A. Delegation Oversight
   1. Delegated Activities

**APPLIES TO:**

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Providers.

**POLICY:**

A. Annually, IEHP evaluates and audits contracted Delegates in accordance with current applicable National Committee for Quality Assurance (NCQA) accreditation standards, Centers for Medicare and Medicaid Services (CMS) regulatory requirements, Department of Health Care Services (DHCS) regulatory requirements, and IEHP standards, modified on an as needed basis.

B. Delegates agree to be accountable for all responsibilities delegated by IEHP and oversight of any sub-delegated activities.

C. Delegates agree to provide periodic reports to IEHP as specified in the Delegation Agreement.

D. In the event deficiencies are identified through this oversight, Delegates will provide a specific corrective action plan acceptable to IEHP within a specified timeframe.

E. IEHP monitors Delegates’ compliance with reporting requirements on a monthly basis.

**DEFINITION:**

A. Delegate is defined as an organization authorized to perform certain functions on IEHP’s behalf.

**PROCEDURES:**

A. IEHP performs an initial, monthly and annual audits of the following Delegated IPA Activities:
   1. Quality Management;
   2. Utilization Management;
   3. Credentialing and Re-credentialing;
   4. Compliance;
   5. Care Management;
   6. Claims Process and Payment; and
   7. Financial Viability.

B. Each of the above activities describes the elements being evaluated, the frequency of the reporting requirements, and the period of time being evaluated.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight
   1. Delegated Activities

   1. For each activity, IEHP has identified its expectations and reporting requirements to be achieved (See Attachments, “Delegated IPA Delegation Agreement – IEHP DualChoice” and “Medicare Provider Reporting Requirements Schedule” in Section 25).

   C. If Delegates are unable to correct or comply with the corrective action plan within the specified timeframe, IEHP will take necessary steps up to and including revocation of delegation in whole and in part or possible termination.

   D. IEHP meets with Delegates to discuss the results of audits and presents all relevant supporting documentation. Meeting date and location to be specified by IEHP.

   E. Delegates can appeal the results of any oversight activity, specialized study, audit and any required CAPs or sanctions to IEHP within thirty (30) calendar days of receiving their results. Delegates must cite reasons for their appeal, including disputed items or deficiencies.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Delegates

POLICY:

A. IEHP delegates certain Utilization Management (UM), Care Management (CM), Credentialing/Re-credentialing activities and activities for Quality Management (QM) and Compliance Program, and Privacy & Security to contracted Delegates that meet IEHP delegation requirements and comply with the most current National Committee for Quality Assurance (NCQA), Department of Health Care Services (DHCS) (when applicable), Centers for Medicare and Medicaid Services (CMS), and IEHP Standards.

B. IEHP does not delegate QI, Preventive Health, Medical Records, Compliance or Member’s Rights and Responsibilities to non-NCQA accredited entities; however, IEHP does require contracted Delegates to perform specific activities related to these areas.

C. IEHP audits Delegates performance in QI, UM, Credentialing/Re-credentialing, Compliance Program, Privacy & Security, CM, Claims and related activities through the Delegation Oversight Audits performed on an annual basis.

D. IEHP may waive elements of the audit for NCQA accredited entities.

E. The Delegation Oversight Audit is used as part of the pre-contractual audit for Delegates applying for participation with IEHP.

F. The Delegation Oversight Audits are performed by IEHP Provider Services, Compliance, Credentialing, QI, UM, Claims and CM Delegation Oversight Staff using the most current NCQA, DHCS, CMS, and IEHP standards.

G. Focused audits may be performed as indicated whenever a quality issue is identified or at the discretion of the Delegation Oversight Committee, Compliance Officer, Compliance Committee, or the IEHP Chief Medical Officer.

H. IEHP reserves the right to revoke delegated responsibilities and take other necessary action up to and including termination of contract from those Delegates that fail to meet IEHP requirements.

DEFINITION:

A. Delegate - A medical group, Health Plan, Delegated IPA, or any contracted organization delegated to provide services.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight
   2. Audit

PROCEDURES:

A. IEHP audits each Delegate prior to contracting and at least annually to verify compliance with IEHP requirements and continued ability to perform delegated functions.

B. IEHP conducts the Delegation Oversight Audit utilizing the most current DHCS, NCQA, CMS, and IEHP standards.


D. IEHP is responsible for coordinating and scheduling the audits with the Delegate’s staff.

E. IEHP notifies the Delegate in writing, at least 30 days in advance of the scheduled audit. The Delegate receives audit preparation instructions (See Attachment, “Delegation Oversight Audit Preparation Instructions – IEHP DualChoice” in Section 25) regarding the types of documents to be available at the time of the audit and standard forms to be completed and returned to IEHP prior to the audit.

1. Delegate Biographical Information (See Attachment, “Delegated Biographical Information Sheet” in Section 25).

2. Delegate Sub-Contracted Service by Facility/Agency (See Attachment, “Subcontracted Facility/Agency Services and Delegated Functions” in Section 25).

3. QI documents:
   a. Quality Management and Improvement (QI) committee and subcommittee meeting minutes, agenda, sign in sheet, and signed confidentiality statement from the auditing period;
      1) Recommendations of policy decisions
      2) Review and evaluation of QI activities
      3) Practitioner participation in the QI program through planning, design, implementation or review Identification and follow up of needed actions
   b. Semi-Annual Health Plan Reports from the audit period;
   c. Notification of Termination policy and evidence that Members were notified of practitioner termination;
   d. Studies, Audits and Surveys completed from the audit period; and

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1 National Committee for Quality Assurance (NCQA), 2020 HP Standards and Guidelines, QI 1D, Factor 1.
2 NCQA, 2020 HP Standards and Guidelines, QI D, Factor 2.
3 NCQA, 2020 HP Standards and Guidelines, QI D, Factor 3.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

e. Standards of Medical Care Access Policies and Procedures.

4. UM documents:
   a. Annual UM Program Description;\(^5\)
   b. UM Annual Work Plan;\(^6\)
   c. UM Annual Evaluation;\(^7\)
   d. Policies and Procedures;
   e. Committee meeting minutes from the audit period:
      1) Board of Directors;
      2) Utilization Management Committee; and
      3) Utilization Management Subcommittee meeting minutes.
   f. Annual Inter-Rater Reliability Audit;
   g. Semi-Annual Health Plan Reports for the audit periods;
   h. Two (2) examples that demonstrate the use of board-certified consultants to assist with determinations;\(^8\)
   i. Criteria for Length of Stay and Medical Necessity used during the past two (2) years;
   j. Fifteen (15) targeted referral files to include Denials, Modifications, Cancellations and Approvals. The Delegate is responsible for walking IEHP through each referral via the Delegate’s medical management system;
   k. Utilization Management statistics from the audit period;
   l. Evidence that the Affirmative Statement has been distributed to Providers and employees who make UM decisions;
   m. Evidence, other than via a denial letter, that the Providers have been notified that they may contact a Physician reviewer to discuss denial decisions;
   n. Provider communications from the audit period;
   o. Evidence of current license for Providers (Doctor of Medicine (MD)/ Doctor of Osteopathic Medicine (DO)) and Employees (Registered Nurse (RN), Licensed Vocational Nurse (LVN)) who make UM Decisions;
   p. Copies of most recent mailroom policies; and

\(^5\) NCQA, 2020 HP Standards and Guidelines, UM 1 A, Factors 1-6.
\(^6\) NCQA, 2020 HP Standards and Guidelines, UM 13 A, Factor 3.
\(^7\) NCQA, 2020 HP Standards and Guidelines, UM 1B.
\(^8\) NCQA, 2020 HP Standards and Guidelines, UM 4 F, Factor 2.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

q. Copies of most recent referral inventory reporting used to manage turnaround time requirements for processing of IEHP referrals.

5. Care Management documents:

a. Program Plan and Description and CM policies and procedures, including Case Management, Guidelines for Care Management and Care Transitions (if different from UM);

b. Care Management logs: (IEHP will utilize previously submitted logs);

c. Five (5) sample cases of Carve Out/ Waiver Programs;

d. Ten (10) CM files; and

e. Five (5) sample cases with documentation of coordination of care with county mental health clinics for Members receiving specialty mental health services in accordance with California-specific measure CA1.7 on Care Coordination. Please see Provider Policy MA_25F1, “Medicare MMP Reporting Requirements – IEHP DualChoice” for more information.

6. Credentialing documents:

a. Policies and Procedures;

b. Committee meeting minutes including date and voting attendees from the last twelve (12) months, including:

1) Board of Directors;
2) Quality Management Committee minutes;
3) Credentialing; and
4) Peer Review Committee.

c. Credentialing and re-credentialing files – thirty (30) credentialing and thirty (30) re-credentialing files randomly selected by IEHP;

d. Practitioner files of those terminated for quality issues;

e. Practitioner files that have appealed a decision;

f. Health Care Delivery Organization files where the IPA is responsible for claims payment for those Organizational Providers, which include but are not limited to:

1) Hospitals
2) Home Health Agencies

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25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

3) Skilled Nursing Facilities
4) Free-Standing Surgical Centers\textsuperscript{11}
5) Hospices
6) Clinical Laboratories
7) Comprehensive Outpatient Rehabilitation Facilities (CORF)
8) Outpatient Physical Therapy Providers
9) Outpatient Speech Pathology Providers
10) End-Stage Renal Disease Services Providers
11) Outpatient Diabetes Self-Management Training Providers
12) Portable X-Ray Suppliers
13) Rural Health Clinics
14) Federally Qualified Health Centers (FSHC)

g. Credentialing delegation data, if applicable; \textsuperscript{12}
h. Health Care Delivery Organization Tracking mechanism for expirables must be assessed at least every three (3) years;
i. Documentation of ongoing monitoring of sanctions, complaints, and quality issues for the past twelve (12) months; \textsuperscript{13}
j. Human Immunodeficiency Virus (HIV/AIDS) Annual Survey to include the written process. Evidence of Implementation and Distribution of Findings; and \textsuperscript{14} 15 16
k. Delegation Agreements between the IPA and Sub-delegate(s).\textsuperscript{17}

7. Compliance and Privacy & Security Documents:
a. Compliance Policies & Procedures;
b. Fraud, Waste and Abuse (FWA) Policies and Procedures;
c. Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Policies & Procedures; and

\textsuperscript{11} NCQA, 2020 HP Standards and Guidelines, CR 7, Element D.
\textsuperscript{12} NCQA, 2020 HP Standards and Guidelines, CR 8, Element A, Factor 2.
\textsuperscript{13} NCQA, 2020 HP Standards and Guidelines, CR 5, Element A, Factors 1-5.
\textsuperscript{14} California Health and Safety Code (Health & Saf. Code), § 1374.16.
\textsuperscript{15} DHCS MMCD All Plan Letter 02001, Medi-Cal HIV/AIDS Home and Community Based Services Waiver Program.
\textsuperscript{16} California Code of Regulations (CCR), § 1300.74.16(e).
\textsuperscript{17} NCQA, 2020 HP Standards and Guidelines, CR 8, Element A, Factor 1.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight
   2. Audit

   d. Sanction/Exclusion Screening Process policies and procedures
   e. Standards of Conduct.
   f. Compliance Committee Meeting minutes from the last 12 months to include agenda and sign in sheet
   g. Annual Compliance Work Plan
   h. Annual Audit Plan
   i. Annual Risk Assessment
   j. Grievance and Appeals Identification Training
   k. The name of the medical management system(s) used for the utilization management, care management, and claims functions.
   l. Employee Universe: Submit a list of all current employees who have performed job duties related to IEHP's lines of business. This includes anyone with administrative responsibilities in managing the IPA in any capacity, including but not limited to, UM, claims, Case Management, compliance staff, Medical Directors, and anyone with clinical decision-making authority. The definition of employees includes full and part time employees as well as temporary employees, interns, or volunteers. Members of the Governing Body should also be included.
   m. Reported Issues Universe: Submit a list of reported suspected Compliance and/or Fraud, waste, and abuse (FWA) issues impacting IEHP lines of business. Include reports such as but not limited to, hotline reports, walk-ins, on-line reports, self-disclosures to regulators, and/or investigation outcomes. Include incidents that were received and/or closed during the audit period.
   n. Privacy Incident Universe: Submit a list of reported suspected privacy incidents impacting IEHP lines of business. Include reports such as but not limited to, hotline reports, walk-ins, on-line reports, incidents reported to regulators, and/or investigation outcomes. Include incidents that were received and/or closed during the audit period.
   o. Audit & Monitoring Universe: Create a list of all audits and monitoring activities of the IPA’s delegated functions started or completed during the audit period.
   p. Downstream Entity/Subcontractors Universe: Submit a list of all downstream entities/subcontractors contracted with the IPA anytime during the audit period, including contract start date, description of services/function performed, identify which entities participate in offshoring or are offshore.
   q. A sample of ten (10) employees will be selected from the Employee Universe by the IEHP Auditor for which evidence of the following will be requested for as follows, but not limited to:
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

1) New Hire Screening of List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM), and Medi-Cal Suspended & Ineligible List (S&I)

2) Monthly Screening performed of LEIE, SAM, and Medi-Cal S&I for a sample of three consecutive months.

3) New hire confidentiality statement upon hire or start

4) Annual confidentiality statement

5) New hire Privacy & Security training upon hire or start

6) Annual Privacy & Security training

7) New Hire General Compliance training upon hire or start

8) Annual General Compliance training

9) New Hire FWA Training upon hire or start

10) Annual FWA training

11) New Hire distribution of Standards of Conduct upon hire or start

12) Annual distribution of Standards of Conduct.

r. A sample of 5 audits and/or monitoring activities will be selected from the A&M Activities Universe. Evidence of the following will be required:

1) Findings Reports

2) Findings were reported to an oversight body, senior leadership, and the board of directors

3) Corrective actions, if applicable.

s. A sample of 5 privacy investigations will be selected from the Privacy Incidents Universe. Evidence of the following will be required:

1) Notice of Privacy Practices was sent to the Member;

2) Date incident was reported to the Privacy/Compliance Office/Officer;

3) Completion of a Risk Assessment for issue/investigation;

4) Notification was sent to IEHP with HIPAA BAA Requirements of discovery of a suspected breach; and

5) Corrective actions taken, if applicable.

t. A sample* of five (5) FDR/Subcontractors will be selected from the FDR_Subcontractor Universe. Evidence of the following will be required:
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

   1) Finding Reports;
   2) Findings were reported to an oversight body, senior leadership, and the board of directors;
   3) Corrective actions, if applicable; and
   4) Evidence of Offshore Contracting Oversight.

8. Other general organizational documents:
   a. Organizational chart(s);
   b. Current job descriptions relevant to audit;
   c. Delegation agreements with any subcontracted practitioner, or entity to which the IPA subcontracts any function (i.e. UM, Credentialing); and
   d. Ownership and Control documentation submitted annually to IEHP.

9. Provider Directory (applies to Kaiser Permanente and American Specialty Health (ASH)):
   a. Report during the lookback period of the annual audit of identified/reported inaccuracies and the timeframe of the correction in compliance with California Health and Safety Code § 1367.27.

F. In preparation for the audit the Delegate should:
   1. Familiarize themselves with DHCS, NCQA, CMS, and IEHP specific standards; and
   2. Audit themselves to make sure they meet the standards.

G. All Delegates are to provide a written roadmap of where each element is located in the policies and procedures. All sections of the audit tool must be road mapped prior to the reviewers going on site.

H. At the time of the audit, the Delegate must have:
   1. All requested documents ready; and
   2. Have appropriate staff available for each functional area that is being audited (the staff need not be present with the auditors for the entire audit).

I. At the time of the audit, IEHP reviews:
   1. The Delegate policies and procedures for completeness and compliance with DHCS, NCQA, CMS, and IEHP standards;
   2. Committee and Subcommittee Minutes (as applicable);
   3. The prior authorization/referral/denial/appeal process for the following:
A. Delegation Oversight

2. Audit

a. Timeliness of UM and appeal decisions for non-urgent and urgent pre-certification, concurrent, and retrospective reviews;
b. Professional review of clinical information;
c. Clinical criteria for UM and appeal decisions;
d. Medical information – relevant clinical information collected to support UM and appeal decision-making;
e. Denial notices – clear documentation and communication of reasons for each denial and appeal decision, alternative treatment offered, and correct appeal language;
f. Evidence of use of board-certified consultants for medical necessity decisions when applicable; and 18
g. Evidence of current license for Providers and employees (RN and LVN) who make UM decisions.19

4. Complex and Care Management (CM) files for demonstration of the CM process for:
   a. Case finding;
   b. Assessment and problem identification;
   c. Care Plans and attainable goals;
   d. Appropriateness of goals/time frames/monthly updates/follow ups;
   e. Implementation;
   f. Monitoring;
   g. Outcomes; and
   h. Recommended referral services.

5. Credentialing Must Pass Elements. If the Delegate does not score “MET” in a Must Pass Element, they must submit a corrective action plan (CAP) within thirty (30) calendar days following receipt of final report, which may require a re-survey. The following credentialing requirements are MUST PASS elements:
   a. CR 1: Credentialing Policies
      1) Element C: Credentialing System Controls
   b. CR 3: Credentialing Verifications
      1) Element A: Verification of Credentials

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25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

- Delegate must score 90%-100% on at least four (4) factors and 60%-89% on file review for the remaining factors. This is a Met score.

2) Element B: Sanction Information
- Delegate must score 90%-100% for at least one (1) factor and 60%-89% on file review for the remaining factor. This is a Met score.

3) Element C: Credentialing Application
- Delegate must score 90%-100% on at least four (4) factors and 60%-89% on file review for the remaining factors. This is a Met score.

c. CR 4: Recredentialing Cycle Length

1) Element A: Recredentialing Cycle Length
- Delegate must score 90%-100% on file review. This is a Met score.
  o You only have one (1) non-compliant file with a score of 90% in CR 4 A. It is important for the Delegate to closely monitor that all recredentialing occurs within thirty-six (36) months.

6. Credentialing and re-credentialing files:

a. All necessary primary source verifications have been performed within the required one hundred eighty (180) day timeframe;

b. All required queries have been performed through appropriate verification sources;

20

c. All credentialing and re-credentialing packets have been approved by the IPA’s Credentialing Committee;

21

d. All pertinent Quality Assurance (QA), grievance and Member information specific to a given Practitioner, as available, have been considered during the credentialing and re-credentialing process;

22,23

e. Processes are in place to ensure Provider documentation including licenses, Drug Enforcement Administration (DEA) certificate, Board Certification and malpractice insurance, are kept current;

20 NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 2.
22 Medicare Managed Care Manual, Relationships with Providers”, Section 60.3.
23 Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019, “Provider Credentialing/Recredentialing and Screening/Enrollment.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

f. Processes are in place to ensure documentation on subcontracted organizational Providers is verified at time of contracting and at least every three (3) years thereafter; 24

g. Re-credentialing of Practitioners was performed within required thirty-six (36)-month timeframe; and 25

h. There is sufficient documentation within each credentialing file to confirm that all primary source verifications, queries and other information reviewed pertinent to the credentialing or re-credentialing decision were received prior to and used in the credentialing and/or re-credentialing decision.

7. Randomly selected ancillary Provider files (i.e., Home Health, Durable Medical Equipment (DME), laboratory) to verify that Health Care Delivery Organizational Providers:

a. Confirms that the Provider is in good standing with state and federal regulatory bodies; to include review of Sanctions that would prevent the Provider from participation in the IEHP network. 26

b. Confirms that the Provider has been reviewed and approved by an accrediting body (e.g., The Joint Commission (TJC), Accreditation Association for Ambulatory Health Care (AAAHC)), as stated in Policy 25B7, “Assessment of Organizational Providers”; 27

c. Conducts an onsite quality assessment, if the Provider is not accredited. The onsite quality assessment will be conducted by IPA’s Quality Management Department. IPA’s assessment process and assessment criteria for each non-accredited Provider with which it contracts will include a process for ensuring that the Provider credentials its Providers, in accordance to NCQA guidelines. A CMS or state review may be used in lieu of a site visit and may not be greater than three (3) years old at the time of verification/approval. 28

d. Ensure that Medicare covered basic benefits are provided only by Providers that have signed participation agreements with CMS and suppliers approved by CMS as meeting conditions for coverage of their services.

e. Ensure that the Provider is not on the Medicare Opt-Out listing for service areas covered by IEHP (i.e. Northern and Southern California). 29

24 NCQA, 2020 HP Standards and Guidelines, CR 7, Element 7, Element D.
25 NCQA, 2020 HP Standards and Guidelines, CR 4, Element A.
29 Medicare Managed Care Manual, Relationships with Providers”, Section 60.2.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

J. IEHP uses the IEHP Credentialing Delegation Oversight Audit (DOA) Tool, Compliance DOA Audit Tool, and the QM/UM/CM DOA Audit Tool which is based upon current NCQA, DHCS, CMS, and IEHP standards to sufficiently document information from the examined policies and procedures, committee minutes, files and other documents to NCQA and CMS specific standards, as well as to support the conclusions reached.

K. The Delegate receives an exit interview with the IEHP auditors at the completion of the Delegation Oversight audit. This interview identifies areas found to be deficient giving the Delegate an opportunity to provide additional information to clear the deficiency and highlighting opportunities for improvements that need to be addressed through the Corrective Action Plan (CAP) process.

L. Within thirty (30) days of the audit, the Delegate receives written notification of the results. The written notification includes a cover letter and a completed audit tool noting any deficiencies found during the audit. The cover letter notes the timeframes for corrective action, and any other pertinent information.

M. Scoring categories for each of the Delegation Oversight Audit are as follows:

1. Full Compliance 90-100%
2. Partial Compliance 80-89%
3. Non-compliance <79%

N. All Delegates that score 90% or greater pass that section of the audit. A CAP is required for all scores that fall below 90%. However, a CAP may be issued at the discretion of IEHP, regardless of the score, even if the score is 90% or above. In addition, any Delegate that receives non-compliance in the credentialing portion of the audit is subject to further action up to termination of their IEHP contract. All CAPs submitted to IEHP must meet the Corrective Action Plan Requirements noted in Policy 25D3, “Quality Management - Corrective Action Plan Requirements.”

O. Focused audits may occur between annual audits in the following circumstances:

1. Deficiencies noted as a result of the annual audit, as applicable;
2. Review of documents submitted to IEHP indicates potentially significant changes to the Delegate program; and
3. Any other circumstance or quality issue identified that in the judgment of IEHP, requires a focused audit.

P. If the Delegate is unable to meet the requirements at the second focused re-audit, IEHP may do one (1) of the following:

1. Immediately freeze the Delegate to new Member enrollment, as applicable;
2. Send a thirty (30) day breach of contract notice with specific cure requirements;
25. **DELEGATION AND OVERSIGHT**

A. **Delegation Oversight**

2. **Audit**

3. Rescind delegated status of Delegate, as applicable;
4. Terminate the IEHP contract with the Delegate; or
5. Not renew the contract.

Q. Delegates who wish to appeal the results of the Delegation Oversight Audit must do so in writing within thirty (30) days of receiving their results to the Provider Delegation Manager. Delegates must cite reasons for their appeal, including disputed items or deficiencies.

R. Delegates who consistently fail to meet IEHP standards, as confirmed through annual and/or focused audits or other oversight activities, are subject to actions up to and including rescission of delegated functions, non-renewal of the IEHP contract or termination of the IPA participation in the IEHP network.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight
   3. Corrective Action Plan Requirements

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Providers.

POLICY:

A. IEHP maintains the responsibility of ensuring that Delegates continue to be in compliance with all applicable State and federal laws, contractual and reporting requirements.¹

B. IEHP’s Delegation Oversight (DO) department is responsible for the oversight, monitoring and tracking of all assessments and Corrective Action Plans (CAPs). CAPs are required to remediate deficiencies identified during focused and/or clinical audits, and the annual Delegation Oversight Audits (DOA).

DEFINITION:

A. Delegate – For the purpose of this policy, a delegate is defined as a health plan, IPA, medical group, or any contracted organization delegated to perform certain functions on IEHP’s behalf.

PROCEDURES:

Delegation Oversight Audit CAP

A. IEHP monitors Delegate compliance with requirements set forth by IEHP, Centers for Medicare and Medicaid Services (CMS) and Department of Health Care Services (DHCS) through its annual DOA. The DOA includes oversight for QM, UM, Credentialing, Compliance, and Care Management. See Policy 25A2, “Delegation Oversight – Audit.” Scoring categories for each section of the DOA are as follows:

1. Full Compliance  90-100%
2. Partial Compliance  80-89%
3. Non-compliance  <79%

B. All Delegates with scores less than 100% may be required to submit a CAP to remedy any deficiencies noted on the audit tool.

   1. The Delegates must submit a complete and comprehensive CAP to IEHP that adequately addresses all deficiencies for each section.

¹ Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004, “Subcontractual Relationships and Delegation”.

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25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

3. Corrective Action Plan Requirements

2. A CAP is considered complete only if all deficiencies from each section are present and submitted together. These sections are as follows:
   a. QM;
   b. UM;
   c. Medi-Cal Addendum;
   d. Compliance;
   e. Credentialing & Recredentialing; and
   f. Care Management.

3. The Delegates are responsible for coordination of its CAP response with each of its internal departments responsible for addressing audit deficiencies.

4. IEHP does not accept CAPs for DOA and deficiencies when received in individual sections. These are returned to the Delegates and considered delinquent until a complete and all-inclusive CAP is received.

5. Each section of the CAP response must be clearly identified with supporting documentation attached and clearly labeled.

6. The CAP must be submitted to IEHP within thirty (30) calendar days of written notification by IEHP of the audit results. Information shall include:
   a. The DOA score received for each section;
   b. A list of the deficiencies identified by IEHP;
   c. Root cause analysis for the deficiency;
   d. How the deficiency is corrected along with supporting documentation, including policies and procedures, training agenda, material and sign-in sheets when applicable;
   e. Completion dates for each of the corrective actions;
   f. Identification of the person responsible for completing the corrective action; and
   g. Follow-up or monitoring plan to ensure that the corrective action plan is successful.

7. Upon receipt of the initial CAP, IEHP reviews the CAP and either approves or denies the CAP in writing within thirty (30) calendar days of receipt.

8. If an IPA submits a CAP that is in full-compliance (above 90%) with no specific identified risk and all prior deficiencies addressed, then the audit is considered complete and is closed.
25. **DELEGATION AND OVERSIGHT**

A. **Delegation Oversight**

3. **Corrective Action Plan Requirements**

9. If the CAP is denied:
   a. IEHP will communicate all remaining deficiencies to the Delegates, with a written request for a second CAP.
   b. Delegates requiring a second CAP may be frozen to new Member assignment until a CAP is received and approved.
   c. The Delegates are required to resubmit a second CAP within fifteen (15) calendar days to IEHP.

10. Upon receipt of the second CAP by IEHP:
   a. If the second CAP is approved, the CAP process is closed. If applicable, the Delegates are then re-opened to new Member assignment.
   b. If the second CAP is denied, the Delegates may be placed in a contract cure process that gives the Delegates thirty (30) calendar days to adequately correct the deficiencies.

C. Delegates wishing to appeal the results of the initial DOA must do so in writing to IEHP’s Director of Delegation Oversight or designee within thirty (30) calendar days of receiving their results. Delegates must cite reasons for their appeal, including disputed items or deficiencies.

D. After receiving a written appeal, the Director of Delegation Oversight or designee responds to the appealing Delegates in writing, noting the status of the appeal. Once an appeal is received, all additional documentation submitted by the Delegates is reviewed and, if appropriate, scores may be adjusted. If necessary, a re-assessment audit is performed for areas with scores being appealed.

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

A. Other QM monitoring activities that could result in CAPs include but are not limited to:

1. Monthly, Quarterly, Semi-Annual and Annual report submissions;
2. UM, CM and Claims focused file audits;
3. Grievance and Appeal audits;
4. Compliance audits;
5. Twenty-four (24) hour access studies;
6. Appointment availability studies;
7. Language competency audits;
8. Clinical audits (including asthma, diabetes, etc.);
9. Specific quality studies;
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

3. Corrective Action Plan Requirements

10. Focused audits;
11. Pharmacy audits;
12. Audits determined necessary by the Delegation Oversight Committee; and/or
13. Follow up audits.

B. IEHP reviews results of each audit or study and identifies deficiencies as noted in IEHP policies and procedures.

C. Within thirty (30) calendar days of the audit or study, the Delegates receive written notification of the results including any required CAPs or sanctions. The written notification includes a cover letter and a completed audit tool (when applicable) noting any deficiencies found during the audit. Identified deficiencies will include requests for standard CAP and/or Immediate CAP (ICAP) (See Attachment “DOA CAP Response Form” in Section 25). The cover letter defines the timeframes for corrective action, and any other pertinent information.

1. The Delegates must submit a complete and comprehensive CAP response to IEHP that adequately addresses all deficiencies for each section within the CAP/ICAP.
2. The Delegates are responsible for coordination of their CAP response with each of its internal departments responsible for addressing audit deficiencies.
3. IEHP does not accept CAPs for multiple deficiencies when received in individual sections. These are returned to the Delegates and considered delinquent until a complete and all-inclusive CAP is received.
4. Each section of the CAP response must be clearly identified with supporting documentation attached and clearly labeled.
5. The CAP for ICAP findings must be submitted to IEHP within seventy-two (72) hours of the issuance of the written notification. The CAP for standard CAP findings must be submitted within thirty (30) calendar days of written notification by IEHP of the audit results.
   a. The Audit or Study score received for each section;
   b. A listing of the deficiencies as identified by IEHP;
   c. CAPs must identify the root cause analysis for the deficiency;
   d. CAPs must specifically state how the deficiency is corrected along with supporting documentation, including policies and procedures, training agenda, training materials, and sign in sheets when applicable;
   e. Completion dates for each of the corrective actions;
   f. Identification and signature of the person responsible for completing the corrective action; and
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

3. Corrective Action Plan Requirements

   g. Follow-up or monitoring plan to ensure that the corrective action plan is successful.

6. Upon receipt of the initial CAP, IEHP reviews the CAP and either approves or denies the CAP in writing within thirty (30) calendar days of receipt. For ICAPs, IEHP will review the CAP and determine to approve or deny the CAP in writing within seventy-two (72) hours of receipt of the CAP.

7. If the CAP is denied:
   a. IEHP will communicate all remaining deficiencies to the Delegates with a written request for a second CAP.
   b. Delegates requiring a second CAP may be frozen to new Member assignment until a CAP is received and approved.
   c. For standard CAP findings, the Delegates are required to resubmit a second CAP response within fifteen (15) calendar days to IEHP. For ICAP findings, the Delegate is required to submit a second CAP response within (72) hours to IEHP.

8. Upon receipt of the second CAP by IEHP:
   a. If the second CAP response is approved, the CAP process is closed. If applicable, the Delegates are then re-opened to new Member enrollment.
   b. If the second CAP response is denied, the Delegates may be placed in a contract cure process that gives the Delegates thirty (30) calendar days to adequately correct the deficiencies.

D. Delegates can appeal the results of any oversight activity, specialized study, audit and any required CAPs or sanctions to IEHP within thirty (30) calendar days of receiving their results. Delegates must cite reasons for their appeal, including disputed items or deficiencies.

E. After receiving a written appeal, IEHP’s Director of Delegation Oversight or designee responds to the appealing Delegates in writing, noting the status of the appeal. Once an appeal is received, all additional documentation submitted by the Delegates is reviewed and, if appropriate, scores may be adjusted. If necessary, a re-assessment audit is performed for areas with scores being appealed.

CAP Submission Requirement

A. Failure to submit CAPs may result in one of the following activities, depending on the nature of the audit or study and the seriousness of the deficiency:
   1. Delegates are frozen to new Member assignment;
   2. Request for cure under contract compliance;
   3. Requirement to subcontract out the deficient activities within Management Services Organization (MSO) or Delegates;
   4. De-delegation of specified functions;
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight
   3. Corrective Action Plan Requirements

   5. Contract non-renewal; or
25. **DELEGATION AND OVERSIGHT**

B. **Credentialing Standards**

   1. **Credentialing Policies**

**APPLIES TO:**

A. This policy applies to all organizations delegated credentialing activities for IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid) Providers.

**POLICY:**

A. Delegates must have a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent Practitioners to provide care to its Members.

B. Delegates’ policies and procedures describe a process for notifying Practitioners about their right to review information submitted to support their credentialing application.

C. Delegates’ policies and procedures describe how primary source information is received, dated and stored; how modified information is tracked and dated from its initial verification; the staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate; the security controls in place to protect the information from unauthorized modification; and how the organization audits the processes and procedures.

D. Delegates’ recredentialing policies and procedures require information from quality improvement activities and Member complaints in the recredentialing decision making process.

E. Delegates’ policies and procedures must ensure that it only contracts with Providers who have not opted out.

F. Delegates must have policies and procedures that prohibit employment or contracting with Practitioners (or entities that employ or contract with such practitioners) that are excluded/sanctioned from participation (Practitioners or entities found on Office of Inspector General (OIG) Report).

G. Delegates must have policies and procedures that they do not contract with Practitioners who are precluded from receiving payment for Medicare Advantage (MA) items and services Part D drugs furnished or prescribed to Medicare beneficiaries.

**PURPOSE:**

A. IEHP promulgates credentialing and recredentialing decision guidelines for Practitioners directly contracted with IEHP and Practitioners credentialed and contracted by IEHP’s Delegates to perform these activities. IPAs are expected to use these guidelines for recommended education and/or training for PCPs and Specialists, patient age ranges for Practitioners, hospital arrangements, and recommendations for review of malpractice or other adverse history when making credentialing and recredentialing decisions.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   1. Credentialing Policies

B. IEHP and Delegates adhere to all procedural and reporting requirements under state and federal laws and regulations regarding the credentialing and recredentialing process, including the confidentiality of Practitioner information obtained during the credentialing process.

C. IEHP will use procedures consistent with Department of Health Care Services (DHCS) for all of Medi-Cal. DHCS can modify these rules at any time and is required to notify Centers for Medicare & Medicaid Services within ninety (90) days prior of any such change.

D. IEHP delegates all credentialing and recredentialing functions to Delegates that meet IEHP’s requirements for delegation of credentialing. The Delegate must demonstrate a rigorous process to select and evaluate Practitioners.

DEFINITION:

A. Verification Time Limit (VTL) - NCQA counts back from the decision date to the verification date to assess timeliness of verification.

B. Verbal Verification - Requires a dated, signed document naming the person at the primary source who verified the information, his/her title, the date and time of verification and include what was verified verbally.

C. Automated Verification - Requires there be a mechanism to identify the name of the entity verifying the information, the date of the verification, the source, and the report date, if applicable.

D. Written Verification - Requires a letter or documented review of cumulative reports. The Delegated IPA must use the latest cumulative report, as well as periodic updates released by the primary source. The date on which the report was queried, and the volume used must be noted.

E. Using the Internet for Primary Source Verification (PSV): PSV on documents that are printed/processed from an internet site (e.g. Breeze, National Practitioner Data Bank (NPDB) etc.), the data source date (as of date, release date) must be queried within the timeframe. The date of the query must be verified prior to the Credentialing Decision. If there is no data source date, the verifier must document the review date on the verification or the checklist. Verification must be from a National Committee for Quality Assurance (NCQA) approved and appropriate state-licensing agency.

F. PSV Documentation Methodology: The organization may use an electronic signature or unique electronic identifier of staff to document verifications (to replace the dating and initialing of each verification) if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The system must identify the individual verifying the information and the date of verification.

G. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   1. Credentialing Policies

Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a subdelegate. The Delegate will be responsible for sub-delegation oversight.
   a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.
   b. If information is gathered from a company website and the Delegate staff is pulling the queries for OIG or other types of queries, it is NOT considered delegation.

**PROCEDURES:**

A. Delegates’ policies and procedures must include the Practitioner Credentialing Guidelines that specify the following:

1. The types of Practitioners it credentials and recredits. Credentialing requirements apply to:
   a. Practitioners who are licensed, certified or registered by the State of California to practice independently (without direction or supervision)
   b. Practitioners who have an independent relationship with the organization.
      1) An independent relationship exists when the organization directs its Member to see a specific practitioner or group of Practitioners, including all Practitioners whom Member can select as Primary Care Providers.
   c. Practitioners who provide care to Members under the organization’s medical benefits.
   d. The criteria listed above apply to Practitioners in the following settings:
      1) Individual or group practices
      2) Facilities
      3) Telemedicine
   e. IEHP credentials and recredits the following types of Practitioners and describes which Providers IEHP and Delegates are required to credential or not credential:
      1) Doctor of Medicine (M.D.)
      2) Doctor of Osteopathic Medicine (D.O.)
      3) Doctor of Podiatric Medicine (D.P.M.)
      4) Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.), who provide medical services only
      5) Occupational Therapists (O.T.)
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   1. Credentialing Policies

   6) Physical Therapy (P.T.)
   7) Physician Assistants (P.A.) or Physician Assistants Certified (P.A.-C)
   8) Certified Nurse Midwives (C.N.M.)¹
   9) Nurse Practitioners (N.P.)
  10) Speech Pathologists (S.P.)
  11) Audiologists (Au.)
  12) Registered Dieticians (R.D.) and Nutritionists
  13) Psychiatrists (M.D.)
  14) Psychologists (Ph.D., Psy.D.)
  15) Licensed Midwives (L.M.)²

   16) IEHP does not require covering Practitioners and locum tenens that do not have an independent relationship with a Delegated IPA to be credentialed.
   17) IEHP does not require Delegated IPAs to credential Practitioners that are hospital based and do not see Members on a referral basis.
   18) IEHP does not require Delegated IPAs to contract with the following Provider types. Services rendered by these Practitioners are covered by IEHP, however, must utilize the network contracted by IEHP. Therefore, credentialing and recredentialing of these Providers will be completed by IEHP.

      • Doctor of Chiropractic (D.C.)
      • Licensed Acupuncturists (L.Ac.)
      • Optometrists (O.D.)
      • Other Behavioral Healthcare Practitioners
        o Addiction Medicine Specialists
        o Master Level Clinical Nurses
        o Licensed Clinical Social Workers
        o Marriage Family Therapists

¹ Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022 supersedes APL 16-017 and APL 15-017, “Provision of Certified Midwife and Alternative Birth Center Facility Services
² Ibid.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   1. Credentialing Policies
      
      o Licensed Professional Clinical Counselors (L.P.C.C.) who have met the couples and families requirement only.\textsuperscript{3,4}

2. Delegates’ credentialing policies and procedures describe the sources the organization uses to verify credentialing information. The policy must describe the sources used to verify credentialing information of each of the following criterion listed below. All verification sources must be included in policy to ensure compliance with IEHP.

   a. State license to Practice (Verification Time Limit (VTL): one hundred-eighty (180) calendar days prior to Credentialing decision date). Must be unencumbered, valid, current, and at the time of committee and remain valid and current throughout the Practitioner’s participation with IEHP. Failure to maintain a valid and current license at all times, will result in an administrative termination of the Practitioner.

      All Practitioners must be licensed by the State of California by the appropriate state licensing agency. The following license verifications must be obtained by the licensing board or their designated licensing and enforcement systems. The following licensures may be verified through BreEZe Online services online or directly with the licensing board via phone or mail:

      1) Medical Board of California (M.D.)
      2) Osteopathic Medical Board of California (D.O.)
      3) Board of Podiatric Medicine (D.P.M.)
      4) Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C)
      5) Board of Psychology (Ph.D., Psy.D.)
      6) Dental Board of California (D.D.S., D.M.D.)
      7) California Board of Occupational Therapy (O.T.)
      8) California State Board of Optometry (O.D.)
      9) Physical Therapy Board of California (P.T.)
     10) Physician Assistant Committee (P.A., P.A.-C)
     11) California Board of Registered Nursing (C.N.M., N.P.)
     12) California Board of Chiropractic Examiners (D.C.)
     13) Speech-Language Pathology & Audiology Board (S.P., Au)
     14) Acupuncture Board (L.Ac.)

   b. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances

\textsuperscript{3} Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3.
\textsuperscript{4} National Committee for Quality Assurance (MCQA), 2020 Health Plan Standards and Guidelines, CR 1, Element A, Factor 1.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   1. Credentialing Policies

(CDS) certificate, if applicable (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). All Practitioners who are qualified to write prescriptions, except non-prescribing Practitioners, must have a valid and current DEA certificate verified through one (1) of the following sources:

1) A photocopy of the current DEA certificate, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision;

2) A query of the National Technical Information Service (NTIS) database, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision.

3) IEHP may credential a Practitioner whose DEA certificate is pending or pending a DEA with a California address, by obtaining written documentation that the Practitioner with a valid DEA certificate will write all prescriptions requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate.

4) If a Practitioner does not have a DEA or CDS certificate, the delegate must have a documented process to require an explanation why the Practitioner does not prescribe medications and to provide arrangements for the Practitioner’s patients who need prescriptions requiring DEA certification.

c. Education and Training (VTL: Prior to the Credentialing Decision) IEHP may use any of the following to verify education and training:

1) The primary source from the Medical School or through a clearinghouse.

2) The state licensing agency or specialty board if the state agency and specialty board, respectively, perform primary source verification. The organization obtains, at least annually, written confirmation of this fact, uses a printed, dated screenshot of the state licensing agency’s or specialty board’s website displaying the statement that it performs primary source verification of Practitioner education and training information or provides evidence of a state statute requiring licensing to obtain verification of education and training directly from the institution.

3) Sealed transcripts if the organization provides evidence that it inspected the contents of the envelope and confirmed that Practitioner completed (graduated from) the appropriate training program.

4) Below are acceptable sources for Physicians (M.D., D.O.) to verify graduation from Medical School:
   • AMA Physician Master File.
   • American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File.
B. Credentialing Standards
   1. Credentialing Policies

   - Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

   Below are acceptable sources for physicians (M.D., D.O.) to verify completion of residency training:
   - Primary source from the institution or clearinghouse where the postgraduate medical training was completed.
   - AMA Physician Master File.
   - AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
   - FCVS for closed residency programs.
     - NCQA only recognizes residency programs accredited by the Accredited Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.

   5) Below are the acceptable sources for Licensed Professional Clinical Counselors (L.P.C.C.’s) to verify training in Couples and Families.

   - The certification must be recognized and verified through the BreEZe Online services website or directly with the licensing board via phone or mail.

   6) Below is the acceptable source for Nurse Practitioners with a Behavioral Health (BH) designation, to verify training in Psych/Mental Health.

   - The certification must be recognized and verified through the BreEZe Online services website or directly with the licensing board via phone or mail.

   7) Below is the acceptable source for Physician Assistants with a Behavioral Health (BH) designation:

   - Primary source verification from the Physician Assistant School, University of California, Irvine (UCI) or through a clearinghouse, that confirms a completed Fellowship in Primary Care Psychiatry.

   d. Board Certification (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). Below are the acceptable sources to verify board certification:

   1) For all Practitioner types

   - The primary source (appropriate specialty board).
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   1. Credentialing Policies

   • The state licensing agency if the primary source verifies board certification.

2) For Physicians (M.D., D.O.)
   • ABMS or its member boards, or an official ABMS Display Agency, where a dated certificate of primary-source authenticity has been provided.
   • AMA Physician Master File.
   • AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
   • Boards in the United States that are not members of the ABMS or AOA if the organization documents within its policies and procedures which specialties it accepts and obtains annual written confirmation from the boards that the boards performs primary source verification of completion of education and training.

3) For other health care professionals
   • Registry that performs primary source verification of board that the registry performs primary source verification of board certification status.

4) For Podiatrists (D.P.M.)
   • American Board of Foot and Ankle Surgery (formerly The American Board of Podiatric Surgery).
   • The American Board of Podiatric Medicine.
   • American Board of Multiple Specialties in Podiatry.

5) For Nurse Practitioners (N.P.)
   • American Association of Nurse Practitioners (AANP).
   • American Nurses Credentialing Center (ANCC).
   • National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties (NCC).
   • Pediatric Nursing Certification Board (PNCB).
   • American Association of Critical-Care Nurses (AACN).

6) For Physician Assistants (P.A.-C).
   • National Commission of Certification of P.A.’s (NCCPA).

7) For Certified Nurse Midwives (C.N.M.).
   • American Midwifery Certification Board (AMCB).

8) For Psychologists (Ph.D., Psy.D.).
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   1. Credentialing Policies

   - American Board of Professional Psychology (ABPP).

   e. Work history (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date) IEHP must obtain a minimum of the most recent five (5) years of work history as a health professional through the application, Curriculum Vitae (CV) or work history summary/attachment, providing it has adequate information.

   f. Malpractice Claim History. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the Practitioner. (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). IEHP will obtain confirmation of the past seven (7) years of malpractice settlements through one of the following sources:
      1) Malpractice Insurance Carrier
      2) National Practitioner Data Bank Query
      3) Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS). Continuous Query must be reviewed within one hundred-eighty (180) calendar days of the initial credentialing decision. Evidence must be documented in the file or on checklist.

   g. Current Malpractice Insurance Coverage: IEHP requires that a copy of the insurance face sheet or Certificate of Insurance (COI) or written verification from the insurance carrier directly, be obtained in conjunction of collecting information on the application. (VTL: Must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee date and remain valid and current throughout the Practitioner’s participation with IEHP).
      1) For Practitioners with federal tort coverage, the Practitioner must submit a copy of the federal tort letter or an attestation from the Practitioner of federal tort coverage.

   h. Hospital Admitting Privileges: IEHP must verify that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating hospital. Verification that all clinical privileges are in good standing to perform functions for which the Practitioner is contracted, to include verification of admitting privileges, must be confirmed with the Hospital, in writing, via approved website or verbally.
      1) If a published Hospital directory is used, the list must include the necessary information and be accompanied by a dated letter from the Hospital attesting that the Practitioner is in “good standing.”
      2) If the Practitioner does not have clinical privileges, the IEHP must have a written statement delineating the inpatient coverage arrangement documented in the Provider’s file. (See Policy 5B, “Hospital Privileges”).
3) Allied Health Professionals (Non-physicians i.e. Chiropractors, Optometrists) will not have hospital privileges and documentation in the file is not required for these types of Practitioners.

4) Advanced Practice Practitioners (Physician Assistants (PA), Nurse Practitioners (NP), Nurse Midwives (NM)) may not have hospital privileges. However, if they provide the IEHP their hospital privileges, IEHP will be responsible for verifying if those privileges are active and ensure they are in good standing.

5) Specialists (MDs, DOs and DPMs) may not have hospital privileges. Documentation must be noted in the file as to the reason for not having privileges. (e.g. A note stating that they do not admit as they only see patients in an outpatient setting is sufficient).

i. State Sanctions and Restrictions on Licensure and Limitation on Scope of Practice.
State sanctions, restrictions on licensure or limitations on scope of practice (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision).

1) Verification sources for sanctions or limitations on licensure include:
   • Chiropractors: State Board of Chiropractic Examiners CIN-BAD, NPDB.
   • Oral Surgeons: State Board of Dental Examiners, or State Medical Board, NPDB.
   • Physicians: Appropriate state board agencies, FSMB, NPDB.
   • Podiatrists: State Board of Podiatric Examiners, Federation of Podiatric Medical Boards, NPDB.
   • Non-physician Healthcare Professionals: State licensure or certification board, appropriate state agency, NPDB.
   • For delegates using the Continuous Query (formerly Proactive Disclosure Service (PDS))
     o Evidence of current enrollment must be provided.
     o Report must be reviewed within one hundred eighty (180) calendar days of the initial credentialing decision.
     o Evidence of review must be documented in the file or on checklist.

j. Medicare/Medicaid Sanctions. Verification Sources for Medicare/Medicaid Sanctions:

1) OIG must be the one (1) of the verification sources for Medicare sanctions, to ensure compliance with CMS. 5
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

1. Credentialing Policies

   - Date of query and staff initials must be evident on a checklist or the OIG page must be in the file.

2) The Medi-Cal Suspended and Ineligible list must be one (1) of the verification source for Medicaid sanctions, to ensure compliance with DHCS.\(^6\)
   - Date of query and staff initials must be evidence on a checklist, or the report page must be in the file.

3) NPDB
4) FSMB
5) FEHB Program Department Record, published by the Office of Personnel Management, OIG.
6) List of Excluded Individuals and Entities (maintained by OIG).
7) Medicare Exclusions Database.
8) State Medicaid Agency or intermediary and the Medicare intermediary.
9) For delegate’s using the Continuous Query (formerly Proactive Disclosure Service (PDS))

k. NPI Number: Practitioners must hold and maintain a valid and active individual National Provider Identification Number (NPI) that can be verified through the National Plan & Provider Enumeration System (NPPES) website.
   1) Group NPI Numbers may be requested by IEHP, in addition to the mandatory individual NPI number.\(^7,8\)

3. Delegates’ policies require credentialing of Practitioners before they provide care to Members. IEHP does not allow provisional credentialing. Policies must define the criteria required to reach a credentialing decision and must be designed to assess the Practitioner’s ability to deliver care. This criterion is used to determine which Practitioners may participate in its network, which may include, but are not limited to:

   a. Verification of Credentials

      1) A current and valid, unencumbered license to practice medicine in California, at the time of Credentialing decision.

      2) Current and valid DEA registered in California, applies to Practitioners who are required to write prescriptions

         - If the Practitioner designates another Practitioner to write all prescriptions on their behalf, while their DEA is still pending, the Practitioner must

\(^6\) DHCS APL 19-004 Supersedes APL 17-019.
\(^7\) NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 2.
\(^8\) DHCS APL 19-004 Supersedes APL 17-019.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   1. Credentialing Policies

   provide the following information for the designated physician to ensure compliance with NCQA:

   - Practitioner Name
   - NPI (IEHP requirement)
     - Used as a unique identifier for the prescribing practitioner
   - DEA Number (IEHP requirement)
     - Used to validate that the DEA is current, active and registered in California.

3) Education and Training. IEHP specific specialty requirements: Medical Doctors (M.D.) and Doctor of Osteopathic (D.O.) must meet the education and training requirements set forth by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) and additional criterion set by IEHP and noted below, if applicable. All IEHP specific specialty requirements are subject for review by the IEHP Medical Director or Chief Medical Officer (CMO). Further review may be completed by the Peer Review Subcommittee who will either approve or deny.

   IEHP will consider all relevant information including practice site demographics, Provider training, experience and practice capacity issues before granting any such change.

   - If the Practitioner is not board certified in the subspecialty in which he/she is applying, there must be evidence of verification of residency and training in the subspecialty (e.g. Fellowship in Cardiology, Rheumatology, Pediatric Endocrinology, etc.), as relevant to the credentialed specialty, and meet the training requirements as set forth by ABMS or AOA.
   - Practitioners who do not meet graduate medical training requirements as set forth by ABMS or AOA for the Provider’s requested subspecialty, will be subject to review by the IEHP Credentialing Subcommittee for review. Further review may be completed by the IEHP Peer Review Subcommittee.
   - Effective January 1, 2017, IEHP Credentialing guidelines require Providers to meet the internship and residency requirements to be a Pediatric, Internal Medicine, Family Practice, or Public Health and General Preventive Medicine Provider in order to be credentialed as a Primary Care Provider in IEHP’s network.
   - Existing Providers who do not meet this requirement are grandfathered into the network, however if the Provider chooses to terminate, the Provider may not reapply or be reinstated as a Primary Care Provider.
   - IEHP specific specialty requirements:
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

1. Credentialing Policies

- Bariatric Surgery requirements effective January 1, 2019. Meet the education and training requirements for General Surgery; and one of the following criteria:
  - Completion of an accredited bariatric surgery fellowship;
  - Documentation of didactic training in bariatric surgery (IEHP recommends the American Society for Metabolic and Bariatric Surgery Course). This information will be verified through:
    - Bariatric training certificate and/or supporting letter from supervising bariatric surgeon, which will be verified by Credentialing. Supporting letter will include the minimum criteria:
      - Supervising bariatric surgeon qualifications;
      - Supervising bariatric surgeon relationship with applicant;
      - Duration of relationship of supervising bariatric surgeon with applicant; and
      - Assessment of applicant’s competency to perform bariatric surgery by supervising bariatric surgeon.

- Attestation of bariatric surgery case volume signed by applicant (See Attachment, “IEHP Bariatric Surgery Attestation” in Section 5) to indicate volume of the following:
  - proctored cases; and
  - cases where applicant was the primary surgeon.
    - IEHP requires a minimum of fifteen (15) cases where applicant was the primary surgeon.

- Current or past “Regular or Senior Member” of American Society for Metabolic and Bariatric Surgery (ASMBS). Verification of membership will be obtained by the Credentialing Department.

- IEHP recommends applicant actively participates with the MBSAQIP (Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program) or an equivalent regional or national quality improvement program.
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- Supportive documentation of participation with program is to be submitted with Credentialing application.\(^9\)

  - Family Practice 1: Family Practice Providers with Obstetrics (OB) services, must meet the education and training requirements for Family Practice, set forth by ABMS or AOA and provide the following:
    - Provide a copy of a signed agreement that states member transfers will take place within the first twenty-eight (28) weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB.
    - The OB must be within the same network as the Family Practice Provider and hold admitting privileges to the IEHP contracted hospital linked with that IPA network.

  - Family Practice 2: Family Practice that includes full OB services and delivery must:
    - Have and maintain full delivery privileges at an IEHP contracted hospital.
    - Provide a written agreement for an available OB back up Provider is required.
    - The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP hospital linked with the Family Practice Provider; and
    - Provide a protocol for identifying and transferring high risk members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc).

  - Obstetrics/Gynecology (OB/GYN) Providers who would like to participate as a Primary Care Provider only, will provide outpatient well woman services only with no hospital or surgical privileges, must provide the following information for consideration:
    - Documentation of primary care practice in the United States;
    - Twenty-five (25) Continuing Medical Education (CME) units for most recent three (3) year period, of which must be in primary care related areas;

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- Applicants must provide two (2) letters of recommendation from a physician coworker (i.e. Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months); and

  - The physician coworkers must hold an active board certification in a Primary Care Specialty (i.e. board certified in Internal Medicine, Family Practice or Pediatrics).

- In lieu of having full hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc), must be available for consultations, as needed and that the OB will provide prenatal care after twenty-eight (28) weeks gestation including delivery. (See Attachment, “Patient Transfer Agreement” in Section 5).

  - The Agreement must include back-up physician’s full delivery privileges at IEHP network hospital, in the same network as the non-admitting OB Provider.

  - The OB Provider must be credentialed and contracted within the same network.

These OB/GYNs provide outpatient well woman services only with no hospital or surgical privileges. This exception must be reviewed and approved by IEHP Medical Director or Chief Medical Officer. Further review may be completed by the Peer Review Subcommittee who will either approve or deny.

- Pediatric Providers may practice outside of scope (with expanding age ranges to all ages) will be processed with a secondary specialty of General Practice, for review and approval by the IEHP Medical Director or Chief Medical Officer (CMO). Further review may be completed by the IEHP Peer Review Subcommittee who will either approve or deny. The following documents are required for consideration:

  - PCPs that have Member assigned ages 0-19 must enroll in the Vaccines for Children (VFC) Program.

  - Provide documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients. (See Attachment, “IEHP Addendum E” in Section 5);
25. DELEGATION AND OVERSIGHT

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- Provide evidence of twenty-five (25) CME units in Adult Primary Care completed within the last three (3) years; and

- Applicants must provide two (2) letters of recommendation from a physician coworker (i.e., Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months). The physician coworkers must hold an active board certification in Internal Medicine or Family Practice.

  - General Preventive Medicine PCPs must complete the following, in addition to meeting the education requirements set by ABMS or AOA:
    - Twelve (12) month internship; and
    - Nine (9) months direct patient care experience (during or after residency);

  - Specialties not recognized by either board (ABMS or AOA) are subject to Medical Director, Chief Medical Officer Review. Further review may be completed by the Credentialing Subcommittee or Peer Review Subcommittee, who will either approve or deny.

  - Urgent Care Providers must:
    - Meet the education and training requirements set forth by ABMS or AOA for at least one (1) of the following Specialty boards:
      - American Board of Pediatrics
      - American Board of Family Practice
      - American Board of Internal Medicine
      - American Board of Obstetrics and Gynecology
      - American Board of Emergency Medicine
      - Osteopathic Board of Pediatrics
      - Osteopathic Board of Family Physicians
      - Osteopathic Board of Internal Medicine
      - Osteopathic Board of Obstetrics and Gynecology
      - Osteopathic Board of Emergency Medicine

      - If the Practitioner is board certified or eligible in a specialty and/or subspecialty recognized by the American Board of Medical Specialties or American Osteopathic Association not referenced above, then those Providers are subject to Medical Director, Chief Medical Officer Review. Further review may
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   1. Credentialing Policies

be completed by the Peer Review Subcommittee, who will either approve or deny. For their review and consideration, the following documents must be submitted:

- Provide evidence of twenty-five (25) CME units in Pediatric Primary Care completed within the last three (3) years if the Provider is requesting to treat Pediatric patients;
- Provide evidence of twenty-five (25) CME units in Adult Primary Care completed within the last three (3) years if the Provider is requesting to treat Adult patients; and
- Applicants must provide two (2) letters of recommendation from a physician coworker (i.e., Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months). The physician coworkers must hold an active board certification in Pediatrics, Family Practice or Internal Medicine

4) Board Certification. IEHP does not require board certification; however IEHP must verify the certification status of the practitioners who state that they are board certified, to include that the board eligibility requirements are met.

5) Work History. IEHP must obtain a minimum of the most recent five (5) years of work history as a health professional through the practitioner’s application or Curriculum Vitae (CV). If the practitioner has less fewer than five years of work history, the time frame starts at the initial licensure date.

The application or CV includes the beginning and ending month and year for each position if employment experience, unless the practitioner has had continuous employment for five (5) years or more with no gap. In such a case, providing the year meets the intent of this factor.

6) Malpractice history. IEHP obtains confirmation of the past seven (7) years of malpractice settlements from the malpractice carrier or queries the National Practitioner Data Bank (NPDB). Appropriate Malpractice History: For Practitioners with a history of malpractice suits or decisions, the following criteria warrants full Credentialing Subcommittee Review of the history and should be applied in making credentialing and recredentialing decisions:
   - Number of claims - any claims within the prior seven (7) years.
   - Results of cases - any settlements within the prior seven (7) years.
   - Trends in cases - Practitioners with multiple malpractice claims in a similar area (e.g., missed diagnosis, negative surgical outcomes, etc.).
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7) Hospital Admitting Privileges. Practitioner must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation(s) or admitting privileges at a participating hospital. Practitioners must have appropriate admitting privileges or arrangements with IEHP’s contracted Hospitals, if applicable See Policy 5B, “Hospital Privileges”.
   - Providers are not required to maintain Hospital admitting privileges if they are only practicing at an Urgent Care or providing Telehealth Services only.

8) NPI: Must confirm Provider has an active Individual NPI with a Primary address that must be registered to an address in California.
   - Group NPI may be submitted to IEHP in conjunction to the Individual NPI.
   - Telehealth Providers are not required to have an NPI registered with a primary address in California.

9) Grievance History
   - Lower than average grievance rate
   - Absence of grievance trend

10) All Primary Care Physician (PCP) and Urgent Care Providers must meet the Facility Site Review (FSR)/Medical Record Review (MRR) Guidelines. See Policy MC06A, “Facility Site Review and Medical Records Review Survey Requirements and Monitoring.”
   - Providers at a site without an active participating PCP must still have an FSR/MRR completed and passed to be considered a Non-Par Provider in the network. No PCPs or Non-Par Providers will be able to provide services at sites without completing an FSR/MRR.
   - All PCPs must pass a required initial facility review performed by IEHP prior to receiving IEHP enrollment and treating Members.
   - IEHP has ninety (90) days from the submission of all required credentialing information to complete the facility site review.

b. Sanction Information

1) State Sanctions, restrictions on licensure and limitations on scope of practice:
   - Any actions, restrictions or limitations on scope of practice, are presented for review of and discussion to the Credentialing Subcommittee and/or Peer Review Subcommittee.

2) Medicare and Medicaid Sanctions

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10 Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3.
25. DELEGATION AND OVERSIGHT

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   - Medi-Cal Suspended & Ineligible List Providers are deemed suspended and
     ineligible from Medi-Cal will be terminated or not be credentialed and
     contracted with for Medi-Cal line of business. IEHP does not allow Medi-
     Cal Suspended & Ineligible List Providers to participate in the IEHP
     network.

   - Providers Excluded/Sanctioned by Medicare or Medicaid (OIG). IEHP
     prohibits employment or contracting with Practitioners (or entities that
     employ or contract with such Practitioners) that are excluded/sanctioned
     from participation (Practitioners found on OIG report). Providers identified
     on the OIG report, will not be credentialed or contacted, and terminated
     from our network if they are existing Providers.

   - Medicare Opt-Out Providers who are identified on the Medicare Opt-Out
     will not be contracted for Medicare line of business. IEHP does not allow
     Medicare Opt-Out Providers to participate in the IEHP network.

   - Preclusions List, Providers identified on the preclusions list will be
     terminated or not be credentialed and contracted with.

   c. Credentialing Application. Practitioners must submit an application or reapplication
      that includes the following:

      1) Attestation to:
         - Reasons for inability to perform the essential functions of the position;
         - Lack of present illegal drug use;
         - History of loss of license and felony convictions;
         - History of loss or limitation of privileges or disciplinary actions;
         - Current Malpractice Insurance coverage; and
         - Malpractice Insurance Coverage: Must have current and adequate
           malpractice insurance coverage that meets the following criteria:
           o Minimum $1 million per claim/$3 million per aggregate.
           o Coverage for the specialty the Provider is being credentialed and
             contracted for.
           o Coverage for all locations the Provider will be treating IEHP patients.\(^\text{11}\)
         - Current and signed attestation confirming the correctness and completeness
           of the application.

      2) Release of Information used for primary source verification.

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\(^{11}\) NCQA, 2020 HP Standards and Guidelines, CR1, Element C, Factor 5.
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   1. Credentialing Policies

   3) Addendum A
      - Practitioner Type
      - Practice Type
      - Name(s) of any employed Advanced Practice Practitioners (e.g. Nurse Practitioners, Nurse Midwives, or Physician Assistants)
      - Age Limitations
      - Practitioner Office Hours
      - Practitioner’s written plan for continuity of care if they do not have hospital privileges
      - Languages spoken by Physician
      - Languages spoken by staff

   4) Addendum B, used for Professional Liability Action explanation(s).

   5) Addendum C, used to confirm Practitioner’s status as a:
      - Certified Workers Compensation Provider
      - Reservist

   6) Addendum D, Notice to Practitioners of Credentialing Rights/Responsibilities

   7) Addendum E, applicable to General Practice and Obstetrics/Gynecology providers who are PCP’s.

   8) Verification of Qualifications for HIV/AIDS Physician Specialist form (See Attachment, “Identification of HIV/AIDS Specialists”, in Section 5) required for Practitioners who would like to be designated as an HIV/AIDS Specialist.

   9) Behavioral Health (Area(s) of Expertise Form. To ensure Practitioners are listed with the types of services they offer, this form is required for all Practitioners with a Behavioral Health Affiliation/Designation, to include but are not limited to:
      - Psychiatrists
      - Psychologists
      - Addiction Medicine Specialists
      - Master Level Clinical Nurses
      - Licensed Clinical Social Workers
      - Licensed Marriage Family Therapists
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   - License Professional Clinical Counselors who have met “Couples and Families” requirement, only
   - Physician Assistants who completed a Primary Care Psychiatry Fellowship

10) Transgender Questionnaire (See Attachment, “Questionnaire for: Providers for Transgender Members”, in Section 5) are required for all Practitioners who are or would like to be designated as a Transgender Competent Provider. At minimum, the Practitioner must meet the following for consideration:
   - Demonstrate ten (10) Continuing Medical Education (CME) hours within the last three (3) years
   - Certification through WPATH
   - Must provide evidence of the following annual staff training on transgender care, that includes:
     - Agenda
     - Sign in sheet
     - Policies and Procedures

   - IEHP requires the backup Licensed Physician, engaged in active clinical obstetrical practice and with whom the Licensed Midwife consults when there are significant deviations from the normal, in either mother or infant, is an active Obstetrics/Gynecology practitioner within the IEHP network.

12) IEHP requires a completed Attachment I: Statement of Agreement by Supervising Provider, for all Advanced Practitioner and Supervising Physician arrangements, to ensure arrangements are documented appropriately, which will be collected at the time of credentialing, recredentialing and upon relationship change.

Delegates must ensure and obtain the appropriate documentation for all Advanced Practice Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs) between the Advanced Practice Practitioner and Supervising Physician are present at each site. Therefore, sites must ensure that these documents are available at the time of audit and are readily available upon request.

- Physician Assistants are required to have a Practice Agreement or Delegation of Services Agreement and Supervising Physician Form. (See
B. Credentialing Standards
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   Attachment, “Delegation of Services Agreement and Supervising Physician Form” in Section 5), This agreement must define specific services identified in practice protocols or specifically authorized by the supervising physician., and
   - Both the physician and PA must attest to, date and sign the document;
   - PAs must be practicing at a site assigned to their supervising physician;
   - An original or copy must be readily accessible at all practice sites in which the PA works; and
   - The agreement must be reviewed, dated and signed annually; and provided to IEHP, upon request.

   - Nurse Practitioners and Nurse Midwives are required to have Standardized Procedures. Standardized Procedures must be on-site site specific and:
     - Reference textbooks and other written sources to meet the requirements of Title 16, CCR § 1474 (3), must include:
       - Book (specify edition) or article title, page numbers and sections.
     - NP and/or NM must be practicing at a site assigned to their supervising physician; and
     - Standardized Procedures must be signed by both the Advanced Practice Practitioner and the supervising physician, initially and annually; and provided to IEHP, upon request. At minimum, the Delegate must collect and submit to IEHP:
       - Table of Contents of the Standardized Procedures used, between the NP and/or CNM and supervising physician, that references the textbook or written sources to meet the requirements of the Board of Registered Nursing.
       - Evidence that the Standards of Care established by the sources were reviewed and authorized by the nurse Practitioner, physician and administrator in the practice setting (i.e. signature page that includes all parties involved)
   - Standardized Procedures written using the Physician Assistants Delegation of Services Agreement and Supervising Physician Form format and/or verbiage is not accepted by IEHP.\textsuperscript{12,13,14}

\textsuperscript{12} NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 3.
\textsuperscript{13} Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3.
\textsuperscript{14} Title 16, California Code of Regulations (CCR) § 1474 (3).
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d. Adverse History Guidelines: IEHP must carefully review the oversight process for the Delegates’ review of all Practitioners with evidence of adverse history are presented to Credentialing Committee for review and documented in the meeting minutes, that may include, but is not limited to Providers who have:

1) Restrictions on licensure
2) Restrictions on DEA
3) Loss of Clinical privileges or negative privilege actions
4) Sanction Other negative actions may include, but are not limited to:
   - Use of illegal drugs
   - Criminal history
   - Engaged in any unprofessional conduct or unacceptable business practices
   - Higher than average grievance rate or trend in grievances

e. Provider Network

1) Advanced Practice Practitioners are allowed to increase only one (1) supervising PCP’s enrollment capacity per location with a maximum of two (2) unique locations allowed. Advanced Practice Practitioners must be practicing at a site assigned to their supervising physician.

2) Practice within IEHP’s service area

3) Practice Parameter expansion(s) or reduction(s). Providers are required to submit a request that includes a detailed explanation when requesting a change in practice parameters such as an expansion or reduction in Member age range or specialty care privileges (i.e. addition of specialty). All Practice Parameter expansions and reductions are subject for review by the IEHP Medical Director or Chief Medical Officer. Further review may be completed by the Peer Review Subcommittee who will either approve or deny.
   - IEHP will consider all relevant information including practice site demographics, Provider training, experience and practice capacity issues before granting any such change. At a minimum, Provider’s written request must include:
     - Documentation of any relevant training (e.g., Continuing Medical Education, post graduate/residency training, etc.); and
     - Practical experience relating to the request (e.g., years in clinical practice, direct care experience with the relevant membership, etc.)

4) Patient age ranges for Primary Care Physicians (PCP) must be specifically
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delineated as part of the Delegated credentialing process. The age range for DualChoice Cal MediConnect Plan (Medicare – Medicaid) line of business are Ages 21 and above.

Guidelines for age ranges for non-physician Practitioners which include Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Physical Therapists (PT), Occupational Therapists (OT), Speech/Language Therapists (S/LT), Opticians, Optometrists (OD), Chiropractors (DC), Dieticians and Nutritionists are as applicable to the training and certification of the non-physician Practitioner.

Patient age ranges for specialty physicians are specific to the specialty involved, training, and education of the physician.

4. Delegates’ policies must define the process used and the criteria required to reach credentialing decisions that are designed to assess the Practitioner’s ability to deliver care. At a minimum:
   a. The Credentialing Committee must receive and review the credentials of the Practitioners who do not meet the Delegates established criteria.
   b. Policy must identify what is considered acceptable to be determined as a clean file, if the Delegate utilized a clean file process.
   c. If retrospective review by IEHPs Credentialing Department reveals that a Practitioner approved by a Delegate does not meet the above requirements, IEHP can submit the Practitioner to IEHPs Peer Review Subcommittee for review.15

5. Delegates may designate to their Medical Director the authority to determine and sign off on a credentialing and recredentialing file that meets the Delegate standards as complete, clean, and approved. Delegates may assign an associate medical director or other qualified medical staff member as the designated medical director if the individual has equal qualifications as the medical director and is responsible for credentialing, as applicable. The Delegate’s Credentialing Committee must review the credentials of all Practitioners being credentialed or recredentialed who do not meet the Delegates established criteria, and to provide advice and expertise for credentialing decisions.
   a. If the Medical Director or equally qualified Practitioner signs off on clean files, the sign off date is the Committee date.
   b. If the Delegate decides not to use the Medical Director or equally qualified Practitioner, the Delegate can continue to send “clean files” to the Credentialing Committee.16

6. Delegates’ policies must describe the process for requiring that credentialing and

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16 NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 5.
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recredentialing are conducted in a nondiscriminatory manner.

a. Policies must explicitly state that credentialing and recredentialing decisions are not based solely on an applicant’s race, ethnic/national identity, gender, age, sexual orientation or patient in which the Practitioner specializes and describe the steps for monitoring or preventing discriminatory practices during the credentialing/recredentialing processes.

b. Delegates procedures for monitoring and preventing discriminatory credentialing decisions may include but are not limited to:

1) Periodic audits of Practitioner complaints to determine if there are complaints alleging discrimination;

2) Maintaining and heterogeneous Credentialing Committee membership and requiring those responsible for credentialing decisions to sign an affirmative statement to make decisions in a non-discriminatory manner.

3) Monitoring involves tracking and identifying discrimination in credentialing and recredentialing processes. Policy must indicate that monitoring is to be conducted at least annually. Examples of monitoring discriminatory practices:

   - Having a process for performing periodic audits of credentialing files (in-process, denied and approved files)

   - Having a process for performing annual audits of Practitioner complaints about possible discrimination. (Can be reviewed and discussed during quarterly or semi-annual review of complaints)

4) Preventing involves taking proactive steps to protect against discrimination occurring in the credentialing and recredentialing processes. Examples for preventing discriminatory practices:

   - Maintaining a heterogeneous credentialing committee and requiring those responsible for credentialing decisions to sign a statement affirming that they do not discriminate.

   - Timeframe for prevention: None. Committee members can attest annually or at each meeting.\(^7\)

7. Delegates’ policies and procedures must describe the process for notifying Practitioners when credentialing information obtained from other sources varies substantially from that provided. A statement that Practitioners are notified of discrepancies does not meet the requirement.

8. Delegates’ policies and procedures must describe the process for notifying Practitioners the credentialing and recredentialing decisions within sixty (60) calendar days of the

\(^7\) NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 6.
25. DELEGATION AND OVERSIGHT

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   Committee’s decision.  

9. Delegates’ policies must describe the medical director or other designated Practitioner’s
   overall responsibility and participation in the credentialing process.  

10. Delegates’ policies and procedures must clearly state the information obtained in the
    credentialing process is confidential and describe the process to ensure confidentiality of
    the information collected during the credentialing process. The Delegates’ mechanisms
    in effect to ensure confidentiality of all information obtained in the credentialing process,
    except as otherwise provided by law, may include, but is not limited to:
    a. Confidentiality statements are signed by Committees and Credentialing staff
    b. Practitioner files are maintained in locked file cabinets and are only accessible by
       authorized personnel; and
    c. Security for database systems is maintained through passwords or other means to
       limit access to Practitioner information to authorized staff only.  

