2025 Quality Improvement and Health Equity Plan

Executive Summary

April 2026

MISSION, VISION, AND VALUES (MVV)

IEHP's Mission, Vision, and Values (MVV) aims to improve the quality of care, access to care, Member safety, and quality of services delivered to IEHP Members. The organization prides itself in four (4) core goals:

Mission: We heal and inspire the human spirit.

Vision: We will not rest until our communities enjoy optimal care and vibrant health.

Values: We do the right thing by:

1. Placing our Members at the center of our universe.
2. Unleashing our creativity and courage to improve health & well-being.
3. Bringing focus and accountability to our work.
4. Never wavering in our commitment to our Members, Providers, Partners, and each other.

QUALITY IMPROVEMENT AND HEALTH EQUITY PLAN (QIHEP) OVERVIEW

IEHP supports an active, ongoing, and comprehensive Quality Improvement & Health Equity Plan (QIHEP) with the primary goal of continuously monitoring and improving the quality of care and service, access to care, Member safety delivered to IEHP Members by providing effective, equitable, understandable, and respectful quality care and services responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. The QIHEP provides a formal process to systematically monitor and objectively evaluate, track, and trend the health plan's quality, efficiency, and effectiveness. IEHP has created a systematic, integrated approach to planning, designing, measuring, assessing, and improving the quality of care and services provided to Members. This comprehensive delivery system includes equity-focused interventions, Member safety, behavioral health, care management, culturally and linguistically appropriate services, and coordination of care, and quality improvement initiatives. In addition, IEHP's operational framework is designed to inform and deploy initiatives to advance health equity, improve quality, help eliminate health disparities, and address identified patterns of over- or under-utilization of physical and behavioral health care services. IEHP will utilize this document for oversight, monitoring, and evaluation of Quality Management (QM) and Quality Improvement (QI) activities to ensure the QIHEP is operating in accordance with standards and processes as defined in this Plan Description. These initiatives are aligned with IEHP's mission, vision, and values. The QIHEP is designed to improve all aspects of care delivered to IEHP Members in all health care settings by:

1. Defining the Program structure;
2. Assessing and monitoring the delivery and safety of care;
3. Assessing and monitoring, population health management provided to Members, including behavioral health and care management services;
4. Supporting Practitioners and Providers to improve the safety of their practices;
5. Overseeing IEHP's QM functions through the Quality Management & Health Equity Transformation Committee;

6. Involving designated physician(s) and staff in the QMHET Program;
7. Involving a behavioral healthcare Practitioner in the behavioral health aspects of the Program;
8. Involving Long-Term Services and Supports (LTSS) Providers and Professionals with expertise in LTSS in the QMHET Program;
9. Reviewing the effectiveness of LTSS programs and services;
10. Ensuring that the LTSS needs of Members are identified and addressed by leveraging available assessment information;
11. Identifying opportunities for QI initiatives, including the identification of health disparities among Members;
12. Implementing and tracking QI initiatives that will have the greatest impact on Members;
13. Measuring the effectiveness of interventions and using the results for future QI activity planning;
14. Establishing specific role, structure and function of the QMHETC and other committees, including meeting frequency;
15. Reviewing resources devoted to the QMHET Program;
16. Assessing and monitoring delivery and safety of care for the IEHP population with complex health needs and Seniors and Persons with Disabilities (SPD); and
17. Assessing and monitoring processes to ensure the Member's cultural, racial, ethnic, and linguistic needs are being met.

To accomplish this, IEHP has established methods that ensure and promote access and delivery of medically necessary services in a culturally competent manner to all Members, including people with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. IEHP has defined the following objectives:

Clinician-Oriented:

- Provide training, support, technical assistance and resources to Providers and their office staff to assist them in the provision of culturally competent and linguistic services.
- Monitor the clinician credentialing and recredentialing processes for discriminatory practices, at each point of the process.

IEHP and Member-Oriented:

- Educate IEHP Team Members on cultural diversity in the Membership and raise awareness of IEHP Cultural and Linguistic policies, procedures, and resources through annual mandatory training.
- Assess the characteristics of IEHP's Membership to identify Member needs and review and updates its structure, operations, and resources accordingly.
- Evaluate areas such as social determinants of health, identification of subpopulations, needs of children/adolescents and individuals with disabilities and with serious and persistent mental illness (SPMI),

Members of Limited English Proficiency (LEP), disparities in Members of different ethnicity groups, and disparities in Members with primary language other than English.

- Identify the threshold languages in the Member population of 200 or more Members and provide vital information in threshold languages and alternate formats upon request. The current threshold languages are English, Spanish, Mandarin, Cantonese, and Vietnamese.
- Use competent translators and evaluate the quality of translation.
- Review and approve externally and internally developed Member materials for readability, content, accuracy, cultural appropriateness, and non-discrimination using DHCS Readability and Suitability Checklist.
- Assess Member's experience with their utilization of language services to assist with improvements to organizational functions and healthcare encounters.
- Review Grievance and Appeals (G&A) Data by race/ethnicity and language to identify areas of opportunity for improvement.
- Support the development of new recruitment and hiring practices that promote diversity and inclusive policies including:
    - Inclusive job descriptions that use gender neutral language, indicate the job specific salary range, clarify minimum qualification requirements, all emphasizing our commitment to diversity and inclusion.
    - Require all applicants to be reasonably considered for positions for which they meet all minimum qualifications.
    - Hold hiring leaders accountable to conducting fair and equitable interview and selection practices to support and sustain equal representation throughout the organization.
    - Deploy technology designed to help reduce the interference of unconscious bias in the selection and hiring process, including the use of resume redaction which removes any information identifying a candidate's gender, age, economic status, and ethnicity to ensure a more equitable initial candidate consideration.
- Conduct ongoing assessment of IEHP' Membership language profile.
- Commit to all IEHP Team Members to promote a work environment built on the premise of gender and diverse equity that encourages and enforces:
    - Respectful communication and cooperation between all Team Members.
    - Teamwork and Team Member participation permitting the representation of all groups and Team Member perspectives.

IEHP GOVERNING BOARD

IEHP was created as a public entity as a result of a Joint Powers Agency (JPA) agreement between Riverside and San Bernardino Counties. Two (2) Members from each County Board of Supervisors sit on the Governing Board as well

as three (3) public Members from each county. The Governing Board provides direction for the QIHEP, evaluates QIHEP effectiveness, and evaluates and approves the annual QIHEP.

The Governing Board's responsibilities include but are not limited to:

1. Providing oversight of health care delivered by contracted Providers and Practitioners;
2. Providing direction for the QIHEP;
3. Evaluating QIHEP effectiveness and progress;
4. Approving the overall QIHEP and its work plan;
5. Appointing an accountable entity or entities within the Plan responsible for oversight of QIHEP;
6. Reviewing written progress reports received from the Quality Management and Health Equity Transformation Committee (QMHETC) that describe actions taken, progress in meeting QIHEP objectives, and improvements made; and
7. Directing necessary modifications to QIHEP policies and procedures to ensure compliance with Quality Management/Quality Improvement and Health Equity standards set forth in the Two-Plan Contract and DHCS Comprehensive Quality Strategy (CQS).

The QMHETC reports delineating actions taken and improvements made are reported to the Board through the Chief Medical Officer (CMO) and Chief Quality Officer (CQO). The Board delegates responsibility for monitoring the quality of health care delivered to Members to the CMO, CQO, and the QMHETC with administrative processes and direction for the overall QMHETP initiated through the CMO and CQO, or Medical Director designee.

QUALITY MANAGEMENT AND HEALTH EQUITY TRANSFORMATION COMMITTEE (QMHETC)

The QMHETC reports to the Governing Board and retains oversight of the Quality Management and Health Equity Transformation Program (QMHETP) and Quality Improvement and Health Equity Plan (QIHEP) with direction from the CMO and CQO. The QMHETC promulgates the quality improvement process to participating groups and Physicians, Providers, Subcommittees, and internal IEHP functional areas with oversight by the CMO and CQO.

1. **Role**: The QMHETC is responsible for continuously improving the quality of care for IEHP Membership.
2. **Structure**: The QMHETC is composed of Network Providers, Specialists, Medical Directors, IPA Medical Directors who are representative of network Practitioners, Practicing Pharmacists, and Public Health Department Representatives from Riverside and San Bernardino Counties. These individuals provide expertise and assistance in directing the QMHETP/QIHEP activities. A designated Behavioral Healthcare Practitioner is an active Member of the IEHP QMHETC to assist with behavioral healthcare-related issues. There are a total of twenty-nine (29) Quality Management and Health Equity Transformation Committee Members. This includes both internal and external participants.

QUALITY SUBCOMMITTEES

The following Subcommittees, chaired by the IEHP Chief Medical Officer, Chief Quality Officer or designee, report findings and recommendations to the QMHET Committee:

1. Quality Improvement Council (QIC)
2. Quality Improvement Subcommittee (QISC)
3. Member Experience Subcommittee (MESC)
4. Population Health Management (PHM) Subcommittee

QUALITY IMPROVEMENT COUNCIL (QIC)

The Quality Improvement Council (QIC) is responsible for quality improvement activities for IEHP. The QIC reviews reports and findings of studies before presenting to QMHETC and works to develop action plans to improve quality and study results. In addition, QIC directs the continuous monitoring of all aspects of Behavioral Health & Care Management (BH &CM) and Population Health Management (PHM) services provided to Members.

QUALITY IMPROVEMENT SUBCOMMITTEE (QISC)

The Quality Improvement Subcommittee (QISC) establishes a culture of quality improvement within IEHP. This subcommittee provides oversight, monitoring and assessment of key organizational processes, outcomes, and reports; and makes recommendations concerning quality improvement initiatives and activities. The cross functional makeup of the QI subcommittee supports an environment of transparency for quality improvement performance, commitment to ongoing evaluation, and wide scale spread identified successes.

