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 Member 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 who are SPD;

2. Participate in committees and workgroups to ensure cross-departmental program deliverables are accessible and appropriate for Members who are SPD;

3. Launch and coordinate initiatives that improve Member physical, communication, and 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 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.

A. **Disability Program Health Services**

1. Review policies and procedures to improve the ability to meet the needs of our Members;

2. Facilitate the Persons with Disabilities Workgroup (PDW) and seek their advice on the delivery of health care services;[1]

3. Promote Member-centric care through the implementation and serving on 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

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[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.

24. PROGRAM DESCRIPTIONS

A.   Disability Program Description

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. 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;[2] and

5. Offer "text-only" navigation on our website (www.iehp.org) and ensure compliance with access standards.

6. Publish a quarterly Member newsletter ("accessAbility") to provide targeted communication for Members with disabilities;

C. **Disability Program Communication**

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

2. Integrate policies for providing sign language interpreters and alternative formats;

3. Monitor IPA requests and distribution of alternative format with Delegation Oversight Department;

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

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

D. **Disability Sensitivity**

1. Develop and provide training materials to IEHP Team Members and Providers, initially and as needed, cultural awareness and sensitivity training required to meet the needs of

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[2] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 11, Access for Disabled Members.

24. PROGRAM DESCRIPTIONS

A. Disability Program Description

SPDs as required by the California Department of Health Care Services.[3,4] Coordinate the annual Disability Sensitivity/Awareness Month with activities that include presentations, guest speakers, community resource fair, classes and demonstrations on deaf awareness, sign language, assistive technology devices, and sports and recreation equipment.

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, includes the designated ADA Coordinator if not solely 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 Community Health Representatives, Project Analyst, Coordinators and Administrative Assistant.

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[3] DHCS All Plan Letter (APL) 11-010, Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities.
[4] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 1, Provision 10, Sensitivity Training.

24. PROGRAM DESCRIPTIONS

B.   Cultural and Linguistic Services Program Description

Cultural and Linguistic (C&L) Services Program Overview

A. **Mission**

To ensure that all medically necessary and covered services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, gender identity, marital status, sexual orientation, health status, 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. Ensure IEHP, its IPAs and Provider network comply with Department of Health Care Services (DHCS) and federal regulations on Culture and Linguistic services;[4]

2. Establish methods that ensure and promote access and delivery of services in a culturally competent manner to all Members;

3. Provide training, support, technical assistance and resources to IPAs and Providers to assist them in the provision of culturally competent and linguistic services;[5]

4. Train IEHP staff on cultural awareness within the first year of employment and provide updates on C&L resources;[6]

5. Participate in committees and workgroups to ensure cross-departmental program deliverables are accessible and appropriate for Members in need of C&L services;

6. Participate in Public Policy Participation Committee (PPPC) comprised of IEHP leaders and health educators, Providers, Members, and community-based organization representatives and seek their advice on the delivery of C&L services; and

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

Cultural & Linguistic Services Program Activities

A. **Member Health Educational Materials**

The Health Education, Marketing, and Independent Living and Diversity Services Departments review and approve externally and internally developed Member health education materials for readability, content, accuracy, cultural appropriateness and non-discrimination using the DHCS Readability and Suitability Checklist. Materials are reviewed every five (5) years or at the time material is updated or changed. Member health education

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[1] Title 45 Code of Federal Regulations (CFR) Part 92
[2] Department of Health Care Services (DHCS)-IEHP 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] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program
[5] Ibid.
[6] Ibid.

24.   PROGRAM DESCRIPTIONS

B.   Cultural and Linguistic Services Program Description

materials must be available to Members in the threshold languages and alternate formats upon request.[7]

B. **Coordination of Local Resources**

IEHP refers Providers and Members 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 with up-to-date information on health, C&L and social services in their community.[8,9]

C. **Policy Development**

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

D. **Development of Language Interpretation Resources**

IEHP assists Providers in providing linguistically appropriate care to Limited English Proficient Members, and Members who need sign language interpretation by assuming financial responsibility and arranging for interpretation services. IEHP contracts with interpreter agencies to provide adequate access to interpretation services. These services include, but are not limited to, telephonic and in-person foreign language, in-person or Video Remote (used when in-person services are not available or timely) sign language interpretation services for Members.[10,11,12,13,14]

E. **Access Provider Linguistic Capabilities**

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

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

[8] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 14, Linguistic Services

[9] DHCS APL 99-005, "Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population"

[10] National Committee for Quality Assurance (NCQA), 2020 Health Plan Standards and Guidelines, ME 2, Element B

[11] DHCS APL 17-011 Supersedes 14 – 008, "Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act"

[12] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 4, Written Member Information

[13] 42 CFR § 43.10(d)

[14] Knox-Keene Health Care Service Plan Act of 1975, § 1300.67.04

in the Provider Directory.[15] To ensure continued availability of the threshold language(s), the IEHP Provider Services Department performs an annual language competency audit to verify this information.[16]

F.   Cultural and Linguistic Training

Training on cultural competence/sensitivity and IEHP C&L Program policies is available to IEHP network IPAs and Providers initially and annually thereafter. New Providers to the IEHP Network are required to receive training in cultural competency, IEHP C&L standards, and IEHP C&L resources provided by the Provider Services Representatives and other appropriate IEHP Team Members.[17] Providers can also participate in the following online cultural competency training:

1. Office of Minority Health – https://www.thinkculturalhealth.hhs.gov/

2. CDC – http://www.cdc.gov/healthliteracy/gettrainingce.html

3. U.S. Department of Health and Human Services, Health Resources and Services administration – https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/resources/

All new employees receive cultural awareness training within the first year of employment.[18,19,20] The Independent Living and Diversity Services Department coordinates and implements activities to raise awareness of C&L resources and to disseminate information to Team Members (e.g., C&L Awareness Weeks, JIVE Postings).

Cultural & Linguistic Services Program Evaluation

IEHP conducts processes to monitor the delivery of and evaluates the impact and/or outcome of C&L services programs, and takes effective action to address any improvements as needed.[21] Program evaluation activities include but are not limited to:

1. Assesses Providers' adherence to program standards based on quality activities and Member grievances;

2. Tracks use of interpretation services; and

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

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[15] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 4, Written Member Information
[16] KKA, § 1300.67.04
[17] DHCS IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program
[18] Ibid.
[19] 42 CFR § 440.262
[20] KKA, § 1300.67.04
[21] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program

24. PROGRAM DESCRIPTIONS

B.   Cultural and Linguistic Services Program Description

Cultural and Linguistic Services Personnel

A.   **Program Manager**

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

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24. PROGRAM DESCRIPTIONS

C. Quality Management and Quality Improvement Program Description

Introduction

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

Mission and Vision

The mission of IEHP is to organize and improve the delivery of quality, accessible and wellness-based healthcare services for our community.[1] The organization prides itself in six (6) core goals:

A. _Member Experience:_ Ensure Members receive the high-quality care and services they need.

B. _Provider Network:_ Provide a network that delivers high-quality and timely care.

C. _Team Member:_ Make IEHP a great place to work, learn and grow.

D. _Operational Excellence:_ Optimize core processes to deliver compliant, high-quality and efficient services.

E. _Technology:_ Deliver innovative & valuable technology solutions.

F. _Financial Stewardship:_ Ensure financial stability of IEHP in support of enterprise goals.

QM Program Purpose

A. The purpose of the QM Program is to provide the structure and framework necessary to monitor and evaluate the quality and appropriateness of care, identify opportunities for clinical, patient safety, and service improvements, ensure resolution of identified problems, and measure and monitor intervention results over time to assess any needs for new improvement strategies. The purpose of the QM Program Description is to provide a written outline of quality improvement goals, objectives, and structure. IEHP will utilize this document for oversight, monitoring, and evaluation of Quality Management (QM) and

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[1] Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.16.

24. PROGRAM DESCRIPTIONS

C. Quality Management and Quality Improvement Program Description

Quality Improvement (QI) activities to ensure the QM Program is operating in accordance with standards and processes as defined in this Program Description.

QM Program Scope

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

1. Defining the Program structure;

2. Assessing and monitoring the delivery and safety of care;

3. Assessing and monitoring population health management provided to Members, including behavioral health and care management services;[2]

4. Supporting Practitioners and Providers to improve and maintain the safety of their practices;

5. Overseeing IEHP's QM functions through the QM Committee;

6. Involving designated Physician(s) and staff in the QM Program;

7. Involving a Behavioral Healthcare Practitioner (must be a medical doctor or have a clinical PhD or PsyD and may be a medical director, clinical director or participating practitioner from IEHP or behavioral healthcare delegate (if applicable) in the behavioral aspects of the Program;[3]

8. Involving Long- Term Services and Supports (LTSS) Provider(s) in the QM Program;[4]

9. Reviewing the effectiveness of LTSS programs and services;[5]

10. Ensuring that LTSS needs of Members are identified and addressed leveraging available assessment information;

11. Identifying opportunities for QI initiatives, including the identification of health disparities among Members;

12. Implementing and tracking QI initiatives that will have the greatest impact on Members;

13. Measuring the effectiveness of interventions and using the results for future QI planning;

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[2] NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 2.
[3] NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 4.
[4] CCI Three-Way Contract September 2019, Section 2.16
[5] Ibid.

24. PROGRAM DESCRIPTIONS

C. Quality Management and Quality Improvement Program Description

14. Establishing specific role, structure and function of the QMC and other committees, including meeting frequency;

15. Reviewing resources devoted to the QM Program;

16. Assessing and monitoring delivery and safety of care for the IEHP population with complex health needs and Seniors and Persons with Disabilities (SPD);

17. Assessing and monitoring processes to ensure the Member's cultural and linguistic (C&L) needs are being met; and

18. Reviewing grievances and appeals data and other pertinent information in relation to Member safety and care rendered at Provider practices/facilities.

QM Program Goals[6]

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

1. Implement strategies for Population Health Management (PHM) that keep Members healthy, manage Members with emerging risks, ensure patient safety and outcomes across settings, improve Member satisfaction, and improve quality of care for Members with chronic conditions;

2. Implement quality programs to support PHM strategies while improving targeted health conditions;

3. Identify clinical and service-related quality and patient safety issues, and develop and implement QI plans, as needed;

4. Share the results of QI initiatives to stimulate awareness and change;

5. Empower all staff to identify QI opportunities and work collaboratively to implement changes that improve the quality of all IEHP programs;

6. Identify QI opportunities through internal and external audits, Member and Provider feedback,[7] and the evaluation of Member grievances and appeals;

7. Monitor over-utilization and under-utilization of services to assure appropriate access to care;

8. Utilize accurate QI data to ensure program integrity; and

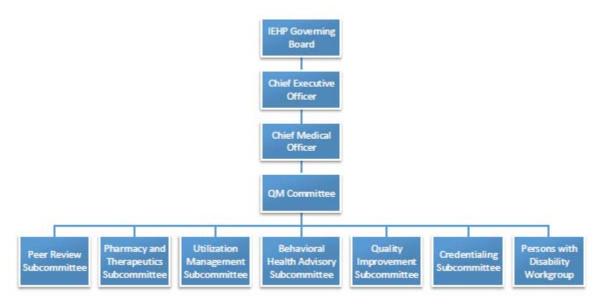
[6] NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 1.
[7] CCI Three-Way Contract September 2019, Section 2.16.

