



**Gold Coast  
Health Plan**<sup>SM</sup>  
A Public Entity

# Quality Improvement and Health Equity Transformation Program **2026**

[www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org)



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## I. BACKGROUND

Gold Coast Health Plan (GCHP) is an independent public entity that was created by County Ordinance and authorized through Federal Legislation and the state Department of Health Care Services (DHCS) to provide health care 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 (VCMCC) 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 health care agency and consumer advocates.

GCHP, under contract with the Centers for Medicare & Medicaid Services (CMS) and CMS-approved State Medicaid Agency Contract (SMAC) approved by DHCS, initiated an Exclusively Aligned Enrollment (EAE) Dual Special Needs Plan (D-SNP) with integration of Medicare and Medicaid requirements.

GCHP provides health care services to Ventura County's Medi-Cal beneficiaries through the Medi-Cal Managed Care Program (MCP), and to Medicare and Medi-Cal dual eligible beneficiaries through the Dual Special Needs Plan (D-SNP). GCHP has been serving Medi-Cal beneficiaries since July 1, 2011 and began serving Medi-Cal and Medicare dual-eligible beneficiaries on Jan. 1, 2026.

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## 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 (GCHP) 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, GCHP'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. Continuous quality improvement is achieved by a commitment to improving and sustaining performance through 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

## Models of Care for Medi-Cal and D-SNP

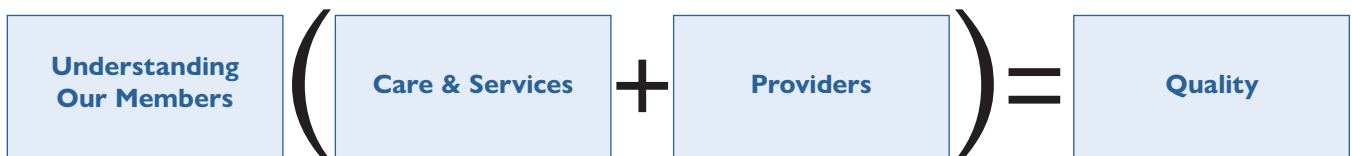
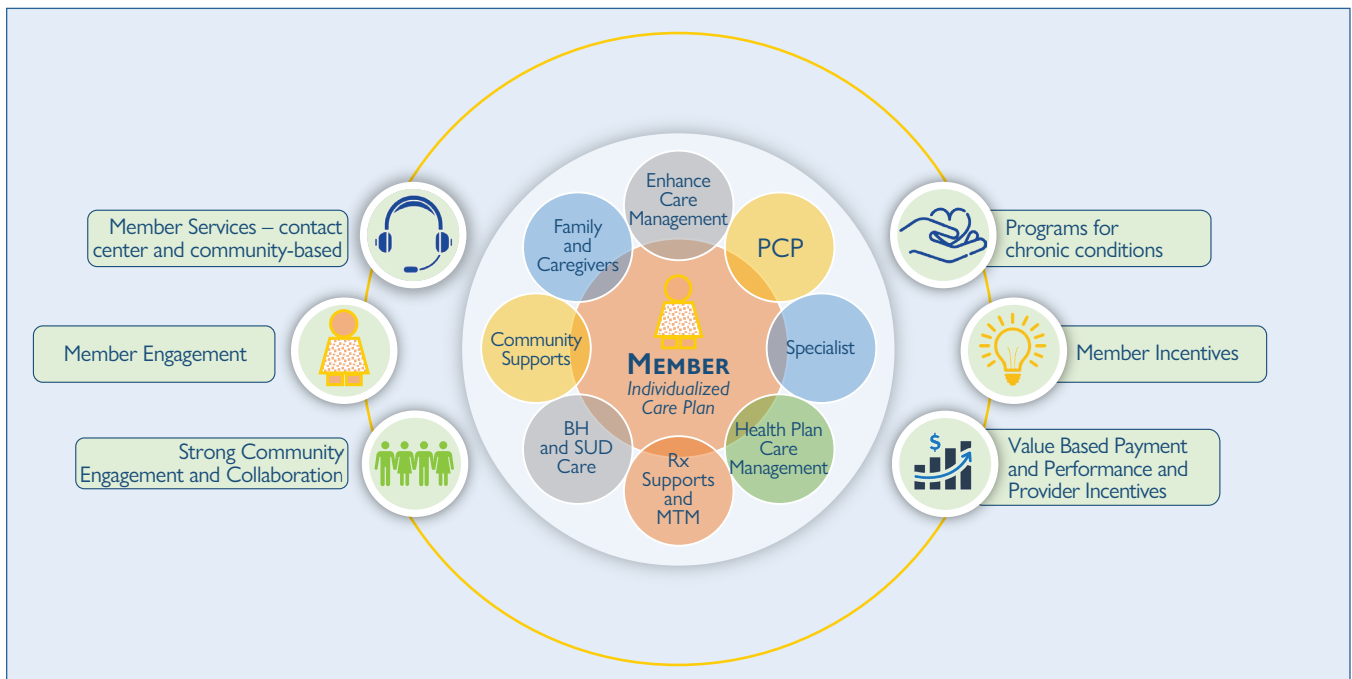
Gold Coast Health Plan’s Medi-Cal and D-SNP Models of Care are frameworks to:

- Improve patient health outcomes, adherence, and prevention
- Enhance care experience through care coordination, access, communication, and personalized care
- Reduce costs, improve efficiency and optimize resource use

### Model of Care for Medi-Cal

The Medi-Cal 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 Healthcare Providers and Systems (CAHPS®) as well as other standard quality measures.

### Model of Care – Greater Than the Sum of It’s Parts



### Model of Care for D-SNP

The 2026 “Gold Coast Health Plan Duals-Special Needs Plan (D-SNP) Initial Model of Care – H9623” meets the National Committee for Quality Assurance (NCQA) standards and DHCS requirements for an Exclusively Aligned Enrollment (EAE) D-SNP as outlined in the California Advancing and Innovating Medi-Cal initiative (CalAIM) Dual Eligible Special Needs Plan (D-SNP) Policy Guide.

### Gold Coast Health Plan D-SNP Model of Care



$$\begin{array}{|c|} \hline \text{Understanding} \\ \text{Our Members} \\ \text{MOC 1} \\ \hline \end{array}
 \left(
 \begin{array}{|c|} \hline \text{Care \& Services} \\ \text{MOC 2} \\ \hline \end{array}
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 \begin{array}{|c|} \hline \text{Quality} \\ \text{MOC 4} \\ \hline \end{array}$$

### III. PURPOSE AND SCOPE

The purpose of the GCHP Quality Improvement and Health Equity Transformation Program (QIHETP) is to achieve the **best health possible, best access possible to equitable and 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 covers the Medi-Cal and D-SNP product lines and 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 health care
- 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 DHCS Comprehensive Quality Strategy (CQS) for Medi-Cal and the CMS National Quality Strategy (NQS) for Medicare by promoting integrated and person-centered care.

