Cologuard screening kits and closed 91 patient gaps in care in Q1 2026. Following an eligibility file update, the Cologuard program with Clinicas del Camino Real resumed in July 2026. Additionally, an amendment was drafted in August 2026 to expand services to Ventura County Medical Center, an independent provider, and TCA/D-SNP members which are planned to launch in October 2026.

4. **Behavioral Health**
   Data sharing enhancements include Manifest Medex finalizing Health Information Exchange (HIE) access for Carelon, while continuing to resolve administrative barriers for Dignity Health. Additionally, the Authorization to Share Confidential Member Information implementation remains pending, awaiting technical specifications from DHCS for their Consent Management Platform.

   Strategies focused on member outreach and care coordination include credentialing Conejo Health Navigators that will be embedded at Dignity Health while a contract amendment to embed Carelon Health Navigators at Ventura County Medical Center is currently under review. Carelon also showed improved year-to-date performance for post- Emergency Department (ED) follow-up performance, achieving a 100% outreach rate and 46.99% completion rate. The Behavioral Health (BH) department is developing a long-term sustainability plan for the 2025-2026 IHI DHCS BH Collaborative, which includes using consolidated member data to improve

care coordination for post-ED follow-up visits and engaging with the BH Data Sharing Learning Collaborative to address data-sharing requirements. Finally, the DHCS Maternal Health Substance Use Disorder (SUD) Affinity Group established a monthly data-driven process using pregnancy and SUD diagnosis codes to identify eligible members and expanded referral pathways across multiple Enhanced Care Management (ECM) providers to improve outreach.

Starting in July 2026, DHCS began tracking 51 performance Behavioral Health Transformation (BHT) Measures across 14 statewide goals to monitor county and managed care behavioral health programs.

5. **Utilization Management / Care Management**
In response to Q2 2026 utilization management turnaround times falling below benchmarks, an action plan was launched to restore performance. Key interventions included stabilizing core staffing with temporary nurses, evaluating prior authorization workflows, and implementing temporary prior authorization auto-approvals.

Recent clinical guideline updates include the retirement of the Chiropractic Services Guideline and the approval of nine guidelines. Among these are five utilization management criteria guidelines (including Transgender Services, Botox Supplemental Clinical, and Medically Tailored Meal/Grocery Boxes) and four clinical practice guidelines covering Diabetes, Asthma, Immunization, and Preventative Services.

The Over/Under Utilization analysis methodology analyzes 12 months of inpatient, emergency department, and Primary Care Provider (PCP) data across 40 demographic and health plan subpopulations. A workgroup is being assembled to clarify reporting requirements, benchmarks, and identify actionable interventions.

6. **Member Services Committee**
The Contact Center met the Q2 2026 access benchmarks, though overall performance and quality declined compared to Q1 2026 due to absorbing new provider and transportation calls. Average Speed of Answer improved from 48 seconds in April to 26 seconds in June, and quality scores exceeded the 95% benchmark in Q1 2026 but dropped to 93.6% by June as agents adapted to the new call types. To address these knowledge gaps, the Contact Center completed provider call handling refresher training in June, which has already shown improvement. Management is now aligning training, coaching, and quality scoring across all call types, with plans to implement further corrective actions if quality does not fully recover by Q3 2026.

AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: November 16, 2026

SUBJECT: Chief Executive Officer (CEO) Report

Chief Executive Officer (CEO) Update

Thank you for your participation in the Strategic Planning Retreat on Oct. 29, 2026. Your insights and guidance helped shape our preparations for what we anticipate will be an exceptionally challenging year ahead. As noted during the retreat, we face significant financial challenges as we navigate the disenrollment of our members with state-only Medi-Cal (UIS) and the barriers to enrollment resulting from H.R. 1. Our plan to address budgetary gaps in both our administrative and medical costs is in full motion and remains on schedule.

To follow up on the information shared during the retreat, we held an all-team meeting on Nov. 1, 2026, to explain the health plan's financial position to staff and discuss the possibility of layoffs in 2027. With newly elected leaders at the local, state, and national level, we remain hopeful that this new group of policymakers will be able to reverse or scale back the harmful policies that are underway for the most vulnerable members of our communities. We will monitor policy developments, assess their implications for our members and financial position, and adjust our budget as warranted.

Commission meeting packet changes

We have made changes to the cadence and order of the information in the Commission meeting packets. This CEO report is now a standalone update that you will continue to receive on a monthly basis. Beginning in January, the chief product officer (CPO) report will provide monthly updates on membership, enrollment, and government affairs. The chief operations officer (COO) report will also be included on a monthly basis to provide updates on claims, contracting, and information technology. Other reports, including those from the chief medical officer (CMO), chief compliance officer (CCO), chief HR and organizational performance officer (CHROPO), and chief diversity officer (CDO), will be provided quarterly.

State Department of Health Care Services (DHCS) rates update

Gold Coast Health Plan (GCHP) has received final 2027 rates from the state Department of Health Care Services (DHCS). Our actuarial partners at Wakely completed their analysis of the

impact on our budget. The rates were slightly higher and were incorporated into the 2027 budget, which Chief Financial Officer Christopher Lee will review.

It remains unclear whether DHCS will adjust the rates any further before the end of the year.

Local Health Plans of California (LHPC) board meeting

On Oct. 19, 2026, I attended the Local Health Plans of California (LHPC) board meeting in Palm Desert. LHPC is in the midst of leadership transition, presenting an opportunity for the trade association to take a more active and assertive advocacy role, with the goal of positioning it as a primary resource on Medi-Cal implementation and on-the-ground experience for the new administration.

In December, Linnea Koopmans will be stepping down as LHPC's CEO after five years. The LHPC Board of Directors is seeking candidates who can build on the association's foundation, carry the vision forward with energy, and collaboratively lead the development of LHPC's strategy and objectives to support its vision, mission and priorities. I am serving on the CEO search committee.

Kathy Mossburg, LHPC's contract lobbyist, has announced plans to retire at the end of the year. LHPC is currently reviewing responses from lobbying firms regarding its request for proposals (RFP). The goal is to onboard a new firm in December to plan for the year ahead.

The LHPC Board of Directors has also passed the baton to new leadership. Yolanda Richardson, CEO of San Francisco Health Plan, is the new board chair. She brings experience in general operations under Gov. Gavin Newsom. I am serving as vice chair. I am looking forward to continuing to partner with our sister health plans to navigate the impending changes to Medi-Cal.

California Association of Health Plans (CAHP) conference

From Oct. 19-21, I, along with several members of the GCHP Executive Team, attended the annual California Association of Health Plans (CAHP) conference in Palm Desert. Discussions in sessions and among attendees underscored the financial pressures health plans are facing, with many planning for personnel reductions as a mechanism for reducing administrative costs. Overwhelmingly, conference vendors presented technology solutions intended to improve efficiency and reduce costs. In the upcoming year, we will be evaluating how we can use any available funds for investment in technologies that provide operational efficiencies.

A key takeaway from the conference was the need for CAHP member health plans to have a more unified approach to engage with policymakers. With a new administration in Sacramento and a change in congress, we must demonstrate that value that Medi-Cal managed care organizations bring. We must be deliberate in our engagement with regulatory agencies, advocating for more efficient regulatory oversight, particularly where requirements from DHCS and the Department of Managed Health Care (DMHC) are duplicative, and seeking relief from

mandates while our current work to transition members with state-only Medi-Cal (UIS) to a fee-for-service model proceeds.

Conference speakers included Michelle Baass, director of DHCS. She provided a summary of state planning for the UIS transition and preparations for H.R. 1 implementation. She did not provide any new insights into the transition of the UIS members beyond what has already been shared with plans. We await an announcement from Governor-Elect Xavier Becerra about whether the state will change course on how members with UIS will receive Medi-Cal coverage.

With the new incoming administration, we also anticipate leadership changes at DHCS and DMHC. At the conference, Mary Watanabe, who served as director of DMHC, announced her transition to Covered California as its new chief deputy executive director of external outreach and strategy.

As new regulatory leaders are announced, we will seek to engage them and look for opportunities for collaboration.

RECOMMENDATION:

Receive and file.

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Suma Simcoe, Chief Operations Officer

DATE: November 16, 2026

SUBJECT: Chief Operations Officer (COO) Report

PowerPoint with Verbal Presentation

ATTACHMENTS:

November COO Report

Gold Coast Health Plan℠
A Public Entity

Gold Coast Health Plan

Integrity

Accountability

Collaboration

Trust

Respect

November 2026

Suma Simcoe, Chief Operating Officer
Open Session Commission

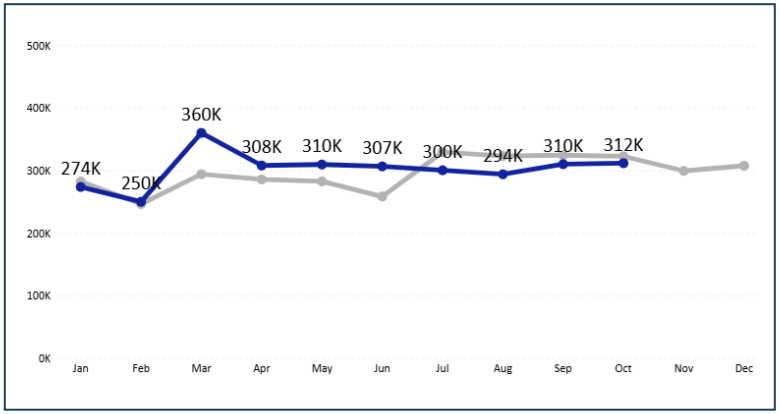
Operations KPI
Medi-Cal

Claims Received – Medi-Cal

Claims Received Jan-2025 to Oct-2026

Total Claims Volume Received

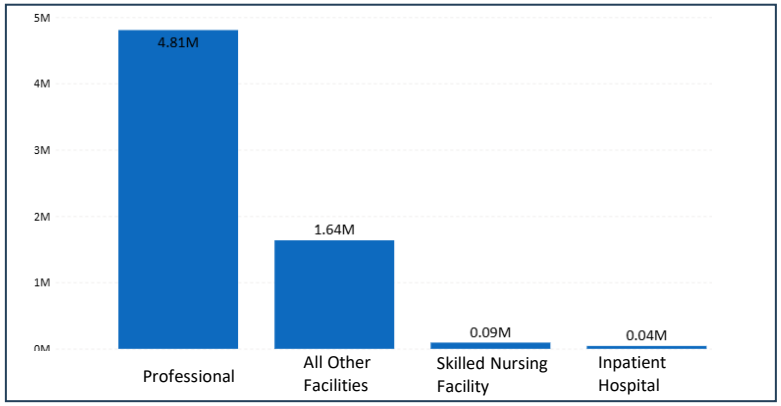
Total volume of all claim's statuses (Final, Denied, Rejected, etc.)



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

Total Claims Volume by Type

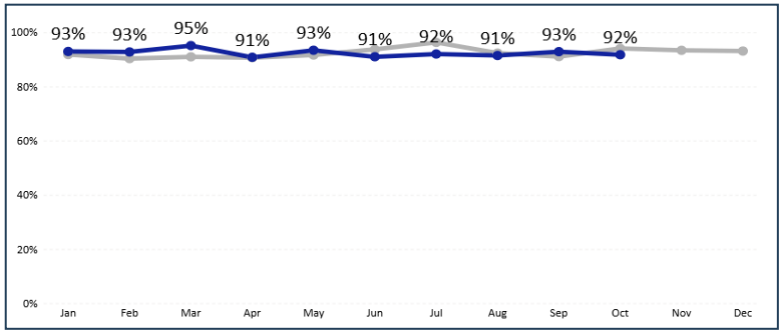
Count of all distinct claims (past 12 months, with a 3-month lag)



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

% of Claims Submitted Electronically

All claim sources non-Paper or unknown



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

Chart Legend: 2025 2026

Charts based on Receipt Date

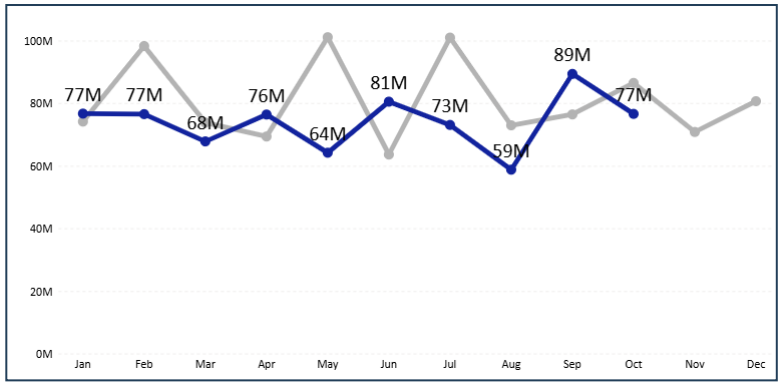
Return to Agenda

Claims Payment and Processing – Medi-Cal

Payment Processing Jan-2025 to Oct-2026

Total Paid ($)

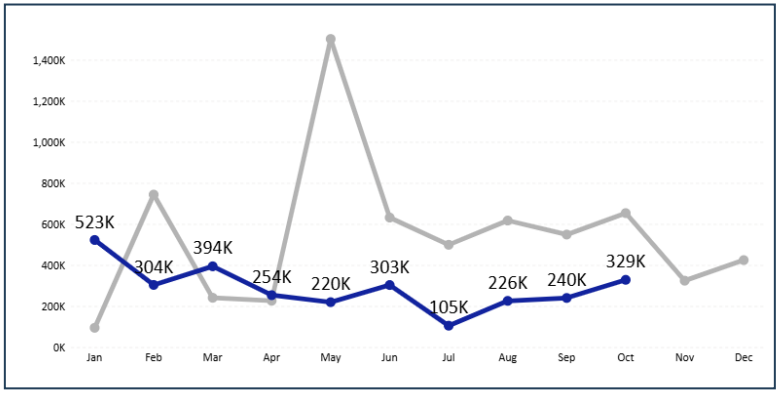
Total paid on final claim based on the month claim was paid



Trend Analysis: The graph represents a decrease in October to our average monthly payments after a spike in Sept related to a retro hospital contract update in addition to large high dollar claims.

Total Interest Paid ($)

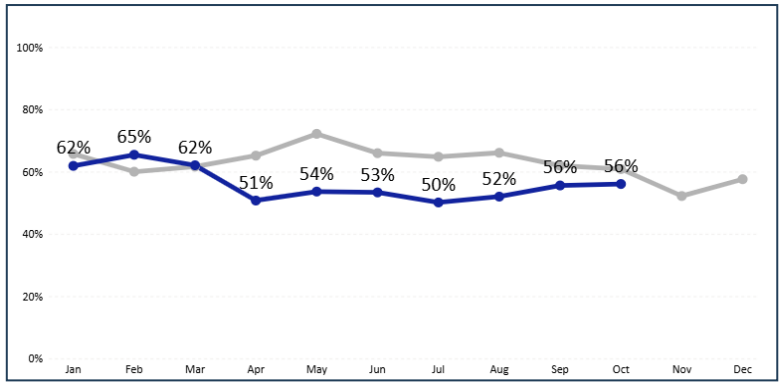
Total interest on final claim based on the month the claim was paid



Trend Analysis: The interest payments have remained stable with a slight increase due to contract cleanup efforts.

% of First-Pass Claims Auto-Adjudicated

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



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

Charts based on Paid Date

Chart Legend: 2025 2026

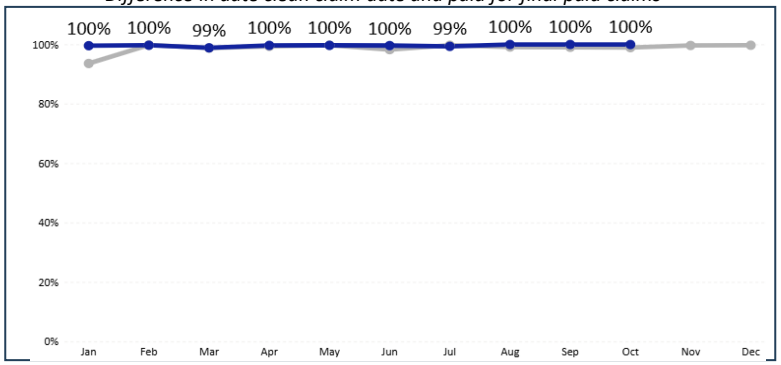
Return to Agenda

Claims Payment Timeline – By Process Date

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

% Paid within 30 Calendar Days

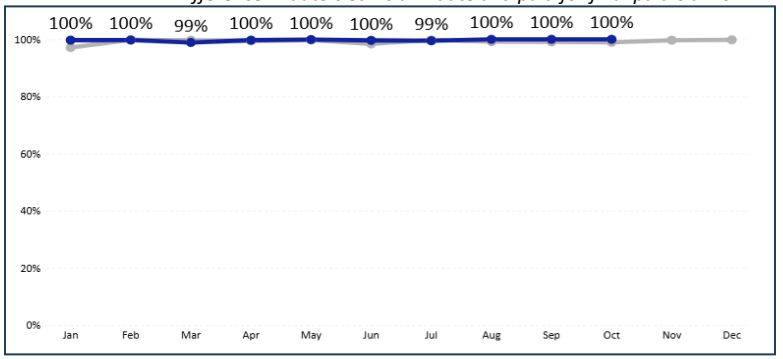
Difference in date clean claim date and paid for final paid claims



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

% Paid within 45 Calendar Days

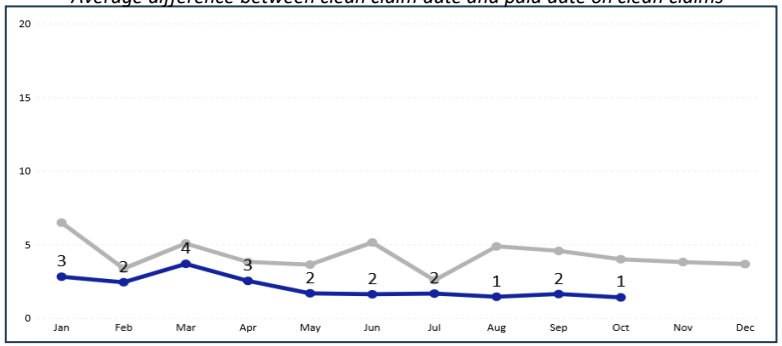
Difference in date clean claim date and paid for final paid claims



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

Average Days to Paid

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



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

Charts based on Paid Date

Chart Legend: 2025 2026

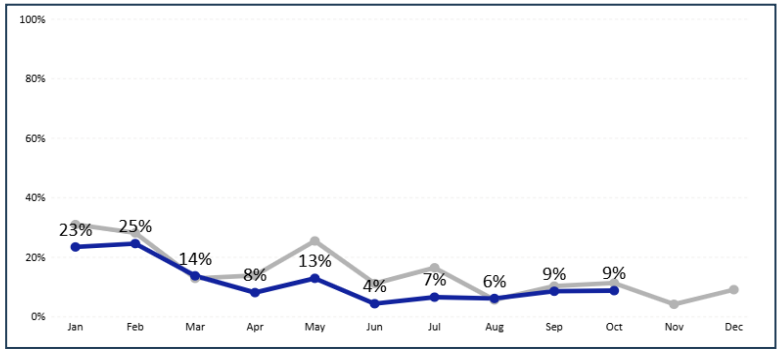
Return to Agenda

Denials, Adjustments & Rejected – Medi-Cal

Claims Denials & Adjustments Jan-2025 to Oct-2026

% of Total Claims Processed that are Adjustments

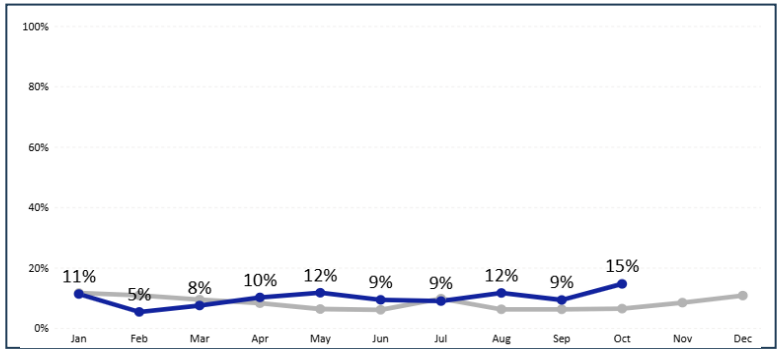
Regardless of final status with any adjustment based on receipt date



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

% Denials

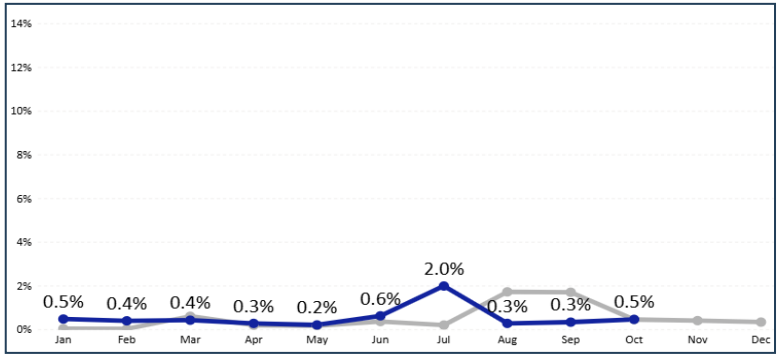
Percentage of claims volume with most recent process status = denied



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

% Rejected

Percentage of claims which have a final status of Rejected



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

Charts based on Paid Date

Chart Legend: 2025 2026

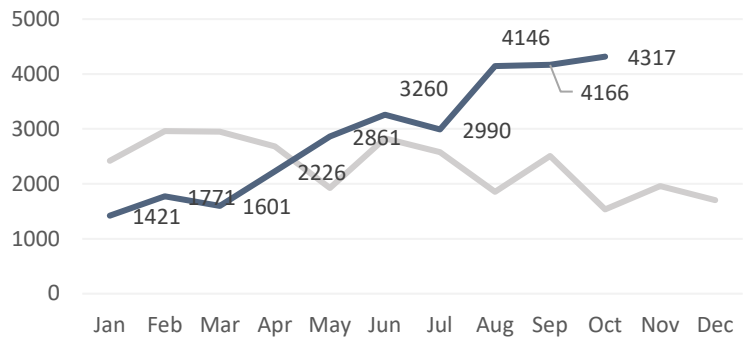
Return to Agenda

Provider Dispute Resolution Processing- all LOBs

Provider Dispute Resolution Processing Jan-2025 to Oct-2026

PDR Volume Received

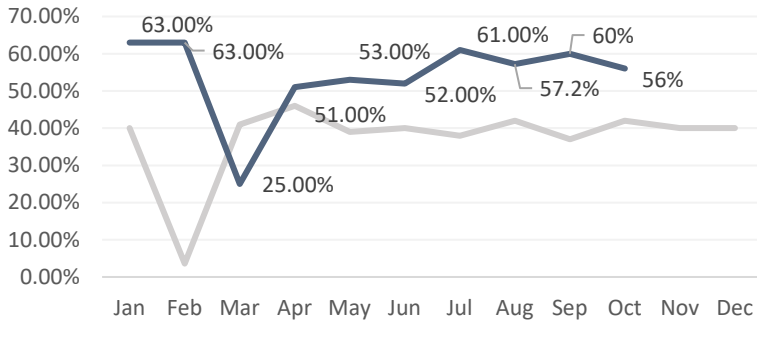
Distinct count of IDs for only PDR



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

% of Closed PDR Cases that are Upheld

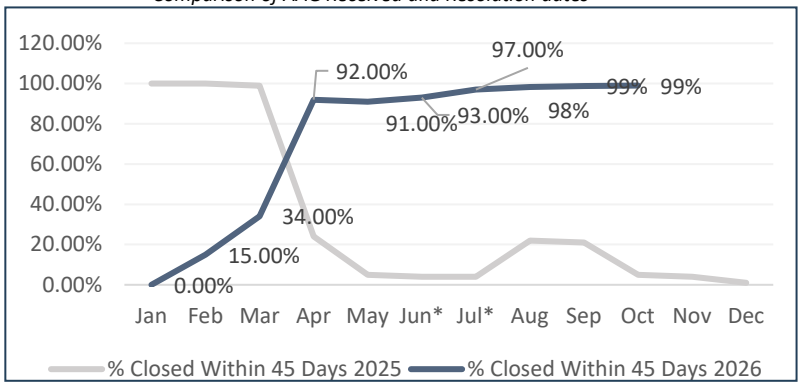
Closed cases with an outcome of Previous Decision Upheld



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

% Closed within 45 Business Days

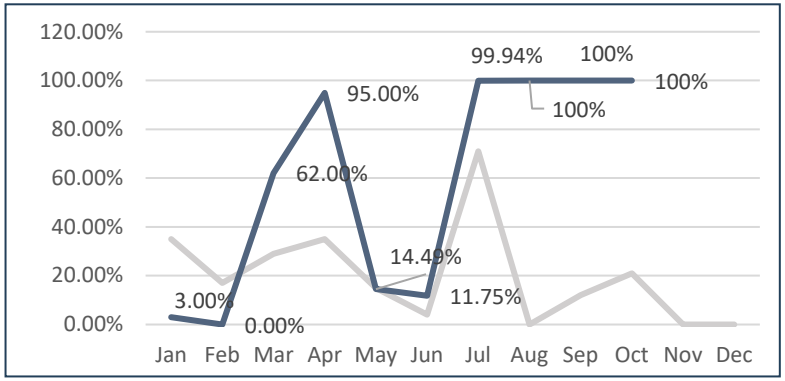
Comparison of AAG Received and Resolution dates



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

% PDRs Acknowledged within 15 Business Days

Comparison of AAG Received and Acknowledged dates



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

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

Chart Legend: 2025 2026

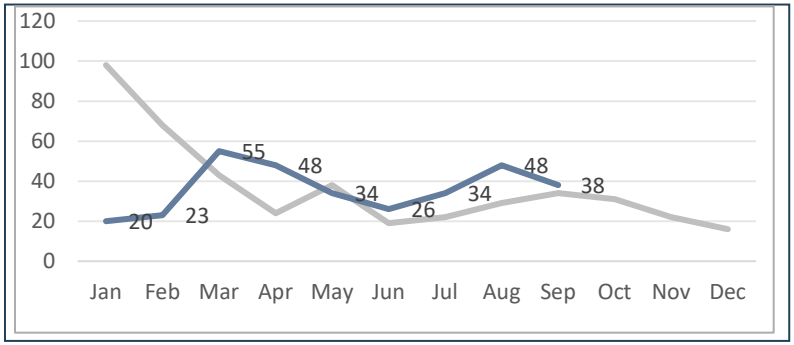
Return to Agenda

Call Center – all LOBs

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

Member Average Speed to Answer (ASA)

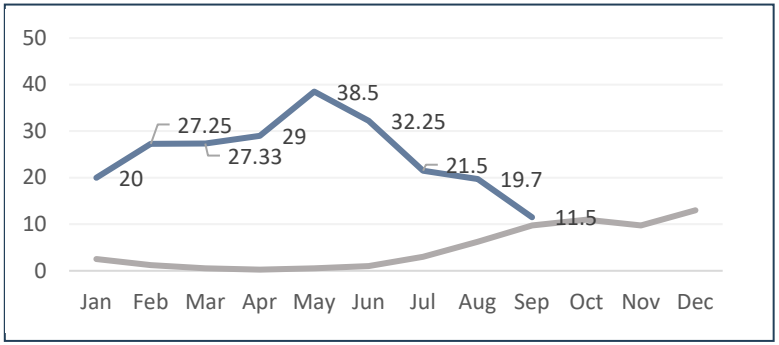
Avg time (seconds) member calls answered in



Trend Analysis: Call volume metrics remained stable and consistent; Open enrollment period for DSNP LOB began October 1st.

Provider Average Speed to Answer (ASA)

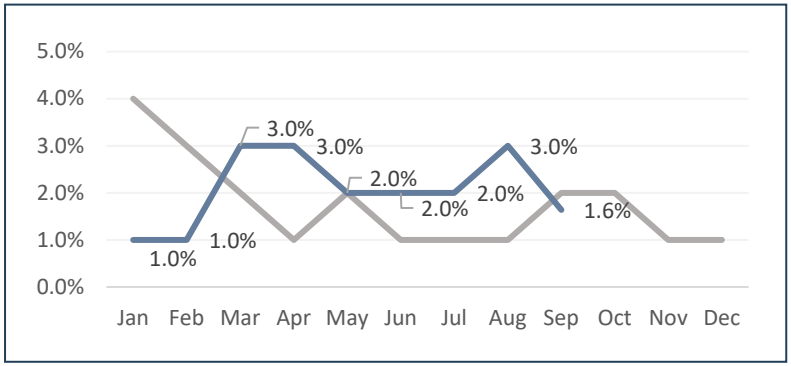
Avg time (minutes) provider calls were answered in



Trend Analysis:

Member Call Abandon %

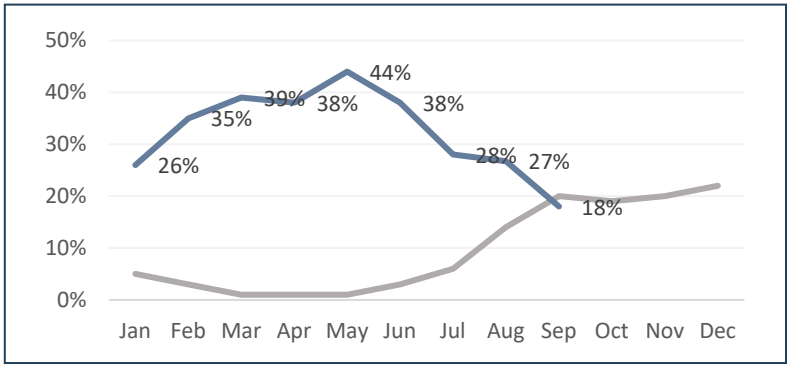
Member calls placed that were abandoned (<5% Target)



Trend Analysis: Call volume metrics remained stable and consistent; Open enrollment period for DSNP LOB began October 1st.

Provider Call Abandon %

Provider calls placed that were abandoned



Trend Analysis:

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

Chart Legend: 2025 2026

Return to Agenda

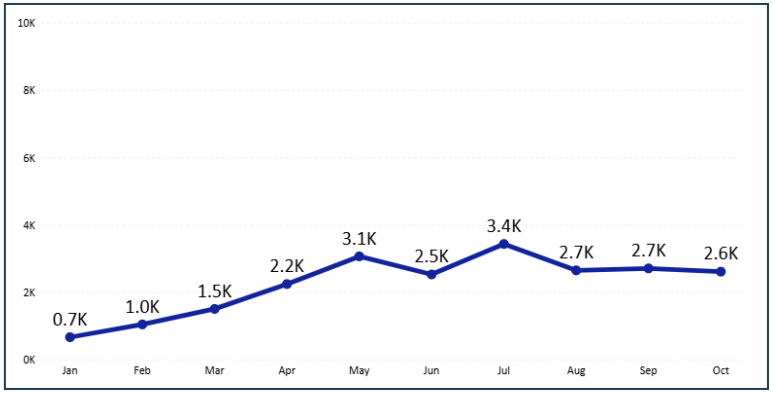
Operations KPI DSNP

Claims Received – DSNP

Claims Received Jan-2025 to Oct-2026

Total Claims Volume Received

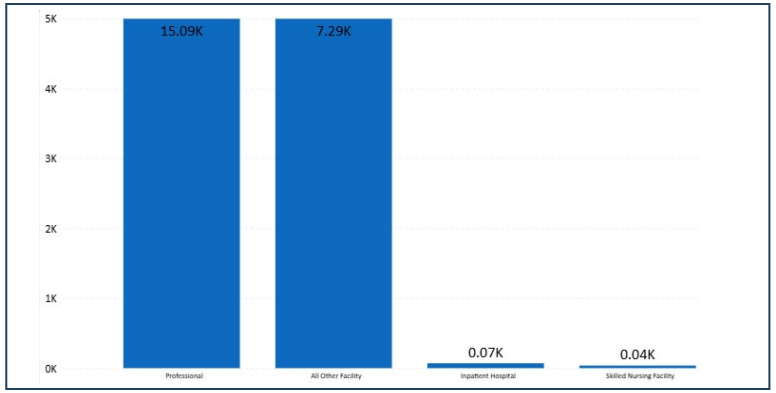
Total volume of all claim's statuses (Final, Denied, Rejected, etc.)



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

Total Claims Volume by Type

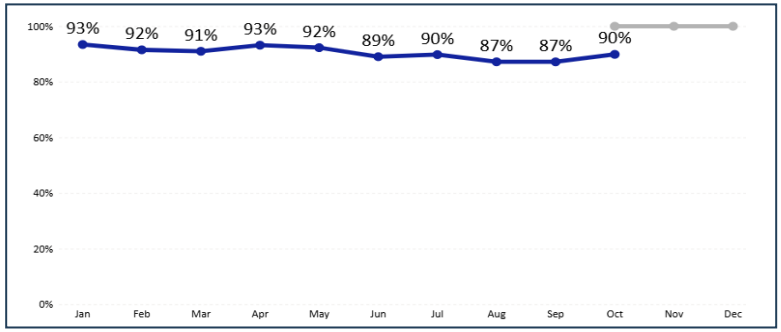
Count of all distinct claims (past 12 months, with a 3-month lag)



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

% of Claims Submitted Electronically

All claim sources non-Paper or unknown



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

Charts based on Receipt Date

Chart Legend: 2026

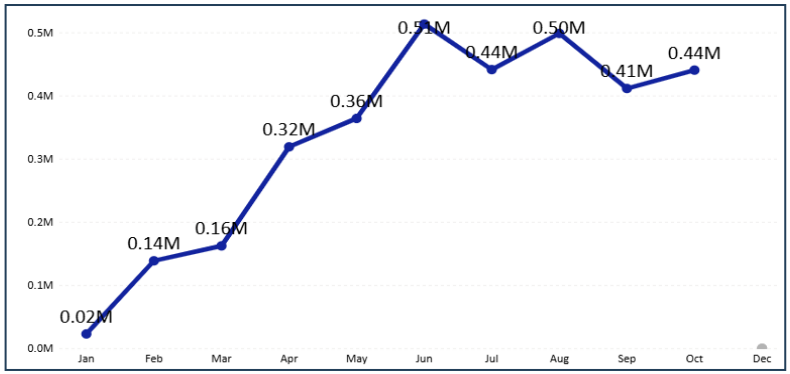
Return to Agenda

Claims Payment and Processing – DSNP

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

Total Paid ($)

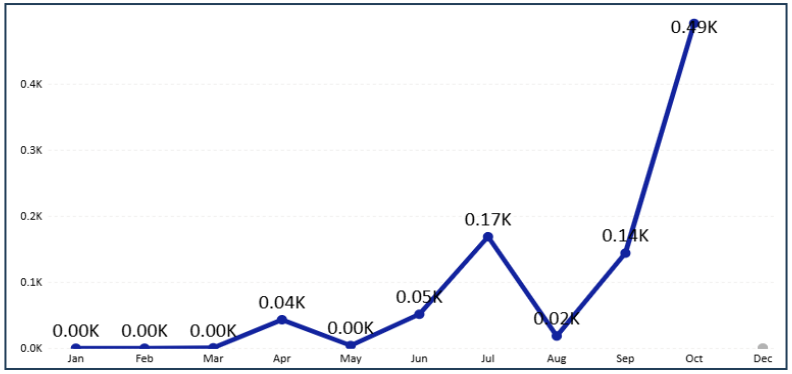
Total paid on final claim based on the month claim was paid



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

Total Interest Paid ($)

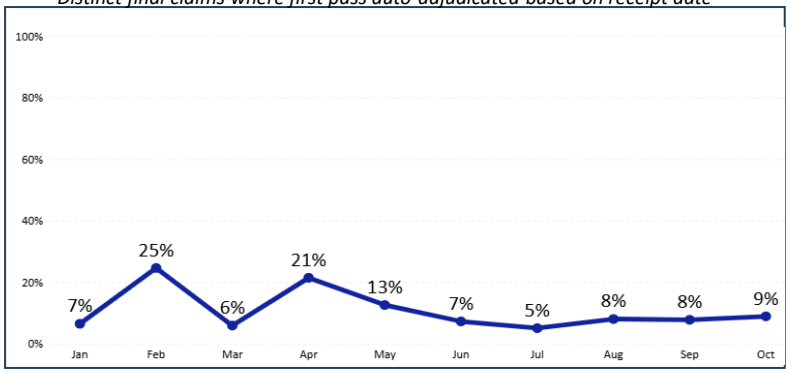
Total interest on final claim based on the month the claim was paid



Trend Analysis: The anomaly reflects low DSNP claim and member counts, not a spike in interest across lines of business this month.

