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Provider Advisory Committee (PAC)

Telephonic Regular Meeting
Executive Order N-25-20
Tuesday, September 8, 2020, 7:30 a.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010
Conference Call Number: 1-805-325-7279
Conference ID: 446 966 600#

AGENDA

CALL TO ORDER

ROLL CALL

PUBLIC COMMENT

The public has the opportunity to address Provider Advisory Committee (PAC) on the agenda. Persons wishing to address the Committee should complete and submit a Speaker Card.

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

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

CONSENT

1. Approval of Provider Advisory Committee (PAC) Minutes of June 9, 2020

Staff: Maddie Gutierrez, MMC – Clerk to the Commission

RECOMMENDATION: Approve the minutes and review the minutes.

UPDATES

2. State Update

Staff: Margaret Tatar, Chief Executive Officer

3. Rx Transition Update

Staff: Nancy Wharfield, M.D., Chief Medical Officer
Anne Freese, PharmD, Directory of Pharmacy

RECOMMENDATION: Receive and file the update.

4. Solvency Action Plan (SAP) Update

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Receive and file the update.

PRESENTATIONS

5. Provider Resources Guide

Staff: Eileen Moscaritolo, HMA Consultant
Vicki Wrighster, Contracts Manager

RECOMMENDATION: Receive and file the update.

ROUNDTABLE/DISCUSSION

ADJOURNMENT

Unless otherwise determined by the PAC, the next meeting is scheduled for December 8, 2020 and will be held at Gold Coast Health Plan at 711 E. Daily Drive, Suite 106, Community Room, Camarillo, CA 93010.

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

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5562. Notification for accommodation must be made by the Monday prior to the meeting by 1:00 p.m. to enable GCHP to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO. 1

TO: Provider Advisory Committee

FROM: Maddie Gutierrez, MMC - Clerk to the Commission

DATE: September 8, 2020

SUBJECT: Meeting Minutes of June 9, 2020

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of Minutes for the June 9, 2020 regular PAC Meeting.

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)
Provider Advisory Committee
June 9, 2020

CALL TO ORDER

Committee Chair David Fein, called the virtual meeting to order at 7:33 a.m., in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

ROLL CALL

Present: Committee members Masood Babeian, David A. Fein, Will Garand. Katy Krul, Sim Mandelbaum and Pablo Velez.

Absent: Linda Baker and Joan Buck-Plassmeyer.

PUBLIC COMMENT

None.

CONSENT

1. Approval of Provider Advisory Committee (PAC) Minutes for November 12, 2019 and review of April 7, 2020 Informal Notes.

Staff: Maddie Gutierrez, CMC, Clerk to the Commission

RECOMMENDATION: Approve the minutes and review the notes.

Committee member Katy Krul motioned to approve the minutes and notes as presented. Committee member Pablo Velez seconded.

AYES: Committee members Masood Babeian, David A. Fein, Will Garand. Katy Krul, Sim Mandelbaum and Pablo Velez.

NOES: None.

ABSENT: Linda Baker and Joan Buck-Plassmeyer.

Committee Chair David Fein declared the motion carried.

UPDATES

2. New Commission Officers and Members.

Staff: Steve Peiser, Senior Director of Network Management.

RECOMMENDATION: Receive and file the update.

Steve Peiser, Senior Director of Network Management, informed the committee that GCHP had new Commissioners, Dr. Sevet Johnson, with Ventura County Health Care Agency. She is the director for the Ventura County Behavioral Health Department. Scott Underwood, M.D., who is the independent designate for the Commission. Dee Pupa was voted in as the new chair to the Commission and Jennifer Swenson got a second term as vice-chair for the Commission.

3. Provider Dispute Resolution (PDR) Update

Staff: Anna Sproule, Senior Director of Finance and Claims

RECOMMENDATION: Receive and file the update.

Anna Sproule, Senior Director of Finance and Claims reviewed regulatory requirements for PDR's. There is a new form as well as training materials on the GCHP website. Ms. Sproule's PowerPoint explained how providers can locate the necessary forms as well as how to fill them out correctly.

4. Health Interoperability

Staff: Helen Miller, Senior Director of IT
Eileen Moscaritolo, HMA Consultant

RECOMMENDATION: Receive and file the update.

Helen Miller, Senior Director of IT reviewed her PowerPoint. Ms. Miller stated there are two (2) new CMS rules which become effective January 2021. The two (2) new rules are the ONC's CURES Act Final Rule and the Interoperability & Patient Access Final Rule. Due to COVID-19 the effective date was deferred to July 2021. Ms. Miller explained how the rules work together to assist in patient and provider access. Mandated technical standards were reviewed. The U.S. Core Data chart was reviewed with the committee. Patient benefits and how the requirements will make an impact. The policies in the rules will help members make informed decisions about their health care. The provider benefits and payer benefits were also reviewed. The

data and analytics graph demonstrated that five (5) years of data is required to be provided. GCHP will have the framework to share data and maintain compliance.

Committee member, Katy Krul, asked if this was only for providers under CMS. Ms. Miller stated it applies to CMS regulated entities. GCHP would meet interoperability requirements. Eileen Moscaritolo HMS Consultant, stated this is a way to try to get Medicaid and Medicare plans up to speed. Committee member Pablo Velez asked if the data is kept for five (5) years and does it keep data for pediatric patients five (5) years after they turn 18 years of age. Ms. Miller responded if it is a regulated entity, and they have five (5) years of data, they are required to share the five (5) years of data.

Committee Chair, David Fein, stated this is a working timeline and he asked that information continue to be shared as it is developed.

Ms. Miller stated she will be presenting to the Commission at the end of June for approval.

5. Legislative Update: Governor's May Revisions to the Budget

Staff: Marlen Torres, Executive Director of Strategy & External Affairs

RECOMMENDATION: Receive and file the update.

Ms. Torres gave a high-level overview of the Governor's May Revise for the 2020/2021 proposed state budget with the committee. There is an estimated $54 billion deficit. Several programs were cut, such as CalAIM, as well as some reserves were proposed to be used; rainy day fund, the safety net reserve and Proposition 98, which is mostly school funding.

The Senate budget proposal expects federal money, if not, trigger cuts will take effect October 1, 2020. Senate and Assembly need to negotiate and present a legislative bill by June 15, 2020. The Medi-Cal proposal table was reviewed. The table showed the Governor's proposal and the Senate proposal.

More information will be provided at the next PAC meeting, once the final state budget has been adopted.

Committee member Katy Krul asked if there has been an increase in members. Ms. Torres stated we must see how rates will be calculated, but we do expect a membership increase. Committee member Pablo Velez stated in the budget proposal, there has been a lack of outpatient services and procedures, he asked if this has t been a savings to the state. Ms. Torres stated she is not aware of any savings.

Once we return to the new normal, we expect to see an increase in claims and there is a prediction that there will be a ramp up. Chief Financial Officer, Kashina Bishop, stated we have seen a savings on the plan side, but it is not much financial benefit due to cuts in rates. The State is increasing long-term care rates. Committee Chair, David Fein, asked if federal funding was going to happen. Ms. Torres stated there has not been a discussion to guarantee it, we are waiting to see what happens in the months to come.

Committee member Katy Krul stated the amount of money GCHP spends affects rates in the future. She askedhow rates will be affected in the future. CFO Bishops stated she did not know. 2020 rates set rates for 2023, we must wait and see.

Committee Chair David Fein asked about the 1.5% reduction. CFO Bishop stated the reduction is significant to GCHP. The reduction is retro to July of 2019. GCHP was looking to January 2021 revenue increase, but we don't know, we may break even at the end of 2021.

6. Solvency Update

Staff: Steve Peiser, Senior Director of Network Management

RECOMMENDATION: Receive and file the update.

Steve Peiser, Senior Director of Network Management, stated COVID-19 has had a significant impact to GCHP. The TNE reflects the Plan's solvency. GCHP has the lowest TNE in the state. Mr. Peiser reviewed the PowerPoint charts. He stated that we hope to keep TNE above 200%. We have had a loss of revenue in the amount of $16 million. Although there have been rate cuts, GCHP has not passed those rate cuts to providers.

CFO Bishop stated GCHP is not a for-profit organization, we have absorbed the difference. Unfortunately, we are at a place where we cannot continue to absorb the difference. We need to save on medical expenses.

Mr. Peiser stated our TNE is at 212% of the required amount by the state. In order to remain solvent, GCHP needs to pass on the rate cuts. Nobody is immune. An update on the Solvency Action Plan will be presented on a monthly basis to the Commission and committees. GCHP is committed to providing quality care to members.

Mr. Peiser reviewed the phases of the Solvency Action Plan. The first wave/phase will take place immediately after the Commission meeting, the second phase will take place in a couple of months and the third phase will be done later in the year. CFO

Bishops stated we are focused on areas where we are paying outlier rates to providers. The first step is to look at capitation and outlier rates. We have been told the State does not plan to increase our rates.

