HEALTH PLAN
FY2026-2027 QUALITY WORK PLAN

ACTIVITY (* denotes monitoring of previously identified issue)	PROGRAM/PROJECT AREA	GOALS & OBJECTIVES	PLANNED ACTIONS TO MEET OBJECTIVES	RESPONSIBLE POSITION	Target Dates for Completion
QUALITY IMPROVEMENT AND EQUITY PROGRAM STRUCTURE					
Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description	Quality of Care	Ensure compliance with accreditation, business and regulatory requirements.	1. Review and update QIHETP PD annually 2. Post the updated QIHETP PD on the Health Plan website annually	Director of HEDIS & NCQA Director of Health Equity	09/30/26
Quality Improvement and Health Equity Tranformation Program (QIHETP) Evaluation	Quality of Care	A comprehensive assessment of the QI and HE activities undertaken, including an evaluation of the effectiveness of QI interventions.	1. Collaborate with internal stakeholders to prepare a comprehensive evaluation of the previous FY's QIHE Program and initiatives 2. Develop a written analysis of required Quality Performance Measure results, and a plan of action to address performance deficiencies, including analyses of each Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's perfromance measure results and actions to address any deficiencies, if applicable 3. Develop an analysis of the actions taken to address any recommendations in the annual EQR technical report and Health Plan specific evaluation reports 3. Develop an analysis of the delivery of services and quality of care based on data from multiple sources, including quality performance results, Encounter Data, Grievances and Appeals, Utilization Review, and the results of member experience surveys. 4. Make the QIHETP Annual Evaluation publicly available on the Health Plan website on an annual basis	Director of HEDIS & NCQA Director of Health Equity	10/30/26
Quality Improvement and Health Equity Work Plan (QIHETP) Work Plan	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. 2. Update the QIHETP at minimum quarterly with progress toward goals. 3. Make the QIHETP publicly available on the Health Plan website on an annual basis	Director of HEDIS & NCQA Director of Health Equity	9/2026, 11/26, 3/27, 5/27
Quality Improvement and Health Equity Committee (QIHEC)	Administrative	Maintain a QIHEC designated and overseen by the Governing Board to analyze and evaluate the results of the QIHETP & CAC activities and findings, institute actions to address performance deficiencies and ensure appropriate follow-up of identified performance deficiencies	1. Convene the QIHEC at minimum quarterly 2. Make written summaries of the QIHEC activities publicly available on the website at least quarterly 3. Provide a written summary of QIHEC activities, findings, recommendations and actions after each meeting to the Governing Board	Director of HEDIS & NCQA	9/26, 11/26, 3/27, 5/27
Managed Care Liaisons	Administrative	Ensure designation, training and notification process for liaisons to support coordination, compliance, and oversight across key program areas.	1. Designate liaisons for the following areas: •Tribal liaison •Long-Term Services and Supports (LTSS) Liaison •Transportation Liaison •California Children's Services Liaison •County Child Welfare Liaison •Justice Involved Liaison •Regional Center Liaison •Dental Liaison •IHSS Liaison 2. Alert other party as soon as possible but within 5 days of any changes to liaisons.	Compliance Director	6/31/2027
Regional Collaborative Meetings	Administrative	Attend regional collaborative meetings with regional partners including, but not limited to, count Mental Health Plans (MHPs), Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), Local Government Agencies, public hospitals, and community-based organizations (CBOs).	1. Stay informed of regional collaborative meeting dates and times 2. Assign staff members to attend meetings and participate and bring back information as needed 3. Attend all regional collaborative meetings as outlined by DHCS.	Health Education Manager BH Director	06/30/27
Community Advisory Committee (CAC)	Mbr Experience	Ensure community feedback is gathered and incorporated into Quality and Health Equity program.	1. Convene the CAC bi-monthly and at minimum quarterly 2. Gather member and family feedback on quality activities, findings and follow up actions. 3. Integrate CAC feedback into QIHE program	Manager of Health Education	8/26, 10/26 12/26, 3/27, 6/27
MEMBER EXPERIENCE and QUALITY OF SERVICES					
Member Services Telephone Access*	Mbr Experience	1. Reduce average speed to answer from 13:23 to under 10:00 minutes by June 31, 2027. 2. Reduce abandonment rate from 18.00% to less than 5.00% by June 31, 2027.	1. Collect and analyze internal health plan telephone access data for average speed of answer (ASA) and abandonment rate 2. Conduct quantitative and qualitative analysis when goals at least annually, when goals are not met. 3. Take actions to improve, as needed.	Customer Service Director	9/26, 12/26, 3/27, 6/27
Medi-Cal CAHPS Survey	Mbr Experience	1. By June 30, 2027, gather, analyze, and highlight areas of opportunity utilizing member experience surveys and grievances. 2. Develop a detailed action plan related to improving at least one CAHPS measure.	1. Conduct quantitative and qualitative analysis of completed RY26 CAHPS survey 2. Present analysis and suggested actions to CAC 3. Develop detailed action plan related to improving at least one CAHPS measure 4. Track improvement using intermediate or process measures 5. Present updates and findings at QIHEC 6. Post annual results of CAHPS to the Health Plan website , including supplemental questions	Manager of Health Education	1. 11/2026 2. 1/2027 3. 3/2027 4. 11/2027 5. 11/2027 6. 9/2026
Medicare CAHPS Survey	Mbr Experience	Gather, analyze, and highlight areas of opportunity utilizing member experience surveys, if Health Plan meets membership thresholds (600) for fielding by July 1, 2026.	1. Assess D-SNP member enrollment for meeting CAHPS fielding threshold. 2. If applicable, host kick off meeting with CAHPS survey vendor. 3. Meet vendor and regulatory deadlines for fielding. 4. Collect member responses and report to applicable agencies.	HEDIS & NCQA Director	06/30/27
Medicare HOS Survey	Mbr Experience	Prepare to successfully field the Health Outcomes Survey,if Health Plan meets membership thresholds for fielding (500) by February 1, 2027.	1. Assess D-SNP member enrollment for meeting HOS fielding threshold. 2. If applicable, host kick off meeting with CAHPS survey vendor. 3. Meet vendor and regulatory deadlines for fielding. 4. Collect member responses and report to applicable agencies.	HEDIS & NCQA Director	06/30/27
