25. DELEGATION AND OVERSIGHT

A. Delegation Oversight
   1. Delegated Activities

APPLIES TO:

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

POLICY:

A. Annually, IEHP evaluates and audits contracted Delegates in accordance with current applicable National Committee for Quality Assurance (NCQA) accreditation standards, and 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 in the following Delegated 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 the documented reporting requirements and delegated activities (See Attachments, “IPA Delegation Agreement – Medi-Cal” and “IPA Reporting Requirements Schedule – Medi-Cal” 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.

   D. IEHP meets with each Delegate 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 Medi-Cal Delegates.

POLICY:

A. IEHP delegates certain Utilization Management (UM), Care Management (CM), Credentialing/Re-credentialing activities and activities for Quality Management (QM), 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), Department of Managed Health Care (DMHC) (when applicable), Centers for Medicare and Medicaid Services (CMS) (when applicable), and IEHP Standards.

B. IEHP does not delegate Quality Management and Improvement (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 and Claims and related activities through the Delegation Oversight Audits performed on an annual basis.

D. IEHP may waive elements of the annual 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, 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 NCQA, DHCS, DMHC, 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 thirty (30) days in advance of the scheduled audit. The Delegate receives audit preparation instructions (See Attachment, “Delegation Oversight Audit Preparation Instructions - Medi-Cal” and “Delegation Oversight Audit Preparation Instructions – Medi-Cal (NCQA Certified)” 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 Services and Delegated Functions” in Section 25).

3. QI documents:
   a. Quality Management and Quality Improvement Program Description;¹ ²
   b. Quality Management Work Plan;³
   c. Quality Management Program Annual Evaluation;⁴
   d. Quality Improvement (QI) Committee and subcommittee meeting minutes, agenda, sign in sheet, and signed confidentiality statement from the auditing period:⁵
      1) Recommendation of policy decisions;⁶
      2) Review and evaluation of QI activities;⁷

¹ National Committee for Quality Assurance (NCQA), 2020 HP Standards and Guidelines, QI 1 A, Factors 1-6.
² DHCS Final Rule Contract Amendment January 2018, Exhibit A Attachment 4, Provision 7, Quality Improvement System.
³ NCQA, 2020 HP Standards and Guidelines, QI 1 B, Factors 1-5.
⁴ NCQA, 2020 HP Standards and Guidelines, QI 1 C, Factors 1-3.
⁵ DHCS Final Rule Contract Amendment January 2018, Exhibit A Attachment 4, Provision 4, Quality Improvement System.
⁶ NCQA, 2020 HP Standards and Guidelines, QI 1 D, Factor 1.
⁷ NCQA, 2020 HP Standards and Guidelines, QI 1 D, Factor 2.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

3) Practitioner participation in the QI program through planning, design, implementation or review; and

4) Identification and follow up of needed actions.

e. Semi-Annual Health Plan Reports from the audit period;

f. Notification of Termination policy and evidence that Members were notified of practitioner termination;

g. Studies, Audits, and surveys completed from the audit period; and

h. Standards of Medical Care Access Policies and Procedures.

4. UM documents:

a. Annual UM Program Description,

b. UM Work Plan;

c. UM Annual Evaluation;

d. Policies and Procedures;

e. Referral Universe for audit file selection;

f. Committee meeting minutes from the audit period:
   1) Board of Directors;
   2) Utilization Management Committee; and
   3) UM Subcommittee meeting minutes.

g. Annual Inter-Rater Reliability Audit;

h. Semi-Annual Health Plan Reports for the audit period:

i. Two (2) examples that demonstrate the use of Board Certified Consultants to assist with determinations;

j. Criteria for Length of Stay and Medical Necessity used during the past two (2) years;

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8 NCQA, 2020 HP Standards and Guidelines, QI D, Factor 3.
10 NCQA, 2020 HP Standards and Guidelines, UM 1 A, Factors 1-6.
13 NCQA, 2020 HP Standards and Guidelines, UM 1B.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

k. Fifteen (15) Approved, Partially Approved, Denied, and Cancelled files selected by IEHP. The Delegate is responsible for walking IEHP through each referral via the Delegate’s medical management system;

l. Utilization Management statistics from the audit period;

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.¹⁵

5. Care Management documents:

a. Program Plan and Description and CM policies and procedures (if different from UM);

b. CM logs and California Children’s Services (CCS) logs (IEHP will utilize previously submitted monthly logs);

c. Ten (10) CM files;

d. Five (5) CCS files; and¹⁶

e. Five (5) sample cases of Carve Out/ Waiver Programs/ Termination of PCP/ Dis-enrollments/ Transition of Care/ Specialist Member letters.

6. Credentialing documents:

a. Policies and Procedures;¹⁷

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 Committee; and
   4) Peer Review Committee.

c. A spreadsheet of all credentialed and recredentialed Providers from for the specified time period (Applicable to Kaiser, MD Live and ASH Specialty Network)

¹⁶ Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 9, California Children’s Services (CCS).
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

- d. Credentialing and re-credentialing files – five percent (5%) or a minimum of thirty (30) credentialing and thirty (30) re-credentialing files randomly selected by IEHP;
- e. Practitioner files of those terminated for quality issues;
- f. Practitioner files that have appealed a decision;
- g. Health Care Delivery Organizational Files where the IPA is responsible for claims payment for those Organizational Providers, which include but are not limited to:
  1) Laboratory files;
  2) Hospital files
  3) Home Health files;
  4) Skilled Nursing Facility (SNF) files; and
  5) Free standing Surgical Center files.
- h. Credentialing delegation data, if applicable;¹⁸
- i. Health Care Delivery Organization Tracking mechanism for expirables must be assessed at least every three (3) years;
- j. Documentation of ongoing monitoring of sanctions, complaints, and quality issues for the past twelve (12) months;
- k. Human Immunodeficiency Virus (HIV/AIDS) Annual Survey to include the written process, Evidence of Implementation and Distribution of Findings; and
- l. Delegation Agreements between the IPA and Sub-delegate(s).¹⁹

7. Compliance Documents:

- a. Compliance Policies & Procedures;
- b. Fraud, Waste and Abuse (FWA) Policies & Procedures;
- d. Standards of Conduct;
- e. Sanction/Exclusion Screening Process policies and procedures;
- f. Compliance Committee Meeting minutes from the last twelve (12) months to include agenda and sign in sheet (attendance);
- g. Annual Compliance Work Plan;

25. DELEGATION AND OVERSIGHT

A. Delegation Oversight
   2. Audit

   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 IEHP for which evidence of the following will be requested:
      1) New Hires:
         - New hire Screening of the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), and Medi-Cal Suspended & Ineligible Provider List (S&I).
         - New hire confidentiality statement upon hire or start.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

- New hire Compliance, FWA, and Privacy & Security training upon hire or start.
- Standards/Code of Conduct distribution.

2) Established Employees
- Monthly Screening performed of OIG LEIE, GSA SAM, and Medi-Cal S&I for a sample of three consecutive months.
- Annual confidentiality statement.
- Annual Compliance, FWA, and Privacy & Security training.

r. A sample of five (5) audits and/or monitoring activities will be selected from the A&M Activities Universe. Evidence of the following will be required:
   1) Finding Reports;
   2) Findings were reported to an oversight body, senior leadership, and the board of directors; and
   3) Corrective actions, if applicable.

s. A sample of five (5) FWA investigations will be selected from the Reported Issues Universe. Evidence of the following will be required:
   1) Suspected FWA was promptly investigated,
   2) Suspected FWA was reported to IEHP with ten (10) days of becoming aware; and
   3) Suspected FWA was reported to Regulatory Agencies within required timeframes.

t. A sample of five (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.

u. 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 IPA should:
   1. Familiarize themselves with NCQA, DHCS (when applicable), DMHC, 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 Delegates policies and procedures for completeness and compliance with NCQA, DHCS (when applicable), DMHC, CMS and IEHP standards;
   2. Committee and Subcommittee Minutes (as applicable);
   3. The prior authorization/referral/denial/appeal process for the following:
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

   a. Timeliness of UM and appeal decisions for non-urgent and urgent pre-service, 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
   g. Evidence of current license for Providers and Employees (RN and LVN) who make UM decisions.

4. 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;
   h. Recommended referral services;
   i. Five (5) Sample Cases of Carve Out/Waiver Programs/Termination of PCP/SPC Member Letters (onsite review); and
   j. California Children Services (CCS logs).

5. 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;

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25. DELEGATION AND OVERSIGHT

A. Delegation Oversight
   
2. Audit
   
   c. All credentialing and re-credentialing packets have been approved by the Delegates Credentialing Committee;
   
   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;
   
   e. Processes are in place to ensure Provider documentation including licenses, Drug Enforcement Administration (DEA) certificate, Board Certification and malpractice insurance, are kept current;
   
   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;
   
   g. Re-credentialing of Practitioners was performed within required thirty-six (36) month timeframe; and
   
   h. There is sufficient documentation within each credentialing file to confirm that all primary source verifications, queries and other information reviewed pertinent to the credentialing or re-credentialing decision were received prior to and used in the credentialing and/or re-credentialing decision.

6. Randomly selected Health Care Delivery Organization Provider files (i.e., Home Health, laboratory) to verify the following:

   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.

   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, “Credentialing Standards - Assessment of Organizational Providers”; and

   c. Conducts an onsite quality assessment, if the Provider is not accredited. The onsite quality assessment will be conducted by Delegates Quality Management Department. Delegates 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.

7. Compliance Training Verification

   a. Training: General Compliance, FWA for new hires and current employees (Temporary or Permanent), Providers, Contracts and Volunteers.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

b. Screening: Proof of sanctions and exclusions screenings for all new hires and current employees (Temporary or Permanent), Providers, Contracts, and Volunteers.

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 (when applicable), DMHC, CMS (when applicable) and IEHP standards to sufficiently document information from the examined policies and procedures, committee minutes, files and other documents to NCQA and Medi-Cal specific standards, as well as to support the conclusions reached.

K. The 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 below 90%. However, a CAP may be issued at the discretion of IEHP regardless of the score, even if the score is at 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. (See Policy 25A4, “Delegation Oversight - 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:
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight
   2. Audit

   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;
   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 Delegates participation in the IEHP network.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight
   3. IPA Performance Evaluation Tool

APPLIES TO:

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

POLICY:

A. Annually IEHP evaluates each contracted IPA using the Performance Evaluation Tool (PET) to determine the overall performance and compliance with its IEHP contract, including compliance with IEHP policies and procedures.

B. The PET is a standardized scoring mechanism that IEHP uses to evaluate and compare each IPA’s health care delivery system and managed care capabilities in relation to compliance with IEHP standards.

C. IEHP uses the PET to evaluate whether an IPA’s contract should be renewed and to determine the length of term of an IPA’s contract with IEHP, if applicable.

PROCEDURES:

A. IEHP evaluates each IPA annually or as required when evaluating for renewal of a contract.

B. IEHP reviews the following functional areas:
   1. Claims;
   2. Communication;
   3. Encounter Data;
   4. Finance;
   5. Grievance and Appeals;
   6. Delegation Oversight Audit Results (including monthly, focused and annual audits); and
   7. IPA Reporting and Member Access Audit.

C. Each of the above categories is divided into specific subcategories. These subcategories describe the elements being scored, the frequency such data is collected, and the period of time being evaluated.
   1. For each element, IEHP has identified its expectations and the level (score) to be achieved (See Attachment, “IPA Performance Evaluation Tool” in Section 25 for a sample tool).
   2. The categories related to measures of an IPA’s competence and quality of Member care (e.g., IPA Reporting and Member Access Audit and the IPA Delegation Oversight Audit Results) are weighted more heavily to ensure the IPAs maintain IEHP’s quality standards and meet regulatory requirements.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

3. IPA Performance Evaluation Tool

3. The data collected throughout the contract year is comprised of reports, summaries and scores of each IPA’s performance and ability in meeting its delegated responsibilities, including results of monitoring and oversight activities, quality studies and medical management audits.

D. IEHP uses the PET results to determine contract renewal terms (years) for each IPA. Term lengths are based on the following:

<table>
<thead>
<tr>
<th>Providers achieving total scores of:</th>
<th>Are awarded a contract term of:</th>
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<tbody>
<tr>
<td>95% or above</td>
<td>3 years</td>
</tr>
<tr>
<td>85% to 94.99%</td>
<td>2 years</td>
</tr>
<tr>
<td>80% to 84.99%</td>
<td>1 year</td>
</tr>
<tr>
<td>Less than 80%</td>
<td>Non-renewal</td>
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</table>

E. IEHP provides each IPA with their PET Tool results. IEHP may meet individually with an IPA to discuss the results of its score and to review all relevant supporting documentation. This meeting can take place at the Joint Operations Meeting (JOM) or at a specific meeting called by IEHP.

F. After all PET scoring is complete, IEHP presents a summary to the IEHP Governing Board. This includes any IPA whose contract is not being renewed as a result of the PET score.

G. IPAs whose contracts are being non-renewed are notified in writing by the IEHP Chief Executive Officer (CEO).

H. IPAs that do not agree with the final outcome, may appeal to IEHP See Policy 16C, “IPA, Hospital and Practitioner Grievance and Appeals Resolution Process.”

I. IEHP reserves the right to change, modify or remove the elements of PET at any time. All decisions regarding the rules and requirements under the IPA PET are at the sole discretion of IEHP.

<table>
<thead>
<tr>
<th>INLAND EMPIRE HEALTH PLAN</th>
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<tbody>
<tr>
<td><strong>Chief Approval:</strong> Signature on file</td>
</tr>
<tr>
<td><strong>Chief Title:</strong> Chief Operating Officer</td>
</tr>
</tbody>
</table>
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

4. Corrective Action Plan Requirements

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Delegates and 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, Department of Health Care Services (DHCS) and National Committee for Quality Assurance (NCQA) 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.

2. A CAP is considered complete only if all deficiencies from each section are present and submitted together. These sections are as follows:

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

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Medi-Cal
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

4. Corrective Action Plan Requirements

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.

9. If the CAP is denied:
    a. IEHP will communicate all remaining deficiencies to the Delegates, with a written request for a second CAP.
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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;
   10. Focused audits;
   11. Pharmacy audits;
   12. Audits determined necessary by the Delegation Oversight Committee; and/or
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13. Follow up audits.

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

C. IEHP shares with its Delegates the annual plan-wide Appointment Availability and Access Study results. While IEHP does not require Delegates to submit CAPs for identified deficiencies in their network, IEHP does require Delegates to submit their Annual Appointment Availability and After-Hours Access Study program, results, corrective actions taken, follow up call campaigns and proof of Provider training given to remediate any identified deficiencies.

D. 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;
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f. Identification and signature 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.

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.

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.

F. 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;
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3. Requirement to subcontract out the deficient activities within Management Services Organization (MSO) or Delegates;
4. De-delegation of specified functions;
5. Contract non-renewal; or
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4. Corrective Action Plan Requirements

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25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   1. Credentialing Policies

APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for Medi-Cal lines of business.

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 they only contract 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 state 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, as well as Practitioners credentialed and contracted by IEHP’s Delegates, who perform these activities. IPAs are expected to use these guidelines when educating and training PCPs and Specialists, outlining patient age ranges for Practitioners, making hospital arrangements, and reviewing potential issues of malpractice or other adverse history when making credentialing and recredentialing decisions.
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B. Credentialing Standards
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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
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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 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 recrendentials. 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 members to see a specific Practitioner or group of Practitioners, including all Practitioners whom Members 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. Delegates are required to contract with and credential all their Practitioners defined as PCPs, Specialists, Non-Physician Practitioners, and Physician Admitters, including employed physicians participating on the Provider panel and published in external directories who provide care to Members. At minimum, the Credentialing policies and procedures include the following types of Practitioners and describes which Providers the Delegate credentials:
         1) Doctor of Medicine (M.D.)
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   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.)
   6) Physical Therapy (P.T.)
   7) Physician Assistants (P.A.) or Physician Assistants Certified (P.A.-C)
   8) Certified Nurse Midwives (C.N.M.)
   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) Licensed Marriage and Family Therapists (L.M.F.T.)
  15) Licensed Clinical Social Workers (L.C.S.W.)
  16) Psychologists (Ph.D., Psy.D.)
  17) Doctor of Chiropractic (D.C.)
  18) Licensed Midwife (L.M.)

f. IEHP does not require covering Practitioners and Locum Tenens who do not have an independent relationship with a Delegated IPA to be credentialed.

g. IEHP does not require Delegated IPAs to credential Practitioners that are hospital based and do not see Members on a referral basis.

h. IEHP does not require Delegated IPAs to contract with the following Provider types, where 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.

   1) Doctor of Chiropractic (D.C.)
   2) Licensed Acupuncturists (L.Ac.)

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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.
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   3) Optometrists (O.D.)
   4) Other Behavioral Healthcare Practitioners:
      • Addiction Medicine Specialists
      • Master Level Clinical Nurses
      • Licensed Clinical Social Workers
      • Marriage Family Therapists
      • Licensed Professional Clinical Counselors (L.P.C.C.) who have met the couples and families requirement only

2. Delegates’ credentialing policies and procedures describe the sources the organization uses to verify credentialing information. Listed below are the sources used and accepted by IEHP to verify credentialing information of each of the following criteria 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, and current, 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.)

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3 Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3.
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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 (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 requiring an explanation of 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.
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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.
   • 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.
     o 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.
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   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 (UC Irvine) 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).

         • 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).
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   - 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.).
   - 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 (1) 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
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   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 5D, “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.
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   • 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.\(^5\)
      • 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.

\(^5\) Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019, “Provider Credentialing / Recredentialing and Screening / Enrollment”.

\(^6\) Ibid.
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1) Group NPI Numbers may be requested by IEHP, in addition to the mandatory individual NPI number.\(^7\),\(^8\)

1. Medi-Cal Enrollment. IEHP uses the California Health & Human Services Agency’s portal to confirm the Providers enrollment status with the Medi-Cal Program through DHCS, prior to the Provider being submitted to IEHP for participation in the IEHP network.\(^9\)

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. Practitioners who do not meet the criteria set forth in this policy are subject for review by the Credentialing Subcommittee and/or Peer Review Subcommittee. This criteria 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 provide the following information for the designated physician to ensure compliance with NCQA:
  o Practitioner Name
  o NPI (IEHP requirement)
    ▪ Used as a unique identifier for the prescribing practitioner
  o DEA Number (IEHP requirement)
    ▪ Used to validate that the DEA is current, active and registered in California.

3) Education and Training. 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

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\(^7\) NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 2
\(^8\) Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019, “Provider Credentialing / Recredentialing and Screening / Enrollment”.
\(^9\) Ibid.
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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.

  - 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:
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- 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:

  1. proctored cases; and
  2. cases where applicant was the primary surgeon.

- IEHP requires a minimum of fifteen (15) cases where applicant was the primary surgeon.\(^{10}\)

- 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.

  Supportive documentation of participation with program is to be submitted with Credentialing application.

- **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

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   contracted hospital linked with that IPA network.
   
   o 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).
   
   o Internal Medicine 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. Further review may be completed by the IEHP Peer Review Subcommittee who will either approve or deny. The following documents are required for consideration:
     ▪ Detailed explanation specifically outlining the material basis for the request to expand practice parameters for Member age range. At minimum, the written request must include:
       Documentation of any relevant training (e.g., Continuing Medical Education, postgraduate/residency training, etc.); and
       Practical experience relating to the request (e.g., years in clinical practice, direct care experience with the relevant membership, etc.).
   
     ▪ 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);
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- Provide evidence of twenty-five (25) CME units in Pediatric 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 Pediatrics or Family Practice.

  - 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;
    - 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...
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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. 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);
  - 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 PCP’s 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
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   ▪ 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 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 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 than five years of work...
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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.
  - Settlements with a minimum payout of $30,000 or more
  - Settlements resulting in major permanent injury or death
- Trends in cases - Practitioners with multiple malpractice claims in a similar area (e.g., missed diagnosis, negative surgical outcomes, etc.).

7) Hospital Admitting Privileges. Practitioners must have clinical privileges in good standing. Practitioners 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 5D, “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 Provider (PCP) and Urgent Care Providers must meet the Facility Site Review (FSR)/Medical Record Review (MRR) Guidelines. See
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B. Credentialing Standards
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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. IEHP must verify the following sanction information for credentialing.

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

2) Medicare and Medicaid Sanctions
   - 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 credentialied 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.

11 Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3.
B. Credentialing Standards

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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. 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.\(^{12}\)
   • Current and signed attestation confirming the correctness and completeness
     of the application.

2) Release of Information used for primary source verification.

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:

\(^{12}\) NCQA, 2020 HP Standards and Guidelines, CR1, Element C, Factor 5.
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   - 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
   - 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) is 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,
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   • 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.

13) Delegates must obtain the appropriate documentation for all Advanced Practice Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs)) working with a Supervising Physician. Copies of the documentation must be readily available onsite upon request, including during an audit.

   • Physician Assistants are required to have a Practice Agreement or 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 practice protocols or specifically authorized by the supervising physician and:

      o Both the physician and PA must attest to, date and sign the document;

      o PAs must be practicing at a site assigned to their supervising Physician;

      o An original or copy must be readily accessible at all practice sites in which the PA works; and

      o 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 site specific and:

      o 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.
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   o NP and/or NM must be practicing at a site assigned to their supervising physician; and
   o 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.$^{13,14,15}$

d. Adverse History Guidelines: IEHP must carefully review the Delegate’s oversight process to ensure all Practitioners with evidence of adverse history are presented to Credentialing Committee for review and documented in the meeting minutes. Adverse history requiring review by the Credentialing Committee 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) Identified on any of the following Sanctions:
   5) Other negative actions may include, but are not limited to:
      • Use of illegal drugs
      • Criminal history
      • Engagement in unprofessional conduct or unacceptable business practices.

e. Provider Network

$^{13}$ NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 3.
$^{14}$ Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3.
$^{15}$ Title 16, California Code of Regulations (CCR) § 1474 (3).
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B. Credentialing Standards
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   1) Advance 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.

   2) Advance Practice Practitioners must:
      • Practice at a site assigned to their supervising physician
      • Practice within IEHP’s service area
      • 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.

   3) 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, postgraduate/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 Provider (PCP) must be specifically delineated as part of the Delegated credentialing process. The guidelines for PCP age ranges are provided below:

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<thead>
<tr>
<th>SPECIALTY</th>
<th>AGE RANGE</th>
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<tbody>
<tr>
<td>Pediatrics</td>
<td>• 0 – 18</td>
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<tr>
<td></td>
<td>• 0 – 21</td>
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<tr>
<td>Family Practice</td>
<td>• All Ages</td>
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<td>• 14 and above</td>
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<td>Internal Medicine</td>
<td>• 14 and above</td>
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<td>• 21 and above</td>
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25. **DELEGATION AND OVERSIGHT**

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| Public Health and General Preventive Medicine | • 18 and above  
|                                            | • 21 and above  
| Obstetrics/Gynecology                      | • 14 and above; restricted to females  
| General Practice                           | • All Ages, if evidence of pediatric training, experience and/or CME is present  
|                                            | • 14 and above  

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

5) 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.

6) 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 the IEHPs Peer Review Subcommittee for review.16

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

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25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
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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.¹⁷,¹⁸

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

¹⁷ NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 5.
B. Credentialing Standards

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- Delegates are 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. 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.19

8. Delegates’ policies and procedures must describe the process for notifying Practitioners the credentialing and recredentialing decisions within sixty (60) calendar days of the Committee’s decision.20

9. Delegates’ policies must describe the medical director or other designated Practitioner’s overall responsibility and participation in the credentialing process.21

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 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.22

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.23

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

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23 NCQA, 2020 HP Standards and Guidelines, CR 1, Element A, Factor 11.
B. Credentialing Standards
   1. Credentialing Policies

3. 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.

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

5. 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. 24

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

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25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   1. Credentialing Policies

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 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.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   1. Credentialing Policies

   2) The oversight of the department responsible for the audit.\textsuperscript{25}

D. Delegates’ recredentialing policies and procedures require information from quality improvement activities and Member complaints in the recredentialing decision making process.\textsuperscript{26,27}

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.\textsuperscript{28}

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.\textsuperscript{29}

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.

\textsuperscript{25} NCQA, 2020 HP Standards and Guidelines, CR 1, Element C, Factors 1-5.
\textsuperscript{26} Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3.
\textsuperscript{27} Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019, “Provider Credentialing / Recredentialing and Screening / Enrollment”.
\textsuperscript{28} Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.2.
\textsuperscript{29} Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019, “Provider Credentialing / Recredentialing and Screening / Enrollment”.