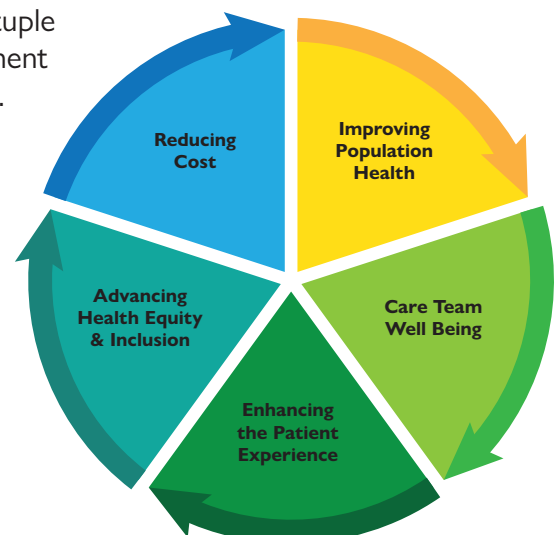
**The DHCS Comprehensive Quality Strategy is anchored by three linked goals:**

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

Additionally, the Institute for Healthcare Improvement's Quintuple Aim adheres to the concept that health care quality improvement should have five aims with connectivity between all the points. The aims are synergistic, build upon one another, and are interdependent.

1. Improve population health
2. Enhance patient experience
3. Advance health equity
4. Reduce costs
5. Improve workforce well-being



**In alignment with the quintuple aim, the goals of the DHCS CQS and CMS NQS include:**

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
9. Advancements in data and technology

**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 Medi-Cal Work Plan
- C. Annual QI D-SNP Work Plan
- D. Annual QIHET Program and Work Plan Evaluations
- E. Quality Improvement and Health Equity Activities
- F. QIHETP Committee Structure
- G. Policies and Procedures

The QIHET 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 and equity of nonclinical services including, but not limited to:
- Accessibility
  - Availability
  - Member and provider satisfaction
  - Grievances and appeals process
  - Culturally and linguistically appropriate services
  - Network adequacy
  - 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 QIHET focus that represents
- All care settings
  - All types of services
  - All demographic groups



## IV. AUTHORITY AND RESPONSIBILITY

The Ventura County Medi-Cal Managed Care Commission (VCMCC), 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 VCMCC, 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 QIHEC 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 VCMCC's role will be to approve the overall QIHEC Program, QIHEC Medi-Cal Work Plan, and QI D-SNP Work Plan annually and will receive at least quarterly verbal and written updates to the Work Plans for review and comment/direction. Updates provided to the VCMCC regarding the QIHEC Program and Work Plans will include reviews of objectives and improvements made. The VCMCC 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 QIHEC Program goals and objectives, the structure consists of the Quality Improvement and Health Equity Committee (QIHEC) supported by ten 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. Grievances & Appeals Committee (G&A)

6. Pharmacy & Therapeutics (P&T) Committee
7. NCQA Key Stakeholder Forum
8. Quality Measures Operations Steering Committee
9. Behavioral Health Quality Subcommittee
10. D-SNP Steering Team

To further support community involvement and achieve the Plan's QIHE goals and objectives, the VCMMCC organized three 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 will attempt to include a mix of consumers such as members, program participants, advocates, as well as practitioners and community representatives, to seek input from people with experience, knowledge or expertise relevant to the diverse cultural, linguistic and other relevant needs of GCHP's members. GCHP will make every attempt to recruit participants through mail, newsletters, and social media. GCHP will assess the composition of these community advisory committees on an annual basis and make enhancements as needed.

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

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

GCHP is governed by the eleven (11) 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.

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## 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 performance measures (e.g. Managed Care Accountability Set (MCAS), CMS Star Measures, HEDIS®, CAHPS®)
- Ongoing evaluation of the Medi-Cal and D-SNP Models of Care
- Alignments with 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.
- Analyze population's needs through ongoing member and community needs assessments
- Review regulatory requirements and industry best practices
- Review health outcomes data, member experience data and health equity data.

- Improve coordination of care and appropriate and equitable delivery of services through early identification and proactive engagement of members into care coordination.
- Enhance care transitions across all health care settings and providers.
- Improve access and affordability of health care using preventive strategies to improve chronic disease management and member engagement with treatment plans.
- Reduce health disparities and improve the appropriateness and accessibility of services.

**The program objectives include:**

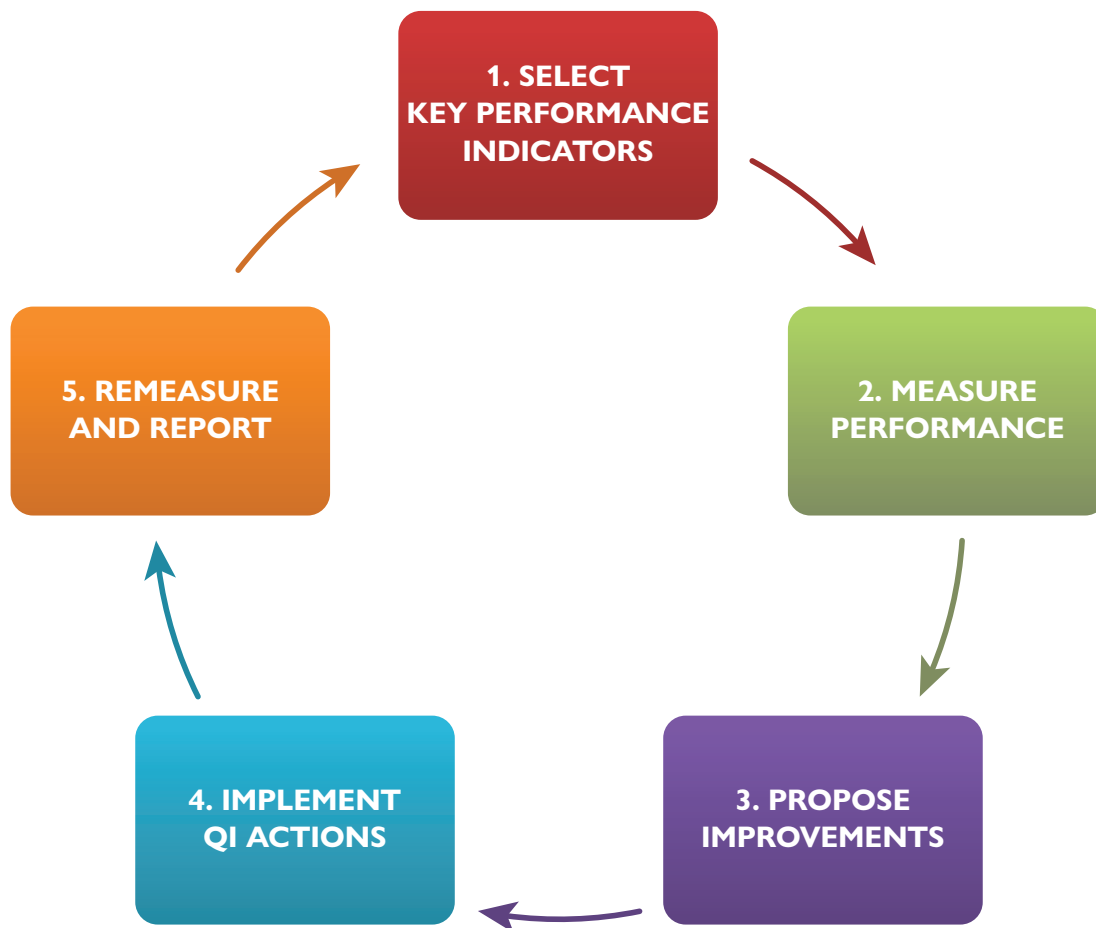
- Integrate the QIHET Program with other key operational functions of GCHP.
- Conduct an annual evaluation of the QIHET Program.
- Establish and conduct an annual review of quality, equity, and performance improvement projects (PIPs) related to significant aspects of clinical and non-clinical services.
- 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, CMS Star Measures, as well as other measure stewards.
- Leverage Sexual Orientation and Gender Identify (SOGI) and Race, Ethnicity, Language and Disability (RELD) data to advance health equity.
- 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