Timely Access Report Survey	Mbr Experience	Meet C&L FY25-26 Timely Access for LEP Survey Benchmarks*	1 Update provider-based and internal training/informational material on interpreter and translation services and disseminate through multiple channels, such as email, provider alerts, Provider Relations, and PlanScan. 2 Establish website refinement cadence with Marketing to review and update translation errors on the website.	Director of Health Equity; Program Manager QIHE; C&L Speacialists	6/30/27
CREDENTIALING					
Credentialing and Recredentialing Decision Notification Timeliness	Member Safety	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	Credentialing Supervisor	06/30/27

Practitioner Monitoring*	Member Safety	Ensure ongoing monitoring, identification, and reporting of practitioners with issues	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): • Practitioners meeting the grievance thresholds in a rolling 12-month period • Any practitioner placed on a CAP for a grievance, adverse event/PQI, sanction, or other issue. • Sanctions - Any of the following: ° Accusations against the practitioner's license reported by the Medical Board of California ° Administrative disciplinary actions imposed by the Medical Board of California ° All Medicare and/or Medicaid sanctions ° Medical Director Discretion: Such as Medicare and Medicaid exclusions, sanctions, license issues to include limitations, sanctions, and expiration, grievances, and adverse events	Credentialing Supervisor	06/30/27
	Quality of Service	Ensure ongoing monitoring, evaluation, and reporting of all member-specific practitioner's complaint history at least semiannually	Collect, evaluate, and report on the history of all complaints for all practitioners at least every 6 months	Credentialing Supervisor	12/26 6/27
	Member Safety	Ensure at least monthly monitoring of practitioner adverse events	Collect data and report on practitioner adverse occurrences/quality of care issues identified for use in recredentialing process	Credentialing Supervisor	06/30/27
Credentialing and Recredentialing Policies and Procedures	Administrative	Ensure that Cred and Recred policies and procedures are reviewed and updated annually as applicable	Review and update Credentialing and Recredentialing policies and procedures annually and as needed to ensure compliance with accreditation, regulatory and business needs	Credentialing Supervisor	06/30/27
Credentialing Information Integrity Training	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 2. Monitor to ensure that all staff complete the training and send training logs to Accreditation Manager	Credentialing Supervisor	5/1/27
Credentialing and Recredentialing File Audits*	Member Safety	Ensure that credentialing and recredentialing files meet NCQA and DHCS requirements	1. Conduct quarterly credentialing and recredentialing file audits quarterly 2. Share individual results with credentialing team members and aggregate results with all team members and implement improvement actions, as needed.	Credentialing Supervisor	9/26, 12/26, 3/27, 6/27
Credentialing Information Integrity	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 2. Identify 5% or 50 files for audit sample 3. Audit credentialing documents (as outlined on the report template) to identify for any inappropriate documentation and updates 4. Convene a group of credentialing SMEs to conduct qualitative analysis of results for each inappropriate documentation and update found 5. List improvement actions and responsible persons for each inappropriate documentation and update 6. Prepare report and include all NCQA-required content 7. Include audit log with report as an attachment 8. Notify Chief Health Services Officer, Compliance, and NCQA for any inappropriate documentation and updates found 9. Monitor to ensure completion of all corrective actions 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	Credentialing Supervisor	9/30/26
PATIENT SAFETY					
Preventive (Practice) Guidelines	Patient Safety	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 2. Present for approval to QIHEC 3. Share with network providers	Manager of Health Education	04/01/27
Facility Site Review	Patient Safety	Ensure PCP sites operate in compliance with all applicable local, state, and federal reuglations, and that sites can maintain patient safety standards and practices.	1. Complete an initial Facility Site and Medical Record Review and the Physical Accessibility review survey for newly contracted PCPs. 2. Conduct periodic full scope reviews for PCPs. 3. Complete corrective action plans for cited deficiencies.	FSR, Master Trainer	06/30/27
Medical Record Review	Patient Safety	Ensure medical records follow legal protocols and providers have documented the provision of preventive care and coordination of primary care services.	Conduct MRR of provider office in accordance with DHCS standards	FSR, Master Trainer	06/30/27
Care of Older Adults	Patient Safety	Ensure the safety of DSNP members through the monitoring of COA measures including Fall Risk Assessment and Medication Review.	1. Collect data on the COA measures through certified HEDIS vendor 2. Provide provider facing material and education to DSNP provider network related to COA measures 3. Analyze data from first year of DSNP product line to identify opportunities for improvement for both care and data collection	Manager of HEDIS & Quality Reporting	06/30/27
Potential Quality Issues*	Patient Safety	Maintaing a PQI rate of ≤ 5 per 1,000 members	1. Accept potential quality issues from any source 2. Fully investigate by requesting and reviewing pertinent medical records, eliciting input from providers, members and facilities, review any previous issues related to the member or provider and any other information that may be pertinent to the current investigation 3. Process all PQIs within 180 days 4. Assign all resolved PQIs a severity code and conduct appropriate follow up	Manager of Quality Management	12/26, 6/27
NCQA ACCREDITATION					
NCQA Health Plan Accreditation (HPA)	Administrative	Achieve NCQA Health Plan Accreditation - Renewal by June 8, 2027.	1. Prepare policies and procedures, reports, materials and case studies in line with the accreditation standards. 2. Submit all accreditation evidence to NCQA through the IRT portal by June 8, 2027 3. Host NCQA surveyor virtual onsite and respond to all initial issues 4. Post NCQA Health Plan Accreditation status on the Health Plan website.	HEDIS& NCQA Director	1. 6/8/27 2. 6/8/27 3. 7/30/27 4. 9/30/27
POPULATION HEALTH MANAGEMENT					
Population Health Management (PHM) Strategy	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: • Keeping members healthy • Managing members with emerging risk • Patient safety or outcomes across settings • Managing multiple chronic illnesses	HEDIS/NCQA Director Accreditation Manager	10/1/26