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9. Annually review the effectiveness of the QM Program and utilize the results to plan future initiatives and program design.

Authority and Responsibility[8]

A. The QM Program includes tiered levels of authority, accountability, and responsibility related to quality of care and services provided to Members. The line of authority originates from the Governing Board and extends to Practitioners through different subcommittees. Further details can be found in the IEHP organizational chart.[9,10]

IEHP Governing Board

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

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[8] CCI Three-Way Contract September 2019, Section 2.16.
[9] NCQA, 20202019 HP Standards and Guidelines, QI 1, Element A, Factor 1.
[10] CCI Three-Way Contract September 2019January 2018, Section 2.16.

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C. Quality Management and Quality Improvement Program Description

B. The Board delegates responsibility for monitoring the quality of health care delivered to Members to the Chief Medical Officer and the QMC with administrative processes and direction for the overall QM Program initiated through the Chief Medical Officer or designee.[11,12]

Role of the Chief Executive Officer (CEO)

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

Role of the Chief Medical Officer (CMO)[13]

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

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

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

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[11] CCI Three-Way Contract September 2019January 2018, Section 2.16.
[12] NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 3.
[13] Ibid.

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C. Quality Management and Quality Improvement Program Description

D. The CMO acts as primary liaison to regulatory and oversight agencies including, but not limited to: the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid Services (CMS), and the National Committee for Quality Assurance (NCQA), with support from Health Services staff as necessary.

The Quality Management Committee (QMC)

A. The QMC reports to the Governing Board and retains oversight of the QM Program with direction from the Chief Medical Officer. The QMC promulgates the quality improvement process to participating groups and Physicians, Providers, Subcommittees, and internal IEHP functional areas with oversight by the CMO.

1. **QM Committee Structure:** Network Practitioners, Specialists, and Medical Directors are voting members of the QMC and related Subcommittees. These individuals provide expertise and assistance in directing the QM Program activities.[14]

2. **Role**: The QMC is responsible for continuously improving the quality of care for IEHP Membership.[15]

3. **Structure:** The QMC is composed of IPA Medical Directors who are representative of network Practitioners Practicing Pharmacists and Public Health Department Representatives from Riverside County and San Bernardino County may also be in attendance.[16] A designated Behavioral Healthcare Practitioner is an active Member of the IEHP QM Committee to assist with behavioral healthcare-related issues.[17] IEHP attendees include multi-disciplinary representation from multiple IEHP Departments including but not limited to:

   a. Quality Management;

   b. Utilization Management;

   c. Care Management;

   d. Pharmaceutical Services;

   e. Behavioral Health;

   f. Member Services;

   g. Family and Community Health;

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[14] CCI Three-Way Contract September 2019, Section 2.16.
[15] Ibid.
[16] Ibid.
[17] NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 4.

h.   Health Education;

i.   Grievance and Appeals;

j.   Quality Informatics;

k.   HealthCare Informatics;

l.   Independent Living and Diversity Services;

m.   Compliance; and

n.   Provider Services.

4.   **Function**: The QMC meets quarterly and reports findings, actions, and recommendations to the IEHP Governing Board annually and reports meeting minutes to DHCS quarterly. The QMC seeks methods to increase the quality of health care for IEHP Members; recommend policy decisions; analyze and evaluate QI activity results; institute and direct needed actions; and ensures follow-up as appropriate. The Committee provides oversight and direction for Subcommittees, related programs, activities, and reviews and approves Subcommittee recommendations, findings, and provides direction as applicable. The Committee provides oversight and direction for Subcommittees, related programs, activities, and reviews and approves Subcommittee recommendations, findings, and provides direction as applicable. QMC findings and recommendations are reported through the CMO to the IEHP Governing Board on an annual basis.[18,19]

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

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

b.   A Behavioral Health Practitioner must be present for behavioral health issues.[20]

c.   Non-physician Committee Members may not vote on medical issues.[21]

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

a.   Per the guidance laid out in Chapters 9 of the Medicare Prescription Drug Benefit Manual and 21 of the Medicare Managed Care Manual (50.6.8 – OIG/GSA

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[18] NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 4.
[19] CCI Three-Way Contract September 2019, Section 2.16.
[20] NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 4.
[21] Ibid.

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Exclusion), "Medicare payments may not be made for items or services furnished or prescribed by an excluded provider or entity".

1) IEHP utilizes the OIG Compliance Now (OIGCN) vendor to conduct the screening of covered entities on behalf of IEHP.

2) In the event, any member of the QMC, or prospective member, is found to be excluded per OIGCN, the Compliance Department will notify the QM department so that they may take immediate action.

b. QMC members must be screened before being confirmed and on a monthly basis, thereafter.

c. The Compliance department and QM department collaborate to ensure Committee members undergo an OIG/GSA exclusion screening prior to schedule QMC meetings.

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

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

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

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

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

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

e. IEHP maintains oversight of Provider and Practitioner confidentiality procedures.

1) IEHP has established and distributes confidentiality standards to contracted Providers and Practitioners in the IEHP Provider Policy and Procedure Manual.

2) All Provider and Practitioner contracts include the provision to safeguard the confidentiality of Members' medical and behavioral health care records,

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C.   Quality Management and Quality Improvement Program Description

treatment records, and access to sensitive services in accordance with applicable state and federal laws.

3) As a condition of participation in the IEHP network, all contracted Providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of Members to their Practitioners.

4) IEHP monitors contracted Providers and Practitioners for compliance with IEHP's confidentiality standards during Delegation Oversight Audits and Facility Site Reviews (FSRs) and Medical Records Reviews (MRRs).

8. **Enforcement/Compliance:** The QM Department is responsible for monitoring and oversight of the QM Program including 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 policies.

9. **Data Sources and Support:** The QM Program utilizes an extensive data system that captures information from claims and encounter data, enrollment data, Utilization Management (UM), QM and QI activities, behavioral health data pharmaceutical data, grievances and appeals, and Member Services, among others.[22]

10. **Affirmation Statement**: The QM Program assures that utilization decisions made for IEHP Members are based solely on medical necessity. IEHP does not compensate or offer financial incentives to Practitioners or individuals for denials of coverage or service or any other decisions about Member care. 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.

11. **Availability of QM Program Information**: IEHP has developed an overview of the QM Program and related activities. This overview is on the IEHP website at www.iehp.org and a paper copy is available to all Members and/or Practitioners upon request by calling IEHP Member Services Department. Members are notified of the availability through the Member Handbook.[23,24] Practitioners are notified in the Provider Manual. The IEHP QM Program Description and Work Plan are available to IPAs and Practitioners upon request. A summary of QM activities and progress toward meeting QM goals is available to Members, Providers, and Practitioners upon request.

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[22] CCI Three-Way Contract September 2019, Section 2.16.
[23] Title 28, California Code of Regulations § 1300.69(i).
[24] NCQA, 2020 HP Standards and Guidelines, MED 8, Element D.

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C. Quality Management and Quality Improvement Program Description

12. **Conflict of Interest**: IEHP monitors IPAs for policies and procedures and signed conflict of interest statements at the time of the Delegation Oversight Annual Audit.

Quality Subcommittees

1. Subcommittee and functional reports are submitted on a quarterly and ad hoc basis. The following Subcommittees, chaired by the IEHP CMO or designee, report findings and recommendations to the QMC:[25]

1. Quality Improvement Subcommittee;

2. Peer Review Subcommittee;

3. Credentialing Subcommittee;

4. Pharmacy and Therapeutics Subcommittee;

5. Utilization Management Subcommittee; and

6. Behavioral Health Advisory Subcommittee.

Quality Improvement Subcommittee[26]

A. The Quality Improvement (QI) Subcommittee is responsible for quality improvement activities for IEHP.
   1. **Role:** The QI Subcommittee reviews reports and findings of studies before presenting to the QMC and works to develop action plans in an effort to improve quality and study results. In addition, QI Subcommittee directs the continuous monitoring of all aspects of Care Management (CM) and Population Health Management (PHM) services provided to Members.

   2. **Structure:** The QI Subcommittee is composed of representation from multiple internal IEHP Departments including but not limited to: Quality Systems, Care Management, Utilization Management, Compliance, Behavioral Health, Community Health, HealthCare Informatics, Health Education, Member Services, and Provider Services. The QI Subcommittee 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 QMC.

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

   4. **Frequency of Meetings:** The QI Subcommittee meets every other month with ad hoc

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[25] NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 5.
[26] CCI Three-Way Contract September 2019, Section 2.16

meetings conducted as needed.

Peer Review Subcommittee

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

1. **Role:** The Peer Review Subcommittee reviews quality performance profiles of Practitioners identified during the Peer Review Program activities that may include escalated cases related to grievances, quality of care and utilization audits, credentialing and re-credentialing and medical-legal issues. The Subcommittee performs oversight of IPAs 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 Practitioners. A Behavioral Health Practitioner and any other Specialist, not represented by committee members, serve on an ad hoc basis for related issues.

3. **Function**: The Peer Review Subcommittee serves as the committee for clinical quality review of Practitioners; evaluates and makes decisions regarding Member or Practitioner grievances and clinical quality of care cases referred by the CMO or Medical Director designee.

4. **Frequency of Meetings:** The Peer Review Subcommittee meets every other month with ad hoc meetings as needed.

Credentialing Subcommittee

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

1. **Role:** The Credentialing Subcommittee is responsible for reviewing individual Practitioners who directly contract with IEHP and denying or approving their participation in the IEHP network.

2. **Structure:** The Credentialing Subcommittee is composed of multidisciplinary participating Primary Care Providers (PCP(PCPs) or specialty Physicians, representative of network Practitioners. A Behavioral Health Practitioner, and any other Specialist not represented by committee members, serves on an ad hoc basis for related issues.

3. **Function:** The Credentialing Subcommittee provides thoughtful discussion and consideration of all network Practitioners being credentialed or re-credentialed; reviews Practitioner qualifications including adverse findings; approves or denies continued participation in the network every three (3) years for re-credentialing; and ensures that

decisions are non-discriminatory.

4. **Frequency of Meetings:** The Credentialing Subcommittee meets every month with ad hoc meetings conducted as needed.

Pharmacy and Therapeutics (P&T) Subcommittee

A. The P&T Subcommittee performs ongoing review and modification of the IEHP Formulary and related processes; conducts oversight of the Pharmacy network including medication prescribing practices by IEHP Practitioners; assesses usage patterns by Members; and assists with study design, clinical guidelines and other related functions. The Subcommittee is responsible for reviewing and updating clinical practice guidelines that are primarily medication related.

1. **Role**: The P&T Subcommittee is responsible for maintaining a current and effective formulary, monitoring medication prescribing practices by IEHP Practitioners, and under- and over-utilization of medications.