% of First-Pass Claims Auto-Adjudicated

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



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

Charts based on Paid Date

Chart Legend: 2026

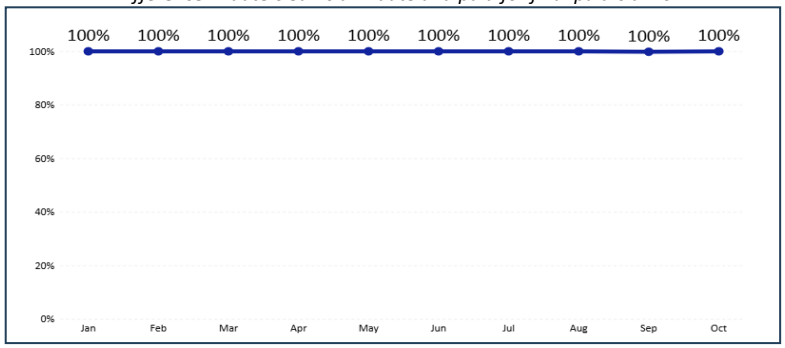
Return to Agenda

Claims Payment Timeline – By Process Date

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

% Paid within 30 Calendar Days

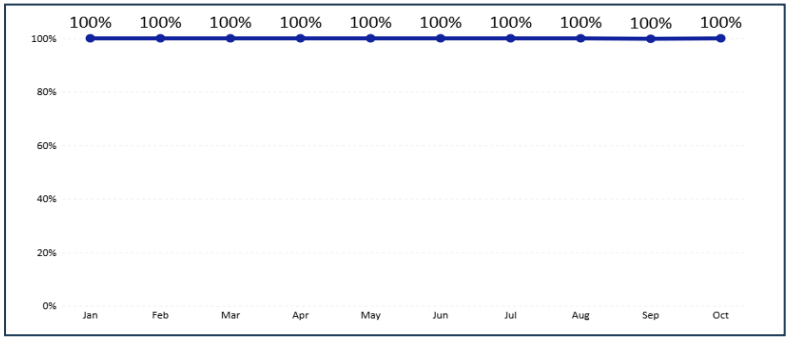
Difference in date clean claim date and paid for final paid claims



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

% Paid within 45 Calendar Days

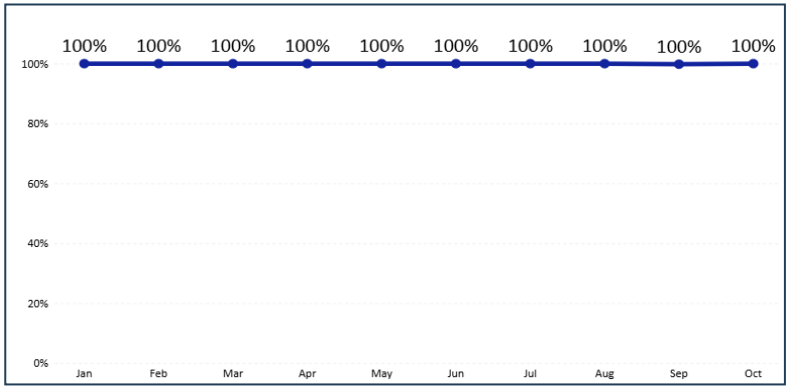
Difference in date clean claim date and paid for final paid claims



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

% Paid within 90 Calendar Days

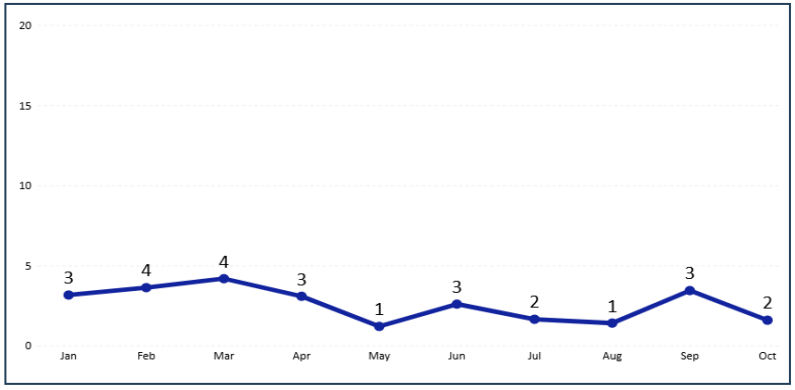
Difference in date clean claim date and paid for final paid claims



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

Average Days to Paid

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



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

Charts based on Paid Date

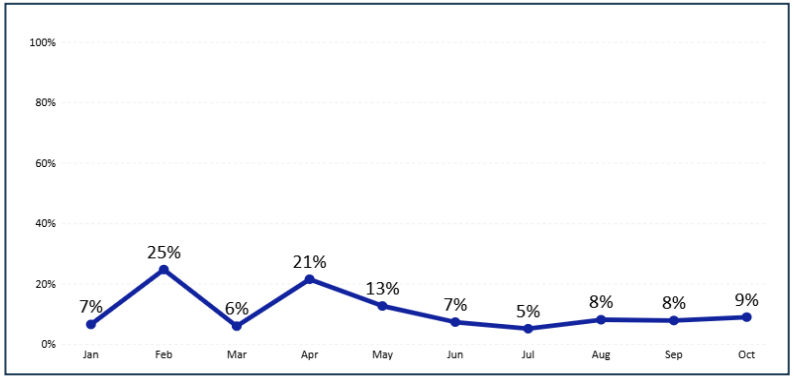
Chart Legend:

Denials, Adjustments & Rejected – DSNP

Claims Denials & Adjustments Jan-2025 to Oct-2026

% of Total Claims Processed that are Adjustments

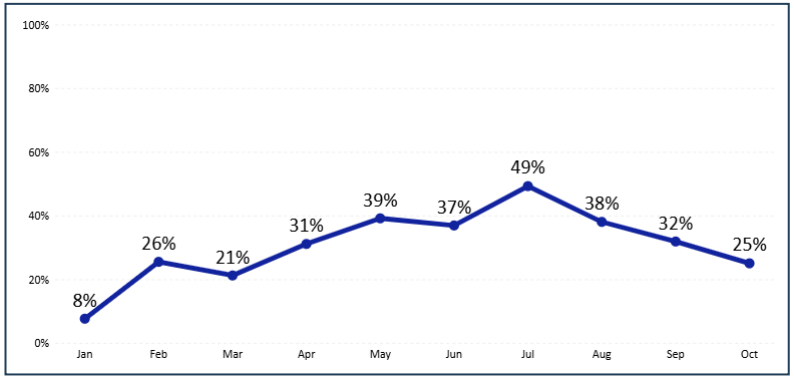
Regardless of final status with any adjustment based on receipt date



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

% Denials

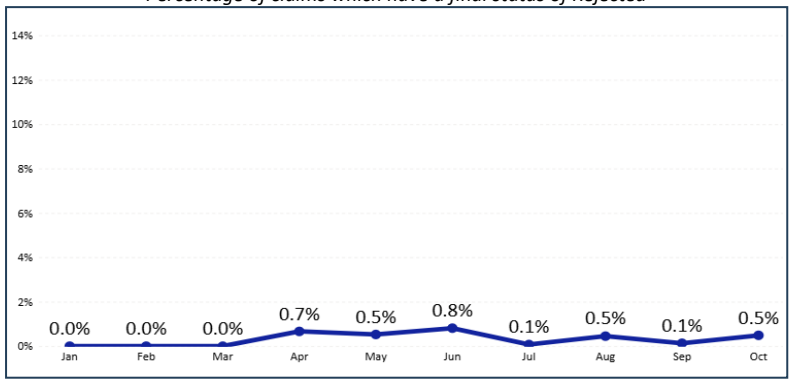
Percentage of claims volume with most recent process status = denied



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

% Rejected

Percentage of claims which have a final status of Rejected



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

Charts based on Paid Date

AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Robert Franco, Chief Compliance Officer
Bianca Naron, Senior Compliance Program Manager

DATE: November 16, 2026

SUBJECT: Approval of Revised Compliance Program Plan and Committee Charter

SUMMARY:

Gold Coast Health Plan has completed revisions to the Compliance Program Plan and Compliance Committee Charter to strengthen compliance governance, enhance accountability, and ensure alignment with current federal and state regulatory requirements. Together, these documents establish the framework for the Compliance Program and define the governance structure responsible for oversight of compliance, ethics, risk management, and regulatory activities. Key updates include:

- **Enhanced** governance and oversight responsibilities
- **Strengthened** compliance education and reporting processes
- **Formalized** oversight of regulatory requirements including DMHC and D-SNP activities
- **Improved** monitoring, auditing, and program effectiveness measures

These updates support continued alignment with CMS, DHCS, DMHC, OIG, and NCQA expectations.

RECOMMENDATION:

Staff recommend that the Commission approve and adopt the revised Compliance Program Plan and Compliance Committee Charter. These updates strengthen organizational oversight, support regulatory compliance, and reinforce GCHP's commitment to ethical and accountable operations.

ATTACHMENTS:

- ***GCHP_COMPLIANCE_PROGRAM_PLAN_112026_V4DRAFT***
- ***GCHP_COMPLIANCE_COMMITTEE_CHARTER_112026_V5DRAFT***

Gold Coast Health Plan℠
A Public Entity

GOLD COAST HEALTH PLAN
TOTAL Care ADVANTAGE℠

Compliance Program Plan **2027**



Compassionate care, accessible to all, for a healthy community

Table of Contents

Article I. Overview 3
Article II. The Compliance Plan 5
Article III. Code of Conduct and Policies and Procedures 7
Article IV. Program Oversight 13
Article V. Effective Education and Training 18
Article VI. Communication and Reporting 23
Article VII. Reporting and Issue Escalation 25
Article VIII. Auditing and Monitoring 28
Article IX. Enforcement 33
Article X. Remediation 36
Article XI. Anti-Fraud Program 39
Article XII. Filing Systems and Record Management 43
Article XIII. Compliance Program Reference Documents 45
Article XIV. Document Control 47

Draft

Article 1. **Overview**

Gold Coast Health Plan (GCHP) is committed to conducting its business operations in accordance with the highest ethical standards and in compliance with its contractual obligations under state and federal programs, as well as all applicable laws, regulations, and guidance issued by the Centers for Medicare & Medicaid Services (CMS), the California Department of Managed Health Care (DMHC), and the California Department of Health Care Services (DHCS). This includes requirements governing the Medi-Cal program and Medicare Advantage (Part C) and Prescription Drug (Part D) programs. This commitment applies to all GCHP employees, Commissioners, network providers, vendors, subcontractors, delegates, and first tier, downstream, and related entities (FDRs), and supports GCHP's accountability for compliance and oversight across all delegated and contracted functions.

GCHP has established a formal Compliance Program led by a designated Chief Compliance Officer with oversight by the Compliance Committee, and the Ventura County Managed Care Commission (Commission), to ensure adherence to applicable legal and regulatory requirements.

The Compliance Program is structured in alignment with the seven elements of an effective compliance program as defined by the Centers for Medicare & Medicaid Services (CMS) and supported by the Office of the Inspector General (OIG) guidance and Federal Sentencing Guidelines.

Section 1.01 Seven Key Elements of an Effective Compliance Program

A. GCHP's Compliance Program incorporates the following elements as required by CMS:

1. Written Policies and Procedures, and Standard of Conduct
2. Compliance Officer, Compliance Committee, and Commission Oversight
3. Effective Training and Education
4. Effective Lines of Communication
5. Well-Publicized Disciplinary Standards
6. Effective Systems for Routine Monitoring, Auditing, and Identification of Compliance Risks
7. Procedures and Systems for Prompt Response to Compliance Issues

B. The Compliance Program applies to the GCHP Commission, as well as GCHP employees and all contracted and delegated entities, including providers, vendors, delegates, subcontractors, and FDRs, consistent with the requirements for enterprise-wide application of compliance programs.

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Section 1.02 Risk Assessment and Work Plan Development

A. GCHP uses a risk-based approach to prioritize compliance activities, which considers internal audit results, regulatory guidance, reported issues, and external audit findings. The results of the enterprise risk assessment are used to inform the annual Compliance Work Plan and to allocate monitoring and auditing resources based on relative risk.

B. This plan is reviewed and approved annually by the GCHP Compliance Committee and the Commission.

Section 1.03 Governance, Approval, and Transparency

A. The Compliance Plan, including the Compliance Work Plan, is reviewed and approved annually by the GCHP Compliance Committee and Commission, consistent with expectations for governing body oversight of the compliance program.

B. The Compliance Plan and associated program components are maintained in an audit-ready format, with supporting documentation for review, approval, and updates maintained within PolicyTech document governance system and related compliance systems.

C. The approved Compliance Plan is made publicly available on the GCHP website to support transparency and accountability.

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Article II. **The Compliance Plan**

The regulatory environment governing GCHP and its programs are complex and continuously evolving. The Compliance Plan establishes the framework for GCHP's compliance program, including its principles, standards, and Policies and Procedures, to ensure adherence to applicable federal and state laws, regulatory requirements, and contractual obligations.

The Compliance Program Plan applies to GCHP's operations and to the activities of its employees, commissioners, network providers, vendors, delegates, subcontractors, downstream subcontractors, and first tier, downstream, and related entities (FDRs), consistent with CMS requirements that sponsors maintain accountabilities for all delegated and downstream functions.

The Compliance Plan is designed to ensure that GCHP operations and business practices are conducted in accordance with applicable laws, ethical standards, and contractual requirements, consistent with OIG guidance emphasizing the importance of written standards and ethical expectations as a foundation of an effective compliance program.

Section 2.01 Compliance Program Plan Structure and Implementation

A. This Compliance Program Plan establishes a structured, operational compliance program aligned with the seven elements of an effective compliance program and the requirements of the California Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the National Committee for Quality Assurance (NCQA).

B. GCHP operationalizes its Compliance Program through:

1. Governance and Oversight by the Chief Compliance Officer, Compliance Committee, Internal Oversight Compliance Committee, Policy Review Committee, senior leadership, and the Commission.
2. Policies and Procedures that are developed, implemented, distributed, and maintained within the PolicyTech system of record.
3. Training and Education that includes Compliance and Fraud, Waste, and Abuse (FWA) training for employees, workforce members, leadership, Commissioners, and FDRs.
4. Effective Lines of Communication that support reporting compliance concerns, including anonymous reporting mechanisms.
5. Integration of Compliance Requirements into business operations, contracts, delegated functions, accreditation activities, and internal controls.

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6. Enforcement and Accountability through established standards of conduct, disciplinary processes, and corrective action requirements.

7. Monitoring, Auditing, and Response Activities designed to identify, investigate, remediate, and prevent compliance risks.

C. The Compliance Program includes processes to identify, interpret, implement, and monitor contractual, legal, regulatory, and accreditation requirements that impact GCHP operations. These processes support ongoing compliance oversight, risk identification, and continuous improvement.

D. The Compliance Department maintains and updates compliance-related policies and procedures through a formal lifecycle management process within PolicyTech. New and revised policies undergo Compliance Committee review and are subject to final approval through the Policy Review Committee. This process helps ensure policies remain current, effective, and aligned with applicable regulatory, contractual, and accreditation requirements.

Section 2.02 Guidance and Escalation

A. GCHP maintains open and accessible lines of communication to support compliance awareness and issue resolution. Employees, Commissioners, network providers, vendors, delegates, subcontractors, downstream subcontractors and FDRs may seek guidance regarding the Compliance Plan, GCHP values, or applicable Policies and Procedures from or through:

1. The Chief Compliance Officer,

2. Members of the Compliance Committee, or

3. Established reporting and communication channels

B. All individuals are expected to be familiar with the contractual, legal, and regulatory requirements relevant to their job responsibilities and to seek clarification when needed.

Section 2.03 Scope and Use of the Compliance Program Plan

A. The Compliance Plan establishes the framework for GCHP's compliance program but does not encompass every operational scenario or legal requirement. As such, employees, providers, Commissioners, vendors, subcontractors, downstream subcontractors and FDRs are expected to escalate questions or issues through appropriate channels, including:

1. Supervisor or Manager

2. Senior Leadership

3. Chief Compliance Officer

4. General Counsel

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Article III. **Code of Conduct and Policies and Procedures**

Section 3.01 Review and Implementation of Standards

A. GCHP maintains a structured and risk-based process to identify, evaluate, and implement contractual, legal and regulatory requirements across its operations. This includes continuous monitoring of applicable federal and state laws, CMS, NCQA, and DHCS guidance, contractual requirements, and identified compliance risks.

B. GCHP operationalizes this process through:

1. Ongoing monitoring and auditing activities, including internal reviews, external audits, and regulatory oversight activities.
2. Evaluation of compliance risk identified through data analysis, audit findings, and reported concerns.
3. Development and revision of Policies and Procedures managed within the PolicyTech system or record.
4. Compliance Committee review at the time of policy revision to ensure regulatory alignment and risk mitigation.
5. Final approval and execution of policies through the Policy Review Committee.

C. GCHP applies these standards enterprise-wide to employees, commissioners, network providers, subcontractors, downstream subcontractors, vendors, delegates, and FDRs, as applicable, while maintaining accountability for delegated functions.

Section 3.02 Code of Conduct

A. GCHP maintains a written Code of Conduct that establishes standards for ethical behavior and compliance with applicable laws and regulations, accreditation standards, and adherence to contractual and program requirements, including those applicable to Medi-Cal, Medicare Part C, and Medicare Part D.

B. In accordance with GCHP Code of Conduct:

1. All employees, Commissioners, network providers, vendors, delegates, subcontractors, downstream subcontractors, and FDRs are expected to act ethically and comply with applicable laws and program requirements.

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2. GCHP maintains standards addressing fraud, waste, and abuse (FWA), conflicts of interest, confidentiality, and interactions with regulatory agencies.
3. Individuals are required to promptly report suspected compliance violations through established reporting mechanisms, including anonymous reporting channels.

Section 3.03 Code of Conduct Implementation and Accountability

A. GCHP operationalizes the Code of Conduct through the following controls:
   1. Distribution: The Code of Conduct is distributed to all applicable employees, subcontractors, and FDRs via the Compass Intranet site and the public website.
   2. Training: The Code of Conduct is incorporated into the general compliance training program and is available on GCHP's Learning Management System (LMS).
   3. Attestation: Individuals are required to certify, at least annually through LMS, that they have received, read, understand, and will comply with Code of Conduct.
   4. Enforcement: Violations of the Code of Conduct are subject to disciplinary action in accordance with established policies.
   5. Monitoring: Adherence to the Code of Conduct is evaluated through monitoring, auditing, and investigation activities.

B. Compliance with the Code of Conduct is a condition of employment, appointment, and contractual engagement, and consistent with expectations for accountability and enforcement.

Section 3.04 Code of Conduct Governance and Approval:

A. The Code of Conduct is formally approved by the GCHP Compliance Committee and the Commission and is reviewed at least annually or more frequently as needed based on regulatory changes and identified risks.

B. Updates to the Code of Conduct follow GCHP Compliance program document approval process:
   1. Compliance Committee review at the time of revisions
   2. Approval and execution through the Commission
   3. Documented version controls in PolicyTech

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Section 3.05 Integration with Policies and Procedures

A. The Code of Conduct serves as the foundational document for GCHP's compliance framework and is supported by detailed Policies and Procedures that operationalize compliance requirements across all functional areas.

B. Policies and Procedures:

1. Define specific processes for compliance with regulatory, accreditation, contractual, and operational requirements.
2. Are maintained and controlled within the PolicyTech system as the single source of truth.
3. Are subject to formal lifecycle management, including review, approval, distribution, and attestation.
4. Are aligned with identified risk and compliance program priorities.

Section 3.06 Policies and Procedures

A. GCHP maintains a centralized, enterprise-wide system of written Policies and Procedures addressing operational functions, compliance activities, and the prevention, detection and correction of fraud, waste, and abuse (FWA). These Policies and Procedures are designed to ensure adherence to applicable federal and state laws, regulatory requirements, and CMS guidance.

B. GCHP uses an electronic policy management system, PolicyTech, which serves as the official system of record for all Policies and Procedures. PolicyTech supports version control, workflow management, automated notifications, attestation tracking, and document retention.

C. Policies and Procedures apply to all employees, Commissioners, subcontractors, downstream subcontractors, vendors, delegates, and first tier, downstream, and related entities (FDRs), as appliable. Individuals and entities are responsible for complying with policies related to their roles and contractual obligations.

Section 3.07 Compliance Policy, Governance and Approval

A. GCHP has established a formal governance structure for policy development, review and approval for Compliance Program policies:

1. Policy owners are responsible for drafting, maintaining and initiating updates.
2. The Compliance Committee conducts individual policy reviews at the time of revision to ensure regulatory alignment, risk mitigation, and consistency with compliance program requirements.

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3. All Policies and Procedures are routed through and formally approved and executed by the monthly Policy Review Committee (PRC), which serves as the final approval authority.

Section 3.08 Policy Lifecycle Management

A. GCHP follows a standardized policy lifecycle process within PolicyTech that includes:

1. Drafting and revision by policy owner
2. Review by Compliance Committee (for Compliance-related policies)
3. Approval by the Policy Review Committee
4. Publication in PolicyTech
5. Assignment and attestation tracking for applicable users (available in PolicyTech)
6. Ongoing monitoring and periodic review as applicable to regulatory changes

b. All policies include defined ownership, review dates, and version control to ensure accountability and traceability.

Section 3.09 Review and Update Requirements

A. Policies and Procedures are reviewed at least annually, or as needed based on:

1. Changes in federal or state laws, accreditation standards, regulatory requirements, or managed care contracts
2. CMS and/or NCQA guidance or audit findings
3. Identified compliance risks, issues or trends
4. Internal audit findings or corrective action plans
5. Operational or organizational changes

b. All updates follow formal governance and approval process.

Section 3.10 Distribution, Training, and Attestation

A. Policies shall be communicated and made available to workforce members and other applicable individuals through approved organizational methods to support awareness of compliance requirements.

1. GCHP maintains records, as applicable, demonstrating:

a. Policy distribution or communication

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b. Completion of required acknowledgments or attestations

c. Acknowledgment of compliance-related expectations

B. Policies related to Compliance and Fraud, Waste, and Abuse (FWA) shall be incorporated into applicable training and education activities and used to support workforce awareness of compliance obligations.

Section 3.11 Network Providers, FDRs, Subcontractors and Downstream Subcontractors

A. GCHP ensures that network providers, subcontractors, downstream subcontractors, vendors and FDRs comply with all applicable contractual and regulatory requirements, including state and federal law, CMS guidance, DHCS requirements, the Medi-Cal Managed Care Contract, and the State Medicaid Agency Contract (SMAC).

1. Compliance obligations are operationalized through:

a. Contractual Requirements: Contracts include provisions requiring adherence to compliance with program requirements.

b. Policy Distribution: Applicable policies and standards of conduct are distributed to FDRs.

c. Attestation Requirements: FDRs acknowledge compliance expectations, including Code of Conduct and FWA requirements.

d. Monitoring and Auditing: GCHP conducts monitoring and auditing of subcontractors and FDR activities as applicable.

e. Corrective Action: Non-compliance is addressed through corrective action plans and validations.

2. GCHP retains ultimate accountability for FDR compliance.

Section 3.12 Compliance Program Policy List & Maintenance

A. GCHP maintains a comprehensive inventory of all Compliance Program Policies and Procedures within the PolicyTech system, which serves as the single source of truth and replaces the former manual Compliance Program Policy List.

1. The PolicyTech inventory provides:

a. Real-time visibility into active policies

b. Version control and document history

c. Assignment ownership and review cycles

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d. Documentation of Compliance Committee review and Policy Review Committee approval

e. Evidence of distribution and attestation

f. The inventory is continuously maintained and updated as policies are created, revised, or retired.

g. Additionally, the inventory is periodically validated against regulatory requirements and internal risk assessments to ensure completeness and alignment with compliance obligations.

Section 3.13 Compliance Program Policies and Procedures

A. The Compliance Program includes Policies and Procedures aligned with the seven elements of an effective compliance program, including standards of conduct, FWA training, reporting mechanisms, and corrective action processes.

1. The Chief Compliance Officer ensures that Compliance Program Policies:

a. Are reviewed annually and updated as needed

b. Reflect current regulatory requirements and risk areas

c. Are reviewed by the Compliance Committee and approved through the Policy Review Committee.

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Article IV. **Program Oversight**

Section 4.01 Commission and Compliance Oversight Committee

A. The GCHP Commission maintains ultimate responsibility for oversight of the Compliance Program and is accountable for ensuring that GCHP has established, implemented, and maintained an effective compliance program.

1. The Commission exercises oversight through:

a. Review of periodic reports from the Chief Compliance Officer (CCO) regarding the effectiveness of the Compliance Program, including identified risks, monitoring and auditing results, and corrective actions.

b. Oversight of the implementation and performance of the Compliance Program across all operational areas, including delegated and downstream activities.

c. Participation in compliance training and education to ensure understanding of compliance requirements and program structure.

B. The Compliance Oversight Committee, a standing subcommittee of the Commission, supports the Commission by providing focused oversight of the Compliance Program.

1. The Committee:

a. Is ad hoc and is convened at the request of the CCO or Commission.

b. Reviews compliance program reports, including enterprise risk assessments, audit results, and corrective action plans.

c. Provides recommendations and escalates significant compliance issues to the full Commission.

Section 4.02 Chief Compliance Officer

A. GCHP maintains a designated Chief Compliance Officer (CCO) who is responsible for the day-to-day operations, implantation, and administration of the Compliance Program.

1. The CCO operates with defined authority, independence, and access to leadership and is responsible for:

a. Overseeing the development, implementation, and maintenance of compliance Policies and Procedures within PolicyTech system of record.

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b. Ensuring compliance with federal and state regulatory requirements, accreditation standards, contractual obligations, and internal standards.

c. Leading enterprise-wide compliance risk assessment, monitoring, and auditing activities.

d. Overseeing the Code of Conduct implementation, training, and enforcement.

e. Directing compliance investigations and corrective action processes.

Section 4.03 Reporting Structure and Independence

A. The CCO has dual reporting to the Chief Executive Officer and to the Commission and Compliance Oversight Committee to report compliance issues, risks, and program effectiveness.

B. The CCO is authorized to escalate significant compliance concerns without interference and is empowered to implement corrective actions, consistent with CMS, NCQA, and DHCS requirements for independence and authority.

C. Performance evaluations for the CCO include measures related to the effectiveness of the Compliance Program and enforcement of compliance requirements.

Section 4.04 Compliance Department

A. The CCO oversees the Compliance Department, which includes compliance professionals responsible for key functional areas, including:

1. Regulatory compliance (Medi-Cal and Medicare Parts C and D)
2. Fraud, Waste, and Abuse (FWA prevention and detection)
3. Privacy and data protection
4. Monitoring and auditing, including oversight of MCP contract requirements and delegated entities
5. Policy development and maintenance in PolicyTech
6. Compliance training and education

Section 4.05 Medicare Compliance Manager

A. GCHP maintains a dedicated Medicare Compliance Manager responsible for oversight of Medicare Parts C and D compliance activities, reporting directly to the CCO.

1. The Medicare Compliance Manager is responsible for:

a. Monitoring compliance with regulatory requirements

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b. Supporting FWA prevention, detection, and reporting activities

c. Overseeing Medicare-related auditing and monitoring

d. Supporting policy development and updates

e. Providing training and education specific to Medicare requirements

f. Monitoring compliance with applicable DMHC requirements, All Plan Letters (APLs), and regulatory guidance impacting D-SNP and Medicare-Medi-Cal plan operations

g. Supporting auditing, monitoring, corrective action, and reporting activities related to DMHC-regulated Medicare products and member protection requirements

Section 4.06 The Compliance Committee

A. GCHP maintains a Compliance Committee responsible for advising and supporting the CCO in the oversight and effectiveness of the Compliance Program.

1. The Compliance Committee:

a. Meets at least quarterly and more frequently as needed

b. Reviews compliance reports, audit results, risk assessments, and corrective actions plans

c. Conducts individual reviews of Policies and Procedures at the time of revision to ensure regulatory alignment and risk mitigation

d. Supports development of compliance strategies and program improvements

e. Maintains meeting minutes documenting discussions, decisions, and follow-up actions

Section 4.07 Compliance Committee Composition

A. The Compliance Committee is comprised of executive leaders and subject matter experts, representing key operational, regulatory, and risk management functions across GCHP. The chiefs and executive directors serve as the voting members of the Compliance Committee and are responsible for providing organizational oversight, strategic direction, and decision-making related to the Compliance Program.

B. The Chief Compliance Officer, Compliance Department representatives, and Legal Counsel participate as subject matter experts and advisory members, providing guidance on regulatory requirements, accreditation standards, compliance risks, investigations, auditing and monitoring activities, policy development, corrective actions, and emerging legal or compliance issues. These individuals support the Committee's deliberation and recommendations through specialized expertise.

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C. This multidisciplinary structure ensures that compliance risks are identified, evaluated, and addressed across the organization through collaboration among operational leadership and compliance subject matter experts.

Section 4.08 Compliance Program Independence

A. GCHP maintains the independence of the Compliance Program and CCO to ensure that compliance activities are conducted objectively and without undue influence from operational functions.

1. The Compliance Program and the CCO have the authority to:

   a. Act independently in identifying, investigating, and addressing compliance concerns.

   b. Access all necessary information and personnel to carry out compliance responsibilities.

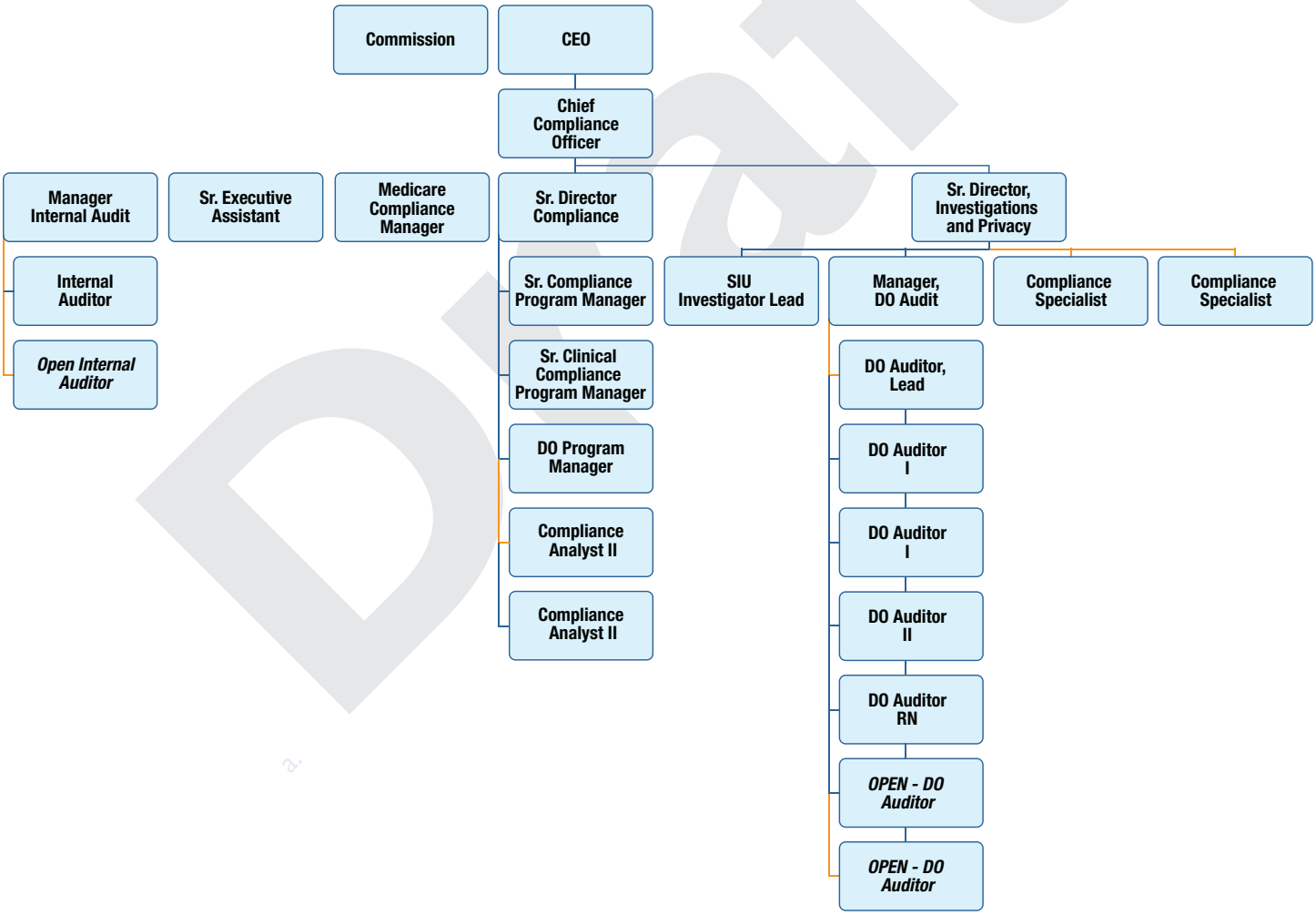
   c. Report findings and escalate concerns directly to the Commission and Compliance Oversight Committee.

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Section 4.09 Compliance Department Organization Chart and Reporting Structure

GCHP maintains a documented Compliance Department organizational structure that defines reporting relationships, roles, and responsibilities. This structure supports effective oversight, communication, and accountability within the Compliance Program.

The organizational chart and reporting structure are maintained as part of the Compliance Program documentation and are updated as needed to reflect organizational changes.



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Article V. **Effective Education And Training**

Section 5.01 Compliance Education and Training Framework

A. GCHP maintains a comprehensive, enterprise-wide Compliance Education and Training Program designed to ensure that employees, workforce members, leadership, Commissioners, network providers, and first tier, downstream, and related Entities (FDRs) understand and comply with applicable regulatory, accreditation, contractual, and ethical requirements.

1. The program ensures that individuals are trained on:

   a. The GCHP Compliance Program and Compliance Plan.

   b. The Code of Conduct and compliance expectations.

   c. Applicable federal and state laws and regulations and accreditation standards including NCQA, Medi-Cal, and Medicare requirements.

   d. Fraud, Waste, and Abuse (FWA), Privacy, and Information Security requirements.

   e. Consequences of non-compliance, including disciplinary action.

Section 5.02 Training Governance and Administration

A. The Compliance Department, under the direction of the CCO, is responsible for the development, implementation, and oversight of the Compliance Education and Training Program, in coordination with the Human Resources Department.

1. Training content is:

   a. Reviewed and updated at least annually.

   b. Updated on a risk-basis in response to regulatory changes, audit findings, or identified compliance risks.

   c. Delivered through Litmos Learning Management System (LMS) to ensure assignment, tracking, and completion documentation are maintained.

Section 5.03 Initial and Annual Training Requirements

A. Initial Training

1. All employees, workforce members, leadership, Commissioners, and appliable FDRs receive compliance training within 30 calendar days of hire, appointment, or contract execution.

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2. Initial training includes:
    a. Code of Conduct
    b. General Compliance Program overview
    c. Fraud, Waste, and Abuse (FWA)
    d. Privacy and Information Security (including Health Insurance Portability and Accountability Act (HIPAA) requirements)
3. Individuals are also provided with access to appliable Policies and Procedures through PolicyTech to support role-based compliance.

B. Annual Training

1. All Employees, workforce members, leadership, and Commissioners complete annual compliance training that includes, at a minimum:
    a. Compliance Program and Code of Conduct
    b. Fraud, Waste, and Abuse (FWA)
    c. Privacy and Informational Security
2. Trainings may be delivered through LMS over the course of the calendar year to support accessibility and completion tracking.

Section 5.04 FDR Training Requirements

A. GCHP ensures that FDRs compliance training is consistent with state and federal requirements by maintaining documentation of annual compliance attestations.

1. FDR can use their own internal training courses and should include:
    a. General compliance training and FWA training
    b. Code of Conduct or equivalent standards of conduct
    c. Documentation of training completion or attestation
2. FDRs who are deemed compliant with FWA training requirements through Medicare enrollment or Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) accreditation are recognized as meeting FWA training requirements, consistent with CMS guidance.

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Section 5.05 Role-Based and Specialized Training

A. GCHP provides or arranges for the provision of additional role-based compliance trainings to employees, leadership, Commissioners, and FDRs based on:

1. Job responsibilities and risk exposure
2. Change in duties or promotion
3. Identified compliance risks or audit findings

B. Specialized training may include:

1. High-risk operational areas
2. Fraud, Waste, and Abuse risk mitigation
3. Regulatory updates and emerging risks

Section 5.06 Commission and Provider Training

A. Commission Training
New Commissioners receive:

1. The Compliance Plan
2. The Code of Conduct
3. FWA, Privacy and Information Security
4. Initial training on compliance program structure and oversight responsibilities

B. Commissioners complete annual training covering:

1. Compliance Program requirements
2. Code of Conduct expectations
3. FWA, Privacy, and Information Security

C. The Chief Compliance Officer provides or arranges for the provision of annual compliance program education to the Commission to support governing body oversight responsibilities.

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Section 5.07 Provider Training

A. Network providers receive:

1. The Code of Conduct
2. The Provider Manual, including compliance requirements and expectations

B. Providers are required or expected (based on contract) to:

1. Train their employees and downstream entities on compliance requirements
2. Comply with applicable laws, regulations, and contractual obligations
3. Provide documentation of compliance training, upon request.

C. GCHP may review subcontractor compliance program and training records as part of its FDR oversight activities.

D. Providers also receive information regarding the False Claims Act in accordance with the Deficit Reduction Action of 2005.

Section 5.08 Training Enforcement and Non-Compliance

A. GCHP maintains processes to ensure completion of required training:

1. Training completion is monitored and tracked through LMS.
2. Individuals who fail to complete required trainings are subject to follow-up and escalation.
3. Disciplinary action may be applied in accordance with established policies and procedures.

Section 5.09 Training Documentation and Recordkeeping

A. GCHP maintains documentation demonstrating compliance with training requirements including:

1. Completion of training modules or courses.
2. Signed or electronic attestation of training completion.
3. Annual acknowledgement of the Code of Conduct.
4. FDR training records and attestations.

B. All training documentation is maintained in an audit-ready format and is available for review to demonstrate compliance with regulatory requirements.

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Section 5.10 Compliance Communications and Ongoing Education

A. GCHP supports continued education through ongoing compliance communications including:

   1. Distribution of fraud alerts, regulatory updates, and policy changes.

   2. Communication of new or revised laws, regulations, contracts, and guidance.

   3. Educational bulletins and compliance awareness messaging.

B. Employees, Commissioners, and providers are informed that additional guidance is available through the Chief Compliance Officer and Compliance Committee.

