24. PROGRAM DESCRIPTIONS

A. Disability Program Description

Disability Program Overview

A. **Mission**

IEHP Disability Program's mission is to improve access, communication, and health care services for seniors and persons with disabilities (SPD) and any other IEHP Members, prospective Members, and community stakeholders, with access and/or functional needs. The Disability Program implements, administers and coordinates the Plan's disability programs and services. IEHP is a Public Entity that complies with the Americans with Disabilities Act (ADA).[1] The Disability Program fulfills its mission through the following activities:

1. Recommend and implement program changes that promote access to barrier-free and culturally appropriate health care services for Members, prospective Members, and community stakeholders who are SPD;
2. Participate in committees and workgroups to ensure cross-departmental program deliverables are accessible and appropriate for Members who are SPD, prospective Members, and community stakeholders;
3. Launch and coordinate initiatives that improve Members' and prospective Members' physical access to services, offer communication in alternative formats, and maintain culturally appropriate access to all health plan services;
4. Provide trainings, resources, and technical assistance to IEHP Team Members and the IEHP Provider network; and
5. Engage in outreach activities to develop and maintain meaningful relationships with community-based organizations that provide Members, prospective Members, and community stakeholders, with access to social community-based supports that promote health, education, and independence.

Disability Program Activities

IEHP has undertaken the following activities to help provide optimal services to Members, prospective Members, and community stakeholders:

A. **Disability Program Health Services**

1. Review policies and procedures to improve the ability to meet the needs of our Members, prospective Members, and community stakeholders;
2. Facilitate the Persons with Disabilities Workgroup (PDW) and seek their advice on the delivery of health care services;

[1] Coordinated Care Initiative (CCI) Three-Way Contract September 2019 Section 2.9

3. Promote Member-centric care through the implementation and ~~serving on~~participation in an Interdisciplinary Care Team (ICT) comprised of medical, behavioral, and social service professionals from governmental and community-based organizations;[2]
4. Participate in departmental and unit meetings including, but not limited to: Behavioral Health and Care Management, Grievance and Appeals, and Quality Management;
5. Assess the needs of Members with disabilities by analyzing responses to the Consumer Assessment of Health Plan Services (CAHPS) and Population Needs Assessment (PNA);[3] and
6. Develop and maintain a community resource database, and provide resources for care managers, nurses, and Member Services Representatives.

B. **Disability Program Access**

1. Serve as an internal consultant in the Facility Site Review process and recommend best practices for the dissemination of accessibility information in the IEHP Provider Directory and IEHP website;[4,5,6]
2. Develop and maintain a current, accessible online resource center on the IEHP website for health Providers, IPAs, and other stakeholders to ensure care is accessible and culturally sensitive for people with diverse disabilities;
3. Conduct live trainings for Providers on enhancing access to medical care for Members with disabilities;
4. Examine accessibility at IEHP's physical building and recommend modifications as necessary including automatic door openers, lowered sinks in restrooms, automatic water and soap dispensers, and assistive listening devices for PA system in meeting rooms;[7] ~~and~~
5. Offer "text-only" navigation on our website (www.iehp.org) and ensure compliance with access standards~~.~~; and
6. Publish a quarterly Member newsletter ("accessAbility") to provide targeted communication for Members with disabilities~~;~~.

[2] ~~CCI Three-Way Contract September 2019, Section 2.5~~
[3] ~~NCQA, 20212 Health Plan (HP) Standards and Guidelines, PHM 2, Element B, Factor 4~~
[4] ~~NCQA, 20212 HP Standards and Guidelines, MED 12, Element A, Factor 3~~
[5] ~~NCQA, 20221 HP Standards and Guidelines, MED 3, Element A, Factor 1~~
[6] ~~NCQA, 20221 HP Standards and Guidelines, MED 3, Element A, Factor 2~~
[7] Medicare Managed Care Manual, "Chapter 6 – Relationships with Providers", Section 60.3

24. PROGRAM DESCRIPTIONS

A. Disability Program Description

C. Disability Program Communication

1. Upon request, provide educational materials in alternative formats to Members, prospective Members, and/or their authorized representative including but not limited to: Braille, large-sized print, video or audio, CD or DVD, over the phone or in-person from a qualified health educator;[8] [9] [10] [11] [12] [13]

2. ~~2.~~ Ensure effective communication with individuals with disabilities through the provision of appropriate auxiliary aids and qualified interpretation services for impaired sensory, manual, and/or speaking skills;[14]

~~2.~~3. Integrate policies for providing sign language interpreters and materials in alternative formats;

~~3.~~4. Monitor IPA requests and distribution of materials in alternative format with Delegation Oversight Department;

~~4.~~5. Provide communication via TTY, Video Remote Interpreting service and Video Phone for Members, prospective Members, and community stakeholders, who are deaf and hard-of-hearing; ~~and~~

6. Work with the Center on Deafness Inland Empire (CODIE) and other organizations for the deaf or hard-of-hearing to publicize Member, and prospective Member access to sign language interpreter services while accessing health plan services; and~~.~~

~~5.~~7. ~~7.~~ Publish a quarterly Member newsletter ("accessAbility") to provide targeted communication for Members with disabilities.

D. Disability Sensitivity

1. Develop ~~and provide~~ cultural awareness and sensitivity training materials and provide training ~~to~~ to IEHP Team Members, IPAs, ~~and~~ Providers and their staff, initially and as

[8] Title 42 Code of Federal Regulations (CFR) § 438.10(d)
[9] ~~DHCS All Plan Letter (APL) 18-016 Supersedes APL 11-018 "Readability and Suitability of Written Health Education Material"~~
[10] ~~NCQA, 2021 HP Standards and Guidelines, MED 13, Element B~~
[11] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 10.4.4
[12] ~~CCI Three-Way Contract September 2019, Section 2.17~~
[13] ~~Knox-Keene Health Care Service Plan Act of 1975,~~California Health & Safety Code (Health & Saf. Code) § 1367.042
[14] ~~DHCS All Plan Letter (APL) 21-004, "Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services"~~42 CFR § 92.101 and 92.102

needed, to meet the needs of SPDs as required by the California Department of Health Care Services and Centers for Medicare and Medicaid Services.[15, 16,17]

~~Train IEHP Team Members, and Providers, and Provider's staff, oon cultural awareness and sensitivity training to meet the needs of SPDs as required by the California Department of Health Care Services and Centers for Medicare and Medicaid Services.~~

~~1.~~2. Coordinate the annual Disability Sensitivity/Awareness Month with activities that include presentations, guest speakers, community resource fair, classes and demonstrations on deaf awareness, sign language, assistive technology devices, and sports and recreation equipment.

~~E.~~ Disability Program Personnel

Reporting relationships, qualifications, and position responsibilities are defined as follows (further details can be found in the Human Resources manual):

A. **Program Manager**

1. Under the direction of Community Health leadership, which includes the designated ADA Coordinator (if not ~~solely~~ also the Program Manager)~~.~~,~~,~~ ~~T~~the Program Manager is responsible for administering IEHP's program for Seniors and Persons with Disabilities, including outreach plan implementation, cross-department program deliverables coordination, and external operational coordination with regulatory agencies and stakeholders. The Program Manager will review health care related legislation and assess their impact on IEHP's Disability Program, as well as manage IEHP's Persons with Disabilities Workgroup and recommend and implement program changes as necessary to meet Disability Program goals. The Program Manager may also serve as and/or support the designated ADA Coordinator.[18]
2. The qualifications for this position include a Master's degree~~,~~ from an accredited institution in Social Work, Public Administration or closely related field required. The Program Manager's staff consist of Community Health Representatives, Project Analyst, Coordinators and Administrative Assistant.[19]

[15] ~~Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.9~~
[16] ~~DHCS APL 11-010, "Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities"~~

[18] ~~CCI Three-Way Contract September 2019, Section 2.11~~
[19] ~~CCI Three-Way Contract September 2019, 2.9~~

24. PROGRAM DESCRIPTIONS

A. Disability Program Description

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2012
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

24. PROGRAM DESCRIPTIONS

B. Cultural and Linguistic Services Program Description

Cultural and Linguistic (C&L) Services Program Overview

A. **Mission**

To ensure that all medically necessary and covered services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, gender identity, marital status, sexual orientation, health status, evidence of insurability (including conditions arising out of acts of domestic violence), source of payment, limited English proficiency or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.[1,2,] The C&L Services program fulfills its mission through the following activities:

1. Ensuring IEHP, its IPAs and Provider network comply with Department of Health Care Services (DHCS) and Federal regulations on Culture and Linguistic services;
2. Establishing methods that ensure and promote access and delivery of services in a culturally competent manner to all Members, including people with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity;[3,4]
3. Providing training, support, technical assistance and resources to IPAs and Providers to assist them in the provision of culturally competent and linguistic services;
4. Training IEHP staff on cultural awareness within the first year of employment and provide updates on C&L resources;[5,6]
5. Program staff participate in committees and workgroups to ensure cross-departmental program deliverables are accessible and appropriate for Members in need of C&L services;
6. Participating in Public Policy Participation Committee (PPPC) comprised of IEHP leaders and health educators, Providers, Members, and community-based organization representatives and seeking their advice on the delivery of C&L services; and
7. Implementing activities to educate Team Members on cultural diversity in the Member and Provider network, and raising awareness of IEHP C&L policies and resources.

Cultural & Linguistic Services Program Activities

A. **Member Health Educational Materials**

The Health Education, Marketing, and Independent Living and Diversity Services Departments review and approve externally and internally developed Member health

[1] Title 45 Code of Federal Regulations (CFR) 92.101(a)
[2] 42 CFR § 440.262
[3] 42 CFR § 422.2268(a)(7)
[4] Title 42 United States Code (USC), § 18116
[5] Title 28 California Code of Regulations (CCR) § 1300.67.04
[6] 42 CFR § 440.262

education materials for readability, content, accuracy, cultural appropriateness and non-discrimination using the DHCS Readability and Suitability Checklist. Materials are reviewed every five (5) years or at the time material is updated or changed. Member health education materials must be available to Members in the threshold languages and alternate formats upon request.[7]

B. **Coordination of Local Resources**

IEHP refers Providers, Members, prospective Members, and community stakeholders to existing resources in the community through IEHP's Resource and Referral Service managed by the Independent Living and Diversity Services Department and IEHP's Long Term Services and Supports unit. IEHP also collaborates with 2-1-1 and Connect IE, a community resource referral service in San Bernardino and Riverside Counties to provide Members, prospective Members, and community stakeholders with up-to-date information on health, C&L and social services in their community.[8]

C. **Policy Development**

The Independent Living and Diversity Services Department assists in interpreting State and Federal requirements for C&L and develops policies and procedures for IEHP Members and Provider network. Policy development includes setting standards specific to IEHP and informing IPAs and Providers of the standards.

D. **Development of Language Interpretation Resources**

IEHP assists Providers in providing linguistically appropriate care to Limited English Proficient (LEP) Members and/or their authorized representatives, and Members and/or their authorized representatives who need sign language interpretation by assuming financial responsibility and arranging for interpretation services. IEHP contracts with interpreter agencies to provide adequate access to interpretation services. These services include, but are not limited to, telephonic and in-person foreign language, in-person or Video Remote (used when in-person services are not available or timely), sign language interpretation services for Members.[9,10]

E. **Access Provider Linguistic Capabilities**

When Members are assigned to Primary Care Providers (PCPs), one of the criteria considered is the specified language capability of Providers and staff in that office. Providers are required to submit their language capability upon application to the Plan, and the language(s) are listed in the Provider Directory. To ensure continued availability of the threshold language(s), the

[7] Department of Healthcare Services (DHCS) All Plan Letter (APL) 21-004, "Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services"
[8] DHCS APL 99-005, "Cultural Competency in Health Care - Meeting the Needs of a Culturally and Linguistically Diverse Population"
[9] 42 CFR § 43.10(d)
[10] 28 CCR § 1300.67.04

IEHP Provider Services Department performs an annual language competency audit to verify this information.[11]

F. **Cultural and Linguistic Training**

Training on cultural competence/sensitivity and IEHP C&L Program policies is available to IPAs and Providers' offices initially and annually thereafter. Providers that are new to the IEHP Network are required to receive training in cultural competency, IEHP C&L standards, and IEHP C&L resources provided by the Provider Services Representatives and other appropriate IEHP Team Members. Providers can also participate in the following online cultural competency trainings:

1. Office of Minority Health – https://www.thinkculturalhealth.hhs.gov/
2. CDC – https://www.cdc.gov/healthliteracy/index.html
3. U.S. Department of Health and Human Services, Health Resources and Services administration – https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/resources/

All new employees receive cultural awareness training within their first year of employment.[12] The Independent Living and Diversity Services Department coordinates and implements activities to raise awareness of C&L resources and disseminates information to Team Members (e.g., C&L Awareness Weeks, JIVE Postings).

Cultural & Linguistic Services Program Development and Evaluation

A. IEHP develops its C&L services program using key resources for guidance including but not limited to:[13]

1. A Practical Guide to Implementing the National CLAS Standards: For Racial, Ethnic and Linguistic Minorities, People with Disabilities, and Sexual and Gender Minorities;
2. Guide to Developing a Language Access Plan; and
3. Providing Language Services: Lessons from the Field.

