

TABLE OF CONTENTS

Section 13: Quality Improvement and Health Equity (QIHE) Overview 13-1

- Medicare Advantage Star Ratings Program Overview 13-1
- Definition of Quality 13-3
- Scope of the QIHETP 13-5
- Responsibilities of Network Providers in Quality Improvement..... 13-9
- Quality Improvement and Health Equity (QIHE) Process 13-11
- Quality Improvement and Health Equity Committee (QIHEC) and Subcommittees 13-12
- Network Provider Committee Participation..... 13-18
- Quality of Care Issues 13-18
- Health Care Effectiveness Data and Information Set (HEDIS)..... 13-19
- Clinical Practice Guidelines..... 13-20
- Enrollee Experience Survey..... 13-21
- Health Outcomes Survey (HOS)..... 13-21
- Provider Satisfaction Survey..... 13-21
- Member Safety 13-21

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

QUALITY IMPROVEMENT AND HEALTH EQUITY (QIHE) OVERVIEW

Health Plan offers a constellation of care, programs and services designed to meet quality and equity standards set forth in CMS, DMHC and DHCS contracts to improve quality, equity, access and availability, detection of under and over utilization of services, and policies and procedures that reflect current medical practice standards. In 2026, Health Plan's product portfolio will expand to include a D-SNP incorporating robust state and federal-specific quality and equity monitoring and reporting requirements.

Health Plan's Quality Improvement and Health Equity Transformation Program (QIHETP) supports its mission through the development and maintenance of a quality-driven Provider network. The QIHETP is a coordinated, comprehensive, equitable, and continuous effort to monitor and improve member safety and performance in all care and services provided.

MEDICARE ADVANTAGE STAR RATINGS PROGRAM OVERVIEW

Health Plans participating in the Medicare Advantage Program require compliance with specific reporting standards and quality measures established by the CMS. All providers working with Health Plan are expected to adhere to the requirements set by Health Plan, CMS, and the designated Quality Improvement Organization (QIO), which reviews compliance on behalf of CMS.

The Medicare Advantage Star ratings evaluate the quality of Medicare Advantage plans which help CMS promote higher standards of care and accountability among providers and health plans. Each year, CMS publishes the Star ratings to guide members in selecting the best plan and to determine Medicare Advantage quality bonus payments. The Star Ratings Program is designed to focus on rewarding better care, fostering healthier communities, and reducing costs through care improvements.

Domains of the Medicare Advantage Star Ratings System

Star rating measures are organized into the following categories:

- Staying Healthy: Screenings, Tests and Vaccines
- Managing Chronic (Long Term) Conditions
- Member Experience with Health Plan
- Member Complaints and Changes in the Health Plan's Performance
- Health Plan Customer Service
- Drug Plan Customer Service
- Member Complaints and Changes in the Drug Plan's Performance
- Drug Safety and Accuracy of Drug Pricing

Member Surveys

Members in a D-SNP may be asked to participate in up to three surveys each year. Not all Members receive all three surveys annually.

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey measures member satisfaction with their doctors and health plan. Sample questions include:

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

- “In the last six months, not counting times when you needed care right away, how often did you get an appointment as soon as you thought you needed one?”
 - “In the last six months, how often did your personal doctor seem informed and up to date about the care you got from Specialists?”
 - “How often did your health plan’s customer service representative give you the information or help you needed?”
2. Health Outcomes Survey (HOS) evaluates both the physical and mental health of Members. Questions may include:
- “In the past 12 months, did a doctor or other healthcare provider advise you to start, increase, or maintain your level of exercise or physical activity?”
 - “Has your doctor or other healthcare provider done anything to help prevent falls or treat problems with balance or walking?”
 - “Have you ever talked with a doctor, nurse or other healthcare provider about leaking of urine?”
3. Health Risk Assessment (HRA) is administered once a year to all Members. The HRA must be completed within 90 days of enrollment in the D-SNP and annually thereafter. This survey collects information about the Member’s health status and any concerns or conditions he/she may have. Responses to the HRA are used to identify member needs, and as the foundation for development of an Individualized Care Plan for the Member.

Other Performance Data Collected

CMS analyzes other performance data to determine a plan’s Star rating. Data includes:

- Healthcare Effectiveness Data and Information Set (HEDIS) - used to measure performance on dimensions of care and services.
- CMS Part C Reporting Elements, including benefit utilization, adverse events, organizational determinations and procedure frequency.
- Medication therapy management measures.
- Clinical and administrative/service quality improvement projects.

Provider Influence on Member Access and Care

Health Plan collaborates with providers to deliver care to Members. Several domains have been identified where providers influence the members’ quality of care and access to services.

Domains include:

- Adult and Pediatric Preventive Care (e.g., well-care visits, screenings, immunizations)
- Chronic Care Management (e.g., asthma, diabetes)
- Acute Care Management (e.g., pharyngitis, bronchitis)
- Behavioral Health Care (e.g., mental illness, substance use treatment)
- Efficiency of Care (e.g., hospital utilization rates, medication adherence)
- Member Experience and Satisfaction with Care (e.g., CAHPS, HOS)

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

Through dedicated work in each domain, Providers meaningfully affect the outcomes of the Star Ratings Program. The Provider's commitment to delivering timely preventive and chronic care increases both clinical performance and member wellness, driving higher ratings in quality metrics. For example, encouraging members to have their annual wellness visits and ensuring medication adherence and following up on abnormal tests results.