11. Delegates’ policies and procedures describe the Delegates’ process for ensuring that
    information provided to IEHP for Member materials and Practitioner directories is
    consistent with the information obtained during the credentialing and recredentialing
    process. At minimum, policy should demonstrate that the information collected during
    the credentialing and recredentialing process and requests received in between cycles, is
    entered, maintained, and submitted to IEHP by the Credentialing Department to ensure
    consistency. 

B. Delegates’ policies and procedures describe how the following three (3) factors are met and
   how the Practitioners are notified (e.g. application, contact, Provider manual, other
   information distributed to Practitioners, website, letter to Practitioners):

   1. Review information submitted to support their credentialing application
      a. Policies should allow for review of information obtained from outside sources (e.g.
         malpractice insurance carriers, state licensing boards) to support their credentialing
         application. Delegates are not required to make available:
            1) References.
            2) Recommendations.
            3) Peer-Review protected information.

   2. Delegate notifies Practitioners of their right to correct erroneous information (submitted
      by another source) and must clearly state:

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18 NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 7.
21 NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 11.
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   a. The time frame for making corrections.
   b. The format for submitting corrections.
   c. Where corrections must be submitted.

   Delegates are not required to reveal the source of information that was not obtained to
   meet the verification requirements or if federal or state law prohibits disclosure.

   Delegate must document receipt of corrected information in the Practitioners
   credentialing file.

   3. Delegates notifies Practitioners of:

      a. Their right to be informed of the status of their application, upon request.
      b. The information it is allowed to share with Practitioners.
      c. Its process for responding to requests for application status.22

C. Delegates credentialing process, both paper and electronic, must describe:

   1. How primary source verification information is received, dated and stored.
   2. How modified information is tracked and dated from its initial verification.

      a. The policy must clearly state how it tracks:
         1) When the information was modified
         2) How the information was modified
         3) Staff who made the modification
         4) Why the information was modified

   3. Staff who are authorized to review, modify and delete information, and circumstances
      when modification or deletion is appropriate.

      a. The delegates’ policies and procedures identify the:
         1) Level of staff who are authorized to access, modify and delete information
         2) Circumstances when modification or deletion is appropriate

   4. The security controls in place to protect the information from unauthorized modification.

      a. Policies and procedures describe the process for:
         1) Limiting physical access to the credentialing information, to protect the accuracy
            of information gathered from primary sources and NCQA-approved sources.
         2) Preventing unauthorized access, changes to and release of credentialing

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   1. Credentialing Policies

      information.

   3) Password-protecting electronic systems, including user requirements to:
      • Use strong passwords
      • Avoid writing down passwords
      • Use different passwords for different accounts
      • Change passwords periodically
      • Changing or withdrawing passwords, including alerting appropriate staff
        who oversee computer security to:
        o Change passwords when appropriate
        o Disable or remove passwords of employees who leave the organization
      • If the Delegate contracts with an external entity to outsource storage of
        credentialing information, the contract describes how the contracted entity
        ensures the security of the stored information.
        o Contract will require review if outsourcing

   5. How the organization audits the processes and procedures in factors 1-4.
      a. The policies and procedures must describe the audit process for identifying and
         assessing risks and ensuring the specified policies and procedures are followed. The
         description includes:
            1) The audit methodology used, including sampling, the individuals involved in the
               audit and audit frequency.
            2) The oversight of the department responsible for the audit.23

D. Delegates’ recredentialing policies and procedures require information from quality
   improvement activities and Member complaints in the recredentialing decision making
   process.24,25

E. Delegates’ policies and procedures must ensure that it only contracts with physicians who
   have not opted out.
   1) Medicare Opt-Out Providers who are identified on the Medicare Opt-Out will not be
      contracted for Medicare line of business. IEHP does not allow Medicare Opt-Out
      Providers to participate in the IEHP network for Medicare lines of business.26

23 NCQA, 2020 HP Standards and Guidelines, CR 1, Element C, Factors 1-5
24 Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3
25 Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019, “Provider
   Credentialing / Recredentialing and Screening / Enrollment”
26 Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.2
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F. Delegates must have policies and procedures that prohibits employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners found on OIG report). Providers identified on the OIG report, will not be credentialed or contacted, and terminated from our network if they are existing Providers.27

G. Delegates must have policies and procedures that they do not contract with Practitioners who are precluded from receiving payment for Medicare Advantage (MA) items and services Part D drugs furnished or prescribed to Medicare beneficiaries. IEHP does not allow Practitioners identified on the preclusions list to participate in the IEHP network.

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27 DHCS APL 19-004 Supersedes APL 17-019.
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2. Credentialing Committee

APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid) Providers.

POLICY:

A. Delegates Credentialing Committee must use participating Practitioners to provide expert advice and expertise for credentialing decisions.

B. Delegates Credentialing Committee must review credentials for Practitioners who do not meet established thresholds.

C. Delegates Credentialing Committee ensures files that meet established criteria are reviewed and approved by a medical director or designated Physician.

PURPOSE:

A. Delegate must designate a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions.

B. Delegate obtains meaningful advice and expertise from participating Practitioners when it makes credentialing decisions.

C. Assessment of Timeliness - In accordance to National Committee for Quality Assurance (NCQA) guidelines, IEHP uses the Credentialing Committee or medical director decision date to assess timeliness in the file review elements if a review board or governing body reviews decisions made by the Credentialing Committee or Medical Director.

D. Providing care to Members - IEHP does not permit Practitioners to provide care to its Members before they are credentialed.

DEFINITION:

A. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, Managed Service Organization (MSO) etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.
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2. Credentialing Committee

a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.

b. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered delegation.

PROCEDURES:

A. Delegates Credentialing Committee must use participating Practitioners to provide expert advice and expertise for credentialing decisions. ¹

1. The Credentialing Committee is a peer-review body with members from the range of Practitioners participating in the organizations network that makes recommendations regarding credentialing decisions. At a minimum, the policy and procedures must include:

a. The Credentialing Committee:

1) Composition of Committee is comprised of a range of participating Practitioners that includes multi-disciplinary representation with the ability to seek the advice of participating Practitioners outside of the Committee, at the Committee’s discretion, when applicable. If the Credentialing Committee is comprised of Primary Care Providers (PCPs) only, the policy must state that Specialists are consulted, when necessary and appropriate. Evidence may include, but is not limited to:
   • Representation includes a range of participating Practitioners in the delegates network;
   • There is evidence through their Committee minutes that a Specialist was consulted, when applicable; and
   • There is a listing that indicates what Specialists were used (if applicable).

2) Quorum requirements of Committee (minimum of three (3));
   • Meetings should include a quorum of Practitioners for each meeting.

3) Identity of voting Members;

4) Identity of who has authority to make final credentialing decisions and the relationship to the Governing Board (if applicable);

5) Frequency of Committee meeting (at minimum, quarterly);

¹ National Committee for Quality Assurance (NCQA), 2020 Health Plan Standards and Guidelines, CR 2, Element A, Factor 1.
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   6) Process to document, review and approve delegate credentialing policies and procedures by the Committee on an annual basis; ²

   7) Committee’s opportunity to review documentation, criteria and credentials of all Practitioners being credentialed or recredentialed prior to rendering a recommendation; and

   8) All primary source information obtained and reviewed in the credentialing or recredentialing process must be no more than one hundred eighty (180) days old at the time of the Committee decision.

B. Delegates Credentialing Committee policies must describe how the Credentialing Committee receives and reviews the credentials of Practitioners who do not meet the Delegates established criteria. The Credentialing Committee must give thoughtful consideration of the credentialing information. Delegate must provide evidence of the following:

   1. The Credentialing Committee reviewed credentials for Practitioners who do not meet established thresholds;

   2. The Credentialing Committee’s discussion must be documented within its meeting minutes; and

   3. Credentialing Committee meetings and decision-making take place in the form of real-time virtual meetings (e.g. through video conferencing or WebEx conferment with audio).
      a. All meetings, including ad hoc, may not be conducted only through email.
      b. Meetings should include a quorum of practitioners for each meeting, as established in the Delegates policy.
      c. Minutes should be signed by the Credentialing Committee Chairperson and dated within one (1) month or by the date of the next meeting.
      d. Ad hoc Credentialing Committee meeting minutes must be documented at the time of the ad hoc meeting and must be presented at the next formal meeting.

C. Delegates must submit all Practitioner files to the Credentialing Committee for review or has a process for medical director or qualified Physician review and approve clean files.

   1. Delegates policy and procedures must state that the Credentialing Committee ensures the files that meet the established criteria are reviewed and approved by a Medical Director or designated Physician.
      a. Delegate may choose to continue to submit all Practitioner files to the Credentialing Committee for review, or it may implement a process for the Medical Director to review clean files, as described in the credentialing policies and procedures.

² NCQA, 2020 HP Standards and Guidelines, CR 2, Element A, Factor 3.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
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   1) If the Medical Director or designated Physician reviews the clean files, there must be evidence of the designated Medical Director’s or designated Physician’s review and approval in the Practitioners file or on a list of all Practitioners who meet the established criteria.

   • Reports may include Credentialing Committee minutes or files, or a list of approved Practitioners signed or initialed by the Medical Director, for evidence that the requirement is met.
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B. Credentialing Standards
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APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) Providers.

POLICY:

A. Delegate verifies that the following are within the prescribed time limits: License to Practice, Drug Enforcement Administration (DEA), education and training, board certification, work history and malpractice history.

B. Delegate verifies the following sanction information for credentialing: State sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions.

C. Delegate ensures applications for credentialing and recredentialing include reasons for inability to perform the essential functions of the position, lack of present illegal drug use, history of loss of license and felony convictions, history of loss or limitation of privileges or disciplinary actions, current malpractice insurance coverage, and a current and signed attestation confirm the correctness and completeness of the application.

D. Delegate verifies that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating Hospital.

E. Delegate monitors its credentialing files to ensure that it only contracts with Practitioners who have not opted out.

F. Delegate includes information from the quality improvement activities and Member complaints in the recredentialing decision-making process.

G. Delegate confirms all Practitioners maintain an active individual National Provider Identifier (NPI) number registered through the Centers for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES) and must be registered to an address in the State of California.

H. Delegate ensures all Primary Care Provider’s (PCP) and Urgent Care’s (UC) are informed that they must pass an on-site site review conducted by IEHP. (See Policy 6A, “Site Review and Medical Record Review Survey Requirements and Monitoring”).

I. Delegates must provide IEHP with Social Security Numbers for all new and existing practitioners participating providers, to ensure all Practitioners are included in IEHP’s screening of the Death Master File.
25. **DELEGATION AND OVERSIGHT**

B. **Credentialing Standards**

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J. Delegates monitors its Provider network and ensures their Providers are not included in the Centers Medicare & Medicaid Services (CMS) Preclusions List.

K. Delegates must ensure all Practitioners are within the appropriate age range guidelines, as appropriate.

L. Delegates must submit appropriate documentation to expand or limit their practice parameters for IEHP review and approval.

M. Delegates must ensure and obtain the appropriate documentation for all Advanced Practice Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Nurse Midwives (NMs) between the Mid-Level and Supervising Physician, provide them to IEHP, and ensure these documents are readily available upon request. (See Policy 6F, “Non-Physician Practitioner Requirements”).

**PURPOSE:**

A. IEHP must ensure Delegates conducts timely verification of information to ensure that Practitioners have the legal authority and relevant training and experience to provide quality care.

B. Pencils are not an acceptable writing instrument for credentialing documentation.

**DEFINITION:**

A. Verification Time Limit (VTL): National Committee for Quality Assurance (NCQA) counts back from the decision date to the verification date to assess timeliness of verification.

B. Each file contains evidence of verification, defined by NCQA as “Appropriate documentation.” IEHP documents verification in the credentialing files using any of the following methods or a combination:

1. Credentialing documents signed (or initialed) and dated by the verifier.

2. A checklist that includes for each verification:
   a. The source used.
   b. The date of verification.
   c. The signature or initials of the person who verified the information.
   d. The report date, if applicable.

3. A checklist with a single signature and a date for all the verifications that has a statement confirming that the signatory verified all of the credentials on that date and that includes for each verification.
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  a. The source used.
  b. The report date, if applicable.
  c. If the checklist does not include checklist requirements listed above appropriate credentialing information must be included.

C. Verbal Verification - Requires a dated, signed document naming the person at the primary source who verified the information, his/her title, the date and time of verification, and include what was verified verbally.

D. Automated Verification - Requires there be a mechanism to identify the name of the entity verifying the information, the date of the verification, the source, and the report date, if applicable.

E. Written Verification - Requires a letter or documented review of cumulative reports. The Independent Practice Association (IPA) must use the latest cumulative report, as well as periodic updates released by the primary source. The date on which the report was queried, and the volume used must be noted.

F. Using the Internet for Primary Source Verification (PSV): PSV on documents that are printed/processed from an internet site (e.g. BreEZe, National Practitioner Data Bank (NPDB), etc.), the data source date (as of date, release date) must be queried within the timeframe. The date of the query must be verified prior to the Credentialing Decision. If there is no data source date, the verifier must document the review date on the verification or the checklist. Verification must be from an NCQA approved and appropriate state-licensing agency.

G. PSV Documentation Methodology. The Delegate may use an electronic signature or unique electronic identifier of staff to document verifications (to replace the dating and initialing of each verification) if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The system must identify the individual verifying the information and the date of verification.

H. NPPES – CMS National Plan and Provider Enumeration System.

I. CMS Preclusions List – List of prescribers and individuals or entities who fall within any of the following categories:
   1. Currently revoked from Medicare:
   2. Under an active re-enrollment bar; or
   3. CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.

J. Death Master File (DMF) contains information about persons who had Social Security numbers and whose deaths were reported to the Social Security Administration from 1962 to
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   the present; or persons who died before 1962, but whose Social Security accounts were still active in 1962.

K. Delegate: If IEHP gives another Delegate (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

   1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.

      a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.

      b. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered delegation.

PROCEDURES:

A. The Delegate must verify that the following are within the prescribed time limits:

   1. A current and valid license to practice in California (Verification Time Limit (VTL): one hundred-eighty (180) calendar days prior to Credentialing decision date).

      a. Must be valid, current, and unencumbered at the time of committee and remain valid and current throughout the Practitioner’s participation with IEHP.

         1) For web queries, the data source data – e.g. release date or as of date is used to assess timeliness of verification.

         2) All Practitioners must be licensed by the State of California by the appropriate state licensing agency. The following license verifications must be obtained by the licensing board or their designated licensing and enforcement systems. The following licensures may be verified through BreEZe Online services online or directly with the licensing board via phone or mail:

            • Medical Board of California (M.D.)
            • Osteopathic Medical Board of California (D.O.)
            • Board of Podiatric Medicine (D.P.M.)
            • Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C)
            • Board of Psychology (Ph.D., Psy.D.)
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- Dental Board of California (D.D.S., D.M.D.)
- California Board of Occupational Therapy (O.T.)
- California State Board of Optometry (O.D.)
- Physical Therapy Board of California (P.T.)
- Physician Assistant Committee (P.A., P.A.-C)
- California Board of Registered Nursing (C.N.M., N.P.)
- California Board of Chiropractic Examiners (D.C.)
- Speech-Language Pathology & Audiology Board (S.P., Au)
- Acupuncture Board (L.Ac.)

3) Failure to maintain a valid and current license at all times, will result in an administrative termination of the Practitioner.¹

2. A valid DEA or Controlled Dangerous Substances (CDS) certificate, if applicable (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). All Practitioners who are qualified to write prescriptions, except non-prescribing Practitioners, must have a valid and current DEA certificate.

a. Must be valid and current at the time of committee and remain valid and current throughout the Practitioner’s participation with IEHP registered with an address in the State of California.

b. Verification may be in the form of:

1) A photocopy of the current DEA certificate, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision; or

2) A query of the National Technical Information Service (NTIS) database, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision.

c. Any Practitioner with a DEA with an “EXEMPT” Fee or status, the DEA is only valid at the exempting institution and any affiliate Hospital or Clinic rotations within the scope of training. The Delegate must confirm the Practitioner’s practice and exempting institutions relationship and document their findings in the Provider file, if the address on the DEA does not match the Providers practice location. If a Practitioner is practicing outside of the exempting institution and/or its affiliates, the Practitioner must obtain a “Paid” status DEA.

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   d. The Delegate may credential a Practitioner whose DEA certificate is pending or pending a DEA with a California address, if the Delegate has a documented process for allowing a Practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate.

   e. If a Practitioner does not have a DEA or CDS certificate, the Delegate must have a documented process to require an explanation why the Practitioner does not prescribe medications and to provide arrangements for the Practitioner’s patients who need prescriptions requiring DEA certification.

   f. Failure to maintain an active DEA, may result in an administrative termination of the Practitioner.²

3. Education and training (VTL: Prior to the Credentialing Decision) All Practitioners must have completed appropriate education and training for practice in the U.S. or a residency program recognized by NCQA, in the designated specialty or subspecialty they request to be credentialled and contracted. The Delegate verifies the highest of the following three (3) levels of education and training obtained by the Practitioner, as appropriate.

   If the Practitioner is not board certified in the specialty or sub-specialty in which he/she is applying, there must be evidence of verification of residency and training in the sub-specialty (e.g. Fellowships in Cardiology, Rheumatology, Pediatric Endocrinology etc.), as relevant to the credentialled specialty.

   The Delegate may use any of the following to verify education and training:

a. The primary source from the Medical School or through a clearinghouse.

b. The state licensing agency or specialty board if the state agency and specialty board, respectively, perform primary source verification. The Delegate obtains, at least annually, written confirmation of this fact, uses a printed, dated screenshot of the state licensing agency’s or specialty board’s website displaying the statement that it performs primary source verification of Practitioner education and training information or provides evidence of a state statute requiring licensing to obtain verification of education and training directly from the institution.

c. Sealed transcripts if the Delegate provides evidence that it inspected the contents of the envelope and confirmed that Practitioner completed (graduated from) the appropriate training program.

d. Below are acceptable sources for physicians (M.D., D.O.) to verify graduation from Medical School:

   1) American Medical Association (AMA) Physician Master File.

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   3) Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

   Below are acceptable sources for Physicians (M.D., D.O.) to verify completion of residency training:
   1) Primary source from the institution or clearinghouse where the postgraduate medical training was completed.
   2) AMA Physician Master File.
   3) AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
   4) Federation Credentials Verification Service (FCVS) for closed residency programs.
      - NCQA only recognizes residency programs accredited by the Accredited Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.3

   4. Board certification status, if applicable (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date).
      a. The Delegate verifies current certification status of Practitioners who state that they are board certified.
         1) The Delegate must document the expiration date of the board certification within the credential file.
            - If a Practitioner has a “lifetime” certification status and there is no expiration date for certification, the Delegate verifies that the board certification is current and documents the date of verification.
         2) If board certification has expired it may be used as verification of education and training.
         3) Verification must be performed through a letter directly from the board or an online query of the appropriate board as long as the board states that they verify education and training with primary sources, is an acceptable source by NCQA, and indicate that this information is correct. Below are the acceptable sources to

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verify board certification:

- For all Practitioner types
  - The primary source (appropriate specialty board).
  - The state licensing agency if the primary source verifies board certification.

- For Physicians (M.D., D.O.)
  - American Board of Medical Specialties (ABMS) or its member boards, or an official ABMS Display Agency, where a dated certificate of primary-source authenticity has been provided.
  - AMA Physician Master File.
  - AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
  - Boards in the United States that are not members of the ABMS or AOA if the Delegate documents within its policies and procedures which specialties it accepts and obtains annual written confirmation from the boards that the boards performs primary source verification of completion of education and training.

- For other health care professionals
  - Registry that performs primary source verification of board that the registry performs primary source verification of board certification status.

- For Podiatrists (D.P.M.)
  - American Board of Foot and Ankle Surgery (formerly The American Board of Podiatric Surgery).
  - The American Board of Podiatric Medicine.
  - American Board of Multiple Specialties in Podiatry.

- For Nurse Practitioners (N.P.)
  - American Association of Nurse Practitioners (AANP).
  - American Nurses Credentialing Center (ANCC).
  - National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties (NCC).
  - Pediatric Nursing Certification Board (PNCB).
  - American Association of Critical-Care Nurses (AACN).
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- For Physician Assistants (P.A.-C).
  - National Commission of Certification of P.A.’s (NCCPA).
- For Certified Nurse Midwives (C.N.M.).
  - American Midwifery Certification Board (AMCB).
- For Psychologists (Ph.D., Psy.D.).
  - American Board of Professional Psychology (ABPP).

5. Work history (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date) The Delegate must obtain a minimum of the most recent five (5) years of work history as a health professional through the application, Curriculum Vitae (CV) or work history summary/attachment, providing it has adequate information.

a. The Delegate must document review of work history on the application, CV, or checklist that includes the signature or initials of staff who reviewed work history and the date of review. Documentation of work history must meet the following:

1) Must include the beginning and ending month and year for each work experience.

2) The month and year do not need to be provided if the Practitioner has had continuous employment at the same site for five (5) years or more. The year to year documentation at that site meets the intent.

3) If the Practitioner completed education and went to straight into practice, this will be counted as continuous work history.

4) If the Practitioner has practiced fewer than five (5) years from the date of credentialing. The work history starts at the time of initial licensure.

5) The Delegate must review for any gaps in work history. If a work history gap of six (6) months to one (1) year is identified, the Delegate must obtain an explanation from the Practitioner. Verification may be obtained verbally or in writing or in writing for gaps of six (6) months to one (1) year.

6) Any gap in work history that exceeds one (1) year must be clarified in writing from the Practitioner. The explanation of the gap needs to be sufficient to ascertain that the gap did not occur as a result of adverse and/or reportable situations, occurrences or activities.4

6. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner. (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date)

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B. Credentialing Standards
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a. The Delegate must obtain confirmation of the past seven (7) years of malpractice settlements through one of the following sources:
   1) Malpractice Insurance Carrier
   2) National Practitioner Data Bank Query
   3) Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS)). Continuous Query must be reviewed within one hundred-eighty (180) calendar days of the initial credentialing decision. Evidence must be documented in the file or on checklist.

b. A minimum the seven (7) years claim history must be reviewed for initial credentialing and all claim history activities after the previous credentialing decision date, will be reviewed for recredentialing.

c. The seven (7) year period may include residency and fellowship years. The Delegate is not required to obtain confirmation from the carrier for Practitioners who had a hospital insurance policy during a residency and fellowship.5

B. Delegate verifies the following sanction information for credentialing:

1. State sanctions, restrictions on licensure or limitations on scope of practice (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision).

   a. Verification sources for sanctions or limitations on licensure include:
      1) Chiropractors: State Board of Chiropractic Examiners, Chiropractic Information Network/Board Action Databank (CIN-BAD), or NPDB.
      2) Oral Surgeons: State Board of Dental Examiners, or State Medical Board, NPDB.
      3) Physicians: Appropriate state board agencies, Federation of State Medical Boards (FSMB), NPDB.
      4) Podiatrists: State Board of Podiatric Examiners, Federation of Podiatric Medical Boards, NPDB.
      5) Non-physician Healthcare Professionals: State licensure or certification board, appropriate state agency, NPDB.
      6) For Delegate’s using the Continuous Query (formerly Proactive Disclosure Service (PDS))
         • Evidence of current enrollment must be provided.

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- Report must be reviewed within one hundred eighty (180) calendar days of the initial credentialing decision.
- Evidence of review must be documented in the file or on checklist.

2. Medicare and Medicaid sanctions. (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision).

a. Verification Sources for Medicare/Medicaid Sanctions:
   1) OIG must be one (1) of the verification sources for Medicare sanctions, to ensure compliance with CMS.
   - Date of query and staff initials must be evident on a checklist or the OIG page must be in the file.
   2) The Medi-Cal Suspended and Ineligible list must be one (1) of the verification source for Medicaid sanctions, to ensure compliance with Department of Health Care Services (DHCS).\(^6\)
   - Date of query and staff initials must be evidence on a checklist, or the report page must be in the file.

1) NPDB
2) FSMB
3) The Federal Employees Health Benefits (FEHB) Program Department Record, published by the Office of Personnel Management, OIG.
4) List of Excluded Individuals and Entities (maintained by OIG).
5) Medicare Exclusions Database.
6) State Medicaid Agency or intermediary and the Medicare intermediary.
7) For Delegate’s using the Continuous Query (formerly Proactive Disclosure Service (PDS))

C. Delegate applications for credentialing and recredentialing include the following:

1. Reasons for inability to perform the essential functions of the position.\(^7\)
2. Lack of present illegal drug use.
   a. Delegate’s application may use alternative language or general language that may not be exclusive to present use or only illegal stances.\(^8\)

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\(^6\) Coordinated Care Initiative (CCII) Three-Way Contract, January 2018, Section 2.10.
\(^7\) NCQA, 2020 HP Standards and Guidelines, CR 3, Element C, Factor 1.
3. History of loss of license and felony convictions.
   a. At initial credentialing, the Practitioner must attest to any loss of license or felony convictions since their initial licensure.
   b. At recredentialing, the Practitioners may attest to any loss of licensure or felony convictions since their last credentialing cycle.\(^9\)

4. History of loss or limitation of privileges or disciplinary actions.
   a. At initial credentialing, the Practitioner must attest to any loss or limitation of privileges since their initial licensure.
   b. At recredentialing, the Practitioners may attest to any loss or limitation of privileges since their last credentialing cycle.\(^10\)

5. Current malpractice insurance coverage. IEHP requires that a copy of the insurance face sheet or Certificate of Insurance (COI) be obtained in conjunction of collecting information on the application.
   (VTL: Must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee date and remain valid and current throughout the Practitioner’s participation with IEHP).
   1) All Practitioners must have current and adequate malpractice insurance coverage that is current and:
      • Meets IEHP’s standard of $1 million/$3 million, as well as the IPAs standards. Professional Liability Insurance coverage and amounts of coverage must be verified with the insurance carrier or through the Practitioner via a copy of the policy and the signed attestation completed by the Practitioner. The copy of the Practitioner’s certificate must be initialed, and date stamped to show receipt prior to the credentialing decision and to show it was effective at the time of the credentialing decision.
      • Must include coverage for the specialty the Practitioner is being credentialed for and for all locations the Practitioner will be treating IEHP patients.
         o If the specialty coverage and/or the locations are not identified on the malpractice insurance certificate, the coverage must be verified with the insurance carrier and documented in the Practitioner’s file.
      • For Practitioners with federal tort coverage, the Practitioner must submit a copy of the federal tort letter or an attestation from the Practitioner of federal

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   • There must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee approval date.
     - Failure to maintain current malpractice coverage for the specialty the Provider is being credentialed for and for all locations the Practitioner will be treating IEHP patients, will result in an administrative termination of the Practitioner.11

6. Current and signed attestation confirm the correctness and completeness of the application. Attestation must be:

   a. Signed and dated within the timeframe and must include all elements to be compliant.

      1) The one hundred-eighty (180) calendar-day time frame is based on the date the Practitioner signed the application.

      • If the signature or attestation exceeds one hundred-eighty (180) calendar-days the Practitioner must only attest that the information on the application remains correct and complete, be re-signing and re-dating the attestation. Practitioner does not need to complete another application.

   b. Signed with a full signature, if the attestation needs to be re-signed by the Practitioner; dating and initialing is not acceptable.

   c. If the attestation is not signed and/or dated, within the appropriate time frame, all application elements are non-compliant (except current malpractice coverage since IEHP requires a face sheet is obtained).

      1) If a question is answered incorrectly, Delegate is responsible for notifying the Practitioner to have them review the question.

      • If the Provider chooses to change their response, the Provider may initial and date next to the change.

      • If the Provider chooses not to change their response, the Delegate will document their attempt to have the Practitioner review their response and that the provide chose not to change their response.

   d. When reviewing the Council for Affordable Quality Healthcare (CAQH) application, Delegate must review attestation questions in addition to the form that contains the generated date and the last updated (attestation date).

      1) If the generated date on the form is older than one hundred-eighty (180) calendar date, but there is a current attestation date, the Delegate may accept the

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D. Delegate verifies that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current Hospital affiliation or admitting privileges at a participating Hospital. Verification that all clinical privileges are in good standing to perform functions for which the Practitioner is contracted, to include verification of admitting privileges, must be:

1. Confirmed with the Hospital, in writing, via approved website or verbally, and must include:
   a. The date of appointment;
   b. Scope of privileges, restrictions (if any i.e. restricted, unrestricted) and recommendations.
   c. Confirmation Provider has admitting privileges in the specialty the Provider is credentialed and contracted for.
   d. If a published Hospital directory is used, the list must include the necessary information and be accompanied by a dated letter from the Hospital attesting that the Practitioner is in “good standing.”
   e. Practitioner must meet the requirements for Hospital Privileges as required by IEHP. (See Policy 5B, “Hospital Privileges”), i.e. if an admitter or hospitalist arrangement is used, a written agreement that meets IEHP admitter requirements, confirming coverage for all inpatient work covering the entire age range of the Practitioner must be included in the Practitioner’s credentialing file.

1) These arrangements must be provided to IEHP for all Practitioners participating in the IEHP network, via Provider profile, admitter report or attachment.

2) If the Provider utilizes an admitter or hospitalist arrangement, the Delegate must document these arrangements in the Provider file, to include when the Provider was notified. Documentation must include:
   - The date the Practitioner was notified
   - Name(s) of the admitter and/or hospitalist, admitting on behalf of the Provider
   - Name(s) of the Hospital, affiliated with the inpatient coverage arrangements

2. If the Practitioner does not have clinical privileges, the Delegate must have a written statement delineating the inpatient coverage arrangement. (See Policy 5B, “Hospital Privileges”).

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25. **DELEGATION AND OVERSIGHT**

B. **Credentialing Standards**

3. **Credentialing Verifications**

3. Allied Health Professionals (Non-physicians i.e. Chiropractors, Optometrists) will not have Hospital privileges and documentation in the file is not required for these types of Practitioners.

4. Advanced Practice Practitioners (Physician Assistants (PA), Nurse Practitioners (NP), Nurse Midwives (NM)) may not have Hospital privileges. However, if they provide the Delegate their Hospital privileges, Delegate will be responsible for verifying if those privileges are active and ensure they are in good standing.

5. Specialists (MDs, DOs and DPMs) may not have Hospital privileges, documentation must be noted in the file as to the reason for not having privileges. (e.g. A note stating that they do not admit as they only see patients in an outpatient setting is sufficient).

   a. These arrangements must be provided to IEHP for all Practitioners participating in the IEHP network, via Provider profile, admitter report or attachment.

      1) These arrangements are subject to IEHP review and approval.

      2) IEHP may request for inpatient coverage arrangements for the Practitioner, if IEHP identified that specialty as a specialty that requires Hospital admitting arrangements.

6. Certified Nurse Midwives (CNMs) may provide care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and delivery services only after they are fully credentialed and approved by the IPA or IEHP directly. CNM Providers must meet the following criteria:

   a. In lieu of having full hospital delivery privileges, provide a written agreement with an Obstetrician (OB) Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed.

      1) The Agreement must include back-up Physician’s full delivery privileges at IEHP network Hospital, in the same network as the CNM Provider.

      2) The OB Provider must be credentialed and contracted within the same practice and network.

7. Family Practice including outpatient Obstetrics (OB) services (FP-1) must provide a copy of a signed agreement that states:

   a. Member transfers will take place within the first twenty-eight (28) weeks of gestation and a protocol for identifying and transferring high risk members with a contracted and credentialed OB.

      1) The OB must be contracted and credentialed by the same network as the Family Practice Provider and must hold admitting privileges to the IEHP Hospital linked with that IPA network.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   3. Credentialing Verifications

8. Family Practice including full Obstetrics services and delivery (FP-2). Providers that fulfill these requirements may be referred to and see Obstetrician/Gynecologist (OB/GYN) Members within the same IPA as the referring Physician, and must have:
   a. Full delivery privileges at an IEHP network Hospital; and
      1) Provide a written agreement for an available OB back up Provider is required. The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP Hospital linked with the Family Practice Provider; and
      2) Provide a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc.).

9. Obstetrics/Gynecology (OB/GYN) Providers who would like to participate as a Primary Care Provider only, will provide outpatient well woman services only with no Hospital or surgical privileges, must provide the following information for consideration:
   a. In lieu of obtaining or maintaining full Hospital delivery privileges, the Practitioners must provide a written agreement with OB that includes:
      1) A protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.).
      2) Must be available for consultations, as needed and that the OB will provide prenatal care after twenty-eight (28) weeks gestation including delivery.
      3) The Agreement must include back-up Physician’s full delivery privileges at IEHP network Hospital, in the same network as the non-admitting OB Provider.
         • The OB Provider must be credentialed and contracted within the same network.

10. Urgent Care Providers are not required to maintain Hospital privileges if they are exclusively practicing at an Urgent Care.\(^{13,14,15}\)

E. Delegate monitors its credentialing files to ensure that it only contracts with Practitioners who have not opted out. Delegate is responsible for:
   1. Reviewing the information via hard copies, electronic or one (1) of the CMS.gov Opt-Out sites.
      a. Certain healthcare Providers categories cannot opt-out of Medicare. These include Chiropractors, physical therapists and occupational therapists in independent

\(^{13}\) Medicare Managed Care Manual, Relationships with Providers”, Section 60.3.
\(^{14}\) Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019, “Provider Credentialing/Recredentialing and Screening/Enrollment.
\(^{15}\) California Code of Regulations (CCR) § 1300.51(d)(H)(iii).
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

3. Credentialing Verifications

practice.  

2. If Delegate employs their Practitioners, the initial credentialing and recredentialing review of employed Practitioners must include a review of the Medicare Opt-Out Report in all files credentialled.

3. The following are acceptable ways to verify review of the Opt-Out report:

a. Checklist/Verification: Must have the following to be compliant:
   1) Staff initials/signature;
   2) Run date from CMS.gov Opt-Out Reports; and
   3) Indicate whether or not the practitioner is listed on the report.

b. Pages of the CMS.gov listing report showing where the providers name would have been listed in alpha order. Must have the following to be compliant:
   1) Staff initials/signature;
   2) Run date from CMS.gov Opt-Out Reports; and
   3) Indicate whether or not the Practitioner is listed on the report.

F. Delegate includes information from the quality improvement activities and Member complaints in the recredentialing decision-making process. (Verification Time Limit: Last recredentialing cycle to present).

1. Quality activities include, but are not limited to:
   a. Adverse events
   b. Medical record review
   c. Data from Quality Improvement Activities
   d. Performance Information, may include but is not limited to:
      1) Utilization Management Data
      2) Enrollee satisfaction surveys
      3) Other activities of the Delegate
   e. Not all quality activities need to be present

2. Grievance/complaints  

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16 Medicare Managed Care Manual, Relationships with Providers”, Section 60.2.
17 Medicare Managed Care Manual, Relationships with Providers”, Section 60.3.
18 DHCS APL) 19-004.
B. Credentialing Standards

3. Credentialing Verifications

G. Delegate ensures all Practitioners hold and maintain a valid and active National Provider Identifier (NPI) Practitioners individual NPI number, and the information provided must be:

1. Verified through the NPPES website;
2. Active while in the IEHP network;
3. Current at all times (i.e. Primary Practice Address must be registered to an address within California).
   a. Telehealth Providers are not required to have an NPI registered to an address within California.
4. Practitioners that have a group NPI number may submit that information to IEHP, in addition to the mandatory individual NPI number.19

H. Delegate ensures all Primary Care Provider’s (PCP) and Urgent Care’s (UC) are informed that they must pass an on-site site review conducted by IEHP. (See Policy 6A, “Site Review and Medical Record Review Survey Requirements and Monitoring”). All PCPs and UCs must pass an IEHP facility on-site review at the time of initials credentialing and every three (3) years thereafter, for Medi-Cal Programs.20

1. Delegates are note delegated to perform on-site visits on behalf of IEHP; however, their policies and procedures must ensure they notify their Practitioners of IEHPs requirements and they remain compliant while they continue participation in IEHPs network. This would apply to, but not limited to:
   a. Prior to participating in the IEHP network as a PCP or an Urgent Care provider; or
   b. When a Practitioner relocates.

I. Delegates must obtain and provide IEHP with Social Security Numbers for all new and existing Practitioners participating providers, to ensure all Practitioners are included in IEHP’s screening of the Social Security Administration’s Death Master File (SSADMF).

1. All Delegated IPA Provider submissions for participation in the IEHP network, the Delegate must include the Provider’s full Social Security Number (SSN).
   a. Submissions without SSN will be ceased and not processed by IEHP.
2. Delegated IPAs with existing Providers without SSNs will be notified. The Delegated IPAs are required to provide all missing SSNs to IEHP.
   a. Delegated IPAs who do not provide the requested information will be placed on a Corrective Action Plan (CAP), until all missing SSNs are submitted.
3. If a Practitioner confirms that his/her SSN is correctly stated on the Social Security

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19 DHCS APL 19-004.
20 Medicare Managed Care Manual, Relationships with Providers”, Section 60.3.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   3. Credentialing Verifications

   Administration’s Death Master File (SSADMF), but is clearly not deceased, the Delegate must request for:
   a. A copy of the Social Security Card;
   b. A photo ID;
   c. A signed attestation from the Practitioner confirming they are who they say they are; and
   d. The Provider to contact the Social Security Administration’s Death Master File (SSADMF) to correct the issue.

4. If a Practitioners’ SSN is correctly stated but the name and Date of Birth (DOB) does not, the Delegate must request for:
   a. A copy of the Social Security Card;
   b. A photo ID;
   c. A signed attestation from the Practitioner confirming they are who they say they are; and
   d. The Provider to contact the Social Security Administration’s Death Master File (SSADMF) to correct the issue.  

J. Delegates monitors its Provider network and ensures their Providers are not included in the Centers Medicare & Medicaid Services (CMS) Preclusions List (See Policy 25B5, “Ongoing Monitoring and Interventions”).

K. Delegates must ensure all Practitioners are within the appropriate age range guidelines, as appropriate. Medicare DualChoice Cal-MediConnect Member age ranges are ages 21 and above.
   1. Specialists Member age ranges are specific to the specialty involved, training, and education of the Physician.
   2. Non-Physician Practitioners which include Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Physical Therapists (PT), Occupational Therapists (OT), Speech/Language Therapists (S/LT), Opticians, Optometrists (OD), Chiropractors (DC), Dieticians and Nutritionists are as applicable to the training and certification of the non-physician Practitioner.

L. Delegates must submit appropriate documentation to expand or limit their practice parameters for IEHP review and approval. Practitioners may practice outside of scope with approval from IEHP, by undergoing the Provide Privilege Adjustment process in this policy.
   1. Primary Care Providers age range expansions.

21 DHCS APL 19-004.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   3. Credentialing Verifications

   a. For PCP’s who have Pediatric age ranges assigned and would like to expand their age range to reflect all ages, will be processed with a secondary specialty of General Practice, must provide the following information for review and consideration:

      1) Provide documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients. (See Attachment, “IEHP Addendum E” in Section 5);

      2) Provide evidence of twenty-five (25) Continuing Medical Education (CME) units in Adult Primary Care completed within the last three (3) years;

      3) Applicants must provide two (2) letters of recommendation from a Physician coworker (i.e., Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months). The Physician coworkers must hold an active board certification in Internal Medicine or Family Practice;

      4) Malpractice coverage for the age range provider is requesting for that covers all locations the Provider will be treating IEHP Members; and

      5) Pass a Medical Record Chart Audit for Adult Members

2. Provider Privilege Adjustment. Practitioners who request a change in practice parameters (i.e. reduction of member age range, additional specialty) must submit a detailed explanation that includes the following, for review and consideration:

   a. Practice site demographics;

   b. Practical experience relating to the request (years in clinical practice, direct care experience with the relevant membership, etc.);

   c. Practice capacity; and

   d. Relevant training in the specialty, if applicable (e.g. Continuing Medical Education (CME), Post-graduate training, etc.)

INLAND EMPIRE HEALTH PLAN

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B. Credentialing Standards

4. Recredentialing Cycle Length

APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid) Providers.

POLICY:

A. Delegates are responsible for formally recredentialing their contracted Primary Care Providers (PCPs), non-physician Practitioners, Specialists, and admitting Physicians at least every thirty-six (36) months from their last credentialing decision date and submit specific updates to IEHP. (See Policy 25B10 “Credentialing Standards – Credentialing Quality Oversight of Delegates”)

PURPOSE:

A. Delegate conducts timely recredentialing.

DEFINITION:

A. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.
   a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.
   b. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered delegation.

PROCEDURES:

A. The length of the recredentialing cycle is within the required thirty-six (36) month time frame.
   1. The thirty-six (36) month recredentialing cycle begins on the date of the previous credentialing decision. The thirty-six (36) month cycle is counted to the month, not to the day.

B. Delegates may extend a Practitioner’s recredentialing cycle time frame (beyond thirty-six (36)
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   4. Recredentialing Cycle Length

   months) if the Practitioner is:
   1. On active military assignment.
   2. On medical leave (e.g., maternity leave).
   3. On sabbatical.

   Delegates must document this and recredential the Practitioner within sixty (60) calendar
days of the Practitioner's return to practice. Failure to meet the thirty-six (36) month time frame
will result in the administrative termination of the Practitioner due to non-compliance to
recredentialing.

C. If the Delegate terminates a Practitioner for administrative reasons (e.g. the Practitioner failed
to provide complete credentialing information) and not for quality reasons, it may reinstate
the Practitioner within thirty (30) calendar days of termination and is not required to perform
initial credentialing.

   1. The Delegate performs initial credentialing if reinstatement is more than thirty (30) days
      after termination.1

   __________________________________________________________________________

   INLAND EMPIRE HEALTH PLAN

   Chief Approval: Signature on File       Original Effective Date: January 1, 2021

   Chief Title: Chief Operating Officer   Revision Date: ________________________

   __________________________________________________________________________

   1 National Committee for Quality Assurance (NCQA), 2020 Health Plan Standards and Guidelines, CR 4, Element A.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   5. Ongoing Monitoring and Interventions

APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid) Providers.

POLICY:

A. Delegate must develop and implement policies and procedures for ongoing monitoring of Practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against Practitioners when it identifies occurrences of poor quality.

B. Delegate maintains a documented process for monitoring whether network Providers have opted out of participating in the Medicare Program.

C. Delegate will verify that their contracted Providers have not been terminated as Medi-Cal Providers or have not been placed on the Suspended and Ineligible Provider List.

D. Delegated maintains a documented process for monitoring whether its Practitioners are included in the Centers for Medicare & Medicaid Services (CMS) Preclusions List, to ensure compliance with the 2019 Medicare Program Final Rule.

E. Delegates that subscribe to a sanctions alert service must have a documented process and evidence for the screening and notification process.

F. Delegate is responsible for notifying IEHP of any findings and the actions decided by the Credentialing Committee regarding the Practitioners identified through the ongoing monitoring of sanctions, complaints, and quality issues between recredentialing cycles.

G. Delegate must have a process to verify and maintain Practitioner licensing status, DEA or CDS certificate, etc., and remedies if the license or certification expires or status changes during the Practitioner’s participation with IEHP regardless of its outside the recredentialing cycle.

H. IEHP expects all Delegates to continuously monitor Practitioner status and performance and to share their findings with IEHP.

PURPOSE:

A. Delegate identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.

DEFINITIONS:
B. Credentialing Standards
   5. Ongoing Monitoring and Interventions

A. Adverse event – An injury that occurs while a Member is receiving healthcare service from a Practitioner.

B. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, Management Service Organization (MSO) etc.), this is considered sub-delegation, and the organization would be considered a subdelegate. The Delegate will be responsible for sub-delegation oversight.
   a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.
   b. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered delegation.

PROCEDURES:

A. Delegates include in their policy and procedures and provide evidence of ongoing monitoring and makes appropriate interventions by:

1. Delegate collects and reviews information from the following sources for Medicare and Medicaid sanctions.
   a. Delegates must use the List of Excluded Individuals and Entities (maintained by OIG) as the verification source for Medicare Sanctions, and review the report on a monthly basis, within thirty (30) days of its release.
      1) Delegate may develop a tracking log to include the report run date, review date, initials of person reviewing report, the list reviewed, and the web link used; or
      2) Delegate can print the entire list
         • The report must be dated and initialed
            o Practitioners identified on the Health & Human Services (HHS)-Office of Inspector General (OIG) Exclusions Report will be administratively terminated for all lines of business, without appeal rights due to IEHP prohibiting employment of contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation.
               ▪ Members will be reassigned to new Practitioners.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

5. Ongoing Monitoring and Interventions

- The Provider will be presented to Peer Review Subcommittee as an administrative termination, for further review and discussion. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance Department findings to include any additional prior quality of care issues and Member complaints for the Provider.¹

2. Delegate collects and reviews information from any of the following sources for reviewing sanctions or limitations on licensure:

a. Physicians. Sanction and limitation on licensure verifications must be verified through:
   1) BreEZe Online services online or directly with the licensing board via phone or mail:
      • Medical Board of California (M.D.)
      • Osteopathic Medical Board of California (D.O.)
   2) Federation of State Medical Boards (FSMB)
   3) National Practitioner Data Bank (NPDB)

b. Chiropractors. Sanction and limitation on licensure verifications must be verified through:
   1) BreEZe Online services online or directly with the licensing board via phone or mail:
      • California Board of Chiropractic Examiners (D.C.)
   2) Federation of Chiropractic Licensing Boards’ Chiropractic Information Network-Board Action Databank (CIN-BAD)
   3) National Practitioner Data Bank (NPDB)

c. Oral Surgeons. Sanction and limitation on licensure verifications must be verified through:
   1) BreEZe Online services online or directly with the licensing board via phone or mail:
      • Dental Board of California (D.D.S., D.M.D.)
   2) National Practitioner Data Bank (NPDB)

d. Podiatrists. Sanction and limitation on licensure verifications must be verified through:

25. DELEGATION AND OVERSIGHT

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5. Ongoing Monitoring and Interventions

through:

1) BreEZe Online services online or directly with the licensing board via phone or mail:
   • Board of Podiatric Medicine (D.P.M.)
2) Federation of Podiatric Medical Board (FPMB)
3) National Practitioner Data Bank (NPDB)

e. Nonphysician healthcare Practitioners. Sanction and limitation on licensure verifications must be verified through:

1) BreEZe Online services online or directly with the licensing board via phone or mail:
   • Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C)
   • Board of Psychology (Ph.D., Psy.D.)
   • California Board of Occupational Therapy (O.T.)
   • California State Board of Optometry (O.D.)
   • Physical Therapy Board of California (P.T.)
   • Physician Assistant Committee (P.A., P.A.-C)
   • California Board of Registered Nursing (C.N.M., N.P.)
   • Speech-Language Pathology & Audiology Board (S.P., Au)
   • Acupuncture Board (L.Ac.)

2) National Practitioner Data Bank (NPDB)

3. Policies for collecting and reviewing complaints must state Delegate:

a. Investigates Practitioner-specific Member complaints upon their receipt and evaluates the Practitioner’s history of complaints, if applicable.

b. Evaluates the history of complaints for all Practitioner’s history of complaints at least every six (6) months.

c. Quality or collecting and reviewing complaints are not delegated and complaints are forwarded to the Health Plans, as applicable.

d. Policy and evidence may be found in the Quality Department.3

4. Policies for collecting and reviewing information from identified adverse events Delegate

2 NCQA, HP Standards and Guidelines, CR 5, Element A, Factor 2.
3 NCQA, HP Standards and Guidelines, CR 5, Element A, Factor 3.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   5. Ongoing Monitoring and Interventions

must state:
   a. Monitoring for adverse events occurs every six (6) months.
   b. Quality/collection and reviewing adverse events are not delegated and events are forwarded to the Health Plans, as applicable.
   c. Policy and evidence may be found in the Quality Department 4

5. Policies for implementing appropriate interventions when it identifies instances of poor quality related for factors 1-4 may be found in the Quality Department. Delegate must have a process to determine if there is evidence of poor quality that could affect the health and safety of its Members and implement the appropriate policy based on action/intervention.
   a. At minimum, Providers identified through ongoing monitoring for licensure actions, sanctions, adverse history, grievances and/or complaints, must be fully discussed and reviewed by the Credentialing Committee. The reason for review must be considered and documented in the meeting minutes.
      1) Interventions can be identified in one of the following:
         • Committee minutes
         • Practitioner files
         • Delegate file binders5
      b. If IEHP believes that a Member’s health or safety may be at risk due to adverse events or quality concerns, IEHP may take one of the following actions:
         1) Refer the Practitioner to the next IEHP Peer Review Subcommittee meeting for direction;
         2) Immediately suspend the Practitioner from participation with IEHP with referral to the next IEHP Peer Review Subcommittee meeting; or
         3) Any other action as appropriate, given the circumstances and severity of the situation.

B. Delegates maintains a documented process for monitoring whether network physicians have opted out of participating in the Medicare Program using one of the CMS.gov Opt-Out sites.
   1. Delegate must review the Opt-Out Report from one of the CMS.gov sites on a quarterly basis, within thirty (30) days of its release.
      a. The report must be dated and initialed

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5 NCQA, 2020 HP Standards and Guidelines, CR 5, Element A, Factor 5.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

5. Ongoing Monitoring and Interventions

b. A checklist may be used to document the date of the electronic file download. The checklist must contain:

1) The date of the download and signature of the Delegate personnel who verified it.

2) Delegates must review quarterly Opt-Out reports even if they employ their Practitioners.

C. Delegates must use the Medi-Cal Suspended & Ineligible List, published monthly by the Department of Health Care Services (DHCS), as the verification source for Medicaid Sanctions. Delegate must review the Suspended & Ineligible List on a monthly basis, within thirty (30) days of its release.

1. Delegate may develop a tracking log to include the report run date, review date, initials of person reviewing report, the list reviewed, and the web link used;

2. Delegate may print the parts of the list that are applicable; or

3. Delegate can print the entire list

   a. The report must be dated and initialed

      1) Providers identified on the Medi-Cal Suspended and Ineligible List will be automatically suspended from participation in all Medi-Cal lines of business, without appeal rights.

         • All Members assigned to suspended Practitioners will be reassigned to new Practitioners.

         • The Suspended Practitioner will be presented to the Peer Review Subcommittee as an administrative termination and for further review, discussion.

            o Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance Department findings to include any additional prior quality of care issues and Member complaints for the Provider.\(^6\)\(^7\)

D. Delegated maintains a documented process for monitoring whether its Practitioners are included in the Centers for Medicare & Medicaid Services (CMS) Preclusions List, to ensure compliance with the 2019 Medicare Program Final Rule. In order for Providers (including entities) to receive payment from Medicare Plan (Part C and D), they must not be included in the Centers for Medicare & Medicaid Services (CMS) Preclusions List.

\(^6\) Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019 “Provider Credentialing/Recredentialing and Screening/Enrollment”.

\(^7\) Coordinated Care Initiative (CCI) Three-Way Contract, January 2018, Section 2.10.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

5. Ongoing Monitoring and Interventions

1. On a monthly basis, IEHP will share updates of the Preclusions List on the Secure File Transfer Portal (SFTP), as it will be made available by CMS approximately every thirty (30) days, around the first (1st) business day of each month.

   a. Delegates are required to screen their Provider network against the Preclusions List monthly, within thirty (30) days of its release.

   b. Notify IEHP within two (2) business days if an exact match is found for:
      1) National Practitioner Identification (NPI)
      2) Employer Identification Number (EIN), specific to entities

E. Delegates that subscribe to a sanctions alert service must have evidence of its subscription to the sanctions alert service during the look back period.

1. Delegates using the Continuous Query:

   a. The Continuous Query generates individual alerts from NCQA-recognized sources reporting an action. Delegate must:
      1) Provide evidence of the Practitioners’ continuous enrollment in the Continuous Query
      2) Have a process for reviewing sanction alerts within thirty (30) days of their release.
      3) Show evidence of the annual enrollment listing of Providers enrolled and review of alerts within thirty (30) calendar days of its release.
      4) If no reports were received for ongoing monitoring, Delegate must document or note that no reports were received during the monthly look-back period.
      5) Documentation can be kept electronically or via electronic or paper log/checklist.
         - A spreadsheet/tracking log may be used as documentation for compliance. Delegate must include:
            o Name of board/entity
            o Date of query
            o Date of report
            o Signature/initials of Delegate personnel who reviewed it.

   b. Delegates using an outside company or sanctions alert service (i.e. OIG Compliance Now, Streamline Verify) for ongoing monitoring or data collection and alert services, must:
      1) Have evidence of its subscription to the sanctions alert service during the look
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back period.

2) Provide a documented process and evidence that includes, but is not limited to:
   • How the list of Providers is compiled and provided to the company for screening
   • List of sanctions screened by outside company, (can be found in an attachment or contract with entity)
   • How the Outside company notifies Delegate of their findings
   • Screening is reviewed within thirty (30) calendar days of their release
   • If no reports were received for ongoing monitoring, Delegate must document or note that no reports were received during the monthly look-back period.
   • Documentation can be kept electronically or via electronic or paper log/checklist.
     o A spreadsheet/tracking log may be used as documentation for compliance. Delegate must include:
       ▪ Name of board/entity
       ▪ Date of query
       ▪ Date of report
       ▪ Signature(s)/initials of Delegate personnel who reviewed it.

c. If the reporting entity does not publish sanction information on a set schedule, the delegates:
   1) Documents that the reporting entity does not release information on a set schedule.
   2) Queries for this information for at least six (6) months.

d. If the reporting entity does not release sanction information reports, the delegate must conduct individual queries of credentialed Practitioners every twelve (12) to eighteen (18) months.

e. Delegates that subscribe to a sanctions alert service reviews the information within thirty (30) calendar days of a new alert. The delegate must:
   1) Show evidence of its subscription to the sanctions alert service during the look-back period and reviews the information within thirty (30) calendar days of a new release.

F. IEHP notifies Delegates of any adverse actions it becomes aware of through sources other
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than the Delegate. In addition, IEHP shares with all Delegates the results of performing monitoring through quality improvement studies, Member complaints and Member satisfaction surveys, as applicable. IEHP reviews the history of each Delegate’s credentialed and approved Practitioners. Delegate is responsible for notifying IEHP of:

1. Any findings and the actions decided by the Credentialing Committee within thirty (30) days of the decision, to include, but not limited to:
   a. Date(s) of the Credentialing Committee the Practitioner was reviewed;
   b. Date of the Credentialing Committee decision;
   c. Delegate’s Plan of action for the Practitioner;
   d. Frequency of monitoring (if applicable); and
   e. Any follow-ups scheduled

   1) All Practitioners identified through the ongoing monitoring will be presented to IEHP’s Peer Review Subcommittee for review and decision.

      • IEHP reserves the right to approve, deny, terminate or otherwise limit Practitioner participation in the IEHP network for any reason including up to quality issues.

         o If a Provider is denied participation due to quality of care and an 805 was filed with the appropriate licensing agency and the National Practitioner Data Bank (NPDB) than the Provider is not eligible to reapply.

            ▪ For administrative terminations or denials, he/she may reapply after one (1) year.

         o Practitioners can appeal adverse decisions by the IEHP Peer Review Subcommittee as delineated in IEHP’s Peer Review Process and Level I Review and Level II Appeal (See Attachments, “IEHP Peer Review Process and Level I Review” and “IEHP Peer Review Process and Level II Appeal” in Section 5).

2. Any of the following occurs with one of their contracted Practitioners:

   a. The surrendering, revocation or suspension of a license;
   b. The surrendering, revocation or suspension of DEA registration;
   c. A change in hospital staff status or hospital clinical privileges, including any restrictions or limitations;
   d. A change in hospital admitting arrangements for Practitioners without IEHP affiliated hospital privileges;
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   e. Loss of malpractice insurance; and
   f. The notification must include the IPA’s proposed action and/or resolution.

3. Delegates are required to notify IEHP in writing within thirty (30) days of its
   knowledge, if any of the following occurs with one of their contracted Practitioners:
   a. Any filing pursuant to Business and Professions Code Sections § 805, 805.01 or 809;
   b. Any filing with the NPDB; and
   c. The notification must include the Delegate’s proposed action and/or resolution.

G. Delegate must have a process to verify and maintain Practitioner licensing status, DEA or
   CDS certificate, etc., and remedies if the license or certification expires or status changes
   during the Practitioner’s participation with IEHP.

1. Delegate is responsible for notifying IEHP of any licensure and DEA changes within
   thirty (30) days of the change. The notification must include:
   a. Date the Delegate was notified;
   b. Type of change;
   c. Effective date of the change;
   d. Date of Credentialing Committee review, (if applicable);
   e. Delegate’s Plan of Action for the Practitioner;
   f. Frequency of monitoring (if applicable); and
   g. Any follow-ups scheduled.
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APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid) lines of business.

POLICY:

A. Delegates policies and procedures must state how the organization reviews participation of Practitioners whose conduct could adversely affect Members’ health or welfare, specify the range of actions that may be taken to improve Practitioner performance before termination, how the Delegate reports its actions to the appropriate authorities and makes the appeal process known to Practitioners.1

B. Delegates policies and procedures regarding suspension or termination of a participating Physician require the Delegate to ensure that the majority of the hearing panel members are peers of the affected Physician.

PURPOSE:

A. A Delegate that has taken action against a Practitioner for quality reasons reports the action to the appropriate authorities and offers the Practitioner a formal appeal process.

B. Delegates must use objective evidence and patient-care considerations when deciding on a course of action for dealing with a Practitioner who does not meet its quality standards.

C. If a Delegate terminates or suspends a Practitioner for quality reasons, it must report to the appropriate authorities, including state licensing agencies, the National Practitioner Data Bank (NPDB), and Inland Empire Health Plan (IEHP).

D. Notification applies to Physicians and nonphysicians for suspensions and terminations for quality reasons.

E. Delegates must provide evidence that it followed its appeal process if it altered the conditions of a Practitioner’s participation based on quality of care or service reasons.

F. Practitioners must appeal directly to their contracted IPA for adverse credentialing decisions rendered by the Delegated IPA.

G. Reporting to appropriate authorities is not applicable in the following circumstances:

1. If there are no instances of suspension, termination, restriction or revocation to report for quality reasons.

1 National Committee for Quality Assurance (NCQA), 2020 Health Plan Standards and Guidelines, CR 6, Element A, Factor 1.
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2. For automatic administrative terminations based on the Practitioners not meeting specific contractual obligations for participation in the network.

H. All credentialing records and proceedings are confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable law.2

DEFINITION:

A. “Peer” is an appropriately trained and licensed Physician in a practice similar to that of the affected Physician.

B. “Licentiate” means a Physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage family therapist, clinical social worker, professional clinical counselor, dentist, licensed midwife, or physician’s assistant. Licentiate also includes a person authorized to practice medicine pursuant to California Code, Business and Professions Code Section 2113 or 2168.

C. “Agency” means the relevant state licensing agency having regulatory jurisdiction over the licentiates.

1. The Medical Board of California is the agency for the following Practitioner types:
   a. Physicians and Surgeons (MDs)
   b. Doctors of Podiatric Medicine (DPMs)
   c. Licensed Midwives (LMs)
   d. Physician Assistants (PAs)

D. “Staff privileges” means any arrangements under which a licentiate can to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.

E. “Denial or termination of staff privileges, membership, or employment” includes failure or refusal to renew a contract or to renew, extend or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

F. “Medical disciplinary cause or reason” means that aspect of a licentiate’s competence or professional conduct that is reasonably likely to be detrimental to the patient’s safety or to the delivery of patient care.

G. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization

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2 California Code, Evidence Code (EVID), § 1157.
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(CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.

   a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.

   b. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered delegation.

PROCEDURES:

A. Delegates policies must specify the Delegate reviews participation of Practitioners whose conduct could adversely affect Members’ health or welfare. Delegates policy must include:

1. The range of actions available to the Delegate, that they may take to improve the Practitioner performance before termination, to include, but not limited to:

   a. Profiling

   b. Corrective actions(s)

   c. Monitoring

   d. Medical Record Audit

2. The Delegates policies and procedures must give the Practitioners the right to appeal and must include the following steps within the appeal process:

   a. Provide written notification when a professional review action has been brought against a Practitioner, including reasons for the action.

   b. Allow Practitioners to request a hearing/appeal and the timing for submitting the request.

   c. Policy must state that the Delegate cannot have an attorney, if the Practitioner does not have attorney representation, to ensure compliance with CA Business & Professions Code 809.3(c).

4 California Code, Business and Professions Code (BPC) § 809.3(c)
3. Practitioner Appeal Process where the Delegate informs the affected Practitioner of its appeal process and includes the following information in process and notification.
   a. Providing written notification indicating that:
      1) A professional review action has been brought against the Practitioner;
      2) Reasons for the action; and
      3) A summary of the appeal rights and process, which can be made known to the Practitioner through an attachment, addendum, policy, contract or manual.
   b. Allowing the Practitioner to request a hearing and the specific time period for submitting the request.
   c. Allowing at least thirty (30) days after the notification for the Practitioner to request a hearing.
   d. Allowing the Practitioner to be represented by an attorney or another person of the Practitioner’s choice.
   e. Appointing a hearing officer or a panel of individuals to review the appeal.
   f. Providing written notification of the appeal decision that contains specific reasons for the decision.5

4. Delegates must have policies and procedures that describe when and how reporting occurs, to whom incidents are reported and what specific incidents are reportable. The policy must address what is expected of the Delegates staff and outline accountability so that staff understand their responsibilities in order to perform their functions correctly. When the Delegate decides to suspend or terminate a Practitioner’s contract, there must be procedures notifying the appropriate authorities (including state agencies, as appropriate) of the action, that includes, but is not limited to:
   a. 805 Reports.
      1) Delegate is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason.
         • If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a Physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.
         • If the California Board of Podiatric Medicine or a licensing agency of another state revokes or suspends, without a stay, the license of a doctor of

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5 NCQA, 2020 HP Standards and Guidelines, CR 6, Element A, Factor 2
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Podiatric medicine, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension of a license.

2) If an 805 is reported, it shall include the following information:

- The name of the licentiate involved;
- The license number of the licentiate involved;
- A description of the facts and circumstances of the medical disciplinary cause or reason; and
- Any other relevant information deemed appropriate by the reporter.

3) Delegates must file an 805 report with the relevant agency within fifteen (15) days after the effective date on which any of the following occur as a result of an action of a peer review body:

- A licentiate’s application for staff privileges or membership is denied or rejected for medical disciplinary cause or reason.
- A licentiate’s membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.
- Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any twelve (12) month period, for a medical disciplinary cause or reason.

4) If a licentiate takes any action listed above, after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason or after receiving notice that his or her application for membership or staff privileges is denied or will be denied for a medical disciplinary cause or reason, the chief of a staff or a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic where the licentiate is employed or has staff privileges or membership or where the licentiate applied for staff privileges or membership, or sought the renewal thereof, shall file an 805 report with the relevant agency within fifteen (15) days after the licentiate takes the action.

- Resigns or takes a leave of absence from membership, staff privileges or employment.
- Withdraws or abandons his or her application for staff privileges or membership.
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   - Withdraws or abandons his or her request for renewal of staff privileges or membership.  

b. 805.01 Reports

   1) Delegate must file an 805.01 within fifteen (15) days after a peer review body makes a final decision or recommendation of termination, suspension or restriction of staff privileges, membership or employment due to an investigation, for at least one (1) of the following reasons:

   - Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one (1) or more patients in such manner as to be dangerous or injurious to any person or the public.
   - The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.
   - Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor.
   - Sexual misconduct with one (1) or more patients during a course of treatment or an examination.

   c. National Practitioner Data Bank (NPDB)
   1) Reports must be submitted to the NPDB within thirty (30) days of the action.

d. Health Plan Reporting

   1) Reports must be submitted to IEHPs Credentialing Manager, within thirty (30) days of the action.

B. Delegates policies and procedures regarding suspension or termination of a participating physician require the Delegate to ensure that the majority of the hearing panel members are peers of the affected Physician.

   1. A Peer is an appropriately trained and licensed Physician in a practice similar to that of

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6 California Code, Business and Professions Code § 805.
7 California Code, Business and Professions Code (BPC) § 805.01.
9 Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Section 60.4.
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   the affected Physician.

   2. Panel members do not have to possess identical specialty training.

   3. Policies and procedures do not always have to state the word “majority”, but at least 51% of the members must be peers.
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APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid) lines of business.

POLICY:

A. Delegates who contract with Organizational Providers to provide medical services to Members as designated in the IEHP Division of Financial Responsibility (DOFR) Matrix.

B. Delegate has written policies and procedures for the initial and ongoing assessment of Providers with which it contracts. IEHP delegates to IPAs that meet IEHP delegation requirements for credentialing, the responsibility for the initial and on-going assessment of subcontracted Providers that render services to Members and the delegate is responsible for claims payment for those Health Care Delivery Organization Providers. IEHP retains oversight responsibilities for all subcontracted Providers.

C. Delegates are required to verify the accreditation status, license, certification and standing with regulatory bodies of all subcontracted organizational Providers (as applicable), in compliance with the most current National Committee for Quality Assurance (NCQA) standards and IEHP requirements. Subcontracted organizational Providers include but are not limited to hospitals, home health agencies, laboratories, skilled nursing facilities, and freestanding surgical centers, including family planning facilities and alternative birth centers. Subcontracted mental health and substance abuse Providers include inpatient, residential, and ambulatory settings are carved out.

D. IEHP is responsible for the initial and ongoing assessment for behavioral healthcare facilities, providing mental health or substance abuse services in inpatient, residential, and ambulatory settings.

E. Delegates must assess contracted medical health care Providers, organizational Providers, against the requirements and within the time frame.

F. IEHP is responsible for the assessment of contracted Behavioral Healthcare Providers against the requirements and within time frame.

G. If during the contract period, the Delegate becomes aware of a change in the accreditation and/or Centers for Medicare and Medicaid Services (CMS) Site Survey, license, certification status, sanctions, fraudulent activity or other legal or remedial actions have been taken against any Provider, the Delegate must notify IEHP’s Compliance Department.

PURPOSE:

A. Delegate evaluates the quality of organizational Providers with which it contracts.

B. IEHP directly contracts with IPAs and Hospitals (Providers). In turn, Providers subcontract with Health Care Delivery Organizational Providers (subcontracted Providers) to provide
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services to Members as designated in the Division of Financial Responsibility (DOFR) Matrix outlined in IEHP’s Capitated Agreements with the Hospitals and IPAs. Subcontracted Providers include, but are not limited to, Hospitals, Home Health Agencies, Skilled Nursing Facilities, Free-Standing Surgical Centers, Behavioral Health Providers (Intensive Outpatient Programs and Residential Treatment Programs), Hospice, Clinical Laboratories, Comprehensive Outpatient Rehabilitation Facilities, Outpatient Physical Therapy Providers, Outpatient Speech Pathology Providers, Providers of End-stage Renal Disease Services (Dialysis), Outpatient Diabetics Self-Management Training providers, Portable X-Ray Supplier, Rural Health Clinics, and Federally Qualified Health Centers.

C. All Providers must adhere to all procedural and reporting requirements under state and federal laws and comply with the most recent NCQA, state and regulatory guidelines for subcontracted organizational Providers, as well as IEHP requirements.

D. Delegated Providers that subcontract with Ancillary and organizational Providers are responsible for ensuring that their subcontracted Providers meet IEHP’s requirements as stated herein and in Policy 05A7, “Credentialing Standards - Assessment of Organizational Providers”, IEHP audits Delegate’s compliance with IEHP requirements on an annual basis, using the IEHP Delegation Oversight Audit Tool beginning with a pre-contractual assessment, in accordance with Policy 25A1, “Delegation Oversight - Delegated Activities.” Delegated IPAs are subject to corrective action as defined in Policy 25A3, “Delegation Oversight - Corrective Action Plan Requirements.”

E. IEHP reserves the right to perform facility site audits when quality of care issues arise and to deny contracted or subcontracted Providers participation in the IEHP network if IEHP requirements for participation are not met.

F. Contracted and/or subcontracted Provider’s failure to meet IEHP’s requirements may result in adverse action up to and including non-renewal or termination of the delegated entity contract or IEHP contract.

DEFINITION:

A. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Sub-delegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a Sub-delegate. The Delegate will be responsible for sub-delegation oversight.
   a. Ongoing monitoring or data collection and alert service are NOT seen as delegation.
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b. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered sub-delegation.

PROCEDURES:

A. Delegates’ policies for assessing a health care delivery provider specifies that before it contracts with a Provider, and at least every thirty-six (36) months thereafter, it:

1. Must specify sources used to confirm that Providers are in good standing with state and federal requirements, that include, but are not limited to:

   a. State (Department of Health Care Services) regulatory body
      1) A copy of the license and expiration date;
         • A current and unencumbered license; must also be appropriately licensed and no other negative license actions that may impact participation
      2) Physician-owned clinics are not required to be licensed by DHCS, but they must be accredited by an agency approved by the Medical Board. (If the physician-owned clinic is appropriately accredited, they would be compliant with the Knox-Keene Act of Title 28);
      3) If a state license is not issued by the Department of Health Care Services, the facility should have a business license or certificate of occupancy.
      4) Licensure must be maintained throughout the duration of the subcontractors’ participation in the IEHP network.

b. Federal Regulatory Bodies

1) Review of OIG or Medicare/Medicaid Sanctions must be completed and documented on the spreadsheet or the file.
   • The monthly review of the OIG report as part of the “Ongoing Monitoring” qualifies as compliant for this section if the facilities are included on the OIG Report.
     ° IEHP prohibits employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners or entities found on OIG Reports). A Provider is considered excluded, sanctioned, or ineligible, if the Provider is named by the appropriate State or Federal departments or agencies on exclusionary lists, including but not limited to the following: The Department of Health & Human Services (DHHS), Office of Inspector General (OIG), List of Excluded Individuals and Entities List (LEIE), General Services Administration
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IEHP (GSA), Excluded Parties Lists System (EPLS), California Department of Health Care Services (DHCS), Medi-Cal Suspended and Ineligible List, and California Department of Public Health (CDPH) Medi-Cal certification as applicable. IEHP reserves the right to terminate the contract for cause, with appropriate notice as defined in the IEHP Agreement.

2) Must have no sanctions that may impact participation

3) Centers for Medicare and Medicaid Services (CMS) signed participating agreement letter, if applicable.¹

4) An attestation from a Provider to the organization regarding the Providers regulatory status is not acceptable.

c. The Organizational Providers must maintain accreditation and license status in good standing and/or current at all times during their participation in the IEHP network.

1) The Organization Provider is responsible for providing the Delegate, with copies of its renewed license and accreditation within sixty (60) days following the expiration of the license and accreditation.²

2. IEHP accepts an accreditation report or a letter from the regulatory and accrediting bodies regarding the status of the Provider, as evidence that the Provider has been reviewed and approved by an accrediting body.

