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

Provider Advisory Committee (PAC) Regular Meeting

Tuesday, June 10, 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: 982 166 789#

Telephonic Locations: 3080 Bristol Street Costa Mesa, CA 92626
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

CONSENT

1. Approval of Regular Meeting Minutes of March 11, 2025

Staff: Maddie Gutierrez, MMC, Clerk of the Commission

RECOMMENDATION: Approve the minutes as presented.

UPDATES

2. Federal and State Updates

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

RECOMMENDATION: Receive and file the update.

3. RISE Grant Update

Staff: Erik Cho, Chief Policy & Programs Officer
Ellen Rudy, Director of Grants Administration & Oversight

RECOMMENDATION: Receive and file the update

PRESENTATION

4. D-SNP from the State Perspective

Staff: Eve Gelb, Chief Innovation Officer
Anastasia Dodson – DHCS

RECOMMENDATION: Receive and file the presentation

FORMAL ACTION

5. Reinstituting PAC AdHoc Committee - Review of Applicants/ Selection of new PAC members

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

RECOMMENDATION: Staff recommends the PAC reinstitute a nomination ad hoc subcommittee to commence the selection process of new members.

ADJOURNMENT

Unless otherwise determined by the PAC, the next meeting is scheduled for September 9, 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: June 10, 2025

SUBJECT: Approval of the regular Provider Advisory Committee Meeting minutes of March 11, 2025

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the March 11, 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
March 11. 2025

CALL TO ORDER

The Dr. Pablo Velez, Vice Chair called the meeting to order at 7:31 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, Vince Pillard, Josie Roemhild, Kristine Supple, and Dr. Pablo Velez.

Absent: Committee member: Sim Mandelbaum and Milad Pezeshki, M.D.

Gold Coast Health Plan Staff in attendance: Felix Nunez, M.D., Acting Chief Executive Officer, Marlen Torres, Chief of Member Experience & External Affairs, Erik Cho, Chief Policy & Program Officer, Eve Gelb, Chief Innovation Officer, Robert Franco, Chief Compliance Officer, Acting Chief Medical Officer, James Cruz, M.D., Vicki Wrighster, Pauline Preciado, David Tovar, Nathan Norbryhn, Erin Slack, Pshyra Jones, and Lucy Marrero.

PUBLIC COMMENT

None.

OPENING REMARKS

CPPO Erik Cho thanked everyone for their participation. He noted that these are uncertain times for Medi-Cal. What we do for our members is important, we will continue to provide care. We will hold steadfast.

CONSENT

1. Approval of Regular Meeting Minutes of December 10, 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 Masood Babaeian seconded.

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

NOES: None.

ABSENT: Committee members Sim Mandelbaum, and Milad Pezeshki, M.D.

The motion carried.

UPDATES

2. Health Risk Assessment Updates

Staff: Nathan Norbryhn, Senior Director Model of Care
Erin Slack, MPH, Senior Manager of Population Health

RECOMMENDATION: Receive and file the update.

Erin Slack, MPH, Senior Manager of Population Health stated she had presented to this committee when the health risk assessment (HRA) process was first being launched. She now wants to provide an update on the assessment and where we are today with learning. The HRA is an integral part of learning and understanding what our members needs are. It is also a part of our established Model of Care. This helps to identify what services and supports are available. It is also a foundational portion of the Population Health Management framework as put forth by DHCS in 2022.

Member information is gathered through the screening process so that at the state level they can understand the risk profile. It has helped GCHP identity social needs for our member population. We do not have a thorough source of data to identical social needs, although we do get some information through provider claims.

The HRA has helped us to be able to augment information and really understand the needs of a population. S. Slack stated that we are currently collaborating with an outside vendor called CareNet. We send them approximately 1400 member records every two weeks, and they review the list against the do not call registry and we get about 900 to 1000 members that are called as part of the HRA Campaign. We have completed approximately 6,204 HRAs to date and that number is climbing. Ms. Slack

reviewed percentages of completed assessments, the English-speaking population, and the Spanish speaking members. We have a process in place that has been determined by a team from Care Management, or our Health Education department, Population Health, or the Call Center. We are currently re-evaluating whether we need staff resources to follow up on these assessments or if we can use other mechanisms to reach out to the member to let them know about resources.

Ms. Slack stated that other information that we have been able to collect is more related to social determinants of health, which we did not have access to. She noted that nineteen percent of members have an unstable living situation, and they may benefit from a new transitional rent. Approximately fifty-two percent are concerned about running out of food; these members are provided information on CalFresh benefits. She also noted that approximately seventeen percent of members have a transportation barrier. She also stated that four percent of members are physically hurt by a family member or friend – these members are referred to care management. We have also found that once asked about this situation members are hesitant to respond. We have also found that about forty percent of our members have seasonal or migrant farm work as their main source of income.

Our plan for 2025 is to continue to launch additional target populations for the health risk assessment, and we are working towards making the assessment available online. We recently launched the availability to change a member's PCP online. With the call center now on board we will be able to outreach to additional members.

We are currently evaluating our current process for the HRA to identify methods of capture outside of a call, and ways to provide resources to members via e-mail, text, or a letter in the mail so that we do not have to use our staff resources.

Nathan Norbryhn, Senior Director Model of Care, presented information on the D-SNP HRA. He stated that the HRA is a requirement of our D-SNP Model of Care. You must provide or complete both within the first ninety days of enrollment into the D-SNP program and annually thereafter with each HRA. The responses are collected, and an individualized care plan will go to an interdisciplinary team. The team is dependent on the responses. If a member has changes in their health status before the annual period, then adjustments to the individualized care plan are made. The health status change is key. The different domains collected in these new HRAs for D-SNP are slightly different. There are certain requirements that CMS mandated in the collection of data. Checking on a member's cognition, their social situation, mental and behavioral health are all potential triggers to certain resources. Mr. Norbryhn stated that there are opportunities in our care coordination to have a social worker engagement link them up with long term services and supports and anything else they may need to help secure their health and safety.

Committee member Amanda Larson stated that she noticed there are questions on living situations, and what percent of their income comes from seasonal, or farm related. She asked what about the elderly population because that is a quite different subset. Mr. Norbryhn stated there are questions related to ability to perform their ADLS and IADLS and their social support network.

CIO Eve Gelb stated that the HRA that is done for our Medi-Cal only members is quite different from the HRA that we do for our D-SNP. She noted that has not been launched yet but did get approved by the state. There are questions tailored for older adults. The State of California, in this assessment, has required that all the populations, which are not children, have their needs assessed.

Committee member Larson also asked if an outside provider has a patient going in and out of the hospital, who do they reach out to find out if the member is already on a program. Mr. Norbryhn responded that the Contact Center has basic information on the member. CIO Gelb state that if the member is on D-SNP, you will get what is needed for the member to get assistance, who their care navigator is will be in the system D-SNP members will have a D-SNP ID card that says they are part of D-SNP and that means they automatically have a care navigator.

For this population it makes sense to assign a specific ACP. We need to collaborate with our provider partners to figure out a model that works best for all.

Committee member Kristine Supple left the meeting at 8:08a.m.

