Gold Coast Health Plan[SM]
A Public Entity

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

Regular Meeting
Monday, May 20, 2024 2:00 p.m.
Meeting Location: 711 E. Daily Drive, #110 Camarillo, CA 93010
Community Room
Members of the public can participate using the Conference Call Number below.

Conference Call Number: 1-805-324-7279
Conference ID Number: 310 557 545 #

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

Clinicas del Camino Real
1040 Flynn Road,
Camarillo, CA 93012

Community Memorial Hosp
147 N. Brent St
Ventura, CA 93003

Human Services Agency
855 Partridge Drive
Ventura, CA 93003

Los Robles Hospital
215 W. Janss Rd
Thousand Oaks, CA 91360

AGENDA

CLERK ANNOUNCEMENT

All public is welcome to call into the conference call number listed on this agenda and follow along for all items listed in Open Session by opening the GCHP website and going to ***About Us > Ventura County Medi-Cal Managed Care Commission > Scroll down to Commission Meeting Agenda Packets and Minutes***

CALL TO ORDER

INTERPRETER ANNOUNCEMENT

OATH OF OFFICE

Phil Buttell, CEO, Los Robles Hospital

ROLL CALL

PUBLIC COMMENT

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

Persons wishing to address VCMMCC and Committee 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 and Committee.

Members of the public may call in, using the numbers above, or can submit public comments to the Commission and 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.

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Regular Commission meeting minutes of April 22, 2024

Staff: Maddie Gutierrez, MMC Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

PRESENTATIONS

2. Operations Of The Future (OOTF) Presentation on Provider Portal and Core Administration

Staff: Anna Sproule, Executive Director of Operations
Vicki Wrighster, Sr. Director of Network Operations
Paul Aguilar, Chief of Human Resources & Organization Performance Officer

RECOMMENDATION: Receive and file the presentation

FORMAL ACTION

3. 2024 Quality Improvement and Health Equity Transformation (QIHET) Program

Staff: Felix L. Nuñez, MD, MPH, Chief Medical Officer
Kim Timmerman, Sr. Director of Quality Improvement

RECOMMENDATION: Approve the 2024 Quality Improvement and Health Equity Transformation Program Description and Work Plan.

4. March 2024 Year-To-Date Financial Results

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests the Commission approve the March 2024 Year-to-Date financial results.

5. Year-To-Date Financial Review and Fiscal Year 2024/2025 Budget Review

Staff: Nick Liguori, Chief Executive Officer, and GCHP Executive Team

RECOMMENDATION: Staff requests the Commission review information and provide feedback to staff for budgeting and planning purposes.

REPORTS

6. Chief Executive Officer (CEO) Report

Staff: Nick Liguori, Chief Executive Officer

RECOMMENDATION: Receive and file the report

7. Human Resources (H.R.) Report

Staff: Paul Aguilar, Chief of Human Resources & Organization Performance Officer

RECOMMENDATION: Receive and file the report

CLOSED SESSION

8. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

9. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Commission &
Chief of Human Resources & Organization Performance Officer
Unrepresented employee: Chief Executive Officer

ADJOURNMENT

The next meeting will be on held on June 24, 2024, at 2:00 p.m., in the Community Room located at GCHP 711 E. Daily Dr. Suite 110, Camarillo, CA 93010

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

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

AGENDA ITEM NO. 1

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Maddie Gutierrez, MMC, Clerk for the Commission

DATE: May 20, 2024

SUBJECT: Regular Meeting Minutes of April 22, 2024

RECOMMENDATION:

Approve the minutes.

ATTACHMENT:

Copy of Commission regular meeting minutes of April 22, 2024

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
Commission Meeting
Regular Meeting via Teleconference & In Person

April 22, 2024

CALL TO ORDER

Committee Chair Dee Pupa called the meeting to order at 2:03 pm. in the Community Room located at Gold Coast Health Plan, 711 East Daily Drive, Suite 110, Camarillo, California.

INTERPRETER ANNOUNCEMENT

The interpreter made her announcement.

OATH OF OFFICE

J. Tabin Cosio took his Oath of Office.

ROLL CALL

Present: Commissioners Anwar Abbas, Allison Blaze, M.D., Tabin Cosio, Laura Espinosa, Melissa Livingston, Supervisor Vianey Lopez, and Dee Pupa.

Absent: Commissioners James Corwin, Anna Monroy, Sara Sanchez, and Scott Underwood, D.O.

Attending the meeting for GCHP were Nick Liguori, Chief Executive Officer, Alan Torres, Chief Information Officer, CPPO Erik Cho, CFO Sara Dersch, Marlen Torres, Executive Director, Strategy and External Affairs, Paul Aguilar, Chief of Human Resources, Felix Nunez, M.D., Chief Medical Officer, Robert Franco, Chief Compliance Officer, Ted Bagley, Chief Diversity Officer, Scott Campbell, General Counsel and Leeann Habte of BBK..

Also in attendance were the following GCHP Staff: Kim Timmerman, Nicole Kanter, David Tovar, Mayra Hernandez, Adriana Sandoval, Michelle Espinosa, Carolyn Harris, Lupe Gonzalez, Lily Yip, Joanna Hioureas, James Cruz, M.D., Kris Schmidt, Benjamin Lacey, Kim Marquez-Johnson, Anna Sproule, Victoria Warner, Zed Haydar. Jeff Yarges, Jan Schmitt, Chris Dulan, Corey Stephenson, Patricia Lingsin, Pauline Preciado, Vicki Wrighster, Jerry Wong, Josephine Gallella. Kevin Ortloff, Stacy Luney, Bianca Naron, Alison Armstrong, TJ Piwowarski, Sandi Walker, Paula Cabral, Lupe Harrion and consultants Don Harbart and Amit Jain.

Guests: Kyle Edrington, and Joe Costa.

PUBLIC COMMENT

Dr. Sandra Aldana stated she had concerns about the intersectionality between the new master plan for developmental disability services, the master plan on aging and CalAIM. She asked GCHP to speak with DHCS to try to figure out what training needs to be done; what educational information can be provided to all the different entities that are going to be implementing those Master Plans in collaboration with GCHP.

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Regular Commission meeting minutes of February 26, 2024

Staff: Maddie Gutierrez, MMC Clerk to the Commission

RECOMMENDATION: Approve the minutes as presented.

Supervisor Lopez motioned to approve Consent Agenda Item 1. Commissioner Espinosa seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Laura Espinosa, Melissa Livingston, Supervisor Lopez, Anna Monroy, and Dee Pupa

ABSTAIN: Commissioner Tabin Cosio abstained on Agenda Item 1

NOES: None.

ABSENT: Commissioners James Corwin, Anna Monroy, Sara Sanchez, and Scott Underwood, D.O.

2. Approval of Funds deposit into the Restricted Account for Knox Keene License

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Approve a deposit of $300,000 into a Restricted Deposit Account, in accordance with the licensure requirements under the Knox-Keene Act.

Supervisor Lopez motioned to approve Consent Agenda Item 1. Commissioner Espinosa seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Tabin Cosio, Laura Espinosa, Melissa Livingston, Supervisor Lopez, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: Commissioners James Corwin, Anna Monroy, Sara Sanchez, and Scott Underwood, D.O.

The clerk declared the motion carried for agenda items 1 and 2.

FORMAL ACTION

3. Election of Chairperson and Vice-Chairperson to serve two-year terms and appointments to the Executive/Finance Committee

Staff: Scott Campbell, General Counsel

RECOMMENDATION:

1. Elect a commissioner to serve as Chairperson for a two-year term.
2. Elect a commissioner to serve as Vice-Chairperson for a two-year term.
3. Make any necessary appointments to the Executive/Finance Committee as follows:
   a. Chairperson (same as Commission Chairperson).
   b. Vice-Chairperson (same as Commission Vice-Chairperson)
   c. Private Hospital Healthcare Representative (if required).
   d. Ventura County Medical Health System Representative (if required).
   e. Clinicas Del Camino Real Representative (if required).

General Counsel, Scott Campbell stated this is the biannual election of the Chair and Vice Chair as well as member of the Executive Finance Committee. He noted that the bylaws stated the current Vice Chair becomes the Chair. Vice Chair Espinosa will become the Commission Chair. There will be a separate vote for the Executive Finance Committee. He noted that both the chair and Vice Chair are automatically members of the Executive Finance Committee. Mr. Campbell also stated that there has to be one member from the private hospital system, one member from Clinicas, and one member from County Health Services.

PUBLIC COMMENT

Cynthia Salas stated that she wanted to speak on the Commission Chair appointment. Ms. Salas acknowledged Commissioner Laura Espinosa on her service with the Commission as a Consumer Representative. Ms. Salas stated Commissioner Espinosa had an unwavering commitment to the Ventura County community. She stated that Commissioner Espinosa worked diligently to ensure community voices were heard and integrated in decision making. Her advocacy was tireless. Ms. Salas voiced her gratitude for Commissioner Espinosa's dedication and noted that this appointment was long overdue.

Commissioner Abbas nominated Commissioner Espinosa as Chair of the Ventura County Medi-Cal Managed Care Commission. No second is needed.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Tabin Cosio, Laura Espinosa, Melissa Livingston, Supervisor Lopez, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: Commissioners James Corwin, Anna Monroy, Sara Sanchez, and Scott Underwood, D.O.

The clerk declared Commissioner Laura Espinosa as Chair.

Commissioner Espinosa stated she had a few words to share. She thanks the Commission for their vote of confidence in the upcoming term of leadership. She noted that she takes this role with commitment to continue the high-quality focus on members, the providers, and all stakeholders. She acknowledged Commissioner Pupa for her solid and competent leadership, and also thanked GCHP staff and legal counsel. She noted there will be a positive change with the addition of the D-SNP. She stated that she believes she brings value to the table along with knowledge, skills, and experience with the County system. She wanted all residents throughout Ventura County to receive a Model of care that they deserve.

Commissioner Espinosa noted that this role is a legacy to her parents. Her father was an early found of the Community Service Organization (CSO) in La Colonia in Oxnard and it was a precursor to the United Farm Workers Union. This organization does support services similar to GCHP with interpretation, food donations, voter registration, and cultural events for low income and farmworkers. She thanks both her parents for setting a good foundation. She stated that she hopes to develop and grow relationships in the upcoming years.

General Counsel, Scott Campbell stated that any member of the Commission is eligible for Vice Chair. The Vice Chair will serve as Chair if the current chair is on vacation or unable to serve at a meeting. Commissioner Pupa volunteered to serve as Vice Chair.

Commissioner Espinosa asked if past tradition were to rotate amongst commission so that there is a hospital rep could hold the seat. She noted that this is the first time for the Consumer Rep to hold a Chair position, this is historical.

Mr. Campbell stated there is no formal structure. Commissioner Espinosa nominated Commissioner Abbas from Clinicas for the Vice Chair seat. Commissioner Abbas accepted the nomination and stated that the commissioners should vote for the right person.

Roll Call Vote as follows:

Commissioner Abbas voted for Commissioner Pupa
Commissioner Blaze voted for Commissioner Pupa
Commissioner Cosio voted for Commissioner Pupa
Commissioner Espinosa voted for Commissioner Pupa
Commissioner Livingston voted for Commissioner Pupa
Supervisor Lopez voted for Commissioner Pupa
Commissioner Pupa voted for Commissioner Pupa

Commissioners Corwin, Monroy, Sanchez, and Underwood were absent.
Commissioner Pupa was elected Vice Chair.

General Counsel, Scott Campbell stated the next election will be for Executive Finance. The Chair and Vice Chair are automatically members of the Executive Finance Committee. He stated that currently Commissioners Abbas and Corwin are on the committee, and they fulfill the Clinicas seat and the private hospital seat. There is one seat open where any member of the Commission can serve on this committee. There are three seats open.

Commissioner Pupa nominated Commissioner Corwin for the hospital seat.

Roll Call Vote as follows:

In favor of Commissioner Corwin are Commissioners Anwar Abbas, Allison Blaze, M.D., Tabin Cosio, Laura Espinosa, Melissa Livingston, Supervisor Lopez, Anna Monroy, and Dee Pupa.

Absent: Commissioners Corwin, Monroy, Sanchez, and Underwood

Commissioner Corwin has been appointed to the Executive Finance Committee.

Next seat which must be filled by a Clinicas representative. Commissioner Espinosa nominated Commissioner Abbas. Commissioner Abbas accepted the nomination.

Roll Call Vote as follows:

In favor of Commissioner Abbas are Commissioners Anwar Abbas, Allison Blaze, M.D., Tabin Cosio, Laura Espinosa, Melissa Livingston, Supervisor Lopez, Anna Monroy, and Dee Pupa.

Absent: Commissioners Corwin, Monroy, Sanchez, and Underwood

Commissioner Abbas has been appointed to the Executive Finance Committee

General Counsel, Scott Campbell stated there is one open seat, and any commissioner can be appointed.

Commissioner Espinosa nominated Commissioner Livingston. Commissioner Livingston declined the nomination, she will be retiring the early part of next year.

Commissioner Espinosa nominated Commissioner Monroy. Commissioner Pupa nominated Commissioner Cosio. Commissioner Cosio accepted the nomination.

Roll Call Vote as follows:

Commissioner Abbas voted for Commissioner Monroy
Commissioner Blaze voted for Commissioner Cosio
Commissioner Cosio voted for Commissioner Monroy
Commissioner Espinosa voted for Commissioner Monroy
Commissioner Livingston voted for Commissioner Cosio
Supervisor Lopez voted for Commissioner Monroy
Commissioner Pupa voted for Commissioner Cosio

Commissioners Corwin, Monroy, Sanchez, and Underwood were absent.
Commissioner Monroy was appointed to the Executive Finance Committee.

General Counsel, Scott Campbell stated the next item on the agenda will be taken out of order to ensure that Commissioner Livingston can hear the presentation.

8. Strategy and Budget Principles and Framework

Staff: Sara Dersch, Chief Financial Officer
Erik Cho, Chief Policy & Programs Officer
Felix L. Nuñez, MD, MPH, Chief Medical Officer

RECOMMENDATION: Staff requests the Commission review information and provide feedback to staff for budgeting and planning purposes.

CEO Liguori stated this agenda item is specifically the principles and framework for the fiscal year 24/25 budget and three-year budgetary planning. He stated that our total revenue will be over $1.3 billion in the coming year. After the launch of D-SNP in 2026, we will see budgets well into the range of $1.5 billion to $2 billion. The Medi-Cal program is becoming increasingly complex with programmatic and regulatory requirements that demand more and changes are happening fast. He noted that management has forecast uncertainty especially in terms of premium revenue and population acuity.

CEO Liguori stated that the approach this year and going forward is to begin the budget engagement sooner to ensure the Commission have the context, concepts, facts, figures, and materials needed to govern a health plan with a billion plus dollar budget which is growing. He stated that D-SNP is a profound change for GCHP, and presents major risks, but also a great opportunity to serve more people. Management will be reporting the baseline information that is being used to draw up plans and budgets for the next three years. CEO Liguori stated that materials for budget review would be sent

to the Commission one week in advance of the meetings for May and June. Before beginning the budget topic CEO Liguori stated that high quality is the only way for us to succeed now and to thrive for the long term. Quality is our mission. Our budgets must ensure funding for our quality care mission and for the providers that deliver the care.

Chief Financial Officer, Sara Dersch, stated she would begin by going through the budget framework from a contextual as well as conceptual standpoint. She stated that this would be a multi-month process and concepts would be repeated throughout so that all would be familiar with the approach. CFO Dersch stated that when reviewing the framework, there are three primary stakeholders: the organization, the providers and most importantly, our members. It is vital that our care delivery system in the county has the sustained funding that is needed to provide timely quality care. We want to maximize our resources so that we can achieve the goals set.

We are committed to the budget process, committed to transparency, and quality will always be paramount ad our budget process will ensure that the delivery system has the appropriate funding. One of our objectives is to optimize that we are maximizing the quality spend for our members that will help us ensure not only viability for tomorrow and years to come. We can only remain viable long term if we have high quality and transparency.

CFO Dersch noted that management is beginning one month early to review budget building to ensure that our dollars are being invested with the maximize return on investment for our members.

Leeann Habte, from BBK Law stated that GCHP's goal is to ensure the fullest funding possible to the Ventura County Medi-Cal healthcare delivery system. We must determine that programs are in full compliance with the Corporate Integrity Agreement. She noted there is a comprehensive legal review to ensure compliance. We are responsible for efficient use of Medi-Cal dollars for the highest quality care funding. Funding must be adequate for providers who deal with inflationary cost and as the system moves toward value-based framework, we are seeking to ensure that funding provides value to the health plan and to our members as well as to our state and federal regulators who look at how we are providing the funding and how is it distributed. Ms. Habte stated that compliance under the Corporate Integrity Agreement remains a key standard for Gold Coast Health Plan. She noted that BBK will be performing a comprehensive legal review of each of the initiatives for providing funding, including the quality incentives, reimbursement arrangements and grants. Ms. Habte stated that BBK has also conducted a comprehensive review on the QIPP Program and will provide reviews on new programs.

CFO Dersch reviewed the process and timeline with key dates. She noted that there is a much more detailed review of the budget with the Executive Finance Committee first and then again with the Commission on May 20, 2024. Feedback is requested from mid-May through mid-June. There will be a reforecast coming up in another year, just as it

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was done this year. She noted that there is time to ensure that our priorities align with the strategies presented at the Strategic Planning meeting in December.

One of the factors to consider when putting the budget together is our Tangible Net Equity (TNE). CFO Dersch stated that we also look at other plans and their TNE. In comparison with other plans, Kaiser is at the top, Contract Costa is at the bottom, we are in the middle with a bit over 1000%. Thie TNE level will allow us to support our D-SNP operations, with its own requirements for reserves, but as we roll out D-SNP we will run losses, for the first few years. This is expected and is typical. Our TNE is healthy and will ensure that we remain in good fiscal health against uncertain events. CFO Dersch review our medical benefits ratio which is how we are trying to spend out money as a benefit. She reviewed the components. She noted that our initial QIPP is running at approximately 87%. There are layers added as we build our budget for next year. One of the layers is the expansion of the QIPP, which has been very successful, and we want to expand it. Another layer is transitional rates. These are the rates that we are providing for our providers to increase access to care and will account for approximately 2% in our medical cost. Another item that will impact our medical cost is the continuation of our grants for providers and community. This has also been a successful program. CFO Dersch did note that there will be some items that will impact our MBR, but those cannot be estimated yet.

CFO Dersch stated there are two sides of risk. There is an upside where the state gives us money through the TRI, but if we spend more that what the state gives us, it is a risk to us – we are responsible for that. This is a new program for this year and we just starting to get initial claims data, but currently it is hard to determine how this will impact our medical benefit ratio. The last component is our member incentives. These incentives have been helpful and successful in getting members into the care they need. Once adding these up you will see that our MBR is going from 85% to low nineties, therefore this will be a factor in our budgeting. Chief Medical Officer, Felix Nunez, M.D. noted that these investments represent real value to our organization, all most all of them touch our MCAS scorecard. CFO Dersch stated these are real investments that are helping to build what we need to build as a health plan to be resilient in the future. These investments will ensure future higher reimbursement revenues from the state. The revenues are driven by quality.

CPPO Erik Cho stated that one key take away is that regional rate setting is coming and that adds a dimension to how we need to plan our costs. We must continue to focus on quality and value, which is how we will stay ahead of the curve. The analysis of unit cost closely approximates a comparison of reimbursement rates. One key to future rate development is the maintenance of traditional fee for service spending should be in line with spending across Medi-Cal plans and outlier fee for service spending is at risk of not being fully reimbursed as DHCS looks to create greater regional cost parity. This means that currently we are held to a way that we set future reimbursement based on the cost that go out is specific to GCHP. The costs are evaluated and brought back to bear as additional reimbursement to the plan. Regional rate setting is not just GCHP, it is GCHP and other plans that are considered to be in the region that we are in. We anticipate it to

be a blended rate. Regional rate setting is going to replace individual rate setting in the near future. We are actively preparing our reimbursement program to success in this new premium paradigm. CPPO Cho noted that quality is first and foremost for us, and that will be a driver to how we can succeed going forward. It is important for us to maintain quality, to maintain funding and for us to stay in line with regional cost. In order to drive forward quality we need to drive forward improvements in MCAS. We want to move the MCAS and quality needle.

CFO Dersch stated she will review how spending our TNE will look from a financial perspective. She reviewed the net income history back to 2011. She noted that those years ended in a deficit. She noted that when we have surpluses, which adds up over time, and that is what comprises our TNE when we have a deficit, we draw back down from that TNE to help fund that deficit. Our TNE has started to grow but over the next three years we expect our TNE to come down due to the provider incentives and the D-SNP.

CFO Dersch reviewed how the organization plans to spend some of our TNE. Currently we are at 1025% of our required TNE. We will not touch 700% of the TNE per Commission rule restricted, this leaves 325% that is available to use. CFO Dersch reviewed how the 325% will be used. When we roll out the D-SNP plan there are going to be reserve requirements specific to that plan. We will put $300,000 into a restricted account. That is the minimum reserve required for zero members. As we grow our members the reserve amount will go up. We are expecting a few members for the first few years – this is typical of a D-SNP plan. If you do not have a certain minimum number of members then fixed costs are going to exceed your revenue, that is expected, and we are going to have to use some of that TNE to help fund the D-SNP plan.

We would like to take $60 million out of our TNE and spread that across the delivery system and value -based care. This will be over the three years. We will revisit the amounts every year. This will help ensure our members get the right care at the right place at the right time. It will also ensure that all of the care is focused on quality so that will lead us to increased revenues in the future. This approach maximizes what we can get out to the care delivery system without dipping below the 700%. It is critical that we maintain the 700% and it is critical that we maintain the $60 million for D-SNP so that it will be successful.

CFO Dersch stated that these are already our members and instead of having to go to another health plan for their Medicare, they can stay with us and their current providers. She noted that we will have deficits for the next three years, but we have plans for how to fund those deficits. It has been well thought through. We are happy to be able to maximize the dollars that will go out to the provider.

CPPO Cho stated we are putting our money into the system, create change now and create a lasting impact and support the delivery system of all our providers in the county. The spend that will include the plan to expand the QIPP plus our grant target is $55 million. We are working to provide the support necessary for our providers, and in doing

that we have increased base and reimbursement rates across the network to an estimated $30 million annually. This is not all the money that is going out to the providers, but we do want to focus on driving quality. We are proposing that funding continue, and it will grow significantly $247.5 million of projected spend over the next three years. This is divided into three areas: quality incentives, transitional rates, and provider grants.

Commissioner Pupa stated she wanted to be clear that she was clear on the information. She stated that the different shaded blue bars on the graph are two different buckets. We need to invest into our current population which is the light blue area. It is an investment into our members, and it helps protect our rates because if you do not spend a certain amount, it has detrimental impact on rates in the future. She noted that enjoyed this presentation in Executive Finance because you are looking forward in the budget process instead of being hung up in the current year. We need to look to the future and where we will be in a few years. Sometimes we need to take a bit of a hit to maintain rates for the future. When were at a loss a few years ago, it was $52 million, but it was not planned. This loss is planned. The two different categories of expense for D-SNP and the rest of the population because it is important when it comes to the rate setting.

CPPO Cho stated that with the $60 million we are trying to put it to best use to impact our members. In looking at 2025, 2026, and 2027 the projected spend is $247.5 million. What we want to do is put out a dollar amount that we are able to within business, legal and compliance. The $60 million would be part of it. The rest of it is coming from the operational budget. We want to put as much of our funding as possible to drive quality for our members. We are looking at a large projection of what we want to put towards the community.

CFO Dersch stated that every year we go through a rate setting with the state. We show our historical cost, and they reimburse a certain dollar amount per member per month based on current utilization and current member mix, as well as based on a category of a demographic category. With regional rate setting, the state is no longer going to look at our cost, they are going to be looking at cost of other Medi-Cal plans in our area; but we do not know what “in our area” means. We are waiting to get more information from the state. We do not want to be at the top because that means when we get to rate setting the state can say that a bit too much everyone is paying less, so we are going to reimburse you less. It is critical that we maintain a position in the middle. We also want to think about quality spend, the state looks at quality scores as part of the rate setting process. The higher the quality scores you get a bonus/ a little bump. The stated can say you spend a lot of money, but you have really high quality, good for you. We have to spend the money for a couple of years to get quality scores up before the state recognizes that. We will see revenue enhancements from our current increase in quality scores in two years, not next year. This is another reason we need to run a deficit. You have to spend the money before the state will recognize, and it is a similar process for Medicare.

CPPO Cho stated the QIPP expansion is going from ten measures to fourteen out of essentially eighteen measures that are held to the MPL (Minimum Performance Level)

for which there will be incentives. These are investments and the idea is to bring value to the organization, to build resilience, and strength as we go forward. Everything that we are doing ties back to the MCAS goals. These incentives are what our providers can earn if our members' health improves, and if there is more access to care.

Last year we presented a concept of $25 million in grant investment for a two -three-year time period. We want to deliver that early and have that initial investment program by the end of this calendar year. CPPO Cho stated that more information will be presented as things unfold.

Chief Medical Officer, Felix Nunez, M.D. reviewed the D-SNP Medicare forecast and how it impacts our TNE. There are four variables considered: membership, year after year, CMS quality rating, managed care savings, and provider reimbursement levels. There will be 3-year cumulative losses. We must be strategic on how we approach the work. Our star rating scenario is critically important, we have to begin to maximize this rating and associate quality payments. The star ratings will impact how we are reimbursed as a health plan. The star rating system is made up of measures, similar to our MCAS measure. They also include our CAPS measures, medication adherence measures, health outcome survey, and our administrative measures. The CAPS, health outcome survey measures, and the medication adherence measure are critically important. The ratings are dependent on those metrics, and we need to build on the framework to be able to succeed and achieve the star ratings. If they are not achieved, it could turn into a risk instead of a positive. We anticipate that membership will come from those who age into Medicare or meet criteria due to disability by 2026. We have to start small and grow slowly. CMO Nunez noted this is a new process in California. We have to be measured, we have to be careful as we do this work, large initial membership will put stresses on our financials. It is a risk that we must try to contain and mitigate as we go forward. The Medicare payment model is based on a benchmark for the county. This is adjusted based on the risk of the membership. Rates are adjusted based on the level of disease burden that our membership has and the needs of the membership. This is not automatic; it is re-set every year. It is a continual process and a discipline that we need to start building within our network. To be financially viable, we have to manage the traditional medical costs of hospital, physician care, and managing pharmacy costs. The takeaway is that we know that bringing in these dual members fully into the network is critically important.

CFO Dersch stated that it is critical that we plan now so that we do not end up with a worst-case scenario. We do expect to be profitable by year four, which is what we have filed with the state. To do that, we need to have the quality in place, we need to have the stars in place, and we also have to have the membership. Success depends on us being ready to manage all of this.

Commissioner Pupa stated that she wanted to congratulate everyone on the Knox Keene license application. It is a tremendous undertaking.

Commissioner Livingston left the meeting at 3:33 p.m.

4. Consideration of appointments to the Compliance Advisory Committee

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Staff requests that the Commission determine whether it wants to fill the vacancy in the Compliance Oversight Committee.

General Counsel, Scott Campbell stated one of the requirements of the Corporate Integrity Agreement is that we have a Compliance Oversight Committee. The committee has consisted of four members: Chair Espinosa, Vice Chair Pupa, and Commissioner Corwin are current members. We can have four members, which is easier to get a quorum. We need to add one more commissioner. The committee meets four times per year, just before a commission meeting.

Commissioner Espinosa stated we need one volunteer. Supervisor Vianey Lopez volunteered to join the committee.

Roll Call Vote as follows:

In favor of Supervisor Lopez are Commissioners Anwar Abbas, Allison Blaze, M.D., Tabin Cosio, Laura Espinosa, Supervisor Lopez, Anna Monroy, and Dee Pupa.

Absent: Commissioners Corwin, Livingston, Monroy, Sanchez, and Underwood

Supervisor Lopez has been appointed to the Compliance Advisory Committee.

5. Revised Provider Advisor Committee Charter

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

RECOMMENDATION: GCHP's management team recommends that the Commission approve the revised PAC Charter.

Marlen Torres, Executive Director of Strategy & External Affairs stated that one of the asks from the last Commission meeting was to go back and determine if all members of the Provider Advisory Committee (PAC) were to have term limits. After review and discussion at the PAC meeting on March 5, 2024, it was determined that all committee members will have a two-year term limit with no exception. The committee was increased from eleven members to thirteen members. These revisions were unanimously approved by the PAC. A key component for the PAC is to also be able to provide feedback on the GCHP Model of Care, as well as feedback on improving access to quality care. Non-traditional providers were also included for this committee. One

other key change was to also include a health equity component review under the PAC charter.

Commissioner Espinosa asked if the Compliance team or legal had reviewed the changes. Scott Campbell, General Counsel, stated the review was done.

Commissioner Pupa motioned to approve Agenda Item 5 as presented. Commissioner Abbas seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Tabin Cosio, Laura Espinosa, Supervisor Lopez, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: Commissioners James Corwin, Melissa Livingston, Anna Monroy, Sara Sanchez, and Scott Underwood, D.O.

Motion carried.

6. Addition of New Provider Advisory Committee (PAC) Members

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

RECOMMENDATION: GCHP's management team recommends that the four (4) individuals recommended be approved by the Commission as new PAC members. Once approved by the Commission, they will be contacted of their official appointment.

CPPO Cho stated this item is in direct relation to the previous agenda item. This is a request for approval of four new PAC members. Ms. Torres reviewed each of the members who are being considered. She stated that we sought and achieved a well-represented group of providers including non-traditional providers and there is now a diverse group to represent the PAC committee.

Commissioner Espinosa stated the diversity of this group will add a different perspective. She asked if practitioners of Indigenous practices might be included when there is a vacancy.

Supervisor Lopez motioned to approve Agenda Item 6 as presented. Commissioner Espinosa seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Tabin Cosio, Laura Espinosa, Supervisor Lopez, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: Commissioners James Corwin, Melissa Livingston, Anna Monroy, Sara Sanchez, and Scott Underwood, D.O.

Motion carried.

7. Operations of the Future (OOTF) Readiness Report

Staff: Jan Schmitt, Principal Project Manager
Anna Sproule, Exec. Director of Operations
Marlen Torres, Exec. Director of Strategy & External Affairs
Alan Torres, Chief Information & system Modernization Officer
Paul Aguilar, Chief of Human Resources & Organization Performance Officer

RECOMMENDATION: Receive and file the report.

Anna Sproule, Executive Director of Operations, stated that GCHP has launched the Operations of the Future initiative which entails transitioning from two vendors to nine vendors for procuring systems and services. The build is currently in progress and is on track with out targeted Go-Live as July 1, 2024. The member portal is currently on hold. All other categories are on track. This initiative represents a significant operational shift since the inception of GCHP. We are currently transitioning from the technical to focusing on operational readiness. It poses a challenge in aligning newly built technical infrastructure with efficient operational workflows and ensuring team preparedness. Expanding our vendor integration from one to nine will test our oversight and management capacity, which will require improved coordination and resource allocation. There are several challenges and opportunities with any operational transformation. Significant opportunities are improving efficiency, agility and ultimately driving long-term success.

CEO Liguori thanked the Commissioner for their support. We are now moving into regular reports on our readiness and these reports will continue to be presented monthly.

Ms. Sproule stated that this report focuses on Member Services Everywhere. It is the key element of the operations of the future and the one piece that is bringing the member services call center function to an in-house team based in Camarillo. We have not only brought in a member services call center but have created a comprehensive community-based service program that aims to enhance the quality of service that we provide, improve responsiveness, and streamline communication channels between the member and the organization.

GCHP has hired call center staff, and they are ready for July 1st. The team in place will handle approximately five hundred inbound calls per day, and up to 10,000 per month. We have tailored the approach and will meet needs effectively by directly managing the work. We can ensure high level of quality control and consistency in the services that we provide to our members. We can implement best practices and adapt quickly to changes as needed, leading to continuous improvement, and fostering a sense of ownership and commitment among the team.

Marlen Torres, Executive Director of Strategy & External Affairs stated that this is about connecting members with care, improving quality and the importance of the scorecard. The staff that has been hired is bilingual, and bicultural, which is critical to understanding our members.

We are embedding member care ambassadors into our provider sites. We are able to be out and meet members, identify care gaps, schedule appointments and provide support outside of the provider office with resources and referrals.

Another key component is possibly having storefronts or resource centers, satellite offices in the community a place where members can go to have questions answered or maybe have a screening. We are looking at some of the most populated focused areas such as South Oxnard, Santa Paula, and Fillmore areas. Once these satellite offices are implemented, updates will be provided.

Ms. Sproule stated the Call Center team has received extensive training covering subjects such as Model of Care, Medi-Cal benefits and services, and also transportation benefits. She noted that the outbound calling initiatives have been in progress to assist with MCAS gaps in care, aiming to connect member with the care that they need.

In the next fiscal year, the budget will include additional call center support staff. Supervisor Lopez asked what the hours for the call center are. Ms. Sproule stated the current hours are 8AM – 6PM Monday through Friday. The Center is streamlined to provide better member support, with the ability to make an appointment while on the phone with the member who maybe having difficulty connecting with a specific type of care. We have the ability to see the entire member profile, discuss gaps in care and provide member care plans all from one centralized location.

Ms. Torres stated that we are making sure that we are supporting the member. These team members leave our members feeling that GCHP will follow through and connect them with the care they need.

Commissioner Cosio asked what other languages other than English and Spanish are represented. Ms. Sproule stated those are the two threshold languages for our county, but there are staff who speak other languages, and we also have a translation service that can get on a call if needed as well as TTY.

Commissioner Cosio asked about the hours being 8AM – 6PM – that is over forty hours per week. Ms. Sproule stated some start at 8AM, some start at 9AM to make sure there is coverage until 6PM.

Ms. Sproule stated we want to ensure that we meet all of our regulatory requirements and serving beyond the regulatory requirements, serving the need of the member. We are not just answering the phone, we spend time connecting the member with an appointment. Some of the staff spends up to thirty minutes on a call to set up first PCP visits. We want to make sure that we are setting ourselves and our members up for a successful relationship.

CEO Liguori stated staff would be available to review in depth our comprehensive demand versus capacity analysis. Our intention is an increase in calls. These are opportunities for us to reach out to new members and understand who they are before claims show up six months to one year later. This is an opportunity at the point of new enrollment to understand what their healthcare needs are and to help get those needs met.

Supervisor Lopez stated this is a breakthrough capability, and asked if twenty-two is actually short of that will be needed. She also thanked Ms. Torres for her dedication to providing service to the community.

Commissioner Pupa motioned to approve Agenda Item 7 as presented. Supervisor Lopez seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Tabin Cosio, Laura Espinosa, Supervisor Lopez, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: Commissioners James Corwin, Melissa Livingston, Anna Monroy, Sara Sanchez, and Scott Underwood, D.O.

Motion carried.

9. February Year- to-Date Financial Results

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff requests the Commission approve the February Year-to-Date financial results.

CFO Dersch stated our results continue to underscore financial health. We have noticed a back to pre-pandemic trend. She stated that some of the excess surplus that we have

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had every month is starting to go down. We are starting to see utilization go back up, but it is safe to say that we expected this to happen.

We continue to see some uncertainties in Medi-Cal. She noted there was a take back in revenue by the state, and that will continue. The state continues to have a significant deficit in their budget, therefore it is critical that we start to tap into the TNE and use that before the state can say you are not using that, so we will use it for you. We want to make sure we get those dollars out to our community.

Membership continues to remain strong. We are having membership growth that we did not anticipate. Much of that is through the redetermination, which has been very successful. Another unanticipated membership growth is in the new expansion population that is newly eligible for Medi-Cal full benefits from the state. Those are adults aged 26 through 49 that have an immigration status that is deemed “unsatisfactory” by the state. We are happy to serve these members, they live in our community.

CFO Dersch reviewed reimbursement categories. Reimbursement levels for the “unsatisfactory” immigration status are less than for the “satisfactory” immigration status, which is tied to the Medi-Cal funding comes mostly from the state. There is a portion that comes from federal government. We cannot use the federal funding for the benefits of the “unsatisfactory”. This is one of the primary reasons for a lower reimbursement amount.

CFO Dersch noted that our quality improvements are on track. We have been able to accelerate the QIPP payments. We are also continuing to track and monitor some of our utilization cost, primarily inpatient and long-term care. We are starting to see upward ticks in inpatient rates, but also in utilization. She will continue to monitor and work closely with Dr. Nunez and his team on understanding encounter data instead of waiting for claims to come in. By using encounter data, we can find out who is in the hospital now, why were they there, and we will be able to provide more reporting.

CFO Dersch stated that we are watching how we are spending our dollars, and we take action when needed and appropriate.

We are trending favorably on revenue for a year-to-date perspective because our membership is higher. One of the measures we monitor is our per member per month, so that normalizes for the membership volumes.

CFO Dersch noted that there was a $16.1 million take back from the state which was associated with 2023 acuity. They say they overpaid. They though we were going to have sicker members. They saw we had quite a lot of money left over at the end of the year, so they said we will take some of that back. We will get final numbers for this take back within the next week or two. It could go up. The stated has reserved the right through the end of April to take back more, so we must be prepared for this uncertainty.

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In our month-to-date versus our year-to-date our MBR is 100.2%. This includes the QIPP acceleration, which we increased by $12.5 million. If you take out the QIPP acceleration, we are down to 85%. This shows that the accelerating of the QIPP was prudent, given our strong fiscal health.

Our incurred but not paid claims – this is our reserves that we set aside. Claims are generally not submitted to us until up to 90 days after the month that the claim was incurred. We have come up with a way to estimate what we think that reserve amount should be. We look at historical data, we look at seasonal data. We are seeing that historical trends for inpatients as indicating we should increase our reserves because that utilization factor is going up. We must also consider the new members that were unplanned, they are going to the doctor and getting services. We also put in a factor for that to cover the services that are being provided. We just have not received a claim. The final factor is redetermination, we have more members that were able to come back than we set aside reserves for. There is nothing in the utilization other than a slight uptick in in-patient that would indicate there is a reason for concern from the medical benefits perspective.

We have a very disciplined approach to reviewing administrative day to day expenses on a monthly basis. We also have a new resource optimization process ensuring we have the right employes at the right time and place. From a February perspective our admin expenses were $7 million versus the reforecast of $7.3 million. If you look at our year to date spend of $57.7 million is less than $100,000 off of our reforecast. We keep our focus on costs we cannot control so that we can maximize the dollars that we use for medical cost and for other initiatives. The project portfolio, while $1.2 million unfavorable for the year and $2.7 million unfavorable was driven by an acceleration so that we could be ready to go on July 1, and we have executed some initiatives that will drive that operation. We will see that deficit minimize.

After we take all of our revenues and then subtract out all of our costs on a month to date perspective, you see we ended up in a deficit situation, that is driven by the acceleration of the QIPP payments from a month-to-date, a year-to-date perspective. We have a positive $17.6 million net income. We continue to add to our TNE, at a much smaller amount than we had reforecast. The reforecast was done before we knew about the state take back, and before we had decided to accelerate the QIPP. We are still managing well.

In looking ahead there will be one more acceleration of QIPP which will results in another $4.9 million of expense for the month of March. There is a potential for a reduction in our reserves in the last quarter of the fiscal year. There is a final acuity change coming from DHCS at the end of the month, and we are waiting on that.

Commissioner Abbas motioned to approve Agenda Item 9 as presented. Supervisor Lopez seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Tabin Cosio, Laura Espinosa, Supervisor Lopez, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: Commissioners James Corwin, Melissa Livingston, Anna Monroy, Sara Sanchez, and Scott Underwood, D.O.

Motion carried.

Commission Chair Espinosa asked if Agenda item 8 was approved. General Counsel, Scott Campbell stated this item was a review of information and request for feedback be provided, which was done. There is no need for a vote.

General Counsel Scott Campbell stated there is a consultant for Closed Session items and Mr. Campbell is requesting that reports 10, 11, and 12 be approved, if there are no questions.

Commission Chair Espinosa asked the members if there were any questions on the reports. Hearing none

Commissioner Pupa motioned to approve Agenda Items 10, 11, and 12 as presented. Commissioner Espinosa seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Allison Blaze, M.D., Tabin Cosio, Laura Espinosa, Supervisor Lopez, Anna Monroy, and Dee Pupa

NOES: None.

ABSENT: Commissioners James Corwin, Melissa Livingston, Anna Monroy, Sara Sanchez, and Scott Underwood, D.O.

Motion carried.

REPORTS

10. Chief Executive Officer (CEO) Report

Staff: Nick Liguori, Chief Executive Officer

RECOMMENDATION: Receive and file the report

11. Chief Medical Officer (CMO) Report

Staff: Felix L. Nuñez, MD, MPH, Chief Medical Officer

RECOMMENDATION: Receive and file the report

12. Human Resources (H.R.) Report

Staff: Paul Aguilar, Chief of Human Resources & Organization Performance Officer

RECOMMENDATION: Receive and file the report

Open session ended at 4:48 p.m. General Counsel, Scott Campbell reviewed the titles of the Closed session items to be discussed.

The Commission went into closed session at 4:50 p.m.

CLOSED SESSION

13. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

14. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Executive Finance Committee
Unrepresented employee: Chief Executive Officer

ADJOURNMENT

The meeting was adjourned at 6;17 p.m. There was no reportable action.

Approved:

____

Maddie Gutierrez, MMC
Clerk to the Commission

AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Anna Sproule, Executive Director of Operations
Vicki Wrighster, Sr. Director of Network Operations
Paul Aguilar, Chief of Human Resources & Organization Performance Officer

DATE: May 20, 2024

SUBJECT: Operations Of The Future (OOTF) Readiness Report

PowerPoint with Verbal Presentation

ATTACHMENTS:

Operations of The Future Readiness Report

Gold Coast Health Plan

Operations of the Future Readiness Report

May 20, 2024

Paul Aguilar, Chief of Human Resources & Organization Performance Officer
Anna Sproule, Executive Director Operations
Vicki Wrighster, Sr. Director, Network Operations

Integrity

Accountability

Collaboration

Trust

Respect

Operations of the Future – Readiness Report

Return to Agenda

GCHP Operational Readiness Update

OOTF Phase Completion:

- GCHP is now completing the Operations of the Future (OOTF) phase of configuration, testing, and training that will yield "Operational Readiness" for Day 1 Operations on July 1st.

Regular Commission Reports:

- At every Commission meeting in 2024, GCHP Management will provide a report on OOTF readiness and performance.

Current Focus:

- This month, we provide a deeper understanding of readiness of the Provider Portal and Core Administration System and Services.

Readiness – Executive Summary

On Track

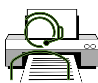
Core Admin
HRP

On Track

Medical Management
TruCare

On Track

BPO
Netmark

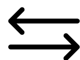


On Track

Print/Fulfilment

On Track

Mail Room/ Imaging



On Track

EDI
Edifecs TMaaS

On Track

Provider Portal
NTT vendor

On Track

Data Conversion
EDP/MDW

On Track

Call Center

On Track

Member Experience

On Track

Org Readiness

Procurement Done

Member Portal
NTT vendor

Provider Portal

Vicki Wrighster, Sr. Director Network Operations

Benefits of NTT Data Portal

- Providers gain improved visibility into the comprehensive care of GCHP members, positively affecting patient care by facilitating better access to member information
- The system's simplicity contributes to heightened provider satisfaction, consequently leading to increased member satisfaction
- The NTT portal is extremely user-friendly
- Advanced functionalities provide clearer insights into the status of authorization and claims processing
- The enhanced user-friendly features result in expedited, timely, and precise access to member information
- A streamlined registration process for provider portal users ensures smoother operations

PROVIDER PORTAL – Current State

- Dependence on GCHP for registration procedures
- Separate sign-on requirements for each provider location
- Few self-service functionalities
- Limited to professional claims submission
- Utilization of electronic claim and authorization submission methods
- Only Network wide provider messaging available
- Providers must contact GCHP to assist if user loses passwords and/or usernames

PROVIDER PORTAL – FUTURE STATE (NTT DATA)

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Enhanced provider autonomy in portal registration processes

Improved intuitiveness and user-friendliness

Capability for both professional and facility claims submission

Integration of global and targeted provider messaging functionalities

Facilitation of access to multiple contracted locations via a unified sign-on mechanism

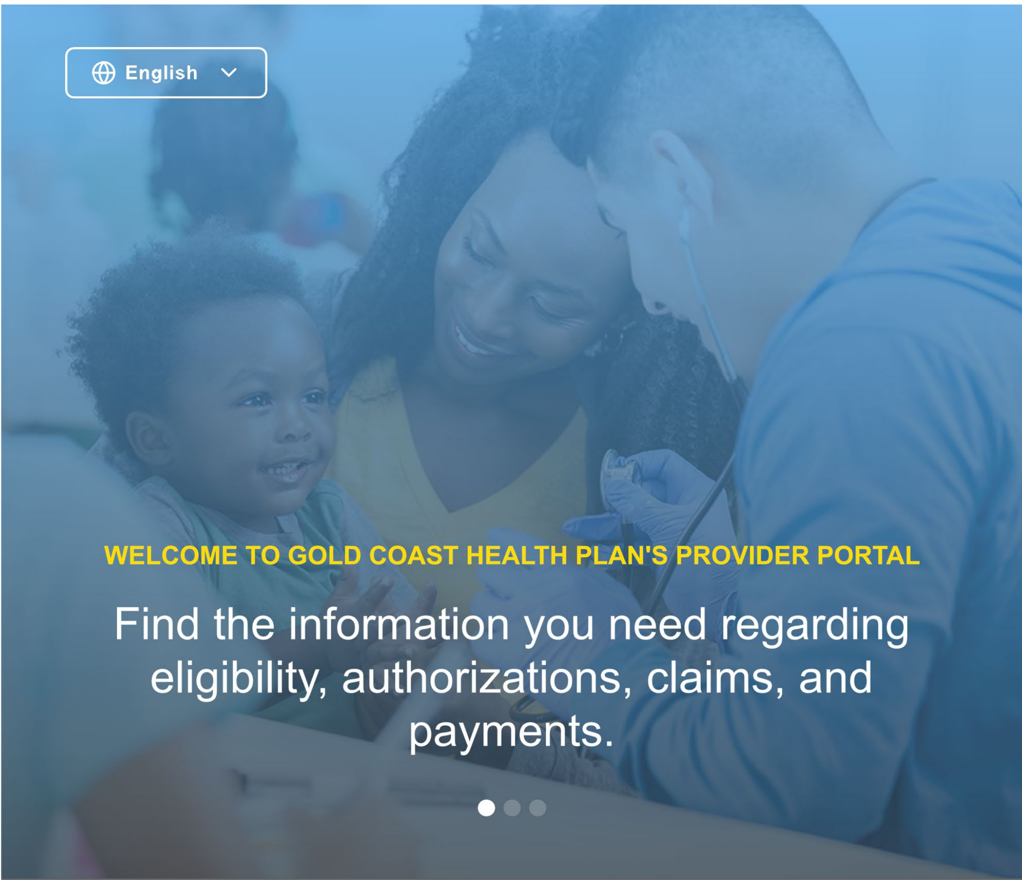
Strengthened security through the implementation of Two Factor Authentication

Self-service functionality available for resolving issues related to lost passwords and usernames

Introduction of a new widget feature providing comprehensive insights into the status of claims and authorization submissions

Eligibility data presented clearly and thoroughly, including Other Health Insurance information

PROVIDER PORTAL DEMO



Username*
abc@zxy.com

Password*
••••••

Forgot Username or Password

Login

Not a Provider? Register here

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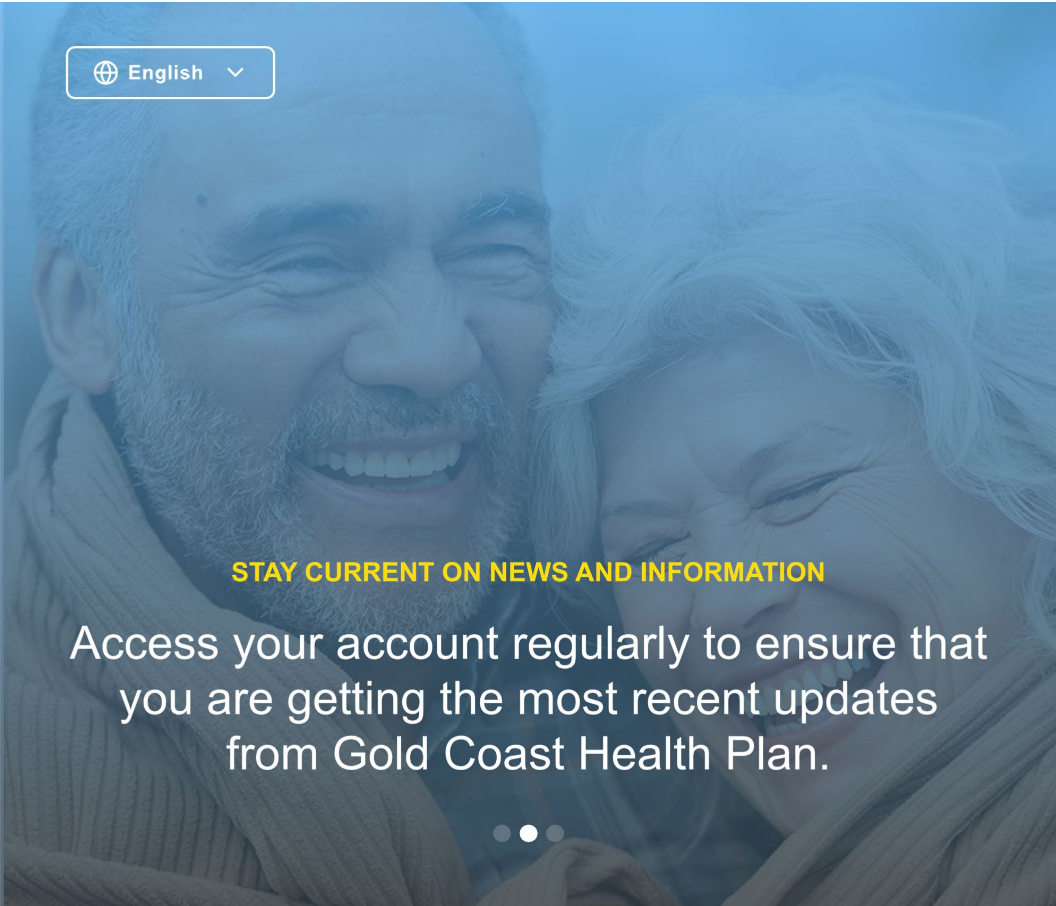
PROVIDER PORTAL DEMO



Username*
abc@zxy.com

Password*
••••••

Forgot Username or Password

Login

Not a Provider? Register here

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PROVIDER PORTAL DEMO

English

GET IN TOUCH WITH YOUR PROVIDER RELATIONS TEAM

Send us a secure message and a member of the team will respond.

