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

Community Advisory Committee (CAC) Meeting

Regular Meeting
Wednesday, October 16, 2024, 4:00 p.m. – 6:00 p.m.
Gold Coast Health Plan,
Community Room
711 E. Daily Drive, Suite 110, Camarillo, CA 93010
Conference Call Number:1-805-324-7279
Conference ID Number: 275 123 786#

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

1721 Saratoga St
Oxnard Ca 93035

AGENDA

INTERPRETER ANNOUNCEMENT

CALL TO ORDER

ROLL CALL

PUBLIC COMMENT

The public has the opportunity to address the Community Advisory Committee (CAC). Persons wishing to address the Committee should complete and submit a Speaker Card.

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

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.

Welcoming Remarks

Marlen Torres, Chief of Member Experience & External Affairs
Felix L. Nunez, M.D., MPH, Acting Chief Executive Officer

CONSENT

1. Approval of Community Advisory Committee Regular Meeting Minutes of April 17, 2024.

Staff: Maddie Gutierrez, MMC – Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

FORMAL ACTION

2. Approval of the 2025 CAC Meeting Calendar

Staff: Maddie Gutierrez, MMC – Clerk to the Commission

RECOMMENDATION: Selection and approval of the 2025 Community Advisory Committee (CAC) calendar as presented

3. Community Advisory Committee (CAC) Charter Review and Approval

Staff: Marlen Torres, Chief of Member Experience & External Affairs

RECOMMENDATION: Approve the revised charter.

4. Creation of an Ad Hoc Subcommittee for the review and selection of new members to Serve on the Ventura County Medi-Cal Managed Care Commission's Community Advisory Committee

Staff: Marlen Torres, Chief of Member Experience & External Affairs

RECOMMENDATION: Staff recommends the CAC establish a AdHoc subcommittee to commence the review and selection process of new members to the CAC.

PRESENTATIONS

5. The National Committee for Quality Assurance (NCQA) Health Equity Accreditation Survey

Staff: Ted Bagley, Chief Diversity Officer

RECOMMENDATION: Receive and file the presentation

6. Diversity, Equity & Inclusion (DEI) Training

Staff: Lupe Gonzalez, PhD, MPH, Sr. Director Health Education, Cultural & Linguistic Services

RECOMMENDATION: Receive and file the presentation.

7. Non-Specific Mental Health Services (NSMHS): Member Outreach Workplan

Staff: Lucy Marrero, Director, Behavioral Health

RECOMMENDATION: Receive and file the presentation

UPDATES

8. Implementation Update: Justice Services

Staff: Pauline Preciado, Exec. Director of Population Health
David Tovar, Incentive Strategy Manager

RECOMMENDATION: Receive and file the update.

9. Expansion Population Outreach Strategies Update

Staff: Marlen Torres, Chief of Member Experience & External Affairs

RECOMMENDATION: Receive and file the update.

10. MCAS Measures and Interventions: Chronic Disease Management and Preventive Screenings

Staff: James Cruz M.D., Acting Chief Medical Officer
Kim Timmerman, Sr. Director of Quality Improvement
Helen Chtourou, QI Program Manager III

RECOMMENDATION: Receive and file the update

11. D-SNP Member Journey and Model of Care Review

Staff: Kimberly Marquez-Johnson, Director of Dual Special Needs Plan

RECOMMENDATION: Receive and file the update

COMMENTS FROM COMMITTEE MEMBERS

CAC Feedback / Roundtable Discussion

ADJOURNMENT

Unless otherwise determined by the Committee, the next regular CAC meeting will be held in 2025 Date to be Determined, from 4PM – 6PM in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Suite 110, 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 Clerk of the Commission.

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

AGENDA ITEM NO. 1

TO: Community Advisory Committee (CAC)

FROM: Maddie Gutierrez, MMC - Clerk to the Commission

DATE: October 16, 2024

SUBJECT: Approval of the Community Advisory Committee regular meeting minutes of April 17, 2024 .

RECOMMENDATION:

Approve the minutes as presented.

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

Community Advisory Committee (CAC) Minutes
Regular Meeting
April 17, 2024

CALL TO ORDER

Committee Chair, Ruben Juarez, called the meeting to order at 4:15 p.m. in the Community Room located at Gold Coast Health Plan, 711 East Daily Drive, Suite 110, Camarillo, California.

INTERPRETER ANNOUNCEMENT

The interpreter made her announcement.

ROLL CALL

Present: Committee members Martha Johnson, Ruben Juarez, Victoria Jump, Elaine Martinez, Rafael Stoneman, and Pablo Velez.

Absent: Committee members Paula Johnson, Laurie Jordan, Rose MacKay, and Juana Quintal.

Attending the meeting for GCHP Executive Team were CEO Nick Liguori, CPPO Erik Cho, CIO Eve Gelb, Chief Innovation Officer, CMO Felix Nunez, M.D., CCO Robert Franco, Marlen Torres, Exec. Director of Strategy & External Affairs, Adriana Sandoval, Luis Aguilar, Susana Enriquez-Euyoque, David Tovar, Kim Timmerman, Erin Slack, Lupe Gonzalez, Anna Sproule, and guest Commissioner Laura Espinosa.

PUBLIC COMMENT

None.

WELCOMING REMARKS

Marlen Torres, Exec. Director of Strategy & External Affairs welcomed all who were attending in person, as well as those who have joined via Teams.

Ms. Torres stated that the committee received meeting materials one week in advance of the meeting date as committed by staff. She noted that we continue to focus on our members

and staff continues to be out in the community and will continue to find ways to engage out members.

CONSENT

1. Approval of Community Advisory Committee Regular Meeting Minutes of January 17, 2024.

Staff: Maddie Gutierrez, MMC – Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

Committee member Victoria Jump motioned to approve consent item 1. Committee member Elaine Martinez seconded.

Roll Call vote as follows:

AYES: Committee members Martha Johnson, Ruben Juarez, Victoria Jump, Elaine Martinez, Rafael Stoneman, and Pablo Velez

NOES: None.

ABSENT: Committee members Paula Johnson, Laurie Jordan, Rose MacKay, and Juana Quintal.

The motion carries.

PRESENTATIONS

2. Community Care

Staff: Marlen Torres, Executive Director of Strategy & External Affairs
Eve Gelb, Chief Innovation Officer

RECOMMENDATION: Receive and file the presentation.

Chief Innovation Officer Eve Gelb stated staff wanted to share the Community care goal. She stated that we want to bring care to our members instead of forcing the member to fit into the health system. Our care goal is to set up an infrastructure, processes, and tools to bring care to our members where and when they need it. This will help them achieve their health goals as well as the goals the state has set for us in quality metrics. We want to implement and evaluate the process to make sure it

works. The goal is to build a process and have a workflow so that members know about events. It will be easy for them to attend events where services are available. This will happen outside of the usual health system, but we also want to make sure that there is clinical follow-up and documentation so that we know that the member got service. This also helps close gaps in quality metrics. CIO Gelb noted that Adriana Sandoval is leading school, work, and community events and David Tovar is leading our home health visits. They are both dedicated to providing services to our members.

CIO Gelb stated that we engage in many events coordinated with our organization and our providers, but on June 2nd GCHP will be hosting a health fair at Oxnard College. We are also going to provide self-test kits. These kits will be given to members so they can perform a screening on themselves instead of going to a doctor's office. CIO Gelb noted there are a variety of self-test kits. GCHP is piloting the use of these kits, but we rely on the member to use the kit, return the sample to the healthy system for processing results and then follow up with the member. We are working toward transforming the way GCHP provides care. We want to provide our members with the right type of care, supporting our members in screening for preventative services. This is all designed to close a gap in care. She noted that we have mammogram vans that are currently going to provider offices and providing services.

Often members will be prescribed medications; they get the Rx filled without much information. We want to provide a resource to help the member understand what their meds do for them. We are focusing on closing gaps and delivering services in the community, and we will continue to look for other ways to address quality outcomes in the community.

Marlen Torres, Executive Director of Strategy & External Affairs acknowledged GCHP Commission Vice-Chair, Laura Espinosa, who was in attendance.

Committee member Martha Johnson asked when staff is out in the community, and they encounter non-members. She asked if those individuals received services or if they are referred to a location. CIO Gelb stated there are multiple barriers to serving non-members. There are multiple rules in place with regards to privacy of health information and for allowable use of Medi-Cal funds. Our mission is to lift the health of Ventura County and still follow all the rules. If we partner with Public Health, they might be able to provide the service that we cannot. Our providers cannot offer services to non-members either. Ms. Johnson stated that partnering with Public Health would be a good option. We need to find a way to do a "warm handoff" without adding layers to a service that is needed.

CPPO Erik Cho stated there might be people who do not have any insurance but might be eligible for GCHP. We want to make sure they receive the care they need too. CIO Gelb stated there are staff who are experts in understanding who is eligible and trained to support these people through the eligibility process. She noted that we do have strong relationships with community partners who can provide care for those that do not meet our criteria. Ms. Torres stated that we work closely with Human Services Agency to make sure folks are able to get eligibility if they qualify or to get a "warm handoff" if needed. There are some screenings that are provided whether they are members or not.

The GCHP Health Fair that is being held on June 2nd is a focused health fair to advance these measures and close care gaps. We will be partnering with other community-based organizations such as Westminster, or Public Health to be available to provide the screenings that we cannot.

Ms. Torres stated that there is also a number of school-based events that her team has started conducting. Staff is also going to a number of growers to provide some screenings. We want to make sure that we are out in the community. She noted that we have not been able to provide screenings at this capacity before. We are innovating, and we are testing. We are working to solve health disparities in the community. We want the community to take advantage of these health fairs and the screenings.

Committee member Martha Johnson suggested a social media tool kit that can be shared with the Ventura County Health Care Agency where we can cross promote through their platforms. Creating an infographic with the verbiage GCHP would like used. Other non-profits can also cross share the information. Committee Chair, Ruben Juarez stated providing the information in other languages, including Mixteco, would be good. Mr. Juarez stated school is ending, and it might be good to connect with sports coaches who would get the information out to the parents. Ms. Torres stated that we have been focusing on schools, summer camps would be a great opportunity. There are also member incentive gift cards that would be available.

CIO Gelb asked how we could engage / motivate people to do self-testing. Committee member Martha Johnson stated that education would be great. She noted that there is an agency from the Los Angeles area that is coming to the PACC to talk about colon cancer. They are getting community members to talk. Education, talks, and hand-outs will be given.

Mr. Juarez suggested a video or app to get instructions. Committee member Rafael Stoneman stated that seniors avoid doing anything with apps or texting. Having the material in person would be best, and having a video to go with it would be helpful.

CPPO Cho stated a multi-pronged approach sounds like the best option. Ms. Johnson stated that you need to find the best approach for individuals, because it might not be the same for everyone. Committee member Victoria Jump asked if the plan was to mail or was it a distribution. CIO Gelb stated the first pass would be a distribution at health fairs. The goals are to eventually get to a point where there would be a good response with mailing, but we also need to see how difficult it is to understand the instructions that come with the kit, and what kind of support we would need to offer.

Ms. Jump stated that for the older population these tests are needed, but they will not go after a certain age, they forget, or do not want to know the results. She suggested tests specific to that age group/population. Ms. Jump suggested targeting public housing, people are there, and kits can be handed out and collected at the same time. CMO Nunez stated home health or IHSS might be a better option for seniors.

David Tovar, Incentive Strategy Manager stated that the home health pilot is very tailored. He stated that there is a development of a list of individuals who have issues getting to doctor appointments, or problems living alone. They might not make it to their annual medical visit, so we are going to send someone to them. We are trying to tailor test and see if our hypothesis actually works and becomes a reality. The other part is to work with our providers in order to connect with long term care members and provide more sustainable care.

Committee Chair Ruben Juarez stated that he sees the kits as a positive. Members see doing the self-tests as being safer in the privacy of their own home, and they can take their time, return the kit, and return it without having to make an appointment or miss work or school. Committee member Rafael Stoneman stated that the instructions need to be simple.

3. Expansion Population: 26 – 49 years old / Outreach Strategies

Staff: Marlen Torres, Executive Director of Strategy & External Affairs
Eve Gelb, Chief Innovation Officer
Anna Sproule, Executive Director of Operations

RECOMMENDATION: Receive and file the presentation

Marlen Torres, Executive Director of Strategy & External Affairs stated that we have gotten a new group of cohorts who qualify for Medi-Cal. These are individuals between the ages of 26 to 49, regardless of their immigration status. It was estimated that over 700,000 individuals across the state from the governor's budgetary perspective. Over 14,000 individuals transitioned in Ventura County from fee for service Medi-Cal to full scope in January. There was guidance from the department of Healthcare services

ensuring that those individuals would continue to receive services once they transitioned. There are a number of outreach initiatives to ensure that we are engaging this new population and that we understand their health care needs.

CIO Eve Gelb stated that we launched our first health risk assessment for this new population. The response rate was approximately 86%. The assessment is conducted over the phone. We have also found that that this population have had barriers accessing care, and in order to get care they have been using the emergency room. There are also barriers in transportation. We have been able to now connect these members with primary care as well as transportation benefits.

We also asked questions about food insecurity, housing insecurity, veteran status, and support for those who have been veterans. We also asked how they rate their own health. Those who identified their health as poor gave us a hint on who to engage with quickly. We also asked about violence in the home, so that we can trigger services quickly. CIO Gelb noted that there is a pathway to our Contact Call Center for those who need support accessing benefits.

Anna Sproule, Executive Director of Operations, stated that we are welcoming new members to the plan in a much more effective manner that we have in the past. We have implemented new member welcome calls to ensure that these members are informed and supported. The health plan is providing them with the information necessary to connect with care and then connect them with the care needed.

Ms. Torres stated that before the pandemic we were providing new member orientation out in the community. We are going to resume the orientations with this new population at our June 2nd health fair. We want to make sure that they understand their health insurance, we will also cover benefits, how to access those benefits, scheduling appointments with providers, and the importance of the card that they receive. These orientations will be conducted in English and Spanish. We are currently working through the logistics.