2. **Structure:** The P&T Subcommittee is composed of clinical pharmacists and designated Physicians representative of network Practitioners. A Behavioral Health Practitioner and any other Specialist not represented by committee Members, serve on an ad hoc basis for related issues.

3. **Function**: The 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.

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

Utilization Management (UM) Subcommittee

A. The UM Subcommittee performs oversight of UM activities in all clinical departments conducted by IEHP and IPAs to maintain high quality health care, as well as effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services. The Subcommittee reviews UM criteria, new technologies, and new applications of existing technologies for consideration as IEHP benefits and is responsible for reviewing and updating evidence-based preventive care and clinical practice guidelines (CPGs) that are not primarily medication-related.

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C. Quality Management and Quality Improvement Program Description

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

2. **Structure:** The UM Subcommittee is composed of IPA Medical Directors, or designated Physicians that are representative of network Practitioners. A Behavioral Health Physician and any other Specialist, not represented by committee members, serve on an ad hoc basis for related issues.[27]

3. **Function**: The UM Subcommittee reviews and approves the Utilization Management Behavioral Health Programs annually. The Subcommittee also monitors for over-utilization and under-utilization; ensures that UM decisions are based only on appropriateness of care and service; and reviews and updates preventive care and clinical practice guidelines that are not primarily medication related.

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

Behavioral Health Advisory Subcommittee[28,29]

A. The BH Advisory Subcommittee serves as a multidisciplinary BH specialty advisory committee. The subcommittee reviews UM and QI activities, reports for BH services as well as review and approve BH clinical criteria, BH clinical guidelines, new BH technology and treatment innovations.

1. **Role:** The BH Advisory Subcommittee directs the continuous monitoring of all aspects of BH services administered to Members.

2. **Structure**: The BH Advisory Subcommittee is composed of licensed clinicians from IEHP's BH network and contracted consulting Clinicians.

3. **Function**: The BH Advisory Subcommittee reviews and approves the Behavioral Health Program annually. The Subcommittee monitors for over-utilization and under-utilization; ensures that BH decisions are based only on appropriateness of care and service; and reviews and updates preventive care and clinical practice guidelines.

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

QM Support Committees/Workgroups

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[27] NCQA, 2020 HP Standards and Guidelines, UM 1, Element A, Factors 2 and 4.
[28] NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 2.
[29] NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 4.

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A. IEHP also has Committees and/or Workgroups that are designed to provide structural input from Providers and Members. These Committees and Workgroups report directly through the QMC, Compliance Committee or through the CEO to the Governing Board. Any potential quality issues that arise from these Committees would be referred to the QMC by attending staff. The Committees include:

1. Coordinated Care Initiative (CCI) Stakeholder Advisory Committee;

2. Provider Advisory Committee (PAC);

3. Public Policy Participation Committee (PPPC);

4. Persons with Disabilities Workgroup (PDW);

1. Delegation Oversight Committee;

5. Compliance Committee; and

6. Grievance & Appeals Review Committee (GARC)..)

Coordinated Care Initiative (CCI) Stakeholder Advisory Committee

A. The CCI Stakeholder Advisory Committee provides a forum for structured input regarding how IEHP will develop, implement, and operate the Coordinated Care Initiative/Duals Demonstration for IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

Provider Advisory Committee (PAC)

A. The PAC was established to provide a forum for Providers and Practitioners to give input and advice on relevant IEHP policies and programs. Based on the input from the PAC, the CEO makes recommendations on relevant IEHP policies and programs that may impact Providers and Practitioners. The PAC meets every other month prior to an IEHP Governing Board Meeting.

Public Policy Participation Committee (PPPC)

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

Persons with Disabilities Workgroup (PDW)

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

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to services for Members with disabilities. The PDW meets at least quarterly.

Delegation Oversight Committee

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

Compliance Committee

A. The Compliance Committee retains oversight of the Compliance Program by assisting the IEHP Compliance Officer to develop and enforce the Compliance Program, including regulatory, monitoring, Fraud Waste and Abuse (FWA), Privacy and Security activities. The Compliance Committee is responsible for advising and supporting the IEHP Compliance Program, overseeing its operation and ensuring its effectiveness. 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 Committee meets on a quarterly basis, or as necessary for oversight of the Compliance program. Its subcommittees include the Delegation Oversight Committee, the Policies and Procedures Committee, the FWA Committee, and Audit & Monitoring Committee.

Grievance &Appeals Review Committee (GARC)

A. The Grievance & Appeals Review Committee provides oversight to grievance trends providing the direction necessary to monitor and evaluate grievance-related data. The committee is chaired by the IEHP Medical Director or designee and provides guidance in identifying trends and develops action plans to resolve grievance trends and focus on improvement activities. The Committee meets monthly and committee members include representation from IEHP Medical Directors, QM, Compliance, Provider Services, Member Services, and Grievance and Appeals. The GARC meets on a quarterly basis with ad hoc meetings conducted as needed.

Organizational Structure and Resources

A. IEHP has designated internal resources to support, facilitate, and contribute to the QM Program. The Organization Chart provides further details on support staff.[30]

Clinical Oversight of QM Program

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[30] CCI Three-Way Contract September 2019January 2018, Section 2.16.

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A. Under the direction of the Chief Medical Officer or designee are responsible for clinical oversight and management of the QM, UM, CM, BH, Health Education, and PHM activities, participating in QM functions 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: developing and implementing medical policy for UM, BH, Health Education, PHM, CM activities and QM functions; reviewing current medical practices ensuring that protocols are implemented and medical personnel of IEHP follow rules of conduct; ensuring that assigned Members are provided health care services and medical attention at all locations; ensuring that medical care rendered by Practitioners meets applicable professional standards for acceptable medical care and that they follow evidence-based CPGs developed by IEHP for all lines of business. Medical Directors actively participate in the QM Program for IEHP and its Practitioners.

Quality Systems Department

A. The Quality Systems (QS) Department operates under the direction of the Vice President of Quality.. The Vice President of Quality is responsible for the oversight of all quality studies, demographic analysis, and other research projects. Areas of accountability include: developing research or methodologies for quality studies; producing detailed criteria and processes for research and studies to ensure accurate and reliable results; designing data collection methodologies or other tools as necessary to support research or study activities; implementing research or studies in coordination with other IEHP functional areas; ensuring appropriate collection of data or information; performing analysis, including barrier analysis of results; managing the Quality Systems staff to ensure high productivity and high quality output; and working with other IEHP staff involved in research or study processes.

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

Quality Management Department

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

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

Pharmaceutical Services Department

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

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

Population Health (Behavioral Health Care Management) Department

A. The Population Health Department operates under the direction of the Vice President of Population Health, who reports to the CMO and encompasses Behavioral HealthCare Management (BHCM),, Community Health, and Health Education. The Director of Behavioral Health and the Director of Case Management report to the Vice President of Population Health. They are responsible for clinical oversight and management of the IEHP Behavioral Health Care Management Programs. In these roles they also participate in quality management and quality improvement, grievance, utilization and credentialing functions and activities related to Behavioral Health and Care Management services.

B. The Vice President of Population Health oversees BHCM Staff with the required qualifications to perform BHCM care coordination activities in a managed care environment. BHCM 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, and customer or provider relations. BHCM staff positions include clinical and/or non-clinical Directors, Managers, Supervisors, and administrative staff.

Utilization Management Department

A. The UM Department operates under the direction of the Senior Director of Medical Management, Clinical Director of UM and Operations and Director of UM. The Senior Director of Medical Management reports to the CMO and is responsible for developing and maintaining the UM Program structure and assisting Providers and Practitioners in providing optimal UM services to Members. The Senior Director of Medical Management, Clinical Director of UM and Operations Director of UM are responsible for oversight of delegated, non-delegated and IEHP Direct UM activities. Additional responsibilities include the

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C. Quality Management and Quality Improvement Program Description

development and implementation of internal UM services, processes, policies and procedures, as well as, oversight and direction of IEHP UM staff and providing support to the IEHP QM Committee and Subcommittees.

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

Health Education Department

A. The Health Education Program operates under the direction of the Director of Health Education who provides oversight of all accreditation and regulatory standards for Member health education. Primary responsibilities include oversight of the Health Education Department for Member health education. The department coordinates with other departments to ensure Member health education materials meet state requirements for readability format, cultural and linguistic relevance. The Director facilitates effective communication and coordination of care among Utilization Management, Care Management, Pharmaceutical Services, and Health Education departments. The Director works with other departments to develop and coordinate policies and procedures for medical services (e.g., medical procedures, denials, pharmaceutical services) that incorporate Member participation in health education programs. The Director of Health Education ensures compliance with all accreditation and regulatory standards for health education, and acts as the primary liaison between IEHP and Providers/external agencies for health education. The Director of Health Education also provides oversight of the Employee Wellness Program and co-chairs the Employee Wellness Advisory Committee to plan and monitor activities to enhance wellness among IEHP Team Members.

B. Staff support for the Director of Health Education consists of non-clinical management and administrative staff.

Community Health Department

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

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Provider Services Department

A. The Provider Services Department operates under the direction of the Chief Operating Officer (COO). Under the direction of the CEO, the COO is responsible for Credentialing and Provider Services, including the resolution of Provider and Practitioner issues, education of Providers and Practitioners concerning IEHP policies and procedures, health plan programs, IEHP website training and all other functions necessary to ensure Providers and Practitioners can successfully participate in IEHP's network and provide appropriate, quality care to IEHP Members. The COO is also responsible for IPA oversight and administration in conjunction with Departments including Audit & Monitoring, QM, UM, Care Management, Credentialing/Re-Credentialing activities, Compliance, and Finance.

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

Credentialing Department

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

B. The Director of Provider Operations is responsible for developing and overseeing the IEHP Credentialing and Re-credentialing Program, under the direction of the Executive Director of Health and Provider Services.

Grievance and Appeals Department

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

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

Information and Technology (IT)

A. The IT Department operates under the Directors of IT who report to the Chief Information

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

Marketing and Communication Department

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

Program Documents

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

Quality Management and Quality Improvement Work Plans[31,32]

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

Annual Evaluation

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

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[31] NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 5.
[32] CCI Three-Way Contract September 2019, Section 2.16.

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including:

1. The QM program structure;

2. The behavioral healthcare aspects of the program;

3. How patient safety is addressed;

4. Involvement of a designated physician in the QM Program;

5. Involvement of a Behavioral Healthcare Practitioner in the behavioral aspects of the program;

6. Oversight of QI functions of the organization by the QI Committee;

7. An annual work plan (QM/QI Work Plan);

8. Objectives for serving a culturally and linguistically diverse membership; and

9. Objectives for serving Members with complex health needs.

B. As such, an annual summary of all completed and ongoing QM Program activities addresses the quality and safety of clinical care and quality of service provided as outlined in the QM 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 or designee. The report includes pertinent results from QM Program studies, Member access to care, IEHP standards, physician credentialing and facility review compliance, Member satisfaction, evidence of the overall effectiveness of the program, and significant activities affecting medical and behavioral health care provided to Members.

