Inland Empire Health Plan
Quality Management and Health Equity Transformation Program Description
Date: January 2026

24. PROGRAM DESCRIPTIONS

C. Quality Management & Health Equity Transformation Program and Quality Improvement Program Description

Introduction

IEHP supports an active, ongoing, and comprehensive Quality Management & 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. po

Mission, Vision, and Values

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.[1] The organization prides itself in four (4) core goals:

A. *Mission:* We heal and inspire the human spirit.

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

C. *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.

Section 1: QMHETP Overview

1.1 QMHETP 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

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2, Quality Improvement and Health Equity Transformation Program (QIHETP)

measure and monitor intervention results over time to assess any needs for new improvement strategies.

1.2 QMHETP Scope

The Quality Management & Health Equity Transformation Committee (QMHETC) approves the QMHETP annually. The QMHETP review includes approval of the QMHETP Description, QMHETP 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]
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;[3,4]
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;[5]
8. Involving Long-Term Services and Supports (LTSS) Provider(s) in the QMHETP;
9. Reviewing the effectiveness of LTSS programs and services;[6]
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;

[2] National Committee for Quality Assurance (NCQA), Health Plan Standards and Guidelines, QI 1, Element A, Factor 1
[3] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2, QIHETP
[4] NCQA, HP Standards and Guidelines, QI 1, Element A, Factor 2
[5] NCQA, HP Standards and Guidelines, QI 1, Element A, Factor 4
[6] Title 42 Code of Federal Regulations (CFR) § 438.330(b)(5)

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.

1.3 QMHETP Goals[7]

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.

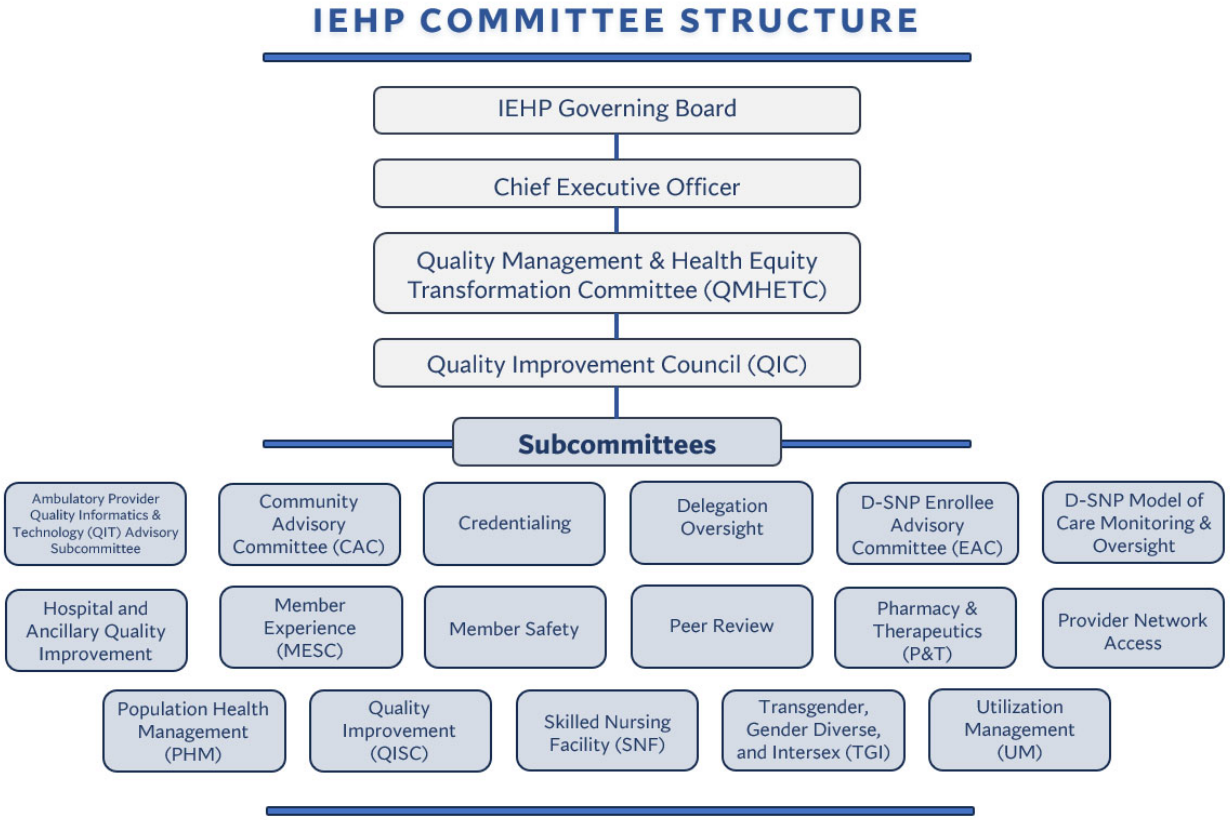
[7] NCQA, HP Standards and Guidelines, QI 1, Element A, Factor 1

24. PROGRAM DESCRIPTIONS

C. Quality Management & Health Equity Transformation Program and Quality Improvement Program Description

Section 2: Authority and Responsibility[8]

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.



2.1. 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;

[8] NCQA, HP Standards and Guidelines, QI 1, Element A, Factor 1.

3. Evaluating QMHETP effectiveness and progress;
4. Evaluating and approving the annual QMHETP Description and Work Plan;[9]
5. Appointing an accountable entity or entities within the Plan responsible for oversight of QMHETP;[10]
6. Reviewing written progress reports received from the QMHETC that describe actions taken, progress in meeting QMHETP objectives, and improvements made;[11]
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.

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).[12]

Quality topics are presented to the Board at least quarterly, and on an as-needed basis. Topics presented to the Board consist of but are not limited to: Overview of IEHP Pay-for-Performance Programs, QMHETP Description and Workplan, Quality Management & Health Equity Program Overview, Provider Satisfaction Survey results, Grievance & Appeals Trends and Log Review, HEDIS® and CAHPS® Annual Reports. Feedback from the Board is shared at the QMHETC.

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.[13,14]

2.2. Role of the Chief Executive Officer (CEO)

Appointed by the Governing Board, the CEO or designee has the overall responsibility for IEHP management and viability. Responsibilities include but are not limited to: IEHP direction, organization, and operation; developing strategies for each Department including the QMHETP; position appointments; fiscal efficiency; public relations; governmental and community liaison; and contract approval. The CEO reports to the Governing Board and is an ex officio Member of all standing Committees. The CEO interacts with the CMO and CQO regarding ongoing QMHETP and QI activities, progress toward goals, and identified health care problems or quality issues requiring corrective action.

[9] DHCS-IEHP Primary Operations Contract, 01/01/24, Exhibit A, Attachment III, Provision 2.2.2, Governing Board
[10] Ibid.
[11] Ibid.
[12] Ibid.
[13] Ibid.
[14] NCQA, HP Standards and Guidelines, QI 1, Element A, Factor 3

2.3. Role of the Chief Medical Officer (CMO)[15]

The CMO or designee has ultimate responsibility for the quality of care and services delivered to Members and has the highest level of oversight for IEHP's QMHETP and QI Program. The CMO must possess a valid Physician's and Surgeon's Certificate issued by the State of California and certification by one of the American Specialty Boards. The CMO reports to the CEO and Governing Board. As a participant of various Subcommittees, the CMO provides direction for internal and external QMHETP functions and supervision of IEHP staff.

The CMO or designee participates in quality activities as necessary; provides oversight of IEHP credentialing and re-credentialing activities and approval of IEHP requirements for IEHP-Direct Practitioners; reviews credentialed Practitioners for potential or suspected quality of care deficiencies; provides oversight of coordination and continuity of care activities for Members; provides oversight of Member safety activities; and proactively incorporates quality outcomes into operational policies and procedures.

The CMO or designee provides direction to the QMHETC and associated Subcommittees; aids with study development; and facilitates coordination of the QMHETP in all areas to provide continued delivery of quality health care for Members. The CMO assists the Chief Network Development Officer with provider network development, contract, and product design. In addition, the CMO works with the Chief Financial Officer (CFO) to ensure that financial considerations do not influence the quality of health care administered to Members.

The CMO acts as primary liaison to regulatory and oversight agencies including but not limited to: the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid Services (CMS), and the National Committee for Quality Assurance (NCQA), with support from Health Services staff as necessary.

2.4. Role of the Chief Quality Officer (CQO)

The CQO is responsible for leading quality strategy for IEHP. This includes the development of new, innovative solutions and quality measures in preventative health and improved quality of care for Members. The CQO reports to the CEO and Governing Board and must possess a valid Physician's and Surgeon's Certificate issued by the State of California and certification by one of the American Specialty Boards. The CQO works with the CEO and Chief Officers to establish goals and priorities for the quality strategy as well as communicating those goals to the Governing Board and its key stakeholders—the IEHP Provider network, regulatory and accrediting bodies. As a participant of various Subcommittees, the CQO provides direction for internal and external QMHETP functions and supervision of IEHP staff.

Along with the CMO, the CQO or designee, provides direction to the QMHETC and associated Subcommittees; aids with quality study development; and facilitates coordination

[15] NCQA, HP Standards and Guidelines, QI 1, Element A, Factor 3.

of the QMHETP in all areas to provide continued delivery of quality health care for Members.

The CQO initiates and leads initiatives for continuous quality improvement and evaluating the effectiveness of interventions across the continuum of care to Members, Providers and internally. The CQO also collaborates with state/federal regulatory agencies, accrediting bodies, and internal Government Relations, Compliance, and Legal leadership staff to ensure all quality regulatory compliance requirements are met.

The CQO provides leadership, develops strategies, and administers programs for accreditation, monitoring, HEDIS® operations, reporting, quality scorecard reporting, and quality-related new business development.