GCHP intends that these standards be construed broadly to avoid even the appearance of improper activity.

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Article VI. **Communication and Reporting**

Section 6.01 Compliance Program Communication Framework

A. GCHP maintains formal communication and reporting processes to ensure that the Compliance Program, including the Compliance Plan, Code of Conduct, and Policies and Procedures, is effectively distributed, understood, and reinforced across the organization and its first tier, downstream, and related entities (FDRs).

B. The CCO, in coordination with the Compliance Committee, is responsible for overseeing communication and reporting activities, ensuring that compliance expectations are clearly communicated and supported by accessible reporting mechanisms.

Section 6.02 Initial Distribution and Access to Compliance Materials

A. GCHP distributes the Compliance Plan, Code of Conduct, and applicable Policies and Procedures through these controlled systems:

1. PolicyTech as the system of record for Policies and Procedures
2. Litmos LMS for training and attestation
3. GCHP public website (as appropriate)
4. New employees receive compliance materials during onboarding
5. Commissioners receive materials upon appointment and annually
6. Policies remain accessible through PolicyTech for ongoing reference

B. Completion of training, acknowledgements, and attestations are tracked and retained in accordance with record retention requirements.

Section 6.03 Annual Reaffirmation and Attestation

A. GCHP requires annual reaffirmation of compliance expectations:

1. Employees and Commissioners review and acknowledge the Code of Conduct annually
2. Attestations are completed through Litmos
3. Individuals are informed of materials updated prior to attestations

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B. The Compliance Department maintains completed attestations and performs follow-up for non-compliance.

Section 6.04 Ongoing Compliance Communications

A. GCHP maintains ongoing communication channels to support awareness and timely dissemination of compliance-related information, including:

1. Fraud alerts, advisory bulletins, and enforcement trends
2. Regulatory changes and legal updates
3. Policy revisions and operational guidance
4. Emerging compliance risks

B. Communication methods include:

1. New hire and Commission orientation
2. Annual compliance training
3. PolicyTech repository
4. Provider Manual updates
5. SharePoint postings
6. Ad hoc communications

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Article VII. **Reporting and Issue Escalation**

Section 7.01 Reporting Framework and Systems

A. GCHP maintains multiple, accessible reporting channels to support the identification and reporting of potential compliance violations, including Fraud, Waste, and Abuse (FWA) and Privacy incidents.

Section 7.02 Primary Reporting Systems

A. Navex Compliance Reporting System (hotline and case management tool):
   1. 24/7 reporting via phone and web (Ethics Point)
   2. Supports anonymous reporting
   3. Captures, tracks, and manages compliance, FWA, and ethical concerns

B. SharePoint Privacy Incident Report (PIR)
   1. Dedicated system for reporting privacy and information security incidents
   2. Supports standardized intake, tracking, investigation, and resolution

C. All reports are logged, tracked, investigated, and resolved in accordance with established compliance and privacy procedures.

Section 7.03 Additional Reporting Channels

A. GCHP provides additional reporting avenues to ensure accessibility and promote reporting:
   1. Open Door Policy: Employees may report concerns to supervisors, managers, or leadership. Management is trained to escalate issues to the Compliance Department.
   2. Direct Reporting to Compliance: Reports may be made directly to the CCO or Compliance Department.
   3. Written Reporting: Reports may be submitted via mail or form documentation channels.

Section 7.04 Duty to Report

A. All employees, Commissioners, providers, subcontractors, downstream subcontractors, and FDRs have an affirmative obligation to report:

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1. Suspected violations of law or regulation,
2. Potential Frad, Waste, or Abuse (FWA),
3. Privacy or security incidents, or
4. Violations of GCHP policies or Code of Conduct

B. Reports may be submitted through Navex, PIR (for privacy incidents), leadership channels, or directly to Compliance.

Section 7.05 Confidentiality, Anonymous Reporting, and Non-Retaliation

A. GCHP maintains strict confidentiality standards:

1. Reports are handled confidentially to the extent permitted by law
2. Anonymous reporting is available through Navex
3. Privacy incidents reported through the PIR are handled in accordance with privacy and security requirements

Section 7.06 GCHP Strictly Prohibits

A. Retaliation against individuals who report concerns in good faith

B. Intimidation or interference with reporting

C. Individuals are informed of protections under appliable laws, including False Claims Act whistleblower protections

Section 7.07 Voluntary Disclosure

A. GCHP promotes a culture of transparency and accountability by encouraging voluntary disclosure of errors, misconduct, or potential violations.

1. Employees are educated annually on voluntary reporting expectations
2. Self-reporting may support timely correction and mitigation of risk

B. However, voluntary disclosure does not shield individuals from appropriate disciplinary or corrective actions.

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Section 7.08 Communication and Reporting Oversight

A. GCHP maintains oversight of communication and reporting effectiveness through:

1. Tracking of training completion and attestations (Litmos)
2. Policy distribution and access tracking (PolicyTech)
3. Case management and reporting trends (Navex and PIR systems)
4. Reporting of compliance activities to the Compliance Committee and Commission

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Article VIII. **Auditing and Monitoring**

Section 8.01 Monitoring and Auditing Framework

A. GCHP maintains a comprehensive, risk-based monitoring and auditing program designed to evaluate compliance with federal and state laws, regulatory requirements, accreditation standards, contractual obligations, and internal Policies and Procedures.

B. Monitoring and auditing activities are conducted across operational areas and delegated functions to identify compliance risks, assess control effectiveness, and support continuous program improvement.

C. All GCHP departments are responsible for conducting routine monitoring activities with their respective areas, based on:

1. Contractual requirements, accreditation standards, and regulatory requirements
2. Internal Policies and Procedures
3. Prior audit findings and corrective actions
4. Identified risks at the department or enterprise level
5. Direction from executive leadership

Section 8.02 Compliance Department Oversight

A. The Compliance Department, under the direction of the Chief Compliance Officer (CCO) and in coordination with the Compliance Committee, is responsible for:

1. Developing and maintaining enterprise-wide monitoring and auditing policies and procedures
2. Conducting and coordinating compliance audits and monitoring activities
3. Performing enterprise risk assessments to identify high-risk areas
4. Developing and maintaining the annual Monitoring and Auditing Work Plan
5. Tracking and reporting audit results, trends, and corrective actions.
    a. All monitoring and auditing policies and procedures are reviewed and approved through the Compliance Committee and follow GCHP's form policy governance process.

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Section 8.03 Enterprise Monitoring Systems and Issue Identification

A. GCHP utilizes multiple systems and processes to identify compliance risks and potential violations, including:

   1. Reports received through Navex (Compliance Hotlines and case management system) for compliance FWA concerns
   2. Reports submitted through SharePoint Privacy Incident Report (PIR) for privacy and information security incidents
   3. Internal departmental monitoring reports and key performance indicators
   4. Audit findings and external regulatory reviews

B. All reported concerns are reviewed, tracked, investigated, and resolved in accordance with established compliance procedures.

C. The CCO or designee coordinates investigations in consultation with appropriate stakeholders, including General Counsel, and ensures appropriate follow-up actions.

Section 8.04 Internal Monitoring and Department -Level Oversight

A. Department leaders are responsible for ongoing monitoring of operational performance and compliance within their functional areas.

   1. Routine review of internal reports to identify trends, anomalies, or red flags
   2. Escalation of suspected compliance issues, including FWA, through established reporting channels (Navex, PIR, or Compliance Department)
   3. Implementation of corrective actions under the direction of the Compliance Department

B. Identified issues and corrective actions are reported to the Internal Compliance Oversight Committee and Compliance Committee.

Section 8.05 Internal Audit Function

A. GCHP maintains an independent internal audit function that provides objective evaluation of:

   1. Operational processes and internal controls
   2. Compliance with regulatory and contractual requirements
   3. Effectiveness or risk mitigation strategies

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B. Internal audit activities include:

1. Development of audit reports with findings and recommendations
2. Communication of results to business units and the Compliance Committee
3. Follow-up on management action plan implementation

Section 8.06 Oversight of Delegated Entities and FDR Oversight

A. GCHP maintains oversight of all delegated functions and ensures that network providers, subcontractors, downstream subcontractors, and FDRs comply with applicable requirements.

B. Oversight activities include:

1. Execution of formal delegation agreements outlining compliance expectations
2. Routine monitoring and auditing of delegated activities
3. Review of reports submitted by delegated entities
4. Validation of compliance program implementation at the downstream level

C. Delegated activities subject to oversight include, but are not limited to:

1. Pharmacy Benefits Management
2. Behavioral Health
3. Credentialing and recredentialing
4. Utilization Management
5. Claims processing
6. Grievances and Appeals
7. Member Services
8. Call Center
9. Population Health Management
10. Claims

D. Monitoring ensures that FDRs apply compliance requirements to their downstream entities.

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Section 8.07 Regulatory and Contractual Audits

A. GCHP:
   1. Cooperates fully with CMS, DHCS, NCQA, and other regulatory agencies
   2. Serves as the central point of contract for audits related to Medicare and Medi-Cal programs
   3. Coordinates responses across internal departments and delegated entities
   4. Implements corrective action plans following audit findings

B. Corrective actions are tracked and validated to ensure resolution and prevent recurrence.

Section 8.08 Monitoring and Auditing Work Plan(s)

A. GCHP maintains an annual Monitoring and Auditing Work Plan(s) that includes:
   1. Risk-based prioritization of audit activities
   2. Defined audit scope, objectives, and methodology
   3. Assigned ownership and timelines
   4. Strategy for monitoring and auditing FDRs
   5. Processes for corrective action and follow-up

B. The Work Plan(s) are developed based on a formal risk assessment that incorporates:
   1. OIG Work Plan priorities
   2. Regulatory agency guidance
   3. Internal audit, delegation oversight audit, and monitoring results
   4. Reported issues (including Navex and PIR trends)

C. The Compliance Committee reviews and approves the Work Plan(s)

Section 8.09 Tracking, Reporting, and Program Effectiveness

A. GCHP tracks and documents monitoring, auditing, and corrective action activities to evaluate compliance program effectiveness.
   1. Audit results and corrective actions are tracked through compliance systems and reports
   2. Trends, root cause, and risk areas are analyzed

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3. Reports are presented to the Compliance Committee and Commission
4. Program effectiveness is periodically evaluated and adjusted based on findings

Section 8.10 Record Retention and Availability

A. GCHP maintains records in accordance with contractual and regulatory requirements and ensures availability for review by regulatory agencies.

Section 8.11 Exclusion Screening and Participation Verification

A. GCHP maintains processes to ensure that it does not employ or contract with individuals or entities excluded from participation in federal or state health care programs.

B. Screening against OIG List of Excluded Individuals and Entities (LEIE) and System of Award Management (SAM)

C. Ongoing monitoring of employee and contractor eligibility

D. Requirements for immediate disclosure of exclusion status

E. Payment associated with excluded individuals are subject to recoupment.

Draft

Article IX. **Enforcement**

Section 9.01 Standard of Enforcement and Disciplinary Expectations

A. GCHP maintains formal and consistently applied disciplinary standards to enforce compliance with applicable laws, regulations, contractual obligations, the Code of Conduct, and organizational Policies and Procedures.

B. Enforcement applies to all employees, Commissioners, network providers, subcontractors, downstream subcontractors, and first tier, downstream, and related entities (FDRs) consistent with CMS requirements that compliance standards be enforced across all levels of the organization and delegated entities.

Section 9.02 Conduct Subject to Enforcement

A. Individuals and entities may be subject to corrective action or disciplinary measures for non-compliance, including but not limited to:

1. Violations of federal or state laws or regulations
2. Fraud, Waste, and Abuse (FWA) activities
3. Violations of the Code of Conduct or GCHP Policies and Procedures
4. Failure to complete required compliance training or attestations
5. Failure to report suspected compliance violations
6. Privacy incidents

B. Disciplinary actions may include:

1. For employees: corrective action up to and including termination
2. For Commissioners: removal in accordance with governing procedures
3. For providers and FDRs: contract termination, suspension, or other contractual remedies

Section 9.03 Zero Tolerance for Illegal Conduct

A. GCHP maintains a zero-tolerance policy for illegal or unethical conduct that affects its operations, mission, or integrity.

1. No improper conduct will be justified on the basis that it benefited GCHP.

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2. Individuals and entities are held accountable regardless of intent or perceived organizational benefit.
3. Violations may result in immediate disciplinary action, up to and including termination or contract action.

Section 9.04 Disciplinary Decision-Making and Consistency

A. GCHP maintains structured processes to ensure that disciplinary actions are:
   1. Applied consistently across similarly situated individuals and entities
   2. Proportionate to the nature, severity, and frequency of the violation
   3. Documented and supported by investigation findings

B. Disciplinary decisions:
   1. For employees: administered in coordination with Human Resources
   2. For providers and FDRs: implemented in accordance with contractual terms and oversight processes
   3. May involve input from the Compliance Department, Compliance Committee, and General Counsel, as appropriate

Section 9.05 Integration with Compliance Reporting and Investigations

A. Enforcement actions are initiated based on findings from:
   1. Reports submitted through Navex (Compliance Hotline case management system)
   2. Privacy incidents reported through SharePoint Privacy Incident Report (PIR)
   3. Internal monitoring and auditing activities
   4. External audit or regulatory findings

B. All potential violations are investigated in accordance with established procedures prior to determination of disciplinary action.

Section 9.06 Consequences of Non-Compliance

A. Individuals and entities should be aware that violations of applicable laws and regulations may result in:
   1. Internal disciplinary action

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2. Civil, criminal, or administrative penalties
3. Contractual remedies or termination
4. Suspension or exclusion from participation in federal or state healthcare programs

B. GCHP enforces these standards to ensure compliance with regulatory requirements and to protect the integrity of its programs.

Section 9.07 Enforcement Oversight and Documentation

A. GCHP maintains documentation of enforcement actions, including:

1. Investigation findings
2. Disciplinary decisions
3. Corrective actions taken
4. Follow-up and validation activities

B. Enforcement trends and significant actions are reported to the Compliance Committee and Commission to support oversight and program effectiveness evaluation.

Draft

Article X. **Remediation**

Section 10.01 Reporting of Violations and Suspected Violations

A. GCHP requires all Commissioners, employees, network providers, subcontractors, downstream subcontractors, and first tier, downstream, and related entities (FDRs) to promptly report any known or suspected violations of applicable laws, regulations, contractual requirements, the Compliance Program, or the Code Conduct.

1. Reports may be submitted through multiple reporting channels, including:

   a. Navex Compliance Reporting Systems (Hotline and online reporting) for FWA concerns

   b. SharePoint Privacy Incident Report (PIR) for privacy and information security incidents

   c. Supervisors, managers, or department leadership, and Chief Compliance Officer (CCO) or Compliance Department for compliance concerns

Section 10.02 Intake, Triage, Investigation

A. Upon receipt of a report, the Compliance Department is responsible for:

1. Logging and tracking the issue within the appropriate system
2. Performing initial triage to determine risk level, impact, and required response
3. Initiating timely and reasonable investigations

B. High- risk or high-severity issues are escalated immediately to the Chief Compliance Officer and, as appropriate:

1. Human Resources (for employee misconduct)
2. General Counsel (for legal review and privilege considerations)
3. Executive leadership or governing bodies

Section 10.03 Corrective Action and Remediation

A. GCHP implements corrective actions to address confirmed compliance violations and mitigate risk of recurrence.

B. Corrective action activities may include:

1. Development and implementation of corrective action plans (CAPs)

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2. Policy and procedure updates through PolicyTech governance processes
3. Targeted training or re-training of impacted individuals or departments
4. Disciplinary action in coordination with Human Resources
5. Process improvements or control enhancements
6. Repayment, disclosure, or reporting to regulatory agencies, as required

C. The Chief Compliance Officer (or designee) is responsible for reviewing investigation results and overseeing implementation of corrective actions.

Section 10.04 Tracking, Reporting, and Oversight

A. All reported issues, investigations, and corrective actions are:

1. Tracked and managed within Navex systems
2. Documented to demonstrate resolution and closure
3. Monitored for trends, root causes, and recurring risk areas

B. The Compliance Department provides:

1. Quarterly reporting of compliance issues, trends, and corrective actions to the Compliance Committee
2. Summary reporting ensures oversight, transparency, and accountability across the Compliance Officer

Section 10.05 Coordination of Disciplinary Action

A. Where violations involve employee misconduct:

1. The Human Resources Department is responsible for implementing disciplinary action in coordination with the Compliance Department.
2. Disciplinary decisions are based on investigation findings and severity of the violation.

B. For Providers and FDRs:

1. Corrective actions and enforcement measures are implemented in accordance with contractual provisions and oversight requirements.

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Section 10.06 Continuous Improvement and Program Effectiveness

A. GCHP uses information derived from reported issues, investigations, and corrective action to:

1. Identify systemic compliance risks
2. Enhance policies, procedures, and internal controls
3. Inform training and communication efforts
4. Update the Monitoring and Auditing Work Plan

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Article XI. **Anti-fraud Program**

Section 11.01 Anit-Fraud Program Framework

A. GCHP maintains a comprehensive Anit-Fraud, Waste and Abuse (FWA) Program as a core component of its Compliance Program. Through its Special Investigation Unit (SIU), GCHP works to prevent, detect, investigate, and remediate fraudulent, wasteful, and abusive activities.

B. The Anti-Fraud Program is overseen by the Chief Compliance Officer (CCO) and Compliance Committee and is evaluated at least annually using a risk-based approach informed by:

1. Regulatory agency guidance (CMS, DHCS, OIG)
2. 2) Internal monitoring and auditing results
3. 3) External audit findings and industry trends
4. 4) GCHP operational experience and identified risks

Section 11.02 Fraud Detection and Data Analysis

A. GCHP employs a proactive, multi-departmental approach to detect fraud, waste, and abuse through data-driven and operational monitoring activities.

B. Detection activities include:

1. Analysis of internal data sources such as claims, enrollment, and financial data
2. Use of analytics tools and dashboards to identify high-risk providers, utilization patterns, and anomalies
3. Integration of external data sources and regulatory alerts
4. Coordination across operational departments and Special Investigations Unit (SIU)

C. GCHP partners with a claims analytics vendor (e.g., Cotiviti) to conduct pre-payment and post-payment review, identify improper payments, and support recovery activities.

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Section 11.03 Reporting and Intake of FWA Concerns

A. GCHP maintains multiple channels to report suspected FWA, including:

   1. Navex Compliance Reporting System (Hotline and case management) for FWA and compliance concerns.
   2. Reports from employees, providers, FDRs, members, law enforcement, and regulatory agencies
   3. Email, phone, or written submissions
   4. Privacy-related concerns are routed through SharePoint PIR when applicable

B. All reports are logged, tracked, and investigated through formal intake and case management processes.

Section 11.04 Investigation and Corrective Action

A. When potential FWA is identified, GCHP conducts a timely and reasonable inquiry to determine validity and scope.

B. Investigation activities include:

   1. Coordination between SIU, Compliance, Privacy, Legal and operational teams
   2. Documentation and tracking of cases within established systems (Navex) documentation and tracking of cases within established systems (Navex)
   3. Determination of root cause and extent of exposure

C. Where FWA is confirmed, corrective actions may include:

   1. Recovery of overpayments
   2. Disciplinary action
   3. Policy or process updates through PolicyTech
   4. Referral to regulatory agencies

Section 11.05 Response to CMS Fraud Alerts

A. GCHP monitors and responds to CMS-issued fraud alerts and law enforcement notifications related to Medicare Parts C and Part D programs.

B. Upon receipt of a fraud alert, GCHP:

   1. Reviews contractual relationships with identified entities

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2. Conducts retrospective claims analysis
3. Identifies and removes impacted claims from reporting, as applicable
4. Evaluates compliance with the "best knowledge, information, and belief" standard

Section 11.06 Departmental Monitoring Activities

A. Each GCHP department plays a role in fraud detection by:
   1. Monitoring operational activities for indicators of potential FWA
   2. Escalating concerns through established reporting channels (Navex, PIR, Compliance Department)
   3. Supporting investigations and remediation efforts

Section 11.07 Referral to DHCS, MEDIC and Law Enforcement

A. GCHP SIU refers case to DHCS and the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC, or successor entities) and/or law enforcement when appropriate, including:
   1. Suspected criminal, civil, or administrative violations
   2. Multi-plan or multi-state fraud schemes
   3. Patterns of fraud affecting beneficiaries
   4. Cases involving significant financial risk

B. Referrals include required documentation and follow CMS-established processes.

Section 11.08 Education and Training

A. GCHP provides FWA training to employees, Commissioners, providers, members, and FDRs.
   1. Initial training occurs within 30 days of hire or engagement
   2. Annual refresher training is required
   3. Training includes:
      a. Identification of FWA
      b. Reporting mechanisms (including Navex)

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c. False Claims Act requirements

d. Non-retaliation protections

B. FDRs meet training requirements through GCHP or their own compliant training program.

Section 11.09 Coordination and Continuous Improvement

A. The SIU, Compliance Department, and operational areas coordinate to:

1. Identify emerging FWA risks
2. Improve detection methodologies
3. Enhance internal controls
4. Implement corrective actions

B. Findings from FWA activities are incorporated into

1. Monitoring and Auditing Work Plans
2. Policy updates through PolicyTech
3. Training and communication programs

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Article XII. **Filing Systems and Record Management**

Section 12.01 Compliance Documentation and Filing Systems

A. GCHP maintains centralized, controlled filing systems to ensure that all compliance-related documentation is properly created, stored, maintained, and retrievable in an audit-ready format.

B. The Chief Compliance Officer (CCO) is responsible for establishing and overseeing systems of record for compliance documentation, ensuring that documentation supports the implementation, monitoring, and evaluation of the Compliance Program.

C. GCHP utilizes system-based environments to manage compliance records, including:

1. PolicyTech for Policies and Procedures, including version control and approval history
2. Litmos Learning Management System for training completion and attestation records
3. Navex for compliance and FWA reporting, case management, and investigation documentation
4. SharePoint Privacy Incident Report (PIR) for privacy and information security incident tracking and documentation

D. These systems serve as the official repositories for compliance documentation and provide audit-ready evidence of compliance program activities.

Section 12.02 Scope of Compliance Records

A. GCHP maintains records sufficient to demonstrate the implementation, operation, and effectiveness of the Compliance Program. Records include, but are not limited to:

1. Compliance Plan and version history
2. Policies and Procedures and approval documentation
3. Compliance Committee and Commission meeting minutes
4. Training materials and completion records
5. Code of Conduct acknowledgements and attestations
6. Monitoring and auditing work plans, reports, and corrective actions
7. Compliance and FWA investigation case records

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8. Privacy incidents and investigations case records
9. FDR oversight documentation and audits results

Section 12.03 Record Retention Requirements

A. GCHP retains compliance-related records in accordance with applicable federal and state laws, regulations, and contractual obligations.

1. Records related to Medi-Cal and other applicable programs are retained for a minimum of 10 years, unless a longer retention period is required.
2. Records are maintained in a manner that ensures accessibility, integrity, and security.
3. Records are available for review by CMS, DHCS, and other regulatory agencies upon request.

Section 12.04 Documentation Controls and Accessibility

A. GCHP maintains controls to ensure that compliance documentation is:

1. Accurately created and maintained
2. Protected from unauthorized access or alteration
3. Easily retrievable for internal review or external review
4. Organized according to defined recordkeeping standards

B. System-based controls, including audit trails, version control, and user access management, are used to ensure integrity and reliability of documentation.

Section 12.05 Oversight and Reporting

A. The Compliance Department monitors documentation practices and ensures that compliance records are maintained in accordance with established policies and procedures and regulatory requirements.

1. Documentation completeness and accuracy are periodically reviewed as part of monitoring and auditing activities.
2. Documentation deficiencies are addressed through corrective actions
3. Summary reporting of compliance program activities is presented to the Compliance Committee and Commission

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Article XIII. **Compliance Program Reference Documents**

Section 13.01 Compliance Program Supporting Documentation Framework

A. Consistent with the requirements of the DHCS Contract, Exhibit A, Attachment III, Section 1.3 (Program Integrity and Compliance Program), GCHP maintains a structured framework of Compliance Program reference documents that support implementation of the Compliance Program. These documents operationalize the Compliance Plan by providing detailed requirements, procedures, controls, and monitoring activities for high-risk, regulatory, contractual, accreditation, and program-critical areas. Together, the Compliance Plan and supporting documentation establish the governance, oversight, and operational processes necessary to maintain an effective compliance program and support ongoing compliance with DHCS, CMS, NCQA, and other applicable requirements.

B. The Compliance Department maintains division-specific plans that collectively support implementation of the Compliance Program across GCHP operations.

Section 13.02 Governance and Documentation Management

A. All Compliance Program reference documents are:

1. Maintained within PolicyTech, the system of record for policy and program documents
2. Subject to formal lifecycle management, including drafting, review, approval, and version control.
3. Reviewed and updated on a risk-based basis and at minimum annually
4. Reviewed by the Compliance Committee at the time of revision for regulatory alignment and risk mitigation
5. Approved and executed through the Compliance Committee and Commission when applicable

Section 13.03 Scope of Compliance Program Reference Documents

A. The Compliance Program reference documents include, but are not limited to, the following program components:

1. Anti-Fraud, Waste, and Abuse (FWA) Program Plan
2. Compliance Education and Training Program
3. Compliance Program Work Plan

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4. Delegation Assessment and Oversight Process
5. Internal Audit Plan and Methodology
6. Medicare Compliance Program (Part C and Part D)
7. Memorandum of Understanding (MOU) Oversight
8. Privacy Program Management and Oversight Plan

B. Each document defines specific program requirements, operational processes, monitoring activities, and reporting structures applicable to its respective functional area.

Section 13.04 Integration with Compliance Program Operations

A. Compliance Program reference documents are integrated into GCHP's overall compliance framework and are used to:

1. Guide implementation of compliance activities across departments
2. Support monitoring and auditing functions
3. Define roles and responsibilities, and accountability
4. Inform training and communication efforts
5. Provide audit-ready documentation of compliance processes

B. These documents are aligned with:

1. The Compliance Plan
2. Policies and Procedures maintained in PolicyTech
3. Monitoring and auditing activities
4. Reporting and remediation processes

Section 13.05 Accessibility and Availability

A. Compliance Program reference documents are accessible to appropriate stakeholders based on role and responsibility through controlled systems (e.g., PolicyTech, or secure internal repositories).

B. Documents are made available to:

1. Employees and operational leaders as needed for their job functions
2. Compliance Committee and Commission for oversight purposes

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3. Regulatory agencies upon request

Section 13.06 Oversight and Continuous Improvement

A. The Compliance Department monitors and periodically evaluates the effectiveness of these reference documents as part of the overall Compliance Program.

1. Updates are driven by risk assessments, audit findings, regulatory changes, and operational needs.
2. Changes are tracked through PolicyTech with version control and approval documentation.
3. Program improvements are reported to the Compliance Committee and Commission.

Article XIV. **Document Control**

Document Update	Date	Summary
Compliance Plan Revision – Compliance Plan 2024 Draft	May 22, 2023	Plan revised for DHCS 2024 Operational Readiness deliverable R.0022 and required plan updates for DHCS 2024 contract.
DHCS Approval	June 12, 2023	DHCS approved updates to draft 2024 Compliance Plan.
Compliance Plan 2024 moved from Draft to Final	Dec. 21, 2023	2024 Compliance Plan published.
Compliance Plan 2025 moved from Draft to Final	Dec. 5, 2024	2025 Compliance Plan published.
Compliance Committee Approval	Dec. 5, 2024	GCHP Compliance Committee annual review and approval.
Compliance Committee Approval	Nov. 6, 2025	GCHP Compliance Committee annual review and approval.
Compliance Committee Approval Pending	Oct. 27, 2026	GCHP Compliance Committee annual review and approval.
Commission Approval Pending	Nov. 16, 2026	GCHP Commission review and approval.

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Gold Coast Health Plan℠
A Public Entity

GOLD COAST HEALTH PLAN
TOTAL Care ADVANTAGE℠

Integrity • Accountability • Collaboration • Trust • Respect



Compliance Program Plan **2027**

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GOLD COAST HEALTH PLAN
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Compliance Committee Charter



Compassionate care, accessible to all, for a healthy community

Table of Contents

I. Purpose 3
II. Guiding Principles 4
III. Authority 6
IV. Leadership Accountability 7
V. Composition 8
VI. Member Expectations 9
VII. Meetings 10
VIII. Responsibilities 11
IX. Annual Committee Effectiveness Review 18
X. Charter Review 19
XI: Document History 20

Draft

I. Purpose

The Gold Coast Health Plan (GCHP) Compliance Committee serves as the organization's executive compliance governance body responsible for providing active oversight of the Compliance Program, promoting ethical conduct, fostering a culture of compliance, and ensuring accountability for compliance and regulatory risk management throughout the organization.

The Compliance Committee supports the Ventura County Medi-Cal Managed Care Commission (Commission) in carrying out its oversight responsibilities by:

- Monitoring the effectiveness of the Compliance Program
- Overseeing enterprise risk
- Promoting ethical business conduct
- Ensuring accountability for compliance obligations
- Monitoring implementation of corrective actions
- Supporting continuous improvement of compliance program effectiveness
- Advancing a culture of integrity, accountability, collaboration, trust, and respect

The Compliance Committee shall serve as a forum in which organizational leaders actively participate in identifying, discussing, escalating, mitigating, and monitoring compliance and regulatory risks affecting GCHP operations and its members. Compliance is a shared responsibility of leadership and management and is not solely the responsibility of the Compliance Department.

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II. Guiding Principles

The Compliance Committee shall conduct its responsibilities in a manner consistent with:

- GCHP Mission
- GCHP Vision
- GCHP Code of Conduct
- GCHP Core Values
- Federal and state healthcare program requirements
- Center for Medicare & Medicaid Services (CMS) compliance program requirements
- California Department of Health Care Services (DHCS) contractual requirements (Managed Care Contract (MCPC) and State Medicaid Agency Contract (SMAC)
- Department of Managed Health Care (DMHC) licensed under the Knox-Keene Act operating Dual Eligible Special Needs Plan (D-SNP)
- Office of the Inspector General (OIG) Compliance Program Guidance
- Federal Sentencing Guidelines for Effective Compliance Program
- National Committee for Quality Assurance (NCQA)

Committee Members shall model and promote:

- **Integrity** - Achieving the highest quality standards of professional and ethical behavior, with transparency in all business and community interactions
- **Accountability** - Taking responsibility for our actions and being good stewards of our resources
- **Collaboration** - Working together to empower our GCHP community to achieve our shared goals
- **Trust** - Building relationships through honest communication and by following through on our commitments
- **Respect** - Embracing diversity and treating people with compassion and dignity
- **Ethical decision making** - Making decisions that are lawful, honest, fair, and align with GCHP's mission, values, Code of Conduct, and compliance obligations, even when those decisions are difficult, unpopular, or create operational challenges

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- **Transparency** - Promoting open, candid, and timely communication regarding compliance risks, concerns, mistakes, investigations, and corrective actions
- **Organizational Stewardship** - Safeguarding GCHP's resources, reputation, mission, and public trust through responsible governance, effective oversight, risk-based decision-making, and a commitment to long-term organizational success

Committee members are expected to demonstrate GCHP's accountability principles:

- **See it**
  - Understand different perspectives
  - Communicate openly and honestly
  - Ask for feedback
  - Speak up and listen to what's really going on
- **Own it**
  - Stay personally invested
  - Learn from success and failures
  - Make sure your work supports key results
  - Action on the feedback you receive
- **Solve it**
  - Ask, "What else can I do?"
  - Work across teams and roles
  - Tackle challenges with creativity
  - Take smart risks when needed
- **Do it**
  - Follow through on commitments
  - Avoid blame and focus on solutions
  - Track process and report transparently

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- Build trust through consistent action

Committee members are expected to demonstrate GCHP's accountability principles when addressing compliance risk, corrective action, and ethical concerns.

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III. Authority

The Compliance Committee is authorized to:

- Request information from any department, business unit, delegate, contractor, first tier, downstream, related entity (FDR), or workforce member
- Review compliance risk, investigations, audits, and corrective action activities
- Require responsible leaders to report on compliance performance within their operational areas
- Escalate significant compliance issues to the Chief Executive Officer, Compliance Oversight Committee, and Commission
- Recommend strategic program improvements and corrective actions
- Monitor implementation and validation of corrective actions
- Conduct oversight necessary to evaluate Compliance Program effectiveness

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IV. Leadership Accountability

Each voting member serves as the accountable executive for compliance within their area of responsibility Voting members shall:

- Identify compliance and regulatory risks
- Ensure implementation of effective controls
- Monitor compliance performance
- Promptly escalate significant risk and concerns
- Ensure corrective actions are completed timely
- Validate effectiveness of corrective actions
- Promote ethical conduct and compliance awareness
- Ensure departmental compliance with laws, regulations, policies and contractual requirements
- Incorporate compliance considerations into operational decision making

Failure to appropriately address known compliance risks may be reported to executive leadership and the Commission as appropriate.

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V. Composition

The Compliance Committee shall be comprised of executive and operational leaders representing key functions across GCHP.

Members	**Voting Capacity:** Chief Compliance Officer (chair), Chief Diversity Officer, Chief Executive Officer, Chief Financial Officer, Chief Human Resource Officer, Chief Product Officer, Chief Medical Officer, Chief Communication and Community Affairs Officer, Chief Operations Officer, Chief of Staff and Strategy, Executive Director Health Equity, Executive Director Health Services, Executive Director IT, Executive Director Population Health & Equity, Executive Director Procurement, Executive Director Provider Network Ops & Strategies, Executive Director Quality Improvement **Advisory Members:** 2 - General Counsel or legal designee(s), 2 - Compliance Director(s), 6 - Compliance Manager(s), 2 - Compliance Specialist(s), 2 - Compliance Analyst(s), 6 - Auditor(s), and 1 – Special Investigative Unit Investigator

Draft

VI. Member Expectations

Committee members are expected to:

- Attend and actively participate in meetings
- Review materials in advance
- Engage in meaningful discussion and challenges
- Represent compliance risk from their operational areas
- Serve as ambassadors for compliance throughout the organization
- Promote reporting, transparency, and ethical conduct
- Support compliance education and awareness efforts

Voting Members shall not serve solely in an informational capacity

- Repeated failure to attend meetings or participate in committee activities may be escalated to the Chief Executive Officer.

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VII. **Meetings**

The Compliance Committee shall meet at least quarterly and more frequently as determined by the Chief Compliance Officer.

Special meetings may be convened to address:

- Significant compliance events
- Regulatory inquiries
- Privacy breaches
- Fraud, waste, and abuse (FWA) matters
- Government investigations
- Urgent compliance risks

A quorum shall consist of a majority of voting members

Meeting minutes shall document:

- Attendance
- Topics discussed
- Decisions made
- Action items
- Assigned owners
- Target completion dates
- Escalations and follow-up requirements

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VIII. Responsibilities

A. Compliance Program Oversight

Authority

- 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi)
- CMS Medicare Managed Care Manual, Chapters 9 and 21, §50; §50.2.2; §50.2.3
- OIG General Compliance Program Guidance (GCPG), Compliance Program Infrastructure and Oversight

Responsibilities

The Compliance Committee shall:

- Review and recommend approval of Compliance Plan and Compliance Work Plan.
- Review and recommend approval of the Code of Conduct and significant Compliance Program policies and procedures.
- Evaluate the effectiveness of the Compliance Program and its alignment with federal and state requirements.
- Monitor implementation of the seven elements of an effective compliance program.
- Recommend enhancements to strengthen the Compliance Program and support continuous improvement.

B. Culture, Ethics, Organizational Integrity Oversight

Authority

- OIG GCPG, Culture of Compliance, and Ethical Leadership
- OIG GCPG, Speak-Up Culture, and Non-Retaliation
- CMS Chapters 9 and 21 §50.4 Effective Lines of Communication
- GCHP Code of Conduct and Core Values

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Responsibilities
The Compliance Committee shall:

- Promote a culture of integrity, accountability, collaboration, trust, and respect throughout the organization.
- Review trends related to employee concerns, hotline reports, and compliance reporting activity
- Monitor for indicators of retaliation, fear of reporting, or barriers to speaking up.
- Evaluate leadership's effectiveness in promoting ethical conduct and compliance accountability
- Assess organizational culture indicators and compliance awareness activities at least annually.

C. Enterprise Risk Oversight

Authority

- CMS Chapters 9 and 21 §50.6 Monitoring and Auditing
- CMS Chapters 9 and 21 §50.6.3 Compliance Work Plan Development
- OIG GCPG, Risk Assessment and Internal Controls

Responsibilities
The Compliance Committee shall:

- Review the annual enterprise risk assessment
- Identify and prioritize compliance and regulatory risk impacting GCHP
- Review emerging enforcement trends, regulatory changes, and agency guidance issued by CMS, DHCS, OIG, HHS, and other governing agencies.
- Ensure significant risks are assigned to accountable operational leaders
- Monitor mitigation efforts and residual risk associated with identified compliance risks.