~~A.~~B. IEHP conducts processes to monitor the delivery of and evaluates the impact and/or outcome of C&L services and programs, and takes effective action to address any improvements as needed. Program evaluation activities include, but are not limited to:[14]

1. Assessing Providers' adherence to program standards based on quality activities and Member grievances;
2. Tracking use of interpretation services; and

[11] 28 CCR § 1300.67.04
[12] 42 CFR § 440.262
[13] Medicare Managed Care Manual, "Chapter 4 – Benefits and Beneficiary Protections, Section 10.5.2

3. Assessing impact of training or cultural awareness events on Team Members through Team Members feedback.

Cultural and Linguistic Services Personnel

A. Program Manager

1. Under direction from Community Health leadership, the Program Manager oversees the C&L Program. The qualifications for this position include a Master's degree from an accredited institution in Social Work, Public Administration or closely related field required. The Program Manager staff consist of Community Health Representatives, Project Analyst, Coordinators and Administrative Assistant.

24. PROGRAM DESCRIPTIONS

B. Cultural and Linguistic Services Program Description

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2012
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

24. PROGRAM DESCRIPTIONS

C. Quality Management and Quality Improvement Program Description

Introduction

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

Mission, Vision, and Values

IEHP's Mission, Vision, and Values (MVV) aims to improve the quality of care, access to care, patient safety, and quality of services delivered to IEHP Members. The organization prides itself in six (6) core goals:

A. *Mission:* We heal and inspire the human spirit.

B. *Vision:* We will not rest until our communities enjoy optimal care and vibrant health.

C. *Values:* We do the right thing by:

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

QM/QI Program Overview

QM/QI Program Purpose

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

24. PROGRAM DESCRIPTIONS

C. Quality Management and Quality Improvement Program Description

QM/QI Program Scope

A. The Quality Management Committee (QMC) approves the QM/QI Program annually. The QM/QI Program review includes approval of the QM/QI Program Description, QM/QI Work Plan, and QM Annual Evaluation to ensure ongoing performance improvement. The QM/QI Program is designed to improve all aspects of care delivered to IEHP Members in all health care settings by:

1. Defining the Program structure;[1]
2. Assessing and monitoring the delivery and safety of care;
3. Assessing and monitoring Health Services Clinical Integration & Operations management provided to Members, including behavioral health and care management services;[2]
4. Supporting Practitioners and Providers to improve and maintain the safety of their practices;
5. Overseeing IEHP's QM functions through the QM Committee;
6. Involving designated Physician(s) and staff in the QM/QI Program;
7. Involving a Behavioral Healthcare Practitioner in the behavioral health aspects of the Program;[3]
8. Involving Long- Term Services and Supports (LTSS) Provider(s) in the QM/QI Program;
9. Reviewing the effectiveness of LTSS programs and services;[4]
10. Ensuring that LTSS needs of Members are identified and addressed leveraging available assessment information;
11. Identifying opportunities for QI initiatives, including the identification of health disparities among Members;
12. Implementing and tracking QI initiatives that will have the greatest impact on Members;
13. Measuring the effectiveness of interventions and using the results for future QI planning;
14. Establishing specific role, structure and function of the QMC and other committees, including meeting frequency;

[1] National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, QI 1, Element A, Factor 1
[2] NCQA, 2022 HP Standards and Guidelines, QI 1, Element A, Factor 2
[3] NCQA, 2022 HP Standards and Guidelines, QI 1, Element A, Factor 4
[4] Ibid.

15. Reviewing resources devoted to the QM/QI Program;
16. Assessing and monitoring delivery and safety of care for the IEHP population with complex health needs and Seniors and Persons with Disabilities (SPD);
17. Assessing and monitoring processes to ensure the Member's cultural, racial, ethnic, and linguistic needs are being met; and
18. Reviewing grievances and appeals data and other pertinent information in relation to Member safety and care rendered at Provider practices/facilities.

QM/QI Program Goals[5]

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

[5] NCQA, 2022 HP Standards and Guidelines, QI 1, Element A, Factor 1

24. PROGRAM DESCRIPTIONS

C. Quality Management and Quality Improvement Program Description

Authority and Responsibility[6]

A. The QM/QI Program includes tiered levels of authority, accountability, and responsibility related to quality of care and services provided to Members. The line of authority originates from the Governing Board and extends to Practitioners through different subcommittees. Further details can be found in the IEHP organizational chart.[7]

IEHP Governing Board

A. IEHP was created as a public entity with the initiation of a Joint Powers Agency (JPA) agreement between Riverside and San Bernardino Counties to serve eligible residents of both counties. Two (2) members from each County Board of Supervisors and three (3) public members selected from the two (2) counties sit on the Governing Board. The Governing Board is responsible for oversight of health care delivered by contracted Providers and Practitioners. The Board provides direction for the QM/QI Program; evaluates QM/QI Program effectiveness and progress; and evaluates and approves the annual QM/QI Program Description and Work Plan. The Quality Management Committee (QMC) reports delineating actions taken and improvements made are reported to the Board through the Chief Medical Officer (CMO) and Chief Quality Officer (CQO).

B. The Board delegates responsibility for monitoring the quality of health care delivered to Members to the CMO, CQO, and the QMC with administrative processes and direction for

[6] NCQA, 2022 HP Standards and Guidelines, QI 1, Element A, Factor 1
[7] NCQA, 2022 HP Standards and Guidelines, QI 1, Element A, Factor 1

the overall QM/QI Program initiated through the CMO and CQO, or Medical Director designee.[8,9]

Role of the Chief Executive Officer (CEO)

A. Appointed by the Governing Board, the CEO or designee has the overall responsibility for IEHP management and viability. Responsibilities include but are not limited to: IEHP direction, organization, and operation; developing strategies for each Department including the QM/QI Program; position appointments; fiscal efficiency; public relations; governmental and community liaison; and contract approval. The CEO reports to the Governing Board and is an ex officio member of all standing Committees. The CEO interacts with the CMO and CQO regarding ongoing QM/QI Program activities, progress toward goals, and identified health care problems or quality issues requiring corrective action.

Role of the Chief Medical Officer (CMO)[10]

A. The Chief Quality Officer (CMO) or designee has ultimate responsibility for the quality of care and services delivered to Members and has the highest level of oversight for IEHP's QM/QI Program. The CMO must possess a valid Physician's and Surgeon's Certificate issued by the State of California and certification by one of the American Specialty Boards. The CMO reports to the CEO and Governing Board. As a participant of various Subcommittees, the CMO provides direction for internal and external QM/QI Program functions and supervision of IEHP staff.

B. The CMO or designee participates in quality activities as necessary; provides oversight of IEHP credentialing and re-credentialing activities and approval of IEHP requirements for IEHP-Direct Practitioners; reviews credentialed Practitioners for potential or suspected quality of care deficiencies; provides oversight of coordination and continuity of care activities for Members; provides oversight of patient safety activities; and proactively incorporates quality outcomes into operational policies and procedures.

C. The CMO or designee provides direction to the QMC and associated Subcommittees; aids with study development; and facilitates coordination of the QM/QI Program in all areas to provide continued delivery of quality health care for Members. The CMO assists the Chief Network Development Officer with provider network development, contract and product design. In addition, the CMO works with the Chief Financial Officer (CFO) to ensure that financial considerations do not influence the quality of health care administered to Members.

D. The CMO acts as primary liaison to regulatory and oversight agencies including, but not limited to: the Department of Health Care Services (DHCS), Department of Managed Health

[8] Ibid.
[9] NCQA, 2022 HP Standards and Guidelines, QI 1, Element A, Factor 3
[10] Ibid.

Care (DMHC), Centers for Medicare and Medicaid Services (CMS), and the National Committee for Quality Assurance (NCQA), with support from Health Services staff as necessary.

Role of the Chief Quality Officer (CQO)

A. The Chief Quality Officer is responsible for leading quality strategy for IEHP. This includes the development of new, innovative solutions and quality measures in preventative health and improved quality of care for Members. The CQO reports to the CEO and Governing Board and must possess a valid Physician's and Surgeon's Certificate issued by the State of California and certification by one of the American Specialty Boards. The CQO works with the CEO and Chief Officers to establish goals and priorities for the quality strategy as well as communicating those goals to the Governing Board and its key stakeholders—the IEHP Provider network, regulatory and accrediting bodies. As a participant of various Subcommittees, the CQO provides direction for internal and external QM/QI Program functions and supervision of IEHP staff.

B. Along with the CMO, the CQO or designee, provides direction to the QMC and associated Subcommittees; aids with quality study development; and facilitates coordination of the QM/QI program in all areas to provide continued delivery of quality health care for Members.

C. The CQO initiates and leads initiatives for continuous quality improvement and evaluating the effectiveness of interventions across the continuum of care to Members, Providers and internally. The CQO also collaborates with state/federal regulatory agencies, accrediting bodies, and internal Government Relations, Compliance, and Legal leadership staff to ensure all quality and regulatory compliance requirements are met.

D. The CQO provides leadership, develops strategies, and administers programs for accreditation, monitoring, HEDIS operations, reporting, quality scorecard reporting, and quality-related new business development.

Quality Management Committee (QMC)

A. The QMC reports to the Governing Board and retains oversight of the QM/QI Program with direction from the CMO and CQO.[11] The QMC promulgates the quality improvement process to participating groups and Physicians, Providers, Subcommittees, and internal IEHP functional areas with oversight by the CMO and CQO.

   1. **Role**: The QMC is responsible for continuously improving the quality of care for IEHP Membership.

   2. **Structure:** The QMC is composed of Network Providers, Specialists, Medical Directors, IPA Medical Directors who are representative of network Practitioners, Practicing

[11] NCQA, 2022 HP Standards and Guidelines, QI 1, Element A, Factor 5

Pharmacists, and Public Health Department Representatives from Riverside and San Bernardino County. These individuals provide expertise and assistance in directing the QM/QI Program activities. A designated Behavioral Healthcare Practitioner is an active Member of the IEHP QM Committee to assist with behavioral healthcare-related issues.[12] IEHP attendees include multi-disciplinary representation from multiple IEHP Departments including but not limited to:

a. Quality Management;

b. Utilization Management;

c. Behavioral Health and Care Management;

d. Pharmaceutical Services;

e. Member Services;

f. Family and Community Health;

g. Health Education;

h. Grievance & Appeals;

i. Quality Informatics;

j. HealthCare Informatics;

k. Independent Living and Diversity Services;

l. Compliance; and

m. Provider Services.

3. **Function**: The QMC meets quarterly and reports findings, actions, and recommendations to the IEHP Governing Board annually (through the CMO) and reports meeting minutes to DHCS quarterly. The QMC seeks methods to increase the quality of health care for IEHP Members; recommend policy decisions; analyze and evaluate QI activity results; institute and direct needed actions; and ensures follow-up as appropriate. The Committee provides oversight and direction for Subcommittees, related programs, activities, and reviews and approves Subcommittee recommendations, findings, and provides direction as applicable. QMC findings and recommendations are reported through the CMO to the IEHP Governing Board on an annual basis.[13]

4. **Quorum**: Voting cannot occur unless there is a quorum of voting Members present. For decision purposes, a quorum can be composed of one (1) of the following:

[12] NCQA, 2022 HP Standards and Guidelines, QI 1, Element A, Factor 4
[13] NCQA, 2022 HP Standards and Guidelines, QI 1, Element A, Factor 5

a. The Chairperson or IEHP Medical Director and two (2) appointed physician Committee Members.

b. A Behavioral Health Practitioner must be present for behavioral health issues.[14]

c. Non-physician Committee Members may not vote on medical issues.[15]

5. **External Committee Members:** QMC members must be screened to ensure they are not active on either the Office of Inspector General (OIG) or General Services Administration (GSA) exclusion lists.

   a. The Compliance and QM departments collaborate to ensure committee members undergo an OIG/GSA exclusion screening prior to scheduling QMC meetings.

   b. IEHP utilizes the OIG Compliance Now (OIGCN) vendor to conduct the screening of covered entities on behalf of IEHP. In the event, any member of the QMC, or prospective member, is found to be excluded per OIGCN, the Compliance Department will notify the QM department so that they may take immediate action.

   c. QMC members must be screened before being confirmed, and monthly thereafter.

   d. QM notifies the Compliance department of any membership changes in advance of the QMC meeting so that a screening can be conducted prior to the changes taking effect.

6. **Confidentiality:** All QMC minutes, reports, recommendations, memoranda, and documented actions are considered quality assessment working documents and are kept confidential. IEHP complies with all State and Federal regulatory requirements for confidentiality. All records are maintained in a manner that preserves their integrity to assure Member and Practitioner confidentiality is protected.

   a. All members, participating staff, and guests of the QMC and Subcommittees are required to sign the Committee/Subcommittee Attendance Record, including a confidentiality statement.

   b. The confidentiality agreements are maintained in the Practitioner files as appropriate.

   c. All IEHP staff members are required to sign a confidentiality agreement upon hiring. The confidentiality agreements are maintained in the employee files as appropriate.

   d. All peer review records, proceedings, reports, and Member records are maintained in in accordance with state, federal and regulatory requirements to ensure confidentiality.

[14] NCQA, 2022 HP Standards and Guidelines, QI 1, Element A, Factor 4
[15] Ibid.

e. IEHP maintains oversight of Provider and Practitioner confidentiality procedures. See policy 7B, "Information Disclosure and Confidentiality of Medical Records."

