

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

Provider Advisory Committee (PAC) Special Meeting

Tuesday, October 6, 2026, 7:30 a.m.
Gold Coast Health Plan, Community Room
New Address: 4880 Santa Rosa Rd
Camarillo, CA 93012

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

Conference Call Number: 1-805-324-7279

Conference ID: 140 834 780 #

3585 Maple Street
Ventura, CA 93003

3080 Bristol Street
Costa Mesa CA 92626

AGENDA

CALL TO ORDER

ROLL CALL

PUBLIC COMMENT

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

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

Members of the public may 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.

OPENING REMARKS / WELCOME

Erik Cho, Chief of Staff & Strategy

- Introduction of Christopher Lee, Chief Financial Officer

CONSENT

1. Approval of Regular Meeting Minutes of June 9, 2026

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

RECOMMENDATION: Approve the minutes as presented.

UPDATES

2. Network Provider Update

Staff: Suma Simcoe, Chief Operations Officer
Michelle Espinoza, Exec. Director of Provider Network Operations & Strategies

RECOMMENDATION: Receive and file the update

3. Enrollment and Retention Update

Staff: Marlen Torres, Chief Communications & Community Affairs Officer
Erik Cho, Chief of Staff & Strategy

RECOMMENDATION: Receive and file the update

ADJOURNMENT

Unless otherwise determined by the PAC, the next meeting is scheduled for December 8, 2026 and will be held at Gold Coast Health Plan located at 4880 Santa Rosa Road, Community Room, Camarillo, CA 93012.

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 (PAC)
FROM: Maddie Gutierrez, MMC, Sr. Clerk of the Commission
DATE: October 6, 2026
SUBJECT: Approval of the regular Provider Advisory Committee Meeting minutes of June 9, 2026

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the June 9, 2026 Provider Advisory Committee meeting minutes.

**Ventura County Medi-Cal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)
Provider Advisory Committee (PAC)
Regular Meeting
June 9, 2026**

CALL TO ORDER

The Clerk called the meeting to order at 7:37 a.m., in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

ROLL CALL

Present: Committee members: Masood Babaeian, Molly Corbett, Claudia Gallard, Katy Krul, Amanda Larson, Kristine Supple, and Pablo Velez

Absent: Committee member: Josie Romehild.

Gold Coast Health Plan Staff in attendance: Felix Nunez, M.D., Chief Executive Officer, Chief Policies & Programs Officer, Erik Cho, Chief Medical Officer, James Cruz, M.D., Chief Compliance Officer, Robert Franco, Chief Innovation Officer Eve Gelb, Vicki Wrighster, Carolyn Harris, Adriana Sandoval, Vallie Coakley, Ellen Rudy, and Kim Marquez-Johnson.

PUBLIC COMMENT

None.

OPENING REMARKS

Chief Policies & Programs Officer Erik Cho thanked the committee members for their participation. We have had and will continue to have positive discussions. He noted it is a trying time in Medi-Cal, and there is a lot of focus on enrollment. Our goal is to keep as many people continue their coverage and access quality care as best we can.

Committee Chair, Dr. Pablo Velez, stated that GCHP leadership has been great, making sure that families and children in our community continue to have support and maintain providers and working together to minimize negative consequences.

CONSENT

1. Approval of Regular Meeting Minutes of March 17, 2026

Staff: Maddie Gutierrez, MMC, Clerk of the Commission

RECOMMENDATION: Approve the minutes as presented.

Committee member Claudia Gallard motioned to approve agenda item 1 as presented.
Committee member Masood Babaeian seconded.

AYES: Committee members: Masood Babaeian, Amelia Breckenridge, M.D., Molly Corbett, Claudia Gallard, Katy Krul, Amanda Larson, Kristine Supple, and Dr. Pablo Velez.

NOES: None.

ABSENT: Committee member Josie Romehild

The motion carried.

UPDATES

2. Enrollment Data Update

Staff: Erik Cho, Chief Policy & Programs Officer
Adriana Sandoval, Community Relations Manager

RECOMMENDATION: Receive and file the update.

Erik Cho, Chief Policy & Programs Officer stated membership trends will be reviewed. He stated that our membership has gone down approximately 3.5%, which is a sizable number. Focus will now be on enrollment efforts. Mr. Cho stated that changes in HR1 are still coming – these changes have already affected the membership change at GCHP. These changes have created an environment of fear, and it also reflects an environment of misinformation.