Committee member Martha Johnson stated that there were people who had emergency Medi-Cal were not sure if they needed to apply for regular Medi-Cal or if they just transitioned over automatically. Staff was able to direct them. Committee member Rafael Stoneman asked how it works with Medicare; if there is someone who has Medi-Cal but also qualifies for Medicare. CIO Gelb stated that for this population, they would not qualify for Medicare because Medicare requires a different immigration status. This new cohort of people will be aging on Medi-Cal only. We will need to understand and support them in order to address health risks as people age. This will bring additional risk to us financially, but it is important to connect them with the right care and services so we can support them as they age.

Chair Juarez stated there is still going to be the same process to qualify, income guidelines, family size, and they will need to do the application process. He asked if there are undocumented adults with chronic multiple health issues, will they get Medi-Cal coverage until age 49, or will it continue. Ms. Sproule replied yes coverage will continue because they then go into the age range or 50/55 plus. Ms. Torres stated that they are in different age brackets and now it is the full spectrum. Ms. Torres stated that it is important to educate members and let them know how to stay qualified.

CPPO Cho stated that we have been able to link a significant majority of members to the clinic systems where they were seen in the past.

Committee member Rafael Stoneman asked if these members fall under the same kind of category as everyone else that is required by law to have health insurance (when you do your taxes). CIO Gelb stated these people are not connected in any way to other government agencies. This is one of the barriers where they are less willing to engage and seek care because they are concerned about future immigration application. We need to get them to use the services that are going to keep them healthy. Mr. Juarez requested an update on this item for future meetings.

Martha Johnson asked if we looked into the infrastructure of having these people connect with a PCP and actually get appointments, which tends to be a barrier. Ms. Sproule answered yes, in some of the welcome calls we have found that they are asking for support in getting them an appointment, and we have had success in doing that. We are also continuing to monitor next available appointments and an update can be given at the next meeting. CMO Nunez stated that just getting them on Medi-Cal puts them in the system and now providers are held accountable for those requirements to have appointment availability within certain time frames that did not exist before.

CIO Gelb stated that we have quality incentive programs for providers, as well as grants to support them in recruiting primary care providers, and specialists to the community. We are also about to launch additional grants and quality incentives to support opening access, which includes weekend, after hour appointments, and working with our providers to understand what they need in order to make it happen. David Tovar, Incentive Strategy Manager, stated that we have offered fifty-seven grants to new physicians or advanced practitioners, and the vast majority have been for primary care physician. CMO Nunez stated that capacity is an issue, and we are looking to address that as quickly as possible.

Ms. Torress stated that Ms. Johnson's request will be added to the next standing item.

Committee member Victoria Jump motioned to approve Presentation items 2 and 3. Committee member Martha Johnson seconded.

Roll Call vote as follows:

AYES: Committee members Martha Johnson, Ruben Juarez, Victoria Jump, Elaine Martinez, Rafael Stoneman, and Pablo Velez

NOES: None.

ABSENT: Committee members Paula Johnson, Laurie Jordan, Rose MacKay, and Juana Quintal.

The motion carries.

UPDATES

4. Member Services Everywhere / Contact Center Update

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

RECOMMENDATION: Receive and file the presentation

Anna Sporule stated that GCHP has begun a new campaign aimed at improving the care provided to its members. The Contact center has been brought to Camarillo. We have transitioned from an external service provider to an in-house team in support of a member-centered health plan. This has allowed the organization to have direct responsibility over the services provided to the members through inbound calls, and to connect members with care in a more efficient manner. This call center aims to enhance the quality of services, improve responsiveness, and streamline communications between members and the organization. We also have a community deployed service team that will be embedded in provider offices and leading community events, as well as plan to open some satellite offices in the community. Ms. Torres noted it was a GCHP team effort and has been a huge undertaking to be able to have more control over the call center. All agents are local and are bilingual, and they have had training and will continue to have training as they begin to have new member calls. There will also be outbound calls beginning July 1st.

We are taking from the redetermination pilot program and exploring being fully embedded at some of the county clinics. We are in early discussions with the county. In having a person at a clinic to support the member and support with closing care gaps. Members will see GCHP as a live agent who can answer questions. We also want satellite offices/storefronts /resource centers out in the community. We want to be out in the community. Mr. Juarez stated that when the call center is in another state, someone has to log in using a zip code and they give directions using a map. Having a storefront, it is someone that lives in the area and knows the area – it is a big plus to have someone who knows the area and the streets. Committee member Martha Johnson stated it is another way to build trust with members, having a familiar face consistently. They will be able to answer questions and be more accessible to people who already have barriers, they want to see someone in person versus someone on the phone. Mr. Stoneman stated that staff must consider bus routes.

Ms. Sproule stated that the call center move has allow us to gain greater alignment and stronger connections between staff and members. We have a deep understanding of the goals of the organization, the values of the community, and the needs of our members. This allows us to refine and tailor our approach to meet those needs specifically and effectively. We also have the ability to directly manage work to ensure higher level of quality control and consistency in our services. We foster a sense of ownership and commitment among our team members. Member engagement is crucial, and it matters for several reasons. One of the reasons is improved health outcomes. We are increasing engagement from our membership, enhance the patient experience, and the experience that our members have. We are hoping to increase utilization of services by educating, sharing information, and helping to connect with care. We also have an opportunity to get feedback from our members so that we continue to improve. Member engagement is essential for promoting better health outcomes, and building a stronger, more sustainable network and overall experience.

Ms. Torres stated that we are enhancing the voice of our members. We want to make sure that we are creating something that is useful to our members. It is not just a regulatory requirement; it is a regulatory requirement that we are meeting and meets member needs. It is important for us to focus being out in the community, hearing from the members and being accessible to them. As we move forward with storefronts, the CAC will be involved in hearing what it would look like. The design will be so that we put something in place that is going to be useful to our members and the communities we serve. We will be presenting more information on programs on which we are working.

5. Implementation Update: Justice Services

Staff: Pauline Preciado, Exec. Director of Population Health
David Tovar, Incentive Strategy Manager

RECOMMENDATION: Receive and file the update.

David Tovar Incentive Strategy Manager stated that he will give a brief update. He noted that he had met with our justice partners, the probation agency, and county Sheriff's office. The state noted that there are two models to work from. We can do an embedded model, which is where a correctional facility will actually contract and have their own ECM team in-house and will be completely separate from us. There is also an In-Reach model, which is where we contract with the provider, and they go into the facilities to engage members. Currently, the correctional facilities need to make a decision. Probation is choosing to go with an embedded model, and they are looking at a local provider for that. They will have full control. They will know who is going into their facility. The Sheriff's Office has not decided yet. We will start to develop workflows for either scenario, and they can choose from an in-reach model. They have to make sure that there are care plans. Mr. Tovar noted that re-entry care plans are separate from traditional care plans. We need to ensure the appropriate engagement with our justice partners. This is a huge transition for inmates, who are used to the justice system not a health care system. Committee Chair Ruben Juarez asked how long an individual would be incarcerated before coverage stops. Mr. Tovar stated they are put on hold and their information will be transmitted to the Human Services Agency – currently the member is covered for one year. If they are released within that year, they can be reinstated, and do not have to reapply and go through the process again. Ninety days prior to release, Medi-Cal will go-live again. After October 1st, a correctional facility will be able to bill state Medi-Cal for specific services such as cyclotronic medications, and traditional health and mental health services as well. Mr. Tovar will provide a list of treatments at the next meeting. Mr. Tovar stated that we are finalizing our contract with our proposed justice serving ECM provider. He will present information at the next meeting.

Chair Ruben Juarez asked that this item also be presented as an update at the next meeting.

Committee member Rafael Stoneman motioned to approve Updates 4 and 5 Committee member Martha Johnson seconded.

Roll Call vote as follows:

AYES: Committee members Martha Johnson, Ruben Juarez, Victoria Jump, Elaine Martinez, Rafael Stoneman, and Pablo Velez

NOES: None.

ABSENT: Committee members Paula Johnson, Laurie Jordan, Rose MacKay, and Juana Quintal.

The motion carries.

PUBLIC COMMENT

None

ADJOURNMENT

With no further business to discuss the meeting was adjourned at 5:48 p.m.

Approved:

_____
Maddie Gutierrez, MMC Clerk to the Commission

AGENDA ITEM NO. 2

TO: Community Advisory Committee (CAC)

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

DATE: October 16, 2024

SUBJECT: Approval of the 2025 Community Advisory Committee Meeting Calendar.

SUMMARY:

To establish the Community Advisory Committee (CAC) meeting dates for regular meetings in the 2025 calendar year.

RECOMMENDATION:

Select and approve one of the options for the 2025 Community Advisory Committee (CAC) calendar.

ATTACHMENTS:

Copies of the options for the 2025 Community Advisory Committee meeting dates.

CAC Regular Mtg, 4-6 PM

2025
Community Advisory Committee Meetings

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Return to Agenda

CAC Regular Mtg, 4-6 PM

2025
Community Advisory Committee Meetings

January

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February

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March

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April

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May

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Return to Agenda

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AGENDA ITEM NO. 3

TO: Community Advisory Committee (CAC)

FROM: Marlen Torres, Chief of Member Experience & External Affairs Officer

DATE: October 16, 2024

SUBJECT: MS-015 Community Advisory Committee (CAC) Policy and Procedure

Due to contractual changes from the Department of Health Care Services (DHCS), MS-015 Community Advisory Committee policy and procedure was updated to reflect the new requirements under the 2024 DHCS contract pertaining to the Community Advisory Committee (CAC).

Community Advisory Committee responsibilities include the following:

1. Implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net Providers.
2. Provide information, advice, and recommendations in policy decisions related to educational, operational, and cultural competency issues.
    a. Involved in developing and updating cultural and linguistic policy and procedure decisions including QI, education, and operational and cultural competency issues affecting groups who speak a primary language other than English.
    b. Advise on necessary member or Provider targeted services, programs, and training.
    c. Provide input on selecting targeted health education, cultural and linguistic, and QI strategies.
    d. Priorities for health education and outreach program.
    e. Member satisfaction survey results.
    f. Finding of Population Needs Assessment (PNA).
    g. GCHP marketing materials and campaigns.
    h. Communication of needs for Network development and assessment.
    i. Community resources and information
    j. Population Health Management
    k. Quality
    l. Health Delivery Systems Reforms to improve health outcomes
    m. Carved Out Services
    n. Coordination of Care

o. Health Equity
p. Accessibility of Services

3. Gather cultural and linguistic information from stakeholders and the community.
4. The CAC shall report every six months to the GCHP Commission and provide advice and recommendations to the GCHP Commission relative to GCHP's programs and initiatives.
5. Appoint CAC Member to serve as the GCHP representative to the DHCS Statewide Consumer Advisory Committee.
6. Identify and advocate for preventive care practices to be utilized by GCHP.
7. Make recommendations to GCHP regarding the cultural appropriateness of communications, partnerships, and services.
8. Review PNA findings and discuss improvement opportunities.
9. CAC Members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by GCHP's conflict of interest code and, in accordance with GCHP Policy.
10. CAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.
11. On an annual basis, CAC shall select a chairperson and vice-chair from its membership to coincide with the annual recruitment and nomination process.

The attached policy was sent to DHCS for review and approval. The DHCS approved the updated P&P earlier this year. Thus, staff recommends that the CAC approve the revised policy and procedure.

FISCAL IMPACT:

None.

RECOMMENDATION:

Staff recommends the CAC approve the revised MS-015 policy and procedure.

ATTACHMENTS:

MS0-015 Community Advisory Committee

POLICY AND PROCEDURE	
TITLE: Community Advisory Committee	
DEPARTMENT: Member Services	**POLICY #:** MS-015
EFFECTIVE DATE: 10/18/2017	**REVIEW/REVISION DATE:** 01/30/20, 02/16/21, 05/03/22
COMMITTEE APPROVAL DATE: 04/28/2021	**RETIRE DATE:**
PRODUCT TYPE: Medi-Cal	**REPLACES:**
	CEO SIGNATURE:

I. Purpose

A. To define the composition and role of the Gold Coast Health Plan (GCHP) Community Advisory Committee (CAC). The role of the CAC is to be included and involved in policy decisions related to Quality Improvement, educational, operational, and cultural competency issues affecting GCHP members and groups who speak a primary language other than English.
B. The purpose of this policy is also to establish a process for recruiting, evaluating, and selecting prospective candidates for GCHP's CAC, as well as to delineate the governance of the GCHP's CAC.

II. Policy

A. GCHP complies with the contract requirement to form a CAC that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net Providers. GCHP shall ensure that the CAC is included and involved in policy decisions related to educational, operational, and cultural competency issues.
B. The CAC composition complies with the contract requirements to ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD), persons with chronic conditions (such as asthma, diabetes, congestive heart failure), are included and participate in establishing public policy within the Contractor's advisory committee or other similar committee or group.
C. The Board of Supervisors of the County of Ventura via Ordinance number 4409 established a member advisory board, CAC.

D. The composition of the CAC reflects the diversity of the population served.
E. GCHP promotes health equity and the identification and addressing of health inequities via the CAC.
F. As directed by GCHP's Commission, CAC shall report on an annual basis to the GCHP Commission and shall provide advice and recommendations to the GCHP Commission relative to GCHP's programs and initiatives.

III. Definitions

Community Advisory Committee: A committee comprised of community advocates and Members, each of whom represents a constituency served by Gold Coast Health Plan (GCHP), which was established by GCHP to advise its Commission on issues affecting Members.

GCHP Commission: The Ventura County Medi-Cal Managed Care Commission (VCMMCC) is the governing body for Gold Coast Health Plan (GCHP). The Commission is comprised of locally elected officials, Providers, hospitals, clinics, the county healthcare agency, and consumer advocates.

Health Disparity: Means differences in health, including mental health, and outcomes closely linked with social, economic, and environmental disadvantage, which are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics such as race, ethnicity, age, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families, and communities.

Health Equity: Means the reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.

Health Inequity: Means a systematic difference in the health status of different population groups arising from the social conditions in which Members are born, grow, live, work, and/or age, resulting in significant social and economic costs both to individuals and societies.

