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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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#### A. Purpose:

The purpose of the QM Program is to provide operational direction 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 the need for new improvement strategies. The QM Program Description provides a written outline of quality improvement goals, objectives and structure.

#### B. Scope:

The QM Program is designed to improve all aspects of care received by IEHP Members in all health care settings by:

1. Assessing and monitoring the delivery and safety of care;
2. Assessing and monitoring behavioral health services health management programs provided to Members;
3. Supporting practitioners and providers to improve the safety of their practices;
4. Identifying opportunities for quality improvement initiatives;
5. Implementing and tracking quality improvement initiatives that will have the greatest impact on Members;
6. Measuring the effectiveness of interventions and using the results for future quality improvement planning;
7. Assessing and monitoring delivery and safety of care for Members with complex health needs and Seniors and Persons with Disabilities; and
8. Assessing and monitoring processes to ensure the Member's cultural and linguistic needs are being met.

#### C. Goals:

The primary goal of the QM Program is to continually monitor and improve the quality of care and services, and safety of clinical care delivered to IEHP Members. The overall program goals are to:

1. Identify clinical and service-related quality and patient safety issues, and develop and implement improvement plans;
2. Share the results of the initiatives to stimulate awareness and change;
3. Empower all staff to identify quality improvement opportunities and to work together to implement changes that improve the quality of all IEHP programs;
4. Implement quality programs designed to improve targeted health conditions;
5. Monitor over- and under-utilization and access to assure appropriate care;
6. Establish accurate quality improvement data to ensure program integrity;

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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7. Annually review the effectiveness of the QM Program and utilize the results to plan future initiatives; and
8. Identify quality improvement opportunities through internal and external audits, Member and provider feedback, and the evaluation of Member grievances and appeals.

#### D. Strategy:

The planning and implementation of annual QM Program activities follows an established process:

1. **Work Plan/Calendar** – Annually, the Quality Management Committee approves a QM Work Plan, which details the current year program initiatives to achieve established goals and objectives including the specific activities, methods, projected time frames for completion, and project leader for each initiative. The scope of the Work Plan incorporates the needs, input, and priorities of IEHP.

Work plan initiatives are either clinical or non-clinical and address the quality and safety of clinical care and quality of service. Initiatives include, but are not limited to, planned monitoring activities for previous initiatives, disease-specific interventions, special projects, quality improvement studies, and the annual evaluation of the QM Program. The Quality Management Committee oversees the prioritization and implementation of clinical and non-clinical Work Plan initiatives, respectively.

2. **Quality Improvement Initiatives**

- a. In general, quality improvement initiatives follow the process below:

- 1) Find a process to improve;
- 2) Organize a team that understands the process;
- 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;
- 7) Implement changes;
- 8) Evaluate the effect of changes; and
- 9) Maintain improvements and continue to improve the process.

- b. The following are the current IEHP Quality Improvement Activities that measure and monitor access to care:

- 1) Appointment Availability Studies;

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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- 2) Nurse Advice Line utilization;
- 3) Access to Behavioral Health Provider;and
- 4) Initial Health Assessment monitoring.
- c. The following are the current IEHP Quality Studies that measure and monitor provider and Member satisfaction:
  - 1) Consumer Assessment of Healthcare Providers and Systems (CAHPS);
  - 2) Provider Satisfaction Survey;
  - 3) Member Grievance Review;and
  - 4) Member satisfaction surveys (CCM and HM).
- d. The following are the current IEHP Quality Studies that evaluate preventive and chronic care, as well as coordination, collaboration, and patient safety:
  - 1) Healthcare Effectiveness Data and Information Set (HEDIS);
  - 2) Behavioral Health Studies;
  - 3) Coordination of Care Studies; and
  - 4) Patient Safety Studies.
- e. The following are the current IEHP Quality Studies that evaluate appropriate care for our Members with complex medical needs and Seniors and Persons with Disabilities:
  - 1) Complex case management annual evaluation;
  - 2) Disease management annual evaluation;
  - 3) Disease specific quality studies; and
  - 4) DHCS required SPD quality studies.
- f. The following are the current IEHP Quality Studies that evaluate our ability to serve a culturally and linguistically diverse membership:
  - 1) Annual provider language competency study;
  - 2) Annual cultural and linguistic study;
  - 3) Ongoing monitoring of interpreter service use; and
  - 4) Ongoing monitoring of grievances.
3. **Measurement Process** – 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

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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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.

4. **Data Collection** – The Healthcare Analytics and Reporting (HAR) Department is responsible for study design, barrier analysis and interpretation for all studies conducted for IEHP. HAR staff has sufficient expertise to support these efforts. Data is collected to quantify performance against targeted baselines, benchmarks, thresholds or indicators. Sources of data include, but are not limited to, medical records, claims data, utilization management activities, encounter data, grievance data, pharmaceutical utilization data, and access assessments. Data is quantified, analyzed, and interpreted to identify trends, variances, improvements, and improvement opportunities. Findings are reported to the Quality Management Committee.
5. **Communication and Feedback** – Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, mailings, and announcements.
  - a. Providers are educated regarding quality improvement initiatives via on-site quality visits, provider newsletter, specific mailings, and the IEHP website.
  - b. Specific performance feedback regarding actions or data is communicated to providers. General and measure-specific performance feedback are shared via special mailings, provider newsletter, and the IEHP website.
  - c. Feedback may include, but is not limited to:
    - 1) Listings of Members who need specific services or interventions;
    - 2) Clinical Practice Guideline recommended interventions;
    - 3) HEDIS and CAHPS results;
    - 4) Recognition for performance or contributions; and
    - 5) Discussions regarding the results of medical chart audits, grievances, appeals, referral patterns, utilization patterns, and compliance with contractual requirements.
  - d. Performance indicators are also used to identify quality issues. When identified, IEHP Quality Management staff investigates cases and determines the appropriate corrective action plans (CAP). IEHP Subcommittees review cases involving patient safety and quality of care issues, and recommend actions to the Quality Management Committee.

