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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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7. Annually review the effectiveness of the QM Program and utilize the results to plan future initiatives;
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 follow 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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- 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 Health Care 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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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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- 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, a requirement to subcontract out the deficient activities within MSO or IPA; de-delegation of specified functions; termination of participation or non-renewal of the Agreement with IEHP.
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

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- and identifies common areas of deficiency in physical facility accommodations and infection control practices throughout the IEHP network.
- 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 reviews 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.
  8. **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.
  9. **Assessment and Monitoring:** To ensure that Providers have the capacity and capability to perform required functions, IEHP has a rigorous pre-contractual and post-contractual assessment and monitoring system.
    - a. **Pre-contractual Assessment of Providers** – All Providers desiring to contract with IEHP must complete a comprehensive pre-contractual document and on-site review.
    - b. **IPA Reporting Requirements** – Contracted IPAs are required to submit the following information to the IEHP QM Department:
      - 1) UM Trend Report – Monthly report of utilization data;
      - 2) Denial Log and Letters – Monthly report of all denials and modifications of requested services;
      - 3) CM Log – Monthly report of CM activities;
      - 4) Second Opinion Tracking Log – Monthly report to track Member requested second opinions;
      - 5) Credentialing Activity – Periodic report of any changes to the network at the IPA level (e.g., terminated PCPs, specialists);

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- 6) Annual QM and UM Program Descriptions;
  - 7) Annual QM and UM Work Plans;
  - 8) Semi-Annual Reports of quality improvement activities;
  - 9) Semi-Annual Reports of utilization management activities;
  - 10) Annual QM and UM Program Evaluations;
- E. **Monitoring Activities** - IEHP performs a series of activities to monitor IPAs and other delegated entities:
1. Annual IPA Delegation Oversight Audit using a designated audit tool that is based on NCQA, DMHC and DHCS Standards
  2. Joint Operations Meetings
  3. Review of grievances and other quality information
  4. 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
    - 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 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

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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, 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, 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.

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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.

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

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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 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

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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 Specialists. The required qualifications for BH care management staff positions consist 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. **UM Staffing** – The Director of Utilization Management oversees UM staff in performing UM activities. The required

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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, 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 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 Recredentialing oversight for directly contracted Providers and delegated IPAs, all Credentialing and Recredentialing functions and resolving credentialing functions and resolving credentialing related Provider issues for directly

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contracted practitioners. The Director of Provider Services is responsible for developing and overseeing the IEHP Credentialing and Recredentialing 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 that 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 Relations, 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 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.**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.
    - b. **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,

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and all plan correspondence and updates to programs.

- c. **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 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 Members and providers 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.

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- 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 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

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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.

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

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## 13. QUALITY MANAGEMENT

### A. IEHP Quality Management Program Description

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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 performs oversight of IPAs who have been delegated credentialing and recredentialing responsibilities and 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.

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 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 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

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### A. IEHP Quality Management Program Description

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including adverse findings; approves or denies continued participation in the network every three years for recertification; 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 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 and delegated 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 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

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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.
- 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)

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### A. IEHP Quality Management Program Description

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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.
  - 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 provide 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

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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.
    - d. IEHP monitors contracted Providers and practitioners for compliance with IEHP's confidentiality standards during annual IPA Delegation Oversight Audits and practitioner Site 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. IPAs are delegated to perform Peer Review within their organization and must maintain the same standard regarding conflict of interest. IPAs can refer issues that cannot be resolved at their level to IEHP for resolution. IEHP monitors IPAs for policies and procedures and signed conflict of interest statements at the time of the annual IPA Delegation Oversight Audit.
- 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 IPAs and practitioners

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### A. IEHP Quality Management Program Description

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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		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Effective date:</b>	August 1, 2006
<b>Chief Title:</b> Chief Medical Officer	<b>Revised date:</b>	January 1, 2012

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## 13. QUALITY MANAGEMENT

### B. IPA Quality Management Program Structure Requirements

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#### APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Members.

#### POLICY:

- A. IEHP is responsible for conducting the Health Plan Quality Management (QM) Program. IPAs are required to have certain QM structural components as noted below:
1. All IPAs must have a written QM Program Description, QM Work Plan, and related QM Policies and Procedures.
  2. The IPA QM Program Description outlines the structure and content of the IPA QM Program, including the QM Committee and related activities.
  3. All IPA QM Program activities must meet IEHP and NCQA standards.
  4. The IPA QM Committee is responsible for oversight and annual approval of the IPA QM Program Description, Work Plan and Annual Evaluation.
  5. IPA QM Committees are responsible for monitoring, measuring, and evaluating the quality, effectiveness, safety, coordination and appropriateness of the care provided by practitioners to Members for the purpose of continued quality improvement.
  6. IPAs must have adequate QM staffing to support QM Program and related activities.
  7. QM Programs must be accountable to the IPA QM Committees.
- B. IEHP monitors IPA QM Program Structure and implementation of QM activities through the IPA Delegation Oversight Audits performed on an annual basis. The audit tool is based upon current NCQA, DHCS and IEHP standards.

#### PROCEDURES:

- A. **Responsibilities** – IEHP has adopted a health care delivery structure that includes QM Program activities required of contracted IPA Medical Group or Hospitals (Providers). Details are noted in both the Agreement between IEHP and Providers and the IEHP Provider Policy and Procedure Manual. Activities related to medical services include:
1. **Quality Management:**
    - a. **Quality Structure** – IEHP is responsible for conducting the Health Plan QM Program. IPAs are also required to have a structure in place that monitors quality activities, including a formal Committee structure and sufficient personnel in place to perform QM activities.

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## 13. QUALITY MANAGEMENT

### B. IPA Quality Management Program Structure Requirements

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- b. **Quality Studies** - IEHP is responsible for performing quality studies to maintain compliance with DHCS and NCQA requirements. In addition, IPAs are required to perform a minimum of two quality studies for their Membership per year. One study must be in the area of access; the other study should be an area pertinent to the IPA, IEHP Membership served by the IPA, and quality issues identified by the IPA. Study results must be made available to PCPs and IEHP Members upon request. IEHP has the right to mandate the type of access study required if the Plan has identified quality or access issues.
    - c. **Peer Review** – IPAs must perform peer review. All IPAs are required to have a Peer Review Committee made up of physicians representative of the network that provides peer review of any practitioner noted to have potential quality issues. Data utilized to identify candidates for peer review include: quality studies by IEHP or the IPA, grievances received by the IPA or IEHP, utilization and/or encounter data, and other data sources.
  2. **Utilization Management (UM)** – IEHP delegates the UM process to those IPAs that have sufficient administrative capacity with accompanying policies and procedures to meet all IEHP and NCQA standards for UM activities. Refer to Section 14, “Utilization Management,” for more information.
  3. **Credentialing/Recredentialing** - IPAs may be delegated the responsibility for credentialing and recredentialing of participating practitioners, as identified in Section 5, “Credentialing and Recredentialing.” This includes a signed attestation by the IPA Medical Director that states all practitioner-required reviews were conducted. IEHP’s Chief Medical Officer and Medical Director review all practitioners (PCPs and Specialists) individually for quality related issues prior to assignment of Members. The IEHP Peer Review Subcommittee performs peer review for practitioners referred by the Chief Medical Officer and Medical Director for potential quality of care concerns. IEHP also performs Credentialing/Recredentialing functions for those practitioners whom are directly contracted with IEHP.
  4. **Care Management (CM)** - IPAs have been delegated CM of Members including: case finding, assessment of needs and care coordination, referral to outside agencies, and all other necessary CM activities. Refer to Policy 12A2, “Care Management Requirements – IPA Responsibilities,” for more information.
  5. **Practitioner Education** - IPAs and IEHP share provider education and training responsibilities including: orientation to managed care, delineation of IEHP policies and procedures pertinent to the practitioner, site and medical record audit preparation, specialized support and training such as Pediatric or Adult Preventive Services and health education. IEHP provides network wide training on a variety

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### B. IPA Quality Management Program Structure Requirements

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of subjects including pediatric and adult preventive services, perinatal standards, IEHP policies and procedures, CM, and Health Education.

IPAs are also required to distribute certain forms, supplied by IEHP, to their practitioners including: PM160s, Perinatal Risk Assessment Forms, Health Education Behavioral Assessment (HEBA) forms, etc.

6. **Health Education** – IEHP actively works to improve the health and welfare of Members. Those Members with chronic conditions are identified through pharmacy data, referral information, and other reporting measures. IEHP notifies the IPA CM department for the purpose of individualized CM and referral to appropriate health education programs. IEHP works collaboratively with Providers and practitioners to identify and educate these Members. IEHP provides certain network-wide Health Education programs to all Members. IEHP supplies IPAs and PCPs with health education brochures, materials, forms and a Provider Resource Directory. Refer to Section 15, “Health Education” for more information.
  7. **Medical Records Maintenance** – IEHP is responsible for establishing and distributing medical record standards to Providers and practitioners. IPAs are required to monitor physician offices for compliance. Practitioners are required to maintain policies and procedures consistent with IEHP requirements. These requirements are outlined in Policy 7A, “PCP and IPA Medical Records Requirements.”
  8. **Preventive Care and Non-Preventive Guidelines** - Practice Guidelines are developed by IEHP using current published literature, current practice standards, and expert opinions. They are based upon specific medical issues commonly found within IEHP’s enrolled Membership. IPAs are expected to monitor practitioner’s care related to clinical guidelines as applicable. IEHP measures its performance against at least four of its standards on an annual basis, two of which relates to Behavioral Health. Standards are reviewed and updated by IEHP at least every two years, or earlier, if necessary.
  9. **Access Standards** – IPAs are required to adhere to IEHP standards for availability and accessibility of services. Refer to Section 9, “Access Standards” for more information. IEHP ensures the standards for appointment availability, after-hours access, practitioner wait time, physician site hours, emergency service availability, medical triage both during and after hours, proximity of specialists and hospitals, and follow-up care through studies and audits. The IPA is required to perform access studies on their practitioners to ensure they meet IEHP requirements.
- B. **Assessment and Monitoring:** To ensure that IPAs have the capacity and capability to perform required functions, IEHP has a rigorous pre-contractual and ongoing assessment

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### B. IPA Quality Management Program Structure Requirements

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and monitoring system. Details of these activities with standards, tools and processes are found in the Provider Services Policies.

1. **Annual Audit** - IEHP performs an annual IPA Delegation Oversight Audit on all contracted IPAs using an audit tool that reflects current NCQA, DHCS, and IEHP standards. Refer to Policy 13E, “IPA Oversight – IPA Delegation Oversight Audit,” for more information.

- C. **IPA Reporting Requirements:** IPAs are required to report the following information on a periodic basis. Policy 13C, “Quality Management Reporting Requirements,” specifies the reporting requirements.

