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www.goldcoasthealthplan.org

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

Regular Meeting
Monday, January 27, 2025 2:00 p.m.
Meeting Location: Community Room
711 E. Daily Drive #110
Camarillo, CA 93010

Members of the public can participate using the Conference Call Number below.

Conference Call Number: 1-805-324-7279
Conference ID Number: 757 134 188 #

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

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

2220 E Gonzales Rd Ste 120AB
Oxnard, CA 93036

Las Islas Clinic
2400 South C Street
Oxnard, CA (3033

855 Partridge Drive
Ventura, CA 93003

800 South Victoria Ave
Ventura CA 93009

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

ROLL CALL

MOMENT OF RECOGNITION

Presentation of the Riding the Wave of Quality Awards

Staff: James Cruz, M.D., Acting Chief Medical Officer
Kim Timmerman, MHA, CPHQ, Sr. Director of Quality Improvement

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 November 18, 2024.

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

RECOMMENDATION: Approve the minutes as presented.

2. Written Summary of Quality Improvement & Health Equity Activities – Q4 2024

Staff: James Cruz, MD, Acting Chief Medical Officer
Kim Timmerman, MHA, CPHQ, Sr. Director of Quality Improvement

RECOMMENDATION: Staff recommends that the Ventura County Medi-Cal Managed Care Commission accept and file the Quarter 4, 2024 Quality Improvement and Health Equity Committee summary.

UPDATES

3. Recap of 2024 Strategic Planning Retreat

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

4. Operations of the Future (OOTF) Update

Staff: Alan Torres, Chief Information & System Modernization Officer
Anna Sproule, Exec. Director of Operations

RECOMMENDATION: Receive and file the update.

FORMAL ACTION

5. Preliminary December YTD Financials and FY 2024-25 Revised Budget

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Receive, file, and approve the revised budget

6. Advance Payment Agreement

Staff: Felix L. Nunez, M.D., MPH, Acting Chief Executive Officer
Leeann Habte, BBK Law

RECOMMENDATION: The GCHP recommends that the Ventura County Medi-Cal Managed Care Commission authorize the CEO to execute the Advance Payment Agreement in the amount of $26,000,000 with the County of Ventura.

7. Quality Improvement and Health Equity Committee 2025 First Quarter Report

Staff: James Cruz, M.D., Acting Chief Medical Officer
Kim Timmerman, MHA, CPHQ, Sr. Director of Quality Improvement

RECOMMENDATION: Approve the 2025 QIHET Program Description and 2025 QIHET Work Plan as presented. Receive and file the complete report as presented.

8. Approval of D-SNP Program

Staff: Eve Gelb, Chief Innovation Officer
Robert Franco, Chief Compliance Officer
James Cruz, M.D., Acting Chief Medical Officer

RECOMMENDATION: It is GCHP's recommendation that the Ventura County Medi-Cal Managed Care Commission approve the D-SNP Program.

REPORTS

9. Chief Executive Officer (CEO) Report

Staff: Felix L. Nunez, M.D., MPH, Acting Chief Executive Officer

RECOMMENDATION: Receive and file the report

10. Chief Medical Officer (CMO) Report

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

RECOMMENDATION: Receive and file the report

11. Human Resources (H.R.) Report

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

RECOMMENDATION: Receive and file the report

ADJOURNMENT

The next meeting will be on held on the next meeting will be on held on February 24, 2025, at 2:00 p.m., in the Community Room located at GCHP 711 E. Daily Dr. Suite 110, Camarillo, CA 93010

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

Gold Coast Health Plan℠
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Integrity
Accountability
Collaboration
Trust
Respect

Moment of Recognition

January 27, 2025

James Cruz, MD, Acting Chief Medical Officer
Kim Timmerman, Sr. Director Quality Improvement

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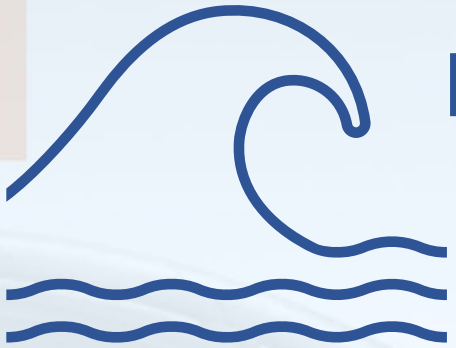

Presentation of Riding the Wave of Quality Awards

Integrity

Accountability

Collaboration

Trust

Respect

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

Highest Performing Individual Clinics Chronic Conditions

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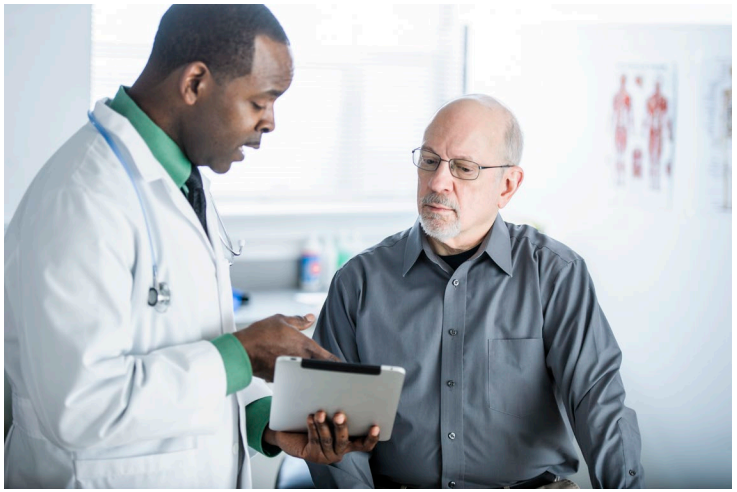
Highest Performing Individual Clinics

Chronic Conditions

Ventura County Healthcare Agency
Fillmore Family Medical Group



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Highest Performing Individual Clinics Cancer Prevention

Return to Agenda

Highest Performing Individual Clinics

Cancer Prevention

Rose Avenue Family Medical Group

Return to Agenda

Highest Performing Individual Clinics Reproductive Health

Return to Agenda

Highest Performing Individual Clinics

Reproductive Health

Clinicas Del Camino Real
Meta Health Center (Oxnard)

Return to Agenda

Highest Performing Individual Clinics Well Baby Care

Return to Agenda

Highest Performing Individual Clinics

Well-Baby Care

Ventura County Healthcare Agency
Las Islas Family Medical Group

Return to Agenda

Highest Performing Individual Clinics Well Child Care

Return to Agenda

Highest Performing Individual Clinics

Well-Child Care

Buena Medical Clinic

Return to Agenda

Most Collaborative

Return to Agenda

Most Collaborative

Partnership in Quality Initiatives

Ventura County Healthcare Agency

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Most Improved in Any One Measure

Return to Agenda

Most Improved in Any One Measure

Well-Child Visits 0-15 Months: 6+

Community Memorial Health

Most Improved

Return to Agenda

Most Improved

Greatest Overall MCAS Improvement by System

Clinicas Del Camino Real

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Quality Champion

Return to Agenda

Quality Champion

Gadiel Chavez
Quality Coordinator
Ventura County Healthcare Agency

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Best in Show

Return to Agenda

Best in Show

Greatest Overall MCAS Achievement by System

Clinicas Del Camino Real

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AGENDA ITEM NO. 1

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: January 27, 2025

SUBJECT: Regular Meeting Minutes of November 18, 2024

RECOMMENDATION:

Approve the minutes.

ATTACHMENT:

Copy of Commission regular meeting minutes of November 18, 2024.

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

November 18, 2024

CALL TO ORDER

Committee Chair Laura Espinosa called the meeting to order at 2:08 p.m. 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.

ROLL CALL

Present: Commissioners Anwar Abbas, Allison Blaze, M.D., James Corwin, Tabin Cosio, Laura Espinosa, Anna Monroy, Dee Pupa, Sara Sanchez, and Scott Underwood D.O.

Absent: Commissioners Melissa Livingston, and Supervisor Vianey Lopez

Attending the meeting for GCHP were Felix L. Nunez, M.D., Acting Chief Executive Officer, CPPO Erik Cho, CFO Sara Dersch, Marlen Torres, Chief of Member Experience &External Affairs, Paul Aguilar, Chief of Human Resources, James Cruz, M.D., Acting Chief Medical Officer, Robert Franco, Chief Compliance Officer, Eve Gelb, Chief Innovation Officer, Ted Bagley, CDO, Anna Sproule, Exec. Director of Operations, Leeann Habte, BBK Law, and Scott Campbell, General Counsel.

Also in attendance were the following GCHP Staff: Kim Timmerman, David Tovar, Mayra Hernandez, Michelle Espinosa, Lupe Gonzalez, TJ Piwowarski, Rachel Ponce, Lucy Marrero, Victoria Warner, Susana Enriquez-Euyoque, Lupe Harrion, Vicki Wrighster, Adriana Sandoval, Holly Krull, Allison Jewell, Sergio Cendejas, Chris Dulan, Joanna Hioureas, Ifsha Butitta, David Kirkpatrick, Yoonhee Kim, Kris Schmidt, Bob Bushey, Nicole Kanter, Ben Lacy, Jerry Wang, Zed Heydar, Jeff Register, Pauline Preciado, Erin Slack, Michael Mitchell, Corey Stephenson, Kim Marquez-Johnson, Ross Hooper, Shannon Robledo, Stacy Luney, Nathan Norbryhn, Paula Cabral, Sandi Walker, Karina Ramirez, and Neil, Meschke.

Guests: Tracy Gallaher – County of Ventura

PUBLIC COMMENT

None.

Acting CEO, Felix L. Nunez gave a brief update on the status of GCHP amid the Mountain Fire and wind emergency. We had office closures starting on Wednesday November 6th due to smoke and ash in the area. The offices remained closed November 6, 7, and 8. He noted that at no time were any operations impacted. We remained fully operational during that time.

Our member call center remained fully operational during that time. As far as members were concerned, we had our Community Services team keep in close contact with HSA. We did find out that some of our members were affected. Those members were elderly and required evacuation, and we were able to coordinate and assist them.

We want to recognize Ventura Transit System (VTS) for how quickly they responded and assisted with the evacuations. Some of our staff received evacuation orders, but there was no loss of property and staff was able to continue operations throughout that time. We also looked for opportunities to assist the community. We identified three agencies and will be contributing within the week.

Commissioner Corwin left the meeting at 2:10 p.m.

CONSENT

1. **Approval of Ventura County Medi-Cal Managed Care Regular Commission meeting minutes of October 28, 2024.**

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

   RECOMMENDATION: Approve the minutes as presented.

2. **Adoption of Commission Meeting Schedule for 2025.**

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

   RECOMMENDATION: Approve the 2025 Commission meeting calendar as presented.

3. **Authorize approval of the Recruitment Firm Agreement ("Agreement") with Morgan Consulting Resources ("MCR") for Chief Executive Officer Recruitment Services**

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

   RECOMMENDATION: Staff recommends the Commission approve the Agreement with MCR and authorize the Acting CEO to execute the Agreement.

Commissioner Monroy motioned to approve Consent items 1 through 3. Commissioner Abbas seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Tabin Cosio, Laura Espinosa, Anna Monroy, Dee Pupa, Sara Sanchez, and Scott Underwood D.O.

NOES: None.

ABSENT: Commissioners James Corwin, Melissa Livingston, and Supervisor Vianey Lopez

Motion carried.

UPDATES

4. Summary of Quality Improvement & Health Equity Committee 2024 Third Quarter Report

Staff: James Cruz, MD, Acting Chief Medical Officer
Kim Timmerman, MHA, CPHQ, Sr. Director of Quality Improvement

RECOMMENDATION: Receive and file the update

Acting Chief Medical Officer, James Cruz, M.D., stated that GCHP has made noteworthy progress in this last quality measurement year. We are not where we want to be, but we are going to do the work to get us where we need to be.

Kim Timmerman, Sr. Director of Quality Improvement, stated that she summarized the current activities of the QI Team. Ms. Timmerman reviewed various measures and their percentiles (75-90 percents). She did note that there was a set of measures in the twenty-five percentile and four measures at the minimum performance level. She stated that staff is aggressively pursing these measures and working with our provider partners. We have measure work groups for the lower performing measures, and they remain a focus of our efforts. We are also continuing with our member incentive programs. For 2024 we have distributed 32,000 gift cards. As part of Q4 we are relaunching our A1C number incentive and will be at the clinic level to help boost members in for their testing and encourage follow-up care.

We also have the flu vaccine member incentive. We will continue well woman clinics on the weekends until the end of the year and we offer some giveaways which encourage women to come in for their WellCare.

Ms. Timmerman also reviewed NCQA accreditation and stated that we have our dates secured with QA and there will be a Health Equity accreditation submission in June 2025. She noted that our current score or what we anticipate we are compliant with is about fifty-two percent of the standard points. In our first reading we were assessed at being

compliant with eleven percent, so there has been a significant jump. There are remediation efforts in place to address those remaining gaps for health plan accreditation.

Commissioner Espinosa asked if a Health Equity Director has been hired. Ms. Timmerman stated that yes, someone was recently hired. Commissioner Espinosa also asked about access /availability of language services because the score is low. Ms. Timmerman stated that we are working with a consultant group to help us write a policy and establish a new process. Even tough we did not score all the possible points, we are working through and ensuring that we did all the compliant processes in time. This does not mean that we do not have processes in place, we are still building requirements. QI works closely with the Cultural Linguistics team.

Dr. Lupe Gonzalez stated that we are updating our policies, so they are compliant. We are working with our consultant and putting everything together. We do currently have language access services available to our members.

Ms. Timmerman stated that a Gold Coast Quality Convocation event was planned but it was scheduled for November 6th and the event had to be postponed due to the fires.

5. Operations of the Future (OOTF)

Staff: Alan Torres, Chief Information & System Modernization Officer
Anna Sproule, Exec. Director of Operations
Sara Dersch, Chief Financial Officer

RECOMMENDATION: Receive and file the update.

Anna Sproule, Executive Director of Operations stated she will give an update on the dashboard and show the progress made to date. Ms. Sproule shared her screen so that Commissioners could see the considerable progress on our claims. We continue to make parallel progress on regular operational activities and the stabilization work. This allows us to keep track of how many providers are getting payments. From a payment perspective it does go up and down base upon the claims that we receive. We continue to make multiple payments a week to make sure that our providers are getting paid. We are also maintaining our A34 process. We can maintain our eligibility and enrollment data on a regular basis, in partnership with our IT department.

Commissioner Pupa asked where we are regarding the remittance advices are, the 835 files because it as an impact to the delivery systems regarding their financials. Michael Mitchell, Executive Director of IT stated that we had a nine percent backlog, which represents about 1500 remittance that needed to go out and we have reduced that by one third. We were able to clear out a third of the backlog and the goal over the next ten days is to eliminate that. We want to ensure that as we are clearing the backlog, it is being done accurately. The backlog will be cleared as we committed in the next seven to ten days.

Commissioner Abbas stated that it was mentioned that more claims are coming up on a regular basis, how will that be overcome that process. It was stated that the team was adjudicating the claims manually, but ninety plus people are there. Are you keeping these people or are you going to improve the outward judication rate so that you can reduce/stop expenditures. Ms. Sproule stated that the number of claims that we currently have in the aged bucked, is typical, it is a standard number. These are not 100% clean claims, so we will always have aged inventory. The 17,000 plus or minus that we have in inventory now is our standard. We are doing a lot of manual adjudication, and our auto-adjudication rate is still low. Mr. Jeff Baltas of Netmark, stated that there are a few exceptions in the claims and t. e exceptions require manual work. The data is being cleaned up and the day-to-day operational aspect as well as the data components. The number of claims that are manually touched will continue to come down in number. The intent is to get back to normalcy.

Ms. Sproule stated that the goal by next summer is to be closer to where we were, which is about 70%.

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Commissioner Pupa motioned to approve Updates 4 and 5. Commissioner Sanchez seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, Tabin Cosio, Laura Espinosa, Anna Monroy, Dee Pupa, Sara Sanchez, and Scott Underwood D.O.

NOES: None.

ABSENT: Commissioners James Corwin, Melissa Livingston, and Supervisor Vianey Lopez

Motion carried.

FORMAL ACTION

6. September Year to Date Financial Results

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Receive and file the financial report.

CFO Dersch stated she will be reviewing the September year to date financial results. She stated that September was a catch-up month We knew that for the first few months of the year there were challenges with Ops of the Future, and we did not have a good basis for booking our claims, so we were booking to budget. September was a quiet month and there were no surprises. She noted that our membership is slightly

unfavorable, and that is putting some downward pressure on our membership/member mix. We are 2.1 million unfavorable from a revenue standpoint year to date. The medical benefits are on point, and we did have some activity in our IBNP are incurred but not processed. We were processing so many claims that we overestimated our IBNP going back to June. The claims data is now flowing, and we can better evaluate what that reserve level should be.

We were able to release a bit more in October, so we are getting to more of a stable state as our Ops of the Future continues to stabilize. From an administrative percent spend perspective, the month to date we were 1.6 million unfavorable, but this simply a true-up to ensure that we are bucketing our Ops of the Future versus core admin expense.

The total variance for the year is only $800,000 favorable and that is a good perspective. In our project portfolio, the Ops of the Future looks close to where we budgeted because we know that the stabilization is now going to take longer and that is where you begin to see the unfavorable variances being with October. From a bottom-line perspective, from a month's day perspective we had a $1 million decrease in our net assets versus a budget loss of 2.8. We were 1.7 million favorable. it was a quiet month.

Commissioner Pupa stated she liked the layout of the financials because it is clear, and the categorization buckets are very helpful. CFO Dersch stated that going forward she wants to pull out the QIPP funding and report on that separately.

Commissioner Cowin joined the meeting at 3:11 p.m.

CFO Dersch reviewed the breakout of medical spend by category of service. She noted that we are not seeing anything in our utilization that would indicate that we have medical costs that are not being managed. We continue to watch the utilization of the unsatisfactorily documented cohort – that is going to be a key for us now that we have had the election.

We know that our results will continue to be influenced by the Ops of the Future and the success with that program. We will continue to monitor it closely. We will have a reprioritization of our strategic initiatives, and we also want to make sure that we are focusing our resources. We will also be going to be monitoring our D-SNP as far as 2024 and 2025 rates, and we expect to see positive revised 2025 rates in approximately three weeks. As a reminder, CFO Dersch noted that our 2025 rates came in at 2.2% less that what we had projected. That is a budgetary hit of $20 million. We are providing the same level of services but $20 million less is a hard gap to fill. If there is increase in utilization the gap gets bigger. We are working closely with our trade associations to advocate to the state requesting that the state review the rates are not sufficient as they stand. This could result in harm to members in reduced care.

Commissioner Espinosa asked if all our contracts are closed. CPPO Cho stated that there is a continual cycle of contracts ongoing. Currently there is no major concern, and

we are stable. CPPO Cho stated that there is a major negotiation on going with Dignity hospital system. We are working to avoid any major impacts. We are currently in a stable place but there are always things happening around us.

Acting CEO, Felix L. Nunez, M.D., stated that the issues are the rates, and we are pushing back and advocating for rates that are fair and reflect the level of need of the community and the number of medical expenditures.

Commissioner Abbas stated that he is looking at ECM and how can we better take care of the patients. In looking at year to date budgeted it was $4.2 million, and the actual expenditure is $2.2 million – why have we not spent the money. How can we expand or do better. CPPO Cho stated that the core thing that needs support is a higher uptake of ECM. We clearly have the budget, and we need to get that more actualized. The expanded capacity from our current providers would be the best thing to be able to move forward. We are also in the process of onboarding to bring on more ECM providers. There are opportunities. Commissioner Corwin stated that what he sees is they have invested, we have invested in the infrastructure which is a big part but the amount of people we know needed and the amount of people willing to participate has been hard to get so we will need to put more incentive dollars out. We have a lot of patients targeted but they still have to say yes.

Commissioner Sanchez asked if there are sufficient ECM providers within the network and is three a sufficient network adequacy. CPPO Cho stated there are opportunities to add providers. Acting CEO, Nunez stated this is a difficult population to work with. Once providers come onboard, they realize the complexity of these members is quite high and takes a great deal of time and effort. Bringing on new providers will be critical for us to be able to increase the population. The return on invests will be significant if we can get these programs in place and get their members connected to care in a way that addresses their needs.

Commissioner Espinosa stated that there is a shortage of providers, and she is hopeful that our educational institutions will be more proactive and we also need to be more proactive through possible provider grants programs to see if we could begin to mentor and grow the type of network that we need.

CFO Dersch stated that she wanted to bring attention the Operations of the Future Expenditures. She noted there was a list of all the Ops of the Future invoices that have been paid since July 1. They are arranged from the most spent down to the least. There has also been a reclassification from one bucket to another. She noted that the spend is categorized by type and will continue to provide this type of detail.

Commissioner Abbas motioned to approve September Financials. Commissioner Monroy seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, James Corwin, Tabin Cosio, Laura Espinosa, Anna Monroy, Dee Pupa, Sara Sanchez, and Scott Underwood D.O.

NOES: None.

ABSENT: Commissioners Melissa Livingston, and Supervisor Vianey Lopez

Motion carried.

7. Conversion of Fiscal Year

Staff: Sara Dersch, Chief Financial Officer

RECOMMENDATION: Staff has presented the information to the Executive Finance Committee. Staff is requesting that Commission approve the plan to convert the fiscal year to follow the calendar year.

CFO Dersch stated that our current fiscal year begins July 1 and ends June 30 which had been consistent with rate cycles from the state. It is not consistent anymore, so our rate cycles run January through December, which is also true for Medicare. It is best practice from an accounting standpoint to have your fiscal cycle mirror your business cycle. That tells us that we should consider converting our fiscal year to be that on the calendar year basis that will make some of our regulatory reporting easier. We will not have to do two datasets. This will also make budgeting easier because we will not have to make guesses as to what we think the rate might be for half the year. This will also help when we move to D-SNP. From a budgeting standpoint we recommend that our budget begin in September and end in November so that the budget is all done by the time we get to the holidays.

Commissioner Abbas motioned to approve the conversion of the fiscal year. Commissioner Sanchez seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, James Corwin, Tabin Cosio, Laura Espinosa, Anna Monroy, Dee Pupa, Sara Sanchez, and Scott Underwood D.O.

NOES: None.

ABSENT: Commissioners Melissa Livingston, and Supervisor Vianey Lopez

Motion carried.

8. FY 2024-25 D-SNP Revised Operational Readiness Costs

Staff: Robert Franco. Chief Compliance Officer
Eve Gelb, Chief Innovation Officer
Sara Dersch, Chief Financial Officer

RECOMMENDATION: It is GCHP's recommendation that Ventura County Medi-Cal Managed Care Commission to approve up to $5.3M additional budget for D-SNP operational readiness for the remainder of the 2024/2025 Fiscal Year.

CIO Gelb reviewed the regulatory timeline. She noted there are two key buckets of work: committing to all the regulatory requirements and doing all the operation work. We want to ensure that we contract the right way and actually deliver. We are on track on our regulatory timeline. CCO Franco stated that we have started securing hires around our D-SNP project. We just hired a D-SNP Compliance Director who will provide regulatory support.

CIO Gelb stated that the notice of intent to apply with CMS, which alerts CMS that we would like to be a D-SNP on January1, 2026 and that have issued us a contract number. In February we will submit our Model of Care, and we will also submit our network and CMS application. The draft Model of Care will be presented to the Commission in January for review. We are on track.

We must build the operations to deliver the product. We plan to go live on January 1, 2026. We will need to enroll our first member on October 15th and all marketing materials need to be out the door and in the hands of the public by October 1. There are lots of detailed tasks, deliverables, and activities that the entire organization will be working on. We have certain items on track and where they need to go, we also have certain items at risk, and some that are greater risks that we need to put mitigation plans in place.

We do have some slight delays in our benefit design, we want to make sure that we get input from or members on what benefits matter to them, and we are engaging the community providers, community partners, and our members to do focus groups on benefits to ensure that we deliver benefits that are meaningful to our members. Our goal is to get those focus groups completed by December 20.

We are also slightly behind on our Model of Care, although in this week we completed the first run through of all our MOC with internal staff. We are now packaging that up into the right kinds of works processes.

We have stabilized our Operations of The Future and now we need to build Medicare. We need to do three main things: first is that while it is our intention to go-live with D-SNP on all of our exiting systems, all of the systems that have been implemented and while it is the capability of all of those existing systems to handle Medicare because of the foresight of the people who selected those systems, we do need a contingency and we will be putting out a request for information for organization that could support as a third party administrator for some or all of the D-SNP processes that would rely on our

existing systems should we not be able to go. The second thing we need to do is to bring resources and close knowledge gaps. We are proposing to bring on subject matter expertise and bandwidth in two ways, one is to hire additional resources to come in and teach us. Medicare is quite different from what we do in Medi-Cal. We need a sales agent working on marketing. We need resources to support the transition.

There is also a requirement to have a special investigation unit, which we do not currently have. We will need to go to market to look for that expertise.

The initial budget for D-SNP for this fiscal year was $2.3 million. There are a few additions to existing items. There are some costs that will remain the same and some costs are different. CIO Gelb then reviewed costs associated with additional work. These costs revise the budget from $2.3 million to between $7.1 and $7.6 depending on where we go with a third-party administrator or not. The ask is for approval of $7.6 and we will report monthly to Commission on the progress.

Commissioner Pupa motioned to approve D-SNP revised operational readiness costs. Commissioner Corwin seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, James Corwin, Tabin Cosio, Laura Espinosa, Anna Monroy, Dee Pupa, Sara Sanchez, and Scott Underwood D.O.

NOES: None.

ABSENT: Commissioners Melissa Livingston, and Supervisor Vianey Lopez

Motion carried.

9. Contribution to Ventura County Community Information Exchange (CIE)

Staff: Erik Cho, Chief Policy & Programs Officer

RECOMMENDATION: The Plan recommends that the Ventura County Medi-Cal Managed Care Commission authorize the CEO to execute the grant funding agreement with the Public Health Institute to assist with the development of the Ventura County Community Information Exchange.

CPPO Cho stated Erin Slack, Sr. Manager of Population Health, stated that the CIE is a community information exchange that is a platform by which we can foster collaboration among local service providers and real time sharing of information and reducing duplication of efforts. This will ensure coordination across the many services people are able to get. This can impact vulnerable populations, low-income families, or people experiencing homelessness, limited English proficiency people, people with disabilities, and those with multiple chronic health conditions They will get better access to vital

resources such as housing, food, community supports, and other social services. We believe there will be improved outcomes from CIE. We will improve community resilience health and social outcomes and benefit the broader community as well as our population. This is being supported by money that has come in through the incentive payment program. We are a co-sponsor for the Community Infrastructure/Community Information Exchange in Ventura County.

Two of the governance board members for CIE, Sarah Conlon, Operations Manager at CDCR, and Rigo Vargas, Public Health Director from Ventura County, spoke in appreciation of the collaboration between GCHP and CIE for grant funding to assist with the development of the CIE.

Commissioner Abbas motioned to approve the contribution to Ventura County Community Information Exchange (CIE). Commissioner Monroy seconded the motion.

Roll Call Vote as follows:

AYES: Commissioners Anwar Abbas, James Corwin, Tabin Cosio, Laura Espinosa, Anna Monroy, Dee Pupa, Sara Sanchez, and Scott Underwood D.O.

NOES: None.

ABSENT: Commissioners Melissa Livingston, and Supervisor Vianey Lopez

Motion carried.

CLOSED SESSION

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

11. PUBLIC EMPLOYEE APPOINTMENT
Title: Chief Executive Officer

Closed Session was tabled.

ADJOURNMENT

With no other business to conduct, the meeting was adjourned at 4:22 p.m.

Approved:

_____

Maddie Gutierrez, MMC
Clerk to the Commission

AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: James Cruz, MD, Acting Chief Medical Officer
Kim Timmerman, MHA, CPHQ, Sr. Director of Quality Improvement

DATE: January 27, 2025

SUBJECT: Written Summary of Quality Improvement and Health Equity Activities – Q4 2024

SUMMARY:

The Department of Health Care Services ("DHCS") contract, Exhibit A Attachment III, Section 2.2.3, requires Gold Coast Health Plan ("GCHP") to prepare a written summary of Quality Improvement and Health Equity Committee (QIHEC) activities, findings, recommendations, and actions after each meeting and submit it to the Governing Board.

The attached report contains a summary of activities of the QIHEC and its subcommittees for Quarter 4, 2024.

FISCAL IMPACT:

None

RECOMMENDATION:

Staff recommends that the Ventura County Medi-Cal Managed Care Commission accept and file the Quarter 4, 2024 Quality Improvement and Health Equity Committee summary.

ATTACHMENTS:

Quality Improvement and Health Equity Committee (QIHEC) Meeting, 2024 Quarter 4 Summary Report, December 3, 2024

Quality Improvement and Health Equity Committee (QIHEC) Meeting
2024 Quarter 4 Summary Report
December 3, 2024

Overview:

The Gold Coast Health Plan (GCHP) Quality Improvement and Health Equity Committee (QIHEC) met quarterly in 2024, with special meetings scheduled as needed to conduct business. The QIHEC is chaired and facilitated by the Chief Medical Officer (CMO), with committee members comprised of internal leadership, the Chairs from the ten QIHEC Subcommittees, one Commissioner, three practicing physicians in the community, and a behavioral health care practitioner. This report represents a summary of the December 3, 2024 QIHEC meeting.

Open Action Items from Prior QIHEC Meeting

- Action Item #63: Topic: Carelon Behavioral Health Quality Improvement Program Description and Work Plan
  - Topic: Carelon to provide feedback on eight follow-up questions from the September 17, 2024 QHIEC meeting.
  - Status: Open

Approval Items

- QI-029 Blood Lead Screening of Young Children: The QI department completed the annual review of policy and made the following updates.
  - Aligned requirements with the Department of Healthcare Services (DHCS) Initial Health Appointment (IHA) for healthcare Providers to monitor lead screening in children.
  - Added blood lead screening resources available to Providers: (1) GCHP Pediatric Lead Screening webpage and (2) DHCS Blood Lead Testing and Anticipatory Guidance.

New Business

1. 2025 Quality Improvement and Health Equity Transformation Program Description and Work Plan Timeline
   - The QI Department shared the timeline for GCHP departments to review and complete updates to the 2025 Quality Improvement and Health Equity Transformation (QIHET) Program Description and Work Plan by December 13, 2024. The QI Department scheduled an organization-wide meeting to review the timeline and deliverables and scheduled separate meetings with each department to review their sections.

2. Non-Specialty Mental Health Services (NSMHS)
   - The Behavioral Health (BH) and Provider Network Operations (PNO) departments discussed the new DCHS All Plan Letter (APL) 24-012 and State Bill 1019 which requires Medi-Cal Managed Care Plans (MCPs) to develop outreach and education plans to address low utilization of mental health benefits and to address gaps in low utilization of NSMHS by ensuring Members and primary care providers (PCPs) are aware of all covered NSMHS. The

NSMHS Outreach and Education Plans are due to DHCS by December 31, 2024 with the following deliverables:
  - Member Outreach and Education Plan
  - PCP Outreach and Education Plan
  - NSMHS Utilization Assessment
  - Website Posting (DHCS-approved Member and PCP Outreach and Education Plan, Utilization Assessment)
- Update plan annually and conduct outreach and education of NSMHS on an annual basis.
- The BH and PNO departments reviewed the stakeholder engagement plans for members and providers and requested feedback from QIHEC members on barriers to mental healthcare and how to improve member and provider access and engagement to mental health services.

3. DHCS and Institute for Healthcare Improvement (IHI) Child Equity Collaborative
   - The QI department reported updates on two of five health equity-driven interventions to increase well-care exams.
   - Intervention 1: Equity & Transparent, Stratified, and Actionable Data
     - Identification of the target population and development of the aim statement was completed and involved an in-depth analysis of the well-care measures. A target population and clinic partner were identified to improve health equity in the target population.
     - Aim Statement: By December 31, 2024, increase well-care exams in English-speaking 12-17 years olds assigned to Clinicas del Camio Real Karen R. Burnham Center from 38.42% to 43.22%.
   - Intervention 2: Understand Provider and Patient/Care Giver Experiences
     - The QI department collaborated with the clinic partner to perform focus studies by interviewing members and clinic staff, via telephone and in-person, to identify barriers to care and determine opportunities for improvement. Barriers reported by patients, caregivers, and clinic staff included appointment availability too far in the future, difficulty taking time off work, and appointments cancelled if appointment was not confirmed.
     - Two workflow changes were made in the clinic to address the barriers. (1) The clinic modified HIPAA restrictions to enable sending appointment text message reminders to 12–17-year-old minor patients. (2) GCHP and the clinic collaborated on scheduling a Saturday clinic and scheduled 90 well-care appointments. To increase member engagement, a $35 Walmart gift card was offered. A total of 70 out of 90 members attended the Saturday clinic and completed their well-care exams.

Standing Items: QIHEC Subcommittee and Department Summaries

1. *Compliance/Delegation Oversight*
   - All delegation activities were completed 100% on time.
   - Oversight audits still open
     - Kaiser Permanente: Claims
     - Conduent: Claims

  - Ventura Transportation Services: Non-emergency and non-medical transportation, new vehicle assessment, downstream contractor
- Oversight audits closed
  - Clinicas del Camino Real: Utilization Management
  - Carelon Health: Utilization Management, Member Experience, Network Operation, Quality Improvement, Cultural & Linguistics

2. *Quality Improvement: Managed Care Accountability Set (MCAS) Steering Committee*
- MCAS/HEDIS® 2024 Quarter 3 Dashboard
  - Status of MCAS measures held to the DHCS Minimum Performance Level (MPL)
    - 9 out of 18 measures met the MPL
    - 3 rates close to meeting the MPL: CHL (-0.54), FUA-30 (-1.51), and AMR (-2.65)
    - All rates improved
  - MCAS report only measures
    - 17 out of *28 rates increased*
- MCAS Operations Steering Committee
  - The MCAS Operations Steering Committee met in September and reviewed the status of interventions.
    - Children's Health
      - Child flu vaccine member outreach campaign is pending script approval from DHCS.
    - Behavioral Health
      - Post-emergency department care coordination with Carelon Behavioral Health and Conejo Health has started to show a positive impact on improving the FUA and FUM measures.
    - Chronic Disease Management
      - Reviewed development of the member outreach and provider education campaigns to improve the asthma medication ratio measure.
      - The asthma member outreach program launched in September.
      - The Provider Asthma Lunch and Learn was completed on November 14, 2024.
      - Discussed plans for a new diabetes HbA1c member incentive program.
    - Cancer Prevention
      - Discussed collaborations with American Cancer Society and Clinicas del Camino Real on a home test kit pilot project to increase colorectal cancer screening.
- QIHET Work Plan Updates
  - Two new programs launched: flu vaccine member incentive and Doula program
  - Provider articles published in the Prover Operations Bulletin on best practice guidelines focused on children' health and cancer prevention
  - Data improvements included the development of a new National Drug Code mapping table to capture more asthma pharmacy claims and the enhancement of the CAIR member file to improve capture of immunization registry data.

3. *Quality Improvement: Facility Site Review (FSR) /Medical Record Review (MRR) / Initial Health Appointment (IHA)*
- Facility Site Reviews

  - In 2024 Quarter 3, 7 FSRs were completed and overall, 95% of DHCS site audit criteria were met.
    - Percentage of Providers that passed FSRs with or without a CAP: 86%.
    - Percentage of DHCS MRR criteria met: 90%.
    - Percentage of Providers that passed the MRR with or without a CAP: 86%.
    - Percentage of applicable DHCS Coordination of Care criteria met: 97%.
    - The QI department continues to collaborate with the three largest clinic systems and provide guidance and training to ensure clinics are aligned with the DHCS FSR/MRR standards.
    - FSR backlog scheduled to be completed by 2024 Quarter 4.
    - Increased need for educational visits for providers and staff.
- Initial Health Assessments
  - In 2024 Quarter 2, 208 medical records were included in IHA audits across three largest clinic systems.
    - The overall percentage of all IHA criteria met: 79%.
    - The overall percentage of records meeting IHA compliance within 120 days: 87%.
    - Blood lead anticipatory guidance documented for members 6 months to 6 years of
    - Age: 28%.
    - Blood lead screenings documented for members 12 months, 24 months, and by 6
    - years of age: 54%.
  - Findings
    - Providers scored high for completing the following assessments: alcohol use, tobacco exposure, developmental screening, dyslipidemia screening and mental health screenings
    - Areas in need of improvement include: STI screening, age-appropriate immunizations, Hepatitis B screening, blood lead anticipatory guidance and blood lead screening at 12 months, 24 months and 6 years of age, psychosocial/behavioral assessment, and intimate partner violence screening.

4. *Population Health Management (PHM) Department*
   - Population Needs Assessment
     - The Population Needs Assessment was completed in 2024 Quarter 3 and will be presented to the Population Health Management workgroup meeting on December 16, 2024.
   - Wellth Program
     - Completed enrollment of additional 4,695 members to the QI program.
     - Instituted blood pressure monitor distribution initiative to members.
     - Provided Wellth with GCHP branded video of instructions for proper use of blood pressure monitor that will be available in the Wellth App.

5. *Behavioral Health Quality Committee*
   - The Behavioral Health (BH) Department continued focus on expanding behavioral health care management that supports effective care coordination and timely transitional care services for members after emergency department (ED) visits or hospital admissions. This included working with internal key delegates and contracted providers (e.g., Carelon and Conejo Health) to deliver enhanced care to members telephonically and onsite in the ED.

- 2024 Quarter 3 Year-to-Date (YTD) data shows that Carelon outreached to 100% of members identified with an ED visit for substance use or mental health conditions and 2024 Quarter 3 YTD appointments scheduled and/or discharge assessments completed was 26.41%.

- The BH department is leading the DHCS-IHI Behavioral Health collaborative with Carelon Behavioral Health and Ventura County Behavioral Health (VCBH).
  - The Plan Do Study Act (PDSA) cycle with the Conejo Health Navigators is complete and the VCBH-led portion of PDSA Cycle is currently in progress.
  - Conejo Health shared their established care coordination process flows for post ED follow-care for members with an ED visit for substance use and is planning to add care coordination for follow-up care for mental health conditions.
  - Conejo Health and GCHP are collaborating with Community Memorial Health System (CMHS) to support their post ED follow-up care coordination which launches in December.
  - Year-to-Date rates for the two behavioral health measures, Follow-Up After ED Visit for Mental Illness (FUM) and Follow-up After ED Visit for Substance Use (FUA) show that Conejo Health has positively impacted 5.2% of the FUA rate and Carelon has positively impacted 4.8% and 6.1% of the FUA and FUM rates respectively.

6. *Utilization Management Committee*

- Utilization Management (UM)
  - UM Turn-Around-Time Metrics (TAT)
    - 2024 Quarter 3 UM TAT were above benchmarks for standard prior authorization and post service requests, but expedited prior authorizations fell below benchmark at 89% and staffing augmentations were made.
    - UM will develop a deeper analysis report that targets cases/metrics that are below benchmark and provide a workflow that brings these measures into compliance.
  - Over/Under Utilization Review
    - UM to develop workgroups in 2024 Quarter 4 that identify priority reports for under/over utilization of services and implement improvement that will enhance service delivery and utilization resources.
  - UM Inpatient and Service Requests
    - Volume of requests in 2024 Quarter 3 versus 2023 Quarter 3 increased by 18%, Inpatient by 7% and Outpatient by 20%.
- Care Management
  - Nurse Advice Line
    - In 2024 Quarter 3, the Nurse Advise Line received 431 calls, 223 triage calls, and 3 program referrals. Utilization based on gender averaged at 134 by women and 89 calls by men.
    - GCHP continues to monitor incoming calls by language; English being the highest spoken language.
  - Enhanced Care Management (ECM) Program
    - 673 unique members were outreached in 2024 Quarter 3: 47% were outreached with services and 47% with no services outreached.
    - 1,428 ECM members were provided with care in 2024 Quarter 3.
    - An average of 83 new members have joined ECM per month since 2022.

7. *Member Services Committee*
   - Membership Update
     - As of September 30, 2024, GCHP had a total of 246,656 members.
     - There has been a 0.7% decrease in membership from 2024 Quarter 2 (248,315 members) to 2024 Quarter3 (246,656 members).
   - Call Center
     - GCHP transitioned from an external call center to an internal Contact Center on July 1, 2024.
     - The average speed of answer and abandonment rate benchmarks were met.
     - Phone quality results were not measured during 2024 Quarter 3 because the team was working through critical issues with the new systems implemented on July 1.
     - Member Services will continue to audit calls and hold weekly calibration meetings with the internal Call Center to identify areas in need of improvement.

8. *Provider Network Operations (PNO)*
   - PNO Metrics were met for number and geographic distribution of specialists and for the ratio of members to specialists and primary care providers (PCPs).
   - The 2024 Provider Accessibility and After-Hours Survey was completed and revealed several categories that did not meet acceptable standards. PNO will implement the following action plan:
     - Identify non-compliant providers for 2024 and issue corrective action plans (CAPs).
     - Identify providers who were non-compliant in both 2023 and 2024 as critical for focused attention.
     - Conduct training sessions to educate providers on accessibility standards and requirements.
     - Require non-compliant providers to submit detailed remediation plans.
     - Continuously monitor the progress of non-compliant providers to ensure they achieve compliance.
   - Provider Welcome Letters and Orientations
     - In 2024 Quarter 3, 407 providers were added to the network and 390 outreach/welcome letters were submitted timely, 17 were submitted beyond the standard timeframe primarily due to retroactive contract effective dates, which impacted timeliness of outreach.
     - In 2024 Quarter 3, 388 provider orientations were completed timely, but 14 were completed beyond the standard timeline due to retroactive contact effective dates.

