PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MPQP1004 (previously QP100104)</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Internal Quality Improvement Committee</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 05/17/2000</td><td colspan="4">Next Review Date: 08/12/2026
Last Review Date: 08/13/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="3">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 08/13/2025</td></tr>
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I. RELATED POLICIES:

A. CMP10 – Confidentiality
B. CMP36 – Delegation Oversight and Monitoring
C. MPQP1002 – Quality/Utilization Advisory Committee
D. MPQP1003 – Physician Advisory Committee (PAC)

II. IMPACTED DEPTS:

A. All

III. DEFINITIONS:

A. IQI – Internal Quality Improvement Committee
B. PAC – Physician Advisory Committee
C. UM – Utilization Management
D. P&T – Pharmacy and Therapeutics Committee
E. Q/UAC – Quality/Utilization Advisory Committee
F. QI – Quality Improvement
G. NCQA – National Committee for Quality Assurance
H. Partnership Advantage: effective Jan. 1, 2027, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The Internal Quality Improvement (IQI) Committee is responsible for advising Partnership HealthPlan of California (Partnership) on quality activities at the health plan, with a goal of improving overall quality of care and service for members, providers and internal operations. Since quality activities are implemented through multiple departments, IQI is a cross-departmental team that reviews new or revised policies, delegation reports, initiatives, activities, and other reports under the purview of Health Services departments

(i.e., Quality Improvement, Care Coordination, Utilization Management, Enhanced Health Services, Population Health Management, Health Equity, Behavioral Health, and Pharmacy). IQI also reviews external-facing Grievance & Appeals, Provider Relations, Credentials, Network Services, Transportation, and Member Services policies. IQI reports to the Quality/Utilization Advisory Committee (Q/UAC), which ensures that plan activities comply with all state and regulatory requirements and meets current National Committee for Quality Assurance (NCQA) standards and guidelines.

VI. POLICY / PROCEDURE:

A. Committee Structure

1. Membership:

a. The IQI Committee is comprised of the following Partnership staff: (Standing committee members are required to appoint and send a designee if unable to attend)

Internal Quality Improvement Committee Standing Members	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy & Government Affairs Officer
	Regional Directors
	Compliance Manager, Grievance and Appeals
Configuration	Configuration Department Leadership
Finance	Director of Health Analytics
Health Services	Chief Medical Officer – Committee Chair
	Medical Director for Quality – Committee Vice Chair
	Medical Director for Medicare Services
	Regional Medical Director(s)
	Associate Medical Director(s)
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Senior Director of Care Management
	Behavioral Health Clinical Director
	Senior Director, Behavioral Health
	Director of Health Equity (Health Equity Officer)
	Director of Population Health
	Director of Quality Management
	Director of Pharmacy Services
	Director, Care Coordination
	Director, Utilization Management
	Director, Enhanced Health Services
	Associate Director(s), Utilization Management
	Associate Director, Population Health
	Manager of Care Coordination Regulatory Performance
	Manager of Member Safety - Quality Investigations
	Manager, Clinical Compliance – Quality Inspections
	Policy Analyst, Utilization Management

	Senior Health Educator
Member Services	Senior Director of Member Services & Grievance
Provider Relations/Network Services	Senior Director, Provider Relations
	Director of Network Services

   b. Standing members are responsible for maintaining an annual attendance rate of 75% or greater. Committee members may appoint a designee to attend.
2. Minutes: Minutes of all meetings are maintained according to the Confidentiality policy/procedure. Approved Minutes are submitted monthly to the Delegation Oversight Reporting Subcommittee (DORS) and Regulatory Affairs and Compliance (RAC) inboxes. RAC submits these Minutes to the Department of Health Care Services (DHCS).
3. Chair: The Chief Medical Officer (CMO) chairs the committee. The Medical Director for Quality serves as Vice Chair. In the event that neither is able to chair, the CMO will appoint a designee.
4. Meetings: The Committee meets at least 10 times a year with the option to add additional meetings if needed.
5. Voting: Standing Members, including the Regional Medical Directors and Associate Medical Directors specifically assigned by the CMO to sit on this committee, will vote and the Chair will acknowledge consensus.

B. Committee Responsibilities
1. Reviews policies and makes recommendations or revisions for effective monitoring and achievement of Quality Improvement (QI) objectives.
2. Monitors quality improvement projects across the organization that impact patient care, focusing on areas such as clinical outcomes, patient experience, including access and service, and cost efficiency.
3. Monitors utilization management activities for both medical and pharmacy management: denials, authorizations, appeals, etc.
4. Reviews policies and clinical guidelines that relate to physical health or behavioral services for our members, including credentialing, performance improvement initiatives, etc.
5. Reviews delegation reports for quality, utilization management, credentialing where concerns exist.
6. Reviews findings from regulatory audits and monitor progress on corrective action plans.
7. Reviews performance metrics (i.e., dashboards and indicator reports) and make recommendations for corrective action for indicators that are below established thresholds; assures appropriate follow-up on corrective actions that relate to quality of care and service concerns.
8. Makes recommendations in implementation of the "QI Trilogy" (i.e., the QI Program Description, Work Plan, and Evaluation), and the like "Grand Analyses" of Partnership's Care Coordination, Population Health, Health Equity, Pharmacy and Utilization Management departments, among others.
9. Oversees the activities of its subcommittees: the Population Needs Assessment (PNA) Committee, the Member Grievance Review Committee (MGRC), the Over/Under Utilization Workgroup, and the Substance Use Internal Quality Improvement Subcommittee (SUIQI).

C. Committee Accountability
1. IQI is accountable to the Q/UAC, and through this body, to the PAC and Partnership's Board of Commissioners.

D. Delegation Oversight and Monitoring
1. Partnership delegates quality improvement activities, responsibilities and committee structure.
2. A formal agreement is maintained and inclusive of all delegated functions.
3. Partnership conducts an audit not less than annually to ensure the appropriate policy and procedures are in place.
4. Results from Oversight and Monitoring activities shall be presented to DORS and RAC for review

and approval.

VII. REFERENCES:
N/A

VIII. DISTRIBUTION:
A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer/Committee Chair

X. REVISION DATES:
Medi-Cal
06/20/01; 09/18/02; 09/15/04; 03/15/06; 03/21/07; 02/20/08; 03/18/09; 04/21/10; 09/19/12; 10/16/13; 04/16/14; 04/15/15; 04/20/16; 04/19/17; *06/13/18; 05/08/19; 09/11/19; 04/08/20; 09/09/20; 09/08/21; 09/14/22; 09/13/23; 09/11/24; 04/09/25; 08/13/25

Partnership Advantage (effective Jan. 1, 2027)
N/A

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
PartnershipAdvantage
MPQP1004 – 03/21/2007 to 01/01/2015

Healthy Kids- 3/21/20017 to 12/01/2016 (Healthy Kids program ended 12/01/2016)