Provider Operations Bulletin

APRIL 2017

32

Table of Contents

Department of Health Care Services (DHCS) Audit

Gold Coast Health Plan (GCHP) will be going through a DHCS Medical Audit from June 5-16. You may be contacted by DHCS nurse evaluators or visited on-site by the auditors to ensure that you are abiding by state standards. Among the Plan's responsibilities when doing site visits is to ensure that materials for members are readily available and that any concerns providers are having are brought to the Plan's attention.

New Pharmacy Benefits Manager (PBM) on June 1

Effective June 1, Gold Coast Health Plan (GCHP) will have a new Pharmacy Benefits Manager (PBM). Below is some preliminary information about the change:

- OptumRx (ORx) will be the new PBM for GCHP effective June 1.
- ORx can be reached at **1-855-297-2870** after May 1.
- GCHP and ORx have been working to minimize any member disruption during the transition.
- Specific concerns or questions regarding the transition can be directed to pharmacy@goldchp.org.

GCHP will be sending out a Provider Update with additional information the week of April 24.

Managed Care Provider Data Improvement Project (MCPDIP)

The state Department of Health Care Services (DHCS) has issued a requirement change for provider data submission. The change replaces the current monthly health plan data submission previously governed by APL-14006. The new project work is being developed under the Managed Care Data Improvement Project (MCPDIP), which will allow DHCS to monitor the Plan's provider network.

How does this impact GCHP providers?
GCHP is required to collect from providers an enhanced set of data, as defined by DHCS. The project requirements, including an outline of the enhanced data (file layout and companion guide) and project timeline, will be distributed to the Plan's contracted providers as soon as it is received from the state.

Providers can click here to register the contact information necessary to ensure that they are ready when this project is implemented. Information on when meetings will be held to discuss this initiative will be distributed to the provided contacts. If you have not registered, please do so as soon as possible.

GCHP looks forward to working with its contracted providers on this effort. If you have any questions about MCPDIP, email ProviderRelations@goldchp.org.

Upcoming Opioid Policy Summit

Gold Coast Health Plan (GCHP), in collaboration with the Ventura County Behavioral Health (VCBH) department, will be holding an Opioid Policy Summit on Friday, May 5.

The abuse of prescription opioid medications has been of serious concern at the national, state, and local levels. Policy makers are attempting to combat the opioid epidemic in their communities by proposing and passing legislation to address the issue.

With the Opioid Policy Summit, the goal of GCHP and VCBH is to engage community stakeholders in a discussion about strategies that can be used to address the opioid epidemic in Ventura County.

The summit will take place at the Ventura Beach Marriott from 7:30 a.m. to 12 p.m. (Breakfast will be served from 7:30 to 8:30 a.m. The program will begin at 8:30 a.m.).

You should have received an email invitation to the event on April 11.

Click here to RSVP

The keynote speaker will be Dr. Corey Waller, an addiction, pain, and emergency medicine specialist and the senior medical director for education and policy at the National Center for Complex Health and Social Needs/Camden Coalition of Healthcare Providers (CCHP). Dr. Waller will be discussing the efforts being made on a national level to combat the crisis.

Dr. Kelly Pfeifer will also be speaking. She is the director of the California Health Care Foundation's High-Value Care Team, which supports policies and care models that align with patient preferences, are proven effective, and are affordable. Dr. Pfeifer will be focusing on the opioid epidemic on a state level.

State Assemblymember Jacqui Irwin will serve as a moderator for a panel of local experts who will discuss Ventura County's approach to the opioid crisis.

If you have any questions, please contact Marlen Torres, GCHP's manager of government and external relations, at mtorres@goldchp.org or **1-805-437-5535**.

Leading Together to Address the Opioid Epidemic in Ventura County

OPIOID POLICY SUMMIT

Speakers: Assemblymember Jacqui Irwin • Dr. Corey Waller • Dr. Kelly Pfeifer

MAY 5, 2017
8:30am — 12:00pm

Ventura Beach Marriott
2055 E. Harbor Blvd., Ventura, CA 93001

Gold Coast Health Plan
A Public Entity

VENTURA COUNTY BEHAVIORAL HEALTH
ALCOHOL & DRUG PROGRAMS

# Authorization Document Upload Through the Provider Portal

Over the last year, Gold Coast Health Plan (GCHP) has been working on making the process of submitting authorizations easier and more effiicient for providers. Authorization submissions are a major part of the day-to-day operations of GCHP, and since the Plan's inception, there has been a two-pronged approach:

1. Create an authorization through the Provider Portal.
2. If the authorization contains clinical information, please fax it to GCHP.

