IEHP Covered

Quality Management and Health Equity Transformation Program

2025 Annual Evaluation

Executive Summary

May 2026

MISSION AND VISION

The purpose of the 2025 IEHP Covered Annual Evaluation is to assess IEHP's Quality Improvement Program. This assessment reviews the quality and overall effectiveness of the program by reviewing all studies performed and implemented by various IEHP departments in 2025, including areas of success and needed improvements in services rendered, and if there is a need to restructure or change the QI program for the subsequent year. This annual evaluation reviews various committee and subcommittee structures, adequacy of resources, minutes and reports submitted both internally and externally, practitioner participation and leadership involvement in the program as well as data to review all program outcomes. The Quality Department leads IEHP's Annual Evaluation assessment in a collective and collaborative process utilizing data and reports from committees, subcommittees, departments, content experts, data analysts, and work plans to analyze and evaluate the effectiveness of the Quality Programs. Overall effectiveness of the programs is assessed by analyzing and trending the goals and actions of the studies, reviewing qualitative and quantitative results, providing a causal analysis and defining barriers, interventions, opportunities for improvement and next steps.
IEHP's Mission, Vision, and Values (MVV) aims to improve the quality of care, access to care, Member safety, and quality of services delivered to IEHP Members. The organization prides itself in four (4) core goals:

Mission: We heal and inspire the human spirit.

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

Values: We do the right thing by:

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

QUALITY MANAGEMENT AND HEALTH EQUITY TRANSFORMATION

PROGRAM DESCRIPTION

IEHP supports an active, ongoing, and comprehensive Quality Management and Health Equity Transformation Program (QMHETP) and Quality Improvement (QI) Program with the primary goal of continuously monitoring and improving the quality of care and service, access to care, and Member safety delivered to IEHP Members. The QMHETP provides a formal process to systematically monitor and objectively evaluate, track, and trend the health plan's quality, efficiency, and effectiveness. IEHP is committed to assessing and continuously improving the care and service delivered to Members. IEHP has created a systematic, integrated approach to planning, designing,

measuring, assessing, and improving the quality of care and services provided to Members. This comprehensive delivery system includes Member safety, behavioral health, care management, culturally and linguistically appropriate services, and coordination of care. IEHP will utilize this document for oversight, monitoring, and evaluation of Quality Management (QM) and QI activities to ensure the QMHETP is operating in accordance with standards and processes as defined in this Program Description. These initiatives are aligned with IEHP's mission and vision.

PROGRAM PURPOSE

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

PROGRAM SCOPE

The Quality Management and Health Equity Transformation Committee (QMHETC) approves the QMHETP annually. The QMHETP review includes approval of the QMHETP Description, QMHETP & CLAS Work Plan, and QMHETP Annual Evaluation to ensure ongoing performance improvement. The QMHETP is designed to improve all aspects of care delivered to IEHP Members in all health care settings by:

1. Defining the Program structure;
2. Assessing and monitoring the delivery and safety of care;
3. Assessing and monitoring population health management provided to Members, including behavioral health and care management services;
4. Supporting Practitioners and Providers to improve and maintain the safety of their practices;
5. Overseeing IEHP's Quality Management & Health Equity functions through the QMHETC;
6. Involving designated Physician(s) and staff in the QMHETP;
7. Involving a Behavioral Healthcare Practitioner in the behavioral health aspects of the Program;
8. Involving Long-Term Services and Supports (LTSS) Provider(s) in the QMHETP;
9. Reviewing the effectiveness of LTSS programs and services;
10. Ensuring that LTSS needs of Members are identified and addressed leveraging available assessment information;
11. Identifying opportunities for QI initiatives, including the identification of health disparities among Members;
12. Implementing and tracking QI initiatives that will have the greatest impact on Members;
13. Measuring the effectiveness of interventions and using the results for future QI planning;

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

PROGRAM GOALS

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

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

AUTHORITY AND RESPONSIBILITY

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

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

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

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

QUALITY MANAGEMENT AND HEALTH EQUITY TRANSFORMATION COMMITTEE (QMHETC): The QMHETC reports to the Governing Board and retains oversight of the QMHETP with direction from the CMO and CQO. The QMHETC promulgates the quality improvement process to participating groups and Physicians, Providers, Subcommittees, and internal IEHP functional areas with oversight by the CMO and CQO. The QMHET Committee meets at least quarterly to report findings, reports actions and recommendations to the IEHP Governing Board, seek methods to increase the quality of health care for Members, recommends policy decisions, evaluate QI activity results, and provide oversight for Subcommittees.

