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## 23. COMPLIANCE

### A. Monitoring of First Tier ~~and~~ -Downstream ~~and Related~~ Entities

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#### **APPLIES TO:**

- A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare Medicaid Plan)~~ Providers; and First Tier ~~and~~; Downstream, ~~and Related~~ Entities (FTEDRs).

#### **POLICY:**

- A. IEHP may delegate the authority and responsibility to carry out program/plan activities that are otherwise performed by IEHP. IEHP retains accountability for services provided by First Tier ~~and~~; -Downstream ~~and Related~~ Entities (FTEDRs). Further, IEHP is responsible for maintaining compliance with applicable State and Federal requirements.<sup>1,2,3,4,5,6,7,8,9,10</sup>
1. The terms and conditions set forth in contracts with FTEDRs require that they perform and maintain delegated functions consistent with IEHP's contractual obligations.
- B. IEHP will conduct a pre-contractual evaluation and annual audit of all IPAs and FTEDRs, as appropriate. IEHP monitors FTEDR performance on an ongoing basis and will implement corrective actions and revoke delegation of duties if it determines that an FTEDR is unable or unwilling to carry out its responsibilities.
- C. An annual risk assessment will be completed to aid in identifying high risk FTEDRs. High risk FTEDRs are those that possess characteristics such as; responsibility for tasks that aid in or have a potential for hindering member access to service, are continually non-compliant or at risk of non-compliance based on regulatory and IEHP requirements, or have a history of non-compliance as identified by a government agency. FTEDRs determined to be high risk may be subjected to a more frequent monitoring and auditing schedule.
- D. The Compliance Department works in conjunction with the Delegation Oversight Committee to evaluate, recommend and implement improvements to the process for monitoring delegated FTEDRs. In addition, the Compliance Department along with the Delegation Oversight

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<sup>1</sup> Title 42 Code of Federal Regulations (CFR) §422.503(b)(4)(vi)(F), 422.504(i), 423.504(b)(4)(vi)(F), 438.230(b)-

<sup>2</sup> ~~IEHP Coordinated Care Initiative (CCI) Three Way Contract.~~

<sup>3</sup> ~~Medicare Managed Care Manual, Chapter 9 and 21, "Compliance Program Guidelines," "Section 40CMS Medicare Managed Care Manual Chapter 21, Compliance Program Guidelines.~~

<sup>4</sup> ~~Medicare Managed Care Manual, Chapter 9, "Prescription CMS Prescription Drug Benefit Manual Chapter 9, Compliance Program Guidelines.~~

<sup>5</sup> ~~Code of Federal Regulations, Title 42, et al.~~

<sup>6</sup> ~~Title 10 Code of Regulations (CFR) § California Code of Regulations, Title 10, et al.~~

<sup>7</sup> ~~22 CFR California Code of Regulations, Title 22, §§ 51000-53999.~~

<sup>8</sup> ~~Title 28 Code of Regulations (CFR) § California Code of Regulations, Title 28, et al.~~

<sup>9</sup> ~~California Welfare and Institutions Code (Welf. & Inst. Code), §-§14100-et seq., 14458.~~

<sup>10</sup> ~~Knox-Keene Health Care Service Plan Act of 1974, Health and Safety Code §-1340 et seq. (Knox-Keene Health Care Service Plan Act of 1975).~~

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Committee develop the annual audit calendar, which includes ~~FTE~~~~DR~~ monitoring activities to validate compliance with contractual standards and regulatory requirements.

- E. The Delegation Oversight Committee is tasked with oversight of the ~~FTE~~~~DR~~ Oversight process. The Committee reviews data as reported by the ~~FTE~~~~DR~~ Committee and recommends modifications where appropriate. The key functions of the Delegation Oversight Committee for oversight of delegation management include:
1. Monthly reviews of ~~FTE~~~~DR~~ performance data.
  2. Review and approval of corrective actions; review recommendations for contractual penalties; assistance with the implementation of corrective actions and penalties; etc.
  3. Approval of the annual audit calendar and any ad-hoc ~~FTE~~~~DR~~ monitoring and auditing.
  4. Determining approval for delegated and sub-delegated activities for new ~~FTE~~~~DR~~s based on the initial evaluation, assessment and approval of the operational functional leads.
  5. Results and actions taken by the Delegation Oversight Committee are reported up to the Compliance Committee.
  6. Provide reports at least annually to the IEHP Governing Board regarding monitoring and auditing activities conducted as part of the ~~FTE~~~~DR~~ Oversight program.
- F. The Compliance Department enforces the compliance program by ensuring all regulatory requirements and policies and procedures are adhered to. There are a variety of ways in which this is achieved, including:
1. Annually reviews and updates the Program, as applicable.
  2. Annually reviews and updates associated policies and procedures, as applicable, incorporating ad-hoc changes as regulatory changes require.
  3. Presents program efforts to the Compliance Committee.
  4. Conducts an annual risk assessment.
- G. The functional areas and business departments implement the ~~FTE~~~~DR~~ Oversight program at an operational level. Oversight activities outlined in the plan are managed by the responsible business areas. The departments are responsible for the following:
1. Managing the day-to-day ~~FTE~~~~DR~~ relationship.
  2. Identifying negative trends or vulnerabilities.
  3. Monitoring ~~FTE~~~~DR~~ compliance according to the Program and associated tools and processes.
  4. Monitoring operational performance.
  5. Day-to-day management of issues and actions; escalated as required.

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6. Assisting with implementation, review and acceptance of corrective action plans.
7. Managing ~~FTEDR~~ operational communications and/or training.
8. Reporting performance to the Delegation Oversight Committee.
9. Assisting the Compliance Department in identifying risk as part of the annual risk assessment.

#### **PURPOSE:**

- A. The purpose of this policy is to ensure that ~~FTEDRs~~ are compliant with meeting the terms and conditions of regulatory elements as established by Centers for Medicare & Medicaid Services (CMS), the State of California, other governmental entities, and IEHP.

#### **PROCEDURES:**

- A. Initial Evaluation: Prior to executing a contract or delegation agreement with a potential ~~FTEDR~~, requests for an initial evaluation may be forwarded to the Delegation Oversight Committee by the department executing the contract or delegation agreement. The Delegation Oversight Committee may ensure an initial evaluation as necessary to determine the ability of the potential ~~FTEDR~~ to assume responsibility for delegated activities and to maintain IEHP standards, applicable Federal, State, and accreditation requirements.
  1. The following will be assessed in the initial evaluation:
    - a. The entity's ability to perform the required tasks. IEHP will verify that the ~~FTEDR~~ meets both contractual and regulatory requirements.
    - b. Policies and procedures specific to the delegated function(s).
    - c. Operational capacity to perform the delegated function(s).
    - d. Resources (administrative and financial) sufficient and qualified to perform the required function(s).
    - e. Exclusion of the ~~FTEDR~~ from participating in State and/or Federal health programs (excluded parties lists):
      - 1) The Department of Health and Human Services (DHHS) Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);<sup>++</sup>
      - 2) The General Services Administration (GSA) System for Award Management (SAM);<sup>+2</sup>

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~~<sup>++</sup> Department of Health and Human Services (DHHS) Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE).~~

~~<sup>+2</sup> General Services Administration (GSA) System for Award Management (SAM).~~

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- 3) The Medicare Opt-Out List<sup>13</sup> (as applicable);
  - 4) CMS Preclusion List<sup>14</sup> (as applicable); and
  - 5) The DHCS Medi-Cal Suspended and Ineligible Provider List.<sup>15</sup>
- f. The entity's annual compliance and FWA training program.
2. An initial onsite evaluation may be conducted. If the ~~FTEDR~~ is not in full compliance with delegated standards, the ~~FTEDR~~'s action plan and timeline to achieve full compliance is reviewed. The oversight process may be modified for accredited/certified ~~FTEDRs~~ as applicable. The need for an onsite visit and/or file audit is at the sole discretion of IEHP. IEHP determines the frequency and format of contact with the ~~FTEDR~~ to verify compliance with established, revised, or new State, CMS, and accreditation requirements. The ~~FTEDR~~ is required to comply with IEHP reporting requirements.
  3. Results and recommendations of the initial evaluation are documented in a report and presented to the Chief Operating Officer (COO) ~~and Chief Network & Development Officer (CNDO)~~. Copies of the results are reviewed by the Delegation Oversight ~~Sub~~Committee and subsequently the Compliance Committee. To accommodate business needs, ad hoc meetings or electronic review and/or approval may substitute for routinely scheduled meetings.
- B. Contract: The contract specifies the delegated activities, responsibilities of the parties, reporting frequency, the process for evaluation, and remedies available to IEHP for inadequate delegate performance, up to and including revocation of delegation or imposition of other sanctions. First Tier entities may not delegate their contractually assigned functions to another organization without the approval of IEHP. A monitoring schedule and process of the downstream or related entity's compliance requirements will be determined by IEHP.
- C. Data: Once delegation is approved and a contract is executed, the ~~FTEDR~~ must submit data as contractually required.
- D. Risk Areas: In identified risk areas, additional reporting may be required from the ~~FTEDR~~. The ~~FTEDR~~ may be obligated to submit a report summarizing activities completed during the quarter, identifying barriers to improvement and the effectiveness of any improvement plans. These reports will be reported to the Delegation Oversight Committee.
- E. Audit Calendar: IEHP conducts a comprehensive review of the ~~FTEDR~~'s ability to provide delegated services in accordance with contractual standards and applicable State, CMS, and accreditation requirements. High risk ~~FTEDRs~~, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual audit calendar. In

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<sup>13</sup> ~~Medicare Opt Out List.~~

<sup>14</sup> ~~CMS Preclusion List.~~

<sup>15</sup> ~~DHCS Medi-Cal Suspended and Ineligible Provider List.~~

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conjunction with policies and procedures, IEHP will not limit its audit calendar to ~~high risk~~high-risk FTEDRs.

#### F. Annual Audits: The following will be assessed during an annual audit:

1. The entities' ability to perform the required tasks. IEHP will verify the FTEDR meets both contractual and regulatory requirements.
2. Policies and procedures specific to the delegation function(s).
3. Operational capacity to perform the delegated function(s).
4. Resources (administrative and financial) sufficient and qualified to perform the required function(s).
5. Annual Ownership and Control documentation.
6. Exclusion of the FTEDR from participating in the federal health program (excluded parties lists):
  - a. The DHHS OIG LEIE;
  - b. The GSA SAM;
  - c. The Medicare Opt-Out List (as applicable);
  - d. CMS Preclusion List (as applicable); and
  - e. The DHCS Medi-Cal Suspended and Ineligible Provider List.
7. Effective training and education that includes:
  - a. General compliance.
  - b. Fraud, Waste and Abuse.
  - c. HIPAA Privacy.
  - d. Training Materials:
    - 1) Presentations.
    - 2) Sign-In Sheets/computer-based training completion reports.
    - 3) Certifications.

#### G. Focused Audits: If IEHP has a reason to believe the FTEDR's ability to perform a delegated function is compromised, a focused audit may be performed. The results of these audits will be reported to the Delegation Oversight Committee. The Compliance Department may also recommend focused audits upon evaluation of non-compliant trends or reported incidents.

1. Focused audit criteria include, but are not limited to, the following:

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- a. Failure to comply with regulatory requirements and/or the IEHP service level performance indicators.
  - b. Failure to comply with a corrective action plan.
  - c. Reported or alleged fraud, waste and/or abuse.
  - d. Significant policy variations that deviate from the IEHP, Federal, State, or accreditation requirements.
  - e. Bankruptcy or impending bankruptcy which may impact services to Members (either suspected or reported).
  - f. Sale, merger or acquisition involving the ~~FTEDR~~.
  - g. Significant changes in the management of the ~~FTEDR~~.
  - h. Changes in resources which impact operations.
- H. Attestation Audits: Attestation audits are a form of validation audit that is performed to validate the information/data in the submitted attestation form are accurate and complete, therefore the scope, the sample size and the documents required at the time of the audit may vary depending on the nature of the attestation. The attestations must be signed by an authorized representative and certifies information such as training and policies and procedures are in compliance.
- I. Annual Risk Assessment: The Delegation Oversight Committee will manage the annual comprehensive risk assessment process to determine the ~~FTEDR~~'s vulnerabilities and high-risk areas. A look-back period is determined which includes any corrective actions; service level performance; reported detected offenses; complaints and appeals, from the previous year. Any ~~FTEDR~~ deemed high risk or vulnerable is presented to the Compliance Committee for suggested action.
- J. Corrective Action: A corrective action plan is developed by the delegated entity and reviewed and approved by the Delegation Oversight Committee in instances where non-compliance is identified. Each corrective action plan is presented to the Delegation Oversight Committee for approval. Supplementary, focused audits and additional reporting and/or targeted auditing may be required until compliance is achieved.
1. At any time IEHP may require remediation by an ~~FTEDR~~ for failure to fulfill contractual obligations including development and implementation of a corrective action plan. Failure to cooperate with IEHP in any manner may result in further remedial action leading up to and including termination of the agreement and/or return of delegated activities to IEHP.
- K. Training: IEHP will make training materials available to ~~FTEDR~~s. However, it is expected that ~~FTEDR~~s institute their own training program intended to communicate the compliance

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characteristics related to the ~~FTEDR~~ and their contractually delegated area(s). Training materials will be reviewed by IEHP during the audit process.

1. IEHP will distribute an annual attestation to the ~~FTEDRs~~. The completed, returned attestation confirms compliance with new hire and annual training and education requirements to include General Compliance; Fraud, Waste and Abuse; and, HIPAA Privacy.
2. ~~FTEDR~~ training documentation will be requested and evaluated as part of the annual audit process. Material for review may include, but not be limited to, training presentations; sign-in sheets; test scores; trainer proficiencies; new hire orientation packets; employee list (including date of hire and date of previous training).
3. First Tier Entities are required to implement a training program that ensures its subcontracted downstream ~~and related~~ entities are also trained and have instituted a similar training program.