Providers also play an essential role in enhancing care delivery and fostering positive Member experiences and in shaping a healthcare system where service quality is continually elevated and recognized through Star ratings.

Provider benefits of Star Ratings Program

Star ratings provide significant benefits to participating providers:

- **Clinical Performance:** Clear guidelines in areas like preventive care and chronic management help enhance member outcomes and professional satisfaction.
- **Quality Care:** Providers' dedication to consistent, timely, and high-quality care is recognized and highlighted within the Star Ratings Program. High performance can enhance a provider's reputation within the health system and the broader community.
- **Member Engagement and Satisfaction:** The program places a strong emphasis on the experience and satisfaction of member, encouraging providers to foster stronger relationships with members, translating to higher member retention and better health outcomes.
- **Performance Data and Support:** Providers receive quality and performance data throughout the year, empowering them to identify areas for improvement and celebrate achievements.
- **Stronger Healthcare Community:** By actively participating in the Star Ratings Program, providers help shape a culture of excellence and improvement; creating a healthcare community where service quality is continually elevated and recognized.

Ultimately, through Star ratings, Providers are empowered to deliver better care, achieve higher ratings, and enjoy greater recognition for their commitment to members and the healthcare system as a whole.

Health Plan offers quality and performance data to Providers throughout the calendar year. For additional information, contact the Provider Services Department at 1-888-361-7526

DEFINITION OF QUALITY

The definition of quality is an extension of Health Plan's vision that is "STEEEP" in Quality.

- | | |
|-----------------------|--|
| S - Safe: | Avoiding injuries to members from the care that is intended to help them. |
| T - Timely: | Reducing waits and sometimes harmful delays for both those who receive and those who give care. |
| E - Effective: | Providing services based on scientific evidence to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse respectively). |

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

E - Efficient:	Avoiding waste, including waste of equipment, supplies, ideas, and energy.
E - Equitable:	Providing care that doesn't discriminate because of gender ethnicity, geographic location, socioeconomic status, or any other classifications prohibited by state or federal law.
P - Patient Centered:	Providing care that is respectful of and responsive to individual member preferences, needs, and values and ensuring that member values guide all clinical decisions.

Better Outcomes

Improving the health of the overall population while creating an improved member experience will help Health Plan with more educated members that can manage their health more effectively. The premise of the Institute for Health Improvement Triple Aim is to assist organizations with creating a foundation for providing an environment that serves to improve quality and satisfaction while reducing costs. Improving the health of populations takes the first individual aspect of the Triple Aim and expands it towards the whole population. Society is facing an increase in chronic diseases, so improving the member experience for all individuals will ultimately lead to a decrease in prevalence and/or severity of chronic diseases and overall better chronic care management.

Lower Costs

The Triple Aim intends to drive down costs while improving the health of populations by improving quality of care. If members visit Providers less frequently because their needs are met using other modalities, their care will be much more affordable.

Improve Clinical Experience

As value-based care becomes more prevalent, the quality of care provided becomes more essential and the Provider is the key to ensuring successful value-based care. In order to ensure the success of the Triple Aim, the care delivered by the Provider is key. It all starts there.

The QIHETP is designed to monitor, evaluate, and take timely action to address necessary improvements in the quality of care delivered by all Providers in any setting and take action to improve equity. It is comprehensive and addresses both the quality and safety of medical and behavioral health care provided to members and participants of the D-SNP. In addition, it facilitates compliance with the CMS requirement that D-SNPs incorporate one or more activities in its quality improvement program to reduce disparities in health and healthcare.

Full service Behavioral Health care benefits are offered to all D-SNP members. Behavioral health services for members who meet criteria for specialty mental health services or substance use disorder services can access these services through the local county Behavioral Health department. The Behavioral Health Case Management team can coordinate care for any members seeking to access County Behavioral Health services.

Members are able to receive access to coordinated behavioral health services directly through Health Plan's contracted Behavioral Healthcare network or with the assistance of our Behavioral Health Case Management team.

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

SCOPE OF THE QIHETP

The QIHETP monitors and improves an array of indicators to measure critical clinical and service processes and outcomes while removing barriers to care and meeting the cultural, linguistic diverse preferences and needs of members.

The QIHETP outlines the delivery system programs and quality metrics that enable members to maintain or improve optimal health status and remediate or manage the debilitation caused by emerging or apparent chronic medical or behavioral illness or disability.

QIHETP activities include but are not limited to:

- Alignment between quality, equity and population health initiatives:
 - Ensuring Health Plan quality objectives align with CMS and DHCS whereby measures meet, at minimum, the Medicare Advantage three Star rating thresholds during its first year as a DSNP, with progressively higher Star ratings targets in subsequent years.
 - Alignment with Health Plan’s NCQA-approved SNP Model of Care and measures its effectiveness in the following domains:
 - Access to care
 - Improvement in member health status
 - Continuity of care
 - Care coordination, including participation by an interdisciplinary care team (ICT)
 - Implementation of an individualized care plan that addresses the member’s functional, psychosocial, and clinical needs
 - Medication management, disease management and behavioral health
 - End-of-life care
 - Integrated systems of communication
 - Ensuring preventive health programs, quality, and equity strategies address quality of care and access to include:
 - Ensure proper screening for women to ensure individuals at high risk are given appropriate follow up.
 - Identify and facilitate delivery of extra services and benefits that meet the specialized needs of the most vulnerable beneficiaries as evidenced by measures from the psychosocial, functional, and end-of-life domains.
 - Ensure network Providers and their staff routinely seen by D-SNP members receive training on the D-SNP Model of Care.
 - Monitor processes and outcomes with achieving compliance with preventive guidelines.

