



Community Health Plan Imperial
Valley Quality Improvement and
Health Education Program
Description

2026

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I. Introduction and Background

A. Health Plan and Membership

The Imperial County Local Health Commission (LHC) is a local public agency. Under California's Medi-Cal managed care program, the LHC dba Community Health Plan Imperial Valley ("CHPIV") is designated as the Local Initiative. CHPIV is contracting with Health Net Community Solutions (HNCS, Health Net, or The Plan), a National Committee for Quality Assurance (NCQA) accredited Medi-Cal managed care plan, for capitated provider services, network, and administrative services to be provided for CHPIV's membership.

CHPIV recognizes the challenges posed by the diverse ethnic, cultural and health needs of Medi-Cal beneficiaries in the Imperial Region. CHPIV, in conjunction with HNCS, has the network, staff, knowledge, systems, infrastructure and cultural and linguistic competence to serve members in the Imperial Region and meet those challenges. As such, CHPIV is well prepared to serve Medi-Cal beneficiaries in Imperial County with quality care through evidence-based practices that emphasize preventive care and encourages self-management for healthy behaviors.

The CHPIV Quality Improvement and Health Education Program (QIHED Program) provides members with access to network-wide, safe, clinical practices and services and ensures they are given the information they need to make better decisions about their healthcare choices. The QIHED Program is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis and to support identification and pursuit of opportunities to improve health outcomes, services and member and provider satisfaction. Opportunities for improvement are identified through continuous monitoring of clinical outcomes, safety, access and service. The QIHED Program employs an organizational structure that reports to the Quality Improvement/Health Equity Committee (QIHEC) and Local Health Commission and is led by committed decision-makers. The QI Program functions in collaboration with multiple departments that have QI-related functions. CHPIV also collaborates externally with network physicians, other provider types and community partners for effective QI integration process. This includes collaborative activities with participating provider groups (PPGs) and provider clinics to complete performance improvement projects (PIPs) and Plan, Do, Study, Act (PDSA) projects to close care gaps and improve provider performance and quality of care for members. Quarterly reports of these activities and outcomes are presented to the QIHEC.

CHPIV works with stakeholders in Imperial County to develop unique programs tailored to the region's needs and continues to interact with the families, health care providers and county administrators to ensure the programs achieve their goal of providing access to needed health care services.

II. Purpose and Goals

A. Mission

We are working with community residents and stakeholders in both the public and private sectors to:

- Advance opportunities for improved health and access to comprehensive health care services

- Promote the long-term viability of safety net providers
- Increase prevention, education, and early intervention services, and
- Partner with Medi-Cal managed care plans to monitor and improve the local healthcare system.

B. Purpose

Quality Improvement Purpose

The CHPIV QI Program establishes standards for both the quality and safety of clinical care and service, as well as monitors and evaluates the adequacy and appropriateness of health care and administrative services on a continuous and systematic basis. The QI Program also supports the identification and pursuit of opportunities to improve health outcomes, and both member and provider satisfaction.

Health Education Purpose

The CHPIV Health Education (HEd) System provides accessible no cost health education programs, services and resources based on the community health, cultural, and linguistic needs of the CHPIV members and contractually required program scope.

C. Goals

Quality Improvement Goals

- Ensure promotion of safe, high-quality care and services while maintaining full compliance with standards established by regulatory and accreditation agencies.
- Objectively and systematically monitor services provided to members to ensure conformity to professionally recognized standards of practice and codes of ethics.
- Provide an integrative structure that links knowledge and processes together throughout the organization to assess and improve the quality and safety of clinical care with quality service provided to members.
- Develop and implement an annual quality improvement work plan and continually evaluate the effectiveness of plan activities aimed at improving and maintaining performance of target measures, and act as need, to improve performance
- Support partnership between members, practitioners, providers, regulators to provide effective health management, health education, disease prevention and management, and facilitate appropriate use of health care resources and services.
- Design, implement and measure organization-wide programs that improve member, practitioners and provider satisfaction with Health Net's clinical delivery system. These programs are population-based, ongoing, clinical assessments and are evaluated to determine the effectiveness of clinical practice guidelines, preventive health guidelines, and care management programs.
- Monitor and improve performance in promoting quality of service to improve member and provider satisfaction through the use of satisfaction surveys, focused studies, and analysis of data (e.g., administrative, primary care, high-volume specialists and specialty services, and mental health and substance use disorder services).
- Promote systems and business operations that provide and protect the confidentiality, privacy and security of member, practitioner and provider information while ensuring the

integrity of data collection and reporting systems. This is done in accordance with state and federal requirements and accreditation guidelines.

- Anticipate, understand and respond to customer needs, be customer-driven and dedicated to a standard of excellence in all customer relationships.
- Provide a means by which members may seek resolution of perceived failure by practitioners and providers or health plan personnel to provide appropriate services, access to care, or quality of care. Identify, review and investigate potential quality of care issues and take corrective action, when appropriate.
- Ensure the development of strategies and processes designed to improve health equity and mitigate health disparities.

Health Education Goals

- To provide culturally and linguistically appropriate health education programs and resources at no cost to
 - Support CHPIV members and the community to achieve optimal physical and mental health.
 - Promote health equity.
 - Improve CHPIV's quality performance.
 - Enhance member satisfaction.
 - To engage communities, stakeholders and partners by providing high quality health education programs and resources and retention.

III. Scope

A. Overview of the QIHED Program

The QIHED Program includes the development and implementation of standards for clinical care and service, the measurement of compliance to the standards and implementation of actions to improve performance. The scope of these activities considers the enrolled populations' demographics and health risk characteristics, as well as current national, state and regional public health goals. The Population Health Management (PHM) strategy provides a unifying framework to support the QIHED Program in delivering a whole-person approach to caring for CHPIV members.

Health education interventions are based on community health and cultural and linguistic needs to encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health and dental care services, and to follow self-care regimens and treatment therapies. Health education services include individual, group or community-level education and are supported by trained health educators and public health professionals to encourage immediate positive knowledge gain and healthy behavioral intentions. Health education programs include individual, community or population-based initiatives designed to encourage long-term behavioral changes for positive health outcomes. Provision of health education resources includes culturally and linguistically appropriate brochures, flyers, posters, newsletters, presentations, website articles, and social media resources. The framework uses risk stratification data compiled from a variety of data sources to help teams target the right members with the right resources to address member health and social drivers of health (SDoH) needs at all stages of life.

The QIHED Program impacts the following:

- **CHPIV Members** in all demographic groups and in the service areas for which Community Health Plan of Imperial Valley is licensed.
- **Network Providers** including practitioners, facilities, hospitals, ancillary providers, and any other contracted or subcontracted provider types.
- **Aspects of Care** including level of care, health promotion, wellness, chronic conditions management, care management, continuity of care, appropriateness, timeliness, and clinical effectiveness of care and services covered by CHPIV.
- **Health Disparities** by supporting activities and initiatives that improve the delivery of health care services, patient outcomes, and reduce health inequities.
- **Health Education** by providing accessible no cost health education programs, services and resources based on the community health, cultural and linguistic needs of members and contractually required program scope and by monitoring the quality and accessibility of health promotion and education resources made available to members by Health Net's subcontracting/delegated vendors, Participating Provider Groups (PPG), and Primary Care Physicians (PCPs).
- **Communication** to meet the cultural and linguistic needs of CHPIV members.
- **Behavioral Health Aspects of Care** integration by monitoring and evaluating the care and service provided to improve behavioral health care in coordination with other medical conditions.
- **Practitioner/Provider Performance** relating to professional licensing, accessibility and availability of care, quality and safety of care and service, including practitioner and office associate behavior, medical record keeping practices, environmental safety and health, and health promotion.
- **Services Covered by CHPIV** including preventive care, primary care, specialty care, telehealth, ancillary care, emergency services, behavioral health services, diagnostic services, pharmaceutical services, skilled nursing care, home health care, Long Term Services and Supports (LTSS): long term care (LTC), Community Based Adult Services (CBAS); CalAim benefits and community supports that meets the special, cultural and linguistic, complex, social or chronic needs of all members.
- **Internal Administrative Processes** which are related to service and quality of care, including customer services, enrollment services, provider relations, practitioner and provider qualifications and selection, confidential handling of medical records and information, care management services, utilization review activities, preventive services, health education, information services and quality improvement.

B. Provider Network

In the Imperial Region, CHPIV partners with HNCS to maintain contracts with a full range of providers and vendors including acute care hospitals, home health care companies, infusion therapy and dialysis companies, durable medical equipment vendors, outpatient surgery facilities, radiology/imaging centers, skilled nursing facilities, acute and sub-acute rehabilitation facilities, laboratory services, outpatient pharmacies, and hospices. HNCS also arranges health care through direct contracts with certain health care providers. In the Imperial Region, all of the provider contracts are a mix of fee-for-service (FFS), capitated delegated, and capitated non-delegated models.

C. Preventive Screening Guidelines (PSGs)

CHPIV adopts nationally recognized preventive health guidelines for health maintenance, improvement and early detection of illness and disease for children and adults. The guidelines are reviewed, updated, and adopted on an annual basis or more frequently when new scientific evidence or national standards are published prior to the scheduled review date. CHPIV along with delegated Health Net Medical Directors with various medical specialties are involved in the adoption of the guidelines. New members receive the Preventive Health Screening guidelines in the new member welcome packet and new providers receive this information with orientation materials within 10 days of becoming authorized to see members. The guidelines inform members of health screening and immunization schedules for all ages. These are available in all threshold languages. Printed guidelines are available to existing practitioners and providers online and for members by calling the Health Education Department. Updates, when applicable, are distributed to all practitioners via Provider Updates.

Preventive services are monitored through the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data Information Set (HEDIS[®]) and other programs as specified in the QIHed Work Plan. In collaboration with physicians and providers, CHPIV encourages members to utilize health promotion and preventive care services.

D. Clinical Practice Guidelines

CHPIV adopts and disseminates evidenced-based clinical practice guidelines that are relevant to its membership for the provision of preventive and non-preventive health care services, acute and chronic medical services and behavioral health services. These clinical practice guidelines assist practitioners, providers and members to make decisions about appropriate health care for specific clinical circumstances, to improve health care, and to reduce unnecessary variations in care.

CHPIV adopts guidelines from recognized organizations that develop or disseminate evidence-based clinical practice guidelines. These include professional medical associations, voluntary and other health organizations such as the National Institutes of Health (NIH) and the U.S. Preventive Services Task Force (USPSTF). Input from specialists is obtained as necessary and clinical practice guidelines are reviewed and approved by Health Net's Medical Directors, (through the Health Net Medical Advisory Council), and CHPIV's Chief Medical Officer (CMO) and the QIHEC. The guidelines are updated and revised at least every two years or more frequently when new scientific evidence or national standards are published.

Guidelines are evaluated for consistency with CHPIV's benefits, utilization management criteria, and member education materials. They are communicated to providers through provider updates and are available to providers on the Health Net websites and to members upon request. CHPIV monitors adherence to guideline recommendations and program outcomes using HEDIS measures.

E. New Technologies

CHPIV has a formal process for recognizing and evaluating advances in new medical technologies, behavioral health procedures, pharmaceuticals, devices, and new applications of existing technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages.

The Change Healthcare InterQual® criteria, the HAYES Technology Directory and other evidence-based resources are used as primary sources. This includes:

- Nationally recognized drug compendia resources such as American Hospital Formulary Service-Drug Information (AHFS DI®), Facts & Comparisons®, Clinical Pharmacology®, DRUGDEX®, Lexi-Drugs®, and the National Comprehensive Cancer Network® (NCCN®) Guidelines.
- Medical association publications, government-funded, or independent entities that assess and report on clinical care decisions and technology, including Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, and National Institute for Health and Care Excellence (NICE).

CHPIV leverages its delegated entity's (Health Net) primary sources, including Centene's (Health Net's corporate organization) Corporate Clinical Policy Department and Clinical Policy Committee along with Health Net of California's Medical Advisory Council. They are responsible for the evaluation of new technology that may be sought by CHPIV members. A critical appraisal of the current published medical literature from peer-reviewed publications is undertaken to assist in the evaluation of medical technology.

F. Population Health Management (PHM)

Annually, through the PHM Program, CHPIV evaluates the needs of its enrolled population and uses that information to assess whether current programs need modification to better address the needs of its membership. CHPIV's PHM Program examines data through population risk stratification using a predictive modeling tool that utilizes data from various sources including medical and behavioral claims and encounters, social needs data, pharmacy claims, laboratory results, health appraisal results, electronic health records (EHRs), data from health plan Utilization Management (UM) and/or Care Management (CM) programs, and advanced data sources such as all-payer claims databases or regional health information. The data are used for:

- Evaluation of the characteristics and needs of the member population including an analysis of the impact of relevant SDoH.
- Evaluation of health status and risks by using utilization data broken out into at least the following cohorts based on the enrolled product lines: birth to age 18, age 19 to 64 and ages 65 and over.
- Evaluation of the needs of members with disabilities.
- Evaluation of the needs of member with severe and persistent mental illness.

Data combined with SDoH and QI data (e.g., HEDIS care gaps), are reported to facilitate an understanding of similarities and differences in health needs and status. When the data analyses are complete, they are used to determine if changes are required to population health management (PHM) programs or resources. In addition, there is an evaluation of the extent to which population health management programs facilitate access and connection to community resources that address member needs outside the scope of the health benefit plan. Modifications to program design and resources are made based on these findings. The Risk Stratification, Segmentation, Tiering (RSST) methodology identifies significant changes in Members' health status or level of care and in this way, members are monitored to ensure appropriate re-stratification and connection to chronic disease management, care management, enhanced care management (ECM), complex care management (CCM), community supports

(CS) and other programs. Outcomes data is stratified by race, ethnicity, language, and age on a plan-level including emergency room (ER)/inpatient (IP) utilization, ambulatory and preventative visits within a twelve-month period, enrollment into CCM, and transitions for high-risk member having connection with their assigned care manager.

The PHM operations team is a cross-unit team composed of talent from multiple departments and is led by a core team of a Medical Director, and a Pharmacist. The team is accountable to the QIHEC.

Basic Population Health Management

CHPIV's Basic Population Health Management (BPHM) services support the ongoing, seasonal, episodic, and occasional needs of our members to ensure appropriate care. Using a multi-pronged, non-delegated, empanelment approach to BPHM, we directly facilitate connections to primary care. New member welcome packets are sent to ask members to schedule their initial health appointment (IHA) and conduct new member outreach to facilitate appointment scheduling, and survey members to ensure they are satisfied with their assigned providers. Primary care providers (PCPs) are also notified of new member enrollment within 10 days of assignment to facilitate PCPs seeing their patients within 120 days of assignment. Members who do not select a PCP within 30-days of enrollment are auto-assigned a PCP within 40-days of enrollment. (Full-benefit dual-eligible members are not required to select a Medi-Cal PCP).