1. QM Program Description - copy of the annual, updated program description;
2. QM Work Plan - copy of the annual work plan , that includes responsible person and anticipated completion date for activities;
3. QM Semi-Annual Reports of quality improvement activities;
4. Quality Studies performed by the IPA; and
5. QM Program Annual Evaluation - annual assessment of IPA QM Program and related activities.

D. **Quality Management Program Description**

1. Contracted IPAs must have a written QM Program Description that describes the structure of the IPAs Quality Program. This program must include the following:
  - a. QM Program goals, objectives, and structure;
  - b. Accountability to the IPA Governing Body;
  - c. Physician involvement in the QM program;
  - d. Patient Safety;
  - e. Description of behavioral health care activities, as applicable;
  - f. Description of behavioral health care practitioner involvement in behavioral health care aspects of the program; as applicable;
  - g. Description of QM Committee oversight of QM functions;
  - h. Role, structure and function of the QM Committee and related Sub-committees including meeting frequency;
  - i. An annual work plan;
  - j. Description of the resources that devote time to meeting the objectives of the QM Program;
  - k. Objectives for serving a culturally and linguistically diverse membership;

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### B. IPA Quality Management Program Structure Requirements

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and

1. Objectives for serving Members with complex health needs and Seniors and Persons with Disabilities.
2. The IPA QM Program Description must be evaluated annually and updated as necessary by the IPA QM Committee. The annual evaluation must include a description, trending, analysis, and evaluation of the overall effectiveness of the IPA QM Program. The QM Annual Evaluation must be submitted to IEHP no later than the 15th of February for each calendar year.
3. The IPA must have a written description for the staff dedicated to perform the activities defined in the QM Program.
4. The IPA must document all resources devoted to the QM Program, not merely the QM Program staff, but also the planned number and type of QM activities. There must also be documentation of the resources regularly devoted to specific QM Activities and if the IPA is completing QM activities in a competent and timely manner. These resources include but are not limited to the following:
  - a. Employees;
  - b. Consultants;
  - c. Data sources; and
  - d. Analytic resources such as statistical persons and/or programs.
5. The IPA must have access to, and the ability to manage, the data supporting measurement of QM activities documented in the QM Work Plan.
6. The IPA Board of Directors is responsible for the QM Program Structure. There must be documentation of this responsibility in the QM Program Description.
7. There must be evidence of the Board of Directors review and approval of the QM Program Description on an annual basis.
8. The QM Program Description must be submitted to IEHP QM Department for final approval. This submission must be received by IEHP no later than the 15th of February for each calendar year.
9. The IPA QM Program Description must outline their approach to address the cultural and linguistic needs of its membership.
10. The IPA QM Program Description must outline their approach to address Members with complex needs. Members with complex needs can include individuals with physical or developmental disabilities, multiple chronic conditions, and severe mental illness.

### E. Quality Management Committee

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## 13. QUALITY MANAGEMENT

### B. IPA Quality Management Program Structure Requirements

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1. The QM Committee is an interdisciplinary committee with participation from IPA appointed practitioners who represent network physicians. The QM Committee is responsible for developing, implementing and overseeing the activities in the QM Program.
2. The IPA's description of the QM Committee must include the following:
  - a. Role;
  - b. Function;
  - c. Structure that includes organizational structure and reporting responsibility;
  - d. Membership;
  - e. Terms of service;
  - f. Voting rights;
  - g. Quorum definition;
  - h. Meeting frequency;
  - i. Minute format and storage; and
  - j. Committees associated with oversight of delegated activities.
3. The IPA's description of the QM Committee must include how the following actions are performed:
  - a. Recommending policy decisions;
  - b. Analyzing and evaluating QM Activity findings;
  - c. Ensuring practitioners participation in the QM Program through planning, design and implementation or review;
  - d. Implementing needed actions; and
  - e. Ensuring needed follow-up.
  - f. Maintain signed and dated meeting minutes.
4. The IPA QM Committee must meet at least quarterly and follow a prescribed agenda.
5. The IPA QM Committee discussions, conclusions, recommendations, and actions must be documented in the signed Committee minutes.
  - a. The IPA QM Committee is responsible for monitoring, measuring, and evaluating the effectiveness of care provided to its Members.

#### F. Quality Management Work Plan

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## **13. QUALITY MANAGEMENT**

### **B. IPA Quality Management Program Structure Requirements**

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1. The QM Work Plan must be a separate document included in the QM Program Description. The Work Plan must document the QM activities scheduled for the year with a brief explanation of timing and party responsible for the activity. The Work Plan must include the following:
  - a. Objectives for the year;
  - b. Quality of clinical care;
  - c. Quality of service;
  - d. Safety of clinical care;
  - e. Program scope;
  - f. Activities planned for the year, including the quality and safety of clinical care and quality of service;
  - g. Time frame within which each activity is to be completed;
  - h. Person responsible for each activity;
  - i. Planned monitoring of previously identified issues; and
  - j. Planned evaluation of the QM Program.
2. The Work Plan must be submitted to IEHP no later than the 15th of February for each calendar year.

### **G. Quality Management Semi-Annual Reports**

1. The IPA QM Semi-Annual Reports document the progress of the QM activities found in the QM Work Plan.
2. The QM Semi-Annual Reports assist the IPA in its development of the QM annual assessment.
3. The QM Semi-Annual Report must include:
  - a. Component/Activity;
    - 1) Clinical Improvement;
    - 2) Continuity and Coordination of Care;
      - a) General Medical Care
      - b) General Medical and Behavioral Health
    - 3) Access;
    - 4) Satisfaction Improvement;
    - 5) Patient Safety; and
    - 6) Other QI Activities.

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### B. IPA Quality Management Program Structure Requirements

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- b. Each Component must include:
  - 1) Objectives;
  - 2) Activities planned;
  - 3) Responsible person for each activity; and
  - 4) Timeframe within each activity is to be completed.
- c. Semi-Annually the IPA must include a description of the following areas for each separate component:
  - 1) Reporting Period;
  - 2) Key findings;
  - 3) Interventions taken;
  - 4) Analysis of findings along with progress; and
  - 5) Any follow-up actions.
- 4. QM Semi-Annual Reports must be submitted to IEHP on the following dates:
  - a. 1st Semi-Annual report covers period from January 1<sup>st</sup> to June 30<sup>th</sup> and must be reported to IEHP by August 15<sup>th</sup>.
  - b. 2nd Semi-Annual report covers period from July 1<sup>st</sup> to December 31<sup>st</sup> and must be reported to IEHP by February 15<sup>th</sup>.
- 5. IEHP has approved the use of the “Industry Collaborative Effort (ICE)” format for submission of Semi-Annual QM Reports.

#### H. Quality Management Program Annual Evaluation:

- 1. The QM Annual Evaluation may be included on the QM Work Plan or in a separate document. The Annual Evaluation must evaluate the IPA’s performance on planned QM Activities described in its QM Program Description and Work Plan, including all delegated activities. The Annual Evaluation must include the following:
  - a. A description of completed and ongoing QM activities that address quality and safety of clinical care and quality of service;
  - b. Trending of measures to assess performance in the quality and safety of clinical care and quality of service;
  - c. Analysis of the results of QM initiatives, including barrier analysis; and
  - d. Evaluation of the overall effectiveness of the QM Program, including progress toward safe clinical practices.

- I. **Continuity and Coordination of Care:** IEHP delegates CM and coordination of care

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### B. IPA Quality Management Program Structure Requirements

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activities to contracted IPAs. CM requirements are delineated in Section 12, “Coordination of Care.”

- J. **Confidentiality:** Providers are required to restrict Member medical records access to those practitioners and associated staff with a legitimate reason to view the files. Records must be maintained in a protective and confidential manner and not be readily accessible to unauthorized persons or visible to the general public. Providers and practitioners must maintain procedures to ensure appropriate records processing to prevent breach of confidentiality.
1. **Medical Records Release** - Medical records contain confidential information that must not be released to any party other than the PCP without the expressed written consent of the Member or legal representative. The PCP must maintain procedures for obtaining such written consent prior to release of records copies. Refer to Policy 7B, “Information Disclosure and Confidentiality of Medical Records,” for more information.
  2. **Members’ Right to Confidentiality** - Members have the right to confidentiality of medical information. All Provider contracts and subcontracts include the provision to safeguard the confidentiality of Member health records and treatment in accordance with applicable state and federal laws. Release of Member medical information may be necessary to protect the health of the Member and/or for coordination of services between practitioners, specialists, or other health care providers of service. Refer to Policy 7B, “Information Disclosure and Confidentiality of Medical Records,” for more information.
  3. **Education of PCP Staff Regarding Confidentiality Issues** - Providers must educate physicians and associated staff regarding confidentiality issues. Signed confidentiality statements are required for participation in the IEHP practitioner network and monitored as part of the facility review process. Referral or access to sensitive services requires the maintenance of high standards of confidentiality. Members requiring family planning services, treatment for sexually transmitted diseases, abortion information and/or treatment, and HIV testing or are requesting assistance with highly sensitive issues, must be treated with respect and consideration for confidentiality.
  4. **Conflict of Interest** - IPAs are required to perform Peer Review within their organization. Should a significant practitioner problem or quality issue arise that cannot be resolved at this level; IPA QM Committees may refer the issue to the IEHP Peer Review Subcommittee for resolution. Should an issue arise involving care provided by a physician member of the QM Committee or any Subcommittee, that physician is replaced by a substitute until the issue is resolved. The member involved in the issue has all rights normally given to anyone with a case presented to the Committee or Subcommittee. IEHP Committee members are required to sign a confidentiality and conflict of interest statement.

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5. **Confidentiality Policy** - IEHP retains oversight for Provider confidentiality procedures through the IEHP QM Committee and Peer Review Subcommittee. As a condition of participation in the IEHP network, all contracted and subcontracted Providers retain signed confidentiality forms for all staff and provide education regarding policies and procedures for maintaining the confidentiality of IEHP Members.
6. **Provider Confidentiality Procedures** - IPAs must have policies and procedures for maintaining the confidentiality of Members.
7. **Informed Consent for Treatment** - Practitioners must obtain appropriate written consent for treatment prior to actual procedure performance. Refer to Policy 7C, "Informed Consent," for more information.

#### K. Provider Participation:

1. **Provider Information** - IPAs are required to inform network practitioners of guidelines, policy and procedure changes, and other important information. IPA methods of practitioner education or notification are evaluated annually during IPA Delegation Oversight Audits performed by IEHP Medical Services staff. Practitioners are informed through the IEHP Provider Newsletter, letters, memorandums, distribution of updates to the Provider Manual, and training sessions. IPAs are notified through letters, memorandums, Provider Manual updates, training sessions for specific issues, Joint Operations Meetings, and by attending IEHP University.
2. **Provider Cooperation:** IEHP requires that IPAs and Hospitals cooperate with IEHP QM Program studies, audits, monitoring, and quality related activities. Requirements for cooperation are included in hospital and IPA Provider contract language that describes contractual agreements for access to information.

