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

## Provider Advisory Committee (PAC) Regular Meeting

**Tuesday, December 10, 2024, 7:30 a.m.**
**Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010**
**Members of the public can participate using the Conference Call Number below.**
**Conference Call Number: 1-805-324-7279**
**Conference ID: 430 467 431 #**

**Telephonic Location**:
3080 Bristol Street
Costa Mesa, CA 92626

3585 Maple Court
Ventura, CA 93033

## AGENDA

**CALL TO ORDER**

**ROLL CALL**

**PUBLIC COMMENT**

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

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

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

## OPENING REMARKS / WELCOME

**Marlen Torres, Chief of Member Experience & External Affairs**
**Erik Cho, Chief Policy & Program Officer**

## CONSENT

**1. Approval of Regular Meeting Minutes of September 10, 2024**

Staff: Maddie Gutierrez, MMC, Clerk of the Commission

RECOMMENDATION: Approve the minutes as presented.

**2. Approval of the 2025 Calendar for PAC Meeting Dates**

Staff: Maddie Gutierrez, MMC, Clerk of the Commission

RECOMMENDATION: Approve the 2025 Provider Advisory Committee meeting calendar as presented.

## UPDATES

**3. Operations of the Future (OOTF) Update**

Staff: Anna Sproule, Executive Director, Operations

RECOMMENDATION: Receive and file the update.

**4. Provider Network Operations Update**

Staff: Michelle Espinoza, Executive Director of Delivery Systems & Operation Strategies

RECOMMENDATION: Receive and file the update.

## PRESENTATIONS

**5. APL 24-012 NSMHS Member and PCP Outreach and Education Plan**

Staff: Lucy Marrero, Director, Behavioral Health

RECOMMENDATION: Receive and file the presentation

## 6. Proposed D-SNP Model of Care Quality Measures

Staff: Eve Gelb, Chief Innovation Officer

Nathan Norbryhn, Sr. Director for Model of Care

RECOMMENDATION: Receive and file the presentation

## ADJOURNMENT

Unless otherwise determined by the PAC, the next meeting is scheduled for March 4, 2025 and will be held at Gold Coast Health Plan located at 711 E. Daily Drive, Suite 110, Community Room, Camarillo, CA 93010.

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

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

# AGENDA ITEM NO. 1

TO: Provider Advisory Committee (PAC)

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

DATE: December 10, 2024

SUBJECT: Approval of the regular Provider Advisory Committee Meeting minutes of September 10, 2024

## RECOMMENDATION:

Approve the minutes.

## ATTACHMENTS:

Copy of the September 10, 2024, Provider Advisory Committee meeting minutes.

**Ventura County Medi-Cal Managed Care Commission (VCMMCC)**
**dba Gold Coast Health Plan (GCHP)**
**Provider Advisory Committee (PAC)**
**Regular Meeting September 10, 2024**

## CALL TO ORDER

The Clerk to the Commission called the meeting to order at 7:32 a.m., in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

## ROLL CALL

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

Absent: Committee members: Molly Corbett, Sim Mandelbaum, Milad Pezeshki, M.D.

Gold Coast Health Plan Staff in attendance: Felix Nunez, M.D., Acting Chief Executive Officer, Marlen Torres, Executive Director of Strategy & External Affairs, Ted Bagley, Chief Diversity Officer, Erik Cho, Chief Policy & Program Officer, Alan Torres, Chief Information Officer, Eve Gelb, Chief Innovation Officer, Paul Aguilar, Chief of Human Resources, Susana Enriquez-Euyoque, Vicki Wrighster, Kim Marquez-Johnson, Alison Armstrong, Anna Sproule, Michelle Espinosa, and General Counsel, Scott Campbell.

## PUBLIC COMMENT

None.

## OPENING REMARKS

CPPO Erik Cho thanked everyone for their participation. He stated there had ben an important change in staff at GCHP. Dr. Felix L. Nunez, M.D., Chief Medical Officer is now serving as Acting Chief Executive Officer. Even though we had had this change, CPPO Cho stated that the core values and our commitment to our providers has not changed.

Felix L. Nunez, M.D. stated that the organization is committed to a mission and our members. He stated that the change was abrupt, but noted that staff is focused on three main things:

- Priority - Care for our members
- Second Priority – Caring for our providers.
- Third Priority - Caring for us, as an organization, especially during this time of transition.

CEO Nunez that Ventura County is a dynamic community with a log of history and culture.

Nothing has changed as far as our strategy to go forward. We want to get out into the community and connect. It is important to understand what people want and need. We will also look at opportunities that the stated gives us. We, as a team will work together and stay focused on our members and this community.

## CONSENT

### 1. Approval of regular meeting minutes of June 11, 2024

Staff: Maddie Gutierrez, MMC, Clerk of the Commission

RECOMMENDATION: Approve the minutes as presented.

Committee member Amanda Larson motioned to approve Agenda item 1 as presented. Committee member Claudia Gallard seconded.

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

NOES: None.

ABSENT: Molly Corbett, Sim Mandelbaum, and Milad Pezeshki, M.D.

The motion carried.

## UPDATES

### 2. Operations of the Future Update (OOTF)

Staff: Anna Sproule, Executive Director of Operations
Alan Torres, Chief Information & Systems Modernization Officer

RECOMMENDATION: Receive and file the update.

Executive Director of Operations, Anna Sproule, stated she will provide an update on the OOTF process. On July 1, GCHP implemented several new systems that included a new core admin system for eligibility claims and payments. She noted that with integrating the new systems there have been some temporary disruptions in workflows which has led to the delays in payments. DHCS was contacted as usual when a provider has a concern about receiving payment – that was specific to our skilled nursing facilities. We have spent a significant amount of time getting to the root cause

of payment delays. Ms. Sproule noted that SNFs claims and payments are more complex that a standard claim payment. We have worked to get the backlog caught up. We have been working with the California Association of Health Facilities to keep them informed of any issues encountered as a part of payments. There are also 835 withdrawal electronic remittances. We know our providers depend on our 835s to apply their payments and the new and improved automation of the 835 capabilities are now being rolled out across the provider network and we will be getting those payments out very soon.