D. Monitoring, Auditing, and Internal Control Oversight

Authority

- 42 C.F.R. §§ 422.503(b)(4)(vi)(F) and 423.504(b)(4)(vi)(F)
- CMS Chapters 9 and 21 §50.6 Monitoring and Auditing

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- CMS Chapters 9 and 21 §50.6.5 Auditing of Operations and Compliance Program Effectiveness
- OIG GCPG, Monitoring and Auditing Framework

Responsibilities

The Compliance Committee shall:

- Review and approve the annual Compliance Monitoring and Auditing Work Plan
- Review audit and monitoring results and significant findings
- Evaluate trends, recurring findings, and systemic control weaknesses
- Monitor the effectiveness of internal controls implemented to address compliance risks
- Ensure monitoring and auditing activities address high-risk operational areas

E. Corrective Action and Remediation Oversight

Authority

- CMS Chapters 9 and 21 §50.7 Response and Corrective Action
- CMS Chapters 9 and 21 §50.7.1 Investigation of Detected Offenses
- CMS Chapters 9 and 21 §50.7.2 Corrective Action Plans
- OIG GCPG, Response, Prevention, and Continuous Improvement

Responsibilities

The Compliance Committee shall:

- Review significant investigations and remediation activities
- Ensure corrective action plans are assigned to responsible leaders
- Monitor overdue corrective actions and require updates from accountable owners
- Require evidence demonstrating that corrective actions effectively addressed the identified issue
- Monitor recurring issues to identify systemic causes and opportunities for improvement

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F. Compliance Reporting and Communication Oversight

Authority

- CMS Chapters 9 and 21 §50.4 Effective Lines of Communication
- CMS Chapters 9 and 21 §50.4.2 Reporting Mechanisms
- OIG GCPG, Communication and Reporting Systems

Responsibilities

The Compliance Committee shall:

- Review hotline, compliance reporting, privacy reporting, and fraud reporting trends
- Evaluate the effectiveness of reporting mechanisms available to employees, providers, FDRs, commissioners, and members
- Promote awareness of compliance reporting obligations and non-retaliation protections.
- Monitor reporting volume and trends as indicators of organizational culture and program effectiveness

G. Education and Training Oversight

Authority

- 42 C.F.R. §§ 422.503(b)(4)(vi)(C) and 423.504(b)(4)(vi)(C)
- CMS Chapters 9 and 21 §50.3 Training and Education
- OIG GCPG, Training and Education Programs

Responsibilities

The Compliance Committee shall:

- Review the annual Compliance Education and Training Plan
- Monitor training completion rates and compliance with training requirements
- Evaluate training effectiveness and knowledge retention measures
- Review role-based and risk-based training activities designed to address emerging risks
- Promote leadership participation in compliance education efforts

Draft

H. Fraud, Waste, and Abuse Oversight

Authority

- CMS Chapters 9 and 21 §50.3.2 Fraud, Waste and Abuse Training
- CMS Chapters 9 and 21 §50.6.9 Data Analysis for FWA Prevention and Detection
- CMS Chapters 9 and 21 §50.6.10 Special Investigation Units
- OIG GCPG, Fraud Risk Management

Responsibilities

The Compliance Committee shall:

- Review significant fraud, waste, and abuse risks and investigations
- Monitor the effectiveness of fraud detection and prevention activities
- Review SIU activities, significant referrals, recoveries, and trends
- Monitor implementation of corrective actions resulting from FWA investigations

I. Delegation and FDR Oversight

Authority

- 42 C.F.R. §§ 422.504(i) and 423.505(i)
- CMS Chapters 9 and 21 §40 FDR Oversight
- CMS Chapters 9 and 21 §50.6.6 Monitoring and Auditing of FDRs

Responsibilities

The Compliance Committee shall:

- Review delegated entity oversight activities
- Monitor compliance performance of delegates and FDRs
- Review audit results, corrective actions, and recurring deficiencies involving delegated entities
- Evaluate recommendations involving delegation continuation, probation, suspension, or termination

Draft

J. NCQA Oversight

Authority

- 23-030242 Exhibit A, Attachment III, Section 2.0
- NCQA Health Plan Accreditation Standards and Guidelines

Responsibilities

The Compliance Committee shall:

- Review final survey results, corrective actions (as applicable), and deficiencies involving delegated entities
- Monitor reaccreditation readiness, with an emphasis on high risk, critical factors, and must pass elements
- Ensure significant risks are assigned to accountable operational leaders
- Monitor compliance with requirements to notify NCQA through their Reporting Hotline or as a reportable event (within 30 calendar days), including but not limited to, issuance by a state or federal regulatory agency of sanctions, request for corrective action, and self-identification of systemic issues by the organization or its delegates affecting 5% or more of eligible CM, CR or UM files
- Ensure compliance with DHCS contractual requirements to provide accreditation agency results, including recommended actions or improvements, corrective action plans, and summary of findings

K. DMHC Regulatory Compliance Oversight

Authority

- California Department of Managed Health Care, Knox-Keene Health Care Services Plan Act of 1975
- DMHC All Plan Letters and regulatory guidance
- DMHC Timely Access Regulations
- DMHC Network Adequacy Standards
- Requirements applicable to Medicare-Medi-Cal Plans and Dual Eligible Special Needs Plans (D-SNPs) operating under DMHC oversight

Responsibilities

The Compliance Committee shall:

- Provide oversight of organizational compliance with applicable DMHC requirements and guidance

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- Monitor significant DMHC regulatory developments, enforcement actions, and emerging compliance risks that many impact the organization
- Review compliance risks related to member rights, access to care, grievance and appeals processes, and other consumer protection requirements
- Oversee compliance activities related to network adequacy, timely access, and accessibility standards
- Receive updates regarding regulatory examinations, audits, surveys, corrective action plans, and other interactions with DMHC
- Monitor compliance with requirements applicable to Medicare-Medi-Cal Plans, including D-SNP regulatory obligations subject to DMHC oversight
- Review significant compliance issues, trends, and corrective actions related to DMCS requirements and member protection standards
- Support organizational accountability for maintaining compliance with Knox-Keene Act and other appreciable state regulatory requirements

L. Compliance Reports and Program Effectiveness

Authority

- CMS Chapters 9 and 21 §50.6.7 Tracking and Documentation
- CMS Chapters 9 and 21 §50.2.2 Compliance Committee
- OIG GCPG, Compliance Program Effectiveness and Continuous Improvement

Responsibilities

The Compliance Committee shall review compliance reports at each meeting that include:

- Compliance training completion rates
- Hotline and reporting activity
- Audit and monitoring results
- Corrective action plan status
- Privacy incidents and investigations
- Fraud, waste, and abuse metrics
- Overpayment activity

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- Exclusion screening results
- Enterprise risk indicators and emerging compliance risks

M. Reporting and Escalation to the Commission

Authority

- CMS Chapters 9 and 21 §50.2.3 Governing Body Oversight
- 42 C.F.R. § 422.503(b)(4)(vi)(B) and 423.504(b)(4)(vi)(B)
- OIG GCPG, Governing Body Oversight and Escalation Frameworks

Responsibilities

The Compliance Committee shall:

- Escalate significant compliance matters to the Commission
- Report significant regulatory, legal, operational, financial, and reputational risks
- Provide quarterly reports regarding Compliance Program effectiveness
- Notify the Commission of significant investigations, government inquiries, major overpayments, enforcement actions, or material privacy breaches.

Draft

IX. Annual Committee Effectiveness Review

The Compliance Committee shall employ the Internal Audits Division to conduct an annual committee effectiveness review as part of the overall Compliance Program effectiveness evaluation.

Authority

- OIG General Compliance Program Guidance, Accountability and Incentives
- OIG General Compliance Program Guidance, Governing Body Oversight
- Federal Sentencing Guidelines §8B2.1

Compliance Committee Performance Standards

The effectiveness of the Compliance Committee shall be measured using:

- Attendance and participation
- Achievement of charter responsibilities
- Risk oversight effectiveness
- Corrective action oversight
- Quality of reporting
- Committee engagement
- Program effectiveness outcomes
- Compliance culture advancement

The Committee shall review these measures annually to evaluate its effectiveness and identify opportunities for improvement.

Draft

X. Charter Review

The Charter shall be reviewed at least annually by the Compliance Committee and approved by the Commission.

Revisions shall be made as necessary to address:

- Regulatory changes
- Organizational changes
- Emerging risks
- Compliance Program maturity objectives
- Lessons learned from audits, investigations, and program effectiveness reviews

Vision for the Committee

The compliance committee exists not only to oversee regulatory compliance, but to ensure GCHP fulfills its mission, with integrity, protects the trust placed in it by members of the community, and promotes a culture in which doing the right thing is everyone's responsibility. Committee members are expected to lead by example and champion compliance, ethics, accountability, and transparency throughout the organization.

Draft

XI. Document History

Committee: Compliance Committee	Original Date: February 2012 Revision Date(s): March 26, 2015 Jan. 1, 2018 Nov. 7, 2022 XX/XX/2026
Approved by: Compliance Committee: Nov. 7, 022	**Version 4: Published November 2022**
Approved by: Compliance Committee: Pending Commission: Pending	**Version 5: Pending Approval**

Gold Coast Health Plan℠
A Public Entity

GOLD COAST HEALTH PLAN
TOTAL Care ADVANTAGE℠

Integrity • Accountability • Collaboration • Trust • Respect



Compliance Committee Charter **2027**

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Published: 2026

AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: November 16, 2026

SUBJECT: Quality Improvement and Health Equity: 2025 QIHET Program Evaluation

SUMMARY:

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

The attached PPT report contains a summary of the 2025 QIHET Program Evaluation.

APPROVAL ITEMS:

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

FISCAL IMPACT:

None

RECOMMENDATION:

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

ATTACHMENTS:

1) Timmerman, K., (2026). Quality Improvement, Ventura County Medi-Cal Managed Care Commission, Quality Improvement and Health Equity 2025 QIHET Program Evaluation, Presentation Slides.

Gold Coast Health Plan℠
A Public Entity

Quality Improvement and Health Equity: 2025 QIHET Program Evaluation

November 16, 2026

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

Integrity
Accountability
Collaboration
Trust
Respect

Q3 2026 Quality Improvement Update

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

Approval Requested



Annual QIHET Program & Work Plan Evaluation: Alignment and Purpose

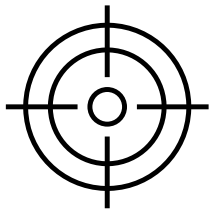


Return to Agenda

2025 QIHET Program Evaluation Highlights

2025 QIHET Program Initiatives

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

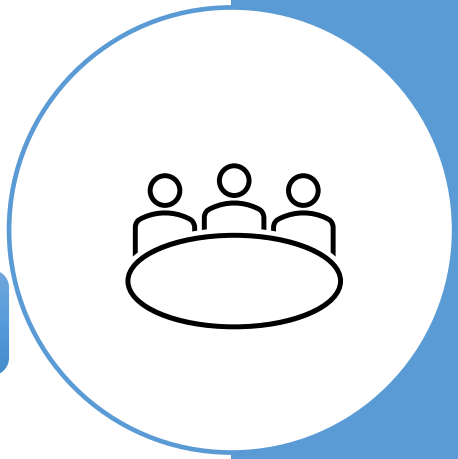


Return to Agenda

2025 QIHET Program Evaluation Highlights

2025 Committee Structure

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



2025 Resources

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

Return to Agenda

2025 QIHET Program Evaluation Highlights

2025 Managed Care Accountability Set (MCAS) Measures

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

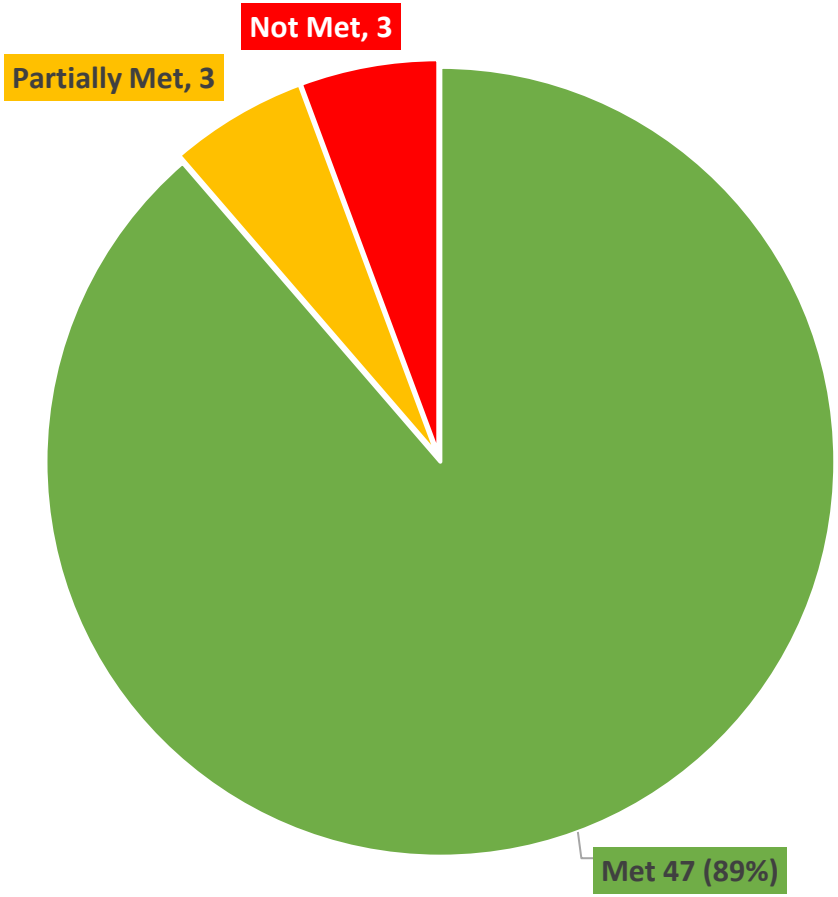


Intervention Focus

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

Return to Agenda

2025 QIHET Work Plan Had 53 Strategic Goals



2025 QIHET Work Plan: Goals Met



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

2025 QIHET Work Plan: Goals Partially Met



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

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

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

2025 QIHET Work Plan: Goals Not Met



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

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

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

2026 QIHET Program and Work Plan Enhancements and Strategic Focus

2026 QIHET Program Description

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

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

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

2026 QIHET Medi-Cal Work Plan

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

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

Assess healthcare landscape for upcoming headwinds and develop remediation plans.

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

2026 QI DSNP Work Plan

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

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

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

Appendix

Objective 1

Improve Quality and Safety of Clinical Care Services

Objective 1: Improve Quality and Safety of Clinical Care Services

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

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

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

Objective 1: Improve Quality and Safety of Clinical Care Services

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

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

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

Objective 1: Improve Quality and Safety of Clinical Care Services

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

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

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

Objective 1: Improve Quality and Safety of Clinical Care Services

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

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

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

Objective 1: Improve Quality and Safety of Clinical Care Services

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

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

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

Objective 1: Improve Quality and Safety of Clinical Care Services

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

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

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

Objective 1: Improve Quality and Safety of Clinical Care Services

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

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

Objective 1: Improve Quality and Safety of Clinical Care Services

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

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

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

Objective 1: Improve Quality and Safety of Clinical Care Services

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

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

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

Objective 1: Improve Quality and Safety of Clinical Care Services

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

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

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

Objective 1: Improve Quality and Safety of Clinical Care Services

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

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

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

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

Objective 1: Improve Quality and Safety of Clinical Care Services

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

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

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

Objective 1: Improve Quality and Safety of Clinical Care Services

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

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

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

Objective 2

Improve Quality and Safety of Non-Clinical Care Services

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

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

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

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

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

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

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

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

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

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

Objective 3

Improve Quality of Services

Objective 3: Improve Quality of Services

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

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

Objective 4

Assess and Improve Member Experience

Objective 4: Assess and Improve Member Experience

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

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

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

Objective 5

Ensure Organizational Oversight of Delegated Activities

Objective 5: Ensure Organizational Oversight of Delegated Activities

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

Questions?

Recommendation:

Approve the 2025 QIHET Program Evaluation

Thank you

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Suma Simcoe, Chief Operating Officer

DATE: November 16, 2026

SUBJECT: Consideration of Termination of Contract with Netmark and Contracting with Health Edge for Claim Payments and Configuration Operations

Executive Summary

Gold Coast Health Plan (GCHP) seeks approval to (a) send a notice of termination to all active Statements of Work with Netmark Business Services LLC without cause, on or before December 1, 2026, and direct the Chief Executive Officer and Legal staff to negotiate the timeframe and plan for transition services, and (b) authorize the Procurement Director to amend the existing contract with HealthEdge for this claims configuration and processing work. The term of the HealthEdge contract will be five years, 6 months commencing December 1, 2026, and expiring on June 30, 2032.

The scope of services for the HealthEdge contract includes:

- System configuration services for GCHP's Health Rules Payer (HRP) claims processing software
- Claims Payment Processing for Medi-Cal and Dual-Special Needs Plan (DSNP) lines of business
- Configuration and Claims auditing and reporting

The recommended termination date of the Netmark contract is January 31, 2027, with a 60-day transition period beginning on December 1, 2026. During the transition period, GCHP would compensate Netmark for the transition services provided in an amount not to exceed $700,000, subject to contract review and final validation. Netmark would remain available during the transition provide any and all necessary transition assistance, answer questions, support knowledge transfer, and turn over relevant data and work products to GCHP.

BACKGROUND/DISCUSSION

GCHP seeks approval to terminate all active Statements of Work with Netmark Business Services without cause, and to amend the existing contract with HealthEdge to include performance as the Business Processing Organization for claims payment and configuration operations. This recommendation is based on Newmark's sustained performance issues, the resulting operational and

financial impact, and HealthEdge's ability to provide an integrated, accountable, and cost-comparable solution.

HealthEdge is the recommended replacement because it offers an integrated solution aligned with GCHP's Health Rules Payer platform and can support both claims configuration and claims processing operations. This alignment is expected to improve accuracy, accountability, and operational control while reducing transition and handoff risk.

HealthEdge is the strongest option based on its platform alignment, implementation experience, potential implementation cost advantages, and ability to support a timely and coordinated transition.

A timely transition is necessary to minimize disruption to claims operations, maintain continuity, and reduce operational risk associated with Netmark's ongoing performance concerns.

Expected benefits include:

- Improved configuration accuracy and claims payment integrity
- Stronger accountability for controllable interest
- Reduced administrative costs associated with:
    - PDRs
    - Claims adjustments
    - Interest payments
    - Disputes
    - Litigation
- Stronger provider relationships through fewer payment and configuration errors
- Reduced provider abrasion and termination risk
- Improved network stability and provider confidence
- More capacity for Provider Network Operations to focus on provider education, training, and billing improvement

Financial Analysis

The financial analysis indicates that transitioning to HealthEdge is expected to be cost-comparable to continuing with Netmark over the applicable remaining contract term, subject to validation of final pricing, approved funding, transition costs, and any contractual obligations. Because the projected costs are nearly equivalent, the recommendation to transition to HealthEdge is based primarily on expected improvements in accuracy, accountability, operational control, and claims payment integrity.

	Netmark Scenario	HealthEdge Scenario	Notes
Comparison period	December 1, 2026 through June 30, 2032 *using Wakely Medicaid membership projections	December 1, 2026 through June 30, 2032 *using Wakely Medicaid membership projections	
Projected costs	**$28,905,095.85** * Assumes Netmark market-rate pricing for claims and configuration services	**$28,917,497.76** * Includes implementation, claims, and configuration services.	HealthEdge has waived 900K in implementation fees.
Approved funding	Approximately $24M		Approximately $17M on the Netmark engagement is unspent.

HealthEdge Overall Value and Reason for Recommendation

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

- HealthEdge offers a solution aligned with GCHP's Health Rules Payer platform and can support both claims configuration and claims processing operations. This solution is immediately implementable, reducing transition and hand-off risk. There is no comparable vendor on the market, aside from the one that we are terminating, Netmark.
- HealthEdge provides platform alignment, implementation experience, implementation cost advantages, and the ability to support a timely and coordinated transition from the existing vendor.

RECOMMENDATION:

It is the Plan's recommendation that the Commission authorize the Plan to (a) terminate the existing statements of work with Netmark without cause and direct the Chief Executive Officer and Legal staff to negotiate the timeframe and plan for transition services, and (b) authorize the Procurement Director to amend the contract with Health Edge to include claims payment and configuration operations. Procurement Director to execute a contract amendment with HealthEdge. The term of the contract will be five years 6 months commencing December 1, 2026, and expiring on June 30, 2032.

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

AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel
Marlen Torres, Chief Communications & Community Affairs Officer

DATE: November 16, 2026

SUBJECT: List of Organizations to Promote Public Participation

RECOMMENDED ACTION(S): Approve list of organizations, media outlets, and other entities for purposes of outreach to groups that do not traditionally participate in Gold Coast Health Plan's public meetings.

REPORT SUMMARY: Senate Bill 707 (SB 707) amended the Brown Act to require eligible legislative bodies to take certain actions to encourage residents, including those in underrepresented communities and non-English-speaking communities, to participate in public meetings. Gold Coast Health Plan's Commission ("Plan") adopted Public Participation and Community Outreach and Disruption of Meetings Policies (the "Policies") earlier this year with the direction for staff to prepare and present to the Commission a list of organizations, media outlets, or entities that will be targeted to expand public meeting access and participation. This staff report provides the prepared list, consistent with the Policies.

Public Participation and Community Outreach Policy
On June 29, 2026, the Plan adopted the Policies to establish reasonable efforts that Gold Coast Health Plan ("Plan") would take to invite groups that do not traditionally participate in public meetings to attend its meetings under the Brown Act (Government Code § 54953.4(b)(2)). This Policy is intended to support inclusive public engagement while preserving the Plan's discretion to determine and adjust appropriate outreach methods based on local needs, priorities, and available resources.

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

- Media organizations that provide news coverage, including media organizations that serve non-English-speaking communities; and
- Community-based organizations such as good government groups, civil rights organizations, civic engagement organizations, neighborhood associations, and other

community or cultural groups active in the Plan's jurisdiction, including organizations active in non-English-speaking communities.

The list of organizations, media outlets, and other entities is provided below:

1. Mixteco/Indigena Community Organizing Project (MICOP)
2. Latino Town Hall
3. Poder Popular
4. Rainbow Connection Family Resource and Empowerment Center
5. Many Mansions
6. El Concilio Family Services
7. Food Share of Ventura County
8. Community Action of Ventura County
9. Promotoras y Promoteres
10. Boys and Girls Club of Greater Oxnard and Port Hueneme
11. First 5 of Ventura County
12. Goodwill Industries
13. United Parents
14. Salvation Army
15. Children Development Resources of Ventura County
16. One Step A la Vez
17. Westminster Free Clinic

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

The Commission may periodically review its outreach practices and make adjustments as appropriate. In doing so, it may consider factors such as community feedback, participation levels, resource availability, and evolving communication practices. The Brown Act provides that the Plan has wide latitude to determine how to pursue reasonable efforts to invite groups that do not traditionally participate in public meetings to participate. Nothing in the Policies requires the use of any particular outreach method.

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

FISCAL IMPACTS: N/A.

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

ATTACHMENT(S):

1. Public Participation and Community Outreach Policies

Public Participation and Community Outreach Policy

1. Background

Senate Bill 707 (2025) amended the Brown Act to require eligible legislative bodies to take certain actions to encourage residents, including those in underrepresented communities and non-English-speaking communities, to participate in public meetings.

2. Purpose Plan

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

3. Identification of Outreach Recipients

Within 6 months of the adoption of this Policy, Gold Coast Health Plan staff will prepare and present to the Ventura County Medi-Cal Managed Care Commission ("Commission") a list of organizations, media outlets, and other entities that may assist in expanding awareness of the Commission meetings. This list may include, but is not limited to,

(a) Media organizations that provide news coverage in Gold Coast Health Plan's jurisdiction, including media organizations that serve non-English-speaking communities; and

(b) community-based organizations such as good groups, civil rights organizations, civic engagement organizations, neighborhood associations, and other community or cultural organizations groups active in Gold Coast Health Plan's jurisdiction, including organizations active in non-English-speaking

The list may be updated periodically as determined appropriate by the Commission or designated staff. Pending such identification, Gold Coast Health Plan staff will make diligent efforts to outreach to such organizations about Commission meetings.

4. Outreach Methods

Using the above list and currently known organizations, media outlets and entities, the Commission may provide direction to staff to utilize a variety of outreach methods, depending on available resources and community needs. These may include direct distribution of meeting information through e-mail or other notification systems; posting of meeting information on the Gold Coast Health Plan's website or other digital platforms; use of social media or electronic communications; and coordination with media outlets or community organizations to share information about upcoming meetings.

The Commission may also provide direction to staff to consider partnerships with community-based organizations or other stakeholders to help disseminate information to broader or underrepresented audiences. Where feasible, outreach efforts may include the use of multilingual communications, culturally relevant messaging, or engagement through media outlets serving diverse communities.

Nothing in this Policy, however, requires the use of any particular outreach method.

5. Role of Staff

The Commission may assign responsibility for supporting outreach efforts to appropriate Gold Coast Health Plan staff, including but not limited to the Clerk's office, Communications staff, or other designated personnel. Staff responsibilities may include maintaining or updating outreach contact lists, preparing and distributing outreach materials, coordinating with community organizations or media outlets, and recommending outreach strategies for consideration by Gold Coast Health Plan. Staff may also assist in identifying opportunities to improve outreach) based on wey eo feedback, or changes in community needs.

6. Documentation and Reporting

The Commission may request periodic summaries of outreach efforts for informational purposes. Such summaries may include general descriptions of outreach activities undertaken, categories of organizations or groups contacted, and observations regarding participation or engagement trends. Reporting may be provided on a periodic basis as determined by the Commission and is not intended to require detailed tracking of every outreach activity.

7. Evaluation and Adjustment

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

8. Discretion and Commission Limitation

This Policy is intended to provide general guidance and does not create mandatory duties or obligations. The Commission retains broad discretion in determining what constitutes reasonable outreach efforts. Consistent with applicable law, failure to provide outreach or notice to any specific organization or group shall not give rise to any claim or liability.

9. Additional Brown Act Public Access Requirements

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

10. Review and Updates

This Policy may be amended by the Commission at a public meeting in open session.

Disruption of Meetings Policy

1. Background

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

2. Purpose

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

3. Definitions

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

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

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

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

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

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

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

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

4. Applicability

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

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

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

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

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

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

5. Remote Public Access Generally

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

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

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

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

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

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

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

6. Response to Service Disruption

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

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

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

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

7. Reconvening the Open Session

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

a. Adjourn the meeting;

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

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

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

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

8. Recordkeeping

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

- The nature and time of the service disruption;

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

9. Response to Members of the Public Disrupting a Meeting

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

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

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

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

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

10. Review and Updates

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

AGENDA ITEM NO. 13

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Christopher Lee, Chief Financial Officer
Baker Tilly Representatives

DATE: November 16, 2026

SUBJECT: Gold Coast Health Plan 2026 Audit Results and Summary

PowerPoint with Verbal Presentation

ATTACHMENTS:

2026 Audit Results

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

December 31, 2026
Audit Planning

Discussion with Management and the Commission

Baker Tilly US, LLP, trading as Baker Tilly, is a member of the global network of Baker Tilly International Ltd., the members of which are separate and independent legal entities. © 2022 Baker Tilly US, LLP.

Return to Agenda

1. Your Service Team
2. Scope of Services
3. Auditor's Responsibilities in a Financial Statement Audit
4. Significant Risks Identified
5. Risks Discussion
6. Consideration of Fraud in a Financial Statement Audit
7. Prior Year Report to Management
8. Audit Timeline
9. Audit Deliverables
10. Expectations
11. Documents Containing Audited Financial Statements and Auditor's Report
12. Recent Accounting Developments
13. Executive Session

Your Service Team



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Other Team Members:

Danila Afonin
Audit Senior

Alyssa Farra
Audit Staff

Scope of Services

Relationships between Baker Tilly and Gold Coast Health Plan:

Annual Audit

Annual financial statement audit as of and for the year ending December 31, 2026

Non-Attest Services

- Assist management with drafting the financial statements as of and for the year ending December 31, 2026, excluding management's discussion and analysis
- Human Resource policy review
- Medical loss ratio review

Auditor's Responsibilities in a Financial Statement Audit

Auditor is responsible for:

- forming and expressing an opinion on whether the financial statements are prepared, in all material respects, in conformity with applicable financial reporting framework.
- communicating significant matters, as defined by professional standards, arising during the audit that are relevant to you.
- when applicable, communicating particular matters required by law or regulation, by agreement with you, or by other requirements applicable to the engagement.

The audit of the financial statements doesn't relieve management or you of your responsibilities.

The auditor is not responsible for designing procedures for the purpose of identifying other matters to communicate to you.

Significant Risks Identified

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

Significant Risks	Procedures
Premium Revenue Recognition	We will test internal controls around revenue recognition, vouch membership and rates to supporting documentation, and reconcile revenue recognized to monthly cash payments from the State of California.
Medical Claims Liability	We will test internal controls over the claims process, perform a lookback analysis on the prior year medical claims liability estimate, review the actuarial specialist's model and report, and perform analytical procedures around the current period estimate.
Management Override of Controls	We will perform inquiries of accounting and operational personnel, perform risk assessment procedures, and test risk-based manual journal entry selections.

Risks Discussion

1. What are your views regarding:
   - Gold Coast Health Plan's objectives, strategies, and business risks that may result in material misstatements
   - Significant communications between the entity and regulators
   - Attitudes, awareness, and actions concerning
     - Gold Coast Health Plan's internal control and importance
     - How those charged with governance oversee the effectiveness of internal control
     - Detection or the possibility of fraud
     - Other matters relevant to the audit
2. Do you have any areas of concern?



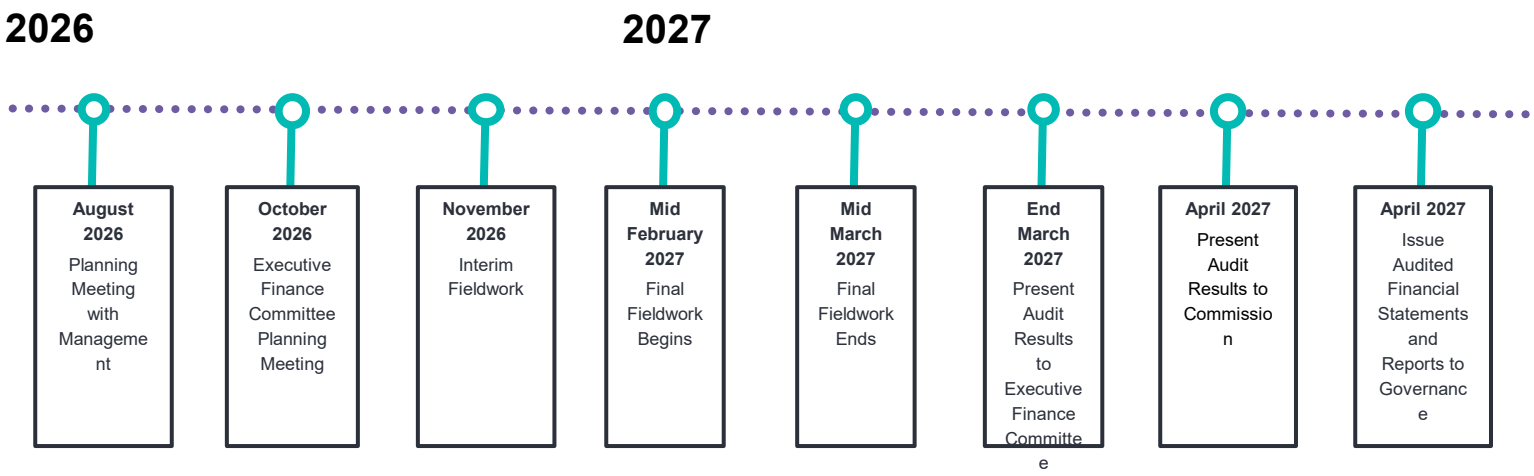
Consideration of Fraud in a Financial Statement Audit

Auditor's responsibility: Obtain reasonable assurance the financial statements as a whole are free from material misstatement – whether caused by fraud or error

To identify fraud-related risks of material misstatement, we:
• Brainstorm with team • Conduct personnel interviews • Document understanding of internal control • Consider unusual or unexpected relationships identified in planning and performing the audit

Procedures we perform:
• Examine general journal entries for nonstandard transactions • Evaluate policies and accounting for revenue recognition • Test and analyze significant accounting estimates for biases • Evaluate rationale for significant unusual transactions

Audit Timeline



Audit Deliverables

Report of Independent Auditors
on financial statements as of and for the year ended December 31, 2026

Report to Management
(communicating internal control related matters identified in an audit)

Report to Those Charged With Governance
(communicating required matters and other matters of interest)



Return to Agenda

Expectations

Gold Coast Health Plan will:
• Have no adjusting journal entries after beginning of field work. • Close books and records before beginning of field work. • Provide auditor requested information in CAP schedule one week prior to the beginning of fieldwork.

Baker Tilly will:
• Communicate proposed adjustments with management when identified. • Communicate control deficiencies with management when identified. • Discuss any additional fees over estimate in engagement letter with management.

Documents Containing Audited Financial Statements and Independent Auditor's Report

Our responsibility under generally accepted auditing standards

Request for advance notification when you intend to include audited financial statements and the independent auditor's report in a document

Arrangements to obtain the other information prior to report issuance

Recent Accounting Developments

Accounting Standards Update – GASB

Statement	Title	Effective
No. 103	*Financial Reporting Model Improvements* – The objective of this Statement is to improve key components of the financial reporting model to enhance its effectiveness in providing information that is essential for decision making and assessing a government's accountability. This Statement also addresses certain application issues.	Fiscal years beginning after June 15, 2025 (Effective for FY26).
No. 104	*Disclosure of Certain Capital Assets* – State and local governments are required to provide detailed information about capital assets in notes to financial statements. Statement No. 34, Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments, requires certain information regarding capital assets to be presented by major class.	Fiscal years beginning after June 15, 2025 (Effective for FY26).

Accounting Standards Update – GASB

Statement	Title	Effective
No. 105	*Subsequent Events* – The primary objective of this Statement is to improve the financial reporting requirements for subsequent events, thereby enhancing consistency in their application and better meeting the information needs of financial statement users. This Statement clarifies the subsequent events that constitute recognized and non-recognized events and establishes specific note disclosure requirements for non-recognized events.	Fiscal years beginning after June 15, 2026 (Effective for FY27).

ABOUT
BAKER
TILLY

Firm Background

At Baker Tilly, we bring a legacy and commitment to helping our clients embrace what's next.

With more than 11,000 professionals from coast to coast, our resources fuel our ability to offer clients deep industry insights, bold thinking and holistic solutions. Our ranking as the sixth-largest advisory CPA firm means we're actively shaping the industry landscape across markets.

6th
largest U.S. accounting firm

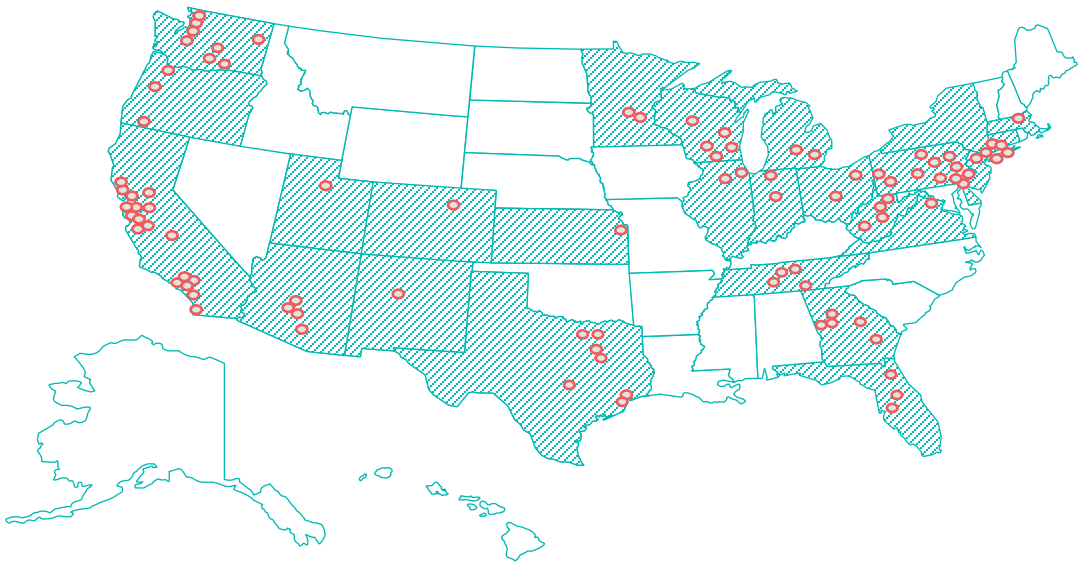
100+
years in business

11,000+
team members, 1,000+ principals

~3,400
Certified Public Accountants

$3B+
firm revenue in FY2024

700+
worldwide office locations



INDUSTRY
EXPERTISE

Committed to Health Care

The demand for vital health care services continues to rise amid a multitude of challenges that impact the quality, accessibility, and efficiency of care.

From helping you comply with new regulations to easing your tax burden to exploring new care models, our dedicated health care professionals have the experience and expertise to help you navigate a complex new world.



Nearly
6,500
HEALTH CARE CLIENTS
across the nation

Nearly
500
PROFESSIONALS
specializing
in health care

More than
60
PRINCIPALS
specializing
in health care

LEADERSHIP INVOLVEMENT
with AICPA Health Care Expert Panel and HFMA National Principles and Practice Board

INDUSTRY EXPERTISE

Health Plans and Insurance

Recognized as a Top Audit Firm by AM Best Company's *Best's Review* consecutively since 2018, **we audit the fifth largest number of health plans** based on 2024 rankings and serve the needs of over 900 clients ranging in size and structure from large,
billion-dollar member insurers to small, captive insurers. In addition to tax and assurance services, we also focus on operational and systems infrastructure.



