17. 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). 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;
2. Participate in committees and workgroups to ensure cross-departmental program deliverables are accessible and appropriate for Members, 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]

[1] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 6, Section 6.1 Basic Customer Service Requirements

3. Promote Member-centric care through the implementation and participation in an Interdisciplinary Care Team (ICT) comprised of medical, behavioral, and social service professionals from governmental and community-based organizations;
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); 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;[2,]
2. Develop and maintain a current, accessible online resource center on the IEHP website for health Providersand 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
5. Offer "text-only" navigation on our website (www.iehp.org) and ensure IEHP compliance with access standards; and
6. Publish a quarterly Member newsletter ("Access Ability") to provide targeted communication for Members with disabilities.

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:

[2]

Braille, large-sized print, video or audio, CD or DVD, over the phone or in-person from a qualified health educator;[3,4,5,6]

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;[7]
3. Integrate policies for providing sign language interpreters and materials in alternative formats;
4. Monitor requests and distribution of materials in alternative format with Delegation Oversight Department. All submissions requiring transcription to alternative formats must be submitted to IEHP within 24 hours of an identified need. IEHP will send any alternative format letters requests to the Vendor;
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;
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
7. Publish a quarterly Member newsletter ("Access Ability") to provide targeted communication for Members with disabilities.

D. **Disability Sensitivity**

1. Develop cultural awareness and sensitivity training materials and provide training to IEHP Team Members, Providers, and their staff initially and as needed, to meet the needs of SPDs, as required by the California Department of Health Care Services and Centers for Medicare and Medicaid Services.[8]
2. Coordinate the annual Equity and Diversity 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.

[3] Title 42 Code of Federal Regulations (CFR) § 438.10(d)
[4]" Ibid.
[5] California Welfare & Institutions Code (Welf. & Inst. Code) § 1367.042
[6] California Health & Safety Code (Health & Saf. Code) § 1367.042
[7]" California Welfare & Institutions Code (Welf. & Inst. Code) § 1367.042(a)(2)
[8] Health & Saf. Code § 1300.67.04

17. PROGRAM DESCRIPTIONS

A. Disability Program Description

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 also the Program Manager), 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.
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 Supervisor, Community Health Representatives, Analyst, Culture and Linguistics Specialist and Coordinator, Community Health Workers.

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17. 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.[1,2,3] The C&L Services program fulfills its mission through the following activities:

1. Ensuring IEHP, Provider network comply with Department of Health Care Services (DHCS) and Federal regulations on Culture and Linguistic services;[4]
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;[5,6]
3. Providing training, support, technical assistance and resources to Providers to assist them in the provision of culturally competent and linguistic services;[7]
4. Training IEHP staff on cultural awareness within the first year of employment and providing updates on C&L resources;[8,9,10]
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;[11] and

[1] Title 45 Code of Federal Regulations (CFR) 92.101(a)
[2] 42 CFR § 422.110(a)
[3] 42 CFR § 440.262
[4] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367.04
[5] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367.042
[6] Ibid.
[7] California Welfare and Institutions Code (Welf. & Inst. Code), § 1367.04(h)(2)
[8] Ibid.
[9] Title 28 California Code of Regulations (CCR) § 1300.67.04
[10] 42 CFR § 440.262
[11] California Welfare & Institutions Code (Welf. & Inst. Code) § 1300.51

7. Implementing activities to educate Team Members on cultural diversity in the Membership and Provider network and raising awareness of IEHP C&L policies and resources.

Cultural & Linguistic Services Program Activities

A. **Member Information Materials**

1. Member Information, as defined by DHCS, includes documents that are vital or critical to obtaining services and/or benefits and includes, but is not limited to, the Member Handbook/Evidence of Coverage; provider directory; welcome packets; marketing information; form letters, including Notice of Action letters and any notices related to Grievances, actions, and Appeals, including Grievance and Appeal acknowledgement and resolution letters; plan generated preventive health reminders (e.g., appointments and immunization reminders, initial health examination notices and prenatal follow-up); member surveys; notices advising LEP persons of free language assistance; and newsletters. [12,13]
2. IEHP provides oral and written Member information in the threshold languages designated by DHCS in accordance with federal and state regulations.[14]
3. Members may make standing requests to receive all written Member information, including clinical Member information, in a specified threshold language and/or in an alternative format. IEHP contracts with qualified translators for the threshold languages and alternative formats identified by DHCS.[15,16]

B. **Member Health Educational Materials**

The Health Education, Marketing, and Independent Living and Diversity Services Departments review and approve externally and internally developed Member health 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.[17]

C. **Coordination of Local Resources**

[12] Covered California (CCA) Qualified Health Plan Issuer Contract, Article 6, Section 6.3, Application and Notices
[13] Ibid.
[14] 42 CFR §438.10(d)
[15] California Welfare & Institutions Code (Welf. & Inst. Code) § 1367.041
[16] Ibid.
[17] California Welfare & Institutions Code (Welf. & Inst. Code) § 1367.042

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.

D. **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's Members and Provider network. Policy development includes setting standards specific to IEHP and informing Providers of the standards.

E. **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.[18, ,19,20]

F. **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.[21] To ensure continued availability of the threshold language(s), the IEHP Provider Services Department verifies threshold language capability on an annual basis.[22]

G. **Cultural and Linguistic Training**

[18] California Welfare & Institutions Code (Welf. & Inst. Code) § 1367.04
[19] 42 CFR § 43.10(d)
[20] 28 CCR § 1300.67.04
[21] California Welfare & Institutions Code (Welf. & Inst. Code) § 1367.049(d)(9)
[22] 28 CCR, § 1300.67.04

Training on cultural competence/sensitivity and IEHP C&L Program policies are available to Providers and their staff initially and annually thereafter. All Providers must complete the DEI eCourse found on the Provider webpage at www.IEHP.org through the following path: Home \ For Providers \ Provider resources \ Training and submit an eAOR annually. IEHP Network are required to receive training in Diversity, Equity, and Inclusion. C&L standards, and IEHP C&L resources provided by the Provider Services Representatives and other appropriate IEHP Team Members.[23] Providers can also participate in the following online cultural competency trainings:

1. Office of Minority Health –https://thinkculturalhealth.hhs.gov
2. CDC – https://www.cdc.gov/healthliteracy/
3. U.S. Department of Health and Human Services, Health Resources and Services administration – https://www.hrsa.gov All new employees receive cultural awareness training within their first year of employment.[24,25,26] 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 Evaluation

A. IEHP conducts processes to monitor the delivery of and evaluates the impact and/or outcome of C&L services and takes effective action to address any improvements as needed.[27] Program evaluation activities include, but are not limited to:[28]

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

[23] California Welfare & Institutions Code (Welf. & Inst. Code) § 1367.043
[24] Ibid.
[25] 42 CFR § 440.262
[26] 28 CCR § 1300.67.04
[27] California Welfare and Institutions Code (Welf. & Inst. Code), § 1300.67.04
[28] Ibid.

required. The Program Manager staff consist of Supervisor, Community Health Representatives, Analyst, Cultural and Linguistics Specialist, Community Health Workers and Coordinators.

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17. 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:

   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.

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.

17. PROGRAM DESCRIPTIONS

C. Quality Management and Quality Improvement Program Description

QM/QI Program Scope

A. The Quality Management & Health Equity Transformation Committee (QMHETC) 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 population health 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 QMHETC;
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;
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 QMHETC and other committees, including meeting frequency;
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);

[1] National Committee for Quality Assurance (NCQA), 2024 Health Plan Standards and Guidelines, QI 1, Element A, Factor 1
[2] NCQA, 2024 HP Standards and Guidelines, QI 1, Element A, Factor 2
[3] NCQA, 2024 HP Standards and Guidelines, QI 1, Element A, Factor 4

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[4]

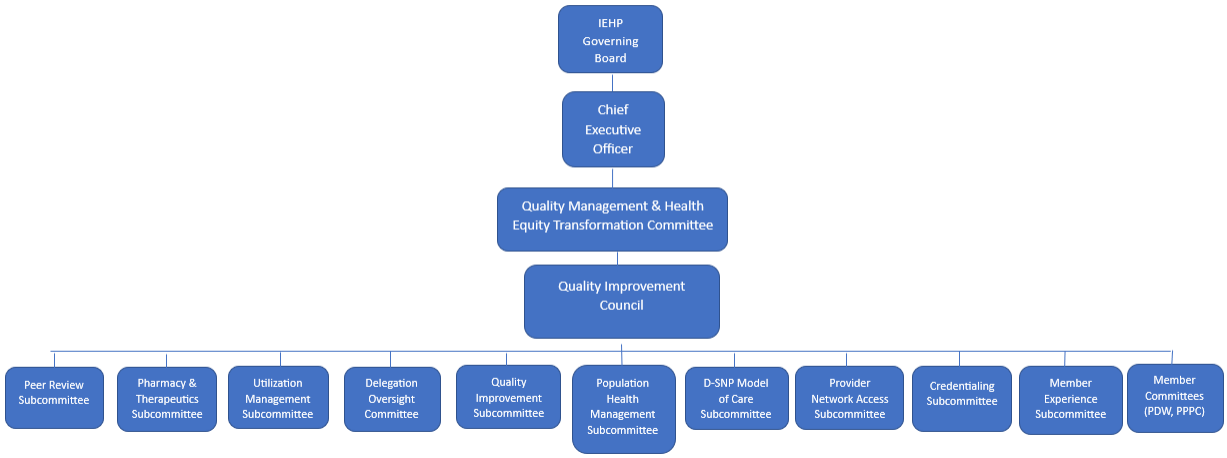
A. The primary goal of the QM/QI Program is to continuously assess and improve the quality of care, services, and safety of healthcare delivered to IEHP Members. The QM/QI Program goals are to:
   1. Implement strategies for Population Health Management (PHM) that keep Members healthy, manage Members 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.

