Gold Coast Health Plan Total Care Advantage D-SNP HMO

GOLD COAST HEALTH PLAN
TOTAL Care ADVANTAGE℠

PROVIDER MANUAL 2026

For questions and Gold Coast Health Plan information,
please call 1-888-301-1228 | www.goldcoasthealthplan.org

GOLD COAST HEALTH PLAN TOTAL Care ADVANTAGE℠

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SECTION 1: Welcome to Gold Coast Health Plan Total Care Advantage (HMO D-SNP)

Gold Coast Health Plan Vision Statement:

Compassionate Care, Accessible to All, for the Health of Our Community.

Gold Coast Health Plan Mission Statement:

To improve the health of our members through the provision of high quality care and services.

Gold Coast Health Plan (GCHP) is a County Organized Health System (COHS) that administers the Medi-Cal program and an Exclusively Aligned Enrollment (EAE) Dual Special Needs Plan (D-SNP), Total Care Advantage, in Ventura County. The Plan is governed by the Ventura County Medi-Cal Managed Care Commission (VCMMCC). The commission meets monthly to review local concerns about healthcare issues, receive advisory input, and revise GCHP policies, as appropriate. GCHP's policies are responsive to local input due to the plan's local governance and operations.

Organization of the Provider Manual

This Provider Manual outlines GCHP operational policies and procedures and responsibilities as a provider in the Total Care Advantage Network. The manual is updated annually and is available on the GCHP **website**.

Additionally, GCHP mentions any Provider Manual updates and/or revisions in the electronically distributed Provider Operations Bulletin.

If you have ideas or suggestions for ways GCHP can improve its service to providers or members, please email them to **ProviderRelations@goldchp.org**.

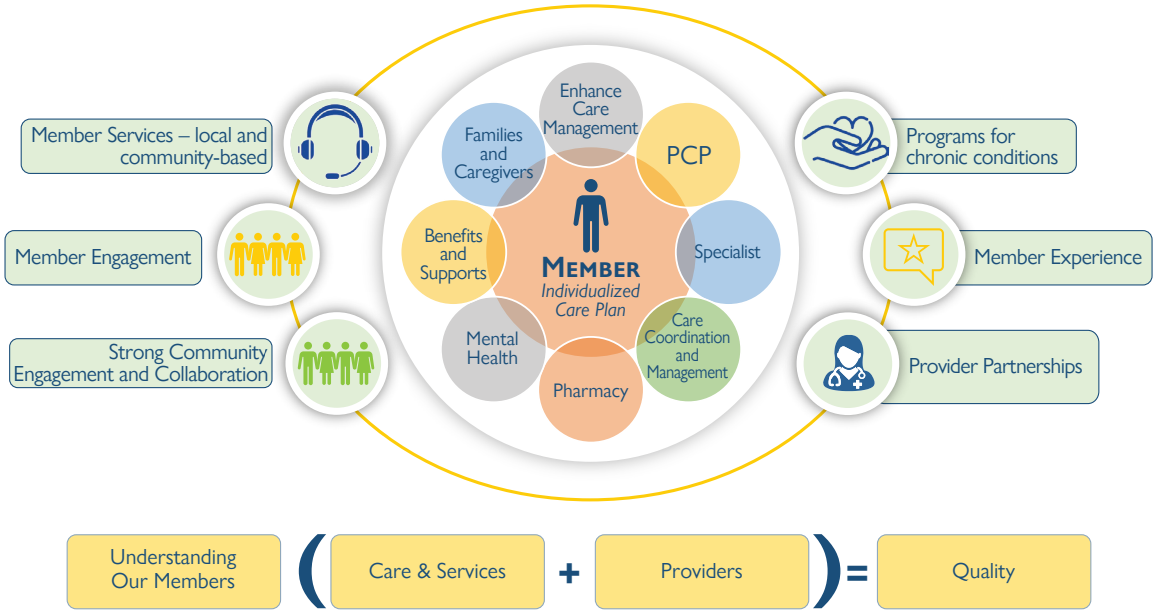
Gold Coast Health Plan Total Care Advantage (HMO D-SNP)

Total Care Advantage is an Exclusively Aligned Enrollment (EAE) Duals Special Needs Plan (D-SNP) for members who qualify as dual-eligible (have both Medicare and Medi-Cal), offered by GCHP. As a D-SNP, Total Care Advantage is responsible for the coordination and access of ALL benefits and services covered by both Medicare (federal plan) and Medi-Cal (state plan) as well as any additional supplemental benefits / services offered by the plan that are specific to those enrolled in the D-SNP. Total Care Advantage operates under a Model of Care (MOC) that ensures members are served in a way that meets their complex needs. Enrollment is voluntary. Members can enroll if they:

- Have both Medicare Parts A and B
- Have full-scope Medi-Cal
- Are 21 years of age or older
- Live in Ventura County

Total Care Advantage operates under a contract with the Centers for Medicare & Medicaid Services (CMS) as well as a CMS-approved State Medicaid Agency Contract (SMAC) approved by the state Department of Health Care Services (DHCS), the California Medicaid Agency. The plan meets state and federal requirements, including Medicare-Medicaid integration requirements. The plan operates under an MOC that describes how GCHP meets the National Committee for Quality Assurance (NCQA) standards and DHCS requirements for an EAE D-SNP as outlined in the California Advancing and Innovating Medi-Cal initiative (CalAIM) Dual Eligible Special Needs Plan (D-SNP) Policy Guide. The MOC is based on a simple formula: Quality is achieved when the care and services we deliver are done in partnership with providers and are based on a deep understanding of our members.

Total Care Advantage Model of Care (MOC)



For a summary of Special Needs Plan MOC requirements, visit **https://snpmoc.ncqa.org**. Other references include: Medicare Managed Care Manual Chapter 5 - Quality Assessment and Chapter 16b – Subchapter B - Special Needs Plans at **https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms019326** and **https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC**.

Provider Orientation and Training

All new providers, including new practitioners being added to an existing provider group, must complete a new provider orientation within 30 days of their signed Total Care Advantage service agreement as part of the contractual obligation to be a Medicare provider with Total Care Advantage. The new provider orientation provides education and training on important GCHP/Total Care Advantage programs and services for members, as well as operational processes and procedures.

Upon execution of a new contract, Total Care Advantage will send a welcome letter to the provider within 10 days of the contract effective date to ensure the transition to the Total Care Advantage network is prompt and seamless. The letter will provide an effective date that the provider can begin to see Total Care Advantage members, and provide training information including due date and training links.

Provider orientation and attestation form is available online at https://www.goldcoasthealthplan.org/for-providers/welcome-providers/.

Annual SNP MOC training is a regulatory requirement for all providers who serve SNP members. The training and attestation form are available on the GCHP website at **https://vimeo.com/1133286974/b6d101547a?share=copy&fl=sv&fe=ci**.

For more information and a summary of SNP MOC requirements visit https://snpmoc.ncqa.org. Other references include Medicare Managed Care Manual Chapter 5 - Quality Assessment and Chapter 16b – Subchapter B - Special Needs Plans at **https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms019326** and **CMS Model of Care (MOC) at Model of Care (MOC) | CMS**.

Resources

Member and provider resources are available online at: **https://www.goldcoasthealthplan.org/for-providers/provider-resources/**.

Member Services	Member Services can be reached at **1-888-301-1228** (TTY **711**) 8 a.m. to 8 p.m., seven days a week from Oct. 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday from April 1 through Sept. 30 or in writing at: Total Care Advantage P.O. Box 9176 Oxnard, CA 93031
Total Care Advantage Total Care Advantage Summary of Benefits	**https://res.cloudinary.com/dpmykpsih/raw/upload/gold-coast-site-258/media/r/f7ca5bfff2c34f748a34d35439a2314c/tca-summary-of-benefits_eng_072025_12pt_digital_v8-final.pdf**
Provider Directory	**https://www.goldcoasthealthplan.org/provider-directory/?memberPlan=Total+Care+Advantage+%28D-SNP%29**
Utilization Management	Request services through the Provider Portal or fax: 855-883-1552
Medical Policy/Clinical Practice Guidelines	**https://res.cloudinary.com/dpmykpsih/raw/upload/gold-coast-site-258/media/r/1744d6a6d2664e438eb1bd65868e25db/gchp_clinical_practice_guidelines_082025_finalp.pdf**
Clinical Decision-Making Hierarchy	**https://res.cloudinary.com/dpmykpsih/raw/upload/gold-coast-site-258/media/r/fc1b36617a834ca3a5c50d101fdc74b6/gchp_clinical_decision_hierarchy_guidelines_092025_v2-finalp.pdf**
GCHP Clinical Decision Support Guidelines	**https://gchp.access.mcg.com/index**
Total Care Advantage Request for Authorization Guidance and Prior Authorization List	**https://www.goldcoasthealthplan.org/for-providers/provider-resources/**
Claims Status	Provider Web Portal
CMS Part D Pharmacy Benefits	**https://www.goldcoasthealthplan.org/for-members/welcome-members-total-care-advantage-hmo-d-snp/total-care-advantage-d-snp-pharmacy-services/**
Medi-Cal Rx Pharmacy Benefits	**https://medi-calrx.dhcs.ca.gov/home/**
Total Care Advantage Part B Drug List and Clinical Guidelines	**https://www.goldcoasthealthplan.org/for-providers/pharmacy-services-for-providers/medicare-part-b-drugs/**

Report Fraud, Waste and Abuse	**secure.ethicspoint.com**
Report HIPPA Breach	**secure.ethicspoint.com**
Initiate an Appeal on Behalf of a Member	Contact Member Services at: 1-888-301-1228
Member Transportation	GCHP transportation service is a supplemental benefit and not covered by Original Medicare. For information related to transportation service, visit **https://www.goldcoasthealthplan.org/for-members/welcome-members-medi-cal/health-and-wellness-services/transportation-benefits/**

Provider Web Portal

To obtain access to the Provider Web Portal, providers must contact Provider Services and provide the group / entity Tax ID number, after which they will receive an invitation to register for portal access by accessing the GCHP Provider Web Portal and completing the registration process. For assistance, contact the GCHP Provider Services Department at 1-888-301-1228 or email **ProviderPortal@goldchp.org**.

Providers should access the Provider Web Portal to:

- Verify member eligibility
- Check the status of a claim
- Submit a request for authorization

SECTION 2: Glossary of Terms

Administrative Day: Any acute inpatient stay day(s) when it has been determined that inpatient care is not medically necessary and a lower level of care such as skilled nursing facility, acute inpatient rehabilitation or long-term acute care hospital stay would meet the member's care needs. Administrative days are paid at a lower rate.

Adverse Coverage Determination: The denial, deferral or limited authorization of a requested covered service, including: determinations on the level of service / care; denials of medical necessity; reduction, suspension, or termination of a previously authorized service; the denial, in whole or part, of payment for a service; failure to provide timely services, as defined by the state, for a resident in a rural area; the denial of a member's ability to exercise the right to obtain services out of GCHP's network; and the denial of a member's request to dispute a financial liability, including cost sharing, deductibles, and other financial liabilities.

Aid Code: A classification to identify the types of services for which a Medi-Cal member is eligible.

Appeal: The procedures in place to process the review of an adverse initial determination made by the plan on healthcare services or benefits the member believes they are entitled to receive. These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an administrative law judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.

Assigned Members: Members who have been assigned to, or who have chosen, a PCP or clinic for their medical care.

Attending Physician: Any physician who is a) acting in the provision of emergency services to meet the medical needs of the member b) who is, through referral from the member's PCP, actively engaged in the treatment or evaluation of a member's condition, and c) is designated by the medical director, or designee, to provide services for GCHP members.

Auto Assignment: The process used by GCHP for assigning members automatically to a particular PCP (physician or clinic) when a member has been unable to complete the selection process within the first 30 days of initial enrollment.

California Advancing and Innovating Medi-Cal (CalAIM): The state Department of Health Care Services (DHCS) initiative to improve the quality of life and health outcomes of Medi-Cal members by implementing delivery system, program and payment reforms across the Medi-Cal program.

California Integrated Care Management (CICM): California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNP plans. Federal regulations require D-SNP plans to provide robust care coordination to Members. CICM layers state-specific requirements on top of federal D-SNP requirements.

Care Management: A collaborative process that assesses, develops, plans, implements, coordinates, monitors, and evaluates the options and services needed to meet a member's health and human service needs and is characterized by advocacy, communication, and resource management.

Care Navigator: Individual who acts as primary contact for members and caregivers for care coordination and transitional care services. Identifies member needs through assessment and supports members in getting needs met by coordinating Medicare and Medi-Cal services for members. Supports members and caregivers through care planning, facilitating care, and advocating for the member's needs. Provides

health coaching and transitional care support following protocols and guidance from clinical supports. Facilitates communication between the member, member's family and the providers. Works closely with the interdisciplinary care team to ensure all needed Care Coordination activities are performed.

Centers for Medicare & Medicaid Services (CMS): The federal agency within the Department of Health and Human Services (HHS) that administers and oversees the nation's major health programs, including Medicare and Medicaid.

Chief Medical Officer (CMO): The senior physician executive, employed by GCHP or designee, responsible for providing strategic clinical leadership, overseeing medical policies, managing utilization, and ensuring the quality of care for members.

Claim Form (UB-04 (CMS-1450): The claim form used by participating hospitals, Federally Qualified Health Centers (FQHC), Long Term Care facilities, Skilled Nursing Facility (Level A (NF-A) and Level B (NF-B) and other facilities to report the provision of services to members, to request payment for services or to report encounter data to GCHP.

Claim Form (CMS-1500): The claim form primarily used by participating physicians, providers and/or suppliers to report the provision of services to members to GCHP.

Clean Claim: A claim in which all information necessary to determine payer liability for the adjudication of the claim is present (Health and Safety Code Section 1371).

Community-Based Adult Services (CBAS): A Medi-Cal managed care benefit providing center-based adult day healthcare. CBAS, outpatient and facility-based programs, offer services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. Services may include skilled nursing care, social services, therapies, personal care, family / caregiver training and support, meals, and transportation to / from the facility-based service to eligible Medi-Cal beneficiaries.

Community Health Worker (CHW): A skilled and trained individual who is able to render clinically appropriate Medi-Cal covered benefits and services and is an enrolled Medi-Cal provider.

Community Supports (CS): Non-medical, community-based services selected by GCHP pursuant to 42 CFR section 438.3(e)(2) as a substitute for services required under the California Medicaid State Plan, designed to help eligible members avoid higher-cost, institutionalized care by addressing social determinants of health. These services focus on housing, nutrition, personal care, and safety.

Concurrent Review: A review that is performed during an inpatient stay for a member receiving acute, rehabilitation or skilled nursing care including requests for extended stays or additional services to ensure the appropriateness of care, care setting, progress and discharge planning.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®): Survey tools developed by the Agency for Healthcare Research and Quality (AHRQ) used to assess the perceptions and experiences of members in the process of evaluating the quality of healthcare services provided by health plans.

Contract Year: The 12-month period following the effective date of the service agreement between a specific participating provider and GCHP.

Contracting Providers: A medical group, independent practice association, or other entity that delivers, furnishes, or otherwise arranges for or provides healthcare services for GCHP members under a contract, but does not include an individual or a plan.

Council for Affordable Quality Healthcare (CAQH) ProView: A nationally recognized central repository for providers to use to self-report professional and practice information to payers, hospitals, large provider groups and health systems.

County Organized Health System (COHS): A managed care health plan serving Medi-Cal members in a designated county. The COHS known as Gold Coast Health Plan serves Ventura County.

Covered Billed Charges: The amount charged by a provider for covered services. This amount may be different from the total billed charges, as some of the billed charges may be for non-covered services. GCHP will deduct the total amount of charges for non-covered services from the total billed amount to determine the Covered Billed Charges.

Covered Services: All medically necessary covered services as set forth in the Member Handbook, including primary care, specialist care, medical, hospital, preventive, ancillary, emergency, and health education services.

Cultural and Linguistic Services: Initiatives designed to deliver respectful, understandable, and high-quality healthcare tailored to members' cultural beliefs, language needs, and literacy levels.

Delegated Provider: A contracted GCHP provider to whom certain services and processes have been delegated for oversight.

Department of Health Care Services (DHCS): The state agency that finances and administers several individual healthcare service delivery programs, including the California Medical Assistance Program (Medi-Cal).

California Department of Health Care Services (DHCS) means the single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs

Doula: A trained non-medical professional that provides person-centered, culturally competent care including physical, emotional, and informational support to individuals before, during, and after childbirth to improve health outcomes for birthing parents and infants.

Dual Special Needs Plan (D-SNP): A Medicare Advantage plan for individuals eligible for both Medicare (Parts A and B) and Medi-Cal.

eApply: A secure web-based module that gives practitioners, groups, and facilities the tools to apply, attest and update their credentialing information online.

Emergency Medical Condition: A sudden, severe illness or injury such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention may result in a) placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

Emergency Services: Health services needed to evaluate or stabilize an emergency medical or psychiatric condition.

Encounter Data: Detailed, transaction-level information submitted by healthcare providers to managed care plans, Medicaid, or Medicare Advantage, documenting every service, item, and diagnosis provided

to a patient. These data are used for tracking care quality, calculating risk-adjusted payments, and monitoring population health.

Encounter Data Validation (EDV): The state Department of Health Care Services (DHCS) contracts with Health Services Advisory Group, Inc. (HSAG), an External Quality Review Organization (EQRO), to conduct an Encounter Data Validation (EDV) study that evaluates the completeness and accuracy of encounter data submitted to DHCS.

Excluded Services: Services that are non-covered or carved out for which GCHP is not responsible and for which it does not receive a capitation payment from the state Department of Health Care Services (DHCS) or CMS.

Expedited Review: Review for an organization determination when the plan or provider indicates that taking time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (72 hours from date of request; Part B Drug within 24 hours of the request)

External Quality Review Organization (EQRO): An independent entity that analyzes and evaluates the quality, timeliness, and access to healthcare services provided by Medicaid and CHIP managed care plans. Mandated by federal regulations (42 CFR Part 438), EQROs produce annual technical reports to hold plans accountable and monitor performance.

Facility Site Review (FSR) – Primary Care Provider (PCP) Site: As required by California Code of Regulations (22 CCR § 56230) and California Department of Health Care Services (DHCS) All Plan Letter 22-017 PCP sites participating in the Medi-Cal Managed Care Program must 1) complete an initial FSR, including a Physical Accessibility Review (PAR) at the time of credentialing, and subsequent (triennially) periodic full scope reviews (FSR, PAR and Medical Record Review (MRR) and 2) complete corrective action plans (CAPs) within 10 business days from the date of FSR visit and/or MRR. An FSR is conducted using DHCS Medi-Cal Managed Care Division (MMCD) Site Review Survey Tool and Medical Record Survey Tool.

Facility Site Review (FSR) – Ancillary Services and Community-Based Adult Services (CBAS): As required by California Code of Regulations (22 CCR § 56230) and DHCS All Plan Letter 15-023 Ancillary and CBAS sites participating in the Medi-Cal Managed Care Program must complete an initial and subsequent Physical Accessibility Review (PAR). A PAR will be conducted using the (DHCS) Medi-Cal Managed Care Division (MMCD) Site Review Survey Tool and Medical Record Survey Tool.

First Tier, Downstream, and Related Entities (FDRs):

- **A first tier entity** is any party that enters a written arrangement, acceptable to CMS, with a Medicare Advantage (MA) organization or Part D plan sponsor or applicant. These arrangements provide administrative or healthcare services to a Medicare-eligible individual under the MA program or Part D program. (See 42 CFR §§ 422.500 and 423.501).
- **A downstream entity** is any party that enters a written arrangement, acceptable to CMS, with persons or entities. These persons or entities are involved with the MA benefit or Part D benefit. They are below the level of the arrangement and between the following:
  - An MA organization or applicant
  - A Part D plan sponsor or applicant
  - A first-tier entity
- **A related entity** is any party that holds common ownership or control of an MA organization or Part D sponsor and:
  - Performs some of the MA organization or Part D plan's management functions under contract or delegation

    - » Furnishes services to Medicare enrollees under an oral or written agreement
    - » Leases real property or sells materials to the MA organization or Part D plan sponsor (this occurs at a cost of more than $2,500 during a contract period) (See 42 CFR §§ 422.500 and 423.50)
- **Healthcare providers are FDRs, too**
- **Compliance requirements** apply to healthcare providers contracted with our Medicare network. This includes physicians, hospitals, and other provider types, like dentists.

Fee-For-Service Payment (FFS): The lowest allowable Medi-Cal payment that is permitted by DHCS or Medicare payment permitted by CMS. This rate is the lower of the following rates applicable at the time the services were rendered by the provider: a) The usual charge made to the general public by the provider; b) The maximum FFS rate determined by DHCS for the service under the Medi-Cal Program and CMS for all services under the Medicare Program; or c) The rate agreed to by the provider. All covered services that are authorized and compensated by GCHP pursuant to its written service agreement will be compensated by GCHP at the lowest allowable FFS rate unless otherwise identified in a special attachment to the signed agreement.

Governmental Agencies: DHCS, Department of Managed Health Care (DMHC), CMS, U.S. DOJ, and California Attorney General and/or any other agency that has jurisdiction over GCHP or Medi-Cal (Medicaid).

Grievance: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of healthcare items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an Late Enrollment Penalty (LEP) determination.

Health Care Effectiveness Data and Information Set (HEDIS®): A set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) used by health plans and healthcare organizations to measure and track quality metrics and compare rats to national and regional benchmarks.

Health Education (HE): The GCHP Health Education Program is committed to helping members stay healthy through collaboration with local clinics, providers, and hospitals to offer high-quality health education materials and resources to all members. No prior authorization is required for members to attend health education or health promotion activities.

Health Outcomes Survey (HOS): The Medicare Health Outcomes Survey (HOS) collects information from people with Medicare who are enrolled in Medicare Advantage (MA) health plans to evaluate their health maintenance and/or improvement over time.

Health Risk Assessment (HRA): An assessment conducted on each D-SNP member within 90 days of enrollment and at least annually to identify medical, functional, cognitive, psychological, and mental health needs.

Hierarchical Condition Category (HCC): Medical code groups used in risk adjustment to predict patient healthcare costs, identifying serious or chronic conditions and assigning risk scores (risk adjustment factor - RAF) to determine payments, primarily for Medicare Advantage plans, ensuring providers treating sicker patients are better compensated. Each HCC represents a set of clinically related ICD-10 diagnoses with similar expected costs, helping insurers and government programs like CMS adjust payments to reflect patient health complexity, moving toward value-based care.

Health Insurance Portability and Accountability Act (HIPAA): A federal law that establishes national standards for protecting sensitive patient health information/protected health information (PHI). Its main purposes include setting rules for the privacy and security of health information, improving the efficiency of healthcare through standardized electronic transactions, and ensuring the portability of health insurance during job changes. HIPAA gives patients' rights over their health information and requires healthcare providers, insurers, and their business associates to implement safeguards for PHI.

Hospital: Any acute general care facility.

Hospital Observation Services: The use of a bed and periodic monitoring by a hospital's nursing or other ancillary staff, which are reasonable and necessary to evaluate an outpatient's condition to determine the need for possible inpatient admission. Authorization is required for observation services beyond the initial 48-hour period (i.e., two 24-hour periods or two calendar days). Failure to notify and request authorization may result in nonpayment.

Identification Card (ID Card): The card that is prepared and issued by GCHP bearing the Total Care Advantage logo and contains the member's: a) Name, b) ID number, c) PCP or clinic (if assigned / regular member) and d) Other identifying information. NOTE: The ID Card is not proof of the member's Medi-Cal or Total Care Advantage eligibility, and Providers are required to verify eligibility. (Refer to the Provider Web Portal section).

Individualized Care Plan (ICP): Based on the HRA and available data, the ICP outlines the health-related goals and interventions specific to the member's identified needs which may include provider appointments, medications and social needs.

Initial Health Appointment (IHA): An IHA is a comprehensive assessment of a patient's health status completed during the initial visit(s) with their primary care provider (PCP). During the IHA, the PCP assesses and manages the patient's acute, chronic and preventative health needs. The California Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS) require PCPs to conduct an IHA with every newly enrolled GCHP member within 120 calendar days of being assigned as the member's PCP.

Interdisciplinary Care Team (ICT): A collaborative group of healthcare professionals that may include physicians, nurses, therapists, social workers, and pharmacists, who work together and with the member/care giver to provide comprehensive, patient-centered care supporting the identified needs and creating the ICP. The composition of the ICT is based on members' specific needs, level of risk in accordance with the stratified HRA results or other data and preferences.

Language Assistance Services: Language assistance services, including alternative formats, auxiliary aids, assistive listening systems, sign language interpreters, captioning, written communication, electronic format, plain language or through other methods are available to GCHP members at no cost.

Limited Service Hospital: A limited service hospital provides specialized, or reduced-scope medical care, often focusing on emergency, outpatient, and observation services rather than comprehensive inpatient care. Key models include Rural Emergency Hospitals (REHs), which provide 24/7 ER services with an average stay of under 24 hours, and critical access hospitals (CAHs), limited to 25 beds and short stays. Any hospital that is under contract with GCHP, but not as a primary hospital because it is located outside of Ventura County. (See: Primary Hospital).

Long-Term Care (LTC): Medical and non-medical care for people who have a chronic illness or disability to support activities of daily living (ADL) such as personal care assistance (dressing, bathing, and using the bathroom), meals, day healthcare, and transportation.

Medically Necessary: Healthcare services, treatments, or supplies essential to diagnose or treat an illness, injury, or disease, meeting evidence based clinical practice guidelines and/or professional recognized standards of medical practice.

Medicare Advantage Plan: An all-in-one health plan (Part C) from a private insurer, approved by Medicare, that bundles hospital (Part A) and medical (Part B) coverage, usually includes prescription drugs (Part D), and often adds benefits like vision, dental, and fitness, serving as an alternative to Original Medicare but typically requiring you to use a network of doctors and hospitals.

Medicare Star Ratings System: An annual, five-star rating program designed by CMS to measure and communicate the quality and performance of Medicare Advantage (Part C) and Medicare Prescription Drug Plans (Part D). Plans are rated on a set of performance measures (including clinical, patient experience, and operational measures) on a scale from 1-5, with 5 being the highest score a plan can achieve. The Medicare Star Rating system helps beneficiaries compare health plans and drives health plan quality improvement initiatives.

Member (Regular): An eligible Medi-Cal beneficiary who is enrolled in GCHP and is required to select a PCP. Enrolled members will have the name of their PCP listed on their GCHP ID cards.

Member Handbook: The Total Care Advantage Summary of Benefits (SOB) / Evidence of Coverage (EOC), including limitations, exclusions, terms of the relationship, and agreement between the enrollee and GHCP, that sets forth the benefits to which a Total Care Advantage member is entitled under the D-SNP operated by GCHP, the limitations and exclusions to which the member is subject, and the terms of the relationship and agreement between GCHP and the D-SNP member.

Model of Care: CMS-approved document outlining how a Dual Eligible Special Needs Plan provides specialized, integrated care to beneficiaries eligible for both Medicare and Medicaid focusing on improving health outcomes through targeted care coordination, individualized care plans (ICPs), and interdisciplinary teams that address medical, social, and functional needs.

Non-Emergency Medical Transportation (NEMT): Transportation by ambulance, wheelchair van, or litter van for members who cannot use public or private transportation to and from covered services as defined in Title 22, CCR, Section 51323. Provider must complete and submit an NEMT prescription/attestation of Medical Necessity form with a Physician Certification Statement (PCS).

Non-Medical Transportation (NMT): Transportation to and from plan-covered medical services for members who can travel safely in a private vehicle, taxi, or public transportation, but lack other means of transportation. It is distinct from NEMT which requires a medically equipped vehicle and physician certification. No authorization required. Provided by Ventura Transit System (VTS) using passenger vehicles.

Non-Physician Medical Practitioner: Physician Assistants (PAs), Advanced Practice Registered Nurses (APRN) (including Certified Registered Nurse Anesthetists (CRNAs), Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs) and Certified Nurse-Midwives (CNMs), Anesthesiologist Assistants (AAs).

Out-of-Area: The geographic area outside of Ventura County.

Out-of-Plan/Out of Network: Non-contracted providers located inside or outside of Ventura County, also referred to as “non-par” providers, indicating that they are not participating providers in Total Care Advantage’s network.

Outpatient Services: Medical procedures, consultations, or treatments provided without an overnight hospital stay, allowing patients to return home the same day such as wellness and prevention (i.e. counseling and weight loss programs), diagnosis (i.e., lab tests and MRI scans), treatment (i.e. some surgeries and chemotherapy), rehabilitation (i.e, physical therapy).

Participating Hospital: A facility licensed by the state as an acute care hospital or other licensed facility that provides covered services or authorized out-of-area / out-of-plan services through a written agreement between the participating hospital and GCHP.

Participating Provider: A health professional, facility or vendor licensed by the state and credentialed to provide covered services to members through a written agreement between the participating provider and GCHP.

Per Diem Payment: The all-inclusive, fixed payment for a hospital day, unless exceptions (carve-outs) are listed, as outlined in the hospital service agreement.