INLAND EMPIRE HEALTH PLAN

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<td>Revision Date:</td>
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25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

2. Credentialing Committee

APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for IEHP Medi-Cal 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 subdelegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for subdelegation oversight.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

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 policy can state the Credentialing Committee is comprised of a range of participating Practitioners.

  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 Physicians’ (PCP) 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.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   2. Credentialing Committee

   6) Process to document, review and approve delegate credentialing policies and procedures by the Committee on an annual basis;

   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.

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25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   2. Credentialing Committee

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.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   3. Credentialing Verifications

APPLIES TO:
A. This policy applies to all organizations delegated credentialing activities for IEHP Medi-Cal lines of business.

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.

J. Delegates must ensure all Practitioners submitted to IEHP for participation, for the Medi-Cal line of business, are enrolled in the Medi-Cal Program.

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

B. Credentialing Standards

3. Credentialing Verifications

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

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

N. 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 Advanced Practice Practitioner 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.
   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.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   3. Credentialing Verifications

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 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.

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 the present; or persons who died before 1962, but whose Social Security accounts were still active in 1962.

K. 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

3. Credentialing Verifications

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. 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.)
         • 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)
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- 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. 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.

   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

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   3. Credentialing Verifications

   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 credentialed 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 credentialed 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 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.

   c. 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.

   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.


      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:

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

3. Credentialing Verifications

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.\(^\text{3}\)

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 verify board certification:
         - For all Practitioner types
           o The primary source (appropriate specialty board).
           o The state licensing agency if the primary source verifies board certification.
         - For Physicians (M.D., D.O.)

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\(^{3}\) NCQA, 2020 HP Standards and Guidelines, CR 3, Element A, Factor 3.
B. Credentialing Standards
3. Credentialing Verifications

- 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 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.

- 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).

- 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.).
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

3. Credentialing Verifications

- 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 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)

   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 prior to Credentialing decision date).

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B. Delegate must verify 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.
         • 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:

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25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   3. Credentialing Verifications

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).  
   • 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) The Federal Employees Health Benefits (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))

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

1. Reasons for inability to perform the essential functions of the position.  

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.

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.

4. History of loss or limitation of privileges or disciplinary actions.

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

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3. Credentialing Verifications

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).

a. All Practitioners must have current and adequate malpractice insurance coverage that is current and:

1) 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.

2) Must include coverage for the specialty the Practitioner is being credentialed for and for all locations the Practitioner will be treating IEHP patients.
   • 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.

3) 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.

4) 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

\(^{11}\) NCQA, 2020 HP Standards and Guidelines, CR 3, Element C, Factor 5.
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 provider 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 application.\[12\]

D. Delegate 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:

1. Confirmed with the Hospital, in writing, via approved website or verbally, and must include:

\[12\] NCQA, 2020 HP Standards and Guidelines, CR 3, Element C, Factor 6
B. Credentialing Standards

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   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”).

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).
25. DELEGATION AND OVERSIGHT

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   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.

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.).
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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 must monitor 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 practice.16

   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 credentialed.

   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

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).
16 Medicare Managed Care Manual, Relationships with Providers”, Section 60.2.
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B. Credentialing Standards
   3. Credentialing Verifications

   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 must include 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 organization
   e. Not all quality activities need to be present

2. Grievance/complaints

G. Delegate must ensure 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.

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

B. Credentialing Standards
   3. Credentialing Verifications

   4. Practitioners that have a group NPI number may submit that information to IEHP, in
      addition to the required individual NPI number.\(^\text{19}\)

H. Delegate must ensure 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.\(^\text{20}\)

   1. Delegates are not 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
      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.

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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

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.\(^{21}\)

J. Delegates must ensure all Practitioners submitted to IEHP for participation, for the Medi-Cal line of business, are enrolled in the Medi-Cal Program, to ensure compliance with Title 42, Code of Federal Regulations (CFR) § 438.602(b) to extend Provider screening and enrollment requirements to all Managed Care Plan’s contracted Providers. The intent of this requirement is to reduce the incidence of fraud and abuse by ensuring that all Providers are individually identified and screened for licensure and certification.

   1. All Delegated IPA Provider submissions for participation in the IEHP network, the Delegate must provide documentation that confirms the Provider is enrolled in the Medi-Cal program state level enrollment through DHCS, prior to their submission to IEHP.
      a. Submissions without proof of Medi-Cal enrollment will be ceased and not processed by IEHP.
      b. The Delegate must use the California Health & Human Services Agency’s portal to confirm the Providers enrollment status with the Medi-Cal Program through DHCS.
         1) The portal can be accessed via:
            • The portal is maintained by the Provider Enrollment Division (PED) and is updated monthly.\(^{22}\)

K. 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”).\(^{23}\)

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

\(^{21}\) DHCS APL 19-004.
\(^{22}\) Ibid.
\(^{23}\) 2019 Medicare Program Final Rule, “Preclusions List Requirements”,

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25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   3. Credentialing Verifications

   1. Primary Care Providers
      a. Pediatrics
         1) PCPs that have members assigned ages 0-19 must enroll in the Vaccines for Children (VFC) Program.\(^{24}\)
         2) 0 – 18
         3) 0 – 21
      b. Family Practice
         1) PCPs that have members assigned ages 0-19 must enroll in the Vaccines for Children (VFC) Program.\(^{25}\)
         2) All Ages
         3) 14 and above
      c. Internal Medicine
         1) PCPs that have members assigned ages 0-19 must enroll in the Vaccines for Children (VFC) Program.\(^{26}\)
         2) 18 and above
         3) 21 and above
      d. Public Health and General Preventive Medicine
         1) 18 and above
         2) 21 and above
      e. Obstetrics/Gynecology
         1) 14 and above; restricted to females
      f. General Practice
         1) PCPs that have members assigned ages 0-19 must enroll in the Vaccines for Children (VFC) Program.\(^{27}\)
         2) All ages, if pediatric training, experience and/or Continuing Medical Education (CME) is present
         3) 14 and above

   2. Specialists Member age ranges are specific to the specialty involved, training, and

\(^{25}\) Ibid.
\(^{26}\) Ibid.
\(^{27}\) DHCS Medi-Cal Provider Manual, “Vaccines for Children (VFC) Program”.

Medi-Cal
education of the Physician.

3. 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.

M. 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.
   a. For PCP’s who have Adult 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) CME units in Pediatric 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 Pediatrics or Family Practice;

      4) PCPs that have Members assigned ages (0-19) must enroll in the Vaccines for Children (VFC) Program;

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

      6) Pass a Medical Record Chart Audit for Pediatric Members

   b. 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);
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

3. Credentialing Verifications

2) Provide evidence of twenty-five (25) 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) PCPs that have Members assigned ages (0-19) must enroll in the Vaccines for Children (VFC) Program;\(^\text{28}\)

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

6) 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.).

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25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

4. Recredentialing Cycle Length

APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for IEHP Medi-Cal Providers.

POLICY:

A. Delegates are responsible for formally recredentialing their contracted 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) months) if the Practitioner is:
   1. On active military assignment.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

4. Recredentialing Cycle Length

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.\(^1\)

\(^1\) 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 Medi-Cal 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 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. IEHP does not allow providers identified on the Medi-Cal Suspended and Ineligible list to participate in the IEHP network.

C. 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

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

E. 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.

F. 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.

G. 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.

DEFINITION:

A. Adverse event – An injury that occurs while a Member is receiving healthcare service from a
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   5. Ongoing Monitoring and Interventions

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.
        ▪ The Provider will be presented to Peer Review Subcommittee as
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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:

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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) Direct contact with the Delegate, if necessary
         - Confirmed information is forwarded to the Delegate for review and decision. Delegates are requested to inform IEHP in writing of their decision within thirty (30) days of the decision.
      4) Direct contact with the Practitioner, if necessary

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.

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2 NCQA, HP Standards and Guidelines, CR 5, Element A, Factor 2.
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c. Quality or collecting and reviewing complaints are not delegated and complaints are forwarded to the Health Plans, as applicable. IEHP also provides the Delegates with copies of any Practitioner specific information such as Member complaints or studies received directly or conducted by IEHP.

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

4. Policies for collecting and reviewing information from identified adverse events Delegate must state:
   a. Monitoring for adverse events occurs every six (6) months.
   b. Quality/collecting 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.

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 binders

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

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4 Ibid.
5 NCQA, 2020 HP Standards and Guidelines, CR 5, Element A, Factor 5.
B. 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.  

C. 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.

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.

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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.
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   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

D. 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
            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
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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.
  - 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 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:
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   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;
   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;
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b. Any filing with the NPDB; and

b. 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 Medi-Cal 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 proceeds 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 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.

\(^2\) California Code, Evidence Code (EVID), § 1157.
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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 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 &

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Professions Code 809.3(c).⁴

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.

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⁴ California Code, Business and Professions Code (BPC) § 809.3(c).
⁵ NCQA, 2020 HP Standards and Guidelines, CR 6, Element A, Factor 2.
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- 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 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.

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.
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   - Withdraws or abandons his or her application for staff privileges or membership.
   - Withdraws or abandons his or her request for renewal of staff privileges or membership.6

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.7

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.8

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

6 California Code, Business and Professions Code § 805.
7 California Code, Business and Professions Code (BPC) § 805.01.

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peers of the affected Physician.⁹

1. A Peer is an appropriately trained and licensed Physician in a practice similar to that of
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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⁹ Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Section 60.4.
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7. **Assessment of Organizational Providers**

**APPLIES TO**

A. This policy applies to all organizations delegated credentialing activities for IEHP Medi-Cal 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 the Delegate 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 the Delegate contracts.

B. IEHP directly contracts with IPAs and Hospitals (Providers). In turn, Providers subcontract
with Health Care Delivery Organizational Providers (subcontracted Providers) to provide
services to Members as designated in the Division of Financial Responsibility (DOFR) Matrix
outlined in IEHP’s Capitated Agreements with 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 25A2, “Delegation Oversight – Audit.” Delegated IPAs are subject
to corrective action as defined in Policy 25A4, “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. 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.
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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’ 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) Successful enrollment in the Medi-Cal Program via the Department of Health
Care Services (DHCS) Provider Enrollment Division (PED) or through a
Managed Care Plan’s enrollment process;

• All Health Care Delivery Organization Providers must periodically
revalidate their enrollment information with the Medi-Cal Program through
DHCS. All Providers must resubmit and recertify the accuracy of their
enrollment information as part of the revalidation process, in accordance
with the DHCS All Plan Letter (APL) 17-019. DHCS’s PED is responsible
for the timely enrollment of Providers into the Medi-Cal Program. The PED
has two (2) options for enrollment:

° Online
  The PED now offers an improved web-based alternative to the current
paper application enrollment process via the Provider Application and
Validation for Enrollment (PAVE) Provider Portal. The PAVE portal
can be accessed using the following link,
http://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx.

° Paper Application
  Application forms, instructions, and tips can be found on the DHCS
website at http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp. The
webpage has information that can assist you in completing and
submitting a complete application package.
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Providers that are successfully enrolled can verify their enrollment utilizing the California Health & Human Services Agency’s portal. The portal will allow Providers to see if they are already enrolled in the Medi-Cal program through DHCS. The portal can be accessed via https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017. The portal is maintained by the PED and is updated monthly.

3) 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);

4) 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.

5) 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 (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
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3) Centers for Medicare and Medicaid Services (CMS) signed participating agreement letter, if applicable.

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

c. The Organizational Providers must always maintain accreditation and license status in good standing and/or current 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. The Delegate may accept 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)

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)
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   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 
      American Osteopathic Association (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 
      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)
      • 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)
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7. **Assessment of Organizational Providers**

- 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)

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) Clinical Laboratories

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

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
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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.

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:

1. Hospitals
2. Home Health Agencies
3. Skilled Nursing Facilities
4. Free-Standing Surgical Centers
5. Clinical Laboratories in its assessment
6. If Delegate policies and procedures address all Provider types, the Delegate will not need to specify which types they do not contract with.

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

D. 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. Delegate 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 reviews are compliant.

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

8. Delegation of Credentialing

APPLIES TO:
A. This policy applies to all organizations delegated credentialing activities for IEHP Medi-Cal 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. 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. 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.
   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.
B. Credentialing Standards

8. Delegation of Credentialing

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.¹

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.²

3. Delegate must determine the method of reporting and the content of the reports, but the agreement specifies:
   a. The reporting is at least quarterly for Medi-Cal line of business, to ensure compliance with California Department of Health Care Services (DHCS). Reporting examples include:
      1) Lists of credentialed and recredentialed providers.
      2) Committee meeting minutes.
      3) Facilities credentialed.

² NCQA, 2020 HP Standards and Guidelines, CR 8, Element A, Factor 2.
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   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 NCQA-Accredited or NCQA Certified Delegates.3

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

5. Delegate retains the right to approve, suspend and terminate Providers, who participate in the Delegates’ network.5
   a. This does not apply if the sub-delegate does not have decision making authority.

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

B. 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.7

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 sub-delegate before implementing delegation.8

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.9

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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5 NCQA, 2020 HP Standards and Guidelines, CR 8, Element A, Factor 5.
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a. Site Visit.
b. Written review of the sub-delegate’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.\(^\text{10}\)

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 sub-delegate’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.\(^\text{11}\)

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 sub-delegate’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

\(^{10}\) NCQA, 2020 HP Standards and Guidelines, CR 8, Element B, Factor 4.
\(^{11}\) NCQA, 2020 HP Standards and Guidelines, CR 8, Element C, Factor 1.
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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).12

   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.).13

   4. Quarterly 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 credentialled and recredentialled 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
         credentialled and recredentialled Practitioners.
      e. For MSOs, reviewing reporting numbers which can usually be found in the Quality
         Improvement Meeting Minutes.14

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.15

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B. Credentialing Standards
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25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

9. Identification of HIV/AIDS Specialists

APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for IEHP Medi-Cal 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.

PURPOSE:

A. Delegates must have a written and documented process to identify and reconfirm the appropriately qualified physicians within IEHP who meet the definition and requirements of an HIV/AIDS Specialist on an annual basis.

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.

B. AIDS – Acquired Immunodeficiency Syndrome.

C. Category 1 continuing medical education:
   1. For Physicians, continuing medical education as qualifying for category 1 credit by the Medical Board of California;
   2. For Nurse Practitioners, continuing medical education contact hours recognized by the California Board of Registered Nursing;
   3. For Physician Assistants, continuing medical education units approved by the American
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

9. Identification of HIV/AIDS Specialists

Association of Physician Assistants.

D. HIV – Human Immunodeficiency Virus.

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, 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
B. Delegate identifies or reconfirms the appropriately qualified physician who meet the definition of an HIV/AIDS Specialist on an 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 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.
B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

**APPLIES TO:**

A. This policy applies to all organizations delegated for credentialing activities for IEHP Medi-Cal lines 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 IEHP's 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 Provider’s 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 semi-annually. 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
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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.

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- Upon receipt of credentialing files into the Delegate’s 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 Cares, once all credentialing information is received, IEHP’s Credentialing Department will request for a facility site review with IEHP’s 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 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

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<thead>
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<th><strong>Mid Level (ML)</strong></th>
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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

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25. DELEGATION AND OVERSIGHT

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<tr>
<td>Staff Languages spoken</td>
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3. Upon receipt of the documentation, IEHP’s Credentialing Department performs a quality review of each delegate’s credentialed and approved Practitioner to ensure compliance with IEHP’s guidelines (See Policy 5A, “Credentialing Standards – Credentialing Policies”).

a. The Practitioner review includes, but is not limited to the following:

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.
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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 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.
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- 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.

B. If a Practitioner is changing from one (1) IPA to another, identified as a “pend change,” the new IPA must submit the Provider’s 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 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:

REcredentialing ACTIVITIES:
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TERMINATIONS:

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

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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

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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”
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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 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.

6 Title 16 California Code of Regulations (CCR) § 1399.540.
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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
       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

7 16 CCR § 1474.
8 NCQA, 2020 HP Standards and Guidelines, CR 8, Element A, Factor 3.
B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

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.

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.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

- 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 Admitter’s name, phone number and fax number for each Provider who utilizes a Hospital Admitter. If Hospitals find discrepancies, they are emailed back to the Credentialing Specialist, who verifies with the IPA’s credentialing contact.
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements
   1. Delegation and Monitoring

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

POLICY:
A. IEHP delegates to its IPAs and their Provider network the responsibility of providing comprehensive case management services to 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 and periodicity schedules, 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.\(^1\)\(^2\)
B. IEHP maintains the responsibility of ensuring that IPAs continue to be in compliance with all applicable State and federal laws, contractual and reporting requirements.\(^3\)
C. IEHP oversees, monitors and evaluates performance of delegated and non-delegated care management activities.\(^4\)\(^5\) Oversight includes monitoring the IPAs’ care management activities monthly, quarterly, annually, and as frequently as necessary.

DEFINITIONS:
A. Interdisciplinary Care Team – A team of individuals who are involved in the Member’s health care. The team is person-centered and will collaborate with the Member and each other to assist in the development of an individualized care plan and assist in the coordination of the Member’s health care needs.\(^6\)

PROCEDURES:
Delegated Responsibilities
Care Management Program
A. IPAs will develop a care management program that includes:
   1. Evidence used to develop the program;

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\(^1\) Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 1, Definitions.
\(^2\) DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 1, Comprehensive Case Management Including Coordination of Care Services.
\(^3\) DHCS All Plan Letter (APL) 17-004, “Subcontractual Relationships and Delegation”.
\(^4\) DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities.
\(^5\) Title 28 California Code of Regulations (CCR) § 1300.70.
\(^6\) DHCS APL 17-012, Supersedes APL 14-010 “Care Coordination Requirements for Managed Long-Term Services and Supports”.

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Medi-Cal
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements

1. Delegation and Monitoring

2. Criteria 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; and
5. Defined program goals.

B. IPA 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.

C. IPAs will establish the frequency of their care management interventions based on the IPA’s written policies, care management program description and the Member’s identified goals, issues, barriers, and risks. IPA Care Manager interventions include:

1. Ensuring continuity of care as appropriate;
2. Following up on Member referrals;
3. Identifying the needs for LTSS services, appropriate community-based resources such as housing/utilities, meals etc.;
4. Identifying the need for behavioral health services;
5. Assisting with the coordination of care across all settings;
6. 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; and
7. Ensuring the PCP and other Members of the care team are updated on the Member’s health status.

D. IPAs are expected to resolve Member needs that range from referral assistance, access issues, and additional medical or non-medical needs in the realm of care coordination.

E. 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), Community-Based Adult Services (CBAS), as well as with California Children’s Services (CCS) and Inland Regional Center (IRC).7

Member Identification

A. IPAs are responsible for identifying Members that may benefit from care management through the following activities:

1. At least monthly, IPAs analyze internal data such as claims, encounters, utilization, pharmacy, Member, Provider and health plan referrals against the identification criteria described in their care management program description.

7 DHCS APL 17-012.
2. IPAs analyze data that is made available to them by IEHP through the secure IEHP Provider portal and Secure File Transfer Protocol (SFTP) server. These data include but are not limited to:
   a. Health Risk Assessment (HRA) for Seniors and Persons with Disabilities (SPD) Members;
   b. For Members receiving MSSP services, their MSSP care plan and health assessment summary (if available);
   c. For Members receiving CBAS, their Individual Plan of Care from the CBAS center, CBAS Eligibility Determination Tool, and Discharge Summary;
   d. For Members receiving IHSS, their approved IHSS service hours and county social worker’s contact information;
   e. Monthly reports that identify new CCS Members;
   f. Monthly reports that identify Members who are turning 21 years of age that will be transitioning out of CCS; and
   g. Monthly roster of children who are currently receiving services through IRC’s Early Start Program

Seniors and Persons with Disabilities (SPD)

A. IEHP performs the HRA on SPD Members, which includes basic assessment questions needed to identify and determine what level of care management would be most appropriate for the Member.\(^8\)
   1. The IPA will review all SPD HRAs on the secure IEHP Provider portal and/or the SFTP daily.
   2. The SPD HRA data that is made available to the IPA will identify the post-HRA risk level as High or Low. An HRA risk level of High indicates that the Member should be immediately reviewed by the IPA for care management needs.
   3. The IPA must have a process to enroll Members into a care management program appropriate for their risk level.
   4. The IPA’s own risk assessment of the Member should include, at a minimum, the post-HRA risk score, utilization patterns, pharmacy data, medical history, behavioral health diagnosis, social determinants, enrollment into an LTSS program such as IHSS, CBAS or MSSP, and care management assessment data.

B. If the IPA is unable to contact the Member to review the HRA or to complete an assessment, the IPA must make, at minimum, three (3) separate contact attempts to locate the Member.

\(^8\) DHCS APL 17-013.
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements
   1. Delegation and Monitoring

   1. Contact attempts must be made within thirty (30) calendar days of IEHP providing the HRA data to the IPA.
   2. Attempts may be telephonic, by mail, by email, etc.
   3. All contact attempts of the same type on the same day are considered one (1) attempt.
   4. All contact attempts must be documented (see Attachment, “Monthly Care Management Log” in Section 25).

C. The IPA must offer an Interdisciplinary Care Team (ICT) to all identified high-risk SPD Members when a need is demonstrated and in accordance with the Member’s functional status, assessed need, and in the ICP. An ICT must also be available to these SPD Members upon their request.9

   1. The ICT consists of, at a minimum, the Member and/or Member’s authorized representative, the Member’s caregiver, the Care Manager, the IHSS Social Worker (if the Member is receiving IHSS benefits), and the PCP or Specialist (if the Specialist is serving as the Member’s PCP). Additional members may include social workers, Specialists, Medical Directors, IEHP staff, and other individuals that are actively involved in the Member’s care.
   2. The IPAs hold case conferences periodically, or at the Member’s discretion. In addition, IEHP also recommends IPAs to consider a case conference after conducting the Member’s yearly assessment.
   3. IEHP holds case conferences on a regular basis and can support the IPA if assistance is needed. The IPA may contact IEHP Provider Relations Team at (909) 890-2054 for assistance with coordinating an ICT case conference.

D. The IPA must develop an Individual Care Plan (ICP) for high-risk SPD Members and other Members that demonstrate a need for an ICP, or when requested by the Member, Provider, IEHP, or as described in the IPA’s care management program description, policies and procedures.10

   1. The IPA must develop the Member’s ICP within thirty (30) business days of the HRA completion date. The Member’s HRA completion date is found in the HRA data file sent to the IPA via SFTP and on the secure IEHP Provider portal.
   2. The ICP must be developed based on the specific health care needs of the Member, and consider input from the Member, data obtained from the HRA, and input from the ICT if appropriate.

E. The ICP must include, but not be limited to, the following elements, as appropriate:

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9 DHCS APL 17-012
10 Ibid.
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements
   1. Delegation and Monitoring

   1. Prioritized goals that are agreed upon by the Member;
   2. Identified barriers to meeting the goals;
   3. Development of a schedule for follow-up that adheres to the risk stratification and program description/policies of the IPA; and
   4. Assessment of the Member’s progress towards the goals and the ICP is adjusted as needed.

   F. ICPs are updated at least annually and in the following instances, at minimum:
      1. A change in the Member’s health condition, including but not limited to a change in the level of care;
      2. A new problem has been identified with the Member;
      3. A goal has changed priority, has been met or is no longer applicable; and
      4. ICP is closed or completed.

   G. IEHP and its IPAs are required to offer and provide, upon request, a copy of the initial ICP and any of its amendments by mail to the Member at least annually. Updates are telephonically provided during each follow up. IEHP and its IPAs must offer to send a copy of the updated ICP to the Member in these scenarios, at minimum:
      1. The ICP is completed or closed;
      2. A change in the Member’s condition (e.g., a change in the level of care); and
      3. A new problem is identified with the Member and added to the ICP, as discussed with the Care Manager.

   H. The ICP will be made available in alternative formats and in the Member’s preferred written or spoken language upon request.

   I. The ICP must be shared with the Member and Provider and be made available to other members of the ICT.

Complex Case Management

A. IEHP does not delegate Complex Case Management (CCM). Members that may benefit from these services are referred to IEHP Behavioral Health and Care Management (BH & CM) Department. The IPA must notify the IEHP BH & CM team with Member information when a review for CCM is requested (see Attachment, “IEHP Care Management Referral Form – Medi-Cal” in Section 25). Members needing CCM typically have (a) health condition(s) status that is severe in nature and without intensive assistance the Member would likely

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11 DHCS APL 17-012.
12 Ibid.
13 Ibid.
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements
   1. Delegation and Monitoring

   decline or use acute services more frequently. Members needing CCM level of assistance often require numerous or extensive resource coordination in order to improve their health or circumstances. Please see Policy 12R, “Complex Case Management” for more information.

