Quality Management and Health Equity Transformation Program

2025 Annual Evaluation

Executive Summary

May 2026

MISSION AND VISION

The purpose of the 2025 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, identifying areas of success and needed improvements in services rendered and determines if there is a need to restructure or change the QI program for the subsequent year. This annual evaluation reviews quality 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 of the Quality Improvement Program 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 IEHP's Quality Programs. Overall effectiveness of the Program is assessed by analyzing and trending the goals and actions of the quality studies, reviewing qualitative and quantitative results, providing a causal analysis and defining barriers, interventions, opportunities for improvement and next steps.

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

Mission: We heal and inspire the human spirit.
Vision: We will not rest until our communities enjoy optimal care and vibrant health.
Values: We do the right thing by:

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

QUALITY MANAGEMENT AND HEALTH EQUITY TRANSFORMATION

PROGRAM DESCRIPTION

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

PROGRAM PURPOSE

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

PROGRAM SCOPE

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

1. Defining the Program structure;
2. Assessing and monitoring the delivery and safety of care;
3. Assessing and monitoring population health management provided to Members, including behavioral health and care management services;
4. Supporting Practitioners and Providers to improve and maintain the safety of their practices;
5. Overseeing IEHP's Quality Management & Health Equity functions through the QMHETC;
6. Involving designated Physician(s) and staff in the QMHETP;
7. Involving a Behavioral Healthcare Practitioner in the behavioral health aspects of the Program;
8. Involving Long-Term Services and Supports (LTSS) Provider(s) in the QMHETP;
9. Reviewing the effectiveness of LTSS programs and services;
10. Ensuring that LTSS needs of Members are identified and addressed leveraging available assessment information;
11. Identifying opportunities for QI initiatives, including the identification of health disparities among Members;
12. Implementing and tracking QI initiatives that will have the greatest impact on Members;
13. Measuring the effectiveness of interventions and using the results for future QI planning;
14. Establishing specific role, structure and function of the QMHETC and other committees, including meeting frequency;
15. Reviewing resources devoted to the QMHETP;
16. Assessing and monitoring delivery and safety of care for the IEHP population with complex health needs and Seniors and Persons with Disabilities (SPD);
17. Assessing and monitoring processes to ensure the Member's cultural, racial, ethnic, and linguistic needs are being met; and
18. Reviewing grievances and appeals data, clinical quality of care cases and other pertinent information in relation to Member safety and care rendered at Provider practices/facilities.

PROGRAM GOALS

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

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

AUTHORITY AND RESPONSIBILITY

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

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

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

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

QUALITY MANAGEMENT AND HEALTH EQUITY TRANSFORMATION COMMITTEE (QMHETC): The QMHETC reports to the Governing Board and retains oversight of the QMHETP with direction from the CMO and

CQO. The QMHETC promulgates the quality improvement process to participating groups and Physicians, Providers, Subcommittees, and internal IEHP functional areas with oversight by the CMO and CQO. The QMHET Committee meets at least quarterly to report findings, reports actions and recommendations to the IEHP Governing Board, seek methods to increase the quality of health care for Members, recommends policy decisions, evaluate QI activity results, and provide oversight for Subcommittees.

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

1. **Quality Improvement Council (QIC)**: IEHP's Quality Improvement Council (QIC) is a standing monthly forum for addressing system- level quality gaps identified at IEHP subcommittees. The purpose of the QIC is to eliminate barriers and secure resources to drive system-level quality improvement solution efforts. Furthermore, the QIC provides a structure to guide solution efforts and maintain oversight of improvement efforts tied to these issues.

2. **Quality Improvement Subcommittee (QISC)**: Analyzes and evaluates QI activities and reports results; develops action items as needed; and ensures follow-up as appropriate. All action plans are documented on the QI Subcommittee Work Plan.
3. **Peer Review Subcommittee**: The Peer Review Subcommittee serves as the committee for clinical quality review of Practitioners; evaluates and makes decisions regarding Member or Practitioner grievances and clinical quality of care cases.
4. **Credentialing Subcommittee**: Provides discussion and consideration of all network Practitioners being credentialed or re-credentialed; reviews Practitioner qualifications including adverse findings; approves or denies continued participation in the network every three (3) years for re-credentialing.
5. **Pharmacy and Therapeutics (P&T) Subcommittee:** Reviews IEHP's medication formulary, monitors medication prescribing practices by IEHP Practitioners, under- and over- utilization of medications, drug utilization reviews, 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 (PNA) Subcommittee:** The Provider Network Access Subcommittee is responsible for reviewing, monitoring, and evaluating program data, outliers, and trends to ensure timely improvement initiatives are initiated. The Provider Network Access Subcommittee is also responsible for initiative oversight, ensuring outcomes are achieved and barriers are removed.
9. **Member Experience Subcommittee (MESC):** The role of the Member Experience Subcommittee is to review, monitor, and evaluate program data and member experience, 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 providers, 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 Improvement(QI), 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.