2.5. Role of the Chief Health Equity Officer (CHEO)

The Chief Health Equity Officer (CHEO) provides leadership in the design and implementation of IEHP's strategies and programs to ensure health equity is prioritized and addressed; ensures all policies and procedures consider health inequities and are designed to promote health equity where possible, including but not limited to marketing strategy, medical and other health services policies, Member and provider outreach, Public Policy Participation Committee, quality improvement activities, including delivery system reforms, grievance and appeals, and utilization management. The CHEO is responsible for developing and implementing policies and procedures aimed at improving health equity and reducing health disparities, engaging and collaborating with Team Members, Subcontractors, Downstream Subcontractors, Network Providers, and entities including local community-based organizations, local health department, behavioral health and social services, child welfare systems and Members in health equity efforts and initiatives. The CHEO is also responsible for implementing strategies designed to identify and address root causes of health inequities, which includes but is not limited to systemic racism, social drivers of health, and infrastructure barriers.

The CHEO has the authority to design and implement policies that ensure Health Equity is prioritized and addressed. The CHEO is an active Member of the QMHETC to ensure engagement and collaboration with both IEHP leadership and external providers. The CHEO is responsible for supervision of all health equity related QMHETP activities. The CHEO develops targeted interventions designed to eliminate health inequities; develops quantifiable metrics that can track and evaluate the results of the targeted interventions designed to eliminate health inequities; and ensures all Contractor, Subcontractor, Downstream Subcontractor, and Network Provider staff receive mandatory diversity, equity and inclusion training annually.

2.6. Quality Management & Health Equity Transformation Committee (QMHETC)[16]

The QMHETC reports to the Governing Board and retains oversight of the QMHETP with

[16] NCQA, HP Standards and Guidelines, QI 1, Element B, Factor 3

direction from the CMO and CQO.[17,18] 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.[19] These individuals provide expertise and assistance in directing the QMHETP activities. A designated Behavioral Healthcare Practitioner is an active Member of the IEHP QMHETC to assist with behavioral healthcare-related issues.[20] There are a total of 29 Quality Management & Health Equity Transformation Committee Members. This includes both internal and external participants. IEHP attendees include multi-disciplinary representation from multiple IEHP Departments including but not limited to:
    a. Quality Management;
    b. Utilization Management;
    c. Behavioral Health and Care Management;
    d. Pharmaceutical Services;
    e. Member Services;
    f. Family and Community Health;
    g. Population Health Management;
    h. Health Education;
    i. Grievance & Appeals;
    j. Quality Informatics;
    k. Program Informatics;
    l. Health Equity Operations;
    m. Independent Living and Diversity Services;
    n. Information Technology;

[17] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2.3, Quality Improvement and Health Equity Committee
[18] NCQA, HP Standards and Guidelines, QI 1, Element A, Factor 5
[19] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2.4, Provider Participation
[20] NCQA, HP Standards and Guidelines, QI 1, Element A, Factor 4

o. Compliance; and

p. Provider Services.

3. **Function**: The QMHETC meets quarterly[21] and reports findings, actions, and recommendations to IEHP Governing Board (through the CQO) annually and reports meeting minutes to DHCS quarterly.[22] The QMHETC seeks methods to increase the quality of health care for IEHP Members; recommend policy decisions; analyze and evaluate QI activity results; institute and direct needed actions; and ensure follow-up as appropriate. The Committee provides oversight and direction for Subcommittees, related programs, activities, and reviews and approves Subcommittee recommendations, findings, and provides direction as applicable. QMHETC findings and recommendations are reported through the CQO to the IEHP Governing Board on an annual basis.[23]

4. **Quorum**: Voting cannot occur unless there is a quorum of voting Members present. For decision purposes, a quorum is defined as the Chairperson or IEHP Medical Director and one (1) appointed Physician Committee Members.

   a. A Behavioral Health Practitioner must be present for behavioral health issues.[24]

   b. Non-physician Committee Members may not vote on medical issues. [25]

5. **External Committee Members:** QMHETC Members must be screened to ensure they are not active on either the Office of Inspector General (OIG) or General Services Administration (GSA) exclusion lists.

   a. The Compliance and QM department collaborate to ensure committee Members undergo an OIG/GSA exclusion screening prior to scheduling QMHETC meetings.

   b. IEHP utilizes the OIG Compliance Now (OIGCN) vendor to conduct the screening of covered entities on behalf of IEHP. In the event, any Member of the QMHETC, or prospective Member, is found to be excluded per OIGCN, the Compliance Department will notify the QM department so that they may take immediate action.

   c. QMHETC Members must be screened before being confirmed, and monthly thereafter.

   d. QM notifies the Compliance department of any Membership changes in advance of the QMHETC meeting so that a screening can be conducted prior to the changes taking effect.

[21] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2.3, QIHEC
[22] Ibid.
[23] Ibid.
[24] NCQA, HP Standards and Guidelines, QI 1, Element A, Factor 4
[25] Ibid.

6. **Confidentiality:** All QMHETC minutes, reports, recommendations, memoranda, and documented actions are considered quality assessment working documents and are kept confidential. IEHP complies with all State and Federal regulatory requirements for confidentiality. All records are maintained in a manner that preserves their integrity to assure Member and Practitioner confidentiality is protected.[26]
    a. All Members, participating staff, and guests of the QMHETC and Subcommittees are required to sign the Committee/Subcommittee Attendance Record, including a confidentiality statement.
    b. The confidentiality agreements are maintained in the Practitioner files as appropriate.
    c. All IEHP staff Members are required to sign a confidentiality agreement upon hiring. The confidentiality agreements are maintained in the employee files as appropriate.
    d. All peer review records, proceedings, reports, and Member records are maintained in accordance with state, federal and regulatory requirements to ensure confidentiality.
    e. IEHP maintains oversight of Provider and Practitioner confidentiality procedures. See policy 7B, "Information Disclosure and Confidentiality of Medical Records."
7. **Enforcement/Compliance:** The QM Department is responsible for monitoring and oversight of QMHETC's enforcement of compliance with IEHP standards and required activities. Activities can be found in sections of manuals related to the specific monitoring activity. The general process for obtaining compliance when deficiencies are noted, and Corrective Action Plans (CAP) are requested, is delineated in internal and external policies.
8. **Data Sources and Support:** The QMHETP utilizes an extensive data system that captures information from claims and encounter data, enrollment data, Utilization Management (UM), QM, Health Equity and QI activities, behavioral health data, pharmaceutical data, grievances and appeals, and Member Services, among others.
9. **Affirmation Statement**: The QMHETP assures that utilization decisions made for IEHP Members are based solely on medical necessity. IEHP does not compensate or offer financial incentives to Practitioners or individuals for denials of coverage or service or any other decisions about Member care.[27] IEHP does not exert economic pressure to Practitioners or individuals to grant privileges that would not otherwise be granted or to practice beyond their scope of training or experience.

[26] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2.3, Quality Improvement and Health Equity Committee
[27] NCQA, HP Standards and Guidelines, MED 9, Element D

10. **Availability of QMHETP Information**: IEHP has developed an overview of the QMHETP and related activities. This overview is on the IEHP website at www.iehp.org and a paper copy is available to all Members and/or Practitioners upon request by calling IEHP Member Services Department. Members are notified of the availability through the Member Handbook.[28,29] Practitioners are notified in the Provider Manual. The IEHP QMHETP Description and Work Plan are available to IPAs and Practitioners upon request. A summary of QM, Health Equity & QI activities and progress toward meeting QM, Health Equity & QI goals are available to Members, Providers, and Practitioners upon request.
11. **Conflict of Interest**: IEHP monitors IPAs for policies and procedures and signed conflict of interest statements at the time of the Delegation Oversight Annual Audit.[30]

2.7. Quality Subcommittees

Subcommittee and functional reports are submitted to the QMHETC on a quarterly and ad hoc basis. The following Subcommittees, chaired by the IEHP CMO or designee, report findings and recommendations to the QMHETC:[31]

1. Ambulatory Provider Quality Informatics & Technology (QIT) Advisory Subcommittee;
2. Credentialing Subcommittee;
3. Delegation Oversight Committee;
4. Hospital and Ancillary Quality Improvement (QI) Subcommittee;
5. Member Experience Subcommittee (MESC);
6. Member Safety Subcommittee;
7. Peer Review Subcommittee;
8. Pharmacy and Therapeutics (P&T) Subcommittee;
9. Population Health Management (PHM) Subcommittee;
10. Provider Network Access Subcommittee;
11. Quality Improvement Council (QIC);
12. Quality Improvement Subcommittee (QISC);
13. Skilled Nursing Facility (SNF) Subcommittee;

[28] Title 28, California Code of Regulations § 1300.69(i)
[29] NCQA, HP Standards and Guidelines, MED 8, Element D
[30] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2.3, Quality Improvement and Health Equity Committee
[31] NCQA, HP Standards and Guidelines, QI 1, Element A, Factor 5

14. Transgender, Gender Diverse, and Intersex (TGI) Subcommittee; and
15. Utilization Management (UM) Subcommittee.

2.7.1 Quality Improvement Council (QIC)

The Quality Improvement Council (QIC) is responsible for quality improvement activities for IEHP.

1. **Role:** The QIC reviews reports and findings of studies before presenting to the 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.
2. **Structure:** The QIC is composed of representation from multiple internal IEHP Departments including but not limited to: Quality Systems, Behavioral Health & Care Management, Population Health Management, Grievance and Appeals, Utilization Management, Compliance, Community Health, Program Informatics, Health Education, Member Services, and Provider Services. The QIC is facilitated by the IEHP VP of Quality of Quality and the VP of Health Services. Network Providers, who are representative of the composition of the contracted Provider network, may participate on the subcommittee that reports to the QMHETC.
3. **Function**: The QIC analyzes and evaluates QI activities and report results; develops action items as needed; and ensures follow-up as appropriate. All action plans are documented on the Work Plan.
4. **Frequency of Meetings:** The QIC meets monthly with ad hoc meetings conducted as needed.