Performance Improvement Project (PIP): A structured, data-driven quality initiative designed to achieve measurable and sustainable improvement in the delivery of care and services to members. PIPs are a core component of the organization's Quality Improvement and Health Equity Transformation (QIHET) Program and are required by both CMS and DHCS).

Physician: A person who holds a degree in Doctor of Medicine (MD) or Osteopathy (DO) from an accredited university.

Plan: Total Care Advantage D-SNP governed by the Ventura County Medi-Cal Managed Care Commission (VCMMCC), doing business as GCHP, serving Ventura County's dual eligible beneficiaries.
Plan Partner: An entity contracted directly with Total Care Advantage, subject to regulation by the Department of Managed Health Care (DMHC) and:

- Is responsible for providing healthcare services for Total Care Advantage members.
- Receives compensation for those services on any capitated or fixed periodic payment basis.
- Is responsible for the processing and payment of claims made by providers for services rendered on behalf of the Plan Partner that are covered under the capitation or fixed periodic payment made by GCHP to the plan partner.

Population Health Management (PHM): A whole-system, person- centered strategy that focuses on wellness and prevention, includes assessments of each member's health risks and health-related social needs, and provides care management and care transitions across delivery systems and settings.

Potential Quality Issue (PQI): A suspected deviation from expected provider performance, clinical care or outcome of care, which requires further investigation to determine whether an actual quality issue or opportunity for improvement exists.

Primary Care Provider (PCP): A clinic, physician(s) or mid-level licensed professional practicing under physician supervision who has an agreement with GCHP to provide primary care services. The individual must be licensed by the appropriate professional state board and enrolled with Total Care Advantage. The PCP is responsible for supervising, coordinating, and providing primary care services to members, initiating referrals, and maintaining the continuity of care for the members who select or are assigned to the PCP. PCPs include general and family practitioners, internists, pediatricians, and other mid-level professionals, such as nurse practitioners and physician assistants.

Provider Directory: A listing of the PCPs, specialists, and other non-PCP providers in the Total Care Advantage network.

Primary Hospital: Any hospital affiliated with participating PCPs that has a written agreement with GCHP to provide covered services to members.

Provider Advisory Committee (PAC): A committee composed of 10 voting members. Each seat represents a constituency served by GCHP and serves as a platform to exchange ideas and present peer / community interests to GCHP regarding healthcare matters at the national, regional, state and local levels.

Provider Information Update Form (PIUF): A universal form used by GCHP to document any additions, changes or terminations for a practitioner, group or facility.

Provider Manual: The manual which outlines GCHP operational policies and procedures.

Provider Preventable Condition (PPC): A medical condition or complication that a patient develops during a hospital stay or ambulatory surgical encounter that was not present at admission. PPCs include "Health Care Acquired Conditions" (HCACs) defined in §1886(d)(4)(D)(ii) and (iv) of the Social Security Act and Other Provider Preventable Conditions (OPPCs) per Title 42 CFR §434.6(a)(12)(i), 438.3(g), and 447.26.

Quality Improvement and Health Equity Transformation (QIHET) Program: The QIHET Program supports GCHP's mission to improve the health of our members through the provision of high quality care and services by using systematic activities that monitor and evaluate clinical and non-clinical service, patient safety, and member experiences provided to members according to the standards set forth in statute, regulations, and GCHP's agreement with DHCS and the Centers for CMS. The QIHET Program consists of processes that measure the effectiveness and quality of care, identify problems, and implement improvement on a continuing basis toward identified target outcomes and measurement. GCHP's QIHET Program is overseen by the Quality Improvement and Health Equity Committee (QIHEC).

Referral Physician (also referred to as a Participating Provider): Any qualified physician, licensed in California, who meets the general credentialing requirements of GCHP and has signed an agreement with GCHP. The provider, to whom a PCP may refer any member for consultation and treatment, has an executed agreement with GCHP.

Referral Services: Covered services, which are not primary care services, provided by specialist physicians on referral from a PCP.

Risk Adjustment: The process in which CMS calculates what to pay a health provider based on a patient's health, their likely use of healthcare services and the costs of those services.

Risk Score: A number representing the predicted cost of treating a specific patient or group of patients compared to the average Medicare patient, based on certain characteristics and health conditions.

Risk Adjustment Data Validation: The Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) program is CMS' primary way to address overpayments to Medicare Advantage Organizations (MAOs). During a MA RADV audit, CMS confirms that any diagnoses submitted by an MAO for risk adjustment are supported in the enrollees' medical records. If diagnoses are unsupported by the medical records, CMS may collect overpayments. MA RADV audits occur after the final risk adjustment data submission deadline for the MA contract year.

Service Area: Total Care Advantage's service area in Ventura County and the zip codes located therein.

Supplemental Benefits: An item or service covered by a Medicare Advantage Plan that is not covered by original Medicare. These benefits do not need to be provided by Medicare providers or Medicare-certified facilities. Supplemental benefits may include dental care, vision care, hearing aids, and gym memberships. Medicare Advantage plans can also cover supplemental benefits that are not primarily health-related for beneficiaries who have chronic illnesses. These benefits should address social determinants of health. These benefits are called Special Supplemental Benefits for the Chronically Ill (SSBCI).

Transitional Care Services: Services provided with the aim to prevent hospital readmissions by providing support through coaching, ensuring timely and safe care, managing medications, and coordinating follow-up appointments. Services are often provided for a limited time, like the first 30 days after discharge. TCS occurs before, during, and after a transition. The period from identification of an enrollee who is at risk for a care transition through completion of a transition. This process includes planning and preparation for transitions and follow-up care after transitions are completed.

Urgent Care Services: Services furnished to an individual who requires services within 48 hours to avoid the likely onset of an emergency medical condition.

Section 3: Member Enrollment And Eligibility

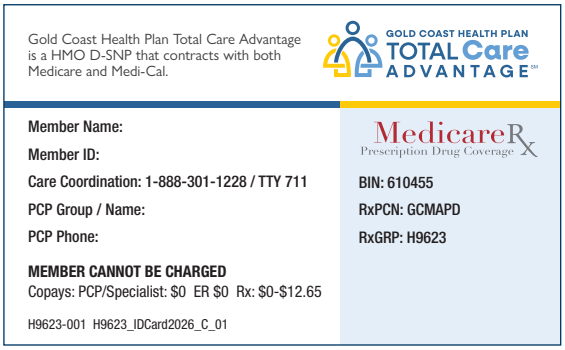
Member Enrollment

Enrollment is voluntary. Prospective members are eligible to enroll in Total Care Advantage if they:

- Have both Medicare Part A and B
- Have full-scope Medi-Cal (determined by CMS and DHCS)
- Are 21 years of age or older
- Live in Ventura County

Member ID Card

Total Care Advantage members will have a specific ID card that is different to the GCHP Medi-Cal only plan ID card. Presentation of a Total Care Advantage ID card alone is not a guarantee of eligibility. Providers must verify member eligibility with GCHP before delivering services.



Member Eligibility

- Eligibility for Total Care Advantage is month-to-month.
- Members must re-certify their eligibility according to state and federal rules and timelines.
- It is not uncommon for individuals to periodically lose Medi-Cal eligibility and regain it at a later date.
  - » Members who lose their Medi-Cal eligibility can remain enrolled in Total Care Advantage for up to four months (referred to as the 'deeming' period) while Total Care Advantage staff support the member to regain Medi-Cal eligibility.
  - » If unable to regain Medi-Cal eligibility after the four-month period, the member is disenrolled from Total Care Advantage.
- Medi-Cal eligibility can be effective retroactively in some cases.

How to Verify Member Eligibility

Member eligibility can be verified online through the GCHP Provider Web Portal. PCPs and specialists are responsible for verifying member eligibility prior to providing care and on the day of service. Through the Provider Web Portal you can:

- Verify patient eligibility
- View demographic information for the providers associated with the registered TIN such as office location, office hours and associated practitioners
- View and export patient panel (primary care clinics). This patient list will indicate:
  - » Member's name,
  - » Member ID number,
  - » Date of birth, and
  - » PCP effective date

- View claims details and claim status
- Submit institutional and professional claims via an 837 file
- Providers can also contact GCHP Member Services at **1-888-301-1228** Monday through Sunday, 8 a.m. to 8 p.m. From Oct. 1 through March 31, and 8 a.m.to 8 p.m., Monday through Friday from April 1 through Sept. 30 (except some holidays). If you use a TTY, call **711**. When you call, please provide the following:
  - The member's full name.
  - The member's Total Care Advantage ID number.
  - The member's date of birth.
  - The date(s) of service for which you want to check eligibility.

Access the state Medi-Cal website to verify fee-for-service Medi-Cal status.

Primary Care Physician Selection

Upon enrollment, members are asked to select a primary care physician (PCP). If a member does not select a PCP, GCHP will auto assign a GCHP contracted PCP.

Member Requests to Change PCP

A member may change their PCP for any reason, at any time. If a member wishes to change their PCP, this change will be effective on the first day of the following month.

Section 4: Member Rights and Responsibilites

Gold Coast Health Plan Total Care Advantage (HMO D-SNP) seeks to provide members with timely access to covered services and drugs and to ensure services, both clinical and non-clinical, are provided to members in a culturally competent and accessible manner, including meeting the needs of members with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Total Care Advantage provides free interpreter services to answer questions in different languages.

Total Care Advantage informs members about plan benefits and member rights and responsibilities in a way that members can understand upon enrollment and annually thereafter. This includes the availability of materials in languages other than English, like Spanish, and in alternative formats, like large print, braille, and/or audio. Members can request alternative formats, including a standing request for alternative formats, by contacting

Contact Member Services at **1-888-301-1228** (TTY **711**), 8 a.m. to 8 p.m., seven days a week from Oct. 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday from April 1 through Sept. 30.

Send written requests to:

Total Care Advantage
P.O. Box 9176
Oxnard, CA 93031

To ensure member rights and responsibilities are adhered to, providers must:

- Treat members with fairness and respect at all times.
- Ensure members get timely access to covered services and drugs.
- Protect the privacy of members' protected health information (PHI).
- Support members' right to make decisions about care.
- Allow members the right to make complaints and to request reconsideration of decisions made.
- Advise members what to do if they believe they are being treated unfairly, or their rights are not being respected; and advise members how to get more information about their rights.

Providers may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in a Medicare Advantage (MA) plan offered by the organization on the basis of any factor that is related to health status, including but not limited to the following: medical condition, including mental as well as physical illness, claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability including conditions arising out of acts of domestic violence, potential third-party liability for payment for the service, or disability. (See 42 CFR 422.110(a) and 42 USC 1396a(a)(25)(D). Providers further may not differentiate or discriminate against any member as a result of their enrollment in GCHP or another managed care organization, because they are a Medicare or Medicaid beneficiary, because they filed a complaint, grievance, or lawsuit, or because of sex, race, color, creed, religion, ancestry, national origin, ethnic group identification, income level, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, identification with any other persons or groups defined in Penal Code 422.56, or on the basis of any other protected class or characteristic under applicable laws. Providers must also ensure equal access to healthcare services for limited English proficient (LEP), limited reading skills, hearing incapacity and speech impaired members through provision of high-quality interpreter and linguistic services.

Emergency Care

Members have the right to access care at any hospital or facility. Once the member is post-stabilized, the member will be moved to a contracted facility if it is medically necessary. Providers should have the following phone prompt: "If this is an emergency, please hang up and call **911** or go to the nearest emergency room."

Member Complaints

If a member has a complaint or thinks Total Care Advantage improperly denied, delayed, or modified a service, they should contact Member Services at **1-888-301-1228** (TTY **711**), 8 a.m. to 8 p.m., seven days a week from Oct. 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday from April 1 through Sept. 30.

Submit a complaint online at: **www.goldcoasthealthplan.org**

Submit a written complaint to:

Total Care Advantage
Attn: Grievances and Appeals
P.O. Box 9176 Oxnard, CA 93031

Members may also contact:

- The Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. For more details about HICAP, refer to Chapter 2 of the Member Handbook.
- The Medi-Cal Ombudsman Program at 1-888-452-8609. For more details about this program, refer to Section F: Your rights as a member of the plan of the Member Handbook.
- Medi-Cal Office of Civil Rights at 916-440-7370. TTY users should call 711.
- U.S Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.
- Medicare at 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048. (Members can also read or download "Medicare Rights & Protections," found on the Medicare website at **www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf**.

Member Responsibilities

As a plan member, members have a responsibility to:

- Advise their doctor and other healthcare providers that they are a Total Care Advantage member and present their member ID card when accessing care/services.
- Read the Member Handbook/Summary of Benefits.
- Disclose any other health or drug coverage to Total Care Advantage.
- Be considerate and respect the rights of others.
- Pay their share of cost as appropriate.
- Provide an up-to-date record:
  - » Notify Total Care Advantage, Medicare and Medi-Cal, or other entity if they move and/or plan to move
    - › If a member moves outside of our service area, they will be disenrolled.
- Notify Total Care Advantage, Medicare and Medi-Cal, or other entity of changes to phone number.
- Help doctors or other healthcare providers to give them the best care by:
  - » Completing an annual health risk assessment.
  - » Providing health information and ensuring care providers know all medications, over-the-counter drugs, vitamins, and supplements they take.
  - » Asking questions and learning as much as they can about their health conditions.

- » Following the treatment plans and instructions that they and their providers agree on.
- » Contacting their assigned care coordinator and/or Member Services for assistance.

All providers should be knowledgeable of the Medi-Cal rights and responsibilities listed below.

Member Rights

- To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information, such as medical history, mental and physical condition or treatment, and reproductive or sexual health.
- To be provided with information about GCHP and its services, including covered services, providers, practitioners, and member rights and responsibilities.
- To get fully translated written member information in your preferred language, including all grievance and appeals notices.
- To make recommendations about GCHP's member rights and responsibilities policy.
- To be able to choose a primary care provider (PCP) within GCHP's network.
- To have timely access to network providers.
- To participate in decision making with providers regarding your own healthcare, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care you got.
- To know the medical reason for GCHP's decision to deny, delay, terminate (end), or change a request for medical care.
- To get care coordination.
- To ask for an appeal of decisions to deny, defer, or limit services or benefits.
- To get free interpreting and translation services in your preferred language, including alternative formats and auxiliary aids and services upon request.
- To get free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To ask for a State Hearing of a service or benefit that is denied, and you have already filed an appeal with GCHP and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible.
- To disenroll (drop) from GCHP and change to another health plan in the county upon request.
- To access minor consent services.
- To get free written member information in other formats (such as braille, large-size print, audio, and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare and Institutions (W&I) Code section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage.
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations (CFR) sections 16.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by GCHP, your providers or the state.
- To have access to family planning services, freestanding birth centers, Federally Qualified Health Centers, Indian Health Care Providers, midwifery services, Rural Health Centers, sexually
- transmitted infection services, and emergency services outside GCHP's network pursuant to federal law.
- To have privacy and your medical information kept confidential.
- To have timely medical appointments.
- To get a second opinion for a diagnosis or treatment plan.

- To have an adult represent them with GCHP once GCHP receives and validates the appropriate permissions.

For a complete summary of member rights and responsibilities, please refer to the **Member Handbook**. If assistance or clarification is required, please call the Provider Services Department at **1-888-301-1228** (TTY **711**).

Section 5: Network Standards

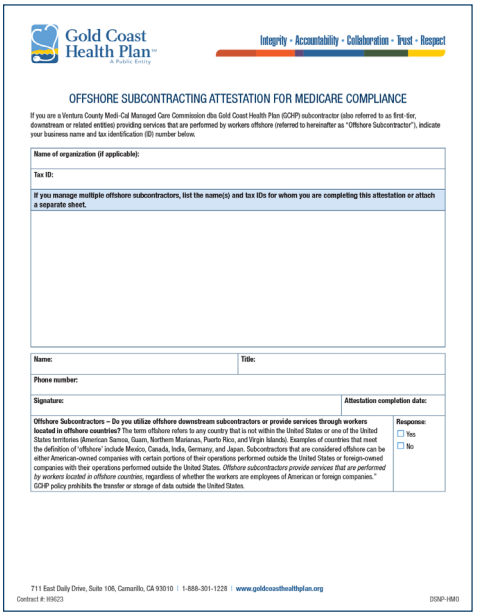
Ensuring access to care is a collaborative effort between Gold Coast Health Plan (GCHP) and the Gold Coast Health Plan Total Care Advantage (HMO D-SNP) provider network through established standards. All network providers are responsible for abiding by these network standards. Panel closures may be initiated at GCHP's sole discretion, including but not limited to ongoing poor performance or non-compliance with network standards, a governing federal or state regulatory requirement, or a contractual or manual requirement. Further actions may be taken if deficiencies are not corrected to GCHP/Total Care Advantage reasonable satisfaction.

First Tier, Downstream and Related Entities (FDR) Medicare Compliance Program and Attestation Requirements

First Tier, Downstream and Related Entities (FDR) Medicare compliance requirements apply to healthcare providers contracted with our Total Care Advantage Medicare network. This includes physicians, hospitals, and other provider types, such as dentists. GCHP FDRs are responsible for complying with applicable Medicare program requirements, including oversight of their Downstream Entities that provide services to Total Care Advantage members.

Offshore Operations and Centers for Medicare & Medicaid Services (CMS) Reporting

To ensure compliance with applicable federal and state laws, rules, and regulations, providers must request permission to provide services through an offshore individual or entity physically located outside of the United States or one of its territories (American Samoa, Guam, Northern Marianas, Puerto Rico and Virgin Islands). These requests must be approved by GCHP/Total Care Advantage.



Gold Coast Health Plan
A Public Entity

Integrity · Accountability · Collaboration · Trust · Respect

OFFSHORE SUBCONTRACTING ATTESTATION FOR MEDICARE COMPLIANCE

If you are a Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan (GCHP) subcontractor (also referred to as first-tier, downstream or related entities) providing services that are performed by workers offshore (referred to hereinafter as "Offshore Subcontractor"), indicate your business name and tax identification (ID) number below.

Name of organization (if applicable):
Tax ID:
If you manage multiple offshore subcontractors, list the name(s) and tax IDs for whom you are completing this attestation or attach a separate sheet.

Name:	**Title:**
Phone number:	
Signature:	**Attestation completion date:**

Offshore Subcontractors – Do you utilize offshore downstream subcontractors or provide services through workers located in offshore countries? The term offshore refers to any country that is not within the United States or one of the United States territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands). Examples of countries that meet the definition of 'offshore' include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be either American-owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. *Offshore subcontractors provide services that are performed by workers located in offshore countries*, regardless of whether the workers are employees of American or foreign companies." GCHP policy prohibits the transfer or storage of data outside the United States.	**Response:** ☐ Yes ☐ No

711 East Daily Drive, Suite 106, Camarillo, CA 93010 | 1-888-301-1228 | www.goldcoasthealthplan.org

Contract #: H9623 DSNP-HMO

Providers must notify GCHP/Total Care Advantage immediately and submit an offshore attestation withing 15 calendar days from the date the contract is signed with the offshore subcontractor providing services involving the receipt, processing, transferring, handling, storing or accessing of Medicare member protected health information (PHI).

Provider Application, Contracting and Credentialing

GCHP/Total Care Advantage has a quality-of-care program designed to ensure GCHP/Total Care Advantage healthcare providers meet professional standards for the delivery of healthcare to our members. As part of this program, providers are required to be credentialed, recredentialed, and provide any necessary updates / changes that may impact member care and/or contractual obligations. Providers are responsible for completing GCHP's credentialing application in a timely manner to avoid delays in processing and/or plan participation interruptions.

Providers are also responsible for completing a Provider Information Update Form (PIUF) to notify GCHP/ Total Care Advantage of any updates that may impact member care and/or contractual obligations. Each provider must meet the minimum Credentialing Standards for participation in the GCHP network. These guidelines are intended to comply with standards of GCHP/Total Care Advantage, the State Department of

Health Care Services (DHCS) or its designee, Centers for Medicare & Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), or any other applicable regulatory and/or accreditation entities where applicable.

GCHP conducts Credentials / Peer Review Committee meetings and reviews practitioners' information in a non-discriminatory manner. No practitioner will be denied privileges with GCHP, have any corrective actions imposed, or have their privileges suspended or terminated solely on the basis of race, ethnic / national identity, age, gender, sexual orientation, or the type of patient the practitioner treats.
The following policies are available on the GCHP **website**.

These policies provide detailed information regarding practitioners' right to review information submitted to support their credentialing application, correct erroneous information, request the status of their credentialing / recredentialing application, and file any issues or concerns regarding fair and non-discriminatory practices in the credentialing / recredentialing process.

- Practitioner Credentialing Policy
- Credentialing for Organizational Providers Policy
- Fair Hearing

Submit any issues or concerns regarding fair and non-discriminatory credentialing / recredentialing practices to **Credentialing@goldchp.org**.

Application and Contracting

To participate in the Gold Coast Health Plan Total Care Advantage (HMO D-SNP) network, providers must be enrolled with the DHCS Medi-Cal program, have Medicare enrollment and certification though the Centers for Medicare & Medicaid Services (CMS) Medicare Provider Enrollment, Chain, and Ownership System (PECOS). and sign a GCHP service agreement. If you are not sure if you are enrolled with DHCS or Medicare or became dis-enrolled, please contact the Contracting Department at **ProviderContracting@goldchp.org** prior to credentialing.

Providers interested in contracting with GCHP should contact **ProviderContracting@goldchp.org**.

Credentialing and Recredentialing

All providers must complete the credentialing process prior to becoming a Total Care Advantage participating provider and must complete the re-credentialing process every 36 months. Any new provider will be considered an out-of-network provider until the credentialing process is complete and will not be listed in the Total Care Advantage provider directory.

Upon notification of completion of a contract, the Credentialing Department will initiate the credentialing process. If the provider is currently participating in the Council for Affordable Quality Healthcare (CAQH), credentialing staff may use information to help with processing the credentialing application. Attestations, release forms, and other required information will be provided, including:

- Notice to Practitioners of Credentialing Rights / Responsibilities: Requires signature.
- Online access to the GCHP Credentialing policies:
  https://www.goldcoasthealthplan.org/for-providers/credentialing/
  - » Credentialing Criteria: Minimum Professional Standards

Additional credentialing requirements may be required, such as:

- Obstetricians: Paneled by the Comprehensive Perinatal Services Program (CPSP).
- HIV/AIDS specialists: Documentation of education and training requirements.

- Facility Site Reviews (FSR): Primary care offices require facility site reviews (FSRs) initial and subsequent (triennially).

For more information on these requirements, please contact GCHP's Provider Contracting Department at **ProviderContracting@goldchp.org**.

Medicare Enrollment and Certification

Medicare enrollment is a separate process from credentialing. In addition to being credentialed, GCHP is required by federal law to ensure GCHP contracted providers are enrolled though the Centers for Medicare & Medicaid Services (CMS) Medicare Provider Enrollment, Chain, and Ownership System (PECOS). If you are not sure if you are enrolled with Medicare or became dis-enrolled, please contact the Contracting Department at **ProviderContracting@goldchp.org** prior to credentialing.

Primary Source Verification

GCHP contracts with the credentialing verification organization, Gemini Diversified Services (GDS), to perform primary source verification. GDS does not make any decisions and/or recommendations related to the approval or denial of admission to the network. All initial credentialing and recredentialing decisions are the sole responsibility of the GCHP Credentials / Peer Review Committee.

Delegation of Credentialing Functions

GCHP may delegate credentialing functions. Entities that have been delegated to perform credentialing functions on behalf of GCHP must comply with all requirements applicable to GCHP. See also SECTION 12: DELEGATION

Facility Site Review (FSR) for Primary Care Office Locations

Facility site reviews (FSRs) are conducted for initial credentialing, then at least every three years as part of the credentialing verification process, recredentialing, and when there is a change in site location. A nurse certified as a facility site reviewer from GCHP will visit each PCP location to conduct a FSR. After the site review has been performed and any applicable corrective action plans (CAPs) have been satisfied, GCHP will complete processing of the information provided (including license status, physical accessibility, safety, etc.) and the initial credentialing and recredentialing files will be submitted to the Credentials / Peer Review Committee for review and approval. If a provider's credentials are approved, the chairperson of the committee or their designee will formally authorize the Provider's Service Agreement. For additional information, contact **ProviderContracting@goldchp.org**.

Adverse Actions

Providers are required to immediately notify GCHP upon discovery of any adverse action against their medical/clinical license, such as an accusation, probation, or other disciplinary action imposed by the Medical Board of California and/or any applicable licensing body. Notification is to be submitted to **credentialing@goldchp.org**.

When credentialing processes are delegated, delegates are required to review healthcare practitioners who have an accusation adverse action against their license declared by the Medical Board of California and/or any applicable licensing body. Review should include, as appropriate, but is not limited to:

- Discussion of the accusation
- Discussion of complaints and grievances concerning quality of care
- Review of prescribing practices (if applicable)
- Implementing appropriate interventions if there is concern of poor quality that could affect member safety (e.g., panel closure, monitoring of practitioner, termination, etc.)

Delegates are also required to monitor healthcare practitioners who have adverse action decisions (e.g., public letter of reprimand, probationary terms, etc.) against their license declared by the Medical Board of California and/or any applicable licensing board. Monitoring should include, as appropriate, but is not limited to:

- Grievances concerning quality of care
- National Practitioner Data Bank (NPDB) queries
- Medical Board of California daily e-mail notifications
- Other applicable licensing board, as appropriate
- Practitioner's registration and/or completion of required courses

Adverse Decisions by the Credentials / Peer Review Committee

The practitioner may appeal and request a hearing related to any Credentials / Peer Review Committee decision that alters the condition of participation with GCHP/Total Care Advantage within 30 days from the date of receipt of the notice of action or proposed action. Request for appeal must be in writing to the Director of the Quality Improvement Department at: **QualityImprovement@goldchp.org**. Failure to request a hearing within 30 days will be deemed a waiver of the right to a hearing on the matter.

When a provider fails to meet the credentialing standards or if their license, certification, or privileges are revoked, suspended, expired, or not renewed, GCHP will terminate the provider from the network and take necessary actions to ensure that the provider does not render services to GCHP/Total Care Advantage's members. Any conduct that could adversely affect the health or welfare of a member will result in written notification instructing the provider not to render services to members until the matter is resolved to GCHP/Total Care Advantage's satisfaction.

Debarment, Suspension, Ineligibility or Voluntary Exclusion

GCHP/Total Care Advantage indirectly receives federal funding through the CMS and DHCS. As such, both require GCHP/Total Care Advantage to monitor federal and state exclusions lists. The parties or entities on these lists are excluded from various activities, including rendering services to Medicare, Medicaid, and any other federal healthcare program members (unless in case of an emergency, as stated in 42 CFR §1001.1901), and employing or contracting with excluded parties to provide services to these members.

As subcontractors, GCHP/Total Care Advantage's contracted providers receive federal funding by nature of their agreement with GCHP/Total Care Advantage are considered "lower tier participants." Providers must attest to the fact that they have not been debarred or otherwise excluded by the federal government from receiving federal funding. Pursuant to this requirement and your agreement with GCHP, you are required to notify GCHP/Total Care Advantage immediately at **ProviderContracting@goldchp.org** if you or any provider with whom you hold a subcontract become suspended or ineligible to receive federal funds.

Provider Contract Termination

To ensure that medically necessary, in-progress, covered medical services are not interrupted due to the termination of a provider's contract, GCHP/Total Care Advantage assures continuity of care for its members, as well as for newly enrolled individuals who have been receiving covered services from a non-participating provider.

GCHP/Total Care Advantage or its delegate are required to make a good faith effort to provide written notice and make at least one attempt at telephonic notice of the termination of PCP and behavioral health providers at least 45 calendar days before the termination effective date to all members who are assigned to or currently receiving care from that PCP and to members who have been patients of that PCP or behavioral health provider within the past three years. Following state and federal requirements, GCHP/Total Care Advantage or its delegate is required to make a good faith effort to provide written notice of the

termination of a contracted specialist provider at least 30 calendar days before the termination effective date to all members who are patients seen on a regular basis by that provider (See 42 CFR 422.111(e) and 42 CFR 438.10(f).

In the case of unforeseen circumstances, if GCHP/Total Care Advantage receives less than 30 calendar days' notice of a change in the provider contract, GCHP/Total Care Advantage shall notify members of the change within 14 calendar days prior to the effective date of the change.

PCPs and specialists shall notify GCHP/Total Care Advantage members no less than 120 days prior to terminating their contract. This allows time to assist beneficiaries with a new PCP assignment. If GCHP/Total Care Advantage terminates a provider's contract without prior notice as a result of his or her endangering the health and safety of members, committing criminal or fraudulent acts, or engaging in grossly unprofessional conduct, GCHP/Total Care Advantage shall provide written notification to affected members within 30 days of the date of the contract termination. If GCHP/Total Care Advantage determines that it is in the best interest of the member, GCHP/Total Care Advantage may modify the notification period to the members.