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

- Engage in planned health equity-focused interventions to address gaps in the quality of and access to care for members, including preventive and screening services.
 - Engage with local entities when developing interventions and strategies to address deficiencies in performance measures related to health care services for members.
- Ensure quality and equity activities align with clinical practice guidelines
 - Ensure quality programs promote physical and behavioral health care through the design of programs which focus on medical and behavioral health conditions.
 - Quality and equity activities align with appropriate utilization.
- Behavioral health care programs that focus on the following:
 - Prevention and screening for evaluation of cognitive development, neurodivergent disabilities, functional and social impairment, substance use, and abuse.
 - Programs that support, recovery, resiliency, and rehabilitation.
 - Exchange of information.
 - Appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care.
 - Monitoring of psychotropic medications.
 - Primary and secondary behavioral health programs.
- Access to primary and specialty Providers and services:
 - Member disengagement with primary care.
 - Accessibility of Providers.
 - Availability of routine, regular, non-urgent and urgent and medical, ancillary, specialty, and behavioral health appointments.
 - Language accessibility at the time of appointment, when applicable.
- Continuity of care and coordination across settings and at all levels of care, including:
 - Referrals between members and Community Based Organizations (CBOs).
 - Transitions of care, with the goal of establishing consistent Provider-member relationships:
 - When members transition between Providers.
 - When members move across care settings.
- Improve member experience with respect to clinical quality, access, and availability, and culturally and linguistically competent health care and services, continuity, and care coordination.
- Population health activities that are designed to address:

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

- Keeping members healthy by focusing on wellness and prevention programs.
- Identifying and managing emerging risks for high and rising risk members:
 - Members with biometric indicators or high-risk behaviors that are known to increase risk for chronic conditions.
 - Members with increased risk of declining medical and/or behavioral health conditions.
- Ensure effective transition planning across delivery systems or settings through care coordination and other means to minimize member risk and ensure appropriate clinical outcomes for members.
- Delivery of extra services and benefits that meet the specialized needs of the most vulnerable beneficiaries.
- Access to a Chronic Care Improvement Program (CCIP). Program aims include:
 - Improving the health of D-SNP members diagnosed with Diabetes Mellitus (DM), are of Hispanic/Latino ethnicity, and have a HgbA1c result >9:
 - Slowing disease progression
 - Prevention of health complications
 - Decreasing inpatient stays

Program elements include:

- Methods for identifying members meeting program criteria
- Mechanisms for monitoring members participating in the CCIP
- Evaluating participant health outcomes
- Systematic and ongoing follow-up on the effect of the program

Goals of the Quality and Health Equity Transformation Program:

- Promote an organization-wide commitment to equality of care and service through strong leadership involvement in improving quality.
- Address, prevent, and resolve health disparities within the network through monitoring quality data and implementation of targeted interventions.
- Enhance continuity and coordination of care among behavioral health and primary Providers.
- Respond actively to member expectations and feedback concerning the quality of member care delivered and services provided.
- Define, oversee, evaluate, and improve the care and service delivered by Health Plan staff, Providers, and delegated entities by:
 - Promoting member safety as a high-level priority through mechanisms designed to minimize member and organizational risk of adverse occurrences.

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

- Improving and enhancing the quality of member care provided through ongoing, objective, and systematic measurement, analysis, and implementation of improvement actions.
- Promoting processes to ensure the availability of safe, timely, effective, efficient, equitable, member-centered care and provide oversight within the network.
- Comply with legislative regulations, accreditation standards, and professional liability requirements.
- Ensure that medically necessary covered services are:
 - Available and accessible.
 - Provided in a culturally and linguistically appropriate manner.
 - Provided in an equitable manner.
 - Provided by qualified, competent Providers who are committed to Health Plan’s mission and vision.
- Promote collaborative relationships between Health Plan, Providers and community partners.
- Promote and create condition specific health education and disease prevention materials that are age, culturally, and linguistically appropriate and encourages optimal behavioral health for members and staff.
- Maintain an appropriate number of credentialed network Providers to meet the access needs of members.
- Ensure Providers, delegated contractors and subcontractors participate in the QIHETP and Population Needs Assessment.
- Ensure members’ protected health information (PHI) is protected, utilized, and released in accordance with state and federal law and regulation.
- Follow all accreditation, regulatory, and licensure survey recommendations within 90 days of identifying improvement opportunities.
- Continue implementing adequate information management systems to support complete data entry, aggregation, display, analysis, and the needs for all quality management activities.
- Incorporate responsibilities for quality management and improvement into management performance standards.

Other areas that have impact on the QIHETP include:

- Provider credentialing and recredentialing.
- Utilization management processes and outcomes.
- Inter-rater reliability.
- Provider performance.