DELEGATION OVERSIGHT

This Delegation Oversight Study provides an annual assessment of the Annual Delegation Oversight Audit (DOA) which evaluates the Delegate's abilities to carry out their delegated responsibilities in the areas of Quality

Improvement(QI, Utilization Management (UM), Care Management (CM), Credentialing, Health Insurance Portability and Accountability Act (HIPAA) Security, HIPAA Privacy, and Compliance & Fraud Waste and Abuse (FWA). Oversight of Medicare Delegates is conducted through regular extensive evaluation including monthly reporting and file audits, quarterly, semi- annual and annual reporting, and the annual DOA. The study lookback period is July 2023 through June 2024. The Delegation Oversight Annual Audit results will be presented at the March 2025 Delegation Oversight Committee. This study includes annual DOA results for all Medicare Delegated Entities for the lookback period of July 2023 through June 2024.

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

The goal of the DOA Study was to evaluate the Medicare Delegates overall performance results from July 2023-June 2024 for delegated responsibilities as compared to the 2022-2023 performance results. The goal for the 2023-2024 DOA period was to ensure that Delegates were providing Member care that meets regulatory and IEHP requirements and guidelines. Monthly oversight auditing and monitoring activities allow IEHP to identify any challenges the Delegates encountered during the course of the lookback period. This higher frequency of auditing and monitoring ensured timely mitigation of identified deficiencies through a structured Corrective Action Plan 7 (CAP) process that supports sustained resolution. The desktop and system validation audits allow IEHP to conduct more comprehensive file and policy documentation reviews and allow for interviewing of delegate staff involved in the delegated activity. IEHP evaluates the results of the Study to identify areas of opportunity to enhance oversight efforts that would lead to further improvement in performance. IEHP will continue to stringently monitor each of the areas within the Delegation Oversight Audit tool and provide on-going training as deemed necessary and/or as requested by our Medicare Delegates.

CLINICAL QUALITY

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

D. 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	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.

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

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

   Based on medical claims and behavioral health claims data, the top diagnoses in the general population are Obesity, Hypertension, hyperlipidemia. For the SPD population, the most common diagnoses are hypertension, hyperlipidemia, and Type 2 diabetes. For children and adolescents, the top diagnoses are obesity, developmental disorder, asthma and anxiety. For BH Members, the top diagnoses are anxiety and depression. The SDOH top diagnoses are Low income, homelessness, and food insecurity. When assessing language, English and Spanish are the primary languages, followed by Vietnamese and Chinese. Members with limited English proficiency had a primary language of Spanish. Of the Members that call into IEHP requiring translator services, the most requested languages were Spanish, Mandarin, and Vietnamese. The

Members that required a face-to-face interpreter during a medical visit, most requested Spanish, American Sign Language (ASL), and Arabic. An assessment of needs of Members that do not speak English as their primary language also revealed disparities in preventative care measures. For the Vietnamese speaking group, disparities were identified in the well-child visits for three (3) consecutive years. An analysis across all ethnic groups revealed disparities in the following groups: For Pediatric Preventative Care, Black Ethnicity disparity across all measures was identified. For Cancer Prevention, the White race/ethnic group had a disparity in Breast Cancer, Cervical Cancer and Colorectal cancer screening for four (4) consecutive years. Prenatal and Postpartum disparities were identified in the White and Black Ethnic groups. Disparities were identified in the White race for Children's Health Measures including the Well Child visit measures, Immunization, lead screening, and Child and adolescent Well Care visits.

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

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

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

- **ECM Program**

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

achieve their personal health goals. The results indicate that 83.8% of Members reported that they either "agreed," or "strongly agreed," with that statement. This exceeded the set goal of 80%.