3. Managed Care Accountability Set and NCQA Accreditation

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

RECOMMENDATION: Receive and file the update.

Acting CMO, James Cruz, M.D. stated he is providing an update on our plans, progress on our managed care accountability set efforts as well as our National Committee on Quality Assurance Accreditation activities. He stated he had good news on both our Managed Care Accountability set as well as our NCQA efforts. Our Managed Care Accountability set rates have continued to upon where we left off last year. Our rates are exceeding where we were last year Two measures are at the 90th percentile, which is the very highest performance level. We have eight measures that are at the 75th percentile, and only two of our measures are at the low performance level: asthma medication ratio and controlling blood pressure. We are collaborating with our providers to improve these rates, and we expect to be able to improve as the year ends.

We also have good news for NCQA efforts. We have two accreditation surveys that will be occurring this year. The first is on HealthEquity accreditation and will be in June of 2025 and then later in October we will have our health plan accreditation survey. We are completing all our system assessments and compiling reports and finalizing the documents that we will use to provide evidence of what we do to reach our accreditation goal. We are forecast to be at an 81% score. This is good because you need to reach 80% to reach the passing score.

Committee member Amanda Larson asked what goes into the network management piece. Vicki Wrighster, Sr. Director of Network Operations stated we look at the composition of our network to determine whether we have adequate specialties or not. We also look at access and availability, and our team also looks at provider satisfaction as part of that accreditation piece.

Committee member Katy Krul asked about the asthma medication ratio which is below 10%. She asked how you reach out to the population with asthma. CMO Cruz stated the asthma medication ratio is based on the ratio of the controller medication, which is what an individual asthma should take on a regular basis to keep their asthma at a steady state and without symptoms and rescue medication, which is used on a more urgent basis. The measure looks at there should be a greater ratio of controller medication than rescue medication. In term of efforts, we are doing a three-part focus on trying to prove that we are working hand in hand with our providers to make sure they understand the measure, how they write the prescriptions, and third to educate the patient. We have provided education material to the providers to hand out to members, so they learn to be aware of how to gauge their progress and their asthma and when to use the recue inhaler. We are making efforts to improve the compliance and the effectiveness of medication, but also the understanding of both the member and the provider.

Acting CEO, Felix L. Nunez, M.D. stated that we need to work on education on inhalers, and nebulizers to meet the requirement. CEO Nunez stated that we are moving away from asthma ratios, asthma medication ratios in the new datasets and we are going to be looking at asthma, post ER is going to be the new measure. Dr. Cruz stated the change in the measure is indicative of how difficult this measure is to meet.

Committee member Amanda Larson asked if this also included nebulizers, and nebulizer education. She stated she has gone into homes and the member states they were given a nebulizer, and they do not know how to use it. Dr. Cruz stated that he has not yet seen the specifications on that measure for 2026, but in order to meet the measure there will be a host of activities and initiatives are going to be foundational to make sure that after a ER visit that there is improvement and how the member uses their treatments.

Committee member Kristine Supple rejoined the meeting at 8:27a.m.

Committee Vice Chair Dr. Pablo Velez asked about childhood immunization status. He noted that measles is a big issue. Committee member Amelia Breckenridge, M.D. stated that vaccines are included with flu vaccine, and it has shown a positive outcome.

Dr. Cruz stated he will follow-up with Dr. Velez. There is vaccination hesitancy and vaccine coverage are questionable.

PRESENTATIONS

4. RISE Grant Program

Staff: Erik Cho, Chief Policy & Programs Officer
David Tovar, Incentive Strategy Manager
Pauline Preciado, Executive Director of Population Health

RECOMMENDATION: Receive and file the presentation

David Tovar, Incentive Strategy Manager, stated he has been collaborating with the team to implement and launch the RISE (Resilience, Innovation, Sustainability and Equity) Grant Program. This program is focused primarily on access to care, how to assist our network providers, and engage our membership. Mr. Tovar stated we have four strategic priorities which can be drilled down to improve access and connection to care, bring care to where our members live, work, and go to school, improve health outcomes, and offer alternatives for non-traditional healthcare solutions.

Mr. Tovar stated that we have received twenty-nine letters from interested applicants. There is a wide range of what interested parties want to do; from building new clinics to in-school services. We have hosted two webinars which have been well attended.

We launched the grant portal on January 22nd, and it can be accessed through the GCHP website. We have our IHI Team answer technical questions, as well as discuss how to develop a driver diagram or complete measurements. We also have assistance from IHI (Institute for Healthcare Improvement) to help in administering these grants, as well as selecting the best applicants for funding. He noted that grant applications will be closing March 31st.

The reviewing committee will be scoring the applications and reviewing them thoroughly. Each applicant might have a different approach for new projects, and we

want to be able to make sure we find the best approach for our community. Grant awards will be announced on June 2nd.

Mr. Tovar noted that within the presented documents there is a link to the application material and information. The grants will go for three years, and this is the first round. Applicants can apply for one, two, or three years. However, the preference will be given to one year grant applicants. The applicant can note that they are applying for a one-year grant but can include what they would like to do in year two and three if selected. Each year may have slightly different strategic priorities, but it will always be focused on access and member engagement. Committee member Roemhild asked how many grants will be awarded. Mr. Tovar stated part of the review process is to look at what comes in, what is feasible to get done within the period that they are applying for and must be approved by our Commission. He stated that there is also a review on potential duplication that might not qualify for funding.

Committee member Amanda Larson asked if this is only going to address new projects or current programs/projects that are underfunded. CPPO Erik Cho stated he would need to see if this is allowed, it might be potentially possible. Committee Vice Chair Dr. Pablo Velez asked if there is a possibility of removing of change of title due to the current political landscape. A great program could be affected by adjusted time even though the goal is to accomplish it Dr Velez stated it is important to include inclusion and equity to the goal framework and provide demographics. CEO Felix Nunez, M.D. stated we are not in a rush to self-censor ourselves. The state of California has made it clear that they are moving forward with their initiatives and supporting DEI.

FORMAL ACTION

5. Potential PAC Sub-Committee

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

RECOMMENDATION: Staff requests Committee approval to create a PAC sub-committee

Marlen Torres, Chief Member Experience & External Affairs Officer stated that over the last six weeks there have been a number of executive orders being issued, and proposed budget cuts. We are looking at the impact of the proposed cuts and how they will impact everyone individually and as a community. The House passed over their proposed resolution of $180 billion cut to the Medi-Cal program, the Senate had a difference proposal however, and they kicked it over to the Senate. Now we are waiting to see how their resolution will look like. We know that both Senate and Congress must have the same marching orders for an Ultimate Reconciliation Act. Ms. Torres stated that there has been a lot of advocacies. All Plan CEOs

met with DHCS regarding this topic. Ms. Torres stated she is requesting a subcommittee for the PAC, which would help us mobilize quicker to continue to advocate for the programs. We are just getting started and once the resolution is passed, you have the reconciliation and ultimately then you have the impact to our state and our community. We want to create a subcommittee to discuss these issues and partner with all to advocate for Medi-Cal or Medicare programs in California.