Username*
abc@zxy.com

Password*
••••••

Forgot Username or Password

Login

Not a Provider? Register here

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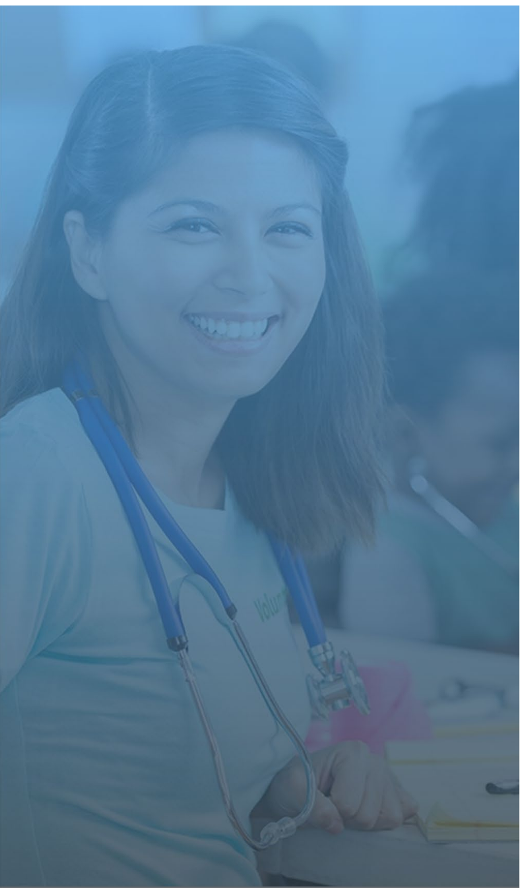
PROVIDER PORTAL DEMO



REGISTRATION

Step 1 of 3

Choose the type of user

- (•) Vendor
- ( ) Office Location

Billing Tax ID*

Note : Third party vendors should not register as provider admin without approval from contracted provider.

Back | Validate

PROVIDER PORTAL DEMO

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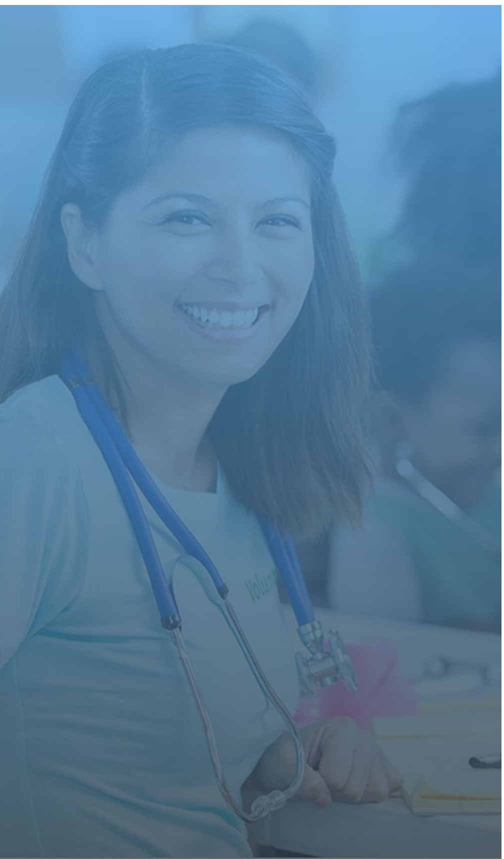

REGISTRATION

Step 1 of 3

Choose the type of user

- ○ Vendor
- ◉ Office Location

Billing Tax ID*

Location ID*

Back **Validate**

PROVIDER PORTAL DEMO

English · Font Size — +
Secure Messages · Hello, Provider Smith

Gold Coast Health Plan

Currently viewing Tax ID: 23-333540 · Manage Tax ID

Dashboard · Patient Eligibility · Authorizations · Claims · My Practice · Account Management · Tools and Resources

Welcome, Provider Smith

I Want To
- Manage Tax ID
- My Panel
- Find a Doctor
- Search for Claims
- View Authorizations

Find A Member

Find your patient and check eligibility

Go to My Patients →

Claim Statuses

Claims Statuses For last 30 Days

Showing Data for
Tax ID XXXXXXXXXX

16 · 7 · 9

Approved · Denied · Pending

Notifications

Incomplete Work History
3 days ago →

Jane Doe, MD
PA - 09/23/2023
The claims from your facility have been processed.
3 days ago →

Jane Doe, MD
PA - 09/23/2023
You have new message in your inbox.
1 day ago →

Claims Financials

Financials In last 30 Days

Showing Data for
Tax ID XXXXXXXXXX

Claims Billed	Claims Denied	Payments Received
$15798	$5266	$5266

Authorizations

Authorizations In last 30 Days

Showing Data for
Tax ID XXXXXXXXXX

3 · 8 · 6 · 4

Approved · Denied · Partial Approval · Pending

Provider News

Appropriations Act, 2020, Medicare Administrative Contractors will be mass adjusting certain Federally Qualified Health Center (FQHC) claims with dates of service on or after January 1 through March 1, 2023. https://www.cms.gov/outreach-and educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-02-27 -
04/18/2023
5 days ago →

Chat

All data is dummy data

Return to Agenda

PROVIDER PORTAL DEMO

English | Font Size – + | Secure Messages | Hello, Provider Smith

Gold Coast Health Plan

Currently viewing Tax ID: 23-333540 | Manage Tax ID

Dashboard | Patient Eligibility | Authorizations | Claims | My Practice | Account Management | Tools and Resources

PATIENT ELIGIBILITY

Minimum Search Combinations:

- Information provided below will be cross-checked with member eligibility records for all programs
- Member ID: Brings back a match only when a complete Member ID is entered and an exact match is found.
- Last Name + Eligible as of Date + Date of Birth: May use partial name.
- First Name + Eligible as of Date + Date of Birth: May use partial name.

Clear | Search

Line	Member ID	Member Last Name	Member First Name	Date of Birth	Eligible as of Date	Actions
1	98768753E				07/12/2023	
2	98746374D				07/12/2023	
3						
4						
5						
6						
7						
8						
9						
10						

Clear | Search

All data is dummy data

PROVIDER PORTAL DEMO

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English | Font Size — + | Secure Messages | Hello, Provider Smith

Gold Coast Health Plan℠ A Public Entity

Currently viewing Tax ID: | **Manage Tax ID**

Dashboard | **Patient Eligibility** | Authorizations | Claims | My Practice | Account Management | Tools and Resources

Home > Patient Eligibility > Search Result

Back to Patient Eligibility | **Export**

Search Result

Please click on the Member ID to view detailed eligibility information.

Eligible as of Date	Member ID	Member Name	Member Date of Birth	Address	Phone No.	Eligibility Status	PCP
07/01/2023		Michelle Swan		Oxnard, CA 93036	9	Eligible: Medi-Cal	Office 5051 Verdugo Way STE 100 PCP Name: Dignity Health Med Group Verdugo Way
07/01/2023		William Jones		Oxnard, CA 93036	9	Inactive	Office 5051 Verdugo Way STE 100 PCP Name: Dignity Health Med Group Verdugo Way

Modify Search | **New Search**

All data is dummy data

PROVIDER PORTAL DEMO

Currently viewing Tax ID: 23- | Manage Tax ID

Dashboard | Patient Eligibility | Authorizations | Claims | My Practice | Account Management | Tools and Resources

PATIENT PANEL

Member ID | Member First Name | Member Last Name

PCP Location* | Search

05 Patient Found

Export

Member ID	First Name	Last Name	DOB & Gender	Effective Date	Term Date	PCP	NPI	Action
10 E		Simpson		01/01/2023	12/01/2023	Crest Medical Group Lakeshore	23 1	⋮
23 A		Wrights		01/01/2023	12/01/2023	Ventura Medical Group	23 1	⋮
23 A		Motto		01/01/2023	12/01/2023	Crest Medical Group Lakeshore		
23 A		Lewis		01/01/2023	12/01/2099	Crest Medical Group Lakeshore	23 4	⋮
2 A		Johnson		01/01/2023	12/01/2099	Crest Medical Group Lakeshore	23 1	⋮

View Claims
View Authorization
View Eligibility

1 | 10 Per Page

16

Core Administration System

Anna Sproule, Executive Director Operations

CORE ADMINISTRATION SYSTEM OVERVIEW

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- **What is the Core Admin System?**
  - Central point technology for claims processing, provider payments, and member eligibility. Also, the data stem of claims, payments, and eligibility data interfacing that occurs withing large complex array of other systems that GCHP uses for care, quality, service, and other major functions of health plan administration.
- **The Primary Goal of Procurement Process for Core Admin System:**
  - Evaluate GCHP current and future needs for core admin system/technology (Medi-Cal and D-SNP Medicare) against the rapidly advancing and value-driven market that provides systems and services to the nationwide health plan industry.
- **System Selected:** HEALTHEDGE
  - On the bases of capabilities, performance, industry reputation, and cost/value, among other factors, Health Edge was selected as the core admin system vendor of the future. This will propel GCHP to best-in-class capabilities. GCHP negotiated a high-value, performance-based contract that will provide state of the art capabilities at a cost that is both lower than current and lower than the next-best bidder.
  - The Core Admin System, supported by our BPO partner Netmark using HealthEdge, is integral to processing claims and eligibility, underscoring the inseparability of the system and the service. Netmark will be formally introduced at an upcoming Commission meeting.

OOTF OPERATIONS LEGACY STATE

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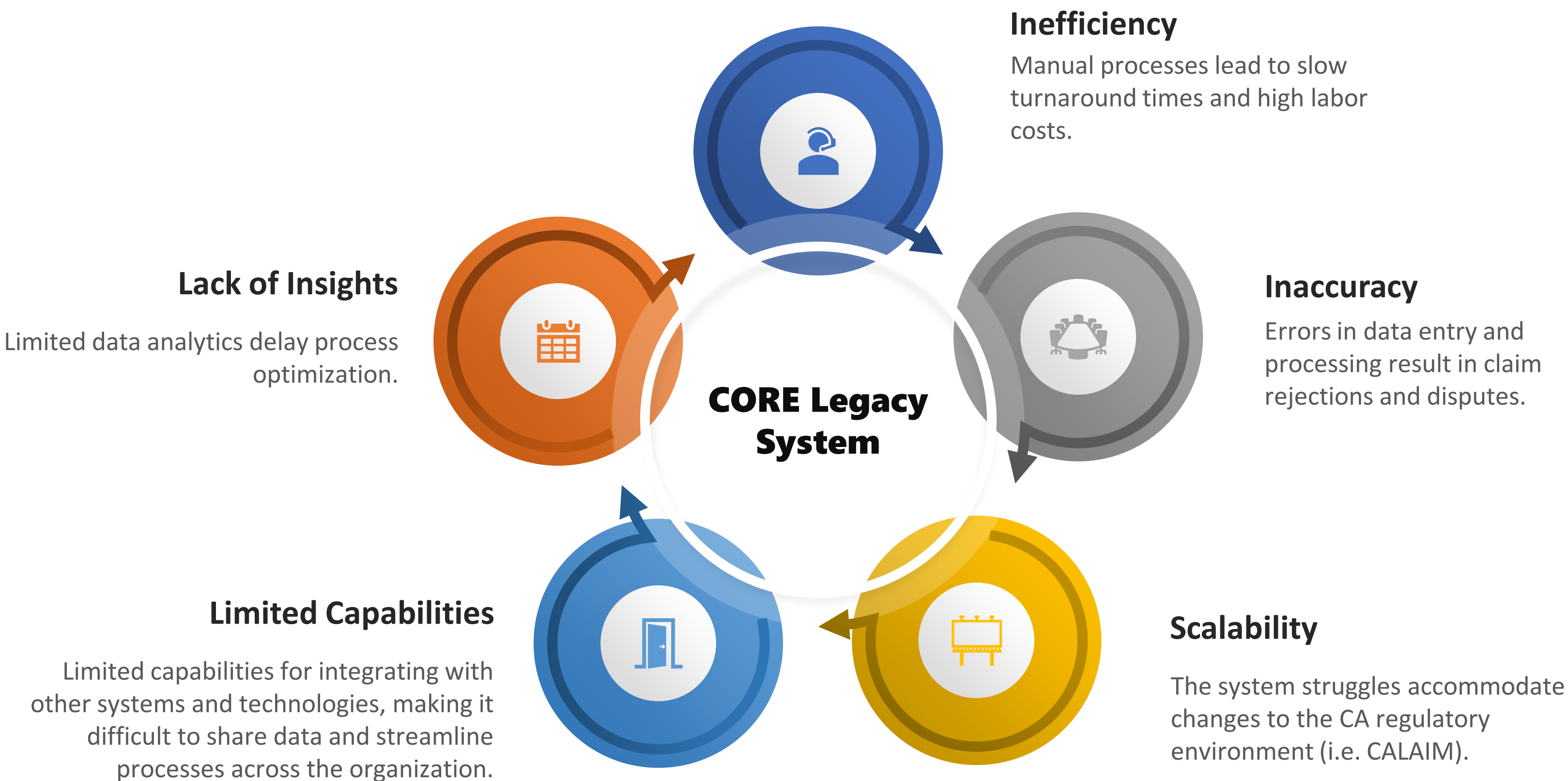

Inefficiency
Manual processes lead to slow turnaround times and high labor costs.

Inaccuracy
Errors in data entry and processing result in claim rejections and disputes.

Scalability
The system struggles accommodate changes to the CA regulatory environment (i.e. CALAIM).

Limited Capabilities
Limited capabilities for integrating with other systems and technologies, making it difficult to share data and streamline processes across the organization.

Lack of Insights
Limited data analytics delay process optimization.

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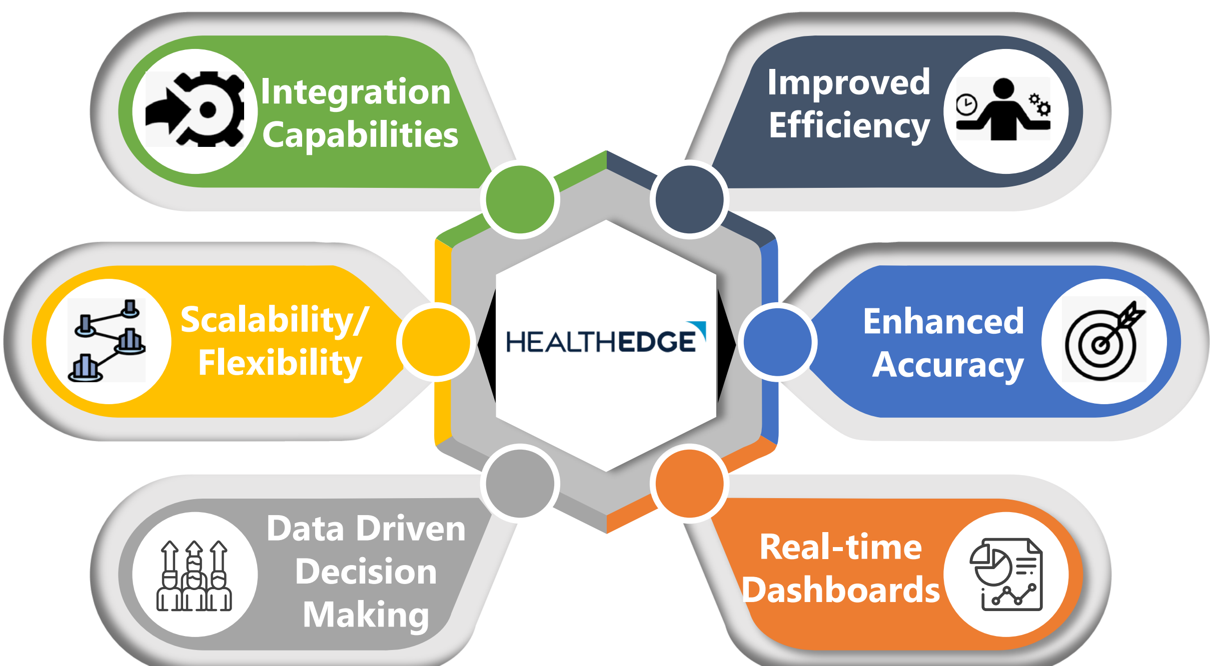
OOTF OPERATIONS FUTURE STATE



- HealthEdge will support the claims turnaround that our providers are accustomed to.
- Over time, HealthEdge will support a much higher auto-adjudication rate than the 60-70% that has been typical with the current core administration system. Our aim is to achieve 90% over time, which will mean accurate and timely claims, at a lower per-claim cost than ever before.

What is next?

- In June, GCHP Management will present an in-depth review of the new Care/Medical Management System and provide a final pre-Go-Live Operational Readiness assessment.
- We extend our gratitude to our incredible vendor partners:
  - HealthEdge (Core Admin System)
  - Edifics (Electronic Data Interchange)
  - KP (Print Fulfillment)
  - Netmark (Claims and Eligibility Processing)
  - NTT (Provider Portal)
  - Salesforce/Silverline (Customer Relationship Management)
  - Zyter/TruCare (Care/Medical Management System)—

…and to the outstanding GCHP Team whose dedicated efforts are bringing the Operations of the Future to life.

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AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Felix L. Nuñez, MD, MPH, Chief Medical Officer
Kim Timmerman, MHA, CPHQ, Sr. Director of Quality Improvement

DATE: May 20, 2024

SUBJECT: 2024 Quality Improvement and Health Equity Transformation Work Plan

SUMMARY:

The Department of Health Care Services ("DHCS") requires Gold Coast Health Plan ("GCHP") to implement an effective quality improvement system and to ensure that the governing body routinely receives written progress reports from the Quality Improvement and Health Equity Committee ("QIHEC").

The attached PPT report contains a summary of activities of the QIHEC and its subcommittees.

APPROVAL ITEMS:

- 2024 Quality Improvement and Health Equity Transformation Work Plan

FISCAL IMPACT:

None

RECOMMENDATION:

Staff recommends that the Ventura County Medi-Cal Managed Care Commission approve the Quality Improvement and Health Equity Transformation Work Plan as presented and receive and file the complete report as presented.

ATTACHMENTS:

Quality Improvement, Ventura County Medi-Cal Managed Care Commission, Quality Improvement and Health Equity Transformation Work Plan, Presentation Slides.

2024 Quality Improvement and Health Equity Transformation Work Plan

May 20, 2024

Felix L. Nuñez, MD, MPH, Chief Medical Officer
Kim Timmerman, Sr. Director Quality Improvement

Integrity

Accountability

Collaboration

Trust

Respect

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mperative

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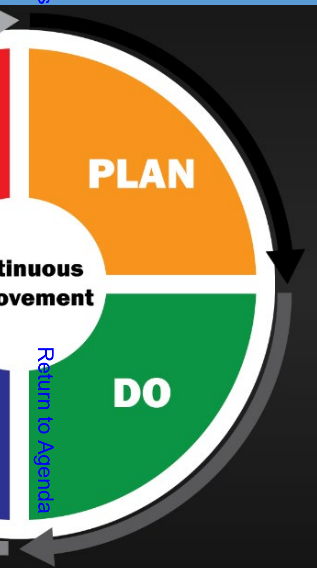
QIHET Work Plan – 2024 Updates

- 48 metrics reviewed and updated:
  - ✓ Goals and objectives, planned activities, completion dates
  - ✓ Percentile benchmark targets for MCAS measures
  - ✓ Added new metrics; retired completed activities; moved items to appropriate Objective category
  - ✓ Includes monitoring of issues/metrics identified in prior years that require continued follow-up
- Objectives modified to align with NCQA standards:
  - ✓ Objective 1: Improve Quality & Safety of Clinical Care Services
  - ✓ Objective 2: Improve Quality & Safety of Non-Clinical Care Services
  - ✓ Objective 3: Improve Quality of Services
  - ✓ Objective 4: Assess and Improve Member Experience
  - ✓ Objective 5: Ensure Organizational Oversight of Delegated Activities
- Status of planned activities updated in the QIHET Work Plan quarterly and reported to the Quality Improvement and Health Equity Committee (QIHEC) with periodic reports to Commission

mperative



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2024 QIHET Work Plan Executive Summary

Quality & Safety of Clinical Care Services

- Structural Requirements: QIHET Program/Work Plan/Evaluation, HEDIS Compliance Audit, Population Needs Assessment
- DHCS Regulatory & Performance Improvement Projects (PIPs)
- Focus areas: Pharmacy, Case Management, Population Health
- All MY 2024 MCAS measures held to MPL

Quality & Safety of Non-Clinical Care Services

- Cultural and Linguistic Needs & Preferences
- Network Access/Adequacy
- Provider Satisfaction
- Facility Site Review
- Credentialing/Recredentialing

Quality of Service

- Grievance and Appeals
- Call Center Monitoring

Member Experience

- CAHPS Assessment and Improvement

Oversight of Delegated Functions

Objective 1: Improve Quality & Safety of Clinical Care Services

Measure	Goals and Objective	Department
2024 Quality Improvement & Health Equity Transformation (QIHET) Program Description	Update the annual QIHET Program Description	Quality Improvement
2024 Quality Improvement and Health Equity Transformation Work Plan	Update the annual QIHET Work Plan	Quality Improvement
2023 Quality Improvement and Health Equity Transformation Program Evaluation	Complete the annual QIHET Program Evaluation	Quality Improvement
2024 HEDIS® Compliance Audit™	Successfully pass the annual HEDIS® Compliance Audit™ and receive reportable status for all measures.	Quality Improvement
Utilization Management: Clinical Practice Guidelines	Complete annual review and adoption of evidence-based Preventive Health Guidelines (PHG), including Diabetes and Asthma Clinical Practice Guideline (CPG).	Utilization Management
CM: Complex Case Management	Develop and implement a standardized Turn Around (TAT) process for members identified as eligible for complex case management per NCQA CCM requirements.	Care Management
CM: Care Gap Closure	Implement strategies to close care gaps for MCAS measures.	Care Management
Tobacco Cessation	Increase rate of tobacco cessation interventions in members identified as tobacco users.	Health Education / Cultural Linguistics
Initial Health Appointment (IHA)	Increase rates of Initial Health Appointment (IHA) completion by providers.	Quality Improvement
Opioid Utilization Monitoring	Monitor member opioid utilization via pharmacy claims from Medi-Cal Rx and monitor for trends where utilization exceeds more than a 5% increase from prior quarter in any category.	Pharmacy

Objective 1: Improve Quality & Safety of Clinical Care Services

Measure	Goals and Objective	Department
Population Needs Assessment (PNA)	NCQA compliant PNA is part of the Population Health Strategy Report submitted to DHCS.	Population Health
Population Health: Wellth Program	Implement a QI focused program with Wellth for full-scope members who are 18+ years of age, taking at least one medication and have multiple care gaps for which GCHP is held to the DHCS MPL (50th%ile).	Population Health
Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness 30 Days	Increase the FUM-30 rate to meet or exceed the DHCS MPL (50th percentile).	Behavioral Health
Behavioral Health: Follow-Up After Emergency Department Visit for Substance Use 30 Days	Increase the FUA-30 rate to meet or exceed DHCS MPL (50th percentile).	Behavioral Health
Asthma Medication Ratio (AMR)	Increase the AMR rate for members, 5 to 64 years of age, who had persistent asthma and had a $\geq$ 0.50 ratio of controller medications to total asthma medications to meet or exceed the DHCS MPL (50th%ile)	Quality Improvement/ Pharmacy
Breast Cancer Screening (BCS)	Increase the percentage of women 50-74 years of age who had a mammogram to screen for breast cancer to increase the rate from 57.79 (2023 MY) to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement
Cervical Cancer Screening (CCS)	Increase percentage of women 21-64 years of age who were screened for cervical cancer to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement
Child and Adolescent Well-Care Visits (WCV)	Increase the percentage of members, 3-21 years of age, who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year to meet or exceed the DHCS HPL (90th %ile).	Quality Improvement
Childhood Immunization Status – Combo 10 (CIS-10)	Increase the percentage of members, two- years of age, who completed all Combo-10 immunizations by their 2nd birthday to exceed the 75th national Medicaid percentile established by NCQA.	Quality Improvement

Objective 1: Improve Quality & Safety of Clinical Care Services

Measure	Goals and Objective	Department
Chlamydia Screening in Women (CHL)	Increase the rate of chlamydia screening in members 16 to 24 years of age to meet or exceed the 75th national Medicaid percentile established by NCQA.	Quality Improvement
Colorectal Cancer Screening (COL)	Increase the percentage of members 45- to 75-years who had an appropriate screening for colorectal cancer from 30.86% (MY 2023) to meet the MPL established by DHCS.	Quality Improvement
Developmental Screening in the First Three Years of Life (DEV)	Increase the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding, or on, their first, second or third birthday, to meet or exceed the DHCS MPL (50th percentile).	Quality Improvement
Health Equity: Controlling Blood Pressure (CBP)	Increase the CBP rate for members 21-44 years of age to meet or exceed the DHCS MPL (50th percentile).	Quality Improvement
Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD-Poor Control)	Decrease the percentage of members with diabetes who are 18-75 years of age and have GSD > 9.0% to meet the DHCS HPL (90th percentile).	Quality Improvement
Immunization Status for Adolescents – Combo 2 (IMA-2)	Increase the percentage of adolescents who completed all IMA-2 immunizations by their 13th birthday to exceed to DHCS HPL (90th percentile).	Quality Improvement
Lead Screening in Children (LSC)	Increase the percentage of children who had one or more capillary or venous lead blood test for lead poisoning by their 2nd birthday to exceed the 75th percentile.	Quality Improvement
Prenatal and Postpartum Care (PPC)	Increase the percentage of members who completed prenatal and postpartum exams to meet or exceed the DHCS HPL (90th percentile) in women.	Quality Improvement

Objective 1: Improve Quality & Safety of Clinical Care Services

Measure	Goals and Objective	Department
Topical Fluoride Varnish (TFL)	Increase the percentage of children, ages 1 through 20, who received at least two topical fluoride applications during the measurement year to meet or exceed the DHCS MPL (50th percentile).	Quality Improvement
Well-Child Visits in the First 30 Months of Life (W30)	Increase the percentage of children who had well-child visits with a PCP to meet or exceed the DHCS MPL(50th percentile).	Quality Improvement
2024 DHCS Required QI Activity(s)	With guidance from DHCS, complete the 2024 required QI activity(s).	Quality Improvement
DHCS Child Health Equity Focused Collaboration on Well-Care Exams	Improve the completion of well child visits	Quality Improvement
2023-2026 PIP Clinical Topic: W30-6+ among Hispanic/Latinx Members	Improve the performance rate for Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) among the Hispanic/Latinx population.	Quality Improvement
2023-2026 PIP Non-Clinical Topic: Percentage of Provider Notifications for Members with SUD/SMH Diagnoses within 7 Days of an ED Visit.	Provider notifications for members with substance use disorder (SUD) and / or specialty mental health (SMH) diagnoses following or within 7 days of emergency department (ED) visit.	Quality Improvement

Objective 2: Improve Quality & Safety of Non-Clinical Care Services

Measure	Goals and Objective	Department
Cultural & Linguistic Needs and Preferences	• By July 31, 2024, GCHP's Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules from four to seven which will include Diversity, Equity, and Inclusion (DEI) training program as per DHCS (APL 23-025) that encompasses sensitivity, diversity, cultural competence and cultural humility, and health equity trainings. • By July 31, 2024, GCHP's HECL Department shall conduct three Cultural and Linguistic (C&L)/DEI trainings with three provider offices per quarter. • By December 31, 2024, GCHP's HECL Department shall report on the number of C&L fulfilment and benchmarks quarterly during the QIHEC meeting.	Health Education / Cultural Linguistics
Primary & Specialty Care Access	• Ensure standards met for minimum of 90% of providers. Members are offered: (1) non-urgent primary care within 10 business days of request and (2) Urgent care within 24 hours. • Specialty Care Access - Members are offered: (1) non-urgent specialty care appointment within 15 business days and (1) non-urgent ancillary services within 15 business days.	Provider Network Operation
Network Adequacy	Assess and improve network adequacy as demonstrated by availability of practitioners.	Provider Network Operations
After Hours Availability	Conduct surveys to ensure members can reach a provider after hours.	Provider Network Operations
Provider Satisfaction	Field provider survey and develop action plan(s) to improve areas of low performance.	Provider Network Operations

Objective 2: Improve Quality & Safety of Non-Clinical Care Services

Measure	Goals and Objective	Department
Facility Site Review Requirements	Maintain 100% compliance with Facility Site Review (FSR) requirements.	Quality Improvement
Facility Site Review Monitoring	Conduct facility site monitoring 100% on time to ensure safety practices.	Quality Improvement
Physical Accessibility Review Surveys (PARS)	Complete Physical Accessibility Reviews (PARs) 100% on time.	Quality Improvement
Credentialing / Recredentialing	Maintain a well-defined credentialing and recredentialing process for evaluating practitioners/ providers to provide care to members.	Quality Improvement

Objective 3: Improve Quality of Services

Measure	Goals and Objective	Department
Grievances and Appeals	Monitor all member grievances and appeals to review for trending issues that will be communicated to various departments to develop action plans to improve the member experience by focusing on highly reported issues.	Grievances and Appeals
Call Center Monitoring	Meet call center benchmarks to ensure members have timely access to call center staff and implement interventions on any deficient benchmarks. (1) ASA: 30 seconds or less; (2) Abandonment Rate: 5% or less; (3) Phone Quality Results: ≥ 95%.	Member Services

Objective 4: Assess and Improve Member Experience

Measure	Goals and Objective	Department
CAHPS: Surveys	Coordinate with DHCS and HSAG to complete the CAHPS surveys and to monitor and improve CAHPS scores.	Quality Improvement
CAHPS: Access to Specialty Care	Improve access to specialty care for adult and children.	Delivery System/Operations & Strategies, Strategy & External Affairs, Quality Improvement
CAHPS: Improve CAHPS Scores	Create interventions to improve CAHPS scores based on MY 2023 outcomes.	Delivery System/Operations & Strategies, Strategy & External Affairs, Quality Improvement

Objective 5: Ensure Organizational Oversight of Delegated Activities

Measure	Goals and Objective	Department
Delegation Oversight: • Credentialing • Quality Improvement • Utilization Management • Member's Rights • Claims • Call Center • Cultural and Linguistics • Non-Emergency and Non-Medical Transportation (NEMT/NMT)	100% of all audits completed with corrective action plans (CAPs) closed timely.	Compliance

Questions?

Recommendation:

Approve the 2024 Quality Improvement and Health Equity Transformation Work Plan

Thank you

GOLD COAST HEALTH PLAN
~~2023~~ 2024 QUALITY IMPROVEMENT & HEALTH EQUITY TRANSFORMATION PROGRAM

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I. BACKGROUND

Gold Coast Health Plan is an independent public entity created by County Ordinance and authorized through Federal Legislation and the California Department of Health Care Services (DHCS) to provide healthcare services to Ventura County's Medi-Cal beneficiaries. The Ventura County Board of Supervisors approved implementation of a County Organized Health System (COHS) model, transitioning from fee-for-service Medi-Cal to managed care, on June 2, 2009. A year later, the board established the Ventura County Medi-Cal Managed Care Commission (VCMMCC) as an independent oversight entity, to govern and operate a single plan — Gold Coast Health Plan — to serve Ventura County's Medi-Cal population. The commission is comprised of locally elected officials, providers, hospitals, clinics, the county healthcare agency and consumer advocates.

~~At our core, GCHP is a community-based health plan. The primary purpose of our work and the fundamental principle that guides us in how we do that work is better health for our members and community.~~

II. MISSION, VISION, VALUES, AND MODEL OF CARE

Mission

The Quality Improvement and Health Equity Transformation Program (QIHETP) is designed to support Gold Coast Health Plan's mission to improve the health of our members through the provision of high-quality care and services. Our member-first focus centers on the delivery of exceptional service to our beneficiaries by enhancing the quality of health care, providing greater access, and improving member choice.

In line with that goal, Gold Coast Health Plan's Quality Improvement and Health Equity Transformation Program defines the processes for continuous quality improvement of clinical care and services, patient safety, and member experience, provided by GCHP and its contracted provider network and community partnerships, through its commitment to improving and sustaining its performance through the prioritization, design, implementation, monitoring, and analysis of performance improvement initiatives with a specific focus on health equity. GCHP is a community-based health plan. The primary purpose of our work and the fundamental principle that guides us in how we do that work is better health for our members and community. Core values of the program include advancing the health of the community by reducing health inequity, and maintaining

respect and diversity for members, providers, and employees. ~~Our **Model of Care is built to meet the unique needs of our members and our community through deep understanding of needs and preference, providing the care and services to meet those needs and preferences through internal programs and partnerships with providers and community-based service delivery organizations, we achieve quality, as measured by** the DHCS Managed Care Accountability Set (MCAS), the National Committee of Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®), the Centers for Medicare and Medicaid (CMS) Core Measures for Medicaid, the Consume assessment of Health Plans and Systems (CAHPS®), as well as other standard quality measures.~~

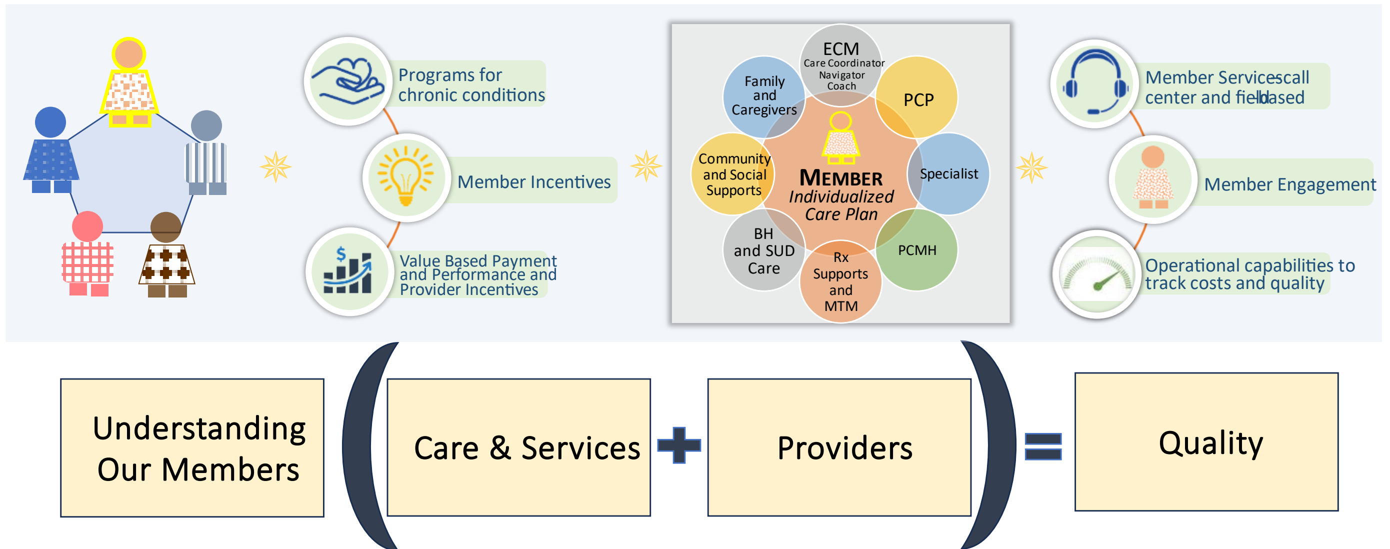
Vision
Compassionate care, accessible to all, for a healthy community.

Values
The QIHET Program supports the organization's values of:

- Integrity: Achieving the highest quality of standards of professional and ethical behavior, with transparency in all business and community interactions
- Accountability: Taking responsibility for our actions and being good stewards of our resources
- Collaboration: Working together to empower our GCHP community to achieve our shared goals
- Trust: Building relationships through honest communication and by following through on our commitments
- Respect: Embracing diversity and treating people with compassion and dignity

Model of Care
Our Model of Care is built to meet the unique needs of our members and our community through deep understanding of needs and preference, providing the care and services to meet those needs and preferences through internal programs and partnerships with providers and community-based service delivery organizations, we achieve quality, as measured by the DHCS Managed Care Accountability Set (MCAS), the National Committee of Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®), the Centers for Medicare and Medicaid (CMS) Core Measures for Medicaid, the Consume assessment of Health Plans and Systems (CAHPS®), as well as other standard quality measures.

Model of Care: Greater than the sum of its parts



III. PURPOSE AND SCOPE

The purpose of the Gold Coast Health Plan (GCHP) Quality Improvement and Health Equity Transformation Program (QIHETP) is to achieve **best health possible, best access possible to quality equitable healthcare, and superior experience for the members and communities we serve** ~~high quality, equitable, and optimal clinical outcomes in all departmental programs~~ in accordance with the State's mission to preserve and improve the health of all Californians. The QIHETP provides the framework for GCHP to:

- Objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable health care and services
- Identify and implement ongoing and innovative strategies to improve the quality, equity, appropriateness, and accessibility of member healthcare
- Implement an ongoing evaluation process that lends itself to improving identified opportunities for under/over utilization of services
- Facilitate organization wide integration of quality management and population health principles
- Promote engagement in local community, statewide, and national collaborations and initiatives aimed at improving quality and equity of care and services

To accomplish this, GCHP's QIHET Program aligns its efforts with the Department of Health Care Services (DHCS) Comprehensive Quality Strategy as well as the goals set forth by the CalAIM Initiative.

The Quality Strategy is anchored by three linked goals:

1. Improve the health of all Californians
2. Enhance quality, including the patient care experience, in all DHCS programs
3. Reduce the Department's per-capita health program costs

~~In conjunction with the Quintuple Aim, the eight priorities of the Quality Strategy are to:~~

~~1. Improve patient safety~~
~~2.~~1.~~Deliver effective, efficient, and affordable care~~
~~3.~~1.~~Engage persons and families in their health~~
~~4.~~1.~~Enhance communication and coordination of care~~
~~5.~~1.~~Advance prevention~~
~~6.~~1.~~Foster healthy communities~~
~~7.~~1.~~Eliminate health disparities~~
~~8.~~1.~~Improve health outcomes~~

Quintuple Aim

~~In conjunction with T~~the Institute for Healthcare Improvement's Quintuple Aim adheres to the concept that healthcare quality improvement should have five aims with connectivity between all the points. The aims are synergistic, build upon one another, and are interdependent. ~~,~~In alignment with the quintuple aim, the eight priorities of the Quality Strategy are to:

1. Improve patient safety
2. Deliver effective, efficient, and affordable care
3. Engage persons and families in their health
4. Enhance communication and coordination of care
5. Advance prevention
6. Foster healthy communities
7. Eliminate health disparities
8. Improve health outcomes

The QIHET Program consists of the following elements:

A. QIHET Program Description including descriptions of key functional areas: The Population Health, ~~Behavioral Health,~~ Care Management, Utilization Management, Behavioral Health, and Pharmacy Programs.
B. Annual QIHET Program Evaluation
C. Annual QIHET Program Work Plan
D. Quality Improvement and Health Equity Activities
E. QIHETP Committee Structure
F. Policies and Procedures

The Quality Improvement and Health Equity Transformation Program will ensure that all medically necessary covered services are available in a culturally and linguistically appropriate manner and are accessible to all

members regardless of race, color, national origin, ethnic group identification, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, medical condition, physical or mental disability, or identification with any other persons or groups identified in Penal Code 422.56. The ~~annual~~ Population Needs Assessment (PNA) will serve to identify and evaluate member health needs and health disparities and implement targeted interventions.

The scope of the QI process encompasses the following:

1. Quality and safety of clinical care services including, but not limited to:

    - Preventive services for children and adults
    - Primary Care
    - Specialty care, including behavioral health services
    - Emergency services
    - Inpatient services
    - Ancillary services
    - Chronic disease management
    - Care Management
    - Population Health
    - Prenatal/perinatal care
    - Family planning services
    - Medication management
    - Coordination and Continuity of Care
    - Long-Term Care

2. Quality of nonclinical services including, but not limited to:

    - Accessibility
    - Availability
    - Member and Provider Satisfaction
    - Grievance and Appeal Process
    - Cultural and Linguistically Appropriate Services
    - Network Adequacy
    - Health Equity
    - Community Supports

3. Patient safety initiatives including, but not limited to:

    - Facility site reviews/Medical record review/Physical Accessibility Review Surveys
    - Credentialing of practitioners/organizational providers
    - Peer review
    - Sentinel event monitoring
    - Potential Quality Issues (PQIs)
    - Provider Preventable Condition (PPC) monitoring
    - Health education
    - Utilization ~~and risk~~ management
    - Transitional Care Services

4. A QI focus which represents

    - All care settings

- All types of services
- All demographic groups

IV. AUTHORITY AND RESPONSIBILITY

The Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba, Gold Coast Health Plan (GCHP), will promote, support, and have ultimate accountability, authority, and responsibility for a comprehensive and integrated Quality Improvement and Health Equity Transformation Program. The VCMMCC, an independent oversight entity and governing body, is ultimately accountable for the quality and equity of care and services provided to members, but has delegated supervision, coordination, and operation of the program to the GCHP Chief Executive Officer (CEO) and Quality Improvement Department under the supervision of the Chief Medical Officer (CMO) in collaboration with the Chief Health Equity Officer (~~CHEO~~HEO), and its Quality Improvement and Health Equity Committee (QIHEC). The CMO in collaboration with the ~~CHEO~~HEO is responsible for the day-to-day oversight of the QIHET Program. The CMO in collaboration with the ~~CHEO~~HEO, through the QIHEC, will guide and oversee all activities in place to continuously monitor health plan quality and equity initiatives.

The VCMMCC's role will be to approve the overall QIHET Program and QIHET Work Plan annually and will receive at least quarterly ~~regular~~ verbal and written updates to the QIHET Work Plan for review and comment/direction. Updates provided to the VCMMCC regarding the QIHET Program and Work Plan will include reviews of objectives and improvements made. The VCMMCC will receive operational information through regular reports from the CMO in collaboration with the ~~CHEO~~HEO in conjunction with the operations of its various committees as described below.

To address the scope of the Plan's QIHET Program goals and objectives, the structure consists of the Quality Improvement and Health Equity Committee (QIHEC) supported by ~~six~~ ~~seven~~ ten subcommittees that meet at least quarterly:

1. Medical Advisory Committee (MAC)
2. Utilization Management Committee (UMC)
3. Health Education & Cultural Linguistics Committee (HE/CL)
4. Credentials/Peer Review Committee (C/PRC)
5. Member Services Committee (MSC)
6. Grievance & Appeals Committee (G&A)
7. Pharmacy & Therapeutics (P&T) Committee
8. NCQA Key Stakeholder Forum
9. MCAS Steering Committee
10. ~~6.~~ Behavioral Health Quality Subcommittee

To further support community involvement and achieve the Plan's QI goals and objectives, the VCMMCC organized ~~two~~ three committees in addition to the QIHEC reporting directly to them:

1. Provider Advisory ~~Committee~~ Committee (PAC)
2. Community Advisory Committee (CAC)
3. ~~2.~~ CalAIM Advisory Committee (CalAIM)

Ventura County Medi-Cal Managed Care Commission (VCMMCC) Membership

GCHP is governed by the ~~eleven~~ twelve (~~11~~12) member VCMMCC. Commission members are appointed for two- or four-year terms, and member terms are staggered. The VCMMCC is comprised of locally elected officials, providers, hospitals, clinics, the Ventura County Healthcare Agency, and consumer advocates.