Authority and Responsibility[5]

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.

[4] NCQA, 2024 HP Standards and Guidelines, QI 1, Element A, Factor 1
[5] NCQA, 2024 HP Standards and Guidelines, QI 1, Element A, Factor 1

Further details can be found in the IEHP organizational chart.



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 & Health Equity Transformation Committee (QMHETC) 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 QMHETC with administrative processes and direction for the overall QM/QI Program initiated through the CMO and CQO, or Medical Director designee.'[6]

[6] NCQA, 2024 HP Standards and Guidelines, QI 1, Element A, Factor 3

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)[7]

A. The Chief Medical 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 QMHETC 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 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.

[7] Ibid.

17. PROGRAM DESCRIPTIONS

C. Quality Management and Quality Improvement Program Description

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 & Health Equity Transformation Committee (QMHETC)

A. The QMHETC reports to the Governing Board and retains oversight of the QM/QI Program with direction from the CMO and CQO.[8] The QMHETC 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 QMHETC is responsible for continuously improving the quality of care for IEHP Membership.

2. **Structure:** The QMHETC is composed of Network Providers, Specialists, Medical Directors, Medical Directors who are representative of network Practitioners, Practicing Pharmacists, and Public Health Department Representatives from Riverside and San

[8] NCQA, 2024 HP Standards and Guidelines, QI 1, Element A, Factor 5

Bernardino Counties. 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 QMHETC to assist with behavioral healthcare-related issues.[9] 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 QMHETC meets quarterly and reports findings, actions, and recommendations to IEHP Governing Board (through the CMO) annually and reports meeting minutes to DHCS quarterly. The QMHETC 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 ensure 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. QMHETC findings and recommendations are reported through the CMO to the IEHP Governing Board on an annual basis.

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:

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

[9] NCQA, 2024 HP Standards and Guidelines, QI 1, Element A, Factor 4

Committee Members.

b. A Behavioral Health Practitioner must be present for behavioral health issues.[10]

c. Non-physician Committee Members may not vote on medical issues. [11]

5. **External Committee Members:** QMHETC 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 department collaborate to ensure committee members undergo an OIG/GSA exclusion screening prior to scheduling QMHETC 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 QMHETC, 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. QMHETC members must be screened before being confirmed, and monthly thereafter.

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

6. **Confidentiality:** All QMHETC 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 QMHETC 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.

[10] NCQA, 2024 HP Standards and Guidelines, QI 1, Element A, Factor 4
[11] Ibid.

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

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 QMHETC'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.[12] 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.[13],[14] Practitioners are notified in the Provider Manual. The IEHP QM/QI Program Description and Work Plan are available to 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 policies and procedures and signed conflict of interest statements at the time of the Delegation Oversight Annual Audit.

[12] NCQA, 2024 HP Standards and Guidelines, MED 9, Element D
[13] Title 28, California Code of Regulations § 1300.69(i)
[14] NCQA, 2024 HP Standards and Guidelines, MED 8, Element D

17. PROGRAM DESCRIPTIONS

C. Quality Management and Quality Improvement Program Description

Quality Subcommittees

A. Subcommittee and functional reports are submitted to the QMHETC on a quarterly and ad hoc basis. The following Subcommittees, chaired by the IEHP CMO or designee, report findings and recommendations to the QMHETC:[15]

1. Quality Improvement Council (QIC);
2. Quality Improvement Subcommittee;
3. Peer Review Subcommittee;
4. Credentialing Subcommittee;
5. Pharmacy and Therapeutics Subcommittee;
6. 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 Care Management (BH & CM) and Population Health 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, Population Health Management, Grievance and Appeals, Utilization Management, Compliance, Community Health, HealthCare Informatics, Health Education, Member Services, and Provider Services. The QI Council is facilitated by an IEHP Medical Director or designee. Network Providers, who are representative of the composition of the contracted Provider network, may participate on the subcommittee that reports to the QMHETC.
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.

[15] NCQA, 2024 HP Standards and Guidelines, QI 1, Element A, Factor 5

Quality Improvement Subcommittee

The Quality Improvement Subcommittee is responsible for quality improvement activities for IEHP.

1. **Role:** Reviews reports and findings of studies before presenting to the QIC and works to develop action plans to improve quality and study results. In addition, QI Subcommittee directs the continuous monitoring of all aspects of Behavioral Health Care Management (BH & CM) and Population Health Management (PHM) services provided to Members.
2. **Structure:** The QI Subcommittee is composed of representation from multiple internal IEHP Departments including but not limited to: Quality Systems, Behavioral Health & Care Management, Population Health Management, Grievance and Appeals, Utilization Management, Compliance, Community Health, HealthCare Informatics, Health Education, Member Services, and Provider Services. The QI Council is facilitated by an IEHP Medical Director or designee. Network Providers, who are representative of the composition of the contracted Provider network, may participate on the subcommittee that reports to the QMHETC.
3. **Function**: The QI Subcommittee 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 Subcommittee Work Plan.
4. **Frequency of Meetings:** The QI Subcommittee meets quarterly 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 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 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 Providers who are either directly contracted with IEHP or for those submitted for approval of participation in the IEHP network by 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 Providers. 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 Providers 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.

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 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 Medical Directors, or designated 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.[16]
3. **Function**: The UM Subcommittee reviews and approves the Utilization Management programs annually. The Subcommittee also monitors for over-utilization and under-utilization; and 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.

[16] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factors 2 and 4

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 QMHETC by attending staff. The Committees and Workgroups include:

1. Public Policy Participation Committee (PPPC);
2. Persons with Disabilities Workgroup (PDW);
3. Delegation Oversight Committee; and
4. Compliance 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, racial, ethnic, cultural 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.

Delegation Oversight Committee

A. The Delegation Oversight Committee is an internal committee that monitors the operational activities of contracted Providers, 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.

Compliance Committee

A. The Compliance Committee assists the IEHP Compliance Officer in developing and

enforcing the Compliance Program, which includes overseeing all aspects of IEHP's compliance with regulatory bodies, compliance with the Health Insurance Portability and Accountability Act (HIPAA); monitoring Fraud, Waste and Abuse (FWA), and Privacy and Security activities. The committee provides leadership in establishing a culture of ethical conduct and compliance within IEHP. The Compliance Committee is responsible for advising on strategies and tactics to address compliance and regulatory risks. The Compliance Committee meets as least quarterly 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 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 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 Senior Director of Quality Systems consists of clinical and/or non-clinical directors, managers, supervisors, and administrative staff.

C. The Senior Director of QS has a master's degree with 10-15 years of progressive management or leadership experience in a health care setting, 7-10 years of experience in leading multi-disciplinary teams and/or leading cross-functional project teams. Experience in leading teams in health care research and study design, implementation, and reporting. Knowledgeable in healthcare quality measurement and programs and knowledge of managed care organizational structures and health plan accreditation programs.

Quality Management Department (QM)

A. The Quality Management Department operates under the direction of the Clinical Director of Quality Management and Director of Accreditation Programs. The Clinical Director of Quality Management and the Director of Accreditation Programs report up to the Senior Director of Quality Systems who reports to the Vice President of Quality. The Clinical Director of QM and the Director of Accreditation programs are responsible for oversight of the quality process; implementing, developing, coordinating, and monitoring for quality improvement, 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 Directors of Quality Management also monitor and evaluate the effectiveness of Providers QM systems; coordinates information for the annual QM/QI Program Evaluation and Work Plan; prepares audit results for presentation to the QMHETC, associated Subcommittees, and the Governing Board; and acts as liaison regarding medical issues for Providers, Practitioners, and Members.