Committee Vice Chair Velez asked if we need to vote on creating a subcommittee for PAC. Ms. Torres referred to the Clerk. The clerk stated the first discussion is if the PAC wants a subcommittee or do, they want to meet as often as needed (more than quarterly). We want feedback from the committee and if all agree with the subcommittee, then vote for it.

Committee member Molly Corbett stated she is in favor of a subcommittee. We must act now and must locally and regionally, and nationally have our voices heard.

Committee member Masood Babaebian motioned to create a PAC subcommittee. Committee member Katy Krul seconded.

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

NOES: None.

ABSENT: Committee members Sim Mandelbaum, and Milad Pezeshki, M.D.

The motion carried.

The Clerk asked for volunteers to be active members of the PAC subcommittee. Ms. Torres asked how many PAC members we would need minimum of two and maximum of three. Ms. Torres then explained that we could have a subcommittee that would include PAC and CAC together. We would have three from CAC and three from PAC and combine the committees.

Volunteers: Katy Krul, Molly Corbett, and Vince Pillard.

Dr. Velez stated that he wanted to volunteer as part of the CAC. Claudia Gallard volunteered for PAC subcommittee.

Committee member Masood Babaebian motioned to approve Katy Krul, Molly Corbett, Vince Pillard, Dr. Pablo Velez, and Claudia Gallard to be members of the PAC subcommittee. Committee member Amelia Breckenridge, M.D. seconded.

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

NOES: None.

ABSENT: Committee members Sim Mandelbaum, and Milad Pezeshki, M.D.

The motion carried.

The Clerk asked for approval of agenda items 2, 3 and 4.

Committee member Amanda Larson motioned to approve agenda items 2, 3, and 4.
Committee member Claudia Gallard seconded.

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

NOES: None.

ABSENT: Committee members Sim Mandelbaum, and Milad Pezeshki, M.D.

The motion carried.

The Clerk stated that the next meeting is scheduled for March 11, 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: Marlen Torres, Chief Member Experience & External Affairs Officer

DATE: June 10, 2025

SUBJECT: Federal and State Updates

SUMMARY:

A. Federal Updates

Republicans Target Work Requirements, Provider Taxes, Undocumented Individuals as Part of Reconciliation Package

In a 215-214 vote in the early hours of May 22, 2025, House Republicans passed their reconciliation bill that includes significant Medicaid cuts as part of their effort to cut $880 billion from the Medicaid Program to fund President Donald Trump's priorities, including extending tax cuts, increased border security, and defense spending. The bill now advances to the Senate, where it faces further discussions and potential amendments.

A summary of key policies is below:

- **Work Requirements:** Requires states to establish "community engagement requirements" for able-bodied adults without dependents. To meet the requirement, an individual must demonstrate at least 80 hours a month of working, enrolling in an educational program, participating in a work program, completing community service, or a combination of these activities for at least 80 hours. Certain individuals are excluded from these requirements including pregnant women, individuals under the age of 19 and over the age of 64, and those with disabilities. *This provision is set to take effect by December 31, 2026.*
- **Increased Eligibility Checks:** Requires states to conduct eligibility determinations for Expansion population adults every six months.
- **Provider Taxes:** Freezes the provider taxes that states have at the rate in effect as of the date of enactment of the legislation and prohibits states from establishing new provider taxes.
- Federal Medical Assistance Percentage (**FMAP) Reduction for States Covering Undocumented Individuals:** Reduces the FMAP for Medicaid Expansion States that

provide health care coverage for undocumented immigrants under Medicaid or another state-based program. *This provision is set to take effect in 2027.*

- **Cost-Sharing for Expansion Population:** Requires states to implement cost sharing – not to exceed $35 per service – on Medicaid Expansion adults with incomes over 100% of the federal poverty level.
- **Moratorium on Biden-era Regulations:** Moratorium on implementation of final rules until Jan. 1, 2035:
    - *Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment*
    - *Medicaid Program: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes*
    - *Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting*

The Congressional Budget Office (CBO) released its estimate on the Medicaid provisions. The CBO estimates that if the bill were enacted, 8.6 million people would lose health insurance coverage, including 7.6 million Medicaid enrollees. According to our trade association, Local Health Plans of California (LHPC), preliminary estimates indicate that the Medicaid provisions could result in a $90-100B decrease in federal funding to California over 10 years. Specifically, FMAP penalties on states that cover undocumented individuals are estimated to result in a $13-15B annual decrease in matching funds to California and implementation of work requirements is estimated to put more than 8 million Californians (4.9 million expansion adults and 3.2 million other adults) at risk of losing coverage.

Republicans in the Senate face staunch opposition from Democrats and stakeholders, including hospitals, providers, consumer advocates, health plans, and other impacted groups. GCHP submitted letters to key Committee officials that underscore the importance of protecting Medicaid and the individuals we serve as well as a coalition letter to our U.S. Senators, on which GCHP is joined by members of the Provider and Community advisory committees, business, community partners, and Ventura County health system leaders, to detail the impacts of proposed cuts and urge the Senate to act to protect the health care of millions of enrollees, including 241,479 Ventura County residents.

LHPC is also conducting outreach and encouraging local plans to advocate for protecting Medicaid. Additionally, advocacy campaigns are underway including the Association for Community Affiliated Plans' (ACAP) Medicaid Is Us campaign that is running television ads in key markets, connects website visitors to their local legislators to advocate for protecting Medicaid, and includes key facts about Medicaid and the individuals covered by the program.

Once the reconciliation language passes out of the Senate, it will go back to the House, where they must pass the same legislation that is passed by the Senate, with a tentative goal set for passage by the 4th of July recess.
GCHP's Government Relations Team is actively monitoring this activity and will continue to provide updates as the language makes its way through the process.

B. State Updates

May Revise Budget Includes Medi-Cal Cuts; Reflects Increased Budget Deficit and Federal Uncertainties
On May 14, 2025, Gov. Gavin Newsom released the updated 2025-26 California state budget proposal known as the May Revise. The revised budget proposes a total state budget of $321.9B and $226.4B GF for 2025-26 with $15.7B in total reserves.
According to the Newsom Administration, there is a reduction in ongoing state revenue ($16B) due to lower wages ($2B), reduced capital gains ($10B), weaker corporate taxable profits ($2.5B), and reduced personal income tax items ($1.5B). Many of these shifts are attributed to federal regulatory changes.

Due to unpredictability in the total state revenue, as well as federal tariff impacts and stock market volatility, California faces a $12B deficit in 2025-26. To address the 2025-26 budget shortfall, the Administration has opted for a variety of budget solutions, including reductions ($5B in 2025-26 and increasing to $14.8B by 2028-29), fund shifts ($1.7B total in 2025-26), and revenue and borrowing ($5.3B total in 2025-26). The May budget includes $302.4B ($85.6B GF) for California Health and Human Services (CalHHS) in 2025-26. For Medi-Cal, the budget allocates $179B ($37.4B GF) in 2024-25 and $194.5B ($44.6B GF) in 2025-26.
According to the Administration, increased state GF expenditures are attributed to the Medi-Cal program and specifically, higher Medi-Cal enrollment numbers as well as associated costs for pharmacy drugs. This information aligns with prior state requests to the Legislature for additional Medi-Cal funding and support. In March 2025, the state Department of Health Care Services (DHCS) testified how it is seeing increased Medi-Cal costs related to a growing older adult population caseload and higher pharmacy expenditures. As a result, the Administration authorized a loan request of $3.44B for DHCS to complete payments to various Medi-Cal providers. In early April, DHCS submitted a request for an additional $2.8B GF, as well as $8.3B federal fund expenditure authority to further offset growing Medi-Cal costs for FY 2024-25.