Accreditation and licensure must be maintained throughout the duration of the subcontractors’ participation in the IEHP network.

a. The following are acceptable accrediting bodies by IEHP:

1) Accreditation Association for Ambulatory Health Care (AAAHC)

2) Accreditation Commission for Health Care Inc (ACHC)

3) American Association for Accreditation for Ambulatory Surgical Facilities (AAAASF)

4) American Association of Diabetes educators (AADE)

5) Clinical Laboratory Association Improvement (CLIA) Certificate or CLIA Waiver

6) College of American Pathology (CAP)

7) Commission for the Accreditation of Birth Centers (CABC)

¹ Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Section 70.
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8) Commission on Accreditation or Rehabilitation Facilities (CARF)
9) Commission on Office Laboratory Accreditation (COLA)
10) Continuing Care Accreditation Commission (CCAC)
11) Center for Improvement in Healthcare Quality (CIHQ)
12) Council on Accreditation (COA)
13) Community Health Accreditation Program (CHAP)
14) Det Norske Veritas National Integrated Accreditation of Healthcare Organization (DNVNIAHO)
15) Federal Drug Administration (FDA) Certification
16) Healthcare Facilities Accreditation Program (HFAP) As of October 2015, the Healthcare Facilities Accreditation Program (HFAP) is no longer owned by the AOA, it is now managed by the Accredited Association for Ambulatory Health Care, Inc. (AAAHC)
17) Indian Health Service (IHS)
18) The Institute for Medical Quality’s (IMQ’s) (CMS approved accrediting body verified by IEHP)
19) The Joint Commission (TJC)
20) An attestation from a provider to the organization regarding the providers regulatory status is not acceptable.

b. IEHP recognizes the following accreditations by Organizational Provider type:

1) Hospitals
   • The Joint Commission (TJC)
   • Healthcare Facilities Accreditation Program (HFAP) As of October 2015, the Healthcare Facilities Accreditation Program (HFAP) is no longer owned by the American Osteopathic Association (AOA), it is now managed by the Accredited Association for Ambulatory Health Care, Inc. (AAAHC)
   • Det Norske Veritas National Integrated Accreditation of Healthcare Organization (DNVNIAHO)
   • Center for Improvement in Healthcare Quality (CIHQ)

2) Home Health Agencies
   • The Joint Commission (TJC)
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- Community Health Accreditation Program (CHAP)
- Accreditation Commission for Health Care Inc (ACHC)

3) Skilled Nursing Facilities
- The Joint Commission (TJC)
- Commission on Accreditation or Rehabilitation Facilities (CARF)
- Continuing Care Accreditation Commission (CCAC)

4) Free-Standing Surgical Centers
- The Joint Commission (TJC)
- American Association for Accreditation for Ambulatory Surgical Facilities (AAAASF)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- Healthcare Facilities Accreditation Program (HFAP) As of October 2015, the Healthcare Facilities Accreditation Program (HFAP) is no longer owned by the AOA, it is now managed by the Accredited Association for Ambulatory Health Care, Inc. (AAAHC)
- The Institute for Medical Quality’s (IMQ’s) (CMS approved accrediting body verified by IEHP)3

5) Behavioral Health Providers (Intensive Programs and Inpatient Treatment Programs)
- The Joint Commission (TJC)
- Commission on Accreditation or Rehabilitation Facilities (CARF)
- Healthcare Facilities Accreditation Program (HFAP)
- Council on Accreditation (COA)

6) Hospice
- The Joint Commission (TJC)
- Community Health Accreditation Program (CHAP)
- Accreditation Commission for Healthcare INC (ACHC) (CMS approved accrediting body verified by IEHP)

7) Clinical Laboratories

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- The Joint Commission (TJC)
- Clinical Laboratory Association Improvement (CLIA) Certificate or CLIA Waiver
- Commission on Office Laboratory Accreditation (COLA)
- College of American Pathology (CAP)

8) Comprehensive Outpatient Rehabilitation Facilities
- The Joint Commission (TJC)
- Commission on Accreditation or Rehabilitation Facilities (CARF)

9) Outpatient Physical Therapy Providers
- American Association for Accreditation of Ambulatory Surgical Services (AAAASF)
- If no Accreditation, must be certified by Medicare (Must have Medicare Part A)

10) Outpatient Speech Pathology Providers
- American Association for Accreditation of Ambulatory Surgical Services (AAAASF)
- If no Accreditation, must be certified by Medicare (Must have Medicare Part A)

11) Providers of End-stage Renal Disease Services (Dialysis)
- The Joint Commission (TJC)
- If no Accreditation, must be certified by Medicare

12) Birth Centers
- Commission for the Accreditation of Birth Centers (CABC)

13) Congregate Living Health Facility
- The Joint Commission (TJC)

14) Outpatient diabetes self-management training Providers
- American Association of Diabetes educators (AADE)
- Indian Health Service (IHS)

15) Portable X-Ray Supplier
- Federal Drug Administration (FDA) Certification
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16) Rural Health Clinics
   • The Joint Commission (TJC)
   • American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
   • If no Accreditation, must be certified by Medicare

17) Federally Qualified Health Centers
   • The Joint Commission (TJC)
   • If no Accreditation, must be certified by Medicare

3. Must conduct an onsite quality assessment if the Provider is not accredited. Policy must include:
   a. Onsite quality assessment criteria for each type of Provider.
   b. A process ensuring that the Providers credential their Practitioners.
   c. Delegates policy may specify it only contracts with accredited Providers to meet this requirement.
   d. A CMS or state quality review in lieu or a site visit under the following circumstances (if the Delegate chooses to substitute the site visit with a with a CMS or state quality review), if it meets the following requirements:
      1) The CMS or state review is no more than three (3) years old.
         • If the CMS or state review is older than three (3) years, the organization conducts its own onsite quality review.
      2) Delegate obtains a survey report or letter from CMS or the state, from either the Provider or the agency, stating that the facility was reviewed and passed inspection.
         • The report meets the Delegates quality assessment criteria or standards.
      3) The Delegate is not required to conduct a site visit if the state or CMS has not conducted a site review of the Provider and the Provider is in a rural area, as defined by the U.S. Census Bureau.⁴ ⁵

B. Delegates’ policies and procedures must state which organizational Providers types are contracted and the Delegate is responsible for claims payment, which includes, but is not limited to:

⁵ Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Section 70.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

7. Assessment of Organizational Providers

1. Hospitals
2. Home Health Agencies
3. Skilled Nursing Facilities
4. Free-Standing Surgical Centers
5. Clinical Laboratories in its assessment
6. Hospices
7. Comprehensive Outpatient Rehabilitation Facilities (CORF)
8. Outpatient Physical Therapy Providers (only applies to institutional facilities who take Medicare Part A. Does not apply to independently licensed Physical Therapists (PTs)).
9. End-Stage Renal Disease Services Providers
10. Outpatient Diabetes Self-Management Training Providers
11. Portable X-Ray Suppliers
12. Rural Health Clinics (RHC)
13. Federally Qualified Health Centers (FQHC)
14. If Delegate policies and procedures address all Provider types, the Delegate will not need to specify which types they do not contract with.\(^6\)

C. IEHP’s delegation arrangements with Delegates “carves out” behavioral healthcare services, therefore, Delegates are not responsible for the initial and ongoing assessment for behavioral healthcare facilities providing mental health or substance abuse services in the following settings:

1. Inpatient

Behavioral Healthcare Facilities providing mental health or substances abuse services in Residential and Ambulatory settings are not covered as an IEHP benefit, therefore IEHP is not responsible for the initial and ongoing assessment.\(^7\)

D. Delegates must assess contracted medical health care Providers, organizational Providers, against the requirements and within the time frame. The Delegate may:

1. Use a comprehensive spreadsheet or log showing credentialing of Medical organizational Providers, to calculate compliance and completion of the File Review.
2. Delegates must have a tracking mechanism for ensuring that expirables and tri-annual

\(^7\) NCQA, 2020 HP Standards and Guidelines, CR 7, Element C, Factor 1.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

7. Assessment of Organizational Providers

reviews are compliant.\(^8\)

E. Delegates are not responsible for assessing Behavioral Healthcare Providers against the requirements and timeframe standards.

1. IEHP use a comprehensive spreadsheet or log showing credentialing of Medical organizational Providers, to calculate compliance and completion of the File Review.\(^9\)

F. If during the contract period, the Delegate becomes aware of a change in the accreditation and/or CMS Site Survey, license, certification status, sanctions, fraudulent activity or other legal or remedial actions have been taken against any Provider, the Delegate must:

1. Notify IEHP’s Compliance Department by emailing compliance@iehp.org or fax (909) 477-8536 or via Compliance Hotline (866) 355-9038 within five (5) business days of discovering any of our Providers have been added to disciplinary or exclusionary lists.

2. The Director of Provider Contracting informs the Provider in writing that it is in violation of its contract with IEHP and begins the cure process. Depending on the seriousness of the offense, IEHP:
   a. Reserves the right to temporarily suspend or terminate the contract for cause, with appropriate notice as defined in the IEHP Provider Agreement;
   b. May report the termination of the contract to regulatory agencies as per contractual requirements and any services provided after the date of exclusion shall not be reimbursable or may be subject to recoupment.\(^10\)

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8. NCQA, 2020 HP Standards and Guidelines, CR 7, Element D.
9. NCQA, 2020 HP Standards and Guidelines, CR 7, Element E.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

8. Delegation of Credentialing

APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid) line of business.

POLICY:

A. IEHP remains responsible for credentialing and recredentialing its Practitioners, even if it delegates all or part of these activities. IEHP Delegates authority for performing the functions within the National Committee for Quality Assurance (NCQA)/Centers for Medicare and Medicaid Services (CMS) standards to another entity; however, the delegate must maintain responsibility for ensuring that the function is being performed according to organization expectations and to NCQA standards.

B. If the Delegate sub-delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities.

PURPOSE:

A. IEHP remains responsible for credentialing and recredentialing its Practitioners, even if it delegates all or part of these activities. Delegates are required to monitor the credentialing and recredentialing status and performance of their contracted Practitioners on a continuous basis in compliance with IEHP requirements and current NCQA, state and federal regulatory guidelines.

B. Delegates must verify that sub-delegates perform the functions discussed in Section 25, of the Provider Manual and what is outlined in the Delegation Agreement between the Delegate and the sub-delegate.

C. IEHP and any regulatory oversight agency, has the right, within two (2) working days advance notice to the Delegate, to examine the Delegates credentialing/recredentialing files or sites as needed to perform oversight of all Practitioners or to respond to a complaint or grievance.

DEFINITION:

A. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub delegation oversight.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

8. Delegation of Credentialing

a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.

b. If information is gathered from a company website and the Delegate staff is pulling the queries for OIG or other types of queries, it is NOT considered sub-delegation.

B. NCQA defines “annual” for this section as “a twelve (12) month period, with a two (2) month grace period.”

PROCEDURES:

A. For all Credentialing delegation arrangements, Delegates must have a delegation agreement that describes all delegated Credentialing (CR), that includes:

1. A mutual agreement that documents delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.
   a. Effective date may be at the front of the delegation agreement.
   b. If date is not in the front, the latest signatory date from both parties will be used as the effective date.

2. The delegation agreement or addendum thereto or other binding communication between the organization and the delegate specifies the CR activities:
   a. Performed by the delegate in detailed language.
   b. Not delegated but retained by the organization.
      1) If the delegate sub-delegates an activity, the delegation agreement must specify which organization is responsible for oversight of the sub delegate.
   c. The delegation agreement(s) must have language that the delegate will adhere to state and federal regulations.
      1) This language is not required for Credentialing Verification Organization (CVO) Agreements.

3. Delegate must determine the method of reporting and the content of the reports, but the agreement specifies:
   a. The reporting is at least semi-annually for DualChoice line of business. Reporting examples include:
      1) Lists of credentialed and recredentialed providers.

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

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2) Committee meeting minutes.
3) Facilities credentialed.³

b. What information is reported by the Delegate about delegated activities.

c. How, and to whom, information is reported (i.e. joint meetings or to appropriate committees or individuals in the organization).

d. Delegate must receive regular reports from all sub-delegates, even California Department of Health Care Services (NCQA) Accredited or NCQA Certified Delegates.⁴

4. Delegates’ Delegation Agreement states the process for monitoring and evaluating the delegate’s performance.⁵

5. Delegate retains the right to approve, suspend and terminate Providers, who participate in the Delegates’ network.

   a. This does not apply if the subdelegate does not have decision making authority.

6. If the subdelegate fails to meet the terms of the agreement and, at a minimum, circumstances that result in revocation of the agreement.⁶

For new delegation arrangements, the Delegate must evaluate the sub-delegates capacity to meet NCQA, state and federal regulatory requirements before delegation began.

1. Delegates may use an accredited Health Plan audit as the pre-delegation evaluation.

   a. If Delegate uses a health plan audit, there must be evidence that the health plan audit was reviewed, e.g. Committee minutes, email approval or other methods indicating acceptance of review.

   b. If Delegate changes Management Services Organizations (MSOs), the Delegate must evaluate the new MSO prior to contracting.

2. For any amendments or newly delegated activities within the last twelve (12) months, the Delegate must have documentation, dated before the delegation began showing that it evaluated the subdelegate before implementing delegation.

3. If the pre-delegation evaluation was performed more than twelve (12) months prior to implementing delegation, the Delegate must conduct another pre-delegation evaluation.

4. The Delegate must have a systematic method for conducting this evaluation, especially if more than one (1) delegation agreement is in effect. The following list are examples:

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25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   8. Delegation of Credentialing

   a. Site Visit.
   b. Written review of the subdelegate’s understanding of the standards and the delegated tasks.
   c. Staffing capabilities.
   d. Performance records (e.g. Audit).
   e. Exchange of documents and review.
   f. Pre-delegation/Committee meetings.
   g. Telephone consultation.
   h. Virtual review.  

C. For delegation arrangements in effect for twelve (12) months or longer the Delegate must:
   1. Annually review its Delegate’s credentialing policy and procedures.
      a. Review for evidence that the Delegate’s staff or committee annually reviewed their subdelegate’s credentialing policies and procedures, e.g. audit tool, audit correspondence, audit summary documentation, committee minutes, and email approval, noted in their database or other methods.
      b. A Delegate may use an accredited health plan audit as the annual evaluation.
         1) If Delegate uses a health plan audit, there must be evidence that the health plan audit was reviewed, e.g. Committee minutes, email approval or other methods indicating acceptance of review.
         2) For NCQA-Certified or Accredited Delegates, including certified CVOs:
            - Review evidence of annual review of policy and procedures for delegated functions, as applicable.  
   2. Annually audits credentialing and recredentialing files against NCQA, state and federal regulatory standards for each year that delegation has been in effect.
      a. Review for evidence that the Delegate’s staff or committee annually reviewed their subdelegate’s credentialing policies and procedures, e.g. audit tool, audit correspondence, audit summary documentation, committee minutes, and email approval, noted in their database or other methods.
      b. A Delegate may use an accredited health plan audit as the annual evaluation.
         1) If Delegate uses an accredited health plan audit, there must be evidence that the health plan audit was reviewed, e.g. Committee minutes, email approval or other methods.

B. Credentialing Standards

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methods indicating acceptance of review.

2) If Delegate does not use an accredited health plan audit, the Delegate must audit per IEHP standards (See Attachment, “Credentialing DOA Audit Tool” in Section 25).9

3. Annually evaluates delegate performance against NCQA, state and federal regulatory standards for delegated activities.

   a. The audit must include all pieces of the credentialing process (e.g., policies and procedures, ongoing monitoring, file audit, etc.).10

4. Semi-annually evaluates regular reports, as specified in element A. Acceptable methods of review include:

   a. Assess the Quality or Credentialing Committee Minutes.

   b. It is acceptable to only receive lists of credentialed and recredentialed Practitioners from NCQA-accredited or NCQA-certified Delegates.

   c. Delegates that are not NCQA-accredited or NCQA-certified need to demonstrate that it collects credentialing data from the delegate, evaluates the data, and takes corrective action if needed and follow-up on deficiencies.

   d. If no performance issues are identified, reporting could be limited to lists of credentialed and recredentialed Practitioners.

   e. For MSOs, reviewing reporting numbers which can usually be found in the Quality Improvement Meeting Minutes.11

D. For delegation arrangements that have been in effect for more than twelve (12) months, at least in the past year, the organization identified and followed up on opportunities for improvement, if applicable.

1. Findings from the Delegates pre-delegation evaluation, annual evaluation, file audits or ongoing reports can be sources for identifying areas of improvement for which it takes actions.

2. The Delegate can use an accredited health plan audit to look for opportunities for improvement. If the Delegate sees that the health plan found opportunities for improvement, the Delegate reviews the corrective action plan (CAP) from the delegated entity and reviews to see if the audit and CAP were reviewed and approved, i.e. committee minutes, email approval or other method indicating acceptance of review of the CAP.12

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   8. Delegation of Credentialing
APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid) lines of business.

POLICY:

A. Delegate has written policy and procedure regarding the identification of HIV/AIDS Specialists.
B. Delegate identifies or reconfirms the appropriately qualified physician who meet the definition of an HIV/AIDS Specialist on an annual basis.
C. The list of identified qualifying physicians is provided to the department responsible for authorizing standing referrals.

DEFINITION:

A. Delegate – If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a subdelegate. The Delegate will be responsible for sub-delegation oversight.
   a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.
   b. If information is gathered from a company website and the Delegate staff is pulling the queries for OIG or other types of queries, it is NOT considered sub-delegation.

PROCEDURES:

A. Delegate has a written policy and procedure describing the process that the Delegate identifies and verifies the appropriately qualified physicians who meet the definition of an HIV/AIDS Specialist. An HIV/AIDS Specialist is a Physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the State of California, who meets any one of the four (4) criterion below:
   1. Is credentialed as an HIV specialist by the American Academy of HIV Medicine (AAHIVM);
   2. Is board certified, or has earned Certificate of Added Qualifications, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties,
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

9. Identification of HIV/AIDS Specialists

should a member board of that organization establish board certification, or a Certificate of Added Qualifications, in the field of HIV medicine; or

3. Is board certified in the field of Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

   a. In the immediately preceding twelve (12) months has clinical managed medical care to a minimum of twenty-five (25) patients who are infected with HIV; and

   b. In the immediately preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of category 1 continuous medical education (CME) in the prevention of HIV infection, combined with diagnosis, treatment, or both, of the HIV-infected patients, including a minimum of five (5) hours related to antiretroviral therapy per year.

4. Meets the following qualifications:

   a. In the immediately preceding twenty-four (24) months has clinically managed medical care to a minimum of twenty (20) patients who are infected with HIV; and

   b. Has completed any of the following:

      1) In the immediately preceding twelve (12) months has obtained board certification or recertification in the field of infectious disease from a member board of the American Board of Medical Specialties; or

      2) In the immediately preceding twelve (12) months has successfully completed a minimum of thirty (30) hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment of both, of HIV-infected patients.

      3) In the immediately preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competence Examination administered by the American Academy of HIV Medicine.

B. Delegate identifies or reconfirms the appropriately qualified physician who meet the definition of an HIV/AIDS Specialist, on annual basis. Delegate must provide:

1. Evidence that the Delegate identifies HIV/AIDS Specialists on an annual basis.

   a. This does not require screening of all the Delegate’s practitioners, only those who potentially may qualify and wish to be listed as HIV/AIDS Specialists.

   b. The department responsible for standing referrals may conduct the annual survey, instead of the Credentialing Department.

   c. Annual screening must be completed within twelve (12) months of the prior year’s
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

9. Identification of HIV/AIDS Specialists

annual screening.

C. The list of identified qualifying physicians is provided to the department responsible for authorizing standing referrals.¹,²,³

1. Once the Delegate has determined which, if any, of its physicians qualify as HIV/AIDS Specialists under the above regulations, this list of qualifying practitioners is sent (e.g. e-mail, letter) or made available to the department responsible for authorizing standing referrals.

   a. Distribution of findings must be communicated within thirty (30) days from the completion of the screening/survey assessment (e.g. Use the date of the last survey collected/signed to begin your calculation).

      1) A verbal statement that the list was provided to the appropriate department is not acceptable evidence of compliance.

   b. If the survey revealed that there are no qualified contracted HIV/AIDS Specialists within the Delegate, communication regarding HIV/AIDS Specialists availability to the appropriate department (e.g. Utilization Management or Case Management) is all that is necessary.

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² DHCS MMCD All Plan Letter 02001, Medi-Cal HIV/AIDS Home and Community Based Services Waiver Program.
³ California Code of Regulations (CCR), § 1300.74.16(e).
25. **DELEGATION AND OVERSIGHT**

B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

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**APPLIES TO:**

A. This policy applies to all organizations delegated credentialing activities for IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid) line of business.

**POLICY:**

A. Delegates must obtain approval of Practitioners seeking participation in the IEHP network, from the Delegates Credentialing Committee and/or Medical Director before submitting the Practitioner to IEHP, for review and approval. Delegates must confirm the Practitioners meet IEHPs criterion as specified in Policy 25B1, “Credentialing Standards – Credentialing Policies.”

B. If a Practitioner is changing from one (1) IPA to another, the new IPA must submit the Providers documentation (as noted in Procedure A below) within sixty (60) calendar days of the effective date of the change.

C. All Delegates are responsible for recredentialing and/or employed Practitioners within the thirty-six (36) months of the last credentialing decision, as required by National Committee for Quality Assurance (NCQA). Delegates are required to report their recredentialing activities to IEHP. Delegates must report recredentialing activities and terminations by the 15th of the following month.

D. All Practitioner terminations and changes (i.e. Address, specialty, age limits, Supervising Physicians, TIN changes etc.) must be submitted to providerrelationsinbox@iehp.org. All changes and terminations submitted through the Secure File Transfer Protocol (SFTP) server will not be processed.

E. Delegates must provide IEHP with a status report of their specialty network on a semi-annual basis during Provider Directory review. Delegates that do not require their Providers to be listed in the Provider Directory submit specialty networks quarterly.

F. IPAs must have established processes for outpatient and inpatient Utilization Management and are responsible for reviewing, maintaining and notifying IEHP of any changes to their Hospital admitting arrangements for each of their affiliated links.

**PURPOSE:**

A. IEHP must receive reports from its Delegates at least semiannually. At a minimum, Delegates must report its progress in conducting credentialing and recredentialing activities, and on performance-improvement activities, if applicable. Findings from the Delegates pre-delegation evaluation, annual evaluation, file audit or ongoing reports can be sources to identify areas of improvement for reporting. Areas could be related to NCQA credentialing
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

Standards or to IEHP’s expectations.¹

B. In addition to IEHP’s quality oversight, IPAs are expected to monitor the performance of their credentialed Practitioners on a continuous basis and to review any performance issues as may be applicable during the recredentialing process obtained by the IPA, from other sources or IEHP.

DEFINITION:

A. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.

   a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.
   b. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered sub-delegation.

PROCEDURES:

A. Delegates must obtain approval of Practitioners seeking participation in the IEHP network, from the Delegates Credentialing Committee and/or Medical Director before submitting the Practitioner to IEHP, for review and approval.

1. All credentialing file information must be submitted to IEHP via the SFTP, into the Delegates assigned ‘Credentialing’ Folder.

   a. Once the upload is complete, the Delegate must take a screenshot showing the files uploaded into the ‘Credentialing’ Folder. The Delegate will need to email Provider Delegation at CredentialingProfileSubmission@iehp.org notifying IEHP when the credentialing files are posted.

      1) IEHP will then respond to the email with a confirmation that the credentialing files were located.

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

- Upon receipt of credentialing files into the Delegates SFTP ‘Credentialing’ folder, IEHP will begin the credentialing process. Submitted files will be forwarded to IEHP Credentialing for processing.
  - For all Primary Care Providers (PCPs), Obstetrics/Gynecology (OB/GYNs) and Urgent Care’s, once all credentialing information is received, IEHPs Credentialing Department will request for a facility site review with IEHPs Quality Management (QM) Department, in accordance to Policy 6A, “Site Review and Medical Record Review Survey Requirements and Monitoring.”
  - If a Practitioner’s submission packet is incomplete and/or missing supporting documentation, the Delegate is notified via email with the reason why that the process was terminated for the Practitioner. The Delegate must resubmit all documents again, to include missing information to IEHP for review and reconsideration.

- Credentialing Files submitted through any other methods will be rejected and the Delegate will be directed to submit the files via the SFTP.

2. The Delegate must submit the following for review and consideration:
   a. Contract (1st and signature pages)
      1) To include any applicable addendums to show the Practitioners relationship or affiliation with that contract.
   b. W-9 for all Tax Identification Numbers (TINs) used by the Practitioner.
   c. Attachment I: Statement of Agreement by Supervising Provider is required for all Physician Extenders (Physician Assistants, Nurse Practitioners and Nurse Midwife’s to confirm the relationship between the Supervising Physician and Physician Extender(s). (See Attachment, “Attachment I - Statement of Agreement by Supervising Provider” in Section 5)
   d. Hospitalist Group or Admitter Agreement arrangements, if applicable, must include:
      1) Hospitalist Group or Admitter Agreement with Delegate.
      2) Hospitalist Group or Admitter Specialty.
      3) Hospitalist Group or Admitter age range covered.
      4) Name of Hospital affiliated with the Agreement.
      5) Hospitalist Group or Admitter’s W-9.
   e. Practitioner Profile or spreadsheet that includes all the elements listed below, otherwise, it will be rejected back to the Delegate with the reason for review and resubmission.
## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

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<th>Mid Level (ML)</th>
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<td>Initial Committee Approval Date</td>
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<tr>
<td>19.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Recredentialing Committee Approval Date (if applicable)</td>
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<td>20.</td>
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<td>✓</td>
<td>✓</td>
<td>Drug Enforcement Administration (DEA) Number and expiration date (if applicable)</td>
</tr>
</tbody>
</table>
### 25. DELEGATION AND OVERSIGHT

#### B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

<table>
<thead>
<tr>
<th>Provider Profile Element(S)</th>
<th>Primary Care Provider (PCP)</th>
<th>Specialist (SCP)</th>
<th>Mid Level (ML)</th>
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<tr>
<td>Hospital Affiliations (Hospital Name, Status, and Type of Service provided - Specialty)</td>
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<td>✓</td>
<td></td>
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<tr>
<td>Hospital Admitter arrangements (Name of Hospital, Name of Admitter)</td>
<td>✓</td>
<td></td>
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<tr>
<td>Malpractice Insurance Coverage (Name of carrier, policy number, coverage per claim, coverage per aggregate and expiration date)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Board Certification (Name of Board, Expiration date/re-verification date, Certification status)</td>
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<td>✓</td>
<td>✓</td>
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<tr>
<td>Medical School (Name of Institution and Graduation Date MM/YY)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Internship (Institution Name, Specialty, Training Type, Start Date MM/DD/YY, and End date MM/DD/YY)</td>
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<td></td>
</tr>
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<td></td>
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<td></td>
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<tr>
<td>Individual National Provider Identifier (NPI) Number</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Name of Supervising Physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Languages spoken</td>
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<td>✓</td>
<td></td>
</tr>
<tr>
<td>Medi-Cal Number</td>
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</tr>
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</table>

3. Upon receipt of the documentation, IEHPs Credentialing Department performs a quality review of each delegate’s credentialed and approved Practitioner to ensure compliance with IEHPs guidelines (See Policy 5A, “Credentialing Standards – Credentialing Policies”).

a. The Practitioner review includes, but is not limited to the following:
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   10. Credentialing Quality Oversight of Delegates

   1) Review of credentialed Practitioner specialty and relevant education, training, practice experience.
   2) Review of requested age range
   3) Review of Hospital arrangements, if applicable
   4) Review of adverse history;
      • Malpractice history;
      • History of negative license action;
      • History of negative privileges action;
      • History of Medicare or Medicaid sanctions; and
      • Other adverse history (including felony convictions, etc.).

   b. In cases where the IPA submitted credentialing information is consistent with IEHP guidelines, no adverse history is present, and the Practitioner has successfully passed IEHP’s site review (if applicable), the PCPs, Specialists, and Mid-Levels are reviewed and signed off by Credentialing Department.

   c. In cases where either the Delegate(s) submitted credentialing information is inconsistent with IEHP guidelines or data, or there is evidence of significant adverse history, the Practitioner is forwarded to the IEHP Peer Review Subcommittee for further review.

   1) For files whose information is inconsistent with IEHP guidelines or data, the Credentialing Department will notify the respective Delegate(s) and Practitioner, if needed, for clarification and correction, if needed. If the discrepancy is clarified and consistent with IEHP standards and data, the files are reviewed and signed off by the Credentialing Specialist.
      • Files that require further review are referred to the Peer Review Subcommittee for review, discussion and decision.

   2) For files who have evidence of significance adverse history, the Practitioner is forwarded to the Peer Review Subcommittee for review. The IEHP Medical Director presents the Practitioner’s credentialing file and any other necessary supporting documentation from the IPA, Practitioners, or IEHP to determine if potential quality of care issues for Members exists.
      • If the IEHP Peer Review Subcommittee determines that no potential quality of care concern exists, no further action or review is undertaken.
      • The IEHP Peer Review Subcommittee reviews all pertinent information necessary. The IEHP Peer Review Subcommittee determines if there is a
B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

potential quality of care concern or adverse event that exists. The Peer Review Subcommittee may make recommendations to improve the performance of a Practitioner, that includes but is not limited to:

- Request for additional information from the Delegate, with review at next meeting;
- Individual counseling by the Delegate or IEHP Medical Director;
- Focused audits of Practitioner’s practice by IEHP Quality Management staff;
- Continuing medical education or training;
- Restriction of privileges, including age range restrictions or other limitations;
- Termination of the Practitioner from the IEHP network; and
- Any other action appropriate for the circumstances

3) Actions by the IEHP Peer Review Subcommittee that differ from the IPA Credentialing Committee decisions, including changes in privileges and termination are tracked by IEHP.

- The IEHP Medical Director reviews the tracking report, the credentialing files and any other supporting information as necessary.
- After review, IEHP takes any of the following action(s) against the delegate:
  - No action;
  - Verbal or written request for additional information from the Delegate’s Medical Director;
  - Request an interim focused credentialing audit of the Delegate by IEHP staff; or
  - Any other action as appropriate, including revocation of delegated credentialing responsibilities.²

B. If a Practitioner is changing from one (1) IPA to another, identified as a “pend change,” the new IPA must submit the Providers documentation (as noted in Procedure A above) within sixty (60) calendar days of the effective date of the change.

1. Failure to meet this timeframe will result in “freezing” the Provider to auto-assignment of Member or possible termination.
   a. IPAs who have outstanding “Pend changes” will be placed on a Corrective Action

² NCQA, 2020 HP Standards and Guidelines, CR 5, Element A, Factor 5.
25. DELEGATION AND OVERSIGHT

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Plan (CAP) until all documents are submitted.

C. All Delegates are responsible for recredentialing Practitioners within the thirty-six (36) months of the last credentialing decision, as required by NCQA. By the 5th of every month, IEHP will post the Delegates outstanding recredentialing report to the SFTP Server. Delegates are required to review these reports and ensure that the Providers identified on the report are submitted to IEHP with their new recredentialing dates. These dates are used to conduct file selections for the Delegates Delegation Oversight Audit for Credentialing.

Failure to submit the current recredentialing dates will result in an administrative termination from the IEHP network. The Delegate will have to submit the Providers information for IEHP Delegated credentialing review, for the Provider to participate in the IEHP network again.

Delegates are required to report their recredentialing activities via excel format. (See Attachment, “Credentialing and Recredentialing Report”, in Section 25). Delegates must report recredentialing activities and terminations by the 15th of the following month.

1. The spreadsheet must include the following information:

<table>
<thead>
<tr>
<th>PCP</th>
<th>SCP</th>
<th>ML</th>
<th>REREDENTIALING REPORT ELEMENT(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>✓</td>
<td>✓</td>
<td>✓ IPA Name</td>
</tr>
<tr>
<td>B.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Previous Credentialing Date</td>
</tr>
<tr>
<td>C.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Recredentialing Date</td>
</tr>
<tr>
<td>D.</td>
<td>✓</td>
<td>✓</td>
<td>✓ License#</td>
</tr>
<tr>
<td>E.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Type (i.e. PCP, Specialty Care Provider (SCP), Mid-Level (ML))</td>
</tr>
<tr>
<td>F.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Last Name</td>
</tr>
<tr>
<td>G.</td>
<td>✓</td>
<td>✓</td>
<td>✓ First Name</td>
</tr>
<tr>
<td>H.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Middle Initial (M.I.)</td>
</tr>
<tr>
<td>I.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Suffix</td>
</tr>
<tr>
<td>J.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Degree</td>
</tr>
<tr>
<td>K.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Specialty (1)</td>
</tr>
<tr>
<td>L.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Specialty (2)</td>
</tr>
</tbody>
</table>

## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 10. Credentialing Quality Oversight of Delegates

<table>
<thead>
<tr>
<th>PCP</th>
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<th>ML</th>
<th>REcredentialing Report Element(s)</th>
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<tr>
<td>M.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Board Certification (1)</td>
</tr>
<tr>
<td>N.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Board Certification (1) expires</td>
</tr>
<tr>
<td>O.</td>
<td>✓</td>
<td></td>
<td>✓ Board Certification (2)</td>
</tr>
<tr>
<td>P.</td>
<td>✓</td>
<td></td>
<td>✓ Board Certification (2) expires</td>
</tr>
<tr>
<td>Q.</td>
<td>✓</td>
<td></td>
<td>✓ Board Certification (3)</td>
</tr>
<tr>
<td>R.</td>
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<td>✓ Board Certification (3) expires</td>
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### TERMINATIONS:

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<td>B.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Previous Credentialing Date</td>
</tr>
<tr>
<td>C.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Recredentialing Date</td>
</tr>
<tr>
<td>D.</td>
<td>✓</td>
<td>✓</td>
<td>✓ License#</td>
</tr>
<tr>
<td>E.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Type (i.e. PCP, SCP, ML)</td>
</tr>
<tr>
<td>F.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Last Name</td>
</tr>
<tr>
<td>G.</td>
<td>✓</td>
<td>✓</td>
<td>✓ First Name</td>
</tr>
<tr>
<td>H.</td>
<td>✓</td>
<td>✓</td>
<td>✓ M.I.</td>
</tr>
<tr>
<td>I.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Suffix</td>
</tr>
<tr>
<td>J.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Degree</td>
</tr>
<tr>
<td>K.</td>
<td>✓</td>
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<tr>
<td>L.</td>
<td>✓</td>
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<td>✓ Specialty (2)</td>
</tr>
<tr>
<td>M.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Termed Date</td>
</tr>
<tr>
<td>N.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Reason for Termination</td>
</tr>
<tr>
<td>O.</td>
<td>✓</td>
<td>✓</td>
<td>✓ Termination Due to Quality of Care (Yes or No)</td>
</tr>
</tbody>
</table>
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

D. All Practitioner terminations and changes (i.e. Address, specialty, age limits, Supervising Physicians, Taxpayer Identification Number (TIN) changes etc.) must be submitted to providerrelationsinbox@iehp.org. All changes and terminations submitted through the SFTP server will not be processed. (See Policy 18, “Provider Network”).

1. PCP relocations must pass a California Department of Health Care Services (DHCS) required FSR Survey and close CAPs prior to receiving assignment of members, within thirty (30) days upon relocation or the date IEHP discovers that the PCP site moved, and a minimum every three (3) years thereafter, unless it was determined that they be placed on annual review. (See Policy 6A, “Facility Site Review and Medical Record Survey Requirements and Monitoring”).

2. Changes in Specialty and age limits are considered practice parameter expansions and reductions and submit the required documentation in Policy 25B1, “Credentialing Standards - Credentialing Policies”).

3. Advanced Practice Practitioners (PAs, NMs, and NPs) relocating or changing supervising Physicians, Delegates must provide a current copy of the following documents to ensure compliance with IEHP guidelines (See Policy 6F, “Non-Physician Practitioner Requirements”).

a. Physician Assistants (PAs) may act as an agent of the supervising Physician in which they have an agreement. A Delegation of Services Agreement may authorize a PA to provide or perform the following activities if there is documentation evidencing the activity was performed:

1) Physician examinations, including interscholastic athletic program examinations;

2) Order durable medical equipment (DME) and make arrangements with regard to home health services or personal care services, as applicable. For home health and/or personal care services, after consultation with the supervising Physician, the PA may approve, sign, modify or add to the plan of treatment of care.

3) Routine visual screenings, which includes non-invasive, non-pharmacological, simple testing for visual acuity, visual field defects, color blindness and depth perception.

Physician Assistants and Supervising Physicians must have the following documents current, in place, and readily available on-site subject for review:

4) Delegation of Services Agreement and Supervising Physician Form. (See Attachment, “Delegation of Services Agreement and Supervising Physician Form” in Section 5), This agreement must define specific services identified in

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5 Department of Health Care Services (DHCS) All Plan Letter (APL) 20-006 Supersedes Policy Letters 14-004 and 03-002 and All Plan Letter 03-007, “Site Reviews: Facility Site Review and Medical Record Review”.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

practice protocols or specifically authorized by the supervising Physician, and

- Both the Physician and PA must attest to, date and sign the document;
- PAs must be practicing at a site assigned to their supervising physician;
- An original or copy must be readily accessible at all practice sites in which
  the PA works; and
- The agreement must be reviewed, dated and signed annually; and provided
  to IEHP, upon request.6

b. Nurse Practitioners (NPs) and Nurse Midwives (NMs) may perform the following
procedures if a standardized procedure is in place:

1) To diagnose mental and physical conditions, to use drugs in or upon human
beings, to sever or penetrate the tissue of human beings and to use other methods
in the treatment of diseases, injuries, deformities or other physical or mental
conditions.

2) Standardized Procedures must be on-site site specific and

- Reference textbooks and other written sources to meet the requirements of
  Title 16, CCR § 1474 (3), must include:
  - Book (specify edition) or article title, page numbers and sections.
- NP and/or NM must be practicing at a site assigned to their supervising
  physician; and
- Standardized Procedures must be signed by both the Practitioner and the
  supervising Physician, initially and annually; and provided to IEHP, upon
  request. At minimum, the Delegate must collect and submit to IEHP:
  - Table of Contents of the Standardized Procedures used, between the
    NP and/or Certified Nurse Midwife (CNM) and supervising Physician,
    that references the textbook or written sources to meet the requirements
    of the Board of Registered Nursing.
  - Evidence that the Standards of Care established by the sources were
    reviewed and authorized by the nurse practitioner, Physician and
    administrator in the practice setting (i.e. signature page that includes all
    parties involved).7
- Standardized Procedures written using the Physician Assistants Delegation
  of Services Agreement and Supervising Physician Form format and/or

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6 Title 16 California Code of Regulations (CCR) § 1399.540.
7 16 CCR § 1474.
25. **DELEGATION AND OVERSIGHT**

B. **Credentialing Standards**

10. **Credentialing Quality Oversight of Delegates**

    verbiage is not accepted by IEHP.

4. **Practitioner Terminations.** All Delegates are required to notify IEHP of any adverse actions against any of their contracted Practitioners. Delegates must provide IEHP sixty (60) calendar days advance notice of any significant change in their network, including the termination of a Practitioner. (See Policy 17A2 – Primary Care Providers Transfers – Involuntary)

E. Delegates must provide IEHP with a status report of their specialty network on a semi-annual basis during Provider Directory review. Delegates that do not require their Providers to be listed in the Provider Directory submit specialty networks quarterly.\(^8\)

On a semi-annual basis, IEHP provides Delegates with the Specialty Roster information via online verification reports on the Secure Provider Portal including admitter and ancillary Providers previously submitted by the Delegate to IEHP that identifies the Delegate’s current Provider Network that includes: Practitioner name, address, phone number, license number, specialty type, Hospital affiliations, IPA credentialing committee dates and, for obstetricians only the Hospitals where they deliver. Delegates are required to verify and update the following information:

1. The IPA Credentialing Committee Date must be completed for all Practitioners with the most recent Committee Date.

2. Indicate for each specialist listed, as applicable, the following:
   a. **“New Hospital Privileges”** – provided to indicate the Practitioner is adding new privileges with an IEHP network Hospital. Indicate privileges (active, courtesy, etc.).
   b. **“New Hospital Link”** – provided to indicate which network Hospital will be added to Practitioner.
   c. **“Information is correct”** – provided to specify information is correct and no changes are required.
   d. **“Provider Term Date”** – provided to indicate the Practitioner is no longer part of the IPA’s specialty network. Provide effective date of termination.
   e. **“Term This Site Only”** – provided to indicate the Practitioner is no longer at this location only. Provide effective date of location closure. Provide IEHP additional details on a separate sheet, if further review is required (i.e. provider is relocating, this site is the providers only existing location with IEHP and needs to add a different location.)
   f. **“Updated information”** – provided to specify new addresses, a typo, or any other changes to the information provided on the secure Provider Portal.

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\(^8\) NCQA, 2020 HP Standards and Guidelines, CR 8, Element A, Factor 3
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   10. Credentialing Quality Oversight of Delegates

   3. IEHP makes the indicated changes that will be reflected on the IPA’s roster.
      a. Delegates are required to update all information online and advise of completion to
         their Provider Service Representative within thirty (30) days of receipt. The online
         verification reports are made available in IEHP’s secure portal.

   F. IPAs must have established processes for outpatient and inpatient Utilization Management
      and are responsible for reviewing, maintaining and notifying IEHP of any changes to their
      Hospital admitting arrangements for each of their affiliated links, through the following
      process:
      1. The Delegation Oversight Analyst emails all Delegates on the 15th of each month for
         verification of all Admitters to ensure accurate information is obtained.
      2. IPAs are responsible for the following:
         a. Ensuring all providers listed with the correct Admitting Provider.
            1) Any changes from the IPAs must be submitted by the 25th of every month, via
               Secure File Transfer Protocol (SFTP) server.
               • The IPAs failure to respond by the 25th of each respective month will result
                 in non-compliance and may result in a corrective action plan on monthly
                 delegation reporting.
         b. If there are changes, the IPAs are responsible for notifying the Provider of the
            changes and of their current admitter arrangements for each respective hospital
         c. For the Admitting Providers, the IPA confirms admitting privileges to the Hospitals
            they are admitting to, are in place and in good standing.
            1) The IPA is responsible for providing a replacement. If not, the Provider will be
               terminated from the IPA’s network for not having Hospital admitting
               arrangements, and;
         d. The IPA is responsible for reviewing the Specialist Providers and reconfirming their
            Hospital arrangements, to ensure that the Admitting Provider is:
            1) Within the same specialty;
            2) Cover the same age range;
            3) Within the same practice; and
            4) Active within the same IPA network as the referring Physician.
         e. Ensuring all Providers on the report are still active with the IPA.

   G. On the last day of the month all network Hospitals are emailed the final Admitter list for that
      month. It includes Admitters name, phone number and fax number for each Provider who
      utilizes a Hospital Admitter. If Hospitals find discrepancies, they are emailed back to the
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

Credentialing Specialist, who verifies with the IPA’s credentialing contact.
25. DELEGATION AND OVERSIGHT

C. Care Management -
   1. Delegation and Monitoring

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP delegates to its IPAs and their Provider network the responsibility of providing case management services and coordination of care for their assigned Members. This includes but is not limited to ensuring the coordination of medically necessary health care services delivered within and outside their network, provision of preventive services in accordance with established standards, continuity of care, health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual’s health care needs.

B. IEHP maintains the responsibility of ensuring that Delegates continues to be, in compliance with all applicable State and federal laws, contractual and reporting requirements.1

C. IEHP oversees, monitors and evaluates performance of delegated and non-delegated care management activities.2,3 Oversight includes monitoring the IPAs’ care management activities monthly, quarterly, annually, and as frequently as needed.

PROCEDURES:

Delegated Responsibilities

Care Management Program

A. IPAs will develop a care management program that includes:
   1. Evidence used to develop the program;
   2. Process for identifying Members who are eligible for the program;
   3. Stratification levels for the care management program;
   4. Frequency of care management contact for each care management stratification level;
   5. Defined program goals;
   6. How the IPA will evaluate the effectiveness of their care management program; and
   7. A process to evaluate Member satisfaction with the IPAs care management program.

B. All IEHP DualChoice Members are required to be enrolled in a care management program,

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1 Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.9.
2 CCI Three-Way Contract September 2019, Section 2.16.
3 Title 28 California Code of Regulations (CCR) § 1300.70.
25. DELEGATION AND OVERSIGHT

C. Care Management -
   1. Delegation and Monitoring

   unless they choose to opt-out. IPAs are required to have a process where they offer care management to all Members and reassess at least annually or when there is a change in Member’s condition.

C. IPAs are responsible for coordinating care with Long-Term Services and Supports (LTSS) programs, which includes Multipurpose Senior Services Program (MSSP), In-Home Supportive Services (IHSS), and Community-Based Adult Services (CBAS). This also includes coordinating care with county behavioral health clinics for Members who are receiving specialty mental health services.4

D. IPA Care Management (CM) staff must include non-restricted California licensed medical personnel including but not limited to Registered Nurses, Licensed Vocational Nurses, Licensed Clinical Social Workers or master’s level Social Workers.

E. IPAs will maintain policies and procedures for how they support Members with complex conditions that include:5
   
   1. Complex case management (CCM) criteria/triggers that are relevant to their Member population;
   2. The process to determine timeframes for re-contact or reassessment at least annually or more frequently as health status changes; and
   3. Other relevant CCM details of the program.

F. IPAs will establish the frequency of their care management interventions based on their written policies and care management program description, as well as the Member’s identified goals, issues, barriers, and risks. IPA Care Manager interventions include:
   
   1. Ensuring continuity of care as appropriate;
   2. Focus on providing services in the least restrictive setting;
   3. Following up on Member referrals;
   4. Identifying the needs for LTSS services, appropriate community-based resources such as housing/utilities, meals etc.;
   5. Identifying the need for behavioral health services;
   6. Assisting with the coordination of care across all settings;
   7. Determining timeframes for re-contact or reassessment as stated in the IPA’s program description and policies as well as determined by the health status of the Member;
   8. Ensuring the PCP and other Members of the care team are updated on the Member’s health status; and

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4 CCI Three-Way Contract September 2019, Section 2.5.
5 Ibid.
25. DELEGATION AND OVERSIGHT

C. Care Management -
   1. Delegation and Monitoring

9. For Members receiving specialty mental health services through the County Behavioral/Mental Health Departments:
   a. Communicating with county behavioral health clinics to discuss diagnoses (medical, behavioral, and social needs), review treatment plans, and/or coordinate mental health services provided by the county with other services such as medical, LTSS, CBAS, MSSP, IHSS, etc.; and
   b. Communicating with the Member to discuss their behavioral health needs and services and how these services may be coordinated with other services such as medical, LTSS, CBAS, MSSP, IHSS, etc.

Health Risk Assessment & Risk Stratification

A. IEHP performs an initial HRA and annual reassessment on all IEHP DualChoice Members and on a daily basis, provides these data to IPAs through the secure IEHP Provider portal and Secure File Transfer Protocol (SFTP) server. IEHP uses a validated HRA tool that was developed to comply with the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS) guidelines.

B. The IPA is responsible for reviewing all HRA data and to utilize this to identify Members that may benefit from care management. Please see Policy 12A2, “Care Management Requirements – Health Risk Assessment” for more information on this process and delegated responsibilities.

Individual Care Plan

A. IEHP and its IPAs develop an individualized care plan (ICP) with each Member and engage the Member and/or Member’s representative in its design, reassessment and updates. Please see Policy 12A3, “Care Management Requirements – Individual Care Plan” for more information on this process and delegated responsibilities.

Interdisciplinary Care Team

A. IPAs are required to establish for each Member, an Interdisciplinary Care Team (ICT) that is based on the Member’s needs and to support the Member in their plan of care. The ICT must be person-centered and collaborate with the Member and/or Member’s authorized representative and each other to assist in the development of an ICP, and assist in the

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7 CCI Three-Way Contract September 2019, Section 2.8.
8 Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 17-001 Supersedes DPL 15-005, “Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect”.
9 DHCS DPL 15-001 Supersedes DPL 13-004, “Interdisciplinary Care Team and Individual Care Plan requirements for Medicare-Medicaid plans”.
10 CCI Three-Way Contract September 2019, Section 2.5.
25. DELEGATION AND OVERSIGHT

C. Care Management -
1. Delegation and Monitoring

coordination of the Member’s health care needs.\(^{11,12}\) Please see Policy 12A4, “Care Management Requirements – Interdisciplinary Care Team,” for more information on this process and delegated responsibilities.

Data Sharing

A. IEHP transfers to another health plan all information necessary to support continuity of care when the Member disenrolls from the health plan. This information includes, but is not limited to: assessment, ICP, and other pertinent information. IEHP provides the information to the Member’s new health plan no later than thirty (30) calendar days from receipt of the notice of disenrollment to IEHP and no later than the effective date of transfer in the method and format specified by the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS).\(^{13,14}\)

B. In order to provide the information within this timeframe, IPAs must provide to IEHP the Member’s ICP and ICT information within fourteen (14) business days of IEHP’s request.

Monitoring and Oversight

A. IEHP performs monitoring and oversight of the IPAs’ care management activities through the review of care management report logs and files monthly, annually and as needed.

B. On a routine basis and utilizing the IPA Care Management Review Tool, IEHP reviews the IPA’s care coordination/care management activities for elements which may include, but are not limited to, the following (See Attachments, “IPA Care Management Review Tool - Medicare” and “Care Management – Delegation Oversight Data Validation Tool” in Section 25):\(^{15}\)

1. A process for offering care management to all Members;
2. A person-centered, outcome-based approach;
3. Spanning medical and LTSS systems, including coordination with IHSS, with a focus on transitions;
4. Coordination with county agencies and IEHP, if applicable, for Behavioral Health services;
5. Development of ICPs with Members;\(^{16}\)
6. Stratification levels for the care management program and appropriate stratification of

\(^{11}\) DHCS DPL 15-001.
\(^{12}\) CCI Three-Way Contract September 2019, Section 2.5.
\(^{13}\) DHCS DPL 17-001.
\(^{14}\) CCI Three-Way Contract September 2019, Section 2.5.
\(^{15}\) Ibid.
\(^{16}\) DHCS DPL 15-001.
25. DELEGATION AND OVERSIGHT

C. Care Management -
   1. Delegation and Monitoring

Members;\textsuperscript{17,18}

7. A process for ICT meetings;\textsuperscript{19} and

8. Frequency of care management contact for each care management stratification level.

C. IEHP selects and reviews, at a minimum, five (5) targeted cases each month to ensure that care management requirements are met. Additional files may be selected depending on population size.

D. IEHP provides education and training on care coordination annually, per IPA request and as needs are identified through oversight activities.

E. Upon request, the IPA must submit a complete and comprehensive Corrective Action Plan (CAP) to IEHP that adequately addresses all deficiencies noted on the audit tool. See Policy 25A3, “Delegation Oversight – Corrective Action Plan Requirements” for more information.
25. DELEGATION AND OVERSIGHT

C. Care Management
   2. Reporting Requirements

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP maintains the responsibility of ensuring that Delegates continue to be in compliance with all applicable state and federal laws, as well as all contractual and reporting requirements. 1

B. IEHP oversees, monitors and evaluates the performance of delegated and non-delegated care management activities. 2,3 Oversight activities include, but are not limited to, reviewing reports submitted by the IPAs, as described below.

PROCEDURES:

A. All reports must be submitted to IEHP within the timeframes specified in Section 25, Attachment, “Medicare Provider Reporting Requirements Schedule” and in the correct format, via IEHP’s Secure File Transfer Protocol (SFTP). Files not submitted in the correct format will be rejected, and the IPA will be required to resubmit in the appropriate format. Reporting requirements include:

1. Monthly Medicare Care Management Logs
   a. The Monthly Medicare Care Management Log includes all Members that are in any program level of care management (i.e. care coordination, high risk, complex) (See Attachment, “Monthly Medicare Care Management Log” in Section 25).
   b. Monthly log should include previously opened active cases, when there is a change in status and newly identified case(s) for the month reporting.
   c. By the 1st business day of every month, IEHP will select cases from various data sources for monthly file review. IPAs will be provided with file selections the 1st business day of the month for submission to the SFTP by the 15th day of the same month.
   d. Member care management contact is based on the needs of the Member. Members who are considered high/complex risk should receive care management contact at least monthly, if not more frequently. Each IPA must submit the information noted in the Monthly Medicare Care Management Log.

2. Monthly Care Coordination for Members Receiving Specialty Mental Health

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1 Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.9.
2 CCI Three-Way Contract September 2019, Section 2.16.
3 Title 28 California Code of Regulations (CCR) § 1300.70.
25. DELEGATION AND OVERSIGHT

C. Care Management
   2. Reporting Requirements

Services Log

a. On the 1st day of each month, IEHP will provide IPAs a report that lists their IEHP DualChoice Members known to be receiving specialty mental health services through the County Mental Health Clinics.

b. IEHP will pre-schedule case conferences to take place on a quarterly basis. The IPA and County Mental Health Clinics are expected to review the status of their respective Members prior to the case conference for a more productive discussion of identified Member issues. These case conferences will serve as the forum for the required county outreach as outlined in Policy 25C1, “Care Management–Delegation and Monitoring.”

c. IPAs will complete the report by providing the data elements specific to the CA1.7 measure, as outlined in Policy 25F1, “Medicare MMP Reporting Requirements – IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)” and Attachment, “Medicare Provider Reporting Requirements Schedule” in Section 25.

B. Repeated failure to submit required reports timely and in the right format may result in the request of a Corrective Action Plan (CAP), freezing of new Member enrollment or termination or non-renewal of the IEHP Agreement. Upon request, the IPA must submit a complete and comprehensive CAP to IEHP that adequately addresses all deficiencies noted on the audit tool. See Policy 25A3, “Delegation Oversight – Corrective Action Plan Requirements” for more information.

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<thead>
<tr>
<th>INLAND EMPIRE HEALTH PLAN</th>
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<tbody>
<tr>
<td>Chief Approval: Signature on file</td>
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<tr>
<td>Chief Title: Chief Medical Officer</td>
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</tbody>
</table>

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25. DELEGATION AND OVERSIGHT

D. Quality Management
   1. Quality Management Reporting Requirements

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Delegates.

POLICY:

A. IEHP maintains the responsibility of ensuring that Delegates continue to be in compliance with all applicable State and federal laws, contractual and reporting requirements.\(^1\)

B. IEHP oversees, monitors and evaluates performance of delegated and non-delegated quality improvement (QI) activities.\(^2,3\) Oversight activities include but are not limited to the review of these semi-annual and annual reports.

DEFINITION:

A. Delegate – For this purpose of this policy, this is defined as a medical group, Health Plan, IPA, or any contracted organization delegated to maintain and/or provide QM, programs and activities.

PROCEDURES:

A. Semi-Annual Reporting Requirements:
   
   1. Reporting requirements include a QM semi-annual assessment, which documents the progress of the QM, QI and Utilization Management (UM) activities found in the QM Work Plan.
      
      a. **Quality Management** – Reports must identify and address the following:
         
         1) Quality of Clinical Care;
         2) Quality of Service;
         3) Safety of Clinical Care;
         4) Members’ Experience;
         5) Program Scope;
         6) Yearly Objectives;
         7) Yearly Planned Activities;

\(^1\) Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004, “Subcontractual Relationships and Delegation”.

\(^2\) Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.9.

\(^3\) Title 28 California Code of Regulations (CCR) § 1300.70.
25. DELEGATION AND OVERSIGHT

D. Quality Management
   1. Quality Management Reporting Requirements

   8) Timeframe within which each activity is to be achieved;
   9) Staff member(s) responsible for each activity;
   10) Monitoring of previously identified issues; and
   11) Evaluation of the QM/QI program.

2. QM Semi-Annual Reports must be submitted to IEHP via IEHP’s Secure File Transfer Protocol (SFTP) by these due dates, regardless of whether these dates fall on a weekend or holiday:
   a. 1st Semi-Annual report covers period from January 1st through June 30th and must be submitted by August 15th; and
   b. 2nd Semi-Annual report covers period from July 1st through December 31st and must be submitted by February 15th.

3. Failure to submit required reports may result in actions that include, but are not limited to, request for Corrective Action Plan (CAP), being frozen to new Member assignment, or termination or non-renewal of the IEHP Agreement. See Policy 25A3 “Delegation Oversight - Corrective Action Plan Requirements.”

B. Annual Reporting Requirements: The following reports must be submitted annually to IEHP via IEHP’s SFTP no later than the 15th of February each calendar year regardless of whether this date falls on a weekend or holiday:

   1. Quality Management
      a. Quality Management Program Description: Reassessment of the QM Program Description must be done on an annual basis by the QM Committee and reported to IEHP. The following must be included with the submission to IEHP:
         1) Any changes made to the QM Program Description during the past year or intended changes identified during the annual evaluation; and
         2) Signature page noting date of committee approval.
      b. Quality Management Work Plan: Submit an outline of planned activities for the coming year, including timelines, responsible person(s) and committee(s). The Work Plan should include planned audits, follow-up activities and interventions related to identified problem areas.
      c. Quality Management Program Annual Evaluation: The evaluation should include a description, trending, barrier analysis and evaluation of the overall effectiveness of the QM Program.

Please see Policy 25D2, “Quality Management - Quality Management Program Structure...”

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CCI Three-Way Contract September 2019, Section 2.16.
25. DELEGATION AND OVERSIGHT

D. Quality Management
   1. Quality Management Reporting Requirements

   Requirements,” for more information.

C. IEHP’s Quality Management Department monitoring and oversight duties include:
   1. Review of all monthly, semi-annual, and annual Delegate reports for tracking and
      trending levels of activity; comparison to other Delegates, variances compared to other
      Delegates and other significant data issues. Reports include but are not limited to those
      listed above.
   2. Review and approval of the semi-annual and annual reports submitted by the Delegates
      (e.g., QM Program Description and Work Plan).
25. **DELEGATION AND OVERSIGHT**

D. **Quality Management**

2. **Quality Management Program Structure Requirements**

**APPLIES TO:**

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Delegates.

**POLICY:**

A. IEHP is accountable for all quality improvement functions and responsibilities that are delegated, and maintains the responsibility of ensuring that Delegates continue to be, in compliance with all applicable State and federal laws, contractual and reporting requirements.

B. Delegates are required to have a Quality Management (QM) Program per their Delegation Agreement with IEHP and as outlined in the IEHP Provider Manual (See Attachment, “IPA Delegation Agreement – IEHP DualChoice” in Section 25). IEHP monitors Delegates’ QM Program Structure and implementation of quality management activities to ensure the delegate is continuously monitoring and improving the quality of care, access to care, service and patient safety delivered to IEHP Members.

C. Delegates must maintain a written QM Program Description, QM Work Plan, Annual QM Evaluation, and related QM Policies and Procedures that meet Department of Health Care Services (DHCS), National Committee for Quality Assurance (NCQA) and IEHP standards for Quality Management.

**DEFINITION:**

A. Delegate – For the purpose of this policy, a delegate is defined as a medical group, Health Plan, IPA, or any contracted organization delegated to maintain and/or provide QM programs and activities.

**PROCEDURES:**

A. **QM Program Requirements** – Delegates’ QM Program must consist of the following:

1. **Quality Management**
   a. **Quality Structure** – Delegates are required to have a structure in place that monitors quality activities, including a formal Committee structure and sufficient personnel in place to perform quality management activities.
   b. **Quality Studies** – Delegates are required to perform a minimum of two (2) quality studies for their Membership per calendar year. One (1) study must be in the area of access; the other study should be an area pertinent to the Delegate, IEHP Membership served by the Delegate, and quality issues identified by the Delegate.

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1 Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.16.
2 Ibid.
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

Study results must be made available to Primary Care Providers (PCPs) and IEHP Members upon request. IEHP has the right to mandate the type of access study required if IEHP has identified quality or access issues.

c. Peer Review – Delegates must perform peer review. All Delegates are required to have a Peer Review Committee made up of Physicians and representatives of the network that provides peer review of any Practitioner noted to have potential quality issues. The Delegates’ Peer Review Committees are responsible for reviewing Provider, Member, or Practitioner grievances and/or appeals, Practitioner-related quality issues and other peer review matters. Should a significant practitioner problem or quality issue arise that cannot be resolved at this level, the Delegate’s QM Committee may refer the issue to the IEHP Peer Review Subcommittee for resolution. In addition, the Delegate’s Peer Review Committee performs oversight of the Credentialing Program and activities, grievance and appeals processes with recommendations for modification as necessary. Data utilized to identify candidates for peer review include quality studies by IEHP or the Delegate, grievances received by the Delegate or IEHP, utilization and/or encounter data, and other data sources.

d. Clinical Data – IEHP provides Member experience and clinical performance data to all Delegates in order for them to conduct quality studies and perform all delegated functions. This data will be provided upon request from the Delegate or as both parties agree to specific quality studies where IEHP has the necessary data. In addition, all Delegates are free to collect their own clinical and Member experience data to support Quality Improvement (QI) initiatives.

2. Utilization Management (UM) – IEHP delegates the utilization management process to those Delegates that have sufficient administrative capacity, with accompanying policies and procedures, to meet all IEHP, DHCS and CMS standards for utilization management activities. Refer to Section 14, “Utilization Management” and Policy 25E1, “Utilization Management - Delegation and Monitoring,” for more information.

3. Credentialing/Recredentialing – IEHP may delegate the responsibility for credentialing and recredentialing of participating Practitioners, as identified in Section 25, “Delegation and Oversight.” This includes a signed attestation by the Delegate’s Medical Director that states all Practitioner-required reviews were conducted. IEHP’s Chief Medical Officer and/or Medical Director designee review all Providers (PCPs and Specialists) individually for quality-related issues prior to assignment of Members. The IEHP Peer Review Subcommittee performs peer review on Practitioners and Providers identified through the Ongoing Monitoring of Sanctions process conducted by Credentialing and those Practitioners referred by the Chief Medical Officer or Medical Director for potential quality of care concerns. IEHP also performs Credentialing/Recredentialing functions for those Practitioners that are directly contracted with IEHP.
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

4. **Care Management (CM)** – IEHP delegates care management for Members including case finding, assessment of needs and care coordination, referral to outside agencies, and all other necessary care management activities. Refer to Section 12, “Coordination of Care” and Policy 25C1, “Care Management – Delegation and Monitoring,” for more information.

5. **Practitioner Education**³ – Delegates and IEHP share Provider education and training responsibilities including orientation to IEHP DualChoice line of business, delineation of IEHP policies and procedures pertinent to the Practitioner, site and medical record audit preparation, specialized support and training such as pediatric or adult preventive services and health education.

Delegates are also required to be aware and require their Practitioners’ use of certain forms, supplied by IEHP on the Provider website, including: Perinatal Risk Assessment Forms, Individual Health Education Behavioral Assessment (IHEBA) forms, etc. IEHP forms are available online at [www.iehp.org](http://www.iehp.org).

6. **Health Education** – IEHP notifies the Delegate’s CM department for the purpose of individualized care management and referral to appropriate health education programs. IEHP works collaboratively with Providers and Practitioners to identify and educate these Members. IEHP provides certain network-wide health education programs to all Members. IEHP supplies Delegates and PCPs with health education brochures, materials, forms and a Provider Resource Directory. Refer to Section 15, “Health Education” for more information.

7. **Medical Records Maintenance** – IEHP and Delegates are required to monitor Physician offices for compliance with medical record requirements. Practitioners are required to maintain policies and procedures consistent with IEHP requirements, outlined in Policy 7A, “Provider and Delegated IPA Medical Records Requirements.”

8. **Preventive Care and Non-Preventive Care Guidelines** – Practice guidelines are developed by IEHP using current published literature, current practice standards, and expert opinions. They are based upon specific medical issues commonly found within IEHP’s Membership. Delegates are expected to monitor Practitioner’s care related to clinical practice guidelines as applicable.

9. **Access Standards**⁴ – Delegates are required to adhere to IEHP standards for availability and accessibility of services, as outlined in Policy 9A, “Access Standards.” IEHP ensures network compliance with the standards for appointment availability, after-hours access, Practitioner office wait time, Physician site hours, emergency service availability, medical triage both during and after hours, proximity of Specialists and Hospitals, and

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³ CCI Three-Way Contract September 2019, Section 2.9.
⁴ CCI Three-Way Contract September 2019, Section 2.10.
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

follow-up care through studies and audits. The Delegate is required to perform access studies on their Practitioners to ensure they meet IEHP requirements.

B. Pre-Delegation Audit - To ensure that newly contracted Delegates have the capacity and capability to perform required functions and meet regulatory requirements, IEHP performs pre-delegation audit within twelve (12) months prior to implementing delegation activities using an audit tool that reflects current NCQA, DHCS, and IEHP standards.5

C. Annual Quality Management Program Description

1. Contracted Delegates must have a written QM Program Description that is reviewed at least annually and describes the structure of the Delegate’s QM Program.6 This program must include the following:

a. QM Program goals, objectives, and structure;7
b. Accountability to the Delegate’s Governing Body;8

c. Designated Physician involvement in the QM Program;9
d. Patient Safety;
e. Member Experience;
f. Description of behavioral health care aspects of the program, as applicable;10
g. Description of behavioral health care Practitioner involvement in behavioral health care aspects of the program; as applicable;11

h. Description of QM Committee oversight of quality management functions;12
i. Role, structure and function of the QM Committee13 and related Subcommittees including meeting frequency;
j. An annual work plan;
k. Description of the resources that devote time and staff dedicated to meeting the objectives of the QM Program (i.e. employees, consultants, data sources, and analytic resources such as statistical persons and/or programs);
l. Objectives for serving a culturally and linguistically diverse membership; and

5 CCI Three-Way Contract September 2019, Section 2.16.
6 Ibid.
7 Ibid.
8 Ibid.
9 Ibid.
10 Ibid.
11 Ibid.
12 Ibid.
13 Ibid.
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

m. Objectives for serving Members with complex health needs and Seniors and Persons with Disabilities (SPD).\(^\text{14}\)

2. The Delegate must document all resources devoted to the QM Program, not merely the QM Program staff. Documentation must indicate the planned number and type of quality management activities to ensure activities are completed in a competent and timely manner.

3. The Delegate must have access to, and the ability to manage, the data supporting measurement of quality management activities documented in the QM Work Plan.

4. There must be evidence of the Board of Directors’ review and approval of the QM Program Description on an annual basis.\(^\text{15}\)

5. The Delegate’s QM Program Description must outline their approach to address Members with complex needs. Members with complex needs can include individuals with physical or developmental disabilities, multiple chronic conditions, and severe mental illness.

D. Quality Management Work Plan

1. The QM Work Plan must be a separate document included in the QM Program Description. The Work Plan must document the QM activities scheduled for the calendar year with a brief explanation of timing and party responsible for the activity. The Work Plan must include the following:

   a. Yearly planned QI activities and objectives for improving;
      1) Quality of clinical care;
      2) Quality of service; and
      3) Safety of clinical care.
   b. Program scope;
   c. Timeframe for each activity’s completion;
   d. Staff members responsible for each activity;
   e. Monitoring of previously identified issues; and
   f. Evaluation of the QM Program.


\(^{14}\) CCI Three-Way Contract September 2019, Section 2.16.

\(^{15}\) Ibid.
25. DELEGATION AND OVERSIGHT

D. Quality Management
   2. Quality Management Program Structure Requirements

E. Quality Management Semi-Annual Reports

1. The Delegate’s QM Semi-Annual Reports document the progress of the QM activities found in the QM Work Plan and assist the Delegate in its development of the QM annual evaluation.

2. The QM Semi-Annual Report must include:
   a. Component/Activity;
      1) Clinical Improvement;
      2) Continuity and Coordination of Care;
         • General Medical Care
         • General Medical and Behavioral Health
      3) Access;
      4) Experience Improvement;
      5) Patient Safety; and
      6) Other QI Activities.
   b. Each Component must include:
      1) Objectives;
      2) Activities planned;
      3) Responsible person for each activity; and
      4) Timeframe within which each activity is to be completed.
   c. Semi-annually, the Delegate must include a description of the following areas for each separate component:
      1) Reporting Period;
      2) Key findings;
      3) Interventions taken;
      4) Analysis of findings along with progress; and
      5) Any follow-up actions.

3. QM Semi-Annual Reports must be submitted to IEHP. Please see Policy 25D1, “Quality Management - Quality Management Reporting Requirements” for information on schedule and method of submission.

F. QM Program Annual Evaluation

1. The QM Annual Evaluation may be included in the QM Work Plan or be a separate
25. DELEGATION AND OVERSIGHT

D. Quality Management
   2. Quality Management Program Structure Requirements

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

2. The QM Annual Evaluation must be submitted to IEHP. Please see Policy 25D1, “Quality Management - Quality Management Reporting Requirements” for more information on schedule and method of submission.

G. QM Reporting Requirements - Delegates are required to report the following information on a periodic basis. See Policy 25D1, “Quality Management - Quality Management Reporting Requirements,” for more information on these reporting requirements:
   1. QM Program Description;
   2. QM Work Plan;
   3. QM Semi-Annual Reports of quality improvement activities; and
   4. QM Program Annual Evaluation; and
   5. Quality Studies performed by the Delegate when appropriate or as requested by IEHP.

H. Quality Management Committee
   1. The QM Committee is an interdisciplinary committee with participation from the Delegate’s appointed Practitioners who represent network Physicians. The Delegate’s QM Committee is responsible for monitoring, measuring, and evaluating the quality, effectiveness, safety, coordination and appropriateness of the care provided by Practitioners to Members for the purpose of continued quality improvement.

2. The Delegate’s description of the QM Committee must include the following:
   a. Role;
   b. Function;
   c. Structure that includes organizational structure and reporting responsibility;
   d. Membership;

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16 CCI Three-Way Contract September 2019, Section 2.16
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

   e. Terms of service;
   f. Voting rights;
   g. Quorum definition;
   h. Meeting frequency;
   i. Minute format and storage; and
   j. Committees associated with oversight of delegated activities.

3. The Delegate’s description of the QM Committee must its involvement and oversight of the following activities:
   a. Recommending policy decisions;
   b. Analyzing and evaluating QM Activity findings;
   c. Ensuring Practitioners’ participation in the QM Program through planning, design and implementation or review;
   d. Implementing needed actions;
   e. Ensuring needed follow-up; and
   f. Maintain signed and dated meeting minutes.

4. The Delegate’s QM Committee must meet at least quarterly and follow a prescribed agenda.

5. The Delegate’s QM Committee discussions, conclusions, recommendations, and actions must be documented in the signed Committee minutes.

I. Confidentiality - Providers must fully comply with all State, Federal and IEHP regulatory requirements pertaining to confidentiality, privacy and information disclosure of medical records. See Policy 7B “Information Disclosure and Confidentiality of Medical Records.”

1. Medical Records Release – Medical records contain confidential information that must not be released to any party other than the Member’s Primary Care Provider (PCP) without the expressed written consent of the Member or legal representative. The PCP must maintain procedures for obtaining such written consent prior to release of records. Refer to Policy 7B, “Information Disclosure and Confidentiality of Medical Records,” for more information.

2. Members’ Right to Confidentiality – Members have the right to confidentiality of medical information. All Provider contracts and subcontracts include the provision to safeguard the confidentiality of Member health records and treatment in accordance with applicable state and federal laws. Release of Member medical information may be

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17 CCI Three-Way Contract September 2019, Appendix B, Enrollee Rights
25. DELEGATION AND OVERSIGHT

D. Quality Management
   2. Quality Management Program Structure Requirements

necessary to protect the health of the Member and/or for coordination of services between Practitioners, Specialists, or other health care Providers of service. Refer to Policy 7B, “Information Disclosure and Confidentiality of Medical Records” for more information.

3. Education of PCP Staff Regarding Confidentiality Issues – Delegates must educate Providers and associated staff regarding confidentiality issues. Signed confidentiality statements are required for participation in the IEHP Practitioner network and monitored as part of the facility site review process. Referral or access to sensitive services requires the maintenance of high standards of confidentiality. Members requiring family planning services, treatment for sexually transmitted diseases, abortion information and/or treatment, and Human Immunodeficiency Virus (HIV) testing or are requesting assistance with highly sensitive issues, must be treated with respect and consideration for confidentiality. See Policy 9D, “Access to Services with Special Arrangements.”

4. Conflict of Interest\(^{18}\) – Should an issue arise involving care provided by a Physician member of the QM Committee or any Subcommittee, that Physician is replaced by a substitute until the issue is resolved. The Member involved in the issue has all rights normally given to anyone with a case presented to the Committee or Subcommittee. Committee members are required to sign a confidentiality and conflict of interest statement.


J. Provider Participation

1. Provider Information – Delegates are required to inform network Practitioners of guidelines, policy and procedure changes, and other important information. Delegates’ methods of Practitioner education or notification are evaluated annually during Delegation Oversight Audits. Providers are informed through the IEHP Provider Newsletter, letters, memorandums, distribution of updates to the Provider Manual, and training sessions. Delegates are notified through letters, memorandums, Provider Manual updates, training sessions for specific issues, Joint Operations Meetings, and by attending IEHP University, when available.

2. Provider Cooperation: IEHP requires that Delegates and Hospitals cooperate with IEHP QM Program studies, audits, monitoring, and quality related activities. Requirements for cooperation are included in Hospital and Delegate Provider contract language that describes contractual agreements for access to information.

\(^{18}\) CCI Three-Way Contract September 2019, Section 2.16
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

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

1. Delegate and Provider Agreements include the following provisions:
   a. Delegate is subject to, and agrees to participate in the IEHP QM Program, with regular IEHP monitoring and evaluation of compliance with QM Program standards and IEHP policies and procedures, including participation in Member grievance and/or appeal resolution.
   b. Delegate shall provide access at reasonable times, upon demand by IEHP, to inspect facilities, equipment, books and records including Member patient records, financial records pertaining to the cost of operations and income received by Delegate for medical services rendered to Members. Delegate shall ensure that Providers allow IEHP to access and use Provider performance data.
   c. Delegate shall cooperate with IEHP’s QM Program and, upon reasonable request, shall provide IEHP with summaries of or access to records maintained by Delegate and required in connection with such programs, subject to applicable state and federal law concerning the confidentiality of medical records.
   d. Delegate shall not impede open Practitioner-patient communication. Members are allowed to participate with doctors in decision-making about their own health care including the ability to talk with their doctor about their medical condition regardless of cost or benefit.

