24. PROGRAM DESCRIPTIONS

A. Disability Program Description

Disability Program Overview

A. **Mission**

IEHP Disability Program's mission is to improve access, communication, and health care services for seniors and persons with disabilities (SPD) and any other IEHP Members, prospective Members, and community stakeholders, with access and/or functional needs. The Disability Program implements, administers, and coordinates the Plan's disability programs and services. IEHP is a Public Entity that complies with the Americans with Disabilities Act (ADA). 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] ~~Department of Health Care Services (DHCS) IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 1, Provision 9, Member Representation~~ DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.1 Access to Network Providers and Covered Services

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;[2,3,4]
2. Develop and maintain a current, accessible online resource center on the IEHP website for health Providers, IPAs, and other stakeholders to ensure care is accessible and culturally sensitive for people with diverse disabilities;
3. Conduct live trainings for Providers on enhancing access to medical care for Members with disabilities;
4. Examine accessibility at IEHP's physical building and recommend modifications as necessary, including automatic door openers, lowered sinks in restrooms, automatic water and soap dispensers, and assistive listening devices for PA system in meeting rooms;[5]
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 ("Aa~~i~~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] NCQA, 2022 Health Plans (HP) Standards and Guidelines, MED 12, Element A, Factor 3
[3] NCQA, 2022 HP Standards and Guidelines, MED 3, Element A, Factor 1
[4] NCQA, 2022 HP Standards and Guidelines, MED 3, Element A, Factor 2
[5] ~~DHCS-IEHP-Two-Plan-Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 11, Access for Disabled Members~~ DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.1.2 Member Services Staff

Braille, large-sized print, video or audio, CD or DVD, over the phone or in-person from a qualified health educator;[6,7,8,9]

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;[10]
3. Integrate policies for providing sign language interpreters and materials in alternative formats;
4. Monitor IPA requests and distribution of materials in alternative format with Delegation Oversight Department. IPAs must submit material requiring ~~alternative formatting~~transcription to alternative formats to IEHP within 24 hours of an identified need. IEHP will send any alternative format letters requests to the ~~Member~~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 ("A~~a~~ccessAbility") 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, IPAs, 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.[11]
2. Coordinate the annual ~~Disability Sensitivity/Awareness~~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.

[6] Title 42 Code of Federal Regulations (CFR) § 438.10(d)
[7] DHCS All Plan Letter (APL) 18-016 Supersedes APL 11-018 "Readability and Suitability of Written Health Education Material"
[8] NCQA, 2022 HP Standards and Guidelines, MED 13, Element B
[9] California Health & Safety Code (Health & Saf. Code) § 1367.042
[10] DHCS All Plan Letter (APL) 21-004, "Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services"
[11] ~~DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 1, Provision 10, Sensitivity Training~~. DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 3.1.6 Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements

24. 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, ~~Project~~ Analyst, Culture and Linguistics Specialist and Coordinator, and Community Health Workers.~~Coordinators and Administrative Assistant.~~

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24. PROGRAM DESCRIPTIONS

A. Disability Program Description

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

24. PROGRAM DESCRIPTIONS

B. Cultural and Linguistic Services Program Description

Cultural and Linguistic (C&L) Services Program Overview

A. **Mission**

To ensure that all medically necessary and covered services are available and accessible to all Members and potential Members, including those less than 21 years of age, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, ~~ancestry, religion, language,~~ age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, ~~marital status~~, sexual orientation, ~~health status,~~ evidence of insurability (including conditions arising out of acts of domestic violence), source of payment, or 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, its IPAs and 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, and potential 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. Ensure that any lack of interpreter services does not impede or delay a Member's timely access to care;[7]
4. ~~3.~~ Providing training, support, technical assistance and resources to IPAs and Providers to assist them in the provision of culturally competent and linguistic services;[8]
5. ~~4.~~ Training IEHP and contracted staff on diversity, equity and inclusion ~~cultural awareness~~ within the first year of employment and providing updates on C&L resources;[9,10,11]

[1] Title 45 Code of Federal Regulations (CFR) 92.101(a)
[2] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.10, Access Rights ~~Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program~~
[3] 42 CFR § 440.262
[4] ~~Department of Health Care Services (~~DHCS~~)~~ -IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.10 Access Rights
[5] National Committee for Quality Assurance (NCQA), 2021 Health Plan Standards and Guidelines, NET 1, Element A, Factor 1
[6] NCQA, 2023 Health Plan Standards and Guidelines, NET 1, Element A, Factor 1
[7] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.10, Access Rights
[8] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program ~~DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.10 Access Rights~~
[9] Ibid.
[10] Title 28 California Code of Regulations (CCR) § 1300.67.04
[11] 42 CFR § 440.262

~~5.~~6. P~~rogram staff p~~articipat~~inge~~ in committees and workgroups to ensure cross-departmental program deliverables are accessible and appropriate for Members and potential members in need of C&L services;

~~6.~~7. 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;[12] and

~~7.~~8. Implementing activities to educate Team Members on cultural diversity among Members, potential Members, and ~~within the IEHP 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); M~~m~~ember surveys; notices advising LEP persons of free language assistance; and newsletters. [13,14]

2. IEHP provides oral and written Member information in the threshold languages designated by DHCS in accordance with federal and state regulations.[15,16]

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.[17,18]

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-

[12] -DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 1.1.10 Member Representation
[13] DHCS APL 21-004, "Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services"
[14] National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, ME 2, Element A
[15] DHCS APL 21-004
[16] 42 CFR §438.10(d)
[17] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.10 Access Rights
[18] DHCS APL 21-004

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.[19]

C. **Coordination of Local Resources**

IEHP refers Providers, Members, prospective Members, and community stakeholders, to existing resources in the community through IEHP's Resource and Referral Service managed by the Independent Living and Diversity Services Department and IEHP's Long Term Services and Supports unit. IEHP also collaborates with 2-1-1 and Connect IE, a community resource referral service in San Bernardino and Riverside Counties to provide Members, prospective Members, and community stakeholders, with up-to-date information on health, C&L and social services in their community.[20,21,22]

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 using national standards for Culturally and Linguistically Appropriate Services (CLAS) for reference,[23] when setting standards specific to IEHP and informing IPAs and Providers of the standards.

E. **Development of Language Interpretation Resources**[24]

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

[19] DHCS All Plan Letter (APL) 18-016, supersedes 11-018, "Readability and Suitability of Written Health Education Material

[20] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.10 Access Rights

[21] DHCS APL 21-004

[22] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.10 Access Rights

[23] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.11, Cultural and Linguistic Programs and Committees

[24] NCQA, 2021 Health Plan Standards and Guidelines, ME 2, Element B

when in-person services are not available or timely) sign language interpretation services for Members.[25,26,27,28,29]

F. **Access Provider Linguistic Capabilities**

1. IEHP actively recruits and retains culturally and linguistically competent Providers that reflect the needs of the Medi-Cal population in the service.[30]

2. 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.

3. Providers are required to submit their language capability upon application to the Plan, and the language(s) are listed in the Provider Directory.[31] To ensure continued availability of the threshold language(s), the IEHP Provider Services Department verifies threshold language capability on an annual basis.[32]

G. **Cultural and Linguistic Training**

IEHP requires ~~Training on cultural competence/sensitivity and IEHP C&L Program policies are available to~~ IPAs and its~~,~~ Provider networks~~s~~ to complete its Diversity, Equity, and Inclusion training~~, and their staff~~ initially and bi-annually thereafter. IEHP also disseminates resources, policies and procedures and information to its IPAs and Provider network to assist them in providing care in a culturally and linguistically appropriate manner. [33] [34] 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/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy

[25] ~~NCQA, 2023 Health Plan Standards and Guidelines, ME 2, Element C~~ Ibid.
[26] DHCS APL 21-004
[27] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 4, Written Member Information ~~DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.10 Access Rights~~
[28] 42 CFR § 43.10(d)
[29] Title 28 IEHP California Code of Regulations 28 CCR § 1300.67.04
[30] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.11, Cultural and Linguistic Programs and Committees
[31] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.1 Member Services
[32] 28 CCR, § 1300.67.04
[33] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 3.2.5, Network Provider Training
[34] DHCS APL 99-005

All new employees and contracted staff receive the Plan's Diversity, Equity, and Inclusion ~~cultural awareness~~ training within their first year of employment.[35,36,37,38] The Independent Living and Diversity Services Department coordinates and implements activities to raise awareness of C&L resources and disseminates information to Team Members and contracted staff (e.g., C&L Awareness Weeks, JIVE Postings).

Cultural & Linguistic Services Program Evaluation

A. IEHP conducts processes to monitor and evaluate the delivery of and evaluates the impact and/or outcome of C&L services and takes effective action to address any ~~improvements~~ identified gaps and opportunities for improvements as needed.[39] Program evaluation activities include, but are not limited to:[40]

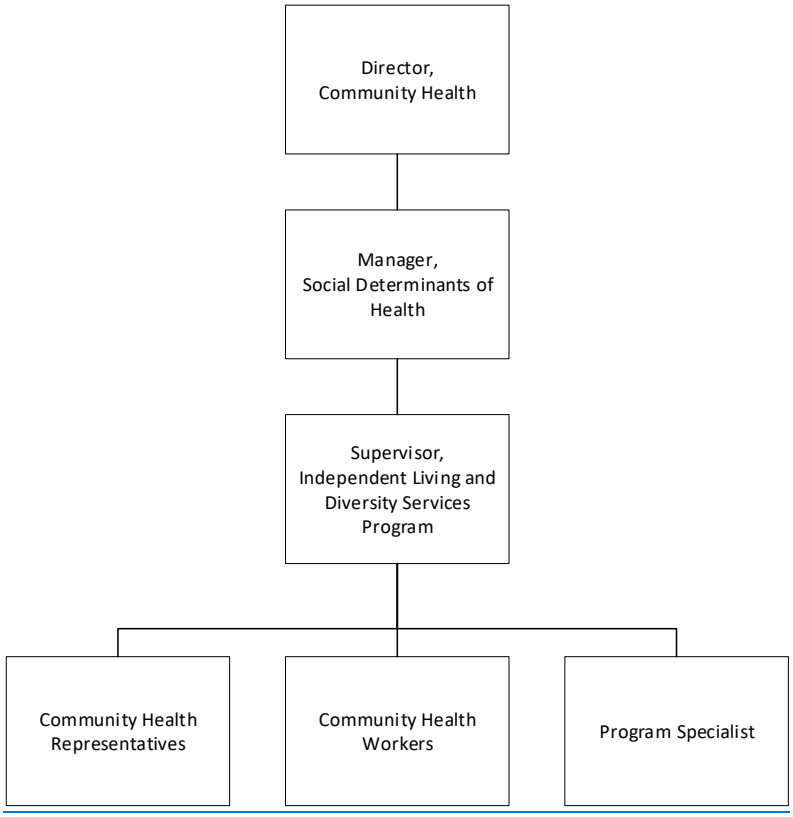
1. Assess~~es~~ing Providers' adherence to program standards based on quality activities and Member grievances;
2. Assessing the performance of Team Members, who provide linguistic services;
~~1.~~3. Assessing and tracking the linguistic capability of contracted interpreters and bilingual staff;
~~2.~~4. Track~~ings~~ use of interpretation services; and
5. Assess~~es~~ing impact of training or cultural awareness events on Team Members through Team Members' feedback.

~~3.~~B. IEHP and its IPAs review and update their Cultural and Linguistic Services program to align with the Population Needs Assessment.[41]

Cultural and Linguistic Services Personnel

A. **Organizational Chart**[LN1] (next page)

[35] ~~Ibid.~~
[36] U.S. DHHS, Office of the Secretary (2013) National Standard for CLAS in Health Care ~~42 CFR § 440.262~~
[37] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2.6, QIHETP Policies and Procedures ~~28 CCR § 1300.67.04~~
[38] 28 CCR § 1300.67.04
[39] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.11 Cultural and Linguistic Programs and Committees
[40] Ibid.
[41] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.11, Cultural and Linguistic Programs and Committees



~~A.~~B. ~~Program Manager~~Personnel

1. **Program Manager -** Under the direction of the Director of Community Health, the Program Manager oversees the C&L Program with assistance from the Supervisor of Independent Living and Diversity Services. ~~rom Community Health leadership, the Program Manager oversees the C&L Program.~~ The qualifications for this position include a Master's degree from an accredited institution in Social Work, Public Administration or closely related field required. The Program Manager staff consist of ~~Supervisor,~~ Community Health Representatives, Project Analyst/Specialist, ~~Cultural and Linguistics Services Specialist and Coordinator~~ and Community Health Workers .
2. **Community Health Representatives –** Under the direction of the Program Manager, Community Health Representatives conduct Diversity, Equity and Inclusion outreach, training/education to internal staff, network Providers and community-based organizations. Required education includes a Bachelor's degree in Human Services or closely related field.
3. **Community Health Workers –** Under the direction of the Program Manager, Community Health Workers process alternate format materials as requested by Members. CHWs also provide culturally appropriate resources for Members, Providers and community-based

organizations, as needed. Required education includes a CHW certificate from an accredited program.

4. **Program Specialist -** Under the direction of the Program Manager, Program Specialist will coordinating internal and external translation services, interpreter services of non-English languages including American Sign Language and alternative format requests. Required education includes a Bachelor's degree in health care related field or cultural and linguistic studies.

~~1.~~

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24. PROGRAM DESCRIPTIONS

C. Quality Management & Health Equity Transformation Program and Quality Improvement Program Description

Introduction

IEHP supports an active, ongoing, and comprehensive Quality Management & Health Equity Transformation Program (QMHETP) 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~~ ~~member~~Member safety delivered to IEHP ~~Member~~Members. The QMHETP 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 ~~Member~~Members. IEHP has created a systematic, integrated approach to planning, designing, measuring, assessing, and improving the quality of care and services provided to ~~Member~~Members. This comprehensive delivery system includes ~~patient~~ ~~member~~Member 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 (QM) and QI~~uality Improvement~~ activities to ensure the QMHETP 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~~ ~~member~~Member safety, and quality of services delivered to IEHP ~~Member~~Members.[1] 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 ~~Member~~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 ~~Member~~Members, Providers, Partners, and each other.

Section 1: QMHETP~~/QI Program~~ Overview

~~D.~~1.1 QMHETP~~QM/QI Program~~ Purpose

~~A.~~ The purpose of the QMHETP is to provide the structure and framework necessary to monitor and evaluate the quality and appropriateness of care, identify opportunities for

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2, Quality Improvement and Health Equity Transformation Program (QIHETP)~~Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 7, Written Description~~

clinical, ~~patient member~~Member 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.

~~E.~~1.2 QMHETP ~~Program~~ Scope

~~A.~~ The Quality Management & Health Equity Transformation Committee (QMHETC) approves the QMHETP annually. The QMHETP review includes approval of the QMHETP Description, QMHETP Work Plan, and QMHETP Annual Evaluation to ensure ongoing performance improvement. The QMHETP is designed to improve all aspects of care delivered to IEHP ~~Member~~Members in all health care settings by:

1. Defining the Program structure;[2]
2. Assessing and monitoring the delivery and safety of care;
3. Assessing and monitoring population health management provided to ~~Member~~Members, including behavioral health and care management services;[3,4]
4. Supporting Practitioners and Providers to improve and maintain the safety of their practices;
5. Overseeing IEHP's Quality Management & Health Equity functions through the QMHETC;
6. Involving designated Physician(s) and staff in the QMHETP;
7. Involving a Behavioral Healthcare Practitioner in the behavioral health aspects of the Program;[5]
8. Involving Long-Term Services and Supports (LTSS) Provider(s) in the QMHETP;
9. Reviewing the effectiveness of LTSS programs and services;[6]
10. Ensuring that LTSS needs of ~~Member~~Members are identified and addressed leveraging available assessment information;
11. Identifying opportunities for QI initiatives, including the identification of health disparities among ~~Member~~Members;
12. Implementing and tracking QI initiatives that will have the greatest impact on ~~Member~~Members;

[2] National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, QI 1, Element A, Factor 1
[3] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2, QIHETP
[4] NCQA, 2023 HP Standards and Guidelines, QI 1, Element A, Factor 2
[5] NCQA, 2023 HP Standards and Guidelines, QI 1, Element A, Factor 4
[6] Title 42 Code of Federal Regulations (CFR) § 438.330(b)(5)

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 QMHETP;
16. Assessing and monitoring delivery and safety of care for the IEHP population with complex health needs and Seniors and Persons with Disabilities (SPD);
17. Assessing and monitoring processes to ensure the ~~Member~~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~~Member safety and care rendered at Provider practices/facilities.

1.3 QMHETP~~QM/QI Program~~ Goals[7]

~~A.~~ The primary goal of the QMHETP is to continuously assess and improve the quality of care, services, and safety of healthcare delivered to IEHP ~~Member~~Members. The QMHETP goals are to:

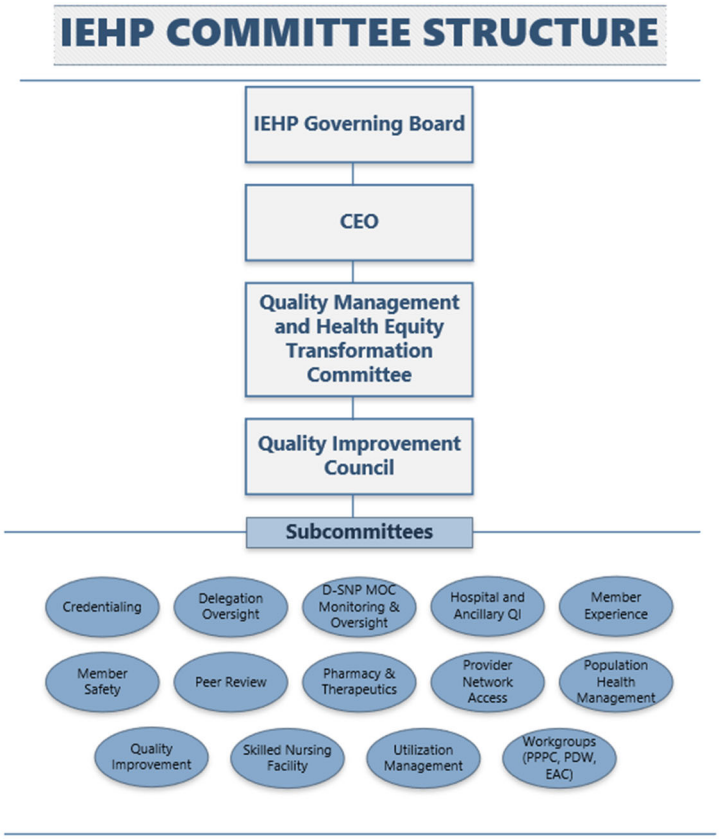
1. Implement strategies for Population Health Management (PHM) that keep ~~Member~~Members healthy, manage ~~Member~~Members with emerging risks, ensure ~~patient member~~Member safety and outcomes across settings, improve ~~Member~~Member satisfaction, and improve quality of care for ~~Member~~Members 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 member~~Member 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~~Member and Provider feedback, and the evaluation of ~~Member~~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 QMHETP and utilize the results to plan future initiatives and program design.

[7] NCQA, 2023 HP Standards and Guidelines, QI 1, Element A, Factor 1

Section 2: Authority and Responsibility[8]

~~A.~~ The QMHETP includes tiered levels of authority, accountability, and responsibility related to quality of care and services provided to ~~Member~~Members. The line of authority originates from the Governing Board and extends to Practitioners through different subcommittees.

[8] ~~NCQA, 2023 HP Standards and Guidelines, QI 1, Element A, Factor 1~~Ibid.



~~F.~~2.1. IEHP Governing Board

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) ~~member~~Members from each County Board of Supervisors and three (3) public ~~member~~Members selected from the two (2) counties sit on the Governing Board.

