

**POLICY AND PROCEDURE**

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|---|--|
| <b>Title:</b><br>Quality Improvement and Health Equity Committee (QIHEC)  |  |
| <b>Primary policy owner:</b><br>QI/Health Equity  | <b>Policy #:</b><br>QM38   |
| <b>Impacted/Secondary policy owner:</b> Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined  |  |
| 1) <input type="checkbox"/> All Departments<br>2) <input type="checkbox"/> Behavioral Health & Social Services (BH/SS)<br>3) <input type="checkbox"/> Benefits Administration (BA)<br>4) <input type="checkbox"/> Case Management (CM)<br>5) <input type="checkbox"/> Claims (CLMS)<br>6) <input type="checkbox"/> Community Marketplace & Member Engagement (MAR)<br>7) <input type="checkbox"/> Compliance (CMP/HPA)<br>8) <input type="checkbox"/> Configuration (CFG)<br>9) <input type="checkbox"/> Provider Contracting (CONT)<br>10) <input checked="" type="checkbox"/> Cultural & Linguistics (CL)<br>11) <input type="checkbox"/> Customer Service (CS) | 12) <input type="checkbox"/> Facilities (FAC)<br>13) <input type="checkbox"/> Finance (FIN)<br>14) <input type="checkbox"/> Human Resources (HR)<br>15) <input type="checkbox"/> Information Technology / Core Systems (IT)<br>16) <input type="checkbox"/> Pharmacy (PH)<br>17) <input type="checkbox"/> Provider Networks (PRO)<br>18) <input checked="" type="checkbox"/> QI Health Equity (GRV/HE/HEQ/PHM/QM)<br>19) <input type="checkbox"/> Utilization Management (UM)<br>20) <input type="checkbox"/> Procurement (PRM)<br>21) <input type="checkbox"/> Administration (SAF/BC/EM)<br>22) <input type="checkbox"/> Medical Management (MM) |
| <b>Product Type:</b><br><input checked="" type="checkbox"/> Medi-Cal<br><input checked="" type="checkbox"/> D-SNP   | <b>Supersedes Policy Number:</b><br>NA   |

**I. PURPOSE**

To document the purpose and role of the Quality Improvement Health Equity Committee (QIHEC), and to outline the role of the governing

body's oversight of the Quality Improvement and Health Equity Transformation Program (QIHETP).

## II. **POLICY**

- A. The role of Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan") Commission (the Governing board) is to:
1. Approve the overall Quality Improvement and Health Equity Transformation Program (QIHETP) and the annual work plan and evaluation of the QIHETP.
  2. Appointments of the Co-Charis and approvals of the QIHEC voting membership are ensured by Health Plan of San Joaquin Commission (Governing Board) members to the QIHEC.
  3. The commission approves the Chief Medical Officer in collaboration with the Chief Health Equity Officer of Health Plan to oversight the QIHETP and to chair the QIHEC.
  4. Receive written reports from the Quality Improvement Health Equity Committee (QIHEC) on at least a quarterly basis. The reports include the actions taken & the progress and improvements made in meeting the QIHETP goals.
  5. Makes recommendations for QIHETP policies and procedures to ensure compliance with the organizational QI and Health Equity Strategy and the Department of Health Care Services (DHCS) Comprehensive Quality Strategy.
  6. The Governing Board is committed to removing structural barriers impacting equity and promotes equity in its governance decisions and within the board's demographic composition. Health Plan recruits and nominates potential board members that represent the patient population. Appointments shall consider racial, ethnic, gender and age diversity as well as qualifications.
- B. Health Plan maintains a Quality Improvement Health Equity Committee (QIHEC) (formerly QMUM) designated by and accountable to the San Joaquin County Health Commission, the governing board. The Commission holds ultimate authority and responsibility for the management of quality of care and service delivered by Health Plan and communicated through the QIHEC. This includes reviewing QIHEC

progress reports that describe actions, objectives and improvements made and approving the overall QIHETP. The Commissions appoints accountable entities responsible for oversight of the QIHETP and directs necessary modifications to the QIHETP policies and procedures to ensure compliance with regulatory requirements. Membership on this committee consists of Health Plan administrative staff, support staff, community practitioners and network providers, each with sufficient knowledge and experience to ensure the QIHETP Plan's responsibility for reviewing the overall quality of care delivered to Health Plan membership. Board recruitment announcements use gender neutral language and emphasize the organization's commitment to diversity and inclusion. Particular attention is paid to representation from marginalized, disenfranchised, or disempowered populations.