Notably, the May Revise opts to freeze enrollment for the full-scope Medi-Cal expansion of those with "Unsatisfactory Immigration Status (UIS)" who are 19 and older, as well as institute $100 monthly Medi-Cal premiums for undocumented enrollees beginning Jan. 1, 2027. Although the implementation of Medi-Cal premiums is estimated to generate $1.1B in GF savings and the enrollment freeze will save the state $86.5M in 2025-26, many stakeholders, including GCHP's trade association, the Local Health Plans of California (LHPC), have concerns with the UIS proposals and intend to voice opposition in upcoming committee hearings on the amended budget.

Due to the growing budget shortfall, as well as probable and impending federal cuts to Medicaid, the Administration has opted to proactively restrict Medi-Cal enrollment for the undocumented population to free up state funding and help maintain the Medi-Cal delivery system. Furthermore, the May Revise also terminates full-scope dental coverage as well as long-term care (LTC) benefits, which include nursing home care and some home health services, for undocumented Medi-Cal enrollees. The removal of the LTC benefit is expected to generate $333M in state GF savings in 2025-26 while the elimination of full-scope state-only dental coverage will result in $308M GF savings in 2026-27.

California's fiscal outlook remains highly uncertain, and as the federal government moves forward with its budget reconciliation process—which is likely to affect state programs and revenues—the proposed 2025–26 state budget could undergo significant changes. The state Legislature is set to begin hearings on the proposals the week of May 19, 2025, and must develop trailer bill language to implement the budget provisions as part of the process. LHPC, is preparing testimony and submitting written comments on the various proposals that impact Medi-Cal to ensure that the Legislature considers the impacts to health plans and providers.
The budget is a working document and requires a three-party agreement (Administration, Senate, and Assembly) to be chaptered into law. Through state constitutional mandate, the Legislature must pass a balanced budget by June 15.

The following table includes important FY 2025-26 key proposals that may impact GCHP operations and/or members. GCHP's Government Relations Team will continue to provide updates on California's 2025-26 budget activity to ensure the business is informed of all pending and significant budgetary or legislative changes that may affect the Medi-Cal delivery system and/or Medi-Cal managed care plans.

Major Budget Proposals		
Investment Name	**May Revise Allocation**	**Summary**
Managed Care Organization (MCO) Tax and Proposition 35	Includes $804M in 2024-25, $2.8B in 2025-26, and $2.4B in 2026-27 for the MCO Tax and Proposition 35 expenditure plan Incorporates $1.6B across 2025-26 and 2026-27 to support increases in managed care base rates in the areas of primary and specialty care, ground emergency medical transportation, and hospital outpatient procedures	In Nov. 2024, Prop 35 was passed into law and creates permissible uses of MCO tax revenues beginning in the 2025 tax year and upon the state Department of Health Care Services' (DHCS) consultation with a stakeholder advisory committee to implement rate reimbursement changes. The May proposal highlights the MCO tax revenue of $9B in 2024-25, $4.2B in 2025-26, and $2.8B in 2026-27 to support existing and increased costs in the Medi-Cal program. Compared to 2025 January proposal, this is an increase of $1.1B in 2024-25 and decreases of $200M in 2025-26 and $400M in 2026-27.
Ongoing Resources for CalHOPE Warm Line	$5M from the Behavioral Health Services Fund (BHSF) for the CalHOPE Warm Line	The CalHOPE Warm Line is a state-funded hotline that helps connect Californians with mental health concerns to peer counselors who provide compassionate support and coping resources.
Additional Support for Adverse Childhood Experiences (ACEs) Provider Trainings	$2.9M total funds ($1.46M BHSF and $1.46M federal funds) in 2025-26	State funds will expand training for ACE providers to accurately screen patients and ensure that patient treatment aligns with trauma-informed care to support the well-being of California children and families. This builds on prior DHCS attempts to screen patients for ACEs that lead to trauma and reduce the likelihood of ACEs-associated health conditions due to toxic stress.

Significant Budget Solutions Related to the UIS Population		
Enrollment Freeze for Full-Scope Medi-Cal Expansion, Adults 19 and Older	Estimated GF savings of $86.5M in 2025-26, increasing to $3.3B by 2028-29.	The May Revise proposes a freeze on new enrollment for full-scope Medi-Cal for undocumented Californians ages 19 or older no sooner than Jan.1, 2026. The freeze is only anticipated to impact **new** Medi-Cal applications from undocumented Californians and will not impact current undocumented Medi-Cal enrollees nor Medi-Cal beneficiaries with a "Satisfactory Immigration Status (SIS)."
Medi-Cal Premiums, Adults 19 and Older with "Unsatisfactory Immigration Status (UIS)"	GF savings are estimated to be $1.1B in 2026-27, increasing to $2.1B by 2028-29	Beginning Jan. 1, 2027, the Administration proposes to implement a state-only monthly Medi-Cal premium of $100 for undocumented Californians ages 19 and older. According to Gov. Newsom, this would allow the state to reinvest limited dollars to other health and human services programs and/or services without fully eliminating access to Medi-Cal for undocumented Californians. This proposal, as well as the enrollment freeze, is highly likely to be met with strong opposition. GCHP's trade association, the Local Health Plans of California (LHPC), recently issued a statement denouncing proposed cuts to Medi-Cal and how this will harm diligent low-income Californians as well as limit access to necessary health care services.
Elimination of Long-Term Care (LTC) for Individuals with UIS	GF savings are estimated to be $333M in 2025-26 and $800M in 2026-27 and ongoing	LTC benefits include access to nursing home care, in-home supportive services, and other types of support including transportation assistance and homemaker services. Under California Advancing and Innovating Medi-Cal (CalAIM), Medi-Cal managed care plans (MCPs) cover and coordinate Medi-Cal institutional LTC in all counties. The May Revise opts to eliminate LTC for undocumented Californians beginning Jan. 1, 2026. This is not anticipated to impact access to LTC for Medi-Cal enrollees with SIS.