The feedback GCHP has received from providers is that they want to be able to upload clinical documents along with the authorization through the portal.

Now they can. The upload button on the portal is now functional. Providers can create an authorization and upload clinical documents without having to fax them to the Plan.

Only documents for outpatient and professional services can be uploaded and they must be in a **pdf format**. If you have any issues or questions regarding the process, please contact ProviderRelations@goldchp.org.
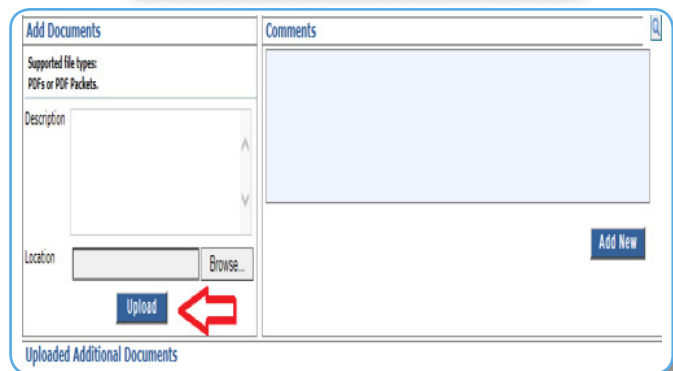
Care Management (CM) Provider Notification

Gold Coast Health Plan (GCHP) Care Management (CM) sent me a letter about my patient. What do I do with it?

When your patient agrees to join GCHP's CM program, you will receive a notification letter summarizing the plan of care. The letter contains identified problems, agreed-upon goals, planned interventions and any barriers that may impede achievement of your patient's stated goals.

The notification letters contain information that may be used to augment the continuum of care and should be included in the member's electronic medical record. We encourage you to speak to your office staff about the importance of including this correspondence in your patient's file.

The CM social worker or nurse who is working with your patient is available to speak to you should you wish to consult. A direct contact number for the care manager is always included in the correspondence.

Your collaboration and counsel is welcome and appreciated!

Collaboration in the Continuum of Care for Seniors and Persons with Disabilities (SPD)

What does this mean?
The state Department of Health Services (DHCS) requires seniors and persons with disabilities (SPD) without other health coverage to enroll in managed care. The presumption is that through care coordination, this population, especially those with chronic conditions, will achieve improved health outcomes.

Who is included?
This population, identified by an aid code, includes all ages - children, the elderly, blind, disabled, disabled adult children, working disabled, and others.

How is it done?
The Gold Coast Health Plan (GCHP) Care Management (CM) team reaches out to SPD members to perform a health risk assessment. Information is gathered about each member's risk for having an adverse health outcome. Members who agree partner with a care manager to reach mutually agreed-upon health goals.

What can you do?
The care manager working with your patient is available to speak to you should you wish to consult. Within the notification letter that you will receive for each of your SPD patients, you will find a direct contact number for the nurse or social worker.

If you have a patient that you feel can benefit from GCHP CM services, please call **1-805-437-5634** or email CareManagement@goldchp.org.

Health Education, Cultural & Linguistic Services, Outreach Events and Updates

Tobacco Cessation Training

Stay tuned for upcoming training dates!
Gold Coast Health Plan (GCHP) hosted a training on April 6 at the Plan's office in Camarillo on the 5A's – Brief Intervention Training. The training is for motivating members to quit smoking; the 5A's training can also be used for motivating members to implement a wide range of behavioral changes. If you or your staff are interested in future trainings, please contact GCHP's Health Education Department at **1-805-437-5500** or HealthEducation@goldchp.org. Health Education can also connect you with other trainings that are occurring throughout the county.

Health Education Classes
GCHP's Health Education Department has several classes available to members and the public on topics that include nutrition, physical activity, diabetes and prediabetes. GCHP offers classes in Spanish, as well as classes for bilingual audiences. GCHP also collaborates with other agencies on various topics. If you have a topic that you would like to learn more about, please contact GCHP's Health Education Department at **1-805-437-5500** or HealthEducation@goldchp.org.

Cultural and Linguistic Resources
GCHP adheres to federal and state guidelines that require health plans to ensure that Limited English Proficient (LEP), non-English speaking or monolingual GCHP members have access to interpreters and translation services at all key points of medical services.