The Plan proactively outreaches to members without a PCP visit in the past year to assist in arranging appointments, transportation, or interpreters, if needed. Hard-to-reach members, including those with unstable housing or no phone, are assigned to the Plan's MemberConnections Field Team or contracted Community Health Worker Organization for in-person outreach. The MemberConnections Representatives (MCR) also assist with PCP selection or change. Members are informed that they can select a variety of providers in lieu of a PCP (e.g., Nurse Practitioner, Certified Nurse Midwife, Physician Assistant).

Chronic Conditions Management

CHPIV offers an integrated care management program to members that address members' physical, behavioral, and psychosocial needs. Care managers support members to increase their awareness of self-care strategies and empower participants to manage their chronic conditions. This program includes a population-based identification process, risk stratification, interventions based on clinical need, patient self-management, disease education, and process and outcome measurement. Multi-disciplinary teams are involved in the development of these efforts. Referrals to care management programs are multichannel and come through provider and member self-referrals. Members enrolled in the care management program with chronic conditions are included in the integrated care model.

CHPIV's delegate's corporate partner, Centene's Population Health Management Office, conducts chronic conditions management for members with designated diagnoses. The program includes member stratification, disease education, and promotion of self-management principles. Members requiring additional support are referred to Care Management.

Complex Health Needs/Care Management

CHPIV is committed to serving members with complex medical or behavioral health needs through coordinating services and assisting them in accessing needed resources.

CHPIV provides care management for Medi-Cal including seniors and persons with disabilities. The goal of Care Management is to support members in achieving optimum health, functional capability, and quality of life through improved management of their disease or condition, and access to available resources.

Members in Complex Care Management have typically experienced a critical event or have a complex diagnosis that may be compounded by SDoH requiring oversight and coordination of care with practitioners, providers and/or community and social service agencies. Members are identified using Health Net data sources and may also be referred into the program via multiple avenues, such as:

- Health information
- Internal program
- Discharge planning referral
- Utilization management referral
- Member or caregiver self-referral
- Practitioner referral, and
- Ancillary providers (e.g., home health, physical therapy, occupational therapy).

Members undergo a comprehensive assessment, which is used to develop a care plan that meets their specific complex care needs. Care plans focus on the member's prioritized needs including monitoring the patient's understanding and adherence to the plan of care, identification and removal of barriers to care, achievement of short- and long-term goals, and restoration of the highest functional level that is possible for the patient.

G. Behavioral Health Services

CHPIV delivers covered mental health services to its members through Health Net. CHPIV delegates the Continuity of Care (COC) and Utilization Management process to its subcontractors, Health Net. Health Net contracts directly with psychiatrists as well as non-MD behavioral health specialists and is delegated to perform certain functions (e.g., credentialing, claims, utilization management, etc.).

CHPIV and HNCS are taking a collaborative approach to educate providers and members on the importance of:

- Coordination of care and exchange of information between medical and behavioral health providers and county mental health plans.
- Diagnosis, treatment, and referrals of members with mental health and substance use disorders to network specialists, county mental health plans, County Drug and Alcohol Programs and other resources as appropriate.
- Appropriate uses of psychopharmacologic medications and treatment adherence.
- Managing coexisting conditions and behavioral health preventive programs.

These areas are measured through the following sources to identify new initiatives or opportunities to enhance existing interventions:

- Member survey to assess satisfaction with and access to covered mental health services.
- Provider survey to assess satisfaction with the timeliness and usefulness of information from behavioral health practitioners, along with their experience with coordination of care.
- Network availability and adequacy of behavioral health providers.
- Member quality of care and service complaints investigation.
- Evaluation of behavioral health HEDIS measures and other QI behavioral health initiatives.

H. Operations and Service

CHPIV's delegate, Health Net, evaluates the adequacy, effectiveness, and timeliness of internal operations against established standards to identify strengths and opportunities to improve member, practitioner, and provider satisfaction. Standards are based on regulatory and accrediting bodies.

Health Net/CHPIV also monitors access to services and availability of the practitioner and provider network, member grievance and appeals, member satisfaction surveys, practitioners and provider satisfaction surveys, marketing material accuracy and provider feedback through Provider Engagement, and Data Strategy & Insight, and Provider Network Management departments.

Quality improvement activities focused on service and internal operations rely on multi-departmental involvement in the QIHED Program. Activities involve associates from Population Health and Clinical Operations, Pharmacy, Health Equity, Appeals and Grievances, Customer Contact Center, Credentialing, Provider Network Management, Provider Engagement, Data Strategy & Insight, Claims, Compliance, Privacy, and Program Accreditation departments.

I. Health Plan Performance

CHPIV conducts ongoing monitoring of health plan performance by participating in annual HEDIS measurement, member and provider satisfaction assessments, monitoring of appeals and grievances, and evaluating the accessibility and availability of medical services. CHPIV maintains a broad range of key performance and operational metrics to monitor clinical and service quality in Appeals & Grievances, Customer Service, Population Health and Clinical Operations (PHCO) which includes Utilization Management, Care Management, Concurrent Review, and the Medical Review Unit. CHPIV's QI Program also monitors key performance metrics for Pharmacy.

CHPIV is NCQA-Accredited and obtained Health Plan and Health Outcomes Accreditation in 2025.

CHPIV's QI Program also has established metrics for key operational processes, such as claims and customer service, and monitoring for service improvement opportunities.

CHPIV monitors HEDIS rates, Medi-Cal Managed Care Accountability Set (MCAS), DMHC Health Equity and Quality measure performance, access and availability standards, quality of care incidents, and CAHPS/ Experience of Care and Health Outcomes (ECHO)/ Outpatient Mental Health (OPMH) Survey results to assess practitioner and provider adherence to best practices and prioritize health plan outreach activities and campaigns. CHPIV emphasizes the importance of technology/Electronic Health Records (EHRs) enabling providers to track and remind patients about regular health screenings. Multiple activities may be in place to improve outcomes, promote safety, increase screening and improve performance metrics. Examples are included in the following list (refer to the QI and HEd Annual Work Plan section for more details):

- Practitioner and provider outreach to improve exchange of quality performance data.
- Member outreach to close care gaps.
- Provider outreach to share quality performance ratings.
- Development of tools to assist practitioners and providers to improve performance.
- Hospital quality monitoring for hospital acquired conditions.

J. Credentialing / Recredentialing

CHPIV has established policies and standards to ensure the selection and retention of qualified practitioners and providers. Policies have also been developed for oversight of those organizations delegated to manage the credentialing of practitioners. Recredentialing is initiated and completed within 36 months of the previous committee decision and incorporates a three year look back review of peer review and member activity that assists the Credentialing Committee in making an informed decision.

Compliance issues are reported to CHPIV's Chief Medical Officer. The Chief Medical Officer will work with CHPIV's Chief Compliance Officer and CHPIV's QIHEC to address such compliance issues.

All providers undergo a quality process of credentialing prior to finalizing contract agreements and are recredentialled every three years. All providers are monitored monthly for Medicaid plan sanctions, license disciplinary actions, quality of care and service incidents, and any other adverse actions. Trendable actions and any high severity-leveled cases are reported to the Peer Review Committee where further actions are taken.

Ongoing monitoring occurs after the practitioner's initial inclusion to our network begins and occurs monthly, to ensure our plan can take immediate action to protect our members and maintain compliance with all regulatory agencies. We take action within 30 calendar days of the released report:

- Member complaints and quality of care service tracking and trending,
- Medicaid sanctions.
- Federal Department report.
- OI/LEIE: The Office of Inspector General list of excluded entities/listing of excluded Medicaid providers.
- State Medical Board disciplinary action reports.
- Medi-Cal Suspended and Ineligible list (SIPL).
- Restricted Provider Database (RPD).
- Ongoing office monitoring.

Any delegates with continued compliance issues are reported to CHPIV's delegated plan, Health Net's Delegation Oversight Committee. The Delegation Oversight Committee is a subcommittee of HNCS QIHEC. The Health Net Appeals and Grievances Department works with the Credentialing and the Peer Review teams to report on potential and substantiated quality of care issues. All practitioners and providers undergo a quality process of credentialing prior to finalizing contractual agreements and are recertified every three years. All practitioners and providers are monitored monthly for Medicaid sanctions, license sanctions, limitations and expirations, quality of care and service incidents, and any other adverse actions. Trended issues and high severity level cases are reported to the Peer Review Committee for review and determination.

K. Continuity and Coordination of Care

A major focus of CHPIV's QI program is ensuring that the care members receive is seamless and integrated. These activities can be divided into the following main areas:

- Across medical care settings that include (but are not limited to) outpatient, inpatient, residential, ambulatory, CBAS centers, and other types of locations where care may be provided.
- Transition between practitioners when practitioners leave the network or changes their health care setting.
- Continuity and coordination between medical care and behavioral health care.
- Referral and coordination with Medi-Cal carved out service providers.

CHPIV, in conjunction with HNCS, identifies opportunities for improvement in continuity and coordination of care through various methodologies, including but not limited to:

- Member satisfaction surveys
- Appeals & Grievance data analysis
- Provider satisfaction surveys
- HEDIS measures, and
- Medical record review.

For all members with identified complex health needs, CHPIV supports their continuity and coordination of care through an integrated healthcare model that provides the level of care management the member needs based on acuity and includes the care management of behavioral health conditions. The nurse advice line also addresses member triage needs 24 hours a day, seven days a week. Provider groups also support members through their coordination of care programs.

Mechanisms are implemented to monitor and facilitate continuity and coordination of care for members. These activities include, but are not limited to:

- Care Management
- Pharmacy programs
- Utilization Management
- Member Services functions
- Communication and data exchange that is appropriate and compliant with state and federal privacy and security regulations, and

- Information will be posted on the Plan website for advising providers, contractors, members, and the public how they can obtain information about the UM processes and guidelines used to authorize, modify, or deny health care services under the benefits provided by CHPIV.

L. Delegation

CHPIV has an Administrative Services Agreement (“ASA”) with HNCS to provide certain administrative services on CHPIV’s behalf (e.g., Quality Improvement, Health Education, utilization management, appeals and grievances, Population Health, claims, credentialing, member/provider services, care management, Pharmacy, behavioral health, and Provider Network Management etc.).

CHPIV evaluates the Plan’s ability to perform Quality Improvement functions by means of a robust delegate oversight process. In its delegate oversight process, CHPIV performs continuous monitoring and regular audits. CHPIV has designated Quality Improvement auditors specially trained to perform these evaluation functions. QI auditors evaluate and monitor delegated entities annually, or more frequently if needed, to ensure compliance with Federal, State, Contractual, and applicable NCQA standards. When the monitoring and auditing process identifies gaps between performance targets and actual performance, root cause analysis will be completed, and corrective action plans (CAP) created. Follow-up monitoring and auditing are performed to ensure the CAPs are completed and performance gaps are resolved.

M. Safety

CHPIV is committed to ongoing collaboration with network providers, facilities and external accrediting agencies to build a safer health system. Current member or patient safety initiatives include:

- Responses to quality of care issues for which an investigation of complaints is conducted, and action taken where applicable. Analyses of overall and individual trends are conducted.
- Monitoring reportable hospital events and investigation of quality of care issues as appropriate.
- Providing educational information to members and practitioners on safe health practices.
- Credentialing and recredentialing to ensure only qualified practitioners and organizations provide care to members.
- Practitioner office site reviews in accordance with established criteria to ensure the environments are safe, clean and accessible for members.
- Clinical practice guidelines distributed to network providers. CHPIV evaluates and makes decisions on utilization management, member education, coverage of services, and other areas to be consistent with CHPIV’s clinical guidelines.
- Careful review of member complaints and member satisfaction surveys related to member safety to ensure action is taken when applicable.
- Care Management conducts activities to ensure that continuity and coordination of care are provided for high-risk members.
- Pharmaceutical information is available for practitioners about member-specific topics and new medications. The Pharmacy Department also conducts utilization reviews and develops quality initiatives related to prescription drugs and best practices.

- Prescription drug information is available on the member portal/website about generic and brand names, warnings, side effects, precautions, drug-drug interactions, overdose information and what to do if a dose is missed.
- Improvement initiatives that promote safety, such as the patient safety QI program which includes hospital-acquired condition monitoring, working to reduce hospital-acquired infections, reducing unnecessary C-sections, and promoting Cal Hospital Compare's Honor Rolls.
- Delegating to Health Net participation in collaborative efforts to improve care with organizations such as The Leapfrog Group, the California Maternal Quality Care Collaborative (CMQCC), California Quality Collaborative (CQC), Cal Hospital Compare, Health Services Advisory Group (HSAG), collaboration with other health plans, HICE (Health Industry Collaboration Effort); CAHP (California Association of Health Plans), Department of Managed Health Care (DMHC) and/or Department of Health Care Services (DHCS) Quality Collaborative meetings with other health plans, Public Health for All Californians Together (PHACT) Coalition, and Integrated Healthcare Association (IHA).

N. Health Equity and Cultural and Linguistic Needs

CHPIV will work very closely with Health Net to address Health Equity and Cultural and Linguistic Needs. Health Net utilizes the Cultural and Linguistic Appropriate Services (CLAS) Standards, developed by the Office of Minority Health, as a guide for provision of culturally and linguistically appropriate services. CLAS Standards assure that services comply with the Office of Civil Rights Guidelines for culturally and linguistically appropriate access to health care services (Title VI of the Civil Rights Act). Health Net's objective is to promote effective communication with limited English proficient CHPIV members by assuring access to culturally appropriate materials, print translations of member informing materials, telephonic and in-person interpreter services, and through culturally responsive Health Net associates and health care practitioners and providers.

At least every two years, Health Net completes an analysis of the cultural and linguistic needs of the membership. Data sources may include the following:

- Membership demographic data
- Call center data
- Appeals and grievance information, and
- Geo Access analysis of provider network language capabilities.

These data sources are used to analyze members' cultural and linguistic needs when developing communications to promote quality and health promotion activities and meet contractual obligations established by regulatory and accrediting bodies.

CHPIV and Health Net is aware of the diverse culture of California and is fully compliant with the contract requirements related to California's Department of Health Care Services (DHCS) regulatory agency Medi-Cal Managed Care Division (MMCD) Policy Letters, DMHC, and Department of Insurance (DOI) regulations for language assistance services and federal rules that require the provision of language assistance services. Additionally, it will ensure meeting contractual and regulatory cultural and linguistic requirements identified by Centers for Medicare and Medicaid Services (CMS), and other regulatory and oversight entities.