Each year, GCHP completes a QIHET program evaluation that includes evaluations of the QIHET Medi-Cal Work Plan and QI D-SNP Work Plan to assess the overall effectiveness of GCHP's goals with improving quality of care and services, ensuring equitable access to care and services, improve health outcomes and advance health equity for all members served. The annual evaluation also functions as a continuous, systematic, and data-driven cycle of monitoring, evaluation, and action that includes the following:

- Assess effectiveness of interventions
- Drive future planning
- Ensure accountability and oversight
- Identify and address disparities
- Monitor compliance
- Improve member and provider satisfaction
- Optimize resource allocation

## VI. QIHET PROGRAM METHODOLOGY

GCHP focuses on identifying opportunities and measuring improvements by utilizing various methodologies, including industry-standard quality improvement tools, to design, implement and test the effectiveness of interventions to achieve continuous quality improvements. Some of these methodologies include but are not limited to, the plan-do-study-act (PDSA) cycle methodology, strengths, weaknesses, opportunities, and threats (SWOT) analysis, QIHE Lean process, cause-and-effect diagrams to identify root cause analysis, data collection and analysis, and ongoing performance monitoring.



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<sup>®</sup>, HEDIS<sup>®</sup>, CMS Core Set for Medicaid, Health Outcome Survey, CMS Medicare Star Ratings measures) 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
  - » Care coordination
  - » 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, CMS Medicare Stars Measures for D-SNP, CAHPS®, and Healthcare Outcomes Survey (HOS), 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. The HOS survey is a patient-reported health survey administered to members of Medicare Advantage plans to collect data on the physical and mental health of these members.

Quality initiatives and performance improvement interventions are developed and implemented as indicated by administrative 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.

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## 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(GCHP) is committed to diversity, equity, and inclusion (DEI) to maintain high-quality, equitable, and affordable health care for all members, their families and their community. GCHP's QIHET Program focuses 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 and 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. To do so, GCHP's 2026 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. Addressing health disparities includes improving access to 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 reduce disparities. GCHP 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. Additionally, GCHP provides specialized care and wrap-around services for dual eligible Medi-Cal and Medicare members enrolled in D-SNP.

### 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 meets their needs, GCHP:

- Reviews member complaints and grievances including those related to culturally and linguistically appropriate level of care.
- Offers timely access to language assistance services for all medical and non-medical services.
- Provides 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.

- Conducts Population Needs Assessments for the Medi-Cal and D-SNP populations as defined by DHCS and CMS.
- Provides cultural competency training for GCHP staff, network providers, subcontractors, and conducts oversight of cultural competency training.
- Conducts surveys of members to determine if cultural and linguistic needs are met by providers.
- Provides 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.
- Assesses provider and provider staff members' linguistic capabilities.
- Assesses GCHP staff language capabilities for direct communication with members.
- Conducts readability and suitability of member informing materials for the Medi-Cal and D-SNP populations that comply with standards set by DHCS and CMS.
- Obtains feedback and advice from the community advisory bodies regarding culturally and linguistically appropriate services and programs.
- Assesses committee members to ensure that community advisory bodies reflect the diversity of the Plan's community and membership.
- Assesses systems and activities that promote high quality and equitable services for members.
- Assesses resources dedicated to addressing health disparities.

## Health Literacy

GCHP aims to ensure member materials are written in plain language and presented in a manner that is easily understood and culturally appropriate for members. Health literacy is being able to access, understand, appraise and use information and services in ways that promote and maintain good health and well-being. Using clear design and consistent terminology in all communications helps meet the needs of GCHP Members and advance health equity. The department of Health Education, Cultural and Linguistic Services works to ensure that health information is clear and understandable for all members, especially those with limited English proficient (LEP) or low health literacy. The state Department of Health Care Services (DHCS) requires that member informing materials be written at a sixth grade reading level or below to ensure they are easy to read and understood. The Centers for Medicare & Medicaid Services (CMS) requires that Medicare materials be written at or below eighth grade reading level.

The following resources are intended to promote health literacy:

- Think Cultural Health - The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care.
- Health Industry Collaboration Effort (HICE)
- National Institutes of Health

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## VIII. PROGRAM ORGANIZATION, OVERSIGHT, RESOURCES, AND EVALUATION

### ORGANIZATION AND OVERSIGHT

#### Chief Medical Officer

The Chief Executive Officer (CEO) has appointed the Chief Medical Officer (CMO) as the designated physician to support the QIHET Program by providing 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 (CMO) 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 Quality Improvement 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 staff.

The Quality Improvement staff assists the Executive Director of Quality Improvement 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
- Collaborate in developing quality improvement and health equity transformation activities for the annual QIHET Medi-Cal Work Plan and D-SNP Work Plan
- Assist in coordination of MCAS/HEDIS®/CMS Core Set for Medicaid data collection, reporting and analysis of results
- Assist in coordination of D-SNP Star Measure data collection, reporting and analysis of results
- Work with other departments to gather information for the annual QIHETP Evaluation
- Identify areas for improvement and implementation of quality improvement and health equity initiatives
- Assist the Executive Director of Quality Improvement in achieving the goals set forth in GCHP's QIHET Program
- The roles and responsibilities of GCHP D-SNP administrative and clinical staff as well as contracted providers are described in MOC 2 Element 1 Factor 1 and Factor 2 of the Gold Coast Health Plan Duals-Special Needs Plan (D-SNP) Initial Model of Care – H9623.