- **My Path Program**

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

- **CCM Program**

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

- **Community Supports Housing Program**

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

- **Healthy Schools Program**

  The Healthy Schools Program was launched in the Fall of 2024. The current data shows 23 Local Education Agencies are engaged. This new Program is available to both Medi-Cal and IEHP Covered Members. The goal of the program is to continue to engage members via the Local Education Agency and/or from contact with an IEHP Health Navigator. For next measurement year,

the following measures will be assessed: 'Proportion of Engaged Members who complete their Well child visit'. The number of engaged members will be identified at the end of 2025. From there the goal will be that 52% of Members complete their Well child visit. In addition, Depression Screening follow up will also be a measure that will be assessed next year. The baseline rate is currently being measured and will be available at the end of 2025.

3. **Long-Term Services and Supports Case Management Participation Study (2025)**

The Long-Term Services & Supports Case Management (LTSS CM) Program launched in April 2025. The population of focus that it serves are high-risk Members who are engaged in one or more of the following services: In-Home Supportive Services (IHSS), Multi-purpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and Assisted Living Waiver (ALW). LTSS CM Members receive case management services through an interdisciplinary care team approach with intense coordination of resources to regain optimal health or improved functionality and an individualized care plan (ICP) developed with relevant Providers. The primary goal of the LTSS CM program is to enable Members with disabilities or chronic conditions to live as independently as possible in their preferred setting, whether at home or in a community-based setting, while receiving necessary supports and services.

In compliance with the NCQA Standard LTSS 2, Elements F-G, IEHP assessed the participation rate of the LTSS CM Program using enrollment data from the medical management system to identify opportunities for improvement. Below is a performance assessment summary of the study measure for Q2 2025. The participation rate for the LTSS CM program in Q2 2025 was evaluated by examining the number of Members actively enrolled in the program. Distinct Members with a completed LTSS CM assessment on file and at least one interactive care team contact following the initial assessment were compared to the total number of Members identified as eligible for the program. The target participation rate of 50 Members (1.1%) was not met, with only 41 Members (0.92%) participating.

In summary, the findings underscore the need to reassess strategies aimed at increasing LTSS CM participation among the eligible population. Preliminary data from Q3 2025 already show improvement, with Member participation surpassing the 1.1% goal. Moving forward, targeted interventions will be implemented to optimize Member engagement in the LTSS CM program, while accounting for Team Member capacity.

4. **Long-Term Services & Supports Case Management Program Effectiveness & Member Experience Study (2025)**

The Long-Term Services & Supports Case Management Program (LTSS CM) serves a high-risk population of Members who are enrolled in one or more of the following services: In-Home Supportive Services (IHSS), Multi-Purpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and Assisted Living Waiver (ALW). Members in the LTSS Case Management Program receive support from an interdisciplinary care team that provides case management services. These services are guided by an individualized care plan (ICP) that is developed collaboratively with relevant Providers. The primary goal of the LTSS CM program is to enable Members with disabilities or chronic conditions to live as

independently as possible in their preferred setting, whether at home or in a community-based setting, while receiving necessary supports and services.

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 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.

2. **Effectiveness of Hospital P4P Measures (2024)**
   Effectiveness of Hospital P4P Measures in Improving Continuity and Coordination of Care: Annually, IEHP conducts the 'Effectiveness of Hospital P4P Measures in Improving Continuity and Coordination of Care' Study. The IEHP Hospital P4P Program was developed to reward Hospitals for providing high quality care to IEHP Members. Specifically, the study assesses the effectiveness of the Hospital P4P Program in improving the following measures: Post Discharge Follow up, Manifest MedEx participation, Follow-Up care for Mental Health or Substance Use Disorder Emergency Department (ED) – 7 Days, and Postpartum Care (PPC). Hospitals with an active IEHP contract for the Medi-Cal population at the beginning of the measurement year are eligible for Hospital P4P Program participation and were included in the 2023 study results. The set goals for three of the four measures assessed in this study were not met for 2023. Only Manifest MedEx participation met the goal of 90% participation. Barriers were identified and interventions for improvement were developed going forward. All measures in the study will continue to be assessed annually to measure performance and identify areas of opportunity. The IEHP Quality Team supports Hospitals with quarterly performance reports and are available to assist Hospitals, individually as requested, with data concerns and overall P4P Program support.