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

Review and Approval of Program Documents

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

B. The QM/QI Work Plan is updated and presented at subsequent Board meetings.

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Quality Improvement Processes

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

IEHP Quality Improvement (QI) Initiatives

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

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

Plan-Do-Study-Act Cycle

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

1. Find a process to improve, usually by presenting deficient results;

2. Organize a team that understands the process and include subject matter experts (SMEs);

3. Clarify knowledge about the process;

4. Understand and define the key variables and characteristics of the process;

5. Select the process to improve;

6. Plan a roadmap for improvement and/or develop a work plan;

7. Implement changes;

8. Evaluate the effect of changes through measurement and analysis; and

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9. Maintain improvements and continue to improve the process.

Data Collection Methodology

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

Measurement Process

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

Evaluation Process

A. IEHP uses a number of 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. [33] IEHP performs this analysis in a focus group-like setting using all the key stakeholders. [34]

Communication and Feedback

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[33] CCI Three-Way Contract September 2019, Section 2.16
[34] Ibid.

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C. Quality Management and Quality Improvement Program Description

A. Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, mailings, and announcements.[35]

  1. Providers are educated regarding quality improvement initiatives through on-site quality visits, Provider newsletters, specific mailings, and the IEHP website.

  2. Specific performance feedback regarding actions or data is communicated to Providers. General and measure-specific performance feedback is shared via special mailings, Provider newsletters, IEHP's Provider Portal, and the IEHP website.

  3. Feedback to Providers may include, but is not limited to, the following:

     a. Listings of Members who need specific services or interventions;

     b. Clinical Practice Guideline recommended interventions;

     c. Healthcare Effectiveness Data Information Sets (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results;[36]

     d. Recognition for performance or contributions; and

     e. Discussions regarding the results of medical chart audits, grievances, appeals, referral patterns, utilization patterns, and compliance with contractual requirements.

Improvement Processes

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

Quality Improvement Initiatives

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

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[35] CCI Three-Way Contract September 2019, Section 2.16.
[36] Ibid.

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C. Quality Management and Quality Improvement Program Description

Quality of Care

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

1. Annual HEDIS® submission for Medi-Cal and IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan);

2. State/Federal-required Performance Improvement Projects and Quality Activities; and

3. Claims and encounter data from contracted Providers (e.g. Primary Care Providers, Specialists, labs, hospitals, IPAs, Vendors, etc.).

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

1. Performance with healthcare outcomes and clinical processes;

2. Adherence to clinical and preventive health guidelines;

3. Effectiveness of chronic conditions, population health and care management Care Management programs; and

4. Member experience with the care they received.

HEDIS® Measures[37]

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

B. IEHP develops a number of Member and Provider engagement programs to improve HEDIS® rates. Interventions include a combination of incentives, outreach and education, Provider-level reports and gaps in care reports, and other activities deemed critical to improve performance. These interventions are tracked and monitored in the QI Work Plan and are presented at the QI Subcommittee. In addition, IEHP's performance on HEDIS® measures is reported and discussed annually at the QI Subcommittee, who provides guidance on prioritizing measures for the subsequent year(s). IEHP's goal is to continually develop and implement interventions that are aimed at improving HEDIS® rates and quality of care for its Members.

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[37] CCI Three-Way Contract September 2019, Section 2.16.

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Performance Improvement Projects (PIPs) (DHCS, CMS and Health Services Advisory Group (HSAG) and Quality Activities)[38]

A. IEHP implements a number of Performance Improvement Projects (PIPs) and HEDIS® PDSA PIPs that are required by regulatory agencies (DHCS, CMS and HSAG) and in accordance with requirements in the Capitated Financial Alignment Model.

1. PIPs – A thorough analysis on a targeted problem is completed. A baseline and key indicators are established and then interventions are implemented. Interventions are designed to enhance quality and outcomes that benefit IEHP Members.

2. HEDIS® PDSA PIPs – These are conducted for each HEDIS® External Accountability Set (EAS) 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.[39]

3. NCQA Quality Activities – These are quality improvement activities conducted to meet NCQA accreditation standards.

B. The Quality Management Department, under the direction of the Medical Director(s), is responsible for monitoring these programs and implementing interventions to make improvements. For 2018 to present, IEHP is focusing on the following studies:

Study Name	Reporting Agency	Type of Study
IEHP All-Cause Readmissions – Statewide Collaborative measure (non-HEDIS® measure) addressing reduction of hospital readmission rates	NCQA	Quality Activity
Disparity Performance Improvement Project – Childhood Immunization Status (CIS) Combo 10	DHCS, HSAG	PIP
Asthma Medication Ratio (AMR)	DHCS, HSAG	PIP
Individualized Care Plan	DHCS, CMS, HSAG	PIP

Continuity and Coordination of Care Studies

A. Continuity and coordination of care are key determinants for overall health outcomes. Comprehensive coordination of care improves patient safety, avoids duplicate assessments, procedures or testing, and results in better treatment outcomes. IEHP evaluates continuity and

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[38] CCI Three-Way Contract September 2019, Section 2.16.
[39] Department of Health Care Services (DHCS) All Plan Letter (APL) 19-017 supersedes 17-014 Quality and Performance Improvement Requirements

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coordination of care on an annual basis through multiple studies. The purpose of these studies is to assess the effectiveness of the exchange of information between:

1. Medical care Providers working in different care settings; and

2. Medical and behavioral healthcare Providers.

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

Improving Quality for Members with Complex Needs

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

1. Complex Care Management (CCM) Program

   a. The CCM program was established for Members with chronic and/or complex conditions. The goal of the CCM program is to optimize Member wellness, improve clinical outcomes, and promote self-management and appropriate resource management across the care continuum, through efficient care coordination, education, referrals to health care resource, and advocacy. IEHP assesses the performance of the CCM program annually using established measures and quantifiable standards. These reports are presented to the QI Subcommittee and QM Committee for discussion and input. Based on the committee recommendations, the Care Management Department collaborates with other Departments within the organization to implement improvement activities.

2. Transition of Care (TOC) Program

   a. IEHP has developed a system to coordinate the delivery of care across all healthcare settings, Providers, and services to ensure all hospitalized Members are evaluated for discharge needs to provide continuity and coordination of care. Multiple studies have shown that the poor transition between care settings have resulted an increase in mortality and morbidity. Transitioning care without assistance for Members with complex needs (e.g. SPD Members that very often have three (3) or more chronic conditions) can be complicated by several other health and social risk factors. IEHP's TOC program has been designed to provide solutions to these challenges. Through the TOC program, IEHP makes concerted efforts to coordinate care when Members move from one setting to another. This coordination ensures quality of care and

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minimizes risk to patient safety. IEHP also works with the Member or their caregiver to ensure they have the necessary medications/supplies to prevent readmissions or complications. The goals of the TOC program include the following:

1) Avoiding of hospital readmissions post discharge;

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

3) Improving Member and caregiver experience with care received.

3. Facility Site Review (FSR)[40]

   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), utilizing a combined Site and Medical Record Review Checklist, prior to the PCP site participating with IEHP.[41] In addition, Physical Accessibility Review Surveys (PARS) are conducted every three (3) years as related to physical accessibility, physical appearance, appearance safety, adequacy of room space, availability of appointments, and adequacy of record keeping or any other issue that could impede quality of care. Sites will be monitored every six (6) months until all deficiencies are resolved. The Quality Management Department is responsible for oversight of PARS activities. In partnership with IEHP key stakeholders, the QM Department is responsible for providing training should physical access issues or deficiencies be identified. The QMC reviews an annual assessment of PARS activities to ensure compliance.

Other Clinical Measures and Studies

A. Initial Health Assessment Monitoring

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

B. Clinical Practice Guidelines (CPGs) and Preventive Health Guidelines[42]

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

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[40] Department of Health Care Services (DHCS) Policy Letter (PL) 14-004 Supersedes PL 02-002, Site Reviews: FSR and Medical Record Review
[41] CCI Three-Way Contract September 2019, Section 2.16
[42] Ibid.

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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[43]

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:

1.   Access to health care services based on geographic regions.

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

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

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

   c.   Income and socioeconomic status.

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

1.

   a.   Identify the dominant utilization patterns within the population.

   b.   Identify groups of high and low utilizers and understand their general characteristics.

Access to Care[44]

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 a number of statewide studies, there are many Members who do not receive appropriate and timely care. IEHP has also seen a growth in the number of grievances received for access to care over the last few years. With the rapid growth in IEHP's

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[43] CCI Three-Way Contract September 2019, Section 2.16.
[44] CCI Three-Way Contract September 2019, Section 2.11

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Membership, access to care is a major area of concern for the plan and hence the organization has dedicated a significant amount of resources to measuring and improving access to care. This analysis is presented to the QI Subcommittee and QM Committee for discussion and recommendations as needed.

Availability of PCPs by Language[45]

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

Availability of Practitioners

A. IEHP monitors the availability of PCP, Specialists and Behavioral Health Practitioners and assesses them against established standards at least annually or when there is a significant change to the network. The performance standards are based on State, NCQA, and industry benchmarks. IEHP has established quantifiable standards for both the number and geographic distribution of its network of Practitioners. IEHP uses a geo-mapping application to assess the geographic distribution. Considering the size of the service area, IEHP evaluates the distribution of Providers since there may be significant gaps in some of the more rural areas covered by IEHP.

Appointment Access

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. In order to measure performance, IEHP collects the required appointment access data from Practitioner offices using a timely access to care survey. IEHP also evaluates the grievances and appeals data quarterly to identify potential issues with access to care. A combination of both these activities helps IEHP identify and implement opportunities for improvement.

After-hours Access to Care

A. IEHP monitors after-hours access to PCPs at least annually. One of IEHP's key initiatives is to reduce inappropriate ER utilization. Ensuring that Members have appropriate access to their

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[45] 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."

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PCP outside of regular business hours can result in reduced ER rates, which can subsequently result in reduced inpatient admissions. The criteria for appropriate after-hours care is that the physician or designated on-call physician be available to respond to the Member's medical needs beyond normal hours. PCP offices can use a professional exchange service or automated answering system that allows the Member to connect to a live party or the physician by phone. It is also required that any after-hours system or service that a physician uses provide emergency instructions in the event that the Member is experiencing a life-threatening emergency.

Telephone Access to IEHP Staff

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

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

Member and Provider Satisfaction

CAHPS®

A. IEHP conducts a comprehensive CAHPS® survey and analysis annually to assess Member satisfaction with the services and care received. 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 like getting needed care; getting appointments to PCPs and Specialty Care Providers (SCPs); satisfaction with IEHP and its Practitioners; and other key areas of the Plan operations. CAHPS® surveys serve as a means to provide usable information about quality of care received by the Members. IEHP uses this tool as one of its key instruments to identify opportunities for improvement. As part of the annual evaluation, IEHP reviews the CAHPS® results to identify relative strengths and weaknesses in performance, determines where improvement is needed, and tracks progress with interventions over time.

Internal Member Satisfaction Studies[46]

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

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[46] CCI Three-Way Contract September 2019, Section 2.16.