Community Health Improvement Plans (CHIP)/Community Health Needs Assessment (CHNA) and NCQA Population Needs Assessment	Quality of Care	Stanislaus: Chronic Disease- 1. Expand and strengthen supportive food systems to improve chronic disease management. 2. Expand community based chronic disease education to improve self-management and prevention. San Joaquin: Chronic Disease- 1. Expand community based chronic disease education to improve self-management and prevention	Stanislaus Chronic Disease 1: Monitor MTM referrals for diabetic members through Roots Foods Vendor. 2. Teach Chronic Disease/Healthy Eating Active Living (HEAL) Classes to members through community partnerships/promotora groups. San Joaquin Chronic Disease 1. Teach Chronic Disease/Healthy Eating Active Living (HEAL) Classes to members in partnership with community based organizations (CBO's)	HEDIS/NCQA Director Health Education Manager QIHE Program Manager	10/18/2026

PHM Program Impact Assessment	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 2. Conduct a quantitative and qualitative analysis with relevant stakeholders 3. Identify opportunities to improve 4. Create a plan to take action on at least two opportunities for improvement.	HEDIS/NCQA Director QIHE Program Manager	8/30/2026
Initial Health Appointment	Quality of Care	Maintain compliance with APL 22-020 and improve completion of IHA for new members to 85%	1. Review and assess compliance with APL 22-020- Initial Health Appointment 2. Provider education through Provider alerts, materials and PPP's 3. Monitor and evaluate IHA completion annually	HEDIS & Quality Reporting Manager	
Chronic Care Improvement Program (CCIP)*	Quality of Care	Reduce A1c level by 10% within 1 year of intervention for at least 60% of CCIP participants for new Medicare Advantage (MA) Dual Eligible Special Needs Plan (D-SNP) members from January 1, 2026 through December 31, 2027.	1. Outreach to all eligible members 2. Provide individualized case management services to include telephonic outreach, diabetes education, promotion of screening and preventive services, monitor A1cs, facilitate needed DME in home, coordinate care with PCP and specialists and monitor for decreased ER and IP utilization through active engagement with patient and care team	Case Management Director	
Well Child Visits in the First 30 Months of Life	Quality of Care	1. Improve Well Visits in the first 15 months of life in San Joaquin County from 50.83% to 68.38% by December 31, 2027. 2. Improve Well Visits in the first 15-30 months of life in San Joaquin County from 60.91% to 77.32% by December 31, 2027. 3. Improve Well Visits in the first 15 months of life in Stanislaus County from 57.67% to 68.38% by December 31, 2027. 4. Improve Well Visits in the first 15-30 months of life in Stanislaus County from 69.17% to 77.32% by December 31, 2027. 5. Reduce geographic disparity in at least 1 target zip code in at least one W30 measure by December 31, 2027. 6. Reduce disparities for Black members' Well Visits in the first 15 months of life in San Joaquin County by increasing rate from 40.82% to 50.83% (MCP 2025 average) by December 31, 2027. 7. Reduce disparities for Black members' Well Visits in the first 15-30 months of life in San Joaquin and Stanislaus Counties by increasing rate in San Joaquin from 46.35% to 69.17% (MCP 2025 average) and in Stanislaus from 50% to 69.17% by December 31, 2027.	1. Work with Health Education to identify a potential community based organization partner that serves Stockton children ages 0-3 and/or birthing parents in ZIP Codes 95202, 95206, 95207, and/or 95210 2. Develop an intervention in partnership with identified CBO 3. Take at least one collaborative action toward improving W30 in target geography	Program Manager for Quality & Health Equity	1. 9/30/26 2. 12/31/2026 3. 6/31/2027
Timely Post Partum Care	Quality of Care	1. Increase timely postpartum care (PPC-Post) rates MCP-wide from 78.16% by 5% to 82.07% by December 31, 2027 2. Reduce disparities in the rate of timely postpartum care for White members in Stanislaus County by increasing rate from 60.56% to 78.16% (MCP 2025 average) by December 31, 2027.	1. Develop provider facing materials encouraging PCPs to conduct a postpartum visit if not completed by perinatal provider 2. Send provider facing material to network providers through means such as Provider Alert 3. Collaborate with TCS regarding new requirements for birthing members 4. Hold Summer/Fall 2026 Town Hall with birthing providers.	Program Manager for Quality & Health Equity	1. 12/31/2026 2. 2/28/2027 3. 6/30/2027 4. 11/2026; 6/2027
Timely Prenatal Care	Quality of Care	Reduce disparities in the rate of timely prenatal care for Black members in San Joaquin and Stanislaus Counties by increasing rate in San Joaquin from 80.5% to 84.03% (MCP 2025 average) and in Stanislaus from 76.36% to 84.03% by December 31, 2027.	1. Develop a partnership with at least one CBO or county agency 2. Develop at least one collaborative intervention aimed at reducing disparity for black members in timely prenatal care 3. Test at least one intervention	Program Manager for Quality & Health Equity	1. 9/30/26 2. 12/31/2026 3. 6/31/2027
Patient Engagement	Quality of Care	1. Increase the percentage of members who had at least one primary care visit in thel ast 12 months from 59.24% to 64.29%. 2. Increase the percentage of members who had at least one primary care visit with their assigned provider within a 12-month period from 25.51% to 30.51%	1. Identify clinic partner(s) to pilot an intervention to increase engagement 2. Develop a plan for improvement in collaboration with clinic partner(s) 3. Test intervention using the PDSA cycle to rapidly identify impact and make adjustments 4. Determine whether to adjust the intervention or adopt on a broader scale	QI Supervisor	1. 12/31/26 2. 3/31/27 3. 6/31/27 4. 9/31/27
Developmental Screenings	Quality of Care	1. Achieve an improvement in DEV from 24.53% to 38.00% in Stanislaus County by December 31, 2027. 2. Achieve an improvement in DEV from 14.00% to 38.00% in El Dorado County by December 31, 2027.	1. Identify high volume, low performance clinics 2. Develop workflow enhancements, EMR integration and use of HEDIS compliant tools 3. Provide technical support to providers to begin sending supplemental data for capturing compliant screenings	HEDIS & Quality Reporting Manager	6/30/27
Adolescent Immunizations	Quality of Care	Improve the adolescent immunizations (IMA-2) rate in El Dorado County from 25.53% to 39.14% by December 31, 2027.	1. Identify clinic partner(s) to pilot an intervention to increase engagement 2. Develop a plan for improvement in collaboration with clinic partner(s) 3. Test intervention using the PDSA cycle to rapidly identify impact and make adjustments 4. Determine whether to adjust the intervention or adopt on a broader scale	QI Supervisor	1. 12/31/26 2. 3/31/27 3. 6/31/27 4. 9/31/27