Members of the VCMMCC are appointed by a majority vote of the Board of Supervisors.

V. QIHET PROGRAM GOALS AND OBJECTIVES

The overall goal of the Quality Improvement and Health Equity Transformation (QIHET) Program is to improve the quality, equity, and safety of clinical care and services provided to members through GCHP's network of providers and its programs and services. Specific goals are established to support the purpose of the QIHET Program. All goals are reviewed annually and revised as needed. The QIHET Program goals are primarily identified through:

- Ongoing activities to monitor care and service delivery
- Issues identified by tracking and trending data over time
- Issues/outcomes identified in the previous year's QIHET Program Evaluation
- Monitoring of performance measures, e.g. Managed Care Accountability Set (MCAS)
- Accreditation standards, regulatory, and contractual requirements

The QIHET Program goals include:

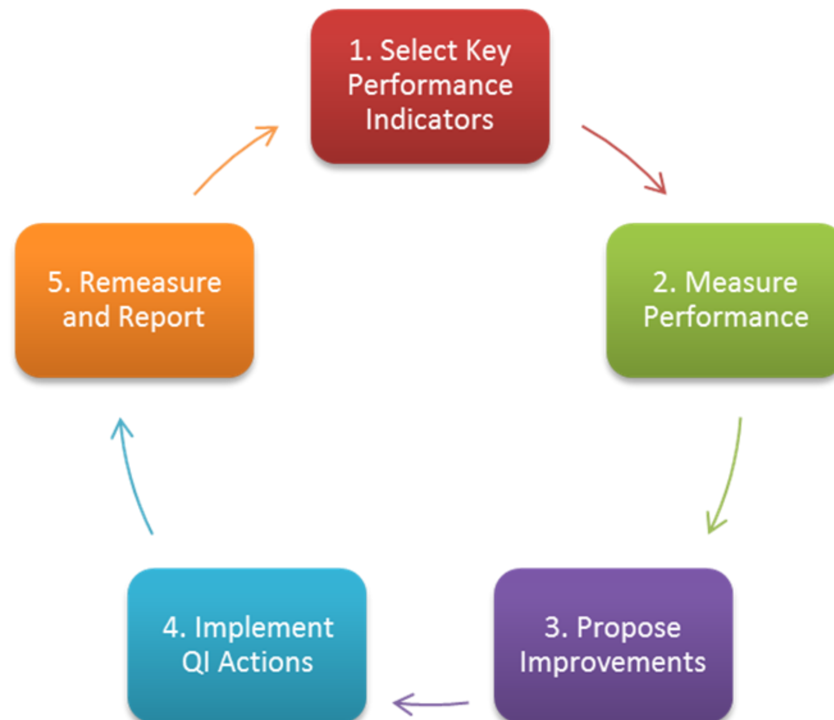
- Develop and maintain QIHET resources, structure, and processes that support the organization's commitment to equitable and quality health care for our culturally and linguistically diverse members.
- Coordinate, monitor and report QIHET activities.
- Develop effective methods for measuring and reporting the outcomes of care, including health disparities -and services provided to members.
- Identify opportunities and make improvements based on measurement, validation, and interpretation of data
- Continuously improve the quality, equity, appropriateness, availability, accessibility, coordination, and continuity of both physical and mental/behavioral healthcare services to members across the continuum of care
- Provide culturally and linguistically appropriate services.
- Measure and enhance member satisfaction with the quality of care and services provided by our network providers.
- Maintain compliance with state and federal regulatory requirements.
- Ensure effective credentialing and re-credentialing processes for practitioners/providers that comply with state, federal and accreditation requirements.
- Ensure network adequacy and member access to primary and specialty care and ethnic and cultural concordance.
- Provide oversight of delegated entities to ensure compliance with GCHP standards as well as State and Federal regulatory requirements.

The Program Objectives include the following:

- To integrate the QIHET Program with other key operational functions of GCHP
- To conduct an annual evaluation of the QIHET Program
- To establish and conduct an annual review of quality, equity, and performance improvement projects (PIPs) related to significant aspects of clinical and non-clinical services
- To identify opportunities for improvement through analysis of utilization patterns and through information collected from quality and performance metrics including the DHCS Managed Care Accountability Set (MCAS), the National Committee of Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®), the Centers for Medicare and Medicaid (CMS) Core Measures for Medicaid, as well as other measure stewards.
- To leverage Sexual Orientation and Gender Identify (SOGI) and Race, Ethnicity, Language and Disability (RELD) data to advance health equity.
- ~~To leverage SOGI and Real data to advance equity~~
- To encourage feedback from members and providers regarding delivery of care and services and to use the feedback to evaluate and improve the manner by which care and services are delivered

VI. QIHET PROGRAM METHODOLOGY

GCHP utilizes the Plan-Do-Study-Act (PDSA) Cycle methodology, which is an improvement process tool used by the Institute for Health Care Improvement's (IHI) Model for Improvement and adopted by the Department of Health Care Services (DHCS) as the standardized process for testing the effectiveness of interventions aimed at improving the quality of care and services. PDSA cycles focus on identifying and measuring improvement opportunities by utilizing small-scale studies to test the effectiveness of interventions that can be modified or expanded to achieve continuous improvement.



The QIHET Program is based on the latest available research in the area of quality improvement and health equity. At a minimum, it includes a method of monitoring, analysis, evaluation, and improvement in delivering high-quality, equitable care and service. The QIHET Program involves tracking and trending of quality indicators to ensure measures are reported, outcomes are analyzed, and goals are achieved. Contractual standards, evidence-based practice guidelines, and other nationally recognized sources (CAHPS®, HEDIS®, CMS Core Set for Medicaid) may be utilized to identify performance/metric indicators, standards, and benchmarks. Indicators are objective, measurable, and based on current knowledge and clinical experience (as applicable).

The indicators may reflect the following parameters of quality:

- Structure, process, or outcome of care
- Administrative and care systems within healthcare services to include:
  - Acute and chronic condition management including care management and population health activities
  - Utilization and risk management
  - Credentialing

- Member experience/satisfaction
- Care and provider experience
- Member grievances and appeals
- Practitioner accessibility and availability
- Plan accessibility
- Member safety
- Preventive care
- Behavioral/mental health
- Health disparities and inequities
- Social ~~determinants~~ drivers of health

MCAS/HEDIS®/CMS Core Set for Medicaid measures and CAHPS® amongst other quality metric results are integrated in the QIHET Program and may be adopted as performance indicators for clinical improvement. The CAHPS® survey is utilized as one of the tools for assessing member satisfaction.

Quality initiatives and performance improvement interventions are developed and implemented as indicated by data analysis and/or medical record reviews. Initiatives are reassessed on a quarterly and/or annual basis to evaluate intervention effectiveness and compare performance.

VII. HEALTH EQUITY, INCLUSION, DIVERSITY, and NON-DISCRIMINATION

Health Equity

The health of our members and our community drives our work.

Gold Coast Health Plan is committed to ~~equity, inclusion, and diversity~~diversity, equity, and inclusion (DEI) to maintain high-quality, ~~equitable, and~~equitable, and affordable healthcare for all Medi-Cal members, their families and their community. Therefore, Gold Coast Health Plan's QIHET Program will continue to focus on community health, improving health equity by work we do within the health plan, with our provider and community-based partners. Lifting the health of our community, lifts the health of our members and reduces the inequities that exist today as well as addresses the structural barriers to equity in the future. ~~in order to~~GCHP develops programs and interventions using the foundational architecture of community health, health equity, and quality improvement theory which drive system transformation and innovation. In order to do so, Gold Coast Health Plan's ~~2023~~ 2024 QIHET Program includes a focus on whole-person care through partnerships with members, providers, community-based organizations, schools, public health agencies, outside counties, and other health care systems. Specifically, improving member SOGI and RE~~aL~~LD data, analyzing health care utilization and performance metrics, and engaging members and the community for recommendations and input in the development of policies and interventions to address disparities. Additionally, Gold Cost Health Plan prioritizes ~~focusing on~~ improving access to services and developing community support strategies for at-risk populations and those populations experiencing health disparities with an emphasis on children's preventive care, maternal health outcomes, and behavioral health.

Inclusion, Diversity, and Non-Discrimination

GCHP assigns members to Primary Care Providers (PCPs) and follows State and Federal civil right laws. GCHP does not unlawfully discriminate, exclude members or treat them differently because of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. All contracted network providers, subcontractors, and downstream subcontractor providers are expected to render services to members they have accepted assignment for or have agreed to accept referrals and shall comply with the State and Federal civil rights laws. Providers shall not refuse services to any member based on the criteria above. GCHP follows up on all grievances alleging discrimination and takes appropriate action.

To ensure that members have equitable access to covered services delivered in a manner that meet their needs, GCHP conducts the following activities:

- Review of member complaints and grievances including those related to culturally and linguistically appropriate level of care.
- Timely access to ~~Provision of~~ language assistance services for all medical and non-medical services ~~to assist providers to provide culturally and linguistically appropriate medical care to Limited English Proficient members~~
- Provision of written materials in threshold language and non-threshold languages upon request, alternative formats, auxiliary aids, and services for members with visual impairments or other disabilities to ensure effective communication.
- Conducting a Population Needs Assessment as defined by DHCS
- Provision of Cultural Competency Training for both providers and GCHP staff, GCHP and contract provider vendors. Conduct oversight of subcontract's Cultural Competency Training.
- Conducting surveys of members to determine if culture and language needs are met by providers
- Provision of d~~D~~iversity, e~~E~~quity, i~~I~~nclusion ~~, and~~ training including sensitivity, communication skills, cultural competency/humility, ~~a~~ and Seniors and Persons with Disabilities (SPD) ~~Cultural Sensitivity~~sensitivity ~~Trainings~~ ~~for~~ to network providers, subcontractors, and downstream subcontractors and GCHP staff
- Assessment of provider and provider staff members' linguistic capabilities
- Assessment of GCHP staff language capabilities for direct communication with members
- Conduct readability and suitability of member informing materials set by DHCS regulations
- Engage Community Advisory Committee feedback and advice regarding services and program including for cultural and linguistic appropriateness.

Culturally and Linguistically Appropriate Services

Gold Coast Health Plan is committed to providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. This commitment includes advancing and sustaining organizational governance and leadership that promotes Culturally and Linguistically Appropriate Services (CLAS) and health equity. GCHP recruits, promotes, and supports a culturally and linguistically diverse governance, leadership, and workforce that are responsive to members in GCHP's service area. GCHP partners with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

Culturally and linguistically appropriate services include:

- Provision of education and training to GCHP leadership and staff in culturally and linguistically appropriate policies and practices on an ongoing basis.
- Ensuring the competence of individuals providing language assistance, specifically recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and non-clinical services.
- Informing all members of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Providing easy-to-understand print and multimedia materials and signage in the GHCP's threshold languages.
- Collection and maintenance of accurate and reliable demographic data to inform service delivery.
- Assessment of community health resources to implement services responsive to identified CLAS needs.

Culturally and linguistically appropriate services are monitored through established goals, and ongoing assessment of CLAS-related goals and activities. GCHP's progress in implementing and sustaining CLAS is regularly communicated to all stakeholders, constituents, and the general public via public-facing committees and stakeholder collaborations.

VIII. PROGRAM ORGANIZATION, OVERSIGHT, RESOURCES, AND EVALUATION

ORGANIZATION AND OVERSIGHT

CHIEF MEDICAL OFFICER

The Chief Executive Officer has appointed the Chief Medical Officer (CMO) as the designated physician to support the QIHET Program by providing ~~day to day~~leadership, oversight, and management of quality improvement activities and has overall responsibility for the clinical direction of GCHP's QIHET Program. ~~Further description of the QIHET Program's multidisciplinary resources and responsibilities are included in Attachment 1. 2023 QIHETP Resources.~~

CHIEF INNOVATION OFFICER

The Chief Innovation Officer (CIO) is responsible for driving the execution of wide-reaching, complex, and cross-functional work plans and performance improvement initiatives in partnership with the health plan's CEO and Executive Team. The CIO reports directly to the CEO and is a member of GCHP's Executive Team. The CIO provides visioning and leadership of processes and practices for Executive/Leadership Team engagement in - and ownership of - goals/workplans/ priorities, communications on goals/workplans/ priorities, Operating Reviews and Status Reports, and performance reporting to innovate the company.

CHIEF HEALTH EQUITY OFFICER

The Chief Executive Officer has appointed the Chief Health Equity Officer (HEO) as the designated executive authority to provide health equity expertise to support the QIHET Program by providing leadership, oversight, and management of quality improvement and health equity activities. The CMO and CIO both serve as Co-Chief Health Equity Officers.

QIHET PROGRAM RESOURCES

Multidisciplinary Staff

Resources for the QIHET Program come from various department staff in addition to the leadership roles described above.

Support for improvement initiatives related to population health, behavioral health, care management, utilization/risk management, and other clinical process improvement and outcome measures are provided by Health Services, Population Health, Information Technology, and QI staff.

Quality initiatives related to service including member satisfaction and those related to complaints and appeals are supported by Member Services and Grievance and Appeals staff.

Quality initiatives related to provider network and provider communication is supported by Provider Network Operations staff.

Credentialing and peer review functions are supported by both Provider Network Operations and QI staff.

The quality improvement staff assists the Sr. QI Director in assessing data for improvement opportunities. They work with other departments to assist in planning and implementing activities that will improve care or service.

Responsibilities of multidisciplinary staff include but are not limited to the following:

- Assist in creating the annual QIHET Program Description
- Assist in coordination of MCAS/HEDIS®/CMS Core Set for Medicaid data collection, reporting and analysis of results
- Work with other departments to gather information for the annual QIHETP Evaluation
- Collaborate in developing quality improvement and health equity transformation activities for the annual QIHETP Work Plan
- Identify areas for improvement and implementation of quality improvement and health equity initiatives
- Assist the Sr. QI Director in achieving the goals set forth in GCHP's QIHET Program

Further description of the QIHET Program's multidisciplinary resources and responsibilities are included in Attachment 1.2024 QIHETP Resources.

Program and Tools
GCHP has dedicated resources to the acquisition of programs and tools that promote high quality and equitable services for our members. These include but are not limited to:

- Online Member Administration Support – provider directories, health plan benefit summaries, drug formularies and claim forms
- Online Provider Resources – eligibility and benefit look-up, claims submittal, formulary information, forms
- Online Member Education and Engagement Resources – members are offered access to comprehensive clinical information in the Health Library on GCHP's website
- Online Data for performance metrics – providers have access to Inovalon's Data Insights® Quality Performance dashboards that offer visualization and customization capabilities that enable measurement of performance against benchmarks and identification of gaps in care
- Quality Performance Reports – providers receive a customized report on at least an annual basis indicating their quality performance compared to GCHP's overall quality performance as well their peer providers.

Sources of Data
GCHP utilizes tools and resources that provide standards, benchmarks, guidelines, best practices, and measurement and evaluation methodologies to assist in guiding our improvement strategies. These resources include:

- *National initiatives and measurement sets* such as Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Healthcare Effectiveness Data and Information Set (HEDIS®), Centers for Medicare and Medicaid (CMS) Core Set for Medicaid, Quality Compass®
- *Government issued laws, regulations and guidance* including those from DHCS, CMS, the U.S. Preventive Services Taskforce (USPSTF), and National Institutes of Health (NIH)
- *Healthcare Quality Improvement Organizations* such as the National Committee for Quality Assurance (NCQA), the Institute for Healthcare Improvement (IHI), and the Agency for Healthcare Research and Quality (AHRQ), Health Services Advisory Group (HSAG)
- *The Guide to Community Preventive Services (The Community Guide);* a collection of evidence-based findings of the Community Preventive Services Task Force established by the U.S. Department of Health and Human Services (DHHS)

Data, Information, and Analytics Support
GCHP's QIHET Program monitors and evaluates performance and information from many different sources throughout the organization including but not limited to:

Collect and utilize enrollment and demographic data, including Race, Ethnicity, and Language and Disability (RELD) data and Sexual and Gender Identify (SOGI) data to advance health equity by identifying, addressing, and reducing health disparities among our patient population. ~~Enrollment and~~

demographic data, including race, ethnicity, and language preference data is collected to monitor health care quality and for identifying and reducing health disparities among our patient population

- Claims and encounter data (utilization by diagnosis/procedure, provider, treatment/medications, site of care, etc.) to ensure members are receiving appropriate care and to mitigate gaps through sharing of this data with other organization business units (e.g. Population Health and Behavioral Health) Population health/Care management reports to assess support of members with complex or chronic medical and behavioral health conditions, and to evaluate coordination of care across the continuum
- Grievance and appeal data, including type of grievances, trends, and root cause analysis
- Ongoing tracking and trending of quality of care and serious reportable event (SRE) data to identify patient safety issues and assess provider qualifications
- Member and provider survey data to assess satisfaction with services and operations
- Credentialing process data to measure timeliness of application processing and quality of network providers
- Network adequacy/accessibility measurement data to assess provider availability and accessibility
- MCAS/HEDIS®/CMS Core Set for Medicaid data to assess the effectiveness of clinical care and services

HEDIS® Certified Software

GCHP's QIHET Program utilizes the HEDIS® Certified Software vendor, Inovalon, to calculate all Managed Care Accountability Set (MCAS) and HEDIS® quality measure rates to ensure accurate calculations. The Inovalon HEDIS® engine is used to calculate monthly prospective rates as well as the rates for the annual MCAS/ HEDIS® audit. The data used to calculate measure rates is produced monthly by GCHP's IT Population Health Enablement Department's Sr. IT Business Analyst, GCHP's IT Population Health Enablement Department's Principal Data Analyst, and GCHP's QI HEDIS Data Master. The engine ingests the following data sources to calculate measure rates:

- Enrollment and demographic data, including race, ethnicity, and language preference data
- Claims data
- Encounter data
- Laboratory data
- Immunization registry data
- Electronic Health Record and Health Information Exchange data
- Medical Record data
- DHCS Supplemental data
- Medi-Cal Dental Program data
- Medi-Cal Rx pharmacy data
- Provider data

The calculated measure rates are used to monitor quality metric performance and identify opportunities for quality improvement and health equity intervention focus areas.

QIHET PROGRAM EVALUATION

A written evaluation of the QIHET Program is completed annually. This annual report includes a comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement and health equity program, including but not limited to the results of performance measures, health equity, outcomes/findings from Performance Improvement Projects (PIPs), consumer and provider satisfaction surveys, and the quality review of services rendered. The analysis includes a review and revision of the QIHET Program Description, evaluation of the prior year's QIHET Work Plan, and the development of the current year's QIHET Work Plan to ensure ongoing performance improvement.

The Evaluation is reviewed and approved by the QIHEC and VCMMCC and includes the following:

- A description of completed and ongoing QIHETP activities that address quality, equity, and safety of both physical and mental/behavioral healthcare provided to GCHP members, including trended measures and an analysis of barriers to success.
- A description of completed and ongoing QIHETP activities that address service quality and the experience of care for GCHP members, including trended measures and an analysis of barriers to success.
- Analysis and evaluation of the overall effectiveness of the QIHET Program (QI committee structure, QI program resources, practitioner participation and leadership involvement), including progress toward influencing network-wide clinical practices, population health needs, health disparities, and addressing the cultural and linguistic needs of GCHP members.
- Recommendation for restructure or changes to the QI Program for the subsequent year to improve effectiveness as appropriate.

IX. ANNUAL QIHET WORK PLAN

The annual QIHET Work Plan serves as the roadmap for the Quality Improvement and Health Equity Transformation Program and outlines measurable, organizational, and multidisciplinary objectives, activities and interventions focused on improving key performance indicators (KPI). The goal is to identify GCHP'sthe health plan's approach to improving and sustaining performance through the prioritization, design, implementation, monitoring, and analysis of performance improvement and health equity initiatives.

The QIHET Work Plan is developed largely from findings and recommendations from the annual QIHET Program Evaluation. Areas of significant focus include partially resolved and unresolved activities from the previous year, and newly identified focus areas for the coming year. The focus areas include clinical and non-clinical care and service improvement activities that have the greatest potential impact on the quality and equity of care and services, and patient safety. The QIHET Work Plan also reflects the contractual requirements of GCHP.

At a minimum, the QIHET Work Plan includes a clear description of the monitoring and improvement activities and objectives, the specific timeframe and responsible parties for conducting the activities, and monitoring of previously identified issues. Activities and outcomes are compared to predetermined goals/benchmarks and/or target improvement metrics.

Additional improvement activities identified during the year or other changes made to the QIHET Work Plan are presented to the QIHEC and VCMMCC for approval on an ongoing basis. The QIHEC oversees the prioritization and implementation of clinical and non-clinical QIHET Work Plan initiatives. The QIHET Work Plan is assessed and updated at a minimum, semi-annually, and is included as part of the Annual QIHET Program Evaluation.

GCHP views the QIHET Work Plan as a living document that reflects ongoing progress on QIHET activities and a tool to focus improvement efforts throughout the year and evaluate progress against the objectives. This continuous quality improvement and health equity transformation effort will help GCHP achieve its mission to improve the health and well-being of the people of Ventura County by providing access to high quality and equitable medical services.

Quality Improvement and Health Equity activities that measure and monitor access to care include the following:

- Access and Availability Studies
- Initial Health Assessment Appointment monitoring
- GeoAccess Studies
- Network Adequacy

Quality Improvement and Health Equity activities that measure and monitor provider and member satisfaction include the following:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Member Grievance Reviews
- Provider Satisfaction Surveys
- Focus Groups

Quality Improvement and Health Equity activities that evaluate preventive care, behavioral healthcare, care of chronic conditions, as well as coordination, collaboration and patient safety include the following:

- MCAS/HEDIS®/CMS Core Set for Medicaid reporting and analysis including race/ethnicity stratification of specific measures
- Coordination of Care Studies
- Facility Site Reviews
- Potential Quality Issue Investigation

Quality Improvement and Health Equity activities that evaluate GCHP's ability to serve a culturally and linguistically diverse membership may include but are~~is~~ not limited to the following:

- Annual provider language study
- Annual cultural and linguistic study
- Ongoing monitoring of interpreter service and use
- Ongoing monitoring of grievances
- Focus groups to determine how to meet needs of diverse members
- Population Needs Assessment intervention implementation and monitoring

Quality Improvement and Health Equity activities that evaluate GCHP's quality of care include the following:

- Credentialing and Recredentialing activities
- Peer Review Activities
- Delegation Oversight

Communication and Feedback
Ongoing education and communication regarding quality improvement and health equity initiatives is accomplished internally and externally through committees, staff meetings, mailings, website content and announcements. Providers are educated regarding quality improvement and health equity initiatives during provider on-boarding, via on-site quality visits, quality improvement focused trainings and webinars, provider update memos/e-blasts, Provider Operations Bulletin articles, and the GCHP website. Reporting of specific MCAS/HEDIS®/CMS Core Set for Medicaid measure performance is communicated to providers via an annual report card and monthly progress reports of current and projected rates including care gap reports of members who need specific clinical services. This reporting is also provided to all relevant internal GCHP departments including GCHP's Population Health and Behavioral Health Teams for internal development of program initiatives.

~~**X. PROGRAM RESOURCES DEDICATED TO QI & HEALTH EQUITY**~~

~~**QIHET Program Resources - Multidisciplinary Staff**~~
~~Resources for the QIHET Program come from various department staff in addition to the leadership roles described in the Program Oversight section of this document.~~

~~Support for improvement initiatives related to population health, behavioral health, care management, utilization/risk management, and other clinical process improvement and outcome measures are provided by Health Services, Population Health, Information Technology, and QI staff.~~

~~Quality initiatives related to service including member satisfaction and those related to complaints and appeals are supported by Member Services and Grievance and Appeals staff.~~

Quality initiatives related to provider network and provider communication is supported by Provider Network Operations staff.

Credentialing and peer review functions are supported by QI staff.

The quality improvement staff assists the Sr. QI Director in assessing data for improvement opportunities. They work with other departments to assist in planning and implementing activities that will improve care or service.

Responsibilities of multidisciplinary staff include but are not limited to the following:

- Assist in creating the annual QIHET Program Description
- Assist in coordination of MCAS/HEDIS®/CMS Core Set for Medicaid data collection, reporting and analysis of results
- Work with other departments to gather information for the annual QIHETP Evaluation
- Collaborate in developing activities for the annual QIHETP Work Plan
- Identify areas for improvement and assist in implementing quality improvement and health equity initiatives
- Assist the Sr. QI Director in achieving the goals of the QIHET Program

Further description of the QIHET Program's multidisciplinary resources and responsibilities are included in Attachment 1. 2023 2024QIHETP Resources.

QIHET Program Resources - Program and Tools

GCHP has dedicated resources to the acquisition of programs and tools that promote high quality and equitable services for our members. These include but are not limited to:

- Online Member Administration Support – provider directories, health plan benefit summaries, drug formularies and claim forms
- Online Provider Resources – eligibility and benefit look-up, claims submittal, formulary information, forms
- Online Member Education and Engagement Resources – members are offered access to comprehensive clinical information in the Health Library on our website
- Online Data for performance metrics – providers have access to Inovalon's INDICES® dashboards that offer visualization and customization capabilities that enable measurement of performance against benchmarks and identification of gaps in care

QIHET Program Resources - Sources of Data

GCHP utilizes tools and resources that provide standards, benchmarks, guidelines, best practices, and measurement and evaluation methodologies to assist in guiding our improvement strategies. These resources include:

- *National initiatives and measurement sets* such as Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Healthcare Effectiveness Data and Information Set (HEDIS®), Centers for Medicare and Medicaid (CMS) Core Set for Medicaid, Quality Compass®
- *Government issued laws, regulations and guidance* including those from DHCS, CMS, the U.S. Preventive Services Taskforce (USPSTF), and National Institutes of Health (NIH)
- *Healthcare Quality Improvement Organizations* such as the National Committee for Quality Assurance (NCQA), the Institute for Healthcare Improvement (IHI), and the Agency for Healthcare Research and Quality (AHRQ), Health Services Advisory Group (HSAG)

- *The Guide to Community Preventive Services (The Community Guide);* a collection of evidence-based findings of the Community Preventive Services Task Force established by the U.S. Department of Health and Human Services (DHHS)

QIHET Program Resources – Data, Information and Analytics Support

GCHP's QIHET Program monitors and evaluates performance and information from many different sources throughout the organization including but not limited to:

- Enrollment and demographic data, including race, ethnicity, and language preference data is collected to monitor health care quality and for identifying and reducing health disparities among our patient population
- Claims data (utilization by diagnosis/procedure, provider, treatment/medications, site of care, etc.) to ensure members are receiving appropriate care and to mitigate gaps through sharing of this data with other organization business units (e.g. Population Health and Behavioral Health)
- Population health/Care management reports to assess support of members with complex or chronic medical and behavioral health conditions, and to evaluate coordination of care across the continuum
- Grievance and appeal data, including type of grievances, trends, and root cause analysis
- Ongoing tracking and trending of quality of care and serious reportable event (SRE) data to identify patient safety issues and assess provider qualifications
- Member and provider survey data to assess satisfaction with services and operations
- Credentialing process data to measure timeliness of application processing and quality of network providers
- Network adequacy/accessibility measurement data to assess provider availability and accessibility
- MCAS/HEDIS®/CMS Core Set for Medicaid data to assess the effectiveness of clinical care and services

QIHET Program Resources - HEDIS® Certified Software

GCHP's QIHET Program utilizes the HEDIS® Certified Software vendor, Inovalon, to calculate all Managed Care Accountability Set (MCAS) and HEDIS® quality measure rates to ensure accurate calculations. The Inovalon HEDIS® engine is used to calculate monthly prospective rates as well as the rates for the annual MCAS/ HEDIS® audit. The data used to calculate measure rates is produced monthly by GCHP's IT Population Health Enablement Department's Sr. IT Business Analyst. The engine ingests the following data sources to calculate measure rates:

- Enrollment and demographic data, including race, ethnicity, and language preference data
- Claims data
- Encounter data
- Laboratory data
- Immunization registry data
- Electronic Health Record and Health Information Exchange data
- Medical Record data
- DHCS Supplemental data
- Medi-Cal Rx pharmacy data
- Provider data

The calculated measure rates are used to monitor quality metric performance and identify opportunities for quality improvement intervention focus areas.

XI.X. QUALITY COMMITTEES AND SUBCOMMITTEES

Gold Coast Health Plan's Quality Committees and Subcommittee Structure consists of tensix subcommittees each reporting up to the Quality Improvement Committee. The Quality Improvement and Health Equity Committee (QIHEC) then reports directly to the Ventura County Medi-Cal Managed Care Commission

(VCMCC) as the overseeing body for quality within Gold Coast Health Plan. In addition to the QIHEC, the VCMCC oversees the Provider Advisory Committee (PAC), ~~and~~ Committee Advisory Committee (CAC), and the CalAIM Advisory Committee. The PAC, ~~and~~ CAC, and CalAIM Advisory Committee ~~both~~ function to support quality improvement and health equity activities by encouraging community participation in QI activities, however each reports directly to the VCMCC.

Committee minutes are recorded at each meeting and reflect key discussion points, recommended policy decisions, analysis and evaluation of QIHET activities, needed actions, planned activities, responsible person, and follow up. Minutes record the practitioner and health plan staff attendance and participation. Minutes will be produced within a reasonable timeframe, at a minimum, within one month or by the date of the next meeting. Minutes are reviewed and approved by the originating committee and are signed and dated within the same reasonable timeframe. Committee meeting minutes shall be submitted to DHCS quarterly, or as requested.

The responsibilities, scope, membership, and objectives of the QIHEC as well as the subcommittees reporting to the QIHEC are as follows:

i. Quality Improvement and Health Equity Committee (QIHEC)

The QIHEC is the principal organizational unit that has been delegated authority to monitor, evaluate, and report to the VCMMCC by the VCMMCC on all component elements of the GCHP Quality Improvement and Health Equity Transformation Program. The QIHEC shall have a minimum of 8 voting members and be chaired by the GCHP Chief Medical Officer (CMO) in collaboration with the Chief Health Equity Officer (~~CHEO~~HEO) and facilitated by the Sr. QI Director.

Membership consists of the chairs of the 10 QIHEC Subcommittees, and at least one Commissioner, and at least one practicing physician in the community, and a behavioral health care practitioner.

Network Providers, delegated subcontractors, and downstream subcontractors participating in the QIHEC will represent the composition of the GCHP Provider Network and include, at a minimum, Network Providers, delegated subcontractors, and downstream subcontractors who provide health care services to:

- Members affected by Health Disparities
- Limited English Proficiency (LEP) Members
- Children with Special Health Care Needs (CSHCN)
- Seniors and Persons with Disabilities (SPDs.
- Persons with chronic conditions~~Membership will consist of the chairs of the 6 QI Subcommittees and at least one Commissioner and at least one practicing physician in the community.~~

The QIC shall meet at least quarterly. Ad hoc committees, however, will meet on an as needed basis. The QIC will critically examine and make recommendations on all quality and equity functions of GCHP described in this program and by California and Federal regulatory authorities as appropriate.

It is the responsibility of the QIC and its subcommittees to assure that QIHET activities encompass the entire range of services provided and include all demographic groups, care settings, and types of service. The committee reviews recommendations from the GCHP quality subcommittees and makes recommendations on their implementation. The VCMMCC is updated at least quarterly or ~~as frequently~~ more frequently as needed to demonstrate follow-up on all findings and required action by the Chair of the QIHEC or designee via a report which may include QIHEC minutes, information packet, performance dashboards, or other communication mechanism. All of the GCHP's Committees/Subcommittees are required to maintain confidentiality and avoid conflict of interest.

An annual QIHET Report is submitted to the VCMMCC addressing:

- Quality improvement and health equity activities such as:
  i. Utilization Reports

ii. Review of the quality of services rendered
iii. MCAS/HEDIS®/CMS Core Set for Medicaid results
iv. Quality Improvement Projects and initiatives - status and/or results
v. Health Equity Projects and initiatives – status and/or results
vi. Satisfaction Survey Results
vii. Collaborative initiatives both internally and externally - status and/or results

- Success in improving patient care and outcomes, health equity, and provider performance.
- Opportunities for improvement.
- Overall effectiveness of quality monitoring and review activities or specific areas that require remedial action as indicated in the annual report issued by the state's EQRO.
- Effectiveness in performing quality and health equity management functions and
- ~~a~~Reporting and ~~chieving~~achievement of goals and objectives through quality and health equity monitoring and improvement programs ~~will be measured and reported~~.
- Presentation of the QIHET Work Plan including recommendations for revision identified as a result of the review.

QIHEC Objectives:

- Ensure communication processes are in place to adequately track work plan and QIHET activities and enable ~~horizontal and lateral~~ system-wide communication as well as closing the loop when issues are resolved.
- Ensure QIHEC members can have a candid discussion about barriers to achieving quality goals and objectives, and to facilitate the removal of such barriers.

QIHEC Responsibilities:

- Oversees the annual review, analysis, and evaluation of goals set forth by the Quality Improvement and Health Equity Transformation Program as well as GCHP's quality improvement policies and procedures.
- Makes recommendations for implementation of interventions or corrective actions based on results of quality improvement and health equity activities including those recommended by network providers, fully delegated subcontractors, and downstream contractors.
- Facilitates data-driven indicator reviews and development for monitoring key quality management activities, including but not limited to: MCAS/HEDIS®, CAHPS®, Access/Availability, Performance Improvement Projects, Service/Clinical Quality measures, UM/CM metrics, Population Health metrics, Behavioral Health metrics, Credentialing performance, and Delegation Oversight.
- Analyzes and evaluates the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other committees such as the Consumer Advisory Committee.
- Institutes actions to address performance deficiencies, including policy recommendations.
- Ensures appropriate follow-up of identified performance deficiencies.
- Reviews reports from GCHP committees and departments, including quarterly dashboards, key activities and action plans including subcommittee updates, and reports regarding monitoring of health plan functions and activities.

QIHEC Membership:

- Chief Medical Officer & Co-Chief Health Equity Officer (Chair)
- Chief Innovation Officer & Co-Chief Health Equity Officer
- Sr. Medical Director ~~– currently vacant~~
- Sr. Director of Quality Improvement
- Sr. Director of Health Education /~~&~~ Cultural Linguistics
- Executive Director, Delivery System Operations & Strategies
- Sr. Director of Network Operations
- Director of Pharmacy Services~~Clinical Programs Pharmacist~~
- Sr. Manager, Population Health
- Chief Compliance Officer
- Sr. Director of Compliance
- Sr. Director of Care Management
- Sr. Director of Utilization Management
- Director, Behavioral Health & Social Programs
- Chief Executive Officer
- Executive Director of Population Health & Equity
- Executive Director of Operations
- Director ~~Sr. Manager~~ of Operations
- Manager, Member Services
- External Practitioner Representatives
- Commissioner
- Carelon (formerly Beacon) Regional Chief Medical Officer Behavioral Health
- Manager, Quality Improvement – Clinical
- Manager, Quality Improvement – Non-Clinical

QIHEC Reporting Structure:

The QIHEC reports to the VCMMCC. The Chair of the QIHEC ensures that quarterly reports are submitted to the VCMMCC.

Meeting Frequency:

The QIHEC meets at a minimum quarterly.

ii. Medical Advisory Committee (MAC)

The purpose of the MAC is to provide feedback and advice to the health plan on any aspect of health plan policy or operations affecting network providers or members. Through MAC, GCHP seeks input/guidance to foster discussion of matters including, but not limited to the following:

- The delivery of medical care to the plan's membership
- Issues of concern to the physician community
- Quality of care concerns
- GCHP clinical programs to ensure optimal effectiveness for members and providers
- Local medical care practices that may affect health plan operations

Scope:

The Committee scope may include, but is not limited to, the following data/activities/processes:

- Clinical Practice and Preventive Healthcare Guidelines (CPGs/PHGs)

- Provider Grievance Process
- Provider Satisfaction
- Provider Access/Availability Standards
- Provider Contracting
- Provider Materials/Communications
- Clinical Programs and Service Delivery
- Utilization Management
- Pharmacy
- Quality Improvement (including clinical studies, MCAS/HEDIS®/CMS Core Set Medicaid/CAHPS® survey outcomes)

Feedback from the MAC is relayed to the QIHEC as well as other QI committees and/or departments where data may be relevant to process improvements. Practitioner feedback may be utilized in a variety of ways, including but not limited to: providing subject matter expertise, help improve outcomes, achieve health equity, assess/revise policies and procedures, and/or modify program offerings.

Membership:

Membership is comprised of 6 to 10 fully credentialed and actively participating physicians representing the contracted provider community for GCHP's programs. The Chief Medical Officer and Co-Chief Health Equity Officer will serve as Chair and will ensure that the membership has adequate specialty representation. Efforts are made to rotate membership every two years; however, in order to ensure continuity of committee activity, membership may be extended.

Meeting Frequency:

The committee meets at a minimum on a quarterly basis.

iii. Member Services Committee (MSC)

The MSC oversees those processes that assist members in navigating GCHP's system. This committee provides oversight of service indicators, analyzes results, and suggests the implementation of actions to correct or improve service levels. Through monitoring of appropriate indicators, the MSC will identify areas of opportunity to improve processes and implement interventions.

MSC Objectives:

- Ensure GCHP members understand their health care system and know how to obtain care and services when they need them.
- Ensure GCHP members will have their concerns resolved quickly and effectively and have the right to voice complaints or concerns without fear of discrimination.
- Ensure GCHP members can trust that the confidentiality of their information will be respected and maintained.
- Have access to appropriate language interpreter services at no charge when receiving medical care.
- Ensure GCHP members can reach the Member Services Department quickly and be confident in the information they receive.
- Utilize the CAHPS® survey to identify service indicators for improvement.
- Ensure GCHP's Member Rights and Responsibilities are distributed and available to members and providers.
- Ensure that GCHP's member materials are developed in a culturally appropriate format.
- Interface with other GCHP committees to improve service delivery to members.

MSC Membership:

- Manager of Member Services (Chair)
- Executive Director of Operations
- Executive Director, Delivery System Operations & Strategies
- Sr. Director of Network Operations or designee
- Executive Director of Strategy and External Affairs
- ~~Sr. Manager~~Director of Operations (Grievance and Appeals) or designee
- Sr. Director of Quality Improvement or designee
- Sr. Director of Care Management or designee
- Chief Medical Officer
- Sr. Director of Health Education & Cultural Linguistics or designee
- Director of Communications
- Sr. Director of Compliance or designee

Meeting Frequency:

The MSC meets quarterly at a minimum.

iv. Grievance and Appeals Committee (G&A)

The Grievance and Appeal Committee monitors expressions of dissatisfaction from members and providers. Information gathered is used to improve the delivery of service and care to Gold Coast Health Plan members.

G&A Committee Objectives:

- Review and respond to all member and provider grievances timely
- Review issues for patterns which may require process changes
- Review all grievances and appeals that may affect the quality and/or equity of care delivered to members
- Ensure all GCHP departments are educated on the appropriate process for communicating member and provider grievances and/or appeals to the correct area for resolution
- Ensure that issues needing intervention are reviewed and routed to the appropriate area for discussion and intervention

G&A Committee Membership:

- ~~Sr. Manager~~Director of Operations (Chair)
- Sr. Grievance and Appeals Specialist
- Chief Medical Officer or designee
- Executive Director of Operations
- Sr. Director of Network Operations or designee
- Manager of Member Services or designee
- Sr. Director of Quality Improvement or designee
- Sr. Director of Care Management
- Sr. Director of Utilization Management
- Sr. Director of Compliance or designee
- Sr. Director of Health Education & Cultural Linguistics or designee
- Director of Pharmacy Services~~Clinical Programs Pharmacist~~ or designee

Meeting Frequency:

The committee meets quarterly.

v. Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) oversees the implementation of the UM Program and promotes the optimal utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM Committee is multi-disciplinary and monitors continuity and coordination of care as well as under- and over-utilization. The committee is charged with reviewing and approving clinical policies, clinical initiatives, and programs before implementation. It is responsible for annually providing input on GCHP's clinical strategies, such as clinical guidelines, utilization management criteria, population health/care management protocols, and the implementation of new medical technologies. The UMC is a subcommittee of the QIHEC, and reports to the QIHEC quarterly.

UMC Responsibilities:

Responsibilities include but are not limited to the following:

- Annual review and approval of the UM and ~~Population Health/~~Care Management Program documents.
- Review and approval of program documents addressing the needs of special populations. This includes but may not be limited to Children with Special Health Care Needs (CSHCN) and Seniors and Persons with Disabilities (SPD).
- Suggest and collaborate with other departments to address areas of patient safety. This may include but is not limited to medication safety and child safety.
- Annual adoption of preventive health criteria and medical care guidelines with guidance on how to disseminate criteria and ensure proper education of appropriate staff.
- Review of the timeliness, accuracy, and consistency of the application of medical policy as it is applied to medical necessity reviews.
- Review utilization and case management monitors to identify opportunities for improvement.
- Review data from Member Satisfaction Surveys to identify areas for improvement.
- Ensure policies are in place to review, approve and disseminate UM criteria and medical policies used in review when requested.
- Review, at least annually, the Interrater Reliability (IRR) test results of UM staff involved in decision making (RN's and MD's) and take appropriate actions for staff that fall below acceptable performance.
- Interface with other GCHP committees for trends, patterns, corrective actions, and outcomes of reviews.

Membership:

- Chief Medical Officer & Co-Chief Health Equity Officer (Chair)
- Chief Innovation Officer & Co-Chief Health Equity Officer
- Sr. Medical Director ~~– currently vacant~~
- Sr. Director of Care Management
- Sr. Director of Utilization Management
- Managers of Care Management
- Managers of Utilization Management
- Director of Pharmacy Services~~Clinical Programs Pharmacist~~
- Physician Reviewers
- Compliance Designee
- Sr. Director of Quality Improvement
- Carelon (formerly Beacon) Regional Chief Medical Officer Behavioral Health

Meeting Frequency:

The UMC meets quarterly at a minimum.

vi. Health Education, Cultural and Linguistics (HE/CL) Committee

The purpose of the HE/CL Committee is to assess the health education, cultural and language needs of the Plan's population. The HE/CL Committee will be responsible to ensure materials of all types are available in languages other than English to appropriately accommodate members with Limited English Proficiency (LEP) skills. The HE/CL Committee will review data to assist GCHP staff and providers to better understand unique characteristics of the ~~varied~~ diverse population served by GCHP. The HE/CL Committee will assist in developing cultural competency and sensitivity training and ensure that those that serve GCHP's population are appropriately trained.

HE/CL Committee Responsibilities:

- Ensure members have access to appropriate health education materials.
- Ensure Providers have access to health education services and materials, including alternative formats.
- Ensure Providers and Plan staff deliver culturally and linguistically (C&L) appropriate healthcare services to GCHP's diverse membership.
- Ensure Providers and staff receive training on cultural competency, language assistance, equity, ~~inclusionSeniors and Persons with Disabilities (SPD) and~~inclusion and/or diversity training.
- Ensure that all members – regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, or language capabilities have equitable access to quality healthcare.
- Ensure that GCHP implements cultural and linguistic requirements set forth by the Department of Health Care Services (DHCS).
- Advises QIHET's programs and initiatives to include but not limited to RE~~aL~~LD and SOGI data collection and usage, provider, members, and community intervention development that addresses disparities, and cultural and linguistic services compliant and grievances analysis and resolution reports.
- ~~Ensure the Population Needs Assessment (PNA) is completed to determine a baseline for serving education and cultural/language needs as well as to develop interventions to address identified unmet population needs~~.
- Collaborate and work with GCHP's Population Health, Health Services, Quality Improvement, Provider Network Operations, and other departments to ensure health education and cultural and linguistic services needs are addressed.
- Ensure opportunities are available to educate members on the disease process, preventive care, behavioral health, plan processes and all other areas essential to good member health.
- Assist providers in educating GCHP members and promote positive health outcomes.
- Ensure that all written information materials comply with the readability and suitability requirements set forth by the Department of Health Care Services. The member informing materials shall be at a sixth grade or lower reading level and be consistent with the GCHP's membership needs.
- Educate GCHP staff on specific cultural barriers that might hinder the delivery of optimal health care.

Membership:

- Sr. Director of Health Education & Cultural Linguistic Services (Chair)
- Chief Medical Officer & Co-Chief Health Equity Officer or designee
- Executive Director of Population Health & Equity
- Representative from Department of Care Management
- Representative from the Department of Communications
- Representative from the Member Services Department
- Representative from Provider Network Operations
- Representative from the Quality Improvement Department
- Representative from Community Relations

- Representative from Grievance and Appeals Department
- Senior Cultural and Linguistic Specialist
- Senior Health Navigator/Health Navigators

Meeting and/or Reporting Frequency:

The committee may meets at a minimum quarterly. The quarterly report will be provided via email to committee members if the committee does not meet.

vii. Credentials/Peer Review Committee (C/PRC)

The Credentials/Peer Review Committee provides guidance and peer input into GCHP's credentialing and practitioner peer review process.

The C/PRC fulfills the credentialing and peer review functions as follows:

Committee Responsibilities:

The C/PRC reviews and evaluates the qualifications of each practitioner/provider applying to become a contracted Network Practitioner/Organizational Provider or seeking recredentialing as a contracted Network Practitioner/Organizational Provider. The C/PRC has authority to:

- Review and ratify Type I Credentialing and Recredentialing practitioner/provider list. Type I files will be presented to the C/PRC on a list of Type 1 files as one group for approvalinformational purposes.
- Receive, review, and act on Type II practitioners/providers applying for Credentialing or Recredentialing.
- Review the quality of carequality-of-care findings resulting from GCHP's credentialing and quality monitoring and improvement activities.
- Act as the final decision maker in regard to the initial and subsequent credentialing of practitioners/providers based on clinical competency and/or professional conduct.
- Review member and provider clinical complaints, grievances, and issues involving clinical quality of care concerns and determine corrective action when necessary.
- Review the Credentialing and Recredentialing policies and procedures annually.
- Establish, implement, and make recommendations regarding policies and procedures.

Membership:

The C/PRC is a peer-review body that includes the CMO and participating practitioners who span a range of specialties, including primary care (i.e., family practice, internal medicine, pediatrics, general medicine, geriatrics, etc.) and specialty care. It consists of 7-9 voting members who serve two-year terms which may be renewed (there are no term limits). Members are nominated by the CMO and approved by the VCMMCC.