CEO Nunez stated that we prioritize getting authorizations through as quick as possible, either knowing it is approved or knowing it is not. He noted that we have an exceptionally low prior authorization denial rate. We are at four to five percent at any given time, this is low for a managed care plan. We struggled initially during this transition, and we dropped in our performance. We have gotten back to our steady state in terms of our authorization process and our numbers have improved. We will continue to monitor and work on improvements. We have been able to maintain standard authorizations, we are making sure that we are getting those through as quickly as possible. We have been able to maintain a high performance on retro authorizations.

CEO Nunez stated that all the systems that we have purchased are state of the art systems, the issue is that we did not buy one suite. These are distinct processes and systems that now must work together and interact. The issue now becomes integrating those systems and make sure issues are resolved.

**3. D-SNP Update**

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

RECOMMENDATION: Receive and file the update.

Chief innovation Officer, Eve Gelb introduced Kimberly Marquez-Johnson, Director of Dual Special Needs Plan presented an update on the D-SNP process. Ms. Marquez-Johnson stated that in 2022 DHCS collaborated with the center of Medicare, Medicaid, CMS, along with other managed care plans to establish the D-SNP model. She noted that seven managed care plans have converted from Medi-Connect to D-SNP. In January of 2023 managed care plans were required to have a D-SNP up and running by January 2026.

Currently our dual eligible beneficiaries known as Medi-Medi's (Medicare/Medi-Cal) operate separately with different funding streams, which can be confusing and hard to navigate. CalAIM/DHCS' approach is to have a health plan coordinate across both the Medicare and the Medi-Cal services, also known as Medi-Medi plans. A Medi-

Medi plan is a type of Medicare Advantage plan in California that is only available to the dually eligible beneficiaries These plans are described as a single plan that is able to cover both Medicare and the Medi-Cal benefits - members will no longer get two sets of insurance cards, instead they will receive one integrated set of materials. There will be one organization to coordinate across both sets of benefits. D-SNP will be able to provide comprehensive care coordination across both Medicare and Medi-Cal.

The goal of the D-SNP Model of Care is to provide a sustainable high-quality plan to ensure our members care is being coordinated and have their needs addressed. We are going to coordinate services and provide wrap-around benefits. We will adhere to Medicare regulations in addition to our Medi-Cal regulations, we will be instituting new Medicare processes that do not exist right now in our Medi-Cal world. We are also going to align our existing processes in an efficient way to ensure superior quality care.

Ms. Marquez-Johnson reviewed the timeline. We have already submitted our initial Knox-Keene application, and we are currently working on comments going back and forth with the Department of Managed Care. She reviewed the regulatory filings that we need to do to operate as a D-SNP. Our Notice of Intent to apply will be in November. We also need to confirm with the state that we are interested in entering a contract with the State and CMS to become a D-SNP. We will also be working on our Model of Care, to make sure that we submit and get approval from CMS and DHCS.

On the Medicare side, we need to provide our members with a benefit structure that needs to be approved by CMS every year. Our first one will be in June of 2026 to get approval and then our Go-Live date will be January 1, 2026. She noted that for members who have chosen to enroll with us as a Medi-Medi, bills will come to us, and we will pay the entire bill at our contracted rate.

Committee member Amanda Larson asked if payments will be closer to the Medicare side or what is current from a managed care plan. CIO Gelb stated that we do not know the reimbursement rate, but we will be negotiating that rate. We need to negotiate with each of our providers because this will be a contracted network. We will have an integrated claims payment process.

Michelle Espinosa, Executive Director of Delivery Systems Operations & Strategies stated that the intent is to create a payment program that is seamless to the provider and the member. She noted that it is hard to say what we are going to pay because things change annually, and we are exploring everything. We will engage with the stakeholder provider group and get feedback.

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Committee member Masood Babeian motioned to approve Agenda items 2 and 3 as presented. Committee member Kristine Supple seconded.

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

NOES: None.

ABSENT: Molly Corbett, Sim Mandelbaum, and Milad Pezeshki, M.D.

The motion carried.

**FORMAL ACTION**

**4. PAC AdHoc Committee Recommendation for Chair and Vice Chair**

Staff: Marlen Torres, Executive Director of Strategy & External Affairs
Erik Cho, Chief Policy & programs Officer

RECOMMENDATION: Staff requests that the PAC Committee accept the PAC AdHoc committee's recommendations for Chair and Vice-Chair.

Ms. Torres thanked the AdHoc committee for their time. Ms. Torres then announced that the new chair selected was Milad Pezeshki, M.D. and Vice-Chair was Dr. Pablo Velez.

Ms. Torres stated that CPPO Cho and she would be working with the Chair and Vice-Chair to develop agendas for future meetings.

Committee member Amelia Breckenridge, M.D. motioned to approve Agenda item 4 as presented. Committee member Masood Babeian seconded.

AYES: Committee members: Masood Babaeian, Amelia Breckenridge, M.D., Claudia Gallard, Katy Krul, Amanda Larsen, Vincent Pillard Josie Roemhild, and Kristine Supple.

NOES: None.

ABSTAIN: Dr. Pablo Velez

ABSENT: Molly Corbett, Sim Mandelbaum, and Milad Pezeshki, M.D.

The motion carried.

The Clerk stated that the next meeting is scheduled for December 10, 2024, with a start time of 7:30AM.

## ADJOURNMENT

With no further items to be addressed, the Clerk adjourned the meeting at 8:38 a.m.

Approved:

_____
Maddie Gutierrez, MMC
Clerk to the Commission

# AGENDA ITEM NO. 2

TO: Provider Advisory Committee (PAC)

FROM: Maddie Gutierrez, MMC Clerk to the Commission

DATE: December 10, 2024

SUBJECT: Approval of the 2025 Provider Advisory Committee Meeting Calendar

## SUMMARY:

This item will establish dates for the Provider Advisory Committee (Committee) meetings for 2025. The calendar schedule has quarterly regular meetings.

## RECOMMENDATION:

Approve the 2025 Provider Advisory Committee meeting calendar as presented.

## ATTACHMENTS:

Copy of 2025 Provider Advisory Committee Meeting Calendar.