B. The Clinical Director of Quality Management and Director of Accreditation Programs oversee staff consisting of clinical Managers, 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 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 Operations Director of UM are responsible for oversight of delegated and non-delegated 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 QMHETC 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 Managers, Supervisors, nurses, analysts, non-clinical 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, racial, ethnic, cultural and linguistic relevance. The Director facilitates effective communication and coordination of care among UM, BH & CM, Pharmaceutical Services, and Health Education departments. Leadership 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 Outreach. 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 or 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 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 delegates, 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 Grievance & 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.

Marketing and Communications Department

A. The Marketing and Communications and Department operates under the direction of the Director of Communications and Marketing, who reports to the Chief Communications and Marketing Officer. The Marketing and Communications 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[17]

A. Annually, and as necessary, the QMHETC 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 QMHETC 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/QI Program Evaluation[18]

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

[17] NCQA, 2024 HP Standards and Guidelines, QI 1, Element A, Factor 5
[18] NCQA, 2024 HP Standards and Guidelines, QI 1, Element C

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 QMHETC 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.

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

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;
   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.
    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 (CAHPS®) results;
        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); de-delegation of specified functions; and/or termination of participation or non-renewal of the agreement with IEHP.

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 initiatives 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. HEDIS® submission for Medi-Cal, IEHP DualChoice and IEHP Covered;
    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, 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, Population Health 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 QM/QI Work Plan and are presented at the QI Subcommittee. In addition, IEHP's performance on HEDIS® measures is reported and discussed annually at the QI Subcommittee, 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. HEDIS® PDSA PIPs - are conducted for each HEDIS® External Accountability Set (EAS) also known as Managed Care Accountability Set (MCAS) measures rates that do not meet the Minimum Performance Level (MPL) or is given an audit result of "Not Reportable". IEHP evaluates ongoing quality improvement efforts on a quarterly basis.
3. NCQA Quality Activities – These are quality improvement activities conducted to meet NCQA accreditation standards.

B. The Quality Improvement/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
All-Cause Readmissions	NCQA	Quality Activity

Disparity Performance Improvement Project – Controlling High Blood Pressure (CBP)	DHCS, HSAG	PIP
Well Care Visits (WCV)	DHCS, HSAG	PIP
Timeliness of Prenatal Care (PPC – Prenatal)	DHCS	PDSA
Cervical Cancer Screening	DHCS	PDSA
Child/Adolescent Health – Well Care Visits in First 30 months of life (W30), Childhood Immunizations	DHCS	SWOT

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. Integrated Care Transitions (ITC) 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 Integrated Care Transitions (ITC) program has been designed to provide solutions to these challenges. Through the ITC 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 ITC program include the following:

      1) Avoiding of hospital readmissions post discharge;

      2) Improvements in health outcomes post discharge from inpatient facilities;

      3) Improving Member and caregiver experience with care received;

      4) Assigned a Care Manager upon each hospital admission who will follow the Member during the entire episode;

      5) Providing a single point of contact for the Member/Caregiver; and

      6) Bi-Directional communication between the Plan, Member and Provider(s)

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

   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 as 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 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 120 calendar days of enrollment for Members. This rate is presented to QI Council for review and analysis. IEHP has a number of 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

1. 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 a number of reasons that include but are not limited to the following:

a. Access to health care services based on geographic regions;

b. Demographic factors also impact over-utilization and under-utilization of services/care:

i. Race, ethnicity, and language preference (RELP);

ii. Knowledge and perceptions regarding health care which are largely driven by cultural beliefs; and

iii. Income and socioeconomic status.

2. 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:
   a. Identify the dominant utilization patterns within the population.
   b. 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 QMHET Committee for discussion and recommendations as needed.

Availability of PCPs by Language

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 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.[19]

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.

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

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.

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;[20]
   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

[20] 28 CCR § 1300.67.2.2(c)

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 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 experience n study is to identify and implement opportunities to improve Member experience.

B. **Population Health 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 Population Health 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.[21]

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 QMHET Committee. The committees review the findings and make recommendations on potential opportunities for improvements.

[21] NCQA, 2024 HP Standards and Guidelines, PHM 2, Element B

Grievances and Appeals[22]

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;
2. Quality of Practitioner Office Site;
3. Access;
4. Quality of Care;
5. Attitude and Service;
6. Compliance;
7. Quality of Service;
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 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 QMHET Committee. 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

[22] NCQA, 2024 HP Standards and Guidelines, ME 7, Element C

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 QMHET 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), and 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, Ethnic, Racial, and Linguistic Needs of Members[23]

A. IEHP is dedicated to ensuring that all medically covered services are available and accessible to all Members regardless of sex, 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, ethnically, racially, 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, ethnic, racial, and linguistic services are adjusted based on the annual assessment of Member needs. Further details about cultural, ethnic, racial, 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, ethnically, racially, 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. **Cultural, Ethnic, Racial, and Linguistic Study:** The purpose of the study is to identify the cultural, racial, linguistic, and ethnic diversity of IEHP's PCP and Member populations. More specifically, they assess the cultural, ethnic, racial, and linguistic needs of Members in accordance with NCQA standards.
    3. **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

[23] NCQA, 2024 HP Standards and Guidelines, QI 1, Element A, Factor 6

for medical appointments to Members at no cost. The purpose is to provide Members with interpretation services to Members/callers.

4. **Ongoing monitoring of grievances related to language and culture:** Grievances are reported to monitor cultural and linguistic services provided to Members.

Delegation Oversight

A. When applicable, IEHP monitors Delegate performance in QM, UM, CM, credentialing and re-credentialing, compliance, and their implementation of related regulatory activities through Delegation Oversight activities. See policy 18A2, "Delegation Oversight – Audit."

Auditing and Monitoring Activities

A. IEHP performs a series of activities to monitor 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 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. The Plans 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. Health Plans with trends of deficient scoring must submit a CAP to remedy any deficiencies. If anthe plan 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 Plan to new Member enrollment, as applicable;

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

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

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

   f. Not renew the contract.

7. **Assessment and Monitoring:** To ensure that the Plan 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.

17. PROGRAM DESCRIPTIONS

C. Quality Management and Quality Improvement Program Description

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☒ NCQA
Original Effective Date:	January 1, 2024	
Revision Effective Date:		

17. 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 certain requirements set forth in the Deficit Reduction Act of 2005 with regard to Federal and State False Claims laws[1], the Department of Managed Health Care (DMHC)[2] , as well as to meet the expectations of the Federal and State government in preventing and detecting fraud, waste, and abuse in Federal or State funded programs such as Medi-Cal.[3] The objective of the IEHP 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, 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.[4]

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.

[1] Title 31 United States Code (U.S.C) §3729
[2] Health and Safety Code §1348
[3] Title 42 Code of Federal Regulations (CFR) §§ 422, 423 and 438.608
[4] Title 31 United States Code (U.S.C) §3729

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.

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

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

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 California Department of Justice (DOJ)

   b. The California Department of Health Care Services (DHCS), Investigations Branch

   c. The Centers for Medicare & Medicaid Services (CMS) through the National Benefit Integrity Medicare Drug Integrity Contractor (Qlarant).

   d. Department of Managed Health Care (DMHC)

   e. IEHP Covered

   f. Local law enforcement agencies

5. Submitting periodic reports to DHCS, DMHC, or 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

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. Developing a FWA Program, implementing fraud, waste, and abuse prevention activities and communicating such program and activities to staff, contractors, and subcontractors.

   2. 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.

   3. 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.

4. Terminating the IEHP Covered network participation of individuals and/or entities who appear on any of the aforementioned exclusion lists. See Policy 17E, "Compliance Program Description".
5. Communicating awareness, including:
   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.
7. Reporting suspected fraud, waste, and abuse issues to IEHP immediately of becoming aware of or notified of such activity.[5]
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. 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 SIU 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.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2024	
Revision Effective Date:		

17. 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 (known as Subcontractors) 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 Subcontractors 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. Subcontractors must implement a Compliance Program to provide a systematic process dedicated to ensuring that management, employees, business associates, Subcontractors, 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.

[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

2. Be overseen by the Board of Directors and senior management levels.
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, Subcontractors, 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. Subcontractors must implement an effective compliance program that meets regulatory guidelines.

Written Policies, Procedures, and Standards of Conduct

A. Code of Conduct – All Subcontractors 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 and 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 90 days of initial employment and annually thereafter.
3. Subcontrators should also provide the 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 Subcontractors 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 Subcontractor 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. Compliance Committee

1. The Compliance Committee, must be accountable to senior management and the Governing Board, is a multidisciplinary body that must meet periodically (on a quarterly basis). The Compliance Officer may chair 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.

