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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 9, 2025, 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: 458 294 135#

Telephonic Location:

3080 Bristol Street Costa Mesa, CA 92626	3 Chandra Lane, Rancho Mirage CA 92270	3585 Maple Street Ventura, CA 93003

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

Felix L. Nunez, M.D., Chief Executive Officer
Erik Cho, Chief Policy & Programs Officer

CONSENT

1. Approval of Regular Meeting Minutes of September 23, 2025

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

RECOMMENDATION: Approve the minutes as presented.

2. Approval of the 2026 Provider Advisory Committee Meeting Calendar

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

RECOMMENTATION: Approve the 2026 Provider Advisory Committee (PAC) meeting calendar as presented.

UPDATES

3. Total Care Advantage Readiness

Staff: Eve Gelb, Chief Innovation Officer
Kim Marquez-Johnson, Director, Dual Special Needs Plan (D-SNP)

RECOMMENDATION: Receive and file the update.

4. NCQA Health Plan Update

Staff: James Cruz, M.D., Chief Medical Officer

RECOMMENDATION: Receive and file the update.

5. Quality Improvement and Health Equity Committee 2025 Third Quarter Update

Staff: James Cruz, M.D., Chief Medical Officer

RECOMMENDATION: Receive and file the update.

FORMAL ACTION

6. PAC AdHoc Committee Recommendation for Chair

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

RECOMMENDATION" Staff requests that the PAC Committee accept the PAC AdHoc committee's Chair recommendation.

7. PAC Recommendations for Vice Chair

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

RECOMMENDATION"

ADJOURNMENT

Unless otherwise determined by the PAC, the next meeting is scheduled for March 17, 2026 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 9, 2025

SUBJECT: Approval of the regular Provider Advisory Committee Meeting minutes of September 23, 2025

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the September 23, 2025 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 23, 2025

CALL TO ORDER

The Clerk called the meeting to order at 7:38 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., Molly Corbett, Claudia Gallard, Katy Krul, Amanda Larson, and Josie Roemhild,

Absent: Committee member: Sim Mandelbaum, Vince Pillard, Kristine Supple, and Dr. Pablo Velez.

.

Gold Coast Health Plan Staff in attendance: Felix Nunez, M.D., Chief Executive Officer, Marlen Torres, Chief of Member Experience & External Affairs, Erik Cho, Chief Policy & Program Officer, Chief Medical Officer, James Cruz, M.D., Chief Financial Officer, Sara Dersch, Chief Compliance Officer, Robert Franco, Scott Campbell, General Counsel, Vicki Wrighster, Michelle Espinoza, Susana Enriquez-Euyoque, Paul VerHaar, and Maria Najar.

Guest: Anthony Russell, M.D. from CMH

PUBLIC COMMENT

None.

WELCOME

CPPO Erik Cho welcomed the committee members. He stated Dr. Velez was not able to attend this meeting. He briefly reviewed the agenda items for today's meeting.

OPENING REMARKS

CEO Felix L. Nunez, M.D. thanked the committee for their dedication. He stated there is a lot of change currently happening both internally at GCHP and externally. Many are concerned about what external pressures look like. Internally, we have accomplished quite a bit this year and there is work still ahead. We have gotten NCQA accreditation, our D-SNP launch is

pending, and we will start enrollment in October. We have received approvals and are moving forward with our contracts with the state. We have received our Knox Keene license as a Medicare health plan. January 1 we will start providing services for members that have enrolled as part of our D-SNP plan.

This year we have been going through an entire system improvement operation, and we have completed the technical elements of that work and now it is just remediation work, doing some cleanup. That work continues and is going to continue to the rest of this year. The D-SNP health plan presents an opportunity for us to grow the plan in a way we have not grown before.

We are seeing changes at the federal level daily that impact healthcare, care to our members, and how providers provide that care. Dr. Nunez stated that GCHP will make vaccines available at the maximum level possible to our members. We are not going to follow the CDC or the FDA recommendations. The American Academy of Family Physicians, American Academy of Pediatrics, the American College of Obstetrics & Gynecology, California Department of Public Health, and the Western Health Alliance have come together to form their own recommendations for vaccines, and we will be following those recommendations. This is the first time that the health plan breaks away from the CDC in terms of vaccine recommendations. We want to be sure that we are providing vaccines that are based on science and data. There was also news about acetaminophen, and Dr. Cruz, our CMO, will be looking into that. We will be making a statement based on science and data, and recommendations that are coming from other advocacy organizations. We will be following those recommendations and following those guidelines.