2.7.2. Peer Review Subcommittee

The Peer Review Subcommittee is responsible for peer review activities for IEHP.

1. **Role:** The Peer Review Subcommittee reviews quality performance profiles of Practitioners identified during the Peer Review Program activities that may include escalated cases related to grievances, quality of care and utilization audits, credentialing and re-credentialing and medical-legal issues. The Subcommittee performs oversight of organizations who have been delegated credentialing and re-credentialing responsibilities and evaluates the IEHP Credentialing and Re-credentialing Program with recommendations for modification as necessary.
2. **Structure:** The Peer Review Subcommittee is composed of IPA Medical Directors or designated physicians that are representative of network Providers. A Behavioral Health Practitioner and any other Specialist, not represented by committee Members, serve on an ad hoc basis for related issues.
3. **Function**: 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 referred by the CMO or Medical Director designee.

4. **Frequency of Meetings:** The Peer Review Subcommittee meets every other month with ad hoc meetings as needed.

2.7.3. Credentialing Subcommittee

The Credentialing Subcommittee performs credentialing functions for Providers who are either directly contracted with IEHP or for those submitted for approval of participation in the IEHP network by IPAs that have not been delegated credentialing responsibilities.

1. **Role:** The Credentialing Subcommittee is responsible for reviewing individual Practitioners who directly contract with IEHP and denying or approving their participation in the IEHP network.
2. **Structure:** The Credentialing Subcommittee is composed of multidisciplinary participating Primary Care Providers (PCP) or specialty Physicians, representative of network Providers. A Behavioral Health Practitioner, and any other Specialist not represented by committee Members, serves on an ad hoc basis for related issues.
3. **Function:** The Credentialing Subcommittee provides thoughtful discussion and consideration of all network Providers 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; and ensures that decisions are non-discriminatory.
4. **Frequency of Meetings:** The Credentialing Subcommittee meets every month with ad hoc meetings conducted as needed.

2.7.5. Pharmacy and Therapeutics (P&T) Subcommittee

The P&T Subcommittee performs ongoing review and modification of the IEHP Formulary and related processes; conducts oversight of the Pharmacy network including medication prescribing practices by IEHP Practitioners; assesses usage patterns by Members; and assists with study design, and other related functions.

1. **Role**: The P&T Subcommittee is responsible for maintaining a current and effective formulary, monitoring medication prescribing practices by IEHP Practitioners, and under- and over-utilization of medications. They are also responsible for reviewing and updating clinical practice guidelines that are primarily medication related.
2. **Structure:** The P&T Subcommittee is comprised of clinical pharmacists and designated Physicians representative of network Practitioners. Other specialists, including a Behavioral Health Practitioner serve on an ad hoc basis for related issues. Changes to Subcommittee Membership shall be reported to CMS during the contract year.

3. **Function**: The P&T Subcommittee serves as the committee to objectively appraise, evaluate, and select pharmaceutical products for formulary inclusion and exclusion. The Subcommittee provides recommendations regarding protocols and procedures for pharmaceutical management and the use of non-formulary medications on an ongoing basis. The Subcommittee ensures that decisions are based only on appropriateness of care and services. The P&T Subcommittee is responsible for developing, reviewing, recommending, and directing the distribution of disease state management or treatment guidelines for specific diseases or conditions that are primarily medication related. The Subcommittee utilizes retrospective Drug Utilization Review (DUR) Board reports to create interventions to ensure therapeutic appropriateness as well as to monitor adverse events, identify incorrect duration of treatment, over or underutilization, inappropriate or medically unnecessary prescribing, gross overprescribing and use, fraud, waste, and abuse and safe prescribing. The DUR Board also reports on Targeted Medication Reviews (TMRs) that include addressing key HEDIS® measures.
4. **Frequency of Meetings:** The P&T Subcommittee meets quarterly with ad hoc meetings conducted as needed.

2.7.6. <u>Delegation Oversight Committee</u>

The Delegation Oversight Committee is an internal committee responsible for IPA oversight and monitoring in conjunction with Departments including QM, UM, BH, CM, Credentialing/Re-Credentialing activities, Compliance and Finance.

1. **Role:** The Delegation Oversight Committee is responsible for monitoring the operational activities of contracted IPAs and other Delegate's activities including Claims Audits, Pre-Service and Payment universe metrics, Financial Viability, Electronic Data Interchange (EDI) transactions, Case Management, Utilization Management, Grievance & Appeals, Quality Management, Credentialing/Re-credentialing activities, and other provider-related activities.
2. **Structure:** The Delegation Oversight Committee is composed of representation from multiple internal IEHP Departments including, but not limited to: Quality Systems, Behavioral Health & Care Management, Population Health Management, Grievance and Appeals, Utilization Management, Compliance, Program Informatics, and Provider Services. The Delegation Oversight Committee is facilitated by the Director of Delegation Oversight.
3. **Function:** The Delegation Oversight Committee analyzes and evaluates Delegation Oversight activities and reports results; develops action items as needed; and ensures follow-up as appropriate.
4. Frequency of Meetings: The Delegation Oversight Committee meets every month with ad hoc meetings conducted as needed.

2.7.7 Transgender, Gender Diverse, and Intersex (TGI) Subcommittee

The TGI Subcommittee is an internal subcommittee responsible for providing the highest level of care to all its Members, including Members who identify as transgender, gender non-binary, gender diverse.

1. **Role:** The TGI Subcommittee is responsible for reviewing, monitoring, and evaluating progress while creating awareness and remediation of systemic issues impacting TGI Members.
2. **Structure:** The TGI Subcommittee is composed of representation from multiple internal IEHP Departments including, but not limited to: Quality Systems, Behavioral Health & Care Management, Population Health Management, Grievance and Appeals, Utilization Management, Health Equity Operations, HealthCare Informatics, and Provider Services. The TGI Subcommittee is facilitated by the Director of Health Equity and co-chaired by the Senior Medical Director.
3. **Function:** The TGI Subcommittee analyzes and evaluates ACA-compliant policies that reduce gender discrimination complaints and improve IT systems to respect Members' gender identities. The subcommittee will also ensure transgender service requests are reviewed by trained professionals, adhering to current standards of care.
4. **Frequency of Meetings:** The TGI Subcommittee meets bimonthly with ad hoc meetings conducted as needed.

2.7.8. Quality Improvement (QI) Subcommittee

The Quality Improvement Subcommittee is responsible for quality improvement activities for IEHP.

1. **Role**: The QI Subcommittee is responsible for reviewing reports and findings of studies before presenting to QMHETC and works to develop action plans to improve quality and study results.
2. **Structure**: The QI Subcommittee is composed of representation from multiple internal IEHP Departments including, but not limited to: Quality Systems, Behavioral Health & Care Management, Population Health Management, Grievance and Appeals, Utilization Management, Compliance, Community Health, Health Education, Program Informatics, Member Services, and Provider Services. The QI Subcommittee is facilitated by the Director of Quality Improvement, and an IEHP Medical Director or designee.
3. **Function**: The QI Subcommittee 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 QMHETP Work Plan.
4. **Frequency of Meetings**: The QI Subcommittee meets quarterly with ad hoc meetings conducted as needed.

2.7.9. **Population Health Management (PHM) Subcommittee**

The PHM Subcommittee provides monitoring and oversight of IEHP's Population Health Management Program as defined in IEHP's Population Health Management Program Description.

1. **Role:** 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.
2. **Structure:** The PHM Subcommittee is composed of representation from multiple internal IEHP Departments including, but not limited to: Quality Systems, Behavioral Health & Care Management, Grievance and Appeals, Utilization Management, Health Equity/Community Health, Community Supports, Integrated Transitions of Care, Enhanced Care Management, Health Education, Program Informatics, Member Services, and Provider Services. The PHM Subcommittee is facilitated by the Vice President of Health Services Clinical Integration and Operations, and an the Vice President of Quality.
3. **Function:** The PHM Subcommittee establishes a cohesive organizational approach to population health management that ensures that all IEHP Members have access to a comprehensive program that leads to longer, healthier, and happier lives, improved outcomes, and health equity. The PHM Subcommittee analyzes and evaluates PHM activities and reports results; develops action items as needed; and ensures follow-up as appropriate. All action plans are documented on the QMHETP Work Plan.
4. **Frequency of Meetings:** The PHM Subcommittee meets monthly with ad hoc meetings conducted as needed.

2.7.10 The Provider Network Access Subcommittee

1. **Role:** 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.
2. **Structure:** The Provider Network Access Subcommittee reports directly to the QIC, who then reports up to the QMHETP. The Provider Network Access Subcommittee is composed of representation from multiple internal IEHP departments, including but not limited to: Quality Systems, Delegation Oversight, Provider Services, Grievance & Appeals. Ad hoc participants may include Operations, Compliance, Regulatory and others on an as-needed basis. The Provider Network Access Subcommittee is facilitated by the Director of Healthcare Informatics, and the Director of Provider Network.
3. **Function:** The Provider Network Access Subcommittee established goals to align with IEHP's strategic commitment to optimal care and vibrant health. Provider Network Access Program performance and outcome measures include but are not limited to: Improving access to preventive health services, Improving access to medical and mental

health services, and Ensuring an adequate provider network. Outcomes are evaluated on an annual basis. Intervention decisions and goal revision is based on data and a multidisciplinary quality committee recommendation.

4. **Frequency of Meetings:** The Provider Network Access Subcommittee meets quarterly with ad hoc meetings conducted as needed.