Population Needs Assessment (PNA): Means a process for:

A. Identifying Member health needs and Health Disparities;

B. Evaluating health education, Cultural & Linguistic (C&L), delivery system transformation and Quality Improvement (QI) activities and other available resources to address identified health concerns; and

C. Implementing targeted strategies for health education, C&L, and QI programs and services.

Social Drivers of Health (SDOH): Means the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk.

Threshold Language/Threshold or Concentration Standard Languages: The non-English threshold and concentration standard languages in which GCHP is required to provide written translations of Member Information, as determined by DHCS.

IV. Procedure

A. CAC Responsibilities

1. Implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net Providers.
2. Provide information, advice, and recommendations in policy decisions related to educational, operational, and cultural competency issues.
    a. Involved in developing and updating cultural and linguistic policy and procedure decisions including QI, education, and operational and cultural competency issues affecting groups who speak a primary language other than English.
    b. Advise on necessary member or Provider targeted services, programs, and training.
    c. Provide input on selecting targeted health education, cultural and linguistic, and QI strategies.
    d. Priorities for health education and outreach program.
    e. Member satisfaction survey results
    f. Finding of Population Needs Assessment (PNA).
    g. GCHP marketing materials and campaigns.
    h. Communication of needs for Network development and assessment.
    i. Community resources and information
    j. Population Health Management
    k. Quality
    l. Health Delivery Systems Reforms to improve health outcomes

m. Carved Out Services
n. Coordination of Care
o. Health Equity
p. Accessibility of Services

3. Gather cultural and linguistic information from stakeholders and the community.
4. The CAC shall report every six months to the GCHP Commission and provide advice and recommendations to the GCHP Commission relative to GCHP's programs and initiatives.
5. Appoint CAC Member to serve as the GCHP representative to the DHCS Statewide Consumer Advisory Committee.
6. Identify and advocate for preventive care practices to be utilized by GCHP.
7. Make recommendations to GCHP regarding the cultural appropriateness of communications, partnerships, and services.
8. Review PNA findings and discuss improvement opportunities.
9. CAC Members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by GCHP's conflict of interest code and, in accordance with GCHP Policy.
10. CAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.
11. On an annual basis, CAC shall select a chairperson and vice-chair from its membership to coincide with the annual recruitment and nomination process.
12. CAC members shall attend all regularly scheduled meetings unless they have an excused absence. An absence shall be considered excused if a CAC member provides notification of an absence to GCHP staff at least four hours prior to the CAC meeting. GCHP staff shall maintain an attendance log of the CAC member's attendance at CAC meetings. Upon request from the CAC chairperson, the vice-chair, the Chief Executive Officer or the GCHP Commission, GCHP staff shall provide a copy of the attendance log to the requester. In addition, GCHP staff shall contact any committee member who has three consecutive unexcused absences. CAC member's attendance will be considered as a criterion upon reapplication.

13. GCHP leadership will participate in CAC meetings. CAC coordinator will also facilitate communication and connection between the CAC and GCHP leadership.
14. GCHP must appoint one member of the CAC, selected by the CAC, or another GCHP member designated by the CAC, to serve as GCHP representative to DHCS' Statewide Consumer Advisory Committee and consistent with Exhibit A, Attachment 5.2.11.D (Community Engagement). GCHP is responsible to compensate the CAC member representative for their time and participation on DHCS' Statewide Consumer Advisory Committee, including transportation expenses to appear in person.

B. CAC Membership

1. The CAC membership reflects the Medi-Cal population of Ventura County.
2. All CAC members shall have direct or indirect contact with GCHP Members.
3. The diversity of the CAC membership is a priority and may include, but is not limited to, individuals representing, or that represent the interest of:
   a. Adolescents
   b. Parents/Caregivers of Members under 21 years old
   c. Seniors and Persons with Disabilities (SPDs)
   d. Persons with chronic conditions (such as asthma, diabetes, congestive heart failure)
   e. Limited English Proficient (LEP) Members
   f. Members from diverse cultural and ethnic backgrounds
   g. Hard-to-reach populations, e.g., Members with physical disabilities
   h. IHS Providers
   i. Foster youth
   j. Individual representative of, or serving populations that experience Health Disparities
   k. County Health Care Agency
   l. County Human Services Agency
4. One GCHP CAC Member will participate in the DHCS Statewide Consumer Advisory Committee.
5. In accordance with the Ventura County Medi-Cal Managed Care Commission (VCMMCC), dba Gold Coast Health Plan (GCHP), CAC shall be comprised of 11 voting members, each seat representing a constituency served by GCHP.

a. Two (2) of the eleven (11) positions are standing seats and are held by the Ventura County Health Care Agency (VCHCA) and the Ventura County Human Services Agency (HSA).
b. Nine (9) members shall serve a two-year term with no limits on the number of terms a representative may serve.
c. One (1) of the positions shall be a dedicated Member seat for a Beneficiary Member or the Parent/Guardian of a Beneficiary Member less than 21 years of age.

6. The CAC members shall serve a two-year term that coincides with the GCHP's fiscal year (i.e., July 1st through June 30th).
7. The CAC shall select a chairperson and vice-chair from its membership to coincide with the annual recruitment and nomination process.
   a. The CAC chairperson and vice-chair may serve one-year terms with unlimited extensions with a vote taken by the CAC members annually.
   b. The CAC chairperson or vice-chair may be removed by a majority vote from GCHP's Commission.

C. CAC Selection Committee

1. Duties of the CAC Selection Committee
   a. Ensure the selection of CAC Members for the GCHP CAC.
   b. Validate the selection of CAC Members that reflect the general Medi-Cal population of Ventura County.

2. The CAC Selection Committee will be comprised of:
   a. Individual from the GCHP Commission
   b. Individual(s) from community-based organizations
   c. Individual(s) that bring different perspectives, ideas, and views
   d. Representatives from diverse and hard-to-reach populations
   e. Representative of or serving populations that experience Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity and sexual orientation and physical disabilities.

3. CAC Membership Selection Timeline
   a. The CAC Selection Committee must select all of its CAC Members no later than 180 calendar days from the date of the Contract with DHCS.

b. Make best efforts to replace CAC Member(s), who resigns or is otherwise unable to serve on the CAC, within 60 calendar days of the vacancy.

4. CAC Recruitment Process
   a. GCHP shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the GCHP population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.
      i. The CAC shall conduct a special recruitment effort if a seat is vacated mid-term.
      ii. Candidates that fill a vacated seat mid-term shall complete the term for that specific seat, which will be less than a full two-year term.
      iii. If a vacancy occurs three months prior to the start of the nomination process, there will be no need for a special election and the vacant seat shall become part of the nomination process.
   b. The CAC shall conduct an annual recruitment and nomination process.
      i. At the end of each fiscal year, approximately half of the CAC seats expire, alternating between four vacancies one year and five vacancies the subsequent year. The two standing seats for VCHCA and HSA are evergreen and do not expire.
      ii. The CAC shall conduct a special recruitment effort if a seat is vacated mid-term. Candidates that fill a vacated seat mid-term shall complete the term for that specific seat, which will be less than a full two-year term.
   c. GCHP shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the GCHP population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.
   d. GCHP shall recruit potential candidates utilizing a variety of notification methods, which may include, but are not limited to, the following:
      i. Outreach to the respective Member community; and
      ii. Placement of vacancy notices on the GCHP website, city halls, public libraries, and the Building Community Newsletter.
   e. An application is sent to prospective candidates and shall be notified at the time of recruitment regarding the deadline to submit their application (attached) to GCHP.

f. The CAC chairperson or vice-chair shall inquire of its members whether there are interested candidates who wish to be considered as a chairperson or vice-chair for the upcoming fiscal year.

5. CAC Nomination Process
   a. To establish a nomination ad hoc subcommittee, the CAC chairperson or vice-chair shall ask three to four members to serve on the ad hoc subcommittee. CAC members who are being considered for reappointment, cannot participate in the nomination ad hoc subcommittee.
   b. Prior to the CAC nomination ad hoc subcommittee meeting:
   c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.
   d. The CAC nomination ad hoc subcommittee shall:
      i. Review, evaluate and select a prospective chairperson, vice-chair, and a candidate for each of the open seats.
      ii. The ad hoc subcommittee shall convene to discuss and select a chairperson, vice-chair, and a candidate for each of the expiring seats using the attendance record if relevant, and the prospective candidate's references.

6. CAC Selection and Approval Process for Chairperson, Vice-Chair, and CAC Candidates
   a. On an annual basis, CAC shall select a Chairperson and Vice-Chair from its membership to coincide with the annual recruitment and nomination process.
      i. The CAC Chairperson and Vice-Chair may serve one-year terms with unlimited extensions with a vote taken by the CAC members annually.
      ii. The CAC Chairperson or Vice-Chair may be removed by a majority vote from GCHP's Commission.
   b. Upon selection of a recommendation for a Chairperson, Vice-Chair and a slate of Candidates, the ad hoc subcommittee shall forward its recommendation to the CAC for consideration.
   c. Following consideration, the CACs recommended slate of new Candidates shall be submitted to GCHP Commission for review and final approval.
   d. Following GCHP's Commission approval of CAC's recommendation, the new CAC members' terms shall be effective July 1 or at the first meeting after July.

e. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following CAC meeting.
f. GCHP shall provide new CAC members with a new CAC member orientation including information on past meetings.

D. Support to CAC Members

1. GCHP actively supports Member's participation in the CAC.
2. The support of CAC Member(s) may include and is not limited to:
   a. Childcare and/or caregiver
   b. Resources to educate CAC members to ensure they are able to effectively participate in CAC meetings
   c. Transportation
   d. Scheduling meeting at times and in formats to ensure the highest participation
   e. Interpretation and translation services
   f. Technology support

E. CAC Coordinator

1. GCHP's CAC Coordinator is the Clerk of the Board
2. The CAC Coordinator's Responsibilities:
   a. Maintain a written job description
      i. The CAC Coordinator will not be a CAC Member
      ii. CAC Coordinator will not be a GCHP Member
   b. Managing operations of the CAC in compliance with requirements
   c. Ensure CAC meetings are scheduled and agendas are developed with the input of the CAC members
   d. Maintain CAC membership that is adequate to carry out the duties of the committee including outreach, recruitment, and onboarding of new members
   e. Actively facilitate communications and connections between the CAC and GCHP leadership
   f. Confirm CAC Meetings and necessary materials are accessible to all participants
   g. Ensure compliance with CAC reporting and public posting requirements

F. CAC Meetings

1. GCHP holds quarterly CAC Meetings.
2. CAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by GCHP's conflict of interest code and, in accordance with GCHP Policy.
3. The GCHP CAC Meetings are open to the public.
4. CAC Meeting information is posted on the GCHP website observing the following timeframes
    a. Thirty (30) calendar days prior to the CAC meeting.
    b. In no event later than seventy-two (72) hours prior to the meeting.
5. GCHP provides a location and all necessary tools and materials to run the meeting.
6. CAC Meeting Minutes
    a. CAC Meeting Minutes are posted on the GCHP website.
    b. The CAC Meeting Minutes are posted on the GCHP website and submitted to DHCS no later than forty-five (45) calendar days.
    c. CAC Meeting Minutes will be retained for no less than ten (10) years.

G. Annual CAC Demographic Report

1. GCHP reports to DHCS, annually, the CAC membership composition and how it is representative of the community.
2. GCHP's Annual CAC Member Demographic Report is presented to the CAC prior to submission to DHCS by April 1 of each year.
3. The CAC Member Demographic Report includes:
    a. Demographic composition of CAC membership
    b. GCHP definition of the demographics and diversity of Members and Potential Members within the Ventura County
    c. The data sources relied upon by GCHP to validate that its CAC membership aligns with GCHP's Member demographics
    d. Barriers to and challenges in meeting or increasing alignment between CAC's membership with the demographics of the Members within GCHP's Ventura County
    e. Ongoing, updated, and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the Members within GCHP's Ventura County

f. A description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped GCHP initiatives and/or policies.

V. Attachments

A. Committee application
B. GCHP Code of Conduct
C. GCHP Conflict of Interest Code

VI. References

A. DHCS Contract Exhibit A, Attachment 9. Access and Availability, Provision 14. Community Advisory Committee or Committees (CAC)
B. DHCS Contract Exhibit A, Attachment 1. Organization and Administration of Plan, Provision 9. Member Representation
C. DHCS Contract Exhibit A, Attachment III, Section 5.211
D. PL 99-01 Community Advisory Committee
E. Ordinance Number 4409

VII. Revision History

STATUS	DATE REVISED	REVIEW DATE	REVISION SUMMARY
		10/18/2017	**Consumer Advisory Committee**
APPROVED		03/09/2018	**Dale Villani, CEO**
REVIEWED		10/02/2018	**Luis Aguilar, Member Services Manager**
REVIEWED		10/29/2018	**VCMMCC**
APPROVED		11/05/2018	**Dale Villani, CEO**
REVISED	01/30/2020		**Luis Aguilar, Member Services Manager**
APPROVED		03/04/2020	**Robert Franco, Interim Compliance Officer**
REVISED	02/16/2021		**Luis Aguilar, Member Services Manager**
APPROVED		03/09/2021	**PRC**
APPROVED		4/28/2021	**Community Advisory Committee (CAC)**
APPROVED		08/04/2021	**Margaret Tatar, CEO**
		05/03/22	**Luis Aguilar**
		5/11/22	**Policy Review Committee**

Gold Coast Health Plan Approval: Signatures on File in C360

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AGENDA ITEM NO. 4

TO: Community Advisory Committee (CAC)

FROM: Marlen Torres, Chief of Member Experience & External Affairs Officer

DATE: October 16, 2024

SUBJECT: Creation of an Ad Hoc Subcommittee for the Nomination of new members to serve on the Ventura County Medi-Cal Managed Care Commission's Community Advisory Committee

SUMMARY:

Pursuant to the Policy and Procedure of the Ventura County Medi-Cal Managed Care Commission's ("Commission") Community Advisory Committee ("CAC"), a nomination ad hoc subcommittee must be created for the selection of new members. Accordingly, staff recommends the CAC establish an ad hoc subcommittee to commence the review and selection process of new members.