9. *Quality Improvement: NCQA Accreditation*
   - The Health Equity Accreditation HEA survey is scheduled for June 10, 2025 and the Health Plan Accreditation (HPA) survey is scheduled for October 7, 2025 with plans to achieve NCQA HPA and HEA accreditation by January 2026.
   - The HPA and HEA mock survey results were completed and will be reviewed with the applicable departments and business owners to review findings and implement remediations plans to close any remaining gaps.
   - Continue the following meeting forums to hold working sessions and provide status updates
     - NCQA Standards Workgroup
     - NCQA Key Stakeholder Forum

10. *Health Education and Cultural Linguistics (HE/CL) Committee*

- Cultural and Linguistic Services
  - In 2024, Quarter 3, a total of 2,313 language assistance referrals were received which was a 7% increase compared to the 2024 Quarter 3 (2,154).
  - Translation services decreased by 32% (322) compared to 2024 Quarter 2 (471).
  - Of the 322 translations, 2 documents were transcribed in alternative formats (e.g., audio compact disc and large print).
- Health Education Services
  - A total of 431 heath education referrals were completed in 2024 Quarter 3. The most common topics included diabetes, hypertension, well-care visits, immunizations, member incentives, tobacco cessation, pregnancy/postpartum, and advance directives.
  - Chronic Disease Management Workshops: Two telephonic workshops (1 English and 1 Spanish) were completed in 2024 Quarter 3 with 10 members enrolled.

11. *Grievance and Appeal (G&A) Committee*

- G&A turn-around-time (TAT) benchmarks were not met in 2024 Quarter 3 due to the new systems implementation that occurred on July 1, 2024. Monitoring has been set up to capture any potential routing issues.
  - Member Grievance
    - Acknowledgement TAT reported 96%
    - Resolution TAT reported 93%
  - Appeals
    - Acknowledgment TAT reported 90%
    - Resolution TAT reported 95%
- G&A reviewed all cases received in 2024 Quarter, with a total of 68 Quality of Care cases reported. Percentages related to the rating outcomes:
  - 37% of the Quality-of-Care cases reported were substantiated
  - 13% were unfounded due to lack of information
  - 29% were not substantiated
  - 21% had no rating applied

12. *Pharmacy and Therapeutics (P & T) Committee*

- Drug Utilization Review (DUR)
  - Opioid prescription utilization met performance metric of less than 5% increase in utilization except for concurrent users of opioid and naloxone (increased by 19%). Continue monitoring opioid claims data/dashboards from Medi-Cal Rx and continue monitoring for any persistent trends in utilization.
- Medi-Cal Rx Pediatric Integration of Members 21 years of Age and Younger on January 31, 2025.
  - Prior authorization requirements and utilization management claims edits for the pediatric population will be reinstated on January 31, 2025.
  - The California Children's Services (CCS) Panel Authority policy will also be implemented for specific CCS Panel providers.
- NCQA Accreditation
  - The pharmacy department is working on aligning the Pharmaceutical Management of Physician Administered Drugs (PADs) and Drug Recall Notification process to meet NCQA accreditation standards.

- Pharmacy & Therapeutics Committee
  - Reviewing and updating PAD list to be compliant with NCQA requirements. PAD list updates will be effective 3/1/2025. Member and provider notifications will be distributed in December 2024 and the updated PAD list and clinical guidelines will be posted on GCHP website.
  - The recommended changes to the list of PADs were reviewed and approved at the P&T Committee on November 14, 2024.

13. *Credentials/ Peer Review Committee (C/PRC)*
    - All credentialing and recredentialing benchmarks were met in 2024 Quarter 3.

14. *Medical Advisory Committee (MAC)*
    - 2024 Quarter 2: MAC member quorum was not met, and meeting was canceled
    - 2024 Quarter 3: MAC approved Clinical Practice and Preventive Services guidelines on July 18, 2024
    - 2024 Quarter 4: Due to limited provider participation in the quarterly Medical Advisory Committee, the MAC committee has proposed the following action plan:
      - Sunset the Medical Advisory Committee effective 2024 Quarter 4.
      - Transition review of Clinical Practice Guidelines and UM Clinical Guidelines and Criteria to the Credentialing/Peer Review Committee in 2025.

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: January 27, 2025

SUBJECT: Recap of 2024 Strategic Planning Retreat

Verbal Presentation

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Alan Torres, Chief Innovation & System Modernization Officer
Anna Sproule, Executive Director of Operations

DATE: January 27, 2025

SUBJECT: Operations of the Future (OOTF) Update

Verbal Presentation

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Sara Dersch, Chief Financial Officer

DATE: January 27, 2025

SUBJECT: Preliminary December YTD Financials and FY 2024-25 Revised Budget

PowerPoint with Verbal Presentation

ATTACHMENTS:

FY 2024-25 December YTD Results and Revised Budget

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

FY2024-25 December YTD Results and Revised Annual Budget

Executive Finance Committee
January 23, 2024
Sara Dersch, Chief Financial Officer

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

Executive Summary

December YTD Results

- Premium revenue variance of $5.4M driven by lower membership offset by slight rate favorability
- Investment income continues to be favorable to budget
- Medical cost unfavorability is primarily result of Dignity contract combined with PCP and Mental Health utilizations
- We continue to release reserves as a result of prior months' claims "completing" at lower-than-projected rates

FY2024-25 Revised Annual Budget

- The Revised Budget is built using July through December actuals and January through June projections; we refer to this as a "6+6" view
- Emerging experience not known at the time of the 2024 calendar year rate assignment combined with a modified rate development methodology by the State has resulted in premium rate increases for half of our Categories of Aid; overall revenue impact is an 8% increase over original projected rates of roughly $10M
- Revised medical cost projections are influenced by a combination of increased PCP utilization and revised contractual rates with providers; note: medical loss ratio remains healthy at 89.0%
- Administrative costs have increased primarily as a result of:
  - continued refinement of Operations of the Future (OOTF)
  - a more-informed development of our Medicare launch
  - expansion of Call Center staff

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Financial Results December YTD Summary

Item	Actual	Budget	Explanation
December Membership	245,627	250,274	Child, Expansion and Adult membership cohorts are driving the variance
Premium Revenue *Revenue pmpm*	$543.3M *$368.68*	$537.9M *$358.70*	Rate driven favorability offset by volume
Investment Income	$10.3M	$8.0M	Favorable Interest Rates
Medical Cost *Medical Costs pmpm* MLR % (% of premium)	$462.7M *$313.94* 85.2%	$460.4M *$307.06* 85.6%	Increased Dignity rates coupled with higher utilization in the Adult Expansion, Adult, and SPD cohorts
Quality Strategy (Grants/Incentives)	$34.1M	$41.3M	Alignment of Quality Strategy spend with available reserves
Administrative Cost	$48.6M	$48.9M	Spend approximates budget
Operations of the Future (OOTF)	$11.4M	$6.7M	Continuation of expanded stabilization plan
Net Income/(Loss)	($3.2M)	($11.4M)	Favorability primarily attributed to reduction of Quality Strategy payments
TNE	$362.5M	$351.7M	We are at 978% of required TNE

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Revised Budget Summary of Changes

Item	Original	Revised	Explanation
Year-End Membership	251,125	244,620	Membership reductions in Child SIS and Adult SIS & UIS
Premium Revenue *Revenue pmpm*	$1,073.3M *$356.16*	$1,084.7M *$368.76*	Rate increases of 8% driving higher revenue in Adult Expansion and Child population despite reduction in overall volume
Investment Income	$16.0M	$18.0M	Investment performance is better than originally budgeted
Medical Cost *Medical Costs pmpm* MLR % (% of premium)	$925.7M *$307.18* 86.2%	$965.9M *$328.35* 89.0%	Increasing utilization trends in Behavioral Health, Primary Care, Specialty, and FQHC in Adult, Child and SPD-LTC categories of aid; Inpatient unit cost is also trending up in the Adult population; the Quality Administrative Costs reclassification is reduced
Quality Strategy (Grants/Incentives)	$82.5M	$52.6M	Alignment of Quality Strategy spend with available reserves
Administrative Cost	$96.0M	$113.1M	The increase reflects continued investment in the Provider Call Center and a reduction in the administrative reclassification to Medical Expense
Operations of the Future (OOTF)	$4.0M	$21.5M	Commission-approved continued investment
D-SNP Readiness	$2.4M	$4.8M	Commission-approved continued investment
Strategic Initiatives	$6.9M	$0	Strategic Initiatives have been rolled-up into Administrative
Net Income/(Loss)	($28.2M)	($55.1M)	Quality Funding and Infrastructure Investment drive the deficit

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2025 Rates: Original Budget Compared to Final

Category of Aid	2024 Rates	2025 Rates (Budget)	2025 Initial (Oct)	2025 Initial (Dec)	2025 Final (Dec)	2025 Final Membership
Adult - SIS	$ 339.69	**$ 368.95**	$ 328.27	$ 334.88	**$ 341.29**	24,750
Adult - UIS	$ 480.75	**$ 551.79**	$ 413.61	$ 420.93	**$ 385.37**	15,065
Adult Expansion - SIS	$ 339.63	**$ 343.99**	$ 344.10	$ 351.27	**$ 405.72**	67,403
Adult Expansion - UIS	$ 559.76	**$ 557.23**	$ 552.00	$ 563.25	**$ 558.41**	12,434
Child - SIS	$ 108.75	**$ 109.51**	$ 110.58	$ 112.96	**$ 129.44**	87,333
Child - UIS	$ 102.30	**$ 125.01**	$ 104.05	$ 106.25	**$ 107.12**	3,958
LTC Dual - SIS	$ 650.41	**$ 649.34**	$ 618.72	$ 630.68	**$ 596.26**	630
LTC Dual - UIS	$ 502.67	**$ 502.13**	$ 606.01	$ 620.27	**$ 724.65**	6
LTC Non-Dual - SIS	$ 1,268.91	**$ 1,281.00**	$ 1,193.38	$ 1,216.03	**$ 1,248.60**	29
LTC Non-Dual - UIS	$ 1,290.23	**$ 1,325.12**	$ 1,446.82	$ 1,478.10	**$ 1,539.34**	20
SPD - SIS	$ 1,311.31	**$ 1,282.78**	$ 1,203.30	$ 1,222.19	**$ 1,248.60**	6,035
SPD - UIS	$ 1,348.14	**$ 1,337.48**	$ 1,446.65	$ 1,477.88	**$ 1,539.34**	1,307
SPD Dual - SIS	$ 655.58	**$ 649.29**	$ 618.72	$ 630.68	**$ 596.26**	25,532
SPD Dual - UIS	$ 513.29	**$ 502.37**	$ 606.01	$ 620.27	**$ 724.65**	119
FY 2025 Final Projected Membership						**244,620**

Note: Font color in "2025 Final" column indicates favorable (green) or unfavorable (red) change from original budget projections.

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FY2024 -25 Headwinds & Tailwinds

The items below represent in broad categories those areas that could change the trajectory of our current planned deficit.

- Utilization (impact: small to large)
- Targeted Rate Increase (impact: small to medium)
- State fiscal actions (impact: small to medium)
- Federal fiscal actions (impact: small to medium)
- Unanticipated provider rate increases (impact: small to large)

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Quality & Access Funding Strategy

Quality Incentive Programs

- Quality Incentive Provider Pool (QIPP) continues in 2025
- Hospital QIPP launches in 2025 and will continue into 2026
- Access-based Incentives: Launching mid-2025

2024 Grant Programs Recap

- 90 provider recruitment grants approved (over $13.6M) with 46 new providers already funded
- 393 pieces of equipment approved (over $1.6M)

2025 Resilience, Innovation, Sustainability, & Equity (RISE) Grant Program

- Professional management by Institute for Healthcare Improvement (IHI) allows for expansion of grant program to Community-Based Organizations
- Applications launch in January

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Labor Expense by Category

Gold Coast Health Plan - Headcount Fiscal Year 2024-25
FY 2024-25 - January 8, 2025

	EMPLOYEE COUNT					CONTINGENT WORKERS			Total Resources	
Function	Active Headcount‡	Open Requisitions	Revised Budget YE Headcount 2024/25	Original Budget 2024/25	Percentage of Total Headcount	Temp Roles	Contractor / Consultant Roles	Total Contingent Workers†	Total Resources	Percentage of Total Resources
Health Services	129	5	134	134	30%	2	2	4	138	24%
Operations	92	13	105	65	23%	5	42	47	152	27%
Information Tech	56	6	62	55	14%	13	5	18	80	14%
Policy & Programs	41	3	44	54	10%	0	0	0	44	8%
Compliance	20	2	22	21	5%	1	0	1	23	4%
Finance & Accounting	18	2	20	18	4%	3	0	3	23	4%
Execuitve & Administration	11	3	14	16	3%	0	0	0	14	2%
Member Experience and Ext Affairs*	31	4	35	19	8%	0	0	0	35	6%
HR&Facilities	11	1	12	11	3%	1	1	2	14	2%
Innovation / DSNP	2	2	4	6	1%	0	0	0	4	1%
Strategic Initiatives	0	0	0	0	0%	0	0	0	0	0%
Grand Total	**411**	**41**	**452**	**399**	**100%**	**25**	**50**	**75**	**527**	**93%**

*Community & Member Relations & Communications combines under Member Experience and Ext Affairs

†Outsourced Labor (BPO) excluded: 41 in Operations - Netmark

‡ Includes 9 positions for which offers have been accepted

Headcount Status	Revised Headcount	Commission Approval
Original Budget	399	Jun-25
D-SNP Adds	11	Nov-25
Provider Call Center	27	Oct-25
Mail Room Staffing	13	Oct-25
CEO Adds	2	
Revised Total	**452**	

CEO Adds	Department
Developer II	**Information Tech**
Director, Accounting	**Finance & Accounting**

Return to Agenda

Gold Coast Health Plan
FY2025 Budget Summary
Updated: January 15, 2025

	Original Budget		Revised Budget		Fav/(Unfav)	Variance Explanation
A. Membership						
Period Ending Membership	251,125		244,620		(6,505)	
Member Months	3,004,113		2,941,574		(62,539)	
B. Revenue	Amount	PMPM	Amount	PMPM		
Base Capitation + Maternity	$ 1,048,311,251	$ 348.96	$ 1,051,799,039	$ 357.56	$ 3,487,788	*Increase in DHCS Rates. Adult Expansion and Child are the primary variance drivers*
Quality Withhold	$ (3,826,164)	$ (1.27)	$ (1,829,941)	$ (0.62)	$ 1,996,223	
Enhanced Care Management	$ 17,753,075	$ 5.91	$ 17,202,793	$ 5.85	$ (550,282)	
Prop 56 / Hyde	$ 11,076,455	$ 3.69	$ 11,372,855	$ 3.87	$ 296,400	
Plan Arrangement	$ -		$ 6,181,973	$ 2.10	$ 6,181,973	*Projected 2024 Rate increase of 8% from DHCS*
Totals	**$ 1,073,314,618**	**$ 357.28**	**$ 1,084,726,719**	**$ 368.76**	**$ 11,412,101**	
C. Medical Expenses:						
1. Fee For Service (FFS):						
Category of Service						
01-Inpatient Hospital	$ 216,179,634	$ 71.96	$ 239,409,359	$ 81.39	$ (23,229,725)	*$12M associated with Dignity revised contract and IP unit cost increases in Adults and ACA Expansion*
02-Outpatient Facility	$ 91,342,329	$ 30.41	$ 100,653,835	$ 34.22	$ (9,311,506)	*Increased utilization across multiple COAs*
03-Emergency Room	$ 38,656,616	$ 12.87	$ 39,744,451	$ 13.51	$ (1,087,835)	
04-Long-Term Care	$ 184,618,913	$ 61.46	$ 175,491,000	$ 59.66	$ 9,127,913	*Change in rate development methodology*
05-Physician Primary Care	$ 23,012,175	$ 7.66	$ 24,955,684	$ 8.48	$ (1,943,509)	
06-Physician Specialty	$ 86,250,542	$ 28.71	$ 94,810,773	$ 32.23	$ (8,560,231)	*Increased utilization in Adult, ACA, OE, and SPD-LTC*
07-FQHC	$ 18,848,776	$ 6.27	$ 26,193,437	$ 8.90	$ (7,344,661)	*Increased utilization in Adult, ACA, OE, and SPD-LTC*
08-Other Medical Professional	$ 4,858,907	$ 1.62	$ 4,991,613	$ 1.70	$ (132,706)	
09-Mental Health - Outpatient	$ 23,618,940	$ 7.86	$ 39,418,086	$ 13.40	$ (15,799,147)	*Increased utilization in Child and LTC COAs*
10-BHT Services	$ 17,884,328	$ 5.95	$ 9,203,757	$ 3.13	$ 8,680,570	*Partial offset in Mental Health outpatient*
12-Laboratory and Radiology	$ 9,821,301	$ 3.27	$ 10,056,728	$ 3.42	$ (235,427)	
13-Transportation	$ 2,162,439	$ 0.72	$ 2,436,029	$ 0.83	$ (273,589)	
14-CBAS	$ 12,127,643	$ 4.04	$ 11,440,258	$ 3.89	$ 687,385	
15-Hospice	$ 6,079,895	$ 2.02	$ 5,227,187	$ 1.78	$ 852,708	
16-HCBS Other	$ 3,073,344	$ 1.02	$ 2,295,177	$ 0.78	$ 778,167	
17-All Other	$ 16,989,511	$ 5.66	$ 39,112,406	$ 13.30	$ (22,122,895)	*Reconciliation between projected rates and YTD actuals*
18-Enhanced Care Management	$ 16,865,421	$ 5.61	$ 16,342,653	$ 5.56	$ 522,768	
19-Community Supports	$ 8,120,368	$ 2.70	$ 10,044,627	$ 3.41	$ (1,924,260)	*Utilizaton of Community Support claims up among all COAs*
Totals	**$ 780,511,081**	**$ 259.81**	**$ 851,827,062**	**$ 289.58**	**$ (71,315,981)**	
2. Provider Sub-Capitation						
Clinicas	$ 36,694,357	$ 12.21	$ 25,160,123	$ 8.55	$ 11,534,234	*Change in capitation agreement (going to FFS)*
VCMC	$ 15,430,743	$ 5.14	$ 16,778,572	$ 5.70	$ (1,347,829)	
Dignity	$ 1,007,023	$ 0.34	$ 1,823,343	$ 0.62	$ (816,320)	
CMH	$ 4,800,275	$ 1.60	$ 5,419,529	$ 1.84	$ (619,254)	
VSP (Vision)	$ 2,373,265	$ 0.79	$ 2,317,332	$ 0.79	$ 55,934	
VTS (Transportation)	$ 16,161,140	$ 5.38	$ 15,546,655	$ 5.29	$ 614,485	
Other Providers	$ 786,512	$ 0.26	$ 1,204,117	$ 0.41	$ (417,605)	
Totals	**$ 77,253,316**	**$ 25.72**	**$ 68,249,670**	**$ 23.20**	**$ 9,003,646**	
3. Quality Strategy						
QIPP	$ 50,000,000	$ 16.64	$ 41,333,808	$ 14.05	$ 8,666,192	*Aligning strategic reserves with Quality Strategy*
Transitional Rates	$ 20,000,000	$ 6.66	$ (1,279,394)	$ (0.43)	$ 21,279,394	*Reversal of Behavioral Health withhold*
Provider Grant Program	$ 12,500,000	$ 4.16	$ 12,500,000	$ 4.25	$ -	
Total	**$ 82,500,000**	**$ 27.46**	**$ 52,554,414**	**$ 17.87**	**$ 29,945,586**	
4. Other Expenditures						
Prop 56	$ 9,595,654	$ 3.19	$ 10,392,054	$ 3.53	$ (796,400)	
Carelon Case Management	$ 2,500,000	$ 1.16	$ 2,500,000	$ 0.85	$ -	*Not included in EHC File*
GEMT	$ 3,471,857	$ 1.16	$ 2,914,025	$ 0.99	$ 557,832	
Reinsurance, net of recoveries	$ 1,900,000	$ 0.63	$ 3,870,636	$ 1.32	$ (1,970,636)	
TRI Reimbursement Pass Through	$ 16,945,324	$ 5.64	$ -	$ -	$ 16,945,324	*TRI captured in FFS rates*
Claim Recoveries, non-system adjusted	$ (1,200,000)	$ (0.40)	$ (1,200,000)	$ (0.41)	$ -	
Total	**$ 33,212,835**	**$ 11.38**	**$ 18,476,715**	**$ 6.28**	**$ 14,736,120**	
D. MBR Portion of Admn Expenses (Care Coord)	**$ 34,708,829**	**$ 11.55**	**$ 27,311,311**	**$ 9.28**		
Total Medical Expenses	$ 1,008,186,061	$ 335.93	$ 1,018,419,172	$ 346.22		
MBR (**with** Care Management)	93.9%		93.9%			
MBR (**without** Care Management)	90.7%		91.4%			
E. Administrative Expenses	**$ 109,319,464**	**$ 36.39**	**$ 139,418,367**	**$ 47.40**		

	Original Budget		Revised Budget		Fav/(Unfav)	Variance Explanation
A. Membership						
F. Interest Income	**$ (16,000,000)**	**$ (5.33)**	**$ (18,000,000)**	**$ (6.12)**		
Net Financial Position	**$ (28,190,908)**	**$ (0.13)**	**$ (55,110,820)**	**$ (18.74)**		

Original Budget vs Revised Budget Summary

Members	244,620
Member months	2,941,574

($Ms)		ORIG BDGT	pmpms and %s	6+6 REV BDGT	pmpms and %s	Variance
Revenue	Premium Revenue	$ 1,073.300		$ 1,084.727		$ 11.427
	Investment Revenue	$ 16.000		$ 18.000		$ 2.000
	Total Revenue	$ 1,089.300	$ 356.16	$ 1,102.727	$ 374.88	$ 13.427
						$ -
Medical Benefits	Medical Cost: FFS	$ 780.511		$ 857.241		$ (76.730)
	Medical Cost: Capitation	$ 77.253		$ 68.250		$ 9.003
	Quality Funding Program	$ 82.500	92.6%	$ 52.554	92.4%	$ 29.946
	Other	$ 33.213		$ 13.063		$ 20.150
	Care Mgmt	$ 34.709		$ 27.311		$ 7.398
	Total Medical Benefits	$ 1,008.186	$ 307.18	$ 1,018.419	$ 346.22	$ (10.233)
						$ -
Admin Costs	Core Admin (labor)	$ 56.513		$ 60.383		$ (3.871)
	Core Admin (non-labor)	$ 74.146		$ 80.039		$ (5.893)
	Care Mgmt credit	$ (34.709)	10.0%	$ (27.311)	12.6%	$ (7.398)
	Ops of the Future	$ 4.000		$ 21.522		$ (17.522)
	D-SNP	$ 2.400		$ 4.785		$ (2.385)
	Strategic Initiatives	$ 6.970		$ -		$ 6.970
	Total Admin Cost	$ 109.320		$ 139.418		$ (30.099)
	Total Cost	$ 1,117.506		$ 1,157.838		$ (40.332)
	Surplus/(Deficit)	$ (28.206)		$ (55.111)		$ (26.905)

Account	Account Title	Original Budget	Revised Budget	Fav/(Unfav) variance	Drivers
	Labor				
various	Salary / Benefits	$ 56,325,033	$ 60,383,428	$ (4,058,395)	Increased Headcount / Provider Call Center - Mailroom Staff Conversion
7240	Overtime	$ 242,916	$ 503,743	$ (260,827)	$277K Ops $64K Network $94K UM $33K CM
7205	Bonus	$ 2,500,000	$ 4,844,330	$ (2,344,330)	Increased Headcount / Provider Call Center - Mailroom Staff Conversion
7210	Temporary Labor Expense	$ 647,800	$ 2,307,518	$ (1,659,718)	($1.0M) IT Temps Jul - Nov - zero last 7 mos. ($0.3M) OOTF Analyst (Liza) - cc110 ($0.2M) G&A Temps ($27K/mo.) - cc121 ($0.2M) Gelmy Ruiz - cc145
7470	Tuition Reimbursement	$ 50,400	$ 34,560	$ 15,840	
	Training, Conference, and Travel				
7500	Staff Training and Seminars	$ 397,617	$ 333,131	$ 64,486	
7510	Conferences	$ 466,626	$ 343,932	$ 122,694	
7520	Meetings & Events	$ 887,333	$ 832,555	$ 54,778	
7600	Travel Expense - Airlines	$ -	$ 36,481	$ (36,481)	
7610	Travel Expense - Hotel	$ -	$ 77,605	$ (77,605)	
7620	Travel Expense - Auto & Transportation	$ -	$ 34,350	$ (34,350)	
7630	Travel Expense - Meals	$ -	$ 11,128	$ (11,128)	
7640	Travel Expense - Misc./ Tips	$ -	$ 5,171	$ (5,171)	
	Outside Services				
6070	Outside Service - ACS	$ 2,384,918	$ 6,622,101	$ (4,237,182)	($4.2M) Shifted from [6340] in - cc120
6340	Outside Services - Other	$ 34,673,245	$ 11,982,811	$ 22,690,434	$4.9M NetMark claims adjudication shift to [6070] - cc120 $4.5M Wellth - Continuation of QI/MCAS program - cc173 $1.3M NetMark - claims processor - cc127 $1M TPA implementation $1M - cc190 $1M CareNet Hedis gap closure $1M - cc140 $0.8M NetMark claims UAT training $0.7M Carelon delegated BH $0.2M Azure (MDW) - cc115
6342	Claims Administration Expense		$ 5,655,495	$ (5,655,495)	BH Carelon and College health claims admin expense shifted from Medical expense in original budget
6345	Outside Service - Member Incentive		$ 7,865,226	$ (7,865,226)	($2.2M) shift from [6340] Wellth - cc173 ($1.8M) shift from [8400] - cc140
	Professional Services				
6300	Accounting & Actuarial Services	$ 180,000	$ 264,749	$ (84,749)	HMA budget shifted from [6320] - cc110
6310	Legal Expense	$ 2,550,000	$ 4,175,379	$ (1,625,379)	Dignity $900K, PMH $100K, legal settlement $600K paid to Stevenson law firm
6320	Consulting Services Expense	$ 2,450,066	$ 5,899,532	$ (3,449,466)	($1.5M) Inovalon Data Lake not incl. in Original Budget - cc140 ($0.4M) Culture Partners shifted from Strategic Initiatives - cc180 ($0.4M) Ironwood shiftd from Strategic Initiatives - cc190 ($0.3M) Jennifer Gonyea / Elizabeth Strammiello (Jan-Jun 2025) - cc120 ($0.3M) Divergent (Aug-Sep 2024) - cc120
6335	Translation Services	$ 292,000	$ 357,667	$ (65,667)	
6360	Committee/Advisory	$ -	$ 1,625	$ (1,625)	
8410	EE Recruitment	$ 1,000,000	$ 1,158,858	$ (158,858)	CEO Search - cc180
	Occupancy, Supplies, Insurance and Others				
7490	Employee Appreciation	$ 5,750	$ 152,550	$ (146,800)	($150K) Bucket List transferred from Strategic Initiatives - cc180
7700	Lease Expense -Office	$ -	$ (2,384)	$ 2,384	
7710	Lease Expense -Equipment	$ 12,800	$ 6,502	$ 6,298	
7720	Lease Expense ROU	$ 1,592,628	$ 1,478,606	$ 114,022	GASB 96 reclass from [8610] Lease Expense
7810	Depreciation & Amortization Expense	$ 4,000,000	$ 9,556,814	$ (5,556,814)	Increased Amortization due from OOTF
7900	Non-Capital - Furniture & Equip.	$ 8,400	$ 18,807	$ (10,407)	
7910	Non-Capital Equipment - Computer	$ 196,800	$ 434,272	$ (237,472)	Provider Call Center laptops
7920	Office & Operating Supplies	$ 77,674	$ 110,336	$ (32,662)	
8000	Shipping & Postage Expense	$ 546,530	$ 978,282	$ (431,752)	DHCS required communication - cc120
8010	Printing Expense	$ 1,127,300	$ 1,674,539	$ (547,239)	DHCS required communication - cc120
8020	Software Subscriptions	$ 13,390,776	$ 6,597,284	$ 6,793,492	Shift to OOTF
8021	Software Licenses-Non-Capital	$ 48,756	$ 32,419	$ 16,337	
8025	Software Maintenance & Support	$ 2,117,925	$ 1,225,426	$ 892,499	Shift to OOTF
8030	Equipment Repairs & Maintenance	$ 291,107	$ 277,196	$ 13,911	
8200	Telephone Services/ Internet Charges	$ 613,532	$ 494,787	$ 118,745	
8400	Advertising and Promotion Expense	$ 1,795,000	$ 495,582	$ 1,299,418	$1.8M shift to [6345] OS Member Incentive - cc140
8500	Insurance	$ 1,515,000	$ 1,672,948	$ (157,948)	
8600	Interest Exp	$ 225,000	$ 1,145,123	$ (920,123)	Increased Claims Interest Expense
8610	Interest Expense ROU	$ -	$ 246,273	$ (246,273)	GASB 96 reclass from Lease Expense [7720]
8700	Prof Dues, Fees and Licenses	$ 276,751	$ 279,903	$ (3,151)	
8710	Subscriptions and Publications	$ 47,114	$ 88,822	$ (41,708)	
8750	Other/ Miscellaneous Expenses	$ 113,000	$ 318,729	$ (205,729)	CEO Contingency
6150	Bank Service Fees Expense	$ 9,000	$ 4,823	$ 4,177	
8720	ARCH/Community Grants	$ -	$ 346,066	$ (346,066)	Community Grants Mixteco, Community Action of VC, El Concilio family services $346K - cc145
8730	Sponsorships		$ 57,709	$ (57,709)	
	Total G&A Expense	**$ 133,058,798**	$ 141,422,789	$ (8,363,991)	
	Targeted Savings		$ (1,000,000)	$ 1,000,000	Targeted Savings TBD

Account	Account Title	Original Budget	Revised Budget	Fav/(Unfav) variance	Drivers
	CMC	$ (34,708,000)	$ (27,311,311)	$ (7,396,689)	2024/25 QI Survey
	Core Admin Total	**$ 98,350,798**	**$ 113,111,478**	**$ (14,760,680)**	
	OOTF	$ 4,000,000	$ 21,521,889	$ (17,521,889)	Commission Approved
	D-SNP	$ -	$ 4,785,000	$ (4,785,000)	Commission Approved
	Strategic Initiatives	$ 6,968,667	$ -	$ 6,968,667	
	Total	**$ 109,319,464**	**$ 139,418,367**	**$ (30,098,903)**	

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Felix Nunez, Acting Chief Executive Officer

DATE: January 27, 2025

SUBJECT: Advance Payment Agreement to County of Ventura

Summary and Background

Gold Coast Health GCHP (GCHP) management seeks approval to provide an advance payment to the County of Ventura, for its Health Care Agency (VCHCA). This Advance Payment Agreement (APA) would be effective January 28, 2025. The APA would specify terms for a one-time payment in the amount of twenty-six million dollars ($26,000,000.00) made by GCHP to the County of Ventura as a payment made in advance of VCHCA services to be performed pursuant to the primary care provider, specialist, and hospital Provider Agreements and GCHP's complete processing of applicable claims. This funding is allowable for reasons stated below, including that it is to a governmental entity for the public purpose of supporting the continued operation and viability of a Safety Net Provider, which is essential to the ability of GCHP to provide an adequate network for its members.

The APA details an Advance Payment that would be fully recouped within a five-month period. The Advance Payment would support VCHCA's critical operational expenses and is necessary due to a cash flow strain impacted by delays in supplemental funding reimbursement from the State of California.

Major terms of the APA are as follows:

- A one-time Advance Payment would be made on February 1, 2025.
- The funds will be recouped from VCHCA in April, May, and June of 2025.
- GCHP will offset against the Advance Payment from capitation payments, fee-for-service payments relating to claims submitted or processed for payment, or any other amounts due to VCHCA for the applicable month.
- The maximum offsets for each month are:
    - April 2025: $2,000,000
    - May 2025: $12,000,000
    - June 2025: $12,000,000
- If the advance payment has not been fully repaid by June 30, 2025, upon the written request of GCHP, VCHCA shall within thirty days of such request pay to GCHP the amount necessary to repay the Advance Payment in full. In addition, GCHP may continue to offset any unpaid amount against capitation payments, fee-for-service payments

relating to claims submitted or processed for payment, or any other amounts due to VCHCA for subsequent months.[1]

- To reimburse GCHP for the additional costs of administering this Advance Payment, a fee of $297,000 will be assessed and offset from payments due to VCHCA starting in April 2025.
- The APA requires GCHP and VCHCA to collaborate in strategic planning activities and permits the GCHP CEO and the VCHCA Director to establish a Strategic Planning Collaborative with the goal of improving and advancing the health care system, specifically hospital services, in Ventura County.

This Advance Payment Funding Agreement does not constitute a gift of public funds because (1) the funds advanced will be fully recouped within five months as described above, and (2) the advance payment includes an administrative fee that was calculated to account for any lost opportunity cost associated with investment of GCHP reserves and related costs. Therefore, the temporary advance of funds from GCHP reserves is not anticipated to result in lost revenue or additional costs to GCHP. Even if the administrative fee were insufficient to cover all costs associated with the advance payment, the payment would not be considered a prohibited gift of public funds because, as described above, the funding is to a governmental entity for a public purpose (Cal Const art XVI, Section 6, *City and County of San Francisco* (1932) 216 C 187, 193), and further such funding further serves a purpose of GCHP, the donor agency. (Golden Gate Bridge & Hwy. Dist. v. Luehring, 4 Cal.App.3d 204 (1970).)

This request for an advance on capitation and claims payments is specifically within the authority and purpose of the Commission. The statutory purpose of the Commission is to "meet the problems of the delivery of publicly assisted medical care in the county and to demonstrate ways of promoting quality care and cost efficiency." (Welf. & Inst. Code §14087.53.) The County Board of Supervisors ordinance establishing the Commission requires the Commission to, among other things, implement "reimbursement mechanisms which promote the long-term viability of a locally operated Medi-Cal managed care system and the existing participating provider networks inclusive of 'Safety Net' providers herein defined as Medi-Cal disproportionate share hospitals, county clinics, federally qualified health centers, and licensed rural health clinics" (Ord. 4613, Art. 6, 1380-4(c).).

Financial Impact

The Advance Payment will result in a temporary reduction in GCHP's reserves. This is not anticipated to have additional financial impact as the administrative fee was calculated to mitigate direct and opportunity costs of providing the advance amount.

[1] This Advance Payment would not be subject to VCHCA's ability to satisfy repayment of any loans or other outstanding payments it may have because it will be directly offset by amounts due to VCHCA by GCHP in future months.

Recommendation

The GCHP recommends that the Ventura County Medi-Cal Managed Care Commission authorize the CEO to execute the Advance Payment Agreement in the amount of $26,000,000 with the County of Ventura.

AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: James Cruz, MD, Acting Chief Medical Officer
Kim Timmerman, MHA, CPHQ, Sr. Director of Quality Improvement

DATE: January 27, 2025

SUBJECT: Quality Improvement and Health Equity Committee 2025 First Quarter Report

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:

- 2025 Quality Improvement and Health Equity Transformation Program Description
- 2025 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 2025 Quality Improvement and Health Equity Transformation Program Description and Work Plan as presented and receive and file the complete report as presented.

ATTACHMENTS:

1) Timmerman, K., (2025). Quality Improvement, Ventura County Medi-Cal Managed Care Commission, Quality Improvement and Health Equity Transformation Program Description and Work Plan, Presentation Slides.

Gold Coast Health Plan℠
A Public Entity

Quality Improvement and Health Equity Committee 2025 First Quarter Report

January 27, 2025

James Cruz, MD, Acting Chief Medical Officer
Kim Timmerman, Sr. Director Quality Improvement

Integrity
Accountability
Collaboration
Trust
Respect

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Quality Improvement and Health Equity Transformation: Approval Items

- 2025 Quality Improvement and Health Equity Transformation Program Description
- 2025 Quality Improvement and Health Equity Transformation Work Plan

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2025 QIHET Program Description Annual Updates

The Quality Improvement and Health Equity Transformation (QIHET) Program Description supports GCHP's mission to improve the health of our members through the provision of high-quality care and services.

The annual review of the QIHET Program Description serves to:

- Define and update processes for continuous quality improvement of clinical and non-clinical care and services, patient safety, health equity, and member experience.
- Ensure continued alignment with the Department of Health Care Services (DHCS) Quality Strategy and contractual requirements.
- Address requirements of the National Committee for Quality Assurance (NCQA) Health Plan and Health Equity Accreditation standards.