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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- e. 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.
- 6. **Annual Evaluation and Update of the QM Program:** On an annual basis IEHP evaluates the effectiveness and progress of the QM Program and Work Plan with updates as needed. A yearly summary of all completed and ongoing QM Program activities addresses quality and safety of clinical care and quality of service. The Evaluation documents evidence of improved health care or deficiencies, progress in improving safe clinical practices, status of studies initiated or completed, time lines, methodologies used, and follow-up mechanisms is reviewed by QM staff and the Chief Medical Officer (CMO).

The report includes pertinent results from QM Program studies, patient 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. Performance measures are trended over time and compared with established performance thresholds to determine service, safe clinical practices, and clinical care issues, with analysis of results, including barrier analysis, to verify improvements. The CMO presents the results to the QM Committee for comments, consideration of performance, suggested program adjustments, and revision of procedures or guidelines as necessary. Also included is a Work Plan and Calendar for the coming year. The Work Plan includes studies, surveys, and audits to be performed, compliance submissions, reports to be generated, and quality activities projected for completion.

The QM Program Description update and yearly QM Program Summary, Work Plan, and Calendar are presented to the Governing Board for review, approval, and 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. The status of follow-up activities is presented in subsequent Board meetings.

- 7. **Member Safety:** IEHP continuously monitors patient safety to support practitioners and providers in improving the safety of their practices.
  - a. **PCP Office** – This study assesses PCP compliance with IEHP and Department of Health Care Services (DHCS) standards for patient safety and identifies common areas of deficiency in physical facility accommodations and infection control practices throughout the IEHP network.

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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- b. **Hospital (In-patient)** – IEHP considers the quality of care in the hospitals to be a top priority. To ensure Member safety, IEHP assesses, tracks, and reports the following measures:
  - 1) Readmission reports;
  - 2) One day length of stay reports;
  - 3) Post-op wound infection referrals; and
  - 4) Quality of Care referrals for any adverse outcome related to an inpatient stay.
- c. **Medication Usage** – IEHP monitors pharmaceutical data to identify patient safety issues. 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 Study data is collected via an administrative data extraction of paid pharmaceutical claims. Actual prescribing performance of PCPs, behavioral health practitioners, and specialists is compared to IEHP standards. The results of the quantitative analysis are presented to IEHP’s Pharmacy and Therapeutics Subcommittee and QM Committee for discussion and action, as necessary.

### E. Monitoring Activities:

IEHP performs a series of activities to monitor PCP, specialists and Health Plan functions including:

- 1. Annual IPA Delegation Oversight Audit using a designated audit tool that is based on NCQA, DMHC and DHCS Standards;
- 2. Review of grievances and other quality information;
- 3. Specified audits:
  - a. Focused Approved and Denied Referral Audits;
  - b. Focused Case Management Audits;
  - c. Focused practitioner audits for clinical care;
  - d. Facility and Medical Record Reviews;
  - e. Utilization data review; and
  - f. Provider Satisfaction Surveys.

### F. 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. Compliance activities can be found in sections of manuals related to the specific

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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monitoring activity. The general process for obtaining compliance when deficiencies are noted, and CAPs are requested, is delineated in internal policies.

#### Structure

##### A. Authority and Responsibility:

Lines of authority originate with the Governing Board and extend to provider organizations and participating practitioners. Further details can be found in the IEHP organizational chart.

1. **IEHP Governing Board** – 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 Members from each County Board of Supervisors sit on the Governing Board that also includes three public Members selected from the two counties. The Governing Board is responsible for oversight of health care delivered by contracted Providers and Practitioners. The Board provides direction for the QM Program; evaluates QM Program effectiveness and progress; and evaluates and approves the annual QM Program Description and Work Plan. QM Committee reports delineating actions taken and improvements made are reported to the Board through the Chief Medical Officer.

The Board delegates responsibility for monitoring the quality of health care delivered to Members to the Chief Medical Officer and QM Committee with administrative processes and direction for the overall QM Program initiated through the Chief Medical Officer.

2. **Chief Executive Officer (CEO)** – Appointed by the Governing Board, the CEO has the overall responsibility for IEHP management and viability. Responsibilities include: IEHP direction, organization and operation; developing strategies for each department including the QM Program; Human Resources direction and 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.
3. **Chief Medical Officer** – The Chief Medical Officer (CMO) has ultimate responsibility for the quality of care and services delivered to Members, and is 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 Chief Medical Officer reports to the Chief Executive Officer (CEO) and Governing Board and, as Chairperson of the QM Committee and co-chair of various Subcommittees,

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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provides direction for internal and external QM Program functions, and supervision of IEHP staff.

The CMO participates in quality activities as necessary; provides oversight of IEHP delegated credentialing and recredentialing activities and approval of IEHP requirements for IEHP Direct providers; 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 incorporates quality outcomes into operational policies and procedures on a proactive basis.

The CMO provides direction to the QM Committee and associated Subcommittees; provides assistance 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 Officer with provider network development and contract design and product design; and works with the Chief Financial Officer to ensure that financial considerations do not influence the quality of health care administered to Members.

The CMO acts as primary liaison to regulatory and oversight agencies including the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid Services (CMS), NCQA, and others, with support from Medical Services staff as necessary.

### B. Organizational Structure and Resources:

IEHP has designated internal resources to facilitate the QM Program. The Organization Chart provides further details on support staff.

1. **Director of Healthcare Analytics** – The Healthcare Analytics Department operates under the direction of the Director of Healthcare Analytics who must possess a Masters degree in a related field with at least five (5) or more years experience in research and study design, implementation, and reporting. The Director of Healthcare Analytics is responsible for initiating, developing, implementing, and reporting on quality studies, demographic analysis, and other research projects. Principal accountabilities 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 for 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 Healthcare Analytics staff to ensure high productivity and high quality output; and working with other IEHP staff involved in research or study processes.