Nearly
900
CLIENTS
across the nation

TOP AUDIT FIRM
by AM Best Company's *Best's Review*

Selected industry involvement

- National association of insurance commissioners (NAIC)
- Insurance accounting and systems association (IASA)
- America's health insurance plans (AHIP)
- American institute of certified public accountants (AICPA) insurance expert panel (past)

Health Care Advisory Services

Audit and tax are vital. But you have complex needs that go beyond these core functions. Our dedicated health care consulting team provides a range of services to address all your emerging needs—both now and in the future.

Health care consulting

STRATEGY & INTEGRATION

- Provider risk analysis, contracting & operational design
- M&A support
- Feasibility studies
- Market intelligence & benchmarking
- Strategic planning & implementation
- Managed care assessment & negotiation
- Service line enhancement & analyses

INFORMATION TECHNOLOGY

- HIPAA security & privacy
- Network security & penetration testing
- HITRUST assessment & certification
- Disaster recovery planning
- PCI DSS audits
- SOC pre-audit gap analysis & readiness
- SOC audits

PROVIDER REIMBURSEMENT ENTERPRISE SERVICES

- Medicare & medicaid
- Provider-based licensure & certification
- Medical education
- Uncompensated care
- Wage index reviews
- Contract compliance

OPERATIONAL IMPROVEMENT

- Revenue cycle enhancement
- Claims recovery
- Litigation support
- Employer health benefits
- Financial turnaround
- Performance excellence
- Valuations

GOVERNMENT COMPLIANCE

- Regulatory compliance
- Coding validation
- Coding department redesign
- EHR internal controls
- Corporate compliance

LEAN TRANSFORMATION

- 3P & innovation
- Lean strategic planning & strategy deployment (hoshin kanri)
- Lean management systems & operations
- Quality & patient safety
- Internal infrastructure development



Join C-suite professionals from across the healthcare ecosystem to discuss the state of the industry and prepare leaders for 2026.

HIGHLIGHTS

Nov. 11: Women's Executive Healthcare Leadership Forum

Nov. 12–13: Executive Healthcare Conference

State of the Union
Political Point-Counterpoints
Reception with Keynotes
Economic Forecast

bakertilly

LEARN MORE

WHAT PAST ATTENDEES HAVE SAID

Caliber of presenters was phenomenal.

The whole conference for a board member was interesting. I wish it were something I had done early on.

Hearing from experts who have intimate knowledge on what the payer landscape looks like, their challenges and goals, helps us help our physicians.

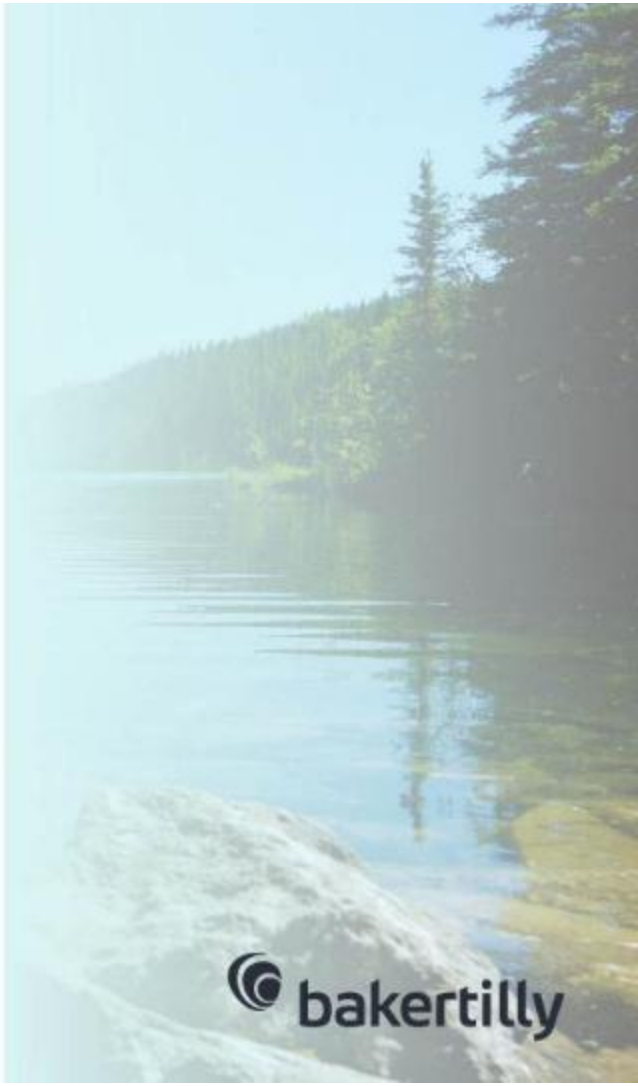
Great speakers and very engaging discussion topics.

Extremely beneficial to blend in the political perspective to the session and how it may impact the industry and our work overall.

It was great to get a broader perspective of the health care ecosystem beyond my region.

Attending the Women's Executive Leadership Forum prior to the conference was most valuable.

The industry, economic, and political presentations and panels were the most intriguing and engaging.



Executive Session

THANK YOU

Gold Coast Health Plan℠
A Public Entity

AGENDA ITEM NO. 14

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: November 16, 2026

SUBJECT: Consideration and Recommendation for Approval of the Claims Payment Advance and Provider Advance Policy

SUMMARY:

Staff are presenting the proposed Claims Payment Advance and Provider Advance Policy for Commission approval. 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.

RECOMMENDATION:

Staff recommend that the Commission approve the policy as presented.

ATTACHMENT:

Provider Advance Policy

POLICY AND PROCEDURE	
TITLE: Claims Payment Advance and Provider Advance Policy	
DEPARTMENT: Finance	**POLICY #:** F-Xxxxx
EFFECTIVE DATE: 11/16/2026	**REVIEW/REVISION DATE:** Not Set
COMMITTEE APPROVAL DATE: Not Set	**RETIRE DATE:** Not Set
PRODUCT TYPE: Medi-Cal and Medicare	**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. Repayment sources may be utilized only if permissible under state or federal law and consistent with any conditions, restrictions, or requirements associated with the source of funding.
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.

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- No history of fraudulent billing activity

Result:
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. Managed Care Plan Liquidity Test

Provider Advance shall not be issued if the proposed advance would cause projected Days Cash on Hand to fall below 60 days.

Prior to issuance of Provider Advance, management shall evaluate the Plan's projected liquidity position after giving effect to the proposed advance.

Projected Days Cash on Hand shall be calculated as follows:

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The Plan's Liquidity Position shall be calculated as:
Cash and Short-Term Investments
Less: MCO Tax Liabilities
Less: Directed Payment Liabilities
Less: Amounts Payable to the State

Average Daily Operating Cash Requirement shall be calculated as:
Year-to-Date Operating Expenses, excluding Depreciation and Amortization, divided by the number of days in the evaluation period.

Days Cash on Hand shall be calculated as:
Liquidity Position ÷ Average Daily Operating Cash Requirement.

Result:
PASS: Projected Days Cash on Hand is equal to or greater than 60 days.
FAIL: Projected Days Cash on Hand is less than 60 days.

H. 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 (≥3.0x)	PASS
Provider History Test	PASS
Insolvency and Viability Test	PASS
Tangible Net Equity Safeguard Test	PASS
Managed Care Plan Liquidity Test	PASS

Provider Advance Limitations
Provider Advance shall not exceed the lesser of:
(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.

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- 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. Offset sources may be utilized only if permissible under state or federal law and consistent with any conditions, restrictions, or requirements associated with the source of funding.

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.
- 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

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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 ÷ $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 ÷ 365 = $164,384
Days Cash on Hand: $6,000,000 ÷ $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 ÷ $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

6. Managed Care Plan Liquidity Test
The following example is provided for illustrative purposes only and is intended to demonstrate the methodology used in calculating the Plan's liquidity position and days cash on hand.

Description	Amount
Cash and Short-Term Investments	$250,000,000
Less: MCO Tax Liabilities	(25,000,000)
Less: Directed Payment Liabilities	(60,000,000)
Less: Amounts Payable to the State	(15,000,000)
Liquidity Position	**$150,000,000**

Average Daily Operating Cash Requirement Calculation	Amount
Year-to-Date Operating Expenses	$365,000,000
Less: Depreciation & Amortization	(15,000,000)
Cash Operating Expenses	**$350,000,000**

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Evaluation Period (Days)	273
Average Daily Operating Cash Requirement	**$1,282,051**

Liquidity Analysis	**Amount**
Liquidity Position Before Provider Advance	$150,000,000
Average Daily Operating Cash Requirement	$1,282,051
Days Cash on Hand Before Advance	**117.0 Days**
Proposed Provider Advance	(10,000,000)
Adjusted Liquidity Position	$140,000,000
Days Cash on Hand After A	**109.2 Days**

Final Determination: The proposed Provider Advance results in projected Days Cash on Hand of 109.2 days, which exceeds the minimum required threshold of 60 days.

Result; PASS

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Gold Coast Health Plan℠
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AGENDA ITEM NO. 15

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: November 16, 2026

SUBJECT: Investment Policy

SUMMARY:

Staff are presenting the proposed updated Investment Policy. The policy establishes the framework for investing Gold Coast Health Plan operating and reserve funds, with the primary objectives of preserving principal, maintaining liquidity, and earning a competitive rate of return consistent with California Government Code requirements.

The policy delegates day-to-day investment management to the Chief Financial Officer, establishes authorized investment types and risk controls, and requires periodic reporting to the Executive Finance Committee and Commission. The policy is intended to strengthen stewardship of public funds while providing staff with appropriate flexibility to manage the Plan's cash resources within Commission-approved parameters.

The Investment Policy outlines the following primary investment objectives in priority order, which are required by law:

- To provide safety of principal;
- To provide sufficient liquidity; and
- To maximize return on investments.]

The Investment Policy preserves the Commission's policy-setting and oversight responsibilities, while delegating the day-to-day management of the investment program to the Chief Financial Officer. Pursuance to the legal framework, such delegation authority, if desired, must be renewed each year. As long as the Chief Financial Officer is delegated such authority, a monthly report of investment transactions must be provided to the Commission. Additionally, any material policy exceptions, credit concerns or significant investment matters must be reported to the Commission at the subsequent regularly scheduled meeting of the Commission.

Exhibit 1 to the Investment Policy lays out the allowable investments that may be utilized for the Plan. The exhibit describes the types of investments that are allowable, the maximum

percentage of the portfolio that may be invested in such investment types, the maximum maturity of the investment, and whether any credit quality is required.

RECOMMENDATION:

Receive and file. Staff recommend that the Commission approve the policy as presented.

ATTACHMENT:

Investment Policy, clean and relined versions.

POLICY AND PROCEDURE	
TITLE: Investment Policy	
DEPARTMENT: Finance	**POLICY #:** F-Xxxxx
EFFECTIVE DATE: 11/XX/2026	**REVIEW/REVISION DATE:** Not Set
COMMITTEE APPROVAL DATE: Not Set	**RETIRE DATE:** Upon Replacement or Rescission
PRODUCT TYPE: Medi-Cal and Medicare	**REPLACES:** New Policy

Purpose:

This Investment Policy ("Investment Policy") sets forth the investment guidelines for all Operating Funds and Commission Designated Reserve Funds (also referred to as Assigned) of Ventura County Medi-Cal Managed Care Commission, ("Commission") dba Gold Coast Health Plan ("Plan"). This Investment Policy does not apply to any bond/debt proceeds invested pursuant to their respective bond documents. The objective of this Investment Policy is to ensure the Plan's funds are prudently invested according to the Commission's objectives to preserve capital, provide necessary liquidity and to achieve a market-average rate of return through economic cycles.

Investments may only be made as authorized by this Investment Policy. The Investment Policy conforms to California Government Code sections 53600 *et seq*. (the "Code") as well as customary standards of prudent investment management. Irrespective of these policy provisions, should the provisions of the Code or any other applicable law be or become more restrictive than those contained herein, such provisions will be considered immediately incorporated into the Investment Policy.

I. OBJECTIVES

The Plan's investment objectives, in order of priority, are as follows:

A. Safety of Principal - Safety of principal is the foremost investment objective of the Plan. Each investment transaction shall seek to ensure that the risks of capital losses are minimized, including risks arising from institutional default, broker-dealer default, or erosion of market value of securities. The Plan shall seek to preserve principal by mitigating the two types of risk, credit risk and market risk, to the extent reasonable under the circumstances.

B. Liquidity - Liquidity is the second most important investment objective of the Plan. The portfolio shall contain investments for which there is a secondary

market or which otherwise offer the flexibility to be sold or liquidated within a reasonable amount time as set forth in this Investment Policy with minimal risk of loss of either the principal or interest based upon then prevailing rates.

C. Total Return - The Plan's portfolio shall be designed to earn a competitive rate of return (i.e., yield) within the confines of the California Government Code, this Investment Policy, and procedural structure.

The length of term for all investments shall be commensurate with the short, medium, and long-term cash flow needs of the Plan, and in compliance with the California Government Code. Market risk and the risk of market value fluctuations due to overall changes in the general level of interest rates shall be mitigated by matching maturity dates, to the extent possible, to the Plan's expected cash flow draws. It is explicitly recognized herein, however, that in a diversified portfolio, occasional losses are inevitable and must be considered within the context of the overall investment return. Consideration will be given to debt securities that would trigger capital gains or losses as market interest rates fluctuate.

II. PRUDENCE

The Plan's Commissioners, officials and employees authorized to make investment decisions on behalf of the Plan are trustees and fiduciaries subject to the prudent investor standard.

The standard of prudence to be used by investment officials shall be the "prudent person" standard as defined in Code Section 53600.3 and shall be applied in the context of managing an overall portfolio of public moneys.

THE PRUDENT PERSON STANDARD: When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the Plan, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the agency.

III. ETHICS AND CONFLICTS OF INTEREST

The Plan's officers and employees involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to make impartial investment decisions. The Plan's officers and employees involved in the investment process are not permitted to have any material financial interests in

financial institutions, including state or federal credit unions, that conduct business with the Plan, and they are not permitted to have any personal financial or investment holdings that could be materially related to the performance of the Plan's investments.

IV. DELEGATION OF AUTHORITY

Authority to manage the Plan's investment program is derived from the policies established by the Commission. Management responsibility for the investment program is hereby delegated to the Plan's Chief Financial Officer (“CFO”). The CFO may engage an independent licensed Investment Advisor ("Investment Advisor") to assist in managing the investment portfolio based upon the investment policies. Any Investment Advisor must comply with this Investment Policy and ensure that the investment objectives are met. The CFO shall be responsible for all actions undertaken and shall establish a system of controls to regulate the activities of any Independent Advisors and/or subordinate investment staff.

The CFO and/or Investment Advisor/s shall mitigate risk by following these guidelines:

A. Pre-qualifying financial institutions with which it will do business through the utilization of Moody's Credit Review Service, Standard and Poor's Financial Institutions Ratings, and Moody's Commercial Paper Record.

B. Diversifying the portfolio so that the failure of any one issuer or backer will not place any undue financial burden on the Plan. Spreading investments over different investment types minimizes the impact a singular industry/investment class can have on the portfolio. Spreading investments over multiple credits/issuers within an investment type minimizes the credit exposure of the portfolio to any single firm/institution.

C. Monitor all the Plan investments on a daily basis to anticipate and respond appropriately to a significant reduction in the credit worthiness of a depository.

D. Structuring the Plan's portfolio so that securities mature at times to meet the Plan's ongoing cash needs. Spreading investments over various maturities minimizes the risk of portfolio depreciation due to a rise in interest rates. An unforeseen liquidity need allows no options if "all your eggs are in one basket."

E. Restructuring the Plan's portfolio to minimize the loss of market value or cash flow.

F. Constructing a portfolio that will consist of securities with active secondary and resale markets. Any investment for which no secondary market exists, such as time deposits, shall not exceed 375 days and no investment shall have a maturity of more than 5 years (to minimize capital losses).

V. GUIDELINES FOR INVESTMENT

The CFO shall maintain and instruct any investment advisor to adhere to these investment protocols:

A. Liquidity

The Plan's portfolio will be structured so that securities will mature at or about the same time as cash is needed to meet demands and in accordance with the economic projections mentioned above.

B. Yield

The CFO and any Investment Advisors shall always attempt to obtain a competitive rate of return on any investment type consistent with the required safety, liquidity, and other parameters of this Investment Policy, departmental procedures, and the laws of the State of California.

C. Internal Controls

The CFO shall establish a system of internal controls, which shall be documented in writing. The controls shall be designed to prevent losses of public funds arising from fraud, employee error, and misrepresentation by third parties, as well as unanticipated changes in financial markets.

D. Safekeeping of Securities

To protect against potential losses caused by the collapse of individual securities dealers, all securities owned by the Plan, including collateral on repurchase agreements shall be held in safekeeping by a third party bank trust department, acting as agent for the Plan under the terms of a custody agreement executed by the bank and the Plan CFO. All trades executed between the Plan and a dealer will settle on a delivery vs. payment basis with a custodial bank. All security transactions engaged in by the CFO shall be countersigned by a second Finance Department official or employee, who the CFO has authorized to countersign security transactions.

E. Rating

If the rating of any depository drops during the course of time with which the Plan has placed an investment, the investment will be matured at the earliest possible convenience.

If any security rating drops below A-1/P-1 for short-term ratings or A-/A3 for long-term ratings, the investment will be reviewed by the CFO and may be sold or allowed to mature at the earliest practical opportunity.

Any sale resulting from a ratings downgrade shall be determined by the CFO based upon market conditions, liquidity needs, and risk considerations.

F. Financial Benchmarks

The Plan's portfolio shall be designed to attain a market-average rate of return through economic cycles given an acceptable level of risk, and in compliance with the required objectives of safety of principal and liquidity described above. The performance benchmark for the investment portfolio will be based upon the market indices for short-term investments of comparable risk and duration. These performance benchmarks will be determined by the CFO (with the assistance of an independent advisor, if needed) and may be reviewed by the Executive Finance Committee.

G. Periodic Review of the Investment Policy

The CFO is responsible for providing the Executive Finance Committee with this Investment Policy and any recommended changes. The Executive Finance Committee is responsible for recommending the Investment Policy to the Commissioners for final approval. This Investment Policy, and any changes hereto, shall be reviewed and approved by the Plan Commissioners at a public meeting.

H. Collateralization

All Certificates of Deposits must be collateralized by U. S. Treasury Obligations. Collateral must be held by a third party trustee and valued on a monthly basis. The Plan may invest surplus funds in deposits at a commercial bank, savings bank, savings and loan association, or credit union in accordance with applicable California Government Code requirements. The Plan shall not utilize private-sector deposit placement programs or intermediaries authorized under California Government Code Section 53601.8. The percentage of collateralization on repurchase and reverse repurchase agreements, if authorized, will adhere to the amount required under California Government Code Section 53601(j)(2). The percentage of collateralization on active or inactive deposits will adhere to the amounts required under California Government Code Section 53652.

I. Securities Lending

Investment securities shall not be lent to an Investment Manager, broker or any other entity.

J. Leverage

The investment portfolio, or investment portfolios, cannot be used as collateral to obtain additional investable funds.

K. Other Investments

Any investment not identified in Exhibit 1, Authorized Investment Schedule, shall be considered a prohibited investment unless specifically authorized by the Commission. Such authorization shall not be construed as directing the purchase, sale, or retention of any particular investment.

L. Underlying Nature of Investments

The Plan shall not make investments in organizations which have a line of business that is visibly in conflict with the interests of public health (which shall be defined by the Commissioners).

M. Derivatives

Investments in derivative securities are not allowed, except as to U.S. Treasury STRIPS.

N. Investments

For purposes of compliance with Section 53601 of the Government Code, an investment's term or remaining maturity shall be measured from the settlement date to final maturity. A security purchased in accordance with Section 53601 must not have a forward settlement date exceeding 45 days from the time of investment. Authorized Investments under this Investment Policy shall be as presented in Exhibit 1, Authorized Investment Schedule.

VI. REPORTING AND REVIEW

The CFO is delegated the responsibility for directing the Plan's investment program and for compliance with this Investment Policy pursuant to the delegation of authority to invest funds or to sell or exchange securities. The CFO shall provide a comprehensive review of the investment portfolio to the Executive Finance Committee at least semi-annually, including:

- Portfolio performance
- Liquidity position
- Compliance with this Investment Policy
- Significant investment matters, if any

Examples of the information that may be included in such reports are provided in Attachment A.

Any material policy exceptions, credit concerns, or significant investment matters shall be reported to the Commission at the next regularly scheduled meeting.

The CFO shall provide a monthly investment report to the Commission.

VII. QUALIFICATIONS OF BROKERS, DEALERS, AND FINANCIAL INSTITUTIONS

The CFO shall transact business with Investment Advisors, direct issuers, broker/dealers licensed by the State, National, or State chartered bank or savings institutions and primary government dealers designated by the Federal Reserve.

Any Investment Advisor or broker/dealer interested in conducting business with the Plan is required to fill out a questionnaire maintained by the CFO.

No broker/dealer shall be eligible to conduct business with the Plan if prohibited under MSRB Rule G-37 or any successor regulation governing political contributions.

The Finance staff shall investigate dealers with which it will conduct business in order to determine the following: if the firm is adequately capitalized and meets the Federal Reserve's minimum capital requirements for broker/dealer operations, makes markets in securities appropriate to the Plan's Investment Policy, the individual covering the account has a minimum of three years dealing with large institutional accounts, and receives three favorable recommendations from other short term cash portfolio managers.

The Plan may engage the support services of outside Investment Advisors in regard to its investment program, so long as it can be clearly demonstrated that these services produce a net financial or necessary financial protection of the Plan financial resources. Investment Advisors shall follow this Investment Policy, the Code, State law and other such written instructions as provided by the CFO.

VIII. DUTIES AND RESPONSIBILITIES OF THE EXECUTIVE FINANCE COMMITTEE:

A. The CFO, with or without the assistance of an independent investment advisor and staff, is responsible for the day-to-day management of the Plan's investment portfolio. The Plan's Commission is responsible for approval of the Plan's Investment Policy. Neither the Commission nor the Executive Finance Committee shall make or direct the Plan staff to make any particular investment, purchase any particular investment product, or do business with any particular investment companies or brokers. It shall not be the purpose of the Executive Finance Committee or Commission to advise on particular investment decisions of the Plan.

B. The duties and responsibilities of the Executive Finance Committee shall consist of the following:

1. Review any changes to the Plan's Investment Policy before consideration by the Plan's Commission and recommend revisions, as necessary.

2. Review the Plan's investment portfolio for conformance to the Plan's Investment Policy diversification and maturity guidelines, and make recommendations as appropriate.

3. Perform such additional duties and responsibilities as may be required from time to time by specific action and direction of the Commissioners.

Attachments:
EXHIBIT 1 - AUTHORIZED INVESTMENT SCHEDULE

ATTACHMENT A - Illustrative Investment Reporting and Questionnaires Examples

References:
Investment of Surplus: California Government Code Section §§53600-53610
Deposit of Funds: California Government Code Section §§53630-53686
Federal Bankruptcy Code

Revision History:

Review Date	Revised Date	Approved By
2/18/2015		PRC
02/02/2015		Ruth Watson, COO (Interim CEO)

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EXHIBIT 1

The below are investments allowable under the Plan's Investment Policy. Percentage limitations, where indicated, apply at the time of purchase. Unless otherwise noted below, no security shall be purchased in accordance with this Investment Policy that has a term remaining to maturity in excess of five years. Rating requirements where indicated, apply at the time of purchase. The term or remaining maturity of a security purchased in accordance with this Investment Policy shall be measured from the settlement date (not the trade date) upon purchase of the security and the stated final maturity of the security. A security purchased in accordance with this Investment Policy shall not have a forward settlement date exceeding forty-five (45) days from the time of investment.

The Chief Financial Officer (CFO) is authorized to invest and manage Plan funds in accordance with this Policy, applicable California law, and the limits set forth in this Authorized Investment Schedule. Investments not identified in this Schedule are prohibited unless specifically authorized by the Commission.

AUTHORIZED INVESTMENT SCHEDULE

Authorized Investment	Govt. Code	Maximum Percentage	Maximum Maturity	Minimum Quality*	Other Constraints
U.S Treasury Obligations	53601(b)	No Limit	5 Years	None	Notes, bonds, bills
U.S. Agency Obligations	53601(f)	No Limit	5 Years	None	Federal agency or U.S. government sponsored enterprise obligations, participations, or other instruments
State Obligations (CA and others)	53601(c) and (d)	No Limit	5 Years	A-/A3 or better	• Registered state warrants, treasury notes or bonds of California • Registered treasury notes or bonds from any of the other 49 states
California Local Agency Bonds	53601(e)	No Limit	5 Years	A-/A3 or better	Bonds, notes, warrants or other evidence of indebtedness of any local agency within California

Authorized Investment	Govt. Code	Maximum Percentage	Maximum Maturity	Minimum Quality*	Other Constraints
Corporate Medium Term Notes	53601(k)	• 30% of portfolio • 5% single issuer	5 Years	A-/A3 or better	Issued by • Domestic corporations or • Depository institutions licensed by the United States of any state and operating in the United States
Negotiable Certificates of Deposit	53601(1)	• 30% of portfolio • 5% single issuer	5 Years	A-/A3 or better	• Issued by nationally or state-chartered banks; savings or federal associations; state of federal credit unions; or federally licensed or state licensed branches of foreign banks. And • Per 53638 deposits may not exceed bank shareholder equity; total net worth of depository savings or federal association; unimpaired capital and surplus of a credit union; unimpaired capital and surplus of industrial loan companies
Supranationals	53601(q)	• 15% of Portfolio • 5% single issuer	5 Years	AAA	U.S. dollar denominated senior unsecured unsubordinated obligations issued by or unconditionally guaranteed by: • International Bank for Reconstruction and Development • International Finance Corporation • Inter-American Development Bank

Authorized Investment	Govt. Code	Maximum Percentage	Maximum Maturity	Minimum Quality*	Other Constraints
Bankers' Acceptances	53601(g)	• 40% of portfolio • 5% single issuer	180 Days	A-1/P-1	
Bank Deposits — Collateralized or FDIC Insured	53630 et seq.	• No Limit	5 Years	Satisfactory rating from national bank rating service from CRA review	• Amounts up to $250,000 per institution are insured by the FDIC • Amounts over the insurance limit must be placed with financial institutions participating in the California Local Agency Security Program, providing for collateralization of public funds • Per 53638 deposits may not exceed bank shareholder equity; total net worth of depository savings or federal association; unimpaired capital and surplus of a credit union; unimpaired capital and surplus of industrial loan companies • Treasurer may waive collateral for the portion of any deposits insured pursuant to federal law The use of private sector entities authorized by 53601.8 to assist in the placement of deposits are NOT permitted
Local Agency Investment Fund ("LAIF")	16429.1 et seq.	• As permitted by LAIF	N/A	N/A	

Authorized Investment	Govt. Code	Maximum Percentage	Maximum Maturity	Minimum Quality*	Other Constraints
Ventura County Pooled Investment Fund	53684	• As permitted by the VCPIF	N/A	None	
Joint Powers Authority Pool	53601(p)	• 15% of portfolio • 10% from single pool or maximum allowed by JPA whichever is less	N/A	See next box	JPA must be: • Organized pursuant to Section 6509.7; • Invest in securities in 53601 subdivisions (a) to (o); and • Retain investment advisor register or exempt from advisor register or exempt from registration with the SEC, with at least 5 years' experience, and has assets under management in excess of $500 million.
Money Market Funds	53601(l)	• 15% of portfolio	N/A	Fund must have the highest ranking by not less than 2 NRSROs	Retain an investment adviser registered or exempt from registered or exempt from registration with the SEC with 5 years' experience managing money market funds in excess of $500 million

Authorized Investment	Govt. Code	Maximum Percentage	Maximum Maturity	Minimum Quality*	Other Constraints
Mutual Funds	53601(l)	• 15% of portfolio • 5% from single mutual fund company	5 years	Fund must have the highest ranking by not less than 2 NRSROs	• Fund must invest in securities that comply with the investment restrictions of 53601(a) through (k) and (n) through (o); and Retain an investment adviser registered or exempt from registration with the SEC with 5 years' experience managing money market funds in excess of $500 million.
Commercial Paper	53601 (h)	• 25% of portfolio • 5% of the outstanding commercial paper from a single issuer	397 Days	A-1/P-1 or equivalent highest rating by an NRSRO	• Corporation must be organized within the United States; have assets in excess of $500 million; and have at least an A rating on its long term debt, if any; or • Corporation must be organized within the United States as a special purpose corporation, trust , or limited liability company; have program wide credit enhancements including, but not limited to, over collateralization letter of credit or a surety bond.

Authorized Investment	Govt. Code	Maximum Percentage	Maximum Maturity	Minimum Quality*	Other Constraints
Repurchase Agreements	53601(j)	• No Limit	90 Days	N/A	• Subject to a Master Repurchase Agreement with a Primary Dealer approved by the CFO and meeting the qualifications of this Policy; • Comply with Government Code 53601(j)

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ATTACHMENT A
Illustrative Investment Reporting and Questionnaires Examples

Purpose
This Attachment provides illustrative examples that may be used to satisfy the requirements established in Investment Policy. The examples are intended to demonstrate the type of information that may be presented to the Commission and Executive Finance Committee and do not constitute minimum requirements or a prescribed format.

Example 1: Executive Finance Committee Investment Portfolio Review
Illustrative Investment Reporting Examples pursuant to Section VI, Reporting Requirements

Investment Portfolio Review

- Portfolio balance: $125.4M
- Average yield: 4.52%
- Liquidity remains sufficient to meet operational requirements.
- All investments remain in compliance with the Investment Policy and applicable California Government Code requirements.
- No credit rating downgrades requiring action occurred during the reporting period.
- No policy exceptions or violations were identified.
- The portfolio continues to prioritize safety and liquidity while maximizing return within approved investment guidelines.

This example is provided for illustrative purposes only. The format and content of investment reports may vary based on portfolio composition, market conditions, regulatory requirements, and management judgment.

Example 2: Broker/Dealer Questionnaire and Certification
Illustrating the requirements set forth in Section VII, Qualifications Of Brokers, Dealers, and Financial Institutions

Firm Information

- Legal Name of Firm:
- Business Address:
- Primary Contact:
- Telephone:
- Email:
- FINRA CRD Number:
- SEC Registration Number (if applicable):
- Years in Business:

Regulatory and Professional Status

1. Is the firm registered with the Securities and Exchange Commission (SEC)?
   ☐ Yes
   ☐ No
2. Is the firm a member of FINRA?
   ☐ Yes
   ☐ No
3. Has the firm or any principal been subject to any regulatory enforcement action, suspension, or disciplinary proceeding within the past five years?
   ☐ Yes
   ☐ No
   If yes, please provide details.

Experience and Qualifications

4. Describe the firm's experience providing investment services to public agencies or healthcare organizations.
5. Identify the individuals who will be responsible for servicing Gold Coast Health Plan's account.

Investment Policy Acknowledgment

6. Has the firm received and reviewed the Gold Coast Health Plan Investment Policy?
   ☐ Yes
   ☐ No
7. Does the firm agree to conduct transactions consistent with the requirements, limitations, and objectives of the Investment Policy?
   ☐ Yes
   ☐ No
8. Does the firm acknowledge its responsibility to notify the CFO if it becomes aware of any transaction that may not comply with the Investment Policy?
   ☐ Yes
   ☐ No

Certification

I certify that the information provided in this questionnaire is true and complete. I acknowledge that I have received and reviewed the Gold Coast Health Plan Investment Policy and understand the investment objectives, authorized investments, and restrictions contained therein.

Authorized Representative: _____
Title: _____
Signature: _____
Date: _____

AGENDA ITEM NO. 16

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Christopher Lee, Chief Financial Officer

DATE: November 16, 2026

SUBJECT: 2026 8+4 Reforecast

PowerPoint with Verbal Presentation

ATTACHMENTS:

8+4 Reforecast for 2026t

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

2026 8+4 Reforecast

Ventura County Medi-Cal Managed Care Commission
November 16, 2026

Christopher Lee, Chief Financial Officer

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 Forecast Total	Fav/(Unfav) 8+4 F vs Budget	Fav/(Unfav) 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

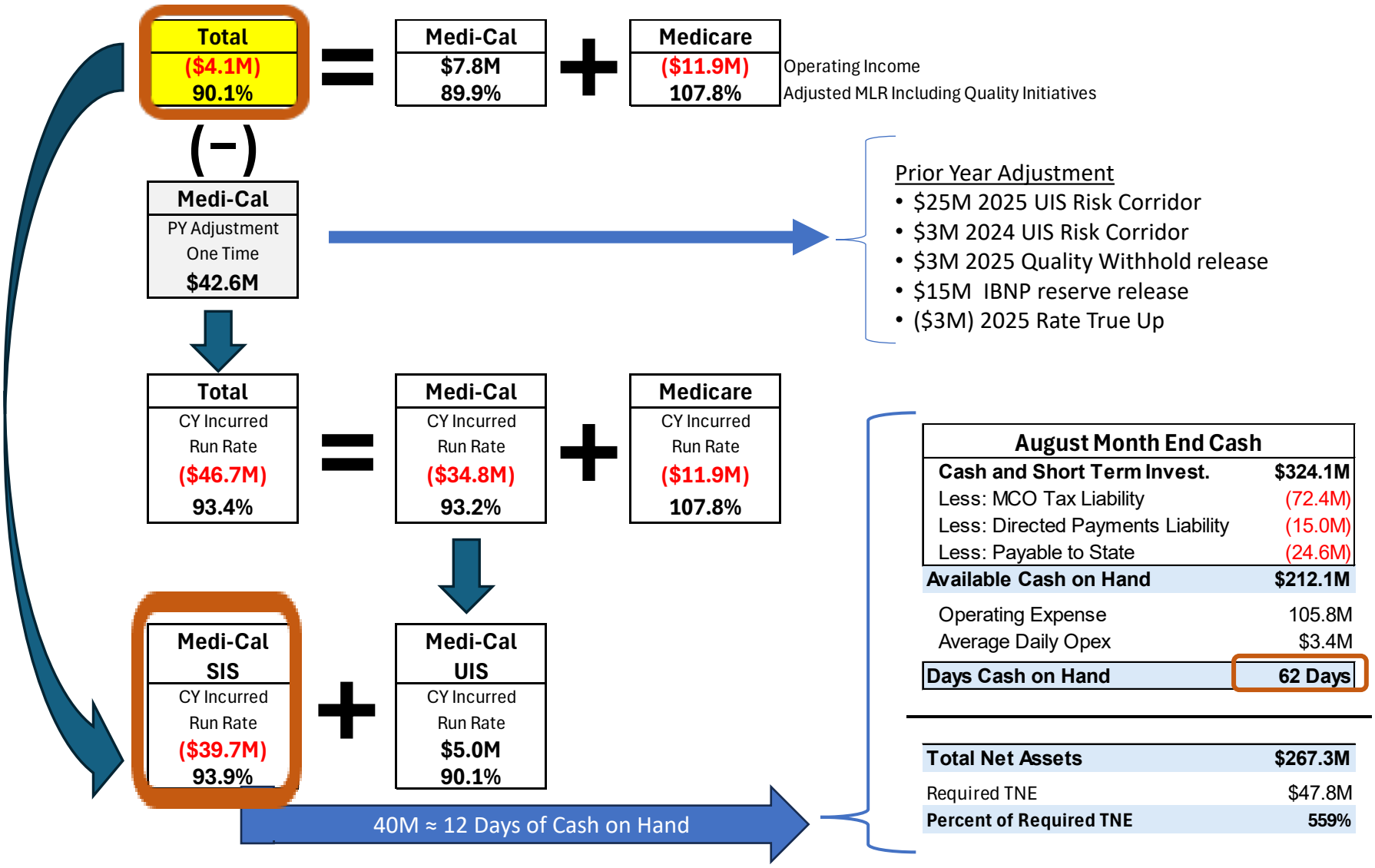
Revenue:
Favorable increase of $18M is primarily due to 2024/2025 Risk Corridor and 2025 Quality Withhold Premiums $10M and volume of $6M and member mix $2M offset by 2025 Rate true up ($3M).

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 Medi-Cal	8+4 Run Rate Medicare	8+4 Run Rate Total	Fav/(Unfav) Budget vs 8+4 RR
Membership (Dec)	223,866	219,832	(4,034)	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%)

Removing Prior Year Adjustments

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.