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QIHET Program Description Key Updates

Enhancements to Address Health Disparities

- ❑ Assessment of committee members to ensure that community advisory bodies reflect the diversity of the Plan's community and membership
- ❑ Assessment of systems and activities that promote high quality and equitable services for members
- ❑ Assessment of resources dedicated to addressing health disparities

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QIHET Program Description Key Updates

Program Organization, Oversight Resources and Evaluation

- Added new Member Advisory Committee
- Added the annual evaluation of the Culturally and Linguistically Appropriate Services (CLAS) Program Description and Work Plan
- Added new role and description: *Executive Director of Health Equity*
- Updated organization charts and the QIHETP resources

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QIHET Program Description Key Updates

Quality Committees and Subcommittees

Updated committee role and membership

- Quality Improvement & Health Equity Committee
- Member Services Committee
- Grievances & Appeals Committee
- Utilization Management Committee
- Health Education & Cultural Linguistics Committee
- Credentials/Peer Review Committee
- Pharmacy & Therapeutics Committee
- NCQA Key Stakeholder Forum
- MCAS Operations Steering Committee
- Behavioral Health Quality Committee

Retired the Medical Advisory Committee

- Approval of Clinical Practice, Preventive Health, and UM Guidelines transitioned to the Credentials/Peer Review Committee

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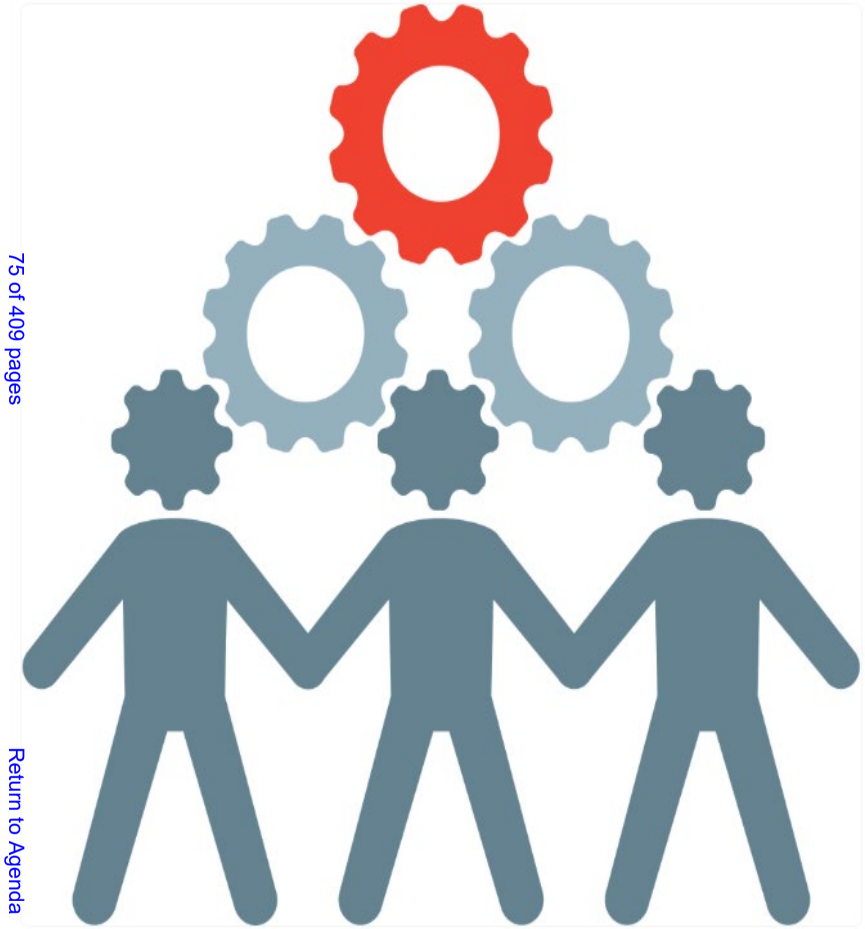
QIHET Program Description Key Updates



Key Functional Areas

Program descriptions updated for the following key functional areas:

- Population Health Management
- Care Management
- Utilization Management
- Behavioral Health
- Pharmacy Services
- Culturally and Linguistically Appropriate Services

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2025 QIHET Work Plan Updates

- Serves as the roadmap to outline specific, measurable, timebound, and multidisciplinary objectives, activities and goals focused on improving key performance indicators.
- Integrates cross functional goals across the organization that comprise key activities to improve member care and service
- 51 focus areas reviewed
  - Updated goals and activities
  - Added 2025 completion dates

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QIHET Work Plan Key Updates

Objective 1: Improve Quality & Safety of Clinical Care Services

- **Focus areas:** QIHET Structural Components, Population Health (PNA, Wellth, HRA), Clinical Guidelines, Care Management, Advance Prevention, Pharmacy, MCAS Measures (Behavioral Health, Cancer Prevention, Chronic Disease, Women's Health, Children's Health), DHCS Improvement Projects
- **Activities**: 32 continued from 2024 and 5 new added = 37

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

- **Focus areas:** Culturally and Linguistically Appropriate Services (CLAS), Network Adequacy (Access, After Hours Availability, Provider Satisfaction), Facility Site Reviews, Credentialing/Re-Credentialing
- **Activities**: 8 continued from 2024

Objective 3: Improve Quality of Services

- **Focus areas:** Grievances & Appeals, Call Center Monitoring
- **Activities:** 2 continued from 2024

Objective 4: Assess and Improve Member Experience

- **Focus areas:** Consumer Assessment of Healthcare Providers and Services (CAHPS)
- **Activities:** 3 continued from 2024

Objective 5: Ensure Organizational Oversight of Delegated Activities

- **Focus areas:** Delegation oversight audits and corrective action caps as needed.
- **Activities:** All audit focus areas continued from 2024 with the addition of Population Health Management in 2025

➢ 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

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Objective 1: Improve Quality & Safety of Clinical Care Services

	Measures / Activities	Goal	Department
1	2025 Quality Improvement & Health Equity Transformation (QIHET) Program Description	Update the 2025 QIHET Program Description	Quality Improvement
2	2025 QIHET Work Plan	Update the 2025 QIHET Work Plan	Quality Improvement
3	2024 QIHET Program and Work Plan Evaluation	Complete the 2024 QIHET Program and Work Plan Evaluation	Quality Improvement
4 ***New***	2025 Culturally and Linguistically Appropriate Services (CLAS) Program Description and Work Plan	Update the 2025 CLAS Program Description and Work Plan	Health Education / Cultural Linguistics
5 ***New***	2024 CLAS Work Program and Work Plan Evaluation	Complete the 2024 CLAS Program and Work Plan Evaluation	Health Education / Cultural Linguistics
6	2025 HEDIS® Compliance Audit™	Successfully complete and pass the annual HEDIS® Compliance Audit™ and receive reportable status for all measures.	Quality Improvement
7	Population Needs Assessment (PNA)	Maintain NCQA compliant PNA as part of the Population Health Strategy Report submitted to DHCS.	Population Health
8	Wellth Program	Maintain and expand QI-focused programs with Wellth for Medi-Cal members 18+ years of age, taking at least one medication, and have multiple MCAS care gaps	Population Health
9 ***New***	Health Risk Assessment	Further develop and expand use of the HRA to meet the CalAIM annual requirement.	Population Health
10	Utilization Management: Preventive Health, Clinical Practice, and UM Guidelines	Complete annual review and adoption of evidence-based Preventive Health Guidelines (PHG), including Diabetes and Asthma Clinical Practice Guideline (CPG), and UM Guidelines.	Utilization Management

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Objective 1: Improve Quality & Safety of Clinical Care Services

	Measures	Goal	Department
11	Complex Case Management	Maintain and monitor a standardized Turn Around (TAT) process for members identified as eligible for complex case management per NCQA CCM requirements	Care Management
12	Case Management: Care Gap Closure	Implement strategies to close care gaps for MCAS measures	Care Management
13	Tobacco Cessation	Increase rate of tobacco cessation counseling and utilization of tobacco cessation medication in members identified as tobacco users	Health Education / Cultural Linguistics
14	Initial Health Appointment (IHA)	Increase rates of Initial Health Appointment (IHA) completion by providers	Quality Improvement
15	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 prior quarter.	Pharmacy
16	Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness – 30 Days (FUM)	Increase the FUM-30 rate to exceed the DHCS MPL (50th percentile).	Behavioral Health
17	Behavioral Health: Follow-Up After Emergency Department Visit for Substance Use – 30 Days (FUA)	Increase the FUA-30 rate to exceed DHCS MPL (50th percentile).	Behavioral Health
18	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
19	2024-2025 DHCS/IHI Behavioral Health Collaborative	DHCS / IHI / VCBH Collaborative focused on improving the existing navigator workflows at the county-run hospital (Ventura County Medical Center) to improve outcomes for individuals who visit the ED for an FUA and FUM condition.	Behavioral Health

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Objective 1: Improve Quality & Safety of Clinical Care Services

	Measures	Goal	Department
20	Breast Cancer Screening (BCS)	Increase the percentage of members 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
21	Cervical Cancer Screening (CCS)	Increase percentage of members 21-64 years of age who were screened for cervical cancer to meet or exceed the DHCS HPL (90th percentile)	Quality Improvement
22	Colorectal Cancer Screening (COL)	Increase the percentage of members 45 to 75 years of age who had an appropriate screening for colorectal cancer to meet the Medicare 50th percentile	Quality Improvement
23	Asthma Medication Ratio (AMR)	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 exceed the DHCS MPL (50th percentile)	Quality Improvement Pharmacy
24 ***New***	Asthma Medication Ratio (AMR)	2025 DHCS Lean Quality Improvement and Health Equity Improvement Project: Implement multi-disciplinary continuous quality improvement activities to improve the Asthma Medication Ratio measure	Quality Improvement
25	Health Equity Controlling Blood Pressure (CBP)	Increase the percentage of members with hypertension who are 21-44 years of age and have a blood pressure rate of <140/90 to exceed the DHCS MPL (50th percentile).	Quality Improvement Population Health
26	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
27	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
28	Prenatal and Postpartum Care (PPC)	Increase the percentage of members with live birth deliveries who completed timely prenatal and postpartum exams to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement

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Objective 1: Improve Quality & Safety of Clinical Care Services

	Measures	Goal	Department
29	Childhood Immunization Status – Combo 10 (CIS-10)	Increase the percentage of members who completed all Combo-10 immunizations by their 2nd birthday to exceed the 75th national NCQA Medicaid percentile	Quality Improvement
30	Immunization Status for Adolescents – Combo 2 (IMA-2)	Increase the percentage of members who completed all IMA-2 immunizations by their 13th birthday to exceed the 75th national NCQA Medicaid percentile	Quality Improvement
31	Developmental Screening in the First Three Years of Life (DEV)	Increase the percentage of members 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 prior measurement year	Quality Improvement
32	Lead Screening in Children (LSC)	Increase the percentage of members who had one or more capillary or venous blood lead tests for lead poisoning by their 2nd birthday to meet the 75th national NCQA Medicaid percentile	Quality Improvement
33	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 exceed the DHCS MPL (50th percentile)	Quality Improvement
34	Well-Child Visits in the First 30 Months of Life (W30)	Increase the percentage of members who had well-child visits with a PCP to exceed the DHCS MPL (50th percentile)	Quality Improvement
35	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 exceed the DHCS MPL (50th percentile)	Quality Improvement
36	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
37	2024-2025 DHCS Child Health Equity Focused Collaboration on Well-Care Exams	Improve the completion of well-child visits	Quality Improvement

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

	Measures	Goal	Department
38	Cultural and Linguistic Needs & Preferences	• Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules to 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 • HECL Department shall conduct Cultural and Linguistic (C&L)/DEI trainings with threeNetwork Provider offices per quarter. • HECL Department shall report on the number of C&L fulfilment and benchmarks quarterly to QIHEC	Health Education / Cultural Linguistics
39	Primary and Specialty Care Access	Ensure primary and specialty care access standards met for minimum of 80% of providers	Provider Network Operations
40	Network Adequacy	Assess and improve network adequacy as demonstrated by availability of practitioners	Provider Network Operations
41	After Hours Availability	Conducts surveys to ensure members are able to reach a provider after hours	Provider Network Operations
42	Provider Satisfaction	Field provider survey and develop action plan(s) to improve areas of low performance	Provider Network Operations

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

	Measures	Goal	Department
43	Facility Site Review Requirements	Maintain 100% compliance with Facility Site Review (FSR) requirements	Quality Improvement
44	Physical Accessibility Review Surveys (PARS)	Complete Physical Accessibility Reviews (PARs) 100% on time	Quality Improvement
45	Credentialing/Recredentialing	Maintain a well-defined credentialing and recredentialing process for evaluating practitioners/ providers to provide care to members	Provider Network Operations

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Objective 3: Improve Quality of Services

	Measures	Goal	Department
46	Grievances and Appeals	Monitor all member grievances and appeals to identify trending issues. Communicate trends to relevant departments to develop actionable plans aimed at addressing highly reported concerns and improve the overall member experience	Grievances and Appeals
47	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

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Objective 4: Assess and Improve Member Experience

	Measures	Goal	Department
48	CAHPS: Surveys	Coordinate with DHCS and HSAG to complete the CAHPS surveys and to monitor and improve CAHPS scores	Quality Improvement
49	CAHPS: Access to Specialty Care	Improve access to specialty care for adults and children	Operations Strategy/External Affairs Quality Improvement
50	CAHPS: Improve CAHPS Scores	Improve CAHPS scores based on MY 2024 CAHPS outcomes, including Getting Care Quickly and Getting Needed Care	Operations Strategy/External Affairs Quality Improvement

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Objective 5: Delegation Oversight

	Measures	Goal	Department
51	Delegation Oversight • Credentialing • Quality Improvement • Utilization Management • Member Experience • Claims • Call Center • Cultural and Linguistics • Transportation (NEMT/NMT) • Population Health Management	100% of all audits completed at least annually with corrective action plans (CAPs) closed timely	Compliance

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Questions?

Recommendation:

Approve the 2025 Quality Improvement and Health Equity Transformation Program Description and Work Plan

Thank you

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Gold Coast Health Plan℠
A Public Entity

~~2024 Quality Improvement & Health Equity Transformation Work Plan~~2025 Quality Improvement & Health Equity Transformation Work Plan

QIHEC Approved: January 21, 2025
Commission Approved: ~~TBD~~January 27, 2025

GOLD COAST HEALTH PLAN

Reference Guide

	Metric	Goal	Department
1	~~2024~~ 2025 Quality Improvement & Health Equity Transformation (QIHET) Program Description	Update the ~~2024~~ 2025 QIHET Program Description.	Quality Improvement
2	~~2024~~ 2025 Quality Improvement and Health Equity Transformation Work Plan	Update the ~~2024~~ 2025 QIHET Work Plan	Quality Improvement
3	~~2023~~ 2024 Quality Improvement and Health Equity Transformation Program and Work Plan Evaluation	Complete the ~~2023~~ 2024 QIHET Program and Work Plan Evaluation.	Quality Improvement
4	2025 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Description	Update the 2025 CLAS Program Description and Work Plan	Health Education & Cultural Linguistics
5	2024 CLAS Program and Work Plan Evaluation	Complete the 2024 CLAS Program and Work Plan Evaluation.	Health Education & Cultural Linguistics
~~4~~6	~~2024~~ 2025 HEDIS® Compliance Audit™	Successfully complete and pass the annual HEDIS® Compliance Audit™ and receive "reportable" status for all measures.	Quality Improvement
~~5~~7	Population Needs Assessment (PNA)	Maintain NCQA compliant PNA as part of the Population Health Strategy Report submitted to DHCS. ~~NCQA compliant PNA is part of the Population Health Strategy Report submitted to DHCS.~~	Population Health
~~6~~8	Wellth Program	~~Implement~~ Maintain and expand 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
9	Health Risk Assessment	Further develop and expand use of the HRA to meet the CalAIM annual requirement.	Population Health
~~7~~10	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
~~8~~11	Complex Case Management	~~Develop and implement~~Maintain and monitor a standardized turn-around-time (TAT) process for members identified as eligible for complex case management per NCQA CCM requirements.	Care Management
~~9~~12	Care Gap Closure	Implement strategies to close care gaps for MCAS measures.	Care Management
~~10~~13	Tobacco Cessation	Increase the rate of tobacco cessation counseling and utilization of tobacco cessation medication~~interventions~~ in members identified as tobacco users.	Health Education / Cultural Linguistics
~~11~~14	Initial Health Appointment (IHA)	Increase rates of Initial Health Appointment (IHA) completion by providers.	Quality Improvement
~~12~~15	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
~~13~~16	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

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	Metric	Goal	Department
~~14~~17	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~~18	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
~~16~~19	2024-2025 DHCS/IHI Behavioral Health Collaborative	DHCS / IHI / VCBH Collaborative focused on improving the existing navigator workflows at the county-run hospital (Ventura County Medical Center) to improve outcomes for individuals who visit the ED for an FUA and FUM condition.	Behavioral Health
~~17~~20	Breast Cancer Screening (BCS)	Increase the percentage of ~~women~~ members 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
~~18~~21	Cervical Cancer Screening (CCS)	Increase percentage of ~~women~~ members 21-64 years of age who were screened for cervical cancer to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement
~~19~~22	Colorectal Cancer Screening (COL)	Increase the percentage of members 45 to 75 years of age who had an appropriate screening for colorectal cancer to meet the Medicare 50th percentile.~~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
~~20~~23	Asthma Medication Ratio (AMR)	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).	Quality Improvement Pharmacy
24	Asthma Medication Ratio (AMR)	Implement multi-disciplinary continuous quality improvement activities to improve the Asthma Medication Ratio.	Quality Improvement
~~21~~25	Health Equity Controlling Blood Pressure (CBP)	Increase the percentage of members with hypertension who are 21-44 years of age and have a blood pressure rate of <140/90 to ~~meet or~~ exceed the DHCS MPL (50th percentile).~~Increase the CBP rate for members 21-44 years of age to meet or exceed the DHCS MPL (50th percentile).~~	Quality Improvement Population Health
~~22~~26	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
~~23~~27	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
~~24~~28	Prenatal and Postpartum Care (PPC)	Increase the percentage of ~~women~~ members with live birth deliveries who completed timely prenatal and postpartum exams to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement
~~25~~29	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

	Metric	Goal	Department
~~26~~30	Immunization Status for Adolescents – Combo 2 (IMA-2)	Increase the percentage of ~~adolescents~~ members who completed all IMA-2 immunizations by their 13th birthday to exceed the 75th national Medicaid percentile established by NCQA. ~~the NCQA established to DHCS MPL (50th percentile).~~	Quality Improvement
~~27~~31	Developmental Screening in the First Three Years of Life (DEV)	Increase the percentage of ~~children~~ members 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
~~28~~32	Lead Screening in Children (LSC)	Increase the percentage of ~~children~~ members 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
~~29~~33	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
~~30~~34	Well-Child Visits in the First 30 Months of Life (W30)	Increase the percentage of ~~children~~ members who had well-child visits with a PCP to ~~meet or~~ exceed the DHCS MPL (50th percentile)	Quality Improvement
~~31~~35	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~~ MPL (~~90th~~ 50th percentile).	Quality Improvement
~~32~~36	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~~37	2024-2025 DHCS Child Health Equity Focused Collaboration on Well-Care Exams	Improve the completion of well-child visits.	Quality Improvement
~~34~~38	Cultural and Linguistic Needs & Preferences	• By July 31, 2025~~4~~, GCHP's Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules ~~from four to seven which will~~to 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, 2025~~4~~, GCHP's HECL Department shall conduct three Cultural and Linguistic (C&L)/DEI trainings with ~~three~~ Network Provider offices per quarter. • By December 31, 2024~~5~~, 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~~39	Primary and Specialty Care Access	Ensure primary and specialty care access standards met for minimum of ~~90~~80% of providers.	Provider Network Operation
~~36~~40	Network Adequacy	Assess and improve network adequacy as demonstrated by availability of practitioners.	Provider Network Operations
~~37~~41	After Hours Availability	Conducts surveys to ensure members are able to reach a provider after hours.	Provider Network Operations
~~38~~42	Provider Satisfaction	Field provider survey and develop action plan(s) to improve areas of low performance.	Provider Network Operations
~~39~~43	Facility Site Review Requirements	Maintain 100% compliance with Facility Site Review (FSR) requirements.	Quality Improvement

	Metric	Goal	Department
~~40~~	~~Facility Site Review Monitoring~~	~~Conduct facility site monitoring 100% on time to ensure safety practices.~~	~~Quality Improvement~~
~~41~~44	Physical Accessibility Review Surveys (PARS)	Complete Physical Accessibility Reviews (PARs) 100% on time.	Quality Improvement
~~42~~45	Credentialing/Recredentialing	Maintain a well-defined credentialing and recredentialing process for evaluating practitioners/ providers to provide care to members.	~~Quality Improvement~~Provider Network Operations
~~43~~46	Grievances and Appeals	Monitor all member grievances and appeals to identify trending issues. Communicate these trends to relevant departments to develop actionable plans aimed at addressing highly reported concerns and improving the overall member experience~~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~~47	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~~48	CAHPS: Surveys	Coordinate with DHCS and HSAG to complete the CAHPS surveys and to monitor and improve CAHPS scores.	Quality Improvement
~~46~~49	CAHPS: Access to Specialty Care	Improve access to specialty care for adults and children.	Operations Strategy/External Affairs Quality Improvement
~~47~~50	CAHPS: Improve CAHPS Scores	Improve CAHPS scores based on MY 2024 CAHPS outcomes, including ~~the DHCS Quality Withhold CAHPS scores focused on~~ Getting Care Quickly and Getting Needed Care~~Improve CAHPS Scores based on MY 2023 CAHPS outcomes.~~	Operations Strategy/External Affairs Quality Improvement
~~48~~51	Delegation Oversight	100% of all audits completed at least annually with corrective action plans (CAPs) closed timely.~~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						
1. Quality: ~~2024~~ 2025 Quality Improvement and Health Equity Transformation (QIHET) Program Description						
Quality	~~2024~~ 2025 QIHET Program Description	Update the ~~2024~~ 2025 QIHET Program Description.	1. Collaborate with business units to review and update the ~~2024~~ 2025 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~~11/18/24-01/15/25 2. ~~03/19/24~~01/21/25 3. ~~04/22/24~~01/27/25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
2. Quality: ~~2024~~ 2025 Quality Improvement and Health Equity Transformation Work Plan						
Quality	~~2024~~ 2025QIHET Work Plan	Update the ~~2024~~ 2025 QIHET Work Plan.	1. Collaborate with business units to review and update the ~~2024~~ 2025 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~~11/18/24-01/15/24 2. ~~03/19/24~~01/21/25 3. ~~04/22/24~~01/27/25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
3. Quality: ~~2023~~ 2024 Quality Improvement and Health Equity Transformation Work Plan Evaluation						
Quality	~~2023~~ 2024 QIHET Work Plan and Program Evaluation	Complete the ~~2023~~ 2024 QIHET Work Plan and Program Evaluation.	1. Collaborate with business units to complete evaluation of the ~~2023~~ 2024 QIHET Work Plan. 2. Evaluate effectiveness of the quality improvement structure and resources. 3. Evaluate the QIHEC subcommittees are occurring according to each subcommittee's charter and cadence. 4. Conduct a~~A~~ssessment of Committee Members 5. Conduct a~~A~~ssessment of systems and activities 6. Conduct a~~A~~ssessment of resources dedicated to addressing disparities ~~3.~~7. Prepare and submit for approval to the QIHEC. 8. Prepare and submit for approval to the Commission.	1. 03/01/~~24~~25-06/30/~~24~~25 2. 03/01/~~24~~25-07/31/~~24~~25 3. 03/01/~~24~~25-07/31/~~24~~25 4. 07/31/25 5. 07/31/25 6. 07/31/25 ~~3.~~7. 09/~~17~~16/~~24~~25 8. 09/23/~~24~~25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
4. Health Equity: 2025 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Description						
Health Equity	2025 CLAS Program Description and Work Plan	Update the 2025 CLAS Program Description and Work Plan	1. Update the 2025 CLAS Program Description and Work Plan	1. 01/31/25	• Sr. Director, Health Education and Cultural Linguistics • Sr. Cultural and Linguistics Specialist • Sr. Health Navigator /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
5. Health Equity: 2024 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Evaluation						
Health Equity	2024 CLAS Program and Work Plan Evaluation	Complete the 2024 CLAS Program and Work Plan Evaluation.	2. Complete evaluation of the 2024 CLAS Program and Work Plan Evaluation. 3. Evaluate effectiveness of the quality improvement structure and resources. 4. Conduct a~~A~~ssessment of Committee Members 5. Conduct a~~A~~ssessment of systems and activities 6. Conduct a~~A~~ssessment of resources dedicated to addressing disparities. 7. Prepare and submit for approval to the QIHEC. 8. Prepare and submit for approval to the Commission.	2. 03/01/25-06/30/25 3. 03/01/25-07/31/25 4. 07/31/25 5. 07/31/25 6. 07/31/25 7. 09/16/25 8. 09/23/25	• Sr. Director, Health Education and Cultural Linguistics • Sr. Cultural and Linguistics Specialist • Sr. Health Navigator /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
6. Quality: 2025 HEDIS® Compliance Audit™						
Quality	2025HEDIS® 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. 01/31/25 2. 03/28/25 3. 04/25/25 4. 05/23/25 5. 06/13/25 6. 06/13/25 7. 06/13/25	• 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						

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

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~5.~~7. 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. 12/31/254	• Sr. Manager of Population Health Management • ~~Sr. Director of Health Education and Cultural Linguistics~~ • Program Analyst of Population Health Management • Senior Healthcare Data Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Updates: ~~o~~ ○ 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.~~8. Population Health: Wellth Program						
Population Health	Wellth Quality Improvement Program	~~Implement~~ Maintain and expand 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).	~~Enroll 3,800 members that qualify for the QI focused program.~~ ~~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.~~ 1. The PHM team will continue to evaluate the outcomes associated with the Wellth QI program. ~~Decision point on whether to enroll additional 1,200 members in the Wellth Utilization or QI program.~~ ~~Decision point on whether to enroll additional 5,550 members in the Wellth Utilization or QI program.~~ 2. Implement a provider referral process. ~~2.~~3. Enroll additional members into Wellth QI program to a total of 10,500.	~~03/29/24~~ 1. ~~03/29/24~~ 01/06/25 - 12/31/25 2. ~~04/30/24~~ 2/28/25 3. ~~06/28/24~~ 3/31/25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~7.~~9. Population: Health Risk Assessment						
Population Health	Health Risk Assessment (HRA)	Further develop and expand use of the HRA to meet the CalAIM annual requirement.	~~1.~~ The PHM team will continue working with Carenet to conduct HRAs at a volume to match capacity for referrals. 2. Implement member HRA outreach via SMS through Carenet. 3. Transition HRA outreach from Carenet to the GCHP Call Center. 4. Enable HRA completion online via CRM.	1. 06/30/25 2. 03/31/25 3. 07/01/25 4. 3/31/25	• Sr. Manager of Population Health • Wellness and Prevention Manager	Annual Goal Met: Yes☒ No☐ Quarterly Updates: Continue Objective: Yes☐~~☒~~ No ☒~~☐~~ New objective added in 2025 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.~~10. Utilization Management: Clinical Practice Guidelines						
Utilization Management	Preventive Health, Clinical Practice, and Utilization Management Guidelines~~Clinical Practice Guidelines~~	Complete annual review and adoption of evidence-based Preventive Health Guidelines (PHG), including the Diabetes and Asthma Clinical Practice Guidelines (CPG), and UM Guidelines.~~.~~	1. Review and approval by the ~~Medical Advisory Committee (MAC).~~Credentialing /Peer Review Committee (C/PRC) 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,~~ ~~04/18/24,~~ ~~07/18/24,~~ ~~10/17/24~~03/06/25, 06/05/25, 09/04/25, 11/20/25 2. 01/01/2~~5~~4-12/31/2~~5~~4 3. 01/01/2~~5~~4-12/31/2~~5~~4	• 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
~~9.~~11. Care Management: Complex Case Management						
Care Management (CM)	Complex Case Management (CCM)	~~Develop and implement~~Maintain and monitor 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-058 Care Management including Complex Case Management.~~ ~~2.~~1. Provide staff training as identified. ~~3.~~2. Review and revise staff auditing tools to align with NCQA and policy HS-058 Care Management including Complex Case Management guidelines associated with~~on~~ TAT for CCM. ~~4.~~3. Strategize with CM, QI, HS analyst on the development of metrics and benchmarks to capture CCM TAT. ~~5.~~4. Monitor CCM TAT dashboard and implement interventions for benchmarks not met.	~~1. 06/30/24~~ ~~2.~~1. 01/01/2~~5~~4-12/31/2~~5~~4 ~~3.~~2. ~~06/30/24~~01/01/2025 – 12/31/2025 ~~4.~~3. 01/01/2~~5~~4-12/31/2~~5~~4 ~~5.~~4. 03/01/2~~5~~4-12/31/2~~5~~4	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~10.~~12. 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.~~1. Continue to ~~I~~include utilization of the MCAS care gaps dashboard as part of the CM process. ~~3.~~2. Review and revise JAM's/resource tools/to align with care gap report utilization. ~~4.~~3. Review and revise staff auditing tools as identified. 4. Provide staff with learning opportunities related to MCAS care gap report, programs and activities~~, as needed, utilization and impact to CM process.~~ 5. Strategize with QI and other departments as identified on the development of programs and activities to address identified care gaps.	1. 01/01/254-12/31/254 2. 04/01/524-12/31/254 3. 01/01/254-12/31/254 4. 01/01/254-12/31/254 ~~4.~~5. 01/01/254-12/31/254	• 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
~~11.~~13. Advance Prevention: Tobacco Cessation						
Advance Prevention	Tobacco Cessation	Increase rate of tobacco cessation ~~interventions~~ counseling and utilization of tobacco cessation medication 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~~45% of identified tobacco users receive counseling. • ~~13~~10% 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. 03/31/25~~4~~ 06/30/~~24~~ 2509/30/~~24~~ 25 12/31/25~~4~~ 2. 12/31/~~24~~25 3. 03/31/~~24~~ 2506/30/~~24~~ 25 09/30/~~24~~ 25 12/31/~~24~~25 4. 03/31/~~24~~25, 09/30/~~24~~25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~12.~~14. 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. 03/31/254, 06/30/~~24~~25, 09/30/~~24~~25, 12/31/~~24~~25 3. 01/01/~~24~~25-12/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25	• 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
~~13.~~15. 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 • Number of high dose utilizers • Number of members who fill opioids at 3 or more pharmacies • Number of members who have opioids prescribed by 3 or more prescribers • ~~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~~03/31/25, ~~06/11/24~~06/30/25, ~~09/17/24~~09/30/25, ~~12/03/24~~12/31/25 2. 01/01/~~24~~25-12/31/~~24~~25	• Director of Pharmacy Services • Clinical Programs Pharmacist	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
~~14.~~16. 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. 5. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 6. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 7. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 8. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions.	1. 12/31/2~~5~~4 2. 12/31/2~~5~~4 3. 12/31/2~~5~~4 4. 12/31/~~24~~25 5. 12/31/2~~5~~4 6. 08/15/~~24~~25 7. 01/31/~~24~~25-12/31/~~24~~25 8. 07/31/~~24~~25	• Director, Behavioral Health and Social Programs • Manager, Behavioral Health • QI Program Manager III • Executive Director, IT • Director of Medical Informatics • Sr. Program Analyst	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

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~15.~~17. 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. 5. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 6. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 7. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 8. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions.	1. 12/31/254 2. 12/31/254 3. 12/31/254 4. 12/31/~~24~~25 5. ~~01/01/24~~ 12/31/254 6. 08/15/~~24~~25 7. 01/31/~~24~~25-12/31/~~24~~25 8. 07/31/~~24~~25	• Director, Behavioral Health and Social Programs • Manager, Behavioral Health • QI Program Manager III • Executive Director, IT • Director of Medical Informatics • Sr. Program Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Update 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

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~16.~~18. Behavioral Health: 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. ~~1.~~2. Perform ongoing evaluation of the intervention and identify opportunities to improve. ~~2.~~3. Report updates/results to QIHEC	1. 09/01/~~24~~25 2. 09/~~17~~16/~~24~~25, ~~12/03/24~~11/18/25	• QI Program Manger III • Sr. Manager, CM & Special ~~Projects~~ • Director of Behavioral Health and Social Program • Clinical Care Manager III, LCSW • Sr. QI Data Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~No~~☐ 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
~~17.~~19. Behavioral Health: 2024-2025 DHCS/IHI Behavioral Health Collaborative with VCBH						
Quality / DHCS	DHCS / IHI / VCBH Collaborative focused on improving the existing navigator workflows at the county-run hospital (Ventura County Medical Center) to improve outcomes for individuals who visit the ED for an FUA and FUM condition.~~DHCS /IHI~~	By June 30 2025, improved care coordination processes and data exchange will increase the rate of follow-up BH services by 5% for Ventura County Medi-Cal beneficiaries with BH-related ED visits.~~FUA/FUM~~	1. Implementation of Data Sharing Mechanism & Development of Data Use Framework 2. Enhancement of Care Coordination in ED and between Collaborating Entities 3. Improvement of Delivery System Processes ~~1. Launch collaboration project.~~ ~~2. Smart AIM~~ ~~3. Intervention determination~~	1. 01/01/25-06/30/25 2. 01/01/25-06/30/25 3. 01/01/01-06/30/25	• ~~BH~~ • ~~QI PM III~~ • GCHP staff ○ Director, Behavioral Health & Social Programs ○ Manager, Behavioral Health ○ Behavioral Health Specialist ○ Director, Medical Informatics ○ Senior Program Analyst ○ QI Manager ○ QI Program Manager III • VCBH Staff ○ Quality Improvement Manager ○ Sr. Program Administrator • Care Coordination 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
~~18.~~20. Cancer Prevention: Breast Cancer Screening (BCS)						
MCAS	Breast Cancer Screening	Increase the percentage of ~~women~~ members 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~~ 2024. MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 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. 7. ~~Fund~~ Promote and support 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	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 12/31/~~24~~25 5. 12/31/~~24~~25 6. 12/31/~~24~~25 7. 09/30/~~24~~25 8. 06/01/~~24~~25-12/31/~~24~~25 9. 01/01/~~24~~25-12/31/~~24~~25	• 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:

Return to Agenda

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			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).	10. 12/31/~~24~~25 11. 01/01/~~24~~25-12/31/~~24~~25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~19.~~21. Cancer Prevention: Cervical Cancer Screening (CCS)						
MCAS	Cervical Cancer Screening (CCS)	Increase percentage of ~~women~~ members 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Evaluate effectiveness of the cervical 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. 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	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 01/31/~~25~~26 5. 12/31/~~24~~25 6. 12/31/~~24~~25 7. 04/01/~~24~~25-11/30/~~24~~25 8. 01/01/~~24~~25-12/31/~~24~~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
			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.~~10. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	9. 12/31/~~24~~25 ~~10. 04/01/24 - 12/31/24~~ ~~11.~~10. 01/01/~~2~~4~~2~~5 - 12/31/~~24~~25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~20.~~22. Cancer Prevention: 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~~ Medicare ~~(~~50th percentile~~)~~.	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. to clinics/providers. 3. Evaluate MY ~~2023~~ 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. Launch educational member mailing campaign.~~ ~~7.~~6. 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 lab vendor to pilot home test kits. ~~Exact Sciences to promote Cologuard through member outreach campaigns, data sharing, and provider ordering efficiencies.~~	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~23~~25 3. 07/31/~~24~~25 4. 07/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 06/30/~~24~~25 7. 01/01/~~24~~25-12/31/~~24~~25 8. 12/31/~~24~~25	• 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.~~7. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	9. 12/31/~~24~~25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~21.~~23. Chronic Disease Management: 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 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 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). 8. Conduct member outreach campaigns to members identify with <50% asthma medication ration. 9. ~~for members identified as non-compliant.~~ Implement the asthma spacer member incentive program	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 09/30/~~24~~25 5. 09/30/~~24~~25 6. 12/31/~~24~~25 7. 12/31/2425 8. 09/30/25 9. 06/30/25	• 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
			10. 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. 11. 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). ~~7.~~12. ~~Create member health education flyer highlighting the importance of managing asthma.~~	10. 01/01/25-12/31/25 11. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
24. Chronic Disease Management: 2025 DHCS Lean Quality Improvement and Health Equity Improvement Project						
MCAS	Asthma Medication Ratio	Implement multi-disciplinary continuous quality improvement activities to improve the Asthma Medication Ratio.	1. Submit lean quality improvement and health equity process form. 2. Submit Program form with SMART goals, run charts, and interventions. 3. Submit final progress form	1. 02/10/25 2. 06/10/25 3. 10/10/25	• QI Program Manager III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☒ New objective added in 2025 Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~22.~~25. Chronic Disease Management: Health Equity Controlling Blood Pressure (CBP)						
MCAS	Controlling Blood Pressure	Increase the percentage of members with hypertension who are ~~CBP rate for members~~ 21-44 years of age and have a blood pressure rate of <140/90 to ~~meet or~~ exceed the DHCS MPL (50th percentile).	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. to clinics/providers. 3. Evaluate MY ~~2023~~ 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. 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. 10. Conduct community health fairs to collect blood pressure data and	1. 08/15/~~24~~25 2. 01/01/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 07/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 03/31/~~24~~25 7. 03/01/~~23~~25-12/31/~~24~~25 8. 09/01/~~24~~25 9. 01/01/~~24~~25-12/31/~~24~~25 ~~9.~~10. 12/31/~~2~~425	• 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: .

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Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			refer members with hypertension to care management. 11. Utilize the ~~e~~Chronic ~~d~~Disease ~~s~~Self-~~m~~Management ~~p~~Program to educate members with hypertension care gaps on self-management skills. 12. Include in the Quality Incentive Provider Pool (QIPP) Program. ~~core measures became optional.~~ 13. Evaluate improvements in data collection to capture BP through administrative data (e.g., EMR, HIE).	~~10.~~11. 12/31/~~2~~425 ~~11.~~12. 12/31/~~2~~425 ~~12.~~13. 12/31/~~2~~425		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~23.~~26. Chronic Disease Management: 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. to clinics/providers. 3. Evaluate MY ~~2023~~ 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. 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.~~8. ~~Execute contracts for additional chronic condition programs for diabetes. (e.g, Arine, Wellth)~~ 9. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 07/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 01/01/~~24~~25-12/31/~~24~~25 7. 12/31/~~24~~25 8. ~~12/31/24~~25 9. 12/31/~~24~~25	• 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:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			10. ~~Launch~~ Continue program to utilize test screenings • Health Fairs • Pop-Clinics 11. Complete data integration and testing for Arine diabetes management program (DMP), 12. Complete Arine platform requirements and configuration phases. 13. Complete Arine platform training for staff. 14. Launch Arine DMP. ~~10.~~15. Continue to promote Chronic Disease Self-Management Program to members with diabetes care gap and other co-morbidities.	10. 01/01/~~24~~25-12/31/~~24~~25 11. 9/1/25 12. 9/1/25 13. 9/13/25 14. 9/13/25 ~~10.~~15. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~24.~~27. Women's Health: 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with prospective MY ~~2024~~ 2025 MCAS rate and gaps in care reporting via Converged Data Insights. 3. Identify low performing providers and conduct best practices presentations. ~~2.~~4. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. ~~3.~~5. 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. ~~4.~~6. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities Trainings for low performing providers. 7. Include in the Quality Incentive Provider Pool (QIPP) Program. ~~core measure.~~	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~23~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 04/30/~~24~~25 6. 06/30/~~23~~25 7. 12/31/~~24~~25	• 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
			~~5.~~8. ~~Launch~~ ~~Continue~~Evaluate programs to ~~distribute~~ utilize ~~at-home~~ chlamydia screenings test kits. • Health Fair • Home Test Kits ~~6.~~9. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	8. 01/01/25-12/31/~~24~~25 ~~8.~~9. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~25.~~28. Women's Health: Prenatal and Postpartum Care (PPC)						
MCAS	Prenatal and Postpartum Care	Increase the percentage of ~~women~~ members with live birth deliveries who completed timely 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 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. Conduct member outreach campaigns to increase postpartum screenings and close gaps in care. 7. Include in the Quality Incentive Provider Pool (QIPP) Program. 8. ~~Create~~ Continue providing report to improve early identification of members who are due for prenatal and postpartum visits. 9. ~~Launch~~ Evaluate effectiveness of the Doula Pilot Program, ~~Promotoras de Parto y Pos Parto, to increase prenatal and postpartum services for the Mixteco speaking population in Ventura County~~	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 07/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 03/01/~~24~~25-12/31/~~24~~25 7. 12/31/~~24~~25 8. 03/01/~~24~~25 9. 06/30/~~24~~25	• 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: .

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Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			10. Provide Pregnancy and Postpartum packets with resources for providers to distribute to members.	~~9.~~10. 09/30/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~26.~~29. Children's Health: 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 immunizations by their 2nd birthday to exceed the 75th national Medicaid percentile established by NCQA.	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 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.	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 03/01/~~24~~25 – 11/30/~~24~~25 7. 12/31/~~24~~25	• 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
			7. Include in the Quality Incentive Provider Pool (QIPP) Program. ~~8. Schedule quarterly health fairs to offer and promote childhood immunizations.~~ 8. Flu vaccine workgroup to improve the CIS-10 rate 9. Evaluate effectiveness of the flu vaccine member incentive program. ~~9.~~10. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	~~01/01/24-12/31/24~~ 8. 08/01/25 – 12/31/25 9. 01/31/26 ~~8.~~10. 12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~27.~~30. Children's Health: Immunizations for Adolescents – Combo 2 (IMA-2)						
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~~ exceed the 75th national Medicaid percentile established by NCQA. ~~exceed the NCQA nationally established (90th percentile benchmark).~~	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 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 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	1. 08/15/~~24~~ 25 2. 01/31/~~24~~ 25- 12/31/~~24~~ 25 3. 07/31/~~24~~ 25 4. 01/01/~~24~~ 25- 12/31/~~24~~ 25 5. 01/01/~~24~~ 25- 12/31/~~24~~ 25 6. 03/~~01240~~ 125- 12/31/~~24~~ 25	• 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~~☐ No☐ Next Steps: .