B. On a monthly basis, IEHP will provide IPAs through the SFTP, a CCM report that identifies the following:
   1. Members assigned to the IPA that are in active CCM with IEHP as of report run date;
   2. Members assigned to the IPA that were closed from CCM with IEHP in the previous month with the reason for CCM closure included; and
   3. Members assigned to the IPA that were referred to IEHP for CCM but where not opened to CCM as of report run date, because the Member did not meet criteria.

C. IPAs are responsible for reviewing cases and evaluating Members who did not meet CCM criteria. IPAs must outreach to these Members and assess for care coordination and case management needs.

California Children’s Services

A. IEHP provides the IPA, through the SFTP, monthly CM CCS reports of Members who are newly enrolled into CCS and those who will be turning 21 years of age within six (6) months.
   1. The IPA must ensure the coordination of care and services for newly enrolled CCS Members. This includes notifying the PCP that CCS services are starting and coordinating between PCP and Specialist on an as needed basis. The IPA must also notify parents of newly eligible CCS Members to advise of CCS services, provide education of service coverage and assess for any care coordination needs.
   2. The IPA must ensure the coordination of care and services when a Member transitions from a pediatric PCP to an adult PCP. This includes notifying the PCP of CCS services ending due to the Member turning 21 years of age, communicating with the Member to ensure care is established with an adult PCP and collaborating with the County CCS program, as needed. The IPA is responsible to assess for care coordination needs and assist with the transition from CCS Providers to in-network or out-of-network Providers as needed.

B. IPAs may identify potential CCS cases during care management activities or through requests for assistance from PCPs or Specialists. Upon identification of a Member with a potential CCS eligible diagnosis, the IPA is to refer the Member to CCS for determination of medical eligibility. This includes providing medical documentation that supports the CCS condition along with the potential CCS referral. IPAs will continually provide any care coordination

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14 DHCS-IEHP Two-Way Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 9, California Children’s Services (CCS).
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements

1. Delegation and Monitoring

needs while the Member is pending CCS eligibility. Please see Policy 12B, “California Children’s Services,” for more information.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

A. IPAs must provide all necessary care management services for Members receiving EPSDT services, as outlined in Policy 12D, “Early and Periodic Screening, Diagnosis and Treatment,” for EPSDT requirements.

Early Start Services

A. IEHP provides the IPAs a monthly list of Members who will be aging out of the Early Start Program within the next three (3) months. The IPA must notify the PCP and Member’s parents when Early Start services are ending. The IPA must assist with the transition of services such as Local Education Agency (LEA), supplemental therapy, and other necessary treatments. This includes coordinating between the Member and their PCP to obtain referrals. Please see Policy 12C, “Early Start Services and Referrals,” for more information.

Waiver Programs

A. IPAs must have procedures in place to identify Members who may benefit from Home and Community-Based Services (HCBS) Waiver programs and referring them to the agency administering the waiver program. These waiver programs include, but are not limited to, the Home and Community-Based Alternatives Waiver Program (formerly known as the Nursing Facility/Acute Hospital Waiver Program) and all other HCBS waivers. Please see Policy 12P, “Home and Community-Based Alternatives Waiver Program” for more information.

B. IPAs must assist in coordinating care for Members who are identified by their PCP or Specialist as a potential candidate for the Acquired Immune Deficiency Syndrome (AIDS) Waiver Program. See Policy 12Q, “AIDS Medi-Cal Waiver Program” for more information.

Monitoring and Oversight

A. IEHP performs monitoring and oversight of the IPAs’ care management activities through file reviews. Audit elements include, but are not limited to the following:

1. Care Management/Care Coordination
   a. IEHP will select and review, at a minimum, five (5) targeted cases each month for monitoring and oversight. The selected cases will be reviewed for the following areas: SPD, LTSS, and Medi-Cal HIV/AIDS Waiver Program. In addition, while IEHP does not delegate CCM to the IPAs, IEHP will review cases that potentially qualify and assess for appropriate referral.

2. CCS, Early Start and EPSDT Cases – IEHP performs quarterly retrospective audit of CCS files submitted by the IPA. IEHP will select and review, at a minimum, five (5) targeted CCS, Early Start and EPSDT cases each quarter for monitoring and oversight (see Attachments, “IPA Reporting Requirements Schedule - Medi-Cal” and “CCS Review
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements
   1. Delegation and Monitoring

Utilizing the IPA Care Management Review Tool (See Attachment, “IPA Care Management Review Tool – Medi-Cal” in Section 25), IEHP may select files each month to review from the following sources to ensure that IPAs provide care management services, including discharge planning in conjunction with IEHP staff, through the following activities:

1. IPA pre-contractual audits;
2. IEHP and IPA Joint Operations Meetings (JOM);
4. Appeal and grievance review;
5. Follow-up on care management cases handed off to the IPA to ensure the cases were received, evaluated and assessed for care management and coordination of care needs;
6. Monthly care management log submission and CM file review (See Attachment, “Monthly Care Management Log” in Section 25);
7. Follow-up on care management needs for Members who were recently discharged from the hospital; and

D. 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 25A4, “Delegation Oversight – Corrective Action Plan Requirements” for more information.

INLAND EMPIRE HEALTH PLAN

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15 DHCS Policy Letter (PL) 14-004 Supersedes PL 02-002, “Site Reviews: Facility and Review and Medical Record Review.”
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements

2. Reporting Requirements

APPLIES TO:

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

POLICY:

A. IEHP maintains the responsibility of ensuring that IPAs 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 care management activities.\(^2,3\) Oversight activities include but is not limited to reviewing reports submitted by the IPAs, as described below.

PROCEDURES:

A. On a monthly basis, IEHP staff reviews care management and care coordination case files for appropriate follow-up and care of the Member, and to ensure all required elements are being captured. All reports must be submitted to IEHP within the timeframes specified and in the correct format. Files not submitted in the correct format will be rejected, and the IPA will be required to resubmit in the required format.

B. Reporting requirements include a monthly assessment of care management data, including California Children’s Services (CCS) activity. Monthly reports are to be submitted to IEHP via the Secure File Transfer Protocol (SFTP) server within the timeframes specified in the Medi-Cal IPA Reporting Requirements Schedule regardless if it falls on a holiday or weekend (See Attachment, “IPA Reporting Requirements Schedule – Medi-Cal” in Section 25). Reporting requirements include:

   1. **Care Management Log** - Monthly report should include previously opened active cases and newly identified cases for the month reporting. Members who are open to care management will have a minimum of a ninety (90) day review or more frequent follow-up as determined by the Member’s individualized needs. Each IPA must submit the information noted in the Monthly Care Management Log (See Attachment, “Monthly Care Management Log” in Section 25).

   2. **CCS Logs** – IPAs must submit a log that identifies Members that IPAs referred to CCS during the month reporting. Each IPA must submit the information noted in the Monthly CCS Referral Log (See Attachment, “Monthly CCS Referral Log” in Section 25).

C. Repeated failure to submit required reports timely and in the right format may result in the

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

\(^2\) DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities.

\(^3\) Title 28 California Code of Regulations (CCR) § 1300.70.
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements
   2. Reporting Requirements

   request of a Corrective Action Plan (CAP), freezing of new Member enrollment or termination or non-renewal of the IEHP Agreement.\(^4\) Upon request, the IPA must submit a complete and comprehensive CAP to IEHP that adequately addresses all deficiencies noted. Please see Policy 25A4, “Delegation Oversight – Corrective Action Plan Requirements” for more information.

\(^4\) DHCS APL 17-004.
25. DELEGATION AND OVERSIGHT

D. Quality Management
   1. Quality Management Reporting Requirements

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal 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;⁴
         2) Quality of Service;⁵
         3) Safety of Clinical Care;⁶
         4) Members’ Experience;⁷

¹ Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004, “Subcontractual Relationships and Delegation”.
² DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities.
³ Title 28 California Code of Regulations (CCR) § 1300.70.
⁴ National Committee for Quality Assurance (NCQA), 2020 Health Plan Standards and Guidelines, QI 1, Element B, Factor 1.
⁵ Ibid.
⁶ Ibid.
⁷ Ibid.
25. DELEGATION AND OVERSIGHT

D. Quality Management
   1. Quality Management Reporting Requirements

   5) Program Scope;
   6) Yearly Objectives;
   7) Yearly Planned Activities;
   8) Timeframe within which each activity is to be achieved;\(^8\)
   9) Staff member(s) responsible for each activity;\(^9\)
   10) Monitoring of previously identified issues;\(^10\) and
   11) Evaluation of the QM/QI program.\(^11\)

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. 1\(^{st}\) Semi-Annual report covers period from January 1\(^{st}\) through June 30\(^{th}\) and must be submitted by August 15\(^{th}\), and
   b. 2\(^{nd}\) Semi-Annual report covers period from July 1\(^{st}\) through December 31\(^{st}\) and must be submitted by February 15\(^{th}\).

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 25A4 “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 15\(^{th}\) of February each calendar year regardless of whether this date falls on a weekend or holiday:

1. Quality Management\(^12\)
   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

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\(^8\) NCQA, 2020 HP Standards and Guidelines, QI 1, Element B, Factor 2.
\(^9\) NCQA, 2020 HP Standards and Guidelines, QI 1, Element B, Factor 3.
\(^11\) NCQA, 2020 HP Standards and Guidelines, QI 1, Element B, Factor 5.
\(^12\) DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 8, Quality Improvement Annual Report.
25. DELEGATION AND OVERSIGHT

D. Quality Management
   1. Quality Management Reporting Requirements

   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.


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).
DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal 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 – Medi-Cal” 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:

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1 Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 1, General Requirement.
2 DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities.
3 DHCS All Plan Letter (APL) 17-004, “Subcontractual Relationships and Delegation”.
4 DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities.
5 Title 28, California Code of Regulations (CCR) §1300.70(b)(2)(G)(1).
6 National Committee for Quality Assurance (NCQA), 2020 Health Plan Standards and Guidelines, QI 1, Element A, Factor 1
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

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. 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 and NCQA 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
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

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.

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 Education⁷ – Delegates and IEHP share Provider education and training responsibilities including orientation to managed care, delineation of IEHP policies and procedures pertinent to the Practitioner, site and medical record audit preparation, specialized support and training such as pediatric or adult preventive services and health education.

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.

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 Maintenance⁸ – 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

⁸ DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 13, Medical Records.
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

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 – 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 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.10,11,12

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.13 This program must include the following:
   a. QM Program goals, objectives, and structure;14,15
   b. Accountability to the Delegate’s Governing Body;16
   c. Designated Physician involvement in the QM Program;17,18,19
   d. Patient Safety;
   e. Member Experience;

9 DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 4, Access Standards.
10 DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities.
11 NCQA, 2020 HP Standards and Guidelines, QI 5, Element B.
12 NCQA, 2020 HP Standards and Guidelines, MED 15, Element C.
13 DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 7, Written Description.
14 Ibid.
15 NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 1.
16 DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 2, Accountability.
17 DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 1, Provision 6, Medical Director.
18 DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 2, Accountability.
19 NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 3.
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

f. Description of behavioral health care aspects of the program, as applicable;\textsuperscript{20}
g. Description of behavioral health care Practitioner involvement in behavioral health care aspects of the program; as applicable;\textsuperscript{21}
h. Description of QM Committee oversight of quality management functions;\textsuperscript{22}
i. Role, structure and function of the QM Committee\textsuperscript{23} and related Subcommittees including meeting frequency;\textsuperscript{24}
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);\textsuperscript{25}
l. Objectives for serving a culturally and linguistically diverse membership;\textsuperscript{26} and
m. Objectives for serving Members with complex health needs and Seniors and Persons with Disabilities (SPD).

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.\textsuperscript{27,28}

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.\textsuperscript{29}

\textsuperscript{20} NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 2.
\textsuperscript{21} NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 4.
\textsuperscript{22} DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 2, Accountability.
\textsuperscript{23} DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 7, Written Description.
\textsuperscript{24} NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 5.
\textsuperscript{25} NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 1.
\textsuperscript{26} NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 6.
\textsuperscript{27} DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 3, Governing Body.
\textsuperscript{28} DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 7, Written Description.
\textsuperscript{29} Ibid.
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

D. Quality Management Work Plan\textsuperscript{30}

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.


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

\textsuperscript{30} NCQA, 2020 HP Standards and Guidelines, QI 1, Element B
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

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 document. 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 information on schedule and method of submission.

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31 NCQA, 2020 HP Standards and Guidelines, QI 1, Element C.
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

G. QM Reporting Requirements\[32,\] 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\[34,35,36\]

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;
   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 include its involvement and

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32 DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities.
33 NCQA, 2020 HP Standards and Guidelines, QI 5, Element C.
34 DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 4, Quality Improvement Committee.
35 NCQA, 2020 HP Standards and Guidelines, QI 1, Element A, Factor 5.
36 NCQA, 2020 HP Standards and Guidelines, MED 15, Element D.
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

oversight of the following activities:37

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.38,39 All Provider contracts and subcontracts include the provision to safeguard the confidentiality of Member health records and treatment in accordance with applicable state and federal laws. Release of Member medical information may be necessary to protect the health of the Member and/or for coordination of services between Practitioners, Specialists, or other health care Providers of service. Refer to Policy 7B, “Information Disclosure and Confidentiality of Medical Records” for more information.

3. Education of PCP Staff Regarding Confidentiality Issues – Delegates must educate Providers and associated staff regarding confidentiality issues. Signed confidentiality statements are required for participation in the IEHP Practitioner network and monitored

37 NCQA, 2020 HP Standards and Guidelines, QI 1, Element D.
38 DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 1, Member Rights and Responsibilities.
39 DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 13, Medical Records.
D. Quality Management

2. Quality Management Program Structure Requirements

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 9E, “Access to Services with Special Arrangements.”

4. Conflict of Interest\textsuperscript{40} – 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.

5. Informed Consent for Treatment – Practitioners must obtain appropriate written consent for treatment prior to actual procedure performance.\textsuperscript{41} See Policy 7C, “Informed Consent,” for more information.

J. Provider Participation

1. Provider Information\textsuperscript{42} – 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.\textsuperscript{43} Requirements for cooperation are included in Hospital and Delegate Provider contract language that describes contractual agreements for access to information.

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.

\textsuperscript{40} DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 4, Quality Improvement Committee.

\textsuperscript{41} DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements.

\textsuperscript{42} DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 7, Provision 5, Network Provider Training.

\textsuperscript{43} NCQA, 2020 HP Standards and Guidelines, QI 1, Element D, Factor 3.
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

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. Hospital shall ensure that Providers allow IEHP to access and use Provider performance data.
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Quality Management Program Structure Requirements

   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\textsuperscript{44,45} - IEHP performs a series of activities to monitor Delegate functions including the following:

1. \textbf{Delegation Oversight Audit} – IEHP performs an annual Delegation Oversight Audit of all contracted Delegates using an audit tool that is based upon current NCQA, 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. \textbf{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. \textbf{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. \textbf{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. \textbf{Focused Audits:} IEHP performs focused audits of Delegates or Practitioners as indicated whenever a quality or clinical issue is identified.

6. \textbf{Review of Referral Universes} - All Delegates are required to submit monthly referral universes to IEHP, as well as, all 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. \textbf{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.

\textsuperscript{44} DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities
\textsuperscript{45} 28 CCR §1300.70(b)(2)(G)(3)
25. DELEGATION AND OVERSIGHT

D. Quality Management
   2. Quality Management Program Structure Requirements

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 – Medi-Cal” in Section 25), and delegated activities as defined in the Delegation Agreement (See Attachment, “IPA Delegation Agreement – Medi-Cal 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. Refer to 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 25A4, “Delegation Oversight – Corrective Action Plan Requirements.”
25. DELEGATION AND OVERSIGHT

E. Utilization Management
   1. Delegation and Monitoring

APPLIES TO:

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

POLICY:

A. IEHP delegates all aspects of utilization management activities related to medical services for assigned Members to its Delegates.¹ Delegate medical services must be rendered by qualified medical Practitioners, unduly influenced by fiscal and administrative management.²,³

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 Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), National Committee on Quality Assurance (NCQA), and IEHP.

D. Authorization and financial responsibilities are delineated in the Division of Financial Responsibilities (DOFR). Delegated responsibilities are outlined in the IPA’s Delegation Agreement.

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.⁵

DEFINITION:

A. Delegate – A health plan, medical group, IPA or any contracted organization delegated to provide utilization management services.

¹ Department of Health Care Services (DHCS)-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 5, Delegating UM Activities
² DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program
³ DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 1, Provision 5, Medical Decisions
⁴ DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program
⁵ National Committee for Quality Assurance (NCQA), 2020 Health Plan Standards and Guidelines, UM 1
25. DELEGATION AND OVERSIGHT

E. Utilization Management
   1. Delegation and Monitoring

PROCEDURES:

UM Program Requirements
A. Delegates must have a UM Program Description that includes, at minimum, the following information:\(^6\)

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 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 at least 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:\(^7\)

1. UM program structure;

\(^6\) NCQA, 2020 HP Standards and Guidelines, UM 1, Element A
\(^7\) NCQA, 2020 HP Standards and Guidelines, UM 1, Element B
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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 following. Please see Policy 18N, “IPA Medical Director Standards” for more information: 8
      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;9,10
      b. Ensuring that medical decisions are rendered by qualified medical personnel and are not influenced by fiscal or administrative management considerations;11,12
      c. Participation in staff training;13
      d. Monitoring documentation for adequacy;14
      e. Be available to UM staff on site or by telephone;15
      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.16 For more information on a UM Committee’s functions, structure, membership, and other requirements, please see Policy 2G, “Utilization Management Subcommittee.”

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8 NCQA, 2020 HP Standards and Guidelines, UM 1, Element A, Factor 3
9 California Health and Safety Code (Health & Saf. Code) §1367.01
10 NCQA, 2020 HP Standards and Guidelines, UM 4, Element A, Factor 1
11 Title 22, California Code of Regulations (CCR) § 53857
12 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 1, Provision 6, Medical Director
13 NCQA, 2020 HP Standards and Guidelines, UM 4, Element A, Factor 1
14 Ibid.
15 Ibid.
16 NCQA, 2020 HP Standards and Guidelines, UM 1, Element A, Factor 3
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, as delegated to do so: 17

   a. UM Technicians/Coordinators – eligibility determination, editing of referral form for completeness, interface with Provider offices to obtain any needed non-medical information, 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, concurrent inpatient, obtaining additional medical information, as needed, from the Provider’s offices, and approval of referrals based on IEHP-approved authorization criteria, 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, 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. 21, 22, 23, 24, 25, 26

4. **Use of Board-Certified Physicians for UM Decisions:** Delegates must have written policy and procedure demonstrating their use of designated physicians with current unrestricted license for UM decisions. 27, 28

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17 NCQA, 2020 HP Standards and Guidelines, UM 4, Element A, Factor 2
18 NCQA, 2020 HP Standards and Guidelines, UM 6, Element A
19 Ibid.
20 Ibid.
21 CA Health & Saf. Code § 1367.01(e)
22 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
23 CCI Three-Way Contract September 2019, Section 2.11
24 NCQA, 2020 HP Standards and Guidelines, UM 4, Element A, Factor 1
25 NCQA, 2020 HP Standards and Guidelines, UM 4, Element C
26 NCQA, 2020 HP Standards and Guidelines, UM 6, Element A
27 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2 Prior Authorizations and Review Procedures
28 NCQA, 2020 HP Standards and Guidelines, UM 4, Element F, Factors 1 and 2
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   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 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.29
Criteria sets approved by IEHP include Title 22 of the California Code of Regulations,
InterQual, Apollo Managed Care Guidelines/Medical Review Criteria, Milliman Care
Guidelines, Department of Health Care Services (DHCS) Medi-Cal Provider Manual, DHCS
All Plan Letters(APLs), and IEHP UM Subcommittee-Approved Authorization Guidelines.30,31,32
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.33,34 IEHP
ensures these criteria or guidelines are consistent with sound clinical principles and
processes and are evaluated at least annually and updated if necessary.35,36,37

2. Application: Delegates must apply criteria in a consistent and appropriate manner based
on available medical information and the needs of individual Members.38 The application
of criteria takes into consideration individual factors such as age, co-morbidities,
complications, progress of treatment, psychosocial situation, and home environment.39

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29 NCQA, 2020 HP Standards and Guidelines, UM 2, Element A
30 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization
Management Program
31 CA Health & Saf. Code § 1363.5(b)
32 NCQA, 2020 HP Standards and Guidelines, UM 2, Element A, Factor 1
33 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization
Management Program
34 NCQA, 2020 HP Standards and Guidelines, UM 2, Element A, Factor 4
35 CA Health & Saf. Code §1365.5
36 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2 Prior
Authorizations and Review Procedures
37 NCQA, 2020 HP Standards and Guidelines, UM 2, Element A, Factor 5
38 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2 Prior
Authorizations and Review Procedures
39 NCQA, 2020 HP Standards and Guidelines, UM 2, Element A, Factor 2
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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 services, including but not limited to 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, home care where needed, 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:

a. IEHP Member Handbook (Evidence of Coverage); then

b. DHCS Medi-Cal Provider Manual or Title 22 of California Code of Regulations (CCR); then

c. National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium or IBM Watson Health Products: Micromedex; then

d. MCG Health Informed Care Strategies Care Guidelines; then

e. InterQual Criteria; then

f. Apollo Medical Review Criteria Guidelines for Managing Care; then

g. 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

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40 NCQA, 2020 HP Standards and Guidelines, UM 2, Element A, Factor 3
41 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program
42 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
43 NCQA, 2020 HP Standards and Guidelines, UM 2, Element A, Factor 1
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.\(^\text{44,45}\)

4. **Process for Obtaining Criteria:** Delegates must disclose to Providers, Members, Member’s representatives, or the public, upon request, the clinical guidelines or criteria used for determining health care services specific to the procedure or condition requested.\(^\text{46,47}\)

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.

The Notice of Action (NOA) must state the address and phone number to call for obtaining the utilization criteria or benefits provision used in the decision.\(^\text{48,49}\) 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).\(^\text{50}\) Delegates must maintain a log of all requests for criteria (See Attachment, “Request for UM Criteria Log” in Section 25).

5. **Annual Assessment of Consistency of UM Decisions (Inter-rater Reliability):** Delegates are responsible for evaluating, at least annually, the consistency with which health care professionals involved in utilization review apply appropriate criteria for decision-making.\(^\text{51,52}\) Delegates must act on identified opportunities to improve consistency.\(^\text{53}\) The sample assessed must be statistically valid, or Delegates may use one (1) of the following three (3) auditing methods:\(^\text{54}\)

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\(^{44}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program  
\(^{45}\) NCQA, 2020 HP Standards and Guidelines, UM 2, Element A, Factor 5  
\(^{46}\) CA Health & Saf. Code §1365.5  
\(^{47}\) NCQA, 2020 HP Standards and Guidelines, UM 2, Element B, Factors 1 and 2  
\(^{48}\) DHCS APL 17-006  
\(^{49}\) NCQA, 2020 HP Standards and Guidelines, UM 7, Element B, Factor 3  
\(^{50}\) CA Health & Saf. Code §1363.5  
\(^{51}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2 Prior Authorizations and Review Procedures  
\(^{52}\) NCQA, 2020 HP Standards and Guidelines, UM 2, Element C, Factor 1  
\(^{53}\) NCQA, 2020 HP Standards and Guidelines, UM 2, Element C, Factor 2  
\(^{54}\) NCQA, 2020 HP Standards and Guidelines, UM 2, Element C, Factor 1
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a. Five percent (5%) or fifty (50) of its UM determination files, whichever is less;
b. NCQA’s 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.

1. UM data reported 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 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 physician for both over-utilization and under-utilization.

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 provision of health care services for Members. These policies and procedures must be available to the public upon request.55

1. Specialty Referral Systems: Delegates must maintain a specialty referral system to track and monitor referrals requiring prior authorization. The system shall include approved, partially approved (modified), and denied referrals received from both contracted and non-contracted providers, as well as the timeliness of these referrals.56

55 CA Health & Saf. Code § 1367.01(b)
56 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program

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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.\(^{57}\)

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. 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.\(^{58,59}\)

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 any delay in care. IEHP will communicate to the Delegate if the request can be handled within the network or does not meet the criteria. In which case, the Delegate can modify or deny as appropriate.