Upon contract termination, the provider will, at GCHP/Total Care Advantage's discretion, continue to provide covered services to members who are under the care of the provider at the time of the termination until the services being rendered are completed, unless GCHP/Total Care Advantage has made arrangements for the assumption of such services by another physician and/or provider. The provider will help GCHP/Total Care Advantage in the orderly transfer of the members to the provider they choose or to whom they are referred after termination, including but not limited to the transfer of the member's medical records. The transition of a member's care post-termination shall be in accordance with the phase-out requirements set forth in the Medi-Cal agreement. Payment by GCHP for the continuation of services by the provider after the effective date of termination will be subject to the terms and conditions set forth in the agreement.

In the event of a natural disaster or emergency, GCHP/Total Care Advantage shall notify members of any significant changes in the availability or location of covered services within 14 calendar days of the change.

Section 6: Physician Responsibilities

Physicians participating in the GCHP/Total Care Advantage network have responsibilities based on their role as primary care providers (PCPs) and/or specialists. This responsibility extends to clinical and non-physician staff responsible for supporting physicians; therefore, all uses of "physician" shall be understood to extend to such staff.

Primary Care Provider (PCP) Responsibilities

The primary care provider (PCP), also referred to as a member's medical home, has the primary responsibility of coordinating and structuring preventive and disease management care for Total Care Advantage members. The PCP is the main provider of healthcare services in the medical home and is responsible for leading their team to ensure appropriate and timely delivery of healthcare to members. The PCP is contractually obligated to provide GCHP with office hours, staffing and any on-call or after-hours coverage arrangements. Office hours and an emergency number must be clearly displayed in the provider's office. The PCP is responsible for supervising, coordinating, and providing primary care services to members and for maintaining the continuity of care for the members who select or are assigned to the medical home. PCPs include general and family practitioners, and internal medicine. Physician assistants and nurse practitioners also act as PCPs; however, members cannot be assigned to them.

As an integral part of the Interdisciplinary Care Team (ICT), the PCP and their team provide clinical leadership, ensure a full understanding of the member needs as identified through the HRA, maintain an updated ICP and ensure the delivery of needed healthcare, and collaborate with GCHP to ensure all needs are identified.

Reporting Encounter Data

Encounter data is detailed information about individual services rendered by a provider contracted with a managed care plan. The level of detail about each service reported is similar to that of a standard claim form. (Encounter data for capitated providers where no claims payment is expected since services are prepaid are also sometimes referred to as "shadow claims" or "dummy claims").

Capitated providers are required by Total Care Advantage to submit claims for all services, even though they are pre-paid by capitation. Claims that have been pre-paid via capitation are considered encounter data in that the claim describes the details of patient encounters with the PCP. Total Care Advantage requires that you submit encounter data at least once a month, as the information is critical for health plan analytics and HEDIS® studies. Most importantly, this data is used by the state to set future GCHP revenue, which has a direct impact on Total Care Advantage's payments to providers.

All providers may transmit their encounter data electronically using the ANSI 837 format as outlined by the Health Insurance Portability and Accountability Act (HIPAA).

If you would like to send this information electronically, please contact GCHP's Provider Services Department at 1-888-301-1228 for assistance and possible referral to GCHP's Information Technology (IT) vendor. Please note that if you are already submitting your encounter data electronically using a clearinghouse, you may be able to submit to GCHP using your existing connection. Please contact your existing clearinghouse to confirm.

Encounter Data Validation

The state Department of Health Care Services (DHCS) partners with Health Services Advisory Group, Inc. (HSAG) to conduct Encounter Data Validation (EDV) studies to evaluate the completeness and accuracy of encounter data submitted to DHCS. The studies may involve the evaluation of encounter data compared to medical record documentation for services rendered during the study period.

Preventive Healthcare

PCPs must provide preventive healthcare according to GCHP-approved nationally recognized clinical practice guidelines designed to aid physicians' and practitioner's diagnostic and treatment clinical decision making for treating specific health conditions. These guidelines are based on peer reviewed scientific evidence, medical literature review, and/or established expertise and authority. All recommendations are grounded in nationally recognized and accepted public health, and professional society guidelines. GCHP clinical practice guidelines do not prioritize diagnostic decisions and clinical treatments based solely on cost. These clinical practice guidelines include:

- **United States Preventive Services Task Force (USPSTF)**
- **American Academy of Family Practitioners (AAFP)**
- **American Cancer Society**
- **Health Matters in Ventura County**

Transitional Care Services - Post Emergency Department and/or Hospitalization Visit Transitions of Care

PCPs must follow best practices to ensure a post emergency department and/or hospitalization visit is performed within seven days of discharge. These follow-up visits present an ideal opportunity for the PCP to prepare the member and family caregiver for self-care activities, make sure the discharge instructions are documented and being followed, ensure medications are reconciled, and to head off situations that could lead to readmission. Members may be eligible for additional benefits, such as short-term home delivered meals and personal care services following an inpatient hospital or SNF stay.
Refer to SECTION 7: CARE COORDINATION AND THE D-SNP MODEL OF CARE

Medicare provides a defined set of preventive care visits for Total Care Advantage members to support establishing and maintaining an individualized plan for wellness and disease prevention. The following visit types are intended to promote early identification of health risks, coordination of preventive services, and ongoing engagement between members and their primary care providers:

- Initial preventive physical examination (IPPE), also known as the Welcome to Medicare visit, which is available within the first 12 months of Medicare Part B enrollment.
- Annual wellness visit (AWV), a yearly Medicare preventive service that focuses on updating the member's health risk assessment, reviewing medical and family history, conducting a required cognitive assessment, and developing or revising a personalized prevention plan of service.

While CMS has rules that require 11 months between AWVs, Total Care Advantage will allow either one AWV or one IPPE in a calendar year.

- The IPPE is a once in a lifetime benefit and for the purposes of Total Care Advantage, the "lifetime" begins when the member begins enrollment with Total Care Advantage.
- For the AWV, it is one per calendar year. There is no requirement for Total Care Advantage that the AWVs are spaced 11 months apart.

See the table below for specific examples.

Example	Decision	Rule
Member had AWV October 2025 and wants to have an AWV in March 2026	Yes. Member can have AWV in March 2026.	One AWV per calendar year.
Member is new to Total Care Advantage in 2026 and wants an IPPE in 2026	Yes. Member can have an IPPE in 2026.	One IPPE in a lifetime. Lifetime begins with enrollment in Total Care Advantage.
Member was a Humana member in January and had an AWV in January 2026. Member joins Total Care Advantage in May 2026 and wants an AWV with their new provider.	Yes. Member can have an AWV in May 2026.	One AWV per calendar year as a Total Care Advantage member.
Member has IPPE in January 2026 and wants AWV in November 2026	No. Member cannot have both an IPPE and AWV in 2026.	Member cannot have both IPPE and AWV in the same year.
Member has AWV in February 2026 and wants AWV in December 2026.	No. Member cannot have two AWVs in 2026.	Member can only have one AWV per calendar year.

For more information about the Medicare required elements of the AWV and the IPPE, **click here**.

Safeguard Privacy and Maintain Records Accurately and Timely

For any medical records or other health and enrollment information maintained with respect to members, providers must establish policies that abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. (See 42 CFR 422.118).

Providers must further:

- Safeguard the privacy of any information that identifies a particular member and have procedures that specify: (1) for what purposes the information will be used within the organization; and (2) to whom and for what purposes it will disclose the information outside the organization;
- Ensure that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas;
- Maintain the records and information in an accurate and timely manner;
- Ensure member timely access to records and information that pertain to them; and
- Timely report breaches of PHI.

Member Reassignment

Requesting a member reassignment should be the last resort for an untenable patient / provider relationship. A request to transfer a member to another PCP requires GCHP approval.

There are situations in which a member's behavior can place a strain on the provider. CMS generally does not permit the involuntary termination of a member, except in very specific circumstances. GCHP will work with providers to find a way to meet the needs of the member while addressing the concerns of the affected providers. Under no circumstances should providers refuse to continue to provide and arrange care for a member. All efforts should first be made to resolve the issue at the practice level. Disruptive behaviors may include abusive, harassing, or derogatory comments to staff, including yelling or profanity; threats of violence; threats of lawsuits; and inappropriate public behavior.

When all efforts have been exhausted, GCHP will work with provider to transfer members to another provider for repeated, continuous, and unabated disruptive behavior by the member that prevents the provider from providing services to the member. Prior to requesting a member transfer, the provider must provide GCHP with contemporaneous documentation of the disruptive behavior and all attempts made to resolve the issue. Refer to Medicare Managed Care Manual, Chapter 2 – Medicare Advantage Enrollment and Disenrollment, Section 50.3.2 – **Disruptive Behavior**.

Providers may not end a relationship with a member because of a member's medical condition, the cost and type of care/treatment required, or for the member's failure to follow treatment recommendations.

Providers may not refuse to continue to coordinate care as long as the member is assigned to the provider.

A member may not be involuntarily transferred to a new provider without the approval of GCHP.

To request a member reassignment promptly notify GCHP at **ProviderRelations@goldchp.org** and include any supporting details and documentation.

Specialist Responsibilities

A specialist physician is a physician credentialed to provide certain specialty care outside the expertise of the PCP. Whenever possible, specialty care will be provided by GCHP contracted providers. If a medically necessary specialty service is unavailable within the contracted network, GCHP will assist in the coordination of care.

Access to Care Standards and Hours of Operation

CMS requires that GCHP employ written standards for timeliness of access to care and services, make these standards known to all providers, continuously monitor its provider networks' compliance with these standards, and take corrective action as necessary. These standards must ensure that GCHP's network hours of operation are: (1) convenient for members, non-discriminatory, and at least as accessible as those offered to other patients; and (2) available 24/7 to provide covered services when medically necessary. See 42 CFR 422.112(a)(6)(i) and 42 CFR 422.112(a)(7)(ii) and Medicare Managed Care Manual (MMCM), Chapter 4, Section 110.1.1.

Under GCHP's contract with DHCS, GCHP is also required to establish acceptable accessibility standards in accordance with 28 CCR Section 1300.67.2.1 and DHCS All Plan Letter (APL) 25-006 Timely Access Requirements. DHCS will review and approve these standards, and GCHP is required to communicate, enforce, and monitor network compliance with these standards. To ensure network access standards are met and network adequacy in accordance with federal and state requirements, GCHP has established the following accessibility standards for all contracted providers:

Accessibility Standards	
Services	**Standard (Measured from Time of Request)**
Urgent/Emergent	
Emergency services / Urgent Care	Immediately 24/7
Urgent Care appointment: PCP / Specialist	48 hours if no prior authorization
Urgent Care appointment: PCP / Specialist	96 hours if prior authorization required
Non-physician mental health or SUD provider	48 hours if no prior authorization
Post-stabilization services*	30 minutes (DHCS = 30 minutes/CMS = 1 hour)
Dental	72 hours (DHCS)
Non-Urgent/Non-Emergent	
Ancillary services	15 business days (DHCS)
Specialty care	15 business days (DHCS)
PCP*	10 business days (DHCS) 7 business days (CMS)
First prenatal visit	10 business days (DHCS)
Non-physician mental health or SUD provider	10 business days (DHCS)
Routine and preventive care (PCP)	30 business days (CMS)
Dental non-preventative	36 business days (DHCS)
24/7 nurse triage line	Response/Call within 30 Minutes (DHCS)
Other	
Interpreter services	24/7 (DHCS)
Dental preventive	40 business days (DHCS)
Member Services line	10 minutes (DHCS)

***Where DHCS and CMS differ, the stricter of the two standards apply.**

Access to and Provision of Records

GCHP may request records from your office for a covered member for reasons related to treatment, payment and/or operations (TPO). Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, a provider does not require a signed authorization to release a patient's protected health information for TPO. These may include a request related to:

- Quality improvement studies mandated by the state, such as the Managed Care Accountability Set (MCAS), CMS Star Ratings Program, and Healthcare Effectiveness Data and Information Set (HEDIS®) studies, Performance Improvement Projects (PIPS), Potential Quality Issues (PQIs) or the Encounter Data Validation (EDV) studies.
- Prior authorization requests.
- Claims payments issues.
- Utilization review.
- Assistance with case coordination.
- Regulatory auditing requests (DHCS, CMS).
- Follow-up to a member complaint.
- Potential quality issues.
- Facility site reviews.
- Medical record reviews.

The California Health and Safety Code § 123100 declares that every person having ultimate responsibility for decisions regarding their healthcare also possesses a right to access information about their condition and care provided. Records are not released without a written, signed and dated authorization from the patient or the patient's representative. Pursuant to U.S. Code of Federal Regulations §164.508c a valid authorization request must include:

- Person authorizing release.
- Person / organization authorized to receive the PHI.
- Description of PHI to be disclosed.
- Purpose of the PHI disclosure.
- Date authorization expires.
- Signature and date of person authorizing the release.

Refer to your GCHP signed service agreement for further details.

Telehealth Services

It is imperative that Total Care Advantage members have access to timely care, including telehealth services, wherever offered. In an effort to continue providing additional access options, and in continuation of the telehealth requirements put into place under section 319 of the Public Health Service (PHS) Act, Total Care Advantage members will have access to telehealth. Accordingly, providers should take steps to allow members to obtain healthcare via telehealth when medically appropriate "as a means to increase provider capacity."

When billing for telehealth services, providers should bill using Place of Service Code 02 and modifier 95 for synchronous telehealth services and modifier GQ for asynchronous telehealth services. Providers will be reimbursed at the same rate whether a service is provided in-person or through telehealth if the service is the same regardless of the modality of delivery.

GCHP providers will be reimbursed for the same amount for a service rendered via telephone as they would if the service was rendered via video provided that the modality, telephone vs video, is medically appropriate (DHCS APL 23-007).

Qualified providers are those currently enrolled in Medicare and Medi-Cal including, but not limited to, physicians, nurses, occupational therapy, physical therapy, mental health practitioners, substance use disorder practitioners, substance use disorder practitioners, as well as FQHCs and RHCs and Tribal 638 Clinics.

Language Assistance Services

To ensure effective communication providers must communicate and/or provide materials for limited English proficient (LEP), limited reading skills, hearing incapacity and speech impaired Members through provision of high quality interpreter and linguistic services. Providers and their staff can email the GCHP Cultural and Linguistic Department at **CulturalLinguistics@goldchp.org**. Or contact Member Services at 1-888-301-1228 for assistance in providing member materials in languages other than English or in alternative formats, like large print, braille, and/or audio, free of charge to the member.

Fraud, Waste and Abuse Reporting

As a provider, you are required to report to GCHP any incident of fraud, waste and/or abuse that may have occurred by members, providers, or employees within 10 days from the date when you first became aware of, or were put on notice of, such activity.

To report fraud, waste and abuse call GCHP's Compliance and Fraud Hotline at 1-866-672-2615 or visit **secure.ethicspoint.com**. All calls and emails can remain anonyms. (See SECTION 6 for further details on Continuity of Care).

Referrals

PCPs and specialist physicians must provide referrals for members timely and appropriately. Providers are expected to direct members to in-network health professionals, hospitals, laboratories, and other facilities unless appropriate specialty care is not available within GCHP's network. In circumstances where out-of-network services are needed, authorization is required except in the case of emergency services.

Continuity of Care

Continuity of Care is continuous coordinated care afforded to all members by a practitioner involved in their care and treatment. This care is a collaborative effort between providers and GCHP/Total Care Advantage. Physicians are responsible for working with GCHP to ensure continuity of care. (See SECTION 6: Utilization Management for further details on Continuity of Care).

Standing Referrals

Standing referrals may be authorized when a member requires continuing specialty care over a prolonged period of time (e.g., member has a life-threatening, degenerative or disabling condition that requires coordination of care by a specialist rather than a PCP). PCPs and referred specialists coordinate care and treatment, along with the member, and develop a treatment plan that addresses the number of approved visits or the period of time during which the visits are authorized and the plan for each visit.

Specialist Physician Referrals

When a PCP refers a member to a specialist physician, in addition to consultation, the specialist may refer the member for additional in-network testing and services that are within the guidelines of their specialty. A treatment plan must be agreed upon by the PCP, the specialist physician, and the member. In addition, a specialist physician may substitute as a PCP for a member with a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, when authorized.

Second and Third Opinions

Second and third opinion consultations are covered even if the service is determined not to be covered. PCPs must provide referrals to another network physician when a second or third opinion is requested and appropriate. Patient-initiated second opinions that relate to the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures are covered. In the event that the recommendation of the first and second physician differs regarding the need for surgery (or other major procedure), a third opinion is also covered. Second and third opinion referrals are for consultation only and do not imply referral for ongoing treatment. (See Medicare Benefit Policy Manual, Chapter 15: Covered Medical and Other Services.)

Clinical Trials

GCHP/Total Care Advantage members may participate in Medicare-approved clinical trials without prior authorization and stay enrolled in GCHP/Total Care Advantage to continue to get care not related to the trial through PCP. For clinical studies approved under Coverage with Evidence Development (CED) and Investigational Device Exemption (IDE) studies, authorization is required.

For Medicare-approved clinical trials other than CEDs and IDEs, clinical trial providers should bill original Medicare for clinical trial-related services. These services are not carved out to GCHP, though GCHP may offer assistance in identification of Medicare-approved clinical trials. Authorization is not required for participation in Medicare approved clinical trials. Experimental and Investigational procedures and items are not covered.

For additional information on coverage of clinical trials, CED/IDE, and experimental/ investigational may refer members to Medicare at 1-800-MEDICARE (1-800-633-4227).

Transplants

Transplant evaluation and services must be provided in a Medicare-approved transplant center; therefore, members may only be referred to facilities that meet minimum standards established by Medicare to ensure member safety. GCHP/Total Care Advantage will render a transplant evaluation authorization which may be performed concurrently with medical management of an inpatient event. Transplant-related professional, facility and diagnostic services (including transplant evaluation) must be billed separately from other services. All other services not directly related to transplant services remain the financial responsibility of the entity at risk for inpatient care.

Refer to Total Care Advantage Request for Authorization Guidance and Prior Authorization List, **here**.

You can also find information on how to request services in the Total Care Advantage Member Handbook available on the GCHP **website**.

Hospice Services

Hospice care will be coordinated with the elected hospice provider and is covered by Original Medicare. Hospice providers must request authorization for non-hospice benefits through Total Care Advantage Utilization Management.

Hospice medication management drugs and biological products paid for under the Part A are excluded from coverage under Part D. In general, hospice will provide medications related to the care plan for the terminal diagnosis, and certain drugs that relieve common symptoms during the end of life, regardless of terminal diagnosis. These symptoms include pain, nausea, constipation, and anxiety. For members enrolled in hospice, The GCHP/Total Care Advantage pharmacy benefit manager (PBM) Prime Therapeutics has member-level prior authorization requirements on the following four medication categories to

determine their coverage under Part A versus Part D benefit: analgesics; antinauseants (antiemetics); laxatives; and antianxiety drugs (anxiolytics) as required by Medicare. For these drugs, hospice-affiliated providers must provide a statement supporting whether the prescribed drug is unrelated to the member's "terminal illness or related condition" for Part D coverage.

Acupuncture/Chiropractic Services

These services are provided by American Specialty Health (ASH). To locate a provider in contact Member Services at 1-888-301-1228 (TTY 711) or go to **https://www.ashlink.com/ash/GCHP**.

Dental Care (Routine Services)

There is no referral needed for the first appointment. Call Medi-Cal Dental at 1-800-322-6384 (TTY 1-800-735-2922) to find a dentist or visit **https://dental.dhcs.ca.gov/**.

Hearing Aid Services

GCHP covers hearing aid services that are provided by TruHearing. Contact TruHearing for additional information or refer Members that may need hearing screening and/or hearing aids to TruHearing at 1-833-723-3311 (TTY: 711).

Non-Emergency Medical Transportation (NEMT)

No authorization is required for transportation from an emergency room to an inpatient setting or from an acute care hospital (immediately following an inpatient stay at the acute level of care) to a skilled nursing facility, an intermediate care facility or imbedded psychiatric unit, free standing psychiatric inpatient hospital, psychiatric health facility, or any other appropriate inpatient acute psychiatric facility.

NEMT to access medically necessary services (e.g., to doctor office and therapy appointments, pharmacy) and/or Supplemental benefits for the Chronically Ill (SSBCI) (e.g., gym, senior center, grocery store, church, personal care) services, when the member's medical or physical condition does not allow them to utilize public/private transportation, require authorization with submission of a physician certification statement (PCS) signed by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender. GCHP/Total Care Advantage will provide authorization for NEMT for the duration of the recurring appointments.

The PCS form is available on the GCHP website at **physician certification statement (PCS)**. For additional information refer to the **Summary of Benefits** or contact the GCHP Transportation Liaison at 1-805-437-5832.

Non-medical Corrective Vision Services (non-surgical)

There is no referral needed. Call Vision Service Plan (VSP) at 1-800-877-7195 (TTY 1-800-428-4833) to find a provider.

Home Delivered Meals

Call Member Services at 1-888-301-1228 for assistance.

Over-the-Counter (OTC) Items

Some over-the-counter (OTC) medications and certain vitamins may be covered by Medi-Cal Rx. Visit the Medi-Cal Rx **website** or call Medi-Cal Rx customer service center at 1-800-977-2273 for additional information.

Behavioral, Mental Health, and Substance Use Disorders

PCPs must screen members for mental and behavioral health needs using validated screening tools at each visit and, when appropriate, initiate a mental health or substance use referral. GCHP contracts with Carelon Behavioral Health. Refer to the GCHP **website** for information.

Section 7: Utilization Management

The role of Utilization Management is to ensure the consistent delivery of high-quality healthcare services to Gold Coast Health Plan Total Care Advantage members. Utilization Management is a collaborative and cooperative effort between Gold Coast Health Plan (GCHP)/Total Care Advantage and its providers. We work together to ensure that members receive covered services that are medically necessary, appropriate to the member's condition, rendered in the appropriate setting, and meet professionally recognized standards of care. GCHP/Total Care Advantage monitors and provides oversight of utilization through the Utilization Management Committee.

Delegation of Utilization Management

GCHP/Total Care Advantage may delegate utilization management functions to its contracted delegated entities. The entities delegated to perform utilization management activities on behalf of GCHP/Total Care Advantage must comply with all requirements applicable to GCHP/Total Care Advantage. Where items or services are not delegated and remain GCHP responsibility, providers should send authorization requests to GCHP/Total Care Advantage Utilization Management.

Organization Determinations

An organization determination is any decision made by a Medicare Advantage (MA) organization, or its delegated entity, regarding receipt of or payment for a managed care item or service. Organization determinations include, but are not limited to, prior authorizations, concurrent review, retrospective review, and requests for continuity of care. Should GCHP/Total Care Advantage receive a request for an organization determination where the responsibility for making the determination has been delegated, GCHP/Total Care Advantage will refer the request to the appropriate delegated entity.

Organization determinations must be made by healthcare professionals who have appropriate clinical expertise in treating the member's condition or disease, in accordance with currently accepted medical or healthcare practices. Organization determinations are always based on member eligibility and appropriateness of care/service. See **Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance**.

Prior Authorization (PA)

Some services require prior authorization under the medical benefit. These include certain physician-administered drugs covered under Medicare Part B referenced in the **Total Care Advantage Part B Clinical Guidelines** and general **Prior Authorizations List**. Providers must submit a prior authorization (PA) request with clinical documentation that supports medical necessity, such as diagnosis, treatment history and dosing details. Once submitted, GCHP/Total Care Advantage will review the request and issue an organization determination within the required Centers for Medicare & Medicaid Services (CMS) timeframe (72 hours for standard requests; 24 hours for expedited requests).

Additional PA rules exist for Medicare Part D drugs. All Part D activity, including authorization and claims payment is managed by GCHP's pharmacy benefit manager, **Prime Therapeutics**. For additional question related to the Part D outpatient pharmacy benefit, call Prime Therapeutics Member Services at 1-855-681-7966.

Prior authorization is never required for emergency services, including behavioral health services, necessary to screen and stabilize members. Prior authorization is always required for planned out of area services that are not urgent or emergent.

All Total Care Advantage providers must adhere to the following decision-making hierarchy when considering coverage criteria for medical necessity determinations, which is publicly available on the GCHP **website**.

A. GCHP and its contracted providers must adhere to the following decision-making hierarchy when considering coverage criteria for medical necessity determinations:
   1. Centers for Medicare & Medicaid (CMS) Guidelines including, but not limited to:
      i. **Medicare National Coverage Determinations (NCDs)**
      ii. **Medicare Local Coverage Decisions (LCDs)**
      iii. **Medicare Local Coverage Articles (LCAs)**
      iv. **Medicare Manuals (Internet Only Manuals (IOM)**
   2. DHCS Medi-Cal Provider Manual Criteria for dual eligible members also refer to: **DHCS Medi-Cal Guidelines**

B. Internal coverage criteria (in the absence of Medicare and Medi-Cal guidelines) based on current evidence in publicly available, widely used treatment guidelines or clinical literature, such as:
   1. Nationally recognized evidence-based guidelines/criteria, in conjunction with the clinical judgement of a qualified health professional, including:
      i. Utilization Management Decision-Support Guidelines (such as MCG®, InterQual®)
      ii. National Comprehensive Cancer Network (NCCN)®
      iii. American Diabetes Association (ADA)®
      iv. American Heart Association (AHA)®
      v. American Academy of Family Physicians (AAFP)®
      vi. American Geriatrics Society (AGS)®
      vii. United States Preventative Services Task Force (USPSTF)®
      viii. Centers for Disease Control and Prevention (CDC)®
      ix. UptoDate®

C. In coverage situations where coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs GCHP may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature. GCHP or its delegates will not develop or apply internal coverage criteria to limit, expand, or otherwise modify the scope of coverage established by an NCD with CED.

NOTE: Federal and state mandates, as well as state contract language (including definitions and specific contract provisions/exclusions) may take precedence over this decision-making hierarchy and must be considered first when determining coverage.

GCHP publicly posts Clinical Decision Support Guidelines at **https://gchp.access.mcg.com/index**

Services Requiring Prior Authorization

Refer to the following resources for a list of services requiring prior authorization.

Total Care Advantage Total Care Advantage Summary of Benefits	**https://res.cloudinary.com/dpmykpsih/raw/upload/gold-coast-site-258/media/r/f7ca5bfff2c34f748a34d35439a2314c/tca-summary-of-benefits_eng_072025_12pt_digital_v8-final.pdf**
Total Care Advantage Request for Authorization Guidance and Prior Authorization List	**https://www.goldcoasthealthplan.org/for-providers/provider-resources/**
Total Care Advantage Part B Drug List and Clinical Guidelines	**https://www.goldcoasthealthplan.org/for-providers/pharmacy-services-for-providers/medicare-part-b-drugs/**
Medical Policy / Clinical Practice Guidelines	**https://res.cloudinary.com/dpmykpsih/raw/upload/gold-coast-site-258/media/r/1744d6a6d2664e438eb1bd65868e25db/gchp_clinical_practice_guidelines_082025_finalp.pdf**
Clinical Decision-Making Hierarchy	**https://res.cloudinary.com/dpmykpsih/raw/upload/gold-coast-site-258/media/r/fc1b36617a834ca3a5c50d101fdc74b6/gchp_clinical_decision_hierarchy_guidelines_092025_v2-finalp.pdf**
GCHP Clinical Decision Support Guidelines	**https://gchp.access.mcg.com/index**

Request services through the GCHP Provider Portal or fax to 855-883-1552.

Timeliness of Pre-Service Organization Determinations

A member or their physician may seek pre-service organization determination from GCHP/Total Care Advantage or, where applicable, its delegated entities. The member or his / her physician may request that an organization determination be expedited when he / she believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.

Type of Request	Integrated Initial Organization Determinations
Non-Urgent / Standard	**14 calendar days from request** For a service / item ***not subject to prior authorization*** **7 calendar days from request** For a ***service / item subject to prior authorization***

Type of Request	Integrated Initial Organization Determinations
Urgent / Expedited	**72 hours from date of request** If determined not meet expedited criteria the request is transferred to a Non-urgent/Standard request – The timeframe begins the day the plan receives the request for expedited integrated organization determination **AND** ***Prompt oral notice*** of transfer and written notification ***within 3 calendar days*** Request for additional information from non-contracted provider ***within 24 hours*** of the request
Post Stabilization	Respond to requests ***within 30 minutes***, or the service is deemed approved.
Part B Drug: Standard	***Within 72 hours***
Part B Drug: Expedited	***Within 24 hours***

Continuity of Care

GCHP/Total Care Advantage will coordinate care and services for members who are newly enrolled and/or transitioning to a new PCP, or where there is potential for disruption in services to ensure uninterrupted care and safe transition. Continuity of care may be requested for, but not limited to: outpatient mental health / chemical dependency treatment; current acute or SNF hospitalization; chemotherapy, radiation therapy or nuclear medicine; complex chronic condition requiring continued care and ongoing services; DME (e.g. oxygen, hospital bed); terminal illness requiring continued care and ongoing services; and pending authorized surgery/procedure scheduled.