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

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

C. Population Health Management (PHM) Population Assessment -Member Experience Survey: Annually, IEHP conducts an internal member experience survey for Medi-Cal Members to assess Member Satisfaction with IEHP's Population Health Management programs. The survey focuses on Member feedback from at least two programs (e.g. disease management or wellness programs). Feedback is specific to the programs being evaluated. Additionally, IEHP analyzes complaints to identify opportunities to improve satisfaction.[47]

Grievances and Appeals[48]

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

1. Billing/Financial;

2. Quality of Practitioner Office Site;

3. Access;

4. Quality of Service;

5. Quality of Care;

6. Attitude and Service;

7. Compliance;

8. Benefits/Coverage;

9. Enrollment/Eligibility;

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[47] NCQA, 2020 HP Standards and Guidelines, PHM 2PHM2, Element B
[48] NCQA, 2020 HP Standards and Guidelines, ME 7ME7, Element C.

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10. Disease Management and Care Management Programs; and

11. Cultural and Linguistics.

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

Provider Satisfaction

A. IEHP monitors performance areas affecting Provider satisfaction annually and submits the results to DHCS and CMS.[49] This study assesses the satisfaction 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 satisfaction of the Provider network in the following areas: overall satisfaction, all other plans, finance issues, utilization and quality management network, coordination of care, pharmacy, Health Plan Call Center Service Staff, and Provider relations. Based on the data collected, IEHPs reports the findings to the QI Subcommittee and QM Committee. The committees review the findings and make recommendations on potential opportunities for improvements.

Patient Safety

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

Appropriate Medication Utilization

A. IEHP monitors pharmaceutical data to identify patient safety issues on an ongoing basis. Drug Utilization Review (DUR) is a structured, ongoing program that evaluates, analyzes, and interprets drug usage against predetermined standards and undertakes actions to obtain improvements. The DUR process is designed to assist pharmacists in identifying potential drug related problems by assessing patterns of medication usage. The goal of the DUR process is to identify potential drug-to-drug interactions, over-utilization and under-utilization patterns, high/low dosage alerts, duplication of medications, and other critical elements that can affect patient safety. The DUR study data is collected via an administrative data extraction of paid pharmaceutical claims. Actual prescribing patterns of PCPs, Behavioral Health

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[49] CCI Three-Way Contract September 2019, Section 2.16

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Practitioners, and Specialists are compared to IEHP standards. The results of the quantitative analysis are presented to IEHP's Pharmacy and Therapeutics (P&T) Subcommittee and QM Committee for discussion and action, as necessary.

Review of Inpatient Admissions

A. IEHP considers the quality of care in the hospitals to be a top priority. To ensure Member safety, IEHP assesses, tracks, and reviews the following measures:

1. Bed Day/Readmission Reporting;

2. Length of stay reports;

3. Provider Preventable Conditions (PPCs);

4. Inappropriate discharges from inpatient settings; and

5. Potential Quality Incidents (PQI) referrals for any adverse outcome related to an inpatient stay.

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

Potential Quality Incidents (PQI) Review

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

Facility Site Review (FSR)

A. IEHP requires all PCPs undergo a full Facility Site Review (FSR) at the time of signing with the Plan and at least every three (3) years thereafter. The purpose of these reviews is to meet the IEHP's quality improvement standards and ensure compliance with applicable local, state, and federal laws and regulations. These site reviews are conducted as a part of the initial

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Provider credentialing process. Additional site reviews are conducted as part of the ongoing Provider re-credentialing process to ensure that each Provider continues to meet the IEHP's site review standards. These are done at least every three (3) years and more often if IEHP has identified any quality of care concerns with the site. A Certified Site Reviewer (CSR), utilizing a combined Site and Medical Record Review survey tools to complete the site audits. Focused site visits or Physical Accessibility Review Surveys are conducted if a Member complaint is received about the quality of a Practitioner's office related to physical accessibility, physical appearance, safety, room space, availability of appointments, and adequacy of record keeping or any other issue that could impede quality of care. Sites will be reevaluated after six (6) months to validate if the deficiencies have been resolved. The Credentialing Subcommittee and QM Committee review the results of the FSR audits.

1. Physical Accessibility Review Survey (PARS)

   IEHP participates in the California FSR collaborative audits, which includes the PARS audit. The purpose of the PARS is to assess the physical accessibility and safety of provider sites using a set of standards established by the Department of Health Care Services (DHCS). PARS are performed on all PCP and high-volume Specialty Care Practitioners (SCP), ancillary provider sites, and other Community Based Adult Services (CBAS) centers. The goal of the PARS review is to ensure provider sites that are seeing Members with disabilities do not have any limitations as Members try to get access to the offices. A PARS audit covers a number of different areas including assessment of parking, office exteriors and interiors, elevators, restrooms, examination rooms, and examination tables.

Promoting Safety Practices for Members

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

Addressing Cultural and Linguistic Needs of Members[50]

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[50] NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 6.

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

1. **Provider Language Competency Study**: The purpose of this study is to verify that the PCP, OB/GYN, and vision provider offices that inform IEHP that they have Spanish speaking office staff actually have those services available to Members.

2. **Cultural and Linguistic Study**: The purpose of the study is to identify the linguistic and ethnic diversity of IEHP's PCP and Member populations. More specifically, they assess the cultural, ethnic, racial, and linguistic needs of Members in accordance with NCQA standards.

3. **Ongoing monitoring of interpreter service use**: The purpose of this report is to monitor the top languages requested by the Members. IEHP offers face-to-face interpreter services for medical appointments to Members at no cost. The purpose is to provide Members with interpretation services and office excellence in service to Members/callers.

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

Delegation Oversight[51]

A. IEHP delegates certain utilization management, care management, credentialing/re-credentialing, and compliance activities to contracted Delegates that meet IEHP delegation requirements and comply with the most current National Committee for Quality Assurance (NCQA), Department of Health Care Services (DHCS) (when applicable) and IEHP standards. IEHP monitors Delegate performance in QM, UM, CM, credentialing and re-credentialing, compliance, and their implementation of related activities through Delegation Oversight activities.[52]

Auditing and Monitoring Activities:

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[51] NCQA, 20202019 HP Standards and Guidelines, QI 1, Element A, Factor 1.
[52] CCI Three-Way Contract September 2019, Sections 2.2 & 2.16.

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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 notification, overturn rate; and

   d. Provider Satisfaction Surveys.

5. Member Contracted IPAs are required to submit the following information to the IEHP Provider Services Department:

   a. Utilization Management (UM) Trend Report – Monthly report of utilization data;

   b. Referral Universe and Letters – Monthly report of all approvals, denials and modifications of requested services;

   c. Care Management (CM) Log – Monthly report of CM activities;

   d. Second Opinion Tracking Log – Monthly report to track Member requested second opinions;

   e. Credentialing Activity – Periodic report of any changes to the network at the Delegate level (e.g., terminated PCPs, specialists);

   f. Annual QM and UM Program Descriptions;

   g. Annual QM/QI and UM Work Plans;

   h. Semi-annual reports of quality improvement activities;

   i. Semi-annual reports of credentialing/re-credentialing;

   j. Semi-annual reports of utilization management activities; and

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k. Annual QM and UM Program Evaluations.[53]

6. IPAs and Health Plans with trends of deficient scoring must submit a CAP to remedy any deficiencies. If an IPA is unable to meet performance requirements, IEHP may implement further remediation action including but not limited to:

   a. Conduct a focused re-audit;

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

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

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

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

   f. Not renew the contract.

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

8. **Pre-contractual Assessment of Providers**: 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.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	September 1, 1999
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2021

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[53] CCI Three-Way Contract September 2019, Section 2.16.

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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 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 and Vision

A. The mission of IEHP is to organize and improve the delivery of quality, accessible and wellness-based healthcare services for our community. The organization prides itself on six (6) core values:

1. *Health and Quality before Costs:* We believe in placing Member's health care needs above all else.

2. *Team Culture:* We are a dedicated and cohesive team focused on Member care and supporting our Providers.

3. *Think and Work LEAN:* We strive to continuously improve our daily operations and delivery of health care services.

4. *Partner with Providers, Members, and the Community:* We recognize the necessity of a strong working relationship with our Providers, Members, and the Community based on mutual respect and collaboration.

5. *Stewardship of Public Funds:* We are accountable to the public and strive for transparency and prudent fiscal management.

6. *Foster Innovation:* We are thinking about the future of health care in terms of digital access, use of data, creative initiatives and other innovations that will improve the lives of our Members, Providers, the Community, and our Team Members.

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]

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[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.

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

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

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

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

F. Providers, First Tier Entities, Downstream Entities, and Contractors with IEHP will comply with Federal and California State laws in regards 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 potential fraudulent activities that may occur in IEHP daily operations, both internally and externally.

Definitions

A. First Tier Entity: Any party that enters into 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 into 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 thereof 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, 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; 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 and physician grievances;

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D.   Fraud, Waste and Abuse Program Description

    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, 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.

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2. Training staff, on IEHP 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 MC_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

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[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.

immediately. Affiliated Providers' employees, managers, and contractors are to report concerns to their immediate supervisor when appropriate.

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

1. By Mail to: IEHP Compliance Officer
   Inland Empire Health Plan
   P.O. Box 1800
   Rancho Cucamonga, CA 91729-1800

2. By E-mail to: compliance@iehp.org

3. By toll free number: (866) 355-9038 (Compliance Hotline)

4. By fax to: (909) 477-8536

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

C. The following information is needed in order 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. Where the suspected fraud may have occurred.

4. Details on the suspected activity.

5. When the suspected fraud took place, for example over what period of time.

6. A description of any documentation in your possession that may support the allegation of fraud, waste and/or abuse.

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

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

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1999
Chief Title: Chief Executive Officer	**Revision Date:**	January 1, 2021

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E.   Compliance Program Description

Introduction

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

Mission, Vision and Values

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

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

C. Values: We do the right thing by:

1. Placing our Members at the center of our universe.

2. Unleashing our creativity and courage to improve health & well-being.

3. Bringing focus and accountability to our work.

4. Never wavering in our commitment to our Members, Providers, Partners, and each other.

Compliance Program Scope

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

B. The Compliance Program must include:

1. Standards of conduct, policies and procedures to support and sustain Compliance Program objectives.

2. Be overseen by the Board 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 and applicable regulatory agencies.

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[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.

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E. Compliance Program Description

4. Screening of employees, Board Members, business associates, FDRs, and other affiliated individuals/entities for the presence/absence of program- related adverse actions and/or sanctions.

5. Education and training: General training on health care regulatory requirements; specific training on job functions; and training to business associates, FDRs 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 have 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 Vendor 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 Vendor 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;

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E.   Compliance Program Description

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 FDRs 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. 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

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E.   Compliance Program Description

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

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

   Training should include, at a minimum:

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

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

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

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

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

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

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

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

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

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

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

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

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

Effective Lines of Communication

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

1. Provider Manuals, newsletters and bulletins. Providers and Delegated entities are required to submit signed acknowledgement of their receipt of the Provider Manual which delineates compliance reporting responsibilities;

2. Annual Compliance training for all FDRs; and

3. The IEHP Code of Business Conduct and Ethics (See Attachment, "IEHP Code of Business Conduct and Ethics" in Section 23).