C. High Level Oversight – The Subcontractor'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 Subcontractor'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 Subcontractor's Compliance Program.

Effective Training and Education

A. IEHP requires Subcontractors provide Compliance Training to all Employees (Temporary and Permanent), Providers, Governing Board Members, contractors, vendors, and volunteers.
   1. Compliance Training must be provided within 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. Subcontractors may use a written test or develop other mechanisms to assess effectiveness of the training.

3. Subcontractors 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. Subcontractors may also meet their FWA training requirements in the following way:

   a. Option 1, Subcontractors 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, Subcontractors 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 10 years. Documentation may include sign-in forms, signed attestations, and the completion of testing results.

Effective Lines of Communication

A. IEHP requires all Subcontractors, 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 Subcontractors are required to submit signed acknowledgement of their receipt of the Provider Manual which delineates compliance reporting responsibilities;
2. Annual Compliance training for all Subcontractors; and
3. The IEHP Code of Business Conduct and Ethics. See "Attachment/IEHP Code of Business Conduct and Ethics" found on the IEHP website.[8]

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, Subcontractors, downstream entities/subcontractors, 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. Subcontractors are expected to develop similar mode of referring compliance issues, including reporting non-compliance issues to IEHP.

Well Publicized Disciplinary Standards

A. Subcontractors 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. Subcontractors 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:

[8] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

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 Subcontractor 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 cost reports; and
   d. Trend analysis and studies that identify deviations in specific areas over a given period.

D. Subcontractors must implement a screening program for employees, Board Members, contractors, downstream entities/subcontractors 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 following Federal and State exclusionary lists:
   a. Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE) that are excluded from participation in government health care programs.[9,10]
   b. General Services Administration System for Award Management (SAM).
   c. Department of Health Care Services Covered California Suspended and Ineligible Provider List.
   d. Centers for Medicare and Medicaid Services Preclusion List.
2. Criminal record checks when appropriate or as required by law.
3. Standard reference checks, including credit for Employees.
4. Review of the National Practitioner Databank (NPDB).
5. Review of professional license status for sanctions and/or adverse actions.

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

6. 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 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. Subcontractors 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 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.

C. **Assessment of Compliance Effectiveness** On an annual basis, Subcontractors 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.

17. PROGRAM DESCRIPTIONS

E. Compliance Program Description

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2024	
Revision Effective Date:		

17. PROGRAM DESCRIPTIONS

F. Utilization Management Program Description

Utilization Management Program Overview:

A. **Mission -** The mission of the Inland Empire Health Plan (IEHP) Utilization Management (UM) Program is to ensure that Members receive timely, appropriate, and medically necessary health services.[1]

B. **Purpose -** The purpose of the UM Program is to manage the health care services utilized by Members in a high-quality manner. Effective monitoring of medical practice patterns and utilization of healthcare services, include the following elements:

1. The mechanisms used to promote effective use of services in the areas of prior authorization, concurrent review, discharge planning and transitions of care, ambulatory care review, retrospective review, non-medical transportation, non-emergent medical transportation, and behavioral health care;
2. Ensuring adequate systems and resources are in place to provide comprehensive care at the appropriate level in the delivery of healthcare services by its employees and contracted entities; and
3. Ensuring that utilization management activities are performed in accordance with the California Health and Safety Code, Section 1367.01.

C. **Objectives -** IEHP has developed and implemented a plan of activities centered on the utilization of health care services and delivery to Members. An evaluation of program objectives and process is performed annually by the UM Subcommittee with revisions as directed by the Quality Management (QM) Committee. Specific objectives include:

1. Develop, implement, and distribute UM standards for all lines of business to contracted Providers as promulgated in the IEHP Provider Manuals;
2. Promote uniformity of UM activities for authorization, medical necessity determination, and Member notification of decisions among delegated Providers;
3. Provide oversight of behavioral health care services through coordination with the Behavioral Health and Care Management (BH & CM) Department for applicable lines of business;
4. Facilitate Member access to the healthcare delivery system by continuous assessment for barriers to care;
5. Develop structural standards for contracted Plans for delegated UM activities including requirements for UM Plans, UM Committees, Medical Directors, out-of-area management, discharge planning and transitions of care, data collection, and reporting;

[1] Health Services – For the purpose of this program description, "Health Services" includes behavioral health services.

6. Assist the Delegation Oversight team, with monitoring activities assigned to Delegates through structured oversight functions including review of denials, grievances, appeals related to UM decisions, audits, and other activities;
7. Perform tracking activities and trending analysis on a wide variety of information including utilization data, denial of services or benefits, for patterns that may indicate restrictions in Member access to care;
8. Assure that authorized services are covered under the Member's health plan benefit;
9. Facilitate Member access to healthcare services consistent with the benefits according to their line of business without regard to race, ethnicity, religion, age, genetic information, national origin, mental or physical disability, sexual identity or orientation, or payment source;
10. Monitor utilization practice patterns of the IEHP health delivery network including practitioners, hospitals, ancillary services, and specialty Providers;
11. Provide a system to identify high-risk Members and assure that care is accessed through appropriate resources, including referral to BH & CM programs, or Health Education, , as applicable;
12. Educate Members, Physicians, Hospitals, ancillary and specialty Providers about IEHP's goals for providing quality, value enhanced managed healthcare; and
13. Continually improve IEHP UM Subcommittee criteria based on outcome data and review of medical literature.

D. **Scope -** The UM Program encompasses all Members accessing medical or behavioral health services. The scope of the UM Program includes the following elements:[2]

1. The UM Program is designed to provide oversight for Members' utilization of healthcare services and benefits through the continuous monitoring of Delegates and Providers. The UM Program also monitors and provides education, support and direction for non-delegated UM activities administered by IEHP.
2. The UM Program is designed to provide direction and consistency of UM activities throughout the IEHP network through adoption of UM Program standards, adoption of nationally recognized criteria, and education of Providers.
3. The UM Program assessment encompasses all UM activities and outcomes concerning IEHP Members including, but not limited to, primary care, specialty and behavioral health care Providers in all applicable care settings including emergency, inpatient, outpatient, and home health.

[2] National Committee for Quality Assurance (NCQA), 2024 Health Plan (HP) Standards and Guidelines, UM 1, Element A, Factor 5

4. The UM Program evaluates the quality of UM activities including, but not limited to, barriers to health care, communication between Providers, and coordination and continuity of care.

E. **Quality Management (QM) Responsibilities of the UM Program**[3] **-** The UM Program monitors UM data and activities to identify potential quality of care issues. UM information relevant to QM is reported to the QM Committee through the UM Subcommittee. Reports to the QM Committee may include readmission rates, standard UM metrics, as well as over and underutilization issues. The UM Subcommittee identifies, investigates, and monitors issues of concern related to the utilization and quality of services provided by the IEHP network as directed by the QM Committee. The UM Program includes continuous quality improvement processes that are coordinated with QM activities as appropriate.

Utilization Management Lines of Authority and Responsibility:

Lines of authority originate with the IEHP Governing Board and extend to Providers and participating Physicians. The Governing Board delegates responsibility for oversight and direction for processes affecting the delivery of health care for Members to the Chief Executive Officer (CEO), Chief Medical Officer (CMO), Medical Directors, and QM Committee. Further details can be found in the IEHP Organizational Chart.

A. UM Subcommittee - The IEHP QM Committee delegates responsibility for oversight and direction of the UM Program to the UM Subcommittee.

1. **Role:** The UM Subcommittee directs the continuous monitoring of all aspects of UM activities conducted by IEHP, its Delegates and Providers, including the development of appropriate standards administered to Members, with oversight by the Chief Medical Officer (CMO) or physician designee.[4]

2. **Function** - The following elements define the functions of the UM Subcommittee in maintaining quality, effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of health care services:

   a. Annual review and approval of the UM Program Descriptions and applicable workplans;

   b. Annual review of UM and BH policies, procedures, and criteria utilized in the evaluation of appropriate clinical and behavioral health care services, coordination, and continuity of care interventions;[5]

   c. Reviews UM trend and bed day utilization reports such as: average length of stay; bed days per thousand; admissions per thousand by category including: Skilled

[3] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factor 1
[4] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factor 3
[5] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factor 2

Nursing Facility (SNF); behavioral health care; over and underutilization; outpatient utilization; Emergency Room (ER) visits; and UM-related appeals;

d. Annual review of results and findings from interrater reliability surveys to ensure that UM decision-making is based only on the appropriateness of care and services, and that established criteria are applied consistently;

e. Annual evaluation of Member and Provider satisfaction with the UM process;

f. Review of proposed new technologies and new applications of existing technologies that are not primarily medication-related, and recommend these to the QM Committee for inclusion as an IEHP benefit;[6] and

g. Review of literature and set standards for non-preventive/preventive clinical care guidelines that are not primarily medication-related and recommend these to the QM Committee for approval.