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PAC Regular Mtg, 7:30-9 AM

# 2025
# Provider Advisory Committee Meetings

## January

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## September

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## November

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## December

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**AGENDA ITEM NO. 3**

TO: Provider Advisory Committee (PAC)

FROM: Anna Sproule, Executive Director of Operations

DATE: December 10, 2024

SUBJECT: Operations of the Future (OOTF) Update

# VERBAL PRESENTATION

## AGENDA ITEM NO. 4

TO: Provider Advisory Committee (PAC)

FROM: Michelle Espinoza, Executive Director of Network Strategies & Operations

DATE: December 10, 2024

SUBJECT: Provider Network Operations Updates

## VERBAL PRESENTATION

1. Medicare Dual Special Needs Plan (D-SNP) Network Build
2. Targeted Rate Increase Rate Update
3. Dignity Medical Group Termination
4. Rest & Recharge Week (Urgent/Escalated Issues)

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**AGENDA ITEM NO. 5**

TO: Provider Advisory Committee (PAC)

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

DATE: December 10, 2024

SUBJECT: Non-Specialty Mental Health Services

# PowerPoint with Verbal Presentation

**ATTACHMENTS:**

*Non-Specialty Mental Health Services*

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Integrity
Accountability
Collaboration
Trust
Respect

# Non-Specialty Mental Health Services (NSMHS)

Tuesday, December 10, 2024

Lucy Marrero
Director, Behavioral Health & Social Programs

# Background: SB 1019

## Background

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

## Rationale and Intent

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

## Bill Requirements

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



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# APL 24-012 Requirements

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

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

MCP Timeline

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



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# Stakeholder Engagement in Plan Development

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

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

## MCPs may also consider partnering with the following groups:

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



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# NSMHS Outreach & Education Plan: Deliverables

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



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# Ventura County Key Players in Behavioral Health Medi-Cal System


**MILD TO MODERATE**

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

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

**MORE SEVERE**

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

**SUBSTANCE USE SERVICES**

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





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# PAC Discussion Questions

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

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

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

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

What else should we know?

**AGENDA ITEM NO. 6**

TO: Provider Advisory Committee (PAC)

FROM: Eve Gelb, Chief Innovation Officer
Nathan Norbryhn, Senior Director – Model of Care

DATE: December 10, 2024

SUBJECT: Proposed D-SNP Model of Care Quality Measures

# PowerPoint with Verbal Presentation

**ATTACHMENTS:**

*Proposed D-SNP Model of Care Quality Improvement Measures*

Gold Coast Health Plan℠
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# Proposed Duals Special Needs Plan (D-SNP) Model of Care Quality Improvement Measures

December 10, 2024

Eve Gelb, Chief Innovation Officer
Nathan Norbryhn, Senior Director, Model of Care

Integrity
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Collaboration
Trust
Respect

# D-SNP Model of Care (MOC)

| Standard—Overarching requirement based on best practice) | Element—Essential piece of the standard that must exist to meet the standard) |
|---|---|
| MOC 1: Description of the Population—Demonstrates understanding of their experience and needs | 2 Elements—Ensure ability to describe the demographic, health and social characteristics of the target population and the most vulnerable members |
| MOC 2: Care Coordination—Ensures that needs and preferences are met | 6 Elements--Ensure the right staffing, collection of health risk information, individualized care plan, interdisciplinary care team, and transition of care process |
| MOC 3: Network—Relevant facilities and providers to address unique and specialized needs | 3 Elements—Ensures that the providers have the specialized expertise, use clinical guidelines, engage with the care team and are properly trained on the MOC |
| MOC 4: Quality and Performance Improvement—Continuously improve ability to deliver services and care | 5 Elements—Demonstrate the process and capability to set and measure health outcomes and patient satisfaction and improve continuously |



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# Section 4 of the Model of Care (MOC4): Quality Measurement and Performance Improvement

Regulations at 42 CFR § 422.152(g) require that all SNPs conduct a quality improvement program that measures the effectiveness of its MOC.
The goal of performance improvement and quality measurement is to improve the SNP's ability to deliver health care services and benefits to its SNP enrollees in a high-quality manner. Achievement of this goal may be the result of increased organizational effectiveness and efficiency through incorporation of quality measurement and performance improvement concepts that drive organizational change.

The leadership, managers, and governing body of a SNP organization must have a comprehensive quality improvement program in place to measure its current level of performance and determine if organizational systems and processes should be modified based on performance results.

There are 5 elements in MOC4:

A. MOC Quality Performance Improvement Plan
**B. Measurable Goals and Health Outcomes for the MOC—Focus of Discussion**
C. Measuring Patient Experience of Care
D. Ongoing Performance Improvement Evaluation of the MOC
E. Dissemination of SNP Quality Performance Related to the MOC


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# Element B: Measurable Goals and Health Outcomes for the MOC

Again, the expectations for this element are aligned with both the Department for Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS) standard quality improvement requirements. However, in the first year of D-SNP Operations, there is latitude with respect to defining targets for the quality goals.

Per 42 CFR 422.101(f)(3)(ii), as part of the evaluation and approval of the SNP model of care, NCQA must evaluate whether goals were fulfilled from the previous model of care. The organization must identify and clearly define measurable goals and health outcomes for the MOC. The organization's MOC must address the following factors:

1. Identify and define the specific measurable goals and health care needs used to improve access and affordability of the SNP population included in MOC 1.
2. Identify specific enrollee health outcome measures used to measure overall SNP population health outcomes at the plan level.
3. Describe how the SNP establishes methods to assess and track the MOC's impact on SNP enrollees' health outcomes.
4. Describe the processes and procedures the SNP will use to determine if health outcome goals are met.
5. Describe the steps the SNP will take if goals are not met in the expected timeframe.