Through a multidisciplinary approach the QISC's primary goal in 2025 was to monitor priority quality measure performance and review assigned quality improvement studies and reports identified on the Quality management (QM) workplan or as designated by Accreditation Programs Leadership. The QISC will either, collectively explore root causes of performance opportunities and propose interventions or escalate to the Quality Improvement Council (QIC) as needed for additional recommendations. All studies, performances reports, and recommended action items are presented to the QIC on a routine basis.

MEMBER EXPERIENCE SUBCOMMITTEE (MESC)

The Member Experience Sub-Committee (MESC) exists to establish a culture focused on continually improving the experience our IEHP Members in their journey navigating their health care. This subcommittee provides oversight, monitoring and assessment of key organizational processes, outcomes and reports; and makes recommendations concerning initiatives and activities that impact the Member experience. The cross functional makeup of the MESC subcommittee supports an environment of transparency for Member satisfaction performance, service levels, grievances, community outreach and a commitment to ongoing evaluation and wide scale spread of identified successes.

The MESC's primary goal is to establish and align with IEHP's strategic commitment to optimal care and vibrant health. MESC Program performance and outcome measures include, but are not limited to:

1. Oversee the Member experience journey using data from regulatory and IEHP generated approaches to identify trends that indicate there are service concerns related to the various Member touchpoints as they interact with the IEHP, our Providers and contractors.
2. Ensure best practices, which are intended to improve the Member experience, are identified, planned, implemented, and monitored.
3. Continually improve the ability to measure the Member Experience journey and touchpoints [including community outreach] to ensure the "Voice of the Member" is measured and understood.

POPULATION HEALTH MANAGEMENT (PHM) SUBCOMMITTEE

The Population Health Management (PHM) Subcommittee is responsible for the monitoring of IEHP's Population Health Management Program as defined in IEHP's Population Health Management (PHM) Program Description. The items included in the QM/QI and CLAS Work Plan are aligned to Population Health Management program requirements from the Department of Healthcare Services (DHCS) and the National Committee for Quality Assurance (NCQA). IEHP's approach to supporting this work is through the participation of a multidisciplinary subcommittee committed to the clinical and operational goals of the PHM program.

Population Health is a broad IEHP initiative that crosses multiple departments. Therefore, a focused, cross-departmental membership with ad hoc participation is necessary from the following departments: Behavioral Health/Care Management, Health Education, Promotion and Prevention, Pharmacy, Integrated Transitions of care, Community Supports, Health Equity, Quality Systems Provider and member Services, Information Technology, and Medical Directors.

The PHM Subcommittee's primary goal is to review and analyze PHM activities and study results that are required for both accreditation and overall regulatory compliance. The subcommittee developed action tracking items which are regularly looked over to ensure that a process to follow-up on these opportunities are set in place. The PHM subcommittee report deliverables are guided by the QMHETC workplan which is reflective of a 36-month review period covering ongoing activities throughout the year. The PHM Subcommittee assesses data to identify opportunities for intervention through processes such as data-driven risk stratification, identification of gaps, and assessment processes.

QUALITY MEMBER WORKGROUPS

IEHP also has Committees and/or Workgroups that are designed to provide structural input from Providers and Members. These Committees and Workgroups report directly through the QMHETC, Compliance Committee or through the CEO to the Governing Board. Any potential quality issues that arise from these Committees would be referred to the QMHETC by attending staff. The Committees and Workgroups include:

1. Delegation Oversight Committee
2. Community Advisory Committee (CAC)
3. Enrollee Advisory Committee (EAC)
4. IEHP Covered Focus Groups

DELEGATION OVERSIGHT COMMITTEE

The Delegation Oversight (DO) Subcommittee provides oversight and monitoring of the Delegate's abilities to carry out their delegated responsibilities in the areas of Quality Management (QM), Utilization Management (UM), Care Management (CM), Grievance and Appeals (G&A), Credentialing (CR), Encounter Data, Financial Viability, Compliance and Fraud Waste and Abuse (FWA), Health Insurance Portability and Accountability Act (HIPAA) Privacy, HIPAA Security, and Claims Processing. The auditing and monitoring of Delegates allows IEHP to detect deficiencies in delegated performance and ensure that remediation efforts are put in place to provide timely, effective and sustained improvement.

COMMUNITY ADVISORY COMMITTEE (CAC)

The Community Advisory Committee (CAC) was developed to identify and advocate for preventative care practices. Committee Members are to be involved in the development and updating of health plan cultural and linguistic policies and procedures, including those that are related to Quality Improvement, education and operational cultural issues affecting IEHP Members.

The CAC may also advise on necessary Member or Provider targeted services, programs, partnerships, and trainings in accordance with requirements of the Department of Health Care Services (DHCS) Primary Contract - Exhibit A Attachment III and IEHP's Cultural and Linguistic Appropriate Services (CLAS) program.

IEHP has strengthened member experience and access to care through its ongoing collaboration with the CAC. Key initiatives include an implementation plan for a new transportation software system to support self-service scheduling, updates to IEHP.org transportation page for improved clarity and resources, and enhancement of telehealth understanding through education campaigns, virtual tutorials, text-based triage, and live-person support for older members. Efforts to improve rural access and address specialty care delays are underway, alongside comprehensive vaccine education initiatives and Community Health Worker outreach, which have contributed to significant improvements in Well-Child Visit compliance.

Language access has also advanced through updated marketing materials, enhanced interpreter request processes via the Member Portal, and expanded distribution of multilingual collateral. Together, these actions reflect IEHP's commitment to equity, accessibility, and member-centered care, with continued improvements planned into 2026.

ENROLLEE ADVISORY COMMITTEE (EAC)

The purpose of the Inland Empire (Riverside and San Bernardino County) DualChoice (HMO D-SNP) Enrollee Advisory Committee (EAC), is to provide a forum for structured input regarding how IEHP will develop, implement, operate, and improve seamless access and coordination across the full-service continuum – from medical care to long term services and supports (LTSS), for dual-eligible beneficiaries in the Inland Empire. Membership is based on the unique and multi-dimensional needs of the Inland Empire dual eligible community, as well as the stakeholder recommendations and readiness requirements established by the California Department of Health Care Services DHCS and State Medicaid Agency Contract(s).

IEHP COVERED FOCUSED GROUPS

IEHP facilitates focus groups, with representation from the culturally diverse communities of IEHP Member demographics, comprised of IEHP Members, stakeholders, community advocates, and health care providers

to seek their advice on the delivery of Culturally and Linguistically appropriate services, identifying and prioritizing opportunities for improvement.

ORGANIZATIONAL STRUCTURE AND RESOURCES

Under the direction of the CMO, CQO, or designee, Medical Directors are responsible for clinical oversight and management of the QM, UM, BH & CM, Health Education, PHM activities, participating in QIHEP for IEHP and its Practitioners, and overseeing credentialing functions. Medical Directors must possess a valid Physician's and Surgeon's Certificate issued by the State of California and certification by one (1) of the American Specialty Boards. Principal accountabilities include:

1. Developing and implementing medical policy for Health Services department activities and QM functions;
2. Reviewing current medical practices ensuring that protocols are implemented and medical personnel of IEHP follow rules of conduct;
3. Ensuring that assigned Members are provided with health care services and medical attention at all locations;
4. Ensuring that medical care rendered by Practitioners meets applicable professional standards for acceptable medical care; and
5. Following evidence-based, Clinical Practice Guidelines (CPGs) developed by IEHP for all lines of business. The QMHET program adopts, disseminates, and monitors the use of preventive care and clinical practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals, considers the needs of Members, and is developed in consultation with contracted health care professionals, as standards of health care are applicable to Members and Providers.

QUALITY MANAGEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM (QMHETP) AND CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) WORKPLAN

Annually, and as necessary, the QMHETC approves the QMHETP and CLAS Work Plan that addresses clinical quality of physical, behavioral health, access and engagement of Providers continuity and coordination across settings and all levels of care, and Member experience. The QMHETP and CLAS Workplan details a 3-year (36 months) look-back period of program initiatives to achieve established goals and objectives including the specific activities, methods, projected timeframes for completion, monitoring of previously identified issues, evaluation of the QI program and Team Members responsible for each initiative. The scope of the Work Plan incorporates the needs, input, and priorities of IEHP. The Work Plan is used to monitor all the different initiatives that are part of the QIHEP. These initiatives focus on improving quality of care and service, access, Member and Provider satisfaction, Member safety, and QI activities that support PHM strategies. The QMHETC identifies priorities for implementing clinical and non-clinical Work Plan initiatives. The Work Plan includes goals and objectives, staff responsibilities, completion timeframes, monitoring corrective action plans (CAPs) and ongoing analysis of the work completed during the measurement year. The Work Plan is submitted to DHCS and CMS annually.

QUALITY IMPROVEMENT PROCESS

IEHP is required to align internal quality and health equity efforts with DHCS' Comprehensive Quality Strategy Report, monitors and reports quality performance DHCS-selected MCAS measures that are stratified by various demographics, and reviews and acts on items identified through DHCS' reports including but not limited to the Technical Repot, Health Disparities Report, Preventive Services Report, Focus Studies, and Encounter Data Validation Report.

IEHP aligns its QIHEP activities with the DHCS Comprehensive Quality Strategy. The planning and implementation of annual QIHEP activities follows an established process. This includes development and implementation of the Work Plan, quality improvement initiatives, and quality studies. Measurement of success encompasses an annual evaluation of the QIHEP.

IEHP aims to support the DHCS Bold Goals including, but not limited to:

1. Closing racial/ethnic disparities in well-child visits and immunizations;
2. Closing maternity care disparities;
3. Improving maternal and adolescent screening;
4. Improving follow up after emergency department visit for mental health conditions; and
5. Providing children's health preventive care services by exceeding national benchmarks.

IEHP participates in DHCS mandated statewide collaborations or additional initiatives that may improve quality and equity of care for Medi-Cal members as directed by DHCS. IEHP also attends, at a minimum, quarterly regional collaborative meetings that may be in-person.