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

- Pharmacy management.
- Facility site reviews (FSRs).
- Care coordination program performance.

RESPONSIBILITIES OF NETWORK PROVIDERS IN QUALITY IMPROVEMENT

Network Providers (primary care physicians, specialists, facilities, etc.) are contractually required to participate in and cooperate with Health Plan's QIHETP.

Primary care physicians and specialty Providers participate with Health Plan's QIHETP through:

- Compliance with Health Plan policies, state and federal requirements by maintaining accurate and timely information and following all public health and regulatory guidelines related to the reporting of communicable diseases, the delivery of preventive care services, procedure consents, and any other required data sets.
- Providing all medical care with attention to confidentiality of care and professional standards of human dignity.
- Maintaining infection control, exposure control and safety policies and procedures.
- Cooperating with, and adhering to, Health Plan's QIHETP, utilization management plan and physician and provider credentialing policy.
- Identifying a staff physician/Chief Medical Officer (CMO) to serve as clinical liaison with Health Plan and who will be authorized to communicate directly with Health Plan's CMO regarding medical services and clinical issues.
- Cooperating with Health Plan's staff during facility and medical record reviews and initiating corrective action for areas identified as requiring improvement.
- Cooperating with Health Plan's staff during the investigation of member grievances and potential quality issues by (1) providing requested documentation of medical care and/or discussing the care with Health Plan's CMO; (2) assisting with the resolution of such grievances and (3) taking corrective action (if any) to prevent the recurrence of problem areas.
- Participating in committees and review panels within areas of expertise as requested and as feasible.
- Completing a credentialing application and requested documents at the time of initial credentialing and recredentialing.
- Cooperation with quality improvement activities to improve quality of care and member experience. Cooperation includes collection and evaluation of data and participation in Health Plan's clinical and service measure QI programs.
- Practitioners understand that Health Plan may use practitioner performance data for quality improvement activities.

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

Hospitals, other facilities and other Providers participate with Health Plan's QIHETP through:

- Permitting access to Health Plan's member's medical records for review when quality of care concerns or potential quality issues are identified.
- Investigating identified quality of care issues and reporting resolutions to Health Plan.
- Participating in the facility credentialing process by providing requested documents, allowing on-site visits, as necessary, and implementing corrective actions, as necessary.

QUALITY IMPROVEMENT AND HEALTH EQUITY (QIHE) PROCESS

The QIHE process includes a comprehensive array of clinical and service indicators that provide information about the systems, processes, and outcomes of clinical care and service delivery. Clear, well-defined quality indicators represent what is most important to Health Plan in measuring and evaluating quality. The measures are developed using sound methodological principles and are rooted in best practice guidelines. Measured performance data is assessed to ensure reliability so that decisions can be made with confidence.

Quality indicators are reflective of areas that are high risk, high volume, problem prone specific populations, and specific conditions, as well as industry standard measures. Most indicators are rate-based outcome measures. Indicators are measurable and have a goal against which to measure performance. Indicators are developed with input from Health Plan's CMO, Chief Health Equity Officer (CHEO) and the Quality Improvement and Health Equity Committee (QIHEC).

To understand and properly implement QIHEC related practices and projects, there are approaches being utilized. Such models help collect and analyze data for test change, provide guidance for effort and improvement in efficiency, member safety, or quality outcomes. These models include:

- Plan Do Study Act (PDSA)
- Performance Improvement Projects (PIPs)

Plan Do Study Act (PDSA)

The PDSA methodology is a rapid cycle, continuous quality improvement process designed to perform small tests of change, which allows more flexibility throughout the improvement process. As part of this approach, Health Plan performs real-time tracking and evaluation of its interventions. PDSAs are the most common continuous quality improvement model utilized by Health Plan and have four major elements or stages:

- Plan:** The first step involves identifying preliminary opportunities for improvement. At this point the focus is to analyze data to identify concerns and ideas for improving process and to determine anticipated outcomes. Key stakeholders and/or people served are identified, data compiled, and solutions proposed.

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

- B. **Do:** This step involves using the proposed solution, and if it proves successful, as determined through measuring and assessing, implementing the solution usually on a trial basis as a new part of the process.
- C. **Study:** At this stage, data is again collected to compare the results of the new process with those of the previous one.
- D. **Act, Adopt or Adapt:** This stage involves making the changes a routine part of the targeted activity. It also means “Acting” to involve others (other staff, program components or consumers) - those who will be affected by the changes, those whose cooperation is needed to implement the changes on a larger scale, and those who may benefit from what has been learned. Finally, it means documenting and reporting findings and follow-up.

Health Equity Program

The Health Equity Program description supports Health Plan’s mission and vision through the development and maintenance of a quality driven, health equity focused, network of care for all lines of business. The CHEO works with various internal and external teams and stakeholders to continuously monitor and implement activities to improve health equity and reduce health disparities among Health Plan’s members. This work aligns with corporate goals and CMS requirements for quality improvement programs. Health Plan has a matrix Health Equity Framework that has four key Pathways. The Pathways run concurrently and are specific to the key stakeholders for Health Plan:

1. Internal pathway focused on Health Plan employees, leadership and culture.
2. Member pathway focused on impacting members’ health disparities.
3. Partner pathway focused on all key stakeholder partners.
4. Community pathway focused on system collaboration and overall community health equity efforts.

