Dual Eligible Special Needs Plans (D-SNP)

Quality Management and Health Equity Transformation Program

2024 Annual Evaluation

Executive Summary

January 2026

MISSION AND VISION

The purpose of the 2024 D-SNP Annual Evaluation is to assess IEHP's Quality Improvement Program. This assessment reviews the quality and overall effectiveness of the program by reviewing all studies performed and implemented by various IEHP departments in 2024, including areas of success and needed improvements in services rendered, and if there is a need to restructure or change the QI program for the subsequent year. This annual evaluation reviews various committee and subcommittee structures, adequacy of resources, minutes and reports submitted both internally and externally, practitioner participation and leadership involvement in the program as well as data to review all program outcomes. The Quality Department leads IEHP's Annual Evaluation assessment in a collective and collaborative process utilizing data and reports from committees, subcommittees, departments, content experts, data analysts, and work plans to analyze and evaluate the effectiveness of the Quality Programs. Overall effectiveness of the programs is assessed by analyzing and trending the goals and actions of the studies, reviewing qualitative and quantitative results, providing a causal analysis and defining barriers, interventions, opportunities for improvement and next steps.
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 MANAGEMENT AND HEALTH EQUITY TRANSFORMATION

PROGRAM DESCRIPTION

IEHP supports an active, ongoing, and comprehensive Quality Management and Health Equity Transformation Program (QMHETP) and Quality Improvement (QI) Program with the primary goal of continuously monitoring and improving the quality of care and service, access to care, and Member safety delivered to IEHP Members. The QMHETP provides a formal process to systematically monitor and objectively evaluate, track, and trend the health plan's quality, efficiency, and effectiveness. IEHP is committed to assessing and continuously improving the care and service delivered to Members. 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 Member safety, behavioral health, care management, culturally and linguistically appropriate services, and coordination of care. IEHP will utilize this document for oversight, monitoring, and evaluation of Quality Management (QM) and QI activities to ensure the QMHETP is operating in accordance with standards and processes as defined in this Program Description. These initiatives are aligned with IEHP's mission and vision.

PROGRAM PURPOSE

The purpose of the QMHETP is to provide the structure and framework necessary to monitor and evaluate the quality and appropriateness of care, identify opportunities for clinical, Member safety, and service improvements, ensure resolution of identified problems, and measure and monitor intervention results over time to assess any needs for new improvement strategies.

PROGRAM SCOPE

The Quality Management & Health Equity Transformation Committee (QMHETC) approves the QMHETP annually. The QMHETP review includes approval of the QMHETP Description, QMHETP & CLAS Work Plan, and QMHETP Annual Evaluation to ensure ongoing performance improvement. The QMHETP 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 and maintain the safety of their practices;
5. Overseeing IEHP's Quality Management & Health Equity functions through the QMHETC;
6. Involving designated Physician(s) and staff in the QMHETP;
7. Involving a Behavioral Healthcare Practitioner in the behavioral health aspects of the Program;
8. Involving Long-Term Services and Supports (LTSS) Provider(s) in the QMHETP;
9. Reviewing the effectiveness of LTSS programs and services;
10. Ensuring that LTSS needs of Members are identified and addressed 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 planning;

14. Establishing specific role, structure and function of the QMHETC and other committees, including meeting frequency;
15. Reviewing resources devoted to the QMHETP;
16. Assessing and monitoring delivery and safety of care for the IEHP population with complex health needs and Seniors and Persons with Disabilities (SPD);
17. Assessing and monitoring processes to ensure the Member's cultural, racial, ethnic, and linguistic needs are being met; and
18. Reviewing grievances and appeals data and other pertinent information in relation to Member safety and care rendered at Provider practices/facilities.

PROGRAM GOALS

The primary goal of the QMHETP is to continuously assess and improve the quality of care, services, and safety of healthcare delivered to IEHP Members. The QMHETP goals are to:

1. Implement strategies for Population Health Management (PHM) that keep Members healthy, manage Members with emerging risks, ensure Member safety and outcomes across settings, improve Member satisfaction, and improve quality of care for Members with chronic conditions;
2. Implement quality programs to support PHM strategies while improving targeted health conditions;
3. Identify clinical and service-related quality and Member safety issues, and develop and implement QI plans, as needed;
4. Share the results of QI initiatives to stimulate awareness and change;
5. Empower all staff to identify QI opportunities and work collaboratively to implement changes that improve the quality of all IEHP programs;
6. Identify QI opportunities through internal and external audits, Member and Provider feedback, and the evaluation of Member grievances and appeals;
7. Monitor over-utilization and under-utilization of services to assure appropriate access to care;
8. Utilize accurate QI data to ensure program integrity; and
9. Annually review the effectiveness of the QMHETP and utilize the results to plan future initiatives and program design.

AUTHORITY AND RESPONSIBILITY

The QMHETP includes tiered levels of authority, accountability, and responsibility related to quality of care and services provided to Members. The line of authority originates from the Governing Board and extends to Practitioners through different subcommittees.

IEHP GOVERNING BOARD: IEHP was created as a public entity with the initiation of a Joint Powers Agency (JPA) agreement between Riverside and San Bernardino Counties to serve eligible residents of both counties. Two (2) Members from each County Board of Supervisors and three (3) public Members selected from the two (2) counties sit on the Governing Board.

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 QMHETP;
3. Evaluating QMHETP effectiveness and progress;
4. Evaluating and approving the annual QMHETP Description and Work Plan;
5. Appointing an accountable entity or entities within the Plan responsible for oversight of QMHETP;
6. Reviewing written progress reports received from the QMHETC that describe actions taken, progress in meeting QMHETP objectives, and improvements made;
7. Directing necessary modifications to QMHETP policies and procedures to ensure compliance with Quality management and Health Equity standards set forth in the Two-Plan Contract and DHCS Comprehensive Quality Strategy.

QUALITY MANAGEMENT AND HEALTH EQUITY TRANSFORMATION COMMITTEE (QMHETC): The QMHETC reports to the Governing Board and retains oversight of the QMHETP 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. The QMHET Committee meets at least quarterly to report findings, reports actions and recommendations to the IEHP Governing Board, seek methods to increase the quality of health care for Members, recommends policy decisions, evaluate QI activity results, and provide oversight for Subcommittees.

QMHETP 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)**: IEHP's Quality Improvement Council (QIC) is a standing monthly forum for addressing system- level quality gaps identified at IEHP subcommittees. The purpose of the QIC is to eliminate barriers and secure resources to drive system-level quality improvement solution efforts. Furthermore, the QIC provides a structure to guide solution efforts and maintain oversight of improvement efforts tied to these issues.
2. **Quality Improvement Subcommittee (QISC)**: analyzes and evaluates QI activities and reports results; develops action items as needed; and ensures follow-up as appropriate. All action plans are documented on the QI Subcommittee Work Plan.
3. **Peer Review Subcommittee**: The Peer Review Subcommittee serves as the committee for clinical quality review of Practitioners; evaluates and makes decisions regarding Member or Practitioner grievances and clinical quality of care cases.
4. **Credentialing Subcommittee**: provides discussion and consideration of all network Practitioners being credentialed or re-credentialed; reviews Practitioner qualifications including adverse findings; approves or denies continued participation in the network every three (3) years for re-credentialing.
5. **Pharmacy and Therapeutics (P&T) Subcommittee:** reviews IEHP's medication formulary, monitors medication prescribing practices by IEHP Practitioners, under- and over- utilization of medications, provides updates to pharmacy related programs, and reviews patient safety reports related to medication.