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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- a. **Healthcare Analytics Staff**– Staff support for the Director of Healthcare Analytics consists of a Healthcare Analytics Manager, Healthcare Analytics Supervisor, Technical Analysts, Business Analyst and Administrative Assistant.
2. **Director of Quality Management** – The Quality Management Department operates under the direction of the Director of QM who must possess a valid unrestricted Registered Nurse (RN) license issued by the State of California and a valid State of California driver’s license. The Director of QM must also possess five (5) or more years experience in a Quality Assurance Program with a Hospital or HMO. The Director of QM assists in developing, coordinating, and maintaining the QM Program and its related activities; oversees the quality process; and monitors for health care improvement. Activities include the ongoing assessment of Provider and practitioner compliance with IEHP requirements and standards including; medical record assessments, access and availability studies, monitoring Provider trends and report submissions, and oversight of facility inspections. The Director of QM monitors and evaluates the effectiveness of IPA QM systems. The Director of QM coordinates information for the annual QM Program Evaluation, Work Plan and Calendar; prepares audit results for presentation to the QM Committee, associated Subcommittees, and the Governing Board; and acts as liaison regarding medical issues for Providers, Practitioners, and Members.
  - a. **QM Program Staffing** – The Director of QM oversees staff consisting of an adequate number of Registered Nurses with the required qualifications to complete the full spectrum of responsibilities for QM Program development and implementation, QM Manager(s), QM Business Analyst, QM Coordinators and the Administrative Assistant.
3. **Director of Pharmaceutical Services** – The Pharmaceutical Services Department operates under the Director of Pharmaceutical Services, who 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 Director of Pharmaceutical Services is responsible for developing and overseeing the IEHP Pharmaceutical Services Program.
  - a. **Pharmaceutical Services Staff** – Staff support for the Director of Pharmaceutical Services consists of a Pharmacy Operations Manager, Pharmacy Program Specialist Supervisors, and Pharmacy Program Specialists who are responsible for performing all prior authorization activities. Clinical Pharmacist(s) also help support the Director of Pharmaceutical Services in all clinical projects.
4. **Medical Director** – Under the direction of the Chief Medical Officer, the

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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Medical Director is responsible for clinical oversight and management of the UM and Care Management (CM) Program activities and participates in QM functions. The Medical Director 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. Principal accountabilities include: developing and implementing medical policy for utilization and CM activities and QM functions; reviewing current medical practices ensuring that medical protocols 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 quality that equals or exceeds the standards for medical practice developed by IEHP and approved by DHCS and other regulatory entities.

5. **Medical Director-Direct** –The Medical Director-Direct is responsible for clinical oversight and management of the IEHP Direct utilization activities and case management; and participates in the quality management, grievance and credentialing functions. The Medical Director-Direct 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. Principal accountabilities include: developing and implementing medical policy for utilization activities for the Direct line of business; overseeing reporting and UM profiling of Direct physicians; and ensuring the appropriate and timely use of UM criteria and guidelines. The Medical Director-Direct actively participates in the QM Program for IEHP and its providers.
6. **Clinical Director of Behavioral Health** – The Behavioral Health Department operates under the direction of the Clinical Director of Behavioral Health who must be a Doctoral level psychologist licensed in the State of California with at least five (5) or more years' behavioral health administrative experience. Under the direction of the Chief Medical Officer, the Clinical Director of BH is responsible for clinical oversight and management of BH Program activities. Principal accountabilities for the BH Program include; clinical oversight and direction of the BH Program; developing and implementing clinical policy for BH activities; participation in IPA BH activities, as necessary; reviewing BH criteria to ensure that protocols and BH personnel of IEHP follow rules of conduct; and monitoring and oversight of BH activities performed by IEHP. The Clinical Director of BH oversees triage and referral decisions and is available to the LCSW to make final triage determinations. .
  - a. **BH Staffing** – The Clinical Director of BH oversees a BH unit consisting of an adequate number of BH Care Managers with the required qualifications to perform BH care management in a managed care environment. BH staff positions include Licensed Clinical Social Workers, Masters Level Social Workers and Bachelor Level Behavioral Health

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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Specialists. The required qualifications for BH care management staff positions consists of experience in BH care management, UM, Social Work, or other clinical quality improvement experience sufficient to oversee and assist with BH care management issues.

7. **Director of Utilization Management (UM)** – The Utilization Management Department operates under the direction of the Director of UM. The Director of UM works directly with contracted IPAs, practitioners, and hospitals to ensure coordinated, continuous cost effective quality health care for Members and serves as the primary IEHP liaison to IPAs, practitioners, and hospitals for UM support. The Director of UM develops procedures for admission and concurrent reviews, referrals conducted by IEHP UM staff, and integration with the CM Program. The Director of UM monitors delegated UM activities through annual Delegation Oversight Audits; review of IPA UM Program Descriptions, processes, and semi-annual/annual UM reports; evaluation of the effectiveness of Provider discharge planning systems for continuity of care; monitoring IPA denial logs for appropriateness of decisions; and the performance of Approved and Denied Referral Audits. The Director of UM and staff assist with improving Provider UM Programs where requested.
  - a. **UM Staffing** – The Director of Utilization Management oversees UM staff in performing UM activities. The required qualifications for UM staff positions may consist of experience in utilization management or care management in a managed care environment. Staff positions may include: prior authorization nurses, care managers, nurse auditors, UM Managers, Supervisors, and concurrent review nurses. UM staff includes Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), Social Workers, and UM Coordinators.
8. **Director of Care Management** - The Care Management Department operates under the direction of the Director of Care Management who must possess a Bachelor of Science Degree in Nursing or related health field, a Masters prepared in health field or related preferred, possess a valid and non-restricted registered nursing license with the State of California with at least five (5) or more years' experience in managing health care operation, HMO or Medical Group preferred. The Director of CM must also possess a valid California Drivers License and valid automobile insurance. The Director of CM is responsible for direct support to the Chief Medical Officer in managing the operation of the Care Management Department. In this capacity, the Director is responsible for a comprehensive and integrated outpatient Care Management program that includes wellness and care management components, such as California Children's Services, disease management, care coordination, and care management.
  - a. **CM Staffing** – The CM Staff consists of Care Managers, Care Management Coordinators, Transitions of Care Nurses and Social

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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Workers who are required to meet certain qualifications to perform CM in a managed care environment. The CM Staff facilitate access to specialists and therapies; advocate, inform, and educate beneficiaries; identify and facilitate access to community resources and social services; and triage beneficiary care needs.