2. Hospital contracts include provisions for the following:
   a. Hospital agrees to participate with IEHP in the IEHP QM Program, with regular IEHP monitoring and evaluation of compliance with QM Program standards and IEHP policies and procedures, including participation in Member grievances and resolution. Hospital shall also provide access to IEHP utilization review and case management personnel for the purpose of conducting concurrent review and case management on Members who are receiving Hospital services.
   b. Hospital shall implement an ongoing QM Program and shall develop procedures for ensuring that the quality of care provided by Hospital conforms with generally accepted Hospital practices prevailing in the managed care industry. Hospital shall develop written procedures for remedial action whenever, as determined by the QM Program, inappropriate or substandard services have been furnished, or services that should have been furnished have not been furnished.
   c. Hospital shall provide access at reasonable times, upon demand by IEHP, to inspect facilities, equipment, books and records including Member patient records and financial records pertaining to the cost of operations and income received by Hospital with a five (5) working day prior written notice of any such inspection.
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Hospital shall ensure that Providers allow IEHP to access and use Provider performance data.

d. Hospital shall cooperate with IEHP’s QM Program and, upon reasonable request, provide IEHP with summaries of or access to records maintained by Hospital and required in connection with such programs, subject to applicable state and federal law concerning the confidentiality of medical records.

L. Auditing and Monitoring Activities

IEHP performs a series of activities to monitor Delegate functions including the following:

1. Delegation Oversight Audit – IEHP performs an annual Delegation Oversight Audit of all contracted Delegates using an audit tool that is based upon current CMS, DHCS and IEHP standards. This audit assesses Delegate’s operational capabilities in the areas of QM, QI, Credentialing, UM, CM, and Compliance. Refer to Policy 25A2, “Delegation Oversight – Audit,” for more information.

2. Joint Operations Meetings (JOMs) - JOMs with Delegates are intended to provide a forum to discuss issues and ideas concerning care for Members. They allow IEHP a method of monitoring plan administration responsibilities that the Delegates are required to perform. JOMs may address specific UM, QM, QI, CM, grievance, study results, or any other pertinent quality issues.

3. Member or Practitioner Grievance Review - IEHP reviews individual grievances and their resolutions for Delegate policies or procedures, actions, or behaviors that could potentially negatively impact health care delivery or Member health status.

4. Specified Audits - IEHP performs specific audits of Delegates and PCPs to assess compliance with IEHP standards. These audits include facility reviews, claims audits, CM audits, and health education audits.

5. Focused Audits - IEHP performs focused audits of Delegates or Practitioners as indicated whenever a quality or clinical issue is identified.

6. Review of Referral Universes - All Delegates are required to submit monthly referral universes to IEHP as well as denial letters sent to Members. All denials are reviewed for appropriateness and trends or patterns of concern. Refer to Policy 25E2, “Utilization Management Reporting Requirements” for complete information on UM reporting requirements.

7. Review of CM Logs and Case Files - All Delegates are required to submit monthly CM Logs to IEHP listing all CM cases from the previous month. In addition, Delegates are required to submit copies of CM files. All files are reviewed for appropriateness and trends or patterns of concern. Refer to Policy 25C2, “Care Management - Reporting Requirements” for complete information on CM reporting requirements.

19 CCI Three-Way Contract September 2019, Section 2.16.
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8. **Delegated Reporting Requirements Review** - IEHP performs review of scheduled submitted reports as defined in the IPA Reporting Requirements Schedule (See Attachment, “IPA Reporting Requirements Schedule – Medicare” in Section 25), and delegated activities as defined in the Delegation Agreement (See Attachment, “IPA Delegation Agreement – IEHP DualChoice” in Section 25).

9. **Focused Referral and Denial Audits** - IEHP performs focused audits of the referral and denial process for Delegates when quality of care issues are identified. Audits examine source data at the Delegate to review referral process timelines, appropriateness of denials and the denial process, including denial letters. See Policy 25E3, “Utilization Management – Referral and Denial Audits,” for more information.

10. **Member and Physician Experience Surveys** - IEHP performs Member and Physician experience surveys to assess their experience with IEHP, their Delegate and managed care.

M. Delegates that are out of compliance with QM requirements will be issued a Corrective Action Plan (CAP). See Policy 25A3, “Delegation Oversight – Corrective Action Plan Requirements.”
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E.  Utilization Management
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**APPLIES TO:**

A.  This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

**POLICY:**

A.  IEHP delegates all aspects of utilization management activities related to medical services for assigned Members to its Delegates.\(^1\)\(^2\)  Delegate medical services must be rendered by qualified medical Practitioners, unhindered by fiscal and administrative management.\(^3\)

B.  IEHP and its Delegates shall develop, implement, and continuously update and improve a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services.\(^4\)

C.  IEHP maintains responsibility of ensuring that its Delegates continue to be in compliance with all applicable State and federal laws and other requirements set forth by the Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and IEHP.\(^5\)

D.  Authorization and financial responsibilities are delineated in the Division of Financial Responsibilities (DOFR).

**PURPOSE:**

A.  To ensure a well-structured UM program and make utilization decisions affecting the health care of Members in a fair, impartial and consistent manner.

**DEFINITION:**

A.  Delegate – A health plan, medical group, IPA, or any contracted organization delegated to provide utilization management services.

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\(^1\) Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.11
\(^2\) Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance,” Section 10.4.3
\(^3\) CCI Three-Way Contract September 2019, Section 2.11
\(^4\) Ibid.
\(^5\) Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance,” Section 10.4.3
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PROCEDURES:

UM Program Requirements

A. Delegates must have a UM Program Description that includes, at minimum, the following information:

1. Mission statement, goals, and objectives;
2. Program structure, which includes at minimum:
   a. UM staff’s assigned activities;
   b. UM Staff who have the authority to deny coverage;
   c. Involvement of a designated physician;
   d. The process for evaluating, approving and revising the UM Program, and the staff responsible for each step;
   e. The UM Program’s role in the Quality Improvement (QI) program, including how the organization collects UM information and uses it for QI activities; and
   f. The organization’s process for handling appeals and making appeal determinations.
3. Senior-level physician involvement, including their responsibilities in setting UM policies, supervising program operations, reviewing UM cases, participating on the UM committee, and evaluating the overall effectiveness of the UM program;
4. Processes and information sources used to make determinations, which includes but is not limited to:
   a. UM functions, the services covered by each function or protocol and the criteria used to determine medical necessity;
   b. How medical necessity and benefits coverage for inpatient and outpatient services are determined and guide the UM decision-making process; and
   c. The description of the data and information the Delegate uses to make determinations; and
5. Other UM program requirements.

B. Delegates must, on an annual basis, evaluate their UM program to ensure that this remains current and appropriate. Delegates must update their UM program based on this program evaluation, which must include but not be limited to the review of the following:

1. UM program structure;

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6 Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance,” Section 10.4.2
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2. Program scope, processes, information sources used to determine benefit coverage and medical necessity;
3. The level of involvement of the senior-level physician in the UM program; and
4. Member and Provider experience data.

C. Delegates must have the following UM structure in place:

1. Delegates must have a designated senior-level physician who holds an unrestricted license in the state of California, responsible for the following. Please see Policy 18N, “IPA Medical Director Standards” for more information:  
   a. Ensuring the process by which the Delegate reviews and approves, partially approves (modifies) or denies, based in whole or in part on medical necessity, requests by Providers prior to, retrospectively, or concurrent with the provision of health care services to Members comply with State, federal and contractual requirements;  
   b. Ensuring that medical decisions are rendered by qualified medical personnel and are not influenced by fiscal or administrative management considerations;  
   c. Participation in staff training; 
   d. Monitoring documentation for adequacy; 
   e. Be available to UM staff on site or by telephone; 
   f. Signing off on all internal policies and procedures related to UM; 
   g. Chairing the UM Committee or designating a Chair; and

Delegates shall communicate to the IEHP Senior Medical Director any changes in the status of their UM Medical Director.

2. UM Committee – Delegates must establish a UM Committee that directs the continuous monitoring of all aspects of UM, including the development of appropriate standards administered to Members, with oversight by the Medical Director. For more information on a UM Committee’s functions, structure, membership, and other requirements, please see Policy 2G, “Utilization Management Subcommittee.”

3. Use of Appropriate Professionals for UM Decisions: To ensure that first-line UM decisions are made by individuals who have the knowledge and skills to evaluate working diagnoses and proposed treatment plans, IEHP requires its Delegates to adopt the following standards for personnel making review decisions and reviewing denials. The following types of personnel can perform the functions listed:

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7 CCI Three-Way Contract September 2019, Section 2.11
8 California Health and Safety Code (Health & Saf. Code) §1367.01
9 Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance,” Section 10.4.2
10 Title 22, California Code of Regulations (CCR) § 53857
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a. UM Technicians/Coordinators – eligibility determination, editing of referral form for completeness, interface with Provider offices to obtain any needed non-medical information,\(^{11}\) and approval of authorizations as determined appropriate (auto authorizations). Delegates should be able to provide a list of all services approvable by UM Technicians/Coordinators.

b. Licensed Vocational Nurses (LVN) – initial review of medical information, initial determination of benefit coverage, obtaining additional medical information,\(^{12}\) as needed, from the Provider’s offices, approval of referrals based on IEHP-approved authorization criteria, concurrent inpatient, and initiate denials for non-covered benefits and carve outs.

c. Registered Nurses (RN) – initial review of medical information, initial determination of benefit coverage, obtaining additional medical information as needed, from the Provider’s office,\(^{13}\) approval of referrals based on medical necessity or IEHP-approved authorization criteria, and providing medical necessity recommendation to the physician reviewer.

d. Physician-Reviewer - A designated physician with unrestricted license in the state of California must review all denials and partial approvals (modifications) based in whole or in part on medical necessity, and obtain additional medical information from the treating physician as needed.\(^{14}\)

4. Use of Board-Certified Physicians for UM Decisions: Delegates must have a written policy and procedure demonstrating their use of designated physicians with current unrestricted license for UM decisions.

a. When a case review falls outside the clinical scope of the reviewer, or when medical decision criteria do not sufficiently address the case under review, a Board-certified physician in the appropriate specialty must be consulted.

b. Delegates must either maintain a list of Specialists to be utilized for UM decisions or consult with an organization contracted to perform such review. The interaction may be completed by a telephone call to a network specialist, a written request for review, or use of a contracted vendor that provides Board Specialist review.

c. The primary physician reviewer determines the type of specialty required for consultation.

Clinical Criteria for UM Decisions

A. Delegates must use nationally recognized clinical criteria and/or IEHP UM Subcommittee-Approved Authorization Guidelines, when making decisions related to medical care. Criteria

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\(^{11}\) Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance,” Section 10.6

\(^{12}\) Ibid.

\(^{13}\) Ibid.

\(^{14}\) Ibid.
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sets approved by IEHP include CMS Local Coverage Determination, Local Coverage Articles and National Coverage Determination, DHCS Duals Plan Letter (DPLs), Milliman Care Guidelines, InterQual, Apollo Managed Care Guidelines/Medical Review Criteria, and IEHP UM Subcommittee-Approved Authorization Guidelines.\textsuperscript{15} IEHP may distribute additional criteria following approval by the IEHP UM Subcommittee.

1. Development: Criteria or guidelines that are developed by IEHP and used to determine whether to authorize, partially approve (modify), or deny health care services are developed with involvement from actively practicing health care Practitioners.\textsuperscript{16} IEHP ensures these criteria are consistent with sound clinical principles and processes and are evaluated at least annually and updated if necessary.\textsuperscript{17,18}

2. Application: Delegates must apply criteria in a consistent and appropriate manner based on available medical information and the needs of individual Members.\textsuperscript{19} The application of criteria takes into consideration individual factors such as, age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment. Decisions to deny services cannot be solely based on codes being listed as non-covered, i.e. Medi-Cal Treatment Authorization Request (TAR) and Non-Benefit list of codes. Additionally, criteria applied takes into consideration whether services are available within the service area, benefit coverage, and other factors that may impact the ability to implement an individual Member’s treatment plan. The organization also considers characteristics of the local delivery system available for specific Members, such as:

- a. Availability of skilled nursing facilities, subacute care facilities or home care in the organization’s service area to support the Member after hospital discharge;
- b. Coverage of benefits for skilled nursing facilities, subacute care facilities or home care, Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), Managed Long-Term Services and Support (MLTSS), Multipurpose Senior Services Program (MSSP), or Behavioral Health; and
- c. Local in-network hospitals’ ability to provide all recommended services within the estimated length of stay.

Delegates must ensure consistent application of UM criteria by following this specific order as the Delegate is licensed to use:\textsuperscript{20}

- a. IEHP Member Handbook (Evidence of Coverage); \textbf{then}
- b. Local Coverage Determination (LCD); \textbf{then}

\textsuperscript{15} CA Health & Saf. Code § 1363.5(b)
\textsuperscript{16} CCI Three-Way Contract September 2019, Section 2.11
\textsuperscript{17} CA Health & Saf. Code §1365.5
\textsuperscript{18} CCI Three-Way Contract September 2019, Section 2.11
\textsuperscript{19} Ibid.
\textsuperscript{20} Ibid.
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c. Local Coverage Article (LCA); then
d. National Coverage Determination (NCD); then
e. Medicare Benefit Policy Manual; then
f. National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium or IBM Watson Health Products: Micromedex; then
g. MCG Health Informed Care Strategies Care Guidelines; then
h. InterQual Criteria; then
i. Apollo Medical Review Criteria Guidelines for Managing Care; then
j. IEHP Utilization Management (UM) Subcommittee Approved Authorization Guidelines or Pharmacy and Therapeutics (P&T) Subcommittee Approved Prior Authorization Criteria.

3. Annual Review and Adoption of Criteria: IEHP develops and/or presents criteria to the IEHP UM Subcommittee for adoption and implementation. Delegates may develop and recommend criteria for review and approval by the IEHP UM Subcommittee. After approval by UM Subcommittee, the criteria are sent to the IEHP Quality Management (QM) Committee for reference and disseminated to Delegates and Providers via letter, website or email. Members of the IEHP UM Subcommittee and Practitioners in the appropriate specialty, review clinical criteria annually and update, as necessary.

4. Process for Obtaining Criteria: Delegates must disclose to Providers, Members, Members’ representative or the public, upon request, the clinical guidelines or criteria used for determining health care services specific to the procedure or condition requested.21

Delegates may distribute the guidelines and any revision through the following methods:

a. In writing by mail, fax, or e-mail; or

b. On its website, if it notifies Providers that information is available online.

Integrated Denial Notices must state the address and phone number to call for obtaining the utilization criteria or benefits provision used in the decision. Every disclosure must be accompanied by the following statement: “The materials provided to you are guidelines used by the plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your health plan” (See Attachment, “Response to Request for UM Criteria” in Section 25). 22 Delegates must maintain a log of all requests for criteria (See Attachment, “Request for UM Criteria Log” in Section 25).

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21 CA Health & Saf. Code §1365.5
22 Ibid.
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5. **Annual Assessment of Consistency of UM Decisions (Inter-rater Reliability):** Delegates are responsible for evaluating, at least annually, the consistency with which healthcare professionals involved in utilization review apply appropriate criteria for decision-making. Delegates must act on identified opportunities to improve consistency. The sample assessed must be statistically valid, or Delegates may use one (1) of the following three (3) auditing methods:
   a. Five percent (5%) or fifty (50) of its UM determination files, whichever is less;
   b. NCQA 8/30 methodology; or
   c. Ten (10) hypothetical cases.

**Review of UM Data**

A. Delegates must collect, report, and analyze UM data related to Members for potential over or under utilization.23
   1. UM data includes, at a minimum, the following:
      a. Enrollment;
      b. Re-admits within thirty (30) days of discharge;
      c. Total number of prior authorization requests;
      d. Total number of denials;
      e. Denial percentage; and
      f. Emergency encounters.
   2. Delegate must present the above data in summary form to its UM Committee for review and analysis at least quarterly.
   3. Delegates must present selected data from above to the its PCPs, Specialists, and/or Hospitals as a group, e.g., Joint Operations Meetings (JOMs), or individually, as appropriate; and
   4. Delegates must be able to provide evidence of review of data above by its UM Committee for trends by physicians for both over-utilization and under-utilization.

**UM Authorization Process Requirements**

A. Delegates must have written policies and procedures regarding the process to review, approve, partially approve (modify) or deny prospective, concurrent, or retrospective requests by Providers concerning the provision of health care services for Members. These policies and procedures must be available to the public upon request.24
   1. **Specialty Referral Systems:** Delegates must maintain a specialty referral system to track and monitor referrals requiring prior authorization. The system shall include approved,
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partially approved (modified), and denied referrals received from both contracted and non-contracted providers, as well as the timeliness of these referrals.25

2. **System Controls:** Delegates must have and be able to demonstrate system controls to protect data specific to denial and appeal notifications and receipt dates from being altered outside of prescribed protocols.

3. **Out-of-Network Services:** Authorization and notification of decision for proposed services, referrals, or hospitalizations involves utilizing information such as medical records, test reports, specialist consults, and verbal communication with the requesting Provider. Part of this review process is to determine if the service requested is available in network, and to ensure coordination of medically necessary care from the non-network specialist. If the service is not available in network, arrangements are made for the Member to obtain the service from an out-of-network provider for this episode of care.

When an outpatient or inpatient service requested appears to be unavailable within the IEHP network or service area and IEHP is responsible for paying for the facility charges, the Delegate must review the request to determine if the request meets criteria. Once the Delegate determines that criteria is met, the clinical information must be sent to IEHP to make the final decision. If IEHP determines the requested service cannot be provided within its network, IEHP will initiate the Letter of Agreement (LOA) process. It is therefore critical that the Delegate fax the referral with all supporting documentation as soon as possible to (909) 890-5751 to prevent delay in care. If the request can be handled within the network or does not meet the criteria, the Delegate can modify or deny as appropriate,

4. **Prior Authorization Requirements:** Delegates must maintain a list of services that require prior authorization or have a list of services that do not require prior authorization like below, at minimum:26

   a. The prior authorization described in this policy do not apply to these services, which do not require prior authorization:

      1) Emergency services and services necessary to treat and stabilize an emergency medical condition (See Policy 14C, “Emergency Services”);27,28

      2) Family planning (See Policy 10K, “Family Planning Services”);29,30

      3) Abortion Services (See Policy 9D, “Access to Services with Special Arrangements”);

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25 CCI Three-Way Contract September 2019, Section 2.11
26 Ibid.
27 CCI Three-Way Contract September 2019, Section 2.10
28 CCI Three-Way Contract September 2019, Section 2.11
29 CCI Three-Way Contract September 2019, Section 2.10
30 CCI Three-Way Contract September 2019, Section 2.11
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4) Sexually Transmitted Infection (STI) services (See Policy 10G, “Sexually Transmitted Infection (STI) Services”); 31
5) Sensitive and confidential services (See Policy 9D, “Access to Services with Special Arrangements”); 32
6) HIV testing and counseling (See Policy 10H, HIV Testing and Counseling”); 33
7) Routine OB/GYN services, including prenatal care by Family Care Practitioner (credentialed for obstetrics) within the IPA’s network; 34
8) Out of area renal dialysis; 35
9) Urgent Care; 36 and
10) Preventive services. 36

b. Delegates must allow Members direct access to Specialists, appropriate for their condition and identified need for special healthcare needs. 37

c. Delegates shall ensure Members have access to American Indian Health Services Programs (AIHSP). AIHSP, whether contracted or not, can provide referrals directly to network Providers without first requesting a referral from a PCP. 38

5. Medical Necessity Determination: Delegates must determine medical necessity for a specific requested service as follows:

a. Employ IEHP-approved UM authorization guidelines, as outlined in this policy and utilize the following definition for determining medical necessity of a health care service:

1) The health care service is reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, or otherwise medically necessary under CMS; and

b. If information reasonably necessary to make a determination is not available with the referral, the requesting Provider should be contacted for the additional clinical information by telephone at least two (2) times and with a third attempt being made

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31 CCI Three-Way Contract September 2019, Section 2.11
32 Ibid.
33 Ibid.
34 Ibid.
35 Ibid.
36 Ibid.
37 Ibid.
38 CCI Three-Way Contract September 2019, Section 2.10
39 Social Security Act § 1862 (a)(1)
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by a Medical Director. The request for additional information must be annotated and include the date of request.40

c. Consider all factors related to the Member including barriers to care related to access or compliance, impact of a denial on short- and long-term medical status of the Member and alternatives available to the Member if denied; and

d. Obtain input from Specialists in the area of the health care services requested either through an UM Committee member, telephonically, or use of an outside service.

6. Review Process and Timeframes: Mandated timeframes for decisions including approval, denial or partial approval (modification) of a request and subsequent notification to the Member and Provider are outlined in this Provider Manual. For Members with Dual coverage, the primary insurance will determine the decision timeframe (see Attachment, “UM Timeliness Standards – IEHP DualChoice” in Section 14).

   a. The prior authorization process is initiated when the Member, Member’s representative, or the Member’s Physician requests a referral or authorization for a procedure or service. The timeframe begins from receipt of the request.

      1) For non-urgent preservice or concurrent referrals, Providers have two (2) working days from the determination that a referral is necessary to submit the referral and all supporting documentation.

      2) Providers must sign and date the referral and provide a direct phone number and fax number to the referring Physician for any questions or communication regarding the referral.

      3)

      4) Delegate will identify upon intake any prior authorization request in which IEHP is responsible for making a determination (including requests for behavioral health, optometry and general anesthesia for routine dental requests) and will ensure these requests are forwarded to IEHP within twenty-four (24) hours of receipt by faxing the request to (909) 890-5751.

      5) For concurrent decisions, care shall not be discontinued until the Member’s treating Provider has been notified of the plan’s decision and a care plan has been agreed upon by the treating Provider that is appropriate for the medical needs of the Member.41

   b. Prior Authorization for Expedited Initial Organization Determinations (EIOD) and Urgent Concurrent:42 Delegates are required to perform Expedited Initial Organization Determinations (EIOD) for service authorization requests where the

40 Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance,” Section 10.6
41 CA Health & Saf. Code § 1367.01
42 Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance,” Section 40.8
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Provider indicates or the Delegate determines that following the standard timeframe could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function. The following requests should be classified as concurrent: Continued Home Health, Physical Therapy (PT), Speech Therapy (ST), Occupational Therapy (OT) and Durable Medical Equipment (DME) when the original preservice authorization has not expired. Please see Policy 14I, “Expedited Initial Organization Determination” for more information.

c. Post-Service Organization Determinations (Retrospective Review): Services rendered without prior authorization require retrospective review for medical necessity and/or benefit coverage. This can include out-of-area admissions, continuity of care and/or services or treatments rendered by a contracted or non-contracted Provider without prior authorization.

1) Relevant clinical information must be obtained and reviewed for medical necessity based on IEHP-approved authorization criteria. If medical necessity is not met, denial determinations must be made by the Delegate Medical Director.

2) Members do not need written notification of the decision in the following situations:
   - Retrospective review is only to determine payment level; or
   - The Member is not at financial risk.

   [For example, a retrospective billing adjustment of an Emergency Department visit does not require Member notification because the services have already been rendered, the Member is not financially impacted by the decision (being dual eligible), and payment must be made for the medical screening exam (MSE)]

d. The timeframes for rendering decisions and sending notifications to the Member and Provider are outlined in this Provider Manual (See Attachment, “UM Timeliness Standards – IEHP DualChoice” in Section 14).

7. Experimental and Investigational Determinations: The determination for all experimental and investigational services is the responsibility of IEHP. The Delegate must send to IEHP all authorization requests for experimental/investigational services as soon as possible after receipt. This must be sent by fax at (909) 890-5751 and to the attention of the IEHP Medical Director, using the Health Plan Referral Form for Out-of-Network and Special Services (See Attachment, “Health Plan Referral Form for Out-of-Network and Special Services” in Section 14). The request must include all supporting clinical information including diagnosis (ICD) and procedure (CPT) codes. IEHP is responsible for decision-making and notifying the Provider, Member and Delegate of the

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43 Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance”, Section 40.8
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determination, per standard timeframes for level of urgency. The Milliman Care
Guidelines (MCG) term “role remains uncertain” does not indicate that a request is
considered experimental/investigational. The Delegate must review these requests
utilizing the next criteria set in the hierarchy. If there are no other criteria to review, the
Delegate must forward the request to IEHP as outlined above.

8. Out-of-Network/Capitated Providers: Prior to redirecting a referral from an out-of-
network provider to a contracted or capitated Provider, the Delegate must first verify and
document the following:
   a. That the redirected Provider is of the same discipline and able to provide equivalent
      service dependent on the Member’s medical condition; and
   b. That the Member can receive services within IEHP’s access standards. Please see

Documentation of the above must include:
   a. Name and title of contact at Provider’s office;
   b. Date of outreach; and
   c. Expected date of Member’s appointment.

9. Denial Notices: Any decision to deny a service authorization based on medical necessity
or to authorize a service that is less than requested in an amount, duration, or scope must
be reviewed and approved by the Delegate Medical Director or physician designee.44,45
Members (unless there is no financial responsibility) and Providers must receive denial
letters for any requested referral that is denied or modified.46

a. IEHP-approved notification templates are available online at www.iehp.org. The
   Delegate is responsible for ensuring they are utilizing the most recent version of the
   template. Denial notices must adhere to the following:
   1) Include required CMS language;
   2) Be typed in 12-point font and written in a manner, format, and language that can
      be easily understood;47
   3) Written in a manner, format, and language that can be easily understood;
   4) Be made available in English & Spanish (IEHP Threshold Languages);48

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44 CA Health & Saf. Code § 1367.01
45 CCI Three-Way Contract September 2019, Section 2.11
46 Ibid.
47 Ibid.
48 Ibid.
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5) Include information about how to request translation services and alternative formats, which shall include materials that can be understood by persons with limited English proficiency; 49

6) Sixth (6th) grade level language appropriate for the Member population describing the reason for the denial;
   - Medical necessity denials must cite the criteria used and the reason why the clinical information did not meet criteria; 50,51,52
   - Non-covered benefit denials must cite the specific provision in the Evidence of Coverage (EOC) (i.e., the IEHP Member Handbook), CMS guideline (LCD, LCA, NCD, or Medicare Benefit Policy Manual) or State/Federal regulations that excludes that coverage.

6) Information for the Member regarding alternative treatment and direction for follow-up care; and

7) Information on how to file an oral or written expedited grievance, file a standard or fast appeal, or file an immediate review or appeal as applicable. 53

The Delegate must have in place Quality Assurance (QA) procedures to monitor the items listed above and check for deficiencies in the medical rationale for the denial, the clarity of the language and the inclusion of correct information in the letter.

b. The written communication to a Provider of a denial based on medical necessity must include the name and telephone number of the UM Medical Director or physician designee responsible for the denial. 54,55 This communication must offer the requesting Provider the opportunity to discuss any issues or concerns regarding the decision. This written notification of denial or partial approvals (modifications) must include language informing the Provider of the appeal process. See Section 16, “Grievance and Appeals Resolution System” for more information.

c. On a monthly basis, for monitoring purposes, the Delegate must send to IEHP all documentation for each denial including the following. Please see Policy 25E2, “Utilization Management – Reporting Requirements” for more information:

1) Referral Universes (See Attachments, “IEHP Universe Standard Auth MSSAR Template” and “IEHP Universe Expedited Auth MESAR Template” in Section 25);

49 CCI Three-Way Contract September 2019, Section 2.11
50 CA Health & Saf. Code § 1367.01
51 CCI Three-Way Contract September 2019, Section 2.11
52 Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance,” Section 40.12.1
53 Ibid.
54 CA Health & Saf. Code § 1367.01
55 CCI Three-Way Contract September 2019, Section 2.11
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2) Letters and attachments;
3) Clinical documentation;
4) Referral;
5) Outreach/call logs, if any
6) Supporting evidence of the following:
   • Received Date;
   • Decision Date and Time;
   • RN/LVN or physician reviewer note from medical management system; and
   • Proof of date and time letter was mailed to the Member.
7) Criteria used for the determination;
8) Initial notification including opportunity to discuss; and
9) Audit trail to include all changes and dates made to the case.

d. For Delegates responsible for Medicare benefit only:
   1) If a service request is covered by both Medicare and Medi-Cal, and does not
      meet Medicare criteria but does meet Medi-Cal criteria, no Medicare denial
      letter is issued prior to forwarding to IEHP.
   2) If a service request is not a covered benefit under Medicare, but is a covered
      benefit under Medi-Cal, no Medicare denial letter is needed prior to forwarding
      to Health Plan (see Attachment 14, “Medicare Non-Covered Services”).

   For both instances, IEHP is responsible for making the determination. As such, the
   Delegate shall forward these requests to IEHP by faxing to (909) 890-5751.

Other UM Program Requirements

A. Referral Requests: PCPs are responsible for supervising, coordinating, and providing initial
   primary care to patients; for initiating referrals; and for maintaining the continuity of patient
   care. PCP and Specialist requests for referral to specialty care should be initiated through
   the Member’s IPA. Please see Policies 14A1, “Review Procedures – Primary Care Provider
   (PCP) Referrals” and 14D, “Pre-Service Referral Authorization Process.”

B. Continuity of Care: Delegates must maintain policies and procedures that ensure Members
   are given the option to continue treatment for up to twelve (12) months with an out-of-network
   provider per DHCS requirements. Please see Policy 12A5, “Coordination of Care – Continuity of Care.”

56 CCI Three-Way Contract September 2019, Section 1.84
57 CCI Three-Way Contract September 2019, Section 2.8
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C. Standing Referrals: Delegates must have policies and procedures by which a PCP may request a standing referral to a Specialist for a Member who requires continuing specialty care over a prolonged period of time or an extended referral to a Specialist or a specialty care center for a Member who has a life threatening, degenerative, or disabling condition that requires coordination of care by a Specialist. IEHP and its Delegates must have a system in place to track open, unused; and standing referrals. For more information, please see Policy 14A2, "Standing Referral and Extended Access to Specialty Care " for more information.

D. Second Opinions: IEHP provides for its Members second opinion from a qualified health professional within the network at no cost to the Member or arranges for the Member to obtain a second opinion outside of the network, if services are not available within the network. Refer to Policy 14B, “Second Opinions” for more information.

E. Behavioral Health: Behavioral Health benefits for IEHP DualChoice Members are obtained through the IEHP Behavioral Health Program.

F. Vision Services: Vision is not a Medicare benefit unless specifically for covered lenses post cataract surgery. IEHP DualChoice Members may have additional limited benefits through Medi-Cal.

G. Pharmacy Services: Please refer to the Division of Financial Responsibility (DOFR) in your contract regarding pharmacy services.

H. Supplemental Benefits: Supplemental benefits may vary and are the responsibility of the Health Plan. Please refer to IEHP’s website for a list of current benefits.

I. Communication Services: Delegates must provide access to staff for Members and Providers seeking information about the UM Process and the authorization of care by providing these communication services:
   1. Delegate shall maintain telephone access for Providers to request authorization for healthcare services.
   2. Delegate UM staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. Communications received after normal business hours will be returned on the next business day.
   3. Outbound communication from staff regarding inquiries about UM are made during normal business hours.
   4. Staff identify themselves by name, title, and organization when initiating or returning calls regarding UM issues.
   5. Staff can receive inbound communication regarding UM issues after normal business hours.

58 CA Health & Saf. Code § 1374.16
59 CCI Three-Way Contract September 2019, Section 2.11
60 CA Health & Saf. Code § 1367.01

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6. There is a toll-free TDD/TTY services for Members who are deaf, hard-of-hearing, or speech impaired.

7. Language assistance is available for IEHP Members to discuss UM issues.

J. Rescinding or Modifying Authorization - Any authorization provided by IEHP or its Delegate must not be rescinded or modified after the Provider has already rendered the health care service in good faith pursuant to the authorization.

K. Record Retention: Delegates shall retain information on decisions, i.e., authorizations, denials or partial approvals (modifications) for a minimum period of ten (10) years.61

L. Documentation of Medical Information and Review Decisions: IEHP and its Delegates must base review decisions on documented evidence of medical necessity provided by the attending physician. Regardless of criteria, the Member’s condition must always be considered in the review decision.

1. Physician Documentation: Attending Physicians must maintain adequate medical record information to assist the decision-making process. The requesting Provider must document the medical necessity for requested services, procedures, or referrals and submit all supporting documentation with the request.

2. Reviewer Documentation: Delegate reviewers must abstract and maintain review process information in written format for monitoring purposes. Documentation must be legible, logical, and follow a case from beginning to end. Rationale for approval, modification or denial must be a documented part of the review process. Decisions must be based on clinical information and sound medical judgment with consideration of local standards of care.

3. Documentation: Delegates must have procedures in place to log requests by date and receipt of information so that timeframes and compliance with those timeframes can be tracked. Delegate documentation of authorizations or referrals must include, at a minimum: Member name and identifiers, description of service or referral required, medical necessity to justify service or referral, place for service to be performed or name of referred physician, and proposed date of service. Delegate documentation must also include a written assessment of medical necessity, relevant clinical information, appropriateness of level of care, and the specific criteria upon which the decision was based. Any denial of a proposed service or referral must be signed by the Medical Director, or physician designee.

M. Inpatient Stay: The utilization management process must include:

1. Determining medical necessity.

2. Determining appropriate level of care.

3. Coordinating with hospital Case Manager’s discharge plan.

61 CCI Three-Way Contract September 2019, Section 2.11
25. DELEGATION AND OVERSIGHT

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N. Discharge Planning: The UM process must include the following activities related to discharge planning:⁶²
   1. Determining level of care (SNF, office visit, home health, home without services);
   2. Arranging necessary follow-up care (home health, follow-up PCP or specialty visits, etc); and
   3. Facilitating transfer of the discharge summary and/or medical records, as necessary, to the PCP office.

O. Repatriation: IEHP and its Delegates must assist with the transfer of Members, as medically appropriate, back into the IEHP network.

P. Non-Discrimination: All Members must receive access to all covered services without restriction based on race, color, ethnicity, ethnic group identification, national origin, ancestry, language, religion, sex, age, mental or physical disability or medical condition, gender, gender identity, sexual orientation, claim experience, medical history, claims history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, marital status, or source of payment. Please see Policy 9H3, “Cultural and Linguistic Services – Non-Discrimination” for more information.

Q. Confidentiality: IEHP recognizes that Members’ confidentiality and privacy are protected. It is the policy of IEHP and Delegates to protect the privacy of individual Member health information by permitting UM staff to obtain only the minimum amount of Protected Health Information (PHI) necessary to complete the healthcare function of activity for Member treatment, payment or UM operations.

R. Affirmative Statement Regarding Incentives: UM decisions for Members must be based only on appropriateness of care and service. Delegates do not provide compensation for Practitioners or other individuals conducting utilization review for issuing denials of coverage or service. Delegates ensure that contracts with physicians do not encourage or contain financial incentives for denial of coverage or service. The Affirmative Statement about incentives is distributed annually to all Practitioners, Providers, and employees involved in authorization review, as well as Members.

S. Economic Profiling: Economic profiling is defined as any evaluation performed by the physician reviewer based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician reviewer. Delegates that engage in economic profiling must document the activities and information sources used in this evaluation and ensure that decisions are rendered, unhindered by fiscal and administrative management.⁶³

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⁶² CCI Three-Way Contract September 2019, Section 2.5
⁶³ CA Health & Saf. Code § 1367.02
25. DELEGATION AND OVERSIGHT

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T. Prohibition of Penalties for Requesting or Authorizing Appropriate Medical Care:
   Physicians cannot be penalized in any manner for requesting or authorizing appropriate medical care.

Grievance and Appeals Process

A. IEHP maintains a formal Appeals and Grievance Resolution System to ensure a timely and responsive process for addressing and resolving all Member grievances and appeals. The Member may file an appeal or grievance by phone, by mail, fax, website, or in person. Please refer to Section 16, “Grievance Resolution System”.

Monitoring Activities and Oversight of Delegate

A. IEHP monitors and oversees delegated UM activities performed by the Delegates. The following oversight activities are performed to ensure compliance with IEHP UM and regulatory standards:

1. Delegation Oversight Audits (DOA) – IEHP performs a Delegation Oversight Audit of its Delegates’ UM program and objectives, policies and procedures, activities and their progress. This audit re-assesses the Delegates’ operational capabilities in the areas of UM and other delegated activities. Please refer to Policy 25A1, “Delegation Oversight Audit,” for further details.

2. Analysis of Provider Data Reports – Through its delegation oversight process, IEHP reviews health plan and delegate reports and utilization data including denial and approval universes and letters, Readmissions, annual & semi-annual work plan. Provider reports and utilization data is subsequently reviewed by the Delegation Oversight Committee (DOC).

3. Review of SARAG Approval and Denial Universe Pre-Service Reports and Letters – IEHP and its Delegates are required to submit a monthly Referral Universe from which authorizations are selected for review. Please refer to Policy 25E2, “Utilization Management – Reporting Requirements” for more information.

4. Focused Referral and Denial Audits – IEHP performs focused audits of the referral and denial process for Delegates. Please refer to Policy 25E3, “Referral and Denial Audits.” Audits examine source data at the Delegate to determine referral process timelines and appropriateness of denials and the denial process, including denial letters.

5. Member or Practitioner Grievance Review – IEHP performs review, tracking, and trending of Member or Practitioner grievances and appeals related to UM. IEHP reviews Delegate grievances and recommended resolutions for policies, procedures, actions, or behaviors that could potentially negatively impact Member health care.

6. Joint Operations Meetings (JOMs) – JOMs are intended to provide a forum to discuss issues and ideas concerning care for Members. JOMs are held with Hospitals and

64 Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance,” Section 10.4.3
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Delegates to address specific Provider Services, UM, QM, CM, grievance, study results, or any other pertinent quality issues. These meetings are designed to address issues from an operational level.

7. Satisfaction with the UM Process: At least annually, IEHP performs Member and Provider Experience Surveys as a method for determining barriers to care and/or satisfaction with IEHP processes including UM.

B. Enforcement/Compliance: IEHP monitors and oversees delegated UM activities performed by Delegates. Enforcing compliance with IEHP standards is a critical component of monitoring and oversight of IEHP Providers, particularly related to delegated activities. Delegates that demonstrate a consistent inability to meet standards can be subject to contract termination.
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2. Reporting Requirements

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP maintains the responsibility of ensuring that Delegates continue to be in compliance with all applicable State and federal laws, contractual and reporting requirements.\(^1\)

B. IEHP oversees, monitors and evaluates performance of delegated and non-delegated utilization management activities.\(^2,3\) Oversight activities include but are not limited to the review of these monthly, semi-annual and annual reports.

DEFINITION:

A. Delegate – A medical group, IPA, or any contracted organization delegated to provide utilization management services.

PROCEDURES:

A. Monthly Reporting Requirements:

1. Monthly reports are due to IEHP by the 15\(^{th}\) of the month following the month in which services were approved, denied or partially approved (modified), and include the following:


   b. Denials and Partial Approvals (Modifications) – The Delegate must submit all referral and clinical information, as well as copies of all denial letters from the reporting period. Partial approvals (modifications) occur when a decision is made, and proposed care is denied or altered.

\(^1\) Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.9.
\(^2\) Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance”, Section 10.4.3.
\(^3\) Title 28 California Code of Regulations (CCR) § 1300.70.
25. **DELEGATION AND OVERSIGHT**

E. **Utilization Management**

2. **Reporting Requirements**

1) **Reasons for Denials and Partial Approvals:**

- **Not Medically Necessary** – Does not meet approved nationally recognized criteria or IEHP UM Subcommittee Approved Authorization Guidelines. Please see Policy 25E1, “Utilization Management Delegation and Monitoring” for a list of these criteria.

- **Out-of-Network** – Requested provider is a non-contracted Provider. Out-of-Network requests must be reviewed by a physician and must be considered as a medical necessity decision.

- **Experimental** – Requested service has not been approved by the Food and Drug Administration (FDA) and/or is not an accepted practice in the medical community and/or has not been proven to have a therapeutic benefit.

- **Non-Benefit** – Not a covered benefit.

c. **Approval File Review** – Using the universe reports submitted by the Delegate, IEHP will select ten (10) Approval Files to audit. Delegate submissions of Approval Letters need to include the supporting documentation used to make the decisions. Delegates must submit all required documentation related to the file selections by the 15th day of the following month.

d. **Second Opinion Tracking Log** – Using the Second Opinion Tracking Log, the Delegate must report all authorizations, partial approvals (modifications), and denial information for second opinion requests. The Log must include the reason the second opinion was requested (See Attachment, “Second Opinion Tracking Log” in Section 25).

B. **Semi-Annual Reporting Requirements:**

1. Semi-annual reports are due to IEHP by February 15th and August 15th. The reports should include, at a minimum, the Delegate’s UM goals and activities, trending of utilization activities for under and over utilization, Member and Practitioner satisfaction activities, intrarater reliability activities, and a narrative of barriers and improvement activities. The Semi-Annual report due in February must also include the:

   a. **UM Program Annual Evaluation/ICE Report** - The Delegate’s evaluation of the overall effectiveness of the UM Program, including whether or not goals were met, data, performance rates, barrier analysis, and improvement activities; and

   b. **UM Workplan Update** - Submit an update of the Annual Workplan which includes planned activities for the year, timelines, responsible person(s) and committee(s). The Work Plan should include measurable goals, planned audits, follow-up activities and interventions related to identified problem areas.
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E. Utilization Management
   2. Reporting Requirements

C. Annual Reporting Requirements: The following reports must be submitted annually to IEHP by February 28th of each calendar year:

1. UM Program Description: Reassessment of the UM Program Description must be completed annually by the UM Committee and/or Quality Management (QM) Committee and reported to IEHP including the following:
   a. Any changes made to the UM Program Description during the past year or intended changes identified during the annual evaluation; and
   b. UM Program Description Signature Page.

2. UM Work Plan/Initial ICE Report: Submit an outline of planned activities for the coming year, including timelines, responsible person(s) and committee(s). The Work Plan should include measurable goals, planned audits, follow-up activities and interventions related to identified problem areas.

D. Delegate reports must be received by IEHP electronically using a Secure File Transfer Protocol (SFTP) server.

E. Reports are due on or before the due dates regardless if the due date is a weekend or a holiday.

F. Repeated failure to submit required reports may result in action that includes, but is not limited to, request for Corrective Action Plan (CAP), and may lead to freezing of new Member enrollment, termination or non-renewal of the IEHP Agreement.
25. DELEGATION AND OVERSIGHT

E. Utilization Management
   3. Referral and Denial Audits

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. IEHP maintains the responsibility of ensuring that Delegates continue to be in compliance with all applicable State and federal laws, contractual and reporting requirements.¹
B. IEHP oversees, monitors and evaluates performance of delegated and non-delegated utilization management activities.²,³ Oversight activities include but are not limited to monthly, annual and focused audits.

DEFINITION:

A. Delegate - A medical group, IPA, or any contracted organization delegated to provide utilization management (UM) services.

PROCEDURES:

Monthly Retrospective Audit of Denials and Partial Approvals (Modifications)

A. IEHP performs a monthly retrospective audit of up to thirty (30) denied and partially approved (modified) referrals submitted by the Delegate (See Attachment, “Denial Log Review Tool – IEHP DualChoice” in Section 25).
B. IEHP may request for more denied and partially approved referral files in addition to those submitted monthly by the Delegate.

¹ Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.9
² Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance”, Section 10.4.3
³ Title 28 California Code of Regulations (CCR) § 1300.70
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3. Referral and Denial Audits

D. In order to pass the Monthly Retrospective Audit for Denials and Partial Approvals (Modifications) audit, the Delegate must achieve an overall score of 90%:

1. See the Denial Log Review Tool for a list of Audit Elements (see Attachment, “Denial Log Review Tool – IEHP DualChoice” in Section 25).
2. The overall denial rate must not exceed 5%, which may include non-benefit, out-of-network, medical necessity denials, etc.

E. If the Delegate fails to achieve a Compliance score of 90% for two (2) consecutive months on any of the audit areas above, a Corrective Action Plan (CAP) will be required. At its discretion, IEHP may also enforce one (1) or more of the following:

1. Concurrent denial/partial approval review for a percentage of total denials/partial approvals (modifications) may be initiated at which time the Delegate may receive a score of zero (0) for each month the concurrent review is conducted. IEHP will determine the percentage required for concurrent review;
2. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly audit for two (2) consecutive months;
3. A focused meeting with the Delegate’s administration and IEHP’s leadership;
4. Sanctions may be enforced as outlined in the Delegate’s contract with IEHP under Retrospective Denial Audits; and/or

F. Other actions as recommended by IEHP’s Delegation Oversight Committee.

G. Repeated non-compliance may result in the termination of the Delegate’s contract.

H. Delegates who disagree with the audit score can appeal in writing to the IEHP Senior Medical Director within thirty (30) calendar days after the release of the final audit results.

Denial Letter Sanction Program

A. IEHP applies the Denial Letter Sanction to ensure that denial letters meet CMS standards (See Attachment, “Program Description - Denial Letter Sanction – IEHP DualChoice” in Section 25).

B. The Denial Letter Sanction Program includes the following components:

1. Denial Letters must meet, with 100% accuracy, the below components (See Attachment, “Denial Log Review Tool – IEHP DualChoice” in Section 25);
2. Use of correct letter template including attachments; Member denial language that is understandable (sixth (6th) grade reading level);
3. Denial letter is processed timely, with the inclusion of accurate dates of receipt; and
4. Denial reason is in accordance with appropriate criteria cited and coincides with denial type.
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E. Utilization Management
   3. Referral and Denial Audits

Monthly Retrospective Audit of Approvals

A. IEHP performs a monthly retrospective audit of ten (10) approved referral files selected by IEHP from the SARAG SOD and SARAG EOD universes submitted by the Delegate for the reporting month.

B. IEHP may request for more approved referral files in addition to the ten (10) referral files submitted monthly by the Delegate.

C. IEHP uses the MSSAR and MESAR universes for the monthly retrospective approval audits to evaluate referral timeliness and document the examined referral results (See Attachments, “IEHP Universe Standard Auth MSSAR Data Dictionary,” “IEHP Universe Standard Auth MSSAR Template,” “IEHP Universe Expedited Auth MESAR Data Dictionary,” and “IEHP Universe Expedited Auth MESAR Template” in Section 25).

D. In order to pass the Monthly Retrospective Audit of Approvals, the Delegates must achieve a score of 90% or greater on the Overall Approval File Review (See Attachment, “Approved Referral Audit Tool” in Section 25).

E. If the Delegate fails to achieve a Compliance score of 90% for two (2) consecutive months, a Corrective Action Plan (CAP) will be issued. At its discretion, IEHP may also enforce one (1) or more of the following:
   1. Concurrent approval review for a percentage of total approvals may be initiated at which time the Delegate may receive a score of zero (0) for each month the concurrent review is conducted. IEHP will determine the percentage required for concurrent review;
   2. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly audit for two (2) consecutive months;
   3. A focused meeting with the Delegate’s administration and IEHP’s leadership; and/or
   4. Other action as recommended by the Delegation Oversight Committee.

F. Repeated non-compliance may result in the termination of the Delegate’s contract.

G. Delegates who disagree with the audit score can appeal in writing to the IEHP Senior Medical Director within thirty (30) calendar days after the release of the final audit results.

Delegation Oversight Audit (DOA)

A. IEHP performs an annual onsite Delegation Oversight Audit (DOA) of all Delegates to review their UM process. Please see Policy 25A2, “Delegation Oversight – Audit” and the Delegation Oversight Audit Preparation Instructions (See Attachment, “Delegation Oversight Audit Preparation Instructions – IEHP DualChoice” in Section 25) for more information.

B. UM Process Review Components:
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   3. Referral and Denial Audits

1. IEHP selects, at minimum, fifteen (15) approved/denied/partially approved/cancelled referrals to review. File review will be performed via webinar. The Delegate is responsible for walking IEHP through each referral via the Delegate’s medical management system.

2. IEHP ensures that mechanisms are in place to ensure data integrity.

3. One (1) hour before the audit, the Delegate will be provided with the list of referrals to be reviewed with the exception of the cancelled referrals.

4. IEHP will request details of the process used by the Delegate to ensure ongoing compliance with CMS regulations and Plan policies.

C. In order to pass the UM Referral and Denial audit sections of the DOA, the Delegate must achieve a score of at least 90% on the file review.

D. Delegates that score below 90% on the approved referral and/or denial and partial approval (modification) sections above are required to submit a CAP addressing all deficiencies noted at the audit within a specified timeframe. Delegates who disagree with the audit results can appeal through the IEHP Provider appeals process by submitting an appeal in writing to the IEHP Senior Medical Director within thirty (30) calendar days after the release of the final audit results.

E. Delegates that score 90% may still be required to submit a CAP to address any deficiencies.

F. Audit results are included in the overall annual assessment of Delegates.

Focused Audits

A. Focused audits are conducted under the following circumstances:
   1. Follow-up audit for deficiencies identified from prior audits including but not limited to the DOA and monthly retrospective audit;
   2. Review of approvals, denials and/or partial approvals (modifications) demonstrate that decisions are being made inconsistently, do not appear to be medically appropriate, or are not based on nationally recognized clinical criteria.
   3. Number of Corrective Action Responses (CARs) issued to Delegate as a result of IEHP routine monitoring;
   4. Compliance issues self-reported by the Delegate;
   5. Potential risk areas identified by IEHP (i.e., Member and Provider grievances, appeals);
   6. Number of months IEHP has placed Delegate on concurrent review for specific delegated UM functions;
   7. Significant increase in volume of IEHP assigned Members in the applicable LOB;
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   3. Referral and Denial Audits

   8. A specific inquiry initiated by the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), or Centers of Medicare and Medicaid Services (CMS); and

   9. Any other circumstance that in the judgment of the IEHP Chief Medical Officer or designee requires a focused audit.

B. Prior to the Focused Audit case file review the Delegate must submit the requested universe within the specified timeframe and successfully complete the Universe Integrity Audit:
   1. Five (5) samples are randomly selected by the auditor and provided to the Delegate one (1) hour before the start of the audit webinar.
   2. Each data element or column of the universe must be validated against the Delegate’s medical management system or documentation to ensure the information is consistent and accurate. Inconsistent or inaccurate data must be substantiated; otherwise, the case is considered a fail.
   3. The Delegate must successfully pass three (3) of the five (5) cases selected. A failed Universe Integrity Audit will result in the auditor requesting the Delegate’s resubmission of a corrected universe. Three (3) failed universe resubmissions will result in an audit finding.

C. IEHP is responsible for conducting timeliness tests on identified measures via submitted universes, to ensure the Delegate’s compliance. Timeliness results falling below thresholds will be considered non-compliant and will be noted as a finding in the audit report.

D. IEHP selects thirty (30) cases which consist of approvals, denials and partial approvals (modifications) for the case file review. The cases are provided to the Delegate one (1) hour before the start of the audit webinar. Sample cases are reviewed against defined compliance standards to determine any areas of non-compliance and/or systemic problems within the Delegate’s utilization management process.

E. IEHP will also select five (5) cancelled referrals from the submitted universe to review for appropriateness. The cancelled referrals will not be provided to the Delegate prior to the audit webinar.

F. If IEHP identifies a potential issue during the case file review, additional detail will be required to determine:
   1. If the issue is systemic;
   2. The root cause of the issue; and
   3. How many Members were impacted.

   If the issue negatively impacted (the) Member(s), an Impact Analysis is requested immediately following the case file review to provide the Delegate adequate time to research
and respond while still providing the auditors time to evaluate and influence the findings report.

G. IEHP determines the significance of audit findings based on results of the case review and impact analysis, if applicable. Audit findings can result in an Immediate Corrective Action Required, Corrective Action Required, an Invalid Data Submission, or Observation as described below:

1. **Immediate Corrective Action Required (ICAR)** – An ICAR is the result of a systemic deficiency identified during an audit that is so severe that it requires immediate correction. These types of issues are limited to situations where the identified deficiency resulted in a lack of access to medications and/or services or posed an immediate threat to the Member’s health and safety. ICARs must be immediately addressed or remediated within three (3) business days from receipt of ICAR notification.

2. **Corrective Action Required (CAR)** – A CAR is the result of a systemic deficiency identified during an audit that must be corrected but does not rise to the level of significance of an ICAR. These issues may affect Members but are not of a nature that immediately affects their health and safety. Generally, they involve deficiencies with respect to non-existent or inadequate policies and procedures, systems, internal controls, training, operations or staffing. CARs must be addressed within thirty (30) calendar days from receipt of CAR notification.

3. **Invalid Data Submission (IDS)** – An IDS condition is cited when the Delegate fails to produce an accurate universe within three (3) attempts.

4. **Observations (OBS)** – Observations are identified conditions of non-compliance that are not systemic or represent a “one-off issue”.

H. IEHP will issue the audit findings report which will include the following and any corrective action requests:

1. Executive summary of the audit detailing the audit elements, the audit period, the number of cases reviewed, and the number of cases failed during the Universe Integrity audit (by category);

2. Universe integrity findings by listing noncompliance with instructions for populating each column in the Referral Universe;

3. The results of timeliness testing for each authorization priority level (urgent, routine and retrospective), including the percent of compliance for decision-making, Member notification and Provider notification; and

4. All identified findings (conditions) for each authorization priority level (urgent, routine and retrospective) referencing the specific regulation, accreditation standard or Plan policy found deficient, including specific examples from the case review audit, and the action steps required.
25. DELEGATION AND OVERSIGHT

E. Utilization Management

3. Referral and Denial Audits

I. IEHP will review and approve ICARs and CARs after IEHP determines that CAPs adequately address all the identified deficiencies.

J. IEHP will perform a CAP validation webinar audit to ensure that all CAPs have been implemented per Delegate’s CAP.

K. Once validation is complete, and all findings have been resolved, then IEHP will close out the focused audit CAP and notify the Delegate accordingly. Any unresolved findings will require for the CAP to remain open. At its discretion, IEHP may also enforce one (1) or more of the following:

1. Concurrent denial review for a percentage of total denials may be initiated at which time the Delegate will receive a score of zero (0) for each month the concurrent review is conducted. IEHP will determine the percentage required for concurrent review;

2. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly Focused audit for two (2) consecutive months;

3. A focused meeting with the Delegate’s Administration and IEHP’s leadership; and/or

4. Sanctions may be enforced as outlined in the Delegate’s contract with IEHP under Retrospective Approval and Denial Audits.

INLAND EMPIRE HEALTH PLAN

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25. DELEGATION AND OVERSIGHT

F. Encounter Data Reporting

1. Medicare MMP Reporting Requirements – IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)

APPLIES TO:

A. This policy applies to IPAs contracting with IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan).

POLICY:

A. IEHP contractually requires IPAs to submit all Medicare – Medicaid Plan (MMP) Core and California-Specific reports according to the IEHP DualChoice MMP Core and California-Specific Measures Reporting Schedule. All IPAs must meet timeliness and accuracy for all MMP Core and California-Specific reporting requirements, as outlined in the most current MMP Core and California-Specific Measures Reporting Requirements document.

PURPOSE:

A. IPAs are required to submit this data to enable IEHP to comply with regulatory reporting requirements.

PROCEDURES:

A. IPAs are required to provide the MMP Core and California-Specific data elements that are reported to the Centers for Medicare and Medicaid Services (CMS) on a pre-determined schedule. IPAs must submit IEHP DualChoice data for all MMP Core measures and California-Specific measures as follows:

1. MMP Core Reporting Requirements (See Attachment, “2020 MM Capitated Financial Alignment Model Reporting,” in Section 25).
2. California-Specific Reporting Requirements (See Attachment, “California Specific Reporting Requirements,” in Section 25).

B. IPAs must submit via IEHP’s Secure File Transfer Protocol (SFTP) the required report using the appropriate naming convention on a monthly, quarterly, semi-annual and/or annual basis (See Attachment, “Medicare Provider Reporting Requirements Schedule” in Section 25).

C. IPAs must provide complete and accurate data submissions for each element requested for each reportable measure. Details for the Universe template layouts are available as follows:

2. Attachment, “IEHP Universe Standard Auth MSSAR Data Dictionary” in Section 25; and
25. DELEGATION AND OVERSIGHT

F. Encounter Data Reporting
   1. Medicare MMP Reporting Requirements – IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)

D. For each reportable measure, IPAs must use the provided reporting template that supports the required reporting elements:
   1. Reporting Template - The report includes aggregate metrics supporting each element specified for each measure (See Attachments, “Care Transition Cases Log,” “IEHP Universe M_Claims Template”, “IEHP Universe Standard Auth MSSAR Template,” “IEHP Universe Expedited Auth MESAR Template,” “Monthly Medicare Care Management Log,” “Monthly Medicare Care Plan Outreach Log” and “Enrollee Protections Report Template” in Section 25).

E. If CMS releases revised MMP Core and/or California-Specific Reporting specifications for the measures requested during the reportable calendar year, IPAs must re-submit reports using reporting templates with the most current reporting specifications. IEHP may re-issue a revised template if necessary. Resubmissions must be complete within IEHP-defined timelines. IEHP and the IPAs must comply with all CMS reporting formats and timeframes.

F. Any questions IPAs have regarding CMS MMP Core or California-Specific reporting requirements should be communicated through the IEHP’s Delegation Oversight Department.

G. IEHP works with each Delegate to ensure that any identified problem areas are corrected in a timely manner. Additionally, when a report and/or data file is not submitted to IEHP by the due date, IEHP requests a Corrective Action Plan (CAP) from the Delegate to remedy the problem, see Policy 25A4, "Delegation Oversight - Corrective Action Plan Requirements."

H. Failure to submit MMP Core and/or California-Specific Reports that meet IEHP’s submission requirements for Timeliness and Accuracy may result in IEHP deducting one percent, unless successfully appealed, of the Delegate’s monthly capitation for reports that fails to meet Timeliness and Accuracy reporting requirement.

ATTACHMENTS (SEE IN SECTION 25):

A. Care Transition Cases Log (TOC Log)
B. Care Coordinator to Member Ratio Template (5.1)
C. IEHP Universe M_Claims Template
D. Monthly Medicare Care Management Log
E. Enrollee Protections Report Template, CA2.1
F. Care Coordinator Training for Supporting Self-Direction
G. Medicare Provider Reporting Requirements Schedule
H. California Specific Reporting Requirements
25. DELEGATION AND OVERSIGHT

F. Encounter Data Reporting
   1. Medicare MMP Reporting Requirements – IEHP
      DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)

I. Monthly Medicare Care Plan Outreach Log
25. DELEGATION AND OVERSIGHT

F. Encounter Data Reporting
   2. Medicare DualChoice Data Sharing Program

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Delegates and Providers.

POLICY:

A. Delegates are required to have a process to receive and act on all information sent to them from IEHP for purposes of supporting Member care coordination activities.

B. Each IPA and subcontractor agree to share with IEHP available supplemental data related to Healthcare Effectiveness Data and Information Set (HEDIS®), STARS, Cal MediConnect Quality Withhold Measures, Risk Adjustment and other Quality Management and Quality Improvement Activities.

DEFINITION:

A. Delegate – For the purpose of this policy, a delegate is defined as a medical group, Health Plan, IPA, or any contracted organization delegated to maintain and/or provide QM programs and activities.

PROCEDURES:

A. IEHP provides IPAs and Provider Subcontractors, Member information that supports Care Coordination activities for its Members, specifically;
   1. Completed Health Risk Assessment (HRA) data;
   2. Care Management Care Plans (if applicable);
   3. Care Management Program Details;
   4. Open Authorizations;
   5. Medicare Hierarchical Condition Categories (HCC) information;
   6. Monthly Membership Report (MMR) and MOR (Model Output Report) data files;
   7. Annual Model Output Report Final (MORF);
   8. Supplemental Data (e.g. Healthcare Effectiveness Data and Information Set (HEDIS®), Risk Adjustment Processing System (RAPS), lab results, pharmacy claims data);
   9. Eligibility;
   10. Encounters;
   11. Capitation; and
25. DELEGATION AND OVERSIGHT

F. Encounter Data Reporting

2. Medicare DualChoice Data Sharing Program

12. Historical Utilization (e.g., Historical claims for assigned IEHP DualChoice Cal MediConnect (Medicare-Medicaid) Members, Medi-Cal Fee-For-Service Claims, Medicare Part A, Part B and Part D data and In-Home Supportive Services (IHSS) Payment Data).

B. On a daily basis, IEHP will provide a file of all newly completed initial HRAs to the IPAs for their assigned IEHP DualChoice Members via the secure IEHP Provider web portal.

C. On a weekly basis, IEHP will provide a file of all newly completed annual reassessment HRAs to the IPAs for their assigned IEHP DualChoice Members via the secure IEHP Provider web Portal.

D. On a monthly basis, IEHP will provide the IPA the following Care Management information on all newly transitioned Members from IEHP-Direct:
   1. Most current HRA completed survey (if applicable); and
   2. Most current and up-to-date Care Plan (if applicable).

   The IPA is required to review this information and assess the Member’s needs for continued support from the IPA’s Care Management program/s.

E. On a monthly basis, IEHP will provide a listing of all open authorizations for Members newly transitioned from IEHP Direct into an IPA. This information is transmitted via IEHP’s Secure File Transfer Protocol (SFTP).

F. On a monthly basis, IEHP provides a roster of all Members due for preventive care services or who have gaps in care based on the IEHP Quality Improvement program via the secure IEHP Provider web portal. This information should be reviewed and incorporated into the IPAs Quality Improvement program activities/work plan.

G. During the first week of each month, IEHP will provide a listing of all CMS-stored HCC Member Information Profile report information related to Members who newly transitioned from IEHP Direct to an IPA (including the MMR, MOR, Annual MORF and RAPS Return Files) via SFTP. This information should be reviewed and incorporated into the IPA’s HCC program activities/annual work plan.

H. During the first week of each month, IEHP will provide HCC Member Information Profile reports for all Members assigned to the IPA via SFTP. This information should be reviewed and incorporated into the IPAs HCC program activities/work plan.

I. On a monthly/weekly basis, IEHP will provide a listing of assigned membership. This information will be transmitted via SFTP.

J. On a monthly/weekly/daily basis, IEHP will provide a summary of encounters submitted to the health plan via SFTP.

K. On a monthly basis, IEHP will provide capitation information for the prior month. This information will be transmitted via SFTP.
25. DELEGATION AND OVERSIGHT

F. Encounter Data Reporting

2. Medicare DualChoice Data Sharing Program

L. On a monthly basis, IEHP will provide historical claims for assigned Cal MediConnect Members, Medi-Cal FFS claims, Medicare Part A, Part B and Part D data and IHSS payment data. This information will be transmitted via SFTP.

M. On a semi-annual basis (or more frequently), the IPA will share with IEHP any supplemental data to support HEDIS®, Quality Withhold, Risk Adjustment or any other Quality Improvement Activities.

1. The type, format, mode of transmission and frequency of this supplemental data sharing will be mutually agreed-upon by both the IPA and IEHP. IEHP will accept the approved ICE (Industry Collaboration Effort) Alternative Submission Method (ASM) data file template in lieu of a RAPS submission. Additionally, the IPA will also be required to submit an encounter for each DOS submitted on the ASM file [http://iceforhealth.org].

2. For HCC supplemental data sharing, the format of HCC supplemental data files must be approved by IEHP prior to submission for RAPS processing. The IPA must submit any additional validated HCC data following CMS Risk Adjustment data submission timelines (e.g., CMS Sweeps). To process data files prior to the CMS Sweeps deadline, all data files should be submitted to IEHP according to the following Sweeps timeline:

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INLAND EMPIRE HEALTH PLAN

Chief Approval: Signature on File | Original Effective Date: July 1, 2014
Chief Title: Chief Medical Officer | Revision Date: January 1, 2021
### 25. DELEGATION AND OVERSIGHT

**Attachments**

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## 25. DELEGATION AND OVERSIGHT

Attachments

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Attachment I – Statement of Agreement by Supervising Provider
MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
REPORTING REQUIREMENTS

Effective as of January 1, 2020; Issued November 1, 2019
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INTRODUCTION

The Medicare-Medicaid Financial Alignment Initiative is designed to test innovative models to better align Medicare and Medicaid financing and the services provided to Medicare-Medicaid enrollees.

The purpose of this document is to provide Medicare-Medicaid Plans (MMPs) with the reporting requirements for the capitated financial alignment model. It provides technical specifications to help assure a common understanding of the data to be reported by MMPs, to assist MMPs in preparing and submitting datasets, to ensure a high level of accuracy in the data reported to the Centers for Medicare & Medicaid Services (CMS) and the states, and to reduce the need for MMPs to correct and resubmit data.

The reporting requirements document is divided into three sections. The first section lists all Medicare Part C Reporting Requirements the MMPs are responsible for submitting via the Health Plan Management System (HPMS). The second section lists all Medicare Part D Reporting Requirements the MMPs are responsible for submitting via HPMS. Upon Office of Management and Budget (OMB) approval, MMPs are required to report these measures according to the existing specifications and must comply with the Part C and Part D data validation requirements.

The third section consists of the MMP-specific Core Reporting Requirements for the capitated financial alignment model. Specifications for these demonstration measures indicate their reporting frequency and due dates. MMPs are also required to comply with validation requirements for MMP-specific measures.

Measures should be reported at the contract level, unless otherwise indicated.

Definitions

The following terms are used throughout the document:

Medicare-Medicaid Plan (MMP): An MMP is a managed care plan that has entered into a three-way contract with CMS and the state in which the plan will operate. Note: some demonstrations might use different terms to refer to their plans, such as One Care plans in Massachusetts.

State: The state with which the MMP has contracted.

Health Plan Management System (HPMS): The CMS centralized information system used by MMPs to submit Part C, Part D, and MMP-specific core measure data.

Calendar Quarter: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year will be as follows: 1/1 – 3/31, 4/1 – 6/30, 7/1 – 9/30, and 10/1 – 12/31.

Calendar Year: All annual measures are reported on a calendar year basis.
Passive Enrollment and Stopping Enrollment

Under the capitated financial alignment model, demonstrations may allow for passive enrollment. During passive enrollment, MMPs must demonstrate adequate performance across a range of measures to remain eligible to receive passive enrollment of beneficiaries. Failure to adequately meet any single measure or set of measures may result in CMS and the state ceasing enrollment. CMS and each state, through the Contract Management Team (CMT), will have the option to discontinue passive enrollment for MMPs for various reasons, including for MMPs failing to completely and accurately report measures or to adequately meet performance standards.

Quality Withhold Measures

CMS and each state will establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, CMS core quality withhold measures are marked with the following symbol for Demonstration Year 1: (I) and the following symbol for Demonstration Years 2 through 8: (II). Note that additional CMS core quality withhold measures are reported through other vehicles or venues, such as HEDIS® and CAHPS®. Any state-specific exceptions to the CMS core quality withhold measures, along with definitions of Demonstration Years, are noted in the state-specific quality withhold appendices. Additional information on the withhold methodology can be found at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html.

Reporting on Passively Enrolled and Opt-In Enrolled Members

When reporting all measures, MMPs should include all members who meet the criteria for inclusion in the measure, regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.

Reporting on Disenrolled and Retro-disenrolled Members

Unless otherwise indicated in the reporting requirements, MMPs should report on all members enrolled in the demonstration who meet the definition of the data elements, regardless of whether that member was subsequently disenrolled from the MMP. Measure-specific guidance on how to report on disenrolled members is provided under the Notes section of each MMP-specific core measure.

Due to retro-disenrollment of members, there may be instances where there is a lag between a member’s effective disenrollment date and the date on which the MMP is informed about that disenrollment. This time lag might create occasional data

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1 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
inaccuracies if an MMP includes members in reports who had in fact disenrolled before the start of the reporting period. If MMPs are aware at the time of reporting that a member has been retro-disenrolled with a disenrollment effective date prior to the reporting period (and therefore was not enrolled during the reporting period in question), then MMPs may exclude that member from reporting. Please note that MMPs are not required to re-submit corrected data should they be informed of a retro-disenrollment subsequent to a reporting deadline. MMPs should act upon their best and most current knowledge at the time of reporting regarding each member’s enrollment status.

Data Submission
All MMPs will submit core measure data in accordance with the guidance in these reporting requirements. Submission requirements vary by measure, but most core measures are reported through HPMS.

Please note, late submissions may result in compliance action from CMS.

Resubmission of MMP-Specific Core Measure Data to HPMS
MMPs must comply with the following steps to resubmit data for MMP-specific core measures after an established due date:

1. Email the applicable NORC HelpDesk to request resubmission.
   a. Specify in the email which measure(s) need resubmission;
   b. Specify for which reporting period(s) the resubmission is needed; and
   c. Provide a brief explanation for why the data need to be resubmitted.

2. After review of the request, the NORC HelpDesk will notify the MMP that the resubmission can be completed.

3. Resubmit data through HPMS.

4. Notify the NORC HelpDesk again after resubmission has been completed.

Please note, requests for resubmission after an established due date may result in compliance action from CMS.
MEDICARE PART C REPORTING REQUIREMENTS

MMPs are required to report the following Part C reporting sections according to existing reporting requirements and technical specifications, which can be found on the CMS website at: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html

Section VI. Rewards and Incentives Programs

Section VII. Payments to Providers
MEDICARE PART D REPORTING REQUIREMENTS

MMPs are required to report the following Part D reporting sections according to existing reporting requirements and technical specifications, which can be found on the CMS website at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_ReportingOversight.html

Section II. Medication Therapy Management Programs

Section III. Grievances

Section IV. Improving Drug Utilization Review Controls

Section V. Coverage Determinations and Redeterminations
MMP-SPECIFIC CORE REPORTING REQUIREMENTS

Introduction

The Core Reporting Requirements section consists of measures developed for all capitated financial alignment demonstrations. State-specific appendices capture the reporting requirements specific to each state’s demonstration. The core and state-specific measures supplement existing Medicare Part C and Part D Reporting Requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS®, HOS, CAHPS® and state Medicaid agencies. In addition, CMS and the states will track key utilization measures, which are not included in this document, using encounter and claims data. The quantitative measures are part of broader oversight, monitoring, and performance improvement processes that include several other components and data sources not described in this document.

Value Sets

The measure specifications in this section refer to code value sets that must be used to determine and report measure data element values. A value set is the complete set of codes used to identify a service or condition included in a measure. The Core Value Sets Workbook includes all value sets and codes needed to report certain MMP-specific measures included in the Core Reporting Requirements and is intended to be used in conjunction with the measure specifications outlined in this document. The Core Value Sets Workbook can be found on the CMS website at the following address: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html

Reporting Phases

There are three distinct types of reporting phases for demonstration measures: “Implementation,” “Ongoing,” and “Continuous Reporting.”

The Implementation phase corresponds with the initial months of the demonstration and will be further defined in the Introduction section of each state-specific appendix. Monitoring will be more intensive during this phase to allow CMS and the state to quickly become aware of any performance or access issues. MMPs will report measures on the Implementation reporting timeline during the Implementation phase only.

The Ongoing phase begins at the inception of the demonstration and continues for the life of the demonstration. MMPs will report measures on the Ongoing reporting timeline during the Ongoing phase. Note: Measures that have both an Implementation and Ongoing phase should be reported concurrently (e.g., Core Measure 2.1, Members with

2 HEDIS® is a registered trademark of NCQA. CAHPS® is a registered trademark of AHRQ.
an assessment completed within 90 days of enrollment). MMPs will cease reporting on the Implementation reporting timeline once the Implementation phase is complete. Some measures do not include an Ongoing phase, meaning data are collected only during the Implementation phase.

Continuous Reporting measures will be reported at the same frequency for the duration of the demonstration. The first reporting period for these measures coincides with the first reporting period of the Ongoing and Implementation phases.

Reporting timelines are defined in terms of calendar days, not business days. If a reporting due date for any core measure falls on a weekend or a federal holiday, MMPs may submit data on the following business day. Table 1 and Table 2 below are examples of reporting timelines that will be found throughout this section. The introduction of each state-specific appendix provides tables describing each state’s Implementation, Ongoing, and Continuous Reporting periods.