Further description of the QIHET Program's multidisciplinary resources and responsibilities are included in Attachment 1. 2026 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 Clinical Practice Guidelines and Decision-Making Criteria
- 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 Provider Enablement™ Quality Performance Dashboards which offer visualization and customization capabilities that enable measurement of performance against benchmarks, trending and of gaps in care reports.

- Quality Performance Reports: Providers receive customized reports on at least an annual basis indicating their quality performance compared to GCHP's overall quality performance as well as their peer providers.

### Sources of Data

GCHP utilizes tools and resources that provide industry standards guidelines, national and regional benchmarks, clinical and best practice guidelines, 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, Quality Compass®, CMS Star Rating measures, and Health Outcome Surveys.
- 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)
- California Department of Public Health (CDPH), and West Coast Health Alliance

### 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) and sexual and gender identify (SOGI) data to advance health equity by identifying, addressing, and reducing health disparities among our member 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 and 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 for the Medi-Cal population.
- CMS Star measures to assess the effectiveness of clinical care and services for the D-SNP population.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Health Outcomes Survey

### **HEDIS® Certified Software**

GCHP's QIHET Program utilizes a HEDIS® Certified Software vendor to calculate all MCAS/HEDIS® and CMS Stars 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 NCQA HEDIS® Compliance Audit™ and the CMS Medicare Advantage 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 data
- Health information exchange data
- Medical record data
- DHCS supplemental data
- Medi-Cal Dental Program data
- Medi-Cal Rx pharmacy data
- Pharmacy benefits manager 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.

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## IX. ANNUAL PROGRAM AND WORK PLAN EVALUATIONS

### **Annual 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. The evaluations provide comprehensive assessments of the quality improvement and health equity activities undertaken. This includes evaluation of areas of success and areas in need of improvement 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 Work Plans, and the development of subsequent year's Program Descriptions and Work Plans to ensure ongoing performance improvement.

The Evaluations are reviewed and approved by the QIHEC and VCOMMCC and include 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 restructuring or changes to the QIHET and CLAS Programs for the subsequent year to improve effectiveness as appropriate

#### **Annual QIHET Medi-Cal Work Plan, QI D-SNP Work Plan**

The annual QIHET Medi-Cal Work Plan and QI D-SNP Work Plan serve as the roadmaps for the Quality Improvement and Health Equity Transformation Program and outline 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 work plans are primarily developed priority initiatives and from findings and recommendations from the annual QIHET Program Evaluation. The QI D-SNP Work Plan is also developed based on the Duals-Special Needs Plan (D-SNP) Initial Model of Care. 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 Medi-Cal Work Plan and QI D-SNP Work Plan also reflect the contractual requirements of GCHP.

At a minimum, the work plans include 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 Work Plans 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 Work Plan initiatives. The work plans are assessed and updated at a minimum, quarterly, and are included as part of the annual QIHET Program Evaluation.

GCHP views the work plans as living documents that reflect 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:

- Access and availability studies
- Initial health appointment monitoring
- GeoAccess studies
- Network adequacy
- Quality measure performance
- Member grievance reviews

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

- 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:

- MCAS/HEDIS®/CMS Core Set for Medicaid reporting and analysis including race/ethnicity stratification of specific measures
- CMS Stars measures for D-SNP reporting and analysis
- Coordination of care studies
- Facility site reviews
- Potential quality issue investigation
- Chronic care improvement programs (CCIP)

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:

- Annual provider language study
- Annual cultural and linguistic study
- Ongoing monitoring of interpreter service and use
- Ongoing monitoring of member 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:

- 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, educational offerings, website content and announcements. Providers are educated regarding quality improvement and health equity initiatives during provider onboarding, via on-site Quality and Provider Relations visits, quality improvement focused trainings and webinars, QI Collaboration meetings, provider update memos/e-blasts, Provider Operations Bulletin articles, and the GCHP website. Performance reporting of specific MCAS/HEDIS<sup>®</sup>/CMS Core Set for Medicaid measures and CMS Star/HOS for D-SNP measures 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 (GCHP) Quality Committees and Subcommittee Structure consists of 10 subcommittees each reporting up to the Quality Improvement and Health Equity Committee (QIHEC). The QIHEC 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), and Member Advisory Committee (MAC). The PAC, CAC, and MAC 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 QIHEC 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, 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. A summary of each QIHEC meeting is sent to DHCS quarterly, shared with the Ventura County Medi-Cal Managed Care Commission and posted on the GCHP website.

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 VCMCC by the VCMCC 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 Executive Director of Quality Improvement.

Membership consists of the chairs of the ten 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 ensure 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 mechanisms. All of GCHP's Committees/Subcommittees are required to maintain confidentiality and avoid conflict of interest.

The annual QIHET Program Evaluation is submitted to the QIHEC and VCMMCC each year addressing:

- Quality improvement and health equity activities such as:
  - » Utilization reports
  - » Review of the quality of services rendered
  - » MCAS/HEDIS<sup>®</sup>/CMS Core Set rate for Medicaid
  - » HEDIS<sup>®</sup>/CMS STAR measure rates for Medicare
  - » CAHPS and HOS surveys
  - » Quality Improvement projects and initiatives - status and/or results
  - » Health Equity projects and initiatives – status and/or results
  - » Satisfaction survey results
  - » Collaborative initiatives both internally and externally - status and/or results

- Success in improving patient care and outcomes, health equity, and provider performance.
- 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, including opportunities for improvement.
- Reporting and achievement of goals and objectives through quality and health equity monitoring and improvement programs.
- Presentation of the QIHET program description and work plans 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:**

- Oversee 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®, CMS STARS, CAHPS®, HOS, 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
- Chief Operating Officer
- Executive Director of Health Equity
- Senior Medical Director
- Medical Director
- Executive Director, Quality Improvement
- Senior Director, Health Education / Cultural Linguistics
- Chief Member Experience and External Affairs Officer
- Executive Director, Delivery System Operations & Strategies
- Senior Director, Network Operations
- Director of Pharmacy
- Executive Director, Population Health
- Senior Manager, Population Health
- Chief Compliance Officer
- Senior Director, Compliance
- Executive Director, Health Services
- Director, Behavioral Health & Social Programs
- Chief Executive Officer (Ex Officio)
- Director, Operations
- Senior Manager, Quality Improvement
- Senior Manager, Clinical Quality Improvement
- Carelon Behavioral Health Medical Director
- External Practitioner Representatives
- Commissioner

**QIHEC reporting structure:**

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

**QIHEC 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:**

- Chief Medical Officer
- Director of Communications
- Director of Network Operations or designee
- Director, Member Contact Center or designee
- Director, Provider Contact Center of Operations or designee
- Executive Director Health Services
- Executive Director of Quality Improvement or designee
- Manager of Community Relations Strategy and External Affairs
- Manager of Operations (Chair)
- Senior Director of Care Management or designee
- Senior Director of Compliance or designee
- Senior Director of Health Education & Cultural Linguistics or designee
- Senior Manager of Operations

**Meeting frequency:**

The MSC meets quarterly at a minimum.