BACKGROUND/DISCUSSION:

Pursuant to its bylaws, the Commission shall establish a Community Advisory Committee ("CAC") the CAC's purpose includes providing feedback and recommendations on the Commission's membership needs with a focus Model of Care and enhancing access to care and the relationships and interactions between community partners and GCHP to enhance member care. The Commission may utilize information gained from the CAC to make recommendations or address issues brought forth by the Committee.

The CAC consists of eleven (11) committee members; there are currently four (4) vacant seats. Each appointed member can serve up to three (3) two-year terms and individuals can apply for reappointment if they haven't met their term limits. Pursuant to the CAC's Policy and Procedure, an ad hoc subcommittee must be created for the selection of new members. Accordingly, staff recommends the CAC establish a nomination ad hoc subcommittee to commence the selection process of new members.

To establish a nomination ad hoc subcommittee, the CAC shall select three to four CAC members to serve on the ad hoc subcommittee. Once selected the slate of candidates will be presented at the next CAC meeting for a vote. Once approved, the slate of candidates will go to the Commission for final approval.

FISCAL IMPACT:

None.

RECOMMENDATION:

Staff recommends the CAC establish a nomination ad hoc subcommittee to commence the selection process of new members.

CONCURRENCE:

N/A.

ATTACHMENT:

1. MS-015 Community Advisory Committee

POLICY AND PROCEDURE	
TITLE: Community Advisory Committee	
DEPARTMENT: Member Services	**POLICY #:** MS-015
EFFECTIVE DATE: 10/18/2017	**REVIEW/REVISION DATE:** 01/30/20, 02/16/21, 05/03/22
COMMITTEE APPROVAL DATE: 04/28/2021	**RETIRE DATE:**
PRODUCT TYPE: Medi-Cal	**REPLACES:**
	CEO SIGNATURE:

I. Purpose

A. To define the composition and role of the Gold Coast Health Plan (GCHP) Community Advisory Committee (CAC). The role of the CAC is to be included and involved in policy decisions related to Quality Improvement, educational, operational, and cultural competency issues affecting GCHP members and groups who speak a primary language other than English.
B. The purpose of this policy is also to establish a process for recruiting, evaluating, and selecting prospective candidates for GCHP's CAC, as well as to delineate the governance of the GCHP's CAC.

II. Policy

A. GCHP complies with the contract requirement to form a CAC that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net Providers. GCHP shall ensure that the CAC is included and involved in policy decisions related to educational, operational, and cultural competency issues.
B. The CAC composition complies with the contract requirements to ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD), persons with chronic conditions (such as asthma, diabetes, congestive heart failure), are included and participate in establishing public policy within the Contractor's advisory committee or other similar committee or group.
C. The Board of Supervisors of the County of Ventura via Ordinance number 4409 established a member advisory board, CAC.

D. The composition of the CAC reflects the diversity of the population served.
E. GCHP promotes health equity and the identification and addressing of health inequities via the CAC.
F. As directed by GCHP's Commission, CAC shall report on an annual basis to the GCHP Commission and shall provide advice and recommendations to the GCHP Commission relative to GCHP's programs and initiatives.

III. Definitions

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Population Needs Assessment (PNA): Means a process for:

A. Identifying Member health needs and Health Disparities;

B. Evaluating health education, Cultural & Linguistic (C&L), delivery system transformation and Quality Improvement (QI) activities and other available resources to address identified health concerns; and

C. Implementing targeted strategies for health education, C&L, and QI programs and services.

Social Drivers of Health (SDOH): Means the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk.

Threshold Language/Threshold or Concentration Standard Languages: The non-English threshold and concentration standard languages in which GCHP is required to provide written translations of Member Information, as determined by DHCS.

IV. Procedure

A. CAC Responsibilities

1. Implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net Providers.
2. Provide information, advice, and recommendations in policy decisions related to educational, operational, and cultural competency issues.
    a. Involved in developing and updating cultural and linguistic policy and procedure decisions including QI, education, and operational and cultural competency issues affecting groups who speak a primary language other than English.
    b. Advise on necessary member or Provider targeted services, programs, and training.
    c. Provide input on selecting targeted health education, cultural and linguistic, and QI strategies.
    d. Priorities for health education and outreach program.
    e. Member satisfaction survey results
    f. Finding of Population Needs Assessment (PNA).
    g. GCHP marketing materials and campaigns.
    h. Communication of needs for Network development and assessment.
    i. Community resources and information
    j. Population Health Management
    k. Quality
    l. Health Delivery Systems Reforms to improve health outcomes

m. Carved Out Services
n. Coordination of Care
o. Health Equity
p. Accessibility of Services

3. Gather cultural and linguistic information from stakeholders and the community.
4. The CAC shall report every six months to the GCHP Commission and provide advice and recommendations to the GCHP Commission relative to GCHP's programs and initiatives.
5. Appoint CAC Member to serve as the GCHP representative to the DHCS Statewide Consumer Advisory Committee.
6. Identify and advocate for preventive care practices to be utilized by GCHP.
7. Make recommendations to GCHP regarding the cultural appropriateness of communications, partnerships, and services.
8. Review PNA findings and discuss improvement opportunities.
9. CAC Members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by GCHP's conflict of interest code and, in accordance with GCHP Policy.
10. CAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.
11. On an annual basis, CAC shall select a chairperson and vice-chair from its membership to coincide with the annual recruitment and nomination process.
12. CAC members shall attend all regularly scheduled meetings unless they have an excused absence. An absence shall be considered excused if a CAC member provides notification of an absence to GCHP staff at least four hours prior to the CAC meeting. GCHP staff shall maintain an attendance log of the CAC member's attendance at CAC meetings. Upon request from the CAC chairperson, the vice-chair, the Chief Executive Officer or the GCHP Commission, GCHP staff shall provide a copy of the attendance log to the requester. In addition, GCHP staff shall contact any committee member who has three consecutive unexcused absences. CAC member's attendance will be considered as a criterion upon reapplication.

13. GCHP leadership will participate in CAC meetings. CAC coordinator will also facilitate communication and connection between the CAC and GCHP leadership.
14. GCHP must appoint one member of the CAC, selected by the CAC, or another GCHP member designated by the CAC, to serve as GCHP representative to DHCS' Statewide Consumer Advisory Committee and consistent with Exhibit A, Attachment 5.2.11.D (Community Engagement). GCHP is responsible to compensate the CAC member representative for their time and participation on DHCS' Statewide Consumer Advisory Committee, including transportation expenses to appear in person.

B. CAC Membership

1. The CAC membership reflects the Medi-Cal population of Ventura County.
2. All CAC members shall have direct or indirect contact with GCHP Members.
3. The diversity of the CAC membership is a priority and may include, but is not limited to, individuals representing, or that represent the interest of:
    a. Adolescents
    b. Parents/Caregivers of Members under 21 years old
    c. Seniors and Persons with Disabilities (SPDs)
    d. Persons with chronic conditions (such as asthma, diabetes, congestive heart failure)
    e. Limited English Proficient (LEP) Members
    f. Members from diverse cultural and ethnic backgrounds
    g. Hard-to-reach populations, e.g., Members with physical disabilities
    h. IHS Providers
    i. Foster youth
    j. Individual representative of, or serving populations that experience Health Disparities
    k. County Health Care Agency
    l. County Human Services Agency
4. One GCHP CAC Member will participate in the DHCS Statewide Consumer Advisory Committee.
5. In accordance with the Ventura County Medi-Cal Managed Care Commission (VCMMCC), dba Gold Coast Health Plan (GCHP), CAC shall be comprised of 11 voting members, each seat representing a constituency served by GCHP.

a. Two (2) of the eleven (11) positions are standing seats and are held by the Ventura County Health Care Agency (VCHCA) and the Ventura County Human Services Agency (HSA).
b. Nine (9) members shall serve a two-year term with no limits on the number of terms a representative may serve.
c. One (1) of the positions shall be a dedicated Member seat for a Beneficiary Member or the Parent/Guardian of a Beneficiary Member less than 21 years of age.

6. The CAC members shall serve a two-year term that coincides with the GCHP's fiscal year (i.e., July 1st through June 30th).
7. The CAC shall select a chairperson and vice-chair from its membership to coincide with the annual recruitment and nomination process.
    a. The CAC chairperson and vice-chair may serve one-year terms with unlimited extensions with a vote taken by the CAC members annually.
    b. The CAC chairperson or vice-chair may be removed by a majority vote from GCHP's Commission.

C. CAC Selection Committee

1. Duties of the CAC Selection Committee
    a. Ensure the selection of CAC Members for the GCHP CAC.
    b. Validate the selection of CAC Members that reflect the general Medi-Cal population of Ventura County.

2. The CAC Selection Committee will be comprised of:
    a. Individual from the GCHP Commission
    b. Individual(s) from community-based organizations
    c. Individual(s) that bring different perspectives, ideas, and views
    d. Representatives from diverse and hard-to-reach populations
    e. Representative of or serving populations that experience Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity and sexual orientation and physical disabilities.

3. CAC Membership Selection Timeline
    a. The CAC Selection Committee must select all of its CAC Members no later than 180 calendar days from the date of the Contract with DHCS.

b. Make best efforts to replace CAC Member(s), who resigns or is otherwise unable to serve on the CAC, within 60 calendar days of the vacancy.

4. CAC Recruitment Process
   a. GCHP shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the GCHP population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.
      i. The CAC shall conduct a special recruitment effort if a seat is vacated mid-term.
      ii. Candidates that fill a vacated seat mid-term shall complete the term for that specific seat, which will be less than a full two-year term.
      iii. If a vacancy occurs three months prior to the start of the nomination process, there will be no need for a special election and the vacant seat shall become part of the nomination process.
   b. The CAC shall conduct an annual recruitment and nomination process.
      i. At the end of each fiscal year, approximately half of the CAC seats expire, alternating between four vacancies one year and five vacancies the subsequent year. The two standing seats for VCHCA and HSA are evergreen and do not expire.
      ii. The CAC shall conduct a special recruitment effort if a seat is vacated mid-term. Candidates that fill a vacated seat mid-term shall complete the term for that specific seat, which will be less than a full two-year term.
   c. GCHP shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the GCHP population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.
   d. GCHP shall recruit potential candidates utilizing a variety of notification methods, which may include, but are not limited to, the following:
      i. Outreach to the respective Member community; and
      ii. Placement of vacancy notices on the GCHP website, city halls, public libraries, and the Building Community Newsletter.
   e. An application is sent to prospective candidates and shall be notified at the time of recruitment regarding the deadline to submit their application (attached) to GCHP.

f. The CAC chairperson or vice-chair shall inquire of its members whether there are interested candidates who wish to be considered as a chairperson or vice-chair for the upcoming fiscal year.

5. CAC Nomination Process
   a. To establish a nomination ad hoc subcommittee, the CAC chairperson or vice-chair shall ask three to four members to serve on the ad hoc subcommittee. CAC members who are being considered for reappointment, cannot participate in the nomination ad hoc subcommittee.
   b. Prior to the CAC nomination ad hoc subcommittee meeting:
   c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.
   d. The CAC nomination ad hoc subcommittee shall:
      i. Review, evaluate and select a prospective chairperson, vice-chair, and a candidate for each of the open seats.
      ii. The ad hoc subcommittee shall convene to discuss and select a chairperson, vice-chair, and a candidate for each of the expiring seats using the attendance record if relevant, and the prospective candidate's references.

6. CAC Selection and Approval Process for Chairperson, Vice-Chair, and CAC Candidates
   a. On an annual basis, CAC shall select a Chairperson and Vice-Chair from its membership to coincide with the annual recruitment and nomination process.
      i. The CAC Chairperson and Vice-Chair may serve one-year terms with unlimited extensions with a vote taken by the CAC members annually.
      ii. The CAC Chairperson or Vice-Chair may be removed by a majority vote from GCHP's Commission.
   b. Upon selection of a recommendation for a Chairperson, Vice-Chair and a slate of Candidates, the ad hoc subcommittee shall forward its recommendation to the CAC for consideration.
   c. Following consideration, the CACs recommended slate of new Candidates shall be submitted to GCHP Commission for review and final approval.
   d. Following GCHP's Commission approval of CAC's recommendation, the new CAC members' terms shall be effective July 1 or at the first meeting after July.

e. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following CAC meeting.
f. GCHP shall provide new CAC members with a new CAC member orientation including information on past meetings.

D. Support to CAC Members

1. GCHP actively supports Member's participation in the CAC.
2. The support of CAC Member(s) may include and is not limited to:
   a. Childcare and/or caregiver
   b. Resources to educate CAC members to ensure they are able to effectively participate in CAC meetings
   c. Transportation
   d. Scheduling meeting at times and in formats to ensure the highest participation
   e. Interpretation and translation services
   f. Technology support

E. CAC Coordinator

1. GCHP's CAC Coordinator is the Clerk of the Board
2. The CAC Coordinator's Responsibilities:
   a. Maintain a written job description
      i. The CAC Coordinator will not be a CAC Member
      ii. CAC Coordinator will not be a GCHP Member
   b. Managing operations of the CAC in compliance with requirements
   c. Ensure CAC meetings are scheduled and agendas are developed with the input of the CAC members
   d. Maintain CAC membership that is adequate to carry out the duties of the committee including outreach, recruitment, and onboarding of new members
   e. Actively facilitate communications and connections between the CAC and GCHP leadership
   f. Confirm CAC Meetings and necessary materials are accessible to all participants
   g. Ensure compliance with CAC reporting and public posting requirements

F. CAC Meetings

1. GCHP holds quarterly CAC Meetings.
2. CAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by GCHP's conflict of interest code and, in accordance with GCHP Policy.
3. The GCHP CAC Meetings are open to the public.
4. CAC Meeting information is posted on the GCHP website observing the following timeframes
    a. Thirty (30) calendar days prior to the CAC meeting.
    b. In no event later than seventy-two (72) hours prior to the meeting.
5. GCHP provides a location and all necessary tools and materials to run the meeting.
6. CAC Meeting Minutes
    a. CAC Meeting Minutes are posted on the GCHP website.
    b. The CAC Meeting Minutes are posted on the GCHP website and submitted to DHCS no later than forty-five (45) calendar days.
    c. CAC Meeting Minutes will be retained for no less than ten (10) years.