Utilization Management Personnel:

Qualified staff are responsible for the UM program. Their reporting relationships and position responsibilities can be found in the organizational charts.

A. **Vice President, Medical Director**

The Vice President of Medical Directors is a board-certified Physician and holds an unrestricted license to practice medicine in the State of California. Under the direction of CMO, the Vice President of Medical Directors provides executive medical leadership across the Health Services Departments. This includes direct oversight and management of the Utilization Management medical directors as well as provision of clinical leadership and strategic direction across Health Services in partnership with the Vice President of Clinical Integration and Operations, Senior Director of Medical Management, and Senior Director of Pharmaceutical Services.

B. **Vice President, Health Services Clinical Integration and Operations**

The Vice President of Clinical Integration and Operations is a Registered Nurse and has the primary responsibility to plan, organize, direct, and coordinate the IEHP approach to an integrated and person-centered care model within the plan, including direct oversight and integration of multiple departments (Utilization Management, Care Management, Behavioral Health, and Pharmaceutical Services).

C. **Senior Medical Director**

The Senior Medical Director is a board-certified Physician and holds an unrestricted license to practice medicine in the State of California. Under the direction of the Vice President of Medical Directors, the Senior Medical Director is responsible for clinical oversight and monitoring of all IEHP UM activities; direction for internal and external UM Program

[6] NCQA, 2024 Health Plan (HP) Standards and Guidelines, UM 10, Element B, Factor 1

functions; and participation in QM functions.[7] Principal accountabilities for the UM Program include:

1. Ensuring the process by which IEHP and its Delegates review and approve, partially approve (modify), delay, or deny, based in whole or in part on medical necessity, requests by Providers prior to, retrospectively, or concurrent with the provision of health care services to Members comply with State, Federal and contractual requirements;[8]
2. Ensuring that medical decisions are rendered by qualified medical personnel and are not influenced by fiscal or administrative management considerations; [9,10]
3. Oversight of medical care rendered by Providers for compliance with applicable professional standards for acceptable medical care[11,] and quality that equals or exceeds the standards for medical practice developed by IEHP and approved by any of its regulating agencies.
4. Participation in Delegates' UM activities, as necessary;
5. Assisting the Delegation Oversight team, as needed, with monitoring and oversight of delegated UM activities including review of UM workplans, activities, processes, results and outcomes;
6. Review of current medical practices ensuring that medical protocols and all medical personnel of IEHP follow accepted medical standards;[12,]
7. Ensuring the receipt of appropriate healthcare services and medical attention of Members at all locations;
8. Participation in staff training;[13]
9. Monitoring documentation for adequacy;[14]
10. Availability to UM staff on site or by telephone;[15]
11. Reviewing and approval of internal policies and procedures related to UM; and
12. Chairing the UM Subcommittee or designating a Chair, as needed.

[7] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factor 3
[8] California Health and Safety Code (Health & Saf. Code) §1367.01
[9] NCQA, 2024 HP Standards and Guidelines, UM 4, Element A, Factor 1
[10] Title 22, California Code of Regulations (CCR) § 53857
[11] 22 CCR § 53857
[12] 22 CCR § 53857
[13] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factor 3
[14] Ibid.
[15] Ibid.

D. **Behavioral Health (BH) Physician Support**

IEHP utilizes a Board-Certified Psychiatrist and Psychologist to support with the development and implementation of UM policies, case review, clinical oversight, and management of the BH aspects of the UM Program.[16]

E. **Senior Director of UM Operations**

The Senior Director of UM Operations is unlicensed and non-clinical, who reports to the Vice President, Health Services Clinical Integration and Operations. The Senior Director of UM Operations is responsible for the development and implementation of operational processes, policies and procedure adherence, and departmental regulatory compliance. The Senior Director of UM Operations is responsible for oversight of delegated and non-delegated UM activities as well as direction to non-clinical UM staff in support of clinical UM staff. Staff support includes Prior Authorization, Letter Review, and UM Delegation.

F. **Senior Director of Integrated Transitional Care**

The Senior Director of Integrated Transitional Care is a Registered Nurse who reports to the Vice President, Health Services Clinical Integration and Operations. The Senior Director of Integrated Transitional Care is responsible for the development and implementation of operational and clinical processes, policies and procedure adherence, and departmental regulatory compliance. Staff support includes Inpatient and Prior Authorization for Specialty Programs, Care Transitions, and Long-Term Care.

G. **UM Clinical and Non-Clinical Staff**

Staff support of UM consists of clinical and non-clinical UM staff. The clinical staff includes Registered Nurses (RNs), Licensed Vocational Nurses (LVNs) and Social Workers with the required qualifications to perform UM in a managed care environment, such as experience in utilization management or care management. The non-clinical support consists of non-licensed UM coordinators with the required qualifications to support UM in a managed care environment. Staff positions include concurrent and long term care review nurses, discharge planning nurses, prior authorization nurses, care transitions specialists, inpatient and prior authorization coordinators, analysts, UM Nurse Managers and Nurse Supervisors.

Annual Evaluation of Utilization Management Program

A. The Senior Medical Director and Senior Directors of Utilization Management evaluate the effectiveness and progress of the UM Program annually. The UM Program Description and associated policies and procedures are reviewed at least annually and updated as needed. A yearly summary of all UM Program activities is documented with assistance from the Quality Management, Behavioral Health & Care Management and HealthCare Informatics (HCI) departments. The report includes a summary of UM activities, changes in criteria or program activities, documented barriers to care, monitoring results, and

[16] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factor 4

significant issues impacting health care provided to Members. The Senior Medical Director, and/or Senior Directors of Utilization Management presents the UM Program Description and the annual evaluation to the UM Subcommittee for approval and then to the QM Committee for comment, suggested program adjustments, and revision of procedures or guidelines, as necessary. The yearly UM program summary is presented to the IEHP Governing Board for assessment of UM activities affecting the health care rendered to Members, comment, activities proposed for the coming year, and approval of changes in the UM Program.

Member Benefits

A. Benefits for Members are mandated by the Department of Managed Health Care (DMHC) for IEHP Covered Members. The Evidences of Coverage is maintained by Marketing.

Clinical Criteria for BH UM and Medical UM Decisions

A. **Clinical Criteria for UM Decisions**

IEHP and its Delegates must use nationally recognized clinical criteria and/or IEHP UM Subcommittee-Approved Authorization Guidelines, when making decisions related to medical care. [17] Criteria sets approved by IEHP include Title 22 of the California Code of Regulations, Apollo Managed Care Guidelines/Medical Review Criteria, Milliman Care Guidelines (MCG), World Professional Association for Transgender Health standards of care (WPATH), National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium, IBM Watson Health Products: Micromedex , UpToDate, DMHC All Plan Letters (APLs), Early Childhood Service Intensity Instrument (ESCII), developed by American Academy of Child and Adolescent Psychiatry, Child and Adolescent Level of Care Utilization System (CALOCUS) 20, developed by the American Association of Community Psychiatry (AACP), Level of Care Utilization System (LOCUS) 20, developed by the American Association of Community Psychiatry (AACP), and for substance use disorders (SUD) of Members at any age, IEHP uses the American Society of Addiction Medicine (ASAM) 3rd Edition 2013.

[18,19,20] IEHP may distribute additional criteria following approval by the UM Subcommittee.

1. **Development -** Clinical criteria guidelines that are developed by IEHP and used to determine whether to authorize, modify, or deny health care services are developed with involvement from actively practicing health care Providers. [21] The criteria or guidelines must be consistent with sound clinical principles and processes and must be evaluated at least annually and updated if necessary. [22] New or updated clinical criteria must be reviewed and approved by the UM Subcommittee. The UM Subcommittee obtains

[17] NCQA, 2024 HP Standards, UM 1, Element A, Factor 6
[18] CA Health & Saf. Code § 1363.5(b)
[19] NCQA, 2024 HP Standards and Guidelines, UM 2, Element A, Factor 1
[20] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factors 5 & 6
[21] NCQA, 2024 HP Standards and Guidelines, UM 2, Element A, Factor 4
[22] CA Health & Saf. Code §1363.5

external independent review, whenever necessary to assist with the development of clinical criteria guidelines.

2. **Application -** IEHP and its Delegates must apply criteria in a consistent and appropriate manner based on available medical information and the needs of individual Members The application of criteria takes into consideration individual factors, such as age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment.[23] Additionally, application of criteria takes into consideration whether services are available within the service area, benefit coverage, and other factors that may impact the ability to implement an individual Member's treatment plan. The organization also considers characteristics of the local delivery system available for specific Members, such as:[24]

   a. Availability of services, including but not limited to skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the Member after hospital discharge; and

   b. Local in-network hospitals' ability to provide all recommended services within the estimated length of stay.