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Original Effective Date:</b>	January 1, 2014
<b>Chief Title:</b> Chief Executive Officer	<b>Revision Date:</b>	January 1, <del>2022</del> 2023

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## 23. COMPLIANCE

### B. HIPAA Privacy and Security

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#### APPLIES TO:

- A. This policy applies to IEHP DualChoice ~~Cal MediConnect~~ Plan (Medicare – Medicaid Plan) Members, ~~and~~ Providers, Business Associates, First Tier Entities, Downstream Entities, Contractors and Health Care Entities, hereby referenced as “entities”.

#### POLICY:

- A. This policy is based on the following principles and procedures related to the access, use and disclosure of Member information.
1. To provide guidance regarding each entity’s responsibility related to identifiable Member information, ~~T~~<sup>h</sup>is policy addresses intentional and unintentional breaches of Member confidentiality, including oral, written and electronic communication. The principles in this policy will help safeguard Member privacy and minimize compromise exposure and/or liability to Members, entities and IEHP.
  2. Entities must make reasonable efforts to safeguard the privacy and security of Members’ Protected Health Information (PHI) and are responsible for adhering to this policy and procedures, by using only the minimum information necessary to perform their responsibilities, regardless of the extent of access provided or available.
  3. Entities must comply with the Health Insurance Portability and Accountability Act (“HIPAA”) laws and regulations including, but not limited to the privacy and security of Members’ PHI, Standards for Privacy of Members’ Identifiable Health Information, the administrative, physical, and technical safeguards of the HIPAA Security Rule, and any and all Federal regulations and interpretive guidelines promulgated there under.<sup>1, 2, 3</sup>
  4. Entities are allowed to release Member PHI to IEHP, without prior authorization from the Member, if the information is for treatment, payment or health care operations related to IEHP plans or programs.<sup>4</sup>
  - ~~5.~~ Entities must notify IEHP, their Members, the Centers for Medicare & Medicaid (CMS), and the U.S. Department of Health & Human Services (DHHS) of any suspected or actual breach regarding the privacy and security of a Member’s PHI within prescribed timelines and through acceptable submission formats.

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<sup>1</sup> Title 45 Code of Federal Regulations (CFR) Part 160, 162, and 164

<sup>2</sup> Health Information Technology for Economic and Clinical Health Act (HITECH)

<sup>3</sup> American Recovery and Reinvestment Act of 2009

<sup>4</sup> 45 CFR §-164.506(c)



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~~5. Due to unauthorized disclosures of protected patient medical records, confidentiality requirements were enhanced, which requires Providers to be accountable for unauthorized access to medical information, not just for unlawful use or disclosure.<sup>5</sup>~~

#### ~~B.A.~~

~~1. Every healthcare entity must implement appropriate administrative, technical, and physical safeguards to protect the privacy of a patient's medical record information and safeguard it from unauthorized access or unlawful access, use, or disclosure. Administrative fines for violations vary significantly.<sup>6</sup>~~

~~2.1. IEHP may impose sanctions, up to and including corrective action or termination, against entities for failure to comply with applicable privacy and security laws and regulations. The extent and scope of sanctions depend on the type of violation and the conduct of the entity.~~

~~3.1. All healthcare entities must educate their employees on privacy laws and their policy on privacy of medical information. The education should be documented and should include attendance.~~

~~4.1. Appropriate, documented action must be taken should unauthorized access occur.~~

#### **DEFINITION:**

- A. Business Associate: A person or entity that performs certain functions or activities that involve the use or disclosure of Protected Health Information (PHI) on behalf of, or providing services to, a covered entity (IEHP). The types of functions or activities that may make a person or entity a business associate include payment or health care operations activities, as well as other functions or activities regulated by the Administrative Simplification Rules.
- B. First Tier Entity: Any party that enters into a written arrangement with IEHP to provide administrative or health care services for an eligible individual.
- C. Downstream Entity: Any party that enters into a Provider agreement with a First Tier Entity to provide health care and administrative services.
- D. Contractors: Includes all contracted Providers and suppliers, first tier entities, downstream entities and any other entities involved in the delivery of payment for or monitoring of benefits.
- E. Health Care Entity: An individual physician or other health care professional, a hospital, a Provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

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<sup>5</sup> ~~California Health and Safety Code (CA Health & Safety Code) § 1280.15~~

<sup>6</sup> ~~45 CFR § 164.530(e)~~

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F. Protected Health Information (PHI): All individually identifiable health information, (including genetic information) whether oral or recorded in any form, that relates to the past, present, or future physical or mental health or condition of a Member; the provision of health care to a Member; or the past, present, or future payment for the provision of health care to a Member.<sup>7</sup>

1. PHI excludes individually identifiable health information in education records; in employment records held by a Covered Entity in its role as employer; and regarding a person who has been deceased for more than fifty (50) years.<sup>8,9</sup>
2. PHI generally refers to demographic information, medical history, test and laboratory results, insurance information and other data that is collected by a health care professional to identify an individual and determine appropriate care.

G. Breach means the acquisition, access, use, or disclosure of PHI in a manner not permitted under 45 C.F.R. Part 164, Subpart E (“Privacy of Individually Identifiable Health Information”) which compromises the security or privacy of the PHI. An impermissible use or disclosure of PHI is presumed to be a breach unless the covered entity can demonstrate that there is a low probability that the PHI has been compromised. Covered entities must consider a four (4) factor objective standard.<sup>10</sup>

1. The nature and extent of PHI involved (including the types of identifies and the likelihood of re-identification.);
2. The unauthorized person who used the PHI or to whom the disclosure was made;
3. Whether the PHI was actually acquired or viewed; and
4. The extent to which the risk of breach to the PHI has been mitigated.
5. Breach excludes:<sup>11</sup>
  - a. Any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under 45 C.F.R. part 164, subpart E.
  - b. Any inadvertent disclosure by a person who is authorized to access PHI at a covered entity or business associate to another person authorized to access PHI at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such

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<sup>7</sup> 45 CFR § 160.103

<sup>8</sup> Family Educational Rights and Privacy Act

<sup>9</sup> Title 20 United States Code § 1232(g)

<sup>10</sup> 45 CFR § 164.402

<sup>11</sup> Ibid.

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disclosure is not further used or disclosed in a manner not permitted under 45 C.F.R. part 164, subpart E.

A disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

c.

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#### **PROCEDURES:**

A. Due to unauthorized disclosures of ~~PHI~~ protected patient medical records, confidentiality requirements were enhanced, which requires entities Providers to be accountable for unauthorized access to medical information, not just for unlawful use or disclosure.<sup>12</sup>

1. Every healthcare entity must implement appropriate administrative, technical, and physical safeguards to protect the privacy of a patient's medical record information and safeguard it from unauthorized access or unlawful access, use, or disclosure. Administrative fines for violations vary significantly.<sup>13</sup>
2. IEHP may impose sanctions, up to and including corrective action or termination, against entities for failure to comply with applicable privacy and security laws and regulations. The extent and scope of sanctions depend on the type of violation and the conduct of the entity.
3. All healthcare entities must educate their employees on privacy laws and their policy on privacy of medical information. The education should be documented and should include attendance.
4. Each entity is responsible for participating in ongoing education regarding Member privacy and Member rights.
5. Appropriate, documented action must be taken should an unauthorized access occur.

A.B. Only entities and their respective staff members with a legitimate business “need to know” may access, use or disclose Member information. This includes all activities related to treatment, payment and health care operations on behalf of IEHP. Each ~~entity Provider~~ and their respective staff members may only access, use or disclose the minimum information necessary to perform his or her designated role regardless of the extent of access provided to him or her.<sup>14</sup>

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<sup>12</sup> [California Health and Safety Code \(CA Health & Safety. Code\) § 1280.15](#)

<sup>13</sup> [45 CFR § 164.530\(c\)](#)

<sup>14</sup> [45 CFR § 164.502\(b\)](#)

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~~B.C.~~ With respect to entity system access, Member privacy ~~must will~~ be supported through authorization, access, and audit controls (e.g., roles-based access) and should be implemented for all systems that contain identifying Member information. Within the permitted access, a Member-system user is only to access what they need to perform his or her job.

~~1.~~ Each delegated entity is responsible to perform the security functions and implement the security controls outlined in the attached CPE Delegation Oversight Annual Audit Tool (See Attachment, “CPE Delegation Oversight Annual Audit Tool” in Section ~~253~~).

~~C.1. Each entity is responsible for participating in ongoing education regarding Member privacy and Member rights.~~

D. Each entity is responsible for ensuring staff members sign a Confidentiality Statement prior to access to PHI or PI and annually thereafter. Confidentiality statements must be retained for a period of six (6) years and include at minimum.<sup>15</sup>

1. General Use;
2. Security and Privacy Safeguards;
3. Unacceptable Use; and
4. Enforcement Policies.

E. Each entity is responsible for compliance in maintaining policies, principals and procedures related to the following:<sup>16</sup>

1. Documenting that PHI in paper form shall not be left unattended at any time unless it is locked up. Applies to work and non-work-related settings (i.e., home office, transportation, travel, fax machines, copy machines, etc.).
2. That ensures visitors ~~to~~ are ~~asa~~ where PHI is contained shall be escorted and PHI shall be kept out of sight while visitors are in the area, unless they are authorized to review PHI.
3. That requires PHI to be disposed of through confidential means, such as cross-shredding or pulverizing, in a manner that prevents reconstruction of contents. There must be evidence of PHI destruction in accordance with HIPAA, if an external vendor is utilized.
4. Stating that PHI is not to be removed from the entities’ premises except for routine business purposes.

~~F. Each entity is responsible for compliance with these PHI policies and principles.~~

~~G.F.~~ Permitted Uses and Disclosures

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<sup>15</sup> Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20, Exhibit G, Attachment A, Section I. Personnel Controls, Paragraph C. Confidentiality Statement

<sup>16</sup> 45 CFR §§ 160.202, 164.530(c)

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~~1. Except as otherwise required by law, entities are allowed to release Member information, including PHI, without Member authorization, to IEHP for treatment, payment, or health care operations related to IEHP plans or programs.~~

~~2.1.~~ Activities which are for purposes directly connected with the administration of services include, but are not limited to:

- a. Establishing eligibility and methods of reimbursement;
- b. Determining the amount of medical assistance;
- c. Arranging or providing services for Members;
- d. Conducting or assisting in an investigation, prosecution, or civil or criminal proceeding related to the administration of IEHP plans or programs; and
- e. Conducting or assisting in an audit related to the administration of IEHP plans or programs.

~~3.2.~~ PHI must be provided to patients, or their representative if requested, preferably in an electronic format, under HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

~~4.3.~~ PHI cannot be sold unless it is being used for public health activities, research or other activities as specified by HIPAA and/or the HITECH Act.

~~5.4.~~ HIPAA gives the patient the right to make written requests to amend PHI that you are responsible for maintaining.

~~6.5.~~ Upon patient request, an accounting of disclosures of PHI, and information related to such disclosures, must be provided to the patient.<sup>17</sup>

#### H.G. Privacy Practices Notice

1. IEHP provides the “Notice of Privacy Practice” (See Attachment, “Notice of Privacy Practices” in Section 23) to each new Member as follows:<sup>18</sup>
  - a. At enrollment and annually thereafter;
  - b. Within sixty (60) days of a material change to the uses or disclosures, the Member’s rights, IEHP’s legal duties, or other material privacy practices stated in the Notice; and
  - c. Upon request by any person including IEHP Members.
  - d. The IEHP Member Handbook details the plan’s security and privacy practices and refers Members to Member Services and/or the IEHP Internet website for further information.

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<sup>17</sup> 45 CFR § 164.528

<sup>18</sup> 45 CFR § 164.520

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### B. HIPAA Privacy and Security

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#### I.H. Reporting of Unauthorized Access or Disclosures

1. IEHP or ~~entities Providers~~ must only provide the following required notifications if the breach involved unsecured PHI. Unsecured PHI is PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in guidance.
2. Reporting of Breaches of Unsecured PHI Affecting Fewer than five hundred (500) Individuals:<sup>19</sup>
  - a. For breaches that affect fewer than five hundred (500) individuals, IEHP or ~~entities Providers~~ must provide the Secretary of the Department of Health and Human Services (DHHS) with notice annually. All notifications of breaches occurring in a calendar year must be submitted within sixty (60) days of the end of the calendar year in which the breaches occurred. This notice must be submitted electronically by completing all information required on the breach notification form which can be found on the DHHS website. A separate form must be completed for every breach that has occurred during the calendar year.
3. Reporting of Breaches of Unsecured PHI Affecting five hundred (500) or More Individuals:<sup>20</sup>
  - a. If a breach affects five hundred (500) or more individuals, IEHP or ~~entities Providers~~ must provide the Secretary of DHHS with notice of the breach without unreasonable delay and in no case later than sixty (60) days from discovery of the breach. This notice must be submitted electronically by completing all information required on the breach notification form which can be found on the DHHS website.
  - b. For all security breaches that require a security breach notification to more than five hundred (500) California residents as a result of a single breach of the security system, IEHP or ~~entities Providers~~ shall electronically submit a single sample copy of that security breach notification, excluding any personally identifiable information, to the Office of the Attorney General.<sup>21</sup>
  - c. In addition to notifying the affected Members, IEHP or ~~entities Providers~~ are required to provide notice to prominent media outlets serving the State or jurisdiction. IEHP will likely provide this notification in the form of a press release to appropriate media outlets serving the affected area. Like individual notice, this media notification must be provided without unreasonable delay and in no case later than sixty (60) days following the discovery of a breach and must include the same information required for the individual notice.

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<sup>19</sup> 45 CFR § 164.404

<sup>20</sup> Ibid.