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

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

6. **Utilization Management (UM) Subcommittee**: The UM Subcommittee reviews and approves the Utilization Management, Disease Management and Behavioral Health Programs annually. The Subcommittee monitors for over-utilization and under-utilization; ensures that UM & BH decisions are based only on appropriateness of care and service; and reviews and updates preventive care and CPGs that are not primarily medication related.
7. **Population Health Management (PHM) Subcommittee:** The PHM Subcommittee is responsible for reviewing, monitoring and evaluating program information and progress while providing regulatory oversight in alignment with DHCS and NCQA requirements and standards.
8. **Provider Network Access Subcommittee (PNA):** The Provider Network Access Subcommittee is responsible for reviewing, monitoring, and evaluating program data, outliers, and trends to ensure timely improvement initiatives are initiated. The Provider Network Access Subcommittee is also responsible for initiative oversight, ensuring outcomes are achieved and barriers are removed.
9. **Member Experience Subcommittee (MESC):** The role of the Member Experience Subcommittee is to review, monitor, and evaluate program data, outliers, and trends to ensure timely improvement initiatives are initiated. The MESC will is responsible for initiative oversight, ensuring outcomes are achieved and barriers are removed.
10. **Member Safety Subcommittee (MSS):** The scope of the Member Safety Subcommittee includes all lines of business and contracted network Provider, direct or delegated, in which care and services are provided to IEHP Members. The Member Safety Subcommittee uses a multidisciplinary and multidepartment approach to explore root causes of poor performance, identify areas of improvement, propose interventions, and take actions to improve the quality of care delivery to our Members.
11. **Skilled Nursing Facility (SNF) Subcommittee:** This subcommittee will identify opportunities that impact efficient transitions of care, clinical outcomes, Member safety, and Member experience while receiving care at a skilled nursing or long-term care facility. This subcommittee serves as a forum for review and evaluation of strategic, operational, and quality measures resulting from but not limited to: Inland Empire Health Plan (IEHP) optimal care strategies, Joint Operations Meeting (JOM) and related workgroups (i.e., throughput, quality, ambulatory operations, payment practices, etc.), and pay for performance initiatives.
12. **Hospital and Ancillary Quality Improvement (QI) Subcommittee:** This Subcommittee was formed in 2023 to identify opportunities that impact clinical outcomes, Member safety and Member experience during acute care hospitalization and/or sub- acute/post-acute network utilization (excluding Skilled Nursing Facilities which are discussed as part of a separate subcommittee).
13. **Delegation Oversight Committee**: The Delegation Oversight Committee (DOC) provides oversight and monitoring of the Delegate's abilities to carry out their delegated responsibilities in the areas of Quality Management (QM), Utilization Management (UM), Care Management (CM), Grievance and Appeals (G&A), Credentialing (CR), Encounter Data, Financial Viability, Compliance and Fraud Waste and Abuse (FWA), Health Insurance Portability and Accountability Act (HIPAA) Privacy, HIPAA Security, and Claims Processing. The auditing and monitoring of Delegates allows IEHP to detect deficiencies in delegated performance and ensure that remediation efforts are put in place to provide timely, effective and sustained improvement.
14. **Ambulatory Provider Quality Informatics and Technology (QIT) Advisory Subcommittee**: The purpose of the Ambulatory Provider Quality Informatics and Technology (Ambulatory QIT) Advisory

Subcommittee is to advance optimal care and vibrant health by engaging ambulatory Providers to guide, enhance and prioritize the development of electronic applications belonging to both IEHP and their respective organizations to advance patient care and seamlessly capture data and quality metrics.

15. **Transgender, Gender Diverse and Intersex (TGI) Subcommittee**: The purpose is to create a healthcare environment where Transgender, Gender non-conforming, and Intersex (TGI) Members receive equitable, respectful, and culturally competent care. By implementing Affordable Care Act (ACA)-compliant policies, improving IT systems, expanding in-network Provider networks, and ensuring trained professionals review transgender service requests, the subcommittee aims to eliminate gender discrimination, provide accurate information, and address grievances effectively. These initiatives will foster a more inclusive and supportive healthcare experience for TGI Members.