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# Health and Social Needs

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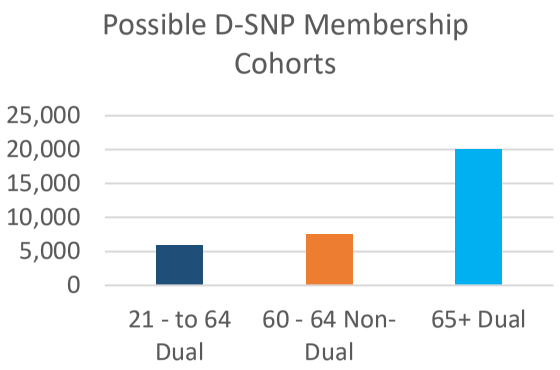
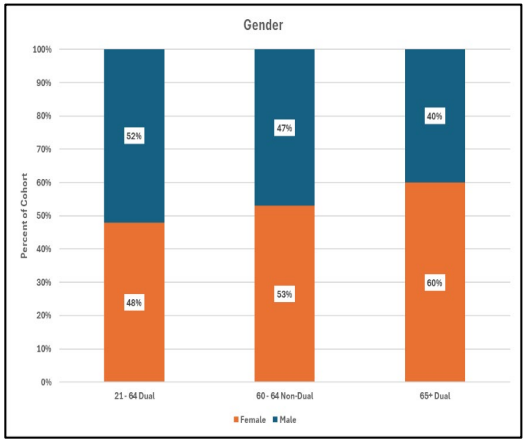
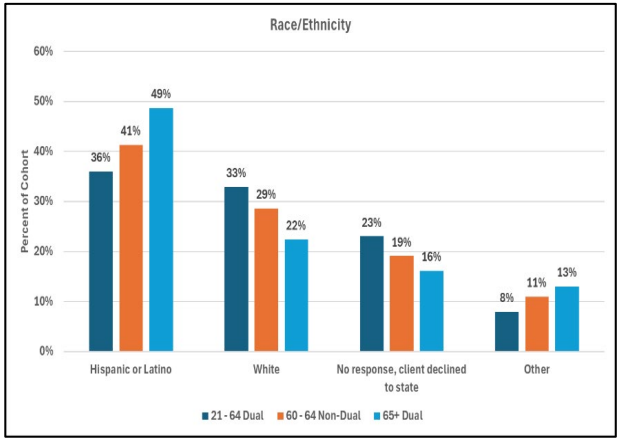
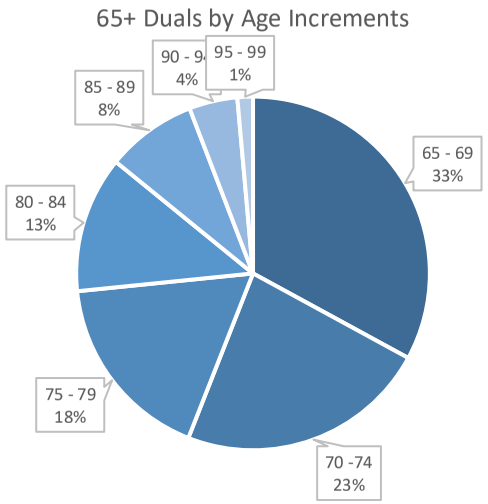
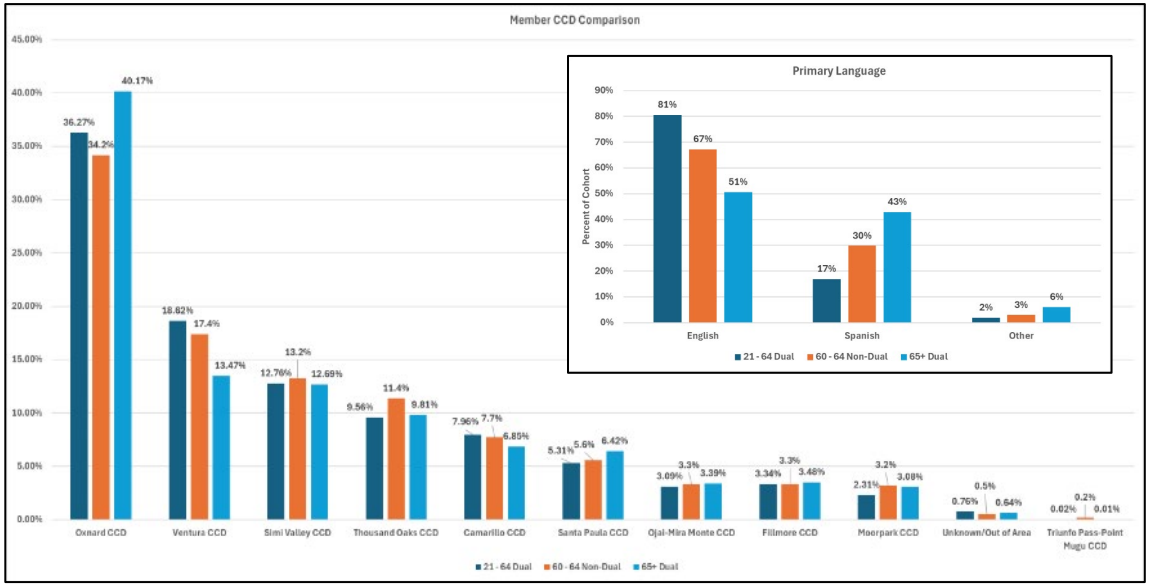
# Demographics



