# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY<br><br>(* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|
| **QUALITY IMPROVEMENT AND EQUITY PROGRAM STRUCTURE/OPERATIONS** | | | | | | | | | | |
| QIHETP Program Description* | QI 1A | Quality of Care | Ensure compliance with accreditation, business and regulatory requirements. | 1. Review and update QIPD annually | • Meets NCQA and applicable regulatory requirements<br>• Reviewed and updated annually<br>• Reviewed and approved by the QIC<br>• Ensure posting on the health plan webiste | Annually | Quality Manager, HEDIS/NCQA Director | 09/30/25 | | 25-26 QIHETP Program |
| QIHETP Evaluation | QI 1B, Factor 5 | Administrative | Evaluate the effectiveness of QI initiatives. | 1. Collaborate with internal stakeholders to prepare a comprehensive evaluation of the previous FY's QI initiatives | **QI Evaluation addresses the following related to the quality and safety of clinical care and quality of service:**<br>• Completed and ongoing activities<br>• Trending of QI measures/results<br>• Evaluation of the overall effectiveness of the QI program and of its progress toward influencing networkwide safe clinical practices. | Annually | Quality Manager, HEDIS/NCQA Director | 09/30/25 | | 24-25 QIHETP Annual evaluation will be presented in January 2026 |
| DSNP MOC Evaluation | MOC 4D | Quality of Care | Evaluate the effectiveness of DSNP QI Initiatives | 1. Collaborate with internal stakeholdes to prepare a comprehensive evaluation of the effectiveness of the DSNP MOC quality initiatives as a separate evaluation document | QI Evaluation addresses the following:<br>• Results, analysis, opportunities, and improvement actions (as applicable) for all DSNP<br>• QI measures outlined in MOC 4A and 4B<br>• Lessons Learned<br>• Planned changes for the upcoming year<br>Communication of the evaluation to stakeholders | Annually | Quality Manager, HEDIS/NCQA Director | Begin monitoring in 2026 | | Components of the DSNP quality program from the MOC will be monitored beginning March 2026 |
| QIHETP Work Plan | QI 1A | Administrative | Ensure compliance with accreditation, business and regulatory requirements. | 1. Collaborate with internal business owners to review and document ongoing QI activities and those identified in the QI evaluation for the annual work plan. | Meets NCQA and applicable regulatory requirements to include:<br>• Yearly planned QI activities and objectives for improving:<br>– Quality of clinical care.<br>– Safety of clinical care.<br>– Quality of service.<br>– Members' experience.<br>• Reviewed and updated annually<br>• Reviewed and approved by the QIC | Quarterly | Quality Manager, HEDIS/NCQA Director | 9/17/25, 11/19/25, 1/21/26 3/18/26, 5/20/26 | | The 25-26 work plan first quarter presented to the QIHEOC 9/2025 |
| | | | | 2. Facilitate periodic review and updates of the QI Work Plan activities throughout the year. | | Ongoing | Quality Manager, HEDIS/NCQA Director | 11/14/25<br><br>3/1/26 | | |
| QI, HE, PHM, Policies and Procedures | NA | Administrative | Ensure that QI, HE, and PHM policies and procedures are reviewed and updated annually as applicable | 1. Review and update QI, HE, PHM policies and procedures as needed to ensure compliance with accreditation, regulatory and health plan business needs | 100% of QI, HE, PHM policies and procedures reviewed and updated annually, as applicable | Annually and more frequently as needed | Policy business owners | 06/30/26 | | |
| **MEMBER EXPERIENCE** | | | | | | | | | | |
| Member Services Telephone Access | NA | Administrative | Assess and improve member experience with telephonic access to health plan member services. Improve and maintain customer service call quality metrics for accuracy of informaiton provided. | 1. Collect and analyze internal health plan telephone access data for average speed of answer (ASA) and abandonment rate | **Telephone Access Goals:**<br>• ASA: 30 seconds<br>• Abandonment rate: ≤ 5%, call quality >90% accuracy | Quarterly | Customer Service Director | 10/14/25, 2/13/26, 5/8/26, 8/14/26 (annual) | | |
| | | | | 2. Collect and analyze any delegate telephone access data for ASA and abandonment rate | | | | | | |
| | | | | 3. Develop and implement improvement plan internally, as applicable, for results that are below the performance goal | | | | | | |

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| Member Call Quality and Accuracy | ME6C | Mbr Experience | Information provided over the phone will maintain appropriate levels of quality and accuracy. | 1. Collect data on quality and accuracy of the information provided to members over the phone.<br>2. Analyze data against goals.<br>3. Determine causes for deficincies, as applicable.<br>4. Act to improve identified decificiences, as applicable. | Quality and accuracy of information provided over the telephone will meet a goal of 90%. | Quarterly | Customer Service Director | 11/14/25, 2/13/26, 5/8/26, 8/14/26 (annual) | | |
| Website Quality | ME6C | Mbr Experience | Information provided over the website will maintain appropriate levels of quality and accuracy. | 1. Collect data on quality and accuracy of the information provided to members over the website.<br>2. Analyze data against goals.<br>3. Determine causes for deficincies, as applicable.<br>4. Act to improve identified decificiences, as applicable. | Quality and accuracy of information on the website will meet a goal of 90%. | Annually | CMME Director | 05/01/26 | | |
| Member Portal Response Evaluation | ME6D | Mbr Experience | Responses to member portal inquiries will be returned timely and will be of high quality. | 1. Maintain process and oversight for responding to member portal inquiries within 1 business day.<br>2. Maintain process and oversight for responding with high quality to portal inquiries.<br>3. Annually analyze data on turnaround time and quality of responses.<br>4. Act to improve identified deficiencies, if applicable. | At least 90% of response to inquiries received electronically will be within 1 business day of receipt.<br><br>Member portal responses will maintain an audit score of at least 95% of quality and accuracy components | Annually | Customer Service Director | 05/01/26 | | |
| Member Experience with health plan services (non-BH) | ME 7C,D | Mbr Experience | Assess and improve member experience with health plan services through analysis of satisfaction survey, complaint and appeal data | 1. Collect health plan member complaint and appeal data related to non-BH services (noncoverage appeals addressed in Element A and Element B and UM coverage appeals from UM 8 and 9) from the following categories:<br>• Quality of Care<br>• Access<br>• Attitude and Service<br>• Billing and Financial Issues<br>• Quality of Practitioner Office Site | Analysis of complaint, appeal and CAHPS and CG-CAHPS data with development and implementation of improvement plans as applicable | Annually | Quality Manager, HEDIS/NCQA Director | 11/14/25, 2/13/26, 5/8/26, 8/14/26 (annual) | | |
| | | | | 2. Collaborate with relevant delegates and vendors to obtain member and complaint data related to non-BH services for all categories listed above. | | | | | | |
| | | | | 3. Convene a team of PR, QI, CMME and MS leaders to conduct quantitative and qualitative analysis of complaint and appeal data | | | | | | |
| | | | | 4. Correlate member CAHPS results into the overall analysis of complaint and appeal data | | | | | | |
| | | | | 5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement actions. | | | | | | |
| | | | | 6. Develop and implement improvement plan as applicable that addresses causes/barriers to performance | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 7. Collaborate with PR, Network Ops, and QI to document all analysis and improvement plans on the HPSJ Availability and Access Report, present to QIHEC | | | | | | |
| | | | | 8. Monitor status/completion of improvement plans | 100% of improvement actions are implemented as applicable | Quarterly | | 11/14/25, 2/13/26, 5/8/26, 8/14/26 | | |
| Assessment of Member Experience with Behavioral Health Care and Services | ME 7E, F | Mbr Experience | Assess and improve member experience with BH services through analysis of complaint and appeal data | 1. Collect member complaint and appeal data **about BH services** from the following categories:<br>• Quality of Care<br>• Access<br>• Attitude and Service<br>• Billing and Financial Issues<br>• Quality of Practitioner Office Site | Analysis of complaint, appeal and BH survey data with development and implementation of improvement plans as applicable | Annually | Quality Manager, HEDIS/NCQA Director | 11/21/25, 2/13/26, 5/30/26, 6/30/26 | | |
| | | | | 2. Collaborate with applicable delegates to obtain member and complaint data related to BH services for all categories listed above. | | | | | | |
| | | | | 3. Collect member CAHPS results for the supplemental BH questions (if applicable): | | | | | | |
| | | | | 4. Convene a team of BH, PR, QI and MS leaders to conduct quantitative and qualitative analysis of member BH complaint, appeal data and results from CAHPS BH survey questions | | | | | | |
| | | | | 5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action. | | | | | | |
| | | | | 6. Develop and implement improvement plans as applicable that address causes/barriers to performance | | | | | | |
| | | | | 7. Collaborate with BH physician(s)/other practitioners, PR, Network Ops, and QI to document all analysis and improvement plans on the HPSJ Availability and Access Report, present to QIHEC | | | | | | |
| | | | | 8. Measure and document effectiveness of improvement actions to determine if interventions improved performance | | Annually | | | | |
| | | | | 9. Monitor status/completion of improvement plans | 100% of improvement actions are implemented as applicable | Quarterly | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|
| Assessment of Clinic and Group Member Experience Surveys. CG-CAHPS | | Mbr Experience | Assess and improve member experience with health plan services through analysis of CG-CAHPS surveys | 1. Collect provider specific member experience data **about services provided at outpatient provider offices** from the following categories:<br>• Quality of Care<br>• Access<br>• Attitude and Service<br>• TBD<br>• TBD | Analysis of quarterly CG-CAHPS survey data with development and implementation of improvement plans as applicable | Quarterly | HEDIS & NCQA Director | 12/19/25, 2/13/26, 5/8/26, (annual), | | Member Experience Task Force activities shared quarterly. |
| | | | | 2. Collect member CAHPS results for the supplemental questions (if applicable): | | | | | | |
| | | | | 3. Convene a team of PR, QI and MS leaders to conduct quantitative and qualitative analysis of results from CG-CAHPS survey questions | | | | | | |
| | | | | 4. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action. | | | | | | |
| | | | | 5. Develop and implement improvement plans as applicable that address causes/barriers to performance | | | | | | |
| | | | | 6. Collaborate with BH physician(s)/other practitioners, PR, Network Ops, and QI to document all analysis and improvement plans on the Availability and Access Report, present to QIHEOC. | | | | | | |
| | | | | 7. Measure and document effectiveness of improvement actions to determine if interventions improved performance | | Annually | | | | |
| | | | | 8. Monitor status/completion of improvement plans | 100% of improvement actions are implemented as applicable | Quarterly | | | | |
| Assessment of Consumer Assessment of Healthcare Providers and Systems Surveys (CAHPS). | | Mbr Experience | Assess and improve member experience with health plan services through analysis of Adult and Child-CAHPS surveys | 1. Collect provider specific member experience data **about services provided throughout the health plan ecosystem** from the following categories:<br>• Getting Needed Care<br>• Getting Care Quickly<br>• Rating of Health Plan and Doctor<br>• Customer Service<br>• Getting Care Tests and Treatment | Analysis of quarterly CG-CAHPS survey data with development and implementation of improvement plans as applicable | Annually and more frequently as needed | HEDIS & NCQA Director | 09/09/25 | | |
| | | | | 2. Collect member CAHPS results for the supplemental questions (if applicable):<br>Member experience with UM<br>Member experience with culturally appropriate care | | | | 09/09/25 | | |
| | | | | 3. Convene a team of PR, QI and MS leaders to conduct quantitative and qualitative analysis of results from CG-CAHPS survey questions | | | | 09/09/25 | | |