7. **Enforcement/Compliance:** The QM Department is responsible for monitoring and oversight of QMC's enforcement of compliance with IEHP standards and required activities. Activities can be found in sections of manuals related to the specific monitoring activity. The general process for obtaining compliance when deficiencies are noted, and Corrective Action Plans (CAP) are requested, is delineated in internal and external policies.
8. **Data Sources and Support:** The QM/QI Program utilizes an extensive data system that captures information from claims and encounter data, enrollment data, Utilization Management (UM), QM and QI activities, behavioral health data, pharmaceutical data, grievances and appeals, and Member Services, among others.
9. **Affirmation Statement**: The QM/QI Program assures that utilization decisions made for IEHP Members are based solely on medical necessity. IEHP does not compensate or offer financial incentives to Practitioners or individuals for denials of coverage or service or any other decisions about Member care.[16] IEHP does not exert economic pressure to Practitioners or individuals to grant privileges that would not otherwise be granted or to practice beyond their scope of training or experience.
10. **Availability of QM/QI Program Information**: IEHP has developed an overview of the QM/QI Program and related activities. This overview is on the IEHP website at www.iehp.org and a paper copy is available to all Members and/or Practitioners upon request by calling IEHP Member Services Department. Members are notified of the availability through the Member Handbook.[17,18] Practitioners are notified in the Provider Manual. The IEHP QM/QI Program Description and Work Plan are available to IPAs and Practitioners upon request. A summary of QM activities and progress toward meeting QM goals are available to Members, Providers, and Practitioners upon request.
11. **Conflict of Interest**: IEHP monitors IPAs for policies and procedures and signed conflict of interest statements at the time of the Delegation Oversight Annual Audit.

Quality Subcommittees

A. Subcommittee and functional reports are submitted to the QMC on a quarterly and ad hoc basis. The following Subcommittees, chaired by the IEHP CMO or designee, report findings

[16] NCQA, 2022 HP Standards and Guidelines, MED 9, Element D
[17] Title 28, California Code of Regulations § 1300.69(i)
[18] NCQA, 2022 HP Standards and Guidelines, MED 8, Element D

and recommendations to the QMC:[19]

1. Quality Improvement Council (QIC);
2. Peer Review Subcommittee;
3. Credentialing Subcommittee;
4. Pharmacy and Therapeutics Subcommittee; and
5. Utilization Management Subcommittee.

Quality Improvement Council (QIC)

A. The Quality Improvement Council (QIC) is responsible for quality improvement activities for IEHP.

1. **Role:** The QI Council reviews reports and findings of studies before presenting to the QMC and works to develop action plans to improve quality and study results. In addition, QI Council directs the continuous monitoring of all aspects of Behavioral Health and Care Management (BH & CM) and Health Services Clinical Integration & Operations Management (PHM) services provided to Members.
2. **Structure:** The QI Council is composed of representation from multiple internal IEHP Departments including but not limited to: Quality Systems, Behavioral Health & Care Management, Health Services Clinical Integration & Operations Management, Grievance and Appeals, Utilization Management, Compliance, Community Health, HealthCare Informatics, Health Education, Member Services, and Provider Services. The QI Council is facilitated by the Vice President of Quality or designee. Network Providers, who are representative of the composition of the contracted Provider network, may participate on the subcommittee that reports to the QMC.
3. **Function**: The QI Council analyzes and evaluates QI activities and report results; develops action items as needed; and ensures follow-up as appropriate. All action plans are documented on the QI Council Work Plan.
4. **Frequency of Meetings:** The QI Council meets monthly with ad hoc meetings conducted as needed.

Peer Review Subcommittee

A. The Peer Review Subcommittee is responsible for peer review activities for IEHP.

1. **Role:** The Peer Review Subcommittee reviews quality performance profiles of Practitioners identified during the Peer Review Program activities that may include escalated cases related to grievances, quality of care and utilization audits, credentialing

[19] NCQA, 2022 HP Standards and Guidelines, QI 1, Element A, Factor 5

and re-credentialing and medical-legal issues. The Subcommittee performs oversight of organizations who have been delegated credentialing and re-credentialing responsibilities and evaluates the IEHP Credentialing and Re-credentialing Program with recommendations for modification as necessary.

2. **Structure:** The Peer Review Subcommittee is composed of IPA Medical Directors or designated physicians that are representative of network Providers. A Behavioral Health Practitioner and any other Specialist, not represented by committee members, serve on an ad hoc basis for related issues.
3. **Function**: The Peer Review Subcommittee serves as the committee for clinical quality review of Practitioners; evaluates and makes decisions regarding Member or Practitioner grievances and clinical quality of care cases referred by the CMO or Medical Director designee.
4. **Frequency of Meetings:** The Peer Review Subcommittee meets every other month with ad hoc meetings as needed.

Credentialing Subcommittee

A. The Credentialing Subcommittee performs credentialing functions for Practitioners who either directly contracted with IEHP or for those submitted for approval of participation in the IEHP network by IPAs that have not been delegated credentialing responsibilities.

1. **Role:** The Credentialing Subcommittee is responsible for reviewing individual Practitioners who directly contract with IEHP and denying or approving their participation in the IEHP network.
2. **Structure:** The Credentialing Subcommittee is composed of multidisciplinary participating Primary Care Providers (PCP) or specialty Physicians, representative of network Practitioners. A Behavioral Health Practitioner, and any other Specialist not represented by committee members, serves on an ad hoc basis for related issues.
3. **Function:** The Credentialing Subcommittee provides thoughtful discussion and consideration of all network Practitioners being credentialed or re-credentialed; reviews Practitioner qualifications including adverse findings; approves or denies continued participation in the network every three (3) years for re-credentialing; and ensures that decisions are non-discriminatory.
4. **Frequency of Meetings:** The Credentialing Subcommittee meets every month with ad hoc meetings conducted as needed.

Pharmacy and Therapeutics (P&T) Subcommittee

A. The P&T Subcommittee performs ongoing review and modification of the IEHP Formulary and related processes; conducts oversight of the Pharmacy network including medication

prescribing practices by IEHP Practitioners; assesses usage patterns by Members; and assists with study design, and other related functions.

1. **Role**: The P&T Subcommittee is responsible for maintaining a current and effective formulary, monitoring medication prescribing practices by IEHP Practitioners, and under- and over-utilization of medications.
2. **Structure:** The P&T Subcommittee is comprised of clinical pharmacists and designated Physicians' representative of network Practitioners. Other specialists, including a Behavioral Health Practitioner serve on an ad hoc basis for related issues. Changes to Subcommittee membership shall be reported to CMS during the contract year.[20]
3. **Function**: The P&T Subcommittee serves as the committee to objectively appraise, evaluate, and select pharmaceutical products for formulary inclusion and exclusion. The Subcommittee provides recommendations regarding protocols and procedures for pharmaceutical management and the use of non-formulary medications on an ongoing basis. The Subcommittee ensures that decisions are based only on appropriateness of care and services. The P&T Subcommittee is responsible for developing, reviewing, recommending, and directing the distribution of disease state management or treatment guidelines for specific diseases or conditions that are primarily medication related. The Subcommittee utilizes retrospective Drug Utilization Review (DUR) Board reports to create interventions to ensure therapeutic appropriateness as well as to monitor adverse events, identify incorrect duration of treatment, over or underutilization, inappropriate or medically unnecessary prescribing, gross overprescribing and use, fraud, waste, and abuse and safe prescribing. The DUR Board also reports on Targeted Medication Reviews (TMRs) that include addressing key HEDIS® measures.
4. **Frequency of Meetings:** The P&T Subcommittee meets quarterly with ad hoc meetings conducted as needed.

Utilization Management (UM) Subcommittee

A. The UM Subcommittee performs oversight of UM activities in all clinical departments conducted by IEHP and IPAs to maintain high quality health care, as well as effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services.

1. **Role:** The UM Subcommittee directs the continuous monitoring of all aspects of UM and Behavioral Health (BH) services provided to Members.
2. **Structure:** The UM Subcommittee is composed of IPA Medical Directors, or designated

[20] Medicare Prescription Drug Benefit Manual, "Chapter 6 – Part D Drugs and Formulary Requirements," Section 30.1.3

Physicians that are representative of network Practitioners. A Behavioral Health Physician and any other Specialist, not represented by committee members, serve on an ad hoc basis for related issues.[21]

3. **Function**: The UM Subcommittee reviews and approves the Utilization Management Programs annually. The Subcommittee also monitors for over-utilization and under-utilization; ensures that UM decisions are based only on appropriateness of care and service. Issues that arise prior to the UM Subcommittee that require immediate attention are reviewed by the Medical Director(s) and reported back to the UM Subcommittee at the next scheduled meeting.
4. **Frequency of Meetings:** The UM Subcommittee meets quarterly with ad hoc meetings conducted as needed.

QM Support Committees/Workgroups

A. IEHP also has Committees and/or Workgroups that are designed to provide structural input from Providers and Members. These Committees and Workgroups report directly through the QMC, Compliance Committee or through the CEO to the Governing Board. Any potential quality issues that arise from these Committees would be referred to the QMC by attending staff. The Committees and Workgroups include:
   1. Public Policy Participation Committee (PPPC);
   2. Persons with Disabilities Workgroup (PDW); and
   3. Delegation Oversight Committee;

Public Policy Participation Committee (PPPC)

A. The PPPC is a standing committee with a majority of its Members drawn from IEHP Membership. The PPPC provides a forum to review and comment on operational issues that could impact Member quality of care including, but not limited to: new programs, Member information, access, cultural, racial, ethnic, and linguistic, and Member Services. The PPPC meets quarterly with ad hoc meetings conducted as needed.

Persons with Disabilities Workgroup (PDW)

A. The PDW is an ad-hoc workgroup made up of IEHP Members with disabilities and Members from community-based organizations that provide recommendations on provisions of health care services, educational priorities, communication needs, and the coordination of and access to services for Members with disabilities. The PDW meets at least quarterly.

[21] NCQA, 2022 HP Standards and Guidelines, UM 1, Element A, Factors 2 and 4

Delegation Oversight Committee

A. The Delegation Oversight Committee is an internal committee that monitors the operational activities of contracted IPAs and other Delegated activities including Claims Audits, Pre-Service and Payment Universe Metrics, Financial Viability, Electronic Data Interchange (EDI) transactions, Care Management, Utilization Management, Grievances and Appeals, Quality Management, Credentialing/Re-credentialing activities, and other Provider-related activities. The Delegation Oversight Committee reports directly to the Compliance Committee and meets monthly with ad hoc meetings conducted as needed.

Organizational Structure and Resources

A. IEHP has designated internal resources to support, facilitate, and contribute to the QM/QI Program.

Clinical Oversight of QM/QI Program

A. Under the direction of the CMO, CQO, or designee, Medical Directors are responsible for clinical oversight and management of the QM, UM, BH & CM, Health Education, PHM activities, participating in the QM/QI Program for IEHP and its Practitioners, and overseeing credentialing functions. Medical Directors must possess a valid Physician's and Surgeon's Certificate issued by the State of California and certification by one (1) of the American Specialty Boards. Principal accountabilities include:

    1. Developing and implementing medical policy for Health Services department activities and QM functions;
    2. Reviewing current medical practices ensuring that protocols are implemented and medical personnel of IEHP follow rules of conduct;
    3. Ensuring that assigned Members are provided health care services and medical attention at all locations;
    4. Ensuring that medical care rendered by Practitioners meets applicable professional standards for acceptable medical care; and
    5. Following evidence-based CPGs developed by IEHP for all lines of business.

Quality Systems Department (QS)

A. The Quality Systems (QS) Department operates under the direction of the Senior Director of Quality Systems. The Senior Director of Quality Systems is responsible for the oversight of all quality studies, demographic analysis, and other research projects; and reports up to the Vice President of Quality. Areas of accountability include:

    1. Developing research or methodologies for quality studies;

2. Producing detailed criteria and processes for research and studies to ensure accurate and reliable results;
3. Designing data collection methodologies or other tools as necessary to support research or study activities;
4. Implementing research or studies in coordination with other IEHP functional areas;
5. Ensuring appropriate collection of data or information;
6. Qualitative and quantitative analysis of research results (including barrier analysis); and
7. Implementing research studies in coordination with other IEHP functional areas to ensure accurate and reliable results for quality studies.

B. Staff support for the Vice President of Quality consists of clinical and/or non-clinical directors, managers, supervisors, and administrative staff.

Quality Management Department (QM)

A. The Quality Management Department operates under the direction of the Director of Quality Management. The Director of Quality Management reports up to the Senior Director of Quality Systems who reports to the Vice President of Quality. The Director of QM is responsible for oversight of the quality process; implementing, developing, coordinating, and monitoring for quality management, and maintaining the QM/QI Program and its related activities. Activities include the ongoing assessment of Provider and Practitioner compliance with IEHP requirements and standards, monitoring Provider trends and report submissions, and oversight of facility inspections. The Director of Quality Management also monitors and evaluates the effectiveness of IPA QM systems; coordinates information for the annual QM/QI Program Evaluation and Work Plan; prepares audit results for presentation to the QMC, associated Subcommittees, and the Governing Board; and acts as liaison regarding medical issues for Providers, Practitioners, and Members.

B. Staff support for the Director of Quality Management consists of clinical Managers, Special Program Manager, analysts, and administrative staff.

Health Services Clinical Integration & Operations Department

A. The Health Services Clinical Integration & Operations Department operates under the direction of the Vice President of Health Services Clinical Integration & Operations, who reports to the CMO and encompasses Behavioral Health and Care Management (BH & CM), Utilization Management, and Pharmacy. These departments are responsible for clinical oversight and management of the IEHP Behavioral Health and Care Management, Utilization Management, and Pharmacy Programs. In these roles they also participate in quality management and quality improvement, grievance, utilization and credentialing functions and activities related to BH & CM, UM, and Pharmacy services.

B. The Vice President of Health Services Clinical Integration & Operations or designee oversees staff with the required qualifications to perform BH & CM care coordination activities in a managed care environment. These staff have various levels of experience and expertise in behavioral health, social work, utilization management, utilization review, care management, long-term services and support, quality assurance, training, pharmaceutical services, and customer or provider relations. These staff positions include clinical and/or non-clinical Directors, Managers, Supervisors, and administrative staff.