CFO Bishop stated we applied for a FEMA grant, but we did not get it. Committee member Katy Krul asked if there was any way of financial help for providers for PPE. CFO Bishop responded no.

Committee Chair David Fein stated that from a provider perspective, it would be helpful to have transparency from GCHP. Mr. Peiser stated that after the June Commission meeting, he will be able to share more information with PAC. Mr. Peiser stated he agreed with Mr. Fein; there will be a lot of direct work with providers in order to be transparent. CFO Bishop stated that if there are opportunities to save without impacting providers, please let GCHP know. We want the least amount of impact to providers as possible.

Committee member Velez stated the goal is to have 400-500 percentTNE, he asked by when that goal will be achieved. CFO Bishop stated that in short term, we are looking at staying above 150-200%. In order to achieve a 400%to 500% it could be 2023 or beyond.

Committee member Krul asked if telehealth is working for GCHP. CFO Bishop stated we are seeing a significant increase in telehealth utilization but there is no projection for long-term savings.

7. Provider Advisory Committee (PAC) Monitoring and Reporting

Staff: Steve Peiser, Senior Director of Network Management

RECOMMENDATION: Receive and file the update.

Steve Peiser, Senior Director of Network Management, stated we need to create a formalized reporting structure to the Commission. A monitoring and reporting process need to be developed.

Mr. Peiser asked if a sub-committee should be created, led by the Committee Chair, to meet and develop the process. Mr. Peiser asked if there were volunteers for this sub-committee. Committee members who volunteered are Pablo Velez, Katy Krul, Sim Mandelbaum and Committee Chair, David Fein. Mr. Peiser stated he will set up a meeting date and time.

Committee member Katy Krul motioned to approve agenda items 2 through 7 as presented. Committee member Pablo Velez seconded.

AYES: Committee members Masood Babeian, David A. Fein, Will Garand. Katy Krul, Sim Mandelbaum and Pablo Velez.

NOES: None.

ABSENT: Linda Baker and Joan Buck-Plassmeyer.

Committee Chair David Fein declared the motion carried.

ROUNDTABLE/DISCUSSION

Marlen Torres, Executive Director of Strategy & External Affairs stated that the Plan developed a Telehealth Tip Sheet located at in the back of the PAC packet. She reviewed the TIP sheet and asked that committee members make copies and share with their members.

Committee member Velez stated information such as the TIP sheet is well received by families. Mr. Peiser stated telehealth will be a staple going forward. From GCHP's perspective, we support telehealth, it has proved to be effective and efficient.

Committee Chair, David Fein, asked how GCHP is operating, he asked if it was closed to the public. Mr. Peiser stated all are working remotely. A timeframe has not been determined when employees will return to the buildings. Surveys are being done and there are internal discussions but there is not a solid date to return to work. CFO Bishop noted services to members continue to be provided

ADJOURNMENT

With no further items to be addressed, Committee member Pablo Velez motioned to adjourn the meeting. Committee member Katy Krul seconded. The meeting was adjourned at 9:01 A.M.

Approved:

_____
Maddie Gutierrez, MMC
Clerk to the Commission

AGENDA ITEM NO. 2

TO: Provider Advisory Committee

FROM: Margaret Tatar, Chief Executive Officer

DATE: September 8, 2020

SUBJECT: State Update

SUMMARY:

State Budget Update, LTC at Home Proposed Benefit, 1115 Waiver Renewal

RECOMMENDATION:

Staff recommends that the Provider Advisory Committee accept and file the presentation

ATTACHMENTS:

State Update, September 8, 2020 PPT Presentation

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State Update

September 8, 2020

Margaret Tatar
Chief Executive Officer

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Trust
Respect

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Agenda

- State Budget Update FY 2020-21
- Long Term Care at Home Proposed Benefit
- 1115 Waiver Renewal (Medi-Cal 2020)

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State Budget Update FY 2020-21

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Medi-Cal Program

- Estimated caseload: 14.5 Million by July 2020
- Maintains the following Benefits:
  - Optional Expansion Benefits
    - ✓ Screening, Brief Intervention and Referral to Treatment (SBIRT)
    - ✓ Podiatry
    - ✓ Optometry
    - ✓ Physical Therapy
  - Diabetes Prevention Program
- Community Based Adult Services (CBAS)
- Multipurpose Senior Services Program (MSSP)
- Proposition 56
  - Supplemental payments for physicians
  - VBP Program
  - Behavioral Health Integration Incentive Program
  - Pediatric Hospital Payments
  - Loan Repayment Program

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Medi-Cal Program (*Continued*)

- Delays CalAIM Implementation
- Delays full-scope Medi-Cal expansion to undocumented seniors in the upcoming budget if the Department of Finance determines there are sufficient General Fund revenues for that fiscal year and the ensuing three fiscal years to support the expansion.
- Authorizes DHCS to reduce capitation rate increments for Medi-Cal managed care plans by up to 1.5 percent for the July 1, 2019, to December 31, 2020, rating period to account for reduced utilization related to the COVID-19 public health emergency.
- Authorizes DHCS, in consultation with affected Medi-Cal managed care plans, to develop and implement a risk corridor to limit the financial risk of either overpayments or underpayments of capitation rates during the July 1, 2019, to December 31, 2020, rating period.

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Long Term Care at Home
Proposed Benefit

(**DHCS is no longer pursuing implementing this benefit**)

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LTC at Home Benefit

Benefit Highlights:

- Provide qualifying Medi-Cal beneficiaries and their families with more choices in living situations and long-term care settings
- The benefit will be provided through State-licensed agencies that will arrange for and/or directly provide skilled nursing care and related services in the home
- Allow qualifying Medi-Cal beneficiaries currently residing in SNFs to safely move from a facility to a home
- Allow qualifying Medi-Cal beneficiaries that may require SNF services in the future to avoid institutionalization
- Allow qualifying Medi-Cal beneficiaries to be discharged from a hospital to a home placement in lieu of a SNF stay
- Support efforts to decompress residency at SNFs
- Statewide Medi-Cal benefit for Fee-For-Service and Managed Care delivery systems

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LTC at Home Benefit

- **Model of Care**
  - Individual, Person-Centered Assessment
  - Transition Services
  - Care Coordination
  - Medical and Home and Community Based Services

- **Financing and Cost**
  - Bundled per diem rate encompassing Long-Term Care at Home services
  - Some services may be billed and reimbursed outside of the per diem
  - Per diem rates may be tiered acuity rates
  - Clinically appropriate utilization controls will be established as benefit is intended to be cost effective option in lieu of institutional placement

- **Benefit Implementation Timeline**
  - June- August 2020 – Stakeholder engagement
  - Fall 2020 – Post 1915(i) State Plan Amendment for public comment and submit formal proposal to CMS
  - Winter 2020/Early 2021 – Stakeholder feedback on implementation
  - Early 2021 – New Long Term Care at Home Benefit goes live 2021 – Increase statewide LTC at Home agency provider network

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1115 Waiver Renewal (Medi-Cal 2020)

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1115 Waiver Renewal

- Prior to the COVID-19 public health emergency, DHCS planned to implement CalAIM in conjunction with the end of the waiver period

- COVID-19 has greatly impacted all aspects of California's health care delivery system, due to focus on surge planning, infection control, transition to telehealth/telework, and reprioritization of resources.

- While the state is still committed to CalAIM, a one-year extension of the Medi-Cal 2020 waiver is crucial to maintaining the current delivery system and services for beneficiaries.

- The final FY 2020-21 state budget reflected a delay in funding for CalAIM.