CPPO Cho stated there is a concern on the amount of disenrollment for people who are eligible and will always be eligible. There is a concern about the number of disenrollments for folks who are eligible and will always be eligible. There has been a quick decline for the older group, but they have now come back around for their redetermination at the beginning of the year. We are hoping it will not be a one-time

bump of a large disenrollment and then level out. CPPO Cho also reviewed some of the categories and reviewed enrollments by city. Mr. Cho reviewed graphs and noted there were fewer disenrollments in March, but we are now ticking back up, which is unfortunate.

Committee Chair, Dr. Pablo Velez, asked about ages 0 to 18 and noted a number of 1,332 individuals – he asked if that is the number of members that have disenrolled. CPPO Cho stated that was correct. There are members coming in but disenrollment is going up. Mr. Cho also noted that the six-month enrollment has not started yet – it begins next year, which is a concern for the adult expansion population.

Committee member Amanda Larson asked if this is an ongoing number or in it an addition. CPPO Cho stated that the graph does not show the people coming in, and there are still folks coming in. There has been a 3.5% reduction in enrollment/members since January – and we are concerned that more areas would be more impacted. Mr. Cho noted the Oxnard rate has been 3.3% down, Santa Paula is at 2.7%, Fillmore is 2.7%, and Piru is 3.1%. We will continue to keep our eye on these numbers. He also noted that 2.9% of these members stated English is their primary language, and 4.8% noted Spanish is their primary. Unfortunately, it is not surprising because we are losing a higher rate of the UIS population versus the SIS population. The UIS population is declining quickly and if they cannot re-enroll now, they will not be able to re-enroll later.

Committee member Amanda Larson asked if there is a number of how many new enrollments we have. Mr. Cho noted there is an enrollment dashboard that is updated regularly and we keep our eye on those numbers as well. CPPO Cho stated that we have a total number of 5,470 members who have disenrolled.

Adriana Sandoval, Community Relations Manager, shared outreach efforts that staff have been conducting since last year to engage and education members and make sure that they renew getting the correct information. Last Fall we started launching community grants through Pathway to Wellness. We awarded seven community-based organizations. Two of them specifically helping with Medicare renewals, education, and outreach efforts. Those two organizations are MICOP and El Concilio. These organizations meet with people out in the community, in their offices, or can help members at home.

Our community relations team has started attending Swap Meet Justice at a location where our community gathers and we support with helping with renewals or setting up a BenefitsCal application. We have also been doing community workshops, providing presentations on the importance of renewing. Just last month we began doing workshops out in the community and inviting families to get renewal assistance at specific locations. Ms. Sandoval noted that by being out in the community we have

learned there is a lot of community fear. There is apprehension of being out in public due to the current situation with ICE raids.

Ms. Sandoval stated that in the last month we have hired ten temporary workers to make outbound calls and remind people to renew, and that there is assistance available over the phone and/or at different clinic sites. We are also starting to engage our non-traditional providers to see if they would like to be educators for renewal assistance. She noted that we have also connected with First Five and we have an MOU with the Human Services Agency – they have been sharing data on members that have been disenrolled from a previous month or are up for renewals. We use that data and begin our outreach. Members that have a satisfactory immigration status have a grace period for reenrollment and we work with them to get them renewed. We do not want them to lose their coverage. We will also be launching the RISE Grants to support these efforts. We are doing everything that we can to keep our membership numbers up. She noted that we welcomed feedback.

Committee member Amanda Larson asked if home visits are done. Ms. Sandoval stated the home visits are done by El Concilio and MICOP. Our staff cannot go into a home, and our Member Care Ambassadors are available over the phone.

3. PNO and Provider Survey Update

Staff: Michelle Espinoza, Executive Director, Delivery System Operations & Strategies
Vicki Wrighster, Sr. Director, Network Operations

RECOMMENDATION: Receive and file the update.

Michelle Espinoza, Executive Director, Delivery System Operations & Strategies, stated last quarter she gave a presentation on our provider satisfaction survey and how we were going to analyze the survey and then return with some takeaways and opportunities where we will find engagement with our provider network and leverage that opportunity on how we can continue to increase our provider satisfaction scores.

She noted there were categories listed, the finance issues related more to claims processing, utilization, and quality management, is tied to health care services, such as prior authorization in the queue, the quality initiatives. The network coordination of care is also clinical. It is how we coordinate care for our members.

Ms. Espinoza review dashboard and key findings. She stated the satisfaction survey results were favorable. She noted that we have an opportunity to trend up on all our measures. GCHP was in the 65th percentile in 2024 at 89.1%. It goes along with everything we do together as a community, as providers, as a health plan to make

sure our members are safe and have access to care. We have good processes, we have good engagement, we have good strengths within the organization. The key driver that we are homing in on is to work with our provider network and make sure that all efforts and steps that we have taken will continue so that we do not get in a position to see numbers drop down. Even though we feel that we have stabilized there is still work to be done. She noted that every other measure was right on par with either industry standard or above par where we would like to be.