G. Annual CAC Demographic Report

1. GCHP reports to DHCS, annually, the CAC membership composition and how it is representative of the community.
2. GCHP's Annual CAC Member Demographic Report is presented to the CAC prior to submission to DHCS by April 1 of each year.
3. The CAC Member Demographic Report includes:
    a. Demographic composition of CAC membership
    b. GCHP definition of the demographics and diversity of Members and Potential Members within the Ventura County
    c. The data sources relied upon by GCHP to validate that its CAC membership aligns with GCHP's Member demographics
    d. Barriers to and challenges in meeting or increasing alignment between CAC's membership with the demographics of the Members within GCHP's Ventura County
    e. Ongoing, updated, and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the Members within GCHP's Ventura County

f. A description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped GCHP initiatives and/or policies.

V. Attachments

A. Committee application
B. GCHP Code of Conduct
C. GCHP Conflict of Interest Code

VI. References

A. DHCS Contract Exhibit A, Attachment 9. Access and Availability, Provision 14. Community Advisory Committee or Committees (CAC)
B. DHCS Contract Exhibit A, Attachment 1. Organization and Administration of Plan, Provision 9. Member Representation
C. DHCS Contract Exhibit A, Attachment III, Section 5.211
D. PL 99-01 Community Advisory Committee
E. Ordinance Number 4409

VII. Revision History

STATUS	DATE REVISED	REVIEW DATE	REVISION SUMMARY
		10/18/2017	**Consumer Advisory Committee**
APPROVED		03/09/2018	**Dale Villani, CEO**
REVIEWED		10/02/2018	**Luis Aguilar, Member Services Manager**
REVIEWED		10/29/2018	**VCMMCC**
APPROVED		11/05/2018	**Dale Villani, CEO**
REVISED	01/30/2020		**Luis Aguilar, Member Services Manager**
APPROVED		03/04/2020	**Robert Franco, Interim Compliance Officer**
REVISED	02/16/2021		**Luis Aguilar, Member Services Manager**
APPROVED		03/09/2021	**PRC**
APPROVED		4/28/2021	**Community Advisory Committee (CAC)**
APPROVED		08/04/2021	**Margaret Tatar, CEO**
		05/03/22	**Luis Aguilar**
		5/11/22	**Policy Review Committee**

Gold Coast Health Plan Approval: Signatures on File in C360

AGENDA ITEM NO. 5

TO: Community Advisory Committee (CAC)

FROM: Ted Bagley, Chief Diversity Officer

DATE: October 16, 2024

SUBJECT: The National Committee for Quality Assurance (NCQA) Health Equity Accreditation Survey

PowerPoint with Verbal Presentation

ATTACHMENTS:

The National Committee for Quality Assurance (NCQA) Health Equity Accreditation Survey

Cultural Identification and Demographic Survey

Completion of this survey is optional.

Participant's Name:

Committee Name:

Date:

Although diverse candidates may feel uncomfortable disclosing their racial identity, there is an opportunity to bring about cultural and social awareness, which can impact the initiatives and investments related to Diversity, Equity and Inclusion. When organizations capture a participant's diversity information, it provides the organization with an opportunity to communicate where systematic barriers may exist within policies and processes, so that organizations can address areas that need improvement.
Organizations interested in achieving success with their Diversity, Equity and Inclusion initiatives must take an honest, fact-based approach to understand where they are falling short. Self-identification is an important tool that provides an avenue for individuals to share their diversity data so that organizations can implement strategies to build a culture that supports all cultures, and measure their progress towards their diversity goals.

Survey questions:

1. Can you tell us the cultural group you identify with? (Optional) Important information to insure cultural / traditional understanding.

2. What are some customs or practices that are unique to your culture?

3. Can you tell me about a tradition or holiday that is important in your culture?

4. We would love to learn more about your cultural background. What are some things you enjoy sharing with others about it?

Please select the culture / gender that you identify being a part of (optional).

Categories of Cultures:

- ☐ Hispanic Male
- ☐ White Male
- ☐ Black Male
- ☐ American Indian Male
- ☐ Native Hawaiian Male
- ☐ Filipino Male
- ☐ Asian Male
- ☐ Hispanic Female
- ☐ White Female
- ☐ Black Female
- ☐ American Indian Female
- ☐ Native Hawaiian Female
- ☐ Filipino Female
- ☐ Asian Female

This information will be retained by the Clerk of the Ventura County Medi-Cal Managed Care Commission and will be used for Diversity, Equity and Inclusion purposes **only**. It is the desire of the Commission and GCHP to consider Diversity, Equity and Inclusion in all of our initiatives.

AGENDA ITEM NO. 6

TO: Community Advisory Committee (CAC)

FROM: Guadalupe González, PhD, MPH, Sr. Director Health Education, Cultural & Linguistic Services

DATE: October 16, 2024

SUBJECT: Diversity, Equity, & Inclusion (DEI) Training Program

SUMMARY:

The purpose of the presentation is to provide an update on the Department of Health Care Services (DHCS) Diversity, Equity, and Inclusion Training Program Requirements and solicit feedback from Community Advisory Committee (CAC) members on GCHP's DEI training curriculum. Members of the CAC will receive an email with the link after the meeting to review the DEI training and a survey will be emailed to members after completion of the online DEI training videos.

RECOMMENDATION:

None

ATTACHMENTS:

1) HECL – DEI Training Program Presentation
2) Enhanced National CLAS Standards

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Community Advisory Committee (CAC) Feedback on Diversity, Equity, and Inclusion (DEI) Training Program

October 16, 2024

Guadalupe González, PhD., MPH
Sr. Director of Health Education,
Cultural and Linguistic Services

Agenda

- ❑ DHCS All Plan Letter 23-025, Diversity, Equity, and Inclusion Training Program Requirements
  - Highlight New Guidelines for Diversity, Equity, and Inclusion (DEI) Training and Education Program
- ❑ Review Current Cultural Competency and Language Access Training with DHCS and National Committee for Quality Assurance (NCQA) Health Equity Accreditation Standards
  - Cultural Humility and Implicit Bias Training
  - Clear Communication using the National Standards for Culturally and Linguistically Appropriate Services (CLAS)
  - NCQA Language Access Member, Staff, and Provider Experience with Services
  - Cultural Beliefs and Traditional Remedies
  - Chronic Health Conditions
  - Gender Affirming Care
- ❑ CAC Member Feedback on DEI Training Curriculum to be Reported in Q1 2025
- ❑ Questions

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DHCS APL 23-025 Guidelines for Diversity, Equity and Inclusion (DEI) Training and Education Program

DHCS released an All Plan Letter 23-025 in September 2023 and is currently being updated.

DHCS is asking Managed Care Plans to collect demographic data and stratify to address health inequities.

Workforce diversity and cultural responsiveness.

Eliminate health disparities within the Medi-Cal population and support policy efforts to eliminate disparities.

DEI Training will be monitored, tracked for completion, and recorded for reporting purposes.

Guidelines for DEI Training Curriculum

- Member Demographic – Specific to Ventura County
- Health Conditions by Race/Ethnicity and Region
- Seniors and Persons with Disabilities (SPD) Population
- Specialty Mental Health Services and Substance Use Disorder Needs
- Intellectual and Developmental Disabilities & Children with Special Needs
- LGBTQ+ and Gender Identity, Sexual Orientation

Reference from **APL 23-025** "The categories of DEI shall include GCHP Member demographics including, but not limited to, member's sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other person or groups defined in Penal Code section 422.56 within specific regions. "

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DEI Training Curriculum Topics

The DEI training content shall be delivered as training modules throughout following major themes:

A. Theme 1: Cultural and Linguistic Services at GCHP

B. Theme 2: Foundations of Diversity (Implicit Bias and Empathy)

C. Theme 3: Diversity, Equity, and Inclusion for Special Groups of Care:
   - Gender, LGBTQ+, Race/Ethnicity, Religion, Disability, Age Breakdown and other Groups.
   - Need for Gender Affirming Care.

D. Theme 4: Diversity, Equity, and Inclusion for Service Groups of Care, which includes learning style (e.g., visual, auditory, or written) and alternative formats (e.g., braille, large print, audio CDs, translation).

E. Theme 5: Populations Specific to Region

F. Evaluation of Effectiveness of DEI Training Program

G. Open for Feedback

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DEI Training Timeline

Phase 1: 1/1/2025

DEI Training Development: 1/24-6/24

DEI Training Program Approval: 7/24-12/24

Phase 2: 1/1/2026

Pilot DEI Training: 1/25-6/25

Completion of Training: 7/25-12/25

GCHP Provider DEI Training Modules - Website

Cultural Competency Training

Welcome to Gold Coast Health Plan's Cultural Competency Training. We created these online training modules to help you work with vulnerable populations and increase your awareness of the diverse health care needs of our membership. We hope you enjoy the training modules and we encourage you to share them with your staff and other providers.

Training Overview

GCHP is required to provide annual Cultural Competency Training to staff, participating network providers and delegated entities. The training is mandated by the state Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) to ensure staff, providers and delegated entities are meeting the unique and diverse needs of all members. All providers and GCHP staff must complete this training.

There are four training modules:

- Module 1: Language Assistance Services
- Module 2: Cultural Competency and Patient Engagement
- Module 3: Gender Identity and Transgender Health Care
- Module 4: Additional Training Resources

Upon completion of the training, you will be able to define:

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Contact us

1.888.301.1228

Gold Coast Health Plan
Attn: Claims
P.O. Box 9152
Oxnard, CA 93031-9152

Gold Coast Health Plan
Attn: Correspondence

[Cultural Competency Training Modules]

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Feedback on GCHP's DEI Online Learning Platform - Litmos

❖ ***Discrimination Prevention*** (15 minutes)

Culture Series - Discrimination Prevention 1.0

Learning objectives:

- Define discrimination
- Describe why it is a workplace issue
- Recognize the type of behaviors that could be considered as discrimination
- Describe the impact discriminations has on its victim

❖ ***Understanding Diversity, Equity and Inclusion*** (15 minutes)

Understanding Diversity, Equity and Inclusion 1.0

Learning objectives:

- Define diversity, equity, and inclusion
- Describe the dimensions of diversity
- Recognize the benefits of diversity, equity, and inclusion

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Open Feedback and Comments

Next Steps:

- Feedback on the Current Training Modules on the Website
- Feedback on the DEI Litmos Training
- Survey link will be released to CAC Members the following day
- Feedback due by October 31, 2024

Thank you!

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AGENDA ITEM NO. 7

TO: Community Advisory Committee (CAC)

FROM: Lucy Marrero, Director of Behavioral Health & Social Services

DATE: October 16, 2024

SUBJECT: Non-Specialty Mental Health Services (NSMHS): Member Outreach, Education, and Experience Requirements

PowerPoint with Verbal Presentation

ATTACHMENTS:

Non-Specialty Mental Health Services (NSMHS)

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Non-Specialty Mental Health Services (NSMHS)

Wednesday, October 16, 2024

Lucy Marrero
Director, Behavioral Health & Social Programs

Background: SB 1019

Background

- Passed by the Legislature in 2022
- DHCS released related final APL September 17, 2024

Rationale and Intent

- To address low utilization of many covered mental health benefits, the CA Legislature passed SB 1019
- Aims to address gaps in low utilization of Non-Specialty Mental Health Services (NSMHS) by ensuring Members & primary care providers (PCPs) are aware of all covered NSMHS.
- Provides a framework to address gaps in utilization by ensuring the cultural and linguistic appropriateness of outreach and education.

Bill Requirements

- MCPs to develop Member and Primary Care Outreach and Enrollment Plans; post to website, informed by key stakeholders; updated annually
- DHCS to assess enrollee experience with covered mental health benefits once every 3 years
- DHCS to publish report every 3 years beginning April 2026 on consumer experience with covered mental health benefits

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APL 24-012 Requirements

MCPs must develop an outreach and education plan for their Members regarding covered NSMHS that is informed by, but not limited, to the following:

- The MCP's stakeholders, including the community advisory committee (CAC) established by the MCP and Quality Improvement and Health Equity Committee (QIHEC). MCPs must attest to convening with their CACs to develop their outreach and education plans, and MCP attestations must be included with the outreach and education plans submitted to DHCS.
- Most recently approved DHCS Population Needs Assessment as defined by the Population Health Management (PHM) Policy Guide
- A utilization assessment of provided NSMHS that is, at a minimum, stratified and analyzed by race, ethnicity, language, age, sexual orientation, gender identity, and disability.

MCP Timeline

- MCP Outreach and education plans are due to the DHCS December 31, 2024.
- MCPs post plan to website and begin outreach and education plan implementation by January 1, 2025.
- MCPs must update plan annually and conduct outreach and education of NSMHS on an annual basis.

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Stakeholder Engagement in Plan Development

Develop plan for Members regarding covered NSMHS that is informed by, but not limited to, the following:

- Community Advisory Committee (CAC) *plan submission must include attestation of convening CAC
- Quality Improvement and Health Equity Committee (QIHEC).
- MCPs should coordinate with County Mental Health Plan (MHP) to educate Members on how to access services.
- Tribal liaisons

MCPs may also consider partnering with the following groups:

- CBOs
- Navigators
- CHWs
- Promotores / Promotoras
- Other providers trained to conduct outreach and education

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NSMHS Outreach & Education Plan: Deliverables

- Member Outreach and Education Plan (informed by CAC,QIHEC, MCH, Tribal Liaison)
- PCP Outreach and Education Plan (informed by QIHEC, DEI Training Program Requirements in APL 23-025)
- NSMHS Utilization Assessment
- Website Posting (DHCS-approved Member and PCP Outreach and Education Plan, Utilization Assessment)

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Ventura County Key Players in Behavioral Health Medi-Cal System

MILD TO MODERATE

Medi-Cal Beneficiaries with **mild-to-moderate distress**

Services include outpatient therapy and medication management, Applied Behavioral Analysis (ABA), through their MCP. Also called Nonspecialty Mental Health Services (NSMHS)

MORE SEVERE

Medi-Cal Beneficiaries with **Serious Mental Illness/Serious Emotional Disturbance in need of more intensive treatment**, such as wraparound, day treatment, or inpatient care, are treated through their county Specialty Mental Health Plan

SUBSTANCE USE SERVICES

Youth and adults in need of substance use treatment at all levels

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CAC Discussion Questions

What do you see as the biggest barriers that our members face to accessing mental health services?