Pharmaceutical Services Department

A. The Pharmaceutical Services Department operates under the direction of the Senior Director of Pharmaceutical Services. The Senior Director of Pharmaceutical Services reports to the Vice President of Health Services Clinical Integration and Operations. The Pharmaceutical Services Department is responsible for pharmacy benefits and pharmaceutical services, including pharmacy network, pharmacy benefit coverage, formulary management, drug utilization program, pharmacy quality management program and pharmacy disease management program. The Senior Director of Pharmaceutical Services is responsible for developing and overseeing the IEHP Pharmaceutical Services Program.

B. Staff support for the Senior Director of Pharmaceutical Services consists of clinical and non-clinical Directors, Managers, Supervisors, analysts and administrative staff.

Utilization Management Department (UM)

A. The Utilization Management (UM) Department operates under the direction of the Senior Director of Medical Management, Clinical Director of UM and Director of UM Operations. The Senior Director of Medical Management reports to the Vice President of Health Services Clinical Integration & Operations and is responsible for developing and maintaining the UM Program structure and assisting Providers and Practitioners in providing optimal UM services to Members. The Senior Director of Medical Management, Clinical Director of UM and Director of UM Operations are responsible for oversight of delegated, non-delegated and IEHP Direct UM activities. Additional responsibilities include the development and implementation of internal UM services, processes, policies, and procedures, as well as oversight and direction of IEHP UM staff and providing support to the IEHP QM Committee and Subcommittees.

B. The Senior Director of Medical Management, Clinical Director of UM and Director of UM Operations oversee UM staff with the required qualifications to perform UM in a managed care environment. The required qualifications for UM staff support may consist of experience in utilization management or care management. Staff positions may include clinical and/or non-clinical Directors, Managers, Supervisors, nurses, analysts, and administrative staff.

Health Education Department

A. The Health Education Program operates under the direction of the Senior Medical Director of Family and Community Health, and Director of Health Education who provides oversight of all accreditation and regulatory standards for Member health education. Primary responsibilities include oversight of the Health Education Department for Member health education and Employee Wellness Program. The department coordinates with other departments to ensure Member health education materials meet state requirements for readability format, cultural, racial, ethnic, and linguistic relevance. The Director facilitates effective communication and coordination of care among UM, BH & CM, Pharmaceutical Services, and Health Education departments. The Director works with other departments to develop and coordinate policies and procedures for medical services (e.g., medical procedures, denials, pharmaceutical services) that incorporate Member participation in health education programs. The Director of Health Education ensures compliance with all accreditation and regulatory standards for health education and acts as the primary liaison between IEHP and Providers/external agencies for health education.

B. The Senior Medical Director of Family and Community Health also provides oversight of the Employee Wellness Program and co-chairs the Employee Wellness Advisory Committee to plan and monitor activities to enhance wellness among IEHP Team Members.

C. The Director of Health Education oversees various levels of staff consisting of non-clinical management and administrative staff.

Community Health Department

A. The Community Health Department operates under the direction of the Senior Director of Community Health. The Senior Director of Community Health oversees various levels of staff, including the Independent Living and Diversity Services (ILDS) and Community Relations. The ILDS Manager is responsible for administering IEHP's program for Seniors and Persons with Disabilities (SPD), including outreach plan implementation, cross-department program deliverables coordination, and external operational coordination with regulatory agencies and stakeholders. The Director of Community Health ensures interaction and enrollment in events that support the community of prospective Members.

B. The Senior Director of Community Health oversees various levels of staff consisting of non-clinical Directors, Managers, Supervisors, Health Navigators, Community Outreach Representatives, analysts, and administrative staff.

Provider Services Department

A. The Provider Services Department operate under the direction of the Chief Operating Officer (COO). There are four Directors who are responsible for the execution of the Provider Services' Department's objectives:

1. Director of Provider Operations is responsible for the Provider Call Center, including the resolution of Provider and Practitioner issues.
2. Director of Provider Relations is responsible for the education of Providers and Practitioners concerning IEHP policies and procedures, health plan programs, IEHP website training and all other functions necessary to ensure Providers and Practitioners can successfully participate in IEHP's network and provide appropriate, quality care to IEHP Members.
3. Director of Delegation Oversight is responsible for IPA oversight and monitoring in conjunction with departments including QM, UM, CM, Credentialing/Re-Credentialing activities, Compliance, and Finance.
4. Director of Provider Network and Director of Provider Communication is responsible for all Provider communications, oversight of the IEHP Provider Manual and network compliance.

B. Staff support for the COO includes Directors, Managers, Supervisors, analysts, and administrative staff.

Credentialing Department

A. The Credentialing Department operates under the Director of Provider Network, who reports to the COO and is responsible for Provider Operations including credentialing and re-credentialing functions, oversight for directly contracted Practitioners, Providers and delegated IPAs, and resolving credentialing-related Provider issues.

Grievance & Appeals Department

A. The Grievance & Appeals Department operates under the Director of Grievance & Appeals, who reports to the Vice President of Operations. The Grievance & Appeals Department is responsible for investigation and resolution of grievances and appeals received from Members, Providers, Practitioners, and regulatory agencies. The Grievance & Appeals Department gathers supporting documentation from Members, Providers, or contracted entities, and resolves cases based on clinical urgency of the Member's health condition. The Director of Grievance & Appeals has the primary responsibility for the timeliness and processing of the resolution for all cases. The Director of Grievances and Appeals is responsible for the maintenance of the Grievance & Appeals Resolution System.

B. Staff supporting the Director of Grievance & Appeals include clinical and/or non-clinical Managers, Supervisors, nurses, and administrative staff.

Information and Technology (IT)

A. The IT Department operates under the Directors of IT who report to the Vice President of Technology – Production Support Infrastructure Services.. The IT Department is responsible

for the overall security and integrity of the data systems that IEHP uses to support Members, Providers and Team Members. IT is responsible for maintaining internal systems that provide access to Member data, received from regulators, Providers, and contracted entities. The system ensures that Team Members have access to data to assist them in providing care and guidance to Members. The IT Department maintains the Member and Provider portals which are extensively used tools for communicating.

Communications and Strategy Department

A. The Communications and Strategy Department operates under the direction of the Director of Communications and Marketing, who reports to the Chief Communications and Marketing Officer. The Communications and Strategy Department is responsible for conducting appropriate product and market research to support the development of marketing and Member communication plans for all products including Member materials (e.g., Member Newsletters, Evidence of Coverage, Provider Directory, website, etc.). The Quality Management Department works closely with the Communications and Strategy and Health Education Departments to ensure that Member materials are implemented in a timely manner.

Program Documents

A. In addition to the detailed QM/QI Program Description, IEHP also develops the QM/QI Work Plan and completes a robust annual evaluation of the QM/QI Program.

Quality Management and Quality Improvement Work Plans[22]

A. Annually, and as necessary, the QMC approves the QM/QI Work Plan, which details a 3-year (36 months) lookback period of program initiatives to achieve established goals and objectives including the specific activities, methods, projected timeframes for completion, monitoring of previously identified issues, evaluation of the QI program and team members responsible for each initiative. The scope of the Work Plan incorporates the needs, input, and priorities of IEHP. The Work Plan is used to monitor all the different initiatives that are part of the QM/QI Program. These initiatives focus on improving quality of care and service, access, Member and Provider satisfaction, patient safety, and QI activities that support PHM strategies. The QMC identifies priorities for implementing clinical and non-clinical Work Plan initiatives. The Work Plan includes goals and objectives, staff responsibilities, completion timeframes, monitoring of corrective action plans (CAPs) and ongoing analysis of the work completed during the measurement year. The Work Plan is submitted to DHCS and CMS annually.

Annual QM Program Evaluation[23]

A. On an annual basis, IEHP evaluates the effectiveness and progress of the QM/QI Program

[22] NCQA, 2022 HP Standards and Guidelines, QI 1, Element A, Factor 5
[23] NCQA, 2022 HP Standards and Guidelines, QI 1, Element C

including:

1. The QM/QI Program structure;
2. The behavioral healthcare aspects of the program;
3. How patient safety is addressed;
4. Involvement of a designated physician in the QM/QI Program;
5. Involvement of a Behavioral Healthcare Practitioner in the behavioral aspects of the program;
6. Oversight of QI functions of the organization by the QI Committee;
7. An annual work plan (QM/QI Work Plan);
8. Objectives for serving a culturally and linguistically diverse membership; and
9. Objectives for serving Members with complex health needs.

B. As such, an annual summary of all completed and ongoing QM/QI Program activities addresses the quality and safety of clinical care and quality of service provided as outlined in the QM/QI Work Plan. The evaluation documents evidence of improved health care or deficiencies, progress in improving safe clinical practices, status of studies initiated or completed, timelines, methodologies used, and follow-up mechanisms that are reviewed by QM staff, the CMO, CQO, or designee. The evaluation includes pertinent results from QM/QI Program studies, Member access to care, IEHP standards, physician credentialing and facility review compliance, Member experience, evidence of the overall effectiveness of the program, and significant activities affecting medical and behavioral health care provided to Members.

C. Performance measures are trended over time and compared with established performance thresholds to determine service, safe clinical practices, and clinical care issues. The results are analyzed to assess barriers and verify and establish additional improvements. The CMO, CQO, or designee presents the results to the QMC for comments, consideration of performance, suggested program adjustments, and revision of procedures or guidelines as necessary.

Review and Approval of Program Documents

A. On an annual basis, the QM/QI Program Description, QM/QI Program Summary, and QM/QI Work Plan are presented to the Governing Board for review, approval, assessment of health care rendered to Members, comments, direction for activities proposed for the coming year, and approval of changes in the QM/QI Program. The Governing Board is responsible for the direction of the program and actively evaluates the annual plan to determine areas for improvement. Board comments, actions, and responsible parties assigned to changes are documented in the minutes.

24. PROGRAM DESCRIPTIONS

C. Quality Management and Quality Improvement Program Description

Quality Improvement Processes

A. The planning and implementation of annual QM/QI Program activities follows an established process. This includes development and implementation of the Work Plan, quality improvement initiatives, and quality studies. Measurement of success encompasses an annual evaluation of the QM/QI Program.

IEHP Quality Improvement (QI) Initiatives

A. QI initiatives are aligned with the organization's Five Star strategic priorities and take into consideration the needs of the IEHP population in addition to populations identified by state and regulatory agencies.

B. IEHP's QI initiatives are selected based on strategic priorities and align with the "Triple Aim"—enhancing patient experience, improving population health, and reducing costs, which is widely accepted as a compass to optimize health system performance. Goals and objectives are selected based on relevance to IEHP's Membership and relation to IEHP's mission and vision. Activities reflect the needs of the Membership and focus on high-volume, high-risk, or deficient areas for which quality improvement activities are likely to result in improvements in care and service, access, safety, and satisfaction. Performance measures and customized metrics form the basis for plans and actions developed to improve care and service. Measure data and performance metrics are collected, compiled, and analyzed to determine strategic priority direction and to ensure that opportunities for improvement are identified and/or best practices are defined and shared.

Plan-Do-Study-Act Cycle[24]

A. The "Plan-Do-Study-Act" (PDSA) Cycle is utilized to implement and test the effectiveness of changes. The model focuses on identifying improvement opportunities and changes and measuring improvements. Successful changes are adopted and applied where applicable. In general, quality improvement initiatives follow the process below:

   1. Find a process to improve, usually by presenting deficient results;
   2. Organize a team that understands the process and include subject matter experts (SMEs);
   3. Clarify knowledge about the process;
   4. Understand and define the key variables and characteristics of the process;
   5. Select the process to improve;
   6. Plan a roadmap for improvement and/or develop a work plan;

[24] Medicare Managed Care Manual, "Quality Assessment," Section 20.1

7. Implement changes;
8. Evaluate the effect of changes through measurement and analysis; and
9. Maintain improvements and continue to improve the process.

Data Collection Methodology

A. Performance measures developed have a specified data collection methodology and frequency. The methodology for data collection is dependent on the type of measure and available data, with data validation being a vital part of the data collection process. Quality assessment and improvement activities are linked with the delivery of health care services. Data is collected, aggregated, and analyzed to monitor performance. When opportunities for improvement are identified, a plan for improvement is developed and implemented. Data is used to determine if the plan resulted in the desired improvement. Data collection is ongoing until the improvement is considered stable. At that time, the need for ongoing monitoring is reevaluated. Data may also indicate the need to abandon an action and reassess options for other action items necessary to drive performance improvement.

Measurement Process

A. Quality measures are used to regularly monitor and evaluate the effectiveness of quality improvement initiatives, and compliance with internal and external requirements. IEHP reviews and evaluates, on not less than a quarterly basis, the information available to the plan regarding accessibility and availability. IEHP measures performance against community, national or internal baselines and benchmarks when available, and applicable, which are derived from peer-reviewed literature, national standards, regulatory guidelines, established clinical practice guidelines, and internal trend reviews.

Evaluation Process

A. IEHP uses several techniques and tools to evaluate effectiveness of QI studies and initiatives. These include conducting a robust quantitative and qualitative analysis. A quantitative analysis includes comparison to benchmarks and goals, trend analysis, and tests of statistical significance. The HCI team selects the appropriate tools to complete the quantitative analysis. The QM Department works closely with the HCI Department and other key stakeholders to complete a robust qualitative analysis. A qualitative analysis includes barrier analysis and attribution analysis. IEHP performs this analysis in a focus group-like setting using all the key stakeholders.