GCHP offers the following interpreter and translation services:

- Sign language interpreter services for the deaf or hard of hearing.
- Telephone interpreter services - available 24 hours a day, seven days a week.
- In-person interpreter services – GCHP requires 5 to 7 business days to schedule an appointment for an in-person interpreter for medical appointments.
- Translation of written documents in the member's preferred language.
- Alternative text format, including Braille.

If you have a member who needs help understanding health care-related materials or needs translation services, please call **1-805-437-5603** or email CulturalLinguistics@goldchp.org.

Outreach – GCHP 6th Annual Community Resource Fair

Gold Coast Health Plan (GCHP) will host its 6th Annual Community Resource Fair at Plaza Park in Oxnard, on Saturday, May 13 from 10 a.m. – 2 p.m. Free health screenings and resource information will be offered by various health and community agencies.

Dignity Health and the Ventura County Health Care Agency will be on-site with mobile medical clinics conducting various health screenings.

There will be fun activities for families and children, such as Zumba demos, face painting, and entertainment. If you have any questions or are interested in participating, please contact Outreach at **1-805-437-5606** or outreach@goldchp.org.

Correct Format of National Drug Codes (NDC) on Paper Claims Submissions

National Drug Codes (NDC) are required, along with the appropriate HCPC or Medi-Cal Local Code, on all physician-administered or physician-dispensed drugs. To ensure accurate data capture of the NDC information on paper claim submissions, please follow the guidelines below.

NDC Product ID Qualifier and NDC Unit of Measurement Qualifier

For all claim types (CMS-1500, UB04), the NDC information must be preceded by the Product ID Qualifier (N4) and must also include the appropriate Unit of Measurement Qualifier:

- F2 = International Unit
- GR = Gram
- ML = Milliliter
- UN = Unit

NDC Information on the CMS-1500

The NDC Product ID Qualifier (N4) and NDC 11-digit number (without hyphens) will be entered in the shaded area of Box 24A (Dates of Service).

The NDC Unit of Measurement Qualifier and 10-digit numeric quantity administered will be entered in the shaded area of Box 24D (Procedures, Services or Supplies). The 10-digit numeric quantity consists of the seven-digit

whole number (leading zeros), followed by the three-digit decimal (ending zeros) without the decimal point.

Example: Five Units administered will be entered as follows:

NDC Information on the UB-04

All NDC information will be entered in Box 43 (Description) of the UB-04 claim form:

- N4 Product ID Qualifier
- Immediately followed by the 11-digit (without hyphens) NDC number
- Immediately followed by the Unit of Measurement Qualifier
- Immediately followed by the 9-digit (6-digit whole number plus 3-digit decimal) quantity

Example: Thirty Units of product with NDC 12345-123-12 will be entered in Box 43 (Description) as follows:

Crossover Claims Processing

A crossover claim is a claim for a member who is eligible for both Medicare and Medi-Cal, where Medicare pays a portion of the claim and Medi-Cal is billed for any remaining deductible and/or coinsurance. These members are often referred to as "Medi-Medi" or dually-eligible members.

California law limits Medi-Cal reimbursement for a crossover claim to an amount that, when combined with the

Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services. (Refer to Welfare and Institutions Code, Section 14109.5.)

The following provides three different examples of crossover claims processing results (dollar amounts are for demonstration only and do not reflect actual allowed amounts for either Medicare or Medi-Cal):

CPT Code	Billed Amount	Medicare Allowed	Deductible/ coinsurance	Medicare Paid	Medi-Cal Allowed	Medi-Cal Paid
99215	$300.00	$100.00	$20.00	$80.00	$50.00	$0.00
No payment is due under Medi-Cal as the Medicare payment exceeds the Medi-Cal allowance. This is referred to as a "zero pay" claim.						
71020	$100.00	$80.00	$16.00	$64.00	$70.00	$6.00
$6.00 of the Medicare deductible/coinsurance can be picked up under Medi-Cal, as that is the difference between what Medicare paid and the Medi-Cal allowance.						
10160	$50.00	$25.00	$5.00	$20.00	$35.00	$5.00
The entire Medicare deductible/coinsurance amount of $5.00 can be picked up, as that amount combined with the Medicare paid amount of $20.00 does not exceed the Medi-Cal allowance.						

Providers who accept persons eligible for both Medicare and Medi-Cal cannot bill them for the Medicare deductible and coinsurance amounts. These amounts can be billed only to Medi-Cal for consideration. Providers should, however, bill Medi-Cal members for any Share of Cost (SOC).