Reporting to the CHEO is the Quality, Grievance and Appeals, Health Equity and Cultural and Linguistics, Credentialing, FSR, Provider Partnership, HEDIS, Accreditation and Health Education Teams.

The QIHETP includes a comprehensive array of clinical and service indicators that provide information about the systems, processes, and outcomes of clinical care and service delivery. The quality indicators emphasize areas representing risk and need across the continuum of care. Indicators are developed with input from the CMO and the QIHEC which include key members of the Provider community. These indicators include, but are not limited to:

- All-cause hospital readmissions.
- Emergency room utilization.
- Ambulatory care utilization.
- Primary and urgent care utilization.
- D-SNP’s ability to deliver high-quality healthcare services and benefits to members

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE (QIHEC) AND SUBCOMMITTEES

The key to Health Plan’s quality management success is integration of information. Health Plan’s committees may function separately, but it is an expectation that data and information be readily available to and from all who are actively involved in Health Plan’s performance improvement processes. Committee information and data is validated, coordinated, aggregated, communicated, reported, and acted upon in a timely manner to ensure success with all performance improvement and quality initiatives. All committee members are required to note their attendance for each meeting and sign an annual “Conflict of Interest” statement. Committee members cannot vote on matters where they have an interest and must abstain until the issue has been resolved. Written minutes are maintained by each committee for each meeting. Many of Health Plan’s QIHETP committees require the participation of Providers.

Quality Improvement and Health Equity Committee (QIHEC) – Governing Board of Quality and Health Equity Transformation Program (QIHETP)

The QIHEC is responsible for collecting and analyzing out-of-network Provider use and referrals to assess Member use of services delivered by participating Providers with targeted clinical expertise and identifies any gaps in care or services relating to possible deficiencies in the network. Ensures a sufficient number of board-certified providers with expertise in such key areas as Geriatrics, Cardiology, Neurology, Endocrinology, Orthopedics, Nephrology, Pulmonology, and Behavioral Health specialties along with acute inpatient hospitals, rehabilitation and psychiatric facilities and subacute nursing facilities are participating in the network. An additional key consideration is to ensure the availability of qualified physicians and/or nurse practitioners willing and available to make home visits when a need arises. For ambulatory and community-based services, the provider contracting team insures the appropriate availability of ancillary service providers such as radiology, laboratory, licensed home health care agencies, transportation, and DME vendors.

The committee is chaired by the Chief Medical Officer and the Chief Health Equity Officer and provides additional input as needed and approves recommendations. QIHEC reports to the San Joaquin County Health Commission which is the highest Committee for quality oversight

The committee:

- Approves the annual QIHETP description, plan and evaluation.
- Recommends policy decisions or oversees recommendations and revisions to the QIHE activities.
- Reviews, analyzes, evaluates, and makes recommendations regarding the progress and outcome of quality improvement and health equity projects and activities.
- Ensures that quality performance standards are met and makes recommendations for improvements.
- Institutes actions to address performance deficiencies, identifies necessary actions and ensures follow-up according to plan.

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

- Assists in establishing the strategic direction for all quality and healthy equity initiatives.
- Receives subcommittee reports, identifies performance improvement opportunities and makes recommendations to be incorporated into the QIHETP work plan.
- Ensures Provider communication, education and follow-up related to quality of care issues.
- Ensures Provider participation in the QIHETP through planning, design, implementation, or review.
- Confirms and reports to the Commission that Health Plan activities comply with all state and federal regulations.
- Reports to the San Joaquin County Health Commission any variance from quality performance goals and the plan to correct.
- Submits to the Commission approved, signed minutes reflecting the committee decisions and actions of each meeting.
- Presents to the Commission an annual reviewed and approved QIHETP description and work plan and prior year evaluation.
- Annually reviews and approves medical review criteria and clinical practice guidelines.
- Oversees QI and health equity activities that validate quality management effectiveness through customer feedback reporting including:
 - Oversees Provider and Member satisfaction/experience surveys.
 - Reviews and approves the annual Healthcare Effectiveness Data and Information Set (HEDIS) rates and provides feedback about improvement initiatives.
 - Reviews and approves the annual Consumer Assessment of Health care Providers and Systems (CAHPS) survey results and provides feedback about improvement initiatives.
 - Reviews and approves the annual HOS results and provides feedback about improvement initiatives.
- Maintains compliance with standards for mandated reporting of diseases or conditions to the local health department.
- Review and provide feedback on quality and equity policies.

Quality Improvement and Health Equity Operations Committee (QIHEOC)

The QIHEOC is responsible for improving the quality of health care and services by monitoring, evaluating and taking timely action on identified quality of care and service issues. The QIHEOC is responsible for reviewing and providing feedback on the processes, programs, and measurement activities undertaken by the organization and by making recommendations to the QIHEC Committee. The QIHEOC is co-chaired by the Director of HEDIS & Accreditation and Director of Health Equity.