At least annually, CHPIV and Health Net informs members, practitioners and providers of the availability of the Language Assistance Program (LAP), which offers language assistance services at no cost to members, including how to access the services and their rights to file grievances, in compliance with legal, contractual, regulatory agency, and oversight agency guidelines. Semi-annually, the LAP is monitored; this report includes trend analysis of grievances, and summary of language preferences. Health Net quality committees approve the appropriate quality benchmarks, review language preference results, and make recommendations for incorporating language preference into QI, and health education programs, follow-up actions or corrective action plans as needed. This process is managed by the Health Equity team.

A Geo Access assessment is conducted using member zip code data and correlated with member language preference every two years. The language capabilities of the practitioner and provider network are compared to the language needs of CHPIV members. The availability of linguistic services by contracted providers for limited English proficient members is analyzed and recommendations are made to further enhance the promotion of available language services in support of members, practitioners, and the provider network. Contracted practitioners and providers are informed of the cultural and linguistic services available via Provider Updates and the Provider Operations Manual. Culturally informative materials, trainings, and in-services are provided to network practitioners and internal department associates periodically. The Health Net Cultural Competency Training Program addresses the delivery of services in a culturally competent manner to all members, including prohibiting discrimination based on national origin, race, color, ancestry, ethnic group identification, sex, sexual orientation, marital status, gender, gender identity, age, physical disability, mental disability, religion, language, medical condition, or genetic information.

Health Net was the first health plan in California to obtain NCQA's Multicultural Health Care (MHC) Distinction for all products, in 2011. Health Net has maintained Health Outcomes Accreditation (HOA) and Community-Focused Care Accreditation (CFCA) since 2022 (formally Health Equity and Health Equity Plus Accreditation).

CHPIV will work with Health Net to implement strategies to support the reduction of health disparities in clinical areas. Health Net facilitates health equity workgroups that are responsible for developing and implementing an action plan to reduce targeted health disparities. The health disparity reduction initiatives are aligned with requirements from NCQA HOA and CFCA, Medi-Cal contract requirements and Health Net internal directive to address health disparities. Disparity reduction actions are implemented through a model that integrates Health Net departments across Quality Improvement, Provider Engagement, Health Equity, Health Education, Wellness, regional clinical teams, and Public Programs. The model utilizes a multidimensional approach to improving quality and delivery of care inclusive of community outreach, member and provider interventions as well as system level initiatives. The following highlights the core components of the disparity reduction model:

- Planning inclusive of data analysis (spatial and descriptive), data validation, key informant interviews, literature reviews, development of community and internal advisory groups, and budget development.
- Implementation of actions targeting three core levels: 1) Member/Community where partnerships are formed to identify existing initiatives and leverage support of community feedback to design and implement interventions; 2) Provider interventions targeting high-volume, low-performing groups and practitioners who have disparate outcomes; and 3)

Internal programs to improve disparities in identification, engagement and outcomes in Care Management and chronic conditions management.

- Evaluation and improvement of health disparity efforts is conducted using process and initiative level evaluation.

Health Net employees can be involved in Centene's national employee networks for veterans, military families, women, LGBTQ+ community, multicultural network, and people with disabilities, and across life stages. The employee networks have community engagement subcommittees that may indirectly impact health equity efforts and support employees in addressing health disparities within their communities.

Health Net is committed to supporting CHPIV diversity, equity, inclusion, and cultural humility and eliminating health inequities and disparities by working to break down the barriers that prevent access to high-quality health care services. Through its Health Outcomes and Community-Focused Care programs and services, the organization is committed to finding solutions and providing appropriate resources and interventions to diverse individuals within its population and community. Finally, the organization is committed to CLAS and addressing social risks and needs by:

- Establishment of the Inclusive Business Practices Council
 - Composed of senior leaders from our business divisions and focuses on strategic accountability across inclusive core pillars
 - Widespread distribution and presentation of the Inclusive Business Practices Annual Report, which reflects our commitment to inclusive practices at Centene and demonstrates Centene's tangible steps to achieving a more inclusive workplace
 - Ensuring policies and practices drive sustainable results throughout the enterprise
 - Advocating for systemic change that embodies social justice, public policy, equity, and inclusion
 - The Council has the following priorities:
 - Our People: We build trust with employees, members, and partners by promoting leadership, growth, and open communication, creating diverse perspectives that improve healthcare.
 - Our Business: By combining cultural awareness with operational excellence and inclusive practices, we remove barriers and align services with community needs, fostering trust and strong performance.
 - Our Communities: We address social and economic factors affecting health by empowering employees to create social impact, using data and partnerships to ensure fair access and stronger communities,
 - local business unit Inclusive Business Practices council development, and
 - enterprise access to inclusive business practice resources.
- Embracing diversity without bias or discrimination.
- Supporting and strengthening equitable care through fair distribution in procedures, resources, systems, and mechanisms.
- Actively including, sharing, and engaging diverse individuals, groups, teams, partner organizations, and community members by providing on-going opportunities and pathways for participation in decision-making processes.
- Exhibiting respect for and value of diverse cultural health beliefs, behaviors, and needs of individuals and the community through responses and interactions when providing services to others.

- Partnership with findhelp to support social needs assessment and community social risk identification.

The Health Equity department services in support of staff include Diversity, Equity, and Inclusion Training Program, in-services, and cultural awareness events. Cultural awareness in-services are provided upon hire to all Member Services staff. In addition, the Health Equity Department collaborates with internal departments such as Provider Engagement, Provider Network Administration, Health Education, and Quality Management to provide in-service of C&L/health equity services and/or Diversity, Equity, and Inclusion Training Program. As needed, Health Equity also provides in-services to case managers to assist in building trust with patients who are recent immigrants. The goal of these in-services is to provide information to staff on the cultural and linguistic requirements, non-discrimination requirements, the LAP, C&L and health equity resources and CHPIV member diversity.

The Health Equity Department supports contracted providers in their efforts to provide culturally responsive care to members. The services offered to contracted providers are intended to:

- Encourage cultural responsiveness and awareness.
- Provide strategies that can easily be implemented into clinical practice.
- Foster improved communication and health outcomes for patients from diverse cultural and ethnic backgrounds, with limited English proficiency, disabilities, regardless of their gender, gender preference or gender identity.
- Foster non-discrimination based on national origin, race, color, ancestry, ethnic group identification, sex, sexual orientation, marital status, gender, gender identity, age, physical disability, mental disability, religion, language, medical condition, or genetic information.

Trainings for providers and their office staff are currently available for the following topics:

- Advancing Health Equity: Diversity, Humility and Equity in Healthcare
- Bridging Linguistic and Cultural Gaps for Equal Access to Health Care
- Health Literacy/Plain Language
- Gender Inclusive/Affirming Care
- Community Connect Program-Social Needs Support, and
- Language Assistance Program/Services and Health Literacy.

O. Access and Availability

CHPIV has established access to care standards for health care services in accordance with the regulatory and accrediting laws and regulations. These standards ensure CHPIV provider network has sufficient numbers and diversity to provide all members with appropriate access to and availability of practitioners, providers, health care services, and language assistance services. These standards also ensure CHPIV members have appropriate access to medical services including primary care, specialty care, and behavioral care appointment access, after-hours access and instruction, urgent and emergent care, ancillary services access, and telephone customer service within a reasonable distance and time period. Health Net, as delegated by CHPIV, monitors effectiveness of this network to meet the needs and preferences of its membership, and to meet regulatory guidelines through annual access and availability surveys. CHPIV maintains detailed access and availability policies and procedures, which

define and discuss the necessary elements for these systems across the continuum of care. Corrective actions are developed for identified performance issues per policy guidelines.

CHPIVs standards, policies, and procedures are based on contractual, state and federal regulatory, and accreditation requirements. The processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, and that all covered services are provided in a culturally and linguistically appropriate manner. Description of the activities, including activities used by members that are seniors and persons with disabilities or persons with chronic conditions, and members who use Managed Medi-Cal Long-Term Supports and Services (MLTSS) in accordance with the standards set forth in 42 CFR 438.330(b)(5), designed to assure the provision of care management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services, and care management.

P. Member Experience (CAHPS)

Health Net continues to monitor CHPIV's member experience year-round by monitoring CAHPS survey results, and monitoring member satisfaction including resolved member appeals and grievances, and call center drivers. CAHPS survey results are integrated into NCQA accreditation and various state and federal performance rating systems and reports including the following:

- DHCS Medi-Cal Managed Care Quality Improvement Reports, and
- DMHC Health Equity and Quality Report.

Improvement efforts focus on educating CAHPS stakeholders and measure owners, offering focused provider webinars, partnering with operational teams to implement initiatives, share CAHPS best practices with provider groups, and participating in monthly Quality Governance Committee and Quality Focus Touchpoint meetings. CAHPS Program Managers meet with several business areas including Population Health and Clinical Operations, Customer Contact Center, Appeals and Grievances, Pharmacy, Provider Network Management, Provider Engagement (both Provider and PPG facing teams), Delegation Oversight, and Marketing. Annually, Program Managers review data, documents, and reports to provide stakeholders with Integrated Member Satisfaction reports and CAHPS survey disparity reports, which are required for NCQA accreditation. These efforts aim to support and enhance member experience

Q. Provider Satisfaction

Provider satisfaction is assessed annually using valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess practitioner and provider satisfaction with the network, claims, quality, utilization management, cultural, linguistic, and disability access services and other administrative services. In addition, the Provider Satisfaction Survey shall evaluate provider perspectives and concerns with the plan's language assistance program regarding:

- Coordination of appointments with an interpreter.
- Availability of an interpreter, based on the needs of the enrollee, and

- The ability of the interpreter to effectively communicate with the provider on behalf of the enrollee.

The Director of Provider Relations, in collaboration with other Health Net departments, is responsible for coordinating the provider satisfaction survey, aggregating and analyzing the findings, and reporting the results. Survey results are reviewed by the HNCS QIHEC with specific recommendations for performance improvement interventions or actions.

R. Health Education Programs

CHPIV provides health education programs, services and resources to Medi-Cal members to encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health care services, and to follow self-care regimens and treatment therapies. A whole person approach is used with a focus on removing barriers to care and providing health education and guidance. Interventions are tailored to meet members' clinical, cultural and linguistic needs.

The following interventions and resources are available at no cost to Medi-Cal members through self-referral or a referral from their primary care physician. Members and providers may obtain more health education information by contacting Member Services. Members will be directed to the appropriate service or resource based on their needs. Telephonic and website-based services are available 24/7. The Plan sends health education materials to members in their preferred threshold language or alternative format.

- Weight Management Resources: Members have access to Krames resources that encourage and promote a healthier lifestyle. These resources can be found at: HealthHub Weight Management.
- CHPIV Pregnancy Program - The pregnancy program incorporates the concepts of case management, care coordination, chronic condition management, and health promotion, teaching members how to have a healthy pregnancy and first year of life for babies. In addition, the program supports the following:
 - Information about pregnancy and newborn care.
 - Community resources to assist parents in getting the things they need during pregnancy and after the baby's birth. These services include food, cribs, housing, and clothing.
 - Breastfeeding support and resources.
 - Professional medical staff who work with doctors and nurses to support members with a more difficult pregnancy.
 - Resources for members who feel down during or after their pregnancy.
 - Methods to help pregnant members quit smoking, alcohol, or drug use.

The program also aims to reinforce the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease. Educational resources include materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy and caring for the baby. High-risk pregnancies receive additional care management services.

- Kick It California - Kick It California is a no-cost, statewide tobacco cessation program that addresses smoking and vaping behaviors. Services include tailored one-on-one telephonic coaching in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), a texting program in English or Spanish, a website chat function, and

mobile apps on smoking and vaping. Members can learn more by calling Kick It California at 1-800-300-8086 Monday-Friday, 7am-9pm, and Saturday, 9am-5pm (excluding holidays) or by visiting www.kickitca.org.

- Diabetes Prevention Program - The Diabetes Prevention Program (DPP) is a twelve-month long program focused on helping Medi-Cal members lower their risk for diabetes through healthy lifestyle choices and weight loss. Eligible members include any member who is 18 years of age and older at risk for developing Type 2 diabetes.
- Teladoc Mental Health Digital Program - Eligible members, ages 13 years and older, have access to an evidence-based, self-help resource to improve their mental health. This program offers interactive, personalized modules that empower members to help manage their depression, anxiety, stress, substance use, chronic pain and many other conditions. This program is available at www.teladoc.com or through the Teladoc mobile app. Members are referred into the program via Care Management, or can also self-refer into the program.
- Member Incentive Programs (Medi-Cal) - The Quality EDGE strategy was developed to strengthen provider and member engagement. Member engagement incentives are distributed at the point of care and are limited to open-access or one-stop clinic events. This approach ensures alignment with actions co-developed by providers and the CHPIV engagement team, fostering collaboration and improving member experience.
- Community and Telephonic Health Education Classes - No-cost health education classes and/or webinars are available for members and the community as needed. Classes are available in English and Spanish. Topics vary and are determined by the community's needs and topic availability.

The following resources are also available to members:

- Health Education Resources - Members or the parents of children and adolescent members may order health education materials on a wide range of topics, such as asthma, weight control, diabetes, immunizations, dental care, breastfeeding, breast cancer, cervical cancer, exercise and more. These materials are available in threshold languages. Members may also access more than 4,000 topics relating to health and medication using Krames Online at <https://chpiv.preview.kramesonline.com/>.
- Health Education Programs and Services Flyer - This flyer contains information on all health education interventions offered to members and information on how to access them.
- Preventive Screening Guidelines - The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in threshold languages: English and Spanish. They are mailed to new members and are also available on www.chpiv.org.
- Member Newsletter - CHPIV's Whole You newsletter is mailed to members once a year and covers various health topics and the most up-to-date information on health education interventions.

S. Telehealth Services

On behalf of CHPIV, Health Net supports members' access to their care through telehealth programs by connecting them to licensed clinicians through leading and global providers of virtual care such as Teladoc Health, and Hazel Health. Members can schedule general medical and behavioral health virtual visits with various pediatric and adult primary care providers.

ConferMed of CA connects providers with California-licensed specialty care experts through secure, digital dialogues.

Members receiving services from Teladoc can access the mobile app to connect to providers anytime, anywhere by phone, video, or app. Remote consultations with doctors and mental health care professionals are provided via a secure HIPAA-compliant, videoconferencing and voice over internet protocol (VOIP) software. Medically trained, certified interpreters are available on-demand to limited English proficiency (LEP) membership across high demand and threshold languages including Spanish and American Sign Language.