Other Budget Solutions Related to Medi-Cal		
Elimination of Acupuncture Optional Medi-Cal Benefit	Estimated GF savings of $5.4M in 2025-26 and $13.1M ongoing	In 2024, the Newsom Administration proposed to eliminate the optional adult acupuncture Medi-Cal benefit as a budget solution. However, the Legislature opted to preserve acupuncture benefits. The 2025-26 May Revise again proposes to eliminate acupuncture as an optional benefit for all Medi-Cal enrollees regardless of immigration status.
Elimination of Prospective Payment System Rates to Federally Qualified Health Centers and Rural Health Clinics for Individuals with UIS	Estimated GF savings of $452.5M in 2025-26 and $1.1B in 2026-27 and ongoing	The amended proposal opts to eliminate Prospective Payment System rates to clinics for state-only-funded services that are provided to undocumented individuals. Clinics will receive reimbursement at the Medi-Cal Fee Schedule rate if they are in the fee-for-service delivery system and at the negotiated reimbursement rate if they are in the managed care delivery system.
Reinstatement of the Medi-Cal Asset Test Limits	Estimated GF savings are $94M in 2025-26, $540M in 2026-27, and $791M ongoing	California removed the asset test for Medi-Cal eligibility beginning Jan. 1, 2024, which prevented assets such as bank accounts and homes from being considered when determining someone's eligibility for Medi-Cal. The May Revise proposes to reinstitute the Medi-Cal asset test limits for seniors and adults with disabilities ($2,000 for an individual or $3,000 for a couple) for all Medi-Cal enrollees.
Proposition 56 Supplemental Payments	Eliminate approximately $504M in 2025-26 and $550M ongoing	Prop 56 provides supplemental payments for specific physician services that are provided to Medi-Cal beneficiaries and these additional payments are added to the base rates of services. The amended budget proposes to eliminate Prop 56 payments to dental, family planning, and women's health providers.

Medi-Cal Minimum Medical Loss Ratio (MLR)	Estimated GF savings of $200M in 2028-29 and ongoing	Beginning Jan. 1, 2026, the amended proposal opts to increase the minimum MLR for managed care plans from 85% to 90%. The proposal raises several concerns for health plans that are advocating for a more deliberative process for policy development and to not rush through such an impactful change. In California, the MLR for managed care plans is 85%, which means that plans must spend at least 85 cents of every premium dollar on medical services and quality improvement efforts.
Prescription Drug Utilization Management	Estimated GF savings of $25M in 2025-26 and $50 million in 2026-27 and ongoing	As outlined in a recent Legislative's Analyst Office (LAO) report, "Medi-Cal Pharmacy Spending," Medi-Cal pharmacy spending has almost doubled in recent years and is the primary reason behind higher than anticipated Medi-Cal spending. The May Revise proposes to implement utilization management and prior authorization for prescription drugs; more information is likely forthcoming in trailer bill language surrounding which drug types may be impacted.

RECOMMENDATION:

Receive and file the update.
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AGENDA ITEM NO. 3

TO: Provider Advisory Committee (PAC)

FROM: Erik Cho, Chief Policy & Programs Officer

DATE: June, 10, 2025

SUBJECT: GCHP RISE Grant Update

PowerPoint with Verbal Presentation

ATTACHMENTS:

GCHP_PAC_Agenda_RISE Grant Update 061025

Gold Coast Health Plan℠
A Public Entity

Gold Coast Health Plan RISE Grant Update

June 10, 2025

Erik Cho, Chief Policy and Programs Officer

Integrity
Accountability
Collaboration
Trust
Respect

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Overview of the RISE Grant Program

Strategic Pillars of the Resilience, Innovation, Sustainability, & Equity (RISE) Grant:

To increase and improve access to care,

To bring care to where members live, work, and go to school,

To improve member outcomes, experience, and education

To offer alternative healthcare solutions and remove structural barriers to care

Key Activities

- Request for applications closed March 31, 2025
- Robust response from the community: **35 grant applications received**
- Institute of Health Improvement (IHI) selected as third party reviewer to review, score and manage applications and grant awards
- 16 organizations selected to fund
  - 13 grants are for 12 months – July 1, 2025 – June 30, 2026
  - 3 grants are for 36 months – July 1, 2025 – June 30, 2028
- Award letters sent out June 2, 2025; grantees accepted awards, June 9, 2025
- Total funding for **yr 1**: **$11.3M; yr 2 $6.4 M committed; yr 3 $4.1M committed. Total commit: $21.9M**

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	List of Grant Awardee Organizations	Topic
1	Amigo Baby, Inc	Peds/staff retention
2	California State University, Northridge/The University Corporation	Vendor access to WIC
3	Clinicas del Camino Real, Inc	Urgent clinic expansion
4	Community Memorial Health System	Expansion/Psychiatry residents
5	Conejo Free Clinic	Clinic expansion
6	Food Share	Food boxes
7	Health Care Foundation for Ventura County, Inc	Mammography equipment and extension of hours
8	Livingston Memorial Visiting Nurse Association	Remote monitoring
9	Mixteco Indigena Community Organizing Project (MICOP)	Doula add services
10	Nate's Place, A Wellness and Recovery Center	Mental health/SUD
11	Santa Barbara Foundation	Community Health Worker
12	Shelter Care Resources	Homeless youth
13	The Boys & Girls Clubs of Greater Oxnard and Port Hueneme	Mental health
14	United Way of Ventura County	School dental varnish
15	Ventura County Public Health	Mobile health STI testing
16	Ventura County Medical System	Clinic expansion

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Appendix
RISE Grantees Project Titles and Brief Descriptions

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	List of Grant Awardees	Project Title	Project Description
1	Amigo Baby, Inc	Benefits of Comprehensive Pediatric Home Health Services	Infrastructure support to expand services to provide retention bonuses to 25 pediatric therapists and nurses.
2	California State University, Northridge/The University Corporation	Every Family Every Market	Promote utilization of the new electronic benefits program at Farmers Markets. Educate farmers and provide TA to farmers and attend farmers market to promote new benefit.
3	Clinicas del Camino Real, Inc	El Rio Urgent Care Expansion	Expand urgent care to add 9 room urgent care center and adding a new mammograph mobile unit
4	Community Memorial Health System	Behavioral Health Psychiatry Program	Support psychiatry residents program. Increase access to timely psychiatric services.
5	Conejo Free Clinic	Women's Wellness & Equity Initiative: Bridging Gaps in Preventive Care	Expanding women's wellness by expanding to create 2 extra exam rooms and a mobile mammogram event.
6	Food Share	Fresh for All: Expanding Access to Fresh Produce for Low-Income Communities	Expanding food boxes to low-income families by 30,000 boxes.

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	List of Grant Awardees	Project Title	Project Description
7	Health Care Foundation for Ventura County, Inc	Ventura County Medical Center Women's Health Breast Imaging Center	Ventura County Medical Center Women's Health Breast Imaging Center. Mammography units.
8	Livingston Memorial Visiting Nurse Association	The Livingston Bridge Program	Remote patient monitoring, in home assessments for Medi-Cal beneficiaries discharged from the hospital.
9	Mixteco Indigena Community Organizing	Access to Traditional Maternal Care for Indigenous Migrant Communities	Access to traditional Maternal Care for Indigenous Migrant Communities. 8 doulas trained and 40 baby boxes distributed.
10	Nate's Place, A Wellness and Recovery Center	Nate's Place, A Wellness and Recovery Center: Expanding Low Barrier Mental Health and Substance Use Services	Expanding Low Barrier Mental Health and Substance Use Services. Goal to increase services to 75 additional youth.
11	Santa Barbara Foundation	Central Coast CHWP Collaborative	Central Coast CHWP Collaborative to train 40 new CHWs across 5 organizations
12	Shelter Care Resources	Shelter Care Resources Wraparound Health Care	Improve Enrollment Navigation for homeless youth and transportation to medical visits.