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

1. Compliance Hotline - (866) 355-9038;

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. 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:

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E.   Compliance Program Description

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 responsibility 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.[6,7]

   2.   Prior to hiring or contracting and monthly thereafter a monthly review of the GSA System for Award Management (SAM).

   3.   A monthly review of the Department of Health Care Services Medi-Cal Suspended and Ineligible list and Centers for Medicare and Medicaid Services Preclusion List.

   4.   Criminal record checks when appropriate or as required by law.

   5.   Standard reference checks, including credit for Employees.

   6.   Review of the National Practitioner Databank (NPDB).

   7.   Review of professional license status for sanctions and/or adverse actions.

   8.   Reporting results to Compliance Committee, Governing Body, and IEHP as necessary.

Procedures and System for Prompt Response to Compliance Issues

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[6] (OIG) List of Excluded Individuals and Entities (LEIE).
[7] Scope and Effect of Exclusion 42 CFR § 1001.1901.

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E. Compliance Program Description

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.

Assessment of Compliance Effectiveness

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

1. Written Policies and Procedures and Standards of Conduct;

2. Designation of a Compliance Officer and High-Level Oversight;

3. Effective Lines of Communication;

4. Well Publicized Disciplinary Standards;

5. Ongoing Education and Training;

6. Effective System for Routing Auditing, Monitoring, and Identification of Compliance Risks; and

7. Reporting and Prompt Response for Non-Compliance, Potential FWA, and Detected Offenses.

INLAND EMPIRE HEALTH PLAN			
Chief Approval: *Signature on file*	**Original Effective Date:**		July 1, 2015
Chief Title: Chief Executive Officer	**Revision Date:**		January 1, 2021

24. PROGRAM DESCRIPTIONS

F. Health Homes Program Description

Introduction

The Inland Empire Health Plan's (IEHP) Health Homes Program (HHP) 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 Primary Care Provider (PCP). This integrated care team, known as the Community-Based Care Management Entity (CB-CME) provides an intensive set of services for a subset of Medi-Cal Members, who require coordination of care at the highest levels.

The HHP 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 HHP service delivery model encompasses a person-centered, comprehensive approach to addressing the Member's goals for improvement and management of behavioral and physical health, acute care, and social needs. The CB-CMEs will address the Members' health needs by delivering some health and behavioral health care services, coordinating with the PCP team, coordinating with community-based organizations (CBOs) and housing agencies, and/or by referring to other resources within the community.

Organizational Model

IEHP's HHP is structured as a health home network functioning as a team to provide care coordination. This network includes the health plan, a network of CB-CMEs, and other CBOs to provide linkages to community and social support services, as needed. Improving Member outcomes and reducing healthcare costs will be accomplished through the partnership between IEHP and its CB-CMEs.

IEHP is responsible for the development, implementation and distribution of requirements for the HHP services and related activities to contracted CB-CMEs. IEHP does not delegate HHP-related managed care plan responsibilities. IEHP provides this policy as guidance for its CB-CMEs, who must develop and implement processes that comply with these requirements. Through its Delegation Oversight process, IEHP monitors the performance of its CB-CMEs to ensure compliance with HHP requirements throughout its network.

Health Plan Responsibilities

IEHP will be responsible for the overall administration of the HHP. This includes but is not limited to:[1]

A. Qualifying, training, and supporting CB-CMEs to provide HHP services;

B. Supporting CB-CMEs by providing them with access to information on admissions and discharges and ensuring timely follow-up care;

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[1] Department of Health Care Services (DHCS) Medi-Cal Health Homes Program (HHP) Guide November 2019, Medi-Cal Managed Care Plan Responsibilities

C. Creating systems which provide meaningful, actionable data with information of complex Members, care gaps and other pertinent data to which the health plan has access;

D. Providing information on housing options for Members who are experiencing homelessness; and

E. Performing regular auditing and monitoring activities to ensure that all HHP care management requirements are completed.

IEHP will also be responsible for performing these duties through all available methods:[2]

A. Attributing assigned HHP Members to CB-CMEs;

B. Certifying, selecting and subcontracting with CB-CMEs for the provision of HHP services and ensuring that these entities fulfill all required CB-CME duties and achieve program goals;

C. Notifying the CB-CMEs of inpatient admissions and emergency department (ED) visits and discharges;

D. Tracking and sharing data with CB-CMEs regarding each Member's health history;

E. Tracking quality measures and state-specific measures, as required by the Centers for Medicare and Medicaid Services (CMS);

F. Collecting, analyzing, and reporting financial measures, health status and other measures and outcome data;

G. Providing Member resources relating to HHP;

H. Ensuring that Members receive assistance with HHP-related inquiries through its Member Services and after-hours Nurse Advice Line;

I. Dispersing funds to CB-CMEs in accordance with the contractual agreement made between the health plan and the CB-CME;

J. Establishing and maintaining a data-sharing agreement with other Providers, with whom the health plan shares HHP Member health information, that is compliant with all federal and state laws and regulations;

K. Developing systems to ensure access to timely services for HHP Members, including seeing HHP Members after discharge from an acute stay;

L. Encouraging participation by HHP Members' contracted Providers, who are not included formally on the CB-CME's multidisciplinary care team, but are responsible for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the Member's Health Action Plan;

M. Developing CB-CME training tools and reporting capabilities; and

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[2] DHCS Medi-Cal HHP Guide November 2019, Duties

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F. Health Homes Program Description

N. Having strong oversight and performing regular auditing and monitoring activities to ensure that all care management requirements are completed.

CB-CME Responsibilities

A Health Homes CB-CME is the central point for coordinating, collaborating and ensuring communication amongst all relevant parties engaged in the delivery of each Member's care. Specifically, a Health Homes CB-CME is responsible for delivering six (6) core services:[3]

A. Comprehensive Care Management;

B. Care Coordination;

C. Health Promotion;

D. Comprehensive Transitional Care;

E. Individual and Family Support Services; and

F. Referral to Community and Social Supports.

The overarching goals include:

A. Improving physical health and behavioral health outcomes;

B. Preventing avoidable hospital admissions and readmissions;

C. Preventing unnecessary emergency room visits;

D. Providing timely post-discharge follow-up; and

E. Decreasing the overall Medi-Cal cost for the individuals meeting eligibility criteria.

A CB-CME consists of an interdisciplinary team made up of a Registered Nurse (RN) care manager, a Care Coordinator/Housing Navigator, a Behavioral Health care manager and a Community Health Worker in conjunction with the Member, the Member's PCP and others the Member identifies. The CB-CME team uses a team-based, person-centered approach, where staff collectively use their skills and knowledge, to ensure that culturally and linguistically competent evidence-based services and supports are employed to address the overall health and wellness of each Member. Each Member should be actively involved with the CB-CME team in setting goals and participating in his/her care planning. The Member's voice and choice should drive service needs to be addressed within the written Health Action Plan, or Shared Care Plan as it is called within IEHP.

Program Participation

A. **Program Service Area**

Implementation of the Health Homes Program will be across IEHP's geographic service area.

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[3] DHCS Medi-Cal HHP Guide November 2019, Health Home Program Services

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F. Health Homes Program Description

B. **Member Eligibility and Identification**

The Department of Health Care Services (DHCS) will provide IEHP with a list of HHP eligible Members through a Targeted Engagement List (TEL).[4] IEHP will screen and validate the list for accuracy and will flag and remove any Member that is already involved in a program that excludes them from participation in the HHP (see below for exclusion criteria). In addition, IEHP will scan its Membership to identify potential HHP eligible Members who are not on the DHCS TEL. The final list will be called the HHP Universe.

To receive Health Homes services, an individual must meet the following:[5]

Eligibility Requirement	Criteria Details
1. Meets at least one chronic condition criteria	• **At least two (2) of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR • **Hypertension and one (1) of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR • **One (1) of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR • **Asthma**
2. Meets at least one (1) acuity/ complexity criteria	• At least three (3) or more of the HHP eligible chronic conditions; OR • At least one (1) inpatient hospital stay in the last year; OR • Three (3) or more emergency department visits in the last year; OR • Chronic homelessness.

IEHP recognizes that Members, Providers and community partners may identify Members, who may benefit from the HHP. Therefore, IEHP will also accept referrals from Providers, Member themselves or any other source to be evaluated for eligibility into the HHP.

C. **Member Exclusions**

Individual Members identified through IEHP's data analysis to be receiving services that are duplicative of HHP services will be excluded. Members also determined to have duplication of services per self-reported information or otherwise not appropriate for HHP will be

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[4] DHCS Medi-Cal HHP Guide November 2019, HHP Eligibility Criteria and the Targeted Engagement List
[5] Ibid.

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identified and excluded during the program review and consent process conducted by the CB-CME.[6]

D.   Member Risk Grouping

IEHP will process the final list of HHP eligible Members, also known as the HHP Universe, through a predictive algorithm that is based upon the Member's service utilization, health conditions, healthcare cost and other predictive risk scores.[7]   This algorithm results in determining three (3) levels of care needs or tiers:

1. Tier 1 will include Members that are highest or most complex and are identified as the priority engagement group for initial focus for outreach once attributed to their CB-CME;[8]

2. Tier 2 will include Members who are moderate or rising risk; and

3. Tier 3 will include Members at the lowest risk.

IEHP will prioritize Members after the administration of the Comprehensive Health Assessment (CHA) by the CB-CME.   Reprioritizing will consider additional elements including medical complexity, medication complexity, co-morbid behavioral health conditions, housing stability and other social determinants of health.

E.   Member Notification

All IEHP Membership will receive initial and ongoing notification of the HHP benefit.

F.   Member Outreach and Engagement

1. Initial Outreach and Engagement

    Over a period of ninety (90) days, Members determined to be eligible for the HHP will be contacted to provide information about the HHP, based on a prioritized tiered approach and using a range of evidence-based and/or best practice outreach and engagement strategies.   In accordance with DHCS and CMS requirements, potentially eligible Members are given the opportunity to voluntarily consent to engage/enroll or decline to participate in HHP.[9]

2. Ongoing Engagement

    Members eligible for the HHP will require not only initial outreach to engage but ongoing outreach if their interactions with the CB-CME decrease beyond what is recommended in the Health Action Plan (HAP)/Shared Care Plan (SCP). Member engagement is the foundation to success for all other HHP services. The traditional hierarchal approach to health care has not proven to be effective with Members who have complex needs. Thus, effective CB-CMEs will recognize that:

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[6] DHCS Medi-Cal HHP Guide November 2019, General HHP Operations
[7] DHCS Medi-Cal HHP Guide November 2019, Risk Grouping
[8] DHCS Medi-Cal HHP Guide November 2019, Priority Engagement Group
[9] DHCS Medi-Cal HHP Guide November 2019, Section VI, Consent

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a. While Members eligible for HHP have, by definition, had interactions with the health care system, those interactions have not led to improved health outcomes. Thus, the goal of the CB-CME must be engagement, not just interaction with Members.

b. A trusting relationship between the Member and their care team must exist for Members to routinely engage with the care team and, more importantly, their own health.

c. Evidence demonstrates that a person-centered approach to engagement, which is based on the Member's strengths, needs, values, and preferences, leads to trusting relationships, Member's confidence to manage their own health, improved health outcomes, and decreased dependence on episodic care.

d. Trusting relationships occur over time. Thus, engagement strategies are ongoing throughout the Member's enrollment in the HHP.