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1115 Waiver Renewal

Program Name	Description (Extension Request)	Financing
Medi-Cal Managed Care	The Medi-Cal managed care delivery system provides high-quality, accessible, integrated, and cost-effective care for beneficiaries, and is the core delivery system for most services. As of March 2020, approximately 80% of the state's Medi-Cal beneficiaries across 58 counties received their health care through managed care.	Budget Neutral
Whole Person Care	There are 25 WPC pilots in operation across the state. A 2019 study by UCLA evaluating care coordination by the WPC pilots found that they have made significant progress in establishing essential care coordination processes and delivering cross-sector care coordination services.	Requesting an additional year ($300 million) of federal funding equal to 2020 program (PY4) expenditures
Global Payment Program	The GPP established a statewide pool of funding for California's remaining uninsured by allocating over $2 billion of combined federal Disproportionate Share Hospital (DSH) allotment and uncompensated care funding to Public Health Care Systems (PHCS). These funds support PHCS efforts to provide health care for California's uninsured population and promotes the delivery of more cost-effective and higher-value care to the uninsured. This amendment is necessary to continue GPP payments, using the federal DSH allotment funds for the relevant time period.	Continued FFP for value-based payments to participating Public Health Care Systems that incur costs for services to the remaining uninsured

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1115 Waiver Renewal

Program Name	Description (Extension Request)	Financing
Drug Medi-Cal Organized Delivery System	Authority for the state to continue to authorize participant counties to provide the expanded continuum of DMC-ODS benefits, including residential SUD treatment services in settings that are considered IMDs. DMC-ODS is now available in 37 counties, Ventura County is one of them.	Budget Neutral
Low-Income Pregnant Women	The state requests authority to continue to provide coverage to pregnant women with incomes from 109 percent up to and including 138 percent of the FPL.	Budget Neutral
Out of State Former Foster Youth	The Medi-Cal 2020 waiver authorizes Medi-Cal coverage for former foster care youth under age 26, who were in foster care under the responsibility of another state or a tribe when they aged out.	Budget Neutral
Community-Based Adult Services	CBAS offers services to eligible older adults and adults with disabilities in an outpatient facility-based setting in order to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization.	Budget Neutral
Coordinated Care Initiative	The state seeks to continue CCI until December 31, 2022 (previously approved by CMS) at which point the state intends to fully transition all dual-eligible beneficiaries into Medi-Cal managed care statewide.	Budget Neutral

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1115 Waiver Renewal

Program Name	Description (Extension Request)	Financing
Dental Transformation Initiative & Designated State Health Programs (DSHP)	This initiative is designed to improve dental health for children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform.	Budget Neutral
Tribal Uncompensated Care	The proposed extension would permit DHCS to make uncompensated care payments for certain optional services previously eliminated from the state plan that are provided by Indian Health Service (IHS) tribal health programs operating under the authority of Indian Self-Determination and Education Assistance Act (ISDEAA) to IHS-eligible Medi-Cal beneficiaries.	Budget Neutral
Rady's CCS Pilot	The 12-month extension would permit the state to continue to test this effective health care delivery model for children with complex medical needs.	Budget Neutral
Program of All-Inclusive Care for the Elderly (PACE)	PACE is a fully integrated Medicare and Medicaid delivery model that coordinates and provides all needed preventive, primary, acute and long-term care services for eligible participants to continue living in the community. Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county.	Budget Neutral

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1115 Waiver Renewal Timeline

Timeline

- The 30-day public comment period started on July 22, 2020
- Waiver extension request & all other documentation will be posted on the DHCS website
- Written comments must be submitted by on August 21, 2020
- **Public Hearings**
  - Friday, August 7, 2020 3:30 p.m. – 5:00 p.m.
  - Monday, August 10, 2020 2:00 p.m. – 3:30 p.m.

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Questions?

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AGENDA ITEM NO. 3

TO: Provider Advisory Committee

FROM: Nancy Wharfield, M.D., Chief Medical Officer
Anne Freese, PharmD, Director of Pharmacy

DATE: September 8, 2020

SUBJECT: Medi-Cal Rx

SUMMARY:

Presentation describing the upcoming changes to pharmacy benefits for GCHP members and the implementation of Medi-Cal Rx, the carve out of pharmacy benefits from managed care plans effective January 1, 2021.

RECOMMENDATION:

Staff recommends that the Provider Advisory Committee accept and file the presentation.

ATTACHMENT:

1) Freese, A., (2020). Director of Pharmacy, Medi-Cal Rx, Presentation Slides.

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Accountability

Collaboration

Trust

Respect

Medi-Cal Rx

Annie Freese, Pharm.D.
Director of Pharmacy

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Agenda

- What is Medi-Cal Rx?
- Claim Responsibilities
- Post Transition Responsibilities
- PA and Appeals
- Transition Benefit
- Provider Communication and Training
- Member Communication
- Medi-Cal Rx Website

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Medi-Cal Rx

- What is Medi-Cal Rx?
  - On January 1, 2021, all retail pharmacy claims will be billed to the state and not to GCHP.
- What do we know so far?
  - Member Communication
  - Transition Benefit
  - Provider Education
- What challenges to we expect?
  - Real time claim access
  - Data sharing
  - Coordination of care
- How will GCHP communicate with the state/assist beneficiaries with prescription issues after the transition?
  - PBM Liaison

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Claim Responsibilities

Delivery System	Claim Type	Pre-Transition	Post Transition
GCHP	Medical/Institutional claim	GCHP	GCHP
	Pharmacy Claims	GCHP (via PBM)	Medi-Cal Rx
FFS	Medical/Institutional claim	FFS Fiscal Intermediary (FI)	FFS FI
	Pharmacy Claims	FFS FI	Medi-Cal Rx

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Post Transition Responsibilities

Responsibility	State	GCHP	Medi-Cal Rx
Maintain Medi-Cal Pharmacy Policy	X		
Make Final Determinations on PAs Denials and SFH	X		
Negotiation of Rebates	X		
Pharmacy Reimbursement Methodology	X		
Pharmacy Network	X		
Care Coordination		X	
Oversee pharmacy adherence and disease/medication management programs		X	
Pharmacy Services billed on medical/institutional claims		X	
Participate in the DUR Board		X	
Pharmacy claim administration, processing and payment			X
Coordination of Benefits with OHI			X
Utilization Management (including all PAs with 24 hours)			X
Prospective and Retrospective DUR			X
Drug Rebate Administration			X

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How Will This Affect PAs and Appeals?

Prior Authorizations

- Submitted by providers via the Magellan Provider Portal.
- Initial review by Magellan pharmacist.
- If denied, secondary review by DHCS pharmacist prior to decision being issued.
- Final decision to be issued within 24 hours or 1 business day of submission.
- Decision may be deferred.

Appeals

- There is NO provider appeal process.
- If an authorization request is denied, the member may request a State Fair Hearing (SFH)
- A provider may request a SFH upon written authorization from the member.
- The SFH process may take up to 135 days to be resolved, with an average resolution turn around time of 52 days.

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What about a Transition Benefit?

DHCS Transition Policy Principals:

- 180 day transition period
- Claim and PA history provided to Medi-Cal Rx PBM
- For existing prescriptions that did not require a PA under the MCP (GCHP), but will under Medi-Cal RX, grandfathering will be offered:
  - Match based upon prescription number, **not** the drug and limited to 1 year from the date the prescription was written
- For existing prescriptions that did require a PA under the MCP (GCHP), and will also need a PA under Medi-Cal RX, grandfathering will be offered:
  - Match based upon PA authorization dates and date prescription was written, **not** the drug and limited to 1 year form the date the prescription was written
- For new prescriptions regardless of need for a prior authorization, grandfathering will not apply.

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Communication Schedule: Providers

Date	Audience	Topic
August 2020	Providers (pharmacies and prescribers)	Training announcements and instructions
September 2020	Providers (pharmacies and prescribers)	120-day pharmacy transition
October 2020	Pharmacies	90-day notice letter
November 2020	Pharmacies	60-day notice letter
December 2020	Pharmacies	30-day notice letter

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Medi-Cal Rx: Training Schedule

Date	Audience	Topic
August 2020	Providers (pharmacies and prescribers)	Registration instructions for the secured portal and associated applications
September 2020	Providers (pharmacies and prescribers)	General training begins
October 2020	Providers (pharmacies and prescribers)	General training continues
November 2020	Pharmacies	Web claims submission trainings
November 2020	Providers (pharmacies and prescribers)	General training continues

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Other GCHP Provider Outreach

Item	Targeted Date	Description
Provider Operations Bulletins (POB)	Mid-October	An article in the POB will be placed regarding Medi-Cal Rx
Provider Emails Blasts	Ongoing	Email blasts containing important information and notification of website updates
Resource Guide	Mid-September	Guide with description of all major changes occurring January 1.
JOM	TBD	Presentations at upcoming JOM to discuss impact of Medi-Cal Rx
GCHP Website Banner and Landing Page	Now live	Website containing important links and information regarding Medi-Cal Rx

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Communication Schedule: Members

Date	Topic	Responsibility
October 2020	90-Day Notice Letter	DHCS
November 2020	60-Day Notice Letter	DHCS
November-December 2020	Outbound Call Campaign	GCHP
December 2020	30-Day Notice Letter	GCHP
January 2021	New ID Cards	GCHP