<sup>21</sup> [California Civil Code §§. 1798.29\(e\); California Civil Code §§. 1798.82\(f\)](#)

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## 23. COMPLIANCE

### B. HIPAA Privacy and Security

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4. Submission of Additional Breach Information to DHHS:<sup>22</sup>
  - a. If a breach notification form has been submitted to the Secretary and additional information is discovered, IEHP or entities Providers may submit an additional form, checking the appropriate box to signal that it is an updated submission. If, at the time of submission of the form, it is unclear how many individuals are affected by a breach, provide an estimate of the number of individuals affected. As this information becomes available, an additional breach report may be submitted as an addendum to the initial report.
5. Reporting Breaches to the Department of Health Care Services (DHCS):<sup>23,24</sup>
  - a. IEHP must also notify DHCS when a breach occurs that affects a Medi-Cal Member. Notification is provided to the DHCS Privacy Office, Information Security Office and to the Contract Manager within the following timelines:
    - 1) By telephone, e-mail or fax within twenty-four (24) hours of discovery if PHI was or suspected to have been acquired by an unauthorized person.
    - 2) After sending initial notice, IEHP will have seventy-two (72) hours from the date of discovery to provide DHCS with an initial Privacy Incident Report (PIR).
    - 3) Within ten (10) calendar days of discovery of the breach a final, completed PIR will be submitted to DHCS, unless an exception has been obtained from DHCS for additional time needed to complete investigation.
  - b. It is the expectation of IEHP that entities involved in breaches affecting IEHP DualChoice MediConnect Plan (Medicare—Medicaid Plan) Members notify IEHP within twenty-four (24) hours of discovery if PHI was, or suspected to have been, acquired by an unauthorized person. In the event that an entity provides notice to DHCS, IEHP should also be notified.
6. Member Breach Notifications:<sup>25</sup>
  - a. The IEHP Member(s) whose PHI has been breached must be notified in writing of the breach in accordance with CMS and DHHS requirements. IEHP or Entities Providers are required to also notify the affected Member(s) in written form and must be provided without unreasonable delay and in no case later than sixty (60) days following the discovery of a breach. This notification must include, to the extent possible, a brief description of the breach, a description of the types of information that were involved in the breach, the steps affected Members should take to protect

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<sup>22</sup> United States Department of Health and Human Services (DHHS) of Public Law 111-5 § 13402(h)(2)

<sup>23</sup> [45 CFR §§ 164.400-414](#)

<sup>24</sup> Department of Health Care Services (DHCS) -IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit G, Provision 3, Section J., Breaches and Security Incidents

<sup>25</sup> [45 CFR §§ 164.400-414](#)

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## 23. COMPLIANCE

### B. HIPAA Privacy and Security

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themselves from potential harm, a brief description of what IEHP and/or Entities Providers are doing to investigate the breach, mitigate the harm and prevent further breaches, as well as IEHP contact information or the contact information of the entity that caused the breach.

7. Reporting Breaches to IEHP:

- a. The IEHP Compliance Officer must be notified of any and all unauthorized breaches within the contractual and regulatory timeline requirements stated above. Reports of such breaches may be sent to IEHP using one of the following methods:

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

By E-Mail to: [compliance@iehp.org](mailto:compliance@iehp.org)

By Fax to: (909) 477-8536

By Compliance Hotline: (866) 355-9038 (for initial notification)

By Webform: [IEHP.org](http://IEHP.org) Provider Resources – Compliance Section

#### J.I. Corrective Action Subsequent to a Breach

1. Entities must take prompt corrective action to mitigate and correct the cause(s) of unauthorized disclosure/breaches. IEHP requires that a written Corrective Action Plan (CAP) be submitted subsequent to a breach of IEHP Member PHI. A CAP can be submitted:

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

By E-Mail to: [compliance@iehp.org](mailto:compliance@iehp.org)

By Fax to: (909) 477-8536



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## 23. COMPLIANCE

### B. HIPAA Privacy and Security

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**23. COMPLIANCE**

**B. HIPAA Privacy and Security**

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INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Original Effective Date:</b>	January 1, 2007
<b>Chief Title:</b> Chief Executive Officer	<b>Revision Date:</b>	January 1, 2023 <del>4</del>

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## 23. COMPLIANCE

### C. Health Care Professional Advice to Members

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#### **APPLIES TO:**

- A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare—Medicaid Plan)~~ Members and Providers.

#### **POLICY:**

- A. IEHP and contracted partners shall not prohibit or restrict a health care professional, acting within their professional scope of work and licensure, from advising or advocating on behalf of an IEHP Member whom they are caring for.<sup>1</sup>

#### **PROCEDURE:**

- A. A health care professional shall be able to give advice or advocate for a Member regarding the Member's:<sup>2</sup>
1. Health Status;
  2. Medical Care;
  3. Treatment options, which include:
    - a. Self-administered alternative treatments; and
    - b. Adequate information to make a decision against treatment options.
  4. Risks and benefits of such treatments or non-treatments;
  5. Right to refuse treatment; and
  6. Right to express preferences about future treatment decisions.
- B. A health care professional must inform Members of their treatment options, including the option of no treatment, in a culturally competent manner. A health care professional shall ensure a Member with a disability has effective communications with participants throughout the health system in making decisions regarding treatment options. See Policies 9C, "Access to Care for People with Disabilities" and 9H1, "Cultural and Linguistic Services – Foreign Language Capabilities."
- C. IEHP shall inform Members of their right to refuse treatment and information regarding advance directives in accordance with Policy 7D, "Advance Health Care Directive."
- D. If a contracted Provider violates the terms of this policy, they will be subject to contract termination.

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Original Effective Date:</b>	January 1, 2007

<sup>1</sup> Title 42, Code of Federal Regulations (CFR) § 422.206

<sup>2</sup> Ibid.

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## 23. COMPLIANCE

### C. Health Care Professional Advice to Members

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<b>Chief Title:</b> Chief Medical Officer	<b>Revision Date:</b>	January 1, <del>2021</del> <u>2023</u>
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## 23. COMPLIANCE

### Attachments

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<u>DESCRIPTION</u>	<u>POLICY CROSS REFERENCE</u>
IEHP Code of Business Conduct and Ethics	<del>24D</del> , 24E
Notice of Privacy Practices	23D



A Public Entity

Inland Empire Health Plan

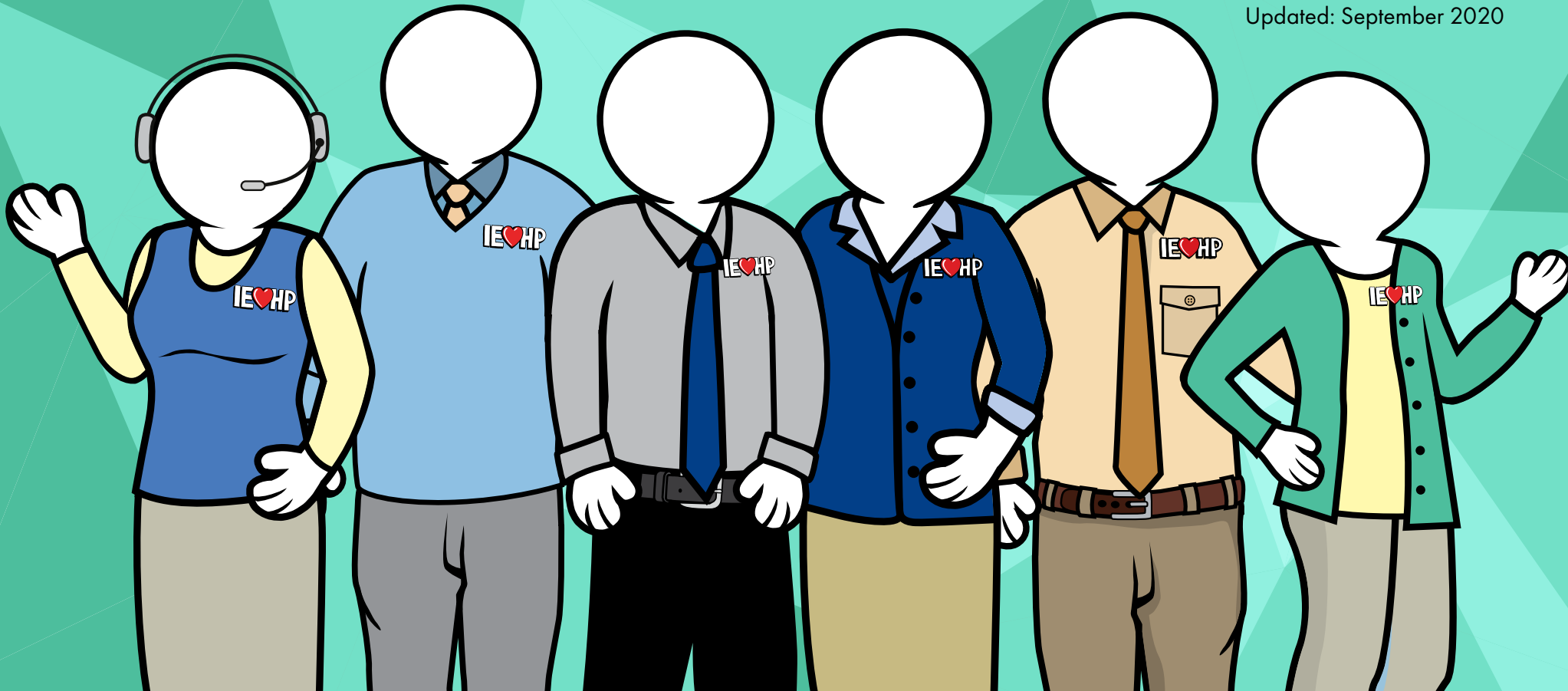
# CODE OF BUSINESS CONDUCT AND ETHICS

COMPLIANCE



Doing what's right, together.

Updated: September 2020



Our shared commitment to honesty,  
integrity, transparency, and accountability

## A message about the IEHP Code of Business Conduct and Ethics

Every day we are confronted with decisions to make and tasks to accomplish as IEHP Team Members. Our choices and the product of our work can directly impact our Members, Providers, and Business Associates. At times, we might find ourselves challenged as to how we should address an issue or how we can best exemplify IEHP's commitment to excellence.

Contained within the *IEHP Code of Business Conduct and Ethics (Code of Conduct)* is information to help guide you in making the most ethical decisions to preserve our workplace culture, preserve our culture of compliance, support our core values, and make IEHP the best place to work in the Inland Empire. Also provided in this *Code of Conduct* are Team Member resources, including how to report compliance issues, how to access the complete library of policies in our *Team Member Handbook*, and other helpful tips and tools to ensure your success.

The information provided in this document applies to all of us – the IEHP Governing Board Members, our Chief Officers, the IEHP Leadership Team, Team Members, Temporary Staff, and IEHP's Business Associates – and it should be reviewed and referenced often. Much like a compass, the *Code of Conduct* sets the direction for IEHP and guides everyone to do the right thing.

Our shared commitment to honesty, integrity, transparency, and accountability helps develop the trust of our Members and our Providers. It also helps us establish good working relationships with our federal and state regulators. The *Code of Conduct* supports this commitment by helping us understand how IEHP Team Members must comply with laws and regulations that govern health care to ensure IEHP maintains a reputation of excellence.

If you are unable to find the answer to your question or concern here, you are encouraged to raise the issue with your Manager, Human Resources Representative, or the Compliance Team to help determine the right thing to do.

Thank you for helping us be leaders in the delivery of health care.



Jarrod McNaughton, MBA, FACHE  
Chief Executive Officer



Janet Nix  
Chief Organizational Development Officer

## 1

### Introduction to the IEHP Code of Conduct

- 1.1 Our Commitment
- 1.2 Mission
- 1.3 Vision
- 1.4 Core Values
- 1.5 Focus Areas

## 2

### Making IEHP a Great Place to

- 2.1 IEHP's Team Culture
- 2.2 IEHP's Rules of Conduct
- 2.3 Respect for Our Members
- 2.4 Respect for Our Providers
- 2.5 Respect for Team Members
- 2.6 Exemplifying the IEHP Brand
- 2.7 Zero Tolerance for Retaliation and Intimidation

## 3

### Preserving IEHP's Culture of Compliance

- 3.1 IEHP's Compliance Program
- 3.2 Fraud, Waste, and Abuse (FWA)
- 3.3 Member Privacy
- 3.4 Conflict of Interest (COI), Gifts, and Entertainment
- 3.5 IEHP's Compliance Training Program
- 3.6 Federal and State Regulators
- 3.7 Interacting with Regulatory Agencies
- 3.8 Eligibility to Participate in Federal and State Healthcare Programs
- 3.9 Protecting IEHP's Assets and Information
- 3.10 Safeguarding IEHP's Systems

## 4

### Know How to Find

- 4.1 Know How to Speak Up
- 4.2 Team Member Resources



# 1

## Introduction to the IEHP Code of Conduct

### 1.1 Our Commitment

IEHP is firmly committed to conducting its health plan operations in compliance with ethical standards, contractual obligations under federal and state programs, laws, and regulations applicable to Medi-Cal and IEHP DualChoice. This commitment extends to the IEHP Governing Board Members, our Chief Officers, the IEHP Leadership Team, Team Members, Temporary Staff, and IEHP's Business Associates who support IEHP's mission.

### 1.2 Mission

We heal and inspire the human spirit.