Ms. Espinoza stated that providers felt that the health plans' facilitation and support of appropriate clinical care for patients was lacking. We will again drill down and talk to our providers. We want to make sure that members and providers feel like there is appropriate engagement and coordination to get our members at the right care, the right place, the right time. We want to see what we can do to support.

Ms. Espinoza stated that just because the score is good, we still want to make sure that we are addressing issues or concerns that the providers have, and we continue to look for opportunities to improve satisfaction. She did note there was a drop in our satisfaction with the provider call center, but we have leveraged a lot of technology and we are hope that with this year's satisfaction survey we push the technology that we have created with greater engagement with our Provider Relations team, better training, tools, resources and stabilization of our operations to help decrease the amount of calls that were coming in. Providers can utilize IVR systems and claims can now be reviewed online to check status. We have also combined the provider call center with the member call center – this is fairly new and we will see how it works.

Ms. Espinoza stated the Provider Relations scores were very high, which reinforces our commitment to making sure that we have educated our providers, educated ourselves, that we are responsive, answering calls, and doing everything we can to make sure the providers have a resource.

Vicki Wrighster, Sr. Director, Network Operations stated that she wanted to discuss our new external provider representative visits. We recognized that we needed a more experienced representative, as well as the way we went out to visit the providers, add additional questions, understand what the needs are, and how we could better communicate so we can improve as well.

Ms. Wrighster stated that we have one representative that crosses all of Ventura County for the visits. We try to meet with managers of the different offices, and at times they are not available, but we have found that conversations with front office staff and back-office staff have given us additional information that we need to improve our service and communications. One of the things we ask is "What do you need from us? How can we better serve you? And What are the things that you would like for us to know?" We are reinforcing not only with providers, but internally, the claims

turnaround training and processes and how we communicate what is occurring. We are directing our providers to the portal for our claims. We are also performing some additional coordination and follow-up with providers – which gives us an opportunity to find out what are the questions for claims and how we can better serve providers. We have increased the number of portal training courses with individual provider offices. We are also working with our non-traditional providers who never used CPT codes and have different services and methods in which they need to bill us. We are working with them so we can transition what they currently do into a way that their payment structures and encounter structures will be much better on a go-forward basis.

Provider disputes and appeals can be tricky. We have noticed that the way the PDR form (provider dispute form) is constructed, we found that as an organization we can understand how that form needs to be filled, but talking to our providers, we have learned that providers do not understand how to complete the form, so we are doing specific trainings for the PDR forms with individual providers, as well as done the trainings in groups. This has helped us understand what additional communication we need to make, and how to provide better training. This allows us to increase our training knowledge. Our teams ins now creating collateral for subjects that will be distributed to our providers within the next month based on different topics.

We have found that provider demographic updates are an issue. We encourage our providers to update us with any changes. We have found that providers are not forwarding us information and that has a significant effect on us operationally, as well as regulatory. Both DHCS and CMS require that we have accuracy in our directories.

Committee member Molly Corbett stated there is a lot of hospice fraud in the area. Ms. Wrihster stated that hospice fraud is a top priority – it is a hot topic. Chief Compliance Officer, Robert Franco stated the issues around hospice have been a statewide initiative and GCHP has engaged in numerous activities around that hospices are legitimate. We have also put in place some standards around out-of-network hospitals, and doing some additional look at the claims. He noted that there is an 800 number where reports can be done anonymously.

4. RISE Grant Update

Staff: Ellen Rudy, Director of Grants Administration & Oversight

RECOMMENDATION: Receive and file the update.

Ellen Rudy, Director of Grants Administration & Oversight, reviewed year 2 of the RISE Grant program. The RISE grant started last year, and the focus was to increase access to care – addressing upstream or downstream factors that affect access to

care for our members. This year the focus is to support organizations who support members in understanding, navigating, and complying with the evolving Medicaid eligibility requirements. This is directly in response to the HR1 bill. We want to help to enroll and re-enroll members in the Medi-Cal program. The grants opened in late January and requests for applications closed on April 15, 2026. We did have a robust response. We had twenty-nine applications. The applications were reviewed and scored. Seven organizations were selected to fund, and the programs start July 1 through June 20, 2027. Award letters were sent out June 1 and grantees had until June 8, 2026, to accept the awards. The following organizations accepted the award: Community Memorial Healthcare, Conejo Health, Mini Mansions, MICOP, Ventura County Healthcare Agency, Ventura County Public Health department, and Westminster Free Clinic. These organizations are addressing or helping anywhere from adult members to helping migrant communities, and unhoused residents continue with enrollment and re-enrollment processes, as well as educate and assist members on the upcoming requirements that will take effect in 2027.