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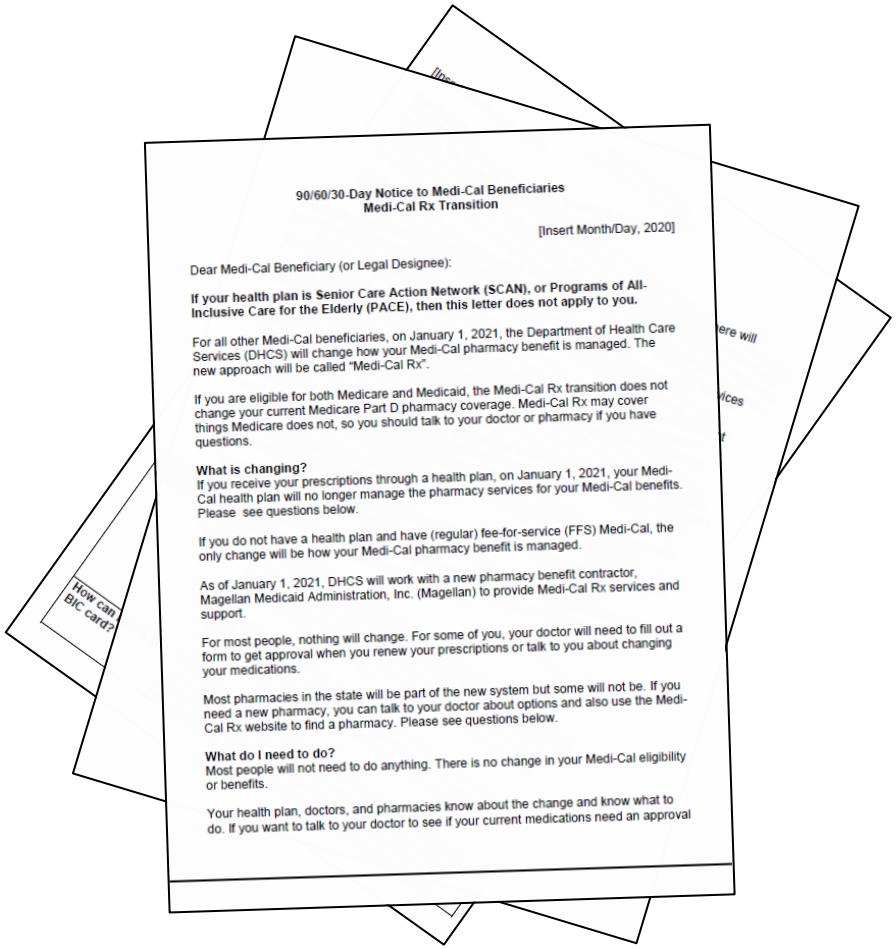
Member Communications

- Draft communication pieces have been developed by DHCS and GCHP has reviewed/provided feedback to the state regarding these items.
- GCHP has reviewed these with the Consumer Advisory Committee (CAC)



90/60/30-Day Notice to Medi-Cal Beneficiaries
Medi-Cal Rx Transition

[Insert Month/Day, 2020]

Dear Medi-Cal Beneficiary (or Legal Designee):

If your health plan is Senior Care Action Network (SCAN), or Programs of All-Inclusive Care for the Elderly (PACE), then this letter does not apply to you.

For all other Medi-Cal beneficiaries, on January 1, 2021, the Department of Health Care Services (DHCS) will change how your Medi-Cal pharmacy benefit is managed. The new approach will be called "Medi-Cal Rx".

If you are eligible for both Medicare and Medicaid, the Medi-Cal Rx transition does not change your current Medicare Part D pharmacy coverage. Medi-Cal Rx may cover things Medicare does not, so you should talk to your doctor or pharmacy if you have questions.

What is changing?
If you receive your prescriptions through a health plan, on January 1, 2021, your Medi-Cal health plan will no longer manage the pharmacy services for your Medi-Cal benefits. Please see questions below.

If you do not have a health plan and have (regular) fee-for-service (FFS) Medi-Cal, the only change will be how your Medi-Cal pharmacy benefit is managed.

As of January 1, 2021, DHCS will work with a new pharmacy benefit contractor, Magellan Medicaid Administration, Inc. (Magellan) to provide Medi-Cal Rx services and support.

For most people, nothing will change. For some of you, your doctor will need to fill out a form to get approval when you renew your prescriptions or talk to you about changing your medications.

Most pharmacies in the state will be part of the new system but some will not be. If you need a new pharmacy, you can talk to your doctor about options and also use the Medi-Cal Rx website to find a pharmacy. Please see questions below.

What do I need to do?
Most people will not need to do anything. There is no change in your Medi-Cal eligibility or benefits.

Your health plan, doctors, and pharmacies know about the change and know what to do. If you want to talk to your doctor to see if your current medications need an approval

Return to Agenda

Medi-Cal Rx Web Portal: NOW LIVE!

https://medi-calrx.dhcs.ca.gov/home/

Information Available:

- Program Overview and FAQs
- Training and Communication Schedules
- Details regarding Transition Policy
- Email subscription service alert sign up – SIGN UP NOW!

Return to Agenda

Medi-Cal Rx: Questions

- For questions and/or comments regarding Medi-Cal Rx, DHCS invites stakeholders to submit those via email to rxcarveout@dhcs.ca.gov

- For questions and/or comments for GCHP regarding pharmacy benefits, please reach out to Annie Freese at afreese@goldchp.org

Return to Agenda

AGENDA ITEM NO. 4

TO: Provider Advisory Committee

FROM: Kashina Bishop, Chief Financial Officer

DATE: September 8, 2020

SUBJECT: Solvency Action Plan (SAP) Update

SUMMARY:

RECOMMENDATION:

Staff recommends that the Provider Advisory Committee accept and file the presentation

ATTACHMENTS:

Solvency Update Progress Report, September 8, 2020 PPT Presentation

Gold Coast Health Plan℠
A Public Entity

Solvency Action Plan

Progress Report:
Provider Advisory Committee
September 8, 2020

Integrity

Accountability

Collaboration

Trust

Respect

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

Agenda

1. Background:
   a. Required Tangible Net Equity (TNE)
   b. Comparison to California Public Plans
   c. State Budget and financial implications

2. Solvency Action Plan – Initiative Update

3. Identify risks and challenges for the upcoming quarter relating to ongoing progress for Solvency Action Plan

4. Questions and comments

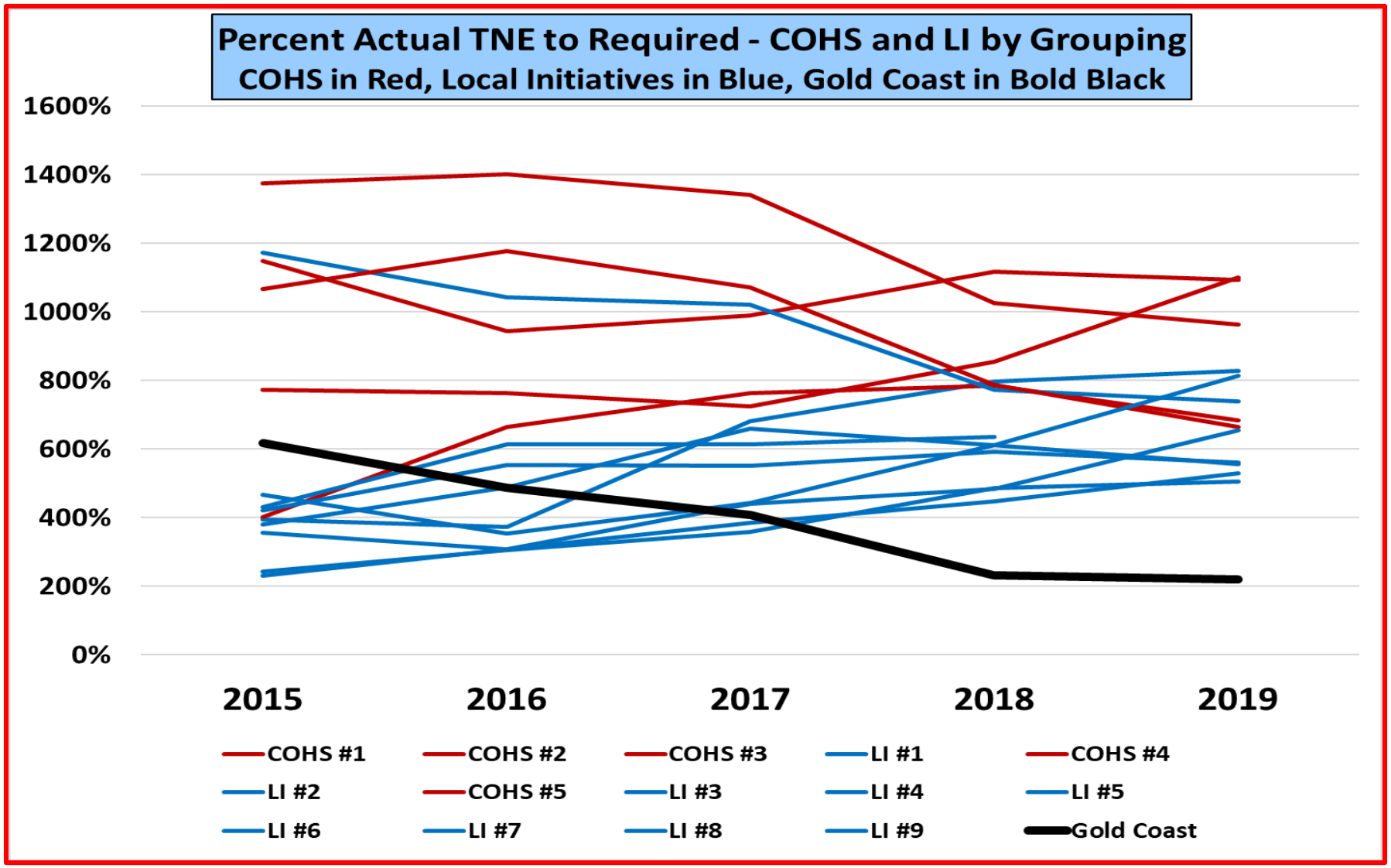
Return to Agenda

Background: Tangible Net Equity Requirements

1. TNE is a health plan's total assets minus total liabilities reduced by the value of intangible assets and unsecured obligations of officers, directors, owners, or affiliates outside of normal course of business.
2. Required TNE for a plan is the greater of 1 million dollars or a % of premium revenues or a % of healthcare expenses.
3. Excess TNE is the difference between total TNE and required TNE.