CEO Nunez stated that HR1 is going to be hugely impactful to the health plan and to all our network partners. We understand the implications of that bill will result in fewer resources coming to the Medi-Cal population and will impact our operations. There is a concern about enrollment. Enrollment is revenue for our providers. We are looking to the state to see what they are going to do about rates, rates are also revenue for our provider network. We are looking at the state to see what they will be doing. We are also concerned about state directed payments. Those are payments coming to our safety net providers to help support the work that they do. Cost of care is not covered by Medi-Cal alone. The actual cost of care to our providers is much higher because of the burden of uncompensated care that they must absorb. That burden of uncompensated care, care for people without insurance is going to increase. As people lose coverage it is important that we continue to be strong as a health plan, fiscally strong and responsible, not just for ourselves, but to help our provider network as they go through challenging times in the coming years.

We will continue to do advocacy; we are not giving up. We will continue to advocate at the federal level, state level, and always think about our members and providers.

CONSENT

1. General Counsel Discussion on Immigration Issues

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Receive and file the information.

General Counsel, Scott Campbell, stated he will present information on ICE access at facilities and what can be done if they show up. He stated there was a 2024 pamphlet by the Attorney General that discusses this issue in more detail. Mr. Campbell will provide an update. On one statement that is in the pamphlet. The pamphlet contains sample policies for providers on how to deal if immigration services show up at your facilities. Immigration officials are allowed to enter public areas of your facilities without a warrant, without your permission to enforce immigration laws. Anywhere that the public can go, Immigration officers can go to the extent that the immigration officers want to enter other areas of the facilities, exam rooms, rooms where patients have gone through screening and are waiting for care. There are only two ways that immigration officials can enter those areas; one – is with a warrant signed by a court, they cannot enter and just flash a badge and say they want to enforce immigration in restricted areas or non-public areas. They must have a warrant to enter those areas. If someone shows up and requests to enter those areas it is permissible to ask to see the warrant and ask for a badge for proper identification. They must provide you a copy of the warrant have to show their badge. If they do not do this, you can respectfully say they are not allowed to enter the facility. The second exception is if there is someone in your facility that is in a private room that poses an immediate threat to the public. Other than those two exceptions, you should not allow them to enter. GCHP has not received any calls from providers to the General Counsel offices, but we wanted to make certain that you are aware of the guidelines and that there are so-called safe zones.

Mr. Campbell stated the Trump administration has rescinded the No-Go order and there are no longer any “no-go” zones. Prior “safe zones” have been dismantled by this administration. Committee member, Amanda Larson, asked what about staff. Mr. Campbell stated that anywhere in pa restricted area, ICE cannot enter without a warrant, whether it is a patient or staff.

2. Approval of Regular Meeting Minutes of June 10, 2025

Staff: Maddie Gutierrez, MMC, Clerk of the Commission

RECOMMENDATION: Approve the minutes as presented.

Committee member Amelia Breckenridge, M.D. motioned to approve agenda items 1 and 2 as presented. Committee member Amanda Larson seconded.

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

NOES: None.

ABSENT: Committee members Sim Mandelbaum, Vince Pillard Kristine Supple and Dr. Pablo Velez.

The motion carried.

PRESENTATION

3. Risk Adjustment Factor (RAF) & How D-SNPs are Paid

Staff: Eve Gelb, Chief Innovation Officer
Paul VerHaar, Sr. Manager, Medicare Financial Analysis

RECOMMENDATION: Receive and file the presentation.

Eve Gelb, Chief Innovation Officer introduced Paul VerHaar, Sr. Manager, Medicare Financial Analysis. Mr. VerHaar stated he would be discussing how D-SNPs are paid. He noted there is a distinction between traditional Medicare plans and Medicare Advantage plans, which D-SNP is one. Traditional Medicare plans pay their patients based on Part A, which is the hospital coverage, and a Part B which is outpatient and doctor visits. Medicare Advantage plans offer pharmacy benefits known as Part D, which is a key distinction between the traditional and the Medicare Advantage plans. Medicare Advantage plans offer supplemental benefits which include vision, hearing, and dental. Those supplemental benefits are available on an in-network basis only.

Traditional Medicare pays providers based on provider accepting Medicare reimbursement as payment in full, which is known as accepting an assignment. Skilled nursing facilities, inpatients at hospitals and Medicare outpatient services are all paid based on a predetermined fee schedule that has been developed by Medicare. The fee schedules are reviewed periodically to make sure that they cover all regional costs of care and are aligned with increases for wage indexing and other things. Medicare Advantage plans are paid with actual funding or capitation received by the plan from Medicare CMS. The capitation payments are based on a PMPM rate that is derived by the actual acuity or risk adjustment factor of each member. The funding is used by the plan to pay claims directly. Another key distinction is that under the Advantage plan the providers will be billing Medicare Advantage plans directly.