Uncontrolled Diabetes	Quality of Care	Reduce the rate of uncontrolled diabetes (GSD>9.0%) in San Joaquin and El Dorado Counties from 33.05% and 33.00%, respectively, to 25.41% by December 31, 2027.	1. Identify clinic partner(s) to pilot an intervention to increase engagement 2. Develop a plan for improvement in collaboration with clinic partner(s) 3. Test intervention using the PDSA cycle to rapidly identify impact and make adjustments 4. Determine whether to adjust the intervention or adopt on a broader scale	QI Supervisor	1. 12/31/26 2. 3/31/27 3. 6/31/27 4. 9/31/27
HEAL/Food Smart	Mbr Experience	85% of members completing Healthy Eating Active Living (HEAL)/ Food Smarts classes will report self improvement	1. Engage 1 Community partner in Stanislaus and San Joaquin Counties to start Leah's Pantry Curriculum. 2. Staff to complete trainings on Curriculum, 3. Start first class and determine series length (1 vs 3 vs 6 month)	Health Education Manager	1. 8/30/26, 2. 9/14/26, 3. 10/15/26
Disease Management Experience	Mbr Experience	85% of members who have completed Disease Management through Health Plan Case Management Department will report a rating of 9 or 10 out of 10 for Disease Management	1. Member satisfaction survey completed upon disenrollment from the DM program 2. Review survey results and identify areas of strengths and areas of concerns. Provide staff education and support as needed 3. If a member selects a rating of less than 8, the surveyor from the CM department will inquire what areas would they suggest could be improved upon.	Director of Case Management	6/30/27

Complex Case Management	Quality of Care	Increase the percentage of members eligible for CCM who are successfully enrolled in the CCM program	1. Staff education on Complex Case Management requirements 2. Decreased initial assessment score to identify medically complex members 3. Review potential Enhanced Care Management referrals prior to reviewing to an ECM provider to ensure medically complex cases remain in CCM with BH and SS support for SDOH needs	Director of Case Management	6/30/27
ACEs Screening	Quality of Care	Increase performance on ACE screening and follow up from Blank to Blank in San Joaquin County, Blank to Blank in Stan County, Blank to Blank in El Dorado County, and BLANK to BLANK in Alpine County by December 31, 2027.	1. Collaborate with Partner with Provider Partnership Program (PPP) and Equity in Practice Transformation (EPT) participants to improve screening and follow up/referral workflows to behavioral health and social services plus ECM and CS (BH integrated in clinics, the Health Plan's NSMHS, and County BH services) through consultation and in-services as requested. 2. Create and distribute new ACEs materials for members and provider offices to support conversations, increase bh awareness and address stigma, and encourage member engagement in care. 3. Reconcile PPP providers conducting ACEs screenings with each provider group's roster and work with groups to increase provider completion of required training and attestation. Focus practice transformation efforts on the highest volume PPP providers.	Director of BH and SS Program Manager for BH	6/30/2027
Depression Screening	Quality of Care	Achieve an improvement in DSF-E (Screening) from Blank to Blank in San Joaquin County, Blank to Blank in Stan County, and Blank to Blank in El Dorado County by December 31, 2027.	1. Partner with Provider Partnership Program (PPP) and Equity in Practice Transformation (EPT) participants to improve screening and follow up/referral workflows to behavioral health services (BH integrated in clinics, the Health Plan's NSMHS, and County BH services) through consultation and in-services as requested. 2. Create and distribute new DSF-E materials for members and provider offices to support conversations, increase BH awareness and address stigma, and encourage member engagement in care.	Director of BH and SS Program Manager for BH	6/30/2027
Follow Up after ER Visits for Substance Use	Quality of Care	Achieve an improvement in FUA (30 Day) from Blank to Blank in San Joaquin County, Blank to Blank in Stan County, and Blank to Blank in El Dorado County by December 31, 2027.	1. Partner with Provider Partnership Program (PPP) and Equity in Practice Transformation (EPT) participants to improve screening and follow up/referral workflows to behavioral health services (BH integrated in clinics, the Health Plan's NSMHS, and County BH services) through consultation and in-services as requested. 2. Create and distribute new FUA materials for members at EDs and hospitals to support conversations, increase bh awareness and address stigma, and encourage member engagement in care. 3. Utilize the ADT report with both the internal BH Case Management team and external PPP participants (14 total) to support report monitoring, outreach, and follow up interventions to meet the required 7 day and 30 day follow up timelines.	Director of BH and SS Program Manager for BH	6/30/2027
Initiation and Engagement in Treatment	Quality of Care	Increase performance on IET-I and IET-E from Blank to Blank in San Joaquin County, Blank to Blank in Stan County, and Blank to Blank in El Dorado County by December 31, 2027.	1. Partner with Provider Partnership Program (PPP) and Equity in Practice Transformation (EPT) participants to improve screening and follow up/referral workflows to behavioral health services (BH integrated in clinics, the Health Plan's NSMHS, and County BH services) through consultation and in-services as requested. 2. Create and distribute new SUD materials for members and provider offices to support conversations, increase BH awareness and address stigma, and encourage member engagement in care.	Director of BH and SS Program Manager for BH	6/30/2027
Increase performance on POD from Blank to Blank in San Joaquin County, Blank to Blank in Stan County, and Blank to Blank in El Dorado County by December 31, 2027.	Quality of Care	Increase performance on POD from Blank to Blank in San Joaquin County, Blank to Blank in Stan County, and Blank to Blank in El Dorado County by December 31, 2027.	1. Partner with Provider Partnership Program (PPP) and Equity in Practice Transformation (EPT) participants to improve screening and follow up/referral workflows to behavioral health services (BH integrated in clinics, the Health Plan's NSMHS, and County BH services). 2. Distribute new POD materials for members and provider offices to support conversations, increase bh awareness and address stigma, and encourage member engagement in care. 3. Participate in Opioid Safety Coalition meetings in San Joaquin, Stanislaus, and El Dorado counties—engaging POD/MAT providers and CBOs to promote the Health Plan's covered services, including transportation, social services, ECM, and CSS, to support members' continuity in treatment. Additionally, collaborate with San Joaquin County's COPN Grant Project Advisory Committee to inform outreach, engagement, and access to care strategies for Black/African American males ages 30–50. Support Stanislaus County's POD PIP interventions by promoting awareness, improving access to care, and partnering with MAT providers to reduce barriers through coordinated efforts between MCPs and MHPs.	Director of BH and SS Program Manager for BH	6/30/2027