3. **LTSS CM Unplanned Transitions Report (2025)**

The Long-Term Services & Supports Case Management Program (LTSS CM) population of focus that it serves are high-risk Members who are engaged in one or more of the following services: In-Home Supportive Services (IHSS), Multi-purpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and Assisted Living Waiver (ALW). LTSS CM Members receive case management services by an interdisciplinary care team, guided by an individualized care plan (ICP) that is developed with relevant Providers. The primary goal of the LTSS CM program is to enable Members with disabilities or chronic conditions to live as independently as possible in their preferred setting, whether at home or in a community-based setting, while receiving necessary supports and services.

The LTSS CM Program focuses on empowering Members with disabilities or chronic conditions to live as independently as possible in their preferred setting. IEHP determines Members eligibility for CBAS. Eligibility for IHSS, MSSP, and ALW is determined by a county social worker or the California Department of Aging via various assessments of needs. Members are notified after they have applied if they are approved or denied for LTSS programs.

In alignment with NCQA Standard LTSS 3 Elements B-C, IEHP identified Members at high risk for unplanned transitions and analyzed the rates of such transitions to better support these members and uncover opportunities for improvement. The LTSS CM has an opportunity to reinforce proper management of chronic conditions, early identification/intervention of issues, and safe hygiene practices, especially after an invasive procedure. In summary, this report highlights existing efforts by the LTSS CM Program to reduce unplanned transitions and take action when Members are identified at risk for an unplanned transition. Interventions will be implemented to minimize unplanned transitions and Members at greatest risk receive robust case management services by the LTSS CM team.

MEMBER EXPERIENCE

HEDIS®:

To generate the rates for different measures, the IEHP Quality Informatics team loads data in an NCQA certified HEDIS® software. Technical specifications from the HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans were utilized for measure reporting. Data collection methods for HEDIS® measures include administrative, hybrid, survey, and electronic clinical data systems data (ECDS). Administrative information is collected through claim and encounter data. Hybrid measure information is captured using administrative data supplemented with medical record review of a sample population. Hybrid specifications allow for a drawing of a random sample using an NCQA-approved proportional systematic sampling method. A medical record review is conducted for these hybrid measures. Survey data is captured from Member surveys and ECDS data is obtained from electronic data exchange systems with contracted partners for data such as electronic health records (EHRs) and clinical registries.

CAHPS®:

Symphony Performance Health Analytics (SPH Analytics), a National Committee for Quality Assurance (NCQA) Certified Survey Vendor, was selected by Inland Empire Health Plan to conduct its 2024 Medicare CAHPS® Survey.

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

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

1. **Annual Grievance and Appeals Study (2024)**
   The Grievance and Appeal (G&A) Study is conducted annually and reviews case volume and rates to identify trends and assess areas of opportunity to improve overall Member satisfaction. More specifically, this study assesses Member experience in accordance with NCQA 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. Behavioral Health Treatment (BHT) Member Experience Survey (2024)

The purpose of this study is to assess member experience with IEHP's Behavioral Health Treatment (BHT) services. BHT services, including Applied Behavior Analysis (ABA) and other evidence-based interventions are based on reliable evidence-based treatments that develop or restore, to the maximum extent practicable, the functioning of an individual. BHT services are provided, observed, and directed by an approved behavioral health plan which is developed by a Qualified Autism Service (QAS) Provider or a Qualified Autism Service (QAS) Professional. Members enrolled in the BHT Program are eligible to receive behavioral health treatment and/or a functional behavior assessment. This study assesses member's experience and satisfaction with IEHP's BHT Program.

In conclusion, the BHT member satisfaction survey results reveal high satisfaction in most areas. Satisfaction with the IEHP SKI/BHT team was higher than the previous year in the overall rating of the SKI/BHT team with 100% of members responding positively. For provider satisfaction regarding overall quality, 86.5% of members reported satisfaction with their BHT provider. Lastly, the BHT grievances decreased from 53 in 2024 to 34 in 2025

4. 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.

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.