6. **Utilization Management (UM) Subcommittee**: The UM Subcommittee reviews and approves the Utilization Management, Disease Management and Behavioral Health Programs annually. The Subcommittee monitors for over-utilization and under-utilization; ensures that UM & BH decisions are based only on appropriateness of care and service; and reviews and updates preventive care and CPGs that are not primarily medication related.
7. **Population Health Management (PHM) Subcommittee:** The PHM Subcommittee is responsible for reviewing, monitoring and evaluating program information and progress while providing regulatory oversight in alignment with DHCS and NCQA requirements and standards.
8. **Provider Network Access Subcommittee:** The Provider Network Access Subcommittee is responsible for reviewing, monitoring, and evaluating program data, outliers, and trends to ensure timely improvement initiatives are initiated. The Provider Network Access Subcommittee is also responsible for initiative oversight, ensuring outcomes are achieved and barriers are removed.
9. **Member Experience Subcommittee (MESC):** The role of the Member Experience Subcommittee is to review, monitor, and evaluate program data, outliers, and trends to ensure timely improvement initiatives are initiated. The MESC will is responsible for initiative oversight, ensuring outcomes are achieved and barriers are removed.
10. **Member Safety Subcommittee (MSS):** The scope of the Member Safety Subcommittee includes all lines of business and contracted network provider, direct or delegated, in which care and services are provided to IEHP Members. The Member Safety Subcommittee uses a multidisciplinary and multidepartment approach to explore root causes of poor performance, identify areas of improvement, propose interventions, and take actions to improve the quality of care delivery to our Members.
11. **Skilled Nursing Facility (SNF) Subcommittee:** This subcommittee will identify opportunities that impact efficient transitions of care, clinical outcomes, Member safety, and Member experience while receiving care at a skilled nursing or long-term care facility. This subcommittee serves as a forum for review and evaluation of strategic, operational, and quality measures resulting from but not limited to: Inland Empire Health Plan (IEHP) optimal care strategies, Joint Operations Meeting (JOM) and related workgroups (i.e., throughput, quality, ambulatory operations, payment practices, etc.), and pay for performance initiatives.
12. **Hospital and Ancillary Quality Improvement (QI) Subcommittee:** This Subcommittee was formed in 2023 to identify opportunities that impact clinical outcomes, Member safety and Member experience during acute care hospitalization and/or sub- acute/post-acute network utilization (excluding Skilled Nursing Facilities which are discussed as part of a separate subcommittee).
13. **Community Advisory Community (CAC)**: The 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.
14. **Delegation Oversight Subcommittee**: 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.

15. **D-SNP Model of Care (MOC) and Medicare Stars Monitoring and Oversight Subcommittee**: The D-SNP MOC Subcommittee exists to identify opportunities that impact clinical outcomes, Member safety, service improvement, and Member experience for IEHP's Dual Eligible Special Needs Program (D-SNP) Medicare population. Quantitative and qualitative data, including but limited to Model of Care performance metrics, Medicare Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) scores, Pay for Performance (P4P), Medicare studies and surveys such as the Health Outcome Survey (HOS), are evaluated to ensure continuous and responsive improvement initiatives to drive quality program excellence.
16. **Ambulatory Provider Quality Informatics and Technology (QIT) Advisory Subcommittee**: The purpose of the Ambulatory Provider Quality Informatics and Technology (Ambulatory QIT) Advisory Subcommittee is to advance optimal care and vibrant health by engaging ambulatory providers to guide, enhance and prioritize the development of electronic applications belonging to both IEHP and their respective organizations to advance patient care and seamlessly capture data and quality metrics.

DELEGATION OVERSIGHT

This Delegation Oversight 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, Health Insurance Portability and Accountability Act (HIPAA) Security, HIPAA Privacy, and Compliance & Fraud Waste and Abuse (FWA). Oversight of Medicare Delegates is conducted through regular extensive evaluation 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 will be presented at the March 2025 Delegation Oversight Committee.

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

The seven (7) Delegated Medicare IPAs Delegates are: *Choice Physicians Network, Dignity Health Medical Network - IE, EPIC Management, Heritage Provider Network - Desert Oasis Healthcare, Heritage Provider Network - Regal Medical Group, Optum Care Network - PrimeCare, and Riverside Medical Clinic*. All are delegated for the functions of Utilization Management, Care Management, Credentialing and Claims Payment. The Annual Delegation Oversight Audit reviews the Delegate's policies, procedures and operational activities for Quality Management, Utilization Management, Care Management, Credentialing, HIPAA Security, HIPAA Privacy, and Compliance & FWA.

The goal of the DOA Study was to evaluate the Medicare Delegates overall performance results from July 2023-June 2024 for delegated responsibilities as compared to the 2022-2023 performance results. The goal for the 2023-2024 DOA period was to ensure that Delegates were providing Member care that meets regulatory and IEHP requirements and guidelines. Monthly oversight auditing and monitoring activities allow IEHP to identify any challenges the Delegates encountered during the course of the lookback period. This higher frequency of auditing and monitoring ensured timely mitigation of identified deficiencies through a structured Corrective Action Plan

(CAP) process that supports sustained resolution. The desktop and system validation audits allow IEHP to conduct more comprehensive file and policy documentation reviews and allow for interviewing of delegate staff involved in the delegated activity. IEHP evaluates the results of the Study to identify areas of opportunity to enhance oversight efforts that would lead to further improvement in performance. IEHP will continue to stringently monitor each of the areas within the Delegation Oversight Audit tool and provide on-going training as deemed necessary and/or as requested by our Medicare Delegates.

QUALITY IMPROVEMENT INITIATIVES

The Healthcare Effectiveness Data and Information Set, better known as HEDIS®, is one component that is utilized by the National Committee for Quality Assurance (NCQA) in the health plan accreditation process. HEDIS® is used by more than 90 percent of health plans in the United States to measure performance on important dimensions of care and service. IEHP uses HEDIS results as a tool to help focus its quality improvement efforts and as a way of monitoring the effectiveness of services provided.

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 16 domains:

A. 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
B. Utilization and Risk Adjusted Utilization
    13. Utilization
    14. Risk Adjusted Utilization
    15. Health Plan Descriptive Information
C. 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.

Measure rates included in this report are final HEDIS® rates reported to NCQA. Measure goals and benchmarks presented in this report were obtained from the most appropriate and up to date source at the time of publication. The different benchmarking sources display varying cut-points for measure percentiles; for HPR measures, only the 10th, 33.33rd, 66.67th, and 90th percentiles are used (along with the 50th percentile for the MPL of any MCAS measures) while the 10th, 25th, 33.33rd, 50th, 66.67th, 75th, and 90th percentiles are used for non-HPR measures. *Figure 1* lists the benchmarking source utilized by measure type.