**iii. Grievance and Appeals Committee (G&A)**

The Grievances 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
- Senior Grievance and Appeals Specialist
- Chief Medical Officer or designee
- Senior Medical Director
- Executive Director of Operations
- Senior Director of Network Operations or designee
- Manager of Member Services or designee
- Executive Director of Quality Improvement or designee
- Executive Director Health Services
- Senior Director of Utilization Management
- Senior Director of Compliance or designee
- Senior Director of Health Education & Cultural Linguistics or designee
- Director of Pharmacy or designee

***G&A meeting frequency:***

The committee meets quarterly.

**iv. Utilization Management Committees (UMC)**

The UMC consists of two subcommittees that report directly to the Quality Improvement and Health Equity Committee (QIHEC). The Medi-Cal UMC and D-SNP UMC oversee the implementation of the UM Program, promoting optimal utilization of health care services, monitoring continuity and coordination of care while protecting and acknowledging member rights and responsibilities, including their right to appeal an unfavorable decision. The UMC subcommittees contribute to the overall GCHP clinical strategy by providing recommendations for medical policy, evidence-based clinical practice guidelines, clinical decision-making criteria, the implementation of new medical technologies, population health care initiatives and management protocols (e.g., Care Management program, D-SNP populations, children with special health care needs (CSHCN), and seniors and persons with disabilities (SPD)). The composition of the UM Committees is multidisciplinary to include participation of providers and staff relevant to the GCHP membership. A majority of UM Committee members are practicing physicians from various clinical

specialties, including primary care and behavioral health. This diverse representation ensures a wide range of conditions are adequately considered during the development of GCHP utilization management policies. Other subject matter experts may attend meetings as needed, based on specific UMC topics and actions.

### ***UMC responsibilities:***

The UMC responsibilities focus on ensuring access to care, policy consistency and transparency. These responsibilities include, but are not limited to, the following activities performed not less than annually:

- Communicate and document processes related to the structure and function of the UM Committee.
- Review and approval of the GCHP UM Program
- Review of UM policies and document decisions related to: (1) services to which UM processes apply; (2) coverage decision guidelines to ensure best practice and compliance with regulatory requirements; (3) relevant and current clinical practice guidelines; (4) relevant medical policy when coverage criteria are not fully established.
- Analyze UM data and reporting
- Implement and monitor initiatives for identified areas of opportunity such as Care Management programs and Population Health programs.
- Oversee delegated entities responsible for UM activities through review and approval of the delegates' UM Program Description, annual UM Work Plan, and reports regarding major aspects of the UM Program.
- Issues identified by a delegate's UM Committee will be reported to the QIHET Committee.

### ***Medi-Cal UMC membership:***

- Chief Medical Officer
- Chief Innovation Officer
- Senior Medical Director
- Executive Director, Health Services
- Managers of Care Management
- Managers of Utilization Management
- Director of Pharmacy
- Physician Reviewers
- Compliance Designee
- Executive Director, Quality Improvement
- Carelon Regional Chief Medical Officer Behavioral Health

### ***D-SNP UMC membership***

- Chief Medical Officer
- Chief Innovation Officer
- Senior Medical Director
- Managers of Care Management

- Managers of Utilization Management
- Director of Pharmacy
- Physician Reviewers
- Compliance Designee
- Executive Director, Quality Improvement
- Executive Director, Health Services
- Executive Director of Health Equity
- Caelon Regional Chief Medical Officer Behavioral Health as needed
- GCHP Reviewing Physicians
- Practicing Physicians
- Physician expert in elderly care
- Behavioral Healthcare Practitioner Consulting Psychiatrist

***UMC meeting frequency:***

The Medi-Cal and D-SNP UM Committees meet quarterly, at a minimum.

**v. 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 health care 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 health care.
- Ensure that GCHP implements cultural and linguistic requirements set forth by the state Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid (CMS).
- 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; 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 DHCS and CMS.
- Educate GCHP staff on specific cultural barriers that might hinder the delivery of optimal health care.
- Conduct focus groups or field testing as needed to ensure materials are culturally and linguistically appropriate.

***HE/CL membership:***

- Senior Director of Health Education & Cultural Linguistic Services (Chair)
- Chief Medical Officer
- Executive Director of Health Equity
- Executive Director of Population Health and/or Designee
- Representative from Department of Care Management
- Representative from Department of Communications
- Member Services Manager and/or Designee
- Representative from the Contact Center Department
- Representative from Provider Network Operations
- Representative from Quality Improvement Department
- Representative from Community Relations
- Representative from Grievance and Appeals Department
- Representative from Health Services
- Representative from D-SNP
- Representative from Pharmacy Department
- Representative from Behavioral Health Department
- Representative from Information Technology and/or Designee
- Representative from Medical Informatics and/or Designee
- Senior Cultural and Linguistic Specialist
- Senior Health Navigator/Health Navigators

***HE/CL 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.

## vi. 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 and fulfills the credentialing and peer review functions summarized below.

### *C/PRC 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 regarding 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 and Clinical Quality Improvement 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 Clinical Practice Guidelines and Decision-Making Criteria

### *C/PRC 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 ensure 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.

### *C/PRC meeting frequency:*

The committee meets quarterly.

## **vii. 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 Medicare Part B Drug List for Dual Special Needs Plan (D-SNP) 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.

### ***P&T Committee responsibilities:***

- Review PAD List and Medicare Part B Drug List inclusions and exclusions, pharmacy policies and procedures, prior authorization requirements, 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.

### ***P&T membership:***

- Director of Pharmacy (Chair) or designee
- Clinical Programs Pharmacist
- Clinical Pharmacist
- Chief Medical Officer
- Senior Medical Director and/or Medical Director
- Physicians and pharmacists representing a variety of clinical specialties.

### ***P&T meeting frequency:***

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

## **viii. NCQA Key Stakeholder Forum**

The purpose of the NCQA Key Stakeholder Forum is to bring key stakeholders together to review NCQA accreditation 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 maintaining NCQA Accreditation and preparing for renewal surveys per the accreditation timeline.