Authorization of medically necessary continuity of care services may extend up to 12 months and will be effective from the date of the member's D-SNP enrollment for primary and specialty providers with whom the member has a pre-existing relationship and who are willing to work with GCHP/Total Care Advantage. The 12-month continuity of care period restarts if:

A. A member changes health plans by choice following the initial enrollment OR
B. A member loses and then later regains health plan eligibility during the 12-month continuity of care period.
C. The 12-month continuity of care period for a pre-existing provider may start over one time based on voluntary enrollment.

Section 8: Care Coordination and the D-SNP Model of Care

Gold Coast Health Plan Total Care Advantage (HMO D-SNP) provides care coordination where every member is assigned a care navigator or care manager who:

- Conducts health risk assessments (HRA) to identify member needs and recommended services / supports / benefits. HRAs are conducted within 90 days of enrollment and at least annually thereafter. They are also conducted with any changes in health status including immediately following hospitalizations.
- Works with the member on an individualized care plan (ICP). The HRA response data is used to develop an ICP specific to the member's identified needs. Care navigator staff reviews the results of the HRA with the member and/or caregiver and works together to develop an ICP based on needs identified and member's preferences. The ICP is provided in members preferred language and font size. The ICP is sent to the member / caregiver by mail and to the Primary Care Provider (PCP) team, with other members of the interdisciplinary care team (ICT) as needed through mail, fax, SFTP or other mechanisms.
- Facilitates ICT. The ICT includes D-SNP care coordination staff, the member / caregiver, PCP team and other providers and community resources, as necessary to prioritize and coordinate care, prompt additional assessments, identify and resolve care gaps, modify the ICP and connect members with resources and treatments. The ICT is to occur following every HRA and via rive / real time (phone calls, in-person meetings) or electronic / paper (faxes, letters, EHR, other secure electronic formats).

  The member, caregiver, PCP, and assigned care navigator and/or California Integrated Care Management (CICM) care manager are core members of the ICT. Members enrolled in Palliative Care must use the Palliative Care ICT that includes their assigned CICM care manager from Total Care Advantage.

- Provides Transitional Care Services (TCS). Care transitions support is offered by their assigned care navigator or care manager with every inpatient admission and related transition in that episode of care. Members will be followed for at least 30 days post discharge. Total Care Advantage uses TCS protocols in partnership with our provider partners (physician organizations and hospitals) and community-based organization partners to support members when moving from one care setting to another.
- Provides Enhanced Care Management (ECM)-like services called California Integrated Care Management (CICM). CICM services are performed by staff with the appropriate training and expertise. Care coordination to support members with more complex needs is provided by a clinical care manager who is a registered nurse, social worker, licensed clinical social worker (LCSW) or other licensed behavioral health professional.
- Provides caregiver support for members living with dementia as a trained specialist through Dementia Care Specialists by Alzheimer's Los Angeles.

Care navigators and clinical care managers provide support to members and their caregivers both via telephonic, virtual and in-person based on members preference.

Providers are encouraged to contact the member's care manager or the Care Coordination department to:

- Provide feedback on the member's ICP.
- Alert if there are member needs that the Care Coordination team can assist with such as ICT meetings, appointment scheduling, referrals, transportation, community resource connections or program enrollment.

Key Provider Activities for ICP, ICT, and TCS in the Model of Care:

- Collaboration in the development of member's ICP.
- Notify Total Care Advantage (HMO D-SNP) care manager of any recommended changes to the ICP.
- Participate in the members ICT.
- Review the ICP during office visits to reinforce goals.
- Contact Total Care Advantage if there are member needs that the Care Coordination team can assist (e.g. ICT meetings, appointment scheduling, referrals, transportation, community resource connections or program enrollment).
- For members experiencing transitions of care, try to accommodate appointments within seven days post discharge, review discharge instructions, perform medication reconciliation, and collaborate on latest ICP from care manager with the member.

To contact Total Care Advantage Care Coordination Team:

- Email **DSNPCareCoordinationTeam@goldchp.org**
- Call **1-888-301-1228** and ask to be connected to the member's assigned care navigator

For additional information, refer to the Total Care Advantage **Model of Care training**

Section 9: Population Health Management (PHM)

Gold Coast Health Plan/Total Care Advantage's Population Health Management (PHM) Program is designed to ensure members have access to a comprehensive, coordinated, and personalized set of services across the continuum of care. By aligning services with individual needs and preferences, the PHM Program supports longer, healthier, and more fulfilling lives, improves health outcomes, and advances health equity for the communities we serve.

Core Functions of the PHM Program

- **Member Engagement and Trust Building**
  The PHM Program fosters meaningful, ongoing relationships with members, promoting trust and encouraging active participation in their health and wellness journeys.
- **Addressing Upstream Drivers of Health**
  The program partners with public health agencies and social service organizations to address social determinants and other upstream factors that influence health outcomes.
- **Preventive Health and Targeted Interventions**
  Guided by QIHETP focus areas, the PHM Program supports preventive care and early intervention through gap reporting and population targeting. These efforts are supported by GCHP's HEDIS®-certified software and quality improvement analyses.
- **Reducing Health Disparities and Addressing Social Drivers of Health (SDOH)**
  Data-driven analyses are used to identify health disparities and inform the development of targeted strategies that promote equity and address social drivers of health.
- **Community Health Assessment (CHA) and Community Health Implementation Strategy (CHIS)**
  Through a collaborative CHA process, the PHM Program identifies community health needs and disparities to inform targeted interventions. This work strengthens partnerships with public health entities and local stakeholders and deepens understanding of social drivers of health.
- **Population Needs Assessment (PNA)**
  In addition to the CHA, the PHM Program conducts an annual Population Needs Assessment to summarize the health needs of GCHP members and identify opportunities where population health strategies can have the greatest impact.
- **Chronic Disease and Cancer Screening Initiatives**
  The PHM Program is assessing opportunities to support chronic disease management for members with diabetes and piloting a self-administered colorectal cancer screening kit program.

GCHP is committed to continuously expanding and refining PHM services through a data-driven, quality improvement approach that adapts to evolving member needs.

The PHM Program operates under the leadership of the Executive Director of Population Health, with clinical quality oversight provided by the Chief Medical Officer (CMO).

Section 10: California State Programs

California Immunization Registry (CAIR2)

California Immunization Registry (CAIR2) is a secure, statewide computerized immunization registry and information system. Providers must use CAIR2 to access their patients' immunization information, utilize the integrated vaccine algorithms to determine vaccination due dates, enter vaccine doses administered, manage vaccine inventory, run patient inventory reports or generate reminder / recall reports for patients who are due for vaccinations. It is a sophisticated and user-friendly tool to help providers manage their patients' immunizations and keep records up to date.

Per Assembly Bill (AB) 1797, starting Jan. 1, 2023, state healthcare providers who administer vaccines are required to enter:

- Immunization information into CAIR2 for Ventura County Providers.
- Race and ethnicity information for each patient to support assessments of health disparities in immunization coverage.
- Tuberculosis (TB) test results.

To learn more about these requirements, view AB 1797 Immunization Registry FAQs.

Additionally, per All Plan Letter (APL) 24-008, the state Department of Health Care Services (DHCS) requires that all GCHP providers:

1. Ensure the timely provision of immunizations to members in accordance with the most recent schedule and recommendations published by the California Department of Public Health (CDPH), regardless of a member's age, gender, or medical condition, including pregnancy.
2. Document each member's need for recommended immunizations as part of all regular health visits, including, but not limited to, the following member encounters:
    - Illness, care management, or follow-up appointments
    - Initial health appointments (IHA)
    - Pharmacy services
    - Prenatal and postpartum care
    - Pre-travel visits
    - Annual wellness visits and physicals
    - Visits to a local health department (LHD)
    - Well patient checkups

CDPH-recommended immunizations are viewed as preventive services and are not subject to prior authorization.

This immunization information is essential to GCHP, as DHCS requires GCHP to ensure member-specific immunization information is reported to CAIR2. GCHP strongly encourages providers to report immunization information the same day they are administered.

For more information about CAIR2 and how to join, call 1-800-578-7889 or visit **www.CairWeb.org**.

Comprehensive Perinatal Services Program (CPSP)

Comprehensive Perinatal Services Program CPSP provides a wide range of services to pregnant women from conception to 60 days postpartum. Women receive enhanced services in addition to standard obstetric services, including nutrition, psychosocial support and health education.

Community-Based Adult Services (CBAS)

CBAS provides services and support to eligible GCHP members to keep them healthy and help them live safely at home. Providers can submit a referral to GCHP for evaluation and prior authorization.
To qualify, members must be:

- 18 years of age or older.
- Diagnosed with a significant physical, behavioral, or memory problem that impedes activities of daily living (ADLs).
- At risk for institutionalization in a long-term care facility.

CBAS Claims submission check list:

- Eligibility must be verified ***prior*** to billing.
- National Provider Identifier (NPI) ***must*** be actively registered with GCHP.
- Prior authorization is required for initiation of all CBAS services.
- Claims must be billed on a UB-04 claim form.
- Claims must be submitted within six months of the date of service to avoid timely filing penalties.
- All required fields must be completed, or your claim will be rejected.
- Providers and clearinghouses are required to enroll as a trading partner to submit claims electronically.

Carved-Out Services and Limited Benefits Under Medi-Cal

Certain medical or allied-health services are covered but are not administered by GCHP. These benefits are covered directly by the state Medi-Cal program. GCHP is not responsible for authorizing or providing those services. These are referred to as carved-out benefits. The following is a list of the benefits that are administered by and billed directly to the state Medi-Cal program:

- Dental services: Call Medi-Cal Dental at 1-800-322-6384 for assistance in locating a Medi-Cal dentist or to obtain prior authorization for service.
- Specialty mental health exceeding Medicare limits: Providers are required to assist GCHP / Medi-Cal members needing inpatient specialty mental health services when Medicare coverage is exhausted. This is done by referring them to Ventura County Behavioral Health Services. Contact the Ventura County Behavioral Health Department's STAR Program and/or Crisis Team at 1-866-998-2243 for referral information.
- Home and community-based waivered services (e.g., In-Home Operations, HIV / AIDS, Home and Community-Based Services Waiver, Multipurpose Senior Services).

For additional details about any of these programs, call GCHP's Member Services Department at 1-888-301-1228.

Section 11: California Advancing and Innovating Medi-Cal (CalAIM)

The state Department of Health Care Services (DHCS) designed a program to improve the health and wellbeing of Medi-Cal members beyond traditional medical services, make services work together better, and improve the quality of services. The program is called California Advancing and Innovating Medi-Cal (CalAIM). CalAIM has many components, some of which impact Gold Coast Health Plan Total Care Advantage (HMO D-SNP) and some that don't.

CalAIM Components with Significant Total Care Advantage	CalAIM Components without Significant Total Care Advantage Impact
• Integrated Care for Dual Eligible Members • California Integrated Care Management (the D-SNP version of Enhanced Care Management) • Community Supports • Population Health Management	• Behavioral Health Initiative • Dental Initiative • Incentive Payment Program • Providing Access and Transforming Health (PATH) • Statewide Managed Long-Term Care • Supporting Health and Opportunities for children • NCQA Health Plan and Health Equity Accreditations

Integrated Care for Dual Eligible Members

This is the component of CalAIM that created Exclusive Aligned Enrollment (EAE) Dual Special Needs Plans (D-SNPs), also known as Medi-Medi Plans. Medi-Medi plans are Medicare Advantage plans that combine Medicare and Medi-Cal benefits and are available in select counties in California. Medi-Medi Plans provide coordinated care through one health plan and include possible additional benefits such as dental, hearing, or vision coverage. For more information visit the DHCS **website**.

California Integrated Care Management (CICM)

California Integrated Care Management (CICM) refers to the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state. Per federal guidance, D-SNPs must provide robust care coordination to members. CICM layers state-specific requirements on top of federal D-SNP requirements. DHCS acknowledges there is significant overlap across the D-SNP Model of Care (MOC) and Medi-Cal Enhanced Care Management (ECM) requirements, which could result in duplication and confusion for members and care teams if a member receives care management from both programs. To avoid confusion and align with federal care management policy for Medicare Advantage plans, DHCS policy for 2026 continues to be that Medicare Advantage plans (rather than Medi-Cal MCPs) are responsible for care management for members who may qualify for ECM. Medicare Advantage plans must provide sufficient care management to members to ensure that members who would otherwise qualify for Medi-Cal ECM are not adversely impacted by receiving care management exclusively through their D-SNP. CICM policy applies to members who may be eligible to receive ECM from their MCP. CICM requirements address the following vulnerable populations:

- Adults experiencing homelessness
- Adults at risk for avoidable hospital or emergency department utilization
- Adults with serious mental health and/or substance use disorder (SUD) needs
- Adults transitioning from incarceration
- Adults living in the community and at risk for long-term care (LTC) Institutionalization
- Adult nursing facility residents transitioning to the community

- Adults who are pregnant or postpartum and subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality (birth equity)
- Adults with documented dementia needs

Total Care Advantage care navigators and care managers provide CICM services to our members. For certain vulnerable populations, Total Care Advantage may partner with community-based organizations to provide CICM.

Community Supports (CS) for Total Care Advantage Members

Community Supports (CS) help address members' health-related needs, help them live healthier lives, and avoid higher, costlier levels of care. Examples include:

- Housing transition and navigation services to secure housing
- Access to medically tailored meals and medically supportive food to manage nutrition-sensitive health conditions.
- Asthma remediation to remove in-home environmental triggers

These services are available to eligible Medi-Cal members regardless of whether they are in a D-SNP or not. All Medi-Cal managed care plans (MCPs) are encouraged to offer as many of the 14 pre-approved CS as possible. Total Care Advantage provides the following CS:

- Assisted living facility transition
- Asthma remediation
- Community or home transition services
- Day habilitation programs
- Home modifications (including personal emergency response systems)
- Housing deposits
- Housing tenancy and sustaining services
- Housing transition navigation services
- Medically tailored meals and groceries
- Personal care and homemaker services
- Recuperative care (medical respite)
- Respite services
- Short-term post-hospitalization housing
- Transitional rent

Details on these services are in the **Member Handbook**.

Section 12: Claims and Billing

How Gold Coast Health Plan (GCHP) Claims are Processed

GCHP's goal is to ensure timely and accurate claims processing. This section is intended to provide guidance to provider billing offices regarding the claim submission process. These guidelines do not, however, supersede any regulatory or contractual requirements published in legally binding documents or notices.

GCHP strives to process all claims in a timely manner and respond courteously to all inquiries from providers. GCHP will process and pay clean claims within 30 calendar days for non-contracted providers and within 60 calendar days for contracted providers. All claims are processed daily on a first-in / first-out basis. Claim payments are generated and mailed weekly.

GCHP processes medical claims primarily per Medi-Cal guidelines and uses key industry standard codes. Each claim is subject to a comprehensive series of edits and audits. All information is validated to determine if the claim should be paid, contested or denied.

Claims that fail an edit or audit check will be flagged for manual review by a claims examiner. Claims examiners cannot correct claim submission errors. Claims requiring medical review will be reviewed by a qualified medical professional in accordance with the California Code of Regulations (CCR), Title 22 and policies established by the state Department of Health Care Services (DHCS).

Refer to GCHP's **Provider Web Portal** to view claim status and details. Claim status can also be obtained by calling GCHP's Provider Services Department at 1-888-301-1228 and using the automated IVR system. For questions about a claim, please call Provider Services, 8 a.m. to 5 p.m., Monday through Friday (except holidays).

There are three ways to submit a claim:

- Electronic data interchange (EDI)
- Paper or hard copy
- NTT Provider Portal

Electronic Data Interchange (EDI)

GCHP strongly encourages electronic claims submission. It is cost effective and promotes the effective use of resources. Providers receive an electronic confirmation of claim submission.

Submit claims electronically through a GCHP-approved electronic billing systems software vendor or clearing-house. Completion of electronic claims submission requirements can speed claim processing and prevent delays.

If you use EDI, you must include:

- Billing provider name
- Rendering provider name (when different than billing provider)
- Legal name
- License number (if applicable)
- Medicare number (if applicable)
- Federal provider tax ID number
- Medi-Cal ID number
- Member's name as it appears on their GCHP ID card
- National Provider Identifier (NPI)

Contact your vendor or billing service for instructions on how to ensure that the Plan Provider ID is coded as a GCHP NPI and to determine how to submit your claim.

If you are not currently submitting claims electronically and would like to learn more about EDI and how to get connected, please contact EDI support at **GCHPOnboardingRequests@edifecs.com**.

To submit your EDI claims to GCHP, your clearinghouse must register your NPI. Please refer your clearinghouse to the instructions to learn how to register your NPI with for EDI submissions. If you are a direct submitter of EDI claims, please refer to the instructions on how to register your NPI.

Claim submissions that require attachments must be submitted via mail to GCHP as our EDI vendor is not able to accept attachments at this time.

Please mail your claims with attachments to:

Gold Coast Health Plan
ATTN: CLAIMS
P.O. Box 9152
Oxnard, CA 93031-9152

NTT Provider Portal

For instructions on how to submit claims via NTT Provider Portal you may download the NTT User Guide available on our GCHP website.

Claim submissions that require attachments must be submitted via mail to GCHP as our NTT Provider Portal is not able to accept attachments at this time,

Please mail your claims with attachments to:

Gold Coast Health Plan
ATTN: CLAIMS
P.O. Box 9152
Oxnard, CA 93031-9152

Claims Submission:

Participating providers must submit claims within six months after the date of service or as defined in the provider contract.

Any claims for services that are not submitted within six months of providing the services will not be eligible for payment, and the provider waives any right to payment.

GCHP/Total Care Advantage reserves the right to deny any claims that are not in accordance with the Medicare Claims Processing Manual and Medicare rules for billing (42 CFR § 422.520(b), and/or Medi-Cal Claims Processing Guidelines.

There are three ways to submit a claim:

Process	Details
Electronic Claim Submission (EDI 837: Healthcare Claim Transaction)	Gold Coast Health Plan (GCHP) encourages providers to submit claims electronically utilizing the EDI 837 Healthcare Claim Transaction. Electronic submission results in earlier processing for clean claims and lower administrative burden for providers. Provider submission must comply with current HIPAA EDI standards. Providers and clearing houses are required to enroll as a trading partner. To setup Electronic Claims submission, contact **Edifecs EDI Support** via email at **GCHPonboardingrequests@edifecs.com**. GCHP's Payer ID is 77160.
Paper Claims	The mailing address for paper claims is: GCHP, Attn: Claims, P.O. Box 9152, Oxnard, CA 93031
Provider Portal	Claims with **no** attachments can be submitted through the Provider Portal. Instructions are in Section 10 of the **Provider Portal User Guide**.

Paper Claim Submission

Paper claims are scanned for optimal processing and recording of data. Paper claims must be legible and provided in nationally accepted standard formats to ensure scanning capabilities. The following paper claim submission requirements can speed claim processing and prevent delays:

- Use the correct form and be sure it meets Centers for Medicare and Medicaid Services (CMS) standards.
- Claims should be submitted on original claim forms, not photo copied or homemade forms.
- Use black or blue ink; do not use red ink, as the scanner may not be able to read it.
- Any data submitted in red ink cannot be read and may result in improper processing.
- Use the "Remarks" field for messages.
- Do not stamp or write over boxes on the claim form.
- Send the original claim form to GCHP and retain the copy for your records.
- Separate each individual claim form. Do not staple original claims together, as GCHP would consider the second claim an attachment and not an original claim to be processed separately.
- Use the member's name as it appears on their GCHP ID card.

Attachments to Paper Claims

Some claims may require additional attachments. Be sure to include all supporting documentation when submitting your claim. Failure to submit required documentation may result in a claim denial.

Mail paper claims to GCHP using the following address to facilitate timely processing and payment:

Gold Coast Health Plan
ATTN: CLAIMS
P.O. Box 9152
Oxnard, CA 93031-9152

Claims Submission by Fax

GCHP is unable to accept or process claims submitted via fax. Claims must be submitted either electronically via EDI, NTT Provider Portal or by paper mail to Gold Coast Health Plan at P.O. Box 9152, Oxnard, CA, 93031, ATTN: CLAIMS.

Clinical Submission Categories

The following is a list of claims categories of which GCHP may routinely require submission of clinical information before or after payment of a claim.

Claims involving pre-certification / prior authorization / pre-determination (or some other form of utilization review) include, but are not limited to:

- Claims pending for lack of pre-certification or prior authorization.
- Claims involving medical necessity or experimental / investigative determinations.
- Claims for pharmaceuticals requiring prior authorization.
- Claims involving certain modifiers.
- Claims involving unlisted codes.
- Claims for which it cannot be determined from the face of the claim whether it involves a covered service. Thus, the benefit determination cannot be made without reviewing medical records (including, but not limited to, emergency service and benefit exclusions).
- Claims that GCHP has reason to believe involve inappropriate (including fraudulent) billing.
- Claims that are the subject of an audit (internal or external), including high-dollar claims.
- Claims for individuals involved in care management or disease management.
- Claims that have been appealed (or that are otherwise the subject of a dispute, including claims being mediated, arbitrated, or litigated).
- Other situations in which clinical information might routinely be requested.
- Credentialing.
- Coordination of benefits (COB).

Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

GCHP cannot be responsible for claims that are never received. Providers must work with their vendors to make sure files are successfully submitted and that there was proper follow-up on paper claims. Failure of a third party to submit a claim to GCHP may put the provider's claim at risk for being denied for untimely filing if those claims are not successfully submitted during the filing limit.

Claims Processing

Once a paper claim is received by GCHP, it is assigned a unique document control number (DCN). The DCN identifies and tracks claims as they move through the Claims Processing System. The number contains the date in which the claim was received. It monitors timely submission of a claim.

Each claim is subject to a comprehensive series of check points called edits. The edits verify and validate that the claim information is compliant with all nationally accepted claim billing procedures and coding regulations and to determine if the claim should be paid, denied, or suspended for manual review. GCHP utilizes the National Correct Coding Initiative (NCCI) Centers for Medicare and Medicaid Services (CMS) policy to promote national correct coding methodologies and to control improper coding.

Providers are responsible for all claims submitted with their national provider identifier (NPI), regardless of who completed the claim. Providers using billing services must ensure that their claims are handled properly.

Claim Return for Additional Information

If a claim is returned to the provider for correction or additional information, GCHP refers to this claim as a rejected claim. GCHP will indicate what information is missing or needs to be corrected by the provider to process the claim. Timely filing requirements still apply.

Gold Coast Health Plan (GCHP) Requests for Additional Information

When Gold Coast Health Plan Total Care Advantage (HMO D-SNP) requests additional information regarding a claim, participating providers have 60 calendar days from the date of the request to submit the requested information. The remittance advice (RA) and explanation of payments (EOP) must be submitted with the requested information.

If a claim is not submitted within 60 calendar days, or the requested information is not returned to Total Care Advantage within 60 calendar days, the claim will be denied, and the participating provider does not have the right to submit or resubmit the claim.

Balance Billing

Total Care Advantage members should not be balanced billed by providers, hospitals, or other agencies. The member is not liable for the differences between billed charges and the contract value or allowable. Balance billing a Medi-Cal or full dual beneficiary for covered services is illegal under federal and state laws The Medi-Cal rates can be accessed at **www.medi-cal.ca.gov**.

Timely Filing Requirements

Claims must be submitted within 365 calendar days of the date of service unless the provider's contract specifies a different limitation. Claims submitted beyond 180 days from the date of service or 180 days beyond the date of discharge for inpatient claims are subject to a timely filing claim payment reduction.

Claims received after 365 calendar days will be denied for timely filing unless circumstances prevented the claims from being filed within 365 calendar days (e.g., if the member has other insurance and the provider must wait for the primary carrier to process the claim before being able to submit the claim to GCHP). If the member has other insurance, the claim must be received within 180 calendar days from the date of the other insurance's Remittance Advice (RA). Corrected claims (replacement of a previously submitted claim, e.g., changes or corrections to charges, clinical codes [provider reviewed clinical documentation and determined the code originally billed was incorrect] or procedure codes, dates of service, member information, etc.) must be submitted within 180 calendar days from the date of last action. A late charge claim (additional charges added to a previous claim submission) must be received within 365 calendar days from the date of service unless the provider's contract specifies a different limitation. Timely filing claim payment reductions apply to all late charge claims. Late charge claims received after 365 calendar days will be denied for timely filing unless circumstances prevented the claim from being filed within 365 calendar days. For information related to claim payment disputes, please refer to Section 18.

If a provider files a claim with the wrong payer and provides documentation verifying the initial timely claims filing (within the applicable claims filing time limits set forth in this section from the date of the other carrier's denial letter or RA form), GCHP will process the provider's claim without denying it for failure to adhere to the timely filing limits.

Claims Payment

When a provider's claim is received, it is analyzed to determine if the services are covered and to identify the corresponding amount to be paid. Once the claim is finalized, GCHP generates an Explanation of Payment (EOP) or Remittance Advice (RA) summarizing services rendered and payer action taken and then sends the appropriate payment amount to the provider, where the claim is payable.

Providers should receive a response from GCHP within 30 calendar days of GCHP's receipt of a clean claim.

If the claim contains all the required information, the claim is entered into GCHP's Claims Processing System, and the provider is sent an EOP or Remittance Advice (RA) at the time the claim is finalized.

Payment:

GCHP/Total Care Advantage strongly recommends that providers sign up for electronic funds transfer (EFT). If you are not already signed up, please complete the **EFT Authorizations Form**.

As an integrated Medicare Advantage plan, Total Care Advantage provides both Medicare and Medi-Cal benefits for our members. This means providers **do not need to follow a crossover claims billing** process. All claims are submitted to GCHP. For claims with both a Medicare and a Medi-Cal component, Total Care Advantage manages any Medicare/Medi-Cal split. The system pays the Medicare portion of the claim first and then any remaining Medi-Cal component. This approach to claims processing may result in changes to provider payment reports on the Provider Portal, the remittance advice, and the evidence of payment.

Claims payments are generated weekly. For clean claims it is expected for the plan to pay 95% of clean claims. Any claims paid after the allotted time will accrue and pay interest. For any Medicare claims that are unclean, the non-contracted provider will be denied or paid with 60 calendar days from the date of the initial request.

Remittance Advice (RA) and Evidence of Payment (EOP):

Once a claim processing is finalized providers will receive a remittance advice (RA) also known as an 835 transaction or evidence of payment (EOP) summarizing the transaction. Total Care Advantage covers both Medicare and Medi-Cal benefits. Therefore, each Total Care Advantage claim line submitted will be represented by two lines on the 835 and the EOP. Each line contains the service dates and procedure / revenue code so providers can associate the two payment segments of the claim line. The first line indicates the portion of the payment attributed to Medicare benefit. The second line indicates the portion of the payment attributed to Medi-Cal benefit. This update will not change anything regarding the claims totals but will allow line of sight to the breakdown between Medicare and Medi-Cal charges for services.

Claims Forms Used by Different Types of Providers

Claim Form	Type of Provider	Services Billed on this Form
CMS-1500	PCPs	All professional services.
CMS-1500	Referral Specialists	All professional services.
CMS-1500	Clinics	All professional services.
CMS-1500	Pharmacies	Pharmacies may also use this for durable medical equipment (DME), medical supplies, incontinence supplies, orthotics and prosthetics.
CMS-1500	Medical Laboratories	All lab services.
CMS-1500	Allied Health Practitioners	All covered services delivered by Allied Health Care Professionals.

Claim Form	Type of Provider	Services Billed on this Form
UB-04	Hospitals / Clinics / FQHCs / SNFs / Surgicenters	All professional or facility services.
CMS-1500	Imaging Centers	Professional X-ray and related services.
UB-04	Long-Term Care (LTC)	All LTC services.

* All claims should be submitted no later than 180 calendar days from the date of service or date of discharge on an inpatient claim to avoid a timely filing claim payment reduction, with the exception of other health coverage. If there is another carrier involved (e.g. Medicare, commercial health insurance, etc.) the claim must first be submitted to the other carrier since Medi-Cal is the payor of last resort. Once the primary carrier has processed the claim, the provider should submit the claim, along with the primary carrier's Explanation of Benefits (EOB) form to GCHP within 180 calendar days from the date of the primary carrier's EOB. GCHP will then consider the claim as the secondary carrier and will determine if any additional payment is due as appropriate up to the Medi-Cal maximum allowable payment amount.

Section 13: Coordination of Benefits

Benefits and Services

Gold Coast Health Plan Total Care Advantage (HMO D-SNP) provides all Medicare and Medi-Cal covered services normally provided by a D-SNP and Medi-Cal Managed Care Plan. Below is a summary of the benefits provided, but a more detailed list of benefits can be found in the **Summary of Benefits**.