Figure 1: IEHP HEIDS® MY 2024 Report Benchmarking Sources by Measure Type

LOB	Measure Type	Source	Publication Date
Medi-Cal & Medicare	Health Plan Rating	2025 Health Plan Ratings Percentiles and Benchmarks	September 2025
Medi-Cal	MCAS Measures MPL	2025 NCQA Quality Compass National Benchmarks *(MPL = 50th percentile)*	September 2025
Medi-Cal	Non–Health Plan Rating	2024 NCQA Quality Compass National Benchmarks	September 2024
D-SNP[1]	Non–Health Plan Rating	2024 NCQA Quality Compass National Benchmarks	October 2025
Medi-Cal	DHCS Auto–Assignment	DHCS Medi-Cal Managed Care: Auto-Assignment Incentive Program Overview	October 2019
Medicare	CMS Star Rating	Medicare 2026 Part C & D Star Ratings Technical Notes	September 2025
IEHP Covered	Quality Rating System (QRS)	2025 QRS National Benchmarks	October 2025
IEHP Covered	Quality Transformation Initiative (QTI)	Quality Transformation Initiative (QTI): MY2024 Assessment	February 2025

IEHP initially prepares the HEDIS® report using the most recent available benchmarks. Upon the release of more updated benchmarks from accrediting bodies, IEHP updates the measure percentile and Health Plan Rating scores as needed to reflect the most up-to-date measure standings and release a new version of this HEDIS® Annual Report.

MODEL OF CARE QUALITY PERFORMANCE

The Annual Model of Care (MOC) Quality Performance Report focuses on the quality measurement and performance improvement plan outlined in MOC 4. MOC 4 provides an overview of how Inland Empire Health Plan (IEHP) provides appropriate services to Special Needs Population (SNP) enrollees based on their unique needs.

IEHP's quality performance improvement plan includes a formal workplan and analyzes how SNP-specific measurable goals and health objective outcomes are integrated to improve the care of this targeted population.

IEHP transitioned to a D-SNP plan in 2023, and every SNP plan must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). IEHP's MOC was developed in 2023 and includes the following measure sets: HEDIS®, CAHPS®, HOS, Prescription Drug Event (PDE), and internal measures. IEHP gathers data and performs analyses on clinical and service performance measures as delineated by the Centers for Medicare and Medicaid Services (CMS). CMS utilizes the Part C & 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.

The Annual MOC Quality Performance Report includes measurement year (MY) 2024 results for the following focus areas:

- CMS Staying Healthy Domain
- CMS Stars Managing Chronic (Long-Term) Conditions Domain
- CMS Stars Safety and Accuracy of Drug Pricing Domain
- CMS Stars Member Experience Domains
- Care Coordination, HRAT, ICP, and ICT
- Cardiovascular and Diabetic Conditions
- Preventative Care

The MOC population includes SNP enrollees, Members residing in Riverside or San Bernardino county and those with cardiovascular disease or diabetes. This encompasses IEHP's most vulnerable population.

HEDIS®:

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. 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 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.

CAHPS®:

Symphony Performance Health Analytics (SPH Analytics), a National Committee for Quality Assurance (NCQA) Certified Survey Vendor, was selected by Inland Empire Health Plan to conduct its 2024 Medicare CAHPS® Survey. The survey was sent and collected via mail, internet or administered telephonically. Surveys were available in both

English and Spanish. Comprehensive quantitative analysis of the survey responses was compiled by SPH and presented to IEHP in a final report.

CAHPS® measures are case-mix adjusted composites that are used to assess how easy it was for a Member to get needed care and see specialists. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.

HOS:

The HOS measure results use a sample of eligible MA Members that live in the United States or U.S. Territories from the Integrated Data Repository (IDR). A random sample of Members was drawn from IEHP's enrolled population which included both aged and disabled Members. To be included in the random sample for the baseline survey, MA Members must be 18 years of age or older at the time of the sample draw. To reduce burden on survey respondents, Members who were sampled and return a completed survey the previous year are excluded from the current year's sampling. The cohort 25 Follow-Up data collection (2024) and Cohort 27 Baseline data collection (2024) are the population for this measurement year. However, IEHP was not required to report in 2024 due to the D-SNP transition and two-year look back. Therefore, no scores will be reported for the HOS measures in 2024.

Prescription Drug Event:

Prescription Drug Event (PDE) data is captured when a Medicare beneficiary with Part D coverage fills a prescription, and the prescription drug plan submits a record to the CMS Drug Data Processing System (DDPS). The data must be submitted and accepted by the 2024 PDE submission deadline for annual Part D reconciliation with dates of service from January 1, 2024, to December 31, 2024.

Figure 2: IEHP MOC MY 2024 Measure References and Benchmarks

Measure Type	Measure Reference	Publication Date
HEDIS®	NCQA HEDIS® MY 2024 Technical Specifications Volume 2	April 2024
CAHPS®	2025 Medicare Advantage Prescription Drug CAHPS® Report	September 2025
HOS	2024 Cohort 25 Follow-Up & Cohort 27 Baseline Report	October 2025
PDE	2025 CMS Patient Safety Report	January 2025
CMS Star Ratings	2026 CMS Star Ratings Technical Notes	October 2025

ACCESS TO CARE

IEHP maintains access standards applicable to all Providers and facilities contracted with IEHP. All PCPs, BH Providers, and Specialists must meet the access standards in order to participate in the IEHP network. IEHP monitors practitioner access to care through access studies, review of grievances and collaboration of interventions. The access studies performed include the following:

1. **Provider Network Status Study (2024)**

   The purpose of the Provider Network Status Study is to ensure IEHP is compliant with regulatory standards for time, distance, and Provider to Member ratios, as well as to monitor NCQA guidelines. Regulatory agencies establish these standards to ensure adequate access to primary and specialty care for Members. The Member counts and percentages contained in the Network Adequacy Study were derived from two network analysis tools within the Esri GIS software suite. The OD Cost Matrix was used to calculate time and distance from every Member to every Provider by specialty. The results were processed within My SQL Studio to produce the Member count and percent within the applied time/distance. Specialties that were below the required percentage were re-evaluated with the Network Service Area tool. This result was used if it was higher than the one produced with the OD Cost Matrix.

   All final results are entered into a results grid for analysis. The findings are presented to the Provider Network Access Subcommittee for review, comments, and approval. The following individuals participated in the review and analysis: Vice President of Quality, Director of Provider Network and Director of Quality Program Informatics.

   The goal of the study for time (minutes) or distance (miles) is to achieve at least 90% compliance for specialties. Another goal of the study is for the Provider to Member ratios to meet or exceed the required number of Providers in each specialty.

   The results of the 2024 Provider Network Status Study – D-SNP reveal that all Provider types and Facilities met the time/distance standards. Overall, all 44 of the time/distance standards were met. For the Provider to Member ratio, all 47 standards were met.