Follow Up after ER Visits for Mental Illness	Quality of Care	Achieve an improvement in FUM (30 Day) from Blank to Blank in San Joaquin County, Blank to Blank in Stan County, and Blank to Blank in El Dorado County by December 31, 2027.	1. Partner with Provider Partnership Program (PPP) and Equity in Practice Transformation (EPT) participants to improve screening and follow up/referral workflows to behavioral health services (BH integrated in clinics, the Health Plan's NSMHS, and County BH services) through consultation and in-services as requested. 2. Create and distribute new FUM materials for members at EDs and hospitals to support conversations, increase bh awareness and address stigma, and encourage member engagement in care. 3. Utilize the ADT report with both the internal BH Case Management team and external PPP participants (14 total) to support report monitoring, outreach, and follow up interventions to meet the required 7 day and 30 day follow up timelines. 4. Continue quality improvement and technical assistance efforts with the largest-volume provider group, Community Medical Centers (CMC) in San Joaquin County, through the monthly CMC and HPSJ FUA/FUM Workgroup.	Director of BH and SS Program Manager for BH	6/30/2027
Follow Up after Hopsitalization	Quality of Care	Increase performance on FUH - 7 & 30 Day from Blank to Blank in San Joaquin County, Blank to Blank in Stan County, and Blank to Blank in El Dorado County by December 31, 2027.	1. Partner with Provider Partnership Program (PPP) and Equity in Practice Transformation (EPT) participants to improve screening and follow up/referral workflows to behavioral health services (BH integrated in clinics, the Health Plan's NSMHS, and County BH services) through consultation and in-services as requested. 2. Create and distribute new FUH materials for members at EDs and hospitals to support conversations, increase BH awareness and address stigma, and encourage member engagement in care.	Director of BH and SS Program Manager for BH	6/30/2027
Increase performance on APP from Blank to Blank in San Joaquin County, Blank to Blank in Stan County, and Blank to Blank in El Dorado County by December 31, 2027.	Quality of Care	Increase performance on APP from Blank to Blank in San Joaquin County, Blank to Blank in Stan County, and Blank to Blank in El Dorado County by December 31, 2027.	1. Update and distribute new APP materials for members and provider offices to support conversations, increase BH awareness and address stigma, and encourage member and family engagement in care.	Director of BH and SS Program Manager for BH	6/30/2027
CULTURAL AND LINGUISTICS PROGRAM					
	Mbr Experience	C&L Quality Improvement Objectives: 1.1 Meet Quality Focus Benchmark by end of MY27: Onsite Interpreter Fulfillment: >/= 90% monthly average. 1.2 Meet CalTAR Timely Access for LEP Survey Benchmarks by end of MY27: - For Verbal translation (interpreting) from Providers, achieve a 90% score for member belief that theywere provided with an interpreter quickly. - For Verbal translation (interpreting) from Providers, achieve a 90% score for member belief that they would have received the same information an English speaker would have. - For Verbal translation (interpreting) from Health Plan, achieve a 90% score member belief that they were provided with an interpreter quickly. - For Verbal translation (interpreting) from Health Plan, achieve a 90% score member belief that they would have received the same information an English speaker would have.	1.1 Refine onsite interpreter request workflow with Customer Service. 1.2 Work with vendors to apply refined structure. 1.3 Update informational and training materials as necessary. 1.4 Educate Providers, Staff, and Members on updates to interpreter request workflow. 1.5 Confirm if goal met by end of MY27, checking onsite fulfillment progress quarterly, and the results from the CalTAR survey administered in CY27.	Director of Health Equity-C&L Speacialists	1.1 9/30/26 1.2 10/31/26 1.3 11/30/26 1.4 12/31/26 1.5 12/31/27

Cultural and Linguistics Program	Mbr Experience	CLAS Improvement Objective by end of MY27: 2.1 Internal qualified bilingual member-facing staff >/= 35%.	2.1 Collaborate with HR on strategy to recruit additional qualified bilinguals for Punjabi, Vietnamese, and other additional languages. 2.2 Implement updates to recruitment plan during FY26-27. 2.3 Confirm if goal met by end of MY27, checking progress quarterly.	Director of Health Equity; C&L Speacialists	2.1 11/30/26 2.2 10/31/26 2.3 12/31/27
	Mbr Experience	3. Provide C&L Support to Improve Clinical Outcome by end of MY27 - Improved CBP measure in subpopulation of race, ethnicity, or language with the highest disparity. - Improved additional measure with subpopulation of race, ethinicity, or languaeg with the highest disparity.	3.1 Meet with HEDIS, NCQA, and Quality Improvement teams regarding CBP rate for Punjabi and Farsi speakers to confirm current state. Confirm what additional C&L support may be useful. Stratify by additional REaL data to determine if other subpopulations should be of focus. 3.2 Select an additional HEDIS measure of focus with a disparity by subpopulation of race, ethnicity, or language. 3.3 Plan and execute C&L interventions around disparities on two HEDIS measures no later than 6/30/27. 3.4 Measure the impact of the C&L intervention in the clinical outcome. Confirm if goal met or unmet through MY27.	Director of Health Equity; C&L Speacialists	3.1 9/30/26 3.2 9/30/26 3.3 1/31/27 3.4 3/31/28
	Administrative	4. FY26-27 Annual QIHETP Evaluation of CLAS Program and FY27-28 Workplan Formation	4.1 Perform end of fiscal year review of C&L/CLAS program workplan, identify goals and metrics that are met or likely to meet, as well as needs for following fiscal year projects, program description, and work plan adjustments. 4.2 Add the 4.1 items to updated QIHETP Program Description, C&L Program Description, and Workplan. 4.3 Complete formal evaluation of fiscal year achievements and gaps for C&L QIHETP Workplan section and Program Description. Update FY27-28 Workplan accordingly.	Director of Health Equity; C&L Speacialists	4.1 7/31/27 4.2 8/31/27 4.3 9/30/27