Under a traditional Medicare Model, the providers bill Medicare directly as opposed to the plan. Medicare Advantage plan payments are based on a bid. A bid is the annual projection that a plan submits to Medicare. It is a projection of what the plan will require in terms of cost to care for all members throughout the year. Medicare then reviews this plan and either accepts or rejects it based on a benchmark. A benchmark is a Medicare derived estimate that is associated with all the costs in the county that Medicare feels should be incurred for the payment. It is their standard on a countywide level. If the benchmark is lower or greater that the bid amount the difference is called a rebate, and that rebate is given back to the plan. If the plan is accepted that rebate is given back to the plan, but not all of it, just a portion is given back. The portion that the plan is allowed to retain must be used on additional benefits for the members. The percentage that the plan retains is based on STAR scores. The higher the STAR scores of a plan, the greater the percentage the plan is allowed to keep of the rebate.

Another component is the Risk score. The Risk score is the measure of a patient's member acuity that CMS uses to assign the PMPM premiums that are paid to the plan. The higher the Risk Adjustment Factor (RAF) translates into a higher monthly premium that the plan will receive. The plan takes the encounter data that providers send to the plan and submits it to Medicare. Medicare takes the data and creates a RAF score on an individual basis.

A key thing to remember for encounter data is that it is important that members go for their annual wellness visits so we can get the proper coding in from the provider. It is important to have good, solid coding at the provider level and we are all aligned in how that coding is conducted. It has a strong relation to the revenue that is collected. Coming next will be a risk score to be determined for Medi-Cal which will be referred to as a regional rate setting.

Committee member Katy Krul asked if the rates for Medi-Cal will have this adjustment and will it be transferred to the providers as well. CIO Eve Gelb stated it will be referred to as a regional ate setting. Right now, for Medi-Cal we submit a proposal every year to the state saying we think it is going to cost us a specific dollar amount per member per month. The state reviews and either agrees with our submission or says no. Under a regional rate setting we submit our proposal, and they are going to look at other managed care plans within the same geography. We will be compared to LA Care, Centene, Molina, and make a proposal comparison and say either yes, they approve or no they do not approve. The concern is that there are various levels of care in Ventura County and how do you compare it to LA County. It is a concern. It is important to make sure providers code correctly/accurately so that we have the most composite risk score that we submit to the state.

Committee member Dr. Pablo Velez joined the meeting at 8:21 a.m.

4. Dual Special Needs Plan (D-SNP) Provider Portal (Demonstration)

Staff: Eve Gelb, Chief Innovation Officer
Vicki Wrighster, Sr. Director of Network Operations
Maria Najar, Provider Services Representative II

RECOMMENDATION: Receive and file the presentation.

Vicki Wrighster, Sr. Director of Network Operations stated that staff has been collaborating with our provider portal vendor to update our current provider portal to have the D-SNP integration. It has been enhanced so that it will have the ability to list D-SNP information. We have added new fields to us to be able to capture the data. Providers will now have additional information on healthcare details for our members which will help them to make informed decisions and care coordination. We have also added some streamlined care management fields which will assist our providers as well. Some of the updates include tools, resources, authorizations, claims, provider information, provider locations, and patient eligibility. She noted that providers will still be able to sign onto the portal as they currently do.

Ms. Wrighster also stated that members have an assigned clinic and PCP in the portal. The patient may not know who it is, but someone is assigned in the system when you look at the patient chart. Committee member Amanda Larson stated that when a hospital opens the portal it will show the name of the clinic the member is assigned. Unfortunately, nine out of ten times the portal will only show clinic and not the PCP. Ms. Wrighster stated she will take this feedback and have a discussion internally on how the hospitals can get more detailed information, such as not only the name of the clinic, but also the PCP.

Ms. Wrighster discussed our tools and resources screen. Traditionally a screen will list resources on our provider website that providers will be able to access. A column has been added for D-SNP tools which include updated provider directory, pharmacy directory, the VSP directory and the Carelon directory. There will also be a formulary added from our PBM Prime as well. The Medi-Cal tools will continue to be the same. We have updated the authorization screen; behavioral health and Medicare Part D outpatient drugs and diabetic supplies there is now a contact number for Prime Therapeutics listed on the screen.

Ms. Wrighster moved onto claim search. We have added the D-SNP line of business to the claim search. For provider information we have recognized that we have providers who participate in D-SNP and providers who are Medi-Cal providers only. It will show provider tax ID number and provider information as well as the mailing

address. There is an additional row that shows the provider's line of business for the providers who do D-SNP and Medi-Cal

Maria Najar, Provider Services Representative II, will discuss provider locations. She stated the provider portal has a feature under My Practice called My Providers. This feature allows the used to view provider location details by selecting a location. The new update will allow the user to view the line of business for the specific provider at a specific location. The provider portal also offers the users the ability to check eligibility for a specific date of service. It will give member eligible as of a specific date, member ID number, name date of birth, address, and enrollment information. There is also a Care Management feature which provides Care Navigator information as well as the RAF score. It will also display the line of business and member eligibility history.