2.7.11 Member Experience Subcommittee (MESC)

1. **Role:** The role of the Member Experience Subcommittee is to review, monitor, and evaluate Member experience program data, outliers, and trends to ensure timely improvement initiatives are initiated. The MESC is responsible for initiative oversight, ensuring outcomes are achieved and barriers are removed.
2. **Structure:** The Member Experience Subcommittee is composed of cross-departmental internal IEHP Leaders. Representing departments include, but are not limited to: Transportation Services, Provider Services/Relations, Member Services, Grievance & Appeals, Quality Systems, Health Services and Marketing/Communication. Other participants may contribute on an ad hoc basis and include, but are not limited to: Hospital Relations, Community Health/Health Equity, Operations, Credentialing, Pharmacy, Compliance, Policy & Regulatory Operations, or other key business units that contribute to focused quality improvement initiative agenda items or discussions. The MESC is facilitated by the Vice President of Member Experience, and the Vice President of Provider Experience.
3. **Function:** The Member Experience Subcommittee, through a multifunctional approach, reviews Member experience and satisfaction/dissatisfaction studies and reports identified on the workplan. The MESC 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, performance reports, and recommended action items are presented to the QIC on a routine basis.
4. **Frequency of Meetings:** The Member Experience Subcommittee meets bi-monthly with ad hoc meetings conducted as needed.

2.7.12 Member Safety Subcommittee

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 delivered to our Members.

1. **Role**: The roles and responsibilities of the Member Safety Subcommittee are as follows: Reviewing and analyzing reports of adverse events, near-misses, and other Member safety incidents to identify areas for improvement; Developing, reviewing, and implementing

policies and procedures to reduce the risk of adverse events and improve Member safety; Identifying areas for improvement to reduce Member harm or injury; Presenting quality of care or quality of service concerns to the Quality Improvement Council (QIC); Collaborating with other subcommittees, departments, and internal or external partners to ensure alignment and consistency in Member safety initiatives; Monitoring and evaluating the effectiveness of Member safety initiatives and recommending improvements; Reporting Member safety issues, trends, and progress in reducing adverse events to Quality Improvement Council (QIC) of.

2. **Structure:** The Member Safety Subcommittee reports any quality concerns directly to the Quality Improvement Council (QIC). The Member Safety Subcommittee will be chaired by a Medical Director and co-chaired by the Clinical Director of Quality Management. The Member Safety Subcommittee will consist of the following voting representatives from internal departments and disciplines including Medical Directors; Quality Management; Quality Improvement; Pharmacy; Hospital Relations; Health Equity; Behavioral Health & Case Management; Utilization Management; Grievance and Appeals; Provider Services and; Administrative Assistant/Special Program Manager (Minutes). Ad hoc participants may include, but not limited to, Operations, Information Technology, Compliance, Legal, and others as determined and appropriate. Ad hoc participants will not be voting representatives.
3. **Function:** The Member Safety Subcommittee monitors and detects the IEHP network and systems to identify potential safety issues/concerns and risks. The purpose of the Member Safety Subcommittee is to promote and ensure the evaluation and monitoring of Members' safety and well-being as well as the quality of care and service provided to IEHP Members by network providers, direct or delegated. The Subcommittee will work towards identifying, preventing, analyzing, evaluating, and addressing potential Member safety issues, implementing effective risk mitigation strategies, issuing corrective action plans (CAPs), and continuously improving the prevention of harm or injury to IEHP Members.
4. **Frequency of Meetings: The** Member Safety Subcommittee will meet on a quarterly basis to discuss Member safety initiatives, review incident reports, review required regulatory and accreditation reports, and make recommendations for improving Member safety processes. Additional meetings may be scheduled on an ad hoc basis to address urgent Member safety concerns.

2.7.13 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.

1. **Role:** The role of the Skilled Nursing Facility Subcommittee is to review, monitor, and evaluate program data, outliers, and trends to ensure timely improvement initiatives. The subcommittee will be responsible for initiative oversight, ensuring outcomes are improved or achieved and barriers are removed.
2. **Structure**: The Skilled Nursing Facility Subcommittee includes representation from the following departments: Behavioral Health and Case Management; Enhanced Care Management; Health Services; Hospital Relations; Medical Directors; Quality and Integrated Transitional Care. Ad hoc participants may include, but are not limited to: Community Health, Grievance and Appeals, Member Services, Pharmacy, Provider Services, and others as identified through evolving areas of focus.
3. **Function**: To establish and maintain a comprehensive Quality Assessment and Performance Improvement (QAPI) program for care delivery services provided to IEHP Members admitted to contracted Skilled Nursing Facility (SNF) organizations. Subcommittee objectives include the development and ongoing monitoring of a quality measures of care based on. improvement opportunities identified through CMS Nursing Home Compare, IEHP claims data and CDPH to include but not limited to survey deficiency results, site visit findings, and complaint findings.
4. **Frequency of Meetings:** The Skilled Nursing Facility Subcommittee meets at least twice per year or as needed based on current areas of focus and to ensure sustained compliance with regulatory requirements.

2.7.14 Ambulatory Provider Quality Informatics & Technology (QIT) Advisory Subcommittee

This subcommittee will 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.

1. **Role**: Participants of the Ambulatory QIT Advisory Subcommittee are expected to review the agenda and presentation material beforehand to foster a meaningful discussion. Topics for discussion shall be preferably submitted in advance to allow participants to prepare. Most importantly, participants are accountable for communicating and implementing the agreed upon changes at their organizations and reporting the progress and barriers at the subsequent meeting.
2. **Structure:** The Ambulatory QIT Advisory Subcommittee includes representation from the following departments: Information Technology; and Quality Systems. The Subcommittee also includes external representation from the following organizations: Arrowhead Regional Medical Center; SAC Health (FQHC); Riverside University Health System;

Loma Linda University; DAP Health; Primary care participants (who utilize Epic, NexGen, etc.); Desert Oasis; Riverside Medical Clinic; and Riverside Family Physicians.

3. **Function**: To establish and adopt a common roadmap for current and future iterations of electronic applications to advance patient care and seamlessly capture data and quality metrics. This goal shall be achieved by utilizing industry standards (when applicable) and adopting a multi-faceted approach.
4. **Frequency of Meetings:** The Ambulatory QIT Advisory Subcommittee meets bi-monthly with ad hoc meetings conducted as needed.

2.7.15 Hospital and Ancillary Quality Improvement (QI) Subcommittee

This subcommittee will serve as the primary forum for discussion of topics related to acute care hospitals and/or sub-acute/post-acute network sites of care (i.e., hospice agencies, home health agencies (HHA), etc.*). IEHP's Optimal Care Subcommittee and the Inland Empire Hospital Alliance (IEHA) will report through this forum which will summarize performance and recommended actions for presentation at the Quality Improvement Council (QIC).

1. **Role**: The role of the Hospital and Ancillary QI Subcommittee is to review, monitor and evaluate program data, outliers and trends to ensure timely improvement initiatives. The subcommittee will be responsible for initiative oversight, ensuring outcomes are improved or achieved and barriers are removed. Furthermore, the Hospital Relations Subcommittee ensures timely communication of hospital, hospice agency and HHA performance to the QIC, including escalations as appropriate. This includes specific reporting of items linked IEHP's Optimal Care strategies.
2. **Structure**: The Hospital and Ancillary QI Subcommittee includes representation from the following departments: Behavioral Health and Care Management; Enhanced Care Management; Health Services; Hospital Relations; Integrated Transitional Care; Medical Directors; Provider Experience and Quality. Ad hoc participants may include, but are not limited to: Community Health, Grievance and Appeals, Member Services, Pharmacy, Provider Services, and others as identified through evolving areas of focus.
3. **Function:** To identify opportunities that impact clinical outcomes, Member safety, and Member experience during acute care hospitalization and/or sub-acute/post-acute network utilization (i.e., hospice agencies, home health agencies (HHA), etc.*). This subcommittee serves as a forum for review and evaluation of strategic and operational 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.
4. **Frequency of Meetings:** The Hospital and Ancillary QI Subcommittee meets at least twice per year or as needed based on current areas of focus and to ensure sustained compliance with regulatory requirements.

2.7.16 Utilization Management (UM) Subcommittee

The UM Subcommittee performs oversight of UM activities in all clinical departments conducted by IEHP and IPAs to maintain high quality health care, as well as effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services.

At a minimum, IEHP evaluates their UM Program to ensure that is remains current and appropriate, which must include but not limited to the review of the following.

- UM Program Structure.
- Program Scope, processes, information sources used to determine benefit coverage and medical necessity.
- The level of involvement of the senior-level physician within the UM Program.
- Annual Inter-rater Reliability (IRR) monitoring performance of decision makers.
- Ensuring that medical decisions are rendered by qualified medical personnel.
- Ensuring that decisions are based off a consistent application of UM Criteria.

IEHP performs quality assurance on both UM authorization and denials via monthly universes to determine process timeliness and appropriateness of decision making.

1. **Role:** The UM Subcommittee directs the continuous monitoring of all aspects of UM and Behavioral Health (BH) services provided to Members.
2. **Structure:** The UM Subcommittee is composed of IPA Medical Directors, or designated Physicians that are representative of network Practitioners. A Behavioral Health Physician and any other Specialist, not represented by committee Members, serve on an ad hoc basis for related issues.[32]
3. **Function**: The UM Subcommittee reviews and approves the Utilization Management programs annually. The Subcommittee also monitors for over-utilization and under-utilization; and ensures that UM decisions are based only on appropriateness of care and service. Issues that arise prior to the UM Subcommittee that require immediate attention are reviewed by the Medical Director(s) and reported back to the UM Subcommittee at the next scheduled meeting.
4. **Frequency of Meetings:** The UM Subcommittee meets quarterly with ad hoc meetings conducted as needed.

Quality Improvement Subcommittee

The Quality Improvement Subcommittee is responsible for quality improvement activities for IEHP.