To assure due process in the performance of peer review investigations, the CMO shall appoint other physician consultants, as necessary, to obtain relevant clinical expertise and representation by an appropriate mix of physician types and specialties.

Meeting Frequency:

The committee meets quarterly.

viii. Pharmacy & Therapeutics (P&T) Committee

To provide a forum for community and practicing pharmacists, physicians, and Gold Coast Health Plan's (GCHP) Health Services team members to collaborate in the management of the formulary for GCHP's covered Medi-Cal drugs (i.e., Physician Administered Drugs) and establishued evidence-based pharmaceutical management policies and procedures. The P&T Committee is responsible for ensuring GCHP's Members receive high quality, cost-effective, safe, and efficacious medical therapy.

Committee Responsibilities:

- Review formulary inclusions and exclusions, pharmacy policies and procedures, evaluation of pharmacy benefit quality and utilization data.
- Review and approve all matters pertaining to the use of medication, including development of prescribing guidelines and protocols and procedures, to promote high quality and cost-effective drug therapy.
- Review any other issues related to pharmacy quality and utilization.

Membership:

- Director of Pharmacy Services (Chair) or designee
- Clinical Programs Pharmacist
- Chief Medical Officer
- Sr. Medical Director
- Physicians and pharmacists representing a variety of clinical specialtiesspecialties.

Meeting Frequency:

The P&T Committee will meet quarterly with ad hoc meetings called by the P&T Committee Chair as needed.

ix. NCQA Key Stakeholder Forum

The purpose of the NCQA Key Stakeholder Forum is to bring key stakeholders together to review NCQA project status, risks, progress with remediation, and next steps. The goal is to support open communication and partnership between Operational Business Teams and the EPMO in support of achieving NCQA Accreditation.

NCQA Key Stakeholder Forum Scope:

- NCQA Health Plan Accreditation
- NCQA Health Equity Accreditation

NCQA Key Stakeholder Forum Objectives:

- Review NCQA remediation progress status and dashboard
- Discuss risks, issues, and key dependencies
- Review timelines and upcoming milestones
- Share communications and project updates from The Mihalik Group (TMG)
- Provide an open forum for discussion of project feedback, constraints, and ideas sharing

NCQA Key Stakeholder Forum Membership:

- Senior Project Manager (Chair)
- Chief Innovation Officer & Co-Chief Health Equity Officer
- Chief Medical Officer & Co-Chief Health Equity Officer

- Chief Policy and Program Officer
- Chief Diversity Officer
- Executive Director, Operations
- Executive Director, Population Health
- Sr. Medical Director
- Sr. Director, Quality Improvement
- Sr. Director, Care Management
- Sr. Director, Utilization Management
- Sr. Director, Health Education & Cultural Linguistics
- Sr. Director, Compliance
- Sr. Director, Network Operations
- Director, Operations
- Director, Communications
- Director, Pharmacy
- Director, Behavioral Health & Social Programs
- Director, IT Infrastructure and Security Operations
- Sr. Manager, CM & Special Programs
- Sr. Manager, Population Health
- Manager, Quality Improvement
- QI Program Manager II
- Key business owners and/or departmental representatives from:
    - Human Resources
    - Pharmacy
    - Credentialing
    - Information Technology
    - Communications
    - Health Education and Cultural Linguistic Services
    - Population Health
    - Provider Network Operations
    - Quality Improvement
    - Behavioral Health
    - Utilization Management
    - Case Management
    - Compliance
    - Operations
    - Member Services

Meeting Frequency:
The committee meets monthly.

x. MCAS Steering Committee

The Managed Care Accountability Set (MCAS) Steering Committee functions as a subcommittee of and reports directly to the Quality Improvement and Health Equity Committee (QIHEC). The QIHEC reports directly to the Ventura County Medi-Cal Managed Care Commission (VCMCC), which is responsible for the implementation and maintenance of the QIHEC as the overseeing body for quality within Gold Coast Health Plan.

MCAS Steering Committee Objectives:
The role of the MCAS Steering Committee is to align and drive the organization's strategy and initiatives around MCAS, including but not limited to, prioritization, goals, work plans, and performance tracking. The MCAS Steering Committee serves to ensure effective communication processes are in place to adequately

track progress toward work plan activities, provide a platform for candid discussions around barriers to achieving MCAS goals, and create pathways for escalation of performance issues, operational/financial/regulatory risks, and fleeting opportunities.

MCAS Steering Committee Responsibilities:

- Holds overall oversight of the MCAS project.
- Facilitates efforts to align, integrate and focus the organization on MCAS goals, workplans, and priorities.
- Reviews measure performance, plan-level comparisons, and future projections in order to develop MCAS performance targets (e.g., MPL, HPL, 75th percentile).
- Identifies and prioritizes disparities goals to uplift health outcomes.
- Raises and expands awareness, understanding, and application of the use of metrics to drive performance measures and key results.
- Establishes consensus around budgetary priorities to drive MCAS improvement.
- Removes barriers, advances decision-making, and resolves conflicts.
- Celebrates small wins early and often and ensures continuous improvement by acknowledging and incorporating lessons learned from intervention success or those that achieved limited impact.

MCAS Steering Committee Membership:

- Chief Innovation Officer & Co-Chief Health Equity Officer (Chair)
- Chief Medical Officer & Co-Chief Health Equity Officer
- Chief Policy and Program Officer
- Chief Executive Officer, Ex Officio
- Sr. Director, Quality Improvement
- Executive Director, Population Health & Equity
- Executive Director, Operations
- Sr. Director, Care Management
- Sr. Director, Health Education/Cultural Linguistics
- Director, Behavioral Health & Social Programs
- Sr. Director, Network Operations
- Clinical Programs Pharmacist
- Director, Medical Informatics
- Sr. Manager, Population Health
- Manager, Quality Improvement
- RN Manager, Quality Improvement

MCAS Steering Committee Reporting Structure:

The MCAS Steering Committee reports to the QIHEC. The Chair of the MCAS Steering Committee ensures that quarterly reports are submitted to the Quality Improvement and Health Equity Committee (QIHEC).

Meeting Frequency:

The MCAS Steering Committee meets monthly.

i. Behavioral Health Quality Committee

The Behavioral Health Quality Subcommittee is attended by both Gold Coast Health Plan (GCHP) and Carelon Behavioral Health Medical and Clinical Leadership and Practitioners to discuss Behavioral Health Network Practitioner Involvement, Medical Practitioner Involvement within the behavioral health scope, review behavioral health measure performance, and elicit provider feedback.

Behavioral Health Quality Subcommittee Objectives:

These meetings are utilized to ensure care coordination and continuity between medical and behavioral health care, to review quality reporting, develop and discuss quality improvement initiatives, and monitor progress towards addressing Member care needs.

Behavioral Health Quality Subcommittee Responsibilities:

- Discussion of the data collection process (e.g., MCAS/HEDIS data).
- Discussion of any potential issues with the data collection process (e.g., data completeness, gaps in encounter data).
- Discussion around identification of potential reasons for low preliminary rates for selected Behavioral Health Continuity and Coordination measures and/or sub measures
- Collaboration and development of opportunities for improvement
- Analyze the interventions developed and outcomes

Behavioral Health Quality Subcommittee Membership:

- GCHP Chief Medical Officer
- GCHP Senior Medical Director
- GCHP Director of Behavioral Health and Social Programs
- GCHP Behavioral Health Manager
- GCHP Behavioral Health Clinician
- GCHP Behavioral Health Program Specialist
- Carelon West Region Medical Officer
- Carelon Behavioral Health Market Director
- Carelon Director of Behavioral Health Services
- Carelon Manager II, Behavioral Health Services
- Carelon Clinical Quality Program Manager

Behavioral Health Quality Subcommittee Reporting Structure:
The Behavioral Health Quality Subcommittee reports to the QIHEC. The Chair of the MCAS Steering Committee ensures that quarterly reports are submitted to the Quality Improvement and Health Equity Committee (QIHEC).

Meeting Frequency:
The Behavioral Health Quality subcommittee meets at least monthly.

~~XII.~~XI. QIHET PROGRAM KEY FUNCTIONAL AREAS

Population Health Management

GCHP's Population Health Management (PHM) Program ensures that all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, which ultimately leads to longer, healthier, and happier lives, improved outcomes, and health equity. Specifically, the PHM Program:

- Builds trust with and meaningfully engages members.
- Gathers, shares, and assesses timely and accurate data to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes. This data is provided by or through collaboration with the QI Department.

- Addresses upstream drivers of health through integration with public health and social services.
- Supports all members in staying healthy through development of PHM interventions guided by QIHETP identified focus areas. This is accomplished through the provision of gaps reporting and identification of target populations by QI. Gaps reporting and identification of target populations is completed utilizing GCHP's HEDIS® certified software engine as well as through QI analyses.
- Provides care management services for members at higher risk of poor outcomes.
- Provides transitional care services (TCS) for members transferring from one setting or level of care to another.
- Reduces health disparities.
- Identifies and mitigates Social Drivers of Health (SDOH).
- Ensures the collaborative Population Needs Assessment (PNA) is completed to promote a deeper understanding of member needs, particularly social drivers of health, and to deepen relationships between GCHP, public health, and other local stakeholders. ~~pleted to determine a baseline for serving education and cultural/language needs as well as to develop interventions to address identified unmet population needs.~~

T~~In the past year, t~~he PHM program ~~has implemented~~includes two~~ new~~ behavioral economics programs to incentivize members to engage in healthy behaviors to improve their health and wellness; one focusing on members with multiple chronic conditions and another focusing on members with two or more gaps in care. ~~In~~ 2024, T~~t~~he PHM program ~~will also~~also is also -launching a chronic disease management program targeting ~~our~~ diabetic members. ~~GCHP is currently in the building phase for its PHM Program and~~ GCHP will continue to improve the depth and breadth of services available to our members as we learn more about their needs and characteristics through a data-driven, quality improvement approach.

The PHM Program functions under the direction of the Executive Director of Population Health & Equity with clinical quality improvement guidance provided by the CMO.

For additional information regarding the PHM Program and Strategy, see Attachment 2. GCHP PHM Strategy ~~2023~~2024.

Care Management

The Care Management team uses a population health framework that incorporates an interdisciplinary structure utilizing data from across the healthcare continuum. This structure aligns with GCHP's efforts to achieve positive health outcomes for defined populations in alignment with the DHCS Comprehensive Quality Strategy as well as the goals set forth by the CalAIM initiative.

Care Management accepts referrals from a variety of sources such as:

- Medical and/or behavioral claims/encounters
- Utilization Management
- HIF/MET
- Health Risk Assessments
- Electronic Health Records
- Internal GCHP Staff
- Practitioners
- Medical Management Program
- Member or Caregiver
- Discharge Planner
- Transitional Care Services
- Advanced data sources which may include, but are not limited to:
  - Health Information Exchanges

- Homeless Data Integration Systems
- MCAS/HEDIS® identified gaps

These data sources will be evaluated to develop actionable interventions to meet the care needs of targeted populations including~~.~~ addressing care gaps. GCHP offers Care Management services which includes Non-Clinical Care Coordination, Clinical Care Coordination/Non-complex Case Management and Complex Case Management. Care Management utilizes person centered planning and collaboration with the member and or the member's representative to address the member's stated health and/or psychosocial needs; this process may ~~or may not~~ include the development of an Individualized Plan of Care (IPC). Interventions are tailored in response to the member's assessed needs ~~or~~, preferences, and stated goals. Throughout the care management process, the member's needs based on the member's preference are reassessed, and adjustments are made as needed to provide the appropriate level of care. ~~The~~ Care Management team documents care management activities in the Medical Management System. ~~coordination through GCHP's care management software, MedHok. The MedHok platform functions to communicate current IPC status, document member communications, and document provider communications, in order to coordinate care both across the organization and with providers as members transition from various settings. It also incorporates data from GCHP's health information exchange to identify members discharged from the hospital for identified diagnoses (e.g. substance use disorder) to ensure they are followed. Additionally the Care Management team utilizes both Indices and MedHok to identify, document, and close gaps for members enrolled in case management programs.~~

The CM Program functions under the direction of the Chief Medical Officer.

For additional information regarding the Care Management Program, refer to ~~the 2023~~ Attachment 3. 2024 Care Management Program Description.

Utilization Management

GCHP's Utilization Management (UM) Program is integrated with the QIHET Program to ensure continuous quality improvement. The UM Program is designed to ensure that medically appropriate services are provided to all GCHP members through a comprehensive framework that assures the provision of high quality, equitable, cost effective, and medically appropriate healthcare services in compliance with the benefit coverage and in accordance with regulatory and accreditation requirements. UM decisions are made by appropriately trained individuals in a fair and consistent manner.

UM/CM staff will assist providers in making referrals to and in locating necessary carved-out and linked services. The UM Program includes continuous quality improvement process which are coordinated with QI Program activities and supported by the QI Department as appropriate. The UMC and QIHEC work together to collaborate on and resolve cross-related issues.

The Utilization Management Program functions under the direction of the Chief Medical Officer.

For additional information regarding the UM Program, refer to the ~~2023~~ Attachment 4. 2024 Utilization Management Program Description.

Behavioral Health

The Behavioral Health (BH) Program ensures that members' behavioral health needs are met through oversight and coordination of the non-specialty mental health benefit, coordination with the County Mental Health Plan for specialty mental health services and substance use disorder treatment and implements incentive programs to advance innovative models of care. Behavioral Health is integrated into the QIHET Program through monitoring

of various metrics and development of interventions for measures such as follow-up after an ED visit for mental illness or substance use. Behavioral Health then coordinates closely with Quality Improvement, Care Management, Population Health Management, and Utilization Management to implement interventions focused on behavioral healthcare.

The Behavioral Health Department and Program functions under the direction of the Executive Director of Population Health & Equity as well as the Director of Behavioral Health & Social Services, a licensed clinical social worker. Clinical quality improvement guidance is ~~also~~ provided by the CMO. ~~Additionally,~~ GCHP delegates behavioral health to an NCQA Accredited ~~leverages it's~~ managed behavioral health organization (MBHO), Carelon. GCHP leverages Carelon's ~~(previously Beacon)'s~~ National Medical Director for Provider Partnerships, a board-certified psychiatrist, within ~~our~~ GCHP's delegated behavioral health network to provide behavioral health clinical quality oversight through participating in GCHP's quality committees (UMC and QIHEC), participation in regular care management meetings, and the provision of clinical feedback to GCHP.

~~The BH Program functions under the Executive Director of Population Health & Equity with clinical quality improvement guidance provided by the CMO.~~

For additional information regarding the BH Program, refer to ~~the~~ Attachment 5. 2024 Behavioral Health Program Description.

For additional information regarding behavioral health quality, refer to Carelon's 2024 Quality Improvement Program Description.

Pharmacy Services

GCHP's Pharmacy Services Program is responsible for developing and implementing effective retrospective Drug Utilization Review (DUR) processes to assure that drug utilization is appropriate, medically necessary, and not likely to result in adverse events. These programs are aligned with DHCS' requirements for GCHP to provide oversight and administration of the Medi-Cal Rx Pharmacy benefit and related activities.

Scope:

The scope may include, but is not limited to, the following data/activities/processes:

- Utilization Management
- Quality Improvement
- Grievance and Appeals
- Provider Materials/Communications
- Clinical Programs and Services
- Member Services

Pharmacy Services Objectives:

- Conduct DURs to analyze and evaluate the appropriate use of medications, to prevent potential overutilization or underutilization of medication, monitor for medication adherence, prevent adverse effects from medication usage, and identify any utilization patterns that require further education or intervention for enrolled members
- Communicate updates and news from DHCS regarding Medi-Cal Rx and other pharmacy related matters/services
- Review and respond to all member and provider questions in a timely manner
- Review any issues or concerns related to pharmacy quality, medication usage, medication safety and medication therapy management

- Review pharmacy claims data to perform quality improvement and to identify opportunities for improvement
- Identify and monitor for potential fraud or abuse of controlled substances by members, providers and/or pharmacies
- Conduct educational programs for staff, providers, and/or pharmacies
- Participate in DHCS Medi-Cal Global DUR Board and other DHCS organized pharmacy committee meetings
- Participate and collaborate with other departments including, but not limited to: Integrated Care Team (ICT) meetings, Joint Operations meetings (JOMs)
- Review and update policies and procedures at least annually

The Pharmacy Services Program functions under the direction of the Chief Medical Officer.

~~XIII.~~XII. DELEGATION OF QUALITY IMPROVEMENT

Delegation is the formal process by which the health plan gives an external entity the authority to perform certain functions on its behalf. These functions may include quality improvement, health equity, population health, utilization management, credentialing/recredentialing, and grievance and appeals. GCHP retains accountability for ensuring the function is being performed according to expectations and standards set forth by DHCS and GCHP.

GCHP will evaluate the delegated entity's capacity to perform the delegated activities prior to delegation. GCHP will only delegate activities to entities who have demonstrated the ability to perform those duties, and who have the mechanisms in place to document the activities and produce associated reports, prior to delegation of that activity. GCHP retains the right to delegate these functions.

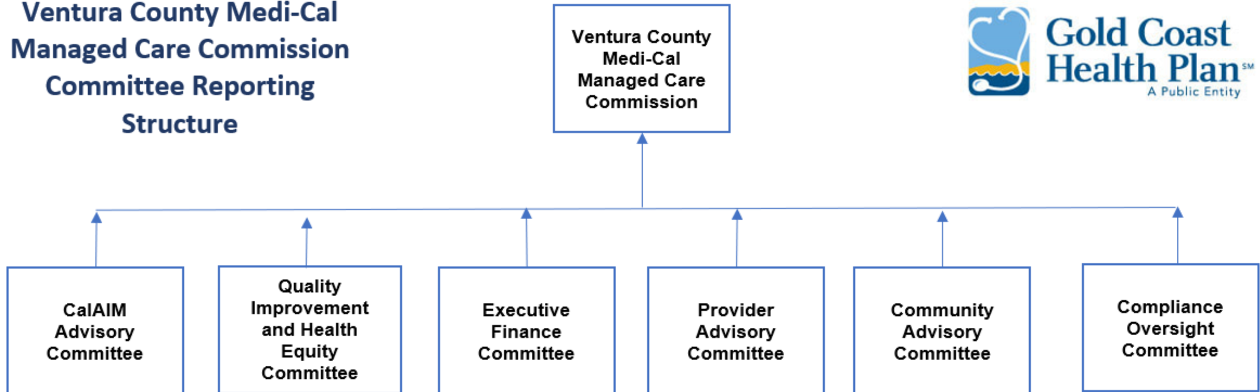
Any delegated functions are fully described in a mutually agreed upon signed and written formal delegation agreement between GCHP and each delegated entity and includes an effective date. All agreements clearly define GCHP's and the delegate's specific duties, responsibilities, activities, reporting requirements and identifies how GCHP will monitor and evaluate the delegate's performance. The agreement also includes the GCHP's right to resume the responsibility for conducting the delegated function should the delegated entity fail to meet GCHP standards.

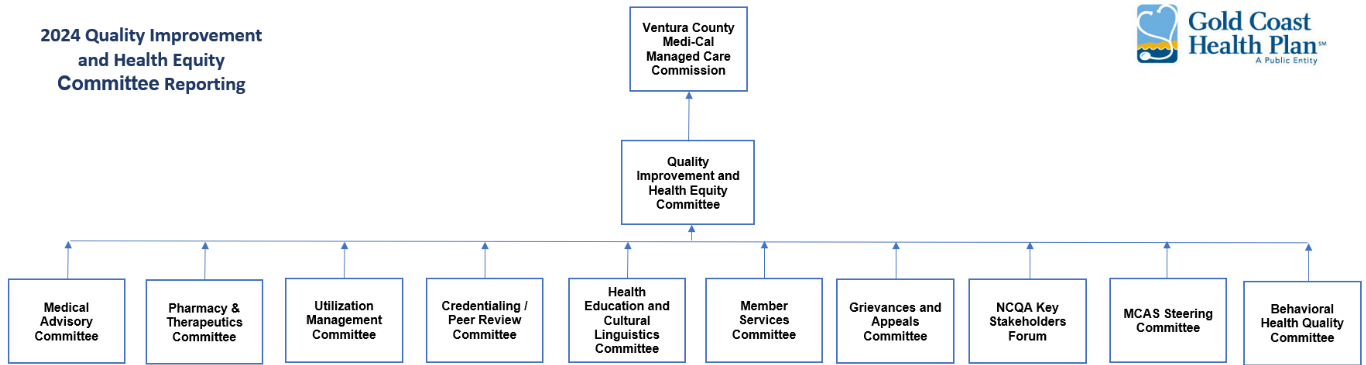
GCHP conducts ongoing oversight, evaluation, and monitoring of the delegate. At a minimum, an annual audit is conducted using an audit tool that is based upon current NCQA, DHCS, and GCHP standards and modified on an as-needed basis. In the event any deficiencies are identified through the oversight process, corrective action plans are implemented based upon areas of non-compliance. If the delegate is unable to correct or does not comply with the corrective action plan within the required timeframe, GCHP will take action that may include imposing sanctions, de-delegation of the delegated function or termination of the contract or agreement. Focused audits may be performed to verify deficiencies have been corrected or if a quality issue is identified. Audit results and outcomes of corrective action plans are reported to QIHEC.

Delegated entities are required to submit at least semi-annual reports to GCHP according to the reporting schedule specified in the delegation agreement. Joint Operation Meetings (JOM) are held on a monthly or quarterly basis as a means of discussing performance measures and findings as needed. JOMs include~~s~~ representation from the delegate and GCHP departments as applicable.

~~XIV.~~XIII. GOLD COAST HEALTH PLAN QUALITY COMMITTEE ORGANIZATIONAL CHART

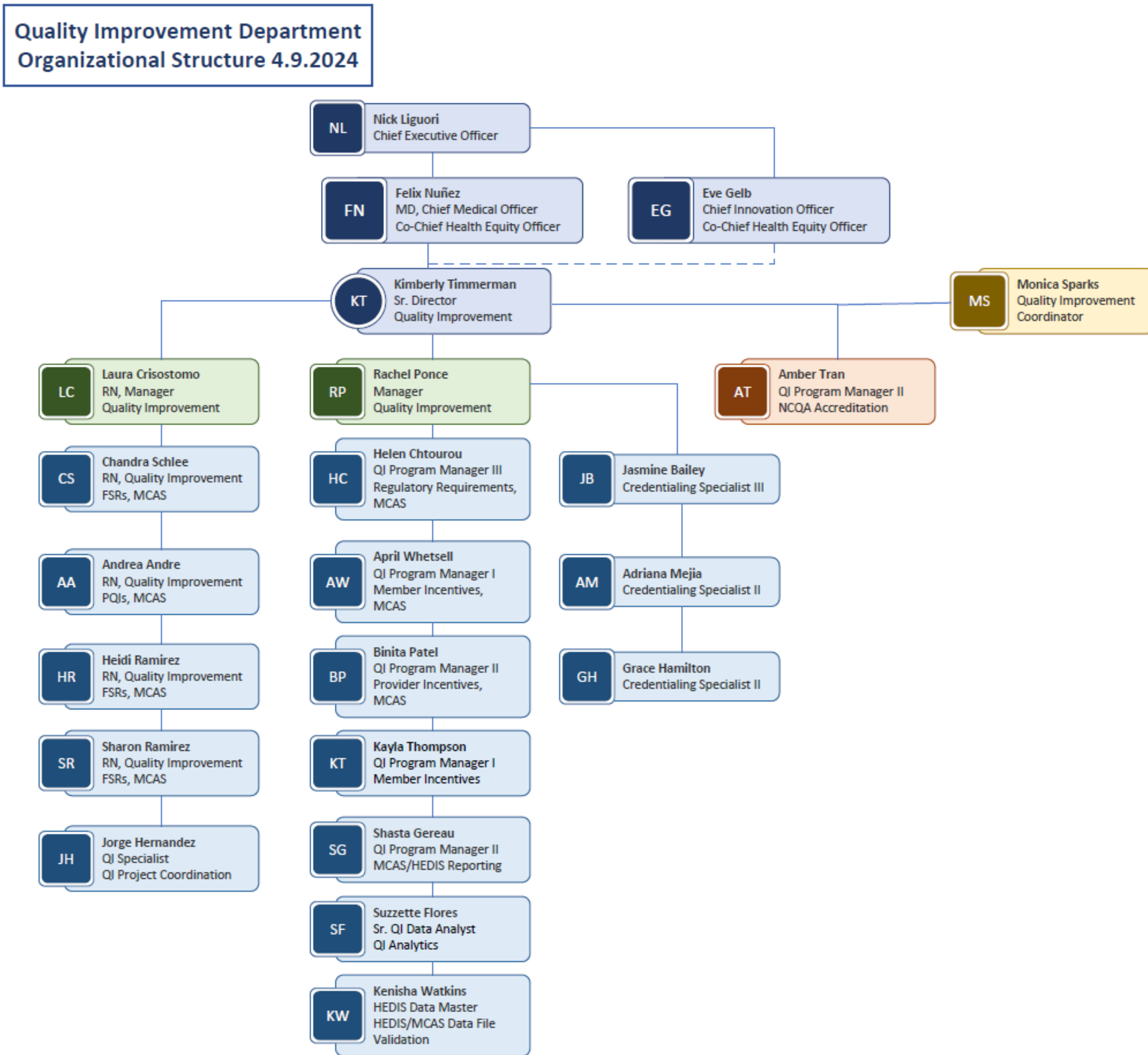
The following organizational chart shows the GCHP Quality Committees that advise the Ventura County Medi-Cal Managed Care Commission and their reporting relationships:





~~XV.~~XIV. QUALITY IMPROVEMENT DEPARTMENT ORGANIZATIONAL CHART

The following organizational chart shows the GCHP Quality Improvement Department reporting relationships:



~~XVI.~~XV. QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE MEETINGS FOR CALENDAR YEAR 202~~3~~4

Dates:	
Tuesday	March ~~21~~19, ~~2023~~2024
Tuesday	June ~~13~~11, ~~2023~~2024
Tuesday	September ~~19~~17, ~~2023~~2024
Tuesday	December ~~5~~3, ~~2023~~2024
Location: GCHP Community Room 711 E. Daily Drive Suite 110, Camarillo CA 93010.~~Bell Canyon Conference Room~~ or via teleconference or web conference (with audio)	

XI. RESOURCES

Availability of QIHET Program to practitioners and members

The QIHET Program Description is available to practitioners and members on GCHP's website at www.goldcoasthealthplan.org. Printed copies are available upon request.

- The 2024 Quality Improvement and Health Equity Transformation Program Description was approved by the Quality Improvement and Health Equity Committee on May 7, 2024.
- ~~An~~d The Quality Improvement and Health Equity Transformation Work Plan was~~ere~~ approved by the Quality Improvement Committee March 20, 2024.
- The2024 Quality Improvement and Health Equity Transformation Program Description and Work Plan were approved by Ventura County Medi-Cal Managed Care Commission (VCMMCC) on May XX~~22~~, 2024

~~REFERENCES~~References

- Gold Coast Health Plan Quality Improvement and Health Equity Committee Charter
- Gold Coast Health Plan Policy QI-002: Quality and Health Equity Performance Improvement Requirements
- ~~Gold Coast Health Plan Utilization Management Program Description~~
- ~~Gold Coast Health Plan Care Management Program Description~~
- ~~Gold Coast Health Plan Behavioral Health Program Description~~
- Carelon's ~~2023~~ 2024 Quality Improvement Program Description
- Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 19-017: Quality and Performance Improvement Requirements
- GCHP DHCS Contract 23-30242~~10-87128 A30~~, Exhibit A, Attachment III~~4~~
- HEDIS® - Healthcare Effectiveness Data and Information Set - a registered trademark of the National Committee for Quality Assurance (NCQA)
- CAHPS® - Consumer Assessment of Healthcare Providers and Systems - a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)
- NCQA Standards and Guidelines for the Accreditation of Health Plans
- DHCS Comprehensive Quality Strategy, February 2022
- DCHS California Advancing and Innovating Medi-Cal (CalAIM)
- National Quality Strategy, Agency for Healthcare Research and Quality (AHRQ)
- The Institute for Healthcare Improvement (IHI)
- Patient Protection and Affordable Care Act, Public Law No. 111-148, enacted March 23, 2010
- Kohn KT, Corrigan JM, Donaldson MS. *To Err Is Human: Building a Safer Health System.* Washington, DC: National Academy Press; 1999
- Title 42, Code of Federal Regulations, Section 438.240 Quality Assessment and Performance Improvement Program

Attachments

- Attachment 1. ~~2023~~ 2024 QIHETP Resources
- Attachment 2. ~~2023~~ 2024 GCHP PHM Strategy ~~2023~~
- Attachment 3. ~~2024~~ 2024 Care Management Program Description ~~Behavioral Health Program Description~~
- Attachment 4. 2024 Utilization Management Program Description ~~2024 Care Management Program Description~~
- Attachment 5. Behavioral Health Program Description ~~2024 Utilization Management Program Description~~

~~**The 2023 Quality Improvement and Health Equity Transformation Program Description and Work Plan were approved by the Quality Improvement Committee on March 21, 2023.**~~

~~**The 2023 Quality Improvement and Health Equity Transformation Program Description and Work Plan were approved by Ventura County Medi-Cal Managed Care Commission (VCMMCC) on April 24, 2023.**~~

GCHP Quality Improvement and Health Equity Transformation Program Resources

CHIEF MEDICAL OFFICER
The Chief Executive Officer (CEO) has appointed the Chief Medical Officer (CMO) as the designated physician to support the QIHET Program by providing day to dayleadership, oversight and management of quality improvement and health equity activities.

The CMO in collaboration with the Chief Health Equity Officer (HEO) has the overall responsibility for the clinical direction of GCHP's QIHET Program. The CMO in collaboration with the HEO ensures that the QIHET Program monitors the full scope of clinical services rendered, that services are rendered equitably, that identified problems are resolved, and corrective actions are initiated when necessary and appropriate.

The CMO serves on the following committees: QIHEC, C/PRC, UM, HE/CL, G&A, MSC, and MAC. The CMO in collaboration with the HEO works directly with all GCHP department heads and executive team members to achieve the goals of the QIHET Program. Further, as CMO and a member of the Quality Improvement and Health Equity Committee, the CMO in collaboration with the HEO annually oversees the approval of the clinical appropriateness of the Quality Improvement and Health Equity Transformation Program.

The CMO reports to the Chief Executive Officer. The CMO's job description also specifies that they have the ability and responsibility to inform the Chief Executive Officer, and if necessary, the VCMMCC, if at any time they believe their clinical decision-making ability is being adversely hindered by administrative or fiscal consideration.

CHIEF INNOVATION OFFICER
The Chief Innovation Officer (CIO) is responsible for driving the execution of wide-reaching, complex, and cross-functional work plans and performance improvement initiatives in partnership with the CEO and Executive Team. The CIO reports directly to the CEO.

The CIO is responsible for organization-wide coordination, collaboration, and integration by enhancing the practice of performance-focused activities, advancing the organization's capability to develop and execute goals and work plans, and to continuously track performance including a focus on quality improvement and health equity. The CIO serves to improve the execution and integration of complex, enterprise-wide strategic initiatives, including timely and meaningful engagement of the Executive and Leadership Teams in quality improvement and health equity activities.

The CIO serves on the QIHEC and works directly with GCHP department heads and executive team members to achieve transparency and communication; cross-functional coordination, collaboration, and integration; and meaningful engagement of management and staff in achievement of the goals set forth by the QIHET Program.

CHIEF HEALTH EQUITY OFFICER
The CEO has appointed the Chief Health Equity Officer (HEO) as the designated executive authority to provide health equity expertise to support the QIHET Program by providing day to day oversight and management of quality improvement and health equity activities. The HEO reports directly to the Chief Executive Officer.

The HEO in collaboration with the Chief Medical Officer (CMO) has the overall responsibility for the health equity direction of GCHP's QIHET Program. The HEO in collaboration with the CMO ensures that the QIHET Program monitors the full scope of clinical services rendered, that services are rendered equitably, that identified problems are resolved, and corrective actions are initiated when necessary and appropriate.

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GCHP Quality Improvement and Health Equity Transformation Program Resources

The HEO serves on the following committees: QIHEC, UM, HE/CL, and CAC. The HEO in collaboration with the CMO works directly with all GCHP department heads and executive team members to achieve the goals of the QIHET Program. Further, as HEO and a member of the Quality Improvement and Health Equity Committee, the HEO in collaboration with the CMO, annually oversees the approval of the health equity appropriateness of the Quality Improvement and Health Equity Transformation Program.

The CMO and CIO both serve as Co-Chief Health Equity Officers.

SENIOR MEDICAL DIRECTOR

The Senior Medical Director (MD) assists in the functions of the Health Services Department by collaborating with the Chief Medical Officer, Health Services Staff, Quality Improvement Department, Grievance and Appeals Department, and other GCHP staff. This collaboration allows the MD to oversee and carry out utilization management decisions, resolve clinical complaints and appeals and monitor clinical quality improvement programs. Key performance and quality of care indicators and criteria are established and reported to the QIHEC by the MD. The MD also serves on committees as directed by the CMO including the QIHEC, C/PRC, UMC and MAC.

Senior Director, Quality Improvement

The Sr. Director, Quality Improvement is responsible for working with sub-committee chairs and appropriate departments to ensure all quality and health equity monitoring activities, analyses, and improvement initiatives are in place. The Sr. Director, Quality Improvement works with the ~~QIC~~QIHEC, quality subcommittees, and leadership to educate all GCHP staff on the importance and role of quality improvement and health equity~~,~~ communication, analysis, and reporting. The Sr. Director, Quality Improvement is a mentor for all department heads and works with them to implement processes that will create ~~both~~ efficient, ~~and~~ high-quality, and equitable services.

The Sr. Director, Quality Improvement reports to the Chief Medical Officer (CMO) to ensure that the CMO is updated on any deficiencies and proposed improvement and equity activities. The CMO in collaboration with the HEO has overall responsibility for the clinical direction of GCHP's Quality Improvement and Health Equity Transformation Program (QIHETP).

Specific roles and responsibilities of the Sr. Director, Quality Improvement include but are not limited to:

- Ensuring that the annual QIHETP Description and Work Plan are created and reviewed by all appropriate ~~areas~~areas.
- Working with all appropriate departments in the creation of the annual QIHETP Evaluation and analysis of results
- Ensuring ~~QIC~~QIHEC approval of all QIHETP documents annually
- Guiding the collection of MCAS for Medicaid data as mandated by contractual requirement and assisting in the development of activities to improve ~~care~~care.
- Ensuring that appropriate principles of data collection and analysis are used by all departments when looking for improvement ~~opportunities~~opportunities.
- Providing educational opportunities for GCHP staff members key to improving care, health equity, and service to better target improvement ~~initiatives~~initiatives.

The Sr. QI Director oversees the GCHP QI Department under the direction of the CMO. The Sr. QI Director directly oversees the QI Department's two QI Managers, each overseeing various functions, 1 QI Program Manager focused on NCQA Accreditation, and 1 Quality Improvement Coordinator. ~~The first~~One QI Manager is a licensed RN overseeing 4~~3~~ QI Registered Nurses and one QI Specialist. The second QI Manager oversees a multidisciplinary team including 5~~3~~ QI ~~Project~~

GCHP Quality Improvement and Health Equity Transformation Program Resources

Program Managers, 1~~2~~ Sr. Quality Improvement Data Analysts, the HEDIS Data Master, and 3~~2~~ QI Credentialing Specialists ~~focused on credentialing of practitioners/organizational providers~~.

The QI Department provides quality improvement subject matter expertise, oversight of ~~various~~ quality improvement and health equity activities, data analytics, and support of other GCHP business units such as Population Health and Behavioral Health. Support of other business units includes but is not limited to guidance on QIHET metrics, identification of opportunities for improvement and QIHET priorities, member-level gap reports, and intervention determination and execution.

Additionally, the QI team is supported by ~~administrative staff,~~ a Principal Data Analyst residing in the IT Population Health Enablement Department, a Sr. IT Business Analyst residing in the IT Population Health Enablement Department, the Sr. Director Data Engineering, the Director of Business Solutions, and the Health Education and Cultural Linguistics Team.

QI Management

QI Manager – Clinical

The Clinical QI Manager is a licensed Registered Nurse overseeing ~~three~~ four QI Registered Nurses and one QI Specialist. The Clinical QI Manager reports directly to the Sr. Director, Quality Improvement and is responsible for oversight of clinical care quality and health equity including but not limited to:

- Potential Quality of Care Investigations (PQI)
- Facility Site Reviews (FSR)
- Physical Accessibility Review Surveys (PARS)
- Annual MCAS/HEDIS® medical record overreads
- Quarterly Initial Health Assessment (IHA) medical record audits
- Bi-annual pediatric lead screening (LSC) medical record audits
- Dissemination of gaps reports for IHAs and LSC
- Clinical Quality Improvement activities for identified areas of focus

QI Manager – Non-Clinical

The Non-Clinical QI Manager oversees a multidisciplinary team including ~~three~~ five QI ~~Project~~ Program Managers, ~~two~~ one Sr. Quality Improvement Data Analysts, a QI HEDIS Data Master, and three~~two~~ QI Credentialing Specialists ~~focused on credentialing of practitioners/organizational providers~~. The Non-Clinical QI Manager reports directly to the Sr. Director, Quality Improvement and is responsible for oversight of quality improvement and health equity activities including but not limited to:

- Completion of the annual QIHETP Description and Work Plan
- Completion of the annual QIHETP Evaluation and results analysis
- Monitoring of quality improvement and health equity metrics
- Identification of opportunities and strategies for quality improvement and health equity
- Development and implementation of quality improvement and health equity activities
- Completion of the annual MCAS/HEDIS® Audit
- Monitoring and improvement of monthly data capture and processing activities for quality and health equity metrics reporting
- Completion of all required Credentialing activities

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GCHP Quality Improvement and Health Equity Transformation Program Resources

QI Team

QI Registered Nurse (~~x3~~x4)

The QI Registered Nurse(s) is a licensed registered nurse completing clinical quality improvement activities. Each QI registered nurse completes various regulatory functions including FSRs, PQIs, PARS, and focused medical record audits. All QI Registered Nurses are responsible for clinical quality improvement and health equity activities as well as annual MCAS/HEDIS® medical record overreads. The QI Registered Nurse(s) directly reports to the Clinical QI Manager.

QI ~~Project~~ Program Manager (~~x3~~x5)

The QI ~~Project~~ Program Manager(s) is responsible for managing, leading, coordinating, and/or assisting with core QI projects and key accountabilities. These projects include performance improvement projects (PIPs/IPs), health initiatives, MCAS/HEDIS® reporting including vendor oversight, quality improvement and health equity interventions to improve quality outcomes or member satisfaction, dashboard monitoring, and reporting analyses. The QI Project Manager(s) directly reports to the Non-Clinical QI Manager.

HEDIS Data Master (x1)

The HEDIS Data Master is accountable for engaging in and supporting ~~all aspects of the~~data submission activities for the MCAS/~~-~~HEDIS program ~~and regulatory operations~~ including ~~vendor oversight,~~ system and technical configurations, data validation and optimization, and management of strategic efforts to maximize MCAS/HEDIS results. The role has responsibilities that range from oversight of ensuring adequate claims and encounter data collection, maintaining data systems, as well as facilitating data transfer efforts.

Senior QI Data Analyst (~~x2~~x1)

The Sr. QI Data Analyst~~(s)~~ is responsible for providing analytical support for the QIHETP. The Sr.QI Data Analyst~~(s)~~ provides ~~coordination, collection,~~ interpretation~~,~~ and analysis of~~,~~ ~~and reporting of~~ quality improvement and health equity data to determine areas suitable for the implementation of a QIHETP ~~Project~~ and leads ~~re-measurement~~analytical efforts to determine effectiveness. They develop and produce reports that monitor and benchmark utilization and quality and health equity performance indicators, monitor for adverse trends, and recommend modifications and corrective action. ~~This is primarily accomplished through oversight of GCHP's MCAS/HEDIS® vendor, Inovalon, as well as coordination of the annual MCAS/HEDIS® audit.~~ Additionally, the Sr. QI Data Analyst~~(s)~~ supports analyses requested by other departments such as Behavioral Health, Care Management, and Population Health. These analyses identify target populations, metrics for improvement, rate trends, ~~value-based performance reporting~~, amongst others. The Sr. QI Data Analyst(s) directly reports to the Non-Clinical QI Manager.

~~QI Specialist –~~ Credentialing Specialist (x3~~2~~)

The ~~QI~~ Credentialing Specialist(s) ~~focused on credentialing of practitioners and organizational providers~~ is responsible for the compilation and verification of information for initial credentialing and re-credentialing of licensed independent practitioners and organizational providers, according to Health Plan and Accreditation Standards. The ~~QI~~ Credentialing Specialist(s) ~~focused on credentialing~~ coordinates quality review information at the time of practitioner credentialing/re-credentialing with the Chief Medical Officer, Provider Network Operations, and the Credentialing/Peer Review Committee. The ~~QI~~ Credentialing Specialist(s) ~~focused on credentialing~~ directly reports to the Non-Clinical QI Manager.

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GCHP Quality Improvement and Health Equity Transformation Program Resources

QI Specialist (x1)
The Quality Improvement Specialist is responsible for coordinating quality improvement functions and activities including, but not limited to, coordination of departmental functions, maintenance of dashboards/tools; support for MCAS/HEDIS, DHCS audits, quality committees; and other regulatory mandates.

Quality Improvement Coordinator (x1) ~~Administrative Support Staff~~
The quality improvement coordinator is responsible for providing ~~A~~administrative support ~~staff is responsible for secretarial~~ and clerical support to the QI Department as well as other quality improvement and health equity activities as necessary. ~~Administrative support staff~~The Quality Improvement Coordinator reports directly ~~report~~ to the Sr. Director, Quality Improvement.

Information Technology (IT) Resources

Sr. Director Data Engineering
The Sr. Director of Data Engineering is responsible for implementing and managing data platforms and analytical capabilities across GCHP's technical ecosystem including MCAS/HEDIS data domains. The Sr. Director of Data Engineering manages the team of data engineers responsible for designing and building the data pipelines that generate the data files submitted to GCHP's HEDIS® certified software vendor, Inovalon. The Sr. Director of Data Engineering actively collaborates with QI leadership to guide technical solutions and data exchanges with GCHP partners. The Sr. Director of Data Engineering directly reports to the Executive Director of IT.

Director of Population Health Enablement and Analytics
The Director of Population Health Enablement and Analytics, plans, coordinates, and supervises all activities related to the design, development, and implementation of organizational information systems and software applications including those applicable to the QIHETP. In this role, they are responsible for oversight of the monthly creation of data files submitted to GCHP's HEDIS® certified software vendor, Inovalon. They provide subject matter expertise regarding the resolution of IT issues related to the design, development, and deployment of mission-critical information and software systems including those applicable to the QIHETP. The Director of Population Health Enablement and Analytics directly reports to the Executive Director of IT.

Principal Data Analyst
The Principal Data Analyst is responsible for the monthly creation of data files submitted to GCHP's HEDIS® certified software vendor, Inovalon. They perform data quality checks for each data source, resolve data integrity issues, and ensure that all required files are accurate when sent to and received by Inovalon. They also ensure that all required files are sent at appropriate intervals for calculation of both monthly prospective rate reporting as well as the annual MCAS/HEDIS® rate reporting. The Principal Data Analyst engages with the QI team to develop and document business requirements in collaboration with the QI HEDIS Data Master. The Principal Data Analyst directly reports to the IT Director of Population Health Enablement and Analytics.

Sr. IT Business Analyst
The Sr. IT Business Analyst is responsible for providing subject matter expertise and historical knowledge of the monthly creation of data files submitted to GCHP's HEDIS®

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certified software vendor, Inovalon. They ensure that all required files are accurate, sent to and received by Inovalon, and sent at appropriate intervals for calculation of both monthly prospective rate reporting as well as the annual MCAS/HEDIS® rate reporting. The Sr. IT Business Analyst directly reports to the IT Director of Population Health Enablement and Analytics~~IT Director of Business Solutions~~.

Health Education/Cultural and Linguistics Staff

The Health Education/Cultural and Linguistics team establishes guidelines for ensuring quality health education materials are available to providers, members, and the communities. The team identifies the best distribution channel to present materials, adhering to a strict set of regulatory guidelines modified as necessary to ensure the collateral is compliant with all state regulations. The Health Education team develops health education materials in the right brand, style, and grade level, guiding the materials through the compliance and approval process.