Hazel Health provides on-demand, physical health and scheduled behavioral health counseling-telehealth care at home and in schools and supports school nurses when a child has an urgent health care need. Via a computer, a child is connected to a health care professional for physical or mental health care. If a primary care physician's information is provided on the new patient questionnaire, Hazel will send follow-up records to the child's provider, improving the continuity of care. For kids needing behavioral health services, Hazel Health can email or fax a referral form to Health Net. Health Net will refer CHPIV members who require care management to the appropriate Health Net Care Management team for follow up. Hazel Health is currently available at approximately 180 participating schools with further expansion to more sites in the coming year. Care is also available in members' home settings.

ConferMed of CA provides an asynchronous, electronic consultation that offers PCPs rapid access to California-licensed specialty care experts through secure, digital dialogues. PCPs use eConsults at their discretion for non-urgent, non-procedural specialty care referrals. A digital referral, along with clinical information, images, lab results, and other content from the medical record, is sent to a specialist. In 70%–75% of cases, an eConsult will result in PCP management which helps prevent unnecessary/low value diagnostic testing and in-person appointments with specialists. Most eConsults are reviewed by the specialist and responded to within 3 business days, most often within 24 hours. This improves timely access for patients and removes potential geographic or language barriers that may occur during in person visits.

The goals of the telehealth program are to:

- Enhance member and provider experiences.
- Address critical provider shortages.
- Optimize care coordination.
- Reduce overall health care costs.
- Provide equal health care access to Limited English Proficiency members.
- Provide rapid and convenient access to urgent care after hours and when members assigned PCPs are not available.
- Reduce the incidence of unnecessary emergency room utilization.

T. MemberConnections® Program

MemberConnections is an educational and outreach Medi-Cal program designed to help members navigate the health care system, promote preventive health practices, and connect them to health and community social services. MemberConnections representatives (MCRs) extend the reach of member engagement and Population Health Team efforts by making telephonic and home visits and providing personalized service to members. MCRs are highly

trained, specialized non-clinical members of our integrated care teams. MCRs serve as a liaison/link/intermediary between the health plan and providers and members.

More specifically, MCRs:

- Conduct assessments to better understand members' needs such as the health risk screening and social drivers of health needs.
- Facilitate access to health services by scheduling medical appointments, helping members find doctors and specialists, and checking the status of referral authorizations.
- Assist with removing barriers to health care by arranging transportation and language services through the health plan vendors.
- Connect and reconnect members to clinical pharmacy, care management and chronic condition management to better manage their chronic and/or complex health conditions.
- Identify and address SDoH needs by linking members to county and community-based organizations.
- Help reduce health care costs by promoting preventive practices and educating members on how to use their benefits and appropriate utilization of health services.
- Support various outreach programs from the Health Plan. These include multiple Plan, Do, Study, Act and Performance Improvement Projects.
- Schedule and complete home visits for noncompliance members. Having "eyes on the member" to do visual assessments while in the member's home.
- Follow-up and monitor the status of high-risk member referrals.
- Help with utilizing telehealth services.
- Completing emergency outreach during natural disasters.
- Engage members based on Population Health Prioritization Reporting and HEDIS Care Gap Reports to connect members to PCP and refer into clinical pharmacy and care management.

U. Member Rights and Responsibilities

CHPIV has established a list of member rights and responsibilities that ensure members are treated with dignity and have full access to information about their care and benefits. These rights and responsibilities are reviewed and approved annually by the appropriate CHPIV staff. Members are informed of their rights and responsibilities through the member Evidence of Coverage (EOC) and other member communications.

Member rights include the right to:

- Be treated with respect, dignity, and courtesy.
- Privacy and confidentiality.
- Receive information about their health plan, its services, its doctors and other providers.
- Choose a primary care physician and get an appointment within a reasonable time.
- Participate in making decisions and have a candid discussion with practitioners regarding appropriate or medically necessary treatment options.
- Decide in advance how they want to be cared for in case they have a life-threatening illness or injury.
- Voice complaints or other feedback about the Plan or the care provided without fear of losing their benefits.
- Appeal if they do not agree with a decision.
- Request a State Fair Hearing.

- Receive emergency or urgent services whenever and wherever they need it.
- Services and information in their language.
- Receive information about your rights and responsibilities.
- Make recommendations regarding the organization's members' rights and responsibilities policies.

Member responsibilities include:

- Acting courteously and respectfully toward doctors and staff and being on time for visits.
- Providing up-to-date, accurate and complete information.
- Following the doctor's advice and participating in the treatment plan.
- Using the Emergency Room only in an emergency.
- Reporting health care fraud or wrongdoing.

CHPIV has established policies that address member grievances and appeals. Grievances and appeals are resolved in a timely manner. Trends are monitored on a regular basis to assess opportunities to improve health plan processes.

V. Medical Records

CHPIV requires practitioners and providers to maintain current organized and detailed medical records. Records must be consistent with standard medical and professional practice and protected health information is handled in accordance with established policies and procedures to safeguard patient confidentiality.

CHPIV's documentation standards address format, documentation, coordination of care and preventive care and include but is not limited to the following areas: adult preventive care, pediatric preventive care and perinatal care. Standards are distributed on a regular basis and at the request of network providers.

Practitioners are required to have systems and procedures to provide consistent, confidential and comprehensive record-keeping practices.

CHPIV monitors both medical record keeping and medical record systems to assess the quality of medical record documentation and compliance with standards through medical record audits. This occurs during the HEDIS process, Department of Managed Health Care (DMHC) and CMS surveys, during routine DHCS audits, and as part of the Managed Care Quality and Monitoring Division of DHCS PCP Full Scope Facility Site and Medical Record Review process. Annually, the data are aggregated and analyzed to evaluate effectiveness of interventions and identify opportunities for improvement. Actions are taken when compliance issues are identified, and interventions are implemented based on compliance rates established for each standard. Interventions may include sending Medical Record review Corrective Action Plans, Provider Updates, revising the Provider Operations Manual, sending educational or reference materials to practitioners or providers, creating medical record form templates.

W. Facility Site Review (FSR)/ Medical Record Review (MRR)/ Physical Accessibility Review Survey (PARS)

CHPIV delegates DHCS's required PCP Facility Site and Medical Record Reviews and Physical Accessibility Review Surveys (PARS) to HNCS. Per APL 22-017, PL 12-006, APL 15-023.

HNCS collaborates with other Medi-Cal Plans to develop and maintain a standardized system-wide process for conducting reviews of Primary Care Physician (PCP) facility sites and medical records. PARS are conducted for PCPs and high-volume specialists (including behavioral health), ancillary providers, Community-Based Adult Services (CBAS) providers and hospitals. Collaboration with other Medi-Cal Plans minimizes FSR and PARS duplication and supports consolidation of FSR and PARS surveys. The FSR/PARS process uses evaluation criteria and guidelines in compliance with the DHCS contractual requirements and is applicable to all Health Plans participating in the MMCD process.

The FSR team will include at least one Quality Compliance nurse, who must be a registered nurse, who has oversight responsibility for the PCP facility and medical record audit processes. This oversight process involves conducting initial evaluation, conducting annual review of activities, identifying areas for improvement, and collaboratively developing action plans to address areas of noncompliance. Results of the annual review are presented to the CHPIV Chief Medical Officer and the CHPIV QIHEC Committee.

IV. Program Structure and Resources

A. QI Committees

1. Governing Body/Board of Commissioners

The CHPIV LHC Board of Commissioners is the governing body with ultimate authority and responsibility for the oversight of the CHPIV QIHEd Program. The Board of Commissioners has delegated the responsibility for development and implementation of the QIHEd Program to the CHPIV QIHEC.

Functions:

- Establish strategic direction for the Population Health Management, Utilization Management, Case Management, Credentialing, Peer Review, Health Equity, and QIHEd Program.
- Receive quarterly updates from QIHEC, and review reports from the QIHEC, delineating actions taken and performance improvements at least annually.
- Ensure the QIHEd, HE, PHM, UM, CM Programs and Work Plans are implemented effectively.

2. CHPIV Provider Advisory Committee (PAC)

The PAC is chaired by CHPIV's Chief Medical Officer. The primary responsibilities of the Provider Advisory Committee (PAC) are to advise and provide perspective to the Chief Medical Officer, CHPIV staff, and Local Health Commission regarding CHPIV policies, programs, and initiatives. Meetings are held quarterly with a minimum of three (3) meetings per year. PAC reports to the Local Health Commission, through committee minutes as well as recommendations for policy revisions and innovations. PAC consists of between eight and twelve contracted CHPIV Network Providers, Chief Medical Officer, Senior Health Services Director, and other staff may attend depending upon agenda items. Membership will reflect demographic representation within practical limits, including geographic distribution and includes Primary Care and Specialists, Behavioral Health Providers,

therapists, pharmacists, Home Health agencies, and DME Providers. The specific number of participating providers shall be determined by the group annually as needed.

3. CHPIV Community Advisory Committee (CAC)

The Community Advisory Committee (CAC) is appointed by the Commission of CHPIV to advocate for CHPIV enrollees (members) by ensuring that CHPIV is responsive to members' diverse health care needs. The CAC empowers members to bring their voices to the table to ensure CHPIV is actively driving interventions and solutions to build more equitable care.

Objectives:

- Obtain local level feedback, insights, and perspectives to inform and address CHPIV operations, including quality and health equity strategy.
- Maintain a stable local presence and forum to engage and collaborate with local community partners and resources to ensure community needs are met.
- Provide perspectives on health equity and disparities, population health, children's services, and relevant plan operations and programs.
- Inform CHPIV's cultural and linguistic services program.
- Maximize member participation and involvement to solicit meaningful insights and perspectives to improve how CHPIV delivers services through ongoing training as well as effective meeting facilitation.
- Inform and advise CHPIV how to utilize Health Equity Improvement zones based on identified health disparities to ensure talent, resources and partnerships are aligned to improve health equity performance outcomes for members and residents of the Imperial Valley County.
- Provide forum for bidirectional communication between committee members and CHPIV leadership to inform use of community reinvestment funds.
- Assess the need for and establish Community Impact Council(s) using data, insights, and considering community and CHPIV priorities, who will collaborate with diverse community stakeholders to further drive community impact and create sustainable forums for continued work.

The CAC comprises key community Stakeholders reflective of the Medi-Cal population in the CHPIV's service area such as members (including those from hard-to-reach populations and members with physical disabilities, and Limited English Proficient (LEP)) from diverse cultural and ethnic backgrounds, community advocates, community-based organizations and traditional and safety-net providers. The Plan will modify the CAC membership as the beneficiary population changes, and in accordance with MMCD Policy Letter 99-001 and the DHCS 2024 contract requirements.

The CAC Selection Committee shall consist of such a number of directors as the Commission shall from time to time determine. The members of the Committee shall be appointed or replaced by the Commission with or without cause. The CAC will submit regular reports of activities, findings, and formal recommendations to the QIHEC to advance the CAC purpose and objectives. CAC recommendations shall include needed interventions where applicable.

The CAC meetings are held quarterly. Detailed records of all CAC meetings, activities and recommendations for improvement activities are maintained and reviewed by staff at regular

intervals, along with the Population Needs Assessment/update, and summary reports of compliance monitoring and evaluation activities. The CAC meeting minutes are publicly posted on CHPIV's website. For a complete description of CHPIV's CAC, refer to the CHPIV CAC Charter.

4. CHPIV Quality Improvement/Health Equity Committee (QIHEC)

The QIHEC is charged with monitoring medical management, health equity activities, and quality of care and services provided to members, including identifying and selecting opportunities for improvement, and monitoring and evaluating the effectiveness of interventions. The QIHEC is chaired by the Chief Medical Officer/Chief Health Equity Officer (CMO/CHEO). The QIHEC meets quarterly.

Functions:

- Review and approve the annual QIHED and Health Equity Program Description and Work Plans.
- Report to the LHC Board of Commissioners at least annually.
- Recommend and revise, or oversee policy changes, effective QI Program operation and program achievement.
- Ensure external providers and subcontractors, who are representative of the specialties in the network (i.e. behavioral health, seniors and persons with disabilities (SPD) and members with chronic conditions) actively participate in the QI Program through planning, design, implementation, or review.
- Maintain meeting minutes for submission to the LHC Board of Commissioners and DHCS upon request; and be made publicly available on a quarterly basis.
- Review behavioral health care initiatives and outcomes, including informing the Non-Specialty Mental Health Services (NSMHS) Member and PCP Outreach & Education Plan.
- Address activities and priorities related to the QI and Health Equity Transformation Program (QIHETP).
- Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys.
- Monitor activities and evaluate the results of QI activities, institutes needed actions, and ensures follow up as appropriate.
- Analyze and evaluate the results of focused audits, studies, quality of care and safety issues and quality of service issues.
- Monitor for compliance and other quality improvement findings that identify trends and opportunities for improvement.
- Provide input and recommendations for corrective actions and monitor previously identified opportunities for improvement.
- Monitor data for opportunities to improve member and practitioner perception of satisfaction with quality of service.
- Address UM, QI, and Health Equity activities which affect implementation and effectiveness of the QI Program and interventions.
- Review, approve, evaluate, and make recommendations for physical accessibility of the practitioners and provider offices.

Representatives from CHPIV and HNCS who report up to the QIHEC include the Quality Improvement Department (including the Behavioral Health QI team), Health Equity and CAHPS teams, Pharmacy Department, Provider Network Management, Delegation Oversight, Customer Service Center, Credentialing, Peer Review, Appeals and Grievances, and Population Health & Clinical Operations (PHCO) which includes Utilization Management and Care Management. Refer to the CHPIV QIHEC Charter for more information on committee members, roles and functions.

CHPIV QIHEC is supported by the following subcommittees:

- Credentialing and Peer Review Committee
- Health Equity Governance Committee
- Pharmacy and Therapeutics Committee
- Delegation Oversight Committee, and
- Network Access and Availability Governance Committee.

5. Credentialing and Peer Review Committee

The Health Net Credentialing Committee (CC) oversees the credentialing and recredentialing process for non-delegated practitioners and providers. This process ensures that the networks of health care practitioners and providers providing professional services to CHPIV members are trained, licensed, qualified and meet criteria for participation in accordance with regulatory requirements and accrediting entity standards. The committee reviews performance data and has final decision-making authority. The Credentialing Committee has representation from primary and specialty care participating practitioners, is chaired by a Health Net Medical Director and meets monthly. Ad-hoc meetings are scheduled on an as-needed basis.