### ***NCQA Key Stakeholder Forum Scope:***

- NCQA Health Plan Accreditation
- NCQA Health Outcomes 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
- Provide an open forum for discussion of project feedback, constraints, and ideas sharing

**NCQA Key Stakeholder Forum membership:**

- Principal Project Manager (Chair)
- Quality Improvement Program Manager (Co-chair)
- Chief Innovation Officer
- Chief Medical Officer
- Chief Policy and Program Officer
- Chief Diversity Officer
- Executive Director of Health Equity
- Executive Director, Population Health
- Executive Director, Quality Improvement
- Executive Director, Health Services
- Senior Director, Health Education & Cultural Linguistics
- Senior Director, Compliance
- Senior Director, Network Operations
- Director, Operations
- Director, Communications
- Director, Pharmacy
- Director, Behavioral Health & Social Programs
- Director, IT Infrastructure and Security Operations
- Senior Manager, Population Health
- Senior Manager, Quality Improvement
- 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:***

Meeting frequency is determined by business need (e.g. bimonthly, monthly, quarterly) depending on accreditation cycle and readiness project plan

## **ix. Quality Measures Operations Steering Committee**

The Quality Measures Operations Steering Committee seeks to align and drive the organization's strategy and initiatives around quality measures, including but not limited to, prioritization, goals, work plans, and performance tracking for the Managed Care Accountability Set (MCAS), Healthcare Effectiveness Data and Information Set (HEDIS®), and Medicare Star Ratings measures. The Quality Measures 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 performance goals, and create pathways for escalation of performance issues, operational/financial/regulatory risks, and fleeting opportunities.

### ***Quality Measures Operations Steering Committee responsibilities:***

- Holds overall oversight of the quality measure performance.
- Facilitates efforts to align, integrate and focus the organization on quality measure goals, workplans, and priorities by providing a forum for reporting and collaboration among business units.
- Reviews measure performance, plan-level comparisons, and future projections in order to develop performance targets (e.g., MPL, 75th percentile, HPL.) and track progress to targets.
- Identifies and prioritizes disparities 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 quality measure improvement.
- Removes barriers, advances decision-making, and resolves any conflicts.
- Celebrate small wins early and often and ensures continuous improvement by acknowledging and incorporating lessons learned from intervention success or those that achieved limited impact.

### ***Quality Measures Operations Steering Committee Membership:***

- Chief Innovation Officer
- Chief Medical Officer
- Chief Policy and Program Officer
- Chief Executive Officer, Ex Officio
- Executive Director, Quality Improvement
- Executive Director of Health Equity

- Executive Director, Population Health
- Executive Director, Operations
- Executive Director Health Services
- Senior Director, Health Education/Cultural Linguistics
- Director, Behavioral Health & Social Programs
- Senior Director, Network Operations
- Director, Pharmacy
- Clinical Programs Pharmacist
- Director, Medical Informatics
- Senior Manager, Population Health
- Senior Manager, Quality Improvement

***Meeting Frequency:***

The Quality Measures Operations Steering Committee meets monthly.

**x. Behavioral Health Quality Committee**

The Behavioral Health Quality Subcommittee is attended by Gold Coast Health Plan (GCHP) and Carelon Behavioral Health Medical and Clinical Leadership and Practitioners. The subcommittee focuses on promoting comprehensive, coordinated care across medical and behavioral health systems.

***Behavioral Health Quality Subcommittee objectives:***

The subcommittee aims 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:***

- Discuss the data collection process (e.g., MCAS/HEDIS® data)
- Discuss any potential issues with the data collection process (e.g., data completeness, gaps in encounter data)
- Facilitate collaborative efforts on CMS and DHCS mandates and implementation to better serve our members
- Discuss identification of potential reasons for low preliminary rates for selected Behavioral Health Continuity and Coordination measures and/or sub measures
- Collaborate and develop opportunities for improvement
- Analyze the interventions developed and outcomes

***Behavioral Health Quality Subcommittee membership:***

- Chief Medical Officer
- Chief Policy and Programs Officer
- Senior Medical Director

- Director of Behavioral Health and Social Programs
- Behavioral Health Manager
- Behavioral Health Program Specialist
- Senior Manager, Quality Improvement
- 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 every two months.

**xi. D-SNP Steering Team**

The D-SNP Steering Team operates workgroups and project teams that are responsible for the implementation, evaluation, and continuous improvement of the D-SNP Model of Care. Project teams are cross-functional and supported by project managers, business process owners and executive sponsors.

D-SNP Steering Team objectives:

- The D-SNP Steering Team's role is to evaluate data and processes, identify gaps, charter needed improvements in quality and health equity interventions, as well as processes, policies, and procedures.
- The D-SNP Steering Team ensures that gap and barrier analysis is conducted when measures do not meet targets and ensures that all outcomes are reported to appropriate committees.

***D-SNP Steering Team responsibilities:***

- Lead operational teams and workgroups through an annual operational and literature review process
- Develop work plans and implements new processes and programs to improve prioritized quality goals and make improvements to the D-SNP Model of Care
- Develop key performance indicators (process metrics) to track progress on projects and to assess elements of D-SNP Model of Care
- Track progress on projects and course corrects based on the continuous flow of data and other stakeholder feedback
- Drive project work and reports status to organizational leadership and into the Quality Committee Structure
- Work with providers in joint quality committees to introduce and support D-DNP quality improvement

***D-SNP Steering Team membership:***

- Director, D-SNP
- Chief Innovation Officer
- Chief Compliance Officer
- Chief Finance Officer
- Chief Medical Officer
- Executive Director, Health Services
- Executive Director, Delivery System Operations & Policy and Programs
- Director, Medicare Sales and Enrollment Strategy and External Affairs
- Medicare Compliance Manager
- Senior Director, Operations
- Director, Pharmacy
- Senior Data Validation Program Manager
- Senior Director, Model of Care
- Senior Manager, Medicare Financial Analysis
- Medicare STARS Program Manager

***Meeting frequency:***

The D-SNP Steering Team meets monthly.



## XI. QIHET PROGRAM KEY FUNCTIONAL AREAS

### Population Health Management

GCHP's Population Health Management (PHM) Program is designed to ensure that all members have access to a comprehensive, personalized set of services across the continuum of care. By aligning services with individual needs and preferences, the PHM Program promotes longer, healthier, and more fulfilling lives, improves health outcomes, and advances health equity.

Core Functions of the PHM Program:

- **Member Engagement & Trust Building:** The program fosters meaningful relationships with members, encouraging active participation in their health journey.
- **Data-Driven Insights & Risk Stratification:** Through collaboration with the Quality Improvement (QI) Department and DHCS via Medi-Cal Connect, the program collects, shares, and analyzes timely, accurate data. This enables targeted interventions using predictive analytics, gap identification, and standardized assessments.
- **Addressing Upstream Drivers of Health:** The PHM Program integrates with public health and social services to address social determinants and other upstream factors impacting health.
- **Preventive Health & Targeted Interventions:** Guided by QIHETP focus areas, the program supports members in maintaining wellness through gap reporting and population targeting. These efforts are powered by GCHP's HEDIS® certified software and QI analyses.