G. **Transition to Lower Level of Care/Disenrollment**

In order to ensure that HHP resources are being deployed to appropriate individuals, IEHP will utilize the following criteria to transition Members out of the CB-CME to a lower level of care and disenrollment from HHP:[10]

1. HHP Members, who have demonstrated improvement in their conditions such that their outcomes demonstrate that they are well-managed and have remained out of the hospital and/or emergency department for a period of three (3) months;

2. Members, who have been contacted for a continuous period of three (3) months but are unreachable;

3. HHP Members, who no longer wish to participate in the program; or

4. HHP Members, who opt into other programs, which then exclude them from receiving HHP services.

Six (6) Core HHP Services

IEHP's HHP will arrange for and coordinate the interventions that address the medical, social, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices available to HHP Members through these core HHP services:[11]

A. **Comprehensive Care Management**

The CB-CME team will collaborate with each other and external partners to provide comprehensive care management services to address each Member's health conditions and well-being. The goal is to maximize health status, functionality, and management of chronic health conditions by arranging for and coordinating necessary interventions to address gaps and goals. Comprehensive Care Management consists of:

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[10] DHCS Medi-Cal HHP Guide November 2019, Disenrollment
[11] DHCS Medi-Cal HHP Guide November 2019, HHP Services

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1. Engaging the Member in HHP and in assessing readiness for and promotion of self-management skill development;

2. Completing a comprehensive health assessment to identify the Members' physical, mental health, substance use, dental, palliative and social service needs including trauma informed care, health literacy and cultural preferences;

3. Development of a Shared Care Plan/Health Action Plan, in partnership with each Member that includes:

   a. The results of the comprehensive health assessment;

   b. Individualized goals agreed upon by the Member and identified by through the complex health assessment with time-frames and strategies for addressing each; and

   c. Tracking and follow up of referrals.

4. Conducting systematic, planned activities to ensure that all engaged HHP Members are assessed to identify risk level and then appropriate level of interventions aligned with their risk level;

5. Employing evidence-based engagement strategies to increase Member's involvement and ownership of their health outcomes and social well-being;

6. Identification of homelessness or housing instability and referral to appropriate supports;

7. Monitoring ongoing progress and health status of all engaged HHP Members and using all CB-CME team members in taking appropriate actions to address identified service needs;

8. Development of partnerships with providers and other community supports, particularly housing supports; and

9. Development and dissemination of reports to include but not be limited to care management process, Member and population health outcomes, Member engagement, experience, service utilization and cost metrics.

B. **Care Coordination**

Care coordination is the implementation of the Member's person-centered goals and objectives as articulated in the Shared Care Plan/Health Action Plan through appropriate linkages, referrals, coordination and follow-up. Care coordination may involve but is not limited to:

1. Member support to implement their care plan and attain their goals;

2. Navigating health care needs and social service supports;

3. Monitoring and supporting treatment and medication adherence;

4. Identifying barriers to adherence;

5. Appointment reminders and accompanying Members to appointments as needed;

6. Encouraging self-management and ongoing engagement in the HHP;

7. Tracking and monitoring referrals and follow-up;

8. Facilitating communication and information sharing across all health care providers and involved parties in the Member's care;

9. Maintain frequent contacts and interventions described in the overall care management policy and procedure to ensure right level and availability of staff and interventions for each of the three tiers in order to address and take action for each identified gap; and

10. Documentation of all attempts and contacts made.

C. **Health Promotion**

Health Promotion Services involves services to educate, encourage, and support Members to make lifestyle choices based on healthy behaviors. This service may include but is not limited to:

1. Providing health education to help the Member and family/support persons with self-monitoring and health management related to specific chronic conditions,

2. Linking the Member to health promotion activities, for example, nutrition, substance abuse prevention, smoking prevention and cessation and physical activity;

3. Connecting Members with peer and recovery supports including self-help, self-management and advocacy groups; and

4. Assisting the Member in symptom self-monitoring and self-management through motivation interviewing and behavioral activation method.

D. **Comprehensive Transitional Care**

Comprehensive Transitional Care includes services designed to ensure the coordination and continuity of health care as HHP Members transfer between different locations or levels of care including admissions and discharges. This includes:

1. Engaging the Member during admission, if possible;

2. Contacting the HHP Member following completed transition (hospital or ED discharge);

3. Providing medication information and reconciliation following discharge;

4. Scheduling timely follow-up visits with the appropriate health and community-based service providers after the completed transition;

5. Communication and coordination with all involved parties;

6. Planning appropriate care for post-discharge (including housing, transportation, or other social services);

7.   Re-assessing and updating the Member's Complex Health Assessment and Health Action Plan/Shared Care Plan; and

8.   Discussing the Member's understanding of rehabilitation activities, self-management, and other prevention techniques for avoidable readmissions.

E.   **Individual and Family Support Services**

Individual and Family Support Services are activities to ensure knowledge about the Member's condition to both the Member and their family and agreement with the overall goals for improving management of their condition(s). Services include:

1.   Assessing strengths and needs of the Member and family/support persons;

2.   Linking the HHP Member and family/support persons to peer supports and self-care programs to help them understand their condition and care plan;

3.   Promoting engagement of the HHP Member and family through shared decision-making;

4.   Maintaining a process for referring to other agencies, such as LTSS or behavioral health agencies, as appropriate;

5.   Identifying barriers to the Member's adherence to treatment and medication and advocate for the Member and family/support persons to identify and obtain resources needed to meet their goals;

6.   Accompanying Members to their clinical appointments if needed; and

7.   Evaluating ongoing needs for services.

F.   **Referral to Community and Social Support Services**

Referral to Community and Social Support Services includes the provision of referrals to a wide array of services that will help Members overcome access or service barriers, increase self-management skills and achieve overall health. Specifically, this activity involves determining appropriate services to meet the needs of the Members, as well as facilitating access to support and assistance for Members to address medical, behavioral, educational, social, and community issues that may impact overall health. This will also include following up with the HHP Member to ensure needed services are obtained. The types of community and social support services to which individuals will be referred may include, but are not limited to:

1.   Housing resources and individual housing transition services;

2.   Wellness programs, including smoking cessation, fitness, weight loss programs;

3.   Specialized support groups (i.e. cancer, diabetes support groups);

4.   Substance use recovery support groups;

5.   Supplemental Nutrition Assistance Program;

6. Legal assistance resources;

7. Faith-based organizations; and

8. Access to employment and educational program or training.

Housing

Housing instability and homelessness are core contributors to poor health outcomes and episodic health care. In order to address housing needs for Members enrolled in HHP, IEHP will assess for homelessness and depending on assessment results will offer two (2) service and support paths.[12]

A. **Housing Instability**

Members with housing instability will be identified and offered the following:

1. Identification of community resources for permanent and supportive housing and housing services and referral to these resources, inclusive of warm handoff;

2. Housing navigation such as linkages to homeless shelters;

3. Provision of referrals to Individual Housing Transition Services, including services that support an individual's ability to prepare for and transition to housing;

4. Provision of referrals to Individual Housing and Tenancy Sustaining Services, including services that support the individual in being a successful tenant in their housing arrangement and thus able to sustain tenancy; and

5. Individualized transitional support when Member is needing post-acute care.

B. **Active Homelessness**

Members who are actively homeless will be:

1. Referred to the IEHP Housing Initiative for formal assessment for both housing and tenancy support;

2. For Members that meet IEHP's Housing Initiative criteria and need tenancy support, IEHP will refer to its subcontractor for tenancy support; and

3. For Members who do not meet IEHP Housing Initiative criteria, CB-CME will assist members to submit an application through the Coordinated Entry System (CES) in either San Bernardino or Riverside counties.-

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[12] DHCS Medi-Cal HHP Program Guide November 2019, Housing Services

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Health Homes Program Network

A. **Community-Based Care Management Entities – Models 1, 2 and 3**

The IEHP HHP structure includes two (2) models of CB-CMEs throughout the network:[13]

1. Model 1 CB-CME

   a. Model 1 CB-CMEs will be embedded within practices that are identified through volume and heat map studies. The studies will indicate geographies within Riverside and San Bernardino with the highest volume of HHP eligible Members and highest volume practices serving HHP eligible Members.   Written solicitations, townhall meetings, webinars, and one-on-one conversations are conducted to assure readiness and secure contracted agreements for these Model 1 CB-CMEs within the provider network.

   b. The Model 1 CB-CME team will be employed by the practice and in some settings, roles may be modified or combined for efficiencies and to meet the unique needs of the CB-CME and the Members they serve.

2. Model 2CB-CME

   a. Model2 teams are IEHP-staffed CB-CMEs that are located within communities where each CB-CME care team supports an average of three (3) PCPs within a designated geographically proximate area. These providers do not have the patient volume to merit their own embedded CB-CME or the Provider does not choose to build their own CB-CME.   IEHP chooses not to use a subcontractor to serve as the CB-CME for these practices.   Additional Model 2 CB-CME care teams will be rolled out as demand and capacity require and their location is driven by high Member volume geographies.

B. **Team-Based Approach**

The HHP uses a team-based approach to deliver the six core services (see Section 3 – Health Homes Program Services) provided by a CB-CME. The CB-CME team includes an HHP Director, Clinical Consultant (PCPs served by the CB-CME), a Nurse Care Manager, a Behavioral Health Care Manager, a Care Coordinator/Housing Navigator, and a Community Health Worker. The CB-CME may add additional staff to the team (e.g. pharmacist; dietician) to meet HHP Members' needs. The table below describes the roles, functions and minimum credentials of required CB-CME team members.[14]

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[13] DHCS Medi-Cal HHP Program Guide November 2019, Organizational Model
[14] DHCS Medi-Cal HHP Program Guide November 2019, Staffing.