4. **Prior Authorization Requirements:** Delegates must maintain a list of services that require prior authorization or a list of services that do not require prior authorization like below, at minimum.

   a. The prior authorization process 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”);\(^{60-61,62}\)

      2) Family planning (See Policy 10G, “Family Planning Services”);\(^{63,64}\)

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\(^{57}\) NCQA, 2020 HP Standards and Guidelines, UM 12, Element A
\(^{58}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 16, Out-of-Network Providers
\(^{59}\) NCQA, 2020 HP Standards and Guidelines, MED 1, Element D
\(^{60}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
\(^{61}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization
\(^{62}\) NCQA, 2020 HP Standards and Guidelines, MED 9, Element C, Factors 1 through 3
\(^{63}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
\(^{64}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements
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3) Abortion services (See Policy 9E, “Access to Services with Special Arrangements”);

4) Sexually Transmitted Infection (STI) services (See Policy 10H, “Sexually Transmitted Infection (STI) Services”);\(^{65,66}\)

5) Sensitive and confidential services (See Policy 9E, “Access to Services with Special Arrangements”);

6) HIV testing and counseling (See Policy 10I, HIV Testing and Counseling”);\(^{67,68}\)

7) Immunizations (See Policy 10C2, “Pediatric Preventive Services – Immunization Services”);

8) Routine OB/GYN services, including prenatal care by Family Care Practitioner (credentialed for obstetrics) within the IPA’s network;\(^{69,70,71}\)

9) Out of area renal dialysis;

10) Urgent Care; and

11) Preventive services.\(^{72}\)

b. Delegates must allow Members direct access to Specialists, appropriate for their condition and identified need for special healthcare needs.\(^{73}\)

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.\(^{74}\)

5. **Medical Necessity Determination:** Delegates must determine medical necessity for a specific requested service as follows:\(^{75}\)

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\(^{65}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures

\(^{66}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements

\(^{67}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures

\(^{68}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements

\(^{69}\) NCQA, 2020 HP Standards and Guidelines, MED 1, Element A

\(^{70}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 7, Emergency Care

\(^{71}\) NCQA, 2020 HP Standards and Guidelines, MED 1, Element A

\(^{72}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures

\(^{73}\) NCQA, 2020 HP Standards and Guidelines, MED 1, Element B, Factor 1.

\(^{74}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements

\(^{75}\) NCQA, 2020 HP Standards and Guidelines, UM 1, Element A, Factor 5
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   a. Employ IEHP-approved UM authorization guidelines, as outlined in this policy and utilize the following definitions for determining medical necessity of a healthcare service: 76

      1) For individuals 21 years of age or older, a service is “medically necessary” or a “medical necessity,” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

      2) For individuals under 21 years of age, a service is “medically necessary” or a “medical necessity,” when the service is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services.

   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 by a Medical Director. 77 The request for additional information must be annotated and include the date of request. 78

   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. 79,80

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 (see Attachment, “UM Timeliness Standards – Medi-Cal” 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.

      1) Providers must submit urgent preservice and urgent concurrent referrals the same day of the determination that the referral is necessary.

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76 CA Welfare and Institutions Code (Welf. & Inst. Code) § 14095.5
77 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
78 NCQA, 2020 HP Standards and Guidelines UM 6, Element A
79 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2 Prior Authorizations and Review Procedures
80 NCQA, 2020 HP Standards and Guidelines, UM 4, Element F, Factors 1 and 2
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   2) 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.

   3) 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.

   4) Delegates may not defer/pend requests due to lack of information provided. Outreach must be made within the timeframe of the request to obtain additional information reasonably necessary to make the determination.\(^{81,82,83}\)

   5) Delegates will identify upon intake any prior authorization request for IEHP is responsible to authorize and will ensure these requests are forward to IEHP within twenty-four (24) hours of receipt by faxing the request to (909) 890-5751. Examples of services/items to be forwarded are requests for behavioral health, general anesthesia for dental treatment, outpatient/inpatient surgery requests when the facility is out of the service area, custom wheelchair/POV purchase/repair.

   6) 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.\(^{84}\)

b. Urgent Preservice or Concurrent Requests: Delegates have forty-eight (48) hours after receipt of an urgent preservice or concurrent request to determine and communicate to the requesting Provider if it meets the following definition for an urgent pre-service or urgent concurrent request.

   1) Delay would be detrimental to the Member’s life or could jeopardize the Member’s ability to regain maximum function;\(^{85}\)

   2) In the opinion of a Provider with knowledge of the Member’s medical condition, delay would subject the Member to severe pain that cannot be adequately managed without the requested care or treatment.

   Examples of requests that may not be downgraded from urgent preservice or urgent concurrent to non-urgent are Hematology/Oncology and Total Fracture Care.

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\(^{81}\) CA Health & Saf. Code § 1367.01
\(^{82}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2 Prior Authorizations and Review Procedures
\(^{83}\) NCQA, 2020 HP Standards and Guidelines, UM 6, Element A
\(^{84}\) CA Health & Saf. Code § 1367.01
\(^{85}\) Ibid.
The determination that a request does not meet the definition of urgent pre-service or urgent concurrent must be made and documented by the physician reviewer. If the request does not meet the definition of urgent pre-service or urgent concurrent, the Delegate RN/LVN or physician reviewer must communicate to the requesting Provider either telephonically or by fax that the request did not meet the definition of urgent pre-service or urgent concurrent:

1) Telephonic communication must be documented, including date, time, name of contact person at the Provider’s office, name of the RN/LVN, or physician reviewer.

2) Faxed communication to the Provider should state that the request did not meet the definition of urgent pre-service.

Delegate must notify both the Provider and Member utilizing the IEHP-approved “Notice of Action” template and provide “Your Rights” attachment with all denials that instructs a Member or Member’s representative about the appeal/grievance process. These IEHP-approved notification templates are available online at: www.iehp.org.

If accepted as an urgent pre-service or urgent concurrent request, the Delegate must render a decision and notify the Member and Provider as expeditiously as the Member’s health condition requires but no more than regulatory timeframes (see Attachment, “UM Timeliness Standards – Medi-Cal”).

c. Post-Service Decisions (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.86 If medical necessity is not met, denial determinations must be made by the Delegate Medical Director.87,88

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.

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86 NCQA, 2020 HP Standards and Guidelines, UM 6, Element A
87 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
88 NCQA, 2020 HP Standards and Guidelines, UM 4, Element A
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[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, and payment must be made for the medical screening exam (MSE).]

d. The timeframes for rendering decisions and sending notifications to the Provider are outlined in this Provider Manual (See Attachment, “UM Timeliness Standards – Medi-Cal” in Section 14).

7. Experimental and Investigational Determinations: The determination for all experimental and investigational services is the responsibility of IEHP.\(^9\) The Delegate must send to IEHP all authorization requests for experimental/investigational services as soon as possible after receipt of the request. 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/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 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 or tertiary facility 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 Policy 9A, “Access Standards” for more information.

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

\(^9\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 9, Investigational Services
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   1. Delegation and Monitoring

be reviewed and approved by the Delegate Medical Director or physician designee. Members (unless there is no financial responsibility) and Providers must receive denial letters for any requested referral that is denied or modified.  

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 DMHC language (in bold within template online);
   2) Include required DHCS language;
   3) Written in a manner, format, and language that can be easily understood;
   4) Be made available in English & Spanish (IEHP Threshold Languages);
   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;
   6) Include the right to appeal the decision, file a grievance, ask for an Independent Medical Review (IMR), refer to “Your Rights”;
   7) Include 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;
      • Non-covered benefit denials must cite the specific provision in the Evidence of Coverage (EOC) (i.e., the IEHP Member Handbook), Medi-Cal Provider

90 CA Health & Saf. Code § 1367.01
91 DHCS-IHEP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2 Prior Authorizations and Review Procedures
92 NCQA, 2020 HP Standards and Guidelines, UM 4, Element A
93 DHCS-IHEP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests
94 NCQA, 2020 HP Standards and Guidelines, UM 7, Element B, Factor 1
95 NCQA, 2020 HP Standards and Guidelines, UM 7, Element E, Factor 1
96 CCI Three-Way Contract September 2019, Section 2.11
97 Ibid.
98 CA Health & Saf. Code § 1367.01
99 DHCS-IHEP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 8, Denial, Deferral or Modification of Prior Authorization Requests
100 NCQA, 2020 HP Standards and Guidelines, UM 7, Element C
101 NCQA, 2020 HP Standards and Guidelines, UM 7, Element F
102 CA Health & Saf. Code § 1367.01
103 DHCS-IHEP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2 Prior Authorizations and Review Procedures
104 DHCS APL 17-006
25. DELEGATION AND OVERSIGHT

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   Manual or State or Federal regulations that exclude that coverage including the section. Non-covered benefits cannot be solely based on a code not being covered;
   - Information on how the Member and Provider can obtain the utilization criteria or benefits provision used in the decision;\(^{105}\)
   - Member-specific denial language should be at a readability level of 6th grade\(^ {106}\) and should not include CPT Codes; and

   8) Information for the Member regarding alternative direction for follow-up care or treatment.

   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.\(^ {107}\) Such communication must offer the requesting Provider the opportunity to discuss with physician review any issues or concerns regarding the decision.\(^ {108}\) This written notification of denial or partial approval (modification) must include language informing the Provider of the appeal process.\(^ {109,110}\) See Section 16, “Grievance and Appeals Resolution System” for more information.

   e. 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 Universe;
   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;

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\(^{105}\) NCQA, 2020 HP Standards and Guidelines, UM 7, Element B, Factor 3
\(^{106}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 4, Written Member Information
\(^{107}\) CA Health & Saf. Code § 1367.01
\(^{108}\) NCQA, 2020 HP Standards and Guidelines, UM 7, Element A
\(^{109}\) NCQA, 2020 HP Standards and Guidelines, UM 7, Element C
\(^{110}\) NCQA, 2020 HP Standards and Guidelines, UM 7, Element F
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   - 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.

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 12A2, “Coordination of Care – Continuity of Care.”

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 specialty care center for a Member who has a life threatening, degenerative, or disabling condition that requires coordination of care by a Specialist. Delegates must have a system in place to track open, unused, and standing referrals. 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...

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111 DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 1, Definitions
112 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 8, Services for All Members
113 DHCS All Plan Letter (APL) Supersedes APL 15-019, “Continuity of Care for Medi-Cal Who Transition into Medi-Cal Managed Care”
114 DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 6, Standing Referral
115 CA Health & Saf. Code § 1374.16
116 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 6, Standing Referrals
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E. Utilization Management

1. Delegation and Monitoring

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. Vision Services: IEHP is responsible for utilization management associated with vision services for Medi-Cal Members.

F. 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.

G. Communication Services: IEHP and its 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. IEHP and its Delegates shall maintain telephone access for Providers to request authorization for healthcare services.
2. IEHP and its Delegates’ 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.
6. There is a toll-free TDD/TTY service for Members who are deaf, hard-of-hearing, or speech-impaired.
7. Language assistance is available for IEHP Members to discuss UM issues.

IEHP will audit to assure that all policies and procedures state that IEHP and its Delegates have these services in place.

117 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program
118 NCQA, 2020 HP Standards and Guidelines, MED 1, Element C
119 NCQA, 2020 HP Standards and Guidelines, UM 3, Element A, Factors 1-5
120 CA Health & Saf. Code § 1367.01
121 NCQA, 2020 HP Standards and Guidelines, UM 3, Element A, Factor 1
122 NCQA, 2020 HP Standards and Guidelines, UM 3, Element A, Factor 3
123 NCQA, 2020 HP Standards and Guidelines, UM 3, Element A, Factor 4
124 NCQA, 2020 HP Standards and Guidelines, UM 3, Element A, Factor 5
25. DELEGATION AND OVERSIGHT

E. Utilization Management

1. Delegation and Monitoring

H. Rescinding or Modifying Authorization - Any authorization provided by a Delegate must not be rescinded or modified after the Provider has already rendered the health care service in good faith pursuant to the authorization.125

I. Record Retention: Delegates shall retain information on decisions, e.g., authorizations, denials or partial approvals (modifications) for a minimum period of ten (10) years.126

J. 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.127

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, partial 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 a procedure 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 Medical Director or physician designee.

K. Inpatient Stay: If delegated to perform inpatient utilization management activities, the process must include:

1. Determining medical necessity;
2. Determining appropriate level of care;

125 CA Health & Saf. Code § 1371.8
126 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
127 NCQA, 2020 HP Standards and Guidelines, UM 1, Element A, Factor 6
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E. Utilization Management
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3. Coordinating with hospital Case Manager’s discharge plan.

L. **Discharge Planning:** If delegated to perform inpatient utilization management activities, the process must include coordination of care with IEHP and facilities and the following activities related to discharge planning: 128

   1. Arranging necessary follow-up care (home health, follow-up PCP or specialty visits, etc.); and
   2. Facilitating transfer of the discharge summary and/or medical records, as necessary, to the PCP office.

M. **Repatriation:** Delegates must assist with the transfer of Members, as medically appropriate, back into the IEHP network during an inpatient stay, as applicable.

N. **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.

O. **Confidentiality:** IEHP recognizes that Members’ confidentiality and privacy are protected. It is the policy of IEHP and its 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.

P. **Affirmative Statement Regarding Incentives:** UM decisions for Members must be based only on appropriateness of care and service and existence of coverage. 129 Delegates do not provide specifically reward Practitioners or other individuals conducting utilization review for issuing denials of coverage or service. 130 Delegates ensure that contracts with physicians do not encourage or contain financial incentives for denial of coverage or service. 131 The Affirmative Statement about incentives is distributed annually to all Practitioners, Providers, and employees involved in authorization review, as well as Members.

Q. **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

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128 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 2, Discharge Planning and Care Coordination
129 NCQA, 2020 HP Standards and Guidelines, MED 9, Element D, Factor 1
130 NCQA, 2020 HP Standards and Guidelines, MED 9, Element D, Factor 2
131 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 1, Provision 1, Utilization Management Program
25. DELEGATION AND OVERSIGHT

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   1. Delegation and Monitoring

   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.132

R. 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 and Appeal Resolution System.”

Monitoring Activities and Oversight
A. IEHP monitors and oversees delegated UM activities performed by its 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, 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 second opinion tracking logs, referral universes and letters, annual and semi-annual work plans. Provider reports and utilization data is subsequently reviewed by the Delegation Oversight Committee (DOC).

3. Review of Approvals and Denials – 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 Provider Grievance Review: IEHP performs review, tracking, and trending of Member or Provider grievances and appeals related to UM. IEHP reviews Delegate

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132 CA Health & Saf. Code § 1367.02
25. DELEGATION AND OVERSIGHT

E. Utilization Management

1. Delegation and Monitoring

   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. They allow IEHP a method of monitoring plan administration responsibilities delegated to Delegates. JOMs may address specific Provider Services, UM, QM, CM, grievance, study results, or any other pertinent quality issues affecting Providers, Hospitals or Delegates. They are held with Delegates and Hospital partners, as applicable. 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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<td><strong>Chief Title:</strong> Chief Medical Officer</td>
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25. DELEGATION AND OVERSIGHT

E. Utilization Management

2. Reporting Requirements

**APPLIES TO:**

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

   a. **Referral Universe** - Using the universe template in Excel file format, the Delegate must report all approved, denied, partially approved (modified), and cancelled referrals during the report period (See Attachment, “Referral Universe” in Section 25).

   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. The overall denial rate must not exceed 5\(\%\), which may include non-benefit, out-of-network, medical necessity denials, etc.

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

\(^2\) DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities.

\(^3\) Title 28 California Code of Regulations (CCR) § 1300.70.
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.

- **CCS** – Services requested are carved-out to California Children’s Services. Member must have an open, active case and active Service Authorization Request (SAR) for the service requested.

- **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 referral universe submitted by the Delegate, IEHP will select ten (10) pre-service/retrospective 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 Delegates UM goals and activities, trending of utilization activities for under and over utilization, Member and Practitioner satisfaction activities, interrater reliability activities, and a narrative of barriers and improvement activities. The Semi-Annual report due in February must also include:

   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
25. DELEGATION AND OVERSIGHT

E. Utilization Management
   2. Reporting Requirements

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.

C. Annual Reporting Requirements: The following reports must be submitted annually to IEHP February 28th.

1. UM Program Description: Reassessment of the UM Program Description must be done on an annual basis by the UM Committee and/or 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: 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), freezing of new Member enrollment, termination or non-renewal of the IEHP Agreement.

INLAND EMPIRE HEALTH PLAN

Chief Approval: Signature on file                                     Original Effective Date: September 1, 1996
Chief Title: Chief Medical Officer                                    Revision Date: January 1, 2021

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E. Utilization Management

3. Referral and Denial Audits

**APPLIES TO:**

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

**POLICY:**

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

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” in Section 25).

B. IEHP may request for more denied and partially approved referral files in addition to those submitted monthly by the Delegate.

C. IEHP evaluates referral timeliness using the Referral Universe received from the IPA and documents the examined referral results.

D. In order to pass the Monthly Retrospective Audit of Denials and Partial Approvals (Modifications), 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” in Section 25).
   2. The overall denial rate must not exceed 5%, which may include non-benefit, out-of-network, medical necessity denials, etc.

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

\(^2\) DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities.

\(^3\) Title 28 California Code of Regulations (CCR) § 1300.70.
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3. Referral and Denial Audits

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 issued. 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

5. Other actions as recommended by IEHP’s 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.

Monthly Retrospective Audit of Approvals

A. IEHP performs a monthly retrospective audit of ten (10) approved referral files selected by IEHP from the Referral Universe submitted by the Delegate for the reporting month.

B. IEHP may request for more approved referral files in addition to those submitted monthly by the Delegate.

C. IEHP evaluates referral timeliness using the Referral Universe received from the IPA and documents the examined referral results (See Attachment, “Referral Universe” in Section 25).

D. In order to pass the Monthly Retrospective Audit of Approvals, the Delegate 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;
25. DELEGATION AND OVERSIGHT

E. Utilization Management

3. Referral and Denial Audits

3. A focused meeting with the Delegate’s administration and IEHP’s leadership; and
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 25A1, “Delegation Oversight – Audit” and the Delegation Oversight Audit Preparation Instructions (See Attachment, “Delegation Oversight Audit Preparation Instructions – Medi-Cal” in Section 25) for more information.

B. UM Process Review Components:

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 Federal and State regulations, NCQA accreditation standards, 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:
25. DELEGATION AND OVERSIGHT

E. Utilization Management
   3. Referral and Denial Audits

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;
8. A specific inquiry initiated by the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), or National Committee for Quality Assurance (NCQA); and/or
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-complaint 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
25. DELEGATION AND OVERSIGHT

E. Utilization Management

3. Referral and Denial Audits

standards to determine any areas of non-compliance and/or systemic problems within the Deleg ate’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.

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**

<table>
<thead>
<tr>
<th>Chief Approval: Signature on file</th>
<th>Original Effective Date:</th>
<th>September, 1996</th>
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<tbody>
<tr>
<td>Chief Title: Chief Medical Officer</td>
<td>Revision Date:</td>
<td>January 1, 2021</td>
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## 25. DELEGATION AND OVERSIGHT

### Attachments

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<thead>
<tr>
<th>DESCRIPTION</th>
<th>POLICY CROSS REFERENCE</th>
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<tr>
<td>Approved Referral Audit Tool</td>
<td>25E1</td>
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<tr>
<td>Precontractual Audit Preparation Instructions – Medi-Cal</td>
<td>25C1</td>
</tr>
<tr>
<td>CCS Review Tool</td>
<td>5A8, 25B8</td>
</tr>
<tr>
<td>Credentialing DOA Audit Tool</td>
<td>25B10</td>
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<td>Credentialing and Recredentialing Report</td>
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<td>IEHP Care Management Referral Form – Medi-Cal</td>
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<td>IPA Biographical Information Sheet</td>
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<td>Delegated IPA Delegation Agreement – Medi-Cal</td>
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<td>IPA Reporting Requirements Schedule – Medi-Cal</td>
<td>25C1, 25C2, 25D2</td>
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<td>Delegated IPA Denial Log Review Tool</td>
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<td>Delegated IPA Performance Evaluation Tool</td>
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<td>Subcontracted Facility Services and Delegated Functions</td>
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<td>Attachment I – Statement of Agreement by Supervising Provider</td>
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<td>DOA CAP Response Form (Template)</td>
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Attachment 25 - Approved Referral Audit Tool

## Approval Review Tool

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<tr>
<th>(a) Approval Tracking #</th>
<th>(b) File Type requested</th>
<th>(c) Auto Authorization</th>
<th>(d) Referral Received Date</th>
<th>(e) Decision Date</th>
<th>(g) Decision Time</th>
<th>(h) Member Written Notification</th>
<th>(i) Physician Written Notification</th>
<th>(j) Member</th>
<th>(k) Practitioner</th>
<th>(l) Information</th>
<th>(m) Template</th>
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### Selected Individual Scores:

- **0%** in each column.

### Total Score:

- **0%**

---

### Data Dictionary

- **Policy and/or Regulation**:

### Comments

---

### Instructions:

IEHP selects 10 Approvals 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 8.

---

### Total Points Earned

- **0**

---

### Total Points Possible

- **8**

---

### Individual Score

- **0%**

---

### Additional Information

- **Language Information Template**
- **Clinical Information**
- **Referral Form**
- **Correct Template**
- **Points Received**
- **Points Possible**
- **Individual Score**

---

### Key Definitions:

- **Decision Time**: Delegates decision to approve, modify or deny a referral request in a timely manner according to regulations.
- **Member Written Notification**: Written Notification to the Member of the requested referral decision by the Delegate.
- **Physician Written Notification**: Written Notification to the physician of the requested referral decision by the Delegate.
- **Member Language**: The approval letter is clear & concise. All approved services/items are listed and have been authorized as requested.
- **Practitioner Language**: The approval letter is clear & concise. All approved services/items are listed and have been authorized as requested.
- **Clinical Information**: Clinical information supporting the request. Not applicable if auto auth.
- **Referral Form**: Form submitted by Provider that includes requested services, CPT and ICD.
- **Correct Template**: Use of IEHP provided CMS template.
- **Points Received**: Total points earned from letters (g)-(l) above.
- **Points Possible**: Total points possible from letters (g)-(l) above, excluding non applicable.
- **Individual Score**: Total points earned from letters (g)-(l) above divided by total points.
IPA California Children's Services (CCS) Review Tool

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<th>(a) Member Name</th>
<th>(b) IEHP Member ID#</th>
<th>(c) Dx - primary CCS eligible condition</th>
<th>(d) Referral to CCS program includes SAR, referred to a CCS paneled provider/hospital,</th>
<th>(e) CCS #</th>
<th>(f) CCS Status</th>
<th>(g) Evidence that demonstrates the coordination of care between, PCP, Specialist, and Member’s PCG or family.</th>
<th>(h) Coordination with the member’s PCP to ensure that medically necessary health care services are provided for conditions not eligible for the CCS program</th>
<th>CCS Case score</th>
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<td>Delegate Type</td>
<td>Delegated Activities between organization and Delegate</td>
<td>Semi-Annual reporting by the delegate to the organization</td>
<td>Describes the process on how the organization evaluates the delegated entity</td>
<td>Organization retains the right to approve, suspend and terminate</td>
<td>Describes remedies available if entity does not fulfill obligations, including revocation of agreement</td>
<td>Documentation in the agreement showing that sub-delegates must adhere to CMS regulations</td>
<td>The written delegation must require at least quarterly reporting of the delegated entity to the organization</td>
<td>Organization evaluates delegate capacity before delegation</td>
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Listed below are the items required for your Delegation Oversight Audit (DOA). We have identified when they should be available, by Department.

All Desktop documents are due by the date specified in the Delegation Oversight Audit Notice.