Return to Agenda

Background: GCHP Outlier Status Among Public Plans



Return to Agenda

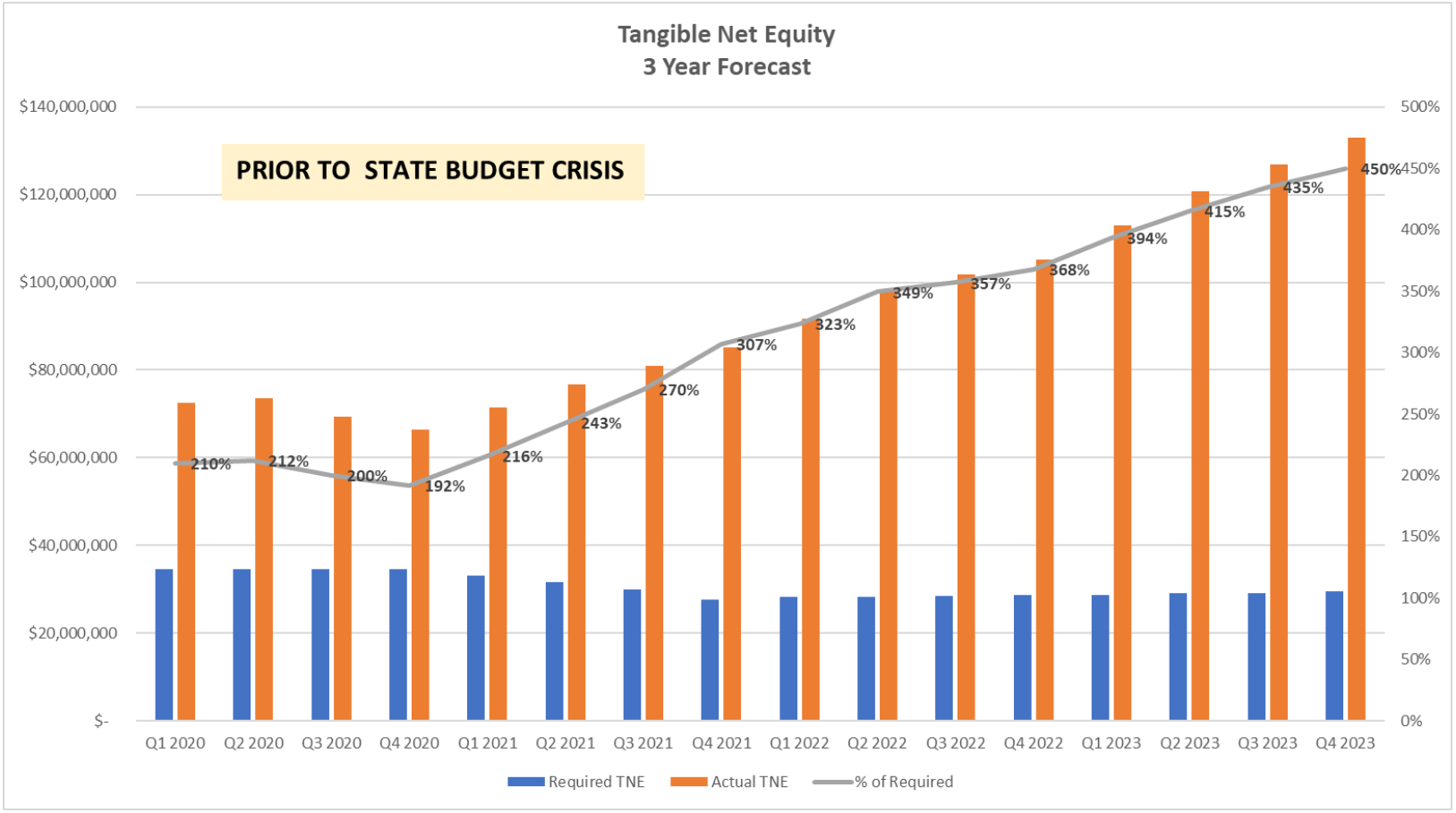
Background: State budget update

As a response to the public health emergency and the negative economic consequences to California, budget proposals include managed care rate reductions and program efficiencies.

1. 1.5% rate reduction retroactive to July 1, 2019
2. Increase of 10% to Long Term Care facility rate effective March 1, 2020 through the emergency (unfunded to plan)
3. Efficiency and acuity adjustments to upcoming rate year beginning January 1, 2021

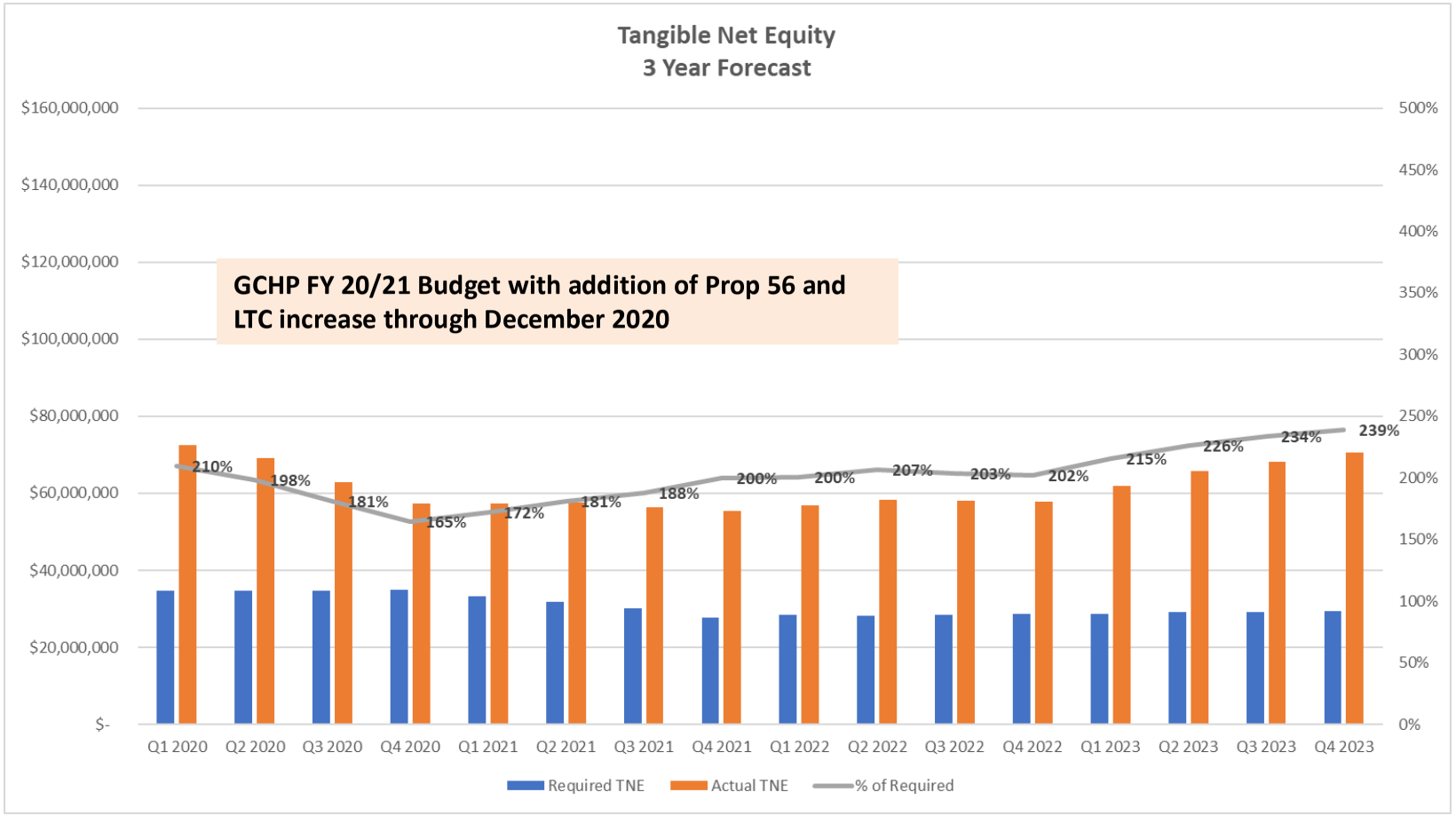
Return to Agenda

Background: State budget update – impact to TNE forecasts



Return to Agenda

Background: State budget update – impact to TNE forecasts



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Update:
Solvency Action Plan – Phased Approach