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|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 4. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action. | | | | 09/09/25 | | |
| | | | | 5. Develop and implement improvement plans as applicable that address causes/barriers to performance | | | | 09/09/25 | | |
| | | | | 6. Collaborate with BH physician(s)/other practitioners, PR, Network Ops, and QI to document all analysis and improvement plans on the HPSJ Availability and Access Report, present to QIC | | | | 09/09/25 | | |
| | | | | 7. Measure and document effectiveness of improvement actions to determine if interventions improved performance | | Annually | HEDIS/NCQA Coordinator | 09/09/25 | | |
| | | | | 8. Monitor status/completion of improvement plans | 100% of improvement actions are implemented as applicable | Quarterly | HEDIS/NCQA Coordinator | 09/09/25 | | |
| Rights and Responsibilities Statement | RR 1A, B | Mbr Experience | Communicate HPSJ/MVHP's commitment to treating members in a manner that respects their rights, and health plan's expectations of members' responsibilities to new and existing members and practitioners annually | 1. Collaborate with Compliance Lead and Grievance Manager to review and update, as applicable, the member rights and responsibilities statement to ensure it meets NCQA and DHCS requirements. | Member R&R statement is current and is provided to new members upon enrollment, new practitioners upon joining the network and existing members and practitioners annually. | Annually | Compliance Director, Accreditation Manager Grievance Manager | 02/13/26 | | |
| | | | | 2. Once R&R statement is reviewed and updated, update the R&R statement located in the following areas/documents:<br>• Health Plan website<br>• Provider Reference Manual<br>• Member EOC/COC<br>• Member and Provider Newsletter template | | | | | | |
| Customer Service Policies and Procedures | | Administrative | Ensure that CS policies and procedures are reviewed and updated annually as applicable | 1. Review and update CS policies and procedures as needed to ensure compliance with accreditation, regulatory and HPSJ business needs | 100% of CS policies and procedures reviewed and updated annually, as applicable | Annually | Customer Service Director | 02/13/26 | | |
| **CREDENTIALING** | | | | | | | | | | |
| Credentialing and Recredentialing Decision Notification Timeliness | CR 1A | Quality of Service | Ensure that credentialing and recredentialing decisions are communicated to practitioners within **30** calendar days of credentialing committee decision. | 1. Collect data and report on notification timeliness for practitioner credentialing and recredentialing decisions | 100% of practitioners are notified of Cred/Recred Committee decision within 30 days | Quarterly | Credentialing Supervisor | 11/14/25, 2/13/26, 5/8/26, 8/14/26 (annual) | | |
| | CR 4A | Administrative | | 2. Collect data and report on recredentialing cycle length | 100% of practitioners are recredentialed $\leq$ 36 months | Quarterly | Credentialing Supervisor | 11/14/25, 2/13/26, 5/8/26, 8/14/26 (annual) | | |

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| Practitioner Monitoring | CR 5A-B | Member Safety | Ensure ongoing monitoring, identification, and reporting of practitioners with issues | 3. Collect the following practitioner sanctions, complaints and other adverse events found during ongoing (and at least monthly) monitoring and report at the next scheduled PRCC (as outlined in the QM42 P&P):<br>• Practitioners meeting the grievance thresholds in a rolling 12-month period<br>• Any practitioner placed on a CAP for a grievance, adverse event/PQI, sanction, or other issue.<br>• Sanctions - Any of the following:<br>° Accusations against the practitioner's license reported by the Medical Board of California<br>° Administrative disciplinary actions imposed by the Medical Board of California<br>° All Medicare and/or Medicaid sanctions<br>° Medical Director Discretion: Such as Medicare and Medicaid exclusions, sanctions, license issues to include | All practitioners with reportable events, as outlined in the QM 42 P&P, will be presented at the next scheduled PRCC meeting | Monthly | Credentialing Supervisor | 7/2025<br>8/2025<br>9/2025<br>10/2025<br>11/2025<br>12/2025<br>1/2026<br>2/2026<br>3/2026<br>4/2026<br>5/2026<br>6/2026 | | Report dates: |
| | CR 5B | Quality of Service | Ensure ongoing monitoring, evaluation, and reporting of all member-specific practitioner's complaint history at least semiannually | 4. Collect, evaluate, and report on the history of all complaints for all practitioners at least every 6 months | The history of all complaints for all practitioners are evaluated at least every 6 months | Quarterly | Credentialing Supervisor | 11/14/25,<br>5/8/26 | | |
| | CR 5B | Member Safety | Ensure at least monthly monitoring of practitioner adverse events | 5. Collect data and report on practitioner adverse occurrences/quality of care issues identified for use in recredentialing process | Adverse events are monitored at least monthly | Monthly | Credentialing Supervisor | 7/2025<br>8/2025<br>9/2025<br>10/2025<br>11/2025<br>12/2025<br>1/2026<br>2/2026<br>3/2026<br>4/2026<br>5/2026<br>6/2026 | | |
| Credentialing and Recredentialing File Audits | NA | Administrative | Ensure that credentialing and recredentialing files meet NCQA and DHCS requirements | 1. Conduct quarterly credentialing and recredentialing file audits | 100% of credentialing and recredentialing files meet NCQA and DHCS requirements | Quarterly | Credentialing Supervisor | 7/1/25<br>10/1/25<br>1/1/26<br>4/1/26 | | |
| | | | | 2. Share individual results with credentialing team members and aggregate results with all team members and implement improvement actions, as needed. | | | | | | |
| Credentialing and Recredentialing Policies and Procedures | NA | Administrative | Ensure that Cred and Recred policies and procedures are reviewed and updated annually as applicable | 1. Review and update Cred and Recred policies and procedures as needed to ensure compliance with accreditation, regulatory and business needs | 100% of Cred and Recred policies and procedures reviewed and updated annually, as applicable | Annually | Credentialing Supervisor | 6/30/26 | | |
| | CR 8B | Administrative | Ensure that Credentialing staff are trained on the Information Integrity Requirements annually. | 1.Send training slides to HR along with a list of credentialing staff that need training and request that HR launch training | 100% of Credentialing staff receive training on the information integrity requirements annually | Annually | Credentialing Supervisor | 10/1/25 | | |
| | | | | 2. Monitor to ensure that all staff complete the training and send training logs to Accreditation Manager | | | | 11/1/25 | | |

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|---|---|---|---|---|---|---|---|---|---|---|
| Credentialing Information Integrity | CR 8C-D | Administrative | Conduct credentialing and recredentialing information integrity audit | 1. Run a report to identify universe of credentialing and recredentialing files completed in the previous FY (July 1, 2024 through June 30, 2025)<br>2. Identify 5% or 50 files for audit sample<br>3. Audit credentialing documents (as outlined on the report template) to identify for any inappropriate documentation and updates<br>4. Convene a group of credentialing SMEs to conduct qualitative analysis of results for each inappropriate documentation and update found<br>5. List improvement actions and responsible persons for each inappropriate documentation and update<br>6. Prepare report and include all NCQA-required content<br>7. Include audit log with report as an attachment<br>8. Notify CMO, Compliance, and NCQA for any inappropriate documentation and updates found<br>9. Monitor to ensure completion of all corrective actions<br>10. Conduct an audit of the effectiveness of corrective actions on findings 3-6 months after completing annual audit and document all NCQA-required content in report | Zero inappropriate documentation or updates to credentialing information<br><br>If any inappropriate documentation or updates are found:<br>Notification to CMO, Compliance and NCQA in a timely manner and resolution of issues | Annually | Credentialing Supervisor | 5/1/26 | | |
| **CLINICAL QUALITY** | | | | | | | | | | |
| Preventive (Practice) Guidelines | | Quality of Care | Ensure that clinical practice guidelines reflect the most current evidence-based recommendations | 1. Collaborate with health plan Medical Director to review evidence based sources for applicable updates to the following clinical practice guidelines:<br>• Diabetes, Asthma, COPD, Heart Failure<br>• AMA Adult and Pediatric Preventative Care | 100% of clinical practice guidelines are reviewed and updated, as applicable, at least biennially | Biennially | Exec. Dir. Clinical Ops, Director of BH and SW, Health Education Manager | 05/01/26 | | |
| | | | | 2. Collaborate with Behavioral Health physician to obtain applicable updates to the following BH clinical practice guidelines:<br>• Depression<br>• Substance use<br>• Comorbid Medical/Behavioral Health | | | | | | |
| | | | | 3. Provide current/updated clinical practice guidelines to members and practitioners via:<br>• In writing, upon request<br>• HPSJ/MVHP website<br>• Provider reference manual<br>• Provider Newsletter | Members and practitioners have access to clinical practice guidelines | Annually | Exec. Dir. Clinical Ops, Director of BH and SW, Health Education Manager | 06/30/26 | | |
| **Focus Studies** | | | | | | | | | | |
| Focus Studies- Blood Lead Screening | N/A | Quality of Care | Ensure that health plan meets DHCS required All Plan Letters. | 1. Review and assess compliance with APL 20-026-Blood Lead Screening in Children | Health plan members recieve blood lead screening and members with identified risk and need receive appropriate follow up. | Annually | HEDIS Manager | 11/14/25 | | |
| | | | | 2. Review and update data collection template | | Annually | HEDIS Manager/ HEDIS/NCQA Director | 02/13/26 | | |

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| | | | | 3. Collect data and medical records for documentation of blood lead screening, anticipatory guidance and caregiver refusal. | | Monthly | HEDIS Manager | 05/15/26 | | |
| | | | | 4. Convene a team of leaders and SMEs to perform qualitative and quantiative analysis of data and determine if corrective action plans are warranted for evidence of APL non-compliance. | | Monthly | HEDIS Manager | 07/14/25 | | |
| | | | | 5. Identify targeted interventions to be implemented to address the specific barriers/root causes identified, and to improve systems of care and develop provider CAPs as needed. | | Monthly | | 07/14/25 | | |
| | | | | 6. Implement targeted improvement actions, including provider education, through the provider partnership and provider alerts and education CAPs | | Ongoing | HEDIS Manager | 02/13/26 | | |
| | | | | 7. Implement targeted member improvement actions via distribution of member education through member newsletters and gap in care calls and other means. | | Ongoing | HEDIS Manager | 06/30/26 | | |
| Lead Screening Follow Up | NA | Quality of care | Ensure provider follow-up of all elevated blood lead screening levels | 1. Collect and analyze data monthly on all members identified with elevated blood screening levels. | 100% of all members with elevated blood lead levels receive follow-up monitoring and care | Annually | HEDIS Manager | 7/1/25<br>8/1/25<br>9/1/25<br>10/1/25<br>11/1/25<br>12/1/25<br>1/1/26<br>2/1/26<br>3/1/26<br>4/1/26<br>5/1/26<br>6/1/26 | | |
| | | | | 2. Notify DHCS of increased rate of members with elevated blood lead levels | | Ongoing | Director of Quality | 08/01/25 | | |
| | | | | 3. Monitor provider CAPs monthly to ensure that members are receiving follow-up care. | | Annually | HEDIS Manager | 02/13/26 | | |
| | | | | 4. Conduct provider and member outreach as needed to reinforce need for follow-up and monitoring until member blood lead levels reach a normal level | | Annually | HEDIS Manager | 06/30/26 | | |
| | | | | 5. Escalate any provider noncompliance issues to CMO and Provider Services | | Annually | HEDIS Manager | 06/30/26 | | |
| Focus Studies- Initial Health Appointment | N/A | Quality of Care | Ensure that health plan meets DHCS required All Plan Letters. | 1. Review and assess compliance with APL 22-020-Initial Health Appointment | Health plan members recieve initial health appointments and members with identified risk and needs receive appropriate follow up. | Annually | HEDIS Manager | 11/14/25 | | |
| | | | | 2. Collect data and medical records for documentation of initial health appointments and documentation of appropriate follow up. | | Annually | HEDIS Manager | 02/13/26 | | |
| | | | | 3. Analyze data and determine if corrective action plans are warranted for evidence of APL non-compliance. Follow up on CAPs timely. | | Annually | HEDIS Manager | 07/30/25 | | |