Note: Providers **are strongly advised** to wait until they receive the Medicare payment before collecting SOC to avoid collecting amounts greater than the Medicare deductible and/or coinsurance.

Monthly Encounter Data Reporting Requirement

An encounter is a documented face-to-face interaction between a provider and a member of a managed care plan. Gold Coast Health Plan (GCHP) is required to submit the encounter data collected for services provided to GCHP members to the state Department of Health Care Services (DHCS).

DHCS analyzes encounter data so it can more effectively monitor the Medi-Cal managed care program. Accurate and complete encounter data is essential for measuring and monitoring managed care plan quality, service utilization, finances, and compliance with contract requirements.

Encounter data is a critical source of information that is used by DHCS to set capitation rates and perform risk adjustments, which affect how DHCS sets future rates paid to

GCHP. This effect on GCHP's revenue impacts the rates GCHP pays providers.

Encounter data includes the data from both fee-for-service (FFS) claims submitted by the provider to the Plan for claims payment and capitated encounters for services provided to GCHP members that are included under the provider's monthly capitation.

Capitated providers are required to submit the encounters for all capitated services at least once a month. Providers may submit encounter data to GCHP in either a paper or electronic format.

For more information on submitting encounters to GCHP, please contact your Network Operations representative.

Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA) Requirements

The state Department of Health Care Services (DHCS) requires that each primary care provider (PCP) complete a comprehensive Initial Health Assessment (IHA) for all newly-eligible GCHP members within 120 days of being enrolled in the Plan, unless the PCP has determined that a member's medical record is sufficiently current to enable an assessment of the individual's health status.

The IHA, at a minimum, shall include:

- A physical and mental health history.
- Identification of high-risk behaviors.
- An assessment of the need for preventative screenings or services and health education.
- A diagnosis and plan for treatment of any diseases.
- An age-appropriate Staying Healthy Assessment (SHA).

GCHP sends a list of newly-enrolled members to each PCP office that is accepting new members, based on assignment, every month. Providers are responsible for reaching out to members to schedule an IHA appointment. Providers must document at least three attempts to contact the member (outreach attempts must include a phone call and a mail notification).

The IHA is an essential part of quality of care and allows providers to better assist GCHP members. GCHP is mandated by the state to conduct medical record reviews to validate that IHA outreach is being conducted and IHAs are being documented in the member's medical record correctly. Failure to conduct IHA outreach may result in a low score during a medical record review or the issuance of a corrective action plan, all of which must be reported to DHCS. If you have any questions regarding IHA, email twagemann@goldchp.org.

Staying Healthy Assessment (SHA)

Since 2014, GCHP's contracted PCPs must provide members with an age-appropriate Staying Healthy Assessment (SHA) during their IHA appointment and future visits in accordance with the SHA Periodicity Table.

The SHA is a tool that allows PCPs to better understand the health care needs of their patients based on a series of age-specific questions. The SHA can be issued during any visit and must be kept in the member's medical record. If a member refuses to complete the SHA, providers must document the refusal on the SHA form as well as the member's medical record and sign the form.

SHA forms are available in multiple languages and, if necessary, providers must offer translation, interpretation and accommodations for any disabled patients. Monitoring of the issuance and medical record documentation of the SHA is conducted by the GCHP Facility Site Review nurse. Failure to provide the assessment can result in the issuance of a corrective action plan, which must be reported to DHCS. If you have any questions regarding the SHA, email twagemann@goldchp.org. Click here for DHCS SHA resources.
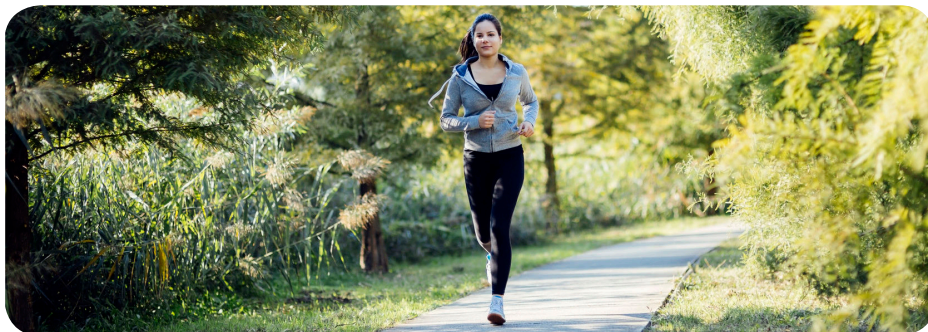
CMS Core Measure: Screening for Clinical Depression and Follow-up Plan (CDF)

Depression is a leading cause of disability in the United States. It affects individuals, families and society and is common in patients seeking treatment in the primary care setting. Major depressive disorder in children and adolescents is strongly associated with recurrent depression in young adulthood, increased risk of suicide attempts and suicide completion. Depression causes suffering, decreased quality of life, and impairment in social and occupational functioning. It is also associated with chronic medical conditions and increased health care costs.