We are currently working on updating the portal to add a hospice indicator for members which will help providers understand what services they will be allowed to perform and be reimbursed for. We are currently collaborating with our vendors to determine where on the provider portal that information will be so that our providers will have an opportunity to see whether a member is assigned to hospice care.

Committee member Katy Krul asked if the provider must be certified for Medicare. Ms. Wrigster stated that if the provider is contracted with GCHP for D-SNP it will show that provider as D-SNP. Committee member Katy Krul asked if GCHP will contract with the provider for D-SNP even if the provider is not Medicare certified. Michelle Espinoza, Executive Director of Delivery Systems/ Operations Strategies, stated a provider must be Medicare approved and certified to contract for D-SNP. We want to create a seamless experience for our members that are currently Medi-Cal and qualify for Medicare. We are outreaching to providers in our network to see if they choose to participate. Ms. Wrighster stated we are currently creating a provider notification to the network to advise that D-SNP will be coming to GCHP effective 1/1/2026. We are also having Medicare 101 trainings with our provider network to ensure that our providers have a level of training or knowledge level for Medicare.

5. Stipend Policy

Staff: Marlen Torres, Chief Member Experience & External Affairs Officer
James Cruz, M.D., Chief Medical Officer

RECOMMENDATION: Receive and file the presentation

James Cruz, M.D., Chief Medical Officer stated there is a new policy which allows all committee members, except for Commission to receive a stipend. The policy was presented and approved by the Commission. All committee members are eligible to receive a $200 per meeting stipend. They are limited to no more than one stipend

payment per month. Committee member may decline to receive the stipend. There is also travel and mileage which may be reimbursed. Committee members must provide evidence/documentation of completing Ethics training and sexual harassment training prior to receiving their stipend. We anticipate that reimbursements and/or stipends will begin mid-October.

Marlen Torres, Chief Member Experience & External Affairs Officer, stated we have been working on sending out a memo with more information and timelines to ensure that we are able to issue payment. She stated that if anyone has questions, to contact the Sr. Clerk, Maddie Gutierrez, or herself for additional information.

Committee member Masood Babeian motioned to approve the updates as presented. Committee member Amanda Larson seconded.

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

NOES: None.

ABSENT: Committee members Sim Mandelbaum, Vince Pillard and Kristine Supple

The motion carried.

FORMAL ACTION

6. Creation of an Ad Hoc Subcommittee for the Nomination of a Chairperson and Vice-Chairperson to Serve on the Provider Advisory Committee and search for an additional member to fill a vacant seat.

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

RECOMMENDATION: Staff recommends the PAC establish a nomination ad hoc subcommittee to commence the selection process of the Chairperson and Vice-Chairperson of the PAC and begin the search to fill a vacant seat on the committee.

Marlen Torres, Chief Member Experience & External Affairs Officer, stated we have some openings, and we need to reconstitute our AdHoc committee to fill open seats. We are accepting self- nominations/recommendations for the Chair role. Currently Dr. Velez is our Vice Chair and has been filling in for the Chair position.

Ms. Torres asked for volunteers for the AdHoc. Volunteers were Amelia Breckenridge, M.D., Claudia Gallard, Katy Krul, and Amanda Larson.

If the recommendation turns out that the Vice Chair move up, we will look for a Vice Chair.

Ms. Torres stated the Sr. Clerk will schedule the AdHoc meeting prior to the December regular PAC meeting.

The Clerk stated that the next meeting is scheduled for December 9, 2025, with a start time of 7:30AM.

ADJOURNMENT

With no further items to be addressed, the Clerk adjourned the meeting at 9:01 a.m.

Approved:

_____
Maddie Gutierrez, MMC
Clerk to the Commission

AGENDA ITEM NO. 2

TO: Provider Advisory Committee (PAC)

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

DATE: December 9, 2025

SUBJECT: Approval of the 2026 Provider Advisory Committee Meeting Calendar

SUMMARY:

This agenda item will establish dates for the Provider Advisory Committee (Committee) meetings for 2026. This committee is scheduled to have quarterly regular meetings.

RECOMMENDATION:

Approve the 2026 Provider Advisory Committee meeting calendar as presented.

ATTACHMENTS:

Copy of 2026 Provider Advisory Committee Meeting Calendar.

PAC Regular Mtg, 7:30-9 AM

2026
Provider Advisory Committee Meetings

January

Su	M	Tu	W	Th	F	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

February

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March

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29	30	31				

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May

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31						

June

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28	29	30				

July

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August

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30	31					

September

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October

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November

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22	23	24	25	26	27	28
29	30					

December

Su	M	Tu	W	Th	F	Sa
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6	7	8	9	10	11	12
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20	21	22	23	24	25	26
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AGENDA ITEM NO. 3

TO: Provider Advisory Committee (PAC)

FROM: Eve Gelb, Chief Innovation Officer
Kimberly Marquez-Johnson, Director, Dual Special Needs Plan

DATE: December 9, 2025

SUBJECT: Total Care Advantage Readiness

PowerPoint with Verbal Presentation

ATTACHMENTS:

Total Care Advantage Update

Gold Coast Health Plan℠
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Integrity
Accountability
Collaboration
Trust
Respect

Total Care Advantage Duals Special Needs Plan (D-SNP) Update

December 9, 2025

Eve Gelb, Chief Innovation Officer
Kimberley Marquez-Johnson, Director, D-SNP

Introducing….