9. **Director of Health Administration** – The Health Administration Department operates under the direction of the Director of Health Administration, who is responsible for direct support to the Chief Medical Officer in managing the operations of the Medical Services Department. In this capacity, the Director of Health Administration coordinates and/or manages activities that involve multiple divisions within Medical Services and coordinates operational planning activities. Under the direction of the Chief Medical Officer, the Director of Health Administration organizes and prepares written responses to requests from regulatory agencies involving Medical Services.
10. **Director of Provider Services** – The Credentialing Department operates under the direction of the Director of Provider Services, who reports to the Chief Network Officer and is responsible for Provider Services, including Credentialing and Re-credentialing (C&R) oversight for directly contracted Providers and delegated IPAs, all C&R functions and resolving credentialing functions and resolving credentialing related Provider issues for directly contracted practitioners. The Director of Provider Services is responsible for developing and overseeing the IEHP Credentialing and Re-credentialing Program, with input from the Chief Medical Officer.
  - a. **Credentialing Staff** – Staff support for the Director of Provider Services consists of a Credentialing Manager and Credentialing Coordinators who are responsible for performing all C&R related activities, including primary source verifications, review of applications and other functions for all practitioners for whom IEHP is responsible for C&R. They are also responsible for verifying Providers meet IEHP requirements for credentialed practitioners.
11. **Provider Services Department** – The Provider Services Department operates under the direction of the Director of Provider Services, who must possess a Bachelor degree in a related field with at least five (5) years experience in a managed care setting. Under the direction of the Chief Network Officer, the Director of Provider Services is responsible for Credentialing and Provider Services, including the resolution of Provider issues, education of Providers concerning IEHP Policies and Procedures, health plan programs, IEHP website training and all other functions necessary to ensure Providers can successfully participate in IEHP’s network and provide appropriate, quality care to IEHP Members. This position is also responsible for IPA oversight and monitoring in conjunction with departments including Quality Management, Utilization

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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Management, Care Management and Finance.

- a. **Provider Services Staff – Staff** support for the Director of Provider Services consists of Provider Services Manager who oversees the Provider Services Representatives and the Provider Call Center Supervisor and Representatives. The Director of Provider Services is also supported by the Provider Services Administrative Manager and Business Analyst.
  - b. **Provider Services Representative** - The Provider Services Representatives (PSRs) are responsible for providing in-services to the IEHP Provider network, including trainings devoted to IEHP’s website, appropriate claims and referral processes, all plan programs and the Provider Policies and Procedures. The PSRs receive and review provider complaints and establish with the Provider Services Manager and Director of Provider Services appropriate resolution. The PSRs also review the **IPA Specialty Networks** on a semi-annual basis as well as work on the resolution of Member access issues by educating Providers on access standards.
  - c. **Provider Call Center Representatives** – The Provider Call Center Representatives are responsible for addressing all Provider calls into the plan regarding concerns, questions and complaints, including but not limited to claims, authorizations, vision benefits, IEHP website navigation, and all plan correspondence and updates to programs.
  - d. **Provider Services Administrative Manager and Business Analyst** - The PS Administrative Manager and the analyst that reports to the manager are responsible for the creation, maintenance and update of the Provider Policy and Procedure manual, correspondence to the Provider network regarding to all plan updates, address of technical and reporting concerns as forwarded by the PSRs and Provider Call Center, and additions and updates to the IEHP Provider website.
12. **Director of Member Services** – The Member Services Department under the direction of the Director of Member Services reports to the Chief Financial Officer and is responsible for Member Services functions, including but not limited to assistance to Members regarding benefits questions, based on the Member’s product line (Medi-Cal, Healthy Families, Healthy Kids, Medicare DualChoice), eligibility questions, assistance with filing grievances and appeals, Plan enrollment and disenrollment questions, doctor changes, assistance in obtaining IEHP material and provider eligibility verifications. The Director of Member Services is responsible for developing and overseeing the Member Services program, with input from the Chief Financial Officer.
- a. **Member Services Staff** – Staff support for the Director of Member Services consists of a Call Center Analyst, who is responsible for Call

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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Center trend analysis and reporting, Call Center Projects Manager, who is responsible for technical and operational analysis and projects, a Call Center Coordinator, who is responsible for day-to-day operational team support, an Administrative Assistant, who is responsible for providing administrative support for the department, a Quality and Training Manager (including Analyst Trainer and Quality Specialists), who are responsible for staff quality support and training, a Call Center Manager (including Call Center Supervisors and Member Services Representatives) who are responsible for assisting Member and provider through different communication methods (telephone, email, in person, fax).

13. **Grievance and Appeals Department** – The Grievance Department under the direction of the Director of Quality Management reports to the Chief Medical Officer, and is responsible for investigation and resolution of grievance and service appeals received from Members, Providers, and regulatory agencies. The Grievance Department gathers supporting documentation from Members, Providers and contracted entities, and resolves cases based on clinical urgency of the Member’s health condition. The Grievance Manager has the primary responsibility for the timeliness and processing of the resolution for all cases. The Chief Medical Officer is the designated officer of the plan that has the primary responsibility for the maintenance of the Grievance and Appeals Resolution System.
  - a. **Grievance Department Staff** – Staff supporting the Grievance Manager include: Grievance Supervisor, Triage and Review Nurse, Administrative Assistant, Grievance Nurses and Grievance Coordinators. The Triage and Review Nurse is responsible for intake of all cases, including triaging/assigning Grievance and Appeal cases, and working directly with the Grievance team to ensure cases are processed based on clinical urgency. The Grievance Supervisor is responsible for the daily monitoring of all cases for compliance with Grievance policies and procedures, and agency regulations and standards. Grievance Nurses are responsible for processing appeals of denied service requests, and conducting clinical grievance investigations. Grievance Coordinators are responsible for all non-clinical case processing functions, including Member and Provider Acknowledgement and Resolution letter generation, obtaining medical records and supporting documentation needed to complete investigations, and monitoring case resolution status.
14. **Director of Information and Technology (IT)** – The IT Department under the direction of the Director of IT 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 beneficiary data, both from regulators and providers. The system ensures that Team Members have access to data to assist them in providing care and guidance

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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to beneficiaries.