Table 1. Sample Implementation and Ongoing Reporting Timeline

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<td>Example</td>
<td>Monthly, beginning after 90 days</td>
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<td>Quarterly</td>
<td>Contract</td>
<td>Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31</td>
<td>By the end of the second month following the last day of the reporting period</td>
</tr>
</tbody>
</table>
Table 2. Sample Continuous Reporting Timeline

<table>
<thead>
<tr>
<th>Reporting Section</th>
<th>Reporting Frequency</th>
<th>Level</th>
<th>Reporting Periods</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>Quarterly</td>
<td>Contract</td>
<td>Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31</td>
<td>By the end of the second month following the last day of the reporting period</td>
</tr>
</tbody>
</table>

**Measure Specifications**

Each measure specification includes information regarding the following subjects:

A. **Data Element Definitions** – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

B. **QA Checks/Thresholds** – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

C. **Edits and Validation Checks** – validation checks that should be performed by each MMP prior to data submission.

D. **Analysis** – how CMS will evaluate reported data, as well as how other data sources may be monitored.

E. **Notes** – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

F. **Data Submission** – how MMPs will submit data collected to CMS and the state.
Section I. Access

1.1 Claims (excluding pharmacy point-of-sale [POS]) denied during the first 90 days of enrollment with the MMP, by reason for denial. – Retired

1.2 Pharmacy point-of-sale (POS) claims denied during passive enrollment, by reason for denial.

<table>
<thead>
<tr>
<th>IMPLEMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Section</td>
</tr>
<tr>
<td>1. Access</td>
</tr>
</tbody>
</table>

The list of pharmacy POS denied claims will be limited to claims denied for the following reasons: non-formulary, prior authorization, and step therapy. A template for providing these claims is located on the CMS website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPIInformationandGuidance/MMPReportingRequirements.html

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

- Required file format is Microsoft Excel file.
- The file name extension should be “.xlsx”
- File name= RX_(STATEABBREVIATION)_(CONTRACTID)_(REPORTING PERIOD)_(SUBMISSIONDATE).xlsx.
• Replace (STATEABBREVIATION) with the two-character state abbreviation (e.g., Massachusetts is MA), (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the month and year of the beginning of the reporting period in YYYYMM format (e.g., January 2020 would be 202001), and (SUBMISSIONDATE) with the year, month, and day of the submission in YYYYMMDD format (e.g., January 17, 2020 would be 20200117).

• The first worksheet in the template should be named “Rejected Claims.”

• The second worksheet in the template should be named “Key Acronyms.”

• The third worksheet in the template should be named “Addl Reject Codes_Pharmacy Msgs.”

### File Layout

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Field Description</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>HICN</td>
<td>Health insurance claim number (HICN) refers to the number assigned by the Social Security Administration to an individual for the purpose of identifying him/her as a Medicare beneficiary. HICN will be shown in the beneficiary’s insurance card and it is on the basis of this number that a beneficiary’s Medicare claims are processed.</td>
<td>Field Type: Alpha-numeric</td>
</tr>
<tr>
<td>Member Enrollment Date</td>
<td>Identifies the date that each member enrolled. Enrollment eligibility begins on the 1st of the month. If a member has a gap in coverage, provide the most recent enrollment date.</td>
<td>Field Type: Date in MM/DD/YYYY format</td>
</tr>
<tr>
<td>Member Disenrollment Date</td>
<td>Identifies the date that each member disenrolled. Eligibility continues through the last day of the month that the member disenrolls.</td>
<td>Field Type: Date in MM/DD/YYYY format</td>
</tr>
<tr>
<td>Cardholder ID</td>
<td>Insurance ID assigned to the cardholder or identification number used by the MMP. May be the same as HICN.</td>
<td>Field Type: Alpha-numeric</td>
</tr>
<tr>
<td>Field Name</td>
<td>Field Description</td>
<td>Allowable Values</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>CCN</td>
<td>Claim Control Number (CCN). A claim control number is a unique number given to each claim.</td>
<td>Field Type: Alphanumeric</td>
</tr>
<tr>
<td>CMS Contract ID</td>
<td>Designation assigned by CMS that identifies a specific sponsor.</td>
<td>Field Type: Alphanumeric</td>
</tr>
<tr>
<td>Plan Name</td>
<td>Plan Name</td>
<td>Field Type: Text</td>
</tr>
<tr>
<td>NDC 11 (no hyphens)</td>
<td>National Drug Code Drug products are identified and reported using a unique, three-segment number, called the National Drug Code (NDC), which serves as a universal product identifier for drugs. FDA publishes the listed NDC numbers and the information submitted as part of the listing information in the NDC.</td>
<td>Field Type: Numeric Note: 11-digit NDC code with no hyphens</td>
</tr>
<tr>
<td>Date of Service</td>
<td>Identifies date the prescription was filled. This date may be outside the reporting period as long as the associated Date of Rejection is after the Date of Service.</td>
<td>Field Type: Date in MM/DD/YYYY Format</td>
</tr>
<tr>
<td>Date of Rejection</td>
<td>Identifies the date the claim was rejected. The Date of Rejection must occur during the reporting period.</td>
<td>Field Type: Date in MM/DD/YYYY Format</td>
</tr>
<tr>
<td>Claim Quantity</td>
<td>Quantity dispensed expressed in metric decimal units.</td>
<td>Field Type: Numeric Allowable Values: &gt;0</td>
</tr>
<tr>
<td>Claim Days Supply</td>
<td>Estimated number of days the prescription will last.</td>
<td>Field Type: Numeric Allowable Values: &gt;0; &lt; 999</td>
</tr>
<tr>
<td>Compound Code</td>
<td>Code indicating whether or not the prescription is a compound.</td>
<td>Field Type: Numeric Allowable Values: 0 = not specified 1 = not a compound 2 = compound</td>
</tr>
<tr>
<td>Rejection Category (1=NF, 2=PA, 3=ST)</td>
<td>Rejection Category: Use category 1 if the rejection is for Non-Formulary drug. Use category 2 if the rejection is for Prior Authorization. Use category 3 if the rejection is for Step Therapy.</td>
<td>Field Type: Numeric Allowable Values: 1=Non-Formulary 2=Prior Authorization 3=Step Therapy</td>
</tr>
<tr>
<td>Field Name</td>
<td>Field Description</td>
<td>Allowable Values</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Reject Code 1</td>
<td>Reject code used in MMP’s claim adjudication system.</td>
<td>Field Type: Alphanumeric</td>
</tr>
<tr>
<td>Pharmacy Message 1</td>
<td>Reject Message used in MMP’s claim adjudication system.</td>
<td>Field Type: Text</td>
</tr>
<tr>
<td>Reject Code 2</td>
<td>Reject code used in MMP’s claim adjudication system.</td>
<td>Field Type: Alphanumeric</td>
</tr>
<tr>
<td>Pharmacy Message 2</td>
<td>Reject Message used in MMP’s claim adjudication system.</td>
<td>Field Type: Text</td>
</tr>
<tr>
<td>Reject Code 3</td>
<td>Reject code used in MMP’s claim adjudication system.</td>
<td>Field Type: Alphanumeric</td>
</tr>
<tr>
<td>Pharmacy Message 3</td>
<td>Reject Message used in MMP’s claim adjudication system.</td>
<td>Field Type: Text</td>
</tr>
<tr>
<td></td>
<td><em><strong>MMP must provide all reject codes and messaging, not limited to the number of fields in the “Rejected Claims” template. Please insert columns in the “Addl Reject Codes_Pharmacy Msgs” template as necessary.</strong></em></td>
<td></td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Field Name</th>
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<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reject Code 1</td>
<td>Reject code used in MMP’s claim adjudication system.</td>
<td>Field Type: Alphanumeric</td>
</tr>
<tr>
<td>Pharmacy Message 1</td>
<td>Reject Message used in MMP’s claim adjudication system.</td>
<td>Field Type: Text</td>
</tr>
<tr>
<td>Reject Code 2</td>
<td>Reject code used in MMP’s claim adjudication system.</td>
<td>Field Type: Alphanumeric</td>
</tr>
<tr>
<td>Pharmacy Message 2</td>
<td>Reject Message used in MMP’s claim adjudication system.</td>
<td>Field Type: Text</td>
</tr>
<tr>
<td>Reject Code 3</td>
<td>Reject code used in MMP’s claim adjudication system.</td>
<td>Field Type: Alphanumeric</td>
</tr>
<tr>
<td>Pharmacy Message 3</td>
<td>Reject Message used in MMP’s claim adjudication system.</td>
<td>Field Type: Text</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- An audit of a sample of claims will be performed. Claims not excluded from the analysis will be flagged as “potentially inappropriate.” A sample of up to 30 potentially inappropriate claims will be selected for further review, including; protected class drugs and non-protected class drugs. If at least 15 protected and 15 non-protected class drugs are submitted, 15 protected and 15 non-protected class drugs will be sampled. If fewer than 15 claims are submitted in either drug class, additional claims from the opposing drug class will be selected, until a sample of 30 is reached (e.g., 13 protected and 17 non-protected drugs). If the MMP submits fewer than 30 rejected claims, the sample will consist of all submitted rejected claims. MMPs will be required to review claims and address the following:
  o Was the claim an appropriate rejection? (Y/N).
  o Patient setting (e.g., nursing facility, acute care hospital, etc.).
  o Patient DOB.
  o Provide a brief explanation as to why the claim was appropriate or inappropriate, related to one of the three rejection categories.
Was the claim paid? (Y/N).
If the claim was paid, provide the date the claims was paid for the drug in question.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission. Any claims that do not pass validation will be excluded from the analysis. These checks will include the following:

- The CMS Contract ID is formatted as 5 alpha-numeric characters.
- The CMS Contract ID matches the submitting Contract ID.
- The NDC consists of 11 numeric characters.
- The NDC is a valid NDC.
- The Date of Service is in the MM/DD/YYYY format.
- The Date of Rejection is in the MM/DD/YYYY format.
- The Date of Rejection is during the reporting period.
- The Date of Rejection is on or after the Date of Service.
- The Rejection Category is 1, 2, or 3.
- The Claim Quantity is greater than zero.
- The Claim Days Supply is greater than zero.
- The Claim Days Supply is between 1 and 3 numeric characters (1-999).

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will calculate an overall score once MMPs have reviewed and provided comments.
- For all class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims sampled (denominator) to calculate an overall rate of inappropriate denials.
- For protected class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims for protected class drugs sampled (denominator) to calculate an overall rate of inappropriate denials.
- For non-protected class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims for non-protected class drugs sampled (denominator) to calculate an overall rate of inappropriate denials.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definitions

- This measure assesses only the following three denial types: non-formulary, prior authorization, and step therapy.
  - Non-formulary drugs are drugs that are not on an MMP’s formulary.
  - Prior Authorization is defined as approval that a member must get from the MMP before filing a prescription in order for the MMP to cover the
prescription. The MMP may require prior authorization for certain drugs.

- **Step Therapy** is a coverage rule used by some MMPs that requires a member to try one or more similar, lower cost drugs to treat their condition before the MMP will cover the prescribed drug.

**Reporting Period Guidance**

- The reporting period for this measure will begin at the start of the passive enrollment period. Once reporting begins, members should be included regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Passive enrollment periods may vary by state. MMPs should refer to their state’s three-way contract for specific requirements.
- Reporting timelines are defined in terms of calendar days, not business days. If a reporting due date for Core Measure 1.2 falls on a weekend or holiday, MMPs may submit data on the following business day.

**POS Claims Guidance**

- MMPs should include all denied claims including adjusted and reprocessed claims, even if repeated claims are attempted on the same day.
- Denials ensuing from requests for early refills should be excluded.

**Additional Submissions**

- CMS reserves the right to extend the reporting frequency after the first wave of passive enrollment, if necessary.
- Subsequent 14-day submissions may be necessary for MMPs that meet or exceed the threshold or have an insufficient sample size. MMPs will receive an MMP-specific report indicating whether an MMP passed, failed, or had an insufficient sample size following the full 28-day period.
  - Any MMP that failed or had an insufficient sample size must undergo another round and must submit data during the next wave of passive enrollment (unless otherwise directed by the CMT).
  - For MMPs in states with monthly passive enrollment, the MMP must report the last 14 days of the next month of passive enrollment (i.e., days 14 through 28).
  - For MMPs with passive enrollment that is not month to month, the MMP must submit the first 14 days of the next wave of passive enrollment.
- MMPs that pass the first 28-day period will not need a subsequent round of review.

**F. Data Submission – how MMPs will submit data collected to CMS and the state.**

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:
  
Section II. Assessment

2.1 Members with an assessment completed within 90 days of enrollment.¹

<table>
<thead>
<tr>
<th>Reporting Section</th>
<th>Reporting Frequency</th>
<th>Level</th>
<th>Reporting Periods</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Assessment</td>
<td>Monthly during the implementation period, beginning after 90 days of implementation</td>
<td>Contract</td>
<td>Current Calendar Month Ex: 1/1 – 1/31</td>
<td>By the end of the month following the last day of the reporting period Ex: Demo implementation is January 1, 2020; 90 days after enrollment is March 31, 2020; the first report is due by April 30, 2020.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reporting Section</th>
<th>Reporting Frequency</th>
<th>Level</th>
<th>Reporting Periods</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Assessment</td>
<td>Quarterly</td>
<td>Contract</td>
<td>Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31</td>
<td>By the end of the second month following the last day of the reporting period</td>
</tr>
</tbody>
</table>
A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.</td>
<td>Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.</td>
<td>Field type: Numeric</td>
</tr>
<tr>
<td>B</td>
<td>Total number of members who were documented as unwilling to participate in the assessment within 90 days of enrollment.</td>
<td>Of the total reported in A, the number of members who were documented as unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment.</td>
<td>Field Type: Numeric Note: Is a subset of A. Unwillingness to participate must be clearly documented.</td>
</tr>
<tr>
<td>C</td>
<td>Total number of members the MMP was unable to reach, following three documented outreach attempts, to participate in the assessment within 90 days of enrollment.</td>
<td>Of the total reported in A, the number of members the MMP was unable to reach, following three documented outreach attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment.</td>
<td>Field type: Numeric Note: Is a subset of A. Three outreach attempts must be clearly documented.</td>
</tr>
<tr>
<td>D</td>
<td>Total number of members with an assessment completed within 90 days of enrollment.</td>
<td>Of the total reported in A, the number of members with an assessment completed within 90 days of enrollment.</td>
<td>Field type: Numeric Note: Is a subset of A. Completed assessments must be clearly documented.</td>
</tr>
</tbody>
</table>
B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that the sum of data elements B, C, and D is less than or equal to data element A.
- MMPs should validate that members included in data element A were enrolled for at least 90 days and the 90th day of enrollment occurred within the reporting period.
- MMPs should validate that members included in data element A were enrolled as of the last day of the reporting period.
- MMPs should validate that members included in data element B were included in data element A.
- MMPs should validate that members included in data element C were included in data element A.
- MMPs should validate that members included in data element D were included in data element A.
- MMPs should validate that members reported in data element B were not reported in data elements C or D.
- MMPs should validate that members reported in data element C were not reported in data elements B or D.
- MMPs should validate that members reported in data element D were not reported in data elements B or C.
- MMPs should validate that members reported in data element B were clearly documented as unwilling to participate in the assessment within 90 days of enrollment.
- MMPs should validate that members reported in data element C had three outreach attempts clearly documented within 90 days of enrollment.
- MMPs should validate that members reported in data element D had a completed assessment clearly documented within 90 days of enrollment.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members who:

- Were documented as unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment.
  - Percentage = \( \frac{B}{A} \times 100 \)
- The MMP was unable to reach, following three documented outreach attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment.
  - Percentage = \( \frac{C}{A} \times 100 \)
• Had an assessment completed within 90 days of enrollment.
  o Percentage = (D / A) * 100
• Were willing to participate and who could be reached who had an assessment completed within 90 days of enrollment.
  o Percentage = (D / (A – B – C)) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

• MMPs should only include those members who are currently enrolled as of the last day of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the MMP.
• The 90th day of enrollment should be based on each member’s most recent effective enrollment date in the MMP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment with no gaps in enrollment.
• For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months. The 90th day of enrollment will always occur on the last day of the third month following a member’s effective enrollment date.
  o When reporting quarterly results for Ongoing reporting periods, MMPs should report all members who reached their 90th day of enrollment at any point during the three months included in the quarter (e.g., members enrolled on May 1, June 1, and July 1 reached their 90th day of enrollment during the third quarter; therefore, these members should be included in Ongoing reporting for the third quarter as long as they were still enrolled on the last day of the reporting period).

Data Element B

• For data element B, MMPs should report the number of members who were documented as unwilling to participate in the assessment if a member (or his or her authorized representative):
  o Affirmatively declines to participate in the assessment, affirmatively declines care management activities overall, or refuses any contact with the MMP. The member may communicate the declination or refusal by phone, mail, fax, or in person. The declination or refusal must be documented by the MMP.
  o Expresses willingness to complete the assessment but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the assessment within 90 days). Discussions with the member must be documented by the MMP.
  o Schedules an appointment to complete the assessment but cancels or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
Initially agrees to complete the assessment, but then declines to answer a majority of the questions in the assessment. The declination must be documented by the MMP.

- If a member was not reached after three outreach attempts, but then subsequently is reached and refuses the assessment within 90 days of enrollment, the member should be classified in data element B.

**Data Element C**

- For data element C, MMPs should report the number of members the MMP was unable to reach after three documented attempts to contact the member. MMPs should refer to their state’s three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (e.g., phone, mail, or email), as CMS and the state may validate this number. If less than three outreach attempts are made to the member within 90 days of enrollment, the member should not be included in data element C.
  - Note that the applicable three-way contract may require more than three outreach attempts. MMPs must continue to follow such contract requirements; however, for purposes of reporting this measure, MMPs may count a member under data element C following three outreach attempts.

- There may be instances when the MMP has a high degree of confidence that a member’s contact information is correct, yet that member is not responsive to the MMP’s outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for data element C.

**Data Element D**

- The assessment for this measure should be the comprehensive health risk assessment as applicable per state-specific guidance. The requirements pertaining to the assessment tool and how the tool should be administered (e.g., in-person, phone, etc.) may vary by state. The assessment tool should meet any state-specific criteria and include the appropriate domains as determined by the state. MMPs should refer to their state’s three-way contract for specific requirements.

- If a member’s assessment is in progress, but is not completed within 90 days of enrollment, then the assessment should not be considered completed, and therefore, the member should not be counted in data element D.

- If a member initially refused the assessment or could not be reached after three outreach attempts, but then subsequently completes the assessment within 90 days of enrollment, the member should be classified in data element D.
General Guidance

- Members reported in data elements B, C, and D must also be reported in data element A since these data elements are subsets of data element A. Additionally, data elements B, C, and D should be mutually exclusive (e.g., a member reported in data element B or C should not also be reported in data element D).
- MMPs should only report members with an initial assessment for this measure. For reporting of members with an annual reassessment, refer to Core Measure 2.3.
- Additional guidance is included in the state-specific reporting appendices. MMPs should refer to their state’s reporting appendix for measure reporting variations from the Core Reporting Requirements and for information on reporting assessments completed by the MMP prior to a member’s effective enrollment date, reporting assessments for members with a break in coverage, and reporting assessments completed previously by the MMP’s affiliated product. Note that the applicability of such guidance varies across states.
- There may be certain circumstances that make it impossible or inappropriate to complete an assessment within the required timeframe. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for an assessment. However, MMPs should not include such members in the counts for data elements B or C.
- For additional guidance on identifying each data element, including examples and scenarios for correctly reporting members who may meet the criteria for multiple data elements, please reference the Core Measure 2.1 FAQ document located on the CMS website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPIInformationandGuidance/MMPReportingRequirements.html

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).
2.2 Members with an assessment completed.

### IMPLEMENTATION

<table>
<thead>
<tr>
<th>Reporting Section</th>
<th>Reporting Frequency</th>
<th>Level</th>
<th>Reporting Periods</th>
<th>Due Date</th>
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</thead>
<tbody>
<tr>
<td>2. Assessment</td>
<td>Monthly</td>
<td>Contract</td>
<td>Current Calendar Month Ex: 1/1 – 1/31</td>
<td>By the end of the month following the last day of the reporting period</td>
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</tbody>
</table>

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

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<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of members with an assessment completed within the reporting period.</td>
<td>Total number of members with an assessment completed within the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>B.</td>
<td>Total number of members enrolled for 90 days or longer as of the last day of the reporting period.</td>
<td>Total number of members enrolled for 90 days or longer as of the last day of the reporting period.</td>
<td>Field type: Numeric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: This data element should not be reported until 90 days after implementation.</td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Total number of members enrolled for 90 days or longer who had an assessment completed.</td>
<td>Of the total reported in B, the number of members enrolled for 90 days or longer who had an assessment completed.</td>
<td>Field type: Numeric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Is a subset of B.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: This data element should not be reported until 90 days after implementation.</td>
<td></td>
</tr>
</tbody>
</table>

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.
C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
   • MMPs should validate that data element C is less than or equal to data element B.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will use enrollment data to evaluate the percentage of members:
   • Who had an assessment completed within the reporting period.
     o Percentage = (A / Total Members Enrolled) * 100
   • Enrolled for 90 days or longer as of the last day of the reporting period who had an assessment completed.
     o Percentage = (C / B) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A
   • MMPs should include all members who meet the criteria outlined in data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).

Data Element B
   • For data element B, MMPs should only include those members who are currently enrolled as of the last day of the reporting period.
   • The 90th day of enrollment should be based on each member’s most recent effective enrollment date in the MMP. Members must be continuously enrolled from the most recent effective enrollment date through at least 90 days of enrollment with no gaps in enrollment.
   • For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months. The 90th day of enrollment will always occur on the last day of the third month following a member’s effective enrollment date.

Data Element C
   • The members reported in data element C could have had an assessment completed at any time prior to the end of the reporting period, not necessarily during the current reporting period.

General Guidance
   • MMPs should only report members with an initial assessment for this measure. For reporting of members with an annual reassessment, refer to Core Measure 2.3.
   • The assessment for this measure should be the comprehensive health risk assessment as applicable per state-specific guidance. The requirements pertaining to the assessment tool and how the tool should be administered
(e.g., in-person, phone, etc.) may vary by state. The assessment tool should meet any state-specific criteria and include the appropriate domains as determined by the state. MMPs should refer to their state’s three-way contract for specific requirements.

- Data element A will be reported after the first month following the beginning of the Implementation period, whereas data elements B and C will not be reported until after 90 days.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

2.3 Members with an annual reassessment.

<table>
<thead>
<tr>
<th>CONTINUOUS REPORTING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reporting Section</strong></td>
</tr>
<tr>
<td>2. Assessment</td>
</tr>
</tbody>
</table>

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of members enrolled as of the last day of the current reporting period.</td>
<td>Total number of members enrolled as of the last day of the current reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>B.</td>
<td>Total number of members who had an assessment completed during the previous reporting period.</td>
<td>Of the total reported in A, the number of members who had an assessment completed during the previous reporting period.</td>
<td>Field Type: Numeric Note: Is a subset of A.</td>
</tr>
<tr>
<td>Element Letter</td>
<td>Element Name</td>
<td>Definition</td>
<td>Allowable Values</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>C.</td>
<td>Total number of members with a reassessment completed during the current reporting period.</td>
<td>Of the total reported in B, the number of members who had a reassessment completed during the current reporting period.</td>
<td>Field Type: Numeric Note: Is a subset of B.</td>
</tr>
<tr>
<td>D.</td>
<td>Total number of members with a reassessment completed within 365 days of the most recent assessment completed.</td>
<td>Of the total reported in C, the number of members with a reassessment completed during the current reporting period that occurred within 365 days of the most recent assessment completed during the previous reporting period.</td>
<td>Field Type: Numeric Note: Is a subset of C.</td>
</tr>
<tr>
<td>E.</td>
<td>Total number of members who did not have an assessment completed during the previous reporting period.</td>
<td>Of the total reported in A, the number of members enrolled for at least 90 continuous days during the previous reporting period who did not have an assessment completed during the previous reporting period.</td>
<td>Field Type: Numeric Note: Is a subset of A.</td>
</tr>
<tr>
<td>F.</td>
<td>Total number of members with an assessment completed during the current reporting period.</td>
<td>Of the total reported in E, the number of members who had an assessment completed during the current reporting period.</td>
<td>Field Type: Numeric Note: Is a subset of E.</td>
</tr>
</tbody>
</table>

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.
C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that data elements B and E are less than or equal to data element A.
- MMPs should validate that data element C is less than or equal to data element B.
- MMPs should validate that data element D is less than or equal to data element C.
- MMPs should validate that data element F is less than or equal to data element E.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members who:

- Had an assessment completed during the previous reporting period who had a reassessment completed during the current reporting period.
  - Percentage = \( \frac{C}{B} \times 100 \)
- Had an assessment completed during the previous reporting period who had a reassessment completed during the current reporting period that was within 365 days of the most recent assessment completed during the previous reporting period.
  - Percentage = \( \frac{D}{B} \times 100 \)
- Were enrolled for at least 90 continuous days during the previous reporting period who did not have an assessment completed during the previous reporting period but had an assessment completed during the current reporting period.
  - Percentage = \( \frac{F}{E} \times 100 \)

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element B

- For reporting data element B, include all members who were enrolled as of the last day of the current reporting period who received an assessment (initial or reassessment) during the previous reporting period.

Data Element C

- For reporting data element C, include all members reported in data element B who had a reassessment completed at any time during the current reporting period.

Data Element D

- For reporting data element D, include all members reported in data element C who had a reassessment completed during the current reporting period that was completed within 365 days of the date of the member’s most recent assessment (initial or reassessment) completed during the previous reporting period.
For example, if a member was assessed twice during CY 2019 (previous reporting period), first on May 15, 2019 and again on October 15, 2019, count 365 days continuously from October 15, 2019 to determine if a reassessment occurred within 365 days.

In this example, if the member completes a reassessment on September 15, 2020, they would be included in data element D for CY 2020 reporting. Conversely, if the member’s reassessment was not completed until November 15, 2020, they would not be included in data element D for CY 2020 reporting. In either case, the member would be captured in data element C.

For members who disenroll and reenroll in the MMP, MMPs should count 365 days continuously from the member’s most recent assessment date within the previous reporting period, even if that assessment was conducted during the member’s prior enrollment period.

**Data Element E**

- For reporting data element E, include all members who were enrolled as of the last day of the current reporting period, who were enrolled for at least 90 continuous days during the previous reporting period who did not receive an assessment (initial or reassessment) during the previous reporting period.
  - For members who disenroll and reenroll in the MMP, MMPs should include members who had any continuous enrollment of 90 days or more in the previous year, even if that enrollment preceded a break in coverage by the MMP.
  - 90 days of enrollment will be equivalent to three full calendar months.

**Data Element F**

- For reporting data element F, include all members reported in data element E who had an assessment completed at any time during the current reporting period.

**General Guidance**

- The assessment for this measure should be the comprehensive health risk assessment as applicable per state-specific guidance. The requirements pertaining to the assessment tool and how the tool should be administered (e.g., in-person, phone, etc.) may vary by state. The assessment tool should meet any state-specific criteria and include the appropriate domains as determined by the state. MMPs should refer to their state’s three-way contract for specific requirements.
- For reporting all data elements, MMPs should report unduplicated counts of members meeting the criteria for each data element. Members with more than one assessment or reassessment completed during a reporting period should be reported only once in the relevant data elements.
- In certain circumstances, a member with a break in coverage who reenrolls in the MMP and has an assessment completed upon reenrollment during the current reporting period may be reported under both Core Measure 2.1 and Core Measure 2.3.
For example, consider a member that was previously assessed on June 15, 2019, subsequently disenrolled on October 1, 2019, reenrolled on January 1, 2020, assessed again on February 15, 2020, and remained enrolled as of December 31, 2020. The member would be counted in Quarter 1 2020 reporting for Core Measure 2.1 (data elements A and D) and in CY 2020 reporting for Core Measure 2.3 (data elements A, B, C, and D).

- The term “current reporting period” in data elements A, C, D, and F refers to the current calendar year. The term “previous reporting period” in data elements B, D, and E refers to the prior calendar year.
- This measure will not be reported until Calendar Year 2.

**F. Data Submission – how MMPs will submit data collected to CMS and the state.**

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).
Section III. Care Coordination

3.1 Members, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted within 24 hours of discharge to the facility or primary care provider or other health care professional designated for follow-up care. (modified from NQF #0648) – Retired

3.2 Members with a care plan completed within 90 days of enrollment.

<table>
<thead>
<tr>
<th>Reporting Section</th>
<th>Reporting Frequency</th>
<th>Level</th>
<th>Reporting Periods</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Care Coordination</td>
<td>Monthly during the implementation period, beginning after 90 days of implementation</td>
<td>Contract</td>
<td>Current Calendar Month Ex: 1/1-1/31</td>
<td>By the end of the month following the last day of the reporting period</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ex: Demo implementation is January 1, 2020; 90 days after enrollment is March 31, 2020; the first report is due by April 30, 2020.</td>
<td></td>
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<tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ONGOING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Care Coordination</td>
<td>Quarterly</td>
<td>Contract</td>
<td>Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 6/1-9/30 7/1-9/30 10/1-12/31</td>
<td>By the end of the second month following the last day of the reporting period</td>
</tr>
</tbody>
</table>
A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.</td>
<td>Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.</td>
<td>Field type: Numeric</td>
</tr>
<tr>
<td>B.</td>
<td>Total number of members who were documented as unwilling to complete a care plan within 90 days of enrollment.</td>
<td>Of the total reported in A, the number of members who were documented as unwilling to complete a care plan and who never had a care plan completed within 90 days of enrollment.</td>
<td>Field Type: Numeric&lt;br&gt;Note: Is a subset of A.&lt;br&gt;Unwillingness to participate must be clearly documented.</td>
</tr>
<tr>
<td>C.</td>
<td>Total number of members the MMP was unable to reach, following three documented outreach attempts, to complete a care plan within 90 days of enrollment.</td>
<td>Of the total reported in A, the number of members the MMP was unable to reach, following three documented outreach attempts, to complete a care plan and who never had a care plan completed within 90 days of enrollment.</td>
<td>Field type: Numeric&lt;br&gt;Note: Is a subset of A.&lt;br&gt;Three outreach attempts must be clearly documented.</td>
</tr>
<tr>
<td>D.</td>
<td>Total number of members with a care plan completed within 90 days of enrollment.</td>
<td>Of the total reported in A, the number of members with a care plan completed within 90 days of enrollment.</td>
<td>Field type: Numeric&lt;br&gt;Note: Is a subset of A.&lt;br&gt;Completed care plans must be clearly documented.</td>
</tr>
</tbody>
</table>
B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that the sum of data elements B, C, and D is less than or equal to data element A.
- MMPs should validate that members included in data element A were enrolled for at least 90 days and the 90th day of enrollment occurred within the reporting period.
- MMPs should validate that members included in data element A were enrolled as of the last day of the reporting period.
- MMPs should validate that members included in data element B were included in data element A.
- MMPs should validate that members included in data element C were included in data element A.
- MMPs should validate that members included in data element D were included in data element A.
- MMPs should validate that members reported in data element B were not reported in data elements C or D.
- MMPs should validate that members reported in data element C were not reported in data elements B or D.
- MMPs should validate that members reported in data element D were not reported in data elements B or C.
- MMPs should validate that members reported in data element B were clearly documented as unwilling to complete the care plan within 90 days of enrollment.
- MMPs should validate that members reported in data element C had three outreach attempts clearly documented within 90 days of enrollment.
- MMPs should validate that members reported in data element D had a completed care plan clearly documented within 90 days of enrollment.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members who:

- Were documented as unwilling to complete a care plan and who never had a care plan completed within 90 days of enrollment.
  - Percentage = (B / A) * 100
- The MMP was unable to reach, following three documented outreach attempts, to complete a care plan and who never had a care plan completed within 90 days of enrollment.
  - Percentage = (C / A) * 100
• Had a care plan completed within 90 days of enrollment.
  o Percentage = (D / A) * 100
• Were willing to participate and who could be reached who had a care plan completed within 90 days of enrollment.
  o Percentage = (D / (A – B – C)) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

• MMPs should only include those members who are currently enrolled as of the last day of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the MMP.
• The 90th day of enrollment should be based on each member’s most recent effective enrollment date in the MMP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment with no gaps in enrollment.
• For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months. The 90th day of enrollment will always occur on the last day of the third month following a member’s effective enrollment date.
  o When reporting quarterly results from Ongoing reporting periods, MMPs should report all members who reached their 90th day of enrollment at any point during the three months included in the quarter (e.g., members enrolled on May 1, June 1, and July 1 reached their 90th day of enrollment during the third quarter; therefore, these members should be included in Ongoing reporting for the third quarter as long as they were still enrolled on the last day of the reporting period).

Data Element B

• For data element B, MMPs should report the number of members who were documented as unwilling to complete a care plan if a member (or his or her authorized representative):
  o Affirmatively declines to complete the care plan, affirmatively declines care management activities overall, or refuses any contact with the MMP. The member may communicate the declination or refusal by phone, mail, fax, or in person. The declination or refusal must be documented by the MMP.
  o Expresses willingness to complete the care plan but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the care plan within 90 days). Discussions with the member must be documented by the MMP.
  o Schedules an appointment to complete the care plan but cancels or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
 Initially agrees to complete the care plan, but then declines to participate in the development of the care plan. The declination must be documented by the MMP.

- If a member could not be reached after three outreach attempts, but then subsequently is reached and refuses to complete a care plan within 90 days of enrollment, the member should be classified in data element B.

Data Element C

- For data element C, MMPs should report the number of members the MMP was unable to reach after three documented attempts to contact the member. The three documented outreach attempts to contact the member must be for the purpose of completing the care plan.
  - If an MMP was able to reach a member for the purpose of completing only an assessment, at least three new and distinct outreach attempts for the purpose of completing the care plan must be made and documented.
  - However, if an MMP was unable to reach a member for the purpose of completing both an assessment and a care plan, and has documented three unsuccessful outreach attempts, the MMP is not expected to make additional outreach attempts about the completion of a care plan. The MMP would report this member in data element C.

- MMPs should refer to their state’s three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (e.g., phone, mail, or email), as CMS and the state may validate this number. If less than three outreach attempts are made to the member within 90 days of enrollment, the member should not be included in data element C.
  - Note that the applicable three-way contract may require more than three outreach attempts. MMPs must continue to follow such contract requirements; however, for purposes of reporting this measure, MMPs may count a member under data element C following three outreach attempts.

- There may be instances when the MMP has a high degree of confidence that a member’s contact information is correct, yet that member is not responsive to the MMP’s outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for data element C.

Data Element D

- The requirements for care plan development may vary by state. The care plan should meet any state-specific criteria and include the appropriate domains as determined by the state. MMPs should refer to their state’s three-way contract for specific requirements.
• If a member’s care plan is in progress, but is not completed within 90 days of enrollment, then the care plan should not be considered completed, and therefore, the member should not be counted in data element D.
• MMPs should only report completed care plans where the member or the member’s authorized representative was involved in the development of the care plan.
• If a member initially refused to complete a care plan or could not be reached after three outreach attempts, but then subsequently completes a care plan within 90 days of enrollment, the member should be classified in data element D.

**General Guidance**

• Members reported in data elements B, C, and D must also be reported in data element A since these data elements are subsets of data element A. Additionally, data elements B, C, and D should be mutually exclusive (e.g., a member reported in data element B or C should not also be reported in data element D).
• MMPs should only report members with an initial care plan for this measure.
• Additional guidance is included in the state-specific reporting appendices. MMPs should refer to their state’s reporting appendix for measure reporting variations from the Core Reporting Requirements and for information on reporting care plans completed by the MMP prior to a member’s effective enrollment date, reporting care plans for members with a break in coverage, and reporting care plans completed previously by the MMP’s affiliated product. Note that the applicability of such guidance varies across states.
• There may be certain circumstances that make it impossible or inappropriate to complete a care plan within the required timeframe. For example, a member may be medically unable to participate and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a care plan. However, MMPs should not include such members in the counts for data elements B or C.
• For additional guidance on identifying each data element, including examples and scenarios for correctly reporting members who may meet the criteria for multiple data elements, please reference the Core Measure 3.2 FAQ document located on the CMS website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPIInformationandGuidance/MMPReportingRequirements.html.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

• MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).
Section IV. Enrollee Protections

4.1 Part D Appeals. – Retired; see Part D Reporting Requirements Section V – Coverage Determinations and Redeterminations for required reporting.

4.2 Grievances and Appeals.

<table>
<thead>
<tr>
<th>IMPLEMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting</td>
</tr>
<tr>
<td>Section</td>
</tr>
<tr>
<td>4. Enrollee</td>
</tr>
<tr>
<td>Protections</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ONGOING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting</td>
</tr>
<tr>
<td>Section</td>
</tr>
<tr>
<td>4. Enrollee</td>
</tr>
<tr>
<td>Protections</td>
</tr>
</tbody>
</table>

Note: MMPs should report all non-Part D (i.e., Part C, Medicaid, and supplemental benefit) grievances and appeals for data elements A-S, in addition to reporting the already required Medicare Part D appeals and grievances as follows:

- Part D grievances are reported according to Part D Reporting Requirements (see Part D Section III Grievances);
- Part D appeals are reported according to Part D Reporting Requirements (see Part D Section V Coverage Determinations and Redeterminations);

Medicare Part D Reporting Requirements can be found on the CMS website at: [https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_RxContracting_ReportingOversight.html](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_RxContracting_ReportingOversight.html).
A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

**Grievances**

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total Grievances –</td>
<td>Total number of grievances for which the MMP provided notification of its decision during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td></td>
<td>Total number of grievances.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Grievance Timeliness –</td>
<td>Of the total reported in A, the number of grievances for which the MMP provided timely notification of its decision during the reporting period.</td>
<td>Field Type: Numeric. Note: Is a subset of A.</td>
</tr>
<tr>
<td></td>
<td>Total number of grievances for which</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>the MMP provided notification of its</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>decision.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Grievance Category –</td>
<td>Of the total reported in A, the number of grievances related to access to care for which the MMP provided notification of its decision during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td></td>
<td>Total number of grievances related to</td>
<td></td>
<td>Note: Is a subset of A.</td>
</tr>
<tr>
<td></td>
<td>access to care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td>Grievance Category –</td>
<td>Of the total reported in A, the number of grievances related to transportation for which the MMP provided notification of its decision during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td></td>
<td>Total number of grievances related to</td>
<td></td>
<td>Note: Is a subset of A.</td>
</tr>
<tr>
<td></td>
<td>transportation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td>Grievance Category –</td>
<td>Of the total reported in A, the number of grievances related to billing for which the MMP provided notification of its decision during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td></td>
<td>Total number of grievances related to</td>
<td></td>
<td>Note: Is a subset of A.</td>
</tr>
<tr>
<td></td>
<td>billing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Element Letter</td>
<td>Element Name</td>
<td>Definition</td>
<td>Allowable Values</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------</td>
<td>------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>F.</td>
<td>Grievance Category – Total number of grievances related to home health/personal care.</td>
<td>Of the total reported in A, the number of grievances related to home health/personal care for which the MMP provided notification of its decision during the reporting period.</td>
<td>Field Type: Numeric. Note: Is a subset of A.</td>
</tr>
<tr>
<td>G.</td>
<td>Grievance Category – Total number of other grievances not related to categories mentioned above.</td>
<td>Of the total reported in A, the number of other grievances not related to categories mentioned above for which the MMP provided notification of its decision during the reporting period.</td>
<td>Field Type: Numeric Note: Is a subset of A.</td>
</tr>
</tbody>
</table>

**Appeals**

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>H.</td>
<td>Total Appeals – Total number of appeals.</td>
<td>Total number of appeals for which the MMP provided notification of its decision during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>I.</td>
<td>Appeal Timeliness – Total number of appeals for which the MMP provided timely notification of its decision.</td>
<td>Of the total reported in H, the number of appeals for which the MMP provided timely notification of its decision during the reporting period.</td>
<td>Field Type: Numeric Note: Is a subset of H.</td>
</tr>
<tr>
<td>J.</td>
<td>Appeal Decision – Total number of appeals for which the MMP’s decision was fully favorable.</td>
<td>Of the total reported in H, the number of appeals for which the MMP provided notification of a fully favorable decision within the reporting period.</td>
<td>Field Type: Numeric Note: Is a subset of H.</td>
</tr>
<tr>
<td>Element Letter</td>
<td>Element Name</td>
<td>Definition</td>
<td>Allowable Values</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------</td>
<td>------------</td>
<td>------------------</td>
</tr>
</tbody>
</table>
| K.             | Appeal Decision – Total number of appeals for which the MMP’s decision was partially favorable. | Of the total reported in H, the number of appeals for which the MMP provided notification of a partially favorable decision within the reporting period. | Field Type: Numeric  
Note: Is a subset of H. |
| L.             | Appeal Decision – Total number of appeals for which the MMP’s decision was adverse. | Of the total reported in H, the number of appeals for which the MMP provided notification of an adverse decision within the reporting period. | Field Type: Numeric  
Note: Is a subset of H. |
| M.             | Appeal Category – Total number of appeals related to denial or limited authorization of specialty services. | Of the total reported in H, the number of appeals related to denial or limited authorization of specialty services for which the MMP provided notification of its decision during the reporting period. | Field Type: Numeric  
Note: Is a subset of H. |
| N.             | Appeal Category – Total number of appeals related to denial or limited authorization of HCBS services. | Of the total reported in H, the number of appeals related to denial or limited authorization of HCBS services for which the MMP provided notification of its decision during the reporting period. | Field Type: Numeric  
Note: Is a subset of H. |
<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
</table>
| O.             | Appeal Category – Total number of appeals related to denial or limited authorization of institutional services. | Of the total reported in H, the number of appeals related to denial or limited authorization of institutional services for which the MMP provided notification of its decision during the reporting period. | Field Type: Numeric  
Note: Is a subset of H. |
| P.             | Appeal Category – Total number of appeals related to denial or limited authorization of mental health services. | Of the total reported in H, the number of appeals related to denial or limited authorization of mental health services for which the MMP provided notification of its decision during the reporting period. | Field Type: Numeric  
Note: Is a subset of H. |
| Q.             | Appeal Category – Total number of appeals related to denial or limited authorization of substance use treatment services. | Of the total reported in H, the number of appeals related to denial or limited authorization of substance use treatment services for which the MMP provided notification of its decision during the reporting period. | Field Type: Numeric  
Note: Is a subset of H. |
| R.             | Appeal Category – Total number of post-service payment appeals. | Of the total reported in H, the number of post-service payment appeals for which the MMP provided notification of its decision during the reporting period. | Field Type: Numeric  
Note: Is a subset of H.  
Note: This data element should not include post-service payment appeals from contract providers. |
### Element Letter | Element Name | Definition | Allowable Values
--- | --- | --- | ---
S | Appeal Category – Total number of other appeals not related to categories mentioned above. | Of the total reported in H, the number of other appeals not related to categories mentioned above for which the MMP provided notification of its decision during the reporting period. | Field Type: Numeric  
Note: Is a subset of H. |

**B. QA Checks/Thresholds** – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

**C. Edits and Validation Checks** – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that the sum of data elements C, D, E, F, and G is equal to data element A.
- MMPs should validate that the sum of data elements J, K, and L is equal to data element H.
- MMPs should validate that the sum of data elements M, N, O, P, Q, R, and S is equal to data element H.

**D. Analysis** – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

CMS and the state will use enrollment data to evaluate the following per 10,000 member months:

- Total number of grievances  
  - Rate = (A / Total Member Months) * 10,000
- Total number of grievances related to:
  - Access to care  
    - Rate = (C / Total Member Months) * 10,000
  - Transportation  
    - Rate = (D / Total Member Months) * 10,000
  - Billing  
    - Rate = (E / Total Member Months) * 10,000
  - Home health/personal care  
    - Rate = (F / Total Member Months) * 10,000
  - Other grievances  
    - Rate = (G / Total Member Months) * 10,000
- Total number of appeals  
  - Rate = (H / Total Member Months) * 10,000
• Total number of appeals related to:
  o Denial or limited authorization of specialty services
    ▪ Rate = (M / Total Member Months) * 10,000
  o Denial or limited authorization of HCBS services
    ▪ Rate = (N / Total Member Months) * 10,000
  o Denial or limited authorization of institutional services
    ▪ Rate = (O / Total Member Months) * 10,000
  o Denial or limited authorization of mental health services
    ▪ Rate = (P / Total Member Months) * 10,000
  o Denial or limited authorization of substance use treatment services
    ▪ Rate = (Q / Total Member Months) * 10,000
  o Post-service payment appeals
    ▪ Rate = (R / Total Member Months) * 10,000
  o Other appeals
    ▪ Rate = (S / Total Member Months) * 10,000

CMS and the state will evaluate the percentage of appeals for which the MMP’s decision was:
  • Fully favorable
    o Percentage = (J / H) * 100
  • Partially favorable
    o Percentage = (K / H) * 100
  • Adverse
    o Percentage = (L / H) * 100

CMS and the state will evaluate the percentage of:
  • Grievances for which the MMP provided timely notification of its decision
    o Percentage = (B / A) * 100
  • Appeals for which the MMP provided timely notification of its decision
    o Percentage = (I / H) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Grievances
  • If a member files a grievance and then files a subsequent grievance on the same issue prior to the MMP’s decision or deadline for decision notification (whichever is earlier), the issue is counted as one grievance.
  • If a member files a grievance and then files a subsequent grievance on the same issue after the MMP’s decision or deadline for decision notification (whichever is earlier), the issue is counted as a separate grievance.
  • MMPs should include oral grievances, even if the oral grievance was resolved during the call.
  • MMPs should exclude withdrawn grievances and grievances only made through the CMS Complaints Tracking Module.
• A grievance involving multiple issues should be reported under each applicable category and also counted the corresponding number of times under data element A.
  o For example, if the MMP receives a grievance that involves two issues – access to care and billing – the grievance would be reported under both data elements C and E and reported twice under data element A.
• Access to care grievances reported in data element C should include grievances related to inability to get an appointment with a provider, excessive wait times for an appointment with a provider, inability to access a provider who demonstrates cultural competency, inability to access a provider who can communicate with the member in his/her primary language or via a translation service, and inability to access a provider that offers sufficient accommodations for the member’s disability. Note that this category does not include grievances related to transportation used to access providers, as those grievances would be reported under data element D.
• Home health/personal care grievances reported in data element F should include all grievances related to home health/personal care benefits, such as (but not limited to) issues with the demeanor of the home health/personal care aide, tardiness/absenteeism from the home health/personal care aide, and quality of home health/personal care provided.

Appeals
• Only appeals decided by the MMP should be included in the measure (i.e., do not include appeal decisions made by the Independent Review Entity, Quality Improvement Organization, and/or state fair hearing agency).
• Include appeals that were requested by the member, the member’s authorized representative, or a provider making the request on behalf of the member. Do not include appeals from contract providers that are governed under the contractual arrangement between the MMP and the provider.
• For data elements M through Q, appeals related to the denial or limited authorization of a service should also include reductions, suspensions, or terminations of a previously authorized service.
• For data element M, specialty services are defined as any service or medical care provided or directed by a “specialist” (as opposed to a Primary Care Provider) that would not be a service offered by a Primary Care Provider or fitting into another category.
  o Specialty service providers should include occupational/physical/speech therapy, dental, vision, transportation, and durable medical equipment.
  o Primary Care Provider will be defined in the state-specific appendix.
• For data element R, MMPs should include all payment disputes (i.e., requests for payment and requests for adjustment to the paid amount), regardless if the appeal is made by the member, the member’s authorized representative, or a non-contract provider who signed a Waiver of Liability. Duplicate payment appeals should be counted only once. Do not include payment disputes from contract providers.
General Guidance

- As noted above, MMPs should report all non-Part D (i.e., Part C, Medicaid, and supplemental benefit) grievances and appeals under this measure.
- There are no minimum enrollment criteria for this measure. All grievances and appeals should be reported regardless of how long a member has been enrolled in the MMP or if he/she has disenrolled from the MMP prior to the end of the reporting period.
- The date the MMP notified the member of its decision should be used to assess which reporting period the grievance or appeal should be reported within.
  - For example, if a grievance was received on March 24 and the MMP provided notification of its decision on April 4, then the grievance would be included in the second quarter when reporting this measure.
- MMPs should refer to their state’s three-way contract for definitions of timely grievance and appeal resolution for purposes of reporting data elements B and I.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).
Section V. Organizational Structure and Staffing

5.1 Care coordinator to member ratio.

<table>
<thead>
<tr>
<th>IMPLEMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Section</td>
</tr>
<tr>
<td>5. Organizational Structure and Staffing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ONGOING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Section</td>
</tr>
<tr>
<td>5. Organizational Structure and Staffing</td>
</tr>
</tbody>
</table>

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of full time equivalent (FTE) care coordinators working on the Demonstration as of the last day of the reporting period.</td>
<td>Total number of FTE care coordinators working on the Demonstration as of the last day of the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>B.</td>
<td>Of the total reported in A, the number of FTE care coordinators assigned to care management and conducting assessments during the reporting period.</td>
<td>Field Type: Numeric Note: Is a subset of A.</td>
<td></td>
</tr>
<tr>
<td>Element Letter</td>
<td>Element Name</td>
<td>Definition</td>
<td>Allowable Values</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>C.</td>
<td>Total number of FTE care coordinators that left the MMP.</td>
<td>Total number of FTE care coordinators that left the MMP during the reporting period.</td>
<td>Field type: Numeric</td>
</tr>
</tbody>
</table>

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that data element B is less than or equal to data element A.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

**Note:** This measure is not adjusted for case mix, and care coordination will vary for each demonstration and each MMP’s care plan model structure. Therefore, this measure will be used solely to track care coordination investments and changes in each MMP’s care coordinator to member ratio longitudinally.

CMS and the state will:

- Use enrollment data to evaluate the number of members per FTE care coordinator.
  - Rate = (Total Members Enrolled / A)
- Evaluate the percentage of FTE care coordinators who were assigned to care management and conducting assessments.
  - Percentage = (B / A) * 100
- Evaluate the percentage of FTE care coordinators that left the MMP during the reporting period.
  - Percentage = (C / (C + A)) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

**Definitions**

- *Care coordinator* will be defined in the state-specific appendix. Different terms may be used in different states.
- *FTE* is defined as full time equivalent.
Data Element C

- Data element C includes care coordinators who are assigned to a different role within the MMP.

General Guidance

- To calculate the number of FTE care coordinators, add up all of the care coordinators’ work hours during the reporting period and divide this value by the number of normal working hours for one full-time employee that occurred during the reporting period.
  - In instances where care coordinators support multiple lines of business, include only the time associated with the demonstration/MMP.
- For all data elements, FTE reported values should be rounded to the nearest positive integer.
- All part-time and full-time care coordinators will be counted, regardless of whether they are subcontracted or employed directly by the MMP.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

5.2 Annual staffing worksheets. – \textit{Retired}

5.3 Establishment of consumer advisory board or inclusion of consumers on a pre-existing governance board consistent with contractual requirements.\textsuperscript{i}

<table>
<thead>
<tr>
<th>CONTINUOUS REPORTING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reporting Section</strong></td>
</tr>
<tr>
<td>5. Organizational Structure and Staffing</td>
</tr>
</tbody>
</table>

MMPs will be required to submit information on each consumer advisory board and/or governance board meeting during the annual reporting period. One template per meeting should be completed and submitted. A template for providing information is located on the CMS website: \texttt{https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPIInformationandGuidance/MMPReportingRequirements.html}
A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Date.</td>
<td>Date each meeting occurred during the annual reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Date in YYYYMMDD Format.</td>
<td>Note: MMPs should input data into the template provided by CMS.</td>
</tr>
<tr>
<td>B.</td>
<td>Total number of board members invited.</td>
<td>Count of all consumer advisory board/governance board members invited to the meeting.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: MMPs should input data into the template provided by CMS.</td>
<td>Note: Is a subset of B.</td>
</tr>
<tr>
<td>C.</td>
<td>Total number of board members in attendance.</td>
<td>Count of all consumer advisory board/governance board members in attendance either in-person or remotely.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: MMPs should input data into the template provided by CMS.</td>
<td>Note: Is a subset of B.</td>
</tr>
<tr>
<td>D.</td>
<td>Total number of board members invited who are actual beneficiaries or family caregivers.</td>
<td>Count of board members invited who are actual beneficiaries or family caregivers. Professional advocates should not be included unless they are also members or caregivers for members of the MMP.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: MMPs should input data into the template provided by CMS.</td>
<td>Note: Is a subset of B.</td>
</tr>
<tr>
<td>Element Letter</td>
<td>Element Name</td>
<td>Definition</td>
<td>Allowable Values</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------</td>
<td>------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>E.</td>
<td>Total number of board members who are actual beneficiaries or family caregivers in attendance.</td>
<td>Count of board members who are actual beneficiaries or family caregivers in attendance either in-person or remotely. Professional advocates should not be included unless they are also members or caregivers for members of the MMP.</td>
<td>Field Type: Numeric Note: MMPs should input data into the template provided by CMS. Note: Is a subset of both C and D.</td>
</tr>
<tr>
<td>F.</td>
<td>Agenda.</td>
<td>Agenda for each meeting during the annual period.</td>
<td>Field Type: N/A Note: MMPs should input data into the template provided by CMS.</td>
</tr>
<tr>
<td>G.</td>
<td>Minutes.</td>
<td>Minutes for each meeting held during the annual reporting period.</td>
<td>Field Type: N/A Note: MMPs should input data into the template provided by CMS.</td>
</tr>
</tbody>
</table>

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- Meeting dates are within the performance period.
- MMPs should validate that the number of members reported in data element C is a subset of the number of members reported in data element B.
- MMPs should validate that the number of members reported in data element D is a subset of the number of members reported in data element B.
- MMPs should validate that the number of members reported in data element E is a subset of the number of members reported in each of the data elements C and D.
D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the:

- Number of board meetings per quarter.
- Number of board meetings per quarter with beneficiaries or family caregivers in attendance.
- Percentage of invited board members who are beneficiaries or family caregivers.
  - \( \frac{\text{Sum of D across meetings}}{\text{Sum of B across meetings}} \times 100 \)
- Percentage of board members in attendance who are beneficiaries or family caregivers.
  - \( \frac{\text{Sum of E across meetings}}{\text{Sum of C across meetings}} \times 100 \)

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should submit one Microsoft Word template per meeting.
- For reporting data elements B, C, D, and E, MMPs should only include established consumer advisory board/governance board members.
- MMPs should only include a total count of the members who satisfy each data element; MMPs are no longer required to provide the full names of the members/board members.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx
- Required File Format is Microsoft Word File.
- The file name extension should be “.docx”.
- File name = (STATEABBREVIATION)_(CONTRACTID)_(REPORTING PERIOD)_(MEETINGDATE).docx.
- Replace (STATEABBREVIATION) with the two-character state abbreviation (e.g., Massachusetts is MA), (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the year and month of the beginning of the reporting period in YYYYMM format (e.g., January 2020 would be 202001), (MEETINGDATE) with the year, month, and date of the meeting in YYYYMDD format (e.g., March 31, 2020 would be 20200331).
- All populated templates should be uploaded to the secure data transmission site in a single zip file.
Section VI. Performance and Quality Improvement

6.1 Screening for Clinical Depression and Follow-up Plan. (modified from NQF #0418) – Retired

Section VII. Provider Network

7.1 Medicare Provider Network.

<table>
<thead>
<tr>
<th>Reporting Section</th>
<th>Reporting Frequency</th>
<th>Level</th>
<th>Reporting Period</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Provider Network</td>
<td>Annually</td>
<td>Contract</td>
<td>Current network as of the date of submission.</td>
<td>By the third Tuesday of September</td>
</tr>
</tbody>
</table>

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>MMP Health Service Delivery Provider Table</td>
<td>Refer to MMP Medicare Network Submission Guidance for data definitions.</td>
<td>Field Type: Data Entry</td>
</tr>
<tr>
<td>B.</td>
<td>MMP Health Service Delivery Facility Table</td>
<td>Refer to MMP Medicare Network Submission Guidance for data definitions.</td>
<td>Field Type: Data Entry</td>
</tr>
</tbody>
</table>

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will assess Health Service Delivery (HSD) tables against Medicare MMP standards that are available on the CMS website.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm HSD tables will properly upload into HPMS using the plan upload functionality.
- MMPs should validate that MMP Medicare Networks meet MMP standards using the plan upload functionality prior to the MMP Medicare Network Annual submission.
D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS will assess the submitted HSD tables against the MMP Medicare Network Standards.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should refer to the MMP Medicare Network Submission Guidance that will be issued separately for the relevant reporting year and posted on the CMS website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPIInformationandGuidance/MMPApplicationandAnnualRequirements.html.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).
Section VIII. Systems

8.1 Long Term Services and Supports (LTSS) clean claims paid within 30 days, 60 days, and 90 days.

### IMPLEMENTATION

<table>
<thead>
<tr>
<th>Reporting Section</th>
<th>Reporting Frequency</th>
<th>Level</th>
<th>Reporting Periods</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Systems</td>
<td>Quarterly</td>
<td>Contract</td>
<td>Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31</td>
<td>By the end of the second month following the last day of the reporting period</td>
</tr>
</tbody>
</table>

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of LTSS clean claims paid within the reporting period.</td>
<td>Total number of LTSS clean claims paid within the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>B.</td>
<td>Total number of clean claims paid within 30 calendar days of receipt.</td>
<td>Of the total reported in A, the number of clean claims paid within 30 calendar days of receipt.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Is a subset of A.</td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Total number of clean claims paid within 60 calendar days of receipt.</td>
<td>Of the total reported in A, the number of clean claims paid within 60 calendar days of receipt.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Is a subset of A.</td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td>Total number of clean claims paid within 90 calendar days of receipt.</td>
<td>Of the total reported in A, the number of clean claims paid within 90 calendar days of receipt.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Is a subset of A.</td>
<td></td>
</tr>
</tbody>
</table>
B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
   - CMS and the state will perform an outlier analysis.
   - As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
   - MMPs should validate that data elements B, C, and D are less than or equal to data element A.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of LTSS clean claims that were paid within:
   - 30 calendar days of receipt.
     - Percentage = (B / A) * 100
   - 60 calendar days of receipt.
     - Percentage = (C / A) * 100
   - 90 calendar days of receipt.
     - Percentage = (D / A) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definitions
   - **Long Term Services and Supports** (LTSS) will be defined in the state-specific appendix.
   - A **clean claim** is one that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

General Guidance
   - The 30-, 60-, and 90-day cutoffs should be calculated using individual calendar days, unlike Core Measures 2.1 and 2.2 where “90 days of enrollment” is considered equivalent to three full calendar months.
   - MMPs should include LTSS clean claims if they were paid during the reporting period. LTSS clean claims submitted during the reporting period, but not paid during the reporting period, should not be included.

F. Data Submission – how MMPs will submit data collected to CMS and the state.
   - MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).
Section IX. Utilization

9.1 Emergency department (ED) behavioral health services utilization.

CONTINUOUS REPORTING

<table>
<thead>
<tr>
<th>Reporting Section</th>
<th>Reporting Frequency</th>
<th>Level</th>
<th>Reporting Periods</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Utilization</td>
<td>Annually</td>
<td>Contract</td>
<td>Calendar Quarters Ex:</td>
<td>By the end of the second month following the last day of the final quarterly reporting period</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1/1-3/31</td>
<td></td>
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<td>4/1-6/30</td>
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<td>7/1-9/30</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>10/1-12/31</td>
<td></td>
</tr>
</tbody>
</table>

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of ED visits with a principal diagnosis related to behavioral health.</td>
<td>Total number of ED visits with a principal diagnosis related to behavioral health during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
</tbody>
</table>

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- N/A.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will use enrollment data to evaluate the total number of ED visits with a principal diagnosis related to behavioral health per 10,000 member months during the reporting period.
  - Rate = (A / Total Member Months) * 10,000
E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- MMPs should include all ED visits with a principal diagnosis related to behavioral health for members who meet the criteria outlined in data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- MMPs should use the ED value set to identify emergency department visits.
- MMPs should use the Mental Health Diagnosis value set to identify a behavioral health diagnosis.
- If there are two different ED visits with the same date of service within the reporting period (and there are two separate, adjudicated claims), then both ED visits should be reported in data element A.

Data Element A Exclusion

- MMPs should exclude ED visits followed by admission to an acute or nonacute inpatient care setting (same or different facility as ED visit) on the date of the ED visit. To identify admissions to an acute or nonacute inpatient care setting:
  - Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
  - Identify the admission date for the stay
  An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay and should be excluded from data element A.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

9.2 Nursing Facility (NF) Diversion.

<table>
<thead>
<tr>
<th>CONTINUOUS REPORTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Section</td>
</tr>
<tr>
<td>9. Utilization</td>
</tr>
</tbody>
</table>
A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of members who were continuously enrolled in the MMP for at least 5 out of the last 6 months during the previous reporting period and continuously enrolled in the MMP for at least 11 out of 12 months during the current reporting period.</td>
<td>Total number of members who were continuously enrolled in the MMP for at least 5 out of the last 6 months during the previous reporting period and continuously enrolled in the MMP for at least 11 out of 12 months during the current reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>B.</td>
<td>The total number of members who were classified as nursing home certifiable for more than 100 continuous days during the previous reporting period who did not reside in a NF for more than 100 continuous days during the previous reporting period.</td>
<td>Of the total reported in A, the number of members who were classified as nursing home certifiable for more than 100 continuous days during the previous reporting period who did not reside in a NF for more than 100 continuous days during the previous reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Is a subset of A.</td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Total number of members who did not reside in a NF for more than 100 continuous days during the current reporting period.</td>
<td>Of the total reported in B, the number of members who did not reside in a NF for more than 100 continuous days during the current reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Is a subset of B.</td>
<td></td>
</tr>
</tbody>
</table>
B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element C is less than or equal to data element B.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- For members classified as nursing home certifiable for more than 100 continuous days during the previous reporting period who did not reside in a NF for more than 100 continuous days during the previous reporting period, CMS and the state will evaluate the percentage of members who did not reside in a NF for more than 100 continuous days during the current reporting period.
  - Percentage = (C / B) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- For the purposes of this measure, the “previous reporting period” is defined as the previous calendar year. The “current reporting period” is defined as the current calendar year.
  - For example, for data submitted on March 1, 2021 (as February 28, 2021 falls on a Sunday), the previous reporting period is January 1, 2019 – December 31, 2019, and the current reporting period is January 1, 2020 – December 31, 2020.
- The member must be enrolled as of the last day of both the previous and current reporting periods to be included in this measure.
- For reporting members in data element A, members must meet both continuous enrollment criteria in order to be included in this data element. Therefore, the member must be continuously enrolled as a Medicare-Medicaid member in the MMP for at least 5 out of the last 6 months during the previous reporting period and continuously enrolled as a Medicare-Medicaid member in the MMP for at least 11 out of 12 months during the current reporting period. Members meeting these criteria for only one of the reporting periods should not be included in data element A.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each reporting period (i.e., July through December
[previous reporting period] and January through December [current reporting period]). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Data Element A Exclusions

- MMPs should exclude members who are transitioned to hospice services in either the current or previous reporting periods when reporting this measure. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Encounter and Hospice Intervention value sets).
- MMPs should exclude members who expired in either the current or previous reporting period when reporting this measure using the Discharges due to Death value set.

Data Element B

- Nursing home certifiable members are defined as members living in the community but requiring an institutional level of care. Additionally, members who have a stay in a NF may be considered nursing home certifiable depending on the length of stay. MMPs should refer to their state’s specific definition for additional information.
- To identify members for inclusion in data element B, MMPs should first identify all members who were nursing home certifiable for more than 100 continuous days at any point during the previous reporting period (January through December). Then, MMPs should exclude any of these members who resided in a NF for at least 101 continuous days during the previous reporting period.
  - For example, a member who entered a NF on September 4 and remained there on December 31 of the previous reporting period has more than 100 continuous days in a NF in the previous reporting period (119 days within the previous reporting period) and would not be included in data element B. A member who entered a NF on October 4 of the previous reporting period and remained there through February 1 of the current reporting period would not have more than 100 continuous days in a NF during the previous reporting period (residing there only 89 days during the previous reporting period) and would be included in data element B as long as they were nursing home certifiable for more than 100 continuous days during the previous reporting period.
  - MMPs should use all available data to document and confirm a member’s status as nursing home certifiable. In the event of missing data for members who had a single, 1-month-long gap in coverage during the previous reporting period and who were documented as nursing home certifiable before the 1-month gap and after the 1-month
gap, MMPs may assume that the member was nursing home certifiable during the 1-month gap.

Data Element C

- For reporting data element C, MMPs should exclude all members who reached their 101st continuous day of a NF stay during the current reporting period. This may include members who entered the NF within the previous reporting period as well as members who entered the NF during the current reporting period.
  - For example, a member who entered a NF on October 4 of the previous reporting period and remained there on February 1 of the current reporting period reached his or her 101st day on January 13 and, therefore, would be excluded from data element C. Alternatively, a member who entered a NF on August 1 of the current reporting period and remained there on December 31 of the current reporting period reached his or her 101st day on November 9 and would also be excluded from data element C.

General Guidance

- For data elements B and C, when determining the number of continuous days a member resided in the NF, if a member is transferred or discharged from the NF and then is readmitted to any NF within 30 days, the transfer/discharge and subsequent readmission do not disrupt the count of continuous days.
  - For example, if a member is transferred from the NF to the hospital on day 57 and is subsequently readmitted to the same or a different NF 29 days later, this will be counted as the same episode. The member’s first day after returning to a NF (i.e., the day the member is readmitted to the NF) will count as day 58 for that episode, not as day 1.
  - If a member is transferred from the NF and then is readmitted to any NF after 30 days, the date of readmission is the start of a new episode in the NF and will count as day 1 toward the member’s continuous days in the facility.
- NF services are those services provided by nursing homes certified by Medicaid, Medicare, or other state agencies. NF includes skilled nursing facilities (not Adult Family Care Homes [AFCH], Assisted Living Facilities [ALF], Intermediate Care Facilities [ICF], or Supportive Living Facilities [SLF]).
- This measure will not be reported until Calendar Year 2.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).
9.3 Minimizing Institutional Length of Stay.

### CONTINUOUS REPORTING

<table>
<thead>
<tr>
<th>Reporting Section</th>
<th>Reporting Frequency</th>
<th>Level</th>
<th>Reporting Period</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Utilization</td>
<td>Annually</td>
<td>Contract</td>
<td>Calendar Year, beginning CY2</td>
<td>By the end of the fourth month following the last day of the reporting period</td>
</tr>
</tbody>
</table>

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of admissions to institutional facilities.</td>
<td>Total number of admissions to institutional facilities between July 1 of the year prior to the reporting period and June 30 of the current reporting period for members who were continuously enrolled from the date of the institutional facility admission (IFA) through 160 days following the IFA date, with no gaps in enrollment.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>B.</td>
<td>Total number of discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission.</td>
<td>Of the total reported in A, the number of discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission.</td>
<td>Field Type: Numeric Note: Is a subset of A.</td>
</tr>
<tr>
<td>Element Letter</td>
<td>Element Name</td>
<td>Definition</td>
<td>Allowable Values</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>C.</td>
<td>Total number of expected discharges to the community.</td>
<td>Total number of expected discharges to the community for all admissions in data element A.</td>
<td>Field Type: Numeric</td>
</tr>
</tbody>
</table>

**B. QA Checks/Thresholds** – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

**C. Edits and Validation Checks** – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element C is less than or equal to data element A.

**D. Analysis** – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. An observed performance rate, expected performance rate, and the ratio of observed to expected rates are reported.

- For the total number of admissions to institutional facilities, CMS and the state will evaluate the percentage of observed discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission. (Observed Performance Rate)
  - Percentage = (B / A) * 100
- For the total number of admissions to institutional facilities, CMS and the state will evaluate the percentage of expected discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission. (Expected Performance Rate)
  - Percentage = (C / A) * 100
- CMS and the state will evaluate the ratio of observed to expected discharge rates.
  - Observed Performance Rate / Expected Performance Rate

**E. Notes** – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

**Definitions**

- An **institutional facility** (i.e., institution) is a Medicaid- or Medicare-certified nursing facility providing skilled nursing/medical care; rehabilitation needed due to injury, illness or disability; and long-term care (also referred to as
“custodial care”) or Medicaid certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

- **An institutional facility admission (IFA)** is an admission to the institutional setting directly from the community between July 1 of the year prior to the reporting period and June 30 of the current reporting period. Includes admissions to the institutional setting from the hospital setting only if the member lived in a community residence prior to the hospital admission.

- **A discharge to the community** is a discharge to a community residence from the institutional facility for all IFA between July 1 of the year prior to the reporting period and October 31 of the current reporting period. Includes discharges to the hospital setting only if the member was discharged from the hospital to a community residence between July 1 of the year prior to the reporting period and October 31 of the current reporting period.

- **A community residence** refers to any residence that is not an institutional facility. This may include assisted living, adult foster care, home, or another residential setting that is not defined as an institution.

- **The classification period is the 180 days prior to and including the IFA date.**

**Data Element A**

- Report on all paid claims only.

- For the purposes of this measure the “year prior to the reporting period” is defined as the previous calendar year. The “current reporting period” is defined as the current calendar year.
  - For example, for data submitted on April 30, 2021, the previous calendar year is January 1, 2019 – December 31, 2019, and the current calendar year is January 1, 2020 – December 31, 2020.

- MMPs should include all IFAs for members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period.

- The denominator for this measure is based on admissions, not members.

- To identify all new IFAs:
  - Step 1: Identify all new admissions to institutional facilities (i.e., do not include admissions for continuing stays) between July 1 of the year prior to the reporting period and June 30 of the current reporting period (Institutional Facility value set).
  - Step 2: Remove admissions that are direct transfers from another institution. If the original admission date to the institutional facility is prior to July 1 of the year prior to the reporting period, exclude both the original admission and the transfer admission from the measure. Otherwise, keep the original admission date as the date of new IFA. A direct transfer is when the discharge date from the first institutional facility setting precedes the admission date to a second institutional facility setting by one calendar day or less. For example:
    - An institutional facility discharge on June 1, followed by an admission to another institutional facility setting on June 1, is a direct transfer.
• An institutional facility discharge on June 1, followed by an admission to an institutional facility setting on June 2, is a direct transfer.
• An institutional facility discharge on June 1, followed by an admission to another institutional facility setting on June 3, is not a direct transfer; these are two distinct new institutional facility stays.
  o Step 3: Remove admissions to the institutional facility from the hospital when the hospital admission originated from an institution. Keep the original IFA date (that preceded the admission to the hospital) as the date of the new IFA.
  o Step 4: Remove admissions that result in death in the institution or death within one day of discharge from the institution.
  o Step 5: If the member is discharged to the hospital and remains in the hospital at the end of the current reporting period or dies in the hospital, exclude the admission from the count of IFA.
  o Step 6: Calculate continuous enrollment. Remove admissions for members who do not meet the continuous enrollment criteria.

Data Element B

• Report on all paid claims only.
• To identify the count of discharges from an institutional facility to a community residence:
  o Step 1: Look for the location of the first discharge for each IFA in between July 1 of the year prior to the reporting period and October 31 of the current reporting period and:
    ▪ If the member is discharged to the community, calculate length of stay (LOS) as the date of institution discharge minus the IFA date.
    ▪ If there is no discharge, calculate LOS as the date of the last day of the current reporting period minus the IFA date.
    ▪ If the member is discharged from the institution to a hospital, look for the hospital discharge and location of discharge from the hospital. If the member is discharged from the hospital to a community residence, calculate LOS as the date of hospital discharge minus the IFA date.
      • For example, consider a member who is admitted to a skilled nursing facility (SNF) from a hospital. After 50 days at the SNF, the member develops an infection and is admitted to a hospital for 14 days. The member is discharged to home from the hospital on day 15. The LOS is 64 days, or the date of hospital discharge minus the IFA date.
    ▪ If the member is discharged from a hospital to the institution, repeat Step 1 until there is a discharge to the community or the end of the current reporting period.
• For example, consider a member who is discharged from a hospital to a SNF for recovery. After 50 days at the SNF, the member develops an infection and is admitted to a hospital for 14 days. The member is discharged from the hospital back to the SNF and is then discharged to home on day 41 of their second stay at the SNF. The LOS is 104 days, starting from the date of the IFA through the discharge home date.

  ▪ If the member is discharged to a different institution (i.e., a transfer), repeat Step 1 until there is a discharge to the community or the end of the current reporting period.
  ▪ When counting the duration of each stay within the reporting period, include the day of entry (admission) but not the day of discharge unless the admission and discharge occurred on the same day, in which case the number of days in the stay is equal to one.

  o Step 2: Using information from Step 1, identify all IFA with length of stay of less than or equal to 100 days. This should include only discharges to the community (either directly from the institution or from the institution to the hospital to a community residence).
  o Step 3: Remove discharge if the member was hospitalized, died or was re-admitted to the institution within 60 days of the day of discharge.