Communication and Feedback

A. Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, joint operation meetings, mailings, and announcements.[25]

1. Providers are educated regarding quality improvement initiatives through on-site quality visits, Provider newsletters, specific mailings, and the IEHP website.
2. Specific performance feedback regarding actions or data is communicated to Providers. General and measure-specific performance feedback is shared via special mailings, Provider newsletters, IEHP's Provider Portal, and the IEHP website.
3. Feedback to Providers may include, but is not limited to, the following:
    a. Listings of Members who need specific services or interventions;
    b. Clinical Practice Guideline recommended interventions;
    c. Healthcare Effectiveness Data Information Sets (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results;[26]
    d. Recognition for performance or contributions; and
    e. Discussions regarding the results of medical chart audits, grievances, appeals, referral patterns, utilization patterns, and compliance with contractual requirements.

Improvement Processes

A. Performance indicators are also used to identify quality issues. When identified, IEHP QM staff investigates cases and determines the appropriate remediation activities including Corrective Action Plans (CAPs). Providers or Practitioners that are significantly out of compliance with QM requirements must submit a CAP. Persistent non-compliance, or failure to adequately address or explain discrepancies identified through oversight activities, may result in freezing of new Member enrollment, a requirement to subcontract out the deficient activities within the Management Services Organization (MSO) or IPA; de-delegation of specified functions; and/or termination of participation or non-renewal of the agreement with IEHP.

[25] Ibid.
[26] Ibid.

24. PROGRAM DESCRIPTIONS

C. Quality Management and Quality Improvement Program Description

Quality Improvement Initiatives

A. IEHP has developed several Quality Improvement initiatives to improve quality of care, access and service, Member and Provider satisfaction, and patient safety. IEHP assesses the performance of these studies against established thresholds and/or benchmarks.

Quality of Care

A. IEHP monitors several externally and internally developed clinical quality measures and tracks the quality of care provided by IEHP. To evaluate these measures IEHP collects data from a number of different sources that include, but are not limited to, the following:

   1. Annual HEDIS® submission for Medi-Cal and IEHP DualChoice;
   2. State/Federal-required Performance Improvement Projects and Quality Activities; and
   3. Claims and encounter data from contracted Providers (e.g. Primary Care Providers, Specialists, labs, hospitals, IPAs, Vendors, etc.).

B. Measuring and reporting on these measures helps IEHP to guarantee that its Members are getting care that is safe, effective, and timely. The clinical quality measures discussed below are used to evaluate multiple aspects of Member care including:

   1. Performance with healthcare outcomes and clinical processes;
   2. Adherence to clinical and preventive health guidelines;
   3. Effectiveness of chronic conditions, Health Services Clinical Integration & Operations and Behavioral Health Care Management programs; and
   4. Member experience with the care they received.

HEDIS® Measures

A. HEDIS® is a group of standardized performance measures designed to ensure that information is available to compare the performance of managed health care plans. IEHP has initiatives in place that focuses on a broad range of HEDIS® measures that cover the entire Membership, including, priority measures that relate to children, adolescents, and Members with chronic conditions.

B. IEHP develops several Member and Provider engagement programs to improve HEDIS® rates. Interventions include a combination of incentives, outreach and education, Provider-level reports and gaps in care reports, and other activities deemed critical to improve performance. These interventions are tracked and monitored in the QI Work Plan and are presented at the QI Council. In addition, IEHP's performance on HEDIS® measures is reported and discussed annually at the QI Council, who provides guidance on prioritizing

measures for the subsequent year(s). IEHP's goal is to continually develop and implement interventions that are aimed at improving HEDIS® rates and quality of care for its Members.

Performance Improvement Projects (PIPs) (DHCS, CMS and Health Services Advisory Group (HSAG) and Quality Activities)

A. IEHP implements several Performance Improvement Projects (PIPs) and DHCS Managed Care Accountability Set (MCAS)that are required by regulatory agencies (DHCS, CMS and HSAG) and in accordance with requirements in the Capitated Financial Alignment Model.

1. PIPs – A thorough analysis on a targeted problem is completed. A baseline and key indicators are established and then interventions are implemented. Interventions are designed to enhance quality and outcomes that benefit IEHP Members.
2. DHCS Managed Care Accountability Set (MCAS)– These are conducted for each MCAS measures with a rate that does not meet the Minimum Performance Level (MPL) as assigned by.[27]
3. NCQA Quality Activities – These are quality improvement activities conducted to meet NCQA accreditation standards.
4. CMS Chronic Care Improvement Project (CCIP) – An improvement project to promote the effective chronic disease management and improvement of care and health outcomes for Members with chronic conditions.[28]

B. The Quality Management Department, under the direction of the Medical Director(s), is responsible for monitoring these programs and implementing interventions to make improvements. IEHP is focusing on the following studies:

Study Name	Reporting Agency	Type of Study
IEHP All-Cause Readmissions – Statewide Collaborative measure (non-HEDIS® measure) addressing reduction of hospital readmission rates	NCQA	Quality Activity
Disparity Performance Improvement Project – Controlling High Blood Pressure (CBP)	DHCS, HSAG	PIP
Child & Adolescent Performance Improvement Project – Well Care Visits	DHCS, HSAG	PIP
Comprehensive Diabetes Care HbA1c Poor Control	DHCS	PDSA

[27] Department of Health Care Services (DHCS) All Plan Letter (APL) 19-017 supersedes 17-014, "Quality and Performance Improvement Requirements"
[28] Medicare Managed Care Manual, "Quality Assessment," Section 20.1

Chronic Care Improvement Project – Osteoporosis Management in Women Who Have Had a Fracture	CMS	CCIP

Continuity and Coordination of Care Studies

A. Continuity and coordination of care are key determinants for overall health outcomes. Comprehensive coordination of care improves patient safety, avoids duplicate assessments, procedures or testing, and results in better treatment outcomes. IEHP evaluates continuity and coordination of care on an annual basis through multiple studies. The purpose of these studies is to assess the effectiveness of the exchange of information between:

   1. Medical care Providers working in different care settings; and
   2. Medical and behavioral healthcare Providers.

B. The results of these studies are presented and discussed by the QI Council and QMC. Based on the findings, the committee members recommend opportunities for improvement that are implemented by the responsible department.

Improving Quality for Members with Complex Needs

A. IEHP has multiple programs, at no cost to the Member, that focus on improving quality of care and services provided to Members with complex medical needs (i.e., chronic conditions, severe mental illness, long-term services and support) and Seniors and Persons with Disabilities (SPD), including physical and developmental, as well as quality of behavioral health services focused on recovery, resiliency and rehabilitation. These programs include, but are not limited to, the following:

   1. Complex Care Management (CCM) Program
      a. The CCM program was established for Members with chronic and/or complex conditions. The goal of the CCM program is to optimize Member wellness, improve clinical outcomes, and promote self-management and appropriate resource management across the care continuum, through efficient care coordination, education, referrals to health care resource, and advocacy. IEHP assesses the performance of the CCM program annually using established measures and quantifiable standards. These reports are presented to the QI Council and QM Committee for discussion and input. Based on the committee recommendations, the Care Management Department collaborates with other Departments within the organization to implement improvement activities.
   2. Transition of Care (TOC) Program
      a. IEHP has developed a system to coordinate the delivery of care across all healthcare settings, Providers, and services to ensure all hospitalized Members are evaluated for

discharge needs to provide continuity and coordination of care. Multiple studies have shown that the poor transition between care settings have resulted an increase in mortality and morbidity. Transitioning care without assistance for Members with complex needs (e.g. SPD Members that very often have three (3) or more chronic conditions) can be complicated by several other health and social risk factors. IEHP's TOC program has been designed to provide solutions to these challenges. Through the TOC program, IEHP makes concerted efforts to coordinate care when Members move from one setting to another. This coordination ensures quality of care and minimizes risk to patient safety. IEHP also works with the Member or their caregiver to ensure they have the necessary medications/supplies to prevent readmissions or complications. The goals of the TOC program include the following:

1) Avoiding of hospital readmissions post discharge;
2) Improvements in health outcomes post discharge from inpatient facilities; and
3) Improving Member and caregiver experience with care received.

3. Facility Site Review (FSR)/Medical Record Review (MRR) and Physical Accessibility Review Survey (PARS)[29]

   a. IEHP requires all Primary Care Physician (PCP) sites to undergo an initial Facility Site Review (FSR) and Medical Record Review (MRR) Survey performed by a Certified Site Reviewer (CSR) prior to the PCP site participating in the IEHP network. The purpose of the FSR/MRR is to ensure a PCP site's capacity to support the safe and effective provision of primary care services. See Policy 6A, "Facility Site Review and Medical Record Review Survey Requirements and Monitoring."

   b. In addition to the FSR/MRR, IEHP also conducts a Physical Accessibility Review Surveys (PARS) prior to the PCP site participating in the IEHP network. The purpose of the PARS is to assess the physical accessibility, physical appearance, safety, adequacy of room space, availability of appointments, and adequacy of record keeping, and any other issue that could impede quality of care. PARS also ensures Provider sites that are seeing Members with disabilities do not have any physical access limitations when visiting a Provider site. See Policy 6B, "Physical Accessibility Review Survey."

   c. The FSR/MRR and PARS are conducted every three (3) years. Sites will be monitored every six (6) months until all deficiencies are resolved. The Quality Management Department is responsible for oversight of PARS and FSR/MRR activities. In partnership with IEHP key stakeholders, the QM Department is also

[29] Department of Health Care Services (DHCS) All Plan Letter (APL) 20-006, Supersedes APL 14-004, "Site Reviews: Facility Site Review and Medical Record Review"

responsible for providing training should physical access issues or deficiencies be identified. The QMC reviews an annual assessment of PARS activities to ensure compliance.

Other Clinical Measures and Studies

A. Initial Health Assessment Monitoring

IEHP also monitors the rate of Initial Health Assessments (IHA) performed on new Members. The timeliness criteria for an IHA is within one hundred twenty (120) calendar days of enrollment for Members. This rate is presented to QI Council for review and analysis. IEHP has several Member and Provider outreach programs to improve the IHA rate.

B. Clinical Practice Guidelines (CPGs) and Preventive Health Guidelines

To make health care safer, higher quality, more accessible, equitable and affordable, IEHP has adopted evidence-based clinical practice guidelines for prevention and chronic condition management. In addition, IEHP considers recommendations for Adult and Pediatric Preventive Services per DHCS contractual requirements which include criteria for the following;

1. FSR/MRR Documentation;
2. Select United States Preventive Services Task Force (USPSTF) recommendations;
3. The American College of Obstetricians and Gynecologists (ACOG);
4. American Diabetes Association (ADA);
5. Bright Futures from American Academy of Pediatrics (AAP); and
6. IEHP/Advisory Committee on Immunization Practices (ACIP) Immunizations Schedule.

C. Over-utilization and Under-utilization

IEHP monitors over-utilization and under-utilization of services at least annually. The QM and UM departments work collaboratively to capture utilization trends or patterns. The results are compared with nationally recognized thresholds. Under-utilization of services can result due to several reasons that include but are not limited to the following:

1. Access to health care services based on geographic regions;
2. Demographic factors also impact over-utilization and under-utilization of services/care:
    a. Race, ethnicity, and language preference (RELP);
    b. Knowledge and perceptions regarding health care which are largely driven by cultural beliefs; and
    c. Income and socioeconomic status.

IEHP also reviews trends of ER utilization, pain medications prescriptions, and potential areas of over-utilization on an annual basis. The purpose of the analysis is to:

1. Identify the dominant utilization patterns within the population.
2. Identify groups of high and low utilizers and understand their general characteristics.

D. Quality Withhold Performance Review

Annually, IEHP's performance on Quality Withhold measures are summarized and presented to IEHP's Quality Improvement Council (QIC).

1. This measure review includes the quality withhold measure descriptions, measure rates, benchmark goals, and whether the measure goal was met or not met.
2. This review with the Quality Improvement Council (QIC) would also include an opportunity to discuss improvement strategies in areas needing improvement.

Access to Care

A. With the rapid expansion of the managed care programs in California, access to health care services within the State has been negatively impacted over the last few years and is now considered unreliable. Based on several statewide studies, there are many Members who do not receive appropriate and timely care. As IEHP's Membership grows, access to care is a major area of concern for the plan and hence the organization has dedicated a significant number of resources to measuring and improving access to care. This analysis is presented to the QI Council and QM Committee for discussion and recommendations as needed.

Availability of PCPs by Language[30]

A. IEHP monitors network availability based on threshold languages annually. IEHP understands the importance of being able to provide care to Members in their language of choice and the impact it has on a Member-Practitioner relationship. To ensure adequate access to PCPs, IEHP has established quantifiable standards for geographic distribution of PCPs for its threshold languages. These two (2) languages cover over 98% of the Membership. The primary objectives are to evaluate network availability against the established language standards and identify opportunities for improvement.

Availability of Practitioners

A. IEHP monitors the availability of PCP, Specialists and Behavioral Health Practitioners and assesses them against established standards at least annually or when there is a significant change to the network. The performance standards are based on State, NCQA, and industry benchmarks. IEHP has established quantifiable standards for both the number and geographic

[30] Department of Health Care Services (DHCS) All Plan Letter (APL) 17-011, Supersedes APL 14-008, "Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act"

distribution of its network of Practitioners. IEHP uses a geo-mapping application to assess the geographic distribution. Considering the size of the service area, IEHP evaluates the distribution of Providers since there may be significant gaps in some of the more rural areas covered by IEHP.

Provider Appointment Availability Survey (PAAS)

A. IEHP monitors appointment access for PCPs, Specialists, and Behavioral Health Providers and assesses them against established standards at least annually. There is significant evidence that timely access to health care services results in better health outcomes, reduced health disparities, lower spending, including avoidable emergency room visits and hospital care.