### 1.3 Vision

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

### 1.4 Core Values

We do the right thing by:

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

### 1.5 Focus Areas



# 2

## Making IEHP a Great Place to Work

### 2.1 IEHP's Team Culture

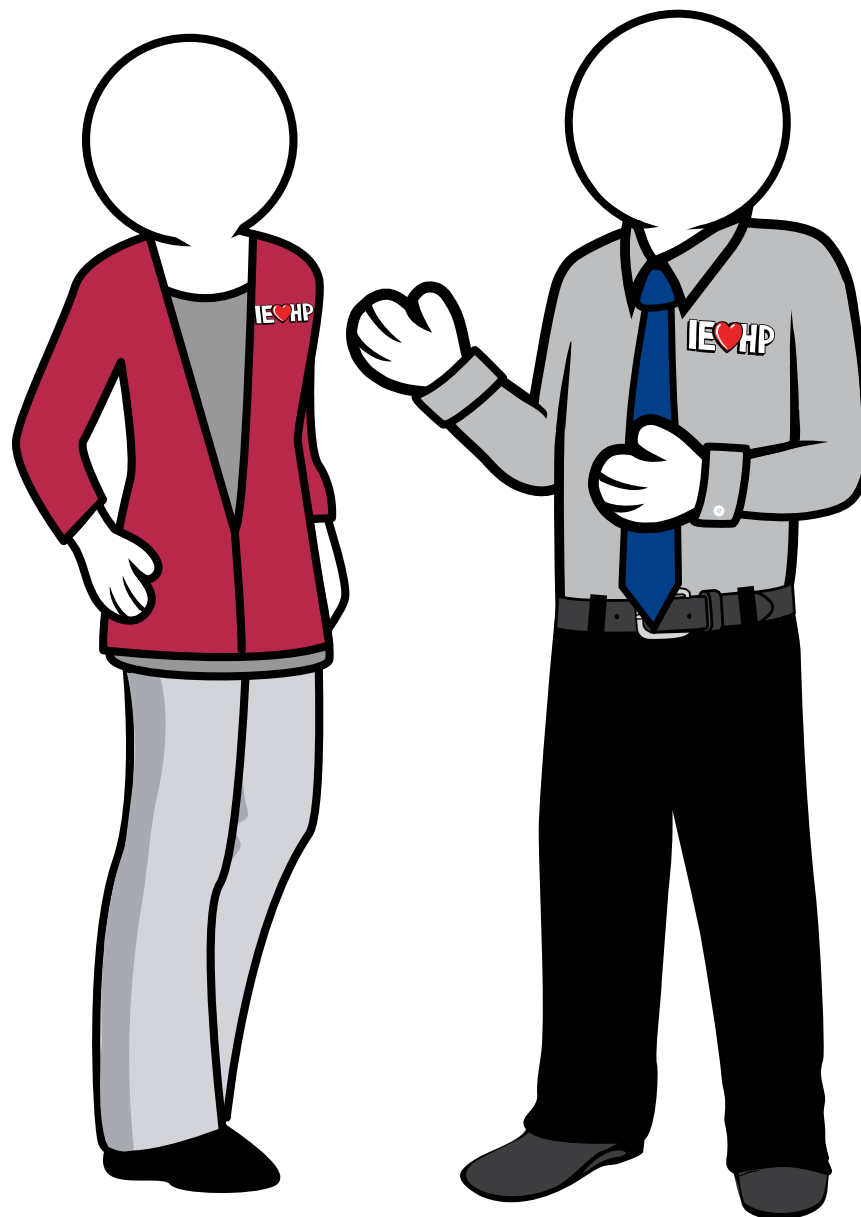
IEHP's Team Culture embodies our values, beliefs, and approach of interacting with people inside and outside our organization.

Our Team Culture sees the Team Member as a valued person. It supports the idea that everyone on the team counts, and everyone can make a difference. It drives us to do the right thing for our Members, our Providers, and each other. However, for our Team Culture to be a success, we need all Team Members to sustain it.

**Here are 10 key traits to sustain IEHP's Team Culture:**

1. Focus on the needs of our Members and Providers
2. Create ideas that move IEHP forward
3. Aspire to make a difference every day
4. Strive to improve every day
5. Work with others in a cooperative and collaborative manner
6. Treat fellow Team Members with courtesy, respect, and professionalism
7. Mix hard work with fun – look forward to coming to work
8. Be a positive influence on everyone
9. Know that everyone's role is vital to our success
10. Take pride in IEHP and our accomplishments

Practice these every day. Aim for success because that's what makes us different. **Always remember that we are here to do the right thing for our Members, our Providers, and each other.**



## 2.2 IEHP's Rules of Conduct

IEHP expects everyone – the IEHP Governing Board Members, our Chief Officers, the IEHP Leadership Team, Team Members, Temporary Staff, and IEHP's Business Associates – to work together in an ethical and professional manner that promotes public trust and confidence in IEHP's integrity. Actions considered contrary to that expectation are listed in this document and may subject anyone mentioned above to disciplinary actions, up to and including contract or employment termination (as applicable).

## 2.3 Respect for Our Members

IEHP Members deserve to be treated with respect and to experience the kind of customer service that each one of us expects to receive. This means every Member encounter with a Team Member is an opportunity to demonstrate excellent customer service.

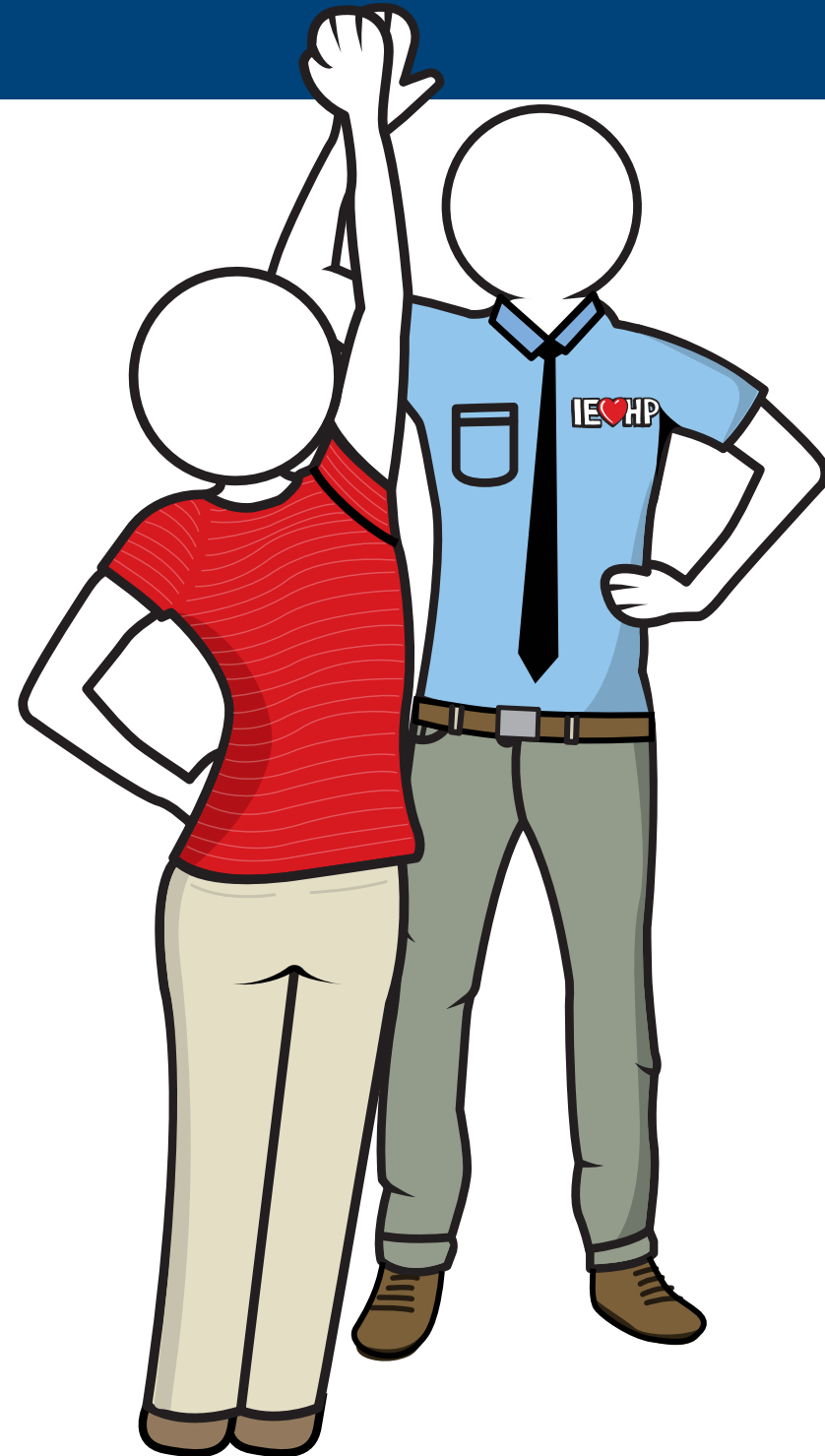
## 2.4 Respect for Our Providers

IEHP is dedicated to giving our Providers a level of service that exceeds their expectations. Every Team Member who interacts with a Provider should do so with professionalism.

## 2.5 Respect for Team Members

IEHP sees you, the Team Member, as a valued person. Every one of your fellow Team Members deserves to be treated with the same level of respect and professionalism that you would expect in return. Everyone counts, and everyone can make a difference.

**You have joined a winning Team!**



## 2.6 Exemplifying the IEHP Brand

### IEHP Branding, Communications, and Marketing

The IEHP brand is one of our organization's most valuable assets. Developing and protecting the brand is an important part of every Team Member's job. This means adhering to established IEHP Branding, Communications, and Marketing standards when communicating about IEHP to Members, your fellow IEHP Team Members, and the community at large.

Here is a quick reference for communicating about IEHP:

- **Ask the IEHP Marketing Department** — All IEHP marketing and Member materials must be developed by the Marketing Department. Please do not write letters to Members or create your own marketing materials without proper management and regulatory approvals.
- **Get co-branded materials approved** — All co-branded (IEHP and other companies or vendors) and other marketing materials created by other companies or vendors must be approved by the Marketing Department prior to distribution. Send materials and requests to the Communications Manager.
- **Refer all media requests** — It doesn't happen often, but if you are approached or contacted by the media to discuss IEHP, please refer them to the Director of Communications and Marketing.

Find our IEHP Team Member Marketing and Branding Fact Sheet located in the IEHP Brand Portal at [iehp.workfrontdam.com/bp/#/](http://iehp.workfrontdam.com/bp/#/).

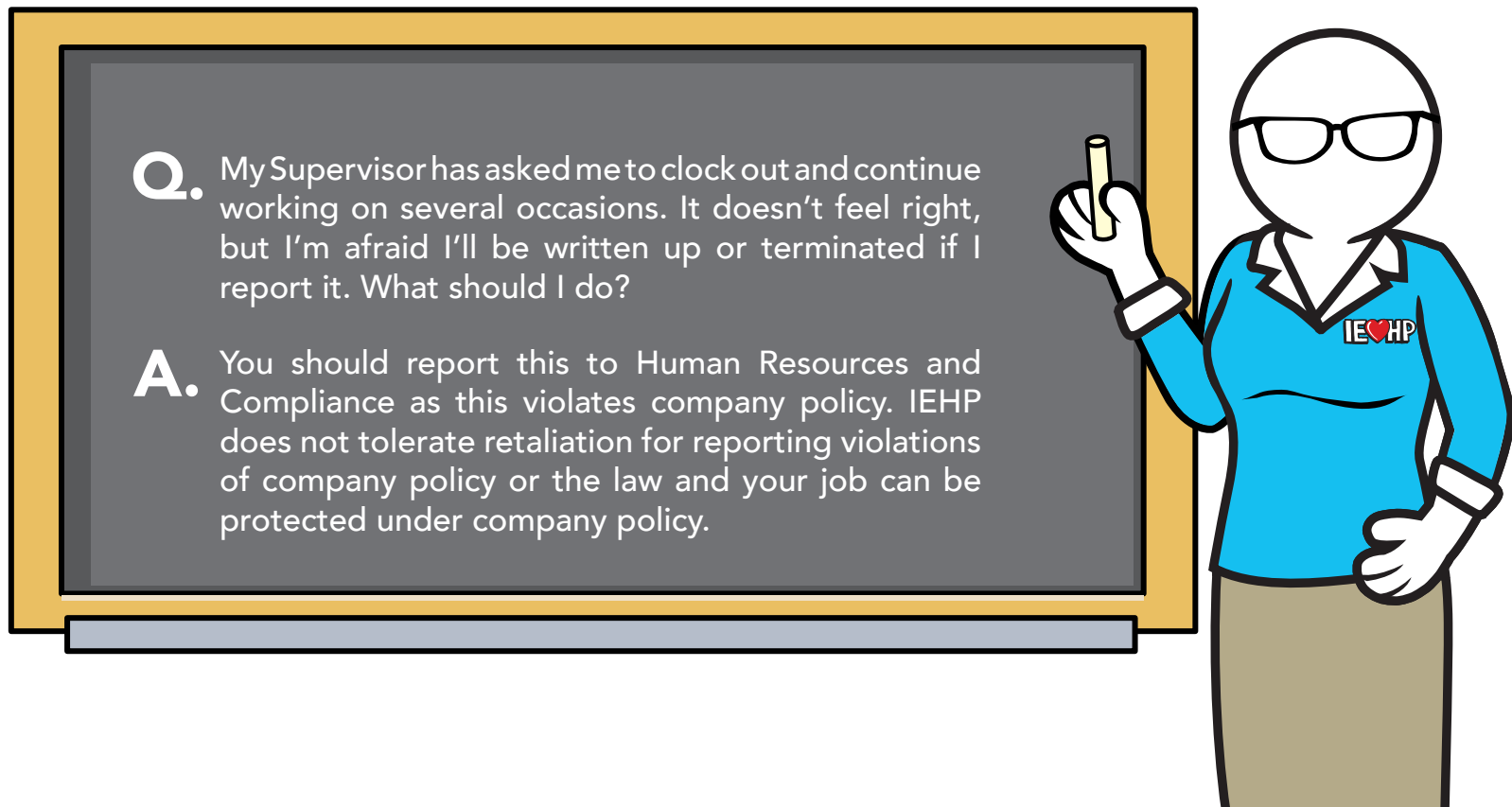


## 2.7 Zero Tolerance for Retaliation and Intimidation

All Team Members are encouraged to report potential compliance issues without fear of intimidation or retaliation, including (but not limited to):

- Reporting potential/suspected compliance issues (Privacy, FWA, or non-compliance)
- Conducting self-evaluations and/or
- Remedial actions

IEHP has a zero-tolerance retaliation policy and will discipline individuals who retaliate with discriminatory behavior or harassment, up to and including termination of employment. Additional information on IEHP's non-retaliation and non-intimidation practices are detailed in the Harassment and Illegal Discrimination Prevention (Policy Against Harassment) and the Corrective Action policies in the *Team Member Handbook* located on DocuShare via JIVE.