### DESKTOP
- **Biographical Information**
- **Sub-Contracted Service by Facility/Agency**
- **All sections** of the DOA tool documented with *road mapping* instructions for each element (see sample roadmap)
- **Organizational chart(s)**
- **Current job descriptions as relevant to the audit**
- **Delegation Agreements with any sub-delegated provider**
- **Ownership and Control Documentation (submitted annually)**

### QUALITY MANAGEMENT
- **Program, Plan and Description**
- **Quality Improvement (QI) Committee meeting minutes from the auditing period that identify the following occurred during the meeting**
  - Recommendation of policy
  - Review and evaluation of QI activities
- **Practitioner participation in the QI program through planning, design, implementation or review**
- **Identification and follow up of needed actions**
- **Annual Work Plan**
- **Annual Program Evaluation**
- **Notification of Termination policy and evidence that Members were notified of practitioner termination**
- **Supportive documentation or materials such as studies, audits and surveys completed during the reporting period**
- **Semi-Annual Reports for Health Plan for the last twelve (12) months;**
- **Standards of Medical Care Access Policy and Procedure**
### UTILIZATION MANAGEMENT

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<th>Program, Plan and Description</th>
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<tr>
<td>✔</td>
<td>✔</td>
<td>Committee meeting minutes from last twelve (12) months for:</td>
</tr>
<tr>
<td>✔</td>
<td>✔</td>
<td>- Board of Directors</td>
</tr>
<tr>
<td>✔</td>
<td>✔</td>
<td>- Utilization Management Committee</td>
</tr>
<tr>
<td>✔</td>
<td>✔</td>
<td>Subcommittee Meeting Minutes</td>
</tr>
<tr>
<td>✔</td>
<td>✔</td>
<td>Annual Inter-rater Reliability Audit (On-Site Review)</td>
</tr>
<tr>
<td>✔</td>
<td>✔</td>
<td>Semi-Annual Health Plan Reports for the last twelve (12) months;</td>
</tr>
<tr>
<td>✔</td>
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<td>Two (2) examples that demonstrate the use of Board Certified consultants to assist with determinations</td>
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<td>(Fifteen (15) referral files to include Denials, Modifications, Cancellations and Approvals; (conducted via Webinar)</td>
</tr>
<tr>
<td>✔</td>
<td>✔</td>
<td>Referral Universe</td>
</tr>
<tr>
<td>✔</td>
<td>✔</td>
<td>Utilization Management statistics from the last twelve (12) months;</td>
</tr>
<tr>
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<td>Evidence that the Affirmative Statement has been distributed to providers and employees who make UM decisions;</td>
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<td>Provider communications from last twelve (12) months</td>
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<td>✔</td>
<td>Evidence of current license for Providers (Doctor of Medicine (MD)/ Doctor of Osteopathic Medicine (DO)) and Employees (RN, LVN) who make UM Decisions</td>
</tr>
<tr>
<td>✔</td>
<td>✔</td>
<td>Copies of most recent referral inventory reporting used to manage turnaround time requirements for processing of IEHP referrals.</td>
</tr>
<tr>
<td>✔</td>
<td>✔</td>
<td>Copies of most recent mailroom policies</td>
</tr>
</tbody>
</table>
## Inland Empire Health Plan
### Delegation Oversight Audit Tool 2020
#### Audit Preparation Instructions
Medi-Cal (NCQA Certified Organizations)

<table>
<thead>
<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th>CARE MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
<td>Program Plan and Description and CM applicable policies and procedures if different from UM; <em>(Desk Review)</em></td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>(5) CM files; (conducted via Webinar)</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>(5) sample cases of Carve Out/ Waiver Programs/ Termination of PCP/Dis-enrollments/ Transition of Care/ SPC member letters <em>(On-site Review)</em></td>
</tr>
</tbody>
</table>
| ✓       |         | California Children’s Services (CCS) logs:  
- Five (5) randomly pulled CCS Case Management files |
| ✓       |         | Documentation of coordination of care with county mental health clinics for Members receiving specialty mental health services. |

<table>
<thead>
<tr>
<th>DESKTOP</th>
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<th>CREDENTIALING</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>✓</td>
<td>Credentialing Policies and Procedures</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Credentialing meeting minutes including date and voting attendees from the look back period, which may include, but not limited to, references from:</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>- Quality Management Committee Minutes</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>- Credentialing Committee Minutes</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>- Peer Review Committee Minutes</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Delegate must submit a spreadsheet of all credentialed and recredentialed providers from for the specified time period <em>(Applicable to Kaiser, Delta Dental &amp; ASH Specialty Network)</em></td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Credentialing files selected by the IEHP auditor will be provided and requested to be available in the order they are listed</td>
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<tr>
<td>✓</td>
<td></td>
<td>Recredentialing files selected by the IEHP auditor will be provided and requested to be available in the order they are listed</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>NCQA Certification to show accredited elements</td>
</tr>
</tbody>
</table>
Inland Empire Health Plan  
Delegation Oversight Audit Tool 2020  
Audit Preparation Instructions  
Medi-Cal (NCQA Certified Organizations)

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<tr>
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</thead>
</table>
|         | ✓       | Policy and File review will include, but not limited to, review for the following items:  
|         |         | - Performance Monitoring  
|         |         | - Medicare Opt-Out Review  
|         |         | - Medicare Exclusions/Sanctions  
|         |         | - Medi-Cal Suspended & Ineligible  
|         |         | - Reporting to Authorities  
|         |         | - Fair Hearing Panel Composition  
|         |         | - Assessment of Organizational Providers  
|         |         | - Delegation Agreements for all Sub-Delegation Arrangements  
|         |         | - HIV/AIDS Identification Process  
|         |         | - DEA Verifications within 180 calendar days  
|         |         | - Work History verification within 180 calendar days  
|         |         | - Hospital Admitting Privileges  
|         | ✓       | Evidence of Ongoing Monitoring of Sanctions  
|         | ✓       | Practitioner files of those providers terminated for Quality Issues  
|         | ✓       | Practitioner files that have appealed a decision  
| ✓       | ✓       | Delegate must submit a spreadsheet of all organizational providers. IEHP will select credentialing and recredentialing files and the delegate may provide their spreadsheet tracking mechanism or file for the file audit  
| ✓       | ✓       | Delegation Agreements with any sub-delegated provider  
| ✓       | ✓       | HIV/AIDS Annual Survey  

<table>
<thead>
<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th>COMPLIANCE (Look back period of 07/2019 to 06/2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
<td>Compliance policies and procedures</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Fraud, Waste and Abuse policies and procedures</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>HIPAA Privacy and Security policies and procedures</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Standards of Conduct</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Compliance Committee Meeting minutes from the last 12 months to include agenda and sign in sheet (attendance)</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Annual Compliance Work Plan</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Annual Audit Plan</td>
</tr>
<tr>
<td>✓</td>
<td>Annual Risk Assessment</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>------------------------</td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>Grievance and Appeals Identification Training</td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>The name of the medical management system(s) used for the utilization management, care management, and claims functions.</td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>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. Refer to tab <em>A. Universe_Employees</em> of the Compliance tool for required template.</td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>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. Refer to tab <em>B. Universe_Reported Issues</em> of the Compliance tool for required template. <strong>Do not include privacy and security incidents as those have been requested in a different universe.</strong></td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>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. Refer to tab <em>C. Universe_Privacy Incidents</em> of the Compliance tool for required template.</td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>Audit &amp; Monitoring Universe: Create a list of all audits and monitoring activities of the IPA’s delegated functions started or completed during the audit period. Refer to tab <em>D. Universe_A&amp;M Activities</em> of the Compliance tool for required template.</td>
<td></td>
</tr>
</tbody>
</table>
### Inland Empire Health Plan
#### Delegation Oversight Audit Tool 2020
##### Audit Preparation Instructions
###### Medi-Cal (NCQA Certified Organizations)

<table>
<thead>
<tr>
<th></th>
<th>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. Refer to tab E. Universe_FDR_Subcontractor of the Compliance tool for required template.</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>a. New Hire Screening of List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM), and Medi-Cal Suspended &amp; Ineligible List (S&amp;I)</td>
</tr>
<tr>
<td></td>
<td>b. Monthly Screening performed of LEIE, SAM, and Medi-Cal S&amp;I for a sample of three consecutive months.</td>
</tr>
<tr>
<td></td>
<td>c. New hire confidentiality statement upon hire or start</td>
</tr>
<tr>
<td></td>
<td>d. Annual confidentiality statement</td>
</tr>
<tr>
<td></td>
<td>e. New hire Privacy &amp; Security training upon hire or start</td>
</tr>
<tr>
<td></td>
<td>f. Annual Privacy &amp; Security training</td>
</tr>
<tr>
<td></td>
<td>g. New Hire General Compliance training upon hire or start</td>
</tr>
<tr>
<td></td>
<td>h. Annual General Compliance training</td>
</tr>
<tr>
<td></td>
<td>i. New Hire FWA Training upon hire or start</td>
</tr>
<tr>
<td></td>
<td>j. Annual FWA training</td>
</tr>
<tr>
<td></td>
<td>k. New Hire distribution of Standards of Conduct upon hire or start</td>
</tr>
<tr>
<td></td>
<td>l. Annual distribution of Standards of Conduct.</td>
</tr>
</tbody>
</table>

|✓ | A sample of five (5) audits and/or monitoring activities will be selected from the A&M Activities Universe. Evidence of the following will be required: |
|   | a. Findings Reports |
|   | b. Findings were reported to an oversight body, senior leadership, and the board of directors |
|   | c. Corrective actions, if applicable. |
Inland Empire Health Plan  
Delegation Oversight Audit Tool 2020  
Audit Preparation Instructions  
Medi-Cal (NCQA Certified Organizations)

<table>
<thead>
<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th>PROVIDER DIRECTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
<td>Report during the lookback period of the annual audit of identified/reported inaccuracies and the timeframe of the correction. (Applies to Kaiser Permanente, Delta Dental, and American Specialty Health (ASH))</td>
</tr>
</tbody>
</table>
Listed below are the items required for your Delegation Oversight Audit (DOA). We have identified when they should be available, by Department. All Desktop documents are by the date specified in the Delegation Oversight Letter.

<table>
<thead>
<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th>DELEGATION OVERSIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
<td>Biographical Information</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Sub-Contracted Service by Facility/Agency</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td><strong>All sections</strong> of the DOA tool documented with <strong>road mapping</strong> instructions for each element (see sample roadmap)</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Organizational chart(s)</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Current job descriptions as relevant to the audit</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Delegation Agreements with any sub-delegated provider</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Ownership and Control Documentation (submitted annually)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th>QUALITY MANAGEMENT (QM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>As Needed</td>
<td>Annual Program Description (no submission required; report was submitted February 2020)</td>
</tr>
<tr>
<td>✓</td>
<td>As Needed</td>
<td>Quality Improvement (QI) Committee meeting minutes from the auditing period that identify the following occurred during the meeting. (If unable to submit meeting minutes please let us know and IEHP will go onsite to review)</td>
</tr>
<tr>
<td>✓</td>
<td>As Needed</td>
<td>- Recommendation of policy decisions</td>
</tr>
<tr>
<td>✓</td>
<td>As Needed</td>
<td>- Review and evaluation of QI activities</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Practitioner participation in the QI program through planning, design, implementation or review</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Identification and follow up of needed actions</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Annual Work Plan</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Annual Program Evaluation</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Notification of Termination policy and evidence that Members were notified of practitioner termination</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Supportive documentation or materials such as studies, audits, and surveys completed during the reporting period</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Semi-Annual Reports for Health Plan for the last twelve (12) months;</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Standards of Medical Care Access Policy and Procedure</td>
</tr>
</tbody>
</table>
### Inland Empire Health Plan
#### Delegation Oversight Audit Tool 2020
**Audit Preparation Instructions**
**Medi-Cal**

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<th>UTILIZATION MANAGEMENT (UM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
<td>Program, Plan and Description (no submission required; reports were submitted February 2020)</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Annual Work Plan (no submission required; reports were submitted February 2020)</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Annual Program Evaluation (no submission required; reports were submitted February 2020)</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Policies and Procedures</td>
</tr>
<tr>
<td>✓</td>
<td>As Needed</td>
<td>Committee meeting minutes from last twelve (12) months for: (If unable to submit meeting minutes please let us know and IEHP will go onsite to review)</td>
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<td>✓</td>
<td></td>
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</tr>
<tr>
<td>✓</td>
<td></td>
<td>- Utilization Management Committee</td>
</tr>
<tr>
<td>✓</td>
<td>As Needed</td>
<td>Subcommittee Meeting Minutes (If unable to submit meeting minutes please let us know and IEHP will go onsite to review)</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Annual Inter-rater Reliability (IRR) Audit</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Semi-Annual Health Plan Reports for the last twelve (12) months;</td>
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<td>✓</td>
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<td>Referral Universe; (Required for ASH only)</td>
</tr>
<tr>
<td>✓</td>
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<td>Utilization Management statistics from the last twelve (12) months;</td>
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## Audit Preparation Instructions – Medi-Cal

### Utilization Management (UM)

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<tr>
<th>Desktop</th>
<th>On-Site</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>📚</td>
<td>Copies of most recent referral inventory reporting used to manage turnaround time requirements for processing of IEHP referrals.</td>
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<td>✔️</td>
<td>📚</td>
<td>Copies of most recent mailroom policies</td>
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### Care Management (CM)

<table>
<thead>
<tr>
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<th>On-Site</th>
<th>Program Plan and Description and CM applicable policies and procedures if different from UM; (Desk Review)*</th>
</tr>
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<tbody>
<tr>
<td>✔️</td>
<td>📚</td>
<td>Ten (10) CM files;</td>
</tr>
<tr>
<td>✔️</td>
<td>📚</td>
<td>Five (5) sample cases of Carve Out/ Waiver Programs; (conducted via Webinar)</td>
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<tr>
<td>✔️</td>
<td>📚</td>
<td>Five (5) California Children’s Services (CCS) logs: (conducted via Webinar)</td>
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<tr>
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### Credentialing

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<th>Credentialing Policies and Procedures</th>
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<tbody>
<tr>
<td>✔️</td>
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<td>✅️</td>
<td>Quality Management Committee Minutes</td>
</tr>
<tr>
<td>✔️</td>
<td>✅️</td>
<td>Credentialing Committee Minutes</td>
</tr>
<tr>
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<td>✅️</td>
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<td>✔️</td>
<td>📚</td>
<td>Credentialing files selected by the IEHP auditor, will be provided and requested to be available in the order they are listed</td>
</tr>
<tr>
<td>DESKTOP</td>
<td>ON-SITE</td>
<td>CREDENTIALING</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>---------------</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Recredentialing files selected by the IEHP auditor, will be provided and requested to be available in the order they are listed</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Policy and File review will include, but not limited to, review for the following items:</td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>- Performance Monitoring;</td>
</tr>
<tr>
<td></td>
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<td>- Medicare Opt-Out Review;</td>
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<td>- Medicare Exclusions/Sanctions;</td>
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<td>- Reporting to Authorities;</td>
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<td>- Fair Hearing Panel Composition;</td>
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<td>- Assessment of Organizational Providers;</td>
</tr>
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<td></td>
<td></td>
<td>- Delegation Agreements for all Sub-Delegation Arrangements;</td>
</tr>
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<td>- Human Immunodeficiency Virus (HIV/AIDS) Identification Process;</td>
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<td>- Drug Enforcement Administration (DEA) Verifications within one hundred and eighty (180) calendar days;</td>
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<td>- Work History verification within one hundred and eighty (180) calendar days; and</td>
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<td>- Hospital Admitting Privileges.</td>
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<td>✓</td>
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<td>Evidence of Ongoing Monitoring of Sanctions</td>
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<td>✓</td>
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<td>Practitioner files of those providers terminated for Quality Issues</td>
</tr>
<tr>
<td>✓</td>
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<td>Practitioner files that have appealed a decision</td>
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<tr>
<td>✓</td>
<td></td>
<td>Delegate must submit a spreadsheet of all organizational providers. IEHP will select credentialing and recredentialing files and the delegate may provide their spreadsheet tracking mechanism or file for the file audit</td>
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<tr>
<td>✓</td>
<td></td>
<td>Delegation Agreements with any sub-delegated Provider</td>
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<td></td>
<td></td>
<td>HIV/AIDS Annual Survey</td>
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<tr>
<th>DESKTOP</th>
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<th>COMPLIANCE (Look back period of 07/2019 to 06/2020)</th>
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<tbody>
<tr>
<td>✓</td>
<td></td>
<td>Compliance policies and procedures</td>
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<td>✓</td>
<td></td>
<td>Fraud, Waste and Abuse policies and procedures</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>HIPAA Privacy and Security policies and procedures</td>
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<tr>
<td>✓</td>
<td></td>
<td>Sanction/Exclusion Screening Process policies and procedures</td>
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<tr>
<td>✓</td>
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<td>Standards of Conduct</td>
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<td>DESKTOP</td>
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<td>COMPLIANCE (Look back period of 07/2019 to 06/2020)</td>
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<tr>
<td>✔️</td>
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<td>Compliance Committee Meeting minutes from the last 12 months to include agenda and sign in sheet (attendance)</td>
</tr>
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<td>✔️</td>
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<td>Annual Compliance Work Plan</td>
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<td>✔️</td>
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<td>Annual Audit Plan</td>
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<td>✔️</td>
<td></td>
<td>Annual Risk Assessment</td>
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<td>✔️</td>
<td></td>
<td>Grievance and Appeals Identification Training</td>
</tr>
<tr>
<td>✔️</td>
<td></td>
<td>The name of the medical management system(s) used for the utilization management, care management, and claims functions.</td>
</tr>
<tr>
<td>✔️</td>
<td></td>
<td>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. Refer to tab A. Universe_Employees of the Compliance tool for required template.</td>
</tr>
<tr>
<td>✔️</td>
<td></td>
<td>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. Refer to tab B.Universe_Reported Issues of the Compliance tool for required template. Do not include privacy and security incidents as those have been requested in a different universe.</td>
</tr>
<tr>
<td>✔️</td>
<td></td>
<td>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. Refer to tab C. Universe_Privacy Incidents of the Compliance tool for required template.</td>
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<td>COMPLIANCE (Look back period of 07/2019 to 06/2020)</td>
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<td>template.</td>
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<td>✓</td>
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<td>Audit &amp; Monitoring Universe: Create a list of all audits and monitoring activities of the IPA’s delegated functions started or completed during the audit period. Refer to tab D. Universe_A&amp;M Activities of the Compliance tool for required template.</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>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. Refer to tab E. Universe_FDR_Subcontractor of the Compliance tool for required template.</td>
</tr>
</tbody>
</table>
| ✓       |         | A sample of ten (10) employees will be selected from the Employee Universe by IEHP for which evidence of the following will be requested:  
  a. New Hires:  
     i. New hire Screening of the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), and Medi-Cal Suspended & Ineligible Provider List (S&I)  
     ii. New hire confidentiality statement upon hire or start  
     iii. New hire Compliance, FWA, and Privacy & Security training upon hire or start  
     iv. Standards/Code of Conduct distribution  
  b. Established Employees:  
     i. Monthly Screening performed of OIG LEIE, GSA SAM, and Medi-Cal S&I for a sample of three consecutive months.  
  c. New hire Confidentiality Statement |
<table>
<thead>
<tr>
<th>DESKTOP</th>
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<th>COMPLIANCE (Look back period of 07/2019 to 06/2020)</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>i. Annual confidentiality statement</td>
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<td>ii. Annual Compliance, FWA, and Privacy &amp; Security training</td>
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<td>✓</td>
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<td>A sample of five (5) audits and/or monitoring activities will be selected from the A&amp;M Activities Universe. Evidence of the following will be required:</td>
</tr>
<tr>
<td></td>
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<td>a. Findings Reports;</td>
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<td>b. Findings were reported to an oversight body, senior leadership, and the board of directors; and</td>
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<tr>
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<td>c. Corrective actions, if applicable.</td>
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<td>✓</td>
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<td>A sample of five (5) FWA investigations will be selected from the Reported Issues Universe. Evidence of the following will be required:</td>
</tr>
<tr>
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<td>a. Suspected FWA was promptly investigated,</td>
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<td>b. Suspected FWA was reported to IEHP with ten (10) days of becoming aware; and</td>
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<td>c. Suspected FWA was reported to Regulatory Agencies within required timeframes.</td>
</tr>
<tr>
<td>✓</td>
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<td>A sample of five (5) privacy investigations will be selected from the Privacy Incidents Universe. Evidence of the following will be required:</td>
</tr>
<tr>
<td></td>
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<td>a. Notice of Privacy Practices was sent to the Member;</td>
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<td>b. Date incident was reported to the Privacy/Compliance Office/Officer;</td>
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<td>c. Completion of a Risk Assessment for issue/investigation;</td>
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<td>d. Notification was sent to IEHP with HIPAA BAA Requirements of discovery of a suspected breach; and</td>
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<td>e. Corrective actions taken, if applicable.</td>
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<td>✓</td>
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<td>A sample of five (5) FDR/Subcontractors will be selected from the FDR_Subcontractor Universe. Evidence of the following will be required:</td>
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<td></td>
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<td>a) Findings Reports;</td>
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<td>b) Findings were reported to an oversight body, senior</td>
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<td>COMPLIANCE (Look back period of 07/2019 to 06/2020)</td>
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<td>leadership, and the Board of Directors;</td>
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<td>c) Corrective actions, if applicable; and</td>
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<td></td>
<td>d) Evidence of Offshore Contracting Oversight.</td>
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<tr>
<th>DESKTOP</th>
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<th>PROVIDER DIRECTORY</th>
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<tbody>
<tr>
<td>✔️</td>
<td></td>
<td>Report during the lookback period of the annual audit of identified/reported inaccuracies and the timeframe of the correction. (Applies to Kaiser Permanente and American Specialty Health (ASH))</td>
</tr>
</tbody>
</table>
### Denial Log Review Tool

**Medi-Cal**

<table>
<thead>
<tr>
<th>(a) Denial Tracking Number</th>
<th>(b) File Type</th>
<th>(c) Request Date</th>
<th>(d) Decision Date</th>
<th>(e) Member Written Notification Date</th>
<th>(f) Physician Review</th>
<th>(g) Alternative Direction</th>
<th>(h) Decision Timeliness</th>
<th>(i) Member Written Notification</th>
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**Total Number of Files Reviewed:** 0

**Data Dictionary**

- **a. Denial Tracking Number:** The number located on the referral forms for tracking purposes.
- **b. File Type:** Pre-Service Routine, Pre-Service Expedited, Post Service Retrospective Review.
- **c. Request Date:** Date the referral was sent to Delegate for review.
- **d. Decision Date:** Date the Delegate decision was made by the Delegate to Approve, Modify or Deny the case.
- **e. Member Written Notification Date:** Date of the Member written notification.
- **f. Physician Review:** Physician review performed and documented rationale for all medical necessity denials/partial approvals.
- **g. Alternative Direction:** The Member is given alternative direction for follow-up care such as following up with their PCP.
- **h. Decision Timeliness:** Delegate decision to approve, modify or deny a referral request is made in a timely manner according to regulations.
- **i. Member Written Notification:** Standard: Evidence the Member written notification was mailed within two (2) business days from decision date. Expedited: Evidence the Member written notification was mailed by the 72nd hour after receipt of request. If successful verbal notice (e.g. spoke with the person that submitted the request or was able to leave a voicemail message) was given, the written notice must be sent within 3 calendar days of the verbal notice.
| j | Practitioner Written Notification | Timely written notification of denial/modification is made to the requesting physician/practitioner. |
| k | Clinical Information | Clinical information supporting the request is made available. |
| l | 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. |
| m | Member Denial Reason | The denial letter reason is clear & concise and all medical terms have been defined. |
| n | Practitioner Denial Reason | The denial letter reason is clear & concise. |
| o | Provider/Member Outreach | 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 the correct criteria hierarchy utilized for denied services. |
| p | Appropriate use of Criteria | Use of IEHP issued Template in correct threshold language with appeal rights. |
| q | Correct Template | Use of IEHP issued Template in correct threshold language with appeal rights. |
| r | Points Received | Total points earned from letters (f)-(q) above. |
| s | Points Possible | Total points possible from letters (f)-(q) above, excluding non applicable elements. |
| t | Individual Score | 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. |
**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>Choose an item.</td>
<td>Click here to enter a date</td>
<td>Click here to enter a date</td>
<td>Click here to enter your text.</td>
</tr>
</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.

<table>
<thead>
<tr>
<th>Printed Name of Individual Attesting to CAP Response</th>
<th>Title of Signing Individual</th>
</tr>
</thead>
</table>

×

Signature of Individual Attesting to CAP Response (Date will automatically populate)
# IEHP Care Management Referral Form

**Member Name:**

**Member ID #:**

**Date:**

**Line of Business:**

- [ ] Medi-Cal
- [ ] Cal MediConnect (LTSS referrals only)

**Member DOB:**

**IPA**

**Member Phone:**

**Alt Phone:**

**Caregiver/Family Member Name:**

**Caregiver/Family Phone:**

**Referral Source:**

- [ ] Member
- [ ] Caregiver
- [ ] PCP
- [ ] IPA
- [ ] Specialist
- [ ] Other

**Reason for Referral:**

- [ ] Diagnosis
- [ ] High Utilization
- [ ] Social Needs
- [ ] Behavioral Health
- [ ] Rx
- [ ] Maternity/Child Health Needs
- [ ] Long-Term Services and Supports (In-Home Support Services, Community-Based Adult Services, Multipurpose Senior Services Program)

**Diagnosis Triggers**

- [ ] Advanced liver disease
- [ ] Metastatic cancer/pediatric cancer
- [ ] Severe psychoses
- [ ] Decompensating neurological conditions
- [ ] New cerebral vascular accident
- [ ] Complex pain management control issues
- [ ] Trauma (current)
- [ ] Multiple chronic illnesses-uncontrolled

**Utilization Triggers**

- [ ] 6 or more ER visits in the past 12 months
- [ ] Projected cost of care within a 12-month period anticipated to be >$100,000 (including high-cost medications and/or DME)
- [ ] 2 or more readmissions to acute setting within 30 days
- [ ] 4 or more inpatient stays in the past 12 months
- [ ] On multiple medications for multiple chronic conditions

**Psychosocial/Frailty Triggers**

- [ ] Malnutrition and/or catabolic illness, loss of weight
- [ ] Decubitus ulcer (Stage 3, Stage 4)
- [ ] Major problems of urine/bowel retention or control
- [ ] Social support needs (e.g., housing/food)
- [ ] Difficulty in walking/fall risk
- [ ] Suspected or reported abuse of Member

**Triggers for referral to Long-Term Services and Supports**

- [ ] 65+ and at risk of placement in a Long-Term Care facility
- [ ] Alzheimer's or Dementia
- [ ] Severe and persistent mental illness
- [ ] Needs a caregiver
- [ ] Disabled, blind, or senior unable to perform activities of daily living
- [ ] Needs ongoing nursing monitoring and supervision at Adult Day Healthcare Center

Please return completed Form via Secure Email to CMReferralTeam@iehp.org and attach all applicable documentation.