Phases	Action(s)	ETA
Phase 1	Secure Commission approval of key elements Institute GCHP administrative reductions Make necessary rate adjustments to Adult Expansion and LTC rates	June 2020
Phase 2	Focus on value-based purchasing throughout network Implement HMS recoveries Analyze additional rate adjustments based on final State budget	August 2020 and ongoing
Phase 3	Advance capitated network development for certain services	February 2021
Phase 4	Advance centers of excellence and HIE with ER notification Shift to APR-DRG for contracted hospitals	April 2021

Return to Agenda

Update:
Solvency Actions - June to August 2020

Actions	Annualized impact in savings
Rate reductions to LTC rates	$3.5 M
Reduction to PCP Adult Expansion rates	$4.5 M
Expansion of provider capitation agreement	Reduces required TNE
Administrative expense reductions	$1.5 M

Return to Agenda

Update:
Solvency Actions – Current Focus

Actions	Annualized impact in savings
Outlier contract rates	TBD
Improved contract language	TBD
Expansion of provider capitation agreement	Reduces risk/required TNE

Return to Agenda

Solvency Action Plan – risks and challenges

1. Receipt of January 2021 capitation rates from the State and calculation of true financial impact
2. Provider acceptance of rate decreases and potential impact to network
3. Unknown impacts to medical expenses with the pandemic

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Questions or comments?

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AGENDA ITEM NO. 5

TO: Provider Advisory Committee

FROM: Eileen Moscaritolo, HMA Consultant
Vicki Wrighster, Contracts Manager

DATE: September 8, 2020

SUBJECT: Provider Resource Guide

SUMMARY:

This multi-part guide will inform providers about the changes prompted by GCHP's Enterprise Transformation initiatives.

RECOMMENDATION:

Staff recommends that the Provider Advisory Committee accept and file the presentation

ATTACHMENTS:

GCHP Enterprise Transformation Initiatives – Provider Resource Guide 2020 Word Doc.

Gold Coast Health Plan

Enterprise Transformation Initiatives

Provider Resource Guide

2020

This multi-part guide will inform providers about the changes prompted by Gold Coast Health Plan's Enterprise Transformation initiatives.

Introduction

Gold Coast Health Plan (GCHP) is transitioning two health care information systems enabling health plan operations:

- Claims administration system;
- Provider credentialing and contracting management system.

These transitions will be effective November 7, 2020.

We developed this guide to inform you of changes that will be visible to you as a provider who is contracted with GCHP and to help you navigate these changes. In each section, we have recommended action steps that you will want to consider when preparing for these changes. We will notify you of any additional updates and will provide new content for this Resource Guide as appropriate.

We understand that there are many changes and hope this Resource Guide enables you to take necessary action to embrace them. We appreciate the value you provide and your commitment as we work together. If you have questions about any of the information provided in this guide, please contact us at ProviderRelations@goldchp.org.

Thank you!
Gold Coast Health Plan
Provider Relations Team

Table of Contents

Changes to GCHP Contact Information

Effective November 7, 2020

Updated Web URLs:

GCHP Website	www.goldcoasthealthplan.org
Provider Portal	<URL>
Forms	<URL>

Updated Claims Mailing Addresses:

Medical Claims	ATTN: Claims Gold Coast HealthPlan P.O. Box 9152 Oxnard, CA 93031	
Pharmacy Claims	**Optum Rx (through 2020)** BIN 610011 PCN GCHP Group GCHP	**Medi-Cal Rx (effective 2021):** BIN 022659 PCN 6334225 Group n/a

Updated Email Addresses:

Provider Relations	ProviderRelations@goldchp.org
Provider Contracting	ProviderContracting@goldchp.org
Provider demographic updates	C@goldchp.org
Encounter data operations team	EncounterData@goldchp.org
Electronic Funds Transfer (EFT) or ERA enrollment questions	Y@goldchp.org
Appeals and Grievances	Z@goldchp.org

Updated Phone Numbers:

Dedicated Provider Line	**(888) 301-1228**
Advice Nurse Line	**(888) 437-5001** or toll-free number **(877) 431-1700**. Those who use a TTY should call 711.

Changes to GCHP Provider Identification Numbers

Effective November 7, 2020

We have issued new Provider Identification Numbers to providers for whom multiple IDs had been previously issued. Effective November 7, 2020, all providers will have one valid provider ID. Provider IDs are used to access the GCHP Provider Portal. To determine whether we've issued you a new Provider ID, visit <URL>. In accordance with the information below, if you have been issued a new Provider Identification number, you should begin using it on or after November 7, 2020.

Provider ID Distribution:

New ID?	Action required:
Yes, a new ID has been issued.	Use the new Provider ID to access the new GCHP Provider Portal.
No, the ID stays the same.	Use the existing Provider ID to access the new GCHP Provider Portal.

Changes to GCHP Member Identification Numbers and Cards

Effective January 1, 2021

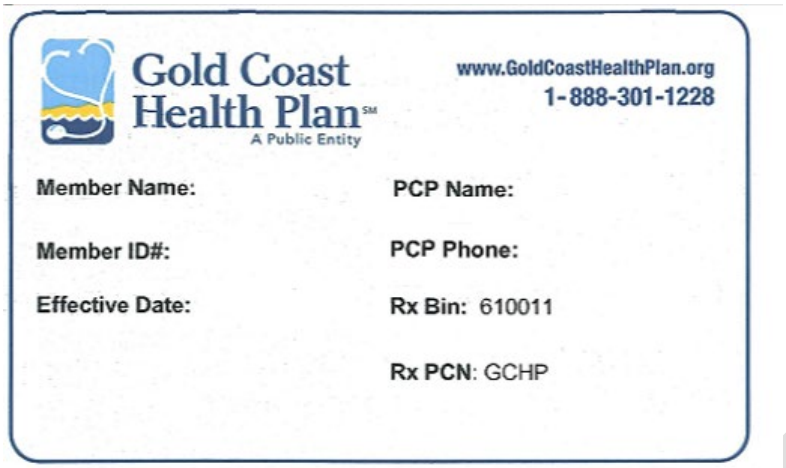
GCHP Member Identification Numbers will not be changing. However, the GCHP Member Identification Cards will be changing.

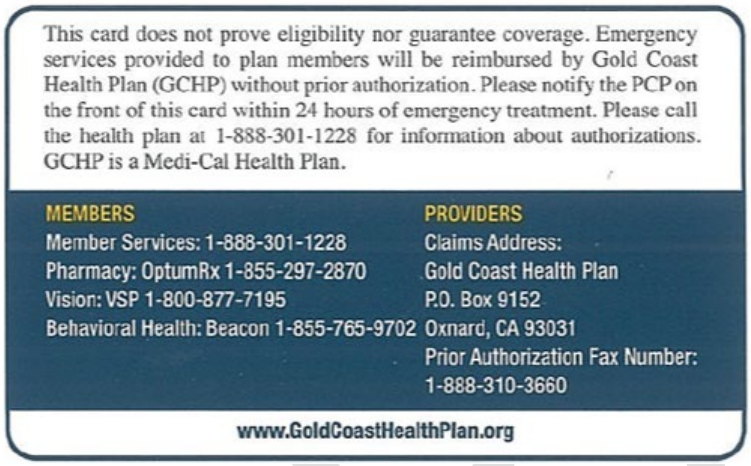
Effective <date>, new members and members requesting a new member ID card will receive the newly formatted member ID card. In early 2021, all GCHP members will be sent newly formatted member ID cards.

- **Changes to Member ID Cards:**
  - Removal of PBM/Pharmacy information
    - Prompted by DHCS' Medi-Cal Rx initiative, OptumRx's information has been removed from the member ID card since GCHP will no longer be responsible for pharmacy benefits as of January 1, 2021. See <URL> for more information regarding DHCS' Medi-Cal Rx initiative.
  - Updated phone numbers
    - The phone number to the 24/7 Advice Nurse Line has been added to the card.
    - TTY numbers for Member Services and GCHP's partners, such as Beacon Health Options and VSP, have been added to the card.
- **Changes to cover letter accompanying Member ID cards:**
  - The cover letter accompanying the Member ID Cards will change slightly when all members are provided newly formatted member ID cards.