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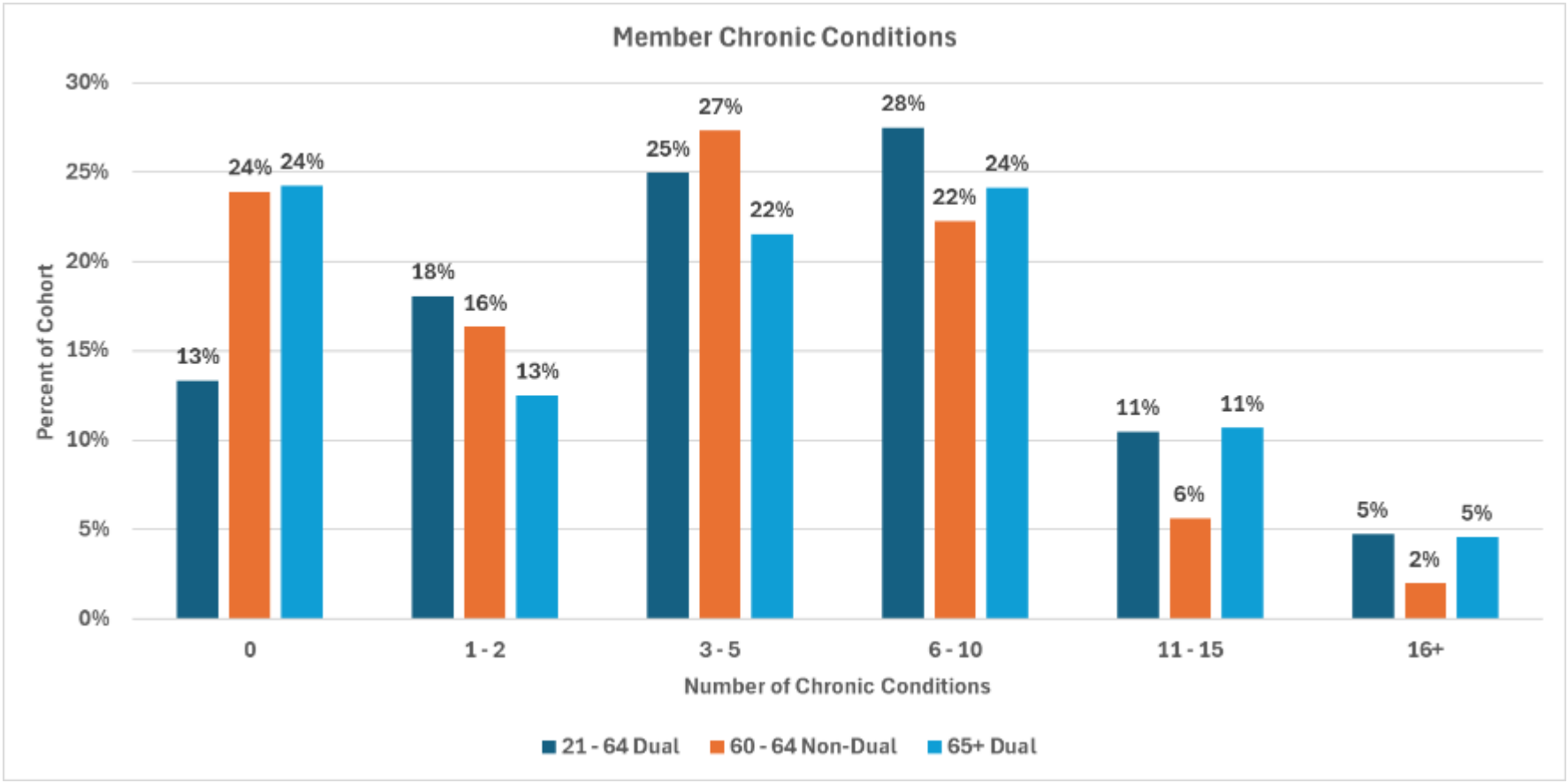
# Number of Chronic Conditions



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# Chronic and Acute Conditions

## Top 10 Chronic by Cohort

| | 21 - 64 Dual | Total GCHP Population |
|---|---|---|
| Hypertension | 46% | 16% |
| Disorders of lipid metabolism | 35% | 14% |
| Anxiety, neuroses | 26% | 10% |
| Type 2 diabetes | 23% | 8% |
| Obesity | 18% | 8% |
| Developmental disorder | 18% | 3% |
| Major depression | 17% | 5% |
| Nonspecific signs and symptoms | 15% | 4% |
| Degenerative joint disease | 15% | 5% |
| Schizophrenia and affective psychosis | 14% | 1% |

| | 60 - 64 Non-Dual | Total GCHP Population |
|---|---|---|
| Hypertension | 48% | 16% |
| Disorders of lipid metabolism | 41% | 14% |
| Degenerative joint disease | 18% | 5% |
| Refractive errors | 17% | 5% |
| Type 2 diabetes | 23% | 8% |
| Anxiety, neuroses | 14% | 10% |
| Obesity | 11% | 8% |
| Nonspecific signs and symptoms | 10% | 4% |
| Musculoskeletal disorders, other | 9% | 3% |
| Hypothyroidism | 8% | 3% |

| | 65+ Dual | Total GCHP Popualation |
|---|---|---|
| Hypertension | 65% | 16% |
| Disorders of lipid metabolism | 43% | 14% |
| Type 2 diabetes | 31% | 8% |
| Degenerative joint disease | 22% | 5% |
| Ischemic heart disease (excluding acute myocardial infarction) | 14% | 2% |
| Refractive errors | 14% | 5% |
| Chronic renal failure | 13% | 2% |
| Anxiety, neuroses | 12% | 10% |
| Musculoskeletal disorders, other | 12% | 3% |
| Cardiac arrhythmia | 12% | 2% |

## Top 10 Acute by Cohort

| | 21 - 64 Dual | Total GCHP Population |
|---|---|---|
| Neurologic signs and symptoms | 34% | 14% |
| Musculoskeletal signs and symptoms | 29% | 13% |
| Low back pain | 22% | 13% |
| Abdominal pain | 20% | 14% |
| Respiratory signs and symptoms | 20% | 8% |
| Chest pain | 19% | 9% |
| Gastrointestinal signs and symptoms | 18% | 9% |
| Cardiovascular signs and symptoms | 18% | 7% |
| Nonspecific signs and symptoms | 18% | 18% |
| Musculoskeletal disorders, other | 17% | 13% |

| | 60 - 64 Non-Dual | Total GCHP Population |
|---|---|---|
| Musculoskeletal signs and symptoms | 30% | 13% |
| Neurologic signs and symptoms | 26% | 14% |
| Low back pain | 19% | 9% |
| Chest pain | 18% | 9% |
| Respiratory signs and symptoms | 17% | 8% |
| Abdominal pain | 17% | 14% |
| Nonspecific signs and symptoms | 16% | 18% |
| Dermatologic signs and symptoms | 15% | 9% |
| Bursitis, synovitis, tenosynovitis | 15% | 5% |
| Gastrointestinal signs and symptoms | 14% | 9% |

| | 65+ Dual | Total GCHP Popualation |
|---|---|---|
| Neurologic signs and symptoms | 28% | 14% |
| Musculoskeletal signs and symptoms | 27% | 13% |
| Low back pain | 20% | 13% |
| Respiratory signs and symptoms | 20% | 8% |
| Chest pain | 19% | 9% |
| Abdominal pain | 16% | 14% |
| Nonspecific signs and symptoms | 16% | 18% |
| Eye, other disorders | 15% | 4% |
| Cataract, aphakia | 15% | 3% |
| Gastrointestinal signs and symptoms | 15% | 9% |