*Please allow up to 5 business days for referral to be processed and response*

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## Biographical Information

### Date of Review:

### Name of IPA:

### IPA Code

### Address:

City/State

### Phone:

FAX:

### Name of Management Company (if applicable)

### Address:

City/State:

### Phone:

FAX:

### IPA Contact Personnel

<table>
<thead>
<tr>
<th>Phone</th>
<th>FAX</th>
<th>E-Mail</th>
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</table>

**IPA Administrator**

**Medical Director:**

**QM Chairperson:**

**QM Contact/Title:**

**UM Chairperson:**

**UM Contact/Title:**

**CM Contact/Title:**

**Credentialing Contact/Title:**

**Provider Relations Contact/Title:**

**Compliance Contact/Title:**

**Case Management Contact/Title:**

### HEALTH PLAN CONTRACTS/ENROLLMENT

**IPA Total Enrollment in all participating health plans:**

**IPA total enrollment for each of the following:**

**Commercial:**

**MediCare:**

**MediCal:**

**IPA Enrollment for (insert health plan) for each of the following:**

**Commercial:**

**MediCare:**

**MediCal:**

### 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>
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</table>

**Total number of OB's:**

**Total number of Pediatricians:**

**Have you included the following in your total:**

**OB/GYN's:** yes no

**Pediatricians:** yes no

**Capitated Specialist: (number/specialty)**
### 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>
<tr>
<td>Delegated Functions:</td>
<td></td>
</tr>
</tbody>
</table>

#### Care Management

#### Credentialing

#### Utilization Management

#### Claims
IPA Care Management Review Tool
Medi-Cal

IPA: 
Service Month: 
Review Date: 
Reviewer: 

Instructions: Randomly select Care Management files from the CM logs maintained by the PMG/IPA. Each file will be reviewed using the elements below and noted as follows: “1” yes the information is present, “0” if the information is not present, and “N/A” if the information is not applicable to the file. Each file has a maximum score of 14.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Member Name</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>b.</td>
<td>IEHP ID# or DOB</td>
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<tr>
<td>c.</td>
<td>Date Case Opened (or Referred to Waiver, CCS)</td>
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<tr>
<td>d.</td>
<td>Case Closure Date</td>
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<tr>
<td>e.</td>
<td>Reason for Closure / Case Outcome Documented</td>
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<tr>
<td>f.</td>
<td>Referral Source</td>
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<tr>
<td>g.</td>
<td>Referral Reason</td>
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<tr>
<td>h.</td>
<td>Care Plan Documented</td>
<td></td>
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</tr>
<tr>
<td>i.</td>
<td>Diagnosis Noted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j.</td>
<td>Problem(s) / Issues Identified</td>
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<tr>
<td>k.</td>
<td>Goal(s) Identified</td>
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<td></td>
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<tr>
<td>l.</td>
<td>Interventions Documented or Noted</td>
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<tr>
<td>m.</td>
<td>Care Plan Sent to PCP</td>
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<tr>
<td>n.</td>
<td>Communication w/ Member Documented</td>
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</tbody>
</table>

Total Score: 0 0

#DIV/0!
## Comments/Audit Findings

<table>
<thead>
<tr>
<th>File#1:</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>File#2:</th>
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</table>

<table>
<thead>
<tr>
<th>File#3:</th>
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<table>
<thead>
<tr>
<th>File#4:</th>
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</table>

<table>
<thead>
<tr>
<th>File#5:</th>
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</table>
IPA Delegation Agreement – Medi-Cal

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) California Children’s Services, (vi) Credentialing and Recredentialing, (vii) Encounter Data, (viii) Claims Adjudication, (ix) and 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. IPA agrees to be accountable for all responsibilities delegated by IEHP and oversight of any sub-delegated activities, except as outlined in the Delegation Agreement. IPA 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) no later than the due date specified. The IPA will provide notice of report submission via email to Provider Services designated contacts. IEHP will oversee the IPA by performing annual audits. In the event deficiencies are identified through this oversight, IPA will provide a specific corrective action plan acceptable to IEHP. If IPA 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. The IPA 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:

1. 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.
2. 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.
3. The IPA has a description of the safeguarding the protected health information from inappropriate use or further disclosure.
4. The IPA has a written description stipulating that the delegate will ensure that sub-delegates have similar safeguards when applicable.
5. The IPA has a written description stipulating that the delegate will provide individuals with access to their protected health information. The IPA will have procedures to receive, analyze and resolve members’ requests for access to their PHI.
6. The IPA will ensure that its organization will inform the organization if inappropriate uses of information occur. The IPA will have procedures to identify and report unauthorized access, use, disclosure, modification or destruction of PHI and the systems used to access or store PHI.
7. 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>Frequency</th>
<th>Submission Deadline</th>
<th>Point of Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Management and Improvement</td>
<td>Annual QM Program Description</td>
<td>Annually</td>
<td>Feb 28</td>
<td>SFTP Server</td>
</tr>
<tr>
<td></td>
<td>Annual GQ P4P Quality Workplan</td>
<td></td>
<td>As designated by P4P Program</td>
<td></td>
</tr>
<tr>
<td>Utilization Management</td>
<td>Monthly Referral Tracking Log</td>
<td>Monthly</td>
<td>15th of each month</td>
<td>SFTP Server</td>
</tr>
<tr>
<td></td>
<td>Monthly Denial Files</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Monthly Second Opinion Log</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Monthly Approval File Review</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Semi Annual UM Program Evaluation / ICE Report</td>
<td>Bi-annually</td>
<td>Aug 15 and Feb 15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Semi Annual UM Work Plan Update</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual UM Program Description</td>
<td>Annually</td>
<td>Feb 28</td>
<td>SFTP Server</td>
</tr>
<tr>
<td></td>
<td>Annual UM Program Evaluation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual UM Workplan / Initial / ICE Report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Management</td>
<td>Monthly CM Log</td>
<td>Monthly</td>
<td>15th of each month</td>
<td>SFTP Server</td>
</tr>
<tr>
<td></td>
<td>Monthly California Children’s Services (CCS) Log</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Monthly CM File Review</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|                                                | Quarterly CCS File Review                                            | Quarterly | May 15
August 15
November 15
February 15 | SFTP Server         |
| Encounter Data                                 | 5010 / Encounters                                                     | Monthly   | Varies within the first days of the month. Refer to Attachment 13 – Delegated IPA Reporting Requirements Schedule – Medi-Cal for details.|

* MUST PASS Element
# REQUIRED REPORTING ELEMENTS

<table>
<thead>
<tr>
<th>Department</th>
<th>Required Documentation/Materials</th>
<th>Frequency</th>
<th>Submission Deadline</th>
<th>Point of Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credentialing and Recredentialing</td>
<td>Written and approved Credentialing, Recredentialing, Peer Review policies and Procedures</td>
<td>As Required</td>
<td>Within 30 days of the Credentialing Committee approval or prior to onsite and/or desktop DOA audit</td>
<td>SFTP server followed by an Email to <a href="mailto:CredentialingProfileSubmission@iehp.org">CredentialingProfileSubmission@iehp.org</a></td>
</tr>
<tr>
<td></td>
<td>Initial credentialing applications for approved providers must be submitted to IEHP by submitting a current profile, contract (1st and signature pages and any applicable addendums) and W-9</td>
<td></td>
<td>After Credentialing approval</td>
<td></td>
</tr>
<tr>
<td></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></td>
<td>By the 15th of the following month, after Committee approval</td>
<td></td>
</tr>
<tr>
<td>Credentialing and Recredentialing</td>
<td>Monthly Credentialing and Recredentialing Report</td>
<td>Monthly</td>
<td>15th of each month</td>
<td>SFTP server followed by an Email to <a href="mailto:CredentialingProfileSubmission@iehp.org">CredentialingProfileSubmission@iehp.org</a></td>
</tr>
<tr>
<td>Claims</td>
<td>Monthly Claims Timeliness Report</td>
<td>Monthly</td>
<td>15th of each month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monthly Claims &amp; PDR Detail Reports</td>
<td>Monthly</td>
<td>15th of each month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quarterly Claims and Provider Payment Dispute Resolution</td>
<td>Quarterly</td>
<td>April 30 May 31 July 31 October 31 January 31</td>
<td>SFTP Server</td>
</tr>
<tr>
<td></td>
<td>Quarterly Statement of Deficiencies Report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims</td>
<td>Annual Claims Payment and Provider Dispute Report</td>
<td>Annually</td>
<td>November 30</td>
<td>SFTP Server</td>
</tr>
</tbody>
</table>

* MUST PASS Element
| | Organizational Informational Disclosures | | Aug 15
| | Annual Audited Financial Statements, Including IBNR Certification Financial Statements, Including IBNR Certification | Annually | Nov 15
| | | | Feb 15
| Compliance | Annual Compliance Plan Program Description | Annually | As required for DOA
| | Annual Fraud Waste and Abuse (FWA) Program Description | | SFTP Server
| | Annual HIPAA Program Description | | SFTP Server
| | Annual Audit Plan | | 
| | Annual Risk Assessment | | 

**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</th>
<th>Corrective Actions if Delegate Fails to Meet Responsibilities</th>
</tr>
</thead>
</table>

* MUST PASS Element
<table>
<thead>
<tr>
<th>Quality Improvement Program Structure (NCQA QI1, Elements A, B, C and D)</th>
<th>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</th>
<th>The IPA has the QI infrastructure necessary to improve the quality and safety of clinical care and services it provides to its members 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</th>
<th>Delegates Performance</th>
<th>IPA is not delegated for this function, however IEHP will review the IPA’s Policies and Procedures. Semi-Annually and Annually as part of the DOA</th>
<th>See Corrective Action Plan (CAP) Requirements in MC_25.</th>
</tr>
</thead>
</table>

* MUST PASS Element
(NCQA QI1, Elements A, B, C and D (continued))

materials and communications.
c. Improve network adequacy to meet the needs of underserved groups.

B. Improve other areas of needs the organization deems appropriate. 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.

<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>
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</table>

* MUST PASS Element
<table>
<thead>
<tr>
<th>Quality Improvement Program Structure (NCQA QI, Elements A, B, C and D) (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual</td>
</tr>
<tr>
<td>C. The organization conducts an annual written evaluation of the QI program that includes the following information:</td>
</tr>
<tr>
<td>1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.</td>
</tr>
<tr>
<td>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:</td>
</tr>
<tr>
<td>a. Adequacy of QI program resources.</td>
</tr>
<tr>
<td>b. QI Committee structure.</td>
</tr>
<tr>
<td>c. Practitioner participation and leadership involvement in the QI program.</td>
</tr>
<tr>
<td>d. Need to restructure or change the QI</td>
</tr>
<tr>
<td>Semi-Annual and Annual</td>
</tr>
<tr>
<td>IPA is not delegated for this function, however IEHP will review the IPA’s program description, work plan and policies and procedures Semi-Annually and Annually.</td>
</tr>
<tr>
<td>Additional review of committee meetings as part of the DOA.</td>
</tr>
</tbody>
</table>

* MUST PASS Element
(NCQA QI1, Elements A, B, C and D (continued))

<table>
<thead>
<tr>
<th>Delegated Activity</th>
<th>IEHP Responsibilities</th>
<th>Delegate Responsibilities</th>
<th>Process for Evaluating Delegates Performance</th>
<th>Corrective Actions if Delegate Fails to Meet Responsibilities</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Frequency of Reporting</td>
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</table>

D. QI Committee Responsibilities:
1. Recommends policy decisions
2. Analyzes and evaluates the results of QI activities
3. Ensures practitioner participation in the QI program through planning, design, implementation or review.
4. Identifies needed actions.
5. Ensures follow-up, as appropriate.

IEHP will review the IPA’s program description, work plan and policies and procedures Semi-Annually and Annually.

Additional review of committee meetings as part of the DOA.

IEHP will review the IPA’s program for the subsequent year.

* MUST PASS Element
| Quality Improvement Program Operations (NCQA MED8 Element D) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | The organization annually makes information about its QI program available to members. | Semi-Annual and Annual | IPA is not delegated for this function, however IEHP will review the IPA’s policies and procedures. Semi-Annually and Annually as part of the DOA | See Corrective Action Plan (CAP) Requirements in MC_25 A4. |

* MUST PASS Element
## ATTACHMENT II: DELINEATION OF CONTINUITY AND COORDINATION OF CARE

<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>Continuity and Coordination of Medical Care and Continued Access to Care (NCQA 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 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</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 MC_25A4.</td>
</tr>
</tbody>
</table>
### ATTACHMENT II: DELINEATION OF CONTINUITY AND COORDINATION OF CARE

<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>Continuity and Coordination of Medical Care and Continued Access to Care (NCQA Q13 Element D and NET4 Elements A and B (continued))</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>2. Continuation of care through the postpartum period for 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 MC_25A4.</td>
</tr>
</tbody>
</table>
## ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

<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>Utilization Management Structure (NCQA UM1 Elements A and B)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>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.</td>
<td>Semi Annual and Annually.</td>
<td>Annual audit of IPA policies and procedures, workplan, program, and committee meetings</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25A4.</td>
</tr>
</tbody>
</table>

A. The IPA UM program description includes the following:

1. A written description of the program structure:
   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 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.
**ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT**

<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>
</table>
| Utilization Management Structure (NCQA UM1 Elements A and B (continued)) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | 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  

B. The IPA annually evaluates and updates the UM program, as necessary.  
C. Must meet applicable IEHP Standards and are consistent with NCQA, State and Federal health care regulatory agencies standards.
## ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

<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>
</table>
| Clinical Criteria for UM Decisions (NCQA UM2 Elements A and C) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | The IPA applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services.  
A. The IPA:  
1. Has written UM decision-making criteria that are objective and based on medical evidence.  
2. Has written policies for applying the criteria based on individual needs; considers at least the following individual characteristics when applying criteria:  
   a. Age.  
   b. Comorbidities.  
   c. Complications.  
   e. Psychosocial situation.  
   f. Home environment, when applicable. | Monthly UM Logs | Annual audit of IPA policies and procedures, workplan, program, and committee meetings.  

* MUST PASS Element
### ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

<table>
<thead>
<tr>
<th>Delegated Activity</th>
<th>IEHP Responsibilities</th>
<th>Delegate Responsibilities</th>
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<th>Corrective Actions if Delegate Fails to Meet Responsibilities</th>
</tr>
</thead>
</table>
| Clinical Criteria for UM Decisions (NCQA UM2 Elements A, B, and C (continued)) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | 3. Has written policies for applying the criteria based on an assessment of the local delivery system.  
4. Involves appropriate practitioners in developing, adopting and reviewing criteria.  
5. Annually reviews the UM criteria and the procedures for applying them and updates the criteria when appropriate. | Monthly UM Logs | Annual audit of IPA policies and procedures, workplan, program, and committee meetings. | See Corrective Action Plan (CAP) Requirements in MC_25A4. |
| 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 public 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. | | | | | |
| 2. Acts on opportunities to improve consistency, if applicable. | | | | | |
### ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

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<tbody>
<tr>
<td>Communication Services (NCQA UM3 Element A)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Members and practitioners can access staff to discuss UM issues.</td>
<td>N/A</td>
<td>Annual audit of IPA policies and procedures and Annual Appointment Availability and Access Study Survey</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25A4.</td>
</tr>
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<td></td>
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<td>A. The IPA provides the following communication services for members and practitioners:</td>
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<td></td>
<td>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.</td>
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<td>2. Staff can receive inbound communication regarding UM issues after normal business hours.</td>
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<td></td>
<td></td>
<td>a. Telephone</td>
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<td>b. Email</td>
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<td>c. Fax</td>
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<td>3. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.</td>
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<td>4. TDD/TTY services for Members who need them.</td>
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<td>5. The IPA refers Members to IEHP who need language assistance for Members to discuss UM issues.</td>
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</table>

* MUST PASS Element
| Appropriate Professionals (NCQA UM4 Elements A, B, C* and F, MED9 Element D) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | 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 clinical license to practice or an administrative license to review UM cases. **C.** The IPA uses a physician or other health care professional, as appropriate, to review any nonbehavioral health denial based on medical necessity*. **F.** Use of 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. | Monthly UM Logs | 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. | See Corrective Action Plan (CAP) Requirements in MC_25A4. |

* MUST PASS Element

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<td>consultants for medical necessity determinations.</td>
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<tr>
<td>Appropriate Professionals (NCQA UM4 Elements A, B, C* and F, MED9 Element D (continued))</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>D. The IPA distributes a statement to all Members and to all practitioners, providers and employees who make 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 practitioners or other individuals for issuing denials of coverage or care. 3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.</td>
<td>Monthly UM Logs</td>
<td>[Grab your reader’s attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.]</td>
<td>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.</td>
</tr>
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</table>

* MUST PASS Element
| Timeliness and Notification of UM Decisions (NCQA UM5 Element A*) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | 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 of non-behavioral healthcare UM decisions*: 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 gives electronic or written notification of the decision to Practitioners and Members within seventy-two (72) hours of the request. 3. Non-Urgent Pre-Service Decisions: The IPA gives electronic or written notification of the decision to Practitioners and Members within fourteen (14) calendar days 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 | **Monthly** | **Monthly** | **See Corrective Action Plan (CAP) Requirements in MC_25 A4.** |
| --- | --- | --- | **Annual audit of IPA policies and procedures, workplan, program, and committee meetings.** | **Monthly log and focused denial and approval file selection review.** |
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| Clinical Information (NCQA UM6 Element A) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | 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. | Monthly | Annual audit of IPA policies and procedures, workplan, program, and committee meetings.  
| 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. | Monthly | Annual audit of IPA policies and procedures, workplan, program, and committee meetings.  

* MUST PASS Element
| Denial Notices (NCQA UM7 Elements A, B* and C* (continued)) | 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.  
Monthly log and focused denial file review.  
Annual audit of IPA policies and procedures, workplan, program, and committee meetings. |
| Denial Notices (NCQA UM7 Elements A, B* and C* (continued)) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | a. Includes a statement that members may be represented by anyone they choose, including an attorney.  
   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.  
4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care. | Monthly | Monthly log and focused denial file review. |
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<tr>
<td>UM System Controls (NCQA UM12 Element A*)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via</td>
<td>The IPA has policies and procedures describing its system controls specific to UM denial notification dates that*:</td>
<td>Annually, at minimum</td>
<td>Annual audit of Delegate’s policies and procedures</td>
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<td>2. Define the date of written notification consistent with NCQA requirements.</td>
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<td>3. Describe the process for recording dates in systems.</td>
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<td>4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate.</td>
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<td>5. Specify how the system tracks modified dates.</td>
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<td>6. Describe system security controls in place to protect data from unauthorized modification.</td>
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<td>7. Describe how the organization audits the processes and procedures in factors 1-6.</td>
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| Second Opinions AB 12 | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | 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 health 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 | Monthly review of second opinion logs and annual audit of IPA policies and procedures | See Corrective Action Plan (CAP) Requirements in MC_25 A4. |
### ATTACHMENT IV: DELINEATION OF CARE MANAGEMENT

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### ATTACHMENT V: DELINEATION OF CALIFORNIA CHILDREN’S SERVICES (CCS)

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<tbody>
<tr>
<td>CCS 1: California Children’s Services (CCS)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. IEHP will also provide a monthly CCS aging report</td>
<td>IPA’s must maintain a log for new CCS referrals made by the IPA for Medi-Cal Members that includes the following: 1. Member Name (First, Last) &amp; ID# 2. DOB 3. County 4. Date Identified 5. Date of CCS referral 6. CCS eligible diagnosis</td>
<td>Monthly</td>
<td>Annual audit of IPA policies and procedures. Monthly CCS log review.</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25 A4.</td>
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* MUST PASS Element

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# ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECredentialing

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<td></td>
<td></td>
<td>1. The types of practitioners it credentials and recredits.</td>
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<td>2. The verification sources it uses.</td>
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<td>3. The criteria for credentialing and recredentialing.</td>
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<td>4. The process for making credentialing and recredentialing decisions.</td>
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<td>5. The process for managing credentialing files that meet the organization’s established criteria.</td>
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<td>6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.</td>
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<td>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.</td>
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<tr>
<td>Practitioner Credentialing Guidelines (NCQA CR1 Element A)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>8. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the credentialing committee’s decision. 9. The Medical Director or other designated physician’s direct responsibility and participation in the credentialing program. 10. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. 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>
<td>Annually, at minimum</td>
<td>Annual audit of Delegate’s policies and procedures</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25 A4.</td>
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<tr>
<td>Provider Credentialing/Recredentialing and Screening/Enrollment (DHCS All Plan Letter (APL) 19-004 supersedes APL 17-019, “Provider Credentialing/Recredentialing and Screening/Enrollment”.)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The process for ensuring all practitioners participating in Medi-Cal lines of business, are enrolled with Medi-Cal directly, prior to submitting to IEHP for addition to the IEHP Medi-Cal network.</td>
<td>Ongoing</td>
<td>Upon review of the Provider submission package by the Delegate, IEHP will screen the provider to ensure the provider is currently enrolled with Medi-Cal directly.</td>
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<tr>
<td>Practitioner Rights (NCQA CR1 Element B)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>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.</td>
<td>Annually, at minimum</td>
<td>Audit of Delegate’s policies and procedures</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25 A4.</td>
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<td>1. How primary source verification information is received, dated and stored.</td>
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<td>2. How modified information is tracked and dated from its initial verification.</td>
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<td>3. Staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate.</td>
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<td>4. The security controls in place to protect the information from unauthorized modification.</td>
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<td>5. How the organization audits the processes and procedures in factors 1-4.</td>
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| CMS/DHCS Performance Monitoring for Recredentialing  
(Medicare Managed Care Manual, Chapter 6 § 60.3; DHCS All Plan Letter (APL) 19-004 and Exhibit A, Attachment 4 of Plan Contract) | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. | Delegate’s recredentialing policies and procedures require 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) | Annually, at minimum | Audit of Delegate’s policies and procedures | See Corrective Action Plan (CAP) Requirements in MC_25 A4. |
| CMS/DHCS Medicare Exclusions/Sanctions  
(Medicare Managed Care Manual, Chapter 6 § 60.2; DHCS All Plan Letter (APL) 19-004) | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual | 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). | Annually, at minimum | Audit of Delegate’s policies and procedures | See Corrective Action Plan (CAP) Requirements in MC_25 A4. |
## ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECredentialing

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| Credentialing Committee (NCQA CR2 Element A) | 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.  
    a. Reviews the credentials of practitioners who do not meet the organization’s criteria for participation in the network.  
    b. Gives thoughtful consideration to credentialing information.  
    c. Documents discussions about credentialing in meeting minutes.  
  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 MC_25 A4. |
## ATTACHMENT VI: DELINEATION OF CREDENTIALING and REREDENTIALING

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| Verification of Credentials (NCQA CR3 Element A*)   | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.                                                                                                                  | A. 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 MC_25 A4.                                                               |
### ATTACHMENT VI: DELINEATION OF CREDENTIALING and REcredentialing