5. **D-SNP Update**

Staff: Eve Gelb, Chief Innovation Officer

Kimberly Marquez-Johnson, Sr. Director, Duals Special Needs Plan

RECOMMENDATION: Receive and file the update

Eve Gelb, Chief Innovation Officer, introduced Kimberly Marquez-Johnson, Sr. Director, Duals Special Needs Plan, stated she will provide a high-level status update. Total Care Advantage has been in daily operation for over five months now. We have established five key performance indicators on which we are focused. The first is to increase our membership. Our goal is to reach a minimum of 1200 members by the end of the year. Currently our membership is 681, and we only have 519 members to go to reach our goal number. The second performance indicator is to optimize our total care advantage provider partnerships to increase our members' completion of their annual wellness visit to 65% by the end of 2026. The third is to achieve our quality target of 80% of our Star measures meeting performance targets for this benefit year. Due to our small membership, our current rates are low, which is to be expected, but we will start to slowly increase. Our fourth goal is to meet our financial targets of less than \$11 million lost for 2026. For quarter one our loss was \$2.7 million, which was expected. Starting a new D-SNP line of business comes with the awareness of an expected loss for a few years until our membership grows. Our fifth key performance indicator is meeting our compliance targets. We have a goal to have 85% of our prioritized metrics meeting compliance targets for 2026. We have 3330 metrics that we track for timeliness and completion based off CMS regulatory requirements. We are at 83% for April.

Ms. Marquez-Johnson then reviewed the breakdown of our active members by age, language and patient need groups using John Hopkins ACG system. Much of our membership are the ages 65 to 69 at 42.5% and 70- to 74-year-olds at 20.5%. We have 12% of our membership between the ages of 21 to 64 and that has a disability that impacts their daily living activities. Our membership by language depicts 57.4% of our members that speak Spanish and 41% that speak English. She noted that the Adjusted Clinical Groups categorize members by complexity and intensity of their healthcare needs. The top group is the multi-morbidity with moderate complexity conditions which is 28.7%, followed by multimorbidity of low complexity conditions at 18.3% - those are moderate needs which I followed by the dominant major chronic condition with high impact to health at 18.1% and the multimorbidity with high complexity at 17.2%.

Ms. Marquez-Johnson stated that she wanted to share the program timeline We have already started our 2027 annual enrollment period activities. Our 2027 Medicare bid has been successfully submitted to CMS on June 1, 2026, and we are awaiting the final state Medicaid agency contract (known as SMAC) to sign and submit to CMS in July. We are focused on October 1 to be ready to sell and October 15 to be ready to enroll and ready to serve our new members January 1, 2027.

Committee member Amanda Larson asked if there was a list of providers for the program. CIO Gelb replied yes that there is a provider directory. The directory can be found on the GCHP website, and anybody can access it. The directory can be found at the same place you access our Medi-Cal provider directory. She noted that our two primary care providers are VCMC and Clinicas. Clinicas has approximately 60% of our membership and VCMC has approximately 40%. We have specialists and all sorts of providers that meet network adequacy. Our goal is to start small, and as our membership grows, we can expand.

CIO Gelb stated that one of the requirements is that we have an overlap with our Medi-Cal network, the state requires particularly on primary care and specialty care that there is an overlap with your Medi-Cal network. This is important because the state is working towards Default Enrollment, which means when a Medi-Cal beneficiary ages in or becomes eligible for Medicare due to disability, they are enrolled in that Medi-Cal managed care plan's D-SNP by default. It is the goal of California to ensure consistency along the aging spectrum so that folks can stay with the providers that they want to stay with. We are waiting for the requirements with respect to the network overlap – we have not seen those yet.

Committee member Amanda Larson asked if someone is a D-SNP member, are they assigned a physician – is it the same as GCHP where they are assigned a clinic or are they assigned a PCP. CIO Gelb stated they are assigned a clinic because our two providers are FCHCs, so it follows how it worked for them when they were a Medi-Cal

member. We want to make sure that it is consistent in how it works for them when they are a Medicare member. Ms. Larson stated that they have a challenge on the realm in post-acute care. They must have a following PCP, and they encounter that GCHP members are assigned to a clinic and she cannot use a clinic – they must have a physician. When they call the clinic, the clinic responds that they have never seen that member, but they are assigned there. They do not have a PCP, and then Ms. Larson's group cannot provide services without a signing physician. CIO Gelb stated she will work with Ms. Larson. She also noted that every one of our Medicare members has a care navigator who is capturing that person's primary care provider.