[32] NCQA, HP Standards and Guidelines, UM 1, Element A, Factors 2 and 4

1. **Role:** Reviews reports and findings of studies before presenting to the QIC and works to develop action plans to improve quality and study results. In addition, QI Subcommittee directs the continuous monitoring of all aspects of Behavioral Health Care Management (BH & CM) and Population Health Management (PHM) services provided to Members.
2. **Structure:** The QI Subcommittee is composed of representation from multiple internal IEHP Departments including but not limited to: Quality Systems, Behavioral Health & Care Management, Population Health Management, Grievance and Appeals, Utilization Management, Compliance, Community Health, Quality Informatics, Health Education, Member Services, and Provider Services. The QI Subcommittee is facilitated by the Director of Quality Improvement, and an IEHP Medical Director or designee.
3. **Function**: The QI Subcommittee analyzes and evaluates QI activities and report results; develops action items as needed; and ensures follow-up as appropriate. All action plans are documented on the QI Subcommittee Work Plan.
4. **Frequency of Meetings:** The QI Subcommittee meets quarterly with ad hoc meetings conducted as needed.

2.8. QM Support Committees/Workgroups

A. 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. Community Advisory Committee (CAC)
2. Delegation Oversight Committee
3. Compliance Committee

2.8.1. Community Advisory Committee (CAC)

The CAC is a Member advisory committee that engages IEHP Members and community advocates within IEHP's service area. The CAC is comprised primarily of IEHP Members to maintain community engagement with stakeholders, community advocates, traditional and Safety-Net Providers and Members. The CAC provides IEHP with recommendations on the provision of equitable health and preventative care practices, educational priorities, Cultural and Linguistic Appropriate Services (CLAS), communication needs, and the coordination of and access to services for Members. Feedback and information from the CAC will also be used to inform IEHP health equity and quality improvement efforts with meetings held quarterly.

2.8.2. Delegation Oversight Committee

The Delegation Oversight Committee is an internal committee that monitors the operational activities of contracted IPAs and other delegate's activities including Claims Audits, Pre-Service and Payment universe metrics, Financial Viability, Electronic Data Interchange (EDI) transactions, Care Management, Utilization Management, Grievances and Appeals, Quality Management, Credentialing/Re-credentialing activities, and other provider-related activities. The Delegation Oversight Committee reports directly to the QMHETC and Compliance Committee and meets monthly with ad hoc meetings conducted as needed.

2.8.3. Compliance Committee

The Compliance Committee assists the IEHP Compliance Officer to develop and enforce the Compliance Program, which includes overseeing all aspects of IEHP's compliance with regulatory bodies, compliance with the Health Insurance Portability and Accountability Act (HIPAA); monitoring Fraud Waste and Abuse (FWA), Privacy and Security activities. The committee provides leadership in establishing a culture of ethical conduct and compliance within IEHP. The Compliance Committee is responsible for advising on strategies and tactics to address compliance and regulatory risks. The Compliance Committee meets at least quarterly with ad hoc meetings conducted as needed.

Section 3: Organizational Structure and Resources

A. IEHP has designated internal resources to support, facilitate, and contribute to the QMHETP and QI Program. The Organization Chart (see Authority and Responsibility, section A) provides further details on support staff.[33]

3.1. Clinical Oversight of QMHETP Program

A. 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 QMHETP and QI Program 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 health care services and medical attention at all locations;

[33] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 7, Written Description

4. Ensuring that medical care rendered by Practitioners meets applicable professional standards for acceptable medical care; and
5. Following evidence-based CPGs developed by IEHP for all lines of business. The QM 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.

3.2. Quality Systems Department (QS)

A. The Quality Systems (QS) Department operates under the direction of the Senior Director of Quality Systems. The Senior Director of Quality is responsible for the oversight of all quality studies, demographic analysis, and other research projects; and reports up to the Vice President of Quality. Areas of Accountability Include:

1. Developing research or methodologies for quality studies;
2. Producing detailed criteria and processes for research and studies to ensure accurate and reliable results;
3. Designing data collection methodologies or other tools as necessary to support research or study activities;
4. Implementing research or studies in coordination with other IEHP functional areas;
5. Ensuring appropriate collection of data or information;
6. Qualitative and quantitative analysis of research results (including barrier analysis); and
7. Implementing research studies in coordination with other IEHP functional areas to ensure accurate and reliable results for quality studies.

B. Staff support for the Senior Director of Quality Systems consists of clinical and/or non-clinical directors, managers, supervisors, and administrative staff.

3.3. Quality Management Department (QM)[34]

A. The Quality Management Department operates under the direction of the Clinical Director of Quality Management and Director of Accreditation Programs. The Clinical Director of Quality Management and the Director of Accreditation Programs reports up to the Senior Director of Quality Systems who reports to the Vice President of Quality. The Clinical Director of QM and the Director of Accreditation Programs is responsible for oversight of the quality process; implementing, developing, coordinating, and monitoring for quality improvement, and maintaining the QMHETP and its related activities. Activities include the

[34] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27) , Exhibit A, Attachment 4, Provision 7, Written Description

ongoing assessment of Provider and Practitioner compliance with IEHP requirements and standards, monitoring Provider trends and report submissions, and oversight of facility inspections. The Clinical Director of QM and Director of Accreditation Programs also monitors and evaluates the effectiveness of Providers QM systems; coordinates information for the annual QMHETP Evaluation and Work Plan; prepares audit results for presentation to the QMHETC, associated Subcommittees, and the Governing Board; and acts as liaison regarding medical issues for Providers, Practitioners, and Members.

B. Staff support for the Director of Quality Management consists of clinical and non-clinical Managers, analysts, and administrative staff.

3.4. Health Services Clinical Integration & Operations Department

A. The Health Services Clinical Integration & Operations Department operates under the direction of the Vice President of Health Services Clinical Integration & Operations, who reports to the CMO and encompasses Behavioral Health and Care Management (BH & CM), Utilization Management, and Pharmacy. These departments are responsible for clinical oversight and management of the IEHP Behavioral Health and Care Management, Utilization Management, and Pharmacy Programs. In these roles they also participate in quality management and quality improvement, grievance, utilization and credentialing functions and activities related to BH & CM, UM, and Pharmacy services.

B. The Vice President of Health Services Clinical Integration & Operations or designee oversees staff with the required qualifications to perform care coordination activities in a managed care environment. These staff have various levels of experience and expertise in behavioral health, social work, utilization management, utilization review, care management, long-term services and support, quality assurance, training, pharmaceutical services, and customer or provider relations. These staff positions include clinical and/or non-clinical Directors, Managers, Supervisors, and administrative staff.

3.5. Pharmaceutical Services Department

A. The Pharmaceutical Services Department operates under the direction of the Senior Director of Pharmaceutical Services. The Senior Director of Pharmaceutical Services reports to the Vice President of Health Services Clinical Integration and Operations. The Pharmaceutical Services Department is responsible for pharmacy benefits and pharmaceutical services, including pharmacy network, pharmacy benefit coverage, formulary management, drug utilization program, pharmacy quality management program and pharmacy disease management program. The Senior Director of Pharmaceutical Services is responsible for developing and overseeing the IEHP Pharmaceutical Services Program.

B. Staff support for the Senior Director of Pharmaceutical Services consists of clinical and non-clinical Directors, Managers, Supervisors, analysts and administrative staff.

3.6. Utilization Management Department (UM)

A. The Utilization Management (UM) Department operates under the direction of the Senior Director of Medical Management, Clinical Director of UM, and Director of UM Operations. The Senior Director of Medical Management reports to the Vice President of Health Services Clinical Integration & Operations and is responsible for developing and maintaining the UM Program structure and assisting Providers and Practitioners in providing optimal UM services to Members. The Senior Director of Medical Management, Clinical Director of UM and Operations Director of UM are responsible for oversight of delegated and non-delegated IEHP Direct UM activities. Additional responsibilities include the development and implementation of internal UM services, processes, policies, and procedures, as well as oversight and direction of IEHP UM staff and providing support to the IEHP QMHETC and Subcommittees.

B. The Senior Director of Medical Management, Clinical Director of UM and Director of UM Operations oversee UM staff with the required qualifications to perform UM in a managed care environment. The required qualifications for UM staff support may consist of experience in utilization management or care management. Staff positions may include clinical and/or non-clinical Managers, Supervisors, nurses, analysts, non-clinical and administrative staff.

3.7. Health Education Department

A. The Health Education Program operates under the direction of the Senior Medical Director of Family and Community Health, and Director of Health Education who provides oversight of all accreditation and regulatory standards for Member health education. Primary responsibilities include oversight of the Health Education Department for Member health education and Employee Wellness Program. The department coordinates with other departments to ensure Member health education materials meet state requirements for readability format, racial, ethnic, cultural and linguistic relevance. The Director facilitates effective communication and coordination of care among UM, BH & CM, Pharmaceutical Services, and Health Education departments. Leadership works with other departments to develop and coordinate policies and procedures for medical services (e.g., medical procedures, denials, pharmaceutical services) that incorporate Member participation in health education programs. The Director of Health Education ensures compliance with all accreditation and regulatory standards for health education and acts as the primary liaison between IEHP and Providers/external agencies for health education.

B. The Senior Medical Director of Family and Community Health also provides oversight of the Employee Wellness Program and co-chairs the Employee Wellness Advisory Committee to plan and monitor activities to enhance wellness among IEHP Team Members.

C. The Director of Health Education oversees various levels of staff consisting of non-clinical management and administrative staff.

3.8. Community Health Department

A. The Community Health Department operates under the direction of the Senior Director of

Community Health. The Senior Director of Community Health oversees various levels of staff, including the Independent Living and Diversity Services (ILDS) and Community Outreach. The ILDS Manager is responsible for administering IEHP's program for Seniors and Persons with Disabilities (SPD), including outreach plan implementation, cross-department program deliverables coordination, and external operational coordination with regulatory agencies and stakeholders. The Director of Community Health ensures interaction and enrollment in events that support the community or prospective Members.