CLINICAL QUALITY

1. HEDIS®, Quality Report (2024)

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

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

A. Effectiveness of Care
    1. Prevention and Screening
    2. Respiratory Conditions
    3. Cardiovascular Conditions
    4. Diabetes
    5. Musculoskeletal Conditions
    6. Behavioral Health
    7. Care Coordination
    8. Overuse/Appropriateness
    9. Measures Collected Through the Medicare Health Outcomes Survey
    10. Measures Collected Through CAHPS Health Plan Survey
    11. Access/Availability of Care
    12. Experience of Care

B. Utilization and Risk Adjusted Utilization
    13. Utilization
    14. Risk Adjusted Utilization

15. Health Plan Descriptive Information

C. Measures Reported Using Electronic Clinical Data Systems

16. Measures Reported Using Electronic Clinical Data Systems

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

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

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

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

IEHP initially prepares the HEDIS® report using the most recent available benchmarks. Upon the release of more updated benchmarks from accrediting bodies, IEHP updates the measure percentile and Health Plan

Rating scores as needed to reflect the most up-to-date measure standings and release a new version of this HEDIS® Annual Report.

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

The purpose of this report is to assess the characteristics of the IEHP Covered Membership to identify Member needs and to review and update its Population Health Management (PHM) structure, strategy, and resources. IEHP assesses areas such as social determinants of health, identification of subpopulations, needs of children/adolescents and individuals with disabilities and with serious and persistent mental illness (SPMI). The needs of Members of different ethnic groups and of those with limited English proficiency (LEP) are also included in this analysis. Based on this assessment, IEHP reviews its PHM structure, activities, and other resources such as Community programs to ensure that Member needs are met. This assessment is conducted annually in accordance with NCQA Standard PHM 2, Elements B and C.

Based on medical claims and behavioral health claims data, the top diagnoses in the general CCA population are hypertension, hyperlipidemia diabetes, and obesity. For children and adolescents, the top diagnoses are acute upper respiratory infections, overweight/obesity, allergic rhinitis, and cough. Asthma, which is a child chronic condition, ranks number nine (#9). For BH Members, the top diagnoses are anxiety, depression, and nicotine dependance. The SDOH top diagnoses are low income and unemployment. When assessing language, 20% of the population is Spanish speaking and 84% of face-to-face interpreter requests are for Spanish translators. For race and ethnicity assessment, the most common diagnosis in White, Asian, and Hispanic ethnicities is hypertension and hyperlipemia.

Additionally, the Quality Transformation Initiative (QTI) (for Covered California's contracted Health Plans) is intended to improve the quality of healthcare and reduce health disparities for Covered California Enrollees. The QTI focuses on improving care for conditions for which there are major opportunities for improvement. One of the areas selected for improvement by the QTI is 'Controlling High Blood Pressure'. This aligns with the population assessment study findings as this diagnosis was found to be the most common of Hispanic, White, and Asian Members. The current findings in this population assessment report will be used to review and update activities, resources and community resources to better support and meet the needs of the Member population. The activities and resources will address the needs of Members with chronic conditions such as hypertension, diabetes and obesity.

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

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

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

(CCM) Program, and the Healthy Schools Program. The Enhanced Care Management (ECM) Program began in January 2022. The populations of focus that it serves are homeless, adults who are high utilizers or have serious mental illness/substance use disorder, and Members leaving incarceration.

- **CCM Program – IEHP Covered**

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

- **Healthy Schools Program – IEHP Covered**

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

CONTINUITY AND COORDINATION OF CARE

1. **HEDIS® Health Plan Ratings (HPR) Measures for Continuity and Coordination of Care (2024)**

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

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

visits for Mental Illness, Substance Use Disorder Treatment and a Depression Screening measure. The ratings for these measures were not available at the time of the report.

MEMBER EXPERIENCE

1. **Annual Grievance and Appeals Study (2025)**

   The Grievance and Appeal (G&A) Study is conducted annually and reviews case volume and rates to identify trends and assess areas of opportunity to improve overall Member satisfaction. More specifically, this study assesses Member experience in accordance with NCQA Measure Element (ME) 7, Element C and D. The purpose of this annual study is to conduct a comprehensive evaluation of grievances and appeals to identify trends, root causes, and opportunities for prioritized performance improvement, with the ultimate goal of enhancing the Member experience.