- C. The San Joaquin County Health Commission (SJCHC) is comprised of eleven (11) members and thirteen (13) seats, and the Board of Supervisors of the Member Counties shall appoint one member each to the Health Commission. The Board reflects the diversity of the population Health Plan serves represent the interest of the public, the County, beneficiaries, physicians, hospitals, health care providers or other health care organizations. Appointments shall consider racial, ethnic, gender and age diversity as well as qualifications set forth herein. The commission members serve at the pleasure of the appointing board of supervisors.
- D. Membership is made up of physicians, members, representatives from the County Boards of Supervisors and community representatives who demonstrate sensitivity and awareness and unbiased perspective towards the problems serving Medicare and Medi-Cal constituents.

### **III. PROCEDURE**

- A. The QIHEC Committee meets at least four (4) times per year. The Committee selects the specific time, day and place for its meetings. Special meetings may be called by the Chair or by a majority votes of the Committee. A quorum of the Committee (at least fifty percent of the voting members) must be present to transact official business and take formal action.

- B. Annually each member is required to sign a conflict-of-interest statement and a confidentiality statement.
- C. Participation in and Membership on the QIHETP, as well as activities including committee & subcommittee is included in the terms of the provider contract and when asked to participate, providers serve for a two (2) year period, or longer if an extension is approved by the committee.
- D. The commission appoints the CMO as the Chair for the QIHEC committee. The Chief Health Equity Officer is the approved Co-chair.
- E. Membership consists of representatives from, at a minimum, the following categories:
  - 1. External Members
    - a. An appointee from the San Joaquin County Health Commission
    - b. Behavioral Health Practitioner from Behavioral Health County partners or representatives from other non-clinical behavioral health providers.
    - c. Hospitals
    - d. Clinics
    - e. County Partners
    - f. Physicians
    - g. Network Providers who provide health care services to:
      - i. Members affected by Health Disparities
      - ii. Limited English Proficiency (LEP) Members
      - iii. Children with Special Health Care Needs (CSHCN)
      - iv. Seniors and Persons with Disabilities (SPDs)
      - v. Persons with chronic conditions
    - f. Subcontractors and Downstream subcontractors
  - 2. Internal Representatives
    - a. The Chief Medical Officer (CMO) has voting authority.
    - b. Chief Health Equity Officer (CHEO) has voting authority.
    - c. The Medical Director has voting authority when the CMO is absent.
    - d. Pharmacist Ad Hoc Specialist
    - e. Director of Health Equity
    - f. Director of HEDIS and NCQA

- g. Director of Utilization Management (UM)
  - h. Utilization Management Manager(s)
  - i. Health Educator/Population Health Manager or Designee
  - j. Medical Management Staff as needed
  - k. Director of Clinical Analytics
  - l. Director of Pharmacy,
  - m. Director Provider Services,
  - n. Director Customer Services
  - o. Manager of Delegation Oversight or Designee
  - p. Director of Provider Services
  - q. Cultural and Linguistics Manager or Designee
- F. Minutes are maintained for each meeting and are filed in the Medical Management Department. Minutes for each meeting are posted publicly on the Health Plan website.
- 1. Copies of the minutes are submitted to the San Joaquin County Health Commission and to Department of Health Care Services (DHCS) on a quarterly basis, following the meeting.
- G. The Role of the Quality Improvement Health Equity Committee (QIHEC) is to analyze and evaluate and make recommendations.
- 1. Review and approve the written Quality Improvement Health Equity Transformation Program Documents (QIHETP), Work Plans and Annual Evaluation & Equity related activities, Utilization Management and Population Health Programs and Plans. The QIHETP, including the Work Plan and Evaluation provides a systematic, comprehensive, and integrated constellation of quality improvement, health equity, population health and utilization management activities. Additionally, its role is to:
    - a. Evaluate the effectiveness of the Quality Improvement Health Equity Program (Including the QIHETP Plan) and its relevance in meeting the goals and objectives.
    - b. Assure the continuous and proper implementation of the QIHETP Workplan (including UM and Population Health Management (PHM) Plans).
  - 2. Routinely review Health Plan policies and procedures.