IEHP QUALITY IMPROVEMENT (QI) INITIATIVES

QI initiatives are also aligned with the IEHP Strategic Plan and Optimal Care, Vibrant Health, and Organizational Strength Vision Commitments that seeks to:

1. Provide clinical care with quality outcomes that exceed national benchmarks, along with health services that are accessible, anticipatory, and coordinated;
2. Provide health care that is equitably experienced across the Inland Empire; and
3. Leverage systems thinking that aligns IEHP's Mission, people, operations technology, and financial performance, respectively.

QI initiatives actively reinforce the Vision Commitments of the IEHP Strategic Plan, with a focus on addressing the specific needs of both IEHP's Membership and those identified by state and regulatory agencies.

QI initiatives undergo a robust process of identification, development, and implementation, ensuring a targeted approach that addresses the specific needs of the IEHP Membership. These initiatives prioritize high-volume, high-risk, or deficient areas, actively seeking improvements in care and service, access, safety, and experience. The proactive monitoring of Managed Care Accountability Set (MCAS) and other quality measures inform the identification and development of QI initiatives, their goals and objectives, and direction of the IEHP Strategic Plan.

Furthermore, a data centered approach with a focus on performance measures and customized metrics form the basis of implementation plans and actions developed to improve care and services.

COMMUNICATION AND FEEDBACK

Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, joint operation meetings, mailings, and announcements.

1. Providers are educated regarding quality improvement initiatives through on-site quality visits, Provider newsletters, specific mailings, and the IEHP website.
2. Specific performance feedback regarding actions or data is communicated to Providers. General and measure-specific performance feedback is shared via special mailings, Provider newsletters, IEHP's Provider Portal, and the IEHP website.
3. Feedback to Providers may include, but is not limited to, the following:
    a. Listings of Members who need specific services or interventions;
    b. Clinical Practice Guideline recommended interventions;
    c. Healthcare Effectiveness Data Information Sets (HEDIS®) and Consumer Assessment of Healthcare Providers (CAHPS®) results;
    d. Recognition for performance or contributions; and
    e. Discussions regarding the results of medical chart audits, grievances, appeals, referral patterns, utilization patterns, and compliance with contractual requirements.

IMPROVEMENT PROCESS

Performance indicators are also used to identify quality issues. When identified, IEHP QM staff investigates cases and determines the appropriate remediation activities including Corrective Action Plans (CAPs). Providers or Practitioners that are significantly out of compliance with QM requirements must submit a CAP. If a Provider or Practitioner does not submit CAP or continues to be non-compliant with the CAP process (including CAP timelines), the Provider is frozen to auto-assignment until such time as the corrections are verified and the CAP is closed. The CAP process must be completed within 90 calendar days from the date of the audit and CAP notification.

QUALITY IMPROVEMENT INITIATIVES – QUALITY OF CARE

IEHP monitors several externally and internally developed clinical quality measures and tracks the quality of care provided by IEHP. To evaluate these measures IEHP collects data from a number of different sources that include, but are not limited to, the following:

1. HEDIS® submission for Medi-Cal, IEHP DualChoice (HMO D-SNP), and IEHP Covered (Covered California);

2. State/Federal required Performance Improvement Projects and Quality Activities; and
3. Claims and encounter data from contracted Providers (e.g., Primary Care Providers, Specialists, labs, hospitals, IPAs, Vendors, etc.).

Measuring and reporting on these measures helps IEHP to guarantee that its Members are receiving care that is safe, effective, and timely. The clinical quality measures discussed below are used to evaluate multiple aspects of Member care including:

1. Performance with healthcare outcomes and clinical processes;
2. Adherence to clinical and preventive health guidelines;
3. Effectiveness of chronic conditions, Population Health and Behavioral Health Care Management programs; and
4. Member experience with the care they received.

HEDIS® MEASURES

Each year, IEHP gathers data and performs analyses on clinical and service performance measures as delineated by the National Committee for Quality Assurance (NCQA), the California Department of Healthcare Services (DHCS), and the Centers for Medicare and Medicaid Services (CMS). Each reporting entity prescribes performance measures for IEHP and is based on IEHP's Member population. Measures typically remain consistent from year to year; however, program changes and measure updates may result in larger performance rate changes.

NCQA

NCQA reporting requirements are based on accreditation standards for the health plan's lines of business. NCQA identifies Health Plan Rating performance measures from the full set of HEDIS® measures. The weighted Health Plan Rating (HPR) measure average result is combined with the accreditation point calculation for IEHP's overall NCQA designated plan rating. To comply with reporting standards, IEHP undergoes a HEDIS® Compliance Audit each year. IEHP's information systems and data collection capabilities are evaluated for validity and completeness.

DHCS

The California Department of Health Care Services (DHCS) also makes use of HEDIS® measures for annual quality reporting. However, because children make up a large proportion of Medi-Cal (Medicaid) plan membership, additional pediatric measures are included in the DHCS reporting set. DHCS also requires that plans undergo a HEDIS® Compliance Audit each reporting year. Plans are held to minimum performance level (MPL) for specific measures which are part of the Managed Care Accountability Sets (MCAS).

CMS

The Centers for Medicare and Medicaid Services (CMS) also makes use of HEDIS® measures for annual quality reporting for the Medicare population. CMS also requires that plans undergo a HEDIS® Compliance Audit each reporting year.

CMS utilizes the Part C and D Star Ratings program to provide quality and performance information to Medicare beneficiaries. The Star Ratings program focuses on optimizing health outcomes by improving quality and the health care system. Measures within the program follow five (5) broad categories: Outcomes, Intermediate Outcomes, Patient Experience, Access, and Process. Although IEHP does not currently report this measure set to CMS, IEHP performs monitoring oversight on these HEDIS® measures.

QRS

The Centers for Medicare & Medicaid Services (CMS) publishes guidance for Qualified Health Plans (QHP) in the Exchanges to specify requirements for participating in the Quality Rating System (QRS). The QRS measure set comprises clinical quality measures, including the NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) measures and PQA measures. The measure set also includes survey measures based on questions from the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey). HEDIS® Compliance Audit for QRS measures is required by CMS for each reporting year.

The Quality Transformation Initiative (QTI) is intended to set direct and substantial financial incentives for Covered California's contracted QHP issuers to improve the quality of healthcare and to reduce health disparities for Covered California Enrollees and all Californians. Specifically, the QTI focuses on improving care for a small number of clinically important conditions for which there are major opportunities for improvement and established measures in current use.

IEHP Quality Achievement Program

As part of IEHP's Quality Achievement Program, executive leadership annually identifies measures to support the Optimal Care goal. Quality achievement measures span across the Medi-Cal and DSNP lines of business. The Quality Achievement Program Measures for HEDIS® Measurement Year (MY) 2024 are:

MY 2024 IEHP Strategic Priority Measures		
PPC	Timeliness of Prenatal Care	Medicaid/Medi-Cal
PPC	Postpartum Care	
CIS	Childhood Immunizations – Combo 10	
IMA	Immunization for Adolescents – Combo 2	
WCV	Child & Adolescent Well-Care Visits	
W30	Well Child Visits in the First 30 Months of Life: First 15 Months	
W30	Well Child Visits in the First 30 Months of Life: 15-30 Months	
COL-E	Colorectal Cancer Screening	Medicare/HMO D-SNP
CBP	Controlling High Blood Pressure	

GSD	Glycemic Status Assessment for Patients With Diabetes – HbA1c Control (<8%)	

To generate the rates for different measures, the IEHP Quality Informatics team loads data in an NCQA certified HEDIS® software. Technical specifications from the *HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans* were utilized for measure reporting. HEDIS® Measurement Year (MY) 2024 includes measures across sixteen (16) domains:

- Effectiveness of Care
  - (1) Prevention and Screening
  - (2) Respiratory Conditions
  - (3) Cardiovascular Conditions
  - (4) Diabetes
  - (5) Musculoskeletal Conditions
  - (6) Behavioral Health
  - (7) Care Coordination
  - (8) Overuse/Appropriateness
  - (9) Measures Collected Through the Medicare Health Outcomes Survey
  - (10) Measures Collected Through CAHPS Health Plan Survey
  - (11) Access/Availability of Care
  - (12) Experience of Care
- Utilization and Risk Adjusted Utilization
  - (13) Utilization
  - (14) Risk Adjusted Utilization
  - (15) Health Plan Descriptive Information
- Measures Reported Using Electronic Clinical Data Systems
  - (16) Measures Reported Using Electronic Clinical Data Systems

Data collection methods for HEDIS® measures include administrative, hybrid, survey, and electronic clinical data systems data (ECDS). Administrative information is collected through claim and encounter data. Hybrid measure information is captured using administrative data supplemented with medical record review of a sample population. Hybrid specifications allow for a drawing of a reduced, random sample using an NCQA-approved proportional systematic sampling method. A medical record review is conducted for these hybrid measures. Survey data is captured from Member surveys and ECDS data is obtained from electronic data exchange systems with contracted partners for

data, such as electronic health records (EHRs) and clinical registries. Rates are reported separately for Medi-Cal, Medicare, and Exchange lines of business.

HEDIS® TIMELINE

HEDIS® data is collected throughout the year. In April 2024, technical specifications were finalized for MY 2024 with the *Volume 2 Technical Update and Value Set Directory*. From January to May 2025, administrative data from claims/encounters continued to be captured and medical records were retrieved from Providers and reviewed for hybrid measures. IEHP reported HEDIS® MY 2024 results to NCQA in June 2025.

QUALITY IMPROVEMENT ACTIVITIES

IEHP develops several Member and Provider engagement programs to improve HEDIS® rates. Interventions include a combination of incentives, outreach and education, Provider-level reports and gaps in care reports, and other activities deemed critical to improve performance. These interventions are tracked and monitored in the QMHET and CLAS Work Plan and are presented at the QI Subcommittee. In addition, IEHP's performance on HEDIS® measures is reported and discussed annually at the QI Subcommittee, who provides guidance on prioritizing measures for the subsequent year(s). IEHP's goal is to continually develop and implement interventions that are aimed at improving HEDIS® rates and quality of care for its Members.