#### L. IPA and Hospital Contracts – The IEHP Capitated and Per Diem Agreements contain language that designates access for IEHP to perform monitoring, and require compliance with IEHP QM Program activities, standards, and review system.

1. Provider Agreements include the following provisions:
  - a. IPA is subject to, and agrees to participate in the IEHP QM Program, with regular IEHP monitoring and evaluation of compliance with QM Program standards and IEHP policies and procedures, including participation in Member grievance and/or appeal resolution.
  - b. IPA shall provide access at reasonable times, upon demand by IEHP, to inspect facilities, equipment, books and records including Member patient records, financial records pertaining to the cost of operations and income received by IPA for Medical Services rendered to Members.

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## 13. QUALITY MANAGEMENT

### B. IPA Quality Management Program Structure Requirements

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- c. IPA shall cooperate with IEHP's QM Program and, upon reasonable request, shall provide IEHP with summaries of or access to records maintained by IPA and required in connection with such programs, subject to applicable state and federal law concerning the confidentiality of medical records.
  - d. IPA shall not impede open practitioner-patient communication. Members are allowed to participate with doctors in decision-making about their own health care including the ability to talk with their doctor about their medical condition regardless of cost or benefit.
2. Hospital contracts include provisions for the following:
- a. Hospital agrees to participate with IEHP in the IEHP QM Program, with regular IEHP monitoring and evaluation of compliance with QM Program standards and IEHP policies and procedures, including participation in Member grievances and resolution. Hospital shall also provide access to IEHP utilization review and case management personnel for the purpose of conducting concurrent review and case management on Members who are receiving Hospital Services.
  - b. Hospital shall implement an ongoing QM Program and shall develop procedures for ensuring that the quality of care provided by Hospital conforms with generally accepted hospital practices prevailing in the managed care industry. Hospital shall develop written procedures for remedial action whenever, as determined by the QM Program, inappropriate or substandard services have been furnished, or services that should have been furnished have not been furnished.
  - c. Hospital shall provide access at reasonable times, upon demand by IEHP, to inspect facilities, equipment, books and records including Member patient records and financial records pertaining to the cost of operations and income received by Hospital with a five working day prior written notice of any such inspection.
  - d. Hospital shall cooperate with IEHP's QM Program and, upon reasonable request, provide IEHP with summaries of or access to records maintained by Hospital and required in connection with such programs, subject to applicable state and federal law concerning the confidentiality of medical records.
- M. **Monitoring Activities:** IEHP performs a series of activities to monitor IPA functions including the following:
- 1. **IPA Delegation Oversight Audit** – IEHP performs an annual Delegation Oversight Audit of all contracted IPAs using an audit tool that is based upon

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## 13. QUALITY MANAGEMENT

### B. IPA Quality Management Program Structure Requirements

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current NCQA, DHCS and IEHP standards. This audit assesses IPA operational capabilities in the areas of QM, Credentialing, UM, and Case Management. Refer to Policy 13E, “IPA Oversight – IPA Delegation Oversight Audit,” for more information.

2. **Joint Operations Meetings (JOMs)** - JOMs are intended to provide a forum to discuss issues and ideas concerning care for Members. They allow IEHP a method of monitoring plan administration responsibilities that the IPAs are required to perform. JOMs may address specific UM, QM, CM, grievance, study results, or any other pertinent quality issues. They are held with IPAs. These meetings are designed to address issues from an operational level.
  3. **Member or Practitioner Grievance Review:** IEHP performs review, tracking, and trending of Member or practitioner grievances and appeals. IEHP reviews individual grievances and their resolutions for IPA policies or procedures, actions, or behaviors that could potentially negatively impact health care delivery or Member health status.
  4. **Specified Audits:** IEHP performs specific audits of IPAs and PCPs to assess compliance with IEHP standards. These audits include facility reviews, claims audits, CM audits, and health education audits.
  5. **Focused Audits:** IEHP performs focused audits of IPAs or practitioners as indicated whenever a quality or clinical issue is identified.
  6. **Review of UM Denial Logs:** All IPAs are required to submit monthly Denial Logs to IEHP listing all denials and modifications of referrals or services from the previous month. In addition, IPAs are required to submit copies of all denial letters sent to Members. All denials are reviewed for appropriateness and trends or patterns of concern. Refer to Policy 14B, “Utilization Management Reporting Requirements,” for more information.
  7. **Focused Referral and Denial Audits:** IEHP performs focused audits of the referral and denial process for IPAs when quality of care issues are identified. Audits examine source data at the IPA to review referral process timelines, appropriateness of denials and the denial process, including denial letters. Refer to Policy 14D, “Focused Referral and Denial Audits,” for more information.
  8. **Member and Physician Satisfaction Surveys:** IEHP performs Member and physician satisfaction surveys to assess their satisfaction with IEHP, their IPA and managed care.
- N. IPAs that are significantly out of compliance with QM requirements receive letters requesting a Corrective Action Plan (CAP). Persistent non-compliance, or failure to adequately address or explain discrepancies identified through oversight activities, may result in freezing of new Member enrollment, termination or non-renewal of the

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### 13. QUALITY MANAGEMENT

#### B. IPA Quality Management Program Structure Requirements

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Agreement with IEHP.

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Effective date:</b>	September 1, 1996
<b>Chief Title:</b> Chief Medical Officer	<b>Revised date:</b>	January 1, 2012

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## 13. QUALITY MANAGEMENT

### C. Quality Management Reporting Requirements

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#### **APPLIES TO:**

- A. This policy applies to all IEHP Medi-Cal Members.

#### **POLICY:**

- A. All IPAs must report Quality Management (QM), Utilization Management (UM) and Care Management (CM) information to IEHP as described below.
- B. IPA reports should be received through the FTP server.
- C. All reports must be received by the 15<sup>th</sup> of the month, regardless if the 15<sup>th</sup> falls on a weekend or holiday.

#### **PROCEDURE:**

##### **A. Monthly Reporting Requirements:**

- 1. Reporting requirements include a monthly assessment of utilization data, denial activity and care management activity. Monthly reports are due to IEHP by the 15<sup>th</sup> of the month following the month in which services were rendered or denials made. Additional information on reporting requirements can be found in the “NCQA Delegation Agreement” (see Attachment 13-3 in Section 13, “Attachments”).

##### **B. Quarterly / Semi-Annual Reporting Requirements:**

- 1. Reporting requirements include a QM semi-annual assessment, which documents the progress of the QM and UM activities found in the work plan.
  - a. **Quality Management** – Reports must include the following:
    - 1) Component/Activity;
    - 2) Key Findings;
    - 3) Interventions;
    - 4) Analysis of findings/progress; and
    - 5) Follow-up actions.
  - b. **Utilization Management** – See Policy 14B, “UM Reporting Requirements.”
- 2. QM Semi-Annual Reports must be submitted to IEHP as follows:
  - a. 1<sup>st</sup> Semi-Annual: August 15<sup>th</sup>
  - b. 2<sup>nd</sup> Semi-Annual: February 15<sup>th</sup>

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## 13. QUALITY MANAGEMENT

### C. Quality Management Reporting Requirements

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3. The reporting periods for each report are as follows:
  - a. 1<sup>st</sup> Semi-Annual: January 1<sup>st</sup> through June 30<sup>th</sup> of the reporting year
  - b. 2<sup>nd</sup> Semi-Annual: July 1<sup>st</sup> through December 31<sup>st</sup> of the reporting year
- C. **Annual Reporting Requirements:** The following reports must be submitted annually to IEHP no later than the 15<sup>th</sup> of February each calendar year:
  1. **Quality Management**
    - a. **Quality Management Program Description:** Reassessment of the QM Program Description must be done on an annual basis by the QM Committee and reported to IEHP. The following must be included with the submission to IEHP:
      - 1) Any changes made to the QM Program Description during the past year or intended changes identified during the annual evaluation; and
      - 2) Signature page noting date of committee approval.
    - b. **Quality Management Work Plan:** Submit an outline of planned activities for the coming year, including timelines, responsible person(s) and committee(s). The Work Plan should include planned audits, follow-up activities and interventions related to identified problem areas.
    - c. **Quality Management Program Annual Evaluation:** The evaluation should include a description, trending, analysis and evaluation of the overall effectiveness of the QM Program.
  2. **Utilization Management:** See Policy 14B, "UM Reporting Requirements."
- D. All Reports must be submitted to IEHP within timeframes specified via IEHP's FTP server.
- E. Persistent failure to submit required reports may result in action that includes, but is not limited to, request for Corrective Action Plan (CAP), freezing of new Member enrollment, or termination or non-renewal of the IEHP Agreement.
- F. IEHP Quality Program Nurses are assigned to monitor and oversee specific contracted IPAs. Their specific monitoring and oversight duties include:
  1. Review all monthly reports, regarding IPAs, for tracking and trending levels of activity; comparison to other IPAs, variances compared to other IPAs, and other significant data issues. Reports include those listed above.
  2. Review and approve the Semi-Annual and annual reports submitted by their assigned IPAs, e.g., QM/UM Program Description and Work Plan.

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## 13. QUALITY MANAGEMENT

### C. Quality Management Reporting Requirements

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3. Monitor required Medical Services reports submitted by assigned IPAs. Follow-up with IPA staff if reports are not submitted, or for questions regarding content of reports.
4. Review all grievances received by IEHP for delegated IPAs. The review includes examination for trends, significant changes in volume or amount of grievances received, quality issues, or other significant findings. Any discrepancies in reported information are addressed with the IPA in accordance with Policy 13B, "IPA Quality Management Program Structure Requirements."

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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

### D. Quality Studies Medical Records Access

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#### **APPLIES TO:**

- A. This policy applies to all IEHP Medi-Cal 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), 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. Title 22, CCR, Section 51009, allows for the exchange of medical record information to fiscal intermediaries such as IEHP.
  - 2. 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. IPA Pre-notification
  - 1. IEHP notifies IPAs at least five business days before PCPs are contacted for medical record information.
  - 2. Notification includes a description of the study purpose and requirements.
- D. PCP Notification
  - 1. IEHP notifies PCPs if any of their assigned Members have been selected for inclusion in a quality study.

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## 13. QUALITY MANAGEMENT

### D. Quality Studies Medical Records Access

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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 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.

### E. 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

### E. IPA Oversight – IPA Delegation Oversight Audit

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#### **APPLIES TO:**

- A. This policy applies to all IEHP Medi-Cal Members.