Health Navigators provide support for the QIHET Program by performing focused outreach attempts to members using a variety of methods. Outreach campaigns are targeted based on review and analysis of available data by the QI team. Campaigns are modified as needed to support improvement. Campaigns may include outreach for services such as chronic conditions, tobacco cessation, and health promotion campaigns to close gaps in care for services related to preventive health. Beyond direct member telephonic outreach, the QIHET Program may also employ other methods of member outreach in our ongoing efforts to ensure members receive appropriate care. These include:

- Live outreach calls
- Text messaging
- Health tips targeted to specific populations or conditions
- Targeted member mailings
- Targeted provider communications
- Community events
- Member Newsletters

2024 Quality Improvement & Health Equity Transformation Work Plan

QIHEC Approved: March 19, 2024

Commission Approved:

GOLD COAST HEALTH PLAN

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Reference Guide

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1	2024 Quality Improvement & Health Equity Transformation (QIHET) Program Description	Update the 2024 QIHET Program Description.	Quality Improvement
2	2024 Quality Improvement and Health Equity Transformation Work Plan	Update the 2024 QIHET Work Plan	Quality Improvement
3	2023 Quality Improvement and Health Equity Transformation Work Plan Evaluation	Complete the 2023 QIHET Work Plan Evaluation.	Quality Improvement
4	2024 HEDIS® Compliance Audit™	Successfully complete and pass the annual HEDIS® Compliance Audit™ and receive "reportable" status for all measures.	Quality Improvement
5	Utilization Management: Clinical Practice Guidelines	Complete annual review and adoption of evidence-based Preventive Health Guidelines (PHG), including the Diabetes and Asthma Clinical Practice Guidelines (CPG).	Utilization Management
6	Complex Case Management	Develop and implement a standardized turn-around-time (TAT) process for members identified as eligible for complex case management per NCQA CCM requirements.	Care Management
7	Care Gap Closure	Implement strategies to close care gaps for MCAS measures.	Care Management
8	Tobacco Cessation	Increase rate of tobacco cessation interventions in members identified as tobacco users.	Health Education / Cultural Linguistics
9	Initial Health Appointment (IHA)	Increase rates of Initial Health Appointment (IHA) completion by providers.	Quality Improvement
10	Opioid Utilization Monitoring	Monitor member opioid utilization via pharmacy claims from Medi-Cal Rx and monitor for any trends where the utilization exceeds more than a 5% increase from the prior quarter in any category.	Pharmacy
11	Population Needs Assessment (PNA)	NCQA compliant PNA is part of the Population Health Strategy Report submitted to DHCS.	Population Health
12	Wellth Program	Implement a QI focused program with Wellth for full-scope Medi-Cal members who are 18+ years of age, are taking at least one medication and have multiple care gaps for which GCHP is held to the DHCS MPL (50th percentile).	Population Health
13	Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	Increase the FUM-30 rate to meet or exceed the DHCS MPL (50th percentile).	Behavioral Health
14	Behavioral Health: Follow-Up After Emergency Department Visit for Substance Use – 30 Days	Increase the FUA-30 rate to meet or exceed DHCS MPL (50th percentile).	Behavioral Health
15	Asthma Medication Ratio (AMR)	Increase the AMR rate for members, 5 to 64 years of age, who had persistent asthma and had a $\geq$ 0.50 ratio of controller medications to total asthma medications to meet or exceed the DHCS MPL (50th percentile).	Quality Improvement Pharmacy
16	Breast Cancer Screening (BCS)	Increase the percentage of women 50-74 years of age who had a mammogram to screen for breast cancer to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement Health Education/ Cultural Linguistics
17	Cervical Cancer Screening (CCS)	Increase percentage of women 21-64 years of age who were screened for cervical cancer to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement

	Metric	Goal	Department
18	Child and Adolescent Well-Care Visits (WCV)	Increase the percentage of members, 3-21 years of age, who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement
19	Childhood Immunization Status – Combo 10 (CIS-10)	Increase the percentage of members, two- years of age, who completed all Combo-10 immunization by their 2nd birthday to exceed the 75th national Medicaid percentile established by NCQA.	Quality Improvement
20	Chlamydia Screening in Women (CHL)	Increase the rate of chlamydia screening in members 16 to 24 years of age to meet or exceed the 75th national Medicaid percentile established by NCQA.	Quality Improvement Health Education / Cultural Linguistics
21	Colorectal Cancer Screening (COL)	Increase the percentage of members 45- to 75-year-old who had an appropriate screening for colorectal cancer from 30.86% (2023 MY) to the minimum performance level (MPL) established by DHCS (50th percentile).	Quality Improvement
22	Developmental Screening in the First Three Years of Life (DEV)	Increase the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding, or on, their first, second or third birthday, by 3% compared to the prior measurement year.	Quality Improvement
23	Health Equity Controlling Blood Pressure (CBP)	Increase the CBP rate for members 21-44 years of age to meet or exceed the DHCS MPL (50th percentile).	Quality Improvement Population Health
24	Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD-Poor Control	Decrease the percentage of members with diabetes who are 18-75 years of age and have GSD > 9.0% to meet the DHCS HPL (90th percentile).	Quality Improvement
25	Immunization Status for Adolescents – Combo 2 (IMA-2)	Increase the percentage of adolescents who completed all IMA-2 immunizations by their 13th birthday to exceed to DHCS MPL (50th percentile).	Quality Improvement
26	Lead Screening in Children (LSC)	Increase the percentage of children who had one or more capillary or venous blood lead tests for lead poisoning by their 2nd birthday to meet the 75th national Medicaid percentile established by NCQA.	Quality Improvement
27	Prenatal and Postpartum Care (PPC)	Increase the percentage of women with live birth deliveries who completed prenatal and postpartum exams to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement
28	Topical Fluoride Varnish (TFL)	Increase the percentage of members, ages 1 through 20, who received at least two topical fluoride applications during the measurement year to meet or exceed the DHCS MPL (50th).	Quality Improvement
29	Well-Child Visits in the First 30 Months of Life (W30)	Increase the percentage of children who had well-child visits with a PCP to meet or exceed the DHCS MPL (50th percentile)	Quality Improvement
30	2024 DHCS Required QI Activity(s)	With guidance from DHCS, complete the 2024 required QI activity (s).	Quality Improvement
31	DHCS Child Health Equity Focused Collaboration on Well-Care Exams	Improve the completion of well-child visits.	Quality Improvement
32	2023-2026 PIP Clinical Topic: W30-6+ among Hispanic/Latinx Members	Improve the performance rate for Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) among the Hispanic/Latinx population.	Quality Improvement
33	2023-2026 PIP Non-Clinical Topic: Percentage of Provider Notifications for Members with SUD/SMH Diagnoses within 7 Days of an ED Visit	Improve the percentage of provider notifications for members with substance use disorder (SUD) and / or specialty mental health (SMH) diagnoses following or within 7 days of emergency department (ED) visit.	Quality Improvement

	Metric	Goal	Department
34	Cultural and Linguistic Needs & Preferences	• By July 31, 2024, GCHP's Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules from four to seven which will include Diversity, Equity, and Inclusion (DEI) training program as per DHCS (APL 23-025) that encompasses sensitivity, diversity, cultural competence and cultural humility, and health equity trainings. • By July 31, 2024, GCHP's HECL Department shall conduct three Cultural and Linguistic (C&L)/DEI trainings with three Provider offices per quarter. • By December 31, 2024, GCHP's HECL Department shall report on the number of C&L fulfilment and benchmarks quarterly during the QIHEC meeting.	Health Education / Cultural Linguistics
35	Primary and Specialty Care Access	Ensure primary and specialty care access standards met for minimum of 90% of providers.	Provider Network Operation
36	Network Adequacy	Assess and improve network adequacy as demonstrated by availability of practitioners.	Provider Network Operations
37	After Hours Availability	Conducts surveys to ensure members are able to reach a provider after hours.	Provider Network Operations
38	Provider Satisfaction	Field provider survey and develop action plan(s) to improve areas of low performance.	Provider Network Operations
39	Facility Site Review Requirements	Maintain 100% compliance with Facility Site Review (FSR) requirements.	Quality Improvement
40	Facility Site Review Monitoring	Conduct facility site monitoring 100% on time to ensure safety practices.	Quality Improvement
41	Physical Accessibility Review Surveys (PARS)	Complete Physical Accessibility Reviews (PARs) 100% on time.	Quality Improvement
42	Credentialing/Recredentialing	Maintain a well-defined credentialing and recredentialing process for evaluating practitioners/ providers to provide care to members.	Quality Improvement
43	Grievances and Appeals	Monitor all member grievances and appeals to review for trending issues that will be communicated to various departments to develop action plans to improve the member experience by focusing on highly reported issues.	Grievances and Appeals
44	Call Center Monitoring	Meet call center benchmarks to ensure members have timely access to call center staff and implement interventions on any deficient benchmarks. (1) ASA: 30 seconds or less; (2) Abandonment Rate: 5% or less; (3) Phone Quality Results: ≥ 95%.	Member Services
45	CAHPS: Surveys	Coordinate with DHCS and HSAG to complete the CAHPS surveys and to monitor and improve CAHPS scores.	Quality Improvement
46	CAHPS: Access to Specialty Care	Improve access to specialty care for adults and children.	Operations Strategy/External Affairs Quality Improvement
47	CAHPS: Improve CAHPS Scores	Improve CAHPS Scores based on MY 2023 CAHPS outcomes.	Operations Strategy/External Affairs Quality Improvement
48	Delegation Oversight	100% of all audits completed with corrective action plans (CAPs) closed timely	Compliance

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update

Objective 1: Improve Quality and Safety of Clinical Care Services

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
1. Quality: 2024 Quality Improvement and Health Equity Transformation (QIHET) Program Description						
Quality	2024 QIHET Program Description	Update the 2024 QIHET Program Description.	1. Collaborate with business units to review and update the 2024 QIHET Program Description. 2. Prepare and submit for approval to Quality Improvement & Health Equity Committee (QIHEC). 3. Prepare and submit for approval to the Commission.	1. 01/01/24-02/29/24 2. 03/19/24 3. 04/22/24	• Sr. Director, Quality Improvement • QI Manager • QI Program Manager III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						
2. Quality: 2024 Quality Improvement and Health Equity Transformation Work Plan						
Quality	2024 QIHET Work Plan	Update the 2024 QIHET Work Plan.	1. Collaborate with business units to review and update the 2024 QIHET Work Plan. 2. Prepare and submit for approval to the QIHEC. 3. Prepare and submit for approval to the Commission.	1. 01/01/24-02/29/24 2. 03/19/24 3. 04/22/24	• Sr. Director, Quality Improvement • QI Manager • QI Program Manager III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						
3. Quality: 2023 Quality Improvement and Health Equity Transformation Work Plan Evaluation						
Quality	2023 QIHET Work Plan Evaluation	Complete the 2023 QIHET Work Plan Evaluation.	1. Collaborate with business units to complete evaluation of the 2023 QIHET Work Plan. 2. Evaluate effectiveness of the quality improvement structure and resources. 3. Evaluate the QIHEC subcommittees are occurring	1. 03/01/24-06/30/24 2. 03/01/24-07/31/24 3. 03/01/24-07/31/24	• Sr. Director, Quality Improvement • QI Manager • QI Program Manager III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			according to each subcommittee's charter and cadence. 4. Prepare and submit for approval to the QIHEC. 5. Prepare and submit for approval to the Commission.	4. 09/17/24 5. 09/23/24		
Evaluation & Barrier Analysis						
4. Quality: 2024 HEDIS® Compliance Audit™						
Quality	2024 HEDIS® Compliance Audit™	Successfully complete and pass the annual HEDIS® Compliance Audit™ and receive "reportable" status for all measures.	1. ROADMAP Submission 2. Non-Standard Supplemental Data Primary Source Validation 3. Preliminary rate review 4. Medical Record Review (MRR) Validation 5. Final rate review 6. Interactive Data Set Submission 7. Submit ROADMAP Management Representation Letter	1. 01/31/24 2. 03/29/24 3. 04/12/24 4. 05/13/24 5. 05/31/24 6. 06/14/24 7. 06/14/24	• Sr. Director, Quality Improvement • QI Manager • QI Program Manager II	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						
5. Utilization Management: Clinical Practice Guidelines						
Utilization Management	Clinical Practice Guidelines	Complete annual review and adoption of evidence-based Preventive Health Guidelines (PHG), including the Diabetes and Asthma Clinical Practice Guidelines (CPG).	1. Review and approval by the Medical Advisory Committee (MAC) 2. Post guidelines on the GCHP website and distribute guidelines to appropriate practitioners, upon request. 3. Ensure alignment of PHG with Provider Manual and applicable policies	1. 01/18/24, 04/1824, 07/18/24, 10/17/24 2. 01/0124-12/31/24 3. 01/01/24-12/31/24	• Chief Medical Officer • Sr. Director Utilization Management • Sr. Director Quality Improvement	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
6. Care Management: Complex Case Management						
Care Management (CM)	Complex Case Management (CCM)	Develop and implement a standardized turn-around-time (TAT) process for members identified as eligible for complex case management per NCQA CCM requirements.	1. Receive DHCS approval for policy HS-055 Care Management including Complex Case Management. 2. Provide staff training as identified. 3. Review and revise staff auditing tools to align with NCQA and policy HS-055 guidelines on TAT for CCM. 4. Strategize with CM, QI, HS analyst on the development of metrics and benchmarks to capture CCM TAT. 5. Monitor CCM TAT dashboard and implement interventions for benchmarks not met.	1. 06/30/24 2. 01/01/24-12/31/24 3. 06/30/24 4. 01/01/24-12/31/24 5. 03/01/24-12/31/24	• Director of CM • Sr. Manager, CM & Special Projects • CM Managers	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						
7. Care Management: Care Gap Closure						
Care Management (CM)	Care Gap Closure	Implement strategies to close care gaps for MCAS measures.	1. Utilize the MCAS care gap dashboard to inform members of their care gaps. 2. Include utilization of the MCAS care gaps dashboard as part of the CM process. 3. Review and revise JAM's/resource tools/to align with care gap report utilization. 4. Review and revise staff auditing tools as identified. 5. Provide staff with learning opportunities related to MCAS care gap report utilization and impact to CM process.	1. 01/01/24-12/31/24 2. 04/01/24-12/31/24 3. 01/01/24-12/31/24 4. 01/01/24-12/31/24 5. 01/01/24-12/31/24	• Director of CM • Sr. Manager, CM & Special Projects • CM Managers • QI Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
8. Advance Prevention: Tobacco Cessation						
Advance Prevention	Tobacco Cessation	Increase rate of tobacco cessation interventions in members identified as tobacco users. **IHA benchmarks** • 100% of identified tobacco users receive counseling. • 32% of tobacco users receive cessation medication. **Admin benchmarks:** • 39% of identified tobacco users receive counseling. • 13% of tobacco users receive cessation medication.	1. Utilize DHCS methodology to identify tobacco users via data pulls for quarterly analysis and reporting. 2. Create and/or update provider and member education campaigns. 3. Measure tobacco cessation medication dispensing and cessation counseling quarterly via IHA medical record review and administrative data. 4. Report tobacco cessation medication dispensing and cessation counseling semi-annually.	1. 03/31/24 06/30/24 09/30/24 12/31/24 2. 12/3124 3. 03/31/24 06/30/24 09/30/24 12/31/24 4. 03/31/24, 09/30/24	• QI RN Manager • Sr. Director of Health Education and Cultural Linguistics • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						
9. Advance Prevention: Initial Health Appointment (IHA)						
Advance Prevention	Initial Health Appointment	Increase rates of Initial Health Appointment (IHA) completion by providers.	1. Distribute new member lists to clinic/health system for member outreach to schedule the IHA visit. 2. Monitor claims data for timely IHA completion within 120 days by clinic system. 3. Conduct medical record audits by provider site and provide feedback on opportunities for improvement. 4. Provide ongoing trainings on the IHA and IHA Outreach Log.	1. 11th day of each month 2. 03/31/24, 06/30/24, 09/30/24, 12/31/24 3. 01/01/24-12/31/24 4. 01/01/24-12/31/24	• QI RN Manager • QI RN	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
10. Pharmacy: Reduction in Potential Unsafe Opioid Prescriptions						
Pharmacy	Opioid Utilization Monitoring	Monitor member opioid utilization via pharmacy claims from Medi-Cal Rx and monitor for any trends where the utilization exceeds more than a 5% increase from the prior quarter in any category.	1. Monitor the following statistics related to opioid utilization via pharmacy claims from Medi-Cal Rx in GCHP members: • Total number of unique users • Concurrent users of opioids and benzodiazepines • Concurrent users of opioids and antipsychotics • Concurrent users of opioids and naloxone 2. Perform retrospective Drug Utilization Review (DUR) and implement Provider Interventions Related to Opioid Utilization as needed.	1. 03/20/24, 06/11/24, 09/17/24, 12/03/24 2. 01/01/24-12/31/24	• Director of Pharmacy Services • Clinical Programs Pharmacist	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						
11. Population Health: Population Needs Assessment (PNA)						
Population Health	Population Needs Assessment	Maintain NCQA compliant PNA as part of the Population Health Strategy Report submitted to DHCS.	1. Develop and implement Population Health Management Strategic Objectives.	1. 12/31/24	• Sr. Manager of Population Health Management • Sr. Director of Health Education and Cultural Linguistics	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
12. Population Health: Wellth Program						
Population Health	Wellth Quality Improvement Program	Implement a QI focused program with Wellth for full-scope Medi-Cal members who are 18+ years of age, are taking at least one medication and have multiple care gaps for which GCHP is held to the DHCS MPL (50th percentile).	1. Enroll 3,800 members that qualify for the QI focused program. 2. The PHM team will create an internal process for evaluating outcomes related to the Wellth Utilization versus QI Program to inform the phased implementation approach. 3. Decision point on whether to enroll additional 1,200 members in the Wellth Utilization or QI program. 4. Decision point on whether to enroll additional 5,550 members in the Wellth Utilization or QI program.	1. 03/29/24 2. 03/29/24 3. 04/30/24 4. 06/28/24	• Sr. Manager of Population Health • Wellness and Prevention Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						
13. Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness – 30 Days						
Behavioral Health	Follow-Up After Emergency Department (ED)Visit for Mental Illness – 30 days. (FUM-30)	Increase the FUM-30 rate to meet or exceed the DHCS MPL (50th percentile).	1. Continuously improve and develop new innovative interventions that promote members' access to behavioral health care services. 2. Monitor Carelon Behavioral Health performance towards the established incentive measure targets within the fully executed contract to ensure adequate follow-up care after ED visit. 3. Improve data exchange to ensure more complete, accurate, and timely data to improve robust capture of follow-up visits. 4. Include in the Quality Incentive Provider Pool (QIPP) Program.	1. 12/31/24 2. 12/31/24 3. 12/31/24 4. 12/31/24	• Director, Behavioral Health and Social Programs • Manager, Behavioral Health • QI Program Manager III	Annual Goal Met: Yes☐ No☐ Quarterly Update Continue Objective: Yes☐ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			5. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 6. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 7. Provide clinics/providers with the prospective MY 2024 MCAS rate and member gaps in care reporting via Converged Data Insights. 8. Evaluate MY 2023 performance to identify barriers, disparities and opportunities for improvement and interventions.	5. 12/31/24 6. 08/15/24 7. 01/31/24-12/31/24 8. 07/31/24		
Evaluation & Barrier Analysis						
14. Behavioral Health: Follow-Up After Emergency Department Visit for Substance Use – 30 Days						
Behavioral Health	Follow-Up After Emergency Department (ED)Visit for Substance Use – 30 days. (FUA-30)	Increase the FUA-30 rate to meet or exceed DHCS MPL (50th percentile).	1. Continuously improve and develop new innovative interventions that promote members' access to behavioral health care services. 2. Monitor Carelon Behavioral Health performance towards the established incentive measure targets within the fully executed contract to ensure adequate follow-up care after ED visit. 3. Improve data exchange to ensure more complete, accurate, and timely data to improve robust capture of follow-up visits with the HIE, diagnoses and ADT feeds. 4. Include in the Quality Incentive Provider Pool (QIPP) Program.	1. 12/31/24 2. 12/31/24 3. 12/31/24 4. 12/31/24	• Director, Behavioral Health and Social Programs • Manager, Behavioral Health • QI Program Manager III	Annual Goal Met: Yes☐ No☐ Quarterly Update Continue Objective: Yes☐ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			5. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 6. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 7. Provide clinics/providers with the prospective MY 2024 MCAS rate and member gaps in care reporting via Converged Data Insights. 8. Evaluate MY 2023 performance to identify barriers, disparities and opportunities for improvement and interventions.	5. 01/01/24-12/31/24 6. 08/15/24 7. 01/31/24-12/31/24 8. 07/31/24		
Evaluation & Barrier Analysis						
15. MCAS: Asthma Medication Ratio (AMR)						
MCAS	Asthma Medication Ratio	Increase the AMR rate for members, 5 to 64 years of age, who had persistent asthma and had a ≥ 0.50 ratio of controller medications to total asthma medications to meet or exceed the DHCS MPL (50th percentile).	1. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2024 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2023 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Retrospective Drug Utilization Review and Provider Interventions Related to Asthma Medication Use. 5. Explore development of community health workers (CHW) home visiting program in	1. 08/15/24 2. 01/31/24-12/31/24 3. 07/31/24 4. 09/30/24 5. 09/30/24	• Director of Pharmacy Services • Clinical Programs Pharmacist • QI Manager • QI Program Manager III • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			collaboration with Health Education. 6. Include as a core measure in the expanded Quality Incentive Provider Pool (QIPP) Program. 7. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	6. 12/31/24 7. 12/31/24		
Evaluation & Barrier Analysis						
16. MCAS: Breast Cancer Screening (BCS)						
MCAS	Breast Cancer Screening	Increase the percentage of women 50-74 years of age who had a mammogram to screen for breast cancer to meet or exceed the DHCS HPL (90th percentile).	1. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2024 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2023 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Evaluate effectiveness of the breast cancer screening member incentive program and identify program changes and enhancements, as applicable. 5. Expand and evaluate the effectiveness of the point-of-care (POC) member incentive program and identify program changes and enhancements as applicable. • Nancy Reagan Breast Center 6. Distribute provider member incentive awards annually.	1. 08/15/24 2. 01/31/24-12/31/24 3. 07/31/24 4. 12/31/24 5. 12/31/24 6. 12/31/24	• QI Manager • QI Program Manager 1 • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			7. Fund access to mobile mammography services. 8. Conduct member outreach campaigns to increase preventive screenings and close care gap. 9. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to implement interventions, promote best practices and increase awareness. 10. Include BCS in the Quality Incentive Provider Pool (QIPP) Program. 11. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	7. 09/30/24 8. 06/01/24-12/31/24 9. 01/01/24-12/31/24 10. 12/31/24 11. 01/01/24-12/31/24		
Evaluation & Barrier Analysis						
17. MCAS: Cervical Cancer Screening (CCS)						
MCAS	Cervical Cancer Screening (CCS)	Increase percentage of women 21-64 years of age who were screened for cervical cancer to meet or exceed the DHCS HPL (90th percentile).	1. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2024 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2023 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Evaluate effectiveness of the cervical cancer screening member	1. 08/15/24 2. 01/31/24-12/31/24 3. 07/31/24 4. 01/31/25	• QI Manager • QI Program Manager I • QI RN • Sr. Health Navigator & Health Education	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			incentive program and identify program changes and enhancements, as applicable. 5. Expand and evaluate the effectiveness of the point-of-care (POC) member incentive program and identify program changes and enhancements as applicable. 6. Distribute provider member incentive awards annually. 7. Conduct member outreach campaigns to increase preventive screenings and close care gap. 8. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to implement interventions, promote best practices and increase awareness. 9. Include CCS in the Quality Incentive Provider Pool (QIPP) Program core measures. 10. Explore grant opportunities to fund increased access to cervical cancer screenings. 11. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	5. 12/31/24 6. 12/31/24 7. 04/01/24-11/30/24 8. 01/01/24-12/31/24 9. 12/31/24 10. 04/01/24-12/31/24 11. 01/01/24-12/31/24		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
18. MCAS: Child and Adolescent Well-Care Visits (WCV)						
MCAS	Child and Adolescent Well-Care Visits	Increase the percentage of members, 3-21 years of age, who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year to meet or exceed the DHCS HPL (90th percentile).	1. Provide clinics/providers with monthly prospective MY 2024 MCAS rate and gaps in care reporting via Converged Data Insights. 2. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 3. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Conduct disparities analysis by race and ethnicity. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). 6. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Health Education, Population Health, Community Relations Department, Help Me Grow/First 5, CHDP, VCPH, VCOE, WIC) to implement interventions to increase access to care, promote best practices and increase awareness. 7. Create and/or update provider and member education campaigns that are culturally and linguistically	1. 07/31/24 2. 01/01/24-12/31/24 3. 07/31/24 4. 07/31/24 5. 01/01/24-12/31/24 6. 01/01/24-12/31/24 7. 01/01/24-12/31/24	• QI Manager • QI Program Manager II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			appropriate to address health disparities. 8. Evaluate effectiveness of the well care member incentive program and identify program changes/enhancements, as applicable. 9. Expand and evaluate the effectiveness of the point-of-care (POC) member incentive program and identify program changes/enhancements as applicable. 10. Distribute provider member incentive awards quarterly. 11. Conduct member outreach campaigns to increase preventive care screenings and close gaps in care. 12. Include in the Quality Incentive Provider Pool (QIPP) Program core measures. 13. Explore grant opportunities to fund increased access to well-care visits.	8. 01/31/25 9. 01/01/24-12/31/24 10. 12/31/24 11. 03/01/24–10/31/24 12. 12/31/24 13. 04/01/24-10/31/24		
Evaluation & Barrier Analysis						
19. MCAS: Childhood Immunization Status – Combo 10 (CIS-10)						
MCAS	Childhood Immunization Status – Combo 10	Increase the percentage of members, two- years of age, who completed all Combo-10 immunization by their 2nd birthday to exceed the 75th national Medicaid percentile established by NCQA.	1. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2024 MCAS rate and member gaps in care reporting via Converged Data Insights.	1. 08/15/24 2. 01/31/24-12/31/24	• QI RN Manager • QI Program Manager II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps: .

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			3. Evaluate MY 2023 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Community Relations Department, VCPH, VCOE, VFC) to implement interventions to increase access to care, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Conduct member outreach campaigns to increase immunizations and close care gaps. 7. Include in the Quality Incentive Provider Pool (QIPP) Program. 8. Schedule quarterly health fairs to offer and promote childhood immunizations.	3. 07/31/24 4. 01/01/24-12/31/24 5. 01/01/24-12/31/24 6. 03/01/24 – 11/30/24 7. 12/31/24 8. 01/01/24-12/31/24		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
20. MCAS: Chlamydia Screening in Women (CHL)						
MCAS	Chlamydia Screening in Women	Increase the rate of chlamydia screening in members 16 to 24 years of age to meet or exceed the 75th national Medicaid percentile established by NCQA.	1. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with prospective MY 2024 MCAS rate and gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2023 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Community Relations Department, Planned Parenthood, VCPH, VCOE) to implement interventions to increase access to care, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities Trainings for low performing providers. 6. Include in the Quality Incentive Provider Pool (QIPP) Program core measure. 7. Launch program to distribute at-home chlamydia screenings. 8. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	1. 08/15/24 2. 01/31/24-12/31/23 3. 07/31/24 4. 01/01/24-12/31/24 5. 04/30/24 6. 06/30/23 7. 12/31/24 8. 12/31/24	• QI RN Manager • QI Program Manager II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
21. MCAS: Colorectal Cancer Screening (COL)						
Advance Prevention	Colorectal Cancer Screening (COL-E)	Increase the percentage of members 45 to 75 years of age who had an appropriate screening for colorectal cancer from 30.86% (2023 MY) to meet the minimum performance level (MPL) established by DHCS (50th percentile).	1. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 2. Provide prospective MY 2024 MCAS rate and member gaps in care reporting via Converged Data Insights. to clinics/providers. 3. Evaluate MY 2023 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Conduct disparities analysis by race and ethnicity. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). 6. Launch educational member mailing campaign. 7. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to implement interventions, promote best practices and increase awareness. 8. Partner with Exact Sciences to promote Cologuard through member outreach campaigns, data sharing, and provider ordering efficiencies.	1. 08/15/24 2. 01/31/24-12/31/23 3. 07/31/24 4. 07/31/24 5. 01/01/24-12/31/24 6. 06/30/24 7. 01/01/24-12/31/24 8. 12/31/24	• QI Manager • QI RN • Sr. Director of Health Education, Cultural and Linguistic Services • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			9. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	9. 12/31/24		
Evaluation & Barrier Analysis						
22. MCAS: Developmental Screening in the First Three Years of Life (DEV)						
MCAS	Developmental Screening in the First Three Years of Life	Increase the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding, or on, their first, second or third birthday, by 3% compared to the prior measurement year.	1. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 2. Provide prospective MY 2024 MCAS rate and member gaps in care reporting via Converged Data Insights. to clinics/providers. 3. Evaluate MY 2023 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Community Relations Department, Help Me Grow/First 5, CHDP, VCPH, VCOE) to implement interventions to improve access to care, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 7. Include in the Quality Incentive Provider Pool (QIPP) Program core measures.	1. 08/15/24 2. 01/31/24-12/31/23 3. 07/31/24 4. 01/01/24-12/31/24 5. 09/30/24 6. 12/31/24 7. 12/31/23	• QI RN Manager • QI Program Manager II • QI RN	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			8. Conduct member outreach campaigns to increase preventive screenings and close care gap.	8. 03/15/24-11/30/24		
Evaluation & Barrier Analysis						
23. MCAS: Health Equity Controlling Blood Pressure (CBP)						
MCAS	Controlling Blood Pressure	Increase the CBP rate for members 21-44 years of age to meet or exceed the DHCS MPL (50th percentile).	1. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 2. Provide prospective MY 2024 MCAS rate and member gaps in care reporting via Converged Data Insights. to clinics/providers. 3. Evaluate MY 2023 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Conduct disparities analysis by race and ethnicity. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). 6. Notify members and providers of the Medi-Cal Rx blood pressure cuff benefits. 7. Monitor and promote member utilization of the blood pressure cuff to improve self-monitoring and reporting of blood pressure. 8. Collaborate with Care Management to promote the blood pressure cuff benefit. 9. Utilize the Wellth to collect blood pressure data.	1. 08/15/24 2. 01/01/24-12/31/24 3. 07/31/24 4. 07/31/24 5. 01/01/24-12/31/24 6. 03/31/24 7. 03/01/23-12/31/24 8. 09/01/24 9. 01/01/24-12/31/24	• QI Manager • QI Program Manager II • QI RN • Manager, Care Management and Special Programs • Sr. Manager of Population Health • Wellness and Prevention Manager • HEDIS Data Master	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps: .

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			10. Conduct community health fairs to collect blood pressure data and refer members with hypertension to care management. 11. Utilize the chronic disease self-management program to educate members on self-management skills. 12. Include in the Quality Incentive Provider Pool (QIPP) Program core measures. 13. Evaluate improvements in data collection to capture BP through administrative data (e.g., EMR, HIE).	10. 12/31/24 11. 12/31/24 12. 12/31/24 13. 12/31/24		
Evaluation & Barrier Analysis						
24. MCAS: Glycemic Status Assessment for Patients with Diabetes (>9.0%) (GSD)						
MCAS	Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD-Poor Control	Decrease the percentage of members with diabetes who are 18-75 years of age and have GSD > 9.0% to meet the DHCS HPL (90th percentile).	1. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 2. Provide prospective MY 2024 MCAS rate and member gaps in care reporting via Converged Data Insights. to clinics/providers. 3. Evaluate MY 2023 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Conduct disparities analysis by race and ethnicity. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee).	1. 08/15/24 2. 01/31/24-12/31/24 3. 07/31/24 4. 07/31/24 5. 01/01/24-12/31/24	• QI Manager • QI Program Manager III • QI RN • Sr. Director of Health Education, Cultural and Linguistic Services • Sr. Health Navigator & Health Education	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps: .

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Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			6. Launch program to distribute at-home HbA1c screenings kits. 7. Include in the Quality Incentive Provider Pool (QIPP) Program core measures. 8. Monitor and evaluate the provider grants to increase POC HbA1c machines at clinics. 9. Execute contracts for additional chronic condition programs for diabetes. 10. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	6. 01/01/24-12/31/24 7. 12/31/24 8. 12/31/24 9. 12/31/24 10. 01/01/24-12/31/24		
Evaluation & Barrier Analysis						

25. MCAS: Immunizations for Adolescents – Combo 2 (IMA-2)

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
MCAS	Immunizations for Adolescents – Combo 2 (IMA-2)	Increase the percentage of adolescents who completed all IMA-2 immunizations by their 13th birthday to exceed to DHCS HPL (90th percentile).	1. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2024 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2023 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Community Relations Department, VCPH, VCOE, VFC) to implement interventions, improve access to care, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that	1. 08/15/24 2. 01/31/24-12/31/24 3. 07/31/24 4. 01/01/24-12/31/24 5. 01/01/24-12/31/24	• QI RN Manager • QI Program Manager II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps: .

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			are culturally and linguistically appropriate to address health disparities. 6. Conduct member outreach campaigns to increase immunizations and close care gap. 7. Evaluate effectiveness of the HPV immunization member incentive program and identify program changes/enhancements, as applicable. 8. Expand and evaluate the effectiveness of the POC member incentive program and identify program changes/enhancements as applicable. 9. Include IMA-2 in the Quality Incentive Provider Pool (QIPP) Program. 10. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	6. 03/0124-12/31/24 7. 12/31/24 8. 12/31/24 9. 12/31/24 10. 01/01/24-12/31/24		
26. MCAS: Lead Screening in Children (LSC)						
MCAS	Lead Screening in Children (LSC)	Increase the percentage of children who had one or more capillary or venous blood lead tests for lead poisoning by their 2nd birthday to meet the 75th national Medicaid percentile established by NCQA.	1. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2024 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2023 performance to identify barriers, disparities and opportunities for improvement and interventions.	1. 08/15/24 2. 01/31/24-12/31/24 3. 07/31/24	• QI RN Manager • QI Program Manger II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:

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Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Community Relations Department, Help Me Grow/First 5, CHDP, CDR, CLPPP, VCPH, VCOE) to implement interventions, promote best practices and increase awareness. • WIC text campaign 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Compile and distribute lead screening gaps in care reports quarterly to providers (per DHCS APL 20-016). 7. Monitor provider compliance with lead screening requirements through medical record audits and issue PIPs for performance below 80% threshold. 8. Conduct member outreach campaigns to increase blood lead screenings and close care gap. 9. Evaluate effectiveness of the LSC immunization member incentive program and identify program changes/enhancements, as applicable. 10. Increase adherence to the DHCS APL (20-016) in the areas of anticipatory guidance and lead screening refusal forms.	4. 01/01/24-12/31/24 5. 01/01/24-12/31/24 6. 05/31/24, 12/31/24 7. 03/15/24-11/30/24 8. 03/01/24-12/31/24 9. 12/31/24 10. 12/31/24		

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			11. Monitor and evaluate the provider grants to increase POC lead screening machines at clinics. 12. Implement per-test lead screening provider incentive of $25 for members 0-2 years age (available to providers who do not select LSC as an optional measure under QIPP) 13. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	11. 12/31/24 12. 01/01/24-12/31/24 13. 01/01/24-12/31/24		
Evaluation & Barrier Analysis						
27. MCAS: Prenatal and Postpartum Care (PPC)						
MCAS	Prenatal and Postpartum Care	Increase the percentage of women with live birth deliveries who completed prenatal and postpartum exams to meet or exceed the DHCS HPL (90th percentile). • Members who received a prenatal care visit during the first trimester, on or before the enrollment start date, or within 42 days of enrollment. • Members who completed a postpartum exam completed with 7 to 84 days after a live-birth delivery.	1. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2024 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2023 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Conduct disparities analysis by race and ethnicity. 5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities with input from external organizations (e.g. Community Advisory Committee). 6. Conduct member outreach campaigns to increase postpartum screenings and close gaps in care.	1. 08/15/24 2. 01/31/24-12/31/24 3. 07/31/24 4. 07/31/24 5. 01/01/24-12/31/24 6. 03/01/24-12/31/24	• QI RN Manager • QI RN • HECL/Sr. Health Navigator & Health Educator • Population Health Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps: .

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			7. Include in the Quality Incentive Provider Pool (QIPP) Program. 8. Create report to improve early identification of members who are due for prenatal and postpartum visits. 9. Launch Doula Pilot Program, Promotoras de Parto y Pos Parto, to increase prenatal and postpartum services for the Mixteco speaking population in Ventura County	7. 12/31/24 8. 03/01/24 9. 06/30/24		
Evaluation & Barrier Analysis						
28. MCAS: Topical Fluoride Varnish (TFL)						
MCAS	Topical Fluoride Varnish (TFL)	Increase the percentage of members, ages 1 through 20, who received at least two topical fluoride applications during the measurement year to meet or exceed the DHCS MPL (50th).	1. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2024 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2023 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Community Relations Department, Help Me Grow/First 5, CHDP, VCPH, VCOE, United Way) to implement interventions to improve access to care, promote best practices and increase awareness. 5. Create and/or update provider and member education campaigns that	1. 08/15/24 2. 01/31/24-12/31/24 3. 07/31/24 4. 01/01/24-12/31/24 5. 12/31/24	• QI RN Manager • QI Program Manager II • QI RN •	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			are culturally and linguistically appropriate to address health disparities. 6. Include as a core measure in the expanded Quality Incentive Provider Pool (QIPP) Program. 7. Explore grant opportunities to fund access to topical fluoride varnish. 8. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	6. 12/31/24 7. 04/01/24-10/31/24 8. 01/01/24-12/31/24		
Evaluation & Barrier Analysis						
29. MCAS: Well-Child Visits in the First 30 Months of Life (W30)						
MCAS	Well-Child Visits in the First 30 Months of Life	Increase the percentage of children who had well-child visits with a PCP to meet or exceed the DHCS MPL (50th percentile) for the following sub-measures. • Well-child visits in the first 15 months of life: Increase the percentage of children with six or more well-care exams within the first 15 months of life. • Well-child visits between 15 and 30 months of age: Increase the percentage of 30-month-old children who had two or more well-child exams between 15 and 30 months of age.	1. Provide clinics/providers with the annual MY 2023 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with monthly prospective MY 2024MCAS rate and gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2023 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Engage in partnerships with internal departments, clinic systems, and external organizations, (e.g., Care Management, Health Education, Population Health, Community Relations, Help Me Grow/First 5, CHDP, VCPH, VCOE, WIC) to implement interventions, promote best practices and increase awareness.	1. 08/15/24 2. 01/31/24-12/31/24 3. 07/31/24 4. 01/01/24-12/31/24	• QI Manager • QI Program Manager II • QI RN • Sr. Health Navigator & Health Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			5. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities. 6. Conduct member outreach campaigns to increase well-child preventive care screenings and close gaps in care. 7. Include in the Quality Incentive Provider Pool (QIPP) Program core measure. 8. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	5. 01/01/24-12/31/24 6. 03/01/24-11/30/24 7. 12/31/24 8. 01/01/24-12/31/24		
Evaluation & Barrier Analysis						
30. Quality/DHCS: 2024 DHCS Required QI Activity(s)						
Quality / DHCS	2024 DHCS Required QI Activity(s)	With guidance from DHCS, complete the 2024 required QI activity (s).	1. To be determined (TBD)	1. 02/16/24	• QI Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						
31. Quality/DHCS: 2024-2025 DHCS Medi-Cal Collaborative Child Health Equity						
Quality / DHCS	DHCS Child Health Equity Focused Collaboration on Well-Care Exams	Improve the completion of well-child visits.	1. Launch collaboration project. 2. Intervention determination	1. 09/01/24 2. 04/01/24-12/31/24	• QI Program Manager II • QI RN	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
Evaluation & Barrier Analysis						
32. Quality/DHCS: 2023-2026 PIP Clinical Topic: W30-6+ among Hispanic/Latinx Members						
Quality / DHCS	2023-2026 PIP Clinical Topic: W30-6+ among Hispanic/Latinx Members	Improve the performance rate for Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) among the Hispanic/Latinx population.	1. Submit Modules as directed by DHCS/HSAG for approval. 2. Report updates/results to QIHEC	1. 09/01/24 2. 09/17/24, 12/03/24	• QI Program Manager II	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						
33. Quality/DHCS: 2023-2026 PIP Non-Clinical Topic: Percentage of Provider Notifications for Members with SUD/SMH Diagnoses within 7 Days of an ED Visit						
Quality / DHCS	2023-2026 Non-Clinical PIP	Improve the percentage of provider notifications for members with substance use disorder (SUD) and / or specialty mental health (SMH) diagnoses following or within 7 days of emergency department (ED) visit.	1. Submit Modules as directed by DHCS/HSAG for approval. 2. Report updates/results to QIHEC	1. 09/01/24 2. 09/17/24, 12/03/24	• QI Program Manger III • Sr. Manager, CM & Special • Projects • Director of Behavioral Health and Social Program • Clinical Care Manager, LCSW	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update

Objective 2: Improve Quality and Safety of Non-Clinical Care Services

34. Cultural and Linguistic Needs & Preferences						
Improve Quality & Safety of Non-Clinical Care Services	Cultural and Linguistic Needs & Preferences	• By July 31, 2024, GCHP's Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules from four to seven which will include Diversity, Equity, and Inclusion (DEI) training program as per DHCS (APL 23-025) that encompasses sensitivity, diversity, cultural competence and cultural humility, and health equity trainings. • By July 31, 2024, GCHP's HECL Department shall conduct three Cultural and Linguistic (C&L)/DEI trainings with three Provider offices per quarter. • By December 31, 2024, GCHP's HECL Department shall report on the number of C&L fulfilment and benchmarks quarterly during the QIHEC meeting.	1. Develop an action plan to evaluate existing C&L/DEI training modules on the GCHP website and develop a process to increase C&L/DEI training modules from four to seven. 2. Engage various departments on the C&L/DEI training modules and solicit feedback. 3. Engage Community-Based Organizations on the C&L/DEI training modules and solicit feedback. 4. Engage Members on the C&L/DEI training modules for Providers and solicit their recommendations to ensure the Providers trainings are inclusive of GCHP membership. 5. Identify three Providers to conduct three C&L/DEI trainings. 6. Evaluate C&L/DEI trainings and prepare summary report of findings. 7. Prepare QIC dashboard summarizing the total number of C&L/DEI trainings and services at the quarterly QIHEC meetings.	1. 01/01/24-07/31/24 2. 08/01/24-12/31/24 3. 12/31/24 4. 12/21/24 5. 12/31/24 6. 12/31/24 7. 03/19/24, 06/11/24, 09/17/24, 12/03/24	• Sr. Director of Health Education and Cultural Linguistics • Sr. C&L Specialist • Sr. Director, Network Operations • Manager, Provider Contracting & Regulatory	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
35. Primary and Specialty Care Access						
Improve Quality & Safety of Non-Clinical Care Services	Primary and Specialty Care Access	Ensure standards met for minimum of 90% of providers. **Primary Care Access** Members are offered: • Non-urgent primary care within 10 business days of request • Urgent care within 24 hours **Specialty Care Access** Members are offered: • Non-urgent specialty care appointment within 15 business days • Non-urgent ancillary services within 15 business days	1. Conduct survey and evaluate results. 2. Develop and implement corrective action plans when timely access standards not met. 3. Report quarterly performance to QIHEC. 4. Monitor complaints and PQIs relating to the member access for appointments and/or referrals and take action as appropriate.	1. 06/30/24 2. 01/01/241-12/31/24 3. 03/21/24, 06/13/24, 09/19/24, 12/05/24 4. 01/01/24-12/31/24	• Sr. Director, Network Operations • Sr. Manager, Provider Network Operations – Program & Policy • QI RN Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						
36. Network Adequacy						
Improve Quality & Safety of Non-Clinical Care Services	Assess and improve network adequacy as demonstrated by availability of practitioners.	• PCP and Provider Ratios: ○ 1 PCP 1:2000 ○ Total Physicians 1: 1200 • Physician Supervision to Non-Physician Practitioner Ratios: ○ Nurse Practitioners 1:4 ○ Physician Assistants 1:4 • Network maintained PCP located within 10	1. Conduct ratio analysis for primary care and high-volume specialties 2. Identify gaps and implement corrective action plan(s). 3. Monitor progress toward action plans to maintain or improve GeoAccess standards: Network maintained PCPs.	1. 03/31/24, 06/30/24, 09/30/24, 12/31/24 2. 03/31/24, 06/30/24, 09/30/24, 12/31/24 12/31/24 3. 01/01/24-12/31/24	• Sr. Director, Network Operations • Sr. Manager, Provider Network Operations – Program & Policy • Executive Director, Delivery System	Annual Goal Met: Yes☐ No☒ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
		miles or 30 minutes from members residence. • Network maintained DHCS Core specialists located within 30 miles or 60 minutes from members residence. • Develop process for network certification (with ratios). • Hospitals 15 miles or 30 minutes from members residence	4. Monitor progress toward action plans to maintain or improve GeoAccess standards: Network maintained DHCS Core Specialists. 5. Develop process for network certification (with ratios). 6. Report biannual ratio analysis and annual GeoAccess findings to QIHEC.	4. 01/01/24-12/31/24 5. 12/31/24 6. 03/21/24, 06/13/24, 09/19/24, 12/05/24	Operations and Strategies	
Evaluation & Barrier Analysis						
37. After Hours Availability						
Improve Quality & Safety of Non-Clinical Care Services	After Hours Availability	Conducts surveys to ensure members are able to reach a provider after hours.	1. Conduct surveys and evaluate results. 2. Develop and implement action plans when timely access standards are not met. 3. Report quarterly performance to QIHEC.	1. 06/30/24 2. 01/01/24-12/31/24 3. 03/21/24, 06/13/24, 09/19/24, 12/05/24	• Sr. Director, Network Operations • Sr. Manager, Provider Network Operations – Program & Policy • Executive Director, Delivery System Operations and Strategies	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
38. Provider Satisfaction						
Improve Quality & Safety of Non-Clinical Care Services	Provider Satisfaction Survey	Field provider survey and develop action plan(s) to improve areas of low performance.	1. Analyze results and identify opportunities for improvement. 2. Implement interventions as needed to improve satisfaction.	1. 06/30/24 2. 01/01/24-12/31/24	• Sr. Director, Network Operations • Sr. Manager, Provider Network Operations – Program & Policy • Executive Director, Delivery System Operations and Strategies	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						
39. Facility Site Review Requirements						
Improve Member Safety	Facility Site Review Requirements	Maintain 100% compliance with Facility Site Review (FSR) requirements.	1. Complete and document Initial, Interim, and Tri-annual Facility Site Reviews timely. 2. Complete FSRs past due because of the public health emergency, in accordance with the DHCS plan. 3. Issue and monitor corrective action plans (CAPs) as needed to facilitate clinic compliance and improvement on identified deficiencies. 4. Submit biannual reports to DHCS: ○ January – June ○ July – December	1. 01/01/24-12/31/24 2. 12/31/24 3. 01/01/24-12/31/24 4. 07/31/24, 12/31/24	• QI RN Manager • QI RN	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						

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Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
40. Facility Site Review Monitoring						
Improve Member Safety	Facility Site Monitoring	Conduct facility site monitoring 100% on time to ensure safety practices.	1. Monitor FSR results and deficiencies, track, and trend. 2. Monitor member complaints/grievances and potential quality issues (PQIs) involving quality of care/safety concerns. 3. Issue CAPS and track improvements as needed. 4. Collaborate with PNO, legal, and CMO on sites not meeting requirements	1. 01/01/24-12/31/24 2. 01/01/24-12/31/24 3. 01/01/24-12/31/24 4. 01/01/24-12/31/24	• QI RN Manager • QI RN	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						
41. Physical Accessibility Review Surveys (PARS)						
Improve Member Safety	Physical Accessibility Review Surveys	Complete Physical Accessibility Reviews (PARs) 100% on time.	1. Compile report for high volume/ancillary specialist visits for Seniors and Persons with Disabilities (SPD) population and submit PARS report to DHCS. 2. Complete and document PARS for identified high volume/ancillary specialist provider sides. 3. Complete and document PARS as indicated during the Initial and Periodic FSRs	1. 01/31/24 2. 12/31/24 3. 01/01/24-12/31/24	• QI RN Manager • QI RN	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						
42. Credentialing/Recredentialing						
Improve Member Safety	Credentialing / Recredentialing	Maintain a well-defined credentialing and recredentialing process for evaluating practitioners/ providers to provide care to members.	1. Perform timely verification of all required credentialing elements to ensure current, accurate and complete files for credentialing decisions. 2. Perform timely recredentialing (within 36 months of last approval date).	1. 01/01/24-12/31/24 2. 01/01/24-12/31/24	• Credentialing Specialist	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			3. Perform ongoing monitoring of sanctions and adverse events timely. 4. Collaborate with Symplr on software configuration and automation to achieve efficiencies in the credentialing process.	3. 01/01/24-12/31/24 4. 01/01/24-05/31/24		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
Objective 3: Improve Quality of Service						
43. Grievances and Appeals						
Assess and improve member experience	Grievances and appeals	Monitor all member grievances and appeals to review for trending issues that will be communicated to various departments to develop action plans to improve the member experience by focusing on highly reported issues.	1. Conduct quarterly assessment of grievances and appeals. 2. Identify opportunities for improvement. 3. Create and implement action plan for improvement	1. 03/31/24, 06/30/24, 09/30/24, 12/31/24 2. 01/01/24-12/31/24 3. 01/01/24-12/31/24	• Director of Operations • Operations Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						
44. Call Center Monitoring						
Assess and improve member experience	Call Center Monitoring	Meet call center benchmarks to ensure members have timely access to call center staff and implement interventions on any deficient benchmarks. • ASA: 30 seconds or less • Abandonment Rate: 5% or less • Phone Quality Results: ≥ 95%	1. Report Member Services Telephone Access Analysis • Monitor Average Speed of Answer (ASA) • Monitor Abandonment Rate • Phone Quality Results 2. Identify opportunities for improvement based on data analysis.	1. 03/31/24, 06/30/24, 09/30/24, 12/31/24 2. 01/01/24-12/31/24	• Director of Operations • Operations Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
Objective 4: Assess and Improve Member Experience						
45. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys						
Assess and improve member experience	CAHPS Surveys	Coordinate with DHCS and HSAG to complete the CAHPS surveys and to monitor and improve CAHPS scores.	1. Assess CAHPS scores.	1. 06/30/24	• Sr. Director, Quality Improvement • QI Manager • QI Program Managers II, III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						
46. Consumer Assessment of Healthcare Providers and Systems (CAHPS): Access to Specialty Care						
Assess and improve member experience	CAHPS: Access to Specialty Care	Improve access to specialty care for adults and children.	1. Develop intervention to improve access to specialty care. 2. Participate in the ACAP CAHPS Collaborative	1. 12/31/24 2. 02/21/24-12/18/24	• Chief Innovation Officer • Executive Director, Delivery Systems, Operations and Strategies • Executive Director, Strategy and External Affairs • QI Program Manager I	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						
47. Consumer Assessment of Healthcare Providers and Systems (CAHPS): Improve CAHPS Scores						
Assess and improve member experience	CAHPS: Improve CAHPS Scores	Improve CAHPS Scores based on MY 2023 CAHPS outcomes.	1. Utilize Voice of the Member to create interventions based on areas of low performance.	1. 12/31/24	• Chief Innovation Officer • Executive Director,	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
					Delivery Systems, Operations and Strategies • Executive Director, Strategy and External Affairs • QI Program Manager I	 Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update

Objective 5: Ensure Organizational Oversight of Delegated Functions

48. Delegation Oversight						
Ensure Organizational Oversight of Delegated Functions	Completion of Delegation Oversight Audits • Credentialing • Quality Improvement • Utilization Management • Member's Rights • Claims • Call Center • Cultural and Linguistics • Transportation (NEMT/NMT)	100% of all audits completed with corrective action plans (CAPs) closed timely.	1. Complete audits per scheduled timeline 2. Issue CAPS as applicable 3. Follow-up on CAPs as applicable 4. Report to Compliance Committee and Quality Improvement Committee	1. 01/01/24-12/31/243 2. 01/01/24-12/31/24 3. 01/01/24-12/31/24 4. 02/8/24, 05/16/24, 08/13/24, 11/14/24	• Sr. Director, Compliance • Delegations Oversight Program Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☐ Next Steps:
Evaluation & Barrier Analysis						

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AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Sara Dersch, Chief Financial Officer

DATE: May 20, 2024

SUBJECT: March Year-to-Date Financial Results

PowerPoint with Verbal Presentation

ATTACHMENTS:

March 2024 Financial Results

Gold Coast Health Plan[SM]
A Public Entity

March 2024 Year-to-Date Financial Results

Ventura County Medi-Cal Managed Care Commission
May 20, 2024
Sara Dersch, Chief Financial Officer

Integrity
Accountability
Collaboration
Trust
Respect

March Year-To-Date (YTD) Financial Results Summary

- GHCP's underlying financial performance today is strong, reflecting a Medi-Cal Managed Care Plan under effective management control and operating in accordance with parameters of our Medi-Cal premiums.