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			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).	7. 12/31/~~24~~ 25 8. 12/31/~~24~~ 25 9. 12/31/~~24~~ 25 10. 01/01/~~24~~ 25- 12/31/~~24~~ 25		

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~28.~~31. Children's Health: 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. to clinics/providers. 3. Evaluate MY ~~2023~~ 2024 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.~~ 8. Conduct member outreach campaigns to increase preventive screenings and close care gap.	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~23~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 09/30/~~24~~25 6. 12/31/~~24~~25 7. 12/31/~~23~~25 8. 03/15/~~24~~25-11/30/~~24~~25	• QI RN Manager • QI Program Manager II • 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
~~29.~~32. Children's Health: 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 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, 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.	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25	• 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:

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 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. 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.~~12. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	6. 05/31/~~24~~25, 12/31/~~24~~25 7. 03/15/~~24~~25- 11/30/~~24~~25 8. 03/01/~~24~~25- 12/31/~~24~~25 9. 12/31/~~24~~25 10. 12/31/~~24~~25 11. 12/31/~~24~~25 ~~12. 01/01/24- 12/31/24~~		

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
				~~13.~~12. 01/01/~~24~~25-12/31/~~24~~25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~30.~~33. Children's Health: 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 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 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.~~ 7. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 12/31/~~24~~25 6. 12/31/~~24~~25 ~~7. 04/01/24-10/31/24~~ 7. 01/01/~~24~~25-12/31/~~24~~25	• QI RN Manager • QI Program Manager II • QI RN •	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~No~~☐ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			8. Work with vendors to administer topical fluoride varnish at health fairs.	8. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~31.~~34. Children's Health: 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with monthly prospective MY ~~2024~~ 2025 MCAS rate and gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024performance 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. 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.~~	1. 08/15/~~24~~25 2. 01/31/245-12/31/~~24~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 03/01/~~24~~25-11/30/~~24~~25 7. 12/31/~~24~~25	• 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
			8. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	8. 01/01/~~24~~25-12/31/~~24~~25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~32.~~35. Children's Health: 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~~ MPL (~~90th~~-50th percentile).	1. Provide clinics/providers with monthly prospective MY ~~2024~~ 2025 MCAS rate and gaps in care reporting via Converged Data Insights. 2. Provide clinics/providers with the annual MY ~~2023~~-2024 MCAS/HEDIS® rate reports. 3. Evaluate MY ~~2024~~-2025 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~~25 2. 01/01/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 07/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 01/01/~~24~~25-12/31/~~24~~25 7. 01/01/~~24~~25-12/31/~~24~~25	• 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.~~ ~~Explore grant opportunities to fund increased access to well-care visits.~~ 13. ~~Create new teen flyer for members 18 years and older to promote taking charge of their own health.~~	8. 01/31/~~25~~25 9. 01/01/~~24~~25-12/31/~~24~~25 10. 12/31/~~24~~25 11. 03/01/~~24~~25–10/31/~~24~~25 12. 12/31/~~24~~25 13. ~~04/01/24-10/31/24~~		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~33.~~36. Children's Health: 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~~25 2. 09/~~17~~16/~~24~~25, ~~12/03/24~~11/18/25	• QI Program Manager II	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
~~34.~~37. Children's Health: 2024-2025 DHCS/IHI Child Health Equity Collaborative						
Quality / DHCS	DHCS Child Health Equity Focused Collaboration on Well-Care Exams	Improve the completion of well-child visits.	1. Complete Interventions 4: Actor mapping & Community Partnership 2. Complete Intervention 5: Partnering for Effective Education and Communication ~~1. Launch collaboration project.~~ ~~2. Intervention determination~~	1. 01/16/2025 2. 01/16/2025-3/20/2025 ~~1. 09/01/24~~ ~~2. 04/01/24-12/31/24~~	~~• QI Program Manager II~~ ~~• QI RN~~ • QI Program Manager I • QI RN • Senior Health Navigator Manager, Community Relations	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						
~~35.~~38. Cultural and Linguistic Needs & Preferences						
Improve Quality & Safety of Non-Clinical Care Services	Cultural and Linguistic Needs & Preferences	• By July 31, ~~2024~~2025, GCHP's Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules ~~from four to seven which~~to ~~will~~ include Diversity, Equity, and Inclusion (DEI) training ~~program~~program curriculum as per DHCS (APL 23-025) that encompasses sensitivity, diversity, cultural competence and cultural humility, and health equity trainings. • By July 31, ~~2024~~2025, GCHP's HECL Department shall conduct three Cultural and Linguistic (C&L)/DEI trainings with three Network Provider offices per quarter. • By December 31, ~~2024~~2025, GCHP's HECL Department shall report on the	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 trainings. ~~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~~25-07/31/~~24~~25 2. 08/01/~~24~~25-12/31/~~24~~25 3. 12/31/~~24~~25 4. 12/~~2~~31/~~24~~225 5. 12/31/~~24~~25 6. 12/31/~~24~~25 7. 03/~~19~~118/~~24~~25, ~~06/11/2425~~05/13/25, 07/15/25, 09/~~17~~16/~~24~~25, ~~12/03/2425~~11/18/25	• 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:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
		number of C&L fulfilment and benchmarks quarterly during the QIHEC meeting.				
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~36.~~39. Primary and Specialty Care Access						
Improve Quality & Safety of Non-Clinical Care Services	Primary and Specialty Care Access	Ensure standards met for minimum of 8~~9~~0% 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~~09/30/2025 2. 01/01/25~~41~~-12/31/25~~4~~ 3. 03/21/25~~4~~, 06/13/25~~4~~, 09/19/25~~4~~, 12/05/25~~4~~ 4. 01/01/25~~4~~-12/31/25~~4~~	• Sr. Director, Network Operations • Sr. Manager, Provider Network Operations – Program & Policy • Manager, Provider Relations • QI RN 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
~~37.~~40. 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: o 1 PCP 1:2000 o Total Physicians 1: 1200 • Physician Supervision to Non-Physician Practitioner Ratios: o Nurse Practitioners 1:4 o Physician Assistants 1:4 • Network maintained PCP located within 10 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	1. Conduct ratio analysis for primary care and high-volume specialties ~~2. Identify gaps and implement corrective action plan(s).~~ ~~3.~~2. Monitor progress toward action plans to maintain or improve GeoAccess standards: Network maintained PCPs. ~~4.~~3. Monitor progress toward action plans to maintain or improve GeoAccess standards: Network maintained DHCS Core Specialists. ~~5.~~4. Develop process for network certification (with ratios). ~~6.~~5. Report biannual ratio analysis and annual GeoAccess findings to QIHEC.	1. 03/31/~~24~~25, 06/30/~~24~~25, 09/30/~~24~~25, 12/31/~~24~~25 ~~2. 03/31/24, 06/30/24, 09/30/24, 12/31/24 12/31/24~~ ~~3.~~2. 01/01/~~24~~25-12/31/~~24~~25 ~~4.~~3. 01/01/~~24~~25-12/31/~~24~~25 ~~5.~~4. 12/31/~~24~~25 ~~6.~~5. 03/21/~~24~~25, 06/13/~~24~~25, 09/19/~~24~~25, 12/05/~~24~~25	• 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.~~41. 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~~09/30/~~24~~25 2. 01/01/~~24~~25-12/31/~~24~~25 3. 03/21/~~24~~25, 06/13/~~24~~25, 09/19/~~24~~25, 12/05/~~24~~25	• Sr. Director, Network Operations • Sr. Manager, Provider Network Operations – Program & Policy • Manager, Provider Relations • 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
~~39.~~42. 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~~10/31/25 2. 01/01/~~24~~25-12/31/~~24~~25	• Sr. Director, Network Operations • Manager, Provider Relations • 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
~~40.~~43. 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 100 % timely. ~~2. Complete FSRs past due because of the public health emergency, in accordance with the DHCS plan.~~ 2. Issue and monitor corrective action plans (CAPs) as needed to facilitate clinic compliance and improvement on identified deficiencies. 3. Collaborate with PNO, legal, and CMO on sites not meeting requirements 4. Monitor member complaints/grievances and potential quality issues (PQIs) involving quality of care/safety concerns. ~~3.~~ ~~4.~~5. Submit biannual ~~reports~~ data to DHCS: ○ January – June ○ July – December	1. 01/01/2~~54~~-12/31/254 ~~2. 12/31/24~~ 2. 01/01/2~~54~~-12/31/254 3. 01/01/25-12/31/25 4. ~~3.~~ 01/01/25-12/31/25 ~~4.~~5. 07/31/~~24~~25, 12/31/~~24~~25	• 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
~~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.~~1. ~~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.~~1. ~~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
~~41.~~44. 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.~~sites. 3. Complete and document PARS as indicated during the Initial and Periodic FSRs	1. 01/31/~~24~~25 2. 12/31/~~24~~5 3. 01/01/~~24~~25-12/31/~~24~~25	• QI RN Manager • QI RN	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~No~~ 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
~~42.~~45. 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). 3. Perform ongoing monitoring of sanctions and adverse events timely. 4. Collaborate with Symplr on software configuration and automation to achieve efficiency in the credentialing process.	1. 01/0125/~~24~~-12/31/2524 2. 01/01/2524-12/31/2524 3. 01/01/2524-12/31/2524 4. 01/01/2524-~~05~~12/3125/~~24~~	• Senior Director, Network Operations • Credentialing Specialist III • Credentialing Specialist II	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 3: Improve Quality of Service						
~~43.~~46. **Grievances and Appeals**						
Assess and improve member experience	Grievances and appeals	Monitor all member grievances and appeals to identify trending issues. Communicate these trends to relevant departments to develop actionable plans aimed at addressing highly reported concerns and improving the overall member experience. ~~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.~~ ~~3.~~1. ~~4.~~2. Identify opportunities for improvement. ~~5.~~3. Create and implement action plan for improvement	1. 03/31/2~~5~~4, 06/30/2~~5~~4, 09/30/2~~5~~4, 12/31/2~~5~~4 2. 01/01/2~~5~~4-12/31/2~~5~~4 3. 01/01/2~~5~~4-12/31/2~~5~~4	• 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
~~44.~~47. 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~~25, 06/30/2~~5~~4, 09/30/2~~5~~4, 12/31/2~~5~~4 2. 01/01/2~~5~~4-12/31/2~~5~~4	• Director of ~~Operation~~Member Contact Center~~s~~ • Sr 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.~~48. 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. Submit Survey Sample Frame data to HSAG ~~1.~~2. Assess CAHPS scores.	1. 01/06/25 ~~1.~~2. ~~06~~07/~~30~~31/~~24~~25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~46.~~49. 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. 12/31/2025~~12/31/24~~ 2. 02/01/2025-12/31/2-025~~02/21/24-12/18/24~~	• Chief Innovation Officer • Executive Director, Delivery Systems, Operations and Strategies • Chief Member Experience and External Affairs Officer ~~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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~47.~~50. 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 2024 CAHPS outcomes, including Getting Care Quickly and Getting Needed Care~~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~~25	• Chief Innovation Officer • Executive Director, Delivery Systems, Operations and Strategies • ~~—~~Chief Member Experience and External Affairs Officer ~~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						

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.~~51. Delegation Oversight						
Ensure Organizational Oversight of Delegated Functions	Completion of Delegation Oversight Audits • Credentialing • Quality Improvement • Utilization Management • ~~Member's Rights~~ • Member Experience • Claims • Call Center • Cultural and Linguistics • Transportation (NEMT/NMT) • Population Health Management	100% of all audits completed at least annually 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. 01/01/254-12/31/2543 2. 01/01/254-12/31/254 3. 01/01/254-12/31/254 4. 02/0668/254, 05/0816/254, 08/0713/254, 11/0614/254	• Sr. Director, Compliance • Delegations Oversight Program Manager • Privacy Officer-Internal Audit Director • Delegation Oversight Audit Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

GOLD COAST HEALTH PLAN
2025 QUALITY IMPROVEMENT & HEALTH EQUITY TRANSFORMATION PROGRAM

Table of Contents

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.

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.

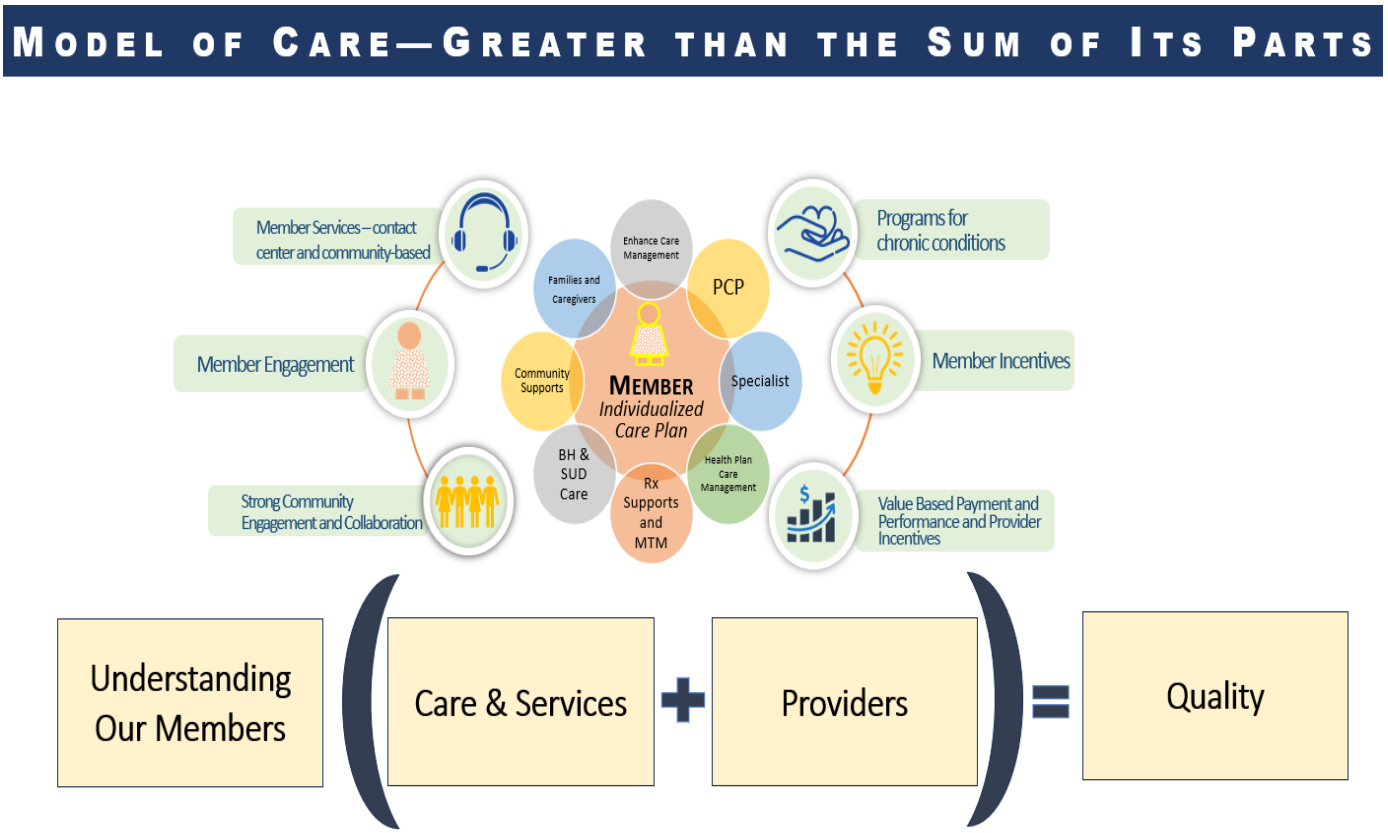
Vision
Compassionate care, accessible to all, for a healthy community.

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 preferences. By 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 high quality of care and services, 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 Consumer Assessment of Health Plans and Systems (CAHPS®) as well as other standard quality measures.



III. PURPOSE AND SCOPE

The purpose of the Gold Coast Health Plan (GCHP) Quality Improvement and Health Equity Transformation Program (QIHETP) is to achieve the **best health possible, best access possible to equitable, quality healthcare, and superior experience for the members and communities we serve** 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 DHCS Comprehensive 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

Quintuple Aim

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 members 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: Population Health, Care Management, Utilization Management, Behavioral Health, Culturally and Linguistically Appropriate Services, and Pharmacy Services.
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 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 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 Innovation Officer (CIO), Executive Director of Health Equity (HEO), and its Quality Improvement and Health Equity Committee (QIHEC). The CMO in collaboration with the HEO is responsible for the day-to-day oversight of the QIHET Program. The CMO, in collaboration with the 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 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 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 nine subcommittees that meet at least quarterly:

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

To further support community involvement and achieve the Plan's QI goals and objectives, the VCMMCC organized four committees in addition to the QIHEC reporting directly to them. To ensure that these community advisory bodies reflect the diversity of the Plan's community, GCHP attempts to include representation by individuals who comprise 5% of the racial, ethnic and linguistic groups within the community. GCHP makes every attempt to recruit members through mail, newsletters, and social media. GCHP assesses the composition of these community advisory committees on an annual basis in the annual evaluation and makes enhancements as needed.

1. Community Advisory Committee (CAC)
2. Provider Advisory Committee (PAC)
3. Member Advisory Committee (MAC)
4. CalAIM Advisory Committee (CalAIM)

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

GCHP is governed by the twelve (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.

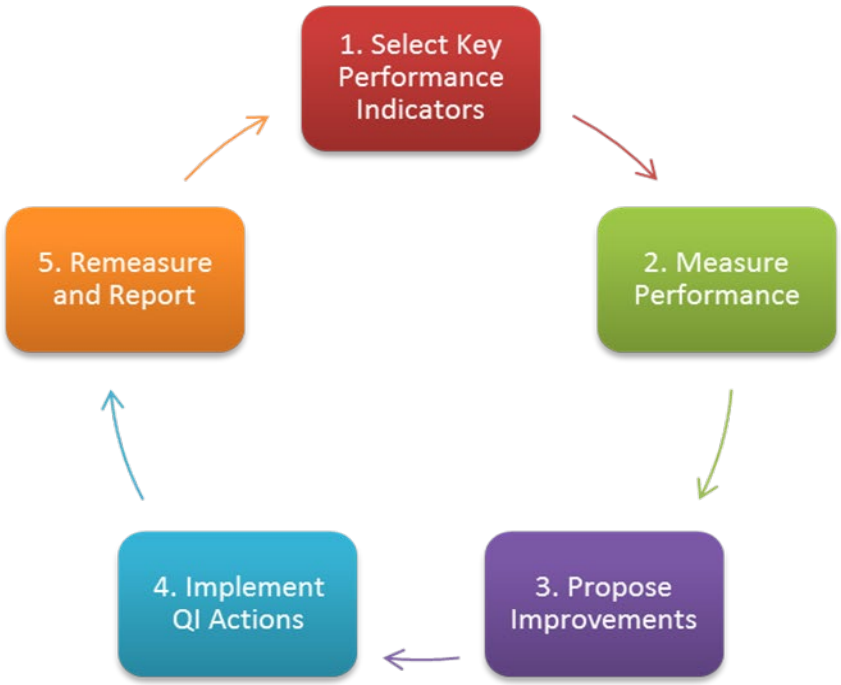
The Program Objectives include the following:

- 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 encourage feedback from members and providers regarding delivery of care and services and to use the feedback to evaluate and improve how care and services are delivered.

VI. QIHET PROGRAM METHODOLOGY

GCHP utilizes industry-standard quality improvement tools such as the Plan-Do-Study-Act (PDSA) Cycle methodology, Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis, Fishbone Diagrams, etc. to test the effectiveness of interventions aimed at improving the quality of care and services. Overall, GCHP focuses 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 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 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 at least 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 diversity, equity, and inclusion (DEI) to maintain high-quality, 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 and 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. 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 2025 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 RELD 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 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.

Assessment of Equitable Access to Covered Services

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 language assistance services for all medical and non-medical services
- 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, 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 diversity, equity, inclusion (DEI) training including sensitivity, communication skills, cultural competency/humility, and Seniors and Persons with Disabilities (SPD) sensitivity 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 feedback and advice from the community advisory bodies regarding culturally and linguistically appropriate services and programs.
- Assessment of committee members to ensure that community advisory bodies reflect the diversity of the Plan's community and membership
- Assessment of systems and activities that promote high quality and equitable services for members
- Assessment of resources dedicated to addressing health disparities

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 leadership, oversight, and management of quality improvement activities and has overall responsibility for the clinical direction of GCHP's QIHET Program.

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.

Executive Director of Health Equity
The Chief Executive Officer has appointed the Executive Director of Health Equity 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 Executive Director of Health Equity reports to the Chief Medical Officer and operates as the Health Equity Officer (HEO). The Executive Director of Health Equity partners with other leaders to guide the organization's commitment and strategy to be a diverse, equitable, and inclusive (DEI) organization with a primary emphasis on developing and implementing strategies to address health disparities and promote equity within GCHP's membership, by overseeing programs, policies, and practices that ensure equitable access to quality healthcare for all members, particularly those within underserved communities.

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, culturally and linguistically appropriate services, and other clinical process improvement and outcome measures are provided by Health Services, Population Health, Health Education/Cultural Linguistics, 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 are supported by Provider Network Operations staff.

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

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 quality improvement 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 1.2025 QIHETP Resources.

Programs 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 – providers have access to a *For Providers* webpage on GCHP's website with access to eligibility and benefit look-up, claims submittal, formulary information, forms and resources.
- Online Member Education and Engagement Resources – members have access to the *For Members* webpage on GCHP's website that includes information on health and wellness services, and comprehensive clinical information in the online Health Library.
- Online Data for performance metrics – providers have access to Inovalon's Data Insights® Quality Performance dashboards which 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, measurement sets, and benchmarks 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, and 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), the National Association for Healthcare Quality (NAHQ), the Agency for Healthcare Research and Quality (AHRQ), and 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:

- 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
- 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 of care
- 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 a HEDIS® Certified Software vendor to calculate all Managed Care Accountability Set (MCAS) and HEDIS® quality measure rates to ensure accurate calculations. The HEDIS® Certified Software vendor engine is used to calculate monthly prospective rates and 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 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.

QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION (QIHET) PROGRAM AND CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) PROGRAM EVALUATIONS

Written evaluations of the QIHET and CLAS Programs are completed annually. These annual reports include comprehensive assessments of the quality improvement and health equity activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the QIHET and CLAS programs, 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 and CLAS Program Descriptions, evaluation of the prior year's QIHET Work Plan and CLAS Work Plan, and the development of the current year's QIHET Work Plan and CLAS Work Plan to ensure ongoing performance improvement.

The Evaluations are reviewed and approved by the QIHEC and VCMMCC and includes the following:

- A description of completed and ongoing 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 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 and CLAS Programs (QIHEC committee and sub-committee structures, 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 QIHET and CLAS Programs 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'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 primarily developed 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, quarterly, 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 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 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, Behavioral Health, and Health Education/Cultural Linguistics Departments for internal development of program initiatives.

X. QUALITY COMMITTEES AND SUBCOMMITTEES

Gold Coast Health Plan's Quality Committees and Subcommittee Structure consists of nine 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), Community Advisory Committee (CAC), Member Advisory Committee (MAC), and the CalAIM Advisory Committee. The PAC, CAC, MAC, and CalAIM Advisory Committee function to support

quality improvement and health equity activities by engaging with community stakeholders regarding 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 Executive Director of Health Equity (HEO) and facilitated by the Sr. QI Director.

Membership consists of the chairs of the 9 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

The QIHEC shall meet six times per year. Ad hoc committees, however, will meet on an as needed basis. The QIHEC 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 QIHEC 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 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 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 External Quality Review Organization (EQRO).
- Effectiveness in performing quality and health equity management functions.
- Reporting and achievement of goals and objectives through quality and health equity monitoring and improvement programs.
- 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 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 Member Advisory Committee and the Community Advisory Committee.
- Institutes actions to address performance deficiencies, including policy recommendations.
- Ensures appropriate follow-up of identified performance deficiencies.
- Reviews reports from GCHP committees and departments, including quarterly dashboards, key activities and action plans including subcommittee updates, and reports regarding monitoring of health plan functions and activities.

QIHEC Membership:

- Chief Medical Officer (Chair)
- Chief Innovation Officer
- Executive Director of Health Equity

- Sr. Medical Director
- Sr. Director of Quality Improvement
- Sr. Director of Health Education / Cultural Linguistics
- Chief of Member Experience and External Affairs
- Executive Director, Delivery System Operations & Strategies
- Sr. Director of Network Operations
- Director of Pharmacy Services
- 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
- Executive Director of Operations
- Director of Operations
- External Practitioner Representatives
- Commissioner
- Carelon (formerly Beacon) Regional Chief Medical Officer Behavioral Health
- Manager, Quality Improvement

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 six times per year.

ii. 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 and linguistically appropriate format.
- Interface with other GCHP committees to improve service delivery to members.

MSC Membership:

- Manager of Operations (Chair)
- Sr. Manager of Operations
- Executive Director of Operations
- Director of Network Operations or designee
- Manager of Community Relations Strategy and External Affairs
- Director of Operations or designee
- Director, Member Contact Center 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:

- Manager of Operations (Chair)
- Director of Operations
- Sr. Grievance and Appeals Specialist
- Chief Medical Officer or designee
- Sr. Medical Director
- 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 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 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 (RNs and MDs) 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
- Chief Innovation Officer
- Sr. Medical Director
- Sr. Director of Care Management
- Sr. Director of Utilization Management
- Managers of Care Management

- Managers of Utilization Management
- Director of Pharmacy Services
- Physician Reviewers
- Compliance Designee
- Sr. Director of Quality Improvement
- Carelon 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 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, 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 RELD 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.
- 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
- Executive Director of Health Equity
- Executive Director of Population Health
- Representative from Department of Care Management
- Representative from Department of Communications
- Representative from Member Services Department
- Representative from Provider Network Operations
- Representative from 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 meet 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 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 informational purposes.
- Receive, review, and act on Type II practitioners/providers applying for Credentialing or Recredentialing.
- Review the quality-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.
- The C/PRC provides feedback and advice to the health plan on any aspect of health plan policy or operations affecting network providers or members including the adoption and approval of the following:
    - Clinical practice and preventive health care guidelines (CPGs/PHGs)

- Utilization Management Criteria

Membership:

The C/PRC is a peer-review body that includes the Chief Medical Officer (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 Physician Administered Drugs (PAD) List for GCHP's Medical Drug Benefit for Medi-Cal members and establish 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 PAD List 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 or Medical Director
- Physicians and pharmacists representing a variety of clinical specialties.

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 Enterprise Project Management Office (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
- Chief Medical Officer
- Executive Director of Health Equity
- 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 (with ad hoc meetings added per business needs).

x. **MCAS Operations Steering Committee**

The Managed Care Accountability Set (MCAS) Operations 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 Operations Steering Committee Objectives:

The role of the MCAS Operations 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 Operations 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 Operations 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, 75th percentile, HPL,).
- 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 Operations Steering Committee Membership:

- Chief Innovation Officer
- Chief Medical Officer

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

Meeting Frequency:

The MCAS Operations Steering Committee meets at least 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

Meeting Frequency:

The Behavioral Health Quality subcommittee meets at least monthly.

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), which serves to identify health disparities and implement targeted interventions, 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.

The PHM program instituted use of a Health Risk Assessment (HRA) to better understand the needs of our members. The PHM program includes two 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.

The PHM program also works closely with our Community Relations and Care Management (CM) Departments to coordinate and provide self-administered test kit screenings for two MCAS

measures (GSD & CHL) at GCHP produced community health fairs. The PHM program is also launching a chronic disease management program targeting diabetic members. 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 with clinical quality improvement guidance provided by the CMO.

For additional information regarding the PHM Program and Strategy, see Attachment 2. GCHP PHM Strategy 2025.

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 include the development of an Individualized Plan of Care (IPC). Interventions are tailored in response to the member's assessed needs, 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. Care Management team documents care management activities in the Medical Management System.

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

For additional information regarding the Care Management Program, refer to Attachment 3. 2025 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 Attachment 4. 2025 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 provided by the CMO. GCHP delegates behavioral health to an NCQA Accredited managed behavioral health organization (MBHO), Carelon. GCHP leverages Carelon's National Medical Director for Provider Partnerships, a board-certified psychiatrist, within 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.

For additional information regarding the BH Program, refer to Attachment 5. 2025 Behavioral Health Program Description.

For additional information regarding behavioral health quality, refer to Carelon's 2025 Quality Improvement Program Description.

Culturally and Linguistically Appropriate Services (CLAS) Program

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.
- Engagement of Community Advisory Committee feedback and advice regarding services and program including for cultural and linguistic appropriateness.

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.

For additional information regarding the CLAS Program, see Attachment 6. 2025 Culturally and Linguistically Appropriate Services Program.

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
- Coordinate and officiate quarterly Pharmacy & Therapeutics Committee meetings

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

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.

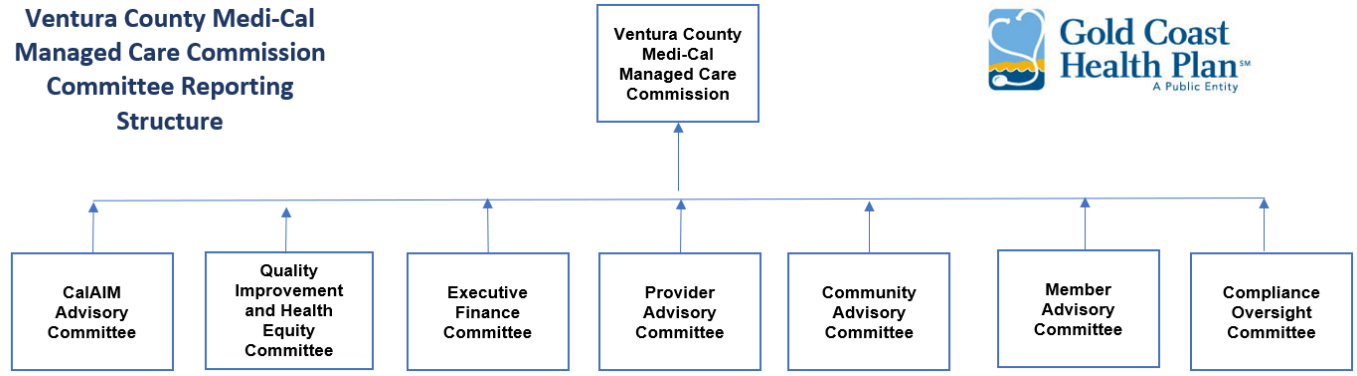
Any delegated functions are fully described in a mutually agreed upon signed and written formal delegation agreement between GCHP and each delegated entity and includes an effective date. All agreements clearly define GCHP's and the delegate's specific duties, responsibilities, activities, reporting 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.

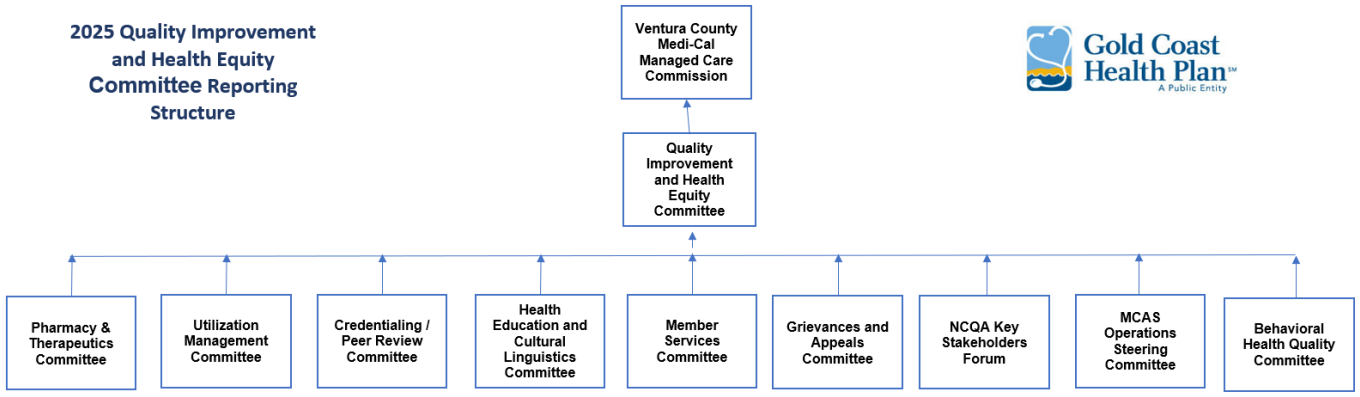
GCHP conducts ongoing oversight, evaluation, and monitoring of the delegate. At a minimum, an annual audit is conducted using an audit tool that is based upon current NCQA, DHCS, and GCHP standards and modified on an as-needed basis. In the event any deficiencies are identified through the oversight 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 representation from the delegate and GCHP departments as applicable.

XIII. GOLD COAST HEALTH PLAN QUALITY COMMITTEE ORGANIZATIONAL CHART

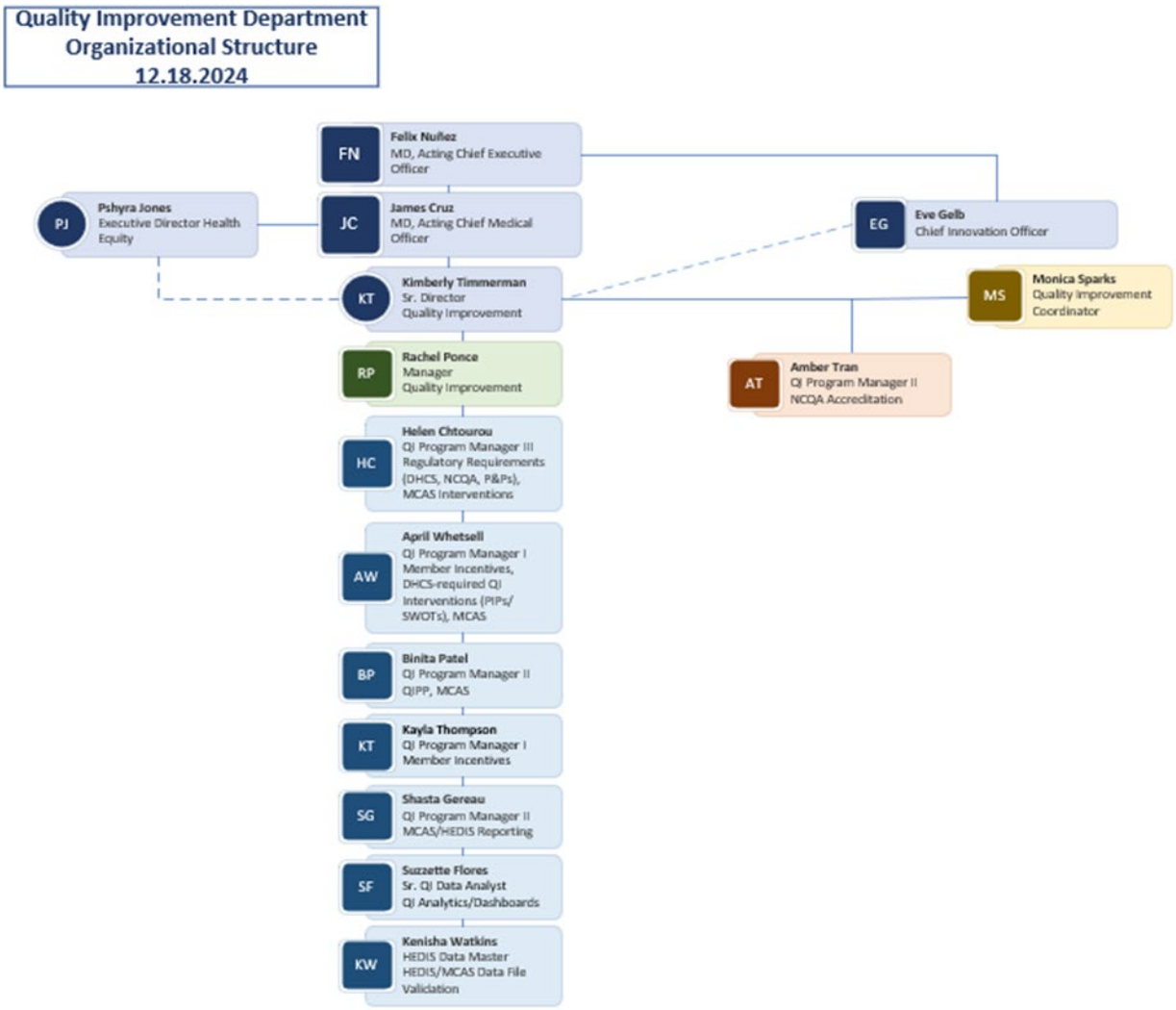
The following organizational chart shows the GCHP Quality Committees that advise the Ventura County Medi-Cal Managed Care Commission and their reporting relationships:





XIV. QUALITY IMPROVEMENT DEPARTMENT ORGANIZATIONAL CHART

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



XV. QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE MEETINGS FOR CALENDAR YEAR 2025

Dates:	
Tuesday	**January 21, 2025**
Tuesday	**March 18, 2025**
Tuesday	**May 13, 2025**
Tuesday	**July 15, 2025**
Tuesday	**September 16, 2025**
Tuesday	**November 18, 2025**
Location: GCHP Community Room 711 E. Daily Drive Suite 110, Camarillo CA 93010 and 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 2025 Quality Improvement and Health Equity Transformation Program Description and Work Plan was approved by the Quality Improvement and Health Equity Committee on January 21, 2025.
- The 2025 Quality Improvement and Health Equity Transformation Program Description and Work Plan were approved by Ventura County Medi-Cal Managed Care Commission (VCMMCC) on January 27, 2025.

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
- Carelon's 2025 Quality Improvement Program Description
- Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 19-017: Quality and Performance Improvement Requirements
- GCHP DHCS Managed Care Contract 2024, Exhibit A, Attachment III
- 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)
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for Health Equity Accreditation
- 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
- Title 42, Code of Federal Regulations, Section 438.240 Quality Assessment and Performance Improvement Program

Attachments

- Attachment 1. 2025 QIHETP Resources
- Attachment 2. 2025 GCHP PHM Strategy
- Attachment 3. 2025 Care Management Program Description
- Attachment 4. 2025 Utilization Management Program Description
- Attachment 5. 2025 Behavioral Health Program Description
- Attachment 6. 2025 Cultural and Linguistically Appropriate Services Program Description

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 Quality Improvement and Health Equity Transformation (QIHET) Program by providing leadership, oversight and management of quality improvement and health equity activities.

The CMO in collaboration with the Executive Director of Health Equity (HEO) has the overall responsibility for the clinical direction of Gold Coast Health Plan's (GCHP) 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: Quality Improvement and Health Equity Committee (QIHEC), Credentialing/Peer Review Committee (C/PRC), Utilization Management Committee (UMC), Health Education/Cultural Linguistics Committee (HE/CL), Grievances and Appeals Committee (G&A), Pharmacy and Therapeutics Committee (P&T), and Member Services Committee (MSC). 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 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 Ventura County Medi-Cal Managed Care Commission (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.

Executive Director of Health Equity
The CEO has appointed the Executive Director of Health Equity (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 Medical 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.

The HEO serves on the following committees: QIHEC and HE/CL. 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.

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, and UMC.

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 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 efficient, 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.
- Working with all appropriate departments in the creation of the annual QIHETP Evaluation and analysis of results.
- Ensuring QIHEC and VCMMCC approval of all QIHETP documents annually.
- Guiding the collection of MCAS data as mandated by contractual requirements and assisting in the development of activities to improve care.
- Ensuring that appropriate principles of data collection and analysis are used by all departments when looking for improvement opportunities.
- Providing educational opportunities for GCHP staff to improving care, health equity, and service to better target improvement 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 1 QI Manager, who oversees various functions, 1 QI Program Manager focused on NCQA Accreditation, and 1 Quality Improvement Coordinator. The QI

GCHP Quality Improvement and Health Equity Transformation Program Resources

Manager oversees a multidisciplinary team including 5 QI Program Managers, 1 Sr. Quality Improvement Data Analyst, and the HEDIS Data Master.

The QI Department provides quality improvement subject matter expertise, oversight of 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 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

The QI Manager oversees a multidisciplinary team including five QI Program Managers, one Sr. Quality Improvement Data Analyst, and a QI HEDIS Data Master. The 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

QI Team

QI Program Manager (x5)

The QI Program Manager(s) are 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 report to the QI Manager.

HEDIS Data Master (x1)

The HEDIS Data Master is accountable for engaging in and supporting data submission activities for the MCAS/HEDIS program including 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. The HEDIS Data Master directly reports to the QI Manager.

Senior QI Data Analyst (x1)

The Sr. QI Data Analyst is responsible for providing analytical support for the QIHETP. The Sr. QI Data Analyst provides interpretation and analysis of quality improvement and health

equity data to determine areas suitable for the implementation of a QIHETP and leads 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. Additionally, the Sr. QI Data Analyst 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, amongst others. The Sr. QI Data Analyst(s) directly reports to the QI Manager.

QI Improvement Coordinator (x1)
The quality improvement coordinator is responsible for providing administrative and clerical support to the QI Department as well as other quality improvement and health equity activities as necessary. The Quality Improvement Coordinator reports directly 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.