   IEHP successfully met 2 out of 2 goals for grievance reduction during the 2025 study year. By shifting from grievance volume to grievance rate, IEHP accounted for Membership fluctuations and achieved significant improvements across all lines of business. For Goal 1, which focused on reducing IEHP grievance rates, there was an overall 28% reduction compared to the prior year. Specifically, Medi-Cal grievances decreased from 0.33 to 0.25 per 1,000 Member months (26% decrease), Medicare grievances dropped from 9.64 to 6.22 (35% decrease), and Covered California grievances fell from 1.37 to 0.71 (48% decrease). For Goal 2, targeting access grievances, IEHP achieved an even greater improvement with a 54% overall reduction. Medi-Cal access grievances declined from 0.31 to 0.13 (59% decrease), Medicare from 3.31 to 2.12 (36% decrease), and Covered California from 0.84 to 0.28 (67% decrease).

2. **Behavioral Health (BH) Member Experience Study (2025)**

   The purpose of this study is to assess IEHP's Behavioral Health (BH) Program in accordance with NCQA standard ME 7 Elements E, Annual Assessment of Behavioral Healthcare Services and ME 7 Element F, Behavioral Healthcare Opportunities for Improvement. The BH Program Member Satisfaction Survey is conducted annually by the Quality Systems Department in partnership with the Behavioral Health and Care Management Department. The survey assesses Members' overall satisfaction with the services provided by the BH Program which include BH Providers and IEHP's BH Department. Additionally, an assessment of all grievances against any IEHP BH Provider, or the BH and CM Program staff was also included in the study. The objective is to assess the quality of IEHP's behavioral health services and identify any areas for improvement.

   IEHP remains committed to our Members and improving their overall experience when it comes to BH services. Areas of strength are in the following.

   - Overall improvement in the 2025 overall ratings questions, Overall Rating of Health Plan for counseling or treatment' and 'Overall Rating of Counseling and Treatment', and Rating of Clinician.
   - The Getting Treatment Quickly composite, and the questions all met the goal, and revealed improvement from the prior year.

- The 'How Well Clinicians Communicate' domain has the highest summary rates. Question 10, 'Clinicians listened carefully to you', Question 11, 'Clinicians explained things in an understandable way', and Question 12, 'Clinicians showed respect for what you had to say'.
- The Access to treatment and information from Health Plan composite met the goal and the composite summary rate increased from prior year. In addition, the composite places IEHP at the 94th percentile when compared to other health plans.
- The Cultural/Background questions show improvement for the last 2 measurement years.

Planned future interventions to support BH Member satisfaction include Patient Empowerment & Understanding Initiative. Integrated Care Management Leaders (ICM) will continue to partner with Provider Services and key stakeholders—including Marketing, County Liaisons, Community BH, Health Equity Operations, Utilization Management, and ICM teams—to strengthen patient understanding of their health conditions and increase confidence in participating in behavioral health (BH) care decisions. Additionally, to ensure Members are well informed of their treatment options, the team will enhance collaboration efforts to promote specific areas of focus that include the area of self-help or support groups, with visibility across digital platforms for Members, and Provider spaces.

3. Cultural Needs Member Experience Survey (2025)

IEHP ensures that all medically necessary and covered services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, sex, gender identity, sexual orientation, sex characteristics, sex stereotypes, intersex traits, marital status, pregnancy or related conditions, health status, evidence of insurability, source of payment, limited English proficiency or disability, or any combination thereof, and that all covered services are provided in a culturally and linguistically appropriate manner. The purpose of this survey is to assess Members experience with the Health Plan and PCPs in the areas of health traditions, trauma, religious beliefs, alternative medicine, and immigration status. Additionally, this survey aims to assess communication and language access. This study is conducted in accordance with NCQA standard, NET 1 Element A.

Current Medi-Cal, D-SNP, and IEHP Covered active Members who opted into SMS text messaging, received an invitation via SMS text to complete the survey. A link was sent to 9,757 Members in the Medi-Cal Line of Business (LOB), 3,774 Members in the D-SNP LOB, and 2,852 Members in the IEHP Covered LOB. Collectively, the survey link was sent to 16,383 active Members in the month of October 2025.

In conclusion IEHP's enhancement to its mandatory Optimal Care for Every Community training course for all Health Plan staff, subcontractors, downstream subcontractors, and Network Providers. The course will support IEHP and its network in approaching Member care in a culturally informed and responsive manner. IEHP's strategy to improve Member and Health Plan staff experience with language services or organization functions and Members experience with language services during health care encounters. As part of this strategy, IEHP will implement enhancements to the Provider and Member Portal to allow Providers and Members to request in-person interpreter services for Members. The enhancements aim to eliminate language access barriers during medical appointments and any points of contact.