GOLD COAST HEALTH PLAN
TOTAL Care
ADVANTAGE

A **local** health plan.

Created in **our community**.

Created for **our community**.

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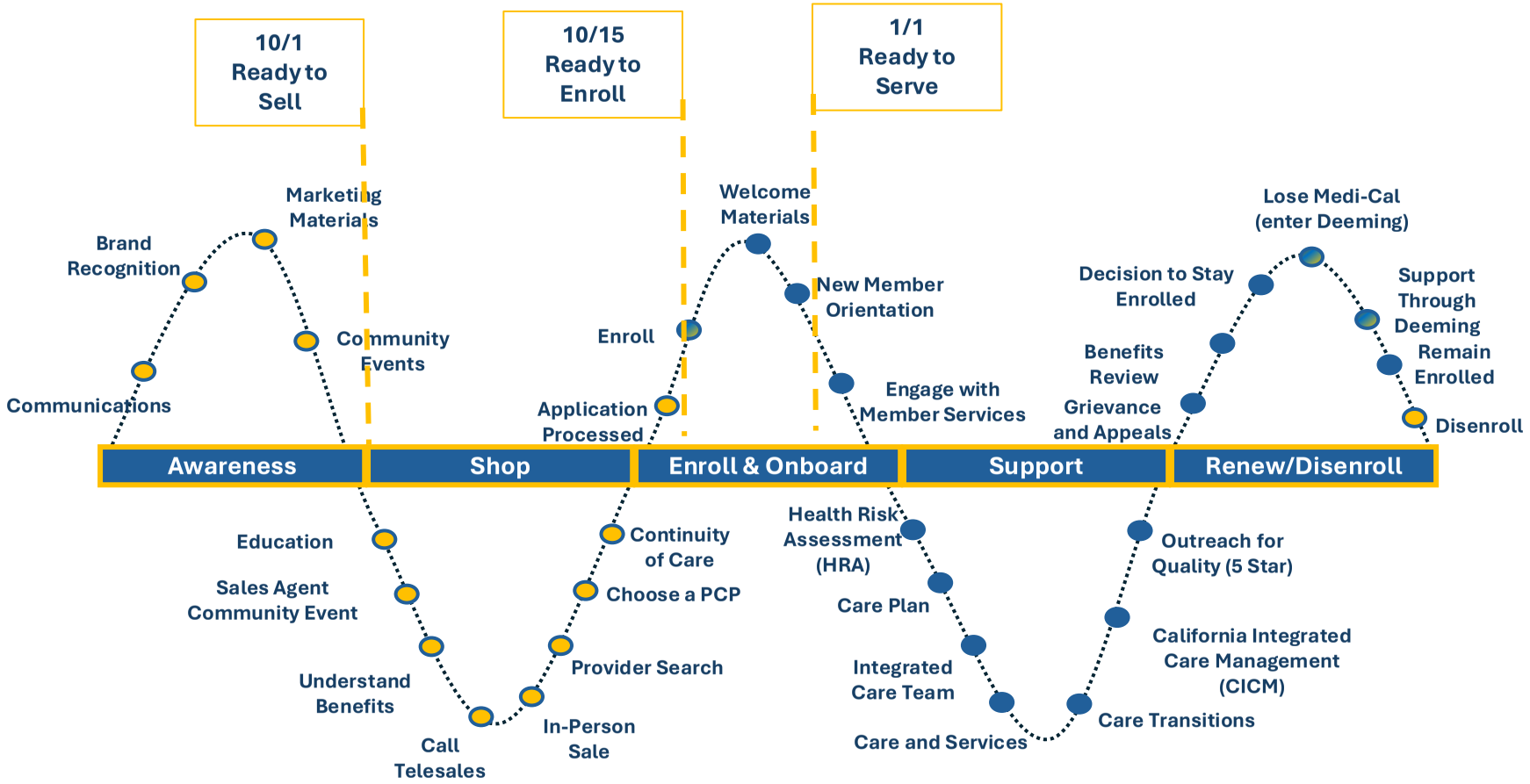
Total Care Advantage Member Journey



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GOLD COAST HEALTH PLAN
TOTAL Care
ADVANTAGE℠

Total Care Advantage Membership

Members can join if they:

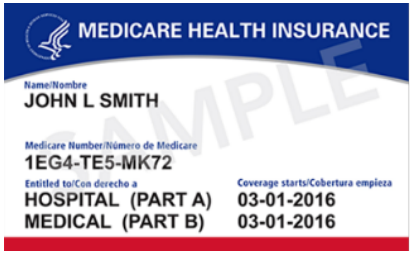
- Have both Medicare Part A and B
- Have full-scope Medi-Cal
- Are 21 years or older
- Live in Ventura County

Enrollment is **voluntary.**

To enroll, people can contact Total Care Advantage at **1-888-808-7879** or call 1-800-MEDICARE.