To identify and treat individuals with depression, the U.S. Preventive Services Task Force (USPSTF) recommends screening for major depressive disorder in adolescents and adults, 12 years of age and older, including pregnant and postpartum women.

To assess the utilization of standardized depression screenings and follow-up plans by health care professionals who bill Medi-Cal (e.g., PCP, MD, NP, PA), the state Department of Health Care Services (DHCS) has mandated all Medi-Cal managed care health plans – including Gold Coast Health Plan (GCHP) – to begin reporting the Clinical Depression and Follow-Up Plan (CDF) CMS Core Measure for the 2017 reporting year.

This measure evaluates the percentage of adolescents and adults, 12 years of age and older, who were screened for clinical depression using an age-appropriate standardized depression screening tool and if positive, had a follow-up plan documented on the date of the positive screening.

Depression Screenings: The name of the age-appropriate standardized depression screening tool that is used must be documented in the medical record. Examples of depression screening tools include, but are not limited to:

- Adolescent Screening Tools (12-17 years)
  - » Patient Health Questionnaire for Adolescents (PHQ-A)
  - » Beck Depression Inventory-Primary Care Version (BDI-PC)
- Adult Screening Tools (18 years and older)
  - » Patient Health Questionnaire (PHQ-9)
  - » Beck Depression Inventory (BDI or BDI-II)
  - » Geriatric Depression Scale (GDS)
  - » Edinburgh Postnatal Depression Scale (EPDS) for pregnant and postpartum women

Follow-Up Plan: A follow-up plan for a positive depression screening must include one or more of the following:

- Additional evaluation for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Exclusions

The following patients will be excluded from the measure if at least one of the following conditions is documented in the medical record:

- Patient has an active diagnosis of depression
- Patient has a diagnosed bipolar disorder
- Patient refuses to participate
- Patient has an urgent or emergent situation and delaying treatment would jeopardize the patient's health
- The patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: court appointed cases or delirium.

Data Sources to Evaluate the CDF Measure

For the 2017 reporting year, 2016 claims/encounter data will be the primary data source used to evaluate the reporting and utilization of depression screenings tools and any follow-up plans completed in 2016. It is highly recommended that providers begin or continue to use one of the HCPCS/Quality Data Codes (QDC) listed in Table 2 to document the presence or absence of a clinical depression screenings and the presence or absence of any follow-up plans.

Coding for the CDF Measure

Table 1: CDF Eligible Population: The following CPT and HCPCS/QDC are used to identify the population (denominator) for the CDF measure.

Code Type	Code	Definition
Codes Reimbursed by Medi-Cal	90791	Psychiatric Diagnostic Evaluation
	90792	Psychiatric Diagnostic Evaluation with Medical Services
	90832	Psychiatric Treatment (Patient & Family); 30 minutes
	90834	Psychiatric Treatment (Patient & Family); 45 minutes
	90837	Psychiatric Treatment (Patient & Family); 60 minutes
	90839	Initial Psychiatric Treatment; 60 minutes
	92625	Tinnitus Assessment
	96116	Neurobehavioral Status Exam
	96118	Neuropsychological test by Psychologist/Physician
	96150	Health/Behavioral Assessment, Initial Visit
	96151	Health/Behavioral Assessment, Subsequent Visit
	97003	Occupational Therapy Evaluation
	99201	Office/Outpatient Visit, New
	99202	Office/Outpatient Visit, New
	99203	Office/Outpatient Visit, New
	99204	Office/Outpatient Visit, New
	99205	Office/Outpatient Visit, New
	99212	Office/Outpatient Visit, Established
	99213	Office/Outpatient Visit, Established
	99214	Office/Outpatient Visit, Established
	99215	Office/Outpatient Visit, Established
HCPCS/QDC Codes for Quality Reporting (Not Reimbursable)	G0101	Cervical or vaginal cancer screening
	G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
	G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
	G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit
	G0444	Annual depression screening, 15 minutes

Table 2: Identification of Services Performed for Reporting and Performance Rate: The following HCPCS/QDC codes are used to identify the presence or absence of a clinical depression screening and follow-up plan in the population selected for the CDF measure.