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	List of Grant Awardees	Project Title	Project Description
13	The Boys & Girls Clubs of Greater Oxnard and Port Hueneme	Mental Health Services for Youth Club Members	Expanding Mental health services afterschool at the BGC. Hire two interns and a FT Wellness manager.
14	United Way of Ventura County	Building Healthy Smiles	Building Healthy Smiles. Expanding the BHS program for students in the Oxnard School District.
15	Ventura County Public Health	Ventura County Public Health Mobile Team	Ventura County Mobile Team to do STI testing, outreach, and enrollment in health coverage to unhoused residents
16	Ventura County Medical System	Expanding Healthcare Access and Colon Cancer Screening in Ventura County	Expanding healthcare access and colon cancer screening. Increasing magnolia clinic by 4,000 sq ft, adding 12 exam rooms and adding 4 nurses and 1 provider to Santa Paula hospital.

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AGENDA ITEM NO. 4

TO: Provider Advisory Committee (PAC)

FROM: Eve Gelb, Chief Innovation Officer

DATE: June 10, 2025

SUBJECT: D-SNP from the State Perspective

PowerPoint with Verbal Presentation

ATTACHMENTS:

Medi-Medi Plans in Ventura County

Medi-Medi Plans in Ventura County

Presentation for

Gold Coast Health Plan's Provider Advisory Meeting

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

June 10, 2025

Agenda

- Overview: Dual Eligible Members
- Medicare Medi-Cal Plans (Medi-Medi Plans)
- 2026 Look-Ahead

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Overview: Dual Eligible Members

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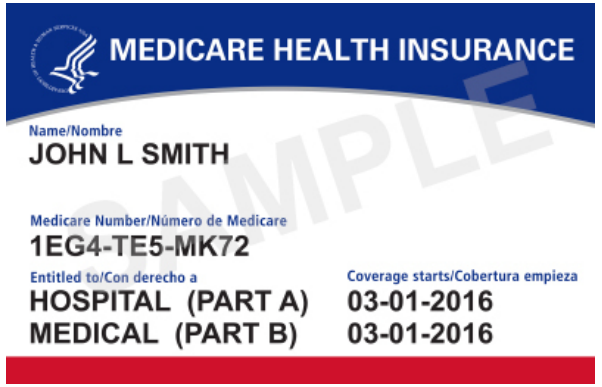
DHCS

Medicare and Medi-Cal

- Some people have both Medicare and Medi-Cal, known as dual eligibles (Medi-Medis).
- Medicare covers doctor visits, hospital stays, labs, prescription drugs, and other benefits.
- Medi-Cal covers Medicare Part B premiums, copays, adult day health care, skilled nursing facility care, dental, and In-Home Supportive Services (IHSS).



Dual Eligible Members

- Nationally, dual eligible individuals are more likely than people with Medicare only to report being in poor health (13% vs. 4%).
  - Heart failure, hypertension, depression diagnoses among dual eligible individuals occur at significantly higher rates than in Medicare-only population.
- Dual eligible individuals have high rates of chronic conditions, high utilization, and are a diverse group:
  - 25% under age 65
  - 33% limited English proficiency
  - About 18% prevalence of dementia
- Over 75% of In-Home Supportive Services (IHSS) recipients and 80% of long-term Medi-Cal Skilled Nursing Facility (SNF) residents are dually eligible.

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Dual Eligible Members in California

- In California, almost a quarter of Medicare members also have Medi-Cal (**1.7 million Californians**).
- Statewide, about 50% of dual eligible members are enrolled in some type of Medicare Advantage (MA) plan, including integrated plans, and 50% are in Original (Fee-For-Service) Medicare.
- All dual eligible members in California are enrolled in Medi-Cal managed care plans.

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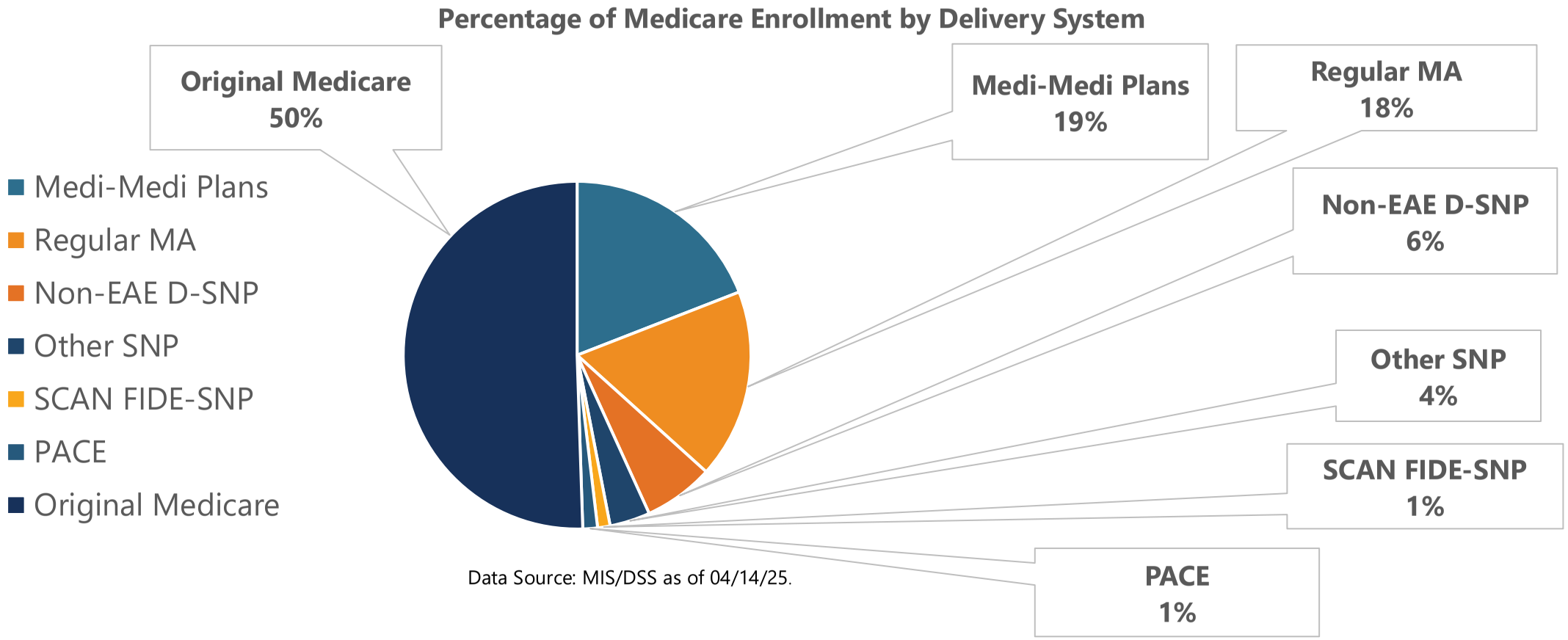
Medicare Delivery System Enrollment for Dual Eligibles in California (January 2025)



Data Source: MIS/DSS as of 04/14/25.

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Dual Eligible members in Ventura County

- As of August 2024, there were about 27,700 dual eligible members in Ventura County.
  - 3,900 of these members were in Medicare Advantage, including Dual Eligible Special Needs Plans (D-SNPs).