Data Element C

• Data element C should be rounded and reported to two decimal places using standard round to nearest rules. For example, a value of 4.7346 rounds down to 4.73, while a value of 4.7352 rounds up to 4.74.

Risk Adjustment Determination

• Report on all paid claims only.
• For each IFA, use the following steps to identify risk adjustment categories based on age and gender, dual eligibility, diagnoses from the IFA, and number of hospital stays and months of enrollment in the classification period.
  o Age and Gender
    ▪ Determine the member’s age and gender on the date of IFA and assign to the following categories:
      • Female age 18-44
      • Female age 45-64
      • Female age 65-74
      • Female age 75-84
      • Female age 85+
      • Male age 18-44
      • Male age 45-64
      • Male age 65-74
      • Male age 75-84
      • Male age 85+
o Dual eligibility
  ▪ Determine the member’s dual eligibility status on the date of IFA. All members should be identified as dually eligible.
o Diagnoses
  ▪ Assign all applicable Chronic Conditions Data Warehouse (CCW) code(s) to the IFA based on the IFA’s diagnoses using the CCW Categories value set.
  ▪ For direct transfers, use all diagnoses that occurred during the episode (i.e., original admission diagnoses and direct transfer’s diagnoses).
  ▪ Exclude diagnoses that cannot be mapped to the Risk Adjustment Weights value set.
o Number of hospital stays
  ▪ Determine if the member had any acute hospitalizations in the six months prior to the reporting period. Classify the total count of acute hospitalizations as 0, 1, or 2 or more.
o Days of enrollment in MMP
  ▪ Determine the number of days the member has been enrolled in the MMP prior to the IFA date. Classify the total days of enrollment as less than 180 days or greater than or equal to 180 days.

Risk Adjustment Weighting

- For each IFA, use the following steps to identify risk adjustment weights based on age and gender, dual eligibility, diagnoses from the IFA, and number of hospital stays and months of enrollment in the classification period. Risk adjustment weights are provided in the Risk Adjustment Weights value set.
  o Step 1: Identify the base risk weight. The base risk weight will be the same for all members.
  o Step 2: Link the age and gender weights for each IFA
  o Step 3: Link the dual eligibility weight for each IFA
  o Step 4: For each IFA with an admission CCW category, link the CCW category weight
  o Step 5: For each IFA with one or more hospitalizations prior to IFA, link the number of hospitalizations weight
  o Step 6: For each IFA with six months or more of enrollment prior to the IFA, link the six months enrollment weight
  o Step 7: Sum all weights associated with the IFA (i.e., base, age and gender, dual eligibility, qualified CCW categories, number of hospitalizations, and six months of enrollment weight) to calculate the expected estimated probability of successful discharge to the community for each IFA
    ▪ Expected Discharge Probability = \[\frac{\exp(\text{sum of weights for IFA})}{1+\exp(\text{sum of weights for IFA})}\]
      Note: “exp” refers to the exponential or antilog function
Step 8: Calculate the count of successful discharges to the community. The count of expected discharges is the sum of the estimated discharge probability calculated in Step 7 for each IFA.

- Count of Expected Discharges = \( \sum \text{(Estimated Discharge Probability)} \)

As an example, Table 3 on the following page provides a sample calculation of expected discharge probability for a hypothetical member with the following characteristics: male; 88 years old; dual eligibility; had two pre-period hospital stays; and had a stroke.

**General Guidance**

- This measure will not be reported until Calendar Year 2. For MMPs that began operating before January 1, 2017, this measure will be reported for the first time in April 2021, where the prior reporting period is CY 2019 and the current reporting period is CY 2020.

**F. Data Submission – how MMPs will submit data collected to CMS and the state.**

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).
### Table 3. Expected Discharge Probability Example

<table>
<thead>
<tr>
<th>Base Risk Weight</th>
<th>Age</th>
<th>Gender</th>
<th>Age and Gender Weight</th>
<th>Dual Eligibility Weight</th>
<th>Number of Hospital Stays</th>
<th>Number of Hospital Stays Weight</th>
<th>ICD-10 Diagnosis Codes</th>
<th>CCW Weight</th>
<th>6+ Months of Enrollment</th>
<th>Sum of Weights</th>
<th>Expected Discharge Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>-0.9966</td>
<td>88</td>
<td>Male</td>
<td>0.4395</td>
<td>0.1157</td>
<td>2</td>
<td>-0.4930</td>
<td>G45.9 Stroke</td>
<td>-0.5140</td>
<td>0</td>
<td>-1.4484</td>
<td>0.1902</td>
</tr>
</tbody>
</table>

In this example, the expected probability of having a successful discharge during the reporting period for this member is:

\[
\text{Expected Discharge Probability} = \frac{\exp(-0.9966 + 0.4395 + 0.1157 - 0.4930 - 0.5140)}{1 + \exp(-0.9966 + 0.4395 + 0.1157 - 0.4930 - 0.5140)} = 0.1902
\]
# Approval Review Tool

## All LOB's

| (a) Approval Tracking # | (b) File Type requested | (c) Auto Authorization | (d) Referral Received Date | (e) Decision Date | (f) Decision Time | (g) Member Written Notification | (h) Physician Written Notification | (i) Member Written Notification | (j) Practitioner Written Notification | (k) Clinical Information | (l) Referral Form | (m) Correct Template | (n) Points Possible | (o) Points Received | (p) Individual Score | (q) Total Score |
|------------------------|------------------------|------------------------|---------------------------|-------------------|------------------|-----------------------------|-----------------------------|-----------------------------|-------------------------------|------------------|----------------|-------------------|----------------|----------------|-------------------|...............|
| 1                      | 0%                     | 0%                     | 0%                        | 0%                | 0%               | 0%                          | 0%                          | 0%                          | 0%                            | 0%               | 0%                        | 0%                | 0%               | 0%                | 0%                        |
| 2                      | 0%                     | 0%                     | 0%                        | 0%                | 0%               | 0%                          | 0%                          | 0%                          | 0%                            | 0%               | 0%                        | 0%                | 0%               | 0%                | 0%                        |
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### Data Dictionary

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### Policy and/or Regulation

- CMS UM Timeliness, IEHP Provider Policy and Procedure Medicare DuaKchoice 01/21 Policy 14A - Denial Letters
MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
REPORTING REQUIREMENTS:
CALIFORNIA-SPECIFIC REPORTING REQUIREMENTS

Issued February 28, 2020
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CALIFORNIA-SPECIFIC REPORTING REQUIREMENTS APPENDIX

Introduction
The measures in this appendix are required reporting for all MMPs in the Cal MediConnect Demonstration. CMS reserves the right to update the measures in this appendix for subsequent demonstration years. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements, which can be found at the following web address:


MMPs should refer to the core document for additional details regarding Demonstration-wide definitions, reporting phases and timelines, and sampling methodology.

The core and state-specific measures supplement existing Part C and Part D Reporting Requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS® and HOS. CMS and the State will also track key utilization measures, which are not included in this document, using encounter and claims data. The quantitative measures are part of broader oversight, monitoring, and performance improvement processes that include several other components and data sources not described in this document.

For the measures contained within the California state-specific appendix, MMPs will be required to submit data at the contract level. Additional information regarding the Data Submission process is provided on page CA-11.

MMPs should contact the CA HelpDesk at CAHelpDesk@norc.org with any questions about the California state-specific appendix or the data submission process.

Definitions
Calendar Quarter: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year will be as follows: January 1 to March 31, April 1 to June 30, July 1 to September 30, and October 1 to December 31.

Calendar Year: All annual measures are reported on a calendar year basis. For example, Calendar Year (CY) 2020 represents January 1, 2020 through December 31, 2020.

Case Management, Information and Payrolling System II (CMIPS II): A system that tracks case information and processes payments for the California Department of Social Services In-Home Supportive Services Program, enabling nearly 400,000 qualified aged, blind, and disabled individuals in California to remain in their own homes and avoid institutionalization.

In-Home Supportive Services (IHSS): Pursuant to Article 7 of the California Welfare and Institutions Code (WIC) (commencing with Section 12300) of Chapter 3, and WIC

1 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
Sections 14132.95, 14132.952, and 14132.956, IHSS is a California program that provides in-home care for people who cannot safely remain in their own homes without assistance. To qualify for IHSS, an Enrollee must be aged, blind, or disabled and, in most cases, have income below the level to qualify for the Supplemental Security Income/State Supplementary Program. IHSS includes the Community First Choice Option (CFCO), Personal Care Services Program (PCSP), and IHSS-Plus Option (IPO).

Implementation Period: The initial months of the demonstration during which MMPs reported to CMS and the state on a more intensive reporting schedule. The Implementation Period started with the first effective enrollment date until the end of the first full quarter following the third wave of passive enrollment (therefore, all MMPs had an Implementation Period of at least six months). For MMPs that added a county in 2015, the Implementation Period continued for a full quarter following the first effective date of enrollment. For MMPs with less than three waves of passive enrollment, the Implementation Period ended September 30, 2014.

Individualized Care Plan (ICP or Care Plan): The plan of care developed by an Enrollee and/or an Enrollee’s Interdisciplinary Care Team or health plan.

Long Term Services and Supports (LTSS): A wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following:

1. IHSS provided pursuant to Article 7 of California WIC (commencing with Section 12300) of Chapter 3, and WIC Sections 14132.95, 14132.952, and 14132.956;
2. Community-Based Adult Services (CBAS);
3. Multipurpose Senior Services Program (MSSP) services; and
4. Skilled nursing facility (SNF) services and subacute care services.

Primary Care Provider (PCP): A person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a physician or non-physician medical practitioner.

Variation from the Core Reporting Requirements Document

Core Measure 9.2

The following section provides additional guidance about identifying individuals enrolled in the MMP as “nursing home certifiable,” or meeting the nursing facility level of care (NF LOC), for the purposes of reporting Core 9.2.

Within Core 9.2, “nursing home certifiable” members are defined as “members living in the community but requiring an institutional level of care” (see the Core Reporting Requirements for more information). Please reference Title 22, CCR Division 3,
sections 51173.1, 51120, 51124, 51124.5, 51125.6, 51334, and 51335 of the CA Code of Regulations for additional information and definitions as it relates to this measure.

The Medicaid 834 eligibility file provided to MMPs by the state on a daily and monthly basis contains variables indicating an individual's status with regard to meeting the NF LOC. The relevant variables are as follows:

- **Variable 3.8. Institutional Indicator (Y):** Identifies actual institutional placement (i.e., anyone residing in a SNF for 90 or more consecutive days).
- **Variable 3.7. CCI Exclusion Indicator (M, N):** Indicates that a member lives in the community and meets the NF LOC for CBAS and MSSP only.
- **Eligibility status code 2K, Loop 2300 REF 01 under ‘CE’** (Note: Status code 2K could be found in any of the following fields - SPEC1-AID, SPEC2-AID, SPEC3-AID): Indicates that a member lives in the community and meets the NF LOC for IHSS only.

In addition to these variables in the 834 file, MMPs should use claims data to ensure the member qualifies as nursing home certifiable, (i.e., is living in the community or has resided in a NF for fewer than 100 days). This may include individuals who have resided in a NF for 90 – 99 days and have thus triggered the long-term care (LTC) indicator, but still fall below the 100-day threshold for the purposes of Core 9.2.

It is possible that some individuals who have never been assessed for LTSS (e.g., community well or individuals stratified as HCBS low) will indeed be nursing home certifiable and this status will be unknown to the MMP. This is a limitation of this measure. Provided that MMPs comply with the requirements for assessment and care planning under the Demonstration, no further action by the MMP to identify these individuals is necessary.

**Quality Withhold Measures**

CMS and the state will establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, state-specific quality withhold measures are marked with the following symbol for Demonstration Year 1: (i) and the following symbol for Demonstration Years 2 through 8: (ii). Note that an additional DY 2 through 8 state-specific quality withhold measure is reported separately through the Core Reporting Requirements. For more information about the state-specific quality withhold measures, refer to the Quality Withhold Technical Notes (DY 1): California-Specific Measures and the Quality Withhold Technical Notes (DY 2-8): California-Specific Measures at [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordinati](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html).

**Reporting on HRAs and ICPs Completed Prior To First Effective Enrollment Date**

MMPs may complete Health Risk Assessments (HRAs) prior to individuals’ effective date of enrollment, provided that the MMP meets the requirements as articulated in the National MMP Enrollment and Disenrollment Guidance. Note that for individuals who
are passively enrolled, the MMP may reach out to complete an HRA no sooner than 20 days before the individual’s effective date of the passive enrollment.

For purposes of reporting data on HRAs (Core 2.1 and Core 2.2), MMPs should report any HRAs completed prior to the first effective enrollment date as if they were completed on the first effective enrollment date. For example, if a member’s first effective enrollment date was June 1 and the HRA for that member was completed on May 25, the MMP should report the HRA as if it was completed on June 1.

MMPs should refer to the Core Reporting Requirements for detailed specifications for reporting Core 2.1 and Core 2.2. For example, Core 2.1 should only include members whose 90th day of enrollment occurred during the reporting period. Members enrolled into the MMP on June 1 would reach their 90th day (three full months) on August 31. Therefore, these members would be reported in the data submission for the Quarter 3 reporting period, even if their HRA was marked as complete on the first effective enrollment date (i.e., June 1).

MMPs must comply with contractually specified timelines regarding completion of ICPs following the HRA. In the event that an ICP is also finalized prior to the first effective enrollment date, MMPs should report completion of the ICP (for measures Core 3.2, CA1.5, and CA1.6) as if it was completed on the first effective enrollment date. For example, if a member’s first effective enrollment date was June 1 and the ICP for that member was completed on May 27, the MMP should report the ICP as if it were completed on June 1.

Guidance on HRAs and ICPs for Members with a Break in Coverage

Health Risk Assessments

To determine if an HRA should be conducted for a member who re-enrolled in the same or a different MMP, the MMP should determine if the member previously received an HRA from any MMP in the Cal MediConnect Demonstration. If the member received an HRA from the same MMP within one year of his/her most recent enrollment date, or from a different MMP within six months of changing MMPs, then the MMP is not necessarily required to conduct a new HRA, until there is a change in the enrollee’s condition. Instead, the MMP can:

1. Perform any risk stratification, claims data review, or other analyses as required by the three-way contract to detect any changes in the member’s condition since the HRA was conducted; and

2. Ask the member (or his/her authorized representative) if there has been a change in the member’s health status or needs since the HRA was conducted.

The MMP must document any risk stratification, claims data review, or other analyses that are performed to detect any changes in the member’s condition. The MMP must also document its outreach attempts and the discussion(s) with the member (or his/her authorized representative) to determine if there was a change in the member’s health status or needs.

If a change is identified, the MMP must conduct a new HRA within the timeframe prescribed by the three-way contract. If there are no changes, the MMP is not required
to conduct a new HRA unless requested by the member (or his/her authorized representative). Please note, if the MMP prefers to conduct HRAs on all re-enrollees regardless of status, it may continue to do so.

Once the MMP has conducted a new HRA as needed or confirmed that the prior HRA is still accurate, the MMP can mark the HRA as complete for the member’s current enrollment. The MMP would then report that completion according to the specifications for Core 2.1 and Core 2.2. When reporting these measures, the MMP should count the number of enrollment days from the member’s most recent enrollment effective date and should report the HRA based on the date the prior HRA was either confirmed to be accurate or a new HRA was completed. Additionally, in certain circumstances a new assessment that has been completed for a member upon reenrollment may also be reported in Core 2.3.

If the MMP is unable to reach a re-enrolled member to determine if there was a change in health status, then the MMP may report that member as unable to be reached so long as the MMP made the requisite number of outreach attempts. If a re-enrolled member refuses to discuss his/her health status with the MMP, then the MMP may report that member as unwilling to participate in the HRA.

If the MMP did not complete an HRA for the re-enrolled member within one year of his/her most recent date of enrollment into the same MMP or an HRA was not completed for the member within the previous six months by a different MMP for those members who changed MMPS, the MMP is required to conduct an HRA for the member within the timeframe prescribed by the three-way contract and relevant Duals Plan Letter (DPL). The MMP must make the requisite number of attempts to reach the member (at minimum) after his/her most recent enrollment effective date, even if the MMP reported that the member was unable to be reached during his/her prior enrollment. Similarly, members who refused the HRA during his/her prior enrollment must be asked again to participate (i.e., the MMP may not carry over a refusal from one enrollment period to the next).

**Individualized Care Plans**

If the MMP conducts a new HRA for the re-enrolled member, the MMP must revise the ICP accordingly within the timeframe prescribed by the three-way contract. Once the ICP is revised, the MMP may mark the ICP as complete for the member’s current enrollment. If the MMP determines that the prior HRA is still accurate and, therefore, no updates are required to the previously completed ICP, the MMP may mark the ICP as complete for the current enrollment at the same time that the HRA is marked complete. The MMP would then follow the Core 3.2, CA1.5, and CA1.6 measure specifications for reporting the completion. Please note, for purposes of reporting, the ICP for the re-enrolled member should be classified as an *initial ICP*.

If the MMP did not complete an ICP for the re-enrolled member during his/her prior enrollment period, or if it has been more than one year since the member’s ICP was completed, the MMP is required to complete an ICP for the member within the timeframe prescribed by the three-way contract. The MMP must also follow the above guidance regarding reaching out to members who previously refused to participate or were not reached.
Annual Reassessments and ICP Updates

The MMP must follow the three-way contract requirements regarding the completion of annual reassessments and updates to ICPs. If the MMP determined that an HRA/ICP from a member’s prior enrollment was accurate and marked that HRA/ICP as complete for the member’s current enrollment, the MMP should count continuously from the date that the HRA/ICP was completed in the prior enrollment period to determine the due date for the annual reassessment and ICP update. For example, when reporting Core 2.3, the MMP should count 365 days from the date when the HRA was actually completed, even if that date was during the member’s prior enrollment period.

Reporting on Passively Enrolled and Opt-In Enrolled Members

When reporting all California state-specific measures, MMPs should include all members who meet criteria for inclusion in the measure regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.

Reporting on Disenrolled and Retro-disenrolled Members

Unless otherwise indicated in the reporting requirements, MMPs should report on all members enrolled in the demonstration who meet the definition of the data elements, regardless of whether that member was subsequently disenrolled from the MMP. Measure-specific guidance on how to report on disenrolled members is provided under the Notes section of each state-specific measure.

Due to retro-disenrollment of members, there may be instances where there is a lag between a member’s effective disenrollment date and the date on which the MMP is informed about that disenrollment. This time lag might create occasional data inaccuracies if an MMP includes members in reports who had in fact disenrolled before the start of the reporting period. If MMPs are aware at the time of reporting that a member has been retro-disenrolled with a disenrollment effective date prior to the reporting period (and, therefore, was not enrolled during the reporting period in question), then MMPs may exclude that member from reporting. Please note that MMPs are not required to re-submit corrected data should they be informed of a retro-disenrollment subsequent to a reporting deadline. MMPs should act upon their best and most current knowledge at the time of reporting regarding each member’s enrollment status.

Hybrid Sampling

Some demonstration-specific measures may allow medical record/supplemental documentation review to identify the numerator. In these instances, the sample size should be 411, plus additional records to allow for substitution. Sampling should be systematic to ensure that all individuals eligible for a measure have an equal chance of inclusion.

MMPs should complete the following steps for each measure that requires medical record review:
**Step 1:** Determine the eligible population. Create a list of eligible members, including full name, date of birth, and event (if applicable).

**Step 2:** Determine the final sample size. The final sample size will be 411 plus an adequate number of additional records to make substitutions. Oversample only enough to guarantee that the targeted sample size of 411 is met. The following oversampling rates are acceptable: 5 percent, 10 percent, 15 percent, or 20 percent. If oversampling, round up to the next whole number when determining the final sample size.

**Step 3:** If the eligible population exceeds the final sample size as determined in Step 2, proceed to Step 5. If the eligible population is less than or equal to the final sample size as determined in Step 2, proceed to Step 4.

**Step 4:** If the eligible population is less than or equal to the final sample size as determined in Step 2, the sample size can be reduced from 411 cases to a reduced final sample size by using the following formula:

\[
\text{Reduced Final Sample Size} = \frac{\text{Original Final Sample Size}}{1 + \left( \frac{\text{Original Final Sample Size}}{\text{Eligible Population}} \right)}
\]

Where the **Original Final Sample Size** is the number derived from Step 2, and the **Eligible Population** is the number derived from Step 1.

**Step 5:** Sort the list of eligible members in alphabetical order by last name, first name, date of birth, and event (if applicable). Sort this list by last name from A to Z during even reporting periods and from Z to A in odd reporting periods (i.e., name will be sorted from A to Z in 2014, 2016, and 2018 and from Z to A in 2015, 2017, and 2019).

**Note:** Sort order applies to all components. For example, for reporting period 2014, the last name, first name, date of birth, and events will be ascending.

**Step 6:** Calculate \( N \), which will determine which member will start your sample. Round down to the nearest whole number.

\[
N = \frac{\text{Eligible Population}}{\text{Final Sample Size}}
\]

Where the **Eligible Population** is the number derived from Step 1. The **Final Sample Size** is either:

- The number derived from Step 2, for instances in which the eligible population exceeds the final sample size as determined in Step 2. **OR**
- The number derived in Step 4, for instances in which the eligible population was less than or equal to the number derived from Step 2.

**Step 7:** Randomly select starting point, \( K \), by choosing a number between one and \( N \) using a table of random numbers or a computer-generated random number.
**Step 8:** Select every \( Kth \) record thereafter until the selection of the sample size is completed.

**Value Sets**

The measure specifications in this document refer to code value sets that must be used to determine and report measure data element values. A value set is the complete set of codes used to identify a service or condition included in a measure. The California-Specific Value Sets Workbook includes all value sets and codes needed to report certain measures included in the California-Specific Reporting Requirements and is intended to be used in conjunction with the measure specifications outlined in this document. The California-Specific Value Sets Workbook can be found on the CMS website at the following address: [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPIInformationandGuidance/MMPRreportingRequirements.html](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPIInformationandGuidance/MMPRreportingRequirements.html).

**California’s Implementation, Ongoing, and Continuous Reporting Periods**

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<tr>
<td>Demonstration Year 8</td>
<td>Ongoing Period</td>
<td>From January 1, 2022 through the end of the eighth full calendar year of the demonstration.</td>
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**Data Submission**

All MMPs will submit state-specific measure data through the web-based Financial Alignment Initiative Data Collection System (FAI DCS) (unless otherwise specified in the measure description). All data submissions must be submitted to this site by 5:00 p.m. ET on the applicable due date. This site can be accessed at the following web address: [https://Financial-Alignment-Initiative.NORC.org](https://Financial-Alignment-Initiative.NORC.org).

(Note: Prior to the first use of the system, all MMPs will receive an email notification with the username and password that has been assigned to their MMP. This information will be used to log in to the FAI DCS and complete the data submission.)
All MMPs will submit core measure data in accordance with the Core Reporting Requirements. Submission requirements vary by measure, but most core measures are reported through the Health Plan Management System (HPMS).

Please note, late submissions may result in compliance action from CMS.

**Resubmission of Data**

MMPs must comply with the following steps to resubmit data after an established due date:

1. Email the CA HelpDesk ([CAHelpDesk@norc.org](mailto:CAHelpDesk@norc.org)) to request resubmission.
   a. Specify in the email which measure(s) need resubmission;
   b. Specify for which reporting period(s) the resubmission is needed; and
   c. Provide a brief explanation for why the data need to be resubmitted.

2. After review of the request, the CA HelpDesk will notify the MMP once the FAI DCS and/or HPMS has been re-opened.

3. Resubmit data through the applicable reporting system.

4. Notify the CA HelpDesk again after resubmission has been completed.

Please note, requests for resubmission after an established due date may result in compliance action from CMS.
Section CA1. Care Coordination

CA1.1 High-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the timely initial Health Risk Assessment (HRA). – Retired

CA1.2 High-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the initial Health Risk Assessment (HRA). – Retired

CA1.3 Low-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the timely initial Health Risk Assessment (HRA). – Retired

CA1.4 Low-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the initial Health Risk Assessment (HRA). – Retired

CA1.5 Members with an Individualized Care Plan (ICP) completed.

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</table>

<table>
<thead>
<tr>
<th>Reporting Section</th>
<th>Reporting Frequency</th>
<th>Level</th>
<th>Reporting Periods</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA1. Care Coordination</td>
<td>Quarterly</td>
<td>Contract</td>
<td>Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31</td>
<td>By the end of the second month following the last day of the reporting period</td>
</tr>
</tbody>
</table>
A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

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<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of high-risk members enrolled for 90 days or longer as of the end of the reporting period.</td>
<td>Total number of high-risk members enrolled for 90 days or longer as of the end of the reporting period who were currently enrolled as of the last day of the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>B.</td>
<td>Total number of high-risk members who had an initial ICP completed.</td>
<td>Of the total reported in A, the number of high-risk members who had an initial ICP completed as of the end of the reporting period.</td>
<td>Field Type: Numeric, Note: Is a subset of A.</td>
</tr>
<tr>
<td>C.</td>
<td>Total number of low-risk members enrolled for 90 days or longer as of the end of the reporting period.</td>
<td>Total number of low-risk members enrolled for 90 days or longer as of the end of the reporting period who were currently enrolled as of the last day of the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>D.</td>
<td>Total number of low-risk members who had an initial ICP completed.</td>
<td>Of the total reported in C, the number of low-risk members who had an initial ICP completed as of the end of the reporting period.</td>
<td>Field Type: Numeric, Note: Is a subset of C.</td>
</tr>
</tbody>
</table>

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
• MMPs should validate that data element B is less than or equal to data element A.
• MMPs should validate that data element D is less than or equal to data element C.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:
  • High-risk members enrolled for 90 days or longer who had an initial ICP completed as of the end of the reporting period.
    o Percentage = (B / A) * 100
  • Low-risk members enrolled for 90 days or longer who had an initial ICP completed as of the end of the reporting period.
    o Percentage = (D / C) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definitions
• **High-risk members** are members who are at increased risk for having an adverse health outcome or worsening of his or her health status if he or she does not receive initial contact within 45 calendar days after their effective enrollment date.
• **Low-risk members** are members who do not meet the minimum requirements of a high-risk member.

Data Elements A and C
• The 90th day of enrollment should be based on each member’s most recent effective enrollment date in the MMP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment (or longer) with no gaps in enrollment.
• For the purposes of reporting data elements A and C, 90 days of enrollment will be equivalent to three full calendar months.

Data Elements B and D
• The completed initial ICPs reported in data elements B and D could have been completed at any point from the member’s first day of enrollment through the end of the reporting period.
• MMPs should only report completed ICPs in data elements B and D when the member or the member’s authorized representative was involved in the development of the ICP.

General Guidance
• MMPs should refer to the California three-way contract for specific requirements pertaining to ICPs.
• Risk level should be determined using an approved health risk stratification mechanism or algorithm. The health risk stratification shall be conducted in accordance with the most recent DHCS DPL. MMPs should use the
member’s initial risk level categorization for purposes of reporting this measure.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

CA1.6 Members with documented discussions of care goals.\textsuperscript{i, ii}

<table>
<thead>
<tr>
<th>Reporting Section</th>
<th>Reporting Frequency</th>
<th>Level</th>
<th>Reporting Period</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA1. Care Coordination</td>
<td>Annually</td>
<td>Contract</td>
<td>Calendar Year</td>
<td>By the end of the second month following the last day of the reporting period</td>
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</tbody>
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A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

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<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of members with an initial Individualized Care Plan (ICP) completed.</td>
<td>Total number of members with an initial ICP completed during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>B.</td>
<td>Total number of members sampled that met inclusion criteria.</td>
<td>Of the total reported in A, the number of members sampled that met inclusion criteria.</td>
<td>Field type: Numeric Note: Is a subset of A.</td>
</tr>
<tr>
<td>C.</td>
<td>Total number of members with at least one documented discussion of care goals in the initial ICP.</td>
<td>Of the total reported in B, the number of members with at least one documented discussion of care goals in the initial ICP.</td>
<td>Field Type: Numeric Note: Is a subset of B.</td>
</tr>
<tr>
<td>D.</td>
<td>Total number of existing ICPs revised.</td>
<td>Total number of existing ICPs revised during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
</tbody>
</table>
Element Letter | Element Name                                                                 | Definition                                                                                                                                                                                                 | Allowable Values                                                                                           |
---|---|---|---|
E. | Total number of revised ICPs sampled that met inclusion criteria. | Of the total reported in D, the number of revised ICPs sampled that met inclusion criteria.                                                                                                                     | Field Type: Numeric                                                                                       |
     |                                                                 |                                                                                                                                           | Note: Is a subset of D.                                                                                   |
F. | Total number of revised ICPs with at least one documented discussion of new or existing care goals. | Of the total reported in E, the number of revised ICPs with at least one documented discussion of new or existing care goals.                                                                                           | Field Type: Numeric                                                                                       |
     |                                                                 |                                                                                                                                           | Note: Is a subset of E.                                                                                   |

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- The quality withhold benchmark is 55% for DY 2 and 3, 60% for DY 4, and 65% for DY 5. For more information, including benchmarks for DY 6 – 8, refer to the Quality Withhold Technical Notes (DY 2-8): California-Specific Measures.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element C is less than or equal to data element B.
- MMPs should validate that data element E is less than or equal to data element D.
- MMPs should validate that data element F is less than or equal to data element E.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Members with an initial ICP completed during the reporting period who had evidence of creation of at least one care goal documented in the initial ICP.
  - Percentage = (C / B) * 100
- Existing ICPs revised during the reporting period that had at least one documented discussion of new or existing care goals.
  - Percentage = (F / E) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

**Data Element A**

- MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the
reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).

- Data element A should include all members with ICPs that were completed for the first time during the reporting period (i.e., the member did not previously have an ICP completed prior to the start of the reporting period). There can be no more than one initial ICP completed per member.
- Only ICPs that included participation from the member (or his/her authorized representative) in the completion of the ICP should be reported.

**Data Elements B and E**

- For reporting, the MMPs may elect to sample since this measure may require documentation review to identify data elements C and F. For further instructions on selecting the sample size, please see pages CA-9 to CA-10 of this document.
- If an MMP does not elect to sample, data element B should be equal to data element A and data element E should be equal to data element D.

**Data Element C**

- The MMP should only count members in data element C when the discussion of care goals with the member (or his/her authorized representative) is clearly documented in the member’s initial ICP.

**Data Element D**

- MMPs should include all ICPs for members who meet the criteria outlined in data element D, regardless of whether the members are disenrolled as of the end of the reporting period (i.e., include all ICPs regardless of whether the members are currently enrolled or disenrolled as of the last day of the reporting period).
- Data element D should include all existing ICPs that were revised during the reporting period. MMPs should refer to the California three-way contract for specific requirements pertaining to updating the ICP.
- Only ICPs that included participation from the member (or his/her authorized representative) in the revision to the ICP should be reported.
- If a member’s ICP is revised multiple times during the same reporting period, each revision should be reported in data element D.
  - For example, if a member’s ICP is revised twice during the same reporting period, two ICPs should be counted in data element D.

**Data Element F**

- MMPs should only include ICPs in data element F when a new or previously documented care goal is discussed with the member (or his/her authorized representative) and is clearly documented in the member’s revised ICP.
- If the initial ICP clearly documented the discussion of care goals, but those existing care goals were not revised or discussed, or new care goals are not discussed and documented during the revision of the ICP, then that ICP should not be reported in data element F.
General Guidance

- If a member has an initial ICP completed during the reporting period, and has their ICP revised during the same reporting period, then the member’s initial ICP should be reported in data element A and the member’s revised ICP should be reported in data element D.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

CA1.7 Members receiving Medi-Cal specialty mental health services that received care coordination with the primary mental health provider.ii

<table>
<thead>
<tr>
<th>CONTINUOUS REPORTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Section</td>
</tr>
<tr>
<td>CA1. Care Coordination</td>
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<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of members receiving Medi-Cal specialty mental health services.</td>
<td>Total number of members who have been continuously enrolled in the same MMP for at least five months during the reporting period and who have received Medi-Cal specialty mental health services for three or more consecutive months during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>Element Letter</td>
<td>Element Name</td>
<td>Definition</td>
<td>Allowable Values</td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| B.             | Total number of members for whom the MMP was unable to reach the member’s county mental health provider/county clinic, following at least three documented outreach attempts, for the purpose of care coordination of the member’s mental health needs. | Of the total reported in A, the number of members for whom the MMP was unable to reach the member’s county mental health provider/county clinic, following at least three documented outreach attempts, for the purpose of care coordination of the member’s mental health needs during the reporting period. | Field Type: Numeric  
Note: Is a subset of A. |
| C.             | Total number of members for whom the MMP successfully contacted the member’s county mental health provider/county clinic for the purpose of care coordination of the member’s mental health needs. | Of the total reported in A, the number of members for whom the MMP successfully contacted the member’s county mental health provider/county clinic for the purpose of care coordination of the member’s mental health needs during the reporting period. | Field Type: Numeric  
Note: Is a subset of A. |
| D.             | Total number of members the MMP was unable to reach, following at least three documented outreach attempts, for the purpose of care coordination of the member’s mental health needs. | Of the total reported in A, the number of members the MMP was unable to reach, following at least three documented outreach attempts, for the purpose of care coordination of the member’s mental health needs during the reporting period. | Field Type: Numeric  
Note: Is a subset of A. |
<table>
<thead>
<tr>
<th>Element Letter</th>
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<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
</table>
| E.            | Total number of members the MMP successfully contacted for the purpose of care coordination of the member’s mental health needs. | Of the total reported in A, the number of members the MMP successfully contacted for the purpose of care coordination of the member’s mental health needs during the reporting period. | Field Type: Numeric  
Note: Is a subset of A.                                                  |

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that data elements B, C, D, and E are less than or equal to data element A.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members who have been continuously enrolled in the same MMP for at least five months during the reporting period and who have received Medi-Cal specialty mental health services for three or more consecutive months during the reporting period:

- For whom the MMP successfully contacted the member’s county mental health provider/county clinic for the purpose of care coordination of the member’s mental health needs during the reporting period.
  - Percentage = \((C / A) \times 100\)

- For whom the member’s county mental health provider/county clinic could be reached and who the MMP was able to successfully contact for the purpose of care coordination of the member’s mental health needs during the reporting period.
  - Percentage = \((C / (A – B)) \times 100\)

- Who the MMP successfully contacted for the purpose of care coordination of the member’s mental health needs during the reporting period.
  - Percentage = \((E / A) \times 100\)

- Who could be reached and who the MMP was able to successfully contact for the purpose of care coordination of the member’s mental health needs during the reporting period.
  - Percentage = \((E / (A – D)) \times 100\)
E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definition

- **Medi-Cal specialty mental health services** are financed and administered by county agencies under the provisions of the 1915(b) SMHS waiver. For more information, including a list of specialty mental health services, refer to the Coordinated Care Initiative and Behavioral Health Services Fact Sheet available at: [http://www.calduals.org/wp-content/uploads/2013/03/FAQ-BH.pdf](http://www.calduals.org/wp-content/uploads/2013/03/FAQ-BH.pdf).

Data Element A

- MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- To identify members who have received Medi-Cal specialty mental health services for three or more consecutive months during the reporting period, MMPs should refer to information provided by the county agencies and/or claims data provided by the state.

Data Element B

- For data element B, the MMP should only report those members for whom the MMP was unable to reach the member’s county mental health provider/county clinic following at least three documented outreach attempts for the purpose of care coordination of the member’s mental health needs during the reporting period. Documentation of outreach attempts must include:
  - The name of the member’s county mental health provider/county clinic;
  - The name of the person the MMP attempted to contact at the member’s county mental health provider/county clinic;
  - The time and date of the outreach attempt;
  - The method of the outreach attempt (e.g., phone, email, fax, in-person, etc.);
  - The outcome of the outreach attempt.

Data Element C

- For data element C, successful contact occurs when the MMP and county provider discuss diagnoses (including medical, behavioral, and social needs), review treatment plans, and/or coordinate mental health services provided by the county provider with any of the services (e.g., medical, LTSS, etc.) provided by the MMP. This exchange of information may be conducted via phone, secure email, fax, or in person.
- If the county provider is reached but is not able to discuss the member’s case at that time (e.g., due to lack of signed release), then the contact is not considered successful, but may be counted as an outreach attempt.
• If the member’s county mental health provider/county clinic was not reached after three outreach attempts, but then subsequently is successfully contacted during the reporting period for the purpose of care coordination of the member’s mental health needs, then the member should be counted in data element C.

Data Element D
• For data element D, the MMP should only report those members the MMP was unable to reach following at least three outreach attempts to contact the member for the purpose of care coordination of the member’s mental health needs during the reporting period. Documentation of outreach attempts must include:
  o The time and date of the outreach attempt;
  o The method of the outreach attempt (e.g., phone, email, fax, in-person, etc.);
  o The outcome of the outreach attempt.

Data Element E
• For data element E, successful contact occurs when the MMP and member discuss the member’s mental health needs and services, and how those services may be coordinated with other services (e.g., medical, LTSS, etc.) provided by the MMP. This discussion may be conducted via phone, secure email, fax, or in person.
• If the member was not reached after three outreach attempts, but then subsequently is successfully contacted during the reporting period for the purpose of care coordination of the member’s mental health needs, then the member should be counted in data element E.

General Guidance
• Data elements B and C are mutually exclusive (i.e., the same member should not be counted in both data elements B and C).
• Data elements D and E are mutually exclusive (i.e., the same member should not be counted in both data elements D and E).
• Data elements B and C are not mutually exclusive with data elements D and E.
  o For example, if a member’s county mental health provider/county clinic was not reached after three outreach attempts, but the member was successfully contacted during the reporting period for the purpose of care coordination of his/her mental health needs, then the member would be reported in both data elements B and E.
• The MMP does not have to conduct separate outreach to the member for the specific purpose of care coordination of the member’s mental health needs (i.e., the MMP may discuss the member’s mental health needs as part of its broader care coordination efforts, such as when conducting the HRA or developing the ICP). If the MMP discusses the member’s mental health needs when conducting the HRA or developing the ICP (or as part of other care
coordination efforts), the MMP must clearly document the outcome of the interaction with the member, following the instructions for documenting outreach attempts as noted above.

- The outreach attempts are meant to coordinate the mental health services being provided at the county with any of the services (e.g., medical, LTSS, etc.) that the MMP is providing.
- For information about care coordination expectations, MMPs should refer to the California three-way contract, which delineates care coordination requirements in several sections. The three-way contract also highlights the California Welfare and Institutions (WIC) Code for the definition and administration of care coordination (see WIC Sections 14182.17(d)(4) and 14186(b)). MMPs are encouraged to reference the three-way contract and the WIC code for guidance on care coordination for all members, including members receiving Medi-Cal specialty mental health services.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

CA1.8 Unmet Need in IHSS. – Retired

CA1.9 IHSS social worker contact with member. – Retired

CA1.10 Satisfaction with IHSS social worker, home workers, personal care. – Retired

CA1.11 Members with first follow-up visit within 30 days of hospital discharge.

<table>
<thead>
<tr>
<th>Reporting Section</th>
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<th>Level</th>
<th>Reporting Periods</th>
<th>Due Date</th>
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<tr>
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<td>Annually</td>
<td>Contract</td>
<td>Calendar Quarters Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31</td>
<td>By the end of the fourth month following the last day of the final quarterly reporting period</td>
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<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of acute inpatient hospital discharges.</td>
<td>Total number of acute inpatient hospital discharges that occurred during the reporting period for members who were continuously enrolled from the date of the inpatient hospital discharge through 30 days after the inpatient hospital discharge, with no gaps in enrollment.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>B.</td>
<td>Total number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the inpatient hospital stay.</td>
<td>Of the total reported in A, the number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the inpatient hospital stay.</td>
<td>Field Type: Numeric, Note: Is a subset of A.</td>
</tr>
</tbody>
</table>

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that data element B is less than or equal to data element A.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will:

- Evaluate the percentage of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of the discharge from the inpatient hospital stay.
  - Percentage = (B / A) * 100
• Use enrollment data to evaluate the total number of acute inpatient hospital discharges per 10,000 member months during the reporting period.
  o Rate = (A / Total Member Months) * 10,000

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

• MMPs should include all acute inpatient hospital discharges for members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period.
• The denominator for this measure is based on acute inpatient hospital discharges, not members.
• To identify all acute inpatient hospital discharges during the reporting period:
  o Identify all acute and nonacute inpatient stays (Inpatient Stay value set).
  o Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set).
  o Identify the discharge date for the stay. The date of discharge must be within the reporting period.
  o Report on all inpatient stays identified with discharges within the reporting period, including denied and pended claims.

  Additionally, MMPs should use UB Type of Bill codes 11x, 12x, 41x, and 84x or any acute inpatient facility code to identify discharges from an inpatient hospital stay.
• If the discharge is followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period, count only the last discharge for reporting in data element A. To identify readmissions and direct transfers to an acute inpatient care setting:
  o Identify all acute and nonacute inpatient stays (Inpatient Stay value set).
  o Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set).
  o Identify the admission date for the stay.

Data Element A Exclusions

• Exclude discharges for members who use hospice services or elect to use a hospice benefit at any time between the hospital discharge date and 30 days following the hospital discharge. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record, claims/encounter data (Hospice Encounter value set; Hospice Intervention value set) or supplemental data.
• Exclude discharges due to death, using the Discharges due to Death value set.
• Exclude from data element A any discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period. To identify readmissions and direct transfers to a nonacute inpatient care setting:
Identify all acute and nonacute inpatient stays (Inpatient Stay value set).

Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay value set) on the claim.

Identify the admission date for the stay.

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

- For example, the following direct transfers/readmissions should be excluded from this measure:
  - An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1 (a direct transfer).
  - An inpatient discharge on June 1, followed by a readmission to a hospital on June 15 (readmission within 30 days).

**Data Element B**

- The date of discharge must occur within the reporting period, but the follow-up visit may or may not occur in the same reporting period.
  - For example, if a discharge occurs during the last month of the reporting period, look to the first month of the following reporting period to identify the follow-up visit.

- A follow-up visit is defined as an ambulatory care follow-up visit to assess the member's health following a hospitalization. Codes to identify follow-up visits are provided in the Ambulatory Visits value set and Other Ambulatory Visits value set.

- MMPs should report ambulatory care follow-up visits based on all visits identified, including denied and pended claims, and including encounter data as necessary in cases where follow-up care is included as part of a bundled payment covering the services delivered during the inpatient stay. MMPs should use all information available, including encounter data supplied by providers, to ensure complete and accurate reporting.

**F. Data Submission – how MMPs will submit data collected to CMS and the state.**

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: [https://Financial-Alignment-Initiative.NORC.org](https://Financial-Alignment-Initiative.NORC.org).
CA1.12 Members who have a care coordinator and have at least one care team contact during the reporting period.i, ii

### CONTINUOUS REPORTING

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<tr>
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<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Total number of members who have/had a care coordinator.</td>
<td>Total number of members continuously enrolled for six months during the reporting period with no gaps in enrollment who have/had a care coordinator during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>B</td>
<td>Total number of members who had at least one care coordinator or other care team contact.</td>
<td>Of the total reported in A, the number of members who had at least one care coordinator or other care team contact.</td>
<td>Field Type: Numeric</td>
</tr>
</tbody>
</table>

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- The quality withhold benchmark is 78% for DY 2 and 3, 83% for DY 4, and 88% for DY 5. For more information, including benchmarks for DY 6 – 8, refer to the Quality Withhold Technical Notes (DY 2-8): California-Specific Measures.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that data element B is less than or equal to data element A.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
• CMS and the state will evaluate the percentage of members who have/had a care coordinator who had at least one care coordinator or other care team contact during the reporting period.
  o Percentage = (B / A) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

• MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).

Data Element B

• The contact can be from the care coordinator or another member of the care team, depending on the member’s needs.
• MMPs should include only successful care coordinator or other care team contacts in data element B.
• MMPs should refer to the California three-way contract for specific requirements pertaining to the care team.
• For the purposes of reporting this measure, care coordinator or care team contact includes a discussion by phone or in person between the member or the member’s authorized representative and the care coordinator or care team.
• Communication via secure emails or mailing/receiving completed HRAs via mail are not acceptable forms of contact for the purposes of reporting this measure.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

• MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.
Section CAII. Enrollee Protections

CA2.1 The number of critical incident and abuse reports for members receiving LTSS.

| IMPLEMENTATION |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| Reporting       | Reporting        | Level           | Reporting       | Due Date        |
| Section         | Frequency        |                 | Period          |                 |
| CA2. Enrollee   | Monthly          | Contract        | Current Month   | By the end of   |
| Protections     |                  |                 | Ex: 1/1 – 1/31  | the month       |
|                 |                  |                 |                 | following the   |
|                 |                  |                 |                 | last day of the |
|                 |                  |                 |                 | reporting       |
|                 |                  |                 |                 | period          |

<table>
<thead>
<tr>
<th>ONGOING</th>
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</thead>
<tbody>
<tr>
<td>Reporting</td>
</tr>
<tr>
<td>Section</td>
</tr>
<tr>
<td>CA2. Enrollee Protections</td>
</tr>
<tr>
<td>Reporting</td>
</tr>
<tr>
<td>Frequency</td>
</tr>
<tr>
<td>Quarterly</td>
</tr>
<tr>
<td>Level</td>
</tr>
<tr>
<td>Contract</td>
</tr>
<tr>
<td>Reporting Periods</td>
</tr>
<tr>
<td>Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31</td>
</tr>
<tr>
<td>Due Date</td>
</tr>
<tr>
<td>By the end of the second month following the last day of the reporting period</td>
</tr>
</tbody>
</table>

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of members receiving IHSS.</td>
<td>Total number of members receiving IHSS during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>B.</td>
<td>Total number of members receiving CBAS.</td>
<td>Total number of members receiving CBAS during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>C.</td>
<td>Total number of members receiving MSSP services.</td>
<td>Total number of members receiving MSSP services during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>Element Letter</td>
<td>Element Name</td>
<td>Definition</td>
<td>Allowable Values</td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>D.</td>
<td>Total number of members receiving nursing facility (NF) services.</td>
<td>Total number of members receiving NF services during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>E.</td>
<td>Total number of critical incident and abuse reports among members receiving IHSS.</td>
<td>Of the total reported in A, the number of critical incident and abuse reports during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>F.</td>
<td>Total number of critical incident and abuse reports among members receiving CBAS.</td>
<td>Of the total reported in B, the number of critical incident and abuse reports during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>G.</td>
<td>Total number of critical incident and abuse reports among members receiving MSSP services.</td>
<td>Of the total reported in C, the number of critical incident and abuse reports during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>H.</td>
<td>Total number of critical incident and abuse reports among members receiving NF services.</td>
<td>Of the total reported in D, the number of critical incident and abuse reports during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
</tbody>
</table>

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- N/A.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

CMS and the state will evaluate the number of critical incident and abuse reports per 1,000 members receiving the following during the current reporting period:

- IHSS.
  - Rate = (E / A) * 1,000
- CBAS.
  - Rate = (F / B) * 1,000
• MSSP services.
  o Rate = \((G / C) * 1,000\)
• NF services.
  o Rate = \((H / D) * 1,000\)

CMS and the state will evaluate the average number of critical incident and abuse reports for members receiving the following during the prior four reporting periods (i.e., rolling year):

• IHSS.
  o Average number = Sum of E for prior four reporting periods / 4
• CBAS.
  o Average number = Sum of F for prior four reporting periods / 4
• MSSP services.
  o Average number = Sum of G for prior four reporting periods / 4
• NF services.
  o Average number = Sum of H for prior four reporting periods / 4

CMS and the state will evaluate the weighted average number of critical incident and abuse reports per 1,000 members receiving the following during the prior four reporting periods:

• IHSS.
  o Rate = \((\text{Sum of E for prior four reporting periods} / \text{Sum of A for prior four reporting periods}) * 1,000\)
• CBAS.
  o Rate = \((\text{Sum of F for prior four reporting periods} / \text{Sum of B for prior four reporting periods}) * 1,000\)
• MSSP services.
  o Rate = \((\text{Sum of G for prior four reporting periods} / \text{Sum of C for prior four reporting periods}) * 1,000\)
• NF services.
  o Rate = \((\text{Sum of H for prior four reporting periods} / \text{Sum of D for prior four reporting periods}) * 1,000\)

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definitions

• Critical incident refers to any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a member.
• Abuse refers to:
  o Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish;
  o Knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which place that individual at risk of injury or death;
  o Rape or sexual assault;
Corporal punishment or striking of an individual; 
Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and 
Use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations.

- **Community-Based Adult Services (CBAS)** is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal beneficiaries, aged 18 years and older, blind, or disabled.

- **Multipurpose Senior Services Program (MSSP)** is a California-specific program, the 1915(c) Home and Community-Based services waiver that provides HCBS to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.

- **Nursing facility (NF) services** include any type of nursing facility care, including skilled and custodial services.

**Data Elements A, B, C, and D**
- MMPs should include all members who meet the criteria outlined in data elements A, B, C, and D regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- For quarterly reporting, if a member is enrolled at any point in time during the reporting period and received one of the specified categories of services, he/she should be included in this measure.
- It may be possible for a member to receive services from IHSS, CBAS, MSSP, and/or NF during the same quarterly reporting period. Certain services, such as NF services, cannot be received during the same month as IHSS, CBAS, and MSSP services, but they can be received during sequential months during the same quarterly reporting period.
- If a member receives services from more than one type of LTSS, they should be reported in all applicable data elements.
  - For example, if a member received both IHSS and MSSP services during the same reporting period, he/she would be reported in data elements A and C.

**Data Elements E, F, G, and H**
- For data elements E through H, MMPs should include all new critical incident and abuse cases that are reported during the reporting period, regardless of whether the case status is open or closed as of the last day of the reporting period.
- Critical incident and abuse reports could be reported by the MMP or any provider and are not limited to only those providers defined as LTSS providers.
• It is possible for members to have more than one critical incident and/or abuse report during the reporting period. All new critical incident and abuse reports during the reporting period should be counted.

• MMPs should report the critical incident/abuse report for the service during which the incident or abuse occurred.
  o For example, if the member had a reported critical incident while receiving MSSP services, the critical incident would be reported in data element G only.

• If the member received multiple services during the reporting period, the critical incident/abuse should only be reported once and MMPs should use their best judgment on which data element to report the critical incident/abuse.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

• MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

CA2.2 Policies and procedures attached to the MOU with county behavioral health agency(ies) around assessments, referrals, coordinated care planning, and information sharing.¹

| CONTINUOUS REPORTING |
|-----------------------|------------------|----------|-----------------|------------------|
| Reporting Section    | Reporting Frequency | Level    | Reporting Period | Due Date         |
| CA2. Enrollee Protections | Annually          | Contract | Calendar Year    | By the end of the second month following the last day of the reporting period |

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.
### Element Name Definition Allowable Values

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
</table>
| A.             | Policies and procedures attached to the MOU with county behavioral health agency(ies) around assessments, referrals, coordinated care planning, and information sharing. | Policies and procedures attached to the MOU with county behavioral health agency(ies) around assessments, referrals, coordinated care planning, and information sharing. | Field Type: N/A  
Note: File will be emailed to the state. |

**B. QA Checks/Thresholds** – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

**C. Edits and Validation Checks** – validation checks that should be performed by each MMP prior to data submission.

- Confirm that the appropriate policies and procedures submitted align with the MOU(s) with county behavioral health agency(ies).

**D. Analysis** – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will verify that the policies and procedures contain, at a minimum, the roles and responsibilities of the MMP and the county behavioral health agency(ies) regarding assessments, referrals, coordinated care planning, and information sharing.

**E. Notes** – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- These policies and procedures should be specific to each MMP/county behavioral health agency(ies) and reflect the appropriate roles and responsibilities of each organization.

**F. Data Submission** – how MMPs will submit data collected to CMS and the state.

- File will be submitted directly to the state via email to: pmmp.monitoring@dhcs.ca.gov.
Section CAIII. Organizational Structure and Staffing

CA3.1 MMPs with an established physical access compliance policy and identification of an individual who is responsible for physical access compliance. – Retired

CA3.2 Care coordinator training for supporting self-direction under the demonstration.

<table>
<thead>
<tr>
<th>CONTINUOUS REPORTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Section</td>
</tr>
<tr>
<td>CA3. Organizational Structure and Staffing</td>
</tr>
</tbody>
</table>

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of care coordinators who have been employed by the MMP for at least 30 days.</td>
<td>Total number of full-time and part-time care coordinators who have been employed by the MMP for at least 30 days at any point during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>B.</td>
<td>Total number of care coordinators who have undergone training for supporting self-direction under the demonstration within the reporting period.</td>
<td>Of the total reported in A, the number of care coordinators who have undergone training for supporting self-direction under the demonstration within the reporting period.</td>
<td>Field Type: Numeric, Note: Is a subset of A.</td>
</tr>
</tbody>
</table>

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that data element B is less than or equal to data element A.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of full-time and part-time care coordinators who have undergone training for supporting self-direction within the reporting period.
  - Percentage = (B / A) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

**Data Element A**

- If a care coordinator was not currently with the MMP at the end of the reporting period but was with the MMP for at least 30 days at any point during the reporting period, they should be included in this measure.

**General Guidance**

- MMPs should refer to the California three-way contract for specific requirements pertaining to care coordinators and training for supporting self-direction.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: [https://Financial-Alignment-Initiative.NORC.org](https://Financial-Alignment-Initiative.NORC.org).
Section CAIV. Utilization

CA4.1 Reduction in emergency department (ED) use for seriously mentally ill (SMI) and substance use disorder (SUD) members.ii

<table>
<thead>
<tr>
<th>Reporting Section</th>
<th>Reporting Frequency</th>
<th>Level</th>
<th>Reporting Period</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA4. Utilization</td>
<td>Annually</td>
<td>Contract</td>
<td>Calendar Year, beginning in CY2</td>
<td>By the end of the fourth month following the last day of the reporting period</td>
</tr>
</tbody>
</table>

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of members enrolled for at least five months with an indication of either SMI or SUD.</td>
<td>Total number of members continuously enrolled for at least five months during the reporting period, with no gaps in enrollment, with an indication of either SMI or SUD problems during the 12 months prior to the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>B.</td>
<td>Total number of member months.</td>
<td>Of the total reported in A, the number of member months during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>C.</td>
<td>Total number of ED visits.</td>
<td>Of the total reported in A, the number of ED visits during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
</tbody>
</table>

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- The quality withhold benchmark for DY 2 through 5 is a 10% decrease in the performance rate for the measurement year compared to the performance rate for the baseline year. For more information, including benchmarks for DY
6 – 8, refer to the Quality Withhold Technical Notes (DY 2-8): California-Specific Measures.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
   - Each member should have a member month value between 5 and 12. A value greater than 12 is not acceptable.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
   - CMS and the state will evaluate the number of ED visits for members with an indication of either SMI or SUD problems during the 12 months prior to the reporting period per 1,000 member months.
     - Rate = \( \frac{C}{B} \times 1,000 \)

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definitions
   - A **member with SMI** is defined as someone with a mental illness diagnosis in Medicare or Medicaid claims in the 12 months prior to the reporting period (Mental Health Diagnosis value set).
     - In the case where the member enrolled for the first time within the reporting period (e.g., February 1, 2019 or later in 2019), MMPs can use Medicare or Medicaid claims in the 12 months prior to the member’s effective enrollment date to identify a SMI diagnosis.
   - A **member with SUD** is defined as someone with a SUD diagnosis in Medicare or Medicaid claims in the 12 months prior to the reporting period (AOD Abuse and Dependence value set).
     - In the case where the member enrolled for the first time within the reporting period (e.g., February 1, 2019 or later in 2019), MMPs can use Medicare or Medicaid claims in the 12 months prior to the member’s effective enrollment date to identify a SUD diagnosis.
   - **Member months** refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year.

Data Element A
   - MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
   - Members diagnosed with SMI and/or SUD should be included in this measure (i.e., members with both SMI and SUD diagnoses should also be included).
   - MMPs should include all members with any diagnosis of SMI and/or SUD, regardless of whether the diagnosis of SMI and/or SUD is the primary diagnosis on the claim.
Data Element B

- Each member should have a member month value between 5 and 12. A value greater than 12 is not acceptable.
- Determine member months using the 15th of the month. This date must be used consistently from member to member, from month to month, and from year to year.
  - For example, if Ms. X is enrolled in the MMP as of January 15, Ms. X contributes one member month in January.

Data Element C Exclusion

- MMPs should exclude ED visits (ED value set) or observation stays (Observation value set) that resulted in an inpatient stay (Inpatient Stay value set). An ED visit or observation stay results in an inpatient stay when the ED/observation date of service and the admission date for the inpatient stay are one calendar day apart or less.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

CA4.2 In-Home Supportive Services (IHSS) utilization. – Retired

CA4.3 Readmissions of short- and long-stay nursing facility (NF) residents after hospitalization for diabetes, chronic obstructive pulmonary disease (COPD), or any medical diagnosis.

<table>
<thead>
<tr>
<th>Reporting Section</th>
<th>Reporting Frequency</th>
<th>Level</th>
<th>Reporting Period</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA4. Utilization</td>
<td>Annually</td>
<td>Contract</td>
<td>Calendar Year</td>
<td>By the end of the fourth month following the last day of the reporting period</td>
</tr>
</tbody>
</table>

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.
<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of short-term stay NF residents.</td>
<td>Total number of short-term stay NF residents who were continuously enrolled in the MMP during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>B.</td>
<td>Total number of short-term stay NF residents with diabetes.</td>
<td>Of the total reported in A, the number of short-term stay NF residents with diabetes.</td>
<td>Field Type: Numeric Note: Is a subset of A.</td>
</tr>
<tr>
<td>C.</td>
<td>Total number of short-term stay NF residents with COPD.</td>
<td>Of the total reported in A, the number of short-term stay NF residents with COPD.</td>
<td>Field Type: Numeric Note: Is a subset of A.</td>
</tr>
<tr>
<td>D.</td>
<td>Total number of transfers for short-term stay NF residents who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF.</td>
<td>For the members reported in A, the number of transfers for short-term stay NF residents who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>E.</td>
<td>Total number of transfers for short-term stay NF residents with diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF.</td>
<td>For the members reported in B, the number of transfers for short-term stay NF residents with diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>Element Letter</td>
<td>Element Name</td>
<td>Definition</td>
<td>Allowable Values</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>F.</td>
<td>Total number of transfers for short-term stay NF residents with COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF.</td>
<td>For the members reported in C, the number of transfers for short-term stay NF residents with COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>G.</td>
<td>Total number of long-term stay NF residents.</td>
<td>Total number of long-term stay NF residents who were continuously enrolled in the MMP during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>H.</td>
<td>Total number of long-term stay NF residents with diabetes.</td>
<td>Of the total reported in G, the number of long-term stay NF residents with diabetes.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>I.</td>
<td>Total number of long-term stay NF residents with COPD.</td>
<td>Of the total reported in G, the number of long-term stay NF residents with COPD.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>J.</td>
<td>Total number of transfers for long-term stay NF residents who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF.</td>
<td>For the members reported in G, the number of transfers for long-term stay NF residents who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF during the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
<tr>
<td>Element Letter</td>
<td>Element Name</td>
<td>Definition</td>
<td>Allowable Values</td>
</tr>
<tr>
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<tr>
<td>K.</td>
<td>Total number of transfers for long-term stay NF residents with diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF.</td>
<td>For the members reported in H, the number of transfers for long-term stay NF residents with diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF during the reporting period.</td>
<td>Field Type: Numeric</td>
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<td>L.</td>
<td>Total number of transfers for long-term stay NF residents with COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF.</td>
<td>For the members reported in I, the number of transfers for long-term stay NF residents with COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF during the reporting period.</td>
<td>Field Type: Numeric</td>
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</tbody>
</table>

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that data elements B and C are less than or equal to data element A.
- MMPs should validate that data elements H and I are less than or equal to data element G.
D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

**Short-Term Stay Analysis**

CMS and the state will evaluate the number of transfers among short-term stay NF residents:

- Who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF during the reporting period per 100 short-term stay NF residents.
  - Rate = (D / A) * 100
- With diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF during the reporting period per 100 short-term stay NF residents with diabetes.
  - Rate = (E / B) * 100
- With COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF during the reporting period per 100 short-term stay NF residents with COPD.
  - Rate = (F / C) * 100

**Long-Term Stay Analysis**

CMS and the state will evaluate the number of transfers among long-term stay NF residents:

- Who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF during the reporting period per 100 long-term stay NF residents.
  - Rate = (J / G) * 100
- With diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF during the reporting period per 100 long-term stay NF residents with diabetes.
  - Rate = (K / H) * 100
- With COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF during the reporting period per 100 long-term stay NF residents with COPD.
  - Rate = (L / I) * 100

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

**Definitions**

- A short-term stay resident is defined as having resided in the nursing facility for less than or equal to 100 cumulative days.
- A long-term stay resident is defined as having resided in the nursing facility for greater than 100 cumulative days.
Data Elements A and G

- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during the reporting period (i.e., January through December). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Data Elements B and H

- There are two ways for MMPs to identify members with diabetes: claim/encounter data and pharmacy data. The MMP must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the current reporting period or the year prior to the current report period.
  - **Claim/encounter data.** Members who met any of the following criteria during the current reporting period or the year prior to the current reporting period (count services that occur over both years):
    - At least two visits of any combination of outpatient visits (Outpatient value set), observation visits (Observation value set), ED visits (ED value set), or nonacute inpatient encounters (Nonacute Inpatient value set) on different dates of service, with a diagnosis of diabetes (Diabetes value set). Visit type need not be the same for the two visits (e.g., one outpatient visit and one ED visit).
    - At least one acute inpatient encounter (Acute Inpatient value set) with a diagnosis of diabetes (Diabetes value set).
  - **Pharmacy data.** Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the current reporting period or the year prior to the current reporting period (Diabetes Medications List).

Data Elements C and I

- MMPs should identify members with a diagnosis of COPD using claims/encounter data. The member must have at least one diagnosis of COPD (COPD Diagnosis value set) during the reporting period to be captured in data elements C and I.

Data Elements D and J

- When determining members with a transfer from the NF and admission to an acute care hospital for any medical diagnosis (i.e., data elements D and J), include members with diabetes and COPD. In other words, members included in data elements D and J can have diabetes, COPD, and other medical diagnoses such as hypertension, asthma, heart failure, etc.
Data Elements E and K

- To identify a diabetes-related hospital admission, the member must have a primary diagnosis code listed in the Diabetes value set.

Data Elements F and L

- To identify a COPD-related hospital admission, the member must have a primary diagnosis code listed in the COPD Diagnosis value set.

Data Elements D, E, F, J, K, and L

- The date of transfer and the discharge back to any NF must occur within the same reporting period.
- It is possible for a member to have more than one transfer during the reporting period. MMPs should count all transfers that occur for each member during the reporting period.

Data Elements D, E, F, J, K, and L Exclusion

- If a member was transferred to a hospital but only had an ED visit or observation stay and then returned to the nursing facility, then the transfer is not counted as an admission to the acute care hospital. A member must be admitted to the hospital to be considered a numerator positive event.

General Guidance

- It is possible for a member to have multiple conditions (i.e., both diabetes and COPD). If a member has both a diabetes and a COPD diagnosis, then these members should be reported in all applicable data elements (i.e., data elements B, C, H, and I).
- MMPs should include sub-acute care facilities and intermediate care facilities as part of NFs, as defined in Title 22 of the California Code of Regulations sections 51120, 51124, and 52224.5.
- MMPs should determine short-term and long-term stay NF residents using the best information available. MMPs should use their plan experience and, whenever possible, integrate analysis of historical claims data to determine if the member’s NF stay qualifies as short-term or long-term.
  - For example, a member may reside in a NF at the time of enrollment (or the first day of the reporting period) and the MMP may use historical data to determine the number of days the member has resided in the NF at the time of enrollment (or on the first day of the reporting period).
- When determining a short-term or long-term stay, if a member is transferred from the NF and then is readmitted to any NF within 30 days (including day 30), the transfer and subsequent readmission does not disrupt the count of cumulative days.
  - For example, if a member is transferred from the NF to the acute care hospital on day 193 and is subsequently readmitted to any NF 24 days later, this will be counted as the same long-term stay episode. The member’s first day back in the NF (i.e., the day the member is
readmitted to the NF) will count as day 194 for that episode, not as day 1.

- When determining a short-term or long-term stay, if a member is transferred from the NF and then is readmitted to any NF after 30 days, the date of readmission is the start of a new episode in the NF and will count as day 1 toward the member’s cumulative days in the facility.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.
## Corrective Action Plan (CAP) Form

### COMPLETION INSTRUCTIONS
- Please complete the below form. Fields that are **BOLD are required.** (Root Cause Analysis, Action Plan and Monitoring Plan)
- E-Sign at the “X” by double-clicking or right-clicking with your mouse in the space provided below.
  - *If E-signature is not available, you may submit a signed and dated PDF copy along with this Microsoft Word version of this form.*
- This CAP is due to IEHP within **30 days** from the date of request.
- If you have any questions regarding this CAP, please contact Juan Ortega at Ortega-J2@iehp.org.

**CAP FORM WILL ONLY BE ACCEPTED IN MICROSOFT WORD FORMAT**

### IPA: Choose an IPA

**Original Date Sent to IPA:** Click here to enter a date

**CAP DUE DATE:** Click here to enter a date

<table>
<thead>
<tr>
<th>Issue #</th>
<th>File Month/Year</th>
<th>Type</th>
<th>Findings</th>
<th>Root Cause Analysis (to be completed by IPA)</th>
<th>Action Plan (to be completed by IPA)</th>
<th>Monitoring Plan (to be completed by IPA)</th>
<th>CAP received from IPA</th>
<th>CAP Status</th>
<th>Decision/Notification Date</th>
<th>Additional Documents Required / Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Click here to enter a date</td>
<td>Report Submission Timeliness</td>
<td>Click here to enter your text.</td>
<td>Click here to enter your text.</td>
<td>Click here to enter your text.</td>
<td>Click here to enter your text.</td>
<td>Click here to enter a date</td>
<td>Choose an item.</td>
<td>Click here to enter a date</td>
<td>Click here to enter your text.</td>
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</tbody>
</table>
By signing below, I attest that the information in this Corrective Action Plan (CAP) including the Root Cause Analysis, Action Plan and Monitoring Plan will be implemented as stated in this form.

Printed Name of Individual Attesting to CAP Response

Title of Signing Individual

Signature of Individual Attesting to CAP Response (Date will automatically populate)
IPA Name:  
Reporting Period:  
Date of Submission:  
IPA Contact:  

5.1 - Care Coordinator to Member Ratio

<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Total number of full time equivalent (FTE) care coordinators working on the Demonstration.</td>
<td>Total number of full time equivalent (FTE) care coordinators working on the Demonstration as of the last day of the reporting period.</td>
<td>Field Type: Numeric</td>
</tr>
</tbody>
</table>
| B.             | Total FTE care coordinators assigned to care management and conducting assessments. | Of the total reported in A, the number of FTE care coordinators assigned to care management and conducting assessments during the reporting period. | Field Type: Numeric  
Note: Is a subset of A. |
| C.             | Total number of FTE care coordinators that left the MMP. | TOTAL number of FTE care coordinators that left the MMP during the reporting period. | Field Type: Numeric |

*CY2018 MMP Core Reporting Requirements, Version October 25, 2017*
<table>
<thead>
<tr>
<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
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<tbody>
<tr>
<td>A.</td>
<td>Total number of care coordinators who have been employed by the MMP for at least 30 days.</td>
<td>Total number of care coordinators who have been employed by the MMP for at least 30 days at any point during the reporting period.</td>
<td>Field Type: Numeric</td>
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<td>B.</td>
<td>Total number of care coordinators that have undergone training for supporting self-direction under the demonstration within the reporting period.</td>
<td>Of the total reported in A, the number of care coordinators that have undergone training for supporting self-direction under the demonstration within the reporting period.</td>
<td>Field Type: Numeric, Note: Is a subset of A.</td>
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<td>CM Data Validation</td>
<td>Validation Review #1</td>
<td>Validation Review #2</td>
<td>Validation Review #3</td>
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<td>Documentation of Members unwilling to complete a care plan within 90 days of enrollment</td>
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<td>Documentation of three (3) outreach attempts to complete a care plan within 90 days of enrollment</td>
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<td>Documentation of care plan development with Member within 90 days of enrollment</td>
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<td>Documentation of initial ICP completion - High Risk Members</td>
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<td>Documentation of initial ICP completion - Low Risk Members</td>
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<td>Documentation of discussion of care goals in the initial ICP</td>
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<td>Documentation of (3) unsuccessful outreach attempts to the Member’s county mental health provider for care coordination of Member’s mental health needs</td>
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<td>Documentation of successful outreach attempts to the Member’s county mental health provider for care coordination of Member’s mental health needs</td>
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<td>Documentation of unsuccessful outreach attempts to the Member for care coordination of Member’s mental health needs</td>
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<td>Documentation of unsuccessful outreach attempts to the Member for care coordination of Member’s mental health needs</td>
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<td>Member First Name</td>
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**Identify the number of:**
Total Cases reported for this month:
<table>
<thead>
<tr>
<th>IPA NAME</th>
<th>INITIAL DATE</th>
<th>RECRED DATE</th>
<th>CRED EXPIRES</th>
<th>LICENSE# TYPE</th>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>M.I.</th>
<th>SUFFIX</th>
<th>DEGREE</th>
<th>SPECIALTY(1)</th>
<th>SPECIALTY(2)</th>
<th>TERMED DATE</th>
<th>REASON FOR TERMINATION</th>
<th>DUE TO QUALITY OF CARE (YES OR NO)</th>
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1 of 1
### Denial Log Review Tool

**Medicare**

#### Instructions:
IEHP selects 30 denials from delegates monthly universe submission. Each file will be reviewed using the elements below and noted as follows: "1" yes the information is present, "0" the information is not present, and a grayed out cell if the information is not applicable. Each file has a maximum score of 12.

#### Data Dictionary

<table>
<thead>
<tr>
<th>(a) Denial Tracking Number</th>
<th>(b) File Type Requested</th>
<th>(c) Referral Received Date</th>
<th>(d) Decision Date</th>
<th>(e) Member Written Notification Date</th>
<th>(f) Physician Reviewed</th>
<th>(g) Decision Timeliness</th>
<th>(h) Member Written Notification</th>
<th>(i) Opportunity to discuss</th>
<th>(j) Comments</th>
</tr>
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<th>(f) Physician Reviewed</th>
<th>(g) Decision Timeliness</th>
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**Total Score:** 0 of 360

---

**Policy and/or Regulation**

- **File Type Requested**
  - Pre-Service Routine, Pre-Service Expedited, Post Service Retrospective Review.

- **Referral Received Date**
  - Date the referral was received by the Delegate for a decision.

- **Decision Date**
  - Date the Delegate decision was made by the Delegate to Approve, Modify or Deny the case.

- **Member Written Notification Date**
  - Date of the Member written notification.

- **Opportunity to discuss**
  - Physician name and phone number is listed for opportunity to discuss medical necessity denial/partial approval determinations. For non-medical necessity determinations reviewing department name and phone number must be listed for opportunity to discuss.

- **Decision Timeliness**
  - Delegates decision to approve, modify, deny a referral request in a timely manner according to regulations.

- **Member Written Notification**
  - Standard: Evidence the Member written notification was mailed non-concurrent/expedited, within 14 calendar days of discharge. Expedited: Evidence the Member written notification was mailed by the 7th calendar day. Evidence the Member written notification was mailed by the 14th calendar day. Evidence the Member written notification was mailed by the 48th hour after receipt of request.