Can you share a specific example of a Medi-Cal member you know of who had trouble finding services?

What is working well? What would you like to see more of?

How would you change the system if you could make any changes you like?

What else should we know?

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AGENDA ITEM NO. 8

TO: Community Advisory Committee (CAC)

FROM: Pauline Preciado, Executive Director, Population Health & Equity
David Tovar, Incentive Strategy Manager

DATE: October 16, 2024

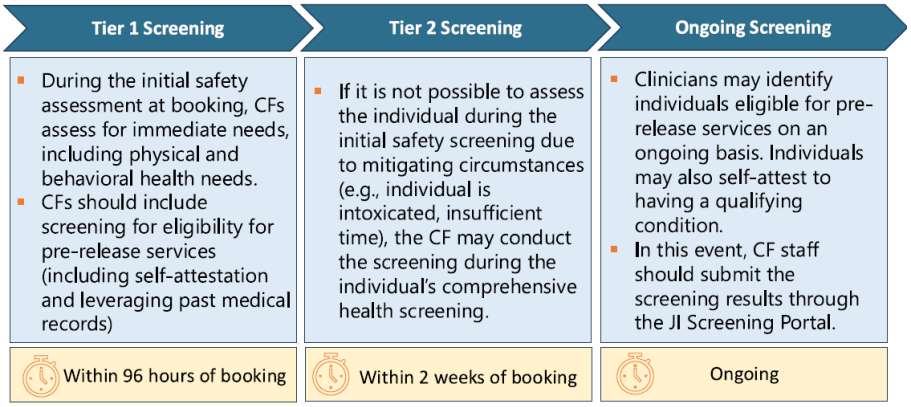
SUBJECT: Implementation Update: Justice Services

Implementation Update: Justice Services – October 2024

On October 1, 2024, the Justice-Involved Reentry Initiative went live in California. Inyo, Santa Clara, and Yuba Counties all went live at the beginning of the month launching this first in the nation initiative. In January of 2025 Orange, San Joaquin, and Siskiyou intend to go live for the second cohort of counties with 90-day pre-release services in their county jails and correctional facilities.

As these counties move forward to provide 90-day pre-release services DHCS has launched a series of technical assistance sessions to assist all of the statewide Justice Initiative (JI) partners to understand and implement these programs and services. Starting in August and moving through December, the Department of Health Care Services (DHCS) is leading a JI Learning Collaborative, with six sessions currently scheduled. Each of the sessions focus on specific portions of the JI program, this includes the new DHCS JI Screening Portal and Short-Term Model, Billing, Behavioral Health Services, Non-Behavioral Health Services (Physical Health), Enhanced Care Management for the JI Population of Focus, and Pharmacy Benefits. DHCS has stated they will continue this series into 2025, with additional topics. Each of these sessions includes a general office hour for all JI partners which include managed care plans, behavioral health, human services, sheriff and probation departments.

A major announcement from DHCS is the launch of the DHCS JI Screening Portal. This screening portal will operate between correctional facilities and DHCS to allow for bi-directional data sharing. The portal was created to enter and confirm information related to Medi-Cal enrollment status, pre-release services eligibility, and release dates. Correctional facilities are expected to screen all Medi-Cal eligible individuals for pre-release services and input results into the portal.



Of upmost importance to managed care plans is that the Screening Portal will Identify individuals and allow DHCS to place new JI aid codes on the 837 file and allow for the activation of individual's Medi-Cal upon release. This new tracking capability will ensure that when a member is released from a facility, they are able to be engaged by the post-release ECM care manager, immediately receive services like substance use treatment, and access primary care services. The portal once used by our local facilities will expedite access to care for this population and assist GCHP and its providers to care for our members.

As DHCS releases new information we will continue to keep this committee updated and informed about the latest developments related to the DHCS Justice Initiative.

AGENDA ITEM NO. 9

TO: Community Advisory Committee (CAC)

FROM: Marlen Torres, Chief of Member Experience & External Affairs Officer

DATE: October 16, 2024

SUBJECT: Expansion Population Outreach Strategies Update

PowerPoint with Verbal Presentation

ATTACHMENTS:

Adult Expansion: Health Risk Assessment

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Adult Expansion: Health Risk Assessments

October 16, 2024

Marlen Torres
Chief Member Experience & External Affairs Officer

Adult Expansion – HRAs

Completed 4,122 HRAs for 26-49 Yrs

Completed 349 for 50+ Years

Referrals made to Care Management, Enhanced Care Management, and Health Education

Total Active Members 26-49

Expansion Population – 19,446

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HRA Summary Statistics

23.1% OF MEMBERS IN **FAIR OR POOR HEALTH**

ONLY 43.9% OF MEMBERS **ALWAYS** GET THE CARE THEY NEED

5.9% OF MEMBERS HAD BEEN TO THE **ER OR HOSPITAL** IN THE PAST 30 DAYS

12.5% OF MEMBERS COULD USE **A LITTLE OR A LOT MORE** HELP WITH ACTIVITIES OF DAILY LIVING (ADLS)

13.8% OF MEMBERS HAVE **DIFFICULTY CONCENTRATING, REMEMBERING OR MAKING DECISIONS** BECAUSE OF A PHYSICAL MENTAL OR EMOTIONAL CONDITION

12.0% OF MEMBERS SCREENED AT RISK FOR MAJOR DEPRESSIVE DISORDER ON THE **PHQ-2**

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HRA Summary Statistics

18.4% of Members have an unstable living situation

53.9% of Members were sometimes or often worried they would run out of food

17.0% of Members had a transportation barrier

4.6% of Members were rarely, sometimes, fairly often, or frequently physically hurt by a family member or friend

47.6% of Members have seasonal or migrant farm work as their main source of income

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AGENDA ITEM NO. 10

TO: Community Advisory Committee (CAC)

FROM: Dr. James Cruz, MD, Interim Chief Medical Officer
Kim Timmerman, Sr. Director Quality Improvement
Helen Chtourou, QI Program Manager III

DATE: October 16, 2024

SUBJECT: MCAS Measures and Interventions: Chronic Disease Management and Preventive Screenings

PowerPoint with Verbal Presentation

ATTACHMENTS:

MCAS Measures and Interventions: Chronic Disease Management and Preventive Screenings

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

MCAS Measures and Interventions: Chronic Disease Management and Preventive Screenings

October 16, 2024

Helen Chtourou, QI Program Manager III

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Addressing Health Disparities

Seeking feedback from the Community Advisory Committee on interventions that are culturally & linguistically appropriate to address health disparities on specific quality measures related to chronic disease management and preventive screenings.

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Managed Care Accountability Set (MCAS) Measures

- MCAS is a set of 42 performance measures selected by the Department of Health Care Services (DHCS) that Medi-Cal Managed Care Plans report annually.
- Some measures must meet the DHCS minimum performance level (MPL) benchmark which is generally the 50th national Medicaid percentile.

Measure	2022	2023	2022-2023 Rate Change	Met DHCS MPL
Child and Adolescent Well-Care (WCV)	42.33%	49.49%	+7.16	Yes
Asthma Medication Ratio (AMR)	52.41%	46.80%	-5.61	No
Controlling Blood Pressure (CBP)	60.34%	62.26%	+1.95	Yes
Hemoglobin A1c Poor Control (>9.0) for Patients with Diabetes (Lower Rate is Better)	35.04%	28.71%	-6.33	Yes
Colorectal Cancer Screening (COL-E)	29.93%	32.04%	+2.44	NA –Not Held to DHCS MPL

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Child and Adolescent Well-Care Visits (WCV)

- Measures the percentage of children 3 to 21 years of age that had an annual well-care exam
- Groups with lowest rates of annual well-care exams
  - Age group 19 to 21
  - Males
  - Non-Hispanic
  - English speakers
- Interventions
  - Member outreach to schedule appointments
  - $25 gift card reward program for completing annual exam
  - Member birthday letter

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Asthma Medication Ratio (AMR)

- Measures the percentage of members ages 5 to 64 who have asthma and had a greater than 50% ratio of controller asthma medications to total asthma medications.
  - It assesses if asthma was managed appropriately with controller medications.
  - If the AMR ratio is less than 50%, it may indicate the member is using too much rescue medication and their asthma is not controlled.
- Groups with lowest AMR rates
  - Age groups 5 to 9 and 20 to 29
  - Males
  - Hispanic
  - Spanish speakers

- Interventions
  - Provider & member education on asthma medication management
  - Member outreach programs to coordinate care and schedule appointments
  - Chronic Disease Self-Management Programs

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Controlling Blood Pressure (CBP)

- Measures the percentage of members 18 to 85 years of age with high blood pressure whose blood pressure was adequately controlled at less than 140/90.
- Groups with lowest rates of controlled blood pressure
  - Age group 20 to 39
  - Males
  - Non-Hispanic
  - English speakers

- Interventions
  - Promote the BP cuff benefits for members to monitor blood pressure at home and report blood pressure to doctor
  - Provider education on best practice guidelines for taking blood pressures and documenting in the medical record.
  - Chronic Disease Self-Management Programs

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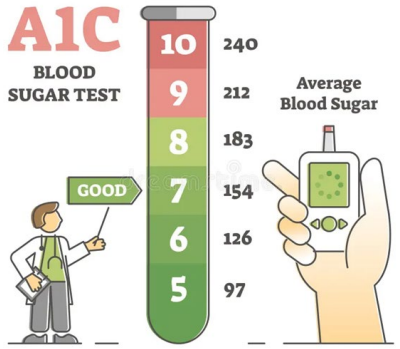
Hemoglobin A1C Poor Control for Patients with Diabetes (HBD)

- Measures the percentage of members 18 to 75 years of age with diabetes and poor HbA1c control greater than 9.0%
- Groups with highest rate of poor HbA1c control
  - Age group 20 to 29
  - Males
  - Non-Hispanic
  - English speakers



- Interventions
  - Member reward program to complete HbA1c blood sugar tests
  - Collect HbA1c tests at health fairs
  - Evaluate efficacy of home test kits
  - Chronic Disease Self-Management Programs

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Colorectal Cancer Screening (COL)

- Measures the percentage of members 45 to 75 years of age who had a colorectal cancer screening.
- Groups with lowest rates of colorectal cancer screenings
  - Age group 46 to 49
  - Males
  - Non-Hispanic
  - English speakers
- Interventions
  - Member outreach to schedule screening appointments
  - Evaluate efficacy of home test kit options

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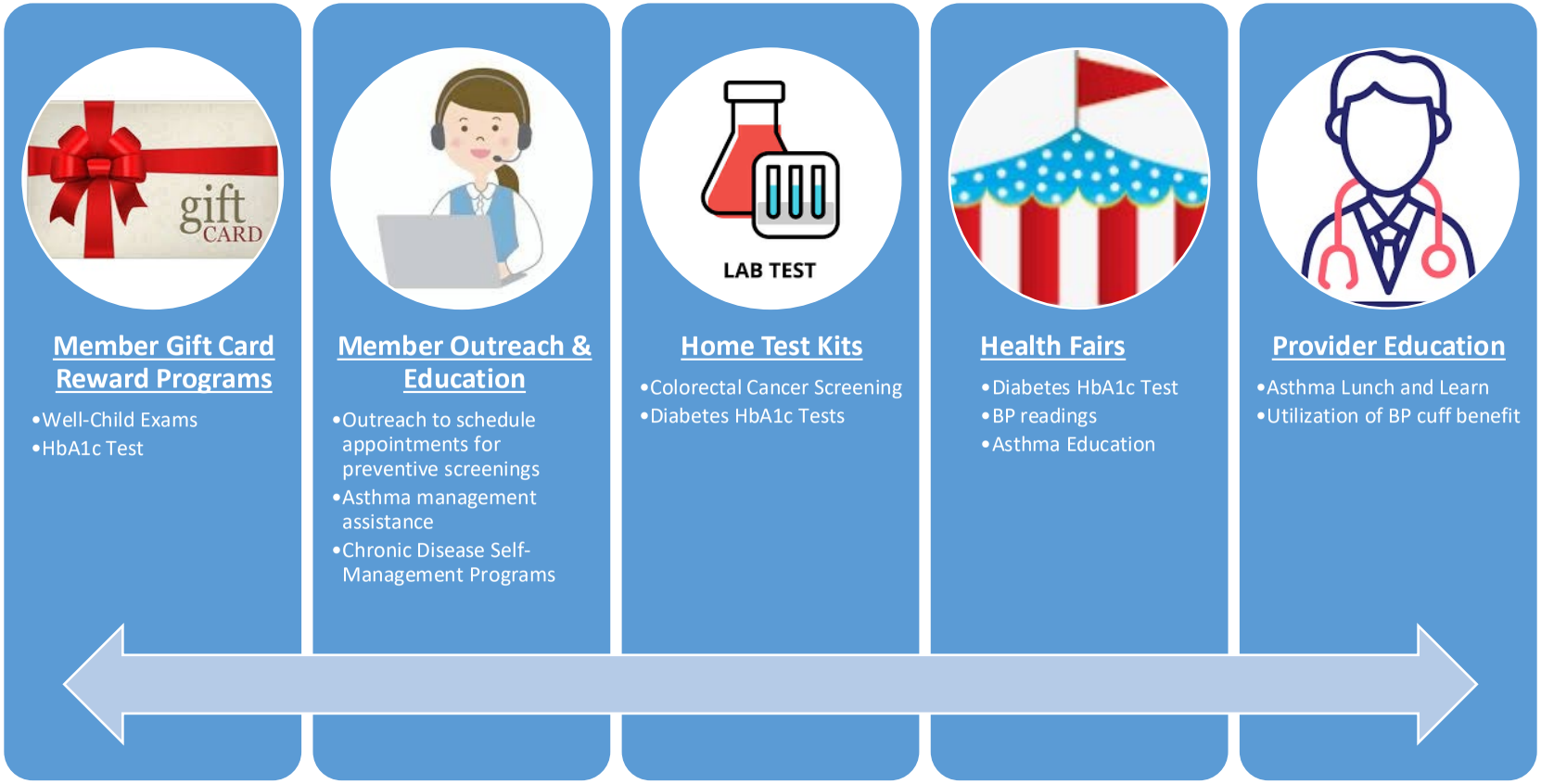
Summary of Interventions



1. Are these the right interventions for these measures for the disparity populations?
2. What barriers need to be considered in developing interventions to improve measure performance and member outcomes?