HEALTH EQUITY					
Member Demographic Data Optimization	Administrative	Member Demographic Data Optimization 1.1 Document data flows for critical or required member demographic categories, as well as gaps or desired enhancements, and request technical support for the gaps or desired enhnacements to be completed by end of FY26-27.	1.1 Map and document the data flow of all critical or required member demographic categories (race, ethinicity, language, sexual orientation, gender identity, etc) 1.2 Identify and document gaps or desired enhancements 1.3 Submit list of gaps or desired enhancements to technical teams for review.	Director of Health Equity	1.1 9/30/26 1.2 11/30/26 1.3 12/31/26
Equity Focused Intervention Framework	Quality of Care	Track and evaluate equity-focused interventions	1. Identify patterns of over- and underutilization of physical and behavioral health care services 2. Develop equity-focused interventions to address identified over/under utilization patterns 3. Establish a unified, equity-driven intervention framework to monitor and track effectiveness 4. Evaluate the effectiveness of equity efforts	Program Manager for Quality & Health Equity	1.6/30/27
Health Equity Stratifications	Quality of Care	Incorporate equity stratification on priority measures into PPP meetings for discussion and intervention	1. Identify measures and demographics to stratify (e.g., race, ethnicity, zip) 2. Create template to display data at the clinic level 3. Socialize and pilot with two practices. 4. Gain feedback. 5. Add at least two additional practices.	Program Manager for Quality & Health Equity	1. 10/31/2026; 2.&3. 1/31/2027; 4. &5. 4/30/2027
HEQMS Reporting and Improvement	Quality of Care	1. Submit HEQMS reporting to DMHC by August 15, 2026 2. Develop corrective action plan for all HEQMS MY24 findings	1. Follow DMHC instructions for measure submission 2. Coordinate with Health Plan Compliance to submit by deadline 3. Meet with interdisciplinary and interdepartmental teams to review root causes for all MY25 findings 4. Develop CAP based on DMHC instructions for all findings	Program Manager for Quality & Health Equity	1. 8/15/26 2. 8/15/26 3. 9/11/26 9/30/26
EHOA and TGI Training Updates	Administrative	4.1 Update EHOA and TGI Trainings, and launch updated training to respective parties	4.1Acquire updated health metrics stratified by demographic categories for DEI training. Include findings from HEDIS. 4.2 Analyze the data and translate findings into EHOA training material/slides. 4.3 Implement changes from updated DHCS and other regulator APLs . 4.4 Work with HR, Procurement, and Provider Services to update and relaunch the existing training to the respective trainees. 4.5 Confirm training completion by respective trainees.	Director of Health Equity;	4.1 8/30/26 4.2 9/30/26 4.3 10/15/26 4.4 10/30/26 4.5 2/28/27
QUALITY ANALYTICS AND REPORTING					
HEDIS Reporting and Quality of Clinical Care	Quality of Care	1. By June 15, 2026, reporting HEDIS MY2026 scores for NCQA Health Plan Accreditation, the DHCS Managed Care Accountability Set (MCAS), and the DMHC Health Equity and Quality Measure Set (HEQMS) 2. Meet or exceed the 50th percentile for 14 measures across HPSJ counties. 3. Meet or exceed the 50th percentile for 18 measures across HPSJ counties. 4. Meet or exceed the 50th percentile for 19 measures across HPSJ counties. 5. Maintain 6 MCAS measures across MVHP that meet or exceed MPL	1. Complete all annual HEDIS, MCAS, and HEQMS activities, ensuring compliance with quality measure regulatory agencies, including NCQA, DHCS, EQRO, and DMHC. 2. Complete annual HEDIS MY2025 report, analyzing yearly trends and identifying areas for improvement. 3. Identify areas of opportunity for data systems and data sources for MY2026. 4. Develop and implement improvement projects	Manager of HEDIS & Quality Reporting	06/30/27
STARS	Quality of Care	1. Train HP staff on STARS mesaures 2. Develop months Stars dashboard	1. Develop staff STARS measure trainings 2. Train health plan staff 3. Develop STARS monthly monitoring dashboard	HEDIS & Quality Reporting Manager	1. 11/30/26 2. 2/28/27 3. 6/30/27
Supplemental Data	Administrative	1. Increase the number of primary care clinics that are sending in supplemental data. 2. Increase the impact that supplemental data feeds have on HEDIS rates.	1. Develop list provider offices to target 2. Outreach and meet with targeted offices to develop plan to implement supplemental data feeds 3. Develop monitoring report for supplemental data feeds to identify and monitor measure impact 4. Share report with providers and develop and implement data improvement plans to maximize supplemental data impact.	HEDIS Specialists	1. 8/30/26 2. 12/31/26 3. 12/31/26 4. 6/31/2027

Health Information Exchange (HIE) Provider Enrollment and DAV Certification	Administrative	1. Increase the number of providers participating in HIE 2. Increase number of provider HIE participants data meeting DAV certification requirements	1. Identify providers not enrolled in HIE to target 2. Outreach to targeted providers to enroll in HIE 3. Identify providers in HIE targeted for DAV certification and partner with providers and Manifest to help support data certification efforts.	HEDIS & Quality Reporting Manager	1. 8/30/26 2. 12/31/26 3. 12/31/26 4. 6/31/2027
ADT Feed Provider Enrollment	Administrative	1. Increase number of providers enrolled in ADT feeds	1. Identify providers not enrolled in ADT feeds 2. Outreach and coordinate enrollment in ADT feeds.	HEDIS & Quality Reporting Manager	1. 8/30/26 2. 6/30/27
Year-round hybrid		1. Implement year round chart retrieval and review efforts 2. Build year round supplemental feeds	1. Develop strategice plan for ongoing chart review 2. Review, monitor and capture data into monthly supplemental feeds	HEDIS & Quality Reporting Manager	1. 10/1/2026 2. 6/30/27
PERFORMANCE IMPROVEMENT					
IHI Child Health Equity Collaborative	Quality of Care	By December 2026, we will increase the W30-6+ Well Child Visit rate for members assigned to Community Medical Center children aged 0–15 months in San Joaquin County by 5 percentage points from 51.59% to 56.59% and W30-2+ children aged 0-30 months from 55.77% to 60.77%, in alignment with the overall collaborative goal.	1. Identify a community based organization to partner with to improve well visits for 0-30 month olds 2. Coordination a collaborative approach to measure improvement with CBO and CMC 3. Develop a PDSA to test a change 4. Implement at least one PDSA cycle	NCQA Coordinator	12/31/26