PERFORMANCE REVIEW OF MANAGED CARE ACCOUNTABILITY SET (MCAS)

Managed Care Accountability Set (MCAS) is founded on the CMS Child and Adult Core Set Measures, which includes NCQA HEDIS® measures. Given that children represent a significant portion of Medicaid/Medi-Cal membership, DHCS incorporates additional pediatric measures into the reporting set and mandates that Managed Care Plans (MCPs), such as IEHP, undergo a HEDIS® Compliance Audit each reporting year. For Measurement Year (MY) 2024, DHCS requires reporting on specific measures across the behavioral health, children's health, chronic disease management, reproductive health, and cancer prevention domains. DHCS establishes a Minimum Performance Level (MPL) for these measures, generally aligned with the NCQA Quality Compass® Medicaid 50th percentile.

IEHP regards MCAS performance as a top priority, as these measures guide the development of its Strategic Plan, QI activities, and department initiatives. Plans that do not meet the established MPL may face financial sanctions and are required to implement quality improvement work for underperforming measures. Furthermore, MCAS performance serves as a key determinant in the DHCS Auto-Assignment Incentive Program, which impacts membership growth. IEHP seeks to not only meet and exceed the MPL but achieve the MCAS High Performance Level (HPL) set at the 90th percentile for qualified measures.

IEHP proactively oversees its performance against these benchmarks to evaluate and enhance clinical quality of care. This evaluation yields insights into Member and Provider behavior, guiding the development of QI activities that are both pertinent and responsive. Based on prior year's performance, IEHP continues to focus on opportunities to improve key MCAS and Auto-Assignment measures, including but not limited to: Childhood Immunization Status (CIS-10), Immunizations for Adolescents (IMA-2), Lead Screening in Children (LSC), and Well-Child Visits (W30 and WCV). Detailed plans on activities to meet or exceed the MPL and HPL for these measures can be found in the CY 2025 Comprehensive Quality Strategy.

PERFORMANCE IMPROVEMENT PROJECTS (PIPs) AND QUALITY ACTIVITIES

IEHP implements quality improvement activities as required by regulatory agencies (DHCS, CMS) and in accordance with requirements in the Capitated Financial Alignment Model. Additionally, in the 2022 Comprehensive Quality Strategy (CQS), the California Department of Health Care Services (DHCS) established children's preventive care, maternal health/birth equity, and behavioral health integration as its core clinical priorities. To drive these improvements, DHCS launched the Bold Goals *50x2025* initiative, which remains a central component of the updated 2025 CQS as it works toward its final targets. The 2025 CQS builds on this foundation by expanding its population health management approach to include behavioral health delivery systems, identifying fourteen (14) specific outcomes for statewide improvement. This expanded strategy specifically targets high-needs populations that face the greatest health disparities, including: individuals with behavioral health conditions who are experiencing homelessness, those involved with or at risk of entering the justice system, youth within the child welfare system, and individuals at high risk of being institutionalized.

1. **Performance Improvement Projects (PIPs)** – A thorough analysis of a targeted problem is completed. A baseline and key indicators are established and then interventions are implemented. Interventions are designed to enhance quality and outcomes that benefit IEHP Members. DHCS Medi-Cal Managed Care Division contracts with Health Services Advisory Group (HSAG), and external quality review organization (EQRO) to conduct validation of these projects.
2. **NCQA Quality Activities** – These are quality improvement activities conducted to meet NCQA accreditation standards.

The Quality Improvement Department, under the direction of the Director of Quality Improvement, is responsible for monitoring these programs and implementing interventions to make improvements.

Report Name	Reporting Agency	Type of Report
IEHP Quality Management and Health Equity Transformation Program (QMHETP) Annual Evaluation [Medi-Cal, HMO D-SNP, IEHP Covered]	NCQA DHCS	Annual Evaluation Report
IEHP A3 Lean Process	DHCS	SMART Goal
External Quality Review Recommendations	DHCS	Quality Improvement Activities

Institute for Healthcare Improvement (IHI) Collaboratives	DHCS	Collaborative Projects
2023–2026 Clinical PIP - Improve Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) measure rates for Black/African American Populations	DHCS	Clinical PIP
2023–2026 Non-Clinical PIP – Improve the percentage of Provider notifications for Members with SUD/SMH diagnoses following or within 7 days of emergency department (ED) visit	DHCS	Non-Clinical PIP
CAHPS® Survey	AHRQ (HHS) CMS	Survey Analysis

CONTINUITY AND COORDINATION OF CARE STUDIES

Continuity and coordination of care are key determinants for overall health outcomes. Comprehensive coordination of care improves Member safety, avoids duplicate assessments, procedures or testing, and results in better treatment outcomes. IEHP evaluates continuity and coordination of care on an annual basis through multiple studies. The purpose of these studies is to assess the effectiveness of the exchange of information between:

1. Medical care Providers working in different care settings; and
2. Medical and behavioral healthcare Providers.

The results of these studies are presented and discussed by the PHM Subcommittee and QMHETC. Based on these findings, the committee Members recommend opportunities for improvement that are implemented by the responsible department.

IMPROVING QUALITY FOR MEMBERS WITH COMPLEX NEEDS

IEHP has multiple programs, at no cost to the Member, that focus on improving quality of care and services provided to Members with complex medical needs (i.e., chronic conditions, severe mental illness, long-term services and support) and Seniors and Persons with Disabilities (SPD), including physical and developmental, as well as quality of behavioral health services focused on recovery, resiliency, and rehabilitation. These programs include, but are not limited to, the following:

Complex Care Management (CCM) Program

The CCM program was established for Members with chronic and/or complex conditions. The goal of the CCM program is to optimize Member wellness, improve clinical outcomes, and promote self-management and appropriate resource management across the care continuum, through efficient care coordination, education, referrals to health care resource, and advocacy. IEHP assesses the

performance of the CCM program annually using established measures and quantifiable standards. These reports are presented to the PHM Subcommittee and QMHETC for discussion and input. Based on the Committee's recommendations, the Care Management Department collaborates with other Departments within the organization to implement improvement activities.

Transition of Care (TOC) Program

IEHP has developed a system to coordinate the delivery of care across all healthcare settings, Providers, and services to ensure all hospitalized Members are evaluated for discharge needs to provide continuity and coordination of care. Multiple studies have shown that the poor transition between care settings have resulted in an increase in mortality and morbidity. Transitioning care without assistance for Members with complex needs (e.g., SPD Members that very often have three (3) or more chronic conditions) can be complicated by several other health and social risk factors. IEHP's TOC program has been designed to provide solutions to these challenges. Through the TOC program, IEHP makes concerted efforts to coordinate care when Members move from one setting to another. This coordination ensures quality of care and minimizes risk to Member safety. IEHP also works with the Member or their caregiver to ensure they have the necessary medications/supplies to prevent readmissions or complications. The goals of the TOC program include the following:

1. Avoiding of hospital readmissions post discharge
2. Improvements in health outcomes post discharge from inpatient facilities; and
3. Improving Member and caregiver experience with care received.

Facility Site Review (FSR) / Medical Record Review (MRR) and Physical Accessibility Review Survey (PARS)

IEHP requires all Primary Care Physician (PCP) sites to undergo an initial Facility Site Review (FSR) and Medical Record Review (MRR) Survey performed by a Certified Site Reviewer (CSR) prior to the PCP site participating in the IEHP network. The purpose of the FSR/MRR is to ensure a PCP site's capacity to support the safe and effective provision of primary care services.

In addition to the FSR/MRR, IEHP also conducts a Physical Accessibility Review Surveys (PARS) prior to the PCP site participating in the IEHP network. The purpose of the PARS is to assess the physical accessibility, physical appearance, safety, adequacy of room space, availability of appointments, and adequacy of record keeping, and any other issue that could impede quality of care. PARS also ensures Provider sites that are seeing Members with disabilities do not have any physical access limitations as when visiting a Provider site.

The FSR/MRR and PARS are conducted every three (3) years. Sites will be monitored every six (6) months until all deficiencies are resolved. The Quality Management Department is responsible for oversight of PARS and FSR/MRR activities. In partnership with IEHP key stakeholders, the QM Department is also responsible for providing training should physical access issues or deficiencies be identified. The QMHETC reviews an annual assessment of PARS activities to ensure compliance.

Initial Health Assessment Monitoring

IEHP also monitors the rate of Initial Health Assessments (IHA) performed on new Members. The timeliness criteria for an IHA is within one hundred twenty 120 calendar days of enrollment for Members. This rate is presented to QI Council for review and analysis. IEHP has a number of Member and Provider outreach programs to improve the IHA rate.

Clinical Practice Guidelines (CPGs) and Preventive Health Guidelines

To make health care safer, higher quality, more accessible, equitable and affordable, IEHP has adopted evidence-based clinical practice guidelines for prevention and chronic condition management. In addition, IEHP considers recommendations for Adult and Pediatric Preventive Services per DHCS contractual requirements which include criteria for the following:

1. FSR/MRR Documentation;
2. Select United States Preventive Services Task Force (USPSTF) recommendations;
3. The American College of Obstetricians and Gynecologists (ACOG);
4. American Diabetes Association (ADA);
5. Bright Futures from American Academy of Pediatrics (AAP); and
6. IEHP/Advisory Committee on Immunization Practices (ACIP) Immunizations Schedule.