Code Type	Code	Definition
HCPCS/QDC Codes for Quality Reporting (Not Reimbursable)	G8431	Screening for clinical depression is documented as being positive AND a follow-up plan is documented
	G8510	Screening for clinical depression is documented as negative and a follow-up plan is not required
	G8433	Screening for clinical depression is not documented; documentation states patient is not eligible
	G8940	Screening for clinical depression is documented as positive AND a follow-up plan is not documented because documentation states patient is not eligible
	G8432	Screening for clinical depression is not documented; reason not given
	G8511	Screening for clinical depression is documented as positive and follow-up plan is not documented; reason not given

If you have any questions, please contact GCHP's Quality Improvement Department at **1-805-437-5592** or hedis@goldchp.org.

Coding Diabetic Retinal Eye Exams for the Comprehensive Diabetes Care Healthcare Effectiveness Data Information Set (HEDIS®) Measure in the Non-Eye Care Profession Setting

Non-eye care professionals, such as primary care providers, who have integrated the diabetic retinopathy screening into their primary care services through telemedicine programs such as EyePACS, are strongly encouraged to include Current Procedural Terminology (CPT) Category II codes on claims so these services can be reported in the Comprehensive Diabetes Care (CDC) performance measure.

The CPT Category II codes are developed by the American Medical Association (AMA) as supplemental codes for reporting services tracked on performance measures, such as the Healthcare Effectiveness Data Information Set (HEDIS®) or the Merit-Based Incentive Payment System (MIPS).

Although CPT Category II codes are optional, they are intended to facilitate data collection for performance measures and the AMA anticipates that the use of CPT Category II codes will reduce practitioners' administrative burden of medical record retrieval and abstraction associated with reporting performance measures.

Practitioners must continue to use applicable ICD-10-CM and HCPCS/CPT codes on claims for billing and reimbursements, but should also include an applicable CPT Category II code on claims so that retinal eye exam services in a non-eye care practitioner setting can be reported in the CDC performance measure using claims data.

CPT II Codes for Reporting Retinal Eye Exams in the CDC Performance Measure

CPT Category II Code	Type of Retinal Eye Exam
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist; results documented and reviewed.
2024F	Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist; results documented and reviewed.
2026F	Eye imaging validated to match diagnosis from seven standard field stereoscopic photos; results documented and reviewed.
3072F	Low risk for retinopathy; no evidence of retinopathy in the prior year.

If you have any questions, please contact the Quality Improvement Department at **1-805-437-5592** or hedis@goldchp.org.

Explanation of Benefits (EOB) Initiative

Gold Coast Health Plan (GCHP) will soon launch an initiative to identify any potential Fraud, Waste and Abuse (FWA).

GCHP will send members Explanation of Benefits (EOB) to confirm if the services listed were received. Members are being asked to contact GCHP's Fraud, Waste and Abuse Hotline at **1-866-672-2615** to report any services not received.

Medical Records

Gold Coast Health Plan (GCHP) has recently received reports from its members that their former providers are not transferring their medical records to their new providers. GCHP has a member-first focus that is aligned with its mission, "To Improve the Health of our Members through the Provision of High Quality Care and Services."

To achieve this, GCHP depends on its provider community to support its mission. GCHP would like to ensure that when its members are re-assigned to another provider, your offices are complying with your contract by forwarding the member's medical records to the new provider within 10 business days of receipt of the Plan's or the member's request to transfer the records. Medical records are essential to the member's care and gives the new provider a historical view of the member's health issues, past treatments and prescribed medications.

Member Benefit Information Meetings

GCHP holds member orientation meetings three times a month for all members. These meetings are held throughout the county and are presented in English and Spanish.

Members learn about their rights and responsibilities as well as how to:

- Establish a medical home.
- Select a PCP.
- Get medical services.

- Get necessary medications.
- Locate and use the resources available in the community.

Meeting times and locations vary monthly. Contact GCHP's Member Services Department at **1-888-301-1228** for meeting times and dates.

[Click here](#) for the current schedule.

NOTES:

NOTES:

Gold Coast Health Plan ℠
A Public Entity

32

Provider Operations Bulletin

APRIL 2017

For additional information, contact
Provider Relations at 888-301-1228
Gold Coast Health Plan
711 East Daily Drive, Suite 106, Camarillo, CA 93010
www.goldcoasthealthplan.org