The committee includes development and oversight of:

- HEDIS

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

- HOS
- CAHPS
- Quality Improvement Projects (QIP) and PDSA initiatives
- Customer Service Call Quality
- Review and approval of all quality improvement corrective action plans (CAPs)
- Wellness and preventive health programs
- Health Education standards/guidelines, and Health promotion actions
- Cultural and Linguistic Services
- Population Health Management
- Member and Provider experience survey results
- Provider access and availability
- Network adequacy
- Grievances and Appeals
- Performance Improvement Projects (PIP)
- Policy and procedures
- FSRs and Credentialing metrics
- Feedback and annual review process of Health Plan's Provider Manual and any new or revised policies and procedures.

Peer Review and Credentialing Committee (PRCC)

The PRCC is responsible for reviewing the initial credentialing, recredentialing, recertification, and reappointment of physicians through a medical peer review committee. PRCC members are appointed by the Commission to which the committee also reports.

The committee is chaired by the Chief Medical Officer and is composed of Providers representing primary and specialty care, as well as other Providers.

The committee:

- Oversees and evaluates Health Plan's credentialing and recredentialing process for evaluating and selecting Providers.
- Reviews the qualifications of new and continuing Providers.
- Ensures a fair and effective peer review process to make recommendations regarding credential decisions.
- Reviews Provider quality service and performance data, including member complaints, FSRs, and identifies opportunities for improvement.

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

- Determines whether health care services were performed in compliance with standards of practice and directs corrective action measures when standards are not met.
- Evaluates and makes recommendations on all Provider adverse actions and takes appropriate disciplinary action against Providers who fail to meet established standards and/or legal requirements as appropriate.
- Ensures and oversees a formal and objective Provider appeal process.
- Reviews and recommends actions related to escalated Quality of Care issues.
- Submits to the Commission approved, signed minutes reflecting the committee's decisions and actions of each meeting.

Grievance and Appeals (G&A) Committee

The Grievance and Appeals Committee ensures that the organization maintains adequate oversight of Member Grievance and Appeals. The G&A Committee provides oversight of the grievance and Appeal system to ensure the continuous and expedited review of grievances occurs and resolution is reached timely and that adverse benefits determinations are thoroughly evaluated. The G&A Committee ensures emergent and urgent trends in care and service are identified and timely action is taken when evidence of non-compliance exists. The G&A Committee meets at least quarterly and reports to the QIHE Committee.

The committee is chaired by the Executive Leadership of Quality Improvement and Health Equity and Manager of Quality.

The committee:

- Oversees and ensures the integrity of the grievance and appeal process, including tracking for timeliness and resolution.
- Evaluates grievances and potential quality of care issues.
- Reviews and evaluates G&A trend reports and identifies and makes recommendations for improvements.
- Ensures compliance with regulatory and contractual requirements.
- Submits to the QIHEOC and QIHEC approved, signed minutes reflecting the committee decisions and actions of each meeting.

Clinical Operations Committee (COC)

The COC is responsible for conducting annual review and approval of medical and behavioral health clinical practice guidelines and medical necessity hierarchy and criteria. This process ensures the delivery of age-appropriate, evidence-based care aligned with industry standards for members. The COC also evaluates program performance, identifies findings and opportunities for improvement, and makes recommendations to the QIHEC. Clinical practice guidelines are reviewed by the COC and QIHEC at least annually.

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

The committee is chaired by the Executive Director of Clinical Operations and the Chief Medical Officer and reports to the QIHEC.

Compliance Committee

The Compliance committee is responsible for assisting the Health Commission Board of Directors in overseeing Health Plan's Compliance Program.

The Committee is Chief Regulatory Affairs & Compliance Officer and reports to the CEO and Board of Directors.

The committee:

- Manages DHCS and CMS contracts, laws and regulations applicable to regulatory requirements.
- Ensures compliance with policies, as applicable to D-SNP; by employees, officers, directors, and other agents of the company.
- Establishes measures that prevent and detect, and correct fraud, waste and abuse or other incidents of non-compliance.

Community Advisory Committee (CAC)

The CAC serves as Health Plan's Member Advisory Committee & is chaired by the Manager of Health Education. The CAC establishes and monitors Health Plan's relevant public policies:

- Transportation availability
- Language requirements
- Cultural issues
- Member health education needs
- The CAC also solicits, reviews and makes recommendations on ways to improve access to covered services, coordination of services, and health equity for underserved populations.

Through the Committee, Health Plan:

- Routinely engages with members and their families through focus groups, listening sessions, surveys and/or interviews and incorporate results into policies and decision-making when appropriate.
- Maintains the process for incorporating member, and their family's, input in policies and decision-making.
- Monitors and measure the impact of the above.
- Maintains processes to share with members and families on how their input impacts Health Plan policies and decision-making.

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

Committee members include, but are not limited to;

- Comprised of the population enrolled in D-SNP or other individuals representing those members. Factors such as racial ethnic representation, language, demography, occupation, and geography are considered in the selection of the committee's members.

Pharmacy and Therapeutics (P&T) Committee

The P&T Committee is responsible for ensuring members receive high quality, safe and efficacious medication therapy. The Committee promotes the appropriate use of high quality and cost-effective pharmaceuticals for members and ensures compliance with state and federal regulations.

The committee is co-chaired by the Director of Pharmacy and the Medical Director and reports to the Clinical Operations Committee.