Medicare Covered Services	Medi-Cal Covered Services
• Hospital and skilled nursing facility care • Emergency care • Primary and specialty care visits • Mental health and substance use services • Lab and diagnostic services • Durable medical equipment • Prescription drugs	• Medicare cost-sharing • Long-term services and supports (LTSS) • Transportation • Community Supports
Medicare Supplemental Benefits	**Services Available for People with Medi-Cal**
• Vision • Hearing • Fitness • Caregiver supports • Readmission prevention	• Dental through Smile California • IHSS through Ventura County Human Services Agency • Medi-Cal Rx

Dual Coverage by Medicare and Medi-Cal (Medi / Medi)

In accordance with the transaction and code sets adopted by the secretary of the Department of Health and Human Services through a final rule published in 45 CFR 162, GCHP is now able to accept electronic Coordination of Benefits Agreement (COBA) crossover claims for dual eligible members (Medi-Medi). GCHP receives both Medicare Part A and Part B crossover claims only directly from the Benefits Coordination Recovery Center (BCRC) for dual eligible members (Medi-Medi).

GCHP does not receive any COBA Medicare Part C (Medicare Advantage) electronic crossover claims.

Other Health Coverage (OHC)

Some Gold Coast Health Plan (GCHP) members have other health coverage (OHC) in addition to their GCHP coverage. Specific rules govern how benefits must be coordinated in these cases. State and federal laws require that all available health coverage be exhausted before billing Medi-Cal. As such, when a Medi-Cal member has OHC, GCHP becomes the secondary (or sometimes tertiary) payer, with Medi-Cal always the payer of last resort.

When a member has both Medicare and Medi-Cal, Medicare will be processed as primary and Medi-Cal will be processed as secondary. In the event that the member has another primary coverage, the claim will be adjudicated to the lesser of the Medicare allowable.

OHC includes any non-Medi-Cal coverage that provides or pays for healthcare services. This can include, but is not limited to:

- Commercial health insurance plans (individual and group policies).
- Prepaid health plans.
- Health maintenance organizations (HMOs).
- Employee benefit plans.
- Union plans.
- Tri-Care, Champus VA.
- Medicare, including Medicare Part D plans, Medicare supplemental plans and Medicare Advantage (Preferred Provider Organization (PPO), HMO, and fee-for-service) plans.

When a GCHP Medi-Cal member also has another primary medical insurance, the member must treat the other insurance plan as the primary insurance company and access services under that company's rules of coverage. For example, if the other coverage is a PPO plan with a closed panel, the member must see a provider within the PPO network. If it is an HMO or a Medicare Advantage plan, the member must receive services from his or her provider under that plan. Any referrals or prior authorizations required by the primary insurance must be obtained before receiving services.

GCHP is not liable for the cost of services for members with OHC who do not obtain the services in accordance with the rules of their primary insurance. If a member elects to seek services outside of the framework of their primary insurance coverage, the member is responsible for the cost.

Exceptions to the 365-calendar-day billing limit / 180-calendar-day claim payment reduction will be made with OHC claims based on the date of the EOB. The claim must be submitted to GCHP within 180 calendar days from the date of the primary carriers EOP.

Medicare / Medi-Cal (Medi / Medi) Crossover Claim Process

California law limits Medi-Cal reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services. (Refer to Welfare and Institutions Code, Section 14109.5.) The following provides three different examples of crossover claims processing results (dollar amounts are for demonstration only and do not reflect actual allowed amounts for either Medicare or Medi-Cal):

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

Share of Cost (SOC)

Some Medi-Cal members must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called share of cost (SOC). Members are not eligible to receive Medi-Cal benefits until their monthly SOC dollar amount has been certified online. Certifying SOC means that the Medi-Cal eligibility verification system shows the subscriber has paid or become obligated for the entire monthly dollar SOC amount owed. The SOC is comparable to a commercial health insurance out-of-pocket deductible in that the carrier does not pay until the deductible is met.

Providers should access the Medi-Cal eligibility verification system to determine if a member must pay an SOC. The eligibility verification system is accessed through the Automated Eligibility Verification System (AEVS) and the Medi-Cal Provider website at **www.medi-cal.ca.gov**.

The provider should ask for or accept obligation from the patient for their Medi-Cal SOC. Remember that when Medi-Cal pays for any portion of the service, the total reimbursement received for the service (including the SOC amount paid directly to the provider from the member) may not exceed the Medi-Cal maximum allowable amount for the services rendered. Claims submitted for members who have not met their SOC requirement for the month of service will be denied.

Examples of two SOC scenarios for a patient with dual coverage are presented in the chart below.

Examples of SOC: Medi-Cal + Medicare

EXAMPLE A	EXAMPLE B
Provider's charges = $250.00	Provider's charges = $250.00
Medicare allows $200.00	Medicare allows $200.00
Medicare pays 80% allowed of $200.00 = $160.00	Medicare pays 80% allowed of $200.00 = $160.00
Medi-Cal allowable $180.00 difference = $20.00	Medi-Cal allowable $190.00 difference = $30.00
Member's SOC = $25.00 GCHP would pay $0 if the SOC is not met.	Member's SOC = $25.00 GCHP would pay $5.00 after the SOC is met.

Gold Coast Health Plan (GCHP) Members with Veterans Benefits

If a GCHP member is a veteran and is eligible for Veteran's Administration (VA) healthcare benefits, they may choose to use VA services (hospitals, outpatient and other government clinics). A description of the services offered to veterans can be found here.

Members with VA benefits may use their own discretion in choosing whether to receive care through the VA system or GCHP. GCHP cannot require or request that they do so; but, if the member wishes, GCHP will facilitate and coordinate their care.

Carved-Out Services Under Medicare:

Hospice

When a Total Care Advantage member elects hospice under Medicare:

- Total Care Advantage must help the member locate a Medicare-approved hospice provider in their area.
- Original Medicare will cover everything related to the member's terminal illness once the hospice benefit starts, even if the member chooses to stay enrolled in Total Care Advantage for non-hospice related services.
- If the member decides to leave hospice care, Total Care Advantage will start again the first day of the following month.
- Total Care Advantage covers services that aren't part of the terminal illness and related conditions.

Section 14: Member Services

Gold Coast Health Plan's (GCHP) Member Services supports providers by helping Gold Coast Health Plan Total Care Advantage (HMO D-SNP) members:

- Choose or change a primacy care provider (PCP), which may be a clinic or physician.
- Learn about their eligibility.
- Provide their claim status.
- Understand how to access care within a managed care health plan.
- Understand member benefits and services available.
- Understand their rights and responsibilities.

New members are sent a welcome packet, which includes a letter, their ID card, the Health Risk Assessment (HRA) form, and a Quick Start Guide to start using Total Care Advantage benefits. The Member Handbook, Provider Directory, and Formulary are available on the GCHP website, but members can request hard copies of these documents, including alternate formats. Members will also receive an invitation to a New Member Benefits Orientation to learn more about their Total Care Advantage Plan.

Every year, members also receive an Annual Notice of Change (ANOC) notifying them of changes in plan benefits and services. Members may also receive newsletters, which include articles on health education topics, service and benefit reminders, and information about how to use Total Care Advantage services.

Member Contact Center

For more information, contact Member Services at 1-888-301-1228 (TTY: 711), seven days a week, 8 a.m. to 8 p.m. Oct. 1 through March 31, and Monday through Friday, 8 a.m. to 8 p.m., April 1 through Sept. 30.

Section 15: Language Assistance Services

Overview of Cultural and Linguistic Services

Gold Coast Health Plan/Total Care Advantage understands that health literacy and cultural diversity are key factors to building a healthy community. GCHP/Total Care Advantage is committed to delivering culturally and linguistically appropriate healthcare services to its diverse membership, including language assistance services to members who are limited English proficient (LEP), including those who have limited ability to read, speak, write, or understand English.

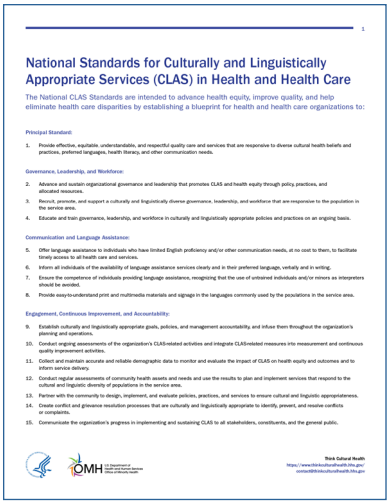
GCHP/Total Care Advantage is committed to ensuring effective communication with members with visual impairments or other disabilities requiring the provision of written materials in alternative formats, and shall facilitate requests for Braille, audio format, large print (no less than 20-point Arial font), and accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate at no cost to members.

GCHP/Total Care Advantage is committed to ensuring that all members and potential members, regardless of race, color, religion, ancestry, national origin, ethnic group identification, age, mental or physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or language ability to have equal access to quality healthcare and services in a member's preferred language of choice or alternative format. If you need language assistance services for your patients, contact GCHP/Total Care Advantage Cultural and Linguistic Services at 1-805-437-5961, Monday through Friday, 8 a.m. to 5 p.m. (except some holidays). Or call Member Services at 1-888-301-1228, 8 a.m. to 8 p.m., seven days a week from Oct. 1 through March 31, and 8 a.m. to 8 p.m. Monday through Friday from April 1 through Sept. 30 (except some holidays. (TTY: 711). Providers can also email **CulturalLinguistics@goldchp.org**.

Culturally and Linguistically Appropriate Services (CLAS)

Culturally and Linguistically Appropriate Services (CLAS) are a way to improve the quality of services provided to members, which ultimately helps to reduce health disparities and achieve health equity. CLAS is about respect and responsiveness: respect the whole individual and respond to the individual's health needs and preferences. The provision of health services that are respectful of and responsive to the health beliefs and needs of diverse patients can help close the gap in health outcomes.

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate healthcare disparities by establishing a blueprint for health and healthcare organizations. Visit the **Think Cultural Health** website to learn more about how you can help improve health outcomes and for training opportunities.



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National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

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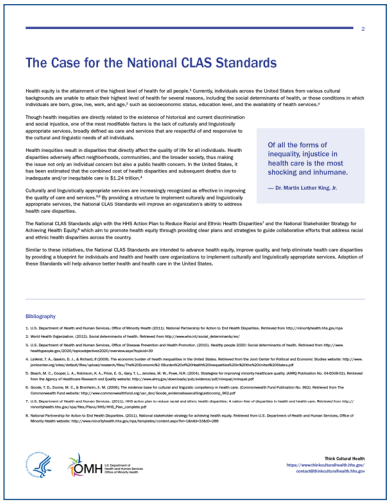
https://www.thinkculturalhealth.hhs.gov/
content@thinkculturalhealth.hhs.gov



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The Case for the National CLAS Standards

Health equity is the attainment of the highest level of health for all people.[1] Currently, individuals across the United States from various cultural backgrounds are unable to attain their highest level of health for several reasons, including the social determinants of health, or those conditions in which individuals are born, grow, live, work, and age,[2] such as socioeconomic status, education level, and the availability of health services.[3]

Though health inequities are directly related to the existence of historical and current discrimination and social injustice, one of the most modifiable factors is the lack of culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals.

Health inequities result in disparities that directly affect the quality of life for all individuals. Health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern. In the United States, it has been estimated that the combined cost of health disparities and subsequent deaths due to inadequate and/or inequitable care is $1.24 trillion.[4]

Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services.[5-8] By providing a structure to implement culturally and linguistically appropriate services, the National CLAS Standards will improve an organization's ability to address health care disparities.

The National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities[1] and the National Stakeholder Strategy for Achieving Health Equity[8] which aim to promote health equity through providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country.

Similar to these initiatives, the National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States.

> Of all the forms of inequality, injustice in health care is the most shocking and inhumane.
>
> — Dr. Martin Luther King, Jr.

Bibliography

1. U.S. Department of Health and Human Services, Office of Minority Health (2011). National Partnership for Action to End Health Disparities. Retrieved from http://minorityhealth.hhs.gov/npa
2. World Health Organization. (2012). Social determinants of health. Retrieved from http://www.who.int/social_determinants/en/
3. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). Healthy people 2020: Social determinants of health. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39
4. LaVeist, N. A., Gaskin, D. J., & Richard, P.(2009). The economic burden of health inequalities in the United States. Retrieved from the Joint Center for Political and Economic Studies website: http://www.jointcenter.org/sites/default/files/upload/research/files/Final%20Economic%20Burden%20of%20Health%20Inequalities.pdf
5. Beach, M. C., Cooper, L. A., Robinson, K. A., Price, E. G., Gary, T. L., Jenckes, M. W., Powe, N.R. (2004). Strategies for improving minority healthcare quality. (AHRQ Publication No. 04-E009-02). Retrieved from the Agency of Healthcare Research and Quality website: http://www.ahrq.gov/downloads/pub/evidence/pdf/minqual/minqual.pdf
6. Goode, T. D., Dunne, M. P., & Bronheim, L. M. (2006). The evidence base for cultural and linguistic competency in health care. (Commonwealth Fund Publication No. 962). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/~/.../publications/publication_962.pdf
7. U.S. Department of Health and Human Services. (2011). HHS action plan to reduce racial and ethnic health disparities: A nation free of disparities in health and health care. Retrieved from http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf
8. National Partnership for Action to End Health Disparities. (2011). National stakeholder strategy for achieving health equity. Retrieved from U.S. Department of Health and Human Services, Office of Minority Health website: http://www.minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&id=289

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Think Cultural Health
https://www.thinkculturalhealth.hhs.gov/
content@thinkculturalhealth.hhs.gov

Language Assistance Services

GCHP/Total Care Advantage adheres to federal and state guidelines that require health plans to ensure that limited English proficiency (LEP), including those who have limited ability to read, speak, write, or understand English. Medi-Cal beneficiaries have access to interpreters and translation services at all key points of covered services at no cost to GCHP/Total Care Advantage members and potential members. GCHP/Total Care Advantage strongly discourages the use of unqualified interpreters, including bilingual office staff, friends or family members - especially minors. Providers shall offer language assistance services to members during their visit / exam. Providers shall document electronically or manually in the member's medical record if the member declines the use of an interpreter at the time of the visit.

GCHP/Total Care Advantage's Cultural and Linguistic Services coordinates interpreting and translation services for members and providers. GCHP/Total Care Advantage offers training opportunities for providers and their staff on language assistance services, cultural competency, diversity, equity, and inclusion to increase awareness of the diverse healthcare needs of GCHP/Total Care Advantage's membership at no cost.

For help getting an interpreter or assistance with the translation of documents into a member's preferred language or format, contact the GCHP/Total Care Advantage Cultural and Linguistic Services Department at 1-805-437-5961 Monday through Friday, 8 a.m. to 5 p.m. (except some holidays). You can also email **CulturalLinguistics@goldchp.org**.

Cancellation Policy

- Providers and/or their staff must call or email GCHP/Total Care Advantage's Cultural and Linguistic Services at least 25 business hours in advance to cancel appointments lasting less than two hours.
- When cancelling a request for services lasting longer than two hours, GCHP/Total Care Advantage requires that Cultural and Linguistic Services to be notified at least 49 business hours in advance.

Telephone Interpreting Services

GCHP/Total Care Advantage offers telephonic interpreting services available to providers 24/7 for covered services. To access telephonic interpreting services after regular business hours, call 1-866-421-3463. GCHP/Total Care Advantage contracts with a vendor that provides telephone interpreting services in more than 240 languages. Call GCHP/Total Care Advantage's Cultural and Linguistic Services during business hours at 1-805-437-5961 to request a provider access code.

In-Person Interpreting Services

GCHP works with various vendors to provide qualified in-person interpreter services. It is important to submit the **Language Assistance and Auxiliary Services Request Form** to GCHP/Total Care Advantage Cultural and Linguistic Services via fax at 1-805-248-7481 or email at **CulturalLinguistics@goldchp.org** at least five to seven business days in advance of the request for a covered service. To cancel an interpreting request, send an email to GCHP's Cultural and Linguistic Services at **CulturalLinguistics@goldchp.org** at least 25 business hours prior to the appointment.

Sign Language Interpreting Services

GCHP/Total Care Advantage complies with the Americans with Disabilities Act (ADA) to ensure that members who need services from a sign language interpreter receive those services. GCHP/Total Care Advantage has contracted with vendors to provide qualified sign language interpreting for members during covered services. The Language Assistance and Auxiliary Services Request Form must be submitted to GCHP/Total Care Advantage at least five to seven business days in advance of the covered service. Submit your request form via fax to 1-805-248-7481 or by email at **CulturalLinguistics@goldchp.org.** If you have questions about language assistance services, call GCHP/Total Care Advantage's

Provider Services at 1-888-301-1228 8 a.m. to 8 p.m., seven days a week from Oct. 1 through March 31, and 8 a.m. to 8 p.m. Monday through Friday from April 1 through Sept. 30. (TTY: 711). You may also call GCHP's Cultural and Linguistic Services at 1-805-437-5961, Monday through Friday, 8 a.m. to 5 p.m. (except some holidays).

How to Access Sign Language Interpreter Services:

- For sign language interpreter services, call GCHP/Total Care Advantage's Provider Services Department at 1-888-301- 1228, 8 a.m. to 8 p.m., seven days a week from Oct. 1 through March 31, and 8 a.m. to 8 p.m. Monday through Friday from April 1 through Sept. 30 (except some holidays). If you use a TTY, call 711. You can also call GCHP/Total Care Advantage's Cultural and Linguistic Services at 1-805-437-5961, Monday through Friday, 8 a.m. to 5 p.m. (except some holidays).
- For emergency, same-day or urgent requests during business hours, call Cultural and Linguistic Services at 1-805-437-5961.

When Requesting Interpreter Services:

- Verify the GCHP member's Medi-Cal and Medicare eligibility before requesting an interpreter.
- Provide advanced notice of at least five to seven business days before any scheduled covered service.
- Provide the member's name, Total Care Advantage / Medi-Cal ID number, the type of service, assignment address, name and phone number of the provider who will be seeing the member, and the date and time of the covered service.

Translation of Documents

GCHP/Total Care Advantage provides translation services to members whose primary language is not English. Providers can request assistance for translation of written materials for members at no cost.

Alternative Formats

GCHP/Total Care Advantage receives a weekly file from the state Department of Health Care Services (DHCS) containing a list of members who requested alternative formats. GCHP/Total Care Advantage informs providers and subcontractors of members requesting member information to be in an alternative format.

GCHP/Total Care Advantage provides alternative formats and appropriate auxiliary aids and services to members with disabilities upon request. Providers and subcontractors shall document member's alternative format preference in the electronic member record system. Alternative formats include the following, but are not limited to:

- Large print (no less than 20-point Arial font)
- Braille
- Accessible electronic format, such as an audio or data CD, and other auxiliary aids and services that may be appropriate.

Plain Language – 6th Grade Reading Level or Below

Evidence shows that patients often do not understand much of the information given by healthcare providers. Per DHCS, member informing materials shall be written in a 6th grade reading level or below. If you need assistance with readability reviews, contact GCHP's Health Education Department at **HealthEducation@goldchp.org**.

GCHP recognizes that using simple language is essential for the effective delivery of healthcare. Plain language makes it easier for everyone to understand and use health information. One way to promote health literacy is by assuring that member-informing materials are at or below a 6th grade reading level.

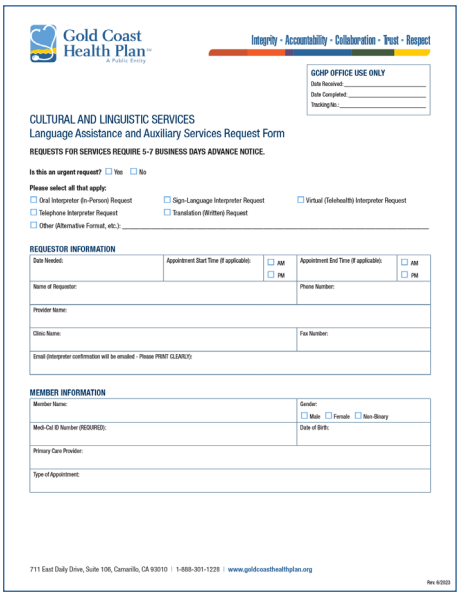
Cultural and Linguistic Resources

GCHP/Total Care Advantage routinely distributes information on interpreting and translation services to provider offices. GCHP/Total Care Advantage makes promotional / educational materials available to providers free of charge to assist with cultural and linguistic requirements, services, and resources.

GCHP/Total Care Advantage recognizes the importance of clear communication with patients, and we are committed to assisting with language assistance services to ensure members are receiving qualified interpreting and translation services. Members are **NOT** required to bring an interpreter or use a friend, family, including minors, to interpret during their medical and behavioral appointments. It is the responsibility of the provider – not the member – to request interpreting services. Providers shall document electronically or manually in the member's medical chart if the member declines the use of an interpreter at the time of the visit.

To request language assistance and auxiliary services, complete and submit the Language Assistance and Auxiliary Services Request Form (available in **English** and **Spanish**) to GCHP's Cultural and Linguistic Services at **CulturalLinguistics@goldchp.org**. For provider training opportunities, visit the **GCHP website**.

Note: If you need to cancel or reschedule a confirmed interpreter request, please email **CulturalLinguistics@goldchp.org** at least 25 business hours in advance.



Gold Coast Health Plan
A Public Entity

Integrity - Accountability - Collaboration - Trust - Respect

GCHP OFFICE USE ONLY
Date Received:
Date Completed:
Tracking No.:

CULTURAL AND LINGUISTIC SERVICES
Language Assistance and Auxiliary Services Request Form

REQUESTS FOR SERVICES REQUIRE 5-7 BUSINESS DAYS ADVANCE NOTICE.

Is this an urgent request? ☐ Yes ☐ No

Please select all that apply:
☐ Oral Interpreter (In-Person) Request ☐ Sign-Language Interpreter Request ☐ Virtual (Telehealth) Interpreter Request
☐ Telephone Interpreter Request ☐ Translation (Written) Request
☐ Other (Alternative Format, etc.): _____

REQUESTOR INFORMATION

Date Needed:	Appointment Start Time (If applicable): ☐ AM ☐ PM	Appointment End Time (If applicable): ☐ AM ☐ PM
Name of Requestor:		Phone Number:
Provider Name:		
Clinic Name:		Fax Number:
Email (Interpreter confirmation will be emailed - Please PRINT CLEARLY):		

MEMBER INFORMATION

Member Name:	Gender: ☐ Male ☐ Female ☐ Non-Binary
Medi-Cal ID Number (REQUIRED):	Date of Birth:
Primary Care Provider:	
Type of Appointment:	

711 East Daily Drive, Suite 106, Camarillo, CA 93010 | 1-888-301-1228 | www.goldcoasthealthplan.org

Rev 6/2023

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SERVICE INFORMATION *Please indicate interpreter location assignment.*

Provider Contact:		Provider Contact Phone Number:
Name of Agency / Clinic:		
Assignment Address:	Dept / Floor / Suite City	Zip
Cross Street:		Parking Location:

Language Needed (Select one): ☐ Spanish ☐ Sign-Language ☐ Other Language (Specify):	Special Instructions (e.g., name of specific interpreter, male, female):
☐ Alternative Format (e.g., braille, large print, audio, electronic form or other format):	If virtual (telehealth) request, include meeting link:

FOR TRANSLATION ONLY

Title of Document:	Number of Pages:	Date Needed:

Submit completed request form to: CulturalLinguistics@goldchp.org

ALL REQUESTS AND/OR CANCELATIONS MUST BE RECEIVED BY EMAIL OR FAX.

To cancel or reschedule a confirmed request, please notify GCHP Cultural and Linguistic Services at least 25 business hours in advance.

For questions, call Cultural and Linguistic Services at **1-805-437-5603**, Monday through Friday, from 8 a.m. to 5 p.m. (excluding holidays). If you use a TTY, call **711**.

Billing Information
Gold Coast Health Plan
Attn: Cultural and Linguistic Services
711 E. Daily Drive, Suite 106, Camarillo, CA 93010
Phone: 1-805-437-5603 Fax: 1-805-248-7481
Email: CulturalLinguistics@goldchp.org

711 East Daily Drive, Suite 106, Camarillo, CA 93010 | 1-888-301-1228 | www.goldcoasthealthplan.org

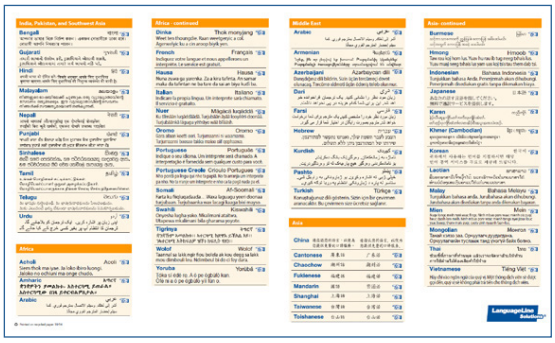
Rev 6/2023

Working with Limited English Proficient (LEP), Deaf, and/or Hard of Hearing Members

When working with limited English proficient (LEP), deaf, and/or hard of hearing members, it is important to know how to identify, offer and access language assistance services.

Below are valuable language identification and awareness tools for members. Providers should keep these resources in visible areas to show members when they need help identifying their preferred language or communication method:

1. **Language ID Guide:** Contain the following statement in 99 languages, “Point to your language. An interpreter will be called. The interpreter is provided at no cost to you.”



2. **Language ID Poster and Desktop Display:** Poster and self-standing display containing the statement “Point to your language. An interpreter will be called. The interpreter is provided at no cost to you.” in 24 languages. This is also known as the “I Speak Card.”

Nondiscrimination Notices and Language Assistance Taglines

It is important that providers know how to identify, offer, and access language services when working with LEP members.

GCHP/Total Care Advantage encourages providers and staff to inform LEP members of the availability of language services free of charge by posting the Language Available poster in clinics, urgent care centers, waiting rooms and places where members can easily point to, and providing the language identification guide to LEP members. If you are unable to identify the member’s preferred language, have the member point to their preferred language.

The posting of the nondiscrimination notice must be visible to members in at least a 20-point San Serif font and must be accompanied by the full set of language taglines in 18 non-English languages as required by the state Department of Health Care Services (DHCS), **All Plan Letter (APL) 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, and Alternative Formats**. Printed nondiscrimination notice and Notice of Availability that informs Members with LEP of the availability of free language assistance services and appropriate auxiliary aids and services for people with disabilities are not to be replaced by the use of quick response codes, otherwise known as QR codes.

To request language assistance services or for questions, visit the **GCHP/Total Care Advantage website** or contact GCHP's Cultural and Linguistic Services at 1-805-437-5961, Monday through Friday, 8 a.m. to 5 p.m. (except some holidays). You can also email **CulturalLinguistics@goldchp.org**.

Bilingual Fluency Assessments

GCHP/Total Care Advantage's subcontractors, downstream subcontractors, and network providers shall ensure that their staff working in the area that requires bilingual fluency are competent in Spanish. Staff working in positions requiring bilingual fluency skills should be assessed in a standard process and providers shall maintain records of bilingual assessments. Policies shall include the frequency of staff being assessed or reassessed for bilingual fluency.

Diversity, Equity, and Inclusion Training

GCHP/Total Care Advantage's subcontractors, downstream subcontractors, network providers and staff are required to complete an annual cultural competency and/or Diversity, Equity, and Inclusion (DEI) training.

The DEI training is mandated by DHCS, **All Plan Letter 24-016, Diversity, Equity, and Including Training Requirements**, and the Centers for Medicare & Medicaid Services (CMS), to ensure GCHP's subcontractors, downstream subcontractors, network providers and staff are meeting the unique and diverse needs of all members. All GCHP's subcontractors, downstream subcontractors, network providers and staff shall complete a DEI training.

Upon completion of the training, please submit the **Cultural Competency Training Acknowledgment Form** to GCHP's Cultural and Linguistic Services.

The Think Cultural Health website features information, continuing education opportunities, additional resources for healthcare professionals to learn about culturally and linguistically appropriate services (CLAS). Culturally and linguistically appropriate services (CLAS) are increasingly recognized as an important strategy for improving quality of care to diverse populations. For more information, **click here**.

GCHP/Total Care Advantage's subcontractors, downstream subcontractors, network providers and staff shall ensure that cultural competency, sensitivity, health equity, and diversity trainings are provided for employees and staff at key points of contact with members in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C (Cultural and Linguistic Programs and Committees).

GCHP/Total Care Advantage's Cultural and Linguistics Department shall collaborate with Provider Network Operations to ensure that the network provider's mandatory training includes information on diversity, equity and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) as specified in the 2024 DHCS contract, Exhibit A, Attachment III, Subsection 5.2.11.C (Diversity, Equity, and Inclusion Training). This process must also include an educational program for network providers regarding health needs to include but not be limited to, the seniors and persons with disabilities (SPD) population, members with chronic conditions, members with specialty mental health service needs, members with substance use disorder needs, members with intellectual and developmental disabilities,

and children with special healthcare needs. Trainings must include social drivers of health and disparity impacts on members' healthcare. GCHP/Total Care Advantage shall maintain attendance records and shall be reviewed and maintained by GCHP's Health Equity Officer or designee.

GCHP created four online training modules to help you work with vulnerable populations and increase your awareness of the diverse healthcare needs of our membership. To access the GCHP Cultural Competency Training, visit the **GCHP website**, under Provider Resources > Cultural Competency Training.