GOLD COAST HEALTH PLAN TOTAL Care ADVANTAGE

Total Care Advantage Benefits



Part A: Hospital
Inpatient care in hospital and mental health hospital, a skilled nursing facility care, some home healthcare.

Part B: Medical
Doctor visits, mental health and substance use treatment, outpatient services, labs, diagnostics, medical equipment and supplies, and preventive services.

Part D: Prescription Coverage
Prescription drugs.

Additional Supplemental Benefits Allowed under Medicare Advantage

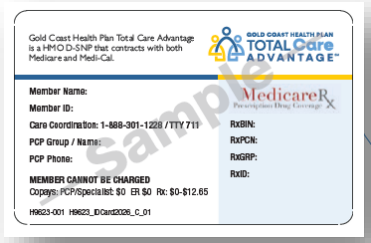
- Vision
- Hearing
- Fitness
- Acupuncture
- Caregiver Support
- Social Transportation
- Readmission Prevention

Medi-Cal Benefits

- Medicare cost sharing
- Transportation
- Community Based Adult Services
- Incontinence Supplies
- Long Term Care
- Community Supports

GOLD COAST HEALTH PLAN TOTAL Care ADVANTAGE

Coordinating Care Across Medicare and Medi-Cal



Health Risk Assessment (HRA)

Initial (first 90 days) or

Annual (365 days from initial)

- Member assigned care navigator/care manager
- Includes **Face to face** encounters at least annually
- Identified members for **California Integrated Care Management(CICM)**

Individualized Care Plan (ICP)

HRA & ICP shared with Interdisciplinary Care Team (ICT)

Activities resulting from HRA are communicated to the members of the ICT as follows:

- Members/caregivers via the mailed ICP and ongoing care coordination interactions
- ICT members collaborate on care
- Referrals and navigation to benefits and services

ICT collaborate on ICP

ICT Collaboration can occur in-person, virtual or asynchronous

Health status changes? Adjust ICP

Transitional Care Services (TCS) by Care Navigator / CICM

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AGENDA ITEM NO. 4

TO: Provider Advisory Committee (PAC)

FROM: James Cruz, MD, Chief Medical Officer

DATE: December 9, 2025

SUBJECT: NCQA Health Plan Update

PowerPoint with Verbal Presentation

ATTACHMENTS:

Provider Advisory Committee NCQA Accreditation Update 091225

Gold Coast Health Plan℠
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Integrity
Accountability
Collaboration
Trust
Respect

Provider Advisory Committee NCQA Accreditation Update

December 9, 2025

James Cruz, MD - Chief Medical Officer

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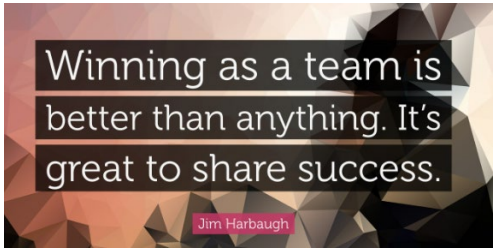
NCQA Health Equity Accreditation

GCHP completed the NCQA Health Equity Accreditation (HEA) submission on **June 10, 2025**

July 28, 2025 Closing Conference - NCQA Surveyor Feedback



Strengths:

- Dedicated & knowledgeable staff
- Documentation well prepared and presented
- Detailed policies and procedures
- Reports demonstrate good quantitative and qualitative analysis
- Assessing and addressing members cultural, ethnic, racial and linguistic needs

Opportunities:

- N/A - All elements scored as **MET**! 100% of standards points achieved.

Health Equity Accreditation is effective 8/25/2025-8/25/2028

- Next survey submission: May 30, 2028

NCQA Health Plan Accreditation

GCHP completed the NCQA Health Plan Accreditation (HPA) submission on **October 7, 2025**

November 24, 2025 Closing Conference - NCQA Surveyor Feedback

Strengths:

- Dedicated and knowledgeable staff.
- Documentation was well prepared and presented.
- Comprehensive Complex Case Management program with effective outreach.
- File review preparations and staff.
- Credentialing of practitioners and providers.

Opportunities:

- N/A - All elements anticipated to be scored as **MET**!