#### **POLICY:**

- A. IEHP delegates certain Utilization Management (UM), Care Management (CM), and Credentialing/Recredentialing activities to contracted IPAs 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.
- B. IEHP does not delegate Quality Management (QM), Preventive Health, Medical Records, or Member's Rights and Responsibilities; however, IEHP does require contracted IPAs to perform specific activities related to these areas.
- C. IEHP monitors IPA performance in QM, UM, Credentialing/Recredentialing, Case Management and their implementation of related activities through the IPA Delegation Oversight Audits performed on an annual basis.
- D. IEHP may waive the annual audit for NCQA accredited entities.
- E. The IPA Delegation Oversight Audit is used as part of the pre-contractual audit for IPAs applying for participation with IEHP.
- F. The IPA Delegation Oversight Audits are performed by IEHP Medical Services, Care Management and Provider Services Staff using the most current NCQA, DHCS and IEHP standards.
- G. The IEHP Delegation Oversight Audit Tool is used for both IPAs Medi-Cal and Commercial Program.
- H. Focused audits may be performed as indicated whenever a quality issue is identified or at the discretion of the Delegation Oversight Committee or the IEHP Chief Medical Officer.
- I. IEHP reserves the right to revoke delegated responsibilities or to terminate the contract from those IPAs that fail to meet IEHP requirements.

#### **PROCEDURES:**

- A. IEHP audits each IPA prior to contracting and at least annually to verify compliance with IEHP requirements and continued ability to perform delegated functions.
- B. IEHP is responsible for performing the IPA Delegation Oversight Audit utilizing the most current NCQA, DHCS, and IEHP standards.
- C. The IPA Delegation Oversight Audit evaluates the IPA capabilities in QM, UM, CM, Credentialing, and DHCS Standards.

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## 13. QUALITY MANAGEMENT

### E. IPA Oversight – IPA Delegation Oversight Audit

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- D. IEHP is responsible for coordinating and scheduling the audits with IPA staff.
- E. IEHP notifies the IPA in writing, at least two weeks in advance of the scheduled audit. The IPA receives audit preparation instructions regarding the types of documents to be available at the time of the audit and standard forms to be completed and returned to IEHP prior to the audit.
1. IPA Biographical Information (see Attachment 13-1 in Section 13, “Attachments”).
  2. IPA Sub-Contracted Service by Facility/Agency (see Attachment 13-2 in Section 13, “Attachments”).
  3. QM documents:
    - a. Program, Plan, Description;
    - b. Policies and procedures for:
      - 1) Quality Management and related activities;
      - 2) Preventive Health; and
      - 3) Medical Records.
    - c. Committee and subcommittee meeting minutes from the last 12 months for:
      - 1) Quality Improvement Committee, and
      - 2) Subcommittees
    - d. Annual Work Plan;
    - e. Annual Program Evaluation;
    - f. Semi-Annual Health Plan Reports for the last 12 months;
    - g. Studies, Audits and Surveys completed during the last 12 months;
    - h. Risk Management Program and Policies and Procedures;
    - i. Health Education and Health Program Policies and Procedures;
    - j. Health Education and Health Promotion materials and evaluations;
    - k. Provider/Member communications from the last 12 months;
    - l. Practitioner/Provider contract (blank sample);
    - m. Physician/Member Satisfaction Surveys from the past two years; and
    - n. Preventive Health Guidelines.
  4. UM documents:
    - a. Program, Plan and Description;

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## 13. QUALITY MANAGEMENT

### E. IPA Oversight – IPA Delegation Oversight Audit

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- b. Annual Work Plan;
  - c. Policies and procedures;
  - d. Committee meeting minutes from last 12 months for:
    - 1) Board of Directors,
    - 2) Utilization Management Committee, and
    - 3) Subcommittee meeting minutes;
  - e. Annual UM Program Evaluation;
  - f. Semi-Annual Health Plan Reports;
  - g. Criteria for Medical Necessity used during the past year;
  - h. 30 denial files;
  - i. 30 approved pre-certification requests;
  - j. 30 Grievance files;
  - k. 30 Appeal files;
  - l. Utilization Management statistics from last 12 months;
  - m. Provider /Member communications from the last 12 months;
5. Care Management documents:
- a. Program Plan and Description and CM policies and procedures (if different from UM);
  - b. CM logs and California Children’s Services (CCS) logs;
  - c. CCS Case Management files (number to be determined by Auditor); and
  - d. 8 CM files;
6. Credentialing documents:
- a. Policies and procedures;
  - b. Committee meeting minutes from the last 12 months, including:
    - 1) Board of Directors;
    - 2) Quality Management Committee minutes;
    - 3) Credentialing; and
    - 4) Peer Review.
  - c. Credentialing and re-credentialing files – five percent or a minimum of 50 files randomly selected by IEHP;
  - d. Practitioner files of those terminated for quality issues;

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## 13. QUALITY MANAGEMENT

### E. IPA Oversight – IPA Delegation Oversight Audit

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- e. Practitioner files that have appealed a decision;
  - f. Home Health files;
  - g. Laboratory files;
  - h. Free standing Surgical Center files;
  - i. Outpatient Rehabilitation files;
  - j. Facility Site Review/Medical Record Review worksheets;
  - k. Credentialing delegation data, if applicable;
  - l. Spreadsheet or tracking mechanism that ensures medical health care delivery providers are assessed.
  - m. Documentation of ongoing monitoring of sanctions, complaints, and quality issues for the past 12 months.
7. Other general organizational documents:
- a. Organizational chart(s);
  - b. Current job descriptions relevant to audit; and
  - c. Delegation agreements with any subcontracted practitioner, or entity to which the IPA delegates any function (i.e. UM, Credentialing).
- F. In preparation for the audit the IPA should:
- 1. Familiarize themselves with NCQA, DHCS (when applicable) and IEHP specific standards; and
  - 2. Audit themselves to make sure they meet the standards.
- G. All IPAs are to provide a written roadmap of where each element is located in the policies and procedures. All sections of the audit tool must be road mapped prior to the reviewers going on site.
- H. At the time of the audit, the IPA must have:
- 1. All requested documents ready; and
  - 2. Have appropriate staff available for each functional area that is being audited (the staff need not be present with the auditors for the entire audit).
- I. At the time of the audit, IEHP reviews:
- 1. The IPA policies and procedures for completeness and compliance with NCQA, Medi-Cal specific (when applicable), and IEHP standards;
  - 2. Committee and Subcommittee Minutes (as applicable);
  - 3. The prior authorization/referral/denial/appeal process for the following:

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## 13. QUALITY MANAGEMENT

### E. IPA Oversight – IPA Delegation Oversight Audit

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- a. Timeliness of UM and appeal decisions for non-urgent and urgent pre-certification, concurrent, and retrospective reviews;
  - b. Professional review of clinical information;
  - c. Clinical criteria for UM and appeal decisions;
  - d. Medical information – relevant clinical information collected to support UM and appeal decision-making;
  - e. Denial notices – clear documentation and communication of reasons for each denial and appeal decision, alternative treatment offered, and correct appeal language; and
  - f. Evidence of use of board certified consultants for medical necessity decisions when applicable.
4. Care Management (CM) files for demonstration of the CM process for:
- a. Case finding;
  - b. Assessment and problem identification;
  - c. Planning and goal setting;
  - d. Appropriateness of goals/time frames;
  - e. Implementation;
  - f. Monitoring;
  - g. Outcomes; and
  - h. Recommended referral services.
5. Credentialing and recredentialing files:
- a. All necessary primary source verifications have been performed within the required 180-day timeframe;
  - b. All required queries have been performed through appropriate verification sources;
  - c. All credentialing and recredentialing packets have been approved by the IPA Credentialing Committee;
  - d. All pertinent QA, grievance and Member information specific to a given practitioner, as available, have been considered during the credentialing and recredentialing process;
  - e. Processes are in place to ensure practitioner documentation including licenses, DEA certificate, Board Certification and malpractice insurance, are kept current;

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## 13. QUALITY MANAGEMENT

### E. IPA Oversight – IPA Delegation Oversight Audit

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- f. Processes are in place to ensure documentation on subcontracted organizational providers is verified at time of contracting and at least every three years thereafter;
    - g. Recredentialing of practitioners was performed within required 36-month timeframe; and
    - h. There is sufficient documentation within each credentialing file to confirm that all primary source verifications, queries and other information reviewed pertinent to the credentialing or recredentialing decision were received prior to and used in the credentialing and/or recredentialing decision.
  - 6. Randomly selected ancillary provider files (i.e., Home Health, Durable Medical Equipment (DME), laboratory) to verify that ancillary providers:
    - a. Are appropriately licensed;
    - b. Are accredited by an IEHP recognized and approved accrediting body (e.g., JCAHO, AAAHC), as stated in Policy 5E, “Subcontracted Organizational Providers”; and
    - c. Do not have sanctions (CMS/DHCS) or other negative license actions that would prevent them from participation in the IEHP network.
- J. IEHP uses the IEHP IPA Delegation Oversight Audit Tool, which is based upon current NCQA, DHCS (when applicable) and IEHP standards to sufficiently document information from the examined policies and procedures, committee minutes, files and other documents to NCQA and Medi-Cal specific standards, as well as to support the conclusions reached.
- K. The IPA receives an exit interview with the IEHP auditors at the completion of the IPA Delegation Oversight audit. This interview identifies areas found to be deficient giving the IPA an opportunity to provide additional information to clear the deficiency, and highlighting opportunities for improvements that need to be addressed through the CAP process.
- L. Within 30 days of the audit, the IPA receives written notification of the results. The written notification includes a cover letter and a completed audit tool noting any deficiencies found during the audit. The cover letter notes the timeframes for corrective action, and any other pertinent information.
- M. Scoring categories for each of the IPA Delegation Oversight Audit are as follows:
  - 1. Full Compliance 96-100%
  - 2. Substantial Compliance 90-95%
  - 3. Partial Compliance 80-89%
  - 4. Non-compliance <80%

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## 13. QUALITY MANAGEMENT

### E. IPA Oversight – IPA Delegation Oversight Audit

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- N. All IPAs that score 80% or greater pass that section of the audit. However, all IPAs with scores less than 96% must submit a CAP to remedy any deficiencies noted on the audit tool. In addition, any IPA that receives non-compliance in the credentialing portion of the audit is subject to the termination of their IEHP contract. All CAPs submitted to IEHP must meet the requirements noted in Policy 13F, “Corrective Action Plan (CAP) Requirements.”
- O. Focused audits may occur between annual audits in the following circumstances:
1. Deficiencies noted as a result of the annual audit, as applicable;
  2. Review of documents submitted to IEHP indicates potentially significant changes to the IPA program; and
  3. Any other circumstance or quality issue identified that in the judgment of IEHP, requires a focused audit.
- P. If the IPA is unable to meet the requirements at the second focused re-audit, IEHP may do one of the following:
1. Immediately freeze the IPA to new Member enrollment, as applicable;
  2. Send a 30-day contract termination notice with specific cure requirements;
  3. Rescind delegated status of IPA, as applicable;
  4. Terminate the IEHP contract with the IPA; or
  5. Not renew the contract.
- Q. IPAs who wish to appeal the results of the IPA Delegation Oversight Audit must do so in writing within 30 days of receiving their results to the IEHP Chief Medical Officer. IPAs must cite reasons for their appeal, including disputed items or deficiencies.
- R. IPAs who consistently fail to meet IEHP standards, as confirmed through annual and/or focused audits or other oversight activities, are subject to actions up to and including rescission of delegated functions, non-renewal of the IEHP contract or termination of the IPA participation in the IEHP network.
- S. IEHP can waive annual audits for NCQA accredited entities.