The committee:

- Is a multidisciplinary committee with a majority of physician and pharmacist members from the community.
- The committee meets at least quarterly.
- Members of the P&T Committee are: Chief Medical Officer, Director of Pharmacy, five practicing physicians in primary and specialty care, one pharmacist, and additional specialists.
- Reviews, oversees, and approves Health Plan's prescription drug formulary
- Identifies processes to evaluate pharmacy safety and effectiveness.
- Ensures the reliable function and maintenance of a notification system for drug alerts.
- Develops, approves, and maintains pharmacy criteria, policies and procedures that ensure safe and effective formulary management and authorization processes.
- Reviews pharmacy data and reports and makes recommendations for improvement.
- Establishes and oversees specialty advisory panels, as necessary, to provide expert opinion on clinical matters for P&T Committee consideration.
- Develops and approves member and Provider education to address member safety.
- Oversees the PBM to ensure practices meet Health Plan's quality standards.
- Submits to the Commission approved, signed minutes reflecting the committee decisions and actions of each meeting.

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

NETWORK PROVIDER COMMITTEE PARTICIPATION

Contracted Providers are expected to cooperate with Health Plan's QIHE activities to improve the quality of care and service, to reduce health disparities and to improve member experience. Cooperation includes collection and evaluation of data and participation in Health Plan's QIHE programs. Providers understand that Health Plan may use Provider performance data for quality improvement activities.

All Providers who participate on our QIHECs or subcommittees receive a stipend for each meeting attendance. If you have an interest in being a participant on one of these committees, please email QIHE@hpsj.com.

QUALITY OF CARE ISSUES

Potential quality of care issues are related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care (e.g., misdiagnosis, inappropriate treatment, care received or not received adversely impacted health).

MONITORING QUALITY OF CARE ISSUES

Health Plan has a process for identifying and receiving reports of potential quality of care issues and responding to the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), designated as the review agent for CMS, within 14 calendar days when notified that it has received a quality-of-care grievance. Health Plan uses licensed personnel to perform case reviews, investigate potential quality of care issues, and determine the severity of the issue. Based upon these investigations, Health Plan will determine the appropriate follow-up action required for individual cases and comply with BFCC-QIO instructions. Health Plan will also aggregate potential quality of care issues data to help identify problems within the Provider network.

REPORTING A POTENTIAL QUALITY OF CARE ISSUES

Members, Providers, and Health Plan staff may report quality of care issues. A quality-of-care issue may be reported to a Quality Management Nurse using the Clinical Potential Quality Issue Report Form. Providers and members can also report quality of care issues by contacting the Customer Service Department at 888-361-7526.

Processing Quality of Care Issues

Upon receipt of a Potential Quality Issue Report Form or notification by the BFCC-QIO that a member has filed a quality-of-care grievance, Health Plan's Quality Management staff will date stamp, log, and document/evaluate the reasons/screening criteria for quality-of-care issues and ensure that all supporting documentation is gathered and included.

- Quality of care issues are prioritized based on the urgency of review or due date of response to the BFCC-QIO.
- The Quality Improvement Nurse initiates an investigation of the quality-of-care issues by requesting and reviewing pertinent medical records and eliciting input from Member and Providers involved.

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

- All quality-of-care issues are reviewed by a Medical Director, or designee, to substantiate if the case can be closed or is determined to be a quality issue.
- Quality of care issues are assigned an action code directing the course for resolution and/or escalation to PRCC review.

Communication to Provider or Party Filing the Complaint

- Each quality-of-care issue is reviewed by a Medical Director who designates an action code that may indicate/ requirement to notify the Provider in writing.

Medicare Stars Program – Overview for Primary Care Physicians

The Medicare Star Ratings Program is a quality measurement system used by the Centers for Medicare & Medicaid Services (CMS) to evaluate Medicare Advantage (MA) and Part D prescription drug plans. Plans are rated from 1 to 5 stars, with 5 stars indicating excellent performance.

For primary care providers, performance in the Stars Program matters because clinical quality, patient experience, and care coordination metrics directly influence a plan's rating — and ultimately, bonus payments and enrollment for health plans.

Key Areas Affecting PCPs

- Clinical Outcomes:
 - Control of chronic conditions (e.g., diabetes A1c, blood pressure, cholesterol).
 - Preventive screenings (e.g., cancer screenings, annual wellness visits).
- Patient Experience:
 - Member satisfaction surveys (CAHPS).
 - Access to care, communication quality, and follow-up after visits.
- Medication Management:
 - Adherence to medications for chronic conditions.

Why It Matters

- High star ratings lead to bonus payments for health plans that can fund provider incentives, quality programs, and better resources for members.
- Providers who deliver high-quality, coordinated, patient-centered care directly contribute to better Star Ratings.

HEALTH CARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

HEDIS consists of a set of performance measures utilized by Health Plan to compare how well a plan performs in the following areas:

- Effectiveness of care
- Effectiveness of care, prevention, screening, care coordination

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

- Access and availability of care
- Experience of care
- Utilization and risk-adjusted utilization
- Health Plan descriptive information

Improving a practice's HEDIS scores has benefits for Providers and Members. Consistently performing well in HEDIS measures can help save Providers time while also potentially reducing health care costs. By proactively managing members' care, Providers can effectively monitor members' health, prevent further complications and identify issues that may arise with Health Plan. Health Plan has tools that are available to PCPs to increase and improve HEDIS measures. HEDIS measures impact the Providers and Health Plan's compliance with DHCS, DMHC and CMS. Please contact the Provider Services Department at 1-888-361-7526 for information on HEDIS tools.