Over-Utilization and Under-Utilization

1. IEHP monitors over-utilization and under-utilization of services at least annually. The QM and UM departments work collaboratively to capture utilization trends or patterns. The results are compared with nationally recognized thresholds. Under-utilization of services can result due to a number of reasons that include but are not limited to the following:
    a. Access to health care services based on geographic regions;
    b. Demographic factors also impact over-utilization and under-utilization of services/care:
        i. Race, ethnicity, and language preference (RELP);
        ii. Knowledge and perceptions regarding health care which are largely driven by cultural beliefs; and
        iii. Income and socioeconomic status.
2. IEHP also reviews trends of ER utilization, pain medications prescriptions, and potential areas of over-utilization on an annual basis. The purpose of the analysis is to:
    a. Identify the dominant utilization patterns within the population.
    b. Identify groups of high and low utilizers and understand their general characteristics.

CAHPS® Survey Report (Medi-Cal)

The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey is a standardized assessment conducted annually to assess the experiences of beneficiaries in Medicare Advantage plans. The overall objective of the Medicare CAHPS® study is to capture accurate and complete information about consumer-reported experiences with health care. CMS uses this information to assign Star Ratings to health plans.

The use of the Medicare CAHPS® survey measures to assess how well plans meet their members' expectations and goals, determine areas of service that have the greatest effect on Members' overall satisfaction, and identifies areas of opportunity for the purpose of increasing the quality of care through quality initiatives.

The goal of the Medicare CAHPS® Survey is to meet or exceed Dual Special Needs Plan (D-SNP) average rate benchmarks published by CMS.

The 2025 administration of the Medicare Advantage Prescription Drug CAHPS® Survey (MA-PD CAHPS®) was conducted in the first half of 2025 and measured members' experiences over the previous six (6) months.

The population was composed of the Medicare DualChoice (SNP) beneficiaries, 18 years and older, enrolled in the contract continuously for six (6) months or longer (at the time of the sample draw), living in the United States and not institutionalized. Six (6) ineligible Members were excluded from the population, including those who are institutionalized (3), or mentally/physically incapable of completing the survey (3).

Sample size consisted of 475 valid collected surveys from the Medicare DualChoice (SNP) sample of 1,473 eligible Members. Delivery modalities consisted of 341 mail, 111 phone, and 29 internet (Note: *the sum of mail & phone completes may be slightly different than the completes reflected in the response rate calculation due to valid surveys marked as disposition 34).* The survey response rate was 32.0%, compared to the response rate of 29.3% for the previous 2024 Medicare survey. A response rate is only calculated for those Members who were eligible and able to respond.

The survey was sent and collected via mail, administered telephonically or electronically by Press Ganey. Surveys were available in both English and Spanish. Comprehensive quantitative analysis of the survey responses was compiled by CMS and presented to IEHP in a final report.

This study includes the measurement years 2023 to 2024 scores for IEHP for composites measures, overall ratings, and the single-item measures when available. Measurement year 2021 results reflect the Cal MediConnect (CMC) survey and have been included for 3-year trending comparison only. Summary rates for all areas are taken from the Press Ganey final report. Measures with less than 100 responses are not reported by CMS. The Medicare CAHPS® survey was not fielded for 2023 (MY2022) due to the sunsetting of IEHP's CalMediConnect product on 12/31/2022. As of 1/1/2023, IEHP launched Medicare benefit coverage under the Dual Special Needs Plan (D-SNP) contract. Summary rates for all areas are taken from the 2024 Medicare Advantage Prescription Drug CAHPS® survey results.

CAHPS® Survey Report (Medi-Cal)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.1H Survey is a standardized Member experience assessment. The CAHPS® Health Plan Survey is a tool for collecting information on enrollees' experiences with health plans and their services. It supports consumers in assessing the performance of health plans and health plans can also use the survey results to identify their strengths and weaknesses and target areas for improvement.

The CAHPS® survey is a vital tool for IEHP to assess Member-centered results of the care delivered, identify areas for improvement, and develop improvement initiatives. The survey asks Members to report on the aspects of their experiences around healthcare domains such as access to care, how well their doctors communicate, customer service, and coordination of care.

The purpose of this study is to analyze the annual CAHPS® results for the Medi-Cal Adult and Child populations. The analysis can be used to identify opportunities for improvement for CAHPS® measures that are not scoring well.

The goal of the Medi-Cal CAHPS® Survey is to meet the NCQA 90th percentile national benchmarks. Measure goals and benchmarks presented in this study are obtained from the 2025 NCQA Health Plan Ratings published in August 2025 for Health Plan Rating (HPR) measures and from 2024 NCQA Quality Compass National Benchmarks published in September 2025 for non-Health Plan Rating measures.

Press Ganey conducted the Member experience survey from February 2025 through May 2025. For the Medi-Cal CAHPS® Adult section of this report, a random sample of 1,836 cases was drawn from IEHP Members 18 years of age or older as of December 31, 2024, who were continuously enrolled with IEHP for the last six (6) months as of December 31, 2024. Out of the 1,836 cases, 27 were ineligible and removed from the denominator. A total of 198 surveys completed were valid with 111 completed by mail, 51 completed by phone, and 36 completed by internet for a total response rate of 10.9%.

For the Medi-Cal CAHPS® Child section of this report, a random sample of 2,244 cases were drawn from IEHP Members 17 years of age or younger as of December 31, 2024, who were continuously enrolled with IEHP for at least five of the last six months of 2024. Out of the 2,244 cases, 15 were ineligible and removed from the denominator. A total of 177 completed surveys were valid with 47 completed by mail, 75 completed by phone, and 55 completed by internet. This yielded a response rate of 7.9%.

Press Ganey, an NCQA Certified Survey Vendor, was selected by Inland Empire Health Plan to conduct its MY 2024 Medicaid CAHPS® Survey. A comprehensive report of results and analyses was submitted to IEHP.

The survey was conducted using a mixed methodology approach (mail, telephone, and internet). The telephone surveys were conducted with Members who did not respond to the mail or internet survey. The mail, telephone, and internet surveys were available in both English and Spanish. Comprehensive quantitative analysis of the survey responses was compiled by Press Ganey and presented to IEHP in a final report.

The Adult and Child Medicaid Members were surveyed separately; therefore, results in this report are presented separately for Adult and Child populations. In addition, an analysis of race/ethnicity and Member experience by IPA is also included.

This study includes the measurement years 2022 to 2024 scores for IEHP for composites measures, overall ratings, and the single-item measures when available. Summary rates for all areas are taken from the Press Ganey final report. Measures with less than 100 responses are not reported to NCQA. Changes from MY 2023 to MY 2024 were assessed using a z-test of proportions. A p-value of <0.05 is set as the standard of statistical significance.

QUALIFIED HEALTH PLAN (QHP) ENROLLEE EXPERIENCE SURVEY REPORT (COVERED CALIFORNIA)

As a condition of participation in the Exchanges, CMS requires that Qualified Health Plan (QHP) issuers submit Quality Rating System (QRS) clinical measure data and Qualified Health Plan (QHP) Enrollee Survey response data for their respective QHPs offered through an Exchange in accordance with CMS guidelines.

The QHP Enrollee Survey is used to measure the experience of the enrollee population in the Exchanges. While the survey uses questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Surveys, modifications and new questions were designed specifically for use with the Exchange enrollee population. Measures derived from a subset of survey questions are included in the QRS measure set and accompanying ratings. CMS uses this information to assign Star Ratings to health plans.

The goal of the QHP Enrollee Survey report is to assess how well IEHP has met their members' expectations and goals, determine areas of service that have the greatest effect on Members' overall satisfaction, and identify areas of opportunity for the purpose of increasing the quality of care through quality initiatives.

The 2025 administration of the QHP Enrollee Experience Survey was conducted February 2025 to May 2025 and measured members' experiences over the previous six (6) months. The population was composed of beneficiaries who had primary coverage through Covered California , 18 years and older, enrolled in the contract continuously for six months or longer (at the time of the sample draw), living in the United States and not institutionalized. Twenty-one ineligible Members were excluded from the population, including deceased (1), or institutionalized, mentally/physically incapable of completing the survey (20).

Sample size consisted of 118 valid collected surveys from the sample of 1,691 eligible Members. Delivery modalities consisted of 44 mail, 30 phone, and 44 internet. The survey response rate for this first year of administration was 14.7%. A response rate is only calculated for those Members who were eligible and able to respond.

The survey was sent and collected via mail, administered telephonically or electronically by Press Ganey. Surveys were available in both English and Spanish. Comprehensive quantitative analysis of the survey responses was compiled by Press Ganey and presented to IEHP in a final report.

This study includes the final results for measurement year 2024 scores for IEHP for composites measures, overall ratings, and the single-item measures when available. Summary rates for all areas are taken from the Press Ganey final report. Measures with less than 100 responses are not reported by CMS.

POPULATION HEALTH MANAGEMENT (PHM) PROGRAM DESCRIPTION

IEHP's vision for Population Health is explained as an organizational commitment: IEHP commits to assure a culture of health and equity, internally and along with our Members, Providers, and Partners, where everyone in the Inland Empire has the opportunity to live their healthiest life. The IEHP Population Health Vision is focused on the complete physical, social, and mental well-being of the Member as part of the community. This vision reflects a desire to accomplish population management and population health.

Population Management is the delivery of health care services toward the achievement of specific health care related metrics and outcomes for a defined population. Population Health is ensuring the health outcomes of a group of individuals, including the distributions of such outcomes within a group.

IEHP's Population Health Strategy is a plan of action for identifying and addressing individual and population-based needs. It is Member-centered and based on standardized assessment processes, data analyses, and risk stratification. Data tools and systems integrate data from multiple sources, both from within the health plan and from external systems such as state registries, health information exchanges, provider electronic medical records and other publicly available community data sets. This information is used to identify disparities and priority population needs. Programs and services are then developed to engage with Members, Providers, and community-based organizations to improve health outcomes. IEHP ensures that Members receive Whole-Person Care through its strategy in targeting social determinants of health that create health inequities of Members.