- There have been a couple of material revenue and cost adjustments that have resulted in a cumulative $(33.4M) impact to the Operating Gain:

  - $16.1M revenue "take-back" by the State associated with the State's assessment that our members in 2023 had lower acuity (were healthier in general than originally forecasted).

  - $17.3M in earlier-than-forecasted provisioning of Quality Incentive Pool and Program (QIPP) payments; these investments help our community partners have resources to ensure access to and delivery of high-quality care for our members; these expenses have been contemplated in the complete year forecast.

- Medi-Cal populations have grown the most in those premium categories of aid experiencing the greatest rate reductions.

- While there are, and always will be, economic events that we cannot foresee (ex: retroactive rate adjustments), GCHP management continues to diligently monitor and take action on those Income Statement and Balance Sheet line items that are controllable and weather those items that not controllable.

March YTD P&L: Revenue

($Ms except pmpms & mm)	MTD			YTD		
	Actual	Reforecast	Var Fav / (Unfav)	Actual	Reforecast	Var Fav / (Unfav)
Member Months	250,139	237,795	12,344	2,270,106	2,233,671	36,435
Revenue	$ 89.3	$ 86.1	$ 3.2	$ 791.8	$ 782.7	$ 9.2
pmpm	*$ 357.16*	*$ 362.14*	*$ (4.99)*	*$ 348.81*	*$ 350.40*	*$ (1.58)*
Non-Operating Revenue / (Expense)	$ 1.6	$ 0.9	$ 0.7	$ 12.9	$ 10.4	$ 2.5
pmpm	*$ 6.24*	*$ 3.79*	*$ 2.45*	*$ 5.68*	*$ 4.66*	*$ 1.02*
Medical Benefits	$ 90.1	$ 78.8	$ (11.3)	$ 698.4	$ 668.4	$ (30.0)
pmpm	*$ 360.11*	*$ 331.30*	*$ (28.8)*	*$ 307.66*	*$ 299.24*	*$ (8.4)*
% of Revenue	*100.8%*	*91.5%*		*88.2%*	*85.4%*	
Admin Exp	$ 8.7	$ 7.7	$ (1.0)	$ 66.4	$ 65.4	$ (1.1)
pmpm	*$ 34.87*	*$ 32.51*	*$ (2.36)*	*$ 29.26*	*$ 29.27*	*$ 0.01*
% of Revenue	*9.8%*	*9.0%*		*8.4%*	*8.4%*	
Project Portfolio	$ 1.3	$ 2.8	$ 1.5	$ 18.0	$ 16.8	$ (1.2)
pmpm	*$ 5.19*	*$ 11.86*	*$ 6.67*	*$ 7.93*	*$ 7.54*	*$ (0.39)*
% of Revenue	*1.5%*	*3.3%*		*2.3%*	*2.2%*	
Operating Gain/(Loss)	$ (10.8)	$ (3.2)	$ (7.5)	$ 9.0	$ 32.0	$ (23.0)
	$ (43.01)	*$ (13.53)*	*$ (29.48)*	*$ 3.96*	*$ 14.35*	*$ (10.38)*
Retro Revenue Adjustments	$ 0.1	$ -	$ 0.1	$ (13.5)	$ -	$ (13.5)
pmpm	*$ 0.31*	*$ -*	*$ 0.31*	*$ (5.93)*	*$ -*	*$ (5.93)*
Total Increase / (Decrease) in Unrestricted Net Assets	$ (9.1)	$ (2.3)	$ (6.8)	$ 8.4	$ 42.5	$ (34.0)
pmpm	*$ (36.45)*	*$ (9.74)*	*$ (26.71)*	*$ 3.72*	*$ 19.01*	*$ (15.29)*
% of Revenue	*-10.2%*	*-2.7%*		*1.1%*	*5.4%*	

- Membership favorability comes from the new members aged 26-49 years covered regardless of immigration documentation; GCHP forecasted 5K members but realized 17K additional members, a variance of 12K.
- While membership is greater than forecasted, the membership “mix” (breakout of members by age and acuity categories) skews towards more members in lower premium cohorts.
- $16.1M Revenue “Take Back” in January as a result of a retroactive reduction in 2023 rates is partially offset by $2.7M pick-up membership-related retroactivity, resulting in a cumulative adjustment of $(13.5M).

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March YTD P&L: Medical Benefit

($Ms except pmpms & mm)	MTD Actual	MTD Reforecast	MTD Var Fav / (Unfav)	YTD Actual	YTD Reforecast	YTD Var Fav / (Unfav)
Member Months	250,139	237,795	12,344	2,270,106	2,233,671	36,435
Revenue	$ 89.3	$ 86.1	$ 3.2	$ 791.8	$ 782.7	$ 9.2
pmpm	*$ 357.16*	*$ 362.14*	*$ (4.99)*	*$ 348.81*	*$ 350.40*	*$ (1.58)*
Non-Operating Revenue / (Expense)	$ 1.6	$ 0.9	$ 0.7	$ 12.9	$ 10.4	$ 2.5
pmpm	*$ 6.24*	*$ 3.79*	*$ 2.45*	*$ 5.68*	*$ 4.66*	*$ 1.02*
Medical Benefits	$ 90.1	$ 78.8	$ (11.3)	$ 698.4	$ 668.4	$ (30.0)
pmpm	*$ 360.11*	*$ 331.30*	*$ (28.8)*	*$ 307.66*	*$ 299.24*	*$ (8.4)*
% of Revenue	*100.8%*	*91.5%*		*88.2%*	*85.4%*	
Admin Exp	$ 8.7	$ 7.7	$ (1.0)	$ 66.4	$ 65.4	$ (1.1)
pmpm	*$ 34.87*	*$ 32.51*	*$ (2.36)*	*$ 29.26*	*$ 29.27*	*$ 0.01*
% of Revenue	*9.8%*	*9.0%*		*8.4%*	*8.4%*	
Project Portfolio	$ 1.3	$ 2.8	$ 1.5	$ 18.0	$ 16.8	$ (1.2)
pmpm	*$ 5.19*	*$ 11.86*	*$ 6.67*	*$ 7.93*	*$ 7.54*	*$ (0.39)*
% of Revenue	*1.5%*	*3.3%*		*2.3%*	*2.2%*	
Operating Gain/(Loss)	$ (10.8)	$ (3.2)	$ (7.5)	$ 9.0	$ 32.0	$ (23.0)
	$ (43.01)	*$ (13.53)*	*$ (29.48)*	*$ 3.96*	*$ 14.35*	*$ (10.38)*
Retro Revenue Adjustments	$ 0.1	$ -	$ 0.1	$ (13.5)	$ -	$ (13.5)
pmpm	*$ 0.31*	*$ -*	*$ 0.31*	*$ (5.93)*	*$ -*	*$ (5.93)*
Total Increase / (Decrease) in Unrestricted Net Assets	$ (9.1)	$ (2.3)	$ (6.8)	$ 8.4	$ 42.5	$ (34.0)
pmpm	*$ (36.45)*	*$ (9.74)*	*$ (26.71)*	*$ 3.72*	*$ 19.01*	*$ (15.29)*
% of Revenue	*-10.2%*	*-2.7%*		*1.1%*	*5.4%*	

YTD MBR approximates our target of 88%, influenced largely by QIPP and fee-for-service (FFS) rate increases.

- Acceleration of QIPP funding has resulted in $7.0M of MTD expense, a $(5.8M) variance.
  - QIPP expenses total $29.4M vs a forecast of $12.1M.
  - Excluding QIPP, YTD MBR is 86.0%.
- FFS medical benefit spend is increasing in most care categories (please see the next slide for detail) due in large part to unit cost increases , not utilization.
- Total FFS spend was $606.7M versus a forecast of $573.3M, including QIPP.
- Minor favorability in claims recoveries and capitation offset some of the FFS variance.
- While some of the increase in spend is associated with a higher level of membership, increases in provider rates also contribute to the variance.

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March YTD P&L: Medical Benefit Categories

	Mar 2024	March 2024 Year-To-Date		Variance	Variance
	Actual	Actual	Reforecast	Fav / (Unfav)	%
Medical Benefits:					
Capitation:					
PCP, Specialty, Kaiser, NEMT & Vision	8,154,224	71,151,877	69,422,596	(1,729,280)	-2.5%
ECM	583,495	3,668,128	6,890,668	3,222,540	46.8%
Total Capitation	8,737,719	74,820,005	76,313,264	1,493,259	2.0%
FFS Claims:					
Inpatient	24,094,950	152,324,633	151,156,524	(1,168,109)	-0.8%
LTC / SNF	12,205,720	140,319,254	147,595,946	7,276,692	4.9%
Outpatient	7,349,522	63,808,910	59,766,696	(4,042,214)	-6.8%
Laboratory and Radiology	1,720,416	9,786,625	7,124,531	(2,662,094)	-37.4%
Directed Payments - Provider	1,258,092	23,940,118	21,182,675	(2,757,443)	-13.0%
Emergency Room	4,000,078	29,896,354	27,761,286	(2,135,068)	-7.7%
Physician Specialty	7,686,803	59,232,385	57,700,584	(1,531,801)	-2.7%
Primary Care Physician	3,531,323	25,735,890	24,084,688	(1,651,202)	-6.9%
Home & Community Based Services	3,632,815	24,635,415	19,708,963	(4,926,452)	-25.0%
Applied Behavioral Analysis/Mental Health Services	2,756,674	27,254,950	27,734,268	479,318	1.7%
Quality Incentives/Provider Reserves	*(22,307,610)*	*2,276,053*	-	(2,276,053)	0.0%
Quality Incentive Provider Program (QIPP)	*29,494,938*	*29,494,938*	*12,157,644*	(17,337,293)	-142.6%
Other Medical Professional	494,436	3,675,869	3,513,563	(162,306)	-4.6%
Other Medical Care		-	3,640	3,640	100.0%
Other Fee For Service	2,082,711	13,342,972	11,408,153	(1,934,819)	-17.0%
Transportation	(21,995)	1,097,769	2,380,592	1,282,823	53.9%
Total Claims	77,978,873	606,737,940	573,279,753	(33,542,381)	-5.9%
Provider Grant Program	-	-	3,333,333	3,333,333	100.0%
Medical & Care Management	3,255,142	17,929,956	16,140,000	(1,789,956)	-11.1%
Reinsurance	396,846	1,164,015	810,723	(353,292)	-43.6%
Claims Recoveries	(292,083)	(2,325,115)	(1,478,586)	846,529	-57.3%
Sub-total	3,359,906	16,853,049	18,805,470	2,036,615	10.8%
Total Medical Benefits	**90,076,498**	**698,410,994**	**668,398,487**	**(30,012,507)**	**-4.5%**

March YTD P&L: Administrative Costs

($Ms except pmpms & mm)	MTD Actual	MTD Reforecast	MTD Var Fav / (Unfav)	YTD Actual	YTD Reforecast	YTD Var Fav / (Unfav)
Member Months	250,139	237,795	12,344	2,270,106	2,233,671	36,435
Revenue	$ 89.3	$ 86.1	$ 3.2	$ 791.8	$ 782.7	$ 9.2
pmpm	*$ 357.16*	*$ 362.14*	*$ (4.99)*	*$ 348.81*	*$ 350.40*	*$ (1.58)*
Non-Operating Revenue / (Expense)	$ 1.6	$ 0.9	$ 0.7	$ 12.9	$ 10.4	$ 2.5
pmpm	*$ 6.24*	*$ 3.79*	*$ 2.45*	*$ 5.68*	*$ 4.66*	*$ 1.02*
Medical Benefits	$ 90.1	$ 78.8	$ (11.3)	$ 698.4	$ 668.4	$ (30.0)
pmpm	*$ 360.11*	*$ 331.30*	*$ (28.8)*	*$ 307.66*	*$ 299.24*	*$ (8.4)*
% of Revenue	*100.8%*	*91.5%*		*88.2%*	*85.4%*	
Admin Exp	$ 8.7	$ 7.7	$ (1.0)	$ 66.4	$ 65.4	$ (1.1)
pmpm	*$ 34.87*	*$ 32.51*	*$ (2.36)*	*$ 29.26*	*$ 29.27*	*$ 0.01*
% of Revenue	*9.8%*	*9.0%*		*8.4%*	*8.4%*	
Project Portfolio	$ 1.3	$ 2.8	$ 1.5	$ 18.0	$ 16.8	$ (1.2)
pmpm	*$ 5.19*	*$ 11.86*	*$ 6.67*	*$ 7.93*	*$ 7.54*	*$ (0.39)*
% of Revenue	*1.5%*	*3.3%*		*2.3%*	*2.2%*	
Operating Gain/(Loss)	$ (10.8)	$ (3.2)	$ (7.5)	$ 9.0	$ 32.0	$ (23.0)
	$ (43.01)	*$ (13.53)*	*$ (29.48)*	*$ 3.96*	*$ 14.35*	*$ (10.38)*
Retro Revenue Adjustments	$ 0.1	$ -	$ 0.1	$ (13.5)	$ -	$ (13.5)
pmpm	*$ 0.31*	*$ -*	*$ 0.31*	*$ (5.93)*	*$ -*	*$ (5.93)*
Total Increase / (Decrease) in Unrestricted Net Assets	$ (9.1)	$ (2.3)	$ (6.8)	$ 8.4	$ 42.5	$ (34.0)
pmpm	*$ (36.45)*	*$ (9.74)*	*$ (26.71)*	*$ 3.72*	*$ 19.01*	*$ (15.29)*
% of Revenue	*-10.2%*	*-2.7%*		*1.1%*	*5.4%*	

- Controlling administrative costs continues to be a Management focus.
- The YTD variance of $(1.1M) is attributed to the increase in membership; more membership results in additional "day-to-day" costs.
  - $460K of vendor fees associated with new member welcome letters.
  - All core health plan operations delegated to Conduent costs, which are calculated on a "per member per month" basis.
- We expect Project Portfolio (primarily "Operations of the Future") costs will continue to realign with the Reforecast as the year progresses.

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March YTD P&L: Net Assets

($Ms except pmpms & mm)	MTD Actual	MTD Reforecast	MTD Var Fav / (Unfav)	YTD Actual	YTD Reforecast	YTD Var Fav / (Unfav)
Member Months	250,139	237,795	12,344	2,270,106	2,233,671	36,435
Revenue	$ 89.3	$ 86.1	$ 3.2	$ 791.8	$ 782.7	$ 9.2
pmpm	*$ 357.16*	*$ 362.14*	*$ (4.99)*	*$ 348.81*	*$ 350.40*	*$ (1.58)*
Non-Operating Revenue / (Expense)	$ 1.6	$ 0.9	$ 0.7	$ 12.9	$ 10.4	$ 2.5
pmpm	*$ 6.24*	*$ 3.79*	*$ 2.45*	*$ 5.68*	*$ 4.66*	*$ 1.02*
Medical Benefits	$ 90.1	$ 78.8	$ (11.3)	$ 698.4	$ 668.4	$ (30.0)
pmpm	*$ 360.11*	*$ 331.30*	*$ (28.8)*	*$ 307.66*	*$ 299.24*	*$ (8.4)*
% of Revenue	*100.8%*	*91.5%*		*88.2%*	*85.4%*	
Admin Exp	$ 8.7	$ 7.7	$ (1.0)	$ 66.4	$ 65.4	$ (1.1)
pmpm	*$ 34.87*	*$ 32.51*	*$ (2.36)*	*$ 29.26*	*$ 29.27*	*$ 0.01*
% of Revenue	*9.8%*	*9.0%*		*8.4%*	*8.4%*	
Project Portfolio	$ 1.3	$ 2.8	$ 1.5	$ 18.0	$ 16.8	$ (1.2)
pmpm	*$ 5.19*	*$ 11.86*	*$ 6.67*	*$ 7.93*	*$ 7.54*	*$ (0.39)*
% of Revenue	*1.5%*	*3.3%*		*2.3%*	*2.2%*	
Operating Gain/(Loss)	$ (10.8)	$ (3.2)	$ (7.5)	$ 9.0	$ 32.0	$ (23.0)
pmpm	*$ (43.01)*	*$ (13.53)*	*$ (29.48)*	*$ 3.96*	*$ 14.35*	*$ (10.38)*
Retro Revenue Adjustments	$ 0.1	$ -	$ 0.1	$ (13.5)	$ -	$ (13.5)
pmpm	*$ 0.31*	*$ -*	*$ 0.31*	*$ (5.93)*	*$ -*	*$ (5.93)*
Total Increase / (Decrease) in Unrestricted Net Assets	$ (9.1)	$ (2.3)	$ (6.8)	$ 8.4	$ 42.5	$ (34.0)
pmpm	*$ (36.45)*	*$ (9.74)*	*$ (26.71)*	*$ 3.72*	*$ 19.01*	*$ (15.29)*
% of Revenue	*-10.2%*	*-2.7%*		*1.1%*	*5.4%*	

In summary, the YTD Net Asset balance variance of $(34.0M) is primarily the result of:

- $9.2M premium revenue favorability (membership volume-related).
- $(30.0M) unfavorability in medical spend (driven by the $(17.3M) in acceleration of QIPP payments and $(16.1M) increase in FFS medical costs, offset by favorability in non-FFS spend.
- $(16.1M) 2023 acuity adjustment State "take-back" in premium rates (not known at time of reforecast) offset by other minor retroactivity.

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Looking Ahead....

- Potential for reduction in Incurred But Not Paid (IBNP: Expected expenses for services provided but not yet submitted for provider reimbursement) in the last quarter of the year.
- Benefit utilization for membership in new eligibility category could add pressure to MBR.
- State actions could result in additional prior period revenue take-backs:
  - Covid Testing Risk Corridor reconciliation/adjustment.
  - Targeted Rate Increase Reconciliation.

Exhibits

<u>This section contains the following exhibits</u>

- March Balance Sheet
- March Cash and Short-Term Investment Portfolio
- Revenue and Medical Benefit Per Member Month Values
- Membership Breakdown

March YTD Balance Sheet: Assets

ASSETS	03/31/24	06/30/23
Current Assets:		
Total Cash and Cash Equivalents	**568,700,715**	**344,166,987**
Total Short-Term Investments	**98,537,175**	**95,269,796**
Medi-Cal Receivable	176,593,108	96,222,357
Interest Receivable	(482,596)	462,872
Provider Receivable	6,316,034	422,995
Other Receivables	79,547	59,542
Allowance for Doubtful Accounts	(639,602)	
Total Accounts Receivable	**181,866,492**	**97,167,766**
Total Prepaid Accounts	12,804,175	5,545,603
Total Other Current Assets	135,560	135,560
Total Current Assets	**862,044,117**	**542,285,711**
Total Fixed Assets	**8,527,164**	**9,224,593**
Total Assets	**$ 870,571,281**	**$ 551,510,304**

- Medi-Cal Receivable: 2024 Managed Care Organization tax for January through March plus expected State premiums.
- Provider Receivable: includes payment advances related to Change Healthcare data breach.
- Total Prepaid Accounts: primarily member incentives we have purchased but not yet disbursed.

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March YTD Balance Sheet: Liabilities

LIABILITIES & NET ASSETS	03/31/24	06/30/23
Current Liabilities:		
Incurred But Not Reported	$ 111,346,872	$ 84,436,777
Claims Payable	18,803,088	12,923,764
Capitation Payable	8,019,870	8,998,514
Physician Payable	34,025,397	31,865,385
AB 85 Payable	-	-
DHCS - Reserve for Capitation Recoup	44,932,112	10,411,049
Lease Payable- ROU	3,386,589	3,300,319
Accounts Payable	296,221	1,455,088
Accrued ACS	4,707,627	3,902,303
Accrued Provider Incentives/Reserve	25,223,140	17,427,573
Accrued Pharmacy	-	-
Accrued Expenses	94,821,928	7,559,682
Accrued Premium Tax	147,573,159	-
Accrued Interest Payable	-	-
Current Portion of Deferred Revenue	-	-
Accrued Payroll Expense	4,011,590	3,189,633
Current Portion Of Long Term Debt	-	-
Other Current Liabilities	-	-
Total Current Liabilities	**497,147,593**	**185,470,089**
Long-Term Liabilities:		
Lease Payable - NonCurrent - ROU	5,036,269	6,088,559
Deferred Revenue - Long Term Portion	-	-
Notes Payable	-	-
Total Long-Term Liabilities	**5,036,269**	**6,088,559**
Total Liabilities	**502,183,862**	**191,558,647**
Net Assets:		
Beginning Net Assets	359,951,657	176,617,059
Total Increase / (Decrease in Unrestricted Net Assets)	8,435,762	183,334,598
Total Net Assets	**368,387,419**	**359,951,657**
Total Liabilities & Net Assets	**$ 870,571,281**	**$ 551,510,304**

- Incurred But Not Reported: Expected expenses for services provided but not yet submitted for provider reimbursement: increasing due to claims payments timing, membership levels, and unit cost rates.
- Accounts Payable is down due to faster invoice processing.
- Accrued Premium Tax reflects our expected Managed Care Organization Tax (this appears only our Balance Sheet and does not impact our financial results).

Cash and Short-Term Investment Portfolio

SCHEDULE OF INVESTMENTS AND CASH BALANCES

		Market Value* March 31, 2024	Account Type
Local Agency Investment Fund (LAIF)[1]	$	42,080,748	investment
Ventura County Investment Pool[2]	$	19,054,764	investment
CalTrust	$	37,401,663	short-term investment
Bank of West	$	412,201,156	money market account
Pacific Premier	$	156,499,058	operating accounts
Mechanics Bank[3]	$	-	operating accounts
Petty Cash	$	500	cash
Investments and monies held by GCHP	***$***	***667,237,888***	

Cash and short-term investments: $667.2M.

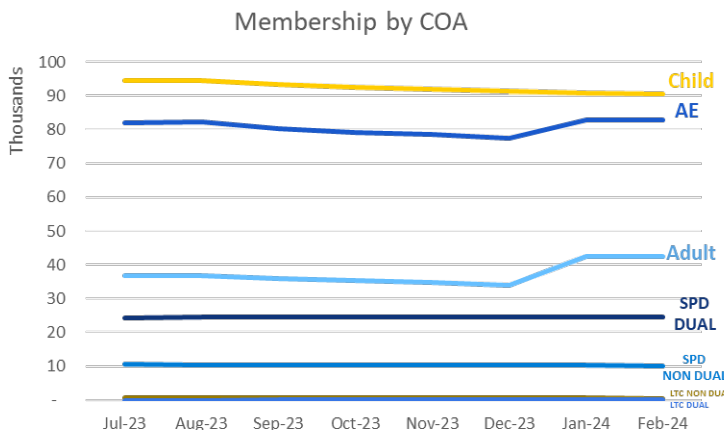
- The investment portfolio includes Ventura County Investment Pool $19.1M; LAIF CA State $42.1M; Cal Trust $37.4.

PMPM and TNE Values

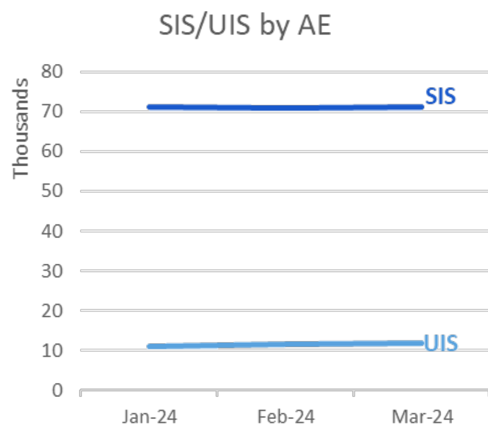
	FYTD 23/24 Reforecast	FYTD 23/24 Actual	FYTD 22/23 Actual	FYTD 21/22 Actual
Average Enrollment	248,186	252,234	247,854	229,367
PMPM Revenue	$ 350.40	$ 348.81	$ 340.86	$ 347.72
Medical Benefits				
Capitation	$ 34.16	$ 32.96	$ 34.18	$ 32.44
Inpatient	$ 67.67	$ 67.10	$ 54.64	$ 68.62
LTC / SNF	$ 66.08	$ 61.81	$ 54.86	$ 59.92
Outpatient	$ 26.76	$ 28.11	$ 23.88	$ 22.59
Emergency Room	$ 12.43	$ 13.17	$ 11.32	$ 10.80
Physician Specialty	$ 25.83	$ 26.09	$ 23.44	$ 22.49
Quality Incentives	$ 5.44	$ 1.00	$ 0.69	$ -
Provider Grant Program *	$ 1.49	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ (0.15)	$ 29.71
All Other	$ 59.37	$ 64.42	$ 53.03	$ 45.41
Total Per Member Per Month	$ 299.24	$ 294.66	$ 255.89	$ 291.97
Medical Benefit Ratio	85.4%	88.2%	75.1%	86.9%
Total Administrative Expenses	$ 82,227,487	$ 84,434,267	$ 78,852,534	$ 53,680,738
% of Revenue	10.5%	10.7%	7.8%	5.6%
TNE	$ 402,411,706	$ 368,387,419	$ 359,814,027	$ 176,562,922
Required TNE	$ 41,438,176	$ 35,817,173	$ 32,913,795	$ 36,609,789
% of Required	971%	1029%	1093%	482%

Membership Breakdown

- Child and Adult Expansion cohorts account for about three-quarters of GCHP’s membership.
- The State of California provides Medi-Cal coverage to people who meet Medi-Cal requirements regardless of immigration status. For purposes of rate and specific benefit eligibility, the State uses the term “Unsatisfactory Immigration Status” (UIS) to refer to people without immigration documentation.



Data source: IBNP MM – Feb 2024



Data source: [DIM_GCHP_MEMBERS], [ACS_MEMBER_OTHER_PARAMETERS]

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AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nick Liguori, Chief Executive Officer, and the Executive Team

DATE: May 20, 2024

SUBJECT: Year-To-Date Financial Review and Fiscal Year 2024/2025 Budget Review

PowerPoint with Verbal Presentation

ATTACHMENTS:

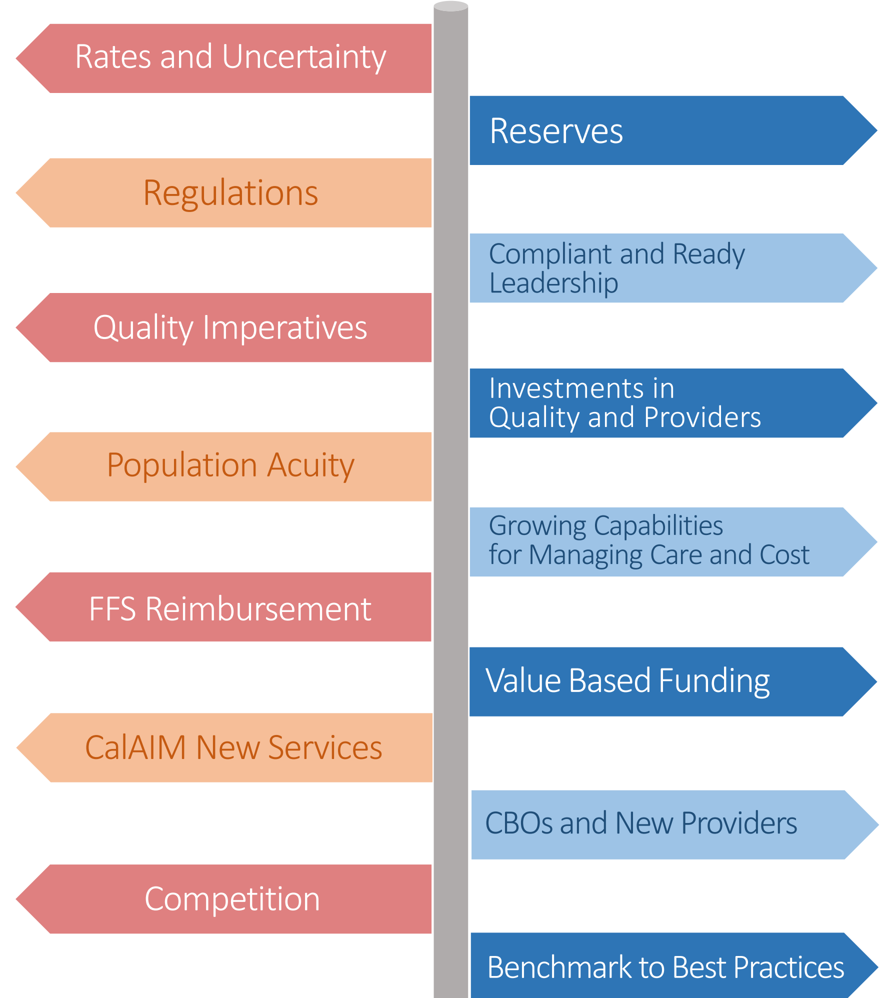
Year-To-Date Financial Review and Fiscal Year 2024/2025 Budget Review

All Pages DRAFT

FY2024/25 Budget and 3 Year Planning

Ventura County Medi-Cal Managed Care Commission
May 20, 2024

Nick Liguori, Chief Executive Officer
Sara Dersch, Chief Financial Officer
Eve Gelb, Chief Innovation Officer
Paul Aguilar, Chief Human Resources and Organizational Performance Officer
Dr. Felix Nuñez, Chief Medical Officer
Erik Cho, Chief Policy and Program Officer
Marlen Torres, Executive Director, Strategy and External Affairs



Topics We Will Review

1. Today's Objectives
2. Budget Design
3. Medi-Cal Industry Environment
    - Opportunities and Challenges
    - Question and Answer Session with Kyle Edrington, Founder of Edrington Health Consulting
    - Provider Environment
    - Quality Environment
4. Gold Coast Health Plan Environment
    - Membership and Associated Premium Rates
    - Medical Benefit Cost Trends
    - Unique Needs of New Members
5. FY2024/25 Proposed Budget

Return to Agenda

OBJECTIVES

(1) Understand where we are in the budget process.

(2) Understand Medi-Cal program and industry trends.

(3) Understand the need to plan for to use a portion of our reserves to expand the investment in Quality and Providers begun 2 years ago.

(4) Gain feedback from the Commission.

In April, Management provided the FY2024-25 budget framework outlining planned use of reserves.

Today, we will review the budget as well as important considerations for how management has developed the budget and will successfully implement that budget.

In June, we will bring the final budget packet which will include more-detailed administrative budget content. This administrative content will include the following: the personnel budget, a comprehensive review of existing and new vendor/consultant contracts and related budgets, operations of the future budget, and more.

Gold Coast Health Plan
Fiscal Year (FY) 2024-25 Budget Design

- GHCP's underlying financial performance today is strong, reflecting a Medi-Cal Managed Care Plan under effective management control, and operating in accordance with parameters of our Medi-Cal premiums.

  Excluding GCHP's Quality Funding Program:

  – 88% of premiums go to Medi-Cal member benefit spend.

  – 10% goes to efficient operations of the health plan and ongoing investments in Operations of the Future.

  – 2% would be available for addition to reserves.

- In order to meet the imperative of our Mission to improve Quality Care and Access for our members and to support the Ventura County Medi-Cal healthcare delivery system, management has developed a pioneering Quality Funding Programs that increases funds available for quality care and services by $90M in FY 2024-25 and by $250M over the next 3 years. These unprecedented new programs build off the funding programs and plan-provider partnerships that produced incredible successes in MCAS improvements in the current fiscal year.

- **Bottom line change in reserves**: The new Quality Funding Programs will involve a $22.5M spend down of reserves by the end of FY 2024-25. This will appear as a planned $22.5M reduction of reserves in the health plan's income statements.

Return to Agenda

Environment – Medi-Cal Program and Industry

Return to Agenda

Medi-Cal Environment Presents Opportunities and Challenges

New Programs and Populations provide great opportunities to serve our members and our community in new and important ways. These opportunities require significant strategic foresight, coordination and partnering with others to connect members with care, along with sophisticated budgeting with a strong grasp on administrative costs, medical cost management, and other health plan investments for underfunded efforts. Therefore, progressive quality focused plans must balance the opportunities with the risks to remain sustainable.

Do More

- Medi-Cal Managed Care Plans (MCPs) need to broaden their footprint and infrastructure to support social drivers of health and behavioral health initiatives.
- Community Supports are expected to be converted into regular member benefits.
- Adult Expansion, elimination of asset limits, new Medi-Cal benefits, and D-SNP.
- Added requirements such as expanded Transitional Care Services and Health Equity.

Do Better

- Withholding a percentage of payments with an opportunity for MCPs to earn it back by achieving quality and health equity benchmarks.
- New requirement to invest 5% to 7.5% of margin back into the community. MCPs that don't meet quality expectations will have to reinvest an additional 7.5% of their profits into the community.
- Compete with Kaiser.
- New standardized contracts that will strengthen and clarify requirements and expectations regarding oversight and compliance. Greater penalties for poor performance.
- NCQA Health Plan and Health Equity Accreditation.

Get Paid Differently

- Rate transparency to support cost containment and downstream provider margins.
- Regional Rate Setting to create price leverage.
- 2024 Targeted Rate Increases (TRI) and expanded TRI in 2025+.
- Payment based on acuity.
- Managed Care Organization (MCO) Tax if successful would inject funding into the funding pool.

Return to Agenda

Edrington Q&A – Guest Speaker on Industry Trends

1) What is driving the changes in the Medi-Cal Program that we learned about on the previous slide?

2) How is the Medi-Cal industry-wide "premium environment" changing now and over the next few years? How do you expect GCHP's premiums to change based on actual cost data?

3) Can you provide more detail on regional rate setting? Why is it coming, when is it coming, and what will it mean for GCHP?

4) The historical Medi-Cal premium development paradigm essentially provided managed care plans with near full "reimbursement" of costs, albeit on a 2-year lag. How will regional rate setting change this?

5) How important is GCHP's development of care and cost management capabilities and Model of Care around the following:

    1) Care management of those high-cost members with multiple chronic conditions?

    2) Continued high-Quality performance across all MCAS measures?

6) Open questions from the Commission

Kyle Edrington founded Edrington Health Consulting (EHC) in 2014 and has provided actuarial, financial, and strategic support to Local Medi-Cal health plans for over 15 years, including support for Gold Coast Health Plan since 2018. Kyle and the EHC team currently work with 14 of the 17 Local Medi-Cal health plans as trusted advisors supporting each health plan's operations and strategy. In addition, Kyle contributes to DHCS workgroups and other technical discussions to support its capitation rate development process and strategic direction of Medi-Cal. EHC is a subsidiary of HMA.

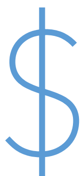
Return to Agenda

Provider Environment

Understanding the provider delivery system – needs, challenges, and goals – is key to GCHP's strategies, essential to the strength of plan-provider partnership, and GCHP's budget success.

Workforce Shortages Impact Access to Care

The healthcare industry is still feeling the impact of "the great resignation" and has pressing need for primary care providers, certain specialists, and nursing staff. The pressures in finding, hiring, and retaining talent are exacerbated by burdensome administrative issues (such as prior authorization), and the increased cost of living and other drivers that create wage inflation. Additionally, space limitations prevent full execution of staffing plans.



Rate Pressure

Rate Stability and sufficiency is an ongoing issue. Providers are facing lower reimbursement compared to increasing delivery costs with a greater dependency on supplemental funding and funding based on quality performance. It is difficult for providers to get internal commitment and build new capabilities needed for sustained quality when payment is not guaranteed.

Technology is Both an Opportunity and a Challenge

Both the promise of new tools and systems as well as the challenges of data/cyber security. Many are somewhere in the process of new system implementation and felt the immediate impact of and are dealing with the vulnerabilities identified in the Change Healthcare Cybersecurity Issue.

Quality and Community Focus

We have alignment with goals and approaches to lift the health of the community by connecting members with care. Innovation and targeted interventions are needed to address individual needs in areas of:

Chronic conditions
- Hypertension
- Diabetes
- Asthma

Targeted populations:
- School aged children with developmental needs
- Teens with mental health needs
- Frailty driven by age, disability, and/or medical complexity
- Social complexity, especially housing insecurity

Quality Environment

Quality is the basis of evaluation and funding for GCHP today and in the future. Adequate funding for GCHP and the Ventura County delivery system are now and will be increasingly tied to better scores on the Managed Care Accountability Set (MCAS), Consumer Assessment of Health Plans and Systems (CAHPS) and other standardized quality measures aligning with the National Quality Strategy.

Quality Withhold 0.5% of Revenue in 2024, increasing in 2025 and beyond to approximate our margin.	=	8 Managed Care Accountability Set (MCAS) Measures, with 9th measure added in 2025	+	4 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Measures (2 adult and 2 children)	×	Improvement Factor
Quality Sanctions	=	MCAS Measures below Minimum Performance Level (MPL)	×	Volume of Members in the measures that are not at MPL	×	Corrective Actions Factor
Risk Adjusted Rates using Chronic Illness and Disability Payment System(CDPS) + Medicaid Pharmacy (Rx)	=	CDPS: Presence of Certain disease Categories and the severity of the disease based on diagnosis codes	+	Rx: Use of certain medications indicating disease or risk	−	Certain carved out populations

Connecting *with* Care: Members who have access to high quality care and a positive experience with care will have improved health outcomes. Medi-Cal requires it. Our members deserve it. GCHP is leading he way.

This is the Quality Imperative.

Return to Agenda

Understanding Challenges and Opportunities in Order to Manage the Business of Gold Coast Health Plan

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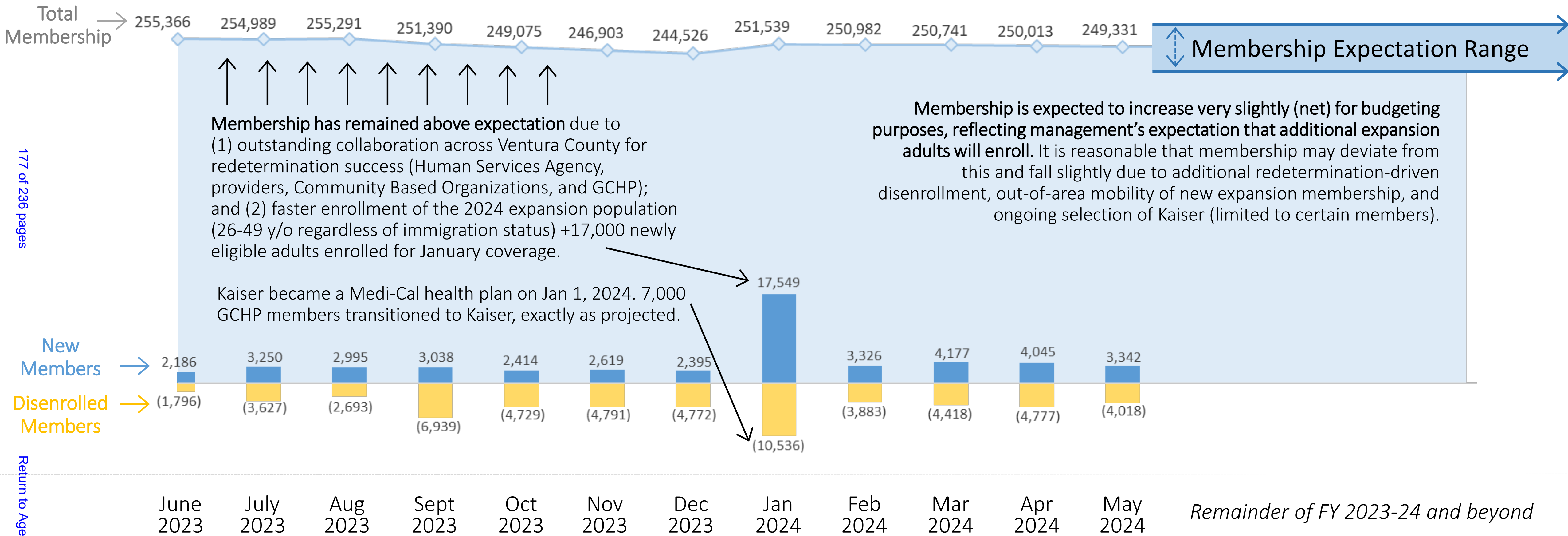
Data Based Foundation for Budgeting: Membership Trends



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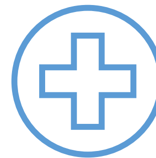
Unique Needs of New Members

Health Risk Assessments (HRAs) launched in Q1 for our newest members have helped us better understand their needs.

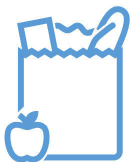
22% of the members rate their health as fair or poor. This is a predicter of health decline and increased utilization.

53% of the members had problems getting care from a doctor in the past 6 months.



17% of members either have used the Emergency Department or Hospital in the past 6 months or had a family member use those resources.

32% of the members felt down, depressed or hopeless in the last 2 weeks.



57% of the members are worried about food running out before they get more money.

48% of the members have seasonal or migrant farmwork as their family's main source of income.

Gold Coast Health Plan
Key Insights for Our Management of Costs and Sustainability

- Medi-Cal populations have grown the most in premium categories of aid that have decreased the fastest.
- While outsiders view Medi-Cal as increasing premiums, the reality for Medi-Cal Managed Care Plans is that premiums are remaining flat due to the interplay of membership mix and rate setting.
- “Fee for Service” reimbursement rate increase demands in the provider delivery system remain high and in fact are significantly greater than funding available in premiums.
- Healthier members left the health plan through redetermination and the Kaiser transition, as expected. The population that remains has a higher acuity (higher need for care and services).
- GCHP’s “Top 10%”population has an extraordinary occurrence of multiple chronic conditions and a great need for programmatic solutions and integrated care team interventions to improve health and “bend the future cost curve.”
- GCHP is developing a full profile of Inpatient and Long-Term Care costs and utilization drivers as well as a responsive solution to keeping these costs in line with available premium funding.

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Data Based Foundation for Budgeting: Membership Mix and Premium Development

- DHCS develops premiums at a population cohort level ("Categories of Aid"), based on age (child or adult), level of need (age and disability), and immigration status (UIS, SIS).
- CY 2024 premiums developed favorably for some categories and unfavorably for others – yielding a flat plan-wide composite premium between CY 2023 and CY 2024. Essentially this means there was no more money per-capita to cover cost increases that were being created by contracted provider reimbursement rate increases.