GCHP Quality Improvement and Health Equity Transformation Program Resources

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

Gold Coast Health Plan℠
A Public Entity

~~2024 Quality Improvement & Health Equity Transformation Work Plan~~2025 Quality Improvement & Health Equity Transformation Work Plan

QIHEC Approved: January 21, 2025
Commission Approved: ~~TBD~~January 27, 2025

GOLD COAST HEALTH PLAN

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Reference Guide

	Metric	Goal	Department
1	~~2024~~ 2025 Quality Improvement & Health Equity Transformation (QIHET) Program Description	Update the ~~2024~~ 2025 QIHET Program Description.	Quality Improvement
2	~~2024~~ 2025 Quality Improvement and Health Equity Transformation Work Plan	Update the ~~2024~~ 2025 QIHET Work Plan	Quality Improvement
3	~~2023~~ 2024 Quality Improvement and Health Equity Transformation Program and Work Plan Evaluation	Complete the ~~2023~~ 2024 QIHET Program and Work Plan Evaluation.	Quality Improvement
4	2025 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Description	Update the 2025 CLAS Program Description and Work Plan	Health Education & Cultural Linguistics
5	2024 CLAS Program and Work Plan Evaluation	Complete the 2024 CLAS Program and Work Plan Evaluation.	Health Education & Cultural Linguistics
~~4~~6	~~2024~~ 2025 HEDIS® Compliance Audit™	Successfully complete and pass the annual HEDIS® Compliance Audit™ and receive "reportable" status for all measures.	Quality Improvement
~~5~~7	Population Needs Assessment (PNA)	Maintain NCQA compliant PNA as part of the Population Health Strategy Report submitted to DHCS. ~~NCQA compliant PNA is part of the Population Health Strategy Report submitted to DHCS.~~	Population Health
~~6~~8	Wellth Program	~~Implement~~ Maintain and expand 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
9	Health Risk Assessment	Further develop and expand use of the HRA to meet the CalAIM annual requirement.	Population Health
~~7~~10	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
~~8~~11	Complex Case Management	~~Develop and implement~~Maintain and monitor a standardized turn-around-time (TAT) process for members identified as eligible for complex case management per NCQA CCM requirements.	Care Management
~~9~~12	Care Gap Closure	Implement strategies to close care gaps for MCAS measures.	Care Management
~~10~~13	Tobacco Cessation	Increase the rate of tobacco cessation counseling and utilization of tobacco cessation medication~~interventions~~ in members identified as tobacco users.	Health Education / Cultural Linguistics
~~11~~14	Initial Health Appointment (IHA)	Increase rates of Initial Health Appointment (IHA) completion by providers.	Quality Improvement
~~12~~15	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
~~13~~16	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

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	Metric	Goal	Department
~~14~~17	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~~18	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
~~16~~19	2024-2025 DHCS/IHI Behavioral Health Collaborative	DHCS / IHI / VCBH Collaborative focused on improving the existing navigator workflows at the county-run hospital (Ventura County Medical Center) to improve outcomes for individuals who visit the ED for an FUA and FUM condition.	Behavioral Health
~~17~~20	Breast Cancer Screening (BCS)	Increase the percentage of ~~women~~ members 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
~~18~~21	Cervical Cancer Screening (CCS)	Increase percentage of ~~women~~ members 21-64 years of age who were screened for cervical cancer to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement
~~19~~22	Colorectal Cancer Screening (COL)	Increase the percentage of members 45 to 75 years of age who had an appropriate screening for colorectal cancer to meet the Medicare 50th percentile.~~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
~~20~~23	Asthma Medication Ratio (AMR)	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).	Quality Improvement Pharmacy
24	Asthma Medication Ratio (AMR)	Implement multi-disciplinary continuous quality improvement activities to improve the Asthma Medication Ratio.	Quality Improvement
~~21~~25	Health Equity Controlling Blood Pressure (CBP)	Increase the percentage of members with hypertension who are 21-44 years of age and have a blood pressure rate of <140/90 to ~~meet or~~ exceed the DHCS MPL (50th percentile).~~Increase the CBP rate for members 21-44 years of age to meet or exceed the DHCS MPL (50th percentile).~~	Quality Improvement Population Health
~~22~~26	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
~~23~~27	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
~~24~~28	Prenatal and Postpartum Care (PPC)	Increase the percentage of ~~women~~ members with live birth deliveries who completed timely prenatal and postpartum exams to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement
~~25~~29	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

	Metric	Goal	Department
~~26~~30	Immunization Status for Adolescents – Combo 2 (IMA-2)	Increase the percentage of ~~adolescents~~ members who completed all IMA-2 immunizations by their 13th birthday to exceed the 75th national Medicaid percentile established by NCQA. ~~the NCQA established to DHCS MPL (50th percentile).~~	Quality Improvement
~~27~~31	Developmental Screening in the First Three Years of Life (DEV)	Increase the percentage of ~~children~~ members 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
~~28~~32	Lead Screening in Children (LSC)	Increase the percentage of ~~children~~ members 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
~~29~~33	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
~~30~~34	Well-Child Visits in the First 30 Months of Life (W30)	Increase the percentage of ~~children~~ members who had well-child visits with a PCP to ~~meet or~~ exceed the DHCS MPL (50th percentile)	Quality Improvement
~~31~~35	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~~ MPL (~~90th~~ 50th percentile).	Quality Improvement
~~32~~36	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~~37	2024-2025 DHCS Child Health Equity Focused Collaboration on Well-Care Exams	Improve the completion of well-child visits.	Quality Improvement
~~34~~38	Cultural and Linguistic Needs & Preferences	• By July 31, 2025~~4~~, GCHP's Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules ~~from four to seven which will~~to 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, 2025~~4~~, GCHP's HECL Department shall conduct three Cultural and Linguistic (C&L)/DEI trainings with ~~three~~ Network Provider offices per quarter. • By December 31, 2024~~5~~, 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~~39	Primary and Specialty Care Access	Ensure primary and specialty care access standards met for minimum of ~~90~~80% of providers.	Provider Network Operation
~~36~~40	Network Adequacy	Assess and improve network adequacy as demonstrated by availability of practitioners.	Provider Network Operations
~~37~~41	After Hours Availability	Conducts surveys to ensure members are able to reach a provider after hours.	Provider Network Operations
~~38~~42	Provider Satisfaction	Field provider survey and develop action plan(s) to improve areas of low performance.	Provider Network Operations
~~39~~43	Facility Site Review Requirements	Maintain 100% compliance with Facility Site Review (FSR) requirements.	Quality Improvement

	Metric	Goal	Department
~~40~~	~~Facility Site Review Monitoring~~	~~Conduct facility site monitoring 100% on time to ensure safety practices.~~	~~Quality Improvement~~
~~41~~44	Physical Accessibility Review Surveys (PARS)	Complete Physical Accessibility Reviews (PARs) 100% on time.	Quality Improvement
~~42~~45	Credentialing/Recredentialing	Maintain a well-defined credentialing and recredentialing process for evaluating practitioners/ providers to provide care to members.	~~Quality Improvement~~Provider Network Operations
~~43~~46	Grievances and Appeals	Monitor all member grievances and appeals to identify trending issues. Communicate these trends to relevant departments to develop actionable plans aimed at addressing highly reported concerns and improving the overall member experience~~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~~47	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~~48	CAHPS: Surveys	Coordinate with DHCS and HSAG to complete the CAHPS surveys and to monitor and improve CAHPS scores.	Quality Improvement
~~46~~49	CAHPS: Access to Specialty Care	Improve access to specialty care for adults and children.	Operations Strategy/External Affairs Quality Improvement
~~47~~50	CAHPS: Improve CAHPS Scores	Improve CAHPS scores based on MY 2024 CAHPS outcomes, including ~~the DHCS Quality Withhold CAHPS scores focused on~~ Getting Care Quickly and Getting Needed Care~~Improve CAHPS Scores based on MY 2023 CAHPS outcomes.~~	Operations Strategy/External Affairs Quality Improvement
~~48~~51	Delegation Oversight	100% of all audits completed at least annually with corrective action plans (CAPs) closed timely.~~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

1. Quality: ~~2024~~ 2025 Quality Improvement and Health Equity Transformation (QIHET) Program Description						
Quality	~~2024~~ 2025 QIHET Program Description	Update the ~~2024~~ 2025 QIHET Program Description.	1. Collaborate with business units to review and update the ~~2024~~ 2025 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~~11/18/24-01/15/25 2. ~~03/19/24~~01/21/25 3. ~~04/22/24~~01/27/25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
2. Quality: ~~2024~~ 2025 Quality Improvement and Health Equity Transformation Work Plan						
Quality	~~2024~~ 2025QIHET Work Plan	Update the ~~2024~~ 2025 QIHET Work Plan.	1. Collaborate with business units to review and update the ~~2024~~ 2025 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~~11/18/24-01/15/24 2. ~~03/19/24~~01/21/25 3. ~~04/22/24~~01/27/25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
3. Quality: ~~2023~~ 2024 Quality Improvement and Health Equity Transformation Work Plan Evaluation						
Quality	~~2023~~ 2024 QIHET Work Plan and Program Evaluation	Complete the ~~2023~~ 2024 QIHET Work Plan and Program Evaluation.	1. Collaborate with business units to complete evaluation of the ~~2023~~ 2024 QIHET Work Plan. 2. Evaluate effectiveness of the quality improvement structure and resources. 3. Evaluate the QIHEC subcommittees are occurring according to each subcommittee's charter and cadence. 4. Conduct a~~A~~ssessment of Committee Members 5. Conduct a~~A~~ssessment of systems and activities 6. Conduct a~~A~~ssessment of resources dedicated to addressing disparities ~~3.~~7. Prepare and submit for approval to the QIHEC. 8. Prepare and submit for approval to the Commission.	1. 03/01/~~24~~25-06/30/~~24~~25 2. 03/01/~~24~~25-07/31/~~24~~25 3. 03/01/~~24~~25-07/31/~~24~~25 4. 07/31/25 5. 07/31/25 6. 07/31/25 ~~3.~~7. 09/~~17~~16/~~24~~25 8. 09/23/~~24~~25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
4. Health Equity: 2025 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Description						
Health Equity	2025 CLAS Program Description and Work Plan	Update the 2025 CLAS Program Description and Work Plan	1. Update the 2025 CLAS Program Description and Work Plan	1. 01/31/25	• Sr. Director, Health Education and Cultural Linguistics • Sr. Cultural and Linguistics Specialist • Sr. Health Navigator /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
5. Health Equity: 2024 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Evaluation						
Health Equity	2024 CLAS Program and Work Plan Evaluation	Complete the 2024 CLAS Program and Work Plan Evaluation.	2. Complete evaluation of the 2024 CLAS Program and Work Plan Evaluation. 3. Evaluate effectiveness of the quality improvement structure and resources. 4. Conduct a~~A~~ssessment of Committee Members 5. Conduct a~~A~~ssessment of systems and activities 6. Conduct a~~A~~ssessment of resources dedicated to addressing disparities. 7. Prepare and submit for approval to the QIHEC. 8. Prepare and submit for approval to the Commission.	2. 03/01/25-06/30/25 3. 03/01/25-07/31/25 4. 07/31/25 5. 07/31/25 6. 07/31/25 7. 09/16/25 8. 09/23/25	• Sr. Director, Health Education and Cultural Linguistics • Sr. Cultural and Linguistics Specialist • Sr. Health Navigator /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
6. Quality: 2025 HEDIS® Compliance Audit™						
Quality	2025HEDIS® 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. 01/31/25 2. 03/28/25 3. 04/25/25 4. 05/23/25 5. 06/13/25 6. 06/13/25 7. 06/13/25	• 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						

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

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~5.~~7. 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. 12/31/254	• Sr. Manager of Population Health Management • ~~Sr. Director of Health Education and Cultural Linguistics~~ • Program Analyst of Population Health Management • Senior Healthcare Data Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Updates: ~~o~~ ○ 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.~~8. Population Health: Wellth Program						
Population Health	Wellth Quality Improvement Program	~~Implement~~ Maintain and expand 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).	~~Enroll 3,800 members that qualify for the QI focused program.~~ ~~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.~~ 1. The PHM team will continue to evaluate the outcomes associated with the Wellth QI program. ~~Decision point on whether to enroll additional 1,200 members in the Wellth Utilization or QI program.~~ ~~Decision point on whether to enroll additional 5,550 members in the Wellth Utilization or QI program.~~ 2. Implement a provider referral process. ~~2.~~3. Enroll additional members into Wellth QI program to a total of 10,500.	~~03/29/24~~ 1. ~~03/29/24~~ 01/06/25 - 12/31/25 2. ~~04/30/24~~ 2/28/25 3. ~~06/28/24~~ 3/31/25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~7.~~9. Population: Health Risk Assessment						
Population Health	Health Risk Assessment (HRA)	Further develop and expand use of the HRA to meet the CalAIM annual requirement.	~~1.~~ The PHM team will continue working with Carenet to conduct HRAs at a volume to match capacity for referrals. 2. Implement member HRA outreach via SMS through Carenet. 3. Transition HRA outreach from Carenet to the GCHP Call Center. 4. Enable HRA completion online via CRM.	1. 06/30/25 2. 03/31/25 3. 07/01/25 4. 3/31/25	• Sr. Manager of Population Health • Wellness and Prevention Manager	Annual Goal Met: Yes☒ No☐ Quarterly Updates: Continue Objective: Yes☐~~☒~~ No ☒~~☐~~ New objective added in 2025 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.~~10. Utilization Management: Clinical Practice Guidelines						
Utilization Management	Preventive Health, Clinical Practice, and Utilization Management Guidelines~~Clinical Practice Guidelines~~	Complete annual review and adoption of evidence-based Preventive Health Guidelines (PHG), including the Diabetes and Asthma Clinical Practice Guidelines (CPG), and UM Guidelines.~~.~~	1. Review and approval by the ~~Medical Advisory Committee (MAC).~~Credentialing /Peer Review Committee (C/PRC) 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,~~ ~~04/18/24,~~ ~~07/18/24,~~ ~~10/17/24~~03/06/25, 06/05/25, 09/04/25, 11/20/25 2. 01/01/25~~4~~-12/31/25~~4~~ 3. 01/01/25~~4~~-12/31/25~~4~~	• 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
~~9.~~11. Care Management: Complex Case Management						
Care Management (CM)	Complex Case Management (CCM)	~~Develop and implement~~Maintain and monitor 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-058 Care Management including Complex Case Management.~~ ~~2.~~1. Provide staff training as identified. ~~3.~~2. Review and revise staff auditing tools to align with NCQA and policy HS-058 Care Management including Complex Case Management guidelines associated with~~on~~ TAT for CCM. ~~4.~~3. Strategize with CM, QI, HS analyst on the development of metrics and benchmarks to capture CCM TAT. ~~5.~~4. Monitor CCM TAT dashboard and implement interventions for benchmarks not met.	~~1. 06/30/24~~ ~~2.~~1. 01/01/2~~5~~4-12/31/2~~5~~4 ~~3.~~2. ~~06/30/24~~01/01/2025 – 12/31/2025 ~~4.~~3. 01/01/2~~5~~4-12/31/2~~5~~4 ~~5.~~4. 03/01/2~~5~~4-12/31/2~~5~~4	• 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						

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Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~10.~~12. 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.~~1. Continue to ~~I~~include utilization of the MCAS care gaps dashboard as part of the CM process. ~~3.~~2. Review and revise JAM's/resource tools/to align with care gap report utilization. ~~4.~~3. Review and revise staff auditing tools as identified. 4. Provide staff with learning opportunities related to MCAS care gap report, programs and activities~~, as needed, utilization and impact to CM process.~~ 5. Strategize with QI and other departments as identified on the development of programs and activities to address identified care gaps.	1. 01/01/254-12/31/254 2. 04/01/524-12/31/254 3. 01/01/254-12/31/254 4. 01/01/254-12/31/254 ~~4.~~5. 01/01/254-12/31/254	• 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
~~11.~~13. Advance Prevention: Tobacco Cessation						
Advance Prevention	Tobacco Cessation	Increase rate of tobacco cessation ~~interventions~~ counseling and utilization of tobacco cessation medication 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~~45% of identified tobacco users receive counseling. • ~~13~~10% 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. 03/31/25~~4~~ 06/30/~~24~~ 2509/30/~~24~~ 25 12/31/25~~4~~ 2. 12/31/~~24~~25 3. 03/31/~~24~~ 2506/30/~~24~~ 25 09/30/~~24~~ 25 12/31/~~24~~25 4. 03/31/~~24~~25, 09/30/~~24~~25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~12.~~14. 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. 03/31/254, 06/30/~~24~~25, 09/30/~~24~~25, 12/31/~~24~~25 3. 01/01/~~24~~25-12/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25	• 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
~~13.~~15. 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 • Number of high dose utilizers • Number of members who fill opioids at 3 or more pharmacies • Number of members who have opioids prescribed by 3 or more prescribers • ~~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~~03/31/25, ~~06/11/24~~06/30/25, ~~09/17/24~~09/30/25, ~~12/03/24~~12/31/25 2. 01/01/~~24~~25-12/31/~~24~~25	• Director of Pharmacy Services • Clinical Programs Pharmacist	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
~~14.~~16. 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. 5. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 6. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 7. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 8. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions.	1. 12/31/254 2. 12/31/254 3. 12/31/254 4. 12/31/~~24~~25 5. 12/31/254 6. 08/15/~~24~~25 7. 01/31/~~24~~25-12/31/~~24~~25 8. 07/31/~~24~~25	• Director, Behavioral Health and Social Programs • Manager, Behavioral Health • QI Program Manager III • Executive Director, IT • Director of Medical Informatics • Sr. Program Analyst	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

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~15.~~17. 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. 5. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 6. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 7. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 8. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions.	1. 12/31/254 2. 12/31/254 3. 12/31/254 4. 12/31/~~24~~25 5. ~~01/01/24~~ 12/31/254 6. 08/15/~~24~~25 7. 01/31/~~24~~25-12/31/~~24~~25 8. 07/31/~~24~~25	• Director, Behavioral Health and Social Programs • Manager, Behavioral Health • QI Program Manager III • Executive Director, IT • Director of Medical Informatics • Sr. Program Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Update 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

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Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~16.~~18. Behavioral Health: 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. ~~1.~~2. Perform ongoing evaluation of the intervention and identify opportunities to improve. ~~2.~~3. Report updates/results to QIHEC	1. 09/01/~~24~~25 2. 09/~~17~~16/~~24~~25, ~~12/03/24~~11/18/25	• QI Program Manger III • Sr. Manager, CM & Special ~~Projects~~ • Director of Behavioral Health and Social Program • Clinical Care Manager III, LCSW • Sr. QI Data Analyst	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~No~~☐ 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
~~17.~~19. Behavioral Health: 2024-2025 DHCS/IHI Behavioral Health Collaborative with VCBH						
Quality / DHCS	DHCS / IHI / VCBH Collaborative focused on improving the existing navigator workflows at the county-run hospital (Ventura County Medical Center) to improve outcomes for individuals who visit the ED for an FUA and FUM condition.~~DHCS /IHI~~	By June 30 2025, improved care coordination processes and data exchange will increase the rate of follow-up BH services by 5% for Ventura County Medi-Cal beneficiaries with BH-related ED visits.~~FUA/FUM~~	1. Implementation of Data Sharing Mechanism & Development of Data Use Framework 2. Enhancement of Care Coordination in ED and between Collaborating Entities 3. Improvement of Delivery System Processes ~~1. Launch collaboration project.~~ ~~2. Smart AIM~~ ~~3. Intervention determination~~	1. 01/01/25-06/30/25 2. 01/01/25-06/30/25 3. 01/01/01-06/30/25	• ~~BH~~ • ~~QI PM III~~ • GCHP staff ○ Director, Behavioral Health & Social Programs ○ Manager, Behavioral Health ○ Behavioral Health Specialist ○ Director, Medical Informatics ○ Senior Program Analyst ○ QI Manager ○ QI Program Manager III • VCBH Staff ○ Quality Improvement Manager ○ Sr. Program Administrator • Care Coordination 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
~~18.~~20. Cancer Prevention: Breast Cancer Screening (BCS)						
MCAS	Breast Cancer Screening	Increase the percentage of ~~women~~ members 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~~ 2024. MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 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. 7. ~~Fund~~ Promote and support 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	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 12/31/~~24~~25 5. 12/31/~~24~~25 6. 12/31/~~24~~25 7. 09/30/~~24~~25 8. 06/01/~~24~~25-12/31/~~24~~25 9. 01/01/~~24~~25-12/31/~~24~~25	• 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
			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).	10. 12/31/~~24~~25 11. 01/01/~~24~~25-12/31/~~24~~25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~19.~~21. Cancer Prevention: Cervical Cancer Screening (CCS)						
MCAS	Cervical Cancer Screening (CCS)	Increase percentage of ~~women~~ members 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Evaluate effectiveness of the cervical 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. 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	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 01/31/~~25~~26 5. 12/31/~~24~~25 6. 12/31/~~24~~25 7. 04/01/~~24~~25-11/30/~~24~~25 8. 01/01/~~24~~25-12/31/~~24~~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~~☐ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			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.~~10. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	9. 12/31/~~24~~25 ~~10. 04/01/24 - 12/31/24~~ ~~11.~~10. 01/01/~~2~~425 - 12/31/~~24~~25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~20.~~22. Cancer Prevention: 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~~ Medicare ~~(~~50th percentile~~)~~.	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. to clinics/providers. 3. Evaluate MY ~~2023~~ 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. Launch educational member mailing campaign.~~ ~~7.~~6. 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 lab vendor to pilot home test kits. ~~Exact Sciences to promote Cologuard through member outreach campaigns, data sharing, and provider ordering efficiencies.~~	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~23~~25 3. 07/31/~~24~~25 4. 07/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 06/30/~~24~~25 7. 01/01/~~24~~25-12/31/~~24~~25 8. 12/31/~~24~~25	• 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.~~7. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	9. 12/31/~~24~~25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~21.~~23. Chronic Disease Management: 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 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 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). 8. Conduct member outreach campaigns to members identify with <50% asthma medication ration. 9. ~~for members identified as non-compliant.~~ Implement the asthma spacer member incentive program	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 09/30/~~24~~25 5. 09/30/~~24~~25 6. 12/31/~~24~~25 7. 12/31/2425 8. 09/30/25 9. 06/30/25	• 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~~ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			10. 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. 11. 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). ~~7.~~12. ~~Create member health education flyer highlighting the importance of managing asthma.~~	10. 01/01/25-12/31/25 11. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
24. Chronic Disease Management: 2025 DHCS Lean Quality Improvement and Health Equity Improvement Project						
MCAS	Asthma Medication Ratio	Implement multi-disciplinary continuous quality improvement activities to improve the Asthma Medication Ratio.	1. Submit lean quality improvement and health equity process form. 2. Submit Program form with SMART goals, run charts, and interventions. 3. Submit final progress form	1. 02/10/25 2. 06/10/25 3. 10/10/25	• QI Program Manager III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☒ New objective added in 2025 Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~22.~~25. Chronic Disease Management: Health Equity Controlling Blood Pressure (CBP)						
MCAS	Controlling Blood Pressure	Increase the percentage of members with hypertension who are ~~CBP rate for members~~ 21-44 years of age and have a blood pressure rate of <140/90 to ~~meet or~~ exceed the DHCS MPL (50th percentile).	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. to clinics/providers. 3. Evaluate MY ~~2023~~ 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. 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. 10. Conduct community health fairs to collect blood pressure data and	1. 08/15/~~24~~25 2. 01/01/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 07/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 03/31/~~24~~25 7. 03/01/~~23~~25-12/31/~~24~~25 8. 09/01/~~24~~25 9. 01/01/~~24~~25-12/31/~~24~~25 ~~9.~~10. 12/31/~~2~~425	• 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~~☐ No☐ Next Steps: .

Return to Agenda

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			refer members with hypertension to care management. 11. Utilize the ~~e~~Chronic ~~d~~Disease ~~s~~Self-~~m~~Management ~~p~~Program to educate members with hypertension care gaps on self-management skills. 12. Include in the Quality Incentive Provider Pool (QIPP) Program. ~~core measures became optional.~~ 13. Evaluate improvements in data collection to capture BP through administrative data (e.g., EMR, HIE).	~~10.~~11. 12/31/~~2~~425 ~~11.~~12. 12/31/~~2~~425 ~~12.~~13. 12/31/~~2~~425		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~23.~~26. Chronic Disease Management: 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. to clinics/providers. 3. Evaluate MY ~~2023~~ 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. 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.~~8. ~~Execute contracts for additional chronic condition programs for diabetes. (e.g, Arine, Wellth)~~ 9. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 07/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 01/01/~~24~~25-12/31/~~24~~25 7. 12/31/~~24~~25 8. ~~12/31/24~~25 9. 12/31/~~24~~25	• 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:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			10. ~~Launch~~ Continue program to utilize test screenings • Health Fairs • Pop-Clinics 11. Complete data integration and testing for Arine diabetes management program (DMP), 12. Complete Arine platform requirements and configuration phases. 13. Complete Arine platform training for staff. 14. Launch Arine DMP. ~~10.~~15. Continue to promote Chronic Disease Self-Management Program to members with diabetes care gap and other co-morbidities.	10. 01/01/~~24~~25-12/31/~~24~~25 11. 9/1/25 12. 9/1/25 13. 9/13/25 14. 9/13/25 ~~10.~~15. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~24.~~27. Women's Health: 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with prospective MY ~~2024~~ 2025 MCAS rate and gaps in care reporting via Converged Data Insights. 3. Identify low performing providers and conduct best practices presentations. ~~2.~~4. Evaluate MY ~~2023~~ 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. ~~3.~~5. 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. ~~4.~~6. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities Trainings for low performing providers. 7. Include in the Quality Incentive Provider Pool (QIPP) Program. ~~core measure.~~	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~23~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 04/30/~~24~~25 6. 06/30/~~23~~25 7. 12/31/~~24~~25	• 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~~ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			~~5.~~8. ~~Launch~~ ~~Continue~~Evaluate programs to ~~distribute~~ utilize ~~at-home~~ chlamydia screenings test kits. • Health Fair • Home Test Kits ~~6.~~9. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	8. 01/01/25-12/31/~~24~~25 ~~8.~~9. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~25.~~28. Women's Health: Prenatal and Postpartum Care (PPC)						
MCAS	Prenatal and Postpartum Care	Increase the percentage of ~~women~~ members with live birth deliveries who completed timely 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 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. Conduct member outreach campaigns to increase postpartum screenings and close gaps in care. 7. Include in the Quality Incentive Provider Pool (QIPP) Program. 8. ~~Create~~ Continue providing report to improve early identification of members who are due for prenatal and postpartum visits. 9. ~~Launch~~ Evaluate effectiveness of the Doula Pilot Program, ~~Promotoras de Parto y Pos Parto, to increase prenatal and postpartum services for the Mixteco speaking population in Ventura County~~	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 07/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 03/01/~~24~~25-12/31/~~24~~25 7. 12/31/~~24~~25 8. 03/01/~~24~~25 9. 06/30/~~24~~25	• 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
			10. Provide Pregnancy and Postpartum packets with resources for providers to distribute to members.	~~9.~~10. 09/30/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~26.~~29. Children's Health: 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 immunizations by their 2nd birthday to exceed the 75th national Medicaid percentile established by NCQA.	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 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.	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 03/01/~~24~~25 – 11/30/~~24~~25 7. 12/31/~~24~~25	• 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
			7. Include in the Quality Incentive Provider Pool (QIPP) Program. ~~8. Schedule quarterly health fairs to offer and promote childhood immunizations.~~ 8. Flu vaccine workgroup to improve the CIS-10 rate 9. Evaluate effectiveness of the flu vaccine member incentive program. ~~9.~~10. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	~~01/01/24-12/31/24~~ 8. 08/01/25 – 12/31/25 9. 01/31/26 ~~8.~~10. 12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~27.~~30. Children's Health: Immunizations for Adolescents – Combo 2 (IMA-2)						
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~~ exceed the 75th national Medicaid percentile established by NCQA. ~~exceed the NCQA nationally established (90th percentile benchmark).~~	1. Provide clinics/providers with the annual MY ~~2023~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 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 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	1. 08/15/~~24~~ 25 2. 01/31/~~24~~ 25- 12/31/~~24~~ 25 3. 07/31/~~24~~ 25 4. 01/01/~~24~~ 25- 12/31/~~24~~ 25 5. 01/01/~~24~~ 25- 12/31/~~24~~ 25 6. 03/~~01240~~ 125- 12/31/~~24~~ 25	• 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~~☐ No☐ Next Steps: .

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			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).	7. 12/31/~~24~~ 25 8. 12/31/~~24~~ 25 9. 12/31/~~24~~ 25 10. 01/01/~~24~~ 25- 12/31/~~24~~ 25		

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~28.~~31. Children's Health: 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. to clinics/providers. 3. Evaluate MY ~~2023~~ 2024 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.~~ 8. Conduct member outreach campaigns to increase preventive screenings and close care gap.	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~23~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 09/30/~~24~~25 6. 12/31/~~24~~25 7. 12/31/~~23~~25 8. 03/15/~~24~~25-11/30/~~24~~25	• QI RN Manager • QI Program Manager II • 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
~~29.~~32. Children's Health: 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 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, 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.	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25	• 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:

Return to Agenda

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 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. 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.~~12. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	6. 05/31/~~24~~25, 12/31/~~24~~25 7. 03/15/~~24~~25- 11/30/~~24~~25 8. 03/01/~~24~~25- 12/31/~~24~~25 9. 12/31/~~24~~25 10. 12/31/~~24~~25 11. 12/31/~~24~~25 ~~12. 01/01/24- 12/31/24~~		

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
				~~13.~~12. 01/01/~~24~~25-12/31/~~24~~25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~30.~~33. Children's Health: 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY ~~2024~~ 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024 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 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.~~ 7. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	1. 08/15/~~24~~25 2. 01/31/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 12/31/~~24~~25 6. 12/31/~~24~~25 ~~7. 04/01/24-10/31/24~~ 7. 01/01/~~24~~25-12/31/~~24~~25	• QI RN Manager • QI Program Manager II • QI RN •	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ ~~No~~☐ No☐ Next Steps:

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
			8. Work with vendors to administer topical fluoride varnish at health fairs.	8. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~31.~~34. Children's Health: 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~~ 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with monthly prospective MY ~~2024~~ 2025 MCAS rate and gaps in care reporting via Converged Data Insights. 3. Evaluate MY ~~2023~~ 2024performance 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. 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.~~	1. 08/15/~~24~~25 2. 01/31/245-12/31/~~24~~25 3. 07/31/~~24~~25 4. 01/01/~~24~~25-12/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 03/01/~~24~~25-11/30/~~24~~25 7. 12/31/~~24~~25	• 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
			8. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	8. 01/01/~~24~~25-12/31/~~24~~25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~32.~~35. Children's Health: 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~~ MPL (~~90th~~-50th percentile).	1. Provide clinics/providers with monthly prospective MY ~~2024~~ 2025 MCAS rate and gaps in care reporting via Converged Data Insights. 2. Provide clinics/providers with the annual MY ~~2023~~-2024 MCAS/HEDIS® rate reports. 3. Evaluate MY ~~2024~~-2025 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~~25 2. 01/01/~~24~~25-12/31/~~24~~25 3. 07/31/~~24~~25 4. 07/31/~~24~~25 5. 01/01/~~24~~25-12/31/~~24~~25 6. 01/01/~~24~~25-12/31/~~24~~25 7. 01/01/~~24~~25-12/31/~~24~~25	• 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.~~ ~~Explore grant opportunities to fund increased access to well-care visits.~~ 13. ~~Create new teen flyer for members 18 years and older to promote taking charge of their own health.~~	8. 01/31/~~25~~25 9. 01/01/~~24~~25-12/31/~~24~~25 10. 12/31/~~24~~25 11. 03/01/~~24~~25–10/31/~~24~~25 12. 12/31/~~24~~25 13. ~~04/01/24-10/31/24~~		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~33.~~36. Children's Health: 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~~25 2. 09/~~17~~16/~~24~~25, ~~12/03/24~~11/18/25	• QI Program Manager II	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
~~34.~~37. Children's Health: 2024-2025 DHCS/IHI Child Health Equity Collaborative						
Quality / DHCS	DHCS Child Health Equity Focused Collaboration on Well-Care Exams	Improve the completion of well-child visits.	1. Complete Interventions 4: Actor mapping & Community Partnership 2. Complete Intervention 5: Partnering for Effective Education and Communication ~~1. Launch collaboration project.~~ ~~2. Intervention determination~~	1. 01/16/2025 2. 01/16/2025-3/20/2025 ~~1. 09/01/24~~ ~~2. 04/01/24-12/31/24~~	~~• QI Program Manager II~~ ~~• QI RN~~ • QI Program Manager I • QI RN • Senior Health Navigator Manager, Community Relations	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						
~~35.~~38. Cultural and Linguistic Needs & Preferences						
Improve Quality & Safety of Non-Clinical Care Services	Cultural and Linguistic Needs & Preferences	• By July 31, ~~2024~~2025, GCHP's Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules ~~from four to seven which~~to ~~will~~ include Diversity, Equity, and Inclusion (DEI) training ~~program~~program curriculum as per DHCS (APL 23-025) that encompasses sensitivity, diversity, cultural competence and cultural humility, and health equity trainings. • By July 31, ~~2024~~2025, GCHP's HECL Department shall conduct three Cultural and Linguistic (C&L)/DEI trainings with three Network Provider offices per quarter. • By December 31, ~~2024~~2025, GCHP's HECL Department shall report on the	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 trainings. ~~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~~25-07/31/~~24~~25 2. 08/01/~~24~~25-12/31/~~24~~25 3. 12/31/~~24~~25 4. 12/~~2~~31/~~24~~225 5. 12/31/~~24~~25 6. 12/31/~~24~~25 7. 03/~~19~~118/~~24~~25, ~~06/11/2425~~05/13/25, 07/15/25, 09/~~17~~16/~~24~~25, ~~12/03/2425~~11/18/25	• 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:

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Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
		number of C&L fulfilment and benchmarks quarterly during the QIHEC meeting.				
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~36.~~39. Primary and Specialty Care Access						
Improve Quality & Safety of Non-Clinical Care Services	Primary and Specialty Care Access	Ensure standards met for minimum of ~~8~~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~~09/30/2025 2. 01/01/25~~41~~-12/31/25~~4~~ 3. 03/21/25~~4~~, 06/13/25~~4~~, 09/19/25~~4~~, 12/05/25~~4~~ 4. 01/01/25~~4~~-12/31/25~~4~~	• Sr. Director, Network Operations • Sr. Manager, Provider Network Operations – Program & Policy • Manager, Provider Relations • QI RN 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
~~37.~~40. 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: o 1 PCP 1:2000 o Total Physicians 1: 1200 • Physician Supervision to Non-Physician Practitioner Ratios: o Nurse Practitioners 1:4 o Physician Assistants 1:4 • Network maintained PCP located within 10 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	1. Conduct ratio analysis for primary care and high-volume specialties ~~2. Identify gaps and implement corrective action plan(s).~~ ~~3.~~2. Monitor progress toward action plans to maintain or improve GeoAccess standards: Network maintained PCPs. ~~4.~~3. Monitor progress toward action plans to maintain or improve GeoAccess standards: Network maintained DHCS Core Specialists. ~~5.~~4. Develop process for network certification (with ratios). ~~6.~~5. Report biannual ratio analysis and annual GeoAccess findings to QIHEC.	1. 03/31/~~24~~25, 06/30/~~24~~25, 09/30/~~24~~25, 12/31/~~24~~25 ~~2. 03/31/24, 06/30/24, 09/30/24, 12/31/24 12/31/24~~ ~~3.~~2. 01/01/~~24~~25-12/31/~~24~~25 ~~4.~~3. 01/01/~~24~~25-12/31/~~24~~25 ~~5.~~4. 12/31/~~24~~25 ~~6.~~5. 03/21/~~24~~25, 06/13/~~24~~25, 09/19/~~24~~25, 12/05/~~24~~25	• 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.~~41. 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~~09/30/~~24~~25 2. 01/01/~~24~~25-12/31/~~24~~25 3. 03/21/~~24~~25, 06/13/~~24~~25, 09/19/~~24~~25, 12/05/~~24~~25	• Sr. Director, Network Operations • Sr. Manager, Provider Network Operations – Program & Policy • Manager, Provider Relations • 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
~~39.~~42. 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~~10/31/25 2. 01/01/~~24~~25-12/31/~~24~~25	• Sr. Director, Network Operations • Manager, Provider Relations • 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
~~40.~~43. 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 100 % timely. ~~2. Complete FSRs past due because of the public health emergency, in accordance with the DHCS plan.~~ 2. Issue and monitor corrective action plans (CAPs) as needed to facilitate clinic compliance and improvement on identified deficiencies. 3. Collaborate with PNO, legal, and CMO on sites not meeting requirements 4. Monitor member complaints/grievances and potential quality issues (PQIs) involving quality of care/safety concerns. ~~3.~~ ~~4.~~5. Submit biannual ~~reports~~ data to DHCS: ○ January – June ○ July – December	1. 01/01/2~~54~~-12/31/254 ~~2. 12/31/24~~ 2. 01/01/2~~54~~-12/31/254 3. 01/01/25-12/31/25 4. ~~3.~~ 01/01/25-12/31/25 ~~4.~~5. 07/31/~~24~~25, 12/31/~~24~~25	• 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
~~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.~~1. ~~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.~~1. ~~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
~~41.~~44. 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.~~sites. 3. Complete and document PARS as indicated during the Initial and Periodic FSRs	1. 01/31/~~24~~25 2. 12/31/~~24~~5 3. 01/01/~~24~~25-12/31/~~24~~25	• 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
~~42.~~45. 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). 3. Perform ongoing monitoring of sanctions and adverse events timely. 4. Collaborate with Symplr on software configuration and automation to achieve efficiency in the credentialing process.	1. 01/0125/~~24~~-12/31/2524 2. 01/01/2524-12/31/2524 3. 01/01/2524-12/31/2524 4. 01/01/2524-~~05~~12/3125/~~24~~	• Senior Director, Network Operations • Credentialing Specialist III • Credentialing Specialist II	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 3: Improve Quality of Service						
~~43.~~46. **Grievances and Appeals**						
Assess and improve member experience	Grievances and appeals	Monitor all member grievances and appeals to identify trending issues. Communicate these trends to relevant departments to develop actionable plans aimed at addressing highly reported concerns and improving the overall member experience. ~~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.~~ ~~3.~~1. ~~4.~~2. Identify opportunities for improvement. ~~5.~~3. Create and implement action plan for improvement	1. 03/31/254, 06/30/254, 09/30/254, 12/31/254 2. 01/01/254-12/31/254 3. 01/01/254-12/31/254	• 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
~~44.~~47. 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~~25, 06/30/2~~5~~4, 09/30/2~~5~~4, 12/31/2~~5~~4 2. 01/01/2~~5~~4-12/31/2~~5~~4	• Director of ~~Operation~~Member Contact Center~~s~~ • Sr 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.~~48. 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. Submit Survey Sample Frame data to HSAG ~~1.~~2. Assess CAHPS scores.	1. 01/06/25 ~~1.~~2. ~~06~~07/~~30~~31/~~24~~25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~46.~~49. 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. 12/31/2025~~12/31/24~~ 2. 02/01/2025-12/31/2-025~~02/21/24-12/18/24~~	• Chief Innovation Officer • Executive Director, Delivery Systems, Operations and Strategies • Chief Member Experience and External Affairs Officer ~~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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
~~47.~~50. 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 2024 CAHPS outcomes, including Getting Care Quickly and Getting Needed Care~~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~~25	• Chief Innovation Officer • Executive Director, Delivery Systems, Operations and Strategies • ~~—~~Chief Member Experience and External Affairs Officer ~~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						

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.~~51. Delegation Oversight						
Ensure Organizational Oversight of Delegated Functions	Completion of Delegation Oversight Audits • Credentialing • Quality Improvement • Utilization Management • ~~Member's Rights~~ • Member Experience • Claims • Call Center • Cultural and Linguistics • Transportation (NEMT/NMT) • Population Health Management	100% of all audits completed at least annually 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. 01/01/254-12/31/2543 2. 01/01/254-12/31/254 3. 01/01/254-12/31/254 4. 02/0668/254, 05/0816/254, 08/0713/254, 11/0614/254	• Sr. Director, Compliance • Delegations Oversight Program Manager • Privacy Officer-Internal Audit Director • Delegation Oversight Audit Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒~~☐~~ No☐ Next Steps:
Evaluation & Barrier Analysis						

Gold Coast Health Plan℠
A Public Entity

2025 Quality Improvement & Health Equity Transformation Work Plan

QIHEC Approved: January 21, 2025
Commission Approved: January 27, 2025

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GOLD COAST HEALTH PLAN

Reference Guide

	Metric	Goal	Department
1	2025 Quality Improvement & Health Equity Transformation (QIHET) Program Description	Update the 2025 QIHET Program Description.	Quality Improvement
2	2025 Quality Improvement and Health Equity Transformation Work Plan	Update the 2025 QIHET Work Plan	Quality Improvement
3	2024 Quality Improvement and Health Equity Transformation Program and Work Plan Evaluation	Complete the 2024 QIHET Program and Work Plan Evaluation.	Quality Improvement
4	2025 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Description	Update the 2025 CLAS Program Description and Work Plan	Health Education & Cultural Linguistics
5	2024 CLAS Program and Work Plan Evaluation	Complete the 2024 CLAS Program and Work Plan Evaluation.	Health Education & Cultural Linguistics
6	2025 HEDIS® Compliance Audit™	Successfully complete and pass the annual HEDIS® Compliance Audit™ and receive "reportable" status for all measures.	Quality Improvement
7	Population Needs Assessment (PNA)	Maintain NCQA compliant PNA as part of the Population Health Strategy Report submitted to DHCS.	Population Health
8	Wellth Program	Maintain and expand a QI focused programs 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
9	Health Risk Assessment	Further develop and expand use of the HRA to meet the CalAIM annual requirement.	Population Health
10	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
11	Complex Case Management	Maintain and monitor a standardized turn-around-time (TAT) process for members identified as eligible for complex case management per NCQA CCM requirements.	Care Management
12	Care Gap Closure	Implement strategies to close care gaps for MCAS measures.	Care Management
13	Tobacco Cessation	Increase the rate of tobacco cessation counseling and utilization of tobacco cessation medication in members identified as tobacco users.	Health Education / Cultural Linguistics
14	Initial Health Appointment (IHA)	Increase rates of Initial Health Appointment (IHA) completion by providers.	Quality Improvement
15	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.	Pharmacy
16	Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	Increase the FUM-30 rate to exceed the DHCS MPL (50th percentile).	Behavioral Health
17	Behavioral Health: Follow-Up After Emergency Department Visit for Substance Use – 30 Days	Increase the FUA-30 rate to exceed DHCS MPL (50th percentile).	Behavioral Health

	Metric	Goal	Department
18	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
19	2024-2025 DHCS/IHI Behavioral Health Collaborative	DHCS / IHI / VCBH Collaborative focused on improving the existing navigator workflows at the county-run hospital (Ventura County Medical Center) to improve outcomes for individuals who visit the ED for an FUA and FUM condition.	Behavioral Health
20	Breast Cancer Screening (BCS)	Increase the percentage of members 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
21	Cervical Cancer Screening (CCS)	Increase percentage of members 21-64 years of age who were screened for cervical cancer to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement
22	Colorectal Cancer Screening (COL)	Increase the percentage of members 45 to 75 years of age who had an appropriate screening for colorectal cancer to meet the Medicare 50th percentile.	Quality Improvement
23	Asthma Medication Ratio (AMR)	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 exceed the DHCS MPL (50th percentile).	Quality Improvement Pharmacy
24	Asthma Medication Ratio (AMR)	Implement multi-disciplinary continuous quality improvement activities to improve the Asthma Medication Ratio.	Quality Improvement
25	Health Equity Controlling Blood Pressure (CBP)	Increase the percentage of members with hypertension who are 21-44 years of age and have a blood pressure rate of <140/90 to exceed the DHCS MPL (50th percentile).	Quality Improvement Population Health
26	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
27	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
28	Prenatal and Postpartum Care (PPC)	Increase the percentage of members with live birth deliveries who completed timely prenatal and postpartum exams to meet or exceed the DHCS HPL (90th percentile).	Quality Improvement
29	Childhood Immunization Status – Combo 10 (CIS-10)	Increase the percentage of members who completed all Combo-10 immunizations by their 2nd birthday to exceed the 75th national Medicaid percentile established by NCQA.	Quality Improvement
30	Immunization Status for Adolescents – Combo 2 (IMA-2)	Increase the percentage of members who completed all IMA-2 immunizations by their 13th birthday to exceed the 75th national Medicaid percentile established by NCQA.	Quality Improvement
31	Developmental Screening in the First Three Years of Life (DEV)	Increase the percentage of members 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
32	Lead Screening in Children (LSC)	Increase the percentage of members 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
33	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 exceed the DHCS MPL (50th).	Quality Improvement