2. **Provider Access After-Hours Study (2024)**

   The Provider Access After-Hours study is conducted annually to assess the after-hours accessibility of Providers within the IEHP network. Specifically, the study assesses the after- hours call handling protocol of contracted Primary Care Providers (PCPs) and Behavioral Health Practitioners.
   The study is used to monitor Provider compliance and to ensure that IEHP Members have appropriate guidance and access if care is needed from their Providers after office hours. The study is conducted in accordance with the NCQA NET 2 standard as well as DMHC standards. An assessment of Member Satisfaction Survey questions related to Provider After-Hours care was also included in this study.

   IEHP's goal for Provider After-Hours Access is to meet a **90%** compliance rate in:

   - Ability to connect to an on-call physician
   - Appropriate protocol for life-threatening emergency calls

   IEHP's goal for Member Satisfaction Survey Results for After-Hour Access is to meet an **80%** compliance rate in the following questions:

   - In the last 6 months, how often was it easy to get the after-hours care you thought you needed?
   - In the last 6 months, when you needed after-hours care, what did you do?

Overall, Providers scored higher in the life-threatening emergency calls than in the on-call physician access calls. PCP providers met the goal for life-threatening emergency calls. A drill down by PCP type show that Family Practice perform higher than other PCP types for on-call Physician Access calls and Pediatric Providers score higher for Life-threatening emergency calls. An assessment of provider after-hours access by IPA was assessed. IEHP Direct scored 55.6% for on-call Physician access (goal not met) and 92.7% for life-threatening emergency calls (goal met).

Low performance on Provider after-hours standards was further supported by the monthly Member experience results. In 2024, 71.0% of Members reported it was easy to get afterhours care needed. This rate did not meet the goal of at least 80%.

3. After-Hours Nurse Advice Line Study (2024)

The After-Hours Nurse Advice Line (NAL) study assesses the after-hours access availability for IEHP's Members through a contracted after-hours NAL. IEHP ensures the arrangement of a triage or screening service by telephone 24 hours a day, 7 days a week. During a triage or screening call, the Member's health is assessed via telephone by a qualified health professional for the purpose of determining the urgency of the need for care. IEHP must also ensure that triage or screening services are provided in a timely manner. The after-hours NAL provides IEHP monthly reports which include average speed to answer a call and average call abandonment rates. To assess trends and verify if study goals were met, the final rates were compared to rates from previous years.

The results of the quantitative analysis are presented to IEHP's Provider Network Access Subcommittee for review and approval. The following individuals participated in this analysis: Vice President of Quality and the Health Services Medical Director.

In conclusion, Carenet Health met the key performance indicator goals for 2024. The IEHP Health Services Team and Medical Director meet with Carenet Health on a monthly basis to discuss metrics and any issues that may arise. The performance is tracked monthly and is presented annually to the Provider Network Access Subcommittee.

4. Provider Appointment Availability Study (2024)

The purpose of the Provider Appointment Availability study is to assess appointment access for PCPs, Specialist Providers, and Mental Health Providers in accordance with NCQA, DMHC, and DHCS standards. IEHP annually assesses the access standards of Primary Care Physicians (PCPs), high volume and high impact Specialists, and Mental Health Providers, using the Department of Managed Health Care (DMHC) Provider Appointment Availability Survey (PAAS) methodology. This study examines the availability of practitioners for different appointment types such as urgent care appointments and routine care appointments in accordance with NCQA standard NET 2 Elements A-C. The goals of the survey were to assess appointment wait times and compliance with appointment standards and assess the availability of In-Person and Telehealth PCP appointments.

In conclusion, appointment availability compliance rates improved for Specialty Providers, NPMH Providers and Psychiatrists. PCP showed improvement only for non-urgent appointments. The DMHC goal of 80% was met for PCP and NPMH Providers for non-urgent appointments. DMHC goal of 80% and IEHP Stretch goal of 90% was met for Psychiatry Providers – Non-urgent appointments. Regional analysis and grievance data did not reveal any trends.

5. **Provider Language Competency Study**

The Provider Language Competency Study is conducted annually in which we perform outreach to all active PCP and high-volume/impact specialist sites that have reported staff in their office are able to speak a threshold language. The data is collected through means of a faxed survey or a call in which the offices confirm their information. The intention of this annual process is to monitor the language capability of our network and ensure up-to-date information. The data is then analyzed in this study for further insights. This study is conducted in accordance with the National Committee for Quality Assurance (NCQA) Health Equity Accreditation (HEA) Standard 4, Element A.

IEHP met the goal of a compliance rate of at least 85% for the overall offices surveyed. This means that for the combined PCP and high-volume/impact specialist offices, 85% of the offices confirmed either through fax or phone that the language is spoken at the office. However, improvement is needed for PCP sites that speak Chinese and Specialist sites that speak Vietnamese as both of these fell below the goal of 85%.

6. **Provider Directory Accuracy Study**

The purpose of the Provider Directory Accuracy Study is to verify that the information listed in the Provider Directory is correct. IEHP performs an annual evaluation of its physician directories for: 1.) Accuracy of office locations and phone numbers, 2.) Accuracy of hospital affiliations, 3.) Accuracy of accepting new patients, and 4.) Awareness of physician office staff of physician's participation in the health plan's networks. The study is conducted in accordance with NCQA Standard NET 5 Elements C & D.

The results of the 2024 Provider Directory Accuracy Study revealed that IEHP exceeded the goal of at least 90% compliance for all factors. The compliance rate for all four factors was relatively the same across all specialties. The overall accuracy rate for all factors combined increased slightly from 97.1% in 2023 to 99.8% in 2024. IEHP will continue the current process of verifying the Provider directory on a bi-annual basis to ensure network accuracy. In addition, the process is reviewed and enhanced bi-annually, if needed.

7. **Provider Office Wait Times Study**

The Provider Office Wait Times Study assesses IEHP's monitoring processes and Provider compliance with access standards related to office wait times for Primary Care Providers (PCPs), Specialists, Behavioral Health (BH) Providers, and Vision Providers in the IEHP Network. This study satisfies the contract requirement with the Department of Health Care Services (DHCS), Access and Availability category to monitor Provider office waiting times. This study also aligns with IEHP's Policy and Procedure MC_09A Access Standards which states office wait time must not exceed sixty (60) minutes for a scheduled appointment or four (4) hours for a walk-in visit. Lack of monitoring procedures for Provider office wait times may lead to delays in medically necessary treatments which could potentially affect a Member's health and well- being.

The results of the 2025 Annual Provider Office Wait Times study revealed that IEHP met the goal of office wait times of less than 60 minutes for a scheduled appointment. Each surveyed Provider type group achieved a compliance rate of 98.8% or higher, which is above the goal of 90%. The total number of survey responses received this year decreased from the prior year (3,386, but in line with the prior year surveys with 2,885 and 3,073 responses). The largest changes in the network are locations that have the specialties of Licensed Marriage and Family Therapy and Licensed Clinical Social Worker. Significant recruitment is also noticeable for the specialties of Psychiatry, and Mental Health Nurse Practitioner. In addition, the grievance volume analysis did not reveal any negative trends. Quality Program Nurses and Provider Relation Managers continue to educate Providers on office wait times during educational office visits. The Quality Systems and Provider Services department will continue the process to collect, record, and track office wait times through the biannual Provider verification process.