The Peer Review Committee (PRC) is an independent review body established to achieve an effective mechanism for continuous review and evaluation of the quality of care and service delivered to enrollees. This includes monitoring whether the provision and utilization of services meets professional standards of practice and care, identifying quality of care problems, addressing deficiencies, deliberating corrective actions, and when necessary, initiating remedial actions with follow up monitoring. The goal of the PRC is to ensure enrolled members receive quality care and service from network practitioners, providers, medical groups, and sub-contractors. This is accomplished through the following:

- Collection, review and interpretation of data and provider feedback that can be used in evaluating performance.
- Sharing results of analyses with practitioners and providers in a systematic and routine process.
- Prescribing and/or requesting necessary action steps for remediation of identified problems.
- Rendering ongoing observations and evaluations of issues with recommendations for quality improvement.

The PRC is a multidisciplinary committee with representation from a range of practitioners. The PRC is chaired by a Health Net Medical Director and meets at least monthly. Ad-hoc meetings are scheduled as-needed.

The following highlighted sections are applicable to the Credentialing and Peer Review Committees, not just Peer Review Committee as written: The health plan's Chief Medical Officer or designee appoints the committee chairperson, who must be an internal Medical Director. The composition of voting PRC members includes internal Medical Directors as well as community physicians; all of whom are credentialed by the health plan and are either engaged in clinical practice or belong to a medical group as a Medical Director or Administrator. All are expected to use their independent clinical judgment in assessing the appropriateness of clinical care and recommendations for corrective actions, when warranted.

On a quarterly basis, the PRC will report to the designated quality committee all cases with impact to member care and/or services. Reports include but are not limited to access to care issues and adverse events.

If at any time PRC deliberations result in recommendation for termination, suspension or altered condition of participation, the recommendation will be presented to the Credentialing Committee for acceptance, enactment of appeal rights and regulatory reporting, when applicable.

Credentialing and Peer Review Committee members and guests must sign a confidentiality and conflict of interest statement at least annually. Peer review records and proceedings are confidential and protected under applicable state and federal regulatory requirements and health plan policies for system controls.

6. Internal Health Equity Governance Committee

The Internal Health Equity Governance Committee (IHEGC) supports Medi-Cal line of business and addresses identified health disparities, social risks, SDoH, and community needs and makes ongoing recommendations to improve individual and community outcomes. The Chief Health Equity Officer and Health Equity Director convene and lead the IHEGC, which includes cross-functional representation and participation from:

- Provider, member, and community-facing teams
- Quality Improvement, Health Equity, and Accreditation
- Public Policy, Government Affairs, Strategic Giving
- Medi-Cal Product Leadership and Regional Teams
- CalAIM and Systems of Care
- Population Health and Clinical Operations
- Operations
- Provider Engagement
- Human Resources
- Data and Analytics
- Marketing and Communications
- Medical Affairs

Key focus areas include:

- Driving connectedness across internal functional teams and external committees (Public Policy Committee and Community Advisory Committee), to inform, address, and as appropriate approve community insights, gaps, or recommendations, to drive execution of long-term programming and maintain strategic health equity objectives.

- Supporting and strengthening equitable care via procedures, resources, systems, and mechanisms.
- Identifying priority areas of individual social needs and create responses and interventions accordingly.
- Selecting and engaging with social and community partners to improve health equity and access to available community resources.
- Implementing and evaluating community partnerships and sponsorships to enhance health and community resources and determine effectiveness.
- Monitoring health equity programs that aim to reduce health care inequities and disparities.
- Using SMART goals, reviewing, and providing feedback and input focusing on inclusion of adequate and appropriate health equity considerations in all new recommendations, benefits, and projects.
- Embedding a health equity lens and member voice into all operations. The leaders who participate in the IHEGC serve as health equity champions in other committees and governing bodies by giving voice to health equity considerations and approaches stemming from their shared knowledge and engagement on priorities advancing CHPIV's health equity strategy.

7. Pharmacy and Therapeutics Committee

The Centene Pharmacy and Therapeutics Committee (P&T) is a decision-making body that meets quarterly to develop and update the company's drug formulary or drug list. The P&T Committee's primary goal is to assure continuous member access to quality-driven, rational, affordable drug benefits. The committee's members provide oversight for the development, implementation and maintenance of a regional strategy to optimize pharmacotherapy that is cost-effective for members.

The Committee membership includes Pharmacy Services pharmacists and associates and practicing pharmacists and practitioners from the provider network. A Centene medical director chairs the P&T Committee. Responsibilities include:

- Review and approve policies that outline pharmaceutical restrictions, preferences, management procedures, delineation of recommended drug list exceptions, substitution/interchange, step-therapy protocols and adoption of pharmaceutical patient safety procedures.
- Review of pharmaceutical utilization and prescribing practice patterns.
- Review, revising and adoption of the formulary on an annual basis.
- Report to the HNCS and CHPIV QIHEC at least quarterly.

8. Pharmacy Advisory Committee

The Health Net Pharmacy Advisory Committee (PAC) is responsible for oversight and communication about CHPIV's pharmaceutical program. The quarterly Committee advises on medical and pharmacy drug benefit services to ensure they are managed effectively and efficiently, while ensuring quality care is provided to the health plan membership. Membership includes Health Net's Medical Directors or his/her designees, Centene Pharmacy Services California Pharmacy team, physicians and pharmacists, and other areas that may be impacted by pharmacy operations. The Committee functions include:

- Reviews and approves Pharmacy Policy and Procedures specific to California pharmacy operations.
- Provides input on CHPIV's Prior Authorization criteria and policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, and therapeutic interchange.
- Review medical drugs authorization requirements and alignment with Pharmacy and Medical policies.
- Presents Health Plan Pharmacy Business Review and Quarterly Corporate DUR outcomes and/or clinical initiatives reporting.
- Review and approve DOFR drug categorizations.
- Reviews Corporate P&T Meeting minutes.
- Report on Annual Inter-rater Reliability (IRR) review results.
- Discuss other pharmacy-related issues specific to California i.e., regulatory, Pharmacist compensation, etc.
- Discuss Pharmacy benefit options to remain competitive.
- Coordinate with various departments, including Health Care Services, Legal, Underwriting, Compliance, Finance, Program Accreditation and Provider Services Department to ensure legal and regulatory compliance.
- Report quarterly to the HNCS and CHPIV QHIEC on drug therapy management opportunities that promote the quality of care and/or services provided to members.
- Review California pharmacy operational key performance indicators to identify drug trends (financially impactful) and/or improvement areas, design action plans to improve performance, measure performance improvement, and report results to appropriate committees.

9. Delegation Oversight Committee

The Delegation Oversight Committee (DOC) is responsible for overseeing the formal process by which another entity is given the authority to perform functions on behalf of Health Net. The Delegation Oversight Committee (DOC) provides a forum for discussion of delegates performance and an opportunity to discuss significant risks with health plan leadership. The Delegation Oversight Committee meets at once a quarter with additional meetings added as needed to meet the business requirements.

Responsibilities include:

- Ensuring there is a delegation agreement between Health Net and the entity, which outlines responsibilities, activities, reporting, evaluation process, and remedies for deficiencies.
- Monitoring and evaluating a delegate's performance with regulatory and accreditation standards through ongoing monitoring and annual audits of the entities' functions.
- Taking action if oversight activities reveal deficiencies in the delegate's processes.
- Evaluating a delegate's performance prior to granting delegation.

10. Network Access and Availability Governance Committee

The Network Access and Availability Governance Committee (NAAG) provides strategic direction, guidance and oversight to the Access and Availability Workgroup. Its goal and mission statement are to ensure members have access to comprehensive, quality care and services to obtain the right care at the right time. The committee will ensure sponsorship of

planned initiatives and provide management of the execution of initiatives planned by the workgroup to proactively improve access, member experience and satisfaction across all lines of business and networks. Functions of the committee include:

- Provide strategic direction, guidance and oversight informed by data-driven evidence that ensures positive experience for members as they access their care with practitioners or interact with the health plan.
- Increase oversight of PPGs and direct network providers through monitoring, evaluation and communication of access and availability results.
- Sponsor approved initiatives to improve access and availability.
- Approve the Access and Availability Program Description and Work Plan.
- Provide feedback and approval on recommended key initiatives and actions.
- Recommend and approve policy decisions.
- Ensure follow-up, as appropriate. Report key findings and initiatives to QIHEC.

11. Other: Quality Governance Committee and Quality Focus Touchbase Meetings

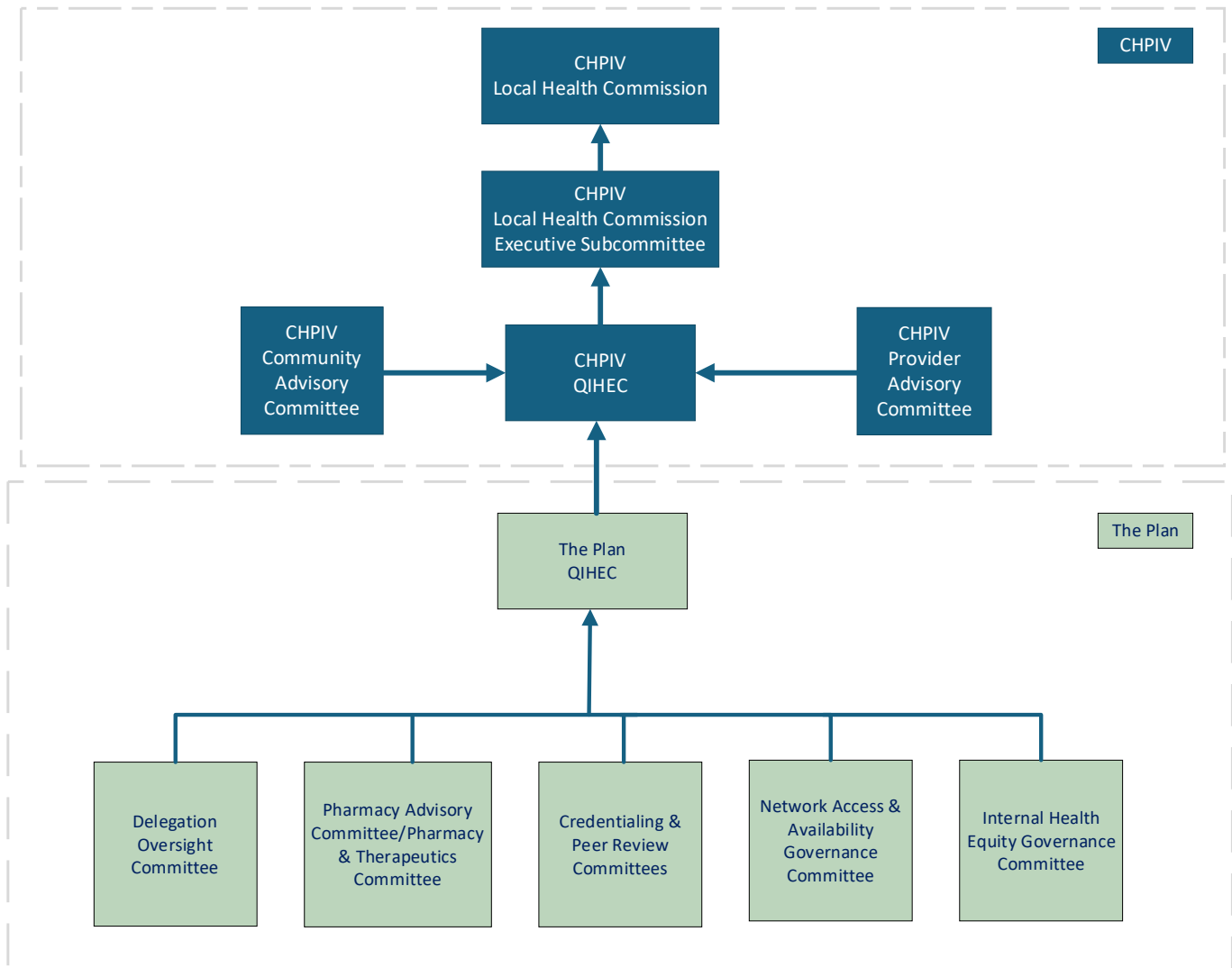
Quality Governance Committee

The Committee is accountable for monitoring quality improvement programs, performance and organization-wide engagement pertaining to the Department of Health Care Services (DHCS) MCAS Program, HEDIS default measures and rate setting, and publicly reported report cards (e.g. NCQA Health Plan Rankings). The overall focus of the Committee is to ensure that appropriate resources and activities are dedicated to and applied resulting in improved outcomes for members with chronic and preventive care needs.

At Quality Focus Touchbase meetings the provider engagement team strategizes with the quality improvement team on ways to improve provider/group performance on specific measures. QI shares best practices as PE shares the actions plans that they have developed with providers/groups to lead to improvements.

The CAHPS team attends the Quality Governance Committee and Quality Focus Touchbase Meetings with the Medical Affairs and Provider Engagements Teams. These meetings address all CAHPS-related measures. These forums review CAHPS implementation, CAHPS results, and are an opportunity to identify areas of improvement for CAHPS member experience survey results. These meetings are cross-functional and include employees from multiple member-facing and provider-facing teams across the organization.

12. Committee Organizational Chart



B. Staff Resources and Accountability

1. CHPIV Chief Medical Officer

The CHPIV Chief Medical Officer's responsibilities include chairing the QIHEC and work group, providing oversight of QIHed Programs, and assuring that the QIHed, Health Equity (HE) and PHCO Programs are compatible and interface appropriately with the provider network, overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in QIHed/HE operations. This position makes recommendations to the Local Health Commission to initiate major program revisions and communicates the Local Health Commission's directives to both internal and external stakeholders. This position is directly supported by the Senior Director of Health Services.

Health Net Department Resources:

CHPIV staff, with assistance from HNCS interdisciplinary staff, contributes to the success of the CHPIV QIHed Program. These administrative and clinical staff works with CHPIV's Chief Medical Officer to carry out QIHed activities for CHPIV's Medi-Cal members and provider network. The resources and responsibilities of departments most involved in the QIHed process are described below.

1. Health Net, LLC Chief Medical Officer (CMO)

This position has responsibility for the Quality and Medical Affairs Programs and must assure that the programs are compatible and interface appropriately with the provider network; oversee compliance with regulatory standards and reporting requirements; and achieve consistency in leading QI operations. This individual has direct authority over California's QI Program and staff, Medical Directors, and the Population Health program.

The Health Net LLC Chief Medical Officer (CMO) designates at least one medical director to provide clinical and administrative physician leadership to the QIHed Program, including:

- Oversight of the development, implementation and evaluation of QI projects and population-based care programs.
- Physician leadership for NCQA and regulatory agency surveys/audits.
- Representing Health Net as the physician QI liaison to external organizations, as needed.
- Chairing the Health Net quality committees.