4. Quality Health Plan (QHP) Enrollee Experience Survey (2024)

As a condition of participation in the Exchanges, CMS requires that Qualified Health Plan (QHP) issuers submit Quality Rating System (QRS) clinical measure data and Qualified Health Plan (QHP) Enrollee Survey response data for their respective QHPs offered through an Exchange in accordance with CMS guidelines. The QHP Enrollee Survey is used to measure the experience of the enrollee population in the Exchanges. While the survey uses questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Surveys, modifications and new questions were designed specifically for use with the Exchange enrollee population. Measures derived from a subset of survey questions are included in the QRS measure set and ac-companying ratings.

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

When assessing IEHP's first year performance in 2025 (MY 2024) for the QHP Enrollee Experience Survey, "Access to Information" and "Plan Administration" were identified as performing measure comparably to the National average and meeting the 66.66th percentile benchmark.

Performance for Rating of Health Care, Rating of Personal Doctor, Rating of Specialist and Care Coordination were not scoreable due to not meeting the minimum denominator size of 100. Rating of Health Plan and Access to Care performed average in comparison to the National average but did not meet the 66.66th percentile benchmark.

IEHP will continue to explore opportunities for improvement in these measures with the goal of performing above the National average and continuing to improve performance year after year. In addition to identified interventions, IEHP is identifying additional opportunities for improvement for the performance of next year.

5. Quality and Accuracy of IEHP Member Portal (2024)

IEHP conducts an annual quality and accuracy assessment of Member information and functionality available on IEHP's Member Portal in compliance with ME 6 Element C. Testing conducted by IEHP's Quality Assurance (QA) team included both positive and negative scenarios for Member ID cards and Member PCP changes. The goal is 100% in all accuracy and quality testing scenarios.

For each of the testing scenarios, a QA tester receives Member IDs for each scenario that should produce the expected results. Member ID selection is based on the Member's current eligibility status with IEHP at the time the testing is conducted. The QA tester uses the Firefox browser to log into IEHP's Internal Member Portal as the Member, conducts a test scenario, compares their results to the expected results, and records the outcome. These scenarios test the accuracy of data as well as the quality of the functionality available on IEHP's Member Portal.

IEHP's Quality Assurance team conducted testing scenarios to assess the quality and accuracy of Member information and functionality available on IEHP's Member Portal in April 2023. During the assessment, all of the tests produced the expected results, meeting the overall goal of 100% in all accuracy and quality test

scenarios. The results of the testing done in 2024 were comparable to the results in 2023 and there were no significant changes or issues identified.

IEHP identified no deficiencies in any of the testing scenarios conducted and issued no corrective action plans. IEHP will continue to conduct annual quality and accuracy testing of the Member information available on IEHP's Member Portal.

NETWORK/ACCESS

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

1. **Provider Network Status Study (2025)**
   The purpose of the Provider Network Status Study is to ensure IEHP is compliant with regulatory standards for time, distance, and Provider to Member ratios, as well as to monitor NCQA guidelines. Regulatory agencies establish these standards to ensure adequate access to primary and specialty care for Members. The Member counts and percentages contained in the Network Adequacy Study were derived from two network analysis tools within the Esri GIS software suite. The OD Cost Matrix was used to calculate time and distance from every Member to every Provider by specialty. The results were processed within My SQL Studio to produce the Member count and percent within the applied time/distance. Specialties that were below the required percentage were re-evaluated with the Network Service Area tool. This result was used if it was higher than the one produced with the OD Cost Matrix.

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

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

   The results of the 2025 Provider Network Status Study – CCA reveal that all Provider types and Facilities met the time/distance standards. Overall, all 44 of the time/distance standards were met. For the Provider to Member ratio, all 48 standards were met.

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

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

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

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

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

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

Overall, all Providers scored higher in the life-threatening emergency calls than in the on-call physician access calls. PCPs met the overall goal for life-threatening emergency calls and for PCP types, Pediatrics, Internal Medicine, and Family Practice all met the goal of at least 90%. An assessment of Provider after-hours access by IPA was assessed. IEHP Direct scored 55.6% for on-call Physician access (goal not met) and 92.7% for life-threatening emergency calls (goal met).

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

3. Assessment of Ethnic and Linguistic Needs Study (2025)

The purpose of the study is to identify the ethnic and linguistic diversity of IEHP's PCP and Member populations. More specifically, the study assesses the ethnic, racial and linguistics needs of Members in accordance with NCQA standard, NET 1 Element A. This study utilizes data from three sources. PCP language, race and ethnicity is self-reported and is stored in a Microsoft Access® Database (NetworkDevelopment.accdb) which houses the IEHP Provider information. The Department of Health Care Services (DHCS) eligibility files provide the Members' language, race and ethnicity data to IEHP. Grievance data is tracked and stored in IEHP's Grievance Database.