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AGENDA ITEM NO. 11

TO: Community Advisory Committee (CAC)

FROM: Kimberly Marquez-Johnson, Director of Dual Special Needs Plan

DATE: October 16, 2024

SUBJECT: Dual Eligible Special Needs Plan (D-SNP) Member Journey & Model of Care Review

PowerPoint with Verbal Presentation

ATTACHMENTS:

Dual Eligible Special Needs Plan (DSNP) Update

Gold Coast Health Plan℠
A Public Entity

Gold Coast Health Plan Dual Eligible Special Needs Plan (DSNP) Update

October 16, 2024

Kimberley Marquez-Johnson, Director DSNP

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Respect

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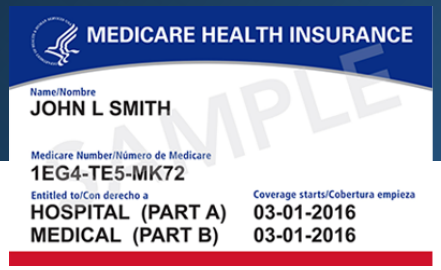
Coverage for People with Medicare and Medi-Cal (Duals)



Federal health insurance program for people aged 65 or older and younger people with certain disabilities. Services covered include:

- **Medicare Part A:** Inpatient care in hospitals and skilled nursing facilities (not custodial or long-term care), some home health care.
- **Medicare Part B:** Medically necessary doctors' services, outpatient care, home health services, durable medical equipment, mental health services, and other medical services.
- **Medicare Part D:** Prescription drugs.

Medicare Advantage (MA) Plans include Part A and Part B, and additional benefits such as vision, hearing, and dental, bundled together in one plan. MA plans usually cover prescription drugs (Medicare Part D) as well in an Medicare Advantage Part D (MAPD) Plan.

California's version of the Federal Medicaid program that offers no-cost and low-cost health coverage to people based on low income or other needs.

Benefits include:

- Doctor visits
- Emergency services and hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Laboratory services, such as blood tests
- Programs such as physical therapy
- Medical supplies and devices
- Children's services, including oral and vision care
- In-home care and other long-term services and supports

Options for California's Duals: Medi-Medi Plans

Medicare Medi-Cal Plans (Medi-Medi Plans) are a type of Medicare Advantage plan in California that are only available to dual eligible beneficiaries.

Beneficiaries enrolled in a Medi-Medi Plan receive their Medicare benefits through a Dual Eligible Special Needs Plan (D-SNP) and their Medi-Cal benefits through a Medi-Cal Managed Care Plan (MCP).

The Federal goverment calls this type of plan and Exclusively Aligned Enrollment (EAE) D-SNP.

D-SNP + MCP
Medi-Medi Plan

D-SNPs provide Medicare services, such as:

- Hospitals
- Providers
- Prescription drugs

MCPs provide wrap-around services, such as:

- Medicare cost-sharing
- Long-Term Services and Supports (LTSS)
- Transportation

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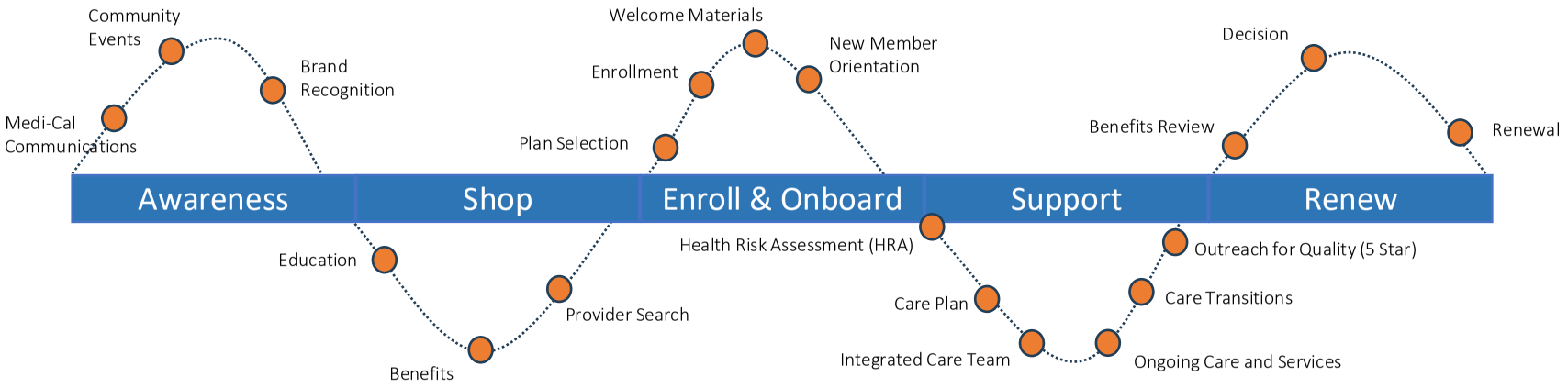
Member Journey Through the Future Gold Coast Health Plan D-SNP



Benefit design, provider network contracts, vendor contracts for pharmacy benefit management and supplemental benefits, and other costs combine to form a bid that is submitted to Medicare.

The Model of Care supports the member from the moment they enroll in the plan through their renewal or disenrollment improving health outcomes and supports medical cost management.

Plans that connect members with ongoing high quality care and receive higher reimbursement from Medicare through risk adjustment and quality bonuses.

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Your Input on Stakeholder Engagement

As we build our D-SNP we are engaging with stakeholders on:

1. Benefit Design
2. Network Design
3. Model of Care Design

We are seeking your input on which stakeholders we should engage and how best to engage.

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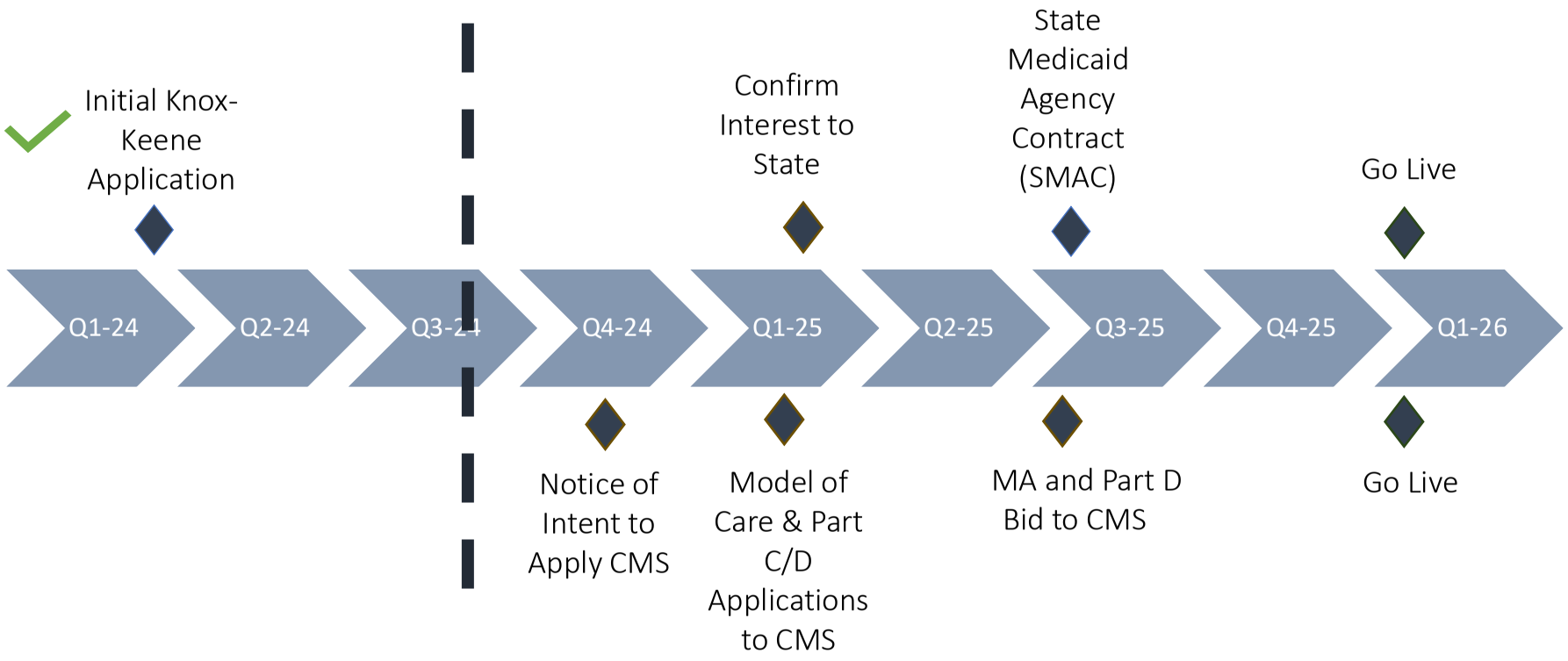
Regulatory Schedule Timeline

There are several regulatory requirements steps that must be completed and obtain with DMHC, CMS, and DHCS for GCHP to operate as an Exclusively Aligned Enrollment(EAE) D-SNP, Medi-Medi Plan starting on January 1, 2026.



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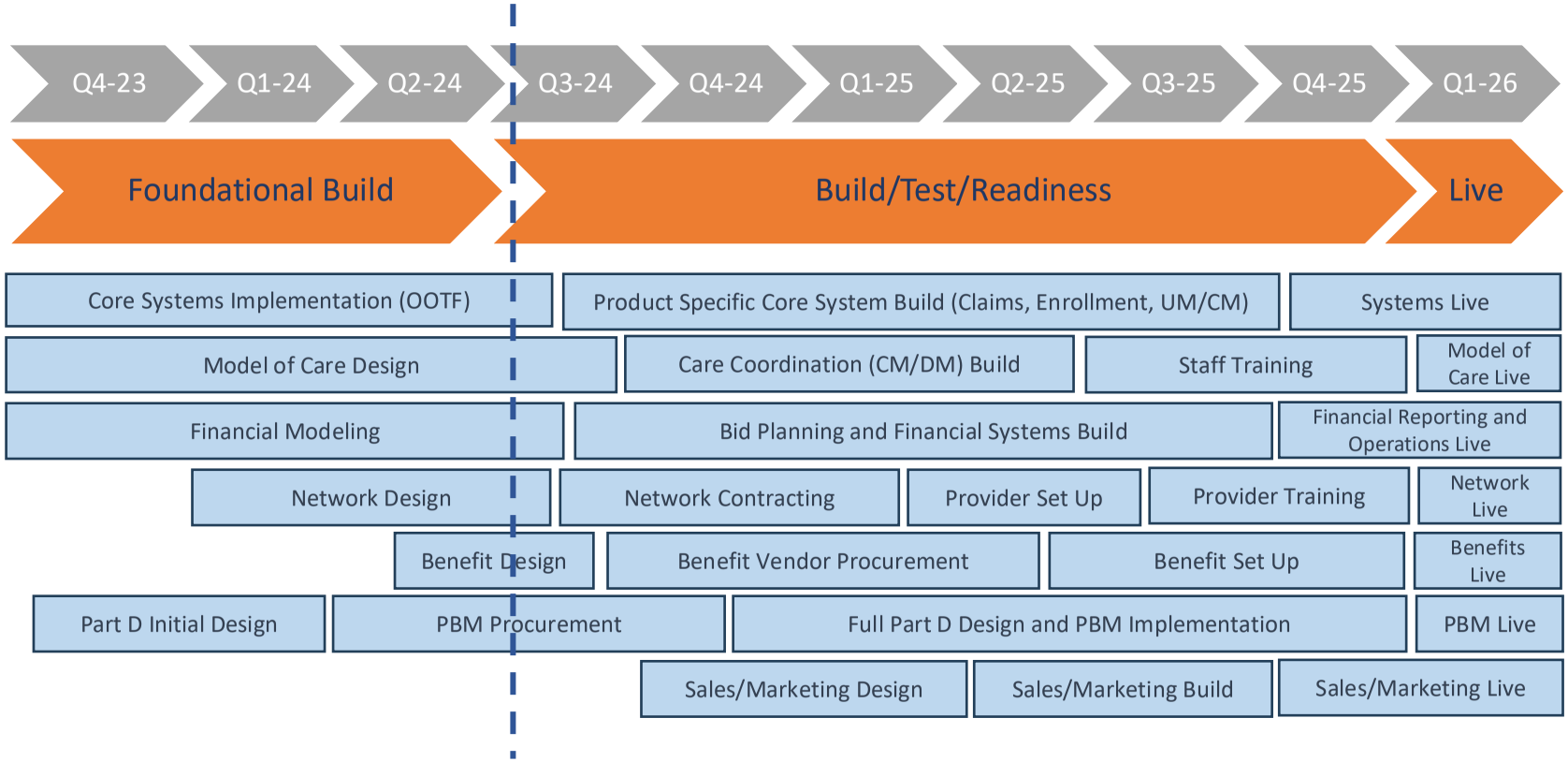
D-SNP Operations and Systems Implementation

We have completed most of the foundational work and will soon embark on operations and systems build.



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Appendix

The following items are provided for background and definition:

1. What is Medicare Advantage (MA)?
2. How are MA Plans Paid?
3. What is 5 Star?
4. What is a Pharmacy Benefit Manager (PBM)?
5. What is a D-SNP?
6. What is a Model of Care?
7. What is a Knox Keene License?

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1. What is a Medicare Advantage Plan?