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| | | | | 4. Convene a team to perform qualitative and quantiative analysis. | | Annually | | 07/30/25 | | |
| | | | | 5. Identify whether improvement opportunities are warranted to improve systems of care. | | Annually | | 10/31/25 | | |
| | | | | 6. Distribute provider education through the provider partnership and provider alerts. | | Annually | HEDIS Manager | 06/30/26 | | |
| | | | | 7. Distribute member education through new member packets and outreach for preventative care. | | | HEDIS Manager | 06/30/26 | | |
| Focus Studies - Diabetic Eye Exams | QI 3C | Quality of Care | Improve Diabetic Eye Exams | 1. Outreach to identified pilot clinics for coordination and implementation of hand-held portable retinopathy machines | Increase the rate of diabetic eye exams from 38.93% to MY25 50th percentile by 12/31/2026 | Once | HEDIS & NCQA Coordinators | 10/31/25 | | |
| | | | | 2. Establish benchmarks and goals for pilot clinics along with data feeds for monitoring implementation and adoption | | Once | HEDIS & NCQA Manager<br>HEDIS & NCQA Coordinators | 12/31/25 | | |
| | | | | 3. Facilitate staff training and EMR integration | | Once | HEDIS & NCQA Coordinators | 12/31/25 | | |
| | | | | 4. Report quarterly progress, identified barriers, and proposed solutions to Health Plan leadership through QIHEC | | Quarterly | HEDIS & NCQA Manager<br>HEDIS & NCQA Coordinators | 06/30/25 | | |

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|---|---|---|---|---|---|---|---|---|---|---|
| **POPULATION HEALTH MANAGEMENT** | | | | | | | | | | |
| PHM Strategy and Program Description | PHM 1A | Administrative | Ensure PHM program strategy and related materials are reviewed and updated annually, as needed | 1. Review and update PHM Strategy program description to include: target populations, goals, program and services, for each of the following focus areas:<br>• Keeping members healthy<br>• Managing members with emerging risk<br>• Patient safety or outcomes across settings<br>• Managing multiple chronic illnesses | Annual review and updates to the PHM program strategy description and applicable member materials | Annually | HEDIS/NCQA Director Accreditation Manager | 10/1/25 | | 1. Complete. Updated PHM strategy will be presented to QIHEC 9/17/25 for approval |
| | PHM 6A | Quality of Care | | 2. Based on PHM Assessment, determine if any changes are needed to the **4** measures that are used to evaluate the impact of the PHM program:<br>• Clinical measure<br>• Cost/utilization measure<br>• Member expedience measures (at least one measure for two PHM programs) | | | HEDIS/NCQA Director Accreditation Manager | 10/1/26 | | 2. Complete - Population assessment results were complied and reviewed. Improvement opportunities were identified for well visits and additional resources and activities were identified to support well visits. |
| | PHM 1B | Administrative | | 2. Review PHM Program Strategy description and applicable member materials; update descriptive information in the PHM Program Strategy as needed for:<br>• Non-member interventions<br>• How members are informed of all PHM programs<br>• How members are provided the following information re: interactive PHM programs<br>-- How members become eligible to participate.<br>-- How to use program services.<br>-- How to opt in or opt out of the program. | | | HEDIS/NCQA Director Accreditation Manager | 10/1/27 | | 2. Complete. Updated PHM strategy will be presented to QIHEC 9/17/25 for approval |
| | PHM 1A-B | Administrative | | 3. Present updated PHM Program Strategy Description and any applicable updated member materials to the QIHEC. | | | HEDIS/NCQA Director Accreditation Manager | 10/1/28 | | On Track - Updated PHM Strategy will be presented to QIHEC on 9/17/25 |
| | | | | 4. Provide copies of updated PHM Program Strategy Description and all updated and approved materials to the Accreditation Manager. | | | HEDIS/NCQA Director Accreditation Manager | 10/1/29 | | On Track |
| Population Health Data Integration | PHM 2A | Administrative | Ensure data integration from all required sources to facilitate PHM program activities. | 1. Review and update PHM program strategy description (or P&P), as needed, to reflect integration of data from the following:<br>• Medical and behavioral claims or encounters.<br>• Pharmacy claims.<br>• Laboratory results.<br>• Health appraisal results.<br>• Electronic health records.<br>• Health services programs within the organization.<br>• Advanced data sources. | Annual review and updates to the PHM program strategy description or P&P to reflect integration of data for PHM activities | Annually | HEDIS/NCQA Director Accreditation Manager | 10/1/30 | | 1. Complete |
| | | | | 2. Obtain copies of reports (PHI redacted) and/or screen shots showing integration of data for all sources listed in #1 (above) and provide to Accreditation Manager. | | | HEDIS/NCQA Director Accreditation Manager | 9/1/2025 | | 2. Complete |

# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY (* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|
| Population Health Assessment | PHM 2B-C | Administrative | Review and update the PHM strategy, including programs, services, activities and resources to meet member needs. | 1. Collect population health data, assess the characteristics and needs for the following categories of members, and document findings in the Population Health Assessment Report:<br>• Social determinants of health<br>• Children and adolescents age 2-19<br>• Members with disabilities<br>• Members with serious mental illness or serious emotional disturbance<br>• Members of racial or ethnic groups<br>• Members with limited English proficiency<br>• Relevant member subpopulations (as defined by HPSJ) | Annual assessment of population characteristics and needs to ensure PHM program services, activities, and resources meet member needs | Annually | HEDIS/NCQA Director<br>Accreditation Manager | 8/1/25 | | 1. Complete - Population needs assessment in line with NCQA requirements developed and presented to internal stakeholders on 8/1/25. |
| | | | | 2. Based on member needs identified (from #1 above), conduct and document the following in the Population Health Assessment Report:<br>• Review and update of PHM activities<br>• Review and update of PHM resources<br>• Review and update of a PHM program, service, activity, or resource to address health care disparities for at least one identified population<br>• Review community resources for integration into program offerings | | | HEDIS/NCQA Director<br>Accreditation Manager | 9/1/25 | | 2. Complete - Quantitative and qualitative anlaysis completed by stakeholders in review of population needs assessment, including identified updates to activities, resources, health equity, and community resource integration |
| | | | | 3. Update PHM program strategy to reflect updates to programs, activities, services or resources. | | | HEDIS/NCQA Director<br>Accreditation Manager | 10/31/25 | | 3. On Track - Updated PHM Strategy will be presented to QIHEC on 9/17/25 |
| Population Health Stratification | PHM 2D | Administrative | Segment or stratify the entire population into subsets for targeted intervention. | 1. Segment the entire population into appropriate population health management programing based on need and risk.<br>2. Assess segmentation methodology for racial bias. | All Health Plan members will have population health management interventions appropriate for their level of risk and specific medical needs. | Annually | HEDIS/NCQA Director<br>Clinical Analytics Director | 10/31/25 | | 1. On track - stratification data received<br>2. On track - write up in process |
| Population Health Management | | Quality of Care | Assess and improve member status by implementing population health management programs with provider and members. Implement programs in alignment with NCQA Standards and DHCS requirements. | 1. Collect health plan member risk stratification data to evaluate performance and update current PHM program and identifying health disparities for focus areas: Analyze stratification data with development and implementation of population health management programs that address focus areas:<br>• Disengaged<br>• Keeping members healthy,<br>• High Risk Obstetric Care,<br>• Managing emerging risk,<br>• Mitigating rising risk,<br>• Safety Across Settings,<br>• Complex Case Management,<br>• Enhanced Case Management | Disengaged Members: Decrease the number of members with no ambulatory or preventive visit within a 12-month period by 5% by 12/31/2025.<br><br>Keeping members healthy: Well child visits meet 50th percentile.<br><br>High Risk Obsetric Care: Improving the rate of prenatal and postpartum care for Black and African American birthing<br><br>Emerging Risk: An additional 10 eligible prediabetic members will enroll and complete the Diabetes Prevention Program by 12/31/25.<br><br>Mitigating Rising Risk: Decrease the rate of diabetic members whose A1c is poorly controlled as measured by an A1c greater than 9% from the 50th percentile to the 66th percentile based on the MY24 Medicaid Managed Care benchmark by 12/31/2025<br><br>Safety Across Settings: Increase rate at which pregnant | Quarterly | Accreditation Manager | 6/30/26 | | 1. Complete<br>2. Complete<br>3. On track<br>4. On track<br>7. On track<br>8. On track |
| | | | | 2. Collaborate with internal stakeholders to determine proper alignment of programs to member needs. | | | | | | |

# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY (* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 3. Ensure program materials are shared with network providers and members. | Safety Across Settings: Increase rate at which pregnant people receive prenatal care within the first trimester or 42 days of enrollment from above the 50th to above the 75th percentile based on the National Medicaid Managed Care Benchmark by 12/31/2025.<br><br>Complex Case Management: An additional 10% of members meeting eligibility criteria for complex case management will enroll in program services by 12/31/2025. | | | | | |
| | | | | 4. Integrate data for population health. Obtain screen shots and reports for PHM data integration. | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | 7. Reevaluate programs and processes to ensure focus area programs are updated if needed. | | | | | | |
| | | | | 8. Communicate programs to members and providers and make available on the web. | Ensure 100% of PHM programs are communicated to members and providers. | Annually | | | | |
| Provider Delivery System Supports | PHM 3A | Administrative | Promote collaborative to practitioners or providers to achieve HPSJ population health management goals. | 1. Evaluate existing provider delivery system supports and determine if any changes are needed:<br>• Sharing data<br>• Offering evidence-based or certified decision-making aids<br>• Providing practice transformation support to primary care practitioners<br>• Providing comparative quality information on selected specialties<br>• Providing comparative pricing information on selected services<br>• Providing training on equity, cultural competency, bias, diversity or inclusion | Minimum of 3 provider delivery system supports in place | Annually | HEDIS/NCQA Director Accreditation Manager | 6/1/25 | | 1. Complete - Documented processes reviewed and updated as appropriate |
| | | | | 2. Update PHM Strategy description or P&P to reflect current delivery system supports. | | | HEDIS/NCQA Director Accreditation | 10/31/25 | | 2. Complete |
| | | | | 3. Obtain screen shots or copies of materials evidencing how delivery system support is provided for at least 3 of the 6 NCQA categories (outlined in #1), and provide to Accreditation Manager. | | | Accreditation Manager | 6/30/26 | | 3. On track |
| Provider Value Based Payment (VBP) Arrangements | PHM 3B | Administrative | Ensure that HPSJ has practitioner agreements that promote quality, value, and improved health outcomes | 1. Collaborate with Contracting and Finance department to obtain information on value based payouts to practitioners and providers and complete the VBP worksheet. | At least 1-2 VBP contracts in place | Annually | Sr. Financial Analyst Accreditation Manager | 6/30/26 | | Compliant and ongoing |

# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

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|---|---|---|---|---|---|---|---|---|---|---|
| Self-Management Tools | PHM 4B | Administrative | Ensure that self-management tools are derived from evidence-based sources and are avaiable to members | 1. Review and update P&P or program description (as needed) to reflect PHM self-management tools and their evidence based sources that are available to members:<br>• Healthy weight (BMI) maintenance<br>• Smoking and tobacco use cessation<br>• Encouraging physical activity<br>• Healthy eating<br>• Managing stress<br>• Avoiding at-risk drinking<br>• Identifying depressive symptoms | Self-management tools and evidence based sources reviewed and updated annually | Annually | Health Education Manager | 12/31/25 | | On track |
| | | | | 2. Provide screen shots and a description of each self-management tool available to members (as outlined in #1 above) to the Accreditation Manager. | | | Accreditation Manager | 6/30/26 | | On track |
| Complex Case Management | PHM 5A-C | Quality of Care | Assist members with multiple or complex conditions to obtain access to care and services, and coordinate their care. | 1. Review and update CCM program description or P&P re: referrals to CCM and provide to Accreditation Manager:<br>• Medical management program referral<br>• Discharge planner referral<br>• Member or caregiver referral<br>• Practitioner referral | CCM program description or P&Ps updated annually to refect cuurent CCM processes and that complies with DHCS and NCQA requirements | Annually | Case Management Director | | | |
| | | | | 2. Provide screen shots, reports, or member/provider materials evidencing how members can access CCM services for each of the 4 referral methods (outlined in #1) to the Accreditation Manager | | Annually | Case Management Director | | | |
| | | | | 3. Review and update CCM program description or P&P to reflect CCM system capabilities re:<br>• Evidence-based clinical guidelines or algorithms to conduct assessment and management.<br>• Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred.<br>• Automated prompts for follow-up, as required by the case management plan. | | Annually | Case Management Director | | | |
| | | | | 4. Prepare screen shots evidencing CCM system capabilities (as outlined in #3) to the Accreditation Manager. | | Annually (or every 2 years) | Case Management Director | | | |
| | | | | 5. Review and update CCM Assessment and Care Plan P&Ps to ensure compliance with all NCQA factors/requirements for CCM 5C (see NCQA standard for full details of requirements of factors 1-17). | | Annually | Case Management Director | | | |
| | | | | 6. Conduct quarterly audits of a random sample of CCM files to assess compliance with DHCS and NCQA requirements. | | Quarterly | Case Management Director | | | |
| | | | | 7. Present updated CCM P&Ps, Program Descriptions, and audit results to QIHEC at least annually. | | Annually | Case Management Director | | | |

# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY<br><br>(* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|
| PHM Program Impact Assessment | PHM 6A-B | Quality of Care | Assess the impact and effectiveness of the PHM program strategy | 1. Collect data on each of the following clinical, cost/utilization, and member experience measures used to monitor and evaluate the effectiveness of the PHM program strategy:<br><br>**DM Program**<br>• ED visit rates<br>• Inpatient admission rates<br>• Member experience survey<br><br>**Me and My Baby Program**<br>• Prenatal care<br>• Postpartum care<br>• Member experience survey<br><br>**Keeping Members Healthy**<br>• Well child visit rates (0-15 months, 15-30 months, and children and adolescents from 3-21 years) | **Keeping Members Healthy**<br>• **Well child visit rates: 50th %tile**<br>-- 0-15 mos: 58.38%<br>-- 15-30 mos: 66.76%<br>-- 3-21 years: 48.07%<br><br>**DM Program**<br>• ED visit rates: <602.025/1000 mbr years<br>• AMR: 65.61% (50th %ile)<br>• DM Member experience survey: 80%<br>• Hypertension Member experience survey: 80%<br><br>**Me and My Baby Program**<br>• Prenatal care: 88.33% (75th %tile)<br>• Postpartum care: 82.00% (75th %tile) | Annually | HEDIS/NCQA Director Accreditation Manager | 9/30/25 | | |
| | | | | 2. Convene a team of PHM, QI and other leaders and SMEs to conduct quantitative and qualitative analysis of results, and a comprehensive assessment of the impact of the PHM program. | | | HEDIS/NCQA Director Accreditation Manager | 9/30/25 | | |
| | | | | 3. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action. | | | HEDIS/NCQA Director Accreditation Manager | 9/30/25 | | |
| | | | | 4. Develop and implement improvement plans as applicable that address causes/barriers to performance. | | | HEDIS/NCQA Director Accreditation Manager | 6/30/26 | | |
| | | | | 5. Measure and document effectiveness of improvement actions to determine if interventions improved performance | | | HEDIS/NCQA Director Accreditation Manager | 9/30/26 | | |
| | | | | 6. PHM lead person documents all analysis and improvement plans, to include the comprehensive assessment/conclusion of the impact of the PHM program, on the PHM 6A-B Population Health Impact report and presents to QIHEC. | | | HEDIS/NCQA Director Accreditation Manager | 6/30/2026 | | |
| | | | | 7. Monitor status/completion of improvement plans | | | HEDIS/NCQA Director Accreditation Manager | 6/30/2026 | | |
| **CULTURAL AND LINGUISTICS PROGRAM** | | | | | | | | | | |

# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY<br>(* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|
| Cultural and Linguistics Program | | Mbr Experience | 1. Increase Interpreter Services Utilization* | 1/2.1 Roll out at least one new onsite, phone, or video remote interpreting service to at least one provider entity.<br>1/2.2 Update provider-based and internal training/informational material on interpreter services and disseminate through multiple channels, such as email, provider alerts, Provider Relations, and PlanScan.<br>1/2.3 Conduct Formal Request for Quotation (RFQ) from service area onsite interpreter services vendors and establish or reconfirm contracts to ensure the availability of onsite interpreters.<br>1/2.4 Complete HHS's Implementation Checklist for the National CLAS Standards, selecting at least 1 item to implement that could increase interpreter services utilization.<br>1/2.5 Implement the 1 item prior to calendar 2024 end<br>1/2.6 Coordinate with CBO that is focused on serving a language group with low interpreter service utilization to complete at least one activity to increase engagement with the Health Plan, Providers, or Langage Access Services | 1.1 Increase Interpreting Encounters vs Membership Ratio by 3% for Khmer<br>1.2 Increase overall interpreter services utilization by 10%<br>1.3 Increase ratio of total fiscal year interpreted encounters vs average fiscal year LEP member count by 5% | Annually | C&L Manager; C&L Speacialists | 1.1 6/30/25<br>1.2 6/30/25<br>1.3 6/30/25 | | 1.1 In Progress<br>1.2 In Progress<br>1.3 In Progress |
| | | | 2. Meet C&L FY25 Quality Benchmarks | 1/2.1 Roll out at least one new onsite, phone, or video remote interpreting service to at least one provider entity.<br>1/2.2 Update provider-based and internal training/informational material on interpreter services and disseminate through multiple channels, such as email, provider alerts, Provider Relations, and PlanScan.<br>1/2.3 Conduct Formal Request for Quotation (RFQ) from service area onsite interpreter services vendors and establish or reconfirm contracts to ensure the availability of onsite interpreters.<br>1/2.4 Complete HHS's Implementation Checklist for the National CLAS Standards, selecting at least 1 item to implement that could increase interpreter services utilization.<br>1/2.5 Implement the 1 item prior to calendar 2024 end | 2.1 Grievances related to language access vendors: <2/mo ave<br>2.2 Potential Quality Issues (PQIs) related to language access vendors: <3/mo ave<br>2.3 Video Remote Interpreting Star Rating by provider entity for interpreter quality: >/= 4.8/5.0 monthly average<br>2.4 Video Remote Interpreting Star Rating by provider entity for video quality: >/= 4.8/5.0 monthly average<br>2.5 Vendor Written translation timeliness: >/= 99%<br>2.6 Internal staff qualified bilingual contingent (% of member-facing staff): >/= 35%<br>2.7 Onsite Interpreting Request vs Fulfillment rate: >/= 90% per mo monthly average | Annually | C&L Manager; C&L Speacialists | 2.1 6/30/25<br>2.2 6/30/25<br>2.3 6/30/25<br>2.4 6/30/25<br>2.5 6/30/25<br>2.6 6/30/25<br>2.7 6/30/25 | | 2.1 In Progress<br>2.2 In Progress<br>2.3 In Progress<br>2.4 In Progress<br>2.5 In Progress<br>2.6 In Progress<br>2.7 In Progress |

# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY<br><br>(* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | 3. Meet C&L FY25 Timely Access for LEP Survey Benchmarks* | 3.1 Confirm the instructions members are given by the health plan to acquire appointments with primary care providers, as well as urgent care appointments.<br>3.2 Evaluate the appointment request process for PCPs and urgent care providers to identify gaps.<br>3.3 Evaluate process for instructions given to PCPs, urgent care providers, and member-facing health plan staff on how to engage language access services. Identify gaps.<br>3.4 Analyze identified gaps to confirm at least one PCP or urgent care provider, and at least one health plan team for which to provide focused support in the provision of meaningful, timely access to members with limited English Proficiency.<br>3.5 Begin implementing improvement strategies no later than December 30th, 2024. Use the 2025 timely access survey to measure any immediate progress.<br>3.6 Continue efforts through 2026 timely access survey, and measure against those results. (Carry over to FY26 project tracker) | 3.1 Regarding written information from doctors, increase % of respondents who felt that doctors gave them written information they needed in their language quickly: 89%<br>3.2 Regarding verbal interpreting from doctors, increase % of respondents who believed they got the same information as an English speaker would: 92%<br>3.3 Regarding written information from the Health Plan, increase % of respondents who felt that if information was not available in their language, the Health Plan was able to translate it for them: 90%<br>3.4 Regarding verbal interpreting from the health plan, increase % of respondents who believed the health plan told them the same information they would have given to an English speaker: 89%<br>3.5 Create report on overall network provider and staff language capabilities (qualified interpreter services, qualified bilingual/multilingual staff) compared against member language reports to evaluate adequacy of network language and cultural responsiveness at a high level. Report will include perceived gaps. | Annually | C&L Manager; C&L Speacialists | 3.1 6/30/25<br>3.2 6/30/25<br>3.3 6/30/25<br>3.4 6/30/25<br>3.5 6/30/25 | | 3.1 In Progress<br>3.2 In Progress<br>3.3 In Progress<br>3.4 In Progress<br>3.5 In Progress |
| | | | 4. Provide C&L Support to Improve Clinical Outcome | 4.1 Connect with Quality Improvement team to identify HEDIS or MCAS measure to focus on for improved clinical Outcomes.<br>4.2 C&L to provide interpreting or translation support to reach relevant limited English proficient population to improve the given outcome.<br>4.3 Measure the impact of the C&L intervention in the clinical outcome. | 4.1 Increase HEDIS performance of Controlling Blood Pressure (CBP) measure for Punjabi speakers from 45.29% to 59.73% (12/31/2025). Continue focus until reaching ultimate goal of 64.48% (12/31/2026) | Annually | C&L Manager; C&L Speacialists | 4.1 12/31/25 | | 4.1 In Progress |
| | | | 5. FY25 Evaluation of CLAS Program and FY26 Workplan Formation | 5.1 Perform end of fiscal year review of C&L/CLAS program workplan, identify goals and metrics that are met, as well as needs for following fiscal year projects, program description, and work plan adjustments. | 5.1 Complete C&L and CLAS evaluation, with deliverables being an annual evaluation report and preparation of the FY26 C&L/CLAS workplan | Annually | C&L Manager; C&L Speacialists | 5.1 12/31/25 | | 5.1 Not Started |
| | | | 6. DEI Training Dev Phases 2-3 + TGI | 6.1 Coordinate with Project Manager to meet milestones.<br>6.2 Work proactively with internal and external stakeholders to gather required training feedback.<br>6.3 Work with instructional designer to apply feedback to training program.<br>6.4 Work with web team to upload training to appropriate external website location, or for TGI, work with HR to add training to HealthStream<br>6.6 Work with configuration team and HR to track appropriate training completion. | 6.1 Begin development of DEI Program<br>6.2 Cross colaborate with other area MCPs in DEI Creation<br>6.3 Submit DEI Training Program to DHCS for review<br>6.4 Launch Pilot of DEI Training Program<br>6.5 Assess the training programs and address issues/concerns learned from pilot<br>6.6 Acquire vendor for Transgender, Gender Diverse, and Intersex Training<br>6.7 Train all internal, member-facing staff on Transgender, Gender Diverse, and Intersex Themes<br>6.8 Implement reporting and monitoring structure per DEI and TGI regulations. | Annually | C&L Manager; C&L Speacialists | | | Carried forward from 24-25 work plan |
| **CHRONIC CARE IMPROVEMENT PROGRAM (CCIP)** | | | | | | | | | | |