- a. **IT Staff** – Staff support for the Director of IT consists of a Decision Support Manager, Systems Support Manager, Applications Support Manager, and Applications Configuration Manager who, with their staff, are responsible for maintaining electronic systems, developing tools for both internal and external partners, assessing risks and vulnerabilities to individual health data, and maintaining appropriate administrative, physical and technical security measure.
15. **Director of Marketing** – The Marketing Department operates under the direction of the Director of Marketing, 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; developing and executing marketing plans; creating and distributing advertising materials (e.g., radio, billboard, print ad, etc.) and Member materials (e.g., Member Newsletters, Evidence of Coverage, Provider Directory, website, etc.) The Marketing Director is responsible for developing and overseeing the IEHP Marketing and Member Communications programs, under the vision and oversight from the Chief Marketing Officer.
- a. **Marketing Staff** – Staff support for the Director of Marketing consists of Product and Research team (Product Manager, Technical Analysts, and Administrative Assistant) and Communications team (Communications Writers, Graphic Designers, and Marketing Coordinator). The Product and Research team is responsible for conducting necessary research about the target audience to support the Communications team in creating effective advertising and Member materials. In addition, the Product Team develops the Member Handbooks (Evidence of Coverage) for all products and submits appropriate marketing and Member materials to the regulators for approval. The Communications team is responsible for developing advertising collaterals (radio, billboard, print ads, etc.), Member materials (Member Newsletters, Health Education brochures, website, etc.) and provider materials (Provider Newsletter, Office Staff Newsletter, etc.).
16. **Data Sources and Support** – The QM Program utilizes an extensive data system that captures information from claims and encounter data, enrollment data, UM and QM activities, pharmaceutical data, grievances and appeals, and Member Services, among others.

### C. Committee Structure and Function:

Network practitioners, specialists, and Medical Directors are voting members of the QM Committee and related Subcommittees and provide expertise and assistance in directing the QM Program activities.

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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1. **QM Committee** – The QM Committee reports to the Governing Board and retains oversight of the QM Program with direction from the Chief Medical Officer. The QM Committee promulgates the quality improvement process to participating groups and physicians, Providers, Subcommittees, and internal IEHP functional areas with oversight by the Chief Medical Officer. The QM Committee meets at least quarterly or more frequently as needed.
  - a. **Role** – The Quality Management Committee is responsible for continually improving the quality of care for IEHP Membership.
  - b. **Structure** – The QM Committee is composed of IPA Medical Directors who are representative of network practitioners. Also attending are practicing Optometrists, practicing Pharmacists, Public Health Department Representatives from Riverside County and San Bernardino County. Committee findings and recommendations are reported through the Chief Medical Officer to the IEHP Governing Board. A designated behavioral health care practitioner is an active member of the IEHP QM Committee to assist with behavioral healthcare related issues.
  - c. **Function** – The QM Committee seeks methods to increase the quality of health care for the served population; recommends policy decisions; analyzes and evaluates QI activity results; institutes and directs needed actions; and ensures follow-up as appropriate. The Committee provides oversight and direction for subcommittees and related programs and activities and reviews and approves Subcommittee recommendations and findings and provides direction as applicable.
2. **Subcommittees** – The following Subcommittees, chaired by the IEHP Chief Medical Officer, or designee report findings and recommendations to the QM Committee. The Subcommittees meet quarterly or more frequently if necessary.
  - a. **Peer Review** – The Peer Review Subcommittee is responsible for peer review activities for IEHP.
    - 1) **Role** – The Peer Review Subcommittee reviews Provider, Member or Practitioner grievances and/or appeals; practitioner related quality issues; and other peer review matters as directed by the IEHP Chief Medical Officer or Medical Director. The Subcommittee evaluates the IEHP Credentialing and Recredentialing Program with recommendations for modification as necessary.
    - 2) **Structure** – The Peer Review Subcommittee is composed of four IPA Medical Directors or designated physicians representative of network practitioners and a network Optometrist. A behavioral health practitioner and any other specialist not represented by committee members serves on an ad hoc basis for related issues.

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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- 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.
- b. **Credentialing** – Performs credentialing functions for practitioners who either directly contract with IEHP.
  - 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 five primary care physicians or specialists representative of network practitioners and an Optometrist. A behavioral health practitioner, and any other specialty as needed, 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 recredentialed; reviews practitioner qualifications including adverse findings; approves or denies continued participation in the network every three years for recredentialed; and ensures that decisions are non-discriminatory.
- c. **Pharmacy and Therapeutics (P&T)** – The P&T Subcommittee performs ongoing review and modification of the IEHP Formulary and related processes; oversight of the pharmacy network including medication prescribing practices by IEHP providers; assessing usage patterns by Members; and assisting 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, effective formulary and monitoring medication prescribing practices by IEHP practitioners, and under- and over-utilization of medications.
  - 2) **Structure** – The P&T Subcommittee is composed of five clinical pharmacists and five physicians representative of the network. A behavioral health physician serves ad hoc for related issues.
  - 3) **Function** – The P&T Subcommittee objectively appraises, evaluates, and selects pharmaceutical products for formulary inclusion and exclusion. The Subcommittee provides recommendations regarding protocols and procedures for pharmaceutical management and the use of non-formulary

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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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.