- **Physician Reviewed**
  - Physician reviewed and documented rationale for all denied medical necessity denial/partial approvals.
<table>
<thead>
<tr>
<th></th>
<th>Clinical Information</th>
<th>Clinical information supporting the request is made available.</th>
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<tr>
<td>k</td>
<td>Alternative Direction</td>
<td>The Member is given alternative direction for follow-up care such as following up with their PCP.</td>
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<td>l</td>
<td>Member Written Notification</td>
<td>Written Notification to the Member of the requested referral decision. A minimum of at least two (2) efforts to obtain all necessary information or additional information such as clinical documentation and medical records were made and documented in order to make a decision.</td>
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<tr>
<td>m</td>
<td>Physician Written Notification</td>
<td>Written Notification to the physician of the requested referral decision. If the illegible or (two) efforts to obtain all necessary information or additional information such as clinical documentation and medical records were made and documented in order to make a decision. A minimum of at least two (2) efforts to obtain all necessary information or additional information such as clinical documentation and medical records were made and documented in order to make a decision.</td>
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<tr>
<td>n</td>
<td>Member Language</td>
<td>The denial letter reason is clear &amp; concise and all medical terms have been defined.</td>
</tr>
<tr>
<td>o</td>
<td>Practitioner Language</td>
<td>The denial letter reason is clear &amp; concise.</td>
</tr>
<tr>
<td>p</td>
<td>Appropriate use of Criteria</td>
<td>The correct criteria hierarchy utilized for denied services.</td>
</tr>
<tr>
<td>q</td>
<td>Correct Template</td>
<td>Use of IEHP issued CMS Template in correct threshold language with appeal rights.</td>
</tr>
<tr>
<td>r</td>
<td>Points Received</td>
<td>Total points earned from letters (f)-(q) above.</td>
</tr>
<tr>
<td>t</td>
<td>Points Possible</td>
<td>Total points possible from letters (f)-(q) above, excluding non-applicable elements.</td>
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<tr>
<td>s</td>
<td>Individual Score</td>
<td>Total points earned from letters (f)-(q) above divided by total points possible from letters (f)-(q) above, excluding non-applicable elements for each file.</td>
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<td>Files that earn a “0” score for Decision Timeliness will produce an “X” in this cell. An “X” in this cell will result in a CAP for Decision Timeliness.</td>
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# 2021 AUDIT RESULTS

## Delegate: ____________________

## Reviewed by: ____________________

### 2021 AUDIT RESULTS

#### CR 1: Credentialing Policies
- Points Received: 0
- Points Possible: 3
- Grade: A

#### CR 2: Credentialing Committee
- Points Received: 0
- Points Possible: 1
- Grade: B

#### CR 3: Credentialing Verification
- Points Received: 0
- Points Possible: 0
- Grade: A

#### CR 4: Recredentialing Cycle Length
- Points Received: 0
- Points Possible: 0
- Grade: A

#### CR 5: Ongoing Monitoring and Interventions
- Points Received: 0
- Points Possible: 1
- Grade: B

#### CR 6: Notification to Authorities and Practitioner Appeal Rights
- Points Received: 0
- Points Possible: 3
- Grade: A

#### CR 7: Assessment of Organizational Providers
- Points Received: 0
- Points Possible: 3
- Grade: A

#### CR 8: Delegation of CR
- Points Received: 0
- Points Possible: 3
- Grade: A

#### TOTAL
- Points Received: #DIV/0!
- Points Possible: 9

### CMS/DHCS/DMHC REQUIREMENTS

#### CR 1: Credentialing Policies
- 1. Recred Performance Monitoring: 0
- 3. OIG Sanction: 0

#### CR 3: Credentialing Verification
- 1. OIG Query: #DIV/0!
- 3. Verification of Hospital Admitting Privileges: #DIV/0!
- 4. Opt Out Query (within 180 days): #DIV/0!
- 5. Performance Monitoring at Recredentialing: #DIV/0!

#### CR 5: Ongoing Monitoring and Interventions
- 1. Ongoing Monitoring for Providers who have Opted Out: *
- 2. Ongoing Monitoring of the Medi-Cal Suspended & Ineligible: *

#### CR 6: Notification to Authorities and Practitioner Appeal Rights
- 1. Ensure that the majority of hearing panel members are peers of the affected physician (a hearing officer does not meet intent): *

#### CR 7: Assessment of Organizational Providers
- B. Documented processes for additional provider types - CMS: *
- D. Assessment of additional CMS provider types: *
- F. Accreditation/Certification of Free Standing Surgical Centers: *

#### CR 8: Delegation of CR
- 1. Sub-delegates must adhere to CMS regulations: #DIV/0!
- 2. Sub-delegates must submit quarterly rosters: #DIV/0!

#### CA 9: Identification of HIV/AIDS Specialists
- A. Written policy: *
- B. Evidence of Implementation: *

#### TOTAL
- Points Received: #DIV/0!
- Points Possible: #DIV/0!

* **MUST PASS ELEMENTS**
### CA21 - The number of critical incident and abuse reports for Members receiving LTSS

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<th>Element Letter</th>
<th>Element Name</th>
<th>Definition</th>
<th>Allowable Values</th>
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<td>Total number of members receiving MSSP services</td>
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<td>Total number of members receiving nursing facility (NF) services</td>
<td>Total number of members receiving NF services during the reporting period</td>
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<td>Total number of critical incident and abuse reports among members receiving IHSS services</td>
<td>Of the total reported in A, the number of critical incident and abuse reports during the reporting period</td>
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### IEHP Universe Expedited Service Authorization Request (MESAR) Data Dictionary

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<td>Date the request was received</td>
<td>CHAR</td>
<td>Always Required</td>
<td>10</td>
</tr>
<tr>
<td>J</td>
<td>Time the request was received</td>
<td>CHAR</td>
<td>Always Required</td>
<td>8</td>
</tr>
<tr>
<td>K</td>
<td>Diagnosis</td>
<td>CHAR</td>
<td>Always Required</td>
<td>100</td>
</tr>
<tr>
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<td>Field Name</td>
<td>Field Type</td>
<td>Field Length</td>
<td>Description</td>
</tr>
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</tr>
<tr>
<td>L</td>
<td>Type of service</td>
<td>CHAR Always Required</td>
<td>50</td>
<td>Enter &quot;BH&quot; for Behavioral Health services, &quot;LTSS&quot; for Long Term Services and Supports, 'SU' for Substance Use services. Other service / benefit types might include, but are not limited to DME, SNF care, dental, vision, etc.</td>
</tr>
<tr>
<td>M</td>
<td>Issue Description</td>
<td>CHAR Always Required</td>
<td>2,000</td>
<td>Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the service request was denied.</td>
</tr>
<tr>
<td>N</td>
<td>Level of Service</td>
<td>CHAR Always Requested</td>
<td>50</td>
<td>Provide the level of service requested (e.g., inpatient / outpatient / ER / post stabilization care / urgent care / point of sale transaction / home healthcare).</td>
</tr>
<tr>
<td>O</td>
<td></td>
<td></td>
<td></td>
<td>Does not apply to California and so is not on the template. Applies to New York only.</td>
</tr>
<tr>
<td>P</td>
<td>Identify whether the request involves any of the following scenarios: 1) authorization for treatment regimen already in place, 2) retrospective authorization (service already provided), or 3) Routine authorizations (requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization)</td>
<td>CHAR Always Required</td>
<td>50</td>
<td>For California MMPs- identify whether any of the following scenarios applies to the service request : 1) authorization for treatment regimen already in place, 2) retrospective authorization (service already provided), or 3) Routine authorizations (requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization). CA MMPs should enter &quot;NA&quot; if none of the above categories apply, and all other MMPs may enter &quot;NA&quot; for this column.</td>
</tr>
<tr>
<td>Q</td>
<td>Subsequent Expedited Request</td>
<td>CHAR Always Required</td>
<td>3</td>
<td>If a request to expedite the service authorization request was made after the request was received, indicate who made the subsequent request to expedite the request: contract provider (CP), non-contract provider (NCP), member (M), member’s representative (MR) or MMP/ sponsor (S). Answer NA if no subsequent expedited timeframe was requested.</td>
</tr>
<tr>
<td>R</td>
<td>Was a timeframe extension taken?</td>
<td>CHAR Always Required</td>
<td>2</td>
<td>Yes (Y) / No (N) / Not Applicable (NA) indicator of whether the MMP extended the timeframe to make the service authorization decision.</td>
</tr>
<tr>
<td>Column ID</td>
<td>Field Name</td>
<td>Field Type</td>
<td>Field Length</td>
<td>Description</td>
</tr>
<tr>
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</tr>
<tr>
<td>S</td>
<td>If an extension was taken, did the MMP notify the member of the reason(s) for the delay and of their right to file an expedited grievance?</td>
<td>CHAR Always Required</td>
<td>2</td>
<td>Yes (Y) / No (N) indicator of whether the MMP notified the member of the delay. Answer NA if no extension was taken.</td>
</tr>
<tr>
<td>T</td>
<td>Request Disposition</td>
<td>CHAR Always Required</td>
<td>8</td>
<td>Status of the request. Valid values are: Approved or Denied. MMPs should note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.</td>
</tr>
<tr>
<td>U</td>
<td>Date of MMP decision</td>
<td>CHAR Always Required</td>
<td>10</td>
<td>Date of the MMP decision. Submit in CCYY/MM/DD format (e.g., 2017/01/01). MMPs should answer NA for untimely cases that are still open. Note: This is separate from effectuation, notice, etc. This is the determination to approve/deny and may not be a captured field but rather a field to be populated from notes.</td>
</tr>
<tr>
<td>V</td>
<td>Time of MMP Decision</td>
<td>CHAR Always Required</td>
<td>8</td>
<td>Time of the MMP decision (e.g., approved, denied). Submit in HH:MM:SS military time format (e.g., 23:59:59). MMPs should answer NA for untimely cases that are still open. Note: This is separate from effectuation, notice, etc. This is the determination to approve/deny and may not be a captured field but rather a field to be populated from notes.</td>
</tr>
<tr>
<td>W</td>
<td>Was the request denied for lack of medical necessity?</td>
<td>CHAR Always Required</td>
<td>2</td>
<td>Yes (Y) / No (N) indicator of whether the request was denied for lack of medical necessity. Answer NA if the request was approved. Answer No if the request was denied because it was untimely.</td>
</tr>
<tr>
<td>X</td>
<td>If denied for lack of medical necessity, was the review completed by a physician or other appropriate health care professional?</td>
<td>CHAR Always Required</td>
<td>2</td>
<td>Yes (Y) / No (N) indicator of review by a physician or other appropriate health care professional if request was denied for lack of medical necessity. Answer NA if the request was approved or not denied due to lack of medical necessity.</td>
</tr>
<tr>
<td>Y</td>
<td>Date oral notification provided to member</td>
<td>CHAR Always Required</td>
<td>10</td>
<td>Date oral notification provided to member. Submit in CCYY/MM/DD format (e.g., 2017/01/01). Answer NA if no oral notification. If good faith effort was made to contact the member, CMS recommends including the last good faith effort made within the notification timeframe.</td>
</tr>
<tr>
<td>Column ID</td>
<td>Field Name</td>
<td>Field Type</td>
<td>Field Length</td>
<td>Description</td>
</tr>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Z</td>
<td>Time oral notification provided to member</td>
<td>CHAR Always Required</td>
<td>8</td>
<td>Time oral notification provided to member. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no oral notification. If good faith effort was made to contact the member, CMS recommends including the last good faith effort made within the notification timeframe.</td>
</tr>
<tr>
<td>AA</td>
<td>Date written notification provided to member</td>
<td>CHAR Always Required</td>
<td>10</td>
<td>Date written notification provided to member. The term &quot;provided&quot; means when the letter left the MMP’s establishment by US Mail, fax, or electronic communication. Do not enter the date a letter is generated or printed within the MMP’s organization. Submit in CCYY/MM/DD format (e.g., 2017/01/01). Answer NA if no written notification.</td>
</tr>
<tr>
<td>AB</td>
<td>Time written notification provided to member</td>
<td>CHAR Always Required</td>
<td>8</td>
<td>Time written notification provided to member. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no written notification was provided.</td>
</tr>
<tr>
<td>AC</td>
<td>Date service authorization entered/effectuated in the MMP’s system</td>
<td>CHAR Always Required</td>
<td>10</td>
<td>Date service authorization/approval was entered in the MMP’S system. Submit in CCYY/MM/DD format (e.g., 2017/01/01). Answer NA for denials. Note: This is the point at which the member could obtain the service.</td>
</tr>
<tr>
<td>AD</td>
<td>Time service authorization entered/effectuated in the MMP’s system</td>
<td>CHAR Always Required</td>
<td>8</td>
<td>Time service authorization/approval entered in the MMP’S system. Submit in HH:MM:SS military format (e.g., 23:59:59). Answer NA for denials. Note: This is the point at which the member could obtain the service.</td>
</tr>
<tr>
<td>AE</td>
<td>AOR Receipt date</td>
<td>CHAR Always Required</td>
<td>10</td>
<td>Date the Appointment of Representative (AOR) form or other appropriate documentation received by the MMP. Submit in CCYY/MM/DD format (e.g., 2017/01/01). Answer NA if no AOR form was required.</td>
</tr>
<tr>
<td>AF</td>
<td>AOR Receipt time</td>
<td>CHAR Always Required</td>
<td>8</td>
<td>Time the Appointment of Representative (AOR) form or other appropriate documentation received by the MMP. Submit in HH:MM:SS military format (e.g., 23:59:59). Answer NA if no AOR form was required.</td>
</tr>
<tr>
<td>AG</td>
<td>First Tier, Downstream, and Related Entity</td>
<td>CHAR Always Required</td>
<td>70</td>
<td>Insert the name of the First Tier, Downstream, and Related Entity that processed the standard organization determination (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.</td>
</tr>
</tbody>
</table>
# Universe Expedited Service Authorization Requests (MESAR) Template

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
<th>L</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member First Name</td>
<td>Member Last Name</td>
<td>Cardholder ID</td>
<td>Contract ID</td>
<td>Plan ID</td>
<td>Authorization or Claim Number</td>
<td>Who Made the Request</td>
<td>Provider Type</td>
<td>Date the Request was Received</td>
<td>Time the Request was Received</td>
<td>Diagnosis</td>
<td>Type of Service</td>
<td>Issue Description</td>
</tr>
<tr>
<td>First name of the member.</td>
<td>Last name of the member.</td>
<td>Cardholder identifier used to identify the member. This is assigned by the MMP. Note: IEHP 14 digit ID Number</td>
<td>The contract number of the organization. Note: H5355 identifies the CMC line of business</td>
<td>The plan number of the organization. Note: IEHP's assigned Plan ID Number is 081</td>
<td>The associated authorization number assigned by the MMP for this request. If an authorization number is not available, please provide your internal tracking or case number. Answer NA if there is no authorization or other tracking number available.</td>
<td>Indicate whether the service authorization request was made by a contract provider (CP), non-contract provider (NCP), member (M), member’s representative (MR), or Service Coordinator / Care Coordinator (SC). Note: the term &quot;provider&quot; encompasses physicians and facilities.</td>
<td>Indicate whether the provider performing the service is a contract provider (CP), non-contract provider (NCP), or members representative (MR), or Service Coordinator / Care Coordinator (SC).</td>
<td>Provide the date the request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2017/01/01). Note: If the request was received as a standard service authorization request, but later expedited, enter the date of the request to expedite the service authorization request.</td>
<td>Provide the time the request was received by your organization. Submit in HH:MM:SS military time format (e.g., 23:59:59). Note: This is the original receipt of the request by the MMP or delegated entity and not the date that the request became valid via an ADR. Also, if the request was received as a standard service authorization request, but later expedited, enter the time of the request to expedite the service authorization.</td>
<td>Provide the member diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.</td>
<td>Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the service request was denied.</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>P</td>
<td>Q</td>
<td>R</td>
<td>S</td>
<td>T</td>
<td>U</td>
<td>V</td>
<td>W</td>
<td>X</td>
<td>Y</td>
<td>Z</td>
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<tr>
<td><strong>Level of Service</strong> Identify whether the Request involves any of the Following Scenarios: 1) Authorization for Treatment Regimen already in Place 2) Retrospective Authorization (Service already Provided) 3) Routine Authorizations (Requests for Specialty Service, Cost Control purposes, Out-of-Network not otherwise exempt from Prior Authorization)</td>
<td><strong>Subsequent Expedited Request</strong> If an Extension was taken, did the MMP notify the Member of the Reason(s) for the Delay and of their Right to file an Expedited Grievance?</td>
<td><strong>Request Disposition</strong> Date of MMP Decision</td>
<td><strong>Was the Request Denied for Lack of Medical Necessity?</strong></td>
<td><strong>If Denied for Lack of Medical Necessity, was the Review completed by a Physician or other Appropriate Health Care Professional?</strong></td>
<td><strong>Date Oral Notification provided to Member</strong></td>
<td><strong>Time Oral Notification provided to Member</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Was a Timeframe Extension Taken?</strong> Yes (Y) / No (N) / Not Applicable (NA) indicator of whether the MMP extended the timeframe to make the service authorization decision.</td>
<td><strong>Status of the request</strong> Valid values are: Approved or Denied. MMPs should only send these requests that are ultimately not yet resolved (still outstanding) as denied. All unsubmitted pending requests should be treated as denials for the purposes of populating the rest of this record layout's fields.</td>
<td><strong>Time of MMP Decision</strong> (e.g., approved, denied). Submit in HH:MM:SS military time format (e.g., 23:59:59). MMPs should answer NA for unsubmitted cases that are still open.</td>
<td><strong>Date of MMP decision.</strong> Submit in CCYY/MM/DD format (e.g., 2017/01/01). MMPs should answer NA for unsubmitted cases that are still open.</td>
<td><strong>If Denied for Lack of Medical Necessity, was the Review completed by a Physician or other Appropriate Health Care Professional?</strong></td>
<td><strong>Date Oral Notification provided to Member</strong></td>
<td><strong>Time Oral Notification provided to Member</strong></td>
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</tr>
<tr>
<td><strong>Provide the level of service requested (e.g., inpatient / outpatient / ER / post stabilization care / urgent care / point of sale transaction / home healthcare).</strong></td>
<td><strong>Was the Request Denied for Lack of Medical Necessity?</strong> Yes (Y) / No (N) / Not Applicable (NA) indicator of whether the request was denied for lack of medical necessity. Answer NA if the request was approved or not denied due to lack of medical necessity.</td>
<td><strong>If Denied for Lack of Medical Necessity, was the Review completed by a Physician or other Appropriate Health Care Professional?</strong> Yes (Y) / No (N) / Not Applicable (NA) indicator of review by a physician or other appropriate health care professional if the expedited request was denied for lack of medical necessity. Answer NA if the request was approved or not denied due to lack of medical necessity.</td>
<td><strong>Date Oral Notification provided to Member</strong></td>
<td><strong>Time Oral Notification provided to Member</strong></td>
<td><strong>Date Oral Notification provided to Member</strong></td>
<td><strong>Time Oral Notification provided to Member</strong></td>
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</tr>
</tbody>
</table>

**Note:** This is separate from effectuation, notice, etc. This is the determination to approve/deny and may not be a captured field but rather a field to be populated from notes. **Note:** This is separate from effectuation, notice, etc. This is the determination to approve/deny and may not be a captured field but rather a field to be populated from notes. **Note:** This is separate from effectuation, notice, etc. This is the determination to approve/deny and may not be a captured field but rather a field to be populated from notes.
<table>
<thead>
<tr>
<th>AA</th>
<th>Time Written Notification provided to Member</th>
<th>Time Written Notification provided to Member</th>
<th>Time Service Authorization Entered / Effectuated in the MMP's System</th>
<th>Time Service Authorization Entered / Effectuated in the MMP's System</th>
<th>AOR Receipt Date</th>
<th>AOR Receipt Time</th>
<th>First Tier, Downstream, and Related Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date Written Notification provided to Member</td>
<td>Date Written Notification provided to Member</td>
<td>Date Service Authorization/Approval entered in the MMP's system</td>
<td>Date Service Authorization/Approval entered in the MMP's system</td>
<td>AOR Receipt Date</td>
<td>AOR Receipt Time</td>
<td>AOR Receipt Date First Tier, Downstream, and Related Entity</td>
</tr>
<tr>
<td></td>
<td>Time written notification provided to member. The term &quot;provided&quot; means when the letter left the MMP's establishment by US Mail, fax, or electronic communication. Do not enter the date a letter is generated or printed within the MMP's organization. Submit in CCYY/MM/DD format (e.g., 2017/01/01). Answer NA if no written notification was provided.</td>
<td>Time written notification provided to member. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no written notification was provided.</td>
<td>Time service authorization/approval was entered in the MMP's system. Submit in CCYY/MM/DD format (e.g., 2017/01/01). Answer NA for denials. Note: This is the point at which the member could obtain the service.</td>
<td>Time service authorization/approval was entered in the MMP's system. Submit in CCYY/MM/DD format (e.g., 2017/01/01). Answer NA for denials. Note: This is the point at which the member could obtain the service.</td>
<td>Time the Appointment of Representative (ACOR) form or other appropriate documentation received by the MMP. Submit in CCYY/MM/DD format (e.g., 2017/01/01). Answer NA if no AOR form was required.</td>
<td>Time the Appointment of Representative (ACOR) form or other appropriate documentation received by the MMP. Submit in HH:MM:SS military format (e.g., 23:59:59). Answer NA if no AOR form was required.</td>
<td>Insert the name of the First Tier, Downstream, and Related Entity that processed the standard organization determination (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.</td>
</tr>
</tbody>
</table>

**Notes:**
- Do not enter the date a letter is generated or printed within the MMP's organization.
- Submit in CCYY/MM/DD format (e.g., 2017/01/01).
- Submit in HH:MM:SS military format (e.g., 23:59:59).
### IEHP Universe MMP Provider Payment Request (M_Claims) Data Dictionary

<table>
<thead>
<tr>
<th>Column ID</th>
<th>Field Name</th>
<th>Field Type</th>
<th>Field Length</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>Member First Name</td>
<td>CHAR Always Required</td>
<td>50</td>
<td>First name of the member</td>
</tr>
<tr>
<td>B</td>
<td>Member Last Name</td>
<td>CHAR Always Required</td>
<td>50</td>
<td>Last name of the member</td>
</tr>
<tr>
<td>C</td>
<td>Cardholder ID</td>
<td>CHAR Always Required</td>
<td>20</td>
<td>Cardholder identifier used to identify the beneficiary. This is assigned by the MMP. Note: IEHP 14 digit ID Number.</td>
</tr>
<tr>
<td>D</td>
<td>Contract ID</td>
<td>CHAR Always Required</td>
<td>5</td>
<td>The contract number of the organization. Note: H5355 identifies the CMC line of business.</td>
</tr>
<tr>
<td>E</td>
<td>Plan ID</td>
<td>CHAR Always Required</td>
<td>3</td>
<td>The plan number of the organization. Note: IEHP's assigned Plan ID is 001</td>
</tr>
<tr>
<td>F</td>
<td>Authorization or Claim Number</td>
<td>CHAR Always Required</td>
<td>40</td>
<td>The associated claim or payment request number assigned by the MMP for this request. If a claim or payment request number is not available, please provide your internal tracking or case number. Answer NA if there is no claim, payment request or other tracking number available.</td>
</tr>
<tr>
<td>G</td>
<td>Provider Type</td>
<td>CHAR Always Required</td>
<td>3</td>
<td>Indicate whether the provider who performed the service is a contract provider (CP) or non-contract provider (NCP). Note: the term &quot;provider&quot; encompasses physicians and facilities.</td>
</tr>
<tr>
<td>H</td>
<td>Is this a clean claim?</td>
<td>CHAR Always Required</td>
<td>2</td>
<td>Yes/No indicator flag to indicate whether the claim is clean (Y) or unclean (N). Answer NA for untimely requests that are still open or if clean status has not been determined.</td>
</tr>
<tr>
<td>I</td>
<td>Date the request was received</td>
<td>CHAR Always Required</td>
<td>10</td>
<td>Provide the date the payment request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2017/01/01).</td>
</tr>
<tr>
<td>J</td>
<td>Diagnosis</td>
<td>CHAR Always Required</td>
<td>100</td>
<td>Provide the member diagnosis/diagnoses ICD-9/ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.</td>
</tr>
<tr>
<td>K</td>
<td>Type of service</td>
<td>CHAR Always Required</td>
<td>50</td>
<td>Enter &quot;BH&quot; for Behavioral Health services, &quot;LTSS&quot; for Long Term Services and Supports, 'SU' for Substance Use services. Other service types might include, but are not limited to DME, SNF care, dental, vision, etc.</td>
</tr>
<tr>
<td>L</td>
<td>Issue Description</td>
<td>CHAR Always Required</td>
<td>2,000</td>
<td>Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the Claim was denied.</td>
</tr>
<tr>
<td>Column ID</td>
<td>Field Name</td>
<td>Field Type</td>
<td>Field Length</td>
<td>Description</td>
</tr>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>M</td>
<td>Level of Service</td>
<td>CHAR</td>
<td>Always Requested</td>
<td>50</td>
</tr>
<tr>
<td>N</td>
<td>Request Disposition</td>
<td>CHAR</td>
<td>Always Requested</td>
<td>8</td>
</tr>
<tr>
<td>O</td>
<td>Date the claim was paid or denied</td>
<td>CHAR</td>
<td>Always Requested</td>
<td>10</td>
</tr>
<tr>
<td>P</td>
<td>Was interest paid on the Claim?</td>
<td>CHAR</td>
<td>Always Requested</td>
<td>1</td>
</tr>
<tr>
<td>Q</td>
<td>Was the request denied for lack of medical necessity?</td>
<td>CHAR Always Requested</td>
<td>2</td>
<td>Yes (Y) / No (N) indicator of whether the request was denied for lack of medical necessity. Answer NA if the request was approved. Answer No if the request was denied because it was untimely.</td>
</tr>
<tr>
<td>R</td>
<td>If denied for lack of medical necessity, was the review completed by a physician or other appropriate health care professional?</td>
<td>CHAR Always Requested</td>
<td>2</td>
<td>Yes (Y) / No (N) indicator of review by a physician or other appropriate health care professional if request was denied for lack of medical necessity. Answer NA if the request was approved or not denied due to lack of medical necessity.</td>
</tr>
<tr>
<td>S</td>
<td>Date written notification provided to member</td>
<td>CHAR</td>
<td>Always Requested</td>
<td>10</td>
</tr>
<tr>
<td>Column ID</td>
<td>Field Name</td>
<td>Field Type</td>
<td>Field Length</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------------------</td>
<td>-----------------------------------</td>
<td>--------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>T</td>
<td>Date written notification provided to provider</td>
<td>CHAR Always Required</td>
<td>10</td>
<td>Date written notification provided to enrollee. The term &quot;provided&quot; means when the EOB, IDN or letter left the sponsor's establishment by US Mail, fax, or electronic communication. Do not enter the date a letter is generated or printed within the sponsor's organization. Submit in <strong>CCYY/MM/DD</strong> format (e.g., 2017/01/01). Answer <strong>Pending</strong> if written notification has not yet been provided, but is anticipated to be provided in a forthcoming EOB or IDN notice. Answer <strong>NA</strong> if no written notification provided to the enrollee.</td>
</tr>
<tr>
<td>U</td>
<td>First Tier, Downstream, and Related Entity</td>
<td>CHAR Always Required</td>
<td>70</td>
<td>Insert the name of the First Tier, Downstream, and Related Entity that processed the standard organization determination (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.</td>
</tr>
</tbody>
</table>
## Universe MMP Provider Payment Requests (M_Claims) Template

<table>
<thead>
<tr>
<th>Member First Name</th>
<th>Member Last Name</th>
<th>Cardholder ID</th>
<th>Contract ID</th>
<th>Plan ID</th>
<th>Authorization or Claim Number</th>
<th>Provider Type</th>
<th>Is this a Clean Claim?</th>
<th>Date the Request was Received</th>
<th>Diagnosis</th>
<th>Type of Service</th>
<th>Issue Description</th>
<th>Level of Service</th>
<th>Request Disposition</th>
</tr>
</thead>
</table>

- **Member First Name**: First name of the member.
- **Member Last Name**: Last name of the member.
- **Cardholder ID**: Cardholder identifier used to identify the member. This is assigned by the MMP provider.
- **Contract ID**: The contract number of the organization.
  - Note: H5355 identifies the CMC line of business.
- **Plan ID**: The plan number of the organization.
  - Note: IEHP's assigned Plan ID Number is 001.
- **Authorization or Claim Number**: The associated claim or payment request number assigned by the MMP for this request. If a claim or payment request number is not available, please provide your internal tracking or case number. Answer NA if there is no claim, payment request or other tracking number available.
- **Provider Type**: Indicate whether the provider who performed the service is a contract provider (CP) or non-contract provider (NCP).
  - Note: the term ‘provider’ encompasses physicians and facilities.
- **Is this a Clean Claim?**: Yes/No indicator flag to indicate whether the claim is clean (Y) or unclean (N). Answer NA if the claim was not yet determined.
- **Date the Request was Received**: Provide the date the payment request was received by the organization. Submit in CCYY/MM/DD format (e.g., 2017/01/01).
- **Diagnosis**: Provide the member diagnosis/diagnoses ICD-10 codes related to the request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.
  - Enter “BH” for Behavioral Health services, “LTSS” for Long Term Services and Supports, “SU” for Substance Use services. Other service types might include, but are not limited to DME, SHF care, dental, vision, etc.
- **Type of Service**: Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the Claim was denied.
- **Issue Description**: Provide a description of the issue.
- **Level of Service**: Provide the level of service requested (e.g., inpatient/ outpatient / E/R / post stabilization care / urgent care / point of sale transaction / home healthcare).
- **Request Disposition**: Status of the request. Valid values are: Approved or Denied. MMPs should note any requests that are unhandled and not yet assigned (still outstanding) as denied. All unhandled and pending cases should be treated as denied for the purposes of populating the rest of the record layout’s fields.
<table>
<thead>
<tr>
<th>Q</th>
<th>P</th>
<th>Q</th>
<th>R</th>
<th>S</th>
<th>T</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date the Claim was Paid or Denied</td>
<td>Was Interest Paid on the Claim?</td>
<td>Was the Request Denied for Lack of Medical Necessity?</td>
<td>If Denied for Lack of Medical Necessity, was the Review completed by a Physician or other appropriate Health Care Professional?</td>
<td>Date Written Notification Provided to Member</td>
<td>Date Written Notification Provided to Provider</td>
<td>First Tier, Downstream, and Related Entity.</td>
</tr>
<tr>
<td>Date the Claim was paid. Submit in CCYY/MM/DD format (e.g., 2017/01/01). Answer DENIED for claims that were denied. Answer NA for untimely cases that are still open.</td>
<td>Yes (Y) / No (N) indicator of whether interest was paid on the claim.</td>
<td>Yes (Y) / No (N) indicator of whether the request was denied for lack of medical necessity. Answer NA if the request was approved.</td>
<td>Yes (Y) / No (N) indicator of whether the request was denied for lack of medical necessity. Answer NA if the review was completed by a physician or other appropriate health care professional.</td>
<td>Date written notification provided to member. The term &quot;provided&quot; means when the letter left the MMP's establishment by US Mail, fax, or electronic communication. Do not enter the date a letter is generated or printed within the MMP's organization. If no proof of mailing is available, populate based on worst case. Submit in CCYY/MM/DD format (e.g., 2017/01/01). Answer NA if no written notification provided to the member.</td>
<td>Date written notification provided to provider. The term &quot;provided&quot; means when the EOB, IDN or letter left the sponsor's establishment by US Mail, fax, or electronic communication. Do not enter the date a letter is generated or printed within the sponsor's organization. Submit in CCYY/MM/DD format (e.g., 2017/01/01). Answer Pending if written notification has not yet been provided, but is anticipated to be provided in a forthcoming EOB or IDN notice. Answer NA if no written notification provided to the enrollee.</td>
<td>Insert the name of the First Tier, Downstream, and Related Entity that processed the claim (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.</td>
</tr>
</tbody>
</table>
## IEHP Universe Standard Service Authorization Request (MSSAR) Data Dictionary

<table>
<thead>
<tr>
<th>Column ID</th>
<th>Field Name</th>
<th>Field Type</th>
<th>Field Length</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Member First Name</td>
<td>CHAR</td>
<td>50</td>
<td>First name of the member</td>
</tr>
<tr>
<td>B</td>
<td>Member Last Name</td>
<td>CHAR</td>
<td>50</td>
<td>Last name of the member</td>
</tr>
<tr>
<td>C</td>
<td>Cardholder ID</td>
<td>CHAR</td>
<td>20</td>
<td>Cardholder identifier used to identify the beneficiary. This is assigned by the MMP. Note: IEHP 14 digit ID Number.</td>
</tr>
<tr>
<td>D</td>
<td>Contract ID</td>
<td>CHAR</td>
<td>5</td>
<td>The contract number of the organization. Note: H5355 identifies the CMC line of business.</td>
</tr>
<tr>
<td>E</td>
<td>Plan ID</td>
<td>CHAR</td>
<td>3</td>
<td>The plan number of the organization. Note: IEHP's assigned Plan ID is 001</td>
</tr>
<tr>
<td>F</td>
<td>Authorization or Claim Number</td>
<td>CHAR</td>
<td>40</td>
<td>The associated authorization number assigned by the MMP for this request. If an authorization number is not available, please provide your internal tracking or case number. Answer NA if there is no authorization or other tracking number available.</td>
</tr>
<tr>
<td>G</td>
<td>Who made the request</td>
<td>CHAR</td>
<td>3</td>
<td>Indicate whether the service authorization request was made by a contract provider (CP), non-contract provider (NCP), member (M) or member's representative (MR). Note: The term &quot;provider&quot; encompasses physicians and facilities.</td>
</tr>
<tr>
<td>H</td>
<td>Provider Type</td>
<td>CHAR</td>
<td>3</td>
<td>Indicate whether the provider performing the service is a contract provider (CP) or non-contract provider (NCP).</td>
</tr>
<tr>
<td>I</td>
<td>Date the request was received</td>
<td>CHAR</td>
<td>10</td>
<td>Provide the date the request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2017/01/01). Note: This is the original receipt of the request by the MMP or delegated entity and not the date that the request became valid via an AOR.</td>
</tr>
<tr>
<td>J</td>
<td>Diagnosis</td>
<td>CHAR</td>
<td>100</td>
<td>Provide the member diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.</td>
</tr>
<tr>
<td>K</td>
<td>Type of service</td>
<td>CHAR</td>
<td>50</td>
<td>Enter &quot;BH&quot; for Behavioral Health services, &quot;LTSS&quot; for Long Term Services and Supports, &quot;SU&quot; for Substance Use services. Other service / benefit types might include, but are not limited to DME, SNF care, dental, vision, etc.</td>
</tr>
<tr>
<td>Column ID</td>
<td>Field Name</td>
<td>Field Type</td>
<td>Field Length</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>------------</td>
<td>------------</td>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>L</td>
<td>Issue Description</td>
<td>CHAR Always Required</td>
<td>2,000</td>
<td>Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the service request was denied.</td>
</tr>
<tr>
<td>M</td>
<td>Level of Service</td>
<td>CHAR Always Requested</td>
<td>50</td>
<td>Provide the level of service requested (e.g., inpatient / outpatient / ER / post stabilization care / urgent care / point of sale transaction / home healthcare).</td>
</tr>
<tr>
<td>N</td>
<td>Does not apply to California and so is not on the template. Applies to New York only.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>Identify whether the request involves any of the following scenarios: 1) authorization for treatment regimen already in place, 2) retrospective authorization (service already provided), or 3) Routine authorizations (requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization)</td>
<td>CHAR Always Required</td>
<td>50</td>
<td>For California MMPs- identify whether any of the following scenarios applies to the service request : 1) authorization for treatment regimen already in place, 2) retrospective authorization (service already provided), or 3) Routine authorizations (requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization). CA MMPs should enter &quot;NA&quot; if none of the above categories apply, and all other MMPs may enter &quot;NA&quot; for this column.</td>
</tr>
<tr>
<td>P</td>
<td>Was request made under the expedited timeframe, but processed by the plan under the standard timeframe?</td>
<td>CHAR Always Required</td>
<td>1</td>
<td>Yes (Y)/No (N) indicator of whether the request was made under an expedited timeframe but was processed under a standard timeframe.</td>
</tr>
<tr>
<td>Q</td>
<td>Request for expedited timeframe</td>
<td>CHAR Always Required</td>
<td>3</td>
<td>If there was a request expedite the service authorization request after it was initially requested, indicate who made the subsequent request to expedite the request: contract provider (CP), non-contract provider (NCP), member (M), member’s representative (MR), Service Coordinator / Care Coordinator (SC), or the MMP / sponsor (S). Answer NA if no expedited timeframe request was made after the service authorization was submitted.</td>
</tr>
<tr>
<td>Column ID</td>
<td>Field Name</td>
<td>Field Type</td>
<td>Field Length</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>R</td>
<td>Was a timeframe extension taken?</td>
<td>CHAR Always Required</td>
<td>2</td>
<td>Yes (Y) / No (N) / Not Applicable (NA) indicator of whether the MMP extended the timeframe to make the service authorization decision.</td>
</tr>
<tr>
<td>S</td>
<td>If an extension was taken, did the MMP notify the member of the reason(s) for the delay and of their right to file an expedited grievance?</td>
<td>CHAR Always Required</td>
<td>2</td>
<td>Yes (Y) / No (N) indicator of whether the MMP notified the member of the delay. Answer NA if no extension was taken.</td>
</tr>
<tr>
<td>T</td>
<td>Request Disposition</td>
<td>CHAR Always Required</td>
<td>8</td>
<td>Status of the request. Valid values are: Approved or Denied. MMPs should note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout’s fields.</td>
</tr>
<tr>
<td>U</td>
<td>Date of MMP decision</td>
<td>CHAR Always Required</td>
<td>10</td>
<td>Date of the MMP decision. Submit in CCYY/MM/DD format (e.g., 2017/01/01). MMPs should answer NA for untimely cases that are still open. Note: This is separate from effectuation, notice, etc. This is the determination to approve/deny and may not be a captured field but rather a field to be populated from notes.</td>
</tr>
<tr>
<td>V</td>
<td>Was the request denied for lack of medical necessity?</td>
<td>CHAR Always Required</td>
<td>2</td>
<td>Yes (Y) / No (N) indicator of whether the request was denied for lack of medical necessity. Answer NA if the request was approved. Answer No if the request was denied because it was untimely.</td>
</tr>
<tr>
<td>W</td>
<td>If denied for lack of medical necessity, was the review completed by a physician or other appropriate health care professional?</td>
<td>CHAR Always Required</td>
<td>2</td>
<td>Yes (Y) / No (N) indicator of review by a physician or other appropriate health care professional if request was denied for lack of medical necessity. Answer NA if the request was approved or not denied due to lack of medical necessity.</td>
</tr>
<tr>
<td>X</td>
<td>Date oral notification provided to member</td>
<td>CHAR Always Required</td>
<td>10</td>
<td>Date oral notification provided to member. Submit in CCYY/MM/DD format (e.g., 2017/01/01). Answer NA if no oral notification. If good faith effort was made to contact the member, CMS recommends including the last good faith effort made within the notification timeframe.</td>
</tr>
<tr>
<td>Y</td>
<td>Date written notification provided to member</td>
<td>CHAR Always Required</td>
<td>10</td>
<td>Date written notification provided to member. The term &quot;provided&quot; means when the letter left the MMP’s establishment by US Mail, fax, or electronic communication. Do not enter the date a letter is generated or printed within the MMP’s organization. Submit in CCYY/MM/DD format (e.g., 2017/01/01). Answer NA if no written notification.</td>
</tr>
<tr>
<td>Column ID</td>
<td>Field Name</td>
<td>Field Type</td>
<td>Field Length</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------</td>
<td>--------------------</td>
<td>--------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Z</td>
<td>Date service authorization entered/effectuated in the MMP's system</td>
<td>CHAR Always Required</td>
<td>10</td>
<td>Date service authorization entered in the MMP’S system. Submit in <strong>CCYY/MM/DD</strong> format (e.g., 2017/01/01). Answer <strong>NA</strong> for denials. Date service authorization / approval entered in the MMP's system. Note: This is the point at which the member could obtain the service.</td>
</tr>
<tr>
<td>AA</td>
<td>AOR Receipt date</td>
<td>CHAR Always Required</td>
<td>10</td>
<td>Date the Appointment of Representative (AOR) form or other appropriate documentation received by the MMP. Submit in <strong>CCYY/MM/DD</strong> format (e.g., 2017/01/01). Answer <strong>NA</strong> if no AOR form was required.</td>
</tr>
<tr>
<td>AB</td>
<td>First Tier, Downstream, and Related Entity</td>
<td>CHAR Always Required</td>
<td>70</td>
<td>Insert the name of the First Tier, Downstream, and Related Entity that processed the standard organization determination (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer <strong>NA</strong> if not applicable.</td>
</tr>
<tr>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Member First Name</strong></td>
<td><strong>Member Last Name</strong></td>
<td><strong>Cardholder ID</strong></td>
<td><strong>Contract ID</strong></td>
<td><strong>Plan ID</strong></td>
</tr>
<tr>
<td>First name of the member.</td>
<td>Last name of the member.</td>
<td>Cardholder identifier used to identify the member. This is assigned by the MMP.</td>
<td>Note: IEHP 14 digit ID Number</td>
<td>Note: IEHP Universe Standard Service Authorization Requests (MSSAR) Template</td>
</tr>
<tr>
<td><strong>Cardholder ID</strong></td>
<td><strong>Contract ID</strong></td>
<td><strong>Plan ID</strong></td>
<td><strong>Authorization or Claim Number</strong></td>
<td><strong>Who Made the Request</strong></td>
</tr>
<tr>
<td>First name of the member.</td>
<td>Last name of the member.</td>
<td>Cardholder identifier used to identify the member. This is assigned by the MMP.</td>
<td>Note: IEHP 14 digit ID Number</td>
<td>Note: IEHP’s assigned Plan ID Number is 001</td>
</tr>
<tr>
<td>Q</td>
<td>P</td>
<td>G</td>
<td>O</td>
<td>S</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| Identify whether the Request involves any of the Following Scenarios:  
1) Authorization for Treatment Regimen already in Place  
2) Retrospective Authorization (Service already Provided)  
3) Routine Authorizations (Requests for Specialty Service, Cost Control purposes, Out-of-Network not otherwise exempt from Prior Authorization) | Was Request made under the Expedited timeframe, but Processed by the plan under the Standard Timeframe? | Request for Expedited Timeframe | Was a Timeframe Extension Taken? | If an Extension was taken, did the MMP notify the Member of the Reason(s) for the Delay and of their Right to file an Expedited Grievance? | Request Disposition | Date of MMP Decision | Was the Request Denied for Lack of Medical Necessity? | If Denied for Lack of Medical Necessity, was the Review completed by a Physician or other Appropriate Health Care Professional? | Date Oral Notification Provided to Member | Date Written Notification Provided to Member | Date Service Authorization Entered / Effectuated in the MMP's System |
| **Yes** / **No** of the above categories apply. | **Yes** / **No** / **Not Applicable (NA)** indicator of whether the request was made under expedited timeframe, but was processed under a standard timeframe. | **Yes** / **No** / **Not Applicable (NA)** indicator of whether the request was made under expedited timeframe, but was processed under a standard timeframe. | **Yes** / **No** / **Not Applicable (NA)** indicator of whether the MMP notified the member of the delay. | **Yes** / **No** / **Not Applicable (NA)** indicator of whether the request was made under expedited timeframe, but was processed under a standard timeframe. | **Yes** / **No** / **Not Applicable (NA)** indicator of whether the request was made under expedited timeframe, but was processed under a standard timeframe. | **If Denial for Lack of Medical Necessity, was the Review completed by a Physician or other Appropriate Health Care Professional?** | **Date Oral Notification Provided to Member** | **Date Written Notification Provided to Member** | **Date Service Authorization Entered / Effectuated in the MMP's System** |
| **Yes** / **No** / **Not Applicable (NA)** indicator of whether the request was made under expedited timeframe, but was processed under a standard timeframe. | **Yes** / **No** / **Not Applicable (NA)** indicator of whether the request was made under expedited timeframe, but was processed under a standard timeframe. | **Yes** / **No** / **Not Applicable (NA)** indicator of whether the request was made under expedited timeframe, but was processed under a standard timeframe. | **Yes** / **No** / **Not Applicable (NA)** indicator of whether the request was made under expedited timeframe, but was processed under a standard timeframe. | **Yes** / **No** / **Not Applicable (NA)** indicator of whether the request was made under expedited timeframe, but was processed under a standard timeframe. | **Yes** / **No** / **Not Applicable (NA)** indicator of whether the request was made under expedited timeframe, but was processed under a standard timeframe. | **If Denial for Lack of Medical Necessity, was the Review completed by a Physician or other Appropriate Health Care Professional?** | **Date Oral Notification Provided to Member** | **Date Written Notification Provided to Member** | **Date Service Authorization Entered / Effectuated in the MMP's System** |

**Note:** This is separate from effectuation, notice, etc. This is the determination to approve/deny and may not be a captured field but rather a field to be populated from notes.

**Date of MMP Decision**

**Was the RequestDenied for Lack of Medical Necessity?**

**If Denied for Lack of Medical Necessity, was the Review completed by a Physician or other Appropriate Health Care Professional?**

**Date Oral Notification Provided to Member**

**Date Written Notification Provided to Member**

**Date Service Authorization Entered / Effectuated in the MMP’s System**

**Date Service Authorization Entered in the MMP’s System.** Submit in **CCYY/MM/DD** format (e.g., 2017/01/01). **Answer NA** if no written notification. If good faith effort was made to contact the member, CMS recommends including the last good faith effort made within the notification timeframe.

**Date Written Notification Provided to Member.** The term “provided” means when the letter left the MMP’s establishment by US Mail, fax, or electronic communication. Do not enter the date a letter is generated or printed within the MMP’s organization. Submit in **CCYY/MM/DD** format (e.g., 2017/01/01). **Answer NA** if no written notification.

**Date Service Authorization Entered in the MMP’s System.** Submit in **CCYY/MM/DD** format (e.g., 2017/01/01). **Answer NA** if not applicable. Date service authorization approval entered in the MMP’s system.
<table>
<thead>
<tr>
<th>AOR Receipt Date</th>
<th>First Tier, Downstream, and Related Entity</th>
</tr>
</thead>
</table>

Date the Appointment of Representative (AOR) form or other appropriate documentation received by the MMP. Submit in CCYY/MM/DD format (e.g., 2017/01/01). Answer NA if no AOR form was required.

Insert the name of the First Tier, Downstream, and Related Entity that processed the standard organization determination (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.
<table>
<thead>
<tr>
<th>Date of Review:</th>
<th>Surveyor:</th>
</tr>
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<tbody>
<tr>
<td>Name of IPA:</td>
<td>IPA Code</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City/State:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td>FAX:</td>
</tr>
<tr>
<td>Name of Management Company (if applicable)</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City/State:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td>FAX:</td>
</tr>
</tbody>
</table>

**IPA Contact Personnel**

<table>
<thead>
<tr>
<th>Role</th>
<th>Phone</th>
<th>FAX</th>
<th>E-Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPA Administrator:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Director:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QM Chairperson:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QM Contact/Title:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UM Chairperson:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UM Contact/Title:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM Contact/Title:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credentialing Contact/Title:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Provider Relations Contact/Title:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Compliance Contact/Title:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management Contact/Title:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HEALTH PLAN CONTRACTS/ENROLLMENT**

<table>
<thead>
<tr>
<th>IPA Total Enrollment in all participating health plans:</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPA total enrollment for each of the following:</td>
</tr>
<tr>
<td>Commercial:</td>
</tr>
<tr>
<td>IPA Enrollment for (insert health plan) for each of the following:</td>
</tr>
<tr>
<td>Commercial:</td>
</tr>
</tbody>
</table>

**CONTRACTED PHYSICIANS**

<table>
<thead>
<tr>
<th>Total Number:</th>
<th>Total number of PCP’s:</th>
<th>Total number of specialist:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of OB’s:</td>
<td>Total number of Pediatricians:</td>
<td></td>
</tr>
<tr>
<td>Have you included the following in your total:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB/GYN’s: yes no</td>
<td>Pediatricians: yes no</td>
<td></td>
</tr>
<tr>
<td>Capitated Specialist: (number/specialty)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Offshore Subcontracts for Delegated Functions

<table>
<thead>
<tr>
<th>Name of offshore vendor:</th>
<th>Date of initial contract agreement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>City/State/Country:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Fax:</td>
<td></td>
</tr>
</tbody>
</table>

#### Delegated Functions:
- Care Management
- Credentialing
- Utilization Management
- Claims
<table>
<thead>
<tr>
<th>Element</th>
<th>Regulatory Criteria &amp; Policy</th>
<th>Methodology</th>
<th>Scope</th>
<th>Benchmark</th>
<th>Look-back Period</th>
<th>Data Source</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation of review of the HRA</td>
<td>CCI Three-Way Contract, 2.8.2.1. IEHP Provider Policy and Procedure Manual - MA, 12A2</td>
<td>Review of case notes to show evidence of case manager review of completed HRA. Each identified risk in the HRA is addressed within the clinical documentation system. Must demonstrate that HRA was retrieved from either the Provider Portal or SFTP. For example, automatically loaded or manually retrieved.</td>
<td>CMC members with an initial or a reassessment HRA completed within the past 90 calendar days as identified on the Care Management Logs submitted by the IPA and/or other data sources.</td>
<td>&lt;90%</td>
<td>13 Months</td>
<td>Care management clinical documentation</td>
<td>Monthly</td>
</tr>
<tr>
<td>Review of all available Member data</td>
<td>CCI Three-Way Contract, 2.8.2.1. IEHP Provider Policy and Procedure Manual - MA, 12A2</td>
<td>Review of case notes to assess that all identified risks on assessment(s) such as CBAS, MSSP care plans, County BH Treatment plan and any other assessment available of the Member to add in ICP development were addressed to mitigate known risk, or a plan to document to address risk(s). Review of Provider Portal and/or SFTP to review HRA availability to determine that there was none available.</td>
<td>CMC members with an initial or a reassessment HRA completed within the past 90 calendar days as identified on the Care Management Logs submitted by the IPA and/or other data sources.</td>
<td>&lt;90%</td>
<td>13 Months</td>
<td>Care management clinical documentation</td>
<td>Monthly</td>
</tr>
<tr>
<td>If no HRA is available for review, an assessment is completed with Member</td>
<td>CCI Three-Way Contract, 2.8.2.2. IEHP Provider Policy and Procedure Manual - MA, 12A2</td>
<td>Each identified risk in the HRA is addressed within the clinical documentation system with plans to mitigate within care management plans. Review of case notes to assess that all identified risks on assessment(s) such as CBAS, MSSP care plans, County BH Treatment plan and any other assessment available of the Member to add in ICP development were addressed to mitigate known risk, or a plan to document to address risk(s).</td>
<td>CMC members without a completed HRA within the lookback period.</td>
<td>&lt;90%</td>
<td>13 Months</td>
<td>Care management clinical documentation</td>
<td>Monthly</td>
</tr>
<tr>
<td>Care Plan developed with Members and/or authorized representatives within 90 days of initial enrollment</td>
<td>CCI Three-Way Contract, 2.5.2.9. IEHP Provider Policy and Procedure Manual - MA, 12A2</td>
<td>Care Plan must include the name and contact information of Member’s PCP, any specialists and county workers (as applicable), complete and current list of Member’s medications.</td>
<td>CMC members with a care plan developed or updated within lookback period.</td>
<td>&lt;90%</td>
<td>13 Months</td>
<td>Care management clinical documentation</td>
<td>Monthly</td>
</tr>
<tr>
<td>Member given the ability to opt out or disenroll from the care plan process</td>
<td>CCI Three-Way Contract, 2.5.2.13.1. &amp; 2.5.2.13.2. IEHP Provider Policy and Procedure Manual - MA, 12A2</td>
<td>Review of clinical documentation that demonstrates the Member and/or representative was offered the ability to opt out of the ICP process. If Member refuses to be involved in ICP development, refusal is reinstated at the time of reassessment, change of condition, or if the Member’s PCP changes. Review of case notes to assess that all identified risks on assessment(s) such as CBAS, MSSP care plans, County BH Treatment plan and any other assessment available of the Member to add in ICP development were addressed to mitigate known risk, or a plan to document to address risk(s).</td>
<td>CMC members with a care plan developed or updated within lookback period.</td>
<td>&lt;90%</td>
<td>13 Months</td>
<td>Care management clinical documentation</td>
<td>Monthly</td>
</tr>
<tr>
<td>Member and/or their authorized representative must have the opportunity to review and sign the care plan and any amendments</td>
<td>CCI Three-Way Contract, 2.5.2.9.1. IEHP Provider Policy and Procedure Manual - MA, 12A2</td>
<td>Review of clinical documentation demonstrates the Member and/or representative was allowed to review and sign the ICP, that ICP was provided in Member preferred preference and/or alternative formats.</td>
<td>CMC members with a care plan developed or updated within lookback period.</td>
<td>&lt;90%</td>
<td>13 Months</td>
<td>Care management clinical documentation</td>
<td>Monthly</td>
</tr>
<tr>
<td>ICP has Member’s goals, preferences, measurable objectives, timelines and interventions meet medical, Behavioral Health and LTSS needs</td>
<td>CCI Three-Way Contract, 2.8.3. IEHP Provider Policy and Procedure Manual - MA, 12A2</td>
<td>Review of ICP to ensure Member’s goals, preferences, measurable objectives, timelines and interventions meet medical, Behavioral Health and LTSS needs.</td>
<td>CMC members with a care plan developed or updated within lookback period.</td>
<td>&lt;90%</td>
<td>13 Months</td>
<td>Care management clinical documentation</td>
<td>Monthly</td>
</tr>
<tr>
<td>Facilitate communication and coordination among Member’s medical and/or behavioral health care providers as appropriate</td>
<td>CCI Three-Way Contract, 2.8.2.4. IEHP Provider Policy and Procedure Manual - MA, 12A2</td>
<td>Review of clinical documentation to ensure care manager coordinated care as appropriate between Member’s Providers as appropriate.</td>
<td>CMC members with a care plan developed or updated within lookback period.</td>
<td>&lt;90%</td>
<td>13 Months</td>
<td>Care management clinical documentation</td>
<td>Monthly</td>
</tr>
<tr>
<td>Provide Member with self-directed care options and assistance available to self direct care</td>
<td>CCI Three-Way Contract, 2.5.2.11. IEHP Provider Policy and Procedure Manual - MA, 12A2</td>
<td>Review of clinical documentation to ensure evidence of care manager providing Member with self-directed care options.</td>
<td>CMC members with a care plan developed or updated within lookback period.</td>
<td>&lt;90%</td>
<td>13 Months</td>
<td>Care management clinical documentation</td>
<td>Monthly</td>
</tr>
<tr>
<td>ICT meetings conducted annually and was offered when a need was demonstrated by Member and/or representative</td>
<td>CCI Three-Way Contract, 2.5.2.8. IEHP Provider Policy and Procedure Manual - MA, 12A2</td>
<td>Review of clinical documentation to ensure ICT is completed annually and offered when a need was demonstrated or requested.</td>
<td>CMC members with a care plan developed or updated within lookback period.</td>
<td>&lt;90%</td>
<td>13 Months</td>
<td>Care management clinical documentation</td>
<td>Monthly</td>
</tr>
<tr>
<td>ICT documentation includes the dates, participants, notes and actions discussed during the ICT including any Member discussions</td>
<td>Review of notes to ensure documentation of ICT meeting has the discussion of the meeting and attendees. Notes should include follow-up and action items should be addressed until need is met.</td>
<td>CMC members with ICT conducted within lookback period</td>
<td>90%</td>
<td>13 Months</td>
<td>Care management clinical documentation</td>
<td>Monthly</td>
<td></td>
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<tr>
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</tr>
<tr>
<td>If the Member does not demonstrate the need for an ICT, there is documentation to support</td>
<td>CCI Three-Way Contract, 2.5.2.8.10. IEHP Provider Policy and Procedure Manual ‐ MA_12A4</td>
<td>Review of notes to ensure documentation is noted when there is no identified need for ICT meeting.</td>
<td>CMC members with a care plan developed or updated within lookback period</td>
<td>90%</td>
<td>13 Months</td>
<td>Care management clinical documentation</td>
<td>Monthly</td>
</tr>
<tr>
<td>Member given the ability to opt out of the ICT</td>
<td>CCI Three-Way Contract, 2.5.2.8.10. IEHP Provider Policy and Procedure Manual ‐ MA_12A4</td>
<td>Review of case notes to demonstrate documentation when a Member declines participation in ICT.</td>
<td>CMC members with a care plan developed or updated within lookback period</td>
<td>90%</td>
<td>13 Months</td>
<td>Care management clinical documentation</td>
<td>Monthly</td>
</tr>
<tr>
<td>Documentation of 3 attempts (different dates and times) for Member outreach prior to determining Member(s) is unable to reach</td>
<td>Core 3.2 Requirement IEHP Provider Policy and Procedure Manual ‐ MA_12A4</td>
<td>Review of case notes to identify 3 outreach attempts were made to the Member/Member representative prior to determining Member is unable to reach.</td>
<td>CMC members with an initial or a reassessment HRA completed within the past 90 calendar days as identified on the Care Management Logs submitted by the IPA and/or other data sources</td>
<td>90%</td>
<td>13 Months</td>
<td>Care management clinical documentation</td>
<td>Monthly</td>
</tr>
<tr>
<td>Care coordination of Member’s mental health needs</td>
<td>CA 1.7 Requirement IEHP Provider Policy and Procedure Manual ‐ MA_25A2</td>
<td>Review of case notes to demonstrate documentation that Member’s mental health needs were addressed and met between county mental health provider/county clinic and Member.</td>
<td>CMC Members who have received Medi-Cal specialty mental health services for three or more consecutive months during the reporting period</td>
<td>90%</td>
<td>13 Months</td>
<td>Care management clinical documentation</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
DELEGATED IPA DELEGATION AGREEMENT – IEHP DUALCHOICE

The purpose of the following grid is to specify the activities delegated by Inland Empire Health Plan (IEHP) under the Delegation Agreement with respect to: (i) Quality Management and Improvement, (ii) Continuity and Coordination of Care, (iii) Utilization Management, (iv) Care Management, (v) Credentialing and Recredentialing, (vi) Encounter Data, (vii) Claims Adjudication and (viii) Compliance. All Delegated activities are to be performed in accordance with currently applicable NCQA accreditation standards, DHCS regulatory requirements, DMHC regulatory requirements, and IEHP standards, as modified from time to time. Delegate agrees to be accountable for all responsibilities delegated by IEHP and oversight of any sub-delegated activities, except as outlined in the Delegation Agreement. Delegate will submit the reports to IEHP as described in the Required Reporting Elements of the Delegation Agreement to the Delegation Oversight Department through IEHP Secure File Transfer Protocol (SFTP) by no later than the due date specified. The IPA will provide notice of report submission via email to the Provider Services designated contacts. IEHP will oversee the delegate by performing annual audits. In the event deficiencies are identified through this oversight, Delegate will provide a specific corrective action plan acceptable to IEHP. If Delegate does not comply with the corrective action plan within the specified time frame, IEHP will take necessary steps up to and including revocation of delegation in whole or in part. Delegate is free to collect data as needed to perform delegated activities. IEHP will provide Member experience and clinical performance data, upon request.

In accordance, the Health Insurance Portability and Accountability Act, IPA/Medical group shall comply with the following provisions:

- The IPA has a list of the allowed uses of protected health information. The IPA may only use PHI associated with performing functions outlined in this agreement. It may only be disclosed to the member, their authorized representative, IEHP, and other authorized healthcare entities.
- The IPA has a process in place for ensuring that Members and Practitioners information will remain protected. Protections must include oral, written, and electronic forms of PHI.
- The IPA has a description of the safeguarding of the protected health information from inappropriate use or further disclosure.
- The IPA has a written description stipulating that the IPA will ensure that sub-delegates have similar safeguards when applicable.
- The IPA has a written description stipulating that the delegate will provide individuals with access to their protected health information. The delegate will have procedures to receive, analyze and resolve Members’ requests for access to their PHI.
- The IPA will ensure that its organization will inform the organization if inappropriate uses of information occur. The IPA will have policies and procedures to identify and report unauthorized access, use, disclosure, modification or destruction of PHI and the systems used to access or store PHI.
- The IPA will ensure that the protected health information is returned, destroyed or protected if the delegation agreement ends.
## REQUIRED REPORTING ELEMENTS

<table>
<thead>
<tr>
<th>Department</th>
<th>Required Documentation/Materials</th>
<th>Submission Deadline</th>
<th>IEHP Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual QM Program Description</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual QM Program Evaluation</td>
<td>Feb 28</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual QM Work Plan</td>
<td></td>
<td></td>
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### REQUIRED REPORTING ELEMENTS

<table>
<thead>
<tr>
<th>Department</th>
<th>Required Documentation/Materials</th>
<th>Submission Deadline</th>
<th>IEHP Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization Management</td>
<td>Monthly Denials and Partial Approvals (Modifications)</td>
<td>15th of each month</td>
<td>SFTP Server</td>
</tr>
<tr>
<td></td>
<td>Monthly Approval File Review</td>
<td></td>
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<tr>
<td></td>
<td>Monthly Long Term Care (LTC) Data Sheet</td>
<td></td>
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<tr>
<td></td>
<td>Monthly Second Opinion Tracking Log</td>
<td></td>
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<td></td>
<td>Monthly MESAR</td>
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<td></td>
<td>Monthly MSSAR</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Part C Organization Determinations- Authorizations</td>
<td>May 15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Semi Annual UM Annual Evaluation/ICE Report</td>
<td>Aug 15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Semi Annual UM Workplan Update</td>
<td>Nov 15</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Feb 09</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual UM Program Description</td>
<td>Feb 15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual UM Workplan/Initial ICE Report</td>
<td>Aug 15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual UM Program Evaluation</td>
<td>Feb 28</td>
<td></td>
</tr>
</tbody>
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## REQUIRED REPORTING ELEMENTS

<table>
<thead>
<tr>
<th>Department</th>
<th>Required Documentation/Materials</th>
<th>Submission Deadline</th>
<th>IEHP Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Management</td>
<td>Monthly CM Log</td>
<td>15(^{th}) of each month</td>
<td>SFTP Server</td>
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<tr>
<td></td>
<td>Monthly CM File Review</td>
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<td></td>
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<tr>
<td></td>
<td>Monthly Care Transition Cases Log</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Monthly Care Plan Outreach Log</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of critical incident and abuse reports for members receiving LTSS</td>
<td>May 13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quarterly Care Coordinator to Member Ratio Report</td>
<td>Aug 15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual Guidelines for Care Management Provider and Internal Staff Training Completion records</td>
<td>Nov 15</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Jan 15</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Feb 28</td>
<td></td>
</tr>
<tr>
<td>HCI</td>
<td>Annual HCC WorkPlan</td>
<td>Feb 15</td>
<td>SFTP Server</td>
</tr>
<tr>
<td></td>
<td>MMP Provider Payment Requests (M_Claims) Record Layout/Universe</td>
<td>15(^{th}) of each month</td>
<td></td>
</tr>
<tr>
<td>Credentialing and Recredentialing</td>
<td>Monthly Credentialing and Recredentialing Report</td>
<td>15th of each month</td>
<td>SFTP server and email to <a href="mailto:CredentialingProfileSubmission@iehp.org">CredentialingProfileSubmission@iehp.org</a></td>
</tr>
<tr>
<td>Credentialing and Recredentialing</td>
<td>Written and approved Credentialing, Recredentialing, Peer Review policies and Procedures</td>
<td>Within 30 days of the Credentialing Committee approval or prior to onsite and/or desktop DOA audit</td>
<td>SFTP server and email to <a href="mailto:CredentialingProfileSubmission@iehp.org">CredentialingProfileSubmission@iehp.org</a></td>
</tr>
<tr>
<td>Credentialing and Recredentialing</td>
<td>Initial credentialing applications for approved providers must be submitted to IEHP, by submitting a current profile, contract (1(^{st}) and signature pages and any applicable addendums) and W-9.</td>
<td>After Credentialing Approval</td>
<td>SFTP Server and email to <a href="mailto:CredentialingProfileSubmission@iehp.org">CredentialingProfileSubmission@iehp.org</a></td>
</tr>
</tbody>
</table>
## REQUIRED REPORTING ELEMENTS

<table>
<thead>
<tr>
<th>Department</th>
<th>Required Documentation/Materials</th>
<th>Submission Deadline</th>
<th>IEHP Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credentialing and Recredentialing</td>
<td>Recredentialing applications for approved providers must be submitted to IEHP via IEHP Excel Recred Template identified in the IEHP Provider Manual, 05B – Practitioner Credentialing Requirements.</td>
<td>By the 15th of the following month, after Committee approval</td>
<td>SFTP Server and email to <a href="mailto:CredentialingProfileSubmission@iehp.org">CredentialingProfileSubmission@iehp.org</a></td>
</tr>
<tr>
<td>Encounter Data</td>
<td>5010 / Encounters</td>
<td>1st of each month</td>
<td>SFTP Server</td>
</tr>
<tr>
<td>Claims Adjudication</td>
<td>Monthly Claims Timeliness Reports</td>
<td>15th of each month</td>
<td>SFTP Server</td>
</tr>
<tr>
<td></td>
<td>Monthly MMP Provider Payment Request (M_Claims record layout/universe)</td>
<td>April 29</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quarterly Provider Payment Dispute Resolution</td>
<td>July 29</td>
<td></td>
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<tr>
<td></td>
<td>Quarterly Part C Organizations Determinations-Claims</td>
<td>October 31</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>January 31</td>
<td></td>
</tr>
<tr>
<td>Compliance</td>
<td>Annual Compliance FWA/HIPAA Training</td>
<td>Annually as required for DOA</td>
<td>SFTP Server</td>
</tr>
<tr>
<td>Compliance</td>
<td>Annual Sanction and Exclusions Screenings</td>
<td>Annually as required for DOA</td>
<td>SFTP Server</td>
</tr>
<tr>
<td>Compliance</td>
<td>Annual Compliance Plan Program Description and evidence of training</td>
<td>Annually as required for DOA</td>
<td>SFTP Server</td>
</tr>
</tbody>
</table>
## REQUIRED REPORTING ELEMENTS

<table>
<thead>
<tr>
<th>Department</th>
<th>Required Documentation/Materials</th>
<th>Submission Deadline</th>
<th>IEHP Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance</td>
<td>Annual FWA Program Description and evidence of training</td>
<td>Annually as required for DOA</td>
<td>SFTP Server</td>
</tr>
<tr>
<td>Compliance</td>
<td>Annual HIPAA Program Description and evidence of training</td>
<td>Annually as required for DOA</td>
<td>SFTP Server</td>
</tr>
<tr>
<td></td>
<td>Organizational Informational Disclosures</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual Audited Financial Statements, Including IBNR Certification</td>
<td>5 months after end of IPAs Fiscal year</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Financial Statements, Including IBNR Certification</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT

<table>
<thead>
<tr>
<th>Delegated Activity</th>
<th>IEHP Responsibilities</th>
<th>Delegate Responsibilities</th>
<th>Frequency of Reporting</th>
<th>Process for Evaluating Delegates Performance</th>
<th>Corrective Actions if Delegate Fails to Meet Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Improvement Program Structure (NCQA QI1 Elements A, B, C and D, NCQA MED8 Element D and MA Manual Ch. 5 Section 20)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The IPA has the QI infrastructure necessary to improve the quality and safety of clinical care and services it provides to its members</td>
<td>Semi-Annual and Annual</td>
<td>IPA is not delegated for this function, however IEHP will review the IPA’s Policies and Procedures.</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
</tr>
</tbody>
</table>

A. The QI program description specifies:
1. The QI program structure
   a. The QI program’s functional areas and their responsibilities.
   b. Reporting relationships of QI Department staff and the QI Committee.
   c. Resources and analytical support.
   d. QI activities.
   e. Collaborative QI activities, if any.
2. Involvement of a designated physician in the QI program.
3. Oversight of QI functions of the organization by the QI Committee.
4. Objectives for serving a culturally and linguistically diverse membership to:
   a. Reduce health care disparities in clinical areas.
   b. Improve cultural competency in materials and communications.
   c. Improve network adequacy to meet the needs of underserved groups.
| Quality Improvement Program Structure (NCQA QI1 Elements A, B, C and D, NCQA MED8 Element D and MA Manual Ch. 5 Section 20 (continued)) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | B. A QI annual work plan that reflects ongoing activities throughout the year and addresses:  
1. Yearly planned QI activities and objectives that address:  
   a. Quality of clinical care.  
   b. Safety of clinical care.  
   c. Quality of service.  
   d. Members’ experience.  
2. Time frame for each activity’s completion.  
3. Staff members responsible for each activity.  
4. Monitoring of previously identified issues.  
5. Evaluation of the QI program.  
C. The organization conducts an annual written evaluation of the QI program that includes the following information:  
1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.  
3. Analysis and evaluation of the overall effectiveness of the QI program and its progress toward influencing networkwide safe clinical practices with a summary addressing:  
   a. Adequacy of QI program resources.  
   b. QI Committee structure.  
   c. Practitioner participation and leadership involvement in the QI program.  
   d. Need to restructure or change the QI program for the subsequent year.  
D. QI Committee Responsibilities:  
1. Recommends policy decisions  
2. Analyzes and evaluates the results of QI activities | Semi-Annual and Annual | IPA is not delegated for this function, however IEHP will review the IPA’s Policies and Procedures. Semi-Annual review and Annually as part of the DOA | See Corrective Action Plan (CAP) Requirements in MA_25D3. |
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<tr>
<td>Quality Improvement Program Structure (NCQA QI Elements A, B, C and D, NCQA MED8 Element D and MA Manual Ch. 5 Section 20 (continued))</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>3. Ensures practitioner participation in the QI program through planning, design, implementation or review. 4. Identifies needed actions. 5. Ensures follow-up, as appropriate. D. The organization annually makes information about its QI program available to members.</td>
<td>Semi-Annual and Annual</td>
<td>IPA is not delegated for this function, however IEHP will review the IPA’s Policies and Procedures.</td>
<td>Semi-Annual review and Annually as part of the DOA</td>
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* MUST PASS Element
### ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT

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<tr>
<td>Continuity and Coordination of Medical Care and Continued Access to Care (NCQA QI3 Element D and NET4 Elements A and B)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The IPA helps with members’ transition to other care when their benefit ends, if necessary. The IPA uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system. A. The IPA notifies members affected by the termination of a practitioner, family or internal medicine or pediatrics, at least thirty (30) calendar days prior to the effective termination date and helps them select a new practitioner. B. If the practitioner’s contract is discontinued, the IPA allows affected members continued access to the practitioner, as follows: 1. Continuation of treatment through the current period of active treatment, or for up to ninety (90) calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition 2. Continuation of care through the postpartum period for the members in their second or third trimester of pregnancy.</td>
<td>Monthly through UM Logs</td>
<td>Annual audit of IPA Policies and Procedures and sample cases</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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</table>

### ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT
| Utilization Management Program Structure and Process (NCQA UM1 and MA Manual Ch.5) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | The IPA has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner. A. The IPA UM program description includes the following: 1. A written description of the program structure: a) UM Staff member’s assigned activities, b) UM staff who have the authority to deny coverage, c) Involvement of a designated physician d) The process for evaluating, approving and revising the UM program, and the staff responsible for each step e) The UM program’s role in the QI program, including how the organization collects UM information and uses it for QI activities. f) The organization’s process for handling appeals and making appeal determinations. 2. Involvement of a designated senior-level physician in UM program implementation 3. The program scope and process used to determine benefit coverage and medical necessity including: a) How the organization develops and selects criteria b) How the organization reviews, updates and modifies criteria 4. Information sources used to determine benefit coverage and medical necessity. | Semi-Annual and Annually. | Annual audit of IPA Policies and Procedures, Workplan, Program, and Committee Meetings | See Corrective Action Plan (CAP) Requirements in MA_25D3. |

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<tr>
<td>Structure and Process (NCQA UM1 and MA Manual Ch.5 (continued))</td>
<td>Procedures via IEHP Provider Manual.</td>
<td>C. Must meet applicable IEHP Standards and are consistent with NCQA, State and Federal Health Care Regulatory Agencies Standards.</td>
<td></td>
<td>Program, and Committee Meetings</td>
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<tr>
<td>Clinical Criteria for UM Decisions – Approve or Denial (NCQA UM2 Elements A and C)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The IPA applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the health appropriateness of health care services. A. The IPA: 1. Has written UM decision-making criteria that are objective and based on health evidence. 2. Has written policies for applying the criteria based on individual needs; considers at least the following individual characteristics when applying criteria”</td>
<td>Monthly UM Logs</td>
<td>Annual Audit of IPA Policies and Procedures, Workplan, Program, and Committee Meetings. Monthly log and focused denial file selection review.</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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</table>
| Clinical Criteria for UM Decisions – Approve or Denial (NCQA UM2 Elements A and C (continued)) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | a. Age.  
b. Comorbidities.  
c. Complications.  
e. Psychosocial situation.  
f. Home environment, when applicable.  
3. Has written policies for applying the criteria based on an assessment of the local delivery system.  
4. Involves appropriate practitioners and in consultation with contracting health care professionals in developing.  
5. Annually reviews the UM criteria and the procedures for applying them and updates the criteria when appropriate.  
B. The IPA:  
1. States in writing how practitioners and Members can obtain UM criteria.  
2. Makes the UM criteria available to its practitioners and Members upon request.  
C. At least annually, the IPA:  
1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision-making.  