   Once eligibility and benefit coverage has been established IEHP and its Delegates must ensure consistent application of UM criteria by following this specific order as IEHP or Delegate is licensed to use: [25]

3. **For Medical Services:**

   a. Federal and State Laws, Title 22 of the California Code of Regulations (CCR) or DMHC All Plan Letters; then

   b. World Professional Association for Transgender Health standards of care (WPATH), National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium or IBM Watson Health Products: Micromedex; then

   c. MCG Health Informed Care Strategies Care Guidelines; then

   d. Apollo Medical Review Criteria Guidelines for Managing Care; then

4. UpToDate **For Behavioral Health Services:**

   a. Federal and State Laws, Title 22 of the California Code of Regulations (CCR) or DMHC All Plan Letters;; then

   b. World Professional Association for Transgender Health standards of care (WPATH), for mental health (MH) disorders of Members ages 0 through 5, IEHP uses the Early Childhood Service Intensity Instrument (ESCII), developed by American Academy of Child and Adolescent Psychiatry, for mental health (MH) disorders of Members

[23] NCQA, 2024 HP Standards and Guidelines, UM 2, Element A, Factor 2
[24] NCQA, 2024 HP Standards and Guidelines, UM 2, Element A, Factor 3
[25] NCQA, 2024 HP Standards and Guidelines, UM 2, Element A, Factor 1

ages 6 through 17, IEHP uses the Child and Adolescent Level of Care Utilization System (CALOCUS) 20, developed by the American Association of Community Psychiatry (AACP), for mental health (MH) disorders of Members ages 18 and older, IEHP uses Level of Care Utilization System (LOCUS) 20, developed by the American Association of Community Psychiatry (AACP), for substance use disorders (SUD) of Members at any age, IEHP uses the American Society of Addiction Medicine (ASAM) 3rd Edition 2013.

5. **Annual Review and Adoption of Criteria -** IEHP develops and/or presents criteria to the IEHP UM Subcommittee for adoption and implementation. After approval by UM Subcommittee, the criteria are sent to the IEHP Quality Management (QM) Committee for reference and disseminated to Delegates and Providers via letter, website or email. Members of the UM Subcommittee and practitioners in the appropriate specialty, review criteria annually with updates as necessary.[26]

6. **Process for Obtaining Criteria-** IEHP discloses to Providers, Members, and Member's representatives, or the public, upon request, the clinical guidelines or criteria used for determining health care services specific to the procedure or condition requested. [27,28]

   a. Providers may obtain information about criteria, either in general or relating to specific UM decisions, from IEHP by contacting the IEHP UM Department.[29] Providers may also access and review IEHP UM Subcommittee Approved Authorization Guidelines from the IEHP website.

   b. Members may obtain criteria used as the basis for any health care service denial they have received by contacting IEHP Covered Member Services Department.[30] IEHP Member Services staff relay the request to the UM Department for response to the Member.

   c. All requests for UM clinical criteria are logged and processed upon request. Every disclosure of information is accompanied by the following statement: "The materials provided to you are guidelines used to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on an individual need and the benefits covered under your Health Plan."[31]

7. **Annual Assessment of Consistency of UM Decisions (Inter-rater Reliability) -** IEHP evaluates, at least annually, the consistency with which health care professionals involved

[26] NCQA, 2024 HP Standards and Guidelines, UM 2, Element A, Factors 4 and 5
[27] CA Health & Saf. Code §1365.5
[28] NCQA, 2024 HP Standards and Guidelines, UM 2, Element B, Factors 1 and 2
[29] CA Health & Saf. Code § 1363.5(b)(4)
[30] CA Health & Saf. Code § 1363.5(b)(4)
[31] CA Health & Saf. Code § 1363.5(c)

in utilization review appropriately apply criteria in decision making.[32] IEHP acts on identified opportunities to improve consistency.[33]

Behavioral Health Care Services[34]

A. **Behavioral Health Care Referral**

IEHP covers and complies with coverage requirements for medically necessary treatment of mental health and substance use disorders (MH/SUD) including those listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM). Members can self-refer to therapy services in their respective counties. IEHP Member Services and/or Behavioral Health Department can assist Members desiring to self-refer and/or with accessing behavioral health services as needed. IEHP UM Program is responsible for ensuring that referral decisions are made according to protocols that define the level of urgency and appropriate setting of care. Referral protocols for behavioral health care services include the following:[35]

1. Address the urgency of the Member's clinical circumstances and define the appropriate care settings and treatment resources that are to be used for behavioral health care and substance use cases;
2. Referral staff members must utilize protocols and guidelines that are up-to-date and specifically address behavioral health care and substance abuse;
3. Staff must be provided appropriate education and training regarding use of the protocols;[36] and
4. Protocols provided to and used by staff are reviewed and/or revised annually.

The UM Program does not impose Quantitative Treatment Limitations or Non Quantitative Treatment Limitations to its timelines and processes more stringently on plan-covered mental health and substance use disorder services than are imposed on medical/surgical services.[37]

B. **Intensive Outpatient and Partial Hospitalization Programs**

IEHP can authorize this level of service for IEHP Members who are experiencing severe symptoms but not severe enough to require inpatient services. Intensive Outpatient Programs (IOPs) can be used to treat co-occurring mental health and substance use disorders when clinical criteria guidelines are met. Partial Hospitalization Programs (PHPs) can be used as an alternative or a step-down from an acute psychiatric inpatient facility. PHPs and IOPs may be

[32] NCQA, 2024 HP Standards and Guidelines, UM 2, Element C, Factor 1
[33] NCQA, 2024 HP Standards and Guidelines, UM 2, Element C, Factor 2
[34] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factor 2
[35] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factor 2
[36] NCQA, 2024 HP Standards and Guidelines, UM 4, Element A, Factor 1
[37] Title 22, Code of Federal Regulations (CFR) § 438.900 et. seq

approved for Members, when the Member is experiencing an eating disorder and/or treatment is medically necessary.

C. **Acute Psychiatric Inpatient Services**

IEHP can authorize inpatient services for IEHP Members experiencing severe and acute symptoms relating to a behavioral health condition.

Use of Appropriate Professionals for UM Decisions

A. **IEHP Personnel Standards**

To ensure that first-line UM decisions are made by individuals who have the knowledge and skills to evaluate working diagnoses and proposed treatment plans, IEHP adopted the following standards for personnel making review decisions and reviewing denials:[38,39]

1. UM Technicians/Specialists/Coordinators can make eligibility determinations, review referral forms for completeness, interface with Provider offices to obtain any needed non-medical information,[40] and approval of authorizations, as determined appropriate (auto authorizations).
2. Licensed Vocational Nurses (LVNs) or contracted UM review staff can perform initial review of medical information, make the initial determination of benefit coverage, obtain additional medical information as needed from Provider offices,[41] approve referrals based on IEHP-approved authorization criteria, concurrent inpatient, and initiate denials for non-covered benefits and carve-outs.
3. Registered Nurses (RNs)/Licensed and Master Level BH Care Managers can perform initial review of medical information, initial determination of benefit coverage, obtaining additional medical information as needed,[42] from the Provider's office, approval of referrals based on medical necessity or IEHP-approved authorization criteria, and providing medical necessity recommendation to the physician reviewer.
4. Physician Reviewer - A designated board-certified physician, who holds an unrestricted license to practice medicine in the State of California must review all denials and partial approvals (modifications) based in whole or in part on medical necessity, and obtain additional medical information from the treating physician as needed.[43,44,45]

[38] NCQA, 2024 HP Standards and Guidelines, UM 4, Element A, Factor 2
[39] NCQA, 202 HP Standards and Guidelines, UM 1, Element A, Factor 1
2024A
[41] Ibid.
[42] Ibid.
[43] CA Health & Saf. Code § 1367.01(e)
[44] NCQA, 202 HP Standards and Guidelines, UM 4, Element A, Factor 1
[45] NCQA, 202 HP Standards and Guidelines, UM 4, Element C

B. **Use of Board-Certified Physicians for UM Decisions**

When a case review falls outside the clinical scope of the reviewer, or when medical decision criteria do not sufficiently address the case under review, IEHP consults with Board-certified physicians in the appropriate specialty. IEHP has created a Physician Specialty Review Panel and contracts with an external review company for these specialty consultations.[46]

IEHP UM Authorization Process Standards

IEHP maintains written policies and procedures regarding the process to review, approve, partially approve (modify) or deny prospective, concurrent, or retrospective requests by Providers concerning the provision of health care services for Members. These policies and procedures are available to the public upon request.[47] The information on how to obtain a copy of IEHP's Utilization Management processes is outlined in the Member's Evidence of Coverage.

A. **Specialty Referral System**

IEHP maintains a specialty referral system that tracks and monitors referrals requiring prior authorization. The system includes approved, partially approved (modified), and denied referrals received from both contracted and non-contracted providers, as well as the timeliness of these referrals.

B. **System Controls**

IEHP have system controls in place to protect data specific to denial and appeal notifications and receipt dates from being altered outside of prescribed protocols.[48]

C. **Out-of-Network Services**

Authorization and notification of decision for proposed services, referrals, or hospitalizations involve utilizing information such as medical records, test reports, specialist consults, and verbal communication with the requesting Provider. Part of this review process is to determine if the service, whether seldom used or an unusual specialty service, is available in network. If the service is not available in network, arrangements must be made for the Member to obtain the service from an out-of-network provider for this episode of care.[49]

D. **Prior Authorization Requirements**

The prior authorization process described in this policy do not apply to these services, which do not require prior authorization:

1. Emergency services and services necessary to treat and stabilize an emergency medical condition;
2. Family planning;

[46] NCQA, 2024 HP Standards and Guidelines, UM 4, Element F, Factor 1
[47] CA Health & Saf. Code § 1363.5(a)
[48] NCQA, 2024 HP Standards and Guidelines, UM 12, Element A
[49] NCQA, 2024 HP Standards and Guidelines, MED 1, Element D

3. Abortion services;
4. Sexually transmitted infection (STI) services diagnosis and treatment;
5. Sensitive and confidential services;
6. HIV testing and counseling at the Local Health Department;
7. Immunizations at the Local Health Department;
8. Routine OB/GYN Services, (including prenatal care by Family Care Practitioner (credentialed for obstetrics) within the IEHP Network;
9. Out of area renal dialysis; and
10. Biomarker testing for advanced or metastatic stage 3 or 4 cancers[50]
11. Urgent Care;[51] and

Preventative servicesIEHP allows Members direct access to Specialists, appropriate for their condition and identified need for special healthcare needs. [52]

E. **Medical Necessity Determination**

IEHP determines medical necessity for a specific requested service as follows:[53]

1. IEHP employs IEHP-approved clinical criteria, as outlined in this policy and utilizes the following definition for determining the medical necessity of a healthcare service:
   a. A service is a "medical necessity" when it is reasonable and necessary to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attach, maintain, or regain functional capacity. [54]
2. If information reasonably necessary to make a determination is not available with the referral, IEHP contacts the requesting Provider for the additional clinical information by telephone at least two (2) times and with a third attempt being made by a Medical Director. The request for additional information must be annotated and include the date of request.[55] If, after making these attempts, IEHP is still not in receipt of all the information reasonably necessary and requested to make a determination within regulatory timeframes, the Delegate must notify the Member and requesting Provider within the required timeframe, or as soon as the Delegate becomes aware that it will not meet the initial authorization timeframe, whichever is earlier using the "CCA Notice of Action" template. This notification shall include the information requested but not

[50] California Health and Safety Code (CA HSC) §1367.665
[51] Ibid.
[52] NCQA, 2024 HP Standards and Guidelines, MED 1, Element B, Factor 1
[53] NCQA, 202 HP Standards and Guidelines, UM 1, Element A, Factor 5
[54] 22 CCR § 51303(a)
[55] NCQA, 2024 HP Standards and Guidelines UM 6, Element A

received, or the expert reviewer to be consulted, or the additional examinations or tests required, along with the anticipated date on which a decision may be rendered.[56]

3. IEHP considers all factors related to the Member including barriers to care related to access or compliance, impact of a denial on short and long-term health status of the Member and alternatives available to the Member if denied.

4. IEHP obtains input from appropriate specialists in the area of the health care services requested either through a UM Subcommittee member, telephonically, or use of an outside service.

F. **Experimental and Investigational Determinations**

1. If coverage is denied to a Member with a terminal illness, which for the purposes of this section refers to an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services or supplies deemed experimental, the Member and/or their authorized representative are offered the opportunity to request a conference, which shall be held within 30 calendar days or as early as five (5) business days (if requested by the prescribing physician) of the denial.[57]

G. **Notifications**

Communications regarding authorization requests will adhere to the following requirements:[58]

1. Decisions to approve requests shall specify the specific health care service approved.

2. Decisions to deny or modify health care services shall be communicated to the Member in writing, and to Provider initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include:59

   a. Clear and concise explanation of the reasons for the decision;

   b. A description of the criteria or guidelines used; [60,61] and

   c. Clinical reasons for the decisions regarding medical necessity.

3. Any decision to deny a service authorization based on medical necessity or to authorize a service that is less than requested in an amount, duration, or scope must be reviewed and approved by a UM Medical Director or physician designee.[62,63] Members and Providers must receive denial letters for any requested referral that is denied or modified. The initial notification which is written communication to a Provider of a denial must

[56] CA Health & Saf. Code § 1367.01(5)
[57] CA Health & Saf. Code § 1368.1(a)
[58] CA Health & Saf. Code § 1367.01(h)
[59] CA Health & Saf. Code § 1363.5(b)(4)
[60] NCQA, 2024 HP Standards and Guidelines, UM 7, Element B, Factor 2
[61] NCQA, 2024 HP Standards and Guidelines, UM 7, Element E, Factor 2
[62] CA Health & Saf. Code § 1367.01(e)
[63] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factor 1

include the name and telephone number of the UM Medical Director or designee responsible for the denial. [64,65] Such communication must offer the requesting Provider the opportunity to discuss with the physician reviewer issues or concerns regarding the decision.[66,67] This written notification of denial or partial approval (modification) must also inform the requesting Provider of the appeal process.[68,69]

Written notifications:

d. Are made available in IEHP's threshold languages;

e. Are written in a manner, format and language that can be easily understood;[70,71]

f. Include information on how to request for translation services and alternative formats;[72] and

4. For written notifications of a denial or modification, information on the Member's right to appeal the decision, file a grievance and request an administrative hearing

Other UM Program Requirements

A. **Rescinding or Modifying Authorization**

Any authorization provided by IEHP or its Delegate must not be rescinded or modified after the Provider has already rendered the health care service in good faith pursuant to the authorization.[73]

B. **Continuity of Care**

IEHP ensures Members with pre-existing provider relationships who make a Continuity of Care (COC) request are given the option to continue treatment for up to 12 months with an out-of-network provider per DHCS requirements.

C. **Standing Referrals**

A PCP may request a standing referral to a Specialist for a Member who, as a component of ongoing ambulatory care, requires continuing specialty care over a prolonged period of time or an extended access to a Specialist or specialty care center for a Member who has a life threatening, degenerative, or disabling condition that requires coordination of care by a Specialist.[74]

[64] Ibid.
[65] CA Health & Saf. Code § 1367.01
[66] NCQA, 2024 HP Standards and Guidelines, UM 7, Element A
[67] NCQA, 2024 HP Standards and Guidelines, UM 7, Element D
[68] NCQA, 2024 HP Standards and Guidelines, UM 7, Element C
[69] NCQA, 2024 HP Standards and Guidelines, UM 7, Element F
[70] NCQA, 2024 HP Standards and Guidelines, UM 7, Element B, Factor 1
[71] NCQA, 2024 HP Standards and Guidelines, UM 7, Element E, Factor 1
[72] Ibid.
[73] CA Health & Saf. Code § 1371.8
[74] CA Health & Saf. Code § 1374.16

D. **Second Opinions**

IEHP provides for its Members second opinion from a qualified health professional within the network at no cost to the Member or arranges for the Member to obtain a second opinion outside of the network, if services are not available within the network.[75]

E. **Vision Services**

IEHP is responsible for UM activities associated with Vision Services for applicable lines of business. Ophthalmology requests must be submitted through the UM prior authorization process.

F. **Communication Services**

IEHP provides access to staff for Members and Providers seeking information about the UM process and the authorization of care by contacting Member or Provider Services. This includes the following:

1. IEHP maintains telephone access for Providers to request authorization for healthcare services through the Provider Relations Team.[76]
2. IEHP UM Staff are available at least eight (8) hours a day during normal business hours (8:00 AM – 5:00 PM) Monday through Friday, to receive phone calls regarding the UM process or issues. The toll-free numbers are (800) 440-4347 for Medi-Cal and (877) 273-4347 for IEHP DualChoice. IEHP staff can accept collect calls regarding specific cases and UM decision inquiries.[77] Communications received after normal business hours will be returned on the next business day.
3. IEHP's Nurse Advice Line service is available after hours to receive inbound communication.[78]
4. Outbound communication from staff regarding inquiries about UM are made as needed during the hours of 8:00 AM and 6:30 PM Monday through Saturday.
5. Staff identifies themselves by name, title, and organization when initiating or returning calls regarding UM issues.[79]
6. There is a toll free TDD/TTY number, (800) 718-4347, for Members who are deaf, hard of hearing or speech-impaired.[80]
7. Language assistance is available for Members to discuss UM issues.[81]

[75] NCQA, 2024 HP Standards and Guidelines, MED 1, Element C
[76] CA Health & Saf. Code § 1367.01
[77] NCQA, 2024 HP Standards and Guidelines, UM 3, Element A, Factor 1
[78] NCQA, 2024 HP Standards and Guidelines, UM 3, Element A, Factor 2
[79] NCQA, 2024 HP Standards and Guidelines, UM 3, Element A, Factor 3
[80] NCQA, 2024 HP Standards and Guidelines, UM 3, Element A, Factor 4
[81] NCQA, 2024 HP Standards and Guidelines, UM 3, Element A, Factor 5

G. **Record Retention**

IEHP retains information on all decisions, e.g., authorizations, denials or partial approvals (modifications) for a minimum period of 10 years.

H. **Documentation of Medical Information and Review Decisions**

IEHP bases its review decisions on documented evidence of medical necessity provided by the attending physician. Regardless of criteria, the Member's condition must always be considered in the review decision.[82]

1. **Physician Documentation** - Attending physicians must maintain adequate medical record information to assist the decision-making process. The requesting Provider must document the medical necessity for the requested service, procedure, or referrals and submit all supporting documentation with the request.
2. **Reviewer Documentation** - Reviewers must abstract and maintain review process information in written format for monitoring purposes. Decisions must be based on clinical information and sound medical judgment with consideration of local standards of care. Documentation must be legible, logical, and follow a case from beginning to end. Rationale for approval, modification or denial must be a documented part of the review process. Documentation must also include a written assessment of medical necessity, relevant clinical information, appropriateness of level of care, and the specific criteria upon which the decision was based.
3. **Documentation** - IEHP logs requests by date and receipt of information so that compliance with timeframes can be tracked. Documentation of authorizations or referrals include, at a minimum: Member name and identifiers, description of service or referral required, medical necessity to justify service or referral, place for service to be performed or name of referred physician, and proposed date of service. Documentation also includes a written assessment of medical necessity, relevant clinical information, appropriateness of level of care, and the specific criteria upon which the decision was based. All referrals must be signed by the requesting physician and dated. The Medical Director or physician designee must sign any denial of a proposed service or referral in the medical management system.

I. **Inpatient Stay**

The utilization management process for inpatient stays must include:

1. Determining medical necessity;
2. Determining appropriate level of care;
3. Coordinating with hospital Case Manager's discharge plan.

[82] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factor 6

J. **Discharge Planning and Care Coordination**

The UM process must include the following activities related to discharge planning:

1. Determining level of care (SNF, office visit, home health, home without services);
2. Arranging necessary follow-up care (home health, follow-up PCP or specialty visits, etc.);
3. Facilitating transfer of the discharge summary and/or medical records, as necessary, to the PCP office; and
4. Continuity and coordination (including transition) of care across all patient care settings.

K. **Repatriation**

IEHP manages Members that access care out of network. This includes assisting with the transfer of Members, as medically appropriate, back into the IEHP network during an inpatient stay.

L. **Non-Discrimination**

All Members must receive access to all covered services without restriction based on race, color, ethnicity, ethic group identification, national origin, ancestry, language, religion, sex, age, mental or physical disability or medical condition, gender, gender identity, sexual orientation, claims experience, medical history, claims history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, marital status, or source payment.

M. **Confidentiality**

IEHP recognizes that Members' confidentiality and privacy are protected. It is the policy of IEHP and its Delegates to protect the privacy of individual Member health information by permitting UM staff to obtain only the minimum amount of Protected Health Information (PHI) necessary to complete the healthcare function of activity for Member treatment, payment or UM operations.

N. **Affirmative Statement Regarding Incentives**

UM decisions for Members must be based only on appropriateness of care and service.[83] IEHP does not provide compensation for practitioners or other individuals conducting utilization review for denials of coverage or service.[84] IEHP ensures that Delegates contracts with physicians do not encourage or contain financial incentives for denial of coverage or service. Practitioners and employees/staff who make utilization-related decisions need to be concerned about the risks of underutilization. The Affirmative Statement about incentives is distributed annually to all practitioners, providers, and employees involved in authorization review, as well as Members.

[83] NCQA, 2024 HP Standards and Guidelines, MED 9, Element D, Factor 1
[84] NCQA, 2024 HP Standards and Guidelines, MED 9, Element D, Factor 2

O. **Economic Profiling**

Economic profiling is defined as any evaluation performed by the physician reviewer based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician reviewer. Delegates that engage in economic profiling must document the activities and information sources used in this evaluation and ensure that medical decisions are rendered, unhindered by fiscal and administrative management.[85]

P. **Prohibition of Penalties for Requesting or Authorizing Appropriate Medical Care**

Physicians cannot be penalized in any manner for requesting or authorizing appropriate medical care.

Grievance and Appeal Process

A. IEHP maintains a formal Grievance Resolution System to ensure a timely and responsive process for addressing and resolving all Member grievances and appeals.[86] The Member may file a grievance or appeal by phone, by mail, fax, website, or in person. For further details regarding investigation of grievances/appeals and the time frames for resolution, please refer to internal Grievance and Appeals policies and procedures.

New Technology

A. IEHP evaluates the inclusion of new technologies and the new application of existing technologies in its benefits plan, including medical and behavioral healthcare procedures, pharmaceuticals, and devices.[87] The Quality Management (QM) Committee directs the Utilization Management (UM) and Pharmacy and Therapeutics (P&T) Subcommittees to ensure the appropriate evaluation and implementation of new technologies and new applications of existing technologies.

Section 13: Monitoring Activities and Oversight

A. IEHP maintains responsibility of ensuring that Delegates continue to be in compliance with all applicable State and federal laws and other requirements set forth by the Department of Managed Health Care (DMHC), and the National Committee for Quality Assurance (NCQA). For information on the monitoring and oversight activities performed by IEHP on its Delegates, please see Provider policy 18A1, "Utilization Management – Delegation and Monitoring." The following describes IEHP's internal UM program monitoring and oversight activities:

1. **Review of UM Data** - The collection, reporting, and analysis of UM data related to Members include internally generated reports as well as specific Delegate UM reports. Significant monthly variations suggesting over or underutilization in any of the reported data components are reviewed with IEHP Senior Medical Director, Senior Director of

[85] CA Health & Saf. Code § 1367.02
[86] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factor 1
[87] NCQA, 2024 HP Standards and Guidelines, UM 10, Element A, Factors 1-4

Medical Management, and UM Directors. Comparisons are performed by IEHP's UM Directors, CMO, and Medical Directors with summary reports reviewed by the UM Subcommittee on a quarterly basis.

a. UM reports must include, at a minimum, the following:

1) Enrollment;

2) Member months;

3) Acute bed days/1000;

4) Number of admissions/1000;

5) Average Hospital LOS;

6) Re-admissions within 30 days of discharge;

7) SNF bed days;

8) Total number of prior authorization requests;

9) Total number of denials;

10) Denial percentage;

11) Emergency encounters/1000;

12) Disease-specific over and under utilization metrics.

The above data must be presented in summary form to the UM Subcommittee for review and analysis.

b. Monthly report (Universe) of all prior auth requests to include denials modifications, approvals, cancelled or withdrawn requested services;

c. Monthly report of all second opinion requests by Members;

d. Presentation of selected data from above to PCPs, specialists, or Hospitals as a group or individually, as appropriate; and

e. Evidence of review of data listed above by the UM Subcommittee for trends by physicians for both over and underutilization.

2. **Satisfaction with the UM Process:** At least annually, IEHP performs Member and Provider Satisfaction Surveys as a method for determining barriers to care and/or satisfaction with IEHP processes, including UM, with subsequent implementation of actions for improvement as applicable.

a. Provider Satisfaction Survey: A Provider Satisfaction Survey is conducted annually by a third-party vendor. For details on IEHP's Provider Satisfaction Survey, please refer to internal Quality Systems policies and procedures.

b. Member Satisfaction Survey: IEHP utilizes the Consumer Assessment of Health Plans Survey (CAHPS®) for Member Satisfaction as administered through a third party, NCQA-certified data collection vendor. For details on IEHP's Member Satisfaction Survey, please refer to internal Quality Systems policies and procedures.

Enforcement/Compliance

A. Enforcing compliance with IEHP UM standards is a critical component of monitoring and oversight of Delegates and practitioners, particularly related to delegated activities. Delegates that demonstrate a consistent inability to meet standards can be subject to contract termination.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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