| HEALTH PLAN<br>FY2025-2026 QUALITY WORK PLAN | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **ACTIVITY**<br>(* denotes monitoring of previously identified issue) | **NCQA STANDARD** | **CATEGORY** | **OBJECTIVE** | **ACTIONS** | **PERFORMANCE TARGET/ GOAL** | **FREQUENCY** | **RESPONSIBLE POSITION** | **DUE DATE** | **DATE APPROVED** | **STATUS UPDATES/ RESULTS** |
| Chronic Care Improvement Plan (CCIP) | MOC 4A, B | Quality of Care+$B$198 | Establish baseline metrics and a monitoring frameworkd for Hispanic D-SNP members with poor diabetes control (A1c > 9.0%) | 1. Identify and validate CCIP-eligible D-SNP members using integrated data from claims, labs and race/ethnicity data sources.<br>2. Define key performance metrics<br>3. Establish report parameters and data sources to monitor CCIP progress and efficacy | By 6/30/2026, a dashboard for monitoring the quality and effectiveness of the CCIP will be developed with data collection completed to develop baseline rates | 1. Ongoing<br>2. Once with updates as indicated<br>3. Once, with updates as indicated | 1. Clinical Analytics Director<br>2. HEDIS & NCQA Director<br>3. HEDIS & NCQA Director and Clinical Analytics Director | 1. 12/31/25<br>2. 9/1/25<br>3. 10/31/25 | | |
| | MOC 4A, B | | Build internal capacity to support data-informed CCIP operations | 1. Provide training to relevant staff on the CCIP metrics, tracking tools, and goals<br>2. Develop and distribute CCIP desk procedures that outline data definitions, sources, and reporting responsibilities to relevant staff<br>3. Establish internal feedback loops with case management to share findings and recommendations based on data on a quarterly basis | Relevant documentation and processes related to quality aspects of the CCIP program will be developed and shared with staff in advance of D-SNP go-live date | 1. Once<br>2. Once<br>3. Once | 1. HEDIS & NCQA Director<br>2. HEDIS & NCQA Director<br>3. HEDIS & NCQA Director and Case Management Director | 10/31/25 | | |

# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY (* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|
| **QUALITY AND EQUITY PROJECTS** | | | | | | | | | | |
| Improving MCAS performance with Controlling Blood Pressure (CBP)* | | Quality of Care | Assess and improve member blood pressure control by implementing improvement initatives with provider and members and improved data capture. | 1. Collect health plan member blood pressure data to evaluate current performance and health disparities. | Analysis of barriers and rate stratification data with development and implementation of improvement plans as applicable. Improve MCAS CBP measure. | Quarterly | Quality Manager, HEDIS/NCQA Director | , 8/14/25 (annual), 10/30/25, 2/2026, 5/2026 | | Carried forward from 24-25 work plan |
| | | | | 2. Collaborate with providers to obtain provider, member and data barrier analysis . | | | | | | |
| | | | | 3. Convene a team of PR, QI and MD leaders to conduct quantitative and qualitative analysis of blood pressure data | | | | | | |
| | | | | 4. Correlate blood pressure rate results into the overall analysis of health plan performance | | | | | | |
| | | | | 5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement actions. | | | | | | |
| | | | | 6. Develop and implement improvement plan as applicable that addresses causes/barriers to performance | | | | | | |
| | | | | 7. Collaborate with PR, Network Ops, and QI to document all analysis and improvement plans on the DHCS template documents and present to QIHEOC. | | | | | | |
| | | | | 8. Monitor status/completion of improvement plans | 100% of improvement actions are implemented as applicable | Annually | | 10/30/25 | | |
| **CHILD HEALTH EQUITY PROJECTS** | | | | | | | | | | |
| Improving MCAS performance with Childhood Vaccination Status - Combo 10 for two year olds.* | | Quality of Care | Close racial and ethnic disparities in immunizations by 50% | 1. Collect and analyze member, provider and data current performance and perform a barrier analysis of childhood vaccination processes. Analyze data by antigen to identify patterns of non-compliance. Analyze data by subpopulation to identify health disparities. | Close rate of immunizations for all racial and ethnic groups below the MPL by a minimum of 50% | Quarterly | Quality Manager, HEDIS/NCQA Director | 8/14/25 (annual), 10/30/25, 2/2026, 5/2026 | | Carried forward from 24-25 work plan |
| | | | | 2. Collaborate with applicable stakeholders to obtain member and provider performance data related to vaccination services. | | | | | | |
| | | | | 3. Collect member CIS-10 results by antigen and member characteristics including but not limited to race and ethnicity | | | | | | |
| | | | | 4. Convene a team of QI, HE, PHM and MD leaders to conduct quantitative and qualitative analysis of vaccination rate performance and subpopulation stratifications. | | | | | | |
| | | | | 5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action. | | | | | | |
| | | | | 6. Develop and implement improvement plans as applicable that address causes/barriers to performance | | | | | | |
| | | | | 7. Collaborate with physician(s)/other practitioners, QI, Network Ops, and BI to document all analysis and improvement plans on the DHCS QI/HE Report Template present to QIHEOC. | | | | | | |
| | | | | 8. Measure and document effectiveness of improvement actions to determine if interventions improved performance | | Quarterly | Quality Manager, HEDIS/NCQA Director | | | |

| HEALTH PLAN<br>FY2025-2026 QUALITY WORK PLAN | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **ACTIVITY**<br>(* denotes monitoring of previously identified issue) | **NCQA STANDARD** | **CATEGORY** | **OBJECTIVE** | **ACTIONS** | **PERFORMANCE TARGET/ GOAL** | **FREQUENCY** | **RESPONSIBLE POSITION** | **DUE DATE** | **DATE APPROVED** | **STATUS UPDATES/ RESULTS** |
| | | | | 9. Monitor status/completion of improvement plans | 100% of improvement actions are implemented as applicable | Quarterly | Quality Manager, HEDIS/NCQA Director | | | |
| Improving MCAS performance with Immunizations for Adolescents - Combo 2 | | Quality of Care | Close racial and ethnic disparities in immunizations by 50% | 1. Collect and analyze member, provider and data current performance and perform a barrier analysis of childhood vaccination processes. Analyze data by antigen to identify patterns of non-compliance. Analyze | Close rate of immunizations for adolescents for all racial and ethnic groups below the MPL by a minimum of 50% | Quarterly | Quality Manager, HEDIS/NCQA Director | 8/14/25 (annual), 10/30/25, 2/2026, 5/2026 | | |
| | | | | 2. Collaborate with applicable stakeholders to obtain member and provider performance data related to vaccination services. | | | | | | |
| | | | | 3. Collect member IMA-2 results by antigen and member characteristics including but not limited to race and ethnicity | | | | | | |
| | | | | 4. Convene a team of QI, HE, PHM and MD leaders to conduct quantitative and qualitative analysis of vaccination rate performance and subpopulation stratifications. | | | | | | |
| | | | | 5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action. | | | | | | |
| | | | | 6. Develop and implement improvement plans as applicable that address causes/barriers to performance | | | | | | |
| | | | | 7. Collaborate with physician(s)/other practitioners, QI, Network Ops, and BI to document all analysis and improvement plans on the DHCS QI/HE Report Template present to QIHEOC. | | | | | | |
| | | | | 8. Measure and document effectiveness of improvement actions to determine if interventions improved performance | | Quarterly | Quality Manager, HEDIS/NCQA Director | | | |
| | | | | 9. Monitor status/completion of improvement plans | 100% of improvement actions are implemented as applicable | Quarterly | Quality Manager, HEDIS/NCQA Director | | | |
| Improving MCAS performance with well-child visits for W30-2 and W30-6 | | Quality of Care | Close racial and ethnic disparities in well-child visits by 50% | 1. Collect and analyze member, provider and data current performance and perform a barrier analysis of child well-visit processes. Analyze data by subpopulation to identify health disparities. | Close rate of well visit attendance for all racial and ethnic groups below the MPL by a minimum of 50% | Quarterly | Quality Manager, HEDIS/NCQA Director | 8/14/25 (annual), 10/30/25, 2/2026, 5/2026 | | |
| | | | | 2. Collaborate with applicable stakeholders to obtain member and provider performance data related to well visit attendance. | | | | | | |
| | | | | 3. Collect member W30 results by member characteristics including but not limited to race and ethnicity | | | | | | |
| | | | | 4. Convene a team of QI, HE, PHM and MD leaders to conduct quantitative and qualitative analysis of well visit rate performance and subpopulation stratifications. | | | | | | |
| | | | | 5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action. | | | | | | |
| | | | | 6. Develop and implement improvement plans as applicable that address causes/barriers to performance | | | | | | |
| | | | | 7. Collaborate with physician(s)/other practitioners, QI, Network Ops, and BI to document all analysis and improvement plans on the DHCS QI/HE Report Template present to QIHEOC. | | | | | | |
| | | | | 8. Measure and document effectiveness of improvement actions to determine if interventions improved performance | | | Quality Manager, HEDIS/NCQA Director | | | |

# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY (* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 9. Monitor status/completion of improvement plans | 100% of improvement actions are implemented as applicable | | Quality Manager, HEDIS/NCQA Director | | | |
| Improving MCAS performance with adolescent depression screening | | Quality of Care | Close racial and ethnic disparities in adolescent depression screenings by 50% | 1. Collect and analyze member, provider and data current performance and perform a barrier analysis of adolescent depression screening processes. Analyze data by subpopulation to identify health disparities. | Close rate of depression screening and follow up for all racial and ethnic groups below the MPL by a minimum of 50% | Quarterly | Quality Manager, HEDIS/NCQA Director | 8/14/25 (annual), 10/30/25, 2/2026, 5/2026 | | |
| | | | | 2. Collaborate with applicable stakeholders to obtain member and provider performance data related to well visit attendance. | | | | | | |
| | | | | 3. Collect member depression screening and follow up results by member characteristics including but not limited to race and ethnicity | | | | | | |
| | | | | 4. Convene a team of QI, HE, PHM and MD leaders to conduct quantitative and qualitative analysis of depression screening and follow up performance and subpopulation stratifications. | | | | | | |
| | | | | 5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action. | | | | | | |
| | | | | 6. Develop and implement improvement plans as applicable that address causes/barriers to performance | | | | | | |
| | | | | 7. Collaborate with physician(s)/other practitioners, QI, Network Ops, and BI to document all analysis and improvement plans on the DHCS QI/HE Report Template present to QIHEQC. | | | | | | |
| | | | | 8. Measure and document effectiveness of improvement actions to determine if interventions improved performance | | | Quality Manager, HEDIS/NCQA Director | | | |
| | | | | 9. Monitor status/completion of improvement plans | 100% of improvement actions are implemented as applicable | Quarterly | Quality Manager, HEDIS/NCQA Director | | | |
| **CHILDHOOD WELL VISITS- DHCS/IHI Collaborative** | | | | | | | | | | |
| Equity Collaborative- Childhood Well Visits - Facilitated by the Institute for Health Improvement | NA | Quality of Care | To improve the rate of well visits at Golden Valley Health Centers | 1. Collect data and stratify data for childhood well visits. | Meet with clinic to unconver ongoing inequities and determine areas for intervention | One time | Accreditation Manager | TBD | | Timelines are dictated by IHI. Convening in late September 2025 |
| | | | | 2. Collect data and analyze barriers to continuity to care | Analyze scheduling systems, information sharing processes, gaps in communication, liaison roles, etc. to better understand where there are gaps in access and continuity | One time | Accreditation Manager | TBD | | |
| | | | | 3. Collect strategies for communicating with families to support access and incorporate into workflow design and feedback loops | Engage patients and families as partners in designing improvements | One time | Accreditation Manager | TBD | | |
| | | | | 4. Established shared data submission plan that supports timely feedback and learning across participating sites. | Identify data sources and reporting capabilities with participating clinics related to child well visit access and continuity of care and frequency, format, stratification categories, and level of | One time | Accreditation Manager | TBD | | |
| | | | | 5.Adapt successful interventions and communication approaches to meet unique needs of diverse settings | Develop strategies to engage and onboard additional clinics and community partners in scaling improvement efforts | One time | Accreditation Manager | TBD | | |
| | | | | 6. Monitor and report status of improvement plan. | 100% of improvement plans are implemented as applicable. | Annually | Accreditation Manager | TBD | | |
| **HEALTH EQUITY ACCREDITATION** | | | | | | | | | | |