The Governing Board's responsibilities include but are not limited to: ~~is responsible for~~

1. Providing oversight of health care delivered by contracted Providers and Practitioners.
2. ~~The Board p~~Providing~~s~~ direction for the QMHETP;
3. Evaluating~~s~~ QMHETP effectiveness and progress;
4. ~~and~~ Evaluating~~s~~ and approving~~s~~ the annual QMHETP Description and Work Plan;[9]
5. Appointing an accountable entity or entities within the Plan responsible for

[9] DHCS-IEHP Primary Operations Contract, 01/01/24, Exhibit A, Attachment III, Provision 2.2.2, Governing Board

oversight of QMHETP.;[10]

6. Reviewing written progress reports received from the QMHETC that describe actions taken, progress in meeting QMHETP objectives, and improvements made;[11]

7. Directing necessary modifications to QMHETP policies and procedures to ensure compliance with Quality management and Health Equity standards set forth in the Two-Plan Contract and DHCS Comprehensive Quality Strategy.[12] [OT1]

A. 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).[13]

B. Quality topics are presented to the Board at least quarterly, and on an as-needed basis. Topics presented to the Board consist of but are not limited to:; Overview of IEHP Pay-for-Performance Programs, QMHETP Description and Workplan, Quality Management & Health Equity Program Overview, Provider Satisfaction Survey results, Grievance & Appeals Trends and Log Review, Patient MemberMember Safety Executive Summary, Assessment of Network Adequacy, HEDIS® and CAHPS® Annual Reports. Feedback from the Board is shared at the Quality Management & Health Equity Transformation CommitteeQMHETC.

C. The Board delegates responsibility for monitoring the quality of health care delivered to MemberMembers to the CMO, CQO, and the QMHETC with administrative processes and direction for the overall QMHETP initiated through the CMO and CQO, or Medical Director designee.[14,15]

G.2.2. 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 QMHETP; 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 memberMember of all standing Committees. The CEO interacts with the CMO and

[10] Ibid.
[11] Ibid.
[12]
[13] DHCS-IEHP Primary Operations Contract, 01/01/24, Exhibit A, Attachment III, Provision 2.2.2, Governing BoardIbid.DHCS-IEHP-Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 3, Governing Body
[14] DHCS-IEHP Primary Operations Contract, 01/01/24, Exhibit A, Attachment III, Provision 2.2.2, Governing BoardIbid.Ibid.
[15] NCQA, 2023 HP Standards and Guidelines, QI 1, Element A, Factor 3

CQO regarding ongoing QMHETP and QI activities, progress toward goals, and identified health care problems or quality issues requiring corrective action.

~~H.~~2.3. Role of the Chief Medical Officer (CMO)[16]

~~A.~~ The ~~Chief Medical Officer (~~CMO~~)~~ or designee has ultimate responsibility for the quality of care and services delivered to ~~Member~~Members and has the highest level of oversight for IEHP's QMHETP and QI Program.[17] 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 QMHETP 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 ~~Member~~Members; provides oversight of ~~patient member~~Member safety activities; and proactively incorporates quality outcomes into operational policies and procedures.

~~B.~~ The CMO or designee provides direction to the QMHETC and associated Subcommittees; aids with study development; and facilitates coordination of the QMHETP in all areas to provide continued delivery of quality health care for ~~Member~~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 ~~Member~~Members.

~~C.~~ 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.

~~I.~~2.4. Role of the Chief Quality Officer (CQO)

~~A.~~ The C~~hief~~ Q~~uality~~ O~~fficer~~ 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 ~~Member~~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

[16] Ibid.

~~[17] DHCS IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 2, Accountability~~

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 QMHETP functions and supervision of IEHP staff.

~~B.~~ Along with the CMO, the CQO or designee, provides direction to the QMHETC and associated Subcommittees; aids with quality study development; and facilitates coordination of the QMHETP in all areas to provide continued delivery of quality health care for ~~Member~~Members.

~~C.~~ The CQO initiates and leads initiatives for continuous quality improvement and evaluating the effectiveness of interventions across the continuum of care to ~~Member~~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.

2.5. Role of the Chief Health Equity Officer (CHEO)~~0~~

The Chief Health Equity Officer (CHEO) provides leadership in the design and implementation of IEHP's strategies and programs to ensure health equity is prioritized and addressed; ensures all policies and procedures consider health inequities and are designed to promote health equity where possible, including but not limited to marketing strategy, medical and other health services policies, ~~Member~~Member and provider outreach, Public Policy Participation Committee, quality improvement activities, including delivery system reforms, grievance and appeals, and utilization management. The CHEO is responsible for developing and implementing policies and procedures aimed at improving health equity and reducing health disparities; engaging and collaborating with Team ~~Member~~Members, Subcontractors, Downstream Subcontractors, Network Providers, and entities including local community-based organizations, local health department, behavioral health and social services, child welfare systems and ~~member~~Members in health equity efforts and initiatives. The CHEO is also responsible for implementing strategies designed to identify and address root causes of health inequities, which includes but is not limited to systemic racism, social drivers of health, and infrastructure barriers.

The CHEO has the authority to design and implement policies that ensure Health Equity is prioritized and addressed. The CHEO is an active ~~member~~Member of the QMHETC to ensure engagement and collaboration with both IEHP leadership and external providers. The CHEO is responsible for supervision of all QMHETP activities. The CHEO develops targeted interventions designed to eliminate health inequities; develops quantifiable metrics that can track and evaluate the results of the targeted interventions designed to eliminate health

inequities; and ensures all Contractor, Subcontractor, Downstream Subcontractor, and Network Provider staff receive mandatory diversity, equity and inclusion training annually.

~~J.~~2.6. Quality Management & Health Equity Transformation Committee (QMHETC)[18]

~~A.~~ The QMHETC reports to the Governing Board and retains oversight of the QMHETP with direction from the CMO and CQO.[19,20] 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 ~~Member~~Membership.[~~21~~]
2. **Structure:** The QMHETC is composed of Network Providers, Specialists, Medical Directors, IPA Medical Directors who are representative of network Practitioners, Practicing Pharmacists, and Public Health Department Representatives from Riverside and San Bernardino Counties.[22] These individuals provide expertise and assistance in directing the QMHETP activities. A designated Behavioral Healthcare Practitioner is an active ~~Member~~Member of the IEHP QMHETC to assist with behavioral healthcare-related issues.[23] There are a total of 29 Quality Management & Health Equity Transformation Committee ~~Member~~Members. This includes both internal and external participants. 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~~Member Services;
   f. Family and Community Health;

[18] NCQA, 2023 HP Standards and Guidelines, QI 1, Element B, Factor 3
[19] DHCS-IEHP ~~Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 4, Quality Improvement Committee~~Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2.3, Quality Improvement and Health Equity Committee
[20] NCQA, 2023 HP Standards and Guidelines, QI 1, Element A, Factor 5
[21] ~~DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 7, Written Description~~
[22] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2.4, Provider Participation~~DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 4, Quality Improvement Committee~~
[23] NCQA, 2023 HP Standards and Guidelines, QI 1, Element A, Factor 4

~~f.~~g. Population Health Management;

~~g.~~h. Health Education;

~~h.~~i. Grievance & Appeals;

~~i.~~j. Quality Informatics;

~~j.~~k. HealthCare Informatics;

~~k.~~l. Independent Living and Diversity Services;

~~l.~~m. Compliance; and

~~m.~~n. Provider Services.

3. **Function**: The QMHETC meets quarterly[24] and reports findings, actions, and recommendations to IEHP Governing Board (through the CMO) annually and reports meeting minutes to DHCS quarterly.[25] The QMHETC seeks methods to increase the quality of health care for IEHP ~~Member~~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.[26]
4. **Quorum**: Voting cannot occur unless there is a quorum of voting ~~Member~~Members present. For decision purposes, a quorum is defined as the Chairperson or IEHP Medical Director and two (2) appointed Physician Committee ~~Member~~Members.
   a. A Behavioral Health Practitioner must be present for behavioral health issues.[27]
   b. Non-physician Committee ~~Member~~Members may not vote on medical issues.[28]
5. **External Committee ~~Member~~Members:** QMHETC ~~member~~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.

[24] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2.3, QIHEC
[25] ~~DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2.3, Quality Improvement and Health Equity Committee~~Ibid.~~DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 4, Quality Improvement Committee~~
[26] ~~DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2.3, Quality Improvement and Health Equity Committee~~Ibid.~~Ibid.~~
[27] NCQA, 2023 HP Standards and Guidelines, QI 1, Element A, Factor 4
[28] Ibid.

a. The Compliance and QM department collaborate to ensure committee ~~member~~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~~Member of the QMHETC, or prospective ~~member~~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 ~~member~~Members must be screened before being confirmed, and monthly thereafter.

d. QM notifies the Compliance department of any ~~member~~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~~Member and Practitioner confidentiality is protected.[29][30]

a. All ~~member~~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 ~~member~~Members are required to sign a confidentiality agreement upon hiring. The confidentiality agreements are maintained in the employee files as appropriate.

d. All peer review records, proceedings, reports, and ~~Member~~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."

[29] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2.3, Quality Improvement and Health Equity Committee~~DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 4, Quality Improvement Committee~~

[30] ~~DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 2 Program Terms and Conditions, Provision 21, Confidentiality of Information~~

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 QMHETP utilizes an extensive data system that captures information from claims and encounter data, enrollment data, Utilization Management (UM), QM, Health Equity and QI activities, behavioral health data, pharmaceutical data, grievances and appeals, and ~~Member~~Member Services, among others.
9. **Affirmation Statement**: The QMHETP assures that utilization decisions made for IEHP ~~Member~~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~~Member care.[31,32,33] 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 QMHETP Information**: IEHP has developed an overview of the QMHETP and related activities. This overview is on the IEHP website at www.iehp.org and a paper copy is available to all ~~Member~~Members and/or Practitioners upon request by calling IEHP ~~Member~~Member Services Department. ~~Member~~Members are notified of the availability through the ~~Member~~Member Handbook.[34,35] Practitioners are notified in the Provider Manual. The IEHP QMHETP Description and Work Plan are available to IPAs and Practitioners upon request. A summary of QM, Health Equity & QI activities and progress toward meeting QM, Health Equity & QI goals are available to ~~Member~~Members, Providers, and Practitioners upon request.
11. **Conflict of Interest**: IEHP monitors IPAs for policies and procedures and signed conflict of interest statements at the time of the Delegation Oversight Annual Audit.[36]

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[31] ~~DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program~~

[32] ~~DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 8, Provision 3, Physician Incentive Plan Requirements~~

[33] NCQA, 2023 HP Standards and Guidelines, MED 9, Element D

[34] Title 28, California Code of Regulations § 1300.69(i)

[35] NCQA, 2023 HP Standards and Guidelines, MED 8, Element D

[36] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.2.3, Quality Improvement and Health Equity Committee~~DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 4, Quality Improvement Committee~~

2.7. 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:[37]~~,~~[38]

1. Quality Improvement Council (QIC);
2. ~~Quality Improvement Subcommittee (QISC);~~
3. Peer Review Subcommittee;
4. Credentialing Subcommittee;
5. Provider Network Access Subcommittee;
6. D-SNP Model of Care (MOC) Subcommittee;
7. Delegation Oversight Committee;
8. Hospital and Ancillary Quality Improvement (QI) Subcommittee;
9. ~~Member~~Member Experience Subcommittee (MESC);
10. ~~Member~~Member Safety Subcommittee;
11. Population Health Management (PHM) Subcommittee;
12. Skilled Nursing Facility (SNF) Subcommittee;
13. Pharmacy and Therapeutics (P&T) Subcommittee; and
14. Utilization Management (UM) Subcommittee.

~~Quality Improvement Council (QIC);~~

[37] ~~DHCS IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 7, Written Description~~

[38] NCQA, 2023 HP Standards and Guidelines, QI 1, Element A, Factor 5

2.7.1 Quality Improvement Council (QIC)

~~1. Peer Review Subcommittee;~~

~~2. Credentialing Subcommittee;~~

~~3. Pharmacy and Therapeutics Subcommittee;~~

~~4. Delegation Oversight Committee;~~

~~5. Quality Improvement Subcommittee;~~

~~6. Population Health Management (PHM) Subcommittee;~~

~~7. Provider Network Access Subcommittee;~~

~~8. Member Experience Subcommittee (MESC); and~~

~~9. Utilization Management Subcommittee (UMSC).~~

~~Quality Improvement Council (QIC)[39]~~

~~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 QMHETC 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 ~~Member~~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~~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.

~~[39] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 7, Written Description.~~

4.

2.7.2. Peer Review Subcommittee

~~B.~~ 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 IPA Medical Directors or designated physicians that are representative of network Providers. A Behavioral Health Practitioner and any other Specialist, not represented by committee ~~member~~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~~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.

2.7.3. Credentialing Subcommittee

~~C.~~ 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 IPAs that have not been delegated credentialing responsibilities.

1. **Role:** The Credentialing Subcommittee is responsible for reviewing individual Practitioners who directly contract with IEHP and denying or approving their participation in the IEHP network.
2. **Structure:** The Credentialing Subcommittee is composed of multidisciplinary participating Primary Care Providers (PCP) or specialty Physicians, representative of network Providers. A Behavioral Health Practitioner, and any other Specialist not represented by committee ~~member~~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.

2.7.4. D-SNP Model of Care (MOC) Subcommittee

The D-SNP MOC Subcommittee identifies opportunities that impact clinical outcomes, ~~Member~~Member safety, service improvement, and ~~Member~~Member experience for IEHP's D-SNP population. Quantitative and qualitative data including, but not limited to MOC performance metrics, Medicare Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) scores, Pay for Performance (P4P) and Medicare studies and surveys, are all evaluated to ensure continuous and responsive improvement initiatives to drive quality program excellence.

1. **Role:** The D-SNP MOC Subcommittee is responsible for reviewing MOC performance outcomes using a multidisciplinary approach, exploring root causes of performance opportunities and propose interventions.
2. **Structure:** The D-SNP MOC Subcommittee has cross-departmental internal IEHP ~~member~~Members. Representing departments include, Quality Systems, Delegation Oversight, Provider Services, Behavioral Health and Care Management, Pharmacy, Utilization Management, ~~Member~~Member Services, Grievance & Appeals and Medical Directors. Ad hoc participants may include, Operations, Eligibility, Medicare Network Development, Compliance, and others as needed.
3. **Function:** The D-SNP MOC Subcommittee provides oversight of D-SNP activities and reviews, monitors, and evaluates program data, outliers, and trends ensuring timely improvement initiatives are initiated. The D-SNP MOC Subcommittee is responsible for initiative oversight, ensuring outcomes are achieved and barriers are removed.
4. **Frequency of Meetings:** The D-SNP MOC Subcommittee meets every other month with ad hoc meetings conducted as needed.

2.7.5. Pharmacy and Therapeutics (P&T) Subcommittee

~~Pharmacy and Therapeutics (P&T) Subcommittee~~[40]

~~***D.***~~ 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 ~~Member~~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

[40] ~~DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 8, Services for All Member~~Members

under- and over-utilization of medications. They are also responsible for reviewing and updating clinical practice guidelines that are primarily medication related.

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 ~~member~~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.

2.7.6. Delegation Oversight Committee

The Delegation Oversight Committee is an internal committee responsible for IPA oversight and monitoring in conjunction with Departments including QM, UM, BH, CM, Credentialing/Re-Credentialing activities, Compliance and Finance.

1. -**Role:** The Delegation Oversight Committee is responsible for monitoring the operational activities of contracted IPAs and other Delegate's activities including Claims Audits, Pre-Service and Payment universe metrics, Financial Viability, Electronic Data Interchange (EDI) transactions, Case Management, Utilization Management, Grievance & Appeals, Quality Management, Credentialing/Re-credentialing activities, and other provider-related activities.

2. **Structure:** The Delegation Oversight Committee 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, HealthCare Informatics, and Provider Services. The Delegation Oversight Committee is facilitated by the Director of Delegation Oversight.

3. **Function:** The Delegation Oversight Committee analyzes and evaluates Delegation Oversight activities and reports results; develops action items as needed; and ensures follow-up as appropriate.

4. -Frequency of Meetings: The Delegation Oversight Committee meets every month with ad hoc meetings conducted as needed.

2.7.7. Quality Improvement (QI) Subcommittee

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

1. **Role:** The QI Subcommittee is responsible for reviewing reports and findings of studies before presenting to QMHETC and works to develop action plans to improve quality and study results.

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, Health Education, HealthCare Informatics, ~~Member~~Member Services, and Provider Services. The QI Subcommittee is facilitated by the Director of Quality Improvement, and an IEHP Medical Director or designee.

3. **Function:** The QI Subcommittee analyzes and evaluates QI activities and reports results; develops action items as needed; and ensures follow-up as appropriate. All action plans are documented on the QMHETP Work Plan.

4. **Frequency of Meetings:** The QI Subcommittee meets quarterly with ad hoc meetings conducted as needed.

2.7.8. Population Health Management (PHM) Subcommittee

The PHM Subcommittee provides monitoring and oversight of IEHP's Population Health Management Program as defined in IEHP's Population Health Management Program Description.

1. **Role:** The PHM Subcommittee is responsible for reviewing, monitoring and evaluating program information and progress while providing regulatory oversight in alignment with DHCS and NCQA requirements and standards.

2. **Structure:** The PHM Subcommittee is composed of representation from multiple internal IEHP Departments including, but not limited to: Quality Systems, Behavioral Health & Care Management, Grievance and Appeals, Utilization Management, Health Equity/Community Health, Community Supports, Integrated Transitions of

Care, Enhanced Care Management, Health Education, HealthCare Informatics, ~~Member~~Member Services, and Provider Services. The PHM Subcommittee is facilitated by the Vice President of Health Services Clinical Integration and Operations, and an the Vice President of Quality.

3. **Function:** The PHM Subcommittee establishes a cohesive organizational approach to population health management that ensures that all IEHP ~~Member~~Members have access to a comprehensive program that leads to longer, healthier, and happier lives, improved outcomes, and health equity. The PHM Subcommittee analyzes and evaluates PHM activities and reports results; develops action items as needed; and ensures follow-up as appropriate. All action plans are documented on the QMHETP Work Plan.
4. **Frequency of Meetings:** The PHM Subcommittee meets quarterly with ad hoc meetings conducted as needed.

~~H.~~2.7.9. The Provider Network Access Subcommittee

1. **Role:** The Provider Network Access Subcommittee is responsible for reviewing, monitoring, and evaluating program data, outliers, and trends to ensure timely improvement initiatives are initiated. The Provider Network Access Subcommittee is also responsible for initiative oversight, ensuring outcomes are achieved and barriers are removed.
2. **Structure:** The Provider Network Access Subcommittee reports directly to the QI Council, who then reports up to the QMHETP. The Provider Network Access Subcommittee is composed of representation from multiple internal IEHP departments, including but not limited to: Quality Systems, Delegation Oversight, Provider Services, Grievance & Appeals. Ad hoc participants may include Operations, Compliance, Regulatory and others on an as-needed basis. The Provider Network Access Subcommittee is facilitated by the Director of Healthcare Informatics, and an the Director of Provider Network.
3. **Function:** The Provider Network Access Subcommittee established goals to align with IEHP's strategic commitment to optimal care and vibrant health. Provider Network Access Program performance and outcome measures include but are not limited to: Improving access to preventive health services, Improving access to medical and mental health services, and Ensuring an adequate provider network. Outcomes are evaluated on an annual basis. Intervention decisions and goal revision is based on data and a multidisciplinary quality committee recommendation.
4. **Frequency of Meetings:** The Provider Network Access Subcommittee meets quarterly with ad hoc meetings conducted as needed.

~~I.~~2.7.10. ~~Member~~Member Experience Subcommittee (MESC)

1. **Role:** The role of the ~~Member~~Member Experience Subcommittee is to review, monitor, and evaluate program data, outliers, and trends to ensure timely improvement initiatives are initiated. The MESC will is responsible for initiative oversight, ensuring outcomes are achieved and barriers are removed.