Upon completion of the training, return a completed **Cultural Competency Training Acknowledgement Form** to GCHP, Cultural and Linguistic Services. If a training was provider by another organization or entity, providers shall attest to having received and confirmed that a training was completed. Training must be completed as required by DHCS. GCHP shall track and maintain records of completed training by GCHP's subcontractors, downstream subcontractors, network providers and staff.

In addition to training modules available on the GCHP website, the U.S. Department of Health and Human Services (HHS) offers free credits on presentations, webinars, and other online training programs for healthcare providers. The website, Think Cultural Health, features information on the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and healthcare and other resources for healthcare professionals to learn about culturally and linguistically appropriate services. For more information, **click here**.

For additional questions or resources, please email **CulturalLinguistics@goldchp.org** or call 1-805-437-5961 Monday through Friday, 8 a.m. and 5 p.m. (except some holidays). For provider training opportunities, visit the **GCHP website**.

Section 16: Health Education

Overview of Services

The goal of Gold Coast Health Plan/Total Care Advantage's (GCHP) Health Education Department is to ensure that all members have access to health education services, health promotion programs, materials, and classes. GCHP/Total Care Advantage will work collaboratively with local health agencies, clinics, hospitals, community-based organizations, and PCPs to provide quality health education classes and materials at no charge to members.

Members may be referred by GCHP/Total Care Advantage, PCPs, or they may self-refer for health education services, programs and classes. Contact the Health Education Department for a **referral form**.

No prior authorization is necessary for members to attend and participate in health education services, health promotion activities, or classes. For program details, providers may call Member Services at 1-888-301-1228 / TTY: 711. To reach GCHP/Total Care Advantage's Health Education Department, call 1-805-437-5961, Monday through Friday, 8 a.m. to 5 p.m. (except holidays) or email **HealthEducation@goldchp.org**.

Health Education Contract Requirements for Gold Coast Health Plan (GCHP) Providers

Providers are required to make health education programs and services available to members at no cost. All health education activities must be documented in the member's medical record. For a listing of approved health education materials, contact GHCP/Total Care Advantage's Health Education Department at 1-805-437-5961, Monday through Friday, 8 a.m. to 5 p.m. (except holidays) or email **HealthEducation@goldchp.org**.

Health Promotion, Disease Prevention Programs and Health Education Classes

As a benefit of partnering with GCHP, the Plan offers providers helpful information about health promotion, disease prevention programs, and health education classes. Health education materials and information about local health education activities are available on GCHP/Total Care Advantage's website. Additionally, GCHP's website has a calendar that allows providers to view a list of upcoming events and health education classes for members. Providers can also view flyers for the corresponding classes for detailed information, such as a description of the event, date and time.

Below is a sample of health education services available for members. To obtain a complete listing, visit GCHP/Total Care Advantage's website, call GCHP's Health Education Department at 1-805-437-5961, Monday through Friday, 8 a.m. and 5 p.m. except holidays), or email **HealthEducation@goldchp.org**.

- **Asthma Education** – GCHP/Total Care Advantage works with providers and local agencies to host asthma education classes. Classes are held at various locations. If you are interested in partnering with GCHP to hold an asthma education class, please contact the Health Education Department.
- **Breastfeeding Support** – GCHP/Total Care Advantage works with the Ventura County Women, Infants, and Children (WIC) program to promote the benefits of breastfeeding and provide information on the support groups available to women.
- **Centers for Disease Control and Prevention (CDC)** – The Health Education Department uses the California Department of Public Health's (CDPH) website to provide GCHP/Total Care Advantage members with the most current immunization schedules and other useful health information. Materials available on the CDPH's website are available in English and Spanish.
- **Chronic Disease Self-Management Classes** – GCHP/Total Care Advantage offers partners with agencies who offer the Chronic Disease Self-Management Program (CDSMP) classes in English and Spanish. The goal of the classes is to build self-confidence and improve skills needed to manage chronic conditions.

- **Diabetes Education** – GCHP/Total Care Advantage works with providers and local agencies to identify diabetes self- management classes and support groups. If you would like to hold classes in your clinic or office, please contact the Health Education Department or call Provider Services at 1-888-301-1228. New classes are continually being held in cities through different public and private providers.
- **Diabetes Prevention Program** – The Diabetes Prevention Program (DPP) is available to members with pre-diabetes or at high risk for type 2 diabetes. The DPP assist members with lifestyle changes related to healthy eating and physical activity. The DPP provides group support, weekly lessons, personal health coach and tools. The DPP is available in English and Spanish at no cost to members.
- **Healthwise Digital Health Education Member Engagement Tool**
- **My Plate** – GCHP's encourages members to access the U.S. Department of Agriculture's (USDA) **Choose My Plate website**. Materials from the site are provided for members to use as a guide. Materials are available in English and Spanish. Providers can also download materials in other languages.
- **Prenatal / Postpartum Care** – GCHP/Total Care Advantage's website maintains a health library with information about prenatal and postpartum care. Members can sign up **here** to receive an e-newsletter on pregnancy. Providers can **request** for members to receive a pregnancy or postpartum packet, which include resources for parents, or providers can request packets to be delivered and provide them to members during their visits by emailing **HealthEducation@goldchp.org**.
- **Rethink Your Drink** – The state Department of Public Health's website maintains a list of materials and resources for the Rethink Your Drink campaign. Materials may be downloaded directly from the website. Contact GCHP/Total Care Advantage's Health Education Department for more information about materials.
- **Tobacco Cessation and Vaping** – GCHP/Total Care Advantage works with various agencies to help member quit smoking, vaping, or using smokeless tobacco and promote tobacco cessation classes throughout the county. For information on free tobacco cessation classes, support groups and nicotine replacement products, contact the Health Education Department or the Kick It California at 1-800-300-8086 or visit **https://kickitca.org**. For information in Spanish, call 1-800-600-8191. The Ventura County Health Care Agency (VCHCA) offers free "Call It Quits" classes. Registration is required. For program information, call 1-805-201-STOP (7867) or email **CallItQuits@ventura.org**.
- **Urgent Care Brochure** – A brochure on **urgent care service** hours and locations is available for members. Contact GCHP/Total Care Advantage's Health Education Department for copies.
- **Weight Management and Physical Activity** – GCHP/Total Care Advantage collaborates with local public health agencies, community clinics, hospitals, and doctors to ensure that Plan providers have information about local support groups and exercise and nutrition classes.

Health Library - Healthwise by WebMD Ignite

GCHP/Total Care Advantage has partnered with Healthwise, a leader in evidence-based health education and self-management health promotion. This digital health education tool helps empower members through its user-friendly materials, resulting in improved health outcomes and increased satisfaction. Providers and members can visit the **GCHP website** to review the online library of interactive culturally and linguistically appropriate health education resources, available in English and Spanish at no cost. Materials may be downloaded directly from the website. Healthwise also offers tailored health education videos on chronic health conditions to assist members in managing their health conditions.

Gold Coast Health Plan (GCHP) Event Calendar

Members and providers can view the **GCHP Event Calendar** for upcoming events, including health education classes, workshops, health fairs and more. Topics include:

- Asthma
- Behavioral health and substance use
- Colon cancer
- Diabetes
- Heart health
- Men's health
- Prenatal and postpartum care
- Tobacco cessation
- Well-care visits
- Women's health

Providers can request health education classes, workshops, or presentations to be hosted at their clinic sites by requesting service through the GCHP Speakers Bureau. This free service is offered to community organizations, providers, government agencies, and more. Speakers are available for community events, staff in-services, and as requested. For more information, email **CommunityRelations@goldchp.org**. To request a speaker, complete and submit the request form at least four weeks in advance.

Health Navigator Program

GCHP/Total Care Advantage offers a Health Navigator Program to help link members with services in the community. The health navigators work with members who frequent the emergency rooms for non-emergency conditions to help them connect with their PCP. In addition, the program also helps link members who have chronic health conditions with GCHP/Total Care Advantage's Care Management program.

To learn more about the Health Navigator Program, call GCHP/Total Care Advantage's Health Education Department at 1-805- 437-5961, Monday through Friday, 8 a.m. to 5 p.m. (except holidays) or email **HealthEducation@goldchp.org**.

Women's Health

GCHP/Total Care Advantage's Health Library has information available to help support women's efforts to stay healthy. Information and education about routine breast and cervical cancer screening exams can be found there, as well as information on prenatal and postpartum care and obstetrics (OB) tours. This information can also be found on the GCHP/Total Care Advantage **website**. GCHP/Total Care Advantage's **health library** offers videos for member highlighting the importance of these important screenings.

Health Promotion Materials

GCHP/Total Care Advantage continues to collaborate with local clinics and other agencies to promote support groups and classes for members. Below is a list of additional health promotion and disease prevention topics that GCHP/Total Care Advantage providers may access:

- AIDS / HIV screening
- Breast and cervical health
- Breastfeeding
- Disease management
  - » Asthma
  - » Diabetes and prediabetes
- Health library

- High blood pressure
- Immunizations and COVID-19 resources
- Pregnancy and postpartum
- Sexually transmitted infections (STI) and family planning
- Tobacco cessation and vaping
- Well-care exams

The Health Education Department is continually developing new classes on various topics. If there is a class that you would like to see taught, please email **HealthEducation@goldchp.org**.

Materials on Other Topics or In Different Languages

GCHP/Total Care Advantage acknowledges the role that language barriers can play in reducing the quality of care to monolingual and limited English proficiency (LEP) members. The Health Education Department works with GCHP/Total Care Advantage providers to ensure that health promotion materials are available for distribution in English, Spanish, and other languages upon request. Contact GCHP/Total Care Advantage's Health Education Department at **HealthEducation@goldchp.org** for more information.

Health Education Trainings for Providers

The Health Education Department provides ongoing trainings to contracted providers. Contact the Health Education Department if you have questions on specific trainings. Many of the trainings are approximately an hour long and can be scheduled at the provider's convenience. Trainings offered by GCHP include:

- Health Education and Nutrition
  - MyPlate
  - Rethink Your Drink
- Health Education program overview
- Tobacco cessation training – The 5 A's

Provider Order Forms / Health Education Materials

GCHP/Total Care Advantage's Health Education Department created a list of approved health education resources for providers. To obtain the list of approved health education materials, call 1-805-437- 5961, Monday through Friday, 8 a.m. to 5 p.m. (except holidays) or email **HealthEducation@goldchp.org**.

The health education materials and resources that are available in English and Spanish include, but are not limited to:

- GCHP Tobacco Education and Quit Smoking Resource Guide
- Kick It California Helpline brochures
- GCHP Health Education Referral Form
- GCHP Asthma Action Plan
- GCHP Chronic Disease Self-Management Program Flyer
- GCHP My Blood Pressure Check Up Flyer
- GCHP My Diabetes Exam Record Flyer
- GCHP Community Resource Guide

Section 17: Pharmacy

Gold Coast Health Plan Total Care Advantage (HMO D-SNP)

Gold Coast Health Plan Total Care Advantage (HMO D-SNP) is a Medicare Advantage Dual Eligible Special Needs Plan for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. Gold Coast Health Plan (GCHP) manages the Medicare Part B pharmacy benefits, while Prime Therapeutics, our contracted pharmacy benefits manager (PBM), will be managing the Medicare Part D pharmacy benefits. A detailed description of the pharmacy benefits coverage and exclusions can be found in the **Member Handbook/Evidence of Coverage (EOC)** on the **GCHP Total Care Advantage website**.

Medicare Part B – Medical Coverage

Medicare Part B covers physician-administered drugs (PADs) and biologics that are typically provided in a clinical setting (in-office, outpatient infusion centers). This includes chemotherapy infusions, IV infusions, and most injectable medications that are NOT self-administered. These medications are billed by a provider on a medical claim using a procedure code (e.g., J-code, C-code, Q-code). Certain preventative vaccines are also covered under Part B, including influenza, COVID-19, hepatitis B and pneumococcal vaccines. In addition, Part B covers diabetic testing supplies, continuous glucose monitors (CGMs), durable medical equipment (DME) and drugs and biologics related to end-stage renal disease (ESRD).

Part B Physician Administered Drugs (PADs)

Part B medications are billed under the Total Care Advantage medical benefit. Some of these Part B medications require prior authorization before they can be administered. Providers must submit a prior authorization request with clinical documentation that supports medical necessity, such as diagnosis, treatment history and dosing details.

GCHP will review prior authorization requests and will issue a determination within the required CMS timeframe. For a list of the Medicare Part B Drugs that *require prior authorization* and review for approval, please check the GCHP's **TCA Medicare Part B Drug List**. This list is updated quarterly in alignment with guidance and direction received by CMS and the GCHP Pharmacy and Therapeutics (P&T) Committee.

To avoid delays or denials, providers should submit a completed prior authorization request with all necessary clinical documentation. To submit prior authorization requests for Part B drugs, you may submit it electronically on the **Provider Portal** (preferred) or manually by completing and faxing a **Prior Authorization Treatment Request Form**. PADs that are billed on a medical claim are the responsibility of GCHP

*NOTE: Prior authorization requests are subject to CMS-mandated turnaround times (TATs). Standard requests will be reviewed within **72 hours** from receipt of request. Expedited requests will be reviewed within **24 hours** from receipt of request; however, a request should ONLY be deemed expedited if waiting the standard 72-hour TAT could jeopardize the member's life, health, or ability to regain maximum function.

Medicare Part D – Outpatient Prescription Drugs

Medicare Part D covers outpatient prescription drugs that are typically self-administered, including oral medications, inhalers, self-administered injectables and maintenance medications for chronic conditions. All adult vaccines recommended by ACIP are also covered under Part D.

Over-the-counter (OTC) medications are NOT covered under Part D; however, certain **OTC products** may be covered under Medi-Cal Rx. For list of covered Part D medications, refer to **GCHP Total Care Advantage 2026 Formulary** or **myPrime website** (online searchable formulary).

Part D medications are dispensed through contracted retail and mail-order pharmacies, up to a 100-day supply for maintenance medications, which can be found on the **GCHP website** or by visiting the **myPrime website**.

GCHP contracts with Prime Therapeutics as the pharmacy benefit manager (PBM) for the Part D pharmacy benefit for TCA members. Prime Therapeutics is responsible for processing Part D pharmacy claims, some Part B pharmacy claims, and diabetic testing supplies (DTS) and continuous glucose monitors (CGMs) billed by pharmacies.

*NOTE: these medications and supplies may be subject to **co-pays**.

Preferred Diabetes Testing Supplies Manufacturers: *Abbott* and *Ascensia*	
Glucose Monitoring Systems (meter, tests strips, lancets)	Freestyle Lite Freestyle Freedom Lite Freestyle Precision Neo Freestyle Optium Neo Precision Xtra Contour Next EZ Contour Next GEN Contour Next ONE
Continuous Glucose Monitors (sensors, receiver, transmitter)	Dexcom G6 Dexcom G7 Freestyle Libre 2 PLUS Freestyle Libre 3 PLUS

Please NOTE:

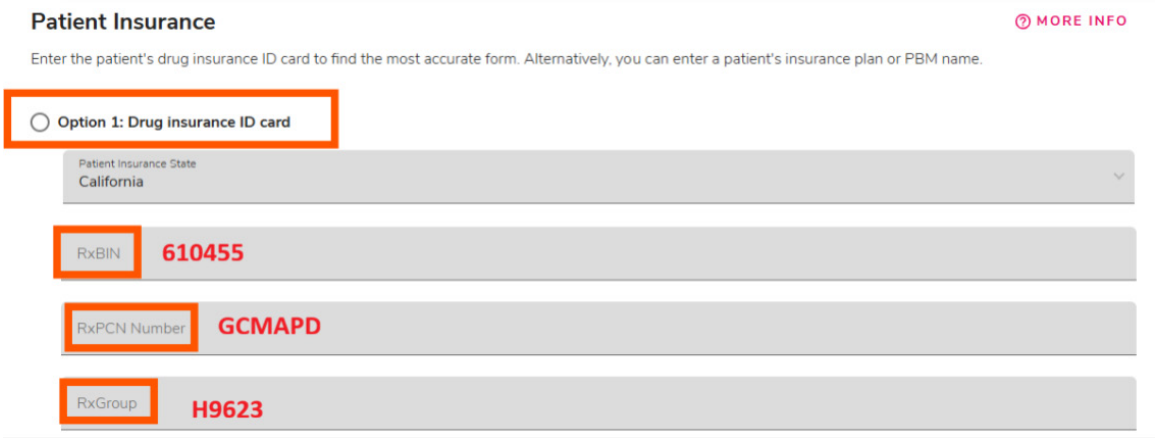
- **ALL formulary** diabetic testing supplies and CGMs will require a one-time **prior authorization** submitted to Prime Therapeutics to ensure appropriate use.
- **NON-formulary** diabetic testing supplies and CGMs will require a **formulary exception** to be submitted to Prime if providers are unable to switch to a preferred manufacturer.

Our Total Care Advantage plan provides members with access to a comprehensive pharmacy benefit through a broad network of contracted pharmacies, both retail and mail-order. Providers and members can locate contracted pharmacies by visiting our **Pharmacy Directory** or by utilizing the **Prime Pharmacy lookup tool**.

Medications covered by our Part D formulary that may require additional supporting documentation will require a **Prior Authorization**; drugs not covered on the TCA Part D Formulary will require a **Formulary Exception**. Both prior authorizations and formulary exceptions should be submitted to Prime (fax number is 855-212-8110). All other forms can be found on the **MyPrime website**.

You can submit prior authorizations electronically using **CoverMyMeds** - please ensure you are following one of these two options when entering insurance information for our Total Care Advantage members:

- **Option 1:** Entering the **RxBIN 610455, RxPCN GCMAPD, RxGroup H9623** (this will take you directly to the Prime Gold Coast Health Plan Medicare Coverage Determination Form), or



- **Option 2:** When manually searching for the insurance plan or PBM name, enter **"California"** as the state, enter **"Gold Coast"** as the plan name, and selecting the **"Prime Gold Coast Health Plan Medicare Coverage Determination Form"** and NOT the Medi-Cal Rx Medicaid Prior Authorization Request Form (which is for Medi-Cal members only)

Prime Therapeutics *Member Services* can be reached at **1-855-681-7966**, 24/7 to assist with any questions or issues regarding pharmacy claims or prior authorizations.

Providers may also call Prime Therapeutics at **1-877-277-5449 – option 3** to submit prior authorizations for Part D verbally over the phone.

For more information regarding pharmacy services, please check the **GCHP pharmacy website**. For additional questions, the GCHP Pharmacy Team can be reached at **1-805-437-5738** or by email at **Pharmacy@goldchp.org**.

Section 18: Provider Resolution of Disputes and Greivances

Provider Dispute Resolution (PDR) Process

Gold Coast Health Plan/Total Care Advantage's (GCHP) Provider Dispute Resolution (PDR) process offers providers who are dissatisfied with the processing or payment of a claim a method for resolving claim related issues. The provider dispute must be filed in writing by completing GCHP/Total Care Advantage's Provider Claim Reconsideration Form within 365 calendar days of the action or inaction date.

Do not submit a dispute if the claim is "in a pend" status. The provider may also include additional information that may affect the outcome of the dispute.

Providers must exhaust GCHP/Total Care Advantage's internal dispute resolution process before pursuing other available options.

Below are examples of concerns that can be addressed through the GCHP/Total Care Advantage's Provider Dispute Resolution process:

- A claim was underpaid.
- A claim was overpaid due to a payment or billing error.
- A procedure was denied as inclusive to another procedure in error.
- A corrected claim where a previous payment was made.
- A claim payment based on the utilization management decision.
- Resolution of a billing determination or other contract dispute.
- Claims believed to be inappropriately denied, adjusted, or contested.

Provider Dispute Resolution (PDR) are submitted by completing the **Provider Claim Reconsideration Form**.

- **By mail:**
  Total Care Advantage ATTN: Provider Disputes
  P.O. Box 9176
  Oxnard, CA 93031

- **By fax:**
  Total Care Advantage Grievances and Appeals Department
  1-805-512-8599

- **By email:**
  Grievances@goldchp.org

When completing the Provider Claim Reconsideration Form, please ensure that the resolution request type option is selected, and all fields are completed based on the request type:

- **DISPUTE Request:** Reconsideration of an original claim that has been previously denied or underpaid.
- **APPEAL Request:** Reconsideration of an authorization denial or a notice of action.
- **GRIEVANCE Request:** Reconsideration of a previously disputed claim in which the provider is not satisfied with the resolution.

It is imperative that all the following information is included on the dispute request:

- Provider and/or group name.
- Provider NPI, and Tax ID number.
- Provider contact information, including email address.
- A clear explanation of the issue in question.
- If the dispute involves a claim or request for reimbursement of overpayment, provide the original claim number and date of service.
- A clear explanation of why it is believed the payment or other action is incorrect.
- The member's full name, date of birth and complete nine-character Total Care Advantage ID number.

Claim disputes submitted with incomplete information will be returned to the provider along with a clear identification of the missing information that is necessary for the review and resolution of the dispute.

*Please note that if the dispute does not include an attached Provider Claim Reconsideration Form, the dispute request will be returned to the provider requesting the completed form.

Providers have 30 working days after the receipt of a returned provider dispute to resubmit the amended dispute with additional information. If the information is not submitted, or not submitted timely, the dispute is closed without further action.

If a provider has multiple disputes addressing the same issue, they may file a single dispute by including a list of each claim associated with the issue, along with all other information required for filing multiple disputes.

GCHP/Total Care Advantage will acknowledge the dispute within 15 working days of receipt. GCHP/Total Care Advantage will send a written resolution to the dispute within **60 calendar days** from the date the dispute was received. For assistance in filing a dispute, please call GCHP/Total Care Advantage's Provider Services at 1-888-301-1228.

Non-Contracted Provider Disputes

Non-contracted providers who want to submit a Total Care Advantage appeal of a benefit determination on behalf of a member must submit the appeal and waiver of liability to the Grievance and Appeals Department. Non-contracted providers must sign a waiver of liability statement attesting that they waive any right to collect payment from the member for GCHP to process the appeal.

Provider Grievance

Provider grievance is the final step in the administrative process and a method for GCHP providers to resolve claim issues related to their provider dispute outcome. The request should be submitted only after a Provider Dispute Resolution Process has been submitted and the resolution of the dispute does not meet the provider's satisfaction. Grievances related to claim dispute decisions must be submitted within 180 calendar days from the date of the provider dispute resolution letter. The request for review must be submitted by completing the Provider Claim Reconsideration Form to initiate the process. Failure to submit the request within the timeframe specified will result in the request being denied for past timely to submit. GCHP reviews each case individually using the documents presented by the provider to render a fair decision depending on the nature of the grievance. All grievances must be acknowledged within five calendar days of receipt and resolved within 30 calendar days of receipt.

All grievances received will be promptly acknowledged, reviewed, and researched by GCHP's Grievance and Appeals team. Research may require the participation of staff from other relevant GCHP departments.

Grievances related to medical-necessity decision disputes will be reviewed as an Appeal, only if they are submitted timely within 60 calendar days from the date of the Notice of Action (NOA) letter.

A provider grievance can be filed by completing the Provider Reconsideration Request Form and submitting the form as follows:

- **By mail:**
  Total Care Advantage
  Attn: Provider Grievances and Appeals
  P.O. Box 9176
  Oxnard, CA 93031

- **By fax:**
  Total Care Advantage's Grievances and Appeals Department
  1-805-512-8599

- **By email:**
  Grievances@goldchp.org

Appeals, Grievances, and Payment Disputes

GCHP maintains processes to receive, review and resolve provider grievance, claim related issues and/or Provider Disputes, Providers are required to respond timely to requests for information and/or records from GCHP/Total Care Advantage.

The Provider Claim Reconsideration Form can be found on the GCHP website at **https://www.goldcoasthealthplan.org/for-providers/provider-resources/**

Submit the completed form to:

Gold Coast Health Plan
Attn: Provider Disputes & Grievances
P.O. Box 9176
Oxnard, CA 93031

Members voicing dissatisfaction or requests for appeal of a plan decision must be referred to GCHP on the day of receipt.

Provider Responsibilities

When a member brings a complaint to your attention, you must investigate and try to resolve the complaint in a fair and equitable manner. In addition, providers must cooperate with GCHP/Total Care Advantage in identifying, processing and resolving all member complaints. Cooperation includes, but is not limited to, completing a provider response form, providing pertinent information related to the complaint, and/or speaking with GCHP/Total Care Advantage Grievances and Appeals representatives to assist with resolving the complaint in a reasonable manner. When responding, it is imperative that your response is on the provider's letterhead and not submitted on a blank word document or in the body of an email. Responses received in the body of an email will not be accepted. If you are assisting the member with their complaint, the forms are available in English and Spanish.

Section 19: Member Appeals and Grievances

As an Exclusively Aligned Enrollment (EAE) Dual Special Needs Plan (D-SNP) Gold Coast Health Plan (GCHP) applies an integrated Medicare and Medi-Cal process for grievances and appeals. These integrated processes include integrated notification templates that include all rights and procedures related to decisions.

- **Members' Rights:** The fundamental protections and entitlements of individuals enrolled in Medicare, Medi-Cal, or a specific health plan (GCHP), ensuring they receive high-quality care, participate in treatment decision, and are treated with dignity.
- **Appeal:** The procedures in place to process the review of an adverse initial determination made by the plan on healthcare services or benefits the member believes they are entitled to receive. These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
  - » **A member can appeal a denied decision within 65 calendar days from the date of decision (an extension may be granted).**
- **Grievance:** An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of healthcare items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or a late enrollment penalty (LEP) determination.

Filing an Appeal or Grievance

Providers should direct a member who wishes to file an appeal or grievance to GCHP. Members can file an appeal or grievance by:

- **Phone:** 888-301-1228 (TTY 711)
  Email: grievances@goldchp.org
  Fax: 805 512-8599

- **Mail:**
  Total Care Advantage
  Attn: Member Grievances and Appeals
  P.O. Box 9176
  Oxnard, CA 93031

- **In Person with a Member Services representative:**
  Monday – Friday, 8 a.m. to 5 p.m.
  Gold Coast Health Plan
  4880 Santa Rosa Road
  Camarillo, CA 93012

Member Grievances

The member, an authorized representative (such as family member, friend, caregiver), or a provider acting on behalf of the member may file a grievance at any time from the event.

GCHP can accept a written appointment of representative (AOR) or equivalent written notice from a member that complies with regulatory requirements.

Members who do not speak English or limited English proficient (LEP), limited reading skills, hearing incapacity or speech impaired have access to high quality interpreter and linguistic services at no cost by contacting Member Services at 1-888-301-1228 (TTY: 711).

Members have the right to obtain representation by an advocate or legal counsel to assist them in resolving the grievance and can contact the state Office of the Ombudsman at 1-888-452-8609 (TTY: 1-800-735-2922) to request assistance.

GCHP/Total Care Advantage will send a written acknowledgement letter to the member within five calendar days of the receipt date of the grievance. The acknowledgement letter states that the grievance has been received, the date of receipt, and includes the provider's name, telephone number and address of the Grievances and Appeals representative that may be contacted regarding the grievance. GCHP/Total Care Advantage will research and resolve standard grievances within 30 calendar days from the grievance receipt date. The written resolution will contain a clear explanation of GCHP/Total Care Advantage's decision.

A member can request an expedited grievance when the standard timeframe for making decisions could seriously jeopardize their life or health or ability to regain maximum function. GCHP/Total Care Advantage will resolve these cases that meet the expedited criteria within 72 hours of receipt of the request.

Member Discrimination Grievances

GCHP/Total Care Advantage is required by the state Department of Health Care Services (DHCS) to investigate grievances alleging any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination laws. GCHP/Total Care Advantage has implemented procedures to provide for the prompt equitable resolution of discrimination-related grievances. The discrimination grievances might include – without limitation: sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups defined in Penal Code section 422.56. This requirement includes language access complaints and complaints alleging failure to make reasonable accommodations under the Americans Disability Act (ADA).

GCHP/Total Care Advantage is required to report all discrimination cases to the DHCS Office of Civil Rights within 10 calendar days of mailing the discrimination grievance resolution letter to the member. GCHP is required to submit detailed information regarding the discrimination grievance, including the provider's or other accused party's response to the grievance and/or any corrective action taken.

Member Appeals

A member can request an appeal within 60 calendar days from the date on the notice of action (NOA). The member, an authorized representative or a provider acting on behalf of a member and with the member's written consent, may file a Member Appeal in writing or orally, by contacting the Member Service Department. GCHP/Total Care Advantage's Member Services representatives are trained to initiate and assist with documenting the appeal request for a member. Unless the member is requesting an expedited appeal, an oral request for an appeal must be followed by a written and signed appeal that can be either faxed or mailed directly to GCHP's Grievances and Appeals Department. A member can contact Member Services to get assistance in preparing a written appeal or be directed to the GCHP/Total Care Advantage website to obtain a form, which can be either faxed or mailed to the department. The date of the oral request will be used as the appeal notification date.