2. Health Net Community Solutions Chief Medical Officer/Vice President, Medical Director, Medi-Cal

The Health Net Community Solutions Chief Medical Officer/VP Medical Director, Medi-Cal reports to the Health Net LLC CMO and is responsible for the development and implementation of strategies for access to care, improved quality outcomes, regulatory compliance and cost of care management. Reporting to the HNCS CMO/VP Medical Director are Supervisory (Regional) Medical Directors. In this role, the HNCS CMO/VP Medical Director works closely with the Medical Affairs and Management teams, and cross-functional teams to create a culture of quality and accomplish the goals of the Quadruple Aim (Better Health, Better Care, Lower Cost, and Improved Provider Satisfaction).

3. Vice President, Medical Affairs

The Vice President of Medical Affairs (VPMA) reports to the Health Net LLC CMO. The VPMA is responsible for clinical leadership and oversight of the following:

- Precertification, Concurrent, and Retrospective Review
- Appeals
- Grievances (both Quality of Care and Potential Quality Issues)
- Care Management, and
- Medical Policy.

4. Vice President of Quality Management

The VP of Quality Management reports directly to the Chief Medical Officer and is responsible for the overall direction and management of the QIHed Program and staff including:

- Organization-wide QI and HEd Program, outcomes and compliance with regulatory and accreditation bodies.
- Successful accreditation outcomes.
- Overall HEDIS operations and performance.
- Credentialing, quality of care and peer review activities to ensure criteria for practitioner performance is measured and acted upon in a timely and consistent manner.
- Health Education and Health Equity program and services are developed and implemented for all members.

5. Behavioral Health Medical Director

The Behavioral Health Medical Director is involved with the behavioral health care aspects of the QI Program and participates in the HNCS QIHEC. To ensure that a close, coordinated approach to provision of behavioral health services and coordination of care with medical services is in place, the Medical Director is responsible for evaluating:

- Continuity and coordination care between behavioral and medical health
- Triage and referral processes, and
- Access and availability performances.

6. Supervisory (Regional) Medical Directors

The Medical Directors are licensed physicians responsible and accountable for assuring appropriate clinical relevance and focus of the Utilization Management, Care Management, Risk Adjustment, and QI Program. The Medical Directors interface with providers and individual practitioners and facilities to ensure the performance of the provider community meets established Health Net and CHPIV standards. The Medical Directors participate in HNCS QIHEC and other QI activities.

7. Senior Director/Director of Quality Improvement

The Senior Director of Quality Improvement reports to the Vice President of Quality Management. Three Directors of Quality Improvement report to the Senior Director of

Quality Improvement. The Directors provide leadership and oversight for activities related to the Quality Improvement (QI) and Health Education (HEd) Program, including but not limited to:

- Overall management of the QIHED Program, including behavioral health.
- Resolve barriers that prevent appropriate monitoring of quality of care and quality of services.
- Assure implementation of quality improvement and wellness activities.
- Review reports, identify issues, formulate policies and procedures and make recommendations to the QI committees.
- Provide consultation to Quality Management associates.
- Maintain NCQA accreditation, QI and Health Education compliance.
- Direct and lead a cross-functional Health Net team, identifying and ensuring action is taken on priorities, leveraging relationships, and leading, to ensure appropriate and substantive interventions among leaders.
- Continuously assess the data and information available on performance measures, identify trends and risk areas, and then create a platform for change amongst the key CHPIV stakeholders.
- Lead reporting and enterprise communication processes to share gaps and opportunities for improvement.
- Manage vendor relationships as necessary to support the processes to improve HEDIS and Medi-Cal MCAS performance.
- Overall direction and management of the health education and wellness related programs including health disparities reduction efforts.
- Leads national health education/promotion projects to operationalize regulatory requirements, establish best practices, design policies, establish standards, and ensure implementation and compliance.
- Review reports, identify issues, and make recommendations to the QI committees.
- Direct and oversee department-led interventions and programs that address CAHPS measures and identify and ensure action is taken on priorities.

8. Senior Director, Reporting and Business Analytics

The Senior Director of Reporting and Business Analysis reports to the VP of Quality Management and oversees a team of data analysts, project managers and support staff. Responsibilities related to the QI Program include:

- Direct management oversight for business process initiatives and optimize quality and efficiency in support of HEDIS objectives.
- Develop HEDIS organizational structure and resources allocation to assure the most efficient and successful HEDIS operation results.
- Building adequate resources within HEDIS Operations who are accountable for determining, operation and maintaining appropriate HEDIS reporting and operating systems.
- Serve as liaison and subject matter expert for the HEDIS business areas, providing assistance and direction for business processes to ensure timelines and desired business outcomes are realized.

9. Senior Director Vendor Partnerships

The Senior Director of Vendor Partnerships reports to the Vice President of Quality Management and oversees four key functions of the Clinical Vendor Management Team:

- Vendor Engagement, which includes researching and vetting vendors, managing RFPs, identifying service overlap, and maintaining strategic corporate and market-level relationships;
- Contract Set-Up and Maintenance, which manages SOWs, BAAs, legal review, security assessments, data-exchange setup, and invoice/payment workflows;
- Program Implementation, which drives operational rollout through promotional strategy, member and provider communications, targeting and data pulls, meeting coordination, IT testing, and grievance management; and
- Contract Oversight, which ensures performance through JOC meetings, SLA and ROI monitoring, corrective action plans, cost tracking, issue resolution, and collaboration with Provider Engagement teams.

10. Director of Quality Improvement Data Analysis

The Director of Data Analysis reports to the Sr. Director, Reporting and Business Analysis. Responsibilities related to the QI Program include:

- Assure identification of opportunities for quality improvement activities, related to achieving quality outcomes (e.g., MCAS, clinical metrics, NCQA accreditation, member satisfaction).
- Review reports and guide the analytic approach across all lines of business and make recommendations to QI Committees.
- Assure implementation of quality improvement metrics and outcome measures.
- Ensure delivery of in-depth analysis to evaluate quality of care and service, member satisfaction and overall CHPIV performance to identify opportunities for improvement.
- Continuously assess the data and information available on performance measures, identify trends and risk areas, and then create a platform for change amongst the key CHPIV stakeholders.
- Lead reporting and enterprise communication processes to share gaps and opportunities for improvement.
- Ensure collaboration with HEDIS staff to identify areas of opportunity.
- Develop tools to track progress toward established goals and identify areas of opportunity.
- Provide feedback on quality outcomes and progress to Corporate and Market leadership.
- Identify data to be collected for QI initiatives, ensuring sound methodology and data collection for use in applicable outcome studies/evaluations.

11. Director of Clinical Services

The Director of Clinical Services reports to the VP of Quality Management. Responsibilities related to the QI Program include:

- Assure the Credentialing Department conducts credentialing/recredentialing activities in accordance with Health Net and CHPIV standards, state and federal regulatory requirements, and accrediting entity standards.
- Oversee Peer Review and Credentialing activities including the investigation of track and trend issues, identification of adverse action events, and presentation of quality issues to the Peer Review or Credentialing Committee.
- Oversee the Clinical Quality of Care (QOC)/Potential Quality Issues (PQI) Department is meeting state and federal compliance standards.
- Oversee facility site and medical record reviews activities, including identifying deficiencies for PCPs meeting DHCS standards, corrective action plans, and physical accessibility review surveys for both primary care practitioners and high-volume specialty providers, including behavioral health, ancillary and CBAS centers.

The Director of Clinical Services directs the clinical quality of care and the potential quality issues with guidance from the Senior Medical Director. Potential quality of care issues are reviewed by a Health Net Medical Director and based on findings, are given a severity level, and if indicated, submitted to the Peer Review Committee (PRC) for appropriate resolution. Quarterly, an aggregate report of the number, severity, actions taken, adverse events and trends noted are reported to the HNCS QIHEC.

The Credentialing Department is responsible for implementation of the credentialing program and the credentialing/recredentialing of health care practitioners and providers in accordance with Health Net and CHPIV standards for participation requirements, state and federal regulatory requirements, and accrediting entity standards. The department is also responsible for the credentialing adverse actions process, as well as peer review activities and committees.

12. Quality Improvement Senior Managers/Managers

Health Net Quality Improvement Senior Managers/Managers report to the Senior Director/Director of Quality Improvement. Managers oversee and manage the functions of the Quality Improvement Program and Health Education System, including HEDIS reporting, quality improvement and health education activities and other regulatory and compliance reporting. Responsibilities related to the QI Program include:

- Provide support to staff and facilitate daily quality improvement (QI) and health education functions through effective communication with departments and staff.
- Review and analyze reports, records, and directives for quality improvement and health education programs and services.
- Manage, oversee, and monitor all assigned quality improvement and health education programs, services, and initiatives.
- Confer with staff to obtain necessary data for planning work activities, including HEDIS reporting.
- Verify data submission compliance with government program requirements and ensure adherence with state, federal and certification requirements.
- Prepare and oversee reports and records on work activities for management.
- Evaluate and improve current procedures and practices and to meet required standards.
- Manage delegate vendor oversight and corrective action plans as indicated.
- Monitor and analyze costs and assist with budget preparation.
- Communicate (or be a point person for) goals and objectives.

- Support Programs, Owners, and Drivers (POD) results and productivity by communicating expectations and monitoring staff deliverables and participation.
- Provide manager oversight for respective PODs, including the development and implementation of strategies to drive performance improvement and promotion of programs.
- Maintain and address staffing and personnel needs.
- Oversees the completion of work plans, program descriptions, work plan evaluations, annual and semi-annual Member Incentive reports, policies & procedures.
- Provide oversight and management of rating systems such as the Medi-Cal MCAS.

13. Health Equity Manager

The Health Equity Manager leads the planning and administration of health equity and cultural and linguistic programs/services and co-leads HOA and CFCA program for Medi-Cal line of business. Responsibilities for cultural and linguistic (C&L)/Health Equity include the following: planning and administration of C&L/Health Equity services and mandated requirements statewide; designing policies, establishing standards and ensuring implementation and compliance for Health Net to meet Department of Health Services, Centers for Medicare and Medicaid, National Committee on Quality Assurance, and C&L/Health Equity contractual/accreditation requirements; providing leadership and management for Health Equity staff; and representing the health plan at external regulator and accreditation meetings and taskforces. The Health Equity Manager also educates department leads on proposed and/or newly enacted legislation, oversees the delivery of culturally and linguistically appropriate services at all plan member points of contact, and ensures that regulatory and accreditation requirements are met.

The following Health Equity Department's goals are implemented through four core competencies – language services, cultural competency, health literacy and health disparities reduction:

- Ensure language services meet regulatory requirements and achieve metric goals.
- Achieve appropriate reading grade level requirements and cultural appropriateness at market and product levels.
- Complete staff and provider trainings for required topics.
- Address health disparities through targeted cross-collaborative projects.
- Implement social needs assistance strategies with integrated approaches for mitigating social risks.

14. Health Education Lead

The Health Education Lead has a Master's degree in Public Health (MPH). The lead is responsible for the oversight, planning, coordination, and administration of health education programs and services for CHPIV members. The lead is also responsible for:

- Overseeing the implementation and evaluation of the department's health education interventions and policies.
- Participating (or delegating participation) in community partnerships with local and state health departments.
- Budgeting and overseeing the department's operations.

- Maintaining compliance with government contracts including DHCS, CMS and DMHC for all contracted counties and services areas.
- Overseeing Health Education System staffing functions, implementing and evaluating health education interventions.

15. Quality Analytics Program Managers

Quality Analytics Program Managers are responsible for identifying, managing and tracking clinical, quality, correct coding, documentation and data submission projects that advance the objectives of CHPIV's strategic goals.

Responsibilities include:

- Working across functional teams to develop performance trackers and tools as needed to meet national performance targets and drive quality improvement.
- Addressing the DHCS Corrective Action Plan (Medi-Cal) by providing insight through statistical analysis of utilization and member data to identify opportunity areas that inform QI intervention.
- Facilitating the development of internal and external reports and the delivery of data as needed to support and monitor the action plans to accomplish the Quadruple Aim:
 - a) to improve member experience
 - b) to improve the quality of care
 - c) to reduce health care costs, and
 - d) to improve the provider experience.

16. Quality Improvement Analysts

The Quality Improvement Analysts reporting under the Director of QI Data Analysis conduct in-depth analysis to evaluate quality of care and service, member and provider satisfaction and overall CHPIV performance to identify strategic opportunities for improvement.

Responsibilities include:

- Conduct deep dive strategic analyses to identify provider performance deficiencies and population vulnerabilities to target QI interventions.
- Review and assist in study design/methodology and provide data to be utilized for QI studies to meet regulatory requirements.
- Review and analyze the study findings and recommend corrective actions and next steps.
- Establish and implement programs and initiatives to meet NCQA and regulatory requirements.
- Continuously assess the data and information available on plan performance, to identify trends and risk areas.
- Provide support, guidance and collaboration with stakeholders in other Health Net Departments to ensure implementation, analysis and follow-up of CHPIV activities.
- Develop tools to track progress toward established goals and identify areas of opportunity.

17. Quality Management Program Managers

The Quality Management Program Managers reporting to the Quality Improvement Directors/Senior Director/Sr. Managers are responsible for setting the tactical priorities for HEDIS performance improvement and managing projects across lines of business that advance the objectives of CHPIV's strategic goals.

Responsibilities include:

- Serving as functional leaders across lines of business for targeted areas, including:
 - Child/adolescent health
 - Behavioral health
 - Health education promotion strategies
 - Oversight of quality contractual requirements, and fostering statewide partnerships
 - Member engagement strategy
 - CAHPS strategy support, and
 - Provider engagement strategy.
- Setting tactical priorities based on data, provider partners and membership, oversight of quality contractual requirements, and fostering statewide partnerships..
- Managing programs and evaluating effectiveness to achieve the targeted benchmarks and above.
- Assessing risks and monitoring performance of prior year's lower priority measures, elevating risk as needed, and setting as new tactical priority.
- Evaluating monthly HEDIS data, where applicable, to identify and/or track targeted population's progress.
- Supporting statewide program implementation and evaluation locally.

18. Quality Improvement Project Managers

Quality Improvement Project Managers implement QI Direct Care and Supportive Services initiatives and design associated studies to evaluate initiative effectiveness for Imperial County. They report to the Senior QI Manager, Manager of Program Accreditation, or QI Director.