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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

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

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#### **APPLIES TO:**

- A. This policy applies to all IEHP Medi-Cal Members.

#### **POLICY:**

- A. IEHP Quality Management (QM) is responsible for oversight, monitoring and tracking of all assessments and Corrective Action Plans (CAPs), including but not limited to, Site Review and Medical Record Review Surveys, IPA Delegation Oversight Audits, Clinical and Focused Audits, or as determined by the Delegation Oversight Committee.
- 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. IEHP monitors IPA Quality Management (QM), Utilization Management (UM), Care Management (CM), Credentialing, Encounter Data, and Grievance and Appeals program structure and implementation of policies through the IPA Delegation Oversight Audits that are performed on an annual basis. These audits are performed using current NCQA, DHCS, and IEHP standards. IEHP also monitors these areas through their monthly submissions presented to the Delegation Oversight Committee.
- F. 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). See 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

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## 13. QUALITY MANAGEMENT

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

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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.

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 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 note 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

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## 13. QUALITY MANAGEMENT

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

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- d. Attach evidence of correction(s) (e.g. in-service 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). 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.

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## 13. QUALITY MANAGEMENT

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

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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.

### 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 requires 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

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## 13. QUALITY MANAGEMENT

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

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from the network and plan Members are appropriately reassigned to other network providers.

- e) Providers terminated 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 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.

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

#### **IPA Delegation Oversight Audit**

- A. IEHP monitors IPA compliance with IEHP and NCQA requirements through its annual IPA Delegation Oversight Audits, which includes oversight for QM, UM, Credentialing, Care Management, and DHCS specific requirements. See Policy 13E, “IPA Oversight – IPA Delegation Oversight Audit.” These audits are performed using current NCQA, IEHP, and DHCS (when appropriate) standards.
- B. IEHP uses the IEHP IPA Delegation Oversight Audit Tool, which is based on current NCQA standards, to sufficiently document information from the examined policies and procedures, committee minutes, files and other documents to meet NCQA and other regulatory specific standards, as well as to support the conclusions reached.
- C. The IPA receives an exit interview with IEHP auditors at the completion of the IPA Delegation Oversight Audit. This interview identifies areas found to be deficient, allowing the IPA an opportunity to provide additional information to clear the deficiency, and highlighting opportunities for improvements that need to be addressed through the CAP process.
- D. Within 30 days of the audit, the IPA receives written notification of the results of the audit. The written notification includes a cover letter and a completed audit tool noting any deficiencies found during the audit noted. The cover letter defines the timeframes for corrective action, and any other pertinent information.

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## 13. QUALITY MANAGEMENT

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

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- E. Scoring categories for each section of the IPA Delegation Oversight Audit are as follows:
1. Full Compliance 96-100%
  2. Substantial Compliance 90-95%
  3. Partial Compliance 80-89%
  4. Non-compliance <80%
- F. All IPAs that score 80% or greater pass that section of the audit. However, all IPAs with scores less than 96% must submit a CAP to remedy any deficiencies noted on the audit tool. CAPs are not required for scores of 96% or greater.
1. The IPA must submit a complete and comprehensive CAP to IEHP that adequately addresses all deficiencies for each section.
  2. A CAP is considered complete only if all deficiencies from each section are present and submitted together. These sections are as follows:
    - a. QM;
    - b. UM, including a UM Addendum;
    - c. Medi-Cal Addendum;
    - d. Credentialing & Recredentialing; and
    - e. Care Management.
  3. The IPA is responsible for coordination of its CAP response with each of its internal departments responsible for addressing audit deficiencies.
  4. IEHP does not accept CAPs for IPA Delegation Oversight Audit and deficiencies when received in individual sections. These are returned to the IPA and considered delinquent until a complete and all-inclusive CAP is received.
  5. Each section of the CAP response must be clearly identified with supporting documentation attached and clearly labeled.
  6. The CAP must be submitted to IEHP within 30 calendar days of written notification by IEHP of the audit results. Information shall include:
    - a. The IPA Delegation Oversight Audit score received for each section;
    - b. A list of the deficiencies identified by IEHP;
    - c. CAPs must specifically state how the deficiency is corrected and must include supporting documentation, including policies and procedures, when applicable;
    - d. Completion dates for each of the corrective actions; and

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## 13. QUALITY MANAGEMENT

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

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- e. Identification of the person responsible for completing the corrective action.
7. Upon receipt of the initial CAP, IEHP reviews the CAP and either approves or denies the CAP in writing within 30 calendar days of receipt.
8. If the CAP is denied:
  - a. IEHP meets with the IPA to review remaining deficiencies.
  - b. For those deficiencies not rectified during the IEHP/IPA meeting, the IPA receives written notification of the remaining issues with a request for a second CAP.
  - c. IPAs requiring a second CAP are frozen to new Member enrollment until a CAP is received and approved.
  - d. The IPA is required to resubmit a second CAP within 20 working days to IEHP.
9. Upon receipt of the second CAP by IEHP:
  - a. If the second CAP is approved, the IPA is then re-opened to new Member enrollment.
  - b. If the second CAP is denied, the IPA is placed in a contract cure process that gives the IPA 30 working days to adequately correct the deficiencies.
- G. IPAs wishing to appeal the results of the IPA Delegation Oversight Audit must do so in writing to the IEHP Chief Medical Officer within 30 days of receiving their results. IPAs must cite reasons for their appeal, including disputed items or deficiencies.
- H. After receiving a written appeal, the IEHP Chief Medical Officer responds to the appealing IPA in writing, noting the status of the appeal. Once an appeal is received, all additional documentation submitted by the IPA is reviewed and, if appropriate, scores may be adjusted. If necessary, a re-assessment audit is performed for areas with scores being appealed.
- I. IEHP monitors for subsequent IPA deficiencies through review of grievances, assessment of reports, and results of activities related to each area addressed by the Delegation Oversight Audits.

#### **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;

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## 13. QUALITY MANAGEMENT

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

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4. Language competency audits;
  5. Clinical audits (including asthma, diabetes, etc.);
  6. Specific quality studies;
  7. Focused audits;
  8. Pharmacy audits; or
  9. Determined necessary by the Delegation Oversight Committee.
- 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. IPA is frozen to new Member enrollment;
  2. Request for cure under contract compliance;
  3. Requirement to subcontract out the deficient activities within MSO or IPA;
  4. De-delegation of specified functions;
  5. Contract non-renewal; or
  6. Contract termination.
- E. IPAs can appeal the results of any oversight activity or specialized study or audit in accordance with Policy 16C, "Provider (IPA, Hospital & Practitioner) Grievance and Appeal Resolution Process."

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Effective date:</b>	January 1, 2001
<b>Chief Title:</b> Chief Medical Officer	<b>Revised date:</b>	January 1, 2012

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## 13. QUALITY MANAGEMENT

### G. QM Program Overview for Members, Providers and Practitioners

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#### **APPLIES TO:**

- A. This policy applies to all IEHP Medi-Cal Members.

#### **POLICY:**

- A. IEHP makes information about the Quality Management (QM) Program, including information on achieving established quality goals, available to all Members, network providers and practitioners.
- B. An overview of the QM Program is available to Members, network providers and practitioners via the IEHP website.

#### **PROCEDURE:**

- A. Two information pieces regarding the QM Program are available for Members, network providers and practitioners:
1. The “IEHP Annual Evaluation of Quality Improvement Activity Effectiveness Executive Summary” addresses progress in achieving quality goals and contains yearly Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results. This information is posted on the IEHP web site at [www.iehp.org](http://www.iehp.org) or by request.
  2. The “Quality Management Program Description” provides information on goals and objectives, QM activities addressing access to care, satisfaction surveys, clinical practice guidelines and IEHP monitoring activities. This information is available on the IEHP website at [www.iehp.org](http://www.iehp.org) or by request.
- B. IEHP provides information regarding IEHP’s progress in meeting quality goals to Members, providers and practitioners as follows:
1. The Member Services Department receives calls regarding the QM Program and/or activities.
  2. Member Services staff directs the caller to the web site at [www.iehp.org](http://www.iehp.org).
  3. Callers, who are not able to access the web site, are mailed a copy of the information.
- C. Members, network providers and practitioners may also receive information about QM Program activities by submitting a written request to IEHP at:

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## 13. QUALITY MANAGEMENT

### G. QM Program Overview for Members, Providers and Practitioners

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Inland Empire Health Plan  
P.O. Box 19026  
San Bernardino, CA 92423-9026  
Attention: Quality Management Department

Upon receipt of a written request for information letter, QM Department staff mails a packet to the requesting party consisting of the annual evaluation of “Quality Improvement Activity Effectiveness Executive Summary” and the “Quality Management Program Description.”

- D. Members, providers and practitioners are advised to contact IEHP in writing if they have suggestions or would like further information on the QM Program.

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on File</i>	<b>Effective date:</b>	August 1, 2007
<b>Chief Title:</b> Chief Medical Officer	<b>Revised date:</b>	

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## 13. QUALITY MANAGEMENT

### H. Delegated Activities

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#### **APPLIES TO:**

- A. This policy applies to all IEHP Medi-Cal Members.

#### **POLICY:**

- A. Annually, IEHP evaluates and audits each contracted IPA in accordance with current applicable National Committee for Quality Assurance (NCQA) accreditation standards, Department of Health Care Services (DHCS) regulatory requirements, and IEHP standards, modified on as needed basis.
- B. IPA Delegate agrees to be accountable for all responsibilities delegated by IEHP and oversight of any sub-delegated activities.
- C. IPA Delegate agrees to provide periodic reports to IEHP as specified in the Delegation Agreement.
- D. In the event deficiencies are identified through this oversight, Delegate will provide a specific corrective action plan acceptable to IEHP within a specified timeframe.
- E. IEHP monitors IPA compliance with reporting requirements on an annual basis.

#### **PROCEDURE:**

- A. IEHP performs annual audits in the following Delegated Activities:
  - 1. Quality Management and Improvement;
  - 2. Utilization Management;
  - 3. Credentialing and Recredentialing; and
  - 4. Care Management Adjudication.
- B. Each of the above activities describes the elements being evaluated, the frequency of the reporting requirements, and the period of time being evaluated.
  - 1. For each activity, IEHP has identified its expectations and reporting requirements to be achieved (see Attachment 13-3 in Section 23, “Attachments”).
- C. If the Delegate is unable to correct or comply with the corrective action plan within the specified timeframe, IEHP will take necessary steps up to and including revocation of delegation in whole and in part.
- D. IEHP meets with each IPA to discuss the results of its audits and presents all relevant supporting documentation. This meeting can take place at a specific meeting called by IEHP.