Ms. Larson recommended that when one of the GCHP members is hospitalized, there should be some communication to where the hospital gets that PCP's name, rather than say follow up with the clinic. If you tell a patient to follow up with their clinic, there is no connection. When they try to get DME, they are trying to get other things, home health services, infusion, etc., it becomes a challenge.

CIO Gelb stated that we will work to create a workflow to make sure information is shared.

Committee member Amanda Larson motioned to approve agenda items 2 through 5 as presented. Committee member Claudia Gallard seconded.

AYES: Committee members: Masood Babaeian, Amelia Breckenridge, M.D., Molly Corbett, Claudia Gallard, Katy Krul, Amanda Larson, Josie Roemhild, Kristine Supple, and Dr. Pablo Velez.

NOES: None.

ABSENT: Committee member Josie Romehild

The motion carried.

ADJOURNMENT

With no further items to be addressed, the Clerk adjourned the meeting at 9:03 a.m.

Approved:

Maddie Gutierrez, MMC
Clerk to the Commission



AGENDA ITEM NO. 2

TO: Provider Advisory Committee (PAC)

FROM: Suma Simcoe, Chief Operations Officer
Michelle Espinoza, Exec. Director of Provider Network Operations & Strategies
Vicki Wrighster, Sr. Director Provider Network Operations

DATE: October 6, 2026

SUBJECT: Provider Network Update

**PowerPoint with
Verbal Presentation**

ATTACHMENTS:

Provider Network

Gold Coast Health Plan

October 2026

S. Michelle Espinoza
Executive Director Provider Network Operations and
Vicki Wrighster
Sr. Director Provider Network Operations

Integrity

Accountability

Collaboration

Trust

Respect

KEY FOCUS AND MISSION STATEMENT

What We Do

Provider Network Operations acts as the central touchpoint between providers and GCHP for provider recruitment, education, credentialing, contracting, reporting and the maintenance of an adequate provider network while addressing the everyday concerns of our providers.

Mission Statement

Provider Network Operations is committed to improving the health outcomes for the community of members we serve through:

- Provision of high-quality healthcare through our network of providers
- Collaborate, educate, train and partner with providers
- Drive transformation and innovation in provider networking

PNO Functional Areas

Provider Relations

- Serve as provider advocates and primary points of contact
- Conduct orientations, site visits, and ongoing provider education
- Support contract operational compliance and issue resolution
- Collaborate with internal departments to meet DHCS, CMS and other regulatory requirements

Provider Contracting

- Negotiate, execute and manage provider agreements
- Ensure contract terms meet DHCS and CMS requirements
- Support network expansion and rate negotiations
- Coordinate with Credentialing, Provider Relations & Operations during onboarding

Credentialing

- Verify provider qualifications, licensure, training and sanctions
- Conduct initial credentialing and recredentialing per DHCS, CMS and NCQA Standards
- Maintain credentialing data

Provider Regulatory & Analytics

- Monitor and report network adequacy for Medi-Cal (DHCS) and D-SNP (CMS)
- Manage provider directories (printed and online)
- Lead provider network regulatory deliverables (ANC, SNC, NAV, HSD, CMS Aligned Template, Medicare templates)

MediCal Network – Traditional Health

Provider Type	Total Counts
Hospitals:	25
- Acute Care	19
- Long-Term Acute Care (LTAC)	1
- Tertiary	5
Providers:	9,484
- Primary Care Providers (PCPs) & Mid-levels	508
- Specialists	8,036
- Hospitalists	940
Ancillary:	657
- Ambulatory Surgery Center (ASC)	10
- Community-Based Adult Services (CBAS)	14
- Durable Medical Equipment (DME)	95
- Home Health	38
- Hospice	21
- Laboratory	38
- Occupational Therapy (OT) / Physical Therapy (PT) / Speech Therapy (ST)	190
- Radiology / Imaging	60
- Skilled Nursing Facility (SNF) / Long-Term Care (LTC) / Intermediate Care Facility (ICF)	84
17 of 41 pages	Return to Agenda