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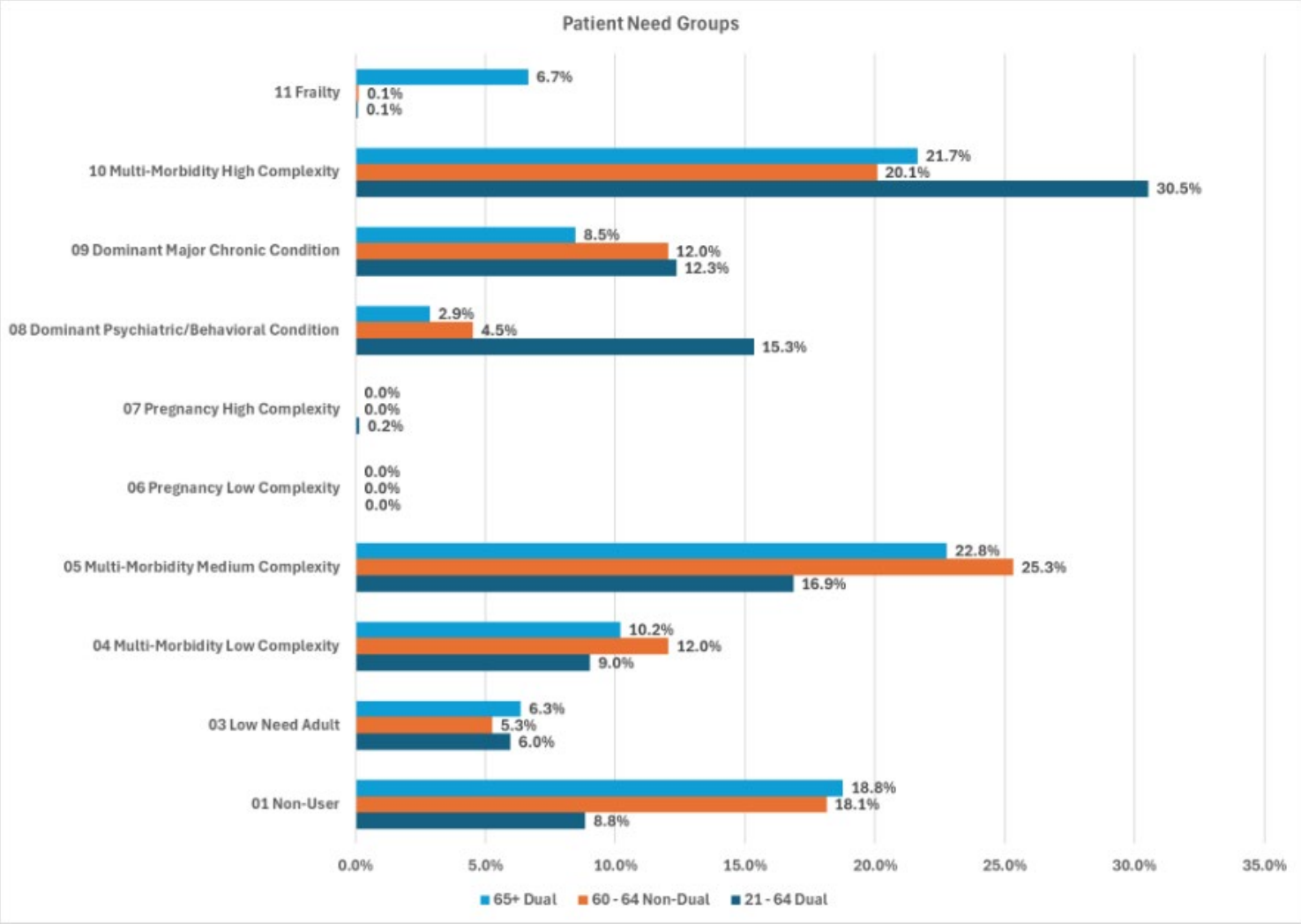
# Patient Need Groups



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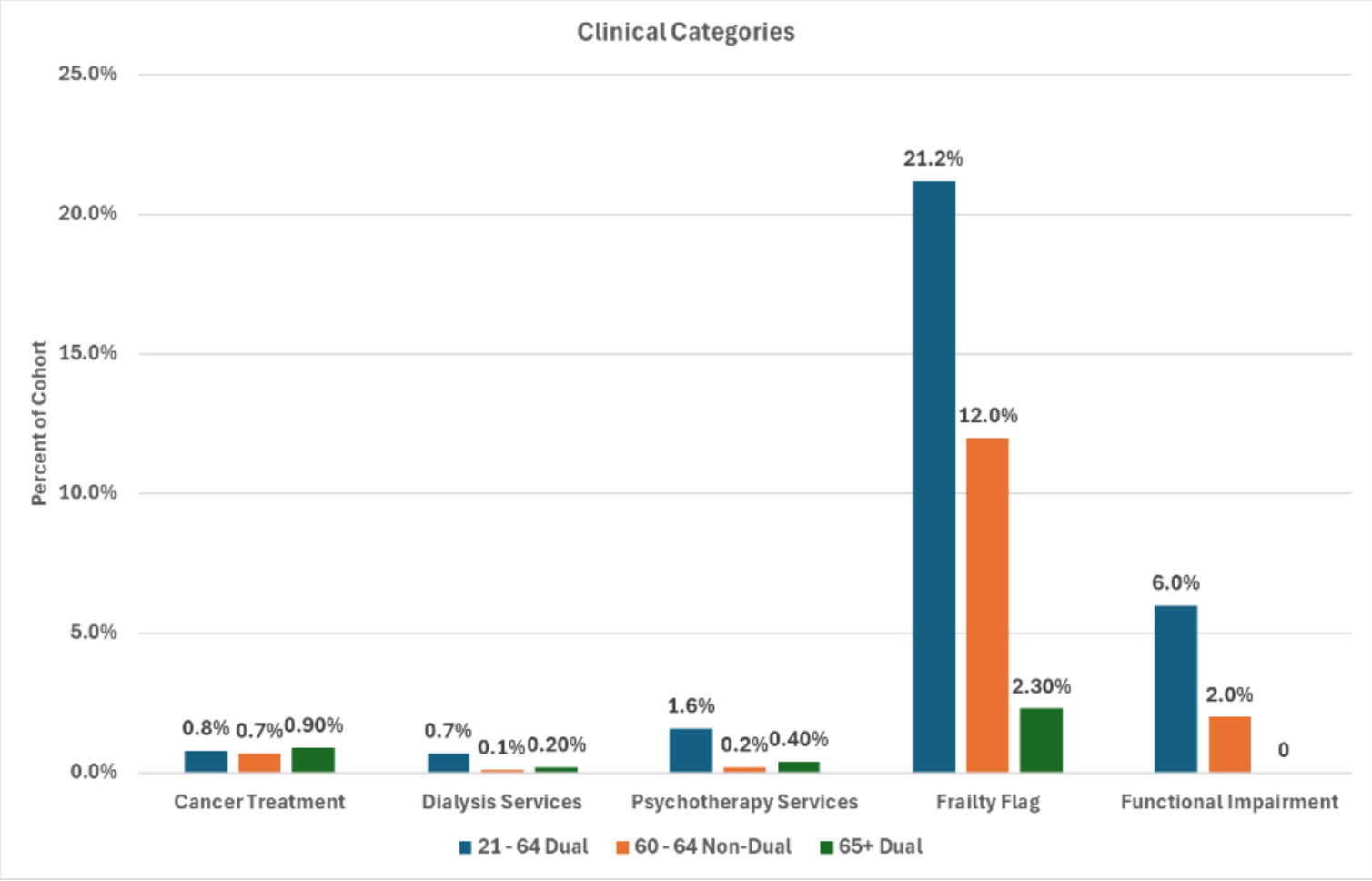
# Clinical Categories