5. CAHPS® Survey (Medi-Cal) (2024)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey is a standardized assessment conducted annually to assess the experiences of beneficiaries. The CAHPS® survey is a vital tool for IEHP to assess how well the plan is meeting Members' expectations and goals, determining areas of service that have the greatest effect on Members' overall satisfaction, and identify areas of opportunity for the purpose of increasing the quality of care through quality initiatives. The survey asks Members to report on the aspects of their experiences around healthcare domains such as access to care, how well their doctors communicate, customer service, and coordination of care. The purpose of this study is to analyze the annual CAHPS® results for the Medi-Cal Adult and Child populations. The analysis can be used to identify opportunities for improvement for CAHPS® measures that are not scoring well. The National Committee Quality Assurance (NCQA) requires Health Plans to submit CAHPS® survey results in compliance with HEDIS® accreditation requirements.

Press Ganey conducted the Member experience survey from February 2025 through May 2025. For the CAHPS® Adult section of this report, a random sample of 1,836 cases was drawn from IEHP Members 18 years of age or older as of December 31, 2024, who were continuously enrolled with IEHP for the last six months as of December 31, 2024.

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

The 2025 CAHPS® survey results for the Adult population (Measurement Year 2024) indicate an overall decline in Member experience ratings. Notably, the Rating of Health Plan decreased from a five (5)-star to a four (4)-star level, while the Rating of Health Care experienced a statistically significant drop from four (4) to two (2) stars. Similarly, the Rating of Personal Doctor declined from three (3) to one (1) star, reflecting reduced satisfaction with primary care services. Among the composite measures, Getting Needed Care met the minimum sample size threshold and was reported with a two (2)-star rating. However, Getting Care Quickly did not meet the required sample size and was therefore not reported for MY2024. In contrast, the Child CAHPS® survey results showed mixed performance compared to MY2023. The Rating of Health Plan remained stable at a five (5)-star level, while the Rating of Personal Doctor improved from one (1) to two (2) stars, and the Rating of Health Care increased from one (1) to three (3) stars. The Rating of Specialist was not reported due to insufficient sample size and is not considered a Health Plan Rating measure. Composite measures such as Getting Needed Care, Getting Care Quickly, Coordination of Care, and Customer Service have not met sample size requirements for the past three years. Additionally, the How Well Doctors Communicate measure has consistently remained below the 10th percentile during this period.

6. **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 (2024)**
   The purpose of the Provider Network Status Study is to ensure IEHP is compliant with regulatory standards for time, distance, and Provider to Member ratios, as well as to monitor NCQA guidelines. Regulatory agencies establish these standards to ensure adequate access to primary and specialty care for Members. The Member counts and percentages contained in the Network Adequacy Study were derived from two network analysis tools within the Esri GIS software suite. The OD Cost Matrix was used to calculate time and distance from every Member to every Provider by specialty. The results were processed within My SQL Studio to produce the Member count and percent within the applied time/distance. Specialties that were below the required percentage were re-evaluated with the Network Service Area tool. This result was used if it was higher than the one produced with the OD Cost Matrix.

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

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

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

2. **Provider Access After-Hours Study (2024)**
   The Provider Access After-Hours study is conducted annually to assess the after-hours accessibility of Providers within the IEHP network. Specifically, the study assesses the after- hours call handling protocol of contracted Primary Care Providers (PCPs) and Behavioral Health Practitioners.

   The study is used to monitor Provider compliance and to ensure that IEHP Members have appropriate guidance and access if care is needed from their Providers after office hours. The study is conducted in accordance with the NCQA NET 2 standard as well as DMHC standards. An assessment of Member Satisfaction Survey questions related to Provider After-Hours care was also included in this study.
   IEHP's goal for Provider After-Hours Access is to meet a **90%** compliance rate in:

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

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

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

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

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

3. After-Hours Nurse Advice Line Study (2025)

The After-Hours Nurse Advice Line (NAL) study assesses the after-hours access availability for IEHP's Members through a contracted after-hours NAL. IEHP ensures the arrangement of a triage or screening service by telephone 24 hours a day, 7 days a week. During a triage or screening call, the Member's health is assessed via telephone by a qualified health professional for the purpose of determining the urgency of the need for care. IEHP must also ensure that triage or screening services are provided in a timely manner.

The after-hours NAL provides IEHP monthly reports which include average speed to answer a call and average call abandonment rates. To assess trends and verify if study goals were met, the final rates were compared to rates from previous years.