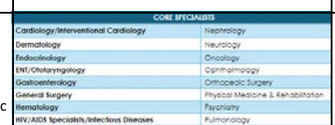
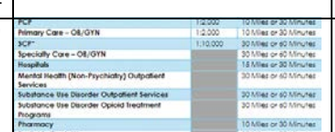
# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY (* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|
| Health Equity Accreditation | | Administrative | Maintain Health Equity Accreditation | Implement data storage elements submitted as implementation plans in initial survey. | Update QNXT to include all SOGI response option requirements | One time | Accreditation Manager | 12/31/2025 | | |
| | | | | Implement data collection elements submitted as implementation plans in initial survey. | Implement member portal REaL and SOGI questions | One time | Health Equity Director / Accreditation | 12/31/2025 | | |
| | | | | Conduct annual reports, quantitative anlaysis, qualitative analysis and presentation to the appropriate stakeholders | | Annually | Accreditation Manager / Health Equity Director | 4/30/2026 | | |
| | | | | Implement actions to improve identified opportunities | | Annually | | 4/30/2026 | | |
| | | | | Identify, Implement and Evaluate interventions to improve health care outcomes and language services. | | Annually | | 4/30/2026 | | |
| **REPRODUCTIVE CARE** | | | | | | | | | | |
| Improving MCAS performance with reproductive health measures until all subpopulations reach Medicaid 50th percentile.* | | Quality of Care | Close maternity care disparity for Black and Native American persons by 50% | 1. Collect and analyze member, provider and data | Close rate of prenatal and postpartum care for all racial and ethnic groups below the MPL by a minimum of 50% | Quarterly | Quality Manager, HEDIS/NCQA Director | 8/14/25 (annual), 10/30/25, 2/2026, 5/2026 | | |
| | | | | 2. Collaborate with applicable stakeholders to obtain | | | | | | |
| | | | | 3. Collect rate reports and member characteristics | | | | | | |
| | | | | 4. Convene a team of QI, HE, PHM and MD leaders to | | | | | | |
| | | | | 5. Outline and prioritize opportunities for improvement, | | | | | | |
| | | | | 6. Develop and implement improvement plans as | | | | | | |
| | | | | 7. Collaborate with physician(s)/other practitioners, QI, | | | | | | |
| | | | | 8. Measure and document effectiveness of | | Annual | Quality Manager, | 08/14/25 | | |
| | | | | 9. Monitor status/completion of improvement plans | 100% of improvement actions are implemented | Annual | Quality Manager, | 08/14/25 | | |
| Improving MCAS performance for maternal depression screening | | Quality of Care | Close maternal depression screening disparity by one and a half times baseline rate (M24) | 1. Collect and analyze member, provider and data current performance and perform a barrier analysis of reproductive health processes. Analyze data to identify patterns of non-compliance. Analyze data by subpopulation to identify health disparities. | Close rate of maternal depression screening for all racial and ethnic groups below the MPL by a minimum of 50% | Quarterly | Quality Manager, HEDIS/NCQA Director | 8/14/25 (annual), 10/30/25, 2/2026, 5/2026 | | |
| | | | | 2. Collaborate with applicable stakeholders to obtain member and provider performance data related to reproductive mental health services. | | | | | | |
| | | | | 3. Collect rate reports and member characteristics including but not limited to member race and ethnicity | | | | | | |
| | | | | 4. Convene a team of QI, HE, PHM and MD leaders to conduct quantitative and qualitative analysis of vaccination rate performance and subpopulation stratifications. | | | | | | |
| | | | | 5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action. | | | | | | |
| | | | | 6. Develop and implement improvement plans as applicable that address causes/barriers to performance | | | | | | |
| | | | | 7. Collaborate with physician(s)/other practitioners, QI, Network Ops, and BI to document all analysis and improvement plans on the DHCS QI/HE Report Template present to QIHEOC. | | | | | | |
| | | | | 8. Measure and document effectiveness of improvement actions to determine if interventions improved performance | | Annual | Quality Manager, HEDIS/NCQA Director | 08/14/25 | | |
| | | | | 9. Monitor status/completion of improvement plans | 100% of improvement actions are implemented as applicable | Annual | Quality Manager, HEDIS/NCQA Director | 08/14/25 | | |
| **EQUITY AND PRACTICE TRANSFORMATION** | | | | | | | | | | |

# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY<br><br>(* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|
| DMHC Health Equity Quality Metrics | | Quality of Care | IMp | 1. Collect and analyze member, provider and data current performance and perform a barrier analysis of follow up processes. Analyze data by subpopulation to identify health disparities. | Analysis of provider, member and process data with development and implementation of improvement plans as applicable. | Quarterly | Director of Special Projects, Quality, Quality Manager | 8/14/25 (annual), 10/30/25, 2/2026, 5/2026 | | EPT practices are engaged with MCAS improvements and on track for EPT milestone achievement. |
| | | | | 2. Collaborate with applicable stakeholders to obtain member and provider performance data related to follow-up processes. | | | | | | |
| | | | | 3. Collect FUA/FUM rates and member characteristics: | | | | | | |
| | | | | 4. Convene a team of QI, HE, PHM and MD leaders to conduct quantitative and qualitative analysis of vaccination rate performance and subpopulation stratifications. | | | | | | |
| | | | | 5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action. | | | | | | |
| | | | | 6. Develop and implement improvement plans as applicable that address causes/barriers to performance | | | | | | |
| | | | | 7. Collaborate with physician(s)/other practitioners, QI, Network Ops, and BI to document all analysis and improvement plans on the DHCS QI/HE Report Template present to QIHEOC. | | | | | | |
| | | | | 8. Measure and document effectiveness of improvement actions to determine if interventions improved performance | | Quarterly | Director of Special Projects, Quality, Quality Manager | | | |
| | | | | 9. Monitor status/completion of improvement plans | 100% of improvement actions are implemented as applicable | Quarterly | Director of Special Projects, Quality, Quality Manager | | | |
| **DMHC Health Equity Metrics** | | | | | | | | | | |
| Improve the DMHC required measure set metrics to improve quality of care and reduce health disparities. | | Quality of Care | Improve DMHC HEQMS metrics whereby all subpopulation performance reaches Medicaid 50th percentile. | 1. Collect and analyze subpopulation current performance and perform a barrier analysis of follow up processes. Analyze data by subpopulation to identify health disparities. | Analysis of provider, member and process data with development and implementation of improvement plans as applicable. | Quarterly | HEDIS & Accreditation Director, Equity Director, Quality Managers, Health Education Manager | 8/14/25 (annual), 10/30/25, 2/2026, 5/2026 | | DMHC Corrective action in process. |
| | | | | 2. Collaborate with applicable stakeholders to obtain member and provider performance data related to follow-up processes. | | | | | | |
| | | | | 3. Collect rates and member characteristics: | | | | | | |
| | | | | 4. Convene a team of QI, HE, PHM and MD leaders to conduct quantitative and qualitative analysis of vaccination rate performance and subpopulation stratifications. | | | | | | |
| | | | | 5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action. | | | | | | |
| | | | | 6. Develop and implement improvement plans as applicable that address causes/barriers to performance | | | | | | |
| | | | | 7. Collaborate with stakeholders to remediate DMHC Corrective Actions- Report Template to QIHEOC. | | | | | | |
| | | | | 8. Measure and document effectiveness of improvement actions to determine if interventions improved performance | | Quarterly | Director of Special Projects, Quality, Quality Manager | | | |
| | | | | 9. Monitor status/completion of improvement plans | 100% of improvement actions are implemented as applicable | Quarterly | Director of Special Projects, Quality, Quality Manager | | | |

# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY (* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|
| **NETWORK MANAGEMENT** | | | | | | | | | | |
| Member to Provider Ratio | NET 1B, C | Administrative | Ensure member:provider ratios are in compliance with regulatory standards | 1. Collect data to evaluate member:provider ratios<br><br>2. Conduct quantitative and qualitative analysis of results, outline opportunities and improvement actions (as applicable), and measure effectiveness of interventions. | • Primary Care Practitioners 1:2,000<br>• Specialty Provider 1:10,000 | Semiannually | Director, Provider Services | 10/31/25, 4/30/26 | | |
| High Volume and High Impact Specialties | NET 1C | Administrative | Identify high volume and high impact practitioners and ensure member access to practitioners | 1. Identify Identify high volume specialty practitioner types based on claims volumes. Identify high impact providers by evaluating practitioners that have high probability of high morbiditiy and mortality. At a minimum oncology, neurology and HIV-AIDS, orthopedic surgery.<br><br>2. Collect data to evaluate performance against standards<br><br>3. Conduct quantitative and qualitative analysis of results, outline opportunities and improvement actions (as applicable), and measure effectiveness of interventions. |  | Annually | Director, Provider Services | 04/30/26 | | |
| Prescribing and Non Prescribing BH Practitioners | NET 1C | Administrative | Define all types of behavioral healthcare practitioners – not only high-volume practitioners – in the delivery system across the continuum of care and ensure member access to practitioners | 1. Define and outline all types of prescribing and nonprescribing BH practitioners in the HPSH network and the member:practitioner ratio for each type of practitioner (see NCQA's example) separated by prescribing and nonprescribing practitioners.<br><br>2. Collect separate data for prescribing and nonprescribing BH practitioners to evaluate performance against standards.<br><br>3. Conduct quantitative and qualitative analysis of results by prescribing and nonprescribing practitioners, outline opportunities and improvement actions (as applicable), and measure effectiveness of interventions. | | Annually | Director of Provider Services | 09/01/25<br><br>04/30/26<br><br>04/30/26 | | |
| Geographic access | NET 1B, C, D | Administrative | Ensure practitioner access requirements are met for the entire membership | 1. Identify the time and distance standards for travel to access Primary, HV and HI specialists, Prescribing and Nonprescribing practitioners (separate standards for prescribing and nonprescribing)<br><br>2. Collect data for all Primary, HV and HI specialists, Prescribing and Nonprescribing practitioner types (collect separate data for BH prescribing and nonprescribing practitioners). |  | Annually | Director, Provider Services | 09/01/25<br><br>04/30/26 | | |

# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY (* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 3. Conduct quantitative and qualitative analysis of all Primary, HV and HI specialists, Prescribing and Nonprescribing practitioner type results (separate results and analysis for BH prescribing and nonprescribing), outline opportunities and improvement actions (as applicable), and measure effectiveness of interventions. | | | | 04/30/26 | | |
| Practitioner Appointment Availability | NET 2A, B, C | Administrative | Ensure appointment availability for all PCP, HV and HI Specialists, and BH Prescribing and Nonprescring Practitioner types for all applicable appointment types. | 1. Collect data for all Primary, HV and HI specialists, BH Prescribing and Nonprescribing practitioner types (collect separate data for BH practitioner types).<br><br>2. Conduct quantitative and qualitative analysis of all Primary, HV and HI specialists, Prescribing and Nonprescribing practitioner type results (separate results and analysis for BH practitioner types), outline opportunities and improvement actions (as applicable), and measure effectiveness of interventions. | **Primary Care:**<br>**Urgent Car**e: 96 Hours<br>**Routine Care:** 10 business days<br>**After Hours Care:**<br><br>**HV and HI Specialty Care**:<br>**Urgen**t: 96 hours<br>**Routine Care**: 15 business Days<br><br>**Non-Physician BH:**<br>**Urgent Care:** 96 Hours**,**<br>**Routine:** 10 business days.<br><br>**BH (Prescribing and NonPrescribing)**<br>**Non-life-threatening emergency:** w/in 6 hours.<br>**Urgent care:** w/in 48 hours.<br>**Initial visit for routine care:** w/in 10 business days.<br>4. Follow-up routine care.<br>5. After-hours care. | Annually, quarterly if non-compliant | Director, Provider Services | 05/01/26 | | |
| Physician Directory Accuracy | NET 5CD | Quality of Service | Ensure accuracy of information in the directory to promote member access to care. | 1. Collect data for each of the four factors<br><br>2. Conduct quantitative and qualitative analysis of results and outline in a report<br><br>3. Identify opportunities for improvement and, if any, implement improvement actions that are designed to address the root causes (qualitative analysis) | Accuracy of 85% or greater in each of the following areas:<br>1. Provider address/phone number<br>2. Hospital Affiliations<br>3. Accepting New Patients<br>4. Awareness of physician office staff of physician's participation in the organization's networks. | Annually and more frequently as needed | Director, Provider Services | 05/30/26 | | |
| PS Policies and Procedures | NA | Quality of Service | Ensure that provider services and network policies and procedures are reviewed and updated annually as applicable | 1. Review and update PS/NET policies and procedures as needed to ensure compliance with accreditation, regulatory and business needs | 100% of QI policies and procedures reviewed and updated annually, as applicable | Annually and more frequently as needed | Policy business owners | 06/30/26 | | |
| **PROVIDER SATISFACTION** | | | | | | | | | | |
| Provider Satisfaction | NA | Administrative | Assess and improve provider experience with health plan provider services. Improve and maintain providerexperience with health plan systems and processes. | 1. Collect and analyze provider satisfaction data to identify provider satisfaction opportunities.<br><br>2. Collect and analyze survey results agains book of business and trending over time. Identify key drivers of satisfaction. | **Achieve top 25% provider satisfaction acheivement and Improve Provider Satisfaction Composites until achievement is maintained in the top 25% for all composites:**<br>• Overall Satisfaction<br>• Other Plan Compare • Finance Issues •UM and Quality • Customer Service Staff • Provider | Annually | Director, Provider Services | 03/01/26 | | |

# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY (* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 3. Develop and implement improvement plan internally for results that are below the performance goal. Report to QIHEOC | Relations | | | | | |
| Provider and Practitioner Supports | PHM 3A | Administrative | Provide supports to providers and/or practitioners to include at minimum three of the following:<br>-Sharing data<br>-Offering evidence-based or certified decision-making aids<br>-Providing practice transformation support to primary care practitioners<br>-Providing comparative quality information on selected specialties<br>-Providing comparative pricing information on selected services<br>-Providing training on equity, cultural competency, bias, diversity, or inclusion. | 1. Hold Provider Partnership meetings to share provider HEDIS data | | Ongoing | Manager, Quality Improvement | 03/31/26 | | |
| | | | | 2. Provide financial and consultant support to providers to adopt practice transformations through the Equity Practice Transformation program | | Ongoing | Director, Special Projects | 03/31/27 | | |
| | | | | 3. Provide training to practitioners and providers on cultural competency upon joining the network, annually, and upon demand through the Health Plan website ***(Scored NA by NCQA through 6/30/26)*** | | Ongoing | Director, Provider Services | 03/31/27 | | |
| **PROVIDER PARTNERSHIP/Clinical Quality MCAS** | | | | | | | | | | |
| MCAS/HEQMS Rate Improvement with Provider Partners | | Quality of Care | Assess and improve HEDIS/MCAS/HEQMS measures through analysis of Quality Metric Reporting | 1. Collect health plan MCAS data by provider for the following metric domains;<br>• Children's Health<br>• Cancer Prevention • Reproductive Health<br>• Behavioral Health<br>• Chronic Conditions<br>• Long Term Care | Analysis HEDIS/MCAS/HEQMS data with development and implementation of improvement plans as applicable to achieve NCQA Quality Compass Medicaid Managed Care 50th percentile. | Quarterly | Quality Manager, HEDIS Manager | 9/17/25, 11/19/25, 1/21/26 3/18/26, 5/20/26 (annual) | 9/18/2025 | |
| | | | | 2. Collaborate with providers to share and compare quality metric rate data for all categories listed above. | | | | | | |
| | | | | 3. Convene a team of PR, QI, NCQA leaders to conduct quantitative and qualitative analysis of HEDIS data | | | | | | |
| | | | | 4. Correlate barriers to rate data | | | | | | |
| | | | | 5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement actions. | | | | | | |
| | | | | 6. Develop and implement improvement plan as applicable that addresses causes/barriers to performance | | | | | | |
| | | | | 7. Collaborate with PR, Network Ops, and QI to document all analysis and improvement plans in partnership meetings, present to QIHEOC. | | | | | | |

# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY (* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 8. Monitor status/completion of improvement plans | 100% of improvement actions are implemented as applicable. | Quarterly | | 9/17/25, 11/19/25, 1/21/26 3/18/26, | | |
| Provider Resources | | Quality of Service | Provide resources to provider partners that assist with care and service to members and facilitate more accurate MCAS reporting. | Facilitate access to provider enablement software. Offer best practice supports from high performing providers. | Implement data sharing with at least 10 provider partners. | Quarterly, Annually | HEDIS Manager | 09/18/24 | N/A | |
| Funding opportunities | | Quality of Service | Facilitate provider partner collaboration with incentive and promotional activities designed to improve MCAS rates. | Inform provider partners about grant projects, data exchange opportunities and screening tools and and referral resources. | Offer provider partners all eligible funding opportunities. | Quarterly | Director of Special Projects, Quality | 9/17/25, 11/19/25, 1/21/26 3/18/26, | | |
| Provider Education | | Quality of Service | Ensure that regulatory and accreditation, and equity and health education resources are communicated to practitioners within 60 days of publication. | 1. Create provider friendly educational materials related to regulatory and accreditation resources. | 100% of provider partnership providers receive information. | Annually | Health Education Manager, HEDIS Manager | 06/30/26 | N/A | |
| **PROVIDER ALERTS** | | | | | | | | | | |
| Provider Alerts for high priority MCAS metrics | | Administrative | Ensure updates to MCAS measures are shared through provider alerts | 1. Review HEDIS Specification changes | Distribute provider alerts annually. Initial Health Assessment<br>Controlling High Blood Pressure<br>Follow-Up after ED Visit for Mental Illness<br>Follow-Up after ED Visit for Substance Use<br>Follow-Up After High-Intensity Care for Substance Use Disorder<br>Follow-Up After Hospitalization for Mental Illness<br>Diabetes Screening for People w/ Schizophrenia<br>Bipolar Disorder Using Antipsychotic Medications<br>Adherence to Antipsychotic Medications for Individuals With Schizophrenia<br>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics<br>Initiation and Engagement of Substance Use Disorder Treatment - Engagement of SUD Treatment<br>Colorectal Cancer Screening<br>Breast Cancer Screening | Annually | HEDIS Manager | 12/31/25 | | |
| | | | | 2. Validate provider contact information. | | Annually | HEDIS Manager | 12/31/25 | | |
| | | | | 3. Create alert schedule | | Annually | HEDIS Manager | 12/31/25 | | |
| | | | | 4. Distribute alerts on schedule. | | Annually | Provider Services Director | 06/30/26 | | |

# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY (* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Breast Cancer Screening<br>Cervical Cancer Screening<br>Childhood Immunizations Status - combonation 10<br>Immunizations in Adolescents Combonation 2<br>Well Child exams for babies 0-30 months of age (0-15 6+ visits & 15-30 2+ visits)<br>Child and Adolescent Well-Care Visits<br>Well Child Exams - BMI Percentile (article merged with WCV)<br>Developmental Screening in the first three years of life<br>Lead Screening in Children<br>Topical Fluoride for Children<br>HbA1c Control and Poor Control for people with Diabetes<br>Eye Exams for people with Diabetes<br>Kidney Health Evaluation for Patients with diabetes<br>Controlling Blood pressure for people with diabetes<br>Statin Therapy for Patients with Diabetes<br>Metabolic Monitoring for Children and Adolescents on Antipsychotics<br>Social Determinants of Health Collection | | | | | |
| **ENHANCING NETWORK RESPONSIVENESS** | | | | | | | | | | |
| Ensure the practitioner network is able to meet the cultural and lingistic needs of the membership. | HE 4B | Administrative | Assess practitioner network's ability to meet language and cultural needs of the membership and take actions to address any identified gaps. | 1. Develop practitioner-focused survey questions to assess practitioner network cultural responsiveness baseline | At least one action will be taken to address identified gaps in network responsiveness by 6/30/2024. | Annually | Accreditation Manager<br>C&L Manager | 12/01/25 | | |
| | | | | 2. Gather network language capacity data, including languages spoken by practitioners, presence of bilingual staff in practitioners' offices, and whether practitioners have worked with an interpreter | | Annually | Accreditation Manager<br>Provider Network Program Manager<br>C&L Manager | 02/15/26 | | |
| | | | | 3. Field surveys to network practitioners and gather responses. | | Annually | Accreditation Manager<br>Provider Network Program Manager | 02/28/26 | | |
| | | | | 4. Consolidate practitioner demographics, findings from network language capacity data and practitioner network cultural responsiveness survey results into quantitative analysis. | | Annually | Accreditation Manager | 03/31/26 | | |
| | | | | 5. Conduct qualitative analysis to understand causal factors for results and assessment of identified needs. | | Annually | Accreditation Manager<br>Provider Network Program Manager<br>C&L Manager | 03/31/26 | | |

| HEALTH PLAN<br>FY2025-2026 QUALITY WORK PLAN | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **ACTIVITY**<br><br>(* denotes monitoring of previously identified issue) | **NCQA STANDARD** | **CATEGORY** | **OBJECTIVE** | **ACTIONS** | **PERFORMANCE TARGET/ GOAL** | **FREQUENCY** | **RESPONSIBLE POSITION** | **DUE DATE** | **DATE APPROVED** | **STATUS UPDATES/ RESULTS** |
| | | | | 6. Develop plan to address gaps. | | Annually | Accreditation Manager<br>C&L Manager | 03/31/26 | | |
| | | | | 7. Take action to address gaps. | | Annually | Accreditation Manager<br>Provider Network Program Manager<br>C&L Manager | 04/30/26 | | |

# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY (* denotes monitoring of previously identified issue) | DHCS REQUIREMENT | CATEGORY | OBJECTIVE | ACTIONS | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | APPROVAL AUTHORITY | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **LONG-TERM CARE QUALITY** | | | | | | | | | | | |
| Claims Data Collection for SNF residents | APL24-009 | Quality of Care | Identify opportunities to improve quality of care for members receiving care at SNF facilities | 1. Collect the following claims data **by SNF facility and SNF patients** annually:<br>• Emergency room visits (rates and diagnoses)<br>• HAIs requiring hospitalization (rates and diagnoses)<br>• Potentially preventable readmissions (rates and diagnoses)<br>Quarterly:<br>*Identify trends in grievances and ensure quality of care issues are investigated. Monitor CDPH findings and incorporate into payment methodologies. | ER Visits will be monitored for outlier facilities. HAIs monitored for outlier facilities. PPRs monitored for outlier facilities. | Quarterly and Annually | Kathleen Dalziel | 2/13/26, 5/8/26, 10/30/25 (annual) | | | |
| | | | | 2. Incorporate DHCS supplied quarterly WQIP data as part of claims analysis | | | | | | | |
| | | | | 3. Convene a team of QI, UM, and PHM leaders and SMEs to conduct qualitative analysis of of claims and WQIP data | | | | | | | |
| | | | | 4. Develop and implement improvement plan as applicable that addresses causes/barriers to performance | | | | | | | |
| | | | | 5. Monitor effectiveness of improvement plans quarterly | | | | | | | |
| MCAS LTC Measures | APL24-009 | Quality of Care | Comply with DHCS MCAS reporting requirements for LTC measures | 1. Report the following MCAS LTC measure results **for each SNF facility** to DHCS annually:<br>• Number of Out-patient ED Visits per 1,000 Long Stay Resident Days<br>• Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization<br>• Potentially Preventable 30-day Post-Discharge Readmission | Meaure results are reported to DHCS by 6/30 of each year. | Annually | Kathleen Dalziel | 06/30/26 | | | |
| | | | | | | | | | | | |
| DHCS QAPI Program Reports | APL24-009<br>APL 19-017<br>APL 23-012 | | | 1. Prepare QAPI program reports with outcome and trending data as specified by DHCS. | Meaure results are reported to DHCS by 6/30 of each year. | Annually | Kathleen Dalziel | 10/30/25 | | | |
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# HEALTH PLAN
# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY (* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | GOAL | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **CMS STARS-Part C** | | | | | | | | | | | |
| Improve CMS Star Measure Performance to achieve 3 star ratings | | All categories | Obtain 3 star acheivement on all Part C measures | Outline measures in 5 domains of care: 1. Staying Healthy, tests, screenings and vaccines. 2. Managing Chronic Conditions, 3. Member Experience with the Plan, 4. member Complaints and changes in Plan Performance, 5. Health Plan Customer Service. | Ensure all Star metrics reach 3 star achievement. | Analysis of barriers and rate stratification data with development and implementation of improvement plans as applicable | Quarterly | HEDIS/NCQA Director, Director of Special Projects, Quality, Business Intelligence | 3/2026, 5/2026, 6/2026 | | New Metric Monitoring. In development, will be presented in early 2026. |
| | | | | 2. Create monitoring dashboards to monitor monthly performance. . | | | | | | | |
| | | | | 3. Convene a team of PR, QI and MD leaders to conduct quantitative and qualitative analysis of Part C measures. | | | | | | | |
| | | | | 4. Correlate rate results into the overall analysis of health plan performance | | | | | | | |
| | | | | 5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement actions. | | | | | | | |
| | | | | 6. Develop and implement improvement plan as applicable that addresses causes/barriers to performance | | | | | | | |
| | | | | 7. Collaborate with Provider Relations, Network Ops, Member Services, and QI to document all analysis and improvement plans on the Stars improvement channel and present to QIHEOC. | | | | | | | |
| | | | | 8. Monitor status/completion of improvement plans | | 100% of improvement actions are implemented as applicable | Annually | | 10/30/25 | | |
| **CMS STARS-Part D** | | | | | | | | | | | |
| Improve CMS Star Measure Performance to achieve 3 star ratings | | | Obtain 3 star acheivement on all Part D measures | Outline measures in 4 domains of care: 1. Health Plan Customer Service, 2. member Complaints and Changes in Health Plan Performance, 3. Member Experience and Drug Plan, 4. Drug Safety and Accuracy of Pricing. | Ensure all Star metrics reach 3 star achievement. | Analysis of barriers and rate stratification data with development and implementation of improvement plans as applicable | Quarterly | Pharmacy Director, HEDIS/NCQA Director | 3/2026, 5/2026, 6/2026 | | New metric monitoirng. In development, will be presented in early 2026. |
| | | | | 2. Collaborate with applicable stakeholders to obtain performance data related to Part D care and services. | | | | | | | |
| | | | | 3. Collect Part D measure performance. | | | | | | | |
| | | | | 4. Convene a team of QI, Case Management, PHM, HEDIS, Pharmacy, Customer Service and MD leaders to conduct quantitative and qualitative analysis of Part D rate performance. | | | | | | | |
| | | | | 5. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as the reasons for taking or not taking action. | | | | | | | |

| HEALTH PLAN<br>FY2025-2026 QUALITY WORK PLAN | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **ACTIVITY**<br>(* denotes monitoring of previously identified issue) | **NCQA STANDARD** | **CATEGORY** | **OBJECTIVE** | **ACTIONS** | **GOAL** | **PERFORMANCE TARGET/ GOAL** | **FREQUENCY** | **RESPONSIBLE POSITION** | **DUE DATE** | **DATE APPROVED** | **STATUS UPDATES/ RESULTS** |
| | | | | 6. Develop and implement improvement plans as applicable that address causes/barriers to performance | | | | | | | |
| | | | | 7. Collaborate with physician(s)/other practitioners, QI, Network Ops, Vendors, Pharmacy, and BI to document all analysis and improvement plans , then present to QIHEOC. | | | | | | | |
| | | | | 8. Measure and document effectiveness of improvement actions to determine if interventions improved performance | | | Quarterly | Quality Manager, HEDIS/NCQA Director | | | |
| | | | | 9. Monitor status/completion of improvement plans | | 100% of improvement actions are implemented as applicable | Quarterly | Quality Manager, HEDIS/NCQA Director | | | |
| **MODEL OF CARE MONITORING** | | | | | | | | | | | |
| Achieve goal for DSNP access related measures | | Administrative | Assess and improve member access to care. | 1. Collect specific access to care metric performance; A. Ambulatory Care or preventive care visit during the year/HEDIS metric. B. Follow-up visit after Hospital Stay for Mental Illness (within 30 days of Discharge)/ HEDIS® C Initiation of SUD Treatment: Alcohol Abuse or Dependence, Opioid Abuse or Dependence | Preventive care >94.3%, FUM >48.7%, SUD Alcohol >38.8%, Opioid >33.2% | Analysis of access metrics will be presented through the QIHEOC and/or Clinical Operations. | Quarterly | Director of HEDIS & NCQA, Director Behavioral Health/Social Work | 2/1/2026 | | New Metric Monitoring. In development, will be presented in early 2026. |
| | | | | 2. Determine Health Plan performance for specified measures and identify any with performance lower than goal. | | | | | | | |
| | | | | 3. Convene a team of Health Plan leaders and stakeholders to evaluate opportunities for improvement. | | | | | | | |
| | | | | 4. Outline and prioritize opportunities for improvement, identify which opportunities will be pursued for improvement, as well as how progress will be monitored and responsible parties. | | | | | | | |
| | | | | 5. Develop and implement improvement plans as applicable that address causes/barriers to performance | | | | | | | |
| | | | | 6. Collaborate with BH physician(s)/other practitioners, PR, Network Ops, and QI to document all analysis and improvement plans and present to QIHEOC | | | | | 6/30/2026 | | |
| | | | | 7. Measure and document effectiveness of improvement actions to determine if interventions improved performance | | | Annually | | | | |

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# FY2025-2026 QUALITY WORK PLAN

| ACTIVITY (* denotes monitoring of previously identified issue) | NCQA STANDARD | CATEGORY | OBJECTIVE | ACTIONS | GOAL | PERFORMANCE TARGET/ GOAL | FREQUENCY | RESPONSIBLE POSITION | DUE DATE | DATE APPROVED | STATUS UPDATES/ RESULTS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 8. Monitor status/completion of improvement plans | | 100% of improvement actions are implemented as applicable | Quarterly | | 06/30/26 | | |
| **MODEL OF CARE MONITORING** | | | | | | | | | | | |
| Improve and maintain affordable care. | MOC | | Reduce costs of care, reduce/improve utilization rates for high risk members. Remove barriers to care. | 1. Collect metric rates for Emergency Room utilization, Hospitalization following Skilled Nursing Facility discharge, Generic Prescription drug utilization, Yearly medication reconciliation, Initial Health Risk Assessment, Annual Health Risk Assessment, Face to Face Encounters, Interdisciplinary Care Plan and Interdisciplinary Care Team, Annual Cognitive Assessment, | Er utilization HEDIS EDIS =<326.4/1000, HEDIS HFS= <12.9%, GDR=90%, Medication review =>98%, HRA= >96%, AHRA=>96%, Face to Face = >70%, ICP=>84%, ICT= >80%, Cognitive assessment= >2.4%, | Analysis of access metrics will be presented through the QIHEOC and/or Clinical Operations. | Quarterly | Director, HEDIS & NCQA, Director, Special Projects Quality | 02/01/26 | | New metric monitoring. In development, will be presented in early 2026. |
| | | | | 2. Create dashboards to minitor plan specific performance and determine reporting structure for measures that span medical management. | | | | | | | |
| | | | | 3. Outline opportunities for improvement and present to respective committees. | | | | | | | |
| | | | | 4. Collaborate with stakeholders to implement improvement. | | | | | | | |
| | | | | 5. Measure and document effectiveness of improvement actions to determine if interventions improved performance | | | | | | | |
| | | | | 6. Monitor status/completion of improvement plans | | | | | | | |
| | | | | | | | | | | | |
| Achieve 3 Star performance for HEDIS related Model of Care Metrics. | | Administrative | Improve Processes and Health Outcomes for DSNP members. | 1. Create DSNP dashboards for HEDIS MOC metric performance monitoring. | Diabetic Eye Exams= >83%, A1c Testing= >90%, Colorectal Cancer Screening=>83%, Breast Cancer Screening=> 82%, Flu Vaccine=>76%, Prescription diabetes medication adherence=> 91%, Hypertension medication adherence= >92%, Statin medication adherence=>93%, Controlling BP=> 85%, | Analysis of access metrics will be presented through the QIHEOC and/or Clinical Operations. | Quarterly | Director, HEDIS & NCQA, Director, Special Projects Quality | 02/01/26 | | New metric monitoring. In development, will be presented in early 2026. |
| | | | | 2. Create dashboards to minitor plan specific performance and determine reporting structure for measures that span medical management. | | | | | | | |
| | | | | 3. Outline opportunities for improvement and present to respective committees. | | | | | | | |
| | | | | 4. Collaborate with stakeholders to implement improvement. | | | | | | | |

| HEALTH PLAN<br>FY2025-2026 QUALITY WORK PLAN | | | | | | | | | | | |
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| **ACTIVITY**<br>(* denotes monitoring of previously identified issue) | **NCQA STANDARD** | **CATEGORY** | **OBJECTIVE** | **ACTIONS** | **GOAL** | **PERFORMANCE TARGET/ GOAL** | **FREQUENCY** | **RESPONSIBLE POSITION** | **DUE DATE** | **DATE APPROVED** | **STATUS UPDATES/ RESULTS** |
| | | | | 5. Measure and document effectiveness of improvement actions to determine if interventions improved performance. Monitor status of improvement plans. | | | | | | | |
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