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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>B. 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 MC_25 A4.</td>
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<tr>
<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>C. Delegate verifies that applications for credentialing include the following*:</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 MC_25 A4.</td>
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<td>1. Reasons for inability to perform the essential functions of the position.</td>
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<td>2. Lack of present illegal drug use.</td>
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<td>3. History of loss of license and felony convictions.</td>
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<td>4. History of loss or limitations of privileges or disciplinary actions.</td>
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<td>5. Current malpractice insurance coverage.</td>
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<td>6. Current and signed attestation confirming the correctness and completeness of the application.</td>
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<tr>
<td>Practitioner must have clinical privileges in good standing. CMS (Medicare Managed Care Manual, Chapter 6 § 60.3), DMHC (DMHC TAG 6/09/14), DHCS (All Plan Letter (APL) 17-019)</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 MC_25 A4.</td>
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<tr>
<td>CMS/DHCS Review of Performance Information (Medicare Managed Care Manual, Chapter 6 § 60.3; DHCS All Plan Letter (APL) 19-004)</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 MC_25 A4.</td>
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<tr>
<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 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 MC_25 A4.</td>
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### ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECredentialing

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<tr>
<td>Performance Standards and Thresholds (NCQA MED3 Element A)</td>
<td>IEHP sets site performance standards and thresholds for:</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>
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<td>1. Accessibility equipment.</td>
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<td>2. Physical accessibility.</td>
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<td>3. Physical appearance.</td>
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<td>4. Adequacy of waiting and examining room space.</td>
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<td>5. Adequacy of medical/treatment medical record keeping.</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.</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>
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| Site Visits and Ongoing Monitoring (NCQA MED3 Element B) | 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. | Delegate is responsible for ensuring the providers are compliant with IEHP Facility Site Review and Medical Record Audits. | Not Applicable         | Not Applicable                              | Not Applicable                                                  |
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| Ongoing Monitoring and Interventions (NCQA CR5 Element A) | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. | 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:  
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. | Annually, at minimum  
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. | IEHP reviews the organization’s policies and procedures, monitoring reports, and documentation of interventions | See Corrective Action Plan (CAP) Requirements in MC_25 A4. |

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<tr>
<td>DHCS– 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 organization’s policies and procedures, monitoring reports, and documentation of interventions</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25 A4.</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.</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25 A4.</td>
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<tr>
<td>Actions Against Practitioners (NCQA CR6 Element A)</td>
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| Review and Approval of Providers (NCQA CR7 Element A) | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. | 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.  
| Medical Providers (NCQA CR7 Element B) | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. | Delegate includes at least the following medical providers in its assessment:  
1. Hospitals.  
2. Home health agencies.  
3. Skilled nursing facilities.  
4. Free-standing surgical centers  
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<td>Assessing Medical Providers (NCQA CR7 Element D)</td>
<td>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 MC_25 A4.</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>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 Element A</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25 A4.</td>
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<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>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 Delegated entity. 3. Requires at least semiannual reporting of the Delegated entity to IEHP. 4. Describes the process by IEHP evaluates the Delegated entity’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</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 MC_25 A4.</td>
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<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>6. 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 MC_25 A4.</td>
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<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>Delegated entity 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 MC_25 A4.</td>
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<td>Pre-delegation Evaluation (NCQA CR8 Element B)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>For new delegation agreements initiated in the look-back period, IEHP evaluated delegate capacity to meet NCQA requirements before delegation began.</td>
<td>Annually, at minimum</td>
<td>IEHP reviews the delegates pre-delegation evaluation 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 MC_25 A4.</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 Delegates 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 MC_25 A4.</td>
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<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 MC_25 A4.</td>
</tr>
<tr>
<td>Identification of HIV/AIDS Specialists – Written Process (CA H&amp;SC §1374.16; DMHC TAG (QM-004). DHCS MMCD All-Plan Letter 01001)</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>IEHP reviews delegate policies and procedures</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25 A4.</td>
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<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 MC_25 A4.</td>
</tr>
<tr>
<td>Distribution of Findings</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider 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 MC_25 A4.</td>
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## ATTACHMENT VII: DELINEATION OF ENCOUNTER DATA

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| ENC 1: Encounter Data Reporting | 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. | Submit Encounter Data within ninety (90) days after each month of service | Initial Onsite Assessment  
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.
## ATTACHMENT VIII: DELINEATION OF CLAIMS ADJUDICATION

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<td>AB1455: Claims Payment Performance and Dispute Resolution Mechanism</td>
<td>IEHP monitors the performance of the delegate in between audits through monthly and quarterly reporting. IEHP assesses compliance with regulatory and contractual requirements and performs comparative analysis and trends for possible indicators of potential or emerging patterns of unfair payment practices or inability to perform delegated functions.</td>
<td>The Delegate must accurately process claims and resolve disputes within contracted and regulatory timeframes as established by IEHP.</td>
<td>▪ Provide a copy of the Monthly Timeliness Report (MTR) by the 15th of each month&lt;br&gt;▪ Provide a copy of the Monthly Claims and Disputes Detailed Report by the 15th of each month&lt;br&gt;▪ Provide a copy of the Quarterly Provider Dispute Resolution (PDR) Report and Statement of Deficiencies Report by the 30th of the month following the end of the quarter&lt;br&gt;▪ Provide a copy of the Annual Claims Payment and Provider</td>
<td>Please refer to MC_20G.</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_20D.</td>
</tr>
</tbody>
</table>
## ATTACHMENT VIII: DELINEATION OF CLAIMS ADJUDICATION

<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></td>
<td></td>
<td></td>
<td></td>
<td>Dispute Mechanism Report (Annual Report) by November 30th of each year</td>
<td></td>
</tr>
</tbody>
</table>

* MUST PASS Element
<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>
</table>

* 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 MC_25 A4. |
<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></td>
<td>of such problems promptly and thoroughly.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delegated Activity</td>
<td>IEHP Responsibilities</td>
<td>Delegate Responsibilities</td>
<td>Frequency of Reporting</td>
<td>Process for Evaluating Delegates Performance</td>
<td>Corrective Actions if Delegate Fails to Meet Responsibilities</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>---------------------------------------------</td>
<td>--------------------------------------------------------------</td>
</tr>
<tr>
<td>Fraud, Waste and Abuse Program (CMS Managed Care Manual Ch. 21 and DHCS Two Plan Contract Exhibit E, Attachment 2)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>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:   A. Provider grievances   B. Claims activity   C. Financial Statements   D. Utilization management monitoring   E. Chart audits   F. Clinical Audits   G. Internal auditing and monitoring process   H. 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.</td>
<td>Precontractual Assessment and Annually as part of the DOA</td>
<td>Initial Onsite Assessment Annual DOA</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25 A4.</td>
</tr>
</tbody>
</table>

ATTACHMENT IX: DELINEATION OF FRAUD, WASTE, AND ABUSE / HIPAA

* MUST PASS Element
<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></td>
<td></td>
<td>A. Uses and disclosures of PHI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>B. Member access to PHI and amendment/restriction process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>C. Auditing/Monitoring of Business Associates, Downstream/Subcontracted and Related Entities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>D. Security of Facilities and Information Systems</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>E. Record Retention</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>F. Non-retaliation for exercising rights provided by the Privacy Rule.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>G. Reporting incidents of HIPAA non-compliance to IEHP</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>A privacy officer has been designated by the IPA.</td>
<td></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>
<td></td>
<td></td>
</tr>
<tr>
<td>IPA NAME:</td>
<td>IPA CODE:</td>
<td>00A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>FUNCTIONAL AREA</th>
<th>Pts Poss</th>
<th>Raw Score</th>
<th>Pts Score</th>
<th>IEHP Expectation</th>
<th>IEHP Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLAIMS</strong></td>
<td></td>
<td></td>
<td></td>
<td>Total possible points: 20</td>
<td></td>
</tr>
<tr>
<td>1 Claims Audit – 01/20 - 12/20 (9 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A</strong> Audit Type:</td>
<td>Audit Date:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of ICARs and CARs. (If an Annual Audit and Verification Audit are performed in the same year, only the Annual Audit Score will apply.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Audits: No ICARs or CARs received</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>All Verification Audits must pass.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Were all Claims Universes submitted timely, accurately and completed in their entirety?</td>
<td></td>
<td></td>
<td></td>
<td>Provides complete and accurate Claims Universe by due date</td>
<td>YES=1; NO=0</td>
</tr>
<tr>
<td>C Were all Claims Audit documents submitted timely, accurately and completed in their entirety?</td>
<td></td>
<td></td>
<td></td>
<td>Provides complete and accurate Audit Documents by due date</td>
<td>YES=1; NO=0</td>
</tr>
<tr>
<td>D If IPA was required to submit a CAP resulting from the Annual Audit, was it accepted on the first submission? For Verification Audits, was the CAP implemented?</td>
<td></td>
<td></td>
<td></td>
<td>Annual Audits: CAP is accepted upon first submission. Verification Audit: CAP is implemented.</td>
<td>0-1 CAP=1 &gt;1 CAP=0</td>
</tr>
<tr>
<td>E Were CAPs submitted timely for the Annual Audit?</td>
<td></td>
<td></td>
<td></td>
<td>Provides CAP by due date</td>
<td>YES=1; NO=0</td>
</tr>
<tr>
<td>F Was a Focused Audit performed at any time during the year?</td>
<td></td>
<td></td>
<td></td>
<td>No Focused Audit required during timeframe</td>
<td>NO=1; YES=0</td>
</tr>
<tr>
<td>2 Claims Reports – 01/20 - 12/20 (5 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A How many months were the MTRs submitted timely, accurately and completed in their entirety?</td>
<td></td>
<td></td>
<td></td>
<td>Complete and Accurate reports submitted by the 15th of each month</td>
<td>10-12 Months=2; 7-9 Months=1; Under 7 Months=0</td>
</tr>
<tr>
<td>B Were all quarterly reports and the annual report submitted timely, accurately and completed in their entirety?</td>
<td></td>
<td></td>
<td></td>
<td>Complete and Accurate reports are submitted by the last day of the month following end of QTR.</td>
<td>YES=1; NO=0</td>
</tr>
<tr>
<td>C How many extensions were granted over the year?</td>
<td></td>
<td></td>
<td></td>
<td>Extensions are requested before the reporting deadline, for extenuating circumstances only</td>
<td>0-3 Extensions=1; 4 or more Extensions=0</td>
</tr>
<tr>
<td>D Did the IPA report whether or not they had any deficiencies through out the year?</td>
<td></td>
<td></td>
<td></td>
<td>The IPA must report even if they had no deficiencies</td>
<td>YES=1; NO=0</td>
</tr>
<tr>
<td>3 Claims Appeals – 01/20 - 12/20 (4 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Did the IPA have any appealed claims?</td>
<td></td>
<td></td>
<td></td>
<td>No appealed claims; if appealed claims proceed to 3B.</td>
<td>0 appeals=4; Go to Question 4; Appealed claims=Go to Question 3B</td>
</tr>
<tr>
<td>B If Provider had appealed claims:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a What percentage of IPA claims did the IPA fail to respond to IEHP's written request for claims payment or denial information which lead to IEHP having to pay the claim and deduct from the IPA's capitation?</td>
<td></td>
<td></td>
<td></td>
<td>Score is equal or less than 24%</td>
<td>100%-75% =0; 74%-50%=1; 49%-25%=2; &lt;25%=3</td>
</tr>
<tr>
<td>b What percentage of all IPA denials were overturned and paid by IEHP?</td>
<td></td>
<td></td>
<td></td>
<td>Score less than or equal to 10%</td>
<td>0-10%=1; &gt;10%=0</td>
</tr>
<tr>
<td>FUNCTIONAL AREA</td>
<td>Pts Poss</td>
<td>Raw Score</td>
<td>Pts Score</td>
<td>IEHP Expectation</td>
<td>IEHP Scoring</td>
</tr>
<tr>
<td>-----------------</td>
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<td>-----------</td>
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<td>------------------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>II</strong></td>
<td>11</td>
<td>Total possible points:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COMMUNICATION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Communication of PCP Changes – 01/20 - 12/20 (4 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Does IPA communicate changes in its PCP network in a timely manner and include required information as stated in policy 18.C?</td>
<td>4</td>
<td>Provides 60-day advance notification for all changes</td>
<td>100%-75%=4; 74%-50%=2; &lt;50%=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Bi-annual Review of Specialty and Ancillary Network - 01/20 - 12/20 (4 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Does IPA complete the online Specialist and Ancillary network on a bi-annual basis in timely, complete manner and including all required information as stated in policy 18.F?</td>
<td>4</td>
<td>Verified network review completed by due date specified in bi-annual request</td>
<td>100%-75%=4; 74%-50%=2; &lt;50%=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Monthly Review of Admitter/Hospitalist Report - 01/20 - 12/20 (3 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Does the IPA respond to Admitter/Hospitalist monthly review emails within 10 days of receipt with corrections or confirmation that information is current and accurate?</td>
<td>3</td>
<td>IPA Admitter/Hospitalist report is emailed to designated contact on the 15th day of each month. Corrections and/or confirmation is received by IEHP within 10 days of receipt.</td>
<td>100-80%=3; 79-50%=1; &lt;50%=0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CLAIMS POINTS SCORED:** 16
## ENCOUNTDER DATA

<table>
<thead>
<tr>
<th>FUNCTIONAL AREA</th>
<th>Pts</th>
<th>Raw Score</th>
<th>Pts</th>
<th>IEHP Expectation</th>
<th>IEHP Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Data Submission – 2020 (8 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Are IPA submissions meeting IEHP validity requirements?</td>
<td>4</td>
<td>100%-97%=4 96%-75%=3; 74%-50%=1; &lt;50%=0</td>
<td>See standards outlined in Policy 21A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Are IPA submissions meeting IEHP adequacy requirements?</td>
<td>4</td>
<td>100%-97%=4 96%-75%=3; 74%-50%=1; &lt;50%=0</td>
<td>See standards outlined in Policy 21A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ENCOUNTER DATA POINTS SCORED:** 8

## FINANCE

<table>
<thead>
<tr>
<th>FUNCTIONAL AREA</th>
<th>Pts</th>
<th>Raw Score</th>
<th>Pts</th>
<th>IEHP Expectation</th>
<th>IEHP Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Viability – Calendar Year 2020 Submissions (10 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Does the IPA submit their quarterly financial reports within the required timeframe?</td>
<td>1</td>
<td>Reports submitted to IEHP by the 15th of the month due</td>
<td>100%=1; &lt;100%=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Did the IPA always pass IEHP's quarterly financial viability test the first time?</td>
<td>1</td>
<td>Passed quarterly financial viability test each quarter; no corrective action needed</td>
<td>PASS=1, FAIL=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Did the IPA pass DMHC’s quarterly financial viability test each quarter?</td>
<td>2</td>
<td>Passed quarterly financial viability test each quarter; no corrective action needed</td>
<td>PASS=2, FAIL=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D Did the IPA submit the current Audited Annual Financial Statement within the required timeframe?</td>
<td>2</td>
<td>Provided as requested by IEHP</td>
<td>YES=2; NO=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Did the IPA pass the Audited Annual Financial Viability Test?</td>
<td>2</td>
<td>Passed quarterly financial viability test each quarter; no corrective action needed</td>
<td>PASS=2, FAIL=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F Did the IPA secure the required Letter of Credit (LOC)?</td>
<td>2</td>
<td>Provided as requested by IEHP</td>
<td>YES=2; NO=0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FINANCE POINTS SCORED:** 10
<table>
<thead>
<tr>
<th>FUNCTIONAL AREA</th>
<th>Pts</th>
<th>Raw</th>
<th>Pts</th>
<th>IEHP Expectation</th>
<th>IEHP Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>V  GRIEVANCES</strong></td>
<td></td>
<td></td>
<td></td>
<td>Total possible points: 6</td>
<td></td>
</tr>
<tr>
<td>1 Member Grievances (Rec’d by IPA) – 01/20 - 12/20 (3 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>1. Grievances responses received timely from the IPA?</td>
<td></td>
<td></td>
<td>1. Timeliness/Grievance Response; ≥90% received within 14 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. CAP Issued?</td>
<td></td>
<td></td>
<td>2. Corrective action plan (CAP) was not issued during the 2020 reporting period</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>1. Timeliness/Grievance Response at ≥90%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Corrective Action Plan (CAP) issued: 0 per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0 point – 1. Timeliness/Grievance Response at ≤79% 2. CAPs issued: ≥2 per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Member Appeals : 01/20 - 12/20 (3 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.</td>
<td></td>
<td></td>
<td>3 points – 1. ≤10 Appeals reported; with 0 CAPS issued (OT rate is null) and/or; 2. ≥11 Appeals reported with 0 CAPS, Annual overturn rate ≤25%</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>2. OT Appeals</td>
<td></td>
<td></td>
<td>1. ≥12 Appeals reported</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. CAP issued</td>
<td></td>
<td></td>
<td>2. OT appeals at ≤26% - 35% annual rate 3. ≤1 CAP issued per calendar year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>0 points – 1. ≥11 Appeals reported 2. ≥36% OT appeal annual rate 3. ≥2 or more CAPs issued per calendar year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**GRIEVANCES POINTS SCORED:** 6
<table>
<thead>
<tr>
<th>FUNCTIONAL AREA</th>
<th>Pts Poss</th>
<th>Raw Score</th>
<th>Pts Score</th>
<th>IEHP Expectation</th>
<th>IEHP Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>VI DELEGATION OVERSIGHT AUDIT RESULTS -2020</td>
<td></td>
<td></td>
<td></td>
<td>Total possible points: 13</td>
<td></td>
</tr>
<tr>
<td>1 Quality Management (1 points)</td>
<td></td>
<td></td>
<td></td>
<td>Must score a minimum of 90% to pass audit. Score based upon initial audit score</td>
<td></td>
</tr>
<tr>
<td>A Delegation Oversight Audit score:</td>
<td>1</td>
<td></td>
<td></td>
<td>100-90%=1; &lt; 90%=0</td>
<td></td>
</tr>
<tr>
<td>2 Utilization Management (1 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Delegation Oversight Audit score:</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Credentialing (1 points)</td>
<td></td>
<td></td>
<td></td>
<td>Must score a minimum of 90% to pass audit. Score based upon initial audit score</td>
<td></td>
</tr>
<tr>
<td>A Delegation Oversight Audit score:</td>
<td>1</td>
<td></td>
<td></td>
<td>100-90%=1; &lt; 90%=0</td>
<td></td>
</tr>
<tr>
<td>4 Credential File Review (2 points)</td>
<td></td>
<td></td>
<td></td>
<td>Must score a minimum of 90% to pass audit. Score based upon initial audit score</td>
<td></td>
</tr>
<tr>
<td>A Delegation Oversight Audit score:</td>
<td>2</td>
<td></td>
<td></td>
<td>100-96%=2; 95-80%=1; &lt; 80%=0</td>
<td></td>
</tr>
<tr>
<td>5 Recredential File Review (2 points)</td>
<td></td>
<td></td>
<td></td>
<td>Must score a minimum of 90% to pass audit. Score based upon initial audit score</td>
<td></td>
</tr>
<tr>
<td>A Delegation Oversight Audit score:</td>
<td>2</td>
<td></td>
<td></td>
<td>100-96%=2; 95-80%=1; &lt; 80%=0</td>
<td></td>
</tr>
<tr>
<td>6 HDO File Review (2 points)</td>
<td></td>
<td></td>
<td></td>
<td>Must score a minimum of 90% to pass audit. Score based upon initial audit score</td>
<td></td>
</tr>
<tr>
<td>A Delegation Oversight Audit score:</td>
<td>2</td>
<td></td>
<td></td>
<td>100-96%=2; 95-80%=1; &lt; 80%=0</td>
<td></td>
</tr>
<tr>
<td>7 Care Management (1 Points)</td>
<td></td>
<td></td>
<td></td>
<td>Must score a minimum of 90% to pass audit. Score based upon initial audit score</td>
<td></td>
</tr>
<tr>
<td>A Delegation Oversight Audit Score:</td>
<td>1</td>
<td></td>
<td></td>
<td>100-90%=1; &lt; 90%=0</td>
<td></td>
</tr>
<tr>
<td>8 Compliance (1 Points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Delegation Oversight Audit Score:</td>
<td>1</td>
<td></td>
<td></td>
<td>100-90%=1; &lt; 90%=0</td>
<td></td>
</tr>
<tr>
<td>9 Tool Roadmapped (1 Points)</td>
<td></td>
<td></td>
<td></td>
<td>Entire DOA Tool needs to be completed</td>
<td></td>
</tr>
<tr>
<td>A DOA Tool Completely Roadmapped and available at time of the IPAs Audit</td>
<td>1</td>
<td></td>
<td></td>
<td>Complete Tool=1; Incomplete/None=0</td>
<td></td>
</tr>
<tr>
<td>10 Documents Submitted Timely (1 Points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Was all DOA document request submitted timely, accurately and completed in their entirety?</td>
<td>1</td>
<td></td>
<td></td>
<td>All DOA documentation requests submitted by due date</td>
<td>YES=1; NO=0</td>
</tr>
</tbody>
</table>

DELEGATION OVERSIGHT AUDIT RESULTS PTS SCORED: 13
<table>
<thead>
<tr>
<th>FUNCTIONAL AREA</th>
<th>Pts Poss</th>
<th>Raw Score</th>
<th>Pts Score</th>
<th>IEHP Expectation</th>
<th>IEHP Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VII</strong> DELEGATE REPORTING AND MEMBER ACCESS AUDIT</td>
<td></td>
<td></td>
<td></td>
<td>Total possible points: 32</td>
<td></td>
</tr>
<tr>
<td>1 Monthly Reports – 01/20 - 12/20 (20 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Is the Delegate denial decision turnaround time compliant with guidelines?</td>
<td>4</td>
<td></td>
<td></td>
<td>Compliant with IEHP turn around timeframes 90% of the time.</td>
<td>100-90% = 4; 89-75% = 2; &lt; 75% = 0</td>
</tr>
<tr>
<td>B Does the Delegate utilize the correct denial letter templates?</td>
<td>4</td>
<td></td>
<td></td>
<td>Delegate utilizes IEHP approved denial letter templates with correct attachments.</td>
<td>100-90% = 4; 89-75% = 2; &lt; 75% = 0</td>
</tr>
<tr>
<td>C Is the Delegate compliant with all denial guidelines?</td>
<td>4</td>
<td></td>
<td></td>
<td>Complaint with IEHP overall Denial process 90% of the time.</td>
<td>100-90% = 4; 89-75% = 2; &lt; 75% = 0</td>
</tr>
<tr>
<td>D Is the Delegate compliant with all approval guidelines?</td>
<td>4</td>
<td></td>
<td></td>
<td>Complaint with IEHP overall approval process 80% of the time.</td>
<td>100-90% = 4; 89-75% = 2; &lt; 75% = 0</td>
</tr>
<tr>
<td>E Does Delegate submit monthly Care Management logs that are comprehensive and adhere to IEHP guidelines?</td>
<td>4</td>
<td></td>
<td></td>
<td>Reports adhere to IEHP policy 12.A.3. and reference all elements.</td>
<td>100-90% = 4; 89-75% = 2; &lt; 75% = 0</td>
</tr>
<tr>
<td>2 Reports - 01/20 - 12/20 (4 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Does the Delegate submit Monthly, Semi-Annual and Annual Reports that are timely, comprehensive and adhere to IEHP guidelines?</td>
<td>4</td>
<td></td>
<td></td>
<td>Received by IEHP: Monthly by 15th of every month, Semi Annual by August 15th (Jan 1- June 30) &amp; Annual by February 15th (July 1- Dec 31)</td>
<td>100-90% = 4; 89-75% = 2; &lt; 75% = 0</td>
</tr>
<tr>
<td>3 Member Access 01/20 - 12/20 (8 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A What percentage of Delegate's PCPs passed the Routine (visit within 10 days) appointment access audit?</td>
<td>2</td>
<td></td>
<td></td>
<td>Score is ≥ to 75%</td>
<td>100%-75%=2; 74%-50%=1; &lt;50%=0</td>
</tr>
<tr>
<td>B What percentage of Delegate's PCP passed the Urgent (visit within 48 hours) appointment availability audit?</td>
<td>2</td>
<td></td>
<td></td>
<td>Score is ≥ to 75%</td>
<td>100%-75%=2; 74%-50%=1; &lt;50%=0</td>
</tr>
<tr>
<td>C What percentage of Delegate's Specialist passed the Routine (visit within 15 days) appointment access audit?</td>
<td>2</td>
<td></td>
<td></td>
<td>Score is ≥ to 75%</td>
<td>100%-75%=2; 74%-50%=1; &lt;50%=0</td>
</tr>
<tr>
<td>D What percentage of Delegate's Specialist passed the Urgent (visit within 48 hours) appointment availability audit?</td>
<td>2</td>
<td></td>
<td></td>
<td>Score is ≥ to 75%</td>
<td>100%-75%=2; 74%-50%=1; &lt;50%=0</td>
</tr>
<tr>
<td><strong>SCORED:</strong></td>
<td>32</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCORING SUMMARY*</td>
<td>TOTAL POINTS SCORED</td>
<td>TOTAL POINTS POSSIBLE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------</td>
<td>-----------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I CLAIMS</td>
<td>0</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II COMMUNICATION</td>
<td>0</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III ENCOUNTER DATA</td>
<td>0</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV FINANCE</td>
<td>0</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V GRIEVANCES</td>
<td>0</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VI DELEGATION OVERSIGHT AUDIT RESULTS</td>
<td>0</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VII DELEGATE REPORTING AND MEMBER ACCESS AUDIT</td>
<td>0</td>
<td>32</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL POINTS</strong></td>
<td><strong>0</strong></td>
<td><strong>100</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**# CONTRACT YEARS AWARDED**