- d. **Utilization Management (UM)** – The UM Subcommittee performs oversight of UM activities conducted by IEHP to maintain high quality health care as well as effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services. The Subcommittee reviews new technologies and new applications of existing technologies for consideration as IEHP benefits and is responsible for reviewing and updating preventive care and clinical practice guidelines that are not primarily medication related.
- 1) **Role** – The UM Subcommittee directs the continuous monitoring of all aspects of UM administered to Members, with oversight by the IEHP Chief Medical Officer and the Medical Director.
  - 2) **Structure** – The UM Subcommittee is composed of four IPA Medical Directors, UM Directors, network physicians, or designees representative of network practitioners and two rotating guest physicians. A behavioral health physician and an optometrist serve ad hoc for related issues.
  - 3) **Function** – The UM Subcommittee reviews and approves the Utilization Management, Care Management, and Health Management Programs annually. The Subcommittee monitors for over- 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.
- e. **Behavioral Health Advisory Subcommittee** – The BH Advisory Subcommittee will serve as a multidisciplinary BH specialty advisory committee which will review the Utilization Management (UM) and Quality Improvement (QI) activities and reports for BH services as well as review BH clinical guidelines, new BH technology and treatment innovations. The BH Advisory Subcommittee will meet quarterly and will consist of licensed clinicians from IEHP’s BH network and contracted consulting clinicians including at least one psychiatrist, one psychologist, one LCSW and one MGT. The IEHP Clinical Director of Behavioral Health or the IEHP Consulting Psychiatrist will chair the Subcommittee. Members will be selected to serve on a voluntary basis for a term of at least one year.

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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- f. **Compliance Committee** – The Compliance Committee oversees the organizational Compliance Program which includes compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and subsequent updates; the Fraud Waste and Abuse Program (FWA) to prevent, detect, investigate, manage and report incidents of suspected fraud; and, ethical considerations including the entity’s Code of Conduct. The Compliance Committee was organized to comply with state and federal regulatory requirements cited by the California Department of Managed Health Care (DMHC) in the California Health and Safety Code § 1348, enacted through SB 956 in 1998; the California Department of Health Care Services (DHCS) 04-35765; the Centers for Medicaid & Medicare (CMS) in the Code of Federal Regulations, Title 42; and most recently, the compliance related requirements of the American Recovery and Reimbursement Act (ARRA) of 2009. The Committee is accountable to the Governing Board for oversight of all compliance activities related to the Medi-Cal, Healthy Families , Healthy Kids and Medicare DualChoice Programs. The mission of the Compliance Committee is to monitor ongoing compliance with the seven core elements of an effective Program including the identification of deficiencies and the corrective action(s) required to remediate them.
3. **Support Committees** – IEHP also has Committees that are designed to provide structural input from providers and Members. These Committees report through the CEO to the Governing Board. Any potential quality issues that arise from these Committees would be referred to the QM Committee by attending staff. The Committees include:
- a. **Grievance Committee** – The Grievance Committee is an internal oversight committee responsible for monitoring all Member grievances to ensure timeliness and compliance with regulatory guidelines. Grievance reports are presented to the IEHP Governing Board, Quality Management Committee, Peer Review Subcommittee, Utilization Management Subcommittee, P & T Subcommittee, and regulatory agencies.
- b. **Provider Advisory Councils (PAC)** – The PAC consists of hospital, PCP, pharmacy, vision provider, and IPA representatives from the two counties to address Provider and practitioner issues. The PAC reports directly to the CEO and the Governing Board.
- c. **Public Policy Participation Committee (PPPC)** – The PPPC is a standing committee with a majority of members drawn from IEHP enrollees. 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 linguistics, and Member Services.

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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- d. **Persons with Disabilities Workgroup (PDW)** – The PDW is an ad-hoc workgroup made up of IEHP Members with disabilities and members from community based organizations that provides recommendations on provisions of health care services, educational priorities, communication needs, and the coordination of and access to services for Members with disabilities.
- e. **Nurse Advice Line Steering Committee (NAL)** – The NAL Steering Committee is an internal committee responsible for making recommendations and reporting oversight activities to IEHP’s UM Subcommittee. The NAL Steering Committee provides advice to the Director of Health Administration in support of day-to-day management of the IEHP/NAL contract. The committee meets every other month to review NAL operations, including a review of current utilization and performance reports.

### D. Confidentiality and Conflict of Interest:

IEHP complies with all DHCS and HIPAA regulatory requirements for confidentiality.

- 1. All members, participating staff, and guests of the QM Committee and Subcommittees are required to sign the Committee/Subcommittee Attendance Record, including a statement regarding confidentiality and conflict of interest.
- 2. All IEHP staff members are required to sign a confidentiality agreement upon hiring. The confidentiality agreements are maintained in the practitioner or employee files as appropriate.
- 3. All peer review records, proceedings, reports, and Member records are maintained in a confidential manner in accordance with state, federal and regulatory requirements to ensure confidentiality.
- 4. IEHP maintains oversight of Provider and practitioner confidentiality procedures.
  - a. IEHP has established and distributed confidentiality standards to contracted Providers and practitioners in the IEHP Provider Policy and Procedure Manual.
  - b. All Provider and practitioner contracts include the provision to safeguard the confidentiality of Member medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and federal laws.
  - c. 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.

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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- d. IEHP monitors contracted Providers and practitioners for compliance with IEHP's confidentiality standards during audits and practitioner Facility and Medical Records Reviews.

#### E. Conflict of Interest:

All Committee members are required to sign a conflict of interest statement. Committee members cannot vote on matters where they have an interest and must be replaced by a substitute until the issue has been resolved.

#### F. Availability of QM Program Information:

Member and Practitioner Information on QM Program Activities – IEHP has developed an overview of the QM Program and related activities. This overview is on the IEHP web site at [www.iehp.org](http://www.iehp.org) and a paper copy is available to all Members and/or practitioners upon request by calling IEHP Member Services at 1-800-440-IEHP (4347). Members are notified of the availability through the Member Handbook. Practitioners are notified in the Provider Manual. The IEHP QM Program Description and Work Plan are available to practitioners upon request. A summary of QM activities and progress toward meeting QM goals is available to Members, providers, and practitioners upon request.

INLAND EMPIRE HEALTH PLAN		
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<b>Chief Title:</b> Chief Medical Officer	<b>Revised date:</b>	January 1, 2012

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## 13. QUALITY MANAGEMENT

### B. Quality Studies Medical Records Access

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#### **APPLIES TO:**

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

#### **POLICY:**

- A. IEHP performs a variety of quality studies that meet contractual and regulatory requirements and are relevant to the IEHP Member population.
- B. All Providers must provide access to Members' medical records for use in quality studies.