# 3

## Preserving IEHP's Culture of Compliance

### 3.1

#### IEHP's Compliance Program

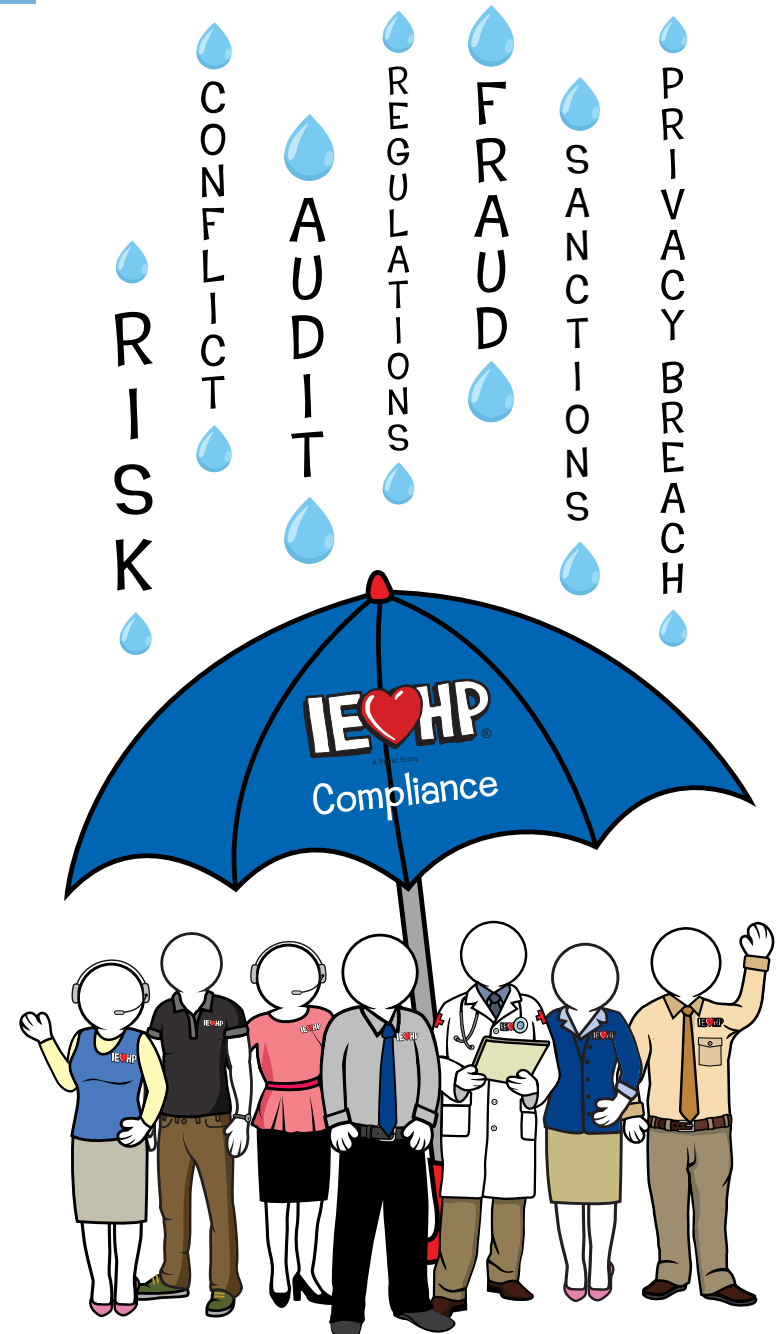
IEHP is committed to maintaining a working environment that fosters conducting business with integrity and that permits the organization to meet the highest ethical standards in providing quality health care services to our Members. This commitment extends to our Business Associates and Delegated Entities that support IEHP's mission.

Our Compliance Program is designed to:

- Ensure we comply with applicable laws, rules, and regulations
- Reduce or eliminate Fraud, Waste, and Abuse (FWA)
- Prevent, detect, and correct non-compliance
- Reinforce our commitment to culture of compliance for which we strive
- Establish and implement our shared commitment to honesty, integrity, transparency, and accountability

Additional information on IEHP's Compliance Program can be found on IEHP Intranet page (JIVE), Compliance Corner, and on IEHP's website: [www.iehp.org](http://www.iehp.org), including:

- Reporting potential issues of non-compliance, Fraud, Waste, or Abuse, and Privacy incidents
- IEHP's *Code of Business Conduct and Ethics*
- Non-Retaliation and Non-Intimidation policies
- IEHP's Fraud, Waste, and Abuse (FWA) Program
- IEHP's Privacy Program
- Details about IEHP's Regulatory Agencies
- Links to helpful Compliance Program resources



## 3.2 Fraud, Waste and Abuse (FWA)

IEHP has established a Fraud, Waste, and Abuse Program that investigates allegations of fraud, waste and/or abuse on the part of Members, Providers, vendors, pharmacies, health plans, Team Members, and any entity doing business with IEHP. A powerful weapon against FWA is a knowledgeable and responsible Team Member who can recognize potential fraud and know how to report it. Every Team Member has a responsibility to report suspected FWA under federal and state laws, and in accordance with IEHP Policy.

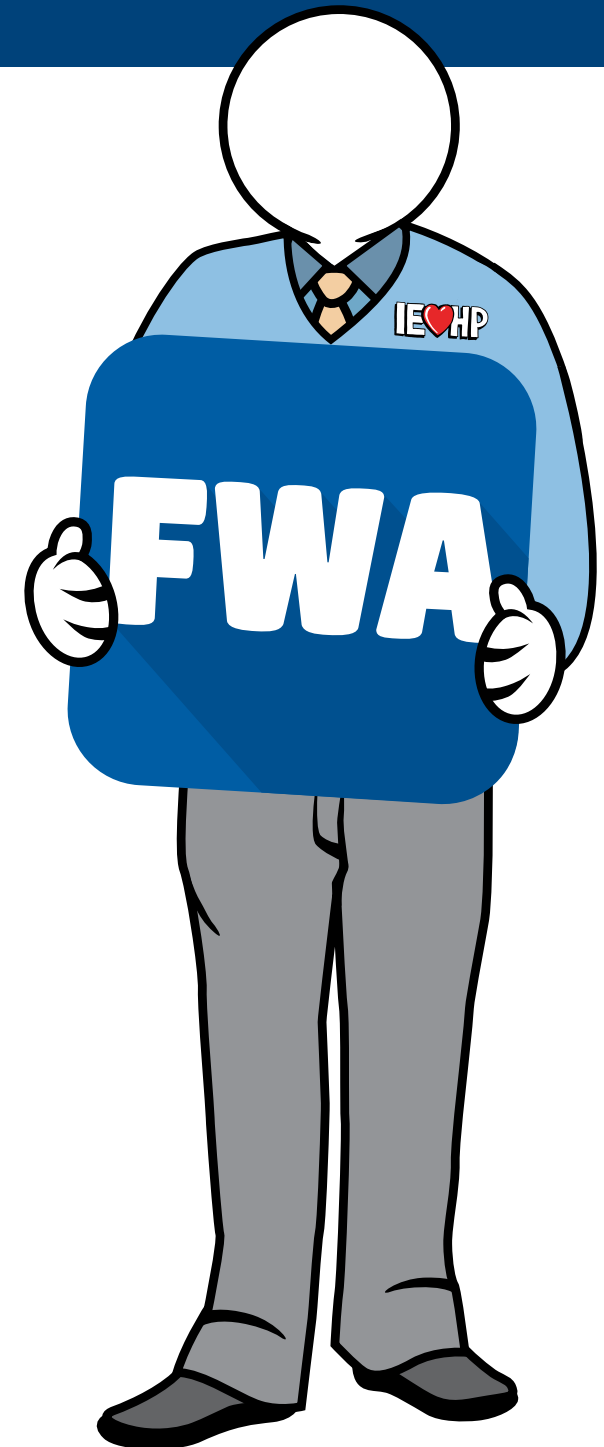
The Federal False Claims Act and similar state laws make it a crime to submit a false claim to the government for payment. False claims include, but are not limited to billing for treatment not rendered; upcoding to bill for higher reimbursement; and falsifying records to support billed amounts.

These same laws protect individuals known as “whistleblowers.” These individuals generally have inside knowledge of potential non-compliant or fraudulent activities such as false claims billing by companies for whom they work or have worked.

Under the Federal False Claims Act, whistleblowers may bring a civil lawsuit against the company on behalf of the U.S. Government and, if the suit is successful, they may be awarded a percentage of the funds recovered.

There is a provision in the Federal False Claims Act that protects a whistleblower from retaliation by an employer. Actions such as suspension, threats, harassment, or discrimination could be considered retaliatory. IEHP will not tolerate retaliation against any person who has suspected fraudulent activity and reported those suspicions in compliance with IEHP policy.

See Section 4.1 **Know How to Speak Up** for information on how to report any concerns of potential FWA. See Compliance Policy and Procedure, *Fraud, Waste, and Abuse Program* available on Compliance 360 for more information on the IEHP FWA Program.



**Q.** I've been working recently with billing information from a Provider's office. I've noticed the office has been billing for services that seem unusual or that don't make sense according to the Member's diagnosis. What should I do?

**A.** Your observation could be a potential fraud- or abuse-related concern. You are required to make a report to the Special Investigations Unit in the Compliance Department via the Compliance Mailbox, the Compliance Hotline, or any of the reporting methods outlined in Section **4.1 Know How to Speak Up** found in this document. Any information that you have available related to your report should be submitted to assist in the investigation. All Team Members are required to report suspected fraud, waste, or abuse concerns.

**Q.** If my Supervisor directs me to do something that I think will result in non-compliance with a regulation or IEHP policy, should I do it?

**A.** No, you should not. Laws, regulations, contract requirements, and IEHP policies must be observed. If anyone, even your Supervisor or Manager, asks or directs you to ignore or break them, speak to your Supervisor or Manager about it. If you are uncomfortable speaking with your Supervisor or Manager about it, contact Human Resources and/or Compliance.

**Q.** While working on a Member's case, I noticed that he had a lot of different prescribing physicians who are prescribing him narcotic prescriptions and had many visits to the Emergency Room. Is this something I should report?

**A.** Yes, Doctor shopping and overutilization could be considered a form of abuse of the Member's benefits. You are required to make a report to the Special Investigations Unit in the Compliance Department via the Compliance Mailbox, the Compliance Hotline, or any of the reporting methods outlined in Section **4.1 Know How to Speak Up** found in this document.



## 3.3 Member Privacy

A Member's protected health information (PHI) is protected by the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and state confidentiality laws. The Member information that is protected by these regulations includes, but is not limited to:

### Demographic Information

- Name
- Social Security Number
- Address
- IEHP Member ID Number
- Date of Birth
- Medi-Cal ID Number
- Driver's License
- Health Plan Name

### Financial Information

- Credit Card Numbers
- Bank Account Numbers
- Claims Information

### Clinical Information

- Diagnosis
- Psychotherapy Notes
- Condition
- Authorizations
- Medications
- Mental Health Data
- Lab Results
- Clinical Notes

The law defines a breach of Member privacy as the acquisition, access, use, or disclosure of PHI that is not permitted under HIPAA. This generally means that a breach occurs when PHI is accessed, used, or disclosed to an individual or entity that does not have a business reason to know that information. The law does allow information to be accessed, used or disclosed when it is **related to treatment, payment, or health care operations (TPO)** directly related to the work that we do here at IEHP on behalf of our Members. Examples of breaches include, but are not limited to:

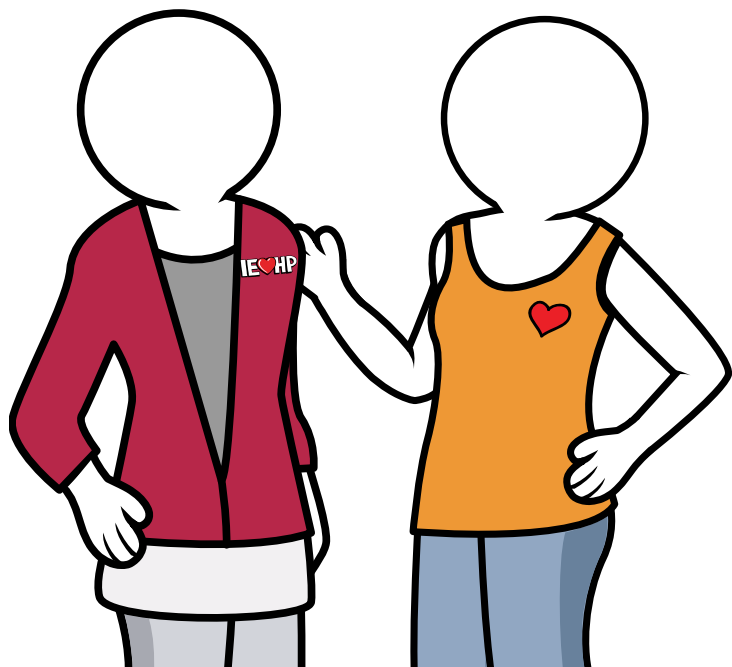
- Accessing information when it does not pertain to your job
- Sending information to the incorrect fax number
- Disclosing unauthorized information verbally (in person or over the phone)
- Sending mail to the wrong address
- Sending unsecured emails outside of the IEHP network or to the incorrect recipient

**If a Team Member discovers a potential privacy incident or breach, he or she is required to report the issue immediately to the Special Investigations Unit in the Compliance Department via the Compliance Mailbox, the Compliance Hotline, or any of the reporting methods outlined in Section 4.1 *Know How to Speak Up* found in this document.**

When a breach of PHI is discovered, IEHP must report it to the DHCS Privacy Office, DHCS Contract Manager, and DHCS Information Security Officer within twenty-four hours of discovery and to the Office for Civil Rights (OCR) under the Department of Health and Human Services (HHS) within the required time frames. A failure to report according to our regulated time frames may result in monetary penalties and/or sanctions against IEHP. **If a Team Member identifies a potential breach, he or she should notify the Special Investigations Unit in the Compliance Department immediately so that the issue can be investigated and the incident reported, if necessary, to the appropriate regulatory agencies.**

Unauthorized access, use or disclosure of confidential information may make a Team Member subject to a civil action and may subject IEHP to penalties under prevailing federal and state laws and regulations, including HIPAA and the HITECH Act. Failure to comply with IEHP confidentiality, privacy, and security policies may result in disciplinary action, up to and including termination of employment or contract termination.