MediCal Network – CalAIM

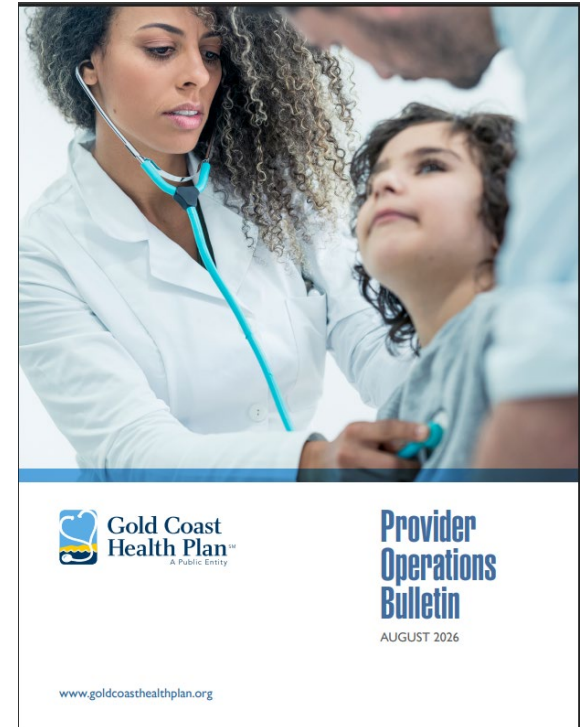
Provider Type	Total Counts
Enhanced Care Management	13
Community Health Worker	6
Doula Services	11
Community Supports :	
- Recuperative Care	2
- Asthma Remediation	2
- Community & Nursing Facility Transition/Diversion to Assisted Living	4
- Community Transition	14
- Environmental Accessibility/Home Modification	3
- Housing Deposits/Tenancy & Sustaining/Transition Services	4
- Medically Supported/Tailored Meals	4
- Personal Care & Homemaker Services	4
- Respite	7
- Transitional Rent	1

Supplemental Vendors

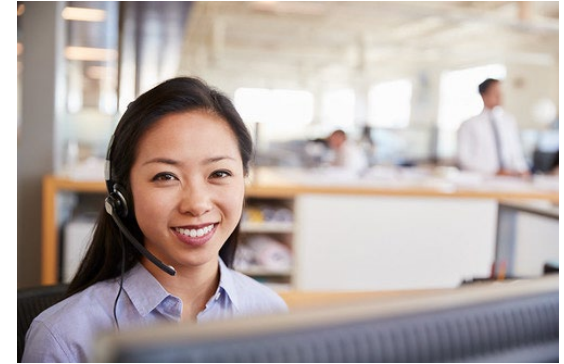
- Carelon Behavioral Health (MediCal and DSNP)
- Vision Service Plan (MediCal and DSNP)
- Ventura Transit System (MediCal and DSNP)
- TruHearing (DNSP)
- American Specialty Network (Chiro & Acupuncture) (DSNP)
- Connect America (Emergency Response) (DSNP)

Provider Relations

- Provider Education to Providers and Staff
- External and Internal Provider Relations focused
- Collaborate with GCHP internal departments
- Ensure Provider Operational compliance
- Provider Communication Outreach
- Provider Data Maintenance



Internal Provider Relations



- Email Communication with Provider
 - June 1, 2026 – August 15, 2026
 - 6002 emails including Provider Portal trainings and education
- Provider Operations Bulletin
 - Distributed Quarterly – 2026 – February, April, June, August
- Provider Manual
 - Reviewed and updated bi-annually
- Provider Portal
 - Total Number of Provider Portal Registered Users: 10,741

External Provider Relations

- Face to Face visits with contracted Providers and Facilities
- Dedicate External Provider Representative in field 3 days per week
- Total Visits (January 1, through August 31, 2026)
 - **582**
- Materials distributed to offices include
 - Medi-Cal/TCA updates
 - Cultural/Linguistics Services
 - List of GCHP Contacts
 - Operational Information for Claims, Health Services and Operations



Network Adequacy (Medi-Cal vs. D-SNP)

Medi-Cal Requirements	D-SNP Requirements
Governed by DHCS	Governed by CMS
Uses Time & Distance standards for PCPs, specialists, hospitals, and behavioral health within plan's service area	Uses Time & Distance standards specific to Medicare population within plan's service area
Network capacity/provider-to-member ratios and coverage of full scope benefits (60%)	Percent of members with access within time/distance standards (90% in metro county)
Annual Network Certification (ANC) and Network Adequacy Validation (NAV) Audit	Aligned Network and Medicare Provider Network Templates
274 Provider Network File	Health Service Delivery (HSD) Template
Monthly, quarterly & annual monitoring	Annual and ad-hoc monitoring
Requires biannual provider directory submission	No directory submission beyond initial D-SNP application process

Medi-Cal Network Adequacy

PCP Access (Adult / Ped)
100.0% | 100.0%
Standard 10 mi / 30 min

Hospitals Access
100.0%
Standard 15 mi / 30 min

Core Specialists Access
100.0%
Standard 30 mi / 60 min

Behavioral Outpatient (Adult / Ped)
100.0% | 100.0%
Standard 30 mi / 60 min

Provider-to-Member Capacity (DHCS 60%)
PCP: 1:381 ✓ Spec: 1:21 ✓
Base: Ventura Medi-Cal = 182,889