#### **PROCEDURE:**

- A. Quality Studies
1. IEHP performs quality studies to meet requirements of California Department of Health Care Services (DHCS), the California Managed Risk Medical Insurance Board (MRMIB), CMS Medical policy determinations and the National Committee for Quality Assurance (NCQA). These studies cross over total IEHP Membership.
  2. IEHP utilizes NCQA's Healthcare Effectiveness Data Information Set (HEDIS<sup>®</sup>) methodology for all applicable quality studies. For studies not addressed by HEDIS<sup>®</sup>, IEHP uses a format approved by the agency requesting the study.
  3. In order to complete these studies according to required methodologies, IEHP must gather information both from administrative data (i.e., encounter data) and Members' medical records.
- B. Medical Record Access
1. The California Civil Code, Section 56.10, allows for the release of medical records to health plans for the purposes of medical data processing, quality of care assessment and other research purposes.
- C. PCP Notification
1. IEHP notifies PCPs if any of their assigned Members have been selected for inclusion in a quality study.
  2. Notification includes a description of the study purpose and requirements as well as a list of the Members whose records are needed and the method of data collection.
  3. IEHP collects medical record data in one of the following ways, depending on the nature of the study and the location of the PCP's office:
    - a. IEHP staff may make appointments with the PCP's office to visit the site

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## 13. QUALITY MANAGEMENT

### B. Quality Studies Medical Records Access

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for the purpose of medical record review and/or data collection. Data collection includes making photocopies and/or scanning selected medical records for audit purposes.

- b. IEHP may request that the PCPs office retrieve the requested records and mail copies to IEHP. Under this method, PCPs are reimbursed a fixed amount per record for mailing and copying costs.

#### D. Confidentiality

1. IEHP maintains compliance with HIPAA requirements with all Member medical record information, including information used for the purpose of a quality study.
2. IEHP maintains strict confidentiality when using Member records for quality studies.
3. Members' identities are not disclosed in quality study results.
4. IEHP maintains medical records in locked cabinets that are accessed only by IEHP authorized personnel.

INLAND EMPIRE HEALTH PLAN		
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## 13. QUALITY MANAGEMENT

### C. Corrective Action Plan (CAP) Requirements

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#### **APPLIES TO:**

- A. This policy applies for all IEHP Medicare DualChoice (HMO SNP) Members.

#### **POLICY:**

- A. IEHP Quality Management (QM) is responsible for oversight, monitoring and tracking of all assessments and Corrective Action Plans (CAPs) related to medical services, including but not limited to, Site Review and Medical Record Review Surveys and Clinical and Focused Audits.
- B. IEHP monitors PCP compliance against pertinent IEHP, Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and National Committee for Quality Assurance (NCQA) requirements through Site Review and Medical Record Review Surveys.
- C. The CAP Process addresses deficiencies found during the Site and/or Medical Record Reviews and provides guidance for PCPs to bring their site into full compliance with regulatory standards.
- D. All PCPs are responsible for developing and submitting their CAPs directly to IEHP.
- E. CAPs are also required for deficiencies identified during focused and/or clinical audits.

#### **PROCEDURE:**

##### **Site Review and Medical Record Review Survey CAP**

- A. Deficiencies that are identified through the Site Review Survey resulting in an audit score below 90% or above 90% with deficiencies in the nine (9) critical elements, pharmacy, and/or infection control sections require a CAP. Medical Record Review Surveys scoring below 90% also require a CAP. A CAP may also be required at the discretion of the Certified Site Reviewer (CSR) as outlined in Policy 6A, "Site Review and Medical Records Review Survey Requirements and Monitoring."
- B. The CAP is a standardized, pre-formatted document developed to assist the PCP in meeting Medi-Cal Managed Care Division (MMCD) and IEHP requirements. This CAP includes deficiencies noted during the PCP Site Review and Medical Record Review Surveys, specified corrective actions, their evidence of corrections, date corrections were implemented, physician or designee responsible for corrective actions, and the name and title of the CSR. In addition, there is a section for IEHP's verification of corrections. The CAP contains three (3) separate sections: Site Review Survey; Critical Elements Survey; and Medical Record Review Survey.

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## 13. QUALITY MANAGEMENT

### C. Corrective Action Plan (CAP) Requirements

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The CAP includes Disclosure and Release statements regarding CAP submission timeline and authorization to furnish results of the reviews and corrective actions to Health Plans participating in the collaboration, government agencies that have authority over the Health Plans, and authorized county entities in the State of California. The CAP informs the PCP that Health Plans participating in the collaborative for Site Review and Medical Record Review Surveys agree to accept the survey findings and to furnish each other with surveys and CAP. The collaborative process does not supersede any contractual requirement and participation is voluntary.

#### C. CAP Process

1. The IEHP CSR evaluates the Site and Medical Record Review findings and documents deficiencies on the review tool and CAP. IEHP provides a survey findings report and a formal written request for corrections of all (i.e. critical and/or non-critical) deficiencies to Providers.
2. Upon completion of the review, the IEHP CSR discusses the findings and the required corrective actions with the PCP or designee as follows:
  - a. The PCP must submit a CAP that includes implementation dates and evidence of corrections to IEHP within 45 calendar days from the date of the survey;
  - b. The Critical Element deficiencies must be addressed with a CAP submitted to IEHP within 10 business days with evidence of corrections verified by IEHP within 30 calendar days;
  - c. The survey findings and CAP information are shared with collaborative Health Plans, if applicable; and
  - d. The CSR explains that the PCP/designee signature acknowledges receipt of the CAP and agreement to comply with designated timeframes.
3. The PCP should notes corrections on the CAP as follows:
  - a. Document the corrective actions taken in the “Corrective Action Taken” column;
  - b. Document the date the correction was implemented. PCP may document additional steps taken in this column;
  - c. Initial the appropriate column on the CAP (by person responsible for corrective actions); and
  - d. Attach evidence of correction(s) (e.g. inservice sign-in sheet and agenda, invoices, forms, used, etc).
4. Site CAPs: CAP verification may be accomplished by PCP submission of appropriate evidence of corrections (e.g. invoices for receipt of safety needles).