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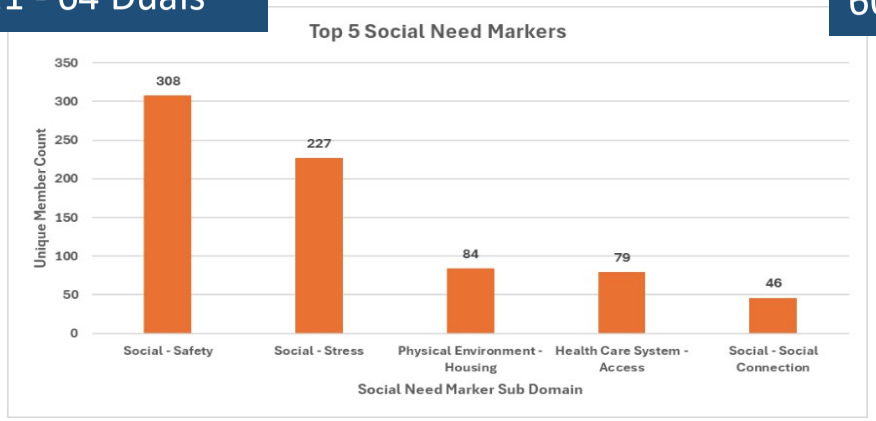
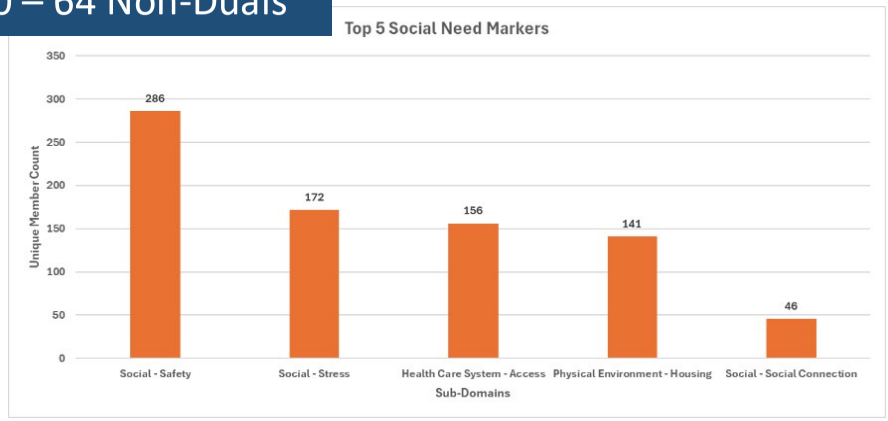
# Social Needs Markers

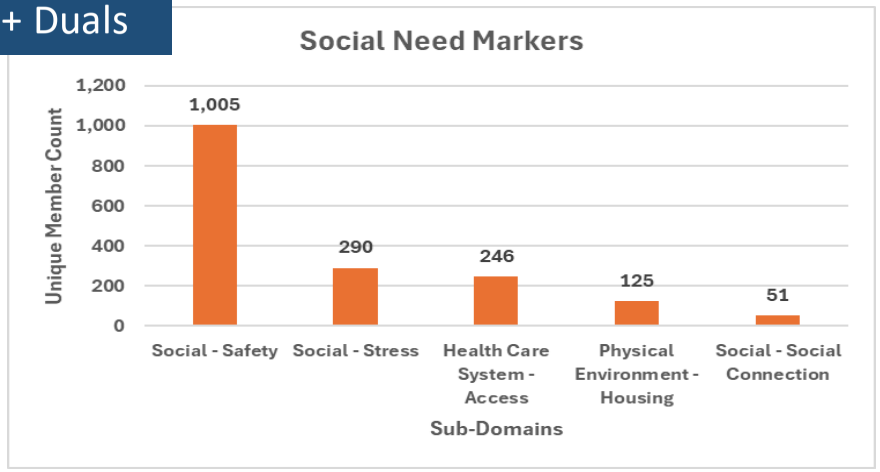
## 21 - 64 Duals




## 60 – 64 Non-Duals




## 65+ Duals




The ACG System will read the ICD-10 codes from medical services and/or supplemental files and assign domain-specific social needs for each patient. Given the sometimes-low frequency of coding of the social needs ICD-10 codes, only the overall Social Need Marker sub-domain and domain-specific markers will be displayed in the frequency distributions report. Enhanced reporting will be developed in future versions based on customer feedback.