MEMBER AND PROVIDER SATISFACTION

IEHP is committed to improving the quality of health care delivered to its Members. The studies noted below were completed in and analyzed for results in developing interventions and a purposeful focus in improving the experience for Members and Providers.

1. **CAHPS® Survey (MY 2024)**

   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.

   When assessing IEHP's performance in 2025 (MY 2024), '*Rating of Health Plan*' was identified as a high performing measure which performed ***above*** the 2025 National average. The measure showed statistical significance and increased in star rating from the previous measurement year. IEHP's performance was ***significantly below*** the 2025 National average in '*Rating of Health Care Quality', 'Getting Needed Care', 'Getting Care Quickly', 'Care Coordination' 'Getting Needed RX Drugs' and 'Annual Flu Vaccine'*. '*Rating of Health Care Quality', 'Getting Needed Care', 'Getting Care Quickly', and 'Annual Flu Vaccine'* decreased in star rating from the previous measurement year, while *'Care Coordination' 'Getting Needed RX Drugs'* star rating remained consistent with the previous measurement year.

2. **Provider Experience Study (2024)**

This study assesses the satisfaction of IEHP's Primary Care Providers, Specialty Providers, and Behavioral Health Providers. The 2024 Provider Experience Study is designed to support the NCQA QI 3 and QI 4 standards (continuity and coordination of care) as well as Department of Managed HealthCare (DMHC) requirements.

More specifically, this study examines the satisfaction of the provider network in the following composite areas: Overall Satisfaction, All Other Plans (Comparative Rating), Finance Issues, Utilization and Quality Management, Network/Coordination of Care, Pharmacy, Health Plan Call Center Service Staff, Provider Relations, and Likelihood of Recommending to other Physicians Practices.

The annual Provider Satisfaction Survey is fielded annually and is intended to identify opportunities for improvement as well as meet regulatory DMHC requirements. The overall goals are to achieve Health Plan Satisfaction >90% and rate significantly higher than other health plans in all other composites. The survey met these two (2) goals.

All composites rank at the 96th percentile or higher when compared to other health plans. For the Custom composites (Timely Access, Interpreter Services, and Telehealth), a comparison to other health plans was not available, however, when compared to the prior year, only the Telehealth composite show improvement.

3. **Annual Grievance and Appeals Study (2024)**

The Grievance and Appeal (G&A) Study is conducted annually and reviews case volume and rates to identify trends and assess areas of opportunity to improve overall Member satisfaction. More specifically, this study assesses Member experience in accordance with NCQA ME 7 Element C and D. The purpose of this study is to assess Member experience with Inland Empire Health Plan (IEHP) services by evaluating grievances and appeals trends. A grievance is a Member complaint expressing dissatisfaction with any aspect of IEHP or its Providers and a Member appeal is a review (reconsideration) by IEHP on services the Member believes he or she is entitled to receive.

In conclusion, IEHP met its goal to identify grievance and appeals trends from 2024 in relation to the established goals. The results of the 2024 Grievance and Appeals annual assessment revealed an overall decrease in grievance cases in the Medi-Cal and Medicare line of business. The Medi-Cal standard grievance volume decreased from 36,796 in 2023 to 32,184 in 2024 (13% decrease). The significant decrease is attributed to a reduction in grievances in Attitude Service with specific trends in Transportation grievances. The Medicare standard grievance volume decreased from 13,146 in 2023 to 11,766 in 2024 (10% decrease). The grievance reduction goal established 10% was met. The results of the 2024 Grievance and Appeals annual assessment revealed an overall increase in the appeals volume with trends identified in Medical Appeals. IEHP will continue to work on improvement initiatives in 2024 to address areas with high appeals volume.

4. **Medicare Health Outcomes Survey (HOS) Cohort 27 Baseline Report**

The Centers for Medicare and Medicaid Services (CMS) requires IEHP to annually participate in Medicare Health Outcomes Survey (HOS) reporting for the Medicare product lines. Health outcomes are assessed for a randomly selected set of Members from each participating Medicare Advantage Organization (MAO) over a two-year interval, with a baseline measure and a two-year follow up. Respondents to this baseline cohort,

who remain alive and are Members of the same plan in 2026, will be resurveyed for the Cohort 27 Follow Up. The follow-up survey will be fielded in the Spring/Summer of 2026. Results from the combined baseline and follow up surveys will be available in the 2024-2026 Cohort 27 Performance Measurement Report that is planned for distribution in the Summer of 2028.

Effective January 1st 2023, IEHP's CalMediConnect population transitioned to the Dual Eligible Special Needs Plan (D-SNP), also known as IEHP DualChoice. Due to this transition, no baseline Health Outcomes Survey (HOS) was fielded in 2023. The IEHP D-SNP Medicare population is considered high-risk and vulnerable, with members experiencing multiple chronic conditions, identified behavioral health needs, and lower socioeconomic status compared to the broader HOS population. In response, IEHP introduced several initiatives in 2023 to enhance monitoring and identify opportunities for improvement, including the D-SNP Model of Care Subcommittee and the D-SNP Model of Care Incentive Program for IPAs, which incorporates the Chronic Care Improvement Program requirement.

MEMBER SAFETY

IEHP recognizes that member safety is a key component of delivering quality health care and focuses on promoting best practices that are aimed at improving patient safety. IEHP engages Members and Providers in order to promote safety practices. IEHP also focuses on reducing the risk of adverse events that can occur while providing medical care in different delivery settings.

1. **Annual Potential Quality Incidents (PQI) Report (2024)**

   This study assesses IEHP's Quality Management (QM) Department's reviews, monitors, and reports of all Potential Quality Incidents (PQI) for all network Providers and facilities including, but not limited to, primary and specialty care, facilities, hospitals, Long Term Care, Skilled Nursing Facilities, Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP) services, home health agencies, and transportation providers. All IEHP departments, including but not limited to Grievances and Appeals department, are responsible for the evaluation and improvement of the quality of care and have the responsibility to report any PQI issues/concerns to the QM Department who is responsible for investigating and reviewing the alleged quality issue. This report identifies metrics related to PQIs, which include Provider Preventable Conditions (PPCs).

   With the internal and external reporting processes set in place, 1276 PQI cases were processed during CY 2024 compared to the 581 cases in CY 2023. The QM Department initiated a robust PQI leveling system in 2023 which allows for more granular identification of PQI levels with accompanying Member harm. This will allow the QM Department to better identify serious trends by Provider, identify Providers with significant opportunities to improve care, and to take appropriate actions.