B. The Senior Director of Community Health oversees various levels of staff consisting of non-clinical Directors, Managers, Supervisors, Health Navigators, Community Outreach Representatives, analysts, and administrative staff.

3.9. Provider Services Department

A. The Provider Services Department operate under the direction of the Chief Operating Officer (COO). There are four Directors who are responsible for the execution of the Provider Services' Department's objectives:

1. Director of Provider Operations is responsible for the Provider Call Center, including the resolution of Provider and Practitioner issues.
2. Director of Provider Relations is responsible for the education of Providers and Practitioners concerning IEHP policies and procedures, health plan programs, IEHP website training and all other functions necessary to ensure Providers and Practitioners can successfully participate in IEHP's network and provide appropriate, quality care to IEHP Members.
3. Director of Delegation Oversight is responsible for IPA oversight and monitoring in conjunction with departments including QM, UM, CM, Credentialing/Re-Credentialing activities, Compliance, and Finance.
4. Director of Provider Network and Director of Provider Communication is responsible for all Provider communications, oversight of the IEHP Provider Manual and network compliance.

B. Staff support for the COO includes Directors, Managers, Supervisors, analysts, and administrative staff.

3.10. Credentialing Department

A. The Credentialing Department operates under the Director of Provider Network, who reports to the COO and is responsible for Provider Operations including credentialing and re-credentialing functions, oversight for directly contracted Practitioners, Providers, and delegated IPAs, and resolving credentialing-related Provider issues.

3.11. Grievance & Appeals Department

A. The Grievance & Appeals Department operates under the Director of Grievance & Appeals,

who reports to the Vice President of Operations. The Grievance & Appeals Department is responsible for investigation and resolution of grievances and appeals received from Members, Providers, Practitioners, and regulatory agencies. The Grievance & Appeals Department gathers supporting documentation from Members, Providers, or contracted entities, and resolves cases based on clinical urgency of the Member's health condition. The Director of Grievance & Appeals has the primary responsibility for the timeliness and processing of the resolution for all cases. The Director of Grievance & Appeals is responsible for the maintenance of the Grievance & Appeals Resolution System.

B. Staff supporting the Director of Grievance & Appeals include clinical and/or non-clinical Managers, Supervisors, nurses, and administrative staff.

3.12. Information and Technology (IT)

A. The IT Department operates under the Directors of IT who report to the Vice President of Technology – Production Support Infrastructure Services. The IT Department is responsible for the overall security and integrity of the data systems that IEHP uses to support Members, Providers and Team Members. IT is responsible for maintaining internal systems that provide access to Member data received from regulators, Providers and contracted entities. The system ensures that Team Members have access to data to assist them in providing care and guidance to Members. The IT Department maintains the Member and Provider portals which are extensively used tools for communicating.

3.13. Communications and Strategy Department

A. The Communications and Strategy Department operates under the direction of the Director of Communications and Marketing, who reports to the Chief Communications and Marketing Officer. The Communications and Strategy Department is responsible for conducting appropriate product and market research to support the development of marketing and Member communication plans for all products including Member materials (e.g., Member Newsletters, Evidence of Coverage, Provider Directory, website, etc.). The Quality Management Department works closely with the Communications and Strategy and Health Education Departments to ensure that Member materials are implemented in a timely manner.

3.14. Regional Quality and Health Equity Teams

A. IEHP is required to develop or leverage existing regional quality and health equity teams to support the QI and health equity work for all IEHP counties. IEHP regional teams develop partnerships within their designated regions that include at a minimum, Network Providers, partner MCPs, county Behavioral Health Plans (BHP), local health departments, community-based organizations (CBOs), local governmental agencies (e.g., department/county of social services, Women, Infant, and Children agencies, child welfare departments), regional centers, home and community-based service programs, continuum of care programs, First 5 programs, Area Agencies of Aging, caregiver resource centers, local education agencies, Individual

Family Service Plans, and Members. The regional teams participate in state-driven collaborative meetings and projects to improve partnerships in these regions.[35]

Section 4: Program Documents

A. In addition to the detailed QMHETP Description, IEHP also develops and implements the QMHETP Work Plan and completes a robust annual evaluation of the QMHETP Program.

4.1. QMHETP Work Plans[36]

A. Annually, and as necessary, the QMHETC approves the QMHETP 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.[37] The QMHETP Work Plan details a 3-year (36 months) lookback 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 QMHETP. 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 of corrective action plans (CAPs) and ongoing analysis of the work completed during the measurement year. The Work Plan is submitted to DHCS and DMHC annually.[38]

4.2. Annual QMHETP Evaluation[39]

A. On an annual basis, IEHP evaluates the effectiveness and progress of the QMHETP including:

1. The QMHETP structure;
2. The behavioral healthcare aspects of the program;
3. How Member safety is addressed;
4. Involvement of a designated physician in the QM/QI Program;
5. Involvement of a Behavioral Healthcare Practitioner in the behavioral aspects of the program;
6. Oversight of QI functions of the organization by the QI Subcommittee;

---

[35] DHCS APL 24-004
[36] NCQA, HP Standards and Guidelines, QI 1, Element A, Factor 5
[37] DHCS APL 24-004
[38] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 4, Quality Improvement Committee
[39] NCQA, HP Standards and Guidelines, QI 1, Element C

7. An annual work plan (QMHETP Work Plan);
8. Objectives for serving a culturally and linguistically diverse Membership; and
9. Objectives for serving Members with complex health needs.

B. As such, an annual summary of all completed and ongoing QMHETP activities addresses the quality and safety of clinical care and quality of service provided as outlined in the QMHETP Work Plan. The evaluation documents evidence of improved health care or deficiencies, progress in improving safe clinical practices, status of studies initiated or completed, timelines, methodologies used, and follow-up mechanisms that are reviewed by QM staff, the CMO, CQO, or designee. The evaluation includes pertinent results from QMHETP studies, Member access to care, IEHP standards, physician credentialing and facility review compliance, Member experience, evidence of the overall effectiveness of the program, and significant activities affecting medical and behavioral health care provided to Members.

C. Performance measures are trended over time and compared with established performance thresholds to determine service, safe clinical practices, and clinical care issues. The results are analyzed to assess barriers and verify and establish additional improvements. The CMO, CQO, or designee presents the results to the QMHETC for comments, consideration of performance, suggested program adjustments, and revision of procedures or guidelines as necessary.

4.3. Review and Approval of Program Documents[40]

A. On an annual basis, the QMHETP Description, QMHETP Summary, and QMHETP Work Plan are presented to the Governing Board for review, approval, assessment of health care rendered to Members, comments, direction for activities proposed for the coming year, and approval of changes in the QMHETP. The Governing Board is responsible for the direction of the program and actively evaluates the annual plan to determine areas for improvement. Board comments, actions, and responsible parties assigned to changes are documented in the minutes.

Section 5: Quality Improvement Processes

A. 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.[41]

[40] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Quality Improvement System
[41] DHCS APL 24-004 Quality Improvements and Health Equity Transformation Requirements

B. IEHP aligns its QMHETP activities with the DHCS Comprehensive Quality Strategy. The planning and implementation of annual QMHETP 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 QMHETP.

C. 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.

D. 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.42 IEHP also attends, at a minimum, quarterly regional collaborative meetings that may be in-person.

5.1. IEHP Quality Improvement (QI) Initiatives

A. 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.

B. 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.

C. 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

[42] DHCS APL 24-004

customized metrics form the basis of implementation plans and actions developed to improve care and service.

5.1.1 Plan-Do-Study-Act Cycle

A. The "Plan-Do-Study-Act" (PDSA) Cycle is utilized to implement and test the effectiveness of changes. The model focuses on identifying improvement opportunities and changes and measuring improvements. Successful changes are adopted and applied where applicable. In general, quality improvement initiatives follow the process below:

1. Find a process to improve, usually by presenting deficient results;
2. Organize a team that understands the process and include subject matter experts (SMEs);
3. Clarify knowledge about the process;
4. Understand and define the key variables and characteristics of the process;
5. Select the process to improve;
6. Plan a roadmap for improvement and/or develop a work plan;
7. Implement changes;
8. Evaluate the effect of changes through measurement and analysis; and
9. Maintain improvements and continue to improve the process.

5.1.2. Data Collection Methodology

A. Performance measures developed have a specified data collection methodology and frequency. The methodology for data collection is dependent on the type of measure and available data, with data validation being a vital part of the data collection process. Quality assessment and improvement activities are linked with the delivery of health care services. Data is collected, aggregated, and analyzed to monitor performance. When opportunities for improvement are identified, a plan for improvement is developed and implemented. Data is used to determine if the plan resulted in the desired improvement. Data collection is ongoing until the improvement is considered stable. At that time, the need for ongoing monitoring is reevaluated. Data may also indicate the need to abandon an action and reassess options for other action items necessary to drive performance improvement.

5.1.3. Measurement Process

A. Quality measures are used to regularly monitor and evaluate the effectiveness of quality improvement initiatives, and compliance with internal and external requirements. IEHP reviews and evaluates, on not less than a quarterly basis, the information available to the plan regarding accessibility and availability. IEHP measures performance against community, national or internal baselines and benchmarks when available, and applicable, which are derived from peer-reviewed literature, national standards, regulatory guidelines, established clinical practice guidelines, and internal trend reviews.

5.1.4. Evaluation Process[43]

A. IEHP uses several techniques and tools to evaluate effectiveness of QI studies and initiatives. These include conducting a robust quantitative and qualitative analysis. A quantitative analysis includes comparison to benchmarks and goals, trend analysis, and tests of statistical significance. The Program Informatics team selects the appropriate tools to complete the quantitative analysis. The QM Department works closely with the Program Informatics team and other key stakeholders to complete a robust qualitative analysis. A qualitative analysis includes barrier analysis and attribution analysis. IEHP performs this analysis in a focus group-like setting using all the key stakeholders.