For additional information, refer to IEHP's *HIPAA Authorization to Disclose PHI* available in the *Team Member Handbook* located on DocuShare and to IEHP Compliance Policy and Procedure, *HIPAA Program Description*, available on Compliance 360.



**Q.** My family member is an IEHP Member, and she has asked me to check on the status of an authorization. Can I access and view the information as an IEHP Team Member?

**A.** Accessing information outside the scope of your job would be considered inappropriate according to IEHP's policies and HIPAA. You are encouraged to direct your family member to call Member Services, just like any other IEHP Member.

**Q.** I heard that my neighbor, who is an IEHP Member, has been sick recently. Can I look at his record to make sure he's receiving services and is doing well?

**A.** No, concern over your neighbor's well-being does not give you the right to access or view his information. As IEHP Team Members, we are only allowed to access, use or disclose information when it is related to treatment, payment or health care operations for one of our Members and it pertains to a business purpose.

**Q.** My brother, who is an IEHP Member, asked me to check on the status of a referral. Since he has given me permission, can I view his account?

**A.** No, even though your brother has given you permission, he should be directed to call Member Services to ensure that he receives the correct guidance on the status of his referral and ensure it is appropriately documented in our systems.

**Q.** I need to look up my friend's address. I know he is an IEHP Member, and it would be easier to obtain his information from his account rather than calling him. Am I allowed to do so?

**A.** No, if you access your friend's account without a business purpose, you are violating your friend's right to privacy, IEHP's policies, and HIPAA. Just because we have the ability to access the information does not mean we have the right to do so.

## 3.4

# Conflict of Interest (COI) and Gifts and Entertainment

Workplace business decisions must be made with objectivity and fairness. A Conflict of Interest (COI), or even the appearance of one, should be avoided. A COI presents itself in the form of a personal or financial gain for an individual or entity that could possibly corrupt the motivation of that individual or entity.

At IEHP, our actions and choices should be guided by our desire to serve our Members, our organization, and the entities that we conduct business with. Any COI may distort or cloud our judgment when making decisions on behalf of IEHP. Team Members at all levels in the organization are required to comply with the conflict of interest policy. Examples of COI include, but are not limited to:

- Accepting concurrent employment with, acting for, or rendering services to any business or endeavor, with or without compensation, which competes with or conducts business with IEHP
- Selling products directly or indirectly in competition with IEHP financial interest or business involvement with an outside concern which conducts business with or is a competitor of IEHP
- Representing IEHP in any transaction in which a personal interest exists  
Accepting gifts, like free tickets or

- any substantial favors, from an outside company that does business with or is seeking to do business with IEHP

Team Members should avoid any business, activity or situation, which may possibly constitute a COI between their personal interests and the interests of IEHP. Team Members must disclose to their Supervisor any situation which may involve a COI.

Additional information is provided in IEHP Human Resources Policy, *Conflict of Interest*.

While creating and maintaining strong relationships with our Members, business partners, and customers is vital to the success of IEHP, a Team Member may not accept gifts, entertainment, or any other personal favor or preferential treatment to or from anyone with whom IEHP has, or is likely to have, any business dealings. Doing so allows others to raise at least the possibility that business decisions are not being made fairly or objectively.

Team Members must disclose to their Supervisor any activity or situation related to offering or receiving gifts related to their employment with IEHP.

**Q.** A Member sent me a twenty-dollar gift card for a local restaurant as a way to thank me for the services I provided to him. I know I can't accept the gift, but could I buy food to share with my department as a way to spread the gift around?

**A.** No, unfortunately you cannot accept the gift card, even if you shared it with your department. The gift should be returned to the Member. Please work with your Manager for appropriate handling.

**Q.** One of our vendors would like to send my entire team tickets to a baseball game. They told me that they appreciate all of the business that IEHP does with them and want to express their gratitude. Can we accept the tickets?

**A.** No, you may not accept the tickets. IEHP must always remain free of potential conflicts of interest. By taking the tickets, you might create the perception that IEHP conducts business with this particular vendor because of the gifts or "perks" that they provide to our organization. Talk to your Supervisor or Manager about how to handle the situation.

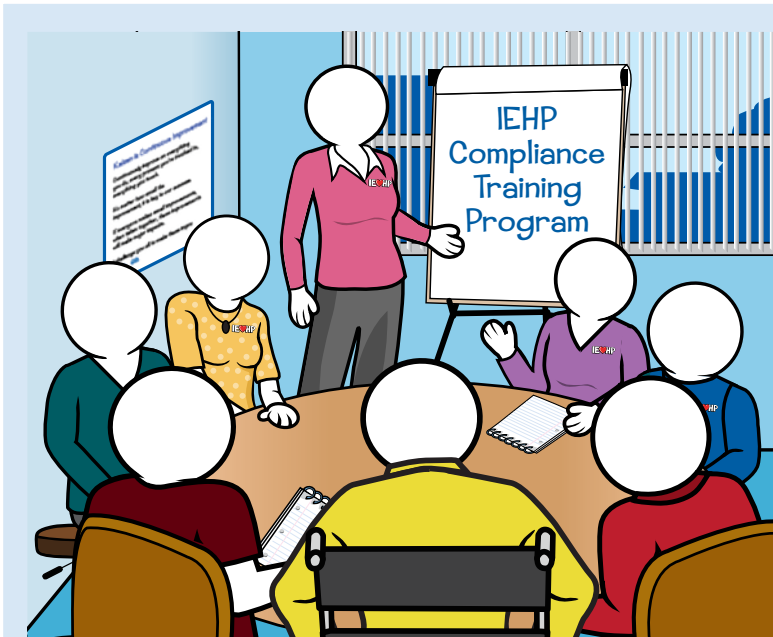
## 3.5

# IEHP Compliance Training Program

The Compliance Training Program focuses on information related to IEHP's Compliance Policies and Procedures; *Code of Conduct*; elements of an effective compliance program; Fraud, Waste, and Abuse; and HIPAA programs.

**Compliance Training is mandatory:**

- Compliance Training must be completed by all of the IEHP Governing Board Members, IEHP Team Members, Temporary Employees, Interns, and Volunteers within 90 days of hire, assignment or appointment.
- All of the IEHP Governing Board Members, IEHP Team Members, Temporary Employees, Interns, and Volunteers are also required to complete Compliance Training on an annual basis.
- IEHP requires **First Tier Entities** to provide Compliance Training to their employees and **Downstream Entities** within 90 days of hire, assignment or appointment, and annually thereafter.



**First Tier Entity** is any party that enters into a written arrangement with IEHP to provide administrative services or health care services to an IEHP Member.

**Downstream Entity** is any party that enters into a written arrangement with persons or entities below the level of the arrangement between IEHP and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

**All Team Members are responsible for ensuring they receive, understand, and attest to the New Hire and Annual Compliance Training.**

## 3.6 Federal and State Regulators

The health care industry is heavily regulated by federal and state agencies responsible for ensuring health care organizations operate in compliance with contractual and regulatory obligations. IEHP is regulated by the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS), and the Department of Managed Health Care (DMHC).

### The Centers for Medicare & Medicaid Services (CMS)

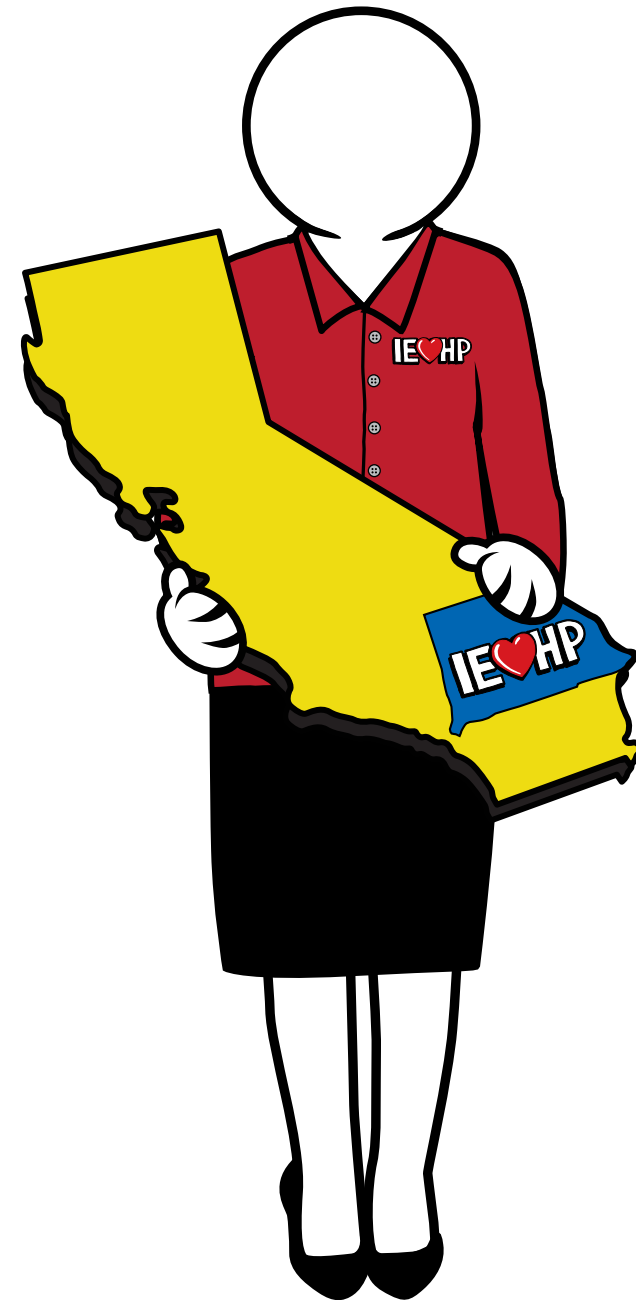
CMS is an agency within the U.S. Department of Health & Human Services responsible for administration of several key federal health care programs. CMS oversees Medicare (the federal health insurance program for seniors and persons with disabilities) and Medicaid (the federal needs-based program). IEHP maintains a contract with CMS to operate as a Medicare-Medicaid Plan (MMP).

### The Department of Health Care Services (DHCS)

DHCS is one of thirteen departments within the California Health and Human Services Agency (CHHS) that provides a range of health care services, social services, mental health services, alcohol and drug treatment services, income assistance, and public health services to Californians. DHCS administers publicly financed health insurance and safety net programs and works to effectively use federal and state funds to operate the Medi-Cal program. DHCS ensures that high-quality, efficient health care services are delivered to more than 13 million Californians (or one in three Californians). IEHP maintains contracts with DHCS to operate Medi-Cal managed care services.

### The Department of Managed Health Care (DMHC)

DMHC regulates health care service plans that deliver health, dental, vision, and behavioral health care benefits. DMHC protects the rights of approximately 20 million enrollees, educates consumers about their rights and responsibilities, ensures financial stability of the managed health care system, and assists Californians in navigating the changing health care landscape. DMHC reviews all aspects of the plan's operations to ensure compliance with California law. IEHP maintains two Knox-Keene Licenses with DMHC to operate in California.



## 3.7 Interacting with Regulatory Agencies

IEHP maintains open and frequent communications with regulatory agencies, such as CMS, DHCS, and DMHC. You may be contacted by a regulatory agency via inquiry, subpoena, or other legal document regarding IEHP's operations or Member care. If you are contacted by a regulatory agency through the course of your work, contact your Supervisor and the Compliance Officer right away. All of the IEHP Governing Board Members, Team Members, Business Associates, and Delegated Entities are

expected to respond to regulatory agencies in a truthful, accurate, and complete manner. Responses should be coordinated with leadership, compliance, or legal, as appropriate. If through the course of your work, you identify or suspect that a response provided to a regulatory agency has been misrepresented – either by dishonesty, omission, or misunderstanding – you must correct it and contact your Supervisor and the Compliance Officer right away.

## 3.8 Eligibility to Participate in Federal and State Health Programs

As a part of compliance program oversight, IEHP performs Participation Status Reviews. This involves a review of several federal and state databases which list individuals and entities that have been excluded, suspended, or opted out from participation, contract, or subcontract with federal or state health care programs. Lists reviewed include, but are not limited to: the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE); the U.S. General Services Administration (GSA) System for Award Management (SAM); Medicare Opt Out Lists; the CMS Preclusion List (as applicable); and the DHCS Medi-Cal Suspended and Ineligible List. Exclusion screening is conducted upon appointment, hire or commencement of a contract, as applicable, and monthly thereafter. This ensures the Governing Board Members, Team Members and/or Delegated Entities are not excluded/suspended or do not become excluded/suspended from participating in federal and state health care programs.