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## 13. QUALITY MANAGEMENT

### H. Delegated Activities

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- E. IPAs that do not agree with the final outcome, may appeal to IEHP in accordance with Policy 16C, “Provider (IPA, Hospital & Practitioner) Grievance and Appeals Resolution Process.”

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Effective Date:</b>	January 1, 2009
<b>Chief Title:</b> Chief Executive Officer	<b>Revised Date:</b>	January 1, 2012

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## 13. QUALITY MANAGEMENT

### Attachments

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<u>ATTACHMENT</u>	<u>DESCRIPTION</u>	<u>POLICY CROSS REFERENCE</u>
13-1	Biographic Information Sheet	13E
13-2	Subcontracted Facility/Agency Services and Delegated Functions	13E
13-3	Delegation Agreement	13C, 13H

Inland Empire Health Plan  
IPA Delegation Oversight Audit Tool  
Biographical Information

Date of Review:		Surveyor:	
Name of PO:			ID. #
Address:			
City/State			
Phone:			FAX:
Name of Management Company (if applicable)			
Address:			
City/State:			
Phone:			FAX:

PO Contact Personnel	Phone	FAX	E-Mail
Executive Director:			
Medical Director:			
QI Chairperson:			
QI Contact/Title:			
UM Chairperson:			
UM Contact/Title:			
Credentialing Contact/Title:			
Provider Relations Contact/Title:			
Member Services Contact/Title:			
Case Management Contact/Title:			
HEALTH PLAN CONTRACTS/ENROLLMENT			
PO Total Enrollment in all participating health plans:			
PO total enrollment for each of the following:			
Commercial:	MediCare:	MediCal:	
PO Enrollment for ( insert health plan) for each of the following:			
Commercial:	MediCare:	MediCal:	
CONTRACTED PHYSICIANS			
Total Number:	Total number of PCP's:	Total number of specialist:	
Total number of OB's:		Total number of Pediatricians:	
Have you included the following in your total:			
OB/GYN's:    yes      no		Pediatricians:    yes      no	
Capitated Specialist: (number/specialty)			
UM Criteria used by PO:		Copyright Date:	

## Inland Empire Health Plan IPA Delegation Oversight Audit Tool Sub-Contracted Facility/Agency Services and Delegated Functions

This form is to be completed for all ancillary services where the PO has established a contract directly with a facility or agency.

- Directions:
1. Mark yes or no (Y or N) for each Service listed where your PO has established a contract.
  2. In the **CONTRACTED FACILITY/AGENCY** list the name of each contracting facility or agency.
  3. In the **ACCREDITED BY** column, indicate if the facility or agency is accredited and by whom. (Refer to CR Appendix for the list of acceptable regulatory and or accrediting bodies.)
  4. In the **DELEGATED FUNCTION** column mark X in each row where your PO has delegated any functions.

<b>ANCILLARY SERVICE REVIEW</b>							
<b>Service</b>	<b>Y</b>	<b>N</b>	<b>Contracted Facility/Agency</b>	<b>Accredited by</b>	<b>Date Accreditation Expiration</b>	<b>Delegated Function</b>	<b>Date License Expiration</b>
1. Alcohol/Substance Abuse							
2. Home Health Agency							
3. DME, Orthotics, Prosthesis							
4. Mental Health							
5. Short-term Rehabilitation; P.T./O.T.							
6. Short-term Rehabilitation; Speech							
7. Hospice							
8. Infusion Center							
9. Renal Dialysis							
10. Family Planning							
11. Chiropractor							
12. Skilled Nursing Facilities							
13. Tertiary Care Facility							
14. X-ray							
15. Ultrasound MRI/CT							
16. Laboratory							
17. Surgi-Centers							
18. Urgent Care Centers							
19. Transportation (ambulance, ambi-vans)							

**Note:** The Delegated Credentialing function is evaluated separately

**Description of Delegated Activities**

The purpose of the following grid is to specify the activities delegated by Inland Empire Health Plan (IEHP) under the Delegation Agreement with respect to: (i) quality management and improvement, (ii) utilization management, (iii) care management, (iv) California Children’s Services, (v) credentialing and recredentialing, and (vi) Encounter Data. All Delegated Activities are to be performed in accordance with currently applicable NCQA accreditation standards, DHCS regulatory requirements, and IEHP standards, as modified from time to time. Delegate agrees to be accountable for all responsibilities delegated by IEHP and oversight of any sub-delegated activities, except as outlined in the Delegation Agreement. Delegate will provide the reports to IEHP as described in the Reporting Requirements column of the Delegation Agreement. IEHP will oversee the delegation by performing annual audits. In the event deficiencies are identified through this oversight, Delegate will provide a specific corrective action plan acceptable to IEHP. If Delegate does not comply with the corrective action plan within the specified time frame, IEHP will take necessary steps up to and including revocation of delegation in whole or in part.

Standard	Delegated Activities	Reporting Requirements
<p>NCQA QI 1: Program Structure</p>	<p>The Delegate has the QI infrastructure necessary to improve the quality and safety of clinical care and services it provides to its members</p> <ul style="list-style-type: none"> <li>▪ The QI program description includes the following               <ol style="list-style-type: none"> <li>1. A written description of the QI program structure</li> <li>2. Patient safety is specifically addressed in the program description</li> <li>3. The QI program is accountable to the governing body</li> <li>4. A designated physician has substantial involvement in the QI program</li> <li>5. A QI committee oversees the QI functions of the organization</li> <li>6. The specific role, structure and function of the QI Committee and other committees, including meeting frequency, are addressed in the program description</li> <li>7. An annual work plan</li> <li>8. A description of resources that the organization devotes to the QI program</li> <li>9. Objectives for serving a culturally and linguistically diverse membership</li> <li>10. Objectives for serving Member with complex health needs</li> </ol> </li> <li>▪ There is an annual written evaluation of the QI program that includes the following information               <ol style="list-style-type: none"> <li>1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service</li> <li>2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>▪ QM Program Description – Annual (February 15<sup>th</sup>)</li> <li>▪ QM Program Evaluation – Annual (February 15<sup>th</sup>)</li> <li>▪ QM Work Plan – Annual February 15<sup>th</sup>)</li> <li>▪ QM Work Plan Update – Semi-Annual (August 15<sup>th</sup>)</li> </ul>

**Description of Delegated Activities**

<b>Standard</b>	<b>Delegated Activities</b>	<b>Reporting Requirements</b>
	<ol style="list-style-type: none"> <li>3. Analysis of the results of QI initiatives, including barrier analysis</li> <li>4. Evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide safe clinical practices.</li> </ol>	
<p>NCQA QI 2: Program Operations</p>	<p>The Delegate’s QI Committee and practitioners develop, implement and oversee the QI program.</p> <ul style="list-style-type: none"> <li>▪ The Delegate’s QI Committee: <ol style="list-style-type: none"> <li>1. Recommends policy decisions</li> <li>2. Analyzes and evaluates the results of QI activities</li> <li>3. Ensures practitioner participation in the QI program through planning, design, implementation or review</li> <li>4. Institutes needed actions</li> <li>5. Ensures follow-up, as appropriate</li> <li>6. Maintains signed and dated meeting minutes</li> </ol> </li> <li>▪ The organization annually makes information about its QI program available to the following groups. <ol style="list-style-type: none"> <li>1. Members</li> <li>2. Practitioners</li> </ol> </li> </ul>	
<p>NCQA QI 10: Continuity and Coordination of Medical Care</p>	<p>The Delegate uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system.</p> <ul style="list-style-type: none"> <li>▪ The Delegate notifies members affected by the termination of a practitioner or practice group in general, family and internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner.</li> <li>▪ If the practitioner’s contract is discontinued, the organization allows affected members continued access to the practitioner, as follows. <ol style="list-style-type: none"> <li>1. Continuation of treatment through the lesser of the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition</li> <li>2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy</li> </ol> </li> </ul>	
<p>NCQA UM 1: Utilization Management</p>	<p>The Delegate has a well structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner.</p> <ul style="list-style-type: none"> <li>▪ The Delegate UM program description includes the following:</li> </ul>	<ul style="list-style-type: none"> <li>▪ UM Program Description – Annual (February 15<sup>th</sup>)</li> <li>▪ UM Program Evaluation/ICE</li> </ul>

**Description of Delegated Activities**

<b>Standard</b>	<b>Delegated Activities</b>	<b>Reporting Requirements</b>
Structure	<ol style="list-style-type: none"> <li>1. A written description of the program structure</li> <li>2. A designated senior physician is involved in UM program implementation</li> <li>3. The program scope and process used to determine benefit coverage and medical necessity</li> <li>4. Information sources used to determine benefit coverage and medical necessity.</li> </ol> <ul style="list-style-type: none"> <li>▪ A senior physician is actively involved in implementing the delegate’s UM program.</li> <li>▪ The Delegate annually evaluates and updates the UM Program, as necessary.</li> <li>▪ Must meet applicable IEHP Standards and are consistent with NCQA, State and Federal health care regulatory agencies standards.</li> </ul>	<p>Report – Semi-Annually (February 15<sup>th</sup> and August 15<sup>th</sup> )</p> <ul style="list-style-type: none"> <li>▪ UM Work Plan/ICE Report – Annually (February 15<sup>th</sup>)</li> </ul>
NCQA UM 2: Clinical Criteria for UM Decisions	<p>The Delegate applies objective and evidence-based criteria and takes individual circumstances and the local deliver system into account when determining the medical appropriateness of health care services.</p> <ul style="list-style-type: none"> <li>▪ The Delegate: <ol style="list-style-type: none"> <li>1. Has written UM decision-making criteria that are objective and based on medical evidence.</li> <li>2. Has written policies for applying the criteria based on individual needs.</li> <li>3. Has written policies for applying the criteria based on an assessment of the local delivery system.</li> <li>4. Involves appropriate practitioners in developing, adopting and reviewing criteria.</li> <li>5. Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate.</li> </ol> </li> <li>▪ The Delegate: <ol style="list-style-type: none"> <li>1. States in writing how practitioners can obtain UM criteria.</li> <li>2. Makes the UM criteria available to its practitioners upon request.</li> </ol> </li> <li>▪ At least annually, the Delegate: <ol style="list-style-type: none"> <li>1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision-making.</li> <li>2. Acts on opportunities to improve consistency, if applicable.</li> </ol> </li> </ul>	
NCQA UM 3: Communication Services	<p>Members and practitioners can access staff to discuss UM issues.</p> <ul style="list-style-type: none"> <li>▪ The Delegate provides the following communication services for members and practitioners. <ol style="list-style-type: none"> <li>1. Staff are available at least eight hours a day during normal business hours for inbound calls regarding UM issues</li> </ol> </li> </ul>	