2. **Measuring Care Transitions Effectiveness Study (2024)**

   The Measuring Care Transitions Study measures the effectiveness of the Medicare D-SNP Program in managing care transitions for the D-SNP population. IEHP coordinates the delivery of care across all healthcare settings, Providers, and services, to ensure safe transitions. In addition, the team works to identify, monitor and reduce unplanned transitions.

The goal of the study is to address the following objectives: 1) effective sharing of Member reports between settings during each stage of the transition process, 2) effective communication with the Member's PCP regarding all transitions within specified timeframes, and 3) effective communication with the Member during the transition process.

In conclusion, the goals were met for 6 of the 10 measures assessed. Sharing of Member Reports Between Settings During Each Stage of The Transition Process assessed 2 measures. 'Receipt of discharge instructions', did meet the goal while 'Member Profile admission report sent to facility' showed statistically significant improvement but did not meet the goal. Effective communication with the PCP met the goal for 4 of the 5 measures. The "Rate of PCPs accessing the Inpatient Discharge roster on the Provider portal of 32.33% did not meet the goal of 40%, however, only data for the first half of the year was available at the time of the report. The rate will be updated as soon as the data becomes available. Lastly, 'effective communication with the Member' was assessed using three (3) measures. 'Timely communication with Member about consistent point of contact during all transitions' met the goal of 100% but 'Member contact timely for all admissions and all discharges' did not meet the goal. Further analysis revealed the following barriers: Late admission/discharge notifications or no admission/discharge notifications received, admission/discharge notifications received outside of business hours (i.e. weekends/holidays), and IEHP does not get real time notification on OON facilities admission. Planned interventions to address these barriers include collaborating with HIE for a new report and improved TOC team process oversight and heightened trend monitoring.

3. Annual Medical Record Review (MRR) Report

This study assesses IEHP's overall Primary Care Providers (PCPs) network compliance rates for Medical Record Review (MRR) standards for CY 2024. The California Department of Health Care Services (DHCS) requires all Primary Care Providers (PCPs) to undergo a MRR survey utilizing state mandated audit tools at a minimum of every three years. In addition, new PCPs have up to six months from the time the MCP assigns members to obtain an MRR score from IEHP.

The MRR audit verifies that the PCP is compliant with DHCS's medical record documentation standards for the following sections of the MRR tool: Format, Documentation, Coordination, and as applicable, the following sections: Pediatric Preventive, Adult Preventive, and OB/CPSP Preventive as applicable. The PCP then receives final scoring, falling into one of three categories: *Exempted Pass* (with a 90% score or above with all section scores greater than or equal to 80%), *Conditional Pass* (with a score of 80-89%, or 90% or above with one or more sections scores below 80%), and *Fail* for a score of 79% or below.

Provider education remained ongoing throughout CY 2024. Additional Practitioner education focused on medical record documentation will continue to be developed, as well as education on all immunizations during site visits. Additionally, all MRR and FSR tools, resources, and helpful guides have been published to the IEHP website. This feature was made possible through collaboration with IEHP's Provider Communications team.

4. **Physical Accessibility Review Survey (PARS) Study (2024)**
   This study assesses IEHP's overall physical accessibility of facilities to include primary care providers (PCPs), high-volume specialist, identified ancillary services, and Community-Based Adult Services (CBAS) that serve a high volume of seniors and persons with disabilities. Ancillary service provider sites are free-standing facilities that provide diagnostic and therapeutic services, such as, but not limited to: laboratory, infusion, radiology, imaging, cardiac testing, renal dialysis, occupational therapy, speech therapy, physical therapy, pulmonary testing, and cardiac rehabilitation. CBAS centers offer a package of health, therapeutic, and social services in a community-based day care setting.

   In summary, overall compliance rates is 82.6% for PCP and High-Volume Specialists, 86.0% for Ancillary services, and 84.0% for CBAS facilities. The highest scoring sections for all three (3) survey types is '*Parking,*' lowest scoring sections are '*Exam Room*' for PCP/Specialists, '*Interior Building*' for Ancillary and '*Interior Route*' for CBAS. Comparison of results by county revealed that Riverside County scored better than San Bernardino County for PCP and Specialists survey results. No trends were noted for Ancillary or CBAS survey results. The results of the PARS assessments are informational and unlike the Facility Site Review (FSR) and Medical Record Review (MRR) Surveys, do not require a Corrective Action Plan (CAP) for any deficiencies. Barriers to noncompliance include may include:
   - Sites unaware of requirements
   - Facilities constructed prior to January 26, 1992
   - Financial barriers
   - Sites unwilling to complete ADA recommendations

CONTINUITY AND COORDINATION OF CARE

1. **HEDIS® Health Plan Ratings (HPR) Measures for Continuity and Coordination of Care (2024)**
   This study assesses continuity and coordination of care through performance on required Health Plan Ratings HEDIS® measures for measurement year (MY) 2024 through various measures. IEHP monitors and tasks action as necessary to improve continuity and coordination of care across its network. Continuity of care is the consistent and seamless delivery of health care management to a patient over time, ensuring coordinated and high-quality treatment across various providers and settings. The goal of this study is to demonstrate performance through IEHP's Health Plan Ratings scored and identify and highlight activities to support continuity and coordination of care.

   The results for all measures related to Continuity and Coordination of Care revealed a rating of two (2) or higher for all measures assessed. For the Medi-Cal line of business, the highest rating measures are 'Eye exams in Patients with Diabetes' (EED) and 'Timeliness of Prenatal Care' (PPC-Pre), as seen in *Table 1*. Fall Risk Management (FRM) is the highest rating measure of the Medicare line of business as seen on *Table 3*. The goal is that all measures achieve a health plan rating of '5' (i.e. 90th percentile or above). A performance improvement plan of activities is documented in *Tables 2* and *4* to support 2026 performance for some of these measures. Performance results for the QRS measures include a Member experience measure (COC), Prenatal and Postpartum Care, Follow-up after ED visits for Mental Illness, Substance Use Disorder

Treatment and a Depression Screening measure. The ratings for these measures were not available at the time of the report.

POPULATION HEALTH MANAGEMENT

1. **Population Health Assessment Study (2024)**
   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.

   Based on medical claims and behavioral health claims data, the top diagnoses in the general population are Obesity, Hypertension, hyperlipidemia. For the SPD population, the most common diagnoses are hypertension, hyperlipidemia, and Type 2 diabetes. For children and adolescents, the top diagnoses are obesity, developmental disorder, asthma and anxiety. For BH Members, the top diagnoses are anxiety and depression. The SDOH top diagnoses are Low income, homelessness, and food insecurity. When assessing language, English and Spanish are the primary languages, followed by Vietnamese and Chinese. Members with limited English proficiency had a primary language of Spanish. Of the Members that call into IEHP requiring translator services, the most requested languages were Spanish, Mandarin, and Vietnamese. The Members that required a face-to-face interpreter during a medical visit, most requested Spanish, American Sign Language (ASL), and Arabic. An assessment of needs of Members that do not speak English as their primary language also revealed disparities in preventative care measures. For the Vietnamese speaking group, disparities were identified in the well-child visits for three (3) consecutive years. An analysis across all ethnic groups revealed disparities in the following groups: For Pediatric Preventative Care, Black Ethnicity disparity across all measures was identified. For Cancer Prevention, the White race/ethnic group had a disparity in Breast Cancer, Cervical Cancer and Colorectal cancer screening for four (4) consecutive years. Prenatal and Postpartum disparities were identified in the White and Black Ethnic groups. Disparities were identified in the White race for Children's Health Measures including the Well Child visit measures, Immunization, lead screening, and Child and adolescent Well Care visits.