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## 13. QUALITY MANAGEMENT

### C. Corrective Action Plan (CAP) Requirements

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CAP verification may require an onsite visit within 45 calendar days from receipt of the CAP if evidence of corrections are insufficient or deficiency cannot be verified in writing.

5. Medical Record Review Survey CAPs: Follow-up action is scheduled at the discretion of IEHP and may include the following within 45 days of receipt of the CAP:
  - a. Score < 80%: Onsite visit to verify processes have been implemented;
  - b. Score 80-89%: Accept documented CAP and/or a CAP verification visit or focused record review may be requested at the discretion of IEHP; or
  - c. Score 90-100%: Exempted Pass without CAP required; however, CAP and CAP verification may be requested at the discretion of IEHP for any individual section that scores below 90% on the Medical Record Review.
6. Communication to Participating Health Plans: IEHP monitors the CAP until completion. Information regarding PCPs showing no improvement and/or non-compliance to the CAP within the defined MMCD timeframes is communicated to the collaborative Health Plans.

### D. Pre-contractual PCP Surveys and CAPs

1. New sites scoring below 80% are not accepted into the PCP network, but may appeal this decision to the IEHP Chief Medical Officer.
2. PCPs wishing to appeal the results of a Site and Medical Record Review Survey must do so in writing to the IEHP Chief Medical Officer within 14 days of the date of the notification letter.
3. After receiving a written appeal, the IEHP Chief Medical Officer responds to the appealing PCP in writing noting the status of the appeal within 30 days.
4. If the appeal is accepted by IEHP, the PCP has 30 days to submit a CAP addressing all deficiencies noted in the Site and Medical Record Review Survey.
5. If the CAP is approved by IEHP, a re-assessment is scheduled within 30 days. If upon re-assessment the site and/or medical record review score is less than 80%, it is considered a “failed site” and is not approved as a participating site with IEHP.
6. Initial providers who do not pass the survey may correct deficiencies, reapply to IEHP after six (6) months, and be re-surveyed.
7. Any PCP whose site review reveals significant quality of care issues is not eligible for initial participation in the IEHP network, pending the outcome of a review by the IEHP Chief Medical Officer, and possible further review by the IEHP Peer Review Subcommittee.

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## 13. QUALITY MANAGEMENT

### C. Corrective Action Plan (CAP) Requirements

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#### E. PCP Non-compliance for CAP Completion

1. If a PCP submits a CAP but continues to be non-compliant with the CAP process, the PCP is frozen to auto assignment until such time as the corrections are verified and the CAP is closed.
  - a. Delayed CAP submission process:
    - 1) If the CAP for the critical element was not completed and submitted within ten (10) business days from the date of the review, a second and final critical element CAP request letter is sent to the PCP. Failure to submit required documentation within 72 hours of the second notice results in the freezing of Member assignment.
    - 2) CAP deficiencies other than critical elements should be received within 45 calendar days from the date of the request.
      - a) If a CAP is not received within 45 calendar days of the request, a reminder phone call is made to the PCP, followed by a 2<sup>nd</sup> CAP letter requesting CAP completion within five (5) business days. If the CAP is not received within five (5) business days, IEHP notifies the collaborative Health Plans. Each Health Plan follows internal escalation procedures.
      - b) IEHP tracks the CAP process and may contact its collaborative partners with a mutual contract to meet with the PCP to review deficiencies and to make joint efforts to bring the PCP into compliance with MMCD requirements.
      - c) PCP failure to submit a CAP within the established CAP timelines require IEHP to notify its collaborative partners for submission to their appropriate committee for review and action.
      - d) As stated in the MMCD Policy 02-02, providers who do not correct survey deficiencies within established CAP timelines are not assigned new Members until such time as corrections are verified and the CAP is closed. Any network provider who does not come into compliance with survey criteria within the established timelines is removed from the network and plan Members are appropriately reassigned to other network providers.
      - e) Providers removed from the IEHP network shall have the right to appeal the decision with the health plan. IEHP has a formal and fair process to resolve grievances and

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## 13. QUALITY MANAGEMENT

### C. Corrective Action Plan (CAP) Requirements

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complaints submitted by providers of medical services. If verified evidence of corrections is accepted by IEHP and the decision is reversed, IEHP shall repeat the full scope survey or accept the current survey and CAP as completed and place the PCP site on intensive review for twelve (12) months and shall re-survey the site at the end of 12 months from the last survey. The provider must receive 80% on both surveys. If the appeal decision is not reversed by IEHP, the provider may re-apply through the application process. All applicants shall undergo an initial Full Scope Review Survey, and be required to adhere to the requirements and standards established by this policy.

- H. IEHP monitors all sites for subsequent deficiencies through review of grievances and information from quality improvement activities.

#### **Other Oversight Activities or Focused and/or Clinical Audits**

- A. Other QM monitoring activities that could result in CAPs include but are not limited to:
1. 24-hour access studies;
  2. Appointment availability studies;
  3. Health education audits;
  4. Language competency audits;
  5. Clinical audits (including asthma, diabetes, etc.);
  6. Specific quality studies, and;
  7. Focused audits.
- B. IEHP reviews results of each audit or study and identifies deficiencies as noted in IEHP policies and procedures.
- C. IEHP requests CAPs to be submitted addressing deficiencies according to established policy or as otherwise directed by IEHP.
- D. Failure to submit CAPs may result in one of the following activities, depending on the nature of the audit or study and the seriousness of the deficiency:
1. PCP is frozen to new Member enrollment;
  2. Peer Review Referral;
  3. Termination from the IEHP Network.

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## 13. QUALITY MANAGEMENT

### C. Corrective Action Plan (CAP) Requirements

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INLAND EMPIRE HEALTH PLAN		
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