B. IEHP collects the required appointment access data from Practitioner offices using the Department of Managed Health Care (DMHC) PAAS methodology and tool. IEHP also evaluates the grievances and appeals data quarterly to identify potential issues with access to care, including incidents of non-compliance resulting in substantial harm to Member. Following the completion of the survey, all responses were compiled and entered into a results grid. The compliance rate then can be calculated to be compared with the goal established and the previous year's rate to identify patterns of non-compliance. Results of the quantitative analysis are presented to IEHP's Provider Network Access Subcommittee for review and identification of priorities for interventions. This includes establishing goals and objectives, opportunities for improvement, completion timeframes, monitoring of corrective action plans (CAPs), and ongoing analysis of the work completed during the measurement year.[31]

C. CAP consists of follow-up call campaigns, Provider education, identifying and tracking any incidents that have resulted in substantial harm, peer review, and implementing corrective actions when necessary to address any patterns of non-compliance.

After-hours Access to Care

A. IEHP monitors after-hours access to PCPs at least annually. One of IEHP's key initiatives is to reduce inappropriate ER utilization. Ensuring that Members have appropriate access to their PCP outside of regular business hours can result in reduced ER rates, which can subsequently result in reduced inpatient admissions. The criteria for appropriate after-hours care are that the physician or designated on-call physician be available to respond to the Member's medical needs beyond normal hours. PCP offices can use a professional exchange service or automated answering system that allows the Member to connect to a live party or the physician by phone. It is also required that any after-hours system or service that a physician uses provide emergency instructions if the Member is experiencing a life-threatening emergency.

[31] Title 28 California Code of Regulations (CCR) § 1300.67.2.2(b)(12)(A), (f)(1)(I), (d)(3), and (h)(6)(c)

Telephone Access to IEHP Staff

A. IEHP monitors access to its Member Services Department on quarterly basis. IEHP has established the following standards and goals to evaluate access to Member services by telephone.

Standards of Care for Telephone Access Standards	Goal
% Of Calls answered by a live voice within 30 seconds	80 %
Calls Abandoned Before Live Voice is Reached	≤ 5%

Member and Provider Experience

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

A. IEHP conducts a comprehensive CAHPS® survey and analysis annually to assess Member experience with the services and care received based on a statistically valid and reliable survey methodology. CAHPS® is a set of standardized surveys that ask health care consumers to report on and evaluate their care experience. The survey focuses on key areas to evaluate:
   1. Member perspective and concerns regarding experience obtaining timely appointments within the standards;[32]
   2. Experience with health care services related to access to care, coordination of care, office customer service, health plan experience, and personal doctor;
   3. Satisfaction with IEHP Programs;
   4. Member grievances and appeals; and
   5. Member Services Department's call services levels.

B. CAHPS® surveys serve as a means to provide usable information about quality of care received by the Members. IEHP uses this tool as one of its key instruments to identify opportunities for improvement. As part of the annual evaluation, IEHP reviews the CAHPS® results and compared with prior year results to identify relative strengths and weaknesses in performance, determines where improvement is needed, and tracks progress with interventions over time.

Internal Member Experience Studies

A. **BH Member Experience Survey**: IEHP surveys Members who are receiving behavioral care services at least annually to evaluate their experience with the services received. The survey

[32] 28 CCR § 1300.67.2.2(c)

focuses on key areas like getting care needed; getting appointments to BH Practitioners; experience with IEHP staff and network of BH Practitioners; and other key areas of the Plan operations. The goal of the experiencestudy is to identify and implement opportunities to improve Member satisfaction.

B. **Behavioral Health Treatment (BHT) Autism Member Experience Survey**: IEHP conducts an internal survey for Medi-Cal Members to assess Member Experience with IEHP's Behavioral Health Treatment (BHT) services. The survey focuses on key areas like Access to BHT services; experience with their BHT Provider; experience with IEHP's BH & CM Department and other key areas of the Plan operations. The goal of the experience study is to identify, review and implement opportunities to improve services and Member experience.

C. **Health Services Clinical Integration & Operations Management (PHM) Population Assessment -Member Experience Survey**: Annually, IEHP conducts an internal member experience survey for Medi-Cal Members to assess Member Experience with IEHP's Health Services Clinical Integration & Operations Management programs. The survey focuses on Member feedback from at least two programs (e.g. disease management or wellness programs). Feedback is specific to the programs being evaluated. Additionally, IEHP analyzes complaints to identify opportunities to improve experience.[33]

Provider Experience

A. IEHP monitors performance areas affecting Provider experience annually and submits the results to DHCS and CMS. This study assesses the experience experienced by IEHP's network of PCPs, Special Care Providers (SCPs), and Behavioral Health Providers. Information obtained from these surveys allows plans to measure how well they are meeting their Providers' expectations and needs. This study examines the experience of the Provider network in the following areas: overall experience, all other plans, finance issues, utilization and quality management network, coordination of care, pharmacy, Health Plan Call Center Service Staff, and Provider relations. Based on the data collected, IEHPs reports the findings to the QI Council and QM Committee. The committees review the findings and make recommendations on potential opportunities for improvements.

Grievances and Appeals[34]

A. IEHP monitors performance areas affecting Member experience. IEHP has established categories and quantifiable standards to evaluate grievances received by Members. All grievances are categorized in a number of different categories including but not limited to the following:

    1. Billing/Financial;

[33] NCQA, 2022 HP Standards and Guidelines, PHM 2, Element B
[34] NCQA, 2022 HP Standards and Guidelines, ME 7, Element C

2. Quality of Practitioner Office Site;
3. Access;
4. Quality of Service;
5. Quality of Care;
6. Attitude and Service;
7. Compliance;
8. Benefits/Coverage;
9. Enrollment/Eligibility;
10. Disease Management and Care Management Programs; and
11. Cultural and Linguistics.

B. The organization's goal is to resolve all grievances within thirty (30) days of receipt. IEHP calculates the grievance rate per 1000 Members on a quarterly basis and presents this information to the QI Council and QM Committees. IEHP's goal is to maintain the overall compliance rate below thresholds as established by regulatory agencies such as DHCS, DMHC, and CMS.

Patient Safety

A. IEHP recognizes that patient safety is a key component of delivering quality health care and focuses on promoting best practices that are aimed at improving patient safety. IEHP engages Members and Providers to promote safety practices. IEHP also focuses on reducing the risk of adverse events that can occur while providing medical care in different delivery settings.

Appropriate Medication Utilization

A. IEHP monitors pharmaceutical data to identify patient safety issues on an ongoing basis. Drug Utilization Review (DUR) is a structured, ongoing program that evaluates, analyzes, and interprets drug usage against predetermined standards and undertakes actions to obtain improvements. The DUR process is designed to assist pharmacists in identifying potential drug related problems by assessing patterns of medication usage. The goal of the DUR process is to identify potential drug-to-drug interactions, over-utilization and under-utilization patterns, high/low dosage alerts, duplication of medications, and other critical elements that can affect patient safety. The DUR study data is collected via an administrative data extraction of paid pharmaceutical claims. Actual prescribing patterns of PCPs, Behavioral Health Practitioners, and Specialists are compared to IEHP standards. The results of the quantitative analysis are presented to IEHP's Pharmacy and Therapeutics (P&T) Subcommittee and QM Committee for discussion and action, as necessary.

Review of Inpatient Admissions

A. IEHP considers the quality of care in the hospitals to be a top priority. To ensure Member safety, IEHP assesses, tracks, and reviews the following measures:
   1. Bed Day/Readmission Reporting;
   2. Length of stay reports;
   3. Provider Preventable Conditions (PPCs);
   4. Inappropriate discharges from inpatient settings; and
   5. Potential Quality Incidents (PQI) referrals related to an inpatient stay.

B. Monthly reports are produced using relevant utilization data. These reports are reviewed by the UM and QM staff to identify potential quality of care issues. Any significant findings are reviewed by IEHP's Medical Directors and summary reports are provided to the UM Subcommittee and QM Committee. The UM Subcommittee identifies potential quality of care issues and makes recommendations to address them as needed. The committee delegates the implementation of these recommendations to the UM and/or QM Department. The QM Department collaborates with different Departments (e.g. UM, CM, PS, etc.) to implement and monitor the improvement activities.

Potential Quality Incidents (PQI) Review

A. The Quality Management (QM) Department reviews all Potential Quality Incidents (PQI) for all Practitioners and Providers. Areas of review include but are not limited to primary and specialty care, facilities (Hospital, Long Term Care (LTC)), Skilled Nursing Facility (SNF), Community-Based Adult Services (CBAS)), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP) services, Home Health agencies, and transportation Providers. The QM Department is responsible for investigating and reviewing the alleged Potential Quality Incidents. The Medical Director(s) review all cases and may refer to the QM Committee and/or Peer Review Subcommittee for further evaluation and review.

Promoting Safety Practices for Members

A. IEHP offers various safety programs to Members including the Bicycle Safety Program for children between 5 to 14 years old and Members who have a child between 5 to 14 years old. This interactive program assesses children's and parents' knowledge on bicycle safety and offers a free helmet to program participants. IEHP also offers the Child Car Seat Safety Program to keep children safe in a car, providing information on the latest car seat laws, and choosing the right car seat. Additionally, Member education materials that cover different health topics are available to Members including immunizations, flu and cold facts, avoiding allergens, medication reconciliation etc. Additional safety initiatives are developed in

collaboration with Health Education and various IEHP departments as safety needs are identified.

Addressing Cultural, Racial, Ethnic, and Linguistic Needs of Members[35]

A. IEHP is dedicated to ensuring that all medically covered services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, ethnic group identification, religion, language, age, gender, gender identity, marital status, sexual orientation, medical condition, genetic information, physical or mental disability, and identification with any other persons or groups and that all covered services are provided in a culturally, racially, ethnically, and linguistically appropriate manner. IEHP strives to reduce health care disparities in clinical areas, improving cultural competency in Member materials and communications, and ensuring network adequacy to meet the needs of underserved groups. Services to address cultural, racial, ethnic, and linguistic services are adjusted based on the annual assessment of Member needs. Further details about cultural, racial, ethnic, and linguistic services provided to Members are seen in the individual reports supporting each of the current IEHP Quality Studies that evaluate our ability to serve a culturally and linguistically diverse Membership:

   1. **Provider Language Competency Study**: The purpose of this study is to verify that the PCP, OB/GYN, and vision provider offices that inform IEHP that they have Spanish speaking office staff actually have those services available to Members.
   2. **Ongoing monitoring of interpreter service use**: The purpose of this report is to monitor the top languages requested by the Members. IEHP offers face-to-face interpreter services for medical appointments to Members at no cost. The purpose is to provide Members with interpretation services and office excellence in service to Members/callers.
   3. **Ongoing monitoring of grievances related to language and culture**: Grievances are reported to monitor cultural, racial, ethnic, and linguistic services provided to Members.

Delegation Oversight

A. IEHP monitors Delegate performance in QM, UM, CM, credentialing and re-credentialing, compliance, and their implementation of related activities through Delegation Oversight activities. See Policy 25A2, "Delegation Oversight—Audit."

Auditing and Monitoring Activities:

A. IEHP performs a series of activities to monitor IPAs and other Delegates:

   1. An annual Delegation Oversight Audit is conducted using a designated audit tool that is based on the NCQA, DMHC and DHCS standards. Delegation Oversight Audits are

[35] NCQA, 2022 HP Standards and Guidelines, QI 1, Element A, Factor 6

performed by IEHP Health Services, Provider Services and Compliance Staff using the most current NCQA, DHCS, CMS and IEHP standards;

2. Joint Operations Meetings (JOM) – These meetings are called by IEHP as a means of discussing performance measures and findings as needed. The JOM includes representation from the Delegate and IEHP Departments as applicable;
3. Review of grievances and other quality information;
4. Specified audits:
    a. Focused Approved and Denied Referral Audits;
    b. Focused Case Management Audits;
    c. Utilization data review (Denial/Approval Rates, timely Member notification, overturn rate); and
    d. Provider Satisfaction Surveys.
5. IPAs are required to submit the following information to the IEHP Provider Services Department:
    a. Utilization Management (UM) Trend Report – Monthly report of utilization data;
    b. Referral Universe and Letters – Monthly report of all approvals, denials and modifications of requested services;
    c. Care Management (CM) Log – Monthly report of CM activities;
    d. Second Opinion Tracking Log – Monthly report to track Member requested second opinions;
    e. Credentialing Activity – Periodic report of any changes to the network at the Delegate level (e.g., terminated PCPs, specialists);
    f. Annual QM and UM Program Descriptions;
    g. Annual QM/QI and UM Work Plans;
    h. Semi-annual reports of quality improvement activities;
    i. Semi-annual reports of credentialing/re-credentialing;
    j. Quarterly reports of utilization management activities; and
    k. Annual QM and UM Program Evaluations.
6. IPAs and Health Plans with trends of deficient scoring must submit a CAP to remedy any deficiencies. If an IPA is unable to meet performance requirements, IEHP may implement further remediation action including but not limited to:

a. Conduct a focused re-audit;

b. Immediately freeze the IPA to new Member enrollment, as applicable;

c. Send a 30-day contract termination notice with specific cure requirements;

d. Rescind delegated status of IPA or Provider, as applicable;

e. Terminate the IEHP contract with the IPA or Provider; or

f. Not renew the contract.

7. **Assessment and Monitoring:** To ensure that IPA or Providers have the capacity and capability to perform required functions, IEHP has a rigorous pre-contractual and post-contractual assessment and monitoring system. IEHP also provides clinical and Member experience data to Delegates upon request so they can initiate improvement activities.

8. **Pre-Delegation Evaluation**: All Providers desiring to contract with IEHP must complete a comprehensive pre-contractual document and on-site review.