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Medi-Medi Plans

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DHCS

The Need for Coordinated Care

- For most dual eligible members, Medicare and Medi-Cal operate separately, with different funding streams.
- This fragmented system can be confusing and hard to navigate. It may not provide person-centered services.
- CalAIM Approach: Health plan to coordinate care across Medicare and Medi-Cal, known as **Medi-Medi Plans.**
  - Available in twelve counties in 2025: Fresno, Kings, Los Angeles, Madera, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, Santa Clara, and Tulare, with total current enrollment of 330,000.
  - Will launch in additional counties on January 1, 2026.

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Medi-Medi Plans

- **Medi-Medi Plans** are a type of Medicare Advantage plan in California that are only available to dual eligible members.
- Members enrolled in a Medi-Medi Plan receive their Medicare benefits through a Dual Eligible Special Needs Plan (D-SNP) and their Medi-Cal benefits through a Medi-Cal Managed Care Plan (MCP).
- Enrollment in Medi-Medi Plans is **voluntary**.

D-SNPs provide Medicare services, such as:

- Hospitals
- Providers
- Prescription drugs

MCPs provide wrap-around services, such as:

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

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Medi-Medi Plans in California

- The program name "Medicare Medi-Cal Plans" is used by the Department of Health Care Services (DHCS), Health Care Options (HCO), and in beneficiary notices.
  - Health plans may use their own marketing name, such as in plan-specific member materials.
- Medi-Medi Plans are described as **a single plan** in beneficiary-facing materials, as members will receive one card, one welcome packet, and have one phone number to call for member services.
- Fact sheets for members and providers as well as other resources are posted on the DHCS Medi-Medi Plan website.
- A list of 2025 Medi-Medi Plans by county is also available on the DHCS website.

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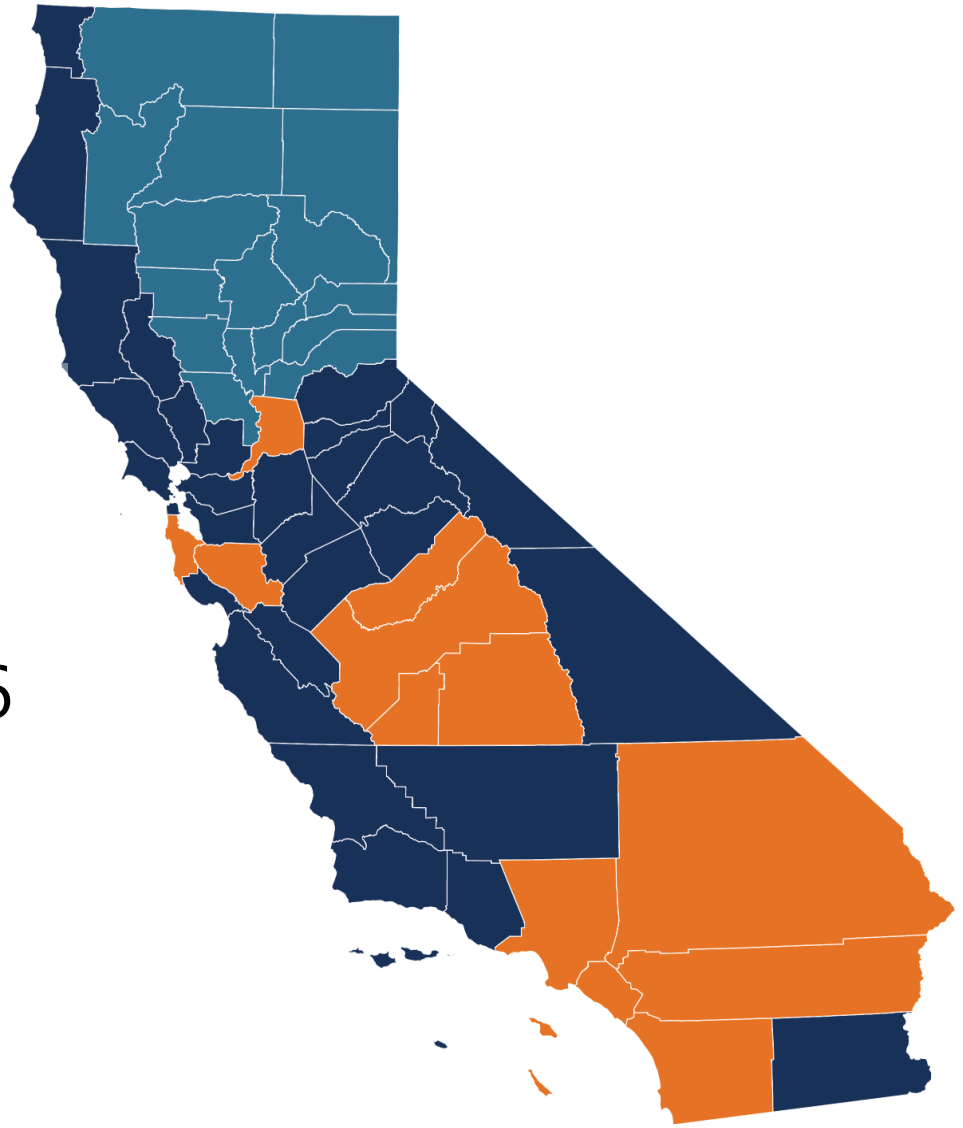
Medi-Medi Plans in California Counties

Plans are currently available

Plans will be available starting 2026

Plans phased in after 2026



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Care Coordination in Medi-Medi Plans

- Medi-Medi Plans help members with all their health care needs and coordinate benefits and care, including carved-out benefits, medical and home and community-based services, durable medical equipment, and prescriptions.
- Instead of Medi-Cal ECM, Medi-Medi Plans provide **California Integrated Care Management** (CICM).

Coordination with Related Medi-Cal Benefits

- Medi-Medi Plans are required to coordinate all Medicare and Medi-Cal benefits, including "carved-out" benefits such as:
  - In-Home Supportive Services (IHSS)
  - Specialty Mental Health and Substance Use Disorder Services provided by the county
  - Medi-Cal Dental (including Dental Managed Care plans)
  - Multipurpose Senior Services Program (MSSP)
- Joining a Medi-Medi Plan will **not** impact a beneficiary's IHSS benefits.
  - members can keep their IHSS providers and hours.
  - members still retain the right to hire, fire, and manage their IHSS providers.

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Community Supports and Enhanced Care Management (ECM) for Members in Medi-Medi Plans

- Members in Medi-Medi Plans can receive Community Supports.
  - Community Supports are provided by a member's Medi-Cal MCP.
  - The Medi-Medi Plan is responsible for coordinating Community Supports, as with other Medi-Cal benefits.
- Dual eligible members in Medi-Medi Plans may also receive California Integrated Care Management (CICM), which is similar to Medi-Cal ECM.
  - Care management is provided by a member's D-SNP, including clinical care management for chronic conditions.
  - The Medi-Medi Plan is responsible for providing sufficient care management.