	Metric	Goal	Department
34	Well-Child Visits in the First 30 Months of Life (W30)	Increase the percentage of members who had well-child visits with a PCP to exceed the DHCS MPL (50th percentile)	Quality Improvement
35	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 exceed the DHCS MPL (50th percentile).	Quality Improvement
36	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
37	2024-2025 DHCS Child Health Equity Focused Collaboration on Well-Care Exams	Improve the completion of well-child visits.	Quality Improvement
38	Cultural and Linguistic Needs & Preferences	• By July 31, 2025, GCHP's Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules to 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, 2025, GCHP's HECL Department shall conduct three Cultural and Linguistic (C&L)/DEI trainings with Network Provider offices per quarter. • By December 31, 2025, GCHP's HECL Department shall report on the number of C&L fulfilment and benchmarks quarterly during the QIHEC meeting.	Health Education / Cultural Linguistics
39	Primary and Specialty Care Access	Ensure primary and specialty care access standards met for minimum of 80% of providers.	Provider Network Operation
40	Network Adequacy	Assess and improve network adequacy as demonstrated by availability of practitioners.	Provider Network Operations
41	After Hours Availability	Conducts surveys to ensure members are able to reach a provider after hours.	Provider Network Operations
42	Provider Satisfaction	Field provider survey and develop action plan(s) to improve areas of low performance.	Provider Network Operations
43	Facility Site Review Requirements	Maintain 100% compliance with Facility Site Review (FSR) requirements.	Quality Improvement
44	Physical Accessibility Review Surveys (PARS)	Complete Physical Accessibility Reviews (PARs) 100% on time.	Quality Improvement
45	Credentialing/Recredentialing	Maintain a well-defined credentialing and recredentialing process for evaluating practitioners/ providers to provide care to members.	Provider Network Operations
46	Grievances and Appeals	Monitor all member grievances and appeals to identify trending issues. Communicate these trends to relevant departments to develop actionable plans aimed at addressing highly reported concerns and improving the overall member experience	Grievances and Appeals
47	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

	Metric	Goal	Department
48	CAHPS: Surveys	Coordinate with DHCS and HSAG to complete the CAHPS surveys and complete analysis of survey results.	Quality Improvement
49	CAHPS: Access to Specialty Care	Improve access to specialty care for adults and children.	Operations Strategy/External Affairs Quality Improvement
50	CAHPS: Improve CAHPS Scores	Improve CAHPS scores based on MY 2024 CAHPS outcomes, including Getting Care Quickly and Getting Needed Care.	Operations Strategy/External Affairs Quality Improvement
51	Delegation Oversight	100% of all audits completed at least annually with corrective action plans (CAPs) closed timely.	Compliance

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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

1. Quality: 2025 Quality Improvement and Health Equity Transformation (QIHET) Program Description						
Quality	2025 QIHET Program Description	Update the 2025 QIHET Program Description.	1. Collaborate with business units to review and update the 2025 QIHET Program Description. 2. Prepare and submit for approval to the Quality Improvement & Health Equity Committee (QIHEC). 3. Prepare and submit for approval to the Commission.	1. 11/18/24-01/15/25 2. 01/21/25 3. 01/27/25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
2. Quality: 2025 Quality Improvement and Health Equity Transformation Work Plan						
Quality	2025QIHET Work Plan	Update the 2025 QIHET Work Plan.	1. Collaborate with business units to review and update the 2025 QIHET Work Plan. 2. Prepare and submit for approval to the QIHEC. 3. Prepare and submit for approval to the Commission.	1. 11/18/24-01/15/25 2. 01/21/25 3. 01/27/25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
3. Quality: 2024 Quality Improvement and Health Equity Transformation Work Plan Evaluation						
Quality	2024 QIHET Program and Work Plan Evaluation	Complete the 2024 QIHET Program and Work Plan Evaluation.	1. Collaborate with business units to complete 2024 QIHET Program and Work Plan Evaluation. 2. Evaluate effectiveness of the quality improvement structure and resources. 3. Evaluate the QIHEC subcommittees are occurring according to each subcommittee's charter and cadence. 4. Conduct assessment of Committee Members. 5. Conduct assessment of systems and activities. 6. Conduct assessment of resources dedicated to addressing disparities. 7. Prepare and submit for approval to the QIHEC. 8. Prepare and submit for approval to the Commission.	1. 03/01/25-06/30/25 2. 03/01/25-07/31/25 3. 03/01/25-07/31/25 4. 07/31/25 5. 07/31/25 6. 07/31/25 7. 09/16/25 8. 09/23/25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
4. Health Equity: 2025 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Description						
Health Equity	2025 CLAS Program Description and Work Plan	Update the 2025 CLAS Program Description and Work Plan.	1. Update the 2025 CLAS Program Description and Work Plan.	1. 01/31/25	• Sr. Director, Health Education and Cultural Linguistics • Sr. Cultural and Linguistics Specialist • Sr. Health Navigator /Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☒ New objective added in 2025. Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
5. Health Equity: 2024 Culturally and Linguistically Appropriate Services (CLAS) Work Plan and Program Evaluation						
Health Equity	2024 CLAS Program and Work Plan Evaluation	Complete the 2024 CLAS Program and Work Plan Evaluation.	1. Complete evaluation of the 2024 CLAS Program and Work Plan Evaluation. 2. Evaluate effectiveness of the quality improvement structure and resources. 3. Conduct assessment of Committee Members 4. Conduct assessment of systems and activities 5. Conduct assessment of resources dedicated to addressing disparities. 6. Prepare and submit for approval to the QIHEC. 7. Prepare and submit for approval to the Commission.	1. 03/01/25-06/30/25 2. 03/01/25-07/31/25 3. 07/31/25 4. 07/31/25 5. 07/31/25 6. 09/16/25 7. 09/23/25	• Sr. Director, Health Education and Cultural Linguistics • Sr. Cultural and Linguistics Specialist • Sr. Health Navigator /Educator	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☒ New objective added in 2025. 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. Quality: 2025 HEDIS® Compliance Audit™						
Quality	2025 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. 01/31/25 2. 03/28/25 3. 04/25/25 4. 05/23/25 5. 06/13/25 6. 06/13/25 7. 06/13/25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
7. 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. 12/31/25	• Sr. Manager of Population Health Management • Program Analyst of Population Health Management • Senior Healthcare Data Analyst	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. Population Health: Wellth Program						
Population Health	Wellth Quality Improvement Program	Maintain and expand QI focused programs 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. The PHM team will continue to evaluate the outcomes associated with the Wellth QI program. 2. Implement a provider referral process. 3. Enroll additional members into the Wellth QI program to a total of 10,500.	1. 01/06/25 - 12/31/25 2. 2/28/25 3. 3/31/25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
9. Population: Health Risk Assessment						
Population Health	Health Risk Assessment (HRA)	Further develop and expand use of the HRA to meet the CalAIM annual requirement.	1. The PHM team will continue working with Carenet to conduct HRAs at a volume to match capacity for referrals. 2. Implement member HRA outreach via SMS/test through Carenet. 3. Transition HRA outreach from Carenet to the GCHP Call Center. 4. Enable HRA completion online via Customer Relation Management (CRM) software.	1. 06/30/25 2. 03/31/25 3. 07/01/25 4. 03/31/25	• Sr. Manager of Population Health • Wellness and Prevention Manager	Annual Goal Met: Yes☒ No☐ Quarterly Updates: Continue Objective: Yes☐ No☒ New objective added in 2025. 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. Utilization Management: Clinical Practice Guidelines						
Utilization Management	Preventive Health, Clinical Practice, and Utilization Management Guidelines	Complete annual review and adoption of evidence-based Preventive Health Guidelines (PHG), including the Diabetes and Asthma Clinical Practice Guidelines (CPG), and UM Guidelines.	1. Review and approval by the Credentialing /Peer Review Committee (C/PRC) 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. 03/06/25, 06/05/25, 09/04/25, 11/20/25 2. 01/01/25-12/31/25 3. 01/01/25-12/31/25	• 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
11. Care Management: Complex Case Management						
Care Management (CM)	Complex Case Management (CCM)	Maintain and monitor a standardized turn-around-time (TAT) process for members identified as eligible for complex case management per NCQA CCM requirements.	1. Continue staff training as identified. 2. Review and revise staff auditing tools to align with NCQA and policy HS-058 Care Management including Complex Case Management guidelines associated with TAT for CCM. 3. Strategize with CM, QI, HS analyst on the development of metrics and benchmarks to capture CCM TAT. 4. Monitor CCM TAT dashboard and implement interventions for benchmarks not met.	1. 01/01/25-12/31/25 2. 01/01/25 – 12/31/25 3. 01/01/25-12/31/25 4. 03/01/25-12/31/25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
12. Care Management: Care Gap Closure						
Care Management (CM)	Care Gap Closure	Implement strategies to close care gaps for MCAS measures.	1. Continue to include utilization of the MCAS care gaps dashboard as part of the CM process. 2. Review and revise JAM's/resource tools/to align with care gap report utilization. 3. Review and revise staff auditing tools as identified. 4. Provide staff with learning opportunities related to MCAS care gap report, programs and activities. 5. Strategize with QI and other departments as identified on the development of programs and activities to address identified care gaps.	1. 01/01/25-12/31/25 2. 04/01/25-12/31/25 3. 01/01/25-12/31/25 4. 01/01/25-12/31/25 5. 01/01/25-12/31/25	• 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
13. Advance Prevention: Tobacco Cessation						
Advance Prevention	Tobacco Cessation	Increase rate of tobacco cessation counseling and utilization of tobacco cessation medication in members identified as tobacco users. **IHA benchmarks** • 100% of identified tobacco users receive counseling. • 32% of tobacco users receive cessation medication. **Admin benchmarks:** • 45% of identified tobacco users receive counseling. • 10% 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. 03/31/25, 06/30/25, 09/30/25, 12/31/25 2. 12/31/25 3. 03/31/25, 06/30/25, 09/30/25, 12/31/25 4. 03/31/25, 09/30/25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
14. 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. 03/31/25, 06/30/25, 09/30/25, 12/31/25 3. 01/01/25-12/3125 4. 01/01/25-12/31/25	• 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
15. 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.	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 • Number of high dose utilizers • Number of members who fill opioids at 3 or more pharmacies • Number of members who have opioids prescribed by 3 or more prescribers 2. Perform retrospective Drug Utilization Review (DUR) and implement Provider Interventions Related to Opioid Utilization as needed.	1. 03/31/25, 06/30/25, 09/30/25, 12/31/25 2. 01/01/25-12/31/25	• Director of Pharmacy Services • Clinical Programs Pharmacist	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
16. 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 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 FUM in the Quality Incentive Provider Pool (QIPP) Program. 5. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 6. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 7. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 8. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions.	1. 12/31/25 2. 12/31/25 3. 12/31/25 4. 12/31/25 5. 12/31/25 6. 08/15/25 7. 01/31/25-12/31/25 8. 07/31/25	• Director, Behavioral Health and Social Programs • Manager, Behavioral Health • QI Program Manager III • Executive Director, IT • Director of Medical Informatics • Sr. Program Analyst	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
17. 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 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. 4. Include FUA in the Quality Incentive Provider Pool (QIPP) Program. 5. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 6. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 7. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 8. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions.	1. 12/31/25 2. 12/31/25 3. 12/31/25 4. 12/31/25 5. 12/31/25 6. 08/15/25 7. 01/31/25-12/31/25 8. 07/31/25	• Director, Behavioral Health and Social Programs • Manager, Behavioral Health • QI Program Manager III • Executive Director, IT • Director of Medical Informatics • Sr. Program Analyst	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
18. Behavioral Health: 2023-2026 PIP Non-Clinical Topic: Percentage of Provider Notifications for Members with SUD/SMH Diagnoses within 7 Days of an ED Visit						
Evaluation & Barrier Analysis	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 PIP Modules as directed by DHCS and HSAG for review and approval. 2. Perform ongoing evaluation of the interventions and identify opportunities to improve. 3. Report updates and results to the QIHEC.	1. 09/01/25 2. 09/16/25, 11/18/25 3. 03/31/25, 06/30/25, 09/30/25, 12/31/25	• QI Program Manger III • Sr. Manager, CM & Special • Director of Behavioral Health and Social Program • Clinical Care Manager III, LCSW • Sr. QI Data Analyst	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
19. Behavioral Health: 2024-2025 DHCS/IHI Behavioral Health Collaborative with VCBH						
Quality / DHCS	DHCS / IHI / VCBH Collaborative focused on improving the existing navigator workflows at the county-run hospital (Ventura County Medical Center) to improve outcomes for individuals who visit the emergency department (ED) for an FUA and FUM condition.	By June 30 2025, improved care coordination processes and data exchange to increase the rate of follow-up behavioral health services by 5% for Ventura County Medi-Cal beneficiaries with behavioral health-related ED visits.	1. Implementation of data sharing mechanism & development of data use framework. 2. Enhance care coordination in the ED and between collaborating providers. 3. Improvement of delivery system processes.	1. 01/01/25-06/30/25 2. 01/01/25-06/30/25 3. 01/01/25-06/30/25	• GCHP staff ○ Director, Behavioral Health & Social Programs ○ Manager, Behavioral Health ○ Behavioral Health Specialist ○ Director, Medical Informatics ○ Senior Program Analyst ○ QI Manager ○ QI Program Manager III • VCBH Staff ○ Quality Improvement Manager ○ Sr. Program Administrator ○ Care Coordination 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
20. Cancer Prevention: Breast Cancer Screening (BCS)						
MCAS	Breast Cancer Screening	Increase the percentage of members 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 2024. MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 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. 6. Distribute provider member incentive awards annually. 7. Promote and support 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	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 12/31/25 5. 12/31/25 6. 12/31/25 7. 09/30/25 8. 06/01/25-12/31/25 9. 01/01/25-12/31/25	• 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
			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).	10. 12/31/25 11. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
21. Cancer Prevention: Cervical Cancer Screening (CCS)						
MCAS	Cervical Cancer Screening (CCS)	Increase percentage of members 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 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 4. Evaluate effectiveness of the cervical 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. 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.	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 01/31/26 5. 12/31/25 6. 12/31/25 7. 04/01/25-11/30/25 8. 01/01/25-12/31/25	• 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
			9. Include CCS in the Quality Incentive Provider Pool (QIPP) Program core measures. 10. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	9. 12/31/25 10. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
22. Cancer Prevention: 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 to meet the Medicare 50th percentile.	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights 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., American Cancer Society, Community Relations Department) to implement interventions, promote best practices and increase awareness. 7. Partner with lab vendors to pilot home test kits. 8. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 07/31/25 5. 01/01/25-12/31/25 6. 01/01/25-12/31/25 7. 06/30/25 8. 01/01/25-12/31/25	• 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:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
23. Chronic Disease Management: 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 exceed the DHCS MPL (50th percentile).	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 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 collaboration with Health Education. 6. Include AMR in the Quality Incentive Provider Pool (QIPP) Program. 7. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 8. Conduct member outreach campaigns to members identify with <50% asthma medication ration. 9. Implement the asthma spacer member incentive program. 10. Engage in partnerships with internal departments, clinic	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 09/30/25 5. 09/30/25 6. 12/31/25 7. 12/31/25 8. 09/30/25 9. 06/30/25 10. 01/01/25-12/31/25	• 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
			systems, and external organizations, (e.g., American Cancer Society, Community Relations Department) to implement interventions, promote best practices and increase awareness. 11. 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).	11. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
24. Chronic Disease Management: 2025 DHCS Lean Quality Improvement and Health Equity Improvement Project						
MCAS	Asthma Medication Ratio	Implement multi-disciplinary continuous quality improvement activities to improve the Asthma Medication Ratio.	1. Submit the lean quality improvement and health equity process form. 2. Submit the initial progress form with SMART goals, run charts, and interventions. 3. Submit the final progress form.	1. 02/10/25 2. 06/10/25 3. 10/10/25	• QI Program Manager III	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☐ No☒ New objective added in 2025. Next Steps:
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
25. Chronic Disease Management: Health Equity Controlling Blood Pressure (CBP)						
MCAS	Controlling Blood Pressure	Increase the percentage of members with hypertension who are 21-44 years of age and have a blood pressure rate of <140/90 to exceed the DHCS MPL (50th percentile).	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights 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. Notify members and providers of the Medi-Cal Rx blood pressure cuff benefits. 7. Monitor and promote member utilization of the blood pressure devices 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 Program to collect blood pressure data. 10. Conduct community health fairs to collect blood pressure data and refer members with hypertension to care management.	1. 08/15/25 2. 01/01/25-12/31/25 3. 07/31/25 4. 07/31/25 5. 01/01/25-12/31/25 6. 03/31/25 7. 03/01/25-12/31/25 8. 09/01/25 9. 01/01/25-12/31/25 10. 12/31/25	• 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
			11. Utilize the Chronic Disease Self-Management Program to educate members with hypertension care gaps on self-management skills. 12. Include CBP in the Quality Incentive Provider Pool (QIPP) Program. 13. Evaluate improvements in data collection to capture BP through administrative data (e.g., EMR, HIE).	11. 12/31/25 12. 12/31/25 13. 12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
26. Chronic Disease Management: 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 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 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. Launch program to distribute at-home HbA1c screenings kits. 7. Include in the Quality Incentive Provider Pool (QIPP) Program 8. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 9. Continue community program to utilize test screenings: • Health Fairs • Pop-Clinics 10. Launch the new Arine Diabetes Management Program 11. Continue to promote Chronic Disease Self-Management Program to members with diabetes care gap and other co-morbidities.	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 07/31/25 5. 01/01/25-12/31/25 6. 01/01/25-12/31/25 7. 12/31/25 8. 12/31/25 9. 01/01/25-12/31/25 10. 09/01/25 11. 01/01/25-12/31/25	• 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:

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

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Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
27. Women's Health: 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 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with prospective MY 2025 MCAS rate and gaps in care reporting via Converged Data Insights. 3. Identify low performing providers and conduct best practices presentations. 4. Evaluate MY 2024 performance to identify barriers, disparities and opportunities for improvement and interventions. 5. 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. 6. Create and/or update provider and member education campaigns that are culturally and linguistically appropriate to address health disparities Trainings for low performing providers. 7. Include CHL in the Quality Incentive Provider Pool (QIPP) Program. 8. Evaluate programs to utilize chlamydia screenings test kits. • Health Fair • Home Test Kits	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 01/01/25-12/31/25 5. 04/30/25 6. 06/30/25 7. 12/31/25 8. 01/01/25-12/31/25	• 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
			9. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	9. 01/01/25-12/31/25		
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Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
28. Women's Health: Prenatal and Postpartum Care (PPC)						
MCAS	Prenatal and Postpartum Care	Increase the percentage of members with live birth deliveries who completed timely 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 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 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. Conduct member outreach campaigns to increase postpartum screenings and close gaps in care. 7. Include PPC in the Quality Incentive Provider Pool (QIPP) Program. 8. Continue monthly reports to improve early identification of members who are due for prenatal and postpartum visits. 9. Evaluate effectiveness of the Doula Pilot Program, 10. Provide Pregnancy and Postpartum packets with resources for providers to distribute to members.	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 07/31/25 5. 01/01/25-12/31/25 6. 03/01/25-12/31/25 7. 12/31/25 8. 03/01/25 9. 06/30/25 10. 09/30/25	• 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: .
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Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
29. Children's Health: Childhood Immunization Status – Combo 10 (CIS-10)						
MCAS	Childhood Immunization Status – Combo 10	Increase the percentage of members who completed all Combo-10 immunizations by their 2nd birthday to exceed the 75th national Medicaid percentile established by NCQA.	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 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 CIS-10 in the Quality Incentive Provider Pool (QIPP) Program. 8. Continue the flu vaccine workgroup to improve the CIS-10 rate. 9. Evaluate effectiveness of the flu vaccine member incentive program.	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 01/01/25-12/31/25 5. 01/01/25-12/31/25 6. 03/01/25–11/30/25 7. 12/31/25 8. 08/01/25–12/31/25 9. 01/31/26	• 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
			10. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	10. 12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
30. Children's Health: Immunizations for Adolescents – Combo 2 (IMA-2)						
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 the 75th national Medicaid percentile established by NCQA.	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 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 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.	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 01/01/25-12/31/25 5. 01/01/25-12/31/25 6. 03/0125-12/31/25 7. 12/31/25 8. 12/31/25	• 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
			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).	9. 12/31/25 10. 01/01/25-12/31/25		
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Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
31. Children's Health: 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 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 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, 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 8. Conduct member outreach campaigns to increase preventive screenings and close care gap.	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 01/01/25-12/31/25 5. 09/30/25 6. 12/31/25 7. 12/31/25 8. 03/15/25-11/30/25	• QI RN Manager • QI Program Manager II • 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
32. Children's Health: 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 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 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, Help Me Grow/First 5, , CDR, CLPPP, VCPH, VCOE) to implement interventions, 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. 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.	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 01/01/25-12/31/25 5. 01/01/25-12/31/25 6. 05/31/25, 12/31/25 7. 03/15/25-11/30/25	• 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:

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 blood lead screenings and close care gap. 9. Evaluate effectiveness of the LSC 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. 11. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	8. 03/01/25-12/31/25 9. 12/31/25 10. 12/31/25 11. 01/01/25-12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
33. Children's Health: 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 exceed the DHCS MPL (50th).	1. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with the prospective MY 2025 MCAS rate and member gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024 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, 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 are culturally and linguistically appropriate to address health disparities. 6. Include TFL in the Quality Incentive Provider Pool (QIPP) Program. 7. Evaluate improvements in data collection (e.g., administrative data sources, coding audits). 8. Work with vendors to administer topical fluoride varnish at health fairs.	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 01/01/25-12/31/25 5. 12/31/25 6. 12/31/25 7. 01/01/25-12/31/25 8. 01/01/25-12/31/25	• QI RN Manager • QI Program Manager II • 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
34. Children's Health: 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 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 2024 MCAS/HEDIS® rate reports. 2. Provide clinics/providers with monthly prospective MY 2025 MCAS rate and gaps in care reporting via Converged Data Insights. 3. Evaluate MY 2024performance 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. 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 W30 in the Quality Incentive Provider Pool (QIPP) Program 8. Evaluate improvements in data collection (e.g., administrative data sources, coding audits).	1. 08/15/25 2. 01/31/25-12/31/25 3. 07/31/25 4. 01/01/25-12/31/25 5. 01/01/25-12/31/25 6. 03/01/25-11/30/25 7. 12/31/25 8. 01/01/25-12/31/25	• 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

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Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
35. Children's Health: 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 exceed the DHCS MPL (50th percentile).	1. Provide clinics/providers with prospective MY 2025 MCAS rate and gaps in care reporting via Converged Data Insights. 2. Provide clinics/providers with the annual MY 2024 MCAS/HEDIS® rate reports. 3. Evaluate MY 2025 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, , VCPH, VCOE, WIC) to implement interventions to increase access to care, promote best practices and increase awareness. 7. Evaluate effectiveness of the well care member incentive program and identify program changes/enhancements, as applicable.	1. 07/31/25 2. 01/01/25-12/31/25 3. 07/31/25 4. 07/31/25 5. 01/01/25-12/31/25 6. 01/01/25-12/31/25 7. 01/31/25	• 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
			8. Expand and evaluate the effectiveness of the point-of-care (POC) member incentive program and identify program changes/enhancements as applicable. 9. Distribute provider member incentive awards quarterly. 10. Conduct member outreach campaigns to increase preventive care screenings and close gaps in care. 11. Include WCV in the Quality Incentive Provider Pool (QIPP) Program	8. 01/01/25-12/31/25 9. 12/31/25 10. 03/01/25–10/31/25 11. 12/31/25		
Evaluation & Barrier Analysis						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
36. Children's Health: 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. 09/01/25 2. 09/16/25, 11/18/25	• QI Program Manager II	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
37. Children's Health: 2024-2025 DHCS/IHI Child Health Equity Collaborative						
Quality / DHCS	DHCS Child Health Equity Focused Collaboration on Well-Care Exams	Improve the completion of well-child visits.	1. Complete Interventions 4: Actor mapping & Community Partnership 2. Complete Intervention 5: Partnering for Effective Education and Communication	1. 01/16/2025 2. 01/16/2025-3/20/2025	• QI Program Manager I • QI RN • Senior Health Navigator • Manager, Community Relations	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						
38. Cultural and Linguistic Needs & Preferences						
Improve Quality & Safety of Non-Clinical Care Services	Cultural and Linguistic Needs & Preferences	• By July 31, 2025, GCHP's Health Education, Cultural and Linguistic (HECL) Services Department shall expand current training modules to include Diversity, Equity, and Inclusion (DEI) training program curriculum as per DHCS (APL 23-025) that encompasses sensitivity, diversity, cultural competence and cultural humility, and health equity trainings. • By July 31, 2025, GCHP's HECL Department shall conduct three Cultural and Linguistic (C&L)/DEI trainings with three Network Provider offices per quarter. • By December 31, 2025, 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 trainings. 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. 01/01/25-07/31/25 2. 08/01/25-12/31/25 3. 12/31/25 4. 12/31/225 5. 12/31/25 6. 12/31/25 7. 03/31/25, 06/30/25, 09/30/25 12/31/25	• 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
39. Primary and Specialty Care Access						
Improve Quality & Safety of Non-Clinical Care Services	Primary and Specialty Care Access	Ensure standards met for minimum of 80% 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 are not met. 3. Report quarterly performance to QIHEC. 4. Monitor complaints and potential quality issues (PQIs), relating to the member access for appointments and/or referrals, and take action as appropriate.	1. 09/30/2025 2. 01/01/25-12/31/25 3. 03/31/25, 06/30/25, 09/30/25, 12/31/25 4. 01/01/25-12/31/25	• Sr. Director, Network Operations • Sr. Manager, Provider Network Operations – Program & Policy • Manager, Provider Relations • QI RN 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
40. 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 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	1. Conduct ratio analysis for primary care and high-volume specialties. 2. Monitor progress toward action plans to maintain or improve GeoAccess standards for Network maintained PCPs. 3. Monitor progress toward action plans to maintain or improve GeoAccess standards for Network maintained DHCS Core Specialists. 4. Develop process for network certification (with ratios). 5. Report biannual ratio analysis and annual GeoAccess findings to the QIHEC.	1. 03/31/25, 06/30/25, 09/30/25, 12/31/25 2. 01/01/25-12/31/25 3. 01/01/25-12/31/25 4. 12/31/25 5. 03/31/25, 06/30/25, 09/30/25, 12/31/25	• 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
41. 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 the QIHEC.	1. 09/30/25 2. 01/01/25-12/31/25 3. 03/31/25, 06/30/25, 09/30/25, 12/31/25	• Sr. Director, Network Operations • Sr. Manager, Provider Network Operations – Program & Policy • Manager, Provider Relations • 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
42. 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. 10/31/25 2. 01/01/25-12/31/25	• Sr. Director, Network Operations • Manager, Provider Relations • 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
43. 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 100 % timely. 2. Issue and monitor corrective action plans (CAPs) as needed to facilitate clinic compliance and improvement on identified deficiencies. 3. Collaborate with PNO, Legal, and CMO on sites not meeting requirements. 4. Monitor member complaints / grievances and potential quality issues (PQIs) involving quality of care and safety concerns. 5. Submit biannual FSR data to DHCS: o January – June o July – December	1. 01/01/25-12/31/25 2. 01/01/25-12/31/25 3. 01/01/25-12/31/25 4. 01/01/25-12/31/25 5. 07/31/25, 12/31/25	• 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
44. Physical Accessibility Review Surveys (PARS)						
Improve Member Safety	Physical Accessibility Review Surveys	Complete Physical Accessibility Reviews (PARs) 100% on time.	1. Compile reports for high volume / ancillary specialist visits for the Seniors and Persons with Disabilities (SPD) population and submit PAR reports to DHCS. 2. Complete and document PARs for identified high volume / ancillary specialist provider sites. 3. Complete and document PARs as indicated during the Initial and Periodic FSRs	1. 01/31/25 2. 12/31/5 3. 01/01/25-12/31/25	• 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
45. 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. 3. Perform ongoing monitoring of sanctions and adverse events timely. 4. Collaborate with Symplr on software configuration and automation to achieve efficiency in the credentialing process.	1. 01/01/25-12/31/25 2. 01/01/25-12/31/25 3. 01/01/25-12/31/25 4. 01/01/25-12/31/25	• Senior Director, Network Operations • Credentialing Specialist III • Credentialing Specialist II	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 3: Improve Quality of Service						
46. Grievances and Appeals						
Assess and improve member experience	Grievances and appeals	Monitor all member grievances and appeals to identify trending issues. Communicate these trends to relevant departments to develop actionable plans aimed at addressing highly reported concerns and improving the overall member experience.	1. Conduct quarterly assessment of grievances and appeals. 2. Identify opportunities for improvement. 3. Create and implement action plans for improvement.	1. 03/31/25, 06/30/25, 09/30/25, 12/31/25 2. 01/01/25-12/31/25 3. 01/01/25-12/31/25	• 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
47. 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. 03/31/25, 06/30/25, 09/30/25, 12/31/25 2. 01/01/25-12/31/25	• Director of Member Contact Center • Sr 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

48. 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 complete analysis of survey results.	1. Submit Survey Sample Frame data to HSAG. 2. Assess CAHPS scores and complete analysis.	1. 01/06/25 2. 07/31/25	• 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						

Category	Area of Focus	Goals and Objectives	Planned Activities	Timeframe for Completion of Activities	Responsible Staff/Department	Status Update
49. 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 interventions to improve access to specialty care. 2. Participate in the ACAP CAHPS Collaborative.	1. 12/31/25 2. 02/01/25-12/31/25	• Chief Innovation Officer • Executive Director, Delivery Systems, Operations and Strategies • Chief Member Experience and External Affairs Officer	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
50. 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 2024 CAHPS outcomes, including Getting Care Quickly and Getting Needed Care.	1. Utilize Voice of the Member to create interventions based on areas of low performance.	1. 12/31/25	• Chief Innovation Officer • Executive Director, Delivery Systems, Operations and Strategies • Chief Member Experience and External Affairs Officer	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 5: Ensure Organizational Oversight of Delegated Functions

51. Delegation Oversight						
Ensure Organizational Oversight of Delegated Functions	Completion of Delegation Oversight Audits • Credentialing • Quality Improvement • Utilization Management • • Member Experience • Claims • Call Center • Cultural and Linguistics • Transportation (NEMT/NMT) • Population Health Management	100% of all audits completed at least annually 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. 01/01/25-12/31/25 2. 01/01/25-12/31/25 3. 01/01/25-12/31/25 4. 03/31/25, 06/30/25, 09/30/25, 12/31/25	• Sr. Director, Compliance • Delegations Oversight Program Manager • Privacy Officer-Internal Audit Director • Delegation Oversight Audit Manager	Annual Goal Met: Yes☐ No☐ Quarterly Updates: Continue Objective: Yes☒ No☐ Next Steps:
Evaluation & Barrier Analysis						

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Eve Gelb, Chief Innovation Officer
James Cruz, MD, Acting Chief Medical Officer
Robert Franco, Chief Compliance Officer

DATE: January 27, 2025

SUBJECT: Duals Special Needs Plan (D-SNP) Program Approval

Executive Summary

GCHP staff is seeking approval of the D-SNP Program.

BACKGROUND/DISCUSSION:

GCHP is required to implement at D-SNP by January 1, 2026. The D-SNP Program requires regulatory submissions and operational work with strong project support and governance.

Current Project Status

The D-SNP Program has two core components:

1. The regulatory filings required by the California Department of Health Care Services (DHCS), the California Department of Managed Health Care (DMHC) and the federal Centers for Medicare and Medicaid Services (CMS).
2. The operational design, build, test and go-live of systems and processes to serve Medicare members and meet regulatory requirements.

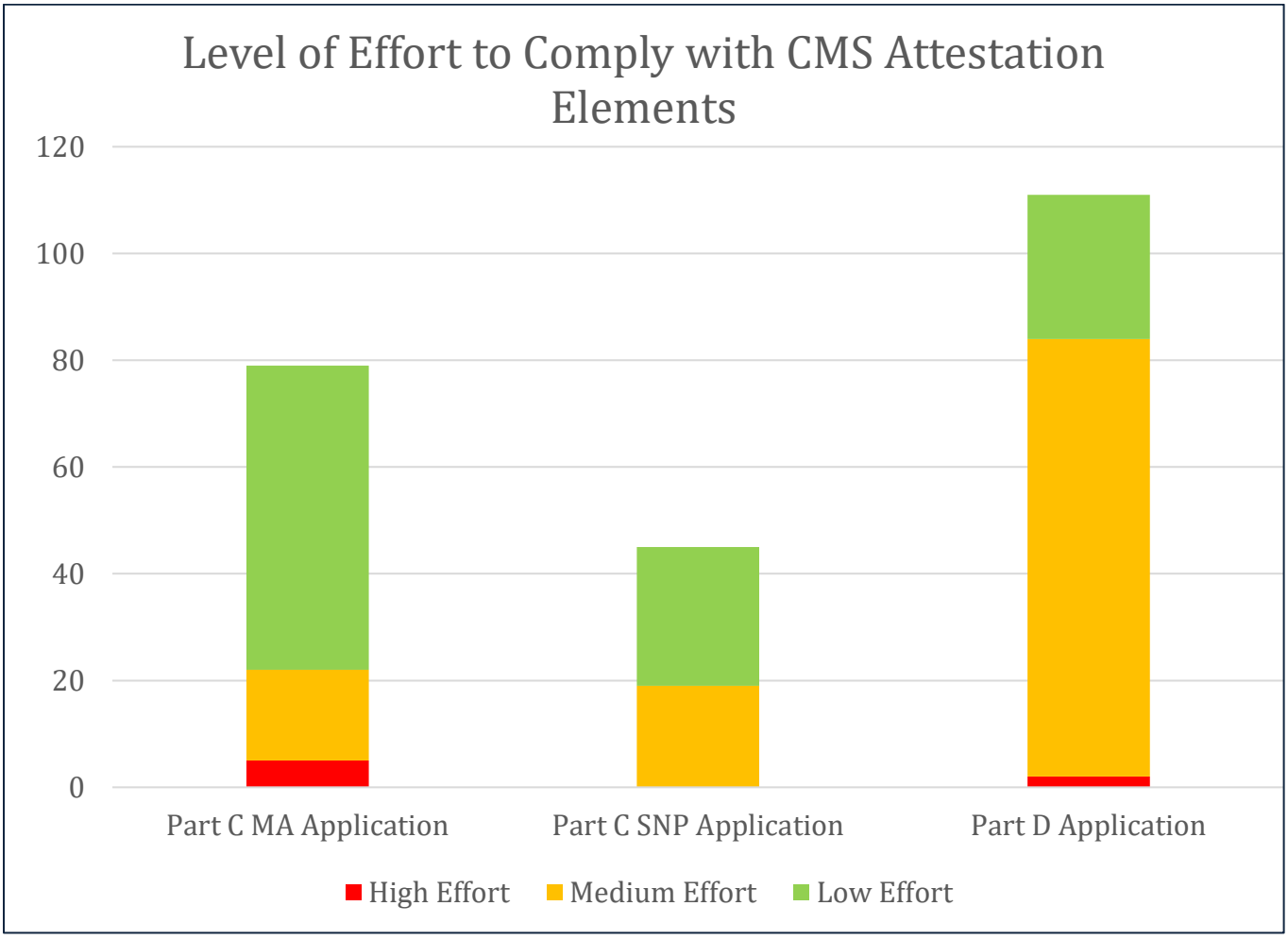
Regulatory Activities Status

All regulatory filing work is on track and there are two significant regulatory submissions in February 2025. The first is the CMS Application and the second in the Model of Care.

All Health plans must fill out Part C and D application to offer Medicare Advantage plans to potential beneficiaries. The detailed applications outline the specifics of the Part C and D plans (coverage details, premiums, and service areas, to be able to offer these options to Medicare beneficiaries). The GCHP CMS Application will also have a third componet as it will be a special needs plan (SNP). The three components are:

1. Part C Medicare Advantage Application
2. SNP Application
3. Part D Medicare Advantage Application

These three components are comprised of 235 elements that GCHP must attest to being able to meet. GCHP staff have reviewed the requirements, confirmed our ability to meet all elements, and evaluated the level of effort reuired to meet the requirements. Approximately 47% of the elements have low efforts to meet. These elements are related to structures and processes that already exist at GCHP for Medi-Cal, or are usual process. Fifty percent of the elements require medium effort, meaning there is a similar process that requires some modifications or a new process that requires minimal effort to put in place. The bulk of these elements are in the Part D or Pharmacy Plan application. GCHP's Pharmacy Benefit Manager (PBM) has all the required elements in place, but GCHP staff has indicated that many of these elements require medium level of effort because GCHP does not yet have experience with Medicare Part D and as such it will take effort for the GCHP team to fully implement the PBM partnership. Lastly, three percent of the elements require a high level of effort. These elements are related to data sharing and testing between GCHP and CMS. The engagment of a system implementation partner, as discussed below, is vital to implentation of these elements.

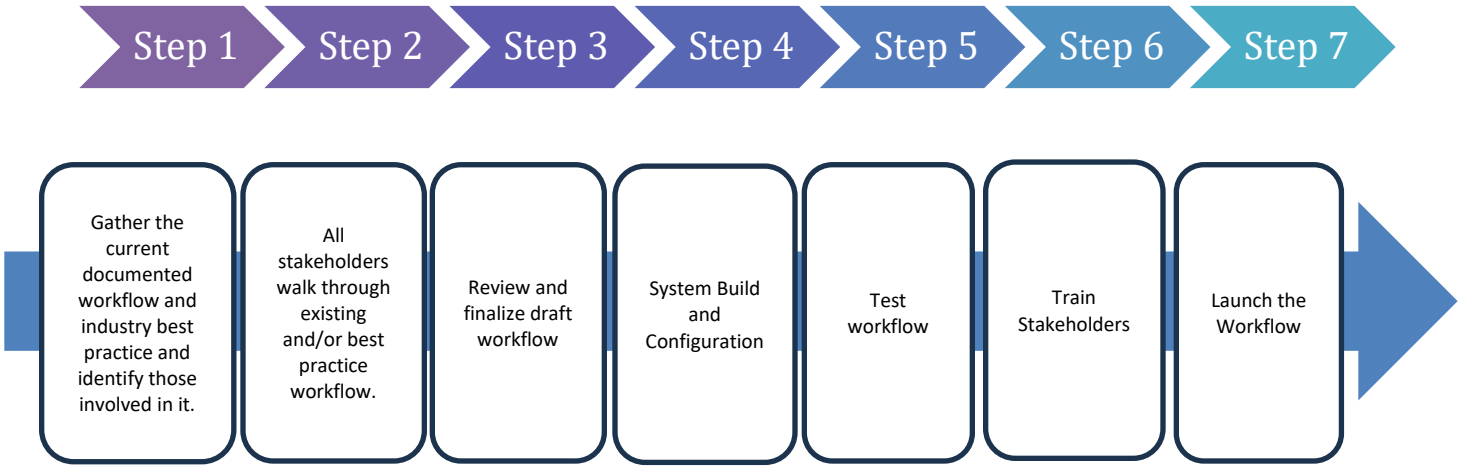


In addition to the CMS applications, all SNPs must submit a Model of Care that meets National Committee for Quality Assurance (NCQA) SNP Requirements. For the California Exclusively Aligned Enrollment D-SNP, the state requires that the Model of Care include some California specific programs and quality measures. The Model of Care is submitted to CMS and DHCS. CMS scores the Model of Care and determines if the Model of Care is approved and at what level. GCHP's goal is to obtain a three year approval which equates to a score of 85% or higher.

GCHP has drafted a Model of Care based on a deep understanding of the needs of the target population gained through data analysis and engagement with members, staff, providers and community organisations. The Model of Care has been reviewed by the GCHP Quality Improvement and Health Equity Committee and an external reviewer in a mock review. It the mock review the Model of Care was scored at 91%. While this score would achieve three year approval, NCQA reviewers score differently, so to increase likelihood of three year approval, GCHP has revised the Model of Care based on the external reviewer's feedback and resubmitted for an additional review mock review. Once received, GCHP will make final revesions and submit to CMS by February 12, 2025.

Operational Activities Status

The operational design, build, test and go-live of systems and processes to serve Medicare members involves work across the entire organization. There is a seven step process to launching each work flow. GHCP has begun work on these seven steps for approximately 30% of the workflows.



As planned, to mitigate risks associated with Operations of the Future stabilization and resource gaps, GCHP put our two requests for information (RFI) to determine the feasibility of:

1. Parterning with a third party administrator to perfrom D-SNP functions on behalf of GCHP; or
2. Partnering with a system implementation partner to build D-SNP processes on GCHP systems.

GCHP reviewed the RFI resoponses and evaulated options with respect to:

- Time to market
- Member, staff, and provider experience
- Cost
- Complexity
- Organizational readiness
- Regulatory risk
- Reusability of the work effort
- Alignment with strategy

GCHP determned that engaging a system implementation partner would best meet our needs. As such, GCHP issues a request for proposal for a system implementation partner and is currently evaluating responses and making the vendor selection.

RECOMMENDATION:

It is GCHP's recommendation that the Ventura County Medi-Cal Managed Care Commission approve the D-SNP Program.