3. Review results of quality, safety and equity of clinical care, utilization management, provider and member satisfaction surveys, access and availability and provision of covered services and language services, preventive care for children and adults, perinatal, primary and specialty care, Emergency and inpatient and behavioral healthcare and ancillary services, coordination with Seniors and Persons with Disabilities and chronic diseases, Children with Special Health Care Needs, child welfare and long term services and supports, Stars, Healthcare Effectiveness Data and Information Set (HEDIS) and other quality metrics, and prioritizes and Institutes actions to address performance deficiencies, makes recommendations to address opportunities for improvement including policy recommendations .
4. Assure that objective measures are used to gauge the clinical outcomes of care and financial risk.
5. Advise appropriate committees on the results of studies and reviews and make recommendations for action.
6. Review applicable reports and studies from other QIHEC sub-committees and issues that are reported from Health Plan delegated contractors d subcontractors. Define, request, and review reports from the Quality Department concerning, but not limited to:
  - a. Facility site and medical record review of care investigation and reports.
  - b. Give directions for deficiencies and corrective action requirements.
  - c. Recommend corrective action, including provider disciplinary action, when trends or patterns of inappropriate, poor quality health care and/or improper resource utilization are identified.
7. Serve as physician review panel for member and provider grievances.
  - a. Refer to the Peer Review and Credentialing Committee (PRCC) recommendations to suspend or terminate provider contracts because of consistent practice outside the established program and community standards or evidence of unjustifiable adverse outcomes.
8. QIHEC Prepares ongoing reports to the Health Commission regarding the QM/UM activities. These reports shall be sufficiently detailed to

- include findings and actions taken as a result of the identification, through the QM Program, of significant or chronic quality care issues.
- H. The committee:
1. Provides oversight of the plan's health equity activities including:
    - a. Quality Improvement, Health Equity and Utilization Management (UM) work plans and reports
    - b. Progress toward achieving recognition and accreditation program compliance.
    - c. Case Management and Disease Management information
    - d. Health Education program and activities
    - e. Population Health and Member Outreach activities
    - f. Cultural and Linguistic Services; translation and interpretation activities
    - g. Credentialing and Peer Review activities
    - h. Customer Service, Grievances, Complaints and Appeals reports
    - i. Member Satisfaction surveys, studies and/or reports
    - j. NCQA and Star performance measures results
    - k. Provider Access and Availability Studies
    - l. Provider Satisfaction Surveys/Studies
    - m. Healthcare Over- and Under- Utilization Studies
    - n. Clinical Practice and Preventive Health Guidelines
    - o. Potential Quality of Care (PQOC) issues as reported through Peer Review Committee, other committees, or individual reports by organization staff via the PQOC policy and procedure
    - p. Behavioral Health activities including program descriptions, and policy documents
    - q. Delegation Oversight reports and activities
    - r. Policies and procedures in compliance with state, federal and accreditation requirements
    - s. Ad-Hoc reports as determined by CMO or designee
  2. Applicable reports from the Community Advisory Committee including the results of the population Needs Assessments.
    - a. Review reports on number and types of services, denials, deferrals, modifications, Appeals and Grievances.

3. May serve as a physician review panel for member and provider grievances and potential quality of care case reviews.
4. Routinely receives written progress reports from the quality operations committee describing actions taken, progress in meeting QIS objectives, and improvements made.
5. Directs the operational QIS to be modified as needed and tracks all review findings for follow-up.
6. Submits ongoing reports to the Health Commission from the Quality Improvement Health Equity Committee. These reports shall be sufficiently detailed to include findings and actions taken because of the identification, through the QM Program, of significant or chronic quality of care issues.
7. Reviews evaluation and improvement of Quality and Health Equity of clinical care services provided, including, but not limited to, preventive services for Children and adults, perinatal care, Primary Care, specialty, emergency, inpatient, behavioral health, and ancillary care services.
8. Considers the composition of the QIHEC and Health Plan subcommittees, both internal and external membership:
  - a. Organizational committee membership reflects the diversity of the population served.
  - b. Groups that are inadequately represented in committees.
  - c. Groups that are marginalized, disenfranchised or disempowered by the organization's recruitment and selection process and/or practices for committee membership.
  - d. At a minimum, all external committees are required to reflect the diversity of the organization. Resources shall be allocated to actively recruiting membership that is reflective of the community Health Plan serves and/or addressing barriers to participation by marginalized groups.
9. Ensures Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, findings, recommendations, and actions after each meeting and submit this to SJCHC. The plan makes the written summary of the QIHEC activities publicly available on the