5.1.5. Communication and Feedback

A. Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, joint operation meetings, mailings, and announcements.[44]

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;[45]
    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.

5.1.6 Improvement Processes

A. 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

[43] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 7, Written Description.
[44] Ibid.
[45] Ibid.

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

B. IEHP has developed several Quality Improvement initiatives to improve quality of care, access and service, Member and Provider satisfaction, and Member safety. IEHP assesses the performance of these initiatives against established thresholds and/or benchmarks.

Section 6: Quality Improvement Initiatives

6.1. Quality of Care

A. 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. Annual HEDIS® submission for Medi-Cal and IEHP DualChoice (HMO D-SNP) and IEHP Covered;
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.).

B. Measuring and reporting on these measures helps IEHP to guarantee that its Members are getting 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.

6.1.1. HEDIS® Measures[46]

A. HEDIS® is a group of standardized performance measures designed to ensure that information is available to compare the performance of managed health care plans. IEHP has initiatives in place that focuses on a broad range of HEDIS® measures that cover the entire Membership, including, priority measures that relate to children, adolescents, and Members with chronic conditions.

[46] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 9, External Quality Review Requirements

B. 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 QMHETP 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.

6.1.2. Performance Review of Managed Care Accountability Set (MCAS)

A. MCAS is founded on the CMS Child and Adult Core Set Measures, which includes NCQA HEDIS® measures. For the year, there are 39 measures spanning the behavioral health, children's health, chronic disease management, reproductive health, and cancer prevention domains. Managed Care Plans (MCPs), such as IEHP, are mandated by DHCS to submit annual reports on their performance of MCAS measures. DHCS sets a Minimum Performance Level (MPL) for specific MCAS measures, aligning with NCQA's national Medicaid 50th percentile.

B. IEHP regards MCAS measures a priority. IEHP's MCAS measure performance guide the development of its Strategic Plan, QI activities, and department initiatives. IEHP seeks to not only meet and exceed the MCAS MPL established by DHCS but achieve the MCAS High Performance Level (HPL) set at the 90th percentile for qualified measures.

C. IEHP proactively oversees its performance of MCAS measures and their corresponding MPL to evaluate and enhance clinical quality of care. The evaluation yields insights into Member and Provider behavior, guiding the development of QI activities and direction of the IEHP Strategic Plan that are both pertinent and responsive. These QI activities may be incorporated into IEHP's Strategic Plan or department initiatives with the ultimate objective to meet or exceed the MCAS HPL.

D. Based on prior year performance, IEHP continues to find opportunities to improve these MCAS measures including, but not limited to: Childhood Immunization Status: Combination 10 (CIS-10), Immunizations for Adolescents: Combination 2 (IMA-2), Lead Screening in Children (LSC), Well-Child Visits in the First 30 Months of Life – 15 to 30 Months (W30-2), Child and Adolescent Well-Care Visits (WCV) and Cervical Cancer Screening (CCS). Detailed plans on activities to meet or exceed the MPL for these measures can be found on the MY 2022 | CY 2024 Comprehensive Quality Strategy.

6.1.3. Performance Improvement Projects (PIPs) (DHCS, and CMS) and Quality Activities[47]

A. IEHP implements quality improvement activities as required by regulatory agencies (DHCS, CMS) and in accordance with requirements in the Capitated Financial Alignment Model.

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. For 2026, IEHP is focusing on the following studies:

Study Name	Reporting Agency	Type of Study
Continuity and Coordination of Care Measure Performance Study	NCQA	Quality Activity
2023–26 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	PIP
2023–26 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	PIP

6.1.4. Continuity and Coordination of Care Studies

A. 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

[47] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 9, External Quality Review Requirements

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.

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

6.1.5. 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 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 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)[48]

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. See policy 6A, "Facility Site Review and Medical Record Review Survey Requirements and Monitoring."

In addition to the FSR/MRR, IEHP also conducts 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. See policy 6B, "Physical Accessibility Review Survey."

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.

6.1.6. Other Clinical Measures and Studies

Initial Health Assessment Monitoring[49]

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 QIC 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

[48] Department of Health Care Services (DHCS) All Plan Letter (APL) 20-006, Supersedes APL 14-004, "Site Reviews: Facility Site Review and Medical Record Review"
[49] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 3, Initial Health Assessment

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[50]

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:

1. Access to health care services based on geographic regions;
2. Demographic factors also impact over-utilization and under-utilization of services/care:
    a. Race, ethnicity, and language preference (RELP);
    b. Knowledge and perceptions regarding health care which are largely driven by cultural beliefs; and
    c. Income and socioeconomic status.

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:

1. Identify the dominant utilization patterns within the population.
2. Identify groups of high and low utilizers and understand their general characteristics.

6.2. Access to Care

With the rapid expansion of the managed care programs in California, access to health care services within the State has been negatively impacted over the last few years and is now considered unreliable. Based on several statewide studies, there are many Members who do not receive appropriate and timely care. As IEHP's Membership grows, access to care is a major area of concern for the plan and hence the organization has dedicated a significant number of resources to measuring and improving access to care. This analysis is presented to

[50] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 9, External Quality Review Requirements

the Provider Network Access Subcommittee and QMHETC for discussion and recommendations as needed.

6.2.1. Availability of PCPs by Language[51]

A. IEHP monitors network availability based on threshold languages annually. IEHP understands the importance of being able to provide care to Members in their language of choice and the impact it has on a Member-Practitioner relationship. To ensure adequate access to PCPs, IEHP has established quantifiable standards for geographic distribution of PCPs for its threshold languages. These two (2) languages cover over 98% of the Membership. The primary objectives are to evaluate network availability against the established language standards and identify opportunities for improvement.

6.2.2. Availability of Practitioners

A. IEHP monitors the availability of PCP, Specialists and Behavioral Health Practitioners and assesses them against established standards at least annually or when there is a significant change to the network. The performance standards are based on State, NCQA, and industry benchmarks. IEHP has established quantifiable standards for both the number and geographic distribution of its network of Practitioners. IEHP uses a geo-mapping application to assess the geographic distribution. Considering the size of the service area, IEHP evaluates the distribution of Providers since there may be significant gaps in some of the more rural areas covered by IEHP.

6.2.3. Provider Appointment Availability Survey (PAAS)

A. IEHP monitors appointment access for PCPs, Specialists and Behavioral Health Providers and assesses them against established standards at least annually. There is significant evidence that timely access to health care services results in better health outcomes, reduced health disparities, lower spending, including avoidable emergency room visits and hospital care.

B. IEHP collects the required appointment access data from Practitioner offices using the Department of Managed Health Care (DMHC) PAAS methodology and tool. IEHP also evaluates the grievances and appeals data quarterly to identify potential issues with access to care, including incidents of non-compliance resulting in substantial harm to Member. Following the completion of the survey, all responses are compiled and entered into a results grid. The compliance rate then can be calculated to be compared with the goal established and the previous year's rate to identify patterns of non-compliance. Results of the quantitative analysis are presented to IEHP's Provider Network Access Subcommittee for review and identification of priorities for interventions. This includes establishing goals and objectives,

[51] Department of Health Care Services (DHCS) All Plan Letter (APL) 17-011, Supersedes APL 14-008, "Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act"

opportunities for improvement, completion timeframes, monitoring of corrective action plans (CAPs), and ongoing analysis of the work completed during the measurement year.[52]

C. CAP consists of follow-up call campaigns, Provider education, identifying and tracking any incidents that have resulted in substantial harm, peer review, and implementing corrective actions when necessary to address any patterns of non-compliance. See 26B, "Glossary" for definitions of "patterns of non-compliance," "incidents of non-compliance," and "substantial harm incident."

6.2.4. After-hours Access to Care

A. IEHP monitors after-hours access to PCPs at least annually. One of IEHP's key initiatives is to reduce inappropriate ER utilization. Ensuring that Members have appropriate access to their PCP outside of regular business hours can result in reduced ER rates, which can subsequently result in reduced inpatient admissions. The criteria for appropriate after-hours care are that the physician or designated on-call physician be available to respond to the Member's medical needs beyond normal hours. PCP offices can use a professional exchange service or automated answering system that allows the Member to connect to a live party or the physician by phone. It is also required that any after-hours system or service that a physician uses provide emergency instructions if the Member is experiencing a life-threatening emergency.

6.2.5. Telephone Access to IEHP Staff

A. IEHP monitors access to its Member Services Department on a quarterly basis. IEHP has established the following standards and goals to evaluate access to Member services by telephone.

Standards of Care for Telephone Access	
Standards	**Goal**
% Of Calls answered by a live voice within 30 seconds	80 %
Calls Abandoned Before Live Voice is Reached	≤ 5%

6.3. Member and Provider Experience[53]

6.3.1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

A. IEHP conducts a comprehensive CAHPS® survey and analysis annually to assess Member experience with the services and care received based on a statistically valid and reliable survey methodology. CAHPS® is a set of standardized surveys that ask health care consumers to report on and evaluate their care experience. The survey focuses on key areas to evaluate:

[52] Title 28 California Code of Regulations (CCR) § 1300.67.2.2(b)(12)(A), (f)(1)(I), (d)(3), and (h)(6)(c)
[53] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 9, External Quality Review Requirements

1. Member perspective and concerns regarding experience obtaining timely appointments within the standards;[54]
2. Experience with health care services related to access to care, coordination of care, office customer service, health plan experience, and personal doctor;
3. Satisfaction with IEHP Programs;
4. Member grievances and appeals; and
5. Member Services Department's call services levels.