If IEHP learns that any prospective or current, Board Member, Team Member or Delegated Entity has been proposed for exclusion or excluded, IEHP will promptly remove the individual

or entity from IEHP's Programs consistent with applicable policies and/or contract terms. Payment may not be made for items or services furnished or prescribed by an excluded person or entity. Payments made by IEHP to excluded persons or entities after the effective date of their suspension, exclusion, debarment, or felony conviction, and/or for items or services furnished at the medical direction or on the prescription of a physician who is suspended, excluded, or otherwise ineligible to participate are subject to repayment/recoupment. The Compliance Department will review potential organizational obligations related to the reporting of identified excluded or suspended individuals or entities and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

As an IEHP Team Member, if you are ever excluded from participating in any federal or state program, it is your obligation to notify IEHP Human Resources and the Compliance Department immediately.

## 3.9 Protecting IEHP's Assets and Information

The resources and information Team Members use and obtain during their employment at IEHP is to be used solely for the purpose of conducting IEHP business.

### Confidential information includes, but is not limited to:

- IEHP's proprietary information about the company
- Proprietary information about IEHP's contracted entities
- Private information about our Providers
- Personal and/or private information about our Team Members

### Confidential information may be in the form of:

- Documents and tapes
- Electronic information
- Lists and computer print-outs
- Studies and reports
- Drafts and charts
- Records and files

Such confidential information should never be disclosed to individuals outside of IEHP during employment or at anytime thereafter except as required by a Team Member's immediate Supervisor or as required by law. This would include telling an individual something confidential or saying something confidential where it can be overheard by those without a business need to know. **It also includes viewing confidential information that is unrelated to your job.**



## The IEHP Rules of Conduct for Computer Systems and Mobile Devices

IEHP expects Team Members and business entities utilizing IEHP computer systems, networks, and mobile communication devices to use these systems in an ethical and professional manner.

The following are examples of actions which may subject a Team Member or business entity to disciplinary action, up to and including termination of employment or contract termination. This is not a complete list, and activities that are not covered in this list will be handled on a case-by-case basis:

### ■ Improper use of email systems including:

- Sending threatening, hateful, and offensive email messages
- Excessive usage of business email accounts for personal use
- Sending IEHP data to personal email accounts

### ■ Improper use of IEHP's internet access connections including:

- Online gambling
- Excessive access to websites that are not work-related or that don't provide information beneficial to IEHP, its Members and/or Providers
- Unsecure transmission of ePHI, PII and other sensitive information
- Hosting unauthorized web-based services
- Activities related to copyright infringement
- Unauthorized usage of Cloud-based or Online Hosted Services
- The use of internet-based email services, including, but not limited to, Hotmail, Gmail and Yahoo mail to transmit or receive PHI or other sensitive company information

### ■ Unauthorized/improper access or usage of IEHP computer systems including:

- Removal of IEHP data in any form
- Disabling and/or bypassing computer security applications and security controls
- Software installation
- Removal of IEHP computer systems and/or components
- Modification of IEHP computer systems
- Access, removal and/or sharing of IEHP encryption technologies
- Attempts to access computer systems, networks and/or unauthorized data
- Sharing individually assigned network or application login credentials
- Not reporting computer system anomalies, errors, malfunctions, and/or security incidents
- Not reporting lost or stolen IEHP computer resources
- Intentional distribution of inappropriate materials in electronic form



## Social Media

IEHP understands that various forms of communication occur through social media, including, but not limited to, Facebook, Twitter, Instagram, Snapchat, LinkedIn, Blogs, and YouTube, and may occur in the form of social networking, blogging, and video/image sharing.

IEHP Team Members are prohibited from using IEHP computer and network resources to access social media sites that do not serve IEHP business needs or purposes. Accessing personal social media accounts should be done on personal time using a personally owned device.

Team Members may not post or transmit any material or information that includes confidential or proprietary information, information specific to internal operations, or information that would compromise the confidentiality of protected health information (PHI). Unacceptable use of social media may include (this is not a complete list):

- Posting of statements, pictures, or cartoons that could constitute any form of unlawful harassment, including sexual harassment, bullying, or abusive conduct of any kind
- Posting of pictures taken in IEHP work areas where confidential information or PHI may be visible
- Unauthorized representation of posting on behalf of IEHP or inappropriately “tagging” IEHP, its Team Members, or other business affiliates
- Posting of statements that are slanderous or detrimental to IEHP, fellow Team Members, or other business affiliates
- Posting of confidential or proprietary information of IEHP, vendors, or other business affiliates

Team Members who violate IEHP’s Social Media policy or demonstrate poor judgment in how they use social media will be subject to disciplinary action, up to and including, termination.

Additional information on IEHP’s Social Media policy is available in the *Team Member Handbook* located on DocuShare, via JIVE. Team Members may also be notified through email of any change (revisions and/or additions) to the Social Media Policy.

**Q.** I need to do some work from home and was thinking about emailing a copy of a report that is generated by IEHP to my personal email account. If it doesn’t contain PHI, can I send the report to myself?

**A.** No, transmitting IEHP proprietary information to a personal email account is not permissible. Team Members are encouraged to use their remote access connection to conduct any IEHP business remotely. If you don’t have remote access, ask your Supervisor or Manager if remote access is an option for you.

**Q.** I’ve noticed that one of my co-workers spends more than just her break time utilizing the internet for personal use on her desktop computer. Is that a violation of the *Code of Conduct*?

**A.** Excessive activity on websites that are not work related or that do not provide information that is beneficial to IEHP, its Members or Providers could be considered a violation of the *Code of Conduct*. Please share the issue with your Supervisor, Manager or with Human Resources to handle appropriately.

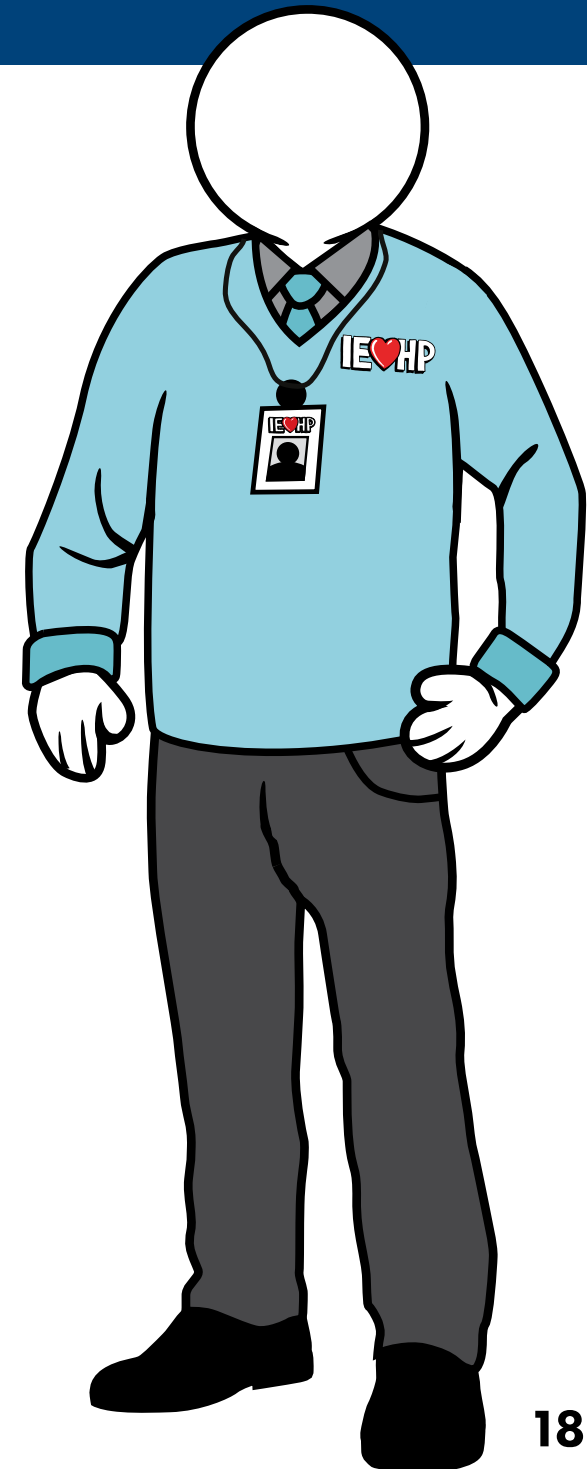
## Facilities

- All Team Members are responsible for providing their own badge access when entering IEHP facilities and are responsible for requesting a new company badge, if needed.
- All Team Members are responsible for checking out a temporary company badge when their badge is misplaced. All Team Members are also responsible for returning their temporary badge once a new, permanent badge has been issued.
- All Team Members must play a role in making our facility a safe place:
  - Ensure building doors successfully close completely after entering
  - Ensure no outside entity “piggy backs” on IEHP Team Members
  - Report any suspicious activity or individuals in the building, suites, or parking lots to:  
**Atrium.Security@Securitasinc.com**
  - Offer guidance and/or question the attendance of an individual who appears lost

For information about IEHP’s policies and procedures, please visit the Facilities Page on JIVE.

**Q.** I think it would be rude to question someone without a badge who is trying to enter the facility. Why are Team Members responsible for this?

**A.** As IEHP Team Members, we are all responsible for safeguarding IEHP assets, information, and our facilities from abuse and inappropriate access. If someone is attempting to enter our building without proper authorization (i.e., an IEHP-issued badge or checking in with reception) we run the risk of allowing an unauthorized individual having access to private information or IEHP property. Please ensure that any individuals coming through a locked door behind you have a badge on. Do not allow anyone to enter through a locked door behind you without first verifying that he or she is wearing a badge.



# 4

## Know How to Find Help

### 4.1 Know How to Speak Up

IEHP's *Code of Conduct* provides guidance on the behavior expected of all IEHP Governing Board Members, Team Members, Business Associates, and Delegated Entities. These individuals and entities are encouraged to discuss the *Code of Conduct* with their Manager, Director, or Chief Officer; with the Human Resources Department; with the Compliance Team or the IEHP Compliance Officer. These resources are available to you in assessing the situation and reaching a decision to report a compliance concern. All individuals and entities doing business with IEHP have a right and a responsibility to promptly report known and/or suspected violations of this Code.

Compliance concerns will be reviewed and investigated, where warranted, thoroughly, and as confidentially as the law allows. IEHP will conduct a fair, impartial and objective investigation into your concerns and will take appropriate action to correct any violations or issues of non-compliance that are identified. IEHP maintains a system to receive, record, respond to, and track compliance questions or reports from any source. Investigative findings that meet federal and/or state criteria for additional investigation are referred to the appropriate federal and/or state entity.

The following are reporting methods any individual can use to report compliance concerns – remember, reports can be made without fear of retaliation, anonymously, or you may reveal your identity – it is up to you. When reporting an issue, be prepared to provide as much detail as possible to allow proper investigation of the issue.

- **Call:** the **Compliance Hotline** toll free at **1-866-355-9038**, 24 hours/day, 365 days/year. If a Compliance Team Member is not available, a confidential voice mailbox will take your message and the Team will pick it up on the next business day.
- **Email:** [compliance@iehp.org](mailto:compliance@iehp.org)
- **Mail:** IEHP Compliance Officer  
P.O. Box 1800  
Rancho Cucamonga, CA 91729-1800
- **Visit:** the IEHP Compliance Officer or the Compliance Special Investigations Unit at IEHP.
- **Access JIVE:** IEHP Team Members can also report compliance issues on JIVE, IEHP's intranet. Click on "Compliance Corner," then click on "Report a Compliance Issue." On this page you will find information and links on reporting potential compliance issues.
- **Go online:** visit IEHP's website at [www.iehp.org](http://www.iehp.org) search for links to "report forms."



## 4.2 Team Member Resources

The *Team Member Handbook* is intended to provide you with some basic information about the policies and procedures of IEHP and about the benefits provided to you as a Team Member.

You are encouraged to read the entire manual to familiarize yourself with our policies and procedures. Should you need to reference these policies, refer to the *Team Member Handbook* located on DocuShare, via JIVE.

Team Member resources include:

Resource	Location	Description
The Compliance Corner	JIVE	Contains information related to the Compliance Programs, report forms and the latest Compliance news
Compliance 360	JIVE	Contains IEHP company policies and policy attachments
IEHP <i>Team Member Handbook</i>	DocuShare, via JIVE	Provides basic information about the policies of IEHP for Team Members
Compliance Program Information and Reporting Information	<a href="http://www.iehp.org">www.iehp.org</a>	General information about IEHP's Compliance, Fraud, Waste, and Abuse, and Privacy Programs

# THANK YOU!

Our mission and reputation at IEHP are entrusted to all of the IEHP Governing Board Members, Team Members, Business Associates, and Delegated Entities to foster, build, and continuously improve upon. We can look to our *Code of Conduct* to help promote our values and guide us in always doing the right thing.

Thank you for carefully reading the IEHP *Code of Business Conduct and Ethics*, referencing it often, and committing to following it in your daily work here at IEHP.



**NOTES:**

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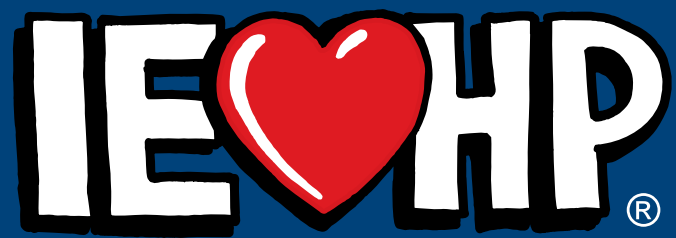
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A Public Entity

Inland Empire Health Plan



Message From  
INLAND EMPIRE HEALTH PLAN (IEHP)  
**Notice of Privacy Practices**

Effective: April 14, 2003

Revised: January 1, 2022

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IEHP provides health care to you through Federal, State and Commercial programs. We are required by state and federal law to protect your health information. And we must give you this Notice that tells how we may use and share your information and what your rights are.