Strategy Objectives

1. Achieve improved physical health and psychosocial outcomes, lower overall healthcare costs by decreasing preventable health care expenditures, and enhance patient experience of health care;
2. Risk stratify populations utilizing predictive and psycho-social models;
3. Improve IEHP internal processes to promote an approach to population health that is whole person and patient centered, transdisciplinary, evidence-based, and reflects empathy and personalized services/supports;
4. Manage Member safety outcomes during transitions, across settings through effective care coordination; and
5. Identify social determinants of health and reduce health disparities.

Areas of Focus

IEHP's PHM Strategy ensures that all population health priorities, programs, and interventions align across four (4) areas of focus. These areas of focus are designed to ensure that IEHP is meeting the needs of Members at all points across the continuum of care.

1. **Keeping Members Healthy:** Members who are healthy or who have a well-managed condition;
2. **Members with Emerging Risk:** Members who have multiple risk factors, such as an individual with chronic diabetes who also has mild to moderate depression or a tobacco addiction;
3. **Patient Safety or Outcomes Across Settings**: Interventions in this focus area address Members whose safety and/or health outcomes are at risk due to care transitions; and
4. **Members with Multiple Chronic Illnesses or At High Risk:** Members with multiple chronic conditions, including behavioral health conditions, and complicated psychosocial factors.

CalAIM (California Advancing and Innovating Medi-Cal) Implementation

CalAIM is a transformative, multi-year initiative led by California's Department of Health Care Services (DHCS) that aims to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing delivery system and payment reforms across the program. CalAIM leverages Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents and takes a person-centered approach that targets social determinants of health and reduces health disparities and inequities.

The primary goals of CalAIM are to:

1. Identify and manage member risk and needs through whole person care approaches and address social determinants of health.
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
3. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reforms.

IEHP continues to develop and implement CalAIM Population Health requirements and incorporate them into the IEHP Population Health Program.

Closed Loop Referrals

Closed-Loop Referrals (CLR) are a key component of DHCS' Population Health Management Program under CalAIM. IEHP uses a standardized process to operationalize a Closed Loop Referral for Community Supports and Enhanced Care Management. A Closed Loop Referral is initiated from internal or external sources of IEHP on behalf of a Member that is tracked, supported, monitored via a dashboard to ensure referral is closed.. A known closure occurs when a Member's initial referral loop is completed with a known closure reason such as the "Member receiving services." IEHP monitors the progress of referrals to support timely connection of Members to services.

Bold Goals: 50x2025 Initiative

Population Health Management is a broader arc of change to improve health outcomes. In an effort to improve health outcomes, DHCS's Comprehensive Quality Strategy (CQS) highlights three "Clinical Focus Areas" which include children's preventive care, behavioral health integration, and maternity outcomes/birth equity. CQS established the Bold Goals: 50x2025 initiative to drive specific and accelerated improvement in these three areas. PHM Programs continue to be developed to help achieve the following Bold Goals:

1. Close racial/ethnic disparities in well-child visits and immunizations by 50%.
2. Close maternity care disparity for Black and Native American persons by 50%.
3. Improve maternal and adolescent depression screening by 50%.
4. Improve follow-up for mental health and substance use disorder by 50%.
5. Ensure all health plans exceed the 50th percentile for all children's preventative care measures.

PHM Population Assessment Study

Annually, IEHP assesses the characteristics of the membership to identify Member needs and to review and update its Population Health Management (PHM) structure, strategy, and resources. IEHP assesses areas such as social determinants of health, identification of subpopulations, needs of children/adolescents and individuals with disabilities and with serious and persistent mental illness (SPMI). Furthermore, health disparities among different populations are identified. The needs of Members of different ethnic groups and of those with limited English proficiency (LEP) are also included in this analysis.

Data was extracted from IEHP's claims and encounters systems, IEHP's Medical Management System (MedHOK), HEDIS® data and ACG data. All Members who were currently active at the time of the study (January 2025) were

included in this analysis. The assessment includes membership from both the Medi-Cal and Medicare lines of business. The following individuals participated in this analysis: Vice President of Quality, Sr Director of Quality, Senior Director of Population Health, Clinical Informatics Manager. The results of these analyses are presented to IEHP's Population Health Management Subcommittee annually for review, comment, and approval.

Study Measures

1. Assesses the characteristics and needs, including social determinants of health, of its member population using the following analysis:
    - Seniors and Persons with Disabilities (SPD) breakdown by line of business
    - Ethnicity
    - Language
    - Age
    - Homeless
    - Transportation Needs
    - Top Diagnosis
        - Overall Chronic conditions
        - Social Determinants of Health Top Diagnoses (All Plan Letter 21-009 'Collecting SDOH Data')
    - HEDIS® Disparities
        - Disparity analysis for Members using key quality of care measures in Disease Management, Behavioral Health, and Women's Health. (using HEDIS® measures) Disparity analysis includes ethnicity and language.
2. Identifies and assesses the needs of relevant member subpopulations using the following analysis:
    - Frail and Elderly
    - Chronic Condition Count (ACG)
    - Direct Vs. Delegated Membership distribution
    - IPA Membership
    - Risk Categorization (High risk, Rising risk, low risk)
3. Assesses the needs of child and adolescent members using the following analysis:
    - Children with Special Needs
    - Age ranges of children enrolled in the BHT Program
    - Childhood Depression Stats
    - Top Diagnoses – Child / Adolescents (ages 2-20)
4. Assesses the needs of members with disabilities and serious and persistent mental illness (SPMI):

- Top Diagnoses- SPD
- Top BH Diagnoses
- Top BH Medications Filled by County

5. Assesses the needs of members of racial and ethnic groups:
    - Disparity analysis for Members using key quality of care measures in Disease Management, Behavioral Health, and Women's Health (using HEDIS® measures).
    - Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Medicaid Disparity analysis for Members of different ethnicities (White, Black, Hispanic, Asian, Native Hawaiian, American Indian) was assessed using the following key measures: Overall Rating of Health Plan, Overall Rating of Health Care, Getting Needed Care, Getting Care Quickly, Rating of Personal Doctor, Rating of Specialist, Customer Service, How Well Doctors Communicate, and Coordination of Care. The annual survey results are conducted by a third-party vendor.
6. Assesses the needs of Members with limited English proficiency (LEP)
    - Hanna Interpreting Service, a third-party vendor is utilized by IEHP Members when requesting face to face interpreters during the Member's medical appointments.
    - Pacific Interpreters, a third-party vendor, submitted data to IEHP for calendar year 2024.
    - Disparity Analysis by language (including Spanish, Vietnamese, Mandarin, and Cantonese) for Members using key quality of care measures in Disease Management, Behavioral Health, and Women's Health.
    - CAHPS® Member experience survey results are assessed by Primary member language, English and Spanish. Key measures assessed include: Overall Rating of Health Plan, Overall Rating of Health Care, Getting Needed Care, Getting Care Quickly, Rating of Personal Doctor, Rating of Specialist, Customer Service, How Well Doctors Communicate, and Coordination of Care. The annual survey results are conducted by a third-party vendor.

Member Population

Table 1 shows Members with an SPD Aid code. These SPD Members require a higher level of care management as they are identified as high-risk and composed of 4.6% of IEHP's total Member population.

Table 1: SPD Breakdown by Line of Business

Category	SPD	Non-SPD	All
D-SNP	0	38,460	38,460
MMD	0	107,971	107,971
D-SNP and MMD	0	0	0
Non-DSNP/Non-MMD	78,549	1,496,877	1,575,426
Total	**78,549**	**1,643,308**	**1,721,857**

PHM STRATEGY EFFECTIVENESS STUDY

The organization measures the effectiveness of its Population Health Management (PHM) Strategy. Annually, IEHP outlines its PHM Strategy for meeting the care needs of its Members and designs a cohesive plan of action to address Members' needs. This study assesses the impact of the PHM Strategy using clinical, utilization and Member experience measures and identifying opportunities for improvement in accordance with NCQA Standard PHM 6 Elements A and B.

This study assesses the effectiveness of the following programs: Enhanced Care Management Program (ECM), My Path, IEHP's Housing Benefit with Community Supports, the Complex Case Management (CCM) Program, and the Healthy Schools Program

The Enhanced Care Management (ECM) Program began in January 2022. The populations of focus that it serves are homeless, adults who are high utilizers or have serious mental illness/substance use disorder, and Members leaving incarceration. The ECM Program is a clinical service delivery model that focuses on providing individualized, whole-person care by a trained, integrated care team that works in close connection with the Member's Primary Care Provider (PCP). This integrated care team provides an intensive set of services to Members who require coordination of care at the highest levels. The ECM Program's overarching goals are to improve care coordination, integrate services, facilitate community resources, address social determinants of Health (SDOH), improve health outcomes, and decrease inappropriate utilization and duplication of services.

Members experiencing housing insecurity may benefit from being referred to one or more of the housing-related services provided under CalAIM Community Supports. These services can substitute for and potentially decrease utilization of a range of covered Medi-Cal benefits, such as hospital care, nursing facility care, and emergency department (ED) use. If the Member meets criteria for Community Supports, the assigned Community Supports Provider(s) will assist the Member with potential housing options and other supportive services. IEHP offers a robust and comprehensive menu of 14 pre-approved Community Supports to comprehensively address the needs of the Members, which includes those with the most complex challenges affecting health such as homelessness, unstable and unsafe housing, food insecurity and/or other social needs. The effectiveness of the five (5) community supports services related to Housing will be measured in this study.

My Path is a palliative care approach for IEHP Members with advanced diseases. These Members have a life expectancy of two (2) years or less and are most likely to use the emergency room to best manage their symptoms and disease. The My Path Program is a patient and family-centered approach that addresses the physical, emotional, social, and spiritual needs of our Members and caregivers. My Path's goal is to optimize the quality of life by anticipating, preventing and treating suffering.

Complex Case Management (CCM) provides coordination of care and services to Members who have experienced a critical event or diagnosis that requires the extensive use of resources. The purpose of the CCM Program is to improve the quality of life for the Member and ensure that Members obtain optimal health through appropriate settings, time frames, and provider utilization. The program is designed based on the principles of case management as defined by the Case Management Society of America. Clinical practice guidelines are used to develop goals and interventions for conditions that are identified as program triggers and common comorbidities.