website at least on a quarterly basis and submits it to DHCS upon request.

10. Ensure that Health Plan and Health Plan's Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain a QIHEC that meets the Centers for Medicare & Medicaid Services (CMS) First Tier, Downstream and Related Entity requirements and those as set in the DHCS contract. Health Plan and Health Plan also ensure that the Fully Delegated Subcontractor reports to the QIHEC quarterly, at a minimum.
11. Ensure Member confidentiality is maintained in Quality Improvement discussions and ensure avoidance of conflict of interest among the QIHEC members.
12. Recommend actions or initiatives to address quality improvements and health disparities based on reports from committees or subcommittees.
13. Ensure appropriate follow-up of identified actions or initiatives

**IV. ATTACHMENT(S)**

- A. *Desk- Level Procedure (DLP) or Department Job Aide*
- B. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
- C. [Glossary of Terms Link](#)
- D. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

**V. REFERENCES**

- A. DHCS Contract Exhibit A, Attachment 4 (4)
- B. Title 28, CCR, Section 1300.70
- C. Medicare Managed Care Manual, Chapter 5 “Quality Assessment
- D. State Medicaid Agency Contract (SMAC)
- E. Health Plan Contract with Centers for Medicare & Medicaid Services (CMS)

**VI. REVISION HISTORY**

| Version* | Revision Summary | Date |
|----------|------------------|------|
|----------|------------------|------|

|   |   |         |
|---|---|---------|
| 001                                       | Removed Quality Improvement Director and added Director of Health Equity under Internal Representatives. Updated template for D-SNP | 9/15/25 |
| 002                                       |   |         |
| <b>Initial Effective Date: 02/01/1996</b> |   |         |
| <b>Published Date:12/08/2025</b>          |   |         |

**VII. Committee Review and Approval To Be Completed by Compliance**

| Committee Name  | Version | Date       |
|---|---------|------------|
| Compliance Committee (CC)   | 001     | 12/03/2025 |
| <ul style="list-style-type: none"> <li>Privacy &amp; Security Oversight Committee (PSOC)</li> </ul> |         |            |
| <ul style="list-style-type: none"> <li>Program Integrity Committee (PIC)</li> </ul>                 |         |            |
| <ul style="list-style-type: none"> <li>Audits &amp; Oversight Committee (AOC)</li> </ul>            |         |            |
| <ul style="list-style-type: none"> <li>Policy Review Committee (PRC)</li> </ul>                     |         |            |
| Quality Improvement Health Equity Committee (QIHEC)   | 001     | 09/17/2025 |
| <ul style="list-style-type: none"> <li>Quality Operations Committee (QOC)</li> </ul>                |         |            |
| <ul style="list-style-type: none"> <li>Grievance Committee (GC)</li> </ul>                          |         |            |

**VIII. REGULATORY AGENCY APPROVALS**

| Department                               | Reviewer | Version | Date |
|--|----------|---------|------|
| Department of Healthcare Services (DHCS) |          |         |      |

|                                   |  |  |  |
|-----------------------------------|--|--|--|
| Department of Managed Care (DMHC) |  |  |  |
|-----------------------------------|--|--|--|

**IX. Approval signature\***

| <b>Signature</b> | <b>Name<br/>Title</b>   | <b>Date</b> |
|------------------|-------------------------|-------------|
|                  | PRC Chairperson         |             |
|                  | Policy Owner            |             |
|                  | Department Executive    |             |
|                  | Chief Executive Officer |             |

\*Signatures are on file, will not be on the published copy