**Your information is personal and private.**

We receive information about you from Federal, State and local agencies after you become eligible and enroll in our health plan. We also receive medical information from your doctors, clinics, labs, and hospitals in order to approve and pay for your health care.

**CHANGES TO NOTICE OF PRIVACY PRACTICES**

IEHP must obey the Notice currently in effect. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future. If we do make changes, we will revise this Notice and send it to you right away.

**How We May Use and Share Information About You**

Your information may be used or shared by IEHP only for treatment, payment and health care operations associated with the particular program in which you are enrolled. The information we use and share includes, but is not limited to:

- Your name,
- Address,
- Personal facts,
- Medical care given to you, and
- Your medical history.

Some actions we take when we act as your Health Plan include:

- Checking your eligibility, enrollment, and amount of medical aid
- Approving, giving, and paying for health care services
- Investigating or prosecuting cases (like fraud)
- Checking the quality of care that you receive
- Coordinating the care you receive



### **Some examples of why we would share your information with others involved in your health care:**

- 1. For treatment:** You may need medical treatment that requires us to approve care in advance. We will share information with doctors, hospitals and others in order to get you the care you need.
- 2. For payment:** IEHP reviews, approves, and pays for health care claims sent to us for your medical care. When we do this, we share information with the doctors, clinics, and others who bill us for your care. We may also forward bills to other health plans or organizations for payment.
- 3. For health care operations:** We may use information in your health record to judge the quality of the health care you receive. We may also use this information in audits, fraud and abuse investigations, planning, and general administration.

We may also contact you to provide information about other health-related benefits and services that may be of interest to you, such as health education programs and management of certain health conditions.

### **Other Uses for Your Health Information**

1. Sometimes a court will order us to give out your health information. We will also give information to a court, investigator, or lawyer if it is about the operation of one of the other programs. This may involve fraud or actions to recover money from others, when the Federal, State, Commercial entity or IEHP has paid your medical claims.
2. You or your doctor, hospital, and other health care providers may appeal decisions made about claims for your health care. Your health information may be used to make these appeal decisions.
3. We may also share your health information with agencies and organizations, which check how our health plan is providing services.
4. We must share your health information with the federal government when it is checking on how we are meeting privacy rules.

### **When Written Permission is Needed**

If we want to use your information for any purpose not listed above, we must get your written permission. If you give us your permission, you may take it back in writing at any time.

### **What Are Your Privacy Rights?**

You have the right to ask us not to use or share your protected health care information in the ways described above. We may not be able to agree to your request.

You have the right to ask us to contact you only in writing or at a different address, post office box, or by telephone. We will accept reasonable requests when necessary to protect the safety of your information.

You and your personal representative have the right to inspect and get a paper or electronic copy of your health information. You will be sent a form to fill out and may be charged a fee for the costs of copying and mailing records. (We may keep you from seeing certain parts of your records for reasons allowed by law.)

You have the right to ask that information in your records be amended if it is not correct or complete. We may refuse your request if:

- The information is not created or kept by IEHP, or
- We believe it is correct and complete.

If we don't make the changes you ask, you may ask that we review our decision. You may also send a statement saying why you disagree with our records and your statement will be kept with your records.

You have the right to be notified of a breach of unsecured protected health information in the event that you are affected by the breach.

You have the right to restrict certain disclosures of protected health information to IEHP where you pay, or another person on your behalf pays, out of pocket in full for the health care item or service.

You have the right to receive an account of instances where your protected health information was shared.

\*\*\*\* IMPORTANT \*\*\*\*

IEHP DOES NOT HAVE COMPLETE COPIES OF YOUR MEDICAL RECORDS. IF YOU WANT TO LOOK AT, GET A COPY OF, OR CHANGE YOUR MEDICAL RECORDS, PLEASE CONTACT YOUR DOCTOR OR CLINIC.

When we share your health information you have the right to request a list of:

- Whom we shared the information with,
- When we shared it,
- For what reasons, and
- What information was shared.

You have a right to request a paper copy of this Notice of Privacy Practices.

You can also find this Notice on our website at: [www.iehp.org](http://www.iehp.org)

### How do you Contact us to Use Your Rights?

If you want to use any of the privacy rights explained in this Notice, please write us at:

**IEHP Director of Compliance and Regulatory Affairs**

INLAND EMPIRE HEALTH PLAN

P.O. Box 1800

Rancho Cucamonga, CA 91729

Email: [compliance@iehp.org](mailto:compliance@iehp.org)

Or, you can call IEHP Member Services at 1-800-440-IEHP (4347); TTY/TDD users should call 1-800-718-4347.

### Complaints

If you believe that we have not protected your privacy and wish to complain, you may file a complaint by writing:

INLAND EMPIRE HEALTH PLAN

P.O. Box 1800

Rancho Cucamonga, CA 91729

Or, you can call IEHP Member Services at 1-800-440-IEHP (4347); TTY/TDD users should call 1-800-718-4347.

Or, you may contact the agencies below:

**Privacy Officer**

c/o: Office of HIPAA Compliance

Department of Health Care Services

P.O. Box 997413, MS 4722

Sacramento, CA 95899-7413

Email: [Privacyofficer@dhcs.ca.gov](mailto:Privacyofficer@dhcs.ca.gov)

Telephone: (916) 445-4646

Fax: (916) 440-7680

**Secretary of the U.S. Department of Health and Human Services**

Office for Civil Rights

Attention: Regional Manager

90 Seventh St.; Federal Bldg., St. 5-100

San Francisco, CA 94103

For additional information, call (800) 368-1019 or

U.S. Office for Civil Rights at (866) OCR-PRIV (866-627-7748) or (866) 788-4989 TTY

**Use Your Rights Without Fear**

IEHP cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights in this Notice.

IEHP has always been committed to protecting Members' privacy and maintaining the confidentiality of their personal and medical information in all settings in accordance with and in compliance with HIPAA and all other state and federal laws. All IEHP employees are required to have education and training upon hire and annually thereafter about ways to protect your health information from being looked at and/or talked about by others who are not a part of your healthcare delivery system. We have, and enforce, policies about limiting building access and visitors to IEHP. Electronic records are protected by administrative, physical, and technical safeguards. Our Business Associates are required to have the same privacy protections that IEHP has in place.

**Questions**

If you have any questions about this Notice and want further information, please contact the IEHP Privacy Officer at the address and phone number listed on page 3.



## DISCRIMINATION IS AGAINST THE LAW LA DISCRIMINACIÓN ES UN ACTO CONTRA LA LEY

Inland Empire Health Plan (IEHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. IEHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

### IEHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact IEHP Member Services at 1-800-440-4347 (TTY: 1-800-718-4347).

If you believe that IEHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator  
Inland Empire Health Plan  
10801 Sixth Street, Suite 120  
Rancho Cucamonga, CA 91730  
**Telephone:** 1-800-440-4347 (TTY: 1-800-718-4347)  
**Fax:** 1-909-890-5748  
**Email:** [CivilRights@iehp.org](mailto:CivilRights@iehp.org)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



## DISCRIMINATION IS AGAINST THE LAW LA DISCRIMINACIÓN ES UN ACTO CONTRA LA LEY

Inland Empire Health Plan (IEHP) cumple con las leyes Federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. IEHP no excluye a las personas ni las trata de forma diferente debido a su raza, color, nacionalidad, edad, discapacidad o sexo.

IEHP:

- Proporciona asistencia y servicios gratuitos a personas con discapacidad para que se comuniquen de manera eficaz con nosotros, como los siguientes:
  - Intérpretes de lenguaje de señas calificados
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Proporciona servicios lingüísticos gratuitos a personas que prefieren comunicarse en un idioma diferente al inglés, como los siguientes servicios:
  - Intérpretes calificados
  - Información escrita en otros idiomas

Si necesita recibir estos servicios, comuníquese con Servicios para Miembros de IEHP al 1-800-440-4347 (TTY: 1-800-718-4347).

Si considera que IEHP no le proporcionó estos servicios o lo discriminó de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja formal ante el Coordinador de Derechos Civiles:

Civil Rights Coordinator  
Inland Empire Health Plan  
10801 Sixth Street, Suite 120  
Rancho Cucamonga, CA 91730  
**Teléfono:** 1-800-440-4347 (TTY: 1-800-718-4347)  
**Fax:** 1-909-890-5748      **Correo electrónico:** [CivilRights@iehp.org](mailto:CivilRights@iehp.org)

Puede presentar una queja formal en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, el Coordinador de Derechos Civiles está a su disposición para ayudarle.

También puede presentar una queja de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los Estados Unidos de manera electrónica a través del Portal de Quejas de la Oficina de Derechos Civiles, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Puede obtener los formularios de queja en el sitio web <http://www.hhs.gov/ocr/office/file/index.html>.



# DISCRIMINATION IS AGAINST THE LAW LA DISCRIMINACIÓN ES UN ACTO CONTRA LA LEY

## ARABIC

يلتزم IEHP بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس. ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1-800-440-4347 (رقم هاتف الصم والبكم: 1-800-718-4347).

## ARMENIAN

IEHP-ը հետևում է քաղաքացիական իրավունքների մասին գործող դաշնային օրենքներին և խտրականություն չի ցուցաբերում՝ ցեղի, մաշկի գույնի, ազգային պատկանելության, տարիքի, հաշմանդամության կամ սեռի հիման վրա:

ՈւՇԱԴՐՈՒԹՅՈՒՆՆԵՐԷՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Չանգահարեք 1-800-440-4347 (TTY (հեռատիպ)՝ 1-800-718-4347):

## CHINESE

IEHP 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-440-4347 (TTY : 1-800-718-4347)。

## FARSI

IEHP از قوانین حقوق مدنی فدرال مربوطه تبعیت می کند و هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت افراد قایل نمی شود.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-440-4347 (TTY: 1-800-718-4347) تماس بگیرید.

## HINDI

IEHP लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-440-4347 (TTY: 1-800-718-4347) पर कॉल करें।

## HMONG

IEHP ua raws cov kev cailij choj pej xeeem uas yuam siv ntawm Tsom Fwv Teb Chaw (Federal civil rights laws) thiab tsis muaj kev ntxub ntxaug vim yog ibhom neeg, cev nqaij tawv, neeg keeb kwm hauv lub teb chaws, hnub nyoog laus hluas, kev tsis taus, los sis txiv neeg los yog poj niam.

LUS CEEV: Yog tias koj hais lus Hmoob, muaj kev pab txhais lus hmoob pub dawb rau koj. Hu rau 1-800-440-4347 (TTY: 1-800-718-4347).

## JAPANESE

IEHP は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害または性別に基づく差別をいたしません。注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-440-4347 (TTY:1-800-718-4347) まで、お電話にてご連絡ください。

## KHMER

IEHP ប្រតិបត្តិការច្បាប់សិទ្ធិស៊ីវិលនៃរដ្ឋបាលសហព័ន្ធជាធរមាន និងមិនរើសអើង យោងទៅលើជាតិសាសន៍ ពណ៌សំបុរ ដើមកំណើត អាយុ ភាពពិការ ឬភេទ ឡើយ។

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ ទូរស័ព្ទទៅលេខ 1-800-440-4347 (TTY: 1-800-718-4347)។



# DISCRIMINATION IS AGAINST THE LAW LA DISCRIMINACIÓN ES UN ACTO CONTRA LA LEY

## KOREAN

IEHP은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-440-4347 (TTY: 1-800-718-4347)번으로 전화해 주십시오.

## PUNJABI

IEHP, ਲਾਗੂ ਫੈਡਰਲ ਸਿਵਲ ਅਧਿਕਾਰ ਕਾਨੂੰਨ ਦੀ ਪਾਲਣਾ ਕਰਦਾ ਹੈ ਅਤੇ ਨਸਲ, ਰੰਗ, ਰਾਸ਼ਟਰੀ ਮੂਲ, ਉਮਰ, ਅੰਗਤਾ, ਜਾਂ ਸੈਕਸ ਦੇ ਆਧਾਰ ਤੇ ਵਿਤਕਰਾ ਨਹੀਂ ਕਰਦਾ ਹੈ। ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-800-440-4347 (TTY: 1-800-718-4347) 'ਤੇ ਕਾਲ ਕਰੋ।

## RUSSIAN

IEHP соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-440-4347 (линия TTY: 1-800-718-4347).

## TAGALOG

Sumusunod ang IEHP sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-440-4347 (TTY: 1-800-718-4347).

## THAI

IEHP ได้ปฏิบัติตามรัฐธรรมนูญฉบับที่คุ้มครองสิทธิที่เหมาะสม และไม่ได้แบ่งแยกทางชาติพันธุ์ สีผิว เชื้อชาติ อายุ ความพิการ หรือเพศ

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-440-4347 (TTY: 1-800-718-4347).

## LAO

IEHP ປະຕິບັດຕາມກົດໝາຍວ່າດ້ວຍສິດທິພົນລະເມືອງຂອງຮຸບຮ່າງທີ່ບັງຄັບໃຊ້ແລະບໍ່ຈຳເລກໂດຍອີງໃສ່ພື້ນຖານດ້ານເຊື້ອຊາດ, ສີ່ຜິວ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມພິການ, ຫຼືເພດ. ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-440-4347 (TTY: 1-800-718-4347).

## VIETNAMESE

IEHP tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-440-4347 (TTY: 1-800-718-4347).