Time & Distance (DHCS Standard)

County	Provider Type	Required	Achieved	% Members	Status
Ventura	PCP (Adult)	10 / 30	17.4 / 18.9	100.0%	✓ Meets
Ventura	PCP (Pediatric)	10 / 30	22.8 / 24.8	100.0%	✓ Meets
Ventura	Hospital	15 / 30	17.0 / 20.4	100.0%	✓ Meets
Ventura	OB/GYN	30 / 60	22.9 / 24.9	100.0%	✓ Meets
Ventura	Specialist (Core)	30 / 60	33.0 / 39.1	100.0%	✓ Meets
Ventura	Behavioral Outpt (Adult)	30 / 60	17.0 / 18.9	100.0%	✓ Meets
Ventura	Behavioral Outpt (Pediatric)	30 / 60	21.4 / 23.3	100.0%	✓ Meets

PCP source: Geo Access Adult & Pediatric PCPs — Ventura. Max Dist/Time Adult 17.4/18.9, Ped 22.8/24.8.

Provider Counts

Member Capacity

Validation & Sources

D-SNP Network Adequacy



PCP Access
100.0%

Standard 10 mi / 15 min



Hospital Access
100.0%

Standard 30 mi / 45 min



Specialist Access
94.0%

Grouped CMS standards



Behavioral Health Access
99.3%

Adult practitioners only



Provider-to-Member Capacity
PCP 1:8 | Spec 1:1

Informational only — no D-SNP capacity standard

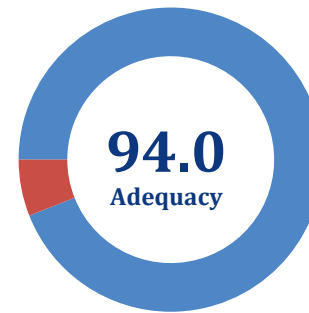
Time & Distance (CMS)

Ventura County adequacy by grouped D-SNP standards

County	Provider Type	Required	Achieved	% Members	Status
Ventura	PCP	10 / 15	1.1 mi	100.0%	✓ Meets
Ventura	Spec 20/30 Group	20 / 30	4.4 mi	100.0%	✓ Meets
Ventura	Spec 30/45 Group	30 / 45	6.5 mi	100.0%	✓ Meets
Ventura	Spec 40/60 Group	40 / 60	5.8 mi	100.0%	✓ Meets
Ventura	Hospitals	30 / 45	10.9 mi	100.0%	✓ Meets
Ventura	BH Adult	30 / 45	14.7 mi	99.3%	Review

D-SNP Adequacy Summary

Ventura County D-SNP Access Summary



Grouped CMS standards met

Network Counts + Member Access

PCP (97) **100.0%**

Specialists (683) **100.0%**

Facility APs (80) **100.0%**

BH Pract. (197) **99.3%**

BH Fac. NPIs (92 · N/A)

Medi-Cal Appointment Access & Availability (2025)



PCPs have the highest rates of compliance for Urgent Care (97.6%) and Urgent Care (prior authorization required) (88.9%).



Specialists have the highest rate of compliance for office wait time (84.4%).



LTSS facilities have a compliance rate of 76.9%.

Q#	Audit Item	PCP				Specialist			
		Total Answering	Total Compliant	Total Non-compliant	Compliance Rate	Total Answering	Total Compliant	Total Non-compliant	Compliance Rate
Q2/Q2B	Urgent Care - Overall Compliance	250	244	6	97.6%	3926	2540	1386	64.7%
Q2_2/Q2_2B	Urgent Care (prior authorization required) - Overall Compliance	253	225	28	88.9%	3379	2297	1082	68.0%
Q3/Q3B	Non-Urgent Appt. - Overall Compliance	258	210	48	81.4%	4081	2301	1780	56.4%
Q6	Routine Care (Physical/Well-Woman Exam/Initial Visit)	207	127	80	61.4%	4056	1992	2064	49.1%
Q7	Preventive Check-Up/Well-Child Exam	242	147	95	60.7%	—	—	—	—
Q7A	Well-Woman Exam (OBGYN)	—	—	—	—	285	136	149	47.7%
Q4	Office Wait Time	253	201	52	79.4%	4081	3446	635	84.4%
Q5	Patient Call Back Time	258	153	105	59.3%	3943	2107	1836	53.4%

Q#	Audit Item	LTSS			
		Total Answering	Total Compliant	Total Non-compliant	Compliance Rate
Q12	LTSS Patient Admission	13	10	3	76.9%



Note: "Total Answering" is the number of providers who answered the question with either a compliant or noncompliant response. "Total Compliant" represents the number of providers who gave a compliant response for the given question. "Total Noncompliant" represents the number of providers who answered in a noncompliant manner. "Compliance Rate" represents the percentage of provider offices that answered in a compliant manner for the given question.