➢ **Decision Notification**

- GCHP will receive a final decision letter, certificate, and NCQA seal by **December 31, 2025**

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AGENDA ITEM NO. 5

TO: Provider Advisory Committee (PAC)

FROM: James Cruz, MD, Chief Medical Officer

DATE: December 9, 2025

SUBJECT: Quality Improvement and Health Equity Committee 2025 Third Quarter Update

PowerPoint with Verbal Presentation

ATTACHMENTS:

Provider Advisory Committee Quality Improvement Update 091225

Gold Coast Health Plan℠
A Public Entity

Provider Advisory Committee Quality Improvement Update

December 9, 2025

James Cruz, MD, Chief Medical Officer

Integrity
Accountability
Collaboration
Trust
Respect

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711 East Daily Drive, Suite 106, Camarillo, CA 93010 www.goldcoasthealthplan.org

Annual 2024 QIHET Program Evaluation

- The annual program evaluation provides a comprehensive assessment of quality improvement and health equity activities
  - Ensures a culture of **continuous quality improvement**
  - Measures and assesses **effectiveness** of program initiatives
  - Evaluates **accountability and compliance** with standards
  - Evaluates **program structure and resources**
  - Provides **framework** for developing the 2025 QIHET Program and Work Plan

- The QIHET Program and Work Plan supports and aligns with:
  - California Department of Health Care Services (**DHCS**) Comprehensive Quality Strategy
  - California Advancing and Innovating Medi-Cal (**CalAIM**) Program
  - National Committee for Quality Assurance (**NCQA**) Health Plan and Health Equity Accreditation Standards

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Highlights from the 2024 QIHET Program Evaluation

2024 QIHET Program Initiatives

- 2024 program initiatives successfully achieved overall goals
- Leadership advocated for organization-wide commitment to quality improvement and health equity through the “Model of Care” to meet the unique needs of our members.
- Programs initiatives included:
  - ✓Internal / external programs and partnerships with providers and community-based organizations
  - ✓Programs to support and improve member access to care and improve member experience
  - ✓Systems upgrades and enhancements to improve clinical data processing and management
  - ✓Advances in data analytics and validation to improve data quality and clinical-decision making.

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Highlights from the 2024 QIHET Program Evaluation

2024 Committee Structure

- The QIHET Program's Committee and Subcommittees structure consisted of ten subcommittees each reporting up to the Quality Improvement and Health Equity Committee (QIHEC)
- The structure served its defined function to provide oversight of the QIHET Program by giving internal / external stakeholders, providers, community organizations and members a platform to provide feedback.

2024 Resources

- Resources for the QIHET Program were comprised of multidisciplinary GCHP staff with leadership from the Chief Medical Officer (CMO)
- The resources dedicated to the QIHET Program effectively supported organizational goals and initiatives
- However, resources were strained due to competing priorities with other critical organization-wide deliverables

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Highlights from the 2024 QIHET Program Evaluation

2024 Managed Care Accountability Set (MCAS) Measures

- Successfully passed the HEDIS® Compliance Audit for the 12th consecutive year
- Almost 8,000 more care gaps were closed in 2024
- 41 MCAS measures reported
- 17 out of 18 measures met or exceeded the DHCS MPL
  - 3 met the 90th percentile; 8 met the 75th percentile; 6 met the 50th percentile
- Rates for 16 measures improved and some measures had significant rate improvement:
  - BCS (+6.85%); W30 6+(+7.95%); DEV (+8.08%); LSC (+8.27%); AMR (+11.13%); FUA (+17.49%); FUM (+37.39%)

Interventions

- Quality Incentive Pool and Program (QIPP) and provider grants
- Member Rewards programs (Mail and Point-of-Care)
- Member outreach campaigns to schedule appointments to close gaps in care
- Enhanced behavioral health care coordination for follow up to ED
- Robust provider and member education campaigns
- Data improvements and collection of new supplemental data sources
- Health fairs (clinic-sponsored events, mobile mammograms, self-collection test kits)

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Highlights from the 2024 QIHET Work Plan Evaluation

2024 QIHET Work Plan Goals

- Goals met for 40 out of 49 initiatives

2024 QIHET Work Plan Highlights

- Wellth Program met enrollment goals and Wellth members showed improved medication adherence, decrease in ED utilization, inpatient and readmission, and increase in gap closure.
- Population Needs Assessment completed and used to implement PHM strategies.
- C&L training expanded to include DEI training that was approved by DHCS.
- UM completed annual review of clinical practice and preventive health guidelines timely.
- CM maintained compliance with turn-around times for complex case management.
- Network adequacy and time-to-distance standards were met.
- Children CAHPS Scores improved with 9 out of 20 scores meeting 50th %ile.
- 100% of all facility site reviews and CAPS were completed timely.
- 100% of all credentialing and recredentialing activities were completed timely.
- 100% of all delegation oversight audits and CAPs closed timely.