- **By phone**, call GCHP/Total Care Advantage Member Services: 1-888-301-1228 (TTY: 711)

- **By mail**, complete a Member Appeal form and/or written correspondence and send to:
  Total Care Advantage
  Attn: Grievances and Appeals
  P.O. Box 9176 Oxnard, CA 93031

- **By fax** to GCHP/Total Care Advantage's Grievances and Appeals Department: 1-805-512-8599

A GCHP/Total Care Advantage Grievances and Appeals representative will send an acknowledgement letter within five calendar days from the date the appeal is received. The letter of acknowledgement shall advise the member that the appeal has been received, the date of receipt, and provide the name, telephone number and address of the Grievances and Appeals representative that may be contacted regarding the appeal. GCHP will provide a response to the member as expeditiously as the member's health condition requires, but no later than 30 calendar days from the day GCHP/Total Care Advantage receives the appeal.

The member can request a timeframe extension for additional time to provide more documentation. GCHP/Total Care Advantage will make reasonable efforts to accommodate the member's request. If GCHP/Total Care Advantage is unable to resolve the appeal in the specified timeframe, the member will be given information on the right to file a member grievance for the delay.

Deemed Exhaustion

In the event GCHP/Total Care Advantage fails to adhere to the state and federal notice and timeframe requirements for either an NOA or NAR, including the failure to provide a fully translated notice, the member is deemed to have exhausted GCHP's internal appeal process and may initiate a State Hearing.

Expedited Review

An expedited review of an appeal can be requested in certain cases. This request can be made by the member, an authorized representative or by the provider on behalf of the member. GCHP/Total Care Advantage supports a process to resolve appeals in an expedited manner when a delay in a decision may seriously jeopardize the member's life, health, or the ability to attain, maintain or regain maximum function. The expedited appeal would need to be filed orally and followed up with a written request.

During the expedited appeal process, GCHP/Total Care Advantage will ensure the member is informed of the limited timeframe for an expedited appeal. GCHP/Total Care Advantage will provide a member notice as quickly as the member's health condition requires, or within 72 hours from the time and date the request is received. If the request for an expedited appeal does not meet criteria, the appeal will be handled as a standard appeal and be subjected to the timeframes for a standard appeal.

GCHP/Total Care Advantage will provide the member with a Notice of Appeal Resolution (NAR) letter, which will include the resolution. The NAR letter will include the member's right to request a State Hearing, how to request a State Hearing, how to request the continuation of benefits, and the requirements to file a continuation within 10 calendar days of when the NAR was sent, or before the intended effective date of the proposed action.

If GCHP/Total Care Advantage makes the decision to overturn the appeal, GCHP/Total Care Advantage will authorize or provide the disputed services as promptly as the member's health condition requires, but no later than 72 hours from the decision date.

State Hearing

GCHP/Total Care Advantage offers members only one level of appeal. Members must exhaust GCHP/Total Care Advantage's internal process prior to proceeding to a State Hearing. Members may request a State Hearing after receiving a NAR stating that their member appeal is denied, or if they have exhausted the

appeals process due to GCHP failing to adhere to the defined appeal notice and timing requirements. Members may request a State Hearing up to 120 calendar days from the date of the NAR.

The member request for a State Hearing will be considered as a standard hearing and the State Hearing unit will reach a decision within 90 calendar days of the date of the request. However, if the member requests an Expedited Hearing, the State Hearing unit will reach a decision within three working days from the date of the request. For any overturned decision, GCHP/Total Care Advantage shall authorize or provide the disputed services as promptly as the member's health condition requires, but no later than 72 hours from the date of the notice reversing the determination.

You can ask for a State Hearing:

- **By phone**, call 1-800-952-5253. This number can be frequently busy. You may get a message to call back later. If you use a TTY, please call 1-800-952-8349.

- **By mail:** Fill out a State Hearing form or send a letter to:
  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430

- **Online: www.cdss.ca.gov**

- **Fax:** 916-309-3487 or toll-free at 1-833-281-0903

A State Hearing form or the request letter should include the member's name, address, telephone number, Social Security Number (SSN) and/or Common Identification Number (CIN) number, and the reason for the requesting a State Hearing. If someone is helping the member request a State Hearing, add their name, address, and telephone number to the form or letter. If the member needs an interpreter, tell the State Hearings Division what language they speak. The member will not have to pay for an interpreter. The State Hearings Division will provide one. If the member has a disability, the State Hearings Division can provide special accommodation free of charge to help the member participate in the hearing. Please include information about the disability and the accommodation required.

Appeal

The member, an authorized representative or a provider acting on behalf of a member and with the member's written consent, may file a member appeal in writing or orally, by contacting member Services within 65 days from receipt of denial (an extension may be granted). Unless the member is requesting an expedited appeal, an oral request for an appeal must be followed by a written and signed appeal that can be either faxed or mailed directly to GCHP's Grievance and Appeals Department. The member can contact member services for assistance in preparing a written appeal or be directed to the GCHP website to obtain a form, which can be either faxed or mailed to the department. The date of the oral request will be used as the appeal notification date.

- **By Phone:** GCHP/Total Care Advantage Member Services
  Call 1-888-301-1228 (TTY: 711)

- **By Mail:**
  Total Care Advantage
  Attn: Grievances and Appeals
  P.O. Box 9176 Oxnard, CA 93031

- **By Fax:** 1-805-512-8599

Requesting Reconsideration/Redetermination on Behalf of a Member

Generally, the right of appeal for a denial of a pre-service organization determination belongs solely to the member. However, CMS allows a physician who is providing treatment to a member, upon providing notice to the member, to request Reconsideration on the member's behalf. In such a case, the physician is not required to submit proof that he/she is the member's representative. For post-service the right belongs solely to the member or authorized representative.

Appeal Processing Timelines

Type	Appeal	Grievance
Part C Standard	• Pre-service: Within 30 calendar days • Post-service (claims): Within 60 calendar days	Resolved within 30 calendar days
Part C Expedited	Resolved within 72 hours from date/ time of receipt	Resolved within 24 hours
Part B Standard	Resolved within 72 hours from date/ time of receipt	Resolved within 30 calendar days
Part B Expedited	Resolved within 24 hours from date/ time of receipt	Resolved within 24 hours

*NOTE: Part D Grievances and Appeals will be delegated to Prime Therapeutics our Pharmacy Benefit Manager (PBM) to conduct. Prime Therapeutics Member Services can be reached directly at 1-855-681-7966, 24/7 to assist with any questions or issues regarding grievances and appeals.

Expedited	
Payment Requests: Cannot be expedited (except for FIDE-SNP members that can prove financial burden)	24 hours (where criteria are met)
Further Levels of Review	
Second Level: Independent Review Entity (IRE) **Third Level:** Administrative Law Judge (ALJ) Hearing **Fourth Level:** Medicare Appeals Council (MAC) **Judicial Review:** Federal District Court	Enrollee may file a complaint with the Quality Improvement Organization (QIO) in addition to or in lieu of a Grievance

Part C & D Level 1 Appeal Adjudication Timeframes in accordance with CMS requirements:

Type	Part C	Part D
Standard Item, Service or Part D	30 calendar days	7 calendar days
Standard Part B	7 calendar days	
Expedited	72 hours	72 hours
Payment	60 calendar days	14 calendar days

Potential Quality Issue (PQI)

To determine opportunities for improvement in the provision of care and services to GCHP members, there is a systematic method in place that identifies, investigates, and reports potential quality issues (PQIs) and directs actions for improvement based upon risk, frequency and severity.

PQIs are identified and referred to the Clinical Quality Improvement Department for further review and investigation. Identification of a PQI is made through the systematic review of a variety of data sources such as information gathered through concurrent, prospective and retrospective utilization review, referrals by health plan staff, health plan providers or provider staff, and referrals by non-health plan contracted staff. A PQI may also be identified through an FSR, claims and encounter data, pharmacy utilization data, MCAS / HEDIS® / CMS Core Measures medical record review and quality audits, and grievances filed by members.

A PQI investigation is conducted by a QI registered nurse and may include the following:

- Contacting the provider's office for medical records and/or other information pertaining to the issue.
- A request for provider response.
- Interviewing provider or facility staff.

PQIs are rated, or leveled, by GCHP/Total Care Advantage's designee for member outcome (O), system issues (S), and provider care (P). A scale is used to rate / level the PQI and is based on the severity of member outcome and/or level of opportunity for improvement.

Depending on the rating / leveling of a PQI, the case could be sent to the Credentials / Peer Review Committee (C/PRC) for consideration in a provider's recredentialing process.

PQI Reporting

PQIs may be reported by any of the following:

- GCHP staff member
- Anonymous
- Any member of the community
- Any contracted or non-contracted provider / staff

A PQI is reported to the Clinical QI department by submitting a completed PQI Referral Form here or emailing inquiries to PQIReporting@goldchp.org. Complaints Tracking Module (CTM)

GCHP/Total Care Advantage must use the Complaints Tracking Module (CTM) through the Health Plan Managed System (HPMS) to track, and resolve complaints received from CMS about Medicare from beneficiaries, providers, and/ or beneficiaries' representatives.

As a provider you are required to work with GCHP/Total Care Advantage to resolve any provider specific CTM complaints within the following timelines based on the Issue Level regardless of the day of the week, including weekends and holidays.

- **Immediate Need Complaints:** An immediate need complaint involves a situation that prevents a beneficiary from accessing care or a service for which they have an immediate need. Immediate need complaints must be resolved **within two calendar days** of the assignment date.

- **Urgent Complaints:** An urgent complaint involves a situation that prevents a beneficiary from accessing care or a service for which they do not have an immediate need. Urgent complaints must be resolved **within seven calendar days** of the assignment date.

- **All Other Complaints:** All other complaints will be resolved **within 30 calendar days** of the assignment date.

Section 20: Delegation

Gold Coast Health Plan/Total Care Advantage delegates activities in accordance with the terms and conditions identified in individual contracts. GCHP/Total Care Advantage will perform oversight of an entity's applicable activities to ensure full compliance with applicable plan policies, delegation agreements and the most current National Committee for Quality Assurance (NCQA), federal, state, and GCHP/Total Care Advantage standards.

GCHP/Total Care Advantage monitors each entity's compliance with delegated functions and responsibilities, makes recommendations for improvement, and monitors corrective actions. Delegation oversight includes:

- Desktop and annual onsite reviews.
- Monitoring.
- Continuous improvement activities.

Annual Audit

Each delegate is audited at least annually to verify compliance with GCHP/Total Care Advantage requirements and continued ability to perform delegated functions. The Delegation Oversight Audit evaluates the delegate's capabilities in each of the delegated functions.

Audit Process

Delegation oversight audits are performed using GCHP/Total Care Advantage approved audit tools which abide by the most current state, federal, NCQA and GCHP/Total Care Advantage standards:

Reporting Requirements

Reporting requirements are identified in the Delegated Service Standards / Delegation Agreement included as an attachment to each contract. Delegates are responsible for the timely submission of reports as outlined in the contract.

Non-Compliance

Findings from the annual evaluation, file audit and reports are used to identify areas of improvement and to implement a CAP when warranted. GCHP/Total Care Advantage reserves the right to revoke the delegation of responsibilities when delegate entities demonstrate non-compliance.

Section 21: Privacy and Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Gold Coast Health Plan (GCHP) requires that providers respect the privacy of GCHP members and comply with all applicable laws and regulations regarding the privacy of patients and members. Privacy and security of member and patient protected health information (PHI) should only be used or disclosed as permitted or required by applicable law.

Inadvertent Disclosures of PHI:

GCHP/Total Care Advantage may, on occasion, inadvertently misdirect or disclose PHI pertaining to GCHP member(s) who are not the patients of the provider. In such cases, the provider shall return or securely destroy the PHI of the affected GCHP Members in order to protect their privacy. The provider must not further use or disclose such PHI and will provide an attestation of return, destruction, and nondisclosure of any such misdirected PHI upon the reasonable request of GCHP.

The **Health Insurance Portability and Accountability Act** (HIPAA) provides a floor for patient privacy. Where state law is more stringent than HIPAA, state law should be followed. In addition to HIPAA, GCHP/Total Care Advantage and GCHP/Total Care Advantage providers may be subject to other legal requirements concerning the privacy of Member information. For example, GCHP/Total Care Advantage must notify the state Department of Health Care Services (DHCS) immediately of suspected security incidents and within 24 hours of breaches involving a Medicare / Medi-Cal beneficiary. Furthermore, GCHP is required to notify Office for Civil Rights (OCR) of HIPAA breaches involving 500 or more members, without unreasonable delay. By meeting the obligations in this Section, GCHP/Total Care Advantage and its providers ensure that all HIPAA obligations are met. The business associate agreement (BAA) between GCHP/Total Care Advantage and a delegated provider details the business associate's responsibilities with respect to member PHI, including reporting PHI breaches to GCHP/Total Care Advantage. While timeframes are set forth in each BAA, GCHP/Total Care Advantage requests that providers notify GCHP of member PHI breaches immediately or as soon as possible in order to meet strict regulatory incident notice expectations. In order for GCHP/Total Care Advantage to meet regulatory incident reporting expectations, prompt reporting, cooperation, and follow up from its business associates is critical.

In the event of a member PHI breach, providers must notify GCHP/Total Care Advantage immediately or as soon as possible after the discovery of any breach, but no later than the time frame set forth in the provider's BAA. Notice should be addressed to the GCHP/Total Care Advantage Privacy Office via email (preferred) at **compliance@goldchp.org** or certified mail to:

Total Care Advantage
Attention: Privacy Office
4880 Santa Rosa Road
Camarillo, CA 93012

Section 22: Quality Improvement and Health Equity Transformation (QIHET) Program

Gold Coast Health Plan/Total Care Advantage's Quality Improvement and Health Equity Transformation (QIHET) Program is designed to support GCHP's mission to improve the health of our members through the provision of high-quality and equitable healthcare and services through a member-first focus that centers on the delivery of exceptional service to our beneficiaries by enhancing the quality of healthcare, providing greater access, and improving member choice. The QIHET Program also defines the processes for continuous quality improvement of clinical care and services, patient safety, and member experience provided by GCHP and its contracted provider network, and community partnerships. These processes include a commitment to improving and sustaining performance through the prioritization, design, implementation, monitoring, and analysis of performance improvement initiatives with a specific focus on health equity.

GCHP's QIHET Program aligns its efforts with the state Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS), the goals set forth by the California Advancing and Innovating Medi-Cal (CalAIM) Initiative, as well as the Centers for Medicare & Medicaid Services (CMS) National Quality Strategy (NQS). The scope of the quality improvement (QI) process encompasses the following:

1. Quality and safety of clinical care services including, but not limited to:
    - Preventive service for children and adults
    - Primary care
    - Specialty care, including behavioral health services
    - Emergency services
    - Inpatient services
    - Ancillary services
    - Chronic disease management
    - Care management
    - Population Health
    - Prenatal / perinatal care
    - Family planning services
    - Medication management
    - Coordination and continuity of care
    - Long-term care

2. Quality of non-clinical services including, but not limited to:
    - Accessibility
    - Availability
    - Member and provider satisfaction
    - Grievance and appeals process
    - Culturally and linguistically appropriate services
    - Network adequacy
    - Health equity
    - Community supports

3. Member safety initiatives including, but not limited to:
    - Facility site reviews / medical record reviews / physical accessibility review surveys
    - Credentialing of practitioners / organizational providers
    - Peer review
    - Sentinel event monitoring
    - Potential quality issues (PQIs)

- Provider preventable condition (PPC) monitoring
- Health education
- Utilization and risk management
- Transitional care services

4. A QI focus that represents all categories below:
   - All care settings
   - All types of services
   - All demographic groups
   - Health equity

Quality Improvement and Health Equity Transformation Program (QIHET) Program Goals

The QIHET Program goals include:

- Develop and maintain QIHET resources, structure, and processes that support the organization's commitment to equitable and quality healthcare for our culturally and linguistically diverse members.
- Objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable healthcare and services.
- Identify and implement ongoing and innovative strategies to improve the quality, equity, appropriateness, and accessibility of member healthcare.
- Implement an ongoing evaluation process to improve identified opportunities for under / over utilization of services.
- Facilitate organization-wide integration of quality management and population health principles.
- Measure and enhance member satisfaction with the quality of care and services provided by GCHP/ Total Care Advantage's network providers.
- Promote engagement in local community, statewide, and national collaborations and initiatives aimed at improving quality and equity of care and services.
- Maintain compliance with state and federal regulatory requirements.
- Provide oversight of delegated entities to ensure compliance with GCHP standards as well as state and federal regulatory requirements.

For more information about GCHP's QIHET Program, visit the GCHP **website**.

Quality Improvement and Health Equity Committee (QIHEC)

The QIHEC is responsible for the monitoring, evaluating, and reporting of organization-wide health equity and quality improvement processes and initiatives that ensure the delivery of and access to quality and equitable healthcare and customer service. The QIHEC is accountable to the Ventura County Medi-Cal Managed Care Commission (VCMMCC) and must submit QIHEC reports to the VCMMCC.

QIHEC Objectives

- Ensure QIHEC members can have candid discussions about barriers to achieve quality goals and objectives, and to facilitate the removal of such barriers.
- Ensure a communication process is in place to adequately track work plan and QIHET Program activities and enable system-wide communication and resolve action items on the annual Quality Improvement and Health Equity Transformation (QIHET) Medi-Cal Work Plan and the Quality Improvement Dual-Special Needs Plan (D-SNP) Work Plan.
- Encourage feedback from members and providers regarding delivery of care and services and to use the feedback to evaluate and improve how care and services are delivered.

QIHEC's Responsibilities

- Facilitate data-driven indicator reviews and development for monitoring key quality management activities, including but not limited to: MCAS / HEDIS® / CMS Child and Adult Core Medicaid, Medicare Star Rating Measures, CAHPS®, Access / Availability, Performance Improvement Projects, Service / Clinical Quality measures, UM/CM metrics, Population Health metrics, Behavioral Health metrics, Credentialing performance, Culturally and Linguistically Appropriate Services and Oversight.
- Review reports from GCHP committees and departments, including QIHEC committee meeting minutes, action item logs, dashboards, key activities and action plans including subcommittee updates, and reports regarding monitoring of health plan functions and activities.
- Analyze and evaluate the results of quality improvement and health equity activities including annual review of the results of performance measures, Performance Improvement Projects (PIPs) related to clinical and non-clinical care, utilization data, consumer satisfaction surveys, and the findings and activities of other committees such as the Community Advisory Committee (CAC).
- Make recommendations for implementation of interventions or corrective actions based on results of quality improvement and health equity activities, including those recommended by network providers, fully delegated subcontractors, and downstream contractors.
- Oversee the annual review, analysis and evaluation of goals set forth by the QIHET Program as well as GCHP/Total Care Advantage's quality improvement policies and procedures.
- Recommend policy changes or implementation of new policies to GCHP's administration and commission.

Star Ratings System for Medicare

The Medicare Star ratings system is an annual, five-star rating program designed by CMS to measure and communicate the quality and performance of Medicare Advantage (Part C) and Medicare Prescription Drug Plans (Part D). Plans are rated on a set of performance measures on a scale from 1-5, with 5 being the highest score a plan can achieve.

The Medicare Star ratings system was designed to empower beneficiaries and drive quality improvement among Medicare Advantage plans in the following ways:

- Help beneficiaries make informed choices
- Measure and improve quality of care
- Incentivize high performance

The Star ratings are based on measures across various categories, including:

- Staying healthy: Preventive services like screenings and vaccinations
- Chronic condition management: How well plans manage chronic conditions like diabetes and hypertension
- Member experience: member satisfaction with the plan, including complaints and disenrollment rates
- Customer service: Responsiveness and access to care
- Plan and pharmacy services: For Part D plans, this includes measures like medication adherence and drug pricing accuracy

CMS uses multiple data sources to calculate specific performance measures including:

- Health Effectiveness Data and Information Set (HEDIS®) collects clinical outcomes and data. HEDIS® data reflects care delivered by providers and staff

- Prescription drug event data collected to provide insight for prescription drug-related measures
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is an annual survey sent to a random sample of members every spring to measure their experience with care delivered and the health plan
- The Health Outcomes Survey (HOS) is sent every spring to a random sample of members to measure self- reported health status and the quality of their healthcare
- Operations data from health plans is used to assess the quality of customer service and other services health plans are providing to their members

An overall Medicare Star rating is assigned after a weighted average of the scores for individual measures and the various performance domains is calculated. Ratings are updated each year and published on medicare.gov. For more information on the Medicare Star Rating System, **click here**.

Providers can support Star ratings by:

- Promoting preventive care and screenings
- Ensuring complete and accurate documentation
- Managing chronic conditions effectively
- Improving medication adherence
- Closing gaps in care
- Enhancing care coordination
- Optimizing patient experience and access to care

Monthly Star Measure Dashboard and Gap Reports:

- Providers have access to the Inovalon Converged Data Insights Dashboards to view their performance on
- Star measures, including member and clinic level data for monitoring current and projected measure performance, trending, and gap analysis.
- Reports can be downloaded for additional analytics, managing care gaps and patient outreach.

Facility Site Review (FSR)

GCHP/Total Care Advantage conducts a DHCS-required, full-scope facility site review (FSR), medical records review (MRR), and physical accessibility review survey (PARS) of PCP sites as part of its provider credentialing and re- credentialing process. The purpose of the FSR, MRR and PARS is to ensure that GCHP's PCPs meet certain minimum state-required standards for their office sites, maintenance of patient medical records, and to ensure physical accessibility for seniors and persons with disabilities.

The FSR / MRR is conducted by a certified site reviewer (CSR) nurse and/or certified master trainer (CMT) nurse and includes an on-site inspection and interview with office personnel. State-mandated tools and standards are used by CSR and/or CMT to conduct the reviews.

An FSR, MRR and PARS is conducted a minimum of every three years for each primary care site. A PARS is performed every three years on designated high-volume ancillary and specialty providers as well as for Community Based Adult Services (CBAS) sites. New PCP sites are not eligible to be assigned members until they pass an initial FSR. GCHP will contact the PCP site to schedule initial and periodic site visits. In accordance with DHCS guidance, GCHP reserves the right to perform unannounced site visits.

The MRR is based on an audit of randomly selected medical records per PCP and is comprised of pediatric, adult, and obstetric records, when applicable. The MRR includes, but is not limited to, a review of format, legal documentation practices, and documentary evidence of the provision of preventive care and coordination of primary care services.

The PARS focuses on facility site access including the building / PCP's office, parking, elevators, exam rooms, and assesses for accessible drinking water, internet access, and accessible electronic content.

If deficiencies are identified during the FSR/MRR, the reviewer will issue a corrective action plan (CAP). The CAP will include specific time frames for addressing the identified deficiencies. In some cases, assignment of new members will be held until the identified deficiencies have been corrected.

All site reviews / PARs conducted, and CAPs completed are reported to DHCS as mandated for evaluation / audit.

For questions or more information regarding FSR, MRRs, or PARs, click **here** or contact the Clinical QI Facility Site Review Team at **FSR@goldchp.org**.

Performance Improvement Projects (PIP)

GCHP/Total Care Advantage is required to conduct and/or participate in a minimum of two performance improvement projects (PIPs) at a cadence set forth by DHCS for its Medi-Cal population. PIP topics are chosen in consultation with DHCS and the EQRO. The PIP topics selected are based on demonstrated areas of poor performance, such as low HEDIS® / MCAS / CMS Core Measure, CAHPS® scores, or DHCS / EQRO recommendations, and must be aligned with the state's Quality Strategy for preserving and improving the health of Californians, as well as the goals set forth in the CalAIM initiative. GCHP will utilize the PIP format approved by DHCS / EQRO and complete PIP documentation by the submission dates established by DHCS / EQRO. The status of each PIP is reported at the QIHEC meetings.

As required by CMS, GCHP also conducts one or more PIPs annually for its Medicare D-SNP program to improve outcomes and quality of care for enrollees - especially those with complex or chronic needs. CMS requires that each PIP:

- Include a clearly identified performance goal
- Implement interventions to improve performance
- Measure performance using objective quality indicators
- Evaluate the effectiveness of interventions over time

GCHP will complete PIP documentation and report results to CMS annually.

Performance Improvement Methodology

GCHP/Total Care Advantage focuses on identifying opportunities and measuring improvements by utilizing various methodologies, including industry-standard quality improvement tools, to design, implement and test the effectiveness of interventions to achieve continuous quality improvements. Some of these methodologies include but are not limited to, the Plan-Do-Study-Act (PDSA) Cycle methodology, Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis, QIHE Lean Process, Cause-and-Effect Diagrams to identify root cause analysis, data collection and analysis, and ongoing performance monitoring.

Quality Incentive Pool & Program (SNP QIPP)

The Dual Special Needs Quality Incentive Pool & Program (SNP QIPP) is an initiative designed to ensure the establishment of an operational framework necessary to manage the complex medical and social needs of dually eligible members and improvement in CMS Star measure quality metrics held to the performance levels stated for each measure in the agreement.

GCHP/Total Care Advantage designed the SNP QIPP to support providers in delivering high-quality care to dual-eligible members through activities including workflows for accurate documentation, coding, risk

adjustment and Star measure monitoring. Year one efforts prioritize provider support and readiness for launching a D-SNP product line.

Performance and payment methodology for SNP QIPP are determined by the completion of required "ramp Up" activities and performance on selected Star measures held to stated performance levels.

SNP QIPP additionally requires operational integration activities, such as leadership and operational meetings and annual and quarterly provider work plan submissions to GCHP.

For more information about the GCHP Quality Improvement and Health Equity Transformation (QIHET) Program see SECTION 11: QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION (QIHET) PROGRAM and the CMS Star Program or contact GCHP's Quality Improvement Team at **QualityImprovement@goldchp.org**.

Member Incentives

- Breast cancer screening: Medicaid and D-SNP members 40 to 74 years of age can earn a $50 gift card for completing a breast cancer screening (mammogram).
- Annual health visits: D-SNP members can earn a $50 gift card for completing an annual health visit.
- Hemoglobin A1c blood test: D-SNP members with diabetes 18 to 75 years of age can earn a $50 gift card for completing a hemoglobin A1c blood test (HgA1c).

To receive the incentive, members must fill out a member incentive form, including their member ID, service date, and a signature / stamp by the rendering provider. This form can be submitted via fax, mail, or email. Providers can also submit this form to the Quality Improvement (QI) Department on a member's behalf. These forms can be found on GCHP/Total Care Advantage's website in the Member Rewards Program Section under the For Members tab.

For more information about GCHP's member incentive programs you can contact QI at **QualityImprovement@goldchp.org**

Provider Preventable Conditions (PPC)

Pursuant to Title 42 of the Code of Federal Regulations, states are prohibited from permitting payment to Medicaid providers for treatment of PPCs, except when the condition existed prior to the initiation of treatment for that beneficiary by that provider. PPCs consist of healthcare-acquired conditions (HCAC), when they occur in acute inpatient hospital settings only, and other provider-preventable conditions (OPPC) when they occur in any healthcare setting.

GCHP is required to comply with the guidelines established by DHCS by screening claims and encounter data for provider preventable conditions and report each PPC to DHCS.

Providers caring for GCHP members must report each PPC to DHCS and GCHP after discovery of the PPC and confirmation that the patient is a Medi-Cal beneficiary. PPCs can be reported to DHCS via their secure online reporting portal or by fax. PPCs must be reported to GCHP via secure email at **PQIReporting@goldchp.org**.

SECTION 23: Fraud, Waste, and Abuse Policy

To establish a formalized organizational process for detecting, investigating, documenting and reporting suspected fraud, waste or abuse of any Gold Coast Health Plan (GCHP) program by a member, provider, employee, or any other person, in accordance with GCHP's contract with the state Department of Health Care Services (DHCS), The Center for Medicare & Medicaid Services (CMS), Health and Human Services (HHS), The Office of the Inspector General (OIG), The Department of Justice (DOJ), The Federal Bureau of investigation (FBI) and federal and state regulations.