Membership				DHCS Major "Categories of Aid" Premium Rate Categories	Base Premium Rates			
Actual CY 2023	Actual CY 2024	CY 2024 vs CY 2023 Change	CY 2024 vs CY 2023 % Change		Actual CY 2023	Actual CY 2024	CY 2024 vs CY 2023 $ Change	CY 2024 vs CY 2023 % Change
91,687	87,350	(4,337)	-4.7%	Child - SIS	95.84	$ 103.73	7.89	8.2%
3,720	3,788	68	1.8%	Child - UIS	78.69	$ 100.40	21.71	27.6%
27,601	25,946	(1,655)	-6.0%	Adult - SIS	296.66	$ 326.48	29.82	10.1%
5,992	15,990	9,998	166.9%	Adult - UIS	508.72	$ 470.51	(38.21)	-7.5%
71,180	67,563	(3,617)	-5.1%	Adult Expansion - SIS	357.8	$ 331.05	(26.75)	-7.5%
6,385	12,023	5,638	88.3%	Adult Expansion - UIS	761.52	$ 544.21	(217.31)	-28.5%
10,086	9,928	(158)	-1.6%	SPD - SIS	1177.93	$ 1,252.52	74.59	6.3%
1,178	1,221	43	3.7%	SPD - UIS	1824.05	$ 1,333.13	(490.92)	-26.9%
24,583	24,501	(82)	-0.3%	SPD Dual - SIS	579.44	$ 638.58	59.14	10.2%
638	677	39	6.2%	LTC Dual - SIS	579.44	$ 638.58	59.14	10.2%

GCHP experienced some of the largest declines in rates for our fastest growing population cohorts (expansion groups).

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Data Based Foundation for Budgeting: Drivers of Benefit Cost Growth

Unit Cost

(excluding the Quality Funding Program)

- Reimbursement rate increases contracted in FY 2023-24 grew annual benefit costs by ~4%; LTC and inpatient costs trends are even steeper.
- Reimbursement rate increases are budgeted to further grow annual benefit costs >1% in FY 2024-25.
- DHCS' Targeted Rate Increase (TRI), a resetting of the baseline Medi-Cal payment schedule, added ~1.5% to benefit costs (MHSA, LTC, and other medical costs) in FY 2023-24 and the TRI program will expand in CY 2025 in yet to be defined ways.
- **Going forward, GCHP must prudently align unit cost increases with premium developments → long-term sustainability requires we spend only what we have in premiums.**

Population/Utilization

- After redetermination and the Kaiser transition, we are seeing a higher acuity (higher need) membership remain and a lower acuity group exit. This is as expected. The group that has left has costs that are ~40% lower than those who remain. **GCHP and provider partners must be increasingly effective at managing care and cost of high acuity, multiple chronic condition populations.**
- The 2024 expansion group of 26-49 regardless of immigration status comes to managed care with a history of high ER use for care. Also, there is potentially a pent-up demand for care and services. **GCHP must understand membership needs and tailor solutions that deliver high engagement in regular outpatient primary healthcare, specialty healthcare, and behavioral healthcare.**

- Unit Costs are <u>not</u> decreasing in any way.

- CY 2024 premiums include DHCS/Mercer's assumption that utilization in the 2024 expansion population will decrease over the near term after some early pent-up demand. This is expected by DHCS to result in ~1.3% lower costs in FY 2024-25. **Will this show up?**
- GCHP program interventions aimed at "bending the curve of costs= growth" for higher need members, including those with multipole chronic conditions, is having unprecedented, yet expected, favorable impact in the form of prevented readmissions and greater quality care. **We must expand the use of these pioneering and highly effective programs.**

Proposed Budget

Gold Coast Health Plan

Summary of Management’s Proposed FY2024/25 Budget

	FY2023/24 Forecast	FY2024/25 Budget	Comments
Membership	228,289	**251,125**	Higher-than-expected membership levels are driven by successful redetermination efforts and a newly-eligible population cohort. Membership is now relatively stable and is not expected to change majorly. But membership can change if redetermination disenrollment picks up or Kaiser is expanded as a Medicaid Managed Care Plan by the State.
Premium Revenue	$1.042B	**$1.073B**	As presented, this reflects essentially flat revenue even though membership is favorable; the changing member “mix” accounts for the minimal revenue increase; an additional $10M in investment income brings total revenue to $1.084B. MCO tax (which is a pass-through from the Federal government to the State) of $303.7M brings total receipts to $1.376B.
Medical Benefit Cost *(Ratio)*	$885.7M *85.0%*	**$987.2M** ***92.0%***	Prior to the $82.5M Quality Funding Programs, the underlying MBR is 88%.
Administrative Expense *(Ratio)*	$135.5M *13.0%*	**$107.3M** ***10.0%***	The $28M reduction in administrative expenses is due to significantly less funding needed for the Operations of the Future build-out in FY 2024-25 and continuous efficiency improvement in the operations of the health plan. The year-over-year administrative expense reduction is also after accounting for proposed new investments in staffing and additional consulting services.”
Reserve Increase/(Decrease)	$33.8M	**$(22.5M)**	Net income prior to the Quality Funding Programs is $60M, or 2% of total revenue (premium revenue plus investment income). The Quality Funding Program produces a planned $(22.5M) decrease to reserves.
Net Increase to Reserves	$33.8M	**$0**	We will be using our $60M operating margin plus $22.5M in reserves for the Quality Funding Programs.

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A Planned Spend Down of Reserves Has Significant Risks

Going into a planned spend-down position requires us to be even more sensitive to variabilities in our environment that can adversely impact our financial position. Unfavorable changes in any of a multitude of factors could create a far larger spend down than planned. *For instance, think of another $16.3M premium acuity adjustment on top of a planned $22.5M reduction in reserves.*

- Membership Health
  Factors such as redetermination and the introduction of newly-eligible populations could result in a higher-utilizing membership.

- State Rate Actions
  The State has the ability and precedent to invoke revenue reductions retroactively using the historical utilization as rationale.

- Provider Reimbursement Expectations
  The narrowing gap between premium revenues and medical benefits puts pressure on our ability to fund continued fee-for-service increases.

Management Actions

Including but not limited to

✓ Proactive monitoring of member health to ensure acuity needs are met timely, preventing unnecessary care in expensive settings.

✓ Rate advocacy with State for premium adequacy.

✓ Recalibrate reserve recommendations should unfavorable developments require.

✓ Advance sophisticated capabilities for managing care and cost, especially of high acuity, chronic condition populations.

✓ High discipline on what we can control.

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Budget FY2024/25 MBR Components → Getting to 92%

Quality Funding Programs

85.0% — Includes 2.5% current QIPP

FY 2023-24 current base benefit cost

2.3% — QIPP Expansion

Continuation of Quality-based Incentives

1.8% — Value-based Rates*

Incremental increases related to improving access to care (ex: evening and weekend hours)

1.2% — Provider and Community Grants

Continued support for Providers and Community Organizations to improve access to care

1.5% — Targeted Rate Increase (TRI)

TRI is supposed to be net neutral, however MCOs retain risk should TRI utilization exceed State forecasts

0.2% — Member Incentives

Increase in member incentives for Wellth expansion, member activities that close MCAS gaps in care, etc.

= 92%

*Incremental increases related to improving access to care or quality related activities

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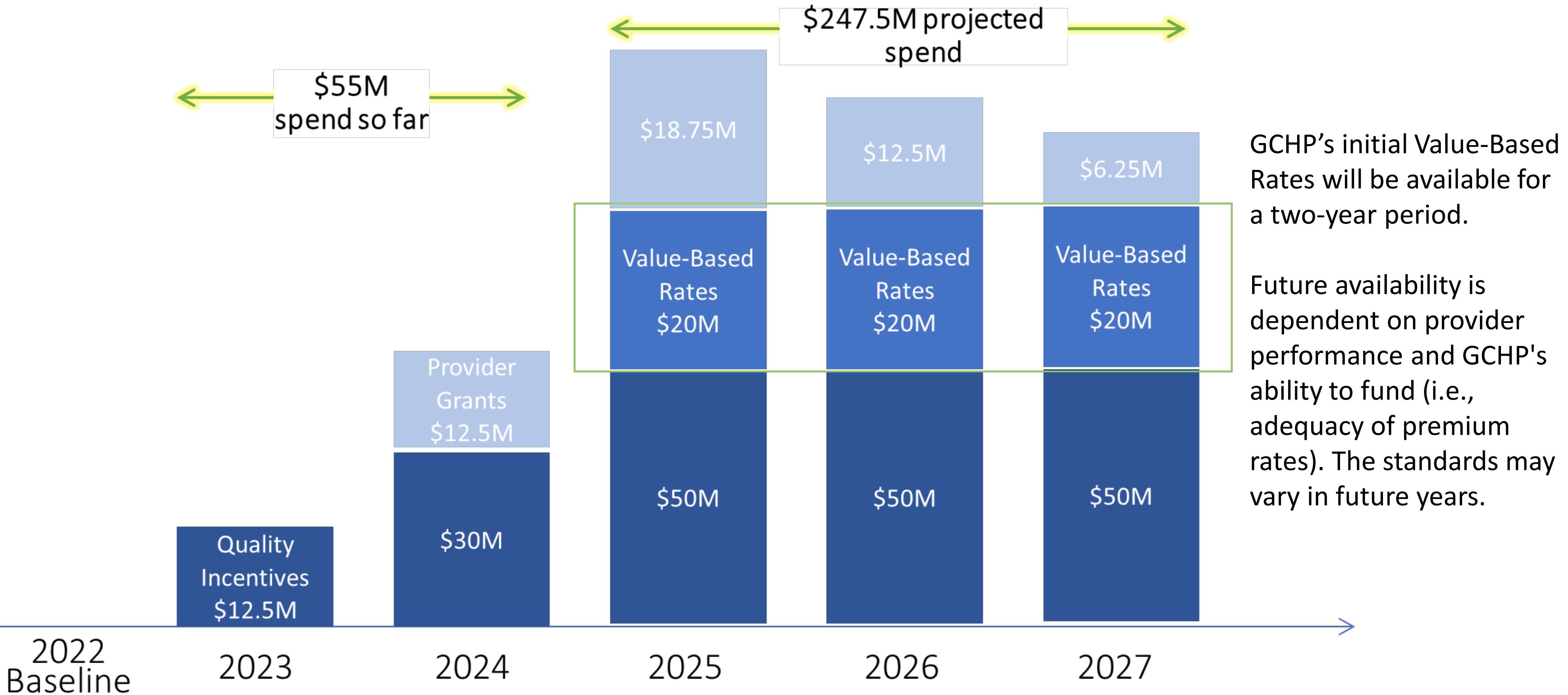
Budget FY 2024-25 | Quality Funding Programs and Value-Based Rates

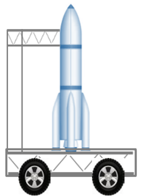
Valued Based Rates reward providers based on increased access, efficiency, and/ or quality.



GCHP's initial Value-Based Rates will be available for a two-year period.

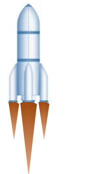
Future availability is dependent on provider performance and GCHP's ability to fund (i.e., adequacy of premium rates). The standards may vary in future years.

Effective Execution of an Unprecedented Budget



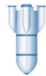
Getting Ready for Takeoff 2024/25

- Integrated Care Team full implementation
- Voice of the Member (surveys, feedback); deep understanding of member and community need
- Service Everywhere community resource centers
- Performance Management and Leadership Development
- Strengthening project management capability organization-wide
- Financial strength and continued investment in modernizing health plan capabilities to improve health, quality healthcare, and member experience



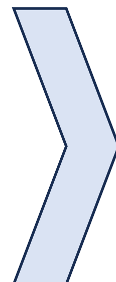
Launched 2023/24

- State of art operating systems and services and operational performance excellence
  - Core Admin and BPO
  - Care Management System
  - Provider Portal
  - Modern Data Warehouse
  - CRM
- Community Care model bringing healthcare to members where they want it including school, work, home and neighborhood
- Delegation and vendor oversight to drive performance and value
- DSNP Readiness/Knox Keene
- NCQA Accreditation
- Optimized Data, Analytics & Metrics
- Corporate Integrity Agreement implementation



Landing Well 2023/24

- Highly effective system-wide quality improvement program achieving unprecedented MCAS improvement
- Procurement of best-in-class systems to implement the model of care
- Stellar performance on DHCS, MLR and Claims Audits.
- In-house local contact center
- Healthcare Programs and Services connect members with healthcare/services including Wellth, Community Supports, Member Incentive Programs



- All members get care “Whenever/ wherever” they need it (access and equity for all); High MCAS scores reflect this
- High member engagement in health and healthcare (members know, want, get, and stay active in health and regular primary and specialty care and Rx adherence) yields lasting impacts to individual, family, and community health and wellbeing
- The healthcare system and providers of community-based services are higher performing and continuously improving to meet GCHP/DHCS goals for quality, satisfaction, and equity

Gold Coast Health Plan
Fiscal Year (FY) 2024-25 Budget Design conclusion

- GHCP’s underlying financial performance today is strong.
- We are planning a judicious use of reserves to further the Quality Funding Programs.
- We seek your feedback on our proposed FY 2024/25 budget today and in 1:1’s scheduled for the next few weeks.

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Appendices

(1) "Strategy and Budget Principles and Framework" presented to the Executive Finance Committee on April 18,2024 and to the Ventura County Medi-Cal Managed Care Commission on April 22, 2024

Appendix 1—Strategy and Budget Principles and Framework

Strategy and Budget Principles and Framework

Executive Finance Committee
April 18, 2024

Nick Liguori, Chief Executive Officer
Sara Dersch, Chief Financial Officer
Erik Cho, Chief Program and Policy Officer
Dr. Felix Nuñez, Chief Medical Officer

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Framework for Budget Fiscal Year 2024-25 and 3-Year Planning

Budgets bring our Mission, Vision, and Strategies to life. GCHP Management is developing a budget for the Fiscal Year (FY) 2024-25 and the 3-year period July 2024 – June 2027 that will accomplish the following in alignment with our **MISSION**:

1. **GCHP** | Ensure GCHP has the health plan capabilities necessary to meet our Mission of the best health possible, best access possible to quality healthcare, and superior experience for the members and communities we serve – for both Medi-Cal (low income vulnerable) and D-SNP (low income and/or disabled dually eligible) programs.
   - GCHP is now in the second annual budget of a multi-year transformation of health plan capabilities to meet its Mission, having historically performed low relative to other Medi-Cal local/community health plans in Mission-related measures (MCAS, CAHPS, health outcomes).
   - While always seeking to improve Quality and Satisfaction, we must also build (invest in) our capabilities to better manage medical costs to ensure long term financial viability.
2. PROVIDERS | Ensure we can make substantial, sustained, and transformational investments in Ventura County's delivery system of healthcare and healthcare-supportive services with the objective of increasing access to - *and provision of* - quality healthcare for the vulnerable members and communities enrolled in Medi-Cal, where and when they need the care and services.
3. MEMBERS | The primary purpose of our work and the fundamental principle that guides us in how we do that work is better health for our members and communities. Our members will be the main beneficiaries of all our many and major efforts to crate a more capable health plan and greater access to needed care across the healthcare system.

Budget FY 2024-25 | Commitments

- Management's objective with the budget is to optimize quality care for our members and to ensure the long-term viability and success of GCHP. We do this by ensuring the Ventura County Medi-Cal delivery system has funding to achieve high standards of access and quality care.

- Transparency is a paramount commitment by Management to Commission.

- Management's aim is to provide all information that supports the Commission in making budget decisions compliant with their fiduciary duty, legal requirements and accountability for the health plan's viability and success.

- GCHP continuous improvement: Per best practice, Management is engaging the Commission earlier (April) and more meaningfully in the budget process than ever before.

Management values feedback from Commissioners and we are available to answer questions and take in your feedback at any time.

Budget FY 2024-25 | Compliance and Legal Review

- ✓ GCHP Management desires to ensure the fullest funding possible to the Ventura County's Medi-Cal healthcare delivery system, and our funding programs since 2022 demonstrate this commitment.
- ✓ GCHP Management's funding programs are rooted in fundamental principles:
  - We are entrusted with the best use of taxpayer funds.
  - Funding for healthcare services must be adequate for safety net providers dealing with inflationary cost trends.
  - Funding must provide value (access, quality, outcomes) to the health plan and our membership as well as to our State and federal regulators who determine funding and its purpose.
  - Funding must always be compliant with state and federal laws/regulations that define permissible use of funds.
  - Funding must always be reasonable relative to value, services, market standards, industry practices, etc.
- ✓ Compliance is paramount under all circumstances. Compliance under the Corporate Integrity Agreement requires the highest standards of compliance.
- ✓ These slides describe GCHP's plans. BBK (Leeann Habte) on behalf of GCHP is performing a comprehensive legal review of all provider funding, including Quality Incentives, Reimbursement Arrangements, and Grants for compliance with federal and State laws and GCHP's Corporate Integrity Agreement with the Office of the Inspector General. This expert-based review includes consultation with an outside consultant with specialized expertise in value-based funding programs.

Budget FY 2024-25 | Process and Timeline

April 2024 Key Dates and Deliverables

- April 18th – Executive Finance Committee presentation on background, context, concepts, and process for Budget FY 2024-25 and 3-Year Plan. Staff request: questions and feedback.
- April 22nd – Commission presentation on the same. Staff request: questions and feedback.

May 2024 Key Dates and Deliverables

- May 16th – Executive Finance Committee presentation on preliminary Budget FY 2024-25 and 3-Year Plan. Staff request: questions and feedback.
- May 20th – Commission presentation on the same. Staff request: questions and feedback.

May 17th to June 14th – 1:1s with Executive Finance Committee

June 2024 Key Dates and Deliverables

- June 20th—Executive Finance Committee presentation on proposed final Budget FY 2024-25. Staff request: recommendation.
- June 24th—Commission presentation on the same. Staff request: approval.
- June 25th—Management begins new budget implementation.

April 2024

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5	6
8	9	10	11	12	13
15	16	17	18 Executive Finance Committee	19	20
22 Commission	23	24	25	26	27
29	30				

May 2024

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3	4
6	7	8	9	10	11
13	14	15	16 Executive Finance Committee	17	18
20 Commission	21	22	23	24	25
27 Executive Finance 1:1's	28 Executive Finance 1:1's	29 Executive Finance 1:1's	30 Executive Finance 1:1's	31 Executive Finance 1:1's	

June 2024

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1
3 Executive Finance 1:1's	4 Executive Finance 1:1's	5 Executive Finance 1:1's	6 Executive Finance 1:1's	7 Executive Finance 1:1's	8
10 Executive Finance 1:1's	11 Executive Finance 1:1's	12 Executive Finance 1:1's	13 Executive Finance 1:1's	14 Executive Finance 1:1's	15
17	18	19	20 Executive Finance Committee	21	22
24 Commission	25	26	27	29 28	29

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Budget FY 2024-25 | TNE Industry Perspective

GCHP Management desires to invest some reserves in value-based financing of the Ventura County healthcare delivery system. The Plan is outlined in the following slides. Here is an updated view of TNE across the Medi-Cal industry.

Industry Perspective | Tangible Net Equity by Medi-Cal Managed Care Plan (as % of required TNE)

Source: "Financial Summary of Medi-Cal Managed Care Plans (Quarters Ending June 30, 2023 and September 30, 2023); GCHP source is internal financial reporting.
Non-Governmental Medi-Cal Plans not included - reserves are generally kept at parent

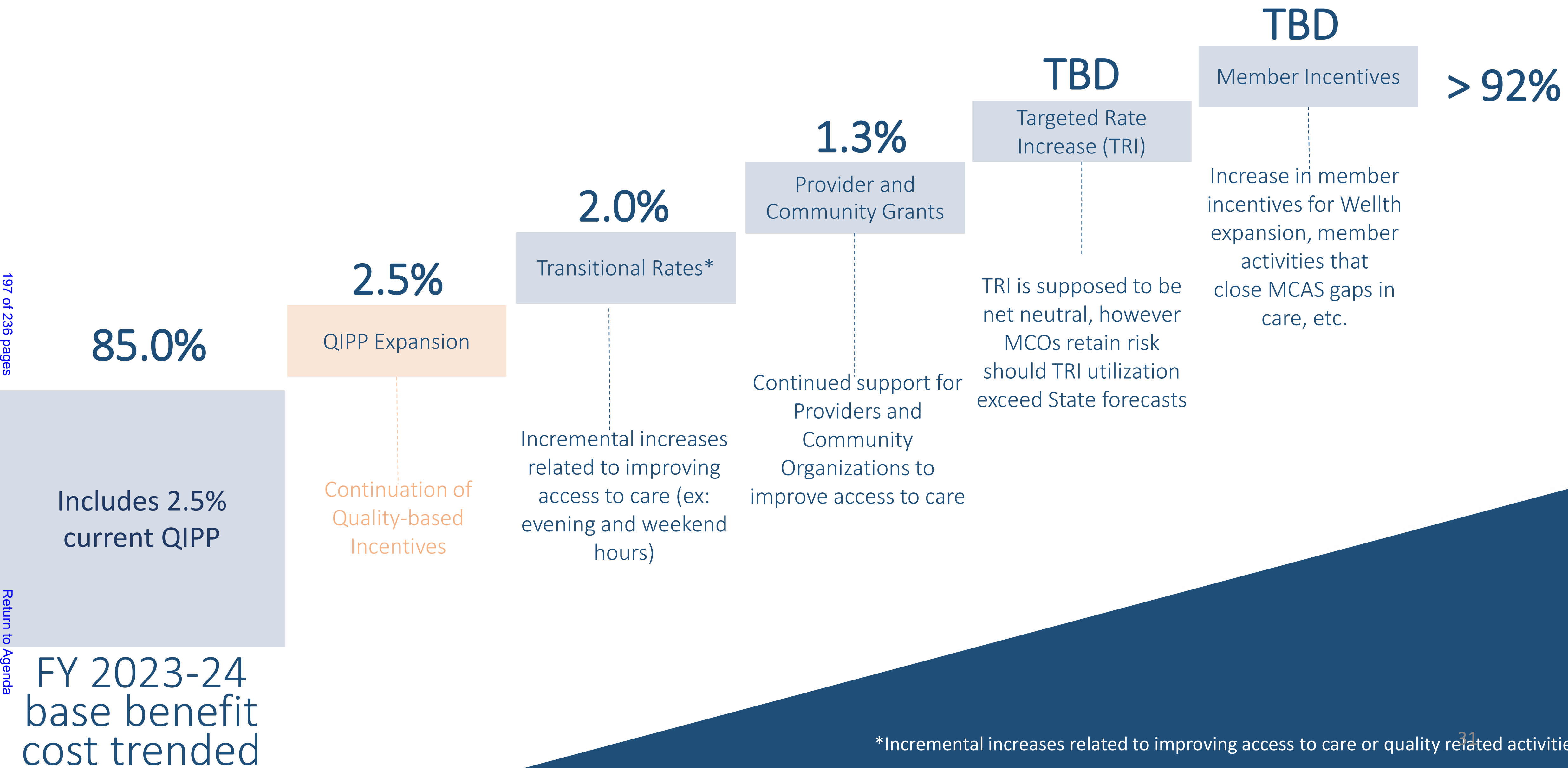
	June 2022	December 2022	June 2023	September 2023
Kaiser Foundation Health Plan		2154%	2209%	2252%
CalOptima	1340%	1482%	1556%	1577%
Health Plan of San Joaquin	988%	1220%	1447%	1381%
Scan Health Plan	1352%	1332%	1306%	1318%
Health Plan of San Mateo	977%	1268%	1275%	1241%
Central California Alliance for Health	1092%	1156%	1180%	1211%
Gold Coast Health Plan	482%	750%	1094%	1025%
L.A. Care Health Plan	716%	690%	789%	954%
CalViva Health	789%	838%	853%	866%
CenCal Health	563%	666%	811%	820%
Inland Empire Health Plan	725%	712%	794%	796%
Kern Health Systems	545%	623%	729%	741%
Alameda Alliance	605%	677%	758%	737%
Partnership HealthPlan	784%	829%	771%	729%
San Francisco Health Plan	1024%	1413%	784%	710%
Santa Clara Family Health Plan	585%	640%	716%	654%
Contra Costa Health Plan	554%	585%	617%	604%

Kaiser and SCAN are shown for additional perspective. Kaiser is included as it is now a fully licensed Medi-Cal Managed Care Plan. SCAN is a standard bearer for managing D-SNP. GCHP will be responsible for fiscally managing D-SNP and its reserves in the next budget year (FY ‘25-’26).

GCHP ranks near the middle as compared to other Medi-Cal Plans. GCHP TNE declined slightly due to changes in total assets and liabilities.

Preliminary 2024 financial reports are that LA Care will exceed GCHP’s position in Year End rankings due to its pace of reserve growth.

Budget FY 2024-25 | MBR Components



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Budget FY 2024-25 | Actuarial Unit Cost Comparison

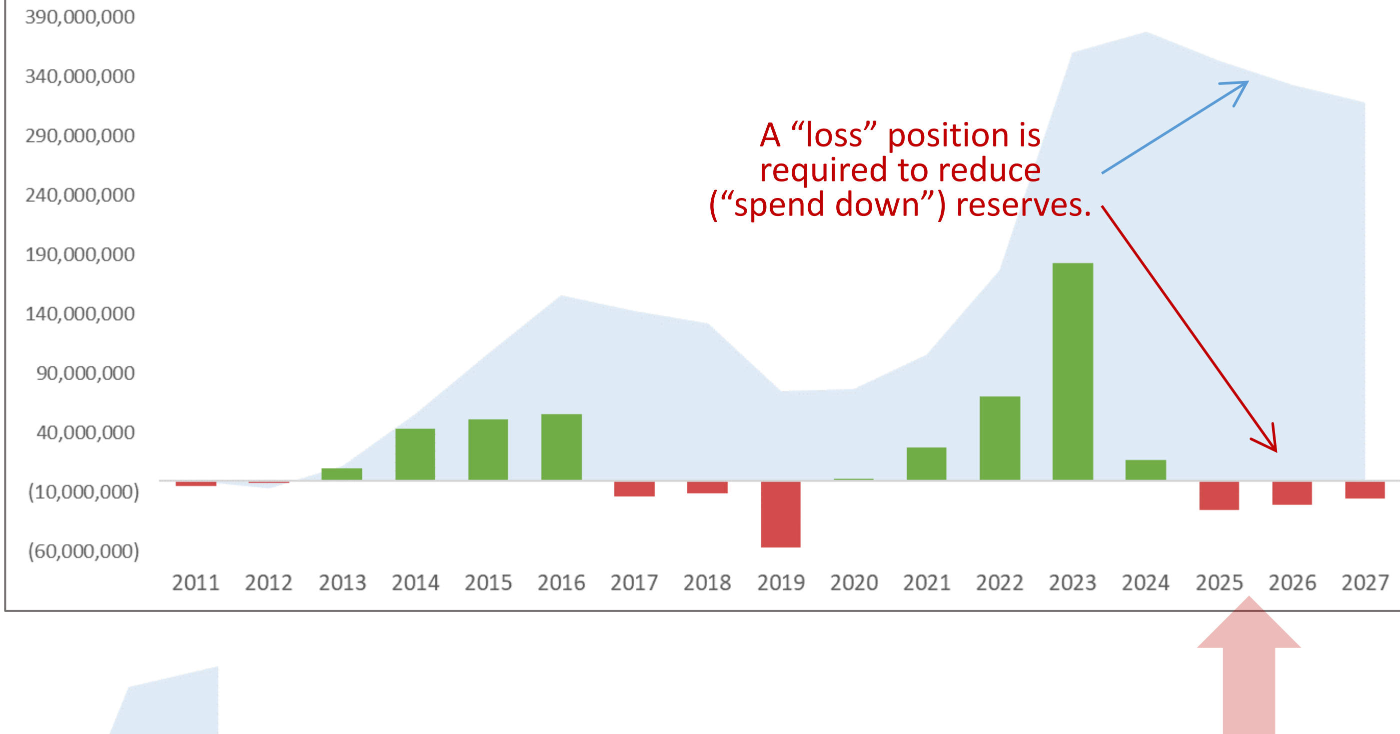
- This analysis of GCHP Unit Cost vs. those of other Southern California Medi-Cal regions (7 counties, 7 Medi-Cal Managed Care Plans) provides valuable insight for forecasting future premium rates. This analysis of unit cost closely approximates a comparison of reimbursement rates.
- Key to future rate development will be the maintenance of traditional FFS spending that is "in line" with spending across Medi-Cal plans. **Outlier FFS spending is at risk of not being fully reimbursed as DHCS looks to create greater regional cost parity.**
- Regional rate setting will replace individual plan rate setting in the near future. GCHP Management is actively preparing our reimbursement program to succeed in this new premium paradigm – **a focus on value/quality is one way to ensure long term success** (both financial success and Mission success).
- Key findings of the analysis strongly support Management's plan to focus spending increases for the greatest Quality (MCAS) impact:
  1. **MCAS improvements are principally achieved by greater use of outpatient primary healthcare, specialty healthcare, behavioral healthcare, and transportation to care.**
  2. **Physician Primary Care, Behavioral Healthcare, and Transportation unit costs are low relative to the industry.**

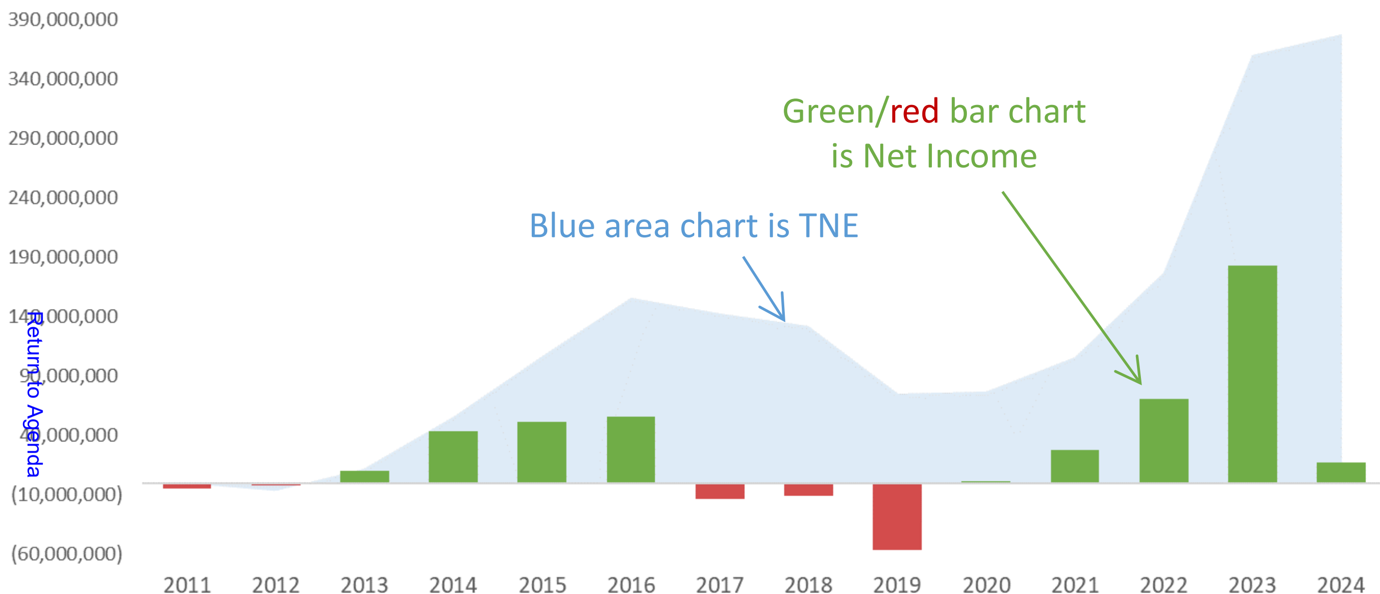
Category of Healthcare Service	GCHP Percentile (100% = Highest Rate in Region)
Inpatient Hospital	100.0%
Hospice	93.2%
Laboratory and Radiology	91.9%
CBAS	83.7%
BHT Services	76.6%
FQHC	76.6%
Physician Specialty	76.5%
Long-Term Care	75.4%
Emergency Room	61.5%
Other Medical Professional	56.6%
Outpatient Facility	55.2%
Mental Health - Outpatient	46.1%
All Other (small category $-wise)	37.6%
Physician Primary Care	37.2%
Home and Community Based Services	34.9%
Transportation	33.7%
Overall	71.6%

Costs are for the adult population and excludes the impact of population acuity and utilization. Counties include Kern, Los Angeles, Riverside, Santa Barbara, San Bernardino, San Luis Obispo, and Ventura.

Income and TNE Position

- Net Income adds to or reduces health plan reserves – adds to if Net Income is positive, reduces if negative. You can see the historical relationship in the chart below – when Net Income is positive, reserves grow by that amount; conversely, "losses" reduce reserves.





- To achieve a spend down of some Unrestricted Reserves (i.e., not in the 700% of TNE Policy), GCHP must go into a negative Net Income ("loss") position.

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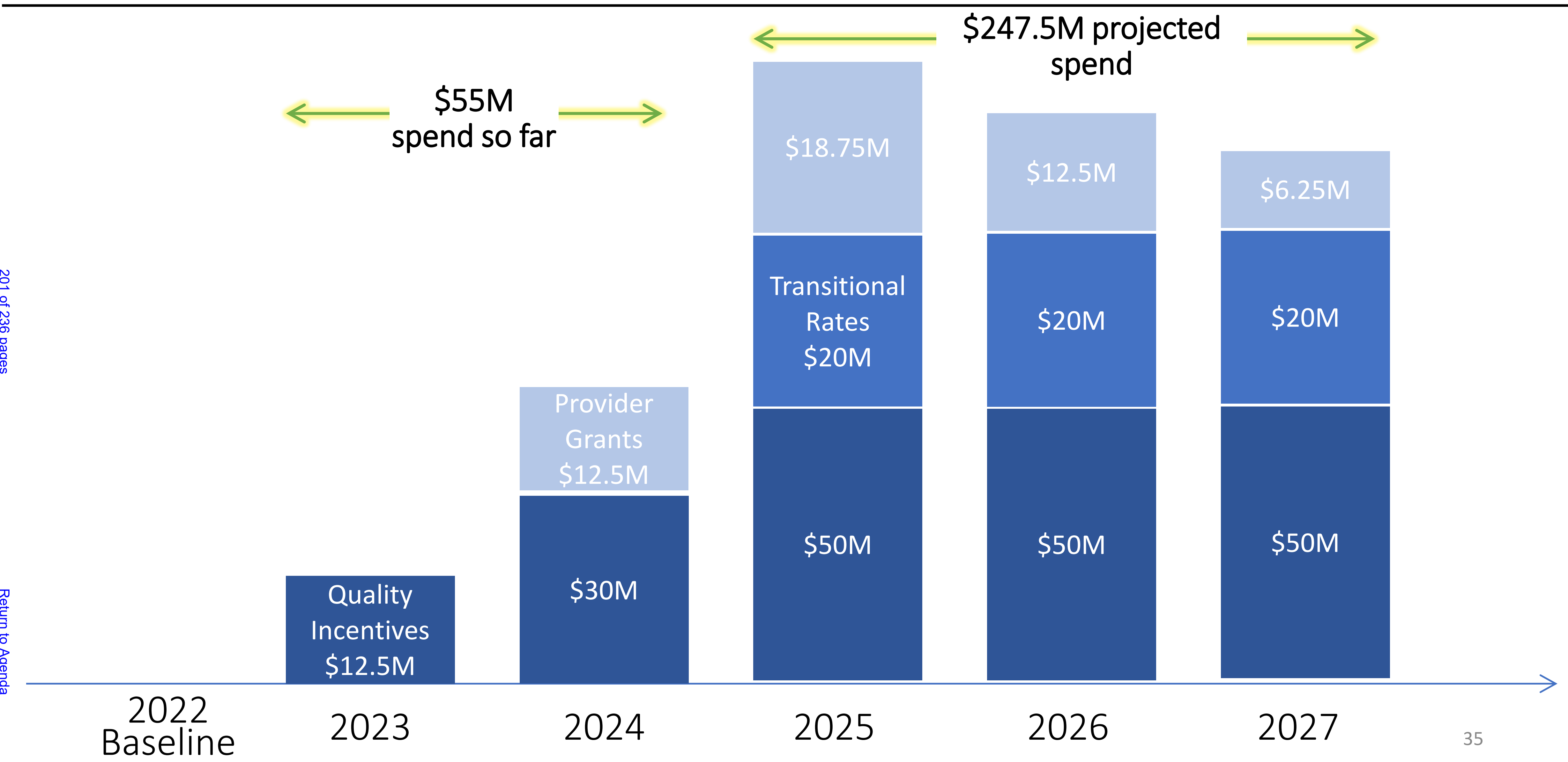
Budget FY 2024-25 | TNE Composition and Planning

		Today	Management Analysis
1025%	Unrestricted Reserves 325%	$60M	GCHP Management proposes to plan for a $60M reduction in reserves over the next 3 budgets (spanning July 2024 – June 2027) in the form of compliant and value-based funding for providers.
		$60M	D-SNP expenses (provider and administrative) are highly sensitive to minor changes in our modeling assumptions. Slightly adverse developments increase magnitude of losses. These are expected losses for D-SNP (actuarially developed) which has been filed with DMHC in its Knox Keene license application.
	Restricted Reserves 700%	$258M	These funds are restricted for maintenance of adequate reserves for long term viability of GCHP. These funds were established as GCHP TNE Reserve by Commission approval of the FY 2023-24 Budget (current year). For Medi-Cal alone, this provides for adequate long-term thinking and planning and investments to GCHP and providers. For Medi-Cal AND D-SNP combined, these reserve levels are inadequate. Management recommends adding to these reserves to meet satisfactory TNE for both programs.

GCHP Management Recommended Actions

- ✓ We seek to invest in providers through enhanced Quality-based funding. To do this, we must plan for 3 years of losses. We will course correct if rates and/or medical cost pressures trend adversely to forecast.
- ✓ GCHP Management and Actuaries recommend combining D-SNP TNE and Medi-Cal TNE to account for combined reserve needs.
- ✓ GCHP's actuarial model for D-SNP financial performance filed with the Knox Keene application expects $30M cumulative losses Years 1-3.
- ✓ An additional $30M reserves (on top of $30M expected losses) is prudent due to significant uncertainty in D-SNP performance/losses in 2026-2029.
- ✓ GCHP is entering a period of industry-wide anticipated premium pressures.

Budget FY 2024-25 | Quality-Focused Funding Increase 23-27



Budget FY 2024-25 | Quality-Focused TNE Investment

Program	FY 2024	FY 2025	FY 2026	FY 2027
PCP Quality Improvement Programs Up To:	$30M	$35M	$35M	$35M
Hospital and other incentives which may include Specialty, Long Term Care and Behavioral Health Integration Up To:		$15M	$15M	$15M
Transitional Rates Up To:		$20M	$20M	$20 M
Provider and Community Grants Up To:	$12.5M	$18.75M	$12.5M	$6.25 M

GCHP's financial targets will drive Quality and Access through provider investments aligned with Commission- Approved spend.

- **Quality Incentives:** $10 MQIPP Expansion to roll out this FY with incentive programs across other provider areas in development.
- **Transitional Rates:** These rates will be impacted, as much as possible, by quality, access to care, and transitions of care activities and improvements.
- **Provider and Community Grants:** We aim to deliver early on the $25M, 2–3-year commitment made starting in FY 23-24 and provide an additional $25M in funding through FY 2027.

D-SNP/Medicare Forecast Impact on TNE

Model Assumptions	Knox Keene Filed Scenario	Lower Stars Higher Reimbursement	Higher Membership, Lower Stars, Lower Savings Higher Reimbursement
Membership by Year 3	5,190	5,190	13,080
CMS Quality Star Rating	4	3.5	3.5
Managed Care Savings (from "unmanaged FFS")	20%	20%	15%
Provider Reimbursement (% of Medicare Fee Schedule)	102.5%	105%	105%
3- Year Cumulative Losses	-$17M	-$39M	-$60M or more*

* Management is working with actuaries on additional scenario planning

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Budget FY 2024-25 | Key Terms (1 of 2)

CMS Quality Star Rating: The Medicare equivalent of the DHCS Managed Care Accountability Set (MCAS). Ratings focus on health plan quality based on measurements of customer satisfaction and the quality of care a plan delivers. Plans are rated on a scale of one to five, with one star representing poor performance and five stars representing excellent performance.

D-SNP: A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan specifically designed to provide targeted care and limit enrollment to special needs individuals. A Dual Eligible Special Needs Plans (D-SNPs) is a type of SNP that enrolls individuals who are entitled to both Medicare and Medicaid (Medi-Cal in California).

Medical Benefit Expense: Costs for medical, dental, vision, transportation, meals, and other covered supplemental benefits.

Medical Benefit Ratio (MBR): Ratio of Medical Benefits to Premium Revenue; the percentage of state revenue that is spent on medical care.

Medicare Fee Schedule: A complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fees used to reimburse a physician and/or other providers on a fee-for-service basis.

Medical Management Savings: Savings generated from health plan activities related to the medical management of health services as compared to the Medicare Fee-For-Service costs.

Net Income: The remaining profit or loss after all expenses have been subtracted from all revenues. The Net Income increases reserves if positive or reduces reserves if negative.

Budget FY 2024-25 | Key Terms (2 of 2)

Premium Revenue: Amount received from the State to provide medical care and other covered services to GCHP members.

Quality Incentive Pool and Program (QIPP): A focused effort to direct funding to Providers for the achievement of Quality measures.

Restricted Reserves: The portion of Tangible Net Equity (TNE) that GCHP is required by policy to maintain (i.e. not be used). For GCHP's existing line of business (Medi-Cal), this amount is currently set at 700% of the Department of Health Care Services (DHCS) required minimum TNE.

Tangible Net Equity (TNE): GCHP total assets (cash, physical property, amounts we are owed) less total liabilities (both realized and incurred, such as amounts GCHP owes to pay current claims, vendors, personnel, etc). GCHP is required to maintain the DHCS formula-derived minimum TNE to ensure continuity of payments and services.

Targeted Rate Increase: To improve access to care, quality and equity, the California Department of Health Care Services (DHCS) is increasing rates to 87.5% of Medicare for certain Medi-Cal services.

Unrestricted Reserves: The portion of GHCP's TNE above and beyond the Commission-specified minimum. The unrestricted reserves will be used to cover expected losses in the first years of D-SNP as well as the quality-related funding for providers and other Commission-approved uses.

Value-Based Care: Care that ties the amount providers earn to the results they deliver for their patients, such as the quality, access and equity.

Gold Coast Health Plan[SM]
A Public Entity

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nick Liguori, Chief Executive Officer

DATE: May 20, 2024

SUBJECT: Chief Executive Officer (CEO) Report

GCHP Family Day / Día de la Familia and Health Fair

During last year's fourth quarter push to connect members with care for their annual screenings, GCHP assembled a cross-functional team to launch community health fairs where preventive screenings were offered to members and the community at large. Members who were eligible received a gift card after completing their screening. These health fairs proved to be an effective way to close care gaps, so to build on that success, GCHP is hosting a Family Day / Día de la Familia and Health Fair on Sunday, June 2, 2024, at Oxnard College from 10 a.m. to 3 p.m.

The GCHP Family Day / Día de la Familia and Health Fair will help connect our community with care through numerous preventive health screenings and will feature health education workshops, GCHP member orientations, community resources, and more. Families will also enjoy a day filled with Zumba, face painting, music, and prizes.

For more details, click here.

I. External Affairs

A. Federal Affairs

The Centers for Medicare & Medicaid Services (CMS) released two final rules, *Ensuring Access to Medicaid Services* *(Access rule)* and *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality* *(Managed Care rule).* CMS has published fact sheets for the Access and Managed Care rules, along with an Informational Bulletin related to hold harmless arrangements and the state-directed payment provisions, a timeline for the various effective dates in the Access rule, and a Managed Care rule timeline.

The Managed Care rule was largely finalized as proposed with some technical modifications and expanded timelines for compliance. The rule focuses on five primary areas:

1. **Access to Services in Managed Care & Maximum Wait Time Standards:** The rule requires states to establish appointment wait time standards for routine visits, monitor compliance, and use secret shopper surveys that must be submitted to CMS and posted to the state agency's website.

   CMS established maximum wait time standards of 10 and 15 business days for Medicaid or CHIP managed care enrollees for the following appointment types:
   - Outpatient mental health and substance use disorder (no longer than 10 business days)
   - Primary Care (no longer than 15 business days)
   - Obstetrics and gynecology (no longer than 15 business days)
   - State selected services type and maximum appointment wait time

   CMS will require 90% compliance with the 10- and 15-business day maximum appointment wait time standards. These standards are consistent with standards set for Marketplace plans.

2. **State Directed Payments (SDPs):** The final rule includes process and transparency-related changes to SDPs, including a requirement that SDP amounts for inpatient hospital services, outpatient hospital services, nursing facility services and qualified practitioner services at an academic medical center do not exceed the average commercial rate. The final rule creates new payment transparency for states by conducting a managed care provider payment rate analysis for certain services.

3. **Medical Loss Ratio (MLR) Standards:** Clarifies that the summary description must be provided for each MCO under contract with the state and that it also includes line items for the amount of SDPs made by the Managed Care Organization (MCO) to its providers and the amount of SDPs made by the state Medicaid agency to each MCO; this reporting will not be made public.

4. **In Lieu of Services and Settings (ILOS):** Broadens the definition of ILOS that includes services that are "an immediate or longer-term substitute for a covered service or setting" or that "can be expected to reduce or prevent the future need to utilize the covered service or setting." The rule also limits ILOS spending to no more than 5% of the capitation for managed care plans.

5. **Quality and Performance Assessment:** States must seek public comment on the state's quality strategy every three years and submit the plan to CMS for review and input. States must post the full evaluation of the effectiveness and results of the triennial review of the quality strategy. Additionally, the final rule updates the Quality Rating System (QRS) requirements including stronger mandatory metrics for QRS systems and requires states to issue a quality rating for each mandatory measure, not just a single overarching rating for each plan.

The Access rule addresses three primary areas:

1. **Documentation of Access to Care and Service Payment Rates:** The rule rescinds the Access Monitoring Review Plan (AMRP) and creates a new, two-tiered system for reviewing state requests to reduce or restructure Medicaid fee-for-service payment rates.

2. **Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council:** The Access rule changes the name of the Medical Care Advisory Committee (MCAC) to the Medicaid Advisory Committee (MAC), reflecting the broader scope of topics the MACs would be able to address such as: additional or changes to services; coordination of care; quality of services; eligibility, enrollment, and renewal processes; beneficiary and provider communications by the agency and MCOs; cultural competency, language access, health equity, and disparities and biases in the Medicaid program; and other issues. The rule would also require states to form a Beneficiary Advisory Council (BAC) made up of Medicaid beneficiaries or their representatives.

3. **Home and Community-Based Services (HCBS):** The rule finalizes a series of changes to create a more uniform system for monitoring quality and improving oversight across HCBS authorities. The new rules will apply to § 1915(c) HCBS waivers and §§ 1915(i) state plan services, (j) personal assistance services, and (k) Community First Choice. The new rules will also apply under § 1115 demonstration projects unless specifically waived, and under fee-for-service (FFS) and managed care delivery systems.