The Healthy School Program provides targeted services and support to identified students and families promoting appropriate utilization of benefits, healthcare access navigation and linkage to community resources based on

identified need. In partnership with Local Educational Agencies (LEA) in the Inland Empire, the program empowers Members to understand the importance of utilization of preventative services and mental health. The program provides targeted on-site and at home support to students and families, identifies and closes gaps in care related to immunizations and well child visits, provides education, and assists with coordination of referrals to other Programs.

Study Period and Population

Members enrolled in the program during 2023-2024 are included in the results.

Data Collection and Methodology

Data sources used include Enrollment, Claims, Encounters, Pharmacy Claims, Care Management Systems Data.

Administrative data was extracted from all data sources listed above. Once all data was compiled, an analysis was reviewed and approved by the following individuals: Vice President of Quality, Senior Director of Integrated Care management, Director of Integrated Care Management, Care Management Medical Director, Director of Community Supports, Clinical Director of Community Behavioral Health, Health Services Evaluation Manager, and BHCM Manager. The results of these analyses are presented to IEHP's Population Health Management (PHM) Subcommittee annually for review, comment, and approval.

PHM Programs and Study Measures

The ECM Program is a clinical service delivery model that focuses on providing whole person care to high-risk Members. This study examines five (5) measures to determine the effectiveness of program goals for blood pressure control, depression documentation, depression response, transition of care, and member experience. This program addresses the following areas of focus: Managing Members with Multiple Chronic Illnesses and Managing Members with Rising Risk. Each measure is described on the table below. The ECM Program targets Medi-Cal Members.

DELEGATION OVERSIGHT (AUDITING AND MONITORING ACTIVITIES)

IEHP does not delegate quality or health equity activities. Standards that are delegated include Credentialing/Re-Credentialing and Utilization Management.

IEHP performs a series of activities to monitor IPAs and other Delegates:

1. An annual Delegation Oversight Audit is conducted using a designated audit tool that is based on the NCQA, DMHC and DHCS standards. Delegation Oversight Audits are performed by IEHP Health Services, Provider Services and Compliance Staff using the most current NCQA, DHCS, CMS and IEHP standards;
2. Joint Operations Meetings (JOM) – These meetings are called by IEHP as a means of discussing performance measures and findings as needed. The JOM includes representation from the delegate and IEHP Departments as applicable;
3. Review of grievances and other quality information;
4. Specified audits:
    a. Focused Approved and Denied Referral Audits;
    b. Focused Case Management Audits;

c. Utilization data review (Denial/Approval Rates, timely Member notification, overturn rate; and

d. Provider Satisfaction Surveys.

5. IPAs are required to submit the following information to the IEHP Provider Services Department:

   a. Utilization Management (UM) Trend Report – Monthly report of utilization data;

   b. Referral Universe and Letters – Monthly report of all approvals, denials and modifications of requested services;

   c. Care Management (CM) Log – Monthly report of CM activities;

   d. Second Opinion Tracking Log – Monthly report to track Member requested second opinions;

   e. Credentialing Activity – Periodic report of any changes to the network at the Delegate level (e.g., terminated PCPs, specialists);

   f. Annual QMHETP and UM Program Descriptions;

   g. Annual QMHETP and UM Work Plans;

   h. Semi-annual reports of quality improvement activities;

   i. Semi-annual reports of credentialing/re-credentialing;

   j. Quarterly reports of utilization management activities; and

   k. Annual QMHETP and UM Program Evaluations.

6. IPAs and Health Plans with trends of deficient scoring must submit a CAP to remedy any deficiencies. If an IPA is unable to meet performance requirements, IEHP may implement further remediation action including but not limited to:

   a. Conduct a focused re-audit;

   b. Immediately freeze the IPA to new Member enrollment, as applicable;

   c. Send a 30-day contract termination notice with specific cure requirements;

   d. Rescind delegated status of IPA or Provider, as applicable;

   e. Terminate the IEHP contract with the IPA or Provider; or

   f. Not renew the contract.

7. Assessment and Monitoring: To ensure that IPA or Providers have the capacity and capability to perform required functions, IEHP has a rigorous pre-contractual and post-contractual assessment and monitoring system. IEHP also provides clinical and Member experience data to Delegates upon request so they can initiate improvement activities.

8. Pre-Delegation Evaluation: All Providers desiring to contract with IEHP must complete a comprehensive pre-contractual document and on-site review.

9. Reporting: IEHP's Delegation Oversight Committee (DOC) monitors and evaluates the operational activities of contracted Delegates to ensure adherence to contractual obligations, regulatory requirements

and policy performance. Elements of delegation are monitored on monthly, quarterly and annual basis for trending and assessment of ongoing compliance. The reporting includes review of monthly assessment packets, encounter adequacy reports and Provider Services highlights. All oversight audits performed on delegates are reported to the DOC. CAP activities are implemented as deficiencies are identified. Findings and summaries of DOC activities are reported to the Compliance Committee.

DELEGATION OVERSIGHT STUDY (MEDI-CAL)

This study provides an annual assessment of the Annual Delegation Oversight Audit (DOA) which evaluates the Delegate's abilities to carry out their delegated responsibilities in the areas of Quality Management (QM), Utilization Management (UM), Care Management (CM), Credentialing (CR), Compliance & Fraud Waste and Abuse (FWA), Health Insurance Portability and Accountability Act (HIPAA) Privacy, and HIPAA Security. Oversight of Medi-Cal Delegates is conducted through regular extensive evaluations including monthly reporting and file audits, quarterly, semi- annual and annual reporting, and the annual DOA. The study lookback period is July 2023 through June 2024. The Delegation Oversight Annual Audit results are presented at the March 2025 Delegation Oversight Committee.

- Audit Study Period and Sample Size

This study includes the annual DOA results for all Medi-Cal Delegated Entities for the lookback period of July 2023 through June 2024.

Six (6) of the ten (10) Delegates include Medi-Cal IPAs: Alpha Care Medical Group, Dignity Health Medical Network-IE, Horizon Valley Medical Group, Optum Care Network - Inland Faculty Medical Group, LaSalle Medical Associates and Physicians Health Network. These entities are delegated for the functions of Utilization Management, Care Management, Credentialing and Claims Processing and Payment. The Annual Delegation Oversight Audit reviews the Delegate's policies and procedures and operational activities for Quality Improvement, Utilization Management, Care Management, Compliance & FWA, Credentialing, HIPAA Privacy and HIPAA Security.

One (1) of the ten (10) Medi-Cal Delegates: American Specialty Health, a provider of Acupuncture services and delegated for Utilization Management, is audited in the areas of Quality Improvement, Utilization Management, Compliance & FWA, Credentialing, HIPAA Privacy, and HIPAA Security.

One (1) of the ten (10) Medi-Cal Delegates: MD Live, a Provider of telehealth services who is delegated for Credentialing, is audited for the areas of Compliance and FWA, Credentialing, HIPAA Privacy, and HIPAA Security.

Two (2) of the ten (10) Medi-Cal Delegates: Loma Linda University Medical Center and Rady Children's Specialists of San Diego, delegated for Credentialing, are audited for Credentialing and Recredentialing activities.

Following the desktop review of all requested documentation, the scheduled virtual audit, which includes interviews and System File Reviews are conducted. Care Management (CM) and Delegation Oversight conducted their audits onsite.

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) PROGRAM DESCRIPTION

As the region's first Medi-Cal managed care plan, Inland Empire Health Plan (IEHP), a Joint Powers Agency, is a not-for-profit health plan. Established on July 26, 1994, IEHP received its Knox-Keene license from the California

Department of Managed Health Care (DMHC) on July 22, 1996. IEHP commenced operations on September 1, 1996. Today, IEHP serves more than 1.5 million residents in San Bernardino and Riverside counties. Since 1996, IEHP has worked to improve access to quality and equitable care for vulnerable populations. IEHP's mission is to heal and inspire the human spirit by placing Members at the center of its universe.

Purpose

The Culturally and Linguistically Appropriate Services (CLAS) Program Description is to integrate the National CLAS Standards within IEHP's operational framework to ensure the delivery of care and programs is safe, effective, patient centered, equitable, culturally, and linguistically appropriate for our diverse population as well as to inform and deploy initiatives to advance health equity, improve quality, and help eliminate health disparities.

IEHP is committed to providing services that are respectful of and responsive to each Member's culture and communication needs by taking into consideration cultural health beliefs, preferred languages, health literacy levels, and communication needs. The National CLAS Standards provide a framework and action steps to deliver services that are respectful, understandable, effective, and equitable. The CLAS Standards provide guidance on the following domains and is comprised of fifteen (15) Standards:

1. Principal Standard (Standard 1): Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
2. Governance, Leadership, and Workforce (Standards 2-4)
3. Communication and Language Assistance (Standards 5-8)
4. Engagement, Continuous Improvement, and Accountability (Standards 9-15)

The Principal Standard (Standard 1) frames the essential goal of all the Standards, and it will be achieved if the other fourteen (14) Standards are adopted, implemented, and maintained.

The CLAS Program fulfills IEHP's mission by ensuring that all medically necessary and covered services are available and accessible to all Members and potential Members, including those less than 21 years of age, regardless of race, color, national origin, creed, ancestry, religion, language, age, sex, gender identity, sexual orientation, sex characteristics, sex stereotypes, intersex traits, marital status, pregnancy or related conditions, health status, evidence of insurability, source of payment, limited English proficiency and primary language or disability, or any combination thereof, and that all covered services are provided in a culturally and linguistically appropriate manner.