Performance Improvement Projects (PIPs)*	Quality of Care	Conduct or participate in, at a minimum, two (2) PIPs per year as directed by DHCS. Conduct or participate in any additional PIPs, including statewide PIPs, as directed by DHCS.	1. Submit final non-BH PIP to DHCS by August 6 2. Respond to feedback or questions, if applicable 3. Follow DHCS guidance for any new PIPs that are assigned	QI Supervisor	1. 8/6/26 2.10/30/26 3. 6/30/27
STARS	Quality of Care	Establish a baseline for completed AWV/IPPE visits for D-SNP members. Improve completion rate of AWV/IPPE visits for D-SNP members.	1. Develop a report that captures AWV/IPPE completion for DSNP members 2. Establish a baseline rate and develop a goal rate for AWV/IPPE 3. Develop provider facing materials to educate providers on AWV/IPPE 4. Begin sending providers gap in care lists for members without their AWV/IPPE 5. Provide feedback and education to providers as needed.	HEDIS Manager	1. 8/30/26 2. 1/30/27 3. 10/31/26 4. 10/31/26 5.6/30/27
Timely Prenatal Care	Quality of Care	1. Improve the rate of timely prenatal care in San Joaquin County from 89.17% to 91.37% by December 31, 2027. 2. Improve the rate of timely prenatal care in El Dorado County from 76.67% to 91.37% by December 31, 2027.	1. Develop improved reporting to identify pregnant members 2. Conduct outreach to members through TCS	TOC Manager	1. 12/31/26 2. 6/30/27
Timely Postpartum Care	Quality of Care	1. Improve the rate of timely postpartum care in Stanislaus County from 84.76% to 87.48% by December 31, 2027. 2. Improve the rate of timely postpartum care in El Dorado County from 63.33% to 87.48% by December 31, 2027.	1. Develop provider facing materials encouraging PCPs to conduct a postpartum visit if not completed by perinatal provider 2. Send provider facing material to network providers through means such as Provider Alert 3. Collaborate with TCS regarding new requirements for birthing members 4. Hold Summer/Fall 2026 Town Hall with birthing providers.	Program Manager for Quality & Health Equity	1. 12/31/2026 2. 2/28/2027 3. 6/30/2027 4. 11/2026; 6/2027
Perinatal Depression Screenings	Quality of Care	1. Address racial disparity in PDS-E (Screening) by December 31, 2027. 2. Address racial disparity in PND-E (Screening) by December 31, 2027.	1. Identify rates for PDS-E and PND-E by race 2. Assess for racial disparities 3. Identify areas to address racial disparities 4. Develop a plan of action 5. Take at least one action	Program Manager, BH & SW Program Manager, Health Equity and Quality	
Controlling Blood Pressure	Quality of Care	1. Establish standardized process for distribution of blood pressure cuffs for members with hypertension 2. Expand blood pressure cuff distribution project to 1 additional provider group	1. Collect and review current state for blood pressure cuff distribution 2. Establish written process and best practices resources, as needed 3. Explore use with additional clinics 4. Operationalize with at least one additional clinic	QI Supervisor	1. 12/31/26 2. 12/31/26 3. 12/31/26 4. 6/30/27
Breast Cancer Screening	Quality of Care	1. Kick off use of the CMC Mobile Mammography van 2. Maximize the number of patients attending Alinea events	1. Meet with CMC and develop plan for mobile mammography van kick off event and coordination 2. CMC to host at least one mammography screening event with the van by 12/31/26 3. Track Alinea screenings and use iterative process to get as close as possible to 100% capacity at each event.	QI Supervisor	1. 10/1/26 2. 12/31/26 3. 6/30/27
Blood Lead Screening	Quality of Care	1. Ensure that health plan meets DHCS required All Plan Letters. 2. Ensure provider follow-up of all elevated blood lead screening levels 3. Reach the MPL for LSC in El Dorado County by 12/31/2026	1. Review and assess compliance with APL 20-026- Blood Lead Screening in Children 2. Collect and analyze data monthly on all members identified with elevated blood screening levels. 3. Promote blood lead screening with El Dorado provider partnership partners 4. Send gap in care lists to provider to target children who have not yet had their screenings.	HEDIS Manager QI Supervisor	1. 6/30/27 2. 6/30/27 3. 12/31/26 4. 12/31/26
LONG-TERM CARE QUALITY					
CDPH Findings	Quality of Care	Collect quality assurance and improvement findings from CDPH to include survey deficiency results, site visit findings, and complaint findings.	1. Pull a list of all actively contracted LTC SNFs for the CY under review 2. Access to CDPH website to document the number of survey deficiencies, site visit findings and complaint findings for each contracted SNF	Quality Coordinator	06/30/26
MCAS LTC Measures	Quality of Care	Comply with DHCS MCAS reporting requirements for LTC measures	1. Report the following MCAS LTC measure results to DHCS annually: • Number of Out-patient ED Visits per 1,000 Long Stay Resident Days • Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization • Potentially Preventable 30-day Post-Discharge Readmission	Quality Coordinator	06/30/26
Quality Assurance Performance Improvement (QAPI) Program	Quality of Care	Ensure each SNF that provides services to health plan members has implemented a quality program that includes the 5 essential elements of a QAPI, as per APL24-009	1. Obtain QAPI attestation from each SNF upon initial contracting and every 36 months thereafter.	Credentialing Supervisor	12/31/26 6/30/27
SNF LTC Annual Report	Quality of Care	Analyze multiple data sources to oversee and act on improvements for LTC services provided to members in SNFs.	1. Collect CDPH findings including at minimum survey deficiency results, site visit findings, and complaint findings 2. Collect LTC HEDIS measures 3. Reviw QAPI attestations gathered from each contracted SNF 4. Collect SNF related member grievances, appeals and PQIs 5. Consolidate data into an annual report with data analysis, summary of findings, and recommended actions. 6. Report to QIHEOC for stakeholder feedback and identification and prioritization of actions, if any.	HEDIS& NCQA Director	9/30/26
ACCESS TO CARE					

Member to Provider Ratio	Access	Ensure member:provider ratios are in compliance with regulatory standards	1. Collect data to evaluate member:provider ratios 2. Conduct quantitative and qualitative analysis of results, outline opportunities and improvement actions (as applicable), and measure effectiveness of interventions.	Director, Provider Services	10/31/26, 4/30/27
High Volume and High Impact Specialties	Access	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, at a minimum OB/Gyns. 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. 2. Collect data to evaluate performance against standards 3. Conduct quantitative and qualitative analysis of results, outline opportunities and improvement actions (as applicable), and measure effectiveness of interventions.	Director, Provider Services	04/30/27