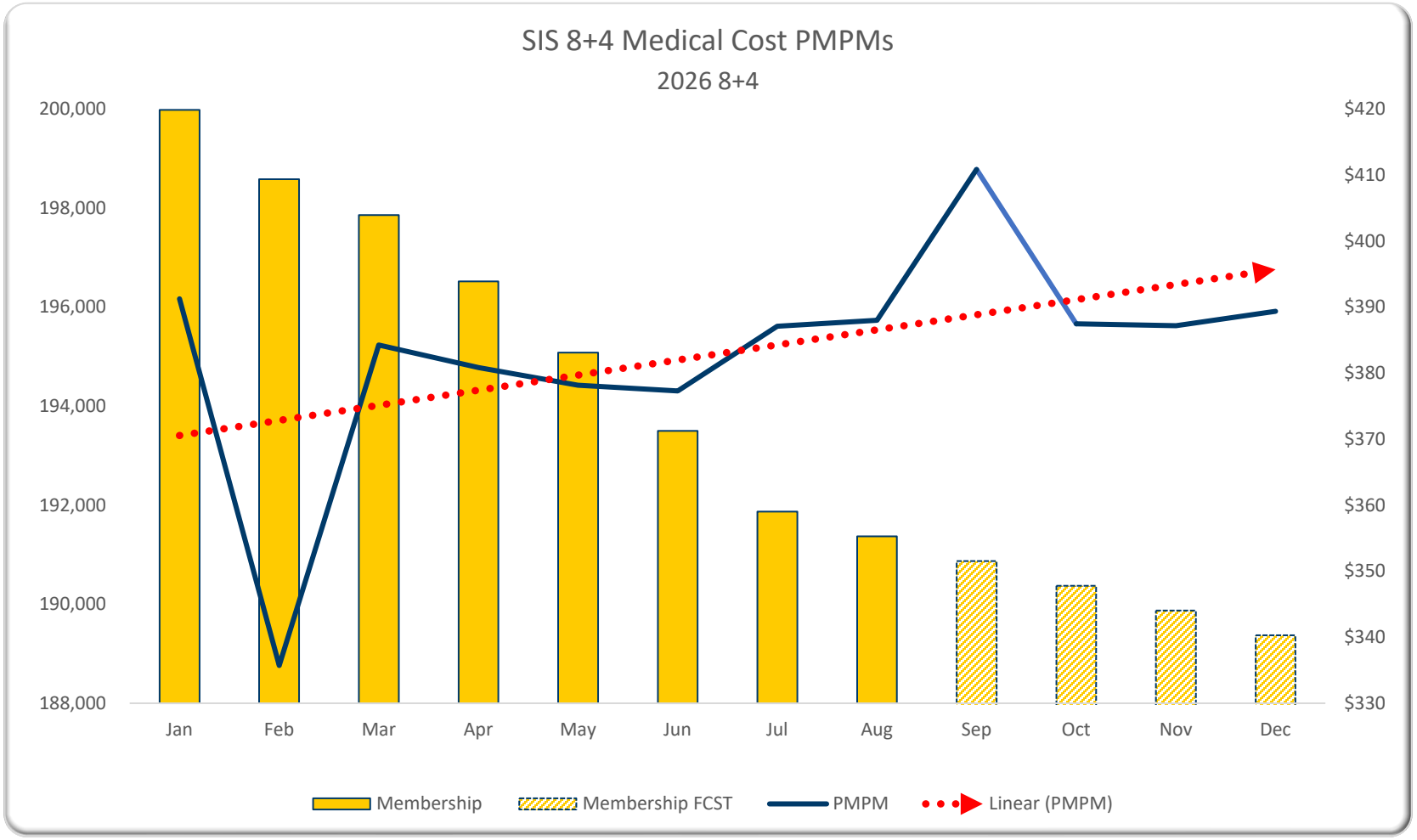
Medical Expense:
Run rate is unfavorable ($8M) to budget primarily due to provider contract changes and higher-than–expected increase in claims trend.

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



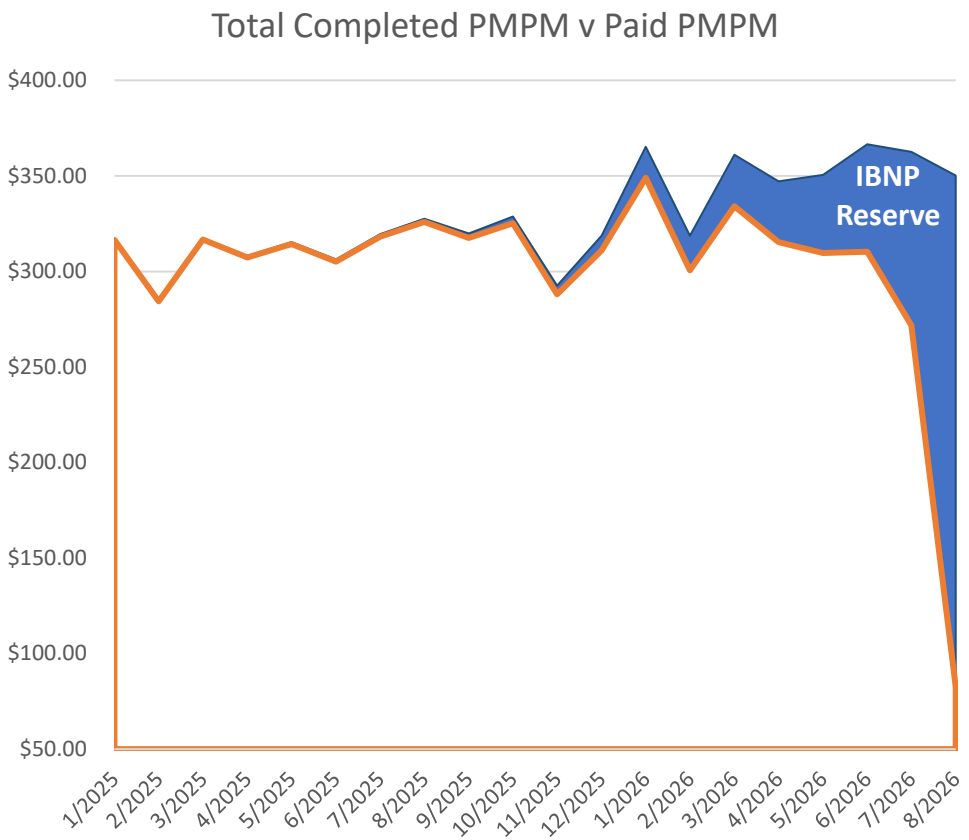
Balance Sheet Reserve Review

August Balance Sheet Reserve Liabilities

Armounts	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 interet.
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 falure 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			

Return to Agenda

IBNP Reserve information with completion



MOS	MMs	Paid PMPM	Complete PMPM	Compltion 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

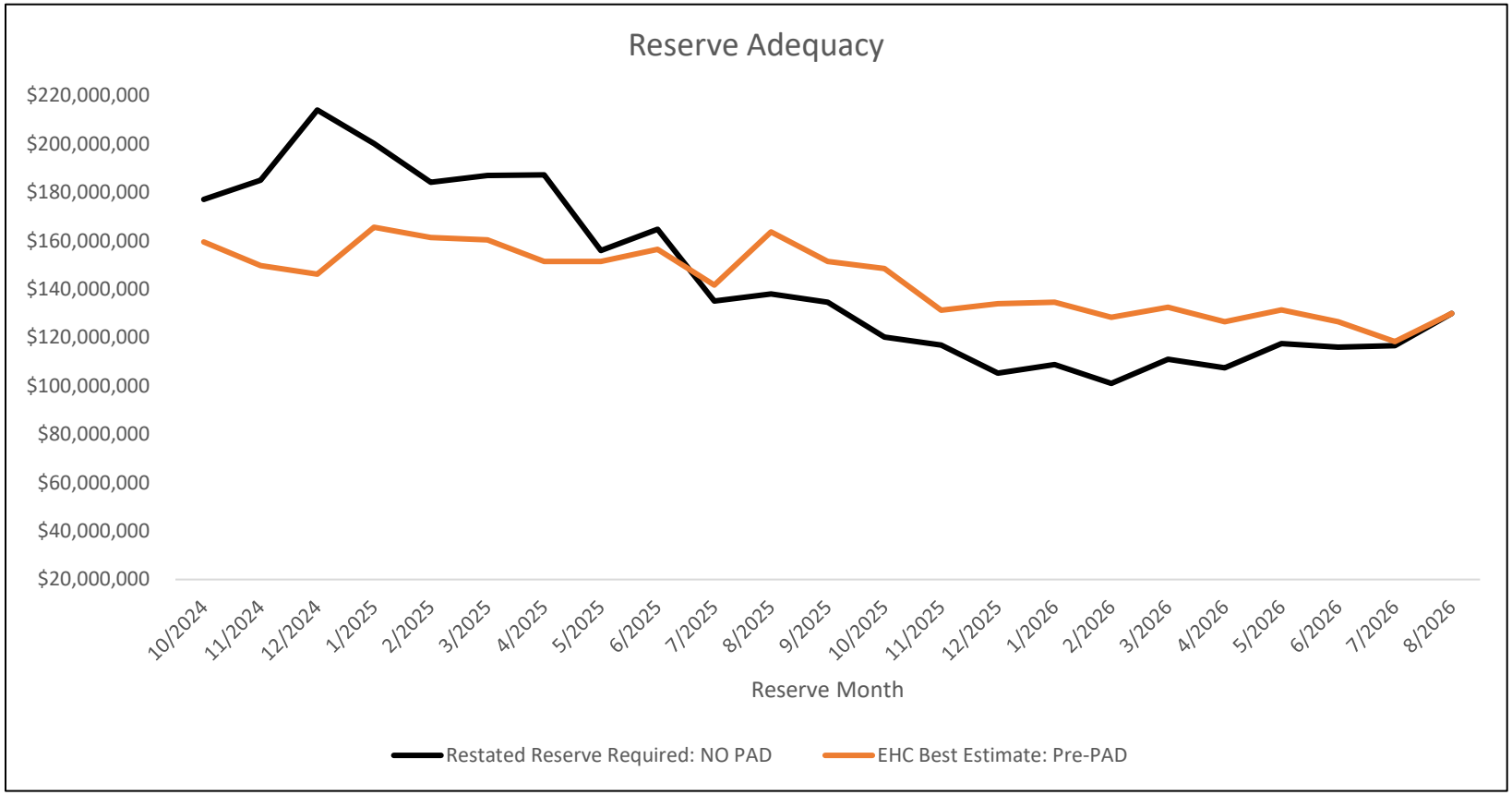
MOS	MMs	Paid PMPM	Complete PMPM	Compltion Rate	IBNP $	IBNP with PAD
CY2023	1,717,802	$ 241.60	$ 241.60	100.0%	$ -	$ -
CY2024	2,988,446	$ 277.50	$ 277.55	100.0%	$ 147,275	$ 162,003
CY2025	2,909,863	$ 310.82	$ 312.96	99.3%	$ 6,205,948	$ 6,826,543
Recent 12	2,793,320	$ 293.90	$ 339.72	86.5%	$ 127,989,598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

* 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.

Return to Agenda

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.

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

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	Actuals Aug YTD	FCST Sep- Dec	8+4 Full Year	4+8 Full Year	Original Budget Full Year	8+4 vs 4+8 B / (W) Full Year	8+4 vs Budget 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	Actuals Aug YTD	FCST Sep- Dec	8+4 Full Year	4+8 Full Year	Original Budget Full Year	8+4 vs 4+8 B / (W) Full Year	8+4 vs Budget 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	Actuals Aug YTD	FCST Sep- Dec	8+4 Full Year	4+8 Full Year	Original Budget Full Year	8+4 vs 4+8 B / (W) Full Year	8+4 vs Budget 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. 17

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Christopher Lee, Chief Financial Officer

DATE: November 16, 2026

SUBJECT: September 2026 Year to Date Financial Results

SUMMARY:

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

ATTACHMENT:

September 2026 Financial Package

APPENDIX:

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

Gold Coast Health Plan℠
A Public Entity

September 2026 YTD Results

Ventura County Medi-Cal Managed Care Commission
November 16, 2026

Christopher Lee, Chief Financial Officer

Integrity
Accountability
Collaboration
Trust
Respect

Current Month September Net Income is favorable $3.1M to forecast primarily due to lower admin spending $2.4M and favorable prior year IBNP $0.7M.

Item	Actual	8+4 Forecast	Fav / (Unfav)
Membership	220,844	221,679	(835)
Revenue	$102.3M	$100.4M	$1.8M
Revenue pmpm	*$463.03*	*$443.42*	*$19.61*
Medical Cost	$97.4M	$96.1M	($1.3M)
Medical Costs pmpm	*$440.98*	*$424.25*	*($16.72)*
Medical Loss Ratio	95.2%	95.7%	0.4%
Administrative Cost	$10.4M	$12.8M	$2.4M
Admin Cost PMPM	*$47.20*	*$56.55*	*$9.34*
Administrative Loss Ratio	10.2%	12.8%	2.6%
Operating Results	**($5.6M)**	**($8.5M)**	**$2.9M**
Investment Income	$1.2M	$1.0M	$0.2M
Quality Strategy (Grants/Incentives)	$4.4M	$4.5M	$0.1M
Non Operating Results	**($3.3M)**	**($3.5M)**	**$0.2M**
Net Income/(Loss)	**($8.8M)**	**($11.9M)**	**$3.1M**
TNE	$258.5M		

MTD Vs Forecast Highlights

- Membership is unfavorable (835) with a greater loss of UIS enrollment than anticipated; however, we have 1.8k of positive retroactive restated enrollment driving favorable revenue.
- Revenue is $1.8M favorable primarily due to expected $2.0M ECM risk corridor offset by unfavorable Medicare ($0.2M) primarily due to volume.
- Medical expense is ($1.3M) unfavorable primarily due to greater ECM Claims of ($2.0M) offset by risk corridor revenue and unfavorable prior year IBNP ($0.8M) offset by better-than-expected claims results $1.5M
- Administrative spending continues below forecast as management proactively aligns staffing, consulting, and discretionary spending with anticipated 2027 membership declines.
- Investment income is $0.2M favorable due to better-than-expected investment performance.
- Quality Strategy is $0.1M favorable due to timing of anticipated expenses.
- The August TNE is 539% of the state requirement

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

Excluding one-time, unanticipated prior-year claims and revenue adjustments, adjusted YTD Net Income is $3.8M favorable to 8+4 Forecast driven by lower administrative expenses $2.4M and favorable claims experience $1.4M leading to the MLR improvement of 0.1%.

September YTD				
Item	**Actual**	**8+4 Forecast**	**Fav / (Unfav)**	**Explanation**
Net Income/(Loss)	**$12.1M**	**$8.9M**	**$3.1M**	
Revenue	($30.1M)	($30.0M)	($0.1M)	2025 UIS Risk Corridor ($25.0M) 2024 UIS Risk Corridor ($3.0M) 2025 Quality Withhold ($3.0M) 2025 Rate True-up ($2.7M)
Claims (IBNP)	($14.6M)	($15.4M)	$0.8M	2025 medical expenses paid in 2026 are less than the amount reserved as of 12/31/2025.
Other	$3.3M	$3.3M	$0.0M	The $3.3M is 2025 Carelon Incentive accounting $2.0M. Prior year settlements make up the balance
Net Income/(Loss), net of Prior Year Activity	**($29.4M)**	**($33.2M)**	**$3.8M**	
MLR - Adjusted	89.5%	89.6%	0.1%,	

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

September YTD Net Income $14.0M favorable to budget. Favorability driven by favorable member mix and lower administrative expenses partially offset by increased spending on Quality Strategy Initiatives.

September YTD			
Item	**Actual**	**Budget**	**Fav / (Unfav)**
Ending Membership	220,844	226,443	(5,599)
Revenue	$947.4M	$938.6M	$8.7M
Revenue pmpm	*$459.40*	*$453.31*	*$6.09*
Medical Cost	$806.3M	$806.2M	($0.1M)
Medical Costs pmpm	*$391.00*	*$389.33*	*($1.66)*
Medical Loss Ratio	85.1%	85.9%	0.8%
Administrative Cost	$96.8M	$108.5M	$11.7M
Admin Cost PMPM	*$46.93*	*$52.39*	*$5.47*
Administrative Loss Ratio	10.2%	11.6%	1.3%
Operating Results	**$44.3M**	**$24.0M**	**$20.3M**
Investment Income	$8.7M	$9.0M	$0.3M
Quality Strategy (Grants/Incentives)	$40.9M	$34.9M	($6.0M)
Non Operating Results	**($32.2M)**	**($25.9M)**	**($6.3M)**
Net Income/(Loss)	**$12.1M**	**($1.9M)**	**$14.0M**
TNE	$258.5M		
Adjusted Days Cash on Hand [1]	**62**		

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

YTD Vs Budget Highlights

- Membership is 2.5%, or (5.6k) member below budget in September, reducing both revenue and medical expenses
- Revenue, excluding $10.6M* of prior-year adjustments, is ($1.9M) unfavorable to budget, primarily driven by lower membership volume, partially offset by favorable member mix and risk adjustment revenue.
- Medical expenses, excluding a $14.6M prior-year IBNP release, are ($14.5M) unfavorable to budget, reflecting higher-than-expected claims experience.
- Administrative expenses, excluding $3.3M of prior year expenses, is favorable $15.0M due to lower consulting costs $6.8M, labor savings from the hiring freeze $4.1M, reduced community grants $1.9M, and other administrative reductions $2.2M
- Investment income is $0.3M favorable to budget due to greater than expected investment results.
- Continued strong investment in Quality Strategy initiatives
- The August TNE is 539% of the state requirement

* 2026 Budget included $19.5M of anticipated 2025 UIS Risk Corridor adjustments

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

The year-end operating loss is projected at approximately ($21.0M), reflecting the 8+4F projected loss of ($4.1M), offset by a September YTD gain of $3.1M and adjusted for estimated reserves related to the 2025/2026 UIS Risk Corridor ($27M), the 2026 ECM Risk Corridor ($7M), and prior-year reserve developments $14M.
This result is ($12.3M) unfavorable to the budgeted operating loss of ($8.7M).

Risks:

- DHCS reinterpreted the 2025 UIS State-Only Risk Corridor methodology by changing the classification of state-specific and non-state-specific claims. This revision reduced the anticipated risk corridor payment to GCHP, resulting in an estimated unfavorable financial impact of approximately ($26M).
- The revised DHCS 2026 UIS State-Only Risk Corridor calculation methodology is expected to result in an estimated unfavorable financial exposure of approximately ($1M).
- DHCS has reinterpreted 2026 ECM risk corridor requirements to require encounter validation for capitated ECM payments. Based on preliminary encounter reconciliation analysis, management estimates potential exposure of approximately ($7M), subject to ongoing validation and remediation efforts.
- Risk of higher-than-expected Q4 claims costs due to seasonal flu and RSV activity, which may increase emergency room utilization, inpatient admissions, and overall medical expenses.
- Unanticipated provider disputes and payments.
- Membership attrition could remain above forecast, resulting in additional revenue pressure.

Opportunities:

- Evaluate potential release of approximately $14M of prior-year reserves related to FY22/23 retroactive overpayments and FY20/21 COVID-19 Risk Corridor settlements.
- Continued administrative savings reflect proactive cost management and position the organization for anticipated 2027 UIS and SIS membership declines.

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

Membership continues to decline, but monthly losses slowed in August and September.

Restated Medicaid Membership Volumes and Rates

COA	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Rates
Adult Expansion - SIS	63,046	62,352	61,685	61,328	61,024	60,779	$ 464.43
Adult - SIS	20,931	20,739	20,602	20,463	20,430	20,408	$ 411.21
Child - SIS	78,361	78,159	77,637	77,009	76,681	76,633	$ 151.35
SPD - SIS	9,238	9,181	9,142	9,067	9,069	8,734	$ 1,474.57
SPD Dual - SIS	24,269	24,148	24,085	24,077	23,978	23,714	$ 661.69
Long Term Care - SIS	42	42	40	37	34	27	$ 1,474.57
Long Term Care - Dual - SI	664	648	654	650	666	677	$ 661.69
Adult Expansion - UIS	13,053	12,714	12,326	11,738	11,511	11,366	$ 679.05
Adult - UIS	14,384	14,116	13,800	13,424	13,156	13,037	$ 350.38
Child- UIS	3,536	3,450	3,386	3,290	3,237	3,119	$ 135.34
SPD - UIS	1,765	1,744	1,701	1,658	1,649	1,609	$ 1,560.75
SPD Dual - UIS	311	316	309	158	154	180	$ 827.64
Long Term Care - UIS	17	16	12	10	12	11	$ 1,560.75
Long Term Care - Dual - UI	7	8	8	8	8	9	$ 827.64
Total	**229,624**	**227,633**	**225,387**	**222,917**	**221,609**	**220,303**	
Total SIS	**196,551**	**195,269**	**193,845**	**192,631**	**191,882**	**190,972**	**$ 404.65**
Total UIS	**33,073**	**32,364**	**31,542**	**30,286**	**29,727**	**29,331**	**$ 524.80**
Montly reduction - SIS	**(1,274)**	**(1,282)**	**(1,424)**	**(1,214)**	**(749)**	**(910)**	**Current Month 3% reduction**
Montly reduction - UIS	**(510)**	**(709)**	**(822)**	**(1,256)**	**(559)**	**(396)**	**Current Month 1% reduction**

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

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	For the Month Ended September 2026				Fiscal Year to Date Through September 2026		
	ACTUALS	8+4 Forecast	2026 Plan	CM Vs Forcast	ACTUALS	2026 Plan	YTD Vs Bud
Membership	220,844	221,679	226,443	(835)	2,062,152	2,070,603	(8,451)
Revenue							
Premium	$ 135,307,091	$ 100,409,647	$ 136,787,624	$ 34,897,444	$ 1,254,712,681	$ 1,249,553,129	$ 5,159,552
Facility Expense AB85						-	-
Reserve for Cap Requirements	-	-	(239,064)	-	-	(2,197,778)	2,197,778
Incentive Revenue	-	-	-	-	-	-	-
MCO Premium Tax	(33,753,485)	-	(33,704,593)	(33,753,485)	(306,781,062)	(308,726,511)	1,945,449
Total Net Premium	**101,553,606**	**100,409,647**	**102,843,968**	**1,143,959**	**947,931,619**	**938,628,840**	**9,302,779**
						-	
Other Revenue:							
Miscellaneous Income	704,887	-	-	704,887	(573,260)	-	(573,260)
Total Other Revenue	704,887	-	-	704,887	(573,260)	-	(573,260)
Total Revenue	**102,258,493**	**100,409,647**	**102,843,968**	**1,848,847**	**947,358,359**	**938,628,840**	**8,729,519**
Medical Benefits:							
Capitation:							
PCP, Specialty, Kaiser, NEMT & Vision	7,417,060	7,661,164	4,339,596	244,104	36,791,764	40,046,831	3,255,067
ECM	2,657,238	1,222,807	1,036,811	(1,434,431)	18,898,834	9,506,322	(9,392,512)
Total Capitation	**10,074,298**	**8,883,971**	**5,376,406**	**1,190,328**	**55,690,598**	49,553,153	**(6,137,445)**
FFS Claims:							
Inpatient	16,045,517	21,511,628	20,001,363	5,466,111	167,239,914	179,669,517	12,429,603
LTC / SNF	14,029,255	15,268,128	16,994,984	1,238,873	137,336,879	151,678,969	14,342,090
Outpatient	13,510,344	10,191,045	9,899,112	(3,319,299)	87,314,606	87,896,299	581,692
Laboratory and Radiology	2,695,590	821,972	825,483	(1,873,618)	14,419,129	7,647,587	(6,771,542)
Directed Payments - Provider	769,852	733,029	802,122	(36,823)	7,215,384	7,282,447	67,062
Emergency Room	5,191,366	5,005,003	4,502,658	(186,363)	40,861,116	39,745,115	(1,116,001)
Physician Specialty	10,062,434	6,979,950	7,175,129	(3,082,485)	87,233,914	65,350,403	(21,883,511)
Primary Care Physician	5,055,005	7,088,285	7,404,138	2,033,280	51,218,878	66,626,287	15,407,409
Home & Community Based Services	2,406,383	1,573,139	4,703,930	(833,244)	25,420,502	41,597,789	16,177,286
Medically Supportive Food	1,225,472	1,460,711	-	235,239	14,097,332	-	(14,097,332)
Applied Behavior Analysis Services	8,202,848	6,161,983	5,699,534	(2,040,865)	56,989,442	49,691,454	(7,297,988)
Pharmacy	31,144	272,215	312,488	241,071	2,780,097	1,774,933	(1,005,164)
Quality Incentive Provider Program (QIPP)	3,782,853	3,859,382	3,245,263	76,529	33,633,909	29,179,032	(4,454,877)
Other Medical Professional	789,474	2,814,426	1,817,083	2,024,952	-	16,474,369	16,474,369
Other Medical Care	-	-	-	-	7,094,479	-	(7,094,479)
Other Fee For Service	2,731,078	2,400,524	1,993,831	(330,554)	19,060,802	18,001,928	(1,058,874)
Settlements - Medical	385,193	-	-	(385,193)	1,497,234	-	(1,497,234)
Transportation	269,479	666,421	491,150	396,942	3,986,239	4,437,858	451,619
HHIP & IPP	-	-	-	-	-	-	-
Total Claims	**87,183,288**	**86,807,841**	**85,868,268**	**375,447**	**757,399,857**	**767,053,985**	**9,654,128**
Provider Grant Program	625,938	625,938	62,737	-	7,223,443	5,679,708	(1,543,735)
Medical & Care Management	2,288,906	2,565,831	1,903,281	276,925	22,499,728	17,420,338	(5,079,390)
Reinsurance	382,120	306,743	297,057	(75,377)	527,771	2,734,212	2,206,441
Claims Recoveries	1,241,084	1,364,170	(158,333)	123,086	3,810,025	(1,425,000)	(5,235,025)
Sub-total	**4,538,048**	**4,862,682**	**2,104,742**	**(324,634)**	**34,060,967**	**24,409,259**	**(9,651,708)**
Total Medical Benefits	101,795,634	100,554,494	93,349,417	(1,241,141)	847,151,422	841,016,396	(6,135,026)
Contribution Margin	**462,859**	**(144,847)**	**9,494,551**	**607,706**	**100,206,937**	**97,612,443**	**2,594,493**
General & Administrative Expenses:							
Salaries, Wages & Employee Benefits	6,263,133	6,691,852	7,060,493	428,719	59,427,634	63,544,441	4,116,808
Training, Conference & Travel	34,401	184,532	52,500	150,131	426,847	472,500	45,653
Outside Services	1,900,093	2,871,116	2,470,733	971,023	19,627,100	22,236,596	2,609,497
Professional Services	989,245	1,022,113	1,406,687	32,867	8,489,704	12,660,187	4,170,483
Occupancy, Supplies, Insurance & Others	3,181,483	3,947,851	2,754,097	766,369	27,508,247	24,786,874	(2,721,373)
ARCH/Community Grants	22,428	125,000	183,975	102,572	246,222	1,655,772	1,409,550
Sponsorships	6,750	49,960	61,325	43,210	50,250	551,924	501,674
Haircut ($4M)	-	477,688	-	477,688	-	-	-
Vacancy (calculated at 5.85%)	-	-	-	-	-	-	-
Amortization	-	-	-	-	-	-	-
Care Management Reclass to Medical	(2,288,906)	(2,565,831)	(1,903,281)	(276,925)	(22,499,728)	(17,420,338)	5,079,390
G&A Expenses	**10,108,627**	**12,804,281**	**12,086,529**	**(2,695,653)**	**93,276,275**	**108,487,957**	**15,211,682**
D-SNP	316,123	-	-	(316,123)	3,496,882	-	(3,496,882)
Project Portfolio	**316,123**	**-**	**-**	**316,123**	**3,496,882**	**-**	**(3,496,882)**
Total G&A Expenses	**10,424,750**	**12,804,281**	**12,086,529**	**2,379,531**	**96,773,157**	**108,487,957**	11,714,800
Total Operating Gain / (Loss)	**(9,961,891)**	**(12,949,128)**	**(2,591,978)**	**2,987,237**	**3,433,779**	**(10,875,514)**	**14,309,293**
Retro Premium Adj	-	-	-		-	-	-
Non Operating							
Revenues - Interest	1,157,081	1,000,000	1,000,000	157,081	8,658,548	9,000,000	(341,452)
Expenses - Interest		-	-	-		-	-
Gain/(Loss) on Sale of Asset	-	-	-	-	-		
Total Non-Operating	**1,157,081**	**1,000,000**	**1,000,000**	**157,081**	**8,658,548**	**9,000,000**	(341,452)
Total Increase / (Decrease) in Unrestricted Net Assets	**$ (8,804,810)**	**$ (11,949,128)**	**$ (1,591,978)**	**$ 3,144,318**	**$ 12,092,327**	**$ (1,875,514)**	**$ 13,967,841**

STATEMENT OF FINANCIAL POSITION

	As of Month Ending, September 2026	As of Month Ending, December 2025
ASSETS		
Current Assets:		
Total Cash and Cash Equivalents	**$ 263,688,148**	**$ 294,296,392**
Total Short-Term Investments	**109,542,806**	**106,685,365**
Medi-Cal Receivable	166,995,101	156,518,148
Interest Receivable	854,192	808,060
Provider Receivable	6,600,598	13,571,218
Other Receivables	11,477,413	8,823,232
Total Accounts Receivable	**185,927,304**	**179,720,658**
Total Prepaid Accounts	10,536,687	8,959,028
Total Other Current Assets	726,422	320,402
Total Current Assets	**570,421,367**	**589,981,845**
Total Fixed Assets	**72,715,696**	**66,277,453**
Total Assets	**$ 643,137,063**	**$ 656,259,298**
LIABILITIES & NET ASSETS		
Current Liabilities:		
Incurred But Not Reported	$ 125,407,215	$ 131,690,924
Claims Payable	9,072,718	7,252,812
Capitation Payable	6,114,083	8,073,833
Physician Payable	15,226,550	11,519,669
DHCS - Reserve for Capitation Recoup	22,534,993	53,643,320
Lease Payable- ROU	6,511,013	7,376,788
Accounts Payable	17,045,683	(50)
Accrued ACS	1,184,189	407,101
Accrued Provider Incentives/Reserve	8,459,702	18,558,113
Accrued Expenses	9,269,780	25,109,373
Accrued Premium Tax	106,171,444	106,146,397
Accrued Payroll Expense	22,484,855	10,929,318
Quality Withhold	4,900,595	5,482,802
Total Current Liabilities	**355,492,029**	**386,618,131**
Long-Term Liabilities:		
Lease Payable - NonCurrent - ROU	29,142,297	23,230,757
Total Long-Term Liabilities	**29,142,297**	**23,230,757**
Total Liabilities	**384,634,326**	**409,848,888**
Net Assets:		
Beginning Net Assets	246,410,410	234,318,083
Total Increase / (Decrease in Unrestricted Net Assets)	12,092,327	12,092,327
Total Net Assets	**258,502,737**	**246,410,410**
Total Liabilities & Net Assets	**$ 643,137,063**	**$ 656,259,298**

STATEMENT OF CASH FLOWS

	For the Month Ended September 2026	Fiscal Year to Date Through September 2026
Cash Flows Provided By Operating Activities		
Net Income (Loss)	$ (8,804,810)	$ 12,092,327
Adjustments to reconciled net income to net cash provided by operating activities		
Depreciation on fixed assets	(1,325,135)	1,453,373
Disposal of fixed assets	-	-
Amortization of discounts and premium	-	-
Changes in Operating Assets and Liabilities		
Accounts Receivable	31,875,148	(6,206,646)
Prepaid Expenses	1,196,454	(1,913,338)
Accrued Expense and Accounts Payable	3,101,278	(29,865,917)
Current Portion of Deferred Revenue	-	-
Claims Payable	1,161,617	3,567,038
MCO Tax liability	33,753,485	25,047
IBNR	(13,526,422)	(6,283,709)
Net Cash Provided by (Used in) Operating Activities	**47,431,615**	**(27,131,824)**
Cash Flow Provided By Investing Activities		
Proceeds from Restricted Cash & Other Assets		
Proceeds from Investments	(44,526)	(2,857,441)
Proceeds for Sales of Property, Plant and Equipment		
Payments for Restricted Cash and Other Assets		
Purchase of Investments plus Interest reinvested		
Purchase of Property and Equipment	1,709,549	(7,961,956)
Net Cash (Used In) Provided by Investing Activities	**1,665,023**	**(10,819,397)**
Cash Flow Provided By Financing Activities		
Lease Payable - ROU	33,531	7,342,932
Net Cash Used In Financing Activities	**33,531**	**7,342,932**
Increase/(Decrease) in Cash and Cash Equivalents	49,130,169	(30,608,289)
Cash and Cash Equivalents, Beginning of Period	214,557,979	294,296,437
Cash and Cash Equivalents, End of Period	**263,688,148**	**$ 263,688,148**

SCHEDULE OF INVESTMENTS AND CASH BALANCES

		Market Value as of Month Ending, September 2026	Account Type
Local Agency Investment Fund (LAIF)	$	46,875,521	Short-term investment
Ventura County Investment Pool	$	21,192,191	Short-term investment
CalTrust	$	41,475,093	Short-term investment
Bank of Montreal	$	161,308,008	Money market account
Columbia Bank	$	102,380,140	Operating accounts
Investments and monies held by GCHP	***$***	***373,230,954***	

Gold Coast Health Plan℠
A Public Entity

AGENDA ITEM NO. 18

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Christopher Lee, Chief Financial Officer
DATE: November 16, 2026
SUBJECT: 2027 Budget

SUMMARY:
Staff is presenting the 2027 Budget of Gold Coast Health Plan to the Commission.

RECOMMENDATION:
Receive and file. Staff recommend that the Commission approve the 2027 Budget.

ATTACHMENT:
2027 Budget

Gold Coast Health Plan℠
A Public Entity

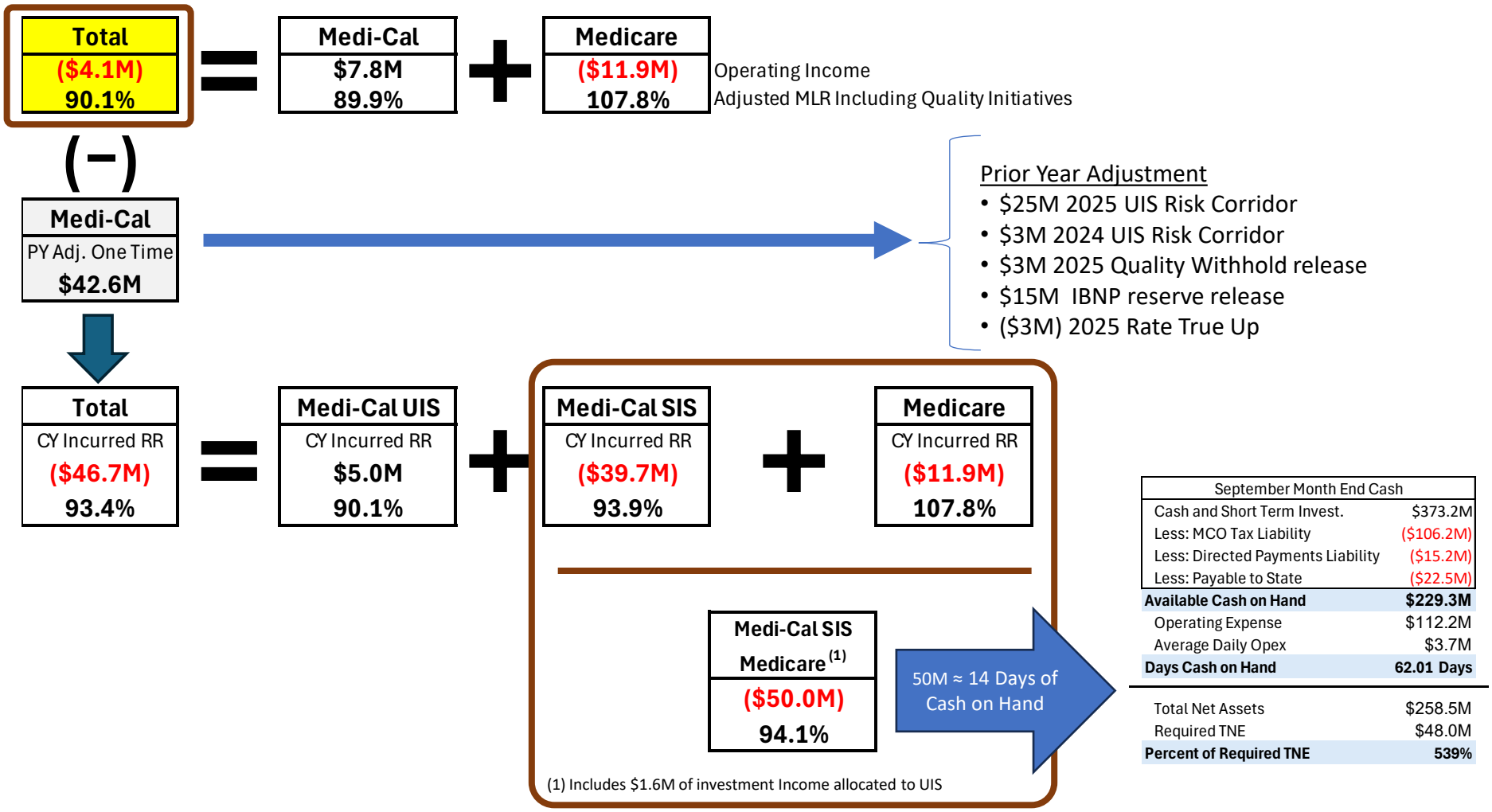
Integrity
Accountability
Collaboration
Trust
Respect

2027 Budget

Ventura County Medi-Cal Managed Care Commission
November 16, 2026

Christopher Lee, Chief Financial Officer

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.



September Month End Cash	
Cash and Short Term Invest.	$373.2M
Less: MCO Tax Liability	($106.2M)
Less: Directed Payments Liability	($15.2M)
Less: Payable to State	($22.5M)
Available Cash on Hand	**$229.3M**
Operating Expense	$112.2M
Average Daily Opex	$3.7M
Days Cash on Hand	**62.01 Days**
Total Net Assets	$258.5M
Required TNE	$48.0M
Percent of Required TNE	**539%**

2027 Final Rates project an operational loss of ($59M), a $15M improvement from Preliminary Rates but ($9M) below the 2026 8+4 Forecast run rate. The decline is primarily driven by the Satisfactory Immigration Status (SIS) population, where provider rate increases, higher utilization, and rising service costs continue to outpace funding.