Gold Coast Health Plan℠
A Public Entity

Duals Special Needs Plan (D-SNP) Program Approval

Integrity
Accountability
Collaboration
Trust
Respect

Monday, January 27, 2025

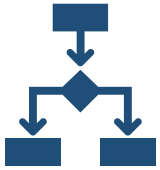
Eve Gelb, Chief Innovation Officer
Robert Franco, Chief Compliance Officer
James Cruz, MD, Acting Chief Medical Officer

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

GCHP D-SNP Program Elements

Regulatory

- Knox Keene License
- CMS Application
- Model of Care Submission
- CMS Bid
- State Medicaid Agency Contract (SMAC)



Governance

- System Implementation Partner
- Program Structure

Operations

- Operational Work Plan
- Budget

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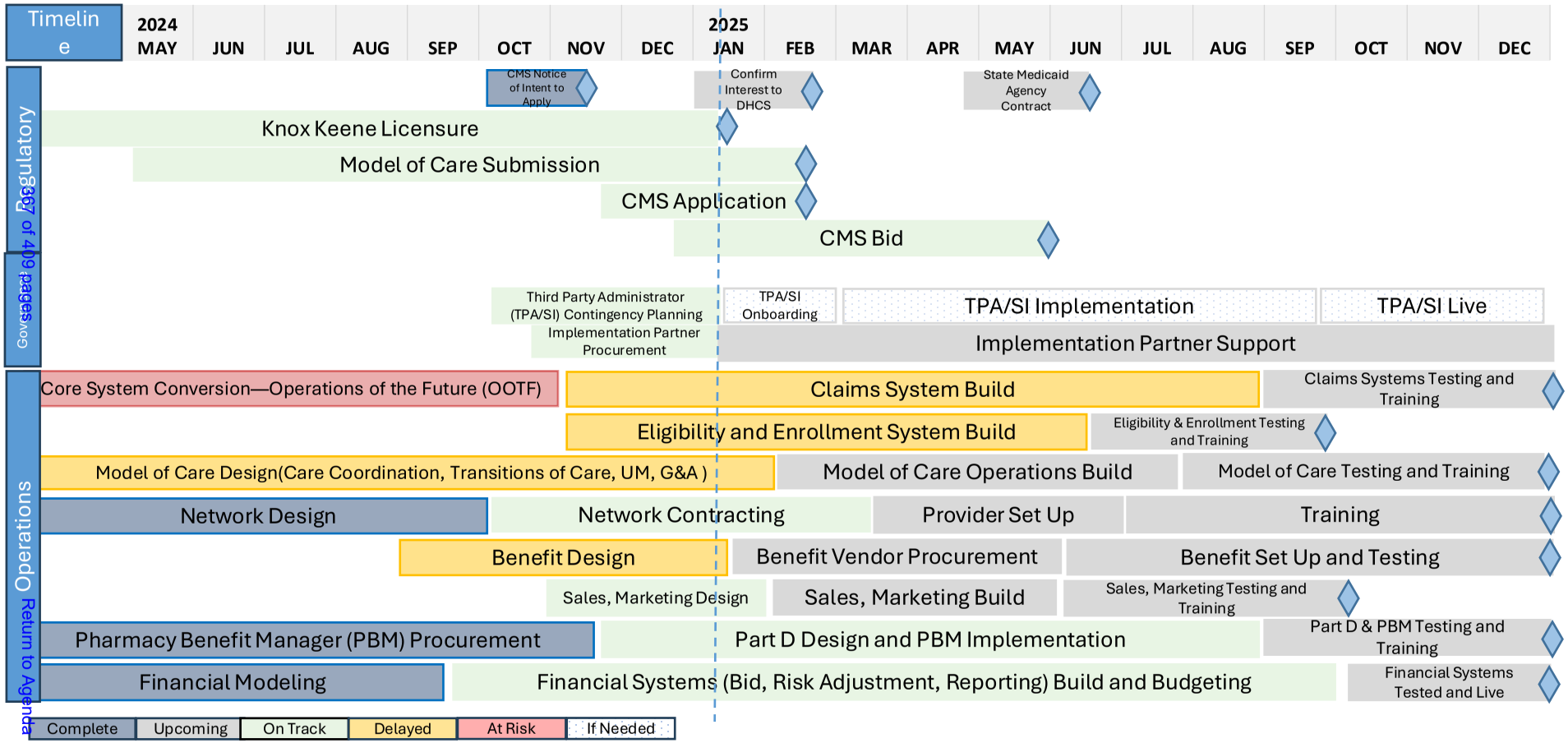
GCHP D-SNP Program Timeline



Regulatory

- Knox Keene License— 95% complete. All materials in to Department of Managed Health Care (DMHC) and waiting for final approval.
- CMS Application—50% complete. Elements assigned and work in process. On time for 2/12/25 submission.
- Model of Care Submission—80% complete. External review complete. Final draft in production. On track for 2/12/25 submission.
- CMS Bid—10% complete. Gathering internal data and conducting training. On track for 6/2/25 submission
- State Medicaid Agency Contract (SMAC)—Not yet started

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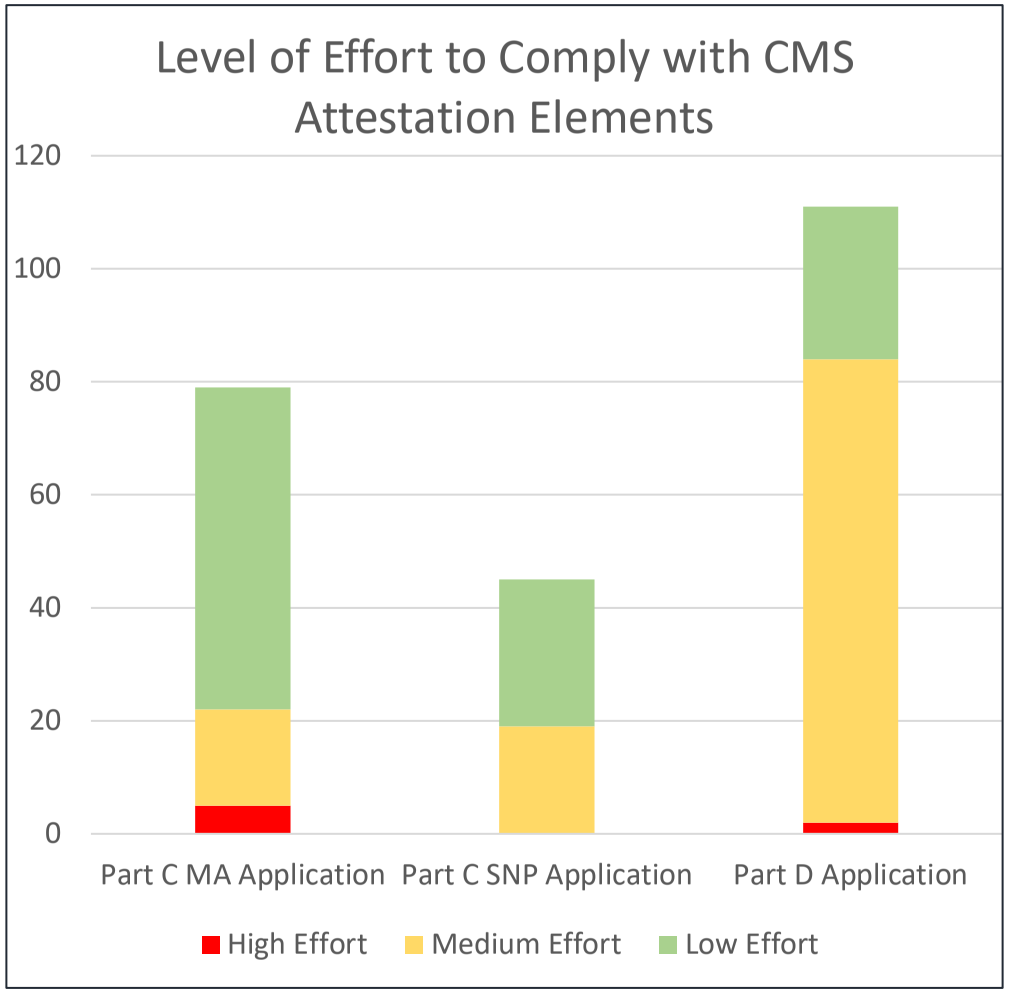
CMS Application Deeper Dive

All Health plans must fill out Part C and D application to offer Medicare Advantage plans to potential beneficiaries. This is an annual requirement, Health plans need to submit detailed applications to CMS outlining the specifics of the Part C and D plans (coverage details, premiums, and service areas, to be able to offer these options to Medicare beneficiaries).

- Part C: Medicare Advantage Application
  - 17 Sections
  - 79 Elements (questions to attest to)
  - 7 Uploads
- Part C: Special Needs Plan Application
  - 5 Sections
  - 28 Elements (questions to attest to)
  - 2 Uploads
- Part D Application
  - 24 Sections
  - 111 elements (questions to attest to)
  - 17 Uploads



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Model of Care (MOC) Deeper Dive

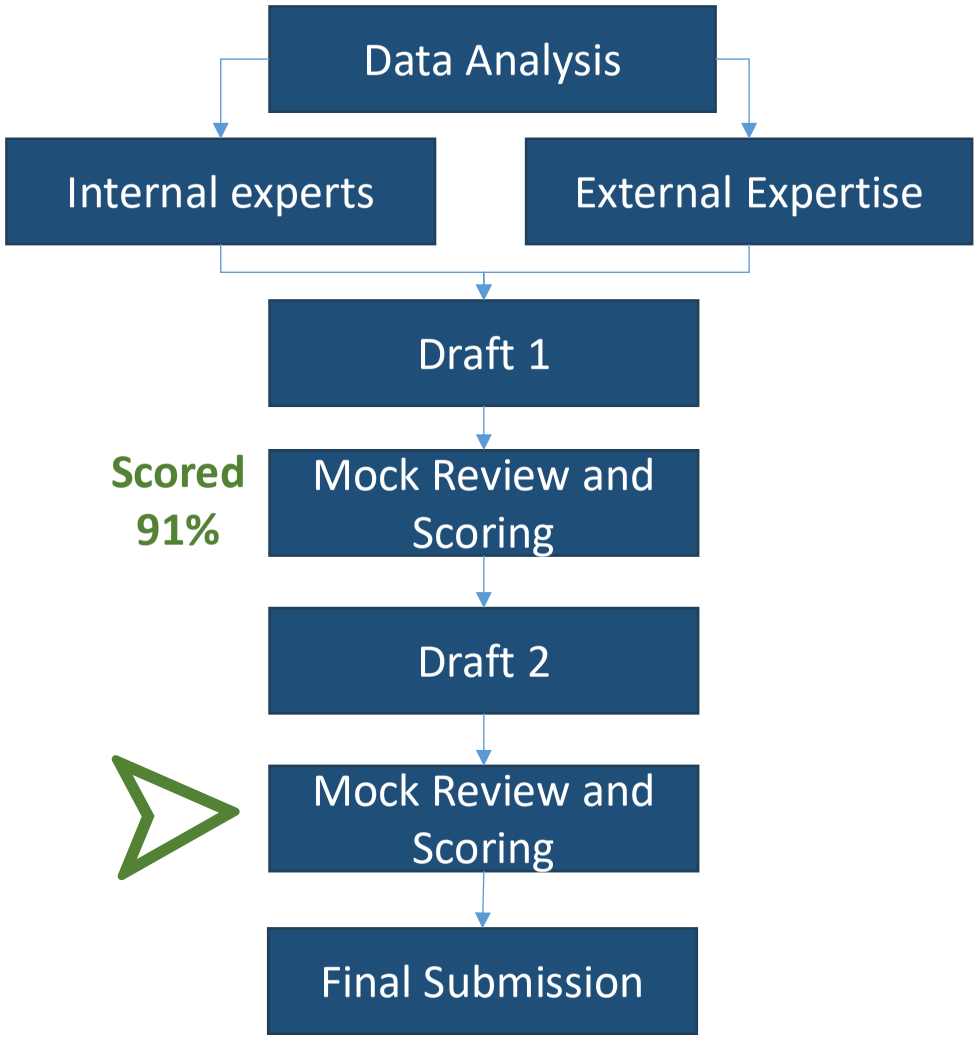
All Health plans must submit a Model of Care that meet National Committee for Quality Assurance (NCQA) SNP Requirements. California requires additional details. Goal is 3-year approval (score of 85% or higher).

MOC 1: Description of the Population—Demonstrates understanding of their experience and needs

MOC 2: Care Coordination—Ensures that needs and preferences are met

MOC 3: Network—Relevant facilities and providers to address unique and specialized needs

MOC 4: Quality and Performance Improvement—Continuously improve ability to deliver services and care



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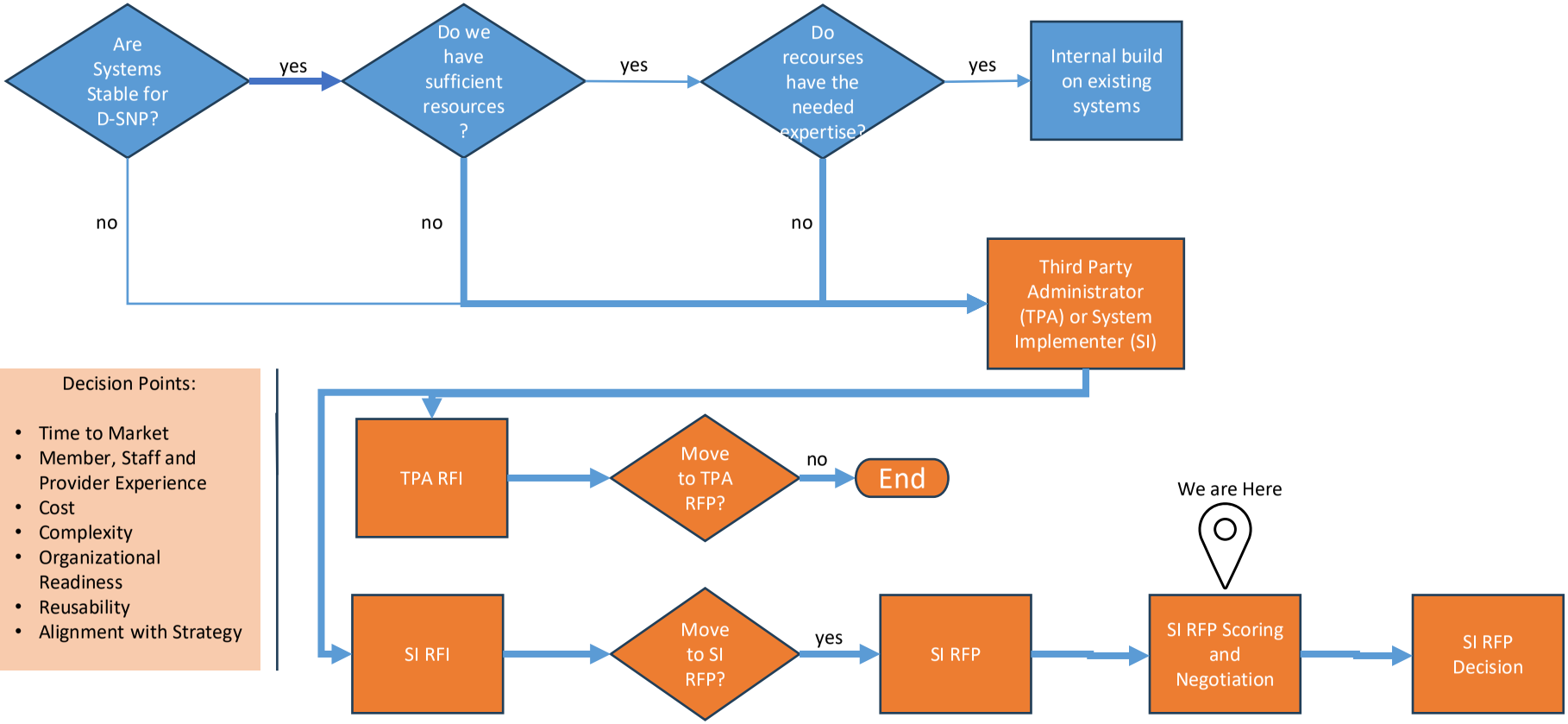
Governance System Implementation Partner Deeper Dive



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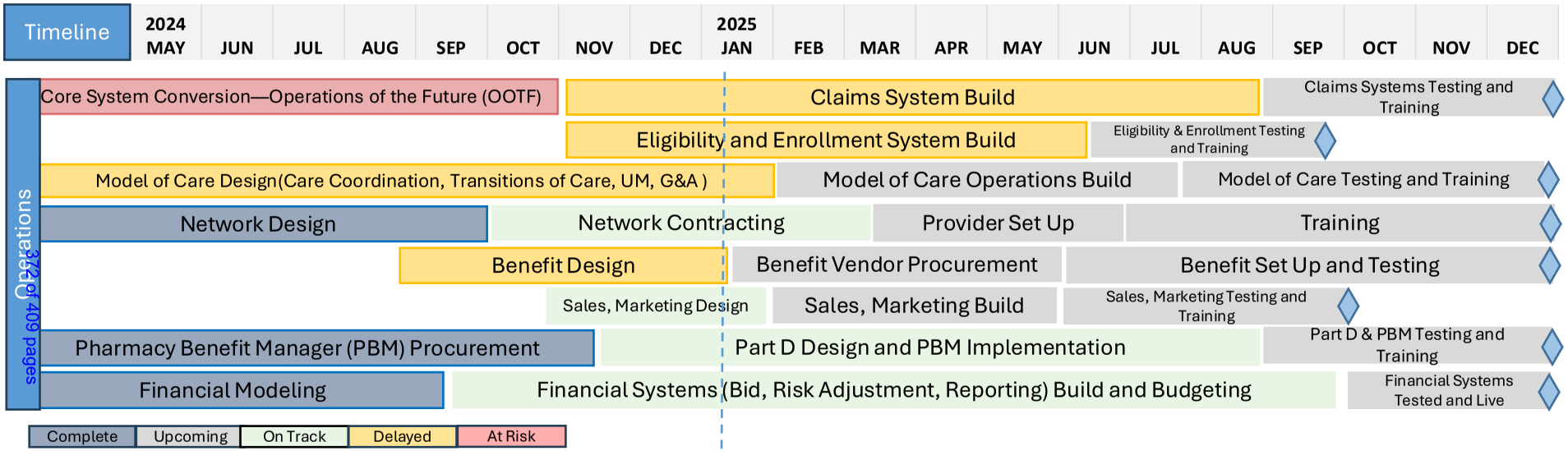
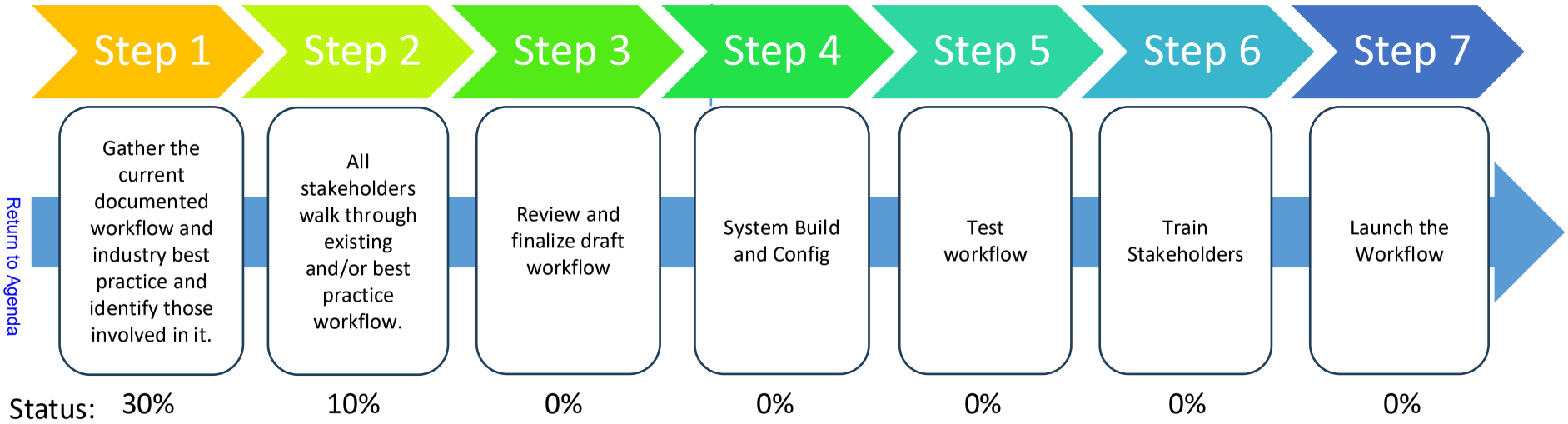
Operations Work Plan Deeper Dive





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AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Felix L. Nunez, M.D., Acting Chief Executive Officer

DATE: January 27, 2025

SUBJECT: Chief Executive Officer (CEO) Report

Acting Chief Executive Officer (CEO) Update

I am pleased to share a brief update as Acting Chief Executive Officer (CEO) and report on our ongoing activities and initiatives that support our mission of providing access to high quality and coordinating care for our members. As you will hear in reports today from our Leadership Team and staff, we remain busy and focused on the work of stabilizing our operational systems, implementing our D-SNP line of business, accelerating our quality efforts, and strengthening organizational development.

In my role, I have focused on supporting our talented mission-driven leadership and staff in their work, fostering alignment, collaboration, and accountability. The Executive and Leadership teams remain focused on working to better define our goals, communicate with staff, and improve project planning to accomplish these goals. We continue hold our Operating Steering, Leadership, and All-Team meetings to maintain our strategic alignment and foster an environment of transparency and open dialogue.

Today, you will hear from our Chief Financial Officer (CFO), Sara Dersch, about our mid-year budget reforecast. At this critical time of organizational development, this reforecast will detail key investments in our future. This commitment to our growth as a health plan includes significant investments in our operational and technical capabilities, as well as in our network and community. I wish to recognize the work of our Finance Team, led by Ms. Dersch, in advocating for and securing rates that best reflect the true cost of providing high quality care to our members. These efforts have helped us maintain momentum as we look to improve access and quality across our network.

You will also get an update from our Quality Team, which is led by our Senior Director of Quality Improvement, Kim Timmerman, and supported by our Chief Medical Officer, Dr. James Cruz, and our Chief Innovation Officer, Eve Gelb. The efforts of this team have reaped wonderful results, resulting in GCHP ranking fourth among all health plans for connecting members with vital screenings and immunizations.

We couldn't do it without partnering with our providers, and the team will be recognizing them later in the meeting with some awards for the highest performing individual clinics, most collaborative, most improved, and best in show. We will also be recognizing a quality champion!

While work remains in our never-ending quest for greater quality care for our members, we have made remarkable progress and remain committed to collaborating with and supporting our network partners in these efforts.

I, along with our Executive and our Leadership teams, have continued engaging with our sister health plans through direct communication with their leadership, as well as through our ongoing engagement with our trade associations:

- Local Health Plans of California (LHPC)
- California Association of Health Plans (CAHP)
- Association of Community Affiliated Plans (ACAP)

We value these relationships and have engaged in collaborative advocacy to strengthen funding for Medi-Cal, support County Organized Health Systems, and advance initiatives which improve access and quality of care for our members. Our collaborative efforts will continue with planned meetings with Marina Owen, CEO of CenCal Health and current chair of the LHPC Board of Directors, as well as attendance at meetings and conferences at the regional and national level, which will serve to provide key information and insights that will inform our ongoing work.

We remain closely connected to our state regulatory leadership at the state Department of Health Care Services (DHCS) through regular communications with key staff and attendance at health plan leadership meetings in Sacramento. We have worked to proactively engage with DHCS staff during this time of operational system implementation and have provided updates related to issues affecting our providers on a regular basis.

I also wish to express my sincere gratitude to the Commission for their participation in our Dec. 12, 2024, strategic planning retreat. Your engagement was the key to the success of the retreat, and as you will hear, your insights will be incorporated into our workplans and goal setting for the coming year. A heartfelt thank you to our commissioners who served on the planning committee and to our GCHP team, which was led by our Chief Member Experience and External Affairs Officer, Marlen Torres, along with vital support from Eve Gelb, Paul Aguilar, and Josephine Gallella.

I also wish to update you on the status of GCHP operations amid the wind and fire emergencies that have affected our community and our neighbors in Los Angeles County. We were able to maintain full operations during the wind emergency and catastrophic fires. Out of an abundance of caution, we limited onsite staff to critical personnel only. Prior to and during the wind and fire emergencies, we activated our internal emergency response team, which was led by our Operations Team leader, Holly Krull, and supported by Executive Director of Operations, Anna Sproule. The team met multiple times a day for several days to assess network and facility status, member and staff impact, and plan for business continuity. In addition, the team approved three sponsorships to support victims of the wind and fire emergency. The sponsorships are for:

- The American Red Cross: $50,000

- California Community Foundation: $50,000
- World Central Kitchen: $50,000

Lastly, I want to share that GCHP was recently recognized by the Partnership for a Healthy Ventura County as a 2025 Health Champion Award for our "leadership, dedication, and commitment to the residents of Ventura County, and for going above and beyond to improve the health, well-being, and overall quality of life of all those who they serve."

The Healthy Ventura County coalition and its leadership aims to formally acknowledge this year's Health Champions during a Ventura County Board of Supervisors meeting in March 2025.

Resilience, Innovation, Sustainability, & Equity (RISE) Grant Program

Since the Ventura County Medi-Cal Managed Care Commission (VCMMCC) approved the contract for the Institute for Health Care Improvement (IHI) as Gold Coast Health Plan's (GCHP) Grant Administrator in Oct. 2024, GCHP and the IHI team have worked diligently to stand up the Resilience, Innovation, Sustainability, & Equity (RISE) Grant Program. IHI and GCHP began meeting weekly to design the grant program and its administration.

The RISE Grant Program looks to measurably improve the quality of and access to medical and behavioral health care for the GCHP Medi-Cal population in Ventura County. The priority for the grants include:

1. Improving access and connections to care for GCHP member populations and/or geographic areas of Ventura County where there are objective unmet health care needs or access issues (e.g., pediatric care, where the average wait time for access exceeds objectively reasonable time periods).
2. Bringing care to GCHP members where they live, work, and/or go to school, through home-, community-, school-, and worksite-based care, or otherwise addressing how care is organized or grouped for ease of use.
3. Improving GCHP member health outcomes, experience, and education, including update of benefits and services that are culturally responsive and focused on health equity as measured by the state or federal funding sources.
4. Offering alternative and/or non-traditional health care solutions or modalities intended to remove structural barriers to care, reduce health care costs, and/or otherwise improve access and/or efficiency concerns, including, but not limited to, transportation, mobile clinics, telemedicine and other technology driven initiatives.

On Dec. 16, 2024, the RISE grant announcement and the opening of the grant's letter of interest intake form was posted on GCHP's website and shared with partners. The letter of interest allows organizations to propose grant ideas and concepts to GCHP and IHI. Prospective applicants should submit an optional letter of interest by Feb. 5, 2025.

The RISE Grant Program's application period will open on Jan. 22, 2025, and close on March 31, 2025. Once all applications are reviewed by the Grant Review Committee, GCHP will announce the grant awards on June 2, 2025.

GCHP will host two informational webinars to provide an overview of the program's application, application process, and timeline. GCHP will also hold virtual office hours to answer any additional questions.

Registration for informational webinars:

- Jan. 21, 2025 at 11 a.m. **Click here to register.**
- Feb. 4, 2025 at 8 a.m. **Click here to register.**

Registration for office hours:

- Feb. 12, 2025 at 9 a.m. **Click here to register.**
- March 6, 2025 at 11 a.m. **Click here to register.**

GCHP and IHI are now finalizing documents for the grant's administration, including applications and budgets, quarterly report templates and budgets, application FAQs, example applications for prospective applicants, and the grant review rubric.

For more information about the RISE Grant Program please visit, https://www.goldcoasthealthplan.org/community/grants/provider-grants-program/.

I. External Affairs

A. Federal Updates

The Centers for Medicare & Medicaid Services (CMS) Releases Proposed Medicare Advantage Part D Rule with D-SNP Impacts

On Nov. 26, 2024, the Centers for Medicare and Medicaid Services (CMS) released the Contract Year (CY) 2026 Policy and Technical Changes to the Medicare Advantage (MA) Program, Medicare Prescription Drug Benefit Program (Part D), Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE) proposed rule and accompanying fact sheet. The rule proposes new policies related to the coverage of anti-obesity medications in Part D and Medicaid, medical loss ratio and utilization management requirements, use of artificial intelligence (AI) tools, and provisions relating to Dual Special Need Plans (D-SNPs).

The proposed rule would require D-SNP plans to:

- Have integrated member ID cards for both Medicare and Medicaid plans. The proposal is limited to Applicable Integrated Plans (AIPs). **The state Department of Health Care Services (DHCS) already meets this requirement. However, stakeholders are seeking clarification on whether the Medi-Cal Rx ID card satisfies this requirement.**
- Conduct a single, integrated Health Risk Assessment (HRA) for both Medicare and Medicaid, replacing the separate HRAs currently used for each. CMS also proposes adopting specific standards to implement the requirement that all MA SNPs conduct an initial assessment and an annual reassessment of the individual's physical, psychosocial, and functional needs. ***These proposed requirements impose a stricter standard than what is currently required by DHCS.***

- Codify timeframes for all SNPs to conduct HRAs and develop Individualized Care Plans (ICPs), emphasizing active participation by enrollees or their representatives in the ICP development process. Specifically, CMS proposes to require that SNPs conduct the initial HRA within 30 days of the effective date of enrollment. CMS also proposes new requirements for all SNPs related to outreach to enrollees regarding completion of the HRA. CMS proposes that the SNP make at least three non-automated phone call attempts. If the enrollee has not responded, the SNP must send a follow-up letter. The SNP must document attempts to contact the enrollee, and if applicable, the enrollee's choice not to participate. **The DHCS D-SNP Policy Guide requires plans to "encourage participation of both members and primary care providers in development of the ICP and Interdisciplinary Care Teams (ICT) activities." Therefore, this would not be a significant change from current practice.**

GCHP is working with its trade associations to review and develop comments in response to the proposed rule. Comments are due to CMS by Jan. 27, 2025. The rule must be finalized by the next administration, so there is an increased likelihood that several of the proposed policies will not be finalized. Updates will be provided upon release of the final rule.

B. State Updates

Gov. Gavin Newsom Releases Proposed Budget

On Jan. 10, 2025, Gov. Gavin Newsom unveiled the Jan. 2025-26 budget proposal. Below are the high-level takeaways and GCHP Government Relations will follow up with an in-depth summary of the proposed budget in the February Commission report.

The January budget proposes a total state budget of $322.3B ($228.9B General Fund [GF]). Most funding will be allocated to health and human services ($127.1B), K-12 education ($84.7B), and higher education ($23.9B).

Notably, California has mitigated the GF deficit; the state's improving economic circumstances and last year's budget solutions including program reductions, reserve withdrawals, revenue and internal borrowing, fund shifts, programmatic delays and/or pauses, and deferrals were sufficient to fully eliminate the $46B shortfall. As a reminder, the budget deficit is the difference between projected state revenue and the estimated current baseline of spending on services. To protect against future budget shortfalls in the outyears, the Administration continues to prioritize ongoing commitments rather than new initiatives with fiscal obligations in 2025-26 budget.

For health care, $296.1B ($83.7B GF) is allocated for California Health and Human and Services (CalHHS) and $188.1B ($42.1B GF) is allotted for the Medi-Cal delivery system in 2025-26. The Administration has opted to increase Medi-Cal GF spending by $6.2B in 2025-26 compared to the 2024-25 January proposed GF budget allocations ($35.9B). According to the January budget, Medi-Cal is expected to cover about 14.5 million Californians in 2025-26, representing more than one-third of the total state population.

Health care, and specifically Medi-Cal programs and initiatives, continue to be a major priority for the Administration and the state to protect. Some specific initiatives that the Administration seeks to implement and/or expand include behavioral health transformation, managed care

organization (MCO) tax and Prop 35 changes, and the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT).

The budget is a working document; after extensive stakeholder discussions over the next few months, the Administration will release its updated budget in May. Through a state constitutional mandate, the Legislature must pass a balanced budget by June 15, 2025.

MCO Tax Update

To address last year's state budget shortfall, the Legislature and Gov. Newsom approved $46.8B in various budget solutions to achieve a balanced budget and protect core services. One notable budget solution was to increase the size of the existing MCO tax, which was approved in the 2023-24 budget and set to end in 2026. The 2024-25 final budget agreement expanded the MCO tax revenue limit and maintained $133M in 2024-25, $728M in 2025-26 and $1.2B in 2026-27 for provider rate increases.

In June 2024, California submitted a modification of the MCO tax waiver to CMS. The state put forward two key amendments: the inclusion of health plan Medicare revenue in the revenue limit calculation and the increase of the per-member tax rate from $205 to $274. These changes sought to expand the tax size, increase the ability of the state to draw down additional federal dollars, and augment the total state revenue.

In Nov. 2024, California voters approved Prop 35, which makes the MCO tax permanent beginning in 2027 and creates guidelines around which provider types and services will receive rate increases. With the passage of Prop 35, the rate increases outlined in California's 2024-25 budget are automatically inoperable. Below is the side-by-side breakdown of which services would be funded under the 2024-25 budget compared to Prop 35.

Services	2024-25 Budget	Passage of Prop. 35
Abortion Care and Spending	✓	✓
Air Ambulances	✓	
Behavioral Health Throughput		✓
Community-Based Adult services	✓	
CHWs	✓	
Community Hospital Outpatient		✓
Congregate Living Health Facilities	✓	
Continuous Coverage (Ages 0-5)	✓	
Public Hospitals		✓
Emergency Services	✓	✓
FQHCs and RHCs	✓	✓
Graduate Medical Education		✓
Ground Emergency Medical Transportation	✓	✓
Medi-Cal Workforce	✓	✓
Non-Emergency Medical Transportation	✓	
Pediatric Day Health Centers	✓	
Physician and Non-Physician Professional Services	✓	✓
Private Duty Nursing	✓	

Source: CalMatters

On Dec. 20, 2024, CMS approved California's MCO waiver amendment, which allows the state to proceed with implementation. With federal consent, the state receives approximately $7.2B in net revenue through Dec. 2026 to support the Medi-Cal delivery system. In terms of next steps, DHCS must certify federal approval in writing and provide notice to each MCO that is subject to the tax, outlining due dates and amounts payable for each installment and tax period.

Although the MCO waiver amendment was approved, the viability of future MCO taxes especially of this size is somewhat uncertain. Previously, the Trump Administration attempted to limit the scope, duration, and use of an MCO tax to draw down federal dollars. Although prior efforts have failed, these attempts may prove successful in the upcoming Trump presidency.

CMS Approves BH-CONNECT Waiver Including Transitional Rent Assistance

On Dec. 20, 2024, CMS approved the Section 1115 demonstration for BH-CONNECT, which includes Transitional Rent Assistance for five years, through 2029, the entirety of the BH-CONNECT waiver. Under the BH-CONNECT waiver, Transitional Rent Assistance will provide up to six months of rental support, through a member's managed care plan (MCP), for eligible Medi-Cal members transitioning from institutions, congregate settings, or homelessness. MCPs have the option to offer the benefit beginning in July 2025 and will be required to provide Transitional Rent Assistance to eligible members beginning Jan. 1, 2026.

For members with significant behavioral health needs, Transitional Rent is intended to serve as a bridge to permanent housing. The Behavioral Health Transformation funding dedicated to housing interventions will provide permanent rental subsidies and housing following transitional rent. GCHP is participating in the DHCS stakeholder workgroups to refine the policy previously outlined in the Transitional Rent Concept Paper.

GCHP continues to be actively engaged in stakeholder discussions at the local and state level on the development of the transitional rent policy and will continue to work with its trade association, Local Health Plans of California (LHPC), to provide input and feedback as DHCS develops and rolls out this new benefit.

DHCS Releases Quarterly Report on Enhanced Care Management (ECM) and Community Supports (CS)

On Dec. 20, 2024, DHCS published the latest update to the Enhanced Care Management (ECM) and Community Supports (CS) Quarterly Implementation Report. The report reflects claims data received by DHCS for dates of service from Jan. 1, 2022, through June 30, 2024. The report includes data at the state, county, and plan level for various utilization-based metrics involving ECM and CS services. As exemplified in the report, member enrollment and utilization of ECM and CS services has been rapidly increasing in California since the launch of the programs. GCHP follows the statewide trend, showing significant increases in member utilization of the ECM and CS benefits, and rendering services to more than 9,500 members in Ventura County since the launch of the program in 2022.

Between June 30, 2023, and June 30, 2024, GCHP delivered ECM services to 1,974 members (approximately 0.79% of GCHP's total membership) and delivered CS services to 7,574 members (approximately 3.02% of GCHP's total membership).

The ECM Populations of Focus (POF) with the highest utilization by GCHP members in Q2 2024 are:

- Individuals Experiencing Homelessness: 610 members
- Individuals with Serious Mental Health and/or SUD Needs: 342 members

- Adults Living in the Community and At-Risk for LTC: 320 members
- Individuals At-Risk for Avoidable Hospital or ED Utilization: 275 members

The CS services with the highest utilization by GCHP members in Q2 2024 are:

- Medically Tailored Meals: 4,020 members
- Housing Transition & Navigation Services: 583 members
- Recuperative Care: 75 members
- Respite Services: 73 members

DHCS continues to emphasize the importance of ECM and CS and has proposed ECM and CS measures to ensure that MCPs provide ECM and CS to members who need it in a timely manner while addressing their key care management needs. The latest reporting includes new data points reflecting the POFs Birth Equity and Individuals Transitioning from Incarceration and adds data relating to the percentage of active members enrolled in ECM by quarter. The new data points align with the proposed ECM and CS measures; the proposed primary measures are outlined below:

Proposed Primary ECM Measures:

- Demonstrate > 0% growth in the percentage of MCP members receiving ECM for the 12-month period from July 1, 2023, to June 30, 2024.
- Beginning Jan. 1, 2025, have at least one active provider per POF.
- Beginning Jan. 1, 2026, have at least one specialized provider per POF.
- Beginning Jan. 1, 2026, have at least 1% of MCO members receiving ECM, stratified by adult and children and youth members.

Proposed Primary CS Measures:

- Demonstrate > 0% growth in the number of CS community-based referrals, in the 12-month period from July 1, 2023, to June 30, 2024.
- Beginning Jan. 1, 2025, have at least one active CS provider for each CS service offered.
- MCP website must include 100% of required member and provider information and provider directories.

DHCS also intends to pursue secondary measures relating to equitable access, timely payment to providers, and ECM and CS utilization. DHCS will work with MCPs in 2025 on strategies for improving equitable access, continue the work on timely payment, and track and begin publicly reporting the ECM and CS utilization measurement data. Failure to meet the measures may result in Corrective Action Plans or other actions by DHCS. GCHP's Government Relations Team will continue to provide updates as the measures are finalized and updated reporting is released.

DHCS Updates Closed Loop Referral (CLR) and Member Information Sharing Guidance

As part of continued efforts to increase the availability and uptake of ECM and CS services, DHCS released updated Closed Loop Referral (CLR) guidance. Effective July 1, 2025, MCPs are required to communicate the "Loop Closure Date" and "Loop Closure Reason" the referring provider within two business days from receipt of the Return Transmission File from ECM and CS Services providers. Additionally, MCPs must respond to referring entities status requests within two business days.

In Dec. 2024, DHCS released updated guidance pertaining to Member-Level Information Sharing Between MCPs and ECM Providers and CS Member Information Sharing Guidance. The revised guidance is intended to support the implementation of CLR tracking requirements.

GCHP will participate in a DHCS webinar on the CLR guidance in early Feb. 2025 to support stakeholder implementation of the requirements. GCHP's Government Relations Team will provide updates as they become available.

MCPs Begin Rollout of Outreach and Education Plan to Increase Awareness of NSMHS Benefits

As required by SB 1019 and APL 24-012, GCHP developed a Member and Primary Care Provider (PCP) Outreach and Education plan to increase awareness of the availability of Non-specialty Mental Health Services (NSMHS). GCHP developed the plan using feedback from its Community Advisory Committee (CAC), Quality Improvement and Health Equity Committee (QIHEC), and other stakeholders on how to best educate members and providers on the availability and coverage of NSMHS. The most recent Population Needs Assessment and a Utilization Assessment of NSMHS were also used to develop the plan.

DHCS required all plans to be submitted by Dec. 31, 2024, and will communicate any requested changes to plans during this Initial Implementation Phase. MCPs are required to address modifications in the written plan and return to DHCS for approval by June 30, 2025. GCHP submitted all required materials to DHCS in advance of the Dec. 31, 2024 deadline and has posted the required materials to GCHP's website. Upon full implementation, managed care plans are required to annually review and submit to DHCS by Dec. 31, the updated Outreach and Education Plan and make corresponding updates to the website materials by Jan. 1.

All-Plan Letters

DHCS rounded out 2024 with the release several draft and final APLs. The draft APLs cover issues including Threshold Language Requirements and Community Advisory Committees and the final APLs cover issues including training programs, medical loss ratios (MLR), and minor consent for mental health services.

DHCS sought public feedback on a draft APL updating Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, and Alternative Formats. The draft includes changes in response to 2024 Office of Civil Rights (OCR) guidance. Specifically, DHCS proposes to remove the four-factor analysis and replace it with regulation that contains more specificity and flexibility for the meaningful access to individuals with low English proficiency (LEP). The draft also provides specific requirements for a nondiscrimination notice. GCHP contributed feedback to its trade association, LHPC, to recommend alignment

with the National Association of Quality Assurance (NCQA) and request other clarifications to ensure managed care plans have all information necessary for implementation. Government Relations will provide updates when the final APL is released.