   States requirements include:

   - Updating functional assessments and person-centered plans at least once every 12 months;
   - Providing assurances that payment rates are adequate to ensure a sufficient direct care workforce;
   - Collecting and reporting data to monitor access (e.g., waiting lists, average amount of time between approval for and delivery of HCBS services, percent of authorized hours provided); and
   - Reporting on core measures in the HCBS Quality Measure Set.

GCHP's Government Relations Team provided overviews of the proposed regulations in summer 2023 and the Association for Community Affiliated Plans (ACAP) held a four-part roundtable series and submitted comment letters in response to both the Managed Care and Access proposed rules. The Local Health Plans of California (LHPC) also submitted comments on the Access rule. Government Relations is attending a series of webinars, hosted by our trade associations, ACAP and LHPC, to review and discuss the final rules and the impacts to Medi-Cal. We will continue to share updates as the state Department of Health Care Services (DHCS) issues guidance in response to the final regulations.

B. Redetermination Update

The final group of GCHP members received redetermination notices in May. This last batch includes members who have not yet undergone renewal redeterminations since the Public Health Emergency (PHE) ended and the unwinding process began. The final cohort of members undergoing redetermination has until Aug. 2024 to provide all necessary information for eligibility determination.

As of May 1, 2024, the Kaiser Family Foundation reports that states have reported renewal outcomes for two-thirds of people who were enrolled in Medicaid / CHIP prior to the start of the unwinding. Based on the most recently reported state data, nationally, 69% of individuals who have been through the renewal process continued coverage and 31% of those individuals were disenrolled. DHCS's February data indicates that Ventura County's disenrollment rate of 11% continues to be lower than California's statewide disenrollment rate of 13%. Several factors, including GCHP's significant community outreach efforts and the state's federally-approved unwinding flexibilities, have contributed to lower disenrollment rates than the national average.

The Centers for Medicare & Medicaid Services (CMS) issued an informational bulletin on May 9, 2024, that extends all Medi-Cal member redetermination unwinding-related flexibilities through June 30, 2025. The Section 1902(e)(14)(A) waivers were first set to expire in June 2024, but were extended through Dec. 2024, and now through June 2025. CMS notes that the extension is "due to the persistence of the unprecedented volume of renewals faced by these states, they continue to experience an administrative emergency beyond their control…and that they are likely to continue to do so into the first half of 2025."

Available waiver flexibilities include:

- Options to increase ex parte renewals.
- Supporting enrollees in completing and submitting renewal forms.
- Updating enrollee contact information.
- Facilitating reenrollment for individuals disenrolled for procedural terminations.

California has adopted 14 flexibilities. All states, except Florida, have adopted at least one flexibility. GCHP continues to support making several of the waiver flexibilities permanent. CMS states in the bulletin that "CMS currently is reviewing all section 1902(e)(13)(A) waiver strategies to determine which can be implemented on a longstanding basis under other authorities." Recently, CMS made three strategies permanent, including updating beneficiary contact information with information from managed care plans and the U.S. Postal Service National Change of Address database and mail forwarding service.

GCHP's Government Relations Team will continue to advocate for administratively efficient policies, including making the available flexibilities that improve the annual renewal and verification process permanent.

GCHP is continuing to support members through the redetermination process and will be assisting members through the duration of the cure period. A comprehensive update on all our redetermination efforts and the impacts to GCHP will be provided at a future Commission meeting.

C. State Regulatory Update

DHCS Launches Phase 1 of Health Equity Roadmap Initiative

In April 2024, DHCS publicly launched the Health Equity Roadmap initiative, a phased, multi-year process with the goal of creating a more equitable, person-centered Medi-Cal delivery system. The initiative is part of a Comprehensive Quality Strategy (CQS), which outlines DHCS's process for developing and maintaining a broader quality strategy to assess Medi-Cal members' care, regardless of the delivery system. The CQS includes details on the Health Equity Roadmap and DHCS' health equity framework to improve data collection and stratification, build workforce diversity and cultural responsiveness, and improve quality and care delivery to eliminate racial, ethnic, and other health disparities among Medi-Cal members.

The first step in this process (Phase 1) was a statewide listening tour from Sep. 29, 2023 to Mar. 1, 2024, during which DHCS leaders and community partners listened to Medi-Cal members' experiences with Medi-Cal. The sessions followed a standardized format and participants were asked to respond to questions about how they would improve Medi-Cal and what is important to them about their health care?

During Phase 2, DHCS will compile the feedback and identify common themes heard from Medi-Cal members throughout the state. During this process, DHCS will work with experts, advocates, providers, members, and stakeholders to ensure that all relevant choices and experiences are included.

In Phase 3, the common themes and experiences will be used by DHCS to develop a final "Health Equity Roadmap." It will identify specific action items to mitigate systemic racism and eliminate health inequities and disparities. These action items will be communicated by DHCS, and ultimately, will lead to the development of various programs and initiatives aimed at advancing health equity throughout the state. Updates will be provided as they become available.

DHCS Continues Focus on Quality Improvement and Health Equity Transformation

DHCS released APL 24-004 Quality Improvement and Health Equity Transformation Requirements (supersedes APL 19-017). The updated APL requires Managed Care Plans (MCPs) to align Quality and Health Equity Improvement Frameworks and health equity goals with DHCS's CQS report. MCPs are also required to develop Regional Quality and Health Equity Teams that are informed by partners within the region, such as behavioral health plans, local government agencies, regional centers, and other health and human services / community-based programs and providers. The APL requires MCPs to implement member

satisfaction surveys in alignment with National Committee for Quality Assurance (NCQA) Health Plan Accreditation requirements.

The Government Relations Team reviewed the APL requirements with the business and is assisting in revising policies and procedures to ensure the updates reflect the new requirements.

DHCS Removes "High Performance Option" from Housing and Homelessness Incentive Program (HHIP)

DHCS released APL 24-005 California Housing and Homelessness Incentive Program (HHIP) (supersedes APL 22-007). The APL reflects the removal of the "High Performance Option" (HPO) from the HHIP. Previously, MCPs that failed to achieve points on select measures in Submissions 1 and 2 were able to earn back some or all of those points by performing over and above thresholds on select Priority Measures in the same reporting period. The HPO is no longer available to plans and its removal has significant impacts on the ability of MCPs to earn incentive payments, which may dilute the effectiveness of the program. DHCS noted that the change "was made after careful consideration and evaluation of program effectiveness and MCP reporting challenges." The Government Relations Team is not aware of any reporting challenges and industry consensus indicates that the changes may be largely due to budget constraints.

D. State Legislative Update

Gov. Gavin Newsom released the updated 2024-25 budget proposal, known as the "May Revise," on May 10, 2024. The May Revise incorporates revised state revenue and expenditure information, as well as input from key stakeholders, including the Legislature, community organizations, health care plans, and other advocates.

The revised May budget proposes a total state budget of $288 billion ($200.9 billion General Fund [GF]) for 2024-25. The majority of the 2024-25 available funds will be allotted to K-12 education ($76.3 billion GF) and health and human services ($70.1 billion GF). For 2024-25, health and human services only experience a slight decrease in GF expenditures (4.7%) compared to 2023-24.

Some specific Medi-Cal and health care initiatives that the administration seeks to maintain include:

- Care Court
- California Advancing and Innovating Medi-Cal (CalAIM)
- The expansion of full-scope Medi-Cal to all eligible Californians

The budget shortfall has grown by $7 billion from the Jan. 2024-25 proposed budget of $37.9 billion to $44.9 billion. However, due to the Legislature's Early Action Plan, which passed last month and implemented $17.3 billion in early action budget resolutions, the remaining budget shortfall is approximately $27.6 billion.

To ensure a balanced budget, the Administration opted for additional one-time and ongoing GF solutions. Solutions for 2024-25 include:

- Reserve withdrawals ($4.2 billion)
- Efficiencies ($3B)
- Funding reductions ($15.2 billion)
- Expansion pauses and shifts ($14.8 billion)
- Revenue and internal borrowing ($7.5 billion)

The administration put forward 260 program reductions across various government departments, including one-time reductions of:
- $426 million for the Children and Youth Behavioral Health Initiative (CYBHI)
- $820 million for the health care workforce
- $450.7 million from the last round of the Behavioral Health Continuum Infrastructure Program

Some ongoing program reductions include $300 million for public health funding and $47.1 million for the CalWORKs Home Visiting Program. To avoid mass layoffs, the administration also proposes an approximate 8% funding cut to all state agencies and departments. Other budgetary information surrounding the funding plan to address last year's health care worker minimum wage bill (SB 525) is yet to be released, as negotiations are ongoing.

Regarding specific Medi-Cal budget items, the administration proposes extensive changes to the in-home supportive services (IHSS) for undocumented individuals and the managed care organization (MCO) tax.

Since his 2018 election, Gov. Newsom has been a vocal supporter of expanding full-scope Medi-Cal for Californians regardless of immigration status. The state has moved forward with this goal through the Older Adult Expansion, Young Adult Expansion, and the Ages 26-49 Adult Expansion. However, due to the growing budget shortfall, the administration has proposed eliminating IHSS coverage for undocumented individuals and free up $94.7 million ongoing for the state.

Additionally, the May Revise proposes to amend the MCO tax to include health plan Medicare revenue in the revenue limit calculation. This will expand the tax size, increase the ability of the state to draw down additional federal dollars, and augment the total state revenue. With this change, there will be additional net state benefit of $689.9 million in 2024-25, $950 million in 2025-26, and $1.3 billion in 2026-27. Further, the administration proposes a $6.7 billion reduction from Medi-Cal provider rate increases, Graduate Medical Education, and the Medi-Cal labor workforce over the next few years.

GCHP's Government Relations Team has attended numerous hearings on the MCO tax and other state Department of Health Care Services (DHCS) budget proposals for 2024-25. Our trade association, the Local Health Plans of California (LHPC), testified in April 2024 that managed care plans are highly supportive of the MCO tax and stated that the tax revenue must be reinvested in the Medi-Cal program to help expand the provider network and bolster timely access to care for the most vulnerable Californians. There was widespread agreement from a variety of diverse stakeholders, including the Legislature, LHPC, California Medical Association (CMA), California Planned Parenthood, and the Western Center on Law and

Poverty that the revenue from the MCO tax should not be used to backfill GF dollars. With the administration's proposed MCO shifts, provider rate increases will be limited with the majority of the MCO tax revenue allocated as a GF budget solution.

Further information on the updated Medi-Cal tax amounts will be released by DHCS shortly.

GCHP's Government Relations Team will continue to provide updates on California's 2024-25 budget activity to ensure the business is informed of all pending and significant budgetary or legislative changes that may impact the Medi-Cal delivery system and/or Medi-Cal managed care plans. The budget is a working document and requires a three-party agreement (Administration, Senate, and Assembly) to become law. Through state constitutional mandate, the Legislature must pass a balanced budget by June 15, 2024.

State Legislative Activity

Below is a list of priority bills that GCHP's Government Relations Team is currently tracking. This list will continue to be updated as bills move through the legislative process.

Bill Title	Summary	GCHP Potential Impact(s)
AB 236: Provider Directories	AB 236 mandates health care plans to ensure provider directories are up-to-date and accurate on an annual basis. Plans will be mandated to delete erroneous information and ensure directory is 60% accurate by July 1, 2025, and 95% accurate by July 1, 2028. Beginning July 1, 2025, plans are required to remove providers from the directory if plans have not financially compensated that provider in the prior year, with some limited exceptions. Failure to meet deadlines and inaccurate provider listings will result in monetary penalties for the plan.	GCHP is compliant with existing provider directory requirements, including providing a current and continuously updated directory of Network Providers. Upon becoming Knox-Keene licensed, GCHP would need to build additional processes to routinely pull data on providers who have not been financially compensated in the prior year and remove those providers from the provider directory. CAHP is opposing the bill, asserting that it places the full responsibility of accurate provider directories on plans and without shared provider accountability, the bill will not increase access to timely and appropriate care. Discussions with the trade associations and sponsors continues. *Status:* AB 236 has passed in the Assembly and was referred to the Senate Committee on Health on May 1, 2024.

Bill Title	Summary	GCHP Potential Impact(s)
AB 2466: Medi-Cal Managed Care: Network Adequacy Standards	Under federal and state network adequacy requirements, there are time and distance standards for certain Medi-Cal covered services. This includes appointment time thresholds. This bill notes that a Medi-Cal managed care plan would be considered not compliant with regulatory requirements if less than 85% of network providers had an appointment available within the appointment time standards and if the state is provided information that the plan did not deliver timely or accessible health care to members. If a plan is found noncompliant, plans can face contract termination or the consequences of sanctions.	This bill increases the penalties for network inadequacy and highlights how accountability continues to be a priority for the Legislature, as failure to comply with appointment time standards may lead to contract termination or the imposition of sanctions on managed care plans. GCHP will have to ensure that contract requirements surrounding network adequacy are consistently met and continue to provide timely, efficient, and accessible care to members. LHPC has taken an oppose-unless-amended position and noted how the 85% threshold conflicts with the Department of Managed Health Care (DMHC) appointment time standards, as outlined in APL 23-018, and also limits the ability of DHCS to implement recommendations from the *Children Enrolled in Medi-Cal Face Challenges in Accessing Behavioral Health Care* audit report. *Status*: AB 2466 was referred to the Assembly Committee on Appropriations on April 22, 2024.
Bill Title	**Summary**	**GCHP Potential Impact(s)**
AB 1943: Health Information	Originally, AB 1943 would request DHCS to track telehealth outcomes associated with patient and population health. Some key measurable data points include information surrounding morbidity rates, public health interventions, and environmental factors.	AB 1943 was gutted and amended. The bill now requires DHCS to research telehealth access and utilization, determine the effects of telehealth on access and quality of care, and understand the impact on clinical outcomes. Using this information, DHCS must create and publicize a report on telehealth outcomes and future policy recommendations. Although AB 1943 will not directly impact MCPs, implementation of this bill will provide needed utilization data that may help to identify and mitigate health disparities and access issues.

Bill Title	Summary	GCHP Potential Impact(s)
AB 3275: Health Care Coverage: Claim Reimbursement	AB 3275 would require a health plan to reimburse claims from small and rural, critical access, or distressed providers within a 10-day timeframe and notify the provider within five business days if the claim is contested or denied. The health plan has 15 days after additional information is submitted to reconsider the claim. To ensure plan compliance, the bill includes a 15% per annum interest that will accrue beginning the first calendar day after the 10-day period if an uncontested claim is not reimbursed.	This bill attempts to create a separate claim reimbursement process for a specific subset of providers. As of now, GCHP currently pays all clean claims within a 40-day timeframe. With the structuring of a separate claims timeline and process, this will require significant internal programming to satisfy this requirement and may impact the standard claims processing timelines that are associated with the medical record reviews and Fraud, Waste and Abuse (FWA) prepayment processes. There are ongoing conversations between the Legislature, CAHP, and LHPC on proposed amendments to the bill, including removing the bifurcated claims processing process defining and expediting the process of clean claims. GCHP remains actively engaged in providing feedback on proposed amendments. *Status*: AB 3275 was re-referred to the Assembly Committee on Appropriations on April 22, 2024.
Bill Title	**Summary**	**GCHP Potential Impact(s)**
AB 1975: Medi-Cal: Medically Supportive Food and Nutrition Interventions	Subject to federal approval and final guidance from DHCS, AB 1975 would make medically supportive food and nutrition interventions a covered Medi-Cal benefit through both the fee-for-service and managed care delivery systems beginning July 1, 2026.	Although GCHP currently offers medically supportive food for individuals that have recently been hospitalized for diabetes or congestive heart failure-related reasons within the past 30 days, this bill would require GCHP to provide medically supportive food and nutrition interventions for up to twelve weeks if found medically necessary for a member. *Status*: AB 1975 was referred to the Assembly Committee on Appropriations suspense file on May 1, 2024.

Bill Title	Summary	GCHP Potential Impact(s)
SB 516: Health Care Coverage: Prior Authorization	SB 516 restricts a health plan or insurer from requiring a contracted provider to acquire prior authorization (PA) for covered services if the plan or insurer approved or would have approved a minimum of 90% of all PA requests in the last one-year contract period. The bill also creates standards for the PA exemption and outlines details for process, rescission, and appeal. SB 516 allows the plan or insurer to examine the continuation of exemption once every 12 months and rescind an exemption at the end of the 12-month period if certain conditions are met.	If enacted, SB 516 will require GCHP to align PA protocols with the revised state and federal requirements. GCHP will continue to monitor federal and state PA requirements as there continues to be an increased focus on streamlining the process for enrollees. *Status*: There are ongoing conversations with the Administration, Legislature, and LHPC to address concerns with this bill and ensure it aligns with MCP processes. The California Medical Association (CMA) has proposed various amendments, including allowing plans to petition DHCS to reinstitute preauthorization of a covered service depending on increased utilization.
SB 953: Medi-Cal: Menstrual Products	SB 953 would add the coverage of menstrual products as a Medi-Cal benefit and requires DHCS to seek and garner federal approvals and use federal funds to implement this new benefit.	There are a variety of Medi-Cal services that are covered for Medi-Cal enrollees and GCHP members, including violence prevention services, diabetes testing supplies, certain nutrition products, and in-home medical care services. This bill will expand the list of Medi-Cal covered services and help low-income, vulnerable populations have access to necessary medical supplies. *Status*: SB 953 was referred to the Senate Committee on Appropriations suspense file on April 8, 2024.

E. Community Relations: Sponsorships

Through its sponsorship program, GCHP continues to support the efforts of community-based organizations in Ventura County to help Medi-Cal members and other vulnerable populations. The following organizations were awarded in April 2024:

Organization	Description	Amount
Turning Point	Turning Point creates hope by offering compassionate and proactive essential services to adults struggling with mental illness. The sponsorship will help fund supports for community members to overcome the challenges of mental illness and homelessness to live healthy and productive lives.	$1,000
Oxnard Police Activities League (PAL)	The Oxnard PAL hosts various events and programs at no charge to the youth in the City of Oxnard. The sponsorship supports their annual fundraising event to continue to provide youth with an outlet for healthy activities.	$3,000
Organization	**Description**	**Amount**
United Way of Ventura County	United Way of Ventura County's vision is ensuring residents achieve their full potential in education, financial stability, and health. The sponsorship will help fund Women United, an affinity group within United Way's strategic platform whose leaders fight for the health, education, and financial stability of low-income single mothers in the community.	$1,000
City Impact	City Impact is a diverse multicultural community-based organization established in 1995 to meet the growing needs of children, youth, and families of Ventura County. The sponsorship supports City Impact's half marathon, which raise money to support their programs and services for at-risk youth.	$1,000
TOTAL		**$6,000**

F. Community Relations: Community Meetings and Events

In April, the Community Relations team participated in 26 collaborative meetings and community events and partnered with community-based organizations on health fairs. The purpose of these events is to connect with community partners and members to raise awareness about benefits and services and connect members with care.

Food Distributions	
GCHP's Community Relations Team was onsite at these food distributions to provide resources and answer questions about Medi-Cal renewals.	
Organization	**Date**
El Rio School District Food Giveaway	April 2, 2024
	April 16, 2024
Cabrillo Economic Development (CEDC) Rodney Fernandez Apartments	April 5, 2024
Fillmore Police Store Front	April 10, 2024
St. Johns Health Ministries Cristo Rey Church	April 11, 2024
Westpark Community Center	April 17, 2024
The Samaritan Center Simi Valley	April 18, 2024
Salvation Army Oxnard	April 22, 2024
Help of Ojai	April 24, 2024
Organization	**Date**
San Buenaventura Housing Authority Buena Vida Apartments	April 30, 2024
Gregory Garden Apartments	
Food Banks / Pantries	
Manna Conejo Valley	April 9, 2024
Somis Church	April 10, 2024
Collaborative Meeting	
The collaborative meeting engages parents and community representatives in the sharing of resources, announcements, and upcoming community events.	
Strengthening Families	April 3, 2024
Resource Events	
The Promotoras y Promotores Foundation is a wellness organization connecting community members with behavioral health resources and services. GCHP team members were onsite to provide resources and answer questions about Medi-Cal renewals.	April 6, 2024
The Mexican Consulate provides consular protection and assistance with immigration, human rights, education opportunities, and health guidance. GCHP's community relations is onsite to provide resources and answer questions about Medi-Cal benefits and services.	April 16, 2024

Open Houses	
The open houses allow parents / guardians to connect with the school and engage with community organizations. Participants learned about community resources.	
Mar Vista Elementary	April 18, 2024
Tierra Vista Elementary	April 24, 2024
Laguna Vista Elementary	April 25, 2024
Health Fairs	
Pacifica High School GCHP provided students at Pacifica High School with education on asthma medication use and teen health topics.	April 25, 2024
Proyecto Esperanza & Ventura County Health Care Agency Oxnard College Festival At the Dia del Nino Community Resource Fair and the Oxnard College Festival, GCHP conducted blood pressure screenings, and provided education on asthma medication use to members and the community.	April 28, 2024

II. PLAN OPERATIONS

A. Membership

	VCMC	CLINICAS	CMH	DIGNITY	PCP-OTHER	ADMIN MEMBERS	NOT ASSIGNED
Apr-24	97,121	52,693	34,451	7,122	5,054	48,786	3,499
Mar-24	95,346	53,767	34,660	7,106	5,169	49,599	3,359
Feb-24	90,017	49,754	34,059	7,060	4,944	49,628	13,622

NOTE:

Unassigned members are those who have not been assigned to a Primary Care Provider (PCP) and have 30 days to choose one. If a member does not choose a PCP, GCHP will assign one to them.

Administrative Member Details

Category	Apr 2024
Total Administrative Members	48,786
Share of Cost (SOC)	607
Long-Term Care (LTC)	701
Breast and Cervical Cancer Treatment Program (BCCTP)	36
Hospice (REST-SVS)	29
Out of Area (Not in Ventura County)	283
DUALS (A, AB, ABD, AD, B, BD)	27,047
Commercial Other Health Insurance (OHI) (Removing Medicare, Medicare Retro Billing, and Null)	21,481

NOTE:

The total number of members will not add up to the total number of Administrative Members, as members can be represented in multiple boxes. For example, a member can be both Share of Cost and Out of Area. They would be counted in both boxes.

METHODOLOGY

Administrative members for this report were identified as anyone with active coverage with the benefit code ADM01. Additional criteria follows:

1. Share of Cost (SOC-AMT) > zeros
   a. AID Code is not 6G, 0P, 0R, 0E, 0U, H5, T1, T3, R1 or 5L
2. LTC members identified by AID codes 13, 23, and 63.
3. BCCTP members identified by AID codes 0M, 0N,0P, and 0W.
4. Hospice members identified by the flag (REST-SVS) with values of 900, 901, 910, 911, 920, 921, 930, or 931.
5. Out of Area members were identified by the following zip codes:
   a. Ventura Zip Codes include: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93000-12, 93015-16, 93020-24, 93030-36, 93040-44, 93060-66, 93094, 93099, 93225, 93252
   b. If no residential address, the mailing address is used for this determination.
6. Other commercial insurance was identified by a current record of commercial insurance for the member.

B. Provider Contracting Update

Provider Network Contracting Initiatives

Provider Network Operations (PNO)

Regulatory / Audit Updates

PNO received notice that GCHP must participate in the Network Adequacy Validation (NAV) audit. NAV is a federal audit focusing on provider network adequacy; its completion is required by the state Department of Health Care Services (DHCS). DHCS hired Health Services Advisory Group (HSAG) to conduct an audit for provider network adequacy. It is similar to the annual medical audit where GCHP must provide documentation of its processes, procedures, and systems, and participate in a virtual interview. Documentation is due HSAG on May 15, 2024; the virtual audit with HSAG is scheduled for June 05, 2024.

Additionally, DHCS implemented provider network readiness assessments used to monitor a Managed Care Plan's (MCP's) network for newly launched covered services. PNO submitted deliverables for the Long-Term Care (LTC) Carve-In, which included a DHCS approved Intermediate Care Facility / Developmentally Disabled (ICF/DD) Network Provider Agreement Template outlining invoice submission guidance.

Lastly, PNO is in final discussions with Press Gainey for the completion of the Provider Access and After-Hours Survey and the Provider Satisfaction Survey, which are expected to begin this quarter.

Operations of the Future

PNO created a training plan and outreach strategy for the July 1, 2024, Provider Portal launch. The team provided an update on the new system to the Ventura County Medical Center (VCMC) to share the new design and functionality, and to obtain feedback and suggestions from a provider perspective. The discussion resulted in positive feedback, which supporting training content for the expanded outreach strategy to GCHP's broader provider network. Next steps are to start a series of routine communications and start scheduling engagement meetings and training with the provider network.

Other notable Operations of the Future deliverables include:

- Provider Contract and Credentialing (PCCM) system upgrade
- HealthPayer Core System Implementation

Exclusively Aligned Enrollment / Dual Special Needs (EAE/D-SNP)

PNO continues to support the GCHP expansion into the EAE/D-SNP through continued support of key deliverables. Most recently, PNO helped prepare responses to the DHCS Readiness Checklist, which assesses preparedness and progress of GCHP ahead of the Jan. 2026 transition to statewide Medi-Medi Plan (MMP) structure.

PNO will also start the network development for EAE/D-SNP by engaging with the target providers that signed a Letter of Intent.

Provider Network Developments: March 1-31, 2024

Network Developments for New Contracts	
Provider Additions Fulfilling Network Gaps	**Count**
Pathology Group	1
Dermatology	1
Midwife	1

Note: The numbers above represent contract completion in targeted specialties to close GCHP provider network gaps. PNO continues its outreach to targeted specialties and areas, such as eastern Ventura County, where provider network gaps exist.

GCHP Provider Changes from Feb. to March 2024	
Provider Additions and Terminations	**Count**
Additions	68

GCHP Provider Changes from Feb. to March 2024 (con't)	
Provider Additions and Terminations	**Count**
Terminations	16
Midwife	1

Note: The additions and terminations above are for GCHP tertiary providers and do not have a significant impact on member access for services.

GCHP Provider Network Additions and Total Counts by Provider Type			
Provider Type	**Network Additions**		**Total Counts**
	Feb-24	**Mar-24**	
Hospitals:	**0**	**0**	**25**
Acute Care	0	0	19
Long-Term Acute Care (LTAC)	0	0	1
Tertiary	0	0	5
Providers:	**59**	**182**	**7,510**
Primary Care Providers (PCPs) & Mid-levels	14	0	506
Specialists	42	177	6,276
Hospitalists	3	5	728
Ancillary:	**4**	**9**	**1,127**
Ambulatory Surgery Center (ASC)	1	0	8
Community-Based Adult Services (CBAS)	0	0	14
Durable Medical Equipment (DME)	1	0	97
Home Health	0	0	29

GCHP Provider Network Additions and Total Counts by Provider Type (con't)			
Provider Type	**Network Additions**		**Total Counts**
	Feb-24	**Mar-24**	
Hospice	0	0	23
Laboratory	0	0	40
Optometry	0	0	104
Occupational Therapy (OT) / Physical Therapy (PT) / Speech Therapy (ST)	0	1	151
Radiology / Imaging	1	0	68
Skilled Nursing Facility (SNF) / Long-Term Care (LTC) / Congregate Living Facility (CLF) / Intermediate Care Facility (ICF)	1	0	83
Behavioral Health	0	8	510

C. Delegation Oversight

Gold Coast Health Plan (GCHP) is contractually required to perform oversight of all functions delegated through subcontracting arrangements. Oversight includes, but is not limited to:

- Monitoring / reviewing routine submissions from subcontractors
- Conducting onsite audits
- Issuing a Corrective Action Plan (CAP) when deficiencies are identified

**Ongoing monitoring denotes the delegate is not making progress on a CAP issued and/or audit results were unsatisfactory. GCHP is required to monitor the delegate closely, as it is a risk to GCHP when delegates are unable to comply.*

Compliance will continue to monitor all CAPs. GCHP's goal is to ensure compliance is achieved and sustained by its delegates. It is a state Department of Health Care Services (DHCS) requirement for GCHP to hold all delegates accountable. The oversight activities conducted by GCHP are evaluated during the annual DHCS medical audit. DHCS auditors review GCHP's policies and procedures, audit tools, audit methodology, and audits conducted and corrective action plans issued by GCHP during the audit period. DHCS continues to emphasize the high level of responsibility plans have in the oversight of their delegates.

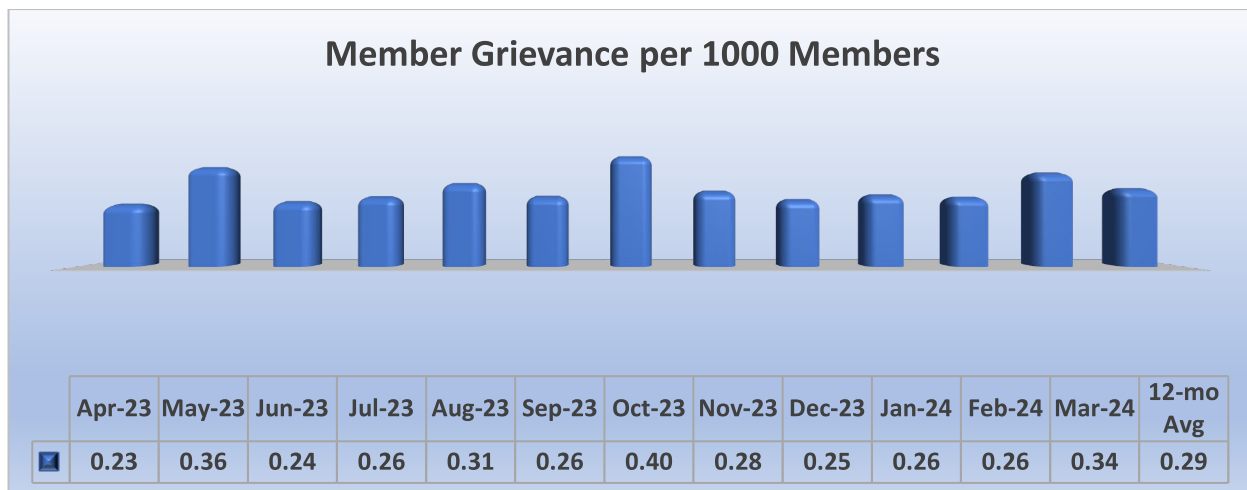
The following table includes audits and CAPs that are open and closed. Closed audits are removed after they are reported to the Commission. The table reflects changes in activity through April 30, 2024.

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Clinicas del Camino Real (CDCR)	2023 Q4 Focused Claim Audit	Open	3/8/2024	Under CAP	N/A
CDCR	2023 Annual Claims audit	Open	2/8/2024	Under CAP	N/A
CDCR	2023 Quarterly Focused Claim Audit (July)	Open	9/7/2023	Under CAP	N/A
CDCR	2024 Q1 Focused Claim Audit	Open	4/5/2023	Under CA	N/A
Conduent	2022 Annual Claims Audit	Open	8/31/2022	Under CAP	N/A
Conduent	2023 Annual Claims Audit	Open	8/1/2023	Under CAP	N/A
Conduent	2023 Annual Call Center Audit	Closed	3/8/2024	4/12/2024	N/A

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Ventura Transit System (VTS)	2023 Focused Call Center Audit	Closed	12/21/2023	4/15/2024	N/A
VTS	2024 Annual Call Center	Open	4/19/2024	Under CAP	N/A
Privacy & Security CAPs					
Delegate	**CAP Type**	**Status**	**Date CAP Issued**	**Date CAP Closed**	**Notes**
N/A	N/A	N/A	N/A	N/A	N/A
Operational CAPs					
Delegate	**CAP Type**	**Status**	**Date CAP Issued**	**Date CAP Closed**	**Notes**
Conduent	IKA Inventory, KWIK Queue, APL 21-002	Open	4/28/2021	N/A	IKA Inventory and KWIK Queue Findings Closed
Conduent	Sept. 23, 2021 CAP	Open	9/23/2021	N/A	N/A
Conduent	Oct. 2021 CAPs	Open	11/22/2021	N/A	N/A
Conduent	Nov. 2021 Service Level Agreements (SLA)	Open	1/28/2022	N/A	N/A
Conduent	Jan. 2021 Contract Deficiencies	Open	2/4/2022	N/A	N/A

Delegate	CAP Type	Status	Date CAP Issued	Date CAP Closed	Notes
Conduent	Dec. 2021 Contract Deficiencies	Open	2/11/2022	N/A	N/A
Conduent	March 2022 SLA Deficiencies & Findings	Open	3/11/2022	N/A	N/A
Conduent	Jan. 2022 SLA CAP	Open	3/25/2022	N/A	N/A
Conduent	Feb. 2022 SLA CAP	Open	4/15/2022	N/A	N/A
Conduent	March 2022 SLA CAP	Open	6/17/2022	N/A	N/A

D. Grievance and Appeals

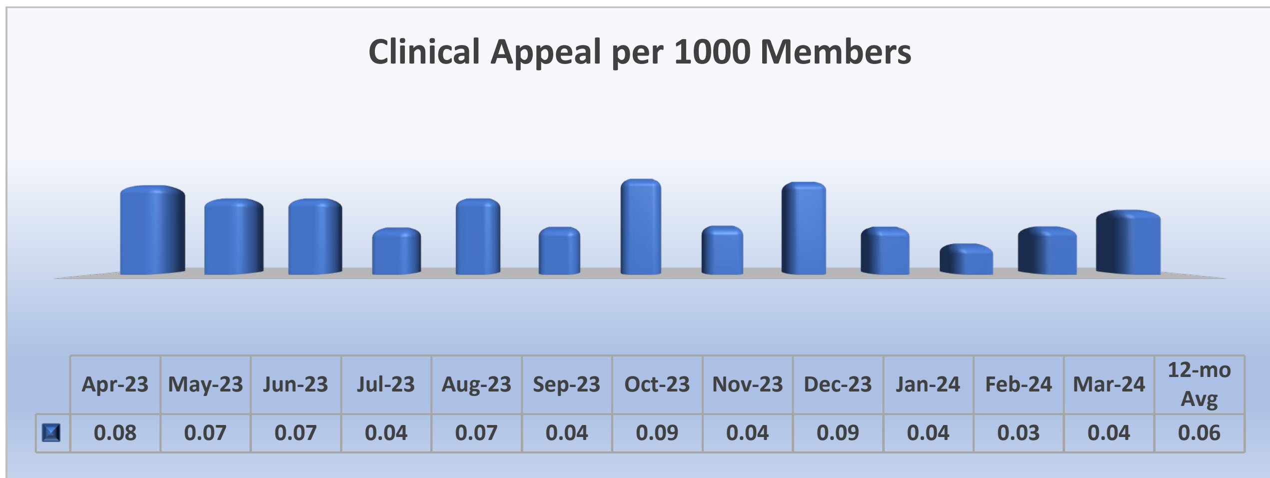


Member Grievances per 1,000 Members

The data show GCHP's volume of grievances increased in March. In March, GCHP received 86 member grievances. Overall, the volume is still relatively low, compared to the number of

enrolled members. The 12-month average of enrolled members is 251,121, with an average annual grievance rate of .29 grievances per 1,000 members.

In March 2024, the top reason reported was "Quality of Care," which is related to member concerns about the care they received from their providers.



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	12-mo Avg
	0.08	0.07	0.07	0.04	0.07	0.04	0.09	0.04	0.09	0.04	0.03	0.04	0.06

Clinical Appeals per 1,000 Members

The data comparison volume is based on the 12-month average of .06 appeals per 1,000 members.

In March 2024, GCHP received 11 clinical appeals:

1. Five were overturned.
2. Four were upheld.
3. One was withdrawn.
4. One is in progress.

RECOMMENDATION:

Accept and file.

AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Paul Aguilar, Chief Human Resources & Organization Performance Officer

DATE: May 20, 2024

SUBJECT: Human Resources (H.R.) Report

Human Resources Activities

Over the last few months, the Human Resources team has been focused on:

(1) Acquiring talent.

(2) Developing the leadership team.

(3) Building a people focused and engaged organization.

Below is a summary of the year-to-date activities through April.

Organization: We have filled 90 positions through April, which has increased GCHP's headcount to 354. The average time to fill these roles was 47 days.

Attrition: Our attrition for the last 12 months is still low at 5.08%. This is a slight decrease from the last month, as terminations have declined. Since July, we have had 15 voluntary terminations. Attrition trends are checked each month to assess pending organization risks or concerns.

Leadership Development: In January we launched "Unleash your Leadership Potential," GCHP's new leadership development program. The purpose of this program is to train our people managers with a set of standard leadership and performance management tools, aimed at increasing the overall performance and effectiveness of GCHP. These core management and leadership skills sets include coaching, providing feedback, having difficult conversations, and performance assessment and actions. On April 24th we held our third cohort session, now having 50 people managers participate in the program.

Employee Pulse Engagement Survey: To gauge the pulse of the organization and better understanding of the "voice of our employees", we conducted an Employee Engagement Survey. The feedback from this survey will be used to enhance the overall engagement of the workforce. The 40-question pulse survey held from April 8th to April 12th using Culture Amp platform to conduct survey, while keeping anonymity and to use Healthcare industry benchmark data comparisons. We had a successful 66% response rate. Below are a few highlights of the survey results:

- 86% Engagement Index confirms measure of how positive people feel about their work and Gold Coast Health Plan organization. This Engagement Index score is significant, given the current organization transformation being managed and when compared to the Healthcare industry average of 82%.
- Overall positive results on Leadership (Executive Team, Director and Management) confirm confidence on strategy and direction.
- Opportunities for Improvement include (1) enhancing leadership communications, (2) recognition and (3) ability to act on innovative ideas.

Summary of the survey results are shown in the attached presentation. The next steps include addressing the opportunities named by the employee feedback to enhance overall engagement.

Looking forward, we will continue to place strong emphasis on recruiting and assessing the organization to find opportunities to develop our staff by positioning them in the right roles that advance our priorities and create the best employee experience.

RECOMMENDATION:

Receive and file.

Gold Coast Health Plan
Pulse Employee Engagement Survey

May 2024

Paul Aguilar
Chief HR & Organizational Performance Officer

Integrity

Accountability

Collaboration

Trust

Respect

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

Executive Summary

- 40 question pulse survey held from April 8th to April 12th
- Culture Amp platform used to conduct survey to maintain anonymity and to leverage Healthcare benchmark
- 66% response rate (226 of 344)
- 86% Engagement Index confirms measure of how positive people feel about their work and GCHP. Only 2% Unfavorable result
- Positive results on Leadership (Executive Team, Director and Management) confirm confidence on strategy and direction.
- Opportunities for Improvement include (1) enhancing leadership communications, (2) recognition and (3) ability to act on innovative ideas

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Engagement Score

Engagement is a measure of how positive people feel about their work

86%

82% Healthcare Benchmark

The percentage of the team has responded favorably to engagement related questions.

Based on participation rate of 66%

Category	Favorable	Neutral	Unfavorable	Benchmark Comparison
Company Strategy	92%	7%	1%	N/A
Alignment & Involvement	85%	11%	4%	-1
Social Connection	84%	13%	3%	+8
Management	80%	15%	5%	-4
Leadership	80%	13%	7%	+9
Diversity, Equity, & Inclusion	77%	15%	8%	N/A
Leadership - Directors	76%	17%	7%	+5
Enablement	72%	17%	11%	N/A
Teamwork & Ownership	70%	17%	13%	-6
Learning & Development	69%	21%	10%	-2
Innovation	68%	24%	8%	-5
Service & Quality Focus	67%	20%	13%	-5
Feedback & Recognition	61%	23%	16%	-9
Collaboration & Communication	61%	23%	16%	-5

Favorable Neutral Unfavorable

Benchmark Comparison: Engagement - Healthcare (200-500), January 2024

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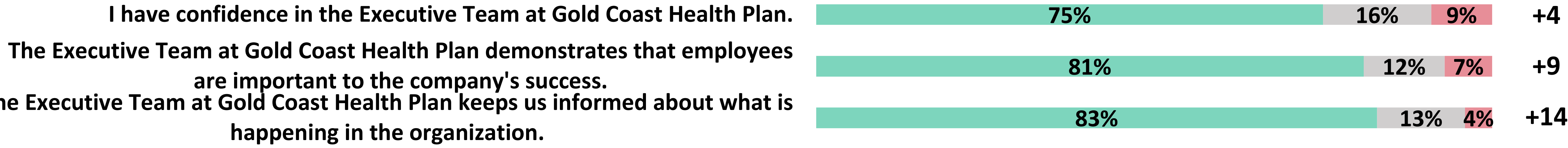
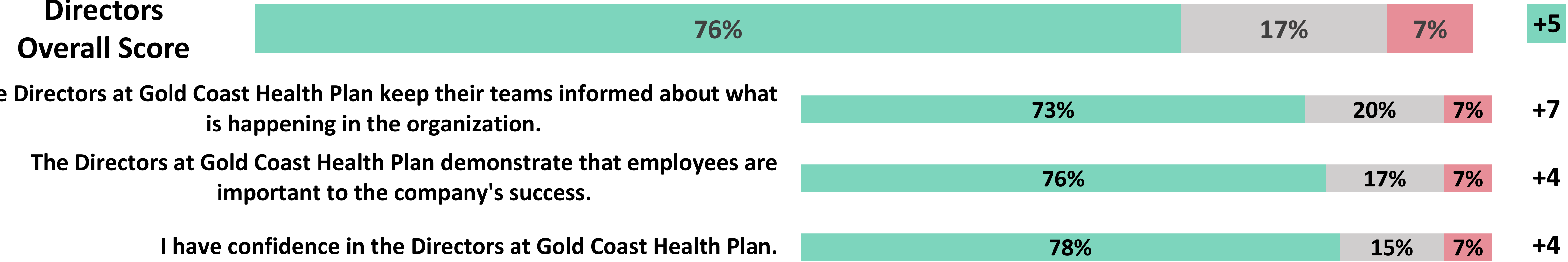
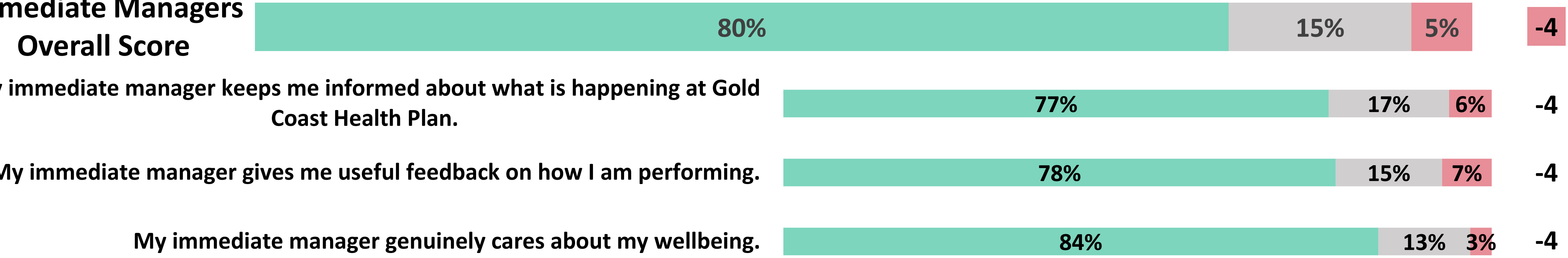

Benchmark Comparison
Executive Team Overall Score
80%
13%
7%
+9
I have confidence in the Executive Team at Gold Coast Health Plan.
75%
16%
9%
+4
The Executive Team at Gold Coast Health Plan demonstrates that employees are important to the company's success.
81%
12%
7%
+9
The Executive Team at Gold Coast Health Plan keeps us informed about what is happening in the organization.
83%
13%
4%
+14

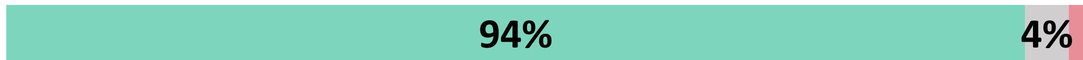

Directors Overall Score
76%
17%
7%
+5
The Directors at Gold Coast Health Plan keep their teams informed about what is happening in the organization.
73%
20%
7%
+7
The Directors at Gold Coast Health Plan demonstrate that employees are important to the company's success.
76%
17%
7%
+4
I have confidence in the Directors at Gold Coast Health Plan.
78%
15%
7%
+4


Immediate Managers Overall Score
80%
15%
5%
-4
My immediate manager keeps me informed about what is happening at Gold Coast Health Plan.
77%
17%
6%
-4
My immediate manager gives me useful feedback on how I am performing.
78%
15%
7%
-4
My immediate manager genuinely cares about my wellbeing.
84%
13%
3%
-4

What We're Doing Well

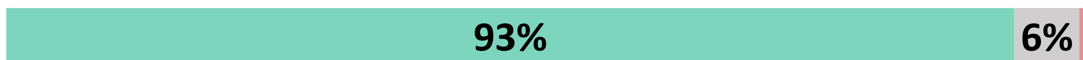
Benchmark Comparison

Racial, sexist, homophobic and/or ethnic jokes are not tolerated at Gold Coast Health Plan.



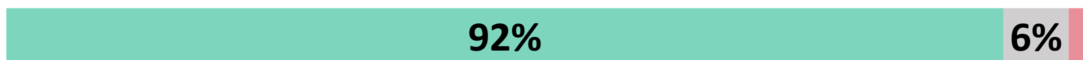
N/A

One Priority - I understand how my work is aligned with and impacts our priority of improving health care quality for our Members.



N/A

One Plan - I understand our organization's Goal Work Plans to improve health care quality for our Members.



N/A

Opportunities for Improvement

At Gold Coast Health Plan , we act on promising or innovative ideas.

-5

At Gold Coast Health Plan there is open and honest two-way communication with the Leadership Team

-2

We acknowledge people who deliver outstanding service.

-12

Gold Coast Health Plan Employee Survey
YOUR VOICE • YOUR WORKPLACE

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Comments Summary

- 77% of participants responded with comments for a total of 999
- Average of 4 comments provided by commenter

Topics & Themes

Negative	Neutral	Positive
• **Workloads** (unbalanced, burn out) • **Resources & Information** (Training, staffing, technology) • **Hiring** (need more staff, better onboarding) • **Systems & Equipment** (Process improvement, digitization, core admin system) • **Leadership** (clear lines of communication, involvement with decision-making, feedback) • **Manager** (constructive feedback, communication, too busy) • **Employee Recognition** (Praise, awards, more shoutouts)	• **Compensation** (roles/workloads don't align with pay, bilingual pay, more promotions) • **Learning & Development** (opportunities for growth needed, more in house workshops/trainings) • **Company Culture** (break down silos, less politics) • **Career** (clear paths to promotions, more opportunities for advancement)	• **Wellbeing** (managers care about employees) • **Benefits** (great) • **Company Strategy & Goals** (Continue great communication and informing employees on a consistent basis) • **Flexible/Remote Working** (great)

Gold Coast Health Plan Employee Survey
YOUR VOICE • YOUR WORKPLACE