	2026 8+4 Forecast (Incurred)			Total SIS + Medicare	2027 Preliminary [1]			2027 Final [1]			vs 2027 Prelim Fav/(Unfav)	vs 8+4F Fav/(Unfav)
($Millions)	SIS	UIS	Medicare		SIS	Medicare	Total	SIS	Medicare	Total		
Ending Membership (Dec)	189,374	29,393	1,065	190,439	172,827	3,729	176,556	184,684	3,729	188,413	11,857	(2,026)
Average Member	193,664	31,393	688	194,352	181,259	2,170	183,429	187,111	2,170	189,281	5,852	(5,071)
Member Months	2,323,973	376,714	8,252	2,332,225	2,175,113	26,040	2,201,153	2,245,332	26,040	2,271,372	70,219	(60,853)
Revenue	$997.3M	$216.0M	$15.3M	$1,012.6M	$998.0M	$53.2M	$1,051.2M	$1,064.6M	$53.2M	$1,117.9M	$66.7M	$105.3M
Revenue pmpm	*$429.15*	*$573.30*	*$1,850.33*	*$434.18*	*$458.81*	*$2,044.83*	*$477.58*	*$474.15*	*$2,044.83*	*$492.16*	*$14.58*	*$57.98*
Medical Cost	$890.6M	$186.3M	$15.7M	$906.3M	$908.7M	$53.6M	$962.3M	$962.8M	$53.6M	$1,016.3M	($54.0M)	($110.0M)
Medical Costs pmpm	*$383.22*	*$494.67*	*$1,907.00*	*$388.61*	*$417.79*	*$2,057.70*	*$437.19*	*$428.78*	*$2,057.70*	*$447.46*	*($10.26)*	*($58.85)*
Medical Loss Ratio	89.3%	86.3%	103.1%	89.5%	91.1%	100.6%	91.5%	90.4%	100.6%	90.9%	0.6%	-1.4%
Quality Strategy (Grants/Incentives)	$45.5M	$8.3M	$0.7M	$46.2M	$34.8M	$0.7M	$35.5M	$32.5M	$0.7M	$33.2M	$2.3M	$13.0M
Quality Strategy PMPM	*$19.56*	*$21.94*	*$86.99*	*$19.80*	*$16.00*	*$27.57*	*$16.14*	*$14.47*	*$27.57*	*$14.62*	*$1.52*	*$5.18*
Total Medical Cost PMPM	$402.77	$516.61	$1,993.98	$408.40	$433.79	$2,085.27	$453.33	$443.25	$2,085.27	$462.08	($8.75)	($53.67)
MLR Includes Quality Strategy	93.9%	90.1%	107.8%	94.1%	94.5%	102.0%	94.9%	93.5%	102.0%	93.9%	1%	0%
Gross Margin	**$61.3M**	**$21.4M**	**($1.2M)**	**$60.1M**	**$54.4M**	**($1.1M)**	**$53.4M**	**$69.4M**	**($1.1M)**	**$68.3M**	**$15.0M**	**$8.2M**
Administrative Cost	$110.9M	$18.0M	$10.7M	$121.7M	$128.9M	$10.7M	$139.7M	$128.9M	$10.7M	$139.7M	-	($18.0M)
Admin Cost PMPM	*$47.73*	*$47.77*	*$1,300.58*	*$52.17*	*$59.27*	*$412.15*	*$63.45*	*$57.42*	*$412.15*	*$61.49*	*$1.96*	*($9.32)*
Administrative Loss Ratio	11.1%	8.3%	70.3%	12.0%	12.9%	20.2%	13.3%	12.1%	20.2%	12.5%	1%	(0%)
Investment Income	$9.9M	$1.6M	-	$11.5M	$12.0M	-	$12.0M	$12.0M	-	$12.0M	$0.5M	$0.5M
Net Income/(Loss)	**($39.7M)**	**$5.0M**	**($11.9M)**	**($50.0M)**	**($62.5M)**	**($11.8M)**	**($74.3M)**	**($47.5M)**	**($11.8M)**	**($59.3M)**	**$15.0M**	**($9.3M)**

(1) Preliminary 2027 Budget assumes 2026 Admin $'s

The 2027 Budget net loss of ($59.3M) is ($9.3M) unfavorable to the 2026 8+4 Forecast, primarily driven by higher administrative costs and provider re-contracting changes.

	2026 8+4F Net Income/(Loss)		**($50.0M)**
	Volume	($3.4M)	
A	Provider re-contracting changes	($10.3M)	
B	Utilization Trend	($3.7M)	
C	Reduction in Quality Strategy	$10.7M	
	Total Gross Margin	($6.7M)	
D	Admin expense reallocation	($18.0M)	
	Investment Income	$0.5M	
	Total Admin & Investment Income	($17.5M)	
	Total Adjustment		**($24.2M)**
	2027 PRELIMINARY Budget Net Income/(Loss)		**($74.3M)**
	Volume	$2.2M	
E	Trend Modification	$18.2M	
F	Risk Adjustment	($5.8M)	
	Other	($1.9M)	
C	Reduction in Quality Strategy	$2.3M	
	Total Gross Margin	$15.0M	
	Total Adjustment		**$15.0M**
	2027 Final Budget Net Income/(Loss)		**($59.3M)**
	Variance to 2026 8+4 Forecast Run Rate		**($9.3M)**

Discussion

- (A) Recent provider contract negotiations have increased unit cost trends beyond the levels funded by DHCS.
- (B) The SIS population continues to experience margin pressure as declining enrollment reduces revenue while the remaining membership reflects a higher-cost risk profile.
- (C) Quality incentive funding is recalibrated to reflect increasing performance thresholds and expected achievement. The revised strategy prioritizes high-impact measures and aligns incentives with meaningful quality outcomes.
- (D) Assumes operational costs supporting UIS would reallocate to support SIS.
- (E) The favorable variance is attributable to DHCS updating its trend assumptions based on more recent QFR and MLR experience. The updated data supported higher projected medical costs, which translated into increased CY27 rates
- (F) Risk adjustment measures the health risk of GCHP members relative to the regional average population used for rate development. Updated member data resulted in lower risk scores and a corresponding reduction in CY27 rates.

Achieving a sustainable 0.5% operating margin in 2027 will require significant operational changes, organizational discipline, and targeted investments, requiring approximately $65M of improvement through a reduction in Administrative Loss Ratio (ALR) from 12.5% to 11.0%($12M) and Medical Loss Ratio (MLR) from 93.9% to 89.1% ($53M).

($Millions)	Preliminay 2027 Budget [1] SIS	Medicare	Total	2027 Target (Run Rate) SIS	Medicare	Total	Variance to Prelim 2027 Budget
Ending Membership (Dec)	184,684	3,729	188,413	184,684	3,729	188,413	-
Average Member	187,111	2,170	189,281	187,111	2,170	189,281	-
Member Months	2,245,332	26,040	2,271,372	2,245,332	26,040	2,271,372	-
Revenue	$1,064.6M	$53.2M	$1,117.9M	$1,064.6M	$53.2M	$1,117.9M	-
Revenue pmpm	*$474.15*	*$2,044.83*	*$492.16*	*$474.15*	*$2,044.83*	*$492.16*	-
Medical Cost	$962.8M	$53.6M	$1,016.3M	$909.7M	$53.2M	$963.0M	$53.4M
Medical Costs pmpm	*$428.78*	*$2,057.70*	*$447.46*	*$405.16*	*$2,044.83*	*$423.95*	*$23.50*
Medical Loss Ratio	90.4%	100.6%	90.9%	85.4%	100.0%	86.1%	4.8%
Quality Strategy (Grants/Incentives)	$32.5M	$0.7M	$33.2M	$32.5M	$0.7M	$33.2M	- -
Quality Strategy PMPM	*$14.47*	*$27.57*	*$14.62*	*$14.47*	*$27.57*	*$14.62*	-
Total Medical Cost PMPM	$443.25	$2,085.27	$462.08	$419.62	$2,072.40	$438.57	$23.50
MLR Includes Quality Strategy	93.5%	102.0%	93.9%	88.5%	101.3%	89.1%	4.8%
Gross Margin	**$69.4M**	**($1.1M)**	**$68.3M**	**$122.4M**	**($0.7M)**	**$121.7M**	**$53.4M**
Administrative Cost	$128.9M	$10.7M	$139.7M	$117.1M	$10.8M	$127.9M	**$11.7M**
Admin Cost PMPM	*$57.42*	*$412.15*	*$61.49*	*$52.16*	*$415.99*	*$56.33*	*$5.16*
Administrative Loss Ratio	12.1%	20.2%	12.5%	11.0%	20.3%	11.4%	1.0%
Investment Income	$12.0M	-	$12.0M	$12.0M	-	$12.0M	-
Net Income/(Loss)	**($47.5M)**	**($11.8M)**	**($59.3M)**	**$17.3M**	**($11.6M)**	**$5.8M**	**$65.1M**

PATH TO OPERATIONAL SUSTAINABILITY:

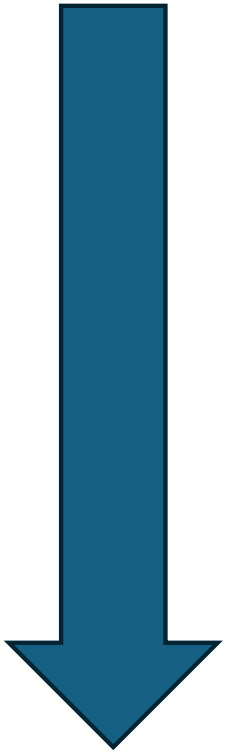
1) **Operational Restructuring** – Administrative layoffs and organizational efficiency.
2) **Strategic Investments** – Prioritize investments that improve long-term sustainability, operational effectiveness, and value creation.
3) **Aggressive Cost Management** – Strengthen oversight of medical expenditures through utilization management, network optimization, site-of-care strategies.
4) **Provider Contracting and Reimbursement Discipline** – Align provider contracts and reimbursement rates with financial capacity and available resources.

Operational Sustainability Investments **$20.0M**

(1) Preliminary 2027 Budget assumes 2026 Admin $'s

The path to operational sustainability is built on a phased approach that begins with immediate operational actions, progresses through strategic portfolio investments, and is strengthened by active management of care delivery and provider contracting strategies that align reimbursement with organizational sustainability.

($59.3M)



	2027 Preliminary Investments	2027 Run Rate Savings
 Operational Restructuring	($8M)	$12M
 Strategic Investments	($12M)	$40M
 Aggressive Cost Management	($3M)	$3M - 10M
 Provider Contracting and Reimbursement Discipline	TBD	$3M
	($22M)	

$5.8M

Total Operational Sustainability Investments Not to exceed $20M.

($20M)	$58M - $65M

2027 Preliminary Project Portfolio
Projects and funding may change. Total funding will not exceed $20M.
- Certain projects will require implementation starting in 2026

Operational Restructuring		
$5.1M	Operational Sustainability Initiative	Including one-time severance and transition costs associated with workforce reductions.
$2.6M	IT Rationalization	Conduct a comprehensive assessment and reorganization of IT operations, technology management, and infrastructure to identify gaps and improvement opportunities. The project will optimize processes, realign resources, maximize existing technology investments, and strengthen IT capabilities, performance, and scalability.
Strategic Initiatives		
$6.0M	Payment Integrity integration and operations	Supports the implementation, integration, and ongoing management of payment integrity solutions to identify, prevent, and recover inappropriate claim payments. Expenses include vendor fees tied to claim avoidance and recovery activities, system integration and oversight, and operational support to maximize savings, strengthen controls, and improve claims payment accuracy.
$2.8M	Member Retention Through Personalized Engagement	Current outreach efforts have not achieved desired retention outcomes amid Medicaid eligibility changes. This project will use data-driven member profiling to deliver targeted engagement through SMS, email, outbound and inbound calls, AI-assisted warm transfers, and peer-to-peer support, improving retention while scaling member outreach and marketing.
$0.4M	Salesforce Agentforce AI Implementation	Current enrollment, outreach, and retention efforts rely on manual processes that limit scalability and consistent member engagement. Implementing Salesforce Agentforce and Usher will automate 50-60% of routine interactions, increasing capacity to 1.7-2.5x current volumes while allowing staff to focus on complex member needs.
$1.4M	NCPDP D.0 to F6 Compliance	NCPDP compliance is federally mandated by January 1, 2028, requiring updates to systems, processes, and integrations. This project will fund assessment, configuration, testing, and implementation support to ensure GCHP and its PBM achieve compliance.
$0.4M	HRP Upgrade	GCHP's current HealthEdge version requires operational workarounds and has fallen behind the vendor's recommended release schedule. Upgrading will provide access to enhanced functionality, improve operational efficiency, and strengthen the stability and value of the core platform.
$0.1M	Symplr Upgrade	The current credentialing platform is not fully optimized, limiting operational efficiency and value realization. Upgrading Symplr will unlock its full functionality, streamline contract management implementation, and reduce administrative complexity.
$1.0M	PACE Application Review and Preliminary Implementation Planning	This initiative prepares the organization for future PACE participation by developing application materials, assessing operational readiness, and establishing implementation plans to support timely program launch when the state moratorium is lifted.
Aggressive Cost Management		
$1.0M	Care Optimization Initiative	This initiative optimizes healthcare utilization and medical spending by ensuring members receive the right care, at the right time, and in the right setting. Through care navigation, utilization management, and site-of-service strategies, the program improves access to appropriate care, enhances member outcomes, and reduces avoidable emergency, hospital, and other unnecessary healthcare utilization.
$0.4M	Contract Management Implementation	The current contracting process lacks a centralized, standardized system, resulting in inconsistent workflows, limited visibility, and contract tracking challenges. Implementing a contract management solution will streamline lifecycle management, improve oversight, and support scalable growth in contracting activities.
$0.3M	CLR Closed Loop Referral	The current referral process is manual and unsustainable, resulting in a growing backlog and delays in care. This project will automate referral workflows to improve access, efficiency, provider experience, and compliance.
$0.3M	Wellth DSNP Gaps in Care	Current D-SNP care management relies heavily on care navigators to drive member engagement and close care gaps. This project will use digital engagement and targeted incentives to improve health outcomes, member experience, and quality performance, resulting in stronger NPS, CAHPS, and HOS scores.
$0.5M	ESRD Medicare Enrollment	Members with ESRD represent a high-cost population, and missed Medicare enrollment shifts avoidable dialysis costs to GCHP. This project will use a specialized vendor to increase Medicare enrollment, reducing costs while ensuring members receive all eligible benefits.
$22.4M		

Return to Agenda

Best Case: Reflects successful execution of strategic investments, utilization management, care delivery optimization, and provider contracting initiatives resulting in improved medical and administrative cost performance.

	2027 Medi-Cal SIS	2027 Medicare	2027 Total	2028 Medi-Cal SIS	2028 Medicare	2028 Total	2029 Medi-Cal SIS	2029 Medicare	2029 Total
Avg Members	187,111	2,170	189,281	169,188	3,900	173,088	167,963	5,950	173,913
Member Months	2,245,332	26,040	2,271,372	2,030,256	46,800	2,077,056	2,015,556	71,400	2,086,956
Revenue	$1,064.6M	$53.2M	$1,117.9M	$993.5M	$101.3M	$1,094.8M	$1,015.9M	$159.1M	$1,175.0M
Revenue PMPM	474.15	2,044.83	492.16	489.33	2,164.71	527.07	504.00	2,228.49	563.00
Medical Cost	$909.7M	$53.2M	$963.0M	$853.9M	$98.3M	$952.1M	$883.3M	$153.9M	$1,037.2M
Medical Cost PMPM	405.16	2,044.83	423.95	420.57	2,099.87	458.40	438.22	2,155.37	496.97
Quality Strategy	$32.5M	$0.7M	$33.2M	$30.3M	$1.3M	$31.6M	$31.0M	$2.1M	$33.1M
Quality Strategy PMPM	14.47	27.57	14.62	14.93	28.45	15.24	15.38		15.86
MLR (incl. Quality Strategy)	88.5%	101.3%	89.1%	89.0%	98.3%	89.9%	90.0%	98.0%	91.1%
Administrative Cost	$117.1M	$10.8M	$127.9M	$99.3M	$15.8M	$115.1M	$91.4M	$16.3M	$107.8M
Admin PMPM	52.16	415.99	56.33	48.93	336.55	55.41	45.36	228.88	51.64
ALR	11.0%	20.3%	11.4%	10.0%	15.5%	10.5%	9.0%	10.3%	9.2%
Investment Income	$12.0M	-	$12.0M	-	-	$12.0M	-	-	$12.0M
Strategy Investment	**-**		**$20.0M**	**-**		**$15.0M**	**-**		**$5.0M**
Net Income/(Loss)	$17.3M	($11.6M)	($14.2M)	$9.9M	($14.0M)	($7.1M)	$10.2M	($13.2M)	$3.9M
Operating Margin	1.6%	(21.7%)	(1.3%)	1.0%	(13.9%)	(0.6%)	1.0%	(8.3%)	0.3%
Ending equity			$227.9M			$220.8M			$224.7M
Required TNE			$42.1M			$41.5M			$44.5M
% of TNE			541.1%			531.7%			504.8%

- **Baseline**: Revenue and medical costs are projected to increase by 3.2% in 2028 and 3.0% in 2029.
- **Best Case**: Assumes Medi-Cal medical cost ratio improves to 88.5% in 2027, 89% in 2028, and 90% in 2029, combined with ALR improvements to 11% in 2027, 10% in 2028, and 9% in 2029, along with the identified strategic investments and operational initiatives.

The best-case scenario illustrates a path to operational sustainability that maintains reserve adequacy while requiring strategic investments to achieve and sustain long-term financial performance.

	Worst Case				Admin Change Only				**Best Case**			
	2026	2027	2028	2029	2026	2027	2028	2029	**2026**	**2027**	**2028**	**2029**
Avg Members	225,565	189,281	173,088	173,913	225,565	189,281	173,088	173,913	225,565	189,281	173,088	173,913
Member Months	2,271,372	2,271,372	2,077,056	2,086,956	2,271,372	2,271,372	2,077,056	2,086,956	2,271,372	2,271,372	2,077,056	2,086,956
Revenue	$1,253.9M	$1,117.9M	$1,094.8M	$1,175.0M	$1,253.9M	$1,117.9M	$1,094.8M	$1,175.0M	$1,253.9M	$1,117.9M	$1,094.8M	$1,175.0M
Medical Cost	$1,075.4M	$1,016.3M	$997.3M	$1,073.5M	$1,075.4M	$1,016.3M	$997.3M	$1,073.5M	$1,075.4M	$963.0M	$952.1M	$1,037.2M
Quality Strategy	$54.4M	$33.2M	$31.6M	$33.1M	$54.4M	$33.2M	$31.6M	$33.1M	$54.4M	$33.2M	$31.6M	$33.1M
MLR (incl. Quality Strategy)	90.1%	93.9%	94.0%	94.2%	90.1%	93.9%	94.0%	94.2%	90.1%	89.1%	89.9%	91.1%
Administrative Cost	$139.7M	$139.7M	$135.9M	$139.2M	$139.7M	$127.9M	$115.1M	$107.8M	$139.7M	$127.9M	$115.1M	$107.8M
ALR	11.1%	12.5%	12.4%	11.8%	11.1%	11.4%	10.5%	9.2%	11.1%	11.4%	10.5%	9.2%
Investment Income	$11.5M	$12.0M	$12.0M	$12.0M	$11.5M	$12.0M	$12.0M	$12.0M	$11.5M	$12.0M	$12.0M	$12.0M
Strategy Investment	-	-	-	-	-	-	**$7.0M**	**$2.5M**	-	**$20.0M**	**$15.0M**	**$5.0M**
Net Income/(Loss)	($4.1M)	($59.3M)	($58.1M)	($58.8M)	($4.1M)	($47.6M)	($44.3M)	($29.9M)	($4.1M)	($14.2M)	($7.1M)	$3.9M
Operating Margin	(0.3%)	(5.3%)	(5.3%)	(5.0%)	(0.3%)	(4.3%)	(4.0%)	(2.5%)	(0.3%)	(1.3%)	(0.6%)	0.3%
Ending equity	$240.7M	$181.3M	$123.2M	$64.4M	$240.7M	$193.0M	$148.8M	$118.9M	$240.7M	$227.9M	$220.8M	$224.7M
Required TNE	$48.1M	$44.3M	$43.3M	$46.0M	$48.1M	$44.3M	$43.3M	$46.0M	$48.1M	$42.1M	$41.5M	$44.5M
% of TNE	500.4%	409.7%	284.4%	140.1%	500.4%	436.2%	343.4%	258.6%	500.4%	541.1%	531.7%	504.8%

- **Baseline**: Revenue and medical costs are projected to increase by 3.2% in 2028 and 3.0% in 2029.
- **Worst Case**: Assumes no cost-of-care improvement initiatives and administrative expenses remain at 2026 levels.
- **Administrative Change Only**: Assumes Medi-Cal Administrative Loss Ratio (ALR) improves to 11% in 2027, 10% in 2028, and 9% in 2029.
- **Best Case**: Assumes Medi-Cal medical cost ratio improves to 88.5% in 2027, 89% in 2028, and 90% in 2029, combined with ALR improvements to 11% in 2027, 10% in 2028, and 9% in 2029, along with the identified strategic investments and operational initiatives.

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AGENDA ITEM NO. 19

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Christopher Lee, Chief Financial Officer
Bob Bushey, Sr. Director, Procurement

DATE: November 16, 2026

SUBJECT: 2027 Contract Renewal List

SUMMARY:

Staff are presenting the 2027 Contract Renewal Proposals to the Commission. The report summarizes the estimated contract renewal amounts for 2027, and such list be approved as part of the 2027 Budget.

RECOMMENDATION:

Staff recommends that the Commission approve the 2027 Contract Renewal List as part of approval of the 2027 Budget.

ATTACHMENT:

2027 Contract Renewal List

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2027 Contract Renewal List

Ventura County Medi-Cal Managed Care
November 16, 2026

Christopher Lee, Chief Financial Officer
Bob Bushey, Executive Director Procurement

Integrity
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Collaboration
Trust
Respect

2027 Contract Renewal Proposals

Supplier	Award Methodology	Brief Description	Current Contract			Renewal Period (1)				Relationship		
			Start Date	End Date	Amount	Start Date	End Date	Amount	% Change	Original Contract Start Date	Years	Cumulative Amount
LinkedIn Corporation	Under Bidding Threshold	Learning hub software	12/03/25	12/02/26	32,418	12/03/26	12/02/27	37,000	14%	12/01/17	10	331,466
Partners In Leadership LLC dba Culture Partners	Sole Source	Culture training services	12/20/25	12/19/26	310,750	12/20/26	12/19/27	155,000	-50%	12/20/24	3	776,500
Cotiviti, Inc.	Sole Source	IT interoperability software	01/01/26	12/31/26	187,000	01/01/27	12/31/28	200,000	7%	01/01/21	8	1,275,106
Health Management Associates, Inc	Sole Source	Consulting services - Finance, actuarial (RDT)	01/01/26	12/31/26	1,240,350	01/01/27	12/31/27	1,250,000	1%	12/01/23	4	5,074,413
Gemini Diversified Services, Inc.	Under Bidding Threshold	Credentialing services	01/01/26	12/31/26	33,551	01/01/27	12/31/27	39,000	16%	07/01/15	13	424,838
The Periscope Group	Under Bidding Threshold	In home medical assessment services	01/01/26	12/31/26	60,000	01/01/27	12/31/28	60,000	0%	02/01/15	14	483,726
LRMN Consulting	Sole Source	Provide medical reviews	01/02/26	01/01/27	254,271	01/02/27	01/01/28	300,000	18%	01/01/26	2	575,460
Crossroads Staffing Services	Competition/RFP	Temporary labor	02/01/26	01/31/27	497,543	02/01/27	01/31/28	500,000	0%	01/23/18	10	5,019,350
Mercy Kagoda MD	Sole Source	Consulting - Medical reviews	02/02/26	02/01/27	240,388	02/02/27	02/01/28	300,000	25%	02/01/26	2	560,420
Manifest Medex	Sole Source	Data sharing services	02/16/26	02/15/27	207,326	02/16/27	02/15/29	212,500	2%	02/15/21	8	1,686,236
Carol Hsu	Sole Source	Medical reviews	03/01/26	02/28/27	149,066	03/01/27	02/29/28	200,000	34%	03/01/23	5	796,265
Shah Health LLC	Sole Source	Medical reviews	03/02/26	03/01/27	244,800	03/02/27	03/01/28	300,000	23%	03/01/25	3	810,000
TTEC Government Solutions, LLC	Competition/RFP	Call center software licenses	04/01/26	03/31/27	104,940	04/01/27	03/31/28	110,000	5%	11/01/24	3	363,604
Navex Global, Inc.	Sole Source	Policy library software	04/23/26	04/22/27	198,833	04/23/27	04/22/28	198,833	0%	12/10/25	2	480,514
OpenText Inc.	Sole Source	Fax services	05/01/26	04/30/27	43,256	05/01/27	04/30/28	165,000	281%	05/12/15	13	684,073
OmniData Insights, Inc.	Sole Source	Azure (Microsoft ELA software)	05/01/26	04/30/27	493,545	05/01/27	04/30/28	1,555,000	215%	05/01/21	7	4,516,268
Infomedia Group dba Carenet Healthcare Services	Competition/RFP	Outreach services	06/01/26	05/31/27	95,074	06/01/27	05/31/28	200,000	110%	03/01/20	8	889,285
Cotiviti, Inc.	Sole Source	EDI software - Technology Solution Only	06/22/26	06/21/27	134,384	06/22/27	06/21/29	141,000	5%	06/22/19	10	1,357,070
Cotiviti, Inc.	Sole Source	Cloud member access software	06/30/26	06/29/27	112,820	06/30/27	06/29/29	118,500	5%	06/30/21	8	913,917
Intelligent Content Solutions LLC	Sole Source	Mailroom scanning software	07/01/26	06/30/27	367,200	07/01/27	06/30/28	375,000	2%	07/01/25	3	1,109,400
UpToDate, Inc.	Sole Source	Pharmacy software	07/01/26	06/30/27	177,229	07/01/27	06/30/28	170,000	-4%	08/01/23	5	864,147

(1) The proposed renewal amount represents a not-to-exceed dollar limit for the renewal period.

Return to Agenda

2027 Contract Renewal Proposals
Continued

Supplier	Award Methodology	Brief Description	Current Contract			Renewal Period (1)				Relationship		
			Start Date	End Date	Amount	Start Date	End Date	Amount	% Change	Original Contract Start Date	Years	Cumulative Amount
Cotiviti, Inc.	Competition/RFP	EDI Software (Business Operations Services Only)	07/01/26	06/30/27	265,000	07/01/27	06/30/29	285,000	8%	07/01/24	5	7,372,284
Wellth Inc.	Sole Source	Disease management services	07/01/26	06/30/27	3,058,477	07/01/27	06/30/28	5,726,279	87%	07/13/23	5	17,960,188
All Languages Interpreting & Translating, Inc.	Competition/RFP	Interpreting services	07/01/26	06/30/27	276,000	07/01/27	06/30/28	280,000	1%	08/01/20	8	949,036
The Mihalik Group LLC	Competition/RFP	NCQA accreditation consulting services	07/01/26	06/30/27	300,787	07/01/27	06/30/30	138,333	-54%	07/01/24	6	1,317,361
SMI Concepts, Inc	Sole Source	Audio visual services	07/01/26	06/30/27	46,372	07/01/27	06/30/28	100,000	116%	09/01/17	11	555,987
Stacy Miller Public Affairs Inc.	Competition/RFP	Media buying services (pass through plus monthly service fee)	07/01/26	06/30/27	166,604	07/01/27	06/30/28	690,000	314%	07/01/23	5	1,356,417
Arine Inc.	Competition/RFP	Software - Used for chronic disease management	08/01/26	07/31/27	185,625	08/01/27	07/31/28	1,800,000	870%	12/06/24	4	2,295,000
Quest Analytics LLC	Sole Source	Provider address software platform	08/12/26	08/11/27	186,633	08/12/27	08/11/28	186,633	0%	08/12/24	4	746,531
KP LLC	Competition/RFP	Document translation services	09/01/26	08/31/27	102,000	09/01/27	08/31/28	100,000	-2%	09/01/25	3	304,000
The Finish Line	Sole Source	Promotional products	09/01/26	08/31/27	66,500	09/01/27	08/31/28	113,756	71%	09/01/21	7	512,756
Simpledatalabs inc dba Prophecy Inc.	Sole Source	IT software	10/01/26	09/30/27	239,500	10/01/27	09/30/28	249,080	4%	10/01/23	5	1,207,080
Baker Tilly Advisory Group LP	Sole Source	Financial audit services	10/01/26	09/30/27	185,000	10/01/27	09/30/28	200,000	8%	10/01/15	13	1,551,780
Tevora Business Solutions, Inc.	Sole Source	OKTA single sign software	11/01/26	10/31/27	25,590	11/01/27	10/31/30	25,000	-2%	10/29/18	12	307,445
Affiliated Monitors Inc.	Competition/RFP	Corporate integrity agreement services	11/02/26	11/01/27	89,873	11/02/27	11/01/28	111,882	24%	11/01/22	6	568,734
TopBloc	Sole Source	Workday support services	12/12/25	12/11/26	236,393	12/12/27	12/11/28	240,000	2%	01/12/26	3	693,087
James Vincent Pezzullo II dba The JVP Group	Sole Source	Website services	12/31/25	12/30/26	96,000	12/31/27	12/30/28	166,432	73%	12/04/14	14	662,933
Milliman	Sole Source	Actuarial services	01/01/27	12/31/27	477,387	01/01/28	12/31/28	525,000	10%	10/31/25	3	1,599,120
Pacific Interpreters	Competition/RFP	Interpreting services	01/01/27	12/31/27	204,000	01/01/28	12/31/28	210,000	3%	08/01/20	8	1,280,774
Stacy Miller Public Affairs Inc.	Competition/RFP	Public relations services	01/01/27	12/31/27	382,559	01/01/28	12/31/28	300,000	-22%	08/01/24	4	1,607,077
Quest Analytics LLC	Sole Source	Provider address verification outreach services	01/01/27	12/31/27	37,149	01/01/28	12/31/28	39,000	5%	12/17/18	10	376,441
SHI International Corp	Competition/RFP	Microsoft Volume Licensing Agreement	01/01/27	12/31/27	533,887	01/01/28	12/31/30	570,000	7%	01/01/25	6	3,311,661
Perfect Gift LLC	Competition/RFP	Gift cards	01/01/27	12/31/27	1,159,584	01/01/28	12/31/28	1,825,000	57%	12/03/21	7	8,879,136

(1) The proposed renewal amount represents a not-to-exceed dollar limit for the renewal period.

Return to Agenda

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AGENDA ITEM NO. 20

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Christopher Lee, Chief Financial Officer
Bob Bushey, Sr. Director, Procurement

DATE: November 16, 2026

SUBJECT: 2026 Q3 Procurement Summary

SUMMARY:

Staff are presenting the 2026 Q3 Procurement Summary to the Commission to show what procurements occurred under the revised Procurement Policy.

RECOMMENDATION:

Receive and file.

ATTACHMENT:

2026 Q3 Procurement Summary

Gold Coast Health Plan℠
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Purchase Summary
June – September 2026

Ventura County Medi-Cal Managed Care Commission

November 16, 2026

Christopher Lee, Chief Financial Officer
Bob Bushey, Executive Director Procurement

Integrity
Accountability
Collaboration
Trust
Respect

Report Overview

- The report reflects every transaction that is governed by the Signature Authority and Procurement Policy
- Transaction approvals are automated and completed via a purchase order using Workday financial software
- Sides 3-6 reflect new purchases that were originated in Workday and completed and awarded from June until September
- Slides 7-10 reflect purchase orders that were migrated from our legacy financial system, (Multiview) and amended to add additional funds or to renew a contract for a new renewal term

Each Procurement is funded via a Purchase Order

Workday Purchase Order Transactions

PO Number	Date	Business Owner Chief	Vendor Name	Vendor Type	Award Method	Description	Total Amount	Commission Approved	Commission Approval Type
PO-000081	6/3/2026	Suma Simcoe	Compuwave, Inc	Preferred	Competition	Laptops	$2,058.00	No	
PO-000082	6/3/2026	Suma Simcoe	SHI International Corp	Preferred	Competition	Desktop Software	$24,435.84	No	
PO-000083	6/3/2026	Suma Simcoe	SHI International Corp	Preferred	Competition	Desktop Software	$1,933.98	No	
PO-000084	6/4/2026	Christopher Lee	Crow Canyon Systems, Inc	Single Purchase	Under $200k	Contract Management Software	$7,200.00	No	
PO-000085	6/5/2026	James Cruz	Health Literacy Innovations LLC	Single Purchase	Under $200k	IT Software - Medical Management	$1,812.00	No	
PO-000086	6/5/2026	Suma Simcoe	Aarete LLC	Contracted	Sole Source	Professional Services - Operations	$608,511.24	Yes	Stabilization Project- Approved as a project item under Agenda Item #5 at the February 23, 2026, Commission meeting.
PO-000087	6/9/2026	Suma Simcoe	Press Ganey Associates LLC	Contracted	Under $200k	Provider Survey Services	$45,765.00	No	
PO-000088	6/11/2026	Suma Simcoe	Cotiviti, Inc	Preferred	Competition	EDI and Interoperability Services	$245,714.50	No	
PO-000089	6/11/2026	Eve Gelb	Press Ganey Associates LLC	Contracted	Under $200k	Member Journey Survey	$100,800.00	No	
PO-000090	6/11/2026	Paul Aguilar	Crossroads Staffing Services	Preferred	Competition	Temporary Labor Services	$726,211.20	Yes	2025 Contract Renewal List
PO-000091	6/11/2026	Suma Simcoe	Compuwave, Inc	Preferred	Competition	Laptops	$641.00	No	
PO-000092	6/11/2026	Suma Simcoe	SHI International Corp	Preferred	Competition	Desktop Software	$33,101.03	No	
PO-000093	6/18/2026	Suma Simcoe	SHI International Corp	Preferred	Competition	Desktop Software	$33,758.90	No	
PO-000094	6/18/2026	Suma Simcoe	Compuwave, Inc	Preferred	Competition	Laptops	$33,800.00	No	
PO-000095	6/18/2026	Christopher Lee	Baker Tilly Advisory Group LP	Contracted	Sole Source	Financial Audit Services	$203,000.00	Yes	2026 Contract Renewal List

Each Procurement is funded via a Purchase Order

Workday Purchase Order Transactions

PO Number	Date	Business Owner Chief	Vendor Name	Vendor Type	Award Method	Description	Total Amount	Commission Approved	Commission Approval Type
PO-000096	6/24/2026	Paul Aguilar	CareNational Healthcare Services LLC	Preferred	Competition	Temporary Labor Services	$4,538.09	No	
PO-000097	6/24/2026	Christopher Lee	CareNational Healthcare Services LLC	Preferred	Competition	Temporary Labor Services	$5,848.62	No	
PO-000098	6/24/2026	Paul Aguilar	Akkodis, Inc	Preferred	Competition	Temporary Labor Services	$79,804.40	No	
PO-000099	6/24/2026	Paul Aguilar	Akkodis, Inc	Preferred	Competition	Temporary Labor Services	$184,164.00	No	
PO-000100	6/24/2026	Paul Aguilar	Crossroads Staffing Services	Preferred	Competition	Temporary Labor Services	$74,630.40	No	
PO-000102	7/2/2026	Suma Simcoe	SHI International Corp	Preferred	Competition	Desktop Software	$8,932.40	No	
PO-000103	7/6/2026	Suma Simcoe	SHI International Corp	Preferred	Competition	Desktop Software	$4,425.74	No	
PO-000105	7/7/2026	Eve Gelb	On Lok, Inc.	New Vendor and New Contract	Under $200k	Consulting Services - PACE Program	$43,000.00	No	
PO-000106	7/10/2026	Paul Aguilar	TotalMed LLC	Contracted	Under $200k	Temporary Labor Services	$154,080.00	No	
PO-000107	7/14/2026	Suma Simcoe	Aarete LLC	Contracted	Sole Source	Professional Services - Operations	$342,000.00	Yes	Stabilization Project- Approved as a project item under Agenda Item #5 at the February 23, 2026, Commission meeting.
PO-000108	7/15/2026	Paul Aguilar	TotalMed LLC	Contracted	Competition	Temporary Labor Services	$154,080.00	No	
PO-000109	7/15/2026	Paul Aguilar	TotalMed LLC	Contracted	Competition	Temporary Labor Services	$79,608.00	No	

Each Procurement is funded via a Purchase Order

Workday Purchase Order Transactions

PO Number	Date	Business Owner Chief	Vendor Name	Vendor Type	Award Method	Description	Total Amount	Commission Approved	Commission Approval Type
PO-000110	7/20/2026	Paul Aguilar	Universal Protection Service L.P.	New Vendor and New Contract	Under $200k	Building OnsiteSsecurity	$71,664.40	No	
PO-000111	7/20/2026	Christopher Lee	Crow Canyon Systems, Inc	Contracted	Under $200k	T&M Services for Contract Management Software	$1,678.00	No	
PO-000112	7/20/2026	Suma Simcoe	Cotiviti, Inc	Preferred	Competition	EDI and Interoperability Services	$125,310.43	No	
PO-000113	7/20/2026	Suma Simcoe	Cotiviti, Inc	Preferred	Competition	EDI and Interoperability Services	$106,490.94	No	
PO-000114	7/21/2026	Paul Aguilar	Crossroads Staffing Services	Preferred	Competition	Temporary Labor Services	$44,380.80	No	
PO-000115	7/21/2026	Paul Aguilar	Crossroads Staffing Services	Preferred	Competition	Temporary Labor Services	$44,380.80	No	
PO-000116	7/21/2026	Paul Aguilar	Crossroads Staffing Services	Preferred	Competition	Temporary Labor Services	$44,380.80	No	
PO-000117	7/21/2026	Suma Simcoe	Compuwave, Inc	Preferred	Competition	Laptops	$5,665.00	No	
PO-000118	7/22/2026	Paul Aguilar	Salary.com	Contracted	Under $200k	Skill Set Market Salary Benchmarking Services	$9,072.00	No	
PO-000119	7/28/2026	Paul Aguilar	Scala Studio LLC	New Vendor and New Contract	Under $200k	New Building Design Services	$22,000.00	No	
PO-000120	7/28/2026	Eve Gelb	Milliman	Contracted	Under $200K	Actuarial Services	$95,000.00	No	
PO-000121	7/28/2026	Suma Simcoe	MRC Smart Technology Solutions dba Mr. Copy, Inc	Contracted	Under $200K	MFD Maintenance Service	$1,000.00	No	
PO-000122	7/29/2026	Suma Simcoe	SHI International Corp	Preferred	Competition	Desktop Software	$32,203.06	No	

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Workday Purchase Order Transactions

PO Number	Date	Business Owner Chief	Vendor Name	Vendor Type	Award Method	Description	Total Amount	Commission Approved	Commission Approval Type
PO-000123	7/30/2026	Christopher Lee	SureShield Inc.	New Vendor and New Contract	Under $200K	Supplier Sanctioned Screening Services	$25,000.00	No	
PO-000124	7/31/2026	James Cruz	Public Health Institute	New Vendor and New Contract	Under $200k	Health Equity Metrics Technology	$5,000.00	No	
PO-000125	7/31/2026	Christopher Lee	Crow Canyon Systems, Inc	Single Purchase	Under $200k	T&M Services for Contract Management Software	$2,700.00	No	
PO-000126	8/3/2026	Suma Simcoe	Tevora Business Solutions, Inc	Contracted	Under $200k	OKTA Single Sign Software	$54,499.26	No	
PO-000128	8/5/2026	Suma Simcoe	Vendor Credentialing Svs LLC dba symplr	Preferred	Competition	Annual Software Hosting Services	$44,849.31	No	
PO-000129	8/5/2026	Suma Simcoe	Enterprise Sys Solutions Corp.dba LA Networks	Preferred	Competition	Network Hardware Maintenance (Cisco Equipment)	$29,500.00	No	
PO-000130	8/5/2026	Suma Simcoe	Aarete LLC	Contracted	Sole Source	Professional Services - Operations	$649,430.00	Yes	Stabilization Project- Approved as a project item under Agenda Item #5 at the February 23, 2026, Commission meeting.
PO-000131	8/5/2026	Suma Simcoe	Vendor Credentialing Svs LLC dba symplr	Preferred	Competition	Annual Software Maintenance Services	$17,013.54	No	
PO-000132	8/11/2026	Suma Simcoe	DEK Industrial Service, LLC dba 360X Staffing	New Vendor and New Contract	Sole Source	Operations Specific - Temporary Labor Services	$51,524.40	No	
PO-000134	8/11/2026	Suma Simcoe	DEK Industrial Service, LLC dba 360X Staffing	New Vendor and New Contract	Sole Source	Operations Specific - Temporary Labor Services	$57,752.40	No	

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Workday Purchase Order Transactions

PO Number	Date	Business Owner Chief	Vendor Name	Vendor Type	Award Method	Description	Total Amount	Commission Approved	Commission Approval Typ
PO-000135	8/11/2026	Suma Simcoe	DEK Industrial Service, LLC dba 360X Staffing	New Vendor and New Contract	Sole Source	Operations Specific - Temporary Labor Services	$56,420.00	No	
PO-000136	8/14/2026	Paul Aguilar	Fame Systems Inc	New Vendor and New Contract	Under $200K	Janitorial Services	$90,995.50	No	
PO-000137	8/16/2026	Suma Simcoe	Cotiviti, Inc	Preferred	Competition	EDI and Interoperability Services	$191,040.00	No	
PO-000138	8/16/2026	Suma Simcoe	NTT DATA Americas, Inc	Preferred	Competition	Provider Document Attachment Project	$155,755.00	No	
PO-000141	8/17/2026	Suma Simcoe	Visix Inc	New Vendor and New Contract	Under $200K	New Building Facilities Software	$8,444.00	No	
PO-000142	8/17/2026	Suma Simcoe	Compuwave, Inc	Preferred	Competition	Laptops	$1,200.00	No	
PO-000143	8/17/2026	Suma Simcoe	Compuwave, Inc	Preferred	Competition	Laptops	$4,876.00	No	
PO-000144	8/17/2026	James Cruz	Advent Advisory Group	New Vendor and New Contract	Under $200K	NCQA Compliant Audit Services	$49,500.00	No	
PO-000145	8/20/2026	Suma Simcoe	Compuwave, Inc	Preferred	Competition	Laptops	$33,480.00	No	
PO-000146	8/26/2026	Suma Simcoe	Cotiviti, Inc	Preferred	Sole Source	EDI and Interoperability Services	$283,148.00	Yes	Funding approved on Agenda Item #7 at the August 24, 202 Commission meeting.
PO-000147	8/26/2026	Suma Simcoe	Cotiviti, Inc	Preferred	Sole Source	EDI and Interoperability Services	$1,258,730.20	Yes	Funding approved on Agenda Item #7 at the August 24, 202 Commission meeting.