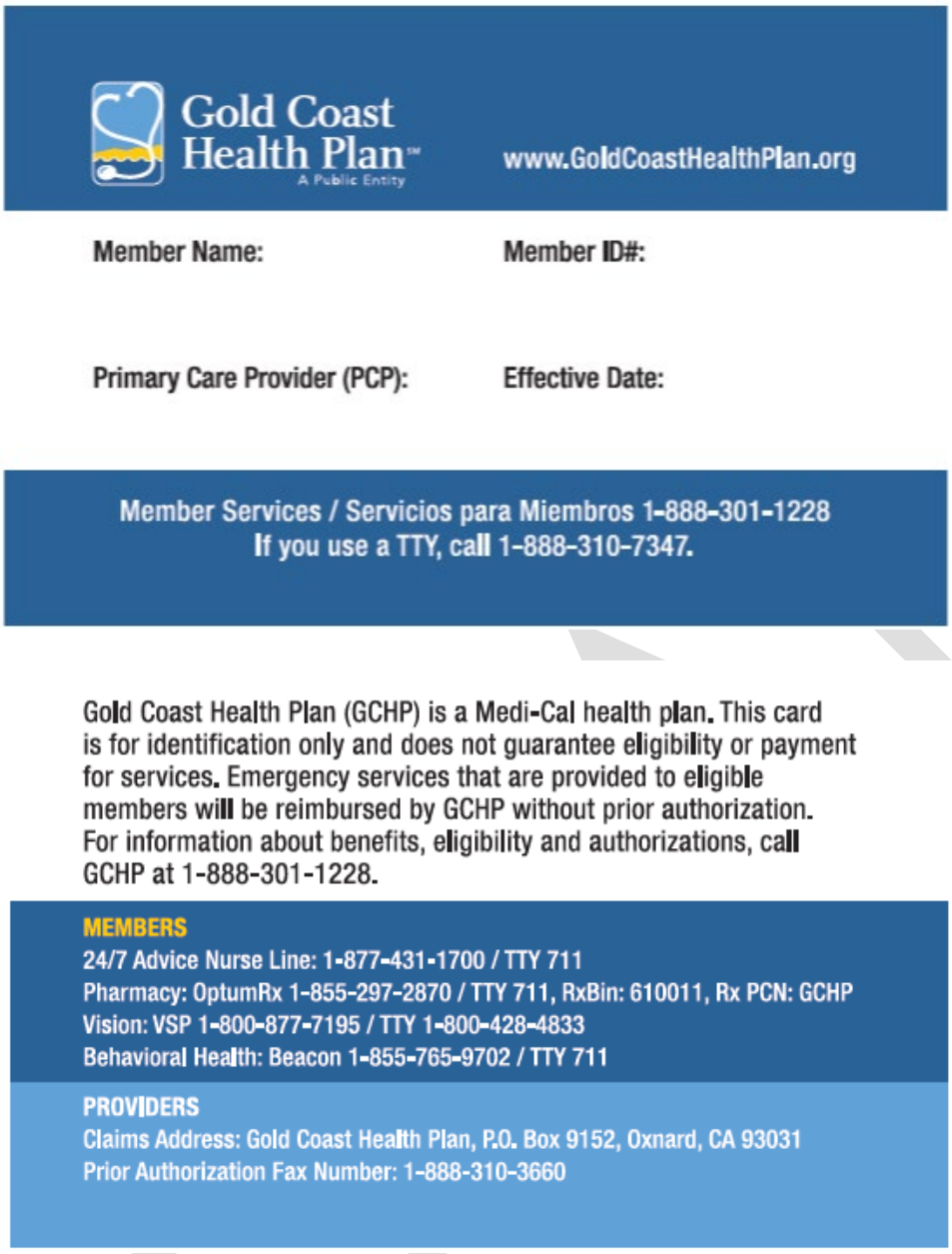
Please note that the design of the final ID cards may vary slightly from the mockups below.

Current GCHP Member ID Card – Front and Back





New GCHP Member ID Card – Front and Back



Required Actions:

Action	How	When
Inform all staff about the new Member ID Card.	Use the information cited above to train staff.	As soon as possible.

Changes to Provider Contracting

Effective November 7, 2020

There are some changes to the contracting of providers administered by GCHP.

- **What changed:**
  - DHCS/Medi-Cal converted Local Codes may no longer be billed.
    - Provider contracts containing the affected Local Codes have been updated to contain the acceptable codes.
    - Valid DHCS/Medi-Cal Local Codes can be accessed at:

    https://files.medi-cal.ca.gov/pubsdoco/hipaacorrelations_home.aspx
  - Pharmacies no longer need to contract with GCHP's Pharmacy Benefit Manager, OptumRx.
    - Any pharmacy wishing to fill prescriptions for GCHP members must enroll with DHCS. See <URL> for more information.
  - GCHP is using a new information system, eVIPS, for provider credentialing.
    - Providers may view and update their demographics via a new system called <name> which may be accessed via <URL>.

- **What did not change:**
  - The way you communicate with GCHP will remain the same, which is through ProviderRelations@Goldchp.org or the dedicated Provider Line: (888) 301-1228.

Required Actions:

Action	How	When
Inform all impacted staff of the changes outlined above.	Use this document and updated provider contract(s) to train staff.	As soon as possible.
Discontinue billing for DHCS converted Local Codes	Review updated contract(s) for affected Local Codes.	As soon as possible.

Changes to Provider Directory

Effective November 7, 2020

GCHP's online Provider Directory will not be changing. However, the online provider search capability is being enhanced.

- **What changed:**
  - GCHP's online provider search capability is being updated to provide enhanced search capabilities.
- **What did not change:**
  - GCHP's online Provider Directory will continue to be updated monthly.

Required Actions:

Action	How	When
Inform staff of the changes outlined above.	Use this document to train staff.	As soon as possible.

Changes to Enrollment and Eligibility Verification

Effective November 7, 2020

GCHP is introducing a new Provider Portal through which member enrollment and eligibility may be verified. Providers will need to establish ***new user accounts*** in order to access the new Provider Portal. Instructions are provided below.

- **What changed:**
  - GCHP is introducing a new Provider Portal through which providers can perform many functions, including member enrollment and eligibility verification.
    - Providers must establish new user accounts in order to access the new Provider Portal as follows:
      - <…>
    - After establishing a new user account, providers may log into the new Provider Portal via <URL>
- **What did not change:**
  - Providers may continue verifying member enrollment and eligibility via the dedicated Provider Line: (888) 301-1228.

Required Actions:

Action	How	When
Inform all impacted staff of the changes outlined above.	Use this document to train staff.	As soon as possible.
Participate in upcoming online training sessions to be scheduled and conducted by GCHP.	Keep an eye out for future notices of online training sessions.	Per dates cited in future notices.
Register to create a new user account to gain access to the new Provider Portal.	See <URL>	Beginning <date>

Changes to Provider Portal

Effective November 7, 2020

GCHP is introducing a new Provider Portal through which member enrollment and eligibility may be verified. Providers will need to establish new user accounts in order to access the new Provider Portal. Instructions are provided below.

- **What has changed:**
  - GCHP is introducing a new Provider Portal through which providers can perform many functions, including member enrollment and eligibility verification, claims status verification, and the submission of prior authorizations and referrals.
    - Providers must establish new user accounts in order to access the new Provider Portal as follows:
      - <…>
    - After establishing a new user account, providers may log into the new Provider Portal via <URL>
  - For providers who have been issued more than one Provider Identification Number, they will be issued a new, single Provider ID to be used to <…>. See the "Changes to GCHP Provider Identification Numbers" section for more information.
  - The new Provider Portal online user experience will be different than the experience providers have been accustomed to. However, similar capabilities are available within the new Provider Portal – e.g.,
    - Member enrollment and eligibility verification
    - Claims status verification
    - Submission of prior authorizations and referrals and related status verification
  - Provider communications can be viewed in the Provider Portal.
  - Providers will have the ability to enter five or more procedure codes when submitting an authorization.
  - Providers will have the ability to add associated attachments *in PDF, Word, and Excel formats and vary in size*. Authorization attachments must be in PDF format.

- **What has not changed:**
  - Current services and functions available in the Provider Portal (e.g., eligibility, claims status)
  - Provider Login Assignment Form is available for new providers to request access.

Required Actions:

Action	How	When
Inform all impacted staff of the changes outlined above.	Use this document to train staff.	As soon as possible.
Participate in forthcoming online training sessions to be scheduled and conducted by GCHP.	Keep an eye out for future notices of online training sessions.	Per dates cited in future notices.
Register to create a new user account to gain access to the new Provider Portal.	See <URL>	Beginning <date>

Changes to Claims Submission

Effective November 7, 2020

There are some changes regarding the submission of claims to GCHP as summarized below.