9. **Reporting**: IEHP's Delegation Oversight Committee (DOC) monitors and evaluates the operational activities of contracted Delegates to ensure adherence to contractual obligations, regulatory requirements and policy performance. Elements of delegation are monitored on monthly, quarterly and annual basis for trending and assessment of ongoing compliance. The reporting includes review of monthly assessment packets, encounter adequacy reports and Provider Services highlights. All oversight audits performed on delegates are reported to the DOC. CAP activities are implemented as deficiencies are identified. Findings and summaries of DOC activities are reported to the Compliance Committee.

24. PROGRAM DESCRIPTIONS

C. Quality Management and Quality Improvement Program Description

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	September 1, 1999
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

24. PROGRAM DESCRIPTIONS

D. Fraud, Waste, and Abuse Program Description

Introduction

A. IEHP believes that compliance with fraud prevention and reporting is everyone's responsibility. IEHP has developed a Fraud, Waste, and Abuse (FWA) Program to comply with the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage requirements in preventing and detecting fraud, waste, and abuse in Federal and State funded programs.[1] The objective of IEHP's FWA Program is to identify and reduce costs caused by fraudulent activities and to protect consumers, Members, Health Care Providers and others in the delivery of health care services.

Mission, Vision and Values

A. Mission: We heal and inspire the human spirit.

B. Vision: We will not rest until our communities enjoy optimal care and vibrant health.

C. Values: We do the right thing by:

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

Fraud, Waste, and Abuse (FWA) Program Scope

A. Providers, First Tier Entities, Downstream Entities, and Contractors are educated regarding the Federal and State False Claims statutes and the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs.[2]

B. IEHP has created a Special Investigations Unit (SIU) that reports to the Compliance Officer to oversee its FWA Program and to manage all instances of suspected fraud, waste, and abuse.

C. All activities of the SIU are confidential to the extent permitted by law.

D. IEHP reports its fraud prevention activities and suspected fraud, waste, and abuse to regulatory and law enforcement agencies as required by law and contractual obligations.

E. Providers, First Tier Entities, Downstream Entities, and Contractors must adhere to Federal and California State laws, including but not limited to False Claims laws.

F. Providers, First Tier Entities, Downstream Entities, and Contractors with IEHP will comply with Federal and California State laws in regard to the detection, reporting, and investigation of suspected fraud, waste, and abuse.

G. Providers, First Tier Entities, Downstream Entities, and Contractors with IEHP will participate in investigations as needed.

[1] Title 42 Code of Federal Regulation (CFR) §§ 422, 423 and 438.608
[2] Title 31 United States Code (U.S.C) §3729

H. The IEHP FWA Program is designed to deter, identify, investigate, and resolve potentially fraudulent activities that may occur in IEHP daily operations, both internally and externally.

Definitions

A. First Tier Entity: Any party that enters a written arrangement with an organization or contract applicant to provide administrative or health care services for an eligible individual.

B. Downstream Entity: Any party that enters an acceptable written arrangement below the level of the arrangement between an organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

C. Contractors: Includes all contracted Providers and suppliers, First Tier Entities, Downstream Entities, and any other entities involved in the delivery of payment for or monitoring of benefits.

D. A complaint of fraud, waste, and/or abuse is a statement, oral or written, alleging that a Practitioner, supplier, or beneficiary received a benefit to which they are not otherwise entitled. Included are allegations of misrepresentations and violations of Medicaid or other health care program requirements applicable to persons applying for covered services, as well as the lack of such covered services.

E. Fraud and Abuse differ in that:

1. Abuse applies to practices that are inconsistent with sound fiscal, business, medical or recipient practices and result in unnecessary cost to a health care program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Mistakes that are repeated after discovery or represent an on-going pattern could constitute abuse.

2. Fraud is an intentional or knowing misrepresentation made by a person with the intent or knowledge that could result in some unauthorized benefit to him/herself or another person. It includes any portion that constitutes fraud under applicable Federal or State law. Mistakes that are not committed knowingly or that are a result of negligence are not fraud but could constitute abuse.

F. Waste includes overuse of services, or other practices that, directly or indirectly, results in unnecessary cost. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources (i.e., extravagant, careless, or needless expenditure of healthcare benefits/services).

IEHP Responsibilities[3]

A. Both IEHP and Providers have responsibilities for fraud prevention.

[3] 42 CFR § 438.608

B. IEHP's Compliance Officer is responsible for ensuring that the objectives of IEHP's FWA Program are carried out, and for preventing, detecting, and investigating fraud-related issues in a timely manner. To accomplish this, the Compliance Officer designates and oversees the Compliance Department to perform the following responsibilities:

1. Developing fraud, waste, and abuse training programs to educate staff, Providers, Practitioners, Members, First Tier Entities, Downstream Entities, and Contractors on prevention, deterrence and detection of fraud, waste, and abuse.
2. Identifying, detecting, thoroughly investigating, managing, and resolving all suspected instances of fraud, waste, and abuse, both internally and externally.
3. Cooperating with, reporting, and referring suspected fraud, waste, and abuse to the appropriate governmental and law enforcement agencies, as applicable, including exchange of information as appropriate.

C. IEHP responsibilities include, but are not limited to the following:

1. Training IEHP staff, Providers, Practitioners, First Tier Entities, Downstream Entities, and Contractors on fraud, waste, and abuse; IEHP Fraud, Waste, and Abuse Program, and fraud prevention activities at least annually.
2. Communicating its FWA Program and efforts through the IEHP Provider Policy and Procedure Manual, IEHP Provider Newsletter, Joint Operation Meetings, the IEHP website, targeted mailings, or in-service meetings.
3. Continuous monitoring and oversight, both internally and externally, of daily operational activities to detect and/or deter fraudulent behavior. Such activities may include, but are not limited to:
    a. Monitoring of Member grievances;
    b. Monitoring of Provider grievances;
    c. Claims Audits and monitoring activities, including audits of the P4P Program and other direct reimbursement programs to physicians;
    d. Review of Providers' financial statements;
    e. Medical Management Audits;
    f. Utilization Management monitoring activities;
    g. Quality Management monitoring activities;
    h. Case Management Oversight activities;
    i. Pharmacy Audits;
    j. Encounter Data Reporting Edits;
    k. Chart Audits; and

l. Clinical Audits.

4. Investigating and resolving all reported and/or detected suspected instances of fraud and taking action against confirmed suspected fraud, waste, or abuse, including but not limited to reporting to law enforcement agencies, termination of the IEHP contract (if a Provider, direct contracting Practitioner, First Tier Entities, Downstream Entities, and Contractors), and/or removal of a participating Practitioner from the IEHP network. IEHP reports suspected fraud, waste, or abuse to the following entities, as deemed appropriate and required by law:
   a. The Centers for Medicare & Medicaid Services (CMS) through the National Benefit Integrity Medicare Drug Integrity Contractor (Qlarant)
   b. The State and/or Federal Offices of the Inspector General (Medicaid/Medicare Fraud)
   c. California Department of Health Care Services (DHCS), in certain instances.
   d. Local law enforcement agencies
5. Submitting periodic reports to CMS as required by law.
6. Encouraging and supporting Provider activities related to fraud prevention and detection.

Providers, First Tier Entities, Downstream Entities, and Contractor's Responsibilities[4]

A. The Providers, First Tier Entities, Downstream Entities, and Contractor's responsibilities for fraud prevention and detection include, but are not limited to, the following:
   1. Training staff on IEHP's and Provider's Fraud, Waste, and Abuse (FWA) Program and fraud, waste, and abuse prevention activities and false claims laws upon initial employment and at least annually thereafter.
   2. Verifying and documenting the presence/absence of office staff and contracted individuals and/or entities by accessing the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE); the General Services Administration Excluded Parties List (GSA); and/or the California Medi-Cal exclusion list, available online, prior to hire or contracting and monthly thereafter.
   3. Terminating the IEHP Medi-Cal network participation of individuals and/or entities who appear on any of the aforementioned exclusion lists. See Policy MA_24E, "Compliance Program Description".
   4. Developing a FWA Program, implementing fraud, waste, and abuse prevention activities and communicating such program and activities to staff, contractors, and subcontractors.
   5. Communicating awareness, including:

[4] 42 CFR § 438.608

a. Identification of fraud, waste, and abuse schemes.

b. Detection methods and monitoring activities to contracted and subcontracted entities and IEHP.

6. Promptly investigating and addressing potential fraud, waste, and abuse issues as they arise. Providers must initiate a reasonable inquiry as quickly as possible, but no later than two (2) weeks after the date the potential issue was identified.[5]

7. Reporting suspected fraud, waste, and abuse issues to IEHP within ten (10) days of becoming aware of or notified of such activity.[6]

8. Participating in the investigation process as needed.

9. Taking action against suspected or confirmed fraud, waste, and abuse.

10. Policing and/or monitoring own activities and operations to detect, deter, and correct fraudulent behavior.

11. Cooperating with IEHP in fraud, waste, and abuse detection and awareness activities, including monitoring, reporting, etc., as well as cooperating with IEHP in fraud, waste, or abuse investigations to the extent permitted by law.

12. Returning identified overpayments of State and/or Federal claims within federal timelines.

Reporting Concerns Regarding Fraud, Waste, Abuse, and False Claims

A. IEHP takes issues regarding false claims and fraud, waste, and abuse seriously. IEHP Providers, and the contractors or agents of IEHP's Providers are to be aware of the laws regarding fraud, waste, and abuse and false claims and to identify and resolve any issues immediately. Affiliated Providers' employees, managers, and contractors are to report concerns to their immediate supervisor when appropriate.

B. IEHP provides the following ways in which to report alleged and/or suspected fraud, waste, and/or abuse directly to the plan:

1.	By Mail to:	IEHP Compliance Officer Inland Empire Health Plan P.O. Box 1800 Rancho Cucamonga, CA 91729-1800
2.	By E-mail to:	compliance@iehp.org
3.	By toll free number:	(866) 355-9038 (Compliance Hotline)
4.	By fax to:	(909) 477-8536

[5] 42 C.F.R. §§422.503(b)(4) & 423.504(b)(4), Medicare Managed Care Manual Chapters 9 & 21, Section 50.7.1
[6] Ibid.

5. By Webform: IEHP.org Provider Resources – Compliance Tab

C. The following information is needed for IEHP to investigate suspected fraud, waste, and/or abuse:

1. Your name, title and organization name, unless you choose to report anonymously. If you choose to give your name, please provide a contact number and a date and time for a return call at a time and place confidential for you.
2. The name(s) of the party/parties/departments involved in the suspected fraud.
3. The name(s) and/or Member identification number(s) of potentially impacted beneficiaries.
4. Where the suspected fraud may have occurred.
5. Details on the suspected activity.
6. When the suspected fraud took place, for example over what period of time.
7. A description of any documentation in your possession that may support the allegation of fraud, waste, and/or abuse.

D. Information reported to the IEHP Compliance Department or Special Investigation Unit will remain confidential to the extent allowable by law.

E. IEHP expressly prohibits retaliation against those who, in good faith, report potential fraud, waste, and abuse. Information about whistleblower protections and the False Claims Act is included in the annual Compliance Training Program available to Providers, First Tier Entities, Downstream Entities, and Contractors.

24. PROGRAM DESCRIPTIONS

D. Fraud, Waste, and Abuse Program Description

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 2007
Chief Title: Chief Executive Officer	**Revision Date:**	January 1, ~~2022~~2023

24. PROGRAM DESCRIPTIONS

E. Compliance Program Description

Introduction

A. IEHP is committed to conducting its business in an honest and ethical manner and in compliance with the law. IEHP has established and implemented a Compliance Program to promote our culture of ethical conduct and compliance. The Compliance Program Description sets forth the principles, policies, and procedures for how IEHP Team Members, Governing Board Members, as well as subcontracted entities (First Tier, Downstream, and Related Entities (FDRs)) are required to conduct business and themselves. IEHP's Compliance Program is built upon and implemented in accordance with applicable Federal and State laws, regulations and guidelines, including those set forth by the Federal Sentencing Guidelines (FSG) and Office of Inspector General (OIG) Seven Elements of an Effective Compliance Program. This Compliance Program Description sets forth the requirements in which IEHP expects the Delegated entities to develop their Compliance Programs.

Mission, Vision and Values

A. Mission: We heal and inspire the human spirit.

B. Vision: We will not rest until our communities enjoy optimal care and vibrant health.

C. Values: We do the right thing by:

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

Compliance Program Scope

A. Delegated entities must implement a Compliance Program to provide a systematic process dedicated to ensuring that management, employees, business associates, FDRs and other associated individuals/entities comply with applicable health care laws, Federal and State requirements, and all applicable regulations and standards.[1,2,3,4,5]

B. The Compliance Program must include:

1. Standards of conduct, policies and procedures to support and sustain Compliance Program objectives.
2. Be overseen by the Board Directors and senior management levels.

[1] Medicare Managed Care Manual, Chapter 21 Compliance Program Guidelines
[2] Prescription Drug Benefit Manual, Chapter 9 Compliance Program Guidelines
[3] General Provisions 42 CFR § 422.503 (b)(4)
[4] Program integrity requirements under the contract 42 CFR § 438.608
[5] Centers for Medicare and Medicaid Services, Policy CMS 4182 Final Rule

3. Process to report compliance activities and outcomes to the Board of Directors/Governing Board ("Board"), senior management, IEHP employees and applicable regulatory agencies.
4. Screening of employees, Board Members, business associates, FDRs, and other affiliated individuals/entities for the presence/absence of program-related adverse actions and/or sanctions.
5. Education and training: General training on health care regulatory requirements; specific training on job functions; and training to business associates, downstream entities/subcontractors, and other external affiliates.
6. Ongoing auditing and monitoring of the organization's compliance performance, including preventive practices identifying potential compliance issues.
7. Enforcement measures, including implementation of corrective action plans (CAP), enacted when issues of non-compliance are identified.
8. Preventive practices to identify potential compliance issues and to implement actions that lower or mitigate risk.
9. Evaluation to determine the effectiveness of the compliance program.