2. **Structure:** The ~~Member~~Member Experience Subcommittee is composed of cross-departmental internal IEHP Leaders. Representing departments include, but are not limited to: Transportation Services, Provider Services/Relations, ~~Member~~Member Services, Grievance & Appeals, Quality Systems, Health Services and Marketing/Communication. Other participants may contribute on an ad hoc basis and include, but are not limited to: Hospital Relations, Community Health/Health Equity, Operations, Credentialing, Pharmacy, Compliance, Policy & Regulatory Operations, or other key business units that contribute to focused quality improvement initiative agenda items or discussions. The MESC is facilitated by the Vice President of ~~Member~~Member Experience, and the Vice President of Provider Experience.

3. **Function:** The ~~Member~~Member Experience Subcommittee, through a multifunctional approach, reviews ~~Member~~Member experience and satisfaction/dissatisfaction studies and reports identified on the workplan. The MESC will either, collectively explore root causes of performance opportunities and propose interventions or escalate to the Quality Improvement Council (QIC) as needed for additional recommendations. All studies, performance reports, and recommended action items are presented to the QIC on a routine basis.

4. **Frequency of Meetings:** The ~~Member~~Member Experience Subcommittee meets quarterly with ad hoc meetings conducted as needed.

2.7.11. ~~Member~~Member Safety Subcommittee

The scope of the ~~Member~~Member Safety Subcommittee includes all lines of business and contracted network provider, direct or delegated, in which care and services are provided to IEHP ~~Member~~Members. The ~~Patient~~~~Member~~Member Safety Subcommittee uses a multidisciplinary and multidepartment approach to explore root causes of poor performance, identify areas of improvement, propose interventions, and take actions to improve the quality of care delivery to our ~~Member~~Members.

1. **Role:** The roles and responsibilities of the ~~Member~~Member Safety Subcommittee are as follows: Reviewing and analyzing reports of adverse events, near-misses, and other ~~Member~~Member safety incidents to identify areas for improvement; Developing, reviewing, and implementing policies and procedures to reduce the risk of adverse events and improve ~~Member~~Member safety; Identifying areas for improvement to reduce ~~Member~~Member harm or injury; Presenting quality of care or quality of service concerns

to the Quality Improvement Council (QIC); Collaborating with other subcommittees, departments, and internal or external partners to ensure alignment and consistency in ~~patient~~~~member~~Member safety initiatives; Monitoring and evaluating the effectiveness of ~~patient~~~~member~~Member safety initiatives and recommending improvements; Reporting ~~patient~~~~member~~Member safety issues, trends, and progress in reducing adverse events to Quality Improvement Council (QIC) of.

2. **Structure:** The ~~Member~~Member Safety Subcommittee reports any quality concerns directly to the Quality Improvement Council (QIC). The ~~Member~~Member Safety Subcommittee will be chaired by a Medical Director and co-chaired by the Clinical Director of Quality Management. The ~~Patient~~~~Member~~Member Safety Subcommittee will consist of the following voting representatives from internal departments and disciplines including Medical Directors; Quality Management; Quality Improvement; Pharmacy; Hospital Relations; Health Equity; Behavioral Health & Case Management; Utilization Management; Grievance and Appeals; Provider Services and; Administrative Assistant/Special Program Manager (Minutes). Ad hoc participants may include, but not limited to, Operations, Information Technology, Compliance, Legal, and others as determined and appropriate. Ad hoc participants will not be voting representatives.

3. **Function:** The ~~Member~~Member Safety Subcommittee monitors and detects the IEHP network and systems to identify potential safety issues/concerns and risks. The purpose of the ~~Member~~Member Safety Subcommittee is to promote and ensure the evaluation and monitoring of ~~patients'~~~~member~~Members' safety and well-being as well as the quality of care and service provided to IEHP ~~Member~~Members by network providers, direct or delegated. The Subcommittee will work towards identifying, preventing, analyzing, evaluating, and addressing potential ~~patient~~~~member~~Member safety issues, implementing effective risk mitigation strategies, issuing corrective action plans (CAPs), and continuously improving the prevention of harm or injury to IEHP ~~Member~~Members.

4. **Frequency of Meetings:** The ~~Member~~Member Safety Subcommittee will meet on a quarterly basis to discuss ~~patient~~~~member~~Member safety initiatives, review incident reports, review required regulatory and accreditation reports, and make recommendations for improving ~~Member~~Member safety processes. Additional meetings may be scheduled on an ad hoc basis to address urgent ~~Member~~Member safety concerns.

2.7.12. Skilled Nursing Facility (SNF) Subcommittee

This subcommittee will identify opportunities that impact efficient transitions of care, clinical outcomes, ~~Member~~Member safety, and ~~Member~~Member experience while receiving care at a skilled nursing or long-term care facility. This subcommittee serves as a forum for review and evaluation of strategic, operational, and quality measures resulting from but not limited to: Inland Empire Health Plan (IEHP) optimal care strategies, Joint Operations Meeting (JOM) and related workgroups (i.e., throughput, quality, ambulatory operations, payment practices, etc.), and pay for performance initiatives.

1. **Role**: The role of the Skilled Nursing Facility Subcommittee is to review, monitor, and evaluate program data, outliers, and trends to ensure timely improvement initiatives. The subcommittee will be responsible for initiative oversight, ensuring outcomes are improved or achieved and barriers are removed.
2. **Structure:** T The Skilled Nursing Facility Subcommittee includes representation from the following departments: Behavioral Health and Case Management; Enhanced Care Management; Health Services; Hospital Relations; Medical Directors; Quality and Integrated Transitional Care. Ad hoc participants may include, but are not limited to: Community Health, Grievance and Appeals, ~~Member~~Member Services, Pharmacy, Provider Services, and others as identified through evolving areas of focus. A chair will lead the meeting discussion. Meetings will be recorded, documented and saved to a central repository. Refer to section 1.9 minutes for more details. ~~Member~~Membership will be reviewed annually and updated, as necessary.
3. **Function**: To establish and maintain a comprehensive Quality Assessment and Performance Improvement (QAPI) program for care delivery services provided to IEHP ~~Member~~Members admitted to contracted Skilled Nursing Facility (SNF) organizations. Subcommittee objectives include the development and ongoing monitoring of a quality measures of care based on. improvement opportunities identified through CMS Nursing Home Compare, IEHP claims data and CDPH to include but not limited to survey deficiency results, site visit findings, and complaint findings.
4. **Frequency of Meetings:** The Skilled Nursing Facility Subcommittee meets at least twice per year or as needed based on current areas of focus and to ensure sustained compliance with regulatory requirements.

2.7.13. Hospital and Ancillary Quality Improvement (QI) Subcommittee

This subcommittee will serve as the primary forum for discussion of topics related to acute care hospitals and/or sub-acute/post-acute network sites of care (i.e., hospice agencies, home health agencies (HHA), etc.*). IEHP's Optimal Care Subcommittee and the Inland Empire Hospital Alliance (IEHA) will report through this forum which will summarize performance and recommended actions for presentation at the Quality Improvement Council (QIC).

1. **Role**: The role of the Hospital and Ancillary QI Subcommittee is to review, monitor and evaluate program data, outliers and trends to ensure timely improvement initiatives. The subcommittee will be responsible for initiative oversight, ensuring outcomes are improved or achieved and barriers are removed. Furthermore, the Hospital Relations Subcommittee ensures timely communication of hospital, hospice agency and HHA performance to the QIC, including escalations as appropriate. This includes specific reporting of items linked IEHP's Optimal Care strategies.
2. **Structure**: The Hospital and Ancillary QI Subcommittee includes representation from the following departments: Behavioral Health and Care Management; Enhanced Care

Management; Health Services; Hospital Relations; Integrated Transitional Care; Medical Directors; Provider Experience and Quality. Ad hoc participants may include, but are not limited to: Community Health, Grievance and Appeals, ~~Member~~Member Services, Pharmacy, Provider Services, and others as identified through evolving areas of focus.

3. **Function:** To identify opportunities that impact clinical outcomes, ~~member~~Member safety, and ~~member~~Member experience during acute care hospitalization and/or sub-acute/post-acute network utilization (i.e., hospice agencies, home health agencies (HHA), etc.*). This subcommittee serves as a forum for review and evaluation of strategic and operational measures resulting from but not limited to: Inland Empire Health Plan (IEHP) optimal care strategies, Joint Operations Meeting (JOM) and related workgroups (i.e., throughput, quality, ambulatory/operations, payment practices, etc.), and pay for performance initiatives.

4. **Frequency of Meetings:** The Hospital and Ancillary QI Subcommittee meets at least twice per year or as needed based on current areas of focus and to ensure sustained compliance with regulatory requirements.

~~J.~~2.7.14. Utilization Management (UM) Subcommittee

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

At a minimum, IEHP evaluates their UM Program to ensure that is remains current and appropriate, which must include but not limited to the review of the following.

- UM Program Structure.
- Program Scope, processes, information sources used to determine benefit coverage and medical necessity.
- The level of involvement of the senior-level physician within the UM Program.
- Annual Inter-rater Reliability (IRR) monitoring performance of decision makers.
- Ensuring that medical decisions are rendered by qualified medical personnel.
- Ensuring that decisions are based off a consistent application of UM Criteria.

IEHP performs quality assurance on both UM authorization and denials via monthly universes to determine process timeliness and appropriateness of decision making.

1. **Role:** The UM Subcommittee directs the continuous monitoring of all aspects of UM and Behavioral Health (BH) services provided to ~~Member~~Members.

2. **Structure:** The UM Subcommittee is composed of IPA Medical Directors, or designated Physicians that are representative of network Practitioners. A Behavioral Health Physician and any other Specialist, not represented by committee ~~member~~Members, serve on an ad hoc basis for related issues.[41]

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.

2.8. QM Support Committees/Workgroups

A. IEHP also has Committees and/or Workgroups that are designed to provide structural input from Providers and ~~Member~~Members. These Committees and Workgroups report directly through the QMHETC, 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); and

2. Persons with Disabilities Workgroup (PDW).

3. Delegation Oversight Committee

~~2.~~4. Compliance Committee

~~K.~~2.8.1. Public Policy Participation Committee (PPPC)

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

2.8.2. Persons with Disabilities Workgroup (PDW)

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.

[41] NCQA, 2023 HP Standards and Guidelines, UM 1, Element A, Factors 2 and 4

2.8.3. Delegation Oversight Committee

The Delegation Oversight Committee is an internal committee that monitors the operational activities of contracted IPAs and other delegate's 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 QMHETC and Compliance Committee and meets monthly with ad hoc meetings conducted as needed.

2.8.4. Compliance Committee

The Compliance Committee assists the IEHP Compliance Officer to develop and enforce 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), 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 at least quarterly with ad hoc meetings conducted as needed.

~~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.~~

Section 3: Organizational Structure and Resources

A. IEHP has designated internal resources to support, facilitate, and contribute to the QMHETP and QI Program. The Organization Chart (see Authority and Responsibility, section A) provides further details on support staff.[42]

3.1. Clinical Oversight of QMHETP /~~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 QMHETP and 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

[42] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 7, Written Description

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 ~~Member~~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. The QM program adopts, disseminates, and monitors the use of preventive care and clinical practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals, considers the needs of ~~Member~~Members, and is developed in consultation with contracted health care professionals, as standards of health care are applicable to ~~Member~~Members and Providers.

3.2. 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.

3.3. Quality Management Department (QM)[43]

A. The Quality Management Department operates under the direction of the Director of Quality Management. The Director of Quality Management reports up to the Senior Director of Quality Systems who reports to the Vice President of Quality. The Director of QM is responsible for oversight of the quality process; implementing, developing, coordinating, and monitoring for quality improvement, and maintaining the QMHETP and its related activities. Activities include the ongoing assessment of Provider and Practitioner compliance with IEHP requirements and standards, monitoring Provider trends and report submissions, and oversight of facility inspections. The Director of Quality Management also monitors and evaluates the effectiveness of IPA QM systems; coordinates information for the annual QMHETP 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 ~~Member~~Members.

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

3.4. 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.

3.5. 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,

[43] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27) , Exhibit A, Attachment 4, Provision 7, Written Description

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.

3.6. 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 ~~Member~~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.

3.7. 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~~Member health education. Primary responsibilities include oversight of the Health Education Department for ~~Member~~Member health education and Employee Wellness Program. The department coordinates with other departments to ensure ~~Member~~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~~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 ~~Member~~Members.

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

3.8. 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 ~~Member~~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.

3.9. 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 ~~Member~~Members.
3. Director of Delegation Oversight is responsible for IPA oversight and monitoring in conjunction with departments including QM, UM, CM, Credentialing/Re-Credentialing activities, Compliance, and Finance.
4. Director of Provider Network and Director of Provider Communication is responsible for all Provider communications, oversight of the IEHP Provider Manual and network compliance.

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

3.10. Credentialing Department

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

3.11. 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 ~~Member~~Members, Providers, Practitioners, and regulatory agencies. The Grievance & Appeals Department gathers supporting documentation from ~~Member~~Members, Providers, or contracted entities, and resolves cases based on clinical urgency of the ~~Member~~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.

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

3.13. Communications and Strategy Department

A. The Communications and Strategy Department operates under the direction of the Director of Communications and Marketing, who reports to the Chief Communications and Marketing Officer. The Communications and Strategy Department is responsible for conducting appropriate product and market research to support the development of marketing and ~~Member~~Member communication plans for all products including ~~Member~~Member materials (e.g., ~~Member~~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~~Member materials are implemented in a timely manner.

Section 4: Program Documents

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

4.1. ~~Quality Management and Quality Improvement~~QMHETP Work Plans[44]

A. Annually, and as necessary, the QMHETC approves the QMHETP 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 ~~member~~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 QMHETP. These initiatives focus on improving quality of care and service, access, ~~Member~~Member and Provider satisfaction, ~~patient member~~Member 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.[45]

4.2. Annual QMHETP Evaluation[46]

A. On an annual basis, IEHP evaluates the effectiveness and progress of the QMHETP including:

1. The QMHETP structure;
2. The behavioral healthcare aspects of the program;
3. How ~~patient member~~Member 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 Subcommittee;
7. An annual work plan (QMHETP Work Plan);
8. Objectives for serving a culturally and linguistically diverse ~~member~~Membership; and
9. Objectives for serving ~~Member~~Members with complex health needs.

B. As such, an annual summary of all completed and ongoing QMHETP activities addresses the quality and safety of clinical care and quality of service provided as outlined in the QMHETP

[44] NCQA, 2023 HP Standards and Guidelines, QI 1, Element A, Factor 5
[45] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 4, Quality Improvement Committee
[46] NCQA, 2023 HP Standards and Guidelines, QI 1, Element C

Work Plan. The evaluation documents evidence of improved health care or deficiencies, progress in improving safe clinical practices, status of studies initiated or completed, timelines, methodologies used, and follow-up mechanisms that are reviewed by QM staff, the CMO, CQO, or designee. The evaluation includes pertinent results from QMHETP studies, ~~Member~~Member access to care, IEHP standards, physician credentialing and facility review compliance, ~~Member~~Member experience, evidence of the overall effectiveness of the program, and significant activities affecting medical and behavioral health care provided to ~~Member~~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.

4.3. Review and Approval of Program Documents[47]

A. On an annual basis, the QMHETP Program Description, QMHETP Program Summary, and QMHETP Work Plan are presented to the Governing Board for review, approval, assessment of health care rendered to ~~Member~~Members, comments, direction for activities proposed for the coming year, and approval of changes in the QMHETP. 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.

Section 5: Quality Improvement Processes

A. IEHP aligns its QMHETP activities with the DHCS Comprehensive Quality Strategy. The planning and implementation of annual QMHETP 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 QMHETP.

B. IEHP aims to support the DHCS Bold Goals including, but not limited to:

1. Closing racial/ethnic disparities in well-child visits and immunizations;
2. Closing maternity care disparities;
3. Improving maternal and adolescent screening;
4. Improving follow up after emergency department visit for mental health conditions; and
5. Providing children's health preventive care services by exceeding national benchmarks.

[47] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Quality Improvement System

~~A. The planning and implementation of annual QMHETP 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 QMHETP.~~

5.1. IEHP Quality Improvement (QI) Initiatives

A. QI initiatives are also aligned with the IEHP Strategic Plan and Optimal Care, Vibrant Health, and Organizational Strength Vision Commitments that seeks to:

1. Provide clinical care with quality outcomes that exceed national benchmarks, along with health services that are accessible, anticipatory, and coordinated;
2. Provide health care that is equitably experienced across the Inland Empire; and
3. Leverage systems thinking that aligns IEHP's Mission, people, operations technology, and financial performance, respectively.

B. QI initiatives actively reinforce the Vision Commitments of the IEHP Strategic Plan, with a focus on addressing the specific needs of both IEHP's ~~Member~~Membership and those identified by state and regulatory agencies.

C. QI initiatives undergo a robust process of identification, development, and implementation, ensuring a targeted approach that addresses the specific needs of the IEHP ~~Member~~Membership. These initiatives prioritize high-volume, high-risk, or deficient areas, actively seeking improvements in care and service, access, safety, and experience. The proactive monitoring of Managed Care Accountability Set (MCAS) and other quality measures inform the identification and development of QI initiatives, their goals and objectives, and direction of the IEHP Strategic Plan. Furthermore, a data centered approach with a focus on performance measures and customized metrics form the basis of implementation plans and actions developed to improve care and service.

~~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.**~~

5.1.1 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.

5.1.2. 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.

5.1.3. 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.

5.1.4. Evaluation Process[48]

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.

5.1.5. 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.[49]

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 ~~Member~~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;[50]
    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.

5.1.6 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. If a Provider or Practitioner does not submit CAP or continues to be non-compliant with the CAP process (including CAP

[48] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 7, Written Description.
[49] Ibid.
[50] Ibid.

timelines), the Provider is frozen to auto-assignment until such time as the corrections are verified and the CAP is closed. The CAP process must be completed within 90 calendar days from the date of the audit and CAP notification. Quality Improvement Initiatives

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

Section 6: Quality Improvement Initiatives

6.1. 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 and IEHP DualChoice (HMO D-SNP);
2. State/Federal required Performance Improvement Projects and Quality Activities; and
3. Claims and encounter data from contracted Providers (e.g., Primary Care Providers, Specialists, labs, hospitals, IPAs, Vendors, etc.).

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

6.1.1. HEDIS® Measures[51]

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 ~~Member~~Membership, including, priority measures that relate to children, adolescents, and ~~Member~~Members with chronic conditions.

B. IEHP develops several ~~Member~~Member and Provider engagement programs to improve HEDIS® rates. Interventions include a combination of incentives, outreach and education,

[51] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 9, External Quality Review Requirements

Provider-level reports and gaps in care reports, and other activities deemed critical to improve performance. These interventions are tracked and monitored in the QMHETP 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 ~~Member~~Members.

6.1.2. Performance Review of Managed Care Accountability Set (MCAS)

A. MCAS is founded on the CMS Child and Adult Core Set Measures, which includes NCQA HEDIS® measures. For the year, there are 39 measures spanning the behavioral health, children's health, chronic disease management, reproductive health, and cancer prevention domains. Managed Care Plans (MCPs), such as IEHP, are mandated by DHCS to submit annual reports on their performance of MCAS measures. DHCS sets a Minimum Performance Level (MPL) for specific MCAS measures, aligning with NCQA's national Medicaid 50th percentile.

B. IEHP regards MCAS measures a priority. IEHP's MCAS measure performance guide the development of its Strategic Plan, QI activities, and department initiatives. IEHP seeks to not only meet and exceed the MCAS MPL established by DHCS, but achieve the MCAS High Performance Level (HPL) set at the 90th percentile for qualified measures.

C. IEHP proactively oversees its performance of MCAS measures and their corresponding MPL to evaluate and enhance clinical quality of care. The evaluation yields insights into ~~Member~~Member and Provider behavior, guiding the development of QI activities and direction of the IEHP Strategic Plan that are both pertinent and responsive. These QI activities may be incorporated into IEHP's Strategic Plan or department initiatives with the ultimate objective to meet or exceed the MCAS HPL.