Prescribing and Non Prescribing BH Practitioners	Access	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.	Director of Provider Services	11/30/26
Geographic access	Access	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) 2. Collect data for all Primary, HV and HI specialists, Prescribing and Nonprescribing practitioner types (collect separate data for BH prescribing and nonprescribing practitioners).	Director, Provider Services	11/30/26
Practitioner Appointment Availability Survey (PAAS)	Access	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).	Director, Provider Services	08/01/26
OB/Gyn Access Monitoring	Access	Ensure appointment availability for OB/Gyn providers	1. Conduct secret shopper calls to gather next available appointment information from network of Ob/Gyns 2. Calculate compliance from provider responses 3. Conduct quantitative and qualitiative analysis 4. Take action to improve, if needed	Director, Provider Services	04/30/27
After Hour Monitoring	Access	Ensure after hours availability for behavioral and non-behavioral healthcare providers	1. Collect data on after hour availability for non-behavioral helathcare providers through contracted vendor 2. Collect data on after hours availability for behavioral healthcare providers through grievances data 3. Conduct quantitative and qualitative anlaysis 4. Take action to improve, if needed	Director, Provider Services Quality Coordinator	04/30/27
Physician Directory Accuracy	Quality of Service	Ensure accuracy of information in the directory to promote member access to care.	1. Conduct provider directory validation study to assess: -Accuracy of office locations and phone numbers -Accuracy of hospital affiliations -Accuracy of accepting new patients -Awareness of physician office staff of physician's participation in HPSJ/MVHPs network	Director, Provider Services	05/30/27
PROVIDER ENGAGEMENT					
Provider Satisfaction	Administrative	Improve Net Satisfaction Score and Net Loyalty Score in annual Provider Satisfaction survey.	1. Collect and analyze provider satisfaction data to identify provider satisfaction opportunities. 2. Report results to QIHEC committee and gather feedback 3. Assess opportunities for improvement	Director, Provider Services	03/01/27
Provider Incentives	Administrative	1. Develop a provider incentive program in support of high quality D-SNP Stars Rates 2. Execute timely and informative payments to providers for MCAS incentive program.	1. Develop a provider incentive program related to Stars ratings 2. Create and disseminate provider education on Stars incentive 3. Calculate provider MCAS performance 4. Disseminate payments timely and with corresponding communication explaining payments	Director of HEDIS & NCQA Manager, HEDIS & Quality Reporting	1. 9/30/26 2. 12/31/26 3. 9/30/26 4. 10/31/26
Provider Partnership	Quality of Care	Work with PPP practices to meet at least 70% of MPLs for their applicable HEDIS measures.	1. In collaboration with Tier 1 providers, identify prioritized areas of opportunity 2. Develop at least 1 PDSA to improve identified improvemenet with each Tier 1 provider group in the PPP 3. Conduct improvement using the PDSA methodology 4. Identify improvement efforts that can be expanded to other provider groups 5. Track and share provider progress toward MPLs throughout the year	QI Supervisor	1. 9/30/26 2. 12/31/26 3. 6/30/27 4. 6/30/27 5. 6/30/27
MEMBER GRIEVANCES AND APPEALS					
Grievance Acknowledgement Letter Timeliness*	Quality of Care Quality of Service	100% of grievance acknowledgement letters are distributed timely: **Standard:** Within 5 calendar days of receipt of grievance	1. Calculate the timeliness of sending standard grievance acknowledgement letters each quarter. 2. Conduct root cause analysis and action planning if performance goals are not met.	Quality Manager Grievance Coordinators	10/15/26 1/15/27 4/15/27 7/15/27
Grievance Resolution Timeliness	Quality of Care Quality of Service	100% of grievance resolution letters are distributed timely: **Expedited:** Within 72 hours of receipt of grievance **Standard:** Within 30 calendar days of receipt of grievance	1. Calculate the timeliness of sending standard and expedited grievance resolution letters each quarter. 2. Conduct root cause analysis and action planning if performance goals are not met.	Quality Manager Grievance Coordinators	10/15/26 1/15/27 4/15/27 7/15/27
Grievance Rates*	Quality of Care Quality of Service Access	**Goals - grievance rate per 1000 members:** Access: ≤3 per 1000 members QOC: ≤3 per 1000 members QOS: ≤5 per 1000 members Billing/Financial: ≤5 per 1000 members Quality of Practitioner Office Site: ≤5 per 1000 members	1. Calculate grievance rate per 1000 members for access, QOC and QOS each quarter. 2. Conduct root cause analysis and action planning if performance goals are not met.	Quality Manager Grievance Coordinators	10/15/26 1/15/27 4/15/27 7/15/27
Appeal Acknowledgement Letter Timeliness	Quality of Care Quality of Service	100% of appeal acknowledgement letters are distributed timely: **Standard:** Within 5 calendar days of receipt of grievance	1. Calculate the timeliness of sending standard appeal acknowledgement letters each quarter. 2. Conduct root cause analysis and action planning if performance goals are not met.	Quality Manager Grievance Coordinators	10/15/26 1/15/27 4/15/27 7/15/27
Appeal Resolution Timeliness	Quality of Care Quality of Service	100% of appeal resolution letters are distributed timely: **Expedited:** Within 72 hours of receipt of grievance **Standard:** Within 30 calendar days of receipt of grievance	1. Calculate the timeliness of sending standard and expedited appeal resolution letters each quarter. 2. Conduct root cause analysis and action planning if performance goals are not met.	Quality Manager Grievance Coordinators	10/15/26 1/15/27 4/15/27 7/15/27
Appeal Rates	Quality of Care Quality of Service Access	**Goals - appeal rate per 1000 members:** QOS/Attitude/Service: ≤5 per 1000 members Access: ≤3 per 1000 members QOC: ≤3 per 1000 members Billing/Financial: ≤5 per 1000 members Quality of Practitioner Office Site: ≤5 per 1000 members	1. Calculate appeal rate per 1000 members for access, QOC and QOS each quarter. 2. Conduct root cause analysis and action planning if performance goals are not met.	Quality Manager Grievance Coordinators	10/15/26 1/15/27 4/15/27 7/15/27
Member Grievance and Appeal P&Ps	Administrative	100% of grievance and appeal policies and procedures reviewed and updated annually, as applicable	1. Review and update grievance and appeal P&Ps as needed to ensure compliance with accreditation, regulatory and health plan business needs.	Quality Manager	06/30/27