Each rate is also compared to the established goal of 1 PCP per 2,000 Members for Language distribution and 1 PCP per 2,000 Members for Race/Ethnicity distribution. An assessment of all IEHP Grievances related to language, race and ethnicity is also included in this study.

IEHP met the threshold language distribution standard for PCP to Member ratio, exceeding the goal of 1.0 PCP per 2,000 Members across all threshold languages. Overall, IEHP met the standard of 1.0 PCP per 2,000

Members for all racial categories, except for the Black category. For ethnicity, IEHP met the standard of 1.0 PCP per 2,000 Members for the Hispanic or Latino category when all lines of business were combined

4. **Provider Appointment Availability Study (2024)**

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

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

5. **Provider Language Competency Study (2025)**

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

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

6. **Provider Directory Accuracy Study (2025)**

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

   The results of the 2025 Provider Directory Accuracy Study revealed that IEHP exceeded the goal of at least 90% compliance for all factors. The compliance rate for all four factors was relatively the same across all specialties. The overall accuracy rate for all factors combined continues to be at an exceptional rate of

99.8%. IEHP will continue the current process of verifying the Provider directory on a bi-annual basis to ensure network accuracy. In addition, the process is reviewed and enhanced bi-annually, if needed.

7. Provider Office Wait Times Study (2025)

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

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

8. Physician and Hospital Web Directory Usability Survey (2025)

The survey's objective is to present characteristics within the web-based Physician and Hospital Directory that will identify the directory as Member-friendly and enhance the ease in which the IEHP Members find the directory useful and valuable. More specifically, the study assesses the needs of the National Committee for Quality Assurance's (NCQA) Network Management (NET) standards NET 5.

All participants were given a questionnaire that referenced navigation, ease of understanding and critical information for Physician and Hospital searches. IEHP Members browsed the website. All were encouraged to share observations, ask questions, and make suggestions. The setting was casual and open.

This forum provided an opportunity for the Provider Services Department to understand how the content of the web directory is interpreted and how an IEHP Member might manipulate the directory as needed. The Survey was successful in identifying those functions on the web that are useful, easy to understand and allows ease of navigation. The Survey was also instrumental in identifying ways to improve the ease of navigation and create better understandability and usefulness in the web directory.

PROVIDER EXPERIENCE

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

1. **Provider Experience Study (2025)**
   This study assesses the satisfaction of IEHP's Primary Care Providers, Specialty Providers, and Behavioral Health Providers. The 2025 Provider Experience Study is designed to support the NCQA QI 3 and QI 4 standards (continuity and coordination of care) as well as Department of Managed HealthCare (DMHC) requirements.

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

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

   All composites rank at the 98th percentile or higher when compared to other health plans. For the Custom composites (Timely Access, Interpreter Services, and Telehealth), a comparison to other health plans was not available, however, when compared to the prior year, only the Telehealth composite show improvement.

SAFETY

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

1. **Annual Potential Quality Incidents (PQI) Report (2024)**
   This study assesses IEHP's Quality Management (QM) Department's reviews, monitors, and reports of all Potential Quality Incidents (PQI) for all network Providers and facilities including, but not limited to, primary and specialty care, facilities, hospitals, Long Term Care, Skilled Nursing Facilities, Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP) services, home health agencies, and transportation Providers. All IEHP departments, including but not limited to Grievances and Appeals department, are responsible for the evaluation and improvement of the quality of care and have the responsibility to report any PQI issues/concerns to the QM Department who is responsible for investigating and reviewing the alleged quality issue. This report identifies metrics related to PQIs, which includes Provider Preventable Conditions (PPCs).

With the internal and external reporting processes set in place, 1,276 PQI cases were processed during CY 2024 compared to the 581 cases in CY 2023. The QM Department initiated a robust PQI leveling system in 2023 which allows for more granular identification of PQI levels with accompanying Member harm. This will allow the QM Department to better identify serious trends by Provider, identify Providers with significant opportunities to improve care, and to take appropriate actions.