PNO Accomplishments

- DSNP Launch with full Network Adequacy
- CMS approval of 2026 Triennial Report
- CMS/HSAG Audit – No Findings
- DHCS NAV Audit – No Findings
- Completion of all contracting/compliance needs for successful achievement of NCQA
- Successful development of CalAim (Community Supports and Enhanced Care Management) provider network

THANK YOU & QUESTIONS



AGENDA ITEM NO. 3

TO: Provider Advisory Committee (PAC)

FROM: Marlen Torres, Chief Communications & Community Affairs Officer
Erik Cho, Chief of Staff & Strategy Officer

DATE: October 6, 2026

SUBJECT: Enrollment & Retention Update

**PowerPoint with
Verbal Presentation**

ATTACHMENTS:

Member Eligibility Changes



**Gold Coast
Health PlanSM**
A Public Entity

Member Eligibility Changes

Provider Advisory Committee

October 6, 2026

Integrity

Accountability

Collaboration

Trust

Respect

Our Why...



Compassionate
care, accessible
to all, for the
health of OUR
community



Member Eligibility Changes

Membership Redetermination Implementation Timeline

Feb.-May 2026

- Launched awareness campaign about Medi-Cal eligibility changes
- Launched Ventura County Access Coalition
- Launched Community Relations boots on the ground outreach

June-Sept. 2026

- GCHP hired Temp Call Center agents to remind members about completing their renewal and assist with completing their application.
- Awarded RISE Grants
- Will develop communications toolkits
- Will launch texting campaign

Oct.-Dec. 2026

- Support members in taking action to complete new requirements
- Share with large provider systems member renewal date
- Collaborate with Ventura County Healthcare Access Coalition to develop and deliver guidance and training at a county wide level

Broad Messaging for Awareness

We have launched an awareness campaign throughout Ventura County on:

- Billboards
- Buses – inside
- Bus shelters (Oxnard, Santa Clara Valley, Simi Valley)
- DMV locations
- Digital platforms (websites)
- Newspapers (Vida, El Latino, Santa Paula Times, Fillmore Gazette)
- Radio
- Social Media



Educating & Engaging Members

- 1. How can we communicate with our members about these changes? Social Media (ex. post, video, FB live, Instagram), Text, radio, etc.**
- 2. How can we prepare / educate members who will be affected by these changes? (ex. townhall, City Council)**
- 3. What materials can be developed and shared by the committee?**

Transitioning Members

UIS Transition

- On Jan. 1, 2027, Medi-Cal beneficiaries with Unsatisfactory Immigration Status (UIS) will transition from Medi-Cal Managed Care to the Fee-for-Service (FFS) program.
- Applies to approximately 2 million UIS Members throughout the state.
 - Approximately 30,000 current GCHP members.
- DHCS' UIS Transition Policy Guide and operational details will cover key elements needed to effectively transition these members such:
 - Care Coordination
 - Member Outreach
 - Navigation Services
 - Language Access
 - Provider Coordination

Care Coordination for UIS Transitioning Members

Strategic Objectives

- Maintain continuity of care for high-risk members.
- Minimize disruption of primary, specialty, facility, and supportive service relationships.
- Identify provider continuity issues before transition.
- Assist members with understanding how to access services under FFS.
- Maintain compliance with DHCS requirements.
- Escalate, wherever possible, systemic barriers impacting care access through DHCS designated channels.

DHCS Transition Policy Guide Version 1.0

Major Components

- 1. Provider Communications:** DHCS requires MCPs to communicate with all contracted network providers serving UIS members within 30 days of the Policy Guide release.
- 2. Continuity of Provider Access:** Although continuity-of-care protections do not apply when members move from Managed Care to FFS, DHCS expects MCPs to minimize disruption and preserve provider relationships whenever possible.
- 3. Member Communications:** While DHCS has the responsibility to for the primary transition notice, MCPs will still have significant required activities: i.e., encourage members to update address in county offices, reinforce BIC card usage, direct members to Medi-Cal FFS provider resources, maintain consistent messaging with DHCS communications, provide culturally and linguistically appropriate communications.
- 4. Data Deliverables:** MCPs must submit authorization data for transitioning members, MCPs must submit a summary of the provider communications and outreach that was done to support the transition, MCPs must submit separate files containing authorization data for all CCS transitioning members.

Transitioning Members

- 1. How else can we help our members during this transition?**
- 2. What are some immediate barriers we can address? (ex. appointment availability)**
- 3. How can we communicate with our members about these changes?**

Questions?