Responsibilities include:

- Design and implement statewide programs that address member barriers and support care gap closures by providing direct care to members through innovative delivery methods.
- Develop strategies to effectively communicate with members through diverse methods and ensure all communication tools are accurate and relevant.
- Deploy methods to drive behavior change by encouraging members to seek care (i.e., member incentives, etc.).
- Design and implement evaluations to determine the most efficient and effective methods for HEDIS performance improvement.
- Tackle and monitor all statewide programs to report progress, address issues and adapt programs to meet target population needs.
- Scale up effective programs from Regional Teams, and deploy programs, trainings, and resources based on Imperial Region priorities.

19. Sr. Quality Improvement Specialists

Senior Quality Improvement Specialists implement quality improvement initiatives and studies for CHPIV through multi-disciplinary workgroups designed to address clinical and service issues to meet all regulatory and accreditation requirements. They report to the QI Senior Managers, or QI Directors.

Responsibilities include:

- Conduct the evaluation and review of the effectiveness of the QI Program and prepare documents for submission to the QI Committees, Executive Management Team, and the Board of Directors.
- Provide support, guidance and collaboration to Health Net departments to assure implementation, analysis and follow-up of CHPIV activities per the QI Work Plan.
- Review and/or revise policies and procedures on an annual basis, or as necessary.
- Identify data to be collected for selected studies and review format and methodology for appropriateness. Review and analyze the findings and recommend corrective actions and re-measurement as applicable.
- Establish and implement programs and initiatives to meet NCQA and regulatory body requirements.
- Development and implementation of member and provider interventions to improve HEDIS outcomes.
- Conduct deep dive analysis to identify provider group performance deficiencies and population vulnerabilities to target QI interventions.

20. Compliance Specialists

The Compliance Specialists report to the Manager of Accreditation and provide the following key deliverables and support to the overall QI Program:

- Support committee maintenance operations as needed.
- Monitor, report and execute necessary changes for programs and initiatives to meet NCQA and regulatory body requirements.
- Review and/or revise policies and procedures on an annual basis, or as necessary.
- Ensure all audit deliverables are prepared and maintained, including resolution of corrective action plans.

21. Manager of Program Accreditation

The Manager of Program Accreditation reports to the Senior Director of Quality Improvement. Responsibilities related to the QI Program include:

- Ensuring maintenance of Health Plan Accreditation and Health Outcomes Accreditation/Community-Focused Care Accreditation, and maintain compliance with additional required NCQA accreditation programs.
- Coordination of the HNCS Quality Improvement/Health Equity Committee.
- Ensure collaboration between Quality, Provider Engagement, and Medical Affairs to increase HEDIS rates as it pertains to Quality EDGE efforts.
- Review reports, identify issues, and make recommendations to the QI committees.

- Organize activities and provide consultation to Quality Management associates and other business units on areas related to accreditation.

22. Sr. Health Education Specialists/Health Educators/ Program Manager II

Health Education staff hold Bachelor and Master degrees in health education, public health, health science, kinesiology, and nursing. They are responsible for the development, promotion, and implementation of member health communications, health education programs, and community-based partnerships benefiting members. These programs and services reach all member households.

Health Education staff are responsible for numerous projects and initiatives within the focus of member wellness, disease prevention and member retention. Projects include, but are not limited to, managing member incentive programs, coaching wellness program, and diabetes prevention programs. Staff oversee the revision of existing programs, updating health education literature, and the design and development of new programs as needed. The staff is also responsible for the regulatory review and compliance of health education collateral and member communication related to Health Net's health education programs..

The Program Manager II (Training Specialist) is responsible for managing quality improvement initiatives, overseeing training programs, and supporting health education activities while ensuring compliance with regulatory requirements. This role leverages expertise in Quality Improvement, Health Education, and Wellness to develop and deliver training materials in collaboration with subject matter experts (SMEs), supporting both internal teams and external stakeholders. This role maintains training schedules, coordinates external training sessions, and assesses training effectiveness, providing recommendations to enhance programs. Regulatory responsibilities include leading SNP compliance by preparing and submitting reports such as the SNP Models of Care and annual evaluations to CMS and DHCS. By supporting the development of QI documentation, pulling QITS tracker data, and ensuring the timely completion of projects, the Program Manager II (Training Specialist) plays a critical role in advancing organizational quality improvement and training objectives.

The Program Manager II (QI Regulatory) is responsible for managing quality improvement initiatives while ensuring compliance with regulatory requirements. Regulatory responsibilities include leading DHCS Performance Improvement Projects (PIP), Plan-Do-Study-Act (PDSA), A-3 Lean Reports, Transformational PIPs, and Comprehensive Quality Improvement Projects. The Program Manger supports routine (monthly/quarterly) assessment of programs, including the development of evaluations plans, drafting criteria (in collaboration with the Program Manger III) to assess program effectiveness and prioritizing programs. The Program Manager also leads workgroups related to the regulatory deliverables with internal and external stakeholders and community partners. This is inclusive of the following coordination: Facilitation of meetings, agenda development, dissemination of action items, and monitoring and reporting progress. Program Managers also manage individual vendors to ensure compliance with the scope of work and timely, accurate invoice submissions. The Program Manger II (QI Regulatory) role is crucial to ensuring the organization meets the regulatory deliverables mandated by each governing body.

23. Quality Improvement Specialists/Quality Program Strategist

The Quality Improvement Specialist and Quality Program Strategist roles support the implementation of quality improvement initiatives, regulatory compliance, and strategic program management across lines of business to enhance member outcomes and provider performance. They report to QI Managers. Responsibilities include:

- Implement and support quality improvement initiatives and programs, ensuring alignment with organizational goals and regulatory requirements.
- Abstract, analyze, and manage data for quality reporting, decision-making, and trend analysis. Prepare ad-hoc and required reports to support project and program objectives.
- Track and coordinate projects to ensure timely execution, compliance, and alignment with specified objectives. Serve as the project liaison between teams to ensure efficient delivery of outcomes.
- Facilitate the development and maintenance of policies, procedures, and materials to align with best practices and regulatory requirements. Support audits and ensure corrective action plans for identified deficiencies are implemented promptly.
- Support the Quality EDGE program through data entry, tracking reports, and assisting provider-facing teams with funding requests.
- Prepare quarterly and board-level committee slides, track updates for workplans and evaluations, and support other activities as needed.
- Prepare for audits, maintain accurate records, and coordinate team input for policies, procedures, and desktop updates to meet compliance standards.

C. Other Departments

1. Utilization Management/Population Health & Clinical Operations (PHCO)

CHPIV's Chief Medical Officer is ultimately responsible for the design, implementation and monitoring of the effectiveness of utilization and PHCO programs. A systematic approach is used by CHPIV with the assistance of HNCS staff, to identify and manage members who are currently accessing inpatient or ambulatory health care services. HNCS Medical Affairs and PHCO Departments partner with contracted practitioners and member/family and/or caregivers to monitor, to evaluate and to facilitate continuity and coordination of care among CHPIV's members. PHCO staff interfaces with the QI staff in development, management and assessment of programs designed to improve the health of CHPIV members. The HNCS UM Department prepares and presents reports to CHPIV's QIHEC at each meeting and presents a semi-annual and annual report on the UM Workplan. HNCS seeks input from the CHPIV QIHEC and Local Health Commission prior to preparing the annual Work Plan. The CHPIV Health Services Division performs regular audits of Health Net's UM and PHCO operations, policies, and processes.

2. Case/Care Management

Case/Care Management (CM), delegated to HNCS, is responsible for the design, implementation and monitoring the effectiveness of the care management program and member outcomes. CM uses a systematic approach to identify and manage members who are currently accessing inpatient, ambulatory health care services, and may have

compounding social drivers of health issues. Health Net's CM team partners with contracted practitioners, and member/family and/or caregivers to monitor, evaluate and facilitate continuity and coordination of care among its members, to improve care transitions and outcomes, and decrease readmission rates.

CM supports the integration of both physical and behavioral health services by ensuring that members who need behavioral health services are referred to the appropriate behavioral health provider to obtain medically necessary services. CM may refer these cases to a behavioral Care Manager who works in tandem with a physical health Care Manager on the member's care plan, as needed.

3. Clinical Vendor Management

Clinical Vendor Management works in conjunction with Population Health and Clinical Operations for the monitoring and oversight of clinical performance metrics and operations for programs such as the Nurse Advice Line, SPD HRA, in-app two-way communication program, telemedicine, surgery decision support program, behavior health services for members, and the specialty UM/prior authorization vendor for musculoskeletal and other select procedures.

4. Credentialing/Recredentialing

CHPIV delegates credentialing/recredentialing of practitioners and organizational providers to HNCS but retains oversight and ultimate authority for such function.

5. Appeals and Grievances

The Appeals and Grievance Department is responsible for conducting full investigation and fair review of all member concerns and/or reconsideration requests. This includes reasonable efforts to gather all information needed to make accurate decisions and provide the member with a resolution in writing within applicable regulatory timeframes. If an appeal has been upheld by the plan, the member is provided with their next level of appeal rights of an independent third-party review and the option to request a State Fair Hearing.

Appeals and grievances are monitored and trended to identify opportunities for improvements in service and quality of care. The Appeals and Grievance Department will provide monthly operational and quarterly reporting to CHPIV QIHEC. These reports are to ensure and allow the departments the ability to review, act and follow-up on services, quality events or trends that are significant at the practitioner, provider, or plan level. Initiatives are put in place, as needed to address any identified deficiencies.

6. Customer Contact Centers

The Plan's Customer Contact Centers, operated by HNCS on CHPIV's behalf, are responsible for addressing telephone inquiries from members and practitioners. Based on established criteria, the Customer Contact Center refers specific appeals and grievances and expedited requests to appropriate CHPIV and HNCS staff for focused evaluation and follow-up for any quality of care or service issues. Quarterly reports on trended member/practitioner service-related issues are compiled and reviewed for action. The analysis of these reports comprises one of the data sources utilized by CHPIV's Chief

Medical Officer to directly identify and/or confirm opportunities for improvement.

7. Provider Network Management

CHPIV delegates provider network management to HNCS. HNCS Provider Network Management staff initiates and directs efforts to recruit and expand hospital, practitioner and ancillary provider networks to serve CHPIV members. The Provider Network Management staff liaisons also collaborate with the hospitals, practitioners and other providers for the resolution of contractual issues related to the terms and conditions and/or payment rate(s) for certain services.

8. Provider Engagement and Data Strategy & Insights

The Provider Engagement and Data Strategy & Insight departments provides oversight and capabilities in support of improving and maintaining performance with providers and their membership across all lines of business. Collaboration between the departments involve the Provider Relations, Practice Transformation, Encounters, RAF, and Data Analytics and Solutions teams. The Provider Engagement and Data Strategy & Insight departments' success is dependent on both "internal" and "external" alignment to improve practitioner and provider performance and satisfaction.

Key responsibilities of the Provider Engagement and Data Strategy & Insight departments include:

- Monitor and maintain and/or improved provider compliance (HEDIS, CAHPS, practitioner/provider satisfaction, UM metrics, RAF and encounter submissions) through provider outreach, training and education.
- Oversee and evaluate provider effectiveness.
- Assure business capabilities meet and support provider and member needs.
- Improve technical support, bi-directional data exchange, and communication channels or methodologies.
- Identify trends, issues, and opportunities to form and adopt best practices and meet or exceed performance targets.
- Engage and collaborate with targeted practitioners and providers through performance improvement projects.
- Collaborate with practitioners, providers and cross-functional departments to build and align incentives based on performance goals.

9. Delegation Oversight

CHPIV staff is responsible for the development, implementation, monitoring, and auditing of the delegation program for functions (e.g., utilization management, credentialing, peer review, claims and claims administration, etc.) delegated to HNCS and other entities as specified in written agreements between CHPIV and the entities. CHPIV staff maintains responsibility for the implementation and monitoring of corrective action plans resulting from oversight recommendations.

10. Vendor Management Office (VMO)

The core responsibilities of the VMO are oversight, monitoring, and auditing of vendor delegates. Regular Joint Oversight Committees (JOCs) are led by the VMO in which

performance metrics, member experience, complaints and grievances and the status of corrective actions are reviewed. Corrective actions are issued for non-compliance with service level requirements or for audit findings and are tracked through remediation.

11. Pharmacy Services

CHPIV is responsible for managing the pharmaceutical benefits for Physician Administered drugs under the medical benefit. The self-administered drug benefit is carved out and managed by DHCS under the program known as Medi-Cal RX. Information regarding Medi-Cal RX can be found at <https://medi-calrx.dhcs.ca.gov/home>.

HNCS will assist CHPIV in the establishment and maintenance of the Pharmacy Medical Drug Benefit. This includes the implementation of policies and procedures ensuring the safety, quality and appropriate use and delivery of drug products, as well as review of requests for pre-service, pre-authorized urgent and prior authorization of medical benefit drugs. Analysis includes drug utilization patterns, pharmacy service indicators and cost-effectiveness monitoring of the pharmaceutical care and services provided to CHPIV members. Pharmaceutical services reports shall be made to the CHPIV QIHEC on a quarterly basis.

12. HEDIS Management and Clinical Reporting

HNCS provides CHPIV with the HEDIS Management and Clinical Reporting Team which is responsible for HEDIS data collection and reporting. This team works collaboratively with CHPIV staff to collect and report data.

13. Public Programs

The Public Programs department monitors and acts as a resource for the LTSS {CBAS, MSSP, in-home support services (IHSS), and LTC} services for members. The department is engaged in the following activities:

- Support access to care initiatives through member outreach, coordination of care, and nursing home transitions.
- Early identification and referral to California Children's Services (CCS), and outreach to members aging out of program twelve months before their twenty-first birthday to avoid interruption in care.
- Referral/connection to carved out Medi-Cal benefits and providers.

14. Program Accreditation

The Program Accreditation (PA) team supports and promotes activities to assess and monitor CHPIV ongoing compliance with requirements of accrediting bodies (NCQA). Responsibilities include managing the accreditation timelines, coordination and submission of documents and implementation of any identified actions based on survey outcomes. PA works with CHPIV staff to ensure all aspects of survey submission. The PA team also manages collaboration between Quality, Provider Engagement, and Medical Affairs to increase HEDIS rates as it pertains to Quality Evaluating Data to Generate Excellence (EDGE) efforts.

15. Additional Resources

Additional resources available to the QI Program:

- Marketing/Sales
- Compliance
- Privacy
- Legal
- Web Development
- Strategic Sourcing and Procurement
- Claims/Encounters
- Provider Communications, and
- Member Communications.