- Reducing Health Disparities and Addressing Social Drivers of Health (SDOH): Data is used to identify disparities and inform the design of interventions aimed at promoting equity and impacting SDOH for our members.
- Collaborative Partnerships: The PHM program coordinates with partner agencies through the Birth Equity Stakeholder Group to enhance services for pregnant women, infants, and children under age 5. PHM Program staff also serve on the Steering Committee for the Ventura County Community Health Improvement Collaborative as well as the Ventura County Community Information Exchange.
- Community Health Assessment (CHA) and Community Health Implementation Strategy (CHIS) Planning: The collaborative CHA process identifies health disparities and informs targeted interventions. It strengthens relationships between GCHP, public health entities, and local stakeholders, with a focus on understanding social drivers of health.
- Population Needs Assessment (PNA): In addition to the collaborative CHA, the PHM program conducts an annual PNA to summarize the health needs of GCHP members. The PNA identifies where population health management strategies may have a positive impact on member needs.
- Health Risk Assessment (HRA): The PHM Program utilizes HRAs to gain deeper insights into member needs and tailor services accordingly.
- Behavioral Economics Initiative: An incentive-based program encourages members to adopt healthier behaviors targeting individuals with multiple chronic conditions with a focus on closing their gaps in care.
- Chronic Disease & Cancer Screening Programs: The PHM Program is launching a chronic disease management initiative for diabetic members and piloting a self-administered colorectal cancer screening kit program.

GCHP remains committed to expanding and refining services through a data-driven, quality improvement approach that evolves with member needs.

The PHM Program functions under the direction of the Executive Director of Population Health, with clinical quality improvement guidance provided by the Chief Medical Officer (CMO).

For additional information regarding the PHM Program, refer to Attachment 2. 2026 Population Health Management Strategy.

## 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
- Health Information Tool / Member Evaluation Tool (HIF/MET)

- Health risk assessments
- Electronic health records
- 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 addressing care gaps. GCHP offers Care Management services that includes non-clinical care coordination, clinical care coordination/non-complex case management and complex case management. Care Management uses 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 members' assessed needs, preferences, and stated goals. Throughout the care management process, the members' 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. 2026 Care Management Program Description.

## Utilization Management

GCHP's Utilization Management (UM) Program is integrated with the QIHET Program to ensure continuous quality improvement. The GCHP UM Program is designed to ensure the provision of high quality, cost effective, medically appropriate health care services across the continuum of care to GCHP members through a comprehensive framework in compliance with the benefits and coverage outlined in the plan benefit package (PBP) and in accordance with state (Medi-Cal) and federal (Centers for Medicare & Medicaid Services (CMS) regulatory and accreditation requirements. The UM structure and processes are clearly defined, and responsibility is assigned to individuals appropriately trained and/or with experience required.

Licensed and non-licensed health care professionals, including administrative support associates, nurses, physicians, pharmacists and other clinically educated professionals have authority to function within the UM Program based upon their job descriptions. The Health Services organizational chart reflects the UM personnel and reporting structure. The staff position descriptions outline the training requirements and associated responsibilities. Staff ratios are consistent with the organization's needs and are accommodated by the departmental budget.

The UM Program functions under the direction of the Chief Medical Officer (CMO).

For additional information regarding the UM Program, refer to the Attachment 4. 2026 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 coordinates closely with Quality Improvement, Care Management, Population Health Management, and Utilization Management to implement interventions focused on behavioral healthcare for Medi-Cal and D-SNP lines of business.

The Behavioral Health Department and Program functions under the direction of the Executive Director of Population Health 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. 2026 Behavioral Health Program Description.

For additional information regarding behavioral health quality, refer to Carelon's 2026 Quality Improvement Program Description.

## **Culturally and Linguistically Appropriate Services (CLAS) Program**

Gold Coast Health Plan (GCHP) is committed to providing appropriate, accessible, 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 by addressing health disparities and ensuring culturally responsive care. 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 services and improve appropriateness and accessibility to care.

Appropriateness and accessibility of services include:

- Provides education and training to GCHP leadership and staff in culturally and linguistically appropriate policies and practices on an ongoing basis.
- Ensures the competence of individuals providing language assistance, specifically recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Offers 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.
- Informs all members of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Provides easy-to-understand print and multimedia materials and signage in GHCP's threshold languages.
- Collects and maintains accurate and reliable demographic data to inform service delivery.
- Assesses community health resources to implement services responsive to identified CLAS needs.
- Seeks Community Advisory Committee (CAC) and Member Advisory Committee (MAC) feedback and advice regarding services, including 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. 2026 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. The Pharmacy Services department and program will also provide oversight of the Pharmacy Benefit Manager (PBM) that is delegated to perform the pharmacy claim adjudication functions for the Part D benefit for D-SNP as well as some delegated Part D services that pertain to quality improvement.

### Scope:

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

- Utilization Management
- Care Management
- Quality Improvement
- Grievances and Appeals

- Compliance
- 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, CMS regarding Medicare Part D requirements, 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 DUR activities and to identify opportunities for quality 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 with Care Management, joint operations meetings (JOMs) with Provider Network Operations, and Utilization Management
- Review and update policies and procedures at least annually
- Coordinate and officiate quarterly Pharmacy & Therapeutics Committee meetings
- Provide oversight of all PBM functions

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

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## 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 GCHP's right to resume the responsibility for conducting the delegated function should the delegated entity fail to meet GCHP standards.

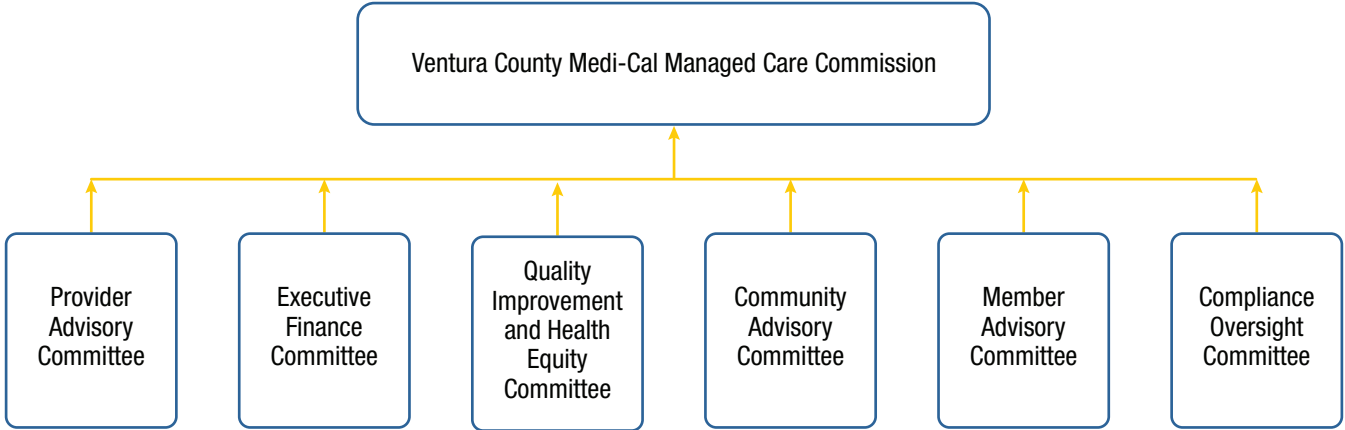
GCHP conducts ongoing oversight, evaluation, and monitoring of the delegate. At a minimum, an annual audit is conducted using an audit tool that is based upon current NCQA, DHCS, and GCHP standards and modified on an as-needed basis. In the event any deficiencies are identified through the oversight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