IEHP is committed to fostering, cultivating, and preserving a culture of diversity, equity, and inclusion. IEHP believes that all persons are entitled to equal employment opportunities and does not discriminate against qualified Team Members or applicants because of race, color, religion, creed, pregnancy, national origin, ancestry, citizenship, age (40 and over), marital status, physical disability, mental disability, medical condition, sex, gender, gender identity, gender expression, sexual orientation, sex stereotypes, sex characteristics, including intersex traits, pregnancy, child birth, breast feeding or related medical conditions, genetic information, disabled veteran or veteran of the Vietnam era or any other characteristic protected by state or federal law, any combination thereof.

IEHP applies this same commitment in the way Team Members interact with Members, Providers, and other members of the community. CLAS are employed by all IEHP Team Members at every point of contact.

Program Objectives and Activities

The objectives of the CLAS program are to provide effective, equitable, understandable, and respectful quality care and services responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. To achieve these objectives, IEHP establishes methods that ensure and promote access and delivery of medically necessary services in a culturally competent manner to all Members, and potential members, including people with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. IEHP has defined the following objectives and activities:

- IEHP- and Member-Oriented

    1. Educate IEHP Team Members on cultural diversity within the Membership and raise awareness of IEHP Cultural and Linguistic policies, procedures, and resources through annual mandatory training.
    2. Assess the characteristics of IEHP's Membership to identify Member needs and review and updates its structure, operations, and resources accordingly.
    3. Evaluate areas such as Social Determinants of Health, identification of subpopulations, needs of children/adolescents and individuals with disabilities and with serious and persistent mental illness (SPMI), Members of Limited English Proficiency (LEP), disparities in Members of different racial and ethnicity groups, and disparities in Members with primary language other than English.

- Clinician-Oriented

    1. Ensure IEHP, its IPAs and Provider network comply with Department of Health Care Services (DHCS) and Federal regulations on Cultural and Linguistic services.
    2. Provide training, support, technical assistance, stigma reduction best practices and resources to IPAs, Providers and their office staff to assist them in the provision of culturally competent and linguistic services. Ensure that any lack of interpreter services does not impede or delay a Member's timely access to care.
    3. Monitor grievances and the clinician credentialing and recredentialing processes for discriminatory practices, at each point of the process.

Clinical Measures

1. Stratify by race/ethnicity the following measures to identify areas of opportunity to act:
    a. Medi-Cal
        - Child and Adolescent Well-Care Visits (WVC)
        - Childhood Immunizations Status- Combination 10 (CIS-10)
        - Asthma Medication (AMR)
        - Colorectal Cancer Screening (COL-E)
        - Breast Cancer Screening (BCS-E)
        - Glycemic Status Assessment for Patients with Diabetes (GSD): Glycemic Status <8%

- Glycemic Status Assessment for Patients with Diabetes (GSD): Glycemic Status >9%
- Controlling Blood Pressure (CBP)
- Timely Prenatal Care (PPC)
- Timeliness of Postpartum Care (PPC)
- Depression Screening and Follow-up for Adolescents and Adults (DSF-E)

b. IEHP DualChoice

- Controlling Blood Pressure (CBP)
- Glycemic Status Assessment for Patients with Diabetes (GSD): Glycemic Status <8%
- Glycemic Status Assessment for Patients with Diabetes (GSD): Glycemic Status >9%
- Adults Immunization Status – Influenza (AIS-E)

c. IEHP Covered

- Childhood Immunizations Status- Combination 10 (CIS-10)
- Colorectal Cancer Screening (COL-E)
- Glycemic Status Assessment for Patients with Diabetes (GSD): Glycemic Status <8%
- Controlling Blood Pressure (CBP)
- Timeliness of Postpartum Care (PPC)
- Timely Prenatal Care (PPC)
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

EQUITY-FOCUSED INTERVENTIONS

IEHP has compiled a Culturally and Linguistically Appropriate Services (CLAS) Program Description to integrate the National CLAS Standards within IEHP's operational framework to ensure the delivery of care and programs is safe, effective, patient centered, equitable, culturally, and linguistically appropriate manner for our diverse population as well as to inform and deploy initiatives to advance health equity, improve quality, and help eliminate health disparities.

Through this work, IEHP has identified patterns of underutilization of clinical services among a subset of our membership when stratified by race/ethnicity and language. Listed are some of these measures (by disparate population) and the intervention to address the clinical disparity:

- Controlling High Blood Pressure: Black/African American
    - o High-touch pilot partnership with a Community Based Organization in delivering heart health and hypertension management support. Community Health Worker's will use culturally relevant and community-centered approaches.
- Child and Adolescent Well-Care Visits: White and American Indian/Alaskan Native

    - Focused outreach by community health workers and other member-facing departments to support in the completion of visits.

- Prenatal/Postpartum Care: Black/African American
    - Collaboration with Enhanced Care Management (ECM) Birth Equity Providers to increase enrollment of members within disparity populations.
    - Targeted outreach by trained Community Health Workers.
    - Partnerships with county Black Infant Health Programs.
- Depression Screening and Follow-Up in Adolescents and Adults: Chinese-Speaking
    - Partnership with Provider Services and Community- Based Organizations to strengthen culturally appropriate depression screening by training providers and expanding awareness and access to multilingual tools.
- Adult Immunizations Status – Flu Vaccine: Black/African American
    - Targeted, culturally responsive outreach to reduce vaccination disparities. Flu vaccine messaging to be delivered through Community-Based Organizations, pharmacies, providers, and member communication channels while coordinating vaccine recommendations and joint clinic opportunities in high-disparity areas.

We expect to leverage findings to identify new ways of identifying patterns of underutilization by populations and regions. The analysis aims to identify persistent disparities within our populations and uncover underlying causes of care gaps among these subpopulations. We are in the process of conducting additional in-depth analysis of over/under utilization of behavioral and physical health services for future targeted interventions working to reduce health disparities.

GLOBAL QUALITY PAY FOR PERFORMANCE (P4P) PROGRAM

As of 2024, the Global Quality (GQ) P4P Program was in its ninth year. The program was designed to increase the provision of preventative health services to IEHP Members as well as improve HEDIS® results to ensure that IEHP Members receive quality care. The program includes core measures, process measures, and penalty "risk" measures.

Both Independent Physician Associations (IPAs) and Primary Care Providers (PCPs) are eligible to participate in the program. To be eligible for incentive payments, Primary Care Providers must have at least 200 assigned Medi-Cal Members at their location as of July and December 2024, with at least 20 Members meeting denominator requirements for at least three quality measure by December 2024. They must also have a minimum of three quality measures that meet denominator requirements to calculate a global quality score and be connected to the CAIR2 immunization registry. Once these four criteria are met, PCP enrollment in the program is automatic. To be eligible for incentive payments, IPAs must have at least 5,000 assigned IEHP Medi-Cal Members as of January 2024 and at least 30 Members

in the denominator for each quality measure by December 2024. They must achieve a Quality Score of 1.0 or higher, submit a Quality Work Plan by April 28, 2024, meet minimum Encounter Data Gates, and designate a dedicated Quality Team of 2-4 staff Members with an attestation and staffing plan submitted by July 1, 2024.

Financial rewards use a tiered system where Providers and IPAs can earn higher payments for better performance levels. The 2024 GQ P4P Program allocated $148 million total for PCP incentives and $50 million for the IPA Program, which will be distributed as monthly Per Member Per Month (PMPM) quality payments from July 2025 through June 2026. Payment amounts may be adjusted based on overall PCP performance to ensure total program costs stay within the budgets.

This evaluation will focus on PCPs (Providers and Provider clinics) for program year 2024. Clinical measures will be the focus of the evaluation. The measures included are aligned with National Committee for Quality Assurance (NCQA) standards, Healthcare Effectiveness Data and Information Set specification (HEDIS®) measures, and IEHP measure definitions. The evaluation aims to determine whether the GQ P4P program is improving healthcare quality by comparing performance and examining how Providers are distributed across quality performance bands.

CONCLUSION

IEHP has developed the annual Quality Improvement and Health Equity Plan (QIHEP) as a comprehensive framework to ensure the delivery of high-quality, safe, equitable, and culturally responsive healthcare services to its Members across Riverside and San Bernardino Counties. The QIHEP underscores IEHP's mission and supports its vision of achieving optimal care and vibrant health for all communities that it serves.

The QIHEP outlines a system-wide approach that integrates quality improvement, health equity, and population health management across all levels of IEHP's operations. This includes oversight from the Governing Board and executive leadership with clearly defined roles. This Plan also includes active participation of interdisciplinary subcommittees and advisory workgroups representing both Providers and Members.

The key elements of the QIHEP include:

1. **Continuous Quality Monitoring and Improvement** – Leveraging standardized measure like HEDIS®, CAHPS®, and PIPs, IEHP tracks service delivery and clinical outcomes to identify improvements opportunities and implement evidence-based interventions.
2. **Health Equity Integration** – The QIHEP prioritizes addressing health disparities through data stratification by race, ethnicity, language, disability, and sexual orientation/gender identity. Targeted interventions, inclusive hiring practices, Provider cultural competence training, and community partnerships are central to advancing equity.
3. **Member and Provider Engagement** – Through its Member Experience Subcommittee and Community Advisory Committee (CAC), IEHP integrates Member feedback into organizational strategies. Provider training, incentives, and robust communication channels support alignment with quality and equity goals.

4. **Accountability and Governance** – All QIHEP activities are reviewed and approved annually by the Governing Board. Evaluation mechanisms are in place to assess the effectiveness of quality initiatives, ensure regulatory compliance, and guide future planning.

The QIHEP is a strategic tool guiding IEHP's efforts to reduce disparities, improve clinical quality, and enhance the overall Member experience. It positions IEHP as a leader in transforming care delivery in all of its lines of business programs, ensuring that every member - regardless of background or circumstances – receives dignified, coordinated and high-quality care. IEHP is committed to improving the quality of healthcare delivered to its Members through proactive analysis of shared processes and integration of health initiatives that align with the industry and government quality standards; including a preventive health model for outreach and preemptive intervention related to health outcomes.