C. Delegated entities must implement an effective compliance program that meets regulatory guidelines.

Written Policies, Procedures, and Standards of Conduct

A. Code of Conduct – All Delegated entities are required to implement a Code of Conduct that demonstrates their commitment to compliance and articulates the core values and principles that guide the organization's business practices and ensures that Compliance with all federal and state laws is the responsibility of all employees. The Code should be communicated to Employees (Temporary and Permanent), Providers, Contractors, Board Members, and Volunteers.

1. The Code can be communicated by various methods, including:
    a. Provided to new Employees in the Employee Handbook upon initial employment.
    b. Discussed during Compliance New Hire and Annual Training.
2. Employees are required to acknowledge their understanding of the Code of Conduct and their commitment to comply with its intent within ninety (90) days of initial employment and annually thereafter.
3. Delegated entities should also provide a Code of Conduct to their business associates that address their obligations toward conducting business at the highest level of moral, ethical and legal standards.
    a. The Code of Conduct should include reporting requirements for any issue of non-compliance.

B. Policies and Procedures – All Delegated entities should develop Policies and Procedures that:

1. Address commitment to complying with all Federal and State standards;
2. Provide direction on dealing with suspected, detected or reported compliance issues;
3. Provide guidance on reporting compliance issues;
4. Include a policy of non-intimidation and non-retaliation for good faith efforts to reporting potential non-compliance issues; and
5. Are reviewed on an annual basis, or more often to incorporate changes in applicable laws, regulations, or other program requirements.

Compliance Officer, Compliance Committee, and High-Level Oversight

A. Compliance Officer

1. The Compliance Officer is an employee of the Delegated entity, or the Management Services Organization (MSO) acting on behalf of the Delegated entity and should report directly to the highest level of the organization. The responsibilities may include, but are not limited to:
   a. Advising the organization and downstream entities/subcontractors on policy requirements and the development, distribution and implementation of policies.
   b. Ensuring that policies accurately and effectively communicate compliance and regulatory requirements.
   c. Periodically reviewing policies and initiating needed updates.
   d. Notifying Senior Management and IEHP of non-compliance issues.
   e. Preparing an update on a periodic basis of the Compliance Program for presentation to the Governing Board, which includes at a minimum:
      1) Policy updates.
      2) Issues of Non-Compliance.
      3) Fraud, Waste and Abuse detection, monitoring and reporting.
      4) Auditing and Monitoring Program Updates.

B. Executive Compliance Committee (ECC)

1. Delegates must implement an Executive Compliance Committee, accountable to oversee and support the Compliance Officer in the implementation of the Compliance Program. The Compliance Committee, is accountable to senior management and the Governing Board, is a multidisciplinary body that must meet periodically (on a quarterly basis). The Compliance Officer chairs the meeting. The Committee Membership must be comprised of individuals with a variety of backgrounds and reflect the size and scope of the delegate.

Members of the Compliance Committee should have decision-making authority in their respective areas of expertise. [6,7]

2. Duties of the Committee should include:

   a. Meeting periodically, however, frequently enough to enable reasonable oversight of the compliance program;

   b. Review the results of the annual risk assessment;

   c. Review corrective action plans and monitor their development;

   d. Review the outcome of compliance activities;

   e. Reviewing and addressing reports of monitoring and auditing of areas in which the delegate is at risk for program noncompliance or potential FWA and ensuring that corrective action plans are implemented and monitored for effectiveness; and

   f. Provide regular reports on the outcome of the Committee's activities to the delegate's Governing Board.

   ~~f.~~g. Review of the Compliance KPI Dashboard report.

C. High Level Oversight – The Delegated entity's Governing Body should be responsible for:

1. The annual review and approval of the Compliance, Fraud, Waste, and Abuse, and HIPAA Programs;

2. Adoption of written standards including the Delegated entity's Code of Conduct;

3. Monitoring and support of the compliance program; and

4. Understanding regulatory and/or contract changes, policy changes and health reform and the impact on the Delegated entity's Compliance Program.

Effective Training and Education

A. IEHP requires FDRs to provide Compliance Training to all Employees (Temporary and Permanent), Providers, Governing Body, contractors, vendors, and volunteers.

1. Compliance Training must be provided within ninety (90) days of initial employment/start, whenever significant changes are made to the Compliance Program, upon changes in regulatory or contractual requirements related to specific job responsibilities or when legislative updates occur and on an annual basis.

   Training should include, at a minimum:

   a. Reinforcement of the organization's commitment to compliance.

[6] General Provisions 42 C.F.R. § 422.503(b)(4)(vi)(B)
[7] General Provisions 42 C.F.R. §423.504(b)(4)(vi)(B)

b. Privacy/confidentiality issues, as well as regulatory updates and recent health care compliance related adverse actions such as penalties and settlements.

c. Fraud, waste, and abuse issues as well as regulatory updates and recent health care compliance related adverse actions such as penalties and settlements.

d. HIPAA Privacy and Security and the Health Information Technology for Economic and Clinical Health (HITECH) Act regulations.

e. Laws that may directly impact job related functions such as anti-kickback laws, privacy breaches, the False Claims Act, and the consequences of non-compliance.

f. Changes in compliance and regulatory requirements and updates on the consequences of non-compliance with these requirements.

g. Responsibilities to report concerns, misconduct, or activities related to non-compliance.

2. Delegated entities may use a written test or develop other mechanisms to assess effectiveness of the training.

3. FDRs who have met the Fraud, Waste, and Abuse (FWA) certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and supplies (DMEPOS), are deemed to have met the training and educational requirements for FWA, but must provide an attestation to IEHP of deemed status. FDRs may also meet their FWA training requirements in the following way:

   a. Option 1, FDRs can adopt IEHP's General Compliance, FWA, HIPAA Privacy Security training.

   b. Option 2, Incorporation of the content of the CMS standardized training modules related to General Compliance, FWA, HIPAA Privacy Security into the organization's existing compliance training materials/systems.

   c. Option 3, FDRs may also utilize the Industry Collaboration Effort (ICE) Fraud, Waste, and Abuse (FWA) training as an acceptable mode of completing FWA requirement.

4. Documentation of education/training activities must be retained for a period of ten (10) years. Documentation may include sign-in forms, signed attestations, and the completion of testing results.

Effective Lines of Communication

A. IEHP requires all FDRs, vendors, and other business associates to report compliance concerns and suspected or actual misconduct regarding delegated functions, IEHP Members, and Providers. This requirement is communicated through:

1. Provider Manuals, newsletters, and bulletins. Providers and Delegated entities are required to submit signed acknowledgement of their receipt of the Provider Manual which delineates compliance reporting responsibilities;
2. Annual Compliance training for all FDRs; and
3. The IEHP Code of Business Conduct and Ethics (See Attachment, "IEHP Code of Business Conduct and Ethics" in Section 23).

B. IEHP has the following mechanisms available for reporting Compliance issues:

1. Compliance Hotline - (866) 355-9038, 24/7 Compliance Hotline with supported language translation capability for confidential reporting are available to Team Members, Members, Providers, Business Associates, First Tier and Downstream entities, and any individual/entity with a compliance concern;
2. E-mail - compliance@iehp.org;
3. Secure fax - (909) 477-8536; or
4. Mail - Compliance Officer, PO Box 1800, Rancho Cucamonga, CA 91729.

C. IEHP has a non-intimidation, non-retaliation policy for good faith reporting of compliance concerns and participation in the compliance program, including any investigation that may occur.

D. Delegated entities are expected to develop similar mode of referring compliance issues, including reporting non-compliance issues to IEHP.

Well Publicized Disciplinary Standards

A. Delegated entities must develop and implement disciplinary policies that reflect the organization's expectations for reporting compliance issues including non-compliant, unethical, or illegal behavior.

B. Policies should provide for timely, consistent, and effective enforcement of established standards when non-compliance issues are identified.

C. Disciplinary standards should be appropriate to the seriousness of the violation.

Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks

A. Delegated entities must develop a monitoring and auditing component of the Compliance Program to test and confirm compliance across functional areas with contractual, legal and regulatory requirements to ensure compliance of their delegated function. The monitoring and auditing processes must be documented to show subject, method and frequency.

B. Definitions:

1. Audit - a formal review of compliance with a set of standards (e.g., policies and procedures, laws and regulations) used as base measures.

2. Monitoring - regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
3. Risk assessments - broad based audits used to identify opportunities for improvement.

C. IEHP utilizes both internal and external resources to conduct the audit program. It is IEHP's expectation that the individual or Delegated entity responsible for the audit content cooperate with the audit process by providing access to documents and other information requested.
   1. Methods of review include, but are not limited to:
      a. Provider/Contractor initial contract and annual Delegation Oversight Audits;
      b. Quarterly Reporting;
      c. External reviews of medical and financial records that support claims for reimbursement and Medicare cost reports; and
      d. Trend analysis and studies that identify deviations in specific areas over a given period.

D. Delegated entities must implement a screening program for employees, Board Members, contractors, and business partners to avoid relationships with individuals and/or entities that tend toward inappropriate conduct. This program includes:
   1. Prior to hiring or contracting and monthly thereafter, review of the Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE) that are excluded from participation in government health care programs.[8,9]
   2. Prior to hiring or contracting and monthly thereafter a monthly review of the GSA System for Award Management (SAM).
   3. A monthly review of the Department of Health Care Services Medi-Cal Suspended and Ineligible list and the Centers for Medicare and Medicaid Services Preclusion List.
   4. Criminal record checks when appropriate or as required by law.
   5. Standard reference checks, including credit for Employees.
   6. Review of the National Practitioner Databank (NPDB).
   7. Review of professional license status for sanctions and/or adverse actions.
   8. Reporting results to Compliance Committee, Governing Body, and IEHP as necessary.

Procedures and System for Prompt Response to Compliance Issues

A. Adverse findings routinely require corrective action plans, designed to identify the root cause of compliance failures; to implement actions directed at improving performance and/or

[8] (OIG) List of Excluded Individuals and Entities (LEIE)
[9] Scope and Effect of Exclusion 42 CFR § 1001.1901

eliminating risk; and, to ensure that desired results are being sustained. Follow-up auditing and/or monitoring is conducted to assess the effectiveness of these processes.

B. Delegated entities must develop and implement a system for reporting and prompt response to non-compliance and detected offenses.

1. When potential and/or actual non-compliance is reported or suspected, the following steps should be taken:

a. The activity causing the non-compliance should be promptly halted and/or mitigated to the extent possible to prevent harm to individuals, entities and/or IEHP.

b. Investigations should be promptly initiated in accordance with the Fraud, Waste, and Abuse Plan; the HIPAA Plan, the Compliance Plan, and/or in consultation with the IEHP Special Investigations Unit (SIU) or the Compliance Officer who has the authority to open and close investigations.

c. The implementation of Corrective Action Plans (CAP) should be based on the policy guidance that address the issue of non-compliance, as appropriate. These may include, but are not limited to:

1) Initiation of corrective action plans and/or agreements.

2) Repayment of identified over-payments.

3) Initiation of Task Forces to address process and/or system deficiencies that may have caused or contributed to the non-compliance.

4) Additional education and training.

5) Modification of policies and procedures.

6) Discipline or termination of Employees or contracts.

d. Preventive measures should be implemented to avoid similar non-compliance in the future, including monitoring of corrective action plans.

1) Investigations may consist of an informal inquiry or involve formal steps such as interviews and document collection, depending on the circumstances involved.

2) Investigations should be conducted in consultation with the Compliance Officer who has the final authority to determine this process.

3) External investigations should be performed by the Special Investigation Unit (SIU) Team or related unit. Referrals to legal counsel and/or other external experts should be utilized as deemed appropriate by the Compliance Officer.

4) The timeliness and progress of the investigation should be documented by the SIU Team or related unit.

5) Documents and evidence obtained during investigations should be retained for a period of no less than ten (10) years.

e. Reporting of these activities and their results should be provided to:

1) The Compliance Officer;

2) The Compliance Committee;

3) Chief Executive Officer;

4) The Governing Body, if the Compliance Officer in consultation with the Chief Executive Officer deems there is a significant non-compliance finding;

5) Governmental authorities, as determined by the Compliance Officer, if there is an obligation to report misconduct that violates criminal, civil or administrative law within a reasonable time of discovery;

6) Responses to government inquiries and investigations should be coordinated by the Compliance Officer; and

7) IEHP Compliance Department.

Assessment of Compliance Effectiveness

A. On an annual basis, Delegated entities must conduct a review of the Compliance Program to ensure the Program is effective in meeting applicable State and Federal regulations, and preventing Fraud, Waste, and Abuse (FWA). The assessment should include, but is not limited to:

1. Written Policies and Procedures and Standards of Conduct;
2. Designation of a Compliance Officer and High Level Oversight;
3. Effective Lines of Communication;
4. Well Publicized Disciplinary Standards;
5. Ongoing Education and Training;
6. Effective System for Routing Auditing, Monitoring, and Identification of Compliance Risks; and
7. Reporting and Prompt Response for Non-Compliance, Potential FWA, and Detected Offenses.

24. PROGRAM DESCRIPTIONS

E. Compliance Program Description

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	July 1, 2015
Chief Title: Chief Executive Officer	**Revision Date:**	January 1, 2022