CONCLUSION

Overall, IEHP's QM Program was effective in reviewing data, assessing trends, identifying opportunities for improvement, and developing improvement activities within the Health Plan related to access to care, Member and Provider experience and quality of care. The current structure of all committees was positive, and we had robust practitioner participation and leadership involvement for 2025. During 2026, IEHP will focus on meeting the program goals and completing all initiatives as outlined in the 2025-2027 Quality Management/Quality Improvement & Culturally Linguistically Appropriate Services (CLAS) Workplan.

During 2025, IEHP continued to produce and distribute the Quality Report. Inside the Quality Report, we walk through our quality journey by looking at our performance over the past year with critical measures. We show how data translates into tangible outcomes for our Members, Providers and Team Members. While there were many areas where we excelled, there were also places where we found opportunities for improvement. The goal of the Quality Report is to be transparent. This journey is ongoing, and we hope to learn from it so we can do better and be better for those who rely on it most. This past year, IEHP placed even greater importance on our relationships with our Partners, especially Providers. Monthly engagement dinners continue to be an example of IEHP's commitment to connecting, supporting, and learning from our Providers.

During 2025, IEHP's performance reflects a strong commitment to quality, equity, and operational excellence. Major accomplishments include IEHP being named to People™ Magazine's *100 Companies That Care*® list, ranked #98; earning Great Place To Work® Certification for the fifth consecutive year; receiving a 99th-percentile national ranking for Provider satisfaction; ranking above the 95th percentile in every measured category, including Pharmacy, Provider Relations, Call Center performance, and overall service responsiveness; and being named a *Fortune Best Workplaces in Health Care™* for the fourth year in a row, ranked No. 28 on the list. In 2025, IEHP also received an Esri Special Achievement in GIS (SAG) Award, which recognizes advanced use of Geographic Information Systems to drive innovation, improve access, and support community health planning. IEHP was the only Hospitals and Health Systems organization in the entire United States to receive this recognition in 2025, demonstrating national leadership in GIS-enabled health equity and service delivery.

IEHP has demonstrated Mission, Vision, and Values by applying for the NCQA Long-Term Services and Supports (LTSS) Distinction, which was earned following a 100% NCQA survey score and program launch in December 2025, demonstrating excellence in coordination and outcomes for Members receiving long-term services and supports. As part of IEHP's dedication to its Mission, the Pay for Performance (P4P) program allocated an additional $237 million for the year 2025 program. The initiative incentivizes Providers who achieve key quality improvement targets. Those who show consistent yearly progress and excel in overall quality across various areas, such as preventive and chronic care, receive financial rewards. In addition, one of IEHP's most innovative partnerships is our Healthcare

Scholarship Fund (HSF). This six-year investment continues to positively address one of the lowest Provider to patient ratios in the state. The program remains active, and IEHP continues to partner with three Inland Empire medical schools—UC Riverside, Loma Linda University, and the California University of Science and Medicine. Through this partnership, students attending medical school, as well as those studying to become nurse practitioners in psychiatry, receive full scholarships.

After earning the IEHP Covered California Accreditation from the National Committee for Quality Assurance (NCQA) at the beginning of 2024 for Health Equity Accreditation, in 2025, IEHP received the NCQA Long-Term Services and Supports (LTSS) Distinction, validating that the organization delivers person-centered care planning, strong care coordination, safe transitions, and robust Member protections. This recognition strengthens IEHP's ability to support medically complex, home- and community-based Members by improving continuity, reducing avoidable hospitalizations, enhancing equity-driven data collection, and aligning with national Medicaid and LTSS quality expectations. NCQA LTSS Distinction, which recognizes organizations that excel in person-centered care planning, care transitions, coordinated services, Provider competency, and critical-incident management. Importantly, this accreditation also evaluates an organization's health equity infrastructure, including an internal culture that promotes equity, the collection of race/ethnicity/language data, access to culturally and linguistically appropriate services, and processes for identifying and reducing inequities. IEHP met these standards through strengthened language services, enhanced demographic data collection, targeted equity initiatives, and Provider network improvements shaped by cultural and linguistic needs by demonstrating that health equity is foundational to its LTSS and broader clinical programs.

In 2025, IEHP advanced its commitment to health equity, Member engagement, disparity populations, and system-level quality improvement through the coordinated efforts of the Member Experience Subcommittee (MESC), Quality Improvement Subcommittee (QISC), Population Health Management (PHM) Subcommittee, and the Quality Improvement Council (QIC). Together, these structures provided essential insight into Member needs, service experience, and organizational performance, supporting IEHP's mission to deliver optimal care and vibrant health. IEHP served as a critical channel for direct community feedback across the Inland Empire. Members identified key barriers to access to care, including:

- Transportation challenges,
- Gaps in telehealth digital literacy,
- Opportunities to clarify vaccine information,
- Rural connectivity limitations,
- Language access needs.