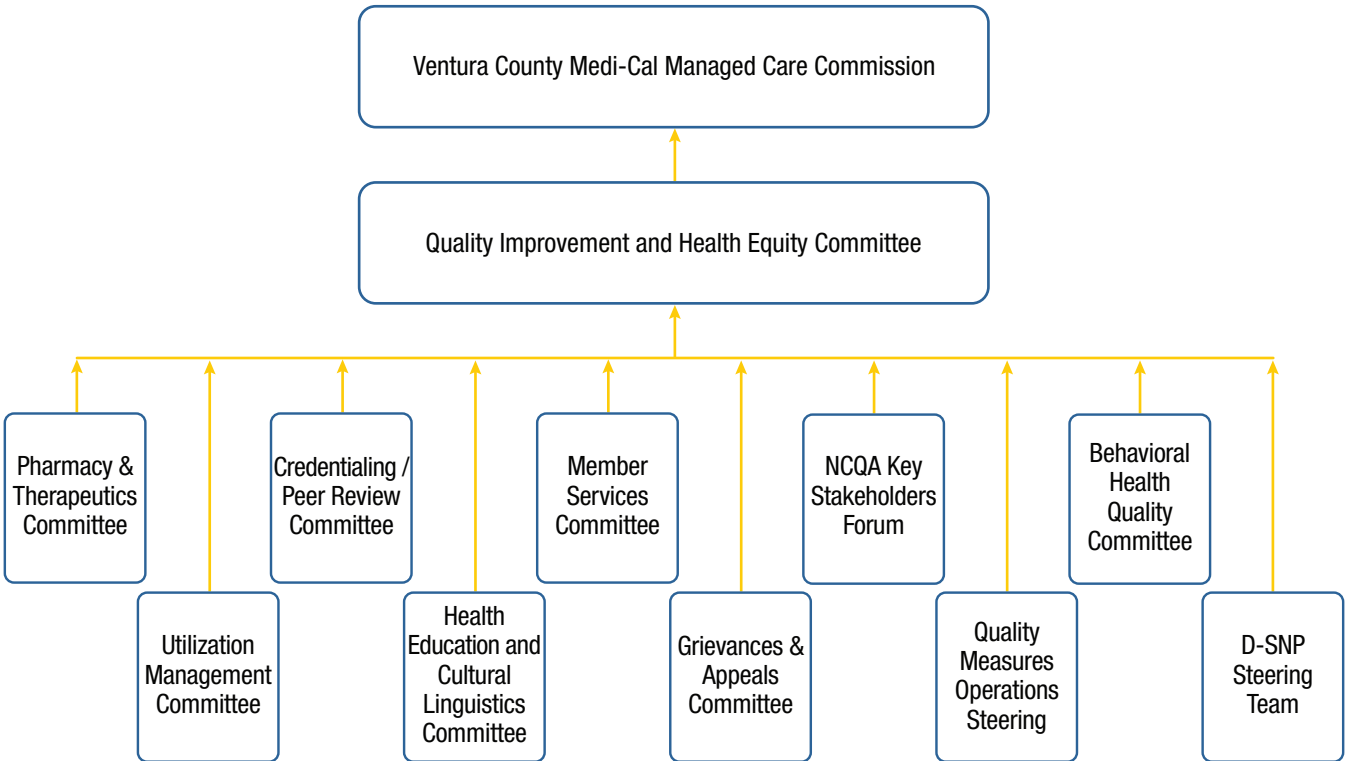
# XIII. GOLD COAST HEALTH PLAN QUALITY COMMITTEE ORGANIZATIONAL CHART

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

## Ventura County Medi-Cal Managed Care Commission Committee Reporting Structure



## 2026 Quality Improvement and Health Equity Committee Reporting Structure



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## XIV. QIHEC MEETINGS FOR CALENDAR YEAR 2026

Dates	
Tuesday	Jan. 20, 2026
Tuesday	March 17, 2026
Tuesday	May 12, 2026
Tuesday	July 14, 2026
Tuesday	Sept. 15, 2026
Tuesday	Nov. 17, 2026
<b>Location: GCHP Community Room 711 E. Daily Drive, Suite 110, Camarillo CA 93010</b> and via teleconference or web conference (with audio)	

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## XV. RESOURCES

### Availability of QIHET Program and Work Plans

The QIHET Program Description and Work Plans are available to practitioners and members on GCHP's website at [www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org). Printed copies are available upon request.

- The 2026 QIHET Program Description, QIHET Medi-Cal Work Plan, and QI D-SNP Work Plan were approved by the Quality Improvement and Health Equity Committee on January 20, 2026.
- The 2026 QIHET Program Description, QIHET Medi-Cal Work Plan, and QI D-SNP Work Plan were approved by Ventura County Medi-Cal Managed Care Commission (VCMCC) on February 23, 2026.

### References

- Gold Coast Health Plan Quality Improvement and Health Equity Committee Charter
- Gold Coast Health Plan Policy QI-002: Quality and Health Equity Performance Improvement Requirements
- Gold Coast Health Plan Duals-Special Needs Plan (D-SNP) Initial Model of Care – H9623
- Carelon's 2026 Quality Improvement Program Description
- Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 24-004: Quality Improvement and Health Equity Transformation Requirements
- GCHP DHCS Managed Care Contract 2025, 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)
- Medicare Health Outcomes Survey (HOS)
- 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 Outcomes Accreditation
- DHCS Comprehensive Quality Strategy, February 2022
- DCHS California Advancing and Innovating Medi-Cal (CalAIM)
- CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide
- 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. 2026 QIHETP Resources
- Attachment 2. 2026 GCHP Population Health Management Strategy
- Attachment 3. 2026 Care Management Program Description
- Attachment 4. 2026 Utilization Management Program Description
- Attachment 5. 2026 Behavioral Health Program Description
- Attachment 6. 2026 Cultural and Linguistically Appropriate Services Program Description
- Attachment 7. 2026 GCHP Duals-Special Needs Plan (D-SNP) Initial Model of Care – H9623

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Gold Coast  
Health Plan<sup>SM</sup>  
A Public Entity

Quality Improvement  
and Health Equity  
Transformation Program

2026

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