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Medi-Medi Plans Support Access to Providers

Provider Network

- members will have access to a provider network through their Medi-Medi Plan.
- If a beneficiary's provider is not in network, a provider can join the Medi-Medi Plan's network or the Medi-Medi Plan will help the beneficiary find a new doctor they like.
- To join a Medi-Medi Plan network, a provider should contact the plan's provider relations department directly.

Continuity of Care

- If a provider is not currently in network, there is a continuity of care period, where the beneficiary can continue to see their provider for up to 12 months (in most cases).
- The beneficiary must have a prior relationship with the provider, and the provider and health plan must agree to terms, including payment terms.

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Medicare Network Adequacy Requirements

- Medicare Advantage (MA) plans, including Medi-Medi Plans, must maintain a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served.
- CMS reviews and monitors Medicare provider networks and Medicare network adequacy.
- CMS network adequacy requirements are at the contract level, not the sub-network (e.g., delegation) level.
- Medicare Advantage Network Guidance is available on the CMS website.
- If any concerns come up about Medicare network access and adequacy for a particular Medi-Medi Plan, please contact the plan first.
  - For further escalation, please contact the CMS Regional Office at ROSFOORA@cms.hhs.gov.
  - Stakeholders can also contact 1-800-Medicare with the member to file a complaint.

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Crossover Billing in Medi-Medi Plans

Crossover Billing Process

- In a Medi-Medi Plan, a member's D-SNP and Medi-Cal plan are operated by the same organization.
- When a provider bills the D-SNP for primary Medicare payment, the same organization should process the secondary (Medi-Cal) claim.

Crossover Billing Resource

- If you have questions about how to bill for dual eligible members enrolled in Medi-Cal managed care, please see the DHCS Crossover Billing Toolkit.

Balance Billing

- Medicare providers cannot bill dual eligible members for Medicare Part A and B cost sharing. This is known as balance billing, or "improper billing," and is illegal under both federal and state law. Dual eligible members may still have a small copay for prescription drugs. Additional information is available on the DHCS website.

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Joining a Medi-Medi Plan

members can join a Medi-Medi Plan if they:

- ✓ Have both Medicare Part A and B and Medi-Cal
- ✓ Are 21 years or older
- ✓ Live in one of the counties that offers Medi-Medi Plans

Beneficiary enrollment in Medi-Medi Plans is **voluntary**.

To enroll, a beneficiary can contact their Medi-Cal plan or 1-800-MEDICARE.

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2026 Look-Ahead

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DHCS Medi-Medi Plan Outreach Support

- DHCS is supporting Medi-Cal plans in their outreach to inform providers and stakeholders about the launch of Medi-Medi Plans throughout California in 2026.
- Providers should direct questions to their contracted Medi-Cal plan. Providers can also submit general questions to DHCS at info@calduals.org.
  - To learn more about Medi-Medi Plans, providers can:
    - Visit the DHCS Medi-Medi Plan Webpage
    - View the Medi-Medi Plans: Information for Providers Fact Sheet
- DHCS encourages Medi-Cal plans to partner with local Health Insurance Counseling and Advocacy Programs (HICAPs) and the Medicare Medi-Cal Ombudsman Program (MMOP) in their outreach efforts.

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Options for Dual Eligible Members in Ventura County in 2026

- A dual eligible beneficiary will have the following choices in 2026 in Ventura County:
  - Original Medicare and a Medi-Cal plan
  - A Medi-Medi Plan
  - A Medicare Advantage plan and a Medi-Cal plan
- DHCS expects Medi-Medi Plans will be available from Gold Coast Health Plan and Kaiser Permanente.
- **Reminder:** 2026 Medicare Open Enrollment is October 15 – December 7, 2025.

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Talking to Members about Medi-Medi Plans

- As trusted sources of information, members may come to providers and community partners with questions about Medi-Medi Plans.
- When talking to members, consider sharing the following messages:
  - A Medi-Medi Plan has care coordination, one health plan card, and one number to call for both Medicare and Medi-Cal benefits.
  - Medi-Medi Plans have care coordinators who can help a member find doctors and make appointments, understand prescription drugs, set up transportation to doctor's visits, get follow-up services after leaving a hospital or facility, and support connections with home and community-based services.
  - Enrollment in a Medi-Medi Plan is voluntary.

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Tips for Providers When Talking to Members about Medicare Options and Medi-Medi Plans

- As a provider, patients may approach you about their health care choices.
- When a patient requests information from you about their Medicare options, per federal regulations, you can:
  - Share unaltered, printed materials created by CMS (e.g., Medicare Plan Finder, "Medicare & You" Handbook, etc.).
  - Provide the names of the Medi-Medi Plans you contract with.
  - Answer questions about Medi-Medi Plans, such as cost sharing and benefit information.
  - Refer members to Medi-Medi Plan marketing materials (available in **common areas** only).
  - Provide information and assistance in applying for the Low-Income Subsidy (LIS).
  - Refer members to other organizations for support, like HICAP and MMOP.

Providers and Medicare Marketing Materials

- As a provider, you may not share any Medicare marketing materials in an area where care is being administered, such as:
  - Exam rooms
  - Hospital patient rooms
  - Treatment areas where patients and providers may interact (e.g., in dialysis treatment facilities)
  - Pharmacy counters
- Medicare marketing materials can be shared in common areas, such as:
  - Common entryways
  - Vestibules
  - Waiting rooms
  - Hospital cafeterias
  - Community, recreational, or conference rooms

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Resources for Members

- Dual eligible members can learn more about Medi-Medi Plans by viewing the Medi-Medi Plan Fact Sheet on the DHCS Medi-Medi Plan Webpage.
  - The fact sheet is available in English, Spanish, Hmong, Vietnamese, Traditional Chinese/Cantonese, Russian, Khmer/Cambodian, Arabic, Farsi, American Sign Language, and Mexican Sign Language.
- To change Medicare plans, a member can contact the health plan of their choice directly or call 1-800-Medicare.
- For support, members can contact:
  - HICAP for free counseling on health care options: 1-800-434-0222
  - MMOP for help resolving issues with providers or health plans: 1-855-501-3077

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Additional Resources

- For more information about coordinated care for dual eligibles, visit the DHCS Integrated Care for Dual Eligible Beneficiaries Website.
- To learn more about D-SNPs, visit the DHCS D-SNPs in California Website.
- Join the next MLTSS and Duals Integration Stakeholder Workgroup on June 25th at 11:00am (registration is required).
- If you have any questions, contact us at info@calduals.org.

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Questions and Discussion

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AGENDA ITEM NO. 5

TO: Provider Advisory Committee (PAC)

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

DATE: June 10, 2025

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

SUMMARY:

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

BACKGROUND/DISCUSSION:

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

The PAC consists of thirteen (13) committee members; there are currently two (2) vacant seats. Each appointed member can serve up to three (3) two-year terms and individuals can apply for reappointment if they haven't met their term limits. Pursuant to the PAC's Policy and Procedure, an ad hoc subcommittee must be created for the selection of new members. Accordingly, staff recommends the PAC re-establish a nomination ad hoc subcommittee to commence the selection process of new members.

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

RECOMMENDATION: Staff recommends the PAC reinstitute a nomination ad hoc subcommittee to commence the selection process of new members.