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2024 QIHET Work Plan Evaluation Summary

Objectives That Met Goals

1. 2024 QIHET Program Description
2. 2024 QIHET Work Plan
3. 2023 QIHET Program Evaluation
4. 2024 HEDIS Compliance Audit
5. Population Needs Assessment
6. Wellth Program
7. Clinical Practice Guidelines
8. Complex Case Management
9. Care Gap Closure
10. Initial Health Appointments
11. Follow-Up After ED for Mental Illness
12. Follow-Up After ED for Substance Use
13. 2023-2026 SUD/SMH PIP
14. 2024-2025 DHCS/IHI Behavioral Health Collaborative with VCBH
15. Breast Cancer Screening
16. Colorectal Cancer Screening
17. Controlling Blood Pressure
18. Glycemic Status Assessment for Diabetes
19. Chlamydia Screening in Women
20. Immunizations for Adolescents
21. Developmental Screening in Children
22. Topical Fluoride Varnish
23. Well-Child Visits in the First 30-Months of Life
24. Child and Adolescent Well-Care Visits
25. 2023-2026 W30-6+ Hispanic/Latinx PIP
26. 2024-2025 DHCS/IHI Well-Child Collaborative
27. 2024 Comprehensive QIHE WCV and W30-6+ Improvement Project
28. Cultural and Linguistic Needs and Preferences
29. Network Adequacy
30. After Hours Availability Survey
31. Provider Satisfaction Survey
32. Facility Site Review Requirements
33. Facility Site Review Monitoring
34. Physical Accessibility Review Surveys
35. Credentialing / Re-Credentialing
36. Grievances and Appeals
37. CAHPS: Surveys
38. CAHPS: Access to Specialty Care
39. CAHPS: Improvement Projects
40. Delegation Oversight

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2024 QIHET Work Plan Evaluation Summary

Objectives That Did Not Met Goals

1. **Tobacco Cessation:** Cessation medication increased 1.64% but did not meet the 13% goal
2. **Reduction in Potential Unsafe Opioid Prescriptions**: 2024 performance goals were met except for an increase in Q1 concurrent users of opioids and benzodiazepines and increase in Q2 concurrent users of opioids and antipsychotics
3. **Cervical Cancer Screening:** Rate increased 4.14% points and met the 75th percentile, but did not meet the 90th percentile HPL internal goal
4. **Asthma Medication Ratio:** Rate increased 11.13% points but did not meet the MPL
5. **Prenatal Care:** Rate decreased 1.94% and met the 75th percentile, but did not meet the 90th percentile HPL internal goal
6. **Childhood Immunization Status – Combo 10:** Rate decreased 2.92% points and met the MPL but did not meet the 75th percentile internal goal
7. **Lead Screening in Children:** Rate increased 8.27% points and met the 75th percentile, but did not meet the 90th percentile HPL internal goal
8. **Primary and Specialty Care Access:** The 90% benchmark standards were not met and Network Operations provided outreach and education to providers that did not meet standards
9. **Call Center Monitoring:** Average speed of answer and phone quality benchmarks were not met in Q4 2024 due to the transition from an external call center to an internal Contact Center and the significant local wildfire disaster resulting in a decrease in staff and increase in call volume

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2025 QIHET Program and Work Plan Enhancements

2025 QIHET Program Description

- Expand Health Equity Initiatives
  - Hired Executive Director of Health Equity
  - Develop the Culturally and Linguistically Appropriate Services (CLAS) Program and Work Plan
  - Initiate strategies to collect sexual orientation gender identity (SOGI) data
- Committee Structure
  - Launch the Member Advisory Committee
  - Sunset the Medical Advisory Committee and transfer approval of preventive health and clinical practice guidelines to the Credentialing / Peer Review Committee
- Strategic initiatives include launching the new RISE Grants Program

2025 QIHET Work Plan

- Five new initiatives:
  - CLAS Program Description and CLAS Work Plan, Health Risk Assessment, DHCS AMR Improvement Project, DHCS/IHI Collaborative Well-Child Performance Improvement Project
- Expanded the QIPP to include all MCAS measures held to MPL

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AGENDA ITEM NO. 6

TO: Provider Advisory Committee (PAC)

FROM: Marlen Torres, Executive Director, Strategy & External Affairs

DATE: December 9, 2025

SUBJECT: PAC AdHoc Committee Recommendation for Chair

SUMMARY:

On Wednesday, December 4, 2025, the PAC AdHoc Committee, comprised of Dr. Amelia Breckenridge, Katy Kurl, Claudia Gallard, and Amanda Larson, met to review the interested candidates for the Chair role. The ad hoc committee unanimously voted to present the following candidate to the PAC for a formal vote:

1. Chair: Pablo Velez

RECOMMENDATION:

Staff requests that the PAC Committee accept the PAC AdHoc committee's Chair recommendation.

AGENDA ITEM NO. 7

TO: Provider Advisory Committee (PAC)

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

DATE: December 9, 2025

SUBJECT: PAC Recommendations for Vice Chair

VERBAL PRESENTATION