Citation: Christina Ramsay, Gretchen Jacobson, Steven Findlay, and Aimee Cicciello, "Medicare Advantage: A Policy Primer, 2024 Update" (explainer), Commonwealth Fund, Jan. 31, 2024. https://doi.org/10.26099/69fq-dy8

Medicare Advantage plans are private health insurance plans paid by the federal government to provide Medicare-covered benefits as an alternative to "traditional" or "original" Medicare.

Most Medicare Advantage plans are either **HMOs,** which generally cover only care provided by in-network doctors, hospitals, and other health providers, or by **PPOs,** which also offer access to out-of-network providers but at a higher cost than in-network providers.

Covered benefits. Medicare Advantage plans must cover all services covered by traditional Medicare under Part A (hospital services, some home health, hospice care, skilled nursing care) and Part B (physician services, durable medical equipment, outpatient drugs, mental health, ambulance services). The vast majority of plans (89% in 2024) also cover Part D prescription drug benefits. Most plans offer additional benefits such as eyeglasses, hearing aids, and some coverage of dental care, such as cleanings.

In 2020, the government began allowing Medicare Advantage plans to include a wide range of telehealth benefits as part of their basic benefit package. Some plans also cover fitness club memberships, caregiver support, meal delivery, or acupuncture.

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2. How are MA Plans Paid?

Citation: Christina Ramsay, Gretchen Jacobson, Steven Findlay, and Aimee Cicciello, "Medicare Advantage: A Policy Primer, 2024 Update" (explainer), Commonwealth Fund, Jan. 31, 2024. https://doi.org/10.26099/69fq-dy8

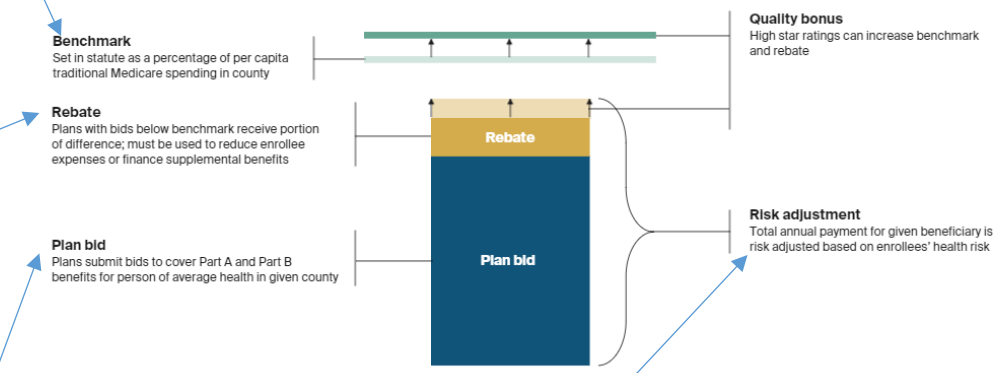
Benchmarks. Plan benchmarks are the maximum amount the federal government will pay a Medicare Advantage plan. Benchmarks are set in statute as a percentage of traditional Medicare spending in a given county, ranging from 115 percent to 95 percent. Special Needs Plans and other Medicare Advantage plans are paid in the same manner, with the same benchmarks.

Rebates. If a plan's bid is *below* the local benchmark — as is the case for the majority of plans — then the plan keeps part of the difference between the bid and benchmark. This amount, called the rebate, is equivalent to a shared savings between the federal government and plans. Plans are required to use the rebate to lower patient cost sharing, lower premiums, or provide some coverage for benefits not included in traditional Medicare. Rebate dollars also can be used to pay for administrative expenses and profits associated with providing additional benefits.

Bids. Health insurance companies bid every year to enroll Medicare beneficiaries in their Medicare Advantage plans. That bid is based on companies' assessment of their costs to provide Part A and Part B services to the average beneficiary.

Quality adjustments. Quality ratings affect benchmarks as well as rebate size.. Benchmarks are raised by 5 percent for plans with four or more stars and, in certain counties, are increased by 10 percent for plans with high ratings. For the rebate, plans with three stars or fewer receive 50 percent of the difference between the bid and the benchmark; plans with three-and-a-half or four stars receive 65 percent of the difference; and plans with four-and-a-half or five stars receive 70 percent of the difference

Medicare Advantage payments are based on a system of benchmarks, bids, and quality incentives.



Source: Christina Ramsay, Gretchen Jacobson, Steven Findlay, and Aimee Cicciello, *Medicare Advantage: A Policy Primer, 2024 Update* (Commonwealth Fund, Jan. 2024). https://doi.org/10.26099/69fq-dy83

Risk adjustment. Both the rebate and the bid amount are "risk adjusted" to account for enrollees' health status. Payment is affected by each beneficiary's risk score, which represents the expected cost of each enrollee relative to the cost of the average Medicare beneficiary. Thus, the average enrollee has a risk score of 1.0. An older person with multiple chronic conditions would have a risk score above 1.0, whereas a younger person with no health issues would have a risk score below 1.0.

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3. What is 5 Star and What Are the 2026 Measures?

The Centers for Medicare & Medicaid Services (CMS) establishes a set of 45 quality measures for Medicare Advantage (Medicare Part C) and Medicare Part D plans. Measures have different weights and measure health outcomes as well as processes. The Star Ratings system helps Medicare consumers compare the quality of Medicare health and drug plans being offered so they are empowered to make the best health care decisions for them. An important component of this effort is to provide Medicare consumers and their caregivers with meaningful information about quality alongside information about benefits and costs to assist them in being informed and active health care consumers. Highly quality plans (4 Star or higher) receive quality bonus payments.

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Table 2. 2026 Star Ratings Part D Measures and Measure Weights

Measure Name	Weighting Category	Part D Summary and MA-PD Overall Weight
Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2
Complaints about the Drug Plan	Patients' Experience and Complaints Measure	2
Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2
Drug Plan Quality Improvement	Improvement Measure	5
Rating of Drug Plan	Patients' Experience and Complaints Measure	2
Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	2
MPF Price Accuracy	Process Measure	1
Medication Adherence for Diabetes Medications	Intermediate Outcome Measure	3
Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measure	3
Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measure	3
MTM Program Completion Rate for CMR	Process Measure	1
Statin Use in Persons with Diabetes (SUPD)	Process Measure	1

Source: https://www.cms.gov/files/document/2026-star-ratings-measures.pdf

Table 1. 2026 Star Ratings Part C Measures and Measure Weights

Measure Name	Weighting Category	Part C Summary and MA-PD Overall Weight
Breast Cancer Screening	Process Measure	1
Colorectal Cancer Screening	Process Measure	1
Annual Flu Vaccine	Process Measure	1
Improving or Maintaining Physical Health	Outcome Measure	1*
Improving or Maintaining Mental Health	Outcome Measure	1*
Monitoring Physical Activity	Process Measure	1
Special Needs Plan (SNP) Care Management	Process Measure	1
Care for Older Adults – Medication Review	Process Measure	1
Care for Older Adults – Pain Assessment	Process Measure	1
Osteoporosis Management in Women who had a Fracture	Process Measure	1
Diabetes Care – Eye Exam	Process Measure	1
Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3
Kidney Health Evaluation for Patients with Diabetes	Process Measure	1
Controlling Blood Pressure	Intermediate Outcome Measure	3
Reducing the Risk of Falling	Process Measure	1
Improving Bladder Control	Process Measure	1
Medication Reconciliation Post-Discharge	Process Measure	1
Plan All-Cause Readmissions	Outcome Measure	3
Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1
Transitions of Care	Process Measure	1
Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Process Measure	1
Getting Needed Care	Patients' Experience and Complaints Measure	2
Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	2
Customer Service	Patients' Experience and Complaints Measure	2
Rating of Health Care Quality	Patients' Experience and Complaints Measure	2
Rating of Health Plan	Patients' Experience and Complaints Measure	2
Care Coordination	Patients' Experience and Complaints Measure	2
Complaints about the Health Plan	Patients' Experience and Complaints Measure	2
Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2
Health Plan Quality Improvement	Improvement Measure	5
Plan Makes Timely Decisions about Appeals	Measures Capturing Access	2
Reviewing Appeals Decisions	Measures Capturing Access	2
Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2

*Measure has a weight of 1 for the 2026 Star Ratings because it is considered a new measure.

4. What is a Pharmacy Benefit Manager (PBM)?

sources:
JAMA Health Forum. 2023;4(11):e233804. doi:10.1001/jamahealthforum.2023.3804
https://www.medicare.gov/drug-coverage-part-d/what-medicare-part-d-drug-plans-cover

PBMs are companies that manage prescription drug benefits for health insurers, Medicare Part D drug plans, self-insured employers, and other payers, such as state Medicaid programs. They provide useful services in a very complex environment.

Formulary Development/Management
The formulary specifies which drugs the PBM will cover and the associated patient-level costs when the drug is dispensed. Formularies are typically developed by a committee of pharmacists and physicians, often called a pharmacy and therapeutics committee.

All MA plans must cover a wide range of prescription drugs that people with Medicare take, including most drugs in certain protected classes," like drugs to treat cancer or HIV/AIDS. Each plan has its own formulary with drugs placed into different levels, called "tiers," on their formularies. Drugs in each tier have a different cost. For example, a drug in a lower tier will generally cost less than a drug in a higher tier.

Utilization Management (UM)
UM encompasses several common practices, including prior authorization, step therapy requirements, supply limits (on dosage or number of days), and various financial incentives (eg, deductibles, co-payments, coinsurance).

Negotiated Rates
PBMs negotiate with pharmacies, wholesalers, and drug manufacturers on behalf of plans. Drug manufacturers offer rebates and discounts to ensure that their branded (high-cost) pharmaceuticals are included in a formulary and/or placed on a preferred tier.

Pharmacy Network
PBMs create and manage a network of pharmacies (including specialty pharmacies) at which members can access prescriptions. The PBM generally ensures that beneficiaries have access to a mix of local retail pharmacies, and specialty pharmacies.

Mail Order
Mail order services enable members to receive medications delivered to their homes. This is usually for routine medications and is a convenient way for people with transportation barriers to easily obtain medications.

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5. What are SNPS and What is a D-SNP?

Special Needs Plans (SNPs) are a type of Medicare Advantage (MA) coordinated care plan designed for individuals with special needs. Initially authorized with the passage of The Medicare Modernization Act of 2003 , SNPs established a type of MA coordinated care plan specifically designed to provide targeted care to individuals with special needs. These individuals' conditions were defined as: 1) institutionalized individuals; 2) 'dual eligibles' (for Medicare and Medicaid); and/or 3) individuals with severe or disabling chronic conditions, as specified by the Centers for Medicare and Medicaid Services.

Congress intended SNPs to exclusively or disproportionately enroll persons with serious chronic conditions to more effectively serve high-risk populations through specialization and a comprehensive benefit offering (SNPs must offer Medicare Parts A, B, and D benefits). These plans function under most of the same Medicare Advantage regulations, with some exceptions, and use the same payment methodology as other MA plans.

- SNPs can limit enrollment to targeted special needs individuals.
- Dually eligible and institutionalized beneficiaries may enroll and disenroll throughout the year rather than only during open enrollment period,
- Plans must submit and adhere to an approved Model of Care (MOC) for all beneficiaries enrolled in any SNP type.
- SNPs integrating Medicare and Medicaid benefits may target enrollment to certain subsets of dual beneficiaries.

Dual Eligible Special Needs Plans (D-SNPs) are MA plans that enroll individuals dually eligible for Medicare and Medicaid.

There are four types of D-SNPs each with varying levels of coordination and integration (types of D-SNPs are Coordination Only, Exclusively Aligned Enrollment, Highly Integrated, and Fully Integrated).

D-SNPs must have existing, executed contract(s) with state Medicaid agencies (SMAs), and must coordinate and integrate all services and benefits covered by Medicare and Medicaid.

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Source: https://snpalliance.org/what-we-do/about-snps/

6. What is a Model of Care (MOC)?

Every SNP must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). The MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices. The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes.

There are four SNP MOC elements (specific requirements and scoring guidelines are available at https://snpmoc.ncqa.org/scoring-guidelines-latest):

MOC 1: Description of the Population—Demonstrates understanding of their experience and needs	MOC 3: Network—Relevant facilities and providers to address unique and specialized needs
MOC 2: Care Coordination—Ensures that needs and preferences are met	MOC 4: Quality and Performance Improvement—Continuously improve ability to deliver services and care

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7. What is a Knox Keene License?

What is a Knox-Keene License?

A Knox-Keene license is a license obtained through the Department of Managed Health Care ("DMHC") pursuant to California's Knox-Keene Health Care Service Plan Act and its implementing regulations (collectively, the "Knox-Keene Act"). The Knox-Keene Act requires California managed care plans to obtain a license from the DMHC to operate in the State of California.

What is the Scope of DMHC's Regulation of GCHP for its D-SNP under the Knox-Keene Act?

Because GCHP is exempt from licensure for its Medi-Cal line of business, DMHC's primary focus is on the GCHP's financial viability and contracts with vendors and providers. It does not enforce network access or quality; those activities fall under the purview of DHCS and CMS.

Why doesn't Gold Coast Health Plan ("GCHP") have a license, and why does GCHP need one now?

The Ventura County Medi-Cal Managed Care Commission d.b.a. Gold Coast Health Plan was created as a County Organized Health Care System ("COHS") to deliver managed care services to Medi-Cal beneficiaries. In COHS counties, a single plan serves all Medi-Cal beneficiaries who are enrolled in managed care. Under California law, COHS are exempt from Knox-Keene licensure for their Medi-Cal line of business.

However, in order to offer a Dual-Special Needs Plan ("D-SNP"), GCHP must obtain approval from the federal Centers for Medicare and Medicaid Services ("CMS"). CMS requires that health plans obtain state licensure before they receive approval from CMS to offer D-SNP plans, and similarly, the Knox-Keene Act requires a license for Medicare lines of business. Therefore, applying for an obtaining a Knox-Keene license is one of the first steps in implementation of the D-SNP.

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Footnote: While there are other Knox-Keene license types, such as restricted Knox-Keene licenses, those restricted Knox-Keene licenses are for provider organizations that bear global risk (i.e., Risk Bearing Organizations) and not health care service plans.