D. Based on prior year performance, IEHP continues to find opportunities to improve these MCAS measures including, but not limited to: Childhood Immunization Status: Combination 10 (CIS-10), Immunizations for Adolescents: Combination 2 (IMA-2), Lead Screening in Children (LSC), Well-Child Visits in the First 30 Months of Life – 15 to 30 Months (W30-2), Child and Adolescent Well-Care Visits (WCV) and Cervical Cancer Screening (CCS). Detailed plans on activities to meet or exceed the MPL for these measures can be found on the MY 2022 | CY 2024 Comprehensive Quality Strategy.

~~B.~~

6.1.3. Performance Improvement Projects (PIPs) (DHCS, and CMS) ~~and Health Services Advisory Group (HSAG)~~ and Quality Activities~~)~~[52]

A. IEHP implements ~~several Performance Improvement Projects (PIPs)~~quality improvement activities ~~and HEDIS® PDSA PIPs that are~~as required by regulatory agencies (DHCS, CMS ~~and HSAG~~) and in accordance with requirements in the Capitated Financial Alignment Model.

1. Performance Improvement Projects (PIPs) ~~PIPs –~~ A thorough analysis of 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 ~~Member~~Members. DHCS Medi-Cal Managed Care Division contracts with Health Services Advisory Group (HSAG), and external quality review organization (EQRO) to conduct validation of these projects.

~~2. HEDIS® PDSA PIPs – conducted for each HEDIS® External Accountability Set (EAS) also known as Managed Care Accountability Set (MCAS) measure with a rate that does 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.~~2. NCQA Quality Activities – These are quality improvement activities conducted to meet NCQA accreditation standards.

~~B.~~ The Quality ~~Management~~ Improvement Department, under the direction of the Chief Quality Officer ~~Medical Director(s)~~, is responsible for monitoring these programs and implementing interventions to make improvements. For 2024, IEHP is focusing on the following studies:

Study Name	Reporting Agency	Type of Study
IEHP All-Cause Readmissions	NCQA	Quality Activity
2023–26 Clinical PIP - Improve Well-Child Visits in the *First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* (W30–6) measure rates for Black/African American populations~~Disparity Performance Improvement Project – Controlling High Blood Pressure (CBP)~~	DHCS~~, HSAG~~	PIP
~~Well Care Visits (WCV)~~ 2023–26 Non Clinical PIP – Improve the percentage of Provider notifications for ~~Member~~Members with SUD/SMH diagnoses	DHCS~~, HSAG~~	PIP

[52] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 9, External Quality Review Requirements

following or within 7 days of emergency department (ED) visit		
~~Timeliness of Prenatal Care (PPC – Prenatal)~~	~~DHCS~~	~~PDSA~~
~~Cervical Cancer Screening~~	~~DHCS~~	~~PDSA~~
2024 Comprehensive Quality Strategy - ~~Child/Adolescent Health~~ – Well Care Visits in First 30 months of life (W30-2), Childhood Immunizations Combination 10 (CIS)~~, and~~ Immunizations for Adolescents Combination 2 (IMA), Lead Screening in Children (LSC), Child and Adolescent Well Care Visits (WCV) and Cervical Cancer Screening (CCS)	DHCS	SWOT

6.1.4. 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 member~~Member 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 PHM Subcommittee and QMHETC. Based on the findings, the committee ~~member~~Members recommend opportunities for improvement that are implemented by the responsible department.

6.1.5. Improving Quality for ~~Member~~Members with Complex Needs

~~A.~~ IEHP has multiple programs, at no cost to the ~~Member~~Member, that focus on improving quality of care and services provided to ~~Member~~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 ~~Member~~Members with chronic and/or complex conditions. The goal of the CCM program is to optimize ~~Member~~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

PHM Subcommittee and QMHETC for discussion and input. Based on the committee recommendations, the Care Management Department collaborates with other Departments within the organization to implement improvement activities.

~~2.~~ *Transition of Care (TOC) Program*

~~a.~~ IEHP has developed a system to coordinate the delivery of care across all healthcare settings, Providers, and services to ensure all hospitalized ~~Member~~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 ~~Member~~Members with complex needs (e.g., SPD ~~Member~~Members that very often have three (3) or more chronic conditions) can be complicated by several other health and social risk factors. IEHP's TOC program has been designed to provide solutions to these challenges. Through the TOC program, IEHP makes concerted efforts to coordinate care when ~~Member~~Members move from one setting to another. This coordination ensures quality of care and minimizes risk to ~~patient member~~Member safety. IEHP also works with the ~~Member~~Member or their caregiver to ensure they have the necessary medications/supplies to prevent readmissions or complications. The goals of the TOC program include the following:

~~1)~~1. Avoiding of hospital readmissions post discharge;

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

~~3)~~3. Improving ~~Member~~Member and caregiver experience with care received.

~~3.~~ ***Facility Site Review (FSR)/Medical Record Review (MRR) and Physical Accessibility Review ~~Survey (PARS)~~***[53]

~~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 ~~Member~~Members with disabilities do not have any physical access limitations as when visiting a Provider site. See policy 6B, "Physical Accessibility Review Survey."

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

~~e.~~ 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 QMHETC reviews an annual assessment of PARS activities to ensure compliance.

6.1.6. Other Clinical Measures and Studies

~~A.~~ *Initial Health Assessment Monitoring*[54]

IEHP also monitors the rate of Initial Health Assessments (IHA) performed on new ~~Member~~Members. The timeliness criteria for an IHA is within one hundred twenty 120 calendar days of enrollment for ~~Member~~Members. This rate is presented to QI Council for review and analysis. IEHP has a number of ~~Member~~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*[55]

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;

[54] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 3, Initial Health Assessment

[55] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 9, External Quality Review Requirements

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.~~ 6.1.7. Quality Withhold Performance Review

Annually, IEHP's performance on Quality Withhold measures are summarized and presented to IEHP's D-SNP MOC Subcommittee.

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.

6.2. 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 ~~Member~~Members who do not receive appropriate and timely care. As IEHP's ~~Member~~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 Provider Network Access Subcommittee and QMHETC for discussion and recommendations as needed.

6.2.1. Availability of PCPs by Language[56]

A. IEHP monitors network availability based on threshold languages annually. IEHP understands the importance of being able to provide care to ~~Member~~Members in their language of choice and the impact it has on a ~~Member~~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

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

~~Member~~Membership. The primary objectives are to evaluate network availability against the established language standards and identify opportunities for improvement.

6.2.2. 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.

6.2.3. 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~~Member. Following the completion of the survey, all responses are 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.[57]

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. See 26B, "Glossary" for definitions of "patterns of non-compliance," "incidents of non-compliance," and "substantial harm incident."

6.2.4. 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 ~~Member~~Members have appropriate access to their PCP outside of regular business hours can result in reduced ER rates, which

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

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~~Member's medical needs beyond normal hours. PCP offices can use a professional exchange service or automated answering system that allows the ~~Member~~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~~Member is experiencing a life-threatening emergency.

6.2.5. Telephone Access to IEHP Staff

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

6.3. ~~Member~~Member and Provider Experience[58]

6.3.1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

A. IEHP conducts a comprehensive CAHPS® survey and analysis annually to assess ~~Member~~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~~Member perspective and concerns regarding experience obtaining timely appointments within the standards;[59]
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~~Member grievances and appeals; and
5. ~~Member~~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 ~~Member~~Members. IEHP uses this tool as one of its key instruments to identify

[58] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 9, External Quality Review Requirements
[59] 28 CCR § 1300.67.2.2(c)

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.

C. Effective with the CAHPS® survey, no later than the 4th Quarter of 2024, IEHP will:[60]

1. Inform ~~Member~~Members of their rights to obtain an appointment within each of the time-elapsed standards including notice of their right to receive interpreter services at the appointment;[61]
2. Evaluate the experience of limited English proficient (LEP) ~~Member~~Members in obtaining interpreter services by obtaining ~~Member~~Members' perspectives and concerns regarding coordination of appointments with an interpreter, availability of interpreters who speak the ~~Member~~Member's preferred language and the quality of interpreter services received; and
3. Translate the ~~Member~~Member Experience Survey into IEHP's threshold languages.

6.3.2. Internal ~~Member~~Member Experience Studies

A. **BH ~~Member~~Member Experience Survey**: IEHP surveys ~~Member~~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~~Member experience.

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

C. **Population Health Management (PHM) Population Assessment -~~Member~~Member Experience Survey**: Annually, IEHP conducts an internal ~~member~~Member experience survey for Medi-Cal ~~Member~~Members to assess ~~Member~~Member Experience with IEHP's Population Health Management programs. The survey focuses on ~~Member~~Member feedback from at least two programs (e.g., disease management or wellness programs). Feedback is

[60] Ibid.
[61] 28 CCR § 1300.67.2.2(c)(4)

specific to the programs being evaluated. Additionally, IEHP analyzes complaints to identify opportunities to improve experience.[62]

6.3.3. 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 Provider Network Access Subcommittee and QMHETC. The committees review the findings and make recommendations on potential opportunities for improvements.

6.3.4. Grievances and Appeals[63]

A. IEHP monitors performance areas affecting ~~Member~~Member experience. IEHP has established categories and quantifiable standards to evaluate grievances received by ~~Member~~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 thirty (30) days of receipt. IEHP calculates the grievance rate per 1000 ~~Member~~Members on a quarterly basis and presents this information to the ~~Member~~Member Experience Subcommittee and QMHETC. IEHP's goal is

[62] NCQA, 2023 HP Standards and Guidelines, PHM 2, Element B
[63] NCQA, 2023 HP Standards and Guidelines, ME 7, Element C

to maintain the overall compliance rate below thresholds as established by regulatory agencies such as DHCS, DMHC, and CMS.

~~HH.~~6.4. ~~Patient Member~~Member Safety

A. IEHP recognizes that ~~patient member~~Member safety is a key component of delivering quality health care and focuses on promoting best practices that are aimed at improving ~~patient member~~Member safety. IEHP engages ~~Member~~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.

6.4.1. Appropriate Medication Utilization

A. IEHP monitors pharmaceutical data to identify ~~patient member~~Member safety issues on an ongoing basis. Drug Utilization Review (DUR) is a structured, ongoing program that evaluates, analyzes, and interprets drug usage against predetermined standards and undertakes actions to obtain improvements. The DUR process is designed to assist pharmacists in identifying potential drug related problems by assessing patterns of medication usage. The goal of the DUR process is to identify potential drug-to-drug interactions, over-utilization and under-utilization patterns, high/low dosage alerts, duplication of medications, and other critical elements that can affect ~~patient member~~Member 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 QMHETC for discussion and action, as necessary.

6.4.2. Review of Inpatient Admissions

A. IEHP considers the quality of care in the hospitals to be a top priority. To ensure ~~Member~~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 QMHETC. 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.

6.4.3. 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 QMHETC and/or Peer Review Subcommittee for further evaluation and review.

6.4.4. Promoting Safety Practices for ~~Member~~Members

A. IEHP offers various safety programs to ~~Member~~Members including the Bicycle Safety Program for children between 5 to 14 years old and ~~Member~~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~~Member education materials that cover different health topics are available to ~~Member~~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.

6.4.5. Addressing Cultural, Ethnic, Racial, and Linguistic Needs of ~~Member~~Members[64]

A. IEHP is dedicated to ensuring that all medically covered services are available and accessible to all ~~Member~~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~~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~~Member needs. Further details about cultural, ethnic, racial, and linguistic services provided to ~~Member~~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 ~~Member~~Membership:

[64] NCQA, 2023 HP Standards and Guidelines, QI 1, Element A, Factor 6

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 ~~Member~~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~~Member populations. More specifically, they assess the cultural, ethnic, racial, and linguistic needs of ~~Member~~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 ~~Member~~Members. IEHP offers face-to-face interpreter services for medical appointments to ~~Member~~Members at no cost. The purpose is to provide ~~Member~~Members with interpretation services to ~~Member~~Members/callers.
4. **Ongoing monitoring of grievances related to language and culture:** Grievances are reported to monitor cultural and linguistic services provided to ~~Member~~Members.

Section 7: Delegation Oversight

A. IEHP monitors Delegate performance in QM, UM, CM, credentialing and re-credentialing, compliance, and their implementation of related regulatory activities through Delegation Oversight activities.[65] See policy 25A2, "Delegation Oversight – Audit."

7.1. Auditing and Monitoring Activities

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

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

[65] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities

d. Provider Satisfaction Surveys.

5. IPAs are required to submit the following information to the IEHP Provider Services Department:
   a. Utilization Management (UM) Trend Report – Monthly report of utilization data;
   b. Referral Universe and Letters – Monthly report of all approvals, denials and modifications of requested services;
   c. Care Management (CM) Log – Monthly report of CM activities;
   d. Second Opinion Tracking Log – Monthly report to track ~~Member~~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 QMHETP 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.[66]
6. IPAs and Health Plans with trends of deficient scoring must submit a CAP to remedy any deficiencies. If an IPA is unable to meet performance requirements, IEHP may implement further remediation action including but not limited to:
   a. Conduct a focused re-audit;
   b. Immediately freeze the IPA to new ~~Member~~Member enrollment, as applicable;
   c. Send a 30-day contract termination notice with specific cure requirements;
   d. Rescind delegated status of IPA or Provider, as applicable;
   e. Terminate the IEHP contract with the IPA or Provider; or
   f. Not renew the contract.
7. **Assessment and Monitoring:** To ensure that IPA or Providers have the capacity and capability to perform required functions, IEHP has a rigorous pre-contractual and post-contractual assessment and monitoring system. IEHP also provides clinical and

[66] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 8, Quality Improvement Annual Report

~~Member~~Member experience data to Delegates upon request so they can initiate improvement activities.

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

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

24. PROGRAM DESCRIPTIONS

C. Quality Management & Health Equity Transformation Program and Quality Improvement Program Description

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2012	
Revision Effective Date:	January 1, 2024	

24. PROGRAM DESCRIPTIONS

D. Fraud, Waste, and Abuse Program Description

Introduction

A. IEHP believes that compliance with fraud prevention and reporting is everyone's responsibility. IEHP has developed a Fraud, Waste, and Abuse (FWA) Program to comply with 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), Bureau of Medi-Cal Fraud

   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. 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 Medi-Cal network participation of individuals and/or entities who appear on any of the aforementioned exclusion lists. See Policy 24E, "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 within ten (10) days 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

[5] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 2. Section 26, Fraud and Abuse Reporting.

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.

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

24. PROGRAM DESCRIPTIONS

E. Compliance Program Description

Introduction

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

Mission, Vision and Values

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

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

C. Values: We do the right thing by:

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

Compliance Program Scope

A. Delegated entities must implement a Compliance Program to provide a systematic process dedicated to ensuring that management, employees, business associates, ~~FDR~~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, ~~FDR~~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. Delegated entities must implement an effective compliance program that meets regulatory guidelines.

Written Policies, Procedures, and Standards of Conduct

A. Code of Conduct – All Delegated entities are required to implement a Code of Conduct that demonstrates their commitment to compliance and articulates the core values and principles that guide the organization's business practices and ensures that Compliance with all federal and state 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 ~~ninety (~~90~~)~~ days of initial employment and annually thereafter.
3. Delegated entities should also provide a Code of Conduct to their business associates that address their obligations toward conducting business at the highest level of moral, ethical and legal standards.

a. The Code of Conduct should include reporting requirements for any issue of non-compliance.

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

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

Compliance Officer, Compliance Committee, and High-Level Oversight

A. Compliance Officer

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

B. ~~Executive~~ Compliance Committee ~~(ECC)~~

1. The ~~Executive~~ Delegated entity's Compliance Committee, is accountable to senior management and the Governing Board, is a multidisciplinary body that must meet periodically (on a quarterly basis). The Compliance Officer chairs the meeting. The Committee Membership must be comprised of individuals with a variety of backgrounds

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

2. Duties of the Committee should include:
   a. Meeting periodically, however, frequently enough to enable reasonable oversight of the compliance program;
   b. Review the results of the annual risk assessment;
   c. Review corrective action plans and monitor their development;
   d. Review the outcome of compliance activities;
   e. Reviewing and addressing reports of monitoring and auditing of areas in which the delegate is at risk for program noncompliance or potential FWA and ensuring that corrective action plans are implemented and monitored for effectiveness; and
   f. Provide regular reports on the outcome of the Committee's activities to the delegate's Governing Board.
   g. Review of the Compliance Key Performance Indicators (KPI) Dashboard report.

C. High Level Oversight – The Delegated entity's Governing Body should be responsible for:
   1. The annual review and approval of the Compliance, Fraud, Waste, and Abuse, and HIPAA Programs;
   2. Adoption of written standards including the Delegated entity's Code of Conduct;
   3. Monitoring and support of the compliance program; and
   4. Understanding regulatory and/or contract changes, policy changes and health reform and the impact on the Delegated entity's Compliance Program.

Effective Training and Education

A. IEHP requires ~~FDR~~subcontractors to provide Compliance Training to all Employees (Temporary and Permanent), Providers, Governing Body, contractors, vendors, and volunteers.
   1. Compliance Training must be provided within ~~ninety (90)~~ days of initial employment/start, whenever significant changes are made to the Compliance Program, upon changes in regulatory or contractual requirements related to specific job responsibilities or when legislative updates occur and on an annual basis.

      Training should include, at a minimum:

[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)

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

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

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

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

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

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

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

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

3. ~~FDR~~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. ~~FDR~~subcontractors may also meet their FWA training requirements in the following way:

   a. Option 1, ~~FDR~~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, ~~FDR~~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 ~~ten (~~10~~)~~ years. Documentation may include sign-in forms, signed attestations, and the completion of testing results.

Effective Lines of Communication

A. IEHP requires all ~~FDR~~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 Delegated entities are required to submit signed acknowledgement of their receipt of the Provider Manual which delineates compliance reporting responsibilities;
2. Annual Compliance training for all ~~FDR~~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]~~in Section 23~~).

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

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

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

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

Well Publicized Disciplinary Standards

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

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

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

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

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

B. Definitions:

[8] https://www.iehp.org/en/providers/provider-resources?target=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 Delegated entity's responsible for the audit content cooperate with the audit process by providing access to documents and other information requested.

1. Methods of review include, but are not limited to:
   a. Provider/Contractor initial contract and annual Delegation Oversight Audits;
   b. Quarterly Reporting;
   c. External reviews of medical and financial records that support claims for reimbursement and Medicare cost reports; and
   d. Trend analysis and studies that identify deviations in specific areas over a given period.

D. Delegated entities must implement a screening program for employees, Board Members, contractors, and business partners to avoid relationships with individuals and/or entities that tend toward inappropriate conduct. This program includes:

1. Prior to hiring or contracting and monthly thereafter, review of the Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE) that are excluded from participation in government health care programs.[9,10]
2. Prior to hiring or contracting and monthly thereafter a monthly review of the GSA System for Award Management (SAM).
3. A monthly review of the Department of Health Care Services Medi-Cal Suspended and Ineligible Provider ~~l~~List and Centers for Medicare and Medicaid Services Preclusion List.
4. Criminal record checks when appropriate or as required by law.
5. Standard reference checks, including credit for Employees.
6. Review of the National Practitioner Databank (NPDB).
7. Review of professional license status for sanctions and/or adverse actions.
8. Reporting results to Compliance Committee, Governing Body, and IEHP as necessary.

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

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

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

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

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

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

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

      2) Repayment of identified over-payments.

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

      4) Additional education and training.

      5) Modification of policies and procedures.

      6) Discipline or termination of Employees or contracts.

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

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

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

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

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

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

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

1) The Compliance Officer;

2) The Compliance Committee;

3) Chief Executive Officer;

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

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

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

7) IEHP Compliance Department.