Policy:

A. GCHP/Total Care Advantage maintains a zero-tolerance policy toward fraud, waste and abuse.
B. GCHP/Total Care Advantage complies with applicable statutory, regulatory and other governmental requirements, and contractual obligations or commitments related to the delivery of GCHP/Total Care Advantage covered benefits, which include, but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, Health Insurance Portability and Accountability Act (HIPAA), the code of Federal Regulations (CFR) 422.503 and 423.504, and other applicable statutes.
C. All GCHP employees, contractors, temporary staff, vendors, first tier, downstream, and related entities (FDRs) including providers and practitioners are responsible for reporting any suspected fraud, waste or abuse to GCHP/Total Care Advantage. GCHP/Total Care Advantage reports suspected fraud, waste or abuse to DHCS and CMS in accordance with its DHCS contract and CMS and this policy.
D. GCHP maintains a policy of non-retaliation toward employees, contractors, providers and practitioners who make such reports in good faith. GCHP employees, contractors, temporary staff, vendors, providers and practitioners are protected from retaliation under Title 31, United States Code, Section 3730(h), for False Claims Act complaints, as well as any other anti-retaliation protections.
E. GCHP/Total Care Advantage maintains Special Investigation Unit (SIU) for complete investigation of all reported suspected fraud, waste, or abuse allegations. GCHP/Total Care Advantage SIU staff under the supervision of the GCHP/Total Care Advantage Compliance Officer, is responsible for activities associated with the investigation and reporting of suspected fraud, waste, or abuse. SIU staff will compile supporting evidence for the investigation, consult with legal counsel as appropriate, and function as the liaison between GCHP/Total Care Advantage, DHCS, CMS, HHS, OIG, DOJ, FBI, the Medical Board, the State Board of Pharmacy, other licensing, law enforcement, and other relevant entities, as appropriate, and cooperate with those agencies related to any fraud, waste, or abuse investigations or audits.
F. GCHP/Total Care Advantage's investigative processes ensure that appropriate confidentiality protocols are followed relating to any investigation of a suspected fraud, waste or abuse violation. GCHP's compliance officer or designee will report the status and results of all suspected fraud, waste or abuse investigations to the GCHP Compliance Committee.
G. GCHP/Total Care Advantage's Compliance Program provides for regular training and information sessions for all GCHP/Total Care Advantage employees, contractors, temporary staff, network providers and practitioners regarding GCHP's fraud, waste and abuse policies and procedures. GCHP/Total Care Advantage members will also be informed via Total Care Advantage Member Handbook and/or newsletters about how to report fraud, waste and abuse. Additionally, GCHP has information posted on the member portal on how to report FWA.
H. GCHP/Total Care Advantage's Compliance Officer will act as the fraud prevention officer, who is responsible for developing, implementing, and ensuring the GCHP/Total Care Advantage fraud prevention program. The Compliance Officer reports directly to the Chief Executive Officer and the Commission. The Compliance Officer will attend and participate in DHCS' quarterly program integrity meetings, as scheduled.

Definitions:

A. **Fraud:** An intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law (Title 42 CFR 455.2; Welfare and Institutions Code 14043.1(i).

B. **Waste:** Overutilization of services and/or misuse of resources not caused by a violation of law. Abuse: Refers to practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the federal Medicaid program, the Medi-Cal program, another state's Medicaid program, or healthcare programs operated, or financed in whole or in part, by the federal government or a state or local agency in this state or another state. It also refers to practices that are inconsistent with sound medical practices and result in reimbursement by the federal Medicaid programs, the Medi-Cal program or other healthcare programs operated, or financed in whole or in part, by the federal government or a state or local agency in this state or another state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2; Welfare and Institutions Code 14043.1(a).

C. **Retaliation:** Adverse punitive action taken against an employee who reports fraud, waste or abuse.

D. **Whistleblower:** An employee, former employee, or member of an organization who reports misconduct, including, but not limited to, fraud, waste or abuse, to people or entities that have the power to take corrective action.

Procedures:

1. **Training of GCHP Staff and Provider Network**
   GCHP/Total Care Advantage provides training for new employees, contract employees, temporary employees and commissioners. Trainings for existing staff are held on an annual basis. Trainings are held on a quarterly basis for all new associates to ensure new associates receive training. The process for detecting suspected fraud, waste, or abuse, the specific provisions regarding fraud, waste, or abuse under the False Claims Act, the reporting process, and the protections afforded to those who report such concerns in good faith are all reviewed during the trainings. All trainings are documented with all attendees noted. GCHP/Total Care Advantage employees, contractors, and temporary staff and commissioners receive a certificate of completion for attending fraud, waste, and abuse training. Providers are informed about fraud, waste, and abuse via the Provider Manual. In addition, contracts with providers have verbiage that is inclusive of fraud reporting.

2. **Identification of Fraud, Waste or Abuse**
   a. GCHP/Total Care Advantage employees, contractors, temporary staff, vendors, members, providers and practitioners may detect fraud, waste or abuse perpetrated by a member in circumstances that include, but are not limited to, the following:
      I. Using another individual's identity, Benefits Identification Card (BIC), GCHP Identification card, Medi-Cal number, or other documentation of Medi-Cal or GCHP/Total Care Advantage program eligibility to obtain covered services, unless such person is an authorized representative who is presenting such document or information on behalf of a member to obtain covered services for that member.
      II. Selling, loaning, or giving a member's identity, BIC, GCHP identification card, Medi-Cal number, or other documentation of Medi-Cal and GCHP/Total Care Advantage program eligibility to another individual to obtain covered services, unless such person is an authorized representative who is obtaining services on behalf of a member.
      III. Making an unsubstantiated declaration of eligibility.

IV. Using a covered service for purposes other than the purposes for which it was prescribed or provided, including use of such covered service by an individual other than the member for whom the covered service was prescribed or provided.
V. Soliciting or receiving a kickback, bribe, rebate or other financial incentive as an inducement to receive or not receive covered services.
VI. Failing to report other health coverage
VII. Soliciting or receiving a kickback, bribe or rebate as an inducement to receive or not receive covered services.
VIII. Altered prescriptions.

b. GCHP/Total Care Advantage employees, contractors, temporary staff, vendors, members, providers and practitioners may detect fraud, waste or abuse by a provider, provider group or practitioner in circumstances that include, but are not limited to, the following:
I. Unsubstantiated declaration of eligibility to participate in the Medi-Cal program or the GCHP/Total Care Advantage program as a provider, provider group or practitioner.
II. Submission of a claim or a request for payment for:
i. Covered services that were not provided to the member for whom such covered services were claimed.
ii. Covered services substantially in excess of the quantity that is medically necessary for the member.
iii. Covered services using a billing code that will result in greater payment than the billing code that reflects the covered services actually provided.
III. Soliciting, offering, receiving, or paying a kickback, bribe or rebate as an inducement to refer, or fail to refer, a member.
IV. Failing to disclose any significant beneficial interest in any other provider to which the provider or practitioner may refer a member for the provision of covered services.
V. False certification of medical necessity.
VI. Attributing a diagnosis code to a member that does not accurately reflect the member's medical condition for the purpose of obtaining higher reimbursement.
VII. Submitting files or reports that contain unsubstantiated data, data that is inconsistent with underlying clinical, encounter, or payment records or data that has been altered in a manner or for a purpose that is not consistent with GCHP/Total Care Advantage's policies, contract, or applicable regulations and statutes.
VIII. Charging a member in excess of allowable co-payments and deductibles for covered services and/or billing Medi-Cal members for services.
IX. Durable medical equipment (DME) – covered services that are not actually provided to a member.
X. Excessive provider pharmacy utilization.

3. **GCHP/Total Care Advantage employees, contractors, temporary staff, vendors, members, providers, and practitioners may detect fraud, waste or abuse by an employee in circumstances that include, but are not limited to, the following:**
a. Use of a member's identity or documentation to obtain services.
b. Use of a member's identity or documentation to obtain a gain.
c. Employee assistance to providers with the submission of false claims for covered services that are not actually provided to the member for which the claim was submitted.
d. Employee deceptively accessing company confidential information for purposes of gain.
e. GCHP/Total Care Advantage providers' responsibilities for fraud prevention and detection include, but are not limited to, the following:
i. Train provider staff, contracted physicians, and other affiliated or ancillary providers and vendors on GCHP and provider's fraud prevention program and fraud prevention activities at least annually.

ii. Develop a fraud program, implement fraud prevention activities and communicate such program and activities to contractors and subcontractors.
iii. Communicate awareness, including identification of fraud schemes, detection methods, and monitoring activities to contracted and subcontracted entities and to GCHP.
iv. Notify GCHP/Total Care Advantage of suspected fraudulent behavior and ask for assistance in completing investigations.
v. Take action against suspected or confirmed fraud, including referring such instances to law enforcement and reporting activity to GCHP/Total Care Advantage.
vi. Police and/or monitor activities and operations to detect and/or deter or prevent fraudulent behavior.
vii. Cooperate with GCHP/Total Care Advantage in fraud detection and awareness activities, including monitoring, reporting, as well as cooperating with GCHP/Total Care Advantage in fraud investigations to the extent permitted by law.

4. **Reporting Fraud, Waste, or Abuse**
GCHP/Total Care Advantage provides for the reporting of suspected fraud, waste or abuse through various mechanisms. This includes, but is not limited to, the following:

- GCHP/Total Care Advantage website-secure portal
- Fraud, Waste, and Abuse toll-free telephone hotline
- Email
- Phone
- In-person reporting to the GCHP/Total Care Advantage Compliance Department.

GCHP's Compliance Department tracks and analyzes data for suspected fraud, waste, and abuse trends.

a. The Fraud Hotline, 1-866-672-2615, or the website at **secure.ethicspoint.com**, can be used to anonymously report a suspected fraud, waste or abuse incident. The hotline number is provided to employees, contractors, temporary staff, vendors, members, providers, and practitioners.
i. GCHP/Total Care Advantage employees may utilize the hotline provided by Navex at 1-866-672-2615, which provides a method to anonymously report suspected fraud, waste, or abuse. Employees may also use secure.ethicspoint.com.
ii. In the event an allegation against a GCHP/Total Care Advantage employee is received via Navex, but the allegation is not related to fraud, waste or abuse, the case will be referred to the Executive Director of Human Resources. If the allegation involves a Commission member the Chief Compliance Officer will contact General Counsel immediately. In the event the allegation involves the Chief Executive Officer (CEO), the Chief Compliance Officer will contact the Commission Chair and GCHP General Counsel.
iii. If the allegation involves the Chief Compliance Officer, the SIU will contact the Chief Executive Officer and GCHP General Counsel immediately. In such circumstances, General Counsel and GCHP will contract with an outside entity for an independent investigation.
iv. Writing to the following address:
Total Care Advantage
Attn: Compliance Officer - Fraud Investigation
4880 Santa Rosa Road
Camarillo, Ca 93012

5. **Investigation and Research**
GCHP/Total Care Advantage treats the detection of suspected fraud, waste or abuse in a confidential manner by (1) ensuring that Compliance staff adheres to GCHP/Total Care Advantage's Health Insurance Portability and Accountability Act (HIPAA) confidentiality protocols in compiling

only the information needed for the investigation to determine if the suspected violation is valid and (2) ensuring that GCHP/Total Care Advantage will not retaliate or make retribution or inflict retribution against any GCHP/Total Care Advantage employee, provider, practitioner, or member for such detection.

Upon receiving a report of a suspected fraud, waste or abuse incident, Compliance staff will review the report, perform an initial triage of the case, and do the following:

a. Determine the nature of the allegation and if it relates to fraud, waste, or abuse in a GCHP/Total Care Advantage program.
b. In the event the report is determined to be inappropriate for investigation by GCHP/Total Care Advantage, an acknowledgement response via Navex will be available online. In addition, the reporter will receive a report number, and may contact Navex global compliance 24 hours a day, seven days a week and request the status of the case.
c. Once it is determined the allegation is valid for GCHP/Total Care Advantage to pursue, the Chief Compliance Officer or their designee will:
    I. Assign the case a unique tracking number (via the tracking software) and establish a file to maintain documents, reports, evidence, and correspondence pertaining to the suspected fraud, waste or abuse, to include, but not limited to, the following:
        i. The reported individual allegation or incident (organized by date),
        ii. Summary results of the investigation
        iii. The resolution, and Reports to/correspondence with the appropriate agency.
    II. The SIU staff will reach out to the reporting party, when the party is unknown, to acknowledge receipt of allegation and will request additional information or documentation, if necessary.
    III. The appropriate department(s) shall be involved based upon the nature of the case to gather the appropriate documentation (e.g., member profiles, claims history, etc.). The department(s) notified will review the allegation and gather any additional information as deemed necessary for a comprehensive report.
    IV. If necessary and upon request, SIU will coordinate the investigation independent of other GCHP departments, including procuring the services of contracted investigators as or if needed. In the event the allegation warrants merit, there is reason to believe that an incident of fraud and/or abuse has occurred based on preliminary findings, SIU will utilize the material reviewed by the department(s) in preparation to report and notify the appropriate agency (DHCS Program Integrity Unit, Medicare HHS OIG, Managed Care Division Member Rights / Program Integrity Unit) of the suspected fraud waste or abuse, within10 working days.
    V. GCHP/Total Care Advantage will also report to the NBI MEDIC when suspected fraud, waste, or abuse for Medicare Part C and Part D.
d. GCHP/Total Care Advantage SIU / Compliance staff will conduct, complete, and report to DHCS and CMS the results of its preliminary investigation of suspected fraud, waste or abuse within 10 working days of the conclusion of the date GCHP/Total Care Advantage first becomes aware of, or is on notice of, such investigation activity.
e. In the event if the issue appears to involve potential fraud or abuse and GCHP does not have either the time or the resources to investigate the potential fraud or abuse in a timely manner, it will refer the matter to the NBI MEDIC within 30 days of the date the potential fraud or abuse is identified so that the potentially fraudulent or abusive activity does not continue.

6. **Disclosure Log**
    a. The Chief Compliance Officer (or designee) shall record all disclosures in a written disclosure log within two working days of receipt. The written disclosure log must include the following information:
        i. A summary of each disclosure received (whether anonymous or not);
        ii. The date the disclosure was received;
        iii. The individual or department responsible for reviewing the disclosure;
        iv. The status of the review;
            - Any corrective action taken in response to the review; and
            - The date the disclosure was resolved

7. **Monitoring**
    GCHP/Total Care Advantage's Chief Compliance Officer will report findings to the Compliance Committee and GCHP governing body. Reports will include quarterly reports and annual summaries that identify any trends needing review, discussion, and possible corrective action plans, as appropriate.

References:

GCHP/Total Care Advantage contracts with the DHCS, Title 42. Code of Federal Regulations (C.F.R) Section 455.2, 42 C.F.R. §Title 42, Code of Federal Regulations (C.F.R) Section 438.608, 422.503 (b)(4)(vi)(F), 423.504, Medicare Managed Care Manual Ch. 21 and Prescription Drug Benefit Manual Ch. 9, Welfare and Institutions Code, Section 14043.1

Appendix 1: Functions of Committees and Gold Coast Health Plan (GCHP) Staff Quality Improvement and Health Equity Committee (QIHEC)

The Quality Improvement and Health Equity Committee (QIHEC) is responsible for the monitoring and evaluation of the overall effectiveness of quality improvement and health equity activities at GHCP. The Quality Improvement and Health Equity Committee (QIHEC) is chaired by the Chief Medical Officer (CMO) in collaboration with the executive director of health equity and is facilitated by the executive director of quality improvement. Membership consists of chairs from the nine QIHEC subcommittees, GCHP management, licensed practitioners from GCHP's provider network, a behavioral health practitioner, and at least one Commissioner. The QIHEC meets six times per year and is responsible for advising GCHP's staff and commissioners on the Quality Improvement and Health Equity Transformation (QIHET) Program.

The QIHEC:

- Oversees annual review, analysis and evaluation of goals set forth by the QIHET Program, Quality Improvement and Health Equity Transformation Medi-Cal Work Plan and the Quality Improvement Dual-Special Needs Plan (D-SNP) Work Plan, as well as GCHP's quality improvement policies and procedures.
- Makes recommendations for implementation of QIHET Program interventions or corrective actions based on results of quality improvement and health equity metrics and activities.
- Facilitates data-driven indicator review and development for monitoring key quality management activities, including but not limited to: MCAS / HEDIS®, CMS Star Rating Measures, Access / Availability, Performance Improvement Projects, Service / Clinical Quality measures, UM/CM metrics, Population Health metrics, Behavioral Health metrics, Credentialing performance, Culturally and Linguistically Appropriate Services, and Delegation Oversight. Analyzes and evaluates the results of QI and Health Equity activities, including the annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other committees, such as the Community Advisory Committee.
- Institutes actions to address performance deficiencies, including policy recommendations.
- Ensures appropriate follow-up of identified performance deficiencies.
- Reviews reports from GCHP committees and departments, including quarterly dashboards, key activities and action plans and reports regarding monitoring of health plan functions and activities, and makes recommendations.

Utilization Management Committee (UMC)

The UMC is established as a standing sub-committee of the QIHEC of GCHP. The committee structures and processes are clearly defined in the Quality Improvement and Health Equity Transformation Program Description.

The UMC oversees the implementation of the program and promotes the optimum utilization of healthcare services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multi-disciplinary and monitors continuity and coordination of care as well as under- and over-utilization of services. Any perceived or actual utilization management problems are reviewed by the UMC. The committee meets quarterly. The QIHEC and UMC work together on overlapping issues.

Pharmacy & Therapeutics (P&T) Committee

The Pharmacy and Therapeutics (P&T) committee is chaired by the Director of Pharmacy and comprised of local physicians and pharmacists. The committee meets quarterly with the primary responsibility

of ensuring cost effective and quality drug management for GCHP members. The committee will also discuss retrospective Drug Utilization Reviews (DURs), review the policies and procedures for Pharmacy Services, review and update the Physician Administered Drug (PAD) list covered under the Medical Drug Benefit and provide recommendations on educational materials and programs regarding drug products and appropriate utilization for Providers. P&T committee members are appointed by the CMO and/or the Director of Pharmacy. The P&T committee reports to the board through the CMO and the QIHEC.

Credentials / Peer Review Committee (C/PRC)

The Credentials / Peer Review Committee (C/PRC) oversees GCHP's credentialing and practitioner peer review process, including guidance and peer input. The C/PRC is chaired by the CMO and attended by GCHP management and licensed practitioners from GCHP's contracted provider network, which includes primary care and specialty practices.

The committee meets quarterly and supports GCHP's efforts to ensure its contracted providers deliver the highest quality of care to its members by:

- Providing guidance and comments on the credentialing process.
- Reviewing and making decisions for initial credentialing and recredentialing.
- Reviewing credentialing policies annually.
- Reviewing potential quality issues involving the quality of care and services.
- Determining corrective action when necessary.
- Reviewing and approving clinical practice and preventive healthcare guidelines and utilization management criteria.

At its discretion, the C/PRC may invite additional specialists to review case records, either in writing or in person. Participants are bound by confidentiality, non-discrimination, and conflict of interest rules.

Health Education, Cultural & Linguistics Committee (HECL Committee)

The HECL Committee is chaired by the senior health education director and staffed by the managers and leadership of QI, Member Services, Network Operations, Health Services, and others, as appropriate. The committee shall meet at least quarterly and reports to the QIHEC.

GCHP's HECL department includes interpretation and translation services, provider education and resources, and cultural competence training for GCHP and contracted staff. Committee objectives are to increase access to high quality care for all GCHP members, reduce health disparities among different cultural groups, and to improve communication among staff, providers and members.

Provider Advisory Committee (PAC)

Comprised of a broad spectrum of community providers, the PAC meets quarterly and offers input to the CMO, commission and management team regarding GCHP policies that involve provider activity and the integrity of the provider network. The GCHP commission appoints PAC members to a renewable one-year term. Recommendations for policy revisions and innovations, if adopted as resolutions by a majority of the appointed members of the PAC, are forwarded to the commission.

Chief Medical Officer (CMO)

The CMO is the principal GCHP position that provides oversight of the provider credentialing process, quality monitoring, evaluation, and improvement activities.

The CMO is responsible for the day-to-day guidance and direction of quality monitoring, improvement activities, and seeking input from specialists as needed to provide guidance in addressing quality issues relevant to a specific area of expertise.

Specific functions of the CMO include:

1. Fulfillment of and adherence to Quality Improvement and Health Equity Transformation (QIHET) Program goals and all regulatory agency and accreditation body requirements.
2. Fulfillment of and adherence to UM / CM Program goals and all regulatory agency and accreditation body requirements.
3. Development and coordination of the peer review process.
4. Serving as chair for the Credentials / Peer Review Committee and Quality Improvement and Health Equity Committee.
5. Consultation with the Health Services, UM, and Quality directors and other staff, as appropriate.
6. Guiding and assisting in the development and revision of quality improvement criteria, practice guidelines, new technology assessments and performance standards, as appropriate, and the development and implementation of quality improvement strategies.
7. Presenting periodic updates on quality improvement, health equity, and utilization management activities to committee chairs and to the commission as appropriate.

Appendix 2: FAQs About Claims and Electronic Billing

1. Does Gold Coast Health Plan (GCHP) follow the same timeliness guidelines as Medi-Cal?

Yes. GCHP requires providers to submit claims within 365 calendar days from the date of service unless the provider's contract specifies a different limitation. If the member has other health coverage, the claim must be received within 180 days from the date of the primary carrier's Explanation of Benefits.

2. What is GCHP's processing time for my claims?

GCHP is contractually bound to process 90% of clean claims within 30 working days of receipt of the claim and 99% of clean claims within 60 calendar days of receipt of the claim. Claims are processed daily, and payments are generated once a week. When a holiday falls on a check run day, checks will be processed on the next business day.

3. What is GCHP's capitation check schedule?

GCHP processes capitation checks to PCPs on the 10th of each month. When a holiday falls on a check run day, checks will be processed on the next business day.

4. Am I required to submit claims for capitated services for members linked to my practice?

Yes. GCHP requires and specifies in your provider contract that all capitated service encounters must be reported every month as "encounter claims" that are not paid.

5. Will GCHP accept electronic claims?

Yes. GCHP accepts and encourages electronic claims submission by network providers. If your practice or facility is interested in submitting claims electronically, please contact **GCHPOnboardingRequests@edifecs.com**. If you use a clearinghouse, please provide this information to your clearinghouse vendor.

6. When and how should I follow up on claims that I believe have not been processed by GCHP?

Please consider the date that the claim was submitted to estimate an appropriate follow-up / re-bill period. GCHP processes claims based on the date they are received. For most practices, the appropriate timeframe for follow up would be 45 calendar days after the claim was originally mailed or transmitted electronically. GCHP suggests that providers use the electronic claims tracking available through the Provider Web Portal or contact Provider Services at 1-888-301-1228 before resubmitting any claims.

7. What about the ability to view claims via the web?

Providers can use GCHP's Provider Web Portal to search for claims that were submitted by paper or electronically. If your office has not registered and is not using the Provider Web Portal, please contact the Provider Services Department at 1-888-301-1228 or email **ProviderRelations@goldchp.org**. Detailed instructions on how to use the Provider Web Portal can be located on the **GCHP Provider Portal** web page.

8. How are refunds or reversals / take backs processed?

GCHP's Recovery Department assesses and identifies overpayments on claims. Research is completed to identify overpayments related to over-utilization of procedures, claims billed incorrectly, duplicate payments, overpayments due to lack of coordination of benefits with members' primary healthcare insurance policy (such as private health insurance, Medicare coverage, or an open case with CCS).

Typically, the overpaid amount is recovered by the provider issuing a lump-sum check payable to GCHP and mailed to:

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

Alternatively, an overpayment may be reversed from monies due to the provider on the same NPI until the recovery is completed. This will only be done as a last resort if the provider does not respond in writing to the notification from GCHP that there is an overpayment that must be reconciled or if the provider asks GCHP to offset the overpaid amount.

When an overpayment is identified by GCHP, the provider will be notified with a letter explaining the overpayment and a request for a refund check in the amount of the overpayment. If the provider does not remit the overpayment, GCHP will notify the provider of its intent to offset the overpayment from future claim payments.

If a provider is not expected to receive money in future payments or does not have a large volume paid out for a particular NPI number from GCHP to recoup the overpayment, the offset(s) must be completed by using the same NPI that was initially paid incorrectly.

Example: A claim was paid for services rendered to John Doe. GCHP discovers that Mr. Doe is not your patient and takes back the payment. The initial payment was paid to NPI #1234567890; therefore, GCHP should be able to recoup the monies owed (excluding any issue beyond GCHP's control) from any following payment made to that NPI. The Claims Department will mail, fax, or e-mail an "Identification of Overpayment" request if offsets are not viable. Payments are expected within 30 days from receipt of this notice.

If you have additional questions or concerns, please contact the Claims Department at 1-888-301-1228.

9. What do I do if I disagree with how a claim was paid or denied?

Claims are processed using Medicare and standard National Correct Coding Initiatives (NCCI) guidelines. If a provider disagrees with either how a claim was priced / paid or whether or not it was denied appropriately, the provider should submit a Provider Claim Reconsideration Form.

For further information, please see the dispute resolution process section of this Provider Manual.

Appendix 3: Financial Disclosure and Reporting

By the terms of its contract with the state, Gold Coast Health Plan (GCHP) is required to monitor the financial viability of its contracted providers and Plan partners. The purpose is to establish that they are financially solvent and that their financial status is not deteriorating over time. The requirements for contracted providers are different from those of GCHP partners.

GCHP will exercise discretion to only collect financial information from contracted providers if and when there is a clear need to do so in order to fulfill its obligations to the state. For example, PCPs who have only a small or limited number of members on their panel will not have to comply with these provisions, nor will tertiary care out-of-area providers that rarely treat GCHP's members or providers that are compensated on a straight fee-for-service rate schedule or case rate basis.

GCHP partners must submit financial statements annually for the first three quarters of the fiscal year to GCHP's Compliance Department no later than 45 calendar days after the close of each applicable quarter for the fiscal year. For the purpose of this section, the quarterly financial statements will consist of the balance sheet, income statement, statement of change in net worth and cash flow statement.

The provider's financial statements should be prepared in accordance with Generally Accepted Accounting Principles (GAAP). Financial statements shall be in the same format and have the same content as the Quarterly Financial Reporting Forms (previously "Orange Blank") that are submitted to the state Department of Managed Health Care (DMHC).

On an annual basis, GCHP partners shall submit to GCHP's Compliance Department financial statements audited by an independent Certified Public Accounting firm. Audited annual financial statements must be filed within 120 days of the end of each fiscal year and will be in the same format and content as the Annual Financial Reporting Form (previously "Orange Blank") submitted to DMHC.

GCHP will review the financial statement(s) to determine if the selected providers and partners meet the minimum acceptable liquidity, profitability, efficiency, and stop-loss protection levels.

The financial viability of each selected contracting provider and all GCHP partners will be determined based on established criteria and DMHC-required grading criteria. For example, the following information will be calculated and analyzed:

Liquidity:

- Current and quick ratios to be equal to or greater than 1.0.
- Acid test ratio of liquid assets (cash) to current payables to be equal to or greater than 0.50 (DMHC-required grading criteria).
- A positive working capital of 1.0 or above (DMHC-required grading criteria).
- A positive tangible net equity (TNE) or net worth of 1.0 or above (DMHC-required grading criteria).

In addition, GCHP partners shall estimate and document, on a monthly basis, the organization's liability for incurred but not reported (IBNR) claims using a lag study, an actuarial estimate, or other reasonable method.

[1] GCHP reserves the right to request more frequent submissions.

On a discretionary basis, the GCHP Compliance Department will have the right to periodically schedule audits to ensure compliance with the above requirements. Since the financial solvency standards apply to the entity as a whole, the audits will be conducted for all books of business, not only for the lines of businesses contracted with GCHP. Representatives of the contracted providers and GCHP partners shall facilitate access to the records necessary to complete the audit.

Appendix 4: FAQs for Member Grievances and/or Appeals

NOTE: This guide is provided to give basic assistance to provider offices in dealing with questions received from Gold Coast Health Plan (GCHP) members related to grievances. For more complicated matters, please refer members to GCHP at 1-888-301-1228 (TTY: 711).

1. What is the GCHP grievance and/or appeal process?

GCHP has a process for evaluation of grievances and appeals. It provides a method for the member to voice their grievances or settle any concerns they may have about the services they receive as GCHP members.

2. What is a grievance?

A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. A grievance may include, but is not limited to, the quality of care or services provided, interpersonal relationships such as rudeness of a provider or employee, and the member's right to dispute an extension of time proposed by GCHP to make an authorization decision.

3. When can a member file a grievance?

A member can file a grievance at any time.

Some examples of grievances include, but are not limited to, the following:

- Member experiences a problem getting services they feel are needed, such as medication, medical equipment, or an appointment with a doctor.
- Member is unhappy with the services received from a healthcare provider.
- Member is unhappy with their healthcare treatment.

In most cases, filing of complaint / grievance must be done within 180 days of the event that caused dissatisfaction. If a complaint is filed because GCHP has denied or modified a request for Prior Authorization, an appeal must be filed within 60 days of GCHP's Notice of Action.

4. What is an appeal?

An appeal is review of GCHP's adverse benefit determination, which means the denial, deferral or limited authorization of a requested covered service, including:

- Determinations on the level of service.
- Denials of medical necessity.
- Reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or part, of payment for a service.
- Failure to provide timely services as defined by the state, for a resident in a rural area.
- The denial of a member's ability to exercise the right to obtain services out of GCHP's network.
- The denial of a member's request to dispute a financial liability including cost sharing, deductibles, and other financial liabilities.

5. When can a member file an appeal?

A member can file an appeal within 60 calendar days from the notice of action.

6. Who can file a grievance and/or an appeal?

- Member
- Authorized representative
- Provider on behalf of the member

7. How can the grievance or appeal be submitted?

- **Phone:**
  1-888-301-1228

- **Mail:**
  GCHP Grievances & Appeals
  P.O. Box 9176
  Oxnard, CA 93031

- **In-person:**
  Gold Coast Health Plan
  4880 Santa Rosa Road
  Camarillo, CA 93010

- **Email**:
  Grievances@goldchp.org

- **Fax:**
  1-805-512-8599

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For more information, call Gold Coast Health Plan at 1-888-301-1228.
If you use a TTY, call 711.

www.goldcoasthealthplan.org