2. **Population Health Management (PHM) Strategy Effectiveness Study (2024)**
   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.

- **ECM Program**

  The *2024 Press Ganey* results for the ECM Member Experience survey showed a slight decrease in the question categories from the previous year. IEHP Members were asked to rate the ECM program, the ECM Team, and the usefulness of the info. For the ECM Program results, the Members thought that the IEHP care teams were effective in providing intensive coordination of health care for our highest risk population with a program rating of 90.8% in 2024. The ECM Team results continued to show strong relationships and rapport formed with Members to help improve their health with a score of 92.0% in 2024. The result for the "Usefulness of info" provided by the ECM care manager was 89.9% in 2024. However, for all three questions examining the ECM Program, ECM Team and ECM Usefulness of Info, the set goal of at least 80% was met. The final question of the survey addressed whether the Members felt that the ECM program helped them achieve their personal health goals. The results indicate that 83.8% of Members reported that they either "agreed," or "strongly agreed," with that statement. This exceeded the set goal of 80%.

- **My Path Program**

  Utilization and cost data six months pre-enrollment and six (6) months post-enrollment into the My Path Program for three (3) years shows that ED visits, and inpatient acute bed days were lower post enrollment compared to pre-enrollment into the My Path Program. This trend is observed annually for the past three (3) calendar years: 2022, 2023, 2024.Total Member Cost also decreased for calendar year 2024 and 2022 but increased by approximately 3.61 million in 2023. For 2023 there was a significant increase in pharmacy costs that explains this increase. Primary Care Physician visits increased for all three measurement periods post enrollment. An important goal of the My Path program is to engage members with their PCPs and increase integrated care. Overall, these results show that participation in My Path improves IEHP Members' health by increasing engagement with their PCPs, decreasing unnecessary ED visits and shifting care from the acute inpatient to outpatient, while decreasing costs.

- **CCM Program**

  The effectiveness of the Complex Case Management (CCM) program was evaluated by analyzing readmission rates, emergency department (ED) visits, primary care physician (PCP) visits, and Member satisfaction scores. The data spanned over the years 2023 and 2024, focusing on members enrolled in the CCM program for at least 60 days to allow ample time for care plan development and

member education.

- **Community Supports Housing Program**

  Five housing-related community supports that support Members with Housing needs were assessed in this report. Emergency Department and hospital admission utilization for measurement year 2024 was examined for members who were assisted with a Housing Deposit, Housing Tenancy and Sustaining Services, Housing Transition/Navigations Services, Short Term Post Hospitalizing Housing, and or Recuperative Care Housing. The data shows that in 2024 there was a reduction in ED visits and in hospital admissions, when compared to the prior year's 2023 data, in Members that received housing assistance. These results revealed that all goals were met and that Members who receive housing support have a decrease in ED visits and Hospital utilization, thus reducing costs as well. Members who need housing support are informed of this benefit through community-based organizations, IEHP brochures, IEHP Events, Providers, and through the IEHP Website. IEHP will continue to monitor the volume and utilization of services provided throughout 2025.

- **Healthy Schools Program**

  The Healthy Schools Program was launched in the Fall of 2024. The current data shows 23 Local Education Agencies are engaged. This new Program is available to both Medi-Cal and IEHP Covered Members. The goal of the program is to continue to engage members via the Local Education Agency and/or from contact with an IEHP Health Navigator. For next measurement year, the following measures will be assessed: 'Proportion of Engaged Members who complete their Well child visit'. The number of engaged members will be identified at the end of 2025. From there the goal will be that 52% of Members complete their Well child visit. In addition, Depression Screening follow up will also be a measure that will be assessed next year. The baseline rate is currently being measured and will be available at the end of 2025.

OSTEOPOROSIS MANAGEMENT IN WOMEN

1. **Osteoporosis Management in Women Who Had a Fracture (OMW) Study (2024)**

   The HEDIS® OMW measure evaluates how well the organization manages women who are at high risk for a second fracture by evaluating whether female Members ages 67 to 85, who sustained a fracture, had evidence of either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the date of the fracture. IEHP has identified the OMW measure as an area of opportunity and continues to explore improvement strategies for Member and Provider engagement and overall improvement in the measure.

   IEHP implemented a multi-faceted strategy to improve OMW measure performance. All Members identified in the denominator were outreached telephonically by IEHP Care Management (CM) Team Members. Members who were reached were offered education which discussed the need for a bone mineral density scan or prescription provided by their Providers. In addition, IEHP partnered with an external vendor to provide in-home bone density scan services for IEHP Direct Members in the denominator. This

study evaluates the successful outreach, education, and completion of bone density scans of these Members. Lastly, IEHP also implemented a Provider level intervention. Providers assigned to Members identified in the OMW denominator were sent a fax on a monthly basis informing them of their patients who had sustained a fracture and the date by which they required treatment.

IEHP continued OMW outreach for MY 2024, the OMW HEDIS rate for the MY 2024 population was 45.62%, an increase from the MY 2023 rate of 28.82%. The MY 2024 successful contact rate for the Delegated population was 82.05%, which exceeded the goal of 75.00%. Successful Member education also surpassed the set goal with a rate of 71.88%. The goal for the OMW compliance rate was set at 15.00%, and the goal was reached with a rate of 47.83%. For the Vendor service interventions, Members were being referred and seen on time, however, when looking at the final MY OMW population, it was found that Members may have been removed due to the exclusion criteria. The unable to contact population continues to be a barrier to achieving improved performance rates. In order to enhance the opportunity for successful engagement, IEHP will be launching a pilot where the internal Care Management team will initiate the outreach and then transfer to Vendor for appointment scheduling.

CONCLUSION

In 2024, Inland Empire Health Plan (IEHP) continued to advance its mission of healing and inspiring the human spirit by delivering high-quality, equitable, and accessible care to its Dual Eligible Special Needs Plan (D-SNP) Members. Through the Quality Management and Health Equity Transformation Program (QMHETP), IEHP demonstrated a strong commitment to continuous improvement, health equity, and member-centered care. The QMHETP structure—anchored by the Quality Management and Health Equity Transformation Committee (QMHETC) and supported by 14 multidisciplinary subcommittees—remained effective in identifying trends, addressing disparities, and implementing targeted interventions. The program benefited from robust practitioner participation, cross-functional collaboration, and leadership engagement across all levels of the organization.