- **What changed:**
  - The 25-1 Long-Term Care (LTC) claim form will no longer be accepted effective November 7, 2020. All LTC services must be billed on the UB-04 claim form or via a HIPAA 5010 837i.
  - Converted DHCS/Medi-Cal Local Codes will no longer be accepted after November 7, 2020 regardless of the date of service.
    - Provider contracts containing the affected Local Codes have been updated to contain the acceptable codes.
- **What did not change:**
  - The clearinghouses through which electronic claims may be submitted to GCHP.
  - Claims mailing address:
    ATTN: Claims
    Gold Coast Health Plan
    P.O. Box 9152
    Oxnard, CA 93031

Note: GCHP has informed the clearinghouses used by our contracted providers of necessary changes and related implications.

Required Actions:

Action	How	When
Inform all impacted staff of the changes outlined above.	Use this document and updated provider contract(s) to train staff.	As soon as possible.
Discontinue billing for affected Local Codes.	Review updated contract(s) for affected Local Codes.	As soon as possible.

Changes to Claims Processing

Effective November 7, 2020

There are some changes regarding the processing (adjudication) of claims.

- **What changed:**
  - Share of Cost
    - Member Share of Cost validation will be applied during claims adjudication.
    - If the Share of Cost has not been met per the Medi-Cal eligibility validation, the claim will be denied.
  - Explanation of Benefits Timely Filing Requirements
    - Payment reduction penalties will be applied if a claim is submitted 7-12 months from the date of service or discharge date on an inpatient claim (UB-04).
      - Months 7-9 will reimburse 75% of allowable covered charges.
      - Months 10-12 will reimburse 50% of allowable covered charges.
      - Claims submitted more than one year from the date of service or discharge date on an inpatient claim (on the 366th day) will not be paid.
  - DHCS/Medi-Cal Local Codes
    - Converted DHCS/Medi-Cal Local Codes will no longer be accepted after November 7, 2020 regardless of the date of service.
      - Provider contracts containing the affected Local Codes have been updated to contain the acceptable codes.
  - Denial Reason Codes
    - Still working with Conduent on what this will look like in Meditrac
  - Provider Identification Number
    - Still working with Conduent on what this will look like in Meditrac (multiple Id's to 1)
    - Medicare Crossover Claims will no longer appear on a separate explanation of benefits/check/EFT.
  - Claim Number
    - Still working with Conduent on what this will look like in Meditrac
  - Claim Rejection Letter
    - Still working with Conduent on what this will look like in Meditrac
    - 835 Remit Advice
- **What did not change:**
  - Share of Cost billing requirements for CMS1500 and UB04 claims and EDI equivalent

Note: GCHP has informed the clearinghouses used by our contracted providers of necessary changes and related implications.

Required Actions:

Action	How	When
Inform all impacted staff of the changes outlined above.	Use this document and updated provider contract(s) to train staff.	As soon as possible.
Discontinue billing for affected Local Codes.	Review updated contract(s) for affected Local Codes.	As soon as possible.

Ensure that claims are submitted within six months after the date of service or discharge.	Use this document and updated provider contract(s) to train staff.	As soon as possible.

Changes to Provider Customer Service / Relations

Effective November 7, 2020

There are no changes regarding Provider Customer Service administered by GCHP.

- **What changed:**
  - N/A
- **What did not change:**
  - You may contact us at ProviderRelations@goldchp.org or via the dedicated Provider Line: (888) 301-1228.

Required Actions:

Action	How	When
No action required.	N/A	N/A

Changes to Encounter Data Submission

Effective November 7, 2020

There are several changes to encounter data and encounter data submission prompted by the systems transition.

- **What changed:**
  - Encounter data may only be submitted through the following clearinghouses
    - Office Ally - Encounter Payer ID - EC1CA
    - Conduent EDI Gateway
  - Converted Local Codes will no longer be accepted after November 7, 2020
    - This applies to any encounters submitted after November 7, 2020 regardless of date of service or date of discharge

- **What did not change:**
  - Contact information for our Encounter Data Team: EncounterData@goldchp.org.
  - Encounter data submission timeliness requirements.

Required Actions:

Action	How	When
Inform all impacted staff of the changes outlined above.	Use this document and updated provider contract(s) to train staff.	As soon as possible.
Discontinue submitting DHCS/Medi-Cal converted Local Codes.	Review updated contract(s) for affected Local Codes.	As soon as possible.

Changes to Delegation Oversight Documents

Effective November 7, 2020

There are changes to delegation oversight compliance documents that must be submitted to Gold Coast Health Plan.

- **What changed:**
  - Details

- **What did not change:**
  - Contact information and primary points of contact. Gold Coast Health Plan will continue to have a dedicated delegation oversight team.
  - Delegation oversight requirements remain unchanged based on your contract.

Audit requests and other forms will be posted on our website at: <URL>

Required Actions:

Action	How	When
Review these forms with staff responsible for submitting compliance forms.	Use these forms as a resource and distribute accordingly.	As soon as possible.

Changes to Utilization Management: Authorization Letters, Processing and Reporting

Effective November 7, 2020

There are no changes to the Utilization Management process. However, GCHP is introducing a new Provider Portal in which requests for authorization for outpatient services may be submitted. See the "Changes to Provider Portal" section for more information.

- **What has changed:**
  - GCHP is introducing a new Provider Portal through which providers can perform many functions including the submission of prior authorizations.

- **What has not changed:**
  - Request for authorization may still be submitted via fax utilizing our prior authorization form available at <URL>

Action	How	When
No action required.	N/A	N/A
Participate in forthcoming online training sessions to be scheduled and conducted by GCHP.	Keep an eye out for future notices of online training sessions.	Per dates cited in future notices.
Register to create a new user account to gain access to the new Provider Portal.	See <URL>	Beginning <date>

Changes to Authorization Request Forms

Effective November 7, 2020

There are no changes to GCHP's authorization request forms.

The authorization request forms remain accessible for download on our website at: <URL>

Required Actions:

Action	How	When
No action required.	N/A	N/A

Changes to Pharmacy Services

Effective January 1, 2021

There are changes to the administration of Pharmacy Benefits prompted by DHCS' Medi-Cal Rx initiative. Members will receive information from DHCS regarding this change starting in October.

- **What changed:**

Line of business/network and claims processing information	**Medi-Cal Rx** BIN 022659 PCN 6334225 Group n/a
Retail Pharmacy Network	Medi-Cal Rx Network
Mail Service Pharmacy	Medi-Cal Rx Network
Specialty Pharmacy	Medi-Cal Rx Network

- New phone number for prescription eligibility and prior authorization issues: **(800) 977-2273.**
- New pharmacy portal for eligibility and/or prior authorization issues: www.Medi-CalRx.dhcs.ca.gov
- Pharmaceuticals billed on medical claims are not affected by this change; this change only affects pharmacy claims.

Required Actions:

Action	**How**	**When**
Review this information with staff responsible for pharmacy services.	Use this information as a resource and distribute accordingly.	As soon as possible.

Updated Provider Manual

Effective November 7, 2020

We continually update GCHP's Provider Manual when warranted. The purpose of the Provider Manual is to provide guidance for the provision of covered health care services to GCHP Members.

GCHP's Provider Manual contains policies, procedures, information on quality and utilization management, encounter reporting, health education, member and provider grievances, and other administrative guidelines to comply with state and federal regulations, which have been updated.

- **What Changed:**
  - The GCHP Provider Manual was updated with the information cited herein.

GCHP's Provider Manual can be accessed and downloaded on our website at: https://res.cloudinary.com/dpmykpsih/image/upload/gold-coast-site-258/media/b769dbe0368e47289baf08f7484c4042/gchp-provider-manual_june2020b_v4p.pdf and within the new Provider Portal.

Required Actions:

Action	How	When
Download updated provider manual(s) and review for any changes that may impact you.	Access the link above to download updated provider manuals.	As soon as possible.

MCAS/HEDIS

There are no changes to the processes for measuring and reporting performance measures, called the Managed Care Accountability Set (MCAS). MCAS measures are derived from select Center for Medicare and Medicaid Services (CMS) Adult and Child Health Care Quality Measures for Medicaid, as well as the Healthcare Effectiveness Data and Information Set (HEDIS) performance measures.

MCAS Resources
Providers can find MCAS resources on the GCHP website. Materials include MCAS Frequently Asked Questions, MCAS Measures Quick Reference Guide, and tip-sheets for MCAS measure specifications. Providers can download these materials at: https://www.goldcoasthealthplan.org/for-providers/provider-resources/.

Required Actions:

Action	How	When
Continue with MCAS/HEDIS reporting processes.	See above.	N/A