The **Management Information Systems (MIS)** supporting the QI Program allows key personnel the necessary access and ability to manage the data required to support the measurement aspects of the QI activities. Analytic resources within the Plan's QI Department are available to support CHPIV efforts, including expertise from the Director of QI Research and Analytics, who holds a master's degree and has SAS and programming experience. Additional analytic and operational support is provided by regional and corporate departments such as Information Systems, Health Care Services, Pharmacy Operations, Medical Informatics, HEDIS Measurement and Reporting, Actuary, Finance, Strategic Planning, and Marketing. Data sources include HEDIS, CAHPS, ECHO/OPMH surveys, appointment access and provider availability surveys, provider satisfaction surveys, and practitioner after-hours access surveys. Computer systems used by the Plan to support Quality Management includes:

- **Centelligence™**: A comprehensive family of integrated decision support and health care informatics solutions. The Centelligence™ platform integrates data from internal and external sources, producing actionable information: everything from care gap and wellness alerts to key performance indicator (KPI) dashboards, provider clinical profiling analyses, population level health risk stratifications, and over 12,000 unique operational and state compliance reports.
- **Centelligence Enterprise Data Warehouse (EDW)**: Supporting both Insight and Foresight, EDW receives, integrates, and continually analyzes an enormous amount of transactional data, such as medical, behavioral, and pharmacy claims, lab test results, health assessments, service authorizations, and enrollee and provider information as required for QI Programs.

The EDW, powered by Teradata Extreme Data Appliance high performance technology, is the central hub for service information that allows collection, integration, and reporting of clinical claim/encounter data (medical, behavioral health, laboratory, pharmacy, and vision); financial information; medical management information (referrals, authorizations, health management); member information (current and historical eligibility and eligibility group, demographics, PCP assignment, member outreach); and provider information (participation status, specialty, demographics) as required by the QI Program. The Plan captures and utilizes data from both internal and subcontractor sources for administration, management and other reporting requirements and can also submit and receive data as well as interface with other systems, as necessary.

- **Statistical Analysis Software:** SAS is an integrated software suite for advanced analytics, business intelligence, data management, and predictive analysis.
- **R:** an open-source software environment for statistical computing and graphics. QI utilizes the R-Shiny package within R to build and display interactive dashboards.
- **Power BI,** a Microsoft product that transforms raw plan data from multiple sources into actionable insights through interactive dashboards, real-time analytics, and secure, collaborative sharing. It boosts efficiency by enabling data-driven QI decision-making, streamlining data visualization, and offering, mobile accessibility for quick, informed actions driving QI programs.
- **MicroStrategy:** MicroStrategy is an enterprise business intelligence (BI) application software vendor. The MicroStrategy platform supports interactive dashboards, scorecards, highly formatted reports, ad hoc query, thresholds and alerts, and automated report distribution.
- **Inovalon's Converged Analytics:** A HEDIS-certified software system used to optimize quality measurement, reporting, and improvement initiatives. Converged Analytics is an NCQA-certified software; its primary use is for the purpose of building and tabulating HEDIS performance measures. Enables the Plan to integrate claims, member, provider and supplemental data into a single repository, by applying a series of clinical rules and algorithms that automatically convert raw data into statistically meaningful information.
- **Cozeva:** A value-based NCQA-certified care operating system with reporting and analytics functionality, offers up-to-date information on quality and risk measures to plan providers. Cozeva gives providers visibility to provider-level incentives, and supports supplemental data submissions, data integrations with EMRs, and biweekly data syncs to CAIR and various EHR systems. Provider groups have the ability to track and trend performance of their providers to better monitor, understand, and take action on performance gaps through customizable dashboards.
- **Tableau:** Tableau is a data visualization tool which connects easily to several data sources and allows for rapid insight by transforming data into dashboards and are also interactive. Quality uses this software for plotting data on maps and displaying outcomes through dash-boarding.
- **Quest Analytics:** Quest analytics allows geo-mapping to conduct analysis on provider and facility access and compliance for our membership.
- **Operational Data Warehouse (ODW),** a hardware that supports Health Net's claims payment system called Automated Benefits System (ABS). Claims, encounters, member and provider information that are processed in ABS are stored in ODW. (Decommissioning and migration to Snowflake Cloud Platform started in 2023) AMISYS Advance, a claims processing engine with extensive capabilities for administration of multiple provider payment strategies. AMISYS Advance receives appropriate enrollee and provider data systematically; receives service authorization information in near real time from TruCare; and is integrated with our encounter production and submission software.
- **Snowflake Platform,** is the next generation of the Enterprise Data Warehouse built on top of the Snowflake platform. The platform allows the organization to unify, analyze, and share health plan data securely through a cloud-native platform. It consolidates data from disparate sources into a single, managed platform for data warehousing, data lakes, and AI/ML, enabling advanced analytics, while providing built-in security, compliance, and auditing tools to monitor data quality and manage access.
- **TruCare:** Enrollee-centric health management platform for collaborative care coordination and management; and behavioral health, disabling condition, and utilization management. Integrated with Centelligence™ for access to supporting clinical data,

TruCare allows Population Health and Clinical Operations staff to capture utilization, care and population-based chronic conditions data; proactively identify, stratify, and monitor high-risk enrollees; consistently determine appropriate levels of care through integration with InterQual Criteria and capture the impact of our programs and interventions.

- **OMNI:** The call center application with guided workflows and business process drivers that allow the business better flexibility and integration with other systems and with changing environments. OMNI application is used to research, record and share information between providers and members.
- **PRIME:** A system application used by employees to handle complaints, grievances and appeals. PRIME includes business process management features that integrate with upstream applications, including Membership, Provider Authorizations and OMNI.

V. QI Program Activities

QI Program activities are selected based on their relevance to CHPIV's membership, the ability to affect a significant portion of the population or the population at-risk and their potential impact on high-volume, high-risk or high-cost conditions or services. Morbidity, mortality and vulnerable groups with special needs are considered in the selection process as well as race, ethnicity, and language disparities.

CHPIV fosters a multi-disciplinary approach to the quality improvement process and involves all functional areas with direct impact on quality and safety of care and service. Activities involve Health Net departments and collaborations with network providers, community entities including public health, quality improvement organization and behavioral health (see QIHed Work Plan for details of performance improvement goals, objectives, and activities). The QI Program uses PDSA cycles as one method for monitoring quality improvement activities.

A. Projects, Surveys and Audits

Issues/topics are selected based on identified opportunities for improvement through member and provider input, nationally and regionally identified or mandated projects, HEDIS, CAHPS/ECHO/OPMH Survey measurement and participation in regional and national coalitions.

B. Incentive Programs

CHPIV rewards targeted members for healthy behaviors and collaborates with providers to build performance-based incentive programs. Development and implementation of incentives are aligned with CHPIV's provider partnership, and strategies.

Member

- CHPIV rewards targeted members for healthy behaviors and engagement with their providers through the Quality EDGE program. The development and implementation of these incentives align with CHPIV's provider partnership strategies and the principles of the Quadruple Aim.

Provider

- CHPIV offers tailored provider and PPG incentive programs that drive quality improvement through enhanced HEDIS performance and complete encounter submissions.

VI. Provider Communications

Effective communication with network providers and subcontractors is crucial in advancing Community Health Plan of Imperial Valley's quality improvement initiatives, studies, and fulfilling contractual obligations. Engagement with the Quality Improvement Health Education (QIHED) Program is facilitated through various methods, including:

- Practitioner and provider office visits: Conducted by designated members to ensure direct and personalized communication.
- Online training and educational webinars: These resources provide continuous learning opportunities and keep participants informed about the latest guidelines and best practices.
- Joint Operation Meetings (JOMs) and work groups: These collaborative forums foster active participation and dialogue, ensuring alignment with quality improvement goals.

This structured approach ensures that all participants are well-informed and actively contributing to Community Health Plan of Imperial Valley's mission of enhancing health care quality and efficiency.

To keep health care providers informed about QIHED and Wellness program activities, modifications and outcomes, as well as available quality resources and programs, several key methods are utilized. The resources described below can be accessed through the Provider Library at providerlibrary.healthnetcalifornia.com or on other provider resource pages available on the Health Net website at healthnet.com. Additionally, CHPIV's provider resource webpage redirects providers to the Health Net Provider Library.

Available Resources

- Provider Operations Manuals and Medi-Cal Operations Guides: Comprehensive manuals and guides outlining the operational policies and procedures necessary for providers to effectively deliver services.
- Provider Updates and Letters: Regular updates and communications sent to providers to keep them informed about important changes and developments.
- Provider Newsletters: Quarterly newsletters offering insights and updates about various health programs, initiatives, engagement in our communities, and best practices.
- Forms and Reference Documents: Essential forms and reference materials needed for administrative and operational purposes.
- Educational Materials and Resources: Resources aimed at enhancing provider knowledge and skills related to QIHED and Wellness programs.

Communication Channels

Provider updates, letters, and educational materials and resources are distributed via multiple channels including fax, mail and email. Additionally, these communications and materials are available in the Provider Library at providerlibrary.healthnetcalifornia.com under the "Updates and Letters" section, or on other provider resource pages on the Health Net provider website at healthnet.com. Additionally, CHPIV's provider resource webpage redirects providers to the Health Net Provider Library.

VII. Corrective Actions

CHPIV takes timely and appropriate action to correct any significant or systemic problems identified through audits, internal reports, complaints, appeals, grievances, and delegation oversight activities.

VIII. Program Evaluation and Work Plan

A. Review and Oversight

The Local Health Commission is responsible for QI Program and annually receives reviews and approves the CHPIV QIHed Program Description, Work Plan and Program Evaluation. The CHPIV QIHEC submits regular reports to the Commission on quality findings related to monitoring and quality issues identified and activities initiated.

B. Annual QIHed Evaluation

The evaluation of the QIHed Program and Work Plan is based on the results of a systematic monitoring and assessment of QIHed efforts. It includes a summary of completed and ongoing QIHed activities, trending of measures to assess performance (quality of service and clinical care, and safety of clinical care), analysis of the results of QIHed initiatives (including barriers), and evaluation of the overall effectiveness of the QIHed program, which is conducted during the year. The process identifies program strengths and limitations, improvement opportunities and unfinished business. The QIHed Evaluation assesses the adequacy of resource allocations needed to plan and implement the QI activities and programs for the upcoming year. The annual QIHed Program Evaluation and Work plan are reviewed and approved by CHPIV QIHEC during the first quarter each year.

C. Annual QIHed Work Plan

The work plan documents the annual QIHed initiatives and defines goals, objectives, specific actions, responsible parties and time frames targeted for completion or resolution of activities that address quality and safety of clinical care and quality of service. The work plan builds on the recommendations and findings of the previous year's program evaluation. The work plan allows integration of QI reporting and studies from various CHPIV and HNCS departments and includes the requirements for both internal and external reporting. The CHPIV and HNCS staff, CHPIV QIHEC, and Local Health Commission utilize the work plan as a tool for monitoring the effectiveness of the CHPIV QIHed Program.

The structure of the work plan outlines the steps necessary to complete the QI cycle: monitoring, planning, implementation, action, assessment and evaluation of outcomes. Each individual department or functional unit retains the responsibility for the implementation and evaluation of their specific activities. It is a dynamic document that CHPIV, with HNCS's

assistance, updates regularly to reflect progress on QIHed activities throughout the year. The QIHed Work Plan documents the annual QIHed Program initiatives and delineates:

- Objectives, scope and population demographics.
- Improvement activities planned for the year covering quality and safety of clinical care, quality of service, and members' experience.
- Timeframes within which each activity is to be achieved and/or reported.
- Responsible department(s) and/or person(s) for each activity.
- Goals and benchmarks for each activity.
- Number of objectives met.
- Number of activities met.
- Planned monitoring of previously identified issues.
- Barriers identified when goals are not achieved.
- Follow-up action plan, including continuation status (close, continue, or continue with modifications).

IX. Confidentiality / Conflict of Interest

CHPIV's Compliance Department is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, appropriate and legitimate use, storage and disclosure of medical information in order to protect the privacy and confidentiality rights of members, employees, providers and the company. CHPIV and HNCS contracts require that providers and practitioners maintain the confidentiality of member information and records. Information or copies or records may be released only to authorized individuals as permitted by state and federal law.

As a public entity, the Plan's QIHEC is subject to the "open meeting" rules of the California Brown Act. Confidential matters presented to the Committee are discussed in a closed session, otherwise all other matters discussed at Committee meetings are open to the public and materials presented in the public portion of meetings are available to the public. Within CHPIV's internal operations, QI activities that will not be presented in the public Committee meetings are conducted and discussed under a code of confidentiality. All documents created as part of the QIHed Program are maintained in accordance with federal and state law. Materials pertaining to confidential QI review will be marked "confidential" and kept secure. CHPIV, HNCS, its providers, vendors and contracted or delegated entities are responsible for safeguarding all confidential materials.

CHPIV fully complies with the Health Insurance Portability and Accountability Act (HIPAA), which regulates the privacy of protected health information (PHI). CHPIV strictly prohibits any unlawful and unauthorized access to, use or disclosure of member or provider information. Members are informed of these rights through the distribution of the Notice of Privacy Practices.

CHPIV has policies and procedures for the collection, handling, storage and release of confidential information to protect the privacy and confidentiality rights of members, employees, providers and the company, and to ensure the appropriate and legitimate use of information. Prior to participation in the QI Program or its non-public committees (Credentialing and Peer Review Subcommittees), participants are educated regarding confidentiality requirements. The CHPIV Chief Compliance Officer is responsible for reviewing, approving and disseminating confidentiality policies and practices regarding the collection, use and disclosure of medical

information.

Conflict of Interest

No person(s) will be assigned or selected for a QIHEC where a conflict of interest exists. Physician members will not review or participate in the review of their own care, referrals, or of other practitioners they are in direct competition with or are associated with through financial arrangements. All Peer Review case presentations are blinded as to member and practitioner identification prior to committee review.

X. QI Program Information Availability

Information about CHPIV's QIHEd Program including program description, activities and progress toward goals is available upon request, to members, prospective members and providers. CHPIV notifies members of the availability of information about the QI Program through the member's evidence of coverage and through the annual member newsletter highlighting the QI Program. Network providers and subcontractors are notified of the availability of information about the QI Program through committee meetings, JOMs, new practitioner/provider welcome letters, Provider Updates (including updates regarding quality improvement findings and outcomes), and through the operations manuals available electronically in the Provider Library on Health Net's online provider portal.

XI. Approval

Imperial Local Health Commission Approval

The Imperial Local Health Commission has reviewed and approved this Program Description.

Lee Hindman, MD, Imperial Region
Local Health Commission Chairperson

Date

Gordon Arakawa, MD, Chief Medical Officer
Chair, CHPIV QIHEC

Date