Providers achieving the following percentages:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Contract Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>95% or above</td>
<td>3 years</td>
</tr>
<tr>
<td>85% to 94.99%</td>
<td>2 years</td>
</tr>
<tr>
<td>80% to 84.99%</td>
<td>1 year</td>
</tr>
<tr>
<td>Less than 80%</td>
<td>Non-renewal</td>
</tr>
</tbody>
</table>

*Any functional area not reviewed in the PET timeframe will not be included as part of the total score*
<table>
<thead>
<tr>
<th>Member First Name</th>
<th>Member Last Name</th>
<th>IEHP Member ID #</th>
<th>DOB</th>
<th>Referral Source</th>
<th>Referral Reason</th>
<th>Case Status (Open or Closed)</th>
<th>Case Level (General or Complex)</th>
<th>Case Open Date (or Ref to waiver, CCS)</th>
<th>Community based services or BH</th>
<th>Individualized Care Plan Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>John</td>
<td>Doe</td>
<td>12345678910111</td>
<td>XX/XX/XXXX</td>
<td>SOURCE</td>
<td>REASON</td>
<td>OPEN / CLOSED</td>
<td>GENERAL / COMPLEX</td>
<td>XX/XX/XXXX</td>
<td>YES / NO</td>
<td></td>
</tr>
</tbody>
</table>

Identify the number of:
New Opened Cases:
Previously Opened Cases:
Total Cases reported for this month:
## Monthly Care Management Log

<table>
<thead>
<tr>
<th>Diagnosis (ICD Codes/Description)</th>
<th>Problems/Issues Identified</th>
<th>Goals Identified</th>
<th>Interventions Documented (ex. monthly follow up, transition in care)</th>
<th>Care Plan Sent to PCP Documented</th>
<th>Case Notes Documented</th>
<th>Communication w/Member Documented</th>
<th>Case Closure Date</th>
<th>Reason for Closure/Case Outcome Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD CODE</td>
<td>YES / NO</td>
<td>YES / NO</td>
<td>YES / NO</td>
<td>YES / NO</td>
<td>YES / NO</td>
<td>XX/XX/XXXX</td>
<td>YES / NO</td>
<td>YES / NO</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 newly identified California Children Services (CCS) cases referred to the County in the reporting month. Refer to the data dictionary for specifics on what each field should contain. 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>County</td>
<td>CHAR Always Required</td>
<td>50</td>
<td>County Member was referred to for CCS services- Riverside or San Bernardino only.</td>
</tr>
<tr>
<td>F</td>
<td>Date Identified</td>
<td>MM/DD/YYYY</td>
<td>10</td>
<td>Date CCS-eligible condition was identified.</td>
</tr>
<tr>
<td>G</td>
<td>Date of CCS Referral</td>
<td>MM/DD/YYYY</td>
<td>10</td>
<td>Date of CCS referral to County for eligibility determination.</td>
</tr>
<tr>
<td>H</td>
<td>CCS Eligible Diagnosis</td>
<td>CHAR Always Required</td>
<td>50</td>
<td>ICD-10 code of CCS Eligible medical condition diagnosis used for referral.</td>
</tr>
</tbody>
</table>
Listed below are the items required for your Pre-contractual Audit
All Desktop documents are due by the date specified in the Notice of Pre-Contractual Audit Letter.

<table>
<thead>
<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th>DELEGATION OVERSIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
<td>Biographical Information</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Sub-Contracted Service by Facility/Agency</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td><strong>All sections</strong> of the Audit tool documented with <strong>road mapping</strong> instructions for each element (see sample roadmap)</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Organizational chart(s)</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Current job descriptions as relevant to the audit</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Delegation Agreements with any sub-delegated provider</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Ownership and Control Documentation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th>QUALITY MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
<td>Quality Improvement Committee meeting minutes from the auditing period that identify the following occurred during the meeting</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>- Recommendation of policy decisions</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>- Review and evaluation of QI activities</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>- Practitioner participation in the QI program through planning, design, implementation or review</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>- Identification and follow up of needed actions</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Sample Program Plan and Description</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Sample Annual WorkPlan</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Sample Annual Program Evaluation</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Notification of Termination policy and evidence that members were notified of practitioner termination</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Continued Access to Practitioners policy and evidence that the delegate followed policy requirements</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Sample supportive documentation or materials such as studies, audits, and surveys completed during the reporting period</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th>UTILIZATION MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
<td>Sample Program, Plan and Description</td>
</tr>
</tbody>
</table>
### Utilization Management

<table>
<thead>
<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
<td>Sample Annual Work Plan</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Sample Annual Program Evaluation</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Policies and Procedures</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Committee meeting minutes from last twelve (12) months for:</td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>- Board of Directors</td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>- Utilization Management Committee</td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>- Subcommittee Meeting Minutes</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Annual Inter-rater Reliability Audit (On-Site Review)</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Sample if Semi-Annual Health Plan Reports for the last twelve (12) months;</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Two (2) examples that demonstrate the use of Board Certified consultants to assist with determinations</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Criteria for Length of Stay and Medical Necessity used during the past two (2) years</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Fifteen (15) redacted referral files to include Denials, Modifications, Cancellations and Approvals; (conducted via Webinar)</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Utilization Management statistics from the last twelve (12) months;</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Evidence that the Affirmative Statement has been distributed to providers and employees who make UM decisions;</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>Evidence, other than via a denial letter, that the providers have been notified that they may contact a physician reviewer to discuss denial decisions;</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Sample Provider communications from last twelve (12) months</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>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</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Copies of most recent mailroom policies</td>
</tr>
</tbody>
</table>

### Care Management

<table>
<thead>
<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
<td>Program Plan and Description and CM applicable policies and procedures if different from UM; (Desk Review)*</td>
</tr>
</tbody>
</table>
### Inland Empire Health Plan
### Pre-Contractual Audit Preparation Instructions
### Medi-Cal

<table>
<thead>
<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th>CARE MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Five (5) Redacted CM files with all required attachments (conducted via Webinar)</td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>Five (5) Redacted sample cases of Carve Out/ Waiver Programs/ Termination of PCP/ Dis-enrollments/ Transition of Care/ SPC member letters <strong>(On-site Review)</strong></td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>California Children’s Services (CCS) logs- Redacted: Five (5) randomly pulled redacted CCS Case Management files</td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>Redacted documentation of coordination of care with county mental health clinics for Members receiving specialty mental health services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th>CREDENTIALING (Look back period of)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>✓</td>
<td>Credentialing Policies and Procedures</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Sample Credentialing meeting minutes including date and voting attendees from the look back period, which may include, but not limited to, references from:</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>- Sample Quality Management Committee Minutes</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>- Sample Credentialing Committee Minutes</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>- Sample Peer Review Committee Minutes</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>30 Credentialing files selected by Delegate</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>30 Recredentialing files selected by Delegate</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Evidence of Ongoing Monitoring of Sanctions</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Practitioner files of those providers terminated for Quality Issues</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Practitioner files that have appealed a decision</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>Sample Delegation Agreements with any sub-delegated provider</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>HIV/AIDS Annual Survey</td>
</tr>
</tbody>
</table>
Inland Empire Health Plan  
Pre-Contractual Audit Preparation Instructions  
Medi-Cal

<table>
<thead>
<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th>CREDENTIALING (Look back period of)</th>
</tr>
</thead>
</table>
| ✔️      |         | Policy and File review will include, but not limited to, review for the following items:  
- Performance Monitoring;  
- Medicare Opt-Out Review;  
- Medicare Exclusions/Sanctions;  
- Medi-Cal Suspended & Ineligibility;  
- Reporting to Authorities;  
- Fair Hearing Panel Composition;  
- Assessment of Organizational Providers;  
- Delegation Agreements for all Sub-Delegation Arrangements;  
- Human Immunodeficiency Virus (HIV/AIDS) Identification Process;  
- Drug Enforcement Administration (DEA) Verifications within one hundred and eighty (180) calendar days;  
- Work History verification within one hundred and eighty (180) calendar days; and  
Hospital Admitting Privileges. |

<table>
<thead>
<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th>CLAIMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td></td>
<td>Policies and Procedures</td>
</tr>
</tbody>
</table>
| ✔️      |         | Contracts Boilerplate(s) for:  
- PCP’s, Specialists, Ancillary Providers, Hospitals |
| ✔️      |         | Blinded Claims Sample:  
- 15 Paid (See Claims Sample Detail Below)  
- 5 Denied (See Claims Sample Detail Below)  
- 5 Provider Payment Disputes (See Claims Sample Detail Below) |
| ✔️      |         | Sample Reports and Logs:  
- Paid Claims (See Claims Sample Detail Below)  
- Denied Claims (See Claims Sample Detail Below)  
- Resolved Provider Disputes (See Claims Sample Detail Below) |
## Pre-Contractual Audit Preparation Instructions

### Medi-Cal

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<thead>
<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th>CLAIMS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Pended Claims (See Claims Sample Detail Below)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Open Claims/Inventory (See Claims Sample Detail Below)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Overpayments (See Claims Sample Detail Below)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Check Mailing Attestation Log (See Claims Sample Detail Below)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Redirected Claims (See Claims Sample Detail Below)</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Claims Processing Systems Review</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Operational Review</td>
</tr>
</tbody>
</table>

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<th>COMPLIANCE</th>
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</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
<td>Compliance Policies and procedures</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Fraud, Waste and Abuse Policies and procedures</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security policies and procedures</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Standards/Code of Conduct</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Copies of Compliance, FWA, and Privacy Training</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Committee meeting minutes from last 12 months to include agenda and sign-in sheet (attendance):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Compliance Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Subcommittees</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Annual Compliance Work Plan</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Annual Audit Plan</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Annual Risk Assessment</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Sanction/Exclusion Screening Process policies and procedures</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>
Inland Empire Health Plan
Pre-Contractual Audit Preparation Instructions
Medi-Cal

<table>
<thead>
<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th>COMPLIANCE</th>
</tr>
</thead>
</table>
| ✓       |         | 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 |
| ✓       |         | Data Integrity Controls and Access Safeguards policies and procedures |
| ✓       |         | The name of the medical management system(s) used for the utilization management, care management, and claims functions. |
| ✓       |         | The participation of an appropriate systems administrator / IT representative that configures user access to the medical management system(s) used for the utilization management, care management, and claims functions. *May be conducted via WebEx.* |
| ✓       |         | A walkthrough of the medical management system(s) to validate data integrity controls and access safeguards. *May be conducted via WebEx.* |
| ✓       |         | User Types Universe: Submit a universe of user types/profiles for the medical management system(s) and claim management system(s). Include descriptions of user types and their applied permissions. Refer to tab *E. Universe_User Types* of the Compliance tool for required template. |
| ✓       |         | Active Users Universe: Submit a universe of all active users within the medical management(s) and the claims management system(s). Refer to tab *F. Universe_Active Users* of the Compliance tool for required template. |
## Inland Empire Health Plan
**Pre-Contractual Audit Preparation Instructions**
**Medi-Cal**

### Claims Sample Details

<table>
<thead>
<tr>
<th>Applicant Entity Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Date:</td>
<td></td>
</tr>
</tbody>
</table>

### PROVIDE FOLLOWING DOCUMENTS FOR CLAIMS REVIEW:

<table>
<thead>
<tr>
<th>1</th>
<th><strong>Paid/Denied (15 paid claims; 5 denied claims; include a mix of contracted and non-contracted outpatient hospital, emergency claims, professional, radiology, labs, anesthesia, other for Medi-Cal and Commercial paid or denied in past 90 days)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Actual Claim Form and supporting documentation submitted with claim (include a mix of contracted and non-contracted outpatient hospital, emergency claims, professional, radiology, labs, anesthesia, other for Medi-Cal and Commercial)</td>
</tr>
<tr>
<td>b.</td>
<td>Provider explanation of benefits or remittance advice for claims and resolved disputes</td>
</tr>
<tr>
<td>c.</td>
<td>Copy of check with documentation regarding date the check was cashed</td>
</tr>
<tr>
<td>d.</td>
<td>Denial letters</td>
</tr>
<tr>
<td>e.</td>
<td>Acknowledgement of Receipt or Proof of Date Entered in System</td>
</tr>
<tr>
<td>f.</td>
<td>Any correspondence and/or pertinent information related to the claim or dispute, including evidence of medical review, eligibility screens, authorizations, information request letters, overpayment/adjustment requests, dispute documentation, original claim information for disputed claims (including claim and EOB/RA), overpayment documentation, applied overpayments (refunds or retractions), etc.</td>
</tr>
<tr>
<td>g.</td>
<td>Copy of fee schedule or contract rate applied to each claim or dispute. 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.</td>
</tr>
<tr>
<td>h.</td>
<td>Copies of contracts or letter of agreements 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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2</th>
<th><strong>Provider Disputes (5 disputes - both overturns and upholds for contracted and non-contracted providers within past 90 days)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Dispute Form and supporting documentation submitted with dispute</td>
</tr>
<tr>
<td>b.</td>
<td>Original Claim (face sheet with date of receipt visible) and EOB</td>
</tr>
<tr>
<td>c.</td>
<td>EOB for Resolved Dispute</td>
</tr>
<tr>
<td>d.</td>
<td>Provider Dispute acknowledgement Letter</td>
</tr>
<tr>
<td>e.</td>
<td>Provider Dispute Resolution Letter(s)</td>
</tr>
<tr>
<td>f.</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 |
| **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 |
## Inland Empire Health Plan
### Pre-Contractual Audit Preparation Instructions
#### Medi-Cal

<table>
<thead>
<tr>
<th>Section</th>
<th>Fields</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Claims/Inventory</td>
<td>- Member name&lt;br&gt;- Member ID#&lt;br&gt;- Date of Service&lt;br&gt;- Provider of Service&lt;br&gt;- Amount Billed&lt;br&gt;- Date claim received&lt;br&gt;- Status of claim received&lt;br&gt;- Status of claim</td>
</tr>
<tr>
<td>Overpayments</td>
<td>- Member Name&lt;br&gt;- Member ID#&lt;br&gt;- Original Claim #&lt;br&gt;- Date original claim Paid/Denied&lt;br&gt;- Provider of service&lt;br&gt;- Provider Contract Status&lt;br&gt;- Date of request for overpayment&lt;br&gt;- Date overpayment processed in System&lt;br&gt;- Recovery Type (i.e., withhold, refund, none)&lt;br&gt;- Total Dollars Recovered</td>
</tr>
<tr>
<td>Resolved Provider Disputes</td>
<td>- Service Date of Claim being Disputed&lt;br&gt;- Original Claim #&lt;br&gt;- Date Dispute Received&lt;br&gt;- Dispute ID #&lt;br&gt;- Submission Type of Dispute (i.e., paper, electronic)&lt;br&gt;- Date Dispute Acknowledged&lt;br&gt;- Provider Submitting Dispute&lt;br&gt;- Disputing Provider Contract Status&lt;br&gt;- Dispute Decision (i.e., upheld, overturned, goodwill)&lt;br&gt;- Date Dispute Resolved&lt;br&gt;- Working Days to Resolution</td>
</tr>
<tr>
<td>Redirected Claims</td>
<td>- Date Received&lt;br&gt;- Billing Provider of Service&lt;br&gt;- Date of Service&lt;br&gt;- Patient Identifier (name, ID#, etc.)&lt;br&gt;- Date Redirected&lt;br&gt;- Where Redirected&lt;br&gt;- Claim # (if applicable)</td>
</tr>
<tr>
<td>Check Mailing Attestation Log</td>
<td>Check #</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------</td>
</tr>
</tbody>
</table>

## NCQA QI 1: Program Structure

The organization clearly defines its quality improvement (QI) structures and processes and assigns responsibility to appropriate individuals.

### Element A - QI Program Structure

<table>
<thead>
<tr>
<th>Point Value</th>
<th>Include: Document Name, Page and Sections</th>
<th>Comment / Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 0.5 1</td>
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</tbody>
</table>

1. The QI program structure.
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.

### Total Requirements Element A - QI Program Structure

<table>
<thead>
<tr>
<th>Requirement Met</th>
<th>% of Requirement Met</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>0%</td>
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</table>

### Element B - Annual Work Plan

The organization develops and executes an annual work plan that reflects ongoing activities throughout the year and addresses:

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<tr>
<th>Point Value</th>
<th>Include: Document Name, Page and Sections</th>
<th>Comment / Guidance</th>
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<tr>
<td>0 0.5 1</td>
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</tbody>
</table>

1. Yearly planned QI activities and objectives.
2. Time frame from each activity’s completion.
3. Staff members responsible for each activity.
4. Evaluation of the QI program.

### Total Requirements Element B - Annual Work Plan

<table>
<thead>
<tr>
<th>Requirement Met</th>
<th>% of Requirement Met</th>
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<tbody>
<tr>
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</table>

### Element C - Annual Evaluation

The organization conducts an annual written evaluation of the QI program that includes the following information:

<table>
<thead>
<tr>
<th>Point Value</th>
<th>Include: Document Name, Page and Sections</th>
<th>Comment / Guidance</th>
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<tr>
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</table>

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 of its progress toward influencing networkwide safe clinical practices.

### Total Requirements Element C - QI Program Structure

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<th>Requirement Met</th>
<th>% of Requirement Met</th>
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</table>

### Element D - QI Committee Responsibilities

The organization’s QI Committee:

<table>
<thead>
<tr>
<th>Point Value</th>
<th>Include: Document Name, Page and Sections</th>
<th>Comment / Guidance</th>
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<tbody>
<tr>
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</table>

1. Recommends policy decisions.
2. Analyzes and evaluates the results of QI activities.
3. Ensures practitioner participation in the QI program through planning, design, implementation or review.
4. Identifies needed actions.
5. Ensures follow-up, as appropriate.

### Total Requirements Element D - QI Committee Responsibilities

<table>
<thead>
<tr>
<th>Requirement Met</th>
<th>% of Requirement Met</th>
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## NCQA NET 4: Continued Access to Care

The organization monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network.

### Element A - Notification of Termination

The organization uses information at its disposal to facilitate continuity and coordination of care across its delivery system.

<table>
<thead>
<tr>
<th>Point Value</th>
<th>Include: Document Name, Page and Sections</th>
<th>Comment / Guidance</th>
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<tr>
<td>0 0.5 1</td>
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</tbody>
</table>

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.

### Total Requirements Element A - Notification of Termination

<table>
<thead>
<tr>
<th>Requirement Met</th>
<th>% of Requirement Met</th>
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### Element B - Continued Access to Practitioners

If a practitioner’s contract is discontinued, the organization allows affected members continued access to the practitioner, as follows:

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<tr>
<th>Point Value</th>
<th>Include: Document Name, Page and Sections</th>
<th>Comment / Guidance</th>
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</table>

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.
2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.

### Total Requirements Element B - Continued Access to Practitioners

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<tr>
<th>Requirement Met</th>
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</table>
### INLAND EMPIRE HEALTH PLAN

**REQUEST FOR UM CRITERIA LOG**

IPA Name: ___________________________  Log for Year: ___________________________

<table>
<thead>
<tr>
<th>Date Requested</th>
<th>Date Sent</th>
<th>Sent via: F = fax, EM = email, GM = ground mail</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>
</tr>
</thead>
<tbody>
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</table>

**Legend:**
- **F** = Fax
- **MC** = Medi-Cal
- **CMC** = IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)
- **EM** = email
- **GM** = Ground
<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>
### INLAND EMPIRE HEALTH PLAN
### SECOND OPINION TRACKING LOG

**IPA Name:** ___________________________  **Date Submitted:** ___________________________

**Report for Month of:** ___________________________  **Submitted by:** ___________________________

<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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Approved</td>
<td></td>
<td></td>
<td>Modified</td>
<td>Approved</td>
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<td></td>
<td></td>
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<td>Modified</td>
<td></td>
<td></td>
<td>Denied</td>
<td>Modified</td>
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<td></td>
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<td></td>
<td>Denied</td>
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<td>Denied</td>
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</tbody>
</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>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2. Home Health Agency</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
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<tr>
<td>3. DME, Orthotics, Prosthesis</td>
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<tr>
<td>4. Mental Health</td>
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Note: The Delegated Credentialing function is evaluated separately.
## Referral Universe

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<th>Priority of Referral*</th>
<th>Date Request Received</th>
<th>Time Request Received (urgent requests)</th>
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<th>Requested Provider Specialty</th>
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<th>Service Category</th>
<th>Diagnosis</th>
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<th>Reason for Denial/Modification/ Cancellation***</th>
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<th>Date Provider Notified</th>
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* Priority of Referral: Urgent, Routine, Concurrent, Post-Service  
** Referral Disposition/Decision: Approved, Modified/Partially Approved, Denied, Cancelled  
*** Reason for denial/modification: Not medically necessary, not a covered benefit, carve out, out of network, etc.  
**** Date Effectuated: Date of effectuation / when was the authorization available in the claims system
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## Medi-Cal Provider Reporting Requirements Schedule

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## Medi-Cal Provider Reporting Requirements Schedule

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## Medi-Cal Provider Reporting Requirements Schedule

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MC 20G - Claims and Provider Dispute Resolution Reporting

Claims

IEHPName_MCL_MTR_MM_2021

Claims Timeliness/Year/Month

28 CCR 1300.71 Section (e)(3)
## Medi-Cal Provider Reporting Requirements Schedule

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## Medi-Cal Provider Reporting Requirements Schedule
### IPA Medi-Cal Calendar Year Reporting Period 2021

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<th>IPA Deliverable</th>
<th>Report Frequency</th>
<th>CY 2021 Reporting Period</th>
<th>Date Due to IEHP</th>
<th>Policy Number(s)</th>
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<th>SFTP Folder</th>
<th>Regulatory Measure(s)</th>
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<tr>
<td>Compliance - Annual HIPAA Program Description</td>
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<td>MC 23D HIPAA Protected Health Info (PHI)</td>
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<td>Compliance - Annual HIPAA Program Description: Code of Federal Regulations, Title 45, Part 160, 162, and 164; U.S. Dept. of Health and Human Services (DHHS), section 13402(h)(2) of Public Law 111-5 (HITECH ACT).</td>
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<td>Compliance - Standards/Code of Conduct</td>
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<td>Compliance - Compliance, FWA, and Privacy Training</td>
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<td>Compliance - Annual Compliance Workplan</td>
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<td>Compliance - Annual Audit Plan</td>
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<td>Compliance - Annual Risk Assessment</td>
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<td>Compliance - Sanction/Exclusion Screening Process policies and procedures</td>
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<td>Compliance - List of Downstream Entity/Subcontractors</td>
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<td>Compliance - Evidence of Sanction/Exclusion Screening, training completion, and annual confidentiality statement</td>
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## Medi-Cal Provider Reporting Requirements Schedule

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<th>File Naming Convention</th>
<th>SFTP Folder</th>
<th>Regulatory Measure(s)</th>
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<td>Compliance - Data Integrity Controls and Access Safeguards policies and procedures</td>
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<tr>
<td>Current Profile, Contract and W-9 (to include any applicable attachments i.e. Attachment I, Practice Agreements, Standardized Procedures, Applicable Contract Addendums)</td>
<td>As needed</td>
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<td>As required for Initial Credentialing Applications</td>
<td>MC 25B10 - Credentialing Standards, Credentialing Quality Oversight of Delegates</td>
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<td>IPA Code_Last Name, First Name_YYYY_MM_DD (YYYY_MM-DD = Date submitted to IEHP)</td>
<td>Credentialing/ and Email to <a href="mailto:CredentialingProfileSubmission@iehp.org">CredentialingProfileSubmission@iehp.org</a></td>
<td>Per most current IEHP, NCQA, State and regulatory guidelines</td>
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<td>Per most current IEHP, NCQA, State and regulatory guidelines</td>
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<td>Written and approved Credentialing, Recredentialing, Peer Review Policies and Procedures</td>
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<td>01/31 - 12/31</td>
<td>Within (30) days following Credentialing Committee approval and prior to on-site and/or desktop audit</td>
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