**Description of Delegated Activities**

Standard	Delegated Activities	Reporting Requirements
	<ol style="list-style-type: none"> <li>2. Staff can receive inbound communication regarding UM issues after normal business hours</li> <li>3. Staff can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon</li> <li>4. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues</li> <li>5. Toll-free number or staff available to accept collect calls regarding UM issues</li> <li>6. Staff are accessible to callers who have questions about the UM process</li> </ol>	
<p>NCQA UM 4: Appropriate Professionals</p>	<p>UM decisions are made by qualified health professionals.</p> <ul style="list-style-type: none"> <li>▪ The Delegate has written procedures:               <ol style="list-style-type: none"> <li>1. Requiring appropriately licensed professionals to supervise all medical necessity decisions</li> <li>2. Specifying the type of personnel responsible for each level of UM decision-making.</li> </ol> </li> <li>▪ The Delegate has a written job description with qualifications for practitioners who review denials for care based on medical necessity. Practitioners are required to have:               <ol style="list-style-type: none"> <li>1. Education, training or professional experience in medical or clinical practice</li> <li>2. A current license to practice without restriction.</li> </ol> </li> <li>▪ The Delegate ensures that a physician or other health care professional, as appropriate, reviews any non-behavioral health denial based on medical necessity.</li> <li>▪ The Delegate has written procedures for using board-certified consultants and evidence that it uses these procedures to assist in making medical necessity determinations.</li> <li>▪ The Delegate distributes a statement to all members and to all practitioners, providers and employees who make UM decisions, affirming the following:               <ol style="list-style-type: none"> <li>1. UM decision making is based only on appropriateness of care and service and existence of coverage</li> <li>2. The Delegate does not specifically reward practitioners or other individuals for issuing denials of coverage or care</li> <li>3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>▪ UM Program Evaluation/ICE Report – Semi-Annually (February 15<sup>th</sup> and August 15<sup>th</sup>)</li> </ul>
<p>NCQA UM 5: Timeliness of UM Decisions</p>	<p>The Delegate makes utilization decisions in a timely manner to minimize any disruption in the provision of health care.</p> <ul style="list-style-type: none"> <li>▪ The Delegate adheres to the following time frames for timeliness of UM decision making.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Denial Logs and Letter with the supporting documentation used to make decisions - Monthly (15<sup>th</sup> of each month)</li> </ul>

**Description of Delegated Activities**

<b>Standard</b>	<b>Delegated Activities</b>	<b>Reporting Requirements</b>
	<ol style="list-style-type: none"> <li>1. For non-urgent pre-service decisions, the Delegate makes decisions within 5 business days of receipt of the request.</li> <li>2. For urgent pre-service decisions, the organization makes decisions within 72 hours of receipt of the request</li> <li>3. For urgent concurrent review, the Delegate makes decisions within 24 hours of receipt of the request</li> <li>4. For post-service decision, the Delegate makes decisions within 30 calendar days of receipt of the request.</li> </ol> <ul style="list-style-type: none"> <li>▪ The Delegate adheres to the following time frames for notification of non-behavioral health UM decision making.               <ol style="list-style-type: none"> <li>1. For non-urgent pre-service denial decisions, the Delegate gives electronic or written notification of the decision to practitioners and members within 2 working days of the decision</li> <li>2. For urgent pre-service denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request</li> <li>3. For urgent concurrent denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 24 hours of the request</li> <li>4. For post-service denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Second Opinion Tracking Logs - Monthly (15<sup>th</sup> of each month)</li> <li>▪ UM Trend Reports by LOB- Monthly (15<sup>th</sup> of each month)</li> </ul>
<p>NCQA UM 6: Clinical Information</p>	<p>The delegate uses all information relevant to a member’s care when it makes UM decisions</p> <ul style="list-style-type: none"> <li>▪ For at least 12 months, the Delegate has had in place a written description that identifies the information needed to support UM decision making.</li> <li>▪ If the delegate provides onsite review services at facilities, it has a documented process that includes the following:               <ol style="list-style-type: none"> <li>1. Guidelines for identifying Delegate staff at the facility, in accordance with facility procedures</li> <li>2. A process for scheduling the onsite review in advance, unless otherwise agreed upon</li> <li>3. A process for ensuring that staff follow facility rules</li> </ol> </li> <li>▪ There is documentation that relevant clinical information is gathered consistently to support non-behavioral health UM decision making.</li> </ul>	<ul style="list-style-type: none"> <li>▪ UM Program Evaluation/ICE Report – Semi-Annually (February 15<sup>th</sup> and August 15<sup>th</sup>)</li> </ul>

**Description of Delegated Activities**

<b>Standard</b>	<b>Delegated Activities</b>	<b>Reporting Requirements</b>
<p>NCQA UM 7: Denial Notices</p>	<p>Members and practitioners receive sufficient information to understand and decide whether to appeal a decision to deny care or coverage.</p> <ul style="list-style-type: none"> <li>▪ The Delegate notifies practitioners about:               <ol style="list-style-type: none"> <li>1. The Delegate’s policy for making an appropriate practitioner reviewer available to discuss any UM denial decision</li> <li>2. How to contact a reviewer.</li> </ol> </li> <li>▪ The Delegate provides practitioners with the opportunity to discuss any non-behavioral health UM denial decision with a physician or other appropriate reviewer.</li> <li>▪ The Delegate provides written notification to members and their treating practitioners of the non-behavioral health denial that contains the following information.               <ol style="list-style-type: none"> <li>1. The specific reasons for the denial, in easily understandable language</li> <li>2. A reference to benefit provision, guideline, protocol or other similar criterion on which the denial decision in based</li> <li>3. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.</li> </ol> </li> <li>▪ The Delegate provides written notification to members and their treating practitioners of a non-behavioral health denial, notification and approval that contains the following:               <ol style="list-style-type: none"> <li>1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal</li> <li>2. An explanation of the appeal process, including the right to member representation and time frames for deciding appeals</li> <li>3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials.</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Denial Logs and Letters with supporting documentation used to make decision - Monthly (15<sup>th</sup> of each month)</li> </ul>
<p>NCQA UM 11: Satisfaction with the UM Process</p>	<p>The Delegate continually assesses customer satisfaction with it’s UM process to identify areas of improvement.</p> <ul style="list-style-type: none"> <li>▪ The Delegate’s annual assessment of satisfaction with the UM process includes:               <ol style="list-style-type: none"> <li>1. Collecting and analyzing data on Member satisfaction for the identification of improvement opportunities</li> <li>2. Collection and analyzing data on practitioner satisfaction for the identification of improvement opportunities</li> <li>3. Taking action designed to improve Member satisfaction based on its assessment of Member data</li> </ol> </li> </ul>	

**Description of Delegated Activities**

<b>Standard</b>	<b>Delegated Activities</b>	<b>Reporting Requirements</b>
	<p>4. Taking action designed to improve practitioner satisfaction based on its assessment of practitioner data</p>	
<p>NCQA CM1: Care Management</p>	<p>IPAs must submit a monthly care management log that includes the following:</p> <ol style="list-style-type: none"> <li>1. Member name</li> <li>2. Member ID number</li> <li>3. Member type (Medi-Cal, Healthy Families, Healthy Kids)</li> <li>4. Date PCP and/or Specialist notified</li> <li>5. Diagnosis/reason for referral</li> <li>6. Problem list</li> <li>7. Interventions (the Member’s Care Plan must be shared with the PCP)</li> <li>8. The name of the treating PCP and/or Specialist</li> <li>9. Monthly Activities</li> <li>10. If the Care Plan was sent to PCP</li> <li>11. Reason for case closure or disposition</li> <li>12. Date case closed</li> </ol> <ul style="list-style-type: none"> <li>▪ Members who remain in Care Management for consecutive months must have an activity update each month,</li> </ul>	<ul style="list-style-type: none"> <li>▪ CM Report Log – Monthly (15<sup>th</sup> of each month)</li> </ul>
<p>NCQA CCS1: California Children’s Services (CCS)</p>	<p>IPAs must maintain a log for new CCS referrals for Medi-Cal Members that includes the following:</p> <ol style="list-style-type: none"> <li>1. Status</li> <li>2. Member name</li> <li>3. Member ID number</li> <li>4. Member date of birth</li> <li>5. The name of the treating PCP and/or Specialist</li> <li>6. County</li> <li>7. Diagnosis description</li> <li>8. Date identified</li> <li>9. State file number</li> <li>10. Date referred</li> </ol>	<ul style="list-style-type: none"> <li>▪ New CCS cases by IPA Log – Monthly (15<sup>th</sup> of each month)</li> </ul>
<p>NCQA SPD1: Continuity of Care for SPD</p>	<ul style="list-style-type: none"> <li>▪ IEHP requires the IPA to report monthly on all continuity of care requests made by the Member or the Provider for newly enrolled and Mandatory SPD Members for the following:</li> </ul>	<ul style="list-style-type: none"> <li>▪ Continuity of Care Report Log – Monthly (15<sup>th</sup> of each month)</li> </ul>

**Description of Delegated Activities**

<b>Standard</b>	<b>Delegated Activities</b>	<b>Reporting Requirements</b>
Members	<ol style="list-style-type: none"> <li>1. Medical Exempt Requests (MERS)</li> <li>2. Expedited Disenrollment Requests (EDERS)</li> <li>3. Short and long term contract arrangements (Letter of Agreement (LOA) when the Provider is out of the network and not contracted with the IPA VS. Contract)</li> </ol> <ul style="list-style-type: none"> <li>▪ The Continuity of Care Report Log must include the following:               <ol style="list-style-type: none"> <li>1. Member ID number</li> <li>2. Type of request                   <ol style="list-style-type: none"> <li>a. One time LOA – approved</li> <li>b. One time LOA – denied</li> <li>c. Long term LOA (up to 12 months) – approved</li> <li>d. Long term LOA (up to 12 months) – denied</li> <li>e. MERS – approved</li> <li>f. MERS – denied</li> <li>g. EDERS – approved</li> <li>h. EDERS – denied</li> <li>i. Contract with out-of-network Provider</li> </ol> </li> <li>3. Reason/diagnosis for request</li> <li>4. The name of the requesting practitioner</li> <li>5. Reason of the denials</li> </ol> </li> <li>▪ IEHP will be responsible to report all IPA Continuity of Care to DHCS.</li> </ul>	
NCQA UM 12: Emergency Services	<p>Members can obtain needed emergency services</p> <ul style="list-style-type: none"> <li>▪ The Delegate’s emergency services policies and procedures require coverage of emergency services in the following situations.               <ol style="list-style-type: none"> <li>1. To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonable, would have believed that an emergency medical condition existed</li> <li>2. If an authorized representative, acting for the organization, authorized the provision of emergency services</li> </ol> </li> <li>▪ A physician or other appropriate practitioner reviews presenting symptoms and the discharge diagnosis for emergency services.</li> <li>▪ The Delegate covers emergency services approved by an authorized representative.</li> </ul>	
NCQA CR 1: Credentialing	<p>The Delegate has a rigorous process to select and evaluate practitioners.</p> <ul style="list-style-type: none"> <li>▪ The Delegate’s credentialing policies and procedures specify:</li> </ul>	<ul style="list-style-type: none"> <li>▪ Active Providers Report for San Bernardino and Riverside Counties</li> </ul>