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

The IEHP Health Services Team and Medical Director meet with Carenet Health on a monthly basis to discuss metrics and any issues that may arise. The performance is tracked monthly and is presented annually to the Provider Network Access Subcommittee.

4. 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

5. **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.

6. **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%.

7. **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.

8. **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.

9. **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.

10. **Delegation Oversight Audit Medi-Cal Study (2025)**

The study presents a comprehensive annual evaluation of the Delegation Oversight Audit (DOA), which evaluates the Delegate's ability to fulfill their contractual and regulatory responsibilities in the areas of Quality Management (QM), Utilization Management (UM), Care Management (CM), Credentialing, Health Insurance Portability and Accountability Act (HIPAA) Security, Compliance and Fraud, Waste, and Abuse (FWA) Programs, and HIPAA Privacy. Oversight of Medi-Cal Delegates is maintained through a structured monitoring framework that includes monthly reporting and file audits, quarterly and semi-annual reviews, and the annual DOA. The lookback period is July 2024 through June 2025. The results of the Delegation Oversight Annual Audit will be presented at the March 2026 Delegation Oversight Committee meeting. The study aims to identify performance trends, barriers, and opportunities for process improvement to strengthen delegated functions and ensure regulatory compliance.

IEHP initiates the DOA process by issuing email notifications to all Medi-Cal Delegates, specifying their scheduled audit dates within the audit window of July 2025 through January 2026. Each notification includes audit preparation guidelines, detailed instructions for document submission, and deadlines. For the Utilization Management audit, IEHP Delegation Oversight Nurses select a sample of fifteen (15) referral files that include Denials, Approvals, and Cancellations from the Delegate's referral universe to be audited. These audits are conducted via virtual platforms, including Microsoft Teams and WebEx, during which Delegates are required to navigate their medical management systems to facilitate file case review.

The 2024–2025 Delegation Oversight Annual Audit evaluated eight (8) Medi-Cal Delegates on key functions, including QI, UM, CM, Credentialing, Compliance and FWA Programs, HIPAA Privacy, and HIPAA Security, ensuring alignment with regulatory and IEHP standards. Results showed improvements in UM Policy Review, Denial File Review, CM Policy Review, CCS Care Coordination, Credentialing Policy and Procedure Review, Credentialing File Review, Total Credentialing Score, HIPAA Security, and Security Assessment, with declines in CM Care Coordination and Compliance and FWA Program File Reviews. Performance in QI Policy Review, Approval File Review, Cancellation

File Review, SPD Care Coordination, Organizational Provider Policy & File Review, and HIPAA Privacy Program File Review remained consistent with the prior-year results. Corrective actions were issued for deficiencies, and IEHP remains committed to rigorous oversight and targeted training to support delegate performance.

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 patient safety. IEHP engages Members and Providers in order to promote safety practices. IEHP also focuses on reducing the risk of adverse events that can occur while providing medical care in different delivery settings.

1. **Physical Accessibility Review Surveys (PARS) Annual Report (2024)**

   This study assesses IEHP's overall physical accessibility of facilities to include primary care providers (PCPs), high-volume specialist, identified ancillary services, and Community-Based Adult Services (CBAS) that serve a high volume of seniors and persons with disabilities. Ancillary service provider sites are free-standing facilities that provide diagnostic and therapeutic services, such as, but not limited to: laboratory, infusion, radiology, imaging, cardiac testing, renal dialysis, occupational therapy, speech therapy, physical

therapy, pulmonary testing, and cardiac rehabilitation. CBAS centers offer a package of health, therapeutic, and social services in a community-based day care setting.

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

- Sites unaware of requirements
- Facilities constructed prior to January 26, 1992
- Financial barriers
- Sites unwilling to complete ADA recommendations

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

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

With the internal and external reporting processes set in place, 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.

IEHP VALUE BASED PAYMENT ARRANGEMENTS

Annually, IEHP assesses the percentage of dollars spent in Value Based Payment Arrangements compared to total medical cost. This study was based on applying NCQA's definitions of Value-Based Payment Arrangements to IEHP's Calendar Year 2024 financial reporting of programs that meet those definitions at the time of this writing: Capitation, Pay-for-Performance Programs and Shared Savings Programs.