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## ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT

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</table>
| Communication Services (NCQA UM 3 Element A) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | Members and practitioners can access staff to discuss UM issues.  
A. The IPA provides the following communication services for members and practitioners.  
1. Staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.  
2. Staff can receive inbound communication regarding UM issues after normal business hours.  
   a. Telephone  
   b. Email  
   c. Fax  
3. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.  
4. TDD/TTY services for members who need them  

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<td>Appropriate Professionals (NCQA UM4 Elements A, B, C*and F, MED9 Element D, MA Manual Chapter 5, 6, and 11)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>UM decisions are made by qualified health professionals. A. The IPA has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision-making. B. The IPA has a written job description with qualifications for practitioners who review denials for care based on medical necessity. Practitioners are required to have: 1. Education, training or professional experience in medical or clinical practice 2. A current license to practice without restriction. C. The IPA ensures that a practitioner, as appropriate, reviews any denial based on medical necessity*. F. Use Board-Certified Consultants 1. The IPA has written procedures for using board-certified consultants to assist in making medical necessity determinations 2. The IPA provides evidence that it uses board-certified consultants for medical necessity determinations. D. The IPA distributes a statement to all members, treating practitioners, the organization’s</td>
<td>Monthly UM Logs</td>
<td>Annual audit of IPA Policies and Procedures, Workplan, Program, Committee Meetings and Ownership and Control documentation.</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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<td>IEHP will provide IPA with guidelines</td>
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<td>Appropriate Professionals (NCQA UM4 Elements A, B, C*and F, MED9 Element D, MA Manual Chapter 5, 6, and 11 (continued))</td>
<td>for Policies and Procedures via IEHP Provider Manual</td>
<td>reviewing practitioners and staff involved in UM decisions, affirming the following: 1. UM decision making is based only on appropriateness of care and service and existence of coverage. 2. The IPA does not specifically reward the organization’s reviewing practitioners or other individuals for issuing denials of coverage. 3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.</td>
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<td>See Corrective Action Plan (CAP) Requirements in MA_25D3</td>
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Annual audit of IPA Policies and Procedures, Workplan, Program, Committee Meetings and Ownership and Control documentation. Monthly log and focused denial and approval file selection review.
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<td><em><em>Timeliness of UM Decisions (NCQA UM5 Element A</em> and 42 CFR 422.568 and 42 CFR 422.572)</em>*</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The IPA makes utilization decisions in a timely manner to minimize any disruption in the provision of health care. A. The IPA adheres to the following time frames for notification and adjudication of the referral as follows*: 1. Urgent Concurrent Decisions: The IPA gives electronic or written notification of the decision to practitioners and members within twenty-four (24) hours of the request. 2. Urgent Pre-Service Decisions: The IPA makes decisions within seventy-two (72) hours from receipt of the request. 3. Non-Urgent Pre-Service Decisions: The IPA makes decisions within fourteen (14) calendar days from receipt of the request. 4. Post-Service Decisions: The IPA gives electronic or written notification of the decision to practitioners and members and written notification to the member within thirty (30) calendar days of the request.</td>
<td>Monthly</td>
<td>Annual audit of IPA Policies and Procedures, Workplan, Program, and Committee Meetings.</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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<td>Clinical Information (NCQA UM6 Element A)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The IPA uses all information relevant to a member’s care when it makes coverage decisions A. There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making.</td>
<td>Monthly</td>
<td>Annual audit of IPA Policies and Procedures, Workplan, Program, and Committee Meetings.</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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| Denial Notices (NCQA UM7 Elements A*, B*, and C*) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | Members and practitioners receive enough information to help them understand a decision to deny care or coverage and to decide whether to appeal the decision.  
A. The IPA gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer*.  
B. The IPA’s written notification of nonbehavioral healthcare denials, provided to members and their treating practitioners, contains the following information*:  
1. The specific reasons for the denial, in easily understandable language.  
2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based.  
3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.  
C. The IPA’s written nonbehavioral healthcare denial notification to members and their treating practitioners contains the following information*:  
1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.  
2. An explanation of the appeal process, including members’ rights to representation and appeal time frames.  
a. Includes a statement that members may be represented by anyone they choose, including an attorney. | Monthly | Monthly log and focused denial file review and Annual DOA | See Corrective Action Plan (CAP) Requirements in MA_25D3. |
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| Denial Notices (NCQA UM7 Elements A*, B*, and C*) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | b. Provides contact information for the state Office of Health Insurance Consumer Assistance or ombudsperson, if applicable.  
c. States the time frame for filing an appeal.  
d. States the organization’s time frame for deciding the appeal.  
e. States the procedure for filing an appeal, including where to direct the appeal and information to include in the appeal.  
3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials.  
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| Emergency Services (NCQA MED9 Element C) | 1. To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.  
2. If an authorized representative, acting for the organization, authorized the provision of emergency services.  
3. To provide post-stabilization care services for the member. | Assembly Bill 12 (AB 12) states that there must be a written process to obtain Second Opinion from PCP and Specialist.  
1. The IPA allows for a second opinion consultation, when a Member has questions/concerns regarding a diagnosis or plan of treatment, with an appropriately qualified health care provider if requested by the Member, or a health care provider who is treating the Member. The second opinion shall be with one of the IPA’s contracted Providers, unless the IPA does not have the appropriately qualified heath care provider in-network. In the event that the services cannot be provided in-network, the IPA must arrange for second opinion out-of-network with the same or equivalent Provider seen in-network. | Monthly | See Corrective Action Plan (CAP) Requirements in MA_25D3. |

AB 12
IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.
### ATTACHMENT I: Delineation of Quality Management & Improvement

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## ATTACHMENT IV: DELINEATION OF CARE MANAGEMENT

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| Guidelines for Care Management     | IEHP will provide IPA with guidelines for Policies and Procedures, and guidelines for Care Management Training via IEHP Provider Manual. | The IPA must develop and implement a guidelines for Care Management that provides the structure for care management processes and systems that will enable them to provide coordinated care for special needs individuals. The Guidelines for Care Management must include the following elements:  
  - Description of Target Population  
  - Care Management for the Most Vulnerable Subpopulations  
  - Staff structure and Care Management Roles  
  - Use of Health Risk Assessment Tool (HRAT) (Provided by Health Plan)  
  - Development and essential components of Individualized Care Plan (ICP)  
  - Interdisciplinary Care Team (ICT)  
  - Care Transition Protocols  
  - Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols  
  - Guidelines for Care Management Training for Personnel and Provider Network Training for Personnel and Provider Network  
  - Guidelines for Care Management Quality Performance Improvement Plan  
  - Measurable Goals and Health Outcomes  
  - Measuring Patient Experience of Care (Member Satisfaction)  
  - Ongoing Performance Improvement Evaluation; and  
  - Dissemination of Quality Improvement Performance | Annually | IPA must demonstrate guidelines for Care Management trainings are conducted annually for personnel and provider network.  
  
  Submission of documents for training include:  
  - Guidelines for Care Management presentation  

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| CM 1: Care Management | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | IPAs must submit a monthly care management log that includes the following:  
1. Member name (First, Last)  
2. Member ID number  
3. Date of Birth  
4. Case Status (Open or Closed)  
5. Case Level  
6. Case Open Date  
7. Name of Care Coordinator  
8. Date ICP Created  
9. Date ICP Updated  
10. Date ICP sent to PCP  
11. Date Care Goals Discussed with Member  
12. Last Date of Member Contract  
13. Date ICT was completed | Monthly | Annual Audit of IPA Policies and Procedures.  

IPAs must submit a monthly care plan outreach log that includes the following:  
1. Member name (First, Last)  
2. Member ID number  
3. Date of Birth  
4. Date of Outreach Attempt  
5. Outreach Method  
6. Outreach Disposition  
7. Care Team Member Title  
8. Clinical Care Team Member

Members who remain in Care Management for consecutive months must have an activity update each month.

(Sources: Medicare CM Log V2.0 and Att 12-CM Outreach Log V1.0)
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| Care Management Complex Case Management | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | ▪ Care Management Program Description that uses Evidence used to develop the program. Criteria for identifying patients who are eligible for the program, Services offered to individuals, Defined program goals, and How case management services are integrated with the services of others involved in the member’s care.  
▪ Annually assess the characteristics and needs of its member population and relevant subpopulations, Reviews and updates its care management processes to address Member needs, and Reviews and updates its care management resources to address member needs.  
▪ Initial Assessment of their health status, including condition-specific issues; Documentation of their clinical history, including medications; Activities of daily living; Mental health status and cognitive functions; Evaluation of their cultural and linguistic needs, preferences or limitations; Evaluation of visual and hearing needs, preferences or limitations; Evaluation of their caregiver resources and involvement; Evaluation of their socio-economic status; Evaluation of their available benefits. | Monthly                 | Annual Audit of IPA Policies and Procedures.  
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<td>Care Management Complex Case Management</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>▪ Development of a care management plan, including prioritized goals that consider the member’s and caregivers’ goals, preferences and desired level of involvement in the care management plan; identification of barriers to meeting their goals or complying with the plan; Development of a schedule for follow-up and communication; Development and communication of their self-management plans; A process to assess their progress against care management plans. ▪ Annually measures the effectiveness of its care management program by using three (3) measures to identify a relevant process or outcome; uses valid methods that provide quantitative results; Sets a performance goal; Clearly identifies measure specifications; Analyzes results; Identifies opportunities for improvement; Implements at least one intervention for each of the three (3) opportunities identified and develops a plan for evaluation of the intervention and re-measurement.</td>
<td>Monthly</td>
<td>Annual Audit of IPA Policies and Procedures. Monthly CM log review and targeted file review.</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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| Care Management    | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | The IPA makes a special effort to coordinate care when members move from one setting to another, such as when they are discharged from a hospital.  
- The IPA facilitates safe transitions by identifying transitions, sharing the sending setting’s care plan with the receiving setting within one business day of notification of the transition, and notifying the patient’s usual practitioner of the transition within twenty-four (24) hours.  
- The IPA facilitates safe transitions by communicating with the members or responsible party about the care transition process, about the changes to the health status and plan of care within three business days, and provides a consistent person or unit within the organization who is responsible for supporting the member through transitions.  
- The IPA annually analyzes its performance on the entire process of managing all care transitions.  
- The IPA identifies unplanned transitions by reviewing hospital admissions within one business day of admission reports and long-term care facilities within one business day of admission reports.  
- The IPA minimizes unplanned transitions and works to maintain members in the least restrictive | Monthly | Annual Audit of IPA Policies and Procedures.  

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<td>Care Management</td>
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<td>setting possible by analyzing data at least monthly and analyzing rates at least annually of all member admissions to hospitals and ED visits to identify areas for improvement. The IPA also implements at least one intervention related to the opportunities identified during the analysis of all member admissions to hospitals and ED visits.</td>
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<tr>
<td>Care Transitions</td>
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<td>▪ Based on the findings from its monthly analysis of data to identify individual members at risk of a transition, the IPA works to reduce unplanned transitions and to maintain members in the least restrictive setting possible by coordinating services for members at high risk of having a transition and educating members or responsible parties about transitions and how to prevent unplanned transitions.</td>
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## ATTACHMENT V: DELINEATION OF CREDENTIALING and RECREREDENTIALING

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| Practitioner Credentialing Guidelines (NCQA CR1 Element A) | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. | Delegate has policies and procedures that specify:  
1. Types of practitioners it credentials and recredits  
2. The verification sources it uses  
3. The criteria for credentialing and recredentialing  
4. The process for making credentialing and recredentialing decisions  
5. The process for managing credentialing files that meet the organizations established criteria  
6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner  
7. The process for notifying practitioners if information obtained during the organization’s credentialing process varies substantially from the information they provided to the organization. | Annually, at minimum | Annual Audit of Delegate’s Policies and Procedures. | See Corrective Action Plan (CAP) Requirements in MA_25D3. |
**ATTACHMENT V: DELINEATION OF CREDENTIALING and REcredentialing**

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<td>9. The Medical Director or other designated physician’s direct responsibility and participation in the credentialing program.</td>
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<td>10. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.</td>
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<td>11. The process for confirming listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty.</td>
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Delegate notifies practitioners about their right to:

1. Review information submitted to support their credentialing application
2. Correct erroneous information
3. Receive the status of their credentialing or recredentialing application, upon request
### ATTACHMENT V: DELINEATION OF CREDENTIALING and REcredentialing

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| Credentialing System Controls (NCQA CRI Element C*) | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. | The Delegates credentialing process describes*:  
1. How primary source verification information is received, dated and stored.  
2. How modified information is tracked and dated from its initial verification.  
3. Staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate.  
4. The security controls in place to protect the information from unauthorized modification.  
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<tr>
<td>CMS</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate has policies and procedures to ensure that it only contracts with physicians who have not opted out.</td>
<td>Annually, at minimum</td>
<td>Annual Audit of Delegate’s Policies and Procedures.</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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<tr>
<td>CMS/DHCS</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate must have policies and procedures that prohibit employment or contracting with practitioners (or entities that employ or contract with such practitioners) that are excluded/sanctioned from participation (practitioners or entities found on OIG Report)</td>
<td>Annually, at minimum</td>
<td>Annual Audit of Delegate’s Policies and Procedures.</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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| NCQA                                   | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. | Delegate’s Credentialing Committee:  
1. Uses participating practitioners to provide advice and expertise for credentialing decisions  
2. Reviews credentials for practitioners who do not meet established thresholds  
3. Ensures that files that meet established criteria, are reviewed and approved by a medical director or designated physician | Annually, at minimum                          | Audit of Delegate’s Policies and Procedures and Credentialing Committee Meeting Minutes       | See Corrective Action Plan (CAP) Requirements in MA_25D3.    |
| CR2 Element A. – Credentialing Committee |                                                                                         |                                                                                                                 |                                        |                                                                                                                  |                                                               |
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| Sanction Information (NCQA CR3 Element B*), (DHCS), (CMS) | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. | Delegate verifies that the following are within the prescribed time limits*:  
  1. A current and valid license to practice.  
  2. A valid DEA or CDS certificate, if applicable.  
  3. Education and training as specified in the explanation.  
  4. Board Certification status, if applicable.  
  5. Work history.  
  6. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner. | Annually, at minimum | IEHP reviews verification of credentials within a random sample of up to 30 initial credentialing files and 30 recredentialing files from the decision made during the look-back period | See Corrective Action Plan (CAP) Requirements in MA_25D3. |

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<td>Sanction Information (NCQA CR3 Element B*), (DHCS), (CMS)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate verifies the following sanction information for credentialing*: 1. State sanctions, restrictions on licensure or limitations on scope of practice. 2. Medicare and Medicaid sanctions a. Medicare and Medicaid Sanctions, OIG must be the verification source b. Medicaid Sanctions, the Medi-Cal Suspended and Ineligible List must be the verification source.</td>
<td>Annually, at minimum</td>
<td>IEHP reviews verification of credentials within a random sample of up to 30 initial credentialing files and 30 recredentialing files from the decision made during the look-back period</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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<td>Credentialing Application (NCQA CR3 Element C*)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate verifies that applications for credentialing include the following*.: 1. Reasons for inability to perform the essential functions of the position. 2. Lack of present illegal drug use. 3. History of loss of license and felony convictions. 4. History of loss or limitations of privileges or disciplinary actions. 5. Current malpractice insurance coverage. 6. Current and signed attestation confirming the correctness and completeness of the application.</td>
<td>Annually, at minimum</td>
<td>IEHP reviews application and attestation within a random sample of up to 30 initial credentialing files and 30 recredentialing files from the decision made during the look-back period</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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<tr>
<td>CMS/DMHC/DHCS</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate verifies the practitioner has privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating hospital. (Source: Medicare Managed Care Manual, Chapter 6 § 60.3; MMCD Policy Letter 02-03 and DMHC TAG 10/11)</td>
<td>Annually, at minimum</td>
<td>IEHP reviews verification of credentials within a random sample of up to 30 initial credentialing files and 30 recredentialing files from the decision made during the look-back period</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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<td>CMS</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate monitors its credentialing files to ensure that it only contracts with practitioners who have not opted out. (Source: Medicare Managed Care Manual, Chapter 6 § 60.2)</td>
<td>Annually, at minimum</td>
<td>IEHP reviews verification of credentials within a random sample of up to 30 initial credentialing files and 30 recredentialing files from the decision made during the look-back period</td>
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<tr>
<td>CMS/DHCS</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate includes information from quality improvement activities and member complaints in the recredentialing decision-making process. (Source: Medicare Managed Care Manual, Chapter 6 § 60.3; MMCD 02-03 and Exhibit A: Attachment 4 of Plan Contract)</td>
<td>Annually, at minimum</td>
<td>IEHP reviews verification of credentials within a random sample of up to 30 recredentialing files from the decision made during the look-back period</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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<td>Recredentialing Cycle Length (NCQA CR4 Element A*)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>A. Delegate conducts timely recredentialing. The length of the recredentialing cycle is within the required thirty-six (36) month time frame*.</td>
<td>Annually, at minimum</td>
<td>IEHP reviews verification of credentials within a random sample of up to 30 initial credentialing files and 30 recredentialing files from the decision made during the look-back period</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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<tr>
<td>Performance Standards and Thresholds (NCQA MED3 Element A)</td>
<td>IEHP sets site performance standards and thresholds for: 1. Accessibility equipment. 2. Physical accessibility. 3. Physical appearance. 4. Adequacy of waiting and examining room space. 5. Adequacy of medical/treatment medical record keeping.</td>
<td>Delegate is responsible for ensuring the providers are compliant with IEHP Facility Site Review and Medical Record Audits.</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
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<tr>
<td>Site Visits and Ongoing Monitoring (NCQA MED3 Element B)</td>
<td>IEHP implements appropriate interventions by: 1. Continually monitoring member complaints for all practitioner sites. 2. Conducting site visits of offices within 60 calendar days of determining that the complaint threshold was met. 3. Instituting actions to improve offices that do not meet thresholds. 4. Evaluating the effectiveness of the actions at least every six months, until deficient offices meet the thresholds. 5. Documenting follow-up visits for offices that had subsequent deficiencies.</td>
<td>Delegate is responsible for ensuring the providers are compliant with IEHP Facility Site Review and Medical Record Audits.</td>
<td>Not Applicable</td>
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<td>Ongoing Monitoring and Interventions (NCQA CR5 Element A)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality by:</td>
<td>Annually, at minimum</td>
<td>IEHP reviews the organization's policies and procedures, monitoring reports, and documentation of interventions</td>
<td>Delegate provides immediate notification of all providers identified through ongoing monitoring to the health plan’s Credentialing Manager, with the delegate’s plan of action for the identified provider and date it was reviewed by their Credentialing/Peer Review Committee.</td>
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1. Collecting and reviewing Medicare and Medicaid sanctions.
2. Collecting and reviewing sanctions or limitations on licensure.
3. Collecting and reviewing complaints.
4. Collecting and reviewing information from identified adverse events.
5. Implementing appropriate interventions when it identifies instances of poor quality related to factor 1-4.

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<tr>
<td>DHCS &amp; NCQA CR5 Element A.– Monitoring Medi-Cal Suspended and Ineligible Provider Reports</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate verifies that their contracted providers have not been terminated as a Medi-Cal provider or have not been placed on the Suspended and Ineligible Provider List. (Source: Exhibit A: Attachment 4, Plan Contract)</td>
<td>Annually, at minimum</td>
<td>IEHP reviews the Delegate’s Policies and Procedures, Monitoring Reports, and Documentation of Interventions</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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<td>CMS Monitoring Preclusions List</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate maintains a documented process for monitoring providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare Beneficiaries. Delegates are responsible for reviewing these reports within thirty (30) days of its release and notify IEHP of any providers identified, to include the delegate’s plan of action.</td>
<td>Annually, at minimum</td>
<td>IEHP reviews the Delegate’s Policies and Procedures, Monitoring Reports, and Documentation of Interventions Delegate provides immediate notification of all providers identified through ongoing monitoring to the health plan, with the Delegate’s plan of action for the identified provider.</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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<td>CMS</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate is required to submit SSN for all new and existing providers to screen against the Death Master File.</td>
<td>Ongoing</td>
<td>Not Applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Monitoring Death Master File</td>
<td>IEHP maintains a documented process for monitoring providers who are identified on the Death Master File</td>
<td>(Source: Department of Health Care Services (DHCS) All Plan Letter (APL) APL 17-019 supersedes APL 16-012, &quot;Provider Credentialing/Recredentialing and Screening/Enrollment)</td>
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<td>Notification to Authorities and Practitioner Appeal Rights (NCQA CR6 Element A)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegates that have taken action against a practitioner for quality reasons reports the action to the appropriate authorities and offers the practitioner a formal appeal process. Delegate has policies and procedures for: 1. The range of actions available to the organization. 2. Making the appeal process known to practitioners.</td>
<td>Annually, at minimum</td>
<td>IEHP reviews evidence that the organization reports to authorities and the health plan’s Credentialing Manager, Information may be de-identified for confidentiality purposes</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D 3.</td>
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<td>Actions Against Practitioners (NCQA CR6 Element A)</td>
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<td>CMS– Appeals Process for Termination/ Suspension</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate’s policies and procedures regarding suspension or termination of a participating physician require the organization to ensure that the majority of the hearing panel members are peers of the affected physician. (Source: Medicare Managed Care Manual, Chapter 6 § 60.4)</td>
<td>Annually, at minimum</td>
<td>IEHP reviews the information sent to practitioners</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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<tr>
<td>Review and Approval of Providers (NCQA CR7 Element A)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate’s policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body. 3. Conducts an onsite quality assessment if the provider is not accredited.</td>
<td>Annually, at minimum</td>
<td>IEHP reviews Delegate’s policies and procedures</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D 3.</td>
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<td>Assessing Medical Providers (NCQA CR7 Element D)</td>
<td>1. IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate assesses contracted medical health care providers. Delegate maintains a checklist, spreadsheet or other record that it assessed providers against the requirements.</td>
<td>Annually, at minimum</td>
<td>IEHP reviews evidence that the organization assessed the providers in NCQA CR7 Element A</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D 3.</td>
</tr>
<tr>
<td>Accreditation/Certification of Free-Standing Surgical Centers in California - CH &amp; SC (California Health and Safety Code § 1248.1)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The Delegate has documentation of assessment of free-standing surgical centers to ensure that if the organization is not accredited by an agency accepted by the State of California, the organization is certified to participate in the Medicare Program, in compliance with California Health and Safety Code § 1248.1</td>
<td>Annually, at minimum</td>
<td>IEHP reviews evidence that the organization assessed the providers in NCQA CR7.A.</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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| Written Delegation Agreement (NCQA CR8 Element A) | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. | Delegate remains responsible for credentialing and recredentialing its practitioners, even if its delegates all or part of these activities. The written delegation agreement:  
1. Is mutually agreed upon.  
2. Describes the delegated activities and the responsibilities of IEHP and the IPA.  
3. Requires at least semianual reporting of the delegate to IEHP.  
4. Describes the process by IEHP evaluates the delegate’s performance.  
5. Specifies that IEHP retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if IEHP delegates decision making | Annually, at minimum | IEHP reviews delegation agreements from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates. | See Corrective Action Plan (CAP) Requirements in MA_25D 3. |
## ATTACHMENT V: DELINEATION OF CREDENTIALING and REcredentialing

<table>
<thead>
<tr>
<th>Delegated Activity</th>
<th>IEHP Responsibilities</th>
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<th>Corrective Actions if Delegate Fails to Meet Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written Delegation Agreement (NCQA CR8 Element A)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual</td>
<td>Describes the remedies available to IEHP if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement</td>
<td>Annually, at minimum</td>
<td>IEHP reviews delegation agreements from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates.</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D 3.</td>
</tr>
<tr>
<td>Written Delegation Agreement (continued) (NCQA CR 8 Element A)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The Delegate retains the right to approve, suspend and terminate individual practitioners, providers and sites in situation where it has delegated decision making. This right is reflected in the delegation document</td>
<td>Annually, at minimum</td>
<td>IEHP reviews delegation agreements from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates.</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D 3.</td>
</tr>
</tbody>
</table>
## ATTACHMENT V: DELINEATION OF CREDENTIALING and REcredentialing

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</thead>
<tbody>
<tr>
<td>CMS</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>All Delegation agreements include a statement that Delegate’s must adhere to MA requirements.</td>
<td>Annually, at minimum</td>
<td>IEHP reviews Delegation Agreements from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
</tr>
<tr>
<td>Review of Credentialing Activities (NCQA CR8 Element C)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>For delegation agreements in effect for 12 months or longer, the organization: 1. Annually reviews the Delegate’s credentialing policies and procedures. 2. Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect. 3. Annually evaluates the Delegate’s performance against NCQA standards for delegated activities. 4. Semi-annually evaluates regular reports</td>
<td>Annually, at minimum</td>
<td>IEHP reviews a sample of up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
</tr>
</tbody>
</table>
# ATTACHMENT V: DELINEATION OF CREDENTIALING and REcredentialing

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</thead>
<tbody>
<tr>
<td>Opportunities for Improvement (NCQA CR8 Element D)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.</td>
<td>Annually, at minimum</td>
<td>IEHP reviews reports for opportunities for improvement if applicable and appropriate actions to resolve issues from up to or four randomly selected delegates, or all delegates if the organization has fewer than four delegates</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
</tr>
<tr>
<td>Identification of HIV/AIDS Specialists – Written Process</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate has a written policy and procedure describing the process that the organization identifies or reconfirms the appropriately qualified physicians who meet the definition of an HIV/AIDS Specialist, according to California State regulations on an annual basis</td>
<td>N/A</td>
<td>IEHP reviews Delegate Policies and Procedures</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
</tr>
<tr>
<td>Evidence of Implementation</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>On an annual basis, Delegate identifies or reconfirms the appropriately qualified physician who meet the definition of an HIV/AIDS, specialist according to California State Regulations</td>
<td>Annually, at minimum</td>
<td>IEHP reviews evidence that the organization identified or reconfirmed the appropriate qualified physicians</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
</tr>
</tbody>
</table>

* MUST PASS Element
## ATTACHMENT V: DELINEATION OF CREDENTIALING and RECredentialing

<table>
<thead>
<tr>
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<th>Corrective Actions if Delegate Fails to Meet Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distribution of Findings</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider P=Manual.</td>
<td>Delegate is to provide the list of identified qualifying physicians to the department responsible for authorizing standing referrals.</td>
<td>Annually, at minimum</td>
<td>IEHP reviews evidence that the organization provided the list of identified qualifying physicians to the department responsible for authorizing standing referrals.</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
</tr>
</tbody>
</table>
# ATTACHMENT VI: DELINEATION OF ENCOUNTER DATA

<table>
<thead>
<tr>
<th>Delegated Activity</th>
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<th>Delegate Responsibilities</th>
<th>Frequency of Reporting</th>
<th>Process for Evaluating Delegates Performance</th>
<th>Corrective Actions if Delegate Fails to Meet Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENC 1: Encounter Data Reporting</td>
<td>The Delegate is required by DMHC, CMS and DHCS to submit Encounter Data for the effective management of IEHP health care delivery system. A. Data must be submitted using the HIPAA compliant 5010 837 file format. B. The Encounter Data must be complete and accurate. C. Submit complete Encounter data within ninety (90) days after each month of service.</td>
<td>Submit Encounter Data within ninety (90) days after each month of service</td>
<td>Initial Onsite Assessment Monthly assessment of encounter data submission rates</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D 3. IEHP may withhold no more than one percent (1%) of the monthly Capitation Payment for failure to submit complete and accurate Encounter Data within ninety (90) days after each month of service.</td>
<td></td>
</tr>
</tbody>
</table>
# ATTACHMENT VII: DELINEATION OF CLAIMS ADJUDICATION

<table>
<thead>
<tr>
<th>Delegated Activity</th>
<th>IEHP Responsibilities</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Correct Claim Determination (CMS MA Manual Ch. 4 Section 10)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The IPA must make correct claim determinations, which include developing the claim for additional information, when necessary, for: A. Services obtained from a non-contracting Provider when the services were authorized by the IPA. B. Ambulance services dispatched through 911 C. Emergency services D. Urgently needed services E. Post-stabilization care services F. Renal dialysis services that Medicare members obtain while temporarily out of the service area.</td>
<td>See Attachment IPA Reporting Requirements Schedule in Section 25</td>
<td>Initial Onsite Assessment Monthly Assessment Annual Oversight Assessment</td>
<td>May result in Request for Corrective Action (CAP) or Focused Audit as defined in MA_20D.</td>
</tr>
<tr>
<td>Reasonable Reimbursement for Covered Services (CMS MA Manual Ch. 4 Section 10)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The IPA must provide reasonable reimbursement for: A. Services obtained from a non-contracting Provider when the services were authorized by the IPA B. Ambulance services dispatched through 911 C. Emergency services D. Urgently needed services E. Post-stabilization care services F. Renal dialysis services that Medicare members obtain while temporarily out of the service area.</td>
<td>See Attachment IPA Reporting Requirements Schedule in Section 25</td>
<td>Initial Onsite Assessment Monthly Assessment Annual Oversight Assessment</td>
<td>May result in Request for Corrective Action (CAP) or Focused Audit as defined in MA_20D.</td>
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## ATTACHMENT VII: DELINEATION OF CLAIMS ADJUDICATION

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</table>
| Reasonable Reimbursement for Covered Services (CMS MA Manual Ch. 4 Section 10 (continued)) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | G. Services for which coverage has been denied by the IPA but found to be services the member was entitled to upon appeal.  
H. IPA must use the appropriate fee-for-service payment mechanisms when determining amounts to pay non-contracted Providers. Note: if the IPA has negotiated lower amounts or if a Provider bills lower amounts than is possible under fee-for-service, paying non-contracted Providers these lower amounts is appropriate. | See Attachment IPA Reporting Requirements Schedule in Section 25 | Initial Onsite Assessment  
Monthly Assessment  
Annual Oversight Assessment | May result in Request for Corrective Action (CAP) or Focused Audit as defined in MA_20D. |
| Timely Payment of Non-Contracting Provider Clean Claims (CMS MA Manual Ch. 11 Section 100 and CMS MA Manual Ch. 13 Section 40) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | The IPA must pay 95 percent of “clean” claims from non-contracting Providers within thirty (30) calendar days of the earliest receipt date. | See Attachment IPA Reporting Requirements Schedule in Section 25 | Initial Onsite Assessment  
Monthly Assessment  
Annual Oversight Assessment | May result in Request for Corrective Action (CAP) or Focused Audit as defined in MA_20D. |
| Interest on Clean Claims Paid Late (CMS MA Manual Ch. 11 Section 100) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | If the IPA pays clean claims from non-contracting Providers in over thirty (30) calendar days, it must pay interest in accordance with 1816 (c)(2)(B) and 1842(c)(2)(B) | See Attachment IPA Reporting Requirements Schedule in Section 25 | Initial Onsite Assessment  
Monthly Assessment  
Annual Oversight Assessment | May result in Request for Corrective Action (CAP) or Focused Audit as defined in MA_20D. |
## ATTACHMENT VII: DELINEATION OF CLAIMS ADJUDICATION

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<tbody>
<tr>
<td>Timely Adjudication of Non-Clean Claims</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The IPA must pay all non-contracted claims that do not meet the definition of “clean claims” within sixty (60) calendar days of the earliest receipt date.</td>
<td>See Attachment IPA Reporting Requirements Schedule in Section 25</td>
<td>Initial Onsite Assessment</td>
<td>May result in Request for Corrective Action (CAP) or Focused Audit as defined in MA_20D.</td>
</tr>
<tr>
<td>Claim Denials (Notice Content)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>If an IPA denies payment resulting in Member liability, a written denial notice must be sent to the member. The written denial must clearly state the service denied and the specific denial reason. The notice must also inform the beneficiary of his or her right to a standard reconsideration and describe the appeal process.</td>
<td>See Attachment IPA Reporting Requirements Schedule in Section 25</td>
<td>Initial Onsite Assessment</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_20D.</td>
</tr>
<tr>
<td>Medicare Secondary Payer</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The IPA must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits. IPA must have written policies and procedures which ensure that claims involving coordination of benefits are identified and paid correctly.</td>
<td>See Attachment IPA Reporting Requirements Schedule in Section 25</td>
<td>Initial Onsite Assessment</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_20D.</td>
</tr>
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## ATTACHMENT VII: Delineation of Claims Adjudication

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<tr>
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<tbody>
<tr>
<td>Submission Standards</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The IPA must allow: &lt;br&gt; A. Contracted Providers ninety (90) days to submit claims &lt;br&gt; B. Non-contracted Providers three hundred and sixty-five (365) days to submit claims &lt;br&gt; C. Claims denied for untimely submission to be considered for adjudication upon receipt of a Provider’s request for a redetermination and demonstration of good cause for delay.</td>
<td>See Attachment IPA Reporting Requirements Schedule in Section 25</td>
<td>Initial Onsite Assessment &lt;br&gt; Monthly Assessment &lt;br&gt; Annual Oversight Assessment</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_20D.</td>
</tr>
<tr>
<td>Misdirected Claims</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>95% of misdirected claims must be forwarded to the appropriate financially responsible entity within ten (10) calendar days.</td>
<td>See Attachment IPA Reporting Requirements Schedule in Section 25</td>
<td>Initial Onsite Assessment &lt;br&gt; Monthly Assessment &lt;br&gt; Annual Oversight Assessment</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_20D.</td>
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# ATTACHMENT VII: DELINEATION OF CLAIMS ADJUDICATION

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</table>
| Denials             | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | A. 100% of member payment denial notices are written and include the denied service and give a specific reason for the denial which is not confusing and/or misleading to the member.  
B. 100% of member denial notices for payment use the CMS approved format and language.  
C. 100% of provider denial determinations include a valid explanation on the remittance advice (RA) which includes language for non-participating providers stating to submit all appeals to IEHP.  
100% of all claim denials must be mailed to the member and/or Provider within 60 calendar days of the earliest receipt date. | See Attachment IPA Reporting Requirements Schedule in Section 25 | Initial Onsite Assessment  
Monthly Assessment  
| Overpayments (CMS MFM Manual Ch. 3 & 4) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | 100% of requests for overpayments must:  
A. Clearly identify the claim, the name of the member, the date of service and a clear explanation of the basis upon which the payor believes the overpayment occurred.  
B. Be made following federal guidelines and no retractions can be made prior to forty-one (41) calendar days after the overpayment was identified.  
C. Not recover overpayments after December 31 of the 3rd calendar year in which the overpayment was identified. | See Attachment IPA Reporting Requirements Schedule in Section 25 | Initial Onsite Assessment  
Monthly Assessment  
## ATTACHMENT VII: DELINEATION OF CLAIMS ADJUDICATION

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</table>
| Contract Standards (CMS MA Manual Ch. 11 Section 100) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | A. All written contracts with downstream entities and providers of service contain a prompt payment provision  
B. All written contracts with downstream entities and providers of service contain a provision that Medicare members are held harmless for payment. | See Attachment IPA Reporting Requirements Schedule in Section 25 | Initial Onsite Assessment  
Monthly Assessment  
| Provider Payment Disputes | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | A. Provider Payment Disputes must be filed within one hundred and twenty (120) calendar days after the notice of initial determination  
B. Provider Payment Disputes may be accepted after one hundred and twenty (120) calendar days if a written request for an extension of the timeframe is for good cause  
C. Provider Payment Disputes must be resolved with a valid determination, and written determination is sent to the Provider within thirty (30) calendar days  
D. Provider Payment disputes in which additional information is requested allows the provider fourteen (14) calendar days to respond | See Attachment IPA Reporting Requirements Schedule in Section 25 | Initial Onsite Assessment  
Monthly Assessment  
## ATTACHMENT VII: DELINEATION OF CLAIMS ADJUDICATION

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<tbody>
<tr>
<td>Effectuation of Third-Party Claims Reconsideration Reversals (42 CFR 422.618)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>If the IPA’s determination is reversed in whole or in part by the health plan, the IPA must pay for the service no later than seven (7) calendar days from the date it receives the notice reversing the organization determination. The IPA must also inform the health plan that the organization has effectuated the decision. If the IPA’s determination is reversed in whole or in part by an administrative law judge (ALJ), or at a higher level of appeal, the IPA must authorize or provide the service under dispute as expeditiously as the member’s health requires, but no later than sixty (60) calendar days from the date it received notice of the reversal.</td>
<td>See Attachment IPA Reporting Requirements Schedule in Section 25</td>
<td>Initial Onsite Assessment Monthly Assessment Annual Oversight Assessment</td>
<td>See Corrective Action Plan (CAP) Requirements in MA_25D3.</td>
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* MUST PASS Element
### ATTACHMENT VIII: DELINEATION OF COMPLIANCE, FRAUD, WASTE, AND ABUSE, AND PRIVACY PROGRAM

<table>
<thead>
<tr>
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* MUST PASS Element
| Compliance Program (CMS Managed Care Manual Ch. 21 and DHCS Two Plan Contract Exhibit E, Attachment 2) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | The Delegate has an Effective Compliance Program which includes the following structural components: A. Written Policies, Procedures and Standards of Conduct that articulate a commitment to comply with all applicable Federal and State requirements; B. Designation of a Compliance Officer who reports directly to the CEO and Board of Directors, Compliance Committee at the Board of Directors and/or Senior Leadership level charged with overseeing the compliance program; C. A system for Effective Training and Education of Compliance program requirements; D. Effective Lines of Communication between the Compliance Officer and employees; E. Well-Publicized Disciplinary Standards; F. Establishment and implementation of an Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks; and G. Implementation of Procedures and System for Prompt Response to Compliance Issues as they are raised, investigation of potential compliance problems as identified through the course of self-evaluation and audits, correction Precontractual Assessment and Annually as part of the DOA | Initial Assessment Annual DOA | See Corrective Action Plan (CAP) Requirements in MA_25D3. |
### ATTACHMENT VIII: DELINEATION OF COMPLIANCE, FRAUD, WASTE, AND ABUSE, AND PRIVACY PROGRAM

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<tr>
<td></td>
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<td>of such problems promptly and thoroughly.</td>
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</tbody>
</table>

* MUST PASS Element
Fraud, Waste and Abuse Program (CMS Managed Care Manual Ch. 21 and DHCS Two Plan Contract Exhibit E, Attachment 2)

**IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.**

The IPA has an Effective Fraud, Waste and Abuse program that is designed to deter, identify, investigate and resolve potentially fraudulent activities that may occur in daily operations, both internally and with contracted providers.

IPA provides monitoring and oversight, both internally and externally, of daily operational activities to detect and/or deter fraudulent behavior. Such activities include, but are not limited to:

- Provider grievances
- Claims activity
- Financial Statements
- Utilization management monitoring
- Chart audits
- Clinical Audits
- Internal auditing and monitoring process
- Risk assessment

The IPA has a compliance training program for its provider network, and requires training internally and externally within ninety (90) days of initial hire/contracting, as updates/changes occur.

The IPA has a process in place, where needed, for reporting suspected fraudulent behavior to appropriate federal, state, local authorities, and IEHP.

<table>
<thead>
<tr>
<th>Precontractual Assessment and Annually as part of the DOA</th>
<th>Initial Onsite Assessment Annual DOA</th>
<th>See Corrective Action Plan (CAP) Requirements in MA_25D3.</th>
</tr>
</thead>
</table>

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* MUST PASS Element

Revised Date: 01/01/2021

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## ATTACHMENT VIII: DELINEATION OF FRAUD, WASTE, AND ABUSE / HIPAA

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<tbody>
<tr>
<td></td>
<td></td>
<td><strong>A.</strong> Uses and disclosures of PHI</td>
<td>Annual DOA</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>B.</strong> Member access to PHI and amendment/restriction process</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>C.</strong> Auditing/Monitoring of Business Associates, Downstream/Subcontracted and Related Entities</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td><strong>D.</strong> Security of Facilities and Information Systems</td>
<td></td>
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<td><strong>E.</strong> Record Retention</td>
<td></td>
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<td><strong>F.</strong> Non-retaliation for exercising rights provided by the Privacy Rule.</td>
<td></td>
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<td></td>
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<td><strong>G.</strong> Reporting incidents of HIPAA non-compliance to IEHP</td>
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<tr>
<td></td>
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<td>A privacy officer has been designated by the IPA.</td>
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<tr>
<td></td>
<td></td>
<td>There are appropriate administrative, technical and physical safeguards to prevent intentional or unintentional use or disclosure of PHI.</td>
<td></td>
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</tbody>
</table>

* MUST PASS Element
<table>
<thead>
<tr>
<th>IPA Deliverable</th>
<th>Report Frequency</th>
<th>CY 2021 Reporting Period</th>
<th>IEHP Due Date</th>
<th>IEHP Policy Number(s)</th>
<th>Department(s)</th>
<th>File Naming Convention</th>
<th>SFTP Folder</th>
<th>Regulatory Measure(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claims Timeliness Reports</strong></td>
<td>Monthly</td>
<td>1/1-1/31</td>
<td>February 15, 2021</td>
<td>MA 20F - Claims and Payment Appeal Reporting</td>
<td>Claims</td>
<td>IPACode_MTR_MM_2021</td>
<td>Claims Timeliness / Month</td>
<td>42 CFR Part 422.520 &amp; Social Security Act Sections 1876(g)(6)(A), 1816(2)(A)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2/1-2/28</td>
<td>March 15, 2021</td>
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## Medicare Provider Reporting Requirements Schedule
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**IPA Deliverable Report Frequency**

- Monthly: Reports are due on the dates specified within the year.
- Yearly: Reports are due on the dates specified within the year, with a January 1 due date for the following year.

**File Naming Convention**

- **IPACode** indicates the specific code for the reporting requirement.
- **ENC** for Encounter Data Submission Requirements.
- **CM** for Care Management Requirements.
- **Outreach** for Care Plan Outreach Log.

**SFTP Folder**

- 5010 / Encounters: Reports related to Encounter Data Submission Requirement.
- IPA Oversight / Year / Month: Reports related to CMS Core Measure 3.2 and Guidelines for Care Management.
### Medicare Provider Reporting Requirements Schedule

**IPA Medicare Calendar Year Reporting Period:** 2021

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### Medicare Provider Reporting Requirements Schedule

**IPA Medicare Calendar Year Reporting Period: 2021**

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<th>IEHP Policy Number(s)</th>
<th>Department(s)</th>
<th>File Naming Convention</th>
<th>SFTP Folder</th>
<th>Regulatory Measure(s)</th>
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<tr>
<td>Compliance - List of Downstream Entity/Subcontractors</td>
<td>Annual</td>
<td>1/1-12/31</td>
<td>As required for Precontractual Assessment and Annual DOA</td>
<td>MA 24E Compliance Program Description</td>
<td>Compliance</td>
<td>N/A</td>
<td>Audits / 2021 DOA Audit</td>
<td></td>
</tr>
<tr>
<td>Compliance - Evidence of Sanction/Exclusion screening, Completion of trainings, and completion of annual Confidentiality Statement</td>
<td>Annual</td>
<td>1/1-12/31</td>
<td>As required for Precontractual Assessment and Annual DOA</td>
<td>MA 24E Compliance Program Description</td>
<td>Compliance</td>
<td>N/A</td>
<td>Audits / 2021 DOA Audit</td>
<td></td>
</tr>
<tr>
<td>Compliance - Annual Compliance Plan</td>
<td>Annual</td>
<td>1/1-12/31</td>
<td>As required for Annual DOA</td>
<td>MA 23B Compliance Reporting Requirements</td>
<td>Compliance</td>
<td>IPACode_Compliance_Description_2021</td>
<td>IPA Oversight / Compliance / Year</td>
<td>MMCM Chapter 21</td>
</tr>
<tr>
<td>Compliance - Annual FWA Program Description</td>
<td>Annual</td>
<td>1/1-12/31</td>
<td>As required for Annual DOA</td>
<td>MA 23B Compliance Reporting Requirements</td>
<td>Compliance</td>
<td>IPACode_FWA Program Description_2021</td>
<td>IPA Oversight / Compliance / Year</td>
<td>Code of Federal Regulations, Title 42, Part 422 and 423; Code of Federal Regulations, Title 42, §438.608 and §455.2; Federal False Claims Act, US Code, Title 31; Health &amp; Safety Code §1348; Welfare &amp; Institutions Code, §14043.1</td>
</tr>
<tr>
<td>Compliance - Annual HIPAA Program Description</td>
<td>Annual</td>
<td>1/1-12/31</td>
<td>As required for Annual DOA</td>
<td>MA 23B Compliance Reporting Requirements</td>
<td>Compliance</td>
<td>IPACode_HIPAA Program Description_2021</td>
<td>IPA Oversight / Compliance / Year</td>
<td>Code of Federal Regulations, Title 45, Part 160, 162, and 164; U.S. Dept. of Health and Human Services (DHHS), section 13402(b)(2) of Public Law 111-5 (HITECH ACT).</td>
</tr>
<tr>
<td>IPA Deliverable</td>
<td>Report Frequency</td>
<td>CY 2021 Reporting Period</td>
<td>IEHP Due Date</td>
<td>IEHP Policy Number(s)</td>
<td>Department(s)</td>
<td>File Naming Convention</td>
<td>SFTP Folder</td>
<td>Regulatory Measure(s)</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>--------------------------</td>
<td>-------------------------------------------</td>
<td>-----------------------</td>
<td>----------------------</td>
<td>------------------------</td>
<td>-------------</td>
<td>----------------------</td>
</tr>
</tbody>
</table>
Instructions: Submit a monthly report of all Individualized Care Plan (ICP) activities completed in the reporting month. Only include Individualized Care Plans that were developed with Member (or Authorized Representative) participation. Send records that are new or have an update from a previous submission (e.g. updated date of care goal discussion). Refer to the data dictionary for specifics on what each field should contain. Do not alter the templates in any way (e.g. adding or deleting columns or header rows). Always submit the most current template in Excel (.xlsx) format.

<table>
<thead>
<tr>
<th>Column ID</th>
<th>Field Name</th>
<th>Field Type</th>
<th>Field Length</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Member First Name</td>
<td>CHAR Always Required</td>
<td>50</td>
<td>First name of the Member</td>
</tr>
<tr>
<td>B</td>
<td>Member Last Name</td>
<td>CHAR Always Required</td>
<td>50</td>
<td>Last name of the Member</td>
</tr>
<tr>
<td>C</td>
<td>IEHP Member ID #</td>
<td>14 digit numeric characters</td>
<td>14</td>
<td>Cardholder identifier used to identify the beneficiary. This is assigned by IEHP and is 14 digits long.</td>
</tr>
<tr>
<td>D</td>
<td>DOB</td>
<td>MM/DD/YYYY</td>
<td>10</td>
<td>Member's Date of Birth</td>
</tr>
<tr>
<td>E</td>
<td>Case Status</td>
<td>MM/DD/YYYY</td>
<td>10</td>
<td>Status of the case: Open or Closed</td>
</tr>
<tr>
<td>F</td>
<td>Case Level</td>
<td>CHAR Always Required</td>
<td>4</td>
<td>Level of risk : High or Low Do NOT enter any other values (e.g. Complex, Medium, a numeric value).</td>
</tr>
<tr>
<td>G</td>
<td>Date Case Opened</td>
<td>MM/DD/YYYY</td>
<td>10</td>
<td>Date the case was opened</td>
</tr>
<tr>
<td>H</td>
<td>Name of Care Coordinator / Manager Assigned</td>
<td>CHAR Always Required</td>
<td>50</td>
<td>List the name of the assigned Care Coordinator or Manager</td>
</tr>
<tr>
<td>I</td>
<td>Date ICP Created</td>
<td>MM/DD/YYYY</td>
<td>10</td>
<td>Date the Individual Care Plan was created. Individualized Care Plans must have Member (or Authorized Representative) participation.</td>
</tr>
<tr>
<td>J</td>
<td>Date ICP Last Updated</td>
<td>MM/DD/YYYY</td>
<td>10</td>
<td>Date the Individual Care Plan was last updated, as defined in policy, 12A3 - Care Management Requirements - Individual Care Plan.</td>
</tr>
<tr>
<td>K</td>
<td>Date ICP sent to PCP</td>
<td>MM/DD/YYYY</td>
<td>10</td>
<td>Date the Individual Care Plan was sent to the PCP</td>
</tr>
<tr>
<td>L</td>
<td>Date Care Goals discussed with Member</td>
<td>MM/DD/YYYY</td>
<td>10</td>
<td>Date the Care Goals were discussed with the Member. Only populate this field if there was successful contact with the member or an authorized representation.</td>
</tr>
<tr>
<td>M</td>
<td>Last date of Member contact</td>
<td>MM/DD/YYYY</td>
<td>10</td>
<td>Date of last Member contact. Only populate this field if there was successful contact with the member or an authorized representation.</td>
</tr>
<tr>
<td>N</td>
<td>Date ICT was completed</td>
<td>MM/DD/YYYY</td>
<td>11</td>
<td>Date of Interdisciplinary Care Team Case Conference / Collaboration</td>
</tr>
</tbody>
</table>
**Instructions:** This report must list all outreach attempts made to the Member or their Authorized Representative during the reporting month, for the purpose of developing or updating the Member's Individual Care Plan (ICP). If the IPA made multiple outreaches to the same Member in one month, then there should be multiple rows for that Member in one reporting month. Each outreach attempt only needs to be submitted once. Refer to the data dictionary for specifics on what each field should contain. Do not alter the templates in any way (e.g. adding or deleting columns or header rows). Always submit the most current template in Excel (.xlsx) format.

<table>
<thead>
<tr>
<th>Column ID</th>
<th>Field Name</th>
<th>Field Type</th>
<th>Field Length</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Member First Name</td>
<td>CHAR Always Required</td>
<td>50</td>
<td>First name of the Member</td>
</tr>
<tr>
<td>B</td>
<td>Member Last Name</td>
<td>CHAR Always Required</td>
<td>50</td>
<td>Last name of the Member</td>
</tr>
<tr>
<td>C</td>
<td>IEHP Member ID #</td>
<td>14 digit numeric characters</td>
<td>14</td>
<td>Cardholder identifier used to identify the beneficiary. This is assigned by IEHP and is 14 digits long.</td>
</tr>
<tr>
<td>D</td>
<td>DOB</td>
<td>MM/DD/YYYY</td>
<td>10</td>
<td>Member's Date of Birth</td>
</tr>
<tr>
<td>E</td>
<td>Date of Outreach Attempt</td>
<td>MM/DD/YYYY</td>
<td>10</td>
<td>Date outreach attempt was made</td>
</tr>
<tr>
<td>F</td>
<td>Time of Outreach Attempt</td>
<td>HH:MM</td>
<td>5</td>
<td>Time outreach attempt was made in military time (e.g., 23:59)</td>
</tr>
<tr>
<td>G</td>
<td>Outreach Method</td>
<td>CHAR Always Required</td>
<td>10</td>
<td>List method used for outreach: email, fax, in person, mail, phone or text</td>
</tr>
<tr>
<td>H</td>
<td>Outreach Disposition</td>
<td>CHAR Always Required</td>
<td>20</td>
<td>State outreach disposition: refused, successful, or unsuccessful</td>
</tr>
<tr>
<td>I</td>
<td>Outreach Care Team Member</td>
<td>CHAR Always Required</td>
<td>50</td>
<td>List the title of the Care Team Member who made the outreach</td>
</tr>
<tr>
<td>J</td>
<td>Clinical Care Team Member?</td>
<td>CHAR Always Required</td>
<td>3</td>
<td>Answer Yes or No: Is the Care Team Member, who made the outreach attempt, Clinical such as a Licensed Clinical Social Worker (LCSW), Licensed Vocational Nurse (LVN) or Registered Nurse (RN), etc.?</td>
</tr>
</tbody>
</table>
The following standard forms should be complete and available at the time of the audit and are included in this packet:

- Biographical Information
- Sub-Contracted Service by Facility/Agency

Prepare for the audit by having the following information available:

- **All sections** of the DOA tool documented with **road mapping** instructions for each element
- Organizational chart(s)
- Current job descriptions as relevant to audit
- Delegation agreements with any sub-delegated provider

The following is a list of items needed to prepare for the Offsite and Onsite audit.

### Quality Management

- Program, Plan and Description (**Desk Review**)*
- Committee meeting minutes from last 12 months to include agenda, sign-in sheet (attendance) and signed confidentiality statement: (**Desk Review or On-site Review)**:
  - Quality Improvement Committee, and
  - Subcommittee
- Annual Work Plan (**Desk Review)***
- Annual QM Program Evaluation (**Desk Review)***
- Semi-Annual Reports for Health Plan (**Desk Review)***
- Standards of Medical Care Access Policy and Procedure (**Desk Review)***

### Utilization Management

- Program, Plan and Description (**Desk Review)***
- Policies and procedures (**Desk Review)***
- Committee minutes from last 12 months: (**On-site Review**)
  - Board of Directors
  - Utilization Management Committee, and
  - Subcommittee meeting minutes
- Annual Inter-Rater Reliability Audit (**On-site Review**)
- Two examples that demonstrate the use of Board Certified consultants to assist with determinations (**On-site Review**)
- Annual UM Program Evaluation (**Desk Review)***
Inland Empire Health Plan
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- Criteria for Length of Stay and Medical Necessity used during the past 2 years (On-site Review)
- Fifteen (15) approved, denied, partially approved and/or cancelled pre-certification requests with all required attachments. Files should de-identify all member PHI. (Webinar)
- Evidence that the Affirmative Statement has been distributed to providers and employees who make UM decisions (On-site Review)
- Evidence, other than via a denial letter, that the providers have been notified that they may contact a physician reviewer to discuss denial decisions (Desk or On-site Review)*
- Provider communications from last 12 months (On-site Review)
- Semi-Annual Reports for last 12 months (Desk Review)*
- Evidence of current license for Providers and Employees (RN, LVN) who make UM Decisions (On-site Review)

Care Management

- Applicable policies and procedures (Desk Review)*
- Complex Case Management Policy and Procedure (Desk Review)*
- CM and CCS logs that reflect evidence that the Member has received care management services (On-site Review)
- Five (5) randomly pulled CM files with care plans. Files should de-identify all member PHI. (On-site Review)
- Five (5) randomly pulled CCM files with care plans. Files should de-identify all member PHI. (On-site Review)
- Five (5) randomly pulled CCS files. Files should de-identify all member PHI. (On-site Review)

Credentialing

- Policies and procedures (Desk Review)*
- Committee meeting minutes from last 12 months: (On-site Review)
  - Board of Director
  - Quality Management Committee minutes
  - Credentialing Committee minutes
  - Peer Review Committee minutes
- Credentialing Files– Twenty-five (25) randomly selected files including PCP, Specialists, Mid-Levels and Urgent Care Providers (On-site Review)
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- Re-credentialing Files – Twenty-five (25) randomly selected files including PCP, Specialists, Mid-Levels and Urgent Care Providers (On-site Review)
- Practitioner files of those terminated for quality issues (On-site Review)
- Practitioner files that have appealed a decision (On-site Review)
- Home Health files (On-site Review)
- Skilled Nursing files (On-site Review)
- Laboratory files (On-site Review)
- Free Standing Surgical Center Files (On-site Review)
- Medical Office Site Review worksheets, tools and summaries (On-site Review)
- Medical Record worksheets, tools and summaries (On-site Review)
- Credentialing delegation data, if applicable (On-site Review)
- Health Delivery Organization Tracking Mechanism for Expirables (On-site Review)

Member Communications Marketing (If Applicable)

- All Member Communication for Marketing, Enrollment, and Disenrollment (Desk Review)*
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Pre-Contractual Audit
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### Claims
- Policies and procedures *(Desk Review)*
- Contracts Boilerplate for: *(Desk Review)*
  - PCPs
  - Specialists
  - Ancillary Providers
  - Hospitals
- Blinded Claims Sample: *(Desk Review)*
  - 15 Paid (See Claims Sample Details below)
  - 5 Denied See Claims Sample Details below)
  - 5 Provider Payment Disputes See Claims Sample Details below))
- Sample Reports and Logs: *(Desk Review)*
  - Paid Claims (See Claims Sample Details below)
  - Denied Claims See Claims Sample Details below)
  - Provider Payment Disputes (See Claims Sample Details below)
  - Pended Claims (See Claims Sample Details below) Open
  - Claims/Inventory (See Claims Sample Details below)
  - Overpayments (See Claims Sample Details below)
  - Check Mailing Attestation Log (See Claims Sample Details below)
  - Redirected Claims (See Claims Sample Details below)
- Claims Processing Systems Review *(On-site Review)*
- Operational Review *(On-site Review)*

### Compliance
- Compliance Policies and procedures *(Desk Review)*
- Fraud, Waste and Abuse Policies and procedures *(Desk Review)*
- HIPAA Policies and procedures *(Desk Review)*
- Standards/Code of Conduct *(Desk Review)*
- Copies of Compliance, FWA, and Privacy Training *(Desk Review)*
- Committee meeting minutes from last 12 months to include agenda and sign-in sheet (attendance) *(Desk Review)* :
  - Compliance Committee
  - Subcommittees
- Annual Compliance Work Plan *(Desk Review)*
- Annual Audit Plan *(Desk Review)*
- Annual Risk Assessment *(Desk Review)*
Inland Empire Health Plan
Pre-Contractual Audit
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- Sanction/Exclusion Screening Process policies and procedures (Desk Review)*
- List of Downstream Entity/Subcontractors: Create a list of all downstream entities/subcontractors contracted with the IPA anytime during the audit period, including contract start date, description of services/function performed, identify which entities participate in offshoring or are offshore. (Desk Review)*
- Evidence of the following for ten (10) randomly selected employees (Webinar):
  - Sanction/Exclusion screening for the last 3 consecutive months immediately preceding the month of this review (all employee Social Security Numbers and Dates of Birth should be redacted)
  - Completion of Compliance Training within the last 12 months
  - Completion of FWA Training within the last 12 months
  - Completion of Privacy Training within the last 12 months
  - Completion of an annual Confidentiality Statement within the last 12 months

Note: *- Denotes items to be sent to IEHP for desk review prior to the audit.

Claims Sample Details

<table>
<thead>
<tr>
<th>Applicant Entity Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Date:</td>
</tr>
</tbody>
</table>

PROVIDE THE FOLLOWING DOCUMENTS FOR CLAIMS REVIEW:

<table>
<thead>
<tr>
<th>1</th>
<th>Paid/Denied (5 paid non-contracted provider clean claims; 5 paid non-contracted provider unclean claims; 5 paid contracted provider claims; 3 denied claims with member liability; 2 denied claims with provider liability; include a mix of inpatient &amp; outpatient hospital, emergency claims, professional, radiology, labs, anesthesia claims paid/denied in past 90 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. Actual Claim Form and supporting documentation submitted with claim</td>
</tr>
<tr>
<td></td>
<td>b. Provider explanation of benefits or remittance advice for claims</td>
</tr>
<tr>
<td></td>
<td>c. Copy of check with documentation regarding date the check was cashed</td>
</tr>
<tr>
<td></td>
<td>d. Denial letters</td>
</tr>
<tr>
<td></td>
<td>e. Acknowledgement of Receipt or Proof of Date Entered in System</td>
</tr>
<tr>
<td></td>
<td>f. Any correspondence and/or pertinent information related to the claim, including evidence of medical review, eligibility screens, authorizations, information request letters, overpayment/adjustment requests, claim appeal documentation, original claim information for provider payment disputes (including claim and EOB/RA), documentation of overpayment requests, applied overpayments (refunds or retractions), etc.</td>
</tr>
</tbody>
</table>
Inland Empire Health Plan  
Pre-Contractual Audit  
Preparation Instructions  
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g. Copy of fee schedule or contract rate applied to each claim. This can be in the form of a page from a contract or a screen print identifying the type of schedule applied (i.e., Medi-Cal, Medicare, etc.). For non-contracted providers, a copy of the policy identifying basis for payment.

h. Copies of contracts or letters of agreement for any providers of service wherein provider has agreed to upcoding or downcoding of services rendered; claims submission or payment timeframes that supersede regulatory requirements; or retraction of overpayments, if applicable.

<table>
<thead>
<tr>
<th>2</th>
<th>Provider Payment Disputes (5 provider payment disputes; include a mix of favorable &amp; unfavorable disputes for contracted &amp; non-contracted providers within past 90 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Provider payment dispute and supporting documentation</td>
</tr>
<tr>
<td>b.</td>
<td>Original Claim (face sheet with date of receipt visible) and EOB/RA</td>
</tr>
<tr>
<td>c.</td>
<td>EOB/RA of the Dispute</td>
</tr>
<tr>
<td>d.</td>
<td>Written Notice of the dispute</td>
</tr>
<tr>
<td>e.</td>
<td>Other supporting documentation or correspondence pertinent to the outcome of the dispute and related adjustment, as applicable.</td>
</tr>
</tbody>
</table>

Report /Log Required Fields

<table>
<thead>
<tr>
<th>Type of Report</th>
<th>Required fields</th>
</tr>
</thead>
</table>
| Paid Claims | - Member name  
- Member ID#  
- Date of Service  
- Provider of Service  
- Provider Contract Status  
- Amount Billed  
- Date claim received  
- Claim Number  
- Amount paid  
- Date claim paid  
- Age of claim |
| Denied Claims | - Member Name  
- Member ID #  
- Date of service  
- Provider of service  
- Provider Contract Status  
- Amount billed  
- Date claim received  
- Claim Number  
- Date claim denied  
- Reason for denial  
- Age of claim |
**Inland Empire Health Plan**  
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| Pended Claims                  | • Member name  
|                               | • Member ID#  
|                               | • Date of service  
|                               | • Provider of service  
|                               | • Amount billed  
|                               | • Date claim received  
|                               | • Claim Number  
|                               | • Date claim pended  
|                               | • Pend Reason (must separately identify requests for ER Notes, Medical Records and all other information)  
|                               | • Age of claim  
|                               | • Processor Initials |

| Open Claims/Inventory          | • Member name  
|                               | • Member ID#  
|                               | • Date of Service  
|                               | • Provider of Service  
|                               | • Amount Billed  
|                               | • Date claim received  
|                               | • Status of claim |

| Overpayments                   | • Member Name  
|                               | • Member ID#  
|                               | • Original Claim #  
|                               | • Date original claim Paid  
|                               | • Provider of service  
|                               | • Provider Contract Status  
|                               | • Date of request for overpayment  
|                               | • Date overpayment processed in System  
|                               | • Recovery Type (i.e., withhold, refund, none)  
|                               | • Total Dollars Recovered |

| Provider Payment Disputes      | • Date of Service  
|                               | • Original Claim #  
|                               | • Date Provider Payment Dispute Received  
|                               | • Provider Payment Dispute Claim #  
|                               | • Date Provider Payment Dispute Acknowledged  
|                               | • Provider of Service Submitting Payment Dispute Request  
|                               | • Determination Decision (i.e., upheld, overturned, goodwill)  
|                               | • Date Provider Payment Dispute Resolved  
|                               | • Date Dispute Payment Made |

| Redirected Claims              | • Date Received  
|                               | • Billing Provider of Service  
|                               | • Date of Service  
|                               | • Patient Identifier (name, ID#, etc.)  
|                               | • Date Redirected  
|                               | • Where Redirected |
### Inland Empire Health Plan
#### Pre-Contractual Audit Preparation Instructions

## Medicare

<table>
<thead>
<tr>
<th>Check Mailing Attestation Log</th>
<th>Claim # (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check #</td>
<td>Check Date</td>
</tr>
<tr>
<td>Check Date</td>
<td>Check Amount</td>
</tr>
<tr>
<td>Check Amount</td>
<td>Payee</td>
</tr>
<tr>
<td>Payee</td>
<td>Signature</td>
</tr>
<tr>
<td>Signature</td>
<td>Title of Signee</td>
</tr>
<tr>
<td>Title of Signee</td>
<td>Date Mailed</td>
</tr>
<tr>
<td>Element A - QI Program Structure</td>
<td>Point Value</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>1 The QI program structure.</td>
<td>X</td>
</tr>
<tr>
<td>2 Involvement of a designated physician in the QI program.</td>
<td>X</td>
</tr>
<tr>
<td>3 Oversight of QI functions of the organization by the QI Committee.</td>
<td>X</td>
</tr>
<tr>
<td>4 Objectives for serving a culturally and linguistically diverse membership.</td>
<td>X</td>
</tr>
<tr>
<td>Total Requirements Element A - QI Program Structure</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Element B - Annual Work Plan</th>
<th>Point Value</th>
<th>Requirement Met</th>
<th>% of Requirement Met</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Yearly planned QI activities and objectives.</td>
<td>X</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>2 Time frame from each activity's completion.</td>
<td>X</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>3 Staff members responsible for each activity.</td>
<td>X</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>4 Evaluation of the QI program.</td>
<td>X</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Total Requirements Element B - Annual Work Plan</td>
<td>4</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Element C - Annual Evaluation</th>
<th>Point Value</th>
<th>Requirement Met</th>
<th>% of Requirement Met</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.</td>
<td>X</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>2 Trending of measures to assess performance in the quality and safety of clinical care and quality of service.</td>
<td>X</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>3 Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing networkwide safe clinical practices.</td>
<td>X</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Total Requirements Element A - QI Program Structure</td>
<td>3</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Element D - QI Committee Responsibilities</th>
<th>Point Value</th>
<th>Requirement Met</th>
<th>% of Requirement Met</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Recommends policy decisions.</td>
<td>X</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>2 Analyzes and evaluates the results of QI activities.</td>
<td>X</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>3 Ensures practitioner participation in the QI program through planning, design, implementation or review.</td>
<td>X</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>4 Identifies needed actions.</td>
<td>X</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>5 Ensures follow-up, as appropriate.</td>
<td>X</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Total Requirements Element B - Annual Work Plan</td>
<td>5</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Element E - Notification of Termination</th>
<th>Point Value</th>
<th>Requirement Met</th>
<th>% of Requirement Met</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 The organization notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner.</td>
<td>X</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Total Requirements Element A - Notification of Termination</td>
<td>1</td>
<td>0</td>
<td>0%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Element F - Continuous Access to Care</th>
<th>Point Value</th>
<th>Requirement Met</th>
<th>% of Requirement Met</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.</td>
<td>X</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>2 Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.</td>
<td>X</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Total Requirements Element B - Continuous Access to Practitioners</td>
<td>2</td>
<td>0</td>
<td>0%</td>
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</tr>
</tbody>
</table>

Updated 1/23/2020
2020 NCQA Standards Page 1 of 1
INLAND EMPIRE HEALTH PLAN
REQUEST FOR UM CRITERIA LOG

Submitted by: __________________________________  Log for Year: __________________________________

<table>
<thead>
<tr>
<th>Date Requested</th>
<th>Date Sent</th>
<th>Sent via:</th>
<th>Name of the Requesting Practitioner or Member</th>
<th>Member Name and IEHP ID #</th>
<th>Line of Business (MC, CMC)</th>
<th>Criteria Requested (i.e. InterQual-MRI Brain)</th>
<th>Reason for Request</th>
<th>Medical Necessity</th>
<th>Benefit</th>
<th>Carve-Out</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>F = fax</td>
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<td>EM = email</td>
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Legend:  
F = Fax  
MC = Medi-Cal  
CMC = IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)  
EM = email  
GM = Ground  

Revised 07/2015
IEHP DualChoice Cal MediConnect Plan (Medicare – Medicare – Medicaid Plan)

<Date>

<Name>
<Address>
<Address>

RE: Request for Utilization Management (UM) Criteria

Dear <Name>:

Attached is the clinical guideline or criteria used for determining health care services specific for the procedure or condition requested.

The materials provided to you are guidelines used by the plan to authorize, modify, or deny services for Members with a similar illness or condition. Specific care and treatment may vary depending on individual needs and the benefits covered under your health plan.

Sincerely,

<Utilization Management Department>
### Second Opinion Tracking Log

**INLAND EMPIRE HEALTH PLAN**

**SECOND OPINION TRACKING LOG**

<table>
<thead>
<tr>
<th>IPA Name:</th>
<th>Date Submitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report for Month of:</td>
<td>Submitted by:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member Name and IEHP ID #</th>
<th>Name of the Requesting Practitioner or Member</th>
<th>Diagnosis</th>
<th>Reason for Second Opinion (use codes below)</th>
<th>Request Date</th>
<th>Decision Date</th>
<th>Decision Code (circle one)</th>
<th>Second Opinion to be provided by (name):</th>
<th>Date of Appoint.</th>
<th>Date Consult Report Received</th>
<th>*See Legend Below For Member Type</th>
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<tbody>
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</table>

**Second Opinion Reason Codes:**

- **Reason 1:** The Member questions the reasonableness or necessity of recommended surgical procedures.
- **Reason 2:** The Member questions a diagnosis or plan or care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment including but not limited to a serious chronic condition.
- **Reason 3:** If clinical indications are not clear or are complex and confusing, a diagnosis is questionable due to conflicting test results, or the treating PCP/Specialist is unable to diagnose the condition and the Member requests an additional diagnosis.
- **Reason 4:** If the treatment plan in progress is not improving the medical condition of the Member within an appropriate time period given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment.
- **Reason 5:** The Member has attempted to follow the plan of care or consulted with the initial physician concerning serious concerns about the diagnosis or plan of care

**Legend:**

- MC = IEHP Medi-Cal
- CMC = IEHP DualChoice Cal MediConnect
This form is to be completed for all ancillary services where the IPA/MSO has established a contract directly with a facility or agency.

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

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

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

**DualChoice Denial Letter Sanction**

**Calendar Year 2021**

**Section I: Overview**
The 2021 DualChoice Sanction Program is a continuation and enhancement to the original 2015-2016 program. In an ongoing effort to collaborate with the IPAs to ensure that denial letters meet CMS standards, IEHP is continuing the Denial Letter Sanction Program with some minor improvements.

**Section II: Oversight and Monitoring**
All IPAs will be required to submit IEHP specified (based on Medicare specifications) universes for Service Authorization Requests. IEHP will continue to conduct monthly review of denial letters. This will allow for timely feedback and more face to face interaction which will enhance communication of regulations and requirements.

**Section III: Denial Letter Sanctions**
Denial Letters must meet, with 100% accuracy, the below components:

1. Use of correct letter template including attachments.
2. Member denial language that is understandable (sixth grade reading level).
3. Denial letter is processed timely, with the inclusion of accurate dates of receipt.
4. Denial reason is in accordance to appropriate criteria cited and coincides with denial type.

**2020 Sanction limits:**
A $1,000 sanction will be issued for each denial letter with a deficiency. A maximum of thirty (30) denial letters per IPA will be reviewed each month. If an IPA has less than thirty (30) denials, all denials will be reviewed.

**New Sanction Limits for 2021:**
There is a maximum of $3,000 sanction total versus $1,000 per case for Timeliness and Template deficiencies (related to system issues) to minimize the impact on IPA’s. The IPA will be allowed 90 days to implement changes to correct system issues. Failure to implement changes within 90 days will result in moving to $1,000 per deficient denial letter for subsequent months until the system issue is rectified. Criteria and Language deficiencies will continue with the current sanction of $1,000 per case (no limit on sanctions). A maximum of thirty (30) denial letters per IPA will be reviewed each month on a random basis selection process. If an IPA has less than thirty (30) denials, all denials will be reviewed.

**Section IV: Appeal Process**
If the IPA wishes to appeal the results of the Denial Letter Sanctions, a written appeal must be submitted within 30 days of receiving the results. The written appeal should be submitted to the Director of Delegation Oversight, Juan Ortega (see Provider Manual policy 16.B.4 Appeal and Grievance Resolution Process for Providers; IPA, Hospital and Practitioner). IPAs (Delegates) must cite reasons for their appeal, including disputed items or deficiencies.
IPAs that consistently fail to meet IEHP standards, as confirmed through monthly monitoring and/or focused audits or other oversight activities, are subject to actions up to and including Corrective Action Plans (CAPs), increased sanctions, rescission of delegated functions, and non-renewal of the IEHP contract or termination of the IPA participation in the IEHP network.