DHCS also released final APLs, including updating the grievance and appeals monitoring systems requirements of the Diversity, Equity, and Inclusion (DEI) Training Program (APL 24-016) and the final Transgender, Gender Diverse or Intersex (TGI) Cultural Competency Training Programs and Provider Directory Requirements (APL 24-017). GCHP will be piloting the DEI training program during the first half of 2025, with full implementation completed by Dec. 31, 2025. The DEI training must be completed by all MCP staff, Contractors, Subcontractors, downstream Subcontractors, and Network Providers.

APL 24-017 requires managed care plans to develop and implement a TGI training program for all member-facing staff and providers as well as update provider directories by March 1, 2025. MCPs must update provider directories to include information identifying which of the MCP's in-network providers have voluntarily affirmed they offer and have provided gender-affirming care and ensure that newly received affirmations are reflected on the directory within 30 calendar days. A cross-functional workgroup is underway to implement the various requirements.

DHCS is also imposing new Medical Loss Ratio requirements on Subcontractors and Downstream Subcontractors through APL 24-018. The APL requires for the calendar year (CY) 2023 MLR reporting year, MCPs must impose MLR reporting requirements to applicable Subcontractors and Downstream Subcontractors. For CY 2023 MLR reporting year, and until modified by DHCS, applicable subcontractors that receive $30M or more in Medi-Cal capitation annually from a single upstream entity as payment for services rendered in a single county or rating region for which they assume risk and are not directly providing, will be subject to MLR reporting requirements. For future reporting years, DHCS will make use of the actual MLR data reported by MCPs and their Subcontractors and Downstream Subcontractors to evaluate the continued appropriateness of the established materiality threshold. GCHP is in the process of communicating and implementing the requirements.

In accordance with Assembly Bill (AB) 665, DHCS issued a final APL 24-019 Dec. 31, 2024, updating Minor Consent for Mental Health Services requirements. The APL aligns with existing law and provides that effective July 1, 2024, without consent from a parent or legal guardian, minors 12 years of age or older may consent to non-specialty outpatient Medi-Cal mental health treatment or counseling if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the outpatient services. The APL removes the requirement that a minor must present a danger of serious physical or mental harm to self or others without mental health treatment or be an alleged victim of incest of child abuse in order to consent to outpatient mental health treatment or counseling. GCHP's Policies and Procedures are in the process of being updated to reflect this change.

D. State Legislative Activity

The state Legislature reconvened on Jan. 6, 2025. Over the next few months, the state Senate and Assembly will meet to discuss key policy bills and the governor's proposed 2025-26 budget.

Accountability continues to be a focal point for the Legislature and Administration. California is in the process of launching several accountability dashboards which allow the public access to county data in the areas of homelessness, housing, and behavioral health. On Jan. 6, 2025, Gov. Newsom held a press conference on the 2025-26 budget and expressed the need to increase accountability measures and ensure that counties are responsible for state commitments especially regarding Community Assistance, Recovery and Empowerment (CARE) Court and the implementation timelines.

On the legislative side, there will likely be several bills aimed at expanding government oversight, enhancing clarity in health care processes such as prior authorization and utilization management, and requiring managed care plans and/or counties to self-report on quality metrics and access to care. Last year, several bills sought to increase transparency on network adequacy, provider directories, and pre-authorization. The Administration and Legislature are committed to increasing accountability efforts and ensuring that state funds are used efficiently to support the most vulnerable Californians.

Another theme is the expansion of reproductive health care protections. With the shift in federal administrations, bills ensuring access to medication for abortion and safeguarding patient reproductive health information are expected. AB 45 and AB 54 are two bills that have been introduced in the 2025 legislative session that seek to limit reproductive health data-sharing and maintain access to abortion medication, such as mifepristone and misoprostol. As a safe-haven state, California continues to lead national efforts to protect women and abortion providers.

The last day for bills to be introduced in either legislative house is Feb. 21, 2025. Policy committees must meet and report bills before July 18, 2025. The governor has until Sept. 12, 2025 to sign or veto bills. GCHP's Government Relations Team will continue to provide key updates about California's 2025-26 legislative cycle to ensure the business and Commission are aware of all significant legislative and/or budgetary changes that may impact the Medi-Cal delivery system and/or Medi-Cal managed care plan.

Bill Number	Bill Title	Sponsor	Current Status	Summary
SB 32	Public Health: Maternity Ward Closures	Weber Pierson	Introduced	Existing law establishes the licensure and regulation of health facilities by the state Department of Public Health, including, among others, general acute care hospitals. This bill would express the intent of the Legislature to enact legislation to address maternity ward closures.

Bill Number	Bill Title	Sponsor	Current Status	Summary
SB 40	Health Care Coverage: Insulin	Wiener	Introduced	This bill would generally prohibit a health care plan or disability insurer from imposing a copayment of more than $35 for a 30-day supply of an insulin prescription drug or imposing a deductible, coinsurance, or any other cost sharing on an insulin prescription drug, except as specified. On and after Jan. 1, 2026, the bill would prohibit a health care service plan or disability insurer from imposing step therapy protocols as a prerequisite to authorizing coverage of insulin.
SB 41	Pharmacy Benefits	Wiener	Introduced	This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after Jan. 1, 2026, that provides prescription drug coverage from calculating an enrollee's or insured's cost sharing at an amount that exceeds the actual rate paid for the prescription drug, and would require the contract or policy to include specified cost-sharing provisions. The bill would prohibit a contract between a pharmacy benefit manager and a health care service plan or health insurer that is executed, amended, or renewed on or after Jan. 1, 2026, from authorizing spread pricing.

Bill Number	Bill Title	Sponsor	Current Status	Summary
AB 29	Medi-Cal: Adverse Childhood Experiences Trauma Screenings: Providers	Arambula	Introduced	This bill would require the department to include: 1. Community-based organizations and local health jurisdictions that provide health services through community health workers, and 2. Doulas that are enrolled Medi-Cal providers, as providers qualified to provide and eligible to receive, payments for ACEs trauma screenings pursuant to the provisions described above. The bill would require the department to file a state plan amendment and seek any federal approvals it deems necessary to implement these provisions and condition implementation on receipt of any necessary federal approvals and the availability of federal financial participation.
AB 40	Emergency Services and Care	Bonta	Introduced	Existing law provides for the licensing and regulation of health facilities by the state Department of Public Health and makes a violation of those provisions a crime. Existing law requires a health facility to provide emergency services and care upon request or when a person is in danger of loss of life, serious injury, or illness, and requires the health care service plan to reimburse providers for emergency and care. This bill would additionally define “emergency services and care” for the above-described purposes to mean reproductive health services, including abortion.

Bill Number	Bill Title	Sponsor	Current Status	Summary
AB 45	Privacy: Health Care Data	Bauer-Kahan	Introduced	This bill would state the intent of the Legislature to enact legislation to make it unlawful to geofence an entity that provides in-person health care services and to prohibit health care providers from releasing medical research information related to an individual seeking or obtaining an abortion in response to a subpoena or request if that subpoena or request is based on another state's laws that interfere with a person's rights under the Reproductive Privacy Act.
AB 54	Access to Safe Abortion Care Act	Krell	Introduced	Existing law, the Reproductive Privacy Act, prohibits the state from denying or interfering with a pregnant person's right to seek an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the pregnant person. The Access to Safe Abortion Care Act would make legislative findings about medication abortion, with a focus on use of the drugs mifepristone and misoprostol. The bill would state the intent of the Legislature to ensure access to medication abortion.
AB 55	Alternative Birth Centers: Licensing and Medi-Cal Reimbursement	Bonta	Introduced	Under existing law, as a criterion under both the licensing provisions and the Medi-Cal reimbursement provisions described above, the facility is required to be a provider of comprehensive perinatal services as defined in the Medi-Cal provisions. This bill would remove, under both sets of criteria, the certification condition of being a provider of comprehensive perinatal services as defined in the Medi-Cal provisions.

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 Dec. 2024:

Organization	Description	Amount
City of Oxnard Senior Services	The City of Oxnard Senior Center operates four senior centers dedicated to meeting the needs of Oxnard's older residents through a variety of programs and enrichment activities. The funding will support their annual "Senior Services Holiday Celebration."	$1,000
Rainbow Connection Family Resources Center, A Program of Tri-Counties Regional Center	Rainbow Connection is dedicated to offering understanding, support, education, information, and resources to all members of the community in both English and Spanish. The sponsorship supports their Annual Toy Event, benefiting children with developmental disabilities served through Tri-Counties Regional Center.	$1,000
For the Troops: Military Tribute Gala Honoring WWII & Korean War Veterans	The "For The Troops Military Tribute Gala Honoring World War II and Korean War Veterans" is held at the Ronald Reagan Presidential Library and Museum—a patriotic and fitting setting for this heartfelt tribute to our U.S. military veterans. Funds raised will be used for care packages to deployed service members.	$1,000
Oxnard Downtowners: Christmas Parade	The Oxnard Downtowners was formed in the late 1980s by a group of downtown merchants and volunteers committed to a healthy and vibrant downtown.	$500
TOTAL		**$ 3,500**

F. Community Relations: Community Meetings and Events

Between Dec. 2024 and Jan. 14, 2025, the Community Relations Team provided information on GCHP benefits and services at four community events. The team also organized a focus group at the ARC Foundation of Oxnard in collaboration with GCHP's Health Education Department to

get input from GCHP members on new benefits. In partnership with Ventura County Medical Center clinics, the team organized four health fairs at three different clinics to continue to connect members with important screenings. Lastly, the team attended four collaborative meetings and exchanged information and resources with community partners.

Food Distributions	
GCHP's Community Relations Team was onsite at these food distributions to provide resources, answer questions, and promote health care initiatives.	
Organization	**Date**
Samaritan Center	Dec. 19, 2024
Collaborative Meeting	
These collaborative meetings engage community-based organizations in the sharing of resources, announcements, and upcoming community events.	
Partnership for Safe Families and Communities	Dec. 4, 2024
Outreach Coordinators meetings	Dec. 4, 2024 Jan. 8, 2025
Oral Health Advisory Health Committee meeting	Jan. 9, 2025
Community Events	
Community events offer an opportunity to engage with community and GCHP members. Participants learned about community resources and GCHP benefits and services.	
Oxnard Tamal Festival and Christmas Parade	Dec. 7, 2024
Dual-Eligible Special Needs Plan focus group at the ARC of Oxnard	Dec. 9, 2024
Oxnard School District Winter Resource Fair at the R.J. Frank Academy	Dec. 10, 2024
City of Oxnard senior services Christmas celebration	Dec. 13, 2024
Health Fairs	
VCMC Magnolia Clinic: Women's health screenings	Dec. 4, 2024

Health Fairs	
VCMC Sierra Vista: Mammogram screenings	Dec. 11, 2024
VCMC Las Islas Clinic: Women's health screenings	Dec. 11, 2024
VCMC Magnolia Clinic: Women's health screenings	Dec. 18, 2024

II. PLAN OPERATIONS

A. Membership

	VCMC	CLINICAS	CMH	DIGNITY	PCP-OTHER	ADMIN MEMBERS	NOT ASSIGNED
Dec-24	94,445	53,535	33,927	0	4,472	46,349	11,150
Nov-24	93,309	53,115	33,512	5,787	5,580	46,127	4,740
Oct-24	93,611	52,449	33,091	6,499	4,570	46,647	3,035

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	Dec. 2024
Total Administrative Members	46,349
Share of Cost (SOC)	659
Long-Term Care (LTC)	773
Breast and Cervical Cancer Treatment Program (BCCTP)	20
Hospice (REST-SVS)	28
Out of Area (Not in Ventura County)	393
DUALS (A, AB, ABD, AD, B, BD)	27,488
Commercial Other Health Insurance (OHI) (Removing Medicare, Medicare Retro Billing, and Null)	20,151

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 Network Operations (PNO)

Regulatory / Audit Updates

The annual Subcontractor Network Certification (SNC), administered by the Department of Health Care Services (DHCS), was launched in Oct. 2024. The SNC is conducted in two phases and ensures that GCHP's subcontractor network meets both state and federal network adequacy and access requirements.

For the Phase 1 deliverable, the Provider Network Operations (PNO) team submitted the SNC Landscape Analysis template. It was approved. Phase 2 deliverables were submitted in Jan. 2025.

DHCS implemented provider network readiness assessments, which are used to monitor a Managed Care Plan's (MCP's) network for newly launched covered services, initiatives, or programs. PNO submitted readiness deliverables for Community Based Adult Services (CBAS) and Memorandums of Understanding (MOUs) with local agencies.

Other notable regulatory deliverables include:

- Quarterly Network Report (QNR)
- Delegation Landscape Report
- DHCS Timely Access Report
- Healthcare Effectiveness Data and Information Set (HEDIS) Work Plan

Provider Directory

PNO updated the web-based provider directory to meet NCQA requirements. It has new features that make it easier for users to locate health care services, including enhanced search option capabilities and a location search tool. Additionally, users can now search by provider, specialty, provider language(s) and provider gender. Users can also filter location search results by facility type, location, and provider name for a more personalized experience.

Targeted Rate Increase (TRI)

To comply with *All-Plan Letter (APL) 24-007, Targeted Provider Rate Increases* PNO worked with the Finance and Operations teams to complete an analysis to identify network providers that are both in and out of scope for the Targeted Rate Increase (TRI) based on whether their reimbursement calculation is above or below the required 87.5% of Medicare. This included a separate calculation of capitation rates to ensure the reimbursement met the TRI threshold amount of 87.5% of Medicare. Network providers whose capitation rates were less than the TRI threshold received a contract amendment reflecting updated capitation rates that meet the reimbursement requirement.

GCHP sent notices to providers about the implementation of TRI in accordance with APL 24-007.

For qualifying network providers, claims were identified to calculate the variance between what was paid and the updated TRI rate. Additionally, an analysis was completed to calculate the retroactive capitation rates for those network providers who received an increase. In both situations, calculations were completed retroactively to Jan. 1, 2024.

Payments for retroactive claims and capitation adjustments were sent to providers ahead of the Jan. 31, 2025, deadline.

Operations of the Future

PNO continues to outreach to and train providers on the new Provider Portal and to address any escalated issues on claims and operational processes. The portal currently has 4,266 registered users.

Additionally, PNO is partnering with the Operations and IT Departments to help facilitate escalated issues for providers that need help with claim payment and remit issues.

Provider Network Developments: Dec. 1-31, 2024

Network Developments for New Contracts	
Provider Additions Fulfilling Network Gaps	**Count**
Bariatrics Specialist	1
Orthopedic Surgery	1
Home Health	1
Provider Additions Fulfilling Network Gaps	**Count**
Dermatology Group	1
Primary Care Provider (PCP) Group	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	
Provider Additions and Terminations	**Count**
Additions	62
Terminations	105
Midwife	0

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**
	Oct-24	**Nov-24**	
Hospitals	**0**	**0**	**25**
Acute Care	0	0	19
Long-Term Acute Care (LTAC)	0	0	1
Tertiary	0	0	5
Providers	**191**	**88**	**8,362**
Primary Care Providers (PCPs) & Mid-levels	2	10	525
Specialists	160	60	7,001
Hospitalists	29	18	836
Ancillary	**6**	**6**	**657**
Ambulatory Surgery Center (ASC)	0	0	8
Community-Based Adult Services (CBAS)	0	0	14
Durable Medical Equipment (DME)	0	0	100
Home Health	0	0	30
Hospice	0	0	22
Laboratory	0	0	40
Optometry	1	1	110
Occupational Therapy (OT) / Physical Therapy (PT) / Speech Therapy (ST)	3	4	184
Radiology / Imaging	0	0	64
Skilled Nursing Facility (SNF) / Long-Term Care (LTC) / Congregate Living Facility (CLF) / Intermediate Care Facility (ICF)	2	1	85
Behavioral Health	**10**	**70**	**674**

California Advancing and Innovating Medi-Cal (CalAIM) and Non-Traditional Providers	Oct24	Nov24	Total
Enhanced Care Management (ECM)	0	0	11
Community Supports (CS)	0	0	42
Community Health Worker (CHW)	0	0	6
Doulas	0	0	1
	0	**0**	**60**

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

Initial contracting efforts are completed for the Exclusively Aligned Enrollment (EAE) / Duals Special Needs Plan (D-SNP) expansion. GCHP sent contract amendments to providers that signed a Letter of Intent for the EAE D-SNP program. This initial phase of amendments represents 82% of the network adequacy required by Medicare.

GCHP secured signed Amendments from the following key providers:

- County of Ventura (Hospital, PCP, SCP)
- Clinicas Del Camino Real (PCP, SCP)
- Community Memorial Health (Hospital, PCP, SCP)
- Coastal View Nursing (Skilled Nursing Facility)
- Ventura Post Acute (Skilled Nursing Facility)
- Greenfield Care Center (Skilled Nursing Facility)
- Simi Dialysis

In preparation for the Network Adequacy / HSD Table submission to the Centers for Medicare & Medicaid Services (CMS), PNO is conducting the necessary analysis to identify network specialty gaps to ensure providers are contracted either directly or through a Letter of Intent. Submission to CMS is Feb. 12, 2025, and PNO anticipates having most – if not all – network gaps filled prior to submission.

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.

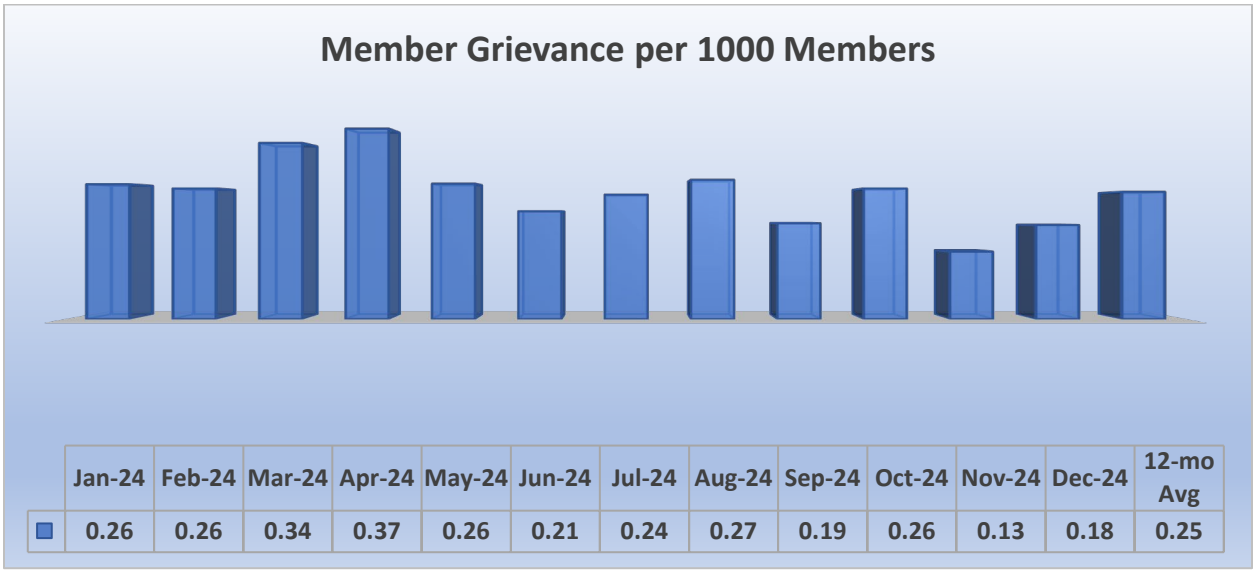
The following table includes audits and CAPs that are open and closed. Closed audits are removed after they are reported to the Commission. The table reflects changes in activity through Dec. 31, 2024.

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Carelon Behavioral Health (Carelon)	Annual Member Experience (ME), Network Management (NET), Quality Improvement (QI), Utilization Management (UM), Cultural & Linguistic (C&L) Audit	Closed	9/12/2024	11/18/2024	N/A
Carelon	2024 Q4 UM Audit	Closed	11/1/2024	12/10/2024	N/A
Carelon	2024 Annual Claims Audit	Closed	7/12/2024	12/03/2024	N/A
Carelon	2024 Annual Call Center Audit	Closed	9/9/2024	12/9/2024	N/A

Delegate	Audit Year / Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Clinicas del Camino Real (CDCR)	2023 Quarterly Focused Claims Audit (July)	Open	9/7/2023	Under CAP	N/A
CDCR	2024 Q3 Focused Claims Audit	Open	10/1/2024	Under CAP	N/A
CDCR	2024 Q4 UM Audit	Closed	10/18/2024	11/20/2024	N/A
Ventura Transit System (VTS)	2024 Annual Call Center Audit	Closed	4/19/2024	11/13/2024	N/A
VTS	2024 Downstream Subcontractor Audit	Open	8/30/2024	Under CAP	N/A
VTS	2024 NMT/NEMT Vehicle Audit	Open	11/20/2024	Under CAP	NA
Vision Service Plan (VSP)	2024 Annual Claims Audit	Open	10/25/2024	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**
N/A	N/A	N/A	N/A	N/A	N/A

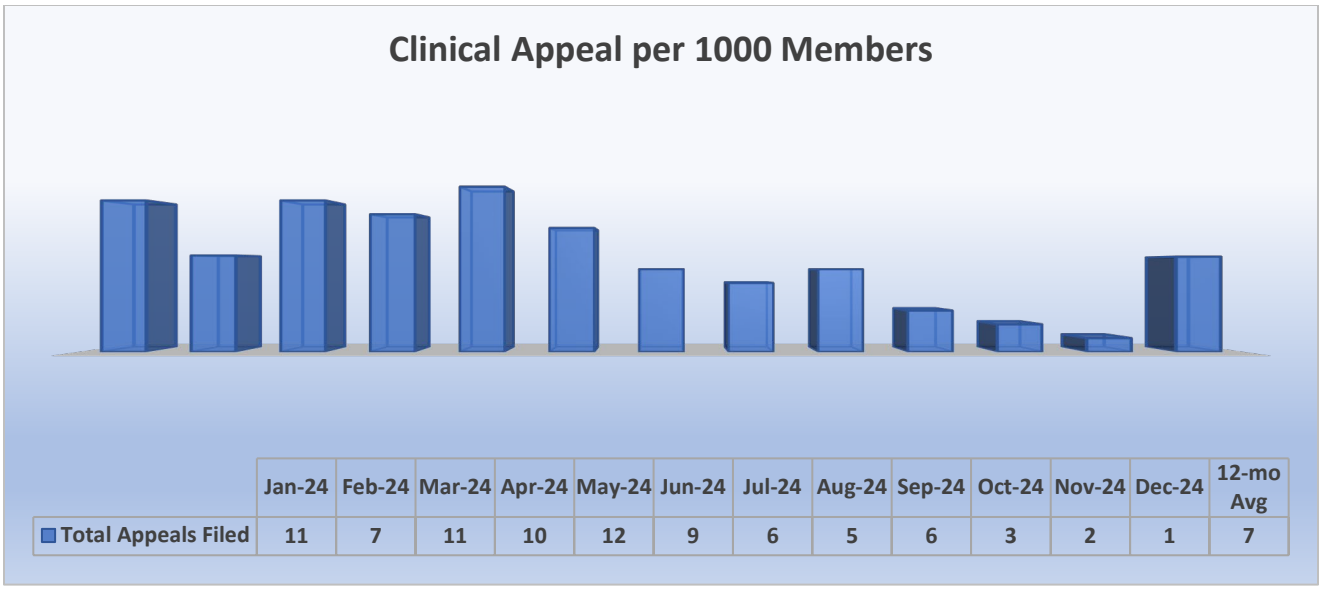
D. Grievance and Appeals



Member Grievances per 1,000 Members

The data show GCHP's volume of grievances increased in Dec. 2024. In Dec. 2024, GCHP received 45 member grievances. Overall, the volume is still relatively low, compared to the number of enrolled members. The 12-month average of enrolled members is 247,353, with an average annual grievance rate of .25 grievances per 1,000 members.

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



	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	12-mo Avg
Total Appeals Filed	11	7	11	10	12	9	6	5	6	3	2	1	7

Clinical Appeals per 1,000 Members

The data comparison volume is based on the 12-month average of .03 appeals per 1,000 members. In Dec. 2024, GCHP received one clinical appeal, which was upheld.*

*Grievance and Appeals case file data can be provided upon request.

RECOMMENDATION:

Accept and file.

AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: James Cruz, MD, Acting Chief Medical Officer

DATE: January 27, 2025

SUBJECT: Chief Medical Officer (CMO) Report

CMO COMMISSION REPORT – January 2025

The Chief Medical Officer report is delighted to present the continuing success and progress within the Health Services Department. Gold Coast Health Plan's (GCHP's) Health Equity Officer, Sr. Director of Quality Improvement, Sr. Director of Utilization Management, Interim Director of Care Management, and Director of Pharmacy have provided a summary of their department's progress since the last Chief Medical Officer report to the Commission.

HEALTH EQUITY

The Health Equity Officer has nearly completed the Human Resources onboarding and new hire orientation process. The Health Equity Officer has initiated work on two key areas.

a. Submitted GCHP's application to the California Improvement Network (CIN). The CIN is a learning and action community, sponsored by the California Health Care Foundation and the University of California, San Francisco, which advances equitable health care experiences and outcomes for Californians through cross-sector connections, spreading best practices, and guidance on how to best implement health equity improvement efforts. Recognizing that advancing health equity requires coordination of health and social services in every community, the CIN is recruiting for 18 Health Care Organizations and 7 Community Based Organizations for their upcoming two-year cycle (March 2025 - March 2027). We anticipate hearing back soon from the CIN that GCHP has been accepted as a participating Health Care Organization. Notable, CIN provides meaningful financial resources to support the Health Plan Organization's participation.

b. In accordance with Department of Health Care Services (DHCS) All Plan Letter 4-017 regarding Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements, GCHP has initiated a plan to deliver the requirement that Medi-Cal managed care plans must provide cultural competency training and provider directory changes for the purposes of providing evidenced based trans-inclusive care to members. The initial training must be completed no later than March 1, 2025. The majority of managed care plans are not prepared to complete the trainings by the March 1, 2025 date due to lack of clarity and guidance from DHCS.

GCHP has joined with the other managed care plans asking for an extension of the March 1 deadline.

CARE MANAGEMENT

During the windstorm emergency, the care management team aggressively worked and prioritized identifying members impacted by the prolonged loss of power. Specifically, during the power outage, one Clinicas Del Camino Real (CDCR) clinic site was closed. CDCR issued a message to patients that redirected them to their sister CDCR clinic sites. GCHP care managers were ready to assist any GCHP members who required transportation to a sister clinic site. A dialysis center in Simi Valley was closed for two days. The GCHP care management team collaborated with the dialysis site, and Ventura Transit System to identify impacted GCHP members scheduled for dialysis on those days. Five GCHP members were identified, and treatment at an alternative dialysis center was coordinated without disrupting the members' scheduled dialysis treatment.

UTILIZATION MANAGEMENT

Utilization Management continues to work in a highly aligned and focused way to maintain regulatory compliance. We continue to work diligently to achieve National Committee for Quality Assurance (NCQA) Health Plan Accreditation (HPA). Utilization Management (UM) completed its second mock audit in October 2024. NCQA compliance increased by 47% with Utilization Management earning 67% of the applicable points in each standard category. To earn HPA, GCHP Utilization Management Department must meet at least 80% of applicable points in each standard category. The utilization management team is participating in bi-weekly workgroups to address gaps in NCQA UM processes and remediate all gaps to achieve 100% of applicable points in each standard category. The Utilization Management Department in on track to meet all NCQA deliverables for Health Plan Accreditation.

Overall, Utilization Management remains dedicated to enhancing our daily operations to improve member access to essential medical care and reduce administrative burdens for our network providers.

QUALITY IMPROVEMENT

Riding the Wave of Quality: Gold Coast Health Plan Quality Convocation

To begin the new year with a continued focus on quality and celebrate MY 2023 achievements, Gold Coast Health Plan intended to host its inaugural Quality Convocation event on January 8th. However, in order to ensure the safety of attendees and GCHP staff, the Quality Convocation was cancelled due to the catastrophic fires in LA County and wind events impacting Ventura County. The intent of the Quality Convocation was to convene network provider quality improvement stakeholders and GCHP quality improvement staff and leaders to celebrate the significant collaborative efforts that demonstrated impressive results on improving member health outcomes and ensuring a high-quality member experience. We would like to thank all planned attendees for their patience as the event was rescheduled

multiple times and congratulate all award winners for their achievements and unwavering dedication to quality improvement.

National Committee for Quality Assurance (NCQA) Accreditation Project Update: January 2025

GCHP continues to prepare to achieve NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA) by January 2026, as mandated under CalAIM. The HEA survey start date is confirmed for June 10, 2025. The HPA survey start date is confirmed for October 7, 2025.

In preparation for the 2025 surveys, the NCQA project team organized mock surveys with our contracted NCQA consultants, The Mihalik Group (TMG), and GCHP business owners. The HEA mock survey was completed in late-September 2024 and scored an overall percentage of 52% (an increase of 41% since the first mock survey). The HEA Workgroup continues to meet bi-weekly to remediate remaining gaps. All HEA policies have been finalized and approved by TMG. HEA reports are being updated with the latest data to meet NCQA's look back period.

The HPA mock survey was completed in mid-December 2024 and the table below shows the overall scoring by each HPA Standard Category. Survey findings were shared and reviewed with business owners, and remediation efforts are in place to address remaining gaps. Note that TMG's scoring was conservatively based on only "fully met" items. Items that were scored as "conditionally met" but are not yet within NCQA's look back period (generally 6 months before survey) were not included in the overall scoring percentage. TMG is confident that once we approach the look back period, items that were previously "conditionally met" will become "fully met" and the percentages will increase.

HPA Standard Category	HEA Standard Category Name	Overall % as of 2/1/24*	Current % as of 12/6/24**	Overall Progress %
CR	Credentialing & Re-credentialing	77.50%	80.95%	3.45%
QI	Quality Improvement	50.00%	71.42%	21.42%
UM	Utilization Management	18.09%	66.00%	47.91%
PHM	Population Health Management	32.61%	60.87%	28.26%
ME	Member Experience	55.56%	54.35%	-1.21%
NET	Network Management	33.93%	36.21%	2.28%

*Score is based on 2024 HPA Standards

** Score is based on 2025 HPA Standards, which introduced changed and/or new requirements

High-level HPA risks and remediation plan currently include:

- Website functionality for members to change PCPs
  - GCHP has engaged Deloitte to develop a solution. The planned system go-live date is 3/1/25.

- Centralized member email communication and evaluation of the quality and accuracy of information provided
    - GCHP has engaged Deloitte to develop a solution. The planned system go-live date is 3/1/25.
- Delegation agreement revisions
    - The NCQA team is working with Legal, Provider Network Operations/Contracting, and Procurement to address delegation agreement gaps.
- NCQA-compliant delegation and reporting oversight process
    - Teams are working with Compliance and Operations Oversight to establish a standardized mechanism for conducting oversight of NCQA delegates' reporting, per NCQA requirements.

The team continues to closely monitor all risks and issues and escalate barriers to leadership, as appropriate.

Measurement Year (MY) 2024 Managed Care Accountability Set (MCAS) Update: January 2025

As of the December administrative rate reporting refresh, with claims/encounter/supplemental data reflecting care rendered through November 2024, all measures continue to perform better compared to the same timeframe last year. Two measures have met the 90th percentile classified as the High Performance Level (HPL), four measures have met the 75th percentile, six measures are currently at the 50th percentile Minimum Performance Level (MPL), and six measures are trending below target. For MY 2024, DHCS has established 18 measures within the MCAS measure set that are required to meet or exceed the MPL.

The grid below details each measure's current performance compared to established internal targets and next steps, as applicable. Those noted in green indicate that the target has been met or is on track to meet, and those noted in red indicate measures that are at risk of not meeting internal performance targets and/or MPL.

Measure	December Prospective Rate (care rendered through 11/30)	MY 2024 Measure Target	Target Met/On Track?	Notes/Next Steps
Breast Cancer Screening	90th percentile (HPL)	90th percentile (HPL)	**Met**	
HbA1c Poor Control (>9%)	50th percentile (MPL)	90th percentile (HPL)	**On Track**	• Hybrid measure (includes medical record

				review). Projected to meet target with rate lift.
Lead Screening in Children	75th percentile	90th percentile (HPL)	**No**	• Inclusion in QIPP • Member incentive • Promotion of lead screening best practices with providers
Cervical Cancer Screening	25th percentile	90th percentile (HPL)	**No**	• Gaps in care outreach/appointment facilitation • Member incentive • VCMS Women's Health Clinic Days (12/4,11,18) not accounted for in rate • Hybrid measure (includes medical record review). Projected to improve with rate lift.
Prenatal Care	50th percentile (MPL)	90th percentile (HPL)	**On Track**	• Hybrid measure (includes medical record review). Projected to meet target with rate lift.
Postpartum Care	90th percentile (HPL)	90th percentile (HPL)	**Met**	
Immunizations for Adolescents	75th percentile	75th percentile	**Met**	
Chlamydia Screening	50th percentile (MPL)	75th percentile	**No**	• Inclusion in QIPP • Health fair testing
Childhood Immunizations	50th percentile (MPL)	75th percentile	**No**	• Inclusion in QIPP • Member incentive for infant flu vaccine. • Hybrid measure (includes medical record review). Projected to improve with rate lift.
Well Child Visits in the First 30 Months of Life	75th percentile	75th percentile	**Met**	
Asthma Medication Ratio	25th percentile	50th percentile (MPL)	**No**	• Inclusion in QIPP • Data mapping improvements • Member outreach • Targeted provider training
Controlling High Blood Pressure	25th percentile	50th percentile (MPL)	**On Track**	• Hybrid measure (includes medical record review). Projected to meet target with rate lift.

Developmental Screening in the First Three Years of Life	50th percentile (MPL)	50th percentile (MPL)	**Met**	
Follow-Up After Emergency Department Visit for Substance Use	50th percentile (MPL)	50th percentile (MPL)	**Met**	
Follow-Up After Emergency Department Visit for Mental Illness	below 25th percentile	50th percentile (MPL)	**No**	• Partnership with BH providers to improve access. • Data sharing improvements with BH providers.
Topical Fluoride Varnish Application	below 25th percentile	50th percentile (MPL)	**On Track**	• Data lag causing artificially low rate. • Varnish applications at health fairs not yet included in rate.
Well Child Visits in the First 15 Months of Life	75th percentile	50th percentile (MPL)	**Met**	
Child and Adolescent Well-Care Visits	25th percentile	50th percentile (MPL)	**On Track**	• Data lag causing artificially low rate. Projected to meet target once data complete.

Strategies for MY 2025 are in development with a continued focus on measures performing below target, and to sustain the gains achieved in prior years. Initiatives implemented in 2023 and 2024 that will continue into 2025 include provider collaboration and expansion of Quality Incentive Pool and Program (QIPP) metrics, targeted member outreach to facilitate appointments to close gaps in care, promotion of member incentive programs, partnering on clinic-sponsored health fairs, mobile mammography, and continued exploration of data enhancements.

PHARMACY SERVICES

GCHP has completed a signed contract with Prime Therapeutics who will be our Pharmacy Benefit Manager (PBM) that will help GCHP prepare and implement a Medicare Part D prescription drug benefit for our future Dual Eligible Special Needs Plan (D-SNP) in 2026. The pharmacy services department and other stakeholders have already started to meet and discuss with the PBM regarding the implementation plan and the timeline for executive milestones that need to be completed to ensure we are on track to be prepared to launch and execute the Part D pharmacy benefit for D-SNP. GCHP is also working closely with our pharmacy consultant, Pharmaceutical Strategies Group (PSG), to ensure the PBM is on track for the implementation plan, to share their expertise as subject matter experts, and to assist

GCHP with completing the Part D application and providing bid support to meet CMS requirements and deadlines. GCHP is working closely with both the PBM and PSG to ensure that we have the materials that we need to submit our Part D application to CMS by February 12, 2025.

Pharmacy and Therapeutics (P&T) Committee Meeting Update

The last P&T committee meeting was held on November 14, 2024. Future P&T committee meeting dates for 2025 were approved as follows: 2/13/25, 5/15/25, 8/14/25, and 11/13/25. The committee reviewed some Physician Administered Drugs (PAD) that are covered under the GCHP Medical Drug Benefit. A total of 44 drugs were reviewed including immune globulins and monoclonal antibodies for chemotherapy. The approved changes to the PAD list will be effective May 1, 2025. A 90-day notification to impacted members and all providers will be sent out by January 31, 2025. The updated PAD list and clinical guidelines will be updated on the GCHP website by May 1, 2025.

AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Paul Aguilar, Chief Human Resources and Organization Performance Officer

DATE: January 27, 2025

SUBJECT: Human Resources (HR) Report

Human Resources (HR) Activities

Since the start of the new fiscal year, the Gold Coast Health Plan (GCHP) HR Team has focused on:

1. Staff engagement
2. Acquiring and retaining talent
3. Enhancing the performance of the organization

Staff engagement

The results from the April 2024 Employee Survey indicated that only 60% of employees responded positively on how they are recognized and rewarded for their accomplishments. To address this issue, the HR team implemented the Golden Glow Recognition and Rewards Program in Nov. 2024 to provide manager and peer-to-peer recognition. This program provides managers the ability to recognize employees for key accomplishments and demonstrating GCHP's values by rewarding them with Golden Glow gold coins. The coins have a monetary value and can be redeemed by employees for items in a virtual marketplace, which is administered by the Bucket List platform. The early adoption of this program is going well; so far, 97 employees have been recognized either by managers or their peers.

Acquiring and retaining talent

From July 1, 2024 through Jan. 13, 2025, GCHP has filled 77 positions, which has increased GCHP's total headcount to 411. Of the new 95 roles budgeted for Fiscal Year (FY) 2024-25, 60 have been filled. The unfilled roles are new D-SNP and Mailroom roles, which were recently posted and should be filled soon.

In Nov. 2024, the HR and Operations teams successfully hired 27 new staff members for the Provider Call Center. The majority of the new hires – 88% – live in Ventura Country. GCHP will transition the Provider Call Center activities from its vendor partner, Netmark, by the end of Jan. 2025.

The following key hires were made during the fiscal year:

Title	Hired Name	Start Date
Director, Network Operations	Kelly Laban	July 15, 2024
Medical Director	Dr. Teri Brown	Sept.23, 2024
Chief Member Experience & External Affairs Officer	Marlen Torres	Sept. 23, 2024
Senior Director, Model of Care	Nathan Norbryhn	Nov. 4, 2024
Executive Director, Health Equity	Pshyra Jones	Dec. 2, 2024
Director, Operations	Ron Reed	Dec. 16, 2024

The table below provides a summary of GCHP's total resources, which includes employees and contingent workers (temps / contractors) by function. You will see the organization remains within the current Employee budget of 452 roles and effectively managing 75 contingent worker counts against the overall FY 2024-25 budget.

Gold Coast Health Plan - Headcount Fiscal Year 2024-25
FY 2024-25 - January 8, 2025

	EMPLOYEE COUNT				CONTINGENT WORKERS			Total Resources	
Function	Active Headcount‡	Open Requisitions	Revised Budget YE Headcount 2024/25	Percentage of Total Headcount	Temps	Contractor / Consultant	Total Contingent Workers†	Total Resources	Percentage of Total Resources
Health Services	129	5	134	30%	2	2	4	138	24%
Operations	92	13	105	23%	5	42	47	152	27%
Information Tech	56	6	62	14%	13	5	18	80	14%
Policy & Programs	41	3	44	10%	0	0	0	44	8%
Compliance	20	2	22	5%	1	0	1	23	4%
Finance & Accounting	18	2	20	4%	3	0	3	23	4%
Execuitve & Administration	11	3	14	3%	0	0	0	14	2%
Member Experience and Ext Affairs*	31	4	35	8%	0	0	0	35	6%
HR&Facilities	11	1	12	3%	1	1	2	14	2%
Innovation / DSNP	2	2	4	1%	0	0	0	4	1%
Strategic Initiatives	0	0	0	0%	0	0	0	0	0%
Grand Total	**411**	**41**	**452**	**100%**	**25**	**50**	**75**	**527**	**93%**

*Community & Member Relations & Communications combines under Member Experience and Ext Affairs

†Outsourced Labor (BPO) excluded: 41 in Operations - Netmark

‡ Includes 9 positions for which offers have been accepted

GCHP's attrition for the last 12 months remains low at 5.6%. This is a slight decrease from the last month, as terminations have declined. Attrition trends are checked each month to assess organization risks or concerns.

Year-end performance management and rewards

At the beginning of the fiscal year, the five core organizational goals were established. These goals are:

1. Stabilize Operations
2. Implement D-SNP
3. Improve Health Outcomes
4. Improve Member Experience
5. Transform Culture

Employees created their goals to align focus to the organizational goals and specific functional goals. The HR team is preparing the organization to conduct formal mid-year check-ins between managers and employees to monitor progress on the individual goals and provide feedback on how employees reflect GCHP's Core Values of Integrity, Accountability, Collaboration, Trust, and Respect as the gauge. The HR team will be conducting trainings for managers and employees to prepare them for preparing and capturing effective Mid-Year Reviews by Feb. 14, 2025.

Employee Medical Benefits: GCHP provides a self-managed / self-funded PPO medical health plans for employees, in addition to the Kaiser HMO. In Oct. 2024, the HR team managed a transition to a new Third-Party Administrator (TPA) for the PPO medical plans to improve employee service, satisfaction, and access to care. Meritain was selected as the new TPA. Meritain has an expanded Aetna provider network and will increase the level of service provided to employees. This change was introduced to employees during the November Benefit Open Enrollment period.

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.