B. CAHPS® surveys serve as a means to provide usable information about the quality of care received by the Members. IEHP uses this tool as one of its key instruments to identify opportunities for improvement. As part of the annual evaluation, IEHP reviews the CAHPS® results and compared with prior year results to identify relative strengths and weaknesses in performance, determines where improvement is needed, and tracks progress with interventions over time.

C. Effective with the CAHPS® survey, no later than the 4th Quarter of 2024, IEHP will:[55]

1. Inform Members of their rights to obtain an appointment within each of the time-elapsed standards including notice of their right to receive interpreter services at the appointment;[56]
2. Evaluate the experience of limited English proficient (LEP) Members in obtaining interpreter services by obtaining Members' perspectives and concerns regarding coordination of appointments with an interpreter, availability of interpreters who speak the Member's preferred language and the quality of interpreter services received; and
3. Translate the Member Experience Survey into IEHP's threshold languages.

6.3.2. Internal Member Experience Studies

A. **BH Member Experience Survey**: IEHP surveys Members who are receiving behavioral care services at least annually to evaluate their experience with the services received. The survey focuses on key areas like getting care needed; getting appointments to BH Practitioners; experience with IEHP staff and network of BH Practitioners; and other key areas of the Plan operations. The goal of the experience n study is to identify and implement opportunities to improve Member experience.

B. **Behavioral Health Treatment (BHT) Autism Member Experience Survey**: IEHP conducts an internal survey for Medi-Cal Members to assess Member Experience with IEHP's Behavioral Health Treatment (BHT) services. The survey focuses on key areas like Access to

[54] 28 CCR § 1300.67.2.2(c)
[55] Ibid.
[56] 28 CCR § 1300.67.2.2(c)(4)

BHT services; experience with their BHT Provider; experience with IEHP's BH & CM Department and other key areas of the Plan operations. The goal of the experience study is to identify, review and implement opportunities to improve services and Member experience.

C. **Population Health Management (PHM) Population Assessment -Member Experience Survey**: Annually, IEHP conducts an internal Member experience survey for Medi-Cal Members to assess Member Experience with IEHP's Population Health Management programs. The survey focuses on Member feedback from at least two programs (e.g., disease management or wellness programs). Feedback is specific to the programs being evaluated. Additionally, IEHP analyzes complaints to identify opportunities to improve experience.[57]

6.3.3. **Provider Experience**

A. IEHP monitors performance areas affecting Provider experience annually and submits the results to DHCS and CMS. This study assesses the experience experienced by IEHP's network of PCPs, Special Care Providers (SCPs), and Behavioral Health Providers. Information obtained from these surveys allows plans to measure how well they are meeting their Providers' expectations and needs. This study examines the experience of the Provider network in the following areas: overall experience, all other plans, finance issues, utilization and quality management network, coordination of care, pharmacy, Health Plan Call Center Service Staff, and Provider relations. Based on the data collected, IEHPs reports the findings to the Provider Network Access Subcommittee and QMHETC. The committees review the findings and make recommendations on potential opportunities for improvements.

6.3.4. **Grievances and Appeals**[58]

A. IEHP monitors performance areas affecting Member experience. IEHP has established categories and quantifiable standards to evaluate grievances received by Members. All grievances are categorized in a number of different categories including but not limited to the following:

1. Billing/Financial;
2. Quality of Practitioner Office Site;
3. Access;
4. Quality of Care;
5. Attitude and Service;
6. Compliance;
7. Quality of Service;

[57] NCQA, HP Standards and Guidelines, PHM 2, Element B
[58] NCQA, HP Standards and Guidelines, ME 7, Element C

8. Benefits/Coverage;
9. Enrollment/Eligibility;
10. Disease Management and Care Management Programs; and
11. Cultural and Linguistics.

B. The organization's goal is to resolve all grievances within 30 days of receipt. IEHP calculates the grievance rate per 1000 Members on a quarterly basis and presents this information to the Member Experience Subcommittee and QMHETC. IEHP's goal is to maintain the overall compliance rate below thresholds as established by regulatory agencies such as DHCS, DMHC, and CMS.

6.4. Patient Safety

A. IEHP recognizes that patient 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 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.

6.4.1. Appropriate Medication Utilization

A. IEHP monitors pharmaceutical data to identify patient safety issues on an ongoing basis. Drug Utilization Review (DUR) is a structured, ongoing program that evaluates, analyzes, and interprets drug usage against predetermined standards and undertakes actions to obtain improvements. The DUR process is designed to assist pharmacists in identifying potential drug related problems by assessing patterns of medication usage. The goal of the DUR process is to identify potential drug-to-drug interactions, over-utilization and under-utilization patterns, high/low dosage alerts, duplication of medications, and other critical elements that can affect Member safety. The DUR study data is collected via an administrative data extraction of paid pharmaceutical claims. Actual prescribing patterns of PCPs, Behavioral Health Practitioners, and Specialists are compared to IEHP standards. The results of the quantitative analysis are presented to IEHP's Pharmacy and Therapeutics (P&T) Subcommittee and QMHETC for discussion and action, as necessary.

6.4.2. Review of Inpatient Admissions

A. IEHP considers the quality of care in the hospitals to be a top priority. To ensure Member safety, IEHP assesses, tracks, and reviews the following measures:

1. Bed Day/Readmission Reporting;
2. Length of stay reports;
3. Provider Preventable Conditions (PPCs);
4. Inappropriate discharges from inpatient settings; and
5. Potential Quality Incidents (PQI) referrals related to an inpatient stay.

B. Monthly reports are produced using relevant utilization data. These reports are reviewed by the UM and QM staff to identify potential quality of care issues. Any significant findings are reviewed by IEHP's Medical Directors and summary reports are provided to the UM Subcommittee and QMHETC. The UM Subcommittee identifies potential quality of care issues and makes recommendations to address them as needed. The committee delegates the implementation of these recommendations to the UM and/or QM Department. The QM Department collaborates with different Departments (e.g., UM, CM, PS, etc.) to implement and monitor the improvement activities.

6.4.3. Potential Quality Incidents (PQI) Review

A. The Quality Management (QM) Department reviews all Potential Quality Incidents (PQI) for all Practitioners and Providers. Areas of review include but are not limited to primary and specialty care, facilities (Hospital, Long Term Care (LTC)), Skilled Nursing Facility (SNF), and Community-Based Adult Services (CBAS)), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP) services, Home Health agencies, and transportation Providers. The QM Department is responsible for investigating and reviewing the alleged Potential Quality Incidents. The Medical Director(s) review all cases and may refer to the QMHETC and/or Peer Review Subcommittee for further evaluation and review.

6.4.4. Promoting Safety Practices for Members

A. IEHP offers various safety programs to Members including the Bicycle Safety Program for children between 5 to 14 years old and Members who have a child between 5 to 14 years old. This interactive program assesses children's and parents' knowledge on bicycle safety and offers a free helmet to program participants. IEHP also offers the Child Car Seat Safety Program to keep children safe in a car, providing information on the latest car seat laws, and choosing the right car seat. Additionally, Member education materials that cover different health topics are available to Members including immunizations, flu and cold facts, avoiding allergens, medication reconciliation etc. Additional safety initiatives are developed in collaboration with Health Education and various IEHP departments as safety needs are identified.

6.4.5. Addressing Cultural, Ethnic, Racial, and Linguistic Needs of Members[59]

A. IEHP is dedicated to ensuring that all medically covered services are available and accessible to all Members regardless of sex, race, color, national origin, creed, ancestry, ethnic group identification, religion, language, age, gender, gender identity, marital status, sexual orientation, medical condition, genetic information, physical or mental disability, and identification with any other persons or groups and that all covered services are provided in a culturally, ethnically, racially, and linguistically appropriate manner. IEHP strives to reduce health care disparities in clinical areas, improving cultural competency in Member materials and communications, and ensuring network adequacy to meet the needs of underserved

[59] NCQA, HP Standards and Guidelines, QI 1, Element A, Factor 6

groups. Services to address cultural, ethnic, racial, and linguistic services are adjusted based on the annual assessment of Member needs. Further details about cultural, ethnic, racial, and linguistic services provided to Members are seen in the individual reports supporting each of the current IEHP Quality Studies that evaluate our ability to serve a culturally, ethnically, racially, and linguistically diverse Membership:

1. **Provider Language Competency Study:** The purpose of this study is to verify that the PCP, OB/GYN, and vision provider offices that inform IEHP that they have Spanish speaking office staff actually have those services available to Members.
2. **Cultural, Ethnic, Racial, and Linguistic Study:** The purpose of the study is to identify the cultural, racial, linguistic, and ethnic diversity of IEHP's PCP and Member populations. More specifically, they assess the cultural, ethnic, racial, and linguistic needs of Members in accordance with NCQA standards.
3. **Ongoing monitoring of interpreter service use:** The purpose of this report is to monitor the top languages requested by the Members. IEHP offers face-to-face interpreter services for medical appointments to Members at no cost. The purpose is to provide Members with interpretation services to Members/callers.
4. **Ongoing monitoring of grievances related to language and culture:** Grievances are reported to monitor cultural and linguistic services provided to Members.

Section 7: Delegation Oversight

A. IEHP monitors Delegate performance in QM, UM, CM, credentialing and re-credentialing, compliance, and their implementation of related regulatory activities through Delegation Oversight activities.[60] See policy 25A2, "Delegation Oversight – Audit."

7.1. Auditing and Monitoring Activities

A. 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:

[60] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities

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. Delegates 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 QM 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 QM and UM Program Evaluations.[61]

6. Delegates 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

[61] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 8, Quality Improvement Annual Report

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 a 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.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA

24. PROGRAM DESCRIPTIONS

C. Quality Management & Health Equity Transformation Program and Quality Improvement Program Description

Original Effective Date:	January 1, 2012
Revision Effective Date:	January 1, 2026