Below are the ACG Social Need Marker domains and subdomains:

| Social Need Domains | Social Need Markers (Sub-domains) |
|---|---|
| Social | Safety<br>Social Connection<br>Stress<br>Race/Ethnicity<br>Migration<br>Incarceration<br>Military Deployment |
| Education | Education |
| Health Care System | Access to Health Services |
| Economic | Finances<br>Employment<br>Nutrition |
| Physical Environment | Housing |

Note: For 21 – 64 Duals, 942 out of 5,861 members in this cohort have social need markers available within the data. For 60 – 64 Non-Duals, 1,006 out of 7,628 members in this cohort have social need markers available within the data. For 65+ Duals, 1,958 out of 19,928 members in this cohort have social need markers available within the data. These markers are based off ICD10 Z codes. Some members may have more than one social need marker.



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# Other Social Needs Data Suggest Education Attainment, Housing, Access to Food and Transportation are Important Factors in Supporting Potential D-SNP Members

## Johns Hopkins Adjusted Clinical Grouping (ACG) Geo Code Analysis

The GCHP analytics team ACG data and member's zip code (Geo Code) to place members in a category based on publicly available data.

This data **IS NOT** member specific. It gives insights on health or socioeconomic criteria in a member's geographic area.

The data looked at characteristics such as living alone, population density, food stamps, Area Deprivation Index, no high school diploma and poverty.

The factor that stood out from this analysis was the likelihood of no high school diploma. Based on members' zip codes:

- 38% of 21 – 64 Duals
- 37% of 60 – 64 Non-Duals, and
- 44% of 65+ Duals

live in an area where there is a high probability of people not having a high school diploma.

## GCHP Health Risk Assessment Data for Members aged 63 and 64 (n=229)

| What is your living situation today? | Count | Percent |
|---|---|---|
| I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park) | 20 | 8.7% |
| I have a place to live today, but I am worried about losing it in the future | 49 | 21.4% |
| I have a steady place to live | 160 | 69.9% |
| **Within the past 12 months, were you worried that your food would run out before you got money to buy more?** | | |
| Never true | 114 | 49.8% |
| Often true | 29 | 12.7% |
| Sometimes true | 86 | 37.6% |
| **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?** | | |
| No | 178 | 77.7% |
| Yes | 51 | 22.3% |



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# Element B: Measurable Goals and Health Outcomes for the MOC
# Goal: Improve access and affordability of the health care needs for the SNP population using preventive strategies to improve chronic disease management and encourage compliance with treatment plan

- Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the Health Risk Assessment, Individualized Care Plan and Interdisciplinary Care Team. The use of Medicare Stars as a goal is only appropriate if the goal is set at 5 Stars (i.e., equivalent to 100%). Anything less than 5 Stars does not meet the requirement.
- Enhanced care transitions across all health care settings and providers for all SNP enrollees.
- Ensuring appropriate utilization of services for preventive health and chronic conditions

Goal: Improve access and affordability of care for the SNP population using preventive strategies to improve chronic disease management and encourage compliance with treatment plan.

Goal: Enhance Care Transitions across all health care settings and providers by increasing post-hospital discharge PCP visits and ensuring timely member contact by the transitions of care team for all hospital and SNF admissions

Goal: Improve Coordination of Care and Appropriate and Equitable Delivery of services through early identification and proactive engagement of high-risk members into care coordination.



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# Goal: Improve access and affordability of the health care needs for the SNP population using preventive strategies to improve chronic disease management and encourage compliance with treatment plan

| Health Care Need | Possible Outcome | Possible Preventive Strategy |
|---|---|---|
| Diabetes | Improve HgA1C Control | Increase HgA1C screening for members with diabetes |
| Hypertension | Improve Blood Pressure Control | Increase Assess to Home Blood Pressure Cuffs<br>Increase blood pressure screening |
| Multiple Conditions | Improve Overall Rating of Health | Increase number of members using ambulatory or preventive visits (PHM KPI 3) |
| Obesity | Reduce Obesity | Increase access to weight management programs<br>Increase physical activity |
| Pain | Lower Pain Score<br>Reduce use of Opioids | Increase access to physical therapy |
| Depression | Lower PHQ9 | Increase Depression Screening |
| Anxiety | Lower GAD7 | Increase Anxiety Screening |
| Schizophrenia | Follow Up after ED for Mental Health Crisis | Increase access to mental health providers<br>Access to CHW |



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# Goal: Enhance Care Transitions across all health care settings and providers by increasing post-hospital discharge PCP visits and ensuring timely member contact by the transitions of care team for all hospital and SNF admissions

| Outcome | Target |
| --- | --- |
| PCP Visit within 7 Days Post Discharge | 5% improvement from baseline |
| Care Transitions Team Contact within 2 days of discharge | 5% improvement from baseline |
| Advance Care Plan Completion | 5% improvement from baseline |



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**Goal:** Improve Coordination of Care and Appropriate and Equitable Delivery of services through early identification and proactive engagement of high-risk members into care coordination.

| Outcome | Target |
| --- | --- |
| Health Risk Assessment Completion | 100% |
| Care Plan Completion | 100% |
| Interdisciplinary Care Team | 100% |
| Face-to-Face Encounters | 100% |
| Enhanced Care Management | Increase acceptance rate by 10% from baseline |
| Food Security | Increase Closed Loop Referral to Food Resources by 10% from baseline |
| Improved Health Communication | Increase use of interpreter by 10% services for members whose provider does not speak their primary language |



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# Discussion

Goal: Improve access and affordability of the health care needs for the SNP population using preventive strategies to improve chronic disease management and encourage compliance with treatment plan

Goal: Enhance Care Transitions across all health care settings and providers by increasing post-hospital discharge PCP visits and ensuring timely member contact by the transitions of care team for all hospital and SNF admissions

Goal: Improve Coordination of Care and Appropriate and Equitable Delivery of services through early identification and proactive engagement of high-risk members into care coordination.

The Model of Care Requires goals around access and affordability, Care Transitions and Care Coordination. Below are the goals. Given the data on the needs of likely D-SNP members and the discussion today:

1. What measures should we select for each of these goals?
2. Which measures should we prioritize?



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