IEHP Value-Based Payments for IEHP Medi-Cal reported for Calendar Year 2024 represent 12 % of IEHP's Medi-Cal Medical expenditures ($797 million of $6.4 billion).

At $592 million Capitation represents 74% of all IEHP's Value-Based Payments and at $205.1 million Pay-for-Performance represents 39% of IEHP's Value-Based Payments.

ENCOUNTER DATA VALIDATION

IEHP conducts a review of Encounter Data Completeness and Encounter Data Accuracy using a random sample of IEHP medical records. The purpose of this study is to assess data completeness and accuracy by examining medical records for accurate procedure codes, diagnosis codes, and elements such as Provider name and Member name in the medical record.

The results of the Encounter Data Validation study reveal positive trends in the accuracy and completeness of medical records. With an overall score of 90.9%, the compliance rate has increased compared to the previous years, 2022 and 2023. The highest rate of compliance when assessed by Study Measure elements, "Valid Member Name" element achieved the highest compliance rate at 99.7%, while the "Valid Rendering Provider ID" element also met the compliance target with a rate of 95.8%.

CONCLUSION

Overall, IEHP's Quality Management & Health Equity Transformation Program (QMHETP) remained effective in 2025 by reviewing data, assessing trends, and implementing improvement activities that strengthen Member access to care, quality of care, and Member and Provider experience. The Program's structure, anchored by robust committee governance, committed practitioner participation, and leadership involvement enabled consistent oversight, timely escalation of system-level gaps, and coordinated execution of targeted interventions. As IEHP advances into 2026, the organization remains aligned with the 2025–2027 QMHETP Workplan, focusing on priority clinical measures, health outcomes initiatives, and operational excellence to sustain momentum and close remaining gaps.

In 2025, IEHP continued to produce and distribute the annual Quality Report. The report continued to serve as one of IEHP's most important strategic tools in 2025, strengthening transparency, accountability, and alignment across the organization and with external partners. It became a comprehensive reflection of the Plan's performance across critical measures. The report demonstrated how data translates into tangible outcomes for Members, Providers, and Team Members. As in prior years, the Quality Report identified both areas of excellence and opportunities for improvement, reinforcing IEHP's commitment to continuous learning and system refinement. Throughout 2025, IEHP also sustained its strong emphasis on Provider partnerships, including recurring engagement dinners. These efforts strengthened collaboration, elevated shared accountability for outcomes, and ensured that Providers remain valued partners in improving the health of the Inland Empire community.

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 100th-percentile national ranking for Provider satisfaction; ranking above the 95th percentile in every measured category from Pharmacy to Provider Relations to Call Center performance, and overall service responsiveness as stating 98% of Providers shared

they would recommend IEHP to other physician practices; 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 Community Advisory Committee (CAC), 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 Member Experience Subcommittee (MESC) maintained oversight of the Member journey and identified opportunities to improve service delivery across all touchpoints. In 2025, the MESC evaluated CAHPS® trends, grievance and appeals patterns, SNF Member Journey reporting, and behavioral and non-behavioral health experiences. Enhancements included system-wide collaboration on Member Experience initiatives such as:

- Improvements to Member Services training,
- Full compliance in Member Portal Quality and Accuracy Testing,
- Stronger integration of CAC insights into Member-facing improvements.

These efforts supported a comprehensive, data-informed approach to improving Member satisfaction and service quality.

The ongoing assessment of key quality measures is part of IEHP's efforts to improve our Members' health outcomes. These core measures monitor IEHP's 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. IEHP emphasizes preventive pediatric care and well-woman visits, partnering to offer mobile mammography services across the Inland Empire. Because managing chronic conditions is vital to primary care quality, IEHP tracks performance in areas such as diabetes, hypertension, and asthma, supported by coordinated programs that involve physicians, pharmacists, utilization management, care teams, behavioral health, and other Providers. Key improvement areas:

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

Additional focus on enhancing,

- Asthma medication ratio.

IEHP made significant progress in strengthening Member protections through the improved oversight of Grievance and Appeals (G&A). 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, including a 26% reduction in Medi-Cal grievances. Behavioral Health grievances also fell from 408 cases in 2024 to 341 in 2025, reflecting the 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. These efforts contributed to consistent execution and lower performance variability. 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. 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, positioning the organization for a successful transition. IEHP's existing systems, governance, and quality strategies 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. 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.