In response, IEHP implemented targeted improvements such as:

- Enhanced transportation benefit communications,
- Planned self-service scheduling technology,
- Expanded telehealth education campaigns,
- Culturally tailored outreach,
- Improved interpreter service visibility.

These actions reflect IEHP's ongoing commitment to addressing disparities and strengthening culturally and linguistically appropriate services.

The ongoing assessment of key quality measures are a part of IEHP's efforts to improve our Members' health outcomes. These core measures track IEHP's quality performance in hospital care, preventive care, chronic care, and behavioral health. The Hospital Pay-for-Performance (P4P) Program, rollout of a new Hospice Value-Based Incentive program for 2025, and our Global Quality P4P Programs incentivize Providers to ensure our Members have access to needed care, prescribed medications and the support needed to get healthy and avoid a hospital readmission. One of the quality areas IEHP remains focused on includes preventive pediatric care in addition to well-women visits. IEHP partners with local organizations to bring mobile mammography services throughout the Inland Empire. Recognized as a key factor in primary health care, IEHP's quality measures include assessing the management of chronic conditions. Care coordination programs are implemented to address chronic care management through a multi-disciplinary team approach to include physicians, pharmacists, utilization management, care management, behavioral health and other health care Providers. Areas of improvement are as follows:

- Eye exam for patients with diabetes,
- Blood pressure control, and
- Controlling high blood pressure.

And opportunities for improvement include:

- Asthma medication ratio.

Lastly, IEHP made significant progress in strengthening Member protections through improved oversight of the Grievance and Appeals (G&A) process. Process enhancements, better communication with Providers, and faster case reviews led to notable decreases in several grievance categories, indicating fewer service-related issues and more effective resolutions. Overall grievances dropped by 28%, with access-related grievances decreasing by 54%, thanks to improved appointment access, transportation support, and service coordination. All major lines of business saw declines. Behavioral Health grievances also fell from 408 cases in 2024 to 341 in 2025, reflecting enhanced quality oversight and Provider engagement. These decreases resulted from targeted efforts like Provider education, clearer benefit information, better interpreter and linguistic services, and improved Member navigation, which together reduced preventable concerns and underscored IEHP's commitment to Member-centered, responsive care. These system refinements, investments in Member Experience, and cross-departmental collaboration have effectively addressed root causes, reduced preventable escalations, and ensured Members receive timely support. The ongoing decline in key grievance types demonstrates IEHP's broader dedication to quality, safety, and responsive service.

IEHP further advanced operational excellence through a series of LEAN and Rapid Improvement Event (RIE) activities that strengthened efficiency, standardization, and system-level problem-solving. Major LEAN RIE initiatives, like the Riverside University Health System (RUHS) collaboration, boosted rounding efficiency and facilitated better information sharing. As a result, measurable improvements were achieved, including increased Behavioral Health Treatment (BHT) authorization productivity, faster referral and denial processing, reduced administrative workload through automation, and better alignment among multidisciplinary teams.

IEHP is dedicated to enhancing healthcare quality for its Members through proactive process analysis and integrating health initiatives aligned with industry and government standards. This includes a preventive health approach focused on outreach and early intervention to improve health outcomes. In late 2025, IEHP learned that NCQA's Health Equity Accreditation will evolve into the more advanced Health Outcomes Accreditation, shifting the focus from demonstrating equity infrastructure to showing measurable improvements in clinical quality, population health, and Member experience. Because IEHP has already incorporated strong equity-focused practices, including detailed demographic data collection, culturally and linguistically appropriate services, GIS-based population analytics, and equity-centered care pathways, the organization is well-positioned for this transition.

Its existing systems, governance, and quality strategies already reflect the outcome-oriented aims of the new accreditation, enabling IEHP to meet and surpass future national standards while continuing to deliver equitable, Member-centered care. IEHP is committed to improving the quality of healthcare delivered to its Members through proactive analysis of shared processes and integration of health initiatives that align with the industry and government quality standards; including a preventive health model for outreach and preemptive intervention related to health outcomes. These initiatives highlight IEHP's ongoing commitment to continuous improvement, operational excellence, and health equity, ensuring that Members, Providers, and the Inland Empire community benefit from a more robust, responsive, and outcome-driven healthcare system as 2026 approaches and beyond.