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Team Member Role	Minimum Credentials	High-Level Description of Role
Health Homes Program Director	Bachelor's level education in a health-related field preferred. This role may be filled by a portion of time of another HHP team role (i.e., RN Care Manager)	• Provides operational oversight and guidance to the CB-CME teams (may be overseeing multiple CB-CME teams); • Responsible for programmatic evaluation of quality measures and team efficiency; • Coaches and informs team members on HHP services, practice guidelines and comprehensive person-centered care planning with special attention to health and wellness; • Builds partnerships and agreements with primary care and other community-based providers to facilitate delivery of effective team-based care; • Ensures compliance and oversees new development of HHP policies, protocols and processes which support optimal functioning of the CB-CME team; and • Monitors and maintains the HHP's compliance with all applicable federal and state laws, rules and regulations.
Registered Nurse Care Manager (RNCM)	Registered Nurse with three (3) or more years of care management experience in a health care delivery setting. Experience in a Health Care Organization or experience in Managed Care setting preferred.	• Responsible for primarily working with a caseload of Members with complex medical needs (primarily Tier 1); • Engages Members and supports/encourages Member activation towards achievement of health goals; • Responsible for promoting a collaborative and effective working environment within the CB-CME by engaging in evidenced-based communication strategies (such as Motivational Interviewing) when discussing responsibility/sharing of tasks, effectively resolving conflicts as they arise, and collaborating on Member case discussions; • Tracks medical and behavioral health outcome measures in the web-based care management platform or equivalent platform;

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Team Member Role	Minimum Credentials	High-Level Description of Role
		• Provides Member and family education about chronic medical and behavioral health conditions to improve health literacy; • Gathers input from other CB-CME team members to prioritize Member cases for systematic population/caseload review; • Facilitates and ensures recommendations are communicated across the health care team; • Works with Members to identify health/wellness goals, and incorporates these goals into Health Action Plans/Shared Care Plan that facilitate communication among Members and Providers; • Champions healthy lifestyle changes; • Coordinates physical care management and care coordination relationships with external healthcare Providers; • Consults with the CB-CME team members about clinical concerns or questions, and provides educational training on chronic disease states, prevention, treatment, medications and healthy living; • Ensures smooth transitions of care, coordination with hospitals regarding Member admission/ discharges; • Conducts medication reconciliations with input from the Member's PCP/clinical consultant; • Tracks and assures required assessments and screenings are performed, including Complex Health Assessment and Health Action Plan/Shared Care Plan; and • Leads development and implementation of a Shared Care Plan/Health Action Plan.
Behavioral Health Care Manager (BHCM)	Licensed clinical social worker or Marriage and Family Therapist, or Master's Level Social Worker or Marriage and Family	• Responsible for primarily working with a caseload of Members with behavioral health needs (may be Tier 1 or 2); • Responsible for utilizing brief behavioral health therapeutic interventions as necessary to improve the Member's ability to manage their own health;

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Team Member Role	Minimum Credentials	High-Level Description of Role
	Therapist getting hours toward licensure, or other licensed behavioral health care professional. Three (3) or more years of care management experience in a health care delivery setting. Experience in a Health Care Organization or experience in Managed Care setting preferred.	• Responsible for brief crisis interventions and warm hand-offs to local crisis resources as needed to address behavioral health needs; • Provides Member and family education about chronic medical and behavioral health conditions to improve health literacy; • Provides formal and informal training and support for HHP Members on behavioral health conditions, including treatments and evidence-base for treatment; • Assists with the coordination of medical and behavioral health access issues with PCP offices, specialists, and ancillary services; • Tracks medical and behavioral health outcome measures in a patient registry; • Ensures smooth transitions of care, coordination with psychiatric hospitals regarding client admission/discharges; • Collaborates on Member care issues with other CB-CME team, participating in weekly systematic case reviews and ad hoc case reviews; • Works with Members to identify health/wellness goals, and incorporates these goals into the Member's Health Action Plan/Shared Care Plan that facilitate communication among Members and Providers; • Responsible for ongoing engagement with Members, both in-person and on the phone, in a manner that utilizes evidence-based approaches (such as Motivational Interviewing) that promotes collaboration between the Member and his or her medical/behavioral team, as well as to increase the Member's sense of control over their whole health; and • Provides consultation for all members of the team when discussing tasks of a clinical nature.

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Team Member Role	Minimum Credentials	High-Level Description of Role
Care Coordinator (CC)/Housing Navigator	Paraprofessional High school diploma or equivalent. Certified medical assistant, nursing assistant, or Associate or Bachelor's.	• Provides on-going monitoring of the TEL; • Assigns Members to the appropriate CB-CME team members based on risk category and available clinical data for HHP engagement activities; • Responsible for primarily working with a caseload of Members identified as being low risk (Tier 3); • Forms and fosters relationships with housing agencies and permanent housing providers, including supportive housing providers; • Partners with housing agencies and providers to offer the HHP Member permanent, independent housing options, including supportive housing; • Connects and assists the HHP Member to get available permanent housing; • Conducts periodic telephonic outreach and follow-up to low-risk HHP Members as outlined on the Health Action Plan/Shared Care Plan; • Supports RN Care Manager, BH Care Manager and Community Health Worker with delegated tasks; • Assists in the coordination of appointments and referrals for physical and behavioral health appointments; • Collaborates on Member care issues with other CB-CME team, participating in weekly systematic case reviews and ad hoc case reviews, and consults with Registered Nurse Care Manager and/or the Behavioral Health Care Manager before taking any action that is clinical in nature; • Connects HHP Member to other social services and supports he/she may need; • Uses relationship-based strategies to engage Members in care as well as motivational interviewing;

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Team Member Role	Minimum Credentials	High-Level Description of Role
		• Assists with arrangements such as transportation, directions and completion of durable medical equipment requests; and • Coordinates with HHP Member in the most easily accessible setting, within IEHP guidelines (e.g. could be patient home, provider or regional office, or other setting).
Community Health Worker (CHW)	Paraprofessional or peer advocate High school diploma Certificate as a CHW or at least two (2) years of experience as a CHW, Promotora, or health navigator	• Assists the RN Care Manager, BH Care Manager and Care Coordinator in panel management by performing delegated activities as assigned; • Assists CB-CME team in engagement efforts of eligible HHP Members; • Assists Members in navigating the healthcare system; • Follows up by phone and in person with eligible HHP Members, helping Members successfully participate in their medical and/or behavioral health care by overcoming barriers to care, and sharing information on barriers with the multi-disciplinary team and providers; • Responsible for engaging with Members, both in-person and on the phone, in a manner that utilizes evidence-based approaches (such as Motivational Interviewing) that promotes collaboration between the Member and his or her medical/behavioral team, as well as to increase the Member's sense of control over their whole health; • Collaborates on Member care issues with other CB-CME team members, participating in weekly systematic case reviews and ad hoc case reviews, and consults with Registered Nurse Care Manager and/or the Behavioral Health Care Manager before taking any action that is clinical in nature; • Accompanies HHP Member to office visits, as needed, and in the most easily accessible setting, within IEHP guidelines; • Distributes health promotion materials;

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Team Member Role	Minimum Credentials	High-Level Description of Role
		• Assists with scheduling Member with other CB-CME team members and care team as appropriate; • Connects HHP Member to other social services and supports he/she may need; • Advocates on behalf of Members with health care professionals; and • Monitors treatment adherence (including medication and HAP/SCP goals).
Clinical Consultant	Clinician consultant(s), who may be primary care provider, psychiatrist or psychiatric Nurse Practitioner.	• Responsible for assisting Members with clinical/medical needs and providing support to non-licensed members on the CB-CME as needed; • Reviews, informs and provides clinical guidance for Member's Health Action Plan/Shared Care Plan development as requested; • Facilitates access to primary care and behavioral health providers, as needed to assist the CB-CME Care Coordinator; • Assists Members in goal setting, education and skills training to facilitate disease self-management and increased health knowledge; • Responsible for utilizing brief medical interventions as necessary to improve the Member's ability to manage their own health; • Champions practice transformation and comprehensive person-centered care with special attention to health and wellness; • Consults with Registered Nurse Care Managers, Care Coordinators and other CB-CME team members as appropriate, regarding specific health and wellness concerns of individual enrollees; and • Collaborates on Member care issues with other CB-CME team, participating in weekly and ad hoc case review meetings, and providing clinical consultation to the CB-CME team and PCP; and

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Team Member Role	Minimum Credentials	High-Level Description of Role
		• Participates in team meetings with CB-CME team members as appropriate.

C. Staffing Ratio

The aggregate minimum care coordinator ratio requirement is 60:1 for the entire enrolled population.[15] The following table illustrates the staffing ratios and estimated caseloads.

Model	Program Staff	Caseload

1	1 CB-CME Team:
	• 1 RNCM
	• 1 BHCM
	• 1 CC
	• 1 CHW
		1 team: 200 Members actively managed
		• It is estimated that after two (2) years:
		  o Tier 1 is approximately 20% of HHP population (40 Members);
		  o Tier 2 is approximately 30% of HHP population (60 Members); and
		  o Tier 3 is approximately 50% of HHP population (100 Members).
		• RN care manager gets assigned a caseload of Members in all Tier levels, whose medical issues are the primary barrier to achieving goals defined in the shared care plan. RN CM ratio is 60:1.
		• BH care manager gets assigned a caseload of Members in all Tier levels, whose behavioral health issues are the primary barrier to achieving goals defined in the shared care plan. BH care manager ratio is 60:1.
		• CC gets assigned a caseload of Members from all Tier levels. CC ratio is 60:1.
		• CHW gets assigned a caseload of Members from all Tier levels. CHW ratio is 20:1.
		• Clinical Consultant will take on advisory role to the CB-CME team.

2	1 CB-CME Team:
	• 1 RNCM
	• 1 BHCM
	• 1 CC
	• 1 CHW
	HHP Director that may
		1 team: 200 Members actively managed
		• It is estimated that after two (2) years:
		  o Tier 1 is approximately 20% of HHP population (40 Members);
		  o Tier 2 is approximately 30% of HHP population (60 Members); and
		  o Tier 3 is approximately 50% of HHP population (100 Members).

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[15] DHCS Medi-Cal HHP Guide November 2019, Staffing.

Model	Program Staff	Caseload
	oversee several CB-CMEs in a geographical region.	• RN CM gets assigned a caseload of Members in all Tier levels, whose medical issues are the primary barrier to achieving goals defined in the shared care plan. RN CM ratio is 60:1. • BH CM gets assigned a caseload of Members in all Tier levels, whose behavioral health issues are the primary barrier to achieving goals defined in the shared care plan. BH CM ratio is 60:1. • CC gets assigned a caseload of Members from all Tier levels. CC ratio is 60:1. • CHW gets assigned a caseload of Members from all Tier levels. CHW ratio is 20:1. • Clinical Consultant will take on advisory role to the CB-CME team.

D. Health Information Technology (HIT)/Data Information Sharing

IEHP has developed HIT support tools and policies and procedures for the CB-CMEs to facilitate data and information sharing amongst the entire care team (including the Member, CB-CME, and IEHP) and pertaining to the provision of the six (6) core HHP services.[16] These tools include:

1. A web-based care management platform that facilitates Member stratification, care coordination, and care planning as a stand-alone tool or through integration with a CB-CME's electronic health record (EHR); and

2. IEHP Provider and Member portals to enhance and support data and information sharing practices.

Measuring and Reporting Health Homes Program Quality

IEHP will track Member activity and report on process and outcomes metrics, as required by DHCS. CB-CME Models 1 and 2 will collect needed process and outcome metrics through the web-based care management platform or equivalent platform and report to IEHP on a regular basis.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2019
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2021

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[16] DHCS Medi-Cal HHP Program Guide November 2019, Health Information Technology/Data