Each Procurement is funded via a Purchase Order

Workday Purchase Order Transactions

PO Number	Date	Business Owner Chief	Vendor Name	Vendor Type	Award Method	Description	Total Amount	Commission Approved	Commission Approval Type
PO-000148	8/28/2026	Eve Gelb	EPIC Hldgs dba Pharmaceutical Stratgs Grp LLC	Contracted	Under $200k	Pharmacy Consulting Services	$41,625.00	No	
PO-000149	8/28/2026	Suma Simcoe	Compuwave, Inc	Preferred	Competition	Laptops	$185.00	No	
PO-000151	8/31/2026	Paul Aguilar	TotalMed LLC	Preferred	Competition	Temporary Labor Services	$94,160.00	No	
PO-000152	8/31/2026	Eve Gelb	Attest Health Care Advisors LLC	New Vendor and New Contract	Under $200K	HEDIS Compliance Audit Services	$75,000.00	No	
PO-000153	9/3/2026	James Cruz	Alinea Imaging Associates, Inc	Contracted	Under $200k	Mobil Imaging Services	$11,030.00	No	
PO-000154	9/16/2026	Eve Gelb	Health Management Associates, Inc	Contracted	Under $200k		$114,400.00	No	
PO-000155	9/4/2026	Suma Simcoe	Inovalon, Inc	Preferred	Competition	HEDIS Services Reporting Software	$569,736.94	Yes	Staff Report Agenda Item #6 at the August 24, 2026 Commission meeting.
PO-000156	9/8/2026	Suma Simcoe	Inovalon, Inc	Preferred	Competition	D-SNP Risk Score Services	$395,638.86	Yes	Staff Report Agenda Item #6 at the August 24, 2026 Commission meeting.
PO-000157	9/8/2026	Suma Simcoe	Inovalon, Inc	Preferred	Competition	HEDIS Services Technology (SaaS)	$1,767,408.85	Yes	Staff Report Agenda Item #6 at the August 24, 2026 Commission meeting.
PO-000158	9/8/2026	Suma Simcoe	Inovalon, Inc	Preferred	Competition	Date Lake Services	$2,527,196.76	Yes	Staff Report Agenda Item #6 at the August 24, 2026 Commission meeting.
PO-000159	9/9/2026	Eve Gelb	Advent Advisory Group	New Vendor and New Contract	Under $200k	Medicare Audit Services	$23,500.00	No	

Each Procurement is funded via a Purchase Order

Workday Purchase Order Transactions

PO Number	Date	Business Owner Chief	Vendor Name	Vendor Type	Award Method	Description	Total Amount	Commission Approved	Commission Approval Type
PO-000148	8/28/2026	Eve Gelb	EPIC Hldgs dba Pharmaceutical Stratgs Grp LLC	Contracted	Under $200k	Pharmacy Consulting Services	$41,625.00	No	
PO-000149	8/28/2026	Suma Simcoe	Compuwave, Inc	Preferred	Competition	Laptops	$185.00	No	
PO-000151	8/31/2026	Paul Aguilar	TotalMed LLC	Preferred	Competition	Temporary Labor Services	$94,160.00	No	
PO-000152	8/31/2026	Eve Gelb	Attest Health Care Advisors LLC	New Vendor and New Contract	Under $200K	HEDIS Compliance Audit Services	$75,000.00	No	
PO-000153	9/3/2026	James Cruz	Alinea Imaging Associates, Inc	Contracted	Under $200k	Mobil Imaging Services	$11,030.00	No	
PO-000154	9/16/2026	Eve Gelb	Health Management Associates, Inc	Contracted	Under $200k		$114,400.00	No	
PO-000155	9/4/2026	Suma Simcoe	Inovalon, Inc	Preferred	Competition	HEDIS Services Reporting Software	$569,736.94	Yes	Staff Report Agenda Item #6 at the August 24, 2026 Commission meeting.
PO-000156	9/8/2026	Suma Simcoe	Inovalon, Inc	Preferred	Competition	D-SNP Risk Score Services	$395,638.86	Yes	Staff Report Agenda Item #6 at the August 24, 2026 Commission meeting.
PO-000157	9/8/2026	Suma Simcoe	Inovalon, Inc	Preferred	Competition	HEDIS Services Technology (SaaS)	$1,767,408.85	Yes	Staff Report Agenda Item #6 at the August 24, 2026 Commission meeting.
PO-000158	9/8/2026	Suma Simcoe	Inovalon, Inc	Preferred	Competition	Date Lake Services	$2,527,196.76	Yes	Staff Report Agenda Item #6 at the August 24, 2026 Commission meeting.
PO-000159	9/9/2026	Eve Gelb	Advent Advisory Group	New Vendor and New Contract	Under $200k	Medicare Audit Services	$23,500.00	No	

Each Procurement is funded via a Purchase Order

Workday Purchase Order Transactions

PO Number	Date	Business Owner Chief	Vendor Name	Vendor Type	Award Method	Description	Total Amount	Commission Approved	Commission Approval Type
PO-000160	9/16/2026	Suma Simcoe	DEK Industrial Service, LLC dba 360X Staffing	New Vendor and New Contract	Sole Source	Operations Specific - Temporary Labor Services	$207,259.20	No	
PO-000161	9/16/2026	Suma Simcoe	DEK Industrial Service, LLC dba 360X Staffing	New Vendor and New Contract	Sole Source	Operations Specific - Temporary Labor Services	$159,430.00	No	
PO-000162	9/16/2026	Paul Aguilar	SigsSigns Inc dba Signature Signs	New Vendor and New Contract	Under $200k	Building Sign	$1,265.92	No	
PO-000163	9/21/2026	Suma Simcoe	HealthEdge Software, Inc	Preferred	Sole Source	Interim Configuration Services	$300,000.00	No	
PO-000164	9/21/2026	Suma Simcoe	ClarisHealth, Inc	New Vendor and New Contract	Competition	Payment Integrity Services	$5,788,805.12	Yes	Staff Report on Agenda Item #11 at the October 5, 2026 Commission meeting.
PO-000165	9/21/2026	Suma Simcoe	ClarisHealth, Inc	New Vendor and New Contract	Competition	Payment Integrity Services	$1,339,921.35	Yes	Staff Report on Agenda Item #11 at the October 5, 2026 Commission meeting.
PO-000166	9/21/2026	Suma Simcoe	ClarisHealth, Inc	New Vendor and New Contract	Under $200k	Payment Integrity Services	$5,082,787.62	Yes	Funding approved on Agenda Item #11 at the October 5, 2026 Commission meeting.
PO-000167	9/21/2026	Paul Aguilar	Crossroads Staffing Services	Preferred	Competition	Temporary Labor Services	$34,444.80	No	
PO-000168	9/21/2026	Paul Aguilar	Southern California Edison	New Vendor and New Contract	Customer Directed Purchase	Utilities - Needed a PO For Payment Purposes	$30,000.00	No	

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Workday Purchase Order Transactions

PO Number	Date	Business Owner Chief	Vendor Name	Vendor Type	Award Method	Description	Total Amount	Commission Approved	Commission Approval Type
PO-000169	9/21/2026	Paul Aguilar	SoCalGas	New Vendor and New Contract	Customer Directed Purchase	Utilities - Needed a PO For Payment Purposes	$1,000.00	No	
PO-000173	9/24/2026	Suma Simcoe	SHI International Corp	Preferred	Competition	Desktop Software	$23,955.74	No	
PO-000174	9/24/2026	Suma Simcoe	SHI International Corp	Preferred	Competition	Desktop Software	$3,177.73	No	
PO-000175	9/28/2026	Paul Aguilar	Turner & Townsend Inc	New Vendor and New Contract	Under $200k	New Building Consulting	$40,300.00	No	
PO-000176	9/29/2026	Suma Simcoe	Inovalon, Inc	Preferred	Competition	HEDIS - PO Migration From Multiview	$166,317.62	No	
PO-000177	9/29/2026	Suma Simcoe	Inovalon, Inc	Preferred	Competition	HEDIS - PO Migration From Multiview	$331,556.18	No	

Each Procurement is funded via a Purchase Order

Migrated Multiview Purchase Order Transactions

PO Number	Date	Business Owner Chief	Vendor Name	Vendor Type	Award Method	Description	Total Amount	Commission Approved	Commission Approval Type
93	8/27/2018	James Cruz	MCG Health LLC	Contracted	Sole Source	Medical Management SaaS	$1,599,789.51	Yes	FY23/24 Contract Renewal List
361	3/13/2020	Christopher Lee	Ryan LLC dba Ryan Tax Compliance Svcs LLC	Contracted	Under $200k	Finance Lease SaaS	$37,500.00	No	
438	9/11/2020	James Cruz	Lourdes Campbell & Associates	Preferred	Competition	Language Interpreting Services	$345,000.00	Yes	Staff Report Agenda Item #9 at the October 5, 2026 Commission Meeting
439	9/14/2020	James Cruz	Pacific Interpreters	Preferred	Competition	Language Interpreting Services	$268,933.00	Yes	Contract Renewal List FY26
488	4/6/2021	Suma Simcoe	Infomedia Group dba Carenet Healthcare Svs	Preferred	Competition	Nurse Advise Hotline	$102,396.60	No	
503	5/13/2021	Suma Simcoe	OmniData, Inc	Contracted	Sole Source	Microsoft Azure Value Add Reseller	$1,024,151.28	Yes	Contract Renewal List FY23/24
540	8/31/2021	Christopher Lee	Multiview Corporation	Contracted	Under $200k	Legacy Financial Software	$35,680.00	No	
554	9/17/2021	Eve Gelb	Ronda Werner dba The Finish Line	Contracted	Under $200k	Promotional Items	$134,509.00	No	
665	5/10/2022	James Cruz	Inovalon, Inc	Preferred	Competition	HEDIS Technology and Services	$262,067.88	No	
774	11/3/2022	James Cruz	Affiliated Monitors, Inc	Contracted	Competition	CIA Consulting Services	$100,134.00	No	
785	11/18/2022	Suma Simcoe	Divurgent LLC	Contracted	Sole Source	Consulting Services - Operations	$203,895.00	No	
826	1/20/2023	Suma Simcoe	Red Gate Software LTD	Contracted	Under $200k	IT Desktop Software	$2,738.20	No	
862	4/13/2023	Paul Aguilar	Salary.com	Contracted	Under $200k	Salary Benchmarking Services	$9,072.00	No	
884	6/2/2023	James Cruz	Glenys Wilbur	Contracted	Under $200k	Nurse Training Services	$49,198.31	No	
898	6/22/2023	Suma Simcoe	Edifecs, Inc	Preferred	Competition	EDI Services	$3,258,922.94	Yes	Staff Report - Agenda Item #5 at the June 26, 2023 Commission meeting.
920	7/13/2023	Suma Simcoe	UpToDate, Inc	Contracted	Sole Source	Pharmacy Software	$121,908.28	Yes	Contract Renewal List FY26

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Migrated Multiview Purchase Order Transactions

PO Number	Date	Business Owner Chief	Vendor Name	Vendor Type	Award Method	Description	Total Amount	Commission Approved	Commission Approval Type
923	7/21/2023	James Cruz	Manifest Medex	Sole Source	Sole Source	IT SaaS	$266,045.13	No	
954	9/1/2023	Eve Gelb	Stacy Miller Public Affairs, Inc	Preferred	Competition	Public Relations Services	$199,944.00	Yes	Contract Renewal List FY26
965	9/22/2023	Suma Simcoe	Netmark Business Services LLC	Preferred	Competition	Claims Processing Services	$16,666,608.20	Yes	Staff Report at the September 25, 2023 Commission Meeting, Project ID 901017 Operations of the Future
984	10/17/2023	Suma Simcoe	Ellit Groups LLC	Contracted	Under $200k	Consulting Services - Operations	$167,349.00	No	
985	7/1/2024	James Cruz	Wellth, Inc	Sole Source	Sole Source	Disease Management Services	$3,794,750.00	Yes	Staff Report at the November 16, 2023 Commission Meeting, Contract Renewal List FY26
1071	4/15/2024	Robert Franco	Navex Global, Inc	Contracted	Under $200k	Policy Library SaaS	$9,685.95	No	
1090	5/24/2024	James Cruz	Infomedia Group dba Carenet Healthcare Svs	Preferred	Competition	Member Outreach Services	$474,854.75	Yes	Contract Renewal List FY 26
1114	7/10/2024	James Cruz	The Mihalik Group LLC	Preferred	Competition	NCQA Certification Services	$307,203.00	Yes	Staff Report June 22, 2022, Contract Renewal List FY26
1116	7/12/2024	Eve Gelb	Coffey Communications, Inc	Contracted	Under $200k	Website Content Management Services	$67,714.00	No	
1132	8/20/2024	Eve Gelb	Perfect Gift LLC	Preferred	Competition	Gift Cards and Services	$1,678,775.70	Yes	Contract Renewal List FY 26
1142	9/23/2024	Suma Simcoe	Quest Analytics LLC	Contracted	Under $200k	Provider Address Software	$188,109.23	Yes	Contract Renewal List FY24/25
1148	10/4/2024	Suma Simcoe	TTEC Government Solutions LLC	Preferred	Competition	Call Center SaaS	$104,939.64	No	
1168	10/31/2024	Suma Simcoe	Salesforce, Inc	Preferred	Competition	CRM SaaS	$662,081.52	Yes	Staff Report at the December 14, 2023 Commission Meeting, Project ID 901017 Operations of the Future
1176	11/6/2024	Paul Aguilar	Iron Mountain	Contracted	Under $200k	Recoords Retrentions Services	$43,755.00	No	

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Migrated Multiview Purchase Order Transactions

PO Number	Date	Business Owner Chief	Vendor Name	Vendor Type	Award Method	Description	Total Amount	Commission Approved	Commission Approval Type
1179	11/8/2024	Suma Simcoe	Emids Technologies	Contracted	Under $200k	Consulting Services - Operations	$125,793.75	No	
1186	11/27/2024	Eve Gelb	EPIC Hldgs dba Pharmaceutical Stratgs Grp LLC	Contracted	Sole Source	Consulting Services - D-SNP PBM	$470,103.30	Yes	Project ID 901018 D-SNP Readiness
1187	12/4/2024	Paul Aguilar	Adecco USA, Inc	Preferred	Competition	Temporary Labor Services	$104,700.86	No	
1203	1/6/2025	Paul Aguilar	Scala Studio LLC	New Vendor and New Contract	Under $200k	Facility Design and Architectual Services	$159,121.08	No	
1215	1/24/2025	Paul Aguilar	Pitney Bowes Global Financial Services LLC	Contracted	Under $200k	Mairoom Equipment	$17,625.80	No	
1224	2/7/2025	Paul Aguilar	MRC Smart Technology Solutions dba Mr. Copy, Inc	Contracted	Under $200k	MFD (Copier) Maintenance	$24,907.54	No	
1227	2/18/2025	Paul Aguilar	Adecco USA, Inc	Preferred	Competition	Temporary Labor Services	$23,166.52	No	
1228	2/18/2025	Paul Aguilar	Adecco USA, Inc	Preferred	Competition	Temporary Labor Services	$20,629.05	No	
1247	3/26/2025	James Cruz	Shah Health LLC	Contracted	Sole Source	Medical Records Review Services	$300,000.00	No	
1253	4/8/2025	Eve Gelb	Prime Therapeutics LLC	Preferred	Competition	D-SNP PBM	$670,000.00	Yes	Staff Report at the October 28, 2024 Commission Meeting, D-SNP Project ID 901018
1256	4/9/2025	Suma Simcoe	Netmark Business Services LLC	Preferred	Competition	Claims Processing Services	$318,635.00	Yes	Staff Report at the September 25, 2023 Commission Meeting, Project ID 901017 Operations of the Futur Project and
1257	4/9/2025	Suma Simcoe	Edifecs, Inc	Preferred	Competition	EDI Services	$355,407.00	Yes	Staff Report - Agenda Item #5 at the June 26, 2023 Commission meeting.
1258	4/10/2025	Suma Simcoe	KP Corporation	Preferred	Competition	Print Services	$160,050.00	No	
1263	4/18/2025	Robert Franco	Inovaare Corporation	Contracted	Competition	Compliance Management Software	$261,735.00	No	
1277	5/5/2025	Eve Gelb	Deloitte Consulting LLP	Preferred	Competition	D-SNP Implementation Services	$5,402,950.00	Yes	Project ID 901018 D-SNP Readiness

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Migrated Multiview Purchase Order Transactions

PO Number	Date	Business Owner Chief	Vendor Name	Vendor Type	Award Method	Description	Total Amount	Commission Approved	Commission Approval Type
1278	5/7/2025	Suma Simcoe	TTEC Government Solutions LLC	Preferred	Competition	Call Center SaaS	361,432.71	Yes	Staff Report at the November 20, 2023 Commission Meeting, Project ID 901017 Operations of the Future
1285	5/19/2025	James Cruz	Vendor Credentialing Svs LLC dba symplr	Sole Source	Competition	Provider Credentialing Services	$70,951.38	No	
1288	5/20/2025	Christopher Lee	Concur Technologies, Inc	Contracted	Under $200k	T&E Expense Reporting Software	$41,946.00	No	
1290	5/27/2025	Paul Aguilar	Securitas Security Services, Inc	Contracted	Under $200k	Building Security Services	$58,767.51	No	
1301	6/11/2025	Suma Simcoe	OptumInsight, Inc	Contracted	Sole Source	IT SaaS - Claims Edit Technology	$1,655,833.56	Yes	Staff Report November 20, 2023 and Project ID 901017 Operations of the Future
1307	6/20/2025	Paul Aguilar	Central Courier LLC	Contracted	Under $200k	Courier Services	$24,120.00	No	
1308	6/20/2025	Christopher Lee	Robert Half, Inc	Sole Source	Under $200k	Temporary Labor Services	$143,141.83	No	
1312	6/26/2025	Suma Simcoe	Intelligent Content Solutions LLC	Sole Source	Sole Source	Mailroom Scanning Software and Services	$540,000.00	Yes	Project ID 901017 Operations of the Future and FY26 Contract Renewal List
1314	6/30/2025	Eve Gelb	Michael A Mitchell	Contracted	Under $200k	Consulting Services - D-SNP	$96,126.00	No	Project ID 901018 D-SNP Readiness
1316	7/5/2025	James Cruz	Inovalon, Inc	Preferred	Competition	HEDIS Technology and Services	$916,478.98	Yes	Contract Renewal List FY24/25
1317	7/5/2025	James Cruz	Inovalon, Inc	Preferred	Competition	HEDIS Technology and Services	$901,292.18	Yes	Contract Renewal List FY24/25
1318	7/5/2025	James Cruz	Inovalon, Inc	Preferred	Competition	HEDIS Technology and Services	$1,542,369.89	Yes	Contract Renewal List FY24/25
1323	7/17/2025	Paul Aguilar	Stericycle, Inc dba Shred-It	New Vendor and New Contract	Under $200k	Facility Shredding Services	$21,618.88	No	
1337	8/26/2025	Paul Aguilar	Adecco USA, Inc	Preferred	Competition	Temporary Labor Services	$47,605.67	No	

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Migrated Multiview Purchase Order Transactions

PO Number	Date	Business Owner Chief	Vendor Name	Vendor Type	Award Method	Description	Total Amount	Commission Approved	Commission Approval Type
1341	9/2/2025	James Cruz	Prana Diabetes Inc dba HabitNu	Contracted	Under $200k	Disease Management	$20,500.00	No	
1343	9/9/2025	Paul Aguilar	Baker Tilly Advisory Group LP	Contracted	Sole Source	HR Consulting Services	$87,849.00	No	
1345	9/12/2025	Suma Simcoe	KP Corporation	Preferred	Competition	Print Services	$219,001.81	No	
1346	9/15/2025	James Cruz	Council for Affordable Quality Healthcare	Contracted	Under $200k	Credentialing Services	$12,838.00	No	
1347	9/15/2025	James Cruz	Gemini Diversified Services, Inc	Contracted	Under $200k	Credentialing Services	$63,125.90	No	
1348	9/16/2025	Paul Aguilar	Adecco USA, Inc	Preferred	Competition	Temporary Labor Services	$143,328.47	No	
1349	9/16/2025	Paul Aguilar	Adecco USA, Inc	Preferred	Competition	Temporary Labor Services	$143,415.64	No	
1352	9/16/2025	Paul Aguilar	Adecco USA, Inc	Preferred	Competition	Temporary Labor Services	$143,589.98	No	
1356	9/29/2025	James Cruz	Inovalon, Inc	Preferred	Competition	Data Lake Technology Database	$561,957.62	Yes	Contract Renewal List FY24/25
1357	9/29/2025	Suma Simcoe	KP Corporation	Preferred	Competition	Print Services	$204,000.00	No	
1367	10/13/2025	Paul Aguilar	CBRE, Inc	Contracted	Under $200k	Facility Building Services	$116,598.33	No	
1369	10/17/2025	Paul Aguilar	CareNational Healthcare Services LLC	Preferred	Competition	Temporary Labor Services	$72,660.00	No	
1370	10/17/2025	Paul Aguilar	Adecco USA, Inc	Preferred	Competition	Temporary Labor Services	$138,176.00	No	
1383	12/9/2025	Paul Aguilar	Akkodis, Inc	Preferred	Competition	Temporary Labor Services	$101,790.40	No	
1387	12/11/2025		540 Consulting LLC	Contracted	Under $200k	Consulting Services - Operations	$117,700.00	No	
15003	6/8/2015	James Cruz	Carol Hsu MD	Contracted	Under $200k	Medical Records Review Services	$104,784.00	No	
15050	7/1/2015	Eve Gelb	James Vincent Pezzullo II dba The JVP Group	Contracted	Under $200k	Website Services	$124,936.50	Yes	Contract Renewal List FY26
15226	6/15/2016	James Cruz	Ephonamation.com/Ansafone Contact Ctr	Contracted	Under $200k	Outbound Calling Technology Servce	$50,332.00	No	
17146	9/5/2017	Paul Aguilar	Valley Wide Air Corporation	Contracted	Under $200k	New Building HVAC Services	$4,191.00	No	

Each Procurement is funded via a Purchase Order

Migrated Multiview Purchase Order Transactions

PO Number	Date	Business Owner Chief	Vendor Name	Vendor Type	Award Method	Description	Total Amount	Commission Approved	Commission Approval Type
17155	9/29/2017	Eve Gelb	SMI Concepts, Inc	Contracted	Sole Source	Audio Visual Services	$191,750.00	Yes	Contract Renewal List FY26
18006	1/24/2018	Paul Aguilar	Pitney Bowes Global Financial Services LLC	Contracted	Under $200k	Mairoom Equipment		Yes	Project ID 901017 Operations of the Future
628	3/9/2022	Suma Simcoe	OpenText, Inc	Contracted	Under $200k	Fax Software	$145,137.00	No	
1007	11/28/2023	Suma Simcoe	TTEC Government Solutions LLC	Preferred	Competition	Call Center SaaS	$361,432.71	Yes	Staff Report at the November 20, 2023 Commission Meeting, Project ID 901017 Operations of the Future
1092	6/5/2024	James Cruz	Arine, Inc	Preferred	Competition	Disease Management	$450,000.00	Yes	Staff Report at the June 19, 2024 Commission Meeting
1182	11/20/2024	Paul Aguilar	Bucketlist Rewards, Inc	Contracted	Under $200k	HR Rewards Program	$110,667.00	No	
1295	5/28/2025	Eve Gelb	Deloitte Consulting LLP	Preferred	Competition	D-SNP Implementation Services	$315,877.05	Yes	Project ID 901018 D-SNP Readiness
1333	8/12/2025	Suma Simcoe	Alinea Imaging Associates, Inc	Contracted	Under $200k	Mobil Imaging	$27,390.00	No	
1379	11/17/2025	Suma Simcoe	Momentum Telecom Inc	Contracted	Under $200k	Telecom Services	$126,000.00	No	
1389	12/16/2025	James Cruz	Marcella R. Young	Contracted	Under $200k	Consulting Service - Medical Management Nurse	$30,500.00	No	
16066	12/2/2016	Suma Simcoe	eFax Corporate c/o j2 Cloud Services LLC	Contracted	Under $200k	IT Fax Software	$8,330.00	No	
17014	1/23/2017	James Cruz	The Periscope Group	Contracted	Under $200k	In Home Medical Assesment Services	$80,546.00	No	
17139	8/18/2017	Suma Simcoe	Verizon Wireless	Sole Source	Under $200k	Cell Phone Utility	$126,415.00	No	
1381	12/5/2025	Christopher Lee	TopBloc	Sole Source	Sole Source	Workday Technical Support Servi	$415,800.00	Yes	Contract Renewal List FY26

Gold Coast Health Plan℠
A Public Entity

AGENDA ITEM NO. 21

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Christopher Lee, Chief Financial Officer
Bob Bushey, Exec. Director Procurement

DATE: November 16, 2026

SUBJECT: 2026 Contract Renewal List

SUMMARY:

Staff is presenting the 2026 Contract Renewal List to the Commission. The report summarizes the actual contract renewal amounts executed during 2026 and compares those amounts to the maximum contract renewal amounts previously authorized by the Commission. The report demonstrates that all contract renewals executed during 2026 were within the Commission-approved authorization levels, reflecting the results of procurement and contract administration activities for the year.

RECOMMENDATION:

Receive and file.

ATTACHMENT:

2026 Contract Renewal List

Gold Coast Health Plan℠
A Public Entity

2026 Contract Renewal List Actual Amounts

Ventura County Medi-Cal Managed Care
November 16, 2026

Christopher Lee, Chief Financial Officer
Bob Bushey, Executive Director Procurement

Integrity
Accountability
Collaboration
Trust
Respect

Actual Renewal Amounts January through August 30, 2026

Every contract renewal amount is below the Commission approved amount.

		Current Contract			Renewal Period				Relationship			Renewal Amounts			
Vendor	Brief Description	Start Date	End Date	Amount	Start Date	End Date	Amount	% Change	Original Contract Start Date	Years	Cumulative Amount	2026 Renewal Amount	Renewal Variance	2026 Cumulative Amount	Cumulative Variance
Edifecs	IT interoperability software	1/1/2025	12/31/2025	180,000	1/1/2026	12/31/2026	187,200	4%	1/1/2021	6	875,106	185,065	(2,135)	872,971	(2,135)
KP LLC	D-SNP Printing	3/1/2025	2/28/2026	420,000	3/1/2026	2/28/2027	436,800	4%	4/7/2025	2	679,467	Termed	-	330,000	(349,467)
Edifecs, Inc.	IT interoperability software	6/22/2025	6/21/2026	121,661	6/22/2026	6/21/2027	126,527	4%	6/22/2019	8	1,075,070	125310	(1,217)	1,004,951	(70,119)
Edifecs, Inc.	IT interoperability software	6/30/2025	6/29/2026	103,389	6/30/2026	6/29/2027	107,525	4%	6/30/2021	6	676,917	106490	(1,035)	654,187	(22,729)
Intelligent Content Solutions LLC dba ICS	Mailroom scanning software	7/1/2025	6/30/2026	360,000	7/1/2026	6/30/2027	374,400	4%	7/1/2025	2	734,400	360,000	(14,400)	720,000	(14,400)
Netmark Business Services	D-SNP claims processing services	7/1/2025	6/30/2026	180,000	7/1/2026	6/30/2027	187,200	4%	4/14/2025	2	372,422	183,000	(4,200)	321,625	(50,797)
The Mihalik Group, LLC	NCQA certification services	7/1/2025	6/30/2026	359,970	7/1/2026	6/30/2027	374,369	4%	7/1/2024	3	902,361	286000	(88,369)	706,000	(196,361)
UpToDate, Inc.	Pharmacy software	7/1/2025	6/30/2026	198,160	7/1/2026	6/30/2027	206,086	4%	8/1/2023	4	694,147	121908	(84,178)	525,505	(168,641)
Wellth Inc.	Disease management services	7/1/2025	6/30/2026	2,880,000	7/1/2026	6/30/2027	2,995,200	4%	7/13/2023	4	12,233,909	2218735	(776,465)	11,593,459	(640,450)
SMI Concepts, Inc.	Audio visual services	7/1/2025	6/30/2026	243,409	7/1/2026	6/30/2027	253,146	4%	9/1/2017	10	455,987	130000	(123,146)	279,213	(176,774)
Quest Analytics LLC	Provider address software	8/12/2025	8/11/2026	157,116	8/12/2026	8/11/2027	163,401	4%	8/12/2024	3	559,898	13189	(150,212)	492,955	(66,943)

Actual Renewal Amounts from September through December 2026

Continued

		Current Contract			Renewal Period				Relationship			Renewal Amounts			
Vendor	Brief Description	Start Date	End Date	Amount	Start Date	End Date	Amount	% Change	Original Contract Start Date	Years	Cumulative Amount	2026 Renewal Amount	Renewal Variance	2026 Cumulative Amount	Cumulative Variance
Simpledatalabs inc dba Prophecy Inc.	IT software	10/1/2025	9/30/2026	200,000	10/1/2026	9/30/2027	208,000	4%	10/1/2023	4	958,000	188,000	(20,000)	788,000	(170,000)
Baker Tilly Advisory Group LP	Financial Auditing Services	10/1/2025	9/30/2026	189,000	10/1/2026	9/30/2027	197,000	4%	10/1/2015	12	1,351,780	188,000	(9,000)	1,163,540	(188,240)
Edelstein Gilbert Robson & Smith LLC	Lobbyist services	10/9/2025	10/8/2026	60,600	10/9/2026	10/8/2027	63,024	4%	10/9/2012	15	346,921	Termed	-	316,400	(30,521)
Milliman	Actuarial services	1/1/2026	12/31/2026	525,000	11/1/2026	12/31/2027	549,120	5%	10/31/2025	2	1,074,120	Pending		525,000	(549,120)
Affiliated Monitors Inc. [AMI]	Corporate integrity agreement services	11/2/2025	11/1/2026	89,167	11/2/2026	11/1/2027	92,733	4%	11/1/2022	5	456,852	50,000	(42,733)	389,600	(67,252)
TopBlock LLC	Workday support services	12/12/2025	12/11/2026	228,000	12/12/2026	12/11/2027	237,120	4%	1/12/2026	2	453,087	207,000	(30,120)	452,700	(387)
Perfect Gift, LLC	Gift cards	12/13/2025	12/12/2026	1,234,850	12/13/2026	12/12/2027	1,284,244	4%	12/13/2021	6	7,054,136	Pending		4,596,784	(2,457,352)
Infomedia Group dba Carenet Healthcare Services	Outreach services	12/31/2025	12/30/2026	378,894	12/31/2026	12/30/2027	394,050	4%	1/1/2024	4	1,361,042	Termed	-	1,160,004	(201,038)
James Vincent Pezzullo II dba The JVP Group	Website services	12/31/2025	12/30/2026	98,864	12/31/2026	12/30/2027	102,818	4%	12/4/2014	13	496,501	Pending		401,665	(94,836)
Stacy Miller Public Affairs Inc.	Public relations services	1/1/2026	12/31/2026	408,301	1/1/2027	12/31/2027	424,633	4%	8/1/2024	3	1,307,077	Pending		984,000	(323,077)
Pacific Interpreters Language Line Services	Interpreting services	1/1/2026	12/31/2026	237,705	1/1/2027	12/31/2027	247,214	4%	8/1/2020	7	1,070,774	Pending		695,509	(375,265)
Inovalon, Inc.	D-SNP risk assessment services	1/1/2026	12/31/2026	171,000	1/1/2027	12/31/2027	177,840	4%	10/1/2025	2	359,486	Renewed under an individual Staff Report at the August 2026 Commission meeting.			
Inovalon, Inc.	Data lake used for quality risk assessment scores	1/1/2026	12/31/2026	1,370,479	1/1/2027	12/31/2027	1,425,298	4%	8/1/2022	5	6,663,647	Renewed under an individual Staff Report at the August 2026 Commission meeting. Agenda Item #6.			
Inovalon, Inc.	Quality and risk assessment reporting (indices)	1/1/2026	12/31/2026	313,242	1/1/2027	12/31/2027	325,771	4%	7/1/2019	9	2,205,455	Renewed under an individual Staff Report at the August 2026 Commission meeting. Agenda Item #6.			
Inovalon, Inc.	Quality and risk assessment software platform	1/1/2026	12/31/2026	891,433	1/1/2027	12/31/2027	927,090	4%	7/1/2019	9	4,724,254	Renewed under an individual Staff Report at the August 2026 Commission meeting. Agenda Item #6.			