Program Effectiveness and Strategic Achievements

IEHP's QMHETP was successful in reviewing data, assessing trends, and developing improvement activities across key domains such as access to care, member and provider experience, and quality of care. The 2024 evaluation highlights several accomplishments:

- **Health Equity Accreditation** was maintained through the National Committee for Quality Assurance (NCQA), reinforcing IEHP's commitment to addressing systemic disparities and social drivers of health.
- **Model of Care (MOC) Performance** showed measurable improvements in preventive screenings, chronic condition management, and care coordination. Notable gains included:
    - Breast Cancer Screening: ↑ 6%
    - Diabetes A1c Control: ↑ 8%
    - Statin Therapy for Cardiovascular Disease: ↑ 5%
- **Member Experience** initiatives, including enhancements to interpreter services, grievance resolution, and the Member Experience Subcommittee (MESC), contributed to improved satisfaction and engagement.

- **Delegation Oversight** was strengthened through expanded audit tools, Corrective Action Plans (CAPs), and targeted training for underperforming IPAs.
- **Population Health Management** advanced through the launch of new programs such as the Healthy School Program and expanded DEI strategies, while maintaining a focus on behavioral health integration and care transitions.
- **Complex Care Management (CCM)** reported 88.5% Member satisfaction and 93.7% PCP visit compliance. However, D-SNP readmissions rose to 105.7 per 1,000, and ED visits increased to 1,143.2 per 1,000.
- **Lean Process Improvement** remained a cornerstone of IEHP's quality culture, with over 1,700 implemented improvement ideas (i3), 31 Rapid Improvement Events (RIEs), and the continued success of the Quality Operating Model.

Measures Performance, Population Health and Social Determinants of Health (SDOH)

The Healthcare Effectiveness Data and Information Set, better known as HEDIS®, is one component that is utilized by the National Committee for Quality Assurance (NCQA) in the health plan accreditation process. HEDIS® is used by more than 90 percent of health plans in the United States to measure performance on important dimensions of care and service. IEHP uses HEDIS® results as a tool to help focus its quality improvement efforts and as a way of monitoring the effectiveness of services provided. 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 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.

IEHP utilized multiple data sources to evaluate performance and identify opportunities for improvement. Key highlights include:

- **HEDIS®**: Breast Cancer Screening increased to 62.39% (↑3.91%), Cervical Cancer Screening rose to 65.93% (↑8.96%), and Colorectal Cancer Screening reached 45.99% (↑6.26%). Controlling Blood Pressure improved to 67.55%.
  - Identified Disparities:
    - Black Members – Controlling Blood Pressure (CBP)
      - Showed lower rates of blood pressure control.
    - Hispanic Members – A1C Control
      - Had lower A1c control.
    - White Members – Cancer Screening
      - Showed disparities in cancer screening rates.
    - Limited English Proficiency (LEP) – Spanish-Speaking Members
      - Rated their care higher than English speakers.

  To address these disparities, IEHP implemented training, developed multilingual educational materials, and launched targeted programs such as the Quality Withhold Incentive Program (QWIP) and Medication Therapy Management (MTM) for diabetes control.

- **CAHPS®**: Member feedback highlighted improvements in interpreter services, appointment coordination, and provider communication. Spanish remained the most requested language for interpretation.
  - Health Plan Rating improved to 90% while the Drug Plan score 89% and Health Care Quality reached 85%.
- **HOS**: Analysis of health outcomes revealed top diagnoses including obesity, hypertension, diabetes, and depression. Disparities were noted in pediatric and women's health across ethnic groups.
  - IEHP served a total of 1.72 million Members in 2024, including:
    - 78,500 Seniors and Persons with Disabilities (SPD)
    - 124,500 Members experiencing homelessness

Top diagnoses included obesity, hypertension, diabetes, and depression. Risk stratification revealed that 10.7% of Members were high-risk, 19.1% were rising-risk, and 70.2% were low-risk. Among children, 9,300 had special needs, with obesity, developmental disorders, and asthma being the most common conditions.

• **MOC**: The **Model of Care (MOC) Quality Performance Report** in the 2024 DSNP QMHETP Annual Evaluation provides a comprehensive assessment of how IEHP is meeting the needs of its Dual Eligible Special Needs Plan (D-SNP) members. Here are the key takeaways:

IEHP's MOC performance is measured across several CMS Star Rating domains. The 2024 results and goals are as follows:

Domain	2024 Score	2025 Goal
Staying Healthy (Preventive Care)	3.00	3.75
Managing Chronic Conditions	2.75	3.50
Drug Safety and Accuracy of Drug Pricing	2.00	3.00
Member Experience with Health Plan	2.33	3.50
Member Experience with Drug Plan	3.00	4.00
Member Complaints and Plan Performance Changes	4.22	5.00
Health Plan Customer Service	2.67	4.00
Drug Plan Customer Service	3.00	3.50

Care Coordination Metrics

IEHP tracked several internal measures to assess care coordination effectiveness:

- **Timely Health Risk Assessment (HRAT)**: 81% of new members completed an HRAT within 90 days.
- **Interdisciplinary Care Team (ICT) Identification**: 95% of members had an ICT identified within 90 days.

- **Timely Individualized Care Plan (ICP) Completion**: 87% of members had an ICP developed within 90 days.
- **Annual Face-to-Face Visit**: 89% of members received a visit with an ICT member.
- **Timely Contact Post-Admission**: 76% of members were contacted within 3 business days of admission.
- **Timely Contact Post-Discharge**: Only 24% of members were contacted within 3 business days of discharge—highlighting a significant opportunity for improvement.

Planned Improvements, Opportunities for Growth, and Continued Focus

IEHP has set ambitious goals for 2025 and beyond, including:

- Increasing timely post-discharge follow-up to reduce readmissions.
- Enhancing MTM outreach and engagement.
- Improving CAHPS® scores through targeted member and provider education.
- Expanding preventive care outreach and incentives.
- Strengthening care coordination workflows and documentation.

While IEHP made significant strides in 2024, the evaluation also identified areas for continued focus:

- **Post-Discharge Follow-Up**: Only 24% of Members received timely contact after discharge—well below the 95% goal—highlighting a critical opportunity to strengthen care transitions.
- **Medication Therapy Management (MTM)**: Completion rates declined slightly, underscoring the need for renewed outreach and engagement strategies.
- **Health Disparities**: Persistent disparities were identified across racial, ethnic, and linguistic groups, particularly in pediatric care, women's health, and chronic disease management. These findings will inform future equity-focused interventions and resource allocation.

IEHP will continue to produce and distribute the Quality Report, which transparently reflects performance across critical measures and translates data into tangible outcomes for Members, Providers, and Team Members. This journey is ongoing, and IEHP remains committed to learning, adapting, and improving. In 2024, IEHP placed even greater importance on its relationships with Providers and community partners. Monthly engagement events in addition to expanded Pay-for-Performance programs, and collaborative improvement initiatives reflect IEHP's dedication to supporting those who serve our Members. As IEHP looks ahead, the organization remains steadfast in its vision: *We will not rest until our communities enjoy optimal care and vibrant health.* Through collaboration, accountability, and a relentless focus on outcomes, 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. It is with this commitment that IEHP will reach the 5-Star Health Plan Rating.