TIPS FOR IMPROVING HEDIS SCORES

- Keep accurate, legible, and complete medical records for all members. Each document in the medical record must contain the member name and date of birth to be acceptable for HEDIS.
- If paper charts are used, document the member's full name and date of birth on the front and back of every page.
- Send out reminders and follow up with members for all U.S. Preventive Services Task Force (USPSTF) grade A and B preventive services guidelines.
- Encourage members to keep appointments for appropriate preventive services.
- Document in the members chart when preventive or other services are completed or are declined.
- Make sure that staff is familiar with HEDIS measures to understand which measures health plans are required to report.
- Report accurate claims and encounter data timely to the health plan.

CLINICAL PRACTICE GUIDELINES

Providers can access *Clinical Practice Guidelines* on Health Plan's website at www.hpsj-mvhp.org. *Clinical Practice Guidelines* are guidelines about a defined task or function in preventive care and clinical practice, such as desirable diagnostic tests or the optimal treatment regimen for a specific diagnosis; generally based on the best available clinical evidence. The health plan adopts nationally recognized peer reviewed published guidelines.

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

ENROLEE EXPERIENCE SURVEY

IN. The survey is called the Consumer Assessment of Health Plan Providers and Systems (CAHPS). The questions are designed to measure access, quality, and satisfaction with Health Plan. The results are then analyzed by Health Plan's HEDIS and Accreditation team and reported to the QIHEOC. Member results are trended and when patterns emerge, action plans are formalized into service expectations which are evaluated as often as quarterly when warranted, then progress against goals are monitored and activities are prioritized for the following year. The results are analyzed in relation to grievance trends, then measured each year to document Health Plan's commitment to serving our communities' health care needs.

HEALTH OUTCOMES SURVEY (HOS)

Annually, NCQA administers an industry standard survey instrument utilizing a contracted certified survey vendor targeting a new cohort of members enrolled with Health Plan's D-SNP. The same cohort is reassessed two years later. The questions are carefully selected to measure member-reported health outcomes. The goal of HOS program is to gather valid and reliable clinically meaningful data that have many uses, such as monitoring health plan performance and rewarding top-performing health plans; helping people with Medicare make informed health care choices; and advancing the science of functional health outcomes measurement.

The results are analyzed by Health Plan's Quality Improvement and Medical Management teams and reported to the QIHEOC. Surveys are sent to a random sample of members. Results are trended and when patterns emerge, action plans are formalized into service expectations which are evaluated quarterly, progress against goals are monitored and activities are prioritized for the following year. The results are then measured each year to document Health Plan's commitment to serving our community's health care needs.

PROVIDER SATISFACTION SURVEY

Each year, Health Plan Providers are surveyed by an independent survey company that surveys all PCPs, and a random selection of specialists and ancillary Providers. Results are reviewed by both Health Plan leadership and various departments within Health Plan. Action plans are incorporated into goals and objectives for the following year to address issues identified by the Provider community.

MEMBER SAFETY

Health Plan is committed to a culture of member safety as a high-level priority. On an ongoing basis, Health Plan fosters a member safety culture that is communicated throughout the organization. Health Plan is committed to developing and implementing activities to improve member safety and clinical practice.

SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

Health Plan defines member safety as “freedom from accidental injury caused by errors in medical care.” Medical errors refer to unintentional, preventable mistakes in the provision of care that have actual or potential adverse impact on members.

Members, their families, Providers, and Health Plan staff, are able to report errors or close calls without fear of reprisal and where errors can be viewed as opportunities for improvement.

Health Plan’s commitment to member safety is demonstrated through the identification and planning of appropriate member safety initiatives. The member safety initiatives promote safe health practices through education and dissemination of information for decision-making and collaboration between our Providers and members, and through:

- Evaluation of pharmacy data for Provider alerts about drug interactions, recall, and pharmacy over and under-utilization.
- Education of Providers regarding the availability and use of clinical practice guidelines. members are educated about the use of guidelines using member facing health education materials.
- Education of Providers regarding improved safety practices in their practice through the Provider newsletter, member profiles, and Health Plan website.
- Evaluation for safe clinic environments during office site reviews and dissemination of information regarding FSR findings and important safety concerns to members and providers.
- Education to members regarding safe practices at home through health education Intervention for safety issues identified through case management, and the grievance and clinical case review processes.
- Evaluation and analysis of data collected regarding hospital activities relating to member safety, including but not limited to the rate of hospital-acquired infections and all cause re-admissions within 30 calendar days of discharge.
- Collaboration and exchanges information between the hospital and PCP when members are admitted to and discharged from acute care facilities.
- Dissemination of information to Providers and members regarding activities in the network related to safety and quality improvement.
- Monitoring Hospital safety scores using publicly reported Leapfrog data: www.leapfroggroup.org/cp.

Health Plan receives information about actual and potential safety issues from multiple sources including, Member and Provider grievances, potential quality issues, pharmacy data, and through FSR CAPs.