**Description of Delegated Activities**

<b>Standard</b>	<b>Delegated Activities</b>	<b>Reporting Requirements</b>
Policies	<ol style="list-style-type: none"> <li>1. The types of practitioners to credential and recredential</li> <li>2. The verification sources used</li> <li>3. The criteria for credentialing and recredentialing</li> <li>4. The process for making credentialing and recredentialing decisions</li> <li>5. The process for managing credentialing files that meet Delegate’s established criteria</li> <li>6. The process to further Delegate (sub-delegate) credentialing or recredentialing</li> <li>7. The process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner</li> <li>8. The process for notifying practitioners if information obtained during the credentialing process varies substantially from the information they provided to the Delegate</li> <li>9. The process for ensuring that practitioners are notified of the credentialing and recredentialing decisions within 60 calendar days of the committee’s decision</li> <li>10. The medical director or other designated physician’s direct responsibility and participation in the credentialing program</li> <li>11. The process for ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law</li> <li>12. The process for ensuring that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty. <ul style="list-style-type: none"> <li>▪ The Delegate’s policies and procedures include the right to: <ol style="list-style-type: none"> <li>1. Review information submitted to support their credentialing application</li> <li>2. Correct erroneous information</li> <li>3. Receive the status of their credentialing or recredentialing application, upon request</li> <li>4. Receive notification of these rights.</li> </ol> </li> </ul> </li> </ol>	<p>Quarterly (15<sup>th</sup> of the month)</p> <ul style="list-style-type: none"> <li>▪ Termed Providers Report for San Bernardino and Riverside Counties Quarterly (15<sup>th</sup> of the month)</li> <li>▪ Added Providers Report for San Bernardino and Riverside Counties Quarterly (15<sup>th</sup> of the month)</li> <li>▪ Reporting Months: January 15<sup>th</sup>, April 15<sup>th</sup>, July 15<sup>th</sup>, and October 15<sup>th</sup></li> </ul>
NCQA CR 2: Credentialing Committee	<p>The Delegate obtains meaningful advice and expertise from participating practitioners when it makes credentialing decisions.</p> <ul style="list-style-type: none"> <li>▪ The Credentialing Committee includes representation from a range of participating practitioners.</li> <li>▪ The Delegate provides evidence of the following: <ol style="list-style-type: none"> <li>1. Credentialing Committee review of credentials for practitioners who do not meet established thresholds</li> </ol> </li> </ul>	

**Description of Delegated Activities**

<b>Standard</b>	<b>Delegated Activities</b>	<b>Reporting Requirements</b>
	2. Medical director's or designated physician's review and approval of clean files.	
NCQA CR 3: Initial Credentialing Verification	<p>The Delegate conducts timely verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care.</p> <ul style="list-style-type: none"> <li>▪ The Delegate verifies that a current, valid license to practice is present and within the prescribed time limits.</li> <li>▪ The Delegate verifies that the following are within the prescribed time limits.               <ol style="list-style-type: none"> <li>1. A valid DEA or CDS certificate, if applicable</li> <li>2. Education and training, including board certification, as specified in the Explanation</li> <li>3. Work history</li> <li>4. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner</li> </ol> </li> </ul>	<p>Within 30 days of committee decision, initial credentialing packets for approved providers must be submitted. Provider termination notices must follow IEHP Provider Manual timeframes.</p>
NCQA CR 4: Application and Attestation	<p>The Delegate requires practitioners to disclose information that may adversely impact their ability to provide care.</p> <ul style="list-style-type: none"> <li>▪ The application includes a current and signed attestation and addresses the following:               <ol style="list-style-type: none"> <li>1. Reasons for inability to perform the essential functions of the position, with or without accommodation.</li> <li>2. Lack of present illegal drug use.</li> <li>3. History of loss of license and felony convictions.</li> <li>4. History of loss or limitation of privileges or disciplinary actions.</li> <li>5. Current malpractice insurance coverage.</li> <li>6. The correctness and completeness of the application.</li> </ol> </li> </ul>	
NCQA CR 5: Initial Sanction Information	<p>The Delegate verifies whether there has been any sanction activity that might impact a practitioner's ability to provide safe, appropriate care to members.</p> <ul style="list-style-type: none"> <li>▪ The Delegate verifies the following sanction information for initial credentialing:               <ol style="list-style-type: none"> <li>1. State sanctions, restrictions on licensure, or limitations on scope of practice.</li> <li>2. Medicare and Medicaid sanctions.</li> </ol> </li> </ul>	
NCQA CR 6: Practitioner Office Site Quality	<p>The Delegate assesses the quality, safety and accessibility of office sites where care is delivered.</p> <ul style="list-style-type: none"> <li>▪ The Delegate sets performance standards and thresholds for:               <ol style="list-style-type: none"> <li>1. Office-site criteria</li> <li>2. Medical/treatment record-keeping criteria.</li> </ol> </li> <li>▪ The Delegate implements appropriate interventions by:</li> </ul>	

**Description of Delegated Activities**

<b>Standard</b>	<b>Delegated Activities</b>	<b>Reporting Requirements</b>
	<ol style="list-style-type: none"> <li>1. Conducting site visits of offices about which it has received member complaints</li> <li>2. Instituting actions to improve offices that do not meet thresholds</li> <li>3. Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds</li> <li>4. Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 days of determining its complaint threshold was met</li> <li>5. Documenting follow-up visits for offices that had subsequent deficiencies.</li> </ol>	
<p>NCQA CR 7: Recredentialing Verification</p>	<p>The Delegate identifies changes that have occurred since the last credentialing which may affect the care provided to members.</p> <ul style="list-style-type: none"> <li>▪ The Delegate verifies that a current, valid license or certification from the state to practice is present and within the prescribed time limits.</li> <li>▪ The Delegate verifies the following within prescribed time limits: <ol style="list-style-type: none"> <li>1. A valid DEA or CDS certificate, as applicable</li> <li>2. Board certification, as applicable</li> <li>3. History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner</li> </ol> </li> <li>▪ The application includes a current and signed attestation and addresses the following: <ol style="list-style-type: none"> <li>1. Reasons for any inability to perform the essential functions of the position, with or without accommodation</li> <li>2. Lack of present illegal drug use</li> <li>3. History of loss of license and felony convictions</li> <li>4. History of loss or limitation of privileges or disciplinary action</li> <li>5. Current malpractice insurance coverage</li> <li>6. Correctness and completeness of application.</li> </ol> </li> <li>▪ The Delegate verifies the following sanction information for recredentialing. <ol style="list-style-type: none"> <li>1. State sanctions, restrictions on licensure or limitations on scope of practice</li> <li>2. Medicare and Medicaid sanctions</li> </ol> </li> </ul>	<p>Within 30 days of committee decision, recredentialing packets for approved providers must be submitted. Provider termination notices must follow IEHP Provider Manual timeframes.</p>
<p>NCQA CR 8: Recredentialing Cycle Length</p>	<p>The Delegate conducts timely recredentialing.</p> <ul style="list-style-type: none"> <li>▪ The length of the recredentialing cycle is within the required 36-month time frame.</li> </ul>	

**Description of Delegated Activities**

<b>Standard</b>	<b>Delegated Activities</b>	<b>Reporting Requirements</b>
<p>CR 9: Ongoing Monitoring</p>	<p>The Delegate identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.</p> <ul style="list-style-type: none"> <li>▪ The Delegate implements ongoing monitoring and makes appropriate interventions by:               <ol style="list-style-type: none"> <li>1. Collecting and reviewing Medicare and Medicaid sanctions.</li> <li>2. Collecting and reviewing sanctions and limitations on licensure.(i.e., DEA registration, hospital privileges, malpractice insurance)</li> <li>3. Collecting and reviewing complaints.</li> <li>4. Collecting and reviewing information from identified adverse events.</li> <li>5. Implementing appropriate interventions when it identifies instances of poor quality, when appropriate.</li> </ol> </li> </ul>	<p>Upon notification, IPA must report providers that have ongoing monitoring concerns (as delineated under Delegated Activities CR 9) and how IPA responded to those concerns.</p>
<p>NCQA CR 10: Notification to Authorities and Practitioner Appeal Rights</p>	<p>The Delegate uses objective evidence and patient-care considerations to decide on the means of altering its relationship with a practitioner who does not meet its quality standards.</p> <ul style="list-style-type: none"> <li>▪ The Delegate has policies and procedures for:               <ol style="list-style-type: none"> <li>1. The range of actions available to the Delegate</li> <li>2. Reporting to authorities</li> <li>3. A well-defined appeal process</li> <li>4. Making the appeal process known to practitioners.</li> </ol> </li> <li>▪ There is documentation that the Delegate reports practitioner suspension or terminations to appropriate authorities.</li> <li>▪ The Delegate has an appeal process for instances in which it chooses to alter the conditions of practitioners’ participation based on issues of quality of care or service, and informs practitioners of the appeal process.</li> </ul>	
<p>NCQA CR 11: Assessment of Organizational Providers</p>	<p>The Delegate evaluates the quality of providers with which it contracts.</p> <ul style="list-style-type: none"> <li>▪ The Delegate policy for assessing a health care delivery provider specifies that it contracts with a provider, and for at least every three years thereafter, it:               <ol style="list-style-type: none"> <li>1. Confirms that the provider is in good standing with state and federal regulatory bodies</li> <li>2. Confirms that the provider has been reviewed and approved by an accrediting body acceptable to Delegate, including which accrediting bodies are acceptable</li> <li>3. Conducts an onsite quality assessment if the provider is not accredited.</li> </ol> </li> <li>▪ The Delegate includes at least the following medical providers in its assessment:               <ol style="list-style-type: none"> <li>1. Hospitals</li> <li>2. Home health agencies</li> </ol> </li> </ul>	

**Description of Delegated Activities**

<b>Standard</b>	<b>Delegated Activities</b>	<b>Reporting Requirements</b>
	3. Skilled nursing facilities 4. Freestanding surgical centers <ul style="list-style-type: none"> <li>▪ The Delegate has documentation that it assessed contracted medical health care delivery providers.</li> </ul>	
NCQA ENC1: Encounter Data Reporting	<p>The Delegate is required by DMHC, CMS and DHCS to submit Encounter Data for the effective management of IEHP health care delivery system.</p> <ul style="list-style-type: none"> <li>▪ This should be sent in a format acceptable to IEHP.</li> <li>▪ The Encounter Data must be complete and accurate.</li> </ul> <p>IEHP may withhold no more than one percent (1%) of the monthly Capitation Payment for failure to submit complete and accurate Encounter Data within ninety (90) days after each month of service.</p>	<ul style="list-style-type: none"> <li>▪ Submit Encounter Data within ninety (90) days after each month of service</li> </ul>