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

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

~~7.~~

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	July 1, 2015	
Revision Effective Date:	January 1, 2024	

~~**INLAND EMPIRE HEALTH PLAN**~~

~~Chief Approval:~~ ~~*Signature on file*~~	**~~Original Effective Date:~~**	~~July 1, 2015~~
~~Chief Title:~~ ~~Chief Executive Officer~~	**~~Revision Date:~~**	~~January 1, 2023~~

24. PROGRAM DESCRIPTIONS

F. Enhanced Care Management Description

Introduction

The Department of Health Care Services (DHCS) has developed a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medi-Cal as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population. One foundational component of CalAIM is Enhanced Care Management (ECM).[1]

Enhanced Care Management provides a whole-person approach to care that addresses the clinical and non-clinical needs of high-need and high-cost Medi-Cal beneficiaries in distinct Populations of Focus, through systematic coordination of services. ECM is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. It serves to build on the Health Homes Program (HHP) and Whole Person Care (WPC) pilots and transitions those pilots to one larger benefit to provide a broader platform to build on positive outcomes from each program.

The Inland Empire Health Plan's (IEHP) ECM is a clinical service delivery model that focuses on providing individualized, whole-person care by a trained, integrated care team that works in close connection with the Member's health care team including the Primary Care Provider (PCP) as well as community-based service Providers. This integrated care team provides an intensive set of care management services for a subset of Medi-Cal Members. The ECM Provider focuses on whole-person, complex care management, which includes changing behaviors and patterns of health care among both Providers and Members with the goal of reducing avoidable, high-cost interventions and increasing the use of appropriate, timely interventions, along with improved self-care management. IEHP's ECM service delivery model encompasses a person-centered, high-touch, comprehensive approach to addressing the Member's goals for improvement and management of behavioral and physical health, acute care, and social needs.

Section 1: Transition of Whole Person Care and Health Homes Program to ECM

This applies to all IEHP Members, who are eligible for the Enhanced Care Management (ECM) benefit and services, including those who were enrolled in either the IEHP Health Homes Program (HHP) or Whole Person Care (WPC) pilots.

Population of focus populations for ECM (January 2022) include:

1. Adults who are high utilizers;
2. Individuals who are homeless as defined by Housing and Urban Development (HUD);

[1] Department of Health Care Services (DHCS), California Advancing & Innovating Medi-Cal (CalAIM) Proposal, January 2021

3. Adults with serious mental illness (SMI) and substance use disorder (SUD); and
4. Individuals transitioning from incarceration (Riverside County only for January 2022, San Bernardino County in January 2024).

IEHP is responsible for the development, implementation, and distribution of requirements for ECM services and related activities to ECM Providers. IEHP provides this policy as guidance for its ECM Providers who must develop and implement processes that comply with these requirements. IEHP monitors the performance of its ECM Providers to ensure compliance with ECM requirements throughout the network.

IEHP ensures continuity from the HHP or WPC through automatic authorization of all currently enrolled HHP and WPC Members into ECM.

IEHP's ECM focuses on providing comprehensive, individualized, in-person whole-person care by a trained ECM Care Team which works in collaboration with the Member's Primary Care Provider (PCP) and serves as the central point for coordinating care and ensuring communication amongst all relevant parties engaged in the delivery of each Member's ECM services.

Through systematic coordination, the ECM Care Team arranges for and coordinates the services and interventions that address the medical, behavioral health, social, functional, cultural, and environmental factors affecting health through providing the following required ECM core services.

1. Outreach and Engagement
2. Comprehensive Assessment and Care Management Plan
3. Enhanced Care Coordination
4. Health Promotion
5. Comprehensive Transitional Care
6. Member and Family Support
7. Coordination of and Referral to Community and Social Support Services

ECM Providers utilizes a team-based care approach to deliver the seven ECM core services. Each ECM Provider may employ one or more ECM Care Teams. An ECM Care Team is a multi-disciplinary, integrated team comprised of four primary roles: registered nurse care manager (RN CM) or Licensed Vocational Nurse (LVN), behavioral health care manager (BH CM), care coordinator (CC), and community health worker (CHW).

1.1. Transition of HHP and WPC to ECM

All Members currently enrolled in the HHP and WPC transitioned to ECM services as of January 1, 2022.

24. PROGRAM DESCRIPTIONS

F. Enhanced Care Management Description

1. Members Transitioning from the HHP
    a. The HHP Care Teams, both provider-embedded Model 1 and health plan regionally based Model 2 Care Teams, transitioned to ECM Care Teams. Members who transitioned from HHP received ECM services from the same Care Team as the Care Team was repurposed as an ECM Provider. Within the first 6 months of ECM go-live, the ECM Care Teams reassessed each enrolled member for ECM population of focus eligibility and appropriateness of level of care. Should a lower level of care be needed, a warm handoff was provided to an appropriate alternate program per Member history and preference.
2. Members transitioning from WPC
    a. In both Riverside and San Bernardino counties the WPC Lead Entity is also an HHP Community Based Care Management Entity (CB-CME). All HHP CB-CMEs were converted to ECM Providers, and WPC Members seamlessly continued care with their newly designated ECM Provider. IEHP worked with DHCS and WPC Lead Entities to ensure WPC Members were seamlessly transitioned into the appropriate populations of focus for ECM. This includes partnering directly with Riverside and San Bernardino Counties, who serve as WPC Lead Entities, to receive their WPC Member Transition List to expedite and ensure the transition of WPC enrollees. Within the first 6 months of ECM go-live, the ECM Care Teams reassessed each enrolled member for ECM population of focus eligibility and appropriateness of level of care. Should a lower level of care be needed, a warm handoff will be provided to an appropriate alternate program per Member history and preference.
3. Ninety days prior to ECM go live, IEHP distributed a written notice by mail in the Member's preferred language to currently enrolled HHP and WPC Members that explained the transition of the HHP and WPC into the ECM benefit, services available and the ability to opt out.
4. IEHP provided training to all frontline CB-CMEs and WPC care team members regarding the transition to ECM. After the distribution of the written notice and prior to ECM go live, CB-CMEs and WPC Care Teams contacted all enrolled HHP or WPC Members to provide education on the transition to ECM and discuss the new ECM benefit. (16.i) (18.v)
5. Effective January 1, 2022 ECM Care Teams contacted grandfathered HHP and WPC Members to initiate the reassessment process.
    a. For HHP and WPC enrolled Members grandfathering into ECM, IEHP ensured the completion of a reassessment within 6 months of transition to ECM by the ECM Care Team. Through the reassessment process ECM Care Teams confirmed population of focus eligibility, appropriate level of service, and appropriate ECM Provider assignment.

b. ECM Care Team members began the reassessment process at the next routine care management contact.

c. Reassessment includes confirming ECM eligibility and identifies the populations of focus for which the Member is eligible. (18.iii) Additionally, the ECM Care Team completed the ECM Comprehensive Health Assessment (CHA) as well as other identified physical and behavioral health assessments to determine the level of service needed. The CHA is a standardized tool that is used to assess medical, behavioral, oral, functional, and social needs of eligible and transitioning Members.

d. If reassessment verifies ECM eligibility and the Member's need for ECM level of care, the ECM Care Team reviewed and updated the Shared Care Plan (SCP) and continued ECM services.

e. An annual reassessment is be repeated yearly from that date and with any transition in care or other major event.

f. Reassessment determines that discontinuation of services is appropriate as demonstrated by:

1) The Member has met all care plan goals;

2) The Member is ready to transition to a lower level of care;

3) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or

4) The ECM Provider has not been able to connect with the Member after multiple attempts.

g. If reassessment determines that discontinuation of services is appropriate based on the above criteria, the ECM Care Team discussed alternate services with the Member, conducts a warm handoff if possible, and follows the procedure for discontinuation of ECM services.

6. ECM Provider Assignment for Transitioning Members

To avoid adverse impacts to Members transitioning from HHP to ECM, the HHP Care Teams, both Models 1 and 2, transitioned to become ECM Care Teams. (16.vi.) Members transitioning from HHP received ECM services from the same Care Teams as the Care Team was repurposed as an ECM Provider. If a Member requested a different ECM Care Team, or a different ECM Care Team was identified as being a better fit for the Member's needs, the current ECM Care Team helped to facilitate a warm handoff to mitigate and minimize any adverse impact to the Member by: (16.iii.) (16.v) (18.vii)

a. Confirming Member preferences and priorities are considered and there is mutual agreement between the Member and ECM Care Team for the transition to a new

ECM Care Team.

b. Scheduling a clinical case review with the receiving ECM Care Team to provide relevant clinical and social history.

c. Reviewing the Member's past clinical history, assessments, and care plan to ensure the receiving ECM Care Team has the skills and qualifications to support the Member's medical, behavioral, and social needs.

d. Following the case review, the new ECM Care Tea coordinated a meeting with the Member to reinforce the purpose of the transfer and to introduce the new ECM Care Team.

Section 2: Identify Members for ECM (20)

2.1. ECM Member Identification

IEHP follows its ECM Population Identification technical specifications and procedures as referenced in Appendix B to identify Individuals and Families Experiencing Homelessness, Individuals At Risk for Avoidable Hospital or Emergency Department Utilization, Adults with Serious Mental Health (SMI) and/or SUD Needs, Individuals Transitioning from Incarceration (Riverside County only), Adults Living in the Community who are at Risk for LTC Institutionalization, Nursing Facility Residents Transitioning to the Community, Children/Youth Enrolled in CCS, Children/Youth Involved in Child Welfare, Individuals with I/DD, and Pregnant and Postpartum Individuals. IEHP uses enrollment, encounter, utilization and claims, pharmacy, SMI/SUD, and SDOH data, in addition to any relevant clinical information on physical and/or behavioral health found in alternate sources such as ADT, Plan Data Feed, and assessments, to identify Membership for these Populations of Focus. Any variations on how this data and information is used to identify these populations are outlined in the ECM Population Identification technical specifications. All data used to identify the Populations of Focus is refreshed monthly.

Members transitioning from incarceration are identified in partnership with Riverside University Health System (RUHS) and the county probation and parole offices. Currently, individuals are released without Medi-Cal by state policy, because Medi-Cal is cancelled upon incarceration. Managed Care Plans in Riverside County are not alerted to inmate release. IEHP works with RUHS and local probation and parole offices to continue the current process of screening newly released individuals and to refer those individuals to Department of Public Social Services (DPSS) for Medi-Cal as needed. Further, IEHP works with the same teams to develop standard protocols to identify individuals who have been recently released, are on probation, and who are likely to be eligible for both Medi-Cal and ECM. As released individuals are transitioned to active Medi-Cal status through Department of Public Social Services (DPSS), IEHP cross-references the list of newly activated IEHP Medi-Cal recipients against the list of newly released individuals and prioritizes these new Members for outreach and engagement into ECM.

2.2. Referral Submissions

IEHP provides written notification and instruction to its Provider network and other external entities about ECM eligibility criteria and how to submit a referral for ECM via IEHP Provider Services or Member Services pathways. This communication occurs with IEHP Providers through mechanisms including but not limited to Provider Blast Fax and via the IEHP Provider Portal. IEHP also hosts webinars and Town Hall forums for the IEHP Provider network and other external entities to provide information on how to access or refer Members for ECM services.

2.3. Accepting and Acting on Referrals from ECM Providers (21)

IEHP accepts and act on referrals from ECM Providers, other Providers, and/or external sources serving Members and families and/or caregivers, including county behavioral health plans.

1. For ECM Providers, IEHP built off the referral process used by HHP CB-CMEs to refer Members to IEHP for the Health Homes Program. This referral process enables ECM Providers to refer Members to IEHP for ECM through IEHP's ECM care management platform.
    a. Upon receipt of the referral, IEHP reviews the ECM Provider's screening assessment of the Member's ECM eligibility, utilizes health plan data to supplement the ECM eligibility assessment, and determines the Member's eligibility for ECM.
    b. The status of the request is communicated back to the ECM Provider via the ECM care management platform as either eligible for ECM or excluded from ECM with the reason for exclusion.
    c. ECM Providers receive web-based training and written instruction on how to submit referrals for ECM via the ECM care management platform.
2. Other Providers and external entities including Community Based Organizations, County Agencies, refer Members to IEHP for ECM by contacting IEHP Provider Services or Member Services. These other Providers and external entities are inclusive of but not limited to:
    a. Nursing Homes
    b. Home Health Agencies
    c. Community Based Adult Service (CBAS) Providers
    d. Home and Community Based Waiver Providers
    e. Area Agencies on Aging (Centers for Independent Living)
    f. County Department of Behavioral Health (SMI/SUD Providers)
    g. County Department of Public Health (CCS Providers)
    h. County Department of Public Social Services (Child Welfare/Foster Care)

i. County Department of Children and Family Services (Child Welfare/Foster Care)

j. Inland Regional Center

k. First Five County Commissions and Centers

l. Women, Infants, & Children (WIC)

m. Indian Health Services

3. Provider Services and Member Services connect referring entities to IEHP ECM Care Extenders. ECM Care Extenders are employed by IEHP to facilitate warm hand-offs to ECM Providers.

   a. When the ECM Care Extenders receive a referral from Members and Providers, they connect with the Member, conduct an ECM screening assessment, determine the Members' assigned ECM Providers, then connect the Member to the ECM Provider for warm handoff.

   b. The outcome of the ECM eligibility determination is communicated directly to the Member by the ECM Care Team and the status of the request is communicated to IEHP through the ECM care management platform.

   c. IEHP communicates the status and outcome of the request to the referring provider via the IEHP Provider Portal.

   ~~d.~~

4. IEHP tracks referral patterns into ECM using the following sources to ensure all ECM care teams, external Providers and internal IEHP Team Members are proactively and properly identifying IEHP ECM eligible Members, and subsequently submitting appropriate referrals for ECM:

   a. UM authorizations via IEHP's Medical Management System

   b. ECM Care Management Platform

   c. IEHP's ECM Care Extenders

   IEHP uses this information to guide improvement in the level of referral across the network by:

   a. Identifying disparities and inequities in referrals across Population's of Focus

   b. Identify disparities and inequities in referrals across different Member racial/ethnic demographics

   c. Identifying geographical disparities in referral volume

   d. External Provider Care Team training and education around referring Members for ECM

   e. Internal team member training and education on referring Members for ECM

2.4. Informing Members, Family Members, Caregivers, and Authorized Support Person about ECM

1. IEHP informs Members, their family member(s), guardian, caregiver, and/or authorized support person(s) about ECM by distributing the ECM errata via mail, no less than thirty (30) days prior to January 1, 2022, to all IEHP Medi-Cal beneficiaries that announced the new ECM benefit and described how to request ECM through IEHP Member Services.
    a. This information is also posted on the IEHP Member portal.
2. A Member or their family members, caregivers, and authorized support person(s) may request ECM by calling IEHP Member Services.
    a. IEHP Member Services informs the Member about the ECM benefit.
    b. If the Member expresses interest in ECM, IEHP Member Services transfers the Member to the IEHP ECM Care Extenders. The Care Extenders provide centralized support for ECM referral management and warm hand-offs to ECM Providers.
        1) When an IEHP ECM Care Extender receives a Member's request for ECM they explain ECM to the Member, complete a prescreen for ECM eligibility, and if the Member is enrolled with IEHP Medi-Cal, the ECM Care Extender connects the Member with their assigned ECM Provider for a comprehensive eligibility assessment.
    c. The results of the ECM Provider's comprehensive eligibility assessment is communicated to the Member by the ECM Provider and IEHP sends an approval or denial letter that reflects the final determination for ECM.

Section 3: Authorizing Members for ECM

3.1. Authorization Timeframes

1. For Provider or Member ECM Requests:
    a. IEHP approves or denies a Provider or Member's request for ECM services no longer than five (5) business days from IEHP's receipt of information reasonably necessary to make a decision.
    b. Written notification to the Provider is made within twenty-four (24) hours of the decision to approve or deny. Member notification is sent via the US Postal Service within two (2) business days from the decision to approve or deny.
    c. To inform Members that ECM has been authorized, IEHP must follow the standard process outlined in APL 21-011.
    d. ECM authorizations are valid for twelve (12) months

e. During the period of 12 months, Member will be continually re-assessed for appropriate level of care needs.

f. If Members do not meet the eligibility criteria for ECM, Members will be offered lower level of care (Complex Case Management).

g. For Members who are not authorized to receive ECM, IEHP must follow its standard Grievances and Appeals process outlined in APL 21-01.

h. IEHP must ensure the Member and the requesting individual or entity (as applicable) who requested ECM on a Member's behalf are informed of the Member's right to appeal and the appeals process by way of the Notice of Action (NOA) process as described in APL 21-011.

2. For Members Identified via Analytics as Potentially Benefiting from ECM Services:

a. ECM Provider assesses Members identified via IEHP analytics for ECM eligibility. The result of the ECM eligibility assessment is submitted to IEHP through IEHP's care management platform, and if the Member is ECM eligible, IEHP approves a request for ECM services within five (5) business days.

b. Written notification to the Provider is made within twenty-four (24) hours of the decision to approve or deny. Member notification is sent via the US Postal Service within two (2) business days from the decision to approve or deny.

c. ECM authorizations are valid for twelve (12) months

d. During the period of 12 months, Members are continually reassessed for appropriate level of care needs.

e. If Members do not meet the eligibility criteria for ECM, Members will be reassessed and collaborate with Medical Director for reconsideration for the ECM benefit. A lower level of care (i.e., Complex Case Management) may also be offered to the Member.

3.2. Presumptive Authorization or Pre-authorization

All ECM Care Teams evaluate each potentially ECM eligible Member through a screening process. If through this process the ECM Care Team believes that the IEHP Member meets eligibility criteria for ECM, they submit this information to IEHP through IEHP's care management platform for eligibility review. IEHP's eligibility review process may take up to 3 business days. The ECM Care Team considers the Member pre-authorized during the month that the request was submitted and commences providing ECM services. IEHP conducts an eligibility review and if the Member is found ECM eligible submits an authorization for ECM for 12 months. If IEHP finds that the Member is not eligible for ECM, IEHP submits a denial to the ECM Provider for ECM services.

3.3. Authorization for ECM Enrolled Members transitioning to IEHP from a prior Managed Care Plan (MCP)

1. IEHP considers Members receiving ECM in a previous health plan to be ECM-eligible upon enrollment into IEHP. IEHP automatically authorizes ECM services for these Members.
    a. IEHP automatically authorizes Member initiated requests that IEHP receives directly from the Member, family or Authorized Representative (AR) by way of the following process.
        1) Member, family or AR contacts Member Services.
        2) Member Services transfers call to ECM Care Extenders.
        3) ECM Care Extenders verify if the Member was enrolled in ECM services by their previous MCP and if the Member meets any ECM exclusionary criteria.
        4) If the Member was enrolled in ECM by their previous MCP and does not meet any ECM exclusionary criteria, then IEHP automatically authorizes ECM services for the Member.
        5) IEHP assigns the Member to an ECM Provider per IEHP's Member assignment methodology found in Section 4.1.
        6) Once assigned, IEHP notifies the assigned ECM Provider of Member authorization via the IEHP ECM care management platform.
        7) If the Member was enrolled in ECM by their previous MCP and does meet ECM exclusionary criteria, then the Member would not be automatically authorized for ECM services. In this instance, the Member would be evaluated for alternative services.
    b. IEHP care teams first work with the Member to obtain a copy of their care plan, and if the Member cannot provide one, make every reasonable attempt to contact the prior ECM Provider and request a copy.
    c. IEHP reviews and processes historical utilization data using the DHCS provided Plan Data Feed (PDF) by using a 90-day look-back period to identify any new Members who have received ECM. IEHP specifically looks for the appropriate HCPCS codes and modifiers used for ECM in the PDF files to identify Members who were enrolled in ECM with a previous MCP. Following Member identification, IEHP automatically authorizes ECM services and loads these Members into IEHP's ECM care management platform.
    d. IEHP takes the necessary steps to re-assess these Members based on discontinuation criteria no later than ninety (90) days from the Member's authorization date. During this 90-day period, care teams assess for Member engagement and level of care needs. If at the end of 90 days the Member has not responded to outreach attempts,

or is more appropriate for a lower level of care, the care team discontinues ECM services and connects the Member with alternative services if indicated.

3.4 Prime & Subcontractor Authorization Alignment

IEHP requires that all ECM subcontractors and delegates align their standards and policies and procedures related to authorization with IEHP. This includes both the adjudication standards and the documentation used for referrals and authorizations. IEHP reviews all ECM subcontractor and delegate authorization standards on an annual basis for any changes to remain compliant with Prime and Subcontractor Authorization Alignment.

Section 4: Assignment to an ECM Provider

4.1 Member Assignment Methodology

1. IEHP ensures every Member authorized for ECM is assigned to an ECM Provider. IEHP utilizes the following algorithm to assign Members to ECM Providers.
    a. If a Member has received more than one service from a county Behavioral Health Provider in the last 12 months, the Member is assigned to the county Behavioral Health ECM Provider.
    b. If the Member has not received more than one service from a county Behavioral Health Provider in the last 12 months, the Member is assigned to their Primary Care ECM Provider.
    c. If the Member's Primary Care Provider is not a contracted ECM Provider, the Member is assigned to a regional ECM Provider care team that is staffed by IEHP.
    d. IEHP will establish a partnership with California Children's Services (CCS) Providers and assess their ability and interest to serve as an ECM Provider. Should CCS be willing to collaborate with IEHP as an ECM Provider, IEHP will assign ECM eligible children preferentially to the CCS ECM Provider.
2. IEHP ensures assignment occurs within ten (10) business days of ECM authorization or based on the agreed upon schedule between IEHP and ECM Provider.
    a. Per an established schedule and at least monthly IEHP identifies newly eligible ECM Members and assigns an ECM Provider based on the ECM Provider assignment algorithm.
    b. ECM Provider assignments are fully processed through all IEHP systems, including the ECM care management platform, within 3-6 days of assignment.
    c. Additionally, a report is run daily to identify authorized Members who were referred for ECM by ECM Providers and other Providers and external sources and who are not yet assigned to an ECM Provider so one can be made.
3. IEHP accounts for Member preference, need and existing Provider relationships by:

a. Allowing Members to request a change in ECM Provider assignment at any time.

b. Maintaining continuity of assignment for Members transitioning from the Health Homes Program and Whole Person Care Program.

c. Prioritizing Members who have recently received mental health or substance use disorder (SUD) services from a county behavioral health provider for assignment to a county behavioral health ECM Provider.

1) IEHP complies with DHCS requirements to assign preferentially to Behavioral Health Providers and Assigned PCPs who are ECM Providers, where applicable, by adhering to an assignment algorithm that first assesses a Member's engagement in county behavioral health and next evaluates the Member's primary care assignment. For Members who are currently engaged in county behavioral health services, assignment is prioritized to behavioral health ECM Providers.

4. IEHP matches ECM Provider experience and skill set to Members. IEHP has built a diverse provider network of ECM Providers (including County Departments of Behavioral Health and Community-based Organizations) who have expertise with SMI, homeless, and post-incarceration target populations. IEHP prioritizes Members with these needs for assignment to these specialized ECM Providers.

5. IEHP documents Member assignment in the ECM care management platform that is accessible by all ECM Providers and in the IEHP Provider Portal that is accessible by all contracted Providers. IEHP retains Member assignment in database tables for reporting purposes.

6. IEHP provides notification to ECM Providers of new assignments electronically through the ECM care management platform. This occurs no less than once a month when IEHP's ECM eligibility algorithm is refreshed. In the ECM care management platform ECM Providers have access to a list of referred Members and each Member's ECM status (eligible, enrolled, or disenrolled.)

7. If a Member is not assigned to their Primary Care Provider for ECM services, IEHP notifies each Member's PCP and other key Providers about the ECM Provider assignment via the IEHP Provider Portal.

a. Primary Care Provider is able to view the assigned ECM Provider's name and contact information in the IEHP Provider Portal.

b. The ECM Provider also receives the name and contact information of the Member's Primary Care Provider via the ECM care management platform and/or IEHP Provider Portal and be required to communicate and collaborate with the Member's Primary Care Provider.

8. IEHP incorporates feedback from prospective ECM Providers and Member PCPs about the appropriateness of the Member's ECM Provider assignment.

a. IEHP's ECM assignment algorithm was developed in partnership with ECM Providers, particularly specialty ECM Providers such as County Departments of Behavioral Health and Community-based Organizations.

b. All ECM Providers receive education on IEHP's ECM assignment algorithm, and an ECM Provider or a Member's PCP may contact IEHP directly via the IEHP ECM electronic mailbox or through their assigned Practice Coach (where applicable) with feedback about any Member's ECM Provider assignment. IEHP reviews all feedback, and requests to change a Member's ECM Provider assignment is reviewed on a case-by-case basis.

4.2 ECM Provider Change Process

1. IEHP responds to Member requests to change ECM Providers as soon as possible to meet the Member's needs and within seven (7) business days. To initiate a change in ECM Provider, a Member can:
   a. Have their current ECM Provider submit this request to IEHP via the IEHP ECM electronic mailbox on their behalf, or
   b. Contact IEHP Member Services. IEHP Member Services connects the Member with the ECM Care Extenders. ECM Care Extenders are employed by IEHP to facilitate warm hand-offs between ECM Providers.
2. Designated IEHP staff monitor the IEHP ECM electronic mailbox daily and receive daily reports from ECM Care Extenders about ECM Provider change requests.
   a. IEHP has a service level agreement to initiate the ECM Provider change within 24 hours of receiving the request.
   b. Once initiated, the ECM Provider change is processed within 3-6 days.

Section 5: Outreach and Engagement into ECM

5.1 Outreach to New ECM Eligible Members for Enrollment for all Population's of Focus

ECM Providers may identify new ECM eligible Members for outreach through two pathways. ECM Care Teams receive a list of assigned Members who are potentially eligible for one or more of the ECM populations of focus and not yet enrolled from IEHP. This list is accessible via the ECM care management platform and refreshed monthly to ensure each ECM Care Team has access to an up-to-date list of ECM eligible Members to drive outreach and engagement efforts. ECM Care Teams may also identify and outreach to prospective ECM eligible Members who do not appear on the IEHP list and assess them for ECM eligibility.

1. ECM Care Teams routinely obtain and review information about new eligible Members, confirm Member PCP assignment, assess Provider engagement, and assign an appropriate Care Team member responsible to outreach and engage ECM eligible Members.

a. ECM Care Teams conduct outreach promptly after receiving a referral for ECM.

b. ECM Care Team assignments for conducting outreach and engagement is customized for the Member, taking into consideration a Member's health needs, conditions, culture, language, location, family dynamics, and other characteristics, as appropriate.

c. Outreach is made through community-based modalities and by providers that have experience with targeted outreach and engagement to these populations including those that experience health disparities. When possible, outreach prioritizes in-person contact where the Member lives/is placed or receives care or as they are released and transitioning from incarceration for that population of focus. If in-person contact attempts are unsuccessful, ECM Care Team members may engage Members and/or their family/caregiver using the following modalities:

1) Mail;

2) Telephone calls;

3) Email;

4) Texts; or

5) Secure teleconferencing.

d. ECM Care Team members provide culturally and linguistically appropriate Member communication per IEHP's policy MC_09H2 Cultural and Linguistic Services, including written materials in all threshold languages and at a 6th grade reading level.

e. All members of the ECM Care Team may conduct outreach and engagement. Field-based outreach is primarily conducted by the community health worker, including outreach to Members and/or their family/caregiver who are hospitalized or experiencing a transition of care as allowed.

2. Outreach and Engagement strategies, including network education and training, are continuously updated and evaluated for improvement. These strategies use various approaches appropriate for each Member and population of focus, especially those with whom it is challenging to make contact such as for Members experiencing homelessness and/or transitioning from incarceration.

a. IEHP mails the annual Evidence of Coverage (EOC) Guide to all IEHP Members which includes a description of the ECM benefit along with information on how to obtain the full EOC. The full EOC is also posted on the IEHP website.

b. Outreach and engagement strategies take into account any information available from EHRs, IEHP's ECM care management platform, claims, or other systems regarding physical and behavioral health conditions, history of trauma, Member's

language and cultural preferences, health literacy, preferred modes of communication, housing and work history, current homelessness, other social factors that may have historically been barriers to locating and contacting the Member, and any patterns of behaviors relevant to when, where and how the Member has sought care in the past. IEHP supports real-time or frequent sharing of this information via the ECM care management platform, the IEHP Provider Portal and reports in a way that meets local, state, and federal privacy and security rules and regulations.

c. All attempts are made to secure a valid phone number (e.g., the PCP office, specialty care provider office, etc.).

d. Active outreach strategies follow a progressive strategy over 60 days where the ECM Care Team uses the least resource intense outreach approaches and builds up to more resource intensive approaches to reach Members who are more difficult to reach. These outreach approaches may include but are not limited to the progressive steps below.

   1) Reviewing Provider schedules and flagging those scheduled with an appointment with their PCP for face-to-face engagement efforts. For example, Child Welfare Social Workers flag their scheduled visits to engage face-to-face efforts.

   2) Direct communications with Members, their family and/or caregiver by letter, telephone, or text.

   3) Outreach to care delivery and social service partners (including parole or probation offices, CCS Public Health Nurse, Medical Therapy Units(s), and/or County Black Infant Health Programs), providers in the IEHP network, and/or specific IEHP personnel, to obtain information to help locate and contact the Member, their family and/or caregiver particularly those who are transitioning from incarceration.

   4) Outreach to other Providers (including but not limited to IEHP Doula and CHW networks).

   5) Outreach to Community Supports Providers, as applicable, to each Population of Focus (including day habilitation programs, recuperative care centers, home modification agencies, palliative care providers, and skilled nursing facilities).

   6) Street level outreach to hold face-to-face meetings at community settings, where the Member, their family and/or caregiver lives and/or where the Member, their family and/or caregiver seeks care or is otherwise accessible.

   7) Street level outreach is prioritized for individuals and families, including children/youth experiencing homelessness and is primarily conducted by the

Community Health Worker (CHW).

e. Outreach to individuals including children/youth, their family and/or caregiver transitioning from incarceration is done in partnership with Riverside University Health System (RUHS), the county probation and parole offices, and San Bernardino County. Currently, individuals are released without Medi-Cal by state policy, because Medi-Cal is cancelled upon incarceration. Managed Care Plans in Riverside County are not alerted to inmate release. IEHP works with RUHS and local probation and parole offices to continue the process of screening newly released individuals and to refer those individuals to Department of Public Social Services (DPSS) for Medi-Cal as needed. Further, IEHP works with the same teams to develop standard protocols to identify individuals who have been recently released, are on probation and who are likely to be eligible for both Medi-Cal and ECM. As released individuals are transitioned to active Medi-Cal status through Department of Public Social Services (DPSS), IEHP cross-references the list of newly activated IEHP Medi-Cal recipients against the list of newly released individuals and prioritizes these new Members for outreach and engagement into ECM.

1) IEHP continues to work with the State to approve legislation to suspend (instead of terminating) Medi-Cal upon incarceration to facilitate rapid Med-Cal reactivation upon release if a Member is incarcerated for less than 12 months. IEHP is also advocating for pre-release Medi-Cal screening for individuals who do not have coverage.

3. IEHP tiers Members to assist ECM Care Teams to prioritize outreach to Members with the most immediate needs. Tailored outreach efforts progress over sixty (60) days, and the number of required outreach attempts for the 60-day period is determined by the Member's tier.

a. IEHP's tiering methodology is a combination of Adjusted Clinical Groups (ACG) risk stratification, focusing on medical related data, and California Healthy Places Index (HPI), focusing on social determinants of health. The HPI, developed by the Public Health Alliance of Southern California, uses local factors that predict life expectancy to provide overall HPI scores. The categories that inform scoring include economic, education, transportation, social, housing, healthcare access, neighborhood, and clean environment. The inclusion of the HPI score improves IEHP's ability to identify populations with indicators associated with disparities and moves them to a higher risk tier. This tiering methodology is applied to the ECM eligible population and informs the prioritized outreach strategy by the care team.

b. The required number of outreach attempts by tier are as follows.

1) High Risk/Tier 1 Members receive a minimum of weekly outreach attempts.

2) Rising Risk/Tier 2 Members receive outreach attempts at a minimum of every other week.

3) Low Risk/Tier 3 Members receive a minimum of monthly outreach attempts.

c. All outreach attempts are documented by the ECM Care Team in the ECM care management platform.

4. During initial contact, the ECM Care Team member conducting outreach informs each Member, their family and/or caregiver about the terms of their participation in ECM in accordance with this policy and obtains consent to participate in ECM. A successful outreach contact consists of the following:

a. Confirm Member eligibility for at least one ECM population of focus.

b. Identify exclusionary criteria that makes the Member ineligible for ECM.

1) If the Member confirms enrollment in any of the following programs, they are advised to choose either that program or ECM:

a) 1915(c) Home and Community Based (HCBS) waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Multipurpose Senior Services Program (MSSP), Home and Community-based Alternatives (HCBA), HCBA Waiver for Individuals with Development Disabilities (I/DD), Self-Determination Program for Individuals with I/DD;

b) Members with Medicare and/or those enrolled in Medicare Advantage plans are eligible for ECM, but ECM is not provided in the CMC/EAE-DSNP/Fully Integrated Dual eligible Special Needs Plans (FIDE-SNPs) delivery system. Members have the choice to leave the CMC/EAE-DSNP/Fully Integrated Dual eligible Special Needs Plans (FIDE-SNPs) delivery systems to receive ECM services;

c) Complex Care Management; or

d) California Community Transitions (CCT), Money Follows The Person (MFTP)

2) Medical Beneficiaries enrolled in the following program are excluded from ECM:

a. Family Mosaic Project

b. Hospice

c. Cal Medi-Connect/EAE-DSNP

d. FIDE-SNPs

e. Program for all inclusive care for elderly (PACE)

c. If the Member is eligible, interested in the ECM benefit, and no exclusionary criteria are identified, the ECM Care Team obtains verbal consent for participation and documents consent in the ECM care management platform.

d. Once the Member agrees to participate, the ECM Care Team assists the Member with scheduling a PCP appointment within the next sixty (60) days.

e. The ECM Care Team also either initiates or plans to complete the CHA, SCP, and/or any other assessments as appropriate for the Member and their population(s) of focus.

f. If during outreach, the Member, their family and/or caregiver declines to participate in ECM:

1) The ECM Care Team instructs the Member, their family and/or caregiver on how to continue care with their PCP and provides referral and warm handoff to alternative care management programs as appropriate.

2) Member, their family and/or caregiver is informed that they may reengage and receive ECM services at any time in the future if the Member continues to meet criteria for one or more of the ECM populations of focus.

3) A Member's, their family and/or caregiver's decision to opt out of ECM is documented in the ECM care management platform.

g. If during outreach the Member, their family and/or caregiver cannot be reached, the ECM Care Team notifies IEHP via documentation in the ECM care management platform. IEHP assesses these Members for alternative care management programs as appropriate.

Section 6: Initiating Delivery of ECM

6.1. ECM Provider Process for Obtaining Member Authorization for Data Sharing

1. At the time ECM services are initiated, and when required by federal law, ECM Providers are required to obtain, document, and transmit Members', and in applicable cases, Members' parent/caregiver authorization to share Personally Identifiable Information (PII) with IEHP, ECM, ILOS, and other Providers who are involved in administering the Member's ECM. IEHP does not require Member authorization for ECM-related data sharing as a condition of initiating delivery of ECM unless required by federal law.
2. The ECM Provider obtains Member's and in applicable cases, Members' parent/caregiver written authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations, or any use or disclosure otherwise

permitted by law. The request for Member's written authorization is in accordance to the specifications required by law for specific protected health information, such as psychotherapy notes and substance abuse disorder treatment.

3. The ECM Provider documents and maintains consent for data sharing in designated fields within IEHP's ECM care management platform and in their Electronic Health Record (EHR), if applicable.
4. ECM Providers communicate Member, and in appliable cases, Members' parent/caregiver authorization for data sharing to IEHP via the ECM care management platform. IEHP has access to all data within the ECM care management platform and extracts and maintains records of Members' authorization for data sharing. IEHP also develops reporting to track and monitor authorizations for data sharing.

6.2. Identifying a Lead Care Manager

1. The Lead Care Manager operates as part of the Member's ECM Care Team and is responsible for ensuring coordination of all aspects of ECM and Community Supports (ILOS).
2. When a Member is assigned to an ECM Provider, the ECM Provider assigns the Member a Lead Care Manager, taking into account the expertise and skills required to meet the unique needs of the Member.
    a. Most Tier 1 Members are assigned to either the RN CM or the BH CM.
    b. Most Tier 2 and 3 Members are assigned to the CC or the CHW.
    c. Some Tier 2 and 3 Members may be assigned to the RN CM or BH CM based on their medical or behavioral health complexity.
    d. When making the Lead Care Manager assignment, the ECM Care Team takes into account any Member information available in their EHR and IEHP's ECM care management platform that informs the Member's level of care needs and identifies their population(s) of focus to ensure alignment between the Member's needs and the Lead Care Manager's background, skills, education, and expertise. For example, Members who belong to the SMI/SUD population of focus would be preferentially assigned to a BH CM as Lead Care Manager.
3. Lead Care Manager assignment incorporates Member preferences which may be based on the Member's language, cultural preferences, health literacy, or connection to a specific ECM Care Team member.
4. Lead Care Managers are trained in person-centered planning for Members with long-term services and supports (LTSS) needs.

5. The Member may request a change in Lead Care Manager at any time during their enrollment in ECM.
    a. Following this request, the ECM Care Team or the Director of the ECM Care Team discusses this request with the Member to appropriately identify an alternative Lead Care Manager.
    b. The previously assigned Lead Care Manager provides a warm hand-off to the new Lead Care Manager to ensure a smooth transition.
6. Lead Care Manager assignment is documented in the ECM care management platform.

Section 7: Core Service Components of ECM

7.1. ECM Core Service Components Overview

1. ECM Core Services are provided by an ECM Care Team, which is a multi-disciplinary, integrated team comprised of four primary roles: registered nurse care manager (RN CM), behavioral health care manager (BH CM), care coordinator (CC), and community health worker (CHW).
    a. RN CM: The RN CM supports ECM Members with complex medical conditions and completes medication reconciliation in collaboration with pharmacy as available for all ECM-enrolled Members.
    b. BH CM: The BH CM supports ECM Members with behavioral health conditions, with particular attention to ECM Members with SMI and/or SUD needs, through brief interventions and behavioral activation strategies.
    c. CC: The CC provides care coordination and connection to services and social supports including services for social determinants of health (SDOH) for ECM Members, including appointment scheduling and referral management.
    d. CHW: The CHW is a field-based member of the ECM Care Team who has lived experience in the ECM Members' community and serves as the bridge between the ECM Member and the healthcare system. The CHW focuses support on ECM Members who are difficult to engage and/or who have cultural, linguistic and/or other SDOH barriers to care via field-based contacts including accompaniment to appointments.
2. The ECM Care Team is trained in all ECM core services as well as in core competencies including team-based care, motivational interviewing, behavioral activation, cultural competency, and trauma-informed care. These competencies are key skills used throughout the engagement and delivery of all ECM core services.
3. The ECM Care Teams employ specific core components to optimize the delivery of the ECM core services. These core components include the following:

a. Systematic Caseload Review (SCR): SCR is a regularly occurring ECM Care Team meeting during which the ECM Care Team, in coordination with primary care, systematically identify and discuss ECM Members who are not improving as expected or according to their SCP in order to initiate changes in treatment.

b. Measurement-based Care (MBC): MBC utilizes the repeated administration of structured clinical data and/or validated tools, such as blood pressure, Hemoglobin A1c (HbA1c), the Patient Health Questionnaire-9 (PHQ-9), and the Brief Addiction Monitor (BAM), to track physical and behavioral health outcomes over time and to guide clinical decision making towards a defined target.

4. Engaging Members Through In-Person Interaction

a. ECM is provided by practice-based and community-based ECM Care Teams. Member contact is conducted primarily through in-person interaction where Members and their family members, guardians, authorized representatives, caregivers, and authorized support persons live seek care, or prefer to access service in their local community. Additionally, contact may also be conducted through remote (i.e., secure teleconferencing and telehealth, telephone, text, etc.) interactions, in a setting most appropriate and convenient for the Member. Whenever possible, the ECM Care Team engages the Member in-person and supplement contacts with remote communications.

b. When completing the CHA and the Member-centered, individualized SCP during the initial assessment, contact frequency and method of communication is established with the Member, considering Member preference, where the Member lives, seeks care, or is accessible, and according to the Member's risk tier.

c. Team Member safety when conducting in-person interactions is of utmost importance, particularly if meeting Members in non-public locations.

i. If care team member doesn't feel safe conducting in-person meeting alone, he/she should do one of the following:

1. Not conduct the interaction
2. Notify their supervisor
3. Attend interaction with another team member
4. Inform another team member the location of interaction and/or have location tracking turning on their phone
5. Alert another team member as to the location of the visit and turn on location tracking using their phone

5. IEHP ensures that the ECM Member's risk tier will be the basis for the appropriate intensity and frequency of ECM services. Members in the higher risk tiers receive more

intensive ECM services at a higher frequency. For each risk tier, the ECM Care Team does the following:

a. High Risk/Tier 1

1) Attempt weekly to bi-weekly contacts with Member using multiple modalities and per Member preference with at minimum one in-person meetings per month;

2) Communicate with the Member's PCP regarding SCP updates and other information-sharing;

3) Conduct periodic, systematic case reviews to review the Member's SCP, their progress towards goals, adherence to the treatment plan, and to make necessary changes in treatment and strategy to engage the Member in their plan of care; and

4) Document each contact and updates to SCP in the ECM care management platform.

b. Rising Risk/Tier 2

1) Attempt bi-weekly (every other week) to monthly contacts with the Member using multiple modalities and per Member preference;

2) Utilize a combination of telephonic and face-to-face encounters, based on the Member's preference;

3) Communicate with the Member's PCP regarding SCP updates and other information-sharing;

4) Conduct periodic, systematic case reviews to review the Member's SCP, their progress towards goals, adherence to the treatment plan, and to make necessary changes in treatment and strategy to engage the Member in their plan of care; and

5) Document each contact and updates to SCP in the ECM care management platform.

c. Low Risk/Tier 3

1) Attempt two (2) contacts with the Member in the first month of enrollment and then at minimum, monthly contacts using multiple modalities and per Member preference;

2) Utilize a combination of telephonic and face-to-face encounters, based on Member's preference;

3) Communicate with the Member's PCP regarding SCP updates and other information-sharing;

4) As needed, conduct a systematic case review to review the Member's SCP, their progress towards goals, adherence to the treatment plan, and to make necessary changes in treatment and strategy to engage the Member in their plan of care; and

5) Document each contact and updates to SCP in the ECM care management platform.

6. Modifications for Mitigation of COVID-19 Transmission Risk

   a. For all in-person Member contacts, the ECM Care Team adheres to current CDC safety recommendations and guidelines regarding strategies to reduce the risk of COVID-19 transmission, including, but not limited to:

      1) Wearing a mask

      2) Maintaining social distancing

      3) Hand hygiene

   b. Should the in-person visit occur at the ECM Care Team's office, the exam room or office will be sanitized following each visit, per clinical protocols.

   c. To encourage in-person contacts, the ECM Care Team provides the Member with safer contact options, such as meeting at an outdoor location, per Member preference.

   d. ECM Care Team assists Members to receive the COVID-19 vaccine or adhere to IEHP Policy.

7. ECM Core Services are Culturally Relevant and Person-centered

   a. IEHP recruits diverse ECM Providers into the ECM Provider network.

      1) IEHP maps potentially ECM eligible membership and identifies ECM Providers who are located in and geographically matched to the membership to address regional diversity.

      2) IEHP also analyzes potentially ECM eligible membership for eligibility characteristics (e.g., homeless, diagnosis of SMI or SUD etc.) and recruits ECM Providers with expertise in these areas to ensure diversity of specialty within the ECM Provider network.

      3) IEHP ensures that ECM Providers have diverse care management staff reflecting the populations they serve. IEHP encourages the ECM Provider to hire the ECM Care Team from the community it serves. Specifically, the CHW, by definition, is a team member that has lived experience in the ECM Members' community.

   b. IEHP continues to apply Policy & Procedure MC_09H2 – Cultural and Linguistic Services to its general provider network and verify the capability of its Providers to

provide services in threshold languages at entry into the IEHP network for Riverside and San Bernardino counties. Providers' threshold languages are listed in the IEHP Provider Directory.

c. IEHP encourages recruitment of diverse ECM Provider staff including multilingual staff with competency in Spanish and other threshold languages. IEHP assesses and s ECM eligible membership for preferred language and focuses efforts on supporting hiring practices of multilingual staff in geographic areas that demonstrate higher preference for languages other than English.

d. IEHP has translated key assessments, including the Comprehensive Health Assessment, into threshold languages for ease of completion with patients that prefer services in threshold languages. IEHP will also utilize translations of standardized assessments, such as the PHQ-9 and General Anxiety Disorder-7 (GAD-7), which are available online in many different languages. The IEHP ECM care management platform supports documentation of a care plan problem, goal, and intervention in English and an alternative language. The care plan may be printed either language.

e. IEHP's ECM benefit promotes a definition of whole health that incorporates the recognition, incorporation, and celebration of Members' life experiences, family structure, culture, language, race, gender, sexual orientation, and abilities. IEHP continues its tradition of providing training and support of cultural competency and humility that was provided in the IEHP Health Homes Program and transitioned to the ECM benefit. Training and support of cultural competency and humility is woven in, as appropriate, to all practice coaching, webinars, learning sessions, and other formal training activities. IEHP continues to hire Practice Coaches with diverse life experiences, cultural backgrounds, language competencies, race, ethnicity, gender, abilities, and sexual orientation.

f. IEHP ensures that ECM Providers target outreach and engagement to underserved communities and populations that experience health disparities. IEHP's risk stratification methodology is a combination of ACG risk stratification, focusing on medical-related data, and California Healthy Places Index (HPI), focusing on social determinants of health. The HPI, developed by the Public Health Alliance of Southern California, uses local factors that predict life expectancy to provide overall HPI scores. The categories that inform scoring include economic, education, transportation, social, housing, healthcare access, neighborhood, and clean environment. The inclusion of the HPI score in the risk stratification methodology improves IEHP's ability to identify populations with indicators associated with disparities and up score their risk tier. Members with the highest risk tiers receive preferential outreach by the ECM Care Team both during initial outreach and ongoing engagement efforts.

g. In addition, IEHP has developed an analytics tool that identifies disparities in outcomes related to age, race, ethnicity, gender, preferred language, and region and allows the user to drill down to Member level detail. IEHP is working towards making this tool visible at the ECM Provider level so that it may further inform prioritized outreach strategies to Members experiencing disparities.

h. IEHP identifies and addresses disparities in engagement, access, or utilization of ECM services at the level of the whole MCP population receiving ECM in a variety of ways. Committed to addressing racial equity and injustice internally, IEHP has created the Open Heart Initiative, inclusive of a Racial Equity & Diversity Taskforce and a Diversity & Inclusion Committee. Both are dedicated to addressing racial inequality, health disparities, and the social inequities across cultural lines through cognitive learning, cultural celebrations, and organizational and community engagement. These efforts seek to create a foundation from which to create IEHP Team Member awareness and competency and thereby energize the work directed at addressing disparities and racial inequities in the communities served.

i. IEHP identifies disparities through utilizing the following tools. Findings drive and inform quality improvement activities and training for the ECM Provider network to address identified disparities.

   1) Population Health Assessment (PHA) and Population Needs Assessment (PNA): The Population Health Assessment and Population Needs Assessment (PNA) are conducted annually by IEHP to identify Member population needs. As part of this approach a disparity analysis is conducted on a select set of HEDIS measures to identify disparate outcomes based on human and environmental characteristics of IEHP's Membership. These findings guide overall strategy to address identified disparities through targeted approaches to interventions and program development.

   2) Public Policy Participation Committee (PPPC): The PPPC is an IEHP Member advisory council that is conducted quarterly. IEHP uses this forum to introduce ECM and solicit feedback on how to better serve ECM Members.

   3) Data analytics: Data analysis is performed on ECM outreach activities, enrollment, services provided and outcomes by age, gender, preferred language, race, ethnicity, and region to identify disparities.

7.2. ECM Core Service: Comprehensive Assessment and Care Management Plan

1. ECM Care Teams utilize a clinical Comprehensive Health Assessment (CHA) to appropriately assess Member health status and gaps in care. All Lead Care Managers as part of the ECM Care team will be trained to conduct the assessment and develop care

plans in accordance with federal requirements.[2] This includes ensuring that the care plan be developed by a person trained in person-centered planning using a person-centered process. The person-centered planning process will be led by the Member where possible and will have a representative in a participatory role as needed. The person-centered service plan will reflect the services and supports important for the Member to meet the needs identified in the CHA. The ECM CHA collects comprehensive information from the Member and their caregiver or support person(s) as applicable about their health needs and priorities. The CHA may be administered by any ECM care team member in a setting that reflects the Member's preference, and it is used to gather information needed to address complex medical conditions and longer-standing psychosocial or health care needs and gaps. Assessment information will include, but is not limited to:

a. Physical health
b. Developmental health
c. Mental health
d. Dementia
e. Substance Use Disorder (SUD)
f. Community-based Long-term Services and Supports (LTSS) specific to DHCS' standardized LTSS referral questions[3], particularly for patients at risk of LTC institutionalization or nursing facility residents who are transitioning to the community
g. Oral health
h. Palliative care
i. Trauma-informed care needs
j. Community-based social services
k. Housing and other Social Determinants of Health
l. Utilization

2. Additional assessments of physical, behavioral, or social determinants of health needs is conducted as part of the routine assessment process and based on the findings of the ECM CHA, i.e., the PHQ-9, GAD-7, blood pressure measurement, etc.

[2] Per 42 CFR § 438.208 the care plan must be developed by a person trained in person-centered planning using a person-centered process and plan as defined in 42 CFR § 441.301(c)(1) and (2)
[3] As established in All Plan Letter (APL) 17-013: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL 17-013.pdf

3. The ECM CHA is conducted at a frequency appropriate for the Member's individual progress, no less than upon enrollment, annually, and with any transition in care or other major event.
4. IEHP ensures that CHA materials are available in the Member's preferred written or spoken language and/or alternate formats that effectively communicate information and will make these available upon request.
5. Findings from the CHA, including Member needs, goals, preferences, and assessed risks are utilized in the development of a comprehensive, individualized, and person-centered Shared Care Plan (SCP).
6. The ECM Care Team completes a SCP within the first 90 days of ECM enrollment in coordination with the Member and leveraging input from the Member's support network and caregivers, as appropriate. The SCP incorporates the Member's needs in the areas of physical health, mental health, dementia, substance use disorder, community-based Long-Term Services and Supports (LTSS), oral health, palliative care, trauma-informed care needs, community-based and social services, and housing, for individuals experiencing homelessness and/or those in need of housing support services.
7. The ECM Care Team works with the Member to develop and prioritize Problems, Goals, and Interventions (PGIs) with the SCP according to the Member's priorities and preferences. Individualized goals have timeframes and strategies for addressing each goal.
8. The SCP is accessible to all members of the Member's extended care team.
    a. A copy of the most recent SCP is provided to the Member after each in-person contact, and upon request a copy may be provided by mail.
    b. A copy of the most recent SCP is shared with the Member's PCP via e-mail, mail, fax, or electronically through the ECM care management platform.
    c. The ECM Care Team has access to the SCP through the ECM care management platform and all members of the ECM care team may contribute to and update the SCP.
9. The ECM Care Team maintains the SCP, reviews the SCP with the Member during each contact, and reassesses and updates it with any changes in the Member's progress, status, or health care needs, such as a recent hospital admission, discharge, or ED visit, and/or according to the SCP follow up plan, no less than monthly. The clinical members of the ECM Care Team, including the RN CM and the BH CM, provide clinical oversight for the care plan by reviewing and contributing to the care plan in collaboration with the CC and CHW.

7.3. ECM Core Service: Enhanced Coordination of Care

1. ECM Care Team members regularly contact the Member and their family member(s), guardian, caregiver, and/or authorized support person(s), when appropriate, and at a frequency determined by the Member's risk tier and as documented in the SCP to support and coordinate the plan of care.
2. The ECM Care Team organizes patient care activities by coordinating with the multi-disciplinary care team and other service providers to implement the Member's SCP. Services may include but are not limited to:
    a. Utilizing referral management workflows to refer to and follow up with primary care/physical and development health, mental health, SUD treatment, community-based LTSS, oral health, palliative care, trauma-informed care, necessary community-based and social services, ILOS, and housing services, as needed;
    b. Assisting Members with scheduling appointments, providing appointment reminders, and attending appointments (including accompanying Members to appointments as needed);
    c. Monitoring and supporting treatment adherence, including medication management and reconciliation;
    d. Coordinating transportation to health-related appointments; and
    e. Supporting engagement in treatment through routine contacts and by addressing barriers to treatment.
3. The ECM Provider maintains regular contact with all Providers that are identified as being part of the Member's multi-disciplinary care team, who's input is necessary for successful implementation of Member goals and needs by organizing a systematic case review with the Member's ECM Care Team and PCP to review and collaborate on Member needs, share information with the Member's key care team members, and implement the Member's care plan.
4. The ECM Care Team communicates Members' needs and preferences timely to all members of the Members' care team via SCR and through regular correspondence with multi-disciplinary care team members in a manner that ensures safe, appropriate, and effective person-centered care.

7.4. ECM Core Service: Health Promotion

1. The ECM Care Team incorporates health promotion strategies in all routine contacts, including development and review of the care plan, to support and promote the Member's health and well-being.

2. The ECM Care Team continuously works with Members, their families, and caregivers as appropriate to build on resiliencies, develop self-management plans, and identify family or community supports. The ECM Care Team also monitors achievement of care plan goals and celebrates these with the Member to further build on successes.
3. The ECM Care Team provides services and interventions that encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' self-management. These interventions are documented in the SCP, and the SCP is shared with the Member so that the Member may proactively monitor lifestyle recommendations and related goals and interventions to further facilitate self-management.
4. The ECM Care Team provides Member education, including connection to resources, to strengthen the Member's existing skills and empower them to manage their conditions and prevent worsening or additional chronic conditions.
5. The ECM Care Team encourages the Member's decision-making and continued participation in ECM.

7.5. ECM Core Service: Comprehensive Transitional Care (35)

1. The ECM Care Team employs multiple strategies to reduce avoidable Member admissions and readmissions. These strategies include but are not limited to:
    a. Initial and ongoing biopsychosocial assessment (i.e., blood pressure, PHQ-9, housing) and medication review/reconciliation;
    b. Routine care management contacts to reinforce ongoing engagement;
    c. Use of care planning and goal setting to engage the Member in treatment, motivate behavior change, and support self-management;
    d. Coordination of needed services, including connection to primary care, specialty care, and social service providers as needed; and
    e. Member education on appropriate utilization, including when to access urgent care.
2. The IEHP ECM care management platform is a tool deployed to ECM Care Teams that provides real-time notification of care transitions from inpatient settings and Emergency Departments. IEHP plans to build additional real-time alerts for transitions from other types of facilities such as residential treatment facilities, justice-based facilities, skilled nursing facilities, and to identify critical health and social determinant status changes (e.g., housing and employment).
3. For ECM Members experiencing a transition of care (TOC) from and among treatment facilities, including hospital admissions and discharges and emergency department (ED) visits, the ECM Care Team is responsible for supporting and facilitating the transition of care.

a. The ECM Care Team receives and tracks automated notification of the transition via the ECM care management platform and begins transition activities for ECM Members. Activities may include, but are not limited to:

1) Communicating the transition to the appropriate care team members and informing the Member of the lead care manager;

2) Engaging the Member during an ED visit or hospitalization to complete an admission assessment (admission Transitions of Care) and schedule an in-home post-discharge appointment with an ECM Care Team member, if possible;

3) Engaging the Member within 72 hours of the Emergency Department (ED) or inpatient visit or seven (7 days) post hospital discharge if unable to engage while in the ED or in patient prior to discharge;

4) Reviewing the discharge plan and completing the discharge transitions of care with the member and their caregiver/support within seven (7) days post discharge from an acute or lower level of care setting;

5) Planning appropriate care and/or a place to stay post-discharge, including housing and other social services;

6) Arranging transportation including to medical appointments, as per Non-Medical Transportation and Non-Emergency Medical Transportation policy and procedures;

7) Conducting a comprehensive medication review and reconciliation;

8) Updating the CHA and SCP with specific goals and interventions focused on mitigating future avoidable transitions of care and prevention of readmissions and visits to the emergency department (transition plan);

9) Coordinating referrals; and

10) Scheduling follow-up appointments with the Member's PCP and specialists, as appropriate, within seven (7) days of discharge .

4. Members who are likely to experience a care transition will receive the following supports:

a. Ongoing assessment, which includes a review of recent transitions, is conducted to identify Member's care needs and to coordinate referral to or access of support services to mitigate avoidable transitions of care;

b. Development of SCP goals and interventions focused on management of current conditions and social determinants of health that put the Member at risk for an avoidable transition of care; and

c. Conducting comprehensive medication review and reconciliation to support adherence.

7.6. ECM Core Service: Member and Family Supports

1. During the reassessment process or initial assessment, the Member's chosen caregiver(s) or family/support person is identified and documented in the ECM care management platform.
2. The Member and their chosen family/support persons, including guardians and caregivers, is included in treatment/care planning meetings, per Member preference, to ensure that they are knowledgeable about the Member's condition(s) with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with Federal, State and local privacy and confidentiality laws.
3. The Member's ECM Lead Care Manager, as documented in the ECM care management platform, serves as the primary point of contact for the Member and their chosen family/support persons.
4. The ECM Care Team helps the Member to identify supports needed for the Member and chosen family/support persons to successfully manage the Member's condition and assists them in accessing needed support services, including facilitating referrals as needed.
5. The ECM Care Team provides ongoing and appropriate education to the Member, family members, guardians, and caregivers on care instructions for the Member.
6. The ECM Care Team provides the Member with a copy of their Care Plan in Member's preferred language after each in-person contact, or by mail upon request, with information about how to request updates.

7.7. ECM Core Service: Coordination of and Referral to Community and Support Services

1. The ECM Care team helps to determine the appropriate services required to meet the needs of the Member, including services that address social determinants of health needs, such as housing, and services that are offered by IEHP's ILOS. This is assessed through the administration of and routine updates to the CHA and other assessments as appropriate.
2. The ECM Care Team is responsible for coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., "closed loop referrals").
3. Referral management is a component of the ECM Care Team's primary responsibilities. The ECM Care Team tracks, monitors, and provides referral coordination and communication for all open, ongoing, closed, or completed referrals using IEHP's Provider Portal and the IEHP care management platform.
4. Referral coordination includes the following activities:

a. Provide system navigation and serve as the point of contact for ECM Members and families for questions or concerns related to referrals;

b. Review details and expectations about the referral with the Member and/or caregivers;

c. Gather and send necessary medical information such as clinical background, diagnosis, prognosis, and referral needs as appropriate to referral source;

d. Maintain a process for referring to agencies such as LTSS or behavioral health agencies, as appropriate;

e. Assist Members in problem-solving potential barriers to following through on referrals (e.g., request interpreters as appropriate, transportation assistance or community resource assistance);

f. Ensure that referrals are addressed in a timely manner, as specified by the ordering Provider;

g. Remind patients of scheduled appointments via mail or telephone;

h. Monitor referral activity daily, providing additional assistance to Members who have not completed referrals within a specified timeframe, have cancellations, missed appointments, or other reasons for an incomplete referral;

i. Maintain ongoing tracking and appropriate documentation of referrals to promote care team communication and continuity of care; and

Section 8: Continuation and Discontinuation of ECM Service Delivery

8.1. Continuation Criteria

1. Reassessment Criteria
    a. Members are reassessed at a frequency appropriate for their individual progress or changes in needs and/or as identified in the care management plan.
    b. Members are assessed against their ECM discontinuation criteria, not the ECM Population of Focus eligibility criteria, to evaluate whether Members are ready to transition of the ECM benefit.

8.2. Discontinuation criteria

1. Members are able to decline or end ECM when any of the following circumstances are met.
    a. The Member has met all care plan goals;
    b. The Member is ready to transition to a lower level of care;

c. The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or

d. The ECM Provider has not been able to connect with the Member and/or parent, caregiver, guardian after multiple attempts.

2. IEHP utilizes the following graduation criteria to discontinue ECM services and transition a Member to a lower level of care.

   a. Members who demonstrate improvement in their conditions such that their outcomes demonstrate that they are well-managed, and

   b. Members who have remained out of the hospital and/or ED for a period of two (2) months, and

   c. Members who demonstrate the ability to self-manage their chronic conditions.

3. ECM services may also be discontinued for any one of the following discontinuation reasons.

   a. Members who have been contacted for a continuous period of three (3) months but are unreachable and do not show any claim or encounter in ED, clinics, pharmacy, or any other health care setting.

   b. Members who no longer wish to receive ECM or are unresponsive or unwilling to engage.

   c. Members who are no longer authorized for ECM.

      1) The current authorization has lapsed, and the ECM Provider has not submitted a request for reauthorization. IEHP electronically notifies the Member's designated Lead Care Manager of an aging authorization by generating a task in the IEHP care management platform when there are 30 days left on the Member's active authorization. These electronic notifications can be supplemented by monthly reports on authorizations that will expire in the next 30 days upon ECM Provider request.

      2) Member is participating in a duplicative care management program.

      3) Loss of IEHP Medi-Cal.

      4) Deceased

      5) Incarcerated

      6) Kaiser ECM Transitioned Member

      7) Moved out of service county

4. Notifying IEHP of Request to Discontinue ECM

a. The ECM Care Team requests discontinuation of ECM for a Member by documenting the date and justification for discontinuing ECM in the designated fields within the ECM care management platform.

b. IEHP receives notification of the discontinuation request through the receipt of this data from the ECM care management platform and determines whether to discontinue ECM and per APL 21-011.

c. If the ECM Operational Care Team has concerns regarding a Member's discontinuation from EM, this will be communicated back to the lead care manager of the Member.

5. Transitioning Members from ECM to Lower Levels of Care

   a. ECM Care Teams will reassess the Member's risk tier and appropriateness for ECM throughout their enrollment.

   b. If at the time of discontinuation, the ECM Care Team determines if the Member would benefit from a program that provides a lower level of care management, and refers or connects the Member with these services.

   c. At a minimum, the ECM Care Team connect the Member with their Primary Care Provider upon discontinuation of ECM.

6. ECM Providers work with Members who have significant barriers to care to engage them in ECM to avoid discontinuation whenever possible.

   a. The ECM Care Team is trained in engagement techniques, including MI, to initially engage Members in care and keep Members engaged in ongoing ECM services.

   b. Social Determinants of Health (SDOH) and other significant barriers to engagement are continually assessed through the CHA, care planning, and at every care management contact to ensure ongoing engagement and to address barriers to care early so discontinuation due to lack of engagement can be avoided, when possible.

   c. The ECM Care Team supports identified barriers through engagement with community-based resources that provide services related to housing, food, transportation, employment, education, financial, and interpersonal safety support.

7. Notifying ECM Providers of ECM Discontinuation

   a. When IEHP receives an ECM Provider's request for the discontinuation of ECM services via the ECM care management platform, IEHP reviews the discontinuation request and notifies the ECM Provider via the ECM care management platform when the discontinuation is complete.

   b. In addition to ECM Provider initiated discontinuation requests, IEHP proactively initiates administrative discontinuations which includes Members who no longer have IEHP Medi-Cal or who have an ECM exclusion. Administrative

discontinuations are processed once a month and ECM Providers are notified of these discontinuations via the following process.

1) IEHP refreshes its ECM eligibility algorithm monthly. If the algorithm identifies Members who are no longer eligible for ECM, IEHP discontinues eligibility for ECM for the identified Members in all IEHP systems, including the ECM care management platform.

2) ECM Providers receive a real-time electronic alert via the ECM care management platform for each Member for whom eligibility for ECM has been discontinued.

3) Within 7 business days of processing the monthly discontinuations, IEHP also sends a secure e-mail to the ECM Provider with a list of all Members whose eligibility for ECM was discontinued by the automated monthly algorithm update. This list includes the date ECM was discontinued and the reason for discontinuing ECM. The secure e-mail includes instructions for whom the ECM Provider can contact for questions or to appeal the discontinuation.

8. When initiating discontinuation services, IEHP complies in accordance with the Notice of Action (NOA) process as described in APL 21-011.

Section 9: Oversight of ECM Providers

9.1. ECM Provider Accountability

IEHP's approach to ensuring ECM Providers are accountable for all ECM requirements as set out in the ECM Contract and ECM Standard Provider Terms and Conditions, and in compliance with ECM Core Services Policies and Procedures, is comprised of activities in two key areas.

1. **Quantitative data collection:** Data related to ECM outreach and engagement and the ECM core services is collected and reviewed no less than quarterly by IEHP and ECM Providers. This information enables IEHP and ECM Providers to quantify and monitor ECM services collectively and by ECM Provider.

2. **Qualitative data collection via an ECM care management system chart audit:** Data is collected from an audit of Member records in the ECM care management platform no less than once a year. This information enables IEHP to monitor the quality of ECM services collectively and by ECM Provider.

9.2. Quantitative Data Collection and Reporting

Quantitative data collection and reporting occurs across ECM outreach and engagement and the ECM core services to support regulatory reporting to DHCS, quality improvement activities, contract compliance, and overall evaluation. To hold ECM Providers accountable for conducting outreach to assigned members, including those who are traditionally hard to reach, specific

outreach and engagement measures are analyzed and reported by patient characteristics including race, ethnicity, language, and region. Additionally, for each ECM core service, specific measures are selected to monitor prioritized aspects of the ECM core service. Data, including data required for regulatory reporting to DHCS, is collected from a variety of sources including the ECM care management system, survey tools, and claims data. The Quality Improvement Subcommittee (QISC) approves all selected measures. Measures are subject to change based on shifting ECM priorities and disparity analysis (e.g., race, ethnicity, language, and region) as appropriate.

9.3. Qualitative Data Collection: The ECM Care Management System Chart Audit

The ECM care management system chart audit supplements the quantitative data elements listed above by providing IEHP with data on the quality and completeness of documentation of ECM outreach and engagement and the ECM core services, including the quality of comprehensive assessment, care planning, coordination of care, health promotion, and Member and family supports through the narrative review of ECM services documented in IEHP's ECM care management system. Audit elements are aligned with ECM provider contract requirements as well as national standards for care management and are also subject to change based on shifting ECM priorities.

1. Cases are selected using systematic random sampling to ensure cases are selected across all ECM Providers.
2. Selected charts are reviewed by an internal auditor.
3. Findings are analyzed to identify learnings about the efficacy and quality of collective ECM services and by ECM Provider.
4. The audit is performed no less than once a year.

9.4. Data Utilization for Quality Improvement

Data collected through these two key activities (data collection and reporting and the ECM care management system chart audit), are regularly and systematically reviewed internally by IEHP and externally by ECM Providers. Measures are reviewed on a frequency appropriate for their data type. For example, utilization measures are reviewed quarterly; health outcome measures are reviewed monthly; ECM engagement and ECM Provider capacity measures are reviewed weekly.

1. IEHP regularly utilizes the data to identify collective trends in performance. If an overarching gap is identified at any time, it is escalated to the ECM Clinical Design Committee to identify implications and priorities for enhanced training and practice coaching.
2. IEHP and ECM Providers regularly utilize the data to monitor ECM Provider performance, and this continuous feedback loop drives small scale process improvements by ECM Providers with the support of a Practice Coach or Manager.

9.5. Data Utilization for ECM Provider Contract Compliance

In addition to regularly reviewing data throughout the year, IEHP systematically and comprehensively conducts an evaluation of each ECM Provider's contract compliance no less than once a year. Although a comprehensive evaluation of an ECM Provider's contract compliance is conducted at least once a year, IEHP may initiate a performance review at any time should lack of compliance be identified. The steps that will be taken if a lack of compliance is identified are as follows.

1. The ECM Monitoring and Evaluation Committee evaluates each ECM Provider's contract compliance including performance on a prioritized subset of measures related to the ECM core services and regulatory reporting requirements as specified by DHCS.
2. Lack of compliance on the prioritized measures may result in any of the following interventions, depending on the severity of the performance or compliance gap.
    a. Additional training by IEHP on key topics.
    b. Enhanced practice coaching or Manager support.
    c. Conference between ECM Provider leadership and IEHP leadership to discuss barriers to improvement and compliance with minimum standards.
3. After the initial intervention(s), ECM Provider and IEHP leadership regularly monitor ECM Provider performance and contract compliance over the next quarter. If the ECM Provider continues to demonstrate poor performance over time, or mission critical poor performance on any single prioritized measure, or under performance over several prioritized measures, the ECM Provider may be subject to a corrective action plan (CAP).
4. In the event of a need for a CAP, the ECM Provider must submit a complete and comprehensive CAP form to IEHP that adequately addresses all areas of noncompliance. *Please refer to Appendix A for the CAP form template.*
5. A CAP is considered complete only if all areas of poor performance from each priority measure are present in the submission.
6. Depending on the nature of the corrective action, the ECM Provider's response to the CAP may be due at any point within a 30 day period from when the ECM Provider received written notification from IEHP regarding the initiation and justification for the CAP.
7. The CAP must include the following:
    a. The poor performance measure(s) received;
    b. Identification of the root cause analysis for the poor performance;

c. A specific statement of how the poor performance will be improved (corrective actions) which must include supporting documentation, including but not limited to policies and procedures, training agendas, training materials, and/or process improvement plans;

d. Completion dates for each of the corrective actions;

e. Identification of the person responsible for completing the corrective action; and

f. A follow-up or monitoring plan to ensure that the corrective action plan is successful.

8. Upon receipt of the CAP, it is reviewed and approved by the ECM Monitoring and Evaluation Committee.

9. The ECM Monitoring and Evaluation Committee monitors the CAP, including tracking the ECM Provider's performance on metrics included in the CAP.

10. If clinic- or community-based ECM Providers fail to submit a CAP and/or are not able to show documentation of appropriate responses and/or after three months of being on the CAP fail to show improvement related to identified gaps, the ECM Provider may be subject to the following:

    a. Freezing new ECM Member enrollment, and/or

    b. Freezing eligibility for the ECM value-based payments, and/or

    c. Non-renewal of the ECM Provider contract, and/or

    d. Termination of the ECM Provider contract

11. If IEHP ECM Providers (IEHP Care Teams) fail to submit a CAP and/or are not able to show documentation of appropriate responses and/or after three months of being on the CAP fail to show improvement related to identified gaps, the IEHP ECM Provider (IEHP Care Teams) may be subject to the following:

    a. IEHP Managers work directly with the IEHP ECM Provider (IEHP Care Teams) on improvement strategies, and/or

    b. An internal performance review, and/or

    c. Disciplinary action up to and including termination.

9.6. Data Utilization for Monitoring and Evaluating Outcomes

1. IEHP employs a robust framework of oversight activities, including reporting, to monitor the utilization of and outcomes resulting from the provision of ECM.

2. IEHP developed a suit of reports that creates visibility into performance on key measures, including buty not limited to:
    a. Outreach and engagement rates
    b. Physical and behavioral health outcomes including changes in blood pressure, HbA1c, PHQ-9, GAD-7, and Brief Activation Monitor (BAM) scores
    c. Utilization outcomes including PCP visit rate, admissions rate, ED visit rate, urgent care visit rate, and readmission rate
3. IEHP applies a disparity analysis to key performance measures where appropriate.
4. Reporting on key performance measures is available at the system level, by ECM Provider, and by population of focus.
5. IEHP regularly and systematically reviews reports to:
    a. Monitor ECM outcomes and utilizations as a whole;
    b. Identify trends in outcome and utilization across ECM Providers;
    c. Identify trends in outcome and utilization across populations of focus;
    d. Recognize opportunities for enhanced training or technical support;
    e. Drive quality improvement activities; and
    f. Support a continuous feedback loop with ECM Providers.
    f.g. Decrease inappropriate utilization and duplication of services.
6. IEHP produces an annual evaluation for internal and external stakeholders that summarizes the end of year outcomes and utilizations for ECM Members.
7. IEHP routinely evaluates milestone performance for those ECM Providers participating in the CalAIM Incentive Payment Program.

9.7. Training

IEHP provides ECM training and technical assistance to ECM Providers as indicated by periodic needs assessment to develop and maintain knowledge and skills necessary for ECM core services. Training utilizes a multi-modal approach and include other adult-learning concepts. Training shall emphasize peer-to-peer support and sharing of knowledge to maximize efficiency and promote field-based learning and innovation. Training includes core competencies including team-based care, motivational interviewing, behavioral activation, cultural competency, and trauma-informed care. The core modalities to deliver IEHP's ECM training and technical assistance are:

1. Leadership Roundtable

2. Practice Coaching
3. ECM care management platform training
4. Onboarding webinars
5. Ongoing webinars
6. Periodic community learning sessions

Section 10: Data System Requirements and Data Sharing to Support ECM

10.1. Data Sharing

IEHP uses defined federal and state standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ECM Providers and with DHCS. IEHP shares the following data elements, at minimum, with ECM Providers:

1. Member assignment files
    a. Member assignment files are shared with ECM Providers through the ECM care management platform. Member assignment is also visible for ECM Providers and other contracted Providers in the IEHP Provider Portal.
2. Encounter and claims data
    a. Encounter and claims data is shared with ECM Providers via the IEHP Provider Portal and supplemental reports. Relevant encounter and claims data, including IEHP's prescription claims data, is available in the ECM care management platform.
3. Physical, behavioral, administrative and SDOH data (e.g., Homeless Management Information System (HMIS) data)
    a. Physical, behavioral, and administrative data is shared with ECM Providers via the ECM care management platform. IEHP is working to integrate SDOH (e.g., HMIS) data into the ECM care management platform.
4. Reports of performance on quality measures/metrics, as requested
    a. Reports of performance on quality measures/metrics is shared with ECM Providers via the ECM care management platform. Any reports that are not available within the ECM care management platform are distributed to ECM Providers on a regular basis via secure e-mail.

24. PROGRAM DESCRIPTIONS

F. Enhanced Care Management Description

Section 11: ECM Provider Network

11.1 Network Capacity

1. IEHP ensures that ECM is available throughout its service area, which encompasses both San Bernardino and Riverside County.
2. IEHP reports to DHCS any significant changes in its ECM Provider capacity as soon as possible but no later than 60 days from the occurrence of the change, in accordance with DHCS reporting requirements in a form and manner specified by DHCS
3. During an exception period approved by DHCS, IEHP will take steps to continually develop and increase its ECM Provider network capacity. After the expiration of an exception period, IEHP will submit a new exception request to DHCS for DHCS review and approval on a case-by-case basis.
4. If IEHP is unable to Providers sufficient capacity to meet the needs of all ECM Populations of Focus through contracts with community-based ECM Providers, Contractor may submit a written request to DHCS for an exception that would authorize Contractor to use its own personnel for ECM. Any such request must be submitted in accordance with DHCS guidelines and must meet at least one of the following criteria:
    a. There are insufficient ECM Providers, or a lack of ECM Providers with qualifications and experience, to Providers ECM for one or more of the Populations of Focus in one or more counties;
    b. There is a justified quality of care concern with one or more of the otherwise qualified ECM Providers;
    c. Contractor and the ECM Providers are unable to agree on rates;
    d. ECM Providers are unwilling to contract;
    e. ECM Providers are unresponsive to multiple attempts to contract;
    f. ECM Providers who have a state-level pathway to Medi-Cal enrollment but are unable to comply with the Medi-Cal enrollment Process or Contractor's verification requirements for ECM Providers; or
    g. ECM Providers without a state-level pathway to Medi-Cal enrollment that are unable to comply with Contractor's verification requirements for ECM Providers.
5. IEHP ensures subcontractors and downstream subcontractor's ECM Provider capacity is sufficient to serve applicable populations of focus
6. IEHP participates in the CalAIM Incentive Payment Program (IPPP) whereby IEHP incentivizes ECM provider capacity building and expansion by establishing provider performance milestones and measures.

11.2 Network Contracts

1. IEHP ensures all ECM Providers who whom a state-level enrollment pathway exists enroll in Medi-Cal.
2. IEHP utilizes the ECM Provider Interest Form for verifying qualifications and experience of the ECM Providers, which extends to individuals employed by or delivering service son behalf of the ECM Provider. IEHP ensures that all ECM Providers meet the capabilities and standards required to be an ECM Provider.
3. IEHP does not require eligible ECM Providers to be National Committee for Quality Assurance (NCQA) certified or accredited as a condition of contracting as an ECM Provider.
4. In developing and executing contracts with ECM Providers, IEHP incorporates all necessary and applicable requirements and policies and procedures described in its Model of Care (MOC)
5. IEHP evaluates the prospective subcontractor's and downstream subcontractor's ability to performance ECM core services
6. IEHP makes all subcontractor agreements and downstream subcontractor agreement available to DHCS upon request.
7. IEHP ensures subcontractor agreements and downstream subcontractor agreements mirrors the requirements set forth by DHCS with all applicable DHCS APLs, as applicable to subcontractor.

11.3 Evaluating Prospective ECM Providers

1. IEHP meets and contracts with new ECM Providers to develop and expand its current volume of ECM Providers to meet the demand of eligible ECM Members.
2. IEHP is reaches out to traditional Primary care-based provider groups and non-traditional providers such as other community-based providers who are competent to provide ECM care management services to the eligible populations of focus.
3. On an ongoing basis, IEHP seeks expertise in process to equip ECM care teams to provide services to all eligible Members within Riverside and San Bernardino County.
4. On an ongoing basis, IEHP explores the use of Skilled Nursing Facility (SNF Providers as ECM Providers. Skilled nursing facility providers have expertise and skillsets to provide needed and required services of IEHP's LTC eligible population.

24. PROGRAM DESCRIPTIONS

F. Enhanced Care Management Description

Section 12: Model of Care

12.1 Model of Care

1. IEHP submits its Model of Care (MOC) for DHCS review and approval. IEHP also submits to DHCS any significant changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including all applicable DHCS APLs. Significant changes may include, but are not limited to, changes to the IEHP's approach to administering or delivering ECM services, approved policies and Procedures, and Subcontractor Agreement and Downstream Subcontractor Agreement boilerplates.
2. IEHP collaborates with other Medi-Cal Managed Care Health Plans within San Bernardino and Riverside Counties on the development of its MOC.

Section 13: ECM Provider Payment

13.1 Payment of ECM Providers

1. IEHP pays ECM Providers for the provisions of ECM in accordance with contracts established between IEHP and each ECM Providers.
2. IEHP ensures that ECM Providers are eligible to receive payment when ECM is initiated for any given Member.
3. IEHP pays ECM Providers value-based payments which are tied to achieving quality performance outcomes related to process and clinical related measures.

24. PROGRAM DESCRIPTIONS

F. Enhanced